



New York State Medicaid General Billing Guidelines

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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 assist the provider community in understanding and complying with the New York State Medicaid (NYS Medicaid) requirements and expectations for billing and submitting claims.

This document is intended to serve as an instructional reference tool for providers who submit claims using either the 837 Institutional or paper UB-04 form. For providers new to NYS Medicaid, it is required to read the Trading Partner Information Companion Guide available at www.emedny.org by clicking on the link to the webpage as follows: [eMedNY Trading Partner Information Companion Guide](#).

2. Claims Submission

Billing for institutional services other than clinic or hospital inpatient services, may be performed using electronic or paper formats. Clinic and inpatient claims may be submitted electronically only.

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 Certification Statements remain in effect and apply to all claims until superseded by another properly executed Certification Statement.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 are asked to update their Certification Statement on an annual basis. Providers are sent renewal information when their Certification Statement nears expiration. Information about these requirements is available at www.emedny.org by clicking on the link to the webpage as follows: [eMedNY Trading Partner Information Companion Guide](#).

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.

eMedNY will process both 4010 and 5010 transaction types between July 21, 2011 and December 31, 2011. All Trading Partners will be required to employ the 5010 standards in accordance with federal mandates as of January 1, 2012.

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

Direct billers should refer to the sources listed below in order to comply with the NYS Medicaid requirements.

- 5010 Implementation Guides (IGs) explain the proper use of 837I standards and other program specifications. These documents are available at store.X12.org.
- The eMedNY 5010 Companion Guide provides specific instructions on the NYS Medicaid requirements for the 837I transaction. This document is available at www.emedny.org by clicking on the link to the web page as follows: [eMedNY Transaction Information Standard Companion Guide](#).

Further information on the 5010 transaction is available at www.emedny.org by clicking on the link to the web page as follows: [eMedNYHIPAASupport](#).

Further information about electronic claim prerequisites is available at www.emedny.org by clicking on the link to the webpage as follows: [eMedNY Trading Partner Information Companion Guide](#).

2.2 Paper Claims

Institutional providers who submit their claims on paper forms must use the National Uniform Billing Committee (NUBC) standard UB-04 claim form.

NOTE: Submission of paper claims for hospital and clinic services is NOT PERMITTED.

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

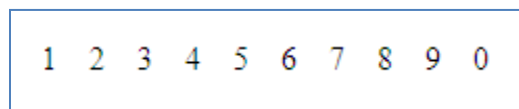
An Electronic/Paper Transmission Identification Number (ETIN) and a Certification Statement are required to submit paper claims. Providers who have a valid ETIN for the submission of electronic claims do not need an additional ETIN for paper submissions. The ETIN and the associated certification qualify 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







- 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										
<table border="1"> <tr> <td></td> <td></td> <td>6.</td> <td>0</td> <td>0</td> </tr> </table>			6.	0	0	6.00	<table border="1"> <tr> <td></td> <td></td> <td>6.</td> <td>6</td> <td>0</td> </tr> </table> → Zero interpreted as six			6.	6	0
		6.	0	0								
		6.	6	0								


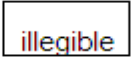
- When typing or printing, stay within the box provided; ensure that no characters (letters or numbers) touch the claim form lines. See the example in Exhibit 2.2.1-3.

Exhibit 2.2.1-3

Written As	Intended As	Interpreted As	
	2		→ Two interpreted as seven
	3		→ 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		→ 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

The UB-04 1450 is a 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 NUBC – Current Revision) should be used in conjunction with this Provider Billing Guideline and the applicable provider 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 General Billing Instructions

This subsection of the Billing Guidelines covers the specific NYS Medicaid billing requirements for Institutional claims. 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 reference purposes, the related electronic fields are provided. For further electronic claim submission information, refer to eMedNY 5010 Companion Guide which is available at www.emedny.org by clicking on the link to the webpage as follows: [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.

2.4.1 Instructions for the Submission of Medicare Crossover Claims

This subsection is intended to familiarize the provider with the submission of crossover claims. Providers can bill claims for Medicare/Medicaid members to Medicare. Medicare will then reimburse its portion to the provider and the provider's Medicare remittance will indicate that the claim will be crossed over to Medicaid. **Medicare Part-C** (Medicare Managed Care) and **Medicare Part-D** claims are *not* part of this process.

Providers must review their Medicare remittances for crossover information to determine whether their claims have been crossed over to Medicaid for processing. Any claim that was indicated by Medicare as a crossover should not be submitted to Medicaid as a separate claim. If the Medicare remittance does not indicate the claim has been crossed over to Medicaid, the provider should submit the claim directly to Medicaid. Claims for services not covered by Medicare should continue to be submitted directly to Medicaid as policy allows.

If a separate claim is submitted directly by the provider to Medicaid for a dual eligible member and the claim is paid before the Medicare crossover claim, both claims will be paid. The eMedNY system will then automatically void the provider submitted claim. Providers may submit adjustments to Medicaid for their crossover claims, because they are processed as a regular adjustment.

Electronic remittances from Medicaid for crossover claims will be sent to the default ETIN when the default is set to electronic. If there is no default ETIN, the crossover claims will be reported on a paper remittance. The ETIN application is available at www.emedny.org by clicking on the link to the webpage as follows: [Default Electronic Transmitter Identification Number \(ETIN\) Selection Form](#).

2.4.2 UB-04 Claim Form Field Instructions

Provider Name, Address, and Telephone Number (Form Locator 1)

837I Ref: Loop 2010AA NM1, N3, N4, and PER

Enter the service location's name and address with the full 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 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: [Inquiry](#).

Patient Control Number (Form Locator 3a)

837I Ref: Loop 2300 CLM01

This field can accommodate up to 20 alphanumeric characters and will be returned on the Remittance Advice.

Type of Bill (Form Locator 4)

837I Ref: Loop 2300 CLM05-1 and CLM05 -3

See the UB-04 manual for proper completion of this field. Provider type specific manuals may provide additional guidance as it relates to NY Medicaid.

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 same date in the FROM and THROUGH boxes
- 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.

Dates must be entered in the format MMDDYYYY.

NOTE: 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

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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: [General Billing](#).

Patient Name (Form Locator 8, line b)

837I Ref: Loop2010BA NM1

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

Birthdate (Form Locator 10)

837I Ref: Loop2010BA DMG02

Enter the member's birth date. This information may be obtained from the CBIC. The birth date must be in the format MMDDYYYY. See the example in Exhibit 2.4.2-6 that follows.

Exhibit 2.4.2-6

10 BIRTHDATE
03051935

Sex (Form Locator 11)

837I Ref: Loop 2010BA DMG03

Enter *M* for male or *F* for female to indicate the member's sex. This information may be obtained from the member's CBIC.

Admission/Start of Care Date (Form Locator 12)

837I Ref: Loop 2300 DTP03 when DTP01 = 435

Enter the admission date for inpatient services performed in both hospital and nursing home settings.

For Home Health services, enter the Start of Care date.

Admission Hour (Form Locator 13)

837I Ref: Loop 2300 DTP03 when DTP01 = 435

Enter the hour of admission for hospital inpatient services. See the UB-04 manual for specific instructions.

Priority (Type) of Visit (Form Locator 14)**837I Ref: Loop 2300 CL101**

Enter a Priority of Visit code. See the UB-04 manual for valid values.

Point of Origin for Admission or Visit (Form Locator 15)**837I Ref: Loop 2300 CL102**

Enter a Point of Origin code. See the UB-04 manual for valid values.

Discharge Hour (Form Locator 16)**837I Ref: Loop 2300 DTP03 when DTP01 = 096**

Enter the Discharge Hour as described in the UB-04 manual.

Patient Discharge Status (Form Locator 17)**837I Ref: 837I Ref: Loop 2300 CL103**

This field is used to indicate the specific condition or status of the member as of the last date of service indicated in Form Locator 6. Select the appropriate code from the NUBC UB-04 Manual.

Condition Codes (Form Locators 18–28)**837I Ref: Loop 2300 HI0x-2**

See the UB-04 manual for proper completion of this field. Provider type specific manuals may provide additional guidance as it relates to NY Medicaid.

Occurrence Code/Date (Form Locators 31–34)**837I Ref: Loop 2300 HI0x-2**

See the UB-04 manual for proper completion of this field. Provider type specific manuals may provide additional guidance as it relates to NY Medicaid.

Occurrence Code/Span (Form Locators 35–36)**837I Ref: Loop 2300 HI0x-2**

See the UB-04 manual for proper completion of this field. Provider type specific manuals may provide additional guidance as it relates to NY Medicaid.

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Value Codes (Form Locators 39-41)

837I Ref: Loop 2300 HI0x-2

NYS Medicaid uses Value Codes to report the following information:

- Locator Code (required for paper claims: see notes for conditions)
- Rate Code (if applicable)
- Recurring Monthly Income (if applicable)
- Other Insurance Payment (if applicable – Paper only)
- Medicaid Covered Days (if applicable)
- Medicaid Non-Covered Days (if applicable)
- Medicare Co-Insurance Days (if applicable)
- Patient Paid Amount (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

For electronic claims, leave this field blank.

For paper claims, enter the locator code assigned by NYS Medicaid.

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. Enter the locator code that corresponds to the address where the service was performed.

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 rate codes or amounts change, providers receive notification from the Department of Health.

Value Code

Code **24** must 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.

Recurring Monthly Income - Value Code 23**Value Code**

Code **23** should be used to indicate that the member's Net Available Monthly Income (NAMI) amount is entered under Amount.

Value Amount

Enter the NAMI amount approved by the local Social Services agency as the member's monthly budget.

In cases where the member's budget has increased, the new amount, rather than the current budgeted amount, should be entered.

If billing occurs more than once a month, enter the full NAMI amount on the *first* claim submitted for the month.

Note: For retroactive NAMI changes, an adjustment to the previously paid claim needs to be submitted. These adjustments can only be submitted when approval for a budget change has been received from the LDSS.

Other Insurance Payment – Value Code A1 - A3 or B1 - B3

If the member has insurance other than Medicaid, it is the responsibility of the provider to determine whether the service being billed is covered by the member's Other Insurance carrier. If the service is covered or if the provider does not know if the service is covered, the claim must first be submitted to the Other Insurance carrier. *Medicaid is always the payer of last resort.*

Value Code

If applicable, enter the appropriate code from the NUBC UB-04 Manual, Form Locator 39-41 to indicate that one (or more) of the following items is entered under Amount.

- Deductible - **A1 or B1**
- Co-insurance - **A2 or B2**
- Co-payment - **A7 or B7**
- Paid - **A3 or B3**

NOTE: These codes are used in conjunction with the value reported in Form Locator 50. These Value Codes are considered as Medicare related only when Line A or B = Medicare. Codes that begin with an A are used when Medicare is primary. Codes that begin with a B are used when Medicare is secondary to another payer.

These value codes are not applicable to electronic submissions.

Value Amount

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Enter the corresponding amount for each value code entered.

Enter the amount the other insurance actually paid for the service. If the other insurance denied payment or if the provider knows that the service would not be covered by the other insurance, enter 0.00. Proof of denial of payment must be maintained in the member's billing record.

Medicaid Covered Days – Value Code 80

Value Code

Code 80 must be used to indicate the total number of days that are covered by Medicaid. If only Medicare co-insurance days are claimed, do not report code 80.

Value Amount

Enter the actual number of days covered by Medicaid. The Covered Days must be entered to the left of the dollars/cents delimiter.

Note: The sum of Medicaid Full covered days, Medicaid non-covered days and Medicare co-insurance days must correspond to the Statement Covers Period in Form Locator 6 and should not reflect the day of discharge.

Medicaid Non-Covered Days – Value Code 81

Value Code

Code 81 must be used to indicate the total number of full days that are not reimbursable by Medicaid or any other third party. This does not include full days covered by Medicare or other third party insurers.

Value Amount

Enter the actual number of Medicaid non-covered days to the left of the dollars/cents delimiter.

NOTE: The sum of Medicaid Full covered days, Medicaid non-covered days and Medicare co-insurance days must correspond to the Statement Covers Period in Form Locator 6 and should not reflect the day of discharge.

Medicare Co-Insurance Days – Value Code 82

Value Code

Code 82 should be used to indicate the total number of Medicare co-insurance days claimed during the service period.

Value Amount

Enter the actual number of Medicare co-insurance days to the left of the dollars/cents delimiter.

NOTE: The sum of Medicaid Full covered days, Medicaid non-covered days and Medicare co-insurance days must correspond to the Statement Covers Period in Form Locator 6 and should not reflect the day of discharge.

Patient Paid Amount - Value Code FC

Value Code

Code **FC** should be used to indicate the amount the member has paid toward the claim.

Value Amount

Enter the Patient Paid Amount.

Revenue Code (Form Locator 42)

837I Ref: Loop 2400 SV201

Revenue codes are to be reported as applicable to the services rendered. The following revenue codes are used to identify specific situations for NYS Medicaid processing:

- 0001 (Total Charge) must be present on paper claims and is not used for electronic
- 0185 – Hospital Leave
- 0183 – Therapeutic Leave

Total Charges

Use Revenue Code **0001** to indicate that total charges are entered in Form Locator 47.

Hospital Leave (Only When Billing for Nursing Home - Room and Board)

To indicate the number of Hospital Leave days entered in Form Locator 46, use revenue code **0185** to indicate the member was hospitalized during the billing period and bed retention was involved.

Hospital Leave must not be claimed together with regular billing; these claims must be submitted on a separate form.

Therapeutic Leave (Only When Billing for Nursing Home - Room and Board)

To indicate that the number of Therapeutic Leave days is entered in Form Locator 46, use Revenue Code **0183** to indicate overnight absences, including leave for personal reasons or to participate in medically acceptable therapeutic or rehabilitative plans of care.

Therapeutic Leave must not be claimed together with regular billing; these claims must be submitted on a separate form.

HCPCS Code (Form Locator 44)

837I Ref: Loop2400 SV202-2

Enter all applicable procedure codes for non-inpatient services.

Service Date (Form Locator 45)

837I Ref: Loop2400 DTP03 when DTP01 = 472

Enter the date the outpatient service was provided.

Service Units (Form Locator 46)

837I Ref: Loop2400 SV205

Enter the appropriate number of days or units.

Notes:

- If Revenue Code **0185** (Hospital Leave) was used in Form Locator 42, enter the total number of Hospital Leave days on the same line where the revenue code appears. The number of units entered in this field must match the entry in Form Locators 39 – 41, Value Code 80, “Covered Days”.
- If Revenue Code **0183** (Therapeutic Leave) was used in Form Locator 42, enter the total number of Therapeutic Leave days on the same line where the revenue code appears. The number of therapeutic days must match the entry in Form Locators 39 – 41, Value Code 80, “Covered Days”.

Total Charges (Form Locator 47)

837I Ref: Loop 2400 SV203 for line charge amounts

Loop2300 CLM02 for the total claim charge Revenue line (Rev Code 0001)

Enter the amount charged for the line.

Paper claims must include a claim charged amount line which is represented by using Revenue Code 0001 in Form Locator 42. See Exhibit 2.4.2-14 for an example.

Exhibit 2.4.2-14

42 REVCOD	43 DESCRIPTION	44 HCPCS /RATE /HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
0001					640 .00	.	
0240			03012007	8	320 .00	.	
0240			03022007	8	320 .00	.	

Both sections of the field (dollars and cents) must be completed; if the charges contain no cents; enter **00** in the cents box.

Note: Revenue Code 0001 is not used for electronic claims.

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

837I Ref: 50A maps to Loop 2010BB NM103; B and C map to Loop 2330B NM103

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.

Medicare/Medicaid Claim

If the member 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 member 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 member 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.

Prior Payments - Payer (Form Locator 54)

837I Ref: Loop2320 AMT02 when AMT01 = D

Enter the amount paid by the payer identified in FL50.

NPI (Form Locator 56)

837I Ref: Loop2010AA NM109

Enter the provider's National Provider Identifier (NPI).

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Other Prv ID [Other Provider ID] (Form Locator 57)**837I Ref: Loop2010BB REF02 when REF01 = G2**

For atypical providers, enter the MMIS ID.

Insured's Unique ID (Form Locator 60)**837I Ref: Loop2010BA NM109**

Enter the member's ID number. This information may be obtained from the Member's Common Benefit ID Card (CBIC)

The Member's 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 Member ID number is entered on lines B or C, the lines above the Medicaid ID number must contain either the member's ID for the other payer(s) or the word *NONE*.

Treatment Authorization Codes (Form Locator 63)**837I Ref: Loop2300 REF02 when REF01 = G1**

When applicable, enter the Prior Approval or Prior Authorization Number.

Document Control Number (Form Locators 64 A, B, C)**837I Ref: Loop2300 REF02 when REF01 = F8**

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 intended to be adjusted or voided. The TCN is the claim identifier and is found in the Remittance Advice.

Notes:

- If a TCN is entered in this field, the Frequency Type 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.

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 *Member'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.

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.

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Voids

A void is submitted to nullify a paid claim. The void must be submitted in a new claim form and all applicable fields must be completed.

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

ICD Version Indicator (Form Locator 66)**837I Ref: Loop2300 HI0x-1**

Enter a value of 9 to indicate ICD-9.

Untitled [Principal Diagnosis Code] (Form Locator 67)**837I Ref: Loop2300 HI0x-2**

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 member. The ICD-9-CM code must be entered exactly as it is listed in the manual.

NOTE: Three-digit and four-digit diagnosis codes will be accepted only when the category has no subcategories.

Untitled [Other Diagnosis Codes] (Form Locator 67 A - Q)**837I Ref: Loop2300 HI0x-2**

Provide other diagnosis codes as appropriate.

Admitting Diagnosis Code (Form Locator 69)**837I Ref: Loop2300 HI0x-2**

Provide when appropriate.

Patient Reason for Visit (Form Locator 70)**837I Ref: Loop2300 HI0x-2**

Provide when appropriate for outpatient visits.

Principal Procedure Code and Date (Form Locator 74)**837I Ref: Loop2300 HI0x-2 (Proc Code) and 837I Ref: Loop2300 HI0x-4**

Provide when appropriate.

Other Procedure Codes and Dates (Form Locator 74a - e)

837I Ref: Loop2300 HI0x-2 (Proc Code) and 837I Ref: Loop2300 HI0x-4

Provide when appropriate.

Attending Provider Name and Identifiers (Form Locator 76)

837I Ref: Loop 2310A NM1

Enter the Attending Provider information.

Operating Physician Name and Identifiers (Form Locator 77)

837I Ref: Loop 2310B NM1

Enter the Operating physician when a surgical procedure is reported on the claim.

Other Provider (Individual) Names and Identifiers (Form Locator 78)

837I Ref: Loop 2310F NM1

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

Enter the NPI of the provider ordering the services.

A facility ID *cannot* be used for the referring/ordering provider. In those instances where an order or referral was made by a facility, the ID of the practitioner at the facility must be used.

When providing services to a member who is restricted to a primary physician or facility, the NPI of the member’s primary physician must be entered in this field. *The ID of the facility cannot be used.*

Instructions for entering an NPI

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”.

On the line below the ID number, enter the last name and first name of the provider. See the example in Exhibit 2.4.2-14.

Exhibit 2.4.2-14

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

78	OTHER	DN	NPI 1234567890	QUAL		
LAST SMITH			FIRST JOHN			

INSTITUTIONAL

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 (by category, status and member ID) 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

MODIFICATION TRACKING

12/23/2011 **Version 2011-02**

2.4.2 UB-04 Claim Form Field Instructions

- Value Codes (Form Locators 39-41): Added “Note: For retroactive NAMI changes, an adjustment to the previously paid claim needs to be submitted. These adjustments can only be submitted when approval for a budget change has been received from the LDSS.”