New York State Electronic Medicaid System UB-04 Billing Guidelines

MANAGED CARE

Version 2011 - 01

1/27/2011

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***For eMedNY Billing Guideline questions, please contact the eMedNY Call Center** 1-800-343-9000.*

1. Purpose Statement

The purpose of this document is to 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 Managed Care providers and should be used by the provider as an instructional, as well as a reference tool. For providers new to NYS Medicaid, it is required to read the All Providers General Billing Guideline Information available at www.emedny.org by clicking on the link to the webpage as follows: Information for All Providers.

2. Claims Submission

Managed Care 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 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 Certification Statements remain in effect and apply to all claims until superseded by another properly executed Certification Statement.

Providers will be asked to update their Certification Statement on an annual basis. Providers will be provided with renewal information when their Certification Statement is near expiration. Information about these requirements is available at www.emedny.org by clicking on the link to the webpage as follows: Information for All Providers.

2.1 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.

Managed Care providers who choose to submit their Medicaid claims electronically are required to use the HIPAA 837 Institutional (837I) transaction. Direct billers should refer to the sources listed below to comply with the NYS Medicaid requirements.

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

Further information about electronic claim pre-requirements is available at www.emedny.org by clicking on the link to the webpage as follows: Information for All Providers.

2.2 Paper Claims

Managed Care 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 a sample Managed Care UB-04 claim form, see Appendix A. The displayed claim form is a sample and the information it contains is for illustration purposes only.

An Electronic Transmission Identification Number (ETIN) and a Certification Statement are required to submit paper claims. Providers who have a valid ETIN for the submission of electronic claims do not need an additional ETIN for paper submissions. The ETIN and the associated certification qualify the provider to submit claims in both electronic and paper formats. Information about these requirements is available at www.emedny.org by clicking on the link to the webpage as follows: Information for All Providers.

2.2.1 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 in Exhibit 2.2.1-1 as possible:

Exhibit 2.2.1-1

1 2 3 4 5 6 7 8 9 0

- Circles (the letter O, the number 0) must be closed.
- Avoid unfinished characters. See the example in Exhibit 2.2.1-2.

Exhibit 2.2.1-2

Written As	Intended As	Interpreted As
6. 0 0	6.00	6. 6 0 → Zero interpreted as six

- When typing or printing, stay within the box provided; ensure that no characters (letters or numbers) touch the claim form lines. See the example in Exhibit 2.2.1-3.

Exhibit 2.2.1-3

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 as seen in Exhibit 2.2.1-4.

Exhibit 2.2.1-4

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.

The address for submitting claim forms is:

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

2.3 UB-04 Claim Form

To view a sample Managed Care UB-04 claim form, see Appendix A. The displayed claim form is a sample and the information it contains is for illustration purposes only.

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.

2.4 Managed Care Services Billing Instructions

This subsection of the Billing Guidelines covers the specific NYS Medicaid billing requirements for Managed Care providers. Although the instructions that follow are based on the UB-04 paper claim form, they are also intended as a guideline for electronic billers to find out what information they need to provide in their claims, in addition to the HIPAA Companion Guides which are available at www.emedny.org by clicking on the link to the webpage as follows: eMedNY Companion Guides and Sample Files.

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.

2.4.1 UB-04 Claim Form Field 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 five-digit ZIP code or the ZIP plus four.

Electronic claim submissions

Enter the nine-digit ZIP code. The Locator Code will default to 003 if the nine digit ZIP code does not match information in the provider's Medicaid file.

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 which can be found at www.emedny.org by clicking on the link to the webpage as follows: Managed Care Manual.

Patient Control Number (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

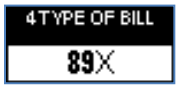
Type of Facility

The source of this code is the UB-04 Manual, Form Locator 4, Type of Facility category.

Bill Classification

The source of this code is the UB-04 Manual, Form Locator 4, Bill Classification category. See Exhibit 2.4.1-1.

Exhibit 2.4.1-1

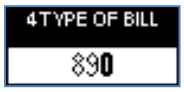


Frequency - Adjustment/Void Code

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.

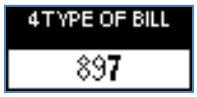
If submitting an original claim, enter the value ***0*** in the third position of this field as in Exhibit 2.4.1-2.

Exhibit 2.4.1-2



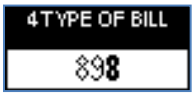
If submitting an adjustment (replacement) to a previously paid claim, enter the value ***7*** in the third position of this field as in Exhibit 2.4.1-3.

Exhibit 2.4.1-3



If submitting a void to a previously paid claim, enter the value ***8*** in the third position of this field as in Exhibit 2.4.1-4.

Exhibit 2.4.1-4



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 a monthly premium, only ***one*** date of service can be billed per claim form. Enter the date in the FROM box. The THROUGH box may contain the same date or may be left blank.

Dates must be entered in the format MMDDYYYY.

NOTE: Claims must be submitted within 90 days of the 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 is available in the All Providers General Billing Guideline Information section available at www.emedny.org by clicking on the link to the webpage as follows: Information for All Providers.

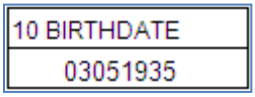
Patient Name (Form Locator 8, line b)

Enter the patient's last name followed by the first name. This information may be obtained from the Client's (Patient's) Common Benefit ID Card.

Birthdate (Form Locator 10)

Enter the patient's birth date. This information may be obtained from the Client's (Patient's) Common Benefit ID Card. The birth date must be in the format MMDDYYYY. See the example in Exhibit 2.4.1-5 that follows.

Exhibit 2.4.1-5



Sex (Form Locator 11)

Enter ***M*** for male or ***F*** for female to indicate the patient's sex. This information may be obtained from the Client's (Patient's) Common Benefit ID Card.

Admission (Form Locators 12-15)

Leave all fields blank.

Stat [Patient Status] (Form Locator 17)

Leave this field blank.

Condition Codes (Form Locators18–28)

Leave these fields blank.

Occurrence Code/Date (Form Locators 31–34)

Leave these fields blank.

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)

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.

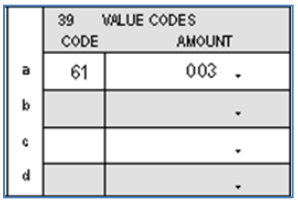
Value Amount

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

Locator codes 001 and 002 are for administrative use only and are not to be entered in this field. The entry may be 003 or a higher locator code. Enter the locator code that corresponds to theclient's county of fiscal responsibility. (The client's county of fiscal responsibility is represented by a two-digit code that is listed on the Monthly Managed Care Enrollee Roster.).

The example in Exhibit 2.4.1-6 illustrates a correct Locator Code entry.

Exhibit 2.4.1-6



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 located at www.emedny.org by clicking on the link to the webpage as follows: Managed Care 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

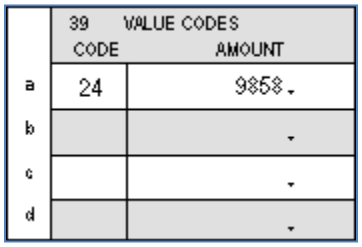
Code ***24*** should be used to indicate that a rate code is entered under Amount.

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 in Exhibit 2.4.1-7 illustrates a correct rate code entry.

Exhibit 2.4.1-7



For Inpatient Newborn Delivery Claims

Claims for inpatient newborn delivery are processed and paid according to the usual processing cycle at the eMedNY contractor site. Costs for inpatient newborn delivery are excluded from the monthly capitation reimbursement for newborns.

The rate code for newborn delivery claims is 2298. The service date must be the same as the date of birth.

The claim will appear on the Medicaid remittance for the cycle (week) in which it is processed.

Rev. Cd. [Revenue Code] (Form Locator 42)

NYS Medicaid uses Revenue Codes to report the ***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.

NOTE: Each claim form will be processed as a unique claim document and must contain only one Total Charges 0001 Revenue Code.

Serv. Date (Form Locator 45)

Leave this field blank.

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 in Form Locator 42 (total charges). Both sections of the field (dollars and cents) must be completed; if the charges contain no cents; enter ***00*** in the cents box. See Exhibit 2.4.1-8 for an example.

Exhibit 2.4.1-8

42 REV CD	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
0001					3000 .00	.	
					.	.	
					.	.	

Payer Name (Form Locator 50 A, B, C)

Enter the word Medicaid on line A of this field. Leave lines B and C blank.

NPI (Form Locator 56)

Leave this field blank.

Other Prv ID [Other Provider ID] (Form Locator 57)

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

Enter the Medicaid Provider ID number on the line (A, B, or C) that corresponds to 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 ID number (Client ID number). This information may be obtained from the Client's (Patient's) Common Benefit ID 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. For example: AB12345C

The Medicaid Client ID should be entered on line A.

Treatment Authorization Codes (Form Locator 63)

Leave this field blank.

Document Control Number (Form Locators 64 A, B, C)

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

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

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

Adjustments

An adjustment is submitted to correct one or more fields of a previously paid claim. Any field, except the ***Provider ID number*** or the ***Patient's Medicaid ID number***, can be adjusted. The adjustment must be submitted in a new claim form (copy of the original form is unacceptable) and all applicable fields must be completed.

An adjustment is identified by the value 7 in the ***third position of Form Locator 4***, Type of Bill, and the claim to be adjusted is identified by the TCN entered in this field (Form Locator 64).

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

Voids

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

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

Untitled [Principal Diagnosis Code] (Form Locator 67 A-Q)

Leave these fields blank.

Other (Form Locator 78)

Leave this field blank.

3. Explanation of Paper Remittance Advice Sections

This Section present a sample of each section of the remittance advice for Managed Care 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.

General Remittance Advice Information is available in the All Providers General Billing Guideline Information section available at www.emedny.org by clicking on the link to the webpage as follows: Information for All Providers.

The remittance advice is composed of five sections.

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

3.1 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).

Exhibit 3.1-1

MEDICAID MANAGEMENT INFORMATION SYSTEM

TO: CITY MANAGED CARE PLAN

DATE: 2010-05-31
REMITTANCE NO: 07080600001
PROV ID: 00111234

00111234 2010-05-31
CITY MANAGED CARE PLAN
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.
2010-05-31 VOID AFTER 90 DAYS	07080600001	00111234

PAY DOLLARS/CENTS $******3306.59

TO THE ORDER OF
CITY MANAGED CARE PLAN
111 MAIN ST
ANYTOWN NY 11111

MEDICAID MANAGEMENT INFORMATION SYSTEM

John Smith
AUTHORIZED SIGNATURE

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

3.1.1 Medicaid Check Stub Field Descriptions

Upper Left Corner

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

Upper Right Corner

Date on which the remittance advice was issued

Remittance Number

PROV ID: This field will contain the Medicaid Provider ID

Center

Medicaid Provider ID/Date

Provider's Name/Address

3.1.2 Medicaid Check Field Descriptions

Left Side

Table

Date on which the check was issued
Remittance Number
Provider ID No.: This field will contain the Medicaid Provider ID

Provider's Name/Address

Right Side

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

3.2 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.

Exhibit 3.2-1

TO: CITY MANAGED CARE PLAN

MEDICAID MANAGEMENT INFORMATION SYSTEM

DATE: 2010-05-31
REMITTANCE NO: 07080600001
PROV ID: 00111234

00111234 2010-05-31
CITY MANAGED CARE PLAN
111 MAIN STREET
ANYTOWN NY 11111

CITY MANAGED CARE PLAN $3306.59

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

3.2.1 EFT Notification Page Field Descriptions

Upper Left Corner

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

Upper Right Corner

Date on which the remittance advice was issued

Remittance Number

PROV ID: This field will contain the Medicaid Provider ID

Center

Medicaid Provider ID/Date

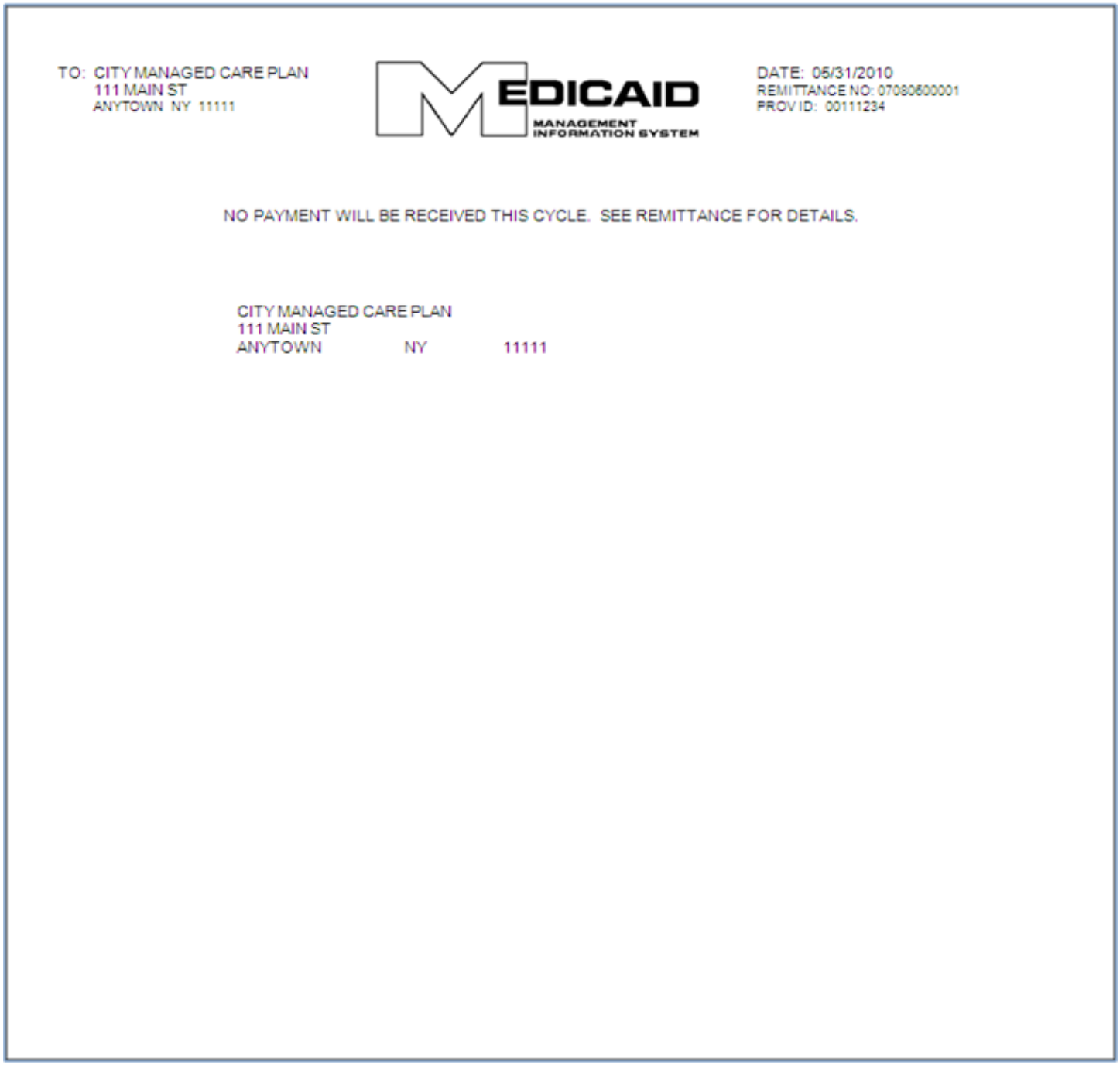
Provider's Name/Address

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.

3.3 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.

Exhibit 3.3-1



TO: CITY MANAGED CARE PLAN
111 MAIN ST
ANYTOWN NY 11111

MEDICAID MANAGEMENT INFORMATION SYSTEM

DATE: 05/31/2010
REMITTANCE NO: 07080600001
PROV ID: 00111234

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

CITY MANAGED CARE PLAN
111 MAIN ST
ANYTOWN NY 11111

3.3.1 Summout (No Payment) Field Descriptions

Upper Left Corner

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

Upper Right Corner

Date on which the remittance advice was issued

Remittance Number

PROV ID: This field will contain the Medicaid Provider ID

Center

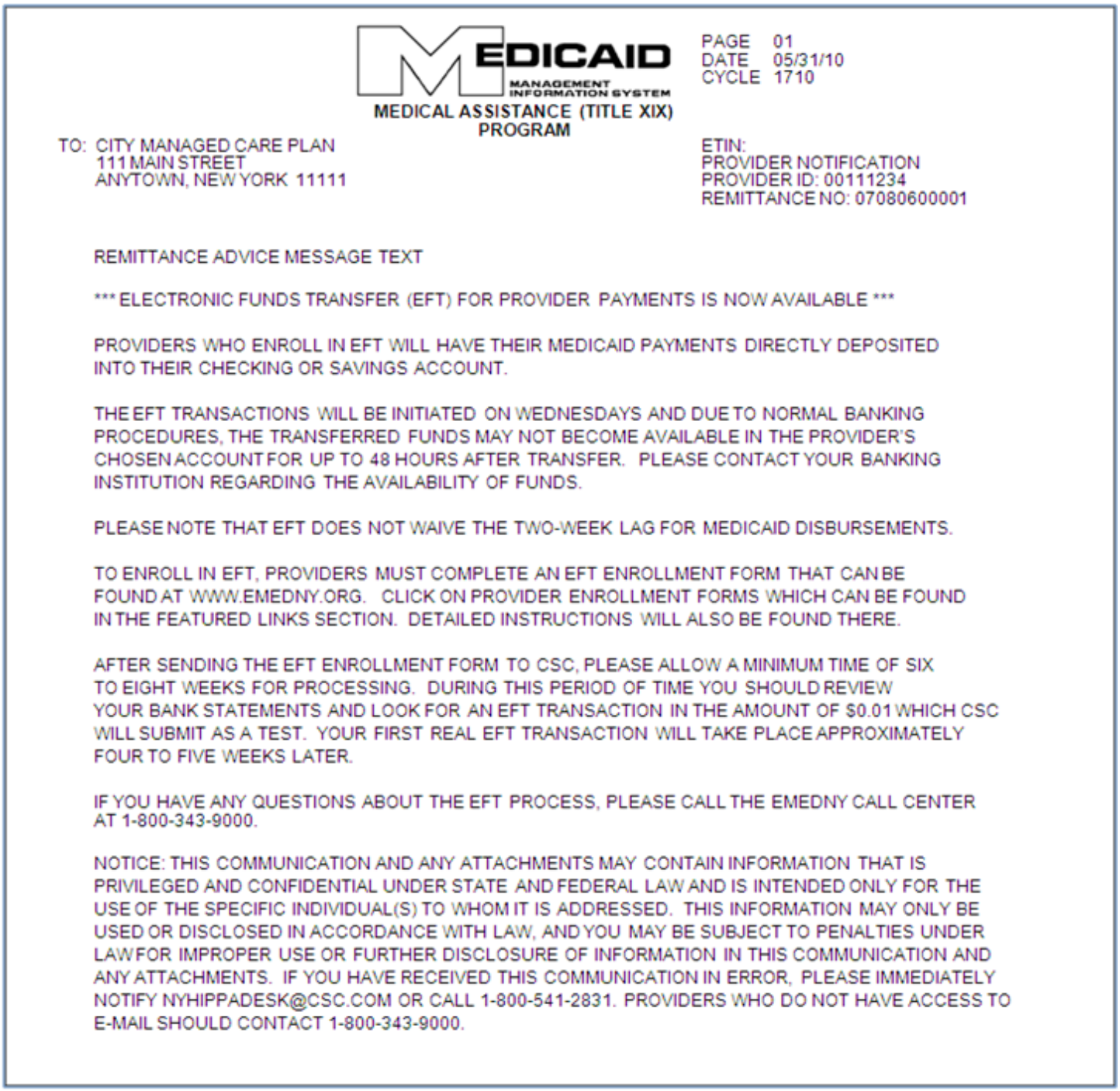
Notification that no payment was made for the cycle (no claims were approved)

Provider Name and Address

3.4 Section Two – Provider Notification

This section is used to communicate important messages to providers.

Exhibit 3.4-1



MEDICAID
MANAGEMENT INFORMATION SYSTEM
MEDICAL ASSISTANCE (TITLE XIX) PROGRAM

PAGE 01
DATE 05/31/10
CYCLE 1710

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

ETIN:
PROVIDER NOTIFICATION
PROVIDER ID: 00111234
REMITTANCE NO: 07080600001

REMITTANCE ADVICE MESSAGE TEXT

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

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

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

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

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

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

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

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

3.4.1 Provider Notification Field Descriptions

Upper Left Corner

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

Upper Right Corner

Remittance page number

Date on which the remittance advice was issued

Cycle Number

ETIN (not applicable)

Name of section: **PROVIDER NOTIFICATION**

PROV ID: This field will contain the Medicaid Provider ID

Remittance number

Center

Message text

3.5 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.

Exhibit 3.5-1

MEDICAID MANAGEMENT INFORMATION SYSTEM

MEDICAL ASSISTANCE (TITLE XIX) PROGRAM

PAGE 02
DATE 05/31/2010
CYCLE 1710

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

ETIN:
MANAGED CARE
PROV ID: 00111234
REMITTANCE NO: 07080600001

OFFICE ACCOUNT NUMBER	CLIENT NAME	CLIENT ID.	TCN	DATE OF SERVICE	RATE CODE	UNITS	CHARGED	PAID	STATUS	ERRORS
CPIC1-00123-4	DOE	XX12345X	07206-000012112-3-2	05/01/10	2210	1.000	472.37	0.00	DENY	00162 00142
CPIC1-00987-6	SAMPLE	XX23456X	07206-000019113-3-1	05/01/10	2210	1.000	472.37	0.00	DENY	00142

*. = PREVIOUSLY PENDED CLAIM
** = NEW PEND

TOTAL AMOUNT ORIGINAL CLAIMS	DENIED	944.74	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

Exhibit 3.5-2

MEDICAID MANAGEMENT INFORMATION SYSTEM

PAGE 03
DATE 05/31/2010
CYCLE 1710

MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

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

ETIN:
MANAGED CARE
PROV ID: 00111234
REMITTANCE NO: 070806000001

OFFICE ACCOUNT NUMBER	CLIENT NAME	CLIENT ID.	TCN	DATE OF SERVICE	RATE CODE	UNITS	CHARGED	PAID	STATUS	ERRORS
CPIC1-00123-4	DOE	XX12345X	07206-000034112-0-2	05/01/10	2210	1.000	472.37	472.37	PAID	
CPIC1-00987-6	SAMPLE	XX23456X	07206-000445113-0-2	05/01/10	2210	1.000	472.37	472.37	PAID	
CPIC1-44444-6	EXAMPLE	XX34567X	07206-000466333-0-2	05/01/10	2210	1.000	472.37	472.37	PAID	
CPIC1-66666-6	SPECIMEN	XX45678X	07206-000445663-0-2	05/01/10	2210	1.000	472.37	472.37	PAID	
CPIC1-33333-6	STANDARD	XX56789X	07206-000447654-0-2	05/01/10	2210	1.000	472.37	472.37	PAID	
CPIC1-55555-6	MODEL	XX67890X	07206-000465553-0-2	05/01/10	2210	1.000	472.37	472.37	PAID	
CPIC1-77777-6	DOE	XX09876X	07206-000455557-0-2	05/01/10	2210	1.000	472.37	472.37	PAID	
CPIC1-11111-6	SAMPLE	XX98765X	07206-000465477-0-2	05/01/10	2210	1.000	472.37	427.37	PAID	
CPIC1-00123-4	DOE	XX12345X	07206-000544444-0-2	05/01/10	2210	1.000	0.00	472.37	VOID	
CPIC1-00123-4	DOE	XX12345X	07206-000544444-0-2	05/01/10	2210	1.000	472.37	472.37-	PAID	ORIGINAL CLAIM PAID 05/11/2010

TOTAL AMOUNT ORIGINAL CLAIMS PAID 3778.96 NUMBER OF CLAIMS 8
NET AMOUNT ADJ./VOIDS 472.37 NUMBER OF CLAIMS 1

Exhibit 3.5-3

MEDICAID MANAGEMENT INFORMATION SYSTEM

PAGE 04
DATE 05/31/2010
CYCLE 1710

MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

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

ETIN:
MANAGED CARE
PROV ID: 00111234
REMITTANCE NO: 07080600001

OFFICE ACCOUNT NUMBER	CLIENT NAME	CLIENT ID.	TCN	DATE OF SERVICE	RATE CODE	UNITS	CHARGED	PAID	STATUS	ERRORS
CPIC1-00123-4	DOE	XX12345X	07206-000034112-3-2	05/01/10	2210	1.000	472.37	**	PEND	00162
CPIC1-00987-6	SAMPLE	XX23456X	07206-000445113-3-1	05/01/10	2210	1.000	427.37	**	PEND	00162

* = PREVIOUSLY PENDED CLAIM
** = NEW PEND

TOTAL AMOUNT ORIGINAL CLAIMS	PEND	944.74	NUMBER OF CLAIMS	2
NET AMOUNT ADJUSTMENTS	PEND	0.00	NUMBER OF CLAIMS	0
NET AMOUNT VOIDS	PEND	0.00	NUMBER OF CLAIMS	0
NET AMOUNT VOIDS – ADJUSTS		0.00	NUMBER OF CLAIMS	0

REMITTANCE TOTALS

VOIDS – ADJUSTS	472.37-	NUMBER OF CLAIMS	1
TOTAL PENDS	944.74	NUMBER OF CLAIMS	2
TOTAL PAID	3779.96	NUMBER OF CLAIMS	8
TOTAL DENIED	944.74	NUMBER OF CLAIMS	2
NET TOTAL PAID	3306.59	NUMBER OF CLAIMS	8

MEMBER ID: 00111234

VOIDS – ADJUSTS	472.37-	NUMBER OF CLAIMS	1
TOTAL PENDS	944.74	NUMBER OF CLAIMS	2
TOTAL PAID	3779.96	NUMBER OF CLAIMS	8
TOTAL DENY	944.74	NUMBER OF CLAIMS	2
NET TOTAL PAID	3306.59	NUMBER OF CLAIMS	8

Exhibit 3.5-4

MEDICAID MANAGEMENT INFORMATION SYSTEM

MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

PAGE: 05
DATE: 05/31/2010
CYCLE: 1710

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

ETIN:
MANAGED CARE
GRAND TOTALS
PROV ID: 00111234
REMITTANCE NO: 07060600001

REMITTANCE TOTALS – GRAND TOTALS

VOIDS – ADJUSTS	472.37-	NUMBER OF CLAIMS	1
TOTAL PENDS	944.74	NUMBER OF CLAIMS	2
TOTAL PAID	3779.96	NUMBER OF CLAIMS	8
TOTAL DENY	944.74	NUMBER OF CLAIMS	2
NET TOTAL PAID	3306.59	NUMBER OF CLAIMS	8

3.5.1 Claim Detail Page Field Descriptions

Upper Left Corner

PLAN Name/Address

Upper Right Corner

Remittance page number

Date: The 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: **MANAGED CARE**

PROV ID: This field will contain the Medicaid Provider ID

Remittance Number

3.5.2 Explanation of 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.

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.
- Information entered in the claim form is invalid or logically inconsistent.

Approved Claims

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

Paid Claims

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

Adjustments

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

Voids

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

Pending Claims

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

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

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

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

Errors

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

3.5.3 Subtotals/Totals/Grand Totals

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

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

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

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

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

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

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

3.6 Section Four – Financial Transactions and Accounts Receivable

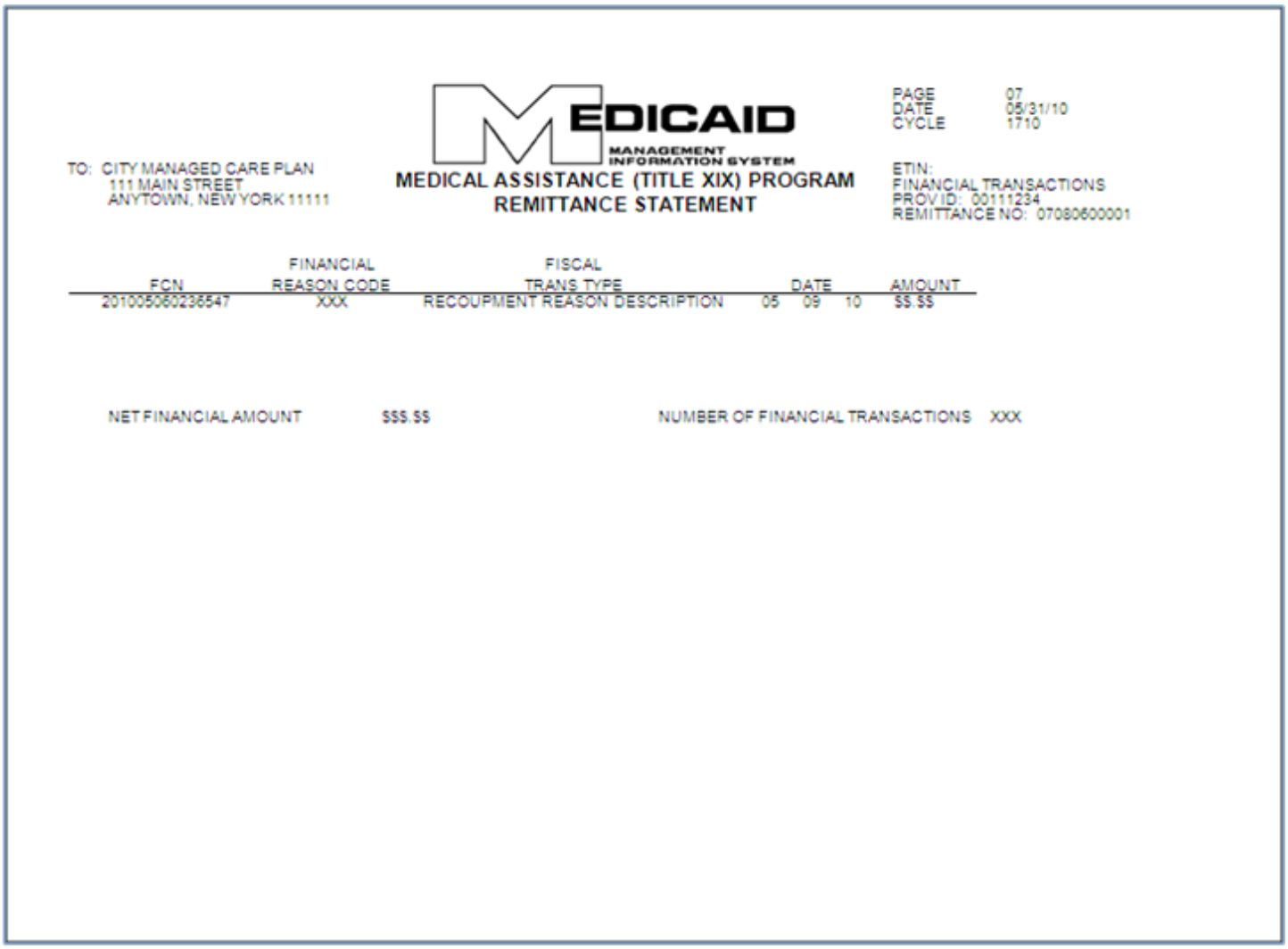
This section has two subsections:

- Financial Transactions
- Accounts Receivable

3.6.1 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.

Exhibit 3.6.1-1



MEDICAID MANAGEMENT INFORMATION SYSTEM

MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

PAGE 07
DATE 05/31/10
CYCLE 1710

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

ETIN:
FINANCIAL TRANSACTIONS
PROV ID: 00111234
REMITTANCE NO: 07080600001

FCN	FINANCIAL REASON CODE	FISCAL TRANS TYPE		DATE			AMOUNT
201005060236547	XXX	RECOUPMENT REASON DESCRIPTION	05	09	10		$$.$$

NET FINANCIAL AMOUNT $$$.$$ NUMBER OF FINANCIAL TRANSACTIONS XXX

3.6.1.1 Explanation of Financial Transactions Columns

FCN

The Financial Control Number (FCN) 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.

Financial 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.

3.6.1.2 Explanation of Totals Section

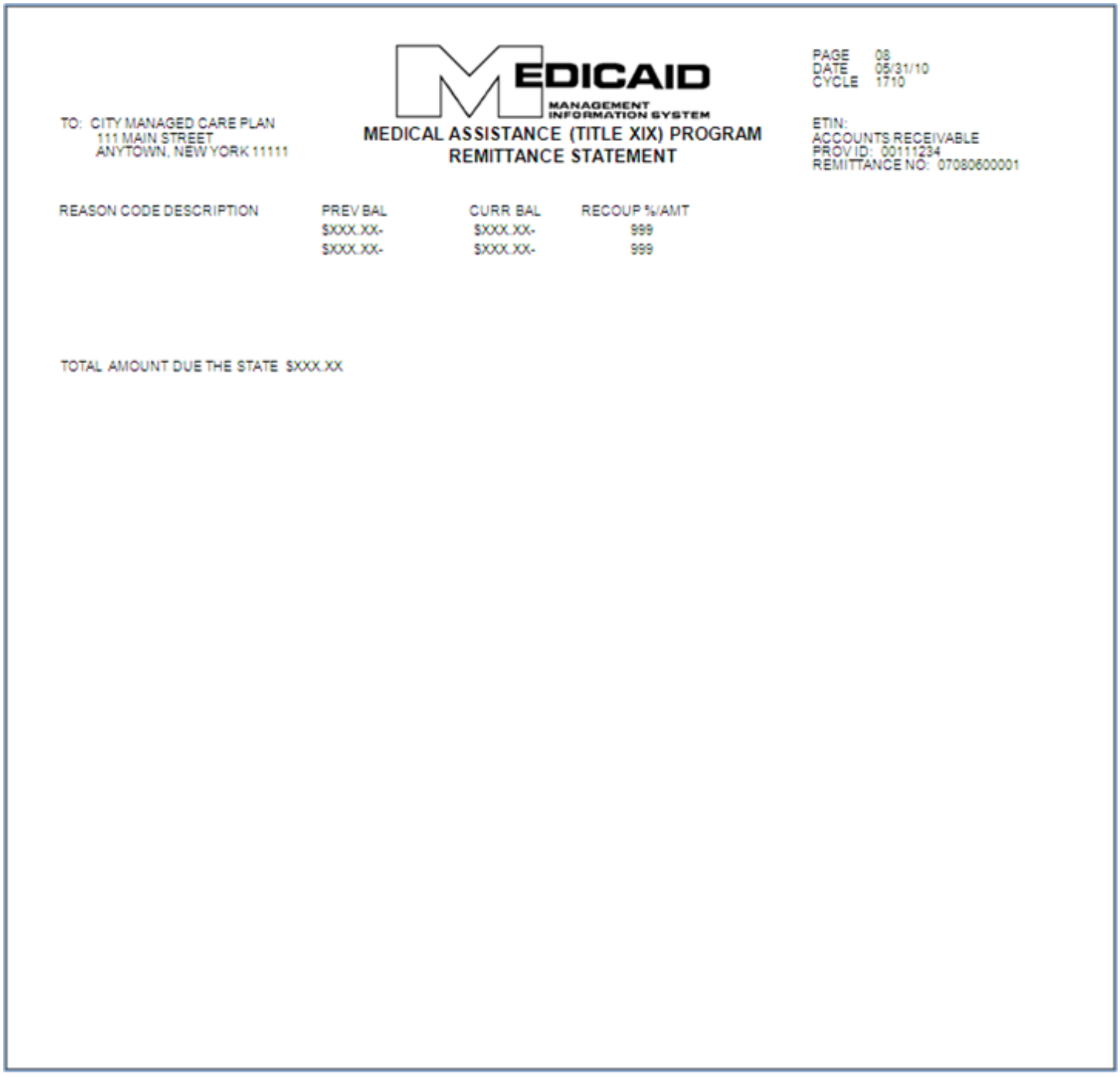
The total dollar amount of the financial transactions (***Net Financial Transaction Amount***) and the total number of transactions (***Number of Financial Transactions***) appear below the last line of the transaction detail list.

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

3.6.2 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.

Exhibit 3.6.2-1



PAGE 08
DATE 05/31/10
CYCLE 1710

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

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

ETIN:
ACCOUNTS RECEIVABLE
PROV ID: 001112234
REMITTANCE NO: 07080600001

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

3.6.2.1 Explanation of Accounts Receivable Columns

If a provider has negative balances of different types or negative balances created at different times, each negative balance will be listed in a different line.

Reason Code Description

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

Original Balance

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

Current Balance

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

Recoupment % Amount

The deduction (recoupment) scheduled for each cycle.

Total Amount Due the State

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

3.7 Section Five – Edit (Error) Description

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.

Exhibit 3.7-1

MEDICAID
MANAGEMENT INFORMATION SYSTEM

PAGE 06
DATE 05/31/2010
CYCLE 1710

MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

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

ETIN:
MANAGED CARE
EDIT DESCRIPTIONS
PROV ID: 00111234
REMITTANCE NO: 07080600001

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

00142 RECIPIENT YEAR OF BIRTH DIFFERS FROM FILE
00162 RECIPIENT INELIGIBLE ON DATE OF SERVICE

APPENDIX A
CLAIM SAMPLES

The eMedNY Billing Guideline Appendix A: Claim Samples contains images of claims with sample data.

Managed Care - UB-04 Sample Claim

APPROVED OMB NO. 0938-0279

1 City Managed Care Plan 111 Main Street Anytown, NY 11111-1111	2	3a PAT. CNTL# AB1234567 b. MED. REC.#	4 TYPE OF BILL 890	
		5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM 04012007 THROUGH	7

8 PATIENT NAME: SMITH, WILLIAM | 9 PATIENT ADDRESS

10 BIRTHDATE	11 SEX	ADMISSION 12 DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	CONDITION CODES 18 19 20 21 22 23 24 25 26 27 28	29 ACDT STATE	30
04191940	M									

31 OCCURRENCE CODE / DATE	32 OCCURRENCE CODE / DATE	33 OCCURRENCE CODE / DATE	34 OCCURRENCE CODE / DATE	35 OCCURRENCE SPAN CODE / FROM / THROUGH	36 OCCURRENCE SPAN CODE / FROM / THROUGH	37

38

	39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
a	61	003.	24	2210.		.
b		.		.		.
c		.		.		.
d		.		.		.

	42 REV CD	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	0001					80.00	.	
2						.	.	
3						.	.	
4						.	.	
5						.	.	
6						.	.	
7						.	.	
8						.	.	
9						.	.	
10						.	.	
11						.	.	
12						.	.	
13						.	.	
14						.	.	
15						.	.	
16						.	.	
17						.	.	
18						.	.	
19						.	.	
20						.	.	
21						.	.	
22						.	.	
23		PAGE ___ OF ___	CREATION DATE		TOTALS	.	.	

50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	
Medicaid				.	.	57 OTHER PRV ID	00123456
				.	.		
				.	.		

58 INSURED'S NAME	59 P REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
		AB12345C		

63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME

66 DX	67	A	B	C	D	E	F	G	H	68
	I	J	K	L	M	N	O	P	Q	

69 ADMIT DX	70 PATIENT REASON DX	a	b	c	71 PPS CODE	72 ECI	a	b	c	73

74 PRINCIPAL PROCEDURE CODE / DATE	a OTHER PROCEDURE CODE / DATE	b OTHER PROCEDURE CODE / DATE	75	76 ATTENDING NPI / QUAL / LAST / FIRST
				77 OPERATING NPI / QUAL / LAST / FIRST
c OTHER PROCEDURE CODE / DATE	d OTHER PROCEDURE CODE / DATE	e OTHER PROCEDURE CODE / DATE		
				78 OTHER NPI / QUAL / LAST / FIRST
80 REMARKS	81 CC a			79 OTHER NPI / QUAL / LAST / FIRST
	b			
	c			
	d			

NUBC — THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

eMedNY is the name of the electronic New York State Medicaid system. The eMedNY system allows New York Medicaid providers to submit claims and receive payments for Medicaid-covered services provided to eligible clients.

eMedNY offers several innovative technical and architectural features, facilitating the adjudication and payment of claims and providing extensive support and convenience for its users. CSC is the eMedNY contractor and is responsible for its operation.

The information contained within this document was created in concert by eMedNY DOH and eMedNY CSC. More information about eMedNY can be found at www.emedny.org.