# New York State Electronic Medicaid System Remittance Advice Guideline

eMedNy

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

# **1.Purpose Statement**

The purpose of this document is to familiarize the provider with the contents of the Remittance Advice.

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 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 and assisting providers in identifying and correcting billing errors, plays an important role in the communication between the provider and the eMedNY Contractor for resolving billing or processing issues.



# **2.Remittance Advice Formats**

Providers may receive remittance advice information in one of three formats:

- The electronic HIPAA 835/820 transaction
- PDF Remittance Advice
- Paper Remittance Advice

Remittance Advices contain a maximum of ten thousand (10,000) claim lines; any overflow will generate a separate 835 and a separate check.

Providers who submit claims under multiple ETINs will receive a separate remittance advice for each ETIN, regardless of advice format.

# 2.1 Electronic HIPAA 835/820 Transaction

The electronic HIPAA 835/820 transaction (Remittance Advice) is available via the eMedNY eXchange or FTP. For institutional providers, retro-adjustment information is also sent in the 835/820 transaction format. Pending claims are listed in the Supplemental file that is delivered with the 835/820.

To request the electronic remittance advice, providers must complete the Electronic Remittance Request Form, which is available at www.emedny.org by clicking on the link to the web page as follows: <u>Electronic Remittance Request Form</u>.

Providers with only one ETIN receiving an electronic remittance will have the status of any claims submitted via paper forms, state-submitted adjustments/voids and Medicare Crossover claims reported on that electronic remittance. The Default Electronic Transmitter Identification Number (ETIN) Selection Form is available on emedny.org by clicking on the link: <u>Default ETIN Selection Form</u>.

Providers with multiple ETINs who receive the 835/820 electronic remittance advice may elect to receive the status of paper claim submissions, state-submitted adjustments/voids and Medicare Crossover claims in the 835 format. The request must be submitted using the Default ETIN Selection Form which is available at www.emedny.org by clicking on the link to the web page as follows: <u>Default ETIN Selection Form</u>.

Further information on the 835 transaction is available at www.emedny.org by clicking on the link to the web page that follows: <u>eMedNY Transaction Information Standard Companion Guide CAQH - CORE CG X12</u>.

For additional information, providers may also call the eMedNY Call Center at 800-343-9000.

# 2.2 PDF Remittance Advice

The PDF Remittance Advice may be received electronically via the eMedNY eXchange or FTP and may opened with Adobe Reader<sup>®</sup> (6.0 release or higher required). This may be downloaded from <u>www.adobe.com</u>.

The PDF itself contains the same layout and fields found in the paper remittance advice that described in section 3 below. Additionally, the remittance can be downloaded and stored electronically for ease of retrieval and you can still print a hard copy.

PDF remittances are not held with the Medicaid check for two weeks but released two weeks earlier.

To request the PDF Remittance Advice, providers must complete the PDF Paper Remittance Request Form which is available at www.emedny.org by clicking on the link: <u>PDF Paper Remittance Request Form</u>.

# 2.3 Paper Remittance Advice

Note: Paper remittance advices are being phased out.

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.

# **2.3.1Remittance Sorts**

The default sort for the paper remittance advice is:

Claim Status (denied, paid, pending) - Patient ID - TCN

Providers can request other sort patterns that may better suit their accounting systems. The additional sorts available are as follows:

- TCN Claim Status Patient ID Date of Service
- Patient ID Claim Status TCN
- Date of Service Claim Status Patient ID

To request a sort pattern other than the default, providers must complete the Paper Remittance Sort Request Form which is available at www.emedny.org by clicking on the link to the web page as follows: <u>Paper Remittance Sort Request</u> <u>Form</u>.

For additional information, providers may also call the eMedNY Call Center at 800-343-9000.

# **3.Paper/PDF Remittance Advice Sections**

This section presents samples of provider remittance advices, followed by an explanation of the elements contained in the section. Unless otherwise noted, the remittance sections are the same for all provider types.

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.

The remittance advice is composed of five sections.

- *Section One* may contain one of the following documents:
  - Medicaid Check
  - Notice of Electronic Funds Transfer
  - Summout (no claims paid)
- *Section Two:* Provider Notification (special messages)
- Section Three: Claim Detail

The layouts and field descriptions for each of the following remittance types will be described in this section.

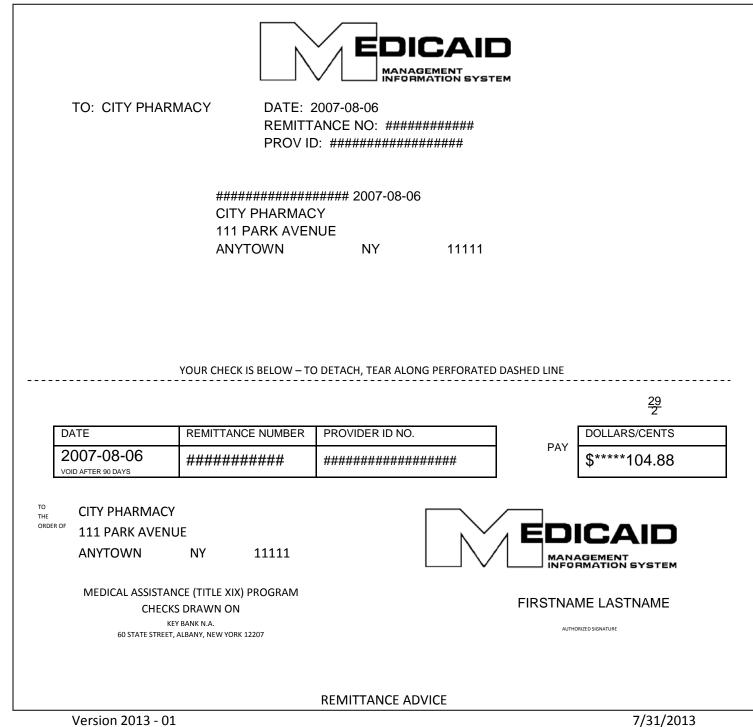
- Child Care
- Clinic APG
- Dental
- Durable Medical Equipment (DME)
- Home Health
- Inpatient
- Nursing Home
- Pharmacy
- Practitioner
- Transportation
- *Section Four* may contain any of the following documents:
  - Financial Transactions (recoupments)
  - Accounts Receivable (cumulative financial information)
- Section Five: Edit (Error) Description



# 3.1 Section One – Medicaid Check

This section contains the check stub and the Medicaid check (payment). A Medicaid check is issued when the provider has claims approved for the cycle and the paid amount is greater than any recoupment amounts scheduled for the cycle.

#### Exhibit 3.1-1





# **3.1.1Medicaid Check Stub Field Descriptions**

# **Upper Left Corner**

Provider's Name (as recorded in the Medicaid files)

#### **Upper Right Corner**

Date the remittance advice was issued

**Remittance Number** 

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

Note: For reissued checks, the original check number will be displayed beneath the PROV ID.

#### Center

Medicaid Provider ID/NPI/Date

Provider's Name/Address

# **3.1.2Medicaid Check Field Descriptions**

#### Left Side

#### Table

Date the check was issued Remittance Number Provider ID No.: This field will contain the Medicaid Provider ID and the NPI, when applicable

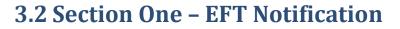
Provider's Name/Address

#### **Right Side**

Dollar/Check Amount: This amount is the:

the Net Total Paid Amount under the Grand Total subsection

+ the total sum of the Financial Transaction section.



This section indicates the amount of the EFT. An EFT transaction is processed when the provider has claims approved for the cycle and the paid amount is greater than any recoupment amounts scheduled for the cycle.

			Exhibit 3.2-1	
TO: CITY PHARMACY			EDICAID MANAGEMENT INFORMATION SYSTEM	DATE: 2007-08-06 REMITTANCE NO: ############ PROV ID: ###################################
######################################	2007-08-0 NY	6 11111		
CITY PHARMACY PAYMENT IN THE ABO	OVE AMO	\$104.88 UNT WILL BE DEF	POSITED VIA AN ELECTRONIC FUND	S TRANSFER.

# **3.2.1EFT Notification Page Field Descriptions**

# **Upper Left Corner**

Provider's Name (as recorded in the Medicaid files)

## **Upper Right Corner**

Date: The date on which the remittance advice was issued

**Remittance Number** 

PROV ID: This field contains the Medicaid Provider ID and the NPI, when applicable

### Center

Medicaid Provider ID/NPI/Date

Provider's Name/Address

Provider's Name – Amount transferred to the provider's account.

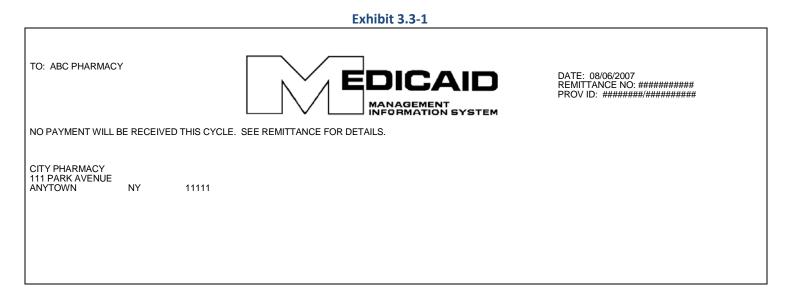
This amount is the:

Net Total Paid Amount from the Grand Total subsection

+ the total sum of the Financial Transaction section.

# 3.3 Section One - Summout (No Payment)

A summout is produced when the provider has no positive total payment. This may happen when the provider has claims approved for the cycle and the expected paid amount is less than or equal to any recoupment amounts scheduled for the cycle.



# **3.3.1Summout (No Payment) Field Descriptions**

## **Upper Left Corner**

Provider's Name (as recorded in the Medicaid files)

## **Upper Right Corner**

Date the remittance advice was issued

**Remittance Number** 

PROV ID: This field contains the Medicaid Provider ID and the NPI, when applicable

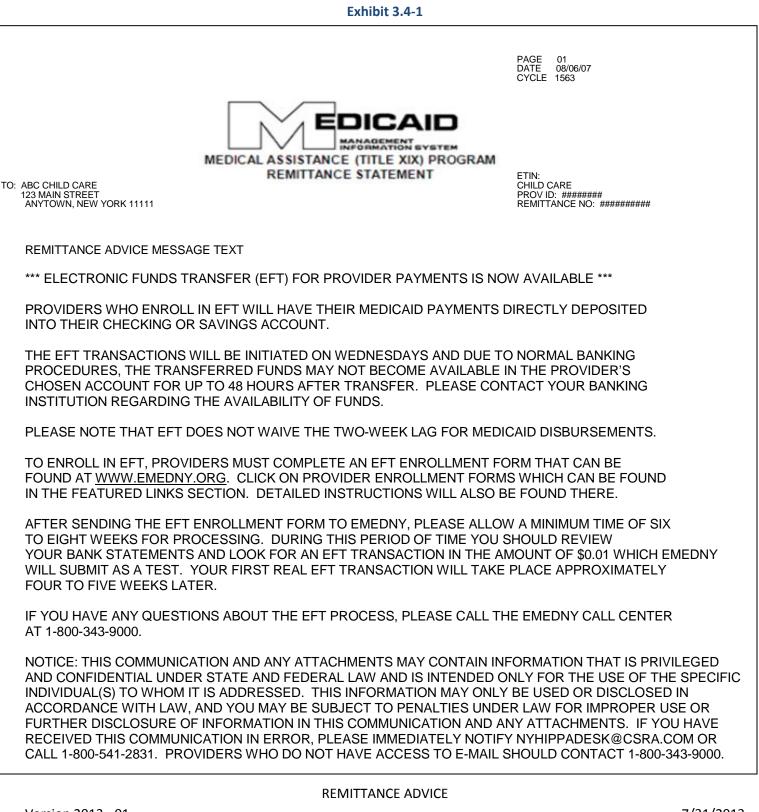
#### Center

Notification that no payment was made for the cycle (no claims were approved)

Provider's Name/Address

# **3.4 Section Two – Provider Notification**

This section is used to communicate important messages to providers.





# **3.4.1Provider Notification Field Descriptions**

## **Upper Left Corner**

Provider's Name/Address (as recorded in the Medicaid files)

## **Upper Right Corner**

Remittance Page Number

Date the remittance advice was issued

Cycle Number: The pre-assigned number for the claims processing period. It is helpful to have the cycle number available when calling the eMedNY Call Center with questions about specific processed claims or payments.

ETIN (not applicable)

Name of Section: **PROVIDER NOTIFICATION** 

PROV ID: This field contains the Medicaid Provider ID and the NPI, when applicable

Remittance Number

#### Center

Message Text



# **3.5 Section Three – Claim Detail**

This section provides a listing of all claims processed during the specific cycle.

There are nine unique Claim Detail types.

- Child Care
- Dental
- Durable Medical Equipment (DME)
- Home Health
- Inpatient
- Nursing Home
- Pharmacy
- Practitioner
- Transportation



# **3.5.1Child Care Claim Detail**

The Child Care Claim Detail section is used by Child Care provider type.

Ex	hi	bi	ŧ	3	5	1	-1
		~	•	-			

							PAC DAT CYC	GE 02 TE 08/06/07 CLE 1563		
TO: ABC CHILD CARE 123 MAIN STREET ANYTOWN, NEW YORK 11111	MED				LE XI		ETII CHI PRO	N: LD CARE DV ID: ####### MITTANCE NO:		##
CLIENT NAME TCN ID NUMBER PATIENT ACCOUNT NUMBER		RATE C. CODE F		FULL DAYS CO-INSURANCE DAYS PAYMENT	PART	TIENT ICIPATION PORTED DUCTED	OTHER INSURANCE	AMOUNT CHARGED AMOUNT PAID	STATUS	ERRORS
LASTNAME XXXXX-###########-X-X LL#####L CPICx-xxxxx-x	MM/DD/YY MM/DD/YY	1210 5 5	5 0	0.0 0.0		0.00	0.00	387.81 0.00	DENY	01023 01035
LASTNAME XXXXX-#############-X-X LL######L CPICx-xxxxx-x	MM/DD/YY MM/DD/YY	1210 5 5		0.0 0.0		0.00	0.00	387.81 0.00		01023
							* = PREVIOU ** = NEW PEN	SLY PENDED (	CLAIM	
TOTAL AMOUNT ORIGINAL CLAIMS	DENIED	775.62		NUMBER OF CL	AIMS	2				
NET AMOUNT ADJUSTMENTS	DENIED	0.00		NUMBER OF CL		0				
NET AMOUNT VOIDS NET AMOUNT VOIDS – ADJUSTS	DENIED	0.00 0.00		NUMBER OF CL		0 0				



Exhibit 3.5.1-2

PAGE 02 DATE 08/06/07 CYCLE 1563 DICAID MANAGEMENT MEDICAL ASSISTANCE (TITLE XIX) PROGRAM REMITTANCE STATEMENT ETIN: CHILD CARE TO: ABC CHILD CARE 123 MAIN STREET PROV ID: ######### ANYTOWN, NEW YORK 11111 REP'TED CALC'ED PATIENT PARTICIPATION REPORTED OTHER AMOUNT SERVICE FULL DAYS TCN CHARGED CLIENT NAME RATE INSURANCE PATIENT ACCOUNT NUMBER CO-INSURANCE DAYS PAYMENT DATES FROM STATUS ERRORS ID NUMBER CODE DAYS AMOUNT F Ċ DEDUCTED PAID THRU LASTNAME *\*###-############# MM/DD/YY 1210 0.00 0.00 0 387.81 387.81 PAID LL######L CPICx-xxxxx-x MM/DD/YY 5 0.00 387.81 LASTNAME MM/DD/YY 1210 5 0 387.81 0.00 0.00 387.81 PAID LL######L CPICX-XXXXX-X MM/DD/YY 5 387.81 0.00 LASTNAME 387.81 5 0 387.81 0.00 0.00 PAID LL######L CPICX-XXXXX-X MM/DD/YY 5 0.00 387.81 MM/DD/YY\_1210 LASTNAME 387.81 387.81 5 5 0 0.00 0.00 PAID LL######L CPICX-XXXXX-X MM/DD/YY 0.00 387.81 LASTNAME 5 5 0 387.81 0.00 0.00 387.81 ADJT ORIGINAL CLAIM PAID MM/DD/YY LL######L CPICX-XXXXX-X MM/DD/YY 0.00 387.81-LASTNAME 0.00 0.00 ADJT 4 4 0 298.77 298.77 LL######L CPICX-XXXXX-X MM/DD/YY 0.00 298.77 \* = PREVIOUSLY PENDED CLAIM \*\* = NEW PEND TOTAL AMOUNT ORIGINAL CLAIMS NUMBER OF CLAIMS PAID 1551.24 5 NET AMOUNT ADJUSTMENTS PAID NUMBER OF CLAIMS 89.04-1 NET AMOUNT VOIDS PAID 0.00 NUMBER OF CLAIMS 0 NET AMOUNT VOIDS - ADJUSTS 89.04-NUMBER OF CLAIMS 1 REMITTANCE ADVICE

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Exhibit 3.5.1-3

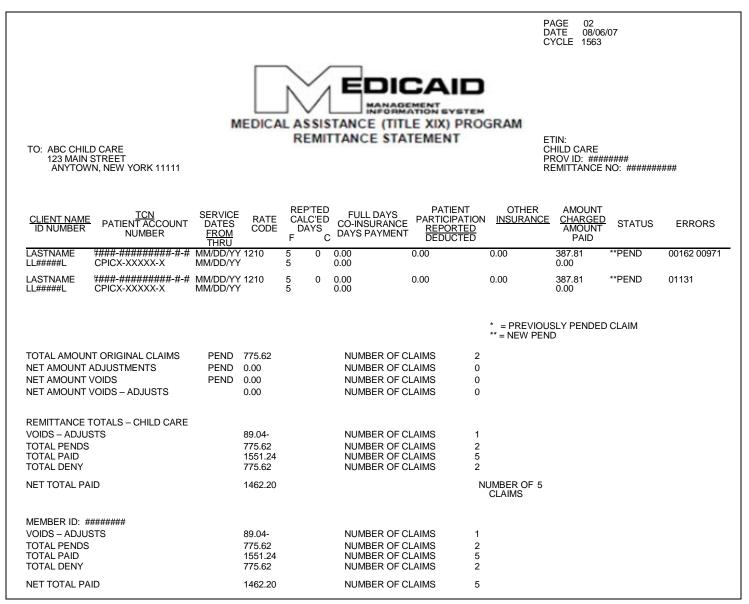




Exhibit 3.5.1-4

			PAGE: DATE: CYCLE:	05 08/06/07 1563
TO: ABC CHILD CARE 123 MAIN STREET ANYTOWN, NEW YORK 11111		STANCE (TITLE XIX) PROGRAM TTANCE STATEMENT	ETIN: CHILD C GRAND PROV ID	
REMITTANCE TOTALS – GRAND TOTALS				
VOIDS – ADJUSTS	89.04-	NUMBER OF CLAIMS	1	
TOTAL PENDS	775.62	NUMBER OF CLAIMS	2	
TOTAL PAID	1551.24	NUMBER OF CLAIMS	5	
TOTAL DENY	775.62	NUMBER OF CLAIMS	2	
NET TOTAL PAID	1462.20	NUMBER OF CLAIMS	33	

# 3.5.1.1Claim Detail Page Field Descriptions

## **Upper Left Corner**

Provider's Name/Address

# **Upper Right Corner**

Remittance page number

Date the remittance advice was issued

Cycle Number: The pre-assigned number for the claims processing period. It is helpful to have the cycle number available when calling the eMedNY Call Center with questions about specific processed claims or payments.

ETIN (not applicable)

Provider Service Classification: CHILD CARE

PROV ID: This field contains the Medicaid Provider ID

Remittance Number

## **3.5.1.2 Explanation of Claim Detail Columns**

#### **Client Name/ID Number**

This column indicates the last name of the member (first line) and the Medicaid Member ID (second line). If an invalid Medicaid Member ID was entered in the claim form, the ID will be listed as it was submitted but no name will appear in this column.

#### **TCN/Patient Account Number**

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

Up to 20 characters of the Patient/Office Account Number is provided in this column (second line).

#### **Service Dates – From/Through**

The first date of service covered by the claim (From date) appears on the first line; the last date of service (Through date) appears on the second line.

#### **Rate Code**

The four-digit rate code that was entered in the claim form appears under this column.

# **Reported/Calculated Days**

This column has two sub-columns: one is labeled F (full days) and the other is labeled C (co-insurance days).

The number of days within the reported first (FROM) service date and the last (THROUGH) service date appear in the first line under the F sub-column. The number of full days calculated by the system appears in the second line under the F sub-column.

The number of co-insurance days reported on the claim form appears under the C sub-column. There are no calculated co-insurance days.

#### **Patient Participation - Reported/Deducted**

This column shows the patient participation amount (NAMI) as it was reported (first line) and as it was deducted (second line). If no patient participation is applicable, this column will show 0.00 amount.

#### **Other Insurance**

If applicable, the amount paid by the member's Other Insurance carrier, as reported on the claim form, is shown in this column. If no Other Insurance payment is applicable, this column will show 0.00 amount.

## **Amount Charged/Amount Paid**

The total charges entered in the claim form appear first under this column. If the claim was approved, the amount paid appears underneath the charges. 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. The following are examples of circumstances that commonly cause claims to be denied:

- 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.

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#### 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: Member ID, Prior Approval. These claims are recycled for a period of time during which the Medicaid files may be updated to match the information on the claim.

In order for a claim to be removed from Pend status, one of the following must occur:

- manual review is completed,
- a successful match is found
- the recycling time expires.

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) number(s) that caused the claim to deny or pend. Up to twenty-five (25) edit codes, including approved edits, may be listed for each claim. Edit code definitions are listed at the end of the claim detail section.



Subtotals of dollar amounts and number of claims are provided as follows:

Subtotals by claim *status* appear at the end of the claim listing for each status. The subtotals are broken down by:

- Original claims
- Adjustments
- Voids
- Adjustments/voids combined

Totals by *service classification and by member ID* are provided next to the subtotals for service classification/locator code. These totals are broken down by:

- Adjustments/voids (combined)
- Pends
- Paid
- Deny
- Net total paid (for the specific service classification)

*Grand Totals* for the entire provider remittance advice, which include all the provider's service classifications, appear on a separate page following the page containing the *totals by service classification*. The grand total is broken down by:

- Adjustments/voids (combined)
- Pends
- Paid
- Deny
- Net total paid (entire remittance)



# 3.5.2 Clinic APG Claim Detail

Exhibit 3.5.2-1

								PAGE 02 DATE CYCLE	08/06/07		
TO: ABC CLINIC 123 MAIN STRE ANYTOWN, NE	ET W YORK 11111		MEDICAL ASSIST REMITT	INFORM		) PRO			0: ####################################		
ANTIU	WN, NEW YOR	( <b>K</b> 11111					REM	ITITTAN	CE NO: ####		
OFFICE ACCOUNT NUMBER CPICXXXXXX CPICXXXXX CPICXXXXX CPICXXXXX CPICXXXXX	CLIENT NAME LASTNAME LASTNAME LASTNAME LASTNAME	CLIENT ID. LL#####L LL#####L LL#####L LL#####L	TCN #####-###############################	DATE OF SERVICE 07/15/07 07/15/07 07/15/07 07/15/07	RATE CODE 2879 2879 2879 2879 2879	UNITS 1.000 1.000 1.000 1.000	CHARGED 95.00 95.00 95.00 95.00	PAID 0.00 0.00 0.00 0.00	STATUS DENY DENY DENY DENY	ERRORS 00146 00142, 00144 00142, 00144 00162	
TOTAL AMOUNT OR NET AMOUT ADJUS NET AMOUNT VOIDS NET AMOUNT VOIDS	TMENTS S		VIED 380.00 VIED 0.00 VIED 0.00 0.00	NUMBER OF NUMBER OF NUMBER OF NUMBER OF	CLAIMS CLAIMS	4 0 0 0	*	= PRE∖ * = NEW	VIOUSLY PEN PEND	IDED CLAIM	



#### Exhibit 3.5.2-2

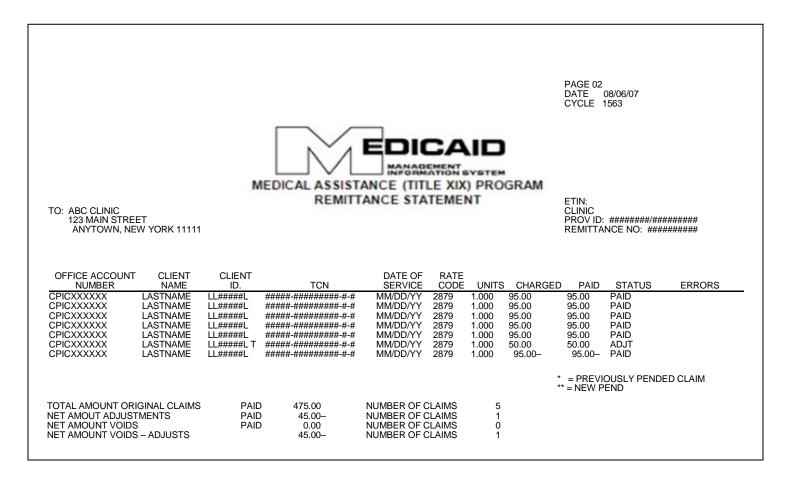




Exhibit 3.5.2-3

ANTIOWN, NEW TORK TITT					REMITITTANCE N	IO: ####################################
						04 08/06/07 5 1563
TO: ABC CLINIC 123 MAIN STREET ANYTOWN, NEW YORK 11111				X) PRO	GRAM ETIN: CLINIC PROV	; ID: #################### TANCE NO: ##############
OFFICE ACCOUNT CLIENT CLIENT NUMBER NAME ID. CPICXXXXX LASTNAME LL#####L CPICXXXXX LASTNAME LL#####L CPICXXXXX LASTNAME LL#####L CPICXXXXX LASTNAME LL#####L	TCI #####-###############################	###-#-# ###-#-# ###-#-#	DATE OF RAT SERVICE COU MM/DD/YY 2879 MM/DD/YY 2879 MM/DD/YY 2879 MM/DD/YY 2879		CHARGED         PAI           95.00         0.00           95.00         0.00           95.00         0.00           95.00         0.00           95.00         0.00           95.00         0.00	D STATUS ERRORS ** PEND 00162 ** PEND 00127 ** PEND 00127 ** PEND 00162
					* = PRE ** = NEV	VIOUSLY PENDED CLAIM
TOTAL AMOUNT ORIGINAL CLAIMS PI	END	38	NUMBER OF CLAIMS	6 4		
NET AMOUT ADJUSTMENTS PI	0.00 END		NUMBER OF CLAIMS	<b>5</b> 0		
NET AMOUNT VOIDS PI	0.00 END		NUMBER OF CLAIMS	S 0		
NET AMOUNT VOIDS – ADJUSTS	0.00 0.00		NUMBER OF CLAIMS	S 0		
REMITTANCE TOTALS – CLINIC VOIDS – ADJUSTS TOTAL PENDS TOTAL PAID TOTAL DENIED NET TOTAL PAID	45.00- 0.00 5.00 0.00 0.00	38 47 38 43	NUMBER OF CLAIMS NUMBER OF CLAIMS NUMBER OF CLAIMS NUMBER OF CLAIMS	6 4 6 5 6 4		
MEMBER ID: ########						
VOIDS - ADJUSTS	45.00-		NUMBER OF CLAIMS			
TOTAL PENDS	0.00	38	NUMBER OF CLAIMS			
TOTAL PAID	5.00	47	NUMBER OF CLAIMS			
TOTAL DENIED	0.00	38	NUMBER OF CLAIMS	6 4		
NET TOTAL PAID	0.00	43	NUMBER OF CLAIMS	6 6		



# **3.5.3Claim Detail Page Field Descriptions**

# **Upper Left Corner**

Provider's Name/Address

# **Upper Right Corner**

Remittance page number

Date the remittance advice was issued

Cycle Number: The pre-assigned number for the claims processing period. It is helpful to have the cycle number available when calling the eMedNY Call Center with questions about specific processed claims or payments.

ETIN (not applicable)

Provider Service Classification: CLINIC

PROV ID: This field contains the Medicaid Provider ID and NPI, when applicable

Remittance Number

# **3.5.3.1Explanation of Claim Detail Columns**

#### **Office Account Number/CPT**

Up to 20 characters of the Patient/Office Account Number entered in the claim form is provided in this column (first line) and the reported procedure code (second line).

## **Client Name/APG**

The Client Name (first line) indicates the last name of the member. 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. The APG Code (second line) assigned by the grouper appears in this column for the service line on the claim.

# **Client ID/Combined with CPT**

The member's Medicaid ID number appears in the Client ID column (first line). The Combined CPT (second line) notes procedures on the claim that caused the APG packaging and zero payment on the line.

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# **TCN/Full Weight APG Amount**

The TCN (first line) is a unique identifier assigned to each claim that is processed. If multiple claim lines are submitted on the same claim, all the lines are assigned the same TCN. The Full Weight APG Amount (second line) is the assigned grouper weight used in pricing the APG Code based on the procedure code and diagnosis codes for the submitted claims.

# Date of Service/PCT APG Weight

The first date of service (From date) entered in the claim appears in the first line 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. The APG Paid Percentage (second line) is related to grouper assigned Payment Action Code. This is the additional weight factor applied to Full Weight.

## Rate Code/APG Paid

The four-digit rate code (first line) that was entered on line one of the claim appears under this column. The APG Paid Amount (second line) is the amount after the 25%, 50% or 75% is applied over each of the first three years.

## Charged/Capital Add On

The total charges entered on the claim line appear in this column (first line). The Capital Add On (second line) is the amount that was added to the payment.

## **Total Paid/Existing Operating Component**

If the claim was approved, the amount paid appears in this column (first line). If the claim was approved, the amount paid for the service line appears in this column. Total line payment includes reductions for Medicaid co-payments, reported or prorated/bundled other insurance payments and prorated spend downs, if any. Total line payments will equal Total TCN paid amount. The Existing Operating Component (second line) is the amount added to clinic payments after the 75%, 50%, 25% is applied over each of the first 3 years and disbursed over paid lines.

#### **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. The following are examples of circumstances that commonly cause claims to be denied:

The service rendered is not covered by the New York State Medicaid Program.

**REMITTANCE ADVICE** 

Version 2013 - 01



- 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: Member ID, Prior Approval. These claims are recycled for a period of time during which the Medicaid files may be updated to match the information on the claim.

In order for a claim to be removed from Pend status, one of the following must occur:

- manual review is completed,
- a successful match is found
- the recycling time expires

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) number(s) that caused the claim to deny or pend. Up to twenty-five (25) edit codes, including approved edits, may be listed for each claim. Edit code definitions are listed at the end of the claim detail section.

# **Total Paid TCN**

Total Claim Payment.

# 3.5.3.2 Subtotals/Totals/Grand Totals

Subtotals of dollar amounts and number of claims are provided as follows:

Subtotals by claim *status* appear at the end of the claim listing for each status. The subtotals are broken down by:

- Original claims
- Adjustments
- Voids
- Adjustments/voids combined

Subtotals by *provider type* are provided at the end of the claim detail listing. These subtotals are broken down by:

- Adjustments/voids (combined)
- Pends
- Paid
- Deny
- Net total paid (for the specific service classification)

Totals by *member ID* are subtotals for the individual practitioners these who provided services as part of the group being paid: These subtotals are broken down by:

- Adjustments/voids (combined)
- Pends
- Paid
- Deny
- Net total paid (sum of approved adjustments/voids and paid original claims)

*Grand Totals* for the entire provider remittance advice appear on a separate page following the page containing the *totals by provider type and member ID*. The grand total is broken down by:

Adjustments/voids (combined)



- Pends
- Paid
- Deny
- Net total paid (entire remittance)



# **3.5.4Dental Claim Detail**

The Child Care Claim Detail section is used by the Dental provider type.

					Exhib	it 3.5.4-1						
			MEDI					EM			06/07 3	
1	ABC DENTAL 123 MAIN STREET ANYTOWN, NEW YORI	K 11111	MEDI			E STATE			ETIN DEN PRO	TAL V ID: ##	#######/#### E NO: ####	
	ANTIOWN, NE	W TURK IIII	1						REMITIT	ANCE N	10: #######	
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	TOTAL AMOUNT AE NET AMOUNT VO NET AMOUNT VO	DJUSTMENTS DIDS		DENIED DENIED DENIED	162.20 0.00 0.00 0.00	NUMBER OF NUMBER OF NUMBER OF	CLAIMS		4 0 0			



Exhibit 3.5.4-2

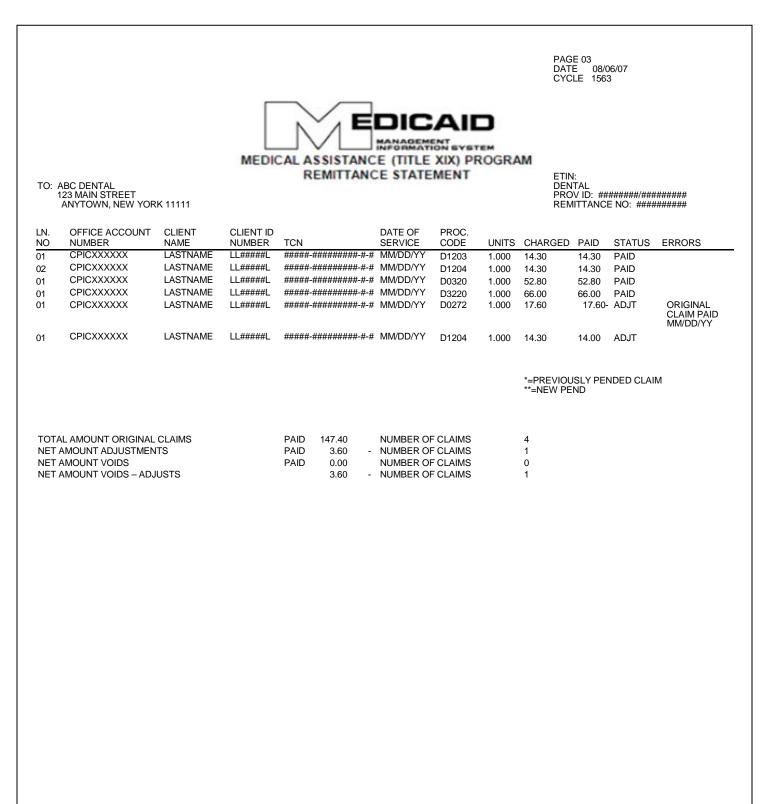


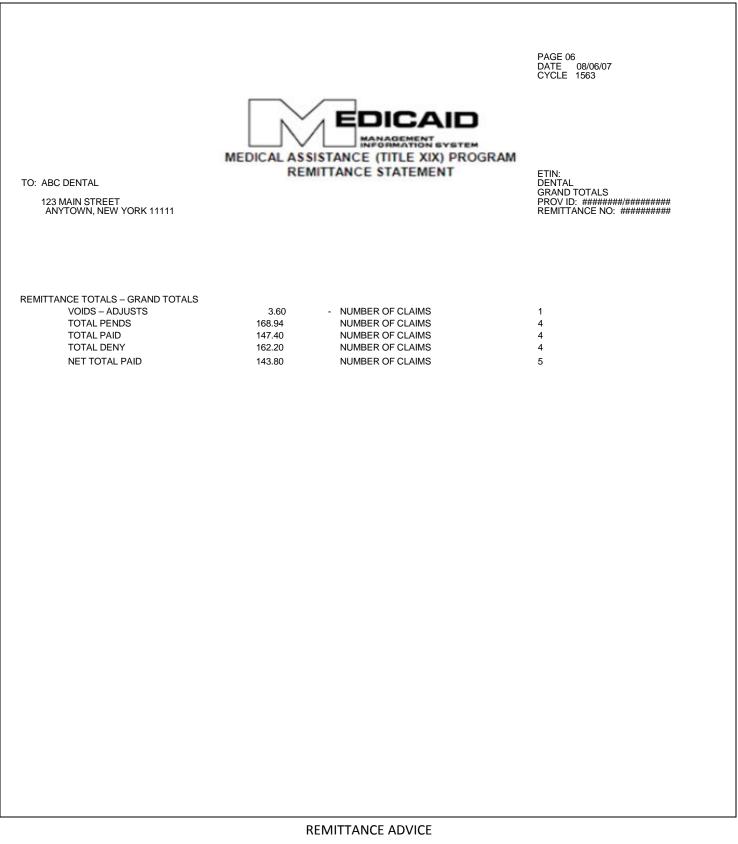


Exhibit 3.5.4-3

TO: ABC DENTAL 123 MAIN STREET ANYTOWN, NEW YORK 11111 LN. OFFICE ACCOUNT CLIENT CLIENT ID NO NUMBER NAME NUMBER TCN SERVICE CODE UNITS CHARGED O1 CPICXXXXX LASTNAME LL###### 1#####-#########################	0.00 **PEND 00162 0.00 **PEND 00162 0.00 **PEND 00142 0.00 **PEND 00131 EVIOUSLY PENDED CLAIM
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N. OFFICE ACCOUNT CLIENT NAME CLIENT ID NUMBER TCN SERVICE CODE UNITS CHARGED 1 CPICXXXXX LASTNAME LL#####L ############################	RGED         PAID         STATUS         ERRORS           0.00         **PEND         00162           0.00         **PEND         00162           0.00         **PEND         00142           0.00         **PEND         00131
IO       NUMBER       NAME       NUMBER       TCN       SERVICE       CODE       UNITS       CHARGED         1       CPICXXXXX       LASTNAME       LL####L       ####################################	0.00 **PEND 00162 0.00 **PEND 00162 0.00 **PEND 00142 0.00 **PEND 00131 EVIOUSLY PENDED CLAIM
N2       CPICXXXXX       LASTNAME       LL#####L       ####################################	0.00 **PEND 00162 0.00 **PEND 00142 0.00 **PEND 00131 EVIOUSLY PENDED CLAIM
1       CPICXXXXX       LASTNAME       LL#####L       ####################################	0.00 **PEND 00131
**=NEW PI TOTAL AMOUNT ORIGINAL CLAIMS PEND 168.94 NUMBER OF CLAIMS 4 VET AMOUNT ADJUSTMENTS PEND 0.00 NUMBER OF CLAIMS 0 VET AMOUNT VOIDS PEND 0.00 NUMBER OF CLAIMS 0 VET AMOUNT VOIDS – ADJUSTS 0.00 NUMBER OF CLAIMS 0 REMITTANCE TOTALS – DENTAL /OIDS – ADJUSTS 3.60 - NUMBER OF CLAIMS 1 TOTAL PENDS 168.94 NUMBER OF CLAIMS 4 TOTAL PAID 147.40 NUMBER OF CLAIMS 4	
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TOTAL PENDS         168.94         NUMBER OF CLAIMS         4           FOTAL PAID         147.40         NUMBER OF CLAIMS         4	
TOTAL DENIED162.20NUMBER OF CLAIMS4NET TOTAL PAID143.80NUMBER OF CLAIMS5	
/EMBER ID: ######## /OIDS – ADJUSTS 3.60 - NUMBER OF CLAIMS 1	
TOTAL PENDS 168.94 NUMBER OF CLAIMS 4	
Instruction         147.40         NUMBER OF CLAIMS         4           Instruction         162.20         NUMBER OF CLAIMS         4	
NET TOTAL PAID 143.80 NUMBER OF CLAIMS 5	



Exhibit 3.5.4-4





# **3.5.4.1Claim Detail Page Field Descriptions**

# **Upper Left Corner**

Provider's Name/Address (as recorded in the Medicaid files)

# **Upper Right Corner**

Remittance page number

Date the remittance advice was issued

Cycle number: The pre-assigned number for the claims processing period. It is helpful to have the cycle number available when calling the eMedNY Call Center with questions about specific processed claims or payments.

ETIN (not applicable)

Provider Service Classification: DENTAL

PROV ID: This field contains the Medicaid Provider ID and the NPI

**Remittance Number** 

## **3.5.4.2Explanation of Claim Detail Columns**

#### Ln. No. (Line Number)

This column indicates the claim number as it corresponds to the procedure lines on the claim form.

#### **Office Account Number**

Up to 20 characters of the Patient/Office Account Number entered in the claim form is provided in this column.

#### **Client Name**

This column indicates the last name of the member. 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 member's Medicaid ID number appears in 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 in 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.

## **Procedure Code**

The five-digit procedure code entered in the claim form appears in this column.

### Units

The total number of units of service for the specific claim appears in this column.

## Charged

The total charges entered in the claim form appear in this column.

### Paid

If the claim was approved, the amount paid appears in 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. The following are examples of circumstances that commonly cause claims to be denied:

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: Member ID, Prior Approval. These claims are recycled for a period of time during which the Medicaid files may be updated to match the information on the claim.

In order for a claim to be removed from Pend status, one of the following must occur:

- manual review is completed,
- a successful match is found
- the recycling time expires

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) number(s) that caused the claim to deny or pend. Up to twenty-five (25) edit codes, including approved edits, may be listed for each claim. Edit code definitions are listed at the end of the claim detail section.

## 3.5.4.3Subtotals/Totals/Grand Totals

Subtotals of dollar amounts and number of claims are provided as follows:

Subtotals by claim *status* appear at the end of the claim listing for each status. The subtotals are broken down by:

- Original claims
- Adjustments
- Voids
- Adjustments/voids combined

Totals by *service classification and by member ID (See definition above)* are provided next to the subtotals for service classification/locator code. Totals by Member ID are subtotals for the individual practitioners who provided services as part of the group being paid. These totals are broken down by:

- Adjustments/voids (combined)
- Pends
- Paid
- Deny
- Net total paid (for the specific service classification)

*Grand Totals* for the entire provider remittance advice, which include all the provider's service classifications, appear on a separate page following the page containing the *totals by service classification*. The grand total is broken down by:

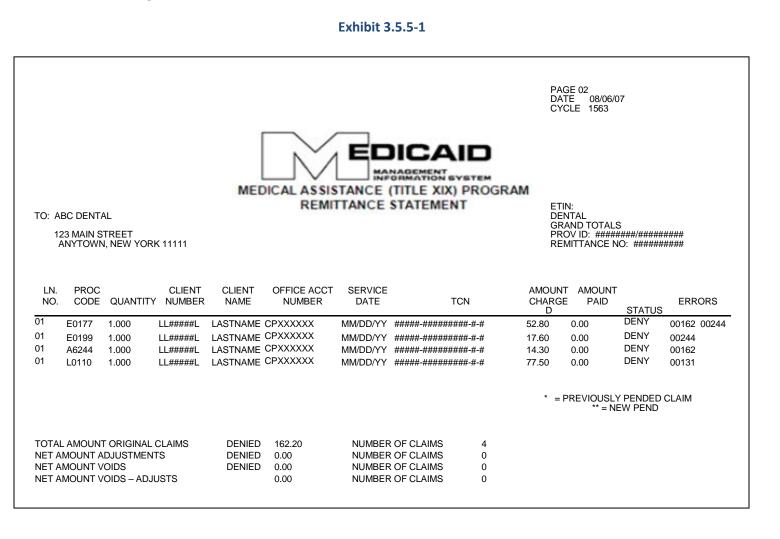
- Adjustments/voids (combined)
- Pends
- Paid
- Deny
- Net total paid (entire remittance)



## **3.5.5DME Claim Detail**

The DME Claim Detail section is used by the following provider types:

- OME
- Hearing Aid





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02	L3580	1.000	LL#####L		CPXXXXXX	MM/DD/YY	#####-#############	-#-#	14.30	14.30	PAID	
01	Z4651		LL#####L	-	CPXXXXXX	MM/DD/YY	#####-#################################			52.80	PAID	
01	Z4714		LL#####L	-	CPXXXXXX	MM/DD/YY	#####-###########			66.00	PAID	
01	L3649	1.000		-					17.60	17.60-	ADJT	ORIGINAL
			LL#####L	LASTNAME	CPXXXXXX	MM/DD/YY	#####-##########	-#-#				CLAIM PAID
01	L3640	1.000	LL#####L	LASTNAME	CPXXXXXX	MM/DD/YY	#####-##########	-#-#	14.30	14.00	ADJT	
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LN. NO.	PROC CODE	QUANTITY	CLIENT NUMBER	CLIENT NAME	OFFICE ACCT NUMBER	SERVICE DATE		TCN	AMOUNT AMOUN" CHARGE PAID D	STATUS	ERRORS
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		ORIGINAL C	-	PEND PEND	168.94 0.00	-	OF CLAIMS OF CLAIMS	4			
NET A	MOUNT V			PEND	0.00	NUMBER	OF CLAIMS OF CLAIMS	0			
REMIT VOIDS TOTAL TOTAL TOTAL	TANCE TO - ADJUS	OTALS – DME TS				NUMBER NUMBER NUMBER		1 4 4 4 5			
VOIDS TOTAL TOTAL TOTAL	ER ID: ## - ADJUS - PENDS - PAID - DENIED OTAL PAII	TS			3.60 - 168.94 147.40 162.20 143.80	NUMBER NUMBER NUMBER	OF CLAIMS OF CLAIMS OF CLAIMS OF CLAIMS OF CLAIMS	1 4 4 5			



			PAGE 05 DATE 08/06/07 CYCLE 1563
TO: ABC DENTAL 123 MAIN STREET ANYTOWN, NEW YORK 11111		EDICAID MANAGEMENT ISTANCE (TITLE XIX) PROGRAM ITTANCE STATEMENT	ETIN: DME PROV ID: ################### REMITTANCE NO: ###########
REMITTANCE TOTALS – GRAND TOTALS VOIDS – ADJUSTS TOTAL PENDS TOTAL PAID TOTAL DENY NET TOTAL PAID	3.60 168.94 147.40 162.20 143.80	- NUMBER OF CLAIMS NUMBER OF CLAIMS NUMBER OF CLAIMS NUMBER OF CLAIMS NUMBER OF CLAIMS	1 4 4 4 5



## **3.5.5.1Claim Detail Page Field Descriptions**

## **Upper Left Corner**

Provider's Name/Address (as recorded in the Medicaid files)

## **Upper Right Corner**

**Remittance Page Number** 

Date: The date on which the remittance advice was issued

Cycle Number: The cycle number should be used when calling the eMedNY Call Center with questions about specific processed claims or payments.

ETIN (not applicable)

Provider Service Classification: DME

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

**Remittance Number** 

## **3.5.5.2Explanation of Claim Detail Columns**

## LN. NO. (Line Number)

This column indicates the line number of each claim as it appears on the claim form.

## **PROC (Procedure) Code**

The five-digit procedure/item code that was entered in the claim form appears under this column.

## Quantity

The quantity of each item dispensed as entered in the claim form appears under this column. The units are indicated with three (3) decimal positions. Since DME providers must only report whole units of service, the decimal positions will always be 000. For example: 3 units will be indicated as 3.000.

## **Client ID Number**

The patient's Medicaid ID number appears 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.

## **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.

### **Service Date**

This column lists the service date as entered in the claim form.

### 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.

## Amount Charged

This column lists either the amount the provider charged for the claim or the Medicare Approved amount if applicable.

### 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 the last page(s) of the remittance advice.

## 3.5.5.3Subtotals/Totals/Grand Totals

Subtotals of dollar amounts and number of claims are provided as follows:

Subtotals by claim *status* appear at the end of the claim listing for each status. The subtotals are broken down by:

- Original claims
- Adjustments
- Voids
- Adjustments/voids combined

Subtotals by *provider type* are provided at the end of the claim detail listing. These subtotals are broken down by:

- Adjustments/voids (combined)
- Pends
- Paid
- Deny
- Net total paid (for the specific service classification)

Totals by *member ID* are provided next to the subtotals for provider type. For individual practitioners these totals are exactly the same as the subtotals by provider type. For practitioner groups, this subtotal category refers to the specific member of the group who provided the services. These subtotals are broken down by:

- Adjustments/voids (combined)
- Pends
- Paid
- Deny
- Net total paid (sum of approved adjustments/voids and paid original claims)

*Grand Totals* for the entire provider remittance advice appear on a separate page following the page containing the *totals by provider type and member ID*. The grand total is broken down by:

- Adjustments/voids (combined)
- Pends
- Paid
- Deny
- Net total paid (entire remittance)

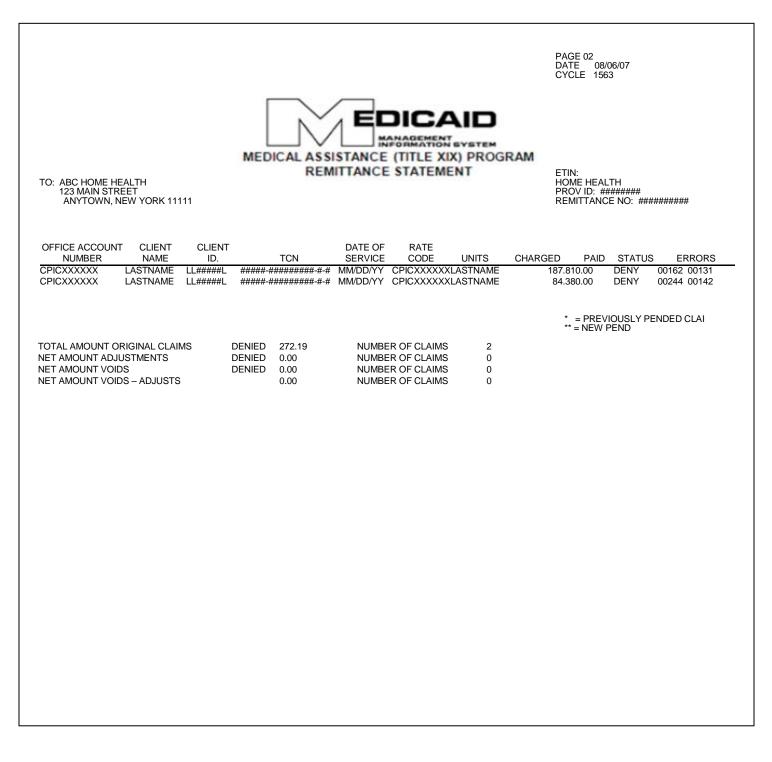


# **3.5.6Home Health Claim Detail**

The Home Health Claim Detail section is used by the following provider types:

- Bridges to Health
- Case Management (CMCM)
- Clinic (Non-APG)
- Home and Community Based Services (HCBS Waiver)
- Home Health
- Limited Licensed Home Care
- Long Term Home Healthcare
- Managed Care
- OMH Certified Rehabilitation Services
- PERS
- Personal Care
- TBI Waiver
- School Supportive Health Services Program (SSHSP)

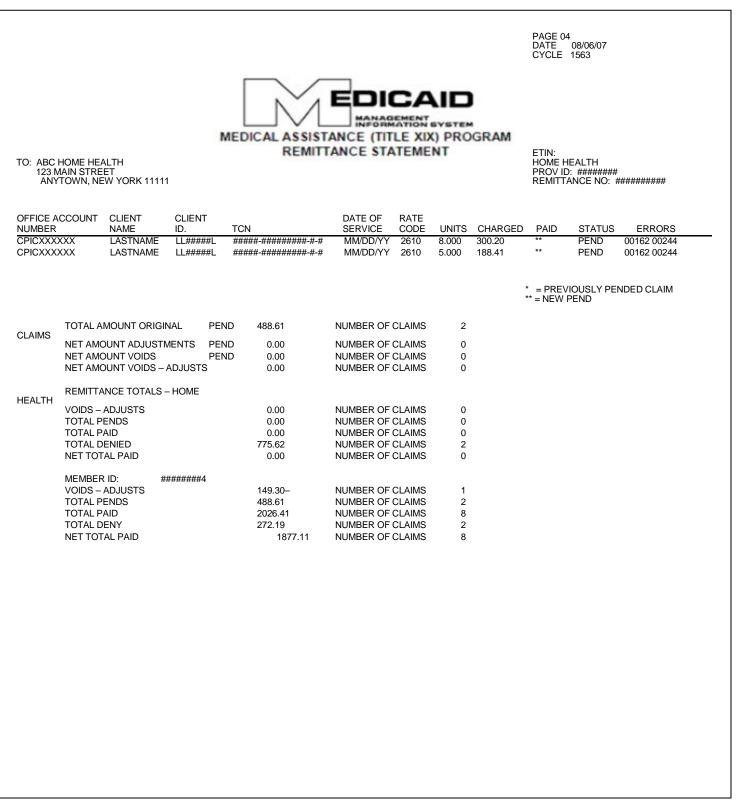




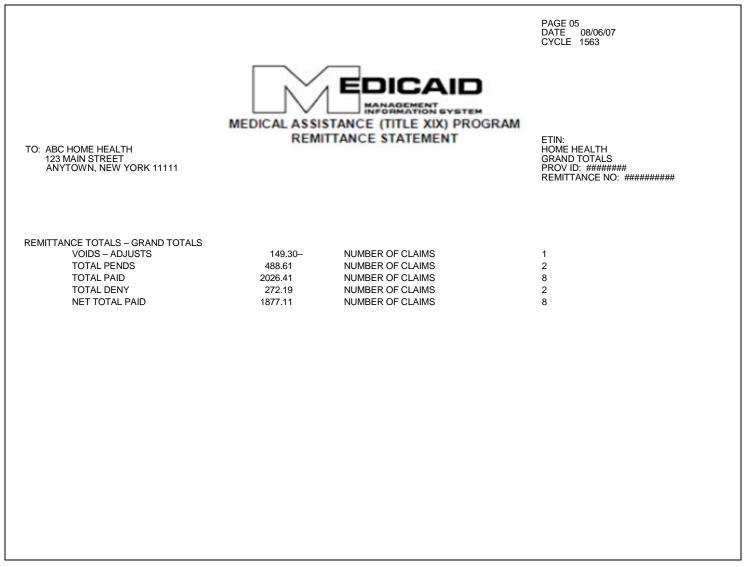


								PAGE 03 DATE 08/0 CYCLE 156	06/07 3	
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OFFICE ACCOUNT NUMBER	CLIENT NAME	CLIENT ID.	TCN	DATE OF SERVICE	RATE CODE		CHARGED	PAID	STATUS	S ERRORS
	LASTNAME	LL#####L	#####-############	MM/DD/YY	2610	8.000	300.20	300.20		
	LASTNAME	LL#####L	#####-#############	MM/DD/YY		5.000	188.41	188.41		
	LASTNAME	LL#####L	#####-############	MM/DD/YY		8.000	300.20	300.20		
	LASTNAME	LL#####L	#####-############	MM/DD/YY		8.000	300.20	300.20		
	LASTNAME	LL#####L	#####-############	MM/DD/YY		8.000	300.20	300.20		
	LASTNAME	LL#####L	#####-###########	MM/DD/YY		7.000	186.10	186.10		
	LASTNAME	LL#####L	#####-###########	MM/DD/YY		8.000	300.20	300.20		
		LL#####L	#####-############	MM/DD/YY		5.000	150.90 300.20	150.90		
	LASTNAME	LL#####L	#####-###############		2010	8.000		- 0.20-	PAID	ORIGINAL CLAIM PAID MM/DD/YY
								REVIOUSLY F EW PEND	PENDED C	CLAIM
		MS	PAID 2026.41	NUMBE			8			
TOTAL AMOUNT ORIGINAL CLAIMS NET AMOUNT ADJUSTMENTS			PAID 2020.41 PAID 49.30-	NUMBE		-	1			
NET AMOUNT VOID			PAID 0.00	NUMBE		-	0			
NET AMOUNT VOID	S – ADJUSTS	6	149.30-	NUMBE	ROFC	LAIMS	1			











## 3.5.6.1 Claim Detail Page Field Descriptions

## **Upper Left Corner**

Provider's Name/Address

### **Upper Right Corner**

Remittance page number

Date the remittance advice was issued

Cycle Number: The pre-assigned number for the claims processing period. It is helpful to have the cycle number available when calling the eMedNY Call Center with questions about specific processed claims or payments.

ETIN (not applicable)

Provider Service Classification: HOME HEALTH

PROV ID: This field will contain the Medicaid Provider ID and NPI, when applicable.

**Remittance Number** 

## **3.5.6.2 Explanation of Claim Detail Columns**

### **Office Account Number**

Up to 20 characters of the Patient/Office Account Number entered in the claim form is provided in this column.

### **Client Name**

This column indicates the last name of the member. If an invalid Medicaid Member 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 Member ID number appears under this column.

### TCN

The Transaction Control Number (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 in 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.

### 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. The following are examples of circumstances that commonly cause claims to be denied:

- 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: Member ID, Prior Approval. These claims are recycled for a period of time during which the Medicaid files may be updated to match the information on the claim.

In order for a claim to be removed from Pend status, one of the following must occur:

- manual review is completed,
- a successful match is found
- the recycling time expires

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) number(s) that caused the claim to deny or pend. Up to twenty-five (25) edit codes, including approved edits, may be listed for each claim. Edit code definitions are listed at the end of the claim detail section.

## 3.5.6.3Subtotals/Totals/Grand Totals

Subtotals of dollar amounts and number of claims are provided as follows:

Subtotals by claim *status* appear at the end of the claim listing for each status. The subtotals are broken down by:

- Original claims
- Adjustments
- Voids
- Adjustments/voids combined

Totals by *service classification and by member ID* for the individual practitioners these who provided services as part of the group being paid are provided next to the subtotals for service classification/locator code. These totals are broken down by:

- Adjustments/voids (combined)
- Pends
- Paid
- Deny
- Net total paid (for the specific service classification)

*Grand Totals* for the entire provider remittance advice, which include all the provider's service classifications, appear on a separate page following the page containing the *totals by service classification*. The grand total is broken down by:

- Adjustments/voids (combined)
- Pends
- Paid
- Deny
- Net total paid (entire remittance)

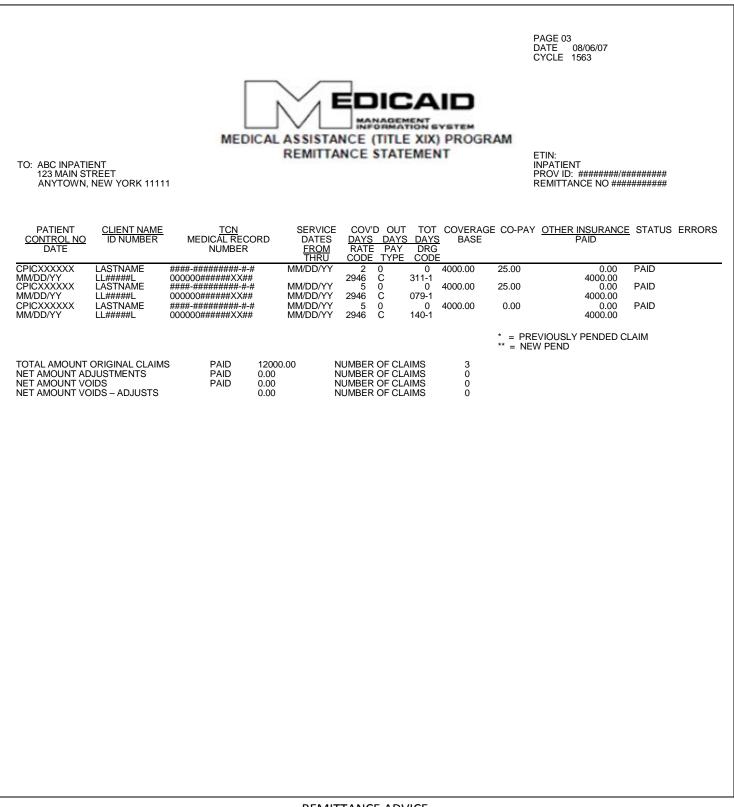


# 3.5.7Inpatient Claim Detail

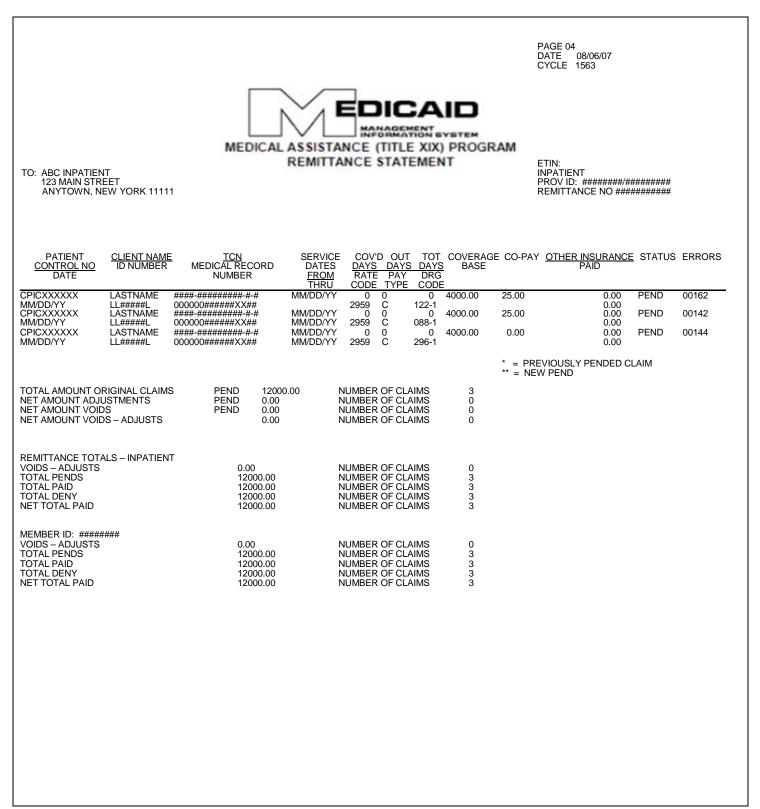
Exhibit 3.5.7-1

							PAGE 02 DATE 08/06/07 CYCLE 1563		
TO: ABC INPATIENT 123 MAIN STREET ANYTOWN, NEW YORK 1117						RAM	ETIN: INPATIENT GRAND TOTALS PROV ID: ########## REMITTANCE NO: ###		
PATIENT <u>CLIENT NAME</u> <u>CONTROL NO</u> ID NUMBER DATE	<u>TCN</u> MEDICAL RECORD NUMBER	SERVICE DATES <u>FROM</u> THRU		AYS DAYS AY DRG	BASE	GE CO-PA	Y <u>OTHER INSURANCE</u> PAID	STATUS	ERRORS
CPICXXXXXX LASTNAME MM/DD/YY LL#####L	#####-################################	MM/DD/YY	0 0 2946 C	0 122-1	4000.00	25.00	0.00 0.00	DENY	00805 00806
CPICXXXXXX LASTNAME MM/DD/YY LL#####L	####-###########-#-# 000000######XX##	MM/DD/YY MM/DD/YY	0 0 2946 C	0 195-1	4000.00	25.00	0.00 0.00	DENY	00848 00162
CPICXXXXXX LASTNAME MM/DD/YY LL#####L	####-#################################	MM/DD/YY MM/DD/YY	0 0 2946 C	0 127-1	4000.00	0.00	0.00 0.00	DENY	00848
								AIM	
TOTAL AMOUNT ORIGINAL CLAIM NET AMOUNT ADJUSTMENTS NET AMOUNT VOIDS NET AMOUNT VOIDS – ADJUSTS	IS DENIED 120 DENIED 0.00 DENIED 0.00 0.00		NUMBER OF NUMBER OF NUMBER OF	CLAIMS CLAIMS	3 0 0		WPEND		



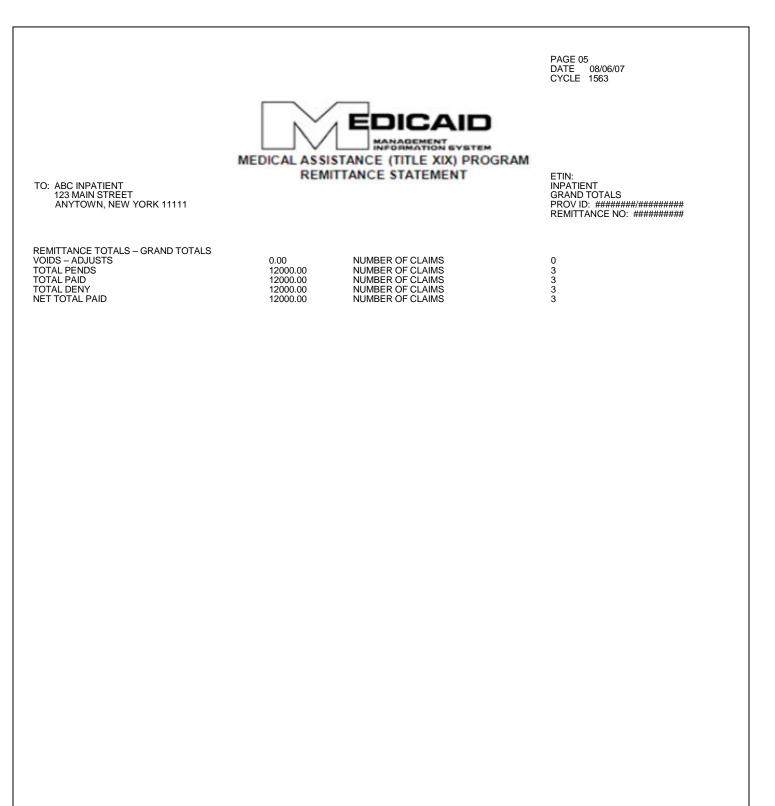






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## **3.5.7.1 Claim Detail Page Field Descriptions**

## **Upper Left Corner**

Provider's Name/Address

### **Upper Right Corner**

Remittance page number

Date the remittance advice was issued

Cycle Number: The pre-assigned number for the claims processing period. It is helpful to have the cycle number available when calling the eMedNY Call Center with questions about specific processed claims or payments.

ETIN (not applicable)

Provider Service Classification: INPATIENT

PROV ID: This field contains the Medicaid Provider ID and the NPI

Remittance Number

## **3.5.7.2 Explanation of Claim Detail Columns**

### Patient Control Number/Date

Up to 20 characters of the Patient/Office Account Number entered in the claim form is provided in this column (first line) and the admission date (second line).

### **Client Name/ID Number**

This column indicates the last name of the member(first line) and the Member ID (second line). If an invalid Medicaid Member ID was entered in the claim form, the ID will be listed as it was submitted but no name will appear in this column.

## **TCN/Medical Record Number**

The Transaction Control Number (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.

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



## **Service Dates – From/Through**

The first date of service covered by the claim (From date) appears on the first line; the last date of service (Through date) appears on the second line.

## Cov'd (Covered) Days/Rate Code

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

## **Out Days/Pay Type**

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

#### Inpatient Payment Type Codes

One of the type codes in Exhibit 3.5.2-1 will appear in the Pay Type field on the Medicaid remittance advice and indicates the type of payment (code) generated by the claim.

#### Exhibit 3.5.2-1

0	NonDRG
Α	Medicare Deductible/Coinsurance/LTR
В	Full DRG
С	Admission Day Claim
D	Short Stay *
E	Outlier Only *
F	ALC Claim
G	Transfer – Paid as Per Diem
Н	Transfer – Paid as DRG
Ι	Transfer – Full DRG Plus Outlier *
J	CostOutlier
Κ	DRG Paid as Inlier/Outlier Combined
L	Transfer – Inlier/Outlier *

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



## TOT (Total) Days/DRG Code [and Severity of Illness Code]

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

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

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

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

### **Coverage Base**

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

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

### **Co-Pay**

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

## **Other Insurance/Paid**

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

### **Status**

This column indicates the status (DENY, PAID/ADJT/VOID, PEND) of 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: Member ID, Prior Approval. These claims are recycled for a period of time during which the Medicaid files may be updated to match the information on the claim.

In order for a claim to be removed from Pend status, one of the following must occur:

- manual review is completed
- a successful match is found
- the recycling time expires.

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) number(s) that caused the claim to deny or pend. Up to twenty-five (25) edit codes, including approved edits, may be listed for each claim. Edit code definitions are listed at the end of the claim detail section.

## 3.5.7.3Subtotals/Totals/Grand Totals

Subtotals of dollar amounts and number of claims are provided as follows:

Subtotals by claim *status* appear at the end of the claim listing for each status. The subtotals are broken down by:

- Original claims
- Adjustments
- Voids
- Adjustments/voids combined

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
- Deny
- Net total paid (for the specific service classification)

Totals by *service classification* and by *Member ID* (the individual practitioners these who provided services as part of the group) are provided next to the subtotals for service classification/locator code. These totals are broken down by:

- Adjustments/voids (combined)
- Pends
- Paid
- Deny
- Net total paid (for the specific service classification)

*Grand Totals* for the entire provider remittance advice, which include all the provider's service classifications, appear on a separate page following the page containing the *totals by service classification*. The grand total is broken down by:

- Adjustments/voids (combined)
- Pends
- Paid
- Deny

Net total paid (entire remittance)

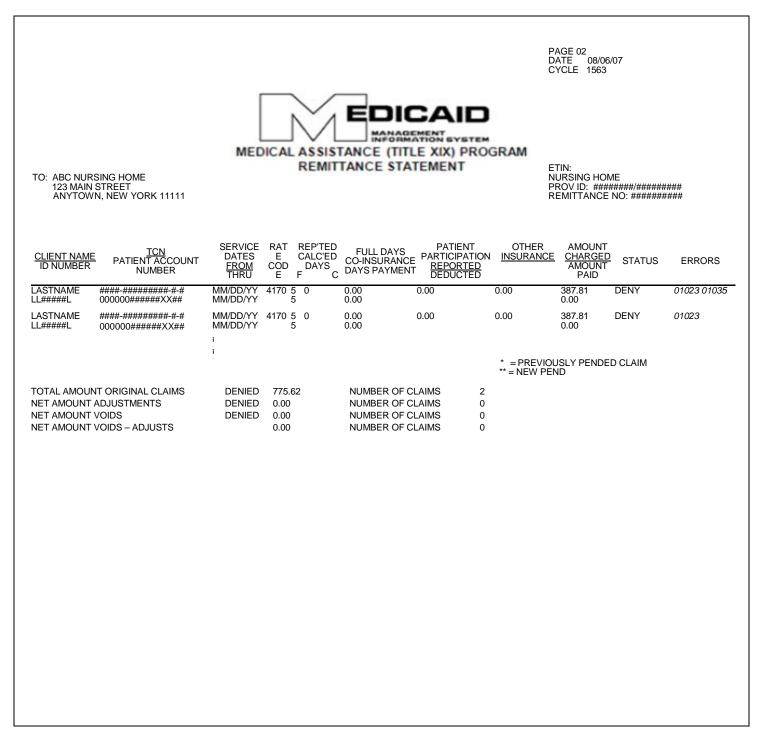


# **3.5.8Nursing Home Claim Detail**

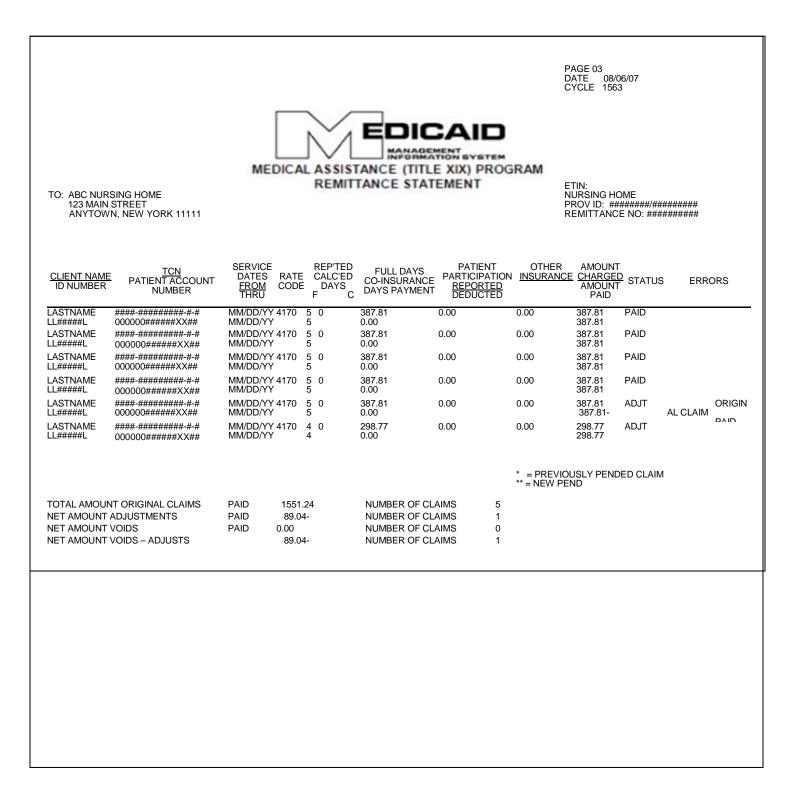
The Nursing Home Claim Detail section is used by the following provider types:

- Intermediate Care Facility/Developmentally Disabled (ICF/DD)
- Assisted Living (ALP)
- Day Treatment
- Hospice
- Residential Health

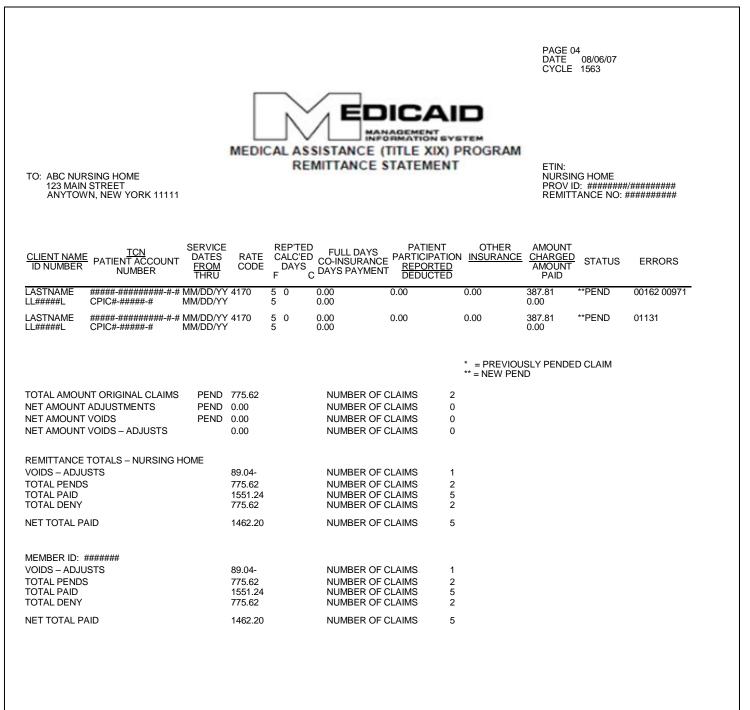




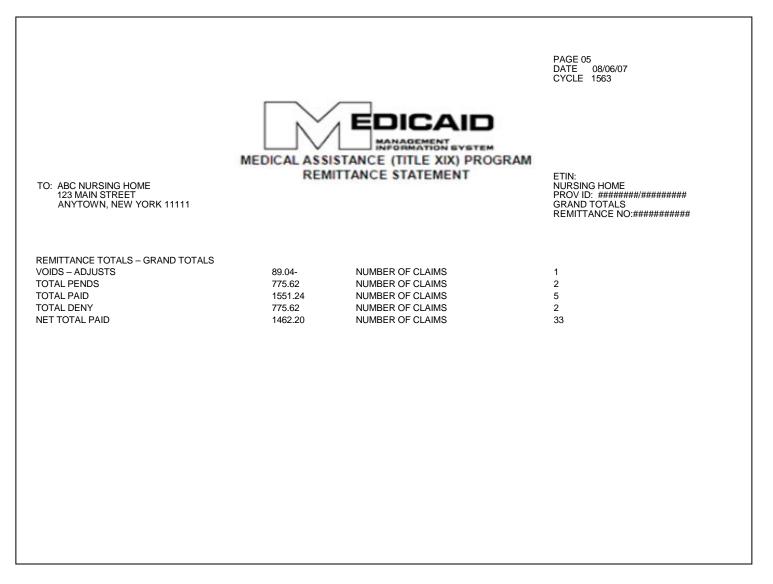














## 3.5.8.1Claim Detail Page Field Descriptions

## **Upper Left Corner**

Provider's Name/Address

### **Upper Right Corner**

Remittance page number

Date the remittance advice was issued

Cycle number: The pre-assigned number for the claims processing period. It is helpful to have the cycle number available when calling the eMedNY Call Center with questions about specific processed claims or payments.

ETIN (not applicable)

Provider Service Classification: NURSING HOME

PROV ID: This field contains the Medicaid Provider ID and the NPI

Remittance Number

## **3.5.8.2 Explanation of Claim Detail Columns**

### **Client Name/ID Number**

This column indicates the last name of the member (first line) and the Member ID (second line). If an invalid Member ID was entered in the claim form, the ID will be listed as it was submitted but no name will appear.

## **TCN/Patient Account Number**

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

If a Patient Account Number was entered in the claim form, up to 20 characters will appear in this column (second line).

### **Service Dates – From/Through**

The first date of service covered by the claim (From date) appears on the first line; the last date of service (Through date) appears on the second line.



## **Rate Code**

The four-digit rate code that was entered in the claim form appears in this column.

### **Reported/Calculated Days**

This column has two sub-columns: one is labeled *F (full days)* and the other is labeled *C (co-insurance days)*.

The number of days within the reported first (FROM) service date and the last (THROUGH) service date appear in the first line under the F sub-column. The number of full days calculated by the system appears in the second line under the F sub-column.

The number of co-insurance days reported on the claim form appears in the C sub-column. There are no calculated co-insurance days.

## **Patient Participation – Reported/Deducted**

This column shows the member participation amount (NAMI) as it was reported (first line) and as it was deducted (second line). If no member participation is applicable, this column will show 0.00 amount.

## **Other Insurance**

If applicable, the amount paid by the member's Other Insurance carrier, as reported on the claim form, is shown in this column. If no Other Insurance payment is applicable, this column will show 0.00 amount.

## Amount Charged/Amount Paid

The total charges entered in the claim form appear first in this column. If the claim was approved, the amount paid appears underneath the charges. 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. The following are examples of circumstances that commonly cause claims to be denied:

- 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: Member ID, Prior Approval. These claims are recycled for a period of time during which the Medicaid files may be updated to match the information on the claim.

In order for a claim to be removed from Pend status, one of the following must occur:

- manual review is completed,
- a successful match is found
- the recycling time expires

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) number(s) that caused the claim to deny or pend. Some edit codes may also be indicated for a PAID claim. Up to twenty-five (25) edit codes, including approved edits, may be listed for each claim. Edit code definitions are listed at the end of the claim detail section.

# 3.5.8.3Subtotals/Totals/Grand Totals

Subtotals of dollar amounts and number of claims are provided as follows:

Subtotals by claim *status* appear at the end of the claim listing for each status. The subtotals are broken down by:

- Original claims
- Adjustments
- Voids
- Adjustments/voids combined

Totals by *service classification and by member ID* are provided next to the subtotals for service classification/locator code. These totals are broken down by:

- Adjustments/voids (combined)
- Pends
- Paid
- Deny
- Net total paid (for the specific service classification)

*Grand Totals* for the entire provider remittance advice, which include all the provider's service classifications, appear on a separate page following the page containing the *totals by service classification*. The grand total is broken down by:

- Adjustments/voids (combined)
- Pends
- Paid
- Deny

Net total paid (entire remittance)



# **3.5.9Pharmacy Claim Detail**

Exhibit 3.5.9-1

			ſ		Ē			PAGE 0 DATE CYCLE	08/06/07	
ro: ABC Phar 123 Main S Anytown		11111	MEDICAL ASSISTANCE (TITLE XIX) PROGRAM REMITTANCE STATEMENT					etin: Pharmacy Prov ID: ###################################		
PRESCRIP TION NO.	ITEM CODE	QUANTITY	CLIENT ID NUMBER	CLIENT NAME	SERVICE DATE	TCN	CHARGED	PAID	STATUS	ERRORS
*######	00173044100	54.000	LL#####L	LAST NAME	MM/MM/YY	####-##################################	100.00	0.00	DENY	00162
*#######	00904391660	5.000	LL#####L	LAST NAME	MM/MM/YY	####-##################################	50.00	0.00	DENY	00162
#######	00904391660	5.000	LL#####L	LAST NAME	MM/MM/YY	####-##################################	30.00	0.00	DENY	00142 00144
****	00002411260	1.000	LL#####L	LAST NAME	MM/MM/YY	####-#################################	60.00	0.00	DENY	00142 00144
FOTAL AMOUNT	ORIGINAL CLAIN	١S		DENIED	240.00	NUMBER OF CLAIMS	4	Ļ		
NET AMOUNT AD	JUSTMENTS			DENIED	0.00	NUMBER OF CLAIMS	0	0		
NET AMOUNT VC	DIDS			DENIED	0.00	NUMBER OF CLAIMS	0			
	DIDS – ADJUSTS				0.00	NUMBER OF CLAIMS	0	)		



Exhibit 3.5.9-2

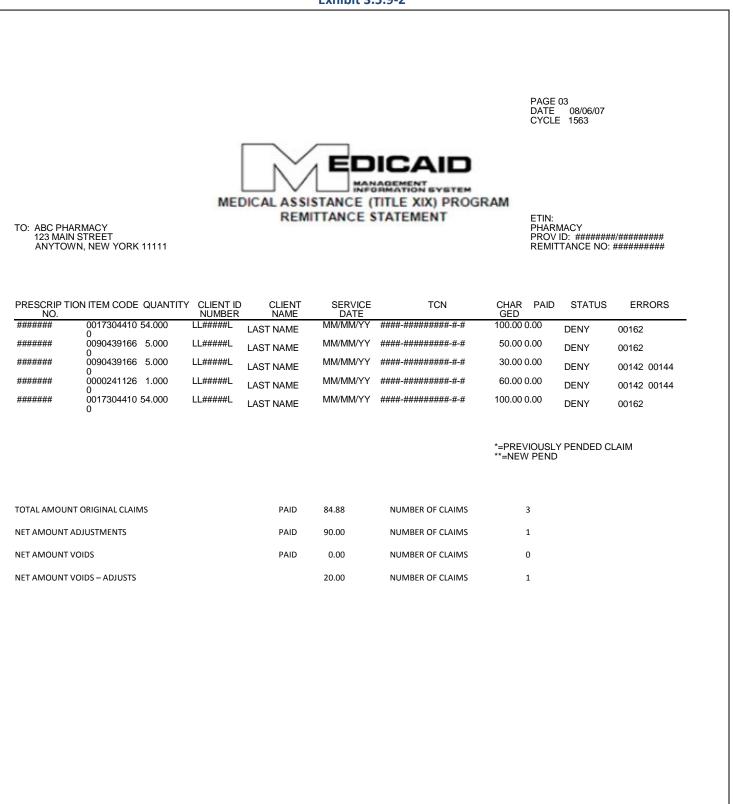


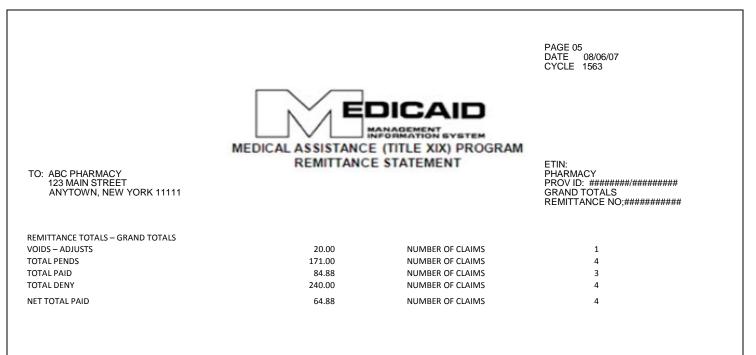


Exhibit 3.5.9-3

				-	_					PAGE DATE CYCL	
123 N	PHARMACY MAIN STREET TOWN, NEW YC	DRK 11111		MEDI			CITLE XIX) PR	IM	м		MACY ID: ####################################
PRESCRI	P TION NO.ITEI	M CODE Q	UANTITY	CLIENT ID		SERVICE DATE	TCN C	HARGE	DPAID	STATUS	SERRORS
########	0017	73044100	54.000		LAST NAME		####-##################################	100.00	0.00	DENY	00162
########	0090	04391660	5.000	LL#####L	LAST NAME	MM/MM/YY	####-##################################	50.00	0.00	DENY	00162
########	0090	04391660	5.000	LL#####L	LAST NAME	MM/MM/YY	####-##################################	30.00	0.00	DENY	00142 00144
########	0000	02411260	1.000	LL#####L	LAST NAME	MM/MM/YY	####-##################################	60.00	0.00	DENY	00142 00144
	TOTAL AMOUNT	ORIGINAL	CLAIMS		PEND171	L.00	NUMBER OF CLAIMS	5 4	Ļ		
	NET AMOUNT A	DJUSTMENT	.s		PEND 00.00		NUMBER OF CLAIMS	5 0	0		
	NET AMOUNT VO	DIDS			PEND 00.00		NUMBER OF CLAIMS	MS 0			
	NET AMOUNT VO	DIDS – ADJU	JSTS		0	0.00	NUMBER OF CLAIMS	S 0			
	REMITTANCE TO	TALS – PHA	RMACY								
	VOIDS – ADJUSTS	S			2	0.00	NUMBER OF CLAIMS	5 1			
	TOTAL PENDS				17	1.00	NUMBER OF CLAIMS	5 4	ļ		
	TOTAL PAID				8	4.88	NUMBER OF CLAIMS	NUMBER OF CLAIMS 3			
	TOTAL DENIED				24	0.00	NUMBER OF CLAIMS	NUMBER OF CLAIMS 4			
	NET TOTAL PAID				6	4.88	NUMBER OF CLAIMS	5 4	ļ		
	MEMBER ID: ###	***									
	VOIDS – ADJUSTS				2	0.00	NUMBER OF CLAIMS	51			
	TOTAL PENDS	-			20.00 171.00		NUMBER OF CLAIMS				
	TOTAL PAID					4.88					
	TOTAL DENIED					0.00	NUMBER OF CLAIMS	NUMBER OF CLAIMS 3 NUMBER OF CLAIMS 4			
	NET TOTAL PAID					4.88	NUMBER OF CLAIMS				
	NET TOTAL PAID				0	00	NOWBER OF CLAIMS	<b>,</b> 4			



Exhibit 3.5.9-4



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# **3.5.9.1 Claim Detail Page Field Descriptions**

# **Upper Left Corner**

Provider's Name/Address

### **Upper Right Corner**

Remittance page number

Date the remittance advice was issued

Cycle Number: The pre-assigned number for the claims processing period. It is helpful to have the cycle number available when calling the eMedNY Call Center with questions about specific processed claims or payments.

ETIN (not applicable)

Provider Service Classification: PHARMACY

PROV ID: This field contains the Medicaid Provider ID and the NPI

**Remittance Number** 

# **3.5.9.2Explanation of Claim Detail Columns**

## **Prescription No. (Line Number)**

This column indicates the prescription number as it appears on the claim form.

## Item Code

This column shows the code that identifies the drug or supply that was dispensed (NDC code or HCPCS CODE).

## Quantity

The quantity dispensed appears in this column. The quantity is indicated with three (3) decimal positions.

# **Client Number**

The Member ID number appears in this column.



## **Client Name**

This column indicates the last name of the member. If an invalid Medicaid Member ID was entered in the claim form, the ID will be listed as it was submitted, but no name will appear in this column.

## **Service Date**

This column lists the service date as entered in the claim form.

## TCN

The Transaction Control Number (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.

## Charged

This column lists either the amount the provider charged for the claim or the Medicare Approved amount if applicable.

## Paid

If the claim was approved, the amount paid appears in 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. The following are examples of circumstances that commonly cause claims to be pended:

- 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.

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### 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.

In order for a claim to be removed from Pend status, one of the following must occur:

- manual review is completed,
- a successful match is found
- the recycling time expires.

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) number(s) that caused the claim to deny or pend. Up to twenty-five (25) edit codes, including approved edits, may be listed for each claim. Edit code definitions are listed at the end of the claim detail section.

# 3.5.9.3 Subtotals/Totals/Grand Totals

Subtotals of dollar amounts and number of claims are provided as follows:

Subtotals by claim *status* appear at the end of the claim listing for each status. The subtotals are broken down by:

- Original claims
- Adjustments
- Voids
- Adjustments/voids combined

Subtotals by *provider type* are provided at the end of the claim detail listing. These subtotals are broken down by:

- Adjustments/voids (combined)
- Pends
- Paid
- Denied
- Net total paid (sum of approved adjustments/voids and paid original claims)

Totals by *Member ID* are subtotals for the individual practitioners these who provided services as part of the group being paid: These subtotals are broken down by:

- Adjustments/voids (combined)
- Pends
- Paid
- Deny
- Net total paid (sum of approved adjustments/voids and paid original claims)

*Grand Totals* for the entire provider remittance advice, which include all the provider's service

classifications, appear on a separate page following the page containing the *totals by service classification*. The grand total is broken down by:

- Adjustments/voids (combined)
- Pends
- Paid
- Deny

Net total paid (entire remittance)

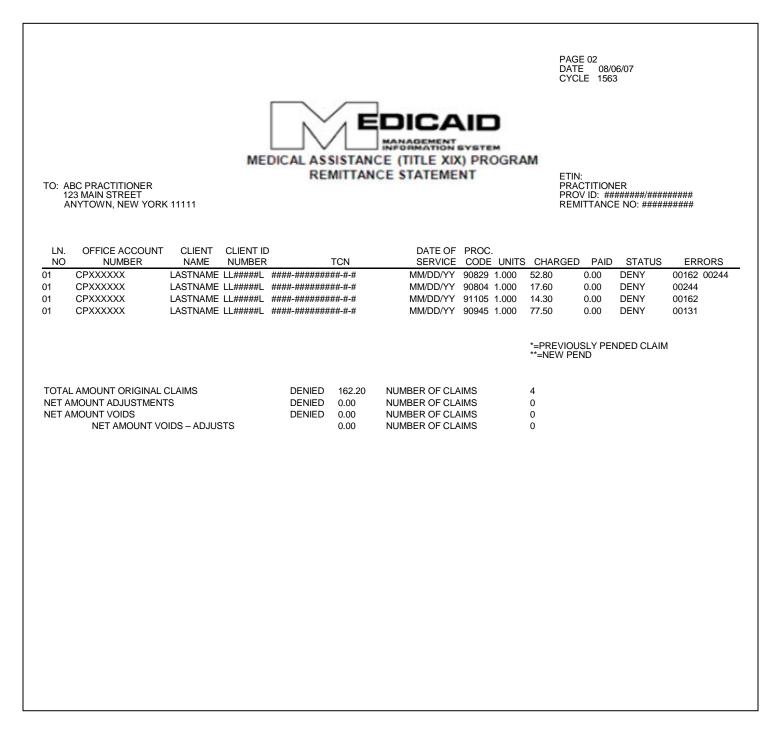


# 3.5.10 Practitioner Claim Detail

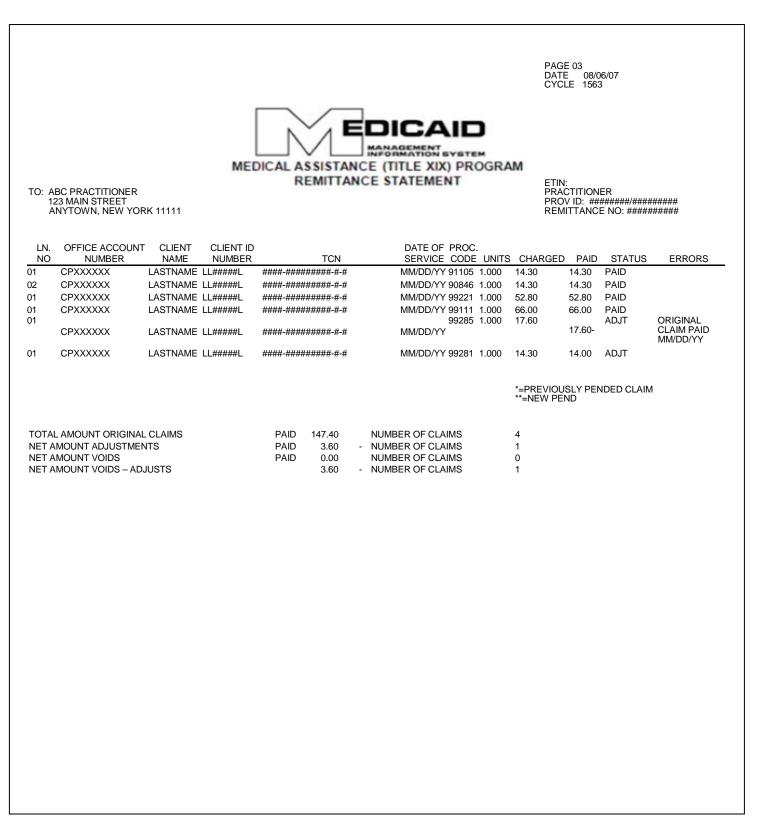
The Practitioner Claim Detail section is used by the following provider types:

- Chiropractor/Portable X-Ray
- Clinical Psychology
- Clinical Social Worker
- Hospital Ordered Ambulatory
- Laboratory
- Midwife
- Nurse Practitioner
- Physician
- Podiatry
- Private Duty Nursing
- Rehabilitation Services
- Vision Care

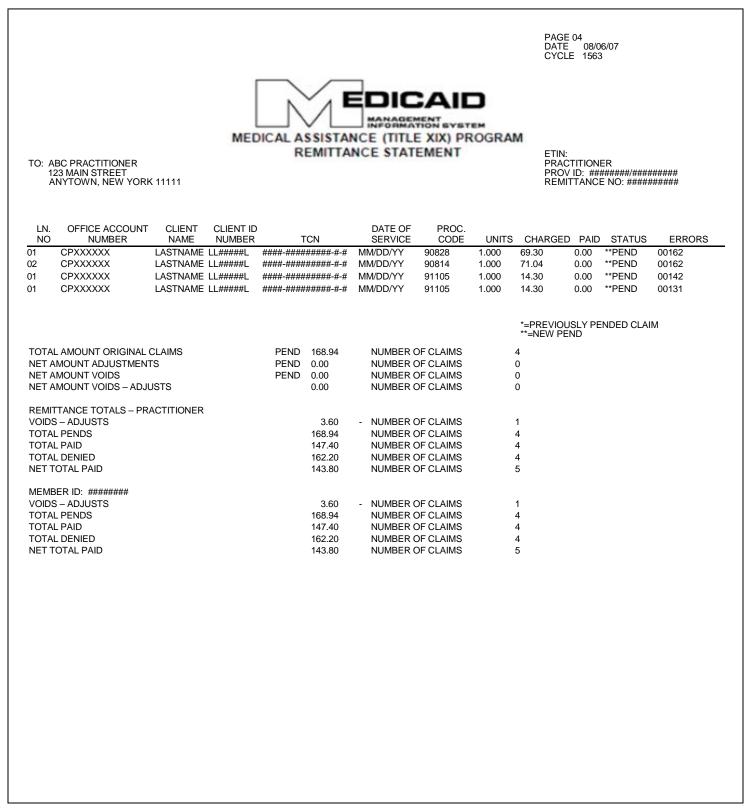






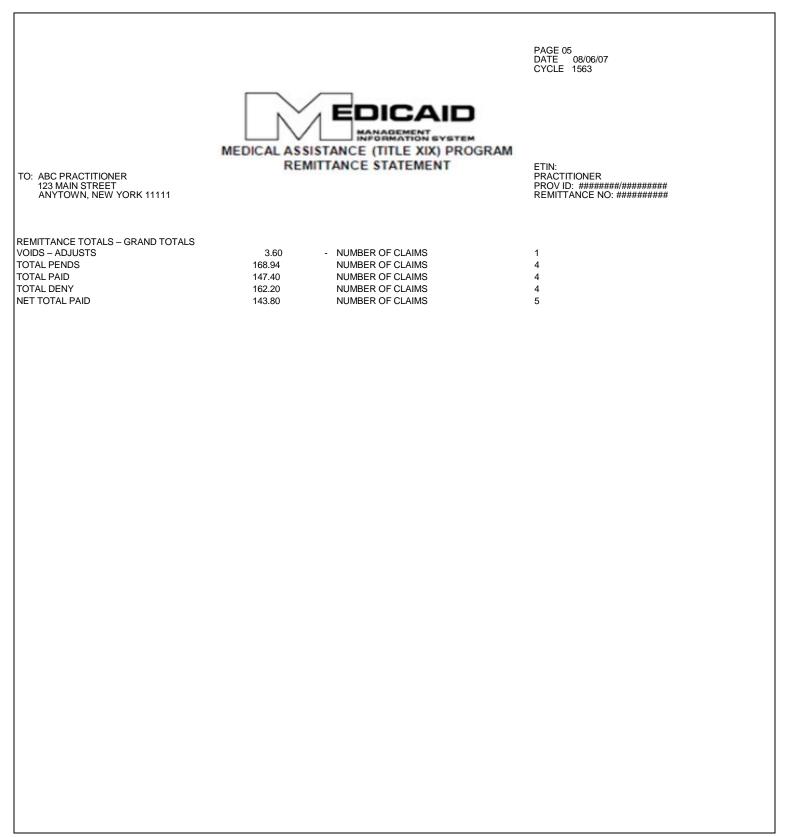








**REMITTANCE ADVICE FORMATS** 





# 3.5.10.1 Claim Detail Page Field Descriptions

## **Upper Left Corner**

Provider's Name/Address (as recorded in the Medicaid files)

## **Upper Right Corner**

Remittance Page Number

Date the remittance advice was issued

Cycle Number: The pre-assigned number for the claims processing period. It is helpful to have the cycle number available when calling the eMedNY Call Center with questions about specific processed claims or payments.

ETIN (not applicable)

Provider Service Classification: **PRACTITIONER** 

PROV ID: This field contains the Medicaid Provider ID and the NPI

Remittance Number

## **3.5.10.2 Explanation of Claim Detail Columns**

### LN. NO. (Line Number)

This column indicates the line number of each claim as it appears on the claim form.

### **Office Account Number**

Up to 20 characters of the Patient/Office Account Number entered in the claim form is provided in this column.

### **Client Name**

This column indicates the last name of the member. If an invalid Medicaid Member 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 Number**

The Member ID number appears in this column.



## TCN

The Transaction Control Number (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 in 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.

## **Procedure Code**

The five-digit procedure code entered in the claim form appears in this column.

### Units

The total number of units of service for the specific claim appears in this column.

### Charged

This column lists either the amount the provider charged for the claim.

### Paid

If the claim was approved, the amount paid appears in this column. If the claim has a pend or deny status, the amount paid will be zero (0.00).

Office-based practitioners and clinics participating in the Patient Centered Medical Home Program may receive enhanced payments for qualifying services. A payment line on the remittance will appear as shown in Exhibit 3.5.10.2-1:

### Exhibit 3.5.10.2-1

LN. NO	OFFICE ACCOUNT NUMBER	CLIENT NAME	CLIENT ID NUMBER	TCN	DATE OF SERVICE	PROC. CODE	UNITS	CHARGED	PAID	STATUS	ERRORS
01 MEDIC	CPXXXXXX AL HOME ADD ON: 22	LASTNAME	LL#####L	****	MM/DD/YY	90828	1.000	35.00	57.00	**PEND	

Information about this program is available by clicking on the link to the webpage as follows: <u>New York's Medicaid</u> <u>Statewide Patient-Centered Medical Home Incentive Program</u>

### 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. The following are examples of circumstances that commonly cause claims to be denied:

- 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: Member ID, Prior Approval. These claims are recycled for a period of time during which the Medicaid files may be updated to match the information on the claim.

In order for a claim to be removed from Pend status, one of the following must occur:

- manual review is completed,
- a successful match is found
- the recycling time expires

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) number(s) that caused the claim to deny or pend. Up to twenty-five (25) edit codes, including approved edits, may be listed for each claim. Edit code definitions are listed at the end of the claim detail section.

# 3.5.10.3 Subtotals/Totals/Grand Totals

Subtotals of dollar amounts and number of claims are provided as follows:

Subtotals by claim *status* appear at the end of the claim listing for each status. The subtotals are broken down by:

- Original claims
- Adjustments
- Voids
- Adjustments/voids combined

Subtotals by *provider type* are provided at the end of the claim detail listing. These subtotals are broken down by:

- Adjustments/voids (combined)
- Pends
- Paid
- Deny
- Net total paid (for the specific service classification)

Totals by *member ID* are subtotals for the individual practitioners these who provided services as part of the group being paid: These subtotals are broken down by:

- Adjustments/voids (combined)
- Pends
- Paid
- Deny
- Net total paid (sum of approved adjustments/voids and paid original claims)

*Grand Totals* for the entire provider remittance advice appear on a separate page following the page containing the *totals by provider type and member ID*. The grand total is broken down by:

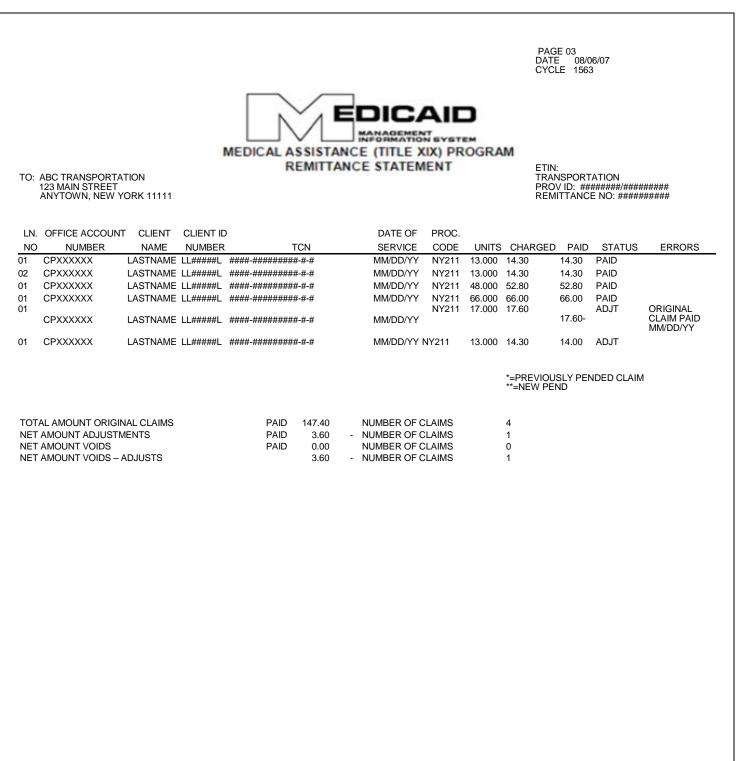
- Adjustments/voids (combined)
- Pends
- Paid
- Deny
- Net total paid (entire remittance)



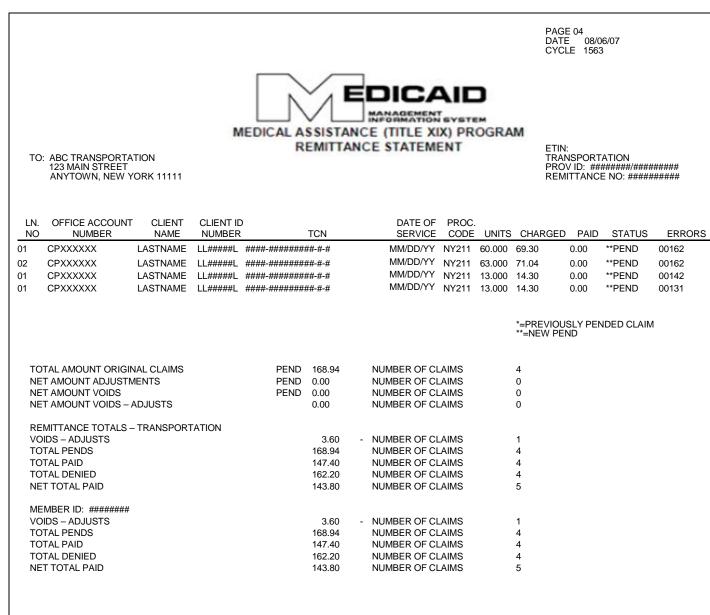
# 3.5.11 Transportation Claim Detail

	Exhib	it 3.5.11-1	
			PAGE 02 DATE 08/06/07 CYCLE 1563
TO: ABC TRANSPORTATION 123 MAIN STREET ANYTOWN, NEW YORK 11111		DICAID MANAGEMENT SYSTEM CE (TITLE XIX) PROGRA CE STATEMENT	AM ETIN: TRANSPORTATION PROV ID: ###################################
LN. OFFICE ACCOUNT CLIEN NO NUMBER NAM	E NUMBER TCN		6 CHARGED PAID STATUS ERRORS
01 CPXXXXXX LASTNA 01 CPXXXXXX LASTNA	ME LL#####L ####-################ ME LL#####L ####-############## ME LL#####L ####-############## ME LL#####L ####-###############	MM/DD/YY NY211 16.000 MM/DD/YY NY211 13.000	52.80         0.00         DENY         00162         00244           17.60         0.00         DENY         00244           14.30         0.00         DENY         00162           77.50         0.00         DENY         00131
			*=PREVIOUSLY PENDED CLAIM **=NEW PEND
TOTAL AMOUNT ORIGINAL CLAIMS NET AMOUNT ADJUSTMENTS NET AMOUNT VOIDS NET AMOUNT VOIDS – ADJUSTS	DENIED 162.20 DENIED 0.00 DENIED 0.00 0.00	NUMBER OF CLAIMS NUMBER OF CLAIMS NUMBER OF CLAIMS NUMBER OF CLAIMS	4 0 0 0



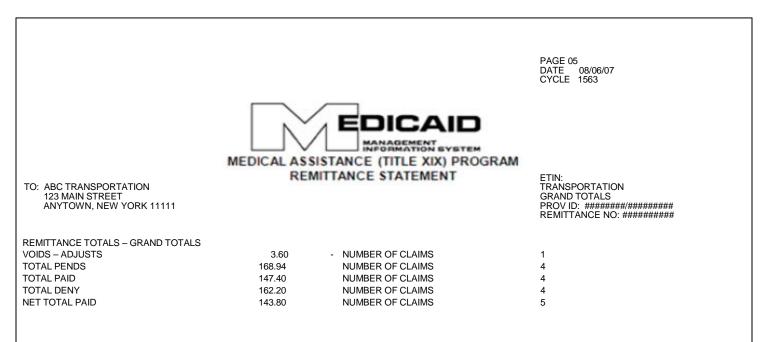








**REMITTANCE ADVICE FORMATS** 





# 3.5.11.1 Claim Detail Page Field Descriptions

# **Upper Left Corner**

Provider's Name/Address (as recorded in the Medicaid files)

# **Upper Right Corner**

Remittance page number

Date the remittance advice was issued

Cycle number: The pre-assigned number for the claims processing period. It is helpful to have the cycle number available when calling the eMedNY Call Center with questions about specific processed claims or payments.

ETIN (not applicable)

Provider Service Classification: TRANSPORTATION

PROV ID: This field contains the Medicaid Provider ID and the NPI, as applicable.

Remittance Number

## **3.5.11.2 Explanation of Claim Detail Columns**

### Ln. No. (Line Number)

This column indicates the claim number as it corresponds to the procedure lines on the claim form.

## **Office Account Number**

Up to 20 characters of the Patient/Office Account Number entered in the claim form is provided in this column.

## **Client Name**

This column indicates the last name of the member. 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 member's Medicaid ID number appears in 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 in 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.

### **Procedure Code**

The five-digit procedure code entered in the claim form appears in this column.

### Units

The total number of units of service for the specific claim appears in this column.

### Charged

The total charges entered in the claim form appear in this column.

### Paid

If the claim was approved, the amount paid appears in 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. The following are examples of circumstances that commonly cause claims to be denied:

- 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: Member ID, Prior Approval. These claims are recycled for a period of time during which the Medicaid files may be updated to match the information on the claim.

In order for a claim to be removed from Pend status, one of the following must occur:

- manual review is completed,
- a successful match is found
- the recycling time expires

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) number(s) that caused the claim to deny or pend. Up to twenty-five (25) edit codes, including approved edits, may be listed for each claim. Edit code definitions are listed at the end of the claim detail section.

# 3.5.11.3 Subtotals/Totals/Grand Totals

Subtotals of dollar amounts and number of claims are provided as follows:

Subtotals by claim *status* appear at the end of the claim listing for each status. The subtotals are broken down by:

- Original claims
- Adjustments
- Voids
- Adjustments/voids combined

Subtotals by *provider type* are provided at the end of the claim detail listing. These subtotals are broken down by:

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

Totals by *Member ID* are subtotals for the individual practitioners who provided services as part of the group being paid. These subtotals are broken down by:

- Adjustments/voids (combined)
- Pends
- Paid
- Deny
- Net total paid (sum of approved adjustments/voids and paid original claims)

*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 provider type and member ID (See definition above)*. The grand total is broken down by:

- Adjustments/voids (combined)
- Pends
- Paid
- Deny

Net total paid (entire remittance)



# 3.6 Section Four – Financial Transactions and Accounts Receivable

This section has two subsections:

- Financial Transactions
- Accounts Receivable

# **3.6.1Financial Transactions**

The Financial Transactions subsection lists all the recoupments applied to the provider during the specific cycle. If there is no recoupment activity, this subsection is not produced.

Exhibit 3.6.1-1

				PAGE 05 DATE 08/06/07 CYCLE 1563
O: ABC TRANSPORTATION 123 MAIN STREET ANYTOWN, NEW YORK	I	MANAGEM	XIX) PROGRAM	ETIN: TRANSPORTATION FINANCIAL TRANSACTIONS PROV ID: ###################################
FCN 200705060236547	FINANCIAL REASON CODE XXX	ASON DESCRIPTION	DATE AMOUNT 05 09 07 \$\$.\$\$	<ul> <li>NET FINANCIAL TRANSACTION AMOUNT \$\$\$.\$\$ NUMBER OF FINANCIAL TRANSACTIONS</li> </ul>

# **3.6.1.1Explanation of Financial Transactions Columns**

## FCN

The Financial Control Number (FCN) is a unique identifier assigned to each financial transaction..

### **Financial Reason Code**

This code identifies the reason for the recoupment.

### **Financial Transaction Type**

This is the description of the Financial Reason Code. For example: Third Party Recovery.

### Date

The date the recoupment was applied. Since all the recoupments listed on this page pertain to the current cycle, all recoupments will have the same date.

### Amount

The dollar amount corresponding to the particular fiscal transaction. This amount is deducted from the provider's total payment for the cycle.

## **3.6.1.2Explanation of Totals Section**

The total dollar amount of the financial transactions (*Net Financial Transaction Amount*) and the total number of transactions (*Number of Financial Transactions*) appear below the last line of the transaction detail list.

The Net Financial Transaction Amount added to the Claim Detail-Grand Total must equal the Medicaid Check or EFT amounts.

# **3.6.2Accounts Receivable**

This subsection displays the original amount of each of the outstanding Financial Transactions and their current balance after the cycle recoupments were applied. If there are no outstanding negative balances, this section is not produced.

			Exhibit 3.6.2-1		
			1		PAGE 05 DATE 08/06/07 CYCLE 1563
TO: ABC TRANSPORTATION 123 MAIN STREET ANYTOWN, NEW YORK 11117			CE (TITLE XIX) P CE STATEMENT	TEM	ETIN: TRANSPORTATION ACCOUNTS RECEIVABLE PROV ID: ###################################
REASON CODE	DESCRIPTION	ORIG BAL \$XXX.XX- \$XXX.XX-	CURR BAL \$XXX.XX- \$XXX.XX-	RECOUP %/AM1 999 999	r
TOTAL AMOUNT DUE THE ST	TATE \$XXX.XX				

# **3.6.2.1 Explanation of Accounts Receivable Columns**

If a provider has negative balances of different types or negative balances created at different times, each negative balance will be listed in a different line.

## **Reason Code Description**

This is the description of the Financial Reason Code. For example, Third Party Recovery.

## **Original Balance**

The original amount (or starting balance) for any particular financial reason.

### **Current Balance**

The current amount owed to Medicaid (after the cycle recoupments, if any, were applied). This balance may be equal to or less than the original balance.

### **Recoupment % Amount**

The deduction (recoupment) scheduled for each cycle.

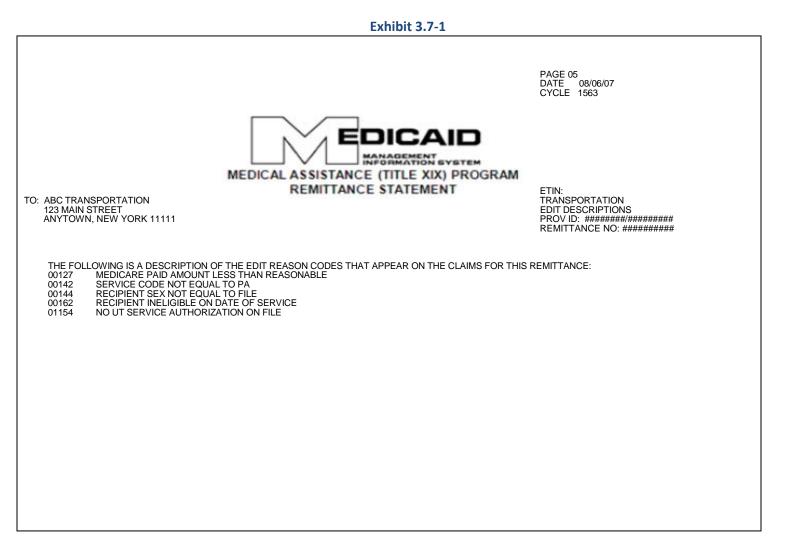
### **Total Amount Due the State**

This amount is the sum of all the *Current Balances* listed above.



# **3.7 Section Five – Edit (Error) Description**

The last section of the Remittance Advice features the description of each of the edit codes that appear in Section Three.



# 4. The Status of Claims

The eMedNY system applies two levels of editing for all incoming claims/files:

- Pre-adjudication editing
- Mainframe adjudication editing

# **Rejected Claims**

During the pre-adjudication, claims can be either <u>accepted</u> or <u>rejected</u>. For electronic claims eMedNY provides the frontend edit report, referred to as 277CA, to inform the providers of accepted or rejected claims. A rejection means the claim will not enter the claims processing system. Providers must review the front-end edit report in order to make corrections for rejected claims and resubmit them for processing in timely manner. Rejected claims will not appear on the submitter's remittance statement.

Providers can also use the Submitter Dashboard tool to check if claims were accepted or rejected. The eMedNY Submitter Dashboard is designed to assist Trading Partners in tracking the status of batch submissions made to New York Medicaid. Trading Partners can follow the progress of their batch submissions here. For additional information on the Dashboard please see the Submitter Dashboard button on the home page on emedny.org

Rejections for electronic claims can be caused by various errors in submitted information. You can find a list of those rejection reasons here:

https://www.emedny.org/HIPAA/5010/transactions/crosswalks/eMedNY%20Pre-Adjudication%20Crosswalk%20(837%20Health%20Care%20Claims).pdf

For ePACES claims providers can view the claims status either by checking the 'Real Time Responses' link for Professional Real Time claims or 'View Previously Submitted claims' link for all other types of claims.

For paper claims missing critical data or having an invalid attachment, the paper claim will be mailed back to the submitter with a rejection explanation.

# **Accepted Claims**

Once a claim is accepted into the eMedNY claims processing system it will appear on a remittance with one of the following statuses:

- Adjustments/Void to a previous claim
- Pending
- Paid
- Denied



## **Information on Pending Claims**

A claim may be pending final adjudication if it contains erroneous information, does not match the New York State Department of Health's records, or requires manual review to be resolved. eMedNY reviews some pending claims. While some other pending claims are resolved by the Department of Health because of the nature of the pended claim, for instance manual pricing.

The majority of pending claims are recycling for either 30, 60 or 90 days to verify if new client information has been received from the county that would allow the claim to be released for payment. An example of a recycling pending claim would be: Recipient Not Eligible on Date of Service. These claims are recycled for 30 days. If no new information is received at the end of this time period, the claim will be denied.

Any claim pending will appear on the weekly remittance for the first week it is pending. Depending on how the provider has set up their choice of how he/she wishes to see pending claims on the remittance and whether the provider receives a paper or an electronic remittance, the pending claim may be reported on the first weekly cycle and when paid or denied, every week or once every 4 weeks. A message will appear on the remittance statement with a description of why the claim is pending.

Pending claims may ultimately be approved for payment, reduced or denied. Some common reasons for pending a claim are:

- New York State Medical Review required
- Procedure requires manual pricing
- Recipient Ineligible on Date of Service

# **Denied Claims**

Claims for which payment is denied will be identified by the *DENY* status. The following are examples of circumstances that commonly cause claims to be denied:

- 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.

Please refer to the Billing Section of your MMIS Provider Manual for details. Providers should review the denied claim on their remittance statement and resubmit on a new claim as described within the Billing Section of your Provider Manual or the HIPAA Companion Guides available on www.emedny.org. Please call the eMedNY Call Center at 800 343-9000 for assistance in understanding the reason why a claim is denied.

Information about re-submitting previously rejected or denied claims may be found here: <u>https://www.emedny.org/HIPAA/QuickRefDocs/FOD-7001\_Sub\_Claims\_Over\_90\_days\_Old\_04-17-12.pdf</u>.





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

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

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