New York State
UB04 Billing Guidelines

LIMITED LICENSED HOME CARE SERVICES AGENCY (LLHCSA)

Version 2011 - 01

6/1/2011

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

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

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

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

1. Purpose Statement

The purpose of this document is to augment the General Billing Guidelines for institutional claims with the NYS Medicaid specific requirements and expectations for the Limited Licensed Home Care Services Agency (LLHCSA).

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

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

2.1 Electronic Claims

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

2.2 Paper Claims

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

2.3 LLHCSA Services Billing Instructions

This subsection of the Billing Guidelines covers the specific NYS Medicaid billing requirements for LLHCSA providers. Although the instructions that follow are based on the UB-04 paper claim form, they are also intended as a guideline for electronic billers to find out what information they need to provide in their claims. For further electronic claim submission information, refer to the eMedNY 5010 Companion Guide which is available at www.emedny.org by clicking: eMedNY Transaction Information Standard Companion Guide CAQH - CORE CG X12.

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

2.3.1 UB-04 Claim Form Field Instructions

Statement Covers Period From/Through (Form Locator 6)

837I Ref: Loop 2300 DTP03 when DTP01 = 434

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

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

All LLHCSA rate codes are based on 15-minute rates. Enter the number of 15-minute intervals that reflect the total time of LLHCSA services provided. The service units must be reported as full units only. Partial units of service (duration of less than 15 minutes) must be rounded to the nearest quarter hour.

For example, 6 units would be used for services rendered in 1 hour and 30 minutes. 5 units would be used for services rendered in 1 hours and 10 minutes. 4 units would be used for services rendered in 1 hour and 5 minutes.

NOTE: If the Service Units field is blank, payment will be made for one unit of service.

Treatment Authorization Codes (Form Locator 63)

837I Ref: Loop2300 REF02 when REF01 = G1

All LLHCSA 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. If the Prior Approval number is entered on lines B or C, the word ***NONE*** must be written on the line(s) ***above*** the Prior Approval line.

For information regarding how to obtain Prior Approval/Authorization for specific services, refer to the Policy Guideline section located at www.emedny.org by clicking on the link to the webpage as follows: Limited License Home Care(LLHCSA) 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.

LLHCSA – UB-04 Sample Claim

APPROVED OMB NO. 0938-0279

1 City Home Care 111 Main Street Anytown, NY 11111	2	3a PAT. CNTL# AB1234567 b. MED. REC.#	4 TYPE OF BILL 340	
		5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM 04012007 THROUGH 04302007	7

8 PATIENT NAME b SMITH, WILLIAM — 9 PATIENT ADDRESS

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	CONDITION CODES	39 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
a															
b															

38

	39 CODE	VALUE CODES AMOUNT	40 CODE	VALUE CODES AMOUNT	41 CODE	VALUE CODES AMOUNT
a	61	003.	24	2610.	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					66.00	.	
2	0240			04022007	12	33.00	.	
3	0240			04252007	12	33.00	.	
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	57 OTHER PRV ID
A	Blue Cross				.	.	1234567890	
B	Medicaid				.	.		
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			
B	12345678901		
C			

66 DX		A	B	C	D	E	F	G	H	68
	344.1									
	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	
c OTHER PROCEDURE CODE	DATE	d OTHER PROCEDURE CODE	DATE	e OTHER PROCEDURE CODE	DATE		77 OPERATING	NPI	QUAL	
							LAST		FIRST	
							78 OTHER	NPI	QUAL	
							LAST		FIRST	
							79 OTHER	NPI	QUAL	
							LAST		FIRST	

80 REMARKS

81 CC	
a	
b	
c	
d	

UB04 CMS1450 — DUE APPROVAL PENDING — NUBC — THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.