New York State Electronic Medicaid System UB-04 Billing Guidelines

COMPREHENSIVE MEDICAID CASE MANAGEMENT (CMCM)

Version 2010 - 02

12/13/2010

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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 CMCM 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

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 Certification Statements remain in effect and apply to all claims until superseded by another properly executed Certification Statement.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

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

- HIPAA 837I Implementation Guide (IG) explains the proper use of the 837I standards and program specifications. This document is available at www.wpc-edi.com/hipaa.
- 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

CMCM 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 CMCM 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 CMCM 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 CMCM Services Billing Instructions

This subsection of the Billing Guidelines covers the specific NYS Medicaid billing requirements for CMCM 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: Comprehensive Medicaid Case Management (CMCM) 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

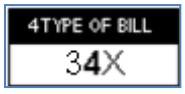
Enter the value ***3*** (Home Health) as the first digit of this field as seen in Exhibit 2.4.1-1. The source of this code is the UB-04 Manual, Form Locator 4, Type of Facility category.

Exhibit 2.4.1-1

Bill Classification

Enter the value ***4*** (Other) as the second digit of this field as in Exhibit 2.4.1-2. The source of this code is the UB-04 Manual, Form Locator 4, Bill Classification (Except Clinics and Special Facilities) category.

Exhibit 2.4.1-2

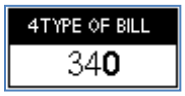


Frequency - Adjustment/Void Code

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.

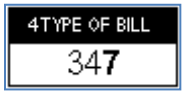
If submitting an original claim, enter the value ***0*** in the third position of this field as in Exhibit 2.4.1-3.

Exhibit 2.4.1-3



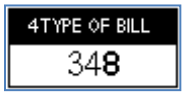
If submitting an adjustment (replacement) to a previously paid claim, enter the value ***7*** in the third position of this field as in Exhibit 2.4.1-4.

Exhibit 2.4.1-4



If submitting a void to a previously paid claim, enter the value ***8*** in the third position of this field as in Exhibit 2.4.1-5.

Exhibit 2.4.1-5



Statement Covers Period From/Through (Form Locator 6)

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

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

Special Instructions for ICM/CMCM Only

Enter the first day of the month subsequent to the month in which services were rendered in the FROM box, unless the patient loses Medicaid eligibility during the service month. If the patient loses eligibility before the first of the month subsequent to the service month, enter the date on which the last of the required four face-to-face encounters took place. Providers should verify patient eligibility through MEVS in order to ensure payment for their services.

Only one ICM (Intensive Case Management) claim can be submitted per claim form.

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.

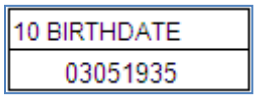
Patient Name (Form Locator 8, line b)

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 2.4.1-6 that follows.

Exhibit 2.4.1-6



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)

This field is used to indicate the specific condition or status of the patient as of the last date of service indicated in Form Locator 6. Select the appropriate code (***except for 43 and 65***) from the UB-04 Manual.

Condition Codes (Form Locators18–28)

NYS Medicaid uses Condition Codes to indicate the following:

- Family Planning
- Possible Disability
- Abortion/Sterilization

NOTE: EPSDT/CTHP and Abortion Sterilization do NOT apply to CMCM claims.

Family Planning – A4

If applicable, enter Condition Code ***A4*** to indicate that the claim relates to family planning.

Under CMCM, the case manager does not provide medical family planning services such as diagnosis, treatment, drugs, supplies and related counseling. These services are furnished, prescribed by, or administered under the supervision of a physician. For the purpose of CMCM billing, except programs with monthly rates, services related to family planning are those that the case manager offers and arranges for to enable individuals to plan their families in accordance with their wishes. CMCM family planning services include, but are not limited to:

- Disseminating information either orally or in writing about available family planning health services;
- Providing for individual or group discussion regarding the need for family planning health services;
- Providing assistance in accessing services by arranging visits with medical family planning providers.

Possible Disability – A5

If applicable, enter Condition Code A5 to indicate that the patient's condition appeared to be of a disabling nature.

If neither Family Planning nor Possible Disability are applicable conditions, leave this field blank.

Occurrence Code/Date (Form Locators 31–34)

NYS Medicaid uses Occurrence Codes to report ***Accident Code***. This field has two components: ***Code*** and ***Date***; both are required when applicable.

Code

If applicable, enter the appropriate Accident Code to indicate whether the service rendered to the patient was for a condition resulting from an accident or crime. Select the code from the UB-04 Manual, Form Locators 31-34, Accident Related Codes.

Date

If an entry was made under Code, enter the date when the accident occurred in the format MMDDYY.

Value Codes (Form Locators 39-41)

NYS Medicaid uses Value Codes to report the following information:

- Locator Code (required: see note for conditions)
- Rate Code (required)
- Medicare Information (only if applicable)
- Other Insurance Payment (only if applicable)
- Patient Participation/Spend-down (only if applicable)

Value Codes have two components: Code and Amount. The ***Code*** component is used to indicate the type of information reported. The ***Amount*** component is used to enter the information itself. Both components are required for each entry.

Locator Code - Value Code 61

Locator codes are assigned to the provider for each service address registered at the time of enrollment in the Medicaid program or at anytime, afterwards, that a new location is added.

Providers using Rate Codes 5210 – 5214 must enter the Locator Code assigned by NYS Medicaid. Providers using Rate Codes other than 5210-5214 should not enter the Locator Code.The Locator Code will be defaulted to 003 if the nine digit ZIP Code submitted on the claim does not match what is on file.

Value Code

Code ***61*** should be used to indicate that a Locator Code is entered under Amount.

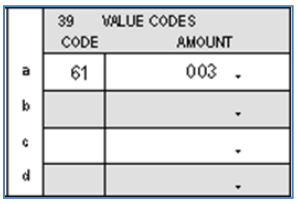
Value Amount

Entries 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. If applicable, enter the Locator Code that corresponds to the address where the service was performed.

The example in Exhibit 2.4.1-7 illustrates a correct Locator Code entry.

Exhibit 2.4.1-7



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: Comprehensive Medicaid Case Management 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

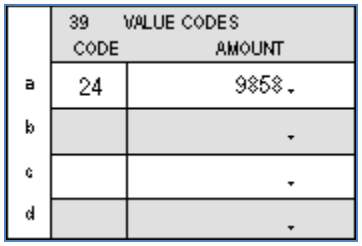
Code *24* should be used to indicate that a rate code is entered under Amount.

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 2.4.1-8 illustrates a correct rate code entry.

Exhibit 2.4.1-8



Rate Code Special Instructions

- ICM/CMCM Only

  The ICM (Intensive Case Management) rate code (5200) is a monthly rate representing a minimum of four face-to-face encounters with the patient within a calendar month.

- SCM/CMCM Only

  The SCM (Supportive Case Management) rate codes - 5205 and 5206 - are monthly rates representing a minimum of two face-to-face encounters with the patient within a calendar month.

- Blended/CMCM Only

  The Blended rate codes - 5250 through 5259 – are monthly rates representing an aggregate minimum number of face-to-face encounters with patients within a calendar month. The minimum number of face-to-face encounters is based on the configuration of the Blended Team. The minimum encounters for each type of team will be based on a schedule provided to Blended Case Management programs by the NYS Office of Mental Health.

- OPWDD/CMCM Only

  For the OPWDD (Office for People With Developmental Disabilities) rate code (5221), a minimum of one monthly encounter per case is required in all cases except for patients residing with their families; in that case, a minimum of one quarterly encounter may be maintained instead, if:

  - The patient is a child who attends a residential school during the school term and requires intensive case management services only part of the year; or
  - The family has requested less frequent contact and the case manager determines that this is appropriate.

- First-time Mothers/Newborns (NPF)/CMCM Only

  The First-time Mothers/Newborns (NPF) rate code (5260) is a 15 minute unit rate. Up to four (4) 15 minute units may be billed per service date when one or more of the CMCM services are provided. Each client is allowed a maximum of 260 units (which can be billed over a two and a half year time period).

Medicare Information (See Value Codes Below)

If the patient is also a Medicare beneficiary, it is the responsibility of the provider to determine whether the service being billed for is covered by the patient's Medicare coverage. If the service is covered or if the provider does not know if the service is covered, the provider must first submit a claim to Medicare, as Medicaid is always the payer of last resort.

Value Code

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

- Medicare Deductible - ***A1 or B1***
- Medicare Co-insurance - ***A2 or B2***
- Medicare Co-payment - ***A7 or B7***

Enter code A3 or B3 to indicate that the Medicare Payment is entered under Amount.

NOTE: The line (A or B) assigned to Medicare in Form Locator 50 determines the choice of codes AX or BX.

Value Amount

Enter the corresponding amount for each value code entered.

Enter the amount that Medicare actually paid for the service. If Medicare denied payment or if the provider knows that the service would not be covered by Medicare, or has received a previous denial of payment for the same service, enter 0.00. Proof of denial of payment must be maintained in the patient's billing record.

Other Insurance Payment – Value Code A3 or B3

If the patient has insurance other than Medicare, it is the responsibility of the provider to determine whether the service being billed for is covered by the patient's Other Insurance carrier. If the service is covered or if the provider does not know if the service is covered, the provider must first submit a claim to the Other Insurance carrier, as Medicaid is always the payer of last resort.

Value Code

If applicable, code ***A3 or B3*** should be used to indicate that the amount paid by an insurance carrier other than Medicare is entered under Amount. The line (A or B) assigned to the Insurance Carrier in Form Locator 50 determines the choice of codes ***A***3 or ***B***3.

Value Amount

Enter the actual amount paid by the other insurance carrier. If the other insurance carrier denied payment enter 0.00. Proof of denial of payment must be maintained in the patient's billing record. Zeroes must also be entered in this field if any of the following situations apply:

- Prior to billing the insurance company, the provider knows that the service will not be covered because:
  - The provider has had a previous denial for payment for the service from the particular insurance policy. However, the provider should be aware that the service should be billed if the insurance policy changes. Proof of denials must be maintained in the patient's billing record. Prior claims denied due to deductibles not being met are not to be counted as denials for subsequent billings.
  - In very limited situations the Local Department of Social Services (LDSS) has advised the provider to zero-fill the Other Insurance payment for the same type of service. This communication should be documented in the client's billing record.
- The provider bills the insurance company and receives a rejection because:
  - The service is not covered; or
  - The deductible has not been met.
- The provider cannot directly bill the insurance carrier and the policyholder is either unavailable or uncooperative in submitting claims to the insurance company. In these cases the LDSS must be notified prior to zero-filling. The LDSS has subrogation rights enabling it to complete claim forms on behalf of uncooperative policyholders who do not pay the provider for the services. The LDSS can direct the insurance company to pay the provider

directly for the service whether or not the provider participates with the insurance plan. The provider should contact the third-party worker in the LDSS whenever he/she encounters policyholders who are uncooperative in paying for covered services received by their dependents who are on Medicaid. In other cases providers will be instructed to zero-fill the Other Insurance payment in the Medicaid claim and the LDSS will retroactively pursue the third-party resource.

- The patient or an absent parent collects the insurance benefits and fails to submit payment to the provider. The LDSS must be notified so that sanctions and/or legal action can be brought against the patient or absent parent.
- The provider is instructed to zero-fill by the LDSS for circumstances not listed above.

The example in Exhibit 2.4.1-9 illustrates a correct Other Insurance Payment entry.

Exhibit 2.4.1-9

	39 CODE	VALUE CODES AMOUNT
a	B3	100 . 00
b		.
c		.
d		.

Patient Participation (Spend Down) - Value Code 31

Some patients of the CMCM Services Program do not become eligible for Medicaid until they pay an overage or monthly amount (spend-down) toward the cost of their medical care.

Value Code

If applicable, enter Code ***31*** to indicate that the patient's spend-down participation is entered under Amount.

Value Amount

Enter the spend-down amount paid by the patient.

The example in Exhibit 2.4.1-10 illustrates a correct Patient Participation entry.

Exhibit 2.4.1-10

	39 CODE	VALUE CODES AMOUNT
a	31	100 . 00
b		.
c		.
d		.

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

Revenue Codes identify specific accommodations, ancillary services, or billing calculations.

NYS Medicaid uses Revenue Codes to report the following information:

- Total Amount Charged
- Units

Total Amount Charged

Use Revenue Code ***0001*** to indicate that total charges for the services being claimed in the form are entered in Form Locator 47.

Units

Use an appropriate Revenue Code from the UB-04 manual to indicate that the units of service are entered in Form Locator 46.

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

NOTE: If the number of service lines (dates of service) exceed the number of lines that can be accommodated on a single UB-04 form, another claim form must be entirely completed. Medicaid cannot process additional claim lines without all the required information. Each claim form will be processed as a unique claim document and must contain only one Total Charges 0001 Revenue Code. Multi-paged documents cannot be accepted.

Serv. Date (Form Locator 45)

Enter the service date corresponding to each iteration of a Revenue Code other than 0001. The dates entered here must be contained within the billing period (FROM/THROUGH) in Form Locator 6.

Serv. Units (Form Locator 46)

Billing for One Date of Service – Multiple Units

If only one date of service was entered in form locator 6 and multiple units of service were performed on that date, enter the number of units on the same line where a Revenue Code other than Revenue Code 0001 was entered in Form Locator 42. To determine the number of units, follow the guidelines below.

All CMCM services, ***except as noted below***, are billed in units of 15-minute intervals at a rate determined by the NYS Department of Health and other state departments and approved by the NYS Division of the Budget. The number of units should be calculated in accordance to Exhibit 2.4.1-11.

Exhibit 2.4.1-11

1 unit	=	from 5 minutes to 15 minutes
2 units	=	from 16 minutes to 30 minutes
3 units	=	from 31 minutes to 45 minutes
4 units	=	from 46 minutes to 60 minutes, etc.

For example, if the time spent providing case management is 20 min, enter two (2) units of service in this field. If one hour of case management service is provided, enter four (4) units of service in this field.

Service Units Special Instructions

For First-time Mothers/Newborns (NPF) Only

Up to four (4) 15 minute units can be billed per service date. Each client is allowed a maximum of 260 units (which can be billed over a two and a half year time period). The number of units should be calculated in accordance with the chart below

Exhibit 2.4.1-12

1 unit	=	from 5 minutes to 15 minutes
2 units	=	From 16 minutes to 30 minutes
3 units	=	From 31 minutes to 45 minutes
4 units	=	From 46 minutes to 60 minutes

For TASA Only

The units are computed as shown in Exhibit 2.4.1-13.

Exhibit 2.4.1-13

1 unit	=	6 minutes	to	21 minutes
2 units	=	22 minutes	to	36 minutes
3 units	=	37 minutes	to	51 minutes
4 units	=	52 minutes	to	1 hour 6 minutes
5 units	=	1 hour 7 minutes	to	1 hour 21 minutes, etc.

Billing for Multiple Dates of Service

If a range of service dates was entered in form locator 6, enter the number of units of service corresponding to each date of service in this field on the same lines where Revenue Code 0240 was entered in form locator 42.

For ICM/CMCM, SCM/CMCM, Blended/CMCM, and OMH/CMCM Only

Leave this field blank.

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

Total Charges (Form Locator 47)

Enter the total amount charged for the service(s) rendered on the lines corresponding to Revenue Code 0001 in Form Locator 42 (total charges for all lines billed) and for any other Revenue Code (individual charges for that one line). Both

sections of the field (dollars and cents) must be completed; if the charges contain no cents; enter ***00*** in the cents box. See Exhibit 2.4.1-13 for an example.

Exhibit 2.4.1-14

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					640.00	.	
0240			03012007	8	320.00	.	
0240			03022007	8	320.00	.	

If billing for multiple units, the total charges should equal the number of units entered in Form Locator 46 multiplied by the rate amount. If no units were reported in Form Locator 46, the total charges should equal the rate amount.

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

This field identifies the payer(s) responsible for the claim payment. The field lines (A, B, and C) are devised to indicate primary (A), secondary (B), and tertiary (C) responsibility for claim payment.

For NYS Medicaid billing, payers are classified into three main categories: Medicare, Commercial (any insurance other than Medicare), and Medicaid. ***Medicaid is always the payer of last resort.*** Complete this field in accordance with the following instructions.

Direct Medicaid Claim

If Medicaid is the only payer, enter the word Medicaid on line A of this field. Leave lines B and C blank.

Medicare/Medicaid Claim

If the patient has Medicare coverage:

- Enter the word ***Medicare*** on line A of this field.
- Enter the word ***Medicaid*** on line B of this field.
- Leave line C blank.

Commercial Insurance/Medicaid Claim

If the patient has insurance coverage other than Medicare:

- Enter the name of the ***Insurance Carrier*** on line A of this field.
- Enter the word ***Medicaid*** on line B of this field.
- Leave line C blank.

Medicare/Commercial/Medicaid Claim

If the patient is covered by Medicare and one or more commercial insurance carriers:

- Enter the word ***Medicare*** on line A of this field.

- Enter the name of the ***Other Insurance Carrier*** on line B of this field.
- Enter the word ***Medicaid*** on line C of this field.

NPI (Form Locator 56)

Enter the provider's 10-digit National Provider Identifier (NPI).

For providers billing rate codes 5210-5214, 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 same line (A, B, or C) that matches the line assigned to Medicaid in Form Locator 50. If the provider's Medicaid ID number is entered in lines B or C, the lines above the Medicaid ID number must contain either the provider's ID for the other payer(s) or the word ***NONE***.

Insured's Unique ID (Form Locator 60)

Enter the patient's 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 the same line (A, B, or C) that matches the line assigned to Medicaid in Form Locators 50 and 57. If the patient's Medicaid Client ID number is entered on lines B or C, the lines above the Medicaid ID number must contain either the patient's ID for the other payer(s) or the word ***NONE***.

Treatment Authorization Codes (Form Locator 63)

Leave 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).

A void should be submitted only when the entire original claim –all claim lines (service dates) – need to be cancelled.

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 CMCM 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 HOME CARE

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

00111234 2010-05-31
CITY HOME CARE
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: $******1877.11

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

MEDICAID
MANAGEMENT INFORMATION SYSTEM

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

John Smith
AUTHORIZED SIGNATURE

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 HOME CARE

MEDICAID MANAGEMENT INFORMATION SYSTEM

DATE: 2010-05-31
REMITTANCE NO: 07060600001
PROVID: 00111234

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

CITY HOME CARE $1877.11

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

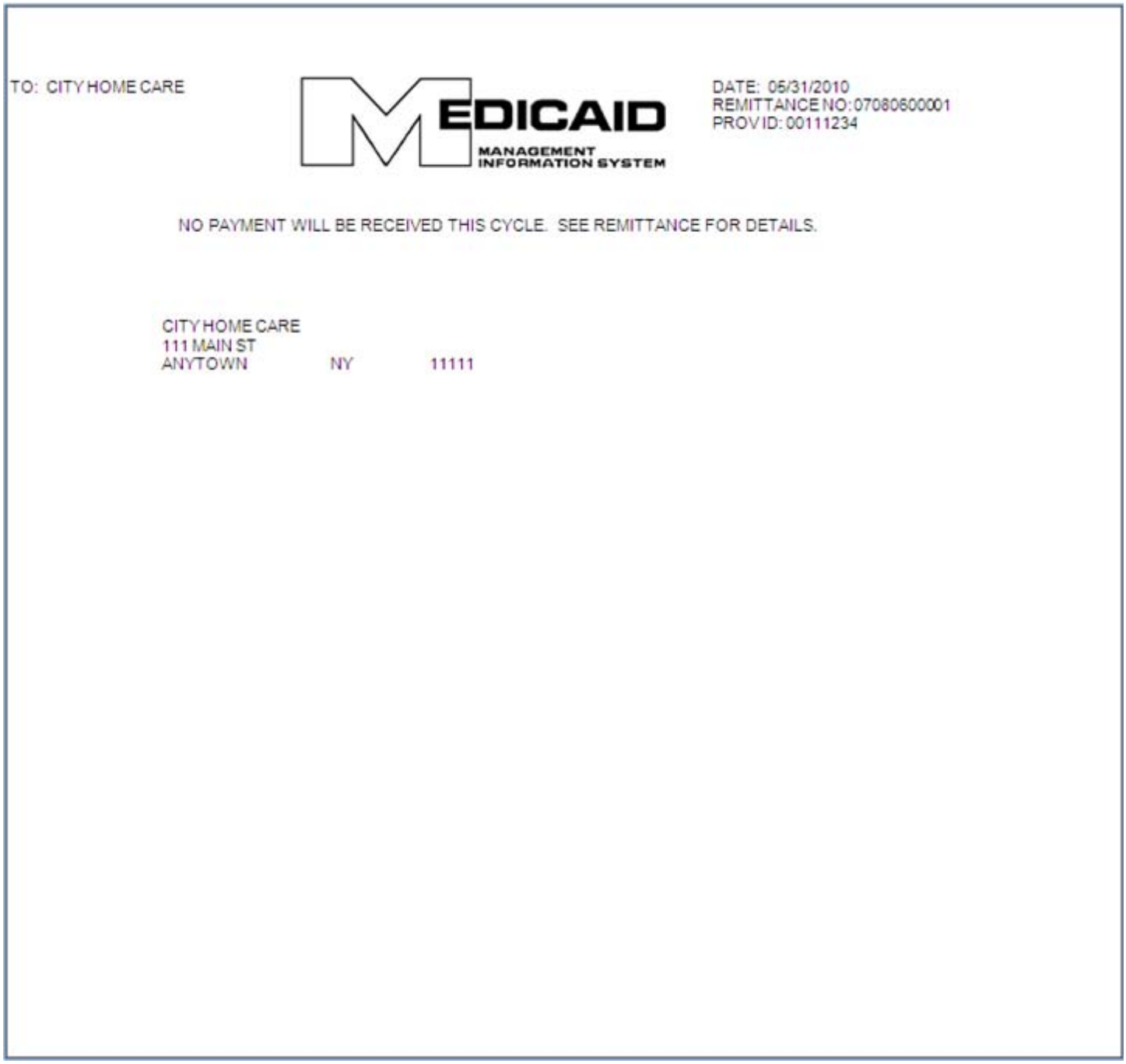
Provider's Name/Address

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 HOME CARE

MEDICAID MANAGEMENT INFORMATION SYSTEM

DATE: 05/31/2010
REMITTANCE NO: 07060600001
PROV ID: 00111234

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

CITY HOME CARE
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
REMITTANCE STATEMENT

PAGE 01
DATE 05/31/10
CYCLE 1710

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

ETIN:
PROVIDER NOTIFICATION
PROV 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
REMITTANCE STATEMENT

PAGE 02
DATE 05/31/2010
CYCLE 1710

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

ETIN:
HOME HEALTH
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	05/25/10	5220	10.000	187.81	0.00	DENY	00162 00131
CPIC1-00987-6	SAMPLE	XX23456X	07206-000019113-3-1	05/25/10	5220	8.000	84.38	0.00	DENY	00244 00142

* = PREVIOUSLY PENDED CLAIM
** = NEW PEND

TOTAL AMOUNT ORIGINAL CLAIMS	DENIED	272.19	NUMBER OF CLAIMS	2
NET AMOUNT ADJUSTMENTS	DENIED	0.00	NUMBER OF CLAIMS	0
NET AMOUNT VOIDS	DENIED	0.00	NUMBER OF CLAIMS	0
NET AMOUNT VOIDS – ADJUSTS		0.00	NUMBER OF CLAIMS	0

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 HOME CARE
111 MAIN STREET
ANYTOWN, NEW YORK 11111

ETIN:
HOME HEALTH
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	07206-000034112-0-2	05/25/10	5220	8.000	300.20	300.20	PAID	
CPIC1-00987-6	SAMPLE	XX23456X	07206-000445113-0-2	05/23/10	5220	5.000	188.41	188.41	PAID	
CPIC1-44444-6	EXAMPLE	XX34567X	07206-000466333-0-2	05/27/10	5220	8.000	300.20	300.20	PAID	
CPIC1-66666-6	SPECIMEN	XX45678X	07206-000445663-0-2	05/22/10	5220	8.000	300.20	300.20	PAID	
CPIC1-33333-6	STANDARD	XX56789X	07206-000447654-0-2	05/22/10	5220	8.000	300.20	300.20	PAID	
CPIC1-55555-6	MODEL	XX67890X	07206-000465553-0-2	05/25/10	5220	7.000	186.10	186.10	PAID	
CPIC1-77777-6	DOE	XX09876X	07206-000455557-0-2	05/25/10	5220	8.000	300.20	300.20	PAID	
CPIC1-11111-6	SAMPLE	XX98765X	07206-000544444-0-2	05/05/10	5220	5.000	150.90	150.90	ADJT	
CPIC1-99999-6	EXAMPLE	XX87654X	07206-000465477-0-2	05/05/10	5220	8.000	300.20	-300.20-	PAID	ORIGINAL CLAIM PAID 05/11/2010

* = PREVIOUSLY PENDED CLAIM
** = NEW PEND

TOTAL AMOUNT ORIGINAL CLAIMS	PAID	2026.41	NUMBER OF CLAIMS	8
NET AMOUNT ADJUSTMENTS	PAID	49.30-	NUMBER OF CLAIMS	1
NET AMOUNT VOIDS	PAID	0.00	NUMBER OF CLAIMS	0
NET AMOUNT VOIDS – ADJUSTS		149.30-	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 HOME CARE
111 MAIN STREET
ANYTOWN, NEW YORK 11111

ETIN:
HOME HEALTH
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	05/25/10	5220	8.000	300.20	**	PEND	00162 00244
CPIC1-00987-6	SAMPLE	XX23456X	07206-000445113-3-1	05/22/10	5220	5.000	188.41	**	PEND	00162 00244

* = PREVIOUSLY PENDED CLAIM
** = NEW PEND

TOTAL AMOUNT ORIGINAL CLAIMS	PEND	488.61	NUMBER OF CLAIMS	2
NET AMOUNT ADJUSTMENTS	PEND	0.00	NUMBER OF CLAIMS	0
NET AMOUNT VOIDS	PEND	0.00	NUMBER OF CLAIMS	0
NET AMOUNT VOIDS – ADJUSTS		0.00	NUMBER OF CLAIMS	0
REMITTANCE TOTALS – HOME HEALTH				
VOIDS – ADJUSTS		0.00	NUMBER OF CLAIMS	0
TOTAL PENDS		0.00	NUMBER OF CLAIMS	0
TOTAL PAID		0.00	NUMBER OF CLAIMS	0
TOTAL DENIED		775.62	NUMBER OF CLAIMS	2
NET TOTAL PAID		0.00	NUMBER OF CLAIMS	0
MEMBER ID: 00111234				
VOIDS – ADJUSTS		149.30–	NUMBER OF CLAIMS	1
TOTAL PENDS		488.61	NUMBER OF CLAIMS	2
TOTAL PAID		2026.41	NUMBER OF CLAIMS	8
TOTAL DENY		272.19	NUMBER OF CLAIMS	2
NET TOTAL PAID		1877.11	NUMBER OF CLAIMS	8

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 HOME CARE
111 MAIN STREET
ANYTOWN, NEW YORK 11111

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

REMITTANCE TOTALS – GRAND TOTALS

VOIDS – ADJUSTS	149.30–	NUMBER OF CLAIMS	1
TOTAL PENDS	488.61	NUMBER OF CLAIMS	2
TOTAL PAID	2026.41	NUMBER OF CLAIMS	8
TOTAL DENY	272.19	NUMBER OF CLAIMS	2
NET TOTAL PAID	1877.11	NUMBER OF CLAIMS	8

3.5.1 Claim Detail Page Field Descriptions

Upper Left Corner

Provider's 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: **HOME HEALTH**

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. The units are indicated with three (3) decimal positions. Since CMCM must only report whole units of service, the decimal positions will always be 000. For example: 3 units will be indicated as 3.000.

Charged

The total charges entered in the claim form appear under this column.

Paid

If the claim was approved, the amount paid appears under this column. If the claim has a pend or deny status, the amount paid will be zero (0.00).

Status

This column indicates the status (DENY, PAID/ADJT/VOID, PEND) of the claim line.

Denied Claims

Claims for which payment is denied will be identified by the ***DENY*** status. A claim may be denied for the following general reasons:

- The service rendered is not covered by the New York State Medicaid Program.
- The claim is a duplicate of a prior paid claim.
- The required Prior Approval has not been obtained.
- Information entered in the claim form is invalid or logically inconsistent.

Approved Claims

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

Paid Claims

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

Adjustments

The status ***ADJT*** refers to a claim submitted in replacement of a paid claim with the purpose of changing one or more fields. An adjustment has two components: the 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

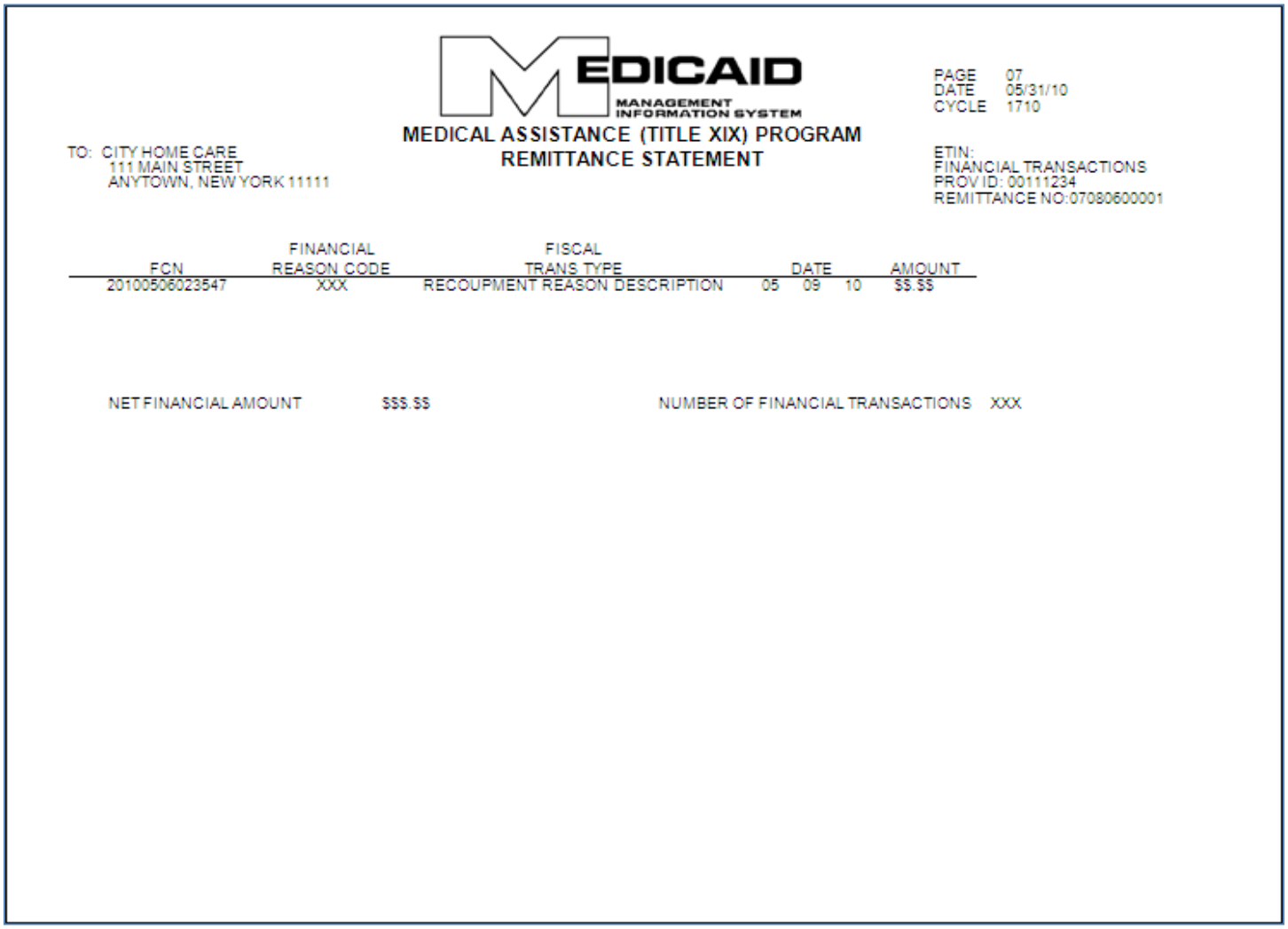
This section has two subsections:

- 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 HOME CARE
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
20100506023547	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

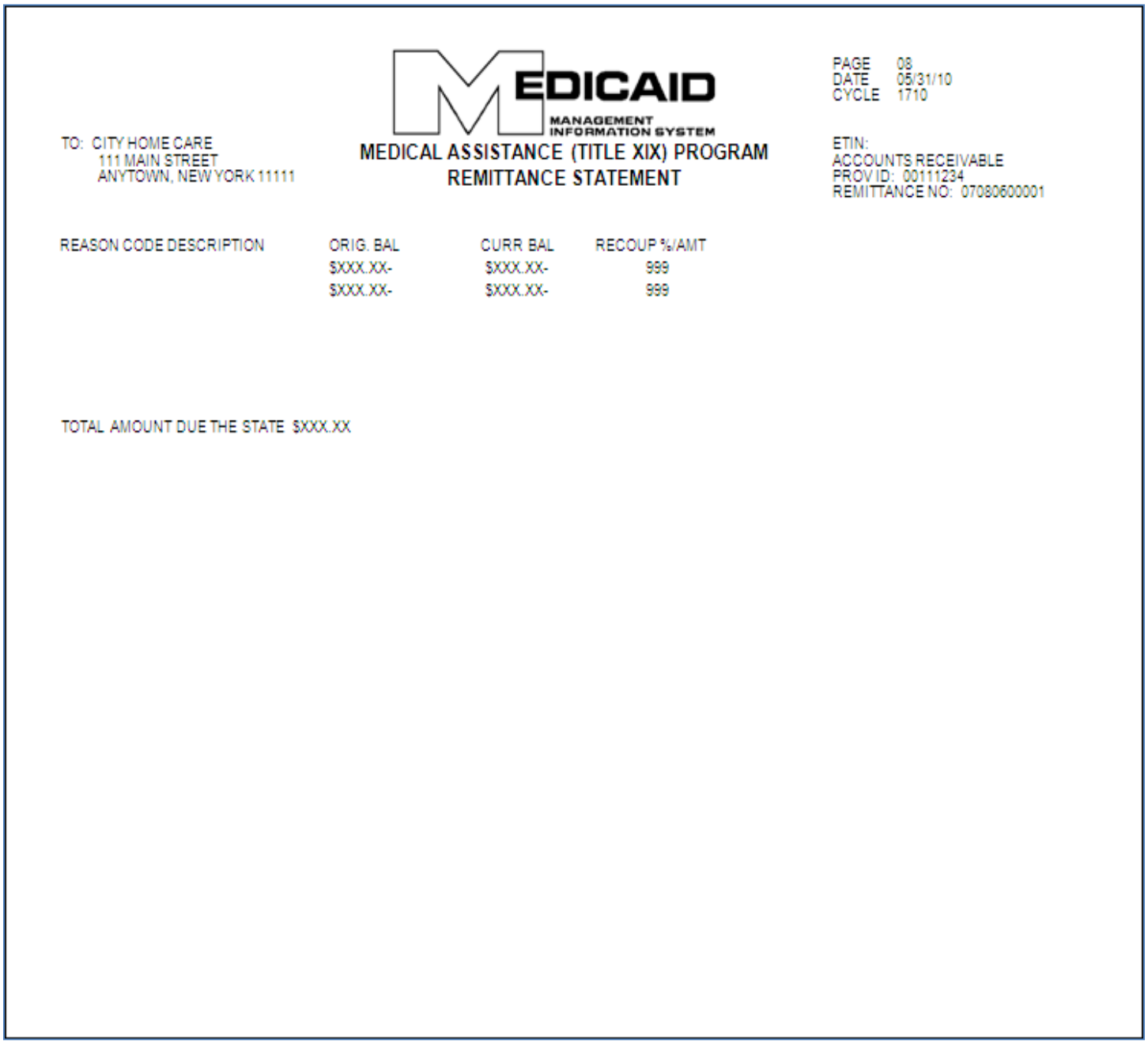
The total dollar amount of the financial transactions (***Net Financial Transaction Amount***) and the total number of transactions (***Number of Financial Transactions***) appear below the last line of the transaction detail list.

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



MEDICAID
MANAGEMENT INFORMATION SYSTEM

PAGE 08
DATE 05/31/10
CYCLE 1710

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

MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

ETIN:
ACCOUNTS RECEIVABLE
PROV ID: 00111234
REMITTANCE NO: 07080600001

REASON CODE DESCRIPTION	ORIG. 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

MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

PAGE 06
DATE 05/31/2010
CYCLE 1710

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

ETIN:
HOME HEALTH
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:

00131 THIRD PARTY INDICATED OTHER INSURANCE PAD BLANK
00142 RECIPIENT YEAR OF BIRTH DIFFERS FROM FILE
00162 RECIPIENT INELIGIBLE ON DATE OF SERVICE
00244 PA NOT ON FILE

APPENDIX A
CLAIM SAMPLES

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

CMCM UB-04 Claim Sample

APPROVED OMB NO. 0938-0279

ST 11843 PLY UB-04

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	9 PATIENT ADDRESS
SMITH, WILLIAM	

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18	19	20	21	CONDITION CODES 22	23	24	25	26	27	28	29 ACDT STATE	30
04191940	M						30	A5												

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

38

	39 CODE	39 VALUE CODES AMOUNT	40 CODE	40 VALUE CODES AMOUNT	41 CODE	41 VALUE CODES AMOUNT
a	61	003.	24	5220.	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	.	
2	0240			04022007	4	40.00	.	
3	0240			04062007	4	40.00	.	
4	0240			04092007	6	60.00	.	
5	0240			04132007	4	40.00	.	
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	1234567890
A	Blue Cross				.	.	57 OTHER PRV ID	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			
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 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

c OTHER PROCEDURE CODE	DATE	d OTHER PROCEDURE CODE	DATE	e OTHER PROCEDURE CODE	DATE

80 REMARKS	81 CC			
	a			
	b			
	c			
	d			

76 ATTENDING	NPI	QUAL	
LAST		FIRST	
77 OPERATING	NPI	QUAL	
LAST		FIRST	
78 OTHER	NPI	QUAL	
LAST		FIRST	
79 OTHER	NPI	QUAL	
LAST		FIRST	

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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.