New York State
Electronic Medicaid System
Remittance Advice Guideline

TABLE OF CONTENTS

REMITTANCE ADVICE

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

1. Purpose Statement

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

Remittance advices contain the following information:

- A listing of all claims (identified by several pieces of information as submitted on the claim) that have entered the computerized processing system during the corresponding cycle
- The status of each claim (deny/paid/pend) after processing
- The eMedNY edits (errors) failed by pending or denied claims
- Subtotals and grand totals of claims and dollar amounts
- Other financial information such as recoupments, negative balances, etc.

The remittance advice, in addition to showing a record of claim transactions and assisting providers in identifying and correcting billing errors, plays an important role in the communication between the provider and the eMedNY Contractor for resolving billing or processing issues.

2. Remittance Advice Formats

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

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

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

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

2.1 Electronic HIPAA 835/820 Transaction

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

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

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

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

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

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

2.2   PDF Remittance Advice

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

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

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

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

2.3 Paper Remittance Advice

Remittance advices are also available on paper.

Providers who bill electronically but do not specifically request to receive the 835 transaction are sent paper remittance advices.

2.3.1 Remittance Sorts

The default sort for the paper remittance advice is:

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

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

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

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

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

3. Paper Remittance Advice Sections

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

The information displayed in the remittance advice samples is for illustration purposes only. The following information applies to a remittance advice with the default sort pattern.

The remittance advice is composed of five sections.

- *Section One* may contain one of the following documents:

  - Medicaid Check
  - Notice of Electronic Funds Transfer
  - Summout (no claims paid)

- *Section Two:* Provider Notification (special messages)
- *Section Three*: Claim Detail

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

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

- *Section Four* may contain any of the following documents:

  - Financial Transactions (recoupments)
  - Accounts Receivable (cumulative financial information)

- *Section Five*: Edit (Error) Description

3.1 Section One – Medicaid Check

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

Exhibit 3.1-1

3.1.1 Medicaid Check Stub Field Descriptions

Upper Left Corner

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

Upper Right Corner

Date the remittance advice was issued

Remittance Number

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

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

Center

Medicaid Provider ID/NPI/Date

Provider's Name/Address

3.1.2 Medicaid Check Field Descriptions

Left Side

Table

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

Provider's Name/Address

Right Side

Dollar/Check Amount: This amount is the:

> the Net Total Paid Amount under the Grand Total subsection

> + the total sum of the Financial Transaction section.

3.2 Section One – EFT Notification

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

Exhibit 3.2-1

```
TO:  JAMES STRONG, M.D.      MEDICAID          DATE: 2010-05-31
                                                REMITTANCE NO: 07080600006
                             MANAGEMENT         PROV ID: 00112233/1123456879
                             INFORMATION SYSTEM


     00112233/1123456879  2010-05-31
     JAMES STRONG, M.D.
     100 BROADWAY
     ANYTOWN            NY          11111



     JAMES STRONG, M.D.                    $143.80

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

3.2.1EFT Notification Page Field Descriptions

Upper Left Corner

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

Upper Right Corner

Date: The date on which the remittance advice was issued

Remittance Number

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

Center

Medicaid Provider ID/NPI/Date

Provider's Name/Address

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

This amount is the:

> Net Total Paid Amount from the Grand Total subsection

> + the total sum of the Financial Transaction section.

3.3 Section One – Summout (No Payment)

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

Exhibit 3.3-1

TO: JAMES STRONG, M.D.

MEDICAID
MANAGEMENT
INFORMATION SYSTEM

DATE: 05/31/2010
REMITTANCE NO: 07080600006
PROV ID: 00112233/1123456789

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

JAMES STRONG, M.D.
100 BROADWAY
ANYTOWN   NY   11111

REMITTANCE ADVICE

3.3.1 Summout (No Payment) Field Descriptions

Upper Left Corner

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

Upper Right Corner

Date the remittance advice was issued

Remittance Number

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

Center

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

Provider's Name/Address

3.4 Section Two – Provider Notification

This section is used to communicate important messages to providers.

Exhibit 3.4-1

M=DICAID
MANAGEMENT
INFORMATION SYSTEM

PAGE   01
DATE   05/31/10
CYCLE   1710

MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

TO: JAMES STRONG, M.D.
    100 BROADWAY
    ANYTOWN, NEW YORK 11111

ETIN:
PROVIDER NOTIFICATION
PROV ID: 00112233/1123456879
REMITTANCE NO: 07080600006

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.

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

REMITTANCE ADVICE

3.4.1Provider Notification Field Descriptions

Upper Left Corner

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

Upper Right Corner

Remittance Page Number

Date the remittance advice was issued

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

ETIN (not applicable)

Name of Section: **PROVIDER NOTIFICATION**

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

Remittance Number

Center

Message Text

3.5 Section Three – Claim Detail

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

There are nine unique Claim Detail types.

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

3.5.1 Child Care Claim Detail

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

Exhibit 3.5.1-1

Exhibit 3.5.1-2

```
                                                              PAGE    03
                                                              DATE    05/31/10
                                                              CYCLE   1710
                         M EDICAID
                            MANAGEMENT
                            INFORMATION SYSTEM        ETIN:
TO:  ABC CHILD CARE     MEDICAL ASSISTANCE (TITLE XIX) PROGRAM   CHILD CARE
     123 MAIN STREET          REMITTANCE STATEMENT               PROV ID:  00111234
     ANYTOWN, NEW YORK 11111                                     REMITTANCE NO:  070806000001
```

CLIENT NAME ID NUMBER	TCN PATIENT ACCOUNT NUMBER	SERVICE DATES FROM THRU	RATE CODE	REP'TED CALC'ED DAYS F C	FULL DAYS CO-INSURANCE DAYS PAYMENT	PATIENT PARTICIPATION REPORTED DEDUCTED	OTHER INSURANCE	AMOUNT CHARGED AMOUNT PAID	STATUS	ERRORS
SAMPLE XX12345X	07206-000000112-3-0 CPIC1-00987-6	05/02/10 05/06/10	1210	5 5	0	387.81 0.00	0.00	0.00	387.81 387.81	PAID	
EXAMPLE XX67890X	07206-000000111-1-0 CPIC1-00345-6	05/02/10 05/06/10	1210	5 5	0	387.81 0.00	0.00	0.00	387.81 387.81	PAID	
MODEL XX98765X	07206-000332456-0-0 CPIC1-00543-6	05/02/10 05/06/10	1210	5 5	0	387.81 0.00	0.00	0.00	387.81 387.81	PAID	
SPECIMEN XX87654X	07206-004445656-0-0 CPIC1-00321-6	05/02/10 05/06/10	1210	5 5	0	387.81 0.00	0.00	0.00	387.81 387.81	PAID	
STANDARD XX76543X	07206-007776546-0-1 CPIC1-00555-6	05/02/10 05/06/10	1210	5 5	0	387.81 0.00	0.00	0.00	387.81 387.81-	ADJT	ORIGINAL CLAIM PAID 05/11/2010
DOE XX65432X	07206-007776546-0-2 CPIC1-00444-6	05/02/10 05/07/10	1210	4 4	0	298.77 0.00	0.00	0.00	298.77 298.77	ADJT	

```
                                                              *  = PREVIOUSLY PENDED CLAIM
                                                              ** = NEW PEND
```

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

REMITTANCE ADVICE

Exhibit 3.5.1-3

PAGE   04
DATE   05/31/10
CYCLE   1710

M·EDICAID
MANAGEMENT INFORMATION SYSTEM
MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

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

ETIN:
CHILD CARE
PROV ID: 00111234
REMITTANCE NO: 07080600001

CLIENT NAME ID NUMBER	TCN PATIENT ACCOUNT NUMBER	SERVICE DATES FROM THRU	RATE CODE	REP'TED CALC'ED DAYS F C	FULL DAYS CO-INSURANCE DAYS PAYMENT	PATIENT PARTICIPATION REPORTED DEDUCTED	OTHER INSURANCE	AMOUNT CHARGED AMOUNT PAID	STATUS	ERRORS
SAMPLE XX12345X	07206-000000112-3-0 CPIC1-00987-6	05/02/10 05/06/10	1210	5 0 5	0.00 0.00	0.00	0.00	387.81 0.00	**PEND	00162 00971
EXAMPLE XX67890X	07206-000000111-1-0 CPIC1-00345-6	05/02/10 05/06/10	1210	5 0 5	0.00 0.00	0.00	0.00	387.81 0.00	**PEND	01131

*   = PREVIOUSLY PENDED CLAIM
** = NEW PEND

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

REMITTANCE TOTALS – CHILD CARE

VOIDS – ADJUSTS	89.04-	NUMBER OF CLAIMS	1
TOTAL PENDS	775.62	NUMBER OF CLAIMS	2
TOTAL PAID	1551.24	NUMBER OF CLAIMS	5
TOTAL DENY	775.62	NUMBER OF CLAIMS	2
NET TOTAL PAID	1462.20	NUMBER OF CLAIMS	5

MEMBER ID: 12345678

VOIDS – ADJUSTS	89.04-	NUMBER OF CLAIMS	1
TOTAL PENDS	775.62	NUMBER OF CLAIMS	2
TOTAL PAID	1551.24	NUMBER OF CLAIMS	5
TOTAL DENY	775.62	NUMBER OF CLAIMS	2
NET TOTAL PAID	1462.20	NUMBER OF CLAIMS	5

REMITTANCE ADVICE

Exhibit 3.5.1-4


```
                    MEDICAID                    PAGE:   05
                    MANAGEMENT                  DATE:   05/31/10
                    INFORMATION SYSTEM          CYCLE:  1710

              MEDICAL ASSISTANCE (TITLE XIX) PROGRAM      ETIN:
                    REMITTANCE STATEMENT                  CHILD CARE
TO:  ABC CHILD CARE                                       GRAND TOTALS
     123 MAIN STREET                                      PROV ID:  00111234
     ANYTOWN, NEW YORK 11111                              REMITTANCE NO:  07080600001


     REMITTANCE TOTALS – GRAND TOTALS
        VOIDS – ADJUSTS              89.04-      NUMBER OF CLAIMS          1
        TOTAL PENDS                 775.62      NUMBER OF CLAIMS          2
        TOTAL PAID                 1551.24      NUMBER OF CLAIMS          5
        TOTAL DENY                  775.62      NUMBER OF CLAIMS          2
        NET TOTAL PAID             1462.20      NUMBER OF CLAIMS         33
```

REMITTANCE ADVICE

3.5.1.1 Claim Detail Page Field Descriptions

Upper Left Corner

Provider's Name/Address

Upper Right Corner

Remittance page number

Date the remittance advice was issued

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

ETIN (not applicable)

Provider Service Classification: **CHILD CARE**

PROV ID: This field contains the Medicaid Provider ID

Remittance Number

3.5.1.2 Explanation of Claim Detail Columns

Client Name/ID Number

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

TCN/Patient Account Number

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

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

Service Dates – From/Through

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

Rate Code

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

Reported/Calculated Days

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

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

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

Patient Participation – Reported/Deducted

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

Other Insurance

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

Amount Charged/Amount Paid

The total charges entered in the claim form appear first under this column. If the claim was approved, the amount paid appears underneath the charges. If the claim has a pend or deny status, the amount paid will be zero (0.00).

Status

This column indicates the status (DENY, PAID/ADJT/VOID, PEND) of the claim line.

Denied Claims

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

- The service rendered is not covered by the New York State Medicaid Program.
- The claim is a duplicate of a prior paid claim.
- The required Prior Approval has not been obtained.
- Information entered in the claim form is invalid or logically inconsistent.

Approved Claims

Approved claims will be identified by the statuses *PAID, ADJT* (adjustment), or *VOID*.

Paid Claims

The status PAID refers to *original* claims that have been approved.

REMITTANCE ADVICE

Adjustments

The status *ADJT* refers to a claim submitted in replacement of a paid claim with the purpose of changing one or more fields. An adjustment has two components: the credit transaction (previously paid claim), and the debit transaction (adjusted claim).

Voids

The status *VOID* refers to a claim submitted with the purpose of canceling a previously paid claim. A void lists the credit transaction (previously paid claim) only.

Pending Claims

Claims that require further review or recycling will be identified by the *PEND* status. The following are examples of circumstances that commonly cause claims to be pended:

- New York State Medical Review required.
- Procedure requires manual pricing.
- No match found in the Medicaid files for certain information submitted on the claim, for example: Member ID, Prior Approval. These claims are recycled for a period of time during which the Medicaid files may be updated to match the information on the claim.

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

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

A new pend is signified by two asterisks (**). A previously pended claim is signified by one asterisk (*).

Errors

For claims with a DENY or PEND status, this column indicates the NYS Medicaid edit (error) number(s) that caused the claim to deny or pend. Up to twenty-five (25) edit codes, including approved edits, may be listed for each claim. Edit code definitions are listed at the end of the claim detail section.

3.5.1.3Subtotals/Totals/Grand Totals

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

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

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

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

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

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

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

3.5.2 Clinic APG Claim Detail

```
                                    MEDICAID                    PAGE    02
                                    MANAGEMENT                  DATE    12/19/2008
                                    INFORMATION SYSTEM          CYCLE   1635
                          MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
 TO: ABC HOSPITAL              REMITTANCE STATEMENT             ETIN:
     P.O. BOX 999                                              CLINIC
     ANYTOWN, NEW YORK 11111                                   PROVIDER ID/NPI: 00987654/0123456789
                                                               REMITTANCE NO: 08122200001
```

OFFICE ACCOUNT NUMBER CPT	CLIENT NAME APG	CLIENT ID COMBINED WITH CPT	TCN FULL WEIGHT APG AMOUNT	DATE OF SERVICE PCT APG WEIGHT	RATE CODE APG PAID	CHARGED CAPITAL ADD ON	TOTAL PAID EXISTING OPERATING COMPONENT	STATUS	ERRORS
1234567890	Bill Smith	AB12345C	0834300078901220	12/01/2008	1400	1000.00	662.50	PAID	
42260	408		6.1	100%	950.00	50.00	500.00	PAID	
1234567890	Bill Smith	AB12345C	0834300078901220	12/01/2008		800.00	0.00	PAID	
80012	410	42260	6.5	0%	0.00	0.00	000.00	PAID	
1234567890	Bill Smith	AB12345C	0834300078901220	12/05/2008		1000.00	662.50	PAID	
42260	408		6.1	100%	950.00	50.00	500.00	PAID	
1234567890	Bill Smith	AB12345C	0834300078901220	12/05/2008		200.00	0.00	PAID	
80012	410	42260	6.5	0%	0.00	0.00	000.00	PAID	

TOTAL PAID TCN: 1325.00

```
               *   = PREVIOUSLY PENDED CLAIM
               **  = NEW PEND


       TOTAL AMOUNT ORIGINAL CLAIMS PAID    1325.00   NUMBER OF CLAIMS 5
          NET AMOUNT ADJUSTMENTS PAID           0.00   NUMBER OF CLAIMS 0
          NET AMOUNT VOIDS PAID                 0.00   NUMBER OF CLAIMS 0
          NET AMOUNT VOIDS  ADJUSTS             0.00   NUMBER OF CLAIMS 0

       LOCATOR 003 TOTALS – CLINIC APG GROUPER
          VOIDS  ADJUSTS                        0.00   NUMBER OF CLAIMS 0
          TOTAL PEND                            0.00   NUMBER OF CLAIMS 0
          TOTAL PAID                         1325.00   NUMBER OF CLAIMS 5
          TOTAL DENY                            0.00   NUMBER OF CLAIMS 0
       NET TOTAL PAID              1325.00   NUMBER OF CLAIMS 5

       PROVIDER 00987654 TOTALS – CLINIC APG GROUPER
          VOIDS  ADJUSTS                        0.00   NUMBER OF CLAIMS 0
          TOTAL PEND                            0.00   NUMBER OF CLAIMS 0
          TOTAL PAID                          262.87   NUMBER OF CLAIMS 5
          TOTAL DENY                            0.00   NUMBER OF CLAIMS 0
       NET TOTAL PAID              1325.00   NUMBER OF CLAIMS 5
```

3.5.3 Claim Detail Page Field Descriptions

Upper Left Corner

Provider's Name/Address

Upper Right Corner

Remittance page number

Date the remittance advice was issued

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

ETIN (not applicable)

Provider Service Classification: **CLINIC**

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

Remittance Number

3.5.3.1 Explanation of Claim Detail Columns

Office Account Number/CPT

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

Client Name/APG

The Client Name (first line) indicates the last name of the member. If an invalid Medicaid Client ID was entered in the claim form, the ID will be listed as it was submitted but no name will appear in this column. The APG Code (second line) assigned by the grouper appears in this column for the service line on the claim.

Client ID/Combined with CPT

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

TCN/Full Weight APG Amount

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

Date of Service/PCT APG Weight

The first date of service (From date) entered in the claim appears in the first line this column. If a date different from the From date was entered in the Through date box, that date is not returned in the Remittance Advice. The APG Paid Percentage (second line) is related to grouper assigned Payment Action Code. This is the additional weight factor applied to Full Weight.

Rate Code/APG Paid

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

Charged/Capital Add On

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

Total Paid/Existing Operating Component

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

Status

This column indicates the status (DENY, PAID/ADJT/VOID, PEND) of the claim line.

Denied Claims

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

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

- The claim is a duplicate of a prior paid claim.
- The required Prior Approval has not been obtained.

💧 Information entered in the claim form is invalid or logically inconsistent.

Approved Claims

Approved claims will be identified by the statuses *PAID, ADJT* (adjustment), or *VOID*.

Paid Claims

The status PAID refers to *original* claims that have been approved.

Adjustments

The status *ADJT* refers to a claim submitted in replacement of a paid claim with the purpose of changing one or more fields. An adjustment has two components: the credit transaction (previously paid claim), and the debit transaction (adjusted claim).

Voids

The status *VOID* refers to a claim submitted with the purpose of canceling a previously paid claim. A void lists the credit transaction (previously paid claim) only.

Pending Claims

Claims that require further review or recycling will be identified by the *PEND* status. The following are examples of circumstances that commonly cause claims to be pended:

💧 New York State Medical Review required.
💧 Procedure requires manual pricing.
💧 No match found in the Medicaid files for certain information submitted on the claim, for example: Member ID, Prior Approval. These claims are recycled for a period of time during which the Medicaid files may be updated to match the information on the claim.

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

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

A new pend is signified by two asterisks (**). A previously pended claim is signified by one asterisk (*).

Errors

For claims with a DENY or PEND status, this column indicates the NYS Medicaid edit (error) number(s) that caused the claim to deny or pend. Up to twenty-five (25) edit codes, including approved edits, may be listed for each claim. Edit code definitions are listed at the end of the claim detail section.

Total Paid TCN

Total Claim Payment.

3.5.3.2 Subtotals/Totals/Grand Totals

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

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

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

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

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

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

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

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

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

3.5.4 Dental Claim Detail

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

Exhibit 3.5.2-1


```
                                                    PAGE    02
                                                    DATE    05/31/2010
                                                    CYCLE   1710
              MEDICAID
              MANAGEMENT
              INFORMATION SYSTEM
      MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
              REMITTANCE STATEMENT                  ETIN:
  TO:  JAMES STRONG, DDS                            DENTAL
       312 MAIN STREET                              PROV ID:  00112233/1123456789
       ANYTOWN, NEW YORK 11111                      REMITTANCE NO:  07080600006
```

LN. NO	OFFICE ACCOUNT NUMBER	CLIENT NAME	CLIENT ID NUMBER	TCN	DATE OF SERVICE	PROC. CODE	UNITS	CHARGED	PAID	STATUS	ERRORS
01	CP111111	DOE	XX12345X	07206-000000227-0-0	05/11/10	D0120	1.000	52.80	0.00	DENY	00162 00244
01	CP222222	SAMPLE	XX23456X	07206-000011334-0-0	05/12/10	D0272	1.000	17.60	0.00	DENY	00244
01	CP333333	EXAMPLE	XX34567X	07206-000013556-0-0	05/14/10	D1204	1.000	14.30	0.00	DENY	00162
01	CP444444	SPECIMEN	XX45678X	07206-000032456-0-0	05/15/10	D0290	1.000	77.50	0.00	DENY	00131

```
                                             *  = PREVIOUSLY PENDED CLAIM
                                            ** = NEW PEND


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

REMITTANCE ADVICE

Exhibit 3.5.2-2

```
                        MEDICAID                    PAGE     03
                        MANAGEMENT                  DATE     05/31/2010
                        INFORMATION SYSTEM          CYCLE    1710
           MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
                  REMITTANCE STATEMENT              ETIN:
                                                    DENTAL
  TO: JAMES STRONG, DDS                             PROV ID:  00112233/1123456879
      312 MAIN STREET                               REMITTANCE NO:  07080600006
      ANYTOWN, NEW YORK 11111
```

LN. NO	OFFICE ACCOUNT NUMBER	CLIENT NAME	CLIENT ID NUMBER	TCN	DATE OF SERVICE	PROC. CODE	UNITS	CHARGED	PAID	STATUS	ERRORS
01	CP111111	DOE	XX12345X	07206-000033667-0-0	05/11/10	D1203	1.000	14.30	14.30	PAID	
02	CP222222	SAMPLE	XX23456X	07206-000033667-0-0	05/12/10	D1204	1.000	14.30	14.30	PAID	
01	CP333333	EXAMPLE	XX34567X	07206-000045667-0-0	05/14/10	D0320	1.000	52.80	52.80	PAID	
01	CP444444	SPECIMEN	XX45678X	07206-000056767-0-0	05/15/10	D3220	1.000	66.00	66.00	PAID	
01	CP777777	STANDARD	XX56789X	07206-000067767-0-0	05/05/10	D0272	1.000	17.60	17.60-	ADJT	ORIGINAL CLAIM PAID 05/24/10
01	CP555555	MODEL	XX67890X	07206-000088767-0-0	05/05/10	D1204	1.000	14.30	14.00	ADJT	

```
                                                    *  = PREVIOUSLY PENDED CLAIM
                                                    ** = NEW PEND


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

REMITTANCE ADVICE

Exhibit 3.5.2-3

MEDICAID
MANAGEMENT INFORMATION SYSTEM

MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

PAGE 04
DATE 05/31/2010
CYCLE 1710

TO: JAMES STRONG, DDS
    312 MAIN STREET
    ANYTOWN, NEW YORK 11111

ETIN:
DENTAL
PROV ID: 00112233/1123456789
REMITTANCE NO: 07080600006

LN. NO	OFFICE ACCOUNT NUMBER	CLIENT NAME	CLIENT ID NUMBER	TCN	DATE OF SERVICE	PROC. CODE	UNITS	CHARGED	PAID	STATUS	ERRORS
01	CP111111	DOE	XX12345X	07206-000033467-0-0	05/11/10	D3220	1.000	69.30	0.00	**PEND	00162
02	CP222222	SAMPLE	XX23456X	07206-000033468-0-0	05/12/10	D7450	1.000	71.04	0.00	**PEND	00162
01	CP333333	EXAMPLE	XX34567X	07206-000035665-0-0	05/14/10	D1204	1.000	14.30	0.00	**PEND	00142
01	CP444444	SPECIMEN	XX45678X	07206-000033660-0-0	05/15/10	D1204	1.000	14.30	0.00	**PEND	00131

```
*  = PREVIOUSLY PENDED CLAIM
** = NEW PEND
```

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

REMITTANCE TOTALS – DENTAL

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

MEMBER ID: 00112233

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

REMITTANCE ADVICE

Exhibit 3.5.2-4

MEDICAID
MANAGEMENT INFORMATION SYSTEM

PAGE: 05
DATE: 05/31/10
CYCLE: 1710

MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

TO: JAMES STRONG, DDS
312 MAIN STREET
ANYTOWN, NEW YORK 11111

ETIN:
DENTAL
GRAND TOTALS
PROV ID: 00112233/1123456789
REMITTANCE NO: 07080600006

REMITTANCE TOTALS – GRAND TOTALS

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

REMITTANCE ADVICE

3.5.4.1 Claim Detail Page Field Descriptions

Upper Left Corner

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

Upper Right Corner

Remittance page number

Date the remittance advice was issued

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

ETIN (not applicable)

Provider Service Classification: **DENTAL**

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

Remittance Number

3.5.4.2 Explanation of Claim Detail Columns

Ln. No. (Line Number)

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

Office Account Number

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

Client Name

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

Client ID

The member's Medicaid ID number appears in this column.

TCN

The TCN is a unique identifier assigned to each claim that is processed. If multiple claim lines are submitted on the same claim form, all the lines are assigned the same TCN.

Date of Service

The first date of service (From date) entered in the claim appears in this column. If a date different from the From date was entered in the Through date box, that date is not returned in the Remittance Advice.

Procedure Code

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

Units

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

Charged

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

Paid

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

Status

This column indicates the status (DENY, PAID/ADJT/VOID, PEND) of the claim line.

Denied Claims

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

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

- The claim is a duplicate of a prior paid claim.
- The required Prior Approval has not been obtained.
- Information entered in the claim form is invalid or logically inconsistent.

Approved Claims

Approved claims will be identified by the statuses *PAID, ADJT* (adjustment), or *VOID*.

Paid Claims

The status PAID refers to *original* claims that have been approved.

Adjustments

The status *ADJT* refers to a claim submitted in replacement of a paid claim with the purpose of changing one or more fields. An adjustment has two components: the credit transaction (previously paid claim), and the debit transaction (adjusted claim).

Voids

The status *VOID* refers to a claim submitted with the purpose of canceling a previously paid claim. A void lists the credit transaction (previously paid claim) only.

Pending Claims

Claims that require further review or recycling will be identified by the *PEND* status. The following are examples of circumstances that commonly cause claims to be pended:

- New York State Medical Review required.
- Procedure requires manual pricing.
- No match found in the Medicaid files for certain information submitted on the claim, for example: Member ID, Prior Approval. These claims are recycled for a period of time during which the Medicaid files may be updated to match the information on the claim.

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

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

A new pend is signified by two asterisks (**). A previously pended claim is signified by one asterisk (*).

Errors

For claims with a DENY or PEND status, this column indicates the NYS Medicaid edit (error) number(s) that caused the claim to deny or pend. Up to twenty-five (25) edit codes, including approved edits, may be listed for each claim. Edit code definitions are listed at the end of the claim detail section.

3.5.4.3 Subtotals/Totals/Grand Totals

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

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

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

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

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

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

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

3.5.5 DME Claim Detail

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

- DME

- Hearing Aid

Exhibit 3.5.3-1

```
                                    ┌─┐┌─┐
                                    │M│EDICAID                    PAGE      02
                                    └─┘└─┘                        DATE      05/31/2010
                                    MANAGEMENT                    CYCLE     1710
                                    INFORMATION SYSTEM
                          MEDICAL ASSISTANCE (TITLE XIX) PROGRAM   ETIN:
  TO:  ABC MEDICAL EQUIPMENT              REMITTANCE STATEMENT     DME
       100 BROADWAY                                               PROV ID:  00112233/1123456789
       ANYTOWN, NEW YORK 11111                                   REMITTANCE NO:  070806000006
```

LN. NO.	PROC CODE	QUANTITY	CLIENT NUMBER	CLIENT NAME	OFFICE ACCT NUMBER	SERVICE DATE	TCN	AMOUNT CHARGED	AMOUNT PAID	STATUS	ERRORS
01	E0177	1.000	XX12345X	DOE	CP444444	05/11/10	07206-000000227-0-0	52.80	0.00	DENY	00162 00244
01	E0199	1.000	XX23456X	SAMPLE	CP555555	05/11/10	07206-000011334-0-0	17.60	0.00	DENY	00244
01	A6244	1.000	XX34567X	EXAMPLE	CP777777	05/19/10	07206-000013556-0-0	14.30	0.00	DENY	00162
01	L0110	1.000	XX45678X	SPECIMEN	CP999999	05/20/10	07206-000032456-0-0	77.50	0.00	DENY	00131

```
                                                                 *   = PREVIOUSLY PENDED CLAIM
                                                                 **  = NEW PEND


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

Exhibit 3.5.3-2

M EDICAID
MANAGEMENT
INFORMATION SYSTEM

MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

PAGE   03
DATE   05/31/2010
CYCLE   1710

TO: ABC MEDICAL EQUIPMENT
     100 BROADWAY
     ANYTOWN, NEW YORK 11111

ETIN:
DME
PROV ID: 00112233/1123456789
REMITTANCE NO: 070806000006

LN. NO.	PROC CODE	QUANTITY	CLIENT NUMBER	CLIENT NAME	OFFICE ACCT NUMBER	SERVICE DATE	TCN	AMOUNT CHARGED	AMOUNT PAID	STATUS	ERRORS
01	L3640	1.000	XX12345X	DOE	CP111111	05/11/10	07206-000033667-0-0	14.30	14.30	PAID	
02	L3580	1.000	XX23456X	SAMPLE	CP222222	05/12/10	07206-000033667-0-0	14.30	14.30	PAID	
01	Z4651	1.000	XX34567X	EXAMPLE	CP333333	05/14/10	07206-000045667-0-0	52.80	52.80	PAID	
01	Z4714	1.000	XX45678X	SPECIMEN	CP444444	05/15/10	07206-000056767-0-0	66.00	66.00	PAID	
01	L3649	1.000	XX56789X	STANDARD	CP777777	05/05/10	07206-000067767-0-0	17.60	17.60-	ADJT	ORIGINAL CLAIM PAID 05/24/10
01	L3640	1.000	XX67890X	MODEL	CP555555	05/05/10	07206-000088767-0-0	14.30	14.00	ADJT	

* = PREVIOUSLY PENDED CLAIM
** = NEW PEND

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

REMITTANCE ADVICE

Exhibit 3.5.3-3

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

PAGE 04
DATE 05/31/2010
CYCLE 1710

ETIN:
DME
PROV ID: 00112233/1123456789
REMITTANCE NO: 070806000006

TO: ABC MEDICAL EQUIPMENT
100 BROADWAY
ANYTOWN, NEW YORK 11111

LN. NO.	PROC CODE	QUANTITY	CLIENT NUMBER	CLIENT NAME	OFFICE ACCT NUMBER	SERVICE DATE	TCN	AMOUNT CHARGED	AMOUNT PAID	STATUS	ERRORS
01	L1090	1.000	XX12345X	DOE	CP444444	05/13/10	07206-000033467-0-0	69.30	0.00	** PEND	00162
01	L1620	1.000	XX23456X	SAMPLE	CP555555	05/14/10	07206-000033468-0-0	71.04	0.00	** PEND	00162
01	A6247	1.000	XX34567X	EXAMPLE	CP777777	05/14/10	07206-000035665-0-0	14.30	0.00	** PEND	00142
01	A6247	1.000	XX45678X	SPECIMEN	CP999999	05/12/10	07206-000033660-0-0	14.30	0.00	** PEND	00131

* = PREVIOUSLY PENDED CLAIM
** = NEW PEND

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

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

MEMBER ID:  00112233
    VOIDS – ADJUSTS                       3.60-   NUMBER OF CLAIMS    1
    TOTAL PENDS                         168.94    NUMBER OF CLAIMS    4
    TOTAL PAID                          147.40    NUMBER OF CLAIMS    4
    TOTAL DENIED                        162.20    NUMBER OF CLAIMS    4
    NET TOTAL PAID                      143.80    NUMBER OF CLAIMS    5
```

REMITTANCE ADVICE

Exhibit 3.5.3-4

MEDICAID
MANAGEMENT
INFORMATION SYSTEM

PAGE: 05
DATE: 05/31/2010
CYCLE: 1710

MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

ETIN:
DME
GRAND TOTALS

TO: ABC MEDICAL EQUIPMENT
    100 BROADWAY
    ANYTOWN, NEW YORK 11111

PROV ID: 00112233/1123456789
REMITTANCE NO: 070806000006

REMITTANCE TOTALS – GRAND TOTALS

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

REMITTANCE ADVICE

3.5.5.1 Claim Detail Page Field Descriptions

Upper Left Corner

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

Upper Right Corner

Remittance Page Number

Date: The date on which the remittance advice was issued

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

ETIN (not applicable)

Provider Service Classification: **DME**

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

Remittance Number

3.5.5.2 Explanation of Claim Detail Columns

LN. NO. (Line Number)

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

PROC (Procedure) Code

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

Quantity

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

Client ID Number

The patient's Medicaid ID number appears under this column.

Client Name

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

Office Account Number

If a Patient/Office Account Number was entered in the claim form, that number (up to 20 characters) will appear under this column.

Service Date

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

TCN

The TCN is a unique identifier assigned to each claim that is processed. If multiple claim lines are submitted on the same claim form, all the lines are assigned the same TCN.

Amount Charged

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

Paid

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

Status

This column indicates the status (DENY, PAID/ADJT/VOID, PEND) of the claim line.

Denied Claims

Claims for which payment is denied will be identified by the *DENY* status. A claim may be denied for the following general reasons:

- The service rendered is not covered by the New York State Medicaid Program.
- The claim is a duplicate of a prior paid claim.
- The required Prior Approval has not been obtained.
- Information entered in the claim form is invalid or logically inconsistent.

Approved Claims

Approved claims will be identified by the statuses *PAID*, *ADJT* (adjustment), or *VOID*.

Paid Claims

The status PAID refers to *original* claims that have been approved.

Adjustments

The status *ADJT* refers to a claim submitted in replacement of a paid claim with the purpose of changing one or more fields. An adjustment has two components: the credit transaction (previously paid claim), and the debit transaction (adjusted claim).

Voids

The status *VOID* refers to a claim submitted with the purpose of canceling a previously paid claim. A void lists the credit transaction (previously paid claim) only.

Pending Claims

Claims that require further review or recycling will be identified by the *PEND* status. The following are examples of circumstances that commonly cause claims to be pended:

- New York State Medical Review required.
- Procedure requires manual pricing.
- No match found in the Medicaid files for certain information submitted on the claim, for example: Patient ID, Prior Approval, Service Authorization. These claims are recycled for a period of time during which the Medicaid files may be updated to match the information on the claim.

After manual review is completed, a match is found in the Medicaid files or the recycling time expires, pended claims may be approved for payment or denied.

A new pend is signified by two asterisks (**). A previously pended claim is signified by one asterisk (*).

Errors

For claims with a DENY or PEND status, this column indicates the NYS Medicaid edit (error) numeric code(s) that caused the claim to deny or pend. Some edit codes may also be indicated for a PAID claim. These are approved edits, which identify certain errors found in the claim and that do not prevent the claim from being approved. Up to twenty-five (25) edit codes, including approved edits, may be listed for each claim. Edit code definitions will be listed on the last page(s) of the remittance advice.

3.5.5.3 Subtotals/Totals/Grand Totals

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

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

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

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

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

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

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

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

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

3.5.6 Home Health Claim Detail

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

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

Exhibit 3.5.4-1

MEDICAID
MANAGEMENT INFORMATION SYSTEM

PAGE   02
DATE   05/31/2010
CYCLE   1710

MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

ETIN:
HOME HEALTH
PROV ID: 00111234
REMITTANCE NO: 07080600001

TO: CITY HOME CARE
     111 MAIN STREET
     ANYTOWN, NEW YORK 11111

OFFICE ACCOUNT NUMBER	CLIENT NAME	CLIENT ID.	TCN	DATE OF SERVICE	RATE CODE	UNITS	CHARGED	PAID	STATUS	ERRORS
CPIC1-00123-4	DOE	XX12345X	07206-000012112-3-2	05/25/10	2601	10.000	187.81	0.00	DENY	00162 00131
CPIC1-00987-6	SAMPLE	XX23456X	07206-000019113-3-1	05/25/10	2601	8.000	84.38	0.00	DENY	00244 00142

* = PREVIOUSLY PENDED CLAIM
** = NEW PEND

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

REMITTANCE ADVICE

Exhibit 3.5.4-2

```
                                      ┌─┐
                                      │M│EDICAID        PAGE      03
                                      └─┘                DATE      05/31/2010
                                   MANAGEMENT            CYCLE     1710
                                   INFORMATION SYSTEM
                        MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
                                 REMITTANCE STATEMENT      ETIN:
                                                           HOME HEALTH
TO:  CITY HOME CARE                                        PROV ID:  00111234
     111 MAIN STREET                                       REMITTANCE NO:  07080600001
     ANYTOWN, NEW YORK 11111
```

OFFICE ACCOUNT NUMBER	CLIENT NAME	CLIENT ID.	TCN	DATE OF SERVICE	RATE CODE	UNITS	CHARGED	PAID	STATUS	ERRORS
CPIC1-00123-4	DOE	XX12345X	07206-000034112-0-2	05/25/10	2601	8.000	300.20	300.20	PAID	
CPIC1-00987-6	SAMPLE	XX23456X	07206-000445113-0-2	05/23/10	2601	5.000	188.41	188.41	PAID	
CPIC1-44444-6	EXAMPLE	XX34567X	07206-000466333-0-2	05/27/10	2601	8.000	300.20	300.20	PAID	
CPIC1-66666-6	SPECIMEN	XX45678X	07206-000445663-0-2	05/22/10	2601	8.000	300.20	300.20	PAID	
CPIC1-33333-6	STANDARD	XX56789X	07206-000447654-0-2	05/22/10	2601	8.000	300.20	300.20	PAID	
CPIC1-55555-6	MODEL	XX67890X	07206-000465553-0-2	05/25/10	2601	7.000	186.10	186.10	PAID	
CPIC1-77777-6	DOE	XX09876X	07206-000455557-0-2	05/25/10	2601	8.000	300.20	300.20	PAID	
CPIC1-11111-6	SAMPLE	XX98765X	07206-000544444-0-2	05/05/10	2601	5.000	150.90	150.90	ADJT	
CPIC1-99999-6	EXAMPLE	XX87654X	07206-000465477-0-2	05/05/10	2601	8.000	300.20	-300.20-	PAID	ORIGINAL CLAIM PAID 05/11/2010

```
                                                       * . = PREVIOUSLY PENDED CLAIM
                                                       ** = NEW PEND

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

REMITTANCE ADVICE

Exhibit 3.5.4-3

M EDICAID
MANAGEMENT
INFORMATION SYSTEM

MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

PAGE   04
DATE   08/06/2007
CYCLE   1563

TO: CITY HOME CARE
     111 MAIN STREET
     ANYTOWN, NEW YORK 11111

ETIN:
HOME HEALTH
PROV ID: 00111234
REMITTANCE NO: 07080600001

OFFICE ACCOUNT NUMBER	CLIENT NAME	CLIENT ID.	TCN	DATE OF SERVICE	RATE CODE	UNITS	CHARGED	PAID	STATUS	ERRORS
CPIC1-00123-4	DOE	XX12345X	07206-000034112-3-2	05/25/10	2601	8.000	300.20	**	PEND	00162 00244
CPIC1-00987-6	SAMPLE	XX23456X	07206-000445113-3-1	05/22/10	2601	5.000	188.41	**	PEND	00162 00244

* = PREVIOUSLY PENDED CLAIM
** = NEW PEND

TOTAL AMOUNT ORIGINAL CLAIMS	PEND	488.61	NUMBER OF CLAIMS	2
NET AMOUNT ADJUSTMENTS	PEND	0.00	NUMBER OF CLAIMS	0
NET AMOUNT VOIDS	PEND	0.00	NUMBER OF CLAIMS	0
NET AMOUNT VOIDS – ADJUSTS		0.00	NUMBER OF CLAIMS	0

REMITTANCE TOTALS – HOME HEALTH

VOIDS – ADJUSTS	0.00	NUMBER OF CLAIMS	0
TOTAL PENDS	0.00	NUMBER OF CLAIMS	0
TOTAL PAID	0.00	NUMBER OF CLAIMS	0
TOTAL DENIED	775.62	NUMBER OF CLAIMS	2
NET TOTAL PAID	0.00	NUMBER OF CLAIMS	0

MEMBER ID: 00111234

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

REMITTANCE ADVICE

Exhibit 3.5.4-4

MEDICAID
MANAGEMENT
INFORMATION SYSTEM

PAGE: 05
DATE: 05/31/2010
CYCLE: 1710

MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

TO: CITY HOME CARE
     111 MAIN STREET
     ANYTOWN, NEW YORK 11111

ETIN:
HOME HEALTH
GRAND TOTALS
PROV ID: 00111234
REMITTANCE NO: 07080600001

REMITTANCE TOTALS – GRAND TOTALS

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

REMITTANCE ADVICE

3.5.6.1 Claim Detail Page Field Descriptions

Upper Left Corner

Provider's Name/Address

Upper Right Corner

Remittance page number

Date the remittance advice was issued

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

ETIN (not applicable)

Provider Service Classification: **HOME HEALTH**

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

Remittance Number

3.5.6.2 Explanation of Claim Detail Columns

Office Account Number

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

Client Name

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

Client ID

The Member ID number appears under this column.

TCN

The Transaction Control Number (TCN) is a unique identifier assigned to each claim that is processed. If multiple claim lines are submitted on the same claim form, all the lines are assigned the same TCN.

Date of Service

The first date of service (From date) entered in the claim appears in this column. If a date different from the From date was entered in the Through date box, that date is not returned in the Remittance Advice.

Rate Code

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

Units

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

Charged

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

Paid

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

Status

This column indicates the status (DENY, PAID/ADJT/VOID, PEND) of the claim line.

Denied Claims

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

- The service rendered is not covered by the New York State Medicaid Program.
- The claim is a duplicate of a prior paid claim.
- The required Prior Approval has not been obtained.
- Information entered in the claim form is invalid or logically inconsistent.

Approved Claims

Approved claims will be identified by the statuses *PAID, ADJT* (adjustment), or *VOID*.

Paid Claims

The status PAID refers to *original* claims that have been approved.

Adjustments

The status *ADJT* refers to a claim submitted in replacement of a paid claim with the purpose of changing one or more fields. An adjustment has two components: the credit transaction (previously paid claim), and the debit transaction (adjusted claim).

Voids

The status *VOID* refers to a claim submitted with the purpose of canceling a previously paid claim. A void lists the credit transaction (previously paid claim) only.

Pending Claims

Claims that require further review or recycling will be identified by the *PEND* status. The following are examples of circumstances that commonly cause claims to be pended:

- New York State Medical Review required.
- Procedure requires manual pricing.
- No match found in the Medicaid files for certain information submitted on the claim, for example: Member ID, Prior Approval. These claims are recycled for a period of time during which the Medicaid files may be updated to match the information on the claim.

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

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

A new pend is signified by two asterisks (**). A previously pended claim is signified by one asterisk (*).

Errors

For claims with a DENY or PEND status, this column indicates the NYS Medicaid edit (error) number(s) that caused the claim to deny or pend. Up to twenty-five (25) edit codes, including approved edits, may be listed for each claim. Edit code definitions are listed at the end of the claim detail section.

3.5.6.3Subtotals/Totals/Grand Totals

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

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

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

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

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

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

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

3.5.7 Inpatient Claim Detail

Exhibit 3.5.5-1

```
                                                              PAGE      02
                                                              DATE      05/31/10
                                                              CYCLE     1710

                    MEDICAID
                    MANAGEMENT
                    INFORMATION SYSTEM
                                                    ETIN:
   TO:   DOWNTOWN HOSPITAL    MEDICAL ASSISTANCE (TITLE XIX) PROGRAM   INPATIENT
         BUSINESS OFFICE         REMITTANCE STATEMENT                  PROV ID:  00234567/1234567890
         123 FIRST STREET                                              REMITTANCE NO:  07080600001
         ANYTOWN, NEW YORK 11111
```

PATIENT CONTROL NO DATE	CLIENT NAME ID NUMBER	TCN MEDICAL RECORD NUMBER	SERVICE DATES FROM THRU	COV'D DAYS RATE CODE	OUT DAYS PAY TYPE	TOT DAYS DRG CODE	COVERAGE BASE	CO-PAY	OTHER INSURANCE PAID	STATUS	ERRORS
CPIC1005432 05/25/10	SAMPLE XX12345X	07230-000000315-2-0 000000585555IH03	05/25/10 05/29/10	0 2946	0 C	0 122-1	4000.00	25.00	0.00 0.00	DENY	00805 00806 00848
CPIC1077777 05/25/10	EXAMPLE XX23456X	07231-000000441-2-0 000000586555IH03	05/25/10 05/30/10	0 2946	0 C	0 195-1	4000.00	25.00	0.00 0.00	DENY	00162
CPIC1004321 05/27/10	TEST XX34567X	07245-000000049-2-0 000000587672IH03	05/27/10 05/30/10	0 2946	0 C	0 127-1	4000.00	0.00	0.00 0.00	DENY	00848

```
                                                         *  = PREVIOUSLY PENDED CLAIM
                                                         ** = NEW PEND

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

REMITTANCE ADVICE

Exhibit 3.5.5-2

```
                                                                    PAGE      03
                                                                    DATE      05/31/10
                        MEDICAID                                    CYCLE     1710
                        MANAGEMENT
                        INFORMATION SYSTEM
TO:   DOWNTOWN HOSPITAL    MEDICAL ASSISTANCE (TITLE XIX) PROGRAM    ETIN:
      BUSINESS OFFICE          REMITTANCE STATEMENT                  INPATIENT
      123 FIRST STREET                                               PROV ID: 00234567/1234567890
      ANYTOWN, NEW YORK 11111                                        REMITTANCE NO: 07080600001
```

PATIENT CONTROL NO DATE	CLIENT NAME ID NUMBER	TCN MEDICAL RECORD NUMBER	SERVICE DATES FROM THRU	COV'D DAYS RATE CODE	OUT DAYS PAY TYPE	TOT DAYS DRG CODE	COVERAGE BASE	CO-PAY	OTHER INSURANCE PAID	STATUS	ERRORS
CPIC1567890 05/25/10	SPECIMEN XX45678X	07230-000000315-2-0 0000005876721H03	05/25/10 05/27/10	2 2946	0 C	0 311-1	4000.00	25.00	0.00 4000.00	PAID	
CPIC1765432 05/25/10	MODEL XX56789X	07231-000000441-2-0 0000005876721H03	05/25/10 05/30/10	5 2946	0 C	0 079-1	4000.00	25.00	0.00 4000.00	PAID	
CPIC1678901 05/25/10	DOE XX67890X	07245-000000049-2-0 0000005876721H03	05/25/10 05/30/10	5 2946	0 C	0 140-1	4000.00	0.00	0.00 4000.00	PAID	

```
                                                              *  = PREVIOUSLY PENDED CLAIM
                                                              ** = NEW PEND


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

REMITTANCE ADVICE

Exhibit 3.5.5-3

MEDICAID MANAGEMENT INFORMATION SYSTEM

PAGE 04
DATE 05/31/10
CYCLE 1710

MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

TO: DOWNTOWN HOSPITAL
BUSINESS OFFICE
123 FIRST STREET
ANYTOWN, NEW YORK 11111

ETIN:
INPATIENT
PROV ID: 00234567/1234567890
REMITTANCE NO: 07080600001

PATIENT CONTROL NO DATE	CLIENT NAME ID NUMBER	TCN MEDICAL RECORD NUMBER	SERVICE DATES FROM THRU	COVD DAYS RATE CODE	OUT DAYS PAY TYPE	TOT DAYS DRG CODE	COVERAGE BASE	CO-PAY	OTHER INSURANCE PAID	STATUS	ERRORS
CPIC155555555 05/25/10	SPECIMEN XX99999X	07230-000000315-2-0 000000587672IH03	05/25/10 05/26/10	0 2959	0 C	0 122-1	4000.00	25.00	0.00 0.00	PEND	00162
CPIC199999999 05/25/10	EXAMPLE XX98765X	07231-000000441-2-0 000000587672IH03	05/25/10 05/30/10	0 2959	0 C	0 088-1	4000.00	25.00	0.00 0.00	PEND	00142
CPIC166666666 05/25/10	SAMPLE XX77777X	07245-000000049-2-0 000000587672IH03	05/25/10 05/30/10	0 2959	0 C	0 296-1	4000.00	0.00	0.00 0.00	PEND	00144

* = PREVIOUSLY PENDED CLAIM
** = NEW PEND

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

REMITTANCE TOTALS – INPATIENT

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

MEMBER ID: 00234567

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

REMITTANCE ADVICE

Exhibit 3.5.5-4

MEDICAID
MANAGEMENT INFORMATION SYSTEM

PAGE: 05
DATE: 05/31/10
CYCLE: 1710

MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

TO: DOWNTOWN HOSPITAL
BUSINESS OFFICE
123 FIRST STREET
ANYTOWN, NEW YORK 11111

ETIN:
INPATIENT
GRAND TOTALS
PROV ID: 00234567/1234567890
REMITTANCE NO: 07080600001

REMITTANCE TOTALS – GRAND TOTALS

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

REMITTANCE ADVICE

3.5.7.1 Claim Detail Page Field Descriptions

Upper Left Corner

Provider's Name/Address

Upper Right Corner

Remittance page number

Date the remittance advice was issued

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

ETIN (not applicable)

Provider Service Classification: **INPATIENT**

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

Remittance Number

3.5.7.2 Explanation of Claim Detail Columns

Patient Control Number/Date

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

Client Name/ID Number

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

TCN/Medical Record Number

The Transaction Control Number (TCN) is a unique identifier assigned to each claim that is processed. If multiple claim lines are submitted on the same claim form, all the lines are assigned the same TCN.

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

Service Dates – From/Through

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

Cov'd (Covered) Days/Rate Code

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

Out Days/Pay Type

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

Inpatient Payment Type Codes

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

Exhibit 3.5.2-1

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

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

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

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

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

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

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

Coverage Base

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

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

Co-Pay

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

Other Insurance/Paid

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

Status

This column indicates the status (DENY, PAID/ADJT/VOID, PEND) of the claim line.

Denied Claims

Claims for which payment is denied will be identified by the *DENY* status. A claim may be denied for the following general reasons:

- The service rendered is not covered by the New York State Medicaid Program.
- The claim is a duplicate of a prior paid claim.
- The required Prior Approval has not been obtained.
- Information entered in the claim form is invalid or logically inconsistent.

Approved Claims

Approved claims will be identified by the statuses *PAID, ADJT* (adjustment), or *VOID*.

Paid Claims

The status PAID refers to *original* claims that have been approved.

Adjustments

The status *ADJT* refers to a claim submitted in replacement of a paid claim with the purpose of changing one or more fields. An adjustment has two components: the credit transaction (previously paid claim), and the debit transaction (adjusted claim).

Voids

The status *VOID* refers to a claim submitted with the purpose of canceling a previously paid claim. A void lists the credit transaction (previously paid claim) only.

Pending Claims

Claims that require further review or recycling will be identified by the *PEND* status. The following are examples of circumstances that commonly cause claims to be pended:

- New York State Medical Review required.
- Procedure requires manual pricing.
- No match found in the Medicaid files for certain information submitted on the claim, for example: Member ID, Prior Approval. These claims are recycled for a period of time during which the Medicaid files may be updated to match the information on the claim.

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

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

A new pend is signified by two asterisks (**). A previously pended claim is signified by one asterisk (*).

Errors

For claims with a DENY or PEND status, this column indicates the NYS Medicaid edit (error) number(s) that caused the claim to deny or pend. Up to twenty-five (25) edit codes, including approved edits, may be listed for each claim. Edit code definitions are listed at the end of the claim detail section.

3.5.7.3 Subtotals/Totals/Grand Totals

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

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

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

Subtotals by *service classification/locator code* combination are provided at the end of the claim detail listing for each service classification/locator code combination. These subtotals are broken down by:

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

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

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

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

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

Net total paid (entire remittance)

3.5.8 Nursing Home Claim Detail

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

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

Exhibit 3.5.6-1

MEDICAID
MANAGEMENT INFORMATION SYSTEM

MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

PAGE   02
DATE   05/31/10
CYCLE   1710

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

ETIN:
NURSING HOME
PROV ID: 01234567/1234567890
REMITTANCE NO: 07080600001

CLIENT NAME ID NUMBER	TCN PATIENT ACCOUNT NUMBER	SERVICE DATES FROM THRU	RATE CODE	REP'TED CALC'ED DAYS F	C	FULL DAYS CO-INSURANCE DAYS PAYMENT	PATIENT PARTICIPATION REPORTED DEDUCTED	OTHER INSURANCE	AMOUNT CHARGED AMOUNT PAID	STATUS ERRORS
SAMPLE XX12345X	07206-000000112-3-0 CPIC1-00987-6	05/02/10 05/06/10	3945	5 5	0	0.00 0.00	0.00	0.00	387.81 0.00	DENY 01023 01035
EXAMPLE XX67890X	07206-000000111-1-0 CPIC1-00678-9	05/02/10 05/06/10	3945	5 5	0	0.00 0.00	0.00	0.00	387.81 0.00	DENY 01023

*. = PREVIOUSLY PENDED CLAIM
** = NEW PEND

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

REMITTANCE ADVICE

Exhibit 3.5.6-2

MEDICAID
MANAGEMENT
INFORMATION SYSTEM

PAGE   03
DATE   05/31/10
CYCLE   1710

MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

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

ETIN:
NURSING HOME
PROV ID: 00123456/1234567890
REMITTANCE NO: 07080600001

CLIENT NAME ID NUMBER	TCN PATIENT ACCOUNT NUMBER	SERVICE DATES FROM THRU	RATE CODE	REP'TED CALC'ED DAYS F C	FULL DAYS CO-INSURANCE DAYS PAYMENT	PATIENT PARTICIPATION REPORTED DEDUCTED	OTHER INSURANCE	AMOUNT CHARGED AMOUNT PAID	STATUS	ERRORS
SAMPLE XX12345X	07206-000000112-3-0 CPIC1-00987-6	05/02/10 05/06/10	3945	5 5	0	387.81 0.00	0.00	0.00	387.81 387.81	PAID	
EXAMPLE XX67890X	07206-000000111-1-0 CPIC1-00678-9	05/02/10 05/06/10	3945	5 5	0	387.81 0.00	0.00	0.00	387.81 387.81	PAID	
MODEL XX98765P	07206-000332456-0-0 CPIC1-00543-6	05/02/10 05/06/10	3945	5 5	0	387.81 0.00	0.00	0.00	387.81 387.81	PAID	
SPECIMEN XX87654X	07206-004445656-0-0 CPIC1-00321-6	05/02/10 05/06/10	3945	5 5	0	387.81 0.00	0.00	0.00	387.81 387.81	PAID	
STANDARD XX76543X	07206-007776546-0-1 CPIC1-00555-6	05/02/10 05/06/10	3945	5 5	0	387.81 0.00	0.00	0.00	387.81 387.81-	ADJT	ORIGINAL CLAIM PAID 05/11/2010
DOE XX65432X	07206-007776546-0-2 CPIC1-00444-6	05/02/10 05/05/10	3945	4 4	0	298.77 0.00	0.00	0.00	298.77 298.77	ADJT	

* = PREVIOUSLY PENDED CLAIM
** = NEW PEND

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

REMITTANCE ADVICE

Exhibit 3.5.6-3

PAGE 04
DATE 05/31/10
CYCLE 1710

MEDICAID
MANAGEMENT
INFORMATION SYSTEM

MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

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

ETIN:
NURSING HOME
PROV ID: 00123456/1234567890
REMITTANCE NO: 07080600001

CLIENT NAME ID NUMBER	TCN PATIENT ACCOUNT NUMBER	SERVICE DATES FROM THRU	RATE CODE	REP'TED CALC'ED DAYS F C	FULL DAYS CO-INSURANCE DAYS PAYMENT	PATIENT PARTICIPATION REPORTED DEDUCTED	OTHER INSURANCE	AMOUNT CHARGED AMOUNT PAID	STATUS ERRORS
SAMPLE XX12345X	07206-000000112-3-0 CPIC1-00987-6	05/02/10 05/06/10	3945	5 0 5	0.00 0.00	0.00	0.00	387.81 0.00	**PEND 00162 00971
EXAMPLE XX67890X	07206-000000111-1-0 CPIC1-00678-9	05/02/10 05/06/10	3945	5 0 5	0.00 0.00	0.00	0.00	387.81 0.00	**PEND 01131

* = PREVIOUSLY PENDED CLAIM
** = NEW PEND

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

REMITTANCE TOTALS – NURSING HOME

VOIDS – ADJUSTS	89.04-	NUMBER OF CLAIMS	1
TOTAL PENDS	775.62	NUMBER OF CLAIMS	2
TOTAL PAID	1551.24	NUMBER OF CLAIMS	5
TOTAL DENY	775.62	NUMBER OF CLAIMS	2
NET TOTAL PAID	1462.20	NUMBER OF CLAIMS	5

MEMBER ID: 12345678

VOIDS – ADJUSTS	89.04-	NUMBER OF CLAIMS	1
TOTAL PENDS	775.62	NUMBER OF CLAIMS	2
TOTAL PAID	1551.24	NUMBER OF CLAIMS	5
TOTAL DENY	775.62	NUMBER OF CLAIMS	2
NET TOTAL PAID	1462.20	NUMBER OF CLAIMS	5

Exhibit 3.5.6-4


```
                    ┌──┐
                    │M │EDICAID            PAGE:      05
                    └──┘                   DATE:      05/31/10
                    MANAGEMENT             CYCLE:     1710
                    INFORMATION SYSTEM
          MEDICAL ASSISTANCE (TITLE XIX) PROGRAM      ETIN:
                 REMITTANCE STATEMENT                 NURSING HOME
  TO: ABC HOSPICE                                     GRAND TOTALS
      123 MAIN STREET                                 PROV ID: 00123456/1234567890
      ANYTOWN, NEW YORK 11111                         REMITTANCE NO: 07080600001
```

REMITTANCE TOTALS – GRAND TOTALS

VOIDS – ADJUSTS	89.04-	NUMBER OF CLAIMS	1
TOTAL PENDS	775.62	NUMBER OF CLAIMS	2
TOTAL PAID	1551.24	NUMBER OF CLAIMS	5
TOTAL DENY	775.62	NUMBER OF CLAIMS	2
NET TOTAL PAID	1462.20	NUMBER OF CLAIMS	33

REMITTANCE ADVICE

3.5.8.1 Claim Detail Page Field Descriptions

Upper Left Corner

Provider's Name/Address

Upper Right Corner

Remittance page number

Date the remittance advice was issued

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

ETIN (not applicable)

Provider Service Classification: **NURSING HOME**

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

Remittance Number

3.5.8.2 Explanation of Claim Detail Columns

Client Name/ID Number

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

TCN/Patient Account Number

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

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

Service Dates – From/Through

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

Rate Code

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

Reported/Calculated Days

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

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

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

Patient Participation – Reported/Deducted

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

Other Insurance

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

Amount Charged/Amount Paid

The total charges entered in the claim form appear first in this column. If the claim was approved, the amount paid appears underneath the charges. If the claim has a pend or deny status, the amount paid will be zero (0.00).

Status

This column indicates the status (DENY, PAID/ADJT/VOID, PEND) of the claim line.

Denied Claims

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

- The service rendered is not covered by the New York State Medicaid Program.
- The claim is a duplicate of a prior paid claim.
- The required Prior Approval has not been obtained.
- Information entered in the claim form is invalid or logically inconsistent.

Approved Claims

Approved claims will be identified by the statuses *PAID, ADJT* (adjustment), or *VOID*.

Paid Claims

The status PAID refers to *original* claims that have been approved.

REMITTANCE ADVICE

Adjustments

The status *ADJT* refers to a claim submitted in replacement of a paid claim with the purpose of changing one or more fields. An adjustment has two components: the credit transaction (previously paid claim), and the debit transaction (adjusted claim).

Voids

The status *VOID* refers to a claim submitted with the purpose of canceling a previously paid claim. A void lists the credit transaction (previously paid claim) only.

Pending Claims

Claims that require further review or recycling will be identified by the *PEND* status. The following are examples of circumstances that commonly cause claims to be pended:

- New York State Medical Review required.
- Procedure requires manual pricing.
- No match found in the Medicaid files for certain information submitted on the claim, for example: Member ID, Prior Approval. These claims are recycled for a period of time during which the Medicaid files may be updated to match the information on the claim.

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

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

A new pend is signified by two asterisks (**). A previously pended claim is signified by one asterisk (*).

Errors

For claims with a DENY or PEND status, this column indicates the NYS Medicaid edit (error) number(s) that caused the claim to deny or pend. Some edit codes may also be indicated for a PAID claim. Up to twenty-five (25) edit codes, including approved edits, may be listed for each claim. Edit code definitions are listed at the end of the claim detail section.

3.5.8.3 Subtotals/Totals/Grand Totals

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

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

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

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

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

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

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

Net total paid (entire remittance)

3.5.9 Pharmacy Claim Detail

Exhibit 3.5.7-1

```
                              MEDICAID                    PAGE    02
                                                         DATE    05/31/2010
                              MANAGEMENT                 CYCLE   1710
                              INFORMATION SYSTEM

                    MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
                         REMITTANCE STATEMENT             ETIN:
                                                         PHARMACY
TO:  CITY PHARMACY                                       PROV ID:  00123456/1123456789
     111 PARK AVENUE                                     REMITTANCE NO:  070806000006
     ANYTOWN, NEW YORK 11111
```

PRESCRIP TION NO.	ITEM CODE	QUANTITY	CLIENT ID NUMBER	CLIENT NAME	SERVICE DATE	TCN	CHARGED	PAID	STATUS	ERRORS
4267229	00173044100	54.000	XX12345X	DOE	05/01/10	07267-000000605-0-2	100.00	0.00	DENY	00162
4267240	00904391660	5.000	XX23456X	SAMPLE	05/15/10	07267-000000614-0-1	50.00	0.00	DENY	00162
0426722	00904391660	5.000	XX34567X	EXAMPLE	05/25/10	07267-000000573-0-1	30.00	0.00	DENY	00142 00144
0042664	00002411260	1.000	XX45678X	SPECIMEN	05/01/10	07267-000000453-2-2	60.00	0.00	DENY	00142 00144

```
                                                         *.  =  PREVIOUSLY PENDED CLAIM
                                                         **  =  NEW PEND


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

REMITTANCE ADVICE

Exhibit 3.5.7-2

```
                    M MEDICAID                          PAGE    03
                                                        DATE    05/31/2010
                       MANAGEMENT                       CYCLE   1710
                       INFORMATION SYSTEM
         MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
                 REMITTANCE STATEMENT                   ETIN:
                                                        PHARMACY
TO:  CITY PHARMACY                                      PROV ID:  00123456/1123456789
     111 PARK AVENUE                                    REMITTANCE NO:  070806000006
     ANYTOWN, NEW YORK 11111
```

PRESCRIPTION NO.	ITEM CODE	QUANTITY	CLIENT ID NUMBER	CLIENT NAME	SERVICE DATE	TCN	CHARGED	PAID	STATUS	ERRORS
0042663	00002411260	5.000	XX56789X	STANDARD	05/05/10	07267-000000437-2-1	100.00	100.00	PAID	
0042663	00002411260	5.000	XX56789X	STANDARD	05/05/10	07188-000000437-2-2	10.00	80.00-	ADJT	ORIGINAL CLAIM AS PAID 05/20/10
0426722	00904391660	1.000	XX56789X	STANDARD	05/25/10	07267-000000562-0-0	5.91	5.91	PAID	
0426711	00002411260	1.000	XX87654X	EXAMPLE	05/10/10	07267-000000260-0-0	28.97	28.97	PAID	
0426712	00002411260	1.000	XX87654X	EXAMPLE	05/20/10	07267-000000263-0-0	50.00	50.00	PAID	

```
                                                        *.  =  PREVIOUSLY PENDED CLAIM
                                                        ** =  NEW PEND


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

REMITTANCE ADVICE

Exhibit 3.5.7-3

```
                            MEDICAID                    PAGE      04
                                                        DATE      05/31/2010
                            MANAGEMENT                  CYCLE     1710
                            INFORMATION SYSTEM
                MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
                       REMITTANCE STATEMENT              ETIN:
                                                        PHARMACY
TO: CITY PHARMACY                                       PROV ID: 00123456/1123456789
    111 PARK AVENUE                                     REMITTANCE NO: 070806000006
    ANYTOWN, NEW YORK 11111
```

PRESCRIP TION NO.	ITEM CODE	QUANTITY	CLIENT ID NUMBER	CLIENT NAME	SERVICE DATE	TCN	CHARGED	PAID	STATUS	ERRORS
4267241	00904391660	5.000	XX12345X	DOE	05/01/10	07272-000000027-0-1	56.00	0.00	PEND	00162 00127
4267241	00904391660	5.000	XX23456X	SAMPLE	05/15/10	07272-000000028-0-2	55.00	0.00	PEND	00162 00127
4267242	00904391660	5.000	XX34567X	EXAMPLE	05/25/10	07272-000000035-0-1	20.00	0.00	PEND	01154
4267243	00904391660	5.000	XX45678X	SPECIMEN	05/01/10	07272-000000044-0-2	40.00	0.00	PEND	01154

```
                                                  * = PREVIOUSLY PENDED CLAIM
                                                 ** = NEW PEND


    TOTAL AMOUNT ORIGINAL CLAIMS        PEND    171.00    NUMBER OF CLAIMS    4
      NET AMOUNT ADJUSTMENTS            PEND     00.00    NUMBER OF CLAIMS    0
      NET AMOUNT VOIDS                  PEND     00.00    NUMBER OF CLAIMS    0
      NET AMOUNT VOIDS – ADJUSTS                 00.00    NUMBER OF CLAIMS    0

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

    MEMBER ID:  00123456
      VOIDS – ADJUSTS                            20.00    NUMBER OF CLAIMS    1
      TOTAL PENDS                               171.00    NUMBER OF CLAIMS    4
      TOTAL PAID                                 84.88    NUMBER OF CLAIMS    3
      TOTAL DENIED                              240.00    NUMBER OF CLAIMS    4
      NET TOTAL PAID                             64.88    NUMBER OF CLAIMS    4
```

REMITTANCE ADVICE

Exhibit 3.5.7-4

MEDICAID
MANAGEMENT
INFORMATION SYSTEM

PAGE: 05
DATE: 05/31/10
CYCLE: 1710

MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

TO: CITY PHARMACY
111 PARK AVENUE
ANYTOWN, NEW YORK 11111

ETIN:
PHARMACY
GRAND TOTALS
PROV ID: 00123456/1123456789
REMITTANCE NO: 070806000006

REMITTANCE TOTALS – GRAND TOTALS

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

REMITTANCE ADVICE

3.5.9.1 Claim Detail Page Field Descriptions

Upper Left Corner

Provider's Name/Address

Upper Right Corner

Remittance page number

Date the remittance advice was issued

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

ETIN (not applicable)

Provider Service Classification: **PHARMACY**

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

Remittance Number

3.5.9.2 Explanation of Claim Detail Columns

Prescription No. (Line Number)

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

Item Code

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

Quantity

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

Client Number

The Member ID number appears in this column.

Client Name

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

Service Date

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

TCN

The Transaction Control Number (TCN) is a unique identifier assigned to each claim that is processed. If multiple claim lines are submitted on the same claim form, all the lines are assigned the same TCN.

Charged

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

Paid

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

Status

This column indicates the status (DENY, PAID/ADJT/VOID, PEND) of the claim line.

Denied Claims

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

- The service rendered is not covered by the New York State Medicaid Program.
- The claim is a duplicate of a prior paid claim.
- The required Prior Approval has not been obtained.
- Information entered in the claim form is invalid or logically inconsistent.

Approved Claims

Approved claims will be identified by the statuses *PAID, ADJT* (adjustment), or *VOID*.

Paid Claims

The status PAID refers to *original* claims that have been approved.

Adjustments

The status *ADJT* refers to a claim submitted in replacement of a paid claim with the purpose of changing one or more fields. An adjustment has two components: the credit transaction (previously paid claim), and the debit transaction (adjusted claim).

Voids

The status *VOID* refers to a claim submitted with the purpose of canceling a previously paid claim. A void lists the credit transaction (previously paid claim) only.

Pending Claims

Claims that require further review or recycling will be identified by the *PEND* status. The following are examples of circumstances that commonly cause claims to be pended:

- New York State Medical Review required.
- Procedure requires manual pricing.
- No match found in the Medicaid files for certain information submitted on the claim, for example: Patient ID, Prior Approval, Service Authorization. These claims are recycled for a period of time during which the Medicaid files may be updated to match the information on the claim.

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

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

A new pend is signified by two asterisks (**). A previously pended claim is signified by one asterisk (*).

Errors

For claims with a DENY or PEND status, this column indicates the NYS Medicaid edit (error) number(s) that caused the claim to deny or pend. Up to twenty-five (25) edit codes, including approved edits, may be listed for each claim. Edit code definitions are listed at the end of the claim detail section.

...

3.5.9.3 Subtotals/Totals/Grand Totals

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

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

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

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

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

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

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

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

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

Net total paid (entire remittance)

3.5.10 Practitioner Claim Detail

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

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

Exhibit 4.5.8-1

MEDICAID
MANAGEMENT
INFORMATION SYSTEM

MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

PAGE   02
DATE   05/31/2010
CYCLE   1710

TO: JAMES STRONG, M.D.
     100 BROADWAY
     ANYTOWN, NEW YORK 11111

ETIN:
PRACTITIONER
PROV ID: 00112233/1123456789
REMITTANCE NO: 07080600006

LN. NO	OFFICE ACCOUNT NUMBER	CLIENT NAME	CLIENT ID NUMBER	TCN	DATE OF SERVICE	PROC. CODE	UNITS	CHARGED	PAID	STATUS	ERRORS
01	CP111111	DOE	XX12345X	07206-000000227-0-0	05/11/10	90829	1.000	52.80	0.00	DENY	00162 00244
01	CP222222	SAMPLE	XX23456X	07206-000011334-0-0	05/12/10	90804	1.000	17.60	0.00	DENY	00244
01	CP333333	EXAMPLE	XX34567X	07206-000013556-0-0	05/14/10	91105	1.000	14.30	0.00	DENY	00162
01	CP444444	SPECIMEN	XX45678X	07206-000032456-0-0	05/15/10	90945	1.000	77.50	0.00	DENY	00131

```
                                              *  = PREVIOUSLY PENDED CLAIM
                                              ** = NEW PEND
```

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

REMITTANCE ADVICE

Exhibit 4.5.8-2

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                                                    PAGE     03
                 MEDICAID                           DATE     05/31/2010
                 MANAGEMENT                          CYCLE    1710
                 INFORMATION SYSTEM

       MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
              REMITTANCE STATEMENT              ETIN:
                                                PRACTITIONER
TO:  JAMES STRONG, M.D.                         PROV ID:  00112233/1123456789
     100 BROADWAY                               REMITTANCE NO:  07080600006
     ANYTOWN, NEW YORK 11111
```

LN. NO	OFFICE ACCOUNT NUMBER	CLIENT NAME	CLIENT ID NUMBER	TCN	DATE OF SERVICE	PROC. CODE	UNITS	CHARGED	PAID	STATUS	ERRORS
01	CP111111	DOE	XX12345X	07206-000033667-0-0	05/11/10	91105	1.000	14.30	14.30	PAID	
02	CP222222	SAMPLE	XX23456X	07206-000033667-0-0	05/12/10	90846	1.000	14.30	14.30	PAID	
01	CP333333	EXAMPLE	XX34567X	07206-000045667-0-0	05/14/10	99221	1.000	52.80	52.80	PAID	
01	CP444444	SPECIMEN	XX45678X	07206-000056767-0-0	05/15/10	99111	1.000	66.00	66.00	PAID	
01	CP777777	STANDARD	XX56789X	07206-000067767-0-0	05/05/10	99285	1.000	17.60	17.60-	ADJT	ORIGINAL CLAIM PAID 05/24/10
01	CP555555	MODEL	XX67890X	07206-000088767-0-0	05/05/10	99281	1.000	14.30	14.00	ADJT	

```
                                                     *  = PREVIOUSLY PENDED CLAIM
                                                    ** = NEW PEND


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

REMITTANCE ADVICE

Exhibit 4.5.8-3

MEDICAID
MANAGEMENT
INFORMATION SYSTEM

PAGE   04
DATE   05/31/2010
CYCLE   1710

MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

TO: JAMES STRONG, M.D.
     100 BROADWAY
     ANYTOWN, NEW YORK 11111

ETIN:
PRACTITIONER
PROV ID: 00112233/1123456879
REMITTANCE NO: 07080600006

LN. NO	OFFICE ACCOUNT NUMBER	CLIENT NAME	CLIENT ID NUMBER	TCN	DATE OF SERVICE	PROC. CODE	UNITS	CHARGED	PAID	STATUS	ERRORS
01	CP111111	DOE	XX12345X	07206-000033467-0-0	05/11/10	90828	1.000	69.30	0.00	**PEND	00162
02	CP222222	SAMPLE	XX23456X	07206-000033468-0-0	05/12/10	90814	1.000	71.04	0.00	**PEND	00162
01	CP333333	EXAMPLE	XX34567X	07206-000035665-0-0	05/14/10	91105	1.000	14.30	0.00	**PEND	00142
01	CP444444	SPECIMEN	XX45678X	07206-000033660-0-0	05/15/10	91105	1.000	14.30	0.00	**PEND	00131

```
                                                    *  = PREVIOUSLY PENDED CLAIM
                                                    ** = NEW PEND
```

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

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

    MEMBER ID:   00112233
        VOIDS – ADJUSTS                           3.60-     NUMBER OF CLAIMS      1
        TOTAL PENDS                             168.94      NUMBER OF CLAIMS      4
        TOTAL PAID                              147.40      NUMBER OF CLAIMS      4
        TOTAL DENIED                            162.20      NUMBER OF CLAIMS      4
        NET TOTAL PAID                          143.80      NUMBER OF CLAIMS      5
```

REMITTANCE ADVICE

Exhibit 4.5.8-4

MEDICAID
MANAGEMENT
INFORMATION SYSTEM

PAGE: 05
DATE: 05/31/10
CYCLE: 1710

MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

TO: JAMES STRONG, M.D.
100 BROADWAY
ANYTOWN, NEW YORK 11111

ETIN:
PRACTITIONER
GRAND TOTALS
PROV ID: 00112233/1123456789
REMITTANCE NO: 07080600006

REMITTANCE TOTALS – GRAND TOTALS

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

REMITTANCE ADVICE

3.5.10.1   Claim Detail Page Field Descriptions

Upper Left Corner

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

Upper Right Corner

Remittance Page Number

Date the remittance advice was issued

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

ETIN (not applicable)

Provider Service Classification: **PRACTITIONER**

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

Remittance Number

3.5.10.2 Explanation of Claim Detail Columns

LN. NO. (Line Number)

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

Office Account Number

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

Client Name

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

Client ID Number

The Member ID number appears in this column.

TCN

The Transaction Control Number (TCN) is a unique identifier assigned to each claim that is processed. If multiple claim lines are submitted on the same claim form, all the lines are assigned the same TCN.

Date of Service

The first date of service (From date) entered in the claim appears in this column. If a date different from the From date was entered in the Through date box, that date is not returned in the Remittance Advice.

Procedure Code

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

Units

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

Charged

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

Paid

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

Office–based practitioners and clinics participating in the Patient Centered Medical Home Program may receive enhanced payments for qualifying services. A payment line on the remittance will appear as shown in Exhibit 3.5.2-1:

Exhibit 3.5.2-1

LN. NO	OFFICE ACCOUNT NUMBER	CLIENT NAME	CLIENT ID. NUMBER	TCN	DATE OF SERVICE	PROC. CODE	UN-ITS	CHARGED	PAID	STATUS	ERRORS
01	EP1396-CP01.002-3	SAMPLE	XX12345X	10060-000000000-4-0	03/01/10	99203	1.000	35.00	57.00	PAID	
MEDICAL HOME ADD-ON : 22.00											

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

Status

This column indicates the status (DENY, PAID/ADJT/VOID, PEND) of the claim line.

Denied Claims

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

- The service rendered is not covered by the New York State Medicaid Program.
- The claim is a duplicate of a prior paid claim.
- The required Prior Approval has not been obtained.
- Information entered in the claim form is invalid or logically inconsistent.

Approved Claims

Approved claims will be identified by the statuses *PAID*, *ADJT* (adjustment), or *VOID*.

Paid Claims

The status PAID refers to *original* claims that have been approved.

Adjustments

The status *ADJT* refers to a claim submitted in replacement of a paid claim with the purpose of changing one or more fields. An adjustment has two components: the credit transaction (previously paid claim), and the debit transaction (adjusted claim).

Voids

The status *VOID* refers to a claim submitted with the purpose of canceling a previously paid claim. A void lists the credit transaction (previously paid claim) only.

Pending Claims

Claims that require further review or recycling will be identified by the PEND status. The following are examples of circumstances that commonly cause claims to be pended:

- New York State Medical Review required.
- Procedure requires manual pricing.
- No match found in the Medicaid files for certain information submitted on the claim, for example: Member ID, Prior Approval. These claims are recycled for a period of time during which the Medicaid files may be updated to match the information on the claim.

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

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

A new pend is signified by two asterisks (**). A previously pended claim is signified by one asterisk (*).

Errors

For claims with a DENY or PEND status, this column indicates the NYS Medicaid edit (error) number(s) that caused the claim to deny or pend. Up to twenty-five (25) edit codes, including approved edits, may be listed for each claim. Edit code definitions are listed at the end of the claim detail section.

3.5.10.3   Subtotals/Totals/Grand Totals

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

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

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

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

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

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

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

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

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

3.5.11   Transportation Claim Detail

Exhibit 3.5.9-1


```
                                                      PAGE    02
                                                      DATE    05/31/2010
                                                      CYCLE   1710

              MEDICAID
              MANAGEMENT
              INFORMATION SYSTEM

         MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
                 REMITTANCE STATEMENT              ETIN:
                                                   TRANSPORTATION
   TO:  ABC TRANSPORTATION                         PROV ID:  00112233/1234567890
        100 BROADWAY                               REMITTANCE NO:  07080600006
        ANYTOWN, NEW YORK 11111


  LN.  OFFICE ACCOUNT  CLIENT    CLIENT ID                  DATE OF   PROC.
  NO   NUMBER          NAME      NUMBER        TCN          SERVICE   CODE   UNITS   CHARGED   PAID   STATUS   ERRORS
  01   CP111111        DOE       XX12345X   07206-000000227-0-0   05/11/10   NY211   48.000   52.80   0.00   DENY   00162  00244
  01   CP222222        SAMPLE    XX23456X   07206-000011334-0-0   05/12/10   NY211   16.000   17.60   0.00   DENY   00244
  01   CP333333        EXAMPLE   XX34567X   07206-000013556-0-0   05/14/10   NY211   13.000   14.30   0.00   DENY   00162
  01   CP444444        SPECIMEN  XX45678X   07206-000032456-0-0   05/15/10   NY211   63.000   77.50   0.00   DENY   00131


                                                        *  = PREVIOUSLY PENDED CLAIM
                                                        ** = NEW PEND


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

REMITTANCE ADVICE

Exhibit 3.5.9-2

M MEDICAID
MANAGEMENT
INFORMATION SYSTEM

PAGE 03
DATE 05/31/2010
CYCLE 1710

MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

TO: ABC TRANSPORTATION
100 BROADWAY
ANYTOWN, NEW YORK 11111

ETIN:
TRANSPORTATION
PROV ID: 00112233/1234567890
REMITTANCE NO: 07080600006

LN. NO	OFFICE ACCOUNT NUMBER	CLIENT NAME	CLIENT ID NUMBER	TCN	DATE OF SERVICE	PROC. CODE	UNITS	CHARGED	PAID	STATUS	ERRORS
01	CP111111	DOE	XX12345X	07206-000033667-0-0	05/11/10	NY211	13.000	14.30	14.30	PAID	
02	CP222222	SAMPLE	XX23456X	07206-000033667-0-0	05/12/10	NY211	13.000	14.30	14.30	PAID	
01	CP333333	EXAMPLE	XX34567X	07206-000045667-0-0	05/14/10	NY211	48.000	52.80	52.80	PAID	
01	CP444444	SPECIMEN	XX45678X	07206-000056767-0-0	05/15/10	NY211	66.000	66.00	66.00	PAID	
01	CP777777	STANDARD	XX56789X	07206-000067767-0-0	05/05/10	NY211	17.000	17.60	17.60-	ADJT	ORIGINAL CLAIM PAID 05/14/10
01	CP555555	MODEL	XX67890X	07206-000088767-0-0	05/05/10	NY211	13.000	14.30	14.00	ADJT	

*. = PREVIOUSLY PENDED CLAIM
** = NEW PEND

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

REMITTANCE ADVICE

Exhibit 3.5.9-3

M⃝EDICAID
MANAGEMENT
INFORMATION SYSTEM

PAGE   04
DATE   05/31/2010
CYCLE   1710

MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

TO: ABC TRANSPORTATION
     100 BROADWAY
     ANYTOWN, NEW YORK 11111

ETIN:
TRANSPORTATION
PROV ID: 00112233/1234567890
REMITTANCE NO: 07080600006

LN. NO	OFFICE ACCOUNT NUMBER	CLIENT NAME	CLIENT ID NUMBER	TCN	DATE OF SERVICE	PROC. CODE	UNITS	CHARGED	PAID	STATUS	ERRORS
01	CP111111	DOE	XX12345X	07206-000033467-0-0	05/11/10	NY211	60.000	69.30	0.00	**PEND	00162
02	CP222222	SAMPLE	XX23456X	07206-000033468-0-0	05/12/10	NY211	63.000	71.04	0.00	**PEND	00162
01	CP333333	EXAMPLE	XX34567X	07206-000035665-0-0	05/14/10	NY211	13.000	14.30	0.00	**PEND	00142
01	CP444444	SPECIMEN	XX45678X	07206-000033660-0-0	05/15/10	NY211	13.000	14.30	0.00	**PEND	00131

*. = PREVIOUSLY PENDED CLAIM
** = NEW PEND

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

REMITTANCE TOTALS – TRANSPORTATION

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

MEMBER ID: 00112233

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

REMITTANCE ADVICE

Exhibit 3.5.9-4

```
                    MEDICAID                    PAGE:    05
                                                DATE:    05/31/10
                    MANAGEMENT                  CYCLE:   1710
                    INFORMATION SYSTEM
          MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
                  REMITTANCE STATEMENT           ETIN:
                                                 TRANSPORTATION
   TO: ABC TRANSPORTATION                        GRAND TOTALS
        100 BROADWAY                              PROV ID: 00112233/1234567890
        ANYTOWN, NEW YORK 11111                   REMITTANCE NO: 07080600006
```

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

REMITTANCE ADVICE

3.5.11.1   Claim Detail Page Field Descriptions

Upper Left Corner

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

Upper Right Corner

Remittance page number

Date the remittance advice was issued

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

ETIN (not applicable)

Provider Service Classification: **TRANSPORTATION**

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

Remittance Number

3.5.11.2   Explanation of Claim Detail Columns

Ln. No. (Line Number)

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

Office Account Number

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

Client Name

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

Client ID

The member's Medicaid ID number appears in this column.

TCN

The TCN is a unique identifier assigned to each claim that is processed. If multiple claim lines are submitted on the same claim form, all the lines are assigned the same TCN.

Date of Service

The first date of service (From date) entered in the claim appears in this column. If a date different from the From date was entered in the Through date box, that date is not returned in the Remittance Advice.

Procedure Code

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

Units

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

Charged

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

Paid

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

Status

This column indicates the status (DENY, PAID/ADJT/VOID, PEND) of the claim line.

Denied Claims

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

- The service rendered is not covered by the New York State Medicaid Program.
- The claim is a duplicate of a prior paid claim.
- The required Prior Approval has not been obtained.
- Information entered in the claim form is invalid or logically inconsistent.

Approved Claims

Approved claims will be identified by the statuses *PAID, ADJT* (adjustment), or *VOID*.

Paid Claims

The status PAID refers to *original* claims that have been approved.

Adjustments

The status *ADJT* refers to a claim submitted in replacement of a paid claim with the purpose of changing one or more fields. An adjustment has two components: the credit transaction (previously paid claim), and the debit transaction (adjusted claim).

Voids

The status *VOID* refers to a claim submitted with the purpose of canceling a previously paid claim. A void lists the credit transaction (previously paid claim) only.

Pending Claims

Claims that require further review or recycling will be identified by the *PEND* status. The following are examples of circumstances that commonly cause claims to be pended:

- New York State Medical Review required.
- Procedure requires manual pricing.
- No match found in the Medicaid files for certain information submitted on the claim, for example: Member ID, Prior Approval. These claims are recycled for a period of time during which the Medicaid files may be updated to match the information on the claim.

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

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

A new pend is signified by two asterisks (**). A previously pended claim is signified by one asterisk (*).

Errors

For claims with a DENY or PEND status, this column indicates the NYS Medicaid edit (error) number(s) that caused the claim to deny or pend. Up to twenty-five (25) edit codes, including approved edits, may be listed for each claim. Edit code definitions are listed at the end of the claim detail section.

3.5.11.3   Subtotals/Totals/Grand Totals

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

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

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

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

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

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

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

Grand Totals for the entire provider remittance advice, which include all the provider's service classifications, appear on a separate page following the page containing the *totals by provider type and member ID (See definition above)*. The grand total is broken down by:

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

Net total paid (entire remittance)

3.6 Section Four – Financial Transactions and Accounts Receivable

This section has two subsections:

- Financial Transactions
- Accounts Receivable

3.6.1 Financial Transactions

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

Exhibit 3.6.1-1

```
                                                              PAGE    07
                                                              DATE    05/31/10
                    MEDICAID                                   CYCLE   1710
                    MANAGEMENT
                    INFORMATION SYSTEM
TO:  JAMES STRONG, M.D.     MEDICAL ASSISTANCE (TITLE XIX) PROGRAM      ETIN:
     100 BROADWAY                 REMITTANCE STATEMENT                  FINANCIAL TRANSACTIONS
     ANYTOWN, NEW YORK 11111                                           PROV ID:  00112233/1123456789
                                                                       REMITTANCE NO: 07080600006


                              FINANCIAL                FISCAL
                  FCN         REASON CODE             TRANS TYPE           DATE      AMOUNT
          201005060236547        XXX      RECOUPMENT REASON DESCRIPTION  05  09  10   $$.$$


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

3.6.1.1 Explanation of Financial Transactions Columns

FCN

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

Financial Reason Code

This code identifies the reason for the recoupment.

Financial Transaction Type

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

Date

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

Amount

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

3.6.1.2 Explanation of Totals Section

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

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

3.6.2Accounts Receivable

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

Exhibit 3.6.2-1

```
                                                           PAGE    08
                                                           DATE    05/31/10
                   M EDICAID                               CYCLE   1710

 TO:  JAMES STRONG, M.D.                                   ETIN:
      100 BROADWAY              MANAGEMENT                  ACCOUNTS RECEIVABLE
      ANYTOWN, NEW YORK 11111   INFORMATION SYSTEM         PROV ID:  00112233/1123456789
                               MEDICAL ASSISTANCE (TITLE XIX) PROGRAM   REMITTANCE NO:  07080600006
                                  REMITTANCE STATEMENT


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


    TOTAL AMOUNT DUE THE STATE  $XXX.XX
```

3.6.2.1Explanation of Accounts Receivable Columns

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

Reason Code Description

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

Original Balance

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

Current Balance

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

Recoupment % Amount

The deduction (recoupment) scheduled for each cycle.

Total Amount Due the State

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

3.7 Section Five – Edit (Error) Description

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

Exhibit 3.7-1

```
                    ┌─┐
                    │M│EDICAID          PAGE    06
                    └─┘                 DATE    05/31/10
                    MANAGEMENT          CYCLE   1710
                    INFORMATION SYSTEM
         MEDICAL ASSISTANCE (TITLE XIX) PROGRAM    ETIN:
                  REMITTANCE STATEMENT              PRACTITIONER
TO: JAMES STRONG, M.D.                              EDIT DESCRIPTIONS
    100 BROADWAY                                    PROV ID: 00112233/1123456789
    ANYTOWN, NEW YORK 11111                         REMITTANCE NO: 07080600006


THE FOLLOWING IS A DESCRIPTION OF THE EDIT REASON CODES THAT APPEAR ON THE CLAIMS FOR THIS REMITTANCE:
    00131    PROVIDER NOT APPROVED FOR SERVICE
    00142    SERVICE CODE NOT EQUAL TO PA
    00162    RECIPIENT INELIGIBLE ON DATE OF SERVICE
    00244    PA NOT ON OR REMOVED FROM FILE
```

REMITTANCE ADVICE

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

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

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