NEW YORK STATE
MEDICAID PROGRAM

INFORMATION FOR ALL PROVIDERS

INTRODUCTION

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Preface

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

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

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

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

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

Past issues of *Medicaid Update* are available at:

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

Foreword

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

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

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

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

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

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

Medicaid Management Information System

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

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

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

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

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

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

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

- Maintains the Medicaid Eligibility Verification System (MEVS).

Key Features

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

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

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

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

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

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

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

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

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

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

  http://www.emedny.org/.

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GENERAL POLICY

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Section I – Enrollee Information

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

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

- Citizens and certain qualified persons who are:

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

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

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

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

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

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

  These groups generally include:

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

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

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

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

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

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

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

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

Identification of Medicaid Eligibility

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

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

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

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

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

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

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

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

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

The MEVS Provider Manual is available online at:

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

Eligible Enrollees

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

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

Ineligible Patients

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

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

Emergency Situations

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

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

Services Available Under the Medicaid Program

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

Payment may be made for necessary:

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

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

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

Qualified Medicare Beneficiary

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

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

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

Free Choice

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

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

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

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

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

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

Right to Refuse Medical Care

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

Civil Rights

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

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

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

Confidentiality

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

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

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

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

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

When Medicaid Enrollees Cannot be Billed

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

Acceptance and Agreement

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

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

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

Claim Submission

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

Collections

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

Emergency Medical Care

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

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

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

Claiming Problems

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

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

Prior Approval

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

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

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

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

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

Prior Approval and Payment

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

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

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

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

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

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

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

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

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

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

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

Prior Authorization

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

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

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

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

Utilization of Insurance Benefits

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

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

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

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

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

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

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

Fair Hearing

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

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

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

Billing

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

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

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

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

Record Keeping

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

Section II – Provider Information

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

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

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

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

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

Enrollment of Providers

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

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

Applications for Enrollment/Re-enrollment

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

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

Denial of an Application

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

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

Review of Denial

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

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

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

Termination of Enrollment

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

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

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

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

Duties of the Provider

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

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

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

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

Keeping Current with Policy Information

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

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

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

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

(800) 343-9000.

Change of Address

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

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

Out-of-State Medical Care and Services

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

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

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

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

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

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

Non-Emergent Inpatient Care

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

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

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

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

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

Prior Approval

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

Billing Procedures

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

Record-Keeping Requirements

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

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

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

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

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

General Exclusions from Coverage Under Medicaid

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

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

- Which are medically unnecessary;

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

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

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

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

Unacceptable Practices

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

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

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

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

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

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

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

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

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

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

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

Process for Resolving Unacceptable Practices

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

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

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

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

Affiliated Persons

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

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

Some examples of affiliated persons are the following:

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

- agents and managing employees of a provider;

- providers who share common managing employees;

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

Agency Action

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

Suspension or Withholding of Payments

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

Hearings

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

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

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

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

Administrative Sanctions

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

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

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

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

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

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

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

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

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

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

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

Guidelines for Sanctions

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

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

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

- The amount of damages to the Program;

- Mitigating circumstances;

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

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

Immediate Sanctions

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

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

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

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

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

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

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

Reinstatement

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

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

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

- Include a complete ownership and control disclosure statement;

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

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

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

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

Audits

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

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

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

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

Recovery of Overpayments

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

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

Recoupment

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

Withholding of Payments

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

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

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

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

The withholding may continue as follows:

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

Fraud

Examples of fraud include when a person knowingly:

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

Office of the Medicaid Inspector General

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

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

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

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

The OMIG also has broad subpoena powers:

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

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

For more information, please refer to the OMIG website:

www.omig.state.ny.us.

The OMIG website contains:

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

Prohibition Against Reassignment of Claims: Factoring

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

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

Exceptions

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

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

Services Subject to Co-Payments

The following services are subject to a co-payment:

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

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

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

Co-payment Maximum

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

Co-payment Exemptions

The following are exempt from all Medicaid co-payments:

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

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

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

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

Section III – Ordering Non-Emergency Medical Transportation

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

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

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

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

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

Responsibilities of the Ordering Practitioner

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

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

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

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

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

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

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

Non-emergency Ambulance

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

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

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

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

Ambulette

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

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

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

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

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

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

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

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

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

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

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

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

Livery Transportation

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

- Attending physician;

- Physician's assistant;

- Nurse practitioner;

- Dentist;

- Optometrist;

- Podiatrist; or

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

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

Day Treatment Transportation

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

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

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

Required Documentation

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

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

Making the Request for Authorization

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

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

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

Section IV - Family Planning Services

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

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

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

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

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

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

Patient Rights

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

Standards for Providers

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

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

Sterilizations

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

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

Informed Consent

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

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

Waiting Period

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

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

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

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

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

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

Minimum Age

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

Mental Competence

The patient must be a mentally competent individual.

Institutionalized Individual

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

Restrictions on Circumstances in Which Consent is Obtained

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

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

Foreign Languages

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

Handicapped Persons

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

Presence of Witness

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

Reaffirmation Statement (NYC Only)

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

Sterilization Consent Form

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

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

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

New York City

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

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

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

Hysterectomies

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

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

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

1. The woman was sterile prior to the hysterectomy;

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

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

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

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

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

Induced Termination of Pregnancy

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

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

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

Obstetrical Services

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

Antepartum Care

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

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

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

Intrapartum Care

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

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

Postpartum Care

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

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

Other Medical Care

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

Section V – Related Programs

Child/Teen Health Program

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

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

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

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

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

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

Preferred Physicians and Children Program

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

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

Application for the Preferred Physicians and Children Program

PPAC provider enrollment applications may be obtained online at:

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

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

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

Physician Eligibility and Practice Requirements

The qualified primary care physician will:

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

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

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

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

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

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

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

- Provide 24-hour telephone coverage for consultation.

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

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

- Provide medical care coordination.

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

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

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

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

The qualified non-primary care specialist physician will:

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

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

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

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

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

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

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

- Notify the primary care physician when scheduling hospital admission;

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

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

Covered Services

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

The PPAC participating provider may NOT bill for:

- physician services provided in Article 28 clinics or

- contractual physician services in emergency rooms.

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

Physically Handicapped Children's Program

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

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

Services Available and Conditions Covered

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

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

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

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

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

Eligibility

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

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

Financing

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

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

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

Prior Approval

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

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

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

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

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

Family Care Program

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

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

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

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

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

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

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

Family Planning Benefit Program

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

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

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

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

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

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

Prenatal Care Assistance Program

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

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

Providers interested in this Program may go online to:

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

or

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

Medicaid Obstetrical and Maternal Services Program

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

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

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

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

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

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

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

(518) 474-1911.

MOMS Eligibility and Practice Requirements
Physicians who participate must:

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

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

For physician enrollment information, please go online to:

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

For additional information, please go to:

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

Utilization Threshold Program

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

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

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

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

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

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

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

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

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

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

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

Recipient Restriction Program

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

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

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

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

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

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

MEVS Implications for the RRP

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

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

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

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

Managed Care

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

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

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

Certain individuals are excluded from participating on Medicaid Managed Care:

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

MEVS Implications for Managed Care

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

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

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

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

Section VI – Definitions

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

Emergency

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

Emergency Services

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

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

Factor

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

Local Professional Director

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

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

Managed Care

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

Prior Approval

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

Prior approval does not guarantee payment.

Prior Authorization

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

Prior authorization does not guarantee payment.

Qualified Medicare Enrollee

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

QMB status is determined via the MEVS.

Unacceptable Practice

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

Urgent Medical Care

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

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

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

NEW YORK STATE
MEDICAID PROGRAM

INFORMATION FOR ALL PROVIDERS
GENERAL BILLING

Table of Contents

Common Benefit Identification Card

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Voice Interactive Phone System

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

Prior Approval Rosters

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

Electronic Roster

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

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

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

What information is included on the electronic roster?

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

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

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

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

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

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

The electronic prior approval request for is available at:

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

Billing for Medical Assistance Services

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

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

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

Claims Submitted for Stop-Loss Payments

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

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

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

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

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

Acceptable Delay Reasons

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

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

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

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

- **Litigation**

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

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

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

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

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

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

- **Delay in Supplying Billing Forms**

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

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

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

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

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

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

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

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

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

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

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

- **Other/Interrupted Maternity Care**

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

Claims Over Two Years Old

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

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

- Court-ordered payments.

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

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

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

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

Electronic Claims Submission

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

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

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

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

Claim Status Options

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

ePACES

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

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

ePACES Real Time

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

Electronic Claim Status Request

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

Electronic Claim Status Responses

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

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

Paper Remittance

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

Electronic Remittance

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

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

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

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

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

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

Electronic Funds Transfer

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

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

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

Claims Pended for Review by the Office of the State Comptroller

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

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

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

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

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

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

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

HIPAA Claim Denials

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

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

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

Good Cause

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

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

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

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

(800) 541-2831.

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

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

Claim Certification Statement

Provider certifies that:

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

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

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

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

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

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

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

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

NEW YORK STATE
MEDICAID PROGRAM

INFORMATION FOR ALL PROVIDERS

INQUIRY

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Computer Sciences Corporation Contact Information

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

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

Hours of Operation

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

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

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

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

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

Telephone Directory

If you are a:

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

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

Then, depending on your question:

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

If you are a:

- Pharmacy Provider

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

Then, depending on your question:

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

If you are a:

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

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

Then, depending on your question:

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

If you are a:

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

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

Then, depending on your question:

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

If your question concerns:

- MOAS; or
- Threshold override application provider support

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

Training Requests

Requests for individual provider training can be made by calling

(800) 343-9000

or email:

emednyproviderrelations@csc.com

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

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

Mailing Addresses for Medicaid Correspondence

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

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

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

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

Medicaid Program Contact Information

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

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

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

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

Fee-for-Service Provider Enrollment File Forms

Fee-for-Service Providers:

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

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

Rate Based Provider Enrollment File Forms

Rate Based Providers:

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

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

Pharmacy Programs

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

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

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

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

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

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

Local Departments of Social Services

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

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

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

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

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

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

NEW YORK STATE
MEDICAID PROGRAM

INFORMATION FOR ALL PROVIDERS

THIRD PARTY INFORMATION

Table of Contents

Third Party Health Resources

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

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

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

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

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

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

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

(800) 343-9000.

Insurance Coverage Codes

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

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

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

Recipient Other Insurance Codes

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

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

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

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

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

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

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

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

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

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

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

Prepaid Capitation Plans (PCP)

Note:

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

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

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

County/District Codes

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

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

NEW YORK STATE
MEDICAID PROGRAM

MANAGED CARE REFERENCE GUIDE:
ENROLLEE ROSTERS

TABLE OF CONTENTS

Section I – Purpose Statement

The purpose of this document is to assist participating managed care organizations in understanding and complying with the New York State Medicaid (NYS-Medicaid) requirements.

The guide addresses Enrollee Rosters.

This document is customized for managed care providers as an instructional as well as a reference tool.

Section II –Enrollee Rosters

Enrollee information is contained in rosters compiled by the State Department of Health (SDOH) for the Plans. The enrollee roster is the vehicle by which data such as Plan enrollment, guarantee date, and county of fiscal responsibility are distributed to the Plan.

Rosters are available on the HPN (Health Provider Network) for the Plan according to the SDOH Medicaid Monthly Schedule which is produced in November for the year ahead. All plans are required to utilize an Internet Service Provider (ISP) to access the HPN for purposes of accessing the Medicaid and Family Health Plus roster site.

The Internet site through which to access the HPN is:

This is a secure site with access granted by the Bureau of Managed Care Financing. **The HPN requires each user to possess a User ID and password** to enter the roster application. If you do not have a User ID and password, you should contact that Bureau at 518-474-5050. You will not be granted access to this site without proper authorization.

- ✓ Enter your **User ID and password**
- ✓ Click on the link for the **Health Provider Network** (HPN)
- ✓ Click on **Programs, Office of Managed Care Page and Rosters Home Page** Once you have clicked on the Rosters Home Page you will be able to select the files you have access to.

The specifications for the enrollee rosters are on the following pages.

A list of the County/District codes is provided in Appendix A and a list Insurance Coverage Codes can be found in Appendix B, at the end of this document. These lists of codes will help you in interpreting information included on your enrollee rosters.

Direct questions about the information contained in a Roster or the HPN, receipt date for Rosters, or the Medicaid Monthly Schedule may be directed to the State Department of Health's Managed Care Unit at (518) 474-5050.

Monthly Managed Care Roster File Layout and Field Descriptions

The Monthly Managed Care Recipient Roster lists every Medicaid recipient who is eligible for Medicaid as of the pulldown or processing date and enrolled in a managed care plan (MCO) for the upcoming month.

There are two roster reports generated each month. One (Primary) is produced around 10 days prior to the beginning of the effective month of the report, which is the weekend of the pulldown (for example, June 22nd for the July roster).

A second roster is produced the first full weekend after the beginning of the effective month (for example, July 6th for the July roster). The second report shows only additional enrollees who were not included on the first roster. These enrollees generally are added because their Medicaid eligibility recertification occurred later than the processing date (pulldown date) of the first roster, but was completed before the first day of the effective month. As a result, they were not reflected on the first roster, but added via the second roster production.

Data Elements

The following data is reported for each enrollee on the roster:

CIN – Enrollee's Medicaid Client Identification Number

Social Security Number – Enrollee's Social Security Number

Enrollee's Name

Enrollee's Sex

Enrollee's Date of Birth

Enrollee's Address

Case Number – Case number assigned by the local district

Local Office Code

Expiration Date – End of the month in which the roster expires

Medicaid Coverage
Code which defines the enrollee's type of Medicaid eligibility.

A	Full Medicaid Coverage
B	Full Medicaid Coverage except Long Term Care
L	Perinatal Family
T	HR/UT
P	Prepaid Capitation Plan (PCP) Coverage
G	PCP/Guarantee Coverage
Q	PCP/HR Coverage
R	PCP Guarantee/HR
U	Family Health Plus
W	Family Health Plus/Guarantee
Y	Aliessa Alien
1	Community Coverage w/Community Based Long Term Care
2	Community Coverage without Long Term Care
6	Community Coverage without Long Term Care (legal alien during 5 year ban)

Note: Generally local districts are expected to change recipients' fee for service coverage code from "A", "B", "L", "T" , "Y", "1", "2" or "6" to "P" or "G" when enrolled in a Medicaid managed care plan; however, failure to do so does not change the validity of plan enrollment.

Aid Category
Defines the type of medical assistance the enrollee is eligible for with the Medicaid program. This code is used to derive the rate code under which the capitation claim is paid (Aid to Dependent Children, HR, SSI, Family Health Plus).

Individual Disposition Status Code
Indicates whether recipient's case is active or closed. Valid code values are:

07	Active
08	Inactive
10	Inactive/Sanctioned
11	Denied
13	Deceased
15	Deleted
20	Case Closed"

Medicaid Exception Code
Code used to restrict type of medical services or to place processing constraints on enrollee. The only code displayed (if applicable) is "83 – Mandated Alcohol Substance and Abuse Treatment". All other exception code values are suppressed.

Medicare Code
Indicates the type of Medicare coverage for an enrollee.

2 Part A,
3 Part B,
1 Both Part A and B

Note: Any enrollee with Medicare coverage in a mainstream managed care plan or special needs plan must be disenrolled prospectively (based on the pulldown dates).

Health Insurance Claim Number (HIC) – Enrollee's Medicare Number

Benefit Package
Benefit package number assigned to the plan. The benefit package value is 70 for all Family Health Plus plans.

Capitation Code – Indicates enrollment in plan. "3" = enrolled

PCP Begin Date – Enrollee's most recent effective enrollment date

Rate Code
Four-digit code assigned during claims processing which represents enrollee's age, sex and aid categories. This corresponds to the capitation premium group. This field is suppressed for Special Needs Plans, as enrollees' HIV status is also factored in determining their rate.

Guarantee Date
The date through which capitation payments are guaranteed to the plan (calculated as 6 months subsequent to the initial enrollment date).

Authorization Through Date
The date through which the enrollee is eligible for Medicaid benefits

Recertification Date
The date of the onset of the recertification process for an enrollee. This date is available for New York City enrollees only.

Transaction Date
The date of the most recent capitation transaction for the enrollee on file

Insurance Code
Indicates any third party insurance for which the enrollee is eligible

Begin Date – The date third party insurance is applicable

End Date – The date third party insurance is terminated

Reason Code – Code indicates reason recipient is enrolled

Codes 00–04 indicate voluntary enrollment

05 and 06 indicate auto assignment

07 indicates automated newborn enrollment

New Indicator
Indicated for enrollees whose most recent enrollment effective date on file is equal to the roster effective date.

Monthly Roster File Layout and Field Descriptions				
Field Name	**Record Positions**		**Field Size**	**Explanation**
Trans-Dist	1	2	2	The two digit county/district code assigned by NYS to the county of fiscal responsibility for enrollee
Provider ID	3	10	8	The MMIS ID number of plan in which the recipient is enrolled
Recipient ID	11	18	8	The MMIS ID number of the enrollee
Filler	19	21	3	
Social Security Number	22	30	9	The SSN of enrollee
Last Name	31	46	16	The last name of enrollee
First Name	47	56	10	The first name of enrollee
Middle Initial	57	57	1	Middle initial of enrollee
Sex	58	58	1	Sex of enrollee (F=Female, M=Male, U=Unborn)
Date of Birth (MMDDCCYY)	59	66	8	Date of birth of enrollee
Care of Name	67	82	16	Name of person in care of enrollee
Street	83	110	28	Street address of person in care of enrollee (Mailing address)
City	111	125	15	City address of person in care of enrollee
State	126	127	2	State address of person in care of enrollee
Zip Code	128	132	5	Zip code of person in care of enrollee
Case Number	133	142	10	Case number assigned by County DSS
Loc Off	143	145	3	Code which indicates the local DSS office
Expiration Date (MMDDCCYY)	146	153	8	The date the roster expires
Medicaid Coverage	154	154	1	Code which defines whether the recipient is eligible for services through a MC plan
Aid Category	155	156	2	Defines the type of medical asst for which the enrollee is eligible within the MA program – this code is used to derive the rate code under which the capitation claim is paid
Aid Category	155	156	2	Defines the type of medical asst for which the enrollee is eligible within the MA program – this code is used to derive the rate code under which the capitation claim is paid
Individual Disposition Status Code	155	156	2	Code indicating if recipient's case is active or closed.
Medicaid Exception Code	157	158	2	Code used to restrict types of medical services or to place processing constraints which require claims review
Medicaid Exception Code	159	160	2	Same as above
Medicaid Exception Code	161	162	2	The two digit county/district code assigned by NYS to the county of fiscal responsibility for enrollee
Medicare Code	163	163	1	Indicates the type of Medicare coverage for enrollee (2=Part A, 3=Part B, 1=Both Part A & B)
Health Insurance Claim No.	164	175	12	Enrollee's Medicare Number

Monthly Roster File Layout and Field Descriptions				
Field Name	**Record Positions**		**Field Size**	**Explanation**
Benefit Package	176	177	2	Benefit package number assigned to plan
Capitation Code	178	178	1	Indicates recipient's enrollment in plan (3=Enrolled)
PCP Begin Date (CCYYMMDD)	179	186	8	Recipient's most recent effective enrollment date
Rate Code	187	190	4	Four digit code assigned during claims processing which represents the age, sex, and aid category of enrollee and corresponds to the capitation payment amount
Guarantee Date (CCYYMMDD)	191	198	8	The date through which capitation payments are guaranteed to the plan
Authorization Date (CCYYMMDD)	199	206	8	The date through which the enrollee is eligible for MA benefits.
Recertification Date	207	214	8	The date of the onset of the recertification process for an enrollee.
Transaction Date	215	222	8	The most recent transaction date for enrollee on file
Insurance Code	223	224	2	Indicates any insurance for which the enrollee is eligible
Begin Date (CCYYMMDD)	225	332	8	The date for which insurance was applicable
End Date (CCYYMMDD)	333	240	8	The date for which insurance was terminated
Insurance Code	241	242	2	Same as above
Begin Date	243	250	8	Same as above
End Date	251	258	8	Same as above
Reason Code	259	260	2	Code indicating method of recipient's enrollment
Fee Flag	261	262	2	For future use
Filler	263	267	5	
New Indicator	268	268	1	Indicates this is the first time recipient is appearing on roster

Monthly Managed Care Recipient Roster File Layout – PIC Format

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01  HMO-ROSTER-RECORD.
        05  HMO-ROS-927-TRANS-DIST                                  PIC X(02).
05  HMO-ROS-048-PROV-ID-NUM                                          PIC X(08).
05  HMO-ROS-CIN                                                      PIC X(08).
05  FILLER                                                           PIC X(03).
05  HMO-ROS-031-SSN                                                  PIC X(09).
05  HMO-ROS-SSN-REDEF REDEFINES HMO-ROS-031-SSN.
10  HMO-ROS-RESP-WORKER                                              PIC X(05).
10  FILLER                                                           PIC X(04).
        05  HMO-ROS-NAME.
10  HMO-ROS-005A-LAST-NAME                                           PIC X(16).
10  HMO-ROS-005B-FIRST-NAME                                          PIC X(10).
10  HMO-ROS-005C-MI                                                  PIC X(01).
05  HMO-ROS-012-SEX                                                  PIC X(01).
05  HMO-ROS-010-DOB.
15  HMO-ROS-DOB-MM                                                   PIC X(02).
15  HMO-ROS-DOB-DD                                                   PIC X(02).
15  HMO-ROS-DOB-CC                                                   PIC X(02).
15  HMO-ROS-DOB-YY                                                   PIC X(02).
05  HMO-ROS-DOB-NUM  REDEFINES HMO-ROS-010-DOB                       PIC 9(08).
05  HMO-ROS-007-C-O-NAME                                             PIC X(16).
05  HMO-ROS-008-STREET                                               PIC X(28).
05  HMO-ROS-883-CITY                                                 PIC X(15).
05  HMO-ROS-884-STATE                                                PIC X(02).
05  HMO-ROS-009-ZIP                                                  PIC X(05).
05  HMO-ROS-928-CASE-NUM                                             PIC X(10).
05  HMO-ROS-014-LOC-OFF                                              PIC X(03).
05  HMO-ROS-EXPIR-DATE.
10  HMO-ROS-EXPIR-MM                                                 PIC X(02).
10  HMO-ROS-EXPIR-DD                                                 PIC X(02).
10  HMO-ROS-EXPIR-CC                                                 PIC X(02).
10  HMO-ROS-EXPIR-YY                                                 PIC X(02).
05  HMO-ROS-EXPIR-NUM  REDEFINES HMO-ROS-EXPIR-DATE                  PIC 9(08).
05  HMO-ROS-027-MAID-COV                                             PIC X(01).
05  HMO-ROS-015-AID-CAT                                              PIC X(02).
05  HMO-ROS-120-INDIV-STATUS                                         PIC X(02).
05  HMO-ROS-022-MAID-EXC-CD OCCURS 2 TIMES                           PIC X(02).
05  HMO-ROS-023-MARE-CD                                              PIC X(01).
05  HMO-ROS-004-HIC-NUM                                              PIC X(12).
05  HMO-ROS-BNFT-PKG                                                 PIC X(02).
05  HMO-ROS-CAP-CODE                                                 PIC X(01).
05  HMO-ROS-PCP-FROM-DT                                              PIC X(08).
05  HMO-ROS-RATE-CODE                                                PIC X(04).
05  HMO-ROS-GUAR-DATE                                                PIC X(08).
05  HMO-ROS-GUAR-NUM  REDEFINES HMO-ROS-GUAR-DATE                    PIC 9(08).
05  HMO-ROS-AUTH-DT                                                  PIC X(08).
05  HMO-ROS-AUTH-DT-NUM REDEFINES HMO-ROS-AUTH-DT                    PIC 9(08).
05  HMO-ROS-RECERT-DT                                                PIC X(08).
05  HMO-ROS-RECERT-DT-NUM REDEFINES HMO-ROS-RECERT-DT                PIC 9(08).
05  HMO-ROS-LAST-TRANS-DT                                            PIC X(08).
** TPHI INSURANCE INFORMATION ***
05  HMO-INSUR-INFO              OCCURS 2 TIMES.
10  HMO-ROS-018-INS-CD                                               PIC X(02).
10  HMO-ROS-INS-DATES.
15  HMO-ROS-019A-BGN-DATE                                            PIC X(08).
15  HMO-ROS-019B-END-DATE                                            PIC X(08).
05  HMO-ROS-REASON-CODE                                              PIC X(02).
05  HMO-ROS-FEE-FLAG                                                 PIC X(02).
05  FILLER                                                           PIC X(05).
05  HMO-ROS-NEW-IND                                                  PIC X(01).
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Monthly Disenrollment Report

The Disenrollment Report provides managed care organizations (MCOs) with a list of those enrollees on the previous month's roster who were disenrolled from the MCO, transferred to another MCO, or whose enrollments were removed from the file. The Disenrollment Report does not include enrollees who were dropped from the roster due to loss of Medicaid coverage (unless the local district also ends the enrollment on file). Enrollees who have lost eligibility, but remain enrolled, are listed on the Error Report. They will not be reflected on the Disenrollment Report, even when they are removed from the Error Report (coverage lapsed greater than 90 days).

Data Elements:

CIN – Client Identification Number or Medicaid Identification Number of disenrolled individual.
Social Security Number
Name
Sex
Date of Birth (DOB)
Address
Case Number – Individual's case number, assigned by local district
Local Office Code
Disenrollment From Date – Effective date of disenrollment/transfer
Disenrollment Reason Code – see (1) below
Disenrollment Reason – see (2) below
Aid Category – Defines the type of medical assistance for which the disenrollee is eligible. Aid category codes of 68, 69, 70 and 72 indicate a Family Health Plus (FHP) recipient.

Those recipients whose Disenrollment Reason is indicated as "Disenrolled" are clarified by use of a Disenrollment Reason Code. These codes are:

59	Lost Family Health Plus eligibility
66	Recipient retroactively disenrolled (plan must void claims subsequent to the disenrollment date
85	Death
86	Enrollee request
93	Enrollee exempt/excluded from managed care enrollment
95	Lost MA eligibility
97	Moved out of plan's service area

Note: A general disenrollment reason is indicated for all enrollees on this report. Reasons indicated are:

Disenrolled (see reason codes under (1) above)
Enrolled in Another Plan – Enrollee transferred to another plan
Enrollment Deleted – Enrollment removed from file (i.e., Enrolled in error)
Undeterminable - Enrollment/disenrollment transactions need to be manually reviewed to determine reason.

This report is also useful in determining why a recipient who was enrolled for less than six months may not have received guaranteed coverage, as they continue to be Medicaid eligible.

Monthly Disenrollment Report, PIC Format

LABEL RECORDS ARE STANDARD
BLOCK CONTAINS 25 RECORDS
RECORD CONTAINS 180 CHARACTER
DATA RECORD IS PCP-DIS-RECORD.

```
01      PCP-DIS-RECORD.
   05  PCP-DIS-TRANS-DIST                  PIC X(02).
   05  PCP-DIS-PROV-ID-NUM                 PIC X(08).
   05  PCP-DIS-CIN                         PIC X(08).
   05  PCP-DIS-SSN                         PIC X(09).
   05  PCP-DIS-NAME.
      10  PCP-DIS-LAST-NAME                PIC X(16).
      10  PCP-DIS-FIRST-NAME               PIC X(10).
      10  PCP-DIS-MI                       PIC X(01).
   05  PCP-DIS-SEX                         PIC X(01).
   05  PCP-DIS-DOB.
      10  PCP-DIS-DOB-MM                   PIC X(02).
      10  PCP-DIS-DOB-DD                   PIC X(02).
      10  PCP-DIS-DOB-YR                   PIC X(04).
   05  PCP-DIS-C-O-NAME                    PIC X(16).
   05  PCP-DIS-STREET                      PIC X(28).
   05  PCP-DIS-CITY                        PIC X(15).
   05  PCP-DIS-STATE                       PIC X(02).
   05  PCP-DIS-ZIP                         PIC X(05).
   05  PCP-DIS-CASE-NUM                    PIC X(10).
   05  PCP-DIS-LOC-OFF                     PIC X(03).
   05  PCP-DIS-FROM-DT.
      10  PCP-DIS-FROM-YR                  PIC X(04).
      10  PCP-DIS-FROM-MM                  PIC X(02).
      10  PCP-DIS-FROM-DD                  PIC X(02).
   05  PCP-DIS-REASON-CD                   PIC X(02).
   05  PCP-DIS-REASON                      PIC X(25).
   05  PCP-DIS-AID-CAT                     PIC X(02).
   05  FILLER                              PIC X(01).
```

Monthly Error Report

The purpose of the error report is to track on an interim basis those enrollees who lost Medicaid eligibility because their case is closed, or because their Medicaid coverage "expired" (no action was taken by the local department of social services to either end or reauthorize the enrollee's eligibility), but who remain enrolled in the plan.

The enrollees are indicated on the Error Report with the following messages:

"No PCP Cov or Eligibility Expired" – Indicates recipients whose Medicaid eligibility has either lapsed or was terminated prior to the last day of the previous month.

"Eligibility Ended (last day of previous month)" – Indicates recipients whose Medicaid eligibility expired the last day of the month before the roster month. If the recipient remains on the Error Report (that is, no action taken to end or reauthorize eligibility), the message will change to (1) above, in subsequent months.

"Eligibility Ended (last day of previous month) (Closed)" – Indicates recipients whose Medicaid eligibility was terminated effective the last day of the month before the roster month. If the recipient remains on the Error Report for subsequent months, the message will change to (1) above.

Generally, recipients who have lost Medicaid eligibility will appear on the Error Report for the first time for reasons (2) and (3) indicated above. However, recipients who were on the previous month's roster and whose eligibility ends effective prior to the last day of the previous month, will appear on the Error Report for the first time with reason (1) indicated above. Also included in (1) will be the carryovers from (2) and (3). Thus, these reason codes alone cannot be used to identify all of the recipients who were on the previous month's roster and are now on the Error Report.

All of the above enrollees are removed from the monthly roster, but their Medicaid records continue to reflect managed care enrollment for 90 days, even though the recipient is not actively enrolled in Medicaid. The Error Report provides a means of tracking these recipients for a 90-day period. If the recipient is re-certified or re-opened as Medicaid eligible within that period, this allows the recipient to be automatically reinstated on the roster, without the need to actively re-enroll in the plan.

In New York City, the expired cases are automatically closed after 90 days, and their PCP enrollment terminated. These expired cases are dropped at this time from the Error Report (no Medicaid coverage or PCP enrollment). Prepaid Capitation Plan (PCP) enrollment for closed cases is terminated after 90 days as well.

Upstate, expired cases are not automatically closed. However, their PCP enrollment is automatically terminated after 90 days. PCP enrollment for closed cases is terminated after 90 days as well, and they, too, are dropped from the Error Report.

The Error Report also indicates recipients whose eligibility has changed from Medicaid to Family Health Plus (FHP) or vice versa, but a corresponding enrollment for the Medicaid managed care or the FHP plan has not been entered in the system. These cases need to be reviewed by the local district and the appropriate enrollment entered in the system.

Cases requiring this review are indicated on the Error Report with the following messages:

"MA Elig Enroll w/FHP Ben Pac"
Indicates recipients who have been determined Medicaid eligible but are still enrolled with a Family Health Plus plan.

"FHP Elig Enroll w/MA Ben Pac"
Indicates recipients who have been determined Family Health Plus eligible but are still enrolled with a Medicaid managed care plan.

Note: Another reason for inclusion on the Error Report is:

"County Codes Do Not Match"
Indicates recipients who are receiving Medicaid in one fiscal district, but enrollment is in another fiscal district (usually due to a change of address). These discrepancies must be reconciled between the two districts, and until that is done, the case is reflected on the Error Report.

Data Elements:
The following data is reported for each enrollee on the Error Report:

Recipient ID: Enrollee's Medicaid Identification Number

County: Enrollee's district of financial responsibility for Medicaid eligibility

Aid Category: Defines the type of medical assistance the enrollee is eligible for with the Medicaid program. Aid categories 68, 69, 70 or 72 designate a Family Health Plus enrollee.

Case Number: Enrollee's case number assigned by the local district

Error Message – see (1)– (6) above.

Monthly Error Report – PIC Format

```
01 PROV-ERR-RECORD.
   05 PROV-IREF-NAME          PIC X(25).
   05 PROV-IREF-CIN           PIC X(08).
   05 PROV-IREF-CNTY          PIC X(02).
   05 PROV-IREF-AID-CAT       PIC X(02).
   05 PROV-IREF-CASE          PIC X(10).
   05 PROV-PCP-CIN            PIC X(08).
   05 PROV-PCP-CNTY           PIC X(02).
   05 PROV-PCP-CASE           PIC X(10).
   05 PROV-PROV-ID            PIC X(08).
   05 PROV-ERR-MSG            PIC X(28).
   05 PROV-RESP-WRKR          PIC X(05).
```

Medicaid Eligibility Verification System (MEVS)

New York State has implemented the Medicaid Eligibility Verification System (MEVS) as a method for providers to verify recipient eligibility prior to provision of Medicaid services. Plans may use MEVS, if necessary, to verify information about Medicaid eligibility.

The Identification Card (Common Benefit or Connect) no longer constitutes full authorization for provision of medical services and supplies. A recipient must present an official Common Benefit Identification Card or Connect Card to the provider when requesting services. The verification process through MEVS can be completed to determine the recipient's eligibility for Medicaid services and supplies.

The verification process through MEVS can be completed using any one of the following methods:

(1) the MEVS Terminal (OMNI 3750)

(2) a telephone verification process

(3) direct CPU link or batch transmissions

Verifications can be completed within seconds with a touchtone telephone, a rotary telephone with a tone generator, or an MEVS terminal. Information available through MEVS will provide you with:

The eligibility status for a Medicaid recipient for a specific date;

The county having financial responsibility for the recipient (used to determine the contact office for prior approval and prior authorization); and

Any Medicare or third party insurance coverage that a recipient may have for the date of inquiry, including managed care coverage.

MEVS is convenient and easy to use – it is available 24 hours a day, seven days a week. MEVS provides current eligibility status information for all Medicaid recipients and is updated on a daily basis.

The MEVS manual is available at and can be downloaded from www.emedny.org. The manual contains different sections discussing the Common Benefit Identification Card, the verification equipment, procedures for verification, a description of eligibility responses, and test transactions.

Section III – Appendices

Appendix A – County / District Codes

An alphabetical listing of all the counties and their corresponding district codes is listed below. These codes are also available at www.emedny.org. Select Provider Manuals under "Information for All Providers."

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

Appendix B – Insurance Coverage Codes

Third Party Health Resources

Insurance codes are used to identify Third Party Resources (TPR) other than Medicaid and Medicare, under which a client has insurance coverage, including managed care. Such coverage must be utilized for payment of medical services prior to submitting claims to Medicaid. Insurance and coverage codes are also available at: www.emedny.org.

- ✓ Select **Provider Manuals** under "Information for All Providers."

- ✓ Under **MEVS**, information specific to managed care will be reported to you when you request an eligibility verification for a Medicaid recipient.

The MEVS response via the Verifone Omni 3750 terminal or alternate access will be INS and COV codes followed by a two-digit insurance code and up to 20 alphabetic coverage codes or the word ALL indicating what services are covered. The telephone response will be insurance and coverage codes and a two-digit insurance code, and up to 20 messages or ALL indicating what services are covered.

Please refer to the MEVS Provider Manual for more detailed information on eligibility verifications, which can be found on the eMedNY website at: http://www.emedny.org/ProviderManuals/AllProviders/MEVS/MEVS_Provider_Manual/10/mevs_manual.html.

The MEVS response will include information on a maximum of two third party insurance carriers. If a Medicaid recipient is covered by more than two carriers you will receive a response of ZZ as an insurance code which indicates additional insurance. To obtain coverage information when there are more than two carriers, call 1-800-343-9000.

Other insurance codes are available at www.emedny.org.

- ✓ Select **Provider Manuals**

- ✓ The codes are listed in the Information for All Providers section, under **Third Party Information**

Insurance Coverage Codes

MEVS will only return coverage codes for Medicaid Managed Care Plans. These codes identify which services are covered by the client's managed care plan.

Code	Description	Explanation
A	Inpatient Hospital	All inpatient services are covered, except psychiatric care.
B	Physician In-Office	Services provided in the physician's office are generally covered.
C	Emergency Room	Self-Explanatory
D	Clinic	Both hospital based and free-standing clinic services are covered.
E	Psychiatric Inpatient	Self-Explanatory
F	Psychiatric Outpatient	Self-Explanatory
G	Physician In-Hospital	Physician services provided in a hospital or nursing home are covered.
H	Drugs No Card	Drug coverage is available, but a drug card is not needed.
I	Lab/X-Ray	Laboratory and x-ray services are covered.
J	Dental	Self-Explanatory
K	Drugs Co-pay	Although the insurance carrier expects a co-payment, you may not request it from the recipient. If the insurance payment is less than the Medicaid fee, you can bill Medicaid for the balance, which may cover the co-payment.
L	Nursing Home	Some nursing home coverage is available. You must bill until benefits are exhausted.
M	Drugs Major Medical	Drug coverage is provided as part of a Major medical policy
N	All Physician Services	Physician services, without regard to where they were provided, are covered.
O	Drugs	Self-Explanatory
P	Home Health	Some home health benefits are provided. Continue to bill until benefits are exhausted.
Q	Psychiatric Services	All psychiatric services, inpatient and outpatient, are covered.
R	ER and Clinic	Self-Explanatory
S	Major Medical	The following services are covered: physician, clinic, emergency room, inpatient, laboratory, referred ambulatory, transportation and durable medical equipment.
T	Transportation	Medically necessary transportation is covered.
U	Coverage to Complement Medicare	All services paid by Medicare, which require a coinsurance or deductible payment, should be billed to the insurance carrier prior to billing Medicaid.
V	Substance Abuse Services	All substance abuse services, regardless of where they are provided, are covered.
W	Substance Abuse Outpatient	Self-Explanatory
X	Substance Abuse Inpatient	Self-Explanatory
Y	Durable Medical Equipment	Self-Explanatory
Z	Optical	Self-Explanatory
All	All of the above	All services are covered.

NEW YORK STATE
MEDICAID PROGRAM

MANAGED CARE

UB-04
BILLING GUIDELINES

Table of Contents

Section I – Purpose Statement

The purpose of this document is to assist participating managed care organizations in understanding and complying with the New York State Medicaid (NYS-Medicaid) requirements and expectations for:

- Billing and submitting claims
- Interpreting and using the information returned in the Medicaid Remittance Advice

This document is customized for Managed Care providers and should be used by the provider's billing staff as an instructional as well as a reference tool.

Section II –Claim Submission

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

Providers are required to submit an Electronic/Paper Transmitter Identification Number (ETIN) Application and a Certification Statement before submitting claims to NYS Medicaid. While a provider is required to recertify on a yearly basis, the certification will remain in effect as long as the provider is participating in the NYS Medicaid Program. You will be provided with renewal information when your Certification Statement is near expiration.

Pre-requirements for the Submission of Claims

Before submitting claims to NYS Medicaid, providers need the following:

- An ETIN
- A Certification Statement

ETIN
This is a submitter identifier issued by the eMedNY Contractor and it must be used in every electronic submission to NYS Medicaid. ETINs may be issued to an individual provider or provider group (if they are direct billers) and to service bureaus or clearinghouses.

ETIN applications are available at www.emedny.org.

✓ Select **Information** from the menu

✓ Click on **Provider Enrollment Forms**

✓ Click on **Electronic/Paper Transmitter Identification Number**

Certification Statement
All providers, either direct billers or those who bill through a service bureau or clearinghouse, must file a notarized Certification Statement with NYS Medicaid for each ETIN used for billing.

The Certification Statement is good for one year, after which it needs to be renewed for billing continuity under a specific ETIN. Failure to renew the Certification Statement for a specific ETIN will result in claim rejection.

The Certification Statement is available at www.emedny.org. together with the ETIN application.

Electronic Claims

Pursuant to the Health Insurance Portability and Accountability Act (HIPAA), Public Law 104-191, which was signed into law August 12, 1996, the NYS Medicaid Program adopted the HIPAA-compliant transactions as the sole acceptable format for electronic claim submission, effective November 2003.

Managed Care providers who choose to submit their Medicaid claims electronically are required to use the HIPAA 837 Institutional (837I) transaction. In addition to this document, direct billers may also refer to the sources listed below to comply with the NYS Medicaid requirements.

- HIPAA 837I Implementation Guide (IG) – A document that explains the proper use of the 837I standards and program specifications. This document is available at www.wpc-edi.com/hipaa.

- NYS Medicaid 837I Companion Guide (CG) – A subset of the IG, which provides instructions for the specific requirements of NYS Medicaid for the 837I. This document is available at www.emedny.org.

  ✓ Select **NYHIPAADESK** from the menu

  ✓ Click on **eMedNY Companion Guides and Sample Files**

  ✓ Look for the box labeled "837 Institutional Health Care Claim" and click on the link for the **837 Institutional Companion Guide**

- NYS Medicaid Technical Supplementary Companion Guide – This document provides technical information needed to successfully transmit and receive electronic data. Some of the topics put forth in this CG are testing requirements, error report information, and communication specifications. The Technical Supplementary CG is available at www.emedny.org.

  ✓ Select **NYHIPAADESK** from the menu

  ✓ Click on **eMedNY Companion Guides and Sample Files**

  ✓ Look for the box labeled "Technical Guides" and click on the link for the **Technical Supplementary CG**

Pre-requirements for Submission of Electronic Claims

In addition to an ETIN and a Certification Statement, providers need the following before submitting electronic claims to NYS Medicaid.

- A User ID and Password
- A Trading Partner Agreement
- Testing

User ID and Password
Electronic submitters need a user ID and password to access the NYS Medicaid eMedNY system through one of the communication methods available. The user ID and password are issued to the submitter at the time of enrollment in one of the communication methods. The method used to apply for a user ID varies depending on the communication method chosen by the provider. For example: An ePACES user ID is assigned systematically via email while an FTP user ID is assigned after the submission of a Security Packet B.

Trading Partner Agreement
This document addresses certain requirements applicable to the electronic exchange of information and data associated with health care transactions. The NYS Medicaid Trading Partner Agreement is available at www.emedny.org.

✓ Select **NYHIPAADESK** from the menu

✓ Click on **Registration Information Trading Partner Resources**

✓ Click on **Trading Partner Agreement**

Testing
Direct billers (either individual providers or service bureaus/clearinghouses that bill for multiple providers) are encouraged to submit production tests to CSC before they start submitting Medicaid claims for the first time after enrollment or any time they update their systems or start using a new system. This testing will assist providers in identifying errors in their system and allow for corrections before they submit actual claims.

Information and instructions regarding testing are available at www.emedny.org.

✓ Select **NYHIPAADESK** from the menu

✓ Click on **eMedNY Companion Guides and Sample Files**

✓ In the box titled "Technical Guides", click on **eMedNY Provider Testing User Guide**

Communication Methods

The following communication methods are available for submission of electronic claims to NYS Medicaid:

- ePACES
- eMedNY eXchange
- FTP
- CPU to CPU
- eMedNY Gateway

ePACES

NYS Medicaid provides a HIPAA-compliant web-based application that is customized for specific transactions, including the 837I. ePACES, which is provided free of charge, is ideal for providers with small-to-medium claim volume.

The requirements for using ePACES include:

- An ETIN and Certification Statement should be obtained prior to enrollment
- Internet Explorer 4.01 and above or Netscape 4.7 and above
- Internet browser that supports 128-bit encryption and cookies
- Minimum connection speed of 56K
- An accessible email address

The following transactions can be submitted via ePACES:

- 270/271 - Eligibility Benefit Inquiry and Response
- 276/277 - Claim Status Request and Response
- 278 – Prior Approval/Prior Authorization/Service Authorization Request and Response
- 837 - Dental, Professional, and Institutional Claims

To take advantage of ePACES, providers need to follow an enrollment process. Additional enrollment information is available at www.emedny.org.

✓ Select **NYHIPAADESK** from the menu

✓ Click on **ePACES General Information and Enrollment**

eMedNY eXchange

The eMedNY eXchange works like email; users are assigned an inbox and they are able to send and receive transaction files in an email-like fashion. Transaction files are attached and sent to eMedNY for processing and the responses are delivered to the user's inbox so they can be detached and saved on the user's computer. **For security reasons, the eMedNY eXchange is accessible only through the eMedNY website** www.emedny.org.

The eMedNY eXchange only accepts HIPAA-compliant transactions.

Access to the eMedNY eXchange is obtained through an enrollment process. To enroll in eXchange, you must first complete enrollment in ePACES and at least one login attempt must be successful.

FTP

File Transfer Protocol (FTP) is the standard process for batch authorization transmissions. FTP allows users to transfer files from their computer to another computer. FTP is strictly a dial-up connection.

FTP access is obtained through an enrollment process. To obtain a user name and password, you must complete and return a Security Packet B. The Security Packet B can be found at www.emedny.org.

✓ Select **Information** from the menu

✓ Click on **Provider Enrollment Forms**

✓ Click on **Security Packet B**

CPU to CPU

This method consists of a direct connection established between the submitter and the processor and is most suitable for high volume submitters. For additional information regarding this access method, please contact the eMedNY Call Center at 800-343-9000.

eMedNY Gateway

This is a dial-up access method. It requires the use of the user ID assigned at the time of enrollment and a password. eMedNY Gateway access is obtained through an enrollment process. To obtain a user name and password, you must complete and return a Security Packet B. The Security Packet B can be found at www.emedny.org.

✓ Select **Information** from the menu

✓ Click on **Provider Enrollment Forms**

✓ Click on **Security Packet B**

Note: For questions regarding ePACES, eXchange, FTP, CPU to CPU or eMedNY Gateway connections, call the eMedNY Call Center at 800-343-9000.

Paper Claims

Managed Care providers who choose to submit their claims on paper forms must use the Centers for Medicare and Medicaid Services (CMS) standard **UB-04** claim form. To view the UB-04 claim form please click on the link provided below. The displayed claim form is a sample and the information it contains is for illustration only.

Managed Care – UB-04 Sample Claim

An ETIN and a Certification Statement are required to submit paper claims. Providers who have a valid ETIN for the submission of electronic claims do not need an additional ETIN for paper submissions. The ETIN and the associated certification qualifies the provider to submit claims in both electronic and paper formats.

General Instructions for Completing Paper Claims

Since the information entered on the claim form is captured via an automated data collection process (imaging), it is imperative that it be legible and placed appropriately in the required fields. The following guidelines will help ensure the accuracy of the imaging output:

- All information should be typed or printed.
- Alpha characters (letters) should be capitalized.
- Numbers should be written as close to the example below as possible:

1 2 3 4 5 6 7 8 9 0

- Circles (the letter O, the number 0) must be closed.
- Void unfinished characters. For example:

Written As	Intended As	Interpreted As	
6.ϭ0	6.00	6.60	→ Zero interpreted as six

- When typing or printing, stay within the box provided; ensure that no characters (letters or numbers) touch the claim form lines. For example:

Written As	Intended As	Interpreted As	
2	2	7	→ Two interpreted as seven
3	3	2	→ Three interpreted as two

- Characters should not touch each other. For example:

Written As	Intended As	Interpreted As	
23	23	illegible	→ Entry cannot be interpreted properly

- Do not write between lines.
- Do not use arrows or quotation marks to duplicate information.
- Do not use the dollar sign ($) to indicate dollar amounts; do not use commas to separate thousands. For example, three thousand should be entered as 3000, not as 3,000.
- For writing, it is best to use a felt tip pen with a fine point. Avoid ballpoint pens that skip; do not use pencils, highlighters, or markers. Only blue or black ink is acceptable.
- If filling in information through a computer, ensure that all information is aligned properly, and that the printer ink is dark enough to provide clear legibility.
- Do not submit claim forms with corrections, such as information written over correction fluid or crossed out information. If mistakes are made, a new form should be used.
- Separate forms using perforations; do not cut the edges.
- Do not fold the claim forms.
- Do not use adhesive labels (for example for address); do not place stickers on the form.

The address for submitting claim forms is:

COMPUTER SCIENCES CORPORATION
P.O. Box 4601
Rensselaer, NY 12144-4601

UB-04 Claim Form

To view the UB-04 claim form please click on the link provided below. The displayed claim form is a sample and the information it contains is for illustration only.

Managed Care – UB-04 Sample Claim

General Information About the UB-04 Form

The UB-04 CMS-1450 is a CMS standard form; therefore CSC does not supply it. The form can be obtained from any of the national suppliers.

The UB-04 Manual (National Uniform Billing Data Element Specifications as Developed by the National Uniform Billing Committee – Current Revision) should be used in conjunction with this Provider Manual as a reference for the preparation of claims to be submitted to NYS Medicaid. The UB-04 manual is available at www.nubc.org.

Form Locators in this manual for which no instruction has been provided have no Medicaid application. These Form Locators are ignored when the claim is processed.

Billing Instructions for Managed Care Providers

This subsection of the Billing Guidelines covers the specific requirements for Managed Care organizations submitting capitation or premium claims to New York State Medicaid. Although the instructions that follow are based on the UB-04 paper claim form, they are also intended as a guideline for electronic billers who should refer to these instructions for the information and codes they need to provide in their claims, etc.

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

Field-by-Field (UB-04) Instructions

PROVIDER NAME, ADDRESS, AND TELEPHONE NUMBER (Form Locator 1)

Enter the billing plan's name and correspondence address.

Note: It is the responsibility of the plan to notify Medicaid of any change of address or other pertinent information within 15 days of the change. For information on where to direct address change requests, please refer to www.emedny.org.

PATIENT CONTROL NO. (Form Locator 3a)

For record-keeping purposes, the provider may choose to identify a patient by using an account/patient control number. This field can accommodate up to 30 alphanumeric characters. If an account/patient control number is indicated on the claim form, the first 20 characters will be returned on the Remittance Advice. Using an account/patient control number can be helpful for locating accounts when there is a question on patient identification.

TYPE OF BILL (Form Locator 4)

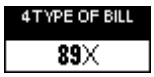
Completion of this field is required. All entries in this field must contain three digits. Each digit identifies a different category as follows:

- 1st Digit – Type of Facility
- 2nd Digit – Bill Classification
- 3rd Digit – Frequency

Type of Facility
The source of this code is the UB-04 Manual, Form Locator 4, Type of Facility category.

Bill Classification
The source of this code is the UB-04 Manual, Form Locator 4, Bill Classification category.

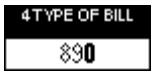
Example:



Frequency - Adjustment/Void Code
The third position of this field identifies whether the claim is an original, a replacement (adjustment), or a void.

- If submitting an original claim, enter the value **0** in the third position of this field.

Example:



- If submitting an adjustment (replacement) to a previously paid claim, enter the value 7 in the third position of this field.

Example:

- If submitting a void to a previously paid claim, enter the value **8** in the third position of this field.

Example:

STATEMENT COVERS PERIOD FROM/THROUGH (Form Locator 6)

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

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

Dates must be entered in the format MMDDYYYY.

Note: Claims must be submitted within 90 days of the earliest date (From date) entered in this field unless acceptable circumstances for the delay can be documented. For more information about billing claims over 90 days from the earliest date of service, please refer to www.emedny.org.

PATIENT NAME (Form Locator 8 – Line b)

Enter the patient's last name followed by the first name.

BIRTHDATE (Form Locator 10)

Enter the patient's birth date. The birth date must be in the format MMDDYYYY.

Example: Mary Brandon was born on March 5, 1975. Enter as 03051975:

10 BIRTHDATE
03051975

SEX (Form Locator 11)

Enter **M** for male or **F** for female to indicate the patient's sex.

ADMISSION (Form Locators 12–15)

Leave all fields blank.

STAT [PATIENT STATUS] (Form Locator 17)

Leave this field blank.

CONDITION CODES (Form Locators 18–28)

Leave these fields blank.

OCCURRENCE CODE/DATE (Form Locators 31–34)

Leave these fields blank.

VALUE CODES (Form Locators 39–41)

NYS Medicaid uses Value Codes to report the following information:

- Locator Code (required)
- Rate Code (required)

Value Codes have two components: Code and Amount. The **Code** component is used to indicate the type of information reported. The **Amount** component is used to enter the information itself. Both components are required for each entry.

Locator Code – Value Code 61
Locator Codes are assigned to the provider for each service address registered at the time of enrollment in the Medicaid program or at anytime, afterwards, that a new location is added.

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

Value Amount
Locator codes 001 and 002 are for administrative use only and are not to be entered in this field. The entry may be 003 or a higher locator code.

The example below illustrates a correct Locator Code entry.

Example:

	39 VALUE CODES CODE	AMOUNT
a	61	003
b		
c		
d		

Note: The provider is reminded of the obligation to notify Medicaid of all service locations as well as changes to any of them. For information on where to direct Locator Code updates, please refer to www.emedny.org.

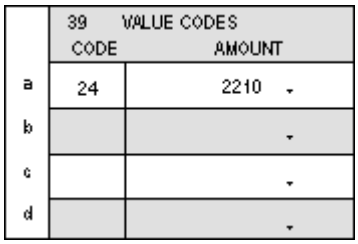
Rate Code - Value Code 24
Rates are established by the Department of Health. At the time of enrollment in Medicaid, providers receive notification of the rate codes and rate amounts assigned to their category of service. The Department of Health notifies providers any time that rate codes or amounts change.

Value Code
Code **24** should be used to indicate that a rate code is entered under Amount.

Value Amount
Enter the rate code that applies to the service rendered. The four-digit rate code must be entered to the left of the dollars/cents delimiter.

The example below illustrates a correct Rate Code entry.

Example:



Inpatient Newborn Delivery Claims

Claims for inpatient newborn delivery are processed and paid according to the usual processing cycle at the eMedNY contractor site. Costs for inpatient newborn delivery are excluded from the monthly capitation reimbursement for newborns.

The rate code for newborn delivery claims is 2298. The service date must be the same as the date of birth.

The claim will appear on the Medicaid remittance for the cycle (week) in which it is processed.

REV. CD. [REVENUE CODE] (Form Locator 42)

NYS Medicaid uses Revenue Codes to report the **Total Amount Charged**.

Use Revenue Code **0001** to indicate that total charges for the services being claimed in the form are entered in Form Locator 47.

Note: Each claim form will be processed as a unique claim document and must contain only one Total Charges 0001 Revenue Code.

SERV. DATE (Form Locator 45)

Leave this field blank.

SERV. UNITS (Form Locator 46)

Leave this field blank.

TOTAL CHARGES (Form Locator 47)

Enter the total amount charged for the service(s) rendered on the lines corresponding to Revenue Code 0001 in Form Locator 42 (total charges). Both sections of the field (dollars and cents) must be completed; if the charges contain no cents, enter **00** in the cents box.

Example:

42 REV CD	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
0001					3000.00		

PAYER NAME (Form Locator 50 A, B, C)

Enter the word Medicaid on line A of this field. Leave lines B and C blank.

NPI (Form Locator 56)

Leave this field blank.

OTHER PRV ID [OTHER PROVIDER ID] (Form Locator 57)

The Medicaid Provider ID number is the eight-digit identification number assigned to providers at the time of enrollment in the Medicaid program.

Enter the Medicaid Provider ID number on the same line (A) that matches the line assigned to Medicaid in Form Locator 50.

INSURED'S UNIQUE ID. (Form Locator 60)

Enter the patient's Medicaid Client ID number. Medicaid Client ID numbers are assigned by the State of New York and are composed of eight characters in the format AANNNNNA, where A = alpha character and N = numeric character.

Example: AB12345C

The Medicaid Client ID should be entered on line A.

TREATMENT AUTHORIZATION CODES (Form Locator 63)

Leave this field blank.

DOCUMENT CONTROL NUMBER (Form Locator 64 A)

Leave this field blank when submitting an original claim or a resubmission of a denied claim.

If submitting an **Adjustment (Replacement)** or a **Void** to a previously paid claim, this field must be used to enter the **Transaction Control Number** (**TCN**) assigned to the claim to be adjusted or voided. The TCN is the claim identifier and is listed in the Remittance Advice. If a TCN is entered in this field, the third position of Form Locator 4, Type of Bill, must be 7 or 8.

The TCN must be entered on the line (A) that matches the line assigned to Medicaid in Form Locators 50 and 57.

Adjustments

An adjustment is submitted to correct one or more fields of a previously paid claim. Any field, except the **Provider ID number** or the **Patient's Medicaid ID number**, can be adjusted. The adjustment must be submitted in a new claim form (copy of the original form is unacceptable) and all applicable fields must be completed. An adjustment is identified by the value **7** in the **third position of Form Locator 4**, Type of Bill, and the claim to be adjusted is identified by the TCN entered in this field (Form Locator 64).

Adjustments cause the correction of the adjusted information in the claim history records as well as the cancellation of the original claim payment and the re-pricing of the claim based on the adjusted information.

Voids

A void is submitted to nullify a paid claim. The void must be submitted in a new claim form (copy of the original form is unacceptable) and all applicable fields must be completed. A void is identified by the value **8** in the **third position of Form Locator 4**, Type of Bill, and the claim to be voided is identified by the TCN entered in this field (Form Locator 64).

Voids cause the cancellation of the original claim history records and payment.

UNTITLED [PRINCIPAL DIAGNOSIS CODE] (Form Locators 67 A–Q)

Leave these fields blank.

OTHER (Form Locator 78)

Leave this field blank.

Section III – Remittance Advice

The purpose of this section is to familiarize the provider with the design and contents of the Remittance Advice.

eMedNY produces remittance advices on a weekly (processing cycle) basis. Weekly remittance advices contain the following information:

- A listing of all **claims** (identified by several pieces of information as submitted on the claim) that have entered the computerized processing system during the corresponding cycle.
- The **status** of each claim (deny/paid/pend) after processing.
- The eMedNY **edits** (errors) failed by pending or denied claims.
- Subtotals (by category, status, locator code, and member ID) and **grand totals** of claims and dollar amounts.
- Other **financial information** such as recoupments, negative balances, etc.

The remittance advice, in addition to showing a record of claim transactions, can assist providers in identifying and correcting billing errors and plays an important role in the communication between the provider and the eMedNY Contractor for resolving billing or processing issues.

Remittance advices are available in electronic and paper formats.

Electronic Remittance Advice

The electronic HIPAA 820 transaction (Remittance Advice) is available via the eMedNY eXchange or FTP. To request the electronic remittance advice (820), providers m call the eMedNY Call Center at 800 343-9000 or complete the HIPAA 820 Transaction Request form, which is available at www.emedny.org.

✓ Select **Information** from the menu

✓ Click on **Provider Enrollment Forms**

✓ Click on **Electronic Remittance Request Form**

The NYS Medicaid Companion Guides for the 820 transaction are available at www.emedny.org.

- ✓ Select **NYHIPAADESK** from the menu
- ✓ Click on **eMedNY Companion Guides and Sample Files**
- ✓ Look for the box labeled "820 Payroll & Other Group Premium PMNT," and click on **820 CG**

Providers who submit claims under multiple ETINs receive a separate 835 for each ETIN and a separate check for each 835. Also, any 835 transaction can contain a maximum of ten thousand (10,000) claim lines; any overflow will generate a separate 835 and a separate check.

Providers with multiple ETINs who choose to receive the 835 electronic remittance advice may elect to receive the status of paper claim submissions and state-submitted adjustments/voids in the 835 format. The request must be submitted using the Electronic Remittance Request Form located at www.emedny.org. If this option is chosen, no paper remittance will be produced and the status of claims will appear on the electronic 835 remittance advice for the ETIN indicated on the request form. Retro-adjustment information is also sent in the 835 transaction format. Pending claims do not appear in the 835 transaction; they are listed in the Supplemental file, which will be sent along with the 835 transaction for any processing cycle that produces pends.

Note: Providers with only one ETIN who elect to receive an electronic remittance will have the status of any claims submitted via paper forms and state-submitted adjustments/voids reported on that electronic remittance.

Paper Remittance Advice

Remittance advices are also available on paper. Providers who bill electronically but do not specifically request to receive the 820 transaction are sent paper remittance advices.

Remittance Sorts

The default sort for the paper remittance advice is:

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

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

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

To request a sort pattern other than the default, providers may call the eMedNY Call Center at 800-343-9000 or complete the Remittance Sort Request Form, which is available at www.emedny.org.

✓ Select **Information** from the menu

✓ Click on **Provider Enrollment Forms**

✓ Look for the column titled "Provider Maintenance Forms" and click on **Paper Remittance Sort Request Form**

Remittance Advice Format

The remittance advice is composed of five sections as described below.

- Section One may be one of the following:
  - ► Medicaid Check
  - ► Notice of Electronic Funds Transfer
  - ► Summout (no claims paid)
- Section Two: Provider Notification (special messages)
- Section Three: Claim Detail
- Section Four
  - ► Financial Transactions (recoupments)
  - ► Accounts Receivable (cumulative financial information)
- Section Five: Edit (Error) Description

Explanation of Remittance Advice Sections

The following pages present a sample of each section of the remittance advice for Managed Care providers followed by an explanation of the elements contained in the section.

The information displayed in the remittance advice samples is for illustration only.

The following information applies to a remittance advice with the default sort pattern.

Section One – Medicaid Check

For Providers that have selected to be paid by check, a Medicaid check is issued when the provider has claims approved for the cycle and the approved amount is greater than the recoupments (if any) scheduled for the cycle. This section contains the check stub and the actual Medicaid check (payment).

MEDICAID MANAGEMENT INFORMATION SYSTEM

TO: CITY MANAGED CARE PLAN

DATE: 2005-05-09
REMITTANCE NO: 05050900001
PROVIDER ID: 00111234

05050900001 2005-05-09
CITY MANAGED CARE PLAN
111 MAIN ST
ANYTOWN NY 11111

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

29/2

DATE	REMITTANCE NUMBER	PROVIDER ID.
2005-05-09 VOID AFTER 90 DAYS	05050900001	00111234

PAY

DOLLARS/CENTS
$******3306.59

TO THE ORDER OF
05050900001 2005-05-09
CITY MANAGED CARE PLAN
111 MAIN ST
ANYTOWN NY 11111

MEDICAID MANAGEMENT INFORMATION SYSTEM

John Smith
AUTHORIZED SIGNATURE

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

Check Stub Information

UPPER LEFT CORNER
Provider's name (as recorded in the Medicaid files)

UPPER RIGHT CORNER
Date on which the remittance advice was issued
Remittance number
Provider ID

CENTER
Remittance number/date
Provider's name/address

Medicaid Check

LEFT SIDE
Table
Date on which the check was issued
Remittance number
Provider ID

Remittance number
Provider's name/address

RIGHT SIDE
Dollar amount. This amount must equal the Net Total Paid Amount under the Grand Total subsection plus the total sum of the Financial Transaction section.

Section One – EFT Notification

For providers that have selected electronic funds transfer (or direct deposit), an EFT transaction is processed when the provider has claims approved during the cycle and the approved amount is greater than the recoupments (if any) scheduled for the cycle. This section indicates the amount of the EFT.

TO: CITY MANAGED CARE PLAN

MEDICAID MANAGEMENT INFORMATION SYSTEM

DATE: 2005-05-09
REMITTANCE NO: 05050900001
PROVIDER ID: 00111234

05050900001 2005-05-09
CITY MANAGED CARE PLAN
111 MAIN STREET
ANYTOWN NY 11111

CITY MANAGED CARE PLAN $3306.59

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

Information on the EFT Notification Page

UPPER LEFT CORNER
Plan name (as recorded in the Medicaid files)

UPPER RIGHT CORNER
Date on which the remittance advice was issued
Remittance number
Provider ID

CENTER
Remittance number/date
Plan name/address

Provider's Name – Amount transferred to the provider's account. This amount must equal the Net Total Paid Amount under the Grand Total subsection plus the total sum of the Financial Transaction section.

Section One – Summout (No Payment)

A summout is produced when the plan has no positive total payment for the cycle and, therefore, there is no disbursement of moneys.

TO: CITY MANAGED CARE PLAN
111 MAIN ST
ANYTOWN NY 11111

DATE: 05/09/2005
REMITTANCE NO: 05050900001
PROVIDER ID: 00111234

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

CITY MANAGED CARE PLAN
111 MAIN ST
ANYTOWN NY 11111

Information on the Summout Page

UPPER LEFT CORNER
Plan Name (as recorded in Medicaid files)

UPPER RIGHT CORNER
Date on which the remittance advice was issued
Remittance number
Provider ID

CENTER
Notification that no payment was made for the cycle (no claims were approved)
Plan name and address

Section Two – Provider Notification

This section is used to communicate important messages to providers.

MEDICAID MANAGEMENT INFORMATION SYSTEM

MEDICAL ASSISTANCE (TITLE XIX) PROGRAM

PAGE 01
DATE 05/09/05
CYCLE 446

TO: CITY MANAGED CARE PLAN
111 MAIN STREET
ANYTOWN, NEW YORK 11111

ETIN:
PROVIDER NOTIFICATION
PROVIDER ID: 00111234
REMITTANCE NO: 05050900001

REMITTANCE ADVICE MESSAGE TEXT

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

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

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

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

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

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

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

Information on the Provider Notification Page

UPPER LEFT CORNER
Provider's name and address

UPPER RIGHT CORNER
Remittance page number
Date on which the remittance advice was issued
Cycle number

ETIN (not applicable)
Name of section: **PROVIDER NOTIFICATION**
Provider ID
Remittance number

CENTER
Message text

Section Three – Claim Detail

This section provides a listing of all new claims that were processed during the specific cycle plus claims that were previously pended and denied during the specific cycle. This section may also contain claims that pended previously.

MEDICAID MANAGEMENT INFORMATION SYSTEM

MEDICAL ASSISTANCE (TITLE XIX) PROGRAM

PAGE 02
DATE 05/09/2005
CYCLE 446

TO: CITY MANAGED CARE PLAN
111 MAIN STREET
ANYTOWN, NEW YORK 11111

ETIN:
MANAGED CARE
PROVIDER ID: 00111234
REMITTANCE NO: 05050900001
LOCATOR CD: 003

OFFICE ACCOUNT NUMBER	CLIENT NAME	CLIENT ID.	TCN	DATE OF SERVICE	RATE CODE	UNITS	CHARGED	PAID	STATUS	ERRORS
CPIC1-00974-6	JONES	AA12345W	04083-000012112-3-2	04/01/05	2210	1.000	472.37	0.00	DENY	00162 00142
CPIC1-00575-6	EVANS	BB54321X	04083-000019113-3-1	04/01/05	2210	1.000	472.37	0.00	DENY	00142

* = PREVIOUSLY PENDED CLAIM
** = NEW PEND

TOTAL AMOUNT ORIGINAL CLAIMS	DENIED	944.74	NUMBER OF CLAIMS	2
NET AMOUNT ADJUSTMENTS	DENIED	0.00	NUMBER OF CLAIMS	0
NET AMOUNT VOIDS	DENIED	0.00	NUMBER OF CLAIMS	0
NET AMOUNT VOIDS – ADJUSTS		0.00	NUMBER OF CLAIMS	0

MEDICAID MANAGEMENT INFORMATION SYSTEM

PAGE 03
DATE 05/09/2005
CYCLE 446

MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

TO: CITY MANAGED CARE PLAN
111 MAIN STREET
ANYTOWN, NEW YORK 11111

ETIN:
MANAGED CARE
PROVIDER ID: 00111234
REMITTANCE NO: 05050900001
LOCATOR CD: 003

OFFICE ACCOUNT NUMBER	CLIENT NAME	CLIENT ID.	TCN	DATE OF SERVICE	RATE CODE	UNITS	CHARGED	PAID	STATUS	ERRORS
CPIC3-16774-6	DAVIS	AA11111Z	04083-000034112-0-2	02/01/05	2210	1.000	472.37	472.37	PAID	
CPIC3-22921-6	THOMAS	BB22222Y	04083-000445113-0-2	02/01/05	2210	1.000	472.37	472.37	PAID	
CPIC1-45755-6	JONES	CC33333X	04083-000466333-0-2	02/01/05	2210	1.000	472.37	472.37	PAID	
CPIC1-60775-6	GARCIA	DD44444W	04083-000445663-0-2	02/01/05	2210	1.000	472.37	472.37	PAID	
CPIC1-33733-6	BROWN	EE55555V	04083-000447654-0-2	02/01/05	2210	1.000	472.37	472.37	PAID	
CPIC1-55789-6	SMITH	GG66666U	04083-000465553-0-2	02/01/05	2210	1.000	472.37	472.37	PAID	
CPIC1-76744-6	WAGNER	HH77777T	04083-000455557-0-2	02/01/05	2210	1.000	472.37	472.37	PAID	
CPIC1-91766-6	STEVENS	KK99999R	04083-000465477-0-2	02/01/05	2210	1.000	472.37	427.37	PAID	
CPIC1-66754-6	MCNALLY	JJ88888S	04083-000544444-0-2	02/01/05	2210	1.000	0.00	472.37	VOID	
CPIC1-66754-6	MCNALLY	JJ88888S	04083-000544444-0-2	02/01/05	2210	1.000	472.37	472.37-	PAID	ORIGINAL CLAIM PAID 04/11/2005

TOTAL AMOUNT ORIGINAL CLAIMS	PAID	3778.96	NUMBER OF CLAIMS	8
NET AMOUNT ADJ.VOIDS		472.37	NUMBER OF CLAIMS	1

MEDICAID MANAGEMENT INFORMATION SYSTEM

PAGE 04
DATE 05/09/2005
CYCLE 446

MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

TO: CITY MANAGED CARE PLAN
111 MAIN STREET
ANYTOWN, NEW YORK 11111

ETIN:
MANAGED CARE
PROVIDER ID: 00111234
REMITTANCE NO: 05050900001
LOCATOR CD: 003

OFFICE ACCOUNT NUMBER	CLIENT NAME	CLIENT ID.	TCN	DATE OF SERVICE	RATE CODE	UNITS	CHARGED	PAID	STATUS	ERRORS
CPIC1-06774-6	EVANS	BB54321X	04083-000034112-3-2	04/01/05	2210	1.000	472.37	**	PEND	00162
CPIC1-00974-6	JONES	AA12345W	04083-000445113-3-1	04/01/05	2210	1.000	427.37	**	PEND	00162

* = PREVIOUSLY PENDED CLAIM
** = NEW PEND

TOTAL AMOUNT ORIGINAL CLAIMS	PEND	944.74	NUMBER OF CLAIMS	2
NET AMOUNT ADJUSTMENTS	PEND	0.00	NUMBER OF CLAIMS	0
NET AMOUNT VOIDS	PEND	0.00	NUMBER OF CLAIMS	0
NET AMOUNT VOIDS – ADJUSTS		0.00	NUMBER OF CLAIMS	0

LOCATOR 003 TOTALS

VOIDS – ADJUSTS	472.37-	NUMBER OF CLAIMS	1
TOTAL PENDS	944.74	NUMBER OF CLAIMS	2
TOTAL PAID	3778.96	NUMBER OF CLAIMS	8
TOTAL DENIED	944.74	NUMBER OF CLAIMS	2
NET TOTAL PAID	3306.59	NUMBER OF CLAIMS	8

REMITTANCE TOTALS

VOIDS – ADJUSTS	472.37-	NUMBER OF CLAIMS	1
TOTAL PENDS	944.74	NUMBER OF CLAIMS	2
TOTAL PAID	3779.96	NUMBER OF CLAIMS	8
TOTAL DENIED	944.74	NUMBER OF CLAIMS	2
NET TOTAL PAID	3306.59	NUMBER OF CLAIMS	8

MEMBER ID: 00111234

VOIDS – ADJUSTS	472.37-	NUMBER OF CLAIMS	1
TOTAL PENDS	944.74	NUMBER OF CLAIMS	2
TOTAL PAID	3779.96	NUMBER OF CLAIMS	8
TOTAL DENY	944.74	NUMBER OF CLAIMS	2
NET TOTAL PAID	3306.59	NUMBER OF CLAIMS	8

MEDICAID MANAGEMENT INFORMATION SYSTEM

MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

PAGE: 05
DATE: 05/09/2005
CYCLE: 446

TO: CITY MANAGED CARE PLAN
111 MAIN STREET
ANYTOWN, NEW YORK 11111

ETIN:
MANAGED CARE
GRAND TOTALS
PROVIDER ID: 00111234
REMITTANCE NO: 05050900001

REMITTANCE TOTALS – GRAND TOTALS

VOIDS – ADJUSTS	472.37-	NUMBER OF CLAIMS	1
TOTAL PENDS	944.74	NUMBER OF CLAIMS	2
TOTAL PAID	3779.96	NUMBER OF CLAIMS	8
TOTAL DENY	944.74	NUMBER OF CLAIMS	2
NET TOTAL PAID	3306.59	NUMBER OF CLAIMS	8

General Information on the Claim Detail Pages

UPPER LEFT CORNER
PLAN name and address

UPPER RIGHT CORNER
Remittance page number
Date on which the remittance advice was issued
Cycle number. The cycle number should be used when calling CSC with questions about specific processed claims or payments.

ETIN (not applicable)
Provider Service Classification: **MANAGED CARE**
Provider ID
Remittance number
Locator Code (Plans with have more than one locator code will receive separate Claim Detail sections for each locator code).

Explanation of the Claim Detail Columns

OFFICE ACCOUNT NUMBER
If a Patient/Office Account Number was entered in the claim form, that number (up to 20 characters) will appear under this column.

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

CLIENT ID
The patient's Medicaid ID number appears under this column.

TCN
The TCN is a unique identifier assigned to each document (claim form) that is processed. If multiple claim lines are submitted on the same claim form, all the lines are assigned the same TCN.

DATE OF SERVICE
The first date of service (From date) entered in the claim appears under this column. If a date different from the From date was entered in the Through date box, that date is not returned in the Remittance Advice.

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

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

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

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

STATUS
This column indicates the status (DENY, PAID/ADJT/VOID, PEND) of the claim line.

Denied Claims
Claims for which payment is denied will be identified by the **DENY** status. A claim may be denied for the following general reasons:

- The service rendered is not covered by the New York State Medicaid Program.
- The claim is a duplicate of a prior paid claim.
- 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.
- Claim requires manual pricing.
- No match found in the Medicaid files for certain information submitted on the claim, for example: Patient ID, Prior Approval, Service Authorization. These claims are recycled for a period of time during which the Medicaid files may be updated to match the information on the claim.

After manual review is completed, a match is found in the Medicaid files or the recycling time expires, pended claims may be approved for payment or denied.

A new pend is signified by two asterisks (**). A previously pended claim is signified by one asterisk (*).

ERRORS
For claims with a DENY or PEND status, this column indicates the NYS-Medicaid edit (error) numeric code(s) that caused the claim to deny or pend. Some edit codes may also be indicated for a PAID claim. These are approved edits, which identify certain errors found in the claim and that do not prevent the claim from being approved. Up to twenty-five (25) edit codes, including approved edits, may be listed for each claim. Edit code definitions will be listed on a separate page of the remittance advice, at the end of the claim detail section.

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

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

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

Subtotals by **service classification/locator code** combination are provided at the end of the claim detail listing for each service classification/locator code combination. These subtotals are broken down by:

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

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

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

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

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

Section Four

This section has two subsections:

- Financial Transactions
- Accounts Receivable

Financial Transactions

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

PAGE 07
DATE 05/09/05
CYCLE 446

TO: CITY MANAGED CARE PLAN
111 MAIN STREET
ANYTOWN, NEW YORK 11111

MEDICAID MANAGEMENT INFORMATION SYSTEM

MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

ETIN:
FINANCIAL TRANSACTIONS
PROVIDER ID: 00111234
REMITTANCE NO: 05050900001

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

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

Accounts Receivable

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

PAGE 08
DATE 05/09/05
CYCLE 446

TO: CITY MANAGED CARE PLAN
111 MAIN STREET
ANYTOWN, NEW YORK 11111

MEDICAID MANAGEMENT INFORMATION SYSTEM

MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

ETIN:
ACCOUNTS RECEIVABLE
PROVIDER ID: 00111234
REMITTANCE NO: 05050900001

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

TOTAL AMOUNT DUE THE STATE $XXX.XX

Explanation of the Financial Transactions Columns

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

FINANCIAL REASON CODE
This code is for DOH/CSC use only; it has no relevance to providers. It identifies the reason for the recoupment.

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

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

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

Totals

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

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

Explanation of the Accounts Receivable Columns

If a provider has negative balances of different nature (for example, the result of adjustments/voids, the result of retro-adjustments, etc.) or negative balances created at different times, each negative balance will be listed in a different line.

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

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

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

RECOUPMENT % AMOUNT
The deduction (recoupment) scheduled for each cycle.

Total Amount Due the State

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

Section Five – Edit Descriptions

The last section of the Remittance Advice features the description of each of the edit codes (included approved codes) failed by the claims listed in Section Three.

MEDICAID MANAGEMENT INFORMATION SYSTEM

MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

PAGE 06
DATE 05/09/2005
CYCLE 446

TO: CITY MANAGED CARE PLAN
111 MAIN STREET
ANYTOWN, NEW YORK 11111

ETIN:
MANAGED CARE
EDIT DESCRIPTIONS
PROVIDER ID: 00111234

REMITTANCE NO: 05050900001

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

00142 RECIPIENT YEAR OF BIRTH DIFFERS FROM FILE
00162 RECIPIENT INELIGIBLE ON DATE OF SERVICE

NEW YORK STATE
MEDICAID PROGRAM

MANAGED CARE MANUAL:
STOP-LOSS POLICY AND PROCEDURE

TABLE OF CONTENTS

Section I – Purpose Statement

The purpose of this document is to assist participating managed care organizations in understanding and complying with the New York State Medicaid (NYS-Medicaid) requirements and expectations for billing.

The guide addresses the following subjects:

- Stop-Loss

This document is customized for managed care providers as an instructional as well as a reference tool.

Section II – Stop-Loss Policy and Procedure

Background

Stop-Loss is a type of reinsurance, or risk protection, offered by NYS to Medicaid managed care plans, which is intended to limit the plan's liability for individual enrollees. The state agrees to pay for costs incurred by the plan that exceed a certain threshold amount. Stop-Loss payments are in addition to the monthly capitation payment made by NYS for each enrollee.

Plans providing comprehensive benefits under the state's 1115 waiver to all eligible Medicaid enrollees may elect to purchase reinsurance from NYS to cover the following:

General Inpatient Reinsurance

- For Mainstream Medicaid managed care plans, hospital inpatient claims with a uniform threshold of $50,000 per enrollee per calendar year are the liability of the plans. For amounts paid in excess of $50,000 a plan will receive 80% reimbursement for the remainder of the calendar year up to $250,000. For amounts in excess of $250,000, the plan will receive 100% reimbursement.

  Reimbursement for hospital inpatient claims is based on the lower of any negotiated rate between the plan and hospital, or the Medicaid calculated rate. Effective 1/1/96, the calculated Medicaid rate is the published alternate Medicaid payment rate that excludes the cost of Graduate Medical Education (GME), as well as the Recruitment and Retention component implemented in 2002. Hospitals bill NYS directly for the GME and Recruitment and Retention components for hospital admissions of Medicaid managed care enrollees.

- HIV Special Need Plans (SNPs) may purchase similar reinsurance from NYS. The reinsurance covers 85% of hospital inpatient expenses exceeding $100,000 per enrollee per calendar year, up to $300,000. Above $300,000, 100% of expenses are covered.

Note the Department of Health (DOH) Bureau of Managed Care Financing will maintain a list of plans that purchase the above reinsurance from NYS.

Mental Health and Alcohol and Substance Abuse Reinsurance

All Mainstream Medicaid and HIV SNP plans are eligible for the following mental health and substance abuse Stop-Loss coverage for enrollees *not* categorized as SSI or SSI related at the time of service, regardless of whether plans purchase general inpatient reinsurance from NYS:

- Medically necessary and clinically appropriate Medicaid reimbursable mental health treatment outpatient visits in excess of twenty (20) visits during any calendar year at rates set forth in contracted fee schedules. Court Ordered Services for mental health treatment outpatient visits specifying the use of Non-Participating Providers will be reimbursed at the Medicaid rate of payment.

- **Through March 31, 2002**: Medically necessary and clinically appropriate Medicaid reimbursable alcohol and substance abuse treatment outpatient visits in excess of sixty (60) visits during any calendar year at rates set forth in contracted fee schedules. Court Ordered Services for alcohol and substance abuse treatment outpatient visits specifying the use of Non-Participating Providers will be reimbursed at the Medicaid rate of payment. **Effective April 1**, **2002**, alcohol and substance abuse treatment outpatient visits will no longer be a covered benefit under the Medicaid managed care program and Stop-Loss coverage will terminate.

- Medically necessary and clinically appropriate Medicaid reimbursable inpatient mental health services and/or inpatient alcohol and substance abuse treatment services in excess of thirty (30) days during a calendar year at the lower of the plan's negotiated inpatient rate or the Medicaid rate of payment. Note inpatient services provided by Article 31 facilities known as Institutions of Mental Disease (IMDs) to enrollees aged 21 through 64 are limited to 30 consecutive days per episode or up to 60 inpatient days per year; Stop-Loss coverage for IMD services began January 1, 2004.

The Stop-Loss insurance does not apply to inpatient detoxification services provided in Article 28 hospitals.

Note: Mental health and substance abuse services provided to members who were not classified as SSI or SSI related *at the time of service* are still covered under the Stop-Loss program even if the enrollee is retroactively classified SSI or SSI related and the retroactive period includes dates when such services were provided. However in this instance, plans are required to submit appropriate documentation (for example the enrollee roster showing the Aid Category at the time of service) along with the attestation and other supporting documentation for the Stop-Loss claim.

Residential Health Care Facility (Nursing Home) Reinsurance

Effective January 1, 2005 for all Mainstream Medicaid managed care plans and April 1, 2005 for HIV SNPs, reinsurance will pay for medically necessary Residential Health Care Facility (RHCF) stays in excess of 60 days per enrollee per calendar year for enrollees who are not in permanent placement status. As with Mental Health and Alcohol and Substance abuse services, the plan is responsible for paying claims to its providers and may bill NYS for visits in excess of the threshold. Stop-Loss payments will be made at the lesser of the plan's negotiated rate with the RCHF or the Medicaid daily rate.

Rate codes to be Used to Submit Stop-Loss Claims

Prior to 2003, plans purchasing general hospital inpatient reinsurance from NYS have used designated rate code 2299 to submit all Stop-Loss claims to the state, including those relating to mental health, alcohol and substance abuse. Effective January 2003, Mainstream Medicaid plans should only use rate code 2299 to submit hospital inpatient claims in excess of $50,000 per calendar year. For other Stop-Loss claims, plans should use the rate codes listed below as applicable.

Stop-Loss Rate Codes

Rate Code	Type of Stop-Loss	Applicability By Type of Managed Care Plan
2294	➢ > 20 Outpatient Mental Health Visits	Mainstream Medicaid, HIV SNP
2295	➢ > 30 Inpatient Mental Health/Alcohol and Substance Abuse Days (see IMD limitation)	Mainstream Medicaid, HIV SNP
2296	➢ Inpatient Expenditures > $100,000 Per Enrollee Per Year, 15% Coinsurance For Payments Up To $300,000	HIV SNP
2297	➢ > 60 RHCF (Nursing Home) Days	Mainstream Medicaid, HIV SNP
2299	➢ Inpatient Expenditures > $50,000 Per Enrollee Per Year, 20% Coinsurance For Payments Up To $250,000	Mainstream Medicaid

Important – Effective March 20, 2005, it is no longer acceptable to enter a trailing fifth digit zero after the rate code when submitting a claim.

Also note there is no reinsurance coverage of any type provided by NYS for the Family Health Plus, Child Health Plus and Medicare/Medicaid Advantage Dual Eligible programs, which should be covered by private reinsurance.

Process for Submission of Stop-Loss Claims

An Expedited Process for submission of Stop-Loss claims has been developed for claims submitted on or after August 1, 1997. Under this process, managed care plans are not required to submit documentation with their requests for Stop-Loss payments from NYS. Instead, plans provide summary information and submit this with an attestation that proper and complete documentation is on file and subject to State audit. Should documentation be found to be incomplete or inaccurate upon audit, plans are subject to recoupment of part or all of the Stop-Loss claims paid. Revised forms to be used to submit Stop-Loss claims are attached to this document.

The following describes the basic steps in submission of Stop-Loss claims, the verification, editing and payment process, and the scope and process for audits of claims.

Submission of Stop-Loss Claims

- Stop-Loss claims must be submitted to the Fiscal Agent in your normal claim submission mode, either on paper or an approved HIPAA compliant electronic format. **Note the following changes effective March 20, 2005:**

  - ► It is no longer necessary to enter a trailing fifth digit zero after the rate code when submitting a claim;

  - ► It is no longer necessary to submit multiple claims for amounts greater than 100,000. Stop-Loss claims of $100,000 or greater can be submitted on one claim form.

The date of service on the claim form may equal the claim submission date but cannot be later than the last date for which the recipient was covered by the Plan and must not be the first of the month or the claim will be denied. If the last day of the recipient's plan enrollment is over two years from the Stop-Loss submission date, then the original claim and the attachments must be sent to the address noted below. The plan also must submit an explanation of the circumstances causing the delay in billing. Claims of this type should first be sent to the Fiscal Agent. Refer to the Billing Guidelines section of the CSC Medicaid Managed Care Manual for additional information on Stop-Loss billing.

Claims will be held to a two-year limit for proper submission. All claims for payment must be finally submitted to the Fiscal Agent, and be payable, within two years from the close of the benefit year in order to be valid and enforceable against the Department. That is, 2002 payable claims must be finally submitted no later than December 31, 2004 with corresponding cutoff for future years.

All attestations and supporting documentation should be submitted separately to the following address:

NYS Department of Health
Division of Managed Care & Program Evaluation
Stop-Loss Review Unit
ESP, Corning Tower, Room 2056
Albany, New York 12237
1-800-562-0856

Initial Verification of Stop-Loss Submission

- A minimum number of basic edits will be performed upon submission of a Stop-Loss claim, prior to payment, such as verification that the identified enrollee was in fact enrolled in the plan during the specific time period indicated by dates of service.

- Prepayment Review will verify that:

  - ► The Stop-Loss threshold is applicable for that plan and time period, based on executed contracts/amendments between the plan and local district, any plan co-payments and applicable third party payments have been properly deducted from the amount of the claims, and the calculation of amount owed is mathematically correct based on the information on the claim summary;

  - ► Only services covered by the applicable Stop-Loss policy (see description of Stop-Loss policy parameters in the Background Section) are included in the claim;

  - ► All data requested is supplied;

  - ► Inpatient claims are reimbursed at the lower of the plan's negotiated hospital rate or the Medicaid calculated rate. Where the calculated Medicaid rate is lower than the amount indicated on the claim submission, the lower amount will be the basis for claim payment.

  - ► The close of the benefit year is not greater than two years from the date submitted; or the provider has clearly demonstrated that the delay was the result of errors by the Department, the local social services districts, or other agents of the Department; or the court has ordered the Department to make payment.

Determination of Threshold

All claims paid by the plan appropriate for the type of Stop-Loss are to be used when determining whether the threshold has been reached. For newborns, the $50,000 inpatient threshold ($100,000 for HIV SNPs) would include the hospital inpatient birth cost if paid by the plan, plus any additional inpatient hospital costs incurred in that calendar year. Note that the plan is responsible for ensuring that it has made every effort to identify and collect any third party payments, PRIOR to submission of a Stop-Loss claim for reimbursement. All Stop-Loss claims must be paid only for expenditures after recovery offsets, as provided for in the attestation statement.

Payment of Claims

Upon completion of this initial verification review, valid claims will be processed for adjudication by the fiscal agent. Submitted claim amounts may be adjusted to reflect the calculated Medicaid inpatient rate or to delete claim amounts that do not contain all information required on the summary form. Plans will be notified of any changes in the amounts billed on the remittance statement. Detail regarding specific changes will be provided to plans by request at 1-800-562-0856. A plan may submit revised information for an inpatient claim, if it would support a re-determination of the Medicaid calculated hospital payment.

Audit Process

Audits will focus on the verification of claims submitted through examination of appropriate and complete documentation maintained by the plan. Documentation must be available on-site at a single central location of the plan. An audit team may request that complete documentation be made available to them via mail or for on-site verification within 2 business days of prior written notice.

Required Audit Documentation

Documentation should consist of an itemized claim from a provider that indicates the enrollee name, date of service, patient diagnoses, provider name and identification number, and the dollar amount of the claim. The plan must be able to provide evidence, via canceled check or similar documentation, of amount and date of payment to provider.

Verification of the appropriateness of amounts paid must also be available on-site at the same location. This would include copies of executed provider contracts containing explicit payment terms and schedules where applicable. Hospital documentation would normally consist of a UB-04 or 837 that reflects all information shown on the Stop-Loss claim summary.

For claims paid to non-participating providers or to providers where no contract exists (other than inpatient) the plan must be able to document through actual paid claims that it routinely reimburses such providers on that basis (i.e., Medicare fee schedule, 80% of charges, etc.).

Any claims paid that appear in excess of amounts routinely paid by the plan for same or similar services will be denied or adjusted downward.

There must also be evidence that any third party coverage was properly identified, that reasonable collection efforts were made prior to submission of the Stop-Loss claim, and that any third party payments received were offset against the amount requested under the Medicaid Stop-Loss program.

To the extent that documentation is lacking for particular dates of service, the amount of Stop-Loss paid relating to these services may be recouped.

Mental Health and Substance Abuse Stop-Loss

Under both the voluntary and mandatory programs, managed care plans must provide all medically necessary mental health and substance abuse services with no limits except for inpatient IMD services explained below. However, plans can receive reimbursement for days and visits incurred for these services in excess of certain threshold amounts per enrollee, per calendar year, as follows:

- For enrollees not categorized as SSI or SSI related at the time of service and with more than 20 mental health treatment outpatient visits during the calendar year, the plan will be compensated for additional visits at amounts set forth in contracted fee schedules.

- For enrollees not categorized as SSI or SSI related at the time of service and with more than 60 alcohol and substance abuse treatment outpatient visits (through March 31, 2002) during the calendar year, the plans will be compensated at the contracted fee schedules for medically necessary and clinically appropriate Medicaid services provided in excess of this amount. Effective April 1, 2002, outpatient alcohol and substance abuse treatment services are no longer covered under Medicaid managed care but are available under the Medicaid fee-for-service program.

- For enrollees not categorized as SSI and SSI related at the time of service with more than a total combined of 30 days of inpatient mental health services during the calendar year in a voluntary, municipal, licensed proprietary hospital or State operated facility or inpatient alcohol and substance abuse treatment services in a free-standing alcohol residential treatment program or voluntary, municipal, licensed or proprietary hospital during a calendar year, the plan will be compensated for medically necessary and clinically appropriate Medicaid services provided in excess of this amount, on the basis of the lower of the plan's negotiated hospital or Medicaid rate of payment.

IMD Services

Note: Beginning January 1, 2004, the excess 30 day inpatient mental health/alcohol and substance abuse Stop-Loss coverage has been expanded to include inpatient services provided to adult enrollees in freestanding Article 31 facilities known as Institutions for Mental Disease up to the IMD coverage limitations under the Medicaid managed care program. Under the federal special terms and conditions in New York's 1115 waiver, both plan determined and court ordered inpatient stays in IMDs for enrollees aged 21 through 64 are limited to 30 consecutive days per episode or up to 60 inpatient days per year. The IMD inpatient days should be included in the accumulation of mental health, alcohol and substance abuse days under the Stop-Loss program and are reimbursable once the 30 day Stop-Loss threshold is reached only for those days within the above stated benefit limits for IMD services.

Enrollees aged 21 through 64 who require IMD inpatient services of more than 30 consecutive days per episode or 60 inpatient days per year should be disenrolled when these thresholds are reached.

Residential Health Care Facility (Nursing Home) Stop-Loss

Medicaid managed care plans are required to provide the full range of NYS Medicaid RHCF benefits to its enrollees. RHCFs are facilities licensed under Article 28 of the NYS Public Health Law and include AIDS nursing facilities. Covered health care services include the following: medical supervision, 24 hour per day nursing care, assistance with the activities of daily living, physical therapy, and speech language pathology services and other services as specified in the NYS Health Code for Residential Health Care Services and AIDS facilities. Plans are responsible for all medically necessary RHCF stays for health plan members who are not in permanent placement status as determined by the Local Department of Special Services (LDSS) - or Human Resources Administration in NYC - and may bill NYS under the Stop-Loss program for all days exceeding 60 per member per calendar year using the procedures described in the beginning of this section.

Permanent Placement Status

Permanent placement status is determined when the LDSS determines the individual is not expected to return home based on medical evidence affirming the individual's need for permanent placement. The plan should disenroll individuals determined by LDSS to be in permanent placement status; the effective day of disenrollment will be the first day of the month following LDSS classification of the RHCF stay as permanent.

Plans are also responsible for paying for RHCF respite days authorized by the plan and bed reservation days, which are included in the Stop-Loss coverage for total days exceeding 60 per member per calendar year. Respite days are paid at the full Medicaid rate while bed reservation days are paid at a lower, reserved bed rate.

Respite Days

Respite days, or scheduled short term nursing care, are days during which an enrollee who is normally cared for in the community resides in an RHCF for purposes of providing respite for an enrollee's caregiver(s), while providing nursing home care for the individual. The plan should only approve Respite days pursuant to a physicians order when the patient needs nursing home level of care. To be reimbursable under the Stop-Loss program, the plan must submit an attestation the patient requires nursing home level of care and the respite is pursuant to a physicians order. Scheduled short term nursing care admissions are generally pre-arranged for 1-30 days per stay and no more than 42 days per year except in extraordinary circumstances.

Bed Reservation Days

Bed reservation days, or bedhold days, are days during which a bed is held for an enrollee who was admitted to a hospital with the expectation the enrollee would return to the nursing home in fifteen days or less. To be reimbursable for Stop-Loss, the plan must attest the recipient has been a resident of the nursing home for at least 30 days since the date of initial admission (at least one of which was paid by Medicaid or by a Medicaid managed care plan), and the nursing home has a vacancy rate of no more than 5% on the first day the recipient is hospitalized or on leave of absence. If the recipient doesn't return to the nursing home by the 15th day but it is expected that a return within 20 days is possible, the nursing home may request an additional 5 reserved bed days subject to the approval of the MCO. The MCO must submit an attestation the 5 additional days were requested by the nursing home and approved by the MCO.

Section III – Common Problems in Stop-Loss Billing and How to Avoid Them

It is important to note that while New York State Department of Health (NYSDOH) will make every effort to assist Plans to receive payment for the Stop-Loss claims they submit, some common problems on the part of the managed care Plans or their representatives may delay or even result in denial of payment. These problems are preventable. As mentioned earlier in this Section, all relevant criteria (e.g. thresholds, copayments and other Third Party insurance payments) must be documented.

After all the appropriate fields have been completed on the **Stop-Loss Claim Form UB-0**4 or in the **Electronic HIPAA 837I Format**, the claims should be submitted to CSC while the supporting documents, including a properly signed, notarized and dated attestation form, should be sent directly to NYSDOH.

The following **Q and A** have been put together in order to prevent instances of delay and denial as a result of common mistakes:

Questions	**Answers**
➢ **What date of service should be used on the claim for instances where the recipient has either lost Medicaid eligibility or disenrolled from the Plan?**	✓ Verify date(s) of Medicaid eligibility and managed care enrollment. ✓ Then, submit claims using a date of service that is both within the Medicaid eligibility and the Plan enrollment period. ✓ If a recipient is no longer enrolled in the Plan, submit claims using the last date of Plan enrollment as the date of service.
➢ **What do I do if I incur additional expenses during the year, after a Stop-Loss claim has been paid?**	When submitting adjustments to a prior Stop-Loss claim: ✓ Include the claim reference number of the most recent paid claim within the same benefit year on the adjusted claim. ✓ The amount of payment being requested must be the total amount due, including the previous payment. ✓ Submit the claim to CSC, and send supporting documents to NYSDOH. (Do not attempt to adjust a claim that has not been paid previously.)
➢ **Can the requested amount on a paper claim form be more than $100,000?**	Yes. Stop-Loss claims greater than $100,000 can be submitted on one claim form.

➢ **Why are claims being rejected for lack of supporting documentation?**

The reports of service and other supporting forms are necessary in order to determine the dollar amount to be paid by NYSDOH.

- ✓ Stop-Loss claims submitted without attestation, inpatient stay and itemized service forms will not be approved.
- ✓ In order to avoid this problem, you must submit all the above forms with all claims to NYSDOH.

➢ **How do I avoid 90-day submission denials by Medicaid?**

Use a current date of service except as noted above in Question 1 for eligibility and disenrollment situations.

➢ **What common mistakes can I avoid when submitting documentation to NYSDOH?**

When submitting attestation, inpatient and itemized service forms, make sure that you denote correctly:

- the name of the eligible recipient
- date of service
- recipient identification number
- date of birth
- male or female
- and other pertinent information.

➢ **What if I need more information and assistance?**

If you need further assistance, please contact:

NYS Department of Health
Division of Managed Care & Program Evaluation
Stop-Loss Review Unit
ESP, Corning Tower, Room 2056
Albany, NY 12237
1-800-562-0856

Section IV –Appendix

STOP-LOSS ATTESTATION STATEMENT

STATE OF NEW YORK

_____COUNTY:

I,_____ on behalf of _____ attest
(Name and Position) (Plan name and Medicaid ID #)
that documentation and proof of payment to providers for all claims for the enrollee listed below are available and will be provided upon request for purposes of verifying that appropriate Stop-Loss payments have been made to the plan by New York State on behalf of the enrollee identified below.

I agree that New York State has the right to recoup from _____ any moneys
(Plan Name)
paid for Stop-Loss claims for which appropriate supporting documentation showing payments made to providers for care rendered to the identified enrollee is not available.

Documentation must include date(s) of service, verification that recipient was enrolled in the plan during all dates of service, patient diagnoses, service provider name(s) and identification number(s), proof of amount(s) actually paid to the service provider(s). Such amount(s) should be consistent with the terms of the contract between the local social services district and the plan or in the absence of specific contract term, justifiable based on specific plan/provider contract terms, or can be shown to be the amount customarily paid by the plan for the service(s).

Enrollee Name - Enrollee ID#_____

Benefit Year _____

Applicable Stop-Loss Threshold_____

Total Amount Over Threshold _____

Less: Any Applicable Plan Liability and Third-party Payments. Please specify (e.g., copayments and other insurance coverage): _____

Net Amount of Stop-Loss Payment Due Plan_____

I attest that all information provided on this statement and the accompanying form(s) is true and accurate to the best of my knowledge and that the Plan identified above is due this Stop-Loss payment for the above enrollee.

Signature _____

Print/Type Name _____

Name of Plan _____

_____ _____
Date Sworn - Notary Public

INPATIENT STAY

Managed Care Plan Name _____ Plan Medicaid ID#_____

Hospital Name_____ Hospital ID#_____

Patient Name_____ Patient ID#_____

Admit Date_____ Date of Birth_____

Discharge Date_____ Age_____ Sex_____

Disposition (status) _____ Birthweight _____

DIAGNOSIS

Admit _ _ _ . _ _ Principal _ _ _ . _ _ Other _ _ _ . _ _

Other _ _ _ . _ _ Other _ _ _ . _ _

Procedures (if applicable)

Principal _ _ _ . _ _ Other _ _ _ . _ _ Other _ _ _ . _ _

Other _ _ _ . _ _ Other _ _ _ . _ _

DRG _____ Amount Paid _____

OR

Exempt Unit (specify type, i.e., Psych, Medical Rehab, Substance Abuse) _____

Amount Paid _____

Residential Health Care Facility (RHCF) Stay

Managed Care Plan Name _____ Plan Medicaid ID#_____

RHCF Name_____ RHCF Medicaid ID#_____

Patient Name_____ Recipient ID#_____

Patient's Placement Status in RHCF (check one): Permanent_____ Temporary_____

Admit Date_____ Discharge Date_____

Disposition (status)_____

Length of Stay (LOS) in RHCF _____ Total Amount Paid _____

Per Diem Rate Paid by Plan _____

RHCF's Medicaid Per Diem Rate _____

Number of Prior Authorized Respite Days included in LOS above _____
(if included requires additional attestation)

Number of Prior Authorized Bed Reservation Days included in LOS above _____
(if included requires additional attestation)

Complete following if Bed Reservation Days included:

Dates of Bed Reservation Days_____

RHCF Occupancy Rate on Date of First Bed Reservation Day_____%

Per Diem Rate Paid to RHCF for Bed Reservation Days_____

STOP-LOSS ITEMIZED BILL

HMO Name and Medicaid ID #
Recipient Name and ID #

Service Date	Provider Name	MMIS/License #	Diagnosis	Units/Days	Basis for Claim Payment, i.e., Procedure Code or per Contract	Amount Paid

NEW YORK STATE
MEDICAID PROGRAM

MANAGED CARE REFERENCE GUIDE:
ENCOUNTER DATA SUBMISSIONS (MEDS II)

TABLE OF CONTENTS

Section I – Purpose Statement

The purpose of this document is to assist participating managed care organizations in understanding and complying with the New York State Medicaid (NYS-Medicaid) requirements and expectations for encounter reporting requirements.

The guide addresses the following subject:

- Encounter Data Submissions

This document is customized for managed care providers as an instructional as well as a reference tool.

Section IV – Medicaid Encounter Data Submissions (MEDS II)

The information in this section should be used in conjunction with the MEDS II Data Element Dictionary available from the Department of Health on this website.

MEDS was originally designed specifically to respond to the unique situation of Medicaid Managed Care Plans in the capitation environment. Plans submit information describing their Medicaid encounters as part of the review, monitoring, and reporting functions required for the New York State Medicaid program. MEDS II compiles all Medicaid encounter data reported by Plans in New York State.

Encounter data is essential to the government on both the state and federal levels. The State needs to report encounter data to the federal government in order to receive appropriate funding for New York's Medicaid program. New York utilizes MEDS reports as a way of looking at statistics and issues within the Medicaid program, such as quality of care.

SDOH uses the data to:

- Describe demographic and health status characteristics of the enrolled population
- Report and monitor service utilization
- Evaluate access and continuity of service issues
- Monitor and develop quality and performance indicators
- Set rates
- Perform cost effectiveness analysis
- Evaluate various service models and environments

MEDS data benefit Plans by providing comparative information that enables Plans to conduct a number of assessment and improvement activities. For a comprehensive look at MEDS including an overview, data submission requirements, format, and descriptions, please refer to the MEDS Data Dictionary created by the SDOH.

The MEDS Data Dictionary is on the State Department of Health Office of Managed Care web site on the Health Provider Network (HPN). Contact the SDOH Office of Managed Care at (518) 486-9012.

Transmittal Specifications for MEDS II:
Plans are contracted with New York State to submit MEDS II encounter information to Computer Sciences Corporation (CSC) on a monthly basis. The means in which this is accomplished is through either the eMedNY eXchange or FTP options for processing.

eMedNY eXchange
eMedNY eXchange is a web based secure file delivery system. In order to access this option Plans need to contact CSC Provider Services (800)-343-9000 select option 4. Once your account is established you will be able to access your mailbox through the eMedNY.org website. eMedNY eXchange is used for **production submissions (not testing)** and accepts files no larger than 10 megabytes. Once enrolled in eXchange, the user (administrator) can establish other users for your account, if necessary.

The alternative options for Managed Care Plans submitting files larger than 10 MB are to:

- ✓ Send them as multiple, smaller files through the eMedNY eXchange,
  or
- ✓ Send files using file transfer protocol (FTP).

FTP
The File Transfer Protocol (FTP) option allows the plans to dial directly into CSC and transfer encounter files without any file size restrictions. In order to access this option Plans need to complete Security Packet B, available at www.emedny.org.

- ✓ Click on **Provider Enrollment forms** under the "Featured Links" section

- ✓ **Submit** the packet to CSC for processing

Please call (800) 343-9000 (select option 5) if you have questions about completion of the packet. Only one user can be established for an FTP account and only one account can be established per Plan ID.

Once your eXchange or FTP User ID has been established, Plans need to contact CSC's MEDS representative (518) 257- 4639 to inform CSC of the following information the Plan will use to submit and retrieve MEDS information: ETIN, Plan ID, and User ID for the Plans eXchange or FTP account.

Testing
The platforms used for testing are different from the production platforms. Plans should not submit production data unless authorized by the Office of Managed Care. Plans should use either emexckout or test FTP account to submit any test data to CSC. The website for emeckout is http://emexckout.emedny.org. The FTP dialup phone number is 1-866-488-3001 (connect to ip address: 172.27.16.30). Please note that testing is limited to 25,000 encounters per file.

MEDS tests will be processed daily by CSC and responses will be available the following morning. In most circumstances your test submission needs to be accepted for processing two hours before midnight. To make sure your response is available the following morning, please submit your data and verify acceptance prior to 5PM.

Tier 1 Edits

After submitting a file of encounter data to CSC, via the eMedNY eXchange or FTP options, for processing, Plans will receive notification that the file was received and processed. When an encounter file does not pass through the front end processing it is due to failing a 'Tier 1' edit. When this occurs the entire file is rejected for one of the following 'Tier 1' edits.

Tier 1 Edit		Explanation
'Incomplete "", Header Record'	=	Record is not 1200 bytes; will give the size and record that is not 1200 bytes
Required "" record missing'	=	Require records missing; will include the record type missing (H1, D1, or T1)
'Record "" is of unknown type or invalid sequence'	=	Require records not in sequence; will include the record type in error (H1, D1, or T1)
'Specified mode "" does not match' 'Test/Prod Indicator'	=	Test/Prod indicator is incorrect; must be PROD
'Misaligned ASCII "", "CR" in record "" column""' OR 'Unexpected ASCII "", "CR" in record "" column""'	=	Carriage return (CR) is to short, long or misaligned
'Unexpected ASCII "", "NL" in record "" column""'	=	Newline/linefeed (NL) in record
'Non-ASCII character'	=	Non-printable characters in file
'Premature end-of-file'	=	End of file not in the correct place
'Unexpected H1 record received' 'at record #:'	=	H1 record is found when unexpected
'Expected H1 control record not received' ' at record #:'	=	H1 record is not found when expected (after user record)
'Invalid D1 record received' 'at record #:'	=	D1 record is found, and it is expected, and the encounter type is other than I, D, T, or P
'Unexpected D1 record received' 'at record #: '	=	D1 record is found when unexpected
'Expected D1 control record not received' 'at record #: '	=	D1 record is not found when expected
'Unexpected T1 record received' 'at record #: '	=	T1 record is found when unexpected
'Received record not H1/D1/T1' 'at record #: '	=	Record is other than H1, D1, or T1

If the encounter transmission is not failed for any of the above listed 'Tier 1' edits the plans will receive a message that the file was passed on for further processing. What this means is that your encounter file will now be processed in the CSC Claims System and a MEDS II Response File will be generated and sent back to the Plan.

MEDS II Response File Specifications

Any files that successfully make it through the front-end editing (or pre-processing) procedures will have a MEDS II response file (C-F-070 Encounter Results) generated. These reports provide valuable feedback to the Plan on the quality of the encounter data they submit. The plan will receive information on whether the record was accepted or rejected as well as up to 25 edits. The Plan should use this information to appropriately identify the encounter status within their own data system. The MEDS II response file reports will either be passed back to your eMedNY eXchange mailbox or FTP account (no longer BBS).

Please note: All encounters processed within the same day will produce one response file regardless of the number of files submitted during that 24 hour period. Once response record will be returned for each encounter processed, approved or rejected. Encounters failing multiple edits will have one record returned per edit.

Encounter Result Record Layout (Header and Line level)

Data Element	Size and Format
ENCOUNTER CONTROL NUMBER	11 bytes alpha-numeric
CLAIM LINE NUMBER	4 bytes numeric
EDIT STATUS CODE	1 bytes alpha-numeric
CLAIM EDIT CODE	5 bytes numeric
COS COD	4 bytes alpha-numeric
TCN	16 bytes alpha-numeric
PLAN ID	8 bytes numeric
ETIN (formerly known as TSN)	3 bytes alpha-numeric
FILLER	28 numeric character record

ENCOUNTER CONTROL NUMBER is a Managed Care Organization (MCO) assigned number used to uniquely identify an encounter transaction. This is the number a Plan would use to match the response record to the previously sent encounter record.

CLAIM LINE NUMBER Encounter Line Number specifies the line number of the service on the encounter.

EDIT STATUS CODE specifies the disposition of an edit that has been posted to an encounter. The values below are assigned during the adjudication process.

Valid Values:

Edit Status Code	Edit Severity
2	**H=Hard Edit (Rejected)**
3	S=Soft Edit (Accepted)
4	R=Recycle
P	Encounter passed with no edits.

CLAIM EDIT CODE is a unique code attached to an encounter as the result of logic applied during the adjudication cycle. (See MEDS II Data Element Dictionary).

COS [CATEGORY OF SERVICE CODE] categorizes provider services for processing and reporting. The first two (2) digits will always be 'EN'. The second two digits will be defined by the following valid value list.

Valid Values:

01	Physicians
03	Podiatry
04	Psychology
05	Eye Care
06	Rehab Therapy
07	Nursing
11	Inpatient
12	Institutional Long Term Care
13	Dental
14	Pharmacy
15	Home Health
16	Lab
19	Transportation
22	DME
28	ICF
41	Nurse Practitioner
73	Hospice
75	Clinical Social Worker
85	Freestanding Clinic
87	Hospital Outpatient

TCN [Transaction Control Number] is a unique identifier assigned by CSC to each encounter transaction received. This number must be stored by Plans for accepted encounters (Edit Status Codes 3 and P) as this is the number required to be submitted when adjustments or voids to previously submitted encounters are required.

PLAN ID is the provider ID assigned to the Plan by NYS DOH.

ETIN [Electronic Transmission Identification Number] is a three or four-character submitter identifier, issued by CSC, upon application and must be used in every electronic transaction submitted to NYS Medicaid.

MEDS II
Data Element Dictionary

Version 2.3

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I. Introduction

This ***MEDS II Data Element Dictionary*** contains descriptive information for the data elements that are required for submission by health care organizations as part of the redesigned Medicaid Encounter Data System (MEDS II). This document contains requirements by MEDS II Category of Service (COS), the transaction layout for data submission, descriptions of the individual data elements and an Appendices section.

An encounter is a professional face-to-face contact or transaction between an enrollee and a provider who delivers services. An encounter is comprised of the procedure(s) or service(s) rendered during the contact. An encounter should be operationalized in an information system as each unique occurrence of recipient and provider. Up to ten separate dates of service can be reported on one encounter line. All claim detail lines should be rolled up under the same encounter control number when possible. If a claim contains more than ten service lines, a second (continuation) encounter should be created with its own unique encounter control number to report the additional lines. Encounters for all incurred services in the plan's benefit package must be reported. Referrals to services outside of the benefit package, which are covered by another payor, should not be reported.

In general, the enrollee must be physically present for an encounter to be recorded. The exception to this criterion is laboratory services. Provider consultation with another provider about an enrollee in the absence of the enrollee or the act of referring the enrollee to another provider in the plan's network is not considered an encounter (the encounter resulting from the referral would be reported by that provider), nor is provider consultation with a third party for the purpose of developing and obtaining services for an enrollee.

There are four Encounter Types for which records are to be submitted:

1. Institutional: Encounters extracted from electronic media 837I format or UB-92 paper claims (Encounter Type = "I"). Institutional encounters are reflective of both inpatient (COS 11) and non-inpatient services.
2. Pharmacy: Encounters extracted from NCPDP format (Encounter Type = "D").
3. Dental: Encounters extracted from electronic media 837D format or ADA paper claims (Encounter Type = "T").
4. Professional: Encounters extracted from electronic media 837P format or CMS-1500 paper claims (Encounter Type = "P").

Similar to the legacy MEDS system, each encounter will consist of a common segment and a detail segment (Institutional, Pharmacy, Dental or Professional).

All managed care plan types will report encounter data, however, not all segments will apply to every plan type. All services defined in a plan's benefit package should be reported. Both paid and administratively denied services should be reported.

Each descriptive data element page in this data dictionary contains the following information:

- MEDS II Transaction Segment**:** The MEDS II Transaction Segment that the data element applies to: Common Detail, Institutional, Pharmacy, Dental or Professional.
- Data Element Name: The name of the MEDS II data element being described.
- Submission Status: Whether the data element is optional, situational upon other information (e.g., other payer data) or required for reporting. If required for reporting, the MEDS Categories of Service (COS) that the data element applies to are listed.
- Encounter Record Position(s): The positions on the transaction layout where the data should be reported.
- Format - Length: The format (Character, Numeric, Date) and length of the data element.
- Effective Date: This version of the data dictionary is dated 3/1/2005 forward.
- Version Number - Date: This version of the data dictionary is Version 2.3 - April 2007
- MEDS II DE#/ DW#: eMedNY Data Element Number and Data Warehouse numbers (if applicable).
- Definition: A description of the data element.
- Mapping: The form based and electronic media mapping for the data element (if applicable).
- Codes and Values: Valid codes and values for the data element.
- Edit Applications: Edits applicable to the input record.

Reporting

Under the new MEDS II reporting requirements, data submitted should be reflective of 2004 encounters that were lagged for submission and all encounters with dates of service as of January 1, 2005. Encounters submitted more than two years after the date of service will be rejected.

Encounter files must be submitted monthly and should include encounters incurred and processed by health organizations, as well as records that were previously submitted and rejected.

There are currently no size limits for production files. However, test files are limited in size to less than 25,000 encounters.

Connectivity Options

Magnetic or physical media such as tape, diskette, and cartridge are not supported in MEDS II. Electronic submissions are available through eMedNY eXchange or through file transfer protocol (FTP).

Information on MEDS II submissions should be directed to CSC Provider Relations staff at (518) 257- 4639.

In order to utilize the MEDS II testing and production environments, a health plan must have established components of the following:

- An active New York State Medicaid Provider ID (MMIS ID);
- An active Provider Transmission Supplier Number (TSN); and
- An active eMedNY eXchange or FTP account.

Connectivity Options

Access Method	Testing	Production
Internet batch file submission via eMedNY eXchange	Access https://emexckout.emedny.org	Batch files may be conducted via https://emex.emedny.org/login.aspx?appName=emex
Dial-up batch file submission using File Transfer Protocol (FTP) over Transmission Control Protocol/Internet Protocol (TCP/IP)	Test submissions via FTP may be conducted by using 866-488-3001 and connecting to 172.27.16.30.	Dial-up batch submissions using FTP may be conducted by using 866-488-3006 and connecting to 172.27.16.79. FTP connection should be established through MS-DOS for best results. Users will have to change the setting to 'binary' by using the 'bin' command. Follow the FTP instructions to ensure that the file is named properly. See MEVS Batch Authorization Manual http://www.emedny.org/ProviderManuals/index.html
Direct connect real-time transaction submission using TCP/IP	No Test Option	Contact CSC Provider Relations Staff at (518) 257-4639.

Submission

Plans are allowed to submit files on a daily basis. The list below indicates 2007 cutoff dates in order to be included in that month's data feed to NYSDOH. Anything submitted after the cutoff date will be included in the department's next month data feed. (Test data are not included in the department's data feed.) * Please remember to account for the seven (7) day lag in processing.

2007 Submission Schedule

- April 26, 2007
- May 24, 2007
- June 21, 2007
- July 26, 2007
- August 23, 2007
- September 20, 2007
- October 25, 2007
- November 22, 2007

- December 27, 2007

Edits

Data elements will be edited for missing or invalid data elements, duplicate encounters and valid enrollment in MMC. A Supplemental Manual of current encounter edit numbers, descriptions and severity is included as Appendix D. The following describes "Tier One Edits", or fatal edits which will stop a file from being processed.

Tier One Edits

Tier One Error	Message Returned
Record is not 1200 bytes	'Incomplete " ", Header Record' – will give the size and record that is not 1200 bytes
Required records missing (H1, D1, and a T1)	Required " " record missing' – will include the record type missing
Required records not in sequence (H1, D1, and a T1)	'Record " " is of unknown type or invalid sequence' – will include the record type in error
Test/Prod indicator is incorrect – must be PROD	'Specified mode " " does not match' 'Test/Prod Indicator'
The carriage return (CR) is too short/long or misaligned	'Misaligned ASCII " ", "CR" in record " " column " " ' 'Unexpected ASCII " ", "CR" in record " " column " " '
Newline/linefeed (NL) in record	'Unexpected ASCII " ", "NL" in record " " column " " '
Non-printable characters in file	'Non-ASCII character'
End of file not in the correct place	'Premature end-of-file'
No records are found	'FILE CONTAINS NO CLAIM RECORDS'
H1 record is found when unexpected	'UNEXPECTED H1 RECORD RECEIVED' 'AT RECORD #:'
H1 record is not found when expected (after user record)	'EXPECTED H1 CONTROL RECORD NOT RECEIVED' 'AT RECORD #:'
D1 record is found, and it is expected, and the encounter type is other than I, D, T, or P	'INVALID D1 RECORD RECEIVED' 'AT RECORD #:'
D1 record is found when unexpected	'UNEXPECTED D1 RECORD RECEIVED' 'AT RECORD #:'
D1 record is not found when expected	'EXPECTED D1 CONTROL RECORD NOT RECEIVED' 'AT RECORD #:'
T1 record is found when unexpected	'UNEXPECTED T1 RECORD RECEIVED' 'AT RECORD #:'
Record is other than H1, D1, or T1	'RECEIVED RECORD NOT H1/D1/T1''AT RECORD #:'

Response Reports

Plans will receive a transmission file for each encounter file submitted. Files will stay within the plans eMedNY Exchange or FTP mailbox for a period of ten (10) days. After that they will be archived for sixty (60) days and then deleted from the system. Plans will also receive a response file for all encounter files submitted during the processing cycle. When submitting to the Integrated Test Facility (ITF) the processing cycle happens daily and you should receive your response file the following day. When submitting to the Production System the processing cycle pulls encounter files in daily and processes them weekly. Therefore, you will receive your response file one week from the date of submission.

The response file provides valuable feedback to the Plan on the quality of the encounter data submitted. The plan will receive information on whether the record was accepted or rejected as well as up to 24 edits.

Response File Layout

Data Element	Width	Record Positions
Encounter Control Number	11	1-11
Claim Line Number	04	12-15
Edit Status Code	01	16
Claim Edit Code	05	17-21
COS Code	04	22-25
Transaction Control Number (TCN)	16	26-41
Plan ID	08	42-49
TSN	03	50-52
Filler	28	53-80

Encounter Control Number

Encounter Control Number is a Managed Care Organization (MCO) assigned number used to uniquely identify an encounter transaction.

Claim Line Number

Claim Line Number specifies the line number of the service.

- Line numbers 01 through 10 will be used to identify service line errors in the encounter record.
- A value of 00 with an Edit Status Code of P will indicate the entire record has been accepted, with no edits.
- A value of 00 and an Edit Status Code of 2 will indicate the entire record has been rejected. The error is identified through the Claim Edit Code.

Edit Status Code

Edit Status Code specifies the disposition of an edit that has been posted to a claim. Valid codes and values include:

Edit Status Code	*Edit Severity*
2	H=Hard Edit (Rejected)
3	S=Soft Edit (Accept)
P	Record passed through with no edits.

Claim Edit Code

Claim Edit Code is a unique code attached to a claim as the result of logic applied during the claim adjudication cycle. The most current list of applicable edit codes, descriptions and severity status, by Encounter Type Indicator, Claim Type and Category of Service is listed as Appendix D, and is also available in the **MEDS II Supplemental Manual on Applicable Edits**.

MEDS Category of Service Code

MEDS Category of Service Code categorizes provider services for the processing and reporting. The first two (2) digits will always be 'EN'. The second two-digits will be defined by the following codes and values (i.e., MEDS Category of Service Codes and Values).

Code	***Value***
01	Physician Services
03	Podiatry
04	Psychology
05	Eye Care / Vision
06	Rehabilitation Therapy
07	Nursing
11	Inpatient
12	Institutional LTC
13	Dental
14	Pharmacy
15	Home Health Care/Non-Institutional Long Term Care
16	Laboratories
19	Transportation
22	DME and Hearing Aids
28	Intermediate Care Facilities
41	NPs/Midwives
73	Hospice
75	Clinical Social Worker
85	Freestanding Clinic
87	Hospital OP/ER Room

Transaction Control Number

Transaction Control Number is a unique identifier assigned to each claim or encounter transaction received. This number is essential to adjust or void records.

Reconciling the Response Report

The plan should use the response report data elements to appropriately tag the encounter status for their internal data system, and resubmit rejected or edited records as appropriate.

Plans should use the [Encounter Control Number (ECN), Line Number, Edit Status Code, Claim Edit Number, Category of Service (COS), and Transaction Control Number (TCN)] to match the status of each line of your encounter.

Since the Response File will report errors on a service line level Plans should be aware of four general rules about feedback reports:

Rule # 1: If the encounter record passes through without any edits, one record line is reported with an edit status code of 'P' at line number '0000'. The Plan should store the associated TCN and the Accepted status in their data system. Any changes to these records should be handled as an adjustment.

Rule # 2: If the encounter record rejects at the header level (line number '0000' and Edit Status Code = '2') the entire encounter is rejected. Plans should correct all errors identified and resubmit the encounter as an original.

Rule # 3: If the encounter record includes both accepted and rejected service lines (line number(s) = '01' – '10' and Edit Status Codes of '2' and '3') the encounter record has been partially accepted. The Plan should store the associated TCN and the accepted and rejected status at each service line. All corrections to the encounter should be handled as an adjustment to the original encounter.

Rule # 4: For every adjusted encounter the Plan will receive two response lines back. The eMedNY claim system creates a 'void' line that removes the original encounter. It then creates a new replacement/adjustment line. The first TCN, which represents the 'void' line, will always end in '1'. Plans should disregard this TCN. The second TCN, which represents the 'replacement/adjustment' line, will always end in '2'. Plans should store this TCN with the new encounter record.

Additional MEDS II Information and Reference Materials

MEDS Home Page on the HPN:
For up to date information on MEDS II reporting requirements and associated activities, please visit the MEDS Home Page on the Health Provider Network (HPN) intranet site at the following direct link:
https://commerce.health.state.ny.us/hpn/omc/meds/index.shtml

CSC/eMedNY Contact Information:
CSC Provider Relations Staff (518)257-4639.
http://www.emedny.org/ProviderManuals/ManagedCare/index.html

MEDS-L Discussion Group:
To join the MEDS-L Listserv discussion group, please contact the MEDS Unit at 518-486-9012. An archive of discussion topics is available on the MEDS Home Page on the HPN.

Please contact us at:

Encounter Data Unit
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II. ENCOUNTER TYPE ASSIGNMENT BY CATEGORY OF SERVICE

For MEDS II submissions, the Category of Service (COS) must be applicable to the encounter type being reported. The table below indicates submission standards for encounter types by MEDS COS. (The Encounter Type Indicator is reflective of the form or electronic media in which the encounter is being submitted to the health organization.)

Category of Service		***Encounter Type***		
Code	***Value***	***Code***	***Value***	***Form Type/ EDI***
01	Physician Services	P	Professional	CMS-1500 / 837P
03	Podiatry	P	Professional	CMS-1500 / 837P
04	Psychology	P	Professional	CMS-1500 / 837P
05	Eye Care / Vision*	P	Professional	CMS-1500 / 837P
06	Rehabilitation Therapy	I	Institutional	UB-92 / 837I
07	Nursing	P	Professional	CMS-1500 / 837P
11	Inpatient	I	Institutional	UB-92 / 837I
12	Institutional LTC	I	Institutional	UB-92 / 837I
13	Dental	T	Dental	ADA / 837D
14	Pharmacy	D	Pharmacy/DME	NCPDP
15	Home Health Care/Non-Institutional Long Term Care	I	Institutional	UB-92 / 837I
16	Laboratories**	P	Professional	CMS-1500 / 837P
19	Transportation	P	Professional	CMS-1500 / 837P
22	DME and Hearing Aids	P	Professional	CMS-1500 / 837P
28	Intermediate Care Facilities	I	Institutional	UB-92 / 837I
41	NPs/Midwives	P	Professional	CMS-1500 / 837P
73	Hospice	I	Institutional	UB-92 / 837I
75	Clinical Social Worker	P	Professional	CMS-1500 / 837P
85	Freestanding Clinic	I	Institutional	UB-92 / 837I
87	Hospital OP/ER Room	I	Institutional	UB-92 / 837I

* Eye glasses should be reported using a HCPCS code and COS 05 Eye Care/Vision.

**If laboratory data is submitted on a UB-92 form, these services should be reported under COS 85 (Freestanding Clinic) or COS 87 (Hospital Outpatient), with an Encounter Type Indicator of "I", and a provider specialty code of "599" All Laboratories.

III. MEDS II DATA ELEMENT REPORTING

Record Positions	Data Element-Header	Data Type	Field Length	Submission Status	Description
1-2	Record Type	Character	2	Required	H1=Header
3-6	Provider Transmission Supplier Number (TSN)	Character	4	Required	Provider Transmission Supplier Number (TSN) is a unique number assigned to the health organization submitting encounter records. The TSN should be left-justified and space-filled.
7-12	Input Serial Number	Character	6	Required	
13-21	TSN Certification	Character	9	Required	This field should contain the word “CERTIFIED”.
22-26	Vendor Software Number	Character	5	Optional	
27-28	Vendor Software Update Level	Character	2	Optional	
29-32	Prod Indicator	Character	4	Required	This field must contain the word “PROD”.
33-40	Plan Identification Number	Character	8	Required	The health organization’s MMIS ID number
41-61	Submitter Name	Character	21	Required	Submitter Name is the name of the health organization as used on official State records.
62-79	Submitter Address 1	Character	18	Required	Submitter Address Line is the street address for the health organization submitting encounter data.
80-97	Submitter Address 2	Character	18	Required	
98-112	Submitter Address City	Character	15	Required	Submitter Address City is the city in which the health organization does business or to which correspondence should be sent.
113-114	Submitter Address State	Character	2	Required	Submitter Address State/Province Code is the two character standard state postal code (i.e., NY)
115-123	Submitter Zip	Character	9	Required	This element specifies the health organizations geographic area denoted by the postal ZIP code.
124-134	Submitter Fax Number	Character	11	Required	Submitter Fax Number is the facsimile number for the health organization.
135-145	Submitter Phone Number	Character	11	Required	Phone Number is the telephone number of the health organization, including 1 and the area code and seven-digit number.
146-148	MEDS Version Number	Character	3	Required	Will contain “002”
Space-fill Record Positions 149 to 1200					

Common Detail Segment

Record Positions	Data Element-Common Detail	Format	Field Length	Submission Status	Description
1-2	Record Type	Character	2	Required	D1=Detail
3	Encounter Type Indicator (ETI)	Character	1	Required	The code that indicates the type of encounter being reported: I=Institutional; D=Pharmacy; T=Dental; P=Professional.
4-14	Encounter Control Number (ECN)	Character	11	Required	Encounter control number is a health organization assigned number used to uniquely identify an encounter transaction.
15-30	Previous Transaction Control Number (TCN)	Character	16	Situational	Transaction Control Number (TCN) is a unique identifier assigned by CSC to each encounter transaction received. The TCN is used for internal control purposes and by plans to adjust or void records identified as failing soft edits.
31	Transaction Status Code	Character	1	Required	Transaction Status Code identifies a transaction as an original encounter or a voids or adjustment to a previously submitted encounter.
32-39	Client Identification Number	Character	8	Required	The CIN is assigned by the state to an enrollee upon determination that an individual is eligible for Medicaid services.
40-64	Beneficiary Identification Number	Character	25	Optional	Beneficiary Identification Number is an identifier given to an individual by the health organization for their internal purposes.
65-67	Provider Profession Code	Character	3	Required	Provider Profession Code specifies the profession of a Provider on the state license file.
68-75	Provider License Number	Character	8	Required	Provider License Number is an identifying number issued by the state licensing board, authorizing a provider to practice within that state under the specific license type applicable to the provider.
76-83	Provider Identification Number (MMIS ID)	Character	8	Required	Provider Identification Number is a unique number assigned to each provider in the Medicaid program.
84-85	FILLER	Character	2	Required	Reserved for NPI Use.

Record Positions	Data Element-Common Detail	Format	Field Length	Submission Status	Description
86-87	Category of Service (COS) Code	Character	2	Required	Category of Service is a two-digit code that classifies the services in the encounter.
88-98	FILLER	Numeric	11	Required	FILLER
99-109	Total Paid Amount	Numeric	11	Required	The total amount paid for each listed service.
110-144	Other Payer Name	Character	35	Situational	Other Payer Name identifies the secondary payer on the encounter (if applicable).
145-155	Other Insurance Total Paid Amount	Numeric	11	Situational	Total amount paid by insurance other than Medicaid (if applicable).
156-157	Other Insurance Type Code	Character	2	Situational	A code indicating insurance payers other than Medicaid (if applicable).

Institutional Segment

Record Positions	Data Element-Institutional	Format	Field Length	Submission Status	Description
158-160	Provider Specialty Code	Character	3	Required: COS 06, 12, 15, 28, 73, 85, 87	A code that identifies a provider's medical, dental, clinic or program type specialty.
161	Hospital Inpatient Claim/Encounter Indicator	Character	1	Required: COS 11	Indicates whether the service provided was a capitated service within the health organization's contract ("E"); a within plan claim ("C") or an administratively denied service ("A").
162-165	New York State Diagnosis Related Group Code	Character	4	Required: COS 11	The NYS AP-DRG code assigned by the providing hospital to the inpatient stay for billing purposes.
166-167	Type of Bill Digits 1 & 2 Code	Character	2	Required: COS 06, 11, 12, 15, 28, 73, 85, 87	The first two digits of a three-digit alphanumeric code. The first digit identifies the type of facility. The second classifies the type of care.
168	Type of Bill Digit 3 Code	Character	1	Required: COS 06, 11, 12, 15, 28, 73, 85, 87	The third digit of a three digit alphanumeric code. The third digit indicates the sequence of the bill in the particular episode of care. It is referred to as the "frequency" code.
169-176	Statement Covers Period From	Date	8	Required: COS	The begin date of the encounter period.

Record Positions	Data Element-Institutional	Format	Field Length	Submission Status	Description
		CCYYMMDD		06, 12, 15, 28, 73, 85, 87	
177-184	Statement Covers Period Thru	Date CCYYMMDD	8	Required: COS 06, 12, 15, 28, 73, 85, 87	The end date of the encounter period.
185	Type of Admission	Character	1	Required: COS 11	One-digit alphanumeric code indicating priority of the admission.
186	Source of Admission	Character	1	Required: COS 11	One digit alphanumeric code indicating the source of the admission or outpatient registration.
187-188	Patient Status or Disposition Code	Character	2	Required: COS 11, 12, 28, 73	A two-digit, alphanumeric code indicating the patient's destination or status upon discharge.
189-208	Medical Record Number	Character	20	Required: COS 11	The number assigned to the patient's medical/health record by the provider.
209-210 218-219	Neonate Birth Weight Value Code [up to 2]	Character	2	Required: COS 11	All newborn encounters will have a birth weight code of "54".
211-217 220-226	Neonate Birth Weight in Grams (Value Code Amount) [up to 2]	Numeric	7	Required: COS 11	The birth weight of the neonate in grams.
227-230 272-275 317-320 362-365 407-410 452-455 497-500 542-545 587-590 632-635	Revenue Code [up to 10]	Character	4	Required: COS 06, 12, 15, 28, 73, 85, 87	The revenue code assigned for each cost center for which a separate charge is billed.
231-237 276-282 321-327 366-372 411-417	HCPCS Code [up to 10]	Character	7	Required: COS 06, 12, 15, 28, 73, 85, 87	HCPCS code(s) describing non-inpatient procedure(s) performed.

Record Positions	Data Element-Institutional	Format	Field Length	Submission Status	Description
456-462 501-507 546-552 591-597 636-642					
238-248 283-293 328-338 373-383 418-428 463-473 508-518 553-563 598-608 643-653	Quantity or Units Submitted [up to 10]	Numeric	11	Required: COS 06, 12, 15, 28, 73, 85, 87	When revenue codes are assigned, this data element quantifies services by revenue category (e.g., number of days of a particular accommodation, pints of blood.) However, when HCPCS codes are assigned, units are equal to the number of times the procedure/service being reported was performed.
249-259 294-304 339-349 384-394 429-439 474-484 519-529 564-574 609-619 654-664	FILLER [up to 10]	Numeric	11		FILLER
260-270 305-315 350-360 395-405 440-450 485-495 530-540 575-585 620-630	Paid Amount [up to 10]	Numeric	11	Required: COS 06, 12, 15, 28, 73, 85, 87	The amount paid for each listed service corresponding to the procedures defined in the HCPCS data element.

Record Positions	Data Element-Institutional	Format	Field Length	Submission Status	Description
665-675					
271 316 361 406 451 496 541 586 631 676	Non-Inpatient Claim/Encounter Indicator [up to 10]	Character	1	Required: COS 06, 12, 15, 28, 73, 85, 87	Indicates whether the service provided was a capitated service within the health organization's contract ("E"); a within plan claim ("C") or an administratively denied service ("A").
677-683	Principal/Primary Diagnosis Code	Character	7	Required: COS 06, 11, 12, 15, 28, 73, 85, 87	The ICD-9-CM diagnosis code that indicates the primary condition for an inpatient stay.
684-690 691-697 698-704 705-711 712-718 719-725 726-732 733-739	Other Diagnosis Codes [up to 8]	Character	7	Required: COS 06, 11, 12, 15, 28, 73, 85, 87	Up to eight additional ICD-9-CM diagnosis codes, indicating additional significant condition(s) during the encounter.
740-746	Admit Diagnosis	Character	7	Required: COS 11	The diagnosis that describes the patient's condition upon admission to the hospital.
747-753	External Diagnosis Code (E Code)	Character	7	Required: COS 11	The ICD-9-CM code for the external cause of an injury, poisoning, or adverse effect.
754-760	Principal Procedure Code	Character	7	Required: COS 11	The ICD-9-CM procedure code identifying the principal procedure performed during an inpatient stay.
761-767 768-774 775-781 782-788 789-795	Other Procedure Codes [up to 5]	Character	7	Required: COS 11	ICD-9-CM Procedure Codes identifying the procedures performed during an inpatient stay

Record Positions	Data Element-Institutional	Format	Field Length	Submission Status	Description
796-798	Attending Provider Profession Code	Character	3	Required: COS 06, 11, 12, 15, 28, 73, 85, 87	The profession code issued by the state of the attending provider for inpatient encounters and the servicing provider for non-Inpatient encounters.
799-806	Attending Provider License Number	Character	8	Required COS 06, 11, 12, 15, 28, 73, 85, 87	The professional license number issued by the state of the attending provider for inpatient encounters and the servicing provider for non-Inpatient encounters.
807-814	Attending Provider ID	Character	8	Required COS 06, 11, 12, 15, 28, 73, 85, 87	The state MMIS of the attending provider for inpatient encounters and the servicing provider for non-Inpatient encounters.
815-816	FILLER	Character	2		Reserved for NPI Use.
817-819	Surgeon Profession Code	Character	3	Required: COS 11	The profession code issued by the State Department of Education that identifies the type of license of the surgeon performing the primary procedure or the surgery.
820-827	Surgeon License Number	Character	8	Required: COS 11	The professional license number, issued by the State Department of Education that identifies the surgeon.
828-835	Surgeon Provider ID	Character	8	Required: COS 11	The State MMIS code of the surgeon.
836-837	FILLER	Character	2		Reserved for NPI Use.
838-845	Admission Date	Date CCYYMMDD	8	Required: COS 11, 12, 28	The admit date for the institutional stay.
846-853	Discharge Date	Date CCYYMMDD	8	Required: COS 11	The date of discharge from an inpatient stay at a hospital.
Space-fill Record Positions 854 to 1200					

Pharmacy Segment

Record Positions	Data Element-Pharmacy	Format	Field Length	Submission Status	Description
158-160	Prescribing Provider Profession	Character	3	Required:	The profession code issued by the State

Record Positions	Data Element-Pharmacy	Format	Field Length	Submission Status	Description
	Code			COS 14	Department of Education that identifies the type of license of the prescribing provider.
161-168	Prescribing Provider License Number	Character	8	Required: COS 14	The professional license number, issued by the State Department of Education that identifies the prescribing provider.
169-176	Prescribing Provider ID	Character	8	Required: COS 14	The State MMIS code of the prescribing provider.
177-178	FILLER	Character	2		Reserved for NPI Use.
179-186	Prescription Ordered Date	Date CCYYMMDD	8	Required: COS 14	The date the prescription was issued by the referring provider.
187-194	Date Filled	Date CCYYMMDD	8	Required: COS 14	The date the prescription was filled.
195-205	National Drug Code (NDC) or Product Code	Character	11	Required: COS 14	An 11-digit national drug identification number assigned by the Federal Drug Administration (or the HCPCS code) used to identify Durable Medical Equipment, Hearing Aids, OTC medications or other pharmacy products without an NDC code.
206-217	Quantity Dispensed	Numeric	12	Required: COS 14	The dispensing quantity based upon the unit of measure as defined by the National Drug Code.
218-220	Drug Days Supply Count	Numeric	3	Required: COS 14	Represents the number of days supply currently dispensed with this prescription service.
221	Pharmacy Claim/Encounter Indicator	Character	1	Required: COS 14	"E" = Capitated encounter; "C" = Within plan claim; "A" = Administratively denied service
Space-fill Record Positions 222 to 1200					

Dental Segment

Record Positions	Data Element-Dental	Format	Field Length	Submission Status	Description
158-160	Provider Specialty Code	Character	3	Required: COS 13	A provider's specialty code identifies a provider's medical, dental, clinic or program type specialty.
161 222 283 344 405 466 527 588 649 710	Dental Claim/Encounter Indicator [up to 10]	Character	1	Required: COS 13	Indicates whether the service provided was a capitated service within the health organization's contract ("E"); a within plan claim ("C") or an administratively denied service ("A").
162-163 223-224 284-285 345-346 406-407 467-468 528-529 589-590 650-651 711-712	Place of Service/Place of Treatment [up to 10]	Character	2	Required: COS 13	Indicates where the dental service took place.
164-170 225-231 286-292 347-353 408-414 469-475 530-536 591-597 652-658 713-719	Procedure Codes [up to 10]	Character	7	Required: COS 13	Procedure Codes identifying the procedures performed during the dental visit.

Record Positions	Data Element-Dental	Format	Field Length	Submission Status	Description
171-181 232-242 293-303 354-364 415-425 476-486 537-547 598-608 659-669 720-730	Dental Number of Units/Visits [up to 10]	Numeric	11	Required: COS 13	The number of times a procedure or service was provided during the encounter; or the number of units, visits, or days a procedure or service was rendered during an episode of care defined by Service Start and End Dates.
182-183 243-244 304-305 365-366 426-427 487-488 548-549 609-610 670-671 731-732	Tooth Number or Letter [up to 10]	Character	2	Required: COS 13	The tooth that the service was performed on.
184-194 245-255 306-316 367-377 428-438 489-499 550-560 611-621 672-682 733-743	FILLER	Numeric	11		FILLER
195-205 256-266 317-327 378-388	Paid Amount [up to 10]	Numeric	11	Required: COS 13	The amount paid by insurer for each listed service.

Record Positions	Data Element-Dental	Format	Field Length	Submission Status	Description
439-449 500-510 561-571 622-632 683-693 744-754					
206-213 267-274 328-335 389-396 450-457 511-518 572-579 633-640 694-701 755-762	Service Start Date [up to 10]	Date CCYYMMDD	8	Required: COS 13	The date the service began.
214-221 275-282 336-343 397-404 458-465 519-526 580-587 641-648 702-709 763-770	Service End Date [up to 10]	Date CCYYMMDD	8	Required: COS 13	The date the service ended.
Space-fill Record Positions 771 to 1200					

Professional Segment

Record Positions	Data Element-Professional	Format	Field Length	Submission Status	Description
158-160	Provider Specialty Code	Character	3	Required: COS 01, 03, 04, 05, 07,	The code identifying a provider's medical, dental, clinic or program type specialty.

Record Positions	Data Element-Professional	Format	Field Length	Submission Status	Description
				16, 19, 22, 41, 75	
161-167 168-174 175-181 182-188	Diagnosis Codes [up to 4]	Character	7	Required: COS 01, 03, 04, 05, 07, 16, 19, 22, 41, 75	Up to four diagnosis codes are to be recorded for diagnosed medical conditions for which the recipient receives services during the encounter or which may have been present at the time of the encounter and recorded by the provider.
189 248 307 366 425 484 543 602 661 720	Professional Claim/Encounter Indicator [up to 10]	Character	1	Required: COS 01, 03, 04, 05, 07, 16, 19, 22, 41, 75	Indicates whether the service provided was a capitated service within the health organization's contract ("E"); a within plan claim ("C") or an administratively denied service ("A").
190-191 249-250 308-309 367-368 426-427 485-486 544-545 603-604 662-663 721-722	Place of Service/Place of Treatment [up to 10]	Character	2	Required: COS 01, 03, 04, 05, 07, 16, 19, 22, 41, 75	Indicates location where service occurred.
192-198 251-257 310-316 369-375 428-434 487-493 546-552	Procedure Codes [up to 10]	Character	7	Required: COS 01, 03, 04, 05, 07, 16, 19, 22, 41, 75	The CPT4/HCPCS procedure code that describes the service(s) rendered during the professional encounter(s).

Record Positions	Data Element-Professional	Format	Field Length	Submission Status	Description
605-611 664-670 723-729					
199-209 258-268 317-327 376-386 435-445 494-504 553-563 612-622 671-681 730-740	Professional Number of Units/Visits [up to 10]	Numeric	11	Required: COS 01, 03, 04, 05, 07, 16, 19, 22, 41, 75	The number of times a procedure or service was provided during the encounter; or the number of units, visits, or days a procedure or service was rendered during an episode of care defined by Service Start and End Dates.
210-220 269-279 328-338 387-397 446-456 505-515 564-574 623-633 682-692 741-751	FILLER	Numeric	11		FILLER
221-231 280-290 339-349 398-408 457-467 516-526 575-585 634-644 693-703 752-762	Paid Amount [up to 10]	Numeric	11	Required: COS 01, 03, 04, 05, 07, 16, 19, 22, 41, 75	The amount paid by insurer for each listed service.
232-239	Service Start Date [up to 10]	Date	8	Required:	The date the service began.

Record Positions	Data Element-Professional	Format	Field Length	Submission Status	Description
291-298 350-357 409-416 468-475 527-534 586-593 645-652 704-711 763-770		CCYYMMDD		COS 01, 03, 04, 05, 07, 16, 19, 22, 41, 75	
240-247 299-306 358-365 417-424 476-483 535-542 594-601 653-660 712-719 771-778	Service End Date [up to 10]	Date CCYYMMDD	8	Required: COS 01, 03, 04, 05, 07, 16, 19, 22, 28, 41, 73, 75	The date the service ended.
Space-fill Record Positions 779 to 1200					

Trailer Record

Record Positions	Data Element-Trailer	Format	Field Length	Submission Status	Description
1-2	Record Type	Character	2	Required	T1=Trailer
3	Submission Record Count	Numeric	9	Required	The total number of records in the file, including the header and trailer records. Zero fill and right justify.
Space-fill Record Positions 12 to 1200					

IV. ENCOUNTER TYPE ASSIGNMENT BY COS: REQUIREMENTS BY MEDS II DATA ELEMENT

R =Required for Reporting

	MEDS Category of Service (COS)																			
	01	03	04	05	06	07	11	12	13	14	15	16	19	22	28	41	73	75	85	87
Encounter Type:	P	P	P	P	I	P	I	I	T	D	I	P	P	P	I	P	I	P	I	I
Institutional Transaction Segment (Encounter Type = "I")																				
Provider Specialty Code					R			R			R				R		R		R	R
Hosp Inpatient Claim/Encounter Indicator							R													
NYS DRG Code							R													
Type of Bill Digits 1 & 2 Code					R		R	R			R				R		R		R	R
Type of Bill Digit 3 Code					R		R	R			R				R		R		R	R
Statement Covers Period From					R			R			R				R		R		R	R
Statement Covers Period Thru					R			R			R				R		R		R	R
Type of Admission							R													
Source of Admission							R													
Patient Status Code							R	R							R		R			
Medical Record Number							R													
Neonate Birth Weight Value Code							R													
Neonate Birth Weight in Grams							R													
Revenue Code					R			R			R				R		R		R	R
HCPCS Code					R			R			R				R		R		R	R
Quantity or Units Submitted					R			R			R				R		R		R	R
Paid Amount					R			R			R				R		R		R	R
Non-Inpatient Claim/Encounter Indicator					R			R			R				R		R		R	R
Principal Diagnosis					R		R	R			R				R		R		R	R
Other Diagnosis Codes					R		R	R			R				R		R		R	R
Admit Diagnosis							R													
External Diagnosis Code							R													
Principal Procedure Code							R													

	MEDS Category of Service (COS)																			
	01	03	04	05	06	07	11	12	13	14	15	16	19	22	28	41	73	75	85	87
Encounter Type:	P	P	P	P	I	P	I	I	T	D	I	P	P	P	I	P	I	P	I	I
Other Procedure Codes							R													
Attending Provider Profession Code					R		R	R			R				R		R		R	R
Attending Provider License Number					R		R	R			R				R		R		R	R
Attending Provider ID					R		R	R			R				R		R		R	R
Surgeon Profession Code							R													
Surgeon License Number							R													
Surgeon Provider ID							R													
Admission Date							R	R							R					
Discharge Date							R	R							R					
Pharmacy Transaction Segment (Encounter Type = "D")																				
Prescribing Provider Profession Code										R										
Prescribing Provider License Number										R										
Prescribing Provider ID										R										
Prescription Ordered Date										R										
Date Filled										R										
National Drug Code (NDC) or Product Code										R										
Quantity Dispensed										R										
Drug Days Supply Count										R										
Pharmacy Claim/Encounter Indicator										R										
Dental Transaction Segment (Encounter Type = "T")																				
Provider Specialty Code									R											
Dental Claim/Encounter Indicator									R											
Place of Service/Place of Treatment									R											
Procedure Codes									R											
Dental Number of Units/Visits									R											
Tooth Number or Letter									R											

	MEDS Category of Service (COS)																			
	01	03	04	05	06	07	11	12	13	14	15	16	19	22	28	41	73	75	85	87
Encounter Type:	P	P	P	P	I	P	I	I	T	D	I	P	P	P	I	P	I	P	I	I
Paid Amount									R											
Service Start Date									R											
Service End Date									R											
Professional Transaction Segment (Encounter Type = "P")																				
Provider Specialty Code	R	R	R	R		R						R	R	R		R		R		
Diagnosis Codes	R	R	R	R		R						R	R	R		R		R		
Professional Claim/Encounter Indicator	R	R	R	R		R						R	R	R		R		R		
Place of Service/Place of Treatment	R	R	R	R		R						R	R	R		R		R		
Procedure Codes	R	R	R	R		R						R	R	R		R		R		
Professional Number of Units/Visits	R	R	R	R		R						R	R	R		R		R		
Paid Amount	R	R	R	R		R						R	R	R		R		R		
Service Start Date	R	R	R	R		R						R	R	R		R		R		
Service End Date	R	R	R	R		R						R	R	R		R		R		

V. HEADER RECORD

MEDS II Transaction Segment:	**Header**
Data Element Name:	**RECORD TYPE**
Submission Status:	Required for Header Record
Encounter Record Position(s):	1-2
Format - Length:	Character - 2
Effective Date:	3/1/2005
Version Number - Date:	2.3 - April 2007
MEDS II DE# / DW#:	NA

Definition: The Record Type identifies the data being submitted as either the header record, the detail section, or the trailer record.

Mapping:

- New York State Specific Data Element

Codes and Values:

Code	***Value***
H1	Header

Edit Applications:

- Must be a valid code of H1 for Header Record
- Tier One Edit

MEDS II Transaction Segment: **Header**
Data Element Name: **PROVIDER TRANSMISSION SUPPLIER NUMBER (TSN)**

Submission Status:	Required for Header Record
Encounter Record Position(s):	3-6
Format - Length:	Character - 4
Effective Date:	3/1/2005
Version Number - Date:	2.3 - April 2007
MEDS II DE# / DW#:	4312/E4312

Definition: Provider Transmission Supplier Number (TSN) is a unique number assigned to the health organization submitting encounter records. The TSN should be left-justified and space-filled.

Mapping:

- New York State Specific Data Element

Codes and Values:

- Left-justified and space-filled.
- Unique to health plan reporting

Edit Applications:

- Must be a valid TSN/Plan Id combination.

MEDS II Transaction Segment:	**Header**
Data Element Name:	**INPUT SERIAL NUMBER**
Submission Status:	Required for Header Record
Encounter Record Position(s):	7-12
Format - Length:	Character - 6
Effective Date:	3/1/2005
Version Number - Date:	2.3 - April 2007
MEDS II DE# / DW#:	NA/E6203

Definition: This is a number assigned by the submitter for electronic submissions.

Mapping:

- New York State Specific Data Element

Codes and Values:

Left-justified and space-filled.
Unique to health plan reporting

Edit Applications:

- None

MEDS II Transaction Segment:	**Header**
Data Element Name:	**TSN CERTIFICATION**
Submission Status:	Required for Header Record
Encounter Record Position(s):	13-21
Format - Length:	Character - 9
Effective Date:	3/1/2005
Version Number - Date:	2.3 - April 2007
MEDS II DE# / DW#:	NA/C110

Definition: This field must contain the word "CERTIFIED" (in UPPERCASE letters) to indicate the submitter is certified to submit electronically.

Mapping:

- New York State Specific Data Element

Codes and Values:

- Left-justified
- "CERTIFIED" in UPPERCASE letters.

Edit Applications:

- None

MEDS II Transaction Segment: **Header**
Data Element Name: **VENDOR SOFTWARE NUMBER**
Submission Status: Optional
Encounter Record Position(s): 22-26
Format - Length: Character - 5
Effective Date: 3/1/2005
Version Number - Date: 2.3 - April 2007
MEDS II DE# / DW#: NA/E2843

Definition: Vendor Software Number

Mapping: New York State Specific Data Element

Codes and Values: Optional Plan Reported Data Element

Edit Applications: None

MEDS II Transaction Segment: **Header**
Data Element Name: **VENDOR SOFTWARE UPDATE LEVEL**
Submission Status: Optional
Encounter Record Position(s): 27-28
Format - Length: Character - 2
Effective Date: 3/1/2005
Version Number - Date: 2.3 - April 2007
MEDS II DE# / DW#: NA/E2825

Definition: Vendor Software Update Level

Mapping: New York State Specific Data Element

Codes and Values: Optional Plan Reported Data Element

Edit Applications: None

MEDS II Transaction Segment:	**Header**
Data Element Name:	**PROD INDICATOR**
Submission Status:	Required for Header Record
Encounter Record Position(s):	29-32
Format - Length:	Character - 4
Effective Date:	3/1/2005
Version Number - Date:	2.3 - April 2007
MEDS II DE# / DW#:	NA/NA

Definition: This field must contain the word "PROD" for either testing in the Integrated Test Facility (ITF) or for submitting files to production. If this field is left blank, the submission will not pass thorugh our "Tier One" editing process an the entire file will reject.

Mapping:

- New York State Specific Data Element

Codes and Values:

- Left-justified
- Must contain the word "PROD".

Edit Applications:

- Tier One Edit: 'Specified mode " " does not match' 'Test/Prod Indicator'

MEDS II Transaction Segment:	**Header**
Data Element Name:	**PLAN IDENTIFICATION NUMBER**
Submission Status:	Required for Header Record
Encounter Record Position(s):	33-40
Format - Length:	Character - 8
Effective Date:	3/1/2005
Version Number - Date:	2.3 - April 2007
MEDS II DE# / DW#:	4397/H056

Definition: The health organization's MMIS Identification Number.

Mapping:

- New York State Specific Data Element

Codes and Values:

- Left-justified with no embedded blanks and Space-filled.
- Must be a valid MMIS Plan Identification Number

Edit Applications:

- 00423 MMIS Plan ID Missing
- 00424 MMIS Plan ID Not On File
- 00425 MMIS Plan ID Not MC Capitation Provider

MEDS II Transaction Segment:	**Header**
Data Element Name:	**SUBMITTER NAME**
Submission Status:	Required for Header Record
Encounter Record Position(s):	41-61
Format - Length:	Character - 21
Effective Date:	3/1/2005
Version Number - Date:	2.3 - April 2007
MEDS II DE# / DW#:	NA/NA

Definition: Name of submitting health organization

Mapping: New York State Specific Data Element

Codes and Values: Name Used on Official State Records

Edit Applications: None

MEDS II Transaction Segment:	**Header**
Data Element Name:	**SUBMITTER ADDRESS1**
Submission Status:	Required for Header Record
Encounter Record Position(s):	62-79
Format - Length:	Character - 18
Effective Date:	3/1/2005
Version Number - Date:	2.3 - April 2007
MEDS II DE# / DW#:	NA/NA

Definition: Street address for submitting health organization

Mapping: New York State Specific Data Element

Codes and Values: Valid Street Address

Edit Applications: None

MEDS II Transaction Segment:	**Header**
Data Element Name:	**SUBMITTER ADDRESS2**
Submission Status:	Required for Header Record
Encounter Record Position(s):	80-97
Format - Length:	Character - 18
Effective Date:	3/1/2005
Version Number - Date:	2.3 - April 2007
MEDS II DE# / DW#:	NA/NA

Definition: Street address for submitting health organization

Mapping: New York State Specific Data Element

Codes and Values:

- Left-justified
- Valid Street Address

Edit Applications:

- None

MEDS II Transaction Segment:	**Header**
Data Element Name:	**SUBMITTER CITY**
Submission Status:	Required for Header Record
Encounter Record Position(s):	98-112
Format - Length:	Character - 15
Effective Date:	3/1/2005
Version Number - Date:	2.3 - April 2007
MEDS II DE# / DW#:	NA/NA

Definition: City in which the submitting health organization correspondence should be sent.

Mapping: New York State Specific Data Element

Codes and Values:

- Left-justified
- Valid City Name

Edit Applications:

- None

MEDS II Transaction Segment:	**Header**
Data Element Name:	**SUBMITTER STATE**
Submission Status:	Required for Header Record
Encounter Record Position(s):	113-114
Format - Length:	Character - 2
Effective Date:	3/1/2005
Version Number - Date:	2.3 - April 2007
MEDS II DE# / DW#:	NA/NA

Definition: Two-character standard state postal code in which the health organization does business.

Mapping: New York State Specific Data Element

Codes and Values: Valid two character state abbreviation (e.g., "NY")

Edit Applications: None

MEDS II Transaction Segment:	**Header**
Data Element Name:	**SUBMITTER ZIP**
Submission Status:	Required for Header Record
Encounter Record Position(s):	115-123
Format - Length:	Character - 9
Effective Date:	3/1/2005
Version Number - Date:	2.3 - April 2007
MEDS II DE# / DW#:	NA/NA

Definition: The health organizations geographic area denoted by the postal zip code.

Mapping: New York State Specific Data Element

Codes and Values: Left-justified

Edit Applications: None

MEDS II Transaction Segment:	**Header**
Data Element Name:	**SUBMITTER FAX NUMBER**
Submission Status:	Required for Header Record
Encounter Record Position(s):	124-134
Format - Length:	Character - 11
Effective Date:	3/1/2005
Version Number - Date:	2.3 - April 2007
MEDS II DE# / DW#:	NA/NA

Definition: Facsimile number for the health organization.

Mapping: New York State Specific Data Element

Codes and Values: Left-justified

Edit Applications: None

MEDS II Transaction Segment:	**Header**
Data Element Name:	**SUBMITTER PHONE NUMBER**
Submission Status:	Required for Header Record
Encounter Record Position(s):	135-145
Format - Length:	Character - 11
Effective Date:	3/1/2005
Version Number - Date:	2.3 - April 2007
MEDS II DE# / DW#:	NA/NA

Definition: Phone number for the health organization, including 1 and the area code and seven digit number.

Mapping: New York State Specific Data Element

Codes and Values: Left-justified

Edit Applications: None

MEDS II Transaction Segment:	**Header**
Data Element Name:	**MEDS VERSION NUMBER**
Submission Status:	Required for Header Record
Encounter Record Position(s):	146-148
Format - Length:	Character - 3
Effective Date:	3/1/2005
Version Number - Date:	2.3 - April 2007
MEDS II DE# / DW#:	NA/NA

Definition: Version Number is "002"

Mapping: New York State Specific Data Element

Codes and Values: 002

Edit Applications: None

VI. COMMON DETAIL

MEDS II Transaction Segment:	**Common Detail**
Data Element Name:	**RECORD TYPE**
Submission Status:	Required: All COS
Encounter Record Position(s):	1-2
Format - Length:	Character - 2
Effective Date:	3/1/2005
Version Number - Date:	2.3 - April 2007
MEDS II DE# / DW#:	NA

Definition: The Record Type identifies the data being submitted as either the header record, the detail section, or the trailer record.

Mapping:

- New York State Specific Data Element

Codes and Values:

Code	***Value***
H1	Header
D1	Detail
T1	Trailer

Edit Applications:

- Must be a valid code of D1 for Common Detail Segment
- Tier One Edit

MEDS II Transaction Segment:	**Common Detail**
Data Element Name:	**ENCOUNTER TYPE INDICATOR (ETI)**
Submission Status:	Required: All COS
Encounter Record Position(s):	3
Format - Length:	Character - 1
Effective Date:	3/1/2005
Version Number - Date:	2.3 - April 2007
MEDS II DE# / DW#:	2764/H054

Definition: The Encounter Type Indicator (ETI) is a one-digit code indicating the type of encounter being reported. The ETI follows the four paper and electronic forms for institutional, pharmacy, dental and professional transactions.

Each of the four encounter types to be reported has different required data element sets and formats.

Mapping:

- New York State Specific Data Element

Codes and Values:

- Code must be valid or the encounter file will reject and no further editing will occur.

Code	*Value*
I	Institutional
D	Pharmacy
T	Dental
P	Professional

Note: Institutional includes inpatient (COS 11) and other Categories of Service. Refer to Section II, Encounter Type Assignment by Category of Service, for more information on proper assignment.

Edit Applications:

- Must be a valid code.
- The combination of Encounter Type and Category of Service must be valid.
- 00901 Claim Type Unknown

MEDS II Transaction Segment:	**Common Detail**
Data Element Name:	**ENCOUNTER CONTROL NUMBER (ECN)**
Submission Status:	Required: All COS
Encounter Record Position(s):	4-14
Format - Length:	Character - 11
Effective Date:	3/1/2005
Version Number - Date:	2.3 - April 2007
MEDS II DE# / DW#:	1121/H073

Definition: Encounter Control Number (ECN) is the health organization assigned number used to uniquely identify an encounter transaction. CSC will include the ECN on edit feedback reports to health organizations. Other than editing the ECN for its presence on the encounter record and special characters, the assignment, composition, and validity of the ECN is the responsibility of the health organization.

The ECN is returned to the plan on the response report file so the plan is able to reconcile the status of the encounter with the original file submitted.

Mapping:

- New York State Specific Data Element

Codes and Values:

- Must be left-justified with no embedded blanks and space-filled
- Can not equal zero or blanks
- Must be numeric (0-9) and/or alphabetic (A-Z). Special Characters are invalid entries.

Edit Applications:

- 00400 Encounter Control Number Missing

MEDS II Transaction Segment:	**Common Detail**
Data Element Name:	**PREVIOUS TRANSACTION CONTROL NUMBER (TCN)**
Submission Status:	Situational
Encounter Record Position(s):	15-30
Format - Length:	Character – 16
Effective Date:	3/1/2005
Version Number - Date:	2.3 - April 2007
MEDS II DE# / DW#:	0537/H055 (TCN) H075 (Prev TCN)

Definition: This data element was formerly called the Previous Encounter Reference Number (ERN).

Transaction Control Number (TCN) is a unique identifier assigned by Computer Sciences Corporation (CSC) to each encounter transaction received. The TCN is used for internal control purposes and by plans to adjust or void records identified as failing edits. Records failing soft edits will be identified to the plans by the assigned TCN and unique, plan-assigned Encounter Control Number (ECN). The previous TCN and appropriate Transaction Status Code are used only to properly adjust or void a previously submitted record. When submitting a second adjustment of a record, use the TCN assigned to the adjustment record (i.e. not the original record).

Additionally, if the encounter record passes through the system without hitting any edits, the plan should store the associated TCN and the "Accepted" status in their internal data system.

Mapping:
- New York State Specific Data Element

Codes and Values:
- Space-filled if the previous ERN is not recorded (i.e. the record is not being adjusted or voided).

Edit Applications:
- 00103 Adj / Void Fields Incomplete
- 00725 Hist Record Not Found Adjus/Void

MEDS II Transaction Segment:	**Common Detail**
Data Element Name:	**TRANSACTION STATUS CODE**
Submission Status:	Required: All COS
Encounter Record Position(s):	31
Format - Length:	Character – 1
Effective Date:	3/1/2005
Version Number - Date:	2.3 - April 2007
MEDS II DE# / DW#:	0705/H066

Definition: The Transaction Status Code identifies an encounter transaction as an original encounter, a void or a replacement to a previously accepted encounter. (This data element was formerly called the Adjustment/Void Code.)

Health organizations may use the adjustment/void process to update previously submitted information, to correct data elements that had previously failed soft edits or to delete records that should not have been submitted.

Mapping:

- New York State Specific Data Element

Codes and Values:

Code	*Value*
0	ORIGINAL ENCOUNTER
7	ADJUSTMENT ENCOUNTER - REPLACEMENT RECORD
8	VOID ENCOUNTER – DELETION RECORD

- All new encounters will be submitted with a value of "0".
- For adjustments, resubmit entire record, with the "7" code and Previous Transaction Control Number
- For Voids, resubmit entire record with an "8" code and Previous TCN
- To resubmit rejected records, resubmit the entire record with a value of "0", with the same Encounter Control Number, but without the TCN.

Edit Applications:

- 00103 Adj / Void fields incomplete

MEDS II Transaction Segment:	**Common Detail**
Data Element Name:	**CLIENT IDENTIFICATION NUMBER (CIN)**
Submission Status:	Required: All COS
Encounter Record Position(s):	32-39
Format - Length:	Character - 8
Effective Date:	3/1/2005
Version Number - Date:	2.3 - April 2007
MEDS II DE# / DW#:	0535/1010

Definition: The CIN is assigned to an enrollee upon determination that an individual is eligible for Medicaid services. All encounter records must contain a valid CIN. Newborn encounters should not be reported under the maternal CIN.

Mapping:

- **Paper Form**:

Encounter Type	Form	Element
Institutional	UB-92	#60
Institutional	UB-04	#60
Pharmacy	UCF	ID
Dental	ADA	#15
Professional	CMS-1500	#1A

- **Electronic**:

Encounter Type	EDI Format	X12 Mapping Loop	X12 Mapping Segment	Seg. Ele. (Ref)	Element ID	Code	Page No.
Institutional	837I	2010BA	NM1 NM1	08 09	66 67	MI	110
Dental	837D	2010CA	NM1	08 09	66 67	MI	137-138
Professional	837P	2010CA	NM1	08 09	66 67	MI	159

Encounter Type	NCPDP Format
Pharmacy/DME	302-C2

Codes and Values:

- The CIN format consists of 2 letters, followed by 5 numbers, and ending with 1 letter (e.g. XY12345Z)

Edit Applications:

- 00074 Recipient ID Number Invalid
- 00140 Recipient ID Not On File
- 00689 Recipient Not Enrolled in Plan on Date of Service
- 00693 Recipient Never Enrolled in Managed Care
- 00694 Recipient Not Enrolled in MC on Date of Service
- 00696 Recipient Enrolled in Another MC Plan on Date of Service

MEDS II Transaction Segment:	**Common Detail**
Data Element Name:	**BENEFICIARY IDENTIFICATION NUMBER**
Submission Status:	Optional
Encounter Record Position(s):	40-64
Format - Length:	Character - 25
Effective Date:	3/1/2005
Version Number - Date:	2.3 - April 2007
MEDS II DE# / DW#:	2767/H072

Definition: The Beneficiary Identification Number is a unique identification number assigned by the health organization to the member. The Beneficiary Identification Number may also be known as the subscriber identification number or a health insurance card identification number. The Beneficiary Identification Number should be identical to the Policy Number used for hospital claims and the Insured's Identification Number used in Professional service claims.

Mapping:

- **Paper Form**:

Encounter Type	Form	Element
Institutional	UB-92	#60
Institutional	UB-04	#60
Pharmacy	UCF	ID
Dental	ADA	#15
Professional	CMS-1500	#1A

- **Electronic**:

Encounter Type	EDI Format	X12 Mapping Loop	X12 Mapping Segment	Seg. Ele. (Ref)	Element ID	Page No.
Institutional	837I	2300	CLM	01	1028	158
Dental	837D	2300	CLM	01	1028	150
Professional	837P	2300	CLM	01	1028	171

Encounter Type	NCPDP Format
Pharmacy/DME	ID

Codes and Values:

- Left-justified.
- Space-fill if not applicable.

Edit Applications:

- None

MEDS II Transaction Segment:	**Common Detail**
Data Element Name:	**PROVIDER PROFESSION CODE**
Submission Status:	Required: 01, 03, 04, 05, 06, 07, 13, 41, 75
Encounter Record Position(s):	65-67
Format - Length:	Character - 3
Effective Date:	3/1/2005
Version Number - Date:	2.3 - April 2007
MEDS II DE# / DW#:	2165/2165_3

Definition: Provider Profession Code specifies the three-digit profession of a provider on the State Education Department (SED) license file. The Profession Code is used in conjunction with the provider license number to identify providers licensed by SED.

Mapping:

- New York State Specific Data Element

Codes and Values:

- Provider Profession Codes and Values are contained within Appendix A. These codes are also available for download on the MEDS Home Page on the HPN.
- Space-fill if not applicable.

Edit Applications:

- Must be a valid code

Important Note:

Plans are now receiving the profession code for every provider on their Provider Network Submission. Please contact the department's Provider Network Unit at (518)486-9012 if you have any questions or need more information.

For up to date information on provider profession codes, plans can also visit the State Education Department website at http://www.nysed.gov/

MEDS II Transaction Segment:	**Common Detail**
Data Element Name:	**PROVIDER LICENSE NUMBER**
Submission Status:	Required: 01, 03, 04, 05, 06, 07, 13, 41, 75
Encounter Record Position(s):	68-75
Format - Length:	Character - 8
Effective Date:	3/1/2005
Version Number - Date:	2.3 - April 2007
MEDS II DE# / DW#:	1570/W047

Definition: The Provider License Number, issued by the New York State Department of Education, is used to identify the health care provider rendering services or primarily responsible for the care provided during the encounter.

Mapping:

- **Electronic**:

Encounter Type	EDI Format	X12 Mapping Loop	X12 Mapping Segment	Seg. Ele. (Ref)	Element ID	Code	Page No.
Institutional	837I	2010AA	REF	01 02	128 127	0B	83-84
Dental	837D	2010AA	REF	01 02	128 127	0B	84
Professional	837P	2010AA	REF	01 02	128 127	0B	92

Codes and Values:

- Right-justified.
- Do not zero fill – Space-fill if not applicable.
- Must be a valid professional license number issued by the New York State Department of Education.

Edit Applications:

- Must be a valid entry.
- Soft edit failures will be recorded if license number is not provided.
- 00416 License Number Is Missing

Important Note:

There is a lookup tool for SED License status on the Health Provider Network Homepage on the HPN. This application supplements the SED license site lookup but gives plans more features and search flexibility. This lookup also returns SED profession code for those needing this information for MEDS submission purposes.
The direct link for this lookup tool is: https://commerce.health.state.ny.us/hpn/cgi-bin/applinks/omcdata/lic_lookup.cgi

MEDS II Transaction Segment:	**Common Detail**
Data Element Name:	**PROVIDER IDENTIFICATION NUMBER**
Submission Status:	Required: All COS
Encounter Record Position(s):	76-83
Format - Length:	Character - 8
Effective Date:	3/1/2005
Version Number - Date:	2.3 - April 2007
MEDS II DE# / DW#:	1563/2001

Definition: Provider Identification Number is a unique MMIS provider ID assigned to each provider that sees Medicaid recipients. This number is the primary way of identifying a provider.

Encounter Type	Provider Type
Professional	Servicing Provider
Dental	Servicing Provider
Institutional	Billing (Referring) Provider
Pharmacy/DME	Dispensing (Referring) Provider

Mapping:

- **Paper Form**:

Encounter Type	Form	Element
Institutional	UB-92	#51
Institutional	UB-04	#56- 57
Pharmacy	UCF	Service Provider ID
Dental	ADA	#54
Professional	CMS-1500	#33

- **Electronic**:

Encounter Type	EDI Format	X12 Mapping Loop	X12 Mapping Segment	Seg. Ele. (Ref)	Element ID	Code	Page No.
Institutional	837I	2010AA	NM1	08 09	66 67	XX	77
Dental	837D	2010AA	NM1	08 09	66 67	XX	78
Professional	837P	2010AA	NM1	08 09	66 67	XX	86

Encounter Type	NCPDP Format
Pharmacy/DME	202-B2 201-B1

Codes and Values:

- Left-justified with no embedded blanks.

- Space-fill if not applicable.

- The following Generic Provider IDs should be used to report encounters involving out-of-network providers (in state or out-of-state) when Provider IDs are unknown.

COS	*COS Description*	*Generic Provider ID*
01	Provider Services	01666119
03	Podiatry	01666119
04	Psychology	01666119
05	Eye Care/Vision	01666119
06	Rehabilitation Therapy	01666119
07	Nursing	01666119
11	Inpatient	01666086
12	Institutional Long Term Care	01666119
13	Dental	01666119
14	Pharmacy	01666137
15	Home Health Care / Non-Institutional Long Term Care	01666119
16	Laboratories	01666100
19	Transportation	01666077
22	DME and Hearing Aids	01666137
28	Intermediate Care Facilities	01666119
41	Nurse Providers/Midwives	01666119
73	Hospice	01666119
75	Clinical Social Worker	01666119
85	Freestanding Clinic	01666095
87	Non-Inpatient/Emergency Room	01666128

Edit Applications:

- Must be a valid entry
- 00409 Inpatient MMIS Provider ID Is Not A Hospital (COS 11 Only)
- 00175 Servicing Provider Id Not on File (Professional and Dental)
- 00078 Referring Provider Identification Number Invalid (Institutional and Pharmacy)

MEDS II Transaction Segment:	**Common Detail**
Data Element Name:	**CATEGORY OF SERVICE**
Submission Status:	Required: All COS
Encounter Record Position(s):	86-87
Format - Length:	Character - 2
Effective Date:	3/1/2005
Version Number - Date:	2.3 - April 2007
MEDS II DE# / DW#:	2694/H001_7

Definition: Category of Service is a two-digit alpha-numeric code which indicates the type of service being provided and/or the provider rendering the service.

Mapping:

- New York State Specific Data Element

Codes and Values: Category of Service must be applicable to the encounter type being reported.

Category of Service		***Encounter Type***	
Code	***Value***	***Code***	***Value***
01	Physician Services	P	Professional
03	Podiatry	P	Professional
04	Psychology	P	Professional
05	Eye Care / Vision	P	Professional
06	Rehabilitation Therapy	I	Institutional
07	Nursing	P	Professional
11	Inpatient	I	Institutional
12	Institutional LTC	I	Institutional
13	Dental	T	Dental
14	Pharmacy	D	Pharmacy/DME
15	Home Health Care/Non-Institutional LTC	I	Institutional
16	Laboratories	P	Professional
19	Transportation	P	Professional
22	DME and Hearing Aids	P	Professional
28	Intermediate Care Facilities	I	Institutional
41	NPs/Midwives	P	Professional
73	Hospice	I	Institutional
75	Clinical Social Worker	P	Professional
85	Freestanding Clinic	I	Institutional
87	Hospital OP/ER Room	I	Institutional

Edit Applications:

- Must be a valid code.
- 00408 Category Of Service Missing
- 00901 Claim Type Unknown

MEDS II Transaction Segment:	**Common Detail**
Data Element Name:	**TOTAL PAID AMOUNT**
Submission Status:	Required: All COS
Encounter Record Position(s):	99-109
Format - Length:	Numeric - 11
Effective Date:	3/1/2005
Version Number - Date:	2.3 - April 2007
MEDS II DE# / DW#:	1028/E1028

Definition: The total amount paid for all listed services. The Total Amount Paid includes the sum of all plan claims (Claim/Encounter Indicator="C") and proxy encounters (Claim/Encounter Indicator="E").

Total Amount Paid should be calculated from the service lines reported. If the record submitted in a continuation encounter, the Total Paid Amount on the first encounter record would be for service lines 1 through 10 and the Total Paid Amount on the second encounter record would be for service lines 11 – 20, etc.

Mapping:

- New York State Specific Data Element

Codes and Values:

- Right-justified and zero filled.
- This amount is defined with two implied decimal places (e.g., $1,000.00 is reported as 100000)

Edit Applications:

- Must be a valid format.
- Must be entered as a positive number.

MEDS II Transaction Segment:	**Common Detail**
Data Element Name:	**OTHER PAYER NAME**
Submission Status:	Situational
Encounter Record Position(s):	110-144
Format - Length:	Character - 35
Effective Date:	3/1/2005
Version Number - Date:	2.3 - April 2007
MEDS II DE# / DW#:	1589/E1589

Definition: Other Payer Name identifies the secondary payer on the encounter.

Mapping:

- **Paper Form**:

Encounter Type	Form	Element
Institutional	UB-92	#50B
Institutional	UB-04	#50B
Pharmacy	UCF	
Dental	ADA	#11
Professional	CMS-1500	

- **Electronic**:

Encounter Type	EDI Format	X12 Mapping Loop	X12 Mapping Segment	Seg. Ele. (Ref)	Element ID	Page No.
Institutional	837I	2010BC	NM1	03	1035	127
Dental	837D	2010BB	NM1	03	1035	118
Professional	837P	2010BB	NM1	03	1035	131

Codes and Values:

- Free-form description of secondary payer.
- Space-fill if not applicable.

Edit Applications:

- None.

MEDS II Transaction Segment:	**Common Detail**
Data Element Name:	**OTHER INSURANCE TOTAL PAID AMOUNT**
Submission Status:	Situational
Encounter Record Position(s):	145-155
Format - Length:	Numeric - 11
Effective Date:	3/1/2005
Version Number – Date:	2.3 - April 2007
MEDS II DE# / DW#:	1085/3031

Definition: The total amount paid by insurance other than Medicaid.

Mapping:

- New York State Specific Data Element

Codes and Values:

- Right-justified and zero-filled.
- This amount is defined with two implied decimal places.

Edit Applications:

- Must be a valid format.
- Must be entered as a positive number.

MEDS II Transaction Segment:	**Common Detail**
Data Element Name:	**OTHER INSURANCE TYPE CODE**
Submission Status:	Situational
Encounter Record Position(s):	156-157
Format - Length:	Character - 2
Effective Date:	3/1/2005
Version Number - Date:	2.3 - April 2007
MEDS II DE# / DW#:	1455/E1455_2

Definition: The Other Insurance Type Code indicates payers other than Medicaid.

Mapping:

- **Electronic**:

Encounter Type	EDI Format	X12 Mapping Loop	X12 Mapping Segment	Seg. Ele. (Ref)	Element ID	Page No.
Institutional	837I	2000B	SBR	09	1032	104
Dental	837D	2000B	SBR	09	1032	101
Professional	837P	2000B	SBR	09	1032	112

Codes and Values:

Code	*Value*
09	Self Pay
10	Central Certification
11	Other Non-Federal Programs
12	Preferred Provider Organizations (PPO)
13	Point of Service (POS)
14	Exclusive Provider Organization (EPO)
15	Indemnity Insurance
16	HMO Medicare Risk
AM	Automobile Medical
BL	Blue Cross/Blue Shield
CA	Capitated
CH	Champus
CI	Commercial Insurance Company
DS	Disability
HM	Health Maintenance Organization
LI	Liability
LM	Liability Medical
MA	Medicare; Part A
MB	Medicare; Part B

Code	*Value*
MC	Medicaid
OF	Other Federal Program
OI	Other Insurance
SC	Sub-Capitated
TV	Title V
VA	Veteran's Admininistration Plan
WC	Workers Compensation Health Plan
ZZ	Mutually Defined

- Space-fill if not applicable.

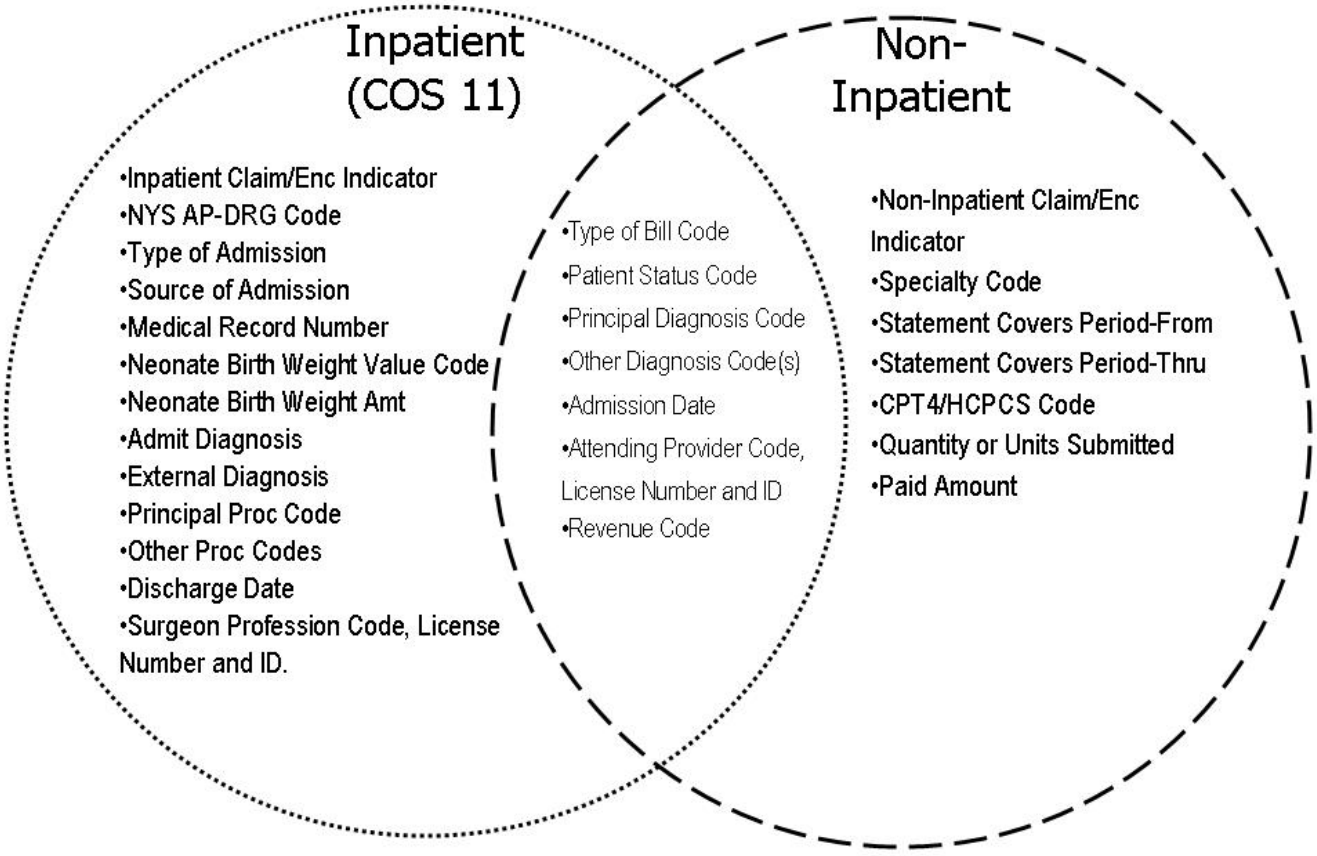
Edit Applications:

- Must be a valid code

Important Note:

This data element, along with Other Insurance Total Paid Amount and Other Insurance Type Code, will be used in MEDS II to identify the first 20 days of a nursing home stay in which Medicare pays 100% of the cost. If the enrollee is not discharged within the first 20 days, then the remainder of the month would be reported as a separate encounter.

Inpatient and Non-Inpatient Reporting Requirements by Data Element



There are two components to the Institutional segment of MEDS II reporting requirements: inpatient and non-inpatient. As the diagram above indicates, many of the Institutional data elements are required for inpatient COS 11 only. The intersection of the diagram above indicates the data elements that are required for both inpatient and non-inpatient reporting.

MEDS II Transaction Segment:	**Institutional**
Data Element Name:	**PROVIDER SPECIALTY CODE**
Submission Status:	Required for COS 06, 12, 15, 28, 73, 85, 87
Encounter Record Position(s):	158-160
Format - Length:	Character - 3
Effective Date:	3/1/2005
Version Number - Date:	2.3 - April 2007
MEDS II DE# / DW#:	1499/2048

Definition: The provider's Specialty Code identifies a provider's medical, dental, clinic or program type specialty.

Mapping:

- New York State Specific Data Element

Codes and Values:

- Refer to Appendix B for valid codes and values. These codes and values are available for download on the MEDS Home Page on the HPN.
- Where applicable, specialty codes must be a valid three-digit MMIS specialty code.
- Space-fill if not applicable.

Edit Applications:

- Must be a valid code.
- 00404 Provider Specialty Missing
- 00413 Provider Specialty Not On File

MEDS II Transaction Segment: **Institutional**

Data Element Name: **HOSPITAL INPATIENT CLAIM/ENCOUNTER INDICATOR**

Submission Status: Required for COS 11
Encounter Record Position(s): 161
Format - Length: Character - 1
Effective Date: 3/1/2005
Version Number - Date: 2.3 - April 2007
MEDS II DE# / DW#: 1983/E1983

Definition: Indicates whether the inpatient service provided was a capitated service within the health organization's contract ("E"); a within plan claim ("C") or an administratively denied service ("A").

Administratively denied encounters are those encounters, which reflect services normally paid for, but were denied due to failure of at least one requirement of the agreement between provider and plan. An example could be that encounters must be submitted within 60 days of service date. A well-child encounter submitted 63 days after date of service would be administrative denied. (Claim received too late).

Mapping:

- New York State Specific Data Element

Codes and Values:

Code	Value
E	Capitated Encounter or service not paid directly by the health organization
C	Within Plan Claim
A	Administrative Denial

- Space-fill if not applicable.

Edit Applications:

- Must be a valid code.
- 00437 Claim Encounter Ind Invalid

Please Note:

Sub-capitation vendor relationships should be reported as encounters.

MEDS II Transaction Segment:	**Institutional**
Data Element Name:	**NYS DIAGNOSIS RELATED GROUP CODE**
Submission Status:	Required for COS 11
Encounter Record Position(s):	162-165
Format - Length:	Character – 4
Effective Date:	3/1/2005
Version Number - Date:	2.3 - April 2007
MEDS II DE# / DW#:	2053/3336

Definition: The NYS Diagnosis Related Group (AP-DRG) Code specifies the group of services received by a recipient during an inpatient stay.

This code is generated by the NYS AP-DRG grouper module during claims processing and is derived using recipient information, diagnosis codes, procedure codes.

In instances where a plan-derived DRG differs from the provider submitted DRG, submit the plan-derived DRG.

Mapping:

- **Paper Form**:

Encounter Type	Form	Element
Institutional	UB-92	#11, #39-41, #78, #84
Institutional	UB-04	#39-41, #78, #80

- **Electronic**:

Encounter Type	EDI Format	X12 Mapping Loop	X12 Mapping Segment	Seg. Ele. (Ref)	Element ID	Code	Page No.
Institutional	837I	2300	HI	01	1		230
			HI	01	2		

Codes and Values:

- Right-justified and zero-filled.
- If there is no DRG to report, a plan must report “0000” for the DRG.

Edit Applications:

- Must be a valid code.
- 00410 DRG Code Missing

MEDS II Transaction Segment:	**Institutional**
Data Element Name:	**TYPE OF BILL DIGITS 1 & 2 CODE**
Submission Status:	Required for COS 06, 11, 12, 15, 28, 73, 85, 87
Encounter Record Position(s):	166-167
Format - Length:	Character - 2
Effective Date:	3/1/2005
Version Number - Date:	2.3 - April 2007
MEDS II DE# / DW#:	0394 / E0394

Definition: Type of Bill Digits 1 & 2 Code is the first two digits of a three digit numeric code which identifies the specific type of bill (inpatient, outpatient, adjustments, voids, etc.). The first digit represents the Type of Facility, the second digit is the Bill Classification.

Mapping:

- **Paper Form**:

Encounter Type	Form	Element
Institutional	UB-92	#4
Institutional	UB-04	#4

- **Electronic**:

Encounter Type	EDI Format	X12 Mapping Loop	X12 Mapping Segment	Seg. Ele. (Ref)	Composite	Element ID	Page No.
Institutional	837I	2300	CLM	05	C023-1 C023-2	1331 1332	159

Codes and Values:

Code	*Value*
11	HOSP-INP INCL MED PART A
12	HOSP-INP MED PART B ONLY
13	HOSP-OUT
14	HOSP-OTHER
15	HOSP-INTER CARE LEVEL I
16	HOSP-INTER CARE LEVEL II
17	HOSP-SUBACUTE INP
18	HOSP-SWING BEDS
21	SNF-INP INCL MED PART A
22	SNF-INP MED PART B ONLY
23	SNF-OUT
24	SNF-OTHER
25	SNF-INTER CARE LEVEL I
26	SNF-INTER CARE LEVEL II
27	SNF-SUBACUTE INP

Code	*Value*
28	SNF-SWING BEDS
32	HOME HLTH-INP MED PART B ONLY
33	HOME HLTH-OUTPATIENT
34	HOME HLTH-OTHER
41	NON-MED HCI-HOSP INP-INP INCL MED PART A
42	NON-MED HCI-HOSP INP-INP MED PART B ONLY
43	NON-MED HCI-HOSP INP-OUT
44	NON-MED HCI-HOSP INP-OTHER
45	NON-MED HCI-HOSP INP-INTER CARE LEVEL I
46	NON-MED HCI-HOSP INP-INTER CARE LEVEL II
47	NON-MED HCI-HOSP INP-SUBACUTE INP
48	NON-MED HCI-HOSP INP-SWING BEDS
51	NON-MED HCI-POST-HOSP EXT CS-INP INCL MED PART A
52	NON-MED HCI-POST-HOSP EXT CS-INP MED PART B ONLY
53	NON-MED HCI-POST-HOSP EXT CS-OUT
54	NON-MED HCI-POST-HOSP EXT CS-OTHER
55	NON-MED HCI-POST-HOSP EXT CS-INTER CARE LEVEL I
56	NON-MED HCI-POST-HOSP EXT CS-INTER CARE LEVEL II
57	NON-MED HCI-POST-HOSP EXT CS-SUBACUTE INP
58	NON-MED HCI-POST-HOSP EXT CS-SWING BEDS
61	INTER CARE-INP INCL MED PART A
62	INTER CARE-INP MED PART B ONLY
63	INTER CARE-OUT
64	INTER CARE-OTHER
65	INTER CARE-INTER CARE LEVEL I
66	INTER CARE-INTER CARE LEVEL II
67	INTER CARE-SUBACUTE INP
68	INTER CARE-SWING BEDS
71	CLINIC-RURAL HLTH
72	CLINIC-HOSP/INDEP DIALYSIS CNTR
73	CLINIC-FREE STANDING
74	CLINIC-ORF
75	CLINIC-CORF
76	CLINIC-COMMUNITY MENTAL HLTH CENTER
79	CLINIC-OTHER
81	SPEC FACI-HOSPICE (NON-HOSP BASED)
82	SPEC FACI-HOSPICE (HOSP BASED)
83	SPEC FACI-AMB SURG CNTR
84	SPEC FACI-FREE STANDING BIRTHING CENTER
85	SPEC FACI-CRITICAL ACCESS HOSP
86	SPEC FACI-RESIDENTIAL FACILITY
89	SPEC FACI-OTHER

For more information refer to the Code Structure described on the UB-92 for Element #4 or in the 837I on pg. 159.

Edit Applications:

- Must be a valid code.
- 01718 Type of Bill is Invalid

MEDS II Transaction Segment:	**Institutional**
Data Element Name:	**TYPE OF BILL CODE DIGIT 3 CODE**
Submission Status:	Required for COS 06, 11, 12, 15, 28, 73, 85, 87
Encounter Record Position(s):	168
Format - Length:	Character – 1
Effective Date:	3/1/2005
Version Number - Date:	2.3 - April 2007
MEDS II DE# / DW#:	0395/ E0395

Definition: Type of Bill Digit 3 Code is the last digit of the three Character Type of Bill code. It represents the frequency of the bill.

Mapping:

- **Paper Form**:

Encounter Type	Form	Element
Institutional	UB-92	#4
Institutional	UB-04	#4

- **Electronic**:

Encounter Type	EDI Format	X12 Mapping Loop	X12 Mapping Segment	Seg. Ele. (Ref)	Composite	Element ID	Page No.
Institutional	837I	2300	CLM	05	C023-3	1325	159

Codes and Values:

Code	*Value*
0	NON-PAYMENT/ZERO CLAIM
1	ADMIT THRU DISCHARGE CLAIM
2	INTERIM - FIRST CLAIM (NOT VALID FOR COS 11 ENCOUNTERS)
3	INTERIM - CONTINUING CLAIM (NOT VALID FOR COS 11 ENCOUNTERS)
4	INTERIM - LAST CLAIM (NOT VALID FOR COS 11 ENCOUNTERS)
5	LATE CHARGE(S) ONLY CLAIM
6	RESERVED
7	REPLACEMENT OF PRIOR CLAIM
8	VOID/CANCEL OF PRIOR CLAIM
9	FINAL CLAIM FOR A HOME HEALTH PPS EPISODE
A	ADMISSION/ELECTION NOTICE (A)

Edit Applications:

- Must be a valid code.
- 00436 Type of Bill Digit 3 Invalid

MEDS II Transaction Segment:	**Institutional**
Data Element Name:	**STATEMENT COVERS PERIOD FROM**
Submission Status:	Required for COS 06, 12, 15, 28, 73, 85, 87
Encounter Record Position(s):	169-176
Format - Length:	Date – CCYYMMDD
Effective Date:	3/1/2005
Version Number - Date:	2.3 - April 2007
MEDS II DE# / DW#:	1022/3013

Definition: Statement Covers Period From date is the first date that a service on an encounter was rendered.

Mapping:

- **Paper Form**:

Encounter Type	Form	Element
Institutional	UB-92	#6
Institutional	UB-04	#6

- **Electronic**:

Encounter Type	EDI Format	X12 Mapping Loop	X12 Mapping Segment	Seg. Ele. (Ref)	Element ID	Code	Pg No
Institutional	837I	2300	DTP	01 02 03	374 1250 1251	434 D8&RD8	167

Codes and Values:

- Must be a valid date format CCYYMMDD

Valid Century (CC)	Valid Year (YY)
20	>=04

Valid Month Code (MM)	Valid Day Code (DD)
01, 03, 05, 07, 08, 10, 12	Greater than 00 and less than 32
04, 06, 09, 11	Greater than 00 and less than 31
02	Greater than 00 and less than 29 (less than 30 on a leap year)

- Must be **spaced-filled** when not applicable. (i.e., COS 11)

Edit Applications:

- Must be on or before the Statement Covers Period – Thru Date
- 00018 Date Of Service/Fill Date Invalid
- 001292 Date of Service Two Years Prior to Date Received

MEDS II Transaction Segment:	**Institutional**
Data Element Name:	**STATEMENT COVERS PERIOD THRU**
Submission Status:	Required for COS 06, 12, 15, 28, 73, 85, 87
Encounter Record Position(s):	177-184
Format - Length:	Date - CCYYMMDD
Effective Date:	3/1/2005
Version Number - Date:	2.3 - April 2007
MEDS II DE# / DW#:	1023/3015

Definition: Statement Covers Period Thru date is the last date that a service on an encounter was rendered.

Mapping:

- **Paper Form**:

Encounter Type	Form	Element
Institutional	UB-92	#6
Institutional	UB-04	#6

- **Electronic**:

Encounter Type	EDI Format	X12 Mapping Loop	X12 Mapping Segment	Seg. Ele. (Ref)	Element ID	Code	Pg No
Institutional	837I	2300	DTP	01 02 03	374 1250 1251	434 D8&RD8	167

Codes and Values:

- Must be a valid date format CCYYMMDD

Valid Century (CC)	Valid Year (YY)
20	>=04

Valid Month Code (MM)	Valid Day Code (DD)
01, 03, 05, 07, 08, 10, 12	Greater than 00 and less than 32
04, 06, 09, 11	Greater than 00 and less than 31
02	Greater than 00 and less than 29 (less than 30 on a leap year)

- Must be **spaced-filled** when not applicable. (i.e., COS 11)

Edit Applications:

- Must be on or after the Statement Covers Period – From Date
- Must be on or after the Admission Date
- 00655 Discharge Date Different Than Statement Thru Date
- 01004 Thru Service Date Invalid
- 01006 Thru Service Prior to From Service Date

MEDS II Transaction Segment:	**Institutional**
Data Element Name:	**TYPE OF ADMISSION**
Submission Status:	Required for COS 11
Encounter Record Position(s):	185
Format - Length:	Character - 1
Effective Date:	3/1/2005
Version Number - Date:	2.3 - April 2007
MEDS II DE# / DW#:	4151/3101

Definition: One-digit alpha-numeric code indicating priority of the admission to a hospital.

Mapping:

- **Paper Form**:

Encounter Type	Form	Element
Institutional	UB-92	#19
Institutional	UB-04	#14

- **Electronic**:

Encounter Type	EDI Format	X12 Mapping Loop	X12 Mapping Segment	Seg. Ele. (Ref)	Composite	Element ID	Page No.
Institutional	837I	2300	CL1	01	n/a	1315	171

Codes and Values:

Code	*Value*
1	Emergency: The patient requires immediate medical intervention as a result of severe, life threatening, or potentially disabling conditions.
2	Urgent: The patient requires immediate attention for the care and treatment of a physical or mental disorder. Generally the patient is admitted to the first available and suitable accommodation.
3	Elective: The patient's condition permits adequate time to schedule the admission based on the availability of a suitable accommodation.
4	Newborn: Use of this code necessitates the use of special codes in the Source of Admission
5	Trauma Center

- Space-fill if not applicable.

Edit Applications:

- Must be a valid entry.
- 00603 Admission Type Code Invalid

MEDS II Transaction Segment:	**Institutional**
Data Element Name:	**SOURCE OF ADMISSION**
Submission Status:	Required for COS 11
Encounter Record Position(s):	186
Format - Length:	Character - 1
Effective Date:	3/1/2005
Version Number - Date:	2.3 - April 2007
MEDS II DE# / DW#:	0138/E0138

Definition: Source of Admission specifies the source of an admission into a hospital.

Mapping:

- **Paper Form**:

Encounter Type	Form	Element
Institutional	UB-92	#20
Institutional	UB-04	#15

- **Electronic**:

Encounter Type	EDI Format	X12 Mapping Loop	X12 Mapping Segment	Seg. Ele. (Ref)	Composite	Element ID	Page No.
Institutional	837I	2300	CL1	02	n/a	1314	172

Codes and Values:

Code	*Value*
1	Provider Referral
2	Clinic Referral
3	HMO Referral
4	Transfer from a Hospital
5	Transfer from a Skilled Nursing Facility
6	Transfer from Another Health Care Facility
7	Emergency Room
8	Court/Law Enforcement
9	Information Not Available
A	Transfer from a Critical Access Hospital
B	Transfer from Another Home Health Agency
C	Readmission to Same Home Health Agency

If the Type of Admission is a Newborn, "4", the following coding scheme must be used for Source of Admission.

Code	*Value*
1	Normal Delivery A baby delivered without complications.
2	Premature Delivery A baby delivered with time and/or weight factors qualifying it for premature status.
3	Sick Baby A baby delivered with medical complications, other than those relating to premature status.
4	Extra Mural Birth A newborn born in a non-sterile environment.
9	Information Not Available

- Space-fill if not applicable.

Edit Applications:

- Must be a valid entry.
- 00435 Source of Admission Code Invalid

MEDS II Transaction Segment:	**Institutional**
Data Element Name:	**PATIENT STATUS OR DISPOSITION CODE**
Submission Status:	Required for COS 11, 12, 28, 73
Encounter Record Position(s):	187-188
Format - Length:	Character - 2
Effective Date:	3/1/2005
Version Number - Date:	2.3 - April 2007
MEDS II DE# / DW#:	0168/3291

Definition: Patient Status Code describes a specific condition or status of an enrollee as of the last date of service on the encounter.

Mapping:

- **Paper Form**:

Encounter Type	Form	Element
Institutional	UB-92	#22
Institutional	UB-04	#17

- **Electronic**:

Encounter Type	EDI Format	X12 Mapping Loop	X12 Mapping Segment	Seg. Ele. (Ref)	Composite	Element ID	Page No.
Institutional	837I	2300	CL1	03	n/a	1352	172

Codes and Values:

- Right-justified and zero-filled.
- Must be a valid code in accordance with Patient Status or Disposition Codes

Code	*Value*
01	DISCHARGE / TRANSFER TO HOME/SELF CARE
02	TRANSFER TO A DRG HOSPITAL
03	DISCHARGE / TRANSFER TO SKILLED NURSING FACILITY
04	DISCHARGE/TRANSFER TO INTER CARE FACILITY/HRF
05	TRANSFERRED TO A NON-DRG HOSPITAL
06	DISCHARGE TO HOME UNDER CARE OF HOME HEALTH ORG.
07	LEFT AGAINST MEDICAL ADVICE
08	DISCHARGED TO HOME IV THERAPY
09	ADMITTED TO INPATIENT HOSPITAL
20	EXPIRED
30	STILL A PATIENT/RESIDENT (NOT VALID FOR COS 11 ENCOUNTERS)
40	EXPIRED AT HOME
41	EXPIRED AT MEDICAL FACILITY

Code	*Value*
42	EXPIRED - PLACE UNKNOWN
43	DISCHARGED TO FEDERAL HOSPITAL
50	HOSPICE – HOME
51	HOSPICE - MEDICAL FACILITY
61	DISCHARGE/TRANSFER TO ALC
62	DISCHARGE/TRANSFER TO INPATIENT REHAB FACILITY
63	DISCHARGE/TRANSFER TO MCARE LTC HOSPITAL
64	DISCHARGE/TRANSFER TO SNF CERTIFIED UNDER MCAID
65	DISCHAGE /TRANSFER TO PSYCHIATRIC HOSPITAL

- Space-fill if not applicable.

Edit Applications:

- Must be a valid entry.
- 00021 Patient Status Code Invalid

MEDS II Transaction Segment:	**Institutional**
Data Element Name:	**MEDICAL RECORD NUMBER**
Submission Status:	Required for COS 11
Encounter Record Position(s):	189-208
Format - Length:	Character – 20
Effective Date:	3/1/2005
Version Number - Date:	2.3 - April 2007
MEDS II DE# / DW#:	1016/3253

Definition: Patient Medical Record Number is an identifier assigned by a provider to a client for the purposes of tracking, accounting or reference. The number used by the Medical Records Department to identify the patient's permanent medical/health record file.

Mapping:

- **Paper Form**:

Encounter Type	Form	Element
Institutional	UB-92	#23
Institutional	UB-04	#3-B

- **Electronic**:

Encounter Type	EDI Format	X12 Mapping Loop	X12 Mapping Segment	Seg. Ele. (Ref)	Composite	Element ID	Page No.
Institutional	837I	2300	REF	01 02	n/a	128 127	200-201

Codes and Values:

- Left-justified with no embedded blanks
- Space-fill if not applicable.
- Must not equal zero or blanks.
- Must be numeric (0-9) and/or alphabetic (A-Z). Special characters are invalid

Edit Applications:

- Must be a valid entry.

MEDS II Transaction Segment:	**Institutional**
Data Element Name:	**NEONATE BIRTH WEIGHT CODE [up to 2]**
Submission Status:	Required for COS 11
Encounter Record Position(s):	209-210; 218-219
Format - Length:	Character – 2
Effective Date:	3/1/2005
Version Number - Date:	2.3 - April 2007
MEDS II DE# / DW#:	1093/3321

Definition: The MEDS II layout allows for up to two Value Codes and up to two Value Code Amounts. At this time, only neonatal birthweight will be using the value codes. All newborn encounters must have a value code of 54.

Mapping:

- **Paper Form**:

Encounter Type	Form	Element
Institutional	UB-92	#39-41
Institutional	UB-04	#39-41

- **Electronic**:

Encounter Type	EDI Format	X12 Mapping Loop	X12 Mapping Segment	Seg. Ele. (Ref)	Composite	Element ID	Page No.
Institutional	837I	2300	HI	01	C022 - 2	1271	281

Codes and Values:

Code	*Value*
54	Newborn Birth Weight In Grams

- Space-fill if not applicable.

Edit Applications:

- If applicable, must be a valid code.
- 00431 Neonate Brth Weight Cd Invalid

MEDS II Transaction Segment:	**Institutional**
Data Element Name:	**NEONATE BIRTH WEIGHT IN GRAMS [up to 2]**
Submission Status:	Required for COS 11
Encounter Record Position(s):	211-217; 220-226
Format - Length:	Numeric – 7
Effective Date:	3/1/2005
Version Number - Date:	2.3 - April 2007
MEDS II DE# / DW#:	1094/3367

Definition: The birth weight of the neonate in grams.

Mapping:

- **Paper Form**:

Encounter Type	Form	Element
Institutional	UB-92	#39-41
Institutional	UB-04	#39-41

- **Electronic**:

Encounter Type	EDI Format	X12 Mapping Loop	X12 Mapping Segment	Seg. Ele. (Ref)	Composite	Element ID	Page No.
Institutional	837I	2300	HI	01	C022-5	782	280

Codes and Values:

- Right-justified and zero-filled.
- Must be a valid number greater than "0099" and less than "8000".
- Birth Weights of "0099" grams or less should be reported as "0100" grams.
- If this field is not applicable it must contain zeroes.

Edit Applications:

- Must be a valid entry.
- 00434 Birthweight Not Reasonable

MEDS II Transaction Segment:	**Institutional**
Data Element Name:	**REVENUE CODE [UP TO 10]**
Submission Status:	Required for COS 06, 12, 15, 28, 73, 85, 87
Encounter Record Position(s):	227-230; 272-275; 317-320; 362-365; 407-410; 452-455; 497-500; 542-545; 587-590; 632-635
Format - Length:	Character - 4
Effective Date:	3/1/2005
Version Number - Date:	2.3 - April 2007
MEDS II DE# / DW#:	0442/0442

Definition: Revenue Codes uniquely identify a provider's cost center.

Mapping:

- **Paper Form**:

Encounter Type	Form	Element
Institutional	UB-92	#42
Institutional	UB-04	#42

- **Electronic**:

Encounter Type	EDI Format	X12 Mapping Loop	X12 Mapping Segment	Seg. Ele. (Ref)	Composite	Element ID	Page No.
Institutional	837I	2400	SV2	01	n/a	234	446

Codes and Values:

- Right-justified.
- Space-fill if not applicable.
- Valid values are assigned by the National Uniform Billing Committee (NUBC).
- If this field is not applicable it must be Space-filled.

Edit Applications:

- Must be a valid code.
- 01705 Revenue Code Not On File

MEDS II Transaction Segment:	**Institutional**
Data Element Name:	**HCPCS CODE [UP TO 10]**
Submission Status:	Required for COS 06, 12, 15, 28, 73, 85, 87
Encounter Record Position(s):	231-237; 276-282; 321-327; 366-372; 411-417; 456-462; 501-507; 546-552; 591-597; 636-642
Format - Length:	Character - 7
Effective Date:	3/1/2005
Version Number - Date:	2.3 - April 2007
MEDS II DE# / DW#:	2042/5055

Definition: The American Medical Association's Current Procedural Terminology 4th Edition (CPT-4) Code or the Healthcare Common Procedure Coding System (HCPCS) code, which applies to the non-inpatient procedure performed and associated with each line of service.

Procedure Codes uniquely describe the service(s) rendered by a provider during an encounter. Fields for reporting up to ten procedures or services are available. If more than ten procedures were performed during the encounter, submit a second encounter record with the additional procedures listed and using the same Encounter Control Number and identical information on all other elements that were included in the first record.

Injections and immunizations administered or DME provided during the encounter should be recorded using the appropriate procedure codes. Diagnostic tests performed during the encounter should be reported. Diagnostic testing performed on subsequent days should be reported as separate encounters.

Mapping:

- **Paper Form**:

Encounter Type	Form	Element
Institutional	UB-92	#44
Institutional	UB-04	#44

- **Electronic**:

Encounter Type	EDI Format	X12 Mapping Loop	X12 Mapping Segment	Seg. Ele. (Ref)	Composite	Element ID	Page No.
Institutional	837I	2400	SV2	02	C0003-1 C0003-2	235 234	446

Codes and Values:

- Space-fill if not applicable.
- Entered exactly as shown in the American Medical Association's Current Procedural Terminology - 4th Edition (CPT-4) or the Centers for Medicare and Medicaid Services HCPCS code for ambulatory surgery and emergency department procedures performed.
- Not applicable for inpatient encounters.

Edit Applications:

- Must be a valid code.
- 00070 Procedure Code Invalid
- 00170 Procedure Code Not On File
- 00710 Procedure Exceeds Service Limits

MEDS II Transaction Segment:	**Institutional**
Data Element Name:	**QUANTITY OR UNITS SUBMITTED [UP TO 10]**
Submission Status:	Required for COS 06, 12, 15, 28, 73, 85, 87,
Encounter Record Position(s):	238-248; 283-293; 328-338; 373-383; 418-428; 463-473; 508-518; 553-563; 598-608; 643-653
Format - Length:	Numeric – 11
Effective Date:	3/1/2005
Version Number - Date:	2.3 - April 2007
MEDS II DE# / DW#:	1092/3029

Definition: Quantity or Units Submitted is the total number of units or quantity submitted by a provider for the service rendered. This element may contain days, metric units, visits, miles, injections, etc. Format and size may vary based on encounter type and nature of the quantity specified.

Mapping:

- **Paper Form**:

Encounter Type	Form	Element
Institutional	UB-92	#46
Institutional	UB-04	#46

- **Electronic**:

Encounter Type	EDI Format	X12 Mapping Loop	X12 Mapping Segment	Seg. Ele. (Ref)	Composite	Element ID	Page No.
Institutional	837I	2400	SV2	04 05		355 380	448

Codes and Values:

- Right-justified and zero-filled. (i.e. '1' would be reported as '00000000001')

Edit Applications:

- 00094 Number of Units Not Greater Than Zero
- 00180 Units Greater Than Maximum
- 00710 Procedure Code Exceeds Service Limits

MEDS II Transaction Segment:	**Institutional**
Data Element Name:	**PAID AMOUNT**
Submission Status:	Required for COS 06, 12, 15, 28, 73, 85, 87
Encounter Record Position(s):	260-270; 305-315; 350-360; 395-405; 440-450; 485-495; 530-540; 575-585; 620-630; 665-675
Format - Length:	Numeric - 11
Effective Date:	3/1/2005
Version Number - Date:	2.3 - April 2007
MEDS II DE# / DW#:	1028/3157

Definition: The amount paid for each listed service, corresponding to the procedures defined in the data element HCPCS Code.

Mapping:

- New York State Specific Data Element

Codes and Values:

- Right-justified and zero filled.
- The amount is defined with two implied decimal places
- Must be entered as a positive number.
- On the service line level the paid amount by Claim/Encounter Indicator should be as follows:

Claim/Encounter Indicator	Total Paid Amount
"E" – Encounter	Proxy Cost Amount
"C" – Within Plan Claim	Actual Cost Amount
"A" – Administrative Denial	Zero Dollars

Edit Applications:

- Must be a valid entry.

Important Note:

Plans should use internal proxy fee schedules when determining the proxy cost amount.

MEDS II Transaction Segment:	**Institutional**
Data Element Name:	**NON-INPATIENT CLAIM/ENCOUNTER INDICATOR**
Submission Status:	Required for COS 06, 12, 15, 28, 73, 85, 87
Encounter Record Position(s):	271; 316; 361; 406; 451; 496; 541; 586; 631; 676
Format - Length:	Character - 1
Effective Date:	3/1/2005
Version Number - Date:	2.3 - April 2007
MEDS II DE# / DW#:	1983/1983

Definition: Indicates whether the non-inpatient service provided was a capitated service within the health organization's contract ("E"); a within plan claim ("C") or an administratively denied service ("A").

Administratively denied encounters are those encounters which reflect services performed normally paid for, but were denied due to failure of at least one requirement of the agreement between provider and plan. An example could be where a contract requires that encounters must be submitted within 60 days of service date. A well-child encounter submitted 63 days after date of service would be administrative denied. (Claim received too late).

Mapping:

- New York State Specific Data Element

Codes and Values:

Code	*Value*
E	Capitated Encounter, or service not paid directly by health organization.
C	Within Plan Claim
A	Administrative Denial

- Space-fill if not applicable.

Edit Applications:

- Must be a valid code.
- 00437 Claim Encounter Ind Invalid

MEDS II Transaction Segment:	**Institutional**
Data Element Name:	**PRINCIPAL/PRIMARY DIAGNOSIS CODE**
Submission Status:	Required for COS 06, 11, 12, 15, 28, 73, 85, 87
Encounter Record Position(s):	677-683
Format - Length:	Character - 7
Effective Date:	3/1/2005
Version Number - Date:	2.3 - April 2007
MEDS II DE# / DW#:	4183/3006

Definition: The ICD-9-CM Principal Diagnosis Code uniquely specifies the condition established after study to be chiefly responsible for admission to an institution.

Mapping:

- **Paper Form**:

Encounter Type	Form	Element
Institutional	UB-92	#67
Institutional	UB-04	#67

- **Electronic**:

Encounter Type	EDI Format	X12 Mapping Loop	X12 Mapping Segment	Seg. Ele. (Ref)	Composite	Element ID	Code	Page No.
Institutional	837I	2300	HI	01	C022-1 C022-2	1270 1271	BK	228

NOTE: The Principal/Primary Diagnosis Code is coded in the first occurrence of C022 Composite for the Principal/Primary Diagnosis Information HI segment.

Codes and Values:

- Must be Left-justified and entered exactly as shown in the ICD-9-CM coding reference, excluding the decimal point, and Space-filled. The decimal point is implied because each ICD-9-CM code is unique.
- Record the appropriate ICD-9-CM code exactly as it appears in the manual. The diagnosis code must be the most specific/precise 3 digit, 4 digit or 5 digit code allowed for in the ICD-9-CM coding format.
- Leading and trailing zeros in a diagnostic code must be recorded (i.e. do not use blanks in place of zeros for any reason). In addition, zeros should not be added to a diagnostic code to fill in blank spaces.
- External diagnosis codes (E Codes) are not valid as Principal Diagnosis Codes.

Edit Applications:

- Must be a valid code.
- 00039 Primary Diagnosis Code Blank
- 00146 Primary Diagnosis not on File

MEDS II Transaction Segment:	**Institutional**
Data Element Name:	**OTHER DIAGNOSIS CODES [UP TO 8]**
Submission Status:	Required for COS 06, 11, 12, 15, 28, 73, 85, 87
Encounter Record Position(s):	684-690; 691-697; 698-704; 705-711; 712-718; 719-725; 726-732; 733-739
Format - Length:	Character - 7
Effective Date:	3/1/2005
Version Number - Date:	2.3 - April 2007
MEDS II DE# / DW#:	4157/W657

Definition: Other Diagnosis Codes indicate additional significant condition(s) during an encounter.

Mapping:

- **Paper Form**:

Encounter Type	Form	Element
Institutional	UB-92	#68-75
Institutional	UB-04	#67A- 67Q

- **Electronic**:

Encounter Type	EDI Format	X12 Mapping Loop	X12 Mapping Segment	Seg. Ele. (Ref)	Composite	Element ID	Code	Page No.
Institutional	837I	2300	HI	01	C022-1 C022-2	1270 1271	BF	232

NOTE: The Other Diagnosis codes are coded in two iterations of C022 Composite for the Other Diagnosis Information HI segment.

Codes and Values:

- Left-justified and entered exactly as shown in the ICD-9-CM coding reference, excluding the decimal point, and Space-filled. The decimal point is implied because each ICD-9-CM code is unique.
- Record the appropriate ICD-9-CM code exactly as it appears in the manual. The diagnosis code must be the most specific/precise 3 digit, 4 digit or 5 digit code allowed for in the ICD-9-CM coding format.
- Leading and trailing zeros in a diagnostic code must be recorded (i.e. do not use blanks in place of zeros for any reason). In addition, zeros should not be added to a diagnostic code to fill in blank spaces.

Edit Applications:

- Must be a valid code.
- If this field is not coded it must contain blanks.
- 00412 Diagnosis Code Not On File

MEDS II Transaction Segment:	**Institutional**
Data Element Name:	**ADMIT DIAGNOSIS**
Submission Status:	Required for COS 11
Encounter Record Position(s):	740-746
Format - Length:	Character - 7
Effective Date:	3/1/2005
Version Number - Date:	2.3 - April 2007
MEDS II DE# / DW#:	0411/3187

Definition: The diagnosis made by the Provider at the time of admission that describes the patient's condition upon admission to an institution. Since the Admitting Diagnosis is formulated before all tests and examinations are complete, it may have been stated in the form of a problem or symptom and it may differ from any of the final diagnoses recorded in the medical record.

Mapping:

- **Paper Form**:

Encounter Type	Form	Element
Institutional	UB-92	#76
Institutional	UB-04	#69

- **Electronic**:

Encounter Type	EDI Format	X12 Mapping Loop	X12 Mapping Segment	Seg. Ele. (Ref)	Comp-osite	Elem-ent ID	Code	Page No.
Institutional	837I	2300	HI	02	C022-1 C022-2	1270 1271	BJ/PR	228

NOTE: The Admitting Diagnosis Code is coded in the second occurrence of C022 Composite for the Principal Diagnosis Information HI segment.

Codes and Values:

- Left-justified and entered exactly as shown in the ICD-9-CM coding reference, excluding the decimal point, and Space-filled.
- Must have been a valid ICD-9-CM code excluding the decimal point. To be valid, ICD-9-CM codes must have been entered at the most specific level to which they are classified in the ICD-9-CM Tabular List. Three-digit codes further divided at the four-digit level must have been entered using all four digits. Four-digit codes further sub-classified at the five-digit level must be entered using all five digits.
- E-codes are not valid as Admitting Diagnosis Codes.

Edit Applications:

- 00604 Admitting Diagnosis Code Missing
- 00412 Diagnosis Code Not On File

MEDS II Transaction Segment: **Institutional**
Data Element Name: **EXTERNAL DIAGNOSIS CODE (E Code)**
Submission Status: Required for COS 11
Encounter Record Position(s): 747-753
Format - Length: Character - 7
Effective Date: 3/1/2005
Version Number - Date: 2.3 - April 2007
MEDS II DE# / DW#: 0411/5004

Definition: The External Diagnosis Code indicates the external cause of an injury, poisoning, or adverse effect.

Mapping:

- **Paper Form**:

Encounter Type	Form	Element
Institutional	UB-92	#77
Institutional	UB-04	#70

- **Electronic**:

Encounter Type	EDI Format	X12 Mapping Loop	X12 Mapping Segment	Seg. Ele. (Ref)	Composite	Element ID	Code	Page No.
Institutional	837I	2300	HI	03	C022-1 C022-2	1270 1271	BN	229

NOTE: The External Cause-of-Injury Code is coded in the third occurrence of C022 Composite for the Principal Diagnosis Information HI segment.

Codes and Values:

- Left-justified including the prefix letter "E" and all digits exactly as shown in the ICD-9-CM coding reference excluding the decimal point, and Space-filled.
- Must have been a valid ICD-9-CM "E" code excluding the decimal point. To be valid, the code must have been entered at the most specific level classified in the ICD-9-CM Tabular List. Three-digit codes further divided to the four-digit level must have been entered using all four digits plus the prefix letter "E". Failure to enter the prefix "E" and all required digits will cause the record to reject.
- If this field is not applicable it must contain blanks.

Edit Applications:

- Must contain a valid code.
- 00412 Diagnosis Code Not On File

MEDS II Transaction Segment:	**Institutional**
Data Element Name:	**PRINCIPAL PROCEDURE CODE**
Submission Status:	Required for COS 11
Encounter Record Position(s):	754-760
Format - Length:	Character - 7
Effective Date:	3/1/2005
Version Number - Date:	1.2 - May 96
MEDS II DE# / DW#:	0606/5055

Definition: The ICD-9-CM Principal Procedure Code is the primary procedure code on a claim reported to the health organization by the providing inpatient facility.

Mapping:

- **Paper Form**:

Encounter Type	Form	Element
Institutional	UB-92	#80
Institutional	UB-04	#74

- **Electronic**:

Encounter Type	EDI Format	X12 Mapping Loop	X12 Mapping Segment	Seg. Ele. (Ref)	Composite	Element ID	Code	Page No.
Institutional	837I	2300	HI	01	C022-1 C022-2	1270 1271	BR	242

NOTE: The Principal Procedure Code is coded in the first occurrence of the C022 Composite for the Principal Procedure Information HI segment.

Codes and Values:

- Left-justified and Space-filled.
- Enter exactly as shown in the ICD-9-CM coding reference, excluding the decimal point.
- If this field is not coded it must be Space-filled.

Edit Applications:

- Must contain a valid code if a procedure was performed.
- 00405 Principal Procedure Code Missing
- 00170 Procedure Code Not on File

MEDS II Transaction Segment: **Institutional**
Data Element Name: **OTHER PROCEDURE CODES [UP TO 5]**
Submission Status: Required for COS 11
Encounter Record Position(s): 761-767; 768-774; 775-781; 782-788; 789-795
Format - Length: Character - 7
Effective Date: 3/1/2005
Version Number - Date: 2.3 - April 2007
MEDS II DE# / DW#: 4159/5055

Definition: Procedure Codes uniquely identify the procedures performed. All significant procedures other than the Principal Procedure Code are to be reported here. They are reported in order of significance, starting with the most significant.

Mapping:

- **Paper Form**:

Encounter Type	Form	Element
Institutional	UB-92	#80
Institutional	UB-04	#74A- 74E

- **Electronic**:

Encounter Type	EDI Format	X12 Mapping Loop	X12 Mapping Segment	Seg. Ele. (Ref)	Composite	Element ID	Code	Page No.
Institutional	837I	2300	HI	01	C022-1 C022-2	1270 1271	BQ	244

NOTE: The Other Procedure codes and dates are coded in two iterations of C022 Composite for the Other Procedure Information HI segment.

Codes and Values:

- Left-justified and Space-filled.
- Enter exactly as shown in the ICD-9-CM coding reference, excluding decimal points.
- If this field is not applicable it must be Space-filled.

Edit Applications:

- ICD-9-CM procedure codes only.
- 00170 Procedure Code Not on File

MEDS II Transaction Segment:	**Institutional**
Data Element Name:	**ATTENDING PROVIDER PROFESSION CODE**
Submission Status:	Required for COS 06, 11, 12, 15, 28, 73, 85, 87
Encounter Record Position(s):	796-798
Format - Length:	Character - 3
Effective Date:	3/1/2005
Version Number - Date:	2.3 - April 2007
MEDS II DE# / DW#:	2165/2165_5

Definition: The NYS profession code of the attending provider for inpatient encounters (COS 11) and the servicing provider for non-inpatient encounters.

Mapping:

- New York State Specific Data Element

Codes and Values:

- Provider Profession Codes and Values are contained within Appendix A
- Space-fill if not applicable.

Edit Applications:

- Must be a valid code.

MEDS II Transaction Segment:	**Institutional**
Data Element Name:	**ATTENDING PROVIDER LICENSE NUMBER**
Submission Status:	Required for COS 06, 11, 12, 15, 28, 73, 85, 87
Encounter Record Position(s):	799-806
Format - Length:	Character – 8
Effective Date:	3/1/2005
Version Number - Date:	2.3 - April 2007
MEDS II DE# / DW#:	1570/3003_2

Definition: The NY professional license number of the attending provider for inpatient encounters (COS 11) and the servicing provider for non-inpatient encounters.

Mapping:

- **Electronic**:

Encounter Type	EDI Format	X12 Mapping Loop	X12 Mapping Segment	Seg. Ele. (Ref)	Element ID	Code	Page No.
Institutional	837I	2420A	REF	01 02	128 127	0B	467

Codes and Values:

- Right-justified.
- Do not zero fill – Space-fill if not applicable.
- Must be a valid professional license number issued by the New York State Department of Education.

Edit Applications:

- Must be a valid entry.
- 00416 License Number is Missing
- 00664 Attending Physician License Number Missing

MEDS II Transaction Segment: **Institutional**
Data Element Name: **ATTENDING PROVIDER IDENTIFICATION NUMBER**

Submission Status: Required for COS 06, 11, 12, 15, 28, 73, 85, 87
Encounter Record Position(s): 807-814
Format - Length: Character – 8
Effective Date: 3/1/2005
Version Number - Date: 2.3 - April 2007
MEDS II DE# / DW#: 1563/W039

Definition: The State MMIS Identification number of the attending provider for inpatient encounters and the servicing provider for non-inpatient encounters.

Mapping:

- **Paper Form**:

Encounter Type	Form	Element
Institutional	UB-92	#82
Institutional	UB-04	#76

- **Electronic**:

Encounter Type	EDI Format	X12 Mapping Loop	X12 Mapping Segment	Seg. Ele. (Ref)	Element ID	Code	Page No.
Institutional	837I	2420A	NM1	01	98	71	463
				02	1065	1	463
				08	66	XX	464
				09	67		464

Codes and Values:

- Left-justified with no embedded blanks.
- Space-fill if not applicable.

Edit Applications:

- Must be a valid entry
- 00432 Attend Prov Id Not on File

MEDS II Transaction Segment:	**Institutional**
Data Element Name:	**SURGEON PROFESSION CODE**
Submission Status:	Required for COS 11
Encounter Record Position(s):	817-819
Format - Length:	Character - 3
Effective Date:	3/1/2005
Version Number - Date:	2.3 - April 2007
MEDS II DE# / DW#:	2165/2165_6

Definition: The profession code issued by the State Department of Education that identifies the type of license of the surgeon.

Mapping:

- New York State Specific Data Element

Codes and Values:

- Provider Profession Codes and Values are contained within Appendix A
- Space-fill if not applicable.

Edit Applications:

- Must be a valid code.

MEDS II Transaction Segment:	**Institutional**
Data Element Name:	**SURGEON LICENSE NUMBER**
Submission Status:	Required for COS 11
Encounter Record Position(s):	820-827
Format - Length:	Character - 8
Effective Date:	3/1/2005
Version Number - Date:	2.3 - April 2007
MEDS II DE# / DW#:	1570/3100

Definition: The professional license number, issued by the NYS Department of Education, used to identify the surgeon.

Mapping:

- **Electronic**:

Encounter Type	EDI Format	X12 Mapping Loop	X12 Mapping Segment	Seg. Ele. (Ref)	Element ID	Code	Page No.
Institutional	837I	2420C	REF	01 02	128 127	0B	481 482

Codes and Values:

- Right-justified.
- Do not zero fill – Space-fill if not applicable.
- Must be a valid professional license number issued by the NYS Department of Education.

Edit Applications:

- If a surgery was performed, must be a valid entry.
- 00416 License Number Is Missing

MEDS II Transaction Segment:	**Institutional**
Data Element Name:	**SURGEON IDENTIFICATION NUMBER**
Submission Status:	Required for COS 11
Encounter Record Position(s):	828-835
Format - Length:	Character - 8
Effective Date:	3/1/2005
Version Number - Date:	2.3 - April 2007
MEDS II DE# / DW#:	1563/W042

Definition: The State MMIS code of the surgeon who performed the surgery.

Mapping:

- **Paper Form**: (Other identification Number)

Encounter Type	Form	Element
Institutional	UB-92	#83
Institutional	UB-04	#77

- **Electronic**:

Encounter Type	EDI Format	X12 Mapping Loop	X12 Mapping Segment	Seg. Ele. (Ref)	Element ID	Code	Page No.
Institutional	837I	2420C	NM1	01	98	73	477
				02	1065	1	477
				08	66	XX	478
				09	67		478

Codes and Values:

- Must be Left-justified with no embedded blanks and Space-filled.

Edit Applications:

- If a surgery was performed, must be a valid entry.
- 00433 Oper Prov Id Not on File

MEDS II Transaction Segment:	**Institutional**
Data Element Name:	**ADMISSION DATE**
Submission Status:	Required for COS 11, 12, 28
Encounter Record Position(s):	838-845
Format - Length:	Date – CCYYMMDD
Effective Date:	3/1/2005
Version Number - Date:	2.3 - April 2007
MEDS II DE# / DW#:	1033/3011

Definition: The date of the patient's admission to the institution or facility.

Mapping:

- **Paper Form**:

Encounter Type	Form	Element
Institutional	UB-92	#17
Institutional	UB-04	#12

- **Electronic**:

Encounter Type	EDI Format	X12 Mapping Loop	X12 Mapping Segment	Seg. Ele. (Ref)	Element ID	Code	Page No.
Institutional	837I	2300	DTP	02	1250 1251	DT	169

Codes and Values:

- Blanks and characters are not permitted.
- Must be a valid date format CCYYMMDD

Valid Century (CC)	Valid Year (YY)
20	>=04

Valid Month Code (MM)	Valid Day Code (DD)
01, 03, 05, 07, 08, 10, 12	Greater than 00 and less than 32
04, 06, 09, 11	Greater than 00 and less than 31
02	Greater than 00 and less than 29 (less than 30 on a leap year)

Edit Applications:

- Must be on or before the Statement Covers Thru Date
- Must be a valid, properly formatted date.
- 00600 Admission Date Invalid

MEDS II Transaction Segment: **Institutional**
Data Element Name: **DISCHARGE DATE**

Submission Status:	Required for COS 11, 12, 28
Encounter Record Position(s):	846-853
Format - Length:	Date - CCYYMMDD
Effective Date:	3/1/2005
Version Number - Date:	2.3 - April 2007
MEDS II DE# / DW#:	1185/3108

Definition: The date of discharge from a stay in an inpatient hospital.

Inpatient encounters should be reported only after the patient is discharged. The entire inpatient stay, identified by actual admission and discharge dates should be reported as one encounter even if there are payers in addition to Medicaid managed care involved.

Mapping:

- **Paper Form**:

Encounter Type	Form	Element
Institutional	UB-92	#6
Institutional	UB-04	#6

- **Electronic**:

Encounter Type	EDI Format	X12 Mapping Loop	X12 Mapping Segment	Seg. Ele. (Ref)	Element ID	Code	Pg No
Institutional	837I	2300	DTP	01 02 03	374 1250 1251	434 D8&RD8	167

Codes and Values:

- Blanks and characters are not permitted.
- Must be a valid date format CCYYMMDD

Valid Century (CC)	Valid Year (YY)
20	>=04
Valid Month Code (MM)	**Valid Day Code (DD)**
01, 03, 05, 07, 08, 10, 12	Greater than 00 and less than 32
04, 06, 09, 11	Greater than 00 and less than 31
02	Greater than 00 and less than 29 (less than 30 on a leap year)

Edit Applications:

- Must be a valid, properly formatted date.
- 00625 Discharge Date Illogical
- 00652 Discharge Date Prior To Admission Date
- 00655 Discharge Date Different Than Statement Thru Date

MEDS II Transaction Segment:	**Pharmacy**
Data Element Name:	**PRESCRIBING PROVIDER PROFESSION CODE**
Submission Status:	Required for COS 14
Encounter Record Position(s):	158-160
Format - Length:	Character - 3
Effective Date:	3/1/2005
Version Number - Date:	2.3 - April 2007
MEDS II DE# / DW#:	2165/2165_2

Definition: The profession code, issued by the NYS Department of Education, is used to identify the type of license of individual health care professionals providing the services or primarily responsible for the care provided during the encounter. The prescribing Provider profession code relates to the Provider who signed the prescription form.

Mapping:

- New York State Specific Data Element

Codes and Values:

- Provider Profession Codes and Values are contained within Appendix A.
- Space-fill if not applicable.

Edit Applications:

- Must be a valid code.

MEDS II Transaction Segment:	**Pharmacy**
Data Element Name:	**PRESCRIBING PROVIDER LICENSE NUMBER**
Submission Status:	Required for COS 14
Encounter Record Position(s):	161-168
Format - Length:	Character - 8
Effective Date:	3/1/2005
Version Number - Date:	2.3 - April 2007
MEDS II DE# / DW#:	1570/3005

Definition: The State issued provider license number of the prescribing provider. Health organizations must submit the State license number or the MMIS identification number on all prescriptions written for Medicaid recipients. When a prescription is written by an unlicensed intern or resident, the supervising physician's NYS MMIS number or State license number must be provided.

Mapping:

Common Detail Section	Paper		Electronic	
	Form	**Element**	**Format**	**Element**
Pharmacy	UCF	Prescriber ID	NCPDP	466-EZ* 411-DB

** Element 466-EZ is a prescriber ID qualifier and will always equal 08.*

Codes and Values:

- Right-justified.
- Do not zero fill – Space-fill if not applicable.
- Must be a valid professional license number issued by the New York State Department of Education.
- Plans should not report a prescriber Drug Enforcement Agency (DEA) number in this field.

Applicable Edit Codes:

- Must be a valid entry.
- 00525 Prescribing License Number Missing

MEDS II Transaction Segment: **Pharmacy**
Data Element Name: **PRESCRIBING PROVIDER IDENTIFICATION NUMBER**

Submission Status: Required for COS 14
Encounter Record Position(s): 169-176
Format - Length: Character - 8
Effective Date: 3/1/2005
Version Number - Date: 2.3 - April 2007
MEDS II DE# / DW#: 1563/W048

Definition: The State MMIS code of the prescribing Provider. Health organizations must submit the State license number or the MMIS identification number on all prescriptions written for Medicaid recipients. When a prescription is written by an unlicensed intern or resident, the supervising physician's NYS MMIS number or State license number must be provided.

Mapping:

Common Detail Section	Paper		Electronic	
	Form	Element	Format	Element
Pharmacy	UCF	Service Provider ID	NCPDP	466-EZ* 411-DB

** The NCPDP qualifier (466-EZ) will always be equal to 05.*

Codes and Values:

- The Provider ID is a unique number.

Applicable Edit Codes:

- Must be a valid entry.
- 00897 Prescriber Id Not on File

MEDS II Transaction Segment:	**Pharmacy**
Data Element Name:	**PRESCRIPTION ORDERED DATE**
Submission Status:	Required for COS 14
Encounter Record Position(s):	179-186
Format - Length:	Date – CCYYMMDD
Effective Date:	3/1/2005
Version Number - Date:	2.3 - April 2007
MEDS II DE# / DW#:	0860/3247

Definition: Prescription Ordered Date is the date that a service was ordered or a prescription was written. (Formerly called Date Prescribed/Ordered)

Mapping:

Encounter Type	Paper		Electronic	
	Form	Element	Format	Element
Pharmacy	UCF	Date Written	NCPDP	414-DE

Codes and Values:

- Must be a valid date format CCYYMMDD

Valid Century (CC)	Valid Year (YY)
20	>=04

Valid Month Code (MM)	Valid Day Code (DD)
01, 03, 05, 07, 08, 10, 12	Greater than 00 and less than 32
04, 06, 09, 11	Greater than 00 and less than 31
02	Greater than 00 and less than 29 (less than 30 on a leap year)

Edit Applications:

- Must be a valid date
- 00534 Date Ordered Invalid
- 00548 Fill Date Precedes Order Date

MEDS II Transaction Segment:	**Pharmacy**
Data Element Name:	**DATE FILLED**
Submission Status:	Required for COS 14
Encounter Record Position(s):	187-194
Format - Length:	Date – CCYYMMDD
Effective Date:	3/1/2005
Version Number - Date:	2.3 - April 2007
MEDS II DE# / DW#:	1022/3013

Definition: Date Filled is the date a prescription or order was filled.

Mapping:

Encounter Type	Paper		Electronic	
	Form	Element	Format	Element
Pharmacy	UCF	Date of Service	NCPDP	401-D1

Codes and Values:

- Must be a valid date format CCYYMMDD

Valid Century (CC)	Valid Year (YY)
20	>=04

Valid Month Code (MM)	Valid Day Code (DD)
01, 03, 05, 07, 08, 10, 12	Greater than 00 and less than 32
04, 06, 09, 11	Greater than 00 and less than 31
02	Greater than 00 and less than 29 (less than 30 on a leap year)

Edit Applications:

- Must be a valid date
- 00018 Date Of Service/Fill Date Invalid
- 00020 Service/Fill Date Later Than Receipt Date
- 00548 Fill Date Precedes Order Date
- 001292 Date of Service Two Years Prior to Date Received

MEDS II Transaction Segment:	**Pharmacy**
Data Element Name:	**NATIONAL DRUG CODE (NDC) / PRODUCT CODE**
Submission Status:	Required for COS 14
Encounter Record Position(s):	195-205
Format - Length:	Character - 11
Effective Date:	3/1/2005
Version Number - Date:	2.3 - April 2007
MEDS II DE# / DW#:	NDC: 1856/E1856 Product Code: 1856/E1856

Definition: National Drug Code (NDC) uniquely identifies a drug and includes information on the manufacturer, product code, and package size.

The Product Code is the HCPCS Code used to identify Durable Medical Equipment, Hearing Aids, Over the Counter medications or other pharmacy products without an NDC code.

Mapping:

NDC Code:

Encounter Type	Paper		Electronic	
	Form	Element	Format	Element
Pharmacy	UCF	Product ID	NCPDP	436-E1 407-D7

Codes and Values:

- Right-justified and zero filled.
- Valid values for this data element are defined and maintained by First DataBank.

Edit Applications:

- 00544 NDC Code Non-Numeric
- 00561 Drug Code Not On file
- 01610 Missing or Invalid Alternate Product Code

MEDS II Transaction Segment:	**Pharmacy**
Data Element Name:	**QUANTITY DISPENSED**
Submission Status:	Required for COS 14
Encounter Record Position(s):	206-217
Format - Length:	Numeric – 12
Effective Date:	3/1/2005
Version Number - Date:	2.3 - April 2007
MEDS II DE# / DW#:	4217/3251

Definition: Quantity Dispensed is the quantity of a drug as submitted on a claim form. The dispensing quantity is based upon the unit of measure as defined by the National Drug Code. (Formerly called NDC Units.)

Mapping:

Encounter Type	Paper		Electronic	
	Form	Element	Format	Element
Pharmacy	UCF	Quantity Dispensed	NCPDP	442-E7

Codes and Values:

- Must be entered if a National Drug Code has been entered
- Right-justified and zero filled.
- Must be a positive numeric value.
- Fractions must be rounded to the nearest whole number.
- Leave blank when reporting DME/Hearing aid and alternate product encounter records.

Edit Applications:

- Must be a valid entry.
- 00528 Missing Or Invalid Quantity Dispensed

MEDS II Transaction Segment:	**Pharmacy**
Data Element Name:	**DRUG DAYS SUPPLY COUNT**
Submission Status:	Required for COS 14
Encounter Record Position(s):	218-220
Format - Length:	Numeric - 3
Effective Date:	3/1/2005
Version Number - Date:	2.3 - April 2007
MEDS II DE# / DW#:	0819/3232

Definition: Drug Days Supply Count specifies the number of days supply dispensed with the prescription service.

Mapping:

Encounter Type	Paper		Electronic	
	Form	Element	Format	Element
Pharmacy	UCF	Days Supply	NCPDP	405-D5

Codes and Values:

- Must be entered if a National Drug Code has been entered.
- Must be a positive whole number.
- Right-justified and zero filled.
- Leave blank when reporting DME/Hearing aid and alternate product encounter records.

Edit Applications:

- Must be a valid entry.
- 00540 Number of Days Supply Invalid

MEDS II Transaction Segment:	**Pharmacy**
Data Element Name:	**PHARMACY CLAIM/ENCOUNTER INDICATOR**
Submission Status:	Required for COS 14
Encounter Record Position(s):	221
Format - Length:	Character - 1
Effective Date:	3/1/2005
Version Number - Date:	2.3 - April 2007
MEDS II DE# / DW#:	1983/E1983

Definition: Indicates whether the service provided was a capitated service within the health organization's contract ("E"); a within plan claim ("C") or an administratively denied service ("A").

Administratively denied encounters are those encounters which reflect services performed normally paid for, but were denied due to failure of at least one requirement of the agreement between provider and plan.

Mapping:

- New York State Specific Data Element

Codes and Values:

Code	*Value*
E	Capitated Encounter, or service not paid directly by the health organization.
C	Within Plan Claim
A	Administrative Denial

Edit Applications:

- Must be a valid code.
- 00437 Claim Encounter Ind Invalid

IX. DENTAL SEGMENT

MEDS II Transaction Segment:	**Dental**
Data Element Name:	**PROVIDER SPECIALTY CODE**
Submission Status:	Required for COS 13
Encounter Record Position(s):	158-160
Format - Length:	Character - 3
Effective Date:	3/1/2005
Version Number - Date:	2.3 - April 2007
MEDS II DE# / DW#:	1499/2048

Definition: The Provider Specialty Code designates the State classification of provider specialties. It is based on a provider's certified medical specialty.

Mapping:

- New York State Specific Data Element

Codes and Values:

- See Appendix B for Valid Codes and Values

Edit Applications:

- Must be a valid code.
- 00404 Provider Specialty Missing
- 00413 Provider Specialty Not On File

MEDS II Transaction Segment:	**Dental**
Data Element Name:	**DENTAL CLAIM/ENCOUNTER INDICATOR**
Submission Status:	Required for COS 13
Encounter Record Position(s):	161; 222; 283; 344; 405; 466; 527; 588; 649; 710
Format - Length:	Character - 1
Effective Date:	3/1/2005
Version Number - Date:	2.3 - April 2007
MEDS II DE# / DW#:	1983/E1983

Definition: Indicates whether the dental service provided was a capitated service within the health organization's contract ("E"); a within plan claim ("C") or an administratively denied service ("A").

Administratively denied encounters are those encounters which reflect services performed normally paid for, but were denied due to failure of at least one requirement of the agreement between provider and plan.

Mapping:

- New York State Specific Data Element

Codes and Values:

Code	*Value*
E	Capitated Encounter, or service not paid directly by the health organization.
C	Within Plan Claim
A	Administrative Denial

Edit Applications:

- Must be a valid code.
- 00437 Claim Encounter Ind Invalid

MEDS II Transaction Segment:	**Dental**
Data Element Name:	**PLACE OF SERVICE/PLACE OF TREATMENT**
Submission Status:	Required for COS 13
Encounter Record Position(s):	162-163; 223-224; 284-285; 345-346; 406-407; 467-468; 528-529; 589-590; 650-651; 711-712
Format - Length:	Character - 2
Effective Date:	3/1/2005
Version Number - Date:	2.3 - April 2007
MEDS II DE# / DW#:	4178/3016

Definition: Place of Service/Place of Treatment Code identifies the place(s) where a service was rendered by a provider.

Mapping:

- **Paper Form**:

Encounter Type	Form	Element
Dental	ADA	#38

- **Electronic**:

Encounter Type	EDI Format	X12 Mapping Loop	X12 Mapping Segment	Seg. Ele. (Ref)	Element ID	Page No.
Institutional	837I	2300	CLM	05-1	1331	159
Dental	837D	2300	CLM	05-1	1331	151

Codes and Values:

Code	*Value*
03	SCHOOL
04	HOMELESS SHELTER
05	INDIAN HLTH SVCS FR-STND FCLTY
06	INDIAN HLTH SVCS PR-BSD FCLTY
07	TRIBAL 638 FRE-STNDNG FACILITY
08	TRIBAL 638 PROV BASED FACILITY
11	OFFICE
12	CLIENT'S HOME
13	ASSISTED LIVING FACILITY
14	GROUP HOME
15	MOBILE UNIT
20	URGENT CARE FACILITY
21	INPATIENT HOSPITAL
22	OUTPATIENT HOSPITAL
23	HOSPITAL EMERGENCY ROOM
24	AMBULATORY SURGICAL CENTER

Code	*Value*
25	BIRTHING CENTER
26	MILITARY TREATMENT FACILITY
31	SKILLED NURSING FACILITY
32	NURSING FACILITY
33	CUSTODIAL CARE FACILITY
34	HOSPICE
41	AMBULANCE – LAND
42	AMBULANCE - AIR OR WATER
49	INDEPENDENT CLINIC
50	FEDERALLY QUALIFIED HEALTH CENTER
51	INPATIENT PSYCHIATRIC FACILITY
52	PSYCHIATRIC FACILITY PARTIAL HOSPITALIZATION
53	COMMUNITY MENTAL HEALTH CENTER
54	INTERMEDIATE CARE FACILITY/MENTALLY RETARDED
55	RESIDENTIAL SUBSTANCE ABUSE TREATMENT FACILITY
56	PSYCHIATRIC RESIDENTIAL TREATMENT CENTER
57	NON-RES SUBST ABS TRTMNT FCLTY
60	MASS IMMUNIZATION
61	COMPREHENSIVE INPATIENT REHABILITATION FACILITY
62	COMPREHENSIVE OUTPATIENT REHALILITATION FACILITY
65	END STAGE RENAL DISEASE TREATMENT FACILITY
71	STATE OR LOCAL PUBLIC HEALTH CLINIC
72	RURAL HEALTH CLINIC
81	INDEPENDENT LABORATORY
99	OTHER UNLISTED FACILITY

Edit Applications:

- Must be a valid entry.
- 00071 Place Of Service Code Invalid

MEDS II Transaction Segment:	**Dental**
Data Element Name:	**PROCEDURE CODE [UP TO 10]**
Submission Status:	Required for COS 13
Encounter Record Position(s):	164-170; 225-231; 286-292; 347-353; 408-414; 469-475; 530-536; 591-597; 652-658; 713-719
Format - Length:	Character - 7
Effective Date:	3/1/2005
Version Number - Date:	2.3 - April 2007
MEDS II DE# / DW#:	4159/5055

Definition: Procedure Codes identifying the procedures performed during the dental visit. Fields for reporting of up to ten procedures or services are available. If more than ten procedures were performed during the encounter, submit a second encounter record with the additional procedures listed and using a different Encounter Control Number and identical information on all other elements that were included in the first record (with the exception of Total Amount Paid).

Mapping:

- **Paper Form**:

Encounter Type	Form	Element
Dental	ADA	#29

- **Electronic**:

Encounter Type	EDI Format	X12 Mapping Loop	X12 Mapping Segment	Seg. Ele. (Ref)	Element ID	Code	Page No.
Institutional	837I	2400	SV2	02-1 02-2	235 234	HC	446 447
Dental	837D	2400	SV3	01-1 01-2	235 234		266-267

Codes and Values:

- Per the 837D, American Dental Association (i.e., CDT) codes may be used to report dental procedures. If CDT2 codes are used, the leading zero of the 5 digit ADA code must be replaced with a 'D" so that the code will conform to the HCPCS coding convention. CDT3 codes conform with HCPCS D codes.
- Left-justified and entered exactly as shown in the CPT coding reference.

Edit Applications:

- Must be a valid code.
- 00070 Procedure Code Invalid
- 00170 Procedure Code Not On File
- 00710 Procedure Code Exceeds Service Limits

MEDS II Transaction Segment:	**Dental**
Data Element Name:	**DENTAL NUMBER OF UNITS/VISITS**
Submission Status:	Required for COS 13
Encounter Record Position(s):	171-181; 232-242; 293-303; 354-364; 415-425; 476-486; 537-547; 598-608; 659-669; 720-730
Format - Length:	Numeric – 11
Effective Date:	3/1/2005
Version Number - Date:	2.3 - April 2007
MEDS II DE# / DW#:	1092/3029

Definition: A whole number indicating the number of times a procedure or service was provided during the dental encounter; or the number of units, visits, or days a procedure or service was rendered during an episode of care defined by Service Start and End Dates.

Mapping:

- **Electronic**:

Encounter Type	EDI Format	X12 Mapping Loop	X12 Mapping Segment	Seg. Ele. (Ref)	Element ID	Code	Page No.
Institutional	837I	2400	SV2	04 05	355 380	UN	448
Dental	837D	2400	SV3	06	380		270

Codes and Values:

- Right justified and zero filled. (i.e. '1' would be reported as '00000000001')
- Must contain a whole number.

Edit Applications:

- Must be a valid entry.
- 00094 Number of Units Not Greater than Zero
- 00180 Units Greater Than Maximum
- 00710 Procedure Code Exceeds Service Limits

MEDS II Transaction Segment:	**Dental**
Data Element Name:	**TOOTH NUMBER OR LETTER**
Submission Status:	Required for COS 13
Encounter Record Position(s):	182-183; 243-244; 304-305; 365-366; 426-427; 487-488; 548-549; 609-610; 670-671; 731-732
Format - Length:	Character - 2
Effective Date:	3/1/2005
Version Number - Date:	2.3 - April 2007
MEDS II DE# / DW#:	1646/E4266

Definition: Dental Site Code specifies a tooth, oral cavity, quadrant, or arch.

Mapping:

- **Paper Form**:

Encounter Type	Form	Element
Dental	ADA	#27

- **Electronic**:

Encounter Type	EDI Format	X12 Mapping Loop	X12 Mapping Segment	Seg. Ele. (Ref)	Element ID	Code	Page No.
Dental	837D	2400	TOO	01 02	1270 1271	JP	271 272

Codes and Values:

- See Appendix C for Valid Codes and Values
- Space-fill if not applicable.

Edit Applications:

- Must be a valid entry.
- 00931 Required Tooth For Procedure Invalid

MEDS II Transaction Segment:	**Dental**
Data Element Name:	**PAID AMOUNT**
Submission Status:	Required for COS 13
Encounter Record Position(s):	195-205; 256-266; 317-327; 378-388; 439-449; 500-510; 561-571; 622-632; 683-693; 744-754
Format - Length:	Numeric - 11
Effective Date:	3/1/2005
Version Number - Date:	2.3 - April 2007
MEDS II DE# / DW#:	1028/3157

Definition: The amount paid by insurer for each listed service.

Mapping:

- New York State Specific Data Element

Codes and Values:

- Right-justified and zero-filled.
- This amount is defined with two implied decimal places and must be entered as a positive number.
- On the service line level the paid amount by Claim/Encounter Indicator should be as follows:

Claim/Encounter Indicator	Total Paid Amount
"E" – Encounter	Proxy Cost Amount
"C" – Within Plan Claim	Actual Cost Amount
"A" – Administrative Denial	Zero Dollars

Edit Applications:

- Must be a valid entry.

Important Note:

Plans should use internal proxy fee schedules when determining the proxy cost amount.

MEDS II Transaction Segment:	**Dental**
Data Element Name:	**SERVICE START DATE**
Submission Status:	Required for COS 13
Encounter Record Position(s):	206-213; 267-274; 328-335; 389-396; 450-457; 511-518; 572-579; 633-640; 694-701; 755-762
Format - Length:	Date - CCYYMMDD
Effective Date:	3/1/2005
Version Number - Date:	2.3 - April 2007
MEDS II DE# / DW#:	1022/3013

Definition: The date the dental service was received or initiated.

Mapping:

- **Paper Form**:

Encounter Type	Form	Element
Dental	ADA	#24

- **Electronic**:

Encounter Type	EDI Format	X12 Mapping Loop	X12 Mapping Segment	Seg. Ele. (Ref)	Element ID	Code	Page No.
Institutional	837I	2300	DTP	02	1250	D8 & RD8	167
				03	1251		168
Dental	837D	2300	DTP	02	1250	D8 & RD8	164
				03	1251		165

Codes and Values:

- Must be a valid date format CCYYMMDD

Valid Century (CC)	Valid Year (YY)
20	>=04

Valid Month Code (MM)	Valid Day Code (DD)
01, 03, 05, 07, 08, 10, 12	Greater than 00 and less than 32
04, 06, 09, 11	Greater than 00 and less than 31
02	Greater than 00 and less than 29 (less than 30 on a leap year)

Edit Applications:

- 00018 Date Of Service/Fill Date Invalid
- 00020 Service/Fill Date Later Than Receipt Date
- 01006 Thru Service Prior to From Service Date
- 001292 Date of Service Two Years Prior to Date Received

MEDS II Transaction Segment:	**Dental**
Data Element Name:	**SERVICE END DATE**
Submission on Status:	Required for COS 13
Encounter Record Position(s):	214-221; 275-282; 336-343; 397-404; 458-465; 519-526; 580-587; 641-648; 702-709; 763-770
Format - Length:	Date - CCYYMMDD
Effective Date:	3/1/2005
Version Number - Date:	2.3 - April 2007
MEDS II DE# / DW#:	1023/3015

Definition: The date the dental service ended.

Mapping:

- **Paper Form**:

Encounter Type	Form	Element
Dental	ADA	#24

- **Electronic**:

Encounter Type	EDI Format	X12 Mapping Loop	X12 Mapping Segment	Seg. Ele. (Ref)	Element ID	Code	Page No.
Institutional	837I	2300	DTP	02	1250	D8 & RD8	167
				03	1251		168
Dental	837D	2300	DTP	02	1250	D8 & RD8	164
				03	1251		165

Codes and Values:

- Must be a valid date format CCYYMMDD

Valid Century (CC)	Valid Year (YY)
20	>=04

Valid Month Code (MM)	Valid Day Code (DD)
01, 03, 05, 07, 08, 10, 12	Greater than 00 and less than 32
04, 06, 09, 11	Greater than 00 and less than 31
02	Greater than 00 and less than 29 (less than 30 on a leap year)

Edit Applications:

- 01004 Thru Service Date Invalid
- 01006 Thru Service Prior to From Service Date

X. PROFESSIONAL SEGMENT

MEDS II Transaction Segment:	**Professional**
Data Element Name:	**PROVIDER SPECIALTY CODE**
Submission Status:	Required for COS 01, 03, 04, 05, 07, 16, 19, 22, 41, 75
Encounter Record Position(s):	158-160
Format - Length:	Character - 3
Effective Date:	3/1/2005
Version Number - Date:	2.3 - April 2007
MEDS II DE# / DW#:	1499/2048

Definition: The provider's Specialty Code identifies a provider's medical, dental, clinic or program type specialty.

Mapping:

- New York State Specific Data Element

Codes and Values:

- Refer to Appendix B for valid codes and values.
- Provider Specialty Code for podiatrist (COS 03) is always 778.
- Provider Specialty Code for laboratory (COS 16) is always 599.
- Provider Specialty Code for DME (COS 22) may be 969 or 970.
- Provider Specialty Code for non-emergency transportation services (COS 19) may be 671 Other Transportation.

Edit Applications:

- Must be a valid code.
- 00404 Provider Specialty Missing
- 00413 Provider Specialty Not On File

MEDS II Transaction Segment:	**Professional**
Data Element Name:	**DIAGNOSIS CODES [UP TO 4]**
Submission Status:	Required for COS 01, 03, 04, 05, 07, 16, 19, 22, 41, 75
Encounter Record Position(s):	161-167; 168-174; 175-181; 182-188
Format - Length:	Character - 7
Effective Date:	3/1/2005
Version Number - Date:	2.3 - April 2007
MEDS II DE# / DW#:	4183/W657

Definition: Up to four diagnosis codes are to be recorded for diagnosed medical conditions for which the recipient receives services during the encounter or which may have been present at time of the encounter and recorded by the provider. V codes should be used to indicate well-child, routine check-ups and screening encounters where no diagnosed condition exists.

Mapping:

- **Paper Form**:

Encounter Type	Form	Element
Professional	CMS-1500	#21

- **Electronic**:

Encounter Type	EDI Format	X12 Mapping Loop	X12 Mapping Segment	Seg. Ele. (Ref)	Elem-ent ID	Comp-osite	Code	Page No.
Professional	837P	2300	H1	01-04	1270 1271	C022-1 C022-2	BK	266-268

Codes and Values:

- Record the appropriate ICD-9-CM code exactly as it appears in the manual. The diagnosis code must be the most specific/precise 3 digit, 4 digit, or 5 digit code allowed for in the ICD-9-CM coding format.
- Left-justified and entered exactly as shown in the ICD-9-CM coding reference, excluding the decimal point, and Space-filled. The decimal point is implied after third digit because each ICD-9-CM code is unique.
- Leading and trailing zeros in a diagnostic code must be recorded (i.e. do not use blanks in place of zeros for any reason). In addition, zeros should not be added to a diagnostic code to fill in blank spaces.
- For editing purposes, only the first four digits of the diagnostic code will be checked for validity against the ICD-9-CM coding system.
- Managed Long Term Care (MLTC) and PACE plans may use V689 – Encounters for Unspecified Administrative Purposes when reporting services that do not have a diagnosis.

Edit Applications:

- 00406 Diagnosis Code Missing
- 00412 Diagnosis Code Not On File

MEDS II Transaction Segment:	**Professional**
Data Element Name:	**PROFESSIONAL CLAIM/ENCOUNTER INDICATOR [UP TO 10]**
Submission Status:	Required for COS 01, 03, 04, 05, 07, 16, 19, 22, 41, 75
Encounter Record Position(s):	189; 248; 307; 366; 425; 484; 543; 602; 661; 720
Format - Length:	Character - 1
Effective Date:	3/1/2005
Version Number - Date:	2.3 - April 2007
MEDS II DE# / DW#:	1983/E1983

Definition: Indicates whether the professional service provided was a capitated service within the health organization's contract ("E"); a within plan claim ("C") or an administratively denied service ("A").

Administratively denied encounters are those encounters which reflect services performed normally paid for, but were denied due to failure of at least one requirement of the agreement between provider and plan. For example, a plan requires encounters be submitted within 60 days of the service date. A well-child encounter submitted 63 days after date of service would be administratively denied. (Claim received too late).

Mapping:

- New York State Specific Data Element

Codes and Values:

Code	*Value*
E	Capitated Encounter, or service not paid directly by the health organization.
C	Within Plan Claim
A	Administrative Denial

Edit Applications:

- Must be a valid entry.
- 00437 Claim Encounter Ind Invalid

MEDS II Transaction Segment:	**Professional**
Data Element Name:	**PLACE OF SERVICE/PLACE OF TREATMENT [UP TO 10]**
Submission Status:	Required for COS 01, 03, 04, 05, 07, 16, 19, 22, 41, 75
Encounter Record Position(s):	190-191; 249-250; 308-309; 367-368; 426-427; 485-486; 544-545; 603-604; 662-663; 721-722
Format - Length:	Character - 2
Effective Date:	3/1/2005
Version Number - Date:	2.3 - April 2007
MEDS II DE# / DW#:	4178/3016

Definition: Place of Service/Place of Treatment Code identifies the place(s) where a service was rendered by a provider.

Mapping:

- **Paper Form**:

Encounter Type	Form	Element
Professional	CMS-1500	#24B

- **Electronic**:

Encounter Type	EDI Format	X12 Mapping Loop	X12 Mapping Segment	Seg. Ele. (Ref)	Element ID	Page No.
Professional	837P	2300	CLM	05-1	1331	173

Codes and Values:

Code	*Value*
03	SCHOOL
04	HOMELESS SHELTER
05	INDIAN HLTH SVCS FR-STND FCLTY
06	INDIAN HLTH SVCS PR-BSD FCLTY
07	TRIBAL 638 FRE-STNDNG FACILITY
08	TRIBAL 638 PROV BASED FACILITY
11	OFFICE
12	CLIENT'S HOME
13	ASSISTED LIVING FACILITY
14	GROUP HOME
15	MOBILE UNIT
20	URGENT CARE FACILITY
21	INPATIENT HOSPITAL
22	OUTPATIENT HOSPITAL

Code	*Value*
23	HOSPITAL EMERGENCY ROOM
24	AMBULATORY SURGICAL CENTER
25	BIRTHING CENTER
26	MILITARY TREATMENT FACILITY
31	SKILLED NURSING FACILITY
32	NURSING FACILITY
33	CUSTODIAL CARE FACILITY
34	HOSPICE
41	AMBULANCE – LAND
42	AMBULANCE - AIR OR WATER
49	INDEPENDENT CLINIC
50	FEDERALLY QUALIFIED HEALTH CENTER
51	INPATIENT PSYCHIATRIC FACILITY
52	PSYCHIATRIC FACILITY PARTIAL HOSPITALIZATION
53	COMUNITY MENTAL HEALTH CENTER
54	INTERMEDIATE CARE FACILITY/MENTALLY RETARDED
55	RESIDENTIAL SUBSTANCE ABUSE TREATMENT FACILITY
56	PSYCHIATRIC RESIDENTIAL TREATMENT CENTER
57	NON-RES SUBST ABS TRTMNT FCLTY
60	MASS IMMUNIZATION
61	COMPREHENSIVE INPATIENT REHABILITATION FACILITY
62	COMPREHENSIVE OUTPATIENT REHALILITATION FACILITY
65	END STAGE RENAL DISEASE TREATMENT FACILITY
71	STATE OR LOCAL PUBLIC HEALTH CLINIC
72	RURAL HEALTH CLINIC
81	INDEPENDENT LABORATORY
99	OTHER UNLISTED FACILITY

Edit Applications:

- Must be a valid entry.
- 00071 Place Of Service Code Invalid

MEDS II Transaction Segment:	**Professional**
Data Element Name:	**PROCEDURE CODES [UP TO 10]**
Submission Status:	Required for COS 01, 03, 04, 05, 07, 16, 19, 22, 41, 75
Encounter Record Position(s):	192-198; 251-257; 310-316; 369-375; 428-434; 487-493; 546-552; 605-611; 664-670; 723-729
Format - Length:	Character - 7
Effective Date:	3/1/2005
Version Number - Date:	2.3 - April 2007
MEDS II DE# / DW#:	2042/5055

Definition: The CPT4/HCPCS procedure code that describes the service(s) rendered during Professional encounters. Fields for reporting of up to ten procedures or services are available. If more than ten procedures were performed during the encounter, submit a second encounter record with the additional procedures listed and using a different Encounter Control Number and identical information on all other elements that were included in the first record (with the exception of Total Amount Paid).

Injections and immunizations administered or DME provided during the encounter should be recorded using the appropriate procedure codes. Diagnostic tests performed during the encounter should be reported. Diagnostic testing performed on subsequent days should be reported as separate encounters.

Mapping:

- **Paper Form**:

Encounter Type	Form	Element
Professional	CMS-1500	#24D

- **Electronic**:

Encounter Type	EDI Format	X12 Mapping Loop	X12 Mapping Segment	Seg. Ele. (Ref)	Element ID	Code	Page No.
Professional	837P	2400	SV1	01-1 01-2	235 234	HC	401

Codes and Values:

- Left-justified.
- Must be a CPT4/HCPCS Code.

Edit Applications:

- Must be a valid entry.
- 00070 Procedure Code Invalid
- 00170 Procedure Code Not On File
- 00710 Procedure Code Exceeds Service Limits

MEDS II Transaction Segment:	**Professional**
Data Element Name:	**NUMBER OF UNITS/VISITS [UP TO 10]**
Submission Status:	Required for COS 01, 03, 04, 05, 07, 16, 19, 22, 41, 75
Encounter Record Position(s):	199-209; 258-268; 317-327; 376-386; 435-445; 494-504; 553-563; 612-622; 671-681; 730-740
Format - Length:	Numeric - 11
Effective Date:	3/1/2005
Version Number - Date:	2.3 - April 2007
MEDS II DE# / DW#:	1092/3029

Definition: A whole number indicating the number of times a procedure or service was provided during the encounter; or the number of units, visits, or days a procedure or service was rendered during an episode of care defined by Service Start and End Dates.

Mapping:

- **Paper Form**:

Encounter Type	Form	Element
Professional	CMS-1500	#24G

- **Electronic**:

Encounter Type	EDI Format	X12 Mapping Loop	X12 Mapping Segment	Seg. Ele. (Ref)	Elem-ent ID	Code	Page No.
Professional	837P	2400	SV1	03 04	355 380	UN	403

Codes and Values:

- Right-justified and zero filled. (i.e. '1' would be reported as '00000000001')
- Must be a non-zero number when an associated procedure has been recorded.

Edit Applications:

- Must be a valid entry.
- 00094 Number of Units Not Greater Than Zero
- 00180 units Greater Than Maximum
- 00710 Procedure Code Exceeds Service Limits

MEDS II Transaction Segment:	**Professional**
Data Element Name:	**PAID AMOUNT [UP TO 10]**
Submission Status:	Required for COS 01, 03, 04, 05, 07, 16, 19, 22, 41, 75
Encounter Record Position(s):	221-231; 280-290; 339-349; 398-408; 457-467; 516-526; 575-585; 634-644; 693-703; 752-762
Format - Length:	Numeric - 11
Effective Date:	3/1/2005
Version Number - Date:	2.3 - April 2007
MEDS II DE# / DW#:	1028/3157

Definition: The amount paid by insurer for each listed service.

Mapping:

- New York State Specific Data Element

Codes and Values:

- Right-justified and zero filled.
- This amount is defined with two implied decimal places and must be entered as a positive number.
- On the service line level the paid amount by Claim/Encounter Indicator should be as follows:

Claim/Encounter Indicator	Total Paid Amount
"E" – Encounter	Proxy Cost Amount
"C" – Within Plan Claim	Actual Cost Amount
"A" – Administrative Denial	Zero Dollars

Edit Applications:

- Must be a valid entry.

Important Note:

Plans should use internal proxy fee schedules when determining the proxy cost amount.

MEDS II Transaction Segment:	**Professional**
Data Element Name:	**SERVICE START DATE**
Submission Status:	Required for COS 01, 03, 04, 05, 07, 16, 19, 22, 41, 75
Encounter Record Position(s):	232-239; 291-298; 350-357; 409-416; 468-475; 527-534; 586-593; 645-652; 704-711; 763-770
Format - Length:	Date - CCYYMMDD
Effective Date:	3/1/2005
Version Number - Date:	2.3 - April 2007
MEDS II DE# / DW#:	1022/3013

Definition: The date the service was received or initiated.

Mapping:

- **Paper Form**:

Encounter Type	Form	Element
Professional	CMS-1500	#24A "From"

- **Electronic**:

Encounter Type	EDI Format	X12 Mapping Loop	X12 Mapping Segment	Seg. Ele. (Ref)	Element ID	Code	Page No.
Professional	837P	2400	DTP	02	1250	D8 & RD8	436
				03	1251		

Codes and Values:

- Must be a valid date format CCYYMMDD

Valid Century (CC)	Valid Year (YY)
20	>=04

Valid Month Code (MM)	Valid Day Code (DD)
01, 03, 05, 07, 08, 10, 12	Greater than 00 and less than 32
04, 06, 09, 11	Greater than 00 and less than 31
02	Greater than 00 and less than 29 (less than 30 on a leap year)

Edit Applications:

- 00018 Date Of Service/Fill Date Invalid
- 00020 Service/Fill Date Later Than Receipt Date
- 01006 Thru Service Prior to From Service Date
- 001292 Date of Service Two Years Prior to Date Received

MEDS II Transaction Segment:	**Professional**
Data Element Name:	**SERVICE END DATE**
Submission Status:	Required for COS 01, 03, 04, 05, 07, 16, 19, 22, 41, 75
Encounter Record Position(s):	240-247; 299-306; 358-365; 417-424; 476-483; 535-542; 594-601; 653-660; 712-719; 771-778
Format - Length:	Date - CCYYMMDD
Effective Date:	3/1/2005
Version Number - Date:	2.3 - April 2007
MEDS II DE# / DW#:	1023/3015

Definition: The date on which the service ended.

Mapping:

- **Paper Form**:

Encounter Type	Form	Element
Professional	CMS-1500	#24A "To"

- **Electronic**:

Encounter Type	EDI Format	X12 Mapping Loop	X12 Mapping Segment	Seg. Ele. (Ref)	Element ID	Code	Page No.
Professional	837P	2400	DTP	02	1250	D8 & RD8	436
				03	1251		

Codes and Values:

- Must be a valid date format CCYYMMDD

Valid Century (CC)	Valid Year (YY)
20	>=04

Valid Month Code (MM)	Valid Day Code (DD)
01, 03, 05, 07, 08, 10, 12	Greater than 00 and less than 32
04, 06, 09, 11	Greater than 00 and less than 31
02	Greater than 00 and less than 29 (less than 30 on a leap year)

Edit Applications:

- 00705 Duplicate Claim in History
- 01004 Thru Service Date Invalid
- 01006 Thru Service Prior to From Service Date

APPENDIX A – Provider Profession Codes

This list is available for download on the MEDS Home Page on the HPN under the heading MEDS II.

Code	*Value*
009	Medical Physicist-Diagnostic Radiological
010	Licensed Practical Nurse
011	Medical Physicist-Medical Health
012	Medical Physicist-Medical Nuclear
013	Medical Physicist-Therapeutic Radiological
020	Pharmacist
021	Pharmacist, limited license (3 year)
022	Registerd Professional Nurse
023	Registered Physician Assistant
024	Registered Specialist Assistant
025	Acupuncture
027	Massage Therapist
028	Midwife
030	Nurse Practitioner, Adult Health
031	Nurse Practitioner, College Health
032	Nurse Practitioner, Community Health
033	Nurse Practitioner, Family Health
034	Nurse Practitioner, Gerentology
035	Nurse Practitioner, Neonatology
036	Nurse Practitioner, Obstetrics & Gynecology
037	Nurse Practitioner, Oncology
038	Nurse Practitioner, Pediatrics
039	Nurse Practitioner, Perinatology
040	Nurse Practitioner, Psychiatry
041	Nurse Practitioner, School Health
042	Nurse Practitioner, Women's Health
043	Nurse Practitioner, Acute Care
044	Nurse Practitioner, Palliative Care
045	Nurse Practitioner, Holistic medicine
048	Dietition/Nutritionist, Certified
049	Dental Assistant
050	Dentist
051	Dental Hygienist
052	Respiratory Therapist
053	Respiratory Therapy Technician
055	Ophthalmic Dispenser
056	Optometrist
057	Audiologist

Code	*Value*
058	Speech-Language Pathologist
059	Dentist, limited license (3 year)
060	Medicine
061	Medicine, limited license (3 year)
062	Physical Therapist
063	Occupational Therapist
064	Occupational Therapy Assistant
065	Podiatrist
066	Physical Therapy Assistant
067	Athletic Trainer
068	Psychologist
069	Dental Hygiene with Limited License
070	Chiropractor
072	Licensed Master Social Worker (no privileges)
073	Licensed Clinical Social Worker (R/P psychotherapy priv.)
080	Social Worker (obsolete split into 072, 073 eff. 9/1/2004)
081	Dental Parenteral Conscious Sedation (eff. 1/1/01)
082	Dental General Anesthesia (eff. 1/1/01)
083	Dental Enteral Conscious Sedation (eff. 1/1/01)
084	Dental Hygiene Anesthesia
088	Dental, Parenteral Conscious Sedation (prior to 1/1/01)
089	Dental Anesthesia (prior to 1/1/01)

APPENDIX B – Provider Specialty Codes

These provider specialty codes for MEDS II reporting are available for download on the MEDS Home Page on the HPN under the heading MEDS II.

Specialty Code	Specialty Description
010	ALLERGY/IMMUN
020	ANESTHESIOLOGY
030	COLON/RECTAL SURG
040	DERMATOLOGY
041	DERMATOPATHOLOGY
050	FAMILY PRACTICE
055	ADOL FAM MEDICINE
056	PED ADOL MEDICINE
057	PED DEVEL/BEHAV
058	PED INTERNAL MED
059	PED RHEUMATOLOGY
060	INTERNAL MED
061	PED INFECTIOUS DIS
062	CARDIOVASCULAR
063	ENDOCRIN/METAB
064	GASTROENTEROLOGY
065	HEMATOLOGY
066	INFECTIOUS DISEASE
067	NEPHROLOGY
068	PULMONARY DIS
069	RHEUMATOLOGY
070	NEURO SURG
071	SPINAL CORD INJ MED
072	PED NEUROSURGERY
073	PED DERMATOLOGY
074	MEDICAL TOXICOLOGY
075	UNDERSEA&HYPERBARIC
076	PED REHABILITATION
080	NUCLEAR MED
081	RADIOL MEDICAL NUCL
089	OB AND GYN
092	MATERNAL AND FETAL
093	REPROD ENDOCRIN
095	DIABETES EDUCATOR
100	OPHTHALMOLOGY
101	PED OPHTHALMOLOGY
110	ORTHOPEDIC SURG
111	HAND SURG - ORTH
112	HAND SURG - PLASTIC
113	HAND SURGERY

Specialty Code	Specialty Description
114	HEAD/NECK SURG-PLAST
120	OTOLARYNGOLOGY
121	PED OTOLARYNGOLOGY
127	CLIA
128	CLIA
129	CLIA
130	CLIA
131	BLOOD BANKING
135	CLINICAL PATH
136	FORENSIC PATH
137	HEMATOLOGY PATH
138	CHEMICAL PATH
139	MED MICROBIOLOGY
140	MOLEC GENE SPEC PATH
141	NEUROPATHOLOGY
142	ANATOMIC PATH
143	DERMATOPATHOLOGY
146	ANATOM/CLINCL PATH
148	RADIOISOTOPIC PATH
149	PED EMERGENCY MED
150	PEDIATRICS
151	PED CARDIOLOGY
152	PED HEMAT/ONCOL
153	PED SURGERY
154	PED NEPHROLOGY
155	NEO/PERINATAL MED
156	PED ENDOCRINOLOGY
157	PED PULMONOLOGY
160	PHYS MED/REHAB
161	PED CRITICAL CARE
162	OSTEO/CHIROPRACTIC
163	PED GASTROENTRLGY
164	CRIT CARE ANESTH
165	CRIT CARE INTERNAL
166	CRIT CARE OBSTET
167	CRIT CARE SURGERY
170	PLASTIC SURGERY
182	PREVENTIVE MED
183	OCCUPATIONAL MED
184	PUBLIC HEALTH

Specialty Code	Specialty Description
186	TB DIR OBS THERAPY
187	PSY MED GENETICS
188	CLINICAL GENETICS
189	MOLECULAR GENETICS
190	PAIN MANAGEMENT-PSYC
191	CHILD PSYCHIATRY
192	PSYCHIATRY
193	CHILD NEUROLOGY
194	NEUROLOGY
195	PSYCH & NEUROLOGY
197	GERIATRIC PSYCH
198	ADDICTION PSYCH
199	NEURIDEV DISABILITY
200	RADIOLOGY
201	DX RADIOLOGY
202	DX NUCL RADIOLOGY
205	THERA RADIOLOGY
206	RADIOLOG PHYSICS
207	THERA RADIOLOGY
208	DX RADIOLOGY
210	GENERAL SURGERY
211	HOSPITALIST
220	THORACIC SURGERY
230	UROLOGY
231	PED UROLOGY
241	MEDICAL ONCOLOGY
242	GYN ONCOLOGY
244	RADIOLOG ONCOLOGY
245	PEDIATRIC RADIOLOGY
246	VASCUL&INTERV RADIOL
249	HIV PCP
250	EMERGENCY MED
254	SPECIALISTS PCMP
280	CHIROPRACTOR
281	CLINICAL SOCIAL WK
282	DRUG&ALC COUNSELOR
283	COUNSELOR
290	ACUPUNCTURIST
300	PHYSICAL THERAPY
301	OCCUPATIONAL THER
302	SPEECH THERAPY
303	AIDS/HIV SERVICES
304	MEDICAL REHAB
305	PED SPECIALIST

Specialty Code	Specialty Description
306	SCHOOL HTH PRG
307	DME SPECIALIST
308	HIV PRIMARY CARE
309	MED SUPR SUB ABUSE
310	MH ADULT CLINIC
311	MH CHILD CLINIC
312	MH CONT DAY TX
313	MH PARTIAL HOSP
314	MH INT PSYCH REHAB
315	MH ADULT CLINIC
316	MH CHILD CLINIC
317	MH CONT DAY TX
318	MH PARTIAL HOSP
319	MH INT PSYCH REHAB
321	COMP SPECIALTY CLN
324	PRE-SCHL SUPP HLTH
326	MH/CR ADULT
327	MH/CR CHILD
328	MH FAMILY BASED TX
329	MH/CR ADULT
330	MH/CR CHILD
331	MH TEACH FAM HOME
332	MRDD CR
350	ORAL SURGERY PPCP
351	DENTAL CLINIC PPCP
353	MH CLINIC PPCP
354	PSYCHIATRY PPCP
355	AIDS DAY HLTH/CNTR
358	TBI SERVICES
411	BACT GENERAL
412	BACT LIMITED
413	BACT AEROBES
414	BACT NEISSERIA GC
415	BACT GC SMEARS
416	BACT RESTRD DENT
419	MYCOBACT SMRS&CULT
420	MYCOBACT GENERAL
421	MYCOBACT LIMITED
422	MYCOBACT SMEARS
423	DX IMMUN COMP
427	DX IMMUN GENRL/LIM
430	HIV RESTRICTED A
431	HIV RESTRICTED B
432	HIV COMP

Specialty Code	Specialty Description
435	CELL IMMUN LIMTD 1
436	CELL IMMUN LIMTD 2
438	CELL IMMUN GENRL
439	CELL IMMUN LIMTD 3
440	VIRO GEN 1/GEN 2
441	VIRO LIMITED
442	VIRO RESTRICTED
450	MYCOLOGIST GENRL
451	MYCOLOGIST YEAST
460	PARASITOLOGY
470	URINE PREG TESTING
481	HEMA COMPREHENSIVE
482	HEMA GENERAL
483	HEMA COAG ONLY
484	HEMA LIMITED
485	HEMA OTHER
486	CYTOHEMA LIMTD/DX
491	BLOOD DX IMM HEMA
510	CHEMISTRY - GENERAL
511	CHEMISTRY - LIMITED
512	TOXI ERYTHRO FLURO
513	TOXI ERYTHRO EXTR
514	TOXI DRUG ANAL
515	TOXI BLOOD LEAD
516	ENDOCRINOLOGY
518	QUAL TOXI REHAB
521	BLOOD PH AND GASES
523	THERA SUBST MONITR
524	URINALYSIS
531	HISTOPATHOLOGY
540	CYTOPATHOLOGY
550	ONCOFETAL GENRL
551	ONCOFETAL LIMTD
552	ONCOFETAL SERA
553	ONCOFETAL AMNIO
560	GENETIC TESTING
571	CYTOGEN GENERAL
572	CYTOGEN LIMITED
573	CYTOGEN HEMA
599	ALL LABORATORIES
601	SPORTS FAMILY MED
602	SPORTS INTERNAL
603	PED SPORTS
620	GERIATRICS FAMILY

Specialty Code	Specialty Description
621	GERIATRICS INTERNAL
630	PAIN MANAGEMENT
640	AUDIOLOGIST
650	VASCULAR SURGERY
651	CARDIO THORAC SURG
652	INTERVEN CARDIOLOGY
660	INSTITUTIONAL LTC
661	SOCIAL & ENVIRON SPTS
662	SOCIAL DAY CARE
663	NUSING HOME CARE
664	ADULT DAY HLTH CARE
665	NON INSTIT LTC
666	ASSTD LIVNG PRGRM
667	HOME DELVRD MEALS
668	HOME CARE - HHA
669	HOSPICE CARE
670	AMBULANCE
671	OTH TRANSPORT
673	PERSONAL CARE
674	RESPIRATORY THERAPY
680	NURSING
714	LOW VISION
715	OPTICIAN
716	OPTOMETRIST
730	INBORN META DIS
740	PERINAT TRANSPORT
741	TRANSPLANT SURGERY
750	MMTP PHYSICIAN
751	MMTP PREF PROV
760	PHARMACY
776	GENERAL PRACTICE
778	PODIATRISTS
779	NURSE PRACTIONER
780	PSYCHOLOGISTS
781	SOCIAL WORKERS
782	CERTIFIED MIDWIVE
790	RESPITE
798	LT HOME HLTH
800	GENERAL DENTIST
801	ORTHODONTURE
802	ENDODONTIST
803	ORAL PATHOLOGIST
804	PEDODONTIST
805	PROSTHODONTIST

Specialty Code	Specialty Description
806	PERIODONTIST
807	DENT PUBLIC HEALTH
808	ORAL SURGEON
809	DENTAL ANESTHES
810	PARENTERAL SEDATN
811	MAXILLOFACIAL SURG
815	ALL DENTISTS
851	OTHER VISION CARE
899	HOSPITAL INPATIENT
901	EMERGENCY ROOM
902	ENDOCRINE
903	DIABETES
904	OBSTETRICS
905	GYNECOLGY
906	FAMILY PLANNING
907	ABORTION
909	NUTRITION PROGRAM
910	ORAL SURGERY
911	GENERAL DENT CLN
912	ORTHODONTIC CLN
913	HEMODIALYSIS
914	GENERAL MED
915	ALLERGY
916	ARTHRITIS
917	RHEUMATOLOGY
918	PODIATRIST CENTER
919	EYE/VISION CNTR
920	PHYS THERAPY CLN
921	SPEECH THERAPY CLN
922	MMTP PROGRAM
923	OCCUP THERAPY CLN
924	REHAB MED CLINIC
925	HYPERTENSION
926	HEMATOLOGY CLINIC
927	CARDIOLOGY
928	CARDIOVASCULAR
929	PULMONARY
930	GASTROENTEROLOGY
931	NEUROLOGY CENTER
932	NEUROSURG CLINIC
933	CANCER DETECTION
934	ONCOLOGY - THERAPY
935	EAR NOSE THROAT
936	PED GENERAL MED

Specialty Code	Specialty Description
937	PED ALLERGY
938	PED NEUROLOGY
939	PED HEMATOLOGY
940	PED CARDIAC
941	PED RENAL
942	PED PULMONARY
943	PED ORTHOPEDIC
944	PED ENDOCRINE
945	PSYCHIATRY INDIVID
946	PSYCHIATRY GROUP
947	PSYCHIATRY 1/2 DAY
948	PSYCHIATRY DAY
949	ALC TX PROGRAM
950	ORTHOPEDIC
951	SURGICAL, MINOR
952	SURGICAL, GENERAL
953	UROLOGY
954	NEPHROLOGY
955	GENITO-URINARY
956	DERMATOLOGY CLINIC
958	OPTHALM CNTR/CLN
959	CHEM DEPEND YOUTH
960	PED DERMATOLOGY
961	PED DIABETES
962	PED SURGEON
963	CHILD PSYCHIATRY
964	PSYCHIATRY
965	TUBERCULOSIS
966	INFECTIOUS DISEASE
967	SPEECH AND HEARING
968	AMPUTEE CNTR
969	HOSP DME/ORTH/PROS
970	DME/ORTH/PROST
971	MH CLINIC TX
972	MH DAY TX
973	MH CONTINUING TX
974	MH CLINIC TX
975	MH DAY TX
976	MH CONTINUING TX
977	MR/DD CLINIC TX
979	MR/DD CLINIC TX
980	TB DIR OBS TX CLN
981	MR DIAG & RESEARCH
983	MR CLINIC

Specialty Code	Specialty Description
984	ALC CLINIC TX
985	ALC DAY REHAB
986	ALC CLINIC TX
987	ALC DAY REHAB
988	COMP ALC CARE
989	ALC DETOX
990	PHYS EXAM SCHOOL
991	ROUTINE VIS SCHOOL
992	COMP PSY EMERG PGM
993	AMBULATORY SURG
994	BLOOD PRODUCTS
995	GENETIC COUNSELING
996	HEARING SERVICES
997	CLINIC OPERATNG RM
998	RADIOLOGY
999	OTHER

APPENDIX C - Codes and Values for Tooth Number or Letter

Code	*Value*
01	PERMANENT THIRD MOLAR-UPPER RIGHT
02	PERMANENT SECOND MOLAR-UPPER RIGHT
03	PERMANENT FIRST MOLAR-UPPER RIGHT
04	PERMANENT SECOND PREMOLAR-UPPER RIGHT
05	PERMANENT FIRST PREMOLAR-UPPER RIGHT
06	PERMANENT CANINE-UPPER RIGHT
07	PERMANENT LATERAL INCISOR-UPPER RIGHT
08	PERMANENT CENTRAL INCISOR-UPPER RIGHT
09	PERMANENT CENTRAL INCISOR-UPPER LEFT
10	PERMANENT LATERAL INCISOR-UPPER LEFT
11	PERMANENT CANINE-UPPER LEFT
12	PERMANENT FIRST PREMOLAR-UPPER LEFT
13	PERMANENT SECOND PREMOLAR-UPPER LEFT
14	PERMANENT FIRST MOLAR-UPPER LEFT
15	PERMANENT SECOND MOLAR-UPPER LEFT
16	PERMANENT THIRD MOLAR-UPPER LEFT
17	PERMANENT THIRD MOLAR-LOWER LEFT
18	PERMANENT SECOND MOLAR-LOWER LEFT
19	PERMANENT FIRST MOLAR-LOWER LEFT
20	PERMANENT SECOND PREMOLAR-LOWER LEFT
21	PERMANENT FIRST PREMOLAR-LOWER LEFT
22	PERMANENT CANINE-LOWER LEFT
23	PERMANENT LATERAL INCISOR-LOWER LEFT
24	PERMANENT CENTRAL INCISOR-LOWER LEFT
25	PERMANENT CENTRAL INCISOR-LOWER RIGHT
26	PERMANENT LATERAL INCISOR-LOWER RIGHT
27	PERMANENT CANINE-LOWER RIGHT
28	PERMANENT FIRST PREMOLAR-LOWER RIGHT
29	PERMANENT SECOND PREMOLAR-LOWER RIGHT
30	PERMANENT FIRST MOLAR-LOWER RIGHT
31	PERMANENT SECOND MOLAR-LOWER RIGHT
32	PERMANENT THIRD MOLAR-LOWER RIGHT
51	SUPERNUMARY 01
52	SUPERNUMARY 02
53	SUPERNUMARY 03
54	SUPERNUMARY 04
55	SUPERNUMARY 05
56	SUPERNUMARY 06
57	SUPERNUMARY 07
58	SUPERNUMARY 08
59	SUPERNUMARY 09
60	SUPERNUMARY 10
61	SUPERNUMARY 11
62	SUPERNUMARY 12
63	SUPERNUMARY 13
64	SUPERNUMARY 14
65	SUPERNUMARY 15
66	SUPERNUMARY 16
67	SUPERNUMARY 17
68	SUPERNUMARY 18
69	SUPERNUMARY 19
70	SUPERNUMARY 20
71	SUPERNUMARY 21
72	SUPERNUMARY 22

Code	*Value*
73	SUPERNUMARY 23
74	SUPERNUMARY 24
75	SUPERNUMARY 25
76	SUPERNUMARY 26
77	SUPERNUMARY 27
78	SUPERNUMARY 28
79	SUPERNUMARY 29
80	SUPERNUMARY 30
81	SUPERNUMARY 31
82	SUPERNUMARY 32
A	PRIMARY SECOND MOLAR-UPPER RIGHT
AL	LOWER ARCH
AS	TOOTH CODES AS
AU	UPPER ARCH UPPER ARCH
B	PRIMARY FIRST MOLAR-UPPER RIGHT
BS	TOOTH CODES BS
C	PRIMARY CANINE-UPPER RIGHT
CS	TOOTH CODES CS
D	PRIMARY LATERAL INCISOR-UPPER RIGHT
DE	ALL DECIDUOUS
DS	TOOTH CODES DS
E	PRIMARY CENTRAL INCISOR-UPPER RIGHT
ES	TOOTH CODES ES
F	PRIMARY CENTRAL INCISOR-UPPER LRFT
FS	TOOTH CODES FS
G	PRIMARY LATERAL INCISOR-UPPER LEFT
GS	TOOTH CODES GS
H	PRIMARY CANINE-UPPER LEFT
HS	TOOTH CODES HS
I	PRIMARY FIRST MOLAR-UPPER LEFT
IS	TOOTH CODES IS
J	PRIMARY SECOND MOLAR-UPPER LEFT
JS	TOOTH CODES JS
K	PRIMARY SECOND MOLAR-LOWER LEFT
KS	TOOTH CODES KS
L	PRIMARY FIRST MOLAR-LOWER LEFT
LL	LOWER LEFT QUADRANT
LR	LOWER RIGHT QUADRANT
LS	TOOTH CODES LS
M	PRIMARY CANINE-LOWER LEFT
MS	TOOTH CODES MS
N	PRIMARY LATERAL INCISOR-LOWER LEFT
NS	TOOTH CODES NS
O	PRIMARY CENTRAL INCISOR-LOWER LEFT
OS	TOOTH CODES OS
P	PRIMARY CENTRAL INCISOR-LOWER LEFT
PE	ALL PERMANENT
PS	TOOTH CODES PS
Q	PRIMARY LATERAL INCISOR-LOWER LEFT
QS	TOOTH CODES QS
R	PRIMARY CANINE-LOWER RIGHT
RS	TOOTH CODES RS
S	PRIMARY FIRST MOLAR-LOWER RIGHT
SS	TOOTH CODES SS
T	PRIMARY SECOND MOLAR-LOWER RIGHT
TS	TOOTH CODES TS
UL	UPPER LEFT QUADRANT
UR	UPPER RIGHT QUADRANT

Medicaid Encounter Data System II (MEDS II) Supplemental Manual On Applicable Edits

I. MEDS II Categories of Service, Applicable Encounter Type Indicators and Form Type/EDI
II. Tier One Edits
III. Edit Logic
IV. Edit Severity Matrix
V. Response Report Reconciliation

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I. MEDS II Categories of Service, Applicable Encounter Type Indicators (ETI) and Form Type/EDI

COS Code	*COS Description*	*ETI*	*ETI Description*	*Form Type/EDI*
01	Physician Services	P	Professional	CMS-1500 / 837P
03	Podiatry	P	Professional	CMS-1500 / 837P
04	Psychology	P	Professional	CMS-1500 / 837P
05	Eye Care / Vision	P	Professional	CMS-1500 / 837P
06	Rehabilitation Therapy	I	Institutional	UB-92 / 837I
07	Nursing	P	Professional	CMS-1500 / 837P
11	Inpatient	I	Institutional	UB-92 / 837I
12	Institutional LTC	I	Institutional	UB-92 / 837I
13	Dental	T	Dental	ADA / 837D
14	Pharmacy	D	Pharmacy/DME	NCPDP
15	Home Health Care/Non-Institutional Long Term Care	I	Institutional	UB-92 / 837I
16	Laboratories	P	Professional	CMS-1500 / 837P
19	Transportation	P	Professional	CMS-1500 / 837P
22	DME and Hearing Aids	P	Professional	CMS-1500 / 837P
28	Intermediate Care Facilities	I	Institutional	UB-92 / 837I
41	NPs/Midwives	P	Professional	CMS-1500 / 837P
73	Hospice	I	Institutional	UB-92 / 837I
75	Clinical Social Worker	P	Professional	CMS-1500 / 837P
85	Freestanding Clinic	I	Institutional	UB-92 / 837I
87	Hospital OP/ER Room	I	Institutional	UB-92 / 837I

Additional Copies:
Additional copies of this manual may be obtained via download from the MEDS Home Page on the HPN. https://commerce.health.state.ny.us/hpn/omc/meds/index.shtml

CSC Contact Information:
CSC Provider Relations Staff (518)257-4639.
http://www.emedny.org/ProviderManuals/ManagedCare/index.html

II. Tier One Edits

After submitting a file of encounter data to CSC via the eMedNY eXchange or FTP options, plans will receive notification that the file was received and processed. When an encounter file does not pass through the front end processing it is due to failing a 'Tier One' edit. When this occurs the entire file is rejected for one of the following 'Tier One' edits.

Tier One Error	Message Returned
Record is not 1200 bytes	'Incomplete " ", Header Record' – will give the size and record that is not 1200 bytes
Required records missing (H1, D1, and a T1)	Required " " record missing' – will include the record type missing
Required records not in sequence (H1, D1, and a T1)	'Record " " is of unknown type or invalid sequence' – will include the record type in error
Test/Prod indicator is incorrect – must be PROD	'Specified mode " " does not match' 'Test/Prod Indicator'
The carriage return (CR) is too short/long or misaligned	'Misaligned ASCII " ", "CR" in record " " column " " ' 'Unexpected ASCII " ", "CR" in record " " column " " '
Newline/linefeed (NL) in record	'Unexpected ASCII " ", "NL" in record " " column " " '
Non-printable characters in file	'Non-ASCII character'
End of file not in the correct place	'Premature end-of-file'
No records are found	'FILE CONTAINS NO CLAIM RECORDS'
H1 record is found when unexpected	'UNEXPECTED H1 RECORD RECEIVED' 'AT RECORD #:'
H1 record is not found when expected (after user record)	'EXPECTED H1 CONTROL RECORD NOT RECEIVED' 'AT RECORD #:'
D1 record is found, and it is expected, and the encounter type is other than I, D, T, or P	'INVALID D1 RECORD RECEIVED' 'AT RECORD #:'
D1 record is found when unexpected	'UNEXPECTED D1 RECORD RECEIVED' 'AT RECORD #:'
D1 record is not found when expected	'EXPECTED D1 CONTROL RECORD NOT RECEIVED' 'AT RECORD #:'
T1 record is found when unexpected	'UNEXPECTED T1 RECORD RECEIVED' 'AT RECORD #:'
Record is other than H1, D1, or T1	'RECEIVED RECORD NOT H1/D1/T1''AT RECORD #:'

If the encounter transmission does not fail for any of the above listed 'Tier One' edits, plans will receive a message that the file was passed on for further processing. What this means is that the encounter file will now be processed in the CSC Claims System and a MEDS II Response File will be generated and sent back to the plan.

III. Edit Logic

Edit Number	Edit Description	Edit Logic
00018	Date of Service/ Fill Date Invalid	If Service Date is not a valid date (MMDDCCYY), the edit is failed.
00020	Service/ Fill Date Later Than Receipt Date	If the Service Start Date or Service End Date is greater than the CSC processing date, the edit is failed.
00021	Patient Status Code Invalid	If Patient Status or Disposition Code is not equal to: 01-09, 20, 30, 40-43, 50-51, 61-65 the edit is failed.
00039	Primary Diagnosis Code Failed	If the Principal/Primary Diagnosis Code for institutional encounters is blank, the edit is failed.
00062	Provider Id Number Invalid	**For Dental and Professional Encounters** – If the Provider Identification Number is spaces, the edit is failed.
00070	Procedure Code Invalid	**For Dental and Professional Encounters** – For each service line reported, if the Procedure Code is blank, the edit is failed. **For Institutional-Outpatient Encounters** - For each service line reported, if the HCPCS Code and Revenue Code are blank, the edit is failed.
00071	Place of Service Code Invalid	If the Place of Service/Place of Treatment Code is not equal to: 03-08, 11-15, 20-26, 31-34, 41-42,49-57, 60-62, 65, 71-72, 81, 99 the edit is failed.
00074	Recipient Id Number Invalid	If the CIN is not a valid CIN (CCNNNNNC), the edit is failed. (C = Character N = Number)
00078	Referring Provider Id Number Invalid	If the Provider Id does not match a Provider Id on the eMedNY Provider Reference File, the edit is failed.
00094	Number of Units Not Greater Than Zero	If the Quantity or Units Submitted is equal to zero, the edit is failed.
00103	Adj/ Void Fields Incomplete	If the Transaction Status Code equals 7 or 8 and the Previous Transaction Control Number equals spaces or zeros, the edit is failed.
00140	Recipient ID Not on File	If the CIN is not on the WMS (Client Demographic Table), the edit is failed.
00146	Primary Diagnosis not on File	If Diagnosis Code is not on the eMedNY Reference Diagnosis Code Table, the edit is failed (i.e., must be a valid diagnosis code as reported in the coding manual.)
00170	Procedure Code Not On File	If the Procedure Code is not on the eMedNY Reference Procedure Code Table, the edit is failed (i.e., must be a valid CPT4/HCPCS code as reported in the coding manual.).

Edit Number	Edit Description	Edit Logic
00175	Provider Id Not on File	If the Provider Id does not match a Provider Id on the eMedNY Provider Reference File, the edit is failed.
00180	Units Greater Than Maximum	If the Procedure Units is greater than allowed amount on the eMedNY Procedure Reference File, the edit is failed.
00400	Encounter Control Number Missing	If the Encounter Control Number is blank, the edit is failed.
00404	Provider Specialty Missing	If the Provider Specialty Code is blank or equal to zero, the edit is failed.
00405	Principal Procedure Code Missing	If Procedure Code is blank or equal to zero, the edit is failed.
00406	Diagnosis Code Missing	**For Practitioner Encounters** - If the first Diagnosis Code is blank, the edit is failed. **For Institutional Encounters** - If the Primary Diagnosis Code is blank, the edit is failed.
00408	Category of Service (COS) Missing	If the Category of Service is not equal to: 01, 03-07, 11-16, 19, 22, 28, 41, 73, 75, 85, 87 the edit is failed.
00409	Inpatient MMIS Provider ID Is Not A Hospital	If the Provider Type Code is not equal to: 012, 016, 028, 038 for referring Provider Id, the edit is failed. (The Provider Type Code is assigned by eMedNY according to the MMIS ID.)
00410	DRG Code Missing	For inpatient encounters, if the AP-DRG Code is blank, the edit is failed
00412	Diagnosis Code Not On File	If the Diagnosis Code is not on the eMedNY Diagnosis Code Reference Table, the edit is failed.
00413	Provider Specialty Not On File	If the Provider Specialty Code is not on the eMedNY Provider Specialty Reference Table, the edit is failed.
00416	License Number Is Missing	If the Provider License Number is blank or equal to all zeros, the edit is failed.
00423	MMIS plan ID Missing	If the MMIS Plan Id is blank, the edit is failed.
00424	MMIS plan ID Not On File	If the MMIS Plan Id does not match a provider Id on the eMedNY Provider Reference File, the edit is failed.
00425	MMIS plan ID Not HMO Provider	If the Provider Type Code associated with the MMIS Plan Id is not 022, the edit is failed. (The Provider Type Code is assigned by eMedNY according to the MMIS ID.)
00431	Neonate Birth Weight Code Invalid	**For Inpatient Encounters** - If the Recipient (CIN) Date of Birth and the Admit Date on the claim are equal and the Neonate Value Code is not equal to '54', the edit is failed.

Edit Number	Edit Description	Edit Logic
00432	Attend Prov Id Not on File	If the Attending Provider Id does not match a Provider ID on the eMedNY Provider Reference File, the edit is failed.
00433	Oper Prov Id Not on File	If the Surgeon Provider Id does not match a Provider Id on the eMedNY Provider Reference File, the edit is failed.
00434	Birth Weight Not Reasonable	If the Neonate Value Code equals '54', the Birth Weight must be between '0000099' and '0008000', else the edit is failed.
00435	Source of Admission Code Invalid	**For Inpatient Encounters** - If Source of Admission Code is not a valid value: '1-9', 'A-C', the edit is failed. For all other institutional encounters, if the Source of Admission Code does not equal spaces, the edit is failed.
00436	Type of Bill Digit 3 Invalid	If the Type of Bill Code is greater than spaces and the third digit of the Type of Bill Code is not a valid value; '0-9', 'A' the edit is failed.
00437	Claim/Encounter Ind Invalid	If the Claim/Encounter Indicator does not equal; 'A', 'C', or 'E', the edit is failed.
00525	Prescribing License Number Missing	If the Prescribing License Number is blank or equal to zero, the edit is failed.
00528	Missing Or Invalid Quantity Dispensed	If the Quantity Dispensed is blank or equal to zero, the edit is failed.
00534	Date Ordered Invalid	If the Date Ordered is not a valid date (MMDDCCYY), the edit is failed.
00540	Number of Days Supply Invalid	If the Days Supply is blank or equal to zero, the edit is failed.
00544	NDC Code Non-Numeric	If the NDC Code is non-numeric or blank, the edit is failed.
00548	Fill Date Precedes Order Date	If the Fill Date is less than the Ordered Date, the edit is failed.
00561	Drug Code Not On File	If the NDC Code is not on the eMedNY Reference Drug Table, the edit is failed.
00600	Admission Date Invalid	If the Admission Date is not a valid date (MMDDCCYY), the edit is failed.
00603	Admission Type Code Invalid	If the Admission Type Code is not: 1-5, the edit is failed.
00604	Admitting Diagnosis Code Missing	If Admit Diagnosis Code is blank, the edit is failed.
00625	Discharge Date Illogical	If the Discharge Date is not a valid date (MMDDCCYY), the edit is failed.
00652	Discharge Date Prior To Admission Date	If Discharge Date is valid, but less than Admission Date, the edit is failed.
00655	Discharge Date Different Than Statement Thru Date	If the Discharge Date is different than the Statement Thru Date, the edit is failed.
00664	Attending Physician License Number Missing	If Attending Physician License Number is blank or equal to zero, the edit is failed.

Edit Number	Edit Description	Edit Logic
00689	Recipient Not Enrolled In Plan on Date of Service	If recipient is not enrolled on Managed Care Master File in your Plan on date of service, the edit is failed.
00693	Recipient Never Enrolled in Managed Care	If the Recipient (CIN) is not on the Managed Care Master File, the edit is failed.
00694	Recipient Not Enrolled in Managed Care on Date of Service	If the Recipient (CIN) is not on the Managed Care Master file on the date of service, the edit is failed.
00696	Recipient Enrolled in Another Managed Care Plan on Date of Service	If the Recipient (CIN) is on the Managed Care Master file on the date of service, but enrolled in another MC Plan, the edit is failed.
00705	Duplicate Claim In History	**For Professional (Not Dental, Not DME) -** If CIN, Provider Id, Date of Service, Procedure Code, Primary Diagnosis Code and Specialty Code are the same, the edit is failed. **For Dental encounters** - If CIN, Date of Service, Provider Id, Procedure Code and Tooth Number are the same, the edit is failed. **For DME encounters** - If CIN, Date of Service, Provider Id and Procedure Code are the same, the edit is failed. **For Institutional (Non-Inpatient) encounters** - If CIN, Date of Service, Provider Id, Primary Diagnosis Code, Procedure Code and Revenue Code are the same, the edit is failed. **For Inpatient encounters** - If CIN, Admit Date, and Provider Id are the same, the edit is failed. **For Pharmacy encounters** - If CIN, Date of Service, Provider Id, and NDC Code are the same, the edit is failed.
00710	Procedure Code Exceeds Service Limits	If the procedure code reported has exceeded the established service limit , the edit is failed.
00725	History Record Not Found Adjustment/Void	If the Previous Transaction Control Number (TCN) is not valid, the edit is failed.
00897	Prescriber Id Not on File	If the Prescriber Id does not match a Provider Id on the eMedNY Provider Reference File, the edit is failed.
00901	Claim Type Unknown	If the Claim/Encounter does not equal a valid claim type (i.e., correct ETI/MEDS II COS combination), the edit is failed. The Encounter Type Indicator (ETI) must be equal to "I", "T", "D" or "P", and in the correct MEDS II Category of Service. Correct submission standards are detailed in the MEDS II Data Element Dictionary in Section II. Encounter Type Assignment by Category of Service.
00903	Provider Id or License Number Missing	**For Institutional or Pharmacy Encounters** - If the Provider Id and Provider License Number are blank, the edit is failed.

Edit Number	Edit Description	Edit Logic
00931	Required Tooth For Procedure Invalid	If the Procedure Code indicates a tooth number is required and Tooth Number or Letter not equal to a value in Appendix C of the MEDS II Data Element Dictionary, the edit is failed.
01004	Thru Service Date Invalid	If the Thru Service Date is not a valid date (MMDDCCYY), the edit is failed.
01006	Thru Service Prior to From Service Date	If the Thru Service Date is prior to From Service Date, the edit is failed.
01292	Date of Service Two Years Prior to Date Received	If the Date of Service/Begin Date is greater than 734 days (2 years) from the CSC processing date, the edit is failed.
01610	Missing or Invalid Alternate Product Code	If the Product Code is entered and the first 11 digits are not alphanumeric, the edit is failed.
01705	Revenue Code Not on File	If the Revenue Code is not found on the eMedNY Revenue Code Table, the edit is failed (i.e., must be a valid Revenue Code as reported in the coding manual.)
01718	Type of Bill Invalid	If the Type of Bill is not equal to: 11-18, 21-28, 32-34, 41-48, 51-58, 61-68, 71-76, 79, 81-86, 89 the edit is failed.
01737	Value Amount Invalid for Submitted Value Code	If the Neonate Value Amount is blank or equal to zero and a Neonate Value Code is present, the edit is failed.

IV. Edit Severity Matrix

This section details current edit severity programming within the CSC Encounter/Claim System Processing. The edits correspond to the logic indicated in Section III, and not all edits apply to all Encounter Type/Category of Service/Claim type record submissions.

Up to 24 edits may be assigned to an encounter record before the entire record is rejected.

Each edit is assigned a severity level as follows:

Code	Edit Severity	File Processing Implication
F	Fatal Record Error	There is a fatal error in the encounter record. The claim system has stopped reading the encounter record, and the entire record is rejected.
H	Hard Edit (Deny)	There is a vital error in the encounter record. If the error is at the header level, the entire record will reject, and should be resubmitted as an original encounter. If the error is on the service line, the affected service line will reject (with an edit code and service line indicated in the response report. Please refer to Section V of this manual for more detail). Subsequent service lines, if correctly submitted, will be accepted for further processing.
S	Soft Edit (Accept)	Edit indicates that the data provided is inaccurate. However, the record is accepted for further processing. The inaccurate information should be corrected and resubmitted as an adjustment.
N	Non-Edit	Edit does not apply to the ETI/Clinic Type/MEDS COS combination.

IV. Edit Severity Matrix

	ETI:	I=Institutional								D	T	P=Professional									
	Claim Type:	Clinic			IP	Nursing Home		HH	ICF	Rx	Dental	Practitioner						Eye	Lab	Trans	DME
Edit Code	COS:	06	85	87	11	12	73	15	28	14	13	01	03	04	07	41	75	05	16	19	22
00018	Date of Service/Fill Date Invalid	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F
00020	Service/Fill Date Later Than Receipt Date	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H
00021	Patient Status Code Invalid	N	N	N	H	H	H	N	H	N	N	N	N	N	N	N	N	N	N	N	N
00039	Primary Diagnosis Code Blank	H	H	H	H	S	S	S	S	N	N	N	N	N	N	N	N	N	N	N	N
00062	Provider Id Number Invalid	N	N	N	N	N	N	N	N	N	H	H	H	H	H	H	H	H	H	H	H
00070	Procedure Code Invalid	H	H	H	N	H	H	H	H	N	H	H	H	H	H	H	H	H	H	H	H
00071	Place of Service Code Invalid	N	N	N	N	N	N	N	N	N	H	H	H	H	H	H	H	H	H	S	H
00074	Recipient ID Number Invalid	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F
00078	Referring Provider ID Number Invalid	H	H	H	H	H	H	H	H	H	N	N	N	N	N	N	N	N	N	N	N
00094	Number of Units Not Greater Than Zero	H	H	H	N	H	H	H	H	N	H	H	H	H	H	H	H	H	H	H	H
00103	Adjustment / Void Fields Incomplete	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H

Legend: F=Fatal; H=Hard Edit (Deny); S=Soft Edit (Accept); N=Non-Edit (Ignore)

	ETI:	I=Institutional								D	T	P=Professional									
	Claim Type:	Clinic			IP	Nursing Home		HH	ICF	Rx	Dental	Practitioner						Eye	Lab	Trans	DME
Edit Code	COS:	06	85	87	11	12	73	15	28	14	13	01	03	04	07	41	75	05	16	19	22
00140	Recipient ID Not On File	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H
00146	Primary Diagnosis not on File	H	H	H	H	S	S	S	S	N	N	N	N	N	N	N	N	N	N	N	N
00170	Procedure Code Not On File	H	H	H	H	H	H	H	H	N	H	H	H	H	H	H	H	H	H	H	H
00175	Provider ID Not On File	N	N	N	N	N	N	N	N	N	H	H	H	H	H	H	H	H	H	H	H
00180	Units Greater than Maximum	S	S	S	N	N	N	S	N	N	S	S	S	S	S	S	S	S	N	N	S
00400	Encounter Control Number Missing	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S
00404	Provider Specialty Missing	H	H	H	N	H	H	H	H	N	H	H	H	H	H	H	H	H	H	H	H
00405	Principal Procedure Code Missing	N	N	N	S	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
00406	Diagnosis Code Missing	H	H	H	H	H	H	H	H	N	N	S	S	S	S	S	S	S	S	S	S
00408	Category of Service (COS) Missing	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F

Legend: F=Fatal; H=Hard Edit (Deny); S=Soft Edit (Accept); N=Non-Edit (Ignore)

	ETI:	I=Institutional								D	T	P=Professional									
	Claim Type:	Clinic			IP	Nursing Home		HH	ICF	Rx	Dental	Practitioner						Eye	Lab	Trans	DME
Edit Code	COS:	06	85	87	11	12	73	15	28	14	13	01	03	04	07	41	75	05	16	19	22
00409	Inpatient MMIS Provider ID Is Not A Hospital	N	N	N	H	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
00410	DRG Code Missing	N	N	N	H	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
00412	Diagnosis Code Not On File	H	H	H	H	H	H	H	H	N	N	H	H	H	H	H	H	H	S	S	S
00413	Provider Specialty Not On File	H	H	H	N	H	H	H	H	N	H	H	H	H	H	H	H	H	H	H	H
00416	License Number Is Missing	N	N	N	N	N	N	N	N	N	S	S	S	S	S	S	S	S	N	N	N
00423	MMIS plan ID Missing	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F
00424	MMIS plan ID Not On File	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F
00425	MMIS plan ID Not HMO Provider	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H
00431	Neonate Birth Weight Code Invalid	N	N	N	H	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
00432	Attend Prov Id Not on File	H	H	H	H	H	H	H	H	N	N	N	N	N	N	N	N	N	N	N	N
00433	Oper Prov Id Not on File	N	N	N	H	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N

Legend: F=Fatal; H=Hard Edit (Deny); S=Soft Edit (Accept); N=Non-Edit (Ignore)

	ETI:	I=Institutional								D	T	P=Professional									
	Claim Type:	Clinic			IP	Nursing Home		HH	ICF	Rx	Dental	Practitioner						Eye	Lab	Trans	DME
Edit Code	COS:	06	85	87	11	12	73	15	28	14	13	01	03	04	07	41	75	05	16	19	22
00434	Birth Weight Not Reasonable	N	N	N	H	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
00435	Source of Admission Cd Invalid	N	N	N	H	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
00436	Type of Bill Digit 3 Invalid	H	H	H	H	H	H	H	H	N	N	N	N	N	N	N	N	N	N	N	N
00437	Claim/Encounter Ind Invalid	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H
00525	Prescribing License No. Missing	N	N	N	N	N	N	N	N	S	N	N	N	N	N	N	N	N	N	N	N
00528	Missing Or Invalid Quantity Dispensed	N	N	N	N	N	N	N	N	H	N	N	N	N	N	N	N	N	N	N	N
00534	Date Ordered Invalid	N	N	N	N	N	N	N	N	H	N	N	N	N	N	N	N	N	N	N	N
00540	Number of Days Supply Invalid	N	N	N	N	N	N	N	N	H	N	N	N	N	N	N	N	N	N	N	N
00544	NDC Code Non-Numeric	N	N	N	N	N	N	N	N	S	N	N	N	N	N	N	N	N	N	N	N
00548	Fill Date Precedes Order Date	N	N	N	N	N	N	N	N	H	N	N	N	N	N	N	N	N	N	N	N
00561	Drug Code Not On File	N	N	N	N	N	N	N	N	S	N	N	N	N	N	N	N	N	N	N	N

Legend: F=Fatal; H=Hard Edit (Deny); S=Soft Edit (Accept); N=Non-Edit (Ignore)

	ETI:	I=Institutional								D	T	P=Professional									
	Claim Type:	Clinic			IP	Nursing Home		HH	ICF	Rx	Dental	Practitioner						Eye	Lab	Trans	DME
Edit Code	COS:	06	85	87	11	12	73	15	28	14	13	01	03	04	07	41	75	05	16	19	22
00600	Admission Date Invalid	N	N	N	H	H	H	N	H	N	N	N	N	N	N	N	N	N	N	N	N
00603	Admission Type Code Invalid	N	N	N	H	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
00604	Admitting Diagnosis Code Missing	N	N	N	S	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
00625	Discharge Date Illogical	N	N	N	H	H	N	N	H	N	N	N	N	N	N	N	N	N	N	N	N
00652	Discharge Date Prior To Admission Date	N	N	N	H	H	N	N	H	N	N	N	N	N	N	N	N	N	N	N	N
00655	Discharge Date Different Than Thru Date	N	N	N	H	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
00664	Attending Physician License Number Missing	S	S	S	S	S	S	S	S	N	N	N	N	N	N	N	N	N	N	N	N
00689	Recipient Not Enrolled in Plan on Date of Service	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H
00693	Recipient Never Enrolled in Mngd Care	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H

Legend: F=Fatal; H=Hard Edit (Deny); S=Soft Edit (Accept); N=Non-Edit (Ignore)

	ETI:	I=Institutional								D	T	P=Professional									
	Claim Type:	Clinic			IP	Nursing Home		HH	ICF	Rx	Dental	Practitioner						Eye	Lab	Trans	DME
Edit Code	COS:	06	85	87	11	12	73	15	28	14	13	01	03	04	07	41	75	05	16	19	22
00694	Recipient Not Enrolled in Managed Care on Date of Service	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H
00696	Recipient Enrolled in Another Managed Care Plan on Date of Service	H	H	H	H	H	H	H	H	H	H	S	S	S	S	S	S	S	S	S	S
00705	Duplicate Claim In History	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H
00710	Procedure Exceeds Service Limits	S	S	S	N	N	N	N	N	H	H	H	H	H	H	H	H	H	H	H	H
00725	Histry Record Not Found Adjustment/Void	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H
00897	Prescriber Id Not on File	N	N	N	N	N	N	N	N	S	N	N	N	N	N	N	N	N	N	N	N
00901	Claim Type Unknown	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F
00903	Provider Id Number Missing	H	H	H	H	H	H	H	H	H	N	N	N	N	N	N	N	N	N	N	N

Legend: F=Fatal; H=Hard Edit (Deny); S=Soft Edit (Accept); N=Non-Edit (Ignore)

	ETI:	I=Institutional								D	T	P=Professional									
	Claim Type:	Clinic			IP	Nursing Home		HH	ICF	Rx	Dental	Practitioner						Eye	Lab	Trans	DME
Edit Code	COS:	06	85	87	11	12	73	15	28	14	13	01	03	04	07	41	75	05	16	19	22
00931	Required Tooth For Procedure Invalid	N	N	N	N	N	N	N	N	N	S	N	N	N	N	N	N	N	N	N	N
01004	Thru Service Date Invalid	H	H	H	N	H	H	H	H	N	H	H	H	H	H	H	H	H	H	H	H
01006	Thru Service Prior to From Service Date	H	H	H	N	H	H	H	H	N	H	H	H	H	H	H	H	H	H	H	H
01292	Date of Service Two Years Prior to Date Received	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S
01610	Missing or Invalid Alternate Product Code	N	N	N	N	N	N	N	N	S	N	N	N	N	N	N	N	N	N	N	N
01705	Revenue Code Not On File	H	H	H	N	H	H	H	H	N	N	N	N	N	N	N	N	N	N	N	N
01718	Type Of Bill Is Invalid	H	H	H	H	H	H	H	H	N	N	N	N	N	N	N	N	N	N	N	N
01737	Value Amount Invalid For Submitted Value Code	N	N	N	H	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N

Legend: F=Fatal; H=Hard Edit (Deny); S=Soft Edit (Accept); N=Non-Edit (Ignore)

V. Response File Reconciliation

Health plans will receive a transmission file for each encounter file submitted. Files will stay within the plans eMedNY Exchange or FTP mailbox for a period of ten (10) days. After that they will be archived for sixty (60) days and then deleted from the system. Plans will also receive a response file for all encounter files submitted during a processing cycle. When submitting to the Integrated Test Facility (ITF) the processing cycle happens daily and the plan should receive a response file the following day. When submitting to the Production System, the processing cycle pulls encounter files in daily and processes them weekly. Therefore, the plan should receive a response file one week from the date of submission.

The response file provides valuable feedback to the plan on the quality of the encounter data submitted. The plan will receive information on whether the record was accepted or rejected as well as up to 24 edits.

Data Element	Width	Record Positions
Encounter Control Number	11	1-11
Claim Line Number	04	12-15
Edit Status Code	01	16
Claim Edit Code	05	17-21
COS Code ("EN" precedes code)	04	22-25
TCN	16	26-41
Plan ID	08	42-49
TSN	03	50-52
Filler	28	53-80

Plans should use information provided in the feedback report [Encounter Control Number (ECN), Claim Line Number, Edit Status Code, Claim Edit Number, Category of Service (COS Code), and Transaction Control Number (TCN)] to match the status of each line of the encounter record.

Since the Response File reports errors on the service line level, plans should be aware of four general rules about feedback reports:

Rule # 1:

If the encounter record passes through without hitting any edits, the plan will receive one record line back with an edit status code of 'P' at line number '0000'. The plan should store the associated TCN and the Accepted status in their data system. Any changes to these records should be handled as an adjustment.

Example:

Plan ID '12345678' with a TSN of 'ABC' submits a professional service encounter with an ECN of '00000000001' and a COS of '01'. The encounter passes all edits. The feedback report will produce the following response:

000000000010000P EN0105220000015495201234567 8ABC

Using the feedback report layout allows the plan to match the result back to the reported encounter.

ECN	= '00000000001'
Line Number	= '0000'
Edit Status Code	= 'P' [Paid/Accepted]
COS	= 'EN01'
TCN	= '0522000001549520'
Plan ID	= '12345678'
TSN	= 'ABC'

Plan ID '12345678' should tag encounter '00000000001' as an accepted encounter with a TCN of '0522000001549520' within their system. If the encounter needs to be adjusted in the future, the plan has stored the transaction control number (TCN) to identify the record.

Rule # 2:

If the encounter record rejects at the header level (line = '0000' and edit status code = '2') the entire encounter record is rejected. Plans should correct all errors identified and resubmit the encounter as an original.

Example:

Plan '12345678' with a TSN of 'ABC' submits a professional services encounter with an ECN of '00000000002', a COS of '01', five different valid procedure codes, but did not submit the MMIS Provider Id. Everything else in the encounter record is correct. The feedback report will produce the following response.

00000000002000020017 5EN0105220000015495 4012345678ABC

Using the feedback report layout allows the plan to match the result back to the reported encounter.

ECN	= '00000000002'
Line Number	= '0000'
Edit Status Code	= '2' [Deny/Rejected]
Claim Edit Code	= '00175' [Servicing Provider Id Not on File]
COS	= 'EN01'
TCN	= '0522000001549540'
plan ID	= '12345678'
TSN	= 'ABC'

Anything that fails at the Header level (line number= '00') will cause the entire encounter to reject. In this case the plan would not store the associated TCN because it will not be used after errors are corrected and the encounter is re-submitted as an original.

Rule # 3:

If the encounter record includes both accepted and rejected service lines (line number(s) = '01' – '10' and edit status codes of '2' and '3') the encounter has been partially accepted. The plan should store the associated TCN and the accepted and rejected status of each service line. All corrections to the encounter would be handled as an adjustment to the original encounter.
Example:

Plan '12345678' with a TSN of 'ABC' submits a professional services encounter with an ECN of '00000000003', a COS of '01'. Within this encounter there are two service lines. One line reports a valid procedure code '99214', and the second line does not '9TY32'. Everything else within the encounter record is correct. The feedback report will produce the following response.

00000000003000220017 0EN01052200000154956012345678ABC

Using the feedback report layout allows the plan to match each result back to the reported encounter. The response file identifies when a record is accepted and when a record has errors. If the plan has submitted a multiple service line encounter and receives responses to only some service lines, the plan should assume the other service lines are accepted. In the example above, the plan will not receive a response line to the first procedure code of '99214' because it was accepted. However, for line '0002' the plan should receive the response line shown above, which is interpreted as follows:

ECN	= '00000000003'
Line Number	= '0002'
Edit Status Code	= '2' [Deny/Rejected]
Claim Edit Code	= '00170' [Procedure Code Not on File]
COS	= 'EN01'
TCN	= '0522000001549560'
Plan ID	= '12345678'
TSN	= 'ABC'

This record has been partially accepted in the claims system. Line '01' with the valid procedure code of '99214' was accepted. Line '02' with the invalid procedure code of '9TY32' was rejected. Plan '12345678' should incorporate the TCN '0522000001549560' and the status code for each claim line into their data system. Line '02' should be corrected, and the entire encounter should be re-submitted as an adjustment.

Rule # 4:

For every adjusted encounter the plan will receive two response lines returned. The eMedNY claims system creates a 'void' line in the claim system that removes the original encounter. It then creates a new replacement/adjustment line. The first TCN, which represents the 'void' line, should always end in '1'. Plans should disregard this TCN. The second TCN, which represents the 'replacement/adjustment' line, will always end in '2'. Plans should store this TCN with the new encounter record.

Example:

Plan '12345678' with a TSN of 'ABC' decides to correct the professional services encounter (ECN '00000000003') that was partially accepted in Example 3. In order to correct the record, the plan changes the second procedure code from '9TY32' to '99215' and submits the adjusted record following the rules identified in the MEDS II Data Element Dictionary. The adjusted encounter is determined to be correct and is accepted for processing. The feedback report produces the following response.

```
000000000030000P    EN0105220000015495911234567 8ABC
000000000030000P    EN0105220000015495921234567 8ABC
```

The first response line indicates the removal of the original encounter was accepted.

ECN	= '00000000003'
Line Number	= '0000'
Edit Status Code	= 'P' [Paid/Accepted]
COS	= 'EN01'
TCN	= '0522000001549591'
Plan ID	= '12345678'
TSN	= 'ABC'

The second response line indicates the 'adjusted' encounter was accepted.

ECN	= '00000000003'
Line Number	= '0000'
Edit Status Code	= 'P' [Paid/Accepted]
COS	= 'EN01'
TCN	= '0522000001549592'
Plan ID	= '12345678'
TSN	= 'ABC'

MEDS-L

The Office of Managed Care has created an email listserv group called MEDS-L. The purpose of the listserv is to provide a forum to interactively discuss issues related to encounter data reporting under the new MEDS II system.

The listserv is closed, restricted to health plans and associated parties that are involved with the submission of Medicaid encounter data.

An archive of MEDS-L questions and answers can be found on the MEDS Home Page on the HPN at the following direct link:
https://commerce.health.state.ny.us/hpn/omc/meds/generalinfo/medsl.shtml

If you wish to be added to the MEDS-L listserv please contact the MEDS Unit at (518) 486-9012.

APPENDIX E – Transaction Layout with Record Positions

The MEDS II transaction file will be a fixed width file of 1200 characters.

Filler should be added at the end of each record type so that the file width equals 1200.

MEDS Data Element Name	Length	Start	End
Header Record			
Record Type	2	1	2
Provider Transmission Supplier Number (TSN)	4	3	6
Input Serial Number	6	7	12
TSN Certification Date	9	13	21
Vendor Software Number	5	22	26
Vendor Software Update Level	2	27	28
Prod Indicator	4	29	32
Plan Identification Number	8	33	40
Submitter Name	21	41	61
Submitter Address 1	18	62	79
Submitter Address 2	18	80	97
Submitter Address City	15	98	112
Submitter Address State	2	113	114
Submitter Zip	9	115	123
Submitter Fax Number	11	124	134
Submitter Phone Number	11	135	145
MEDS Version Number	3	146	148
Common Detail Segment			
Record Type	2	1	2
Encounter Type Indicator	1	3	3
Encounter Control Number	11	4	14
Previous Transaction Control Number	16	15	30
Transaction Status Code	1	31	31
Client Identification Number	8	32	39
Beneficiary Identification Number	25	40	64
Provider Profession Code	3	65	67
Provider License Number	8	68	75
Provider Identification Number	8	76	83
Filler	2	84	85
Category of Service (COS) Code	2	86	87
Filler	11	88	98
Total Paid Amount	11	99	109
Other Payer Name	35	110	144
Other Insurance Total Paid Amount	11	145	155
Other Insurance Type Code	2	156	157
Institutional Segment			
Provider Specialty Code	3	158	160
Hospital Inpatient Claim/Encounter Indicator	1	161	161
NYS DRG Code	4	162	165
Type of Bill Digits 1& 2 Code	2	166	167
Type of Bill Digit 3 Code	1	168	168
Statement Covers Period From	8	169	176

MEDS Data Element Name	Length	Start	End
Statement Covers Period Thru	8	177	184
Type of Admission	1	185	185
Source of Admission	1	186	186
Patient Status or Disposition Code	2	187	188
Medical Record Number	20	189	208
Neonate Birth Weight Value Code [1]	2	209	210
Neonate Birth Weight in Grams [1]	7	211	217
Neonate Birth Weight Value Code [2]	2	218	219
Neonate Birth Weight in Grams [2]	7	220	226
Revenue Code [1]	4	227	230
HCPCS Code [1]	7	231	237
Quantity or Units Submitted [1]	11	238	248
Filler [1]	11	249	259
Paid Amount [1]	11	260	270
Non-Inpatient Claim/Encounter Indicator [1]	1	271	271
Revenue Code [2]	4	272	275
HCPCS Code [2]	7	276	282
Quantity or Units Submitted [2]	11	283	293
Filler [2]	11	294	304
Paid Amount [2]	11	305	315
Non-Inpatient Claim/Encounter Indicator [2]	1	316	316
Revenue Code [3]	4	317	320
HCPCS Code [3]	7	321	327
Quantity or Units Submitted [3]	11	328	338
Filler [3]	11	339	349
Paid Amount [3]	11	350	360
Non-Inpatient Claim/Encounter Indicator [3]	1	361	361
Revenue Code [4]	4	362	365
HCPCS Code [4]	7	366	372
Quantity or Units Submitted [4]	11	373	383
Filler [4]	11	384	394
Paid Amount [4]	11	395	405
Non-Inpatient Claim/Encounter Indicator [4]	1	406	406
Revenue Code [5]	4	407	410
HCPCS Code [5]	7	411	417
Quantity or Units Submitted [5]	11	418	428
Filler [5]	11	429	439
Paid Amount [5]	11	440	450
Non-Inpatient Claim/Encounter Indicator [5]	1	451	451
Revenue Code [6]	4	452	455
HCPCS Code [6]	7	456	462
Quantity or Units Submitted [6]	11	463	473
Filler [6]	11	474	484
Paid Amount [6]	11	485	495
Non-Inpatient Claim/Encounter Indicator [6]	1	496	496
Revenue Code [7]	4	497	500
HCPCS Code [7]	7	501	507
Quantity or Units Submitted [7]	11	508	518
Filler [7]	11	519	529
Paid Amount [7]	11	530	540

MEDS Data Element Name	Length	Start	End
Non-Inpatient Claim/Encounter Indicator [7]	1	541	541
Revenue Code [8]	4	542	545
HCPCS Code [8]	7	546	552
Quantity or Units Submitted [8]	11	553	563
Filler [8]	11	564	574
Paid Amount [8]	11	575	585
Non-Inpatient Claim/Encounter Indicator [8]	1	586	586
Revenue Code [9]	4	587	590
HCPCS Code [9]	7	591	597
Quantity or Units Submitted [9]	11	598	608
Filler [9]	11	609	619
Paid Amount [9]	11	620	630
Non-Inpatient Claim/Encounter Indicator [9]	1	631	631
Revenue Code [10]	4	632	635
HCPCS Code [10]	7	636	642
Quantity or Units Submitted [10]	11	643	653
Filler [10]	11	654	664
Paid Amount [10]	11	665	675
Non-Inpatient Claim/Encounter Indicator [10]	1	676	676
Principal/Primary Diagnosis Code	7	677	683
Other Diagnosis Codes [1]	7	684	690
Other Diagnosis Codes [2]	7	691	697
Other Diagnosis Codes [3]	7	698	704
Other Diagnosis Codes [4]	7	705	711
Other Diagnosis Codes [5]	7	712	718
Other Diagnosis Codes [6]	7	719	725
Other Diagnosis Codes [7]	7	726	732
Other Diagnosis Codes [8]	7	733	739
Admit Diagnosis	7	740	746
External Diagnosis Code (E Code)	7	747	753
Principal Procedure Code	7	754	760
Other Procedure Codes [1]	7	761	767
Other Procedure Codes [2]	7	768	774
Other Procedure Codes [3]	7	775	781
Other Procedure Codes [4]	7	782	788
Other Procedure Codes [5]	7	789	795
Attending Provider Profession Code	3	796	798
Attending Provider License Number	8	799	806
Attending Provider ID	8	807	814
Filler	2	815	816
Surgeon Profession Code	3	817	819
Surgeon License Number	8	820	827
Surgeon Provider ID	8	828	835
Filler	2	836	837
Admission Date	8	838	845
Discharge Date	8	846	853
Pharmacy Segment			
Prescribing Provider Profession Code	3	158	160
Prescribing Provider License Code	8	161	168
Prescribing Provider ID	8	169	176

MEDS Data Element Name	Length	Start	End
Filler	2	177	178
Prescription Ordered Date	8	179	186
Date Filled	8	187	194
National Drug Code (NDC) or Product Code	11	195	205
Quantity Dispensed	12	206	217
Drug Days Supply Count	3	218	220
Pharmacy Claim/Encounter Indicator	1	221	221
Dental Segment			
Provider Specialty Code	3	158	160
Dental Dental Claim/Encounter Indicator [1]	1	161	161
Place of Service/Place of Treatment [1]	2	162	163
Procedure Codes [1]	7	164	170
Dental Dental Number of Units/Visits [1]	11	171	181
Tooth Number or Letter [1]	2	182	183
Filler [1]	11	184	194
Paid Amount [1]	11	195	205
Service Start Date [1]	8	206	213
Service End Date [1]	8	214	221
Dental Claim/Encounter Indicator [2]	1	222	222
Place of Service/Place of Treatment [2]	2	223	224
Procedure Codes [2]	7	225	231
Dental Dental Number of Units/Visits [2]	11	232	242
Tooth Number or Letter [2]	2	243	244
Filler [2]	11	245	255
Paid Amount [2]	11	256	266
Service Start Date [2]	8	267	274
Service End Date [2]	8	275	282
Dental Claim/Encounter Indicator [3]	1	283	283
Place of Service/Place of Treatment [3]	2	284	285
Procedure Codes [3]	7	286	292
Dental Number of Units/Visits [3]	11	293	303
Tooth Number or Letter [3]	2	304	305
Filler [3]	11	306	316
Paid Amount [3]	11	317	327
Service Start Date [3]	8	328	335
Service End Date [3]	8	336	343
Dental Claim/Encounter Indicator [4]	1	344	344
Place of Service/Place of Treatment [4]	2	345	346
Procedure Codes [4]	7	347	353
Dental Number of Units/Visits [4]	11	354	364
Tooth Number or Letter [4]	2	365	366
Filler [4]	11	367	377
Paid Amount [4]	11	378	388
Service Start Date [4]	8	389	396
Service End Date [4]	8	397	404
Dental Claim/Encounter Indicator [5]	1	405	405
Place of Service/Place of Treatment [5]	2	406	407
Procedure Codes [5]	7	408	414
Dental Number of Units/Visits [5]	11	415	425
Tooth Number or Letter [5]	2	426	427

MEDS Data Element Name	Length	Start	End
Filler [5]	11	428	438
Paid Amount [5]	11	439	449
Service Start Date [5]	8	450	457
Service End Date [5]	8	458	465
Dental Claim/Encounter Indicator [6]	1	466	466
Place of Service/Place of Treatment [6]	2	467	468
Procedure Codes [6]	7	469	475
Dental Number of Units/Visits [6]	11	476	486
Tooth Number or Letter [6]	2	487	488
Filler [6]	11	489	499
Paid Amount [6]	11	500	510
Service Start Date [6]	8	511	518
Service End Date [6]	8	519	526
Dental Claim/Encounter Indicator [7]	1	527	527
Place of Service/Place of Treatment [7]	2	528	529
Procedure Codes [7]	7	530	536
Dental Number of Units/Visits [7]	11	537	547
Tooth Number or Letter [7]	2	548	549
Filler [7]	11	550	560
Paid Amount [7]	11	561	571
Service Start Date [7]	8	572	579
Service End Date [7]	8	580	587
Dental Claim/Encounter Indicator [8]	1	588	588
Place of Service/Place of Treatment [8]	2	589	590
Procedure Codes [8]	7	591	597
Dental Number of Units/Visits [8]	11	598	608
Tooth Number or Letter [8]	2	609	610
Filler [8]	11	611	621
Paid Amount [8]	11	622	632
Service Start Date [8]	8	633	640
Service End Date [8]	8	641	648
Dental Claim/Encounter Indicator [9]	1	649	649
Place of Service/Place of Treatment [9]	2	650	651
Procedure Codes [9]	7	652	658
Dental Number of Units/Visits [9]	11	659	669
Tooth Number or Letter [9]	2	670	671
Filler [9]	11	672	682
Paid Amount [9]	11	683	693
Service Start Date [9]	8	694	701
Service End Date [9]	8	702	709
Dental Claim/Encounter Indicator [10]	1	710	710
Place of Service/Place of Treatment [10]	2	711	712
Procedure Codes [10]	7	713	719
Dental Number of Units/Visits [10]	11	720	730
Tooth Number or Letter [10]	2	731	732
Filler [10]	11	733	743
Paid Amount [10]	11	744	754
Service Start Date [10]	8	755	762
Service End Date [10]	8	763	770
Professional Segment			

MEDS Data Element Name	Length	Start	End
Provider Specialty Code	3	158	160
Diagnosis Codes [1]	7	161	167
Diagnosis Codes [2]	7	168	174
Diagnosis Codes [3]	7	175	181
Diagnosis Codes [4]	7	182	188
Professional Claim/Encounter Indicator [1]	1	189	189
Place of Service/Place of Treatment [1]	2	190	191
Procedure Codes [1]	7	192	198
Professional Number of Units/Visits [1]	11	199	209
Filler [1]	11	210	220
Paid Amount [1]	11	221	231
Service Start Date [1]	8	232	239
Service End Date [1]	8	240	247
Professional Claim/Encounter Indicator [2]	1	248	248
Place of Service/Place of Treatment [2]	2	249	250
Procedure Codes [2]	7	251	257
Professional Number of Units/Visits [2]	11	258	268
Filler [2]	11	269	279
Paid Amount [2]	11	280	290
Service Start Date [2]	8	291	298
Service End Date [2]	8	299	306
Professional Claim/Encounter Indicator [3]	1	307	307
Place of Service/Place of Treatment [3]	2	308	309
Procedure Codes [3]	7	310	316
Professional Number of Units/Visits [3]	11	317	327
Filler [3]	11	328	338
Paid Amount [3]	11	339	349
Service Start Date [3]	8	350	357
Service End Date [3]	8	358	365
Professional Claim/Encounter Indicator [4]	1	366	366
Place of Service/Place of Treatment [4]	2	367	368
Procedure Codes [4]	7	369	375
Professional Number of Units/Visits [4]	11	376	386
Filler [4]	11	387	397
Paid Amount [4]	11	398	408
Service Start Date [4]	8	409	416
Service End Date [4]	8	417	424
Professional Claim/Encounter Indicator [5]	1	425	425
Place of Service/Place of Treatment [5]	2	426	427
Procedure Codes [5]	7	428	434
Professional Number of Units/Visits [5]	11	435	445
Filler [5]	11	446	456
Paid Amount [5]	11	457	467
Service Start Date [5]	8	468	475
Service End Date [5]	8	476	483
Professional Claim/Encounter Indicator [6]	1	484	484
Place of Service/Place of Treatment [6]	2	485	486
Procedure Codes [6]	7	487	493
Professional Number of Units/Visits [6]	11	494	504
Filler [6]	11	505	515

MEDS Data Element Name	Length	Start	End
Paid Amount [6]	11	516	526
Service Start Date [6]	8	527	534
Service End Date [6]	8	535	542
Professional Claim/Encounter Indicator [7]	1	543	543
Place of Service/Place of Treatment [7]	2	544	545
Procedure Codes [7]	7	546	552
Professional Number of Units/Visits [7]	11	553	563
Filler [7]	11	564	574
Paid Amount [7]	11	575	585
Service Start Date [7]	8	586	593
Service End Date [7]	8	594	601
Professional Claim/Encounter Indicator [8]	1	602	602
Place of Service/Place of Treatment [8]	2	603	604
Procedure Codes [8]	7	605	611
Professional Number of Units/Visits [8]	11	612	622
Filler [8]	11	623	633
Paid Amount [8]	11	634	644
Service Start Date [8]	8	645	652
Service End Date [8]	8	653	660
Professional Claim/Encounter Indicator [9]	1	661	661
Place of Service/Place of Treatment [9]	2	662	663
Procedure Codes [9]	7	664	670
Professional Number of Units/Visits [9]	11	671	681
Filler [9]	11	682	692
Paid Amount [9]	11	693	703
Service Start Date [9]	8	704	711
Service End Date [9]	8	712	719
Professional Claim/Encounter Indicator [10]	1	720	720
Place of Service/Place of Treatment [10]	2	721	722
Procedure Codes [10]	7	723	729
Professional Number of Units/Visits [10]	11	730	740
Filler [10]	11	741	751
Paid Amount [10]	11	752	762
Service Start Date [10]	8	763	770
Service End Date [10]	8	771	778
Trailer			
Record Type	2	1	2
Submission Record Count	9	3	11