



New York State UB-04 Billing Guidelines

**HOME AND COMMUNITY BASED SERVICES
WAIVER FOR PERSONS WITH TRAUMATIC
BRAIN INJURIES (HCBS/TBI 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 Waiver for Persons with Traumatic Brain Injuries (HCBS/TBI).

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

2.1 Electronic Claims

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

2.2 Paper Claims

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

2.3 HCBS/TBI Services Billing Instructions

This subsection of the Billing Guidelines covers the specific NYS Medicaid billing requirements for HCBS/TBI 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)

837I Ref: Loop 2300 DTP03 when DTP01 = 434

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

- **When billing for one date of service**, enter the date in the FROM box. The THROUGH box may contain the same date or may be left blank.
- **When billing for multiple dates of service for the same rate code**, enter the first service date of the billing period in the FROM box and the last service date in the THROUGH box. The FROM/THROUGH dates must be in

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WAIVER)

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

Serv. Units (Form Locator 46)

837I Ref: Loop2400 SV205

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

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

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.

HCBS/TBI Waiver - UB-04 Sample Claim

1 City Home Care 111 Main Street Anytown, NY 11111		2	3a PAT. CNTL# AB1234567	APPROVED OMB NO. 0938-0279		4 TYPE OF BILL 340
b. MED. REC.#			6 STATEMENT COVERS PERIOD FROM 04012007 THROUGH 04302007		7	
5 FED. TAX NO.						
8 PATIENT NAME a b SAM H. WELLS		9 PATIENT ADDRESS a b				
10 BIRTHDATE 04191940	11 SEX M	12 DATE 13 HR 14 TYPE 15 SRC 16 DHR	17 STAT 30	18 CONDITION CODES 22 23 24 25 26 27 28		
19 ACCT STATE		20				
21 OCCURRENCE CODE	22 DATE	23 OCCURRENCE CODE	24 DATE	25 OCCURRENCE CODE	26 DATE	
27 OCCURRENCE SPAN CODE FROM THROUGH		28 OCCURRENCE SPAN CODE FROM THROUGH		29		
30		31		32		
33		34		35		
36		37		38		
39 VALUE CODES CODE AMOUNT		40 VALUE CODES CODE AMOUNT		41 VALUE CODES CODE AMOUNT		
61 003.		24 9858.		A3 00.00		
b		c		d		
e		f		g		
h		i		j		
k		l		m		
n		o		p		
q		r		s		
t		u		v		
w		x		y		
z		aa		ab		
ac		ad		ae		
af		ag		ah		
ai		aj		ak		
al		am		an		
ao		ap		aq		
ar		as		at		
au		av		aw		
ax		ay		az		
ba		bb		bc		
bd		be		bf		
bg		bh		bi		
bj		bk		bl		
bm		bn		bo		
bp		bq		br		
bs		bt		bu		
bv		bw		bx		
by		bz		ca		
cb		cc		cd		
ce		cf		cg		
ch		ci		cj		
ck		cl		cm		
cn		co		cp		
cq		cr		cs		
ct		cu		cv		
cw		cx		cy		
cz		ca		cb		
cc		cd		ce		
cd		ce		cf		
ce		cf		cg		
cf		cg		ch		
cg		ch		ci		
ch		ci		cj		
ci		cj		ck		
cj		ck		cl		
ck		cl		cm		
cl		cm		cn		
cm		cn		co		
cn		co		cp		
co		cp		cq		
cp		cq		cr		
cq		cr		cs		
cr		cs		ct		
cs		ct		cu		
ct		cu		cv		
cu		cv		cw		
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eh		ei		ej		
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ej		ek		el		
ek		el		em		
el		em		en		
em		en		eo		
en		eo		ep		
eo		ep		eq		
ep		eq		er		
eq		er		es		
er		es		et		
es		et		eu		
et		eu		ev		
eu		ev		ew		
ev		ew		ex		
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ex		ey		ez		
ey		ez		fa		
ez		fa		fb		
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fb		fc		fd		
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fg		fh		fi		
fh		fi		fj		
fi		fj		fk		
fj		fk		fl		
fk		fl		fm		
fl		fm		fn		
fm		fn		fo		
fn		fo		fp		
fo		fp		fq		
fp		fq		fr		
fq		fr		fs		
fr		fs		ft		
fs		ft		fu		
ft		fu		fv		
fu		fv		fw		
fv		fw		fx		
fw		fx		fy		
fx		fy		fz		
fy		fz		ga		
fz		ga		gb		
ga		gb		gc		
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gw		gx		gy		
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hq		hr		hs		
hr		hs		ht		
hs		ht		hu		
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kd		ke		kf		
ke		kf		kg		
kf		kg		kh		
kg		kh		ki		
kh		ki		kj		
ki		kj		kk		
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ku		kv		kw		
kv		kw		kx		
kw		kx		ky		
kx		ky		kz		
ky		kz		la		
kz		la		lb		
la		lb		lc		
lb		lc		ld		
lc		ld		le		
ld		le		lf		
le		lf		lg		
lf		lg		lh		
lg		lh		li		
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lj		lk		ll		
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lm		ln		lo		
ln		lo		lp		
lo		lp		lq		
lp		lq		lr		
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lr		ls		lt		
ls		lt		lu		
lt		lu		lv		
lu		lv		lw		
lv		lw		lx		
lw		lx		ly		
lx		ly		lz		
ly		lz		ma		
lz		ma		mb		
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