



New York State UB04 Billing Guidelines

**INTERMEDIATE CARE FACILITIES FOR THE
DEVELOPMENTALLY DISABLED (ICF/DD)**



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.

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***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 Intermediate Care Facilities for the Developmentally Disabled (ICF/DD) service providers.

For providers new to NYS Medicaid, it is required to read the All Providers General Billing Guideline Information available at www.emedny.org by clicking: [General Institutional Billing Guidelines](#).

2. Claims Submission

ICF/DD providers can submit their claims to NYS Medicaid in electronic or paper formats.

2.1 Electronic Claims

ICF/DD providers who choose to submit their Medicaid claims electronically are required to use the HIPAA 837 Institutional (837I) transaction.

2.2 Paper Claims

ICF/DD 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 ICF/DD UB-04 claim form, see Appendix A.

2.3 ICF/DD Services Billing Instructions

This subsection of the Billing Guidelines covers the specific NYS Medicaid billing requirements for ICF/DD 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, pending, or denied.

2.3.1 UB-04 Claim Form Field Instructions

Value Codes (Form Locators 39-41)

837I Ref: Loop 2300 HI0x-2

Recurring Monthly Income - Value Code 23

Value Code

Code **23** should be used to indicate that the member's Net Available Monthly Income (NAMI) amount is entered under Amount.

Value Amount

Enter the NAMI amount approved by the local Social Services agency as the member's monthly budget.

In cases where the member's budget has increased, the new amount, rather than the current budgeted amount, should be entered.

If billing occurs more than once a month, enter the full NAMI amount on the *first* claim submitted for the month.

Medicaid Covered Days – Value Code 80

Value Code

Code 80 must be used to indicate the total number of days that are covered by Medicaid. If only Medicare co-insurance days are claimed, do not report code 80.

Value Amount

Enter the actual number of days covered by Medicaid. The Covered Days must be entered to the left of the dollars/cents delimiter.

Note: The sum of Medicaid Full covered days, Medicaid non-covered days and Medicare co-insurance days must correspond to the Statement Covers Period in Form Locator 6 and should not reflect the day of discharge.

Rev. Cd. [Revenue Code] (Form Locator 42)

837I Ref: Loop 2400 SV201

Revenue Codes identify specific accommodations, ancillary services, or billing calculations.

NYS Medicaid uses Revenue Codes to identify the following information:

- 0001 (Total Charge) must be present on paper claims and is not used for electronic
- 0185 – Hospital Leave
- 0183 – Therapeutic Leave

Total Charges

Use Revenue Code **0001** to indicate that total charges are entered in Form Locator 47.

Hospital Leave

The patient was hospitalized during the billing period and bed retention was involved. If bed retention for hospitalization was not involved, hospital leave is not applicable. Please refer to the ICF/DD Provider Manual, Policy Guidelines section, for bed reservation information.

If applicable, use Revenue Code **0185** to indicate that the number of Hospital Leave days is entered in Form Locator 46.

Hospital Leave must not be claimed together with regular billing; these claims must be submitted on a separate form.

Therapeutic Leave

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These are overnight absences that include leave for personal reasons or to participate in medically acceptable therapeutic or rehabilitative plans of care. Please refer to the ICF/DD Manual, Policy Guidelines Section, for Bed Reservation information.

If applicable, use Revenue Code **0183** to indicate that the number of Therapeutic Leave days is entered in Form Locator 46.

Therapeutic Leave must not be claimed together with regular billing; these claims must be submitted on a separate form.

Serv. Units (Form Locator 46)

837I Ref: Loop2400 SV205

If Revenue Code 0185 (Hospital Leave) was used in Form Locator 42, enter the total number of Hospital Leave days on the same line where the revenue code appears. The number of units entered in this field must match the entry in Form Locators 39 – 41, Value Code 80, "Covered Days".

If Revenue Code 0183 (Therapeutic Leave) was used in Form Locator 42, enter the total number of Therapeutic Leave days on the same line where the revenue code appears. The number of units entered in this field must match the entry in Form Locators 39 – 41, Value Code 80, "Covered Days".

Other (Form Locator 78)

837I Ref: Loop 2310F NM1

NYS Medicaid uses this field to report the Referring/ Previous Provider.

Enter the NPI of the practitioner who made the determination that the patient should be placed in another facility.

Example: In the case of a patient moving to a hospital (hospital bed reservation), the practitioner who made the determination that the patient should be admitted to the hospital should be entered in this field as the referring provider. The provider number entered should be the NPI of the practitioner.

Completion of this field is required if an admission or a discharge occurred during the service period covered by this statement (Form Locator 6). If no admission or discharge occurred, leave this field blank.

For an Admission

Enter the NPI of the practitioner who determined that residential care was appropriate.

NOTE: If the patient is admitted from home, enter the NPI of the physician who last examined the patient and determined that ICF/DD nursing home care was appropriate. See instructions for entering an NPI below.

For a Discharge

Enter the NPI of the practitioner who made the discharge determination.

For a Bed Reservation

Enter NPI of the practitioner who admitted the patient to the hospital.

Instructions for Entering an NPI

Enter the code **“DN”** in the unlabeled field between the words **“OTHER”** and **“NPI”** to indicate the 10-digit NPI of the provider is entered in the box labeled **“NPI”**.

On the line below the ID numbers, enter the last name and first name of the provider. See the example in Exhibit 2.4.2-14.

Exhibit 2.3.1-1

The referring provider is John Smith with an NPI number 1234567890.

78 OTHER	DN	NPI 1234567890	QUAL		
LAST SMITH			FIRST JOHN		

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.

