

**NEW YORK STATE
MEDICAID PROGRAM**

**HOME AND COMMUNITY BASED
SERVICES WAIVER
FOR PERSONS WITH
TRAUMATIC BRAIN INJURIES
(HCBS/TBI WAIVER)**

**UB-04
BILLING GUIDELINES**

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Section I – Purpose Statement

The purpose of this document is to assist the provider community in understanding and complying with the New York State Medicaid (NYS Medicaid) requirements and expectations for:

- Billing and submitting claims.
- Interpreting and using the information returned in the Medicaid Remittance Advice.

This document is customized for HCBS/TBI Waiver providers and should be used by the provider as an instructional as well as a reference tool.

Section II – Claims Submission

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

Providers are required to submit an Electronic/Paper Transmitter Identification Number (ETIN) Application and a Certification Statement before submitting claims to NYS Medicaid Certification Statements remain in effect and apply to all claims until superseded by another properly executed Certification Statement. You will be asked to update your Certification Statement on an annual basis. You will be provided with renewal information when your Certification Statement is near expiration.

Pre-requirements for the Submission of Claims

Before submitting claims to NYS Medicaid, all providers need the following:

- An ETIN
- A Certification Statement

ETIN

This is a submitter identifier issued by the eMedNY Contractor. All providers are required to have an active ETIN on file with the eMedNY Contractor prior to the submission of claims. ETINs may be issued to an individual provider or provider group (if they are direct billers) and to service bureaus or clearinghouses.

The ETIN application is available at www.emedny.org by clicking on the link to the web page below:

[Provider Enrollment Forms](#)

Certification Statement

All providers, either direct billers or those who bill through a service bureau or clearinghouse, must file a notarized Certification Statement with NYS Medicaid for each ETIN used for billing.

The Certification Statement is good for one year, after which it needs to be renewed for billing continuity under a specific ETIN. Failure to renew the Certification Statement for a specific ETIN will result in claim rejection.

The Certification Statement is available on the third page of the ETIN application at www.emedny.org or can be accessed by clicking on the link above.

Electronic Claims

Pursuant to the Health Insurance Portability and Accountability Act (HIPAA), Public Law 104-191, which was signed into law August 12, 1996, the NYS Medicaid Program adopted the HIPAA-compliant transactions as the sole acceptable format for electronic claim submission, effective November 2003.

HCBS/TBI Waiver providers who choose to submit their Medicaid claims electronically are required to use the HIPAA 837 Institutional (837I) transaction. In addition to this document, direct billers may also refer to the sources listed below to comply with the NYS Medicaid requirements.

- **HIPAA 837I Implementation Guide (IG)** explains the proper use of the 837I standards and program specifications. This document is available at www.wpc-edi.com/hipaa.
- **NYS Medicaid 837I Companion Guide (CG)** is a subset of the IG which provides specific instructions on the NYS Medicaid requirements for the 837I transaction. This document is available at www.emedny.org by clicking on the link to the web page below.
- **NYS Medicaid Technical Supplementary Companion Guide** provides technical information needed to successfully transmit and receive electronic data. Some of the topics put forth in this CG are testing requirements, error report information, and communication specifications. This document is available at www.emedny.org by clicking on the link to the web page below.

[eMedNY Companion Guides and Sample Files](#)

Pre-requirements for the Submission of Electronic Claims

In addition to an ETIN and a Certification Statement, providers need the following before submitting claims to NYS Medicaid:

- A User ID and Password
- A Trading Partner Agreement
- Testing

User ID and Password

Electronic submitters need a user ID and password to access the NYS Medicaid eMedNY system through one of the communication methods available. The user ID and password are issued to the submitter at the time of enrollment in one of the communication methods. The method used to apply for a user ID varies depending on the communication method chosen by the provider. For example: An ePACES user ID is assigned systematically via email while an FTP user ID is assigned after the submission of a Security Packet B.

Trading Partner Agreement

This document addresses certain requirements applicable to the electronic exchange of information and data associated with health care transactions.

The NYS Medicaid Trading Partner Agreement is available at www.emedny.org by clicking on the link to the web page below:

[Provider Enrollment Forms](#)

Testing

Direct billers (either individual providers or service bureaus/clearinghouses that bill for multiple providers) are encouraged to submit production tests to CSC before they start submitting Medicaid claims for the first time after enrollment or any time they update their systems or start using a new system. This testing will assist providers in identifying errors in their system and allow for corrections before they submit actual claims.

Information and instructions regarding testing are available at www.emedny.org by clicking on the link to the web page below:

[eMedNY Companion Guides and Sample Files](#)

Communication Methods

The following communication methods are available for submission of electronic claims to NYS Medicaid:

- ePACES
- eMedNY eXchange
- FTP
- CPU to CPU
- eMedNY Gateway
- Simple Object Access Protocol (SOAP)

ePACES

NYS Medicaid provides ePACES, a HIPAA-compliant web-based application that is customized for specific transactions, including the 837I. ePACES, which is provided free of charge, is ideal for providers with small-to-medium claim volume.

The requirements for using ePACES include:

- An ETIN and Certification Statement should be obtained prior to enrollment
- Internet Explorer 4.01 and above or Netscape 4.7 and above
- Internet browser that supports 128-bit encryption and cookies
- Minimum connection speed of 56K
- An accessible email address

The following transactions can be submitted via ePACES:

- 270/271 - Eligibility Benefit Inquiry and Response
- 276/277 - Claim Status Request and Response
- 278 – Prior Approval/Prior Authorization/Service Authorization Request and Response
- 837 - Dental, Professional, and Institutional Claims

To take advantage of ePACES, providers need to follow an enrollment process. Additional enrollment information is available at www.emedny.org by clicking on the link to the web page below:

[Self Help](#)

eMedNY eXchange

eMedNY eXchange is a method in which claims can be submitted and works similarly to typical electronic mail (email). Users are assigned an inbox in the system and are able to send and receive transaction files. The files are attached to the request and sent to eMedNY for processing. The responses are delivered back to the user's inbox where they can be detached and saved locally. **For security reasons, the eMedNY eXchange is accessible only through the eMedNY website www.emedny.org.**

Access to the eMedNY eXchange is obtained through an enrollment process. To enroll in eXchange, you must first complete enrollment in ePACES and at least one login attempt must be successful.

FTP

File Transfer Protocol (FTP) is the standard process for batch authorization transmissions. FTP allows users to transfer files from their computer to another computer. FTP is strictly a dial-up connection.

FTP access is obtained through an enrollment process. To obtain a user name and a password, you must complete and return a Security Packet B. The Security Packet B is available at www.emedny.org by clicking on the link to the web page below:

[Provider Enrollment Forms](#)

CPU to CPU

This method consists of a direct connection established between the submitter and the processor, and it is most suitable for high volume submitters. For additional information regarding this access method, contact the eMedNY Call Center at 800-343-9000.

eMedNY Gateway

The eMedNY Gateway or Bulletin Board System (BBS) is a dial-up access method that is only available to existing users. CSC encourages new trading partners to adopt a different access method for submissions to NYS Medicaid. (For example: FTP, eMedNY eXchange, SOAP, etc.)

Simple Object Access Protocol (SOAP)

The Simple Object Access Protocol (SOAP) communication method allows trading partners to submit files via the internet under a Service Oriented Architecture (SOA). It is most suitable for users who prefer to develop an automated, systemic approach to file submission.

Access to eMedNY via Simple Object Access Protocol must be obtained through an enrollment process that results in the creation of an eMedNY SOAP Certificate and a SOAP Administrator. Minimum requirements for enrollment include:

- An ETIN and Certification Statement for the enrollee's Provider ID obtained prior to SOAP enrollment
- The enrollee must be a Primary ePACES Administrator **or**
- The enrollee must have existing FTP access to eMedNY

Additional information about 'Getting Started with SOAP' is available on emedny.org by clicking on the link to the web page below:

[eMedNY Companion Guides and Sample Files](#)

Notes:

- **For additional information regarding the Simple Object Access Protocol, please send an e-mail to NYHIPAADESK3@csc.com.**
- **For questions regarding ePACES, eXchange, FTP, CPU to CPU or eMedNY Gateway connections, call the eMedNY Call Center at 800-343-9000.**

Paper Claims

HCBS/TBI Waiver providers who choose to submit their claims on paper forms must use the Centers for Medicare & Medicaid Services (CMS) standard **UB-04** claim form. To view the UB-04 claim form please click on the link provided below. The displayed claim form is a sample and the information it contains is for illustration purposes only.

[HCBS/TBI Waiver – UB-04 Sample Claim](#)

An ETIN and a Certification Statement are required to submit paper claims. Providers who have a valid ETIN for the submission of electronic claims do not need an additional ETIN for paper submissions. The ETIN and the associated certification qualifies the provider to submit in both electronic and paper formats.

General Instructions for Completing Paper Claims

Since the information entered on the claim form is captured via an automated data collection process (imaging), it is imperative that it be legible and placed appropriately in the required fields. The following guidelines will help ensure the accuracy of the imaging output:

- All information should be typed or printed.
- Alpha characters (letters) should be capitalized.
- Numbers should be written as close to the example below as possible:

1 2 3 4 5 6 7 8 9 0

- Circles (the letter O, the number 0) must be closed.
- Avoid unfinished characters. For example:

Written As	Intended As	Interpreted As											
<table border="1" style="border-collapse: collapse; width: 100px; height: 20px;"> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px; text-align: center;">6.</td> <td style="width: 20px; height: 20px; text-align: center;">0</td> <td style="width: 20px; height: 20px;"></td> </tr> </table>			6.	0		6.00	<table border="1" style="border-collapse: collapse; width: 100px; height: 20px;"> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px; text-align: center;">6.</td> <td style="width: 20px; height: 20px; text-align: center;">6</td> <td style="width: 20px; height: 20px;"></td> </tr> </table>			6.	6		→ Zero interpreted as six
		6.	0										
		6.	6										

- When typing or printing, stay within the box provided; ensure that no characters (letters or numbers) touch the claim form lines. For example:

Written As	Intended As	Interpreted As
<div style="border: 1px solid black; display: inline-block; padding: 2px 5px;">2</div>	2	<div style="border: 1px solid black; display: inline-block; padding: 2px 5px;">7</div> → Two interpreted as seven
<div style="border: 1px solid black; display: inline-block; padding: 2px 5px;">3</div>	3	<div style="border: 1px solid black; display: inline-block; padding: 2px 5px;">2</div> → Three interpreted as two

- Characters should not touch each other. For example:

Written As	Intended As	Interpreted As
<div style="border: 1px solid black; display: inline-block; padding: 2px 5px;">23</div>	23	<div style="border: 1px solid black; display: inline-block; padding: 2px 5px;">illegible</div> → Entry cannot be interpreted properly

- Do not write between lines.
- Do not use arrows or quotation marks to duplicate information.
- Do not use the dollar sign (\$) to indicate dollar amounts; do not use commas to separate thousands. For example, three thousand should be entered as 3000, not as 3,000.
- For writing, it is best to use a felt tip pen with a fine point. Avoid ballpoint pens that skip; do not use pencils, highlighters, or markers. Only blue or black ink is acceptable.
- If entering information through a computer, ensure that all information is aligned properly, and that the printer ink is dark enough to provide clear legibility.
- Do not submit claim forms with corrections, such as information written over correction fluid or crossed out information. If mistakes are made, a new form should be used.
- Separate forms using perforations; do not cut the edges.
- Do not fold the claim forms.
- Do not use adhesive labels (for example for address); do not place stickers on the form.

The address for submitting claim forms is:

**COMPUTER SCIENCES CORPORATION
P.O. Box 4601
Rensselaer, NY 12144-4601**

UB-04 Claim Form

To view the UB-04 claim form please click on the link provided below. The displayed claim form is a sample and the information it contains is for illustration purposes only.

[HCBS/TBI Waiver – UB-04 Sample Claim](#)

General Information About the UB-04 Form

The UB-04 CMS-1450 is a CMS standard form; therefore CSC does not supply it. The form can be obtained from any of the national suppliers.

The UB-04 Manual (National Uniform Billing Data Element Specifications as Developed by the National Uniform Billing Committee – Current Revision) should be used in conjunction with this Provider Billing Guideline as a reference guide for the preparation of claims to be submitted to NYS Medicaid. The UB-04 manual is available at www.nubc.org.

Form Locators in this manual for which no instruction has been provided have no Medicaid application. These Form Locators are ignored when the claim is processed.

Billing Instructions for HCBS/TBI Waiver Services

This subsection of the Billing Guidelines covers the specific NYS Medicaid billing requirements for HCBS/TBI 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 who should refer to these instructions for finding out what information they need to provide in their claims, what codes they need to use, etc.

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.

Field-by-Field Instructions for the UB-04 Claim Form

PROVIDER NAME, ADDRESS, AND TELEPHONE NUMBER (Form Locator 1)

Enter the billing provider's name and address, using the following rules for submitting the ZIP code:

- **Paper claim submissions:** Enter the 5 digit ZIP code or the ZIP plus four.
- **Electronic claim submissions:** Enter the 9 digit ZIP code.

Note: It is the responsibility of the provider to notify Medicaid of any change of address or other pertinent information within 15 days of the change. For information on where to direct address change requests, refer to Information for All Providers, Inquiry section, which can be found on the web page for this manual.

PATIENT CONTROL NO. (Form Locator 3a)

For record-keeping purposes, the provider may choose to identify a patient by using an account/patient control number. This field can accommodate up to 30 alphanumeric characters. If an account/patient control number is indicated on the claim form, the first 20 characters will be returned on the paper Remittance Advice. Using an account/patient control number can be helpful for locating accounts when there is a question on patient identification.

TYPE OF BILL (Form Locator 4)

Completion of this field is required for all provider types. All entries in this field must contain three digits. Each digit identifies a different category as follows:

- 1st Digit – Type of Facility
- 2nd Digit – Bill Classification
- 3rd Digit – Frequency

Type of Facility

Enter the value **3** (Home Health) as the first digit of this field. The source of this code is the UB-04 Manual, Form Locator 4, Type of Facility category.

Bill Classification

Enter the value **4** (Other) as the second digit of this field. The source of this code is the UB-04 Manual, Form Locator 4, Bill Classification (Except Clinics and Special Facilities) category.

Example:

4 TYPE OF BILL
34X

Frequency - Adjustment/Void Code

The third position of this field identifies whether the claim is an original, a replacement (adjustment), or a void.

- If submitting an original claim, enter the value **0** in the third position of this field.

Example:

4 TYPE OF BILL
340

- If submitting an adjustment (replacement) to a previously paid claim, enter the value **7** in the third position of this field.

Example:

4 TYPE OF BILL
347

- If submitting a void to a previously paid claim, enter the value **8** in the third position of this field.

Example:

4 TYPE OF BILL
348

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 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**, 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.

Special Instructions: For monthly service coordination, enter the first day of the month subsequent to the month in which the service coordination was rendered.

Notes:

- The provider's 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 earliest date (FROM date) entered in this field unless acceptable circumstances for the delay can be documented. For more information about billing claims over 90 days from the earliest date of service, refer to Information for All Providers, General Billing section, which can be found on the web page for this manual.

PATIENT NAME (Form Locator 8 – Line b)

Enter the patient's last name followed by the first name.

BIRTHDATE (Form Locator 10)

Enter the patient's birth date. The birth date must be in the format MMDDYYYY.

Example: Mary Brandon was born on March 5, 1975.

10 BIRTHDATE
03051975

SEX (Form Locator 11)

Enter **M** for male or **F** for female to indicate the patient's sex.

ADMISSION (Form Locators 12-15)

Leave all fields blank.

STAT [PATIENT STATUS] (Form Locator 17)

This field is used to indicate the specific condition or status of the patient as of the last date of service indicated in Form Locator 6. Select the appropriate code (**except for 43 and 65**) from the UB-04 Manual.

CONDITION CODES (Form Locators 18-28)

Leave all fields blank.

OCCURRENCE CODE/DATE (Form Locators 31-34)

NYS Medicaid uses Occurrence Codes to report **Accident Code**. This field has two components: **Code** and **Date**; both are required when applicable.

Code

If applicable, enter the appropriate Accident Code to indicate whether the service rendered to the patient was for a condition resulting from an accident or crime. Select the code from the UB-04 Manual, Form Locators 31-34, Accident Related Codes.

Date

If an entry was made under Code, enter the date when the accident occurred in the format MMDDYY.

VALUE CODES (Form Locators 39–41)

NYS Medicaid uses Value Codes to report the following information:

- Locator Code (required: see notes for conditions)
- Rate Code (required)
- Medicare Information (only if applicable)
- Other Insurance Payment (only if applicable)
- Patient Participation/Spend-down (only if applicable)

Value Codes have two components: Code and Amount. The **Code** component is used to indicate the type of information reported. The **Amount** component is used to enter the information itself. Both components are required for each entry.

Locator Code - Value Code 61

For electronic claims, leave this field blank. For paper claims, enter the locator code assigned by NYS Medicaid.

Locator codes are assigned to the provider for each service address registered at the time of enrollment in the Medicaid program or at anytime, afterwards, that a new location is added.

Value Code

Code **61** should be used to indicate that a Locator Code is entered under Amount.

Value Amount

Entry must contain three digits and must be placed to the left of the dollars/cents delimiter.

Locator codes 001 and 002 are for administrative use only and are not to be entered in this field. The entry may be 003 or a higher locator code. Enter the locator code that corresponds to the address where the service was performed.

The example below illustrates a correct Locator Code entry.

Example:

39 VALUE CODES	
CODE	AMOUNT
a 61	003 .
b	.
c	.
d	.

Note: The provider is reminded of the obligation to notify Medicaid of all service locations as well as changes to any of them. For information on where to direct Locator Code updates, refer to Information for All Providers, Inquiry section on this web page.

Rate Code - Value Code 24

Rates are established by the Department of Health and other State agencies. At the time of enrollment in Medicaid, providers receive notification of the rate codes and rate amounts assigned to their category of service. Any time that rate codes or amounts change, providers also receive notification from the Department of Health.

Value Code

Code **24** should be used to indicate that a rate code is entered under Amount.

Value Amount

Enter the rate code that applies to the service rendered. The four-digit rate code must be entered to the left of the dollars/cents delimiter.

The example below illustrates a correct Rate Code entry.

Example:

39 VALUE CODES	
CODE	AMOUNT
a 24	9858 .
b	.
c	.
d	.

Medicare Information (See Value Codes Below)

If the patient is also a Medicare beneficiary, it is the responsibility of the provider to determine whether the service being billed for is covered by the patient's Medicare coverage. If the service is covered or if the provider does not know if the service is covered, the provider must first submit a claim to Medicare, as Medicaid is always the payer of last resort.

Value Code

- If applicable, enter the appropriate code from the UB-04 manual, Form Locator 39-41 to indicate that one (or more) of the following items is entered under Amount.
 - ▶ Medicare Deductible – **A1 or B1**
 - ▶ Medicare Co-insurance – **A2 or B2**
 - ▶ Medicare Co-payment – **A7 or B7**
- Enter code **A3 or B3** to indicate that the Medicare Payment is entered under Amount.

Note: The line (A or B) assigned to Medicare in Form Locator 50 determines the choice of codes AX or BX.

Value Amount

- Enter the corresponding amount for each value code entered.
- Enter the amount that Medicare actually paid for the service. If Medicare denied payment or if the provider knows that the service would not be covered by Medicare, or has received a previous denial of payment for the same service, enter 0.00. Proof of denial of payment must be maintained in the patient's billing record.

Other Insurance Payment – Value Code A3 or B3

If the patient has insurance other than Medicare, it is the responsibility of the provider to determine whether the service being billed for is covered by the patient's Other Insurance carrier. If the service is covered or if the provider does not know if the service is covered, the provider must first submit a claim to the Other Insurance carrier, as Medicaid is always the payer of last resort.

Value Code

If applicable, code **A3 or B3** should be used to indicate that the amount paid by an insurance carrier other than Medicare is entered under Amount. The line (A or B) assigned to the Insurance Carrier in Form Locator 50 determines the choice of codes **A3 or B3**.

Value Amount

Enter the actual amount paid by the other insurance carrier. If the other insurance carrier denied payment enter 0.00. Proof of denial of payment must be maintained in the patient's billing record. Zeroes must also be entered in this field if any of the following situations apply:

- Prior to billing the insurance company, the provider knows that the service will not be covered because:
 - ▶ The provider has had a previous denial for payment for the service from the particular insurance policy. However, the provider should be aware that the service should be billed if the insurance policy changes. Proof of denials must be maintained in the patient's billing record. Prior claims denied due to deductibles not being met are not to be counted as denials for subsequent billings.
 - ▶ In very limited situations the Local Department of Social Services (LDSS) has advised the provider to zero-fill the Other Insurance payment for the same type of service. This communication should be documented in the client's billing record.
- The provider bills the insurance company and receives a rejection because:
 - ▶ The service is not covered; or
 - ▶ The deductible has not been met.
- The provider cannot directly bill the insurance carrier and the policyholder is either unavailable or uncooperative in submitting claims to the insurance company. In these cases the LDSS must be notified prior to zero-filling. The LDSS has subrogation rights enabling it to complete claim forms on behalf of uncooperative policyholders who do not pay the provider for the services. The LDSS can direct the insurance company to pay the provider directly for the service whether or not the provider participates with the insurance plan. The provider should contact the third-party worker in the LDSS whenever he/she encounters policyholders who are uncooperative in paying for covered services received by their dependents who are on Medicaid. In other cases providers will be instructed to zero-fill the Other Insurance payment in the Medicaid claim and the LDSS will retroactively pursue the third-party resource.
- The patient or an absent parent collects the insurance benefits and fails to submit payment to the provider. The LDSS must be notified so that sanctions and/or legal action can be brought against the patient or absent parent.

- The provider is instructed to zero-fill by the LDSS for circumstances not listed above.

The following example illustrates a correct Other Insurance Payment entry.

Example:

	39	VALUE CODES
	CODE	AMOUNT
a	E3	100 . 00
b		-
c		-
d		-

Patient Participation (Spend Down) - Value Code 31

Some patients of the HCBS/TBI Waiver services do not become eligible for Medicaid until they pay an overage or monthly amount (spend-down) toward the cost of their medical care.

Value Code

If applicable, enter code **31** to indicate that the patient’s spend-down participation is entered under Amount.

Value Amount

Enter the spend-down amount paid by the patient.

The following example illustrates a correct Patient Participation entry.

Example:

	39	VALUE CODES
	CODE	AMOUNT
a	31	100 . 00
b		-
c		-
d		-

REV. CD. [REVENUE CODE] (Form Locator 42)

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

NYS Medicaid uses Revenue Codes to report the following information:

- Total Charges
- Units

Total Charges

Use Revenue Code **0001** to indicate that total charges for the services being claimed in the form are entered in Form Locator 47.

Units

Use an appropriate Revenue Code from the UB-04 manual to indicate that the units of service are entered in Form Locator 46.

Note: If the number of service lines (dates of service) exceed the number of lines that can be accommodated on a single UB-04 form, another claim form must be entirely completed. Medicaid cannot process additional claim lines without all the required information. Each claim form will be processed as a unique claim document and must contain only one Total Charges 0001 Revenue Code. Multi-paged documents cannot be accepted either.

SERV. DATE (Form Locator 45)

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.

SERV. UNITS (Form Locator 46)

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 HCBS/TBI Waiver service time being claimed.

TOTAL CHARGES (Form Locator 47)

Enter the total amount charged for the service(s) rendered on the lines corresponding to Revenue Code 0001 in Form Locator 42 (total charge for all lines billed) and for any other Revenue Code (individual charges for that one line). Both sections of the field (dollars and cents) must be completed; if the charges contain no cents, enter **00** in the cents box.

Example:

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					640.00	.	
0240			03012007	8	320.00	.	
0240			03022007	8	320.00	.	

If billing for multiple units, the total charges should equal the number of units entered in Form Locator 46 multiplied by the rate amount. If no units were reported in Form Locator 46, the total charges should equal the rate amount.

PAYER NAME (Form Locator 50 A, B, C)

This field identifies the payer(s) responsible for the claim payment. The field lines (A, B, and C) are devised to indicate primary (A), secondary (B), and tertiary (C) responsibility for claim payment.

For NYS Medicaid billing, payers are classified into three main categories: Medicare, Commercial (any insurance other than Medicare), and Medicaid. **Medicaid is always the payer of last resort.** Complete this field in accordance with the following instructions.

Direct Medicaid Claim

If Medicaid is the only payer, enter the word Medicaid on line A of this field. Leave lines B and C blank.

Medicare/Medicaid Claim

If the patient has Medicare coverage:

- Enter the word **Medicare** on line A of this field.
- Enter the word **Medicaid** on line B of this field.
- Leave line C blank.

Commercial Insurance/Medicaid Claim

If the patient has insurance coverage other than Medicare,

- Enter the name of the other **Insurance Carrier** on line A of this field.
- Enter the word **Medicaid** on line B of this field.
- Leave Line C blank.

Medicare/Commercial/Medicaid Claim

If the patient is covered by Medicare and one or more commercial insurance carriers,

- Enter the word **Medicare** on line A of this field.
- Enter the name of the other **Insurance Carrier** on line B of this field.
- Enter the word **Medicaid** on line C of this field.

NPI (Form Locator 56)

Leave this field blank.

OTHER PRV ID [Other Provider ID] (Form Locator 57)

The Medicaid Provider ID number is the eight-digit identification number assigned to providers at the time of enrollment in the Medicaid program.

Enter the Medicaid Provider ID number on the same line (A, B, or C) that matches the line assigned to Medicaid in Form Locator 50. If the provider's Medicaid ID number is entered in lines B or C, the lines above the Medicaid ID number must contain either the provider's ID for the other payer(s) or the word **NONE**.

INSURED'S UNIQUE ID (Form Locator 60)

Enter the patient's Medicaid ID number (Client ID number). Medicaid Client ID numbers are assigned by the State of New York and are composed of eight characters in the format AANNNNNA, where A = alpha character and N = numeric character.

Example: AB12345C

The Medicaid Client ID should be entered on the same line (A, B, or C) that matches the line assigned to Medicaid in Form Locators 50 and 57. If the patient's Medicaid Client ID number is entered on lines B or C, the lines above the Medicaid ID number must contain either the patient's ID for the other payer(s) or the word **NONE**.

TREATMENT AUTHORIZATION CODES (Form Locator 63)

Leave this field blank.

DOCUMENT CONTROL NUMBER (Form Locator 64 A, B, C)

Leave this field blank when submitting an original claim or a resubmission of a denied claim.

If submitting an **Adjustment (Replacement)** or a **Void** to a previously paid claim, this field must be used to enter the **Transaction Control Number (TCN)** assigned to the claim to be adjusted or voided. The TCN is the claim identifier and is listed in the Remittance Advice. If a TCN is entered in this field, the third position of Form Locator 4, Type of Bill, must be 7 or 8.

The TCN must be entered in the line (A, B, or C) that matches the line assigned to Medicaid in Form Locators 50 and 57. If the TCN is entered in lines B or C, the word **NONE** must be written on the line(s) **above** the TCN line.

Adjustments

An adjustment is submitted to correct one or more fields of a previously paid claim. Any field, except the **Provider ID number** or the **Patient's Medicaid ID number**, can be adjusted. The adjustment must be submitted in a new claim form (copy of the original form is unacceptable) and all applicable fields must be completed. An adjustment is identified by the value **7** in the **third position of Form Locator 4**, Type of Bill, and the claim to be adjusted is identified by the TCN entered in this field (Form Locator 64).

Adjustments cause the correction of the adjusted information in the claim history records as well as the cancellation of the original claim payment and the re-pricing of the claim based on the adjusted information.

Voids

A void is submitted to nullify a paid claim. The void must be submitted in a new claim form (copy of the original form is unacceptable) and all applicable fields must be completed. A void is identified by the value **8** in the **third position of Form Locator 4**, Type of Bill, and the claim to be voided is identified by the TCN entered in this field (Form Locator 64).

Voids cause the cancellation of the original claim history records and payment.

UNTITLED [PRINCIPAL DIAGNOSIS CODE] (Form Locator 67)

Using the *International Classification of Diseases, Ninth Edition, Clinical Modification* (ICD-9-CM) coding system, enter the appropriate code that describes the main condition or symptom of the patient. The ICD-9-CM code must be entered exactly as it is listed in the manual. The remaining Form Locators labeled A – Q may be used to indicate secondary diagnosis information.

Example:

268.0

Note: Three-digit diagnosis codes will be accepted only when the category has no subcategories.

Example:

267 – Ascorbic Acid Deficiency – **Acceptable** to Medicaid (no subcategories)
268 – Vitamin D Deficiency – **Not acceptable** to Medicaid (subcategories exist)

Acceptable Diagnosis Codes: 267
268.0
268.1

OTHER (Form Locator 78)

Leave this field blank.

Section III – Remittance Advice

The purpose of this section is to familiarize the provider with the design and contents of the Remittance Advice.

eMedNY produces remittance advices on a weekly (processing cycle) basis. Weekly remittance advices contain the following information:

- A listing of all **claims** (identified by several pieces of information as submitted on the claim) that have entered the computerized processing system during the corresponding cycle.
- The **status** of each claim (deny/paid/pend) after processing.
- The eMedNY **edits** (errors) failed by pending or denied claims.
- **Subtotals** (by category, status, and member ID) and **grand totals** of claims and dollar amounts.
- Other **financial information** such as recoupments, negative balances, etc.

The remittance advice, in addition to showing a record of claim transactions, can assist providers in identifying and correcting billing errors and plays an important role in the communication between the provider and the eMedNY Contractor for resolving billing or processing issues.

Remittance advices are available in electronic and paper formats.

Electronic Remittance Advice

The electronic HIPAA 835 transaction (Remittance Advice) is available via the eMedNY eXchange or FTP. To request the electronic remittance advice (835), providers **must** complete the Electronic Remittance Request Form, which is available at www.emedny.org by clicking on the link to the web page below:

[Provider Enrollment Forms](#)

For additional information, providers may also call the eMedNY Call Center at 800-343-9000.

The NYS Medicaid Companion Guides for the 835 transaction are available at www.emedny.org by clicking on the link to the web page below:

[eMedNY Companion Guides and Sample Files](#)

Providers who submit claims under multiple ETINs receive a separate 835 for each ETIN and a separate check for each 835. Also, any 835 transaction can contain a maximum of ten thousand (10,000) claim lines; any overflow will generate a separate 835 and a separate check.

Providers with multiple ETINs who choose to receive the 835 electronic remittance advice may elect to receive the status of paper claim submissions and state-submitted adjustments/voids in the 835 format. The request must be submitted using the Electronic Remittance Request Form located at www.emedny.org. If this option is chosen, no paper remittance will be produced and the status of claims will appear on the electronic 835 remittance advice for the ETIN indicated on the request form. Retro-adjustment information is also sent in the 835 transaction format. Pending claims do not appear in the 835 transaction; they are listed in the Supplemental file, which will be sent along with the 835 transaction for any processing cycle that produces pends.

Note: Providers with only one ETIN who elect to receive an electronic remittance, will have the status of any claims submitted via paper forms and state-submitted adjustments/voids reported on that electronic remittance.

Paper Remittance Advice

Remittance advices are also available on paper. Providers who bill electronically but do not specifically request to receive the 835 transaction are sent paper remittance advices.

Remittance Sorts

The default sort for the paper remittance advice is:
Claim Status (denied, paid, pending) – Patient ID – TCN

Providers can request other sort patterns that may better suit their accounting systems. The additional sorts available are as follows:

- TCN – Claim Status – Patient ID – Date of Service
- Patient ID – Claim Status – TCN
- Date of Service – Claim Status – Patient ID

To request a sort pattern other than the default, providers **must** complete the Paper Remittance Sort Request Form, which is available at www.emedny.org by clicking on the link to the web page below:

[Provider Enrollment Forms](#)

For additional information, providers may also call the eMedNY Call Center at 800-343-9000.

Remittance Advice Format

The remittance advice is composed of five sections as described below.

- Section One may be one of the following:
 - ▶ Medicaid Check
 - ▶ Notice of Electronic Funds Transfer
 - ▶ Summout (no claims paid)
- Section Two: Provider Notification (special messages)
- Section Three: Claim Detail
- Section Four:
 - ▶ Financial Transactions (recoupments)
 - ▶ Accounts Receivable (cumulative financial information)
- Section Five: Edit (Error) Description

Explanation of Remittance Advice Sections

The next pages present a sample of each section of the remittance advice for HCBS/TBI Waiver providers followed by an explanation of the elements contained in the section.

The information displayed in the remittance advice samples is for illustration purposes only. The following information applies to a remittance advice with the default sort pattern.

Section One – Medicaid Check

For providers who have selected to be paid by check, a Medicaid check is issued when the provider has claims approved for the cycle and the approved amount is greater than the recoupments, if any, scheduled for the cycle. This section contains the check stub and the actual Medicaid check (payment).



TO: CITY HOME CARE

DATE: 2007-08-06
 REMITTANCE NO: 07080600001
 PROV ID: 00111234

00111234 2007-08-06
 CITY HOME CARE
 111 MAIN ST
 ANYTOWN NY 11111

YOUR CHECK IS BELOW – TO DETACH, TEAR ALONG PERFORATED DASHED LINE

29
2

DATE	REMITTANCE NUMBER	PROVIDER ID NO.
2007-08-06 <small>VOID AFTER 90 DAYS</small>	07080600001	00111234

PAY	DOLLARS/CENTS
	\$*****1877.11

TO
THE
ORDER
OF

CITY HOME CARE
 111 MAIN ST
 ANYTOWN NY 11111



MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
 CHECKS DRAWN ON
 KEY BANK N.A.
 60 STATE STREET, ALBANY, NEW YORK 12207

John Smith
AUTHORIZED SIGNATURE

Check Stub Information

UPPER LEFT CORNER

Provider's name (as recorded in the Medicaid files)

UPPER RIGHT CORNER

Date on which the remittance advice was issued

Remittance number

PROV ID: This field will contain the Medicaid Provider ID

CENTER

Medicaid Provider ID/Date

Provider's name/Address

Medicaid Check

LEFT SIDE

Table

Date on which the check was issued

Remittance number

Provider ID No.: This field will contain the Medicaid Provider ID

Provider's name/Address

RIGHT SIDE

Dollar amount. This amount must equal the Net Total Paid Amount under the Grand Total subsection plus the total sum of the Financial Transaction section.

Section One – EFT Notification

For providers who have selected electronic funds transfer (or direct deposit), an EFT transaction is processed when the provider has claims approved during the cycle and the approved amount is greater than the recoupments, if any, scheduled for the cycle. This section indicates the amount of the EFT.

TO: CITY HOME CARE



DATE: 2007-08-06
REMITTANCE NO: 07080600001
PROV ID: 00111234

00111234 2007-08-06
CITY HOME CARE
111 MAIN STREET
ANYTOWN NY 11111

CITY HOME CARE \$1877.11

PAYMENT IN THE ABOVE AMOUNT WILL BE DEPOSITED VIA AN ELECTRONIC FUNDS TRANSFER.

Information on the EFT Notification Page

UPPER LEFT CORNER

Provider's name (as recorded in the Medicaid files)

UPPER RIGHT CORNER

Date on which the remittance advice was issued

Remittance number

PROV ID: This field will contain the Medicaid Provider ID

CENTER

Medicaid Provider ID/Date: This field will contain the Medicaid Provider ID

Provider's name/Address

Provider's Name – Amount transferred to the provider's account. This amount must equal the Net Total Paid Amount under the Grand Total subsection plus the total sum of the Financial Transaction section.

Section One – Summout (No Payment)

A summout is produced when the provider has no positive total payment for the cycle and, therefore, there is no disbursement of moneys.

TO: CITY HOME CARE



DATE: 08/06/2007
REMITTANCE NO: 07080600001
PROV ID: 00111234

NO PAYMENT WILL BE RECEIVED THIS CYCLE. SEE REMITTANCE FOR DETAILS.

CITY HOME CARE
111 MAIN ST
ANYTOWN NY 11111

Information on the Summit Page

UPPER LEFT CORNER

Provider Name (as recorded in Medicaid files)

UPPER RIGHT CORNER

Date on which the remittance advice was issued

Remittance number

PROV ID: This field will contain the Medicaid Provider ID

CENTER

Notification that no payment was made for the cycle (no claims were approved)

Provider name and address

Section Two – Provider Notification

This section is used to communicate important messages to providers.



PAGE 01
DATE 08/06/07
CYCLE 1563

TO: CITY HOME CARE
111 MAIN STREET
ANYTOWN, NEW YORK 11111

ETIN:
PROVIDER NOTIFICATION
PROV ID 00111234
REMITTANCE NO 07080600001

REMITTANCE ADVICE MESSAGE TEXT

*** ELECTRONIC FUNDS TRANSFER (EFT) FOR PROVIDER PAYMENTS IS NOW AVAILABLE ***

PROVIDERS WHO ENROLL IN EFT WILL HAVE THEIR MEDICAID PAYMENTS DIRECTLY DEPOSITED INTO THEIR CHECKING OR SAVINGS ACCOUNT.

THE EFT TRANSACTIONS WILL BE INITIATED ON WEDNESDAYS AND DUE TO NORMAL BANKING PROCEDURES, THE TRANSFERRED FUNDS MAY NOT BECOME AVAILABLE IN THE PROVIDER'S CHOSEN ACCOUNT FOR UP TO 48 HOURS AFTER TRANSFER. PLEASE CONTACT YOUR BANKING INSTITUTION REGARDING THE AVAILABILITY OF FUNDS.

PLEASE NOTE THAT EFT DOES NOT WAIVE THE TWO-WEEK LAG FOR MEDICAID DISBURSEMENTS.

TO ENROLL IN EFT, PROVIDERS MUST COMPLETE AN EFT ENROLLMENT FORM THAT CAN BE FOUND AT WWW.EMEDNY.ORG. CLICK ON PROVIDER ENROLLMENT FORMS WHICH CAN BE FOUND IN THE FEATURED LINKS SECTION. DETAILED INSTRUCTIONS WILL ALSO BE FOUND THERE.

AFTER SENDING THE EFT ENROLLMENT FORM TO CSC, PLEASE ALLOW A MINIMUM TIME OF SIX TO EIGHT WEEKS FOR PROCESSING. DURING THIS PERIOD OF TIME YOU SHOULD REVIEW YOUR BANK STATEMENTS AND LOOK FOR AN EFT TRANSACTION IN THE AMOUNT OF \$0.01 WHICH CSC WILL SUBMIT AS A TEST. YOUR FIRST REAL EFT TRANSACTION WILL TAKE PLACE APPROXIMATELY FOUR TO FIVE WEEKS LATER.

IF YOU HAVE ANY QUESTIONS ABOUT THE EFT PROCESS, PLEASE CALL THE EMEDNY CALL CENTER AT 1-800-343-9000.

NOTICE: THIS COMMUNICATION AND ANY ATTACHMENTS MAY CONTAIN INFORMATION THAT IS PRIVILEGED AND CONFIDENTIAL UNDER STATE AND FEDERAL LAW AND IS INTENDED ONLY FOR THE USE OF THE SPECIFIC INDIVIDUAL(S) TO WHOM IT IS ADDRESSED. THIS INFORMATION MAY ONLY BE USED OR DISCLOSED IN ACCORDANCE WITH LAW, AND YOU MAY BE SUBJECT TO PENALTIES UNDER LAW FOR IMPROPER USE OR FURTHER DISCLOSURE OF INFORMATION IN THIS COMMUNICATION AND ANY ATTACHMENTS. IF YOU HAVE RECEIVED THIS COMMUNICATION IN ERROR, PLEASE IMMEDIATELY NOTIFY NYHIPPADESK@CSC.COM OR CALL 1-800-541-2831. PROVIDERS WHO DO NOT HAVE ACCESS TO E-MAIL SHOULD CONTACT 1-800-343-9000.

Information on the Provider Notification Page

UPPER LEFT CORNER

Provider's name and address

UPPER RIGHT CORNER

Remittance page number

Date on which the remittance advice was issued

Cycle number

ETIN (not applicable)

Name of section: **PROVIDER NOTIFICATION**

PROV ID: This field will contain the Medicaid Provider ID

Remittance number

CENTER

Message text

Section Three – Claim Detail

This section provides a listing of all new claims that were processed during the specific cycle plus claims that were previously pended and denied during the specific cycle. This section may also contain claims that pended previously.


MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

PAGE 02
 DATE 08/06/2007
 CYCLE 1563

TO: CITY HOME CARE
 111 MAIN STREET
 ANYTOWN, NEW YORK 11111

ETIN:
 HOME HEALTH
 PROV ID: 00111234
 REMITTANCE NO: 07080600001

OFFICE ACCOUNT NUMBER	CLIENT NAME	CLIENT ID.	TCN	DATE OF SERVICE	RATE CODE	UNITS	CHARGED	PAID	STATUS	ERRORS
CPIC1-00974-6	JONES	AA12345W	07206-000012112-3-2	07/25/07	9872	10.000	187.81	0.00	DENY	00162 00131
CPIC1-00575-6	EVANS	BB54321X	07206-000019113-3-1	07/25/07	9872	8.000	84.38	0.00	DENY	00244 00142

* = PREVIOUSLY PENDED CLAIM
 ** = NEW PEND

TOTAL AMOUNT ORIGINAL CLAIMS	DENIED	272.19	NUMBER OF CLAIMS	2
NET AMOUNT ADJUSTMENTS	DENIED	0.00	NUMBER OF CLAIMS	0
NET AMOUNT VOIDS	DENIED	0.00	NUMBER OF CLAIMS	0
NET AMOUNT VOIDS – ADJUSTS		0.00	NUMBER OF CLAIMS	0

HCBS/TBI UB-04 Billing Guidelines



PAGE 03
DATE 08/06/2007
CYCLE 1563

ETIN:
HOME HEALTH
PROV ID: 00111234
REMITTANCE NO: 07080600001

TO: CITY HOME CARE
111 MAIN STREET
ANYTOWN, NEW YORK 11111

**MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT**

OFFICE ACCOUNT NUMBER	CLIENT NAME	CLIENT ID.	TCN	DATE OF SERVICE	RATE CODE	UNITS	CHARGED	PAID	STATUS	ERRORS
CPIC3-16774-6	DAVIS	AA11111Z	07206-000034112-0-2	07/25/07	9872	8.000	300.20	300.20	PAID	
CPIC3-22921-6	THOMAS	BB22222Y	07206-000445113-0-2	07/23/07	9872	5.000	188.41	188.41	PAID	
CPIC1-45755-6	JONES	CC33333X	07206-000466333-0-2	07/27/07	9872	8.000	300.20	300.20	PAID	
CPIC1-60775-6	GARCIA	DD44444W	07206-000445663-0-2	07/22/07	9872	8.000	300.20	300.20	PAID	
CPIC1-33733-6	BROWN	EE55555V	07206-000447654-0-2	07/22/07	9872	8.000	300.20	300.20	PAID	
CPIC1-55789-6	SMITH	GG66666U	07206-000465553-0-2	07/25/07	9872	7.000	186.10	186.10	PAID	
CPIC1-76744-6	WAGNER	HH77777T	07206-000455557-0-2	07/25/07	9872	8.000	300.20	300.20	PAID	
CPIC1-66754-6	MCNALLY	JJ88888S	07206-000544444-0-2	07/25/07	9872	5.000	150.90	150.90	ADJT	
CPIC1-91766-6	STEVENS	KK99999R	07206-000465477-0-2	07/24/07	9872	8.000	300.20	-300.20-	PAID	ORIGINAL CLAIM PAID 07/11/2007

* = PREVIOUSLY PENDED CLAIM
** = NEW PEND

TOTAL AMOUNT ORIGINAL CLAIMS	PAID	2026.41	NUMBER OF CLAIMS	8
NET AMOUNT ADJUSTMENTS	PAID	49.30-	NUMBER OF CLAIMS	1
NET AMOUNT VOIDS	PAID	0.00	NUMBER OF CLAIMS	0
NET AMOUNT VOIDS – ADJUSTS		149.30-	NUMBER OF CLAIMS	1

HCBS/TBI UB-04 Billing Guidelines



PAGE 04
DATE 08/06/2007
CYCLE 1563

TO: CITY HOME CARE
111 MAIN STREET
ANYTOWN, NEW YORK 11111

**MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT**

ETIN:
HOME HEALTH
PROV ID: 00111234
REMITTANCE NO: 07080600001

OFFICE ACCOUNT NUMBER	CLIENT NAME	CLIENT ID.	TCN	DATE OF SERVICE	RATE CODE	UNITS	CHARGED	PAID	STATUS	ERRORS
CPIC1-06774-6	EVANS	BB54321X	07206-000034112-3-2	07/25/07	9872	8.000	300.20	**	PEND	00162 00244
CPIC1-00974-6	JONES	AA12345W	07206-000445113-3-1	07/22/07	9872	5.000	188.41	**	PEND	00162 00244

* = PREVIOUSLY PENDED CLAIM
** = NEW PEND

TOTAL AMOUNT ORIGINAL CLAIMS	PEND	488.61	NUMBER OF CLAIMS	2
NET AMOUNT ADJUSTMENTS	PEND	0.00	NUMBER OF CLAIMS	0
NET AMOUNT VOIDS	PEND	0.00	NUMBER OF CLAIMS	0
NET AMOUNT VOIDS – ADJUSTS		0.00	NUMBER OF CLAIMS	0

REMITTANCE TOTALS – HOME HEALTH				
VOIDS – ADJUSTS		0.00	NUMBER OF CLAIMS	0
TOTAL PENDS		0.00	NUMBER OF CLAIMS	0
TOTAL PAID		0.00	NUMBER OF CLAIMS	0
TOTAL DENIED		775.62	NUMBER OF CLAIMS	2
NET TOTAL PAID		0.00	NUMBER OF CLAIMS	0

MEMBER ID: 00111234				
VOIDS – ADJUSTS		149.30-	NUMBER OF CLAIMS	1
TOTAL PENDS		488.61	NUMBER OF CLAIMS	2
TOTAL PAID		2026.41	NUMBER OF CLAIMS	8
TOTAL DENY		272.19	NUMBER OF CLAIMS	2
NET TOTAL PAID		1877.11	NUMBER OF CLAIMS	8

MEDICAID
MANAGEMENT
INFORMATION SYSTEM
**MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT**

PAGE: 05
DATE: 08/06/2007
CYCLE: 1563

ETIN:
HOME HEALTH
GRAND TOTALS
PROV ID: 00111234
REMITTANCE NO: 07080600001

TO: CITY HOME CARE
111 MAIN STREET
ANYTOWN, NEW YORK 11111

REMITTANCE TOTALS – GRAND TOTALS

VOIDS – ADJUSTS	149.30-	NUMBER OF CLAIMS	1
TOTAL PENDS	488.61	NUMBER OF CLAIMS	2
TOTAL PAID	2026.41	NUMBER OF CLAIMS	8
TOTAL DENY	272.19	NUMBER OF CLAIMS	2
NET TOTAL PAID	1877.11	NUMBER OF CLAIMS	8

General Information on the Claim Detail Pages

UPPER LEFT CORNER

Provider's name and address

UPPER RIGHT CORNER

Remittance page number

Date on which the remittance advice was issued

Cycle number. The cycle number should be used when calling the eMedNY Call Center with questions about specific processed claims or payments.

ETIN (not applicable)

Provider Service Classification: **Home Health**

PROV ID: This field will contain the Medicaid Provider ID

Remittance number

Explanation of the Claim Detail Columns

OFFICE ACCOUNT NUMBER

If a Patient/Office Account Number was entered in the claim form, that number (up to 20 characters) will appear under this column.

CLIENT NAME

This column indicates the last name of the patient. If an invalid Medicaid Client ID was entered in the claim form, the ID will be listed as it was submitted but no name will appear in this column.

CLIENT ID

The patient's Medicaid ID number appears under this column.

TCN

The TCN is a unique identifier assigned to each claim that is processed. If multiple claim lines are submitted on the same claim form, all the lines are assigned the same TCN.

DATE OF SERVICE

The first date of service (From date) entered in the claim appears under this column. If a date different from the From date was entered in the Through date box, that date is not returned in the Remittance Advice.

RATE CODE

The four-digit rate code that was entered in the claim form appears under this column.

UNITS

The total number of units of service for the specific claim appears under this column. The units are indicated with three (3) decimal positions. Since Home Health must only report whole units of service, the decimal positions will always be 000. For example: 3 units will be indicated as 3.000.

CHARGED

The total charges entered in the claim form appear under this column.

PAID

If the claim was approved, the amount paid appears under this column. If the claim has a pend or deny status, the amount paid will be zero (0.00).

STATUS

This column indicates the status (DENY, PAID/ADJT/VOID, PEND) of the claim line.

Denied Claims

Claims for which payment is denied will be identified by the **DENY** status. A claim may be denied for the following general reasons:

- The service rendered is not covered by the New York State Medicaid Program.
- The claim is a duplicate of a prior paid claim.
- The required Prior Approval has not been obtained.
- Information entered in the claim form is invalid or logically inconsistent.

Approved Claims

Approved claims will be identified by the statuses **PAID**, **ADJT** (adjustment), or **VOID**.

Paid Claims

The status PAID refers to **original** claims that have been approved.

Adjustments

The status ADJT refers to a claim submitted in replacement of a paid claim with the purpose of changing one or more fields. An adjustment has two components: the credit transaction (previously paid claim), and the debit transaction (adjusted claim).

Voids

The status VOID refers to a claim submitted with the purpose of canceling a previously paid claim. A void lists the credit transaction (previously paid claim) only.

Pending Claims

Claims that require further review or recycling will be identified by the **PEND** status. The following are examples of circumstances that commonly cause claims to be pended:

- New York State Medical Review required.
- Procedure requires manual pricing.
- No match found in the Medicaid files for certain information submitted on the claim, for example: Patient ID, Prior Approval, Service Authorization. These claims are recycled for a period of time during which the Medicaid files may be updated to match the information on the claim.

After manual review is completed, a match is found in the Medicaid files or the recycling time expires, pended claims may be approved for payment or denied.

A new pend is signified by two asterisks (**). A previously pended claim is signified by one asterisk (*).

ERRORS

For claims with a DENY or PEND status, this column indicates the NYS Medicaid edit (error) numeric code(s) that caused the claim to deny or pend. Some edit codes may also be indicated for a PAID claim. These are approved edits, which identify certain errors found in the claim and that do not prevent the claim from being approved. Up to twenty-five (25) edit codes, including approved edits, may be listed for each claim. Edit code definitions will be listed on a separate page of the remittance advice, at the end of the claim detail section.

Subtotals/Totals

Subtotals of dollar amounts and number of claims are provided as follows:

Subtotals by claim **status** appear at the end of the claim listing for each status. The subtotals are broken down by:

- Original claims
- Adjustments
- Voids
- Adjustments/voids combined

Totals by **service classification** and by **member ID** are provided next to the subtotals for service classification/locator code. These totals are broken down by:

- Adjustments/voids (combined)
- Pends
- Paid
- Deny
- Net total paid (for the specific service classification)

Grand Totals for the entire provider remittance advice, which include all the provider's service classifications, appear on a separate page following the page containing the **totals by service classification**. The grand total is broken down by:

- Adjustments/voids (combined)
- Pends
- Paid
- Deny
- Net total paid (entire remittance)


Section Four

This section has two subsections:

- Financial Transactions
- Accounts Receivable

Financial Transactions

The Financial Transactions subsection lists all the recoupments that were applied to the provider during the specific cycle. If there is no recoupment activity, this subsection is not produced.

TO: CITY HOME CARE 111 MAIN STREET ANYTOWN, NEW YORK 11111	 <p>MEDICAID MANAGEMENT INFORMATION SYSTEM MEDICAL ASSISTANCE (TITLE XIX) PROGRAM REMITTANCE STATEMENT</p>	PAGE 07 DATE 08/06/07 CYCLE 1563 ETIN: FINANCIAL TRANSACTIONS PROV ID: 00111234 REMITTANCE NO:07080600001															
<table border="0" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left; border-bottom: 1px solid black;">FCN</th> <th style="text-align: left; border-bottom: 1px solid black;">FINANCIAL REASON CODE</th> <th style="text-align: left; border-bottom: 1px solid black;">FISCAL TRANS TYPE</th> <th style="text-align: left; border-bottom: 1px solid black;">DATE</th> <th style="text-align: left; border-bottom: 1px solid black;">AMOUNT</th> </tr> </thead> <tbody> <tr> <td>20070506023547</td> <td>XXX</td> <td>RECOUPMENT REASON DESCRIPTION</td> <td>07 09 07</td> <td>\$\$\$</td> </tr> <tr> <td colspan="2" style="padding-top: 20px;">NET FINANCIAL AMOUNT</td> <td>\$\$\$</td> <td colspan="2" style="padding-top: 20px;">NUMBER OF FINANCIAL TRANSACTIONS XXX</td> </tr> </tbody> </table>			FCN	FINANCIAL REASON CODE	FISCAL TRANS TYPE	DATE	AMOUNT	20070506023547	XXX	RECOUPMENT REASON DESCRIPTION	07 09 07	\$\$\$	NET FINANCIAL AMOUNT		\$\$\$	NUMBER OF FINANCIAL TRANSACTIONS XXX	
FCN	FINANCIAL REASON CODE	FISCAL TRANS TYPE	DATE	AMOUNT													
20070506023547	XXX	RECOUPMENT REASON DESCRIPTION	07 09 07	\$\$\$													
NET FINANCIAL AMOUNT		\$\$\$	NUMBER OF FINANCIAL TRANSACTIONS XXX														

Explanation of the Financial Transactions Columns

FCN (Financial Control Number)

This is a unique identifier assigned to each financial transaction.

FINANCIAL REASON CODE

This code is for DOH/CSC use only; it has no relevance to providers. It identifies the reason for the recoupment.

FISCAL TRANSACTION TYPE

This is the description of the Financial Reason Code. For example: Third Party Recovery.

DATE

The date on which the recoupment was applied. Since all the recoupments listed on this page pertain to the current cycle, all the recoupments will have the same date.

AMOUNT

The dollar amount corresponding to the particular fiscal transaction. This amount is deducted from the provider's total payment for the cycle.

Totals

The total dollar amount of the financial transactions (**Net Financial Transaction Amount**) and the total number of transactions (**Number of Financial Transactions**) appear below the last line of the transaction detail list.

The Net Financial Transaction Amount added to the Claim Detail-Grand Total must equal the Medicaid Check or EFT amounts.

Accounts Receivable

This subsection displays the original amount of each of the outstanding Financial Transactions and their current balance after the cycle recoupments were applied. If there are no outstanding negative balances, this section is not produced.



TO: CITY HOME CARE
111 MAIN STREET
ANYTOWN, NEW YORK 11111

PAGE 08
DATE 08/06/07
CYCLE 1563

ETIN:
ACCOUNTS RECEIVABLE
PROV ID: 00111234
REMITTANCE NO: 07080600001

REASON CODE DESCRIPTION	ORIG. BAL	CURR BAL	RECOUP %/AMT
	\$XXX.XX-	\$XXX.XX-	999
	\$XXX.XX-	\$XXX.XX-	999

TOTAL AMOUNT DUE THE STATE \$XXX.XX

Explanation of the Accounts Receivable Columns

If a provider has negative balances of different nature (for example, the result of adjustments/voids, the result of retro-adjustments, etc.) or negative balances created at different times, each negative balance will be listed in a different line.

REASON CODE DESCRIPTION

This is the description of the Financial Reason Code. For example, Third Party Recovery.

ORIGINAL BALANCE

The original amount (or starting balance) for any particular financial reason.

CURRENT BALANCE

The current amount owed to Medicaid (after the cycle recoupments, if any, were applied). This balance may be equal to or less than the original balance.

RECOUPMENT % AMOUNT

The deduction (recoupment) scheduled for each cycle.

Total Amount Due the State

This amount is the sum of all the **Current Balances** listed above.

Section Five – Edit Descriptions

The last section of the Remittance Advice features the description of each of the edit codes (including approved codes) failed by the claims listed in Section Three.



TO: CITY HOME CARE
111 MAIN STREET
ANYTOWN, NEW YORK 11111

PAGE 06
DATE 08/06/2007
CYCLE 1563

ETIN:
HOME HEALTH
EDIT DESCRIPTIONS
PROV ID: 00111234
REMITTANCE NO: 07080600001

THE FOLLOWING IS A DESCRIPTION OF THE EDIT REASON CODES THAT APPEAR ON THE CLAIMS FOR THIS REMITTANCE:

- 00131 THIRD PARTY INDICATED OTHER INSURANCE PAD BLANK
- 00142 RECIPIENT YEAR OF BIRTH DIFFERS FROM FILE
- 00162 RECIPIENT INELIGIBLE ON DATE OF SERVICE
- 00244 PA NOT ON FILE