New York State Medicaid

eMedNY Known Issues Resolved
Prior to Six Months from Last Update

This document will be posted on eMedNY HIPAA Support and will be updated as resolved issues age past six months. The list is arranged from oldest to newest. Important Announcements, New eMedNY Issues and Active eMedNY Issues are here. If you have questions about the information in this document, please consult with your technical staff or email us at emednyhipaasupport@csc.com.

Closed eMedNY Issues

- ✓ PEND file format problems –
  some receivers have not been able to process the Supplemental-820/835 files due to the file format. This file is currently sent as an 80-character blocked, with CR/LF. The actual record size is 526 characters, but the unexpected CR/LF characters are making the file hard to process. CSC is working on implementing a fix to remove the blocking and use a record terminator. We expect this change to be implemented for the check run dated May 9th. Update 5/13/05 – This change will be effective with payment cycle 1447 (check date 5/16/05), Supplemental files will be no longer blocked into 80 character fixed records. The supplemental records will be sent as a continuous data stream and will be terminated with a tilde "~".
- ✓ Update 7/20/05 – Edit 00938 failures on DME/eye care services:
  When submitting claims for repairs or replacements for DME/eye care services and an order is not required, enter AB000099 in the Ordering/Referring Provider Identification Number and enter a Profession Code. For example, the Profession Code for Optometrist is 056. In this case, the REF should look as follows: REF*0B*056AB000099~

- ✓ Update 7/20/05 – Fixed CLP01 for Pharmacy Claims:
  A change was implemented on 7/14/05, which will now allow CSC to send the 7-digit RX #. Please note that pharmacy claims processed before 7/14 might not contain the full 7-digit RX # in CLP01 of the 835.

- ✓ Update 7/14/05 – Grouping and Pricing Issue for PAS claims:
  Products of Ambulatory Surgery (PAS) claims: PAS claims involving multiple dates of service should be submitted as individual claims for each date of service rather than one claim with multiple lines for each date of service. This recommendation is due to the process involved in PAS grouping and pricing. The grouping process uses the HCPCS reported on each line. If the HCPCS PAS surgery code changes from line to another, it will change the grouping for the entire claim.

- ✓ Update 7/6/05 – Edit 01154 UT Services not Ordered:
  Some providers were getting their claims pended for Edit 1154 (UT Services Not Ordered) even though their services were exempt from UT. This problem was caused by an incorrect

derivation of category of service and specialty codes. Improvements have been made to the derivation logic, and many of these pended claims paid over the 4th of July weekend.

- ✓ Update 7/6/05 – U277 with A3/41 and later A7|96:
  837P, Professional Claims - Currently in Phase II, the Supervising or Rendering Provider (when the Supervising is not present) is now considered the Billing Provider, which in turn requires that their Medicaid ID have an association with the submitted ETIN. If the Submitter prefers that the Provider rendering the service not replace the Billing Provider, then the intended Medicaid Provider ID to be considered as the Billing ID would need to be included as the Supervising Provider Medicaid ID, and this would supersede the Rendering Provider's Medicaid ID for that claim.
- ✓ Update 7/6/05 – Invalid File Format Message:
  In addition to common errors where the message format does not match the format selected from the submission menu, eMedNY also sends an Invalid File Format message when an X12 file/transaction contains an invalid character. The most common occurrence of this is caused by the Grave, or Accent Acute character, which is the character under the Tilde on most keyboards.
  Solution: please check your transaction to ensure it complies with the specific format and no invalid characters are used
- ✓ Update 6/27/05 – Edit 00127 fix:
  Claims were pending, and eventually denying, due to error in coding of Edit 127.
  A fix was implemented on 6/22 to resolve this problem, and the claims were reprocessed.
- ✓ Update 6/27/05 – 4th of July Processing Schedule:
  There will be no interruption due to the Holiday. The eMedNY system processes on a 24x7 schedule. If you have any questions about cycle dates, please refer to the CYCLE PROCESSING CALENDAR.
- ✓ Update 6/20/05 – Transition Plan ends today:
  Please make sure all of your members are aware that the Legacy MMIS system, which accepts claims under the Transition Plan, will be shut down at 6:00 p.m. on today, June 20, 2005. After this time, all electronic claims must be sent directly to eMedNY for processing using a supported method, such as eMedNY eXchange, ePACES, File Transfer Protocol (FTP), or eMedNY Electronic Gateway.
- ✓ Update 6/20/05 – Understanding Date of Service's use for Phase 2 -
  In the Legacy processing system, certain providers were able to submit multiple lines and receive line level payments for each date of service as entered on each line. This capability exists in Phase 2, but the dates returned on the Remittance Advice are based on the type of document, as per the bullets below which also explain where to enter the dates in the claim. In Phase 2, claims are processed at the Document level and, therefore, the Date of Service that is returned on the 835 or the paper remittance is the date of service sent in at the Document level. If the date of service happens to be a date span, then the 835 will contain that date span. The Date of Service assigned to the Document is determined as follows;
  - o Institutional 837s - the date or date range in the 2300 DTP segment, qualified by the value '434' in DTP01, except 837I Ordered Amb and Lab claims, which will be processed as 837P
  - o Dental 837s - the date in the 2300 DTP segment, qualified by the value '472' in DTP01
  - o Professional 837s - the 2400 DTP segment, qualified by the value '472' in the DTP01, that is located within the first service line (2400 level) for that claim (2300 loop). Ordered Amb and Lab claims submitted as 837I will also follow this rule

Note: For the paper remittance, only the beginning date of service is returned, even if a date span was entered. The date of service from the line is not returned.

- ✓ Update 6/20/05 – Fix to accept LTR in CAS*PR*2 - The MIA segment must contain all the days covered by Medicare Part-A. The total MIA days will include the sum of all full Part-A days, Coinsurance Days and LTR days. The QTY segment will contain those days that Medicare covered as Coinsurance Days and/or LTR days using qualifiers CD for Coinsurance and LA for LTR days. The Coinsurance amount is contained in the CAS as Group Code PR with Reason code 2. The LTR amount is not required and should not be reported, but if it is reported in the CAS as Group Code PR and Reason Code 2, the system will accept the entry and the claim will not be denied.
  The correct LTR payment will be calculated using the number of days entered in the QTY with qualifier LA and the LTR amount in the CAS will not be used.
- ✓ Update 6/13/05 - ePACES Claim search: The search criteria used for a claim status request is Provider ID, Recipient ID and the Date of Service. Although ePACES includes the amount charged as an enterable for the search, the amount is not used by the system when searching for a claim.
- ✓ Update 5/13/05 – If you are still missing remittances, please email eMedNYProviderServices@csc.com. Please include the ETIN, Provider ID(s), User ID, and the cycle(s) you are missing in the email.
  Update 6/13/05 – CSC will be implementing a new process to allow the recreation of remittance from previous cycles. This process should be implemented by the end of June. The process will allow CSC to produce remittances, which failed to be delivered post implementation of the Phase 2 system. In the future, this functionality will be available for providers to request recreation of remittances for a nominal fee.
  Update 6/27/05: Here is the link to the form that needs to be filled out: Copy Of Remit Request and Consent Form
- ✓ Update 6/13/05 - Clarification on the files/transactions we send for Batch File Processing:
  When you send a file to CSC, the first response file you will receive is the “F” file. This is a human-readable format file, which serves as a confirm receipt of your transmission. This response is sent immediately after we receive the transmission.

  The next response we send is the “R” file, which is mostly a 997-transaction for X12 submission. Sometimes a 997 response will be sent within a few minutes, while, in other cases, it may take several hours. Providers can expect a 997 response within 48 hours after we receive the transmission. The 997 might be accompanied by a U277 in the same “R” file, only if there are front-end errors detected. For a list of the errors that might be reported in the U277 and their description, we have provided a document on the site, in the CSC News folder, called 277 Status Code Explanation.

  Eventually we send the remittance Advice (835/820, depending on the type of provider). As of cycle 1451, the electronic remittances will be sent on Monday after each cycle.

- ✓ Effective June 20, 2005 the Transition Plan ends:
  Providers will be required to send their claims directly to eMedNY for processing.
  Changes have been made to eMedNY to assist providers in this transition including the support for ordered ambulatory services on an 837I transaction, and support for two-digit license type codes and two-digit locator codes.
  Many providers are still sending their claims to MMIS. Please encourage your members to make the transition to eMedNY as soon as possible.

The June 20th deadline will not be extended.
A new notice on 10/11/2005 supersedes this notice.

- ✓ Update 6/07/05 – 835s and PENDS for cycle 1450 are being sent out today:
  Starting with cycle 1451 we will start sending the 835s and PENDS on Mondays, unless otherwise notified.
- ✓ Update 6/07/05 – A change is being implemented today to allow the Providers to send the Other Payer Paid Amount and adjustments at either the Claim level or the Line level on 837s. This is a return to the logic that was used in place for Phase I. Up until now, the providers could receive a 277 status of '153' when not sending in the SVD amount (Line level). Starting Wednesday, they should only get this status if they are submitting Line level Other Payer information and the 2430 SVD-01 does not mach back to the 2320 NM1-09 Other Payer ID.
- ✓ Update 6/02/05 – Document level processing in Phase 2 – on the PEND file, there are lines showing without an Edit. This is normal. The reason this is happening is because we are adjudicating at the claim level. The entire claim is pended if a line item is pended.
  Denied line items are different. If a line item is denied, that line will be reported with a CAS Segment on the 835, and the claim will be fully adjudicated.
- ✓ Update 5/31/05 – as previously announced, Phase 1 formatted claims can now be submitted to eMedNY. This change is already in place. Submitters can send 2-digit Locator Code and 2-digit License Types to eMedNY. CSC will convert those values to the appropriate values for Phase 2.
  However, the change to allow 8-digit PA number entries, when an 11-digit PA had been assigned, was not put in. If assigned an 11-digit PA, it must be sent in the claim as assigned. CSC expects to implement the change by 6/20 to allow sending the last 8 digits of an 11-digit assigned PA #.
  Please note that if the assigned PA # is only 8 digits it can be sent in as assigned.
  Update 6/20/05 – CSC has implemented the change to accept the last 8 digits of the assigned 11-digit PA.
  A new notice on 10/11/2005 supersedes this notice.
- ✓ Update 5/25/05 – Files being archived from the users eXchange and FTP accounts before being downloaded. Please download the files when you open them. Files are archived after they are open and become inaccessible to the users.
- ✓ Update 5/17/05 - 835 Patient Responsibility balancing corrected.
  A fix has been implemented for cycle 1447 to balance the Patient Responsibility field (CLP05) with the Patient Responsibility adjustments (CAS*PR*).
  Update 6/7/05 – Please note that CSC will not be recreating 835s to balance the Patient Responsibility. The transactions are corrected going forward from cycle 1447.
- ✓ Update 5/13/05 – Cost outlier claims, which were inappropriately denied during cycle 1441 for Edit 00795, were reprocessed by CSC in cycle 1446.
  Update 5/17/05 – The majority of claims impacted by this issue did not get into cycle 1446. Instead, they will be included in cycle 1447.
- ✓ Update: 5/13/05 – Multi-Lines Rate-Based Claims (original):
  Prior to March 24, 2005, rate-based claims could bill multiple dates of services on a single claim. In eMedNY Phase II these same claims require each date of service to be billed on a separate claim. Currently claims for each day need to be billed separately.
  Update 5/25/05 – Please refer to Section 20 of the 837I Supplemental Companion Guide for a list of claim types that can bill with multiple service dates.
  Also note; from and through dates can't span from one month to another. A separate claim must be submitted for each month. The date in the service line must fall within the date range at

the claim level.
Update 6/27/05 – CSC implemented a fix on of 6/19/05 to allow Clinic claims to be billed with multiple lines for different Dates of Service for the same Rate Code. As a result, the 837I Supplemental CG, Section 20, was updated to list Clinic claims as one of the types. Providers can enter a date range at the claim level and different dates on each line, which must fall within the date range. Different Rate Codes must start a different claim.
Providers will need to submit claim adjustments to get the claim reprocessed. Keep in mind the entire document needs to be resubmitted. Any lines not included in the resubmission will be voided, if previously paid.

- ✓ Update 5/13/05 – Currently paper remits do not show co-pay.
  This will be corrected in cycle 1447.
  Update 5/17/05 – There are no current plans to show co-pay on the paper remittances.
- ✓ Update 5/13/05 – Currently paper remits and PEND files are showing edits that are paid. This is confusing, and will be corrected in cycle 1447.
- ✓ Update 5/13/05 – Some providers are currently sending character * or ~ within data elements of inbound transactions, which is causing problems for eMedNY in creating outbound transactions, as those characters are being used as data element separators and segment terminators. Those characters within data elements cause corruption to the outbound electronic response transactions such as 835 remittance advices. Please refer to the ISA and GS FAQ (ISA and GS Segments – Phase II) on nyhipaadesk.com for expected delimiters.
  Update 5/25/05 – Effective cycle 1449, if these invalid characters are received, they will be replaced with a space on the 835 or 820 transaction.
- ✓ Update 5/13/05: Edit 000234 - Claims for sterilization procedures are denying with a Reason Code 16 and a Remark Code N3 "Missing consent indicator." The logic that existed in legacy to bypass this Edit has not been implemented in Phase 2. No ETA for the fix at this point. This announcement will be updated when the claims can be resubmitted.
  Update 5/25/05 – As of cycle 1447 this edit has been turned off until this has been updated.
- ✓ Update 5/13/05 – Beginning with payment cycle 1447 (check date 5/16/05), the file names for the electronic remittances will be changed to include the eMedNY payment cycle number, X12 transaction type or supplemental file type.
  Update 5/31/05 – As of cycle 1448 the file names have been changed to include the date and time stamp, in addition to the cycle number. This was done to resolve a sequencing problem that existed when there were more than 99 generations created for the same receiver in the same cycle. The new names will appear as follows: R050524220539.1448.835-.00.x12 (for the 835), or R050524221107.1448.835S.00.TXT (for the 835 Supplemental).
- ✓ Update 4/28/05 – A few providers who had pended claims at the time of the conversion to eMedNY Phase II had these claims denied by Edit 00050 – Prior Approval Number Invalid. The conversion program erroneously inserted an “X” in the last digit of the PA number on the claim.
  Resolution - The PA numbers were corrected on these claims, and they will be automatically re-submitted in cycle 1446.
  Update 5/13/05 – These claims will be re-submitted in cycle 1447.
- ✓ Update 4/28/05 – An issue has been identified with the handling of the “procedure code modifier” table, which caused the proper rate adjustments not to occur. Since these adjustments typically lower the Medicaid payments, some providers received overpayments.
  Resolution – This problem has been fixed. Recoupment will be scheduled in a future cycle.
  Update 5/17/05 - These claims will be re-submitted in cycle 1447.

- ✓ Update 7/29/05 – MEVS Transactions - Problem receiving Service Authorizations:
  Many providers are not entering the correct service type and therefore are not getting the correct Service Authorization for the type of claim submitted.
  Section 13.2 Taxonomy and Service Type Codes (Rev 7/04) states: To ensure correct Utilization Threshold Process use the appropriate Taxonomy Code/Service Type Code Combinations. Clinic providers must enter a Taxonomy Code or a Service Type Code or both on a Service Authorization transaction. For more information please visit www.emedny.org; click on the "nyhipaadesk" tab; then select "eMedNY Companion Guides and Sample Files" and finally "270-278 Taxonomy CG".

- ✓ Update 7/29/05 – Coinsurance Reporting at both the claim and line levels error:
  Please Note - prior payer adjustments for any single Claim Adjustment Reason Code should only be reported at either the claim or line level, not repeated at both. Some trading partners are currently reporting this at both levels, which cause adjudication problems.
- ✓ Update 7/29/05 – Claims denying for missing Procedure Code:
  CSC has implemented a fix to look at all the lines in the claim, not just the first line.
- ✓ Update 7/29/05 – 835-Remittances out of Balance:
  An error was identified with the retro during cycles 1455 - 1457. The adjustment amount was being reported at both the claim (CLP Segment) and the PLB (Provider Adjustment) levels, causing an out of balance situation.
  The fix has been implemented for cycle 1458. Providers wishing to have the 835s recreated may call Provider Services at (800) 343-9000.
- ✓ Update 5/13/05 – Rate code 2610 used by Home Health does not require Prior Approval (PA) was improperly assigned a category of service for Personal Care, which does require prior approvals. This was causing claims with the 2610 rate code to incorrectly fail for lack of a PA. This problem has been corrected, and the claims can be re-submitted.
  Update 5/17/05 – Actually, the correction didn't work, so we are still working on this issue. Please check this notice periodically.
  Update 7/29/05 – A correction to the processing was made on 5/24/05 to properly assign category of service for Personal Care. Claims were resubmitted in Cycle 1452.
- ✓ Update 8/19/05 – Edit 00071 for Referred Am – Paper Claims:
  The Billing Manual states the Place of Service field should be left blank, but up until 8/2/05 these claims are denying in Phase 2. A fix was implemented to ignore the absence of the Place of Service Code.
  Claims submitted before 8/2/05 will need to be resubmitted by the provider.
- ✓ Update 8/19/05 – Please Don't Duplicate COB Data at Both Claim and Line Levels:
  For COB claims, NY Medicaid handles in the following manner depending on the on the transaction type:
- ✓ 837 Institutional: If there is COB data at the claim level, Medicaid pays according to that data. If the COB data is at the line level, Medicaid adds up the data from the lines and will pay according to that summed information. If the COB data is on both the claim and line level, Medicaid will pay according to the line level COB data by adding the line level data as described above.
- ✓ 837 Professional and Dental: Medicaid will process COB according to the data entered on the line. If the COB data is at the claim level, Medicaid will allocate to the line. If there is Claim level COB and no line COB present, Medicaid will create the line COB and assume a full payment (submitted charge), zero coinsurance and deductible. If there is no line COB,

Medicaid will create the line level COB by allocating the claim level COB data.

Please be aware that COB data should not be duplicated at both the Claim and Line level, as this will produce undesired results.

- ✓ Update 8/19/05 – Some Personal Care Agency Claims Pending on Edit 00244 and eventually denying for 00254:
  Beginning on 8/1/05 some new PA assigned numbers have begun to overlap with old PAs assigned at Legacy for Personal Care Agency claims. These claims are going into pend status. Eventually these claims deny for Edit 254. CSC has implemented a fix and will be reprocessing these claims for cycle 1462.

- ✓ Update 8/09/05 – NAMI and Spend down Deductions Error:
  A problem has been reported in which NAMI or Spend down deductions (AMT*F5 in loop 2300 of the 837) are being applied to multiple claims for the same patient, when the claims are all reported in the same transaction, resulting in lower payments. This issue does not exist if the provider happens to send the claims in separate transactions.
  CSC implemented a front-end fix on 8/3/05, at 6 PM. Claims submitted after that date will pay correctly, but claims processed previous to 8/3/05 should be voided and resubmitted.

- ✓ Update 8/9/05 – Edit 00170 for some Clinic Claims
  On 7/19/05 the Department decided to turn edit 00170 on to check the validity of ICD 9 procedure codes reported in the 2300 loop HI segment with qualifier BR on Clinic claims. The only Clinic claims requiring this entry are PAS Clinics billing for a date of service prior to 2/1/04. Therefore if a non-PAS Clinic claim is submitted there should be no entry for this loop/segment. If an entry was made, the code was being checked for validity.
  Edit 00170 was turned off as of 8/5/05.
  Update 8/19/05 – CSC will be reprocessing previously denied claims for cycle 1462.

- ✓ Update 8/09/05 – Some Clinic Claims Bypassing Dupe logic – Edit 00705:
  CSC has identified a problem with the duplicate claim logic, as it pertains to Clinic claims. When a Clinic claim is submitted with multiple dates of service, the entire service period is stored in history. Apparently subsequent Clinic claims with service dates that represent a subset of the history service period are inappropriately bypassing the dupe Edit.
  DOH is assessing the possibility of a special input to reprocess the failed claims. Please check this notice periodically for updates.
  Update 8/19/05 – CSC will be voiding duplicate claims during cycle 1463. Providers will need to resubmit the second claim correctly, with no overlapping dates.

- ✓ Update 8/09/05 – Edit 00903 for Transportation Claims:
  This Edit is caused due to an incorrect Category of Service (COS) derivation. The COS derivation is based on the procedure code. Due to the Procedure Code being valid for numerous COS, the system is not making the correct derivation and is therefore requiring Referring Provider information on a claim, when it is not required. Providers that bill for these services will be denied unless they enter Referring Provider information, even though it is not required.

- ✓ Update 7/29/05 – Reprocessing inbound transactions to create missing 997s:
  CSC has identified a reason why some 997s have not been delivered to the trading partners. It is occurring when the front-end process cancels which is resulting in some 997s not being created. In order to produce the missing 997s, the batch of transactions in the failed jobs need to be reprocessed by CSC. These jobs, on an average, process 15 to 25 files (a batch) from different providers at one time.
  Please note that the reprocessing may result in duplicate claims, since entire batches are reprocessed.

CSC is assessing a better method for determining the specific batches/files that need to be reprocessed.

- ✓ Update 7/29/05 – 835 missing NM109 in loop 2100:
  CSC is currently assessing a fix to prevent 835 to be created with noncompliant NM1 Segments.
  Update 8/19/05 - A fix is being implemented during cycle 1462 to prevent blank NM109 elements.

- ✓ Update 7/20/05 – Edit 00547 using Contingency Plan:
  During the Contingency Plan (March 25 – June 20), the system was incorrectly converting the Emergency Indicator from a "1" to a "Y". This was causing claims sent to MMIS for patients with Emergency Service Only eligibility to be denied. We are planning to reprocess these claims at a future date. Please check this notice periodically for updates.
  Update 8/19/05 – CSC reprocessed affected claims during cycle 1457.

- ✓ Update 7/14/05 – ISA06 and GS02 Equals UNKNOWN:
  CSC has initiated the assessment to correct this problem. At this time no ETA for implementation is available.
  Update 7/29/05 – The correction is currently being tested to provide our correct Sender ID in GS02 and ISA06 of our outbound transactions. This change will be implemented on or before 8/19/05.

- ✓ Update 8/26/05 – Balancing Remittances to the Check Amount:
  Due to retros, some providers are under the belief that the remittance does not equal the check issued. To resolve this, the provider can add up the remittance amounts to arrive at a total dollar amount paid (This can be done by adding up the sub totals associated with each claim type - inpatient, clinic, lab etc.) After arriving at the total dollar amount paid, they should subtract the negative retro amount from the total. That balance will equal the total amount paid as reflected on the remittance.
  To arrive at the amount of the check, the provider should use the total amount paid on the remittance and add to it the amount of the negative retro. This figure is the real total paid claim amount. The recovery process for a negative retro is normally 15% of that amount, but the percentage may be different for some providers. Therefore, 15% of the total paid amount (or the amount of the negative retro, whichever is lower) is subtracted from that the total paid amount and that balance equals the check amount. If the negative retro cannot be recouped in a single payment, it will continue to be deducted from future checks until the entire amount is recouped. The amount of each deduction is reflected on the remittance statements.

- ✓ Update 8/09/05 – 835 Adjustments Containing CLP01 = NOT PROVIDED:
  CLP01 is supposed to return the value received from the claim, for example the contents from CLM01, but providers are receiving the literal NOT PROVIDED in this field.
  Update 8/26/05 – Analysis shows this is happening on retro claims that were converted from legacy to Phase 2, in which case the Patient Account # from the claim was not carried over to Phase 2. There are no plans to convert the Patient Account Number from the legacy system.

- ✓ Update 9/13/05 – Edit 01724 – Line Date of Service (DOS) Outside From/Thru Dates:
  Edit 01724 was turned on 9/1/05 to correct a duplicate payment issue. As a result, some claims, where the service date was not within the from/thru date range at the claim level, were pended. The problem primarily impacted Personal Care and Home Health claims. The Edit was turned back off on 9/12/05, and CSC has reprocessed claims pended by the edit. Any claims denied by Edit 01724 must be resubmitted as the State is prohibited from altering such claims. Edit 01724 will be turned back on 9/19/05. At that time submitters will need to ensure

the DOS at the line level is within the date range at the claim level, and that the date range contains a “from” and a “thru” date when billing for multiple dates of service.

- ✓ Update 9/6/05 – Problems identifying retros:
  Some receivers of 835s have reported problems recognizing retros included within the 835 transactions, especially because the CAS*CO*A2 is not present on retros when the corrected paid amount is equal to the original charged amount.
  CSC has initiated a project to resolve this issue in the future. A PER Segment will be sent within the retro claim payments to indicate the reason for the retro adjustment. The ETA for this fix is the middle of December, and the Companion Guide will be published before to allow programming time.
  In the mean time, some receivers of the 835 are sorting the remittances using the value in CLP07. For retros, CLP07 will contain the same TCN for both the reversal and the correction. Another value of importance is CLP02, which for the reversal will contain the Claim Status Code of 22.

- ✓ Update 9/6/05 – Edit 00791 (DRG equals 470 - grouper unable to determine a valid DRG):
  This occurs when invalid information is encountered on a DRG claim. When the grouper encounters invalid information it causes the grouper to assign DRG 470, which in turn triggers edit 791. One example of invalid information is a discharge status code that is not recognized in the grouper (one exception to this is status code 65, for which CSC had a problem, which was recently corrected. These claims can be resubmitted without correction required.) Another example of invalid information is the admission date occurred prior to the birth date of the patient. Providers need to correct the information and resubmit.

- ✓ Update 9/29/05 – Recreating Electronic Remittances (835) Over 4 Weeks Old:
  CSC is not able to recreate 835s older than 4 weeks/cycles. The financial data is archived after 4 weeks, which makes it nearly impossible to recreate the 835. Trading partners are encouraged to download the 835s, the 835 Supplemental, and any other response files deposited in their mailbox, in a timely manner to avoid this issue. Remittance information older than 4 cycles is available in paper format for a nominal fee, and can be obtained by calling 1-800-343-9000.

- ✓ Update 9/16/05 – Incorrect Home Health Adjustments (Paper Claims) :
  (This supersedes Update 8/26 – incorrect Home Health Adjustments:)
  In cycle 1461 (Check date 8/22/05) Home Health claims were internally resubmitted as Adjustments to correct the number of paid units in History. Some Home Health providers have claims that adjusted improperly and are now paid as a single unit rather than the multiple units originally paid. This caused check amounts to be lower than normal.
  DOH is assessing if the incorrect adjustments performed during cycle 1461 can be corrected. Providers are free to resubmit the affected claims as adjustments to correct the payments, or they can wait for future updates to this notice to see if the claims will be reprocessed.

  To submit the adjustment, the claim must be sent in the usual manner (CLM05-3 = 7 and REF*F8*”the original TCN”) with the correct number of units on each line for the dates of service being claimed.

  For paper UB 92 submissions, the first line must contain Revenue Code 0001 and the total claim charge-amount. Subsequent lines must contain a different Revenue Code, not 0001, with the Date of Service and the Number of Units being billed. The adjustment indicator is the number 7 in the 3rd position in field 4 (type of bill) and the TCN in field 37.

There are many claims where the adjustment paid the same amount as the original claim. This is a correct adjustment and nothing has to be done to those claims.

- ✓ Update 8/19/05 – Claims being bypassed and dropped:
  CSC is investigating a potential front-end issue causing some claims not to process. Initial analysis shows this is happening when the claim contains an invalid date of birth. The 997 is returned to the sender specifying the transaction was accepted with errors, but the claims with the invalid dates are dropped and never processed nor reported on the remittance.
  Update 9/29/05 – A change was implemented during cycle 1462 to populate the invalid date of birth with a default date. This change has resolved the issue of the claim being dropped. The claim now appears in the remittance as denied per Edit 00027 – Date of Birth Invalid.

Issues Resolved as of 10/21/2005

- ✓ Update 10/11/05 – Non-Inpatient Claims COB Issue:
  For non-Inpatient claims where the prior payer's adjudication information is reported at the line level, we are adding the paid-amount to the deductible-amount and/or Co-insurance-amount and coming up with the prior payer's allowed-amount. We are then subtracting the allowed-amount from the rate on file... In many instances, the payment is resulting in zeroes. This is not the right process. For non-Inpatient claims, only the paid-amount should be subtracted from the rate on file, and the claim should be adjudicated based on the difference. A fix was implemented on 10/5/05 to correct this problem. Providers can resubmit those claims as adjustments.
- ✓ Update 9/6/05 – Edit 00710 – for DME:
  CSC has identified a programming problem when processing DME claims. The frequency time frame is not being calculated correctly and, therefore, the claims are denying with Edit 00710 even when the claim is valid. CSC is working on a fix, which should be implemented in the near future.
  Please check this notice periodically for updates. We will let you know when the fix is implemented, at which time DOH will decide whether to reprocess the failed claims or ask the providers to resubmit.
  Update 10/11/05 – A fix was implemented on 10/06/2005. Providers will need to resubmit the affected claims.
- ✓ Update 8/26/05 – Emergency Room Claim Overpayment – Rate 2879:
  On Emergency Room claims, if the patient is admitted to the ER on a given day and is still a patient in the ER the following day and both days are reflected on the line level, the system will incorrectly generate a payment for two ER visits for the Rate Code.
  Update 10/11/05 – A fix was implemented on 09/08/2005 to correct the double payment. The affected claims will be reprocessed during cycle 1468.
- ✓ Update 8/09/05 – Edit 00180 for DME Claims:
  This Edit is caused due to the DME Procedure Codes being set to a unit maximum of one. If the claim is for a number of units greater than one, the edit is failed. In Legacy, a Prior Approval would allow the Edit to be bypassed. In Phase II, this is not the case. Therefore DME claims are failing edit 180 even though PA was received for the claim.
  Update 10/11 – A fix was implemented on 09/22/2005. The affected claims can be voided or resubmitted as adjustments by the providers.
- ✓ Update 7/14/05 – 835 transactions reporting a Claim Adjustment Reason Code 16 (CARC) without a Remark Code (RC)?

This appears to be occurring with Edits 00254 (Service Code Not Equal To PA) and with Edit 01044 (Dates of Service Can Not Span Across Months). In both cases the Claim Adjustment Reason Code is 16 with no Remark Code.
Update 9/23/05 – Please refer to the recently updated MMIS Edit Mapping for 835 in the Order of edit number or MMIS Edit Mapping for 835 in the Order of Reason Code. You will find the only CARCs that are listed without the RC are two Edits (00225 and 00226), which have to do with Sterilization and Edit 00098, which is sent when the Locator Code is not valid. We are planning to implement Remark Code N259 (Missing/incomplete/invalid Billing Provider/Supplier Secondary Identifier) for Edit 00098. When this is implemented as suggested for Phase 2, the only time you will have a CARC 16 without a Remark Code will be for Sterilization. Please also note that there are many other CARCs besides 16 listed without a RM. However, in these cases the CARCs are self-explanatory.
Update 10/11/05 – Edit 00098 has been updated to report CARC 16 with Remark Code N259 when the Locator Code on the claim is invalid.

- ✓ Update 7/6/05 – PAS claims deriving wrong Specialty Code:
  Products of Ambulatory Surgery claims (PAS) do not require a Service Authorization. However, due to the current logic in the system, a non-exempt specialty code is being assigned.
  Update 10/11/05 – Please use the SA Exception Code 7 to bypass this issue.

Issues Resolved as of 11/02/2005

- ✓ Update 10/21/05 – eMedNY Test Facility:
  Please note that the eMedNY Testing Facility is still available for limited testing. Submitters can test inbound transactions for X12 and HIPAA compliance. In return, CSC will send back canned responses. Read the information provided in the User Guide at www.eMedNY.org for requirement information.
  UPDATE: 9/20/2011 eMedNY Testing Facility was discontinued in September 2008 in favor of the Provider Testing Environment (PTE). Information about the PTE can be obtained through the eMedNY Trading Partner Information Companion Guide.

Issues Resolved as of 11/14/2005

- ✓ Update 11/02/05 – SPC 901 For Claims Involving rate Codes 1627, 1628, 2888 and 2889:
  A problem was reported regarding claims submitted with these rate codes. The Specialty Code derived was 901 due to a system problem, and the claims hit Edit 01172 (Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan.) This is reported in the 835 with Claim Adjustment Reason Code 24.
  Update 11/02/05 – A fix was implemented on 10/24/05 to correct the derivation problem. Providers can resubmit the affected claims.

Issues Resolved as of 11/22/2005

- ✓ Update 6/20/05 – Series 1700 Edits on PEND files – 01700 Series Edits are showing in the PEND files even though the claims might have paid. CSC will be removing these Edits from the file, as they are internal Edits. In the mean time, please ignore the Series 1700 Edits.

Update 11/14/05 – CSC will not be removing these Edits from the PEND file. Providers just need to keep in mind that these Edits are not the reason why the claim was pended. Many of you already know these Edits are displayed when a multi-line claim has one or more lines that hit an Edit that causes a pend situation, the entire document/claim pends and, therefore, lines that hit internal Edits will be displayed.
One exception to the Series 1700 Edits is Edit 01724, which is set to deny and shows up in the 835 as Claim Adjustment Reason Code 16.

- ✓ Update 6/20/05 - Issue when submitting Ordered Lab and Ordered Am claims in the same 837I: Institutional Providers who are submitting Ordered Lab and Ordered Am cannot mix the claim types within a single document/invoice. Therefore claims for Ordered Lab procedures must be submitted on a separate claim from those procedures for ordered Ambulatory. The Legacy Phase 1 system allowed the mixing of procedures, but eMedNY Phase 2 does not.
  Update 6/27/05 – If submitted combined, the entire claim will not necessarily deny. The Procedure Code on the first line will establish the Category of Service. For example, if an Ordered Lab line comes in first, that COS might pay, but the Ordered Am lines will deny. Ordered Lab and Ordered Am claims can be submitted in the same transaction (ST-SE), but a different claim (CLM, 2300 loop) must be created for each type.
  Update 11/14/05 – after further research, it has been determined that nothing can be done to allow claims of different Category of Service to be submitted in the same document. Providers are asked to continue separating them.

Issues Resolved as of 12/02/2005

- ✓ Update 11/14/05 – Clinic Claims Inappropriately Paid Zero:
  Some Clinic claims processed between 10/27/05 and 11/10/05 were inappropriately paid a zero amount. This only impacted claims with procedure codes (HCPCS) 70000 thru 89999 (Lab tests and X-rays). Modifications have been made and Clinics impacted by this problem MUST rebill these claims as adjustments in order to get paid.
  RETROS: Any Clinic that had retros performed during cycles 1472 & 1473 could have claims that resulted in zero payment due to this issue. Those retro claims are being rerun in cycle 1474. No provider action is required for the zero retros.
  Update 11/22/05 – CSC will be reprocessing ALL affected claims, not just retro, during cycle 1475.

Issues Resolved as of 12/12/2005

- ✓ Update 12/02/05 – EFT Enrollment Form not Posted:
  CSC is already accepting enrollment requests for Electronic Funds Transfer (EFT) for provider payments. The December 2005 Medicaid Update contains an URL (http://www.emedny.org/info/ProviderEnrollment/index.html) but the form is not currently posted. However, it will be posted in the very near future. To enroll in EFT, providers must complete the EFT Provider Enrollment Form, which can be obtained via Fax on Demand (FOD) by calling (800) 370-5809 and following the prompts to order Document 3002, or simply click here to retrieve the document from NYHIPAADESK. Please allow a minimum of 6-8 weeks for processing your request.

- ✓ Update 11/22/05 – Edits 00240 and 00725 when voiding/adjusting claims:
  These Edits are preventing claims to be voided or adjusted. Claims over 2 years old hit Edit 00240 – Over Two Year Old Claim Held For Future Adjudication. Sometimes these claims hit Edit 00725 – No Matching History Record for Adjustment/Void. Void and adjustment claims should not be denied for these Edits. CSC is researching a solution.
  Update 12/02/05 – This issue was resolved during cycle 1475. Providers will need to resubmit the affected claims.
- ✓ Update 10/21/05 – Retro Issue for Hospice Providers:
  Hospice providers with paid claims for Nursing Home Room and Board are not receiving retro payments when the Nursing Home has a rate change. When a Hospice bills for the Nursing Home room and board, the payment is based on the rate file of the Nursing Home the recipient resides in. When that Nursing Home receives a retro payment due to a rate change, the Hospice should also receive a retro payment for that rate change. This is a system issue that was recently discovered and will be fixed in the near future.
  Update 12/02/05 – This issue was resolved during cycle 1475.

- ✓ Update 8/09/05 – Edit 00941 For Mental Health Clinics:
  Claims erroneously denying for Edit 00941 – Service Provider Excluded Prior to Service/Order Date. CSC is assessing a resolution.
  Update 12/02/05 – This issue was resolved back in September. Our apologies for the delay of this update.

Issues Resolved as of 12/22/2005

- ✓ Update 12/12/05 – Edit 01154 for Practitioner Claims:
  Professional claims (837P and paper) have been pending/denying due to Specialty Code derivation problems. A change was implemented on 12/8/05 that will cause a UT exempt Specialty Code to be derived when the provider enters the SA Exception Code 7 on the claim. For ANY claim that should be UT exempt, the provider MUST use the SA Exception Code 7 in order to ensure the correct specialty code is derived.
  Providers will need to resubmit the affected claims.

- ✓ Update 12/12/05 – Retroactive Rate Adjustment Detail on Electronic Remittances
  Effective Monday, December 19, 2005 (Cycle 1478) 820 and 835 Electronic Remittances and the 820 Supplementary File will provide more detailed information for NYS State submitted adjustments and voids and retroactive rate adjustments. The updated Companion Guides and sample files can be found at eMedNY Companion Guides and Sample Files.

- ✓ Update 7/29/05 – Passwords expiring on eXchange:
  When your password expires on ePACES, the system will walk you through a process to change it. However, if it has expired and you're attempting to log into eXchange, it does not give you the opportunity to change it. The page will simply reload and the login attempt will not succeed. If your login fails to work on eXchange and was working previously, you can attempt to login to ePACES to confirm if it has expired and if so change it. Passwords expire every 90 days.
  Update 12/12/05 – CSC will be implementing a change during cycle 1482 to allow the opportunity to change the password in eXchange.

Update 9/16/05 – Bad timing picking up files Issue:
An issue has been identified as to why some response files we distribute to the receivers are sometimes not received. We create a zip file for the receiver during the day. We keep adding other files to the zip-file as long as it is in the mailbox.
A file is archived from the mailbox when the receiver opens the file or downloads it. After the file has been opened, it gets archived 15 minutes or so later. Many times users are downloading the zip-file as we are writing to it, or we write to the zip-file in between the 15 minutes before it gets archived, causing data to never be received.
If the file is archived and we have more data for the receiver during that day, we create a new zip-file with a similar name (time stamp will be different). Receivers must be aware of this because this is not duplicate data. They should download it.
We are trying to resolve this issue, but in the mean time, we are asking receivers to download the next day. The files we create have the date in the name. Users can use the date to retrieve the previous day's files. This might be a cure for this problem until our developers are able to resolve the bad timing of the archive process.
Update 12/12/05 – A fix was implemented on 11/29/2005. Receivers no longer have to wait to pick up the next day.

Issues Resolved as of 01/11/2006

- ✓ Update 12/22/05 – 0FILL When the Pay-Amount is zero:
  Claims fail Edits 00131 (Commercial Payer) or 00152 (Medicare) if the actual pay-amount reported from the prior payer is zeroes. This is due to a problem in our system. Until further notice, these claims can be sent with 0FILL to bypass the Edits.

- ✓ Update 11/02/05 – 835 with Mismatched CARCs and Remark Codes:
  There is a problem with the 835 in which CSC is reporting Claim Adjustment Reason Codes (CARC) and Remark Codes combinations not found in the current Edit Mappings/Crosswalks. This is happening when a claim hits multiple edits and one of the edits translates to a CARC without a Remark Code, for example Edit 00705 which crosswalks to CARC 18 and no Remark Code. A Remark Code from subsequent Edit affecting the same claim is reported in the 835, and most of the times the combination of CARC and Remark Code does not crosswalk to any Edit in the Edit Mapping documents.
  DOH has initiated a project request for CSC to correct this problem ASAP.
  Update 11/14/05 – a fix will be implemented in January 2006. In the mean time, receivers of 835s are asked to ignore the Remark Code if the CARC is self-explanatory, like in the case of 18, 22, 24, etc.
  Update 12/22/05 – a fix was implemented during cycle 1479.

- ✓ Update 12/22/05 – Edit 00267 for Transportation Claims:
  Edit 00267 is currently set to pay, but it will be set to deny in late January. We are seeing a lot of claims that will fail this Edit due to inappropriate use of qualifiers and/or loops/segments. Please refer to the 837 Professional NON-EMERGENCY TRANSPORTATION Companion Guide PHASE II for instructions and make the necessary system changes to avoid denials when this Edit is turned on.

- ✓ Update 8/26/05 – Incorrect Payments to Designated Cerebral Palsy Clinics:
  Any facility that is designated as a Cerebral Palsy Clinic may have experienced incorrect payments on claims for services that were not Cerebral Palsy Clinic services, such as Home Health. In some cases, providers billing for multiple hours of Home Health services were only paid for one hour.
  This issue has been corrected as of 8/19/05; therefore the pricing logic used for CP Clinic

claims will now be applied to only CP Clinic claims and not other types of services.
Update 12/22/05 – No reprocessing scheduled for impacted claims. If you had claims impacted by this problem, you may resubmit the claims as adjustments for these services.

Issues Resolved as of 01/20/2006

- ✓ Update 7/29/05 – Passwords expiring on eXchange:
  When your password expires on ePACES, the system will walk you through a process to change it. However, if it has expired and you're attempting to log into eXchange, it does not give you the opportunity to change it. The page will simply reload and the login attempt will not succeed. If your login fails to work on eXchange and was working previously, you can attempt to login to ePACES to confirm if it has expired and if so change it. Passwords expire every 90 days.
  Update 12/12/05 – CSC will be implementing a change during cycle 1482 to allow the opportunity to change the password in eXchange.
  Update 01/11/05 – This change was implemented this week.

- ✓ Update 9/6/05 – Large Size Files Causing Problems:
  CSC is experiencing front-end processing problems due to large files being received from providers. This is occurring with several transaction types, such as 270, 276, 278 and 837.
  Update 12/12/05 – CSC will be enforcing limit restrictions. For example 837 transactions, CSC will accept no more than 5,000 claims in a ST-SE (hereafter known as Transaction), as recommended in the 837 Implementation Guides. Submitters can add multiple Transactions in a single GS-GE (hereafter known as a Group), and multiple Groups within an ISA-IEA (hereafter known as a File).
  When CSC receives a File, a message is returned to notify the submitter whether the File will be forwarded for additional processing or not. When the File contains Transactions above the threshold, this message will tell the submitter that the File has been rejected.

  Some submitters prefer to send one claim per Transaction and add them all in one Group. This is compliant, but it causes the physical File to become larger due to the extra header/trailer segments for each Transaction. Larger Files require more time to process, which increases the overall time required to return a response. Submitters should be aware of the following:

  - o Real-time processing has priority over batch. Due to the volume of real-time transactions during the day, batch processing is suspended until the evening hours. Smaller Files are typically processed quicker because of the file size.
  - o The larger the File, the longer it will take for CSC to return a response in the form of a Functional Acknowledgment (997) and, if applicable, the front-end edits in the U277. Therefore, submitters usually wait very long to know if the File or a Transaction should be resubmitted.
  - o Some large Files are not processed completely during one night and get suspended during the next day – waiting again. Submitters call the Help Desk trying to find out the status of their Transactions, but the Help Desk can't see them in the system until the entire File passes the front-end. Therefore, the submitter many times submits the large File again, which causes further delays for everyone.
  - o If submitted before the cycle cut off, typically Monday evening, a smaller File has a better chance to be included in the current cycle.

  Enforcement will be implemented during cycle 1481. This is a necessary change to improve performance and throughput.

Update 12/12/05 – This announcement has been rewritten to reduce technical terminologies. The recommendation to add no more than 10 Transactions in a Group has also been removed.
Update 01/11/06 – Please note: enforcement starts on 1/12/06.

- ✓ Update 9/16/05 – Non-emergency Transportation Claim Issue – Edit 00267:
  Due to current system issues processing non-emergency transportation claims, these claims are not required to contain the Driver's License and Vehicle License # at this time. However, a project will be implemented on 11/3/05 to correct this problem. Watch for an update to the Companion Guide in the next few days for details on how to provide this information after the project is implemented
  Those submitters that have implemented a workaround solution to get these claims to pay do not have to change their process prior to 11/3/2005.
  Please note that if the service requires Referring Provider information, loop 2310A still needs to be provided.
  Update 10/21/05 – Changes have been implemented to support the entry of Driver's License and Vehicle License Numbers by Non-Emergency Ambulette Transportation Providers (category of service 0602), as required by DOH. These providers are encouraged to follow the new billing requirements as soon as possible to avoid unnecessary delays/denials. A new Edit 00267 (Vehicle License Plate/Driver's License Number Required) will be implemented within the next few weeks.
  Update 01/11/06 – Please note: Edit 00267 was turned on during cycle 1481 for electronic claims.

- ✓ Update 7/20/05 – CLP02 = 1 and CAS*CO*23 – PART 1:

  CLP02 is sometimes incorrectly reporting Claim Status Code of 1 (Primary) and at the same time reporting Prior Payer information.
  Update 8/09 – this is occurring when a NAMI has been reported on the claim. Our 835 is inappropriately reporting back a CAS*CO*23, when it should report the NAMI as part of the CAS*PR Group.
  Update 8/26/05 – CSC implemented a fix during cycle 1462 to report the NAMI adjustments as part of the Patient Responsibility Group, CAS*PR*142. CLP02 will be 1, 2 or 3 depending on the number of prior payers involved.

Issues Resolved as of 01/27/2006

- ✓ Update 01/20/06 – PAC Grouping Issue:
  On 1/19/06 CSC discovered that PAC claims containing less than four lines were not always grouping properly. The erroneous grouping resulted in incorrect payments due to inappropriate Rate Code derivation.
  The issue was fixed immediately. Providers should identify any of their PAC claims that were not grouped properly and submit adjustments.
- ✓ Update 01/20/06 – Edit 00162 for GME Claims:
  Edit 00162 **(X12 Reason 30)** - Recipient Ineligible on Date of Service - was denying GME claims erroneously due to the system utilizing the wrong date as the Date of Service.
  The issue was quickly resolved on 01/19/2006. Providers should resubmit the affected claims.
- ✓ Update 01/20/06 – Edits 01143 and 01144 failing inappropriately:
  Edits 1143 **(X12 Reason 16|M49)** - Diagnosis does not indicate Alcohol Rehab - and 1144

(X12 Reason 16|M49) - Diagnosis does not indicate Drug Rehab - have been failing inappropriately. The issue was fixed on 12/28/05. Providers can resubmit the affected claims.

- ✓ Update 01/20/06 – Edits 01162 for Providers That Enroll for OMH and Medical/Clinical Services.
  Edit 01162 **(X12 Reason 16|M49)** - Invalid OMH SPC/Rate Code Combination - was denying medical providers claims billed with Rate Code 1610 because the system was deriving the wrong OMH specialty code.
  The issue was resolved on 01/19/2006. Providers can resubmit the affected claims.

- ✓ Update 01/11/06 – Claims Denying for Rate Codes 3836 and 3837:
  Nursing Home claims for the Special Assessment Add-on, Rate Codes 3836 and 3837, are failing edits 00705 or 00727 **(X12 Reason 18) -** duplicate or near duplicate - inappropriately when billed in conjunction with the new Part D rate codes.
  Update 01/20/06 – This particular issue may also have affected nursing home claims submitted with Part D rate codes. In situations where the Special Assessment Add-on claims were adjudicated first the subsequent Part D claims were failing the duplicate edits.
  The issue has already been resolved. Providers can resubmit affected claims.

- ✓ Update 6/20/05 - NYSED created two new profession codes, 72 and 73:
  72 (Licensed Master Social Worker) and 73 (Licensed Clinical Social Worker). New providers, as well as existing providers that were previously Profession Code 80 and renew, are being assigned the new Profession Codes. This change was implemented on 6/1/05, and we now have licenses on file with profession codes 072 and 073. Please advise providers that, if they previously billed with Profession Code 080 and their claims were denied, they should resubmit the claims now with the appropriate Profession Code 072 or 073.
  Please note: Profession Code 080 can't be cross-walked by eMedNY because of ambiguity. Therefore, these claims need to be submitted in Phase 2 format.
  Update 11/02/05 – Some OMH providers have reported that the CSC file is not in sync with the SED file. In going to the SED site, some providers' Licenses are found with a Profession Code of 73, but when sending claims to CSC with 073 for those specific providers, the claims get denied because the provider are still listed in CSC's file as 072 or 080.
  Update 01/11/06 – A full file feed was received from SED and loaded during cycle 1482. All records should now match SED's records. If you encounter any differences/problems, please create an ISSUE by clicking here.

Issues Resolved as of 02/23/2006

- ✓ Update 02/06/06 – Making it Easier to Deal With Denial Issues:
  Reminder: The 820 and 835 Supplementary Files will undergo a change effective February 20th, 2006 (cycle 1487). Upon implementation, each file will provide more detailed information for denied claims. Important changes will be made to the record format of these files. To review the updated Companion Guides (CG) and updated sample test files, please review the appropriate CG.
  Please make system changes now.

- ✓ Update 01/20/06 – COB Transactions Rejecting for Invalid CARCs:
  We have learned that some Coordination of Benefit (COB) transactions are being erroneously rejected at the front-end. The rejection occurs when a transaction contains a CAS Segment with a Claim Adjustment Reason Code (CARC) adopted for use after February 2004 (ex. 165 and 172.) Our translator flags the transaction as invalid, even though these CARCs are correct.
  We are expecting a resolution by cycle 1486. At that time, the affected claims may be

resubmitted. In the mean time, submitters can extract the affected claims from the transactions and resubmit the other claims that are not affected by this issue.
Update 02/06/06 – CSC implemented a fix during cycle 1484. Providers can resubmit the affected claims.

Issues Resolved as of 03/21/2006

- ✓ Update 03/09/06 – Duplicate claims during cycle 1489:
  A problem was encountered February 24, 2006 in claims processing. Some claim transmissions received at CSC on that date may have been processed twice, resulting in both a paid and duplicate claim denial **(X12 Reason 18)** on your remittance, as an error occurred within certain control programs. The decision was made to reprocess certain claim transmissions rather than potentially cause cash flow interruptions. We apologize for any inconvenience this might have caused you, and we hope this has not affected your cash flow.
- ✓ Update 03/09/06 – This announcement was distributed to all known Electronic Remittance receivers on 2/16/02 via email, but some have reported not getting it:
  Effective March 2, 2006 (cycle 1489), a change was implemented to improve the delivery of electronic remittances (835 and 820) files for FTP users. Currently we create zip files in the mailboxes with the following naming convention: P123456.D060215.zip (where P = Provider ID prefix, 123456 = the last 6 bytes of the Provider ID, D = Date prefix, 060215 = the date in which the file is created and zip = file extension). We will continue to create files, such as 997s, U277, etc., with this naming convention, but not for remittances.
  A new file naming convention is used for remittance files. The only difference is that instead of the "P" for the Provider ID prefix, we use an "R". The R123456.D060215.zip contains only remittance transactions.

  UPDATE 9/20/2011 If you are interested in information from CSC regarding news and updates, please sign up for the **eMedNY LISTSERV ®** to subscribe to the distribution list.

- ✓ Update 11/22/05 – Edit 00131 - OMH COPS Claims need 0FILL:
  OMH Clinic claims for COPS ONLY reimbursement (rate codes 4091 thru 4098) must have 0FILL indicated in the 2000B SBR04 when a recipient has other insurance. 0FILL is required to avoid Edit 00131 (X12 Reason 22) when collecting the COPS reimbursement from Medicaid. It is anticipated that Medicaid will have Other Insurance checking bypassed for the above rate codes.
  Update 01/27/06 – CSC will be implementing a fix during cycle 1494.
  Update: 03/09/06 – A change was implemented today, 3/09/2006. 0FILL is no longer required to bypass Edits 00131 and 00152 for these claims.

Issues Resolved as of 03/29/2006

- ✓ Update 11/22/05 – Psychiatric Reduction Reimbursement; CARC 122:
  Some providers have reported that CSC is not reimbursing them for Psychiatric Reductions they receive from Medicare. This is happening because currently CSC only reimburses for Patient Responsibility adjustments, which are CAS*PR*1 and 2, Deductible and Coinsurance, respectively. As a temporary solution, NYSDOH has suggested for providers to add the Medicare adjustments from Claim Adjustment Reason Code (CARC) 122 to the CAS*PR*2, when sending the COB claim to Medicaid.

CSC is working on a long-term solution to pay for CARC 122 independently of Coinsurance. Once implemented, this notice will be updated with new instructions for submitters to forward the adjustments as received from Medicare, instead of adding the amounts from CARC 122 to CAS*PR*2.
Update: 03/27/06 – A fix was implemented on 03/23/06 to recognize CAS*PR*122. Providers no longer have to add these adjustments to Coinsurance.
Please note that paper claim forms do not support these types of adjustments, so providers will still need to add the Psychiatric Reduction adjustments to the Coinsurance for paper claims.

Issues Resolved as of 05/12/2006

- ✓ Update 04/20/06 – Correcting CLP11 Codes on Outbound 835 Transactions:
  CSC implemented a fix to resolve a compliance issues in CLP11 – Diagnosis Related Group (DRG) Code – in the Electronic Remittance Advice (835) Transactions.
  Trading partners had previously reported invalid DRG Codes, which contained leading zeroes. The fix was implemented on 4/18/06.
- ✓ Update 01/11/06 – Edit 00129 for PAS Clinic Claims with DOS 2006:
  Up until 01/10/2006, PAS Clinic Claims with Rate Codes 3089, 3090, 1804 or 1805 and a Date of Service in 2006 failed Edit 00129 (X12 Reason 16|M49) - Rate Code Not on File - due to a system problem. On 01/10/06 we implemented a fix to allow these claims to pay using the 2005 Grouper. Providers may resubmit these claims at this point.
  The 2006 Grouper will be implemented at a future date. At that time, all PAS claims with a date of service in 2006 that have been processed using the 2005 Grouper will be re-processed using the 2006 Grouper. No provider action will be necessary.
  Update: 04/20/06 – The PAC/PAS Grouper was installed on Thursday 3/13/06 and is now in use for all PAC/PAS claims with a 2006 date of service. Reprocessing of previously submitted claims is to be determined.
- ✓ Update 01/27/06 – Hospital DRG Claims – Edit 00791 and Pricing Errors:
  The implementation of Version 23.0 of the All Patient DRG Patient Classification System has been delayed. The grouper, which is effective for discharges of January 1, 2006 and later, will be in place for claims adjudication beginning February 3, 2006. Claims paid prior to that date will be reprocessed by the State in a future cycle if the DRG derived in the new grouper is different than the paid claim. Claims that denied Edit 00791 (X12 Reason A8) will also be resubmitted by the state. It is suggested that your billing office should resubmit claims that denied for other reasons on or after February 3, 2006.
  Update: 04/20/06 – The affected claims were reprocessed during cycle 1491 (check dated 3/20/06).

Issues Resolved as of 06/22/2006

- ✓ Update 12/12/05 – Edit 00843 for Non-DRG Inpatient Claims:
  A fix was implemented on 5/4/ 06 to allow NON DRG Inpatient claims, after Commercial Insurance, to pay correctly. These claims had been failing Edit 843 **(X12 Reason 23)** – Calculated Payment Amount Less than Zero.
  If the days are covered by a commercial insurance, the system will now calculate the Medicaid payment and subtract the commercial insurance payment. The balance will be compared to the Deductible/Coinsurance claimed and the lesser amount will be paid. If no Deductible/Coinsurance amount is claimed, the system will pay the balance. If the commercial insurance paid more than Medicaid would have paid, the claim will fail edit 843. This is because, if the commercial insurance paid more than Medicaid would have paid, there is

no entitlement to additional reimbursement even if a Deductible/Coinsurance is due. Providers can resubmit any previously affected claims.

- ✓ Update 03/21/06 – New File Naming Convention for MCO's Monthly Files:
  In order to distinguish the monthly from the daily encounter data response files sent to the plans, the file extension of the monthly file will be changed to .SMM. The current .SMD will be used for the daily files.
  The ETA for implementation is during cycle 1500 (Mid May 2006).
  Update: 05/12/2006 – This change was implemented on 5/11/06, and MCOs were notified via email. There was a slight change to the naming convention plan. The file extension remained the same. Instead, a new node was inserted in the file name to indicate daily (SMD) or monthly (SMM).
  For files delivered via eXchange, here is an example of a file name:
  R060111145523.0111.SMM-.00.smd (Monthly) or
  R060111145523.0111.SMD-.00.smd (Daily).
  For files delivered via FTP, here is an example of a file name: R060111145523.0111.SMM.00 (Monthly)
  R060111145523.0111.SMD.00 (Daily)
- ✓ Update 8/09/05 – Edit 00268:
  Claims have recently denied due to Edit 00268 – Recipient Age Lower Than Procedure Minimum. DOH is assessing the possibility of a special input to reprocess the failed claims.
  Update: 06/22/06 – Closing this issue, as we don't believe it is relevant any longer.

Issues Resolved as of 07/05/2006

- ✓ Update 03/30/06 – Edit 00129 because non-PAS Procedures or non-PAS Revenue Codes:
  Please be aware of the following to avoid Edit 00129 (X12 Reason 16|M49) - Rate Code Not on File.
  Due to a system problem, for PAS claims containing less than 4 lines, we require the PAS Procedure Code that you are expecting to get paid for on the first line.

  Update: 06/22/06 – A change was implemented on 5/5/06. The system was changed to determine the Principal Procedure using the Procedure Code from the first line that contains a PAS Rev Code, from the bottom up.
  If no PAS Rev Code is found on the claim, the system uses the Procedure from line one.

  Please note the expanded list of Revenue Codes for PAS & PAC claims - 0360' THRU '0369; '0480' THRU '0489'; '0490' '0499'; 0510 thru 0519; 0520 thru 0529; '0750', '0790.
- ✓ Update 6/13/05 – Edit 00901 - Issue for providers that bill for Rate Code 4160 (COS 0385) and other combinations:
  CSC has identified a system issue. There is a table that matches the Rate Code with a COS, and that table does not include the combination for this provider (COS 0385 and Rate Code 4160). The claims denied as a result of this Edit do not show up on the 835 or the PEND file. We will update this announcement when more information/resolution is available.
  Update 6/27/05: A fix was loaded 6/24 to address the derivation logic used within the eMedNY system for Category of Service and Specialty code information. This update will resolve all *known* derivation problems. DOH is considering the possibility of resubmitting the affected claims on your behalf. The next update will advise whether the providers must resubmit these claims.

7/20 – DOH will be resubmitting the affected claims. Because the large number of claims to be reprocessed they may not all be done in one cycle, we expect to have this completed within the next few cycles.
Update 8/19/05 – CSC will be reprocessing Professional claims during cycle 1462.
Update 9/13/05 - This was actually a bigger problem: If any rate code/COS combination is not in the table then that given combination will be denied for 901. In addition, Professional claims, which get assigned to COS 0285, instead of 0287, are getting denied.
Update: 06/22/06 – It is believed all 00901 issues have been resolved. This issue is closed.

Issues Resolved as of 07/31/2006

- ✓ Update 03/21/06 - OMH claims Failing Edit 01209:
  Some OMH claims are failing Edit 01209 - Designated Mental Illness Diagnosis Required **(X12 Reason 47)**, even though the Principal Diagnosis is a mental health diagnosis. The reason for the failure is that providers also include secondary diagnosis which is not a mental health diagnosis thereby causing the failure. A project has been initiated by DOH to modify the Edit logic to look for any primary or secondary diagnosis that falls into the mental health diagnosis range and bypass Edit 01209, regardless of the presence of other non-mental health diagnoses.
  Update: 06/22/2006 – The new logic was implemented on 05/25/2006. Providers can resubmit any previously affected claims.
- ✓ Update 07/05/2006 – Reprocessing DRG Claims:
  Based on a review of inpatient claims by IPRO, situations were found where, due to a mapping error on the Patient Status field, the claims were paid at the full DRG instead of a lower DRG, because the patient left against medical advice (LAMA). We are currently pulling claims that were processed between 3/24/2005 and 6/15/2005, where the patient status was reported as '07' - LAMA and has one of the following DRG codes: 709, 710, 711, 712, 714, 744, 745, 747, 748, 750, and 751. The affected claims have been reprocessed as a special input, which will result in a recovery of money from the impacted providers during cycle 1507, check date 7/10/06.

- ✓ Update 06/22/06 – Correcting Noncompliant Outbound 835 Transactions:
  CSC will implement a fix to resolve compliance issues in Electronic Remittance Advice (835) Transactions.
  Trading partners reported invalid Claim Adjustment Reason Codes (CARCs) and/or Remittance Advice Remark Codes (RARCs). This issue is a result of new Codes added/deactivated to/from the Claim Adjustment Reason Codes and/or Remittance Advice Remark Codes lists, which are maintained by external entities.
  The fix will be implemented in the near future (ETA is cycle 1510, Remittance of 7/31/06).
  Previous Remittances will not be recreated.
  For a list of impacted Edits showing current and new codes, please click here.
  Please check this notice periodically for updates.
  Update: 07/12/06 – This change was implemented for cycle 1510, as planned.

Issues Resolved as of 09/07/2006

- ✓ Update 10/11 – Edit 01162 for OMH Claims:
  This is caused when an OMH provider renders service to a client who is under 21 years old and the provider does not have specialty code 316 on their provider master file. The current logic is: if a patient is less than 21 years old assign specialty code 316, and if the patient is 21 years old or older assign specialty code 315. A provider must have the applicable specialty on file in order for the claim to pay. If the derived specialty code is not on a providers file the result is edit 1162 (Invalid Office of Mental Health Specialty / Rate Code Combination). OMH recently requested a review of the derivation logic stating the cut off age should be 18.
  Update 12/02/05 – This issue was resolved by adding applicable Specialty Code to the short list of providers that were affected.
  Update: 08/08/2006 – A change was implemented on 7/27/06. If a patient is under 18 years old (child) assign specialty code 316, and if the patient is 18 years old or older (adult) assign specialty code 315.

Issues Resolved as of 09/26/2006

- ✓ Update 07/31/2006 – Remark Code N365 Issues on Inbound COB Claims:
  Some 837 Transactions are being rejected by CSC's front-end process, even though the Transactions are compliant. This is happening on Coordination of Benefit claims with line(s) of service with procedure codes for which the prior payer reports a recently implemented Remark Code, such N365 - This procedure code is not payable. It is for reporting/information purposes only.
  CSC is updating its front-end process to accept all valid codes. The ETA for implementation is 8/10/06. In the mean time, some submitters have opted to substitute the impacted Remark Code(s) for any Code CSC currently accepts which gets the claims paid.
  Update: 09/07/2006 – A change was implemented on 8/10/06 as expected. The front-end process now accepts claims with valid Remark Codes.
- ✓ Update 09/07/2006 – OTC Incorrect Payment:
  Some Over the Counter (OTC) drugs are being paid at an incorrect amount due to a file error. CSC is working on a solution to the issue, and the pricing should be corrected by 9/8/06. CSC will reprocess all affected claims in cycle 1517 (check date 9/18) or 1518 (9/25/06), or provider can resubmit the claim as an adjustment once the condition is fixed.
- ✓ Update 02/23/06 - OMH claims for Risperdal Consta failing edit 00172:
  Temporarily, all electronic claims submitted for Risperdal Consta (J2794) will fail edit 00172 **(X12 Reason 16|M51)**. DOH has determined that claims for Risperdal Consta must be billed on paper forms with the cost invoice attached. All Risperdal Consta claims will then pend for Manual Pricing.
  A project has been initiated to allow these claims to be submitted electronically. Update: 06/22/2006 – The project has been delayed due to DIRAD prerequisites.
  Update: 09/07/2006 – Starting with dates of service 9/6/06, providers will be required to obtain a DIRAD PA for all Risperdal claims submitted either electronically or on the paper HCFA 1500 form. Claims submitted electronically won't fail edit 00172 **(X12 Reason 16|M51)**. Paper claims will not require the cost invoice attachment, regardless of the date of service. However, paper claims for dates of service 9/6/06 and after must have the DIRAD PA.

Issues Resolved as of 11/20/2006

- ✓ Update 09/26/2006 – Edit 02002 for Pharmacy Claims:
  Edit 02002 - PRESCRIPTION SERIAL NUMBER MISSING - **(X12 Reason 16|M99)** will be activated on Oct. 19, 2006. Currently close to 1 million pharmacy claims are hitting this Edit each week, and they will fail once the Edit is turned on. The problem is occurring because providers are not using the official NY State prescription pad, which contains the required serial number, or the pharmacies are not entering the serial number. Pharmacy claims will need to contain the serial number in field 454-EK. Watch for the October Medicaid Update for details.
- ✓ Update 7/29/05 – Combine 820 / 835 and Supplemental files – for eXchange Users:
  Some trading partners have expressed concerns about the many files, such as 835s, we are sending to the individual user accounts. A project is in development that will combine files for a given destination based on transaction type.
  Update: 10/11/2006 – A project has been developed and implemented to combine files directed to a given eXchange destination based on transaction type (835, 835 Supplemental, 820, 820 Supplemental). Each transaction type will be contained within its own unique .TAR file. The ".TAR" extension is supported by WinZip, Pkzip, and Unix TAR routines. By combining the files, the users will be able to receive a larger file containing multiple logical files, each with one Interchanges (ISAs), which will reduce the labor needed to retrieve separate files. The .TAR naming convention was implemented October 9, 2006, affecting claims beginning with processing Cycle 1520.
  The implementation of the new file extension does not affect FTP users. FTP users already receive their files in a zip format and will continue to receive their files with the .ZIP file extension.

Issues Resolved as of 12/05/2006

- ✓ Update 11/20/2006 – (MOMS) SPC Derivation Issue Resulting in Underpayments:
  This affects the following four (4) Specialty Codes: 159 - MOMS, 158 - Pediatrics, 249 - HIV, and 247 – Broome.
  Obstetricians, family physicians, nurse midwives and nurse practitioners, who meet certain criteria may enroll in the Medicaid Obstetrical and Maternal Service (MOMS) program and receive increased fees for obstetrical care. All claims for the above Specialties must contain SA Exception Code 7 in order for the system to derive the appropriate Specialty Code. If SA Exception Code 7 is not used, then the claim will be paid the standard reimbursement rate for the procedure code, which will result in an underpayment.
  Providers that have received underpayments can resubmit the claim(s) as an adjustment using SA Exception Code 7.

Issues Resolved as of 01/08/2007

- ✓ Update 12/05/2006 – Unsolicited 277 (U277) with A7|96 for De-certification:
  Providers who submit transactions, such as claims, to the New York State Medicaid program are required by the Department of Health to submit a signed and notarized Certification Statement on a yearly basis. If you do not have an ETIN, you may apply for one here.
  Computer Sciences Corporation (CSC) sends two certification notices to alert providers when the certification period will expire. Notices are generated for providers 45 days and 30 days prior to the certification expiration date, which is included in the notices. Along with the notices providers are also sent preprinted Certification Statements. Providers should return only the

signed certification statement.
If a provider fails to return the Certification Statement prior to the expiration date, the provider is "de-certified" on that date and claims will be rejected with a claim status of A7|96 (ETIN is invalid or not associated with the Provider ID). The front-end reject will be communicated in the U277 Transaction that is sent along with the Functional Acknowledgement (997) Transaction.

Issues Resolved as of 02/06/2007

- ✓ Update 6/20/05 – Edit 00152 and MCO Billing – Reminder: If a patient is in a Medicare Managed Care Plan and the claim is billed to Medicaid, the claim must be submitted with 0FILL, until further notice, and the Plan will be represented by the Payer Code of the Plan, such as Code 16. The amount paid by the Plan must be entered on the claim. Medicaid will then calculate the Medicaid payment and subtract the amount reported as paid by the Medicare plan, and Medicaid will pay the balance. If there is no balance, the claim will pay as zero, or if it is Inpatient, the claim will fail edit 00843 - payment amount less than zero.
  Update 7/14/05 – 837I Claims for Medicare Part-A / Part-B are also affected by this Edit. This happens because the Fiscal Intermediary that adjudicates the claims always reports MA in SBR09, when in reality the funds come out of Part-B, and our Edit is looking for Part-B adjudication information. Until further notice, these claims can also be sent with 0FILL to bypass the Edit.
  Update 7/29/05 – CSC is implementing a fix on Aug. 3, 2005 to recognize Outpatient claims with Part-A payment information. Providers may resubmit at that time. If the claim was previously denied for this reason, and it is now over 90 days, please include an appropriate over 90-day indicator in CLM20, such as value code 9.
  Update: 12/05/2006 – On February 1, 2007 CSC will be implementing systems changes to clarify and improve MCO billing. At that time, 0FILL will no longer be necessary, but new edits (02016 & 02059) will be implemented to ensure proper calculations and payments of claims involving Medicare MCOs. Please refer to the upcoming January 2007 Medicaid Update for complete details.
  Update: 01/08/2007 – The January 2007 Medicaid Update has been posted at http://www.health.state.ny.us/health_care/medicaid/program/update/main.htm. Please refer to the article entitled Medicaid Recipients with Medicare Managed Care (HMO/MCO) Coverage, for complete details. Note for the 835 (Remittance Advice) Edit 02016 (MEDICARE MANAGED CARE (MCO) QUALIFIER 16 CONFLICTS WITH MEDICARE PART A OR PART B QUALIFIERS) will return **(X12 Reason 129|N4),** and Edit 02059 (MEDICAID DAYS INVALID ON CLAIMS WITH MEDICARE HMO DAYS. REBILL SEPARATELY) will return **(X12 Reason 125|N61)**.
  Update: 01/23/2007 – The system change, previously scheduled for 2/1, was implemented on 1/18/07. Also Edit 02016 will return **(X12 Reason 129|N4)**, not 136 as previously communicated.

Issues Resolved as of 03/07/2007

- ✓ Update 02/22/2007 – Edit 00903 for Transportation Claims Missing Referring Provider Identifier:
  Edit 00903 **(X12 Reason 16|N287)** will be activated on 2/22/07 to require the

Ordering/Referring Provider Identified (either MMIS ID or License Number). For coding instructions, please check http://www.emedny.org/hipaa/Edit_Error/DrillDown/edits/00903.html.
Claims previously paid without a Referring Provider ID will be voided during a future cycle.

- ✓ Update 01/08/2007 – 278 Transactions Requirement of DTP Date:
  A compliance issue has been reported to CSC related to the current requirement that the DTP (Service Date) Segment in Loop 2000F of the 278 transactions be populated when the request is procedure based and the HI segment is populated. A project has been initiated to eliminate the requirement if the date is transmitted in the HI.
  Update: 02/22/2007 – A fix was implemented on 2/9/07.

- ✓ Update 09/26/2006 – Error Registering/Reporting NPIs – Implementation Delay:
  As previously Communicated in the August 2006 Announcement, CSC is currently accepting NPI registration via a web enable application and also via the current 837 Transactions. The registration via the web application is working fine. However, we are seeing some errors due to inappropriate registration; for example, entering a Group's Provider ID and multiple individual's NPIs. The individual's Provider IDs should be registered using the individual's NPI(s), and the Group's Provider ID should be registered with the Group's NPI(s).
  We are also seeing problems in the current 837 Transactions being submitted. For example, some claims contain an NPI at the Billing Provider level (loop 2010AA), and the same NPI is repeated at other levels, such as in various 2310 loops. The entities at the 2310 levels should have their own NPIs.
  The above errors in the 837 Transactions are preventing us from building the crosswalk. Therefore, we encourage providers to send the NPI(s) in the 837 Transactions; however we require the registration to be conducted using the web application since the data in the Transactions cannot be used to create the crosswalk.
  Update: 01/25/2007 – CSC has developed a batch facility to allow entities that have a large number of NPIs, and/or those providers that cannot use the web, the ability to register using the batch interface. To utilize the batch facility, please refer to the NPI Batch Registration Reference Guide.
  Update: 12/05/2006 – CSC will be enhancing the NPI Registration programs in 2007 to allow the registration of physicians employed by hospitals. The current application can only be used to register providers with MMIS Ids. The changes will allow NPI registration using MMIS ID or License Number.
  Update: 02/06/2007 – Please refer to the February 2007 Medicaid Update magazine for the NPI Project Implementation Delay announcement. Go to http://www.health.state.ny.us/health_care/medicaid/program/update/2007/2007-02.htm#emed.

Issues Resolved as of 03/20/2007

- ✓ Update: 03/07/2007 – Multi-Lines Rate-Based Clinic Claims:
  A change is being implemented for Clinic claims received on or after 4/1/07 for Rate Codes 1610, 2870, 1629 or 2880. Since these Rate Codes are defined as "Threshold" visits, a date of service must contain a service line for Non-Ancillary services in order to be paid.
  The following revenue codes are lab or radiology Ancillary services, which are not counted in Threshold visits:
  - 030X Lab,
  - 031X Lab (pathological),
  - 032X Radiology,

- 040X Other Imaging Services,
- 073X EKG/ECG,
- 074X EEG,
- 092X other diagnostic

(X = any fourth digit)

If the same date of service has numerous revenue codes spread over multiple lines, then that date of service will be counted as long as it has at least one non-Lab/Radiology revenue code. It is important to note: It is still New York Medicaid policy providers code for the services performed. This clarification in payment policy does not imply or request revenue codes should be used inappropriately.

For additional information, please refer to an article titled Correction in Overpayment of Clinic Claims Spanning Multiple Dates of Service in the March Medicaid Update.

Issues Resolved as of 05/01/2007

✓ Update 12/12/05 – Edit 01172 Due to SPC Derivation for Rate Codes 1610/2870/1629/2880:
CSC suggests the use of the following Revenue Codes and/or Bill Type when billing for Rate Codes 1610, 2870, 1629 or 2880 in order to derive the appropriate Specialty Codes. For SPC:

- 964 – Bill Type 72 or 73 and Revenue Code 0513
- 924 – Revenue Code 0911
- 983 – Bill Type 76 or 86

Update: 05/12/06 – In addition to the above Specialty Code derivation logic, new logic has been implemented to derive the following Specialty Codes, when billing for Rate Codes 1610 or 2870 using the following Revenue Codes:

- 920 – Rev Code 042X (where X = 0-9), or
  300 – if Rev Code 042X and the claim is submitted with SA Exception Code 7
- 923 – Rev Code 043X (where X = 0-9), or
  301 – if Rev Code 043X and the claim is submitted with SA Exception Code 7
- 967 – Rev Code 044X or 047X (where X = 0-9)
- 913 – Rev Code 082X (where X = 0-9)

Update: 08/08/2006 – In addition to the above Specialty Code derivation logic, new logic has been implemented to derive the following Specialty Codes, regardless of the Rate Code used:

- 906 – when Condition Code is A4 (Family Planning).
- 908 – when Condition Code is A1 (EPSDT/CHAP).
- 907 – when Condition Codes AA through AH (Abortion related codes).

Please note: SPC 914 will be assigned when there is no other information on the claim that could be used to determine a specific SPC. If a claim does not contain any of the information above and there is no SA Exception code 7, the system will assign 914, but only if SPC 914 is on the provider's file and is valid for the date of service.
Update: 03/07/2007 – Added Rate Codes 1629 and 2880 to the derivation logic, effective 3/1/07.

✓ Update 10/11/2006 – Edit 01154 For Practitioner claims using consultation procedure codes:
There is currently an issue with the derivation of the Specialty Code for Practitioner claims using consultation procedure codes 99241 thru 99245. This is causing the claims to fail Edit

01154 - NO UT SERVICE AUTHORIZATION RECORD ON FILE **(X12 Reason 15|N54)**. The resolution and ETA are under consideration. Claims denied by Edit 01154 for the Procedures listed above will need to be re-billed after the solution is implemented.
Update: 03/07/2007 – A fix was implemented on 3/1/07. Providers can resubmit claims. Enter the SAE 7 to avoid Edit 01154.

- ✓ Update 03/27/06 – Edit 02015 - Incorrect Billing for Coinsurance When the Pay-Amount is Zeroes:
  A system edit is being developed to prevent incorrect payments of Coordination of Benefit (COB) claims submitted to Medicaid, after Medicare, for a Coinsurance amount greater than zero, when the prior payer's paid-amount is zero. These claims are being received from physicians as well as hospitals, and CSC is currently paying them. However, it is illogical for Medicaid to pay for Coinsurance when the prior payer has not paid. If there is a Coinsurance amount, then the prior payer should have made a payment on the claim. If the payer denied the claim, there would be no Coinsurance and then 0FILL is indicated, in which case the claim is billed to Medicaid and the prior payer's EOB information is omitted.
  The new edit will be implemented around the June 2006 time frame. Affected providers/submitters are urged to start preparing for this change to avoid unnecessary denials.
  Update: 02/06/2007 – Edit 02015 - MEDICARE COINSURANCE > 0 AND MEDICARE PAYMENT = 0 **(X12 Reason 16|MA04)** was implemented on 2/5/2007 to prevent the incorrect billing of Coinsurance when Medicare paid zero.
  Update: 02/22/2007 – A change has been implemented to bypass the Edit when Deductible is greater than zero.
- ✓ Update: 03/07/2007 – Rate Code Conflict, Failing Edit 00705 or 00727:
  There are certain Hospice and Nursing Home rate codes that, if billed by the same provider for the same patient and Date of Service, will fail Edits 00727 - Near duplicate claim in History **(X12 Reason 18)** or 00705 - Duplicate claim in history **(X12 Reason 18)**. The known conflicting Rate Codes are 3945 and 3990; 3945 and 3753; 3771 and 3945. There could be other combinations that are also failing inappropriately. DOH staff is researching the issue and system modifications are planned to allow all valid claims to pay. Providers will be informed via update to this issue when claims can be resubmitted.
  Update: 04/06/2007 – A fix was implemented. Claims can be resubmitted.

Issues Resolved as of 05/23/2007

- ✓ Update 01/23/2007 – Changes to CARCs sent in the Remittance Advice (835):
  Due to industry codes updates, there will be some changes to the Claim Adjustment Reason Codes being sent in the providers' Electronic Remittance Advice transactions (835) when claims hit certain system edits during adjudication. This is because some of the codes are scheduled for deactivation in 2007. The list of impacted Edits and their corresponding current and new codes are posted as an announcement in the nyhipaadesk.com website, Claim Adjustment Reason Code (CARCS) Changes Scheduled for March 2007. The ETA for implementation is March 2007.
- ✓ Update: 05/01/2007 – CARC 42 Batch Claim Rejections:
  Since Friday morning, April 27, 2007, eMedNY has been rejecting 837 transactions when Secondary claims contain Claim Adjustment Reason Code 42. Claims Adjustment Reason Code 42 is scheduled for inactivation on 6/1/07. However, this code was inadvertently inactivated prior to the scheduled date of 6/1/07. Code 42 will be added back today and all

batches rejected for CARC 42 will be reprocessed by eMedNY. No action is necessary by submitters.

Issues Resolved as of 06/13/2007

- ✓ Update 05/23/2007 – Changes to CARCs sent in the Remittance Advice (835):
  Due to industry codes updates, there will be some changes to the Claim Adjustment Reason Codes being sent in the providers' Electronic Remittance Advice transactions (835) when claims hit certain system edits during adjudication. The list of impacted Edits and their corresponding current and new codes are posted as an announcement in the nyhipaadesk.com website,
  at **http://www.emedny.org/HIPAA/News/csc_emedny_news/CARCS_changes_scheduled_for_May_2007.pdf**. The new codes are in effect as of cycle 1553.
- ✓ Update 05/23/2007 – Edit 00152 When Billing for Secondary/Tertiary Medicare MCO Claims:
  When billing Medicaid as Secondary or Tertiary payer, after a Medicare MCO, please make sure the Claim Filing Indicator (SBR09) in loop 2320 for the M-MCO = 16. This will allow the claim to be adjudicated correctly while bypassing Edit 00152 (**X12 Reason 22**). The providers can resubmit previously denied claims.
  Claims previously paid an incorrect amount should be resubmitted as adjustments (replacements), with the appropriate Claim Filing Indicator.
  In addition, a new project will be implemented on 5/24/07 to update the PAS/PAC Grouper for 2007 dates of service. Affected claims previously paid will be reprocessed. The date for the reprocessing is yet to be determined.

Issues Resolved as of 08/07/2007

- ✓ Update 06/13/2007 – Claims Without MMIS IDs:
  Please note: New York State Medicaid is operating under the NPI Contingency Plan. At this point, claims and other transactions need the legacy Ids in order to be processed. Several claim denials have resulted because the claims only contained an NPI. Please continue to use the legacy Ids until further notice on NYS Medicaid claims and other transactions.
- ✓ Update 06/13/2007 – PAS-PAC Grouper Update:
  As a result of a delay to the annual update of the PAC-PAS Grouper Tables, some PAC-PAS claims with service dates of January 1, 2007 and later were not adjudicated correctly. The new PAC-PAS Grouper was in place for claims processing beginning May 24, 2007. Claims priced prior to May 24, 2007 that were not adjudicated correctly will be reprocessed by CSC. We anticipate the reprocessed claims to be reflected in the check dated 6/25/2007.
  If you have any questions pertaining to this issue you may contact CSC Provider Relations at 1-800-343-9000.

Issues Resolved as of 11/27/2007

- ✓ Update: 11/01/2007 – Claims Failing Edit 00941 inappropriately:
  Due to logic changes implemented on 10/28/07, claims started failing Edit 941 in error during cycle 1576. The issue was fixed on 10/31/07, and all affected claims will be reprocessed during cycle 1577. This same issue could have impacted claims that failed Edits 1236, 1237, and 1242. However, those claims will NOT be reprocessed by CSC and will need to be resubmitted by the providers.
  Please note – these Edits have been tightened. Claims containing Referring Providers not authorized to order the services will be denied.

- ✓ Update: 11/01/2007 – SA/DVS (278) and Eligibility (270) Transactions Failed inappropriately:
  Starting 10/28/07 some 278 Transactions failed with AAA*N**43*C~ (Invalid Ordering Provider), and also some 270 Transactions failed with AAA*N**48*C~ (Invalid/Missing Referring Provider Identification Number). The issue was fixed on 10/31/07. Affected transactions can be resubmitted by the provider.
  Please note – these Edits have been tightened. Transactions containing Ordering/Referring Providers not authorized to order/refer the requested services will continue to deny.

Issues Resolved as of 11/30/2007

- ✓ Update 11/27/2007 – Hospital DRG Claims Submitted With Discharge Dates on/after 10/1/07 – Pricing Errors:
  Changes to the ICD-9-CM Codes, effective 10/1/07, were not recognized by eMedNY's claim processing system until November 15, 2007. As a result, some claims may have been paid using an unexpected DRG or denied due to not grouping correctly. The issue has been corrected. Submitters are asked to resubmit any affected claims adjudicated between 10/1/07 and 11/15/07.
  We regret any inconvenience this implementation delay may have caused.

Issues Resolved as of 03/07/2008

- ✓ Update 11/30/2007 – Billing for Emergency Only Coverage:
  Effective 11/27/07, when a Medicaid recipient has coverage for Emergency Services only, the emergency indicator must be entered on the claim, AND the Diagnosis Code, Procedure Code/NDC must be flagged as an emergency by the Department of Health.
  For billing questions call CSC Provider Services at 1 (800) 343-9000.
  For immigrant and other policy questions call the Office of Health Insurance Programs, Bureau of Medicaid and Family Health Plus Enrollment at 1 (518) 474-8887.

Issues Resolved as of 05/19/2008

- ✓ Update 11/30/2007 – Physician-Administered Drugs Claims Need NDC:
  Effective January 1, 2008 all claims for physician-administered drugs (including drugs administered by nurse practitioners, licensed midwives and drugs administered in an ordered ambulatory setting) submitted on 837 claim formats must include NDC information, regardless of the Date of Service. For further details, please see the link below:
  http://www.emedny.org/info/newsletter/NDC%20Provider%20Letter.pdf.
  The 837 Professional and 837 Institutional (for Fee for Service submitted via 837I) Companion Guides were updated to accommodate this requirement when this was first announced in the June 2007 Medicaid
  Update: http://www.health.state.ny.us/health_care/medicaid/program/update/2007/2007-06.htm#nat. Denials may be identified by Edit **02066 (X12 Reason 16|M123)** – Drug Code Invalid. In addition, Edit 00561 - Drug/Supply not on File and Edit 01600 - Discontinued NDC - may also be reported **(X12 Reason 16|M119).**
  Update: 03/07/2008 – In order to receive the rebate for the NDC, the quantity and unit of measure are required. Edit 00528 – Missing or invalid quantity dispensed **- (X12 Reason 16|M123)** will deny claims lacking the required information.
- ✓ Update 04/20/06 – Issues With OMH Claims When Billing For The Add-on Rate 4099: Many providers have contacted CSC to report problems when billing for rate 4099 or to ask for

instructions on how to bill this rate to receive the additional fees, when entitled. Some claims have denied with Edit 00703 **(X12 Reason 57|M63)** – Inappropriate Second Service – Same Day. Specialty Code 316 is derived for these claims. If the provider's file does not contain SPC 316, the claim will fail Edit 01162 **(X12 Reason 16|M49)** - Invalid OMH SPC/Rate Code Combination.
Update: 01/23/2007 – (Modified 11/30/2007 for accuracy) It has been determined that when the enhancement is billed with a qualifying Rate Code (4301, 4304, 4601 or 4604), an additional brief visit on the same day is being denied. For example if 4099 is billed with a qualifying collateral visit 4304, an additional brief visit on the same day is inappropriately denied. A brief visit, a collateral visit and the enhancement should all be paid when appropriate on the same day. A system change has been initiated to allow proper billing. Please note however, if only a brief visit is provided, the enhancement will not be paid. Also, if commercial insurance pays on the regular visit, then that payment must be credited on the claim for the regular visit. 4099 will not be paid in conjunction with a Managed Care encounter.
The billing instructions will change as follows (ETA to be determined): Instructions on how and when to use 4099: This rate code can only be billed in conjunction with a Fee-for-Service (FFS) regular visit - rate codes 4301 or 4601, or with a FFS collateral visit - rate codes 4304 or 4604. The FFS and add-on claims can be submitted in the same transaction, but they must be different claims since the rate code is different. The only field that needs to change for the add-on claim is the rate code – the claim must have the same procedure and revenue codes, etc. 4099 is an add-on rate code for OMH Clinic services rendered to Children after 6:00 PM or on weekends. Providers are asked to wait until the implementation of the system change for the FFS brief to submit Add-on claims for brief visits.
Update: 03/07/2008 – A change has been implemented to allow the payment in accordance with the instructions provided on 11/30/07 (above).

Issues Resolved as of 09/11/2008

- ✓ Update 07/30/2008 – POS Devices Download Issue:
  eMedNY is currently downloading the NPI compliant application (version 2120) to the POS terminals. In order for the automatic download to occur, the devices need to be left "powered on" during non-business hours. eMedNY is experiencing significant download failures due to the unavailability of the devices at night.
  POS terminal users are asked to verify if their terminal(s) have not been updated with the new software. Verification can be accomplished by looking at the "home" screen, which displays the version number. If the terminal is displaying 2120, then it has been updated. If not, please leave it on at night so it can be updated. Please read the August 2008 NPI Special Edition Medicaid Update.
- ✓ Update 07/30/2008 – Low Percentage of Facilities Affiliating Their Providers:
  As announced in the NPI Special Edition Medicaid Update, eMedNY requires facilities (hospitals, clinics and other such facilities) to report the License Numbers and NPIs of the practitioners that may be identified in facilities' claims as Attending/Servicing providers. eMedNY will need to create a crosswalk for each facility's NPI with the License Numbers and NPIs of the practitioners, in order to process claims from the facilities after NPI implementation. To date, a very low percentage (%?) of facilities have done their reporting. This causes a concern for the near future. Please note that Practitioner Affiliation is not the same as NPI Registration. Affiliation is an additional, distinct requirement for the previously mentioned types of facilities.

Please read the August 2008 NPI Special Edition Medicaid Update for additional information and instructions.

- ✓ Update 06/11/2008 – Medicare COB Claims containing Invalid CARC 92:
  The Medicare Part-A Fiscal Intermediary erroneously began issuing Remittance Advice containing an invalid Claim Adjustment Reason Code (CARC). The offending Code is 92 "Claim paid in full", which was end-dated October, 2003. It is not known how long it will be for the Fiscal Intermediary to resolve this issue. Therefore, NYS Medicaid will be implementing a fix to the front-end of the eMedNY processing system to allow Code 92 in for processing. However, until this fix is promoted entire transactions that contain code 92 will be rejected. We recommend submitters to strip any claims with CARC 92 until further notice to minimize cash flow impact. We will provide notification once eMedNY is able to accommodate the invalid code.
  ePACES users may submit claims with the invalid code now as an alternative to holding the claims.
  Update: 07/30/2008 – A fix has been implemented to temporarily accept CARC 92 as valid. Submitters are asked to resubmit any outstanding claims.

• Issues Resolved as of 10/09/2008

- ✓ Update 09/11/2008 – 00103 – Adjust/Void Fields are incomplete for 837I:
  The eMedNY system has experienced a problem in processing electronic institutional (837 I) format adjustments/voids as a result of changes promoted as part of the NPI implementation. The adjustments/voids are being accepted into the system for processing but the original claim transaction control number (TCN) is being dropped resulting in a proprietary edit message of 00103 – Adjust/Void Fields are incomplete **(X12 Reason 129|N59)**.
  The problem has been identified and the resolution was promoted the evening of September 10, 2008. Adjustment/Void claims submitted between September 1 and September 10 should be resubmitted.
- ✓ Update 09/11/2008 – Rejecting Ambulatory Claims Due to A7|96:
  Some Fee-for-Service claims are being erroneously rejected before being passed to the adjudication system. The rejected claims are reported in the Unsolicited Claim Status File (U277) with the X12 error code A7|96 – ETIN invalid or not associated with the Billing Provider. The issue has been identified and the resolution will be implemented Sept. 12, 2008. Please resubmit any affected claims.
- ✓ Update 09/11/2008 – Incorrect Submissions of Affiliated Providers' Start Dates:
  DOH is currently analyzing the Facility Affiliations that have been submitted and is finding anomalies in the physician's start dates that are being reported. Many submitters are reporting 01/01/2008 or today's date as the start.
  The effective start date should be the date the practitioner first became affiliated with the facility. For the initial load period, you may use a default date of 1/1/2000 for practitioners that were affiliated with the facility prior to 1/1/2006. For practitioners whose affiliation began after 1/1/2006, the actual affiliation effective start date should be used. After the initial load period, the actual affiliation effective start and inactive dates should be used.
  The edit is Date-of-Service sensitive, which based on the erroneous reporting may create denials for any claims submitted with services before the reported start date.
- ✓ Update 09/11/2008 – Incorrect Record Length for 835 & 820 Supplemental Files:
  Last week (Sept. 8th - Cycle 1620), the Supplemental files were created with a record-length of

549, instead of the expected 600 bytes.
The problem has been identified and corrected. The Supplemental files starting next week (Cycle 1621) will be 600 bytes. Please note last week's files will not be recreated.

- ✓ Update 05/20/2008 – Edit 01357 - PROVIDER ID AND SERVICE ID IDENTICAL:
This Edit was implemented on April 24, 2008 and has caused some claims to be denied. To allow our trading partners more time to code for this requirement, this Edit will be turned off temporarily. Please resubmit any affected claims.
Edit 01357 - **(X12 Reason 16|N291)** verifies the Billing Provider and the Service/Attending Providers are different. When they are identical, the claim is denied. Until eMedNY is converted to use NPI, the Service/Attending Provider's license number may be used in the Service/Attending Provider loop to bypass the Edit. For Fee for Service claims, when the Billing Provider is the same as the Service Provider it is not necessary to send the Service Provider loop.
Update: 01/23/2007 – This Edit is now active. Electronic claims with identical Provider Identifier at the Billing and Service/Attending Provider levels will be denied.

Issues Resolved as of 11/12/2008

- ✓ Update 10/10/2008 – ePACES Dropping the Medicare Covered Part A Days:
ePACES was dropping the Medicare Covered Part A Days entry, which was causing a variety of denials depending on specific claim characteristics. ePACES was also dropping the discharge date on some claims. These
issues were fixed on October 1, 2008.

- ✓ Update 10/10/2008 – Remittance Advice Creation and Auto-enrolled Providers:
Some trading partners have inquired about some unrecognized MMIS IDs in their Remittance Advice. This happens when the claim is submitted with NPI only. As per the announcement on page 3 of the NPI Special Edition Medicaid Update, NYSDOH created new internal MMIS IDs in order to have a one-to-one relationship with the registered NPIs. The new IDs were created for the following 2 scenarios; 1) It was necessary to create new MMIS IDs when the provider registered multiple NPIs with a single MMIS ID [This is referred to as AUTO-ENROLL]; 2) Similarly, when a provider registered a single NPI with multiple MMIS IDs, the existing MMIS IDs were all merged into a single, new MMIS ID which crosswalks to the NPI [This is referred to as COLLAPSE].
One check and Remittance Advice is produced to reflect all payments from claims processed for the NPI/ETIN combination
While providers get ready to submit NPI-only, claims submitted with both an MMIS ID and NPI are processed based on the submitted MMIS ID and are returned in the Remittance Advice for the MMIS/ETIN combination.

- ✓ Update 10/10/2008 – eMedNY Deactivating Some ePACES User Accounts Due to Improper Use.
Please note: Automated scripting of the ePACES online access and entry process to eMedNY is forbidden. ePACES provides individuals the ability to create and submit transactions to eMedNY over the Internet using their browser. Collecting multiple transactions created in ePACES, and submitting these as batches is also supported. However, automated programmatic scripting of the ePACES online access and entry process to eMedNY is expressly forbidden, and will result in your user ID being revoked.
Scripting is a process of storing transactions in a computer file and programming the computer to enter them in rapid succession expecting online responses. This can create serious

performance problems in ePACES and unnecessarily inconvenience other users of the product.
Another practice that is not permitted is the sharing of User IDs with multiple users to enter information into ePACES at the same time. Users that share their log-on information risk deactivation in ePACES.

Issues Resolved as of 01/19/2009

- ✓ Update 11/12/2008 – Attention ePACES Users and ePACES Administrators:
  The ePACES application has experienced intermittent performance issues lately. The problems are related to some users that share their log-on information with other users and utilize the system simultaneously, which causes processing conflicts in the system. This problem can be resolved by you (the user) by contacting the ePACES Administrators at your facility and obtaining your own user id.
  This issue has brought to light a compliance problem. To resolve this, the Medicaid Confidentiality Regulations agreement that users click before logging on to ePACES has been updated with the following message:
  "Warning: As per the Health Insurance Portability and Accountability Act (HIPAA), CSC or the on-site ePACES Administrator is required to assign unique user ids and passwords for identifying and tracking user's identity [Ref: § 164.312(a)(2)(i)]. Users that share their ePACES user id and password are in violation of the HIPAA Security Regulation. If this practice is detected, the user's access will be revoked and other sanctions may apply."
- ✓ Update 11/12/2008 – Supplemental Files Not Showing Real Source of Problem:
  This issue impacts those claim submitters that are not sending their NPIs.
  Many calls have been received due to some edits not showing in the production 835 Supplemental files. As documented in the 835 Supplemental CG, there is only room for 2 edits for claims with a PEND status. When a claim fails an edit like 00162 (Recipient Ineligible on Service Date), the claim pends and is reported in the Supplemental file. eMedNY tries to show the submitters all the reason/edits the claim may have problems with, including edits that are set to pay but may be set to deny in the near future. Showing pay edits is intended to allow submitters time to prepare. For example, the NPI edits are currently set to pay in order to allow providers to transition to NPI compliance. However, these edits, such as 02023 (Attending Provider NPI Missing), are filling the 2 spots allowed for PEND edits. To mitigate this problem, submitters are asked to submit their NPIs. As long as the NPI is present in the claim, which at this point could be in addition to the legacy IDs, the NPI edits will not be reported.
  Submitting the NPI as required resolves the issue.
- ✓ Update 11/12/2008 – Missing Remittances / Claims in PTE:
  Due to a set up error, some claims have not been reported in the Remittance Advice produced in the Provider Testing Environment (PTE). The reason was the set up of some edits, such as edit 00162 (Recipient Ineligible on Service Date), which are normally set to PEND. These edits will be set to deny going forward to ensure providers get information about their submitted claims as soon as possible. As documented in the PTE User's Guide, no claims shall pend. Submitters are asked to resubmit any claims missing from their test remittance.

Issues Resolved as of 04/21/2009

- ✓ Update 01/29/2009 – APG Issues:
  Please note: all APG related issues will be published in a separate list. Please visit: http://www.health.state.ny.us/health_care/medicaid/rates/apg/docs/apg_known_issues.pdf.