



New York State UB04 Billing Guidelines

PERSONAL CARE SERVICES



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

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

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

1. Purpose Statement

The purpose of this document is to augment the General Billing Guidelines for institutional claims with the NYS Medicaid specific requirements and expectations for Personal Care Services.

For providers new to NYS Medicaid, it is required to read the General Institutional Billing Guidelines available at www.emedny.org or by clicking: [General Institutional Billing Guidelines](#).

2. Claims Submission

Personal Care Services providers can submit their claims to NYS Medicaid in electronic or paper formats.

2.1 Electronic Claims

Personal Care Services providers who choose to submit their Medicaid claims electronically are required to use the HIPAA 837 Institutional (837I) transaction.

2.2 Paper Claims

Personal Care Services providers who choose to submit their claims on paper forms must use the National Uniform Billing Committee (NUBC) UB-04 claim form.

To view a sample Personal Care Services UB-04 claim form, see Appendix A. The displayed claim form is a sample and is for illustration purposes only.

2.3 Personal Care Services Billing Instructions

This subsection of the Billing Guidelines covers the specific NYS Medicaid billing requirements for Personal Care Services providers. Although the instructions that follow are based on the UB-04 paper claim form, they are also intended as a guideline for electronic billers to find out what information they need to provide in their claims. For further electronic claim submission information, refer to the eMedNY 5010 Companion Guide which is available at www.emedny.org by clicking: [eMedNY Transaction Information Standard Companion Guide](#).

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

2.3.1 UB-04 Claim Form Field Instructions

Statement Covers Period From/Through (Form Locator 6)

837I Ref: Loop 2300 DTP03 when DTP01 = 434

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

- When billing for one date of service, enter the date in the FROM box. The THROUGH box may contain the same date or may be left blank.
- When billing for multiple 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.

- When billing for monthly rates, only one date of service can be billed per claim form. Enter the date in the FROM box. The THROUGH box may contain the same date or may be left blank.

Dates must be entered in the format MMDDYYYY.

NOTES:

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

Serv. Units (Form Locator 46)

837I Ref: Loop2400 SV205

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

Hour-based Rate

If the rate is based on one-hour service, enter the number of hours that reflect the total of Personal Care time being claimed. 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.

For example, a service that took 3 hours and 30 minutes would be entered as 4 units. A service that took 3 hours and 25 minutes would be entered as 3 units. A service of 15 minutes would be entered as 1 unit.

If a Personal Care Aide renders fewer hours of service than that for which prior approval has been received, report the actual number of hours in this field.

Treatment Authorization Codes (Form Locator 63)

837I Ref: Loop2300 REF02 when REF01 = G1

All Personal Care services require Prior Approval.

Enter in this field the eleven-digit Prior Approval number issued by the appropriate agency in the county of fiscal responsibility. The Prior Approval number must be entered in the same line (A, B, or C) that matches the line assigned to Medicaid in Form Locators 50 and 57.

NOTE: For information regarding how to obtain Prior Approval/Authorization for specific services, refer to the Policy Guidelines section located at www.emedny.org by clicking on the link to the webpage as follows: [Personal Care Manual](#).

3. Remittance Advice

The Remittance Advice is an electronic, PDF or paper statement issued by eMedNY that contains the status of claim transactions processed by eMedNY during a specific reporting period. Statements contain the following information:

- A listing of all claims (identified by several items of information submitted on the claim) that have entered the computerized processing system during the corresponding cycle
- The status of each claim (denied, paid or pended) after processing
- The eMedNY edits (errors) that resulted in a claim denied or pended
- Subtotals and grand totals of claims and dollar amounts
- Other pertinent financial information such as recoupment, negative balances, etc.

The General Remittance Advice Guidelines contains information on selecting a remittance advice format, remittance sort options, and descriptions of the paper Remittance Advice layout. This document is available at www.emedny.org by clicking: [General Remittance Billing Guidelines](#).

APPENDIX A CLAIM SAMPLES

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

Personal Care - UB-04 Sample Claim APPROVED OMB NO. 0938-0279

1 City Home Care			2		3a PAT CNTRL#	AB1234567		4 TYPE OF BILL			
111 Main Street					b MED REC#					340	
Anytown, NY 11111-1111					5 FED TAX NO		6 STATEMENT COVERS PERIOD		7		
							FROM 04/01/2007		THROUGH 04/30/2007		
8 PATIENT NAME a b SMITH, WILLIAM					9 PATIENT ADDRESS a b						
10 BIRTH DATE 04/19/1948	11 SEX M	12 DATE	ADMISSION 13 HR 14 TYPE 15 SRC		16 D-HR	17 STAT	CONDITION CODES 22 23 24 25 26 27 28				29 ACCT STATE 30
31 OCCURRENCE CODE	32 OCCURRENCE DATE	33 OCCURRENCE CODE	34 OCCURRENCE DATE	35 OCCURRENCE CODE	36 OCCURRENCE DATE	37 OCCURRENCE CODE	OCCURRENCE SPAN THROUGH		38 OCCURRENCE CODE	39 OCCURRENCE DATE	
38			39 VALUE CODES CODE AMOUNT		40 VALUE CODES CODE AMOUNT		41 VALUE CODES CODE AMOUNT				
			a 61 003.		24 2601.		A3 00.00				
			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					180.00	.	1				
2 0240			04022007	4	40.00	.	2				
3 0240			04062007	4	40.00	.	3				
4 0240			04092007	6	60.00	.	4				
5 0240			04132007	4	40.00	.	5				
6					.	.	6				
7					.	.	7				
8					.	.	8				
9					.	.	9				
10					.	.	10				
11					.	.	11				
12					.	.	12				
13					.	.	13				
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18					.	.	18				
19					.	.	19				
20					.	.	20				
21					.	.	21				
22					.	.	22				
PAGE OF		CREATION DATE			TOTALS						
50 PAYER NAME		51 HEALTH PLAN ID	52 REL INFO	53 ASO BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	57 OTHER PRV ID			
A Blue Cross					.	.		None			
B Medicaid					.	.		00123456			
C					.	.					
58 INSURED'S NAME		59 P REL	60 INSURED'S UNIQUE ID		61 GROUP NAME		62 INSURANCE GROUP NO.				
A			None								
B			AB12345C								
C											
63 TREATMENT AUTHORIZATION CODES				64 DOCUMENT CONTROL NUMBER			65 EMPLOYER NAME				
A 12345678901											
B											
C											
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 DIV		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		NP: QAL
								LAST		FIRST	
								77 OPERATING		NP: QAL	
								LAST		FIRST	
								78 OTHER		NP: QAL	
								LAST		FIRST	
								79 OTHER		NP: QAL	
								LAST		FIRST	
								80 REMARKS			
								81 CC			
								a			
								b			
								c			
								d			

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

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