

eMedNY

New York State Department of Health Office of Health Insurance Programs

837 Institutional Health Care Claim: Supplemental Companion Guide

NPI EDITION

eMedNY

HIPAA V4010X096A1 837: Health Care Claim: Institutional

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COMPANION GUIDE DISCLAIMER:

The New York State Department of Health (NYSDOH) has provided this Medicaid Supplemental Companion Guide for the 837 Institutional Transaction, Addendum version (ASC X12N 004010X096A1) for use by Providers, Clearinghouses and all Covered Entities who are Trading Partners of NYSDOH and the New York State Medicaid Program. NYSDOH has focused primarily on the rules and policies regulating the submission of NYS Medicaid data as specified within this Supplemental Companion Guide and the NYSDOH 837 Institutional Companion Guide. NYSDOH has provided this document with related information at <http://www.nyhipaadesk.com> as a resource to assist Providers and other Trading Partners in preparing HIPAA compliant electronic transactions in accordance with the program requirements of NYS Medicaid. NYSDOH does not offer individual training in the use of the ASC X12N transactions.

The information provided herein is believed to be true and correct based on the Addendum Version of the HIPAA guidelines. HIPAA regulations are continuing to evolve, therefore NYSDOH makes no guarantee, expressed or implied, as to the accuracy of the information provided herein. Furthermore, this is a living document and the information provided herein is subject to change as NYSDOH policy changes or as HIPAA legislation is updated or revised.

CG MODIFICATION TRACKING:

>V3.1

- 01/29/2009 Corrected typo in Section "Multiple Unit Rate Codes and the Service Line". HI*BE*24 was corrected to HI*BE:24.
- 12/29/2008 Minor rewording of Cost Avoidance/Zero Fill section.
- 11/20/2008 Modified text for Cost Avoidance Override/Zero Fill section to clarify usage when a payer prior to Medicaid denied the claim or paid zero.
- 09/16/2008 Corrected typo in Providers section, Billing Provider Secondary Identification sub-section. Qualifier "1J" is correct.
- 08/25/2008 Consolidated sections on Spend-down and NAMI into Patient Participation section. Removed codes for Catastrophic, Spend-down, and Surplus from Value Codes section.
- 08/11/2008 Revised National Provider Identifier section of front matter and Billing Provider section to reflect the eMedNY system requirements after NPI implementation.

>V3.0

- 02/06/2008 Changed "CHAP" to "SCHIP" to reflect renamed State Children's Health Insurance Program.
- 11/28/2007 Made corrections to the table in the Specialty Code Derivation section to accurately reflect system processing.
- 08/16/2007 Added the location of the 0FILL data, in addition to the note already present, in the section on Zero Fill.
- 05/02/2007 Removed the section "PAS Claims". The information will be moved to a new Provider Manual.
- 04/23/2007 Corrected the reference in the section "Rate Codes and Type of Bill" to point to the updated location on nyhipaadesk.com. The URL for the list is located under "Crosswalks".
- 03/10/2007 Added information to refer to the Technical Supplementary Companion Guide in NYS Medicaid Notes in the front matter
- 03/07/2007 Added new section Specialty Code Derivation (Clinic)
- 02/26/2007 Added information about non-payable Revenue Codes to Clinic Claims section.
- 02/05/2007 Changed title to reflect new name for NYSDOH Office of Health Insurance Programs, removed "NPI Edition" from title.

>V2.3

- 01/22/2007 – Significant rewording of NPI section to state that the eMedNY system will not be ready to receive the NPI as the primary provider identifier by the Compliance Date of May 23, 2007.
- 01/18/2007 – Modified text in SBR section, added information about Medicare HMO coverage. Also renamed the section.
- 10/30/2006 – Added Specialty Code 192 to table in "Service Authorization Exception Codes" section.
- 10/18/2006 – Corrected typo in NYS Medicaid Note of front matter.
- 09/29/2006 – Added PAS Claims section.
- 06/14/2006 – Added Clinic Claims section. Updated list of Revenue Codes for PAS and PAC. Minor rewording of Disclaimer and NYS Medicaid Note in front matter.
- 05/24/2006 – Removed PAC items and General Classification and AWOL Leave of Absence rows from Revenue Codes table. Removed PERS and OMH Rehabilitation from list in Multiple Unit Rate Codes and the Service Line section.
- 03/23/2006 – clarified Coordination of Benefits balancing in the CAS segment section
- 03/17/2006 – added new "National Provider Identifier (NPI)" section with critical information for sending NPI and related information prior to the Compliance Date of March 23, 2007

>V2.2

- 12/14/2005 – Changed example of "pointer" to the CG in NYS Medicaid Note in front matter
- 11/15/2005 – Removed "Differences between Phase I and Phase II" section from front matter, removed reference to Revenue Code 0240 in Revenue Code section
- 10/24/05 – Added A4, Family Planning to Condition Codes list in section 13

>V2.1

- 09/23/05 – Updated support phone numbers in front matter
- 04/20/05 – Added note about 16-digit TCN to CG Modification Tracking. Added note about TCN in voids and adjustments; and note about receiving TCN using 276/277 to NYS Medicaid Note in front matter. Corrected out-of-state Institutional Unit phone number.

- 04/18/05 – Removed Pre-School Supportive Health and Managed Care from list of multi-service line claims in Section 20 >V2.0
- 03/24/05 – Added Condition Code 60 to Condition Codes section

NYS MEDICAID NOTE:

This Supplemental Companion Guide (CG), which is provided by the New York State Department of Health (NYSDOH), outlines instructions specific to Providers who utilize the 837 Institutional Healthcare Claim (837I). The document includes a listing of the various code sets that are of particular interest to the NYS Medicaid claims processing system. As an aid to developers and programmers using this Supplemental CG, technical references have been added to serve as pointers to specific areas of the 837I Companion Guide (Example from Section 1: Loop-ID 1000A, NM1 where NM101=41 and NM102=1 or 2).

This Supplemental Companion Guide does not modify the standards; rather, it puts forth the subset of information from the Implementation Guide (IG) that will be required for processing transactions. It is important that Providers use this Guide as a supplement to the 837I Companion Guide, which itself is a supplement of the IG.

NYSDOH will process rate-based claims at the claim level (Loop 2300). The Rate Code is to be provided along with a Value Code in the HI (Value Information) segment of this loop. When more than one Procedure or Revenue Code is provided in multiple iterations of the service line loop, rate-based claim payment will still be determined according to the remittance amount associated with the Rate Code. Certain claim types can have multiple units applied to the Rate Code. This is accomplished at the Service Line level (Loop 2400). Please refer to section "Multiple Unit Rate Codes and the Service Line" for a list of claim types for which multiple units of the Rate Code can be applied.

Clinic claims must have a HCPCS code in the SV2 segment of one of the first three iterations of the 2400 loop. This requirement does not apply to Day Treatment or Day Care in a clinic setting. These services are not considered Clinic services and they should not include a HCPCS code.

Fee-for-service claims received with multiple service lines will be processed as a single claim under a single Transaction Control Number (TCN), however each service line will be priced independently. These claims do not contain a Rate Code. Refer to the section "Fee-for-Service on the 837I" for more information.

Voids and adjustments to previous claims require the Transaction Control Number (TCN) from the remittance advice. The TCN can also be retrieved by submitting a 276 transaction and receiving a 277.

Please refer to the Technical Supplementary Companion Guide for information about transaction header structures, transaction size limits, electronic communications methods, and enrollment as a trading partner. This document is available for download at nyhipaadesk.com.

For further assistance, NYSDOH and its fiscal agent, Computer Sciences Corporation (CSC), are urging Providers to visit a web community, <https://www.nyhipaadesk.com/> which will provide Companion Guide and Supplemental Guide updates and other pertinent information. In addition, questions may be sent to NYSDOH's Test Support Team at nyhipaadesk@csc.com.

Providers with questions may call the eMedNY Call Center at: 1-800-343-9000

Please be advised that Unit representatives will only answer questions related to New York Medicaid HIPAA requirements.

The ASC X12N Implementation Guides and their associated addenda are available in electronic format at: www.wpc-edi.com/hipaa.

1. Submitter Name:

The first entity identified in the transaction is the Submitter, identified in the Submitter Name segment (Loop-ID 1000A, NM1 where NM101=41 and NM102=1 or 2). NYSDOH will return the Remittance Advice (RA) to the Submitter identified by Electronic Transmitter Identification Number (ETIN, formerly referred to as TSN) at NM109. This ETIN may differ from the one reported in the ISA and GS segments. The Submitter is not a Provider in all cases. The Submitter may be an intermediary contracted for billing purposes, such as a service bureau or clearinghouse.

2. National Provider Identifier (NPI)

AS OF THE PUBLICATION DATE OF THIS DOCUMENT THE EMEDNY SYSTEM IS SCHEDULED FOR NPI IMPLEMENTATION ON SEPTEMBER 1, 2008. ALL NYS MEDICAID PROVIDERS WHO ARE HEALTH CARE PROVIDERS ARE REQUIRED TO VISIT EMEDNY.ORG TO REGISTER THEIR NPI(S) AS SOON AS POSSIBLE.

For information about the requirements for reporting NPI, refer to the NYS Medicaid Notes for the NM1 segments of each loop at levels 2310 and 2420 in the 837 Institutional Care Claim Companion Guide. Note that after the eMedNY system's NPI implementation the NPI must be used to identify all health care providers reported in the claim, with the sole exception of the Referring Provider reported in the Other Provider Name loop, who may be identified by NYS Medicaid Provider ID or License Number, only if the NPI is not available. However, every effort should be made to use the NPI of the Referring Provider when applicable.

3. Provider(s) Identified in the 837I Institutional Transaction:

Institutional claims submitted on an 837I can include information about a variety of providers. To successfully submit Institutional claims to NYSDOH, care must be taken to include all loops and segments required for processing NYS Medicaid claims.

Billing Provider Name:

NYSDOH requires the Billing Provider to be identified in the Billing Provider Name loop (Loop-ID 2010AA, starting with NM1 where NM101='85'). By default the Billing Provider is also processed as the Servicing Provider, unless the Attending Provider Name loop is sent.

NYSDOH encourages providers to send the NPI in this location. During the period leading up to the eMedNY NPI implementation, the Billing Provider Name NM1 segment that starts loop 2010AA will be accepted with the following Identifiers and Qualifiers:

- NPI (NM108 will contain a Qualifier of 'XX' and NM109 will contain the Billing Provider's NPI), or
- Employer ID Number (NM108 will contain a Qualifier of '24' and NM109 will contain the Billing Provider's Employer ID Number), or
- Social Security Number (NM108 will contain a Qualifier of '34' and NM109 will contain the Billing Provider's Social Security Number).

AFTER NPI IMPLEMENTATION THE NATIONAL PROVIDER IDENTIFIER (NPI) IN THE BILLING PROVIDER NAME NM1 SEGMENT WILL BE REQUIRED,

Billing Provider Secondary Identification:

Prior to the eMedNY NPI implementation, NYSDOH will continue to require a valid NYS Medicaid Provider ID and Locator Code, belonging to the Billing Provider, to satisfy the business requirements for NYS Medicaid

in processing a claim. Two iterations of the Billing Provider Secondary Identification REF segment must be sent with the following Identifiers and Qualifiers:

- NYS Medicaid Provider ID (REF01 will contain a Qualifier of '1D' and REF02 will contain the Billing Provider's Provider ID), and
- Locator Code (REF01 will contain a Qualifier of 'LU' and REF02 will contain the Locator Code for the service location).

AFTER NPI IMPLEMENTATION THERE MUST BE AN ITERATION OF THE BILLING PROVIDER SECONDARY IDENTIFICATION REF SEGMENT WITH:

- Employer ID Number (Qualifier 'EI' in REF01 and the EIN in REF02), or
- Federal Taxpayer ID Number (Qualifier '1J' in REF01 and the TIN in REF02).

Note that the Qualifiers used in the REF segment are different than the ones used in NM1.

During the initial period following NPI implementation, the NYS Medicaid Provider ID and Locator Code will continue to be accepted, but will not be required, in iterations of the REF segment. This does not affect the requirement to send the EIN or Taxpayer ID Identifier and Qualifier.

4. Revenue Codes:

Please reference the NUBC manual for a complete listing of Revenue Codes. The NUBC manual can be ordered at www.nubc.org. Please note: It is important to code all services to the appropriate Revenue Codes. In addition to the codes listed here, Revenue Code totals will be used to calculate Accommodation Total Charges, Accommodation Non-covered Charges, Ancillary Total Charges, and Ancillary Non-covered Charges. Only codes with specific impact upon the NYS Medicaid implementation have been provided. (Loop-ID 2400, SV201)

Revenue codes	
Cost Outlier (Charged)	0110 – 0179, 0200 – 0219, 0250 – 0489, 0610 – 0639, 0700 – 0839, 0900 – 0929, 0940 – 0949, 0960 – 0989
Cost Outlier (Non-Charged)	0510 – 0519, 0560 – 0569, 0990 – 0999
Dental Clinic	0512
Hospice	0235, 0650 – 0659
Leave of Absence, Therapeutic Leave. NYSDOH requires the number of days claimed as Leave Days to be reported in SV205.	0183
Leave of Absence, Nursing Home (for Hospitalization). NYSDOH requires the number of days claimed as Leave Days to be reported in SV205.	0185
PAS/PAC	0360 – 0369, 0480 – 0489, 0490, 0499, 0510 – 0519, 0520 – 0529, 0750, 0790

5. **Rate Codes and Type of Bill:**

NYSDOH maintains an internal Category of Service that is derived from a combination of information on the claim and system reference information. The Rate Code and Type of Bill are key pieces of information for this derivation.

Rate Codes are sent in Loop-ID 2300 in the HI "Value Information" segment, in Data Element HI01. This element is a composite element and therefore has sub-elements. The NYS Medicaid Rate Code goes in sub-element 5, entitled "Monetary Amount". Revenue Codes are sent in Loop-ID 2400, SV2 segment, in Data Element SV201. NYSDOH has published a listing of its Rate Codes with associated Type of Bill values on nyhipaadesk.com under Crosswalks.

6. **Over Ninety Day Indicator:**

HIPAA mandates that any claim that has passed the payers timely filing requirements must include a Delay Reason Code. The NYSDOH filing requirement is 90 days. Therefore, all claims for which more than 90 days has lapsed since the Date of Service must include one of the following HIPAA Codes, if they apply, in order to be considered for payment. Please note that Delay Reason Code 6 is not listed in the table because NYS Medicaid policy does not consider this a valid delay reason, and NYS Medicaid will deny any claim submitted using this code. If the delay reason is for interrupted maternity care or an IPRO denial/reversal, you may use code 11 – Other (Loop-ID 2300, CLM20). New York Medicaid's policy and procedures for submission of claims over 90 days or over 2 years from the date of service can be found in the Provider Manual located at www.emedny.org. Select Provider Manuals from the main menu then select the specific manual for your provider type. Select, Information for All Providers, then click on General Billing.

HIPAA Delay Reason Code	Definition
1	Proof of Eligibility Unknown or Unavailable
2	Litigation
3	Authorization Delays
4	Delay in Certifying Provider
5	Delay in Supplying Billing Forms
7	Third Party Processing Delay
8	Delay in Eligibility Determination
9	Original Claim Rejected or Denied Due to a Reason Unrelated to the Billing Limitation Rules
10	Administration Delay in the Prior Approval Process
11	Other

7. **Service Authorization Exception Codes:**

The following table lists all of the Service Authorization Exception Codes available under HIPAA.

HIPAA Service Authorization Exception Code	Definition
1	Immediate/Urgent Care
2	Services Rendered in Retroactive Period
3	Emergency Care

HIPAA Service Authorization Exception Code	Definition
4	Client Has Temporary Medicaid
5	Request from County for 2nd Opinion to Determine if Recipient Can Work
6	Request for Override Pending
7	Special Handling

As a result of eliminating Specialty Codes, NYS Medicaid will implement the use of the “Special Handling” HIPAA Service Authorization Exception Code for the handling of Utilization Threshold exempt claims. Code 7 – “Special Handling” – must be reported when you would have reported one of the following Specialty Codes (Loop-ID 2300, REF02).

MMIS Specialty Code	MMIS Specialty Code Description
020	PSC ANESTH PSC: ANESTHESIOLOGY
130	CLIA-WV-RG PSC: CLIA WAIVER/REGISTRATION (OBSOLETE 10/12/99)
150	PEDIATRIC PSC PEDIATRICS
151	PEDIA-CARD PSC PEDIATRICS: CARDIOLOGY
152	PEDIA-HEMO PSC PEDIATRICS: HEMATOLOGY – ONCOLOGY
153	PEDIA-SURG PSC PEDIATRICS: SURGERY
154	PEDIA-NEPH PSC PEDIATRICS: NEPHROLOGY
155	NEO-PERIN PSC PEDIATRICS: NEONATAL - PERINATAL MEDICINE
156	PEDIA-ENDO PSC PEDIATRICS: ENDOCRINOLOGY
157	PEDIA-PULM PSC PEDIATRICS: PULMONOLOGY
158	PREF-PHY PSC PPAC: PREFERRED PHYSICIANS AND CHILDREN PROG
159	OB-MAT-SVC PSC MOMS: MEDICAID OBSTETRICAL & MATERNAL SVC PROG
161	PEDIA-CRIT PCP PEDIATRICS: PEDIATRIC CRITICAL CARE
169	MOMS HHS PSC MOMS: HEALTH SUPPORTIVE SERVICES
186	DO-Therapy T.B. DIRECTLY OBSERVED THERAPY/PHYSICIAN
191	CHILD-PSY PSC PSY & NEURO: CHILD PSYCHIATRY
192	PSC PSY & NEURO: PSYCHIATRY (NOT CHILD)
193	CHILD-NEUR PSC PSY & NEURO: CHILD NEUROLOGY
196	PSY-NEUR-C PSC PSY & NEURO: CLOZAPINE CASE MANAGER
205	THER-RAD PSC RAD: THERAPEUTIC RADIOLOGY
247	PHSCN-FEE MANAGED CARE – PHYSICIAN ENHANCED FEE
249	HIV PCS PSC: HIV PRIMARY CARE SERVICES (CONFIDENTIAL)
270	SCHIP PSC SCHIP: STATE CHILDREN'S HEALTH INSURANCE PROGRAM
300	THER-LTM PSC: PHYSICAL THERAPY - LONG TERM MAINTENANCE
301	OCC-LTM PSC: OCCUPATIONAL THERAPY - LONG TERM MAINTENANCE
302	Speech-LTM PSC: SPEECH THERAPY – LONG TERM MAINTENANCE
303	AIDHIV-SRV PSC: AIDS/HIV SERVICES
304	MEDICAL REHABILITATION – LONG TERM MAINTENANCE
305	CLN/PEDIA PSC: PEDIATRIC SPECIALTY - ALL EXCEPT PRIMARY CARE
306	SSHS-PROG PSC: SCHOOL SUPPORTIVE HEALTH SERVICES PROGRAM
307	DME PSC: DURABLE MEDICAL EQUIPMENT (EMEVS USE ONLY)
308	CLNHIV-SRV CLN SP CD: HIV PRIMARY CARE SERVICES
309	SUB-ABUSE CLN SP CD: MEDICALLY SUPERVISED SUBSTANCE ABUSE
312	OMH-CDT-S CLN SP CD: OMH CONTINUING DAY TRTMT (STATE OPR)
313	OMH-HOSPS CLN SP CD: OMH PARTIAL HOSPITALIZATION (STATE OPR)
314	OMH-INTENS CLN SP CD: OMH INTEN PSYCH REHAB TRTMT (STATE OPR)
317	OMH-CDT CLN SP CD: OMH CONTINUING DAY TREATMENT
318	OMH-P-HOSP CLN SP CD: OMH PARTIAL HOSPITALIZATION
319	OMH-INTEN CLN SP CD: OMH INTENSIVE PSYCH REHAB TREATMENT

MMIS Specialty Code	MMIS Specialty Code Description
320	Cloza-Case CLN SP CD: CLOZAPINE CASE MANAGER
323	OMH-OUTCDT OMH COMP OUTPAT PROG (COPS) CONTINUING DAY TRTMT
325	Early-INTE CLN SP CD: EARLY INTERVENTION
750	ME MNT PHY MISC SP CD: METHADONE MAINTENANCE (PHYSICIAN)
798	MISC SP CD LONG TERM HOME HEALTH
900	HMO CLN SP CD: HMO CO-PAYMENT
904	OBSTETRICS CLN SP CD: OBSTETRICS
906	FMLY PLAN CLN SP CD: FAMILY PLANNING
907	ABORTION CLN SP CD: ABORTION
908	CLN SCHIP CLN SP CD: STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP)
913	HEMOD CLN SP CD: HEMODIALYSIS
918	PODIATRY CLN SP CD: PODIATRY
922	ME MA TRT CLN SP CD: METHADONE MAINTENANCE TREATMENT PROGRAM
934	ONCO CHEMO CLN SP CD: ONCOLOGY - THERAPY (RADIATION OR CHEMO)
936	PED GEN ME CLN SP CD: PEDIATRIC GENERAL MEDICINE
937	PED ALLERG CLN SP CD: PEDIATRIC ALLERGY
938	PED NEUR CLN SP CD: PEDIATRIC NEUROLOGY
939	CLN PED HE CLN SP CD: PEDIATRIC HEMATOLOGY
940	PED CARDIA CLN SP CD: PEDIATRIC CARDIAC
941	PED RENAL CLN SP CD: PEDIATRIC RENAL
942	PED PULMO CLN SP CD: PEDIATRIC PULMONARY
943	PED ORTH CLN SP CD: PEDIATRIC ORTHOPEDIC
944	PED ENDOC CLN SP CD: PEDIATRIC ENDOCRINE
949	ALCO TREAT CLN SP CD: ALCOHOLISM TREATMENT PROGRAM
959	OUT CHEM CLN SP CD: OUTPAT CHEM DEPENDENCY PROG FOR YOUTH
960	CLN PD DER CLN SP CD: PEDIATRIC DERMATOLOGY
961	CLN PD DIA CLN SP CD: PEDIATRIC DIABETES
962	CLN PD SUR CLN SP CD: PEDIATRIC SURGERY
967	CLN SPCH CLN SP CD: PHC SPEECH & HEARING
968	CLN AMPUT CLN SP CD: PHC APPROVED AMPUTEE CENTER
969	APPLI VEND CLN SP CD: HOSP DME/ORTHOTIC/PROSTH APPLNC VENDOR
972	MH DAY-ST CLN SP CD: MH DAY TREATMENT (STATE OPERATED)
973	MH CNT-ST CLN SP CD: MH CONTINUING TREATMENT (STATE OPR)
975	MH DAY CLN SP CD: MENTAL HEALTH DAY TREATMENT
976	MH CNT CLN SP CD: MENTAL HEALTH CONTINUING TREATMENT
977	MRDD-ST CLN SP CD: MR/DD CLINIC TREATMENT (STATE OPERATED)
978	PRE PRIM C CLN SP CD: PREFERRED PRIMARY CARE CLINIC
979	CLN MRDD CLN SP CD: MR/DD CLINIC TREATMENT
980	TB DIR OBS T.B. DIRECTLY OBSERVED THERAPY/CLINIC
981	CLN M RETA CLN SP CD: DIAG AND RESEARCH CLINIC MR (STATE OPR)
983	CLN MNTL R CLN SP CD: SPECIALTY CLINIC - MENTAL RETARDATION
984	CLN AL-ST CLN SP CD: ALCOHOLISM CLINIC TREATMENT (STATE OPR)
985	CLN AL DY- CLN SP CD: ALCOHOLISM DAY REHAB (STATE OPERATED)
986	CLN AL CLN CLN SP CD: ALCOHOLISM CLINIC TREATMENT
987	CLN AL REH CLN SP CD: ALCOHOLISM DAY REHABILATION
988	CLN CMP AL CLN SP CD: COMPREHENSIVE ALCOHOLISM CARE
989	CLN AL DET CLN SP CD: ALCOHOLISM DETOXIFICATION (DEMO PROJ)
990	COMP PHYS CLN SP CD: COMP PHYSICAL EXAM (SCHOOL HEALTH PROJ)
991	ROUT VST CLN SP CD: ROUTINE VISIT (SCHOOL HEALTH PROJECT)
992	OMH CMP PS OMH COMPREHENSIVE PSYCHIATRIC EMERGENCY PROG
993	HSP-BS AMB CLN SP CD: HOSPBASD/ FREESTANDING AMBULAT SURGERY
994	BLD PRODUC CLN SP CD: BLOOD PRODUCTS (ORDERED AMBULATORY)
995	GEN COUNSE CLN SP CD: GENETIC COUNSELING (ORDERED AMBULATORY)
996	HEAR SVCS CLN SP CD: HEARING SERVICES (ORDERED AMBULATORY)
997	OPER RM CLN SP CD: OPERATING ROOM (ORDERED AMBULATORY)

MMIS Specialty Code	MMIS Specialty Code Description
998	RADIOLOGY CLN SP CD: RADIOLOGY (ORDERED AMBULATORY)

8. SBR Segment – the Claim Filing Indicator Code:

It is important to populate the correct data elements when reporting Medicare Part A (Claim Filing Indicator Code MA) or Part B (Claim Filing Indicator Code MB) and/or other TPL payers in Coordination of Benefits (COB) claims. Incorrect usage of these codes may create pricing and/or payer coordination errors. The SBR09 field is required to report other payers (Loop-ID 2320, SBR09). If the client has Medicare HMO coverage (Claim Filing Indicator Code 16), there can be no Medicare Part A or Medicare Part B coverage for the same coverage period. Please note that if a client has Medicare HMO coverage on one date and Medicare Part A or B on another date, the services must be billed as two separate claims, except in the case of Hospital Inpatient services. Hospital Inpatient may be billed on one claim if the coverage changed after the admission date.

9. CAS Segment: Claim Level and Line Level Balancing:

Claim level adjustments are reported in a CAS segment in Loop-ID 2320. An iteration of this loop should be sent for each payer whose potential involvement with the claim is being reported except where the provider has submitted under the "OFILL" Plan Name. The CAS segment is used in this loop to report prior payers' claim level adjustments that cause the amount paid to differ from the amount originally charged. Up to five CAS segments can occur in an iteration of the loop, each reporting the adjustment associated with a single Claim Adjustment Group Code at CAS01. Only one Group Code can occur in a CAS segment. The adjustment itself is reported with a group of three values, which can occur up to six times within a single CAS segment; Adjustment Reason Code (CAS02, CAS05, CAS08, CAS11, CAS14, CAS17); Adjustment Amount (CAS03, CAS06, CAS09, CAS12, CAS15, CAS18); and Adjustment Quantity (CAS04, CAS07, CAS10, CAS13, CAS16, CAS19). These values should come from 835 transactions received for the claim. If there were no prior payer adjustments the segment is not sent.

Line level adjustments are reported in a CAS segment in Loop-ID 2430. The segment is required when the payer identified in Loop-ID 2330B made line level adjustments that cause the amount paid to differ from the amount originally charged. The data elements do not differ from a CAS at the claim level. The values reported should come from 835 transactions received for the line item. If there were no line-level prior payer adjustments for the line item the segment is not sent.

Any adjustment amount from one adjustment should be reported only once. Do not repeat a claim-level adjustment at the line level. Also do not report the total of the line-level adjustments in a claim-level CAS segment.

When amounts from distinct claim level and line level adjustments are reported balancing should be done at both the line level (line charge minus total CAS amounts equals paid) and claim level (claim total charge minus total CAS amounts from both claim and line level equals claim level paid).

10. Patient Participation – Spend down and Net Available Monthly Income:

The patient participation amount will be reported as the Patient Paid Amount for all claims. The Patient Paid Amount is the amount the patient actually paid for this specific claim. Both Spend-down and Net Available Monthly Income (NAMI) are included in the Patient Paid Amount AMT segment (Loop-ID 2300, AMT02 where AMT01=F5). Note that the same Medicaid client will never have both Spend-down and NAMI.

11. Occurrence Codes:

Please reference the National Uniform Billing Committee (NUBC) manual for a complete listing of Occurrence Codes. The NUBC manual can be found at www.nubc.org. Only codes with specific impact upon the NYS Medicaid implementation have been provided (Loop-ID 2300, HI01-1="BH").

- a. 02 – No Fault Insurance Involved - Including Auto Accident/Other.
- b. 04 – Accident/Employment Related.
- c. 22 – Date Active Care Ended. This is the first day, which is not to be paid when the hospital utilization review representative approves less than an entire stay. This has been known as the Stay Deny Effective Date in past implementations.
- d. 42 – Discharge Date. Use this code to report the discharge date. The discharge date has been reported as a stand-alone field in past formats.

12. Occurrence Span Codes:

Please reference the National Uniform Billing Committee (NUBC) manual for a complete listing of Occurrence Span Codes. The NUBC manual can be found at www.nubc.org. The following code has specific impact upon the NYS Medicaid implementation.

75 – SNF Level of Care. Use this code when a patient goes to ALC, before the high trim point on an Inpatient DRG claim.

13. Value Codes:

Please reference the NUBC manual for a complete listing of Value Codes. The NUBC manual can be found at www.nubc.org. Only codes with specific impact upon the NYS Medicaid implementation have been provided. (Loop-ID 2300, HIxx)

- a. 24 – Medicaid Rate Code. This is required for all rate-based claims. The Value Code of "24" is to be sent in HI01 - 2 and the Rate Code is sent in HI01 – 5. Only one Rate Code is allowed per claim.
- b. 54 – Newborn Birth Weight in Grams. Only required for inpatient stays when applicable.
- c. In past implementations, value Codes were used to report deductible and coinsurance information. This information is now reported within the CAS segments of the claim COB information.

14. Condition Codes:

Please reference the NUBC manual for a complete listing of Condition Codes. The NUBC manual can be ordered at www.nubc.org. Only codes with specific impact upon the NYS Medicaid implementation have been provided. (Loop-ID 2300, HI Condition Information segment)

- a. 60 – Day Outlier
- b. 61 – Cost Outlier.
- c. A1 – EPSDT/SCHIP (UB92). There is no longer a need to report the referral outcome as in previous implementations.
- d. A4 – Family Planning
- e. Abortion/Sterilization Reason codes. The table below provides the codes allowed for under HIPAA that are used by NYS Medicaid.
- f. AJ – Copay Exempt.

HIPAA Condition Code	Definition
AA	Abortion performed due to rape
AB	Abortion performed due to incest
AC	Abortion performed due to serious fetal genetic defect, deformity, or abnormality
AD	Abortion performed due to a life endangering physical condition caused by, arising from or exacerbated by the pregnancy itself
AE	Abortion performed due to physical health of mother that is not life endangering
AF	Abortion performed due to emotional/psychological health of the mother
AG	Abortion due to social or economic reasons
AH	Elective abortion
AI	Sterilization

15. Co-insurance:

The Co-insurance amount will now be reported as adjustment amounts in the CAS segment, in the Patient Responsibility group (CAS*PR).

16. Diagnosis Codes:

7999 - Other Unknown and Unspecified Cause (HIPAA Requires a Principal Diagnosis for most Institutional claims. There are a large number of Institutional type claims that are not Diagnosis related. Some examples are Child Care, Managed Care, Wavered services Claims - of which there are 4 different types. NYSDOH will accept Code 7999 for these types of claims.)

17. Medicare Approved Amount Calculation:

When submitting claims secondary to Medicare, Providers were required to provide the Medicare Approved Amount. The HIPAA Implementation Guides do not allow this information to be required. As a result, the approved amount will be derived as a calculation of the payment and adjustment information provided in the COB sections of the claim. For claims other than Inpatient and SNF, the sum of the Medicare Paid Amount and the amounts assigned to the Medicare Deductible and Coinsurance Claim Adjustment Reason Codes (Codes 1 & 2) will be considered the Approved Amount.

REMEMBER: It is required that all adjustments are passed into the claim exactly as received in the 835 Remittance Advice from the Primary Payer.

18. Other Payer Covered Days:

The HIPAA Implementation Guides require the reporting of Medicare Covered Days for Coordination of Benefits (COB) claims Medicare is involved in. It allows for the optional usage of covered days for other payers. NYS Medicaid has maintained the requirement of reporting covered days for all payers involved. (Loop-ID 2320, MIA01)

19. Cost Avoidance Override/Zero Fill (0FILL):

“Zero Fill” is a time and cost-saving process implemented by NYSDOH to facilitate claim payment when it is known that the primary payer or any other payer prior to Medicaid, does not cover the services and so will not pay any amount towards the claim. NYSDOH permits providers to bypass submitting the claim to the prior payer(s) who would otherwise deny the claim. Providers may populate the Plan Name field of the Subscriber Information SBR segment with the value “0FILL”. By doing so providers certify that they can provide documentation that the services that were billed are not covered by the prior payer(s) (Loop-ID 2000B, SBR,

SBR04=0FILL). Such documentation should be kept on-file and current by billing to the prior payer(s) for the non-covered services at least once a year.

"0FILL" should also be used on claims which have been denied (the services were not covered) or were paid zero (the entire charge was adjusted, for example, applied to deductible) by any prior payer. Note however that the complete adjudication information from any prior payer who adjudicated the claim must still be included (loop 2320 and sub-loops; and/or loop 2430 and sub-loops).

When the claim is not eligible for processing under the "0FILL" plan, NYSDOH recommends submitters enter "MEDICAID" as the Plan Name (Loop-ID 2000B, SBR04=MEDICAID).

20. Multiple Unit Rate Codes and the Service Line:

All rate-based claims must contain only one NYS Medicaid Rate Code per claim. The Rate Code is reported at the claim level (loop 2300) in the HI Value Information segment (HI*BE:24). Payment for rate-based claims is based on the remittance amount associated with the Rate Code and, for certain claim types, with the units reported at the Service Line level (loop 2400).

Submitters can apply multiple units of service to a Rate Code only for specific service types. This is accomplished at the service line level by reporting a Revenue Code with the number of units to be applied (Loop-ID 2400, SV201, SV204, SV205=number of units).

The 837I transaction may have multiple units applied to a NYS Medicaid Rate Code for the following billing types:

- Home Health
- Traumatic Brain Injury
- Personal Care Services
- Limited License Home Care Services
- Case Management Services
- OMRDD Waiver Services
- Home Care Program
- HHA Professional Services
- Long Term Home Health Care

21. Fee-for-Service on the 837I:

The following service types are billed without NYS Medicaid Rate Codes. If submitted with multiple service lines on a single claim, each service line will be processed independently. Multiple units of service may be reported on each line.

- Hospital Ordered Ambulatory
- Hospital Laboratory
- Free-standing Ordered Ambulatory

22. Cost Outlier Claims:

For Cost Outlier Claims NYSDOH requires the Condition Information HI segment in Loop-ID 2300 with a 'BG' qualifier in HI01 – 1 and '61' in the HI01- 2.

23. Clinic Claims:

Although Clinic services are paid based on the Rate Code, NYSDOH requires a HCPCS procedure code at the Service Line level for processing. This must be present in one of the first three iterations of the Service Line loop (loop 2400). Note that Day Treatment and Day Care in a clinic setting are not processed as Clinic claims and therefore must be submitted without a HCPCS procedure code.

All Clinic claims require at least one NUBC Revenue Code and one HCPCS Procedure Code. Clinic claims are paid by examining the service dates reported at the line level and applying one unit to the clinic's assigned Rate Code for each distinct date of service reported with a payable Revenue Code. Some Revenue Codes are not payable in Clinic claims because they are considered to be ancillary services that are included in the Threshold Clinic rate for the Clinic service.

The following Revenue Codes will not cause units to be applied to the Rate Code in adjudication of Clinic claims received after April 1, 2007 with Rate Codes **1610, 2870, 1629, and 2880** (other Rate Codes and other claim types are not affected). This restriction does not alter the policy requirement of New York State Department of Health that all services must be reported accurately and fully.

Ancillary Revenue Codes Clinic Rate Codes 1610, 2870, 1629, 2880	
Code	Description
030X	Laboratory
031X	Laboratory Pathological
032X	Radiology – Diagnostic
040X	Other Imaging Services
073X	EKG/ECG
074X	EEG
092X	Other diagnostic

For more information please refer to the March 2007 New York State Department of Health Medicaid Update, available for download at http://www.health.state.ny.us/health_care/medicaid/program/update/main.htm.

24. Specialty Code Derivation (Clinic)

Claims payment in the eMedNY system requires an internal Specialty Code derivation. CSC suggests the use of the following Revenue Codes and/or Bill Type when billing for Clinic Rate Codes **1610, 2870, 1629, and 2880** in order to derive the appropriate Specialty Codes.

Please note: Specialty Code 914 will be assigned when there is no other information on the claim that could be used to determine a specific Specialty Code. If a claim does not contain any of the information listed below and Service Authorization Exception code 7 is not present, the system will assign Specialty Code 914, but only if Specialty Code 914 is on the provider's file and is valid for the date of service

Specialty Code Derivation Clinic Rate Codes 1610, 2870, 1629, 2880

Specialty Code	Type(s) of Bill	Revenue Code(s)	Other Code
964	72 or 73	0513	
924		0911	
983	76 or 86		
920		042X	
300		042X	Service Authorization Exception Code 7
923		043X	
301		043X	Service Authorization Exception Code 7
967		044X or 047X	
913		082X	

In addition, the following Condition Codes will cause Specialty Code derivation as follows:

Specialty Code Derivation All Clinic Rate Codes	
Specialty Code	Condition Code
906	A4 (Family Planning)
907	AA through AH (Abortion related codes)
908	A1 (EPSDT/SCHIP)