



New York State UB-04 Billing Guidelines

**HOME AND COMMUNITY BASED SERVICES
(HCBS) WAIVER**



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 the Home and Community Based Services (HCBS) 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 Institutional Billing Guidelines](#).

2. Claims Submission

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

2.1 Electronic Claims

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

2.2 Paper Claims

HCBS 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 HCBS Waiver UB-04 claim form, see Appendix A. The displayed claim form is a sample and is for illustration purposes only.

2.3 HCBS Waiver Services Billing Instructions

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

2.3.1 UB-04 Claim Form Field Instructions

Statement Covers Period From/Through (Form Locator 6)

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

- **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.

NOTE: *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: [General Billing](#).*

Date of Service Rules

For *Community Residence Habilitation* monthly and semi-monthly rate codes, the date of service should be as follows:

- Monthly (Full month) = 21 Days in residence with 4 services delivered

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

- Semi-Monthly (1st half) = 11 Days in residence with 2 services delivered

The patient must be admitted prior to the 11th day of the month. The date of service is the first day of the subsequent month.

- Semi-Monthly (2nd half) = 11 Days in residence with 2 services delivered

The patient must be admitted on or after the 11th day of the month. The date of service is the 2nd day of the subsequent month.

For *Waiver Case Management*, enter the first day of the month subsequent to the month in which services were rendered unless the patient loses Medicaid eligibility during the service month. If the patient loses eligibility before the first of the month subsequent to the service month, the last date of medical coverage should be entered as service date.

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.

Home and Community Based Services - UB-04 Sample Claim										APPROVED OMB NO. 0938-0279								
1 City HomeCare 111 Main Street Anytown, NY 11111				3a PAT. CNTL# AB1234567		4 TIME OF BILL 340												
5 PATIENT NAME SMITH, WILLIAM				6 PATIENT ADDRESS				7 STATEMENT COVERS PERIOD FROM 04/12/07 THROUGH										
10 BIRTH DATE 04/19/40		11 SEX M	12 DATE ADMISSION 13 HR 14 TIME 15 SPD 16 DHR		17 STAT AS		18 CONDITION CODES 21 22 23 24 25 26 27 28 29 30											
21 OCCURRENCE CODE 01		22 OCCURRENCE DATE		23 OCCURRENCE CODE A5		24 OCCURRENCE DATE		25 OCCURRENCE FROM 30		26 OCCURRENCE THROUGH								
39 VALUE CODES 61		40 VALUE CODES 003.		41 VALUE CODES 24		42 VALUE CODES 4413.		43 VALUE CODES A3		44 VALUE CODES 00.00								
42 REV CD 0001		43 DESCRIPTION			44 HCPCS / RATE / HIRPS CODE		45 SERV DATE		46 SERV UNITS		47 TOTAL CHARGES 80.00	48 NON-COVERED CHARGES	49					
50 PAYER NAME Blue Cross Medicaid				51 HEALTH PLAN ID		52 REL INFO	53 REG SEN	54 PRIOR PAYMENTS		55 EST. AMOUNT DUE		56 NPI	57 OTHER PRV ID None 00123456					
58 INSURED'S NAME				59 P REL		60 INSURED'S UNIQUE ID None AB12345C		61 GROUP NAME		62 INSURANCE GROUP NO								
63 TREATMENT AUTHORIZATION CODES				64 DOCUMENT CONTROL NUMBER				65 EMPLOYER NAME										
66 318.0 07	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R
69 ADULT CK		70 PAYMENT REASON CK		a	b	c	71 PPS CODE	72 50	a	b	c	73						
74 PRINCIPAL PROCEDURE CODE DATE		75 OTHER PROCEDURE CODE DATE		76 OTHER PROCEDURE CODE DATE		77 OTHER PROCEDURE CODE DATE		78 ATTENDING NR DUAL		79 OPERATING NR DUAL		80 OTHER NR DUAL						
81 REMARKS		82		83		84		85		86		87						

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