New York State
UB-04 Billing Guidelines

HOME AND COMMUNITY BASED SERVICES (HCBS) WAIVER

Version 2011 - 01

6/1/2011

eMedNY is the name of the electronic New York State Medicaid system. The eMedNY system allows New York Medicaid providers to submit claims and receive payments for Medicaid-covered services provided to eligible members.

eMedNY offers several innovative technical and architectural features, facilitating the adjudication and payment of claims and providing extensive support and convenience for its users.

The information contained within this document was created in concert by DOH and eMedNY. More information about eMedNY can be found at www.emedny.org.

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***For eMedNY Billing Guideline questions, please contact the eMedNY Call Center** 1-800-343-9000.*

1. Purpose Statement

The purpose of this document is to augment the General Billing Guidelines for institutional claims with the NYS Medicaid specific requirements and expectations for the Home and Community Based Services (HCBS) Waiver.

For providers new to NYS Medicaid, it is required to read the General Institutional Billing Guidelines available at www.emedny.org or by clicking: General Institutional Billing Guidelines.

2. Claims Submission

HCBS Waiver providers can submit their claims to NYS Medicaid in electronic or paper formats.

2.1 Electronic Claims

HCBS Waiver providers who choose to submit their Medicaid claims electronically are required to use the HIPAA 837 Institutional (837I) transaction.

2.2 Paper Claims

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

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

2.3 HCBS Waiver Services Billing Instructions

This subsection of the Billing Guidelines covers the specific NYS Medicaid billing requirements for HCBS Waiver providers. Although the instructions that follow are based on the UB-04 paper claim form, they are also intended as a guideline for electronic billers to find out what information they need to provide in their claims. For further electronic claim submission information, refer to the eMedNY 5010 Companion Guide which is available at www.emedny.org by clicking: eMedNY Transaction Information Standard Companion Guide CAQH - CORE CG X12.

It is important that providers adhere to the instructions outlined below. Claims that do not conform to the eMedNY requirements as described throughout this document may be rejected, pended, or denied.

2.3.1 UB-04 Claim Form Field Instructions

Statement Covers Period From/Through (Form Locator 6)

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

- ***When billing for monthly rates***, only ***one*** date of service can be billed per claim form. Enter the date in the FROM box. The THROUGH box may contain the same date or may be left blank.

Dates must be entered in the format MMDDYYYY.

NOTE: Claims must be submitted within 90 days of the date of service entered in this field unless acceptable circumstances for the delay can be documented. Information about billing claims over 90 days or two years from the Date of Service is available in the All Providers General Billing Guideline Information section available at www.emedny.org by clicking: General Billing.

Date of Service Rules

For ***Community Residence Habilitation*** monthly and semi-monthly rate codes, the date of service should be as follows:

- Monthly (Full month) = 21 Days in residence with 4 services delivered

  The date of service must be the first day of the month subsequent to the month in which the services were rendered.

- Semi-Monthly (1st half) = 11 Days in residence with 2 services delivered

  The patient must be admitted prior to the 11th day of the month. The date of service is the first day of the subsequent month.

- Semi-Monthly (2nd half) = 11 Days in residence with 2 services delivered

  The patient must be admitted on or after the 11th day of the month. The date of service is the 2nd day of the subsequent month.

For ***Waiver Case Management***, enter the first day of the month subsequent to the month in which services were rendered unless the patient loses Medicaid eligibility during the service month. If the patient loses eligibility before the first of the month subsequent to the service month, the last date of medical coverage should be entered as service date.

3. Remittance Advice

The Remittance Advice is an electronic, PDF or paper statement issued by eMedNY that contains the status of claim transactions processed by eMedNY during a specific reporting period. Statements contain the following information:

- A listing of all claims (identified by several items of information submitted on the claim) that have entered the computerized processing system during the corresponding cycle
- The status of each claim (denied, paid or pended) after processing
- The eMedNY edits (errors) that resulted in a claim denied or pended
- Subtotals and grand totals of claims and dollar amounts
- Other pertinent financial information such as recoupment, negative balances, etc.

The General Remittance Advice Guidelines contains information on selecting a remittance advice format, remittance sort options, and descriptions of the paper Remittance Advice layout. This document is available at www.emedny.org by clicking: General Remittance Billing Guidelines.

APPENDIX A
CLAIM SAMPLES

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

Home and Community Based Services - UB-04 Sample Claim

APPROVED OMB NO. 0938-0279

1 City Home Care 111 Main Street Anytown, NY 11111		3a PAT. CNTL# AB1234567 b. MED. REC.#	4. TYPE OF BILL 340
		5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM 04012007 THROUGH

8 PATIENT NAME: SMITH, WILLIAM

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

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

38

	39 CODE	39 VALUE CODES AMOUNT	40 CODE	40 VALUE CODES AMOUNT	41 CODE	41 VALUE CODES AMOUNT
a	61	003.	24	4413.	A3	00.00
b		.		.		.
c		.		.		.
d		.		.		.

	42 REV CD	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	0001					80.00	.	
2						.	.	
3						.	.	
4						.	.	
5						.	.	
6						.	.	
7						.	.	
8						.	.	
9						.	.	
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11						.	.	
12						.	.	
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14						.	.	
15						.	.	
16						.	.	
17						.	.	
18						.	.	
19						.	.	
20						.	.	
21						.	.	
22						.	.	
23		PAGE ___ OF ___ CREATION DATE			TOTALS	.	.	

	50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	
A	Blue Cross				.	.	57 OTHER PRV ID	None
B	Medicaid				.	.		00123455
C					.	.		

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

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

66 DX		A	B	C	D	E	F	G	H	69
	318.0									
	I	J	K	L	M	N	O	P	Q	

69 ADMIT DX		70 PATIENT REASON DX	a	b	c	71 PPS CODE		72 ECI	a	b	c	73

74 PRINCIPAL PROCEDURE CODE	DATE	a OTHER PROCEDURE CODE	DATE	b OTHER PROCEDURE CODE	DATE	75
c OTHER PROCEDURE CODE	DATE	d OTHER PROCEDURE CODE	DATE	e OTHER PROCEDURE CODE	DATE	

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

80 REMARKS

81 CC			
a			
b			
c			
d			

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