NEW YORK STATE
MEDICAID PROGRAM

INTERMEDIATE CARE FACILITIES FOR THE DEVELOPMENTALLY DISABLED (ICF/DD)

UB-04
BILLING GUIDELINES

TABLE OF CONTENTS

Section I – 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 ICF/DD providers and should be used by the provider as an instructional as well as a reference tool.

Section II – Claims Submission

ICF/DD 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 a 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 Certification Statements remain in effect and apply to all claims until superseded by another properly executed Certification Statement. You will be asked to update your Certification Statement on an annual basis. You will be provided with renewal information when your Certification Statement is near expiration.

Pre-requirements for the Submission of Claims

Before submitting claims to NYS Medicaid, all providers need the following:

- An ETIN
- A Certification Statement

ETIN
This is a submitter identifier issued by the eMedNY Contractor. All providers are required to have an active ETIN on file with the eMedNY Contractor prior to the submission of claims. ETINs may be issued to an individual provider or provider group (if they are direct billers) and to service bureaus or clearinghouses.

The ETIN application is available at www.emedny.org by clicking on the link to the web page below:

Provider Enrollment Forms

Certification Statement
All providers, either direct billers or those who bill through a service bureau or clearinghouse, must file a notarized Certification Statement with NYS Medicaid for each ETIN used for billing.

The Certification Statement is good for one year, after which it needs to be renewed for billing continuity under a specific ETIN. Failure to renew the Certification Statement for a specific ETIN will result in claim rejection.

The Certification Statement is available on the third page of the ETIN application at www.emedny.org or can be accessed by clicking on the link above.

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.

ICF/DD providers who choose to submit their Medicaid claims electronically are required to use the HIPAA 837 Institutional (837I) transaction. In addition to this document, direct billers may 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 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 below.

- **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 below.:

eMedNY Companion Guides and Sample Files

Pre-requirements for the Submission of Electronic Claims

In addition to an ETIN and a Certification Statement, providers need the following before submitting electronic claims to NYS Medicaid:

- A User ID and Password

- A Trading Partner Agreement

- Testing

User ID and Password

Electronic submitters need a user ID and password to access the NYS Medicaid eMedNY system through one of the communication methods available. The user ID and password are issued to the submitter at the time of enrollment in one of the communication methods. The method used to apply for a user ID varies depending on the communication method chosen by the provider. For example: An ePACES user ID is assigned systematically via email while an FTP user ID is assigned after the submission of a Security Packet B.

Trading Partner Agreement

This document addresses certain requirements applicable to the electronic exchange of information and data associated with health care transactions.

The NYS Medicaid Trading Partner Agreement is available at www.emedny.org by clicking on the link to the web page below:

Provider Enrollment Forms

Testing

Direct billers (either individual providers or service bureaus/clearinghouses that bill for multiple providers) are encouraged to submit production tests to CSC before they start submitting Medicaid claims for the first time after enrollment or any time they update their systems or start using a new system. This testing will assist providers in identifying errors in their system and allow for corrections before they submit actual claims.

Information and instructions regarding testing are available at www.emedny.org by clicking on the link to the web page below:

eMedNY Companion Guides and Sample Files

Communication Methods

The following communication methods are available for submission of electronic claims to NYS Medicaid:

- ePACES
- eMedNY eXchange
- FTP
- CPU to CPU
- eMedNY Gateway
- Simple Object Access Protocol (SOAP)

ePACES

NYS Medicaid provides ePACES, a HIPAA-compliant web-based application that is customized for specific transactions, including the 837I. ePACES, which is provided free of charge, is ideal for providers with small-to-medium claim volume.

The requirements for using ePACES include:

- An ETIN and Certification Statement should be obtained prior to enrollment
- Internet Explorer 4.01 and above or Netscape 4.7 and above
- Internet browser that supports 128-bit encryption and cookies
- Minimum connection speed of 56K
- An accessible email address

The following transactions can be submitted via ePACES:

- 270/271 - Eligibility Benefit Inquiry and Response
- 276/277 - Claim Status Request and Response
- 278 - Prior Approval/Prior Authorization/Service Authorization Request and Response
- 837 - Dental, Professional, and Institutional Claims

To take advantage of ePACES, providers need to follow an enrollment process. Additional enrollment information is available at www.emedny.org by clicking on the link to the web page below:

Self Help

eMedNY eXchange

eMedNY eXchange is a method in which claims can be submitted and works similarly to typical electronic mail (email). Users are assigned an inbox in the system and are able to send and receive transaction files. The files are attached to the request and sent to eMedNY for processing. The responses are delivered back to the user's inbox where they can be detached and saved locally. **For security reasons, the eMedNY eXchange is accessible only through the eMedNY website www.emedny.org**.

Access to the eMedNY eXchange is obtained through an enrollment process. To enroll in eXchange, you must first complete enrollment in ePACES and at least one login attempt must be successful.

FTP

File Transfer Protocol (FTP) is the standard process for batch authorization transmissions. FTP allows users to transfer files from their computer to another computer. FTP is strictly a dial-up connection.

FTP access is obtained through an enrollment process. To obtain a user name and a password, you must complete and return a Security Packet B. The Security Packet B is available at www.emedny.org by clicking on the link to the web page below:

Provider Enrollment Forms

CPU to CPU

This method consists of a direct connection established between the submitter and the processor, and it is most suitable for high volume submitters. For additional information regarding this access method, contact the eMedNY Call Center at 800-343-9000.

eMedNY Gateway

The eMedNY Gateway or Bulletin Board System (BBS) is a dial-up access method that is only available to existing users. CSC encourages new trading partners to adopt a different access method for submissions to NYS Medicaid. (For example: FTP, eMedNY eXchange, SOAP, etc.)

Simple Object Access Protocol (SOAP)

The Simple Object Access Protocol (SOAP) communication method allows trading partners to submit files via the internet under a Service Oriented Architecture (SOA). It is most suitable for users who prefer to develop an automated, systemic approach to file submission.

Access to eMedNY via Simple Object Access Protocol must be obtained through an enrollment process that results in the creation of an eMedNY SOAP Certificate and a SOAP Administrator. Minimum requirements for enrollment include:

- An ETIN and Certification Statement for the enrollee's Provider ID obtained prior to SOAP enrollment
- The enrollee must be a Primary ePACES Administrator **or**
- The enrollee must have existing FTP access to eMedNY

Additional information about 'Getting Started with SOAP' is available on emedny.org by clicking on the link to the web page below:

eMedNY Companion Guides and Sample Files

Notes:

- **For additional information regarding the Simple Object Access Protocol, please send an e-mail to NYHIPAADESK3@csc.com.**
- **For questions regarding ePACES, eXchange, FTP, CPU to CPU, or eMedNY Gateway connections, call the eMedNY Call Center at 800-343-9000.**

Paper Claims

ICF/DD 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 the UB-04 claim form please click on the link provided below. The displayed claim form is a sample and the information it contains is for illustration purposes only.

ICF/DD – UB-04 Sample Claim

An 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.

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 as possible:

1 2 3 4 5 6 7 8 9 0

- Circles (the letter O, the number 0) must be closed.
- Avoid unfinished characters. For example:

Written As	Intended As	Interpreted As	
6.C0	6.00	6.60	→ 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. For example:

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. Example:

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 entering 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, address labels); do not place stickers on the form.

The address for submitting claim forms is:

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

UB-04 Claim Form

To view the UB-04 claim form please click on the link provided below. The displayed claim form is a sample and the information it contains is for illustration purposes only.

ICF/DD – UB-04 Sample Claim

General Information About the UB-04 Form

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.

Billing Instructions for ICF/DD Services

This subsection of the Billing Guidelines covers the specific NYS Medicaid billing requirements for ICF/DD 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 who should refer to these instructions for finding out what information they need to provide in their claims, what codes they need to use, etc.

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.

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 patients 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.

Claims for services **not** covered by Medicare should continue to be submitted directly to Medicaid as policy allows. Also, **Medicare Part-C** (Medicare Managed Care) and **Part-D** claims are **not** part of this process.

Providers are urged to review their Medicare remittances for crossovers beginning December 1, 2009, 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 that are denied by Medicare will **not** be crossed over.

Medicaid will deny claims that are crossed over without a Patient Responsibility.

Providers will not be able to submit a void to for a claim that has crossed over to Medicaid. All voids must be submitted to Medicare. Medicare will then void the Medicare payment and the cross the claim over to Medicaid.

If a separate claim is submitted directly by the provider to Medicaid for a dual eligible recipient and the claim is paid before the Medicare crossover claim, both claims will be paid. The eMedNY system automatically voids the provider submitted claim in this scenario. 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 below:

Provider Enrollment Forms

Note: For crossover claims, the Locator Code will default to 003 if zip+4 does not match information in the provider's Medicaid file.

Field-by-Field Instructions for the UB-04 Claim Form

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, refer to Information for All Providers, Inquiry section which can be found on the web page for this manual.

PATIENT CONTROL NO. (Form Locator 3a)

For record-keeping purposes, the provider may choose to identify a patient by using an office account/patient control number. This field can accommodate up to 30 alphanumeric characters. If an office account/patient control number is indicated on the claim form, the first 20 characters will be returned on the paper Remittance Advice. Using an office 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 **6** from the UB-04 Manual, Form Locator 4, and Type of Facility category, to indicate Intermediate Care.

Bill Classification
Using the UB-04 Manual, Form Locator 4, Bill Classification category, select the code that best describes the type of service being claimed.

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 **0** (zero) in the third position of this field.

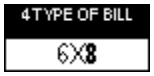
  Example:

- If submitting an adjustment (replacement) to a previously paid claim, enter **7** in the third position of the Type of Bill.

  Example:

- If submitting a void to a previously paid claim, enter **8** in the third position of the Type of Bill.

  Example:



STATEMENT COVERS PERIOD FROM/THROUGH (Form Locator 6)

- **If billing for one date of service**, enter the same date in the FROM and THROUGH boxes or leave the THROUGH box blank.

- **If billing for multiple consecutive services dates**, enter the first service date in the FROM box and the last service date in the THROUGH box. The first and last service dates must be within the same calendar month.

Dates must be entered in the format MMDDYYYY.

Notes:

- **Claims must be submitted within 90 days of the through date (last date) entered in this field unless acceptable circumstances for the delay can be documented. For more information about billing claims over 90 days from the last date of service, please refer to Information for All Providers, General Billing section, which can be found on the web page for this manual.**

- **Do not include full days covered by Medicare or other third-party insurers as part of the period of service.**

- **A separate claim must be completed if the period of service includes therapeutic or hospital leave days.**

- **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.**

PATIENT NAME (Form Locator 8 – Line b)

Enter the patient's last name followed by the first name.

BIRTHDATE (Form Locator 10)

Enter the patient's birth date. The birth date must be in the format MMDDYYYY.

Example: Mary Brandon was born on March 5, 1975.

10 BIRTHDATE
03051975

SEX (Form Locator 11)

Enter **M** for male or **F** for female to indicate the patient's sex.

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 ending 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 Locators 18–28)

Leave all fields blank.

OCCURRENCE CODE/DATE (Form Locators 31–34)

Leave all fields blank.

OCCURRENCE CODE/SPAN (Form Locators 35-36)

Leave all fields blank.

VALUE CODES (Form Locators 39–41)

NYS Medicaid uses Value Codes to report the following information:

- Locator Code (required: see notes for conditions)
- Rate Code (required)
- Patient Participation (only if applicable)
- Other Insurance Payment (only if applicable)
- Medicaid Covered Days (only if applicable)
- Medicaid Non-Covered Days (only if applicable)
- Medicare Co-Insurance Days (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
For electronic claims, leave this field blank. For paper claims, enter the locator code assigned by NYS Medicaid.

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

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

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

Locator codes 001 and 002 are for administrative use only and are not to be entered in this field. The entry may be 003 or a higher locator code. Enter the locator code that corresponds to the address where the service was performed.

The example below illustrates a correct Locator Code entry.

Example:

	39 VALUE CODES CODE	AMOUNT
a	61	003
b		
c		
d		

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, refer to Information for All Providers, Inquiry section on the web page for this manual.

Rate Code - Value Code 24
Rates are established by the Department of Health. At the time of enrollment in Medicaid, providers receive notification of the Rate Codes/amounts assigned to their Category of Service. Any time that Rate Codes or amounts change, providers also receive notification from the Department of Health.

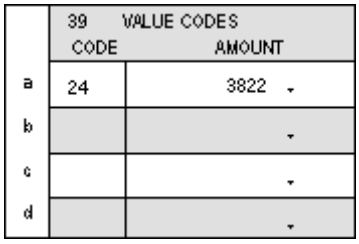
Rate codes indicate the level of health care services rendered; therefore, a rate must always be reported even if only co-insurance is being claimed.

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 below illustrates a correct Rate Code entry.

Example:

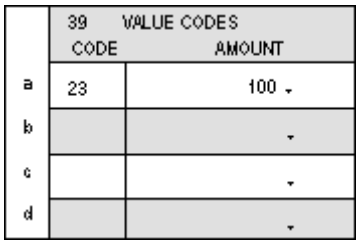


Patient Participation (NAMI) - Value Code 23

Value Code
Code **23** should be used to indicate that the patient'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 patient's monthly budget. In cases where the patient'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 as illustrated below:

Example:



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 Codes 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
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 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 following example illustrates a correct Other Insurance Payment entry.

Example:

	39 VALUE CODES CODE	AMOUNT
a	A3	100 . 00
b		
c		
d		

Medicaid Covered Days – Value Code 80

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

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

The example below illustrates a correct Medicaid Covered Days entry:

Example:

	39 VALUE CODES CODE	AMOUNT
a	80	30
b		
c		
d		

Medicaid Non-Covered Days – Value Code 81

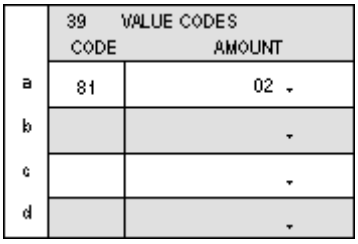
Value Code
Code 81 should be used to indicate the total number of full days that are not reimbursable by Medicaid or any other third party. This does not include full days covered by Medicare or other third-party insurers.

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

Note: For non-resident health care patients, non-covered days are those days occurring within the service period on which health care services were not rendered, for example, weekends.

The example below illustrates a correct Medicaid Non-Covered Days entry:

Example:



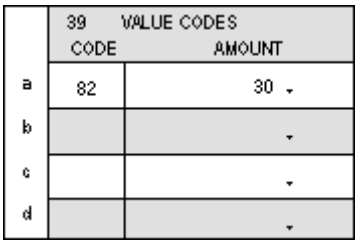
Medicare Co-Insurance Days – Value Code 82

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. 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. The Co-Insurance Days must be entered to the left of the dollars/cents delimiter.

The example below illustrates a correct Medicare Co-Insurance Days entry:

Example:



REV. CD. [REVENUE CODE] (Form Locator 42)

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

NYS Medicaid uses Revenue Codes to identify the following information:

- Total Charges
- Title XIX Days – Hospital Leave
- Title XIX Days – Therapeutic Leave

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

Hospital Leave
The patient was hospitalized during the billing period and bed retention was involved. If bed retention for hospitalization was not involved, hospital leave is not applicable. Please refer to the ICF/DD Provider Manual, Policy Guidelines section, for bed reservation information.

If applicable, use Revenue Code **0185** to indicate that the number of Hospital Leave days is entered in Form Locator 46.

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

Therapeutic Leave
These are overnight absences that include leave for personal reasons or to participate in medically acceptable therapeutic or rehabilitative plans of care. Please refer to the ICF/DD Manual, Policy Guidelines Section, for Bed Reservation information.

If applicable, use Revenue Code **0183** to indicate that the number of Therapeutic Leave days is entered in Form Locator 46.

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

SERV. UNITS (Form Locator 46)

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 units entered in this field must match the entry in Form Locators 39 – 41, Value Code 80, "Covered Days".

TOTAL CHARGES (Form Locator 47)

Enter the total amount charged for the service(s) rendered. This is computed by multiplying the total number of full days times the per diem rate, plus Medicare co-insurance days, if any, times the Medicare co-insurance rate. The charged amount must be entered on the line corresponding to Revenue Code 0001 and both sections of the field (dollars and cents) must be completed; if the charges contain no cents, enter **00** in the cents box.

Example:

	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					3000.00		
2								
3								

If Therapeutic Leave or Hospital Leave units were entered in Form Locator 46, enter the charges for that line in this field as well.

Example:

	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					1500.00		
2	0183				15	1500.00		
3								

PAYER NAME (Form Locator 50 A, B, C)

This field identifies the payer(s) responsible for the 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 to the following instructions.

Direct Medicaid Claim—No Third Party Involved

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

Medicaid/Third Party (Other Than Medicare) Claim

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

NPI (Form Locator 56)

Providers must enter their 10-digit National Provider Identifier (NPI).

OTHER PRV ID [OTHER PROVIDER ID] (Form Locator 57)

Leave this field blank.

INSURED'S UNIQUE ID (Form Locator 60)

Enter the patient's Medicaid ID number (Client ID number) as it appears in the ICF/DD roster. 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.

Example: AB12345C

The Medicaid ID should be entered on the same line (A, B, or C) that corresponds to the line assigned to Medicaid in Form Locators 50 and 57. If the patient's Medicaid 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 if the service does not require Prior Approval.

If the service requires Prior Approval, enter the 11-digit Prior Approval number here. The Prior Approval must 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 Prior Approval number is entered on lines B or C, the word **NONE** must be written on the line(s) **above** the Prior Approval line.

Note: For information regarding how to obtain Prior Approval/Authorization for specific services, please refer to the Policy Guidelines section available at www.emedny.org by clicking on the link to the web page below:

ICF/DD Manual

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

Adjustments

An adjustment is submitted to correct one or more fields of a previously paid claim. Any field, except the **Provider ID number** or the **Patient's Medicaid ID number**, can be adjusted. The adjustment must be submitted in a new claim form (copy of the original form is unacceptable) and all applicable fields must be completed. An adjustment is identified by the value **7** in the **third position of Form Locator 4**, Type of Bill, and the claim to be adjusted is identified by the TCN entered in this field (Form Locator 64).

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

Voids

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

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

Note: Crossover claims cannot be voided through Medicaid. If a void is necessary, the void must be submitted to Medicare and all individual claim lines will be voided. If only the Medicaid portion is incorrect, then an adjustment should be submitted to Medicaid.

UNTITLED [PRINCIPAL DIAGNOSIS CODE] (Form Locator 67 A - Q)

Leave these fields blank.

PRINCIPAL PROCEDURE (Form Locator 74)

Leave this field blank.

OTHER (Form Locator 78)

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

The National Provider ID (NPI) regulations do not allow the submission of a facility NPI as a referring provider. In those instances where the patient is transferred or moved to or from one facility to another facility (Hospital to Residential Care or Residential Care to Hospital, etc.), the entry must be the NPI of the practitioner in the facility who made the determination that the patient should be placed in another facility.

Example: In the case of a patient moving to a hospital (hospital bed reservation), the practitioner who made the determination that the patient should be admitted to the hospital should be entered in this field as the referring provider. The provider number entered should be the NPI of the practitioner.

Completion of this field is required if an admission or a discharge occurred during the service period covered by this statement (Form Locator 6). If no admission or discharge occurred, leave this field blank.

For an admission
Enter the NPI of the referring practitioner who determined that residential care was appropriate.

Note: If the patient is admitted from home, enter the NPI of the physician who last examined the patient and determined that ICF/DD nursing home care was appropriate. See instructions for entering an NPI below.

For a discharge
Enter the NPI of the practitioner who made the discharge determination.

For a bed reservation
Enter NPI of the practitioner who admitted the patient to the hospital.

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 numbers, enter the last name and first name of the provider.

Example:

The referring provider is John Smith with an NPI number 1234567890.

78 OTHER	DN	NPI 1234567890	QUAL		
LAST SMITH			FIRST JOHN		

United States Standard Postal Abbreviations

State	Abbrev.	State	Abbrev.
Alabama	AL	Missouri	MO
Alaska	AK	Montana	MT
Arizona	AZ	Nebraska	NE
Arkansas	AR	Nevada	NV
California	CA	New Hampshire	NH
Colorado	CO	New Jersey	NJ
Connecticut	CT	New Mexico	NM
Delaware	DE	North Carolina	NC
District of Columbia	DC	North Dakota	ND
Florida	FL	Ohio	OH
Georgia	GA	Oklahoma	OK
Hawaii	HI	Oregon	OR
Idaho	ID	Pennsylvania	PA
Illinois	IL	Rhode Island	RI
Indiana	IN	South Carolina	SC
Iowa	IA	South Dakota	SD
Kansas	KS	Tennessee	TN
Kentucky	KY	Texas	TX
Louisiana	LA	Utah	UT
Maine	ME	Vermont	VT
Maryland	MD	Virginia	VA
Massachusetts	MA	Washington	WA
Michigan	MI	West Virginia	WV
Minnesota	MN	Wisconsin	WI
Mississippi	MS	Wyoming	WY

American Territories	Abbrev.
American Samoa	AS
Canal Zone	CZ
Guam	GU
Puerto Rico	PR
Trust Territories	TT
Virgin Islands	VI

Note: Postal codes are only required when reporting out-of-state license numbers.

Section III – Remittance Advice

The purpose of this section is to familiarize the provider with the design and contents of the Remittance Advice.

eMedNY produces remittance advices on a weekly (processing cycle) basis. Weekly remittance advices contain the following information:

- A listing of all **claims** (identified by several pieces of information as submitted on the claim) that have entered the computerized processing system during the corresponding cycle.
- The **status** of each claim (deny/paid/pend) after processing.
- The eMedNY **edits** (errors) failed by pending or denied claims.
- **Subtotals** (by category, status, and member ID) and **grand totals** of claims and dollar amounts.
- Other **financial information** such as recoupments, negative balances, etc.

The remittance advice, in addition to showing a record of claim transactions, can assist providers in identifying and correcting billing errors and plays an important role in the communication between the provider and the eMedNY Contractor for resolving billing or processing issues.

Remittance advices are available in electronic and paper formats.

Note: There are no changes to the content of Medicaid Remittance Statements for Medicare Cross-over claims.

Electronic Remittance Advice

The electronic HIPAA 835 transaction (Remittance Advice) is available via the eMedNY eXchange or FTP. To request the electronic remittance advice (835), providers **must** complete the Electronic Remittance Request Form, which is available at www.emedny.org by clicking on the link to the web page below:

Provider Enrollment Forms

For additional information, providers may also call the eMedNY Call Center at 800-343-9000.

The NYS Medicaid Companion Guides for the 835 transaction are available at www.emedny.org by clicking on the link to the web page below:

eMedNY Companion Guides and Sample Files

Providers who submit claims under multiple ETINs receive a separate 835 for each ETIN and a separate check for each 835. Also, any 835 transaction can contain a maximum of ten thousand (10,000) claim lines; any overflow will generate a separate 835 and a separate check.

Providers with multiple ETINs who choose to receive the 835 electronic remittance advice may elect to receive the status of paper claim submissions and state-submitted adjustments/voids in the 835 format. The request must be submitted using the Electronic Remittance Request Form located at www.emedny.org. If this option is chosen, no paper remittance will be produced and the status of claims will appear on the electronic 835 remittance advice for the ETIN indicated on the request form. Retro-adjustment information is also sent in the 835 transaction format. Pending claims do not appear in the 835 transaction; they are listed in the Supplemental file, which will be sent along with the 835 transaction for any processing cycle that produces pends.

Notes:

- **Electronic remittances reporting Medicare cross over claims will be generated for the provider's default ETIN only.**

- **Providers with only one ETIN who elect to receive an electronic remittance will have the status of any claims submitted via paper forms and state-submitted adjustments/voids reported on that electronic remittance. The Default Electronic Transmitter Identification Number (ETIN) Selection Form is available on emedny.org by clicking on the link to the web page below:**

Provider Enrollment Forms

Paper Remittance Advice

Remittance advices are also available on paper. Providers who bill electronically but do not specifically request to receive the 835 transaction are sent paper remittance advices.

Note: Providers submitting crossover claims who do not set their default ETIN will receive a paper remittance advice.

Remittance Sorts

The default sort for the paper remittance advice is:
Claim Status (denied, paid, pending) – Patient ID – TCN

Providers can request other sort patterns that may better suit their accounting systems. The additional sorts available are as follows:

- TCN – Claim Status – Patient ID – Date of Service
- Patient ID – Claim Status – TCN
- Date of Service – Claim Status – Patient ID

To request a sort pattern other than the default, providers must complete the Paper Remittance Sort Request Form, which is available at www.emedny.org by clicking on the link to the web page below:

Provider Enrollment Forms

For additional information, providers may also call the eMedNY Call Center at 800-343-9000.

Remittance Advice Format

The remittance advice is composed of five sections as described below.

- 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

Explanation of Remittance Advice Sections

The next pages present a sample of each section of the remittance advice for ICF/DD Services 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.

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).

MEDICAID MANAGEMENT INFORMATION SYSTEM

TO: ABC INTERMEDIATE CARE FACILITY

DATE: 2007-08-06
REMITTANCE NO: 07080600001
PROV ID: 00123456/1234567890

00123456/1234567890 2007-08-06
ABC INTERMEDIATE CARE FACILITY
123 MAIN ST
ANYTOWN NY 11111

YOUR CHECK IS BELOW – TO DETACH, TEAR ALONG PERFORATED DASHED LINE

29
2

DATE	REMITTANCE NUMBER	PROVIDER ID NO.
2007-08-06 VOID AFTER 90 DAYS	07080600001	00123456/1234567890

PAY

DOLLARS/CENTS
$*******719.00

TO THE ORDER OF
ABC INTERMEDIATE CARE FACILITY
123 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

Check Stub Information

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 and the NPI

CENTER
Medicaid Provider ID/NPI/Date
Provider's name/Address

Medicaid Check

LEFT SIDE
Table
- Date on which the check was issued
- Remittance number
- Provider ID No.: This field will contain the Medicaid Provider ID and the NPI

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.

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.

TO: ABC INTERMEDIATE CARE FACILITY

DATE: 08-06-2007
REMITTANCE NO: 07080600001
PROV ID: 00123456/1234567890

00123456/1234567890 08-06-2007
ABC INTERMEDIATE CARE FACILITY
123 MAIN ST
ANYTOWN NY 11111

ABC INTERMEDIATE CARE FACILITY $1462.20

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

Information on the EFT Notification Page

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 and the NPI

CENTER
Medicaid Provider ID/NPI/Date: This field will contain the Medicaid Provider ID and the NPI
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.

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.

TO: ABC INTERMEDIATE CARE FACILITY

MEDICAID MANAGEMENT INFORMATION SYSTEM

DATE: 08/06/2007
REMITTANCE NO: 07080600001
PROV ID: 00123456/1234567890

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

ABC INTERMEDIATE CARE FACILITY
123 MAIN ST
ANYTOWN NY 11111

Information on the Summout Page

UPPER LEFT CORNER
Provider Name (as recorded in 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 and the NPI

CENTER
Notification that no payment was made for the cycle (no claims were approved)
Provider name and address

Section Two – Provider Notification

This section is used to communicate important messages to providers.

MEDICAID MANAGEMENT INFORMATION SYSTEM

MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

PAGE 01
DATE 08/06/07
CYCLE 1563

TO: ABC INTERMEDIATE CARE FACILITY
123 MAIN STREET
ANYTOWN, NEW YORK 11111

ETIN:
PROVIDER NOTIFICATION
PROV ID 00123456/1234567890
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.

Information on the Provider Notification Page

UPPER LEFT CORNER
Provider's name and address

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 and the NPI
Remittance number

CENTER
Message text

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.

MEDICAID MANAGEMENT INFORMATION SYSTEM

MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

PAGE 02
DATE 08/06/07
CYCLE 1563

TO: ABC INTERMEDIATE CARE FACILITY
123 MAIN STREET
ANYTOWN, NEW YORK 11111

ETIN:
ICF/DD
PROV ID: 00123456/1234567890
REMITTANCE NO: 07080600001

CLIENT NAME / ID NUMBER	TCN / PATIENT ACCOUNT NUMBER	SERVICE DATES FROM / THRU	RATE CODE	REP'TED CALC'ED DAYS F	REP'TED CALC'ED DAYS C	FULL DAYS CO-INSURANCE DAYS	PATIENT PARTICIPATION REPORTED / DEDUCTED	OTHER INSURANCE	AMOUNT CHARGED / AMOUNT PAID	STATUS	ERRORS
CARLSON	07206-000000112-3-0	07/02/07	3822	5	0	0.00	0.00	0.00	387.81	DENY	01023 01035
AB12345J	CPIC1-00974-6	07/06/07		5		0.00			0.00		
GRANT	07206-000000111-3-0	07/02/07	3822	5	0	0.00	0.00	0.00	387.81	DENY	01023
WX60074T	CPIC1-00974-6	07/06/07		5		0.00			0.00		

* = PREVIOUSLY PENDED CLAIM
** = NEW PEND

TOTAL AMOUNT ORIGINAL CLAIMS	DENIED	775.62	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

PAGE 03
DATE 08/06/07
CYCLE 1563

MEDICAID MANAGEMENT INFORMATION SYSTEM

TO: ABC INTERMEDIATE CARE FACILITY
123 MAIN STREET
ANYTOWN, NEW YORK 11111

MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

ETIN:
ICF/DD
PROV ID: 00123456/1234567890
REMITTANCE NO: 07080600001

CLIENT NAME / ID NUMBER	TCN / PATIENT ACCOUNT NUMBER	SERVICE DATES FROM / THRU	RATE CODE	REP'TED CALC'ED DAYS F	C	FULL DAYS CO-INSURANCE DAYS	PAYMENT	PATIENT PARTICIPATION REPORTED DEDUCTED	OTHER INSURANCE	AMOUNT CHARGED / AMOUNT PAID	STATUS	ERRORS
CARLISLE	07206-000044456-0-0	07/02/07	3822	5	0	387.81		0.00	0.00	387.81	PAID	
AD12344J	CPIC1-00554-6	07/06/07		5		0.00				387.81		
PETERS	07206-000043321-0-0	07/02/07	3822	5	0	387.81		0.00	0.00	387.81	PAID	
BB60000T	CPIC1-04321-6	07/06/07		5		0.00				387.81		
THOMAS	07206-000332456-0-0	07/02/07	3822	5	0	387.81		0.00	0.00	387.81	PAID	
CF66669P	CPIC1-00554-6	07/06/07		5		0.00				387.81		
JENSON	07206-004445656-0-0	07/02/07	3822	5	0	387.81		0.00	0.00	387.81	PAID	
FH92225K	CPIC1-00554-6	07/06/07		5		0.00				387.81		
RODRIQUEZ	07206-007776546-0-1	07/02/07	3822	5	0	387.81		0.00	0.00	387.81	ADJT	ORIGINAL CLAIM
QA88833B	CPIC1-00554-6	07/06/07		5		0.00				387.81-		PAID 07/11/2007
RODRIQUEZ	07206-007776546-0-2	07/02/07	3822	4	0	298.77		0.00	0.00	298.77	ADJT	
QA88833B	CPIC1-00554-6	07/05/07		4		0.00				298.77		

* = PREVIOUSLY PENDED CLAIM
** = NEW PEND

TOTAL AMOUNT ORIGINAL CLAIMS	PAID	1551.24	NUMBER OF CLAIMS	5
NET AMOUNT ADJUSTMENTS	PAID	89.04-	NUMBER OF CLAIMS	1
NET AMOUNT VOIDS	PAID	0.00	NUMBER OF CLAIMS	0
NET AMOUNT VOIDS – ADJUSTS		89.04-	NUMBER OF CLAIMS	1

PAGE 04
DATE 08/06/07
CYCLE 1563

MEDICAID MANAGEMENT INFORMATION SYSTEM

MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

TO: ABC INTERMEDIATE CARE FACILITY
123 MAIN STREET
ANYTOWN, NEW YORK 11111

ETIN:
ICF/DD
PROV ID: 00123456/1234567890
REMITTANCE NO: 07080600001

CLIENT NAME / ID NUMBER	TCN / PATIENT ACCOUNT NUMBER	SERVICE DATES FROM / THRU	RATE CODE	REP'TED CALC'ED DAYS F	REP'TED CALC'ED DAYS C	FULL DAYS CO-INSURANCE DAYS	PATIENT PARTICIPATION REPORTED / DEDUCTED	OTHER INSURANCE	AMOUNT CHARGED / AMOUNT PAID	STATUS	ERRORS
CARLSON	07206-000000112-3-0	07/02/07	3822	5	0	0.00	0.00	0.00	387.81	**PEND	00162 00971
AB12345J	CPIC1-00974-6	07/06/07		5		0.00			0.00		
GRANT	07206-000000111-3-0	07/02/07	3822	5	0	0.00	0.00	0.00	387.81	**PEND	01131
WX60074T	CPIC1-00974-6	07/06/07		5		0.00			0.00		

* = PREVIOUSLY PENDED CLAIM
** = NEW PEND

TOTAL AMOUNT ORIGINAL CLAIMS	PEND	775.62	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 – ICF/DD

VOIDS – ADJUSTS	89.04-	NUMBER OF CLAIMS	1
TOTAL PENDS	775.62	NUMBER OF CLAIMS	2
TOTAL PAID	1551.24	NUMBER OF CLAIMS	5
TOTAL DENY	775.62	NUMBER OF CLAIMS	2
NET TOTAL PAID	1462.20	NUMBER OF CLAIMS	5

MEMBER ID: 12345678

VOIDS – ADJUSTS	89.04-	NUMBER OF CLAIMS	1
TOTAL PENDS	775.62	NUMBER OF CLAIMS	2
TOTAL PAID	1551.24	NUMBER OF CLAIMS	5
TOTAL DENY	775.62	NUMBER OF CLAIMS	2
NET TOTAL PAID	1462.20	NUMBER OF CLAIMS	5

PAGE: 05
DATE: 08/06/07
CYCLE: 1563

MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

TO: ABC INTERMEDIATE CARE FACILITY
123 MAIN STREET
ANYTOWN, NEW YORK 11111

ETIN:
ICF/DD
GRAND TOTALS
PROV ID: 00123456/1234567890
REMITTANCE NO: 07080600001

REMITTANCE TOTALS – GRAND TOTALS

VOIDS – ADJUSTS	89.04-	NUMBER OF CLAIMS	1
TOTAL PENDS	775.62	NUMBER OF CLAIMS	2
TOTAL PAID	1551.24	NUMBER OF CLAIMS	5
TOTAL DENY	775.62	NUMBER OF CLAIMS	2
NET TOTAL PAID	1462.20	NUMBER OF CLAIMS	33

General Information on the Claim Detail Pages

UPPER LEFT CORNER
Provider's name and address

UPPER RIGHT CORNER
Remittance page number
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: **ICF/DD**
PROV ID: This field will contain the Medicaid Provider ID and the NPI
Remittance number

Explanation of the Claim Detail Columns

CLIENT NAME/ID NUMBER
This column indicates the last name of the patient (first line) and the Medicaid Client ID (second line). 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.

TCN/PATIENT ACCOUNT NUMBER
The TCN (first line) is a unique identifier assigned to each claim that is processed.

If a Patient Account Number was entered in the claim form, that number (up to 20 characters) will appear under this column (second line).

SERVICE DATES – FROM/THROUGH
The first date of service covered by the claim (From date) appears on the first line; the last date of service (Through date) appears on the second line.

RATE CODE
The four-digit rate code that was entered in the claim form appears under this column.

REPORTED/CALCULATED DAYS
This column has two sub-columns: one is labeled **F (full days)** and the other is labeled **C (co-insurance days)**.

The number of days within the reported first (FROM) service date and the last (THROUGH) service date appear in the first line under the F sub-column. The number of full days calculated by the system appears in the second line under the F sub-column.

The number of co-insurance days reported on the claim form appears under the C sub-column. There are no calculated co-insurance days.

PATIENT PARTICIPATION – REPORTED/DEDUCTED
This column shows the patient participation amount (NAMI) as it was reported (first line) and as it was deducted (second line). If no patient participation is applicable, this column will show 0.00 amount.

OTHER INSURANCE
If applicable, the amount paid by the patient's Other Insurance carrier, as reported on the claim form, is shown under this column. If no Other Insurance payment is applicable, this column will show 0.00 amount.

AMOUNT CHARGED/AMOUNT PAID
The total charges entered in the claim form appear first under this column. If the claim was approved, the amount paid appears underneath the charges. 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 each 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, or 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.

Subtotals/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. 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)

Section Four

This section has two subsections:

- Financial Transactions
- Accounts Receivable

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.

MEDICAID MANAGEMENT INFORMATION SYSTEM

MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

PAGE 07
DATE 08/06/07
CYCLE 1563

TO: ABC INTERMEDIATE CARE FACILITY
123 MAIN STREET
ANYTOWN, NEW YORK 11111

ETIN:
FINANCIAL TRANSACTIONS
PROV ID: 00123456/1234567890
REMITTANCE NO: 07080600001

FCN	FINANCIAL REASON CODE	FISCAL TRANS TYPE		DATE			AMOUNT
200705060236547	XXX	RECOUPMENT REASON DESCRIPTION	07	09	07		$$.$$

NET FINANCIAL AMOUNT $$$.$$

NUMBER OF FINANCIAL TRANSACTIONS XXX

Explanation of the Financial Transactions Columns

FCN (Financial Control Number)
This 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.

FISCAL 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.

Totals

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.

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.

PAGE 08
DATE 08/06/07
CYCLE 1563

TO: ABC INTERMEDIATE CARE FACILITY
123 MAIN STREET
ANYTOWN, NEW YORK 11111

MEDICAID MANAGEMENT INFORMATION SYSTEM

MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

ETIN:
ACCOUNTS RECEIVABLE
PROV ID: 00123456/1234567890
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

Explanation of the Accounts Receivable Columns

If a provider has negative balances of different natures (for example, the result of adjustments/voids; the result of retro-adjustments, etc.) or negative balances created at different times, each negative balance will be listed on 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.

Section Five – Edit Descriptions

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.

MEDICAID MANAGEMENT INFORMATION SYSTEM

MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

PAGE 06
DATE 08/06/07
CYCLE 1563

TO: ABC INTERMEDIATE CARE FACILITY
123 MAIN STREET
ANYTOWN, NEW YORK 11111

ETIN:
CF/DD
EDIT DESCRIPTIONS
PROV ID: 00123456/1234567890
REMITTANCE NO: 07080600001

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

00162 RECIPIENT INELIGIBLE FOR DATE OF SERVICE
00971 RECIPIENT NOT ON LONG TERM CAE FILE
01023 HOSPITAL LEAVE NOT SEPARATE LINE
01035 STAUS DISCHARGED DESTINATION PROVIDER BLANK
01131 MEDICAID NOT ALLOWED UNTIL MEDICARE IS MAXIMIZED