New York State
Electronic Medicaid System
UB04 Billing Guidelines

SCHOOL SUPPORTIVE HEALTH SERVICES PROGRAM (SSHSP)/PRESCHOOL SUPPORTIVE HEALTH SERVICES PROGRAM (PSHSP)

Version 2010 - 01

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TABLE OF CONTENTS

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 SSHSP/PSHSP 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

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 Certification Statements remain in effect and apply to all claims until superseded by another properly executed Certification Statement.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

SSHSP/PSHSP 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

SSHSP/PSHSP 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 SSHSP/PSHSP 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:

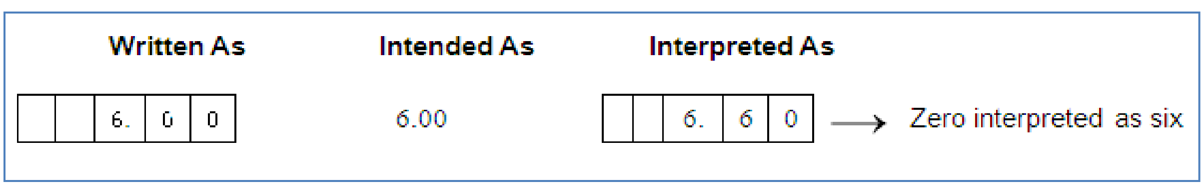
- All information should be typed or printed.
- Alpha characters (letters) should be capitalized.
- Numbers should be written as close to the example below in Exhibit 2.2.1-1 as possible:

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



- 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 Home Health 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 SSHSP/PSHSP Services Billing Instructions

This subsection of the Billing Guidelines covers the specific NYS Medicaid billing requirements for SSHSP/PSHSP 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 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 ***Medicare 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.

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 as follows: 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.

2.4.2 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: School Supportive Health Services Program (SSHSP) 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 ***7*** (Clinic) as the first digit of this field as seen in Exhibit 2.4.2-1. The source of this code is the UB-04 Manual, Form Locator 4, Type of Facility category.

Exhibit 2.4.2-1

4 TYPE OF BILL
7XX

Bill Classification

Enter one value in the range ***1-6 or 9*** as the second digit of this field. The source of this code is the UB-04 Manual, Form Locator 4, Bill Classification (Clinics Only) category.

See Exhibit 2.4.2-2 for an example of the proper position for these entries.

Exhibit 2.4.2-2

4 TYPE OF BILL
7XX

Frequency - Adjustment/Void Code

The third position of this field identifies 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 2.4.2-3.

Exhibit 2.4.2-3

4 TYPE OF BILL
7X0

If submitting an adjustment (replacement) to a previously paid claim, enter the value ***7*** in the third position of this field as in Exhibit 2.4.2-4.

Exhibit 2.4.2-4

4TYPE OF BILL
7X7

If submitting a void to a previously paid claim, enter the value ***8*** in the third position of this field as in Exhibit 2.4.2-5.

Exhibit 2.4.2-5

4TYPE OF BILL
7X8

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***, enter the first service date of the billing period in the FROM box and the last service date in the THROUGH box. The FROM/THROUGH dates must be in the same calendar month. Instructions for billing multiple dates of service are provided below in Form Locators 42 – 47.
- ***When billing for monthly rates***, only ***one*** date of service can be billed per claim form. Enter the date in the FROM box. The THROUGH box may contain the same date or may be left blank.

Dates must be entered in the format MMDDYYYY.

NOTES:

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

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 2.4.2-6 that follows.

Exhibit 2.4.2-6

10 BIRTHDATE
03051935

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)

NYS Medicaid uses these fields to indicate that the service was rendered as a result of a medical ***emergency*** (immediate intervention was required as a result of severe, life threatening, or potentially disabling condition).

If applicable, enter the value ***1*** in Form Locator 14 (Admission Type).

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:

- EPSDT/CTHP
- Possible Disability
- Family Planning
- Abortion/Sterilization

NOTE: Family Planning and Abortion Sterilization do not apply to SSHSP/PSHSP claims.

EPSDT/CTHP

When billing for a comprehensive well child care examination, rate code 5301, enter Condition Code ***A1*** in this field.

Possible Disability

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

If neither EPSDT/CTHP 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

For electronic claims, leave this field blank. 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.

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

The example in Exhibit 2.4.2-7 illustrates a correct Locator Code entry.

Exhibit 2.4.2-7

	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, please refer to Information for All Providers, Inquiry section located at www.emedny.org by clicking on the link to the webpage as follows: School Supportive Health Services Program (SSHSP) 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 2.4.2-8 illustrates a correct rate code entry.

Exhibit 2.4.2-8

	39 VALUE CODES CODE	AMOUNT
a	24	5326 .
b		.
c		.
d		.

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 2.4.2-9 illustrates a correct Other Insurance Payment entry.

Exhibit 2.4.2.-9

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

Patient Participation (Spend Down) - Value Code 31

Some patients of the Home Health services 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 2.4.2-10 illustrates a correct Patient Participation entry.

Exhibit 2.4.2-10

	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:

- HCPCS Procedure Code
- Total Amount Charged
- Units

HCPCS Procedure Code

Use an appropriate Revenue Code from the UB-04 Manual for each HCPCS code entered in Form Locator 44.

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 Locators 44 HCPCS/RATE/HIPPS Code, 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.

HCPS/RATE/HIPPS Code (Form Locator 44)

Enter the appropriate HCPCS procedure code(s) that identifies the service provided to the patient. All procedures applicable to the rate being claimed should be listed. For C/THP services, clinics should indicate immunization and laboratory tests administered as part of the C/THP screening examination.

Serv. Date (Form Locator 45)

For each HCPCS code entered in Form Locator 44, enter the date when the service was provided. 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)

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

When entering the same date of service on multiple lines, the appropriate number of units (if greater than "1") should be entered on only the first line associated with the same date of service as in the sample below. Units entered on subsequent lines (for the same date of service) will be ignored. See Exhibit 2.4.2-11 for an example.

Exhibit 2.4.2-11

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					20 . 00	.	
0240		93001	06012007	2	20 . 00	.	
0240		97530	06012007		.	.	
0240		92506	06012007		.	.	

For determining the number of units, follow the guidelines below.

Multiple Service Rate

There are five SSHSP and ten PSHSP services that may be billed for multiple units (each unit equal to ½ hour) on the same date of service, with the maximum number of units being two (2). These services are shown below:

SSHSP Services and Rate Codes

- Speech-Language Pathology Service 5326
- Physical Therapy Services 5328
- Occupational Therapy Services 5330
- Psychological Counseling Services 5329
- Nursing Services 5304

Individual-Based SSHSP Services and Rate Codes

- Speech-Language Pathology Service 5331
- Physical Therapy Services 5332
- Occupational Therapy Services 5333
- Psychological Counseling Services 5306
- Nursing Services 5372

Central-Based PSHSP Services and Rate Codes

- Speech-Language Pathology Service 5323
- Physical Therapy Services 5324
- Occupational Therapy Services 5325
- Psychological Counseling Services 5307
- Nursing Services 5373

When billing for one these rates, enter the number of units [up to two (2)] in this field.

Visit/Daily Service-Based Rate

All other SSHSP rates can be billed only one time on the same date of service. If the billing period entered in Form Locator 6 covers multiple consecutive service dates, each date of service when services were rendered to the patient must be entered in Form Locator 45 with an appropriate revenue code in Form Locator 42 and the appropriate units (if applicable) in Form Locator 46.

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 2.4.2-12 for an example.

Exhibit 2.4.2-12

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).

Other Prv ID [Other Provider ID] (Form Locator 57)

Leave this field blank.

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).

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

Untitled [Principal Diagnosis Code] (Form Locator 67)

Using the *International Classification of Diseases, Ninth Edition, Clinical Modification* (ICD-9-CM) coding system, enter the appropriate code that describes the main condition or symptom of the patient as indicated in the service order form. Only designated OMH diagnosis codes will be accepted. The ICD-9-CM code must be entered exactly as it is listed in the manual. See the example in Exhibit 2.4.2-13. The remaining Form Locators labeled A – Q may be used to indicate secondary diagnosis information.

Exhibit 2.4.2-13

67
315.39

NOTE: Three-digit and four-digit diagnosis codes will be accepted only when the category has no subcategories. See the example in Exhibit 2.4.2-14.

Exhibit 2.4.2-14

317	–	Mild Mental Retardation	–	**Acceptable** to Medicaid	(no subcategories)
315	–	Specific Arithmetical Disorder	–	**Not acceptable** to Medicaid	(subcategories exist)

Acceptable Diagnosis Codes: 317
315.1
315.39

Other (Form Locator 78)

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

Enter the NPI of the provider ordering the services.

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

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

Instructions for entering an NPI

Enter the code "***DN***" in the unlabeled field between the words "OTHER" and "NPI" to indicate the 10-digit NPI of the provider is entered in the box labeled "NPI".

On the line below the ID number, enter the last name and first name of the provider. See the example in Exhibit 2.4.2-15.

Exhibit 2.4.2-15

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

78 OTHER	DN	NPI 1234567890	QUAL		
LAST SMITH			FIRST JOHN		

3. Explanation of Paper Remittance Advice Sections

This Section present a sample of each section of the remittance advice for SSHSP 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: 00111234/1234567890

00111234/1234567890 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	00111234/1234567890

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 and the NPI

Center

Medicaid Provider ID/NPI/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 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.

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: 07080600001
PROV ID: 00111234/1234567890

00111234/1234567890 2010-05-31
CITY HOME CARE
111 MAIN STREET
ANYTOWN NY 11111

CITY HOME CARE $1677.11

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 and the NPI

Center

Medicaid Provider ID/NPI/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: 07080600001
PROV ID: 00111234/1234567890

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 and the NPI

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

PAGE 01
DATE 05/31/10
CYCLE 1710

MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

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

ETIN:
PROVIDER NOTIFICATION
PROV ID 00111234/1234567890
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.

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 and the NPI

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

PAGE 02
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:
CLINIC
PROV ID: 00111234/1234567890
REMITTANCE NO: 07080600001

OFFICE ACCOUNT NUMBER	CLIENT NAME	CLIENT ID.	TCN	DATE OF SERVICE	RATE CODE	UNITS	CHARGED	PAID	STATUS	ERRORS
CPIC1-00974-6	DOE	XX12345X	07206-000012112-3-2	05/25/10	5301	10.000	187.81	0.00	DENY	00162 00131
CPIC1-00575-6	SAMPLE	XX23456X	07206-000019113-3-1	05/25/10	5301	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

EDICAID
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:
CLINIC
PROV ID: 00111234/1234567890
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	5301	8.000	300.20	300.20	PAID	
CPIC1-00987-6	SAMPLE	XX23456X	07206-000445113-0-2	05/23/10	5301	5.000	188.41	188.41	PAID	
CPIC1-44444-6	EXAMPLE	XX34567X	07206-000466333-0-2	05/27/10	5301	8.000	300.20	300.20	PAID	
CPIC1-66666-6	SPECIMEN	XX45678X	07206-000445663-0-2	05/22/10	5301	8.000	300.20	300.20	PAID	
CPIC1-33333-6	STANDARD	XX56789X	07206-000447654-0-2	05/22/10	5301	8.000	300.20	300.20	PAID	
CPIC1-55555-6	MODEL	XX67890X	07206-000465553-0-2	05/25/10	5301	7.000	186.10	186.10	PAID	
CPIC1-77777-6	DOE	XX09876X	07206-000455557-0-2	05/25/10	5301	8.000	300.20	300.20	PAID	
CPIC1-11111-6	SAMPLE	XX98765X	07206-000544444-0-2	05/05/10	5301	5.000	150.90	150.90	ADJT	
CPIC1-99999-6	EXAMPLE	XX87654X	07206-000465477-0-2	05/05/10	5301	8.000	300.20	-300.20-	PAID	ORIGINAL CLAIM PAID 05/24/2010

* = 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

MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

PAGE 04
DATE 05/31/2010
CYCLE 1710

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

ETIN:
CLINIC
PROV ID: 00111234/1234567890
REMITTANCE NO: 07080600001

OFFICE ACCOUNT NUMBER	CLIENT NAME	CLIENT ID.	TCN	DATE OF SERVICE	RATE CODE	UNITS	CHARGED	PAID	STATUS	ERRORS
CPIC1-00974-6	DOE	XX12345X	07206-000034112-3-2	05/25/10	5301	8.000	300.20	**	PEND	00162 00244
CPIC1-00575-6	SAMPLE	XX23456X	07206-000445113-3-1	05/22/10	5301	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 – CLINIC				
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: 08/06/2007
CYCLE: 1563

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

ETIN:
CLINIC
GRAND TOTALS
PROV ID: 00111234/1234568790
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: **CLINIC**

PROV ID: This field will contain the Medicaid Provider ID and the NPI

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 Home Health 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

EDICAID
MANAGEMENT INFORMATION SYSTEM

PAGE 07
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:
FINANCIAL TRANSACTIONS
PROV ID: 00111234/1234567890
REMITTANCE NO: 07080600001

FCN	FINANCIAL REASON CODE	FISCAL TRANS TYPE	DATE	AMOUNT
200705060236547	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: 00111234/124567890
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

EDICAID
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:
CLINIC
EDIT DESCRIPTIONS
PROV ID: 00111234/1235467890
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.

SSHSP – UB-04 Sample Claim

APPROVED OMB NO. 0938-0279

ST 11843 1 PLY UB-04

1 City Home Care 111 Main Street Anytown, NY 11111-1111	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

8 PATIENT NAME a b SMITH, WILLIAM | 9 PATIENT ADDRESS a b c d e

10 BIRTHDATE	11 SEX	12 DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18–28 CONDITION CODES	29 ACDT STATE	30
04191940	M						30			

31–34 OCCURRENCE CODE / DATE; 35–36 OCCURRENCE SPAN CODE / FROM / THROUGH; 37

38

	39 CODE	39 AMOUNT	40 CODE	40 AMOUNT	41 CODE	41 AMOUNT
a	61	003.	24	5326.	A3	00.00

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					40.00		
0240		92506	06012007	2	10.00		
0240		92506	06032007	2	10.00		
0240		92506	06042007	2	10.00		
0240		92506	06062007	2	10.00		
	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
A	Blue Cross						57 OTHER PRV ID
B	Medicaid						
C							

	58 INSURED'S NAME	59 P. REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
A			None		
B			AB12345C		
C					

	63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME
A			
B	12345678901		
C			

66 DX 67 A B C D E F G H I J K L M N O P Q 68

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

76 ATTENDING NPI QUAL LAST FIRST
77 OPERATING NPI QUAL LAST FIRST
78 OTHER DN NPI 1234567890 QUAL LAST SMITH FIRST JOHN
79 OTHER NPI QUAL LAST FIRST

80 REMARKS | 81 CC a b c d

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

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.