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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 Home Health providers and should be used by the provider as an instructional as well as a reference tool.
Section II – Claims Submission

Home Health 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 Certification Statements remain in effect and apply to all claims until superseded by another properly executed Certification Statement.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-requisites 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.

Home Health 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](http://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.

- **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.

These documents are available at [www.emedny.org](http://www.emedny.org) by clicking on the link to the web page below:

**eMedNY Companion Guides and Sample Files**

Pre-requisites for the Submission of Electronic Claims

In addition to an ETIN and a Certification Statement, providers need the following before submitting electronic 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 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
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

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. 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 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**

This is a dial-up access method. It requires the use of the user ID assigned at the time of enrollment and a password. eMedNY Gateway access is obtained through an enrollment process. To obtain a user name and 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](#)

Note: For questions regarding ePACES, eXchange, FTP, CPU to CPU or eMedNY Gateway connections call the eMedNY Call Center at 800-343-9000.

**Paper Claims**

Home Health providers who choose to submit their claims on paper forms must use the Centers for Medicare and 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.

[Home Health - 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 associated certification qualifies the provider to submit claims 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:

<table>
<thead>
<tr>
<th>Written As</th>
<th>Intended As</th>
<th>Interpreted As</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.0</td>
<td>6.00</td>
<td>6.60</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Written As</th>
<th>Intended As</th>
<th>Interpreted As</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>3</td>
<td>3</td>
<td>2</td>
</tr>
</tbody>
</table>

- Characters should not touch each other. For example:

<table>
<thead>
<tr>
<th>Written As</th>
<th>Intended As</th>
<th>Interpreted As</th>
</tr>
</thead>
<tbody>
<tr>
<td>23</td>
<td>23</td>
<td>illegible</td>
</tr>
</tbody>
</table>
• 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.

Home Health – 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 Home Health Services**

This subsection of the Billing Guidelines covers the specific NYS Medicaid billing requirements for Home Health 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, pended, or denied.

**Field-by-Field (UB-04) Instructions**

**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:

340

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:

340
• If submitting an adjustment (replacement) to a previously paid claim, enter the value 7 in the third position of this field.

  Example:
  
  ![Example Image]

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

  Example:
  
  ![Example Image]

**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 services dates**, 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.

Dates must be entered in the format MMDDYYYY.

**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 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 or two years from the 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, 1935. Enter the birth date as 03051935.

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)

NYS Medicaid uses Condition Codes to indicate the following:

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

Note: EPSDT/CTHP, Family Planning, and Abortion Sterilization Codes are not applicable to Home Health 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 31–34)

NYS Medicaid uses Occurrence Codes to report an 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 note 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
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
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:

<table>
<thead>
<tr>
<th>Code</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>61</td>
<td>003</td>
</tr>
</tbody>
</table>

Notes:

- Until NPI implementation by NYS Medicaid, the Locator Code field must be completed on both 837I electronic transactions and on UB-04 paper claim submissions. After NPI implementation, the Locator Code field is only required for UB-04 paper claim submissions.

- 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 the web page for this manual.

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:

<table>
<thead>
<tr>
<th>Code</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>24</td>
<td>2610</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Code</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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, 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

• 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 A\textsubscript{X} or B\textsubscript{X}.

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
A\textsubscript{3} or B\textsubscript{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) 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:**

<table>
<thead>
<tr>
<th>S9 Code</th>
<th>Value Code: AMOUNT</th>
</tr>
</thead>
<tbody>
<tr>
<td>a</td>
<td>59: 100.00</td>
</tr>
<tr>
<td>b</td>
<td></td>
</tr>
<tr>
<td>c</td>
<td></td>
</tr>
<tr>
<td>d</td>
<td></td>
</tr>
</tbody>
</table>

**Patient Participation (Spend Down) – Value Code 31**

Some patients of the Home Health 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 paid by the patient.

The following example illustrates a correct Patient Participation entry.

**Example:**

<table>
<thead>
<tr>
<th>S9 Code</th>
<th>Value Code: AMOUNT</th>
</tr>
</thead>
<tbody>
<tr>
<td>a</td>
<td>31: 100.00</td>
</tr>
<tr>
<td>b</td>
<td></td>
</tr>
<tr>
<td>c</td>
<td></td>
</tr>
<tr>
<td>d</td>
<td></td>
</tr>
</tbody>
</table>

**REV. CD. [Revenue Code] (Form Locator 42)**

NYS Medicaid uses Revenue Codes to report the following information:

- Total Amount Charged
- Units

**Total Amount Charged**

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.

If billing for multiple dates of service, a revenue code must be entered on each line that corresponds to Form Locator 45 (Serv. Date) and 46 (Serv. Units).

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. Multipaged 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.

Hour-based Rate
If the rate is based on one-hour service, enter the number of hours that reflect the total of home health care time being claimed. When billing for Home Health Aide services on a per hour basis, the service units must be reported as full units only. Partial hours of service must be rounded to the nearest whole hour. In situations where the total amount of service rendered is less than 30 minutes, one (1) hour of service may be claimed.

Examples:
For a service of three hours and 30 minutes, enter 4 units.
For a service of three hours and 25 minutes, enter 3 units.
For a service of 15 minutes, enter 1 unit.

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 charges 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:

<table>
<thead>
<tr>
<th>REC'D</th>
<th>DESCRIPTION</th>
<th>44 HPCS / RATE / HINTS CODE</th>
<th>45 SERV. DATE</th>
<th>46 SERV. UNITS</th>
<th>47 TOTAL CHARGES</th>
<th>48 NON-COVERED CHARGES</th>
<th>49</th>
</tr>
</thead>
<tbody>
<tr>
<td>0001</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>640.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0240</td>
<td></td>
<td></td>
<td>03012007</td>
<td>8</td>
<td>320.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0240</td>
<td></td>
<td></td>
<td>03022007</td>
<td>8</td>
<td>320.00</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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 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:

- 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 **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)

Until National Provider ID (NPI) implementation by NYS Medicaid, the Medicaid Provider ID number must also be completed according to instructions for Form Locator 57 below. However, providers are strongly encouraged to begin reporting their billing provider’s NPI information, as soon as possible.

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 all fields blank.
DOCUMENT CONTROL NUMBER (Form Locators 64 A, B, C)

Leave this field blank when submitting an original claim or 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 on the line (A, B, or C) that matches the line assigned to Medicaid in Form Locators 50 and 57. If the TCN is entered on 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 as indicated by the ordering provider. 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:

![Code: 268.0](image)

**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 billing since subcategories exist.

Acceptable Diagnosis Codes: 267

268.0

268.1

OTHER (Form Locators 78)

NYS Medicaid uses this field to report the Ordering/Referring Provider.

Enter the Medicaid ID number of the provider ordering the services. If the ordering provider is not enrolled in Medicaid, enter his/her license number according to the instructions below.

**Note:** Providers are strongly encouraged to begin reporting National Provider ID (NPI) information for the Ordering/Referring provider. However, until NPI implementation by NYS Medicaid, the Medicaid Provider ID number or license number must be completed.

Instructions for Entering a Medicaid Provider ID Number

Enter the code “DN” in the unlabeled field between the words “OTHER” and “NPI” to indicate the 10-digit NPI of the provider is entered in the box labeled “NPI”. After the word “QUAL,” leave the first box blank to indicate the Medicaid Provider ID number of the provider is entered in the field to the right of the qualifier.
On the line below the ID numbers, enter the last name and first name of the provider.

**Example:**

The ordering/referring provider is John Smith who is enrolled in Medicaid with ID number 01234567 and an NPI of 1234567890.

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>SMITH</td>
<td>JOHN</td>
</tr>
</tbody>
</table>

**Instructions for Entering a License Number**

Enter the code “DN” in the unlabeled field between the words “OTHER” and “NPI” to indicate the 10-digit NPI of the provider is entered in the box labeled “NPI”.

**New York State License**

Enter the first two digits of the Profession Code in the box to the right of the box labeled “QUAL”. In the next box to the right, enter the 3rd digit of the Profession Code and an 8 digit license number. If necessary, place zero(s) between the profession code and the license number to enter a 9-digit number in the field.

Profession Codes can be found at www.emedny.org by clicking on the link to the web page below:

**Crosswalks**

On the line below the ID numbers, enter the last name and first name of the provider.

**Example:**

The ordering/referring provider is Paul Johnson who is not enrolled in Medicaid. The provider’s NPI is 1234567890, his NY State license number is 135790. Profession Code is 060.

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>JOHNSON</td>
<td>PAUL</td>
</tr>
</tbody>
</table>

**Out-of-State License**

If entering an out-of-state license, enter the first two digits of the Profession Code in the box to the right of the box labeled “QUAL”. In the next box to the right, enter the 3rd digit of the Profession Code. Enter the Post Office State Abbreviation from the table below followed by the license number. If necessary, place zero(s) after the state abbreviation to use all 9 digits in this field. If the license number is greater than 6 characters, enter only the first 6 characters, as entries in this Form Locator cannot be greater than 9 characters.
Profession Codes can be found at www.emedny.org by clicking on the link to the web page below:

**Crosswalks**

Post Office State Abbreviations can be found at the end of this section.

**Example:**

The ordering/referring provider is Mary Robinson from Massachusetts. The provider’s NPI is 1234567890, her Massachusetts license number is 579246. Profession Code is 060. I

<table>
<thead>
<tr>
<th>PS OTHER</th>
<th>DN</th>
<th>NPI</th>
<th>QUAL</th>
<th>06</th>
<th>0MA579246</th>
</tr>
</thead>
<tbody>
<tr>
<td>LAST ROBINSON</td>
<td>FIRST MARY</td>
<td>1234567890</td>
<td>06</td>
<td>0MA579246</td>
<td></td>
</tr>
</tbody>
</table>
**United States Standard Postal Abbreviations**

<table>
<thead>
<tr>
<th>State</th>
<th>Abbrev.</th>
<th>State</th>
<th>Abbrev.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alabama</td>
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<td>Missouri</td>
<td>MO</td>
</tr>
<tr>
<td>Alaska</td>
<td>AK</td>
<td>Montana</td>
<td>MT</td>
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<td>Nebraska</td>
<td>NE</td>
</tr>
<tr>
<td>Arkansas</td>
<td>AR</td>
<td>Nevada</td>
<td>NV</td>
</tr>
<tr>
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<td>New Hampshire</td>
<td>NH</td>
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<td>NM</td>
</tr>
<tr>
<td>Delaware</td>
<td>DE</td>
<td>North Carolina</td>
<td>NC</td>
</tr>
<tr>
<td>District of Columbia</td>
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<td>North Dakota</td>
<td>ND</td>
</tr>
<tr>
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<td>OK</td>
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<td>IA</td>
<td>South Carolina</td>
<td>SC</td>
</tr>
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<td>South Dakota</td>
<td>SD</td>
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<td>Vermont</td>
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<td>Michigan</td>
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<td>West Virginia</td>
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</tr>
<tr>
<td>Minnesota</td>
<td>MN</td>
<td>Wisconsin</td>
<td>WI</td>
</tr>
</tbody>
</table>

**American Territories**

<table>
<thead>
<tr>
<th>Abbrev.</th>
</tr>
</thead>
<tbody>
<tr>
<td>AS</td>
</tr>
<tr>
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<tr>
<td>GU</td>
</tr>
<tr>
<td>PR</td>
</tr>
<tr>
<td>TT</td>
</tr>
<tr>
<td>VI</td>
</tr>
</tbody>
</table>

**Note:** Postal codes are only required when reporting out-of-state license numbers.
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 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](http://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](http://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 Home Health 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).
**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 and the NPI (if applicable)

**CENTER**  
*Medicaid Provider ID/NPI/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 or the NPI (if applicable)

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.

* Note: NPI has been included on all examples and is pending NPI implementation by NYS Medicaid.
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.
**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 and the NPI (if applicable)

**CENTER**
*Medicaid Provider ID/NPI/Date: This field will contain the Medicaid Provider ID and the NPI (if applicable)
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: 0111234/0123456789

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
*PROV ID: This field will contain the Medicaid Provider ID and the NPI (if applicable)

**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.

*** 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.
**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 and the NPI (if applicable)
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.

<table>
<thead>
<tr>
<th>OFFICE ACCOUNT NUMBER</th>
<th>CLIENT NAME</th>
<th>TCN</th>
<th>DATE OF SERVICE</th>
<th>RATE CODE</th>
<th>UNITS</th>
<th>CHARGED</th>
<th>PAID</th>
<th>STATUS</th>
<th>ERRORS</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPIC1-00974-6</td>
<td>JONES</td>
<td>AA12345W</td>
<td>07/25/07</td>
<td>2610</td>
<td>10.000</td>
<td>187.81</td>
<td>10.000</td>
<td>DENY</td>
<td>00162</td>
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<tr>
<td>CPIC1-00575-6</td>
<td>EVANS</td>
<td>BB54321X</td>
<td>07/25/07</td>
<td>2610</td>
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<td>84.38</td>
<td>0.00</td>
<td>DENY</td>
<td>00244</td>
</tr>
</tbody>
</table>

* = 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
## Home Health Services UB-04 Billing Guidelines

### MEDICAID MANAGEMENT INFORMATION SYSTEM

**MEDICAL ASSISTANCE (TITLE XIX) PROGRAM**

**REMITTANCE STATEMENT**

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

**ETIN:** HOME HEALTH
**PROV ID:** 00111234/0123456789
**REMITTANCE NO:** 07080600001
**LOCATOR CD:** 003

<table>
<thead>
<tr>
<th>OFFICE ACCOUNT NUMBER</th>
<th>CLIENT NAME</th>
<th>CLIENT ID.</th>
<th>TCN</th>
<th>DATE OF SERVICE</th>
<th>RATE CODE</th>
<th>UNITS</th>
<th>CHARGED</th>
<th>PAID</th>
<th>STATUS</th>
<th>ERRORS</th>
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<tbody>
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<td>CPIC3-16774-6</td>
<td>DAVIS</td>
<td>AA11111Z</td>
<td>07206-000034112-0-2</td>
<td>07/25/07</td>
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<td>300.20</td>
<td>300.20</td>
<td>PAID</td>
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<td>BB22222Y</td>
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<td>CPIC1-76444-6</td>
<td>WAGNER</td>
<td>HH77777T</td>
<td>07206-000455557-0-2</td>
<td>07/25/07</td>
<td>2610</td>
<td>8.000</td>
<td>300.20</td>
<td>300.20</td>
<td>PAID</td>
<td></td>
</tr>
<tr>
<td>CPIC1-91766-6</td>
<td>STEVENS</td>
<td>KK99999R</td>
<td>07206-000465477-0-2</td>
<td>07/24/07</td>
<td>2610</td>
<td>8.000</td>
<td>300.20</td>
<td>-300.20</td>
<td>PAID</td>
<td>ORIGINAL CLAIM PAID 07/11/2007</td>
</tr>
</tbody>
</table>

* = 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 PAID:** 149.30
**NUMBER OF CLAIMS:** 1

* = PREVIOUSLY PENDED CLAIM
** = NEW PEND
### MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
### REMITTANCE STATEMENT

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

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

**DATE:** 08/06/2007  
**CYCLE:** 1563  
**LOCATOR CD:** 003

**OFFICE ACCOUNT CLIENT CLIENT DATE OF RATE**  
**NUMBER NAME ID. TCN SERVICE CODE UNITS CHARGED PAID STATUS ERRORS**

<table>
<thead>
<tr>
<th>OFFICE ACCOUNT</th>
<th>CLIENT</th>
<th>CLIENT</th>
<th>DATE OF SERVICE</th>
<th>RATE CODE</th>
<th>UNITS</th>
<th>CHARGED</th>
<th>PAID</th>
<th>STATUS</th>
<th>ERRORS</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPIC1-00774-6</td>
<td>EVANS</td>
<td>BB54321X</td>
<td>07/25/07</td>
<td>2610</td>
<td>8.000</td>
<td>300.20</td>
<td>** PEND 00162 00244</td>
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<td></td>
</tr>
<tr>
<td>CPIC1-00974-6</td>
<td>JONES</td>
<td>AA12345W</td>
<td>07/22/07</td>
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<td>5.000</td>
<td>188.41</td>
<td>** PEND 00162 00244</td>
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<td></td>
</tr>
</tbody>
</table>

* = PREVIOUSLY PENDED CLAIM  
** = NEW PENDED CLAIM

**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**  
PEND 0.00  
NUMBER OF CLAIMS 0

<table>
<thead>
<tr>
<th>LOCATOR 003 TOTALS – HOME HEALTH</th>
<th></th>
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<th></th>
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<tbody>
<tr>
<td>TOTAL AMOUNT ORIGINAL CLAIMS</td>
<td>PEND 488.61</td>
<td>NUMBER OF CLAIMS 2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TOTAL AMOUNT ADJUSTMENTS</td>
<td>PEND 0.00</td>
<td>NUMBER OF CLAIMS 0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TOTAL AMOUNT VOIDS</td>
<td>PEND 0.00</td>
<td>NUMBER OF CLAIMS 0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TOTAL AMOUNT VOIDS – ADJUSTS</td>
<td>PEND 0.00</td>
<td>NUMBER OF CLAIMS 0</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**REMITTANCE TOTALS – HOME HEALTH**  
VOIDS – ADJUSTS 89.04-  
NUMBER OF CLAIMS 1

**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

**MEMBER ID:** 00111234  
VOIDS – ADJUSTS 149.30-  
NUMBER OF CLAIMS 1

**TOTAL PAID**  
488.61  
NUMBER OF CLAIMS 2

**TOTAL DENIED**  
2026.41  
NUMBER OF CLAIMS 8

**TOTAL PAID**  
272.19  
NUMBER OF CLAIMS 2

**NET TOTAL PAID**  
1877.11  
NUMBER OF CLAIMS 8

**REMITTANCE STATEMENT**  
**VOIDS – ADJUSTS**  
**TOTAL PAID**  
**TOTAL DENIED**  
**NET TOTAL PAID**  
** MEMBER ID:** 00111234  
** VOIDS – ADJUSTS**  
** TOTAL PAID**  
** TOTAL DENIED**  
** NET TOTAL PAID**
REMITTANCE STATEMENT

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

ETIN:  HOME HEALTH
GRAND TOTALS
PROV ID: 00111234/0123456879
REMITTANCE NO: 07080600001

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 and the NPI (if applicable)
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 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 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.
- 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
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
- Denied
- 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
- Denied
- 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.
**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.

<table>
<thead>
<tr>
<th>REASON CODE DESCRIPTION</th>
<th>PREV BAL</th>
<th>CURR BAL</th>
<th>RECOUP %/AMT</th>
</tr>
</thead>
<tbody>
<tr>
<td>$XXX.XX-</td>
<td>$XXX.XX-</td>
<td>999</td>
<td></td>
</tr>
<tr>
<td>$XXX.XX-</td>
<td>$XXX.XX-</td>
<td>999</td>
<td></td>
</tr>
</tbody>
</table>

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.