New York State Electronic Medicaid System Remittance Advice Guideline

Version 2013 - 01

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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: Electronic Remittance Request Form.

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: Default ETIN Selection Form.

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: Default ETIN Selection Form.

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

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® (6.0 release or higher required). This may be downloaded from www.adobe.com.

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: PDF Paper Remittance Request Form.

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.

2.3.1 Remittance Sorts

The default sort for the paper remittance advice is:

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

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

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

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

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

MEDICAID MANAGEMENT INFORMATION SYSTEM

TO: CITY PHARMACY

DATE: 2007-08-06
REMITTANCE NO: ############
PROV ID: ##################

################## 2007-08-06
CITY PHARMACY
111 PARK AVENUE
ANYTOWN NY 11111

YOUR CHECK IS BELOW – TO DETACH, TEAR ALONG PERFORATED DASHED LINE

29
2

DATE	REMITTANCE NUMBER	PROVIDER ID NO.
2007-08-06 VOID AFTER 90 DAYS	############	##################

PAY

DOLLARS/CENTS
$*****104.88

TO THE ORDER OF
CITY PHARMACY
111 PARK AVENUE
ANYTOWN NY 11111

MEDICAID MANAGEMENT INFORMATION SYSTEM

MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
CHECKS DRAWN ON
KEY BANK N.A.
60 STATE STREET, ALBANY, NEW YORK 12207

FIRSTNAME LASTNAME
AUTHORIZED SIGNATURE

REMITTANCE ADVICE

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.

3.2 Section One – EFT Notification

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

MEDICAID MANAGEMENT INFORMATION SYSTEM

TO: CITY PHARMACY

DATE: 2007-08-06
REMITTANCE NO: ############
PROV ID: ##########

########## 2007-08-06
CITY PHARMACY
111 PARK AVENUE
ANYTOWN NY 11111

CITY PHARMACY $104.88

PAYMENT IN THE ABOVE AMOUNT WILL BE DEPOSITED VIA AN ELECTRONIC FUNDS 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.

Exhibit 3.3-1

TO: ABC PHARMACY

MEDICAID MANAGEMENT INFORMATION SYSTEM

DATE: 08/06/2007
REMITTANCE NO: ##########
PROV ID: #########/##########

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

CITY PHARMACY
111 PARK AVENUE
ANYTOWN NY 11111

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.

Exhibit 3.4-1

PAGE 01
DATE 08/06/07
CYCLE 1563

MEDICAID MANAGEMENT INFORMATION SYSTEM
MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

TO: ABC CHILD CARE
123 MAIN STREET
ANYTOWN, NEW YORK 11111

ETIN:
CHILD CARE
PROV ID: ########
REMITTANCE NO: ##########

REMITTANCE ADVICE MESSAGE TEXT

*** ELECTRONIC FUNDS TRANSFER (EFT) FOR PROVIDER PAYMENTS IS NOW AVAILABLE ***

PROVIDERS WHO ENROLL IN EFT WILL HAVE THEIR MEDICAID PAYMENTS DIRECTLY DEPOSITED INTO THEIR CHECKING OR SAVINGS ACCOUNT.

THE EFT TRANSACTIONS WILL BE INITIATED ON WEDNESDAYS AND DUE TO NORMAL BANKING PROCEDURES, THE TRANSFERRED FUNDS MAY NOT BECOME AVAILABLE IN THE PROVIDER'S CHOSEN ACCOUNT FOR UP TO 48 HOURS AFTER TRANSFER. PLEASE CONTACT YOUR BANKING INSTITUTION REGARDING THE AVAILABILITY OF FUNDS.

PLEASE NOTE THAT EFT DOES NOT WAIVE THE TWO-WEEK LAG FOR MEDICAID DISBURSEMENTS.

TO ENROLL IN EFT, PROVIDERS MUST COMPLETE AN EFT ENROLLMENT FORM THAT CAN BE FOUND AT WWW.EMEDNY.ORG. CLICK ON PROVIDER ENROLLMENT FORMS WHICH CAN BE FOUND IN THE FEATURED LINKS SECTION. DETAILED INSTRUCTIONS WILL ALSO BE FOUND THERE.

AFTER SENDING THE EFT ENROLLMENT FORM TO EMEDNY, PLEASE ALLOW A MINIMUM TIME OF SIX TO EIGHT WEEKS FOR PROCESSING. DURING THIS PERIOD OF TIME YOU SHOULD REVIEW YOUR BANK STATEMENTS AND LOOK FOR AN EFT TRANSACTION IN THE AMOUNT OF $0.01 WHICH EMEDNY WILL SUBMIT AS A TEST. YOUR FIRST REAL EFT TRANSACTION WILL TAKE PLACE APPROXIMATELY FOUR TO FIVE WEEKS LATER.

IF YOU HAVE ANY QUESTIONS ABOUT THE EFT PROCESS, PLEASE CALL THE EMEDNY CALL CENTER AT 1-800-343-9000.

NOTICE: THIS COMMUNICATION AND ANY ATTACHMENTS MAY CONTAIN INFORMATION THAT IS PRIVILEGED AND CONFIDENTIAL UNDER STATE AND FEDERAL LAW AND IS INTENDED ONLY FOR THE USE OF THE SPECIFIC INDIVIDUAL(S) TO WHOM IT IS ADDRESSED. THIS INFORMATION MAY ONLY BE USED OR DISCLOSED IN ACCORDANCE WITH LAW, AND YOU MAY BE SUBJECT TO PENALTIES UNDER LAW FOR IMPROPER USE OR FURTHER DISCLOSURE OF INFORMATION IN THIS COMMUNICATION AND ANY ATTACHMENTS. IF YOU HAVE RECEIVED THIS COMMUNICATION IN ERROR, PLEASE IMMEDIATELY NOTIFY NYHIPPADESK@CSRA.COM OR CALL 1-800-541-2831. PROVIDERS WHO DO NOT HAVE ACCESS TO E-MAIL SHOULD CONTACT 1-800-343-9000.

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.

Exhibit 3.5.1-1

PAGE 02
DATE 08/06/07
CYCLE 1563

MEDICAID
MANAGEMENT INFORMATION SYSTEM
MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

TO: ABC CHILD CARE
123 MAIN STREET
ANYTOWN, NEW YORK 11111

ETIN:
CHILD CARE
PROV ID: ########
REMITTANCE NO: ##########

CLIENT NAME ID NUMBER	TCN PATIENT ACCOUNT NUMBER	SERVICE DATES FROM THRU	RATE CODE	REP'TED CALC'ED DAYS F	 C	FULL DAYS CO-INSURANCE DAYS	PATIENT PARTICIPATION REPORTED DEDUCTED	OTHER INSURANCE	AMOUNT CHARGED AMOUNT PAID	STATUS	ERRORS
LASTNAME LL#####L	XXXXX-##########-X-X CPICx-xxxxx-x	MM/DD/YY MM/DD/YY	1210	5 5	0	0.00 0.00	0.00	0.00	387.81 0.00	DENY	01023 01035
LASTNAME LL#####L	XXXXX-##########-X-X CPICx-xxxxx-x	MM/DD/YY MM/DD/YY	1210	5 5	0	0.00 0.00	0.00	0.00	387.81 0.00	DENY	01023

* = PREVIOUSLY PENDED CLAIM
** = NEW PEND

TOTAL AMOUNT ORIGINAL CLAIMS	DENIED	775.62	NUMBER OF CLAIMS	2
NET AMOUNT ADJUSTMENTS	DENIED	0.00	NUMBER OF CLAIMS	0
NET AMOUNT VOIDS	DENIED	0.00	NUMBER OF CLAIMS	0
NET AMOUNT VOIDS – ADJUSTS		0.00	NUMBER OF CLAIMS	0

Exhibit 3.5.1-2

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DATE 08/06/07
CYCLE 1563

MEDICAID MANAGEMENT INFORMATION SYSTEM

MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

TO: ABC CHILD CARE
123 MAIN STREET
ANYTOWN, NEW YORK 11111

ETIN:
CHILD CARE
PROV ID: ########
REMITTANCE NO: ##########

CLIENT NAME ID NUMBER	TCN PATIENT ACCOUNT NUMBER	SERVICE DATES FROM THRU	RATE CODE	REP'TED CALC'ED DAYS F	C	FULL DAYS CO-INSURANCE DAYS PAYMENT	PATIENT PARTICIPATION REPORTED DEDUCTED	OTHER INSURANCE	AMOUNT CHARGED AMOUNT PAID	STATUS	ERRORS
LASTNAME LL######L	####-##########-#-# CPICx-xxxxx-x	MM/DD/YY MM/DD/YY	1210	5 5	0	387.81 0.00	0.00	0.00	387.81 387.81	PAID	
LASTNAME LL######L	####-##########-#-# CPICX-XXXXX-X	MM/DD/YY MM/DD/YY	1210	5 5	0	387.81 0.00	0.00	0.00	387.81 387.81	PAID	
LASTNAME LL######L	####-##########-#-# CPICX-XXXXX-X	MM/DD/YY MM/DD/YY	1210	5 5	0	387.81 0.00	0.00	0.00	387.81 387.81	PAID	
LASTNAME LL######L	####-##########-#-# CPICX-XXXXX-X	MM/DD/YY MM/DD/YY	1210	5 5	0	387.81 0.00	0.00	0.00	387.81 387.81	PAID	
LASTNAME LL######L	####-##########-#-# CPICX-XXXXX-X	MM/DD/YY MM/DD/YY	1210	5 5	0	387.81 0.00	0.00	0.00	387.81 387.81-	ADJT	ORIGINAL CLAIM PAID MM/DD/YY
LASTNAME LL######L	####-##########-#-# CPICX-XXXXX-X	MM/DD/YY MM/DD/YY	1210	4 4	0	298.77 0.00	0.00	0.00	298.77 298.77	ADJT	

* = PREVIOUSLY PENDED CLAIM
** = NEW PEND

TOTAL AMOUNT ORIGINAL CLAIMS	PAID	1551.24	NUMBER OF CLAIMS	5
NET AMOUNT ADJUSTMENTS	PAID	89.04-	NUMBER OF CLAIMS	1
NET AMOUNT VOIDS	PAID	0.00	NUMBER OF CLAIMS	0
NET AMOUNT VOIDS – ADJUSTS		89.04-	NUMBER OF CLAIMS	1

Exhibit 3.5.1-3

PAGE 02
DATE 08/06/07
CYCLE 1563

MEDICAID MANAGEMENT INFORMATION SYSTEM
MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

TO: ABC CHILD CARE
123 MAIN STREET
ANYTOWN, NEW YORK 11111

ETIN:
CHILD CARE
PROV ID: ########
REMITTANCE NO: ##########

CLIENT NAME / ID NUMBER	TCN / PATIENT ACCOUNT NUMBER	SERVICE DATES FROM / THRU	RATE CODE	REP'TED DAYS F	CALC'ED DAYS C	FULL DAYS CO-INSURANCE DAYS	PATIENT PARTICIPATION REPORTED / DEDUCTED	OTHER INSURANCE	AMOUNT CHARGED / AMOUNT PAID	STATUS	ERRORS
LASTNAME	'####-##########-#-#	MM/DD/YY	1210	5	0	0.00	0.00	0.00	387.81	**PEND	00162 00971
LL#####L	CPICX-XXXXX-X	MM/DD/YY		5		0.00			0.00		
LASTNAME	'####-##########-#-#	MM/DD/YY	1210	5	0	0.00	0.00	0.00	387.81	**PEND	01131
LL#####L	CPICX-XXXXX-X	MM/DD/YY		5		0.00			0.00		

* = PREVIOUSLY PENDED CLAIM
** = NEW PEND

TOTAL AMOUNT ORIGINAL CLAIMS	PEND	775.62	NUMBER OF CLAIMS	2	
NET AMOUNT ADJUSTMENTS	PEND	0.00	NUMBER OF CLAIMS	0	
NET AMOUNT VOIDS	PEND	0.00	NUMBER OF CLAIMS	0	
NET AMOUNT VOIDS – ADJUSTS		0.00	NUMBER OF CLAIMS	0	

REMITTANCE TOTALS – CHILD CARE

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	5

MEMBER ID: ########

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	5

Exhibit 3.5.1-4

MEDICAID MANAGEMENT INFORMATION SYSTEM

MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

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

TO: ABC CHILD CARE
123 MAIN STREET
ANYTOWN, NEW YORK 11111

ETIN:
CHILD CARE
GRAND TOTALS
PROV ID: ########
EMITTANCE NO: ##########

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

3.5.1.1 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: **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.

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.

3.5.1.3Subtotals/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)

3.5.2 Clinic APG Claim Detail

Exhibit 3.5.2-1

PAGE 02
DATE 08/06/07
CYCLE 1563

MEDICAID
MANAGEMENT INFORMATION SYSTEM
MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

TO: ABC CLINIC
123 MAIN STREET
ANYTOWN, NEW YORK 11111

ETIN:
CLINIC
PROV ID: ##########
REMITTANCE NO: ##########

ANYTOWN, NEW YORK 11111

REMITITTANCE NO: ##########

OFFICE ACCOUNT NUMBER	CLIENT NAME	CLIENT ID.	TCN	DATE OF SERVICE	RATE CODE	UNITS	CHARGED	PAID	STATUS	ERRORS
CPICXXXXXX	LASTNAME	LL#####L	#####-#########-#-#	07/15/07	2879	1.000	95.00	0.00	DENY	00146
CPICXXXXXX	LASTNAME	LL#####L	#####-#########-#-#	07/15/07	2879	1.000	95.00	0.00	DENY	00142, 00144
CPICXXXXXX	LASTNAME	LL#####L	#####-#########-#-#	07/15/07	2879	1.000	95.00	0.00	DENY	00142, 00144
CPICXXXXXX	LASTNAME	LL#####L	#####-#########-#-#	07/15/07	2879	1.000	95.00	0.00	DENY	00162

* = PREVIOUSLY PENDED CLAIM
** = NEW PEND

TOTAL AMOUNT ORIGINAL CLAIMS	DENIED	380.00	NUMBER OF CLAIMS	4
NET AMOUT ADJUSTMENTS	DENIED	0.00	NUMBER OF CLAIMS	0
NET AMOUNT VOIDS	DENIED	0.00	NUMBER OF CLAIMS	0
NET AMOUNT VOIDS – ADJUSTS		0.00	NUMBER OF CLAIMS	0

Exhibit 3.5.2-2

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MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

TO: ABC CLINIC
123 MAIN STREET
ANYTOWN, NEW YORK 11111

ETIN:
CLINIC
PROV ID: ########/#########
REMITTANCE NO: ##########

OFFICE ACCOUNT NUMBER	CLIENT NAME	CLIENT ID.	TCN	DATE OF SERVICE	RATE CODE	UNITS	CHARGED	PAID	STATUS	ERRORS
CPICXXXXXX	LASTNAME	LL#####L	#####-##########-#-#	MM/DD/YY	2879	1.000	95.00	95.00	PAID	
CPICXXXXXX	LASTNAME	LL#####L	#####-##########-#-#	MM/DD/YY	2879	1.000	95.00	95.00	PAID	
CPICXXXXXX	LASTNAME	LL#####L	#####-##########-#-#	MM/DD/YY	2879	1.000	95.00	95.00	PAID	
CPICXXXXXX	LASTNAME	LL#####L	#####-##########-#-#	MM/DD/YY	2879	1.000	95.00	95.00	PAID	
CPICXXXXXX	LASTNAME	LL#####L	#####-##########-#-#	MM/DD/YY	2879	1.000	95.00	95.00	PAID	
CPICXXXXXX	LASTNAME	LL#####L T	#####-##########-#-#	MM/DD/YY	2879	1.000	50.00	50.00	ADJT	
CPICXXXXXX	LASTNAME	LL#####L	#####-##########-#-#	MM/DD/YY	2879	1.000	95.00–	95.00–	PAID	

* = PREVIOUSLY PENDED CLAIM
** = NEW PEND

TOTAL AMOUNT ORIGINAL CLAIMS	PAID	475.00	NUMBER OF CLAIMS	5
NET AMOUT ADJUSTMENTS	PAID	45.00–	NUMBER OF CLAIMS	1
NET AMOUNT VOIDS	PAID	0.00	NUMBER OF CLAIMS	0
NET AMOUNT VOIDS – ADJUSTS		45.00–	NUMBER OF CLAIMS	1

Exhibit 3.5.2-3

ANYTOWN, NEW YORK 11111

REMITITTANCE NO: ##########

PAGE 04
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CYCLE 1563

MEDICAID
MANAGEMENT INFORMATION SYSTEM
MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

TO: ABC CLINIC
123 MAIN STREET
ANYTOWN, NEW YORK 11111

ETIN:
CLINIC
PROV ID: ########/##########
REMITTANCE NO: ##########

OFFICE ACCOUNT NUMBER	CLIENT NAME	CLIENT ID.	TCN	DATE OF SERVICE	RATE CODE	UNITS	CHARGED	PAID	STATUS	ERRORS
CPICXXXXXX	LASTNAME	LL#####L	#####-#########-#-#	MM/DD/YY	2879	1.000	95.00	0.00	** PEND	00162
CPICXXXXXX	LASTNAME	LL#####L	#####-#########-#-#	MM/DD/YY	2879	1.000	95.00	0.00	** PEND	00127
CPICXXXXXX	LASTNAME	LL#####L	#####-#########-#-#	MM/DD/YY	2879	1.000	95.00	0.00	** PEND	00127
CPICXXXXXX	LASTNAME	LL#####L	#####-#########-#-#	MM/DD/YY	2879	1.000	95.00	0.00	** PEND	00162

* = PREVIOUSLY PENDED CLAIM
** = NEW PEND

TOTAL AMOUNT ORIGINAL CLAIMS	PEND	0.00	38	NUMBER OF CLAIMS	4
NET AMOUT ADJUSTMENTS	PEND	0.00		NUMBER OF CLAIMS	0
NET AMOUNT VOIDS	PEND	0.00		NUMBER OF CLAIMS	0
NET AMOUNT VOIDS – ADJUSTS		0.00		NUMBER OF CLAIMS	0
REMITTANCE TOTALS – CLINIC					
VOIDS – ADJUSTS		45.00–		NUMBER OF CLAIMS	1
TOTAL PENDS		0.00	38	NUMBER OF CLAIMS	4
TOTAL PAID		5.00	47	NUMBER OF CLAIMS	5
TOTAL DENIED		0.00	38	NUMBER OF CLAIMS	4
NET TOTAL PAID		0.00	43	NUMBER OF CLAIMS	6
MEMBER ID: ########					
VOIDS – ADJUSTS		45.00–		NUMBER OF CLAIMS	1
TOTAL PENDS		0.00	38	NUMBER OF CLAIMS	4
TOTAL PAID		5.00	47	NUMBER OF CLAIMS	5
TOTAL DENIED		0.00	38	NUMBER OF CLAIMS	4
NET TOTAL PAID		0.00	43	NUMBER OF CLAIMS	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.

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.

- 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

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

Exhibit 3.5.4-1

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MEDICAID
MANAGEMENT INFORMATION SYSTEM
MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

TO: ABC DENTAL
123 MAIN STREET
ANYTOWN, NEW YORK 11111

ETIN:
DENTAL
PROV ID: ########/##########
REMITTANCE NO: ##########

ANYTOWN, NEW YORK 11111

REMITITTANCE NO: ##########

N. NO	OFFICE ACCOUNT NUMBER	CLIENT NAME	CLIENT ID NUMBER	TCN	DATE OF SERVICE	PROC. CODE	UNITS	CHARGED	PAID	STATUS	ERRORS
01	CPICXXXXXX	LASTNAME	LL#####L	#####-#########-#-#	MM/DD/YY	D0120	1.000	52.80	0.00	DENY	00162 00244
01	CPICXXXXXX	LASTNAME	LL#####L	#####-#########-#-#	MM/DD/YY	D0272	1.000	17.60	0.00	DENY	00244
01	CPICXXXXXX	LASTNAME	LL#####L	#####-#########-#-#	MM/DD/YY	D1204	1.000	14.30	0.00	DENY	00162
01	CPICXXXXXX	LASTNAME	LL#####L	#####-#########-#-#	MM/DD/YY	D0290	1.000	77.50	0.00	DENY	00131

PENDED CLAIM
* = PREVIOUSLY
** = NEW PEND

TOTAL AMOUNT ORIGINAL CLAIMS	DENIED	162.20	NUMBER OF CLAIMS	4
NET AMOUNT ADJUSTMENTS	DENIED	0.00	NUMBER OF CLAIMS	0
NET AMOUNT VOIDS	DENIED	0.00	NUMBER OF CLAIMS	0
NET AMOUNT VOIDS – ADJUSTS		0.00	NUMBER OF CLAIMS	0

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MEDICAID
MANAGEMENT INFORMATION SYSTEM
MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

TO: ABC DENTAL
123 MAIN STREET
ANYTOWN, NEW YORK 11111

ETIN:
DENTAL
PROV ID: ########/##########
REMITTANCE NO: ##########

LN. NO	OFFICE ACCOUNT NUMBER	CLIENT NAME	CLIENT ID NUMBER	TCN	DATE OF SERVICE	PROC. CODE	UNITS	CHARGED	PAID	STATUS	ERRORS
01	CPICXXXXXX	LASTNAME	LL#####L	#####-#########-#-#	MM/DD/YY	D1203	1.000	14.30	14.30	PAID	
02	CPICXXXXXX	LASTNAME	LL#####L	#####-#########-#-#	MM/DD/YY	D1204	1.000	14.30	14.30	PAID	
01	CPICXXXXXX	LASTNAME	LL#####L	#####-#########-#-#	MM/DD/YY	D0320	1.000	52.80	52.80	PAID	
01	CPICXXXXXX	LASTNAME	LL#####L	#####-#########-#-#	MM/DD/YY	D3220	1.000	66.00	66.00	PAID	
01	CPICXXXXXX	LASTNAME	LL#####L	#####-#########-#-#	MM/DD/YY	D0272	1.000	17.60	17.60-	ADJT	ORIGINAL CLAIM PAID MM/DD/YY
01	CPICXXXXXX	LASTNAME	LL#####L	#####-#########-#-#	MM/DD/YY	D1204	1.000	14.30	14.00	ADJT	

*=PREVIOUSLY PENDED CLAIM
**=NEW PEND

TOTAL AMOUNT ORIGINAL CLAIMS	PAID	147.40	NUMBER OF CLAIMS	4	
NET AMOUNT ADJUSTMENTS	PAID	3.60 -	NUMBER OF CLAIMS	1	
NET AMOUNT VOIDS	PAID	0.00	NUMBER OF CLAIMS	0	
NET AMOUNT VOIDS – ADJUSTS		3.60 -	NUMBER OF CLAIMS	1	

Exhibit 3.5.4-3

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MEDICAID
MANAGEMENT INFORMATION SYSTEM
MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

TO: ABC DENTAL
123 MAIN STREET
ANYTOWN, NEW YORK 11111

ETIN:
DENTAL
PROV ID: ########/##########
REMITTANCE NO: ##########

LN. NO	OFFICE ACCOUNT NUMBER	CLIENT NAME	CLIENT ID NUMBER	TCN	DATE OF SERVICE	PROC. CODE	UNITS	CHARGED	PAID	STATUS	ERRORS
01	CPICXXXXXX	LASTNAME	LL#####L	#####-#########-#-#	MM/DD/YY	D3220	1.000	69.30	0.00	**PEND	00162
02	CPICXXXXXX	LASTNAME	LL#####L	#####-#########-#-#	MM/DD/YY	D7450	1.000	71.04	0.00	**PEND	00162
01	CPICXXXXXX	LASTNAME	LL#####L	#####-#########-#-#	MM/DD/YY	D1204	1.000	14.30	0.00	**PEND	00142
01	CPICXXXXXX	LASTNAME	LL#####L	#####-#########-#-#	MM/DD/YY	D1204	1.000	14.30	0.00	**PEND	00131

*=PREVIOUSLY PENDED CLAIM
**=NEW PEND

TOTAL AMOUNT ORIGINAL CLAIMS	PEND	168.94	NUMBER OF CLAIMS	4
NET AMOUNT ADJUSTMENTS	PEND	0.00	NUMBER OF CLAIMS	0
NET AMOUNT VOIDS	PEND	0.00	NUMBER OF CLAIMS	0
NET AMOUNT VOIDS – ADJUSTS		0.00	NUMBER OF CLAIMS	0

REMITTANCE TOTALS – DENTAL				
VOIDS – ADJUSTS		3.60 -	NUMBER OF CLAIMS	1
TOTAL PENDS		168.94	NUMBER OF CLAIMS	4
TOTAL PAID		147.40	NUMBER OF CLAIMS	4
TOTAL DENIED		162.20	NUMBER OF CLAIMS	4
NET TOTAL PAID		143.80	NUMBER OF CLAIMS	5

MEMBER ID: ########				
VOIDS – ADJUSTS		3.60 -	NUMBER OF CLAIMS	1
TOTAL PENDS		168.94	NUMBER OF CLAIMS	4
TOTAL PAID		147.40	NUMBER OF CLAIMS	4
TOTAL DENIED		162.20	NUMBER OF CLAIMS	4
NET TOTAL PAID		143.80	NUMBER OF CLAIMS	5

Exhibit 3.5.4-4

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MEDICAID MANAGEMENT INFORMATION SYSTEM
MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

TO: ABC DENTAL

123 MAIN STREET
ANYTOWN, NEW YORK 11111

ETIN:
DENTAL
GRAND TOTALS
PROV ID: ##################
REMITTANCE NO: ##########

REMITTANCE TOTALS – GRAND TOTALS

VOIDS – ADJUSTS	3.60	-	NUMBER OF CLAIMS	1
TOTAL PENDS	168.94		NUMBER OF CLAIMS	4
TOTAL PAID	147.40		NUMBER OF CLAIMS	4
TOTAL DENY	162.20		NUMBER OF CLAIMS	4
NET TOTAL PAID	143.80		NUMBER OF CLAIMS	5

3.5.4.1 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: **DENTAL**

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

Remittance Number

3.5.4.2 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.

3.5.4.3 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

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:

- DME
- Hearing Aid

Exhibit 3.5.5-1

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MEDICAID MANAGEMENT INFORMATION SYSTEM
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REMITTANCE STATEMENT

TO: ABC DENTAL

123 MAIN STREET
ANYTOWN, NEW YORK 11111

ETIN:
DENTAL
GRAND TOTALS
PROV ID: ########/#########
REMITTANCE NO: ##########

LN. NO.	PROC CODE	QUANTITY	CLIENT NUMBER	CLIENT NAME	OFFICE ACCT NUMBER	SERVICE DATE	TCN	AMOUNT CHARGED	AMOUNT PAID	STATUS	ERRORS
01	E0177	1.000	LL#####L	LASTNAME	CPXXXXXX	MM/DD/YY	#####-#########-#-#	52.80	0.00	DENY	00162 00244
01	E0199	1.000	LL#####L	LASTNAME	CPXXXXXX	MM/DD/YY	#####-#########-#-#	17.60	0.00	DENY	00244
01	A6244	1.000	LL#####L	LASTNAME	CPXXXXXX	MM/DD/YY	#####-#########-#-#	14.30	0.00	DENY	00162
01	L0110	1.000	LL#####L	LASTNAME	CPXXXXXX	MM/DD/YY	#####-#########-#-#	77.50	0.00	DENY	00131

* = PREVIOUSLY PENDED CLAIM
** = NEW PEND

TOTAL AMOUNT ORIGINAL CLAIMS	DENIED	162.20	NUMBER OF CLAIMS	4
NET AMOUNT ADJUSTMENTS	DENIED	0.00	NUMBER OF CLAIMS	0
NET AMOUNT VOIDS	DENIED	0.00	NUMBER OF CLAIMS	0
NET AMOUNT VOIDS – ADJUSTS		0.00	NUMBER OF CLAIMS	0

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MANAGEMENT INFORMATION SYSTEM
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TO: ABC DENTAL
123 MAIN STREET
ANYTOWN, NEW YORK 11111

ETIN:
DME
PROV ID: ########/##########
REMITTANCE NO: ##########

LN. NO.	PROC CODE	QUANTITY	CLIENT NUMBER	CLIENT NAME	OFFICE ACCT NUMBER	SERVICE DATE	TCN	AMOUNT CHARGED	AMOUNT PAID	STATUS	ERRORS
01	L3640	1.000	LL#####L	LASTNAME	CPXXXXXX	MM/DD/YY	#####-#########-#-#	14.30	14.30	PAID	
02	L3580	1.000	LL#####L	LASTNAME	CPXXXXXX	MM/DD/YY	#####-#########-#-#	14.30	14.30	PAID	
01	Z4651	1.000	LL#####L	LASTNAME	CPXXXXXX	MM/DD/YY	#####-#########-#-#	52.80	52.80	PAID	
01	Z4714	1.000	LL#####L	LASTNAME	CPXXXXXX	MM/DD/YY	#####-#########-#-#	66.00	66.00	PAID	
01	L3649	1.000	LL#####L	LASTNAME	CPXXXXXX	MM/DD/YY	#####-#########-#-#	17.60	17.60-	ADJT	ORIGINAL CLAIM PAID MM/DD/YY
01	L3640	1.000	LL#####L	LASTNAME	CPXXXXXX	MM/DD/YY	#####-#########-#-#	14.30	14.00	ADJT	

* = PREVIOUSLY PENDED CLAIM
** = NEW PEND

TOTAL AMOUNT ORIGINAL CLAIMS	PAID	147.40	NUMBER OF CLAIMS	4
NET AMOUNT ADJUSTMENTS	PAID	3.60-	NUMBER OF CLAIMS	1
NET AMOUNT VOIDS	PAID	0.00	NUMBER OF CLAIMS	0
NET AMOUNT VOIDS – ADJUSTS		3.60-	NUMBER OF CLAIMS	1

Exhibit 3.5.5-3

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MEDICAID MANAGEMENT INFORMATION SYSTEM
MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

TO: ABC DENTAL
123 MAIN STREET
ANYTOWN, NEW YORK 11111

ETIN:
DME
PROV ID: ########/##########
REMITTANCE NO: ##########

LN. NO.	PROC CODE	QUANTITY	CLIENT NUMBER	CLIENT NAME	OFFICE ACCT NUMBER	SERVICE DATE	TCN	AMOUNT CHARGED	AMOUNT PAID	STATUS	ERRORS
01	L1090	1.000	LL#####L	LASTNAME	CPXXXXXX	MM/DD/YY	#####-#########-#-#	69.30	0.00	** PEND	00162
01	L1620	1.000	LL#####L	LASTNAME	CPXXXXXX	MM/DD/YY	#####-#########-#-#	71.04	0.00	** PEND	00162
01	A6247	1.000	LL#####L	LASTNAME	CPXXXXXX	MM/DD/YY	#####-#########-#-#	14.30	0.00	** PEND	00142
01	A6247	1.000	LL#####L	LASTNAME	CPXXXXXX	MM/DD/YY	#####-#########-#-#	14.30	0.00	** PEND	00131

* = PREVIOUSLY PENDED CLAIM
** = NEW PEND

TOTAL AMOUNT ORIGINAL CLAIMS	PEND	168.94	NUMBER OF CLAIMS	4
NET AMOUNT ADJUSTMENTS	PEND	0.00	NUMBER OF CLAIMS	0
NET AMOUNT VOIDS	PEND	0.00	NUMBER OF CLAIMS	0
NET AMOUNT VOIDS – ADJUSTS		0.00	NUMBER OF CLAIMS	0

REMITTANCE TOTALS – DME			
VOIDS – ADJUSTS	3.60	- NUMBER OF CLAIMS	1
TOTAL PENDS	168.94	NUMBER OF CLAIMS	4
TOTAL PAID	143.80	NUMBER OF CLAIMS	4
TOTAL DENIED	162.20	NUMBER OF CLAIMS	4
NET TOTAL PAID	143.80	NUMBER OF CLAIMS	5

MEMBER ID: ########			
VOIDS – ADJUSTS	3.60	- NUMBER OF CLAIMS	1
TOTAL PENDS	168.94	NUMBER OF CLAIMS	4
TOTAL PAID	147.40	NUMBER OF CLAIMS	4
TOTAL DENIED	162.20	NUMBER OF CLAIMS	4
NET TOTAL PAID	143.80	NUMBER OF CLAIMS	5

Exhibit 3.5.5-4

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MEDICAID MANAGEMENT INFORMATION SYSTEM

MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

TO: ABC DENTAL
123 MAIN STREET
ANYTOWN, NEW YORK 11111

ETIN:
DME
PROV ID: ##########
REMITTANCE NO: ##########

REMITTANCE TOTALS – GRAND TOTALS				
VOIDS – ADJUSTS	3.60	-	NUMBER OF CLAIMS	1
TOTAL PENDS	168.94		NUMBER OF CLAIMS	4
TOTAL PAID	147.40		NUMBER OF CLAIMS	4
TOTAL DENY	162.20		NUMBER OF CLAIMS	4
NET TOTAL PAID	143.80		NUMBER OF CLAIMS	5

3.5.5.1 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 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

3.5.5.2 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.

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)

Exhibit 3.5.6-1

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MEDICAID
MANAGEMENT INFORMATION SYSTEM
MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

TO: ABC HOME HEALTH
123 MAIN STREET
ANYTOWN, NEW YORK 11111

ETIN:
HOME HEALTH
PROV ID: ########
REMITTANCE NO: ##########

OFFICE ACCOUNT NUMBER	CLIENT NAME	CLIENT ID.	TCN	DATE OF SERVICE	RATE CODE	UNITS	CHARGED	PAID	STATUS	ERRORS
CPICXXXXXX	LASTNAME	LL#####L	#####-#########-#-#	MM/DD/YY	CPICXXXXXXLASTNAME		187.810.00		DENY	00162 00131
CPICXXXXXX	LASTNAME	LL#####L	#####-#########-#-#	MM/DD/YY	CPICXXXXXXLASTNAME		84.380.00		DENY	00244 00142

* = PREVIOUSLY PENDED CLAI
** = NEW PEND

TOTAL AMOUNT ORIGINAL CLAIMS	DENIED	272.19	NUMBER OF CLAIMS	2
NET AMOUNT ADJUSTMENTS	DENIED	0.00	NUMBER OF CLAIMS	0
NET AMOUNT VOIDS	DENIED	0.00	NUMBER OF CLAIMS	0
NET AMOUNT VOIDS – ADJUSTS		0.00	NUMBER OF CLAIMS	0

Exhibit 3.5.6-2

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MEDICAID
MANAGEMENT INFORMATION SYSTEM
MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

TO: ABC HOME HEALTH
123 MAIN STREET
ANYTOWN, NEW YORK 11111

ETIN:
HOME HEALTH
PROV ID: ########
REMITTANCE NO: ##########

OFFICE ACCOUNT NUMBER	CLIENT NAME	CLIENT ID.	TCN	DATE OF SERVICE	RATE CODE	UNITS	CHARGED	PAID	STATUS	ERRORS
CPICXXXXXX	LASTNAME	LL#####L	#####-#########-#-#	MM/DD/YY	2610	8.000	300.20	300.20	PAID	
CPICXXXXXX	LASTNAME	LL#####L	#####-#########-#-#	MM/DD/YY	2610	5.000	188.41	188.41	PAID	
CPICXXXXXX	LASTNAME	LL#####L	#####-#########-#-#	MM/DD/YY	2610	8.000	300.20	300.20	PAID	
CPICXXXXXX	LASTNAME	LL#####L	#####-#########-#-#	MM/DD/YY	2610	8.000	300.20	300.20	PAID	
CPICXXXXXX	LASTNAME	LL#####L	#####-#########-#-#	MM/DD/YY	2610	8.000	300.20	300.20	PAID	
CPICXXXXXX	LASTNAME	LL#####L	#####-#########-#-#	MM/DD/YY	2610	7.000	186.10	186.10	PAID	
CPICXXXXXX	LASTNAME	LL#####L	#####-#########-#-#	MM/DD/YY	2610	8.000	300.20	300.20	PAID	
CPICXXXXXX	LASTNAME	LL#####L	#####-#########-#-#	MM/DD/YY	2610	5.000	150.90	150.90	ADJT	
CPICXXXXXX	LASTNAME	LL#####L	#####-#########-#-#	MM/DD/YY	2610	8.000	300.20	300.20-	- PAID	ORIGINAL CLAIM PAID MM/DD/YY

* = PREVIOUSLY PENDED CLAIM
** = NEW PEND

TOTAL AMOUNT ORIGINAL CLAIMS	PAID	2026.41	NUMBER OF CLAIMS	8
NET AMOUNT ADJUSTMENTS	PAID	49.30-	NUMBER OF CLAIMS	1
NET AMOUNT VOIDS	PAID	0.00	NUMBER OF CLAIMS	0
NET AMOUNT VOIDS – ADJUSTS		149.30-	NUMBER OF CLAIMS	1

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MEDICAID MANAGEMENT INFORMATION SYSTEM
MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

TO: ABC HOME HEALTH
123 MAIN STREET
ANYTOWN, NEW YORK 11111

ETIN:
HOME HEALTH
PROV ID: ########
REMITTANCE NO: ##########

OFFICE ACCOUNT NUMBER	CLIENT NAME	CLIENT ID.	TCN	DATE OF SERVICE	RATE CODE	UNITS	CHARGED	PAID	STATUS	ERRORS
CPICXXXXXX	LASTNAME	LL#####L	#####-#########-#-#	MM/DD/YY	2610	8.000	300.20	**	PEND	00162 00244
CPICXXXXXX	LASTNAME	LL#####L	#####-#########-#-#	MM/DD/YY	2610	5.000	188.41	**	PEND	00162 00244

* = PREVIOUSLY PENDED CLAIM
** = NEW PEND

CLAIMS	TOTAL AMOUNT ORIGINAL	PEND	488.61	NUMBER OF CLAIMS	2
	NET AMOUNT ADJUSTMENTS	PEND	0.00	NUMBER OF CLAIMS	0
	NET AMOUNT VOIDS	PEND	0.00	NUMBER OF CLAIMS	0
	NET AMOUNT VOIDS – ADJUSTS		0.00	NUMBER OF CLAIMS	0
HEALTH	REMITTANCE TOTALS – HOME				
	VOIDS – ADJUSTS		0.00	NUMBER OF CLAIMS	0
	TOTAL PENDS		0.00	NUMBER OF CLAIMS	0
	TOTAL PAID		0.00	NUMBER OF CLAIMS	0
	TOTAL DENIED		775.62	NUMBER OF CLAIMS	2
	NET TOTAL PAID		0.00	NUMBER OF CLAIMS	0
	MEMBER ID: ########4				
	VOIDS – ADJUSTS		149.30–	NUMBER OF CLAIMS	1
	TOTAL PENDS		488.61	NUMBER OF CLAIMS	2
	TOTAL PAID		2026.41	NUMBER OF CLAIMS	8
	TOTAL DENY		272.19	NUMBER OF CLAIMS	2
	NET TOTAL PAID		1877.11	NUMBER OF CLAIMS	8

Exhibit 3.5.6-4

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MEDICAID MANAGEMENT INFORMATION SYSTEM
MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

TO: ABC HOME HEALTH
123 MAIN STREET
ANYTOWN, NEW YORK 11111

ETIN:
HOME HEALTH
GRAND TOTALS
PROV ID: ########
REMITTANCE NO: ##########

REMITTANCE TOTALS – GRAND TOTALS

VOIDS – ADJUSTS	149.30–	NUMBER OF CLAIMS	1
TOTAL PENDS	488.61	NUMBER OF CLAIMS	2
TOTAL PAID	2026.41	NUMBER OF CLAIMS	8
TOTAL DENY	272.19	NUMBER OF CLAIMS	2
NET TOTAL PAID	1877.11	NUMBER OF CLAIMS	8

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

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MEDICAID MANAGEMENT INFORMATION SYSTEM
MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

TO: ABC INPATIENT
123 MAIN STREET
ANYTOWN, NEW YORK 11111

ETIN:
INPATIENT
GRAND TOTALS
PROV ID: ##########
REMITTANCE NO: ##########

PATIENT CONTROL NO / DATE	CLIENT NAME / ID NUMBER	TCN / MEDICAL RECORD NUMBER	SERVICE DATES FROM / THRU	COV'D DAYS / RATE CODE	OUT DAYS / PAY TYPE	TOT DAYS / DRG CODE	COVERAGE BASE	CO-PAY	OTHER INSURANCE PAID	STATUS	ERRORS
CPICXXXXXX	LASTNAME	#####-#########-#-#	MM/DD/YY	0	0	0	4000.00	25.00	0.00	DENY	00805
MM/DD/YY	LL#####L	000000######XX##		2946	C	122-1			0.00		00806 00848
CPICXXXXXX	LASTNAME	####-#########-#-#	MM/DD/YY	0	0	0	4000.00	25.00	0.00	DENY	00162
MM/DD/YY	LL#####L	000000######XX##	MM/DD/YY	2946	C	195-1			0.00		
CPICXXXXXX	LASTNAME	####-#########-#-#	MM/DD/YY	0	0	0	4000.00	0.00	0.00	DENY	00848
MM/DD/YY	LL#####L	000000######XX##	MM/DD/YY	2946	C	127-1			0.00		

* = PREVIOUSLY PENDED CLAIM
** = NEW PEND

TOTAL AMOUNT ORIGINAL CLAIMS	DENIED	12000.00	NUMBER OF CLAIMS	3
NET AMOUNT ADJUSTMENTS	DENIED	0.00	NUMBER OF CLAIMS	0
NET AMOUNT VOIDS	DENIED	0.00	NUMBER OF CLAIMS	0
NET AMOUNT VOIDS – ADJUSTS		0.00	NUMBER OF CLAIMS	0

Exhibit 3.5.7-2

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MEDICAID MANAGEMENT INFORMATION SYSTEM
MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

TO: ABC INPATIENT
123 MAIN STREET
ANYTOWN, NEW YORK 11111

ETIN:
INPATIENT
PROV ID: ########/##########
REMITTANCE NO ###########

PATIENT CONTROL NO / DATE	CLIENT NAME / ID NUMBER	TCN / MEDICAL RECORD NUMBER	SERVICE DATES FROM / THRU	COV'D DAYS / RATE CODE	OUT DAYS / PAY TYPE	TOT DAYS / DRG CODE	COVERAGE BASE	CO-PAY	OTHER INSURANCE PAID	STATUS	ERRORS
CPICXXXXXX	LASTNAME	####-#########-#-#	MM/DD/YY	2	0	0	4000.00	25.00	0.00	PAID	
MM/DD/YY	LL#####L	000000######XX##		2946	C	311-1			4000.00		
CPICXXXXXX	LASTNAME	####-#########-#-#	MM/DD/YY	5	0	0	4000.00	25.00	0.00	PAID	
MM/DD/YY	LL#####L	000000######XX##	MM/DD/YY	2946	C	079-1			4000.00		
CPICXXXXXX	LASTNAME	####-#########-#-#	MM/DD/YY	5	0	0	4000.00	0.00	0.00	PAID	
MM/DD/YY	LL#####L	000000######XX##	MM/DD/YY	2946	C	140-1			4000.00		

* = PREVIOUSLY PENDED CLAIM
** = NEW PEND

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

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MEDICAID MANAGEMENT INFORMATION SYSTEM
MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

TO: ABC INPATIENT
123 MAIN STREET
ANYTOWN, NEW YORK 11111

ETIN:
INPATIENT
PROV ID: ########/##########
REMITTANCE NO ###########

PATIENT CONTROL NO / DATE	CLIENT NAME / ID NUMBER	TCN / MEDICAL RECORD NUMBER	SERVICE DATES FROM / THRU	COV'D DAYS / RATE CODE	OUT DAYS / PAY TYPE	TOT DAYS / DRG CODE	COVERAGE BASE	CO-PAY	OTHER INSURANCE PAID	STATUS	ERRORS
CPICXXXXXX	LASTNAME	####-#########-#-#	MM/DD/YY	0	0	0	4000.00	25.00	0.00	PEND	00162
MM/DD/YY	LL#####L	000000######XX##		2959	C	122-1			0.00		
CPICXXXXXX	LASTNAME	####-#########-#-#	MM/DD/YY	0	0	0	4000.00	25.00	0.00	PEND	00142
MM/DD/YY	LL#####L	000000######XX##	MM/DD/YY	2959	C	088-1			0.00		
CPICXXXXXX	LASTNAME	####-#########-#-#	MM/DD/YY	0	0	0	4000.00	0.00	0.00	PEND	00144
MM/DD/YY	LL#####L	000000######XX##	MM/DD/YY	2959	C	296-1			0.00		

* = PREVIOUSLY PENDED CLAIM
** = NEW PEND

TOTAL AMOUNT ORIGINAL CLAIMS	PEND	12000.00	NUMBER OF CLAIMS	3
NET AMOUNT ADJUSTMENTS	PEND	0.00	NUMBER OF CLAIMS	0
NET AMOUNT VOIDS	PEND	0.00	NUMBER OF CLAIMS	0
NET AMOUNT VOIDS – ADJUSTS		0.00	NUMBER OF CLAIMS	0

REMITTANCE TOTALS – INPATIENT

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

MEMBER ID: ########

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

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MEDICAID MANAGEMENT INFORMATION SYSTEM
MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

TO: ABC INPATIENT
123 MAIN STREET
ANYTOWN, NEW YORK 11111

ETIN:
INPATIENT
GRAND TOTALS
PROV ID: ##########/##########
REMITTANCE NO: ##########

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

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

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

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

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

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

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

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

Coverage Base

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

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

Co-Pay

The co-pay amount for which the 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

Exhibit 3.5.8-1

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CYCLE 1563

MEDICAID MANAGEMENT INFORMATION SYSTEM
MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

TO: ABC NURSING HOME
123 MAIN STREET
ANYTOWN, NEW YORK 11111

ETIN:
NURSING HOME
PROV ID: ##########
REMITTANCE NO: ##########

CLIENT NAME / ID NUMBER	TCN / PATIENT ACCOUNT NUMBER	SERVICE DATES FROM / THRU	RATE CODE	REP'TED CALC'ED DAYS F	C	FULL DAYS CO-INSURANCE DAYS	PATIENT PARTICIPATION REPORTED / DEDUCTED	OTHER INSURANCE	AMOUNT CHARGED / AMOUNT PAID	STATUS	ERRORS
LASTNAME LL#####L	####-#########-#-# 000000######XX##	MM/DD/YY MM/DD/YY	4170	5 5	0	0.00 0.00	0.00	0.00	387.81 0.00	DENY	*01023 01035*
LASTNAME LL#####L	####-#########-#-# 000000######XX##	MM/DD/YY MM/DD/YY	4170	5 5	0	0.00 0.00	0.00	0.00	387.81 0.00	DENY	*01023*

* = PREVIOUSLY PENDED CLAIM
** = NEW PEND

TOTAL AMOUNT ORIGINAL CLAIMS	DENIED	775.62	NUMBER OF CLAIMS	2
NET AMOUNT ADJUSTMENTS	DENIED	0.00	NUMBER OF CLAIMS	0
NET AMOUNT VOIDS	DENIED	0.00	NUMBER OF CLAIMS	0
NET AMOUNT VOIDS – ADJUSTS		0.00	NUMBER OF CLAIMS	0

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CYCLE 1563

MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

TO: ABC NURSING HOME
123 MAIN STREET
ANYTOWN, NEW YORK 11111

ETIN:
NURSING HOME
PROV ID: ########/#########
REMITTANCE NO: ##########

CLIENT NAME / ID NUMBER	TCN / PATIENT ACCOUNT NUMBER	SERVICE DATES FROM / THRU	RATE CODE	REP'TED CALC'ED DAYS F C	FULL DAYS CO-INSURANCE DAYS PAYMENT	PATIENT PARTICIPATION REPORTED / DEDUCTED	OTHER INSURANCE	AMOUNT CHARGED / AMOUNT PAID	STATUS	ERRORS
LASTNAME LL#####L	####-##########-#-# 000000######XX##	MM/DD/YY MM/DD/YY	4170	5 0 5	387.81 0.00	0.00	0.00	387.81 387.81	PAID	
LASTNAME LL#####L	####-##########-#-# 000000######XX##	MM/DD/YY MM/DD/YY	4170	5 0 5	387.81 0.00	0.00	0.00	387.81 387.81	PAID	
LASTNAME LL#####L	####-##########-#-# 000000######XX##	MM/DD/YY MM/DD/YY	4170	5 0 5	387.81 0.00	0.00	0.00	387.81 387.81	PAID	
LASTNAME LL#####L	####-##########-#-# 000000######XX##	MM/DD/YY MM/DD/YY	4170	5 0 5	387.81 0.00	0.00	0.00	387.81 387.81	PAID	
LASTNAME LL#####L	####-##########-#-# 000000######XX##	MM/DD/YY MM/DD/YY	4170	5 0 5	387.81 0.00	0.00	0.00	387.81 387.81-	ADJT	ORIGIN AL CLAIM PAID
LASTNAME LL#####L	####-##########-#-# 000000######XX##	MM/DD/YY MM/DD/YY	4170	4 0 4	298.77 0.00	0.00	0.00	298.77 298.77	ADJT	

* = PREVIOUSLY PENDED CLAIM
** = NEW PEND

TOTAL AMOUNT ORIGINAL CLAIMS	PAID	1551.24	NUMBER OF CLAIMS	5
NET AMOUNT ADJUSTMENTS	PAID	89.04-	NUMBER OF CLAIMS	1
NET AMOUNT VOIDS	PAID	0.00	NUMBER OF CLAIMS	0
NET AMOUNT VOIDS – ADJUSTS		89.04-	NUMBER OF CLAIMS	1

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CYCLE 1563

MEDICAID MANAGEMENT INFORMATION SYSTEM
MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

TO: ABC NURSING HOME
123 MAIN STREET
ANYTOWN, NEW YORK 11111

ETIN:
NURSING HOME
PROV ID: ##########
REMITTANCE NO: ##########

CLIENT NAME / ID NUMBER	TCN / PATIENT ACCOUNT NUMBER	SERVICE DATES FROM / THRU	RATE CODE	REP'TED DAYS F	CALC'ED DAYS C	FULL DAYS CO-INSURANCE DAYS	PATIENT PARTICIPATION REPORTED	PATIENT PARTICIPATION DEDUCTED	OTHER INSURANCE	AMOUNT CHARGED / AMOUNT PAID	STATUS	ERRORS
LASTNAME	#####-#########-#-#	MM/DD/YY	4170	5	0	0.00		0.00	0.00	387.81	**PEND	00162 00971
LL#####L	CPIC#-#####-#	MM/DD/YY		5		0.00				0.00		
LASTNAME	#####-#########-#-#	MM/DD/YY	4170	5	0	0.00		0.00	0.00	387.81	**PEND	01131
LL#####L	CPIC#-#####-#	MM/DD/YY		5		0.00				0.00		

* = PREVIOUSLY PENDED CLAIM
** = NEW PEND

TOTAL AMOUNT ORIGINAL CLAIMS	PEND	775.62	NUMBER OF CLAIMS	2
NET AMOUNT ADJUSTMENTS	PEND	0.00	NUMBER OF CLAIMS	0
NET AMOUNT VOIDS	PEND	0.00	NUMBER OF CLAIMS	0
NET AMOUNT VOIDS – ADJUSTS		0.00	NUMBER OF CLAIMS	0

REMITTANCE TOTALS – NURSING HOME

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	5

MEMBER ID: #######

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	5

Exhibit 3.5.8-4

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MEDICAID
MANAGEMENT INFORMATION SYSTEM
MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

TO: ABC NURSING HOME
123 MAIN STREET
ANYTOWN, NEW YORK 11111

ETIN:
NURSING HOME
PROV ID: ##################
GRAND TOTALS
REMITTANCE NO:###########

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

3.5.8.1 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: **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.

3.5.8.3 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

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

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MEDICAID MANAGEMENT INFORMATION SYSTEM
MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

TO: ABC PHARMACY
123 MAIN STREET
ANYTOWN, NEW YORK 11111

ETIN:
PHARMACY
PROV ID: ########/##########
REMITTANCE NO: ##########

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

TOTAL AMOUNT ORIGINAL CLAIMS	DENIED	240.00	NUMBER OF CLAIMS	4
NET AMOUNT ADJUSTMENTS	DENIED	0.00	NUMBER OF CLAIMS	0
NET AMOUNT VOIDS	DENIED	0.00	NUMBER OF CLAIMS	0
NET AMOUNT VOIDS – ADJUSTS		0.00	NUMBER OF CLAIMS	0

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MEDICAID MANAGEMENT INFORMATION SYSTEM

MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

TO: ABC PHARMACY
123 MAIN STREET
ANYTOWN, NEW YORK 11111

ETIN:
PHARMACY
PROV ID: ########/##########
REMITTANCE NO: ##########

PRESCRIPTION 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
#######	00173044100	54.000	LL#####L	LAST NAME	MM/MM/YY	####-#########-#-#	100.00	0.00	DENY	00162

*=PREVIOUSLY PENDED CLAIM
**=NEW PEND

TOTAL AMOUNT ORIGINAL CLAIMS	PAID	84.88	NUMBER OF CLAIMS	3
NET AMOUNT ADJUSTMENTS	PAID	90.00	NUMBER OF CLAIMS	1
NET AMOUNT VOIDS	PAID	0.00	NUMBER OF CLAIMS	0
NET AMOUNT VOIDS – ADJUSTS		20.00	NUMBER OF CLAIMS	1

Exhibit 3.5.9-3

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MEDICAID MANAGEMENT INFORMATION SYSTEM
MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

TO: ABC PHARMACY
123 MAIN STREET
ANYTOWN, NEW YORK 11111

ETIN:
PHARMACY
PROV ID: ########/#########
REMITTANCE NO: ##########

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

TOTAL AMOUNT ORIGINAL CLAIMS	PEND 171 .00	NUMBER OF CLAIMS	4
NET AMOUNT ADJUSTMENTS	PEND 00.00	NUMBER OF CLAIMS	0
NET AMOUNT VOIDS	PEND 00.00	NUMBER OF CLAIMS	0
NET AMOUNT VOIDS – ADJUSTS	00.00	NUMBER OF CLAIMS	0

REMITTANCE TOTALS – PHARMACY

VOIDS – ADJUSTS	20.00	NUMBER OF CLAIMS	1
TOTAL PENDS	171.00	NUMBER OF CLAIMS	4
TOTAL PAID	84.88	NUMBER OF CLAIMS	3
TOTAL DENIED	240.00	NUMBER OF CLAIMS	4
NET TOTAL PAID	64.88	NUMBER OF CLAIMS	4

MEMBER ID: ########

VOIDS – ADJUSTS	20.00	NUMBER OF CLAIMS	1
TOTAL PENDS	171.00	NUMBER OF CLAIMS	4
TOTAL PAID	84.88	NUMBER OF CLAIMS	3
TOTAL DENIED	240.00	NUMBER OF CLAIMS	4
NET TOTAL PAID	64.88	NUMBER OF CLAIMS	4

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DATE 08/06/07
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MEDICAID
MANAGEMENT INFORMATION SYSTEM
MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

TO: ABC PHARMACY
123 MAIN STREET
ANYTOWN, NEW YORK 11111

ETIN:
PHARMACY
PROV ID: ##########
GRAND TOTALS
REMITTANCE NO;##########

REMITTANCE TOTALS – GRAND TOTALS			
VOIDS – ADJUSTS	20.00	NUMBER OF CLAIMS	1
TOTAL PENDS	171.00	NUMBER OF CLAIMS	4
TOTAL PAID	84.88	NUMBER OF CLAIMS	3
TOTAL DENY	240.00	NUMBER OF CLAIMS	4
NET TOTAL PAID	64.88	NUMBER OF CLAIMS	4

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

3.5.9.2 Explanation 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.

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.

3.5.9.3Subtotals/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
- 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

Exhibit 3.5.10-1

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MEDICAID
MANAGEMENT INFORMATION SYSTEM
MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

TO: ABC PRACTITIONER
123 MAIN STREET
ANYTOWN, NEW YORK 11111

ETIN:
PRACTITIONER
PROV ID: ##########
REMITTANCE NO: ##########

LN. NO	OFFICE ACCOUNT NUMBER	CLIENT NAME	CLIENT ID NUMBER	TCN	DATE OF SERVICE	PROC. CODE	UNITS	CHARGED	PAID	STATUS	ERRORS
01	CPXXXXXX	LASTNAME	LL#####L	####-##########-#-#	MM/DD/YY	90829	1.000	52.80	0.00	DENY	00162 00244
01	CPXXXXXX	LASTNAME	LL#####L	####-##########-#-#	MM/DD/YY	90804	1.000	17.60	0.00	DENY	00244
01	CPXXXXXX	LASTNAME	LL#####L	####-##########-#-#	MM/DD/YY	91105	1.000	14.30	0.00	DENY	00162
01	CPXXXXXX	LASTNAME	LL#####L	####-##########-#-#	MM/DD/YY	90945	1.000	77.50	0.00	DENY	00131

*=PREVIOUSLY PENDED CLAIM
**=NEW PEND

TOTAL AMOUNT ORIGINAL CLAIMS	DENIED	162.20	NUMBER OF CLAIMS	4
NET AMOUNT ADJUSTMENTS	DENIED	0.00	NUMBER OF CLAIMS	0
NET AMOUNT VOIDS	DENIED	0.00	NUMBER OF CLAIMS	0
NET AMOUNT VOIDS – ADJUSTS		0.00	NUMBER OF CLAIMS	0

Exhibit 3.5.10-2

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MEDICAID MANAGEMENT INFORMATION SYSTEM
MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

TO: ABC PRACTITIONER
123 MAIN STREET
ANYTOWN, NEW YORK 11111

ETIN:
PRACTITIONER
PROV ID: ########/##########
REMITTANCE NO: ##########

LN. NO	OFFICE ACCOUNT NUMBER	CLIENT NAME	CLIENT ID NUMBER	TCN	DATE OF SERVICE	PROC. CODE	UNITS	CHARGED	PAID	STATUS	ERRORS
01	CPXXXXXX	LASTNAME	LL#####L	####-#########-#-#	MM/DD/YY	91105	1.000	14.30	14.30	PAID	
02	CPXXXXXX	LASTNAME	LL#####L	####-#########-#-#	MM/DD/YY	90846	1.000	14.30	14.30	PAID	
01	CPXXXXXX	LASTNAME	LL#####L	####-#########-#-#	MM/DD/YY	99221	1.000	52.80	52.80	PAID	
01	CPXXXXXX	LASTNAME	LL#####L	####-#########-#-#	MM/DD/YY	99111	1.000	66.00	66.00	PAID	
01						99285	1.000	17.60		ADJT	ORIGINAL CLAIM PAID MM/DD/YY
	CPXXXXXX	LASTNAME	LL#####L	####-#########-#-#	MM/DD/YY				17.60-		
01	CPXXXXXX	LASTNAME	LL#####L	####-#########-#-#	MM/DD/YY	99281	1.000	14.30	14.00	ADJT	

*=PREVIOUSLY PENDED CLAIM
**=NEW PEND

TOTAL AMOUNT ORIGINAL CLAIMS	PAID	147.40	NUMBER OF CLAIMS		4
NET AMOUNT ADJUSTMENTS	PAID	3.60	- NUMBER OF CLAIMS		1
NET AMOUNT VOIDS	PAID	0.00	NUMBER OF CLAIMS		0
NET AMOUNT VOIDS – ADJUSTS		3.60	- NUMBER OF CLAIMS		1

Exhibit 3.5.10-3

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MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
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TO: ABC PRACTITIONER
123 MAIN STREET
ANYTOWN, NEW YORK 11111

ETIN:
PRACTITIONER
PROV ID: ##########
REMITTANCE NO: ##########

LN. NO	OFFICE ACCOUNT NUMBER	CLIENT NAME	CLIENT ID NUMBER	TCN	DATE OF SERVICE	PROC. CODE	UNITS	CHARGED	PAID	STATUS	ERRORS
01	CPXXXXXX	LASTNAME	LL#####L	####-#########-#-#	MM/DD/YY	90828	1.000	69.30	0.00	**PEND	00162
02	CPXXXXXX	LASTNAME	LL#####L	####-#########-#-#	MM/DD/YY	90814	1.000	71.04	0.00	**PEND	00162
01	CPXXXXXX	LASTNAME	LL#####L	####-#########-#-#	MM/DD/YY	91105	1.000	14.30	0.00	**PEND	00142
01	CPXXXXXX	LASTNAME	LL#####L	####-#########-#-#	MM/DD/YY	91105	1.000	14.30	0.00	**PEND	00131

*=PREVIOUSLY PENDED CLAIM
**=NEW PEND

TOTAL AMOUNT ORIGINAL CLAIMS	PEND	168.94	NUMBER OF CLAIMS	4
NET AMOUNT ADJUSTMENTS	PEND	0.00	NUMBER OF CLAIMS	0
NET AMOUNT VOIDS	PEND	0.00	NUMBER OF CLAIMS	0
NET AMOUNT VOIDS – ADJUSTS		0.00	NUMBER OF CLAIMS	0

REMITTANCE TOTALS – PRACTITIONER

VOIDS – ADJUSTS	3.60 -	NUMBER OF CLAIMS	1
TOTAL PENDS	168.94	NUMBER OF CLAIMS	4
TOTAL PAID	147.40	NUMBER OF CLAIMS	4
TOTAL DENIED	162.20	NUMBER OF CLAIMS	4
NET TOTAL PAID	143.80	NUMBER OF CLAIMS	5

MEMBER ID: ########

VOIDS – ADJUSTS	3.60 -	NUMBER OF CLAIMS	1
TOTAL PENDS	168.94	NUMBER OF CLAIMS	4
TOTAL PAID	147.40	NUMBER OF CLAIMS	4
TOTAL DENIED	162.20	NUMBER OF CLAIMS	4
NET TOTAL PAID	143.80	NUMBER OF CLAIMS	5

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ANYTOWN, NEW YORK 11111

ETIN:
PRACTITIONER
PROV ID: ##################
REMITTANCE NO: ##########

REMITTANCE TOTALS – GRAND TOTALS

VOIDS – ADJUSTS	3.60	-	NUMBER OF CLAIMS	1
TOTAL PENDS	168.94		NUMBER OF CLAIMS	4
TOTAL PAID	147.40		NUMBER OF CLAIMS	4
TOTAL DENY	162.20		NUMBER OF CLAIMS	4
NET TOTAL PAID	143.80		NUMBER OF CLAIMS	5

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	CPXXXXXX	LASTNAME	LL#####L	####-#########-##	MM/DD/YY	90828	1.000	35.00	57.00	**PEND	
MEDICAL HOME ADD_ON: 22.00											

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

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

Exhibit 3.5.11-1

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REMITTANCE STATEMENT

TO: ABC TRANSPORTATION
123 MAIN STREET
ANYTOWN, NEW YORK 11111

ETIN:
TRANSPORTATION
PROV ID: ########/##########
REMITTANCE NO: ##########

LN. NO	OFFICE ACCOUNT NUMBER	CLIENT NAME	CLIENT ID NUMBER	TCN	DATE OF SERVICE	PROC. CODE	UNITS	CHARGED	PAID	STATUS	ERRORS
01	CPXXXXXX	LASTNAME	LL#####L	####-##########-#-#	MM/DD/YY	NY211	48.000	52.80	0.00	DENY	00162 00244
01	CPXXXXXX	LASTNAME	LL#####L	####-##########-#-#	MM/DD/YY	NY211	16.000	17.60	0.00	DENY	00244
01	CPXXXXXX	LASTNAME	LL#####L	####-##########-#-#	MM/DD/YY	NY211	13.000	14.30	0.00	DENY	00162
01	CPXXXXXX	LASTNAME	LL#####L	####-##########-#-#	MM/DD/YY	NY211	63.000	77.50	0.00	DENY	00131

*=PREVIOUSLY PENDED CLAIM
**=NEW PEND

TOTAL AMOUNT ORIGINAL CLAIMS	DENIED	162.20	NUMBER OF CLAIMS	4
NET AMOUNT ADJUSTMENTS	DENIED	0.00	NUMBER OF CLAIMS	0
NET AMOUNT VOIDS	DENIED	0.00	NUMBER OF CLAIMS	0
NET AMOUNT VOIDS – ADJUSTS		0.00	NUMBER OF CLAIMS	0

Exhibit 3.5.11-2

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TO: ABC TRANSPORTATION
123 MAIN STREET
ANYTOWN, NEW YORK 11111

ETIN:
TRANSPORTATION
PROV ID: ##########
REMITTANCE NO: ##########

LN. NO	OFFICE ACCOUNT NUMBER	CLIENT NAME	CLIENT ID NUMBER	TCN	DATE OF SERVICE	PROC. CODE	UNITS	CHARGED	PAID	STATUS	ERRORS
01	CPXXXXXX	LASTNAME	LL#####L	####-#########-#-#	MM/DD/YY	NY211	13.000	14.30	14.30	PAID	
02	CPXXXXXX	LASTNAME	LL#####L	####-#########-#-#	MM/DD/YY	NY211	13.000	14.30	14.30	PAID	
01	CPXXXXXX	LASTNAME	LL#####L	####-#########-#-#	MM/DD/YY	NY211	48.000	52.80	52.80	PAID	
01	CPXXXXXX	LASTNAME	LL#####L	####-#########-#-#	MM/DD/YY	NY211	66.000	66.00	66.00	PAID	
01	CPXXXXXX	LASTNAME	LL#####L	####-#########-#-#	MM/DD/YY	NY211	17.000	17.60	17.60-	ADJT	ORIGINAL CLAIM PAID MM/DD/YY
01	CPXXXXXX	LASTNAME	LL#####L	####-#########-#-#	MM/DD/YY	NY211	13.000	14.30	14.00	ADJT	

*=PREVIOUSLY PENDED CLAIM
**=NEW PEND

TOTAL AMOUNT ORIGINAL CLAIMS	PAID	147.40	NUMBER OF CLAIMS		4
NET AMOUNT ADJUSTMENTS	PAID	3.60	- NUMBER OF CLAIMS		1
NET AMOUNT VOIDS	PAID	0.00	NUMBER OF CLAIMS		0
NET AMOUNT VOIDS – ADJUSTS		3.60	- NUMBER OF CLAIMS		1

Exhibit 3.5.11-3

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MEDICAID MANAGEMENT INFORMATION SYSTEM
MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

TO: ABC TRANSPORTATION
123 MAIN STREET
ANYTOWN, NEW YORK 11111

ETIN:
TRANSPORTATION
PROV ID: ##########
REMITTANCE NO: ##########

LN. NO	OFFICE ACCOUNT NUMBER	CLIENT NAME	CLIENT ID NUMBER	TCN	DATE OF SERVICE	PROC. CODE	UNITS	CHARGED	PAID	STATUS	ERRORS
01	CPXXXXXX	LASTNAME	LL#####L	####-#########-#-#	MM/DD/YY	NY211	60.000	69.30	0.00	**PEND	00162
02	CPXXXXXX	LASTNAME	LL#####L	####-#########-#-#	MM/DD/YY	NY211	63.000	71.04	0.00	**PEND	00162
01	CPXXXXXX	LASTNAME	LL#####L	####-#########-#-#	MM/DD/YY	NY211	13.000	14.30	0.00	**PEND	00142
01	CPXXXXXX	LASTNAME	LL#####L	####-#########-#-#	MM/DD/YY	NY211	13.000	14.30	0.00	**PEND	00131

*=PREVIOUSLY PENDED CLAIM
**=NEW PEND

TOTAL AMOUNT ORIGINAL CLAIMS	PEND	168.94	NUMBER OF CLAIMS		4
NET AMOUNT ADJUSTMENTS	PEND	0.00	NUMBER OF CLAIMS		0
NET AMOUNT VOIDS	PEND	0.00	NUMBER OF CLAIMS		0
NET AMOUNT VOIDS – ADJUSTS		0.00	NUMBER OF CLAIMS		0
REMITTANCE TOTALS – TRANSPORTATION					
VOIDS – ADJUSTS		3.60	- NUMBER OF CLAIMS		1
TOTAL PENDS		168.94	NUMBER OF CLAIMS		4
TOTAL PAID		147.40	NUMBER OF CLAIMS		4
TOTAL DENIED		162.20	NUMBER OF CLAIMS		4
NET TOTAL PAID		143.80	NUMBER OF CLAIMS		5
MEMBER ID: ########					
VOIDS – ADJUSTS		3.60	- NUMBER OF CLAIMS		1
TOTAL PENDS		168.94	NUMBER OF CLAIMS		4
TOTAL PAID		147.40	NUMBER OF CLAIMS		4
TOTAL DENIED		162.20	NUMBER OF CLAIMS		4
NET TOTAL PAID		143.80	NUMBER OF CLAIMS		5

Exhibit 3.5.11-4

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TO: ABC TRANSPORTATION
123 MAIN STREET
ANYTOWN, NEW YORK 11111

ETIN:
TRANSPORTATION
GRAND TOTALS
PROV ID: ##########
REMITTANCE NO: ##########

REMITTANCE TOTALS – GRAND TOTALS

VOIDS – ADJUSTS	3.60	-	NUMBER OF CLAIMS	1
TOTAL PENDS	168.94		NUMBER OF CLAIMS	4
TOTAL PAID	147.40		NUMBER OF CLAIMS	4
TOTAL DENY	162.20		NUMBER OF CLAIMS	4
NET TOTAL PAID	143.80		NUMBER OF CLAIMS	5

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

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ANYTOWN, NEW YORK 11111

ETIN:
TRANSPORTATION
FINANCIAL TRANSACTIONS
PROV ID: ##################
REMITTANCE NO: ##########

FCN	FINANCIAL REASON CODE	FISCAL TRANS TYPE	DATE	AMOUNT
200705060236547	XXX	RECOUPMENT REASON DESCRIPTION	05 09 07	$$.$$

NET FINANCIAL TRANSACTION AMOUNT $$$.$$
NUMBER OF FINANCIAL TRANSACTIONS XXX

3.6.1.1 Explanation 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.

3.6.1.2 Explanation 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

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TO: ABC TRANSPORTATION
123 MAIN STREET
ANYTOWN, NEW YORK 11111

ETIN:
TRANSPORTATION
ACCOUNTS RECEIVABLE
PROV ID: ########/##########
REMITTANCE NO: ##########

REASON CODE	DESCRIPTION	ORIG BAL	CURR BAL	RECOUP %/AMT
		$XXX.XX-	$XXX.XX-	999
		$XXX.XX-	$XXX.XX-	999

TOTAL AMOUNT DUE THE STATE $XXX.XX

3.6.2.1Explanation 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.

Exhibit 3.7-1

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TO: ABC TRANSPORTATION
123 MAIN STREET
ANYTOWN, NEW YORK 11111

ETIN:
TRANSPORTATION
EDIT DESCRIPTIONS
PROV ID: ##########
REMITTANCE NO: ##########

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

00127	MEDICARE PAID AMOUNT LESS THAN REASONABLE
00142	SERVICE CODE NOT EQUAL TO PA
00144	RECIPIENT SEX NOT EQUAL TO FILE
00162	RECIPIENT INELIGIBLE ON DATE OF SERVICE
01154	NO UT SERVICE AUTHORIZATION ON FILE

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 accepted or rejected. For electronic claims eMedNY provides the front-end 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: https://www.emedny.org/HIPAA/QuickRefDocs/FOD-7001_Sub_Claims_Over_90_days_Old_04-17-12.pdf.

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 www.emedny.org.