

**NEW YORK STATE
MEDICAID PROGRAM**

INPATIENT HOSPITAL

BILLING GUIDELINES

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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 Inpatient Hospital providers and should be used by the provider as an instructional as well as a reference tool.

Inpatient Hospital providers can submit their claims to NYS Medicaid in only an electronic format. Because there are a variety of different types of inpatient claiming situations and a variety of electronic billing systems used by providers, the billing instructions included in this manual are intended to give providers an understanding of New York Medicaid's billing procedures in as much detail as practical.

Questions about how this information relates to individual providers' billing software and systems should be directed to the appropriate programming or software development personnel for the hospital or vendor that developed the providers' billing program.

Section II – Claims Submission Information for All Providers

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.

Inpatient Hospital providers 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.
- **837 Institutional Supplemental CG** provides instruction specific to providers who utilize the 837I transaction. It includes information about various codes sets relevant to NYS Medicaid Institutional providers.
- **NYS Medicaid Technical Supplementary CG** provides technical information needed to successfully transmit and receive electronic data. Some of the topics put forth in this CG are enrollment process, header information, response documents and communication specifications.

These documents are 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

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

- An Electronic/Paper Transmitter Identification Number (ETIN)
- A Certification Statement
- A User ID and Password
- A Trading Partner Agreement
- Testing

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 billed through a service bureau or clearinghouse, must file a notarized Certification Statement with NYS Medicaid for each ETIN used for the electronic billing.

The Certification Statement is good for one year, after which it needs to be renewed for electronic 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.

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 test transactions to CSC before they start submitting Medicaid claims for the first time after enrollment, and 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 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 at 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 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 eXchange, FTP, CPU to CPU or eMedNY Gateway connections, call the eMedNY Call Center at 800-343-9000.**

General Inpatient Billing Procedures

The following information details billing instructions and related information for hospital inpatient claims in the following main categories:

- General Inpatient Billing Procedures
- Reporting Present on Admission (POA) Information

General Inpatient Billing Procedures

When calculating the number of days to be reported on a claim, Medicaid counts the date of admission, but not the date of discharge, transfer or death.

The calculation of the number of days in the billing period is impacted by the status of the patient on the statement through date. When the patient status is “30” – Still A Patient, the through date is included in the calculation of days. When the status is a “Discharged” on the through date of service, the through date is not included in the calculation of the number of days. See status codes at the end of this section of the manual.

The sum of the days reported in the following fields **must** equal the days in the statement from-through period of the claim or one less day if the status is discharged as described above:

- Medicare Full Days
- Medicaid Full Days
- Medicaid Non Covered Days and
- Other Insurance Covered Days

Days billed as covered and non-covered, by the various payers, are reported in the 837 Institutional Segments with appropriate qualifiers. The segment and qualifier information below may be useful to providers' programming or software development personnel.

Type of Days	837I Segment Name	Qualifier
Medicare Full Days	MIA Segment	Not Applicable
Medicare Coinsurance Days	QTY Segment	CD
Medicare Life Time Reserve Days	QTY Segment	LA
Medicaid Full Days	QTY segment	CA
Medicaid Non Covered Days	QTY segment	NA
Other Insurance Covered Days	MIA Segment	Not Applicable

Notes:

- **Medicare Life Time Reserve (LTR) Days may also be reported in the MIA Segment. If LTR days are reported in the MIA Segment, they would override any LTR days that may also have been reported in the QTY Segment.**
- **The maximum number of days cannot exceed 9999 on any inpatient claim.**
- **The two basic types of inpatient hospital claims are Diagnosis-Related Group (DRG) and Non-DRG (DRG-exempt) claims.**

Reporting Present on Admission (POA) Information

NYSDOH requires this information to be reported for all reported diagnoses on all hospital inpatient claims. Present On Admission is defined as the diagnosis that is present at the time the order for inpatient admission occurred. Additional information on reporting this information can be found in the 837I Companion Guide. This document is available at www.emedny.org by clicking on the link to the web page below.

[eMedNY Companion Guides and Sample Files](#)

One of the following POA Codes must be submitted with the Primary Diagnosis and each succeeding diagnosis. However, the admitting diagnosis code does **not** require a POA.

- **Y – Yes:** Present at the time of inpatient admission
- **N – No:** Not present at the time of inpatient admission
- **U – Unknown:** Documentation is insufficient to determine if condition is present at time of inpatient admission
- **W – Clinically undetermined:** Provider is unable to clinically determine whether condition was present at time of inpatient admission or not
- **1 – Unreported/Not used:** Exempt from POA reporting

Note: A blank cannot be used. If a code does not require a POA code then a 1 must be entered.

Section III – DRG Claims

This section includes instructions and descriptions for the following:

- Inpatient Billing Procedures for DRG Claims
- Non-DRG Claim Procedures
- Medicaid as Payer of Last Resort
- Special Instructions for Other Inpatient Claims
- Medicaid Policy when Medicare Coverage Begins During an Inpatient Admission

Inpatient Billing Procedures for DRG Claims

This section details instructions for DRG claims with discharge dates prior to December 1, 2009 only. Instructions for claims submitted (including adjustments to previously paid claims) with discharge dates on or after December 1, 2009 are located in the APR DRG Claims section of this manual

Diagnosis-Related Group (DRG) billing classifies inpatient hospital stays into one of approximately 800 groups, also referred to as DRGs. A "grouper" program assigns a DRG by utilizing data submitted on the claim such as ICD-9-CM diagnoses, procedures, patient age, sex, and other information.

Associated with each DRG is an average length of stay, high trim point (threshold), service intensity weight and low trim point. See definitions that follow:

Term	Definition
High Trim	Maximum number of days the patient is expected to be hospitalized based on the assigned DRG
Low Trim	Minimum number of day the patient is expected to be hospitalized for the assigned DRG
Inlier	Portion of the inpatient stay from the date of admission through and including the high trim point
Outlier	Portion of the inpatient stay from the day after the high trim point to date of discharge (also referred to as long stay outlier)
Short Stay Outlier	Portion of the stay from admission to before the low trim point
Cost Per Discharge (CPD)	Dollar amount on file for a hospitals DRG rate code
Service Intensity Weight (SIW)	A weighting factor assigned to each DRG

Term	Definition
Average Length of Stay (ALOS)	Average length of a hospital stay for the DRG assigned

DRG Rate Codes

A claim is classified as a DRG claim based on the submitted rate code. The rate code is sent in the 837 Institutional Claim in loop 2300, in the Value Information Segment. DRG claims are identified by the following Rate Codes:

Type of Claim	Rate Code
New York State Inlier	2946
New York State Outlier	2956
Out-of-state Inlier	2953
Out-of-state Outlier	2958

DRG Payment Calculations

The following describes the calculations used to price Inpatient DRG claims for New York State hospitals by Medicaid.

The **Inlier** claim calculation is as follows:

$$\text{CPD (x) SIW (+) Capital add on} = \text{payment amount}$$

The **Long Stay Outlier** claim calculation is as follows:

$$\frac{\text{CPD (x) SIW}}{\text{ALOS}} \text{ (x) } .275 \text{ (x) number of days} = \text{payment amount}$$

There are two types of Short Stay claims: Non-transfers and Transfers.

The **Short Stay Non-transfer** claim calculation is as follows:

$$\frac{\text{CPD (x) SIW}}{\text{ALOS}} \text{ (+) short cap add-on (x) \# of days} = \text{payment amount}$$

The **Short Stay Transfer** claim calculation is as follows:

$$\frac{\text{CPD (x) SIW}}{\text{ALOS}} \text{ (x) } 1.200\% \text{ (+) cap add (x) number of days} = \text{payment amount}$$

Split-Billing DRG Claims

Rule 1 – Split-Billing

DRG claims can be billed from Admission to Discharge and do not have to be split-billed according to the high trim point, which is the date that separates Inlier and Outlier segments. The rate code billed would be 2946 or 2953. The eMedNY system will calculate one payment combining the appropriate payment for the inlier and outlier period.

DRG claims can also be split-billed at the high trim point for the DRG, i.e., one claim for the inlier period and a separate claim for the outlier period. In this case, each claim must be billed (and will be processed) using the appropriate Inlier and Outlier rate codes.

The inlier claim cannot be split at a date that is before the high trim day for the DRG unless the patient is transferred to ALC and continues on ALC on or after the day of high trim. See information on billing procedures for ALC in the section of this manual entitled “Special Instructions for Other Inpatient Claims”.

If the DRG claim is split-billed at the high trim point, the inlier claim must contain discharge status code 30 and the discharge date.

If the discharge occurs after the high trim point, DRG claims have to be billed, at a minimum, up to the high trim point for the DRG assigned. When billing on separate claims for the inlier and outlier periods, the high trim day itself is included in the Inlier claim.

Note: There are exceptions to this rule in the “Special Instructions for Other Inpatient Claims” section of this manual under ALC instructions.

Rule 2 – Timely Submission of claims

For DRG claims, the NYS Medicaid 90-day timely submission requirement is based on the Through Date of Service reported on the claim.

Rule 3 – Discharge Date

A DRG claim cannot be billed until the patient is discharged. All DRG claims **must** have the actual discharge date regardless of the status code of the patient. The discharge date will not match the end date of service if the patient status is 30 – Still A Patient.

Rule 4 - Newborns

DRG claims for newborns, 28 days or younger, must contain the birth weight in grams. Birth weights must be submitted according to the following example:

If a client’s birth weight is 2500 grams, the provider must enter the value **250000**, to account for the decimal.

Rule 5 – Transfers in the Outlier Period

Transfers in the Outlier period (days after the high trim) are not payable. If the claim is billed as an Admission to Discharge claim, no payment will be made for outlier days. If the outlier claim is billed separately with patient status code 02 - Discharged/transferred to a short-term general hospital for inpatient care, the claim will be denied for Edit 00794, "Outlier Payment Not Allowed for Transfer".

Outlier claims billed with a patient status code 05 - Discharged/transferred to a non-Medicare PPS children's hospital or non-Medicare PPS cancer hospital for inpatient care, will be paid at \$0.00 if the DRG Code assigned is one of the following: 0602 through 0630, 0635 or 0641.

DRG Admission Day Claims

Providers have the option of submitting a claim as an Admission Day claim. Admission Day claims are submitted to receive some form of payment in lieu of the DRG payment, which cannot be made until the patient is discharged.

Admission Day claims **must** be replaced (adjusted) as a DRG claim within 90 days of the payment. If the patient has not been discharged after the 90-day period, the claim should be submitted as an adjusted Admission day claim. All the data will remain the same but the adjudication date of the adjustment will cause the 90-day limitation to be extended for another 90 days. If no adjustment is received, the Admission Day payment will be automatically voided by the system and the admission payment recovered.

Follow these procedures for submission of Admission Day claims:

- The rate code billed on the claim is 2960
- The Admission date is also submitted as the from and through date of service
- The patient status code is billed is 30
- No discharge date is reported and
- One day is entered as the Medicaid Covered Days
- The payment amount for an Admission Day claim is the rate associated with the 2960 rate code.

Non-DRG Claim Procedures

For non-DRG claims the 90-day regulation applies to the statement through date entered on the claim.

Non-DRG claims can be billed from admission to discharge or they can be billed as interim claims. If a Non-DRG claim is billed as an interim bill, the patient status code submitted is 30 – Still A Patient, and no discharge date is entered on the claim.

Medicaid as Payer of Last Resort

All other sources of payments must be exhausted before billing Medicaid. The following section of the manual explains billing procedures for patients with other sources of coverage. The main topics are as follows:

- Medicaid Only (No involvement from any other payer)
- Medicare as Primary – Medicaid as Secondary
- Other Third party Insurance as Primary – Medicaid as Secondary

Medicaid Only (No involvement from any other payer)

The claim can be billed from Admission to Discharge under rate code 2946 regardless of the high trim. eMedNY will calculate the appropriate payment for both the inlier and outlier portions of the hospital stay and pay the claim with one payment amount with rate code 2946.

The claim can also be submitted on two separate claims for the Inlier and Outlier periods using the appropriate rate codes.

The days are reported as Medicaid Full Covered Days.

Medicare as Primary – Medicaid as Secondary

If Medicare covered the entire stay (and there is no ALC), the only payment due is the Deductible/Coinsurance or Life Term Reserve (LTR) amounts – the claim can be billed from Admission to Discharge regardless of the high trim point.

All the days are reported as Full-Covered Medicare days.

If some or all the days are covered as Coinsurance Days or Life Time Reserved (LTR) Days, then those Coinsurance and/or LTR days are included in the Total Covered Medicare Days and are repeated in the Coinsurance or LTR day's fields.

The system will pay the reported Part A deductible, which is entered in the CAS Segment and the Coinsurance and/or LTR amounts.

Note: While the Coinsurance amount is reported in the CAS Segment, there is no LTR amount entered in the CAS Segment. eMedNY will calculate the LTR amount from the number of LTR day's reported on the claim.

If Medicare **Part A** has covered the claim, the **Part B patient responsibility** can be claimed. In this instance the **Part B payment** should not be reported on the claim and, if reported, will be ignored.

If Medicare **Part A** has not covered the claim, **Medicare Part B patient responsibility** will not be paid and the **Medicare Part B payment** must be reported and deducted from the Medicaid payment.

Medicare Part A	Part B Patient Responsibility	Medicare Part B Payment
Covered the stay	Claim to Medicaid	Do not report on claim
Did not cover the stay	Do not report on claim	Must be reported on claim

Medicare Exhausts in the Outlier Period

If Medicare exhausts in the outlier period, then the inlier claim is billed from the day of admission to the last Medicare covered day with patient status code 30 and the actual discharge date. See the rules for reporting Medicare deductible, Coinsurance and/or LTR above.

The period that Medicare did not cover is billed to Medicaid as a separate outlier claim. The outlier claim must contain the appropriate admission date and outlier rate code. The outlier claim must indicate Medicare Full Covered days as zero and zero amounts paid. Additionally, the 0FILL option must be indicated.

Medicare Exhausts Before the High Trim Point

If Medicare exhausts before the high trim, then the inlier claim is billed from the day of admission to the high trim point. The inlier claim must contain the days Medicare covered and the remaining days (Medicare non-covered) are reported as Medicaid Non Covered days.

A separate claim must be submitted for any days after the high trim point with the outlier rate code.

Medicare Coverage Begins After the Admission Date

For billing instructions in this scenario, refer to the Inpatient Policy Guidelines available at www.emedny.org by clicking on the link below:

[Inpatient Manual](#)

Other Third Party Insurance as Primary – Medicaid as Secondary

The claim is submitted as a Medicaid Secondary claim. The days covered by the other insurance are reported as covered by the insurance and the payment received from the other insurance must be reported on the claim.

If another insurance deductible is being claimed it is entered in the CAS Segment of the electronic claim record. eMedNY will calculate the Medicaid payment and, subtract the reported other Insurance payment, then compare that balance to the deductible claimed. eMedNY will pay the lower of the reported deductible or the balance after subtracting the other insurance payment from the amount Medicaid would pay.

Only bill if there is a patient responsibility, i.e., deductible, coinsurance, copay.

Special Instructions for Other Inpatient Claims

This section of the manual explains billing requirements for the following types of claims:

- Alternate Level of Care (ALC) Claims
- Alternate Level of Care - Medicare Non-covered
- Graduate Medical Expense (GME) Claims
- Pass Days Claims
- Cost Outlier Claims

Alternate Level of Care (ALC)

ALC Rule 1 – Patient Cannot Be Admitted Directly to ALC Status

All patients MUST be admitted as acute care patients. A claim submitted indicating the patient was admitted on ALC will be denied.

ALC Rule 2 – Split-Billing

ALC claims are Non-DRG (per diem) claims. The ALC claims can be split-billed. Split-billing means submitting separate multiple claims that can be submitted prior to the discharge (except for the discharge claim).

ALC Rule 3 – Discharge Date

The discharge date and time of discharge is only reported on an ALC claim if the patient status is a discharge or transfer status code.

ALC Rule 4 – Occurrence Span Code

The claims for ALC must contain Occurrence Span Code 75 with the date range the patient was on ALC.

ALC Rule 5 – Admission Date

The admission date on the ALC claim will be the actual acute care admission date.

ALC Rule 6 – Transferred and Discharged on ALC

If the patient is transferred to ALC and is discharged while on ALC, then the DRG claim is billed from the date of admission to the last day the patient was acute care, with status code 30 – Still A Patient. The DRG claim must include the discharge date and occurrence span code 75 with the date span the patient was on ALC. (See billing examples that follow).

ALC Rule 7 – Transferred To and From ALC Multiple Times

If the patient is transferred to and from ALC multiple times during the stay, each ALC time period is a separate claim, with no discharge date and a patient status code 30 – Still A Patient; except for the discharge claim.

The occurrence span code 75 with the date span the patient was on ALC must be reported.

The date range used as the statement-covered period in the header on the DRG claim will include the dates of service the patient was on ALC.

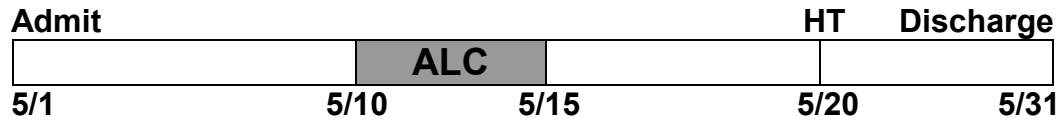
The DRG claim will have an occurrence span code 75 with the date range of each of the ALC time periods.

Please review the following section that describe the submission of ALC and DRG claims for various scenarios.

DRG and ALC Billing Scenarios

Scenario 1 – ALC period occurs prior to high trim (HT)

DRG Timelines



CLAIM 1

The DRG Inlier claim can be billed in one of two ways:

- Submit with from – through dates (5/01 to 5/20) and a patient status code of 30 - Still A Patient, or
- Submit with from – through dates (5/1 to 5/31) with an appropriate discharge status code.

Either way, the claim must include an occurrence span code 75 and the date span the patient was on ALC.

CLAIM 2

If the Inlier claim was submitted using method above, the DRG Outlier claim (the days after HT) must be submitted with from – through dates (5/21 to 5/31), with a patient status of discharged.

CLAIM 3

The ALC claim must be submitted with from – through dates (5/10 to 5/15). The claim **MUST** have a patient status code of 30 and occurrence span code 75 and the date span the patient was on ALC.

Note: No discharge date should be reported on this claim.

Scenario 2 – ALC period ends on or after the HT

DRG Timelines



CLAIM 1

The DRG Inlier claim can be billed in one of two ways:

- a) Submit with from – through dates (5/01 to 5/9) 5/9 is the last day of acute care prior to the HT. The claim must contain patient status code of 30 - Still A Patient, or
- b) Submit with from – through dates (5/1 to 5/31) with an appropriate discharge status code.

Either way, the claim must include an occurrence span code 75 and the date span the patient was on ALC.

CLAIM 2

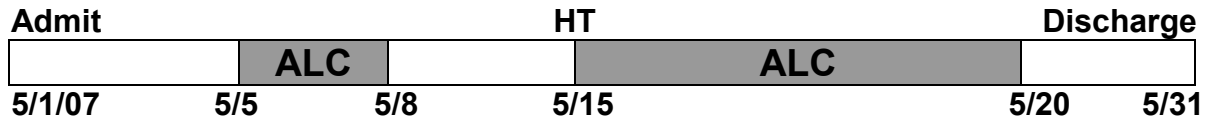
The ALC claim must be submitted with from – through dates (5/10 to 5/21). The ALC claim must also contain the occurrence span code 75 with the date span the patient was on ALC.

CLAIM 3

If the Inlier claim was submitted using method above, the DRG Outlier claim (the days after the HT) must be submitted with from – through dates (5/22 to 5/31) with a patient status of discharged.

Scenario 3 – Multiple ALC periods ends on or after the HT

DRG Timelines



CLAIM 1

The DRG Inlier claim can be billed in one of two ways:

- a) Submit with from – through dates (5/01 to 5/14) 5/14 is the last day of acute care prior to the HT. The claim must contain patient status code of 30 - Still A Patient, or
- b) Submit with from – through dates (5/1 to 5/31) with an appropriate discharge status code.

Either way, the claim must include an occurrence span code 75 and the date span the patient was on ALC.

CLAIMS 2 and 3

The 2nd claim for ALC must be submitted with from – through dates (5/5 to 5/8), and must contain a patient status code of 30.

The 3rd claim for ALC must be submitted with from – through dates (5/15 to 5/20), and must contain a patient status code of 30.

Both ALC claims must contain occurrence span code 75 and the date span the patient was on ALC for each claim.

CLAIM 4

If the Inlier claim was submitted using method a above, the DRG Outlier claim (the days after the HT) must be submitted with from - through dates (5/21 to 5/31) and must contain a patient status of discharged.

Alternate Level of Care After Medicare Scenarios

The scenarios below explain billing requirements when ALC occurs during the inpatient hospital stay and **Medicare does not cover the ALC period(s)**.

Scenario 1 - Patient Discharged On ALC

The **DRG Inlier claim** is submitted with the following information:

- Dates of service would be submitted from the admission day to the last day the patient was on an acute care status.
- Patient Status Code would be 30 – Still A Patient.
- Occurrence Code 75 and the date range the patient was on ALC must be reported.
- Days covered by Medicare are submitted with the applicable Medicare Deductible, Coinsurance or LTR amounts.

The **ALC claim** is submitted with the following information:

- Admission date would be the actual acute care admission date.
- Dates of service would be submitted for the dates the patient was on ALC.
- Occurrence Code 75 must be entered
- Occurrence Span dates should be the dates the patient was on ALC.
- The “0FILL” indicator must be submitted.

Note for programmers and software developers: 0FILL is an indicator submitted in the electronic claim in Loop 2000B, SBR04.

Scenario 2 - ALC Begins After the High Trim Point

The **DRG Inlier claim** is submitted with the following information:

- Dates of service would be submitted from the admission day to the last day the patient was acute care.
- Patient status code must be 30 – Still A Patient.
- Occurrence Code 75 with the occurrence span dates the patient was on ALC.
- Days covered by Medicare are submitted with the applicable Medicare Deductible, Coinsurance and/or LTR amounts.

The **ALC claim** is submitted with the following information:

- Admission date would be the actual acute care admission date.
- Dates of service would be the time period the patient was on ALC.
- Occurrence Code 75 must be submitted.
- Occurrence span dates should be the dates the patient was on ALC.
- The “0FILL” indicator must be submitted.

Note for programmers and software developers: 0FILL is an indicator submitted in the electronic claim in Loop 2000B, SBR04.

Scenario 3 - Patient level of Care Changes from Acute to ALC and Back to Acute

The **DRG Inlier claim** is submitted with the following information:

- Dates of service would be submitted from admission to discharge.
- Medicare covered days are submitted with the applicable Medicare Deductible, Coinsurance and/or LTR amounts.
- ALC days occurring in this period are submitted as Medicaid non-covered days.
- Occurrence Span Code 75 must be submitted.
- Occurrence span dates should be the dates the patient was on ALC.

Note: If there are numerous ALC periods, the Inlier claim will have the Occurrence Span Code 75 and the dates the patient was on ALC for each of the ALC periods include in the date range billed. So there will be multiple Occurrence Codes 75 reported.

The **ALC claim** is submitted with the following information:

- Admission date would be the actual acute care admission date.
- Dates of service would be the time period the patient was on ALC.
- Occurrence Code 75 must be submitted.
- Occurrence Span dates would be the dates the patient was on ALC.
- The “0FILL” indicator must be submitted.

Note for programmers and software developers: 0FILL is an indicator submitted in the electronic claim in Loop 2000B, SBR04.

Graduate Medical Education (GME) Claims

GME payments are made to cover the GME expenses related to an Inpatient stay on behalf of a Medicaid client enrolled in a Medicaid Managed Care plan on the Date of Admission.

GME claims are billed with all the information required on an Inpatient claim with a few modifications such as:

- Discharge date is required.
- Discharge date is repeated as the dates of service from – through.
- Patient status code is the final discharge status code.
- Medicaid full-covered day is one.

The GME payment is determined by the GME rate code entered on the claim. GME Rate Codes are 3130, 3131, 3132, 3134, 3135 and 3137.

Pass Days Claims

Pass day claims are submitted when the patient was readmitted within 31 days of the original discharge for the same or a related condition in accordance with 10NYCRR, Section 86-1.54(m). Claims should be submitted as follows:

- Admission date submitted is from the first stay.
- Discharge date submitted is from the second stay.
- Date of service “From” is the first Admission date.
- Dates between the first discharge and 2nd admission are included in the dates of service.
- Days between the first discharge and 2nd admission are submitted as Medicaid Non-covered days.

Cost Outlier Claims

Hospitals can request additional reimbursement for an inpatient, DRG hospitalization by requesting Cost Outlier consideration. Each cost outlier case must undergo Peer Review. The 837I must include rate code 2946 or 2953 (whichever code appears on the provider's file) and condition code 61 in the 2300 loop.

Please note: (1) Medicaid must be the primary inpatient coverage to qualify for a cost outlier consideration, and (2) transfer cases, as defined in 10NYCRR, Section 86-1.50, do not qualify for cost outlier consideration.

Notes:

- **The Cost Outlier payment is for the entire acute care stay. No long stay outlier portion can be billed separately.**
- **ALC periods are not paid as part of the Cost Outlier, therefore ALC claims can be billed in addition to the Cost Outlier claim.**
- **If a case receives two technical denials it will be closed to cost outlier consideration.**

Other rules may apply.

Medicaid Policy when Medicaid Coverage Begins During an Inpatient Admission

If a patient is ineligible on the date of admission (but becomes eligible during or for part of the service period), the NYS Department of Health (DOH) will pend the claim and review the patient file. If DOH adjudicates that a payment is warranted, a payment will be calculated and the claim remitted as paid at the amount entered by DOH. If DOH determines no payment is warranted, the claim will be denied for edit 833 (Recipient Ineligible for Part of Service Period on DRG Claim).

For additional details, refer to the Inpatient Policy Guidelines available at www.emedny.org by clicking on the link below:

[Inpatient Manual](#)

Please call the NYS Department of Health if you have any questions.

Medicare Part A Coverage Begins During Inpatient Admission

Special processing is required if a patient is covered by Medicaid at admission and becomes eligible for Medicare Part A during that stay. To be paid by Medicaid, submit a paper claim (currently UB-04) to the NYS Department of Health at the address listed below. Include Explanation of Benefits from all other payers.

**Rate Based Provider Bureau
Office of Health Insurance Programs
NYS Department of Health
150 Broadway, Suite 6E
Albany, NY 12204-2736**

Section IV – All Patient Refined Diagnosis Related Groups (APR DRG) Claims

This section contains instructions for the following:

- Inpatient Billing Procedures for DRG Claims
- Special Instructions for Other Inpatient Claims
- Medicaid Policy when Medicare Coverage Begins During an Inpatient Admission

Inpatient Billing Procedures for APR DRG Claims

This section details instructions for APR DRG claims that are effective for claims with discharge dates on or after December 1, 2009. Instructions for claims submitted (including adjustments to previously paid claims) with discharge dates prior to December 1, 2009 are in the DRG section of this manual.

APR DRG billing classifies inpatient hospital stays into one of approximately 1,258 groups, also referred to as APR DRGs. A "grouper" program assigns an APR DRG by utilizing data submitted on the claim such as ICD-9-CM diagnoses, procedures, patient age, sex, and other information.

The Principle Diagnosis and up to 24 Other Diagnosis Codes are processed through the APR DRG Grouper. Up to 25 ICD-9 Procedure Codes are also processed through the APR DRG Grouper.

Associated with each APR DRG is an average length of stay, which will only be applied to claims with a Transfer Discharge Status Code. APR DRG claims are not subject to high trim points (threshold), and low trim points as are DRG Claims. Service Intensity Weights are applied to APR DRG payment calculations. See definitions that follow which may or may not be applicable to the APR DRG payment methodology:

Term	Applicable	Non-Applicable	Definition
High Trim		X	Maximum number of days the patient is expected to be hospitalized based on the assigned DRG
Low Trim		X	Minimum number of day the patient is expected to be hospitalized for the assigned DRG

Inpatient Hospital Billing Guidelines

Term	Applicable	Non-Applicable	Definition
Inlier		X	Portion of the inpatient stay from the date of admission through and including the high trim point
Cost Per Discharge (CPD)	X		Base Rate on file for a hospitals APR DRG rate code
Service Intensity Weight (SIW)	X		A weighting factor assigned to each APR DRG
Average Length of Stay (ALOS)	X		Average length of a hospital stay for the APR DRG assigned for Transfers only

Note: APR DRGs are not subject to the “TOP 20 DRG” Payments as are DRG claims.

APR DRG Rate Codes

A claim is classified as an APR DRG claim based on the submitted rate code. The rate code is sent in the 837 Institutional Claim in loop 2300, in the Value Information Segment. DRG claims are identified by the following Rate Codes:

Type of Claim	Rate Code
New York State	2946
GME Claim	3130
Out-of-state	2953

Notes:

- **A Direct Medical Education (DME) rate code (2589) will be used for calculating DME add-ons. This rate code is not to be submitted on a claim but may appear on retro-active rate adjustment remittances.**
- **For ePACES submitted claims: Only Type of Bill Codes 11, 12 and 14 through 18 will allow the provider to submit up to 24 other diagnosis codes, Present On Admission (POA) codes and up to 25 procedure codes.**

APR DRG Payment Calculations

The following describes the calculations used to price Inpatient APR DRG claims for New York State hospitals by Medicaid.

The **claim calculation** is as follows:

CPD (x) SIW (as determined by the Severity of Illness Code assigned) (+)
Capital add-on (+) DME add-on = Payment Amount

Note: Severity of Illness Code will be sent on the provider's remittance. See Section VI – Remittance Advice below.

The Graduate Medical Expense **shadow bill calculation** is as follows:

Per Discharge Rate Adjusted for Facility Specific Labor and IME (x) APR DRG
Weight (+) Direct Medical Education add-on = Shadow Bill

Note: Capital add-on amounts are not applicable to GME claims.

Rule 1 – There is no “Split-Billing” (Inlier and Outlier Claims) for APR DRG Claims

Note: There are exceptions to this rule in the “Special Instructions for Other Inpatient Claims” section below.

Rule 2 – Timely Submission of claims

For APR DRG claims, the NYS Medicaid 90-day timely submission requirement is based on the Through Date of Service reported on the claim.

Rule 3 – Discharge Date

An APR DRG claim cannot be billed until the patient is discharged. All APR DRG claims must have the actual discharge date regardless of the status code of the patient. The discharge date will not match the end date of service if the patient status is 30 – Still A Patient. The end date of service and the discharge date will be different only if the patient was discharged as an ALC patient. See ALC rule 6 in the “Special Instructions for Other Inpatient Claims” section below.

Rule 4 - Newborns

APR DRG claims for newborns, 28 days or younger, must contain the birth weight in grams. Birth weights must be submitted according to the following example:

If a client's birth weight is 2500 grams, the provider must enter the value **250000**, to account for the decimal.

Special Instructions for Other Inpatient Claims

This section of the manual explains billing requirements for the following types of APR DRG claims:

- Alternate Level of Care (ALC) Claims
- Alternate Level of Care - Medicare Non-covered
- Graduate Medical Expense (GME) Claims
- Pass Days Claims
- Cost Outlier Claims

Alternate Level of Care (ALC)

ALC Rule 1 – Patient Cannot Be Admitted Directly to ALC Status

All patients **MUST** be admitted as acute care patients. A claim submitted indicating the patient was admitted on ALC will be denied.

ALC Rule 2 – Split-Billing

ALC claims are Non-DRG (per diem) claims. The ALC claims can be split-billed. Split-billing means submitting separate multiple claims that can be submitted prior to the discharge (except for the discharge claim).

ALC Rule 3 – Discharge Date

The discharge date and time of discharge is only reported on an ALC claim if the patient status is a discharge or transfer status code.

ALC Rule 4 – Occurrence Span Code

The claims for ALC must contain Occurrence Span Code 75 with the date range the patient was on ALC.

ALC Rule 5 – Admission Date

The admission date on the ALC claim will be the actual acute care admission date.

ALC Rule 6 – Transferred and Discharged on ALC

If the patient is transferred to ALC and is discharged while on ALC, then the APR DRG claim is billed from the date of admission to the last day the patient was acute care, with status code 30 – Still A Patient. The APR DRG claim must include the discharge date and occurrence span code 75 with the date span the patient was on ALC.

ALC Rule 7 – Transferred To and From ALC Multiple Times

If the patient is transferred to and from ALC multiple times during the stay, each ALC time period is a separate claim, with no discharge date and a patient status code 30 – Still A Patient; except for the discharge claim.

The occurrence span code 75 with the date span the patient was on ALC must be reported.

The date range used as the statement-covered period in the header on the APR DRG claim will include the dates of service the patient was on ALC.

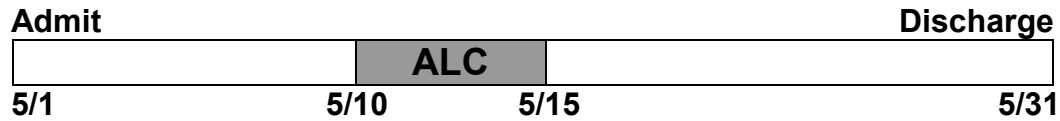
The APR DRG claim will have an occurrence span code 75 with the date range of each of the ALC time periods.

Please review the following section that describe the submission of ALC and APR DRG claims for various scenarios.

APR DRG and ALC Billing Scenarios

Scenario 1 – ALC period occurs during the stay

APR DRG Timelines



The APR DRG and the ALC claims can be billed as follows:

- Submit the acute care claim for the entire stay (admit to discharge). In the above scenario 5/1 through 5/31. Include occurrence code 75.
- Submit the ALC claim with from – through dates 5/10 to 5/15 with discharge status code 30 (Still a patient) and no discharge date.

Scenario 2 – Patient discharged on ALC

APR DRG Timelines

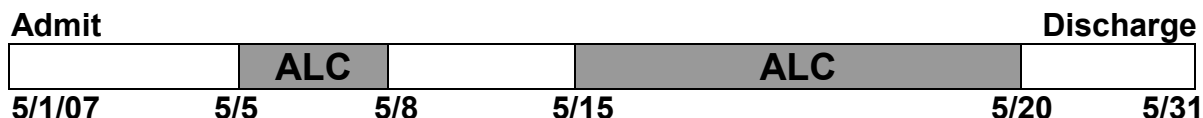


The APR DRG and ALC claims can be billed as follows:

- Submit acute care claim from the admit date to the last day the patient was acute care. In the above scenario 5/1 to 5/9. Include occurrence code 75. This claim can not be submitted until the patient is discharged.
- Submit the ALC claim from the first day of ALC. Note that an ALC claim can be interim billed with status code 30 (Still a patient) and no discharge date. If the ALC is billed through the discharge date, use the appropriate discharge status code and include the discharge date. In the above scenario 5/10 to 5/31.

Scenario 3 – Multiple ALC periods

APR DRG Timelines



The APR DRG and ALC claims can be billed as follows:

- a) Submit the acute care claim for the entire stay (admit to discharge). In the above scenario 5/1 to 5/31, Include occurrence code 75.
- b) Submit the ALC claims for each of the ALC periods. In the above scenario 5/5 to 5/8 and another claim for dates 5/15 to 5/20. Each claim must include an occurrence span code 75 and the date span the patient was on ALC with no discharge date and discharge status 30 (Still a patient).

Alternate Level of Care After Medicare

ALC claims for patients with Medicare are submitted according to the same instructions previously outlined in the DRG Claims section, Special Instructions for Other Inpatient Claims above, except the following additional information is required.

When ALC occurs during the inpatient hospital stay and **Medicare does not cover the ALC period(s)**, the “0FILL” indicator must be submitted to indicate that Medicare is not covering the claim.

Note for programmers and software developers: 0FILL is an indicator submitted in the electronic claim in Loop 2000B, SBR04.

Graduate Medical Education (GME) Claims

GME payments are made to cover the GME expenses related to an Inpatient stay on behalf of a Medicaid client enrolled in a Medicaid Managed Care plan on the Date of Admission.

GME claims are billed with all the information required on an APR DRG Inpatient claim. Under APR DRG billing, the from date of service must match the admission date.

The GME payment is determined by the GME rate code (3130) entered on the claim. Calculations of the GME payment is outlined above in Section III – DRG Claims, Special Instructions for Other Inpatient Claims subsection.

Pass Days Claims

Pass day claims are submitted when the patient was readmitted within 31 days of the original discharge for the same or a related condition in accordance with 10NYCRR, Section 86-1.54(m). Claims should be submitted as follows:

- Admission date submitted is from the first stay.
- Discharge date submitted is from the second stay.
- Date of service “From” is the first Admission date.
- Dates between the first discharge and 2nd admission are included in the dates of service.
- Days between the first discharge and 2nd admission are submitted as Medicaid Non-covered days.

Cost Outlier Claims

Hospitals can request additional reimbursement for an inpatient, DRG hospitalization by requesting Cost Outlier consideration. Each cost outlier case must undergo Peer Review. The 837I must include rate code 2946 or 2953 (whichever code appears on the provider's file) and condition code 61 in the 2300 loop.

Please note: (1) Medicaid must be the primary inpatient coverage to qualify for a cost outlier consideration, and (2) transfer cases, as defined in 10NYCRR, Section 86-1.50, do not qualify for cost outlier consideration.

Notes:

- **The Cost Outlier payment is for the entire acute care stay.**
- **ALC periods are not paid as part of the Cost Outlier, therefore ALC claims can be billed in addition to the Cost Outlier claim.**
- **If a case receives two technical denials it will be closed to cost outlier consideration.**

Other rules may apply.

Medicaid Policy when Medicaid Coverage Begins During an Inpatient Admission

If a patient is ineligible on the date of admission (but becomes eligible during or for part of the service period), the NYS Department of Health (DOH) will pend the claim and review the patient file. If DOH adjudicates that a payment is warranted, a payment will be calculated and the claim remitted as paid at the amount entered by DOH. If DOH determines no payment is warranted, the claim will be denied for edit 833 (Recipient Ineligible for Part of Service Period on DRG Claim). Please call the NYS Department of Health if you have any questions.

For additional details, refer to the Inpatient Policy Guidelines available at www.emedny.org by clicking on the link below:

[Inpatient Manual](#)

Medicare Part A Coverage Begins During Inpatient Admission

Special processing is required If a patient is covered by Medicaid at admission and becomes eligible for Medicare Part A during that stay. To be paid by Medicaid, submit a paper claim (currently UB-04) to the NYS Department of Health at the address listed below. Include Explanation of Benefits from all other payers.

**Rate Based Provider Bureau
Office of Health Insurance Programs
NYS Department of Health
150 Broadway, Suite 6E
Albany, NY 12204-2736**

For additional details, refer to the Inpatient Policy Guidelines available at www.emedny.org by clicking on the link below:

[Inpatient Manual](#)

Medicaid as Payer of Last Resort

All other sources of payments must be exhausted before billing Medicaid. The following section of the manual explains billing procedures for patients with other sources of coverage. The main topics are as follows:

- Medicaid Only (No involvement from any other payer)
- Instructions for the Submission of Medicare Crossover Claims
- Medicare as Primary – Medicaid as Secondary
- Other Third party Insurance as Primary – Medicaid as Secondary

Medicaid Only (No involvement from any other payer)

The APR DRG claim can be billed from Admission to Discharge under rate code 2946/2953. eMedNY will calculate the appropriate payment and pay the claim with one payment amount with rate code 2946.

The days are reported as Medicaid Full Covered Days.

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 Part A and B claims will be crossed over to Medicaid and paid as separate claims. Medicaid will pay the Part A deductible, coinsurance and LTR on one claim and the Medicare Part B patient responsibility will be paid on a separate claim where Part A covered the claim. 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 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](#)

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

Medicare as Primary – Medicaid as Secondary

If Medicare covered the entire stay (and there is no ALC), the only payment due is the Deductible/Coinsurance or Life Term Reserve (LTR) amounts – the claim is be billed from Admission to Discharge.

All the days are reported as Full-Covered Medicare days.

If some or all the days are covered as Coinsurance Days or Life Time Reserved (LTR) Days, then those Coinsurance and/or LTR days are included in the Total Covered Medicare Days and are repeated in the Coinsurance or LTR day's fields.

The system will pay the reported Part A deductible, which is entered in the CAS Segment and the Coinsurance and/or LTR amounts.

Note: While the Coinsurance amount is reported in the CAS Segment, there is no LTR amount entered in the CAS Segment. eMedNY will calculate the LTR amount from the number of LTR day's reported on the claim.

If Medicare **Part A** has covered the claim, the **Part B patient responsibility** can be claimed. In this instance the **Part B payment** should not be reported on the claim and, if reported, will be ignored.

If Medicare **Part A** has not covered the claim, **Medicare Part B patient responsibility** will not be paid and the **Medicare Part B payment** must be reported and deducted from the Medicaid payment.

Medicare Part A	Part B Patient Responsibility	Medicare Part B Payment
Covered the stay	Claim to Medicaid	Do not report on claim
Did not cover the stay	Do not report on claim	Must be reported on claim

Medicare Coverage Begins After the Admission Date

For billing instruction in this scenario, please see the Inpatient Policy Guidelines available at www.emedny.org by clicking on the link below:

[Inpatient Manual](#)

Other Third party Insurance as Primary – Medicaid as Secondary

The claim is submitted as a Medicaid Secondary claim. The days covered by the other insurance are reported as covered by the insurance and the payment received from the other insurance must be reported on the claim.

If another insurance deductible is being claimed it is entered in the CAS Segment of the electronic claim record. eMedNY will calculate the Medicaid payment and, subtract the reported other Insurance payment, then compare that balance to the deductible claimed. eMedNY will pay the lower of the reported deductible or the balance after subtracting the other insurance payment from the amount Medicaid would pay.

Only bill if there is a patient responsibility, i.e., deductible, coinsurance, copay.

Section V – Supplemental Inpatient Billing Information

This section of the manual puts forth information on the following topics:

- Inpatient Services Paid “Offline”
- Replacement/Void of Previously Paid Claims
- Medicaid Managed Care Clients
- Hospital Responsibility For Outside Care
- Patient Status Codes

Inpatient Services Paid "Off-Line"

Information about Inpatient Services Paid “Off-Line” can be found in the Policy Guidelines section of the Inpatient Manual. This document is available at www.emedny.org by clicking on the link to the web page below:

[Inpatient Manual](#)

Replacement/Void of Previously Paid Claims

If submitting an **Adjustment (Replacement)** or a **Void** to a previously paid claim, enter the 16 digit **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 the Original Reference Number Segment (Loop 2300), the Claim Frequency Type Code entered in the Claim Information Segment (Loop 2300 – CLM05-3) must be 7 for a replacement or 8 for a void. When submitting an original claim or the resubmission of a previously denied claim, this information is not to be entered on the claim as resubmissions are considered original claims by eMedNY.

Note: Once a claim is voided, any re-billed claim is subject to the 90 day timeliness policy.

Adjustments

An adjustment is submitted to correct one or more data items of a previously paid claim. Any field, except the **Provider Number**, the **Patient's Medicaid ID number**, or **Bill Type** can be adjusted. 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. Voids cause the cancellation of the original claim history records and payment.

Medicaid Managed Care Clients

If a patient is enrolled in a Medicaid Managed Care Plan on the day of admission, the managed care plan should be billed and is responsible to pay the claim. Even in cases where the patient is disenrolled from the managed care plan during the stay, the managed care plan is responsible for payment.

Hospital Responsibility for Outside Care: Reimbursement Policy

Please see the Policy Guidelines section of the Inpatient manual for information. This document is available at www.emedny.org by clicking on the link to the web page below:

[Inpatient Manual](#)

Patient Status Codes

Providers are responsible to report the correct patient status code.

- 01 Discharged to home or self-care (routine discharge)
- 02 Discharged/transferred to another short-term general hospital for inpatient care
- 03 Discharged/transferred to skilled nursing facility (SNF)
- 04 Discharged/transferred to an intermediate care facility (ICF)
- 05 Discharged/transferred to a non-Medicare PPS children's hospital or non-Medicare cancer hospital for inpatient care
- 06 Discharged/transferred to home under care of organized home health service organization

Inpatient Hospital Billing Guidelines

- 09 Admitted as an inpatient to this hospital
- 20 Expired
- 30 Still Patient
- 40 Expired at home
- 41 Expired in a medical facility (e.g. hospital, SNF, ICF or free standing hospice)
- 42 Expired place unknown
- 43 Discharged/transferred to a federal health care facility
- 50 Hospice – Home
- 51 Hospice – Medical Facility
- 61 Discharged/Transferred within this institution to hospital-based Medicare approved swing bed
- 62 Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part units of a hospital
- 63 Discharged/transferred to a Medicare certified long term care hospital (LTCH)
- 64 Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare
- 65 Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a Hospital
- 66 Discharged/transferred to critical access hospital

Section VI – Remittance Advice

The purpose of this section is to familiarize the provider with the design and contents of the paper 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 Crossover 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 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.**

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.

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 (EFT)
 - ▶ 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 Inpatient Hospital 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).



TO: DOWNTOWN HOSPITAL

DATE: 2007-08-06
 REMITTANCE NO: 07080600001
 PROV ID: 00234567/1234567890

00234567/1234567890 2007-08-06
 DOWNTOWN HOSPITAL
 123 FIRST 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 <small>VOID AFTER 90 DAYS</small>	07080600001	00234567/1234567890

PAY	DOLLARS/CENTS
	\$****12000.00

TO
THE
ORDER
OF

DOWNTOWN HOSPITAL
 123 FIRST ST
 ANYTOWN NY 11111



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: DOWNTOWN HOSPITAL



DATE: 08-06-2007
REMITTANCE NO: 07080600001
PROV ID: 00234567/1234567890

00234567/1234567890 08-06-2007
DOWNTOWN HOSPITAL
123 FIRST ST
ANYTOWN NY 11111

DOWNTOWN HOSPITAL

\$12000.00

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: DOWNTOWN HOSPITAL

DATE: 08/06/2007
REMITTANCE NO: 07080600001
PROV ID: 00234567/1234567890

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

DOWNTOWN HOSPITAL
123 FIRST 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.



PAGE 01
DATE 08/06/07
CYCLE 1563

TO: DOWNTOWN HOSPITAL
BUSINESS OFFICE
123 FIRST STREET
ANYTOWN, NEW YORK 11111

ETIN:
PROVIDER NOTIFICATION
PROV ID: 00234567/1234567890
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

Inpatient Hospital Billing Guidelines

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.



PAGE 02
DATE 08/06/07
CYCLE 1563

TO: DOWNTOWN HOSPITAL
BUSINESS OFFICE
123 FIRST STREET
ANYTOWN, NEW YORK 11111

**MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT**

ETIN:
INPATIENT
PROV ID: 00234567/1234567890
REMITTANCE NO: 07080600001

PATIENT CONTROL NO DATE	CLIENT NAME ID NUMBER	TCN MEDICAL RECORD NUMBER	SERVICE DATES FROM THRU	COV'D	OUT	TOT	COVERAGE BASE	CO-PAY	OTHER INSURANCE PAID	STATUS	ERRORS
				RATE CODE	PAY TYPE	DAYS DRG CODE					
CPIC1008432 05/25/07	SMITH ZZ22222T	07230-000000315-2-0 000000585555IH03	05/25/07 05/29/07	0 2946	0 C	0 122-1	4000.00	25.00	0.00 0.00	DENY	00805 00806 00848 00162
CPIC1088777 05/25/07	TAYLOR AB12345C	07231-000000441-2-0 000000586555IH03	05/25/07 05/30/07	0 2946	0 C	0 195-1	4000.00	25.00	0.00 0.00	DENY	00162
CPIC1005432 05/27/07	BOWN FF33333T	07245-000000049-2-0 000000587672IH03	05/27/07 05/30/07	0 2946	0 C	0 127-1	4000.00	0.00	0.00 0.00	DENY	00848

* = PREVIOUSLY PENDED CLAIM
** = NEW PEND

TOTAL AMOUNT ORIGINAL CLAIMS	DENIED	12000.00	NUMBER OF CLAIMS	3
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

Inpatient Hospital Billing Guidelines



PAGE 03
DATE 08/06/07
CYCLE 1563

TO: DOWNTOWN HOSPITAL
BUSINESS OFFICE
123 FIRST STREET
ANYTOWN, NEW YORK 11111

**MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT**

ETIN:
INPATIENT
PROV ID: 00234567/1234567890
REMITTANCE NO: 07080600001

PATIENT CONTROL NO DATE	CLIENT NAME ID NUMBER	ICN MEDICAL RECORD NUMBER	SERVICE DATES FROM THRU	COV'D DAYS RATE CODE	OUT DAYS PAY TYPE	TOT DAYS DRG CODE	COVERAGE BASE	CO-PAY	OTHER INSURANCE PAID	STATUS	ERRORS
CPIC1563324 05/25/07	WAYTKUS SS44444P	07230-000000315-2-0 000000587672IH03	05/25/07 05/27/07	2 2946	0 C	0 311-1	4000.00	25.00	0.00 4000.00	PAID	
CPIC1768935 05/25/07	GOUGH GG44444L	07231-000000441-2-0 000000587672IH03	05/25/07 05/30/07	5 2946	0 C	0 079-1	4000.00	25.00	0.00 4000.00	PAID	
CPIC1667792 05/25/07	ABRAHAM BB88888S	07245-000000049-2-0 000000587672IH03	05/25/07 05/30/07	5 2946	0 C	0 140-1	4000.00	0.00	0.00 4000.00	PAID	

* = PREVIOUSLY PENDED CLAIM
** = NEW PEND

TOTAL AMOUNT ORIGINAL CLAIMS	PAID	12000.00	NUMBER OF CLAIMS	3
NET AMOUNT ADJUSTMENTS	PAID	0.00	NUMBER OF CLAIMS	0
NET AMOUNT VOIDS	PAID	0.00	NUMBER OF CLAIMS	0
NET AMOUNT VOIDS - ADJUSTS	PAID	0.00	NUMBER OF CLAIMS	0

Inpatient Hospital Billing Guidelines



PAGE 04
DATE 08/06/07
CYCLE 1563

**MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT**

TO: DOWNTOWN HOSPITAL
BUSINESS OFFICE
123 FIRST STREET
ANYTOWN, NEW YORK 11111

ETIN:
INPATIENT
PROV ID: 00234567/1234567890
REMITTANCE NO: 07080600001

PATIENT CONTROL NO DATE	CLIENT NAME ID NUMBER	TCN MEDICAL RECORD NUMBER	SERVICE DATES FROM THRU	COV'D DAYS RATE CODE	OUT DAYS PAY TYPE	TOT DAYS DRG CODE	COVERAGE BASE	CO-PAY	OTHER INSURANCE PAID	STATUS	ERRORS
CPIC156565633 05/25/07	PROUST XX99999V	07230-000000315-2-0 000000587672IH03	05/25/07 05/26/07	0 2959	0 C	0 122-1	4000.00	25.00	0.00	PEND	00162
CPIC196969685 05/25/07	WELBY KK99999N	07231-000000441-2-0 000000587672IH03	05/25/07 05/30/07	0 2959	0 C	0 088-1	4000.00	25.00	0.00	PEND	00142
CPIC183211677 05/25/07	SHEEHAN WW66666G	07245-000000049-2-0 000000587672IH03	05/25/07 05/30/07	0 2959	0 C	0 296-1	4000.00	0.00	0.00	PEND	00144

* = PREVIOUSLY PENDED CLAIM
** = NEW PEND

TOTAL AMOUNT ORIGINAL CLAIMS	PEND	12000.00	NUMBER OF CLAIMS	3
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 – INPATIENT				
VOIDS – ADJUSTS		0.00	NUMBER OF CLAIMS	0
TOTAL PENDS		12000.00	NUMBER OF CLAIMS	3
TOTAL PAID		12000.00	NUMBER OF CLAIMS	3
TOTAL DENY		12000.00	NUMBER OF CLAIMS	3
NET TOTAL PAID		12000.00	NUMBER OF CLAIMS	3

MEMBER ID: 00234567				
VOIDS – ADJUSTS		0.00	NUMBER OF CLAIMS	0
TOTAL PENDS		12000.00	NUMBER OF CLAIMS	3
TOTAL PAID		12000.00	NUMBER OF CLAIMS	3
TOTAL DENY		12000.00	NUMBER OF CLAIMS	3
NET TOTAL PAID		12000.00	NUMBER OF CLAIMS	3

Inpatient Hospital Billing Guidelines



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

**MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT**

TO: DOWNTOWN HOSPITAL
BUSINESS OFFICE
123 FIRST STREET
ANYTOWN, NEW YORK 11111

ETIN:
INPATIENT
GRAND TOTALS
PROV ID: 00234567/1234567890
REMITTANCE NO: 07080600001

REMITTANCE TOTALS – GRAND TOTALS			
VOIDS – ADJUSTS	0.00	NUMBER OF CLAIMS	0
TOTAL PENDS	12000.00	NUMBER OF CLAIMS	3
TOTAL PAID	12000.00	NUMBER OF CLAIMS	3
TOTAL DENY	12000.00	NUMBER OF CLAIMS	3
NET TOTAL PAID	12000.00	NUMBER OF CLAIMS	3

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: **INPATIENT**

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

Remittance number

Explanation of the Claim Detail Columns

PATIENT CONTROL NUMBER/DATE

This column indicates the Patient Control Number assigned to the patient by the hospital at the time of admission (first line) and the admission date (second line).

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/MEDICAL RECORD NUMBER

The TCN (first line) is a unique identifier assigned to each claim.

The Medical Record Number will be indicated below the TCN in this column.

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.

COV'D (COVERED) DAYS/RATE CODE

The number of full covered days (first line) and the four-digit rate code (second line) that were entered in the claim appear under this column.

OUT DAYS/PAY TYPE

This column will show the number of outlier days, if any, and the type of payment (code) generated by the claim.

Inpatient Payment Type Codes – One of the following type codes appears in the Pay Type field on the Medicaid remittance advice and indicates the type of payment (code) generated by the claim.

0	Non DRG
A	Medicare Deductible/Coinsurance/LTR
B	Full DRG
C	Admission Day Claim
D	Short Stay *
E	Outlier Only *
F	ALC Claim
G	Transfer – Paid as Per Diem
H	Transfer – Paid as DRG
I	Transfer – Full DRG Plus Outlier *
J	Cost Outlier
K	DRG Paid as Inlier/Outlier Combined
L	Transfer – Inlier/Outlier *

Note: Inpatient Payment Type Codes with an asterisk (*) are only valid for claims with discharge dates prior to December 1, 2009.

TOT (TOTAL) DAYS/DRG CODE [and SEVERITY OF ILLNESS CODE]

The first line under this column indicates the number of days for which the DRG payment was made.

The DRG code assigned to the claim based on pertinent data submitted on the claim will appear below the Total Days as the first three digits of the second line.

The Severity of Illness Code will be returned from the APR Grouper and used to determine the APR DRG weight. The Code is represented by the fourth digit of the second line.

Note: If the information on the second line of this column is three digits in length, the DRG Code is being returned for the corresponding Patient Control Number without a Severity of Illness Code.

COVERAGE BASE

For non-DRG hospitals, the coverage base is obtained by multiplying the hospital's rate by the number of covered days.

For DRG hospitals, this column indicates the gross DRG calculation prior to other coverage and other payments.

CO-PAY

The co-pay amount for which the patient is responsible and that is deducted from the claim payment appears in this column.

OTHER INSURANCE/PAID

If applicable, the amount paid by any third party insurance other than Medicare appears on the first line of this column. The second line indicates the amount paid by Medicaid for the specific claim.

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 cancelling 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: Recipient 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

Subtotals by service classification/locator code combination are provided at the end of the claim detail listing for each service classification/locator code combination. These subtotals are broken down by:

- Adjustments/voids (combined)
- Pends
- Paid
- Denied
- Net total paid (for the specific combination)

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)

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.

TO: DOWNTOWN HOSPITAL BUSINESS OFFICE 123 FIRST STREET ANYTOWN, NEW YORK 11111	 <p>MEDICAL ASSISTANCE (TITLE XIX) PROGRAM REMITTANCE STATEMENT</p>	PAGE 07 DATE 08/06/07 CYCLE 1563 ETIN: FINANCIAL TRANSACTIONS PROV ID: 00234567/1234567890 REMITTANCE NO: 07080600001										
<table border="0" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left; border-bottom: 1px solid black;">FCN</th> <th style="text-align: left; border-bottom: 1px solid black;">FINANCIAL REASON CODE</th> <th style="text-align: left; border-bottom: 1px solid black;">FISCAL TRANS TYPE</th> <th style="text-align: left; border-bottom: 1px solid black;">DATE</th> <th style="text-align: left; border-bottom: 1px solid black;">AMOUNT</th> </tr> </thead> <tbody> <tr> <td style="border-top: 1px solid black;">200705060236547</td> <td style="border-top: 1px solid black;">XXX</td> <td style="border-top: 1px solid black;">RECOUPMENT REASON DESCRIPTION</td> <td style="border-top: 1px solid black;">08 01 07</td> <td style="border-top: 1px solid black;">\$\$.\$\$</td> </tr> </tbody> </table>			FCN	FINANCIAL REASON CODE	FISCAL TRANS TYPE	DATE	AMOUNT	200705060236547	XXX	RECOUPMENT REASON DESCRIPTION	08 01 07	\$\$.\$\$
FCN	FINANCIAL REASON CODE	FISCAL TRANS TYPE	DATE	AMOUNT								
200705060236547	XXX	RECOUPMENT REASON DESCRIPTION	08 01 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.

TO: DOWNTOWN HOSPITAL BUSINESS OFFICE 123 FIRST STREET ANYTOWN, NEW YORK 11111		 MANAGEMENT INFORMATION SYSTEM MEDICAL ASSISTANCE (TITLE XIX) PROGRAM REMITTANCE STATEMENT		PAGE 08 DATE 08/06/07 CYCLE 1563	ETIN: ACCOUNTS RECEIVABLE PROV ID: 00234567/1234567890 REMITTANCE NO: 07080600001
REASON CODE DESCRIPTION	ORIG BAL \$XXX.XX- \$XXX.XX-	CURR BAL \$XXX.XX- \$XXX.XX-	RECOUP %/AMT 999 999		
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.



PAGE 06
DATE 08/06/07
CYCLE 1563

TO: DOWNTOWN HOSPITAL
BUSINESS OFFICE
123 FIRST STREET
ANYTOWN, NEW YORK 11111

**MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT**

ETIN:
INPATIENT
EDIT DESCRIPTIONS
PROV ID: 00234567/1234567890
REMITTANCE NO: 07080600001

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

- 00142 RECIPIENT YOB NOT EQUAL TO FILE
- 00144 RECIPIENT SEX NOT EQUAL TO FILE
- 00162 RECIPIENT INELIGIBLE ON DATE OF SERVICE
- 00805 MEDICARE CO-INS / LTR DAYS PRESENT-TOTAL MDCR DAYS BLANK
- 00806 CO-INSURANCE AND LTR DAYS GREATER THAN PART-A DAYS
- 00848 THIRD PARTY DAYS NOT EQUAL TO BILLING PERIOD

Appendix A – Edit Information and Explanations

Providers who perform reconciliation of pended or denied claims should visit the Edit/Error Knowledge Base located on www.emedny.org to find explanations for denied or pended claims. This document provides valuable detailed information about what corrective action may be needed to resolve unpaid claims.

If you wish to research denied/pended claims by eMedNY Edit number, please follow the procedures below.

If you are receiving a paper remittance, the eMedNY Edit Number is reported in the last column of the remittance statement (titled ERRORS) where the denied and pended claims are detailed. At the end of each paper remittance, the edits that claims have failed for any given remittance are listed in numeric order along with a description of the reason.

If a provider needs more detailed information about the reason for denial or pending of a claim, visit the Edit/Error Knowledge Base for potential causes and detailed solutions for each eMedNY edit. The Edit/Error Knowledge Base is available at www.emedny.org by clicking on the link to the web page below:

[Edit / Error Knowledge Base](#)

If you wish to research denied/pended claims by HIPAA Claim Adjustment Reason Code and Remittance Advice Remark Code, please follow the procedures below.

If you are receiving an electronic remittance, the HIPAA remittance advice provides Claim Adjustment Reason Codes and the Remittance Advice Remark Codes to explain claim denials. (Please see the eMedNY Companion Guides for the 835 or 820 remittances located at www.emedny.org for the placement of these codes within the remittance file.)

If a provider is seeking further explanation about the reason for denial or pending of a claim, visit the Edit Mapping Crosswalk located at www.emedny.org by clicking on the link to the web page below. This crosswalk will assist a provider to determine the eMedNY edit for any given HIPAA adjustment reason code and remittance advice remark code combination.

[eMedNY Crosswalk](#)

Once you have determined the eMedNY edit number, more detailed information about the reason for denial or pending of a claim can be found in the Edit/Error Knowledge Base. The Edit/Error Knowledge Base is available on www.emedny.org by clicking on the link to the web page below:

[Edit / Error Knowledge Base](#)

Below are direct links to the explanations on the Edit/Error Knowledge Base for some of the most common inpatient edits:

[Edit 00782 For acute DRG claims the discharge date must be after the end date of service](#)

[Edit 00784 Subsequent DRG Bills Must Be After The Threshold Date](#)

[Edit 00785 Alternate Level care \(ALC\) Claims Require an ALC Date](#)

[Edit 00789 Statement From date Not Equal to Admission date for DRG Claim](#)

[Edit 00790 Days Less Than Threshold in Inlier period and patient Discharged In Outlier Period](#)

[Edit 00791 DRG Equals 470- Grouper Was Unable To Determine A Valid DRG](#)

[Edit 00793 Part A Days With Medicaid Days Not Allowed One DRG Claims](#)

[Edit 00795 Claim Does Not Qualify As A Cost Outlier](#)

[Edit 00808 Patient Has Already Met Medicare Deductible- Review Medicare Data](#)

[Edit 00843 Calculated Payment Amount less than Zero](#)

[Edit 00847 Billing For Deductible But No Medicare Days Present](#)

[Edit 00848 Total Third Party Covered and Noncovered Days must equal Total Days in the Billing Period](#)

[Edit 00850 Medicare-A Co-Insurance Amount Present/Co-Insurance Days Missing](#)

Appendix B – Sterilization Consent Form – DSS-3134

A Sterilization Consent Form, DSS-3134, must be completed for each sterilization procedure. **No other form can be used in place of the DSS-3134.** A supply of these forms, available in English and in Spanish [DSS-3134(S)], can be obtained from the New York State Department of Health's website by clicking on the link to the web page below:

[Local Districts Social Service Forms](#)

For electronic claim submissions, the completed and signed DSS-3134 [or DSS-3134(S)] must be kept in the patient's file. If upon audit and examination, it is found that the consent form is not present or is defective, the Department will recoup any and all payments associated with the sterilization procedure.

When completing the DSS-3134, please follow the guidelines below:

- Be certain that the form is completed so it can be read easily. An illegible or altered form is unacceptable. Also, the persons completing the form should check to see that all five copies are legible.
- Each required field or blank must be completed in order to ensure payment.
- If a woman is not currently Medicaid eligible at the time she signs the DSS-3134 [or 3134(S)] form but becomes eligible prior to the procedure and if she is 21 years of age when the form was signed, the 30 day waiting period starts from the date the DSS form was signed regardless of the date the woman becomes Medicaid eligible.

A sample Sterilization Consent Form and step-by-step instructions follow on the next pages.

Field-by-Field Instructions for Completing the Sterilization Consent Form – DSS-3134 and 3134(S)

Patient Identification

Field 1

Enter the patient's name, Medicaid ID number, and chart number; name of hospital or clinic is optional.

Consent To Sterilization

Field 2

Enter the name of the individual or clinic obtaining consent. If the sterilization is to be performed in New York City, the physician who performs the sterilization (24) cannot obtain the consent.

Field 3

Enter the name of sterilization procedure to be performed.

Field 4

Enter the patient's date of birth. Check to see that the patient is at least 21 years old. If the patient is not 21 on the date consent is given (9), Medicaid will not pay for the sterilization.

Field 5

Enter the patient's name.

Field 6

Enter the name of doctor who will probably perform the sterilization. It is understood that this might not be the doctor who eventually performs the sterilization (24).

Field 7

Enter the name of sterilization procedure.

Field 8

The patient must sign the form.

Field 9

Enter the date of patient's signature. This is the date on which the consent was obtained. The sterilization procedure must be performed no less than 30 days nor more than 180 days from this date, except in instances of premature delivery (20, 21), or emergency abdominal surgery (22, 23) when at least 72 hours (three days) must have elapsed.

Field 10

Completion of the race and ethnicity designation is optional.

Interpreter's Statement

Field 11

If the person to be sterilized does not understand the language of the consent form, the services of an interpreter will be required. Enter the language employed.

Field 12

The interpreter must sign and date the form.

Statement of Person Obtaining Consent

Field 13

Enter the patient's name.

Field 14

Enter the name of the sterilization operation.

Field 15

The person who obtained consent from the patient must sign and date the form. If the sterilization is to be performed in New York City, this person cannot be the operating physician (24).

Field 16

Enter the name and address of the facility with which the person who obtained the consent is associated. This may be a clinic, hospital, Midwife's, or physician's office.

Physician's Statement

The physician should complete and date this form after the sterilization procedure is performed.

Field 17

Enter the patient's name.

Field 18

Enter the date the sterilization procedure was performed.

Field 19

Enter the name of the sterilization procedure.

Instructions for Use of Alternative Final Paragraphs

If the sterilization was performed at least 30 days from the date of consent (9), then cross out the second paragraph and sign (24) and date (25) the consent form.

If less than 30 days but more than 72 hours has elapsed from the date of consent as a consequence of either premature delivery or emergency abdominal surgery, proceed as follows:

Field 20

If the sterilization was scheduled to be performed in conjunction with delivery but the delivery was premature, occurring within the 30-day waiting period, check box one and (21) enter the expected date of delivery.

Field 21

If the patient was scheduled to be sterilized but within the 30-day waiting period required emergency abdominal surgery and the sterilization was performed at that time, then check box two and (23) describe the circumstances.

Field 24

The physician who performed the sterilization must sign and date the form.

Field 25

The date of the physician's signature should indicate that the physician's statement was signed after the procedure was performed, that is, on the day of or a day subsequent to the sterilization.

For Sterilizations Performed In New York City

New York City local law requires the presence of a witness chosen by the patient when the patient consents to sterilization. In addition, upon admission for sterilization, in New York City, the patient is required to review his/her decision to be sterilized and to reaffirm that decision in writing.

Witness Certification

Field 26

Enter the name of the witness to the consent to sterilization.

Field 27

Enter the date the witness observed the consent to sterilization. This date will be the same date of consent to sterilization (9).

Field 28

Enter the patient's name.

Field 29

The witness must sign the form.

Field 30

Enter the title, if any, of the witness.

Field 31

Enter the date of witness's signature.

Reaffirmation

Field 32

The patient must sign the form.

Field 33

Enter the date of the patient's signature. This date should be shortly prior to or same as date of sterilization in field 18.

Field 34

The witness must sign the form for reaffirmation. This witness need not be the same person whose signature appears in field 29.

Field 35

Enter the date of witness's signature.

Appendix C – Acknowledgment of Receipt of Hysterectomy Information Form – DSS-3113

An Acknowledgment of Receipt of Hysterectomy Information Form, DSS-3113, must be completed for each hysterectomy procedure. **No other form can be used in place of the DSS-3113.** A supply of these forms, available in English and in Spanish, can be obtained from the New York State Department of Health's website by clicking on the link to the web page below:

[Local Districts Social Service Forms](#)

For electronic claim submissions, the completed and signed DSS-3113 must be kept in the patient's file. If upon audit and examination, it is found that the acknowledgment of hysterectomy form is not present or is defective, the Department will recoup any and all payments associated with the hysterectomy procedure.

When completing the DSS-3113, please follow the guidelines below:

- Be certain that the form is completed so it can be read easily. An illegible or altered form is unacceptable.
- Each required field or blank must be completed in order to ensure payment.

A sample Hysterectomy Consent Form and step-by-step instructions follow on the next pages.

Inpatient Hospital Billing Guidelines: Appendix C

DSS-3113 (Rev. 4/84)

**ACKNOWLEDGEMENT OF RECEIPT OF HYSTERECTOMY INFORMATION
(NYS MEDICAID PROGRAM)**

1. RECIPIENT ID NO.	2. SURGEON'S NAME

EITHER PART I OR PART II MUST BE COMPLETED

Part I: RECIPIENT'S ACKNOWLEDGEMENT STATEMENT AND SURGEON'S CERTIFICATION

RECIPIENT'S ACKNOWLEDGEMENT STATEMENT

It has been explained to me, 3. _____, that the hysterectomy to be performed on me will
(RECIPIENT NAME)
make it impossible for me to become pregnant or bear children. I understand that a hysterectomy is a permanent operation. The reason for performing the hysterectomy and the discomforts, risks and benefits associated with the hysterectomy have been explained to me, and all my questions have been answered to my satisfaction prior to the surgery.

4. RECIPIENT OR REPRESENTATIVE SIGNATURE	5. DATE	6. INTERPRETER'S SIGNATURE (If required)	7. DATE
X		X	

SURGEON'S CERTIFICATION

The hysterectomy to be performed for the above mentioned recipient is solely for medical indications. The hysterectomy is not primarily or secondarily for family planning reasons, that is, for rendering the recipient permanently incapable of reproducing.

8. SURGEON'S SIGNATURE	9. DATE
X	

Part II: WAIVER OF ACKNOWLEDGEMENT AND SURGEON'S CERTIFICATION

The hysterectomy performed on 10. _____ was solely for medical reasons. The
(RECIPIENT NAME)
hysterectomy was not primarily or secondarily for family planning reasons, that is, for rendering the recipient permanently incapable of reproducing. I did not obtain Acknowledgement of Receipt of Hysterectomy information from her and have her complete Part I of this form because (please check the appropriate statement and describe the circumstances where indicated):

- | |
|----|
| 11 |
|----|

1. She was sterile prior to the hysterectomy.
(briefly describe the cause of sterility) _____

- | |
|----|
| 12 |
|----|

2. The hysterectomy was performed in a life threatening emergency in which prior acknowledgement was not possible. (briefly describe the nature of the emergency)

- | |
|----|
| 13 |
|----|

3. She was not a Medicaid recipient at the time the hysterectomy was performed but I did inform her prior to surgery that the procedure would make her permanently incapable of reproducing.

14. SURGEON'S SIGNATURE	15. DATE
X	

DISTRIBUTION: File patient's medical record; hospital submit with claim for payment; surgeon and anesthesiologist submit with claims for payment; patient

***Field-by-Field Instructions for Completing Acknowledgement
Receipt of Hysterectomy Information Form – DSS-3113***

Either Part I or Part II must be completed, depending on the circumstances of the operation. In all cases, Fields 1 and 2 must be completed.

Field 1

Enter the recipient's Medicaid ID number.

Field 2

Enter the surgeon's name.

Part I: Recipient's Acknowledgement Statement and Surgeon's Certification

This part must be signed and dated by the recipient or her representative unless one of the following situations exists:

- The recipient was sterile prior to performance of the hysterectomy;
- The hysterectomy was performed in a life-threatening emergency in which prior acknowledgment was not possible; or
- The patient was not a Medicaid recipient on the day the hysterectomy was performed.

Field 3

Enter the recipient's name.

Field 4

The recipient or her representative must sign the form.

Field 5

Enter the date of signature.

Field 6

If applicable, the interpreter must sign the form.

Field 7

If applicable, enter the date of interpreter's signature.

Field 8

The surgeon who performed or will perform the hysterectomy must sign the form to certify that the procedure was for medical necessity and not primarily for family planning purposes.

Field 9

Enter the date of the surgeon's signature.

Part II: Waiver of Acknowledgment

The surgeon who performs the hysterectomy must complete this Part of the claim form if Part I, the recipient's Acknowledgment Statement, has not been completed for one of the reasons noted above. This part need not be completed before the hysterectomy is performed.

Field 10

Enter the recipient's name.

Field 11

If the recipient's acknowledgment was **not** obtained because she was sterile prior to performance of the hysterectomy, check this box and briefly describe the cause of sterility, e.g., postmenopausal. This waiver may apply to cases in which the woman was not a Medicaid recipient at the time the hysterectomy was performed.

Field 12

If the recipient's Acknowledgment was **not** obtained because the hysterectomy was performed in a life-threatening emergency in which prior acknowledgment was not possible, check this box and briefly describe the nature of the emergency. This waiver may apply to cases in which the woman was not a Medicaid recipient at the time the hysterectomy was performed.

Field 13

If the patient's Acknowledgment was **not** obtained because she was not a Medicaid recipient at the time a hysterectomy was performed, but the performing surgeon did inform her before the procedure that the hysterectomy would make her permanently incapable of reproducing, check this box.

Field 14

The surgeon who performed the hysterectomy must sign the form to certify that the procedure was for medical necessity and not primarily or secondarily for family planning purposes and that one of the conditions indicated in Fields 11, 12, and 13 existed.

Field 15

Enter the date of the surgeon's signature.

Appendix D – Inpatient Glossary of Terms

Adjustment/Replacement	An adjustment transaction is submitted to replace a previously paid claim.
Admission Day Claim	Admission Day claims are submitted to receive some form of payment in lieu of the DRG payment, which cannot be made until the patient is discharged. Admission Day claims must be adjusted as a DRG claim within 90 days of the payment.
Admission Type	Indicates the type of admission, e. g. emergency, urgent, elective, and newborn.
ALC	ALC – Alternate Level of Care (not acute care level).
All Patient Refined Diagnosis Related Groups (APR DRG)	A code assigned to a claim based on diagnosis, procedures and other claim information.
Capital Add-on	A set rate amount added to payment of DRG inlier claims for capital expenses. The amount is added after the calculation of the DRG payment.
CAS	Claim Adjustment Segment of an electronic HIPAA claim where other payer payment information is reported.
Co Payment (Medicaid)	Amount due from the patient that is automatically deducted from the claim.
Co Insurance Days	Medicare covered days at a Co-insurance rate.
Companion Guide	A document that provides detailed instructions for submitting HIPAA-compliant transactions to NY Medicaid. Companion Guides are located at www.emedny.org , select NYHIPAADESK, then select Companion Guides and Sample Files.
Condition Code	Code used to identify conditions relating to a claim. Medicaid uses conditions codes to report day outliers, cost outliers, family planning, abortion/sterilization codes and co-pay exemption.
Cost Outlier	Cost outlier claims can occur when the cost of the hospital stay is much higher than the normal DRG payment would reimburse.
Cost Per Discharge	The base rate used in the calculation of a DRG claim.
Day Outlier	Days that are beyond the high trim point for the assigned DRG.

Inpatient Hospital Billing Guidelines: Appendix D

Delay Reason Code/90 Day Indicator	A code that defines one of the valid reasons for submitting a claim after 90 days from the discharge date (DRG claims) or the through date of service (per diem claims).
DRG	Diagnosis Related Group – A code assigned to a claim based on diagnosis, procedures and other claim information.
Edit (Edit Number)	A NYS Medicaid reason for a claim to be denied and/or pended. The associated Edit number and reason are detailed on a provider’s paper remittance statement.
ePACES	electronic Provider Assisted Claim Entry System - A web-based application that allows enrolled providers to submit and receive electronic claims, claim status request and responses and eligibility requests and responses.
GME	Graduate Medical Expense - Payments made to cover the GME expenses related to an Inpatient stay on behalf of a Medicaid recipient enrolled in a Medicaid Managed Care plan on the Date of Admission.
Groupier	System used to assign a DRG code based on diagnosis, procedure and other claim information.
High Trim Point	Same as threshold. Maximum number of days a patient is expected to be hospitalized for the assigned DRG.
HIPAA 835 Transaction	The name given to the format of a HIPAA-compliant electronic remittance statement.
HIPAA 837 Institutional	The name given to the accepted format for HIPAA-compliant electronic claim submissions for institutional services.
Inlier	Days less than the high trim point for the assigned DRG.
IPRO	IPRO - Island Peer Review Organization is the State's Medicaid Utilization review agent.
Low Trim Point	Minimum number of days a patient is expected to be hospitalized for the assigned DRG.
LTR Days	Medicare covered days at a Life Time Reserved rate.
Non-DRG	Claim processed as a per diem claim.
NYHIPAADESK	Section of the eMedNY website that contains information related to electronic transactions for NYS Medicaid.

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Occurrence Codes	Code defining a significant event relating to a claim. Submitted on DRG claims to indicate alternate level of care portions of the hospital stay.
Occurrence Span	Dates of a significant event relating to a claim. Submitted on DRG claims to indicate dates (from – through) for alternate level of care portions of the hospital stay.
Off Line Payment	Special claims payment processing that occurs outside of systems claims processing.
Outlier	Days after the high trim point for the assigned DRG.
Pass Days	Claims where the patient was admitted to the same hospital twice for the same diagnosis and the admission date of the second stay was close to the discharge date of the first stay.
Patient Control Number	Number assigned by a provider to track and reconcile adjudicated claims.
Patient Status	Status of the patient as of the through date of service on a claim.
Per Diem	A claim paid at a single daily rate amount.
Rate Code	Assigned by OHIP to facilitate correct payment of claims.
Revenue Code	Code that identifies a specific accommodation, ancillary service or billing calculation. Required for inpatient claims. Consult the UB-92 manual or its successor UB-04 for an appropriate code. Consult the 837 Institutional Supplemental Guide at www.emedny.org for Medicaid business rules.
Service Intensity Weight	A weighting factor assigned to each DRG. Used in the payment calculation.
Severity of Illness Code	Severity of Illness Code is used to determine the APR-DRG weight. Each APR DRG has a weight for each severity level subclass (1-4).
Short Stay	A hospital stay that is less number of days for the minimum (low trim point) for the assigned DRG.
Spend Down	A monthly amount a patient must contribute to his/her medical expenses to be qualified as Medicaid eligible.
Stay Denied Date	Date on which hospital peer review deems the hospital stay as not acute.
Surplus	An amount a patient must contribute toward the hospital bill.
Swing Bed	A hospital bed that can be billed as acute care or at a nursing home level if approved by DOH.

Inpatient Hospital Billing Guidelines: Appendix D

Third Party	A Payer other than Medicare and Medicaid.
Threshold	Same as high trim point. The threshold is the number of days a patient is expected to be hospitalized based on the DRG code assigned.
Type of Bill	A code describing the type of facility where services were rendered.
Value Code	A Value Code is a qualifier submitted on a claim to define data that follows in the billing record such as a rate code.
Void	A Void is submitted to negate a previously paid claim.