NEW YORK STATE
MEDICAID PROGRAM

INFORMATION FOR ALL PROVIDERS

INTRODUCTION

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Preface

The purpose of this Manual is the provision of information and guidance to those providers who participate in the New York State Medicaid Program. It is designed to provide instructions for the understanding and completion of forms and documents relating to billing procedures and to serve as a reference for additional information that may be required.

Pertinent policy statements and requirements governing the Medicaid Program have been included. The Manual has been designed to easily incorporate changes since additions and periodic clarifications will be necessary. It should serve as a central reference for updated information.

Providers are responsible for familiarizing themselves with all Medicaid procedures and regulations currently in effect and as they are issued.

The Department of Health publishes a monthly newsletter, the *Medicaid Update*, which contains information regarding Medicaid programs, policy and billing. The *Update* is sent to all active enrolled providers.

New providers need to be familiar with the past issues of *Medicaid Update* to have current policy and procedures.

Past issues of *Medicaid Update* are available at:

http://www.health.state.ny.us/health_care/medicaid/program/update/main.htm.

Foreword

The New York State Department of Health (DOH) is the single State agency responsible for the administration of the New York Medicaid Program under Title XIX of the Social Security Act.

The primary purpose of the Medicaid Program is to make covered health and medical services available to eligible individuals. As the single State agency, DOH promulgates all necessary regulations and guidelines for Program administration, as well as develops professional standards for the Program, develops rates and fees for medical services, hospital utilization review and professional consultation to local department of social service officials for determining adequacy of medical services submitted for Medicaid reimbursement.

The Department is required to maintain a Medicaid State Plan that is consistent with provisions of Federal law and regulations. Administrative functions include development of Program policy, determination of recipient eligibility, ambulatory care utilization review, detection of possible fraud and abuse, and supervision of the Fiscal Agent and all its functions.

In order to carry out aspects of the professional administration of the Program, the DOH's Office of Medicaid Management (OMM) works in conjunction with other state agencies such as the Office of Mental Health (OMH), Office of Mental Retardation and Developmental Disabilities (OMRDD), Office of Alcohol and Substance Abuse Services (OASAS) and the State Education Department (SED) to ensure that the needs of the special populations that these agencies serve are addressed within the parameters of the Medicaid Program.

> Additionally, the DOH works with New York's local departments of social services to administer and fund the Medicaid Program.

The Director of the New York State Division of the Budget promulgates all fees and rates for the Medicaid Program (with the exception of those which by statute are set by OMH, OMRDD and OASAS).

Medicaid Management Information System

Chapter 639 of the Laws of the State of New York, 1976, mandated that a statewide Medicaid Management Information System (MMIS) be designed, developed and implemented.

New York State's MMIS, called eMedNY, is a computerized system for claims processing which also provides information upon which management decisions can be made. The New York State eMedNY design is based on the recognition that Medicaid processing can be highly automated and that provider relations and claims resolution require an interface with experienced program knowledgeable people.

> This approach results in great economies through automation, yet eliminates the frustration which providers frequently encounter in dealing with computerized systems.

DOH has contracted with Computer Sciences Corporation (CSC) to be the Medicaid fiscal agent.

CSC, in its role as Fiscal Agent, maintains a Medicaid claims processing system to meet New York State and Federal Medicaid requirements, and performs the following functions:

- Receives, reviews and pays claims submitted by the providers of health care for services rendered to eligible patients (recipients).

- Interacts with the providers through its Provider Services personnel in order to train providers in what the Medicaid requirements are and how to submit claims; responds to provider mail and telephone inquiries; maintains and issues forms, and notices, to providers.

- Maintains the Medicaid Eligibility Verification System (MEVS).

Key Features

eMedNY has several key features that enable the system to achieve its objectives.

- **Claims Payment**
  This aspect of eMedNY generates prompt payment of all approved claims and prepares a Remittance Statement with each payment cycle which lists the status of all paid, denied and pended claims.

- **Flexibility**
  For rate-based providers, the system has the flexibility to process individual claim lines submitted on a single claim separately. It will not deny payment of the entire

invoice if one line is pended or requires manual pricing.
For fee-for-service providers who utilize ePACES the system can process claims (with up to 4 claim lines) in "real-time". Real time means that the claims process through adjudication within seconds.

- **Manual Review**
  All paper claims are manually screened on the day of receipt prior to computer processing. Any omissions or obvious errors will result in the return of the claim form to the provider.

- **Inquiry Procedures**
  The Fiscal Agent handles written and telephone requests for information. Detailed procedures can be found in Information for All Providers, Inquiry.

- **Service Bureaus**
  The Fiscal Agent will cooperate with the provider's computer service bureau to ensure that the automated claim input meets eMedNY requirements.

- **Provider and Recipient Eligibility**
  The DOH is responsible for the determination of eligibility of providers in the New York Medicaid Program. Local departments of social services retain the responsibility for determining recipient eligibility.

- **Service Limitations and Exclusions**
  The DOH maintains the responsibility for determining covered services and exclusions in the Medicaid Program.

- **Continuing Communications**
  To ensure a flow of information from the State and Fiscal Agent to the providers, community bulletins, newsletters and updates are mailed periodically. Additionally, most information can be found online at:

  http://www.emedny.org/.

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GENERAL POLICY

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Section I – Enrollee Information

The New York State Department of Health (Department, DOH) exercises overall supervision of the Medicaid Program. Enrollee eligibility, however, is handled by the fifty-eight local departments of social services (LDSS) and the New York City Human Resources Administration (HRA).

Generally, the following groups are eligible for Medicaid in New York State:

- Citizens and certain qualified persons who are:

  - eligible for Low Income Families (families with children under age 21; persons under age 21 living alone; and pregnant women); or

  - in receipt of or eligible for Supplemental Security Income (individuals who are aged, certified blind or disabled); or

  - children on whose behalf foster care maintenance payments are being made or for whom an adoption assistance agreement is in effect under Title IV-E of the Social Security Act; or

  - individuals between the ages of 21 and 65 not living with a child under the age of 21, not certified blind or disabled, and not pregnant, whose income and resources are below the Public Assistance Standard of Need.

- Citizens and certain qualified persons who meet the financial and other eligibility requirements for the State's Medically Needy Program.

  These persons have income and resources above the cash assistance levels, but their income and resources are insufficient to meet medical needs.

  These groups generally include:

  - infants up to age one and pregnant women whose family income is at or below 185% of the federal poverty level;

  - children age one through five whose family income is at or below 133% of the federal poverty level;

  - other children with family income at or below 100% of the federal poverty level, including all children under age 19;

  - families with children under age 21 who do not have two parents in the household capable of working and providing support;

- persons related to the Supplemental Security Program (i.e., aged, certified blind or disabled);

- adults in two-parent households who are capable of working and providing support to their children under age 21;

- a special limited category of Medicaid eligibility is available for individuals who are entitled to the payment of Medicare deductibles and coinsurance, as appropriate, for Medicare-approved services. An individual eligible for this coverage is called a Qualified Medicare Enrollee (QMB).

  Any individual who is fully Medicaid-eligible and has Medicare coverage, even if not a QMB, is also entitled to have Medicare coinsurance and deductibles paid for by Medicaid. An individual may also have these benefits as a supplement to other Medicaid eligibility. QMB status is identified through the Medicaid Eligibility Verification System (MEVS).

Identification of Medicaid Eligibility

It is important to determine Medicaid eligibility for each medical visit since Medicaid eligibility is date specific. Each enrollee should have only one Common Benefit Identification Card (CBIC) or Temporary Medicaid Authorization paper document. If the enrollee presents a Temporary Medicaid Authorization paper document, there should be no obstacle to payment of the claim because of the enrollee's ineligibility for Medicaid, for medical services provided within the dates of coverage listed on the form.

The Temporary Medicaid Authorization is completed by the LDSS worker and includes the enrollee's:

- Name;
- Date of Birth;
- Social Security Number;
- Case Number;
- Caseworker's name and telephone number;
- Issuing County; and
- Type of Medicaid coverage authorized;
- Any restrictions that exist;
- Authorized dates of coverage.

It is recommended that the provider make a copy of the Temporary Medicaid Authorization and return the original to the enrollee, as he or she may have further medical needs during the authorization period.

The CBIC has the capability of being activated and authorized for several assistance programs at the same time. It is important for the provider to check the actual card through the MEVS system to assure there is current, active Medicaid coverage. This card may or may not have a photograph on it, as this is not a requirement for some enrollees because of their category or circumstances.

Sometimes, an enrollee may present the provider with more than one card for the same individual. This may occur when the enrollee has reported to the district that their card is lost and is then found after the LDSS issues a replacement card. In these cases, check each card for the sequence number, which is found to the right of the access number on the bottom of the front of the card. The highest sequence number is the most recently issued card, and is usually the one that is authorized with current benefits.

The permanent, plastic CBIC does not contain eligibility dates or other eligibility information. **Therefore, presentation of a CBIC alone is not sufficient proof that an enrollee is eligible for services. Each of the Benefit Cards must be used in conjunction with the MEVS process.** Through this process, the provider must be sure to verify if the enrollee has any special limitations or restrictions.

If the provider does not verify the eligibility and extent of coverage of each enrollee each time services are requested, then the provider will risk the possibility of non-reimbursement for services provided as **the State cannot compensate a provider for a service rendered to an ineligible person.** Eligibility information for the enrollee must be determined via the MEVS.

Eligible enrollees in voluntary child care agencies and residential health care facilities are issued Medicaid ID numbers which are maintained on a roster. A CBIC is usually not issued for these enrollees. If a card is required, a non-photo CBIC will be issued by the LDSS. It is the responsibility of the voluntary child care agency or the residential health care facility to give the enrollee's Medicaid ID number to other service providers; those providers must complete the verification process via MEVS to determine the enrollee's eligibility for Medicaid services and supplies.

The MEVS Provider Manual is available online at:

http://www.emedny.org/ProviderManuals/AllProviders/index.html.

Eligible Enrollees

Swiping the Medicaid card and/or reviewing the paper authorization and making no further comment to the Medicaid enrollee concerning payment for services, leads the enrollee to assume that you, as the provider, will accept Medicaid payment for the service about to be provided.

The Department supports this assumption and expects the provider to bill Medicaid, not the enrollee, for that service.

Ineligible Patients

If you swipe the plastic card and find that the individual is not eligible, then you must inform the patient.

A provider may charge a Medicaid enrollee for services only when both parties have agreed prior to the rendering of the service that the enrollee is being seen as a private pay patient; this must be a mutual and voluntary decision. It is suggested that the provider maintain the patient's signed consent to be treated as private pay in the patient's medical record.

Emergency Situations

In emergency situations where questions regarding health insurance are not normally asked, the Department expects you to accept the patient as a Medicaid enrollee; however, the enrollee is responsible for providing both the ambulance company and the hospital emergency room billing staff with a Medicaid number when it is requested at a later time.

If the enrollee is not cooperative in providing his or her Medicaid information after the transport or emergency room visit has occurred, then the patient may be billed as private pay. The Department does, however, expect that diligent efforts will be made to obtain the Medicaid information from the patient.

Services Available Under the Medicaid Program

Under the Medicaid Program, eligible individuals can obtain a wide variety of medical care and services. To acquaint providers with the scope of services available under this Program, the following list has been developed as a general reference.

Payment may be made for necessary:

- medical care provided by qualified physicians, nurses, optometrists, and other practitioners within the scope of their practice as defined by State Law;
- preventive, prophylactic and other routine dental care services and supplies provided by dentists and others professional dental personnel;
- inpatient care in hospitals, skilled nursing facilities, infirmaries, other eligible medical institutions (except that inpatient care is not covered for individuals from age 21 to 65 in institutions primarily or exclusively for the treatment of mental illness or tuberculosis), and health related care in intermediate care facilities;
- outpatient hospital and clinic services;
- home health care by approved home health agencies;
- personal care services prior authorized by the LDSS;
- physical therapy, speech pathology and occupational therapy;

- laboratory and X-ray services;
- family planning services;
- prescription drugs per the Commissioner's List, supplies and equipment, eyeglasses, and prosthetic or orthotic devices;
- early and periodic screening, diagnosis and treatment for individuals under 21;
- transportation when essential to obtain medical care;
- care and services furnished by qualified health care organizations or plans using the prepayment capitation principle;
- services of podiatrists in private practice only for persons in receipt of Medicare or under age 21 with written referral from a physician, physician's assistant, nurse practitioner or nurse midwife.

Providers must offer the same quality of service to Medicaid enrollee that they commonly extend to the general public and may not bill Medicaid for services that are available free-of-charge to the general public.

Qualified Medicare Beneficiary

The Medicaid Program permits payment toward Medicare deductibles and coinsurance, as appropriate, for certain Medicare Part B services provided to a select group of elderly and disabled Medicare enrollees with low income and very limited assets. These individuals are known as Qualified Medicare Beneficiaries (QMBs).

Not all Medicaid enrollees who have Medicare Part B coverage are QMBs.

Entitlement to QMB benefits must be confirmed by accessing the MEVS. It is crucial to note that the mere presentation of the enrollee's CBIC or other appropriate documentation is not sufficient to confirm an individual's entitlement to QMB services. A provider must confirm an individual's current QMB eligibility by accessing the MEVS prior to the provision of each service.

Free Choice

A person covered under Medicaid is free to choose from among qualified facilities, practitioners and other providers of services who participate in the Medicaid Program.

Enrollment in Medicaid does not mandate practitioners to render services to all Medicaid enrollees who request care. If a private payment arrangement is made with a Medicaid enrollee, the enrollee should be notified in advance of the practitioner's choice

not to accept Medicaid reimbursement. The Medicaid Program cannot be billed for services rendered under these circumstances.

Guidelines that govern reasonable application of "free choice" are:

- Appropriate resources of the local medical market area should first be utilized in order to avoid unnecessary transportation costs;

- Medical "shopping around" habits should be discouraged so that continuity of care may be maintained.

Right to Refuse Medical Care

Federal and State Laws and Regulations provide for Medicaid enrollees to reject any recommended medical procedure of health care or services and prohibits any coercion to accept such recommended health care. This includes the right to reject care on the grounds of religious beliefs.

Civil Rights

In structuring their practice, practitioners must ensure that any limitations are based on criteria which are not discriminatory and continue to comply with a person's civil rights.

Public Law 88-352, the Civil Rights Act of 1964 as amended in 1972, Section 601, and Rehabilitation Act of 1973 reads as follows:

> *"No person in the United States shall, on the ground of race, color, national origin, age, sex, religion or handicap, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance."*

Confidentiality

Information, including the identity and medical records of Medicaid enrollees, is considered confidential and cannot be released without the expressed consent of the enrollee. Medical records and information which are transmitted for the purpose of securing medical care and health services are received and held under the same confidentiality.

All providers **must** comply with these confidentiality requirements.

The DOH, its various political subdivisions, LDSS and eMedNY Contractor, must also observe the confidentiality requirements and must provide safeguards against unauthorized disclosure. This policy should in no way be construed to preclude authorized access to records by the DOH which is under a very strict obligation to monitor medical practices under the Medicaid Program. Authorized representatives of

the Department, its subdivisions, LDSS and eMedNY Contractor have the right to clear access to the medical and financial Medicaid records.

This general policy does not preclude the release of information to the eMedNY Contractor, and to Federal, State and local program officials for purposes directly connected with the administration of the Medicaid Program.

When Medicaid Enrollees Cannot be Billed

This is the policy of the Medicaid Program concerning the enrollee, including those Medicaid enrollees who are enrolled in a Managed Care Plan and in Family Health Plus.

Acceptance and Agreement

When a provider accepts a Medicaid enrollee as a patient, the provider agrees to bill Medicaid for services provided or, in the case of a Medicaid Managed Care enrollee, agrees to bill the enrollee's Managed Care Plan for services covered by the contract. The provider is prohibited from requesting any monetary compensation from the enrollee, or his/her responsible relative, except for any applicable Medicaid co-payments.

Private Pay Agreement
A provider may charge a Medicaid enrollee, including a Medicaid enrollee enrolled in a Managed Care Plan, **ONLY** when both parties have agreed **PRIOR** to the rendering of the service that the enrollee is being seen as a private-pay patient. This must be a mutual and voluntary agreement. It is suggested that the provider maintain the patient's signed consent to be treated as private pay in the patient record.

A provider who participates in Medicaid fee-for-service but does not participate in the enrollee's Medicaid Managed Care Plan may not bill Medicaid fee-for-service for any services that are included in the Managed Care Plan, with the exception of family planning services. Neither may such a provider bill the enrollee for services that are covered by the enrollee's Medicaid Managed Care contract unless there is a prior agreement with the enrollee that he/she is being seen as a private patient as described above. The provider must inform the enrollee that the services may be obtained at no cost to the enrollee from a provider that participates in the enrollee's Managed Care Plan.

Claim Submission

The prohibition on charging a Medicaid enrollee applies when a participating Medicaid provider fails to submit a claim to the Department's eMedNY Contractor, Computer Sciences Corporation (CSC), or the enrollee's Managed Care Plan within the required timeframe. It also applies when a claim is submitted to CSC or the enrollee's Managed Care Plan and the claim is denied for reasons other than that the patient was not Medicaid-eligible on the date of service.

Collections

A Medicaid enrollee, including a Medicaid Managed Care Enrollee, must not be referred to a collection agency for collection of unpaid medical bills or otherwise billed, except for applicable Medicaid co-payments, when the provider has accepted the enrollee as a Medicaid patient. Providers may use any legal means to collect applicable unpaid Medicaid co-payments.

Emergency Medical Care

A hospital that accepts a Medicaid enrollee as a patient, including a Medicaid enrollee enrolled in a Managed Care Plan, accepts the responsibility of making sure that the patient receives all medically necessary care and services.

Other than for legally established co-payments, a Medicaid enrollee should never be required to bear any out-of-pocket expenses for medically-necessary inpatient services or medically-necessary services provided in a hospital-based emergency room (ER). This policy applies regardless of whether the individual practitioner treating the enrollee in the facility is enrolled in the Medicaid Program.

When reimbursing for ER services provided to Medicaid enrollees in Managed Care, health plans must apply the *Prudent Layperson Standard*, provisions of the Medicaid Managed Care Model Contract and Department directives.

Claiming Problems

If a problem arises with a claim submission, the provider must first contact CSC or, if the claim is for a service included in the Medicaid Managed Care benefit package, the enrollee's Medicaid Managed Care plan.

If CSC or the Managed Care Plan is unable to resolve an issue because some action must be taken by the enrollee's LDSS (i.e., investigation of enrollee eligibility issues), then the provider must contact the LDSS for resolution.

Prior Approval

Prior Approval is the process of evaluating the aspects of a plan of care which may be for a single service or an ongoing series of services in order to determine the medical necessity and appropriateness of the care requested.

Prior Approval determinations are made by the Local Professional Director for the district having financial responsibility for the enrollee (which is identified via MEVS). It is the providers' responsibility to verify whether the services and care rendered in their professional areas require prior approval.

Prior Approval contacts can be contacted at the telephone numbers listed in the Information for All Providers, Inquiry Manual, online at:

http://www.emedny.org/ProviderManuals/AllProviders/index.html.

When a provider determined that a service requires prior approval, he/she must obtain a prior approval number by following procedures outlined in the Billing Guidelines and Policy Guidelines sections of each provider manual. Requests for prior approval must be submitted before a service is rendered, except in cases of emergency.

Prior Approval and Payment

No payment will be made when the request for prior approval is submitted after the service is rendered, except in cases of emergency.

Prior approval does not ensure payment. Even when a service has been prior approved, the provider must verify an enrollee's eligibility via the MEVS before the service is provided and comply with all other service delivery and claims submission requirements described in each related section of the provider manual.

Services for which the provider has received prior approval are not subject to Utilization Thresholds.

On the appropriate claim form, the provider must include the prior approval number assigned to his/her request. Information on the claim form must be consistent with the information given and received during the prior approval process.

When a treatment plan has been prior approved for an enrollee, and that enrollee becomes ineligible before the plan is completed, payment for services provided outside the enrollee's eligibility period shall not be made except where:

- the enrollee is enrolled in the Physically Handicapped Children's Program and has an approved treatment plan; or
- failure to pay for services would result in undue hardship to the patient.

When a provider's treatment plan for an enrollee has been prior approved, but the provider becomes ineligible to participate in the Medicaid Program before that plan is completed, payment for services remaining to be provided will not be made unless undue hardship is placed on the enrollee.

When the reason for ineligibility is due to the provider's suspension or disqualification due to improper practices, under no circumstances will services by that provider be paid after the termination date. All efforts will be made by the LDSS to secure a new provider for the enrollee so the plan can be re-evaluated and, where indicated, completed.

Approval will not be given for providers to render services they are not ordinarily qualified to render. In the event such services are provided by a practitioner in the case of an emergency, the provider must attach to the claim form a justification of the services rendered and complete the "SA EXCP CODE" and "EMERGENCY" fields on the claim. Please refer to the Billing Guidelines section of your specific provider manual.

When a fee, rate or price change takes place on a prior approved service, the fee, rate or price in effect at the time the service is rendered must be submitted by the provider on the claim for that service.

When prior approval is granted for services to be rendered by a specific date, any extension of such services beyond the time granted must be submitted on a new prior approval request outlining a new or modified treatment plan. Additionally, should a change be necessary in an approved course of treatment, a new Prior Approval Request must be submitted.

Prior Authorization

Prior authorization is the acceptance by the Local Commissioner of Social Services, or his/her designated representative, of conditional financial liability for a service or a series of services to be rendered by the provider.

Prior authorization does not ensure payment. Even if a service has been prior authorized, the provider still must verify an enrollee's eligibility via the MEVS before rendering service and the claim must be otherwise payable in accordance with the requirements as found in each related section of the provider manual.

In instances when a prior authorized item or service has been ordered, the vendor must confirm that the orderer has not been excluded from the Medicaid Program.

There are certain services which always require prior authorization, i.e., personal care services and non-emergency transportation. Each specific provider manual indicates which services, if any, require prior authorization. Services requiring prior authorization are not subject to Utilization Thresholds.

Utilization of Insurance Benefits

The Medicaid Program is designed to provide payment for medical care and services only after all other resources available for payments have been exhausted; Medicaid is the payer of last resort.

The Medicaid Program does not require providers to enroll as Medicare providers, with few exceptions (i.e., skilled nursing facilities, general hospitals, clinics, and ambulance companies) and are not required to enter into a contract with all other payers simply because Medicaid requires providers to exhaust all existing benefits prior to the billing of

the Medicaid Program. However, if providers do not enter into an agreement with other payers (excluding Medicare), then they must follow the instructions and requirements contained in Title 18 Section 542 of New York State Code of Rules and Regulations. These guidelines are searchable online at:

http://www.health.state.ny.us/nysdoh/phforum/nycrr18.htm.

If an enrollee has third-party insurance coverage, he/she is required to inform the LDSS of that coverage and to use its benefits to the fullest extent before using Medicaid. Supplementary payments may be made by Medicaid when appropriate.

Upon verification of an enrollee's eligibility via MEVS, information specific to an enrollee's eligibility is reported. Eligibility verification responses are detailed in the **MEVS Manual** and Third Party Insurance codes are available in the Third Party Information Manual online at:

http://www.emedny.org/ProviderManuals/AllProviders/index.html.

Fair Hearing

If either the provider or enrollee feels that a service which has been recommended by the provider has been unjustifiably denied, the enrollee may request a Fair Hearing via any one of the following methods:

- Call (800) 342-3334, or
- Fax a copy of the denial notice to (518) 473-6735, or
- Online at http://www.otda.state.ny.us/oah/forms.asp; or
- In writing to:

Disability Assistance
P.O. Box 1930
Albany, New York, 12201.

Billing

Providers must bill all applicable insurance sources before submitting claims to Medicaid. Payment from those sources must be received before submitting a Medicaid claim.

Medicaid providers may not refuse to furnish services to an individual eligible to receive such services because of a third party's liability for payment for the service.

Third party insurers and corresponding coverage codes for a Medicaid-eligible enrollee can be found online in the **Information for All Providers, Third Party Information Manual** at:

http://www.emedny.org/ProviderManuals/AllProviders/index.html.

Record Keeping

Providers must maintain appropriate financial records supporting their determination of available resources, collection efforts, receipt of funds and application of monies received. Such records must be readily accessible to authorized officials for audit purposes.

Section II – Provider Information

The State of New York requires that all providers who participate in the Medicaid Program meet certain basic criteria. For most, this involves the possession of a license or operating certificate and current registration. Compliance with these basic standards is essential not only for medical institutions and facilities, but for professional practitioners as well.

In order to participate in the Medicaid Program, providers are required to enroll with the DOH. For provider enrollment contact information, please refer to the **Information for All Providers, Inquiry Manual**, available online at:

http://www.emedny.org/ProviderManuals/AllProviders/index.html.

Providers must inform DOH of any changes in their status as an enrolled provider in the Medicaid Program, i.e., change of address, change in specialty, change of ownership or control. Provider maintenance forms are available online at:

http://www.emedny.org/info/ProviderEnrollment/index.html.

Enrollment of Providers

Every person who furnishes care, services or supplies and who wishes to receive payment under the Medicaid Program must enroll as a provider of services prior to being eligible to receive such payments.

Continued participation in the Medicaid Program by providers is subject to re-enrollment upon notice by the Department.

Applications for Enrollment/Re-enrollment

Upon receipt of an application for enrollment or re-enrollment, the Department will conduct an investigation to verify or supplement information contained in the application. The Department may request further information from an applicant and may review the background and qualifications of an applicant.

The Department will complete its investigation within ninety days of receipt of the application. If the applicant cannot be fully evaluated within ninety days, the Department may extend the time for acting on the application for up to 120 days from receipt of the application.

Denial of an Application

In determining whether to contract with an applicant, the Department will consider a variety of factors as they pertain to the applicant or anyone affiliated with the applicant. These factors include, but are not limited to, the following:

- Any false representation or omission of a material fact in making the application;
- Any previous or current exclusion or involuntary withdrawal from participation in the Medicaid Program of any other state of the United States or other governmental or private medical insurance program;
- Any failure to make restitution for a Medicaid or Medicare overpayment;
- Any failure to supply further information after receiving written request;
- Any previous indictment for, or conviction of, any crime relating to the furnishing of, or billing for medical care, services or supplies;
- Any prior finding of having engaged in unacceptable practices;
- Any other factor having a direct bearing on the applicant's ability to provide high-quality medical care, services or supplies or to be fiscally responsible to the Program.

Review of Denial

If any application is denied, the applicant will be given a written notice which may be effective on the date mailed.

After denial of an application, the applicant may reapply only upon correction of the factors leading to the denial or after two years if the factors relate to the prior conduct of the applicant or an affiliate.

All persons whose applications are denied shall have an opportunity to request reconsideration of such denial. A person who wishes to appeal must submit documentation to the Department which will establish that an error of fact was made in reviewing his or her application.

Termination of Enrollment

A provider's participation in the Medicaid Program may be terminated by either the provider or the Department upon thirty (30) days written notice to the other without cause. Additionally, the provider's participation in the Medicaid Program may be terminated under the following circumstances:

- When a provider is suspended or excluded from the Medicaid Program;
- When a provider's license to practice his or her profession, or any registration or certification required to provide medical care services or supplies has been terminated, revoked or suspended, or is found to be otherwise out of compliance with local or State requirements;
- When a provider fails to maintain an up-to-date disclosure form;
- When a provider's ownership or control has substantially changed since acceptance of his/her enrollment application;
- When at any time, the Department discovers that the provider submitted incorrect, inaccurate or incomplete information on his/her application where provision of correct, accurate or complete information would have resulted in a denial of the application.

For a more extensive and precise definition of his/her rights and obligations, persons are referred to part 504, 515, 517, 518 and 519 of Title 18 of the New York Code of Rules and Regulations which are found online at:

http://www.health.state.ny.us/nysdoh/phforum/nycrr18.htm.

Duties of the Provider

By enrolling in the Medicaid Program, a provider agrees to:

- prepare and maintain contemporaneous records as required by Department regulations and law;
- notify the Department, *in writing*, of any change in Correspondence, Pay-To or Service Addresses;
- comply with the disclosure requirements of the Department with respect to ownership and controlling interests, significant business transactions and involvement with convicted persons;
- report any change in the ownership or control or a change of managing employees to the Department within fifteen (15) days of the change;
- accept payment under the Medicaid Program as payment in full for the services rendered;
- submit claims for payment for services actually furnished, medically necessary and provided to eligible persons;

- permit audits of all books and records or a sample thereof relating to services furnished and payments received under the Medicaid Program;

- comply with the rules, regulations and official directives of the Department.

Keeping Current with Policy Information

Policy information is relayed through the monthly *Medicaid Update* newsletter, which is available in hard copy and electronically; and is sent automatically to each enrolled Medicaid provider. The *Medicaid Update* is available online at:

http://www.health.state.ny.us/health_care/medicaid/program/update/main.htm.

Providers are responsible to check their Provider Manual on a *monthly basis* to ensure they are current with the latest policy information. This includes the Information for All Providers sections, which contain general Medicaid policy, general billing, inquiry and third party insurance information.

Hard copies of Provider Manuals are available for those providers who do not have access to the Internet. In these cases, the provider must call Computer Sciences Corporation at:

(800) 343-9000.

Change of Address

It is the responsibility of the provider to notify the Medicaid Program of any change in address. Keeping the provider file current will ensure the provider receives all updates and announcements. "Change of Address" forms for Rate-Based or Fee-for-Service providers are available online at:

http://www.emedny.org/info/ProviderEnrollment/index.html.

Out-of-State Medical Care and Services

Out-of-State providers must enroll in the New York State Medicaid Program in order to be reimbursed by the Program. Enrollment contact information is available in the **Information for All Providers - Inquiry Manual** at:

http://www.emedny.org/ProviderManuals/AllProviders/index.html.

Medicaid-eligible individuals normally obtain medical care and services from qualified providers located in New York State. An enrolled out-of-state provider will be reimbursed for services rendered to a New York State Medicaid enrollee only under the following circumstances:

- The provider practices within the "common medical marketing area" of the enrollee's home LDSS as determined by the Local Professional Director;

- An emergency requires that the out-of-state provider render immediate care to an enrollee who is temporarily out-of-state.

Under any of these circumstances, only providers in the United States, Canada, Puerto Rico, Guam, the American Virgin Islands, and American Samoa will be reimbursed for care provided to New York State Medicaid enrollees.

Non-Emergent Inpatient Care

The Medicaid Program provides assistance in the form of payment to enrolled, qualified out-of-state inpatient services providers when the best interest of the applicant or enrollee will be most effectively served because of his/her social situation or when the inpatient care is needed by a patient, as determined in the basis of medical advice, is more readily available in the other state.

A qualified out-of-state provider is normally a facility recognized by their home state as a Medicaid Program inpatient facility services provider (i.e., a hospital, skilled nursing or intermediate care facility, residential treatment center, etc.).

A Medicaid prior approval for the placement of a New York State Medicaid enrollee with an out-of-state medical inpatient facility is required to document that the needed services are not readily available within the State of New York. Approval is based upon a determination made by the Department of Health. Prior approval and medical review contacts are listed in the **Information for All Providers – Inquiry Manual** online at:

http://www.emedny.org/ProviderManuals/AllProviders/index.html.

Where a mentally disabled enrollee is seeking out-of-state care, approval is subject to the approval of the State office that provides services to this patient population within New York State, either the Office of Mental Health or Mental Retardation and Developmental Disabilities.

Prior Approval

For out-of-state services provided in situations other than those noted above, prior approval must be obtained for all services. For services provided in those situations noted above, prior approval requirements will be identical to those mandated for in-state providers.

Billing Procedures

Out-of-state providers enrolled in the Program will follow the regular billing procedures for Medicaid.

Record-Keeping Requirements

Federal Law and State Regulations require providers to maintain financial and health records necessary to fully disclose the extent of services, care, and supplies provided to Medicaid enrollees. Providers must furnish information regarding any payment claim to authorized officials upon request of the DOH or the LDSS.

For medical facilities subject to inspection and licensing requirements provided in Article 28 of the Public Health Law, the State Hospital Code contains specific details concerning content and maintenance of medical records. Practitioners providing diagnostic and treatment services must keep medical records on each enrollee to whom care is rendered. At a minimum, the contents of the enrollee's hospital record should include:

- enrollee information (name, sex, age, etc.);
- conditions or reasons for which care is provided;
- nature and extent of services provided;
- type of services ordered or recommended for the enrollee to be provided by another practitioner or facility;
- the dates of service provided and ordered.

The maintenance and furnishing of information relative to care included on a Medicaid claim is a basic condition for participation in the Program.

For auditing purposes, records on enrollees must be maintained and be available to authorized Medicaid officials for six years following the date of payment. Failure to conform to these requirements may affect payment and may jeopardize a provider's eligibility to continue as a Medicaid participant.

General Exclusions from Coverage Under Medicaid

In an effort to assure quality care and to contain costs under the Medicaid Program, certain restrictions have been placed on Medicaid payments to providers. As a general reference, the following list of medical care and services which do not qualify for payment is presented.

Payment will **not** be made for medical care and services:

- Which are medically unnecessary;

- Whose necessity is not evident from documentation in the enrollee's medical record;
- Which fail to meet existing standards of professional practice, are currently professionally unacceptable, or are investigational or experimental in nature;
- Which are rendered outside of the enrollee's period of eligibility;
- Which were not rendered, ordered, or referred by a restricted enrollee's primary care provider unless the service was provided in an emergency, was a methadone maintenance claim or a service provided in an inpatient setting;
- When the claim was initially received by the Department more than ninety days after the original date of service (refer to the Information for All Providers, General Billing Manual for exceptions);
- Which require prior approval or authorization, but for which such approval/authorization was not obtained or was denied;
- For which third parties (i.e., Medicare, Blue Cross/Blue Shield) are liable;
- Which are rendered out-of-state but which do not meet the qualifications outlined in the section Out-of-State Medical Care and Services;
- Which are fraudulently claimed;
- Which represent abuse or overuse;
- Which are for cosmetic purposes and are provided only because of the enrollee's personal preference;
- Which are rendered in the absence of authorization from the MEVS in accordance with Utilization Threshold requirements. Exceptions to this policy include instances when a provider uses one of the Service Authorization Exception codes on the claim. Details are found in the **Billing Guidelines** section of each specific provider manual.
- Which have already been rejected or disallowed by Medicare when the rejection was based upon findings that the services or supplies provided:
    - Were not medically necessary;
    - Were fraudulently claimed;
    - Represented abuse or overuse;
    - Were inappropriate;

- Were for cosmetic purposes; or
- Were provided for personal comfort.

➢ Which are rendered after an enrollee has reached the Utilization Threshold established for a specific provider service type unless one of the following conditions is satisfied:

- The enrollee has been exempted from the Utilization Threshold;
- The enrollee has been granted an increase in the Utilization Threshold;
- The provider certifies that the care, services or supplies were furnished pursuant to a medical emergency or when urgent medical care was necessary.

Unacceptable Practices

Examples of unacceptable practices include, but are not limited to, the following:

➢ Knowingly making a claim for an improper amount or for unfurnished, inappropriate or unnecessary care, services or supplies;

➢ Ordering or furnishing inappropriate, improper, unnecessary or excessive care, services or supplies;

➢ Billing for an item/service prior to being furnished;

➢ Practicing a profession fraudulently beyond its authorized scope, including the rendering of care, services or supplies while one's license to practice is suspended or revoked;

➢ Failing to maintain or make available for purposes of audit or investigation records necessary to fully disclose the extent of the care, services or supplies furnished;

➢ Submitting bills or accepting payment for care, services or supplies rendered by a person suspended or disqualified from practicing in the Medicaid Program;

➢ Soliciting, receiving, offering or agreeing to make any payment for the purpose of influencing a Medicaid enrollee to either utilize or refrain from utilizing any particular source of care, services or supplies;

➢ Knowingly demanding or collecting any compensation in addition to claims made under the Medicaid Program, except where permitted by law;

- Denying services to an enrollee based upon the enrollee's inability to pay a co-payment; and

- Failure to use the POS Terminal for verification, post and/or clear procedures when designated to do so.

Process for Resolving Unacceptable Practices

If the Department proposes to sanction a person, the DOH will advise that person, in writing, of the following:

- The unacceptable practice with which the person has been charged;

- The administrative action which is proposed (i.e., exclusion, or censure, and its statutory, regulatory or legal basis);

- The person's right to submit documentation or written arguments against the proposed agency action within 30 days from the date of the notice of proposed action.

Affiliated Persons

Whenever the Department sanctions a person, it may also sanction any affiliate of that person. Affiliated persons will be sanctioned on a case-by-case basis with due regard to all the relevant facts and circumstances leading to the original sanction.

> Affiliated persons are those individuals having an overt, covert or conspiratorial relationship with another such that either of them may directly or indirectly control the other or such that they are under a common control.

Some examples of affiliated persons are the following:

- persons with an ownership or controlling interest in a provider;

- agents and managing employees of a provider;

- providers who share common managing employees;

- subcontractors with whom the provider has more than $25,000 in annual business transactions.

Agency Action

If the Department determines to sanction a person, it will send a written notice of agency action advising the person of the final determination at least 20 days before the action becomes effective.

Suspension or Withholding of Payments

Upon notification to the person that he/she has engaged in an unacceptable practice, payment to that person may be withheld for current and subsequently received claims, or all payments may be suspended pending a resolution of the charges.

Hearings

A person has the right to a hearing to review a determination that he/she has engaged in an unacceptable practice. All requests for hearings must be in writing and must be made within sixty days of the date of the notice of agency action notifying the person of the unacceptable practice.

In the even that a person withdraws or abandons his/her request for a hearing, the hearing will be cancelled.

A request for a hearing will not defer any administrative action. All hearings will be conducted in accordance with the procedures contained in Part 519 of Title 18 of the Official Codes, Rules and Regulations of the State of New York which can be found by conducting a search online at:

http://www.health.state.ny.us/nysdoh/phforum/nycrr18.htm.

Administrative Sanctions

When it is determined that a person has been engaged in unacceptable practices, the DOH may take one or more of the following sanctions:

- The person may be excluded from participation in the Medicaid Program. No payments will be made to a person who is excluded from the Medicaid Program for care, services or supplies rendered to enrollees as of the date of his/her exclusion;

- No payments will be made for any medical care, services or supplies ordered by a person who is excluded or suspended from the Medicaid Program;

- The person may be censured in writing with notification to the appropriate governmental licensing and/or regulatory agencies.

A sanction designed to monitor the Program activities of a person may be imposed against anyone who has been previously suspended from the Medicaid Program or as a precondition to a person's continued participation of the Program. Such sanctions include:

- Requiring, prior to payment, a review of any care, services or supplies rendered by the person; or

- Requiring prior approval for all care, services or supplies to be rendered by the person.

The DOH may also choose to impose fiscal sanctions against persons who engage in unacceptable practices. Examples of fiscal sanctions include:

- Restitution plus interest may be collected from a person who has received payment for care, services or supplies associated with an unacceptable practice; or

- Reduction in payment may be utilized when it is determined that the person has rendered care, services or supplies not included in the scope of the Program, or that the person has billed for more costly care, services or supplies that were actually provided; or

- Payment may be denied to a person who has engaged in an unacceptable practice.

Guidelines for Sanctions

In determining the sanction to be imposed, the following factors will be considered:

- The number and nature of the Program violations or other related offenses;

- The nature and extent of any adverse impact the violations have had on enrollees;

- The amount of damages to the Program;

- Mitigating circumstances;

- Other facts related to the nature and seriousness of the violations; and

- The previous record of the person under the Medicare Program, the Medicaid Program and other Social Services Programs.

Immediate Sanctions

In the following cases, a person may be immediately sanctioned on five (5) days notice:

- When a person or an affiliate is suspended from the Medicare Program the person will be suspended from the Medicaid Program for a period of time at least equal to the period of suspension from the Medicare Program;

- When a person has been convicted of any crime relating to the rendering of, or billing for medical care, services or supplies;

- When a person has been charged with a felony offense relating to the rendering of, or billing for medical care, services or supplies;

- When a person has been the subject of administrative, judicial proceeding finding the person to have committed unprofessional misconduct or an act which would constitute an unacceptable practice under the Medicaid Program; or

- When a person's further participation in the Medicaid Program will endanger the public health, or the health, safety or welfare of any enrollee.

A person sanctioned in these cases will not be entitled to an administrative hearing under the Department's regulations. However, within 30 days of being notified of any immediate sanction, a person may submit written material to challenge any mistake of fact or the appropriateness of a sanction.

Reinstatement

A person who is sanctioned may request reinstatement, or removal of any condition or limitation on participation in the Medicaid Program, at any time after the date or time period specified in the notice of agency action, or upon the occurrence of an event specified in the notice.

A request for reinstatement or removal of any condition on participation in the Program is made as an application for enrollment under Part 504 of the Department's regulations and must be denominated as a request for reinstatement to distinguish it from an original application.

The request for reinstatement must be sent to the Enrollment Processing Unit of the Department, and must:

- Include a complete ownership and control disclosure statement;

- State whether the person has been convicted of other offenses related to participation in the Medicare Program, the Medicaid Program or other Social Services Programs which were not considered during the development of the sanction; and

- State whether any State or local licensing authorities have taken any adverse action against the person for offenses related to participation in the Medicare Program, the Medicaid Program or other Social Services Programs which were not considered during the development of the sanction.

For a more extensive and precise definition of his/her rights and obligations, persons are referred to part 504, 515, 517, 518 and 519 of Title 18 of the New York Code of Rules and Regulations which are found by doing a search at:

http://www.health.state.ny.us/nysdoh/phforum/nycrr18.htm.

Audits

The DOH is responsible for monitoring the Medicaid Program in New York State. This includes evaluating whether providers of medical care, services and supplies are in compliance with applicable State and Federal law and regulations.

The Department conducts audits of persons who submit claims for payment under the Medicaid Program, and the Department may seek recovery or restitution if payments were improperly claimed, regardless of whether unacceptable practices have occurred. The Department may either conduct an on-site field audit of a person's records or it may conduct an in-house review utilizing data processing procedures.

If overpayments are found, the Department will issue a draft audit report which will set forth any items to be disallowed and advise the person of the Department's proposed action. The person will then have 30 days to submit documents in response to the draft and/or object to any proposed action.

After considering the person's submittal, if any, the Department will issue a final audit report advising the person of the Department's final determination. The person may then request an administrative hearing to contest any adverse determination.

Recovery of Overpayments

When any person has submitted or caused to be submitted claims for medical care, services or supplies for which payment should not have been made, the Department may require repayment of the amount overpaid.

An overpayment includes any amount not authorized to be paid under the Medicaid Program, whether paid as the result of inaccurate or improper cost reporting, improper claiming, unacceptable practices, fraud, abuse or mistake.

Recoupment

Overpayments may be recovered by withholding all or part of a person's and an affiliate's payments otherwise payable, at the option of the Department.

Withholding of Payments

The Department may withhold payments in the absence of a final audit report when it has reliable information that a person is involved in fraud or willful misrepresentation

involving claims submitted to the Program, has abused the Program or committed an unacceptable practice. Reliable information may consist of:

- Preliminary findings of unacceptable practices or significant overpayments;
- Information from a State professional licensing or certifying agency of an ongoing investigation of a person involving fraud, abuse, professional misconduct or unprofessional conduct; or
- Information from a State investigating or prosecutorial agency or other law enforcement agency of an ongoing investigation of a person for fraud or criminal conduct involving the Program.

Notice of the withholding will usually be given within five days of the withholding of payments. The notice will describe the reasons for the action, but need not include specific information concerning an ongoing investigation.

The withholding may continue as follows:

- If payments are withheld prior to issuance of a draft audit report or notice of proposed agency action, the withholding will not continue for more than 90 days unless a written draft report or notice of proposed agency action is sent to the provider.
    - Issuance of the draft report or notice of proposed agency action may extend the duration of the withholding until an amount reasonably calculated to satisfy the overpayment is withheld, pending a final determination on the matter.
- If payments are withheld after issuance of a draft report or notice of proposed agency action, the withholding will not continue for more than 90 days unless a written final audit report or notice of agency action is sent to the provider.
    - Issuance of the report or notice of agency action may extend the duration of the withholding until an amount reasonably calculated to satisfy the overpayment is withheld, pending a final determination on the matter.
- When initiated by another State agency or law enforcement organization, the withholding may continue until the agency or prosecuting authority determines that there is insufficient evidence to support an action against the person, or until the agency action or criminal proceedings are completed.

Fraud

Examples of fraud include when a person knowingly:

- makes a false statement or representation which enables any person to obtain medical assistance to which he/she is not entitled;
- presents for allowance of payment any false claim for furnishing services or merchandise;
- submits false information for the purpose of obtaining greater compensation than that to which he/she is legally entitled; or
- submits false information for the purpose of obtaining authorization for the provision of services or merchandise.

Office of the Medicaid Inspector General

The Office of the Medicaid Inspector General (OMIG) is an independent fraud-fighting entity within the Department of Health whose functions include:

- conducting and supervising activities to prevent, detect and investigate Medicaid fraud, waste and abuse and, to the greatest extent possible, coordinating such activities amongst:
    - the Offices of Mental Health, Mental Retardation and Developmental Disabilities, Alcoholism and Substance Abuse Services, Temporary Disability Assistance, and Children and Family Services;
    - the Department of Education;
    - the eMedNY Contractor, Computer Sciences Corporation (CSC), employed to operate the Medicaid Management Information System;
    - the State Attorney General for Medicaid Fraud Control; and,
    - the State Comptroller;
- pursuing civil and administrative enforcement actions against those who engage in fraud, waste or abuse or other illegal or inappropriate acts perpetrated against the Medicaid Program;
- keeping the Governor and the heads of agencies with responsibility for the administration of the Medicaid Program apprised of efforts to prevent, detect, investigate, and prosecute fraud, waste and abuse within the Medicaid system;
- making information and evidence relating to potential criminal acts which we may obtain in carrying out our duties available to appropriate law enforcement and consulting with:
    - the New York State Deputy Attorney General for Medicaid Fraud Control;

  - federal prosecutors; and
  - local district attorneys to coordinate criminal investigations and prosecutions;

- receiving and investigating complaints of alleged failures of state and local officials to prevent, detect and prosecute fraud, waste and abuse; and
- performing any other functions that are necessary or appropriate to fulfill the duties and responsibilities of the office.

The OMIG also has broad subpoena powers:

- *ad testificandum* (a subpoena *ad testificandum* is a command to a named individual or corporation to appear at a specified time and place to give oral testimony under oath); and
- *duces tecum* (i.e., a writ or process of the same kind as the *subpoena ad testificandum,* including a clause requiring the witness to bring with him and produce to the court, books, papers, etc.).

The Medicaid Inspector General is headquartered in Albany with regional field offices in New York City, White Plains, Hauppauge, Syracuse, Rochester, and Buffalo.

For more information, please refer to the OMIG website:

www.omig.state.ny.us.

The OMIG website contains:

- An online complaint reporting mechanism;
- Current comprehensive listing of banned Medicaid providers;
- Significant news of OMIG initiatives and actions; and
- Useful links to State and federal resources in the Medicaid field.

Prohibition Against Reassignment of Claims: Factoring

The practice of factoring is prohibited by Federal Medicaid Regulations, which specify that no payment for any care or service provided to a Medicaid enrollee can be made to anyone other than the provider of the service.

Payment shall not be made to or through a factor either directly or by use of a power of attorney given by the provider to the factor.

Exceptions

Exceptions to the prohibition against the reassignment of Medicaid claims are allowed under the following circumstances:

- Direct payment for care or services provided to a Medicaid enrollee by physicians, dentists or other individual practitioners may be made to:
    - The employer (Article 28 facility, or other medical providers certified by State agencies) of the practitioner, if the practitioner is required to turn over fees to his/her employer as a condition of employment;
    - The facility in which the care or service was provided, if there is an arrangement whereby the facility submits the claim for other affiliated persons in its claim for reimbursement;
    - A foundation, plan, or similar organization, including a health maintenance organization which furnishes health care through an organized health care delivery system, if there is a contractual arrangement between the organization and the practitioner furnishing the service under which the organization bills or receives payments on a basis other than a percentage of the Medicaid payments for such practitioner's services.
- Payments are allowed which result from an assignment made pursuant to a court order;
- Payments may be made to a government agency in accordance with an assignment against a provider;
- Payment may be made to a business agent, such as a billing service or accounting firm, that prepares statements and receives payments in the name of a provider, if the business agent's compensation for the service is:
    - Reasonably related to the cost of services;
    - Unrelated, directly or indirectly, to the dollar amounts billed and collected; and
    - Not dependent upon the actual collection of payment.

Services Subject to Co-Payments

The following services are subject to a co-payment:

- Clinic Visits (Hospital-Based and Free-Standing Article 28 Health Department-certified facilities) - $3.00;

- Laboratory Tests performed by an independent clinical laboratory or any hospital-based/free-standing clinic laboratory - $0.50 per procedure;
- X-rays performed in hospital clinics, free-standing clinics -$1.00 per procedure;
- Medical Supplies including syringes, bandages, gloves, sterile irrigation solutions, incontinence pads, ostomy bags, heating pads, hearing aid batteries, nutritional supplements, etc. - $1.00 per claim;
- Inpatient Hospital Stays (involving at least one overnight stay – is due upon discharge) - $25.00;
- Emergency Room – for non-urgent or non-emergency services - $3.00 per visit;
- Pharmacy Prescription Drugs - $3.00 Brand Name, $1.00 Generic;
- Non-Prescription (over-the-counter) Drugs - $0.50.

There is no co-payment on private practicing physician services (including laboratory and/or X-ray services, home health services, personal care services or long term home health care services.

Co-payment Maximum

The annual co-payment maximum per enrollee per state fiscal year (April 1 through March 31) is $200.

Co-payment Exemptions

The following are exempt from all Medicaid co-payments:

- Enrollees younger than 21 years old.
- Enrollees who are pregnant.
    - Pregnant women are exempt during pregnancy and for the two months after the month in which the pregnancy ends.
- Family planning (birth control) services.
    - This includes family planning drugs or supplies like birth control pills and condoms.
- Residents of an Adult Care Facility licensed by the New York State Department of Health (**for pharmacy services only**).

- Residents of a Nursing Home.
    - Residents of an Intermediate Care Facility for the Developmentally Disabled (ICF/DD).
- Residents of an Office of Mental Health (OMH) or Office of Mental Retardation and Developmental Disabilities (OMRDD) certified Community Residence.
- Enrollees in a Comprehensive Medicaid Case Management (CMCM) or Service Coordination Program.
    - Enrollees in an OMH or OMRDD Home and Community Based Services (HCBS) Waiver Program.
- Enrollees in a Department of Health HCBS Waiver Program for Persons with Traumatic Brain Injury (TBI).
- Enrollees in a Care plan.

Enrollees who are eligible for both Medicare and Medicaid and/or receive Supplemental Security Income (SSI) payments *are not exempt* from Medicaid co-payments, unless they also fall into one of the groups listed above. Enrollees cannot be denied care and services because of their inability to pay the co-payment amount.

The potential provider of a service will be required to access the MEVS to enter the applicable co-payment amount, if any is due for the service being provided. When accessing the MEVS, the provider will be given information as to the enrollee's exemption status for co-payments. Specific instructions on the MEVS information obtained by the provider may be found in the MEVS manual.

Section III – Ordering Non-Emergency Medical Transportation

A request for prior authorization of non-emergency medical transportation must be supported by the order of a practitioner who is the Medicaid enrollee's:

- Attending physician;
- Physician's assistant;
- Nurse practitioner;
- Dentist;
- Optometrist;
- Podiatrist; or
- Other type of medical practitioner designated by the district and approved by the Department.

A diagnostic and treatment clinic, hospital, nursing home, intermediate care facility, long term home health care program, home and community based services waiver program, or managed care program may order transportation services on behalf of the ordering practitioner.

Any order practitioner or facilities/programs ordering on the practitioner's behalf, which do not meet the rules of this section, may be sanctioned according to the regulations established by the Department of Health at Title 18 Section 515.3, available online at:

http://www.health.state.ny.us/nysdoh/phforum/nycrr18.htm.

Responsibilities of the Ordering Practitioner

Ordering practitioners are responsible for ordering only necessary transportation at the medically appropriate level. A basic consideration for this should be the enrollee's current level of mobility and functional independence.

The transportation ordered should be the least specialized mode required based upon the enrollee's *current* medical condition. For example, if the orderer feels the enrollee does not require personal assistance, but cannot walk to public transportation, then livery service should be requested.

Enrollees who have reasonable access to a mode of transportation used for the normal activities of daily living; such as shopping and recreational events; are expected to use

this mode to travel to and from medical appointments when that mode is available to them. For most residents of New York City, this mode is usually mass transit.

Medicaid may restrict payment for transportation if it is determined that:

- the enrollee chose to go to a medical provider outside the CMMA when services were available within the CMMA;
- the enrollee could have taken a less expensive form of transportation but opted to take the more costly transportation.

In either case above, if the enrollee can demonstrate circumstances justifying payment, then reimbursement can be *considered*.

Non-emergency Ambulance

Generally, ambulance service is requested when a Medicaid enrollee needs to be transported in a recumbent position or is in need of medical attention while en route to their medical appointments.

A request for prior authorization of non-emergency ambulance services must be supported by the order of a practitioner who is the Medicaid enrollee's:

- Attending physician;
- Physician's assistant; or
- Nurse practitioner.

A diagnostic and treatment clinic, hospital, nursing home, intermediate care facility, long term home health care program, home and community based services waiver program, or managed care program may order non-emergency ambulance transportation on behalf of the ordering practitioner.

Ambulette

Ambulette service is door-to-door; from the enrollee's home through the door at the building where the medical appointment is to take place. Personal assistance by the staff of the ambulette company is required by the Medicaid Program in order to bill the Program for the provision of ambulette service.

> **If personal assistance is not necessary and/or not provided, then livery service should be ordered.**

Ambulettes may also provide taxi (curb-to-curb) service and will transport livery-eligible enrollees in the same vehicle as ambulette-eligible enrollees. The Medicaid Program

does not require the ambulette service to be licensed as a taxi service; but the ambulette must maintain the proper authority and license required to operate as an ambulette.

A request for prior authorization of ambulette transportation must be supported by the order of a practitioner who is the Medicaid enrollee's:

- Attending physician;
- Physician's assistant;
- Nurse practitioner;
- Dentist;
- Optometrist;
- Podiatrist; or
- Other type of medical practitioner designated by the district and approved by the Department.

A diagnostic and treatment clinic, hospital, nursing home, intermediate care facility, long term home health care program, home and community based services waiver program, or managed care program may order transportation services on behalf of the ordering practitioner.

Ambulette transportation may be ordered if any of the following conditions is present:

- The Medicaid enrollee needs to be transported in a recumbent position, needs no medical treatment en route to his or her appointment, and the ambulette service is able to accommodate a stretcher;
- The Medicaid enrollee is wheelchair-bound and is unable to use a taxi, livery service, public transportation or a private vehicle;
- The Medicaid enrollee has a disabling physical condition which requires the use of a walker or crutches and is unable to use a taxi, livery service, public transportation or a private vehicle;
- An otherwise ambulatory Medicaid enrollee requires radiation therapy, chemotherapy, or dialysis treatments which result in a disabling physical condition after treatment, making the enrollee unable to access transportation without personal assistance provided by an ambulette service;

- The Medicaid enrollee has a disabling physical condition other than one described above or a disabling mental condition requiring personal assistance provided by an ambulette services; and,

- The ordering practitioner certifies in a manner designated by and submitted to the Department that the Medicaid enrollee cannot be transported by taxi, livery service, bus or private vehicle and there is a need for ambulette service.

The ordering practitioner must note in the patient's record the condition which qualifies the use of ambulette services.

Livery Transportation

A request for prior authorization for transportation by New York City livery services must be supported by the order of a practitioner who is the Medicaid enrollee's:

- Attending physician;

- Physician's assistant;

- Nurse practitioner;

- Dentist;

- Optometrist;

- Podiatrist; or

- Other type of medical practitioner designated by the district and approved by the Department.

A diagnostic and treatment clinic, hospital, nursing home, intermediate care facility, long term home health care program, home and community based services waiver program, or managed care program may order transportation services on behalf of the ordering practitioner.

Day Treatment Transportation

Day treatment/day program transportation is unique in that this transportation can be provided by an ambulance, ambulette or livery provider. The difference is that a typical transport involves a group of individuals traveling to and from the same site, at the same time, on a daily or regular basis.

The economies of this group ride transport are reflected in a different reimbursement amount than that reimbursed for an episodic medical appointment.

Providers of transportation to day treatment/day program must adhere to the same requirements for their specific provider category.

Required Documentation

In cases where an ordering practitioner believes that a Medicaid enrollee should use a particular form of non-emergency transportation, Medicaid guidelines at Title 18 of the New York Code of Rules and Regulations Section 505.10 (c)(4) indicate that:

> *"The ordering practitioner must note in the [enrollee's] patient record the condition which justifies the practitioner's ordering of ambulette or nonemergency ambulance services."*

Making the Request for Authorization

Requests for medical transportation require the authorization of the local department of social services (DSS). Please refer to the Information for All Providers – Inquiry Manual for telephone numbers of DSS staff.

New York City practitioners and facilities should refer to the Prior Authorization Guidelines manual titled City of New York Transportation Ordering Guidelines, which is available online at:

http://www.emedny.org/ProviderManuals/Transportation/index.html.

Section IV - Family Planning Services

All Medicaid-eligible persons of childbearing age who desire family planning services, without regard to marital status or parenthood, are eligible for such services *with the exception of sterilization*.

Family planning services, including the dispensing of both prescription and non-prescription contraceptives but **excluding sterilization**, may be given to minors who wish them without parental consent.

Medicaid-eligible minors seeking family planning services may not have a Medicaid ID Card in their possession. To verify eligibility, the physician or his/her staff should obtain birth date, sex, social security number, or as much of this information as possible, before contacting the Department at:

(518) 472-1550.
If sufficient information is provided,
Department staff will verify the eligibility of the individual for Medicaid.

Medicaid patients enrolled in managed care plans (identified on MEVS as "PCP"), may obtain HIV blood testing and pre- and post-test counseling when performed as a family planning encounter from the managed care plan or from any appropriate Medicaid-enrolled provider without a referral from the managed care plan.

> *Services provided for HIV treatment may only be obtained from the managed care plan. HIV testing and counseling not performed as a family planning encounter may only be obtained from the managed care plan.*

Patient Rights

Patients are to be kept free of coercion or mental pressure to use family planning services and are free to choose their medical provider of services and the method of family planning to be used.

Standards for Providers

Family planning services can be provided by a licensed private physician, nurse practitioner, clinic, or hospital, which complies with all applicable provisions of law.

In addition, services are available through designated Family Planning Service Programs, which meet specific DOH requirements for such Programs.

Sterilizations

Medical family planning services include sterilizations. Sterilization is defined as any medical procedure, treatment or operation for the purpose of rendering an individual permanently incapable of reproducing.

The physician who performs the sterilization must discuss the information below with the patient shortly before the procedure, usually during the pre-operative examination:

Informed Consent

The person who obtains consent for the sterilization procedure must offer to answer any questions the individual may have concerning the procedure, provide a copy of the *Medicaid Sterilization Consent Form (DSS-3134)* **and provide verbally all of the following information or advice to the individual to be sterilized**:

- Advice that the individual is free to withhold or withdraw consent to the procedure at any time before the sterilization without affecting the right to future care or treatment and without loss or withdrawal of any federally-funded program benefits to which the individual might be otherwise entitled;
- A description of available alternative methods of family planning and birth control;
- Advice that the sterilization procedure is considered to be irreversible;
- A thorough explanation of the specific sterilization procedure to be performed;
- A full description of the discomforts and risks that may accompany or follow the performance of the procedure, including an explanation of the type and possible effects of any anesthetic to be used;
- A full description of the benefits or advantages that may be expected as a result of the sterilization;
- Advice that the sterilization will not be performed for at least 30 days except under the circumstances specified below under "Waiver of the 30-Day Waiting Period."

Waiting Period

The enrollee to be sterilized must have voluntarily given informed consent not less than 30 days nor more than 180 days prior to sterilization.

> *When computing the number of days in the waiting period, the day the enrollee signs the form is not to be included.*

Waiver of the 30-Day Waiting Period
The only exceptions to the 30-day waiting period are in the cases of:

- premature delivery when the sterilization was scheduled for the expected delivery date, or
- emergency abdominal surgery.

In both cases, informed consent must have been given at least 30 days before the intended date of sterilization.

Since premature delivery and emergency abdominal surgery are unexpected but necessary medical procedures, sterilizations may be performed during the same hospitalization, as long as 72 hours have passed between the original signing of the informed consent and the sterilization procedure.

Minimum Age

The enrollee to be sterilized must be at least 21 years old at the time of giving voluntary, informed consent to sterilization.

Mental Competence

The patient must be a mentally competent individual.

Institutionalized Individual

The patient to be sterilized must not be an institutionalized individual.

Restrictions on Circumstances in Which Consent is Obtained

Informed consent may not be obtained while the patient to be sterilized is:

- in labor or childbirth;
- seeking to obtain or obtaining an abortion; or
- under the influence of alcohol or other substances that affect the patient's state of awareness.

Foreign Languages

An interpreter must be provided if the patient to be sterilized does not understand the language used on the consent form or the language used by the person obtaining informed consent.

Handicapped Persons

Suitable arrangements must be made to insure that the sterilization consent information is effectively communicated to deaf, blind or otherwise handicapped individuals.

Presence of Witness

The presence of a witness is optional when informed consent is obtained, except in New York City when the presence of a witness of the patient's choice is mandated by New York City Local Law No. 37 of 1977.

Reaffirmation Statement (NYC Only)

A statement signed by the patient upon admission for sterilization, again acknowledging the consequences of sterilization and his/her desire to be sterilized, is mandatory within the jurisdiction of New York City.

Sterilization Consent Form

A copy of the *NYS Sterilization Consent Form (DSS-3134)* must be given to the patient to be sterilized and completed copies must be submitted with all surgeon, anesthesiologist and facility claims for sterilizations.

Hospitals and Article 28 clinics submitting claims electronically must maintain a copy of the completed *DSS-3134* in their files. This form, in English and in Spanish, is available online at:

http://www.health.state.ny.us/health_care/medicaid/publications/ldssforms.

New York City

New York City Local Law No. 37 of 1977 establishes guidelines to insure informed consent for sterilizations performed in New York City. Since the Medicaid Program will not pay for services rendered illegally, conformance to the New York City Sterilization Guidelines is a prerequisite for payment of claims associated with sterilization procedures performed in New York City.

Any questions relating to New York City Local Law No. 37 of 1977 should be directed to the following office:

Maternal, Infant & Reproductive Health Program
New York City Department of Health
125 Worth Street
New York, NY 10013
(212) 442-1740.

Hysterectomies

Federal regulations prohibit Medicaid reimbursement for hysterectomies which are performed solely for the purpose of rendering the patient incapable of reproducing; or, if there was more than one purpose to the procedure, it would not have been performed but for the purpose of rendering the individual permanently incapable of reproducing.

Any other hysterectomies are covered by Medicaid if the patient is informed verbally and in writing prior to surgery that the hysterectomy will make her permanently incapable of reproducing.

The patient or her representative must sign *Part I of the Acknowledgement of Receipt of Hysterectomy Information Form (DSS-3113)*. The requirement for the patient's signature on Part I of Form DSS-3113 can be waived if:

1. The woman was sterile prior to the hysterectomy;

2. The hysterectomy was performed in a life-threatening emergency in which prior acknowledgement was not possible. For Medicaid payment to be made in these two cases, the surgeon who performs the hysterectomy must certify in writing that one of the conditions existed and state the cause of sterility or nature of the emergency. For example, a surgeon may note that the woman was postmenopausal or that she was admitted to the hospital through the emergency room, needed medical attention immediately and was unable to respond to the information concerning the acknowledgement agreement;

3. The woman was not a Medicaid enrollee at the time the hysterectomy was performed but subsequently applied for Medicaid and was determined to qualify for Medicaid payment of medical bills incurred before her application. For these cases involving retroactive eligibility, payment may be made if the surgeon certifies in writing that the woman was informed before the operation that the hysterectomy would make her permanently incapable of reproducing or that one of the conditions noted above in "1" or "2" was met.

The DSS-3113 documents the receipt of hysterectomy information by the patient or the surgeon's certification of reasons for waiver of that acknowledgement. It also contains the surgeon's statement that the hysterectomy was not performed for the purpose of sterilization.

All surgeons, hospitals, clinics and anesthesiologists must submit a copy of the fully completed DSS-3113 when billing for a hysterectomy. Hospitals and Article 28 clinics submitting claims electronically, must maintain a copy of the completed DSS-3113 in their files. This form, in English and in Spanish, is available online at:

http://www.health.state.ny.us/health_care/medicaid/publications/ldssforms.

Induced Termination of Pregnancy

Performance of induced terminations of pregnancy must conform to all applicable requirements set forth in regulations of the DOH. Except in cases of medical or surgical emergencies, no pregnancy may be terminated in an emergency room.

The NYS Medicaid Program covers abortions which have been determined to be medically necessary by the attending physician. The doctor makes the determination of medical necessity and so indicates on the claim form.

Although Medicaid covers only medically necessary abortions, payment is made for both medically necessary and elective abortions provided to NYC enrollees. Payment for elective abortions is funded with 100% New York City funds.

Obstetrical Services

Obstetrical care includes prenatal care in a physician's office or dispensary, delivery in the home or hospital, postpartum care and, in addition, care for any complications that arise in the course of pregnancy and/or the puerperium. The following standards and guidelines are considered to be part of normal obstetrical care:

Antepartum Care

Under normal circumstances the physician should see the patient every 4 weeks for the first 28 weeks of pregnancy, then every 2 weeks until the 36th week and weekly thereafter, when this is feasible.

As part of complete antepartum care, provision of the following laboratory and other diagnostic procedures is encouraged:

- Papanicolaou smear,
- complete blood count,
- complete urine analysis,
- serologic examination for syphilis and hepatitis,
- chest X-ray with proper shielding of the abdomen, and
- blood grouping and Rh determination with serial antibody titers, where indicated.

Intrapartum Care

Whenever possible, delivery should be performed in a hospital. In addition to these standards, the routine attendance of a qualified anesthesiologist at the time of delivery

is recommended as an important preventive measure in promoting optimum medical care for both mother and infant.

Postpartum Care

Upon discharge from the hospital, the patient should be seen for a postpartum physical exam at 3 to 6 weeks and again in 3 to 6 months.

A Papanicolaou smear should be obtained during the postpartum period at one of the visits.

Other Medical Care

Consultation with specialists in other branches of medicine should be freely sought without delay when the condition of the patient requires such care.

Section V – Related Programs

Child/Teen Health Program

New York State's Medicaid Program (Child Health Plus A) implements federal EPSDT requirements via the Child/Teen Health Program (CTHP). The CTHP care standards and periodicity schedule are provided by the Department of Health, and generally follow the recommendations of the Committee on Standards of Child Health, American Academy of Pediatrics.

New York State's CTHP promotes early and periodic screening, diagnosis and treatment aimed at addressing any health or mental health problems identified during exams. The CTHP includes a full range of comprehensive, primary health care services for Medicaid-eligible youth from birth until age 21.

Many categories of providers directly render or contract for primary health care services for Medicaid-eligible youth services by the CTHP. For example:

- Physicians;
- Nurse Practitioners;
- Clinics;
- Hospitals;
- Nursing Homes;
- Office of Mental Health Licensed Residential Treatment Facilities;
- Office of Mental Retardation and Developmental Disabilities, Licensed Intermediate Care Facilities for the Developmentally Disabled;
- Office of Children and Family Services Authorized Child (Foster) Care Agencies;
- Medicaid Managed Care Organizations; and
- Medicaid-enrolled School-Based Health Centers.

New York State's EPSDT/CTHP Provider Manual for Child Health Plus A (Medicaid) also emphasizes recommendations of *Bright Futures* in order to guide provider practice, and improve health and mental health outcomes for Medicaid-eligible youth. The EPSDT/CTHP Provider Manual for Child Health Plus A (Medicaid) is available online at:

http://www.emedny.org/ProviderManuals/EPSDTCTHP/index.html.

Preferred Physicians and Children Program

The Preferred Physicians and Children (PPAC) program is an important part of the State's effort to assure children access to quality medical care through the Medicaid Program. The PPAC program:

- Encourages the participation of qualified practitioners;
- Increases children's access to comprehensive primary care and to other specialist physician services; and,
- Promotes the coordination of medical care between the primary care physician and other physician specialists.

Application for the Preferred Physicians and Children Program

PPAC provider enrollment applications may be obtained online at:

http://www.emedny.org/info/ProviderEnrollment/index.html.

PPAC Procedure Codes are in the Procedure Code and Fee Schedule Section of this manual, available at:

http://www.emedny.org/ProviderManuals/Physician/index.html.

Physician Eligibility and Practice Requirements

The qualified primary care physician will:

- Have an active hospital admitting privilege at an accredited hospital.

  This requirement may be waived for the physician who qualifies for hospital admitting privilege but does not have one due to such reason as the unavailability of admitting privilege at area hospitals; or nearest hospital too distant from office to be practical.

  Such physician will submit *each of the following* at the time of application:

  - a description of the circumstance that merits consideration of waiver of this requirement,
  - evidence of an agreement between the applicant and a primary care physician who is licensed to practice in New York, has an active hospital admitting privilege and will monitor and provide continuity of care to the applicant's patients who are hospitalized; and

- a curriculum vitae; proof of medical malpractice insurance; and two letters of reference, each from a physician who can attest to the applicant's qualifications as a practicing physician.

- Be board certified (or board admissible for a period of no more than five years from completion of a post graduate training program) in family practice, internal medicine, obstetrics and gynecology, or pediatrics.

  The physician who participates in the PPAC program and is board admissible must re-qualify when board admissibility reaches five years.

- Provide 24-hour telephone coverage for consultation.

  This will be accomplished by having an after-hours phone number with an on-call physician, nurse practitioner or physician's assistant to respond to patients.

  This requirement cannot be met by a recording which refers patients to emergency rooms.

- Provide medical care coordination.

  Medical care coordination will include at a minimum: the scheduling of elective hospital admissions, assistance with emergency admissions; management of and/or participation in hospital care and discharge planning, scheduling of referral appointments with written referral as necessary and with request for follow-up report, and scheduling for necessary ancillary services.

- Agree to provide periodic health assessment examination in accordance with the Child/Teen Health program (CTHP) standards of Medicaid.

- Be a provider in good standing if enrolled in the Medicaid Program at time of application to PPAC.

- Sign an agreement with the Medicaid Program, such agreement to be subject to cancellation with 30-day notice by either party.

The qualified non-primary care specialist physician will:

- Have an active hospital admitting privilege at an accredited hospital;

  This requirement may be waived for the physician who qualifies for hospital admitting privilege but does not have one because the practice of his/her specialty does not support need for admitting privilege.

  Such physician will submit at the time of application, (a) a description of the circumstance that merits consideration of waiver of this requirement, and (b) where applicable, **EITHER** a copy of a letter of active hospital appointment other than admitting **OR** evidence of an agreement between the applicant and a

primary care physician who is licensed to practice in New York, has an active hospital admitting privilege and will monitor and provide continuity of care to the applicant's patients who are hospitalized; and (c) a curriculum vitae; proof of medical malpractice insurance; and two letters of reference, each from a physician who can attest to the applicant's qualifications as a practicing physician.

- Be board certified (or board admissible for a period of not more than five years from completion of a post graduate training program) in a specialty recognized by the DOH;

  The physician who participates in PPAC and is board admissible must requalify when board admissibility reaches five years.

- Provide consultation summary or appropriate periodic progress notes to the primary care physician on a timely basis following a referral or routinely scheduled consultant visit;

- Notify the primary care physician when scheduling hospital admission;

- Be a provider in good standing if enrolled in the Medicaid Program at time of application to PPAC;

- Sign an agreement with the Medicaid Program, such agreement to be subject to cancellation with 30-day notice by either party.

Covered Services

For the PPAC participating provider the visit/examination is the only service claimed and reimbursed through PPAC. Claiming is specific to place of service, such as office.

The PPAC participating provider may NOT bill for:

- physician services provided in Article 28 clinics or

- contractual physician services in emergency rooms.

Claims for physician services other than the visit/examination will continue to be claimed and reimbursed in accordance with the instructions outlined in this Manual.

Physically Handicapped Children's Program

The Physically Handicapped Children's Program (PHCP) is a Federal Grant Program under the Social Security Act established to aid states in the provision of medical services for the treatment and rehabilitation of physically handicapped children. Administration of the Program is supervised by Department of Health.

On the local level, county health commissioners, county directors of PHCP, or the New York City Health Department's Bureau of Handicapped Children have responsibility for the Program. Providers will deal primarily with designated local officials.

Services Available and Conditions Covered

Medical services available under PHCP include diagnostic, therapeutic, and rehabilitative care by medical and paramedical personnel. Necessary hospital and related care, drugs, prosthesis, appliances, and equipment are also available under the Program.

This Program includes care for 125 categories of handicapping conditions. Care is available not only for defects and disabilities of the musculo-skeletal system, but also:

- cardiac defects,
- hearing loss,
- hydrocephalus,
- convulsive disorders,
- dento-facial abnormalities, and
- many other conditions.

Treatment for long-term diseases, i.e., cystic fibrosis, muscular dystrophy, rheumatic heart disease, which are likely to result in a handicap in the absence of treatment, is also available.

For more detailed information on covered services, the provider should contact the county health department or the local PHCP office.

Eligibility

To participate in the PHCP, a child must first be determined medically-eligible, i.e., having one of the defects or disabilities referred to above.

A child under age 21 who, in a physician's professional judgment, may be eligible for the PHCP should be referred to the local medical rehabilitation officer, the county commissioner of health, the local PHCP medical director, or the Bureau of Handicapped Children (New York City) for a determination of the child's eligibility for the Program.

Financing

A great number of PHCP cases will be financed by Medicaid. If the family of a medically-eligible child is not currently covered by Medicaid, the family will be referred by PHCP officials to the LDSS for a determination of Medicaid eligibility.

If the child is determined eligible for Medicaid, payment for services for the child will be paid with Medicaid funds. If the child is determined ineligible for Medicaid, payment for services will be paid by the PHCP and/or the child's family.

Reimbursement for services rendered to PHCP participants (either from Medicaid or PHCP funds) will not exceed the fees and rates established by the Department of Health.

Prior Approval

Prior approval is required for treatment of medical and dental conditions under the Program. Such approval is to assure that:

- The clinical conditions come under the Program;
- The physician or dentist meets the required program qualifications;
- The institution, if necessary, has been specifically approved for the service required.

Prior approval must be obtained from the county health officer or PHCP medical director. Requests for prior approval should be initiated by the attending physician by submission of an appropriate form which may be obtained from city, county, or district health offices, or the eMedNY Contractor.

Prior approval for treatment will be granted only for a specified period of time. Generally, Medicaid reimbursement will only be available for treatment rendered during that approved period of time. Reimbursement, however, will continue to be made should the child's Medicaid coverage be terminated during the treatment period. In such an instance, payment will only be made for the prior-approved treatment and will be discontinued upon completion of that treatment.

In an emergency, care may be provided without prior approval. *However, the county health officer or PHCP medical director must be promptly notified of such care.*

Family Care Program

The Family Care Program of the New York State Office of Mental Health/Office of Mental Retardation and Developmental Disabilities (OMH/OMRDD) provides supervised residence in the community for inpatients of psychiatric or developmental centers who

have responded to treatment and other persons who, though unable to function adequately in their own homes, do not require inpatient care. Individuals who have been determined able to live in the community may be placed in certified family care homes.

Each family care home must possess an OMH or an OMRDD operating certificate. Those who operate family care homes provide room and board, some non-emergency transportation, and basic support services to their residence. The OMH/OMRDD facility making the placement exercises administrative control over the family care home.

Since the emphasis of the Family Care Program is on integration into the community, the use of private practitioners is encouraged for medical care. Enrollees who have been placed in an approved family care home are eligible for the full range of services covered by Medicaid, except when OMH family-care residents require acute psychiatric hospitalization. These enrollees must return to their psychiatric centers.

State regulations also require annual medical, dental and psychiatric or psychological examinations for all family-care residents, which may be provided by practitioners in the community.

The same prior approval requirements in addition to any other Program restrictions that apply when services are provided to other Medicaid enrollees, also apply in cases involving family care residents.

Individuals in the Family Care Program must be determined Medicaid-eligible by the Department of Health in conjunction with the OMH/OMRDD. Residents determined eligible for Medicaid are issued a permanent plastic CBIC.

Family Planning Benefit Program

This program provides Medicaid coverage for family planning services to all persons of childbearing age with incomes at or below 200% of the federal poverty level. This population will have access to all enrolled Medicaid family planning providers and family planning services currently available under Medicaid.

Family planning services under this program can be provided by all Medicaid enrolled family planning providers including physicians and nurse practitioners. Covered family planning services include:

- All FDA-approved birth control methods, devices, pharmaceuticals, and supplies;
- Emergency contraceptive services and follow-up;
- Male and female sterilization in accordance with 18 NYCRR Section 505.13(e); and
- Preconception counseling and preventive screening and family planning options.

The following additional services are considered family planning only when provided during a family planning visit and when the service provided is directly related to family planning:

- Pregnancy testing and counseling;
- Counseling services related to pregnancy and informed consent, and STD/HIV risk counseling;
- Comprehensive reproductive health history and physical examination, including clinical breast exam (excluding mammography);
- Screening for STDs, cervical cancer, and genito-urinary infections;
- Screening and related diagnostic testing for conditions impacting contraceptive choice, i.e. glycosuria, proteinuria, hypertension, etc.;
- HIV counseling and testing;
- Laboratory tests to determine eligibility for contraceptive of choice; and
- Referral for primary care services as indicated.

For more information on the FPBP, please call the Bureau of Policy Development and Coverage at (518) 473-2160.

Prenatal Care Assistance Program

Prenatal Care Assistance Program (PCAP) is a comprehensive prenatal program administered by the DOH that offers complete pregnancy care and other health services to women and teens who live in New York State and meet certain income guidelines. PCAP offers:

- routine pregnancy check-ups,
- hospital care during pregnancy and delivery,
- full Medicaid coverage for the woman until at least two months after delivery, and
- full Medicaid coverage for the baby up to one year of age.

Providers interested in this Program may go online to:

http://www.health.state.ny.us/nysdoh/perinatal/en/

or

http://www.emedny.org/ProviderManuals/Prenatal/index.html.

Medicaid Obstetrical and Maternal Services Program

Obstetricians, family physicians, nurse midwives and nurse practitioners who meet certain criteria may enroll in the Medicaid Obstetrical and Maternal Service (MOMS) program and receive increased fees for obstetrical care.

Practitioners participating in the MOMS program are required to refer Medicaid-eligible pregnant women for non-medical health supportive services such as:

- nutrition and psychosocial assessment and counseling,
- health education, and
- care coordination.

Health supportive services are provided by approved agencies such as county health departments, certified home health agencies and Prenatal Care Assistance Programs (PCAP).

The interested physician, midwife or nurse practitioner may apply to participate in the MOMS program by completing the following two forms, which must be submitted together:

- the "Application for Enrollment as a Medical (or Dental) Specialist" ***and***
- the MOMS Addendum.

For additional information regarding the MOMS and Health Supportive Services programs, please call the Department at:

(518) 474-1911.

MOMS Eligibility and Practice Requirements
Physicians who participate must:

- be board certified or an active candidate for board certification by the American College of Obstetrics and Gynecologists (ACOG) or eligible for board certification by the American Academy of Family Practice Physicians for a period of no more than five years from completion of a post-graduate training period in obstetrics and gynecology or family practice;
- have active hospital-admitting privileges in an appropriately accredited hospital which includes maternity services;

- provide medical care in accordance with the practice guidelines established by the ACOG;
- have 24-hour telephone coverage;
- have an agreement with an approved health supportive service provider to provide non-medical health supportive services such as health education, nutrition, and psychosocial assessment and counseling, case management, presumptive eligibility, and acting as an authorized representative for the Medicaid application;
- provide medical care coordination and agree to participate in managed care programs if the managed care programs are operational within the physician's geographic practice area;
- be a provider in good standing;
- sign an agreement with the Medicaid Program, such agreement to be subject to cancellation with 30-day notice by either party.

For physician enrollment information, please go online to:

http://www.emedny.org/info/ProviderEnrollment/index.html

For additional information, please go to:

http://www.health.state.ny.us/nysdoh/perinatal/en/

Utilization Threshold Program

In order to contain costs while continuing to provide medically necessary care and services, Medicaid will pay for a limited number of certain health services per benefit year unless additional services have been approved. The established thresholds are:

Service	Number of Visits, Items or Lab Tests Allowed per Year
Pharmacy (prescription drugs including initial prescriptions, refills, over-the-counter medicine and medical/surgical supplies)	40 items if the enrollee is: • Under 21 • 65 or over • Certified blind or disabled • Single caretaker of a child under 18 43 items if the enrollee is:

Service	Number of Visits, Items or Lab Tests Allowed per Year
	• 21 to 65 • Not certified blind or disabled • Not a single caretaker of a child under 18
Physician and Medical Clinic	10 visits
Dental Clinic	3 visits
Laboratory	18 procedures
Mental Health Clinic	40 visits

These Utilization Thresholds have been set in accordance with historical information on service use from the Medicaid Program. The threshold limits are high enough so that most enrollees will not be affected. It will be necessary, however, for providers to verify eligibility and to obtain authorization through the MEVS for those services that they provide.

The potential provider of a service will be required to access the MEVS to receive provider/enrollee service data to ascertain whether the enrollee has reached the particular threshold for that type of service. If the enrollee has not reached his/her service limitation, the MEVS will inform the provider that the service is approved and record that approval for transmission to the eMedNY Contractor. Without such approval, the provider's claim for service will not be paid by the eMedNY Contractor. Exceptions to this are situations such as emergency or urgent care when the provider will use on the "SA EXCP CODES" on the claim as described in the **Billing Guidelines** section of each specific provider manual.

The Department recognizes that an initiative such as this must be sensitive to the needs of individual patients who require medically necessary services beyond the normal limits because of a chronic medical condition or an acute spell of illness. To accommodate these patients, the physician may request that higher limits be approved for a particular Utilization Threshold or an exemption be approved for a particular Utilization Threshold by submitting a "Threshold Override Application" form to the Medicaid Override Application System (MOAS).

In order to help avoid a disruption in an enrollee's medical care, a "nearing limits" letter will be sent to the enrollee, when the authorized services are being used at a rate that will utilize all available services, in less than the current benefit year. This letter will advise the enrollee to contact his/her provider who should submit the Threshold Override Application form to increase the enrollee's service limits. The provider will also be alerted to the fact that this letter has been sent via a message on the MEVS terminal.

When an enrollee reaches his/her Utilization Threshold, a letter will be sent to the enrollee and the provider will be alerted to this fact via a message on the MEVS terminal.

Certain Medicaid enrollees will be exempt from most Utilization Thresholds because they receive their medical care though Managed Care Programs, i.e., Health Maintenance Organizations, prepaid capitation service plans.

There are also some services which are exempt from Utilization Threshold and the enrollee's use of these services is not limited under this Program. Such services include:

- Family Planning,
- Methadone Maintenance Treatment,
- Certain obstetric services,
- Child/Teen Health Program services, and
- Kidney dialysis.

Recipient Restriction Program

The Recipient Restriction Program (RRP) is an administrative mechanism whereby selected Medicaid enrollees with a demonstrated pattern of abusive utilization of Medicaid services must receive their medical care from a designated primary provider(s). The goals of the RRP are the elimination of abusive utilization behavior and the promotion of quality care for restricted enrollees through coordination of the delivery of select medical services.

The DOH and LDSS may restrict enrollees to the following provider types:

- Physicians,
- Clinics,
- Pharmacies,
- Inpatient hospitals,
- Podiatrists,
- Dentists and
- Durable Medical Equipment providers.

These restrictions may be imposed individually or in conjunction with one another. To promote coordinated medical care, the RRP prohibits restricted enrollees from obtaining

certain ancillary services such as laboratory and transportation ordered by non-primary providers.

Billing information relating to the RRP is located in the **Billing Guidelines** of each specific provider manual.

MEVS Implications for the RRP

It is important for all providers to properly access the MEVS to ensure that the enrollee is eligible and to:

- Avoid rendering services to a patient who is restricted to another provider; and/or
- Ensure that ordered services are provided at the request of a restricted enrollee's primary provider or a provider to whom the enrollee was referred by his/her primary provider.

For instructions on MEVS transactions, please refer to the MEVS Provider Manual online at:

http://www.emedny.org/ProviderManuals/index.html.

Managed Care

Managed Care is a comprehensive and coordinated system of medical and health care service delivery encompassing ancillary services, as well as acute inpatient care. The Managed Care Organization (MCO) is responsible for assuring that enrollees have access to a comprehensive range of preventative, primary and specialty services. The MCO may provide services directly or through a network of providers. The MCO receives a monthly premium for each enrollee to provide these services.

In a MCO, each Medicaid enrollee is linked to a primary care practitioner. This provider may be a private practicing physician, on staff in a community health center or outpatient department, or may be a nurse practitioner. Regardless of the setting, the primary care provider is the focal point of the Managed Care system. This practitioner is responsible for the delivery of primary care, and also coordinates and case manages most other necessary services. Another feature of managed care is 24-hour, 7-day/week access to care.

A Medicaid enrollee enrolled with a MCO remains eligible for the full range of medical services available in the Medicaid Program. However, an enrolled enrollee is required to access most health care services through his/her MCO. When an enrollee is determined Medicaid-eligible, he/she has the opportunity to enroll with a MCO, but not all enrollees will be enrolled in a MCO.

Certain individuals are excluded from participating on Medicaid Managed Care:

- Individuals who “spend down” to obtain Medicaid eligibility;
- Foster care children whom the fiscally responsible LDSS has placed under the auspices of a voluntary child (foster) care agency;
- Medicare/Medicaid dual eligibles;
- Residents of State-operated inpatient psychiatric facilities;
- Residents of residential treatment facilities for children and youth;
- Enrollees of Mental Health Family Care services;
- Residents of residential health care facilities at the time of enrollment;
- Participants in a long term care capitation demonstration project;
- Infants of incarcerated mothers;
- Participants in the Long Term Home Health Care Program;
- Certified blind or disabled children who are living apart from their parents over 30 days;
- Individuals expected to be eligible for Medicaid less than 6 months;
- Individuals receiving hospice services;
- Individuals receiving services from a Certified Home Health Agency when it has been determined that they are not suitable for managed care enrollment;
- Individuals enrolled in the Restricted Enrollee Program with a primary physician, clinic, dental, DME, or inpatient provider;
- Enrollees who have other third party insurance so that managed care enrollment is not cost-effective.

MEVS Implications for Managed Care

Provider must check the MEVS prior to rendering services to determine the enrollee’s Medicaid eligibility and the conditions of Medicaid coverage. If the Medicaid enrollee is enrolled with a MCO, the first MEVS coverage message will indicate, “Eligible PCP”.

> **Note**: PCP stands for Prepaid Capitation Plan (or MCO). Please refer to the MEVS manual for instructions on Managed Care transactions.

While MCOs are required to provide a uniform benefit package, there may be some variations between MCOs. The MEVS coverage codes are general service categories within the general category. To avoid payment problems, providers should contact the MCO whenever possible before providing services.

Providers may bill Medicaid and receive payment for any services not covered by the MCO. However, Medicaid will deny payment for services which are covered by the MCO. If a provider is not a participating provider in the enrollee's MCO, and the provider is certain that the service is covered by the MCO, then the provider must first refer the enrollee to his/her MCO for that service, or call the MCO prior to providing service.

Section VI – Definitions

For the purposes of the Medicaid Program and as used in this Manual, the following terms are defined to mean:

Emergency

An emergency is defined as care for patients with severe, life threatening, or potentially disabling conditions that require immediate intervention.

Emergency Services

Care provided after a sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity that the absence of immediate medical treatment could reasonably result in:

- serious impairment of bodily functions;
- serious dysfunction of a bodily organ or body part; or
- would otherwise place the enrollee's health in serious jeopardy.

Factor

A person or an organization such as a collection agency, service bureau or an individual that advances money to a provider for accounts receivable in return for a fee, deduction, or discount based on the dollar amount billed or collected. The accounts receivable are transferred by the provider to the factor by means of assignment, sale or transfer, including transfer through the use of power of attorney.

Local Professional Director

The Local Professional Director (also known as the Local Medical Director or Reviewing Health Professional) is an individual who, under Section 365-b of the NYS Social Services Law, serves under the general direction of the Commissioner of Social Services and has responsibility for:

- supervising the medical aspects of the Medicaid Program,
- monitoring the professional activities related to the Program, and
- taking all steps required to ensure that such activities are in compliance with Social Services Law and Regulations and Public Health Law and Regulations.

Managed Care

Managed care is a comprehensive and coordinated system of medical and health care service delivery encompassing ancillary services, as well as acute inpatient care.

Prior Approval

Prior Approval is the process of evaluating the aspects of a plan of care which may be for a single service or an ongoing series of services in order to determine the medical necessity and appropriateness of the care requested.

Prior approval does not guarantee payment.

Prior Authorization

Prior authorization is the acceptance by the Local Commissioner of Social Services, or his/her designated representative, of conditional financial liability for a service or a series of services to be rendered by the provider.

Prior authorization does not guarantee payment.

Qualified Medicare Enrollee

Qualified Medicare Enrollees (QMBs) are individuals who have applied to Medicaid through the LDSS and have been determined eligible for Medicaid payment, as appropriate, of Medicare premiums, deductibles and coinsurance for Medicare-approved services.

QMB status is determined via the MEVS.

Unacceptable Practice

An unacceptable practice is conduct by a person which conflicts with any of the policies, standards or procedures of the State of New York as set forth in the Official Codes, Rules and Regulations of the Department of Health or any other State or Federal statute or regulation which relates to the quality of care, services and supplies or the fiscal integrity of the Medicaid Program.

Urgent Medical Care

A situation in which the patient has an acute or active problem which, if left untreated, might result in:

- an increase in the severity of symptoms;
- the development of complications;

- increase in recovery time;
- the development of an emergency situation.

NEW YORK STATE
MEDICAID PROGRAM

INFORMATION FOR ALL PROVIDERS
GENERAL BILLING

Table of Contents

Common Benefit Identification Card

There are four types of Common Benefit Identification Cards (CBIC) or documents with which you will need to become familiar;

- a photo card,
- a non-photo card,
- a paper replacement CBIC and
- a Temporary Medicaid Authorization (DSS-2831A).

The photo and non-photo cards are permanent plastic cards and each contains information needed for verifying eligibility for a single enrollee. Each card contains the following information for the enrollee:

- Medicaid identification number;
- first name;
- last name;
- middle initial;
- sex; and
- date of birth.

Additionally, each card contains an access number, a sequence number, an encoded magnetic strip and a signature panel. The photo ID card also contains a photo. Neither card contains an expiration date.

The provider must verify enrollee eligibility via the Medicaid Eligibility Verification System (MEVS) each time service is provided to be assured that an enrollee is eligible.

If an enrollee's permanent plastic ID card has been lost, stolen or damaged, the enrollee will be issued a temporary replacement paper CBIC (DSS-3713), which contains the following information for the enrollee:

- Medicaid identification number;
- first name;
- last name;
- middle initial;
- sex; and
- date of birth.

This temporary card carries an expiration date after which the card cannot be used. Verification of eligibility must be completed via MEVS whenever a temporary replacement card (DSS-3713) is presented.

In some circumstances, the enrollee may present a Temporary Medicaid Authorization (DSS-2831A). This document is issued by the local department of social services

(LDSS) when the enrollee has an immediate medical need and a permanent plastic identification card has not yet been received by the enrollee. It is a guarantee of eligibility for the authorization period indicated (maximum 15 days); therefore, verification of eligibility via MEVS is not required. Limitations and/or restrictions are listed on the Authorization. In these cases it will be necessary for some providers to place a code of "M" in the "SA EXCP CODE" field on the eMedNY billing form in order to indicate that the enrollee had a Temporary Medicaid Authorization. Please refer to the Billing Guidelines section of your specific provider manual for instructions. Questions regarding eligibility should be directed to the LDSS issuing the DSS-2831A.

Note: Each of these documents is described in greater detail in the "Common Benefit Identification Card" section of the MEVS Provider Manual.

The MEVS Provider Manual is available to Medicaid enrolled providers. This manual can be accessed at or downloaded from:

http://www.emedny.org/ProviderManuals/index.html.

Samples of the four types of CBIC are shown and detailed descriptions are provided in the **MEVS Provider Manual** section entitled, "Common Benefit Identification Cards".

Note: The sample cards shown in the **MEVS Provider Manual** are issued to New York State Medicaid enrollees whose district of fiscal responsibility is within eMedNY. Claims for patients with non-eMedNY CBIC should be sent to the Local Department of Social Services indicated in the MEVS response.

Voice Interactive Phone System

Medicaid offers the Voice Interactive Phone System (VIPS) to afford providers the opportunity to conduct a name search to locate the Client Identification Number (CIN) of Medicaid enrollees who were unable to present their cards at the time of service. This system is accessible by calling (518) 472-1550 from a touch-tone telephone and following the voice prompts. There is a charge of $.85 per minute.

Prior Approval Rosters

Prior approval/authorization rosters contain information necessary to submit claims for certain services provided to Medicaid enrollees. Rosters contain necessary billing information, including, but not limited to: prior approval/authorization number, client identification number, applicable approved/authorized procedure/rate code/s, and date/s of service.

Electronic Roster

Rosters are available electronically in Portable Document Format (pdf) via the eMedNY eXchange, at no additional expense to providers, and are delivered in advance of hard copy rosters so claims may be submitted and paid earlier. Electronic rosters are not in HIPAA-compliant format, therefore providers need not purchase additional software to read or interpret roster information.

Weekly rosters for transportation and personal care services providers are posted every Monday. For all other provider types, a roster is posted the day after prior approvals are approved.

eXchange works like email. A provider, who has requested an electronic roster, would log on to the eXchange via the eMedNY website. After entering an assigned User Identification Number and password, the provider is able to print the roster and/or detach the roster file to save it on a personal computer for future reference.

What information is included on the electronic roster?

- Roster Date
- PA Number
- Procedure/Rate Code
- Approved Quantity
- Approved Times
- Patient Name
- Patient Medicaid ID
- Patient Gender
- Patient Date of Birth
- Patient County
- Billing Provider Name
- Billing Provider ID
- Ordering Provider ID
- Dates of Service
- Approved Amount

How does a provider obtain a User Identification Number and password for eXchange?

First, the eMedNY eXchange is available only to providers who have enrolled in ePACES. Once a provider is enrolled in ePACES, then the provider is automatically enrolled in eXchange.

After successful enrollment in ePACES, the provider calls the eMedNY Call Center at (800) 343-9000 to activate their eXchange inbox.

Providers not yet enrolled in ePACES will need the following prior to contacting the Call Center to enroll:

- Computer with internet access;
- Valid email address;
- Internet browser (Explorer v.4.01, Netscape v 4.7 or higher);
- Operating system of Microsoft Windows, Macintosh or Linux; and
- NYS Medicaid Provider Identification number.

The electronic prior approval request for is available at:

http://www.emedny.org/info/ProviderEnrollment/index.html.

Billing for Medical Assistance Services

Medicaid regulations require that claims for payment of medical care, services, or supplies to eligible enrollees be initially submitted within **90 days of the date of service** to be valid and enforceable, unless the claim is delayed due to circumstances outside the control of the provider. Acceptable reasons for a claim to be submitted beyond 90 days are listed below.

If a claim is denied or returned for correction, it must be corrected and resubmitted within **60 days of the date of notification** to the provider. Claims not correctly resubmitted within 60 days, or those continuing to not be payable after the second resubmission, are neither valid nor enforceable.

All claims must be **finally** submitted to the eMedNY Contractor and be payable within two years from the date the care, services or supplies were furnished in order to be valid and enforceable against the Department or a social service district.

Claims Submitted for Stop-Loss Payments

All claims for Stop-Loss payment must be finally submitted to the Department, and be payable, within two years from the close of the benefit year in order to be valid and enforceable against the Department.

For example, calendar year 2002 payable claims must be finally submitted no later than December 31, 2004 with corresponding cutoff for future years.

Claims Over 90-Days Old, Less Than Two Years Old

Paper claims over 90 days of the date of service must be submitted with a 90-day letter attached (with the exception of Third Party Insurance Processing Delay). The reason for the delay should be indicated on a piece of paper the same size (8½ x 11) and paper quality as the invoice.

Because the claim forms do not contain an invoice number, **each** claim must have its **own** 90-day letter attached. This allows the imaging system to simultaneously track each claim and attachment.

Acceptable Delay Reasons

Claims over 90 days, and less than two years, from the date of service may be submitted if the delay is due to one or more of the following acceptable conditions. *The applicable delay reason(s) must be included on a 90-day letter attached to the claim.*

- **Proof of Eligibility Unknown or Unavailable – Delay in Medicaid Client Eligibility Determination (including Fair Hearing)**

The enrollee applied for Medicaid and their eligibility was backdated. If the claim ages over 90 days while this process is taking place, then this reason applies.

The claim must be submitted within 30 days from the time of notification.

- **Litigation**

  This means there was some kind of litigation involved and there was the possibility that payment for the claim may come from another source, such as a lawsuit.

  The claim must be submitted within thirty (30) days from the time submission came within the control of the Provider.

- **Authorization Delays/Administrative Delay (Enrollment Process, Prior Approval Process, Rate Changes, etc.) by the Department or other State Agency**

  For example: Provider enrollment may back date the effective date of a Specialty Code.

- **Delay in Certifying Provider/Administrative Delay (Enrollment Process, Prior Approval Process, Rate Changes, etc.) by the Department or other State Agency**

  For example: Provider enrollment may back date the effective date of a Specialty Code.

- **Delay in Supplying Billing Forms**

- **Third Party Processing Delay – Medicare and Other Third Party Processing Delays**

  The claim had to be submitted to Medicare or other Third Party Insurance before being submitted to Medicaid.

  The claim must be submitted within thirty (30) days from the time submission came within the control of the Provider.

- **Delay in Eligibility Determination/Delay in Medicaid Client Eligibility Determination (including Fair Hearing)**

  This means the enrollee applied for Medicaid and their eligibility date was backdated. If the claim ages over 90 days while this process is taking place, then this reason applies.

The claim must be submitted within thirty (30) days from the time of notification.

- **Original Claim Rejected or Denied Due to a Reason Unrelated to the Billing Limitation Rules**

  This means the Provider submitted the claim on time and was denied for some other reason. If the date of service is over 90 days when they rebill, this reason applies.

  The claim must be submitted within thirty (30) days from the time of notification.

- **Administration Delay in the Prior Approval Process/Administrative Delay (prior approval) by the Department of Health or other State agency**

  IPRO denial/reversal (Island Peer Review Organization) previously denied the claim, but the denial was reversed on appeal.

- **Other/Interrupted Maternity Care**

  Prenatal care claims over 90 days because delivery was performed by a different practitioner.

Claims Over Two Years Old

All claims over two years old will be denied for **edit 1292** (*DOS (date of service) Two Yrs (years) Prior to Date Received*). The Department will *only* consider claims over two years old for payment only if the provider can produce documentation verifying that the cause of the delay was the result of one or more of the following:

- Errors by the Department, the local social services district, or another agent of the Department; or

- Court-ordered payments.

If a Provider believes that claims denied for edit 1292 are payable due to one of the reasons above, they may request a review. All claims **must** be submitted **within 90 days of the date on the remittance advice** with supporting documentation to:

New York State Department of Health
Two Year Claim Review
150 Broadway, Suite 6E
Albany, New York 12204-2736.

Claims submitted for review without the appropriate documentation, or those not submitted within the 90-day time period for review, will not be considered.

When a provider **voids** a previously paid claim and now wishes to resubmit, the resubmission is treated as a **new claim** and will be subjected to the criteria above for the submission of claim(s) over two years old. All timely submission rules apply. The new claim will not be considered as an agency error and, therefore, **will not** qualify for a waiver of the two-year regulation. Adjustments, rather than voids, should always be billed to correct a paid claim(s).

Electronic Claims Submission

Most claims for payment of medical care, services and supplies may be submitted electronically, including originals, resubmissions, adjustments and voids. The only exceptions are claims that require paper attachments such as enrollee's "consent forms" or provider's procedure reports for manual pricing.

When a file is submitted to eMedNY, a series of response files are returned to the submitter to communicate the status of the transaction. Errors in transmissions may cause transactions not to be processed. eMedNY sends status files that can prevent surprises and negative impacts on cash flow. Please review the list of frequently asked questions online at:

http://www.emedny.org/hipaa/FAQs/index.html.

If you would like more information about computer generated claims submission or require the input specifications for the submission of the types of claims indicated above, please call the eMedNY Call Center at (800) 343-9000.

Claim Status Options

Medicaid offers a number of tools to assist providers seeking claim status information without having to wait for remittance statements. eMedNY Call Center staff are **not** able to perform routine claim status checks for providers and submitters waiting for their remittances to be delivered.

ePACES

To request claim status for ePACES claims, providers just need to select from a list of submitted claims. The status of ePACES claims is usually available on the same day the claim was submitted.

For claims submitted via other methods, ePACES requires the key entry of a few pieces of claim data in order to retrieve the status, including the paid amount. Availability of the claim status for claims submitted via other methods may vary depending on the submission method and the time it reached the eMedNY Contractor for processing.

ePACES Real Time

The status of claims, including the paid amount, submitted via "Real Time" is available for professional claims immediately following submission.

Electronic Claim Status Request

Electronic requests can be submitted as batch files. Submitters need a software program to produce the requests in a HIPAA-compliant format and to interpret the 277 Claim Status Response.

Electronic Claim Status Responses

These are returned via ePACES or the 277 transaction containing the HIPAA-compliant response codes. To assist providers with interpreting the response codes, an edit mapping document is available online at:

http://www.emedny.org/hipaa/Crosswalk/index.html.

Paper Remittance

Claim status information is available two and one half weeks after processing is completed.

Electronic Remittance

To receive Electronic Remittances, providers must submit a completed *Electronic Remittance Request Form,* available online at:

http://www.emedny.org/info/ProviderEnrollment/index.html.

Electronic Remittances generally include the status of electronically and paper submitted claims as well as state-submitted adjustments and voids whenever providers who have only one Electronic Transmitter Identification Number sign up for electronic remittances.

Note: State-submitted adjustments and voids are transactions submitted by New York State or one of its contractors and are based upon audit findings.

The *Electronic Remittance Request Form* is available online at:

http://www.emedny.org/info/ProviderEnrollment/index.html.

Electronic Funds Transfer

Medicaid funds issued to a provider as a result of paper or electronic claims submission can be electronically transferred to a designated bank account or accounts. Providers do not have to submit claims electronically to take advantage of the convenience of EFT. To enroll in EFT, complete the EFT Provider Enrollment Form, available online at:

http://www.emedny.org/info/ProviderEnrollment/index.html.

After submitting the *Form*, please allow four to six weeks for processing.

Claims Pended for Review by the Office of the State Comptroller

The New York State Constitution requires the Office of the State Comptroller (OSC) to audit all vouchers before payment, including claims that are submitted to the Medicaid Program. OSC will suspend certain claims from the Medicaid payment procedure in order to conduct a thorough review of those claims.

Some providers will see an edit code and reason associated with the OSC audit:

02014 – Claim Under Review by the Office of the State Comptroller.

If a provider is receiving the HIPAA-compliant error codes, then the OSC edit will be mapped to:

Claim Adjustment Reason Code 95 – Benefits Adjusted. Plan Procedures Not Followed.

If a provider has claims pending or denied for this reason, a representative from OSC will contact the provider to discuss the provider's claims. This may include scheduling an appointment to visit the provider's facility to inspect medical records and other documentation supporting the claims being reviewed.

Under the Code of Federal Regulations (45 CFR § 164.512(d)(1) (HIPAA)), medical providers are permitted to disclose protected health information to an oversight agency, for oversight activities which are authorized by law, such as audits. For these purposes, OSC is an oversight agency.

HIPAA Claim Denials

With the implementation of HIPAA-standardized claim error reasons, it can be difficult to pinpoint the specific reason for a claim denial because HIPAA requires that denied claims be assigned a *Claim Adjustment Reason Code*.

An Edit/Error Knowledgebase tool for analyzing claim edit codes and/or claim status codes is available online at:

http://www.emedny.org/hipaa/edit_error/KnowledgeBase.html.

Good Cause

Medicaid providers should always bill available health insurance unless they received authorization from the DOH that "good cause" exists not to bill the health insurance. Health insurance is only determined to be available if the Medicaid Eligibility Verification System (MEVS) indicates that the insurance covers the particular service for which the provider would be billing Medicaid.

Circumstances in which the DOH must determine "good cause" not to bill health insurance involve situations where the billing could jeopardize the emotional or physical health, safety and/or privacy of the Medicaid enrollee. These circumstances commonly arise but are not restricted to occasions on which reproductive health services such as family planning, pregnancy-related services or treatment of sexually transmitted diseases are provided.

> *When warranted, providers on behalf of their patients may request a "good cause" determination and an authorization for not billing the health insurance.*

If a particular patient wants the service to remain confidential, the provider must contact the DOH **weekdays between 8:00am and 4:45pm** at:

(800) 541-2831.

If "good cause" is granted, the provider must document the date of the call and that DOH staff gave permission not to bill the health insurance. The information obtained may be utilized as documentation for future audits or claim reviews.

Once a positive determination of "good cause" has been received, the provider must enter $0.00 in the insurance payment field of the Medicaid claim form. *Since the DOH monitors $0.00 filled claims, it is especially important to obtain the previously described approval and document that approval.*

Claim Certification Statement

Provider certifies that:

- I am (or the business entity named on this form of which I am a partner, officer or director is) a qualified provider enrolled with and authorized to participate in the New York State Medical Assistance Program and in the profession or specialties, if any, required in connection with this claim;
- I have reviewed this form;
- I (or the entity) have furnished or caused to be furnished the care, services and supplies itemized in accordance with applicable federal and state laws and regulations;
- The amounts listed are due and, except as noted, no part thereof has been paid by, or to the best of my knowledge is payable from any source other than, the Medical Assistance Program;
- Payment of fees made in accordance with established schedules is accepted as payment in full; other than a claim rejected or denied or one for adjustment, no previous claim for the care, services and supplies itemized has been submitted or paid;
- All statements made hereon are true, accurate and complete to the best of my knowledge;
- No material fact has been omitted from this form;
- I understand that payment and satisfaction of this claim will be from federal, state and local public funds and that I may be prosecuted under applicable federal and state laws for any false claims, statements or documents or concealment of a material fact;
- Taxes from which the State is exempt are excluded;
- All records pertaining to the care, services and supplies provided including all records which are necessary to disclose fully the extent of care, services and supplies provided to individuals under the New York State Medical Assistance Program will be kept for a period of six years from the date of payment, and such records and information regarding this claim and payment therefore shall be promptly furnished upon request to the local departments of social services, the DOH, the State Medicaid Fraud Control Unit of the New York State Office of Attorney General or the Secretary of the Department of Health and Human Services;

- There has been compliance with the Federal Civil Rights Act of 1964 and with section 504 of the Federal Rehabilitation Act of 1973, as amended, which forbid discrimination on the basis of race, color, national origin, handicap, age, sex and religion;

- I agree (or the entity agrees) to comply with the requirements of 42 CFR Part 455 relating to disclosures by providers; the State of New York through its eMedNY Contractor or otherwise is hereby authorized to

    - (1) make administrative corrections to this claim to enable its automated processing subject to reversal by provider, and

    - (2) accept the claim data on this form as original evidence of care, services and supplies furnished.

By making this claim I understand and agree that I (or the entity) shall be subject to and bound by all rules, regulations, policies, standards, fee codes and procedures of the DOH as set forth in Title 18 of the Official Compilation of Codes, Rules and Regulations of New York State and other publications of the Department, including Provider Manuals and other official bulletins of the Department.

I understand and agree that I (or the entity) shall be subject to and shall accept, subject to due process of law, any determinations pursuant to said rules, regulations, policies, standards, fee codes and procedures, including, but not limited to, any duly made determination affecting my (or the entity's) past, present or future status in the Medicaid Program and/or imposing any duly considered sanction or penalty.

I understand that my signature on the face hereof incorporates the above certifications and attests to their truth.

NEW YORK STATE
MEDICAID PROGRAM

INFORMATION FOR ALL PROVIDERS

INQUIRY

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Computer Sciences Corporation Contact Information

Computer Sciences Corporation (CSC) is the Medicaid Program's eMedNY Contractor. Contact CSC with questions concerning:

- ePACES (electronic claims);
- obtaining claim forms;
- obtaining prior approval forms;
- Medicaid enrollment;
- obtaining transportation prior authorization for New York City enrollees;
- preparing/completing claim forms;
- remittance statements/billing;
- the Medicaid Eligibility Verification System (MEVS).

Hours of Operation

For provider inquiries pertaining to non-pharmacy billing or claims, or provider enrollment:

Monday through Friday 7:00am – 6:00pm EST

For provider inquiries pertaining to eligibility, service authorizations, DVS, and pharmacy claims:

Monday through Friday 7:00am – 10:00pm EST

Weekends and Holidays 8:30am – 5:30pm EST

Telephone Directory

If you are a:

- Physician
- Private Duty Nurse
- Clinical Social Worker
- Dentist
- Nurse Practitioner; or
- Ophthalmic Provider

Call **(800) 343-9000**
Option 1

Then, depending on your question:

If your question is concerning:	Choose:
➢ New Enrollment; ➢ ePACES Enrollment; ➢ TSN/ETIN applications.	**Sub-option 1**
➢ Explanation of eligibility response; ➢ UT service authorization; ➢ POS Device Support.	**Sub-option 2**
➢ Obtaining NYC Transportation Prior Authorizations	**Sub-option 3**
➢ Claims; ➢ Billing; ➢ Remittance; ➢ Form orders; and ➢ Prior approval.	**Sub-option 4**

If you are a:

- Pharmacy Provider

Call **(800) 343-9000**
Option 2

Then, depending on your question:

If your question is concerning:	Choose:
➢ New Enrollment; ➢ ePACES Enrollment; ➢ TSN/ETIN applications.	**Sub-option 1**
➢ For all other questions including: ▪ explanation of eligibility response, ▪ claims, ▪ billing, ▪ remittance and ▪ prior approval questions including DIRAD.	**Sub-option 2**

If you are a:

- Hospital;
- Clinic;
- Long Term Care Facility;
- Nursing Agency; or
- Child Care Agency;
- Home Health Agency

Call **(800) 343-9000**
Option 3

Then, depending on your question:

If your question is concerning:	Choose:
➢ New Enrollment; ➢ ePACES Enrollment; ➢ TSN/ETIN applications.	**Sub-option 1**
➢ Explanation of eligibility response; ➢ UT service authorization; ➢ POS Device Support.	**Sub-option 2**
➢ Obtaining NYC Transportation Prior Authorizations	**Sub-option 3**
➢ Claims; ➢ Billing; ➢ Remittance; ➢ Form orders; and ➢ Prior approval questions.	**Sub-option 4**

If you are a:

- Durable Medical Equipment;
- Hearing Aid; or
- Laboratory;
- Transportation Provider

Call **(800) 343-9000**
Option 4

Then, depending on your question:

If your question is concerning:	Choose:
➢ New Enrollment; ➢ ePACES Enrollment; ➢ TSN/ETIN applications.	**Sub-option 1**
➢ Explanation of eligibility response; ➢ UT service authorization; ➢ POS Device Support.	**Sub-option 2**
➢ Claims; ➢ Billing; ➢ Remittance; ➢ Form orders; and ➢ Prior approval questions.	**Sub-option 3**

If your question concerns:

- MOAS; or
- Threshold override application provider support

Call **(800) 343-9000**
Option 5

Training Requests

Requests for individual provider training can be made by calling

(800) 343-9000

or email:

emednyproviderrelations@csc.com

Training Seminars are also available and are designed for specific provider types. Registration, locations and dates are available online at:

http://www.emedny.org/HIPAA/Provider_Training/Training.html.

Mailing Addresses for Medicaid Correspondence

Correspondence should be mailed to the following address, with the applicable P.O. Box from the table:

Computer Sciences Corporation
P.O. Box _____
Rensselaer, New York 12144.

P.O. Box	Description of Contents	Form Types
4600	Prior Approval and Prior Authorization Requests	• EMEDNY-3614 (Dental) • EMEDNY-3615 (Drugs…Physician) • EMEDNY-2832 (Hearing Aid) • EMEDNY-1260 (Level of Care) • EMEDNY-3897 (Transportation) • EMEDNY-4106 (Group Transportation) • PA Additional Information
4601	Claims	• EMEDNY-1500 (HCFA) • EMEDNY-0002 (Form A) • EMEDNY-0003 (Pharmacy) • UB-04 (Institutional)
4602	Threshold Override Applications	• EMEDNY-0001 (TOA)
4603	Provider Enrollment Applications	• All Fee-For-Service and Rate-Based Enrollment Packets
4604	Edit Review	• Provider submitted documentation to adjudicate claims

P.O. Box	Description of Contents	Form Types
4605	Remittance Retrieval	• Requests from providers for copies of remittance statements
4606	Additional Information	• Provider Enrollment Additional Information Form with attachments
4610	Provider Maintenance	• Provider maintenance (update) forms and related correspondence
4614	Electronic Form Requests	• Electronic Certifications • ETIN Applications • Security Packet A • Security Packet B • Electronic Remittance Request • Electronic Prior Approval Request • Remittance Sort Request • Pended Claim Recycle Request • Request to Disaffiliate/Delete an ETIN
4616	Electronic Funds Transfer	• Electronic Funds Transfer Enrollment Forms

Medicaid Program Contact Information

For questions concerning:	Contact:
Check Amounts To obtain check amounts prior to the release of the check, select the "Check Call" option from the menu of services offered. Only the current week's check amount will be reported.	Department of Health (866) 307-5549
Child Health Plus	(800) 698-4KIDS
Claim Response Status for ePACES Users	http://www.emedny.org/hipaa/Crosswalk/index.html
Dental/Orthodontia Services **Dental Pended Claims**	Dental Review Unit (800) 342-3005 Option #2
Diagnosis Codes	http://www.cms.hhs.gov/icd9providerdiagnosticcodes/ The list of diagnosis codes is also available through publishing houses.
Durable Medical Equipment Prior Approval	Non-DVS/DiRad – Except Buffalo Area Counties (800) 342-3005 Non-DVS/DiRad – Buffalo Area Counties (Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans and Wyoming) (800) 462-8407 PA Overrides of DVS/DiRad (Statewide) (800) 342-3005
Elderly Pharmaceutical Insurance Coverage Program (EPIC)	(800) 634-1340
Electronic Funds Transfer Provider Enrollment Form **Electronic Prior Approval Request Form** **Electronic Transmitter Identifier Number (ETIN)**	http://www.emedny.org/info/ProviderEnrollment/index.html

For questions concerning:	Contact:
Electronic Transactions Vendors	http://www.emedny.org/hipaa/vendors/index.html
eMedNY	http://www.emedny.org
eMedNY Companion Guides **Sample Files**	http://www.emedny.org/HIPAA/index.html
Enrollee Eligibility Determination Eligibility discrepancies must be reported to the enrollee's local social services district. CSC's MEVS staff cannot address these calls nor resolve eligibility issues. When the provider believes the individual is covered by Medicaid, but does not have the client identification number, assistance can be obtained by calling this number and selecting "Name Search" from the menu of services offered. There is a charge of $0.85 per minute for this optional service. A touch-tone telephone is required.	Department of Health (866) 307-5549 (518) 472-1550
Family Health Plus	(877) 9FHPLUS
Managed Care	(518) 486-9015 (800) 206-8125 omcmail@health.state.ny.us
Medicaid Inspector General Fraud Referrals	www.omig.state.ny.us http://www.nysomig.org/data/component/option,com_fileforms/Itemid,47/ **(877) 87FRAUD**
Medical Pended Claims **Two-Year Old Claims**	In State (800) 342-3005 Option #3 Out of State (518) 474-3575

For questions concerning:	Contact:
Medicaid Policy Call Center Help Line/Co-Pay Hotline Fraud/Forgery Hotline Medical/Dental Prior Approval Restricted Recipients/Utilization Threshold Two-year billing regulations	medicaid@health.state.ny.us (800) 541-2831 (877) 891-7283 (800) 342-3005 (518) 474-6866 (800) 562-0856 menu #4
Medical Prior Approval ➢ Nursing ➢ Out-of-State Inpatient Hospital Services ➢ Audiology	(800) 342-3005 Option #1
Medicaid Update • Missing issues • Request to receive electronic version	http://www.nyhealth.gov/health_care/medicaid/program/update/main.htm Email: medicaidupdate@health.state.ny.us (518) 474-5187
New York State Department of Health	www.nyhealth.gov
Newborn Screening Program	(518) 473-7552
Personal Care Services Prior Authorization	Local Department of Social Services
Pharmacy Policy and Operations	(518) 486-3209 ppno@health.state.ny.us
Private Duty Nursing Services	Broome (607) 778-2707 Chemung (607) 737-5487 Erie (716) 858-2375 Oneida (315) 798-5456 Schenectady (518) 386-2253 Tompkins (607) 274-5278 Westchester (914) 813-5440 All others not listed (800) 342-3005
Restricted Recipient Program	**NYC** (212) 630-1081 (212) 630-1087 (212) 630-1089 **Outside NYC** (518) 474-6866

For questions concerning:	Contact:
Sterilization & Hysterectomy Consent Forms ➢ DSS-3113 Hysterectomy Receipt of Information ➢ DSS-3113S Hysterectomy Receipt of Information (Spanish) ➢ DSS-3134 Sterilization Consent ➢ DSS-3134S Sterilization Consent (Spanish)	http://www.health.state.ny.us/health_care/medicaid/publications/ldssforms
Transportation	(518) 474-5187 or (518) 473-2160 MedTrans@health.state.ny.us **Outside NYC** Local Department of Social Services **Obtain NYC Prior Authorization** (800) 343-9000

Fee-for-Service Provider Enrollment File Forms

Fee-for-Service Providers:

- Chiropractor
- Clinical Social Worker
- Midwife
- Nursing Services (LPN/RN)
- Podiatrist
- Rehabilitation Services
- Durable Medical Equipment
- Laboratory
- Service Bureau
- Clinical Psychologist
- Dental/Mobile Van
- Nurse Practitioner
- Physician/Group
- Portable X-Ray Supplier
- Vision Care
- Hearing Aid
- Pharmacy
- Transportation

Enrollment Forms Maintenance Forms	http://www.emedny.org/info/ProviderEnrollment/index.html

Rate Based Provider Enrollment File Forms

Rate Based Providers:

- Adult Day Care Program
- Assisted Living Program
- Case Management
- Child Care Agency
- Clinic
- Community Residence
- Diagnostic & Treatment Center
- Emergency Room
- HCBS/TBI Waiver Provider
- Home Health Agency
- Hospice
- HMO
- Hospital
- Nursing Service (Registry)
- Long Term Home Health Care Prog.
- Personal Emergency Response System Provider
- Personal Care Provider
- Residential Health Care Facility (Nursing Home)
- Prepaid Capitation Group
- School Supportive Health Service
- Intermediate Care Facility for the Developmentally Disabled (ICF/DD)

Provider Change of Address	http://www.emedny.org/info/ProviderEnrollment/index.html
Disclosure of Ownership Form For use when ownership interest changes occur.	To receive the form: Call (800) 342-3005 Option # 4 or write to: RBU@health.state.ny.us ***Subject Line Must State: "Request Disclosure Form" and contain the name and Medicaid provider identification number of the entity.*** ***Completed*** forms should be mailed to: New York State Department of Health Office of Health Insurance Programs Division of Program Operations & Systems Rate Based Provider Unit 150 Broadway Albany, New York 12204-2736

Pharmacy Programs

To obtain prior authorization for drugs subject to the Mandatory Generic Drug Program, the Preferred Drug Program, or the Clinical Drug Review Program, or for prior authorization of non-preferred drugs, call:

(877) 309-9493
and follow the appropriate prompts:

• To validate a prior authorization **ending with "W"**	Press 1
• To validate a prior authorization that **does not end with "W"**	Press 2
• For information or technical assistance with a prior authorization	Press 3
• For a prior authorization program overview • Recent changes to the Preferred Drug Program	Option 9

Requests for prior authorization of non-preferred drugs may also be faxed to:

(800) 268-2990
Faxed requests may take up to 24 hours to process.

For questions concerning:	Contact:
Prior authorization worksheet/fax form	https://newyork.fhsc.com/providers/PDP_forms.asp
Current Preferred Drug List Preferred Drug Quick List	https://newyork.fhsc.com/downloads/providers/NYRx_PDP_PDL.pdf
Request email notification of changes to Preferred Drug List	NYPDPNotices@firsthealth.com
To obtain a supply of Preferred Drug Program educational materials for Medicaid enrollees	(518) 951-2040
Clinical concerns Preferred Drug Program questions	(877) 309-9493
Billing	(800) 343-9000

Local Departments of Social Services

Albany County Department of Social Services 162 Washington Avenue Albany, New York 12210 *(518) 447-7300* http://www.albanycounty.com/departments/dss/	Allegany County Department of Social Services 7 Court Street Belmont, New York 14813 *(585) 268-9622* http://www.alleganyco.com/default.asp?show=btn_dss
Broome County Department of Social Services 36-42 Main Street Binghamton, New York 13905-3199 *(607) 778-8850* http://www.gobroomecounty.com/dss/	Cattaraugus County Department of Social Services One Leo Moss Drive, Suite 6010 Olean, New York 14760 *(716) 373-8070* http://www.co.cattaraugus.ny.us/dss/
Cayuga County Department of Social Services County Office Building 160 Genesee Street Auburn, New York 13021-3433 http://cayugacounty.us/hhs/index.html	Chautauqua County Department of Social Services H.R. Clothier Building Mayville, New York 14757 *(716) 753-4421* http://www.co.chautauqua.ny.us/hservframe.htm
Chemung County Department of Social Services Human Resources Center P.O. Box 588 425 Pennsylvania Avenue Elmira, New York 14902-1795 *(607) 737-5309*	Chenango County Department of Social Services County Office Building P.O. Box 590, 5 Court Street Norwich, New York 13815 *(607) 337-1500*
Clinton County Department of Social Services 13 Durkee Street Plattsburgh, New York 12901 *(518) 565-3300* http://www.clintoncountygov.com/Departments/DSS/index.htm	Columbia County Department of Social Services P.O. Box 458 25 Railroad Avenue Hudson, New York 12534-2514 *(518) 828-9411*

Cortland County Department of Social Services County Office Building 60 Central Avenue Cortland, New York 13045-5590 *(607) 753-5248* http://www.cortland-co.org/dss/	Delaware County Department of Social Services 111 Main Street Delhi, New York 12601-3302 *(607) 746-2325*
Dutchess County Department of Social Services 60 Market Street Poughkeepsie, New York 12601-3302 *(845) 486-3000* http://www.co.dutchess.ny.us/CountyGov/Departments/SocialServices/SSIndex.htm	Erie County Department of Social Services 95 Franklin Street Buffalo, New York 14202-3935 *(716) 858-8000* http://www.erie.gov/depts/socialservices/
Essex County Department of Social Services 7551 Court Street, P.O. Box 217 Elizabethtown, New York 12932-0217 *(518) 873-3302*	Franklin County Department of Social Services Court House 335 West Main Street, Suite 331 Malone, New York 12953 *(518) 483-6770* http://franklincony.org/content/
Fulton County Department of Social Services P.O. Box 549 4 Daisy Lane Johnstown, New York 12095 *(518) 736-5640*	Genesee County Department of Social Services 5130 East Main Street, Suite 3 Batavia, New York 14020-9407 *(585) 344-2580* http://www.co.genesee.ny.us/dpt/socialservices/index.html
Greene County Department of Social Services 411 Main Street P.O. Box 528 Catskill, New York 12414-1716 *(518) 943-3200* http://www.greenegovernment.com/department/socialserv/	Hamilton County Department of Social Services P.O. Box 725- White Birch Lane Indian Lake, New York 12842-0725 *(518) 648-6131*

Herkimer County Department of Social Services 301 North Washington Street, Suite 2110 Herkimer, New York 13350 *(315) 867-1291* http://herkimercounty.org/content/Departments/View/10	Jefferson County Department of Social Services Human Services Building 250 Arsenal Street Watertown, New York 13601 *(315) 782-9030*
Lewis County Department of Social Services P.O. Box 193 Lowville, New York 13367 *(315) 376-5400* http://lewiscountyny.org/content/Departments/View/30?	Livingston County Department of Social Services 3 Murray Hill Drive Mount Morris, New York 14510 *(585) 243-7300* http://www.co.livingston.state.ny.us/dss.htm
Madison County Department of Social Services Madison County Complex P.O. Box 637 Wampsville, New York 13163 *(315) 366-2211* http://www.madisoncounty.org	Monroe County Department of Social Services 111 Westfall Road, Room 660 Rochester, New York 14620-4686 *(585) 274-6000* http://www.monroecounty.gov/hs-index.php
Montgomery County Department of Social Services County Office Building P.O. Box 745 Fonda, New York 12068 *(518) 853-4646*	Nassau County Department of Social Services 101 County Seat Drive Mineola, New York 11501 *(516) 571-4444* http://www.nassaucountyny.gov/agencies/dss/DSSHome.htm
New York City Human Resources Administration 180 Water Street New York, New York 10038 *(877) 472-8411 within the 5 boroughs* *(718) 557-1399 outside of NYC* http://www.nyc.gov/html/hra/html/home/home.shtml	Niagara County Department of Social Services P.O. Box 506, 20 East Avenue Lockport, New York 14095-3394 *(716) 439-7602*

Oneida County Department of Social Services County Office Building 800 Park Avenue Utica, New York 13501-2981 *(315) 798-5733* http://www.ocgov.net/oneidacty/gov/dept/socialservices/dssindex.html	Onondaga County Department of Social Services Onondaga County Civic Center 421 Montgomery Street Syracuse, New York 13202-2933 *(315) 435-2985 or (315) 425-2986* http://www.ongov.net/DSS/
Ontario County Department of Social Services 3010 County Complex Drive Canandaigua, New York 14424 *(585) 396-4060* http://www.co.ontario.ny.us/social_services/	Orange County Department of Social Services Quarry Road, Box Z Goshen, New York 10924-0678 *(845) 291-4000* http://www.co.orange.ny.us/orgMain.asp?orgid=55&storyTypeID=&sid=&
Orleans County Department of Social Services 14016 Route 31 West Albion, New York 14411-9365 *(585) 589-7004* http://orleansny.com/SocialServices/dss.htm	Oswego County Department of Social Services 100 Spring Street, P.O. Box 1320 Mexico, New York 13114 *(315) 963-5000* http://www.co.oswego.ny.us/dss/
Otsego County Department of Social Services 197 Main Street Cooperstown, New York 13326-1196 *(607) 547-7594* http://www.otsegocounty.com/depts/dss/	Putnam County Department of Social Services 110 Old Route Six Building #2 Carmel, New York 10512-2110 *(845) 225-7040* http://www.putnamcountyny.com/socialservices/
Rensselaer County Department of Social Services 133 Bloomingrove Drive Troy, New York 12180-8403 *(518) 283-2000* http://www.rensco.com/departments_socialservices.asp	Rockland County Department of Social Services Building L Sanatorium Road Pomona, New York 10970 *(845) 364-2000* http://www.co.rockland.ny.us/Social/
St. Lawrence County Department of Social Services 6 Judson Street Canton, New York 13617-1197 *(315) 379-2111* http://www.co.st-lawrence.ny.us/Social_Services/SLCSS.htm	Saratoga County Department of Social Services 152 West High Street Ballston Spa, New York 12020 *(518) 884-4140* http://www.co.saratoga.ny.us/dindex.html

Schenectady County Department of Social Services 487 Nott Street Schenectady, New York 12308-1812 *(518) 388-4470* http://www.schenectadycounty.com/default.aspx?m=2	Schoharie County Department of Social Services County Office Building P.O. Box 687 Schoharie, New York 12157 *(518) 295-8334* http://www.schohariecounty-ny.gov/CountyWebSite/index.jsp
Schuyler County Department of Social Services County Office Building 105 Ninth Street - Unit 3 Watkins Glen, New York 14891 *(607) 535-8303* http://www.schuylercounty.us/dss.htm	Seneca County Department of Social Services 1 DiPronio Drive Waterloo, New York 13165-0690 *(315) 539-1800* http://www.co.seneca.ny.us/dpt-divhumserv-children-family.php
Steuben County Department of Social Services 3 East Pulteney Square Bath, New York 14810 *(607) 776-7611* http://www.steubencony.org/dss.html	Suffolk County Department of Social Services 3085 Veterans Memorial Highway Ronkonkoma, New York 11779 *(631) 854-9700* http://www.co.suffolk.ny.us/webtemp3.cfm?dept=17&ID=617
Sullivan County Department of Social Services Box 231, 16 Community Lane Liberty, New York 12754 *(845) 292-0100*	Tioga County Department of Social Services Box 240 Owego, New York 13827 *(607) 687-8300* http://www.tiogacountyny.com/departments/health/social_services/
Tompkins County Department of Social Services 320 West State Street Ithaca, New York 14850 *(607) 274-5336* http://www.tompkins-co.org/departments/detail.aspx?DeptID=41	Ulster County Department of Social Services 1061 Development Court Kingston, New York 12401 *(845) 334-5000* http://www.co.ulster.ny.us/resources/socservices.html

Warren County Department of Social Services Municipal Annex 1340 State Route 9 Lake George, New York 12845 *(518) 761-6300* http://www.co.warren.ny.us/depts.php#SOCIALSERVICES	Washington County Department of Social Services Municipal Center 383 Broadway Fort Edward, New York 12828 *(518) 746-2300* http://www.co.washington.ny.us/Departments/Dss/dss.htm
Wayne County Department of Social Services 77 Water Street P.O. Box 10 Lyons, New York 14489-0010 *(315) 946-4881* http://www.co.wayne.ny.us/departments/dss/dss.htm	Westchester County Department of Social Services County Office Building #2 112 East Post Road White Plains, New York 10601-5272 *(914) 995-5000* http://www.westchestergov.com/health.htm
Wyoming County Department of Social Services 466 North Main Street Warsaw, New York 14569-1080 *(585) 786-8900* http://www.wyomingco.net/socialservices/main.htm	Yates County Department of Social Services County Office Building 417 Liberty Street Penn Yan, New York 14527-1118 *(315) 536-5183* http://www.yatescounty.org/upload/12/dss/frameset.html

NEW YORK STATE
MEDICAID PROGRAM

INFORMATION FOR ALL PROVIDERS

THIRD PARTY INFORMATION

Table of Contents

Third Party Health Resources

Insurance codes are used to identify Third Party Resources (TPR) other than Medicaid and Medicare, under which an enrollee has insurance coverage. Such coverage must be utilized for payment of medical services prior to submitting claims to the Medicaid Program.

Under the Medicaid Eligibility Verification System (MEVS), information specific to TPR will be reported to you when you request eligibility verification of a Medicaid enrollee.

> The MEVS response via the Verifone terminal or alternate access will be a two-digit insurance code.
>
> For **Medicaid Prepaid Capitation Plans** only, the two-digit plan code *and* up to 20 alphabetic coverage codes, or the word "ALL" indicating what services are covered, is displayed. The telephone response will be insurance and coverage codes and a two-digit insurance code and up to 20 messages, or "ALL", indicating which services are covered.

Please refer to the MEVS Provider Manual for more detailed information on eligibility verifications, which can be found at:

http://www.emedny.org/ProviderManuals/index.html.

The MEVS response will include information on a maximum of two third party insurance carriers. If a Medicaid enrollee is covered by more than two carriers, you will receive a response of "ZZ" as an insurance code. "ZZ" indicates additional insurance.

To obtain coverage information when there are more than two carriers, call Computer Sciences Corporation at:

(800) 343-9000.

Insurance Coverage Codes

The following codes are used in MEVS responses to designate the scope of benefits provided by an insurance company.

Code	Description	Explanation
A	Inpatient Hospital	All inpatient services are covered except psychiatric care.
B	Physician In-Office	Services provided in the physician's office are generally covered.
C	Emergency Room	Self-Explanatory.
D	Clinic	Both hospital-based and free-standing clinic services are covered.
E	Psychiatric Inpatient	Self-Explanatory.
F	Psychiatric Outpatient	Self-Explanatory.
G	Physician In-Hospital	Physician services provided in a hospital or nursing home are covered.
H	Drugs No Card	Drug coverage is available but a drug card is not needed.
I	Lab/X-ray	Laboratory and X-ray services are covered.
J	Dental	Self-Explanatory.
K	Drugs Co-pay	Although insurance carrier expects a co-payment, you may *not* request it from the recipient. If the insurance payment is less than the Medicaid fee, you can bill Medicaid for the balance, which may cover the co-payment.
L	Nursing Home	Some nursing home coverage is available. You must bill until benefits are exhausted.
M	Drugs Major Medical	Drug coverage is provided as part of a major medical policy.

Code	Description	Explanation
N	All Physician Services	Physician services, without regard to where they were provided, are covered.
O	Drugs	Self-Explanatory.
P	Home Health	Some home health benefits are provided. Continue to bill until benefits are exhausted.
Q	Psychiatric Services	All psychiatric services, inpatient and outpatient, are covered.
R	ER and Clinic	Self-Explanatory.
S	Major Medical	The following services are covered: physician, clinic, emergency room, inpatient, laboratory, referred ambulatory, transportation and durable medical equipment.
T	Transportation	Medically necessary transportation is covered.
U	Coverage to Complement Medicare	All services paid by Medicare, which require a coinsurance or deductible payment, should be billed to the insurance carrier *prior* to billing Medicaid.
V	Substance Abuse Services	All substance abuse services, regardless of where they are provided, are covered.
W	Substance Abuse Outpatient	Self-Explanatory.
X	Substance Abuse Inpatient	Self-Explanatory.
Y	Durable Medical Equipment	Self-Explanatory.
Z	Optical	Self-Explanatory.
All	All of the above	All services are covered.

Recipient Other Insurance Codes

These codes indicate other insurance carriers under which the enrollee may be covered.

Ins Cd	Description
02	HIP Outpatient
05	Other Insurance Inpt/Outpt
06	Group Health Inc (GHI)
09	Union Inpt/Outpt
10	HIP/HMO
12	BC/BS Empire
14	A&P Health And Welfare
18	Administrative Services Co
20	Aftra Health And Retirement
22	AIG
23	Empire BC
25	Airfreight Warehouse Corp
27	Albany International
28	Allied International Union
29	Allied Security Health & Welfare
30	Amalgamated Services
31	Amerco
32	American Medical Life Ins
34	America's Choice Health Plan
35	Amerihealth Administrators
36	Atlantis Health
38	BACL5NY Welfare Fund
39	Bakers Local 3
40	Bakery Drivers Local 802
41	BC/BS Carefirst
42	BC/BS Healthflex Now
43	BC/BS of Alabama
44	BC/BS of Greater NY
45	Empire BS
47	BC/BS of Iowa-Wellmark
48	BC/BS of Minnesota
49	BC/BS of North Dakota
50	BC/BS of Rhode Island
51	BC/BS through SSA
52	Benefit Concepts
53	Benesight PCHS
54	Better Health Advantage
55	BC/BS PP
56	BC of NY
58	Capitol Administrators
59	Carpenters Healthcare Plan
60	CBSA
61	Central States
62	CENTRUS
65	Chatwins Healthcare Administrators

Ins Cd	Description
66	Christian Brothers Employees
67	Citywide Central Ins Program
69	Coalition for Care
70	Cole Managed Vision
71	Combined Welfare Fund
72	Coresource Inc.
74	Custom Coverage
88	Elderplan
90	Davis Vision
99	New HIP
A1	Union Am Postal Workers
A2	American Psych Systems
A3	American Medical Life Ins Co
A4	Anthem Life
A5	Aetna Medicare Cost
A6	American National
A7	American Pioneer Life Ins Co
A8	Alta Health Strategies
A9	Wells Fargo
AA	Accident Insurance
AC	Aetna Life Insurance Co
AD	Aetna Variable Annuity Life Ins
AE	Countryway Insurance Company
AF	American Family Life Insurance
AG	Allstate Life Insurance Co
AH	Amalgamated Life Ins Co Inc
AI	Allstate Insurance CO
AJ	Absent Parent Responsibility
AK	Allied Benefit Administrators
AL	American Group Administrators
AM	Americorps
AO	Alta Rx Prescription Drugs
AP	AARP
AQ	American Integrity Ins Co
AS	Assoc Plan Admin Inc (APA)
AU	American Medical Ins Co
AY	Virginia Surety Company Inc
AZ	American Progressive Health Ins Co
B1	BC/BS Highmark
B2	BS of Florida
B3	BS of Massachusetts
B4	BC/BS of Tennessee
B5	BC/BS of Northeast Ohio

Ins Cd	Description
B6	BC/BS of New Jersey
B7	Blue Choice Preferred
B8	BC Utica
B9	BS Utica
BA	Banker's Life Company
BB	Banker's Multiple Life Ins Co
BB1	Regence BC/BS of Oregon
BCN	BC/BS of Nebraska
BC	BC Central NY
BE	BS Western NY
BF	Benefit Trust Life Ins Co
BG	BS Central NY
BH	BS Northeastern NY
BI	BS Western NY
BJ	BC Rochester
BK	BS Rochester
BL	BC New Jersey
BM	BS New Jersey
BN	BC/BS of Central NY–Excellus BC/BS
BO	BC/BS of Northeastern NY
BP	BC/BS of Western NY
BQ	BC/BS of Connecticut
BR	BC/BS of Florida
BS	Dental Pay
BT	BC/BS Massachusetts
BV	BC/BS of Vermont
BW	BC Florida
BY	BC of Massachusetts
BZ	BC of Northeastern PA
C1	BC Capital (Pennsylvania)
C3	Capital District Physicians Health Plan
C4	CIGNA
C5	Community Blue (Buffalo)
C6	Choicecare
C8	Confederation Life Ins
C9	Claim Management Services
CA	Tricare Region 1 Claims/CHAMPUS
CB	Colonial Penn Franklin Ins Co
CBS	Corporate Benefit Services of America
CC	Continental Assurance Co
CD	Continental Casualty Co
CE	BC/BS Michigan
CF	BC/BS California
CH	Chubb Life America
CJ	Columbian Mutual Life Ins Co
CK	Combined Life Ins Co of NY
CL	Serv Employees Welfare Fund Union
CM	Comm Travelers Mutual Ins Co
CN	Catskill School Emp Ben Fund Union
CO	Companion Life Ins Co
CR	Consolidated Mutual Ins Co

Ins Cd	Description
CS	Continental American Life Ins Co
CT	Continental Ins Co
CU	CSEA Union
CY	BC/BS Greater NY HMO
D1	BC/BS of the National Capitol Area
D2	ERISCO
D3	Pro Ins Agentents Grp
D4	Oxford Ins Co
D5	DC 37 Health & Security Plan
D6	Benefit Management of Maine
D7	BS of NE Pennsylvania
D8	Chesterfield Resources Inc
D9	Local 32 Health & Pension Fund Union
DA	Benefit Administrators Ins
DB	BC California
DC	Benefit Management Services
DE	BC/BS Delaware
DF	BC/BS Illinois
DG	Diversified Group Brokerage Corp
DH	Comprehensive Benefits Co
DI	Celtic Life Ins Co
DJ	BC/BS Missouri
DK	BC of Philadelphia
DL	Oxford Health Plan Mcare Risk
DP	Diversified Pharmaceutical Svc
DR	HIP Greater NY – Medicare Cost
DS	HIP Greater NY – Medicare Risk
DV	Caremark
DW	Blue Preferred HMO (Utica)
DX	Delta Dental
E1	Equicor
E2	Employee Security Fund
E3	Elm-Co Agency Inc
E5	Express Scripts
E7	BC/BS HMSA
EA	Empire State Mutual Life Ins Co
EB	Equitable Life Assurance Co
EC	Emp Mutual Liability Ins Co of Wis
ED	Equitable Life Ins Co of Iowa
EF	Executive Life Ins Co of NY
EJ	Self Insured
EM	Empire Plan/State Employees
ES	Empire St Carpenters Wlfr Bnft Fnd
F1	First Fortis (Medical)
F2	First Health
F3	Corporate Health Administrators
F5	Pan American Life
F6	SNL Administrators
F7	United Health Care

Ins Cd	Description
F8	Vytra Health Care
F9	First Cardinal
FB	Farmer's/Traders Live Ins Co
FE	Fidelity and Casualty Co of NY
FF	Fidelity Mutual Life Ins Co
FG	Diversified Group Administrators
FH	Fireman's Ins Co of Newark NJ
FI	Fireman's Fund American Life Ins
FJ	Eastern Benefit Systems Inc
FK	Excellus Rx
FL	Pharma Care
FM	ECPA
FN	Educator's Mutual
FQ	EOCNC/Multiplan
FR	Foundation Health Plan
FU	United American Life Ins Co
G1	Group Administrators
G2	Guardian Choice
G4	BC/BS Georgia
GA	Guardian Ins & Annuity Co Inc
GC	Gerber Life Ins Co
GE	Government Employees Health Assoc.
GF	EPOCH Group
GG	Govt Emp Life Ins Co NY (Union)
GI	Assure Care
GJ	Guardian Life Ins Co of America
GK	Genesee Valley Grp Hlth Plan (Roch)
GL	Eye med Vision Plan
GO	FCE Benefit Administrator
GW	Great West Life
GX	Longview Fibre Self Insured
GZ	Medical Claims Service
H1	Hollow Metal Trust Fund
H4	First Rehabilitation Life
H8	Gallagher Bassett Service
HA	HIP – Health Ins Plan of Greater NY
HB	BCS Insurance Company
HC	Health and Welfare Life Ins Assoc
HD	BC of Utica – Hospital Serv Corp
HE	Hartford Acc/Indem Co
HF	Hartford Life Ins Co
HG	Magna Care
HH	National Medical Health Card Systems
HI	Home Life Ins Co
HJ	Health Plan Administrators
HL	Health Care Plan (Buffalo) – Univera
HM	HIP of NJ
HN	Health Services Medical Corp
HO	BC/BS of Utica – Excellus BC/BS
HP	BC of Utica–Hsp Srv Pln Lehigh Valley

Ins Cd	Description
HQ	Health Economics Group
HS	Healthways Inc
HU	Healthnet
HV	Health Claim Services
HZ	Horizon Healthcare
IA	Int Life Investors Ins Co
IB	Genworth Financial
ID	INDECS
IF	Independent Health Assoc Inc
IG	General American Life
IH	Income Protection Policy-Inpt Assign
IJ	HMO CNY
IK	BC Independence (PA)
IT	ITT Life Ins Corp
J1	JJ Newman and Co
J2	Justo Inc
J3	Advantage Health Plan
J4	North Americare
J5	Phoenix Group Services
J8	Jardine Group Services
JA	JC Penney Ins Co
JB	John Deere Ins Co
JP	General Vision
JU	GPA
JX	Group Ins Service Center
K1	Value Behavioral Health
KC	BC/BS Kentucky
KM	BC/BS WNY Sr. Blue
KN	ASO Health Plans
KO	Integ Alternatives Comm Network
L2	Louisiana Office of Grp Benefits
LA	Liberty Mutual Life Ins Co
LB	Liberty Life Assurance Co
LC	Lincoln National Life Ins Co/NY
LD	APA Partners
LG	Lumbermans Mutual Ins Co
LH	Teamsters Local 182 – Union
LI	Life of America Ins Co
LO	Local 1199 – Union
LW	Harvard Pilgrim
M1	The Maxon Co
M3	McCrew Care
M4	BC/BS Montana
MB	Mutual of Omaha Ins Co
MC	Unicare
MD	Medi-Plan
ME	Mail Handlers Benefit Plan

Ins Cd	Description
MF	Medical Administrators
MG	Metropolitan Ins and Annuity
MH	Upstate Administration Svc
MI	United Food Workers – Union
MJ	Monarch Life Ins Co
ML	Montgomery Ward
MM	Mutual Benefit Life Ins Co
MN	Mutual Life Ins Co NY
MP	Mutual Protective/Medico Life Ins Co
MQ	Mohawk Valley Physicians Hlth Plan
MS	Milk Plant Emp Welfare Trust – Union
MT	Mid-Hudson Health Plan
MX	MGA Plan Administrators
N1	National Prescription Admin (NPA)
N2	National Benefit Life Ins Co
N3	National Prescription Svcs
N4	NYS Auto Dealers Assoc
N5	NY Farm Bureau/NYS BG
N6	North Medical Comm Hlth Plan
N7	National Assoc of Letter Carriers
N8	Nassau Co Retiree Health Plan
NA	NY Dental Svcs Group
NB	NY School Athletic Protect/Plan
NC	National Casualty Co
ND	NY Life Insurance Co
NE	Nationwide General Ins Co
NF	First Providian Life/Health Ins
NG	Northcare Partners
NH	Nippon Life Ins
NI	National Ins Svcs Inc
NJ	Partners Health Plan
NK	Nationwide Life Ins Co
NL	New England Mutual Life Ins Co
NM	Meritain Health
NO	Nova Healthcare
NR	Northwestern Nat Ins Co
NS	New Hampshire/Vermont Health Svc
NT	BC/BS of North Carolina
NY	Health Scope Benefits Inc
OA	Healthnow
OB	HEREIU – Union
OX	Hotel Association of NYC
P1	Principal Mutual Ins Co
P3	Pharm Serv Corp of NY (PSCNY)
P5	HRA
P6	Humana
PA	Prudential
PB	Paul Revere Life Ins Co
PC	Phoenix Mutual Life Ins Co

Ins Cd	Description
PD	Peerless Ins Co
PE	Healthsource Inc
PG	Penn General Srv of New England Inc
PI	Pacific Care
PJ	IAA
PK	IBOTV Health and Welfare Fund
PL	Premier Health Network
PM	Provident Life and Accident Ins
PO	Provident Mut Lf Ins Co-Philadelphia
PP	MEDCOHEALTH
PR	Preferred Care
PT	BS Pennsylvania
PU	Pomco Ins
PW	Premera Blue Cross of Washington
Q3	MDNY Healthcare
R1	Catalyst Rx
R3	Equitable Plan Services
R4	Harrington Benefit Services
RA	Insurance Design Administrators
RB	Insurance Management Services
RC	International Benefit Administrator
RD	Island Group Administration
RE	Rochester Health Network
RF	Excellus Blue Cross Blue Shield
RG	HIP Rutgers Health Plan of NJ
RM	RMSCO Insurance
RX	RX West
S1	BC/BS of South Carolina
SB	Sieba Ltd
SD	Susquehanna Administrators Inc
SE	Sears Roebuck and Company
SG	Security Mutual Life Ins Co
SH	Sentry Life Ins Co of NY
SL	St Lawrence/Lewis Schools Ins
SM	Sanus Health Plan – Medicare Risk
SO	Jockey Group Health Plan
SQ	State Farm Life and Accid Assurance
SS	State Mutual Lf Assurance Co/America
SU	Assurant Employee Benefits
SV	Security 65 Plan
SX	Sanus Health Plan
SZ	Suffolk Cty Employee Health Plan
T1	BC/BS Texas
TA	Teachers Ins and Annuity Trust-Union
TB	Travelers
TC	Transamerica Ins Co
TD	Transworld Life Ins Co of NY
TE	John Alden

Ins Cd	Description
TL277	Teamsters Local 277
TP	Prime Therapeutics Pharmacy
TR	Trademark
TU	Travelers Health Network
U1	Bakery and Confect Workers – Union
U2	US Health Care – Medicare Risk
U9	Industry Workers Local 424 – Union
UA	Union Labor Life Ins Co
UB	Union Mutual Life Ins Co
UC	Key Medical/Regence Life
UD	LMH Self Funded Medical Plan
UH	United Mutual Life Ins Co
UL	US Life Ins Co
UO	Utica Mutual Ins Co
UP	Union Fidelity Life of PA
VA	Veterans Aid
W1	Wachovia Insurance
WA	Washington Nat Life Ins Co
WB	Workers Comp
WF	Fiserv

Ins Cd	Description
WI	Whole Health Ins Network
WJ	WJ Jones Admin Svcs
WL	Westchester Gen Labor Welfare Fund
WM	WalMart Self-Ins – Union
WP	William Penn Ins Co of NY
WR	Wellpoint Next Rx
WS	Wassau (NY/NJ Wrkrs Cmp Claim Off)
WT	Wellcare
WV	BC/BS West Virginia
XR	United Concordia Co Inc
ZB	Zurich Insurance Company

Prepaid Capitation Plans (PCP)

Note:

LTC	Long Term Care
PCMP	Physician Case Management Program
FHP	Family Health Plus
SNP	Special Needs Plan
MA	Medical Assistance
ADV	Advantage

MEVS Values	PCP Provider Name	Telephone Number	Plan Type
AN	Hebrew Home Hospital, Inc. (Co-op Care Plan)	(718) 379-5020 or (888) 830-5620	Partial LTC
AR	Patel, Arjunj MD PC (Broome Max)	(607) 758-2543	PCMP
AT	Dygert, Stephen		PCMP
AW	Homefirst, Inc.	(718) 630-2560 or (877) 771-1119	Partial LTC
C2	HealthNow NY, Inc. (Community Blue)	(716) 887-6900	Mainstream
C7	Comprehensive Care Management Corporation	(718) 515-5600 or (877) 226-8500	LTC Pace
CG	Capital District Physician's Health Plan	(716) 885-2261	Mainstream
CV	Capital District Physician's Health Plan	(716) 885-2261	Mainstream
DC	United Medical Associates		PCMP
DD	Driscoll, Dan		PCMP
DY	Lourdes Primary Care Assoc. (Broome Max)	(607) 778-2707	PCMP
E4	PCMP IIA Gold Choice	(716) 898-5968	PCMP
E7	Senior Care Connection	(518) 382-3290	LTC Pace
FO	United Health Services Hospital	(607) 762-3173	PCMP
G3	Bhard-Waj, Gaur MD (Broome Max)	(607) 770-0004	PCMP
GD	Partners in Community Care	(845) 368-5943	Partial LTC
GH	Group Health, Inc. PPO	(518) 446-8010	FHP
GK	GHI HMO Select A	(518) 446-8055	Mainstream
GN	Guildnet	(212) 769-6200	Partial LTC
H1	Senior Health Partners, Inc.	(212) 870-4610	Partial LTC
H4	GHI HMO Select B	(518) 446-8055	Mainstream
HT	HIP of Greater NY	(646) 447-5000	Mainstream
HW	HIP Westchester	(646) 447-5000	Mainstream
HY	HIP Nassau	(646) 447-5000	Mainstream
IE	Independent Health Association	(716) 631-3086	Mainstream
IN	Independent Health Association	(716) 631-3086	Mainstream
IL	Independent Living for Seniors	(585) 922-2836	LTC Pace
IS	Loretto HMO	(315) 469-5570	LTC Pace
IX	Independent Care Systems	(212) 584-2500	Partial LTC
KP	Amerigroup NY, LLC	(800) 535-2814 or (800) 563-5581	Mainstream
KX	Amerigroup Community Connections	(212) 372-6942	Partial LTC
LE	LI Health Partners (Broadlawn)	(516) 336-2006	Partial LTC
M3	Health Advantage Plans, Inc. (Elant Choice)	(845) 569-0500	Partial LTC
M4	Addo, Samuel (Broome Max)	(607) 729-9327	PCMP
MO	United HealthCare of NY, Inc. (Met Life)	(212) 216-6824	Mainstream
MR	Excellus	(585) 454-1700	Mainstream
MV	MVP, Inc. (Dutchess & Ulster Counties)	(518) 388-2427	Mainstream
MZ	Senior Network Health, LLC	(888) 355-4764	Partial LTC

MEVS Values	PCP Provider Name	Telephone Number	Plan Type
N6	Total Aging in Place	(716) 250-3100	Partial LTC
NP	Neighborhood Health Provider PHSP	(800) 558-7970	Mainstream
NW	NY Presbyterian Community PHSP, Inc.	(212) 297-5510	Mainstream
OD	VidaCare, Inc. SN	(212) 337-5180	SNP
OG	NY Presbyterian System Select Health SN	(866) 469-7774	SNP
OM	Metroplus Partnership Care SN	(212) 597-8600	SNP
OZ	Univera	(716) 857-4448	Mainstream
PH	Southern Tier Priority HC	(607) 795-5215	PCMP
PQ	Preferred Care	(716) 325-3920	Mainstream
SA	TotalCare (Syracuse PHSP)	(315) 476-7921	Mainstream
SF	HealthFirst PHSP, Inc.	(800) 580-8540 or (212) 801-6000	Mainstream
SK	Suffolk Health Plan HMO	(800) 763-9132	Mainstream
SP	NYS Catholic Health Plan, Inc. (Fidelis)	(800) 749-0820	Mainstream
CW	NYS Catholic Health Plan, Inc. (Fidelis)	(800) 749-0820	Mainstream
SR	Saeed, Azmat MD	(607) 748-7355	PCMP
SL	Saeed, Azmat MD	(607) 748-7355	PCMP
SY	Southern Tier Pediatrics PC	(607) 734-3252	PCMP
TF	CCM Select	(718) 515-8600	Partial LTC
VC	VNS Choice	(212) 609-5600	Partial LTC
VG	Giordano, Vincent		PCMP
WC	Wellcare of NY, Inc.	(800) 960-2530	Mainstream
WH	Hudson Health Plan, Inc.	(914) 631-1611	Mainstream
WK	Broome County Max Program	(607) 778-2702	PCMP
WN	Wellcare of NY, Inc.		Partial LTC
WR	Ramanujan Ramanujapuram	(607) 723-1676	PCMP
WU	Wellcare of NY, Inc.		MA Adv Plus
Y2	Neighborhood Health Provider, LLC	(212) 883-0883	MA Advantage
Y4	Group Health Inc.	(866) 557-7300	MA Advantage
Y8	Managed Health, Inc.	(212) 801-1638	MA Advantage
Y9	Liberty Health Advantage	(866) 542-4269	MA Advantage
YA	Americhoice of NY	(212) 509-5999	MA Advantage
YC	HIP Health Plan of NY	(646) 447-6200	MA Advantage
YD	Fidelis Dual Advantage	(718) 896-6500	MA Advantage
YM	MetroPlus MA Advantage		MA Advantage
YQ	HealthNow of NY		MA Advantage
YR	Senior Whole Health		MA Advantage
YS	Oxford Health Plan Mosaic	(914) 467-1009	MA Advantage
YT	Touchstone HP (Prestige)	(888) 777-0350	MA Advantage
YW	Wellcare of NY, Inc.	(212) 337-5180	MA Advantage
YX	Oxford Health Plans	(914) 467-1009	MA Advantage
YY	Affinity		MA Advantage
77	Health Plus PHSP, Inc.	(718) 745-0030	Mainstream
82	Affinity Health Plan, Inc.	(800) 553-8247	Mainstream
91	Centercare, Inc. (Manhattan PHSP)	(800) 545-0571	Mainstream
92	Metroplus Health Plan, Inc.	(800) 597-3380	Mainstream
98	HIP of Greater NY	(646) 447-5000	Mainstream
99	HIP of Greater NY	(646) 447-5000	Mainstream

County/District Codes

Below is a listing of all the counties and their corresponding district codes.

01	Albany
02	Allegany
03	Broome
04	Cattaraugus
05	Cayuga
06	Chautauqua
07	Chemung
08	Chenango
09	Clinton
10	Columbia
11	Cortland
12	Delaware
13	Dutchess
14	Erie
15	Essex
16	Franklin
17	Fulton
18	Genesee
19	Greene
20	Hamilton
21	Herkimer
22	Jefferson
23	Lewis
24	Livingston
25	Madison
26	Monroe
27	Montgomery
28	Nassau
29	Niagara
30	Oneida
31	Onondaga
32	Ontario
33	Orange
34	Orleans
35	Oswego
36	Otsego
37	Putnam
38	Rensselaer
39	Rockland
40	St. Lawrence
41	Saratoga
42	Schenectady
43	Schoharie
44	Schuyler
45	Seneca
46	Steuben
47	Suffolk
48	Sullivan
49	Tioga
50	Tompkins
51	Ulster
52	Warren
53	Washington
54	Wayne
55	Westchester
56	Wyoming
57	Yates
66	New York City
97	Office of Mental Health Administered
98	Office of Mental Retardation & Developmental Disabilities
99	Breast & Cervical Cancer Treatment Program

NEW YORK STATE
MEDICAID PROGRAM

COMPREHENSIVE MEDICAID
CASE MANAGEMENT

POLICY GUIDELINES

Table of Contents

Section I - Comprehensive Medicaid Case Management Services

Comprehensive Medicaid Case Management (CMCM) services are those functions/activities of case management which will assist persons eligible for Medicaid to access needed medical, social, psychosocial, educational, financial and other services required to encourage the enrollee's maximum, independent functioning in the community.

Case management provides access to services but does not include the actual provision of the needed services.

CMCM has the following unique characteristics among Medicaid services:

- It is targeted to specific populations who will benefit from a focused effort to improve access to a wide range of medical and social services;
- A separate State Medicaid Plan Amendment is prepared by the Department of Health (DOH) for each targeted population. Each State plan amendment and CMCM program may (within the parameters of 18 NYCRR 505.16) be tailored to the needs of the target population;
- Provider entities, with the exception of early intervention service coordination providers, are enrolled as Medicaid providers of CMCM for the targeted population on the basis of the approved proposal and designation by either the LDSS or the statewide supervising authority, whichever entity submitted the proposal. *Providers may serve only the population for whom they are designated*; and
- Monthly contact requirements, case manager qualifications, service standards, reimbursement methodology and resulting billing rules may be specific to the approved State Plan Amendment (i.e. target population). When applicable to claiming, these variations are noted below under Program Specific Variations.

Scope of Services

In general, case management services consist of the activities listed below. Programs with a rate methodology resulting in quarter hour units of service should refer to the following descriptions of case management activities to determine what constitutes billable services.

For the New York State Office of Mental Health Intensive Case Management Program (OMH-ICM), claiming is based on an all-inclusive monthly rate and only face-to-face contacts (including acute care in hospital) with the enrollee may be counted toward the minimum of four contacts per month required for billing.

Intake and Screening

During initial screening an attempt is made to engage an eligible enrollee's interest and ascertain his/her willingness and need to participate in case management. These intake and screening activities include:

- The initial contact with an enrollee; which should be made as soon as possible subsequent to identification of the enrollee's potential program eligibility.

- Providing information concerning case management sufficient to enable the enrollee to make an informed choice of whether or not to accept the case management service and CMCM provider. ***This should include a clear presentation that participation in CMCM does not affect Public Assistance/Medical Assistance (PA/MA) eligibility or receipt of other Medicaid services.*** It also should include a statement that the enrollee may have only one CMCM provider at a time and that the enrollee may choose any CMCM provider for which the enrollee is eligible as long as the provider is capable of serving the enrollee's needs.

- Identifying potential payors for services such as third party coverage for case management services.

Intake and screening is a billable activity only for those Medicaid enrollees within the target population who voluntarily accept services. The provider must give assurance of the enrollee's appropriateness for and voluntary acceptance of CMCM to the LDSS at the time of registration/authorization in the Medicaid Program.

Providers may bill for intake/screening activities that occur no more than 90 days prior to the date the enrollee accepts service. For enrollees in an acute care general hospital whose discharge is imminent, providers may bill for intake/screening activities for enrollees who accept services.

When provided to the following individuals, intake and screening may not be billed;

- For non-Medicaid individuals;

- For individuals who do not meet the target population characteristics;

- For Medicaid-eligibles in the target population who refuse or do not voluntarily accept services;

- For institutionalized individuals (in settings other than acute care general hospitals).

Program Specific Variations for Intake and Screening

Teen Age Services Act (TASA)

At least two contacts must be made to schedule an interview within 30 days of a referral to the TASA provider by the LDSS. In their referral agreement with the provider, the LDSS may require an additional number of contacts.

All contacts and attempts to contact an enrollee must be recorded in the case record (i.e. date, type of contact completed or attempted). If the required number of contacts fails to secure an interview, the enrollee may be deemed to have refused services. The provider may recontact the enrollee at some future date, but should check the Medicaid Eligibility Verification System (MEVS) to verify Medicaid eligibility.

Office of Mental Health (OMH)

All Medicaid enrollees who are on the OMH Intensive Case Management (ICM) roster are potentially eligible for CMCM services; however, providers may bill only for enrolled, active cases who have voluntarily accepted services.

For purposes of Medicaid billing, enrollees may not be enrolled as active ICM enrollees while they are institutionalized (in settings other than acute care general hospitals). Engagement contacts prior to enrollee's enrollment by ICM are not billable by ICM providers for institutionalized enrollees.

Office of Mental Retardation and Developmental Disabilities (OMRDD)

Upon determining that the enrollee is potentially eligible for CMCM service, the provider of service to the OMRDD target population must, on forms provided by OMRDD, contact the appropriate OMRDD Revenue Management Field Office to receive verification of program acceptance.

Early Intervention

Initial service coordinators should follow the parameters for the intake and screening activities as set forth in 10 NYCRR 69-4.7 and in guidance memoranda issued by the New York State Department of Health Early Intervention Program.

HIV/AIDS Community Follow-Up Program (CFP)

To be eligible for CFP CMCM services, enrollees must be Medicaid eligible and a member of one of the following groups:

1. HIV infected persons;

2. HIV antibody positive infants up to age 3 years if seroconversion has not been firmly established; or

3. Individuals deemed to be ‘high risk” until tested and HIV status is confirmed. High risk individuals are those individuals who are members of the following populations:

- Men who have sex with men (MSM),
- active substance abusers,
- persons with history of sexually transmitted diseases,
- sex workers,
- bisexual individuals,
- sexually active adolescents engaging in unprotected sex, or
- persons who engage in unprotected sex with HIV+ or high risk individuals.

Parameters for enrollee eligibility and Intake and Screening are outlined in the CFP Guidance Document and Standards. Screening and Intake must take place within 15 days of referral to the program. A brief Intake Service Plan must be completed at the time of Intake to address immediate needs. An enrollee may be enrolled and an intake completed during institutionalization in a hospital or long-term care facility as long as discharge is imminent [within 180 days (*per ADA, Olmstead v. L.C.)].*

More information is available online at:

http://cobracm.org/resource/.

Assessment and Reassessment

During this process, information about the enrollee and the resources available to the enrollee are gathered to develop a plan specific to the enrollee's needs.

The case management process must be initiated by a written assessment of the enrollee's need for case management in the areas of medical, social, psychosocial, educational, financial and/or other services. This process should include information from the enrollee and, with the enrollee's permission, from any collateral sources whose information is necessary to make a comprehensive assessment.

Assessment provides verification of the enrollee's current functioning and continuing need for services. It defines the service priorities and provides an evaluation of the enrollee's ability to benefit from such services.

Upon the enrollee's acceptance of case management services, an initial assessment must be completed by a case manager within 15 days of referral from the LDSS or, if not a referral by the local district, within 15 days of the enrollee's acceptance of services.

If the enrollee has been referred to CMCM by another source, the referral for service may include a plan of care containing significant information developed by the referral source, which should be included as an integral part of the case management assessment.

Assessment is a continuous process, which is the result of each encounter with the enrollee and the dialogue between the enrollee and case manager. However, a reassessment of the enrollee's need for case management and other services must be completed by the case manager every six months, or earlier if required by changes in the enrollee's condition or circumstances.

In CMCM services the case manager must secure:

- An evaluation of any functional impairment on the part of the enrollee and, if necessary;
- Refer the individual for a medical assessment;
- A determination of the enrollee's functional eligibility for services;
- Information from other agencies/individuals required to identify the barriers to care and existing gaps in service to the enrollee; and
- A comprehensive assessment of the individual's service needs including medical, social, psychosocial, educational, financial and other services.

Program Specific Variations for Assessment and Reassessment

TASA
An initial assessment and interim plan must be completed at the initial interview to determine:

- The enrollee's emergency needs and how to fulfill them;
- Whether the adolescent is pregnant and if prenatal care is being provided;
- How to access prenatal care for a pregnant adolescent not currently in receipt of such care.

If an interview is scheduled **within** 30 days of referral:

- A comprehensive assessment and plan must be completed within 90 days of the referral, and should address all of the enrollee's needs;
- A reassessment and plan update must be performed within 6 months of the referral;

If an interview is scheduled **after** the first 30 days subsequent to the referral:

- A comprehensive assessment and plan must be completed within 60 days of the initial interview;

- A reassessment and plan update must be performed within 6 months of the interview.

Early Intervention
The timelines specified in regulation (10 NYCRR 69-4), guidance memoranda issued by the DOH Early Intervention Program and local contract language should be followed.

HIV/AIDS Community Follow-up Program
The timelines specified in the CFP Guidance Document and Standards issued by DOH AIDS Institute should be followed. For more information, go online to:

http://cobracm.org/resource/.

An assessment must be completed on all minor children living in the household and/or those minor children of the index enrollee who are dependent on the enrollee.

Case Management Planning and Coordination

At this point in the process, the case manager, with the enrollee, identifies the course of action to be followed, the informal and formal resources that can be used to provide services, and the frequency, duration and amount of service(s) that will satisfy the enrollee's need.

A written case management plan must be completed by the case manager for each enrollee of case management services within 30 days of the date of referral from the social services district or, if not referred from the LDSS, within 30 days of the enrollee's acceptance of services.

Planning includes, but is not limited to, the following activities:

- Identification of the nature, amount, frequency, duration and cost of the case management services to a particular enrollee;

- Selection of the services to be provided to the enrollee;

- Identification of the enrollee's informal support network and providers of services;

- Specification of the long term and short term objectives to be achieved through the case management process;

A primary program goal, such as self sufficiency, must be chosen for each enrollee of CMCM. Additionally, the enrollee's personal goal for the coming year should be

specified. Intermediate objectives leading toward these goals and tasks required for the enrollee to achieve a stated goal should be identified in the plan with the time period within which the objectives and tasks are to be attained.

- Collaboration with the social services district, health care providers and other formal and informal service providers, including discharge planners and others as appropriate.

This may occur through case conferences or other means and is intended to encourage exchange of clinical information and to assure:

- Integration of clinical care plans throughout the case management process;
- Continuity of service;
- Avoidance of duplication of service (including case management services); and
- Establishment of a comprehensive case management plan that addresses the medical, social, psychosocial, educational, and financial needs of the enrollee.

For enrollees temporarily hospitalized in acute care general hospitals, case management should concentrate on the needs of the enrollee once discharged from the hospital. It should not duplicate the efforts of the hospital social service worker or discharge planner, but should concentrate on implementing and monitoring the plan for the enrollee.

> The case manager should meet with the hospital social service worker and/or discharge planner to review their recommendations, medical orders and follow-up care and to advise them of plans for ongoing case management of the enrollee.

The case management plan must be reviewed and updated by the case manager as required by changes in the enrollee's condition or circumstances, but not less frequently than every six months subsequent to the initial plan. Each time the case management plan is reviewed, the objectives established in the initial case management plan must be maintained or revised, and/or new objectives and new time frames established with the participation of the enrollee. The case management plan must specify:

- Those activities which the enrollee or the case manager is expected to undertake within a given period of time toward the accomplishment of each case management objective;
- The name of the person or agency, including the individual and/or family members, who will perform needed tasks;

- The type of treatment program or service providers to which the individual will be referred;
- The method of provision and those activities to be performed by a service provider or other person to achieve the individual's related objectives; and
- The type, amount, frequency, duration and cost of case management and other services to be delivered or tasks to be performed.

Program Specific Variation for Planning and Coordination

TASA
Plans should be established within the time frames listed in this manual under Program Specific Variations for Assessment and Reassessment.

Early Intervention
The case management plan is called an individualized family services plan in early intervention. The timelines specified in regulation (10 NYCRR 69-4), guidance memoranda issued by the DOH Early Intervention Program and local contract language should be followed.

HIV/AIDS Community Follow-up Program
The case management plan is called a Service Plan and should be completed within 7 days of the completion of the Comprehensive Assessment/reassessment. It must be signed by the enrollee to indicate that the enrollee has agreed to the plan. It should include information on needs of those collaterals/family members/children who have a direct bearing on the enrollee's ability to adhere to care and treatment. A copy of the plan must be offered to the enrollee.

For any enrollee in an institutional setting (nursing home, drug rehabilitation), or supportive housing a Joint Treatment Plan must be developed specifying why the enrollee is being "jointly case managed", what CMCM needs are being addressed and by whom, and the goal to move toward case closure.

All timelines specified in the CFP Guidance Document and Standards issued by DOH AIDS Institute should be followed. More information is available online at:

http://cobracm.org/resource/.

Implementation of the Case Management Plan

Implementation means marshalling available resources to translate the plan into action. This includes:

- Becoming knowledgeable about community resources, including the various entitlement programs and the extent to which these programs are capable of meeting enrollee needs;

- Working with various community and human services programs to determine which tasks/functions of the case plan will be carried out by the case manager and which by other community and human services agencies. This activity may involve negotiating functions. The CMCM is responsible for case coordination;

- Securing the services determined in the case management plan to be appropriate for a particular enrollee, through referral to those agencies or persons who are capable of providing the identified services;

- Assisting the enrollee with referral and/or application forms required for the acquisition of services;

- Advocating with all providers of service when necessary to obtain/maintain fulfillment of the enrollee's service needs; and

- Developing alternative services to assure continuity in the event of service disruption.

Program Specific Variation for Implementation of the Case Management Plan

HIV/AIDS Community Follow-up Program
Case Conferences are required at reassessment and also as needed to implement the service plan. Service plans should be amended/updated as the status of the enrollee/family changes and as new needs become apparent.

Case Specific Supervision is also part of the case management plan implementation. Those enrollees/families with ongoing mental health and/or substance use issues may need case specific supervision to redirect the plan to address specific barriers and complex issues that impact the enrollee's ability to adhere to care and treatment.

For more information, please refer to TA Bulletins 1B-03 and 2A-99, located online at:

http://cobracm.org/resource/.

Enrollee contact frequencies as outlined in the CFP Guidance Document, Standards, and TA Bulletins issued by the DOH AIDS Institute should be followed.

Crisis Intervention

A case manager may be required to coordinate case management and other services in the event of a crisis. Crisis intervention includes:

- Assessment of the nature of the enrollee's presenting circumstances;
- Determination of the enrollee's emergency service needs;
- Securing the services to meet the emergency needs; and
- Revision of the case management plan, including any changes in activities or objectives required to achieve the established goal.

Emergency services are defined as those services required to alleviate or eliminate a crisis.

Monitoring and Follow-Up of Case Management Services

Monitoring the acquisition/provision of service and following up with enrollees guarantees continuity of service. Monitoring and follow-up includes:

- Verifying that quality services, as identified in the case management plan, are being received by the enrollee and are being delivered by providers in a cost conscious manner;
- Assuring that the enrollee is adhering to the case management plan and ascertaining the reason for the decision not to follow the agreed upon plan;
- Ascertaining the enrollee's satisfaction with the services provided and advising the preparer of the case management plan of the findings if the plan has been formulated by another practitioner;
- Collecting data and documenting in the case record the progress of the enrollee (this includes documenting contacts made to or on behalf of the enrollee);
- Making necessary revisions to the case management plan;
- Making alternate arrangements when services have been denied or are unavailable to the enrollee; and
- Assisting the enrollee and/or provider of services to resolve disagreements, questions or problems with implementation of the case management plan.

Program Specific Variation for Monitoring and Follow-up

HIV/AIDS Community Follow-up Program
Enrollee contact and monitoring are expected to be frequent and proactive to ensure the enrollee achieves goals defined in the Service Plan.

Counseling and Exit Planning

The counseling referred to in case management is that which is provided to a CMCM enrollee enabling him/her to cooperate with the case manager in carrying out the objectives and tasks required to achieve the goal of CMCM services. It is **not** the provision of an actual service such as employment counseling.

Counseling as a function of case management includes:

- Assuring that the enrollee obtains, on an ongoing basis, the maximum benefit from the services received;
- Developing support groups for the enrollee, the family and informal providers of services;
- Mediating among the enrollee, the family network and/or other informal providers of services to resolve problems with service provision;
- Facilitating access to other appropriate care if and when eligibility for the targeted services ceases; and
- Assisting enrollees to anticipate the difficulties which may be encountered subsequent to admission to or discharge from facilities or other programs including case management.

Early Intervention Counseling and Exit Plan

Service coordination providers should follow guidance memoranda issued by the Department of Health's Early Intervention Program regarding Transition Planning.

Enrollment in the Restriction/Exception Subsystem

The Comprehensive Medicaid Case Management enrollee must be enrolled with an Exception Code **35** in the *Welfare Management System (WMS) Restriction/Exception Subsystem (R/E)* by the local department of social services (LDSS) responsible for the enrollee's Medicaid benefits.

If you bill monthly, the enrollment "From" date of the enrollment request must be the first of the month of service. If the enrollee is not Medicaid eligible on the date of service, the

LDSS will be unable to enroll the enrollee with the R/E Code 35, and thus, the claim for reimbursement will be rejected.

Enrollment in the WMS R/E Subsystem accomplishes the following:

- It identifies the enrollee as an appropriate member of the target population;
- It confirms that the enrollee has freely chosen to participate in the program;
- It links the enrollee to the provider number of the specific Case Management Program providing service; and,
- It establishes a specified "From and Thru Date". Claims for Case Management services provided outside the enrollment time frames will not be paid.

The enrollee must be enrolled in the Case Management program providing services. Registration in that program in the WMS R/E Subsystem will only continue as long as the enrollee is willing to accept services from that provider.

If the enrollee decides to change providers, the LDSS must be notified so that the registration will be changed to reflect the new provider's Medicaid identification number, effective as of the date the new provider rendered Case Management services.
A Medicaid-eligible enrollee is referred to a Case Management provider either by the LDSS, another agency, or through self-referral. The enrollee may choose to accept professional services from the referred provider, to seek service from another provider, or to reject case management services completely.

If the enrollee has been determined to be Medicaid eligible, is enrolled in the WMS R/E Subsystem, and is enrolled with the Case Management Program providing services, the initial Medicaid claim submission should be no sooner than two weeks after the provider received verification of successful enrollment in Case Management by the LDSS.

To assist Case Management Providers with enrollment, disenrollment, and changes to the Case Management information in the WMS R/E Subsystem, the Office of Health Insurance Programs (OHIP), in conjunction with LDSS, is offering forms, plus instruction sheets for enrollment and disenrollment of recipients into Comprehensive Case Management. These forms are modeled on forms used in New York City, and are being offered for use by OHIP and the LDSS providers serving the rest of the State.

> *Please contact your LDSS Case Management contact to obtain forms and instructions.* Return completed forms to the contact person in the LDSS responsible for the Medicaid coverage of the enrollee to whom you are providing Case Management services. Please enclose a self-addressed, stamped envelope, so that verification of the processed enrollments, disenrollments, and/or changes can be returned to you promptly.

If the enrollment or disenrollment forms have not been returned to the provider within 30 days of the date they were sent to the LDSS, the provider should contact the LDSS to determine the status of the enrollment/disenrollment/change.

It is the provider's responsibility to keep track of the form requests sent to and returned from the LDSS. Providers may not submit a claim until successful enrollment verification has been sent to them by the LDSS.

The LDSS responsible for the enrollee's Medicaid eligibility is also responsible for notifying providers within ten calendar days of the denial of a registration, or termination of an existing registration.

*The LDSS **is not responsible** for notifying providers when an enrollee loses Medicaid eligibility*.

Providers are encouraged to notify the LDSS within ten calendar days of any changes which would affect the enrollee's need or eligibility for Case Management services. Providers should also notify the LDSS on a timely basis when they no longer are providing Case Management services to the enrollee.

Program Specific Variations

OMRDD

OMRDD enrollees receive Medicaid Service Coordination (MSC) directly from OMRDD. Each recipient who receives MSC services must be authorized for the services by OMRDD through one of the 13 Developmental Disabilities Service Offices (DDSOs).

These DDSOs enter R/E Code 35 into the WMS R/E Subsystem for appropriate enrollees. In a limited number of counties where the DDSOs cannot enter the code, the DDSO will send a letter to the LDSS to initiate the entry of the R/E code 35 by the LDSS.

Early Intervention

Each enrollee who receives early intervention service coordination must be approved by the municipal early intervention agency.

The municipal early intervention agency is responsible for notifying the LDSS of the enrollee’s EI enrollment or disenrollment. The LDSS in turn is responsible for updating the WMS R/E subsystem accordingly.

HIV/AIDS Community Follow-up Program

Providers should follow the process for enrollment as defined in TA Bulletin 3B-04/4B-04 issued by the DOH AIDS Institute, online at:

http://cobracm.org/resource/.

Section II - Requirements for Participation in Medicaid

All persons accepting Comprehensive Medicaid Case Management (CMCM) services must be registered/authorized in the Welfare Management System - Recipient Restriction/Exception subsystem by the local department of social services (LDSS) responsible for Medical Assistance.

Except as noted below, CMCM registration/authorization forms and information should be obtained from the LDSS. This registration/authorization will:

(1) link one provider of CMCM services to one enrollee;

(2) assure that the enrollee is an appropriate member of the target population and

(3) assure the enrollee has freely chosen to participate in a particular case management program.

The effective date of registration/authorization may be retroactive to the date on which the enrollee accepts CMCM services (as long as this date does not precede the date of the provider's enrollment in the Medicaid Program).

In general, initial registration for CMCM can occur while an enrollee is residing in the community or when discharge from an acute care general hospital is imminent.

For institutionalized enrollees (i.e. settings other than acute care general hospitals), the initial registration date must be after the institution discharge.

When a Medicaid eligible individual is referred to the case management provider, whether by the LDSS, by another agency or by self-referral, the individual has free choice to accept services from that case management provider, to seek services from any other approved case management provider or to reject case management services.

- Only if the individual accepts services can the provider request registration/authorization from the LDSS.

- This registration/authorization, being provider specific, will only continue as long as the enrollee is willing to accept services from that provider.

- If the individual decides to change providers, the registration/ authorization will be changed to the new provider, effective the first day of the following month. The first provider will no longer be able to bill for services, which might be rendered to that individual after the effective date of the change.

The LDSS which is responsible for the enrollee's Medical Assistance is responsible for notifying providers within 10 calendar days of the denial of a registration/authorization request or termination of an existing registration/authorization.

> Local departments of social services are **not** responsible for notifying providers when enrollees lose Medicaid eligibility. The provider must verify an enrollee's eligibility via MEVS before service is provided.

Providers of case management services are responsible for notifying the LDSS within 10 calendar days of any changes which would affect the individual's need or eligibility for CMCM services.

CMCM services must not duplicate case management services that are provided under any program, including the Medicaid Program.

> Since case management/coordination services may be a component of a Federal Home and Community Based Services (HCBS) waiver program, *individuals who are participating in an HCBS waiver program that includes case management/service coordination are **not eligible** to participate in a CMCM program.*
>
> If an individual is participating in such an HCBS waiver they may choose to be is disenrolled from the waiver and enrolled instead in the CMCM program.

Qualifications of Provider Entities and Case Managers

Provider Entity Qualifications

Case management services may be provided by social services agencies, facilities, persons and groups possessing the capability to provide such services that are approved by the Commissioner of Health pursuant to a proposal submitted in accordance with Section 505.16 of Social Services Regulations, found at:

http://www.health.state.ny.us/nysdoh/phforum/nycrr18.htm.

Prospective providers of CMCM may include, but are not limited to:

- Facilities licensed or certified under New York State Law or regulations;
- Health care or social work professionals licensed or certified in accordance with New York State Law;
- State and local government agencies; and
- Home health agencies certified under New York State Law.

Program Specific Variations on Provider Entity Qualifications

TASA, CONNECT and Neighborhood Based Initiatives (NBI)

The Department of Health (DOH) will enter into a Medicaid provider agreement with a community agency who has an approved agreement with a social services district to provide either TASA, CONNECT or NBI case management services in accordance with a plan submitted by the social services district to the Department.

The designated community agencies must apply to become a CMCM provider under Medicaid.

OMH

The DOH will enter into a Medicaid provider agreement with the community agencies with a current and valid designation by the State Office of Mental Health (OMH) as an Intensive Case Management provider.

The Department also has an agreement with the OMH to permit claiming for State-employed case managers located within the community agencies.

Community agencies may claim for services rendered by their own employees.

The State OMH will claim for the services of State-employed case managers. Only those individual case managers identified on the OMH designation worksheet are qualified to claim for service. Changes in staffing should be reported to:

Office of Mental Health
Bureau of Reimbursement Operations
Policy and Analysis
44 Holland Avenue
Albany, New York 12229.

OMRDD

The DOH will enter into a Medicaid provider agreement with community agencies having a current and valid designation by the State Office of Mental Retardation and Developmental Disabilities (OMRDD).

Providers are qualified to serve only the type and number of enrollees with the residential status specified on the designation letter from the State OMRDD.

Early Intervention

The DOH will enter into a provider agreement with only the designated municipal early intervention agencies. Providers who wish to provide EI service coordination must apply to the State Early Intervention Program for approval.

Applications should be sent to:

New York State Department of Health
Early Intervention Program
Corning Tower, Room 208
Albany, New York 12237.

Early Intervention providers with a municipal contract to provide service coordination services must bill the municipal Early Intervention agency directly for the delivery of these services.

Only designated municipal Early Intervention agencies are able to claim Medicaid reimbursement.

HIV/AIDS Community Follow-up Program

The AIDS Institute will enter into a Provider Agreement with agencies designated to provide intensive, family-centered community-based case management to HIV infected and high risk persons.

Applications will be accepted from Article 28 providers, certified home health agencies, community health centers, community service programs, and other community based organizations with:

- two years experience in the case management of persons living with HIV and AIDS; OR
- three years experience providing community based social services to persons living with HIV and AIDS; OR
- three years experience providing case management or community based social services to women, children and families; substance users; MICA enrollees; homeless persons; adolescents; parolees and other high risk populations, and includes one year HIV related experience.

For more information, please contact:

New York State Department of Health
AIDS Institute
Bureau of Community Support Services
Corning Tower, Room 465
Empire State Plaza
Albany, New York 12237

Case Management Staff

Individual case managers must meet the education and experience qualifications listed below or the requirements specified in the approved State (Medicaid) Plan amendment for the target population.

According to 18 NYCRR 505.16 (http://www.health.state.ny.us/nysdoh/phforum/nycrr18.htm), the individual providing case management must have two years of experience in a substantial number of case management activities, including the performance of assessments and development of case management plans. Voluntary or part-time experience, which can be verified, will be accepted on a pro-rated basis.

The following may be substituted for this requirement:

- One year of case management experience and a degree in a health or human service field; or
- One year of case management experience and an additional year of experience in other activities with the target population; or
- A bachelor's or master's degree which includes a practicum encompassing a substantial number of case management activities, including the performance of assessments and development of case management plans; or
- The regulatory requirements of a State department or division for a case manager.

HIV/AIDS Community Follow-up Program

The Community Follow-up Program utilizes a team approach to case management. Members of a "team" include a case manager, case management technician and a community follow-up worker. The use of a multi-level team supports the time, intensity and flexibility needed to provide comprehensive family-centered case management as well as the required community based follow-up which includes home visitation, establishing and maintaining contact with hard to reach families, and agency advocacy.

Direct reimbursement is only available for the case manager and the case management technician positions. Costs associated with the community follow-up worker are included in the rate reimbursement structure.

The following are the minimum qualifications set by the AIDS Institute for case management positions in the Community Follow-up Program:

> For the following positions, **"qualifying experience"** means verifiable full or part-time case management or case work with the following populations:
>
> - persons with HIV infection, and/or
> - persons with a history of mental illness, homelessness, or chemical dependence.
>
> Experience with families preferred.

Case Manager (CM)

- Master's or Bachelor's degree in health, human or education services, and one year of qualifying experience; or
- Associate's degree in health or human services or certification as an R.N. or L.P.N. and two years of qualifying experience.

Case Management Technician (CMT)

- Associates degree in health and human services and one year of qualifying experience; or
- High School diploma or G.E.D., and two years of qualifying experience.

Community Follow-up Worker (CFW)
Ability to read, write, understand and carry out directions. Community resident with knowledge of community resources and sensitivity towards persons with HIV preferred.

For more information, please refer to TA Bulletin 16A – 2006, online at:

http://cobracm.org/resource/.

Record Keeping Requirements

A separate case record must be maintained for each enrollee served and for whom reimbursement is claimed.

In addition to the record requirements listed in Information For All Providers, General Billing, **the case record** must contain, at a minimum:

- the enrollee characteristics which constitute program eligibility;
- a notation of program information given to the enrollee at intake;
- the date and manner of the enrollee's voluntary acceptance of CMCM;
- the initial enrollee assessment and any reassessments done since that time;
- the initial case management plan and subsequent updates, containing goals, objectives, timeframes, etc. as agreed to by the enrollee and the case manager; progress notes;
- a statement on the part of the enrollee of the acceptance of case management services;
- copies of any releases of information signed by the enrollee;
- written referrals made;
- correspondence, and a record of enrollee, and
- collateral contacts.

The **case record entries which record the enrollee and collateral contacts** must contain at a minimum:

- the date of service,
- name of the enrollee or other contact,
- place of service,
- the nature and extent of the service provided,
- name of the provider agency and person providing the service, and
- a statement of how the service supports the enrollee or advances a particular task, objective or goal described in the case management plan.

Program Specific Variation on Case Records

TASA

All plans and assessments must be completed on forms submitted to the DOH with their LDSS referral agreement.

Early Intervention

All plans, assessments and other reports must be completed on forms as promulgated by the Early Intervention Program and/or specified in the municipal contract.

HIV/AIDS Community Follow-up Program

All forms used in the CFP case record must be approved by the AIDS Institute.

Other Records

The provider of case management services shall maintain other records to support the basis for approval or payment for the case management program, including but not limited to:

- referral agreements,
- provider agreements,
- work plans,
- records of costs incurred in providing services,
- employment and personnel records which show staff qualifications, and
- time worked, statistical records of services provided and any other records required as a result of any agreements with either the Department of Health or a local social services district.

All records must be maintained for at least six years after the service is rendered or six years after the enrollee's 18th birthday, whichever is later.

Section III - Basis of Payment for Services Provided

Payment for case management services will be made through the Medicaid Program's eMedNY Contractor. Payment will be enrollee specific and available only for Medicaid eligible members of the target population. Payment will be based on a rate approved by the New York State Department of Health and the New York State Division of the Budget, which was developed from cost estimates, and other relevant information submitted by the local social services district or State-supervising agency.

Billing will be done, whether by units of service, rates, fees or on a capitated basis, according to the proposal submitted by the LDSS or the State supervising agency and approved by the New York State Department of Health.

A minimum of one case contact per month is expected for enrollees to be considered in receipt of CMCM services. Except for enrollee interviews to make assessments and plans, case contacts need not all be face-to-face encounters. They may include contacts with collaterals or service providers in fulfillment of the enrollee's plan.

Program Specific Variation on Frequency of Service

TASA

The TASA Program requires a minimum of one contact per month. Contacts need not be all face-to-face encounters; but may include contacts with service providers or other collaterals in fulfillment of the enrollee's case management plan.

The frequency of routine case contacts are specified in the approved LDSS provider referral agreement. The case manager should document the need for more frequent contacts in the enrollee's case record.

OMH

Enrolled ICM enrollees must be seen in face-to-face meetings at least four (4) times per month in order to be considered active and for a provider to submit a claim.

OMRDD

The case manager must be aware of any change in the individual's status and maintain the minimum of monthly case contact.

> Case contact is defined as direct face to face contact with the individual or his/her family.

HIV/AIDS Community Follow-up Program

The CFP requires a minimum of 3 contacts per month, not all of which are face to face.

Providers should follow the CFP Guidance Document, Standards and TA Bulletins issued by the DOH AIDS Institute. For more information, please refer to:

http://cobracm.org/resource/.

Section IV - Non-Billable Services

Certain activities, which are necessary to the provision of case management services, cannot be billed as a service.

Fundable Activities

The following activities are considered a necessary part of a case management program and may be included in the development of the rate methodology, but may not be billed for separately:

- Case recording, completion of progress notes and other administrative reports;
- Training workshops and conferences attended by case management staff and/or enrollees;
- Supervisory conferences, meetings unless specifically for the purpose of advancing the case or making changes to the enrollee's case management plan;
- Administrative work, including interagency liaison and community resource development related to serving enrollee;
- Intake and screening activities for Medicaid enrollees who while meeting program participation criteria do not accept services;
- Pre-discharge CMCM engagement activities for enrollees in institutional settings other than acute care general hospitals;
- For CMCM enrollees who are temporarily hospitalized/ institutionalized for a period anticipated to be **over 30 days**, it is expected that there would be no Medicaid billing for the period of the hospitalization/ institutionalization. When the admission is initially expected to last **30 days or less**, the case manager/enrollee relationship may be continued, and Medicaid billing is allowed only for CMCM services provided in the first 30 days of hospitalization. The basis for the initial expectation should be documented in the CMCM record for audit purposes.

Non-fundable Activities

Certain other activities, while they may be closely related to case management, or necessary to the achievement of the enrollee's case management goals and objectives, are not included in the definition of case management services and, therefore, may not be either billed or funded through the rate methodology. These activities are:

- Outreach to non-eligible populations when the enrollee does not accept case management services;

- ► Enrollee transportation;
- ► Employment counseling;
- ► Drug and alcohol counseling;
- ► Discharge planning;
- ► Social work treatment;
- ► Preparation and mailing of **general** mailings, flyers, and newsletters;
- ► Child care.

- ➢ MA eligibility determinations, redeterminations, intake processing and prioritization;
  - ► Nursing supervision;
- ➢ Fiduciary activities related to the CMCM enrollee's personal funds;
- ➢ Any other activity which constitutes or is part of another Medicaid or non-Medicaid service.

Note: It may be necessary for a case manager to escort an enrollee to a service provider in order to help them negotiate and obtain services specified in the enrollee's case management plan. At the same time, the case manager should be encouraging the enrollee's maximum independent functioning in the community.

> The ongoing need to escort the enrollee should be well documented in the enrollee's case record.

Furthermore, if the case manager is escorting the enrollee to medical appointments or services, the case management should document in the case why the enrollee was unable to obtain needed medical transportation services from the LDSS.

> In these instances, enrollee transportation may be a billable case management activity.

Section V - Definitions

For the purposes of the Medicaid program and as used in this Manual, the following terms are defined to mean:

Active

Active means that the enrollee who is enrolled in intensive case management is seen in face-to-face contacts at least four times a month.

Case Management

Case management is a process, which assists persons to access necessary services in accordance with goals contained in a written case management plan.

CONNECT CMCM

CONNECT CMCM is targeted to women of child bearing age that are pregnant or parenting, and infants under one year of age who reside in urban areas with a high incidence of infant mortality.

Early Intervention Service Coordination

The target group consists of infants and toddlers from birth through two years of age who have or are suspected of having a developmental delay or a diagnosed physical or mental condition that has a high probability of resulting in developmental delay. These children are referred by the municipal early intervention agency and are known to the New York State Department of Health and are in need of ongoing and comprehensive rather than incidental case management.

Engagement

Engagement means that the intensive case management is working with the rostered enrollee to determine viability to become an active enrollee.

Enrolled

If an enrollee is enrolled in intensive case management, then the enrollee has been selected from a roster to be serviced by the intensive case management case manager.

Free Choice

Free choice is the decision to accept or reject CMCM services or any part of the case management plan, the choice of case management provider, or the choice of provider of any Medicaid service included in the case management plan is that of the Medicaid eligible individual who is referred for case management services.

Neighborhood Based Initiatives (NBI) CMCM

NBI was established through Chapter 657 of the Laws of 1990 aimed at developing a unified strategy in distressed communities which will build upon the community's strengths.

Case management is targeted to individuals who are struggling with the effects of multiple problems compounded by poverty and poor access to services.

OMH Intensive Case Management

OMH ICM is an intensive case management program operated by the Office of Mental Health (OMH) for the seriously and persistently mentally ill with services provided by locally employed intensive case managers at designated community agencies or State OMH employees working at those agencies or out of a State psychiatric facility.

OMRDD CMCM

OMRDD CMCM is a case management program operated by the Office of Mental Retardation and Developmental Disabilities (OMRDD) for developmentally disabled individuals residing at home or in voluntary operated community residences.

Rostered Enrollees

Rostered means the enrollee is on the list of those who meet Intensive Case Management program participation criteria. The list is maintained by each OMH Regional Office.

Target Group

A target group is a group of individuals, sharing common characteristics, such as diagnosis, high service utilization, difficulty in accessing services or vulnerability to certain high risk behaviors.

TASA CMCM

TASA CMCM is a program based upon the Teenage Services Act of 1984 in which a LDSS enters into an agreement with community agencies in fulfillment of the LDSS' obligation to provide case management to pregnant and parenting teens.

NEW YORK STATE
MEDICAID PROGRAM

COMPREHENSIVE MEDICAID CASE MANAGEMENT (CMCM)

UB-04
BILLING GUIDELINES

TABLE OF CONTENTS

Section I – Purpose Statement

The purpose of this document is to assist the provider community in understanding and complying with the New York State Medicaid (NYS Medicaid) requirements and expectations for:

- Billing and submitting claims.
- Interpreting and using the information returned in the Medicaid Remittance Advice.

This document is customized for CMCM providers and should be used by the provider's billing staff as an instructional as well as a reference tool.

Section II – Claims Submission

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

Providers are required to submit an Electronic/Paper Transmitter Identification Number (ETIN) Application and a Certification Statement before submitting claims to NYS Medicaid. While a provider is required to recertify on a yearly basis, the certification will remain in effect as long as the provider is participating in the NYS Medicaid Program. You will be provided with renewal information when your Certification Statement is near expiration.

Pre-requirements for the Submission of Claims

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

- An ETIN
- A Certification Statement

ETIN
This is a submitter identifier issued by the eMedNY Contractor and it must be used in every electronic submission to NYS Medicaid. ETINs may be issued to an individual provider or provider group (if they are direct billers) and to service bureaus or clearinghouses.

ETIN applications are available at www.emedny.org.

✓ Select **Information** from the menu

✓ Click on **Provider Enrollment Forms**

✓ Click on **Electronic/Paper Transmitter Identification Number**

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

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

The Certification Statement is available at www.emedny.org together with the ETIN application.

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.

CMCM providers who choose to submit their Medicaid claims electronically are required to use the HIPAA 837 Institutional (837I) transaction. In addition to this document, direct billers may also refer to the sources listed below to comply with the NYS Medicaid requirements.

- HIPAA 837I Implementation Guide (IG) – A document that 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) – A subset of the IG, which provides instructions for the specific requirements of NYS Medicaid for the 837I. This document is available at www.emedny.org.

  - ✓ Select **NYHIPAADESK** from the menu
  - ✓ Click on **eMedNY Companion Guides and Sample Files**
  - ✓ Look for the box labeled "837 Institutional Health Care Claim" and click on the link for the **837 Institutional Companion Guide**

- NYS Medicaid Technical Supplementary Companion Guide – This document provides technical information needed to successfully transmit and receive electronic data. Some of the topics put forth in this CG are testing requirements, error report information, and communication specifications. The Technical Supplementary CG is available at www.emedny.org.

  - ✓ Select **NYHIPAADESK** from the menu
  - ✓ Click on **eMedNY Companion Guides and Sample Files**
  - ✓ Look for the box labeled "Technical Guides" and click on the link for the **Technical Supplementary CG**

Pre-requirements for the Submission of Electronic Claims

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

- A User ID and Password
- A Trading Partner Agreement
- Testing

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

Trading Partner Agreement
This document addresses certain requirements applicable to the electronic exchange of information and data associated with health care transactions. The NYS Medicaid Trading Partner Agreement is available at www.emedny.org.

✓ Select **NYHIPAADESK** from the menu

✓ Click on **Registration Information Trading Partner Resources**

✓ Click on **Trading Partner Agreement**

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

Information and instructions regarding testing are available at www.emedny.org.

✓ Select **NYHIPAADESK** from the menu

✓ Click on **eMedNY Companion Guides and Sample Files**

✓ In the box titled "Technical Guides," click on **eMedNY Provider Testing User Guide**

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

ePACES

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

The requirements for using ePACES include:

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

The following transactions can be submitted via ePACES:

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

To take advantage of ePACES, providers need to follow an enrollment process. Additional enrollment information is available at www.emedny.org.

✓ Select **NYHIPAADESK** from the menu

✓ Click on **ePACES General Information and Enrollment**

eMedNY eXchange

The eMedNY eXchange works like email; users are assigned an inbox and they are able to send and receive transaction files in an email-like fashion. Transaction files are attached and sent to eMedNY for processing and the responses are delivered to the user's inbox so they can be detached and saved on the user's computer. **For security reasons, the eMedNY eXchange is accessible only through the eMedNY website** www.emedny.org.

The eMedNY eXchange only accepts HIPAA-compliant transactions.

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 can be found at www.emedny.org.

✓ Select **Information** from the menu

✓ Click on **Provider Enrollment Forms**

✓ Click on **Security Packet B**

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, please contact the eMedNY Call Center at 800-343-9000.

eMedNY Gateway

This is a dial-up access method. It requires the use of the user ID assigned at the time of enrollment and a password. eMedNY Gateway 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 can be found at www.emedny.org.

✓ Select **Information** from the menu

✓ Click on **Provider Enrollment Forms**

✓ Click on **Security Packet B**

Note: For questions regarding ePACES, eXchange, FTP, CPU to CPU or eMedNY Gateway connections, call the eMedNY Call Center at 800-343-9000.

Paper Claims

CMCM providers who choose to submit their claims on paper forms must use the Centers for Medicare and Medicaid Services (CMS) standard **UB-04** claim form. To view the UB-04 claim form please click on the link provided below. The displayed claim form is a sample and the information it contains is for illustration purposes only.

Comprehensive Medicaid Case Management Services – UB-04 Sample Claim

An ETIN and a Certification Statement are required to submit paper claims. Providers who have a valid ETIN for the submission of electronic claims do not need an additional ETIN for paper submissions. The ETIN and the associated certification qualifies the provider to submit claims in both electronic and paper formats.

General Instructions for Completing Paper Claims

Since the information entered on the claim form is captured via an automated data collection process (imaging), it is imperative that it be legible and placed appropriately in the required fields. The following guidelines will help ensure the accuracy of the imaging output:

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

1 2 3 4 5 6 7 8 9 0

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

Written As	Intended As	Interpreted As	
6.ɢ0	6.00	6.60	→ Zero interpreted as six

- When typing or printing, stay within the box provided; ensure that no characters (letters or numbers) touch the claim form lines. For example:

Written As	Intended As	Interpreted As	
2	2	7	→ Two interpreted as seven
3	3	2	→ Three interpreted as two

- Characters should not touch each other. For example:

Written As	Intended As	Interpreted As	
23	23	illegible	→ Entry cannot be interpreted properly

- Do not write between lines.
- Do not use arrows or quotation marks to duplicate information.
- Do not use the dollar sign ($) to indicate dollar amounts; do not use commas to separate thousands. For example, three thousand should be entered as 3000, not as 3,000.
- For writing, it is best to use a felt tip pen with a fine point. Avoid ballpoint pens that skip; do not use pencils, highlighters, or markers. Only blue or black ink is acceptable.
- If filling in information through a computer, ensure that all information is aligned properly, and that the printer ink is dark enough to provide clear legibility.
- Do not submit claim forms with corrections, such as information written over correction fluid or crossed out information. If mistakes are made, a new form should be used.
- Separate forms using perforations; do not cut the edges.
- Do not fold the claim forms.
- Do not use adhesive labels (for example for address); do not place stickers on the form.

The address for submitting claim forms is:

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

UB-04 Claim Form

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

Comprehensive Medicaid Case Management Services – UB-04 Sample Claim

General Information About the UB-04 Form

The UB-04 CMS-1450 is a CMS standard form; therefore CSC does not supply it. The form can be obtained from any of the national suppliers.

The UB-04 Manual (National Uniform Billing Data Element Specifications as Developed by the National Uniform Billing Committee – Current Revision) should be used in conjunction with this Provider Manual as a reference guide for the preparation of claims to be submitted to NYS Medicaid. The UB-04 manual is available at www.nubc.org.

Form Locators in this manual for which no instruction has been provided have no Medicaid application. These Form Locators are ignored when the claim is processed.

Billing Instructions for CMCM Services

This subsection of the Billing Guidelines covers the specific NYS Medicaid billing requirements for CMCM providers. Although the instructions that follow are based on the UB-04 paper claim form, they are also intended as a guideline for electronic billers who should refer to these instructions for finding out what information they need to provide in their claims, what codes they need to use, etc.

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

Field-by-Field (UB-04) Instructions

PROVIDER NAME, ADDRESS, AND TELEPHONE NUMBER (Form Locator 1)

Enter the billing provider's name and address.

Note: It is the responsibility of the provider to notify Medicaid of any change of address or other pertinent information within 15 days of the change. For information on where to direct address change requests please refer to www.emedny.org.

PATIENT CONTROL NO. (Form Locator 3a)

For record-keeping purposes, the provider may choose to identify a patient by using an account/patient control number. This field can accommodate up to 30 alphanumeric characters. If an account/patient control number is indicated on the claim form, the first 20 characters will be returned on the Paper Remittance Advice. Using an account/patient control number can be helpful for locating accounts when there is a question on patient identification.

TYPE OF BILL (Form Locator 4)

Completion of this field is required for all provider types. All entries in this field must contain three digits. Each digit identifies a different category as follows:

- 1st Digit – Type of Facility
- 2nd Digit – Bill Classification
- 3rd Digit – Frequency

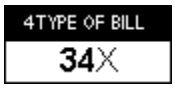
Type of Facility

Enter the value **3** (Home Health) as the first digit of this field. The source of this code is the UB-04 Manual, Form Locator 4, Type of Facility category.

Bill Classification

Enter the value **4** (Other) as the second digit of this field. The source of this code is the UB-04 Manual, Form Locator 4, Bill Classification (Except Clinics and Special Facilities) category.

Example:

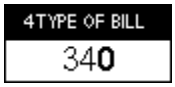


Frequency - Adjustment/Void Code

New York State Medicaid uses the third position of this field **only** to identify whether the claim is an original, a replacement (adjustment) or a void.

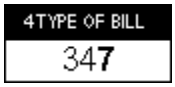
- If submitting an original claim, enter the value **0** in the third position of this field.

Example:



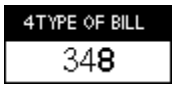
- If submitting an adjustment (replacement) to a previously paid claim, enter the value **7** in the third position of this field.

Example:



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

Example:



STATEMENT COVERS PERIOD FROM/THROUGH (Form Locator 6)

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

- **When billing for one date of service** enter the date in the FROM box. The THROUGH box may contain the same date or may be left blank.

- **When billing for multiple dates of service** enter the first service date of the billing period in the FROM box and the last service date in the THROUGH box. The FROM/THROUGH dates must be in the same calendar month. Instructions for billing multiple dates of service are provided below in Form Locators 42 – 47.

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

Dates must be entered in the format MMDDYYYY.

Special Instructions for ICM/CMCM Only
Enter the first day of the month subsequent to the month in which services were rendered in the FROM box 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, enter the date on which the last of the required four face-to-face encounters took place. Providers should verify patient eligibility through MEVS in order to ensure payment for their services.

Only one ICM claim can be submitted per claim form.

Notes:

- **The provider's paper remittance statement will only contain the date of service in the "FROM" box with the total number of units for the sum of all dates of service reported below. Providers who receive an electronic 835 remittance will receive only the claim level dates of service (from and through) as reported on the incoming claim transaction.**

- **Claims must be submitted within 90 days of the earliest date (FROM date) entered in this field unless acceptable circumstances for the delay can be documented. For more information about billing claims over 90 days from the earliest date of service, please refer to www.emedny.org.**

PATIENT NAME (Form Locator 8 – line b)

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

BIRTHDATE (Form Locator 10)

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

Example: Mary Brandon was born on March 23, 1976.

10 BIRTHDATE
03231976

SEX (Form Locator 11)

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

ADMISSION (Form Locators 12–15)

Leave all fields blank.

STAT [PATIENT STATUS] (Form Locator 17)

This field is used to indicate the specific condition or status of the patient as of the last date of service indicated in Form Locator 6. Select the appropriate code (**except for 43 and 65**) from the UB-04 Manual.

CONDITION CODES (Form Locators 18–28)

NYS Medicaid uses Condition Codes to indicate the following:

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

Note: EPSDT/CTHP and Abortion Sterilization do NOT apply to CMCM claims.

Family Planning – A4
If applicable, enter Condition Code **A4** to indicate that the claim relates to family planning.

Under CMCM, the case manager does not provide medical family planning services such as diagnosis, treatment, drugs, supplies and related counseling. These services are furnished, prescribed by, or administered under the supervision of a physician. For the purpose of CMCM billing, except programs with monthly rates, services related to family planning are those that the case manager offers and arranges for to enable individuals to plan their families in accordance with their wishes. CMCM family planning services include, but are not limited to:

- Disseminating information either orally or in writing about available family planning health services;

- Providing for individual or group discussion regarding the need for family planning health services;

- Providing assistance in accessing services by arranging visits with medical family planning providers.

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

If neither Family Planning nor Possible Disability are applicable conditions, leave this field blank.

OCCURRENCE CODE/DATE (Form Locators 31–34)

NYS Medicaid uses Occurrence Codes to report **Accident Code**. This field has two components: **Code** and **Date**; both are required when applicable.

Code
If applicable, enter the appropriate Accident Code to indicate whether the service rendered to the patient was for a condition resulting from an accident or crime. Select the code from the UB-04 Manual, Form Locators 31-34, Accident Related Codes.

Date
If an entry was made under Code, enter the date when the accident occurred in the format MMDDYY.

VALUE CODES (Form Locators 39–41)

NYS Medicaid uses Value Codes to report the following information:

- Locator Code (required)
- Rate Code (required)
- Medicare Information (only if applicable)
- Other Insurance Payment (only if applicable)
- Patient Participation/Spend-down (only if applicable)

Value Codes have two components: Code and Amount. The **Code** component is used to indicate the type of information reported. The **Amount** component is used to enter the information itself. Both components are required for each entry.

Locator Code – Value Code 61
Locator codes are assigned to the provider for each service address registered at the time of enrollment in the Medicaid program or at anytime, afterwards, that a new location is added.

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

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

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

The example below illustrates a correct Locator Code entry.

Example:

	39 VALUE CODES CODE	AMOUNT
a	61	003
b		
c		
d		

Note: The provider is reminded of the obligation to notify Medicaid of all service locations as well as changes to any of them. For information on where to direct Locator Code updates, please refer to www.emedny.org.

Rate Code – Value Code 24

Rates are established by the Department of Health and other State agencies. At the time of enrollment in Medicaid, providers receive notification of the rate codes and rate amounts assigned to their category of service. Any time that rate codes or amounts change, providers also receive notification from the Department of Health.

Value Code

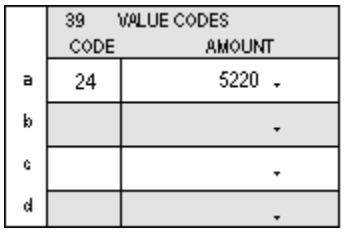
Code **24** should be used to indicate that a rate code is entered under Amount.

Value Amount

Enter the rate code that applies to the service rendered. The four-digit rate code must be entered to the left of the dollars/cents delimiter.

The example below illustrates a correct Rate Code entry.

Example:



	39 VALUE CODES	
	CODE	AMOUNT
a	24	5220
b		
c		
d		

Rate Code Special Instructions

- ICM/CMCM Only
  The ICM rate code (5200) is a monthly rate representing a minimum of four face-to-face encounters with the patient within a calendar month.

- SCM/CMCM Only
  The SCM rate codes - 5205 and 5206 - are monthly rates representing a minimum of two face-to-face encounters with the patient within a calendar month.

- Blended/CMCM Only
  The Blended rate codes - 5250 through 5259 – are monthly rates representing an aggregate minimum number of face-to-face encounters with patients within a calendar month. The minimum number of face-to-face encounters is based on the configuration of the Blended Team. The minimum encounters for each type of team will be based on a schedule provided to Blended Case Management programs by the NYS Office of Mental Health.

- OMRDD/CMCM Only
  For the OMRDD rate code (5221), a minimum of one monthly encounter per case is required in all cases except for patients residing with their families; in that case, a minimum of one quarterly encounter may be maintained instead, if:

  - The patient is a child who attends a residential school during the school term and requires intensive case management services only part of the year; or

  - The family has requested less frequent contact and the case manager determines that this is appropriate.

Medicare Information (See Value Codes Below)
If the patient is also a Medicare beneficiary, it is the responsibility of the provider to determine whether the service being billed for is covered by the patient's Medicare coverage. If the service is covered or if the provider does not know if the service is covered, the provider must first submit a claim to Medicare, as Medicaid is always the payer of last resort.

Value Code

- If applicable, enter the appropriate code, as listed below, to indicate that one (or more) of the following items is entered under Amount.

  - Medicare Deductible – **A1 or B1**

  - Medicare Co-insurance – **A2 or B2**

  - Medicare Co-payment – **A7 or B7**

- Enter code **A3 or B3** to indicate that the Medicare Payment is entered under Amount.

Note: The line (A or B) assigned to Medicare in Form Locator 50 determines the choice of codes <u>A</u>X or <u>B</u>X.

Value Amount

- Enter the corresponding amount for each value code entered.

- Enter the amount that Medicare actually paid for the service. If Medicare denied payment, or if the provider knows that the service would not be covered by Medicare or has received a previous denial of payment for the same service, enter 0.00. Proof of denial of payment must be maintained in the patient's billing record.

Other Insurance Payment – Value Code A3 or B3

If the patient has insurance other than Medicare, it is the responsibility of the provider to determine whether the service being billed for is covered by the patient's Other Insurance carrier. If the service is covered or if the provider does not know if the service is covered, the provider must first submit a claim to the Other Insurance carrier, as Medicaid is always the payer of last resort.

Value Code

If applicable, code **A3 or B3** should be used to indicate that the amount paid by an insurance carrier other than Medicare is entered under Amount. The line (A or B) assigned to the Insurance Carrier in Form Locator 50 determines the choice of codes **A**3 or **B**3.

Value Amount

Enter the actual amount paid by the other insurance carrier. If the other insurance carrier denied payment enter 0.00. Proof of denial of payment must be maintained in the patient's billing record. Zeroes must also be entered in this field if any of the following situations apply:

- Prior to billing the insurance company, the provider knows that the service will not be covered because:
  - ► The provider has had a previous denial for payment for the service from the particular insurance policy. However, the provider should be aware that the service should be billed if the insurance policy changes. Proof of denials must be maintained in the patient's billing record. Prior claims denied due to deductibles not being met are not to be counted as denials for subsequent billings.
  - ► In very limited situations the Local Department of Social Services (LDSS) has advised the provider to zero-fill the Other Insurance payment for the same type of service. This communication should be documented in the client's billing record.
- The provider bills the insurance company and receives a rejection because:
  - ► The service is not covered; or
  - ► The deductible has not been met.

- The provider cannot directly bill the insurance carrier and the policyholder is either unavailable or uncooperative in submitting claims to the insurance company. In these cases the LDSS must be notified prior to zero-filling. The LDSS has subrogation rights enabling it to complete claim forms on behalf of uncooperative policyholders who do not pay the provider for the services. The LDSS can direct the insurance company to pay the provider directly for the service whether or not the provider participates with the insurance plan. The provider should contact the third-party worker in the LDSS whenever he/she encounters policyholders who are uncooperative in paying for covered services received by their dependents who are on Medicaid. In other cases providers will be instructed to zero-fill the Other Insurance payment in the Medicaid claim and the LDSS will retroactively pursue the third-party resource.

- The patient or an absent parent collects the insurance benefits and fails to submit payment to the provider. The LDSS must be notified so that sanctions and/or legal action can be brought against the patient or absent parent.

- The provider is instructed to zero-fill by the LDSS for circumstances not listed above.

The following example illustrates a correct Other Insurance Payment entry.

Example:

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

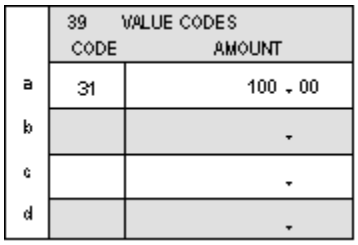
Patient Participation (Spend Down) – Value Code 31
Some patients of the CMCM Services Program do not become eligible for Medicaid until they pay an overage or monthly amount (spend-down) toward the cost of their medical care.

Value Code
If applicable, enter Code **31** to indicate that the patient's spend-down participation is entered under Amount.

Value Amount
Enter the spend-down paid by the patient.

The following example illustrates a correct Patient Participation entry.

Example:



	39 VALUE CODES CODE	AMOUNT
a	31	100.00
b		
c		
d		

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

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

NYS Medicaid uses Revenue Codes to report the following information:

- Total Amount Charged
- Units

Total Amount Charged
Use Revenue Code **0001** to indicate that total charges for the services being claimed in the form are entered in Form Locator 47.

Units
Use an appropriate Revenue Code **from the UB-04 manual** to indicate that the units of service are entered in Form Locator 46.

If billing for multiple dates of service, a revenue code must be entered on each line that corresponds to Form Locator 45 (Serv. Date) and 46 (Serv. Units).

Note: If the number of service lines (dates of service) exceed the number of lines that can be accommodated on a single UB04 form, another claim form must be entirely completed. Medicaid cannot process additional claim lines without all the required information. Each claim form will be processed as a unique claim document and must contain only one Total Charges 0001 Revenue Code. Multi-paged documents cannot be accepted either.

SERV. DATE (Form Locator 45)

Enter the service date corresponding to each iteration of a Revenue Code other than 0001. The dates entered here must be contained within the billing period (FROM/THROUGH) in Form Locator 6.

SERV. UNITS (Form Locator 46)

Billing for One Date of Service – Multiple Units

If only one date of service was entered in form locator 6 and multiple units of service were performed on that date, enter the number of units on the same line where a Revenue Code other than Revenue Code 0001 was entered in Form Locator 42. To determine the number of units, follow the guidelines below.

All CMCM services, **except as noted below**, are billed in units of 15-minute intervals at a rate determined by the NYS Department of Health and other state departments and approved by the NYS Division of the Budget. The number of units should be calculated in accordance to the chart below:

1 unit	=	from 5 minutes to 15 minutes
2 units	=	from 16 minutes to 30 minutes
3 units	=	from 31 minutes to 45 minutes
4 units	=	from 46 minutes to 60 minutes, etc.

Example: Time spent providing case management services is 20 minutes. Enter two (2) units of service in this field.

Example: One hour of case management services is provided. Enter four (4) units of service in this field.

For TASA Only

The units are computed as follows:

1 unit	=	6 minutes	to	21 minutes
2 units	=	22 minutes	to	36 minutes
3 units	=	37 minutes	to	51 minutes
4 units	=	52 minutes	to	1 hour 6 minutes
5 units	=	1 hour 7 minutes	to	1 hour 21 minutes, etc.

Billing for Multiple Dates of Service

If a range of service dates was entered in form locator 6, enter the number of units of service corresponding to each date of service in this field on the same lines where Revenue Code 0240 was entered in form locator 42.

For ICM/CMCM, SCM/CMCM, Blended/CMCM, and OMH/CMCM Only

Leave this field blank.

Note: If the Service Units field is blank, payment will be made for one unit of service.

TOTAL CHARGES (Form Locator 47)

Enter the total amount charged for the service(s) rendered on the lines corresponding to Revenue Code 0001 in Form Locator 42 (total charges for all lines billed) and for any other Revenue Code (individual charges for that one line) . Both sections of the field (dollars and cents) must be completed; if the charges contain no cents, enter **00** in the cents box.

Example:

42 REV CD	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
0001					640 .00	.	
0240			03012007	8	320 .00	.	
0240			03022007	8	320 .00	.	

If billing for multiple units, the total charges should equal the number of units entered in Form Locator 46 multiplied by the rate amount. If no units were reported in Form Locator 46, the total charges should equal the rate amount.

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

This field identifies the payer(s) responsible for the claim payment. The field lines (A, B, and C) are devised to indicate primary (A), secondary (B), and tertiary (C) responsibility for claim payment.

For NYS Medicaid billing, payers are classified into three main categories: Medicare, Commercial (any insurance other than Medicare) and Medicaid. **Medicaid is always the payer of last resort.** Complete this field in accordance with the following instructions.

Direct Medicaid Claim
If Medicaid is the only payer, enter the word Medicaid on line A of this field. Leave lines B and C blank.

Medicare/Medicaid Claim
If the patient has Medicare coverage,

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

Commercial Insurance/Medicaid Claim
If the patient has insurance coverage other than Medicare,

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

Medicare/Commercial/Medicaid Claim
If the patient is covered by Medicare and one or more commercial insurance carriers,

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

NPI (Form Locator 56)

For providers who are required by the Federal government to obtain a National Provider ID (NPI): until National Provider ID (NPI) implementation by NYS Medicaid, the Medicaid Provider ID number must also be completed according to instructions for Form Locator 57 below. However, providers are strongly encouraged to begin reporting their billing provider's NPI information, as soon as possible.

OTHER PRV ID (Form Locator 57)

The Medicaid Provider ID number is the eight-digit identification number assigned to providers at the time of enrollment in the Medicaid program.

Enter the Medicaid Provider ID number on the same line (A, B, or C) that matches the line assigned to Medicaid in Form Locator 50. If the provider's Medicaid ID number is entered in lines B or C, the lines above the Medicaid ID number must contain either the provider's ID for the other payer(s) or the word **NONE**.

INSURED'S UNIQUE ID (Form Locator 60)

Enter the patient's Medicaid Client ID number. Medicaid Client ID numbers are assigned by the State of New York and are composed of eight characters in the format AANNNNNA, where A = alpha character and N = numeric character.

Example: AB12345C

The Medicaid Client ID should be entered on the same line (A, B, or C) that matches the line assigned to Medicaid in Form Locators 50 and 57. If the patient's Medicaid Client ID number is entered on lines B or C, the lines above the Medicaid ID number must contain either the patient's ID for the other payer(s) or the word **NONE**.

TREATMENT AUTHORIZATION CODES (Form Locator 63)

Leave this field blank.

DOCUMENT CONTROL NUMBER (Form Locators 64 A, B, C)

Leave this field blank when submitting an original claim or a resubmission of a denied claim.

If submitting an **Adjustment (Replacement)** or a **Void** to a previously paid claim, this field must be used to enter the **Transaction Control Number (TCN)** assigned to the claim to be adjusted or voided. The TCN is the claim identifier and is listed in the Remittance Advice. If a TCN is entered in this field, the third position of Form Locator 4, Type of Bill, must be 7 or 8.

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

Adjustments

An adjustment is submitted to correct one or more fields of a previously paid claim. Any field, except the **Provider ID number** or the **Patient's Medicaid ID number**, can be adjusted. The adjustment must be submitted in a new claim form (copy of the original form is unacceptable) and all applicable fields must be completed. An adjustment is identified by the value **7** in the **third position of Form Locator 4**, Type of Bill, and the claim to be adjusted is identified by the TCN entered in this field (Form Locator 37).

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

Voids

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

A void should be submitted only when the entire original claim –all claim lines (service dates) – need to be cancelled.

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

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

Leave these fields blank.

OTHER (Form Locator 78)

Leave this field blank.

Section III – Remittance Advice

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

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

- A listing of all **claims** (identified by several pieces of information as submitted on the claim) that have entered the computerized processing system during the corresponding cycle
- The **status** of each claim (deny/paid/pend) after processing
- The eMedNY **edits** (errors) failed by pending or denied claims
- **Subtotals** (by category, status, locator code, 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.

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 may call the eMedNY Call Center at 800-343-9000 or complete the HIPAA 835 Transaction Request form, which is available at www.emedny.org.

- ✓ Select **Information** from the menu
- ✓ Click on **Provider Enrollment Forms**
- ✓ Look for the "Provider Maintenance Forms" column and click on **Electronic Remittance Request Form**

The NYS Medicaid Companion Guides for the 835 transaction are available at www.emedny.org.

- ✓ Select **NYHIPAADESK** from the menu
- ✓ Click on **eMedNY Companion Guides and Sample Files**
- ✓ Look for the box labeled "835 Health Care Claim Payment Advice" and click on **835 Companion Guide**

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

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

Note: 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 may call the eMedNY Call Center at 800-343-9000 or complete the Remittance Sort Request form, available at www.emedny.org.

✓ Select **Information** from the menu

✓ Click on **Provider Enrollment Forms**

✓ Look for the column titled "Provider Maintenance Forms" and click on **Paper Remittance Sort Request Form**

Remittance Advice Format

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

- Section One may be one of the following:
  - Medicaid Check
  - Notice of Electronic Funds Transfer
  - Summout (no claims paid)
- Section Two: Provider Notification (special messages)
- Section Three: Claim Detail
- Section Four
  - Financial Transactions (recoupments)
  - Accounts Receivable (cumulative financial information)
- Section Five: Edit (Error) Description

Explanation of Remittance Advice Sections

The next pages present a sample of each section of the remittance advice for CMCM services followed by an explanation of the elements contained in the section.

The information displayed in the remittance advice samples is for illustration purposes only. The following information applies to a remittance advice with the default sort pattern.

Section One – Medicaid Check

For providers who have selected to be paid by check, a Medicaid check is issued when the provider has claims approved for the cycle and the approved amount is greater than the recoupments, if any, scheduled for the cycle. This section contains the check stub and the actual Medicaid check (payment).

MEDICAID MANAGEMENT INFORMATION SYSTEM

TO: CITY HOME CARE

DATE: 2005-05-09
REMITTANCE NO: 05050900001
PROVIDER ID/NPI: 00111234/0123456789

05050900001 2005-05-06
CITY HOME CARE
111 MAIN ST
ANYTOWN NY 11111

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

29
2

DATE	REMITTANCE NUMBER	PROVIDER ID/NPI
2005-05-09 VOID AFTER 90 DAYS	05050900001	00111234/0123456789

PAY

DOLLARS/CENTS
$******1877.11

TO THE ORDER OF

05050900001 2005-05-09
CITY HOME CARE
111 MAIN ST
ANYTOWN NY 11111

MEDICAID MANAGEMENT INFORMATION SYSTEM

John Smith
AUTHORIZED SIGNATURE

MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
CHECKS DRAWN ON
KEY BANK N.A.
60 STATE STREET, ALBANY, NEW YORK 12207

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
*Provider ID /NPI

CENTER
Remittance number/date
Provider's name/address

Medicaid Check

LEFT SIDE
Table
Date on which the check was issued
Remittance number
*Provider ID/NPI

Remittance number/date
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.

*** Note: NPI has been included on all examples and is pending NPI implementation by NYS Medicaid.**

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: CITY HOME CARE

MEDICAID MANAGEMENT INFORMATION SYSTEM

DATE: 2005-05-09
REMITTANCE NO: 05050900001
PROVIDER ID/NPI: 00111234/0123456879

05050900001 2005-05-09
CITY HOME CARE
111 MAIN STREET
ANYTOWN NY 11111

CITY HOME CARE $1877.11

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
*Provider ID/NPI

CENTER
Remittance number/date
Provider's name/address
Provider's Name – Amount transferred to the provider's account. This amount must equal the Net Total Paid Amount under the Grand Total subsection plus the total sum of the Financial Transaction section.

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: CITY HOME CARE

MEDICAID MANAGEMENT INFORMATION SYSTEM

DATE: 05/09/2005
REMITTANCE NO: 05050900001
PROVIDER ID/NPI: 00111234/0123456789

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

CITY HOME CARE
111 MAIN ST
ANYTOWN NY 11111

Information on the Summout Page

UPPER LEFT CORNER
Provider Name (as recorded in Medicaid files)

UPPER RIGHT CORNER
Date on which the remittance advice was issued
Remittance number
*Provider ID/NPI

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

Section Two – Provider Notification

This section is used to communicate important messages to providers.

MEDICAID MANAGEMENT INFORMATION SYSTEM

MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

PAGE 01
DATE 05/09/05
CYCLE 446

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

ETIN:
PROVIDER NOTIFICATION
PROVIDER ID/NPI 00111234/0123456879
REMITTANCE NO: 05050900001

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.***

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**
*Provider ID/NPI
Remittance number

CENTER
Message text

Section Three – Claim Detail

This section provides a listing of all new claims that were processed during the specific cycle plus claims that were previously pended and denied during the specific cycle. This section may also contain claims that pended previously.

MEDICAID MANAGEMENT INFORMATION SYSTEM

MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

PAGE 02
DATE 05/09/2005
CYCLE 446

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

ETIN:
HOME HEALTH
PROVIDER ID/NPI: 00111234/0123456789
REMITTANCE NO: 05050900001
LOCATOR CD: 003

OFFICE ACCOUNT NUMBER	CLIENT NAME	CLIENT ID.	TCN	DATE OF SERVICE	RATE CODE	UNITS	CHARGED	PAID	STATUS	ERRORS
CPIC1-00974-6	JONES	AA12345W	04083-000012112-3-2	04/25/05	5220	10.000	187.81	0.00	DENY	00162 00131
CPIC1-00575-6	EVANS	BB54321X	04083-000019113-3-1	04/25/05	5220	8.000	84.38	0.00	DENY	00244 00142

* = PREVIOUSLY PENDED CLAIM
** = NEW PEND

TOTAL AMOUNT ORIGINAL CLAIMS	DENIED	272.19	NUMBER OF CLAIMS	2
NET AMOUNT ADJUSTMENTS	DENIED	0.00	NUMBER OF CLAIMS	0
NET AMOUNT VOIDS	DENIED	0.00	NUMBER OF CLAIMS	0
NET AMOUNT VOIDS – ADJUSTS		0.00	NUMBER OF CLAIMS	0

MEDICAID MANAGEMENT INFORMATION SYSTEM

PAGE 03
DATE 05/06/2005
CYCLE 446

MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

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

ETIN:
HOME HEALTH
PROVIDER ID:/NPI 00111234/0123456789
REMITTANCE NO: 05050900001
LOCATOR CD: 003

OFFICE ACCOUNT NUMBER	CLIENT NAME	CLIENT ID.	TCN	DATE OF SERVICE	RATE CODE	UNITS	CHARGED	PAID	STATUS	ERRORS
CPIC3-16774-6	DAVIS	AA11111Z	04083-000034112-0-2	04/25/05	5220	8.000	300.20	300.20	PAID	
CPIC3-22921-6	THOMAS	BB22222Y	04083-000445113-0-2	04/23/05	5220	5.000	188.41	188.41	PAID	
CPIC1-45755-6	JONES	CC33333X	04083-000466333-0-2	04/27/05	5220	8.000	300.20	300.20	PAID	
CPIC1-60775-6	GARCIA	DD44444W	04083-000445663-0-2	04/22/05	5220	8.000	300.20	300.20	PAID	
CPIC1-33733-6	BROWN	EE55555V	04083-000447654-0-2	04/22/05	5220	8.000	300.20	300.20	PAID	
CPIC1-55789-6	SMITH	GG66666U	04083-000465553-0-2	04/25/05	5220	7.000	186.10	186.10	PAID	
CPIC1-76744-6	WAGNER	HH77777T	04083-000455557-0-2	04/25/05	5220	8.000	300.20	300.20	PAID	
CPIC1-66754-6	MCNALLY	JJ88888S	04083-000544444-0-2	04/25/05	5220	5.000	150.90	150.90	ADJT	
CPIC1-91766-6	STEVENS	KK99999R	04083-000465477-0-2	04/24/05	5220	8.000	300.20	-300.20-	PAID	ORIGINAL CLAIM PAID 04/11/2005

* = PREVIOUSLY PENDED CLAIM
** = NEW PEND

TOTAL AMOUNT ORIGINAL CLAIMS	PAID	2026.41	NUMBER OF CLAIMS	8
NET AMOUNT ADJUSTMENTS	PAID	49.30-	NUMBER OF CLAIMS	1
NET AMOUNT VOIDS	PAID	0.00	NUMBER OF CLAIMS	0
NET AMOUNT VOIDS – ADJUSTS		149.30-	NUMBER OF CLAIMS	1

MEDICAID MANAGEMENT INFORMATION SYSTEM

PAGE 04
DATE 05/06/2005
CYCLE 446

MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

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

ETIN:
HOME HEALTH
PROVIDER ID/NPI: 00111234/0123456789
REMITTANCE NO: 05050900001
LOCATOR CD: 003

OFFICE ACCOUNT NUMBER	CLIENT NAME	CLIENT ID.	TCN	DATE OF SERVICE	RATE CODE	UNITS	CHARGED	PAID	STATUS	ERRORS
CPIC1-06774-6	EVANS	BB54321X	04083-000034112-3-2	04/25/05	5220	8.000	300.20	**	PEND	00162 00244
CPIC1-00974-6	JONES	AA12345W	04083-000445113-3-1	04/22/05	5220	5.000	188.41	**	PEND	00162 00244

* = PREVIOUSLY PENDED CLAIM
** = NEW PEND

TOTAL AMOUNT ORIGINAL CLAIMS	PEND	488.61	NUMBER OF CLAIMS	2
NET AMOUNT ADJUSTMENTS	PEND	0.00	NUMBER OF CLAIMS	0
NET AMOUNT VOIDS	PEND	0.00	NUMBER OF CLAIMS	0
NET AMOUNT VOIDS – ADJUSTS		0.00	NUMBER OF CLAIMS	0

LOCATOR 003 TOTALS – HOME HEALTH

VOIDS – ADJUSTS	89.04-	NUMBER OF CLAIMS	1
TOTAL PENDS	0.00	NUMBER OF CLAIMS	0
TOTAL PAID	1939.05	NUMBER OF CLAIMS	5
TOTAL DENIED	775.62	NUMBER OF CLAIMS	2
NET TOTAL PAID	0.00	NUMBER OF CLAIMS	0

REMITTANCE TOTALS – HOME HEALTH

VOIDS – ADJUSTS	0.00	NUMBER OF CLAIMS	0
TOTAL PENDS	0.00	NUMBER OF CLAIMS	0
TOTAL PAID	0.00	NUMBER OF CLAIMS	0
TOTAL DENIED	775.62	NUMBER OF CLAIMS	2
NET TOTAL PAID	0.00	NUMBER OF CLAIMS	0

MEMBER ID: 00111234

VOIDS – ADJUSTS	149.30–	NUMBER OF CLAIMS	1
TOTAL PENDS	488.61	NUMBER OF CLAIMS	2
TOTAL PAID	2026.41	NUMBER OF CLAIMS	8
TOTAL DENY	272.19	NUMBER OF CLAIMS	2
NET TOTAL PAID	1877.11	NUMBER OF CLAIMS	8

MEDICAID MANAGEMENT INFORMATION SYSTEM

MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

PAGE: 05
DATE: 05/06/2005
CYCLE: 446

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

ETIN:
HOME HEALTH
GRAND TOTALS
PROVIDER ID:/NPI 00111234/0123456789
REMITTANCE NO: 05050900001

REMITTANCE TOTALS – GRAND TOTALS

VOIDS – ADJUSTS	149.30–	NUMBER OF CLAIMS	1
TOTAL PENDS	488.61	NUMBER OF CLAIMS	2
TOTAL PAID	2026.41	NUMBER OF CLAIMS	8
TOTAL DENY	272.19	NUMBER OF CLAIMS	2
NET TOTAL PAID	1877.11	NUMBER OF CLAIMS	8

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 CSC with questions about specific processed claims or payments)
ETIN (not applicable)
Provider Service Classification: **HOME HEALTH**
*Provider ID/NPI
Remittance number
Locator Code (providers who have more than one locator code will receive separate Claim Detail sections for each locator code).

Explanation of the Claim Detail Columns

OFFICE ACCOUNT NUMBER
If a Patient/Office Account Number was entered in the claim form, that number (up to 20 characters) will appear under this column.

CLIENT NAME
This column indicates the last name of the patient. If an invalid Medicaid Client ID was entered in the claim form, the ID will be listed as it was submitted but no name will appear in this column.

CLIENT ID
The patient's Medicaid ID number appears under this column.

TCN
The TCN is a unique identifier assigned to each claim that is processed. If multiple claim lines are submitted on the same claim form, all the lines are assigned the same TCN.

DATE OF SERVICE
The first date of service (From date) entered in the claim appears under this column. If a date different from the From date was entered in the Through date box, that date is not returned in the Remittance Advice.

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

UNITS
The total number of units of service for the specific claim appears under this column. The units are indicated with three (3) decimal positions. Since CMCM must only report whole units of service, the decimal positions will always be 000. For example: 3 units will be indicated as 3.000.

CHARGED
The total charges entered in the claim form appear under this column.

PAID
If the claim was approved, the amount paid appears under this column. If the claim has a pend or deny status, the amount paid will be zero (0.00).

STATUS
This column indicates the status (DENY, PAID/ADJT/VOID, PEND) of the claim line.

Denied Claims
Claims for which payment is denied will be identified by the **DENY** status. A claim may be denied for the following general reasons:

- The service rendered is not covered by the New York State Medicaid Program.
- The claim is a duplicate of a prior paid claim.
- The required Prior Approval has not been obtained.
- Information entered in the claim form is invalid or logically inconsistent.

Approved Claims
Approved claims will be identified by the statuses **PAID, ADJT** (adjustment), or **VOID**.

Paid Claims
The status PAID refers to **original** claims that have been approved.

Adjustments
The status ADJT refers to a claim submitted in replacement of a paid claim with the purpose of changing one or more fields. An adjustment has two components: the credit transaction (previously paid claim) and the debit transaction (adjusted claim).

Voids
The status VOID refers to a claim submitted with the purpose of canceling a previously paid claim. A void lists the credit transaction (previously paid claim) only.

Pending Claims
Claims that require further review or recycling will be identified by the **PEND** status. The following are examples of circumstances that commonly cause claims to be pended:

- New York State Medical Review required.
- Procedure requires manual pricing.
- No match found in the Medicaid files for certain information submitted on the claim, for example: Patient ID, Prior Approval, Service Authorization. These claims are recycled for a period of time during which the Medicaid files may be updated to match the information on the claim.

After manual review is completed, a match is found in the Medicaid files or the recycling time expires, pended claims may be approved for payment or denied.

A new pend is signified by two asterisks (**). A previously pended claim is signified by one asterisk (*).

ERRORS
For claims with a DENY or PEND status, this column indicates the NYS Medicaid edit (error) numeric code(s) that caused the claim to deny or pend. Some edit codes may also be indicated for a PAID claim. These are approved edits, which identify certain errors found in the claim and that do not prevent the claim from being approved. Up to twenty-five (25) edit codes, including approved edits, may be listed for each claim. Edit code definitions will be listed on a separate page of the remittance advice, at the end of the claim detail section.

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.

MEDICAID MANAGEMENT INFORMATION SYSTEM

PAGE 07
DATE 05/09/05
CYCLE 446

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

MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

ETIN:
FINANCIAL TRANSACTIONS
PROVIDER ID/NPI: 00111234/0123456789
REMITTANCE NO: 05050900001

FCN	FINANCIAL REASON CODE	FISCAL TRANS TYPE	DATE			AMOUNT
	XXX	RECOUPMENT REASON DESCRIPTION	05	09	05	$$.$$

NET FINANCIAL AMOUNT $$$.$$ NUMBER OF FINANCIAL TRANSACTIONS XXX

Explanation of the Financial Transactions Columns

FCN (Financial Control Number)
This is a unique identifier assigned to each financial transaction.

FINANCIAL REASON CODE
This code is for DOH/CSC use only; it has no relevance to providers. It identifies the reason for the recoupment.

FISCAL TRANSACTION TYPE
This is the description of the Financial Reason Code. For example: Third Party Recovery.

DATE
The date on which the recoupment was applied. Since all the recoupments listed on this page pertain to the current cycle, all the recoupments will have the same date.

AMOUNT
The dollar amount corresponding to the particular fiscal transaction. This amount is deducted from the provider's total payment for the cycle.

Totals
The total dollar amount of the financial transactions (**Net Financial Transaction Amount**) and the total number of transactions (**Number of Financial Transactions**) appear below the last line of the transaction detail list.

The Net Financial Transaction Amount added to the Claim Detail-Grand Total must equal the Medicaid Check or EFT amounts.

Accounts Receivable

This subsection displays the original amount of each of the outstanding Financial Transactions and their current balance after the cycle recoupments were applied. If there are no outstanding negative balances, this section is not produced.

PAGE 08
DATE 05/06/05
CYCLE 446

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

MEDICAID MANAGEMENT INFORMATION SYSTEM

MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

ETIN:
ACCOUNTS RECEIVABLE
PROVIDER ID/NPI: 00111234/0123456789
REMITTANCE NO: 05050900001

REASON CODE DESCRIPTION	ORIG BAL	CURR BAL	RECOUP %/AMT
	$XXX.XX-	$XXX.XX-	999
	$XXX.XX-	$XXX.XX-	999

TOTAL AMOUNT DUE THE STATE $XXX.XX

Explanation of the Accounts Receivable Columns

If a provider has negative balances of different nature (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 in a different line.

REASON CODE DESCRIPTION
This is the description of the Financial Reason Code. For example, Third Party Recovery.

ORIGINAL BALANCE
The original amount (or starting balance) for any particular financial reason.

CURRENT BALANCE
The current amount owed to Medicaid (after the cycle recoupments, if any, were applied). This balance may be equal to or less than the original balance.

RECOUPMENT % AMOUNT
The deduction (recoupment) scheduled for each cycle.

Total Amount Due the State
This amount is the sum of all the **Current Balances** listed above.

Section Five – Edit Descriptions

The last section of the Remittance Advice features the description of each of the edit codes (including approved codes) failed by the claims listed in Section Three.

MEDICAID MANAGEMENT INFORMATION SYSTEM

MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

PAGE 06
DATE 05/09/2005
CYCLE 446

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

ETIN:
HOME HEALTH
EDIT DESCRIPTIONS
PROVIDER ID/NPI: 00111234/0123456789
REMITTANCE NO: 05050900001

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

00131 THIRD PARTY INDICATED OTHER INSURANCE PAD BLANK
00142 RECIPIENT YEAR OF BIRTH DIFFERS FROM FILE
00162 RECIPIENT INELIGIBLE ON DATE OF SERVICE
00244 PA NOT ON FILE