NEW YORK STATE
MEDICAID PROGRAM

HOME AND COMMUNITY BASED SERVICES
(HCBS) WAIVER

BILLING GUIDELINES

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Section I – Purpose Statement

The purpose of this document is to assist the provider community to understand and comply 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 Waiver providers and it should be used by the provider's billing staff as an instructional as well as a reference tool.

Section II – Claims Submission

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

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 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) – A document that explains the proper use of the 837I standards and program specifications. This document is available at http://www.wpc-edi.com/hipaa.

- NYS-Medicaid 837I Companion Guide (CG) – A subset of the IG, which provides instructions for the specific requirements of NYS-Medicaid for the 837I. This document is available at www.nyhipaadesk.com. Click on the News and Resources tab and select Companion Guides from the menu.

- NYS-Medicaid Technical Supplementary Companion Guide – This document 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. The Technical Supplementary CG is available at www.nyhipaadesk.com. Click on the News and Resources tab and select Supplementary Companion Guides from the menu.

Pre-requirements for the Submission of Electronic Claims

Before being able to start submitting electronic claims to NYS-Medicaid, providers need the following:

- An Electronic Transmitter Identification Number (ETIN)

- A Certification Statement

- A User ID and Password

- A Trading Partner Agreement
- Testing

ETIN
This is a four-character submitter identifier, issued by the NYS-Medicaid Fiscal Agent upon application and that must be used in every electronic transaction submitted to the NYS-Medicaid. ETINs may be issued to an individual provider or provider group (if they are direct billers) and to service bureaus or clearinghouses.

ETIN applications are available at www.emedny.org under Information/Provider Enrollment Forms/4010-ETIN Provider.

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

The Certification Statement is good for one year, after which it needs to be renewed for electronic 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 at www.emedny.org together with the ETIN application.

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.

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.

Testing
Direct billers (either individual providers or service bureaus/clearing houses 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 under Information/eMedNY Phase II Overview/eMedNY Provider Testing Guide

Communication Methods

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

- eMedNY eXchange
- FTP
- CPU to CPU
- eMedNY Gateway

eMedNY eXchange
The eMedNY eXchange works like email; users are assigned an inbox and they are able to send and receive transaction files in an email-like fashion. Transaction files are attached and sent to eMedNY for processing and the responses are delivered to the user's inbox so they can be detached and saved on the user's computer. **For security reasons, the eMedNY eXchange is accessible only through the eMedNY website** (www.emedny.org).

The eMedNY eXchange only accepts HIPAA compliant transactions.

Access to the eMedNY eXchange is obtained through an enrollment process. Procedures and instructions regarding how to enroll into the eMedNY eXchange are available at www.emedny.org.

FTP
FTP allows for direct or dial-up connection.

CPU to CPU (FTP)
This method consists of an established direct connection between the submitter and the processor and it is most suitable for high volume submitters. For questions regarding FTP connection, call CSC-Electronic Claims Assistance (ECA) at 518-xxx-xxxx.

eMedNY Gateway
This is a dial-up access method. It requires the use of the User ID assigned at the time of enrollment and a password.

Note: For questions regarding FTP, CPU to CPU or eMedNY Gateway connections call CSC-Provider Enrollment Support at 800-343-9000.

ePACES

Additionally, 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.

To take advantage of ePACES, providers need to follow an enrollment process, which is available at www.emedny.org. Providers who enroll in ePACES will be automatically enrolled in eMedNY eXchange.

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 (except for DVS transactions)
- 837 - Dental, Professional, and Institutional Claims

Paper Claims

HCBS Waiver providers who choose to submit their claims on paper forms must use the CMS- standard UB-92 claim form. A link to this form appears at the end of this subsection.

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
6.00	6.00	6.60 → Zero interpreted as six

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

Written As	Intended As	Interpreted As
2	2	7 → Two interpreted as seven
3	3	2 → Three interpreted as two

- Characters should not touch each other. Example:

Written As	Intended As	Interpreted As
23	23	illegible → 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 filling in 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.
- Do not write or use staples on the bar-code area.

If submitting multiple claim forms, they may be batched up to 100 forms per batch. Use paper clips or rubber bands to hold the claim forms in each batch together. Do not use staples.

For mailing completed claim forms, use the self-addressed envelopes provided by CSC for this purpose. For information on how to order envelopes please refer to Information for All Providers, Inquiry section. The address for submitting claim forms is:

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

UB-92 Claim Form

To view the UB-92 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.

Claim Sample-UB92NR-HCBS

General Information About the UB-92 Form

The UB-92 HCFA-1450 is a CMS standard form; therefore CSC does not supply it. These forms can be obtained from any of the national suppliers.

The UB-92 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 Manual as a reference guide for the preparation of claims to be submitted to NYS Medicaid.

The unlabeled fields in this claim form, with the exception of Fields 1 and 37, have no NYS Medicaid application; therefore instructions for using these fields (2, 11, 31, 38, 49,

56, 57, and 78) are not provided.

The labeled fields listed below have no NYS Medicaid application; therefore instructions for using these fields are not provided:

Fields 5, 10, 13, 16-18, 20, 21, 23, 36, 44, 45, 48, 52–55, 58, 59, 61, 62, 64–66, 76, 77, 79-81, and 84.

Billing Instructions for HCBS Waiver Services

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-92 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 that they need to use, etc.

It is important that the providers adhere to the instructions outlined below. Claims that do not conform to the eMedNY requirements as described throughout this document may be rejected, pended, or denied.

Field-by-Field (UB-92) Instructions

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

Enter the billing provider's name and address.

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 please refer to Information for All Providers, Inquiry section.

PATIENT CONTROL NO. (Form Locator 3)

For record-keeping purposes, the provider may choose to identify a recipient by using an account/patient control number. This field can accommodate up to 20 alpha-numeric characters. If an account/patient control number is indicated on the claim form, it will be returned on the Remittance Advice. Using an account/patient control number can be helpful for locating accounts when there is a question on recipient 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-92 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-92 Manual, Form Locator 4, Bill Classification (Except Clinics and Special Facilities) category.

Example:

4 TYPE OF BILL
34X

Frequency - Adjustment/Void Code
New York State Medicaid uses the third position of this field **only** to identify 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
34**0**

- 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
34**7**

- 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
34**8**

STATEMENT COVERS PERIOD FROM/THROUGH (Form Locator 6)

For **monthly** rates, only **one** date of service can be billed per claim form.

Enter the date of service (according to the instructions below) in the FROM box. The

THROUGH box may contain the same date of service or be left blank.

Dates must be entered in the format MMDDYY.

Note: Claims must be submitted within 90 days of the date of service entered in this field.

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) *	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)	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)	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.

***Note:**
- **Full Month = 21 Days in residence with 4 services delivered**
- **Half Month = 11 Days in residence with 2 services delivered**

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. Providers are required to verify patient eligibility through MEVS in order to ensure payment.

COV D. [COVERED DAYS] (Form Locator 7)

Leave this field blank.

N-CD. [NON-COVERED DAYS] (Form Locator 8)

Leave this field blank.

C-ID. [COINSURANCE DAYS] (Form Locator 9)

Leave this field blank.

PATIENT NAME (Form Locator 12)

Enter the patient's last name followed by the first name as they appear on the Common Benefit Identification Card.

BIRTHDATE (Form Locator 14)

Enter the patient's birth date indicated on the Common Benefit Identification Card. The birth date must be in the format MMDDYYYY.

Example: Mary Brandon was born on March 5, 1975. Enter the birth date as 03051975.

14 BIRTHDATE
03051975

SEX (Form Locator 15)

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

ADMISSION TYPE (Form Locator 19)

Leave this field blank.

STAT [PATIENT STATUS] (Form Locator 22)

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-92 Manual.

CONDITION CODES (Form Locators 24–30)

NYS Medicaid uses Condition Codes to indicate the following:

- EPSDT/CTHP
- Family Planning
- Possible Disability
- Abortion/Sterilization

Note: EPSDT/CTHP, Family Planning, and Abortion Sterilization Code are not applicable to HCBS Waiver services.

Possible Disability – A5

If applicable, enter Condition Code **A5** to indicate that the patient's condition appeared to be of a disabling nature. Otherwise leave this field blank.

OCCURRENCE CODE/DATE (Form Locators 32–35)

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-92 Manual, Form Locators 32-35, Accident Related Codes.

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

UNLABELED [TRANSACTION CONTROL NUMBER (TCN)] (Form Locator 37 A, B, C)

If submitting an **Adjustment (Replacement)** or a **Void** to a previously paid claim, this field must be used to enter the **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 on the line (A, B, or C) that matches the line assigned to Medicaid in Form Locators 50 and 51. If the TCN is entered in lines B or C, the word **NONE** must be written on the line(s) **above** the TCN line.

When submitting an original claim, leave this field blank.

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 37).

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 37).

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

VALUE CODES (Form Locators 39–41 A, B, C, D)

NYS Medicaid uses Value Codes to report the following information:

- Locator Code (required)
- 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

Locator Codes are assigned to the provider for each service address registered at the time of enrollment in the Medicaid program or at any time afterwards that a new location is added. Locator Codes range from 001 through 020. Locator Codes 001 and 002 are for administrative use only and are not to be entered in this field.

Value Code

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

Value Amount

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

Currently, Locator Codes are issued as two-digit codes. Providers need to enter an additional zero to the left of these two-digit codes to comply with eMedNY billing requirements. For example, Locator Code 03 must be entered as 003, etc.

If the provider renders services at **one** location only, enter Locator Code 003. If the provider renders service to Medicaid recipients at **more than one** location, the entry could be any value from 003 through 020. 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 CODE	VALUE CODES 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, please refer to Information for All Providers, Inquiry section.

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 CODE	VALUE CODES AMOUNT	
a	24	4413	•
b			•
c			•
d			•

Medicare Information – See Value Codes Below
If the recipient is also a Medicare beneficiary, it is the responsibility of the provider to determine whether the service being billed for is covered by the recipient'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

1. If applicable, enter the appropriate code, as listed below, 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**

2. 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 B**X**.**

Value Amount

1. Enter the corresponding amount for each value code entered.

2. 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 recipient's billing record.

Other Insurance Payment – Value Code A3 or B3

If the recipient has insurance other than Medicare, it is the responsibility of the provider to determine whether the service being billed for is covered by the recipient'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 **A**3 or **B**3.

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) 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. Since June 1, 1992, the LDSS has new 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 recipient 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 recipient 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 CODE	VALUE CODES AMOUNT	
a	B3	100	•00
b			•
c			•
d			•

Patient Participation (Spend Down) – Value Code 31
Some recipients of the HCBS Waiver services do not become eligible for Medicaid until the pay an overage or monthly amount (spend-down) toward the cost of their medical care.

Value Code
Enter code **31** to indicate that the patient's spend-down participation is entered under Amount.

Value Amount
If applicable, enter the spend-down amount paid by the patient.

The following example illustrates a correct Patient Participation entry.

Example:

	39 CODE	VALUE CODES 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 **Total Amount Charged**.

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

SERV. UNITS (Form Locator 46)

Leave this field blank.

TOTAL CHARGES (Form Locator 47)

Enter the total amount charged for the service(s) rendered on the lines corresponding to Revenue Code 0001. 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/RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
0001					3000.00	.	
					.	.	
					.	.	

PAYER (Form Locator 50, lines 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,

1. Enter the word Medicare on line A of this field.
2. Enter the word Medicaid on line B of this field.
3. Leave line C blank.

Commercial Insurance/Medicaid Claim

If the patient has insurance coverage other than Medicare,

1. Enter the name of the Insurance carrier on line A of this field.
2. Enter the word Medicaid on line B of this field.

3. Leave line C blank.

Medicare/Commercial/Medicaid Claim
If the patient is covered by Medicare and one or more commercial insurance carriers,

1. Enter the word Medicare on line A of this field.

2. Enter the name of the other insurance carrier on line B of this field.

3. Enter the word Medicaid on line C of this field.

PROVIDER NO. (Form Locator 51)

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 payor(s) or the word **NONE**.

CERT.-SSN-HIC-ID NO. (Form Locator 60)

Enter the patient's ID Number (Client ID Number) as it appears on the Common Benefit Identification Card. 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.

The Medicaid ID should be entered on the same line (A, B, or C) that matches the line assigned to Medicaid in Form Locators 50 and 51. If the patient's Medicaid 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**.

Example: AB12345C

60 CERT.-SSN-HIC.-ID NO.	
A	NONE
B	NONE
C	AB12345C

TREATMENT AUTHORIZATION CODES (Form Locator 63)

Leave this field blank.

PRIN. DIAG. CD. (Form Locators 67–75)

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.

Example:

67 PRIN. DIAG. CD.
268.0

Note: Three-digit and four-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 billing since subcategories exist.
Acceptable Diagnosis Codes:
267
268.0
268.1

ATTENDING PHYS. ID (Form Locator 82)

Leave this field blank.

OTHER PHYS. ID (Form Locator 83)

Leave this field blank.

PROVIDER REPRESENTATIVE (Form Locator 85)

An authorized provider's representative must sign the claim form. Rubber stamp signatures are not acceptable.

DATE BILL SUBMITTED (Form Locator 86)

Enter the date on which the provider's authorized representative signed the claim form. The date should be in the format MM/DD/YY.

Example: June 14 2004 = 06/14/04

86 DATE
06/14/04

Note: In accordance with New York State regulations, claims must be submitted within 90 days of the Date of Service unless acceptable circumstances for the

delay can be documented. For more information about billing claims over 90 days or two years from the Date of Service, refer to Information for All Providers, General Billing section.

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, locator code, 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 Fiscal Agent 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 may call CSC-Provider Enrollment Support at 800-343-9000 or complete the HIPAA 835 Transaction Request form, which is available at www.emedny.org under the Information tab, click on Provider Enrollment Forms, and mail it to the address indicated on the form.

The NYS-Medicaid Companion Guides for the 835 transaction are available at www.hipaadesk.com, click on the News and Resources tab and select eMedNY Phase II HIPAA Transactions from the menu.

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 who choose to receive the 835 electronic remittance advice will receive adjudicated claims (paid/denied) detail for their electronic and paper claim submissions in this format. 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 transactions for any processing cycle that produces pends.

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. Providers who bill all of their claims on paper forms can only receive 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, please call CSC-Provider Enrollment Support at 800-343-9000 or complete the Remittance Sort Request form, available at www.emedny.org under the Information tab, click on Provider Enrollment forms, and mail it to the address indicated on the form.

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 non-residential services 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 that the recoupments (if any) scheduled for the cycle. This section contains the check stub and the actual Medicaid check (payment).

MEDICAID MANAGEMENT INFORMATION SYSTEM

TO: CITY HOME CARE

DATE: 2005-05-06
REMITTANCE NO: 05050900001
PROVIDER ID: 00111234

05050900001 2005-05-06
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.
2005-05-09 VOID AFTER 90 DAYS	05050900001	00111234

PAY

DOLLARS/CENTS
$******1877.11

TO THE ORDER OF
05050900001 2005-05-06
CITY HOME CARE
111 MAIN ST
ANYTOWN NY 11111

MEDICAID MANAGEMENT INFORMATION SYSTEM

John
Smith

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

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
Provider ID number

CENTER
Remittance number/date
Provider's name/address

Medicaid Check

LEFT SIDE
Table
Date on which the check was issued
Remittance number
Provider ID number

Remittance number
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 that the recoupments (if any) scheduled for the cycle. This section indicates the amount of the EFT.

TO: CITY HOME CARE

MEDICAID MANAGEMENT INFORMATION SYSTEM

DATE: 2005-05-09
REMITTANCE NO: 05050900001
PROVIDER ID: 00111234

05050900001 2005-05-09
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
Provider ID number

CENTER
Remittance number/date
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

MEDICAID MANAGEMENT INFORMATION SYSTEM

DATE: 05/06/2005
REMITTANCE NO: 05050900001
PROVIDER 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 Summout Page

UPPER LEFT CORNER
Provider Name (as recorded in Medicaid files)

UPPER RIGHT CORNER
Date on which the remittance advice was issued
Remittance number
Provider ID number

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.

MEDICAID MANAGEMENT INFORMATION SYSTEM

PAGE 01
DATE 05/06/05
CYCLE 446

MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

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

ETIN:
PROVIDER NOTIFICATION
PROVIDER ID 00111234
REMITTANCE NO 05050900001

REMITTANCE ADVICE MESSAGE TEXT

EMEDNY WILL BE CLOSED MONDAY, MAY 30, 2005 IN OBSERVANCE OF MEMORIAL DAY.

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**
Provider ID number
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.

MEDICAID MANAGEMENT INFORMATION SYSTEM

MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

PAGE 02
DATE 05/06/2005
CYCLE 446

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

ETIN:
HOME HEALTH
PROVIDER ID: 00111234
REMITTANCE NO: 05050900001
LOCATOR CD: 003

OFFICE ACCOUNT NUMBER	CLIENT NAME	CLIENT ID.	TCN	DATE OF SERVICE	RATE CODE	UNITS	CHARGED	PAID	STATUS	ERRORS
CPIC1-00974-6	JONES	AA12345W	04083-000012112-3-2	04/25/05	4413	10.000	187.81	0.00	DENY	00162 00131
CPIC1-00575-6	EVANS	BB54321X	04083-000019113-3-1	04/25/05	4413	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 AMOUT 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

MEDICAID MANAGEMENT INFORMATION SYSTEM

MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

PAGE 03
DATE 05/06/2005
CYCLE 446

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

ETIN:
HOME HEALTH
PROVIDER ID: 00111234
REMITTANCE NO: 05050900001
LOCATOR CD: 003

OFFICE ACCOUNT NUMBER	CLIENT NAME	CLIENT ID.	TCN	DATE OF SERVICE	RATE CODE	UNITS	CHARGED	PAID	STATUS	ERRORS
CPIC3-16774-6	DAVIS	AA11111Z	04083-000034112-0-2	04/25/05	4413	8.000	300.20	300.20	PAID	
CPIC3-22921-6	THOMAS	BB22222Y	04083-000445113-0-2	04/23/05	4413	5.000	188.41	188.41	PAID	
CPIC1-45755-6	JONES	CC33333X	04083-000466333-0-2	04/27/05	4413	8.000	300.20	300.20	PAID	
CPIC1-60775-6	GARCIA	DD44444W	04083-000445663-0-2	04/22/05	4413	8.000	300.20	300.20	PAID	
CPIC1-33733-6	BROWN	EE55555V	04083-000447654-0-2	04/22/05	4413	8.000	300.20	300.20	PAID	
CPIC1-55789-6	SMITH	GG66666U	04083-000465553-0-2	04/25/05	4413	7.000	186.10	186.10	PAID	
CPIC1-76744-6	WAGNER	HH77777T	04083-000455557-0-2	04/25/05	4413	8.000	300.20	300.20	PAID	
CPIC1-66754-6	MCNALLY	JJ88888S	04083-000544444-0-2	04/25/05	4413	5.000	150.90	150.90	ADJT	
CPIC1-91766-6	STEVENS	KK99999R	04083-000465477-0-2	04/24/05	4413	8.000	300.20	-300.20-	PAID	ORIGINAL CLAIM PAID 04/11/2005

* = PREVIOUSLY PENDED CLAIM
** = NEW PEND

TOTAL AMOUNT ORIGINAL CLAIMS	PAID	2026.41	NUMBER OF CLAIMS	8
NET AMOUT 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

MEDICAID MANAGEMENT INFORMATION SYSTEM

PAGE 04
DATE 05/06/2005
CYCLE 446

MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

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

ETIN:
HOME HEALTH
PROVIDER ID: 00111234
REMITTANCE NO: 05050900001
LOCATOR CD: 003

OFFICE ACCOUNT NUMBER	CLIENT NAME	CLIENT ID.	TCN	DATE OF SERVICE	RATE CODE	UNITS	CHARGED	PAID	STATUS	ERRORS
CPIC1-06774-6	EVANS	BB54321X	04083-000034112-3-2	04/25/05	4413	8.000	300.20	**	PEND	00162 00244
CPIC1-00974-6	JONES	AA12345W	04083-000445113-3-1	04/22/05	4413	5.000	188.41	**	PEND	00162 00244

* = PREVIOUSLY PENDED CLAIM
** = NEW PEND

TOTAL AMOUNT ORIGINAL CLAIMS	PEND	488.61	NUMBER OF CLAIMS	2
NET AMOUT 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

LOCATOR 003 TOTALS – HOME HEALTH

VOIDS – ADJUSTS	89.04-	NUMBER OF CLAIMS	1
TOTAL PENDS	0.00	NUMBER OF CLAIMS	0
TOTAL PAID	1939.05	NUMBER OF CLAIMS	5
TOTAL DENIED	775.62	NUMBER OF CLAIMS	2
NET TOTAL PAID	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: 05/06/2005
CYCLE: 446

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

ETIN:
HOME HEALTH
GRAND TOTALS
PROVIDER ID: 00111234
REMITTANCE NO: 05050900001

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 CSC with questions about specific processed claims or payments.

ETIN (not applicable)
Provider Service Classification: **HCBS Waiver**
Provider ID number
Remittance number
Locator Code (providers who have more than one locator code will receive separate Claim Detail sections for each locator code).

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 document (claim form) 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 debit transaction (adjusted claim) and the credit transaction (previously paid 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.
- Not match found in the Medicaid files for certain information submitted on the claim, for example: Recipient 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

Subtotals by **service classification/locator code** combination are provided at the end of the claim detail listing for each service classification/locator code combination. These subtotals are broken down by:

- Adjustments/voids (combined)

- Pends
- Paid
- Denied
- Net total paid (for the specific combination)

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.

MEDICAID MANAGEMENT INFORMATION SYSTEM

MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

PAGE 07
DATE 05/06/05
CYCLE 446

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

ETIN:
FINANCIAL TRANSACTIONS
PROVIDER ID: 00111234
REMITTANCE NO: 05050900001

FCN	FINANCIAL REASON CODE	FISCAL TRANS TYPE	DATE	AMOUNT
	XXX	RECOUPMENT REASON DESCRIPTION	05 09 05	$$.$$

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.

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DATE 05/06/05
CYCLE 446

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

MEDICAID MANAGEMENT INFORMATION SYSTEM

MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

ETIN:
ACCOUNTS RECEIVABLE
PROVIDER ID: 00111234
REMITTANCE NO: 05050900001

REASON CODE DESCRIPTION	PREV 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.

PERCENTAGE OR 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. The codes are listed in ascending numeric order.

MEDICAID MANAGEMENT INFORMATION SYSTEM

MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

PAGE 06
DATE 05/06/2005
CYCLE 446

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

ETIN:
HOME HEALTH
EDIT DESCRIPTIONS
PROVIDER ID: 00111234
REMITTANCE NO: 05050900001

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