



New York State UB04 Billing Guidelines

RESIDENTIAL HEALTH CARE



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 Residential Healthcare services.

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

Residential Health Care providers can submit their claims to NYS Medicaid in electronic or paper formats.

2.1 Electronic Claims

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

2.2 Paper Claims

Residential Health Care 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 Residential Health Care UB-04 claim form, see Appendix A. The displayed claim form is a sample and is for illustration purposes only.

2.3 Residential Health Care Services Billing Instructions

This subsection of the Billing Guidelines covers the specific NYS Medicaid billing requirements for Residential Health Care 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, pending, or denied.

2.3.1 UB-04 Claim Form Field Instructions

Statement Covers Period From/Through (Form Locator 6)

- *When billing for one date of service*, enter the same date in the FROM and THROUGH boxes or leave the THROUGH box blank.
- *When billing for multiple dates of service*, enter the first service date of the billing period in the FROM box and the last service date in the THROUGH box. The first and last service dates must be in the same calendar month.

Dates must be entered in the format MMDDYYYY.

Non-Occupant Care

In order to properly identify each date of service, the **FROM** and **THROUGH** dates must be inclusive. All services included in the **FROM** and **THROUGH** fields must indicate the same number of hours and must be for consecutive days within the same month.

If services rendered do not have a consistent number of hours scheduled for any given period, then each service day must be billed separately.

NOTES:

- *Claims must be submitted within 90 days of the date of service entered in this field unless acceptable circumstances for the delay can be documented. Information about billing claims over 90 days or two years from the Date of Service is available in the All Providers General Billing Guideline Information section available at www.emedny.org by clicking on the link to the webpage as follows: [General Billing](#).*
- *Do not include full days covered by Medicare or other third-party insurers as part of the period of service.*
- *A separate claim must be completed if the period of service includes therapeutic or hospital leave days.*

Value Codes (Form Locators 39–41)

837I Ref: Loop 2300 HI0x-2

Locator Code - Value Code 61

For electronic claims, leave this field blank.

For paper claims, enter the locator code assigned by NYS Medicaid.

Value Code

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

Value Amount

Entry must be three digits and must be placed to the left of the dollars/cents delimiter. Enter the locator code that corresponds to the address where the service was performed.

Recurring Monthly Income - Value Code 23

Value Code

Code **23** should be used to indicate that the member's Net Available Monthly Income (NAMI) amount is entered under Amount.

Value Amount

Enter the NAMI amount approved by the local Social Services agency as the member's monthly budget.

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In cases where the member's budget has increased, the new amount, rather than the current budgeted amount, should be entered.

If billing occurs more than once a month, enter the full NAMI amount on the first claim submitted for the month.

Note: For retroactive NAMI changes, an adjustment to the previously paid claim needs to be submitted. These adjustments can only be submitted when approval for a budget change has been received from the LDSS.

Rate Code - Value Code 24

The following are special Rate Code rules for Residential Health Centers. All other value codes are to be used as described in the General Institutional Billing Guidelines available at www.emedny.org by clicking: [General Institutional Billing Guidelines](#).

Select the appropriate Rate Code according to the following list:

- Free-Standing Nursing Facilities
 - Use Code 3810 when billing for Medicaid patients who either don't have Medicare coverage or have only Medicare Part A coverage.
 - Use Code 3812 when billing for patients who either have Medicare Part A and B coverage or have only Medicare Part B coverage.
 - Use code 3838 when billing for patients who have only Medicare Part D coverage.
 - Use code 3839 when billing for patients who have Medicare Part B and Part D coverage.
- Hospital-Based Nursing Facilities
 - Use Rate Code 2863 when billing for Medicaid patients who either don't have Medicare coverage or have only Part A coverage.
 - Use Rate Code 2862 when billing for patients who either have Medicare Part A and B coverage or have only Medicare Part B coverage.
 - Use code 3838 when billing for patients who have only Medicare Part D coverage.
 - Use code 3839 when billing for patients who have Medicare Part B and Part D coverage.

NOTES:

- *The Medicare coverage information should be obtained from the eMedNY Eligibility Verification System (MEVS).*
- *Claims for bed reservations may be billed to the higher non-Medicare Part B rate.*
- Free-Standing Day Care Services
 - Use Rate Code 3800.
- Hospital-Based Day Care Services
 - Use Rate Code 3800.

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Other Insurance Payment – Value Code A1 - A3 or B1 - B3

If the member has insurance other than Medicaid, it is the responsibility of the provider to determine whether the service being billed is covered by the member's Other Insurance carrier. If the service is covered or if the provider does not know if the service is covered, the claim must first be submitted to the Other Insurance carrier. *Medicaid is always the payer of last resort.*

Value Code

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

- Deductible - *A1 or B1*
- Co-insurance - *A2 or B2*
- Co-payment - *A7 or B7*
- Paid - *A3 or B3*

NOTE: These codes are used in conjunction with the value reported in Form Locator 50. These Value Codes are considered as Medicare related only when Line A or B = Medicare. Codes that begin with an A are used when Medicare is primary. Codes that begin with a B are used when Medicare is secondary to another payer.

These value codes are not applicable to electronic submissions.

Value Amount

Enter the corresponding amount for each value code entered.

Enter the amount the other insurance actually paid for the service. If the other insurance denied payment or if the provider knows that the service would not be covered by the other insurance, enter 0.00. Proof of denial of payment must be maintained in the member's billing record.

Medicaid Covered Days – Value Code 80

Value Code

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

Value Amount

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

Note: The sum of Medicaid Full covered days, Medicaid non-covered days and Medicare co-insurance days must correspond to the Statement Covers Period in Form Locator 6 and should not reflect the day of discharge.

Medicaid Non-Covered Days – Value Code 81

Value Code

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

Value Amount

Enter the actual number of Medicaid non-covered days to the left of the dollars/cents delimiter.

NOTE: The sum of Medicaid Full covered days, Medicaid non-covered days and Medicare co-insurance days must correspond to the Statement Covers Period in Form Locator 6 and should not reflect the day of discharge.

Medicare Co-Insurance Days – Value Code 82

Value Code

Code 82 should be used to indicate the total number of Medicare co-insurance days claimed during the service period.

Value Amount

Enter the actual number of Medicare co-insurance days to the left of the dollars/cents delimiter.

NOTE: The sum of Medicaid Full covered days, Medicaid non-covered days and Medicare co-insurance days must correspond to the Statement Covers Period in Form Locator 6 and should not reflect the day of discharge.

Patient Paid Amount - Value Code FC

Value Code

Code **FC** should be used to indicate the amount the member has paid toward the claim.

Value Amount

Enter the Patient Paid Amount.

Revenue Code (Form Locator 42)

837I Ref: Loop 2400 SV201

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

NYS Medicaid uses Revenue Codes to identify the following information:

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

Total Charges

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

Hospital Leave

The patient was hospitalized during the billing period and bed retention was involved. If bed retention for hospitalization was not involved, hospital leave is not applicable. For Bed Reservation information, please refer to the Residential Health Care Manual, available at www.emedny.org by clicking on the link as follows: [Policy Guidelines](#).

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

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

Therapeutic Leave

These are overnight absences that include leave for personal reasons or to participate in medically acceptable therapeutic or rehabilitative plans of care. Please refer to the Residential Health Care Manual, Policy Guidelines section for Bed Reservation information.

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

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

Therapeutic Leave When Authorized by Medical Professional

These are overnight absences that include leave to participate in medically acceptable therapeutic or rehabilitative plans of care. Please refer to the Residential Health Care Manual, Policy Guidelines section for Bed Reservation information.

If applicable, use Revenue Code **0189** to indicate that the number of Therapeutic Leave days is entered in Form Locator 46.

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

Therapeutic Leave days when reported as revenue code 0189 are included in the maximum number of days allowed as Hospital Leave days.

Serv. Units (Form Locator 46)

837I Ref: Loop2400 SV205

If Revenue Code 0185 (Hospital Leave) was used in Form Locator 42, enter the total number of Hospital Leave days on the same line where the Revenue Code appears. The number of units entered in this field must match the entry in Form Locators 39 – 41, Value Code 80, “Covered Days”.

If Revenue Code 0183 (Therapeutic Leave) was used in Form Locator 42, enter the total number of Therapeutic Leave days on the same line where the Revenue Code appears. The number of units entered in this field must match the entry in Form Locators 39 – 41, Value Code 80, “Covered Days”.

Other (Form Locator 78)

837I Ref: Loop 2310F NM1

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

Complete this field only if an admission or a discharge (other than to home or self care) occurred during the service period covered by this statement (Form Locator 6).

For an admission

Enter the NPI of the practitioner who determined that residential care was appropriate.

For a discharge

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

Instructions for entering an NPI

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

On the line below the ID numbers, enter the last name and first name of the provider. See the example in Exhibit 2.4.2-14.

Exhibit 2.4.3-1

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

78 OTHER	DN	NPI 1234567890	QUAL		
LAST SMITH			FIRST JOHN		

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.

Residential Health - UB-04 Sample Claim										APPROVED OMB NO. 0938-0279	
1 Anytown Residence		2		3a PAT CNTL#		AB1234567		4 TYPE OF BILL		250	
1 Maple Avenue		b MED. REC#		5 FED. TAX NO.		6 STATEMENT COVERS PERIOD		7			
Anytown, NY 11111						FROM 04012007		THROUGH 04302007			
8 PATIENT NAME				9 PATIENT ADDRESS							
SMITH, WILLIAM											
10 BIRTH DATE		11 SEX		12 DATE		13 HR		14 TYPE		15 SRC	
04191948		M									
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APPENDIX B MODIFICATION TRACKING

Version 2011 - 02 12/23/2011

Value Codes (Form Locators 39–41)

- Added “Note: For retroactive NAMI changes, an adjustment to the previously paid claim needs to be submitted. These adjustments can only be submitted when approval for a budget change has been received from the LDSS.”

Version 2013 - 01 2/11/2013

Revenue Code (Form Locator 42)

- Added new section for Therapeutic Leave When Authorized by Medical Professional.