New York State
UB-04 Billing Guidelines

BRIDGES TO HEALTH WAIVER

Version 2011 - 02

9/14/2011

eMedNY is the name of the electronic New York State Medicaid system. The eMedNY system allows New York Medicaid providers to submit claims and receive payments for Medicaid-covered services provided to eligible members.

eMedNY offers several innovative technical and architectural features, facilitating the adjudication and payment of claims and providing extensive support and convenience for its users.

The information contained within this document was created in concert by DOH and eMedNY. More information about eMedNY can be found at www.emedny.org.

TABLE OF CONTENTS

***For eMedNY Billing Guideline questions, please contact the eMedNY Call Center** 1-800-343-9000.*

1. Purpose Statement

The purpose of this document is to augment the General Billing Guidelines for institutional claims with the NYS Medicaid specific requirements and expectations for the Bridges to Health Waiver.

For providers new to NYS Medicaid, it is required to read the General Institutional Billing Guidelines available at www.emedny.org or by clicking: General Insitutional Billing Guidelines.

2. Claims Submission

Bridges to Health Waiver providers can submit their claims to NYS Medicaid in electronic or paper formats.

2.1 Electronic Claims

Bridges to Health Waiver providers who choose to submit their Medicaid claims electronically are required to use the HIPAA 837 Institutional (837I) transaction.

2.2 Paper Claims

Bridges to Health Waiver providers who choose to submit their claims on paper forms must use the National Uniform Billing Committee (NUBC) UB-04 claim form.

To view a sample Bridges to Health Waiver UB-04 claim form, see Appendix A. The displayed claim form is a sample and is for illustration purposes only.

2.3 Bridges to Health Waiver Services Billing Instructions

This subsection of the Billing Guidelines covers the specific NYS Medicaid billing requirements for Bridges to Health Waiver providers. Although the instructions that follow are based on the UB-04 paper claim form, they are also intended as a guideline for electronic billers to find out what information they need to provide in their claims. For further electronic claim submission information, refer to the eMedNY 5010 Companion Guide which is available at www.emedny.org by clicking: eMedNY Transaction Information Standard Companion Guide CAQH - CORE CG X12.

It is important that providers adhere to the instructions outlined below. Claims that do not conform to the eMedNY requirements as described throughout this document may be rejected, pended, or denied.

2.3.1 UB-04 Claim Form Field Instructions

Statement Covers Period From/Through (Form Locator 6)

837I Ref: Loop 2300 DTP03 when DTP01 = 434

Enter the date(s) of service claimed in accordance with the instructions provided below.

- ***When billing for one date of service***, enter the date in the FROM box. The THROUGH box may contain the same date or may be left blank.
- ***When billing for multiple dates of service for the same rate code***, enter the first service date of the billing period in the FROM box and the last service date in the THROUGH box. The FROM/THROUGH dates must be in the same calendar month. Instructions for billing multiple dates of service are provided below in Form Locators 42 – 47.

- ***When billing for monthly rates***, only ***one*** date of service can be billed per claim form. Enter the date in the FROM box. The THROUGH box may contain the same date or may be left blank.

Dates must be entered in the format MMDDYYYY.

NOTES:

- ***The provider's paper remittance statement will only contain the date of service in the "FROM" box with the total number of units for the sum of all dates of service reported below. Providers who receive an electronic 835 remittance will receive only the claim level dates of service (from and through) as reported on the incoming claim transaction.***
- ***Claims must be submitted within 90 days of the date of service entered in this field unless acceptable circumstances for the delay can be documented. Information about billing claims over 90 days or two years from the Date of Service is available in the All Providers General Billing Guideline Information section available at www.emedny.org by clicking on the link to the webpage as follows:*** Information for All Providers.

Serv. Date (Form Locator 45)

837I Ref: Loop2400 DTP03 when DTP01 = 472

Services Furnished on a Monthly Basis

Submit using a date of service of the first day of the month following the service provision. For example, Health Care Integrator (HCI) services rendered during January are billed using February 1st. If the member loses eligibility any day during the month prior to the billing month, providers would enter the date on which the member's waiver eligibility ended as the service date.

Services Rendered During a Transfer Month

- For services rendered on the 1st half-month basis, use the first day of the month following the service provision as the date of service.
- For services rendered on the 2nd half monthly basis, use the second day of the month following the provision of services. For example, HCI services provided by the new HCIA during the last half of January are billed using February 2nd.

Services Rendered on a Daily, Hourly or 15 Minute Basis

Submit using the actual date the service was provided. For example, if Skill Building is provided on January 14th, then that day is used as the date of service.

Enter the service date corresponding to each iteration of a revenue code other than 0001. The dates entered here must be contained within the billing period (FROM/THROUGH) in Form Locator 6.

NOTE: If multiple dates of service for the same rate code are reported on multiple lines of the claim form, providers should be aware that the only date of service reported on the provider's remittance statement will be the date of service reported in FL 6 (the from date).

Serv. Units (Form Locator 46)

837I Ref: Loop2400 SV205

If billing for more than one unit of service, enter the number of units on the same line where a Revenue Code other than Revenue Code 0001 was entered in Form Locator 42. For determining the number of units, follow the guidelines below.

If the rate is based on increments, such as one-hour of service, enter the units that reflect the total Bridges to Health Waiver service time being claimed.

The following is a list of Bridges To Health rate codes and how the Service Date field is to be completed. Providers must bill only the rate codes they have been assigned by NYS DOH.

- Regular Full Month - Rate Codes 1300, 1327, 1354:

  The date of service must be the first day of the month subsequent to the month in which the services were rendered.

- Enrollment Month (Rate Codes 1301, 1328, 1355):

  For network development and other case-related activities during initial enrollment period. Billed only one time per child.

- HCIA Transfer from Original HCIA (Rate Codes 1302, 1329, 1356):
  - The date of service must be the first day of the month subsequent to the month in which the services were rendered.
  - For case transfers from original HCIA, the number of days assigned must be greater than or equal to11 days but less than 21 days.

- HCIA Transfer to a New HCIA (Rate Codes 1303, 1330, 1357):
  - The date of service must be the second day of the month, subsequent to the month in which the services were rendered.
  - For case transfers to another HCIA, the number of days assigned must be greater than or equal to 11 days but less than 21 days.

- Hospitalization Occurrence from 1-10 days (Rate Codes 1304, 1331, 1358):
  - The date of service must be the first day of the month subsequent to the month in which the services were rendered.
  - The number of days hospitalized must be greater than or equal to 1 day but less than or equal to 10 days.

- Hospitalization Occurrence from 11-30 days (Rate Codes 1305, 1332, 1359):
  - The date of service must be the first day of the month subsequent to the month in which the services were rendered.
  - The number of days hospitalized must be greater than or equal to 11 but less than or equal to 30.

Service Units (Form Locator 46)

837I Ref: Loop2400 SV205

The following rate codes must be billed according to the units shown in Exhibit 2.4.1-11.

Exhibit 2.4.1-11

Service	Rate Codes	Description	Units
Family Caregiver Supports and Services	1306 SED 1333 DD 1360 MedF	Individual rate	Per 15 minutes
Family Caregiver Supports and Services	1307 SED 1334 DD 1361 MedF	Group rate	Per 15 minutes
Skill Building	1308 SED 1335 DD 1362 MedF	Individual rate	Per 15 minutes
Skill Building	1309 SED 1336 DD 1363 MedF	Group rate	Per 15 minutes
Day Habilitation	1310 SED 1337 DD 1364 MedF	Individual rate	Per hour
Day Habilitation	1311 SED 1338 DD 1365 MedF	Group rate	Per hour
Special Needs Community Advocacy and Support	1312 SED 1339 DD 1366 MedF	Individual rate	Per 15 minutes
Special Needs Community Advocacy and Support	1313 SED 1340 DD 1367 MedF	Group rate	Per 15 minutes
Prevocational Services	1314 SED 1341 DD 1368 MedF	Individual rate	Per hour
Prevocational Services	1315 SED 1342 DD 1369 MedF	Group rate	Per hour
Supported Employment	1316 SED 1343 DD 1370 MedF	Individual rate	Per 15 minutes
Planned Respite	1317 SED 1344 DD 1371 MedF	Less than full day rate	Per 15 minutes
Planned Respite	1318 SED 1345 DD 1372 MedF	Full day rate	Per day
Crisis Avoidance, Management and Training	1319 SED 1346 DD 1373 MedF	Individual rate	Per 15 minutes
Crisis Avoidance, Management and Training	1320 SED 1347 DD 1374 MedF	Group rate – charged for each child in the group	Per 15 minutes
Immediate Crisis Response Services	1321 SED 1348 DD 1375 MedF	Individual rate	Per 15 minutes
Intensive In-home Supports and Services	1322 SED 1349 DD 1376 MedF	Individual rate	Per 15 minutes
Crisis Respite	1323 SED 1350 DD 1377 MedF	Less than full day rate	Per 15 minutes
Crisis Respite	1324 SED 1351 DD 1378 MedF	Full day rate	Per day
Adaptive and Assistive Equipment	1325 SED 1352 DD 1379 MedF	Submit the full amount charged in FL 47 Total Charges	Units must be blank
Accessibility Modifications	1326 SED 1353 DD 1380 MedF	Submit the full amount charged in FL 47 Total Charges	Units must be blank

3. Remittance Advice

The Remittance Advice is an electronic, PDF or paper statement issued by eMedNY that contains the status of claim transactions processed by eMedNY during a specific reporting period. Statements contain the following information:

- A listing of all claims (identified by several items of information submitted on the claim) that have entered the computerized processing system during the corresponding cycle
- The status of each claim (denied, paid or pended) after processing
- The eMedNY edits (errors) that resulted in a claim denied or pended
- Subtotals and grand totals of claims and dollar amounts
- Other pertinent financial information such as recoupment, negative balances, etc.

The General Remittance Advice Guidelines contains information on selecting a remittance advice format, remittance sort options, and descriptions of the paper Remittance Advice layout. This document is available at www.emedny.org by clicking: General Remittance Billing Guidelines

APPENDIX A
CLAIM SAMPLES

The eMedNY Billing Guideline Appendix A: Claim Samples contains images of claims with sample data.

Bridges to Health Waiver - UB-04 Sample Claim

APPROVED OMB NO. 0938-0279

- 1: City Home Care, 1 Maple Avenue, Anytown, NY 11111-1111
- 3a PAT. CNTL #: AB1234567
- b. MED. REC. #:
- 4 TYPE OF BILL: 340
- 5 FED. TAX NO.:
- 6 STATEMENT COVERS PERIOD FROM / THROUGH: 02012008
- 8 PATIENT NAME: Smith, William
- 9 PATIENT ADDRESS:
- 10 BIRTHDATE: 04191940
- 11 SEX: M
- ADMISSION: 12 DATE, 13 HR, 14 TYPE, 15 SRC
- 16 DHR
- 17 STAT: 30
- CONDITION CODES 18–28
- 29 ACDT STATE
- 30
- 31–34 OCCURRENCE CODE / DATE
- 35–36 OCCURRENCE SPAN CODE / FROM / THROUGH
- 37
- 38

39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
61	003.	24	1300.	A3	00.00

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
0001			02012008		180.00		

PAGE ___ OF ___ CREATION DATE TOTALS

50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE
Blue Cross					
Medicaid					

- 56 NPI:
- 57 OTHER PRV ID: None / 00123456

58 INSURED'S NAME	59 P. REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
		None		
		AB12345C		

- 63 TREATMENT AUTHORIZATION CODES
- 64 DOCUMENT CONTROL NUMBER
- 65 EMPLOYER NAME
- 66 DX
- 67: 854.05
- A B C D E F G H / I J K L M N O P Q
- 68
- 69 ADMIT DX
- 70 PATIENT REASON DX: a b c
- 71 PPS CODE
- 72 ECI: a b c
- 73
- 74 PRINCIPAL PROCEDURE CODE / DATE; a. OTHER PROCEDURE CODE / DATE; b. OTHER PROCEDURE CODE / DATE; c. OTHER PROCEDURE CODE / DATE; d. OTHER PROCEDURE CODE / DATE; e. OTHER PROCEDURE CODE / DATE
- 75
- 76 ATTENDING NPI QUAL LAST FIRST
- 77 OPERATING NPI QUAL LAST FIRST
- 78 OTHER NPI QUAL LAST FIRST
- 79 OTHER NPI QUAL LAST FIRST
- 80 REMARKS
- 81 CC a b c d

NUBC

THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.