

New York State Medicaid

eMedNY News & Issues as of 03/15/2010

The purpose of eMedNY News & Issues is to share eMedNY related information and identify system issues relevant to our NY Medicaid provider community. The document includes Important Announcements, New eMedNY Issues and Active eMedNY Issues and will be updated as issues are corrected and/or new issues are identified. Closed eMedNY issues are archived and posted [here](#). eMedNY News & Issues will be posted on www.nyhipadesk.com ([ISSUES of eMedNY](#)). Please visit this site periodically for updates. If you have questions about the information in this document, please consult with your technical staff or email us at nyhipadesk@csc.com.

Important Announcements

Enroll NPI with Medicaid for Medicare Crossover

Providers are reminded that the NPI that is submitted on their claim to Medicare MUST be enrolled with NYS Medicaid. If the NPI on your Medicare claim is not enrolled with NYS Medicaid, the crossover claims will be rejected and affected providers will NOT receive a notice of the rejection.

Due to the large volume of rejections, National Government Services has suspended sending letters advising providers that their claims did not crossover to Medicaid because of a rejection due to an NPI that is not enrolled with Medicaid.

If your Medicare remittance is indicating that the claims were crossed over to Medicaid, you should ensure the NPI on the Medicare remittance is also the NPI that is used for Medicaid billing. If the NPI is not the NPI used for Medicaid billing then the NPI must be enrolled with Medicaid. Medicaid enrollment forms and information can be found at www.emedny.org. Questions about the enrollment process can be directed to the eMedNY Call Center at 1-800-343-9000.

MMIS Payments Release to be Delayed

Due to the State's financial plan for State Fiscal Year 2009/2010, Medicaid checks and Electronic Funds Transfers (EFTs) scheduled for release on Wednesday, March 31, 2010 will be released one day later on Thursday, April 1, 2010. The check date for these funds is March 15, 2010.

New eMedNY Issues

- **Update 3/11/2010: Direct Medical Education (DME) Add On Not Paid for Inpatient Outlier DRG**
When a DRG inpatient cost outlier claim is submitted with condition code 61 and the hospital is entitled to a DME add on, the DME add on amount is not being included in the Medicaid payment.
Update 3/11/2010: A fix is expected March 26, 2010.

- **Update 3/8/2010: 835 Reporting CLP02 = 1 for Medicare Xover claims when Medicare Paid \$0.00**
eMedNY is currently reporting Claim Status Code of "1" (Processed as Primary) on the 835 Remittance Advice on crossover claims for which Medicare paid \$0.00. This may cause problems if the provider system already identifies the claim as processed by Medicare as Primary. CSC is aware of the issue and will be working on a long-term solution.
Please check this notice periodically for status update.
- **Update 2/10/2010: Crossover – Medicaid Overpays When Claim Simultaneously Crosses Over to Other Insurance:**
The Department of Health is aware that Medicare is crossing claims to both NYS Medicaid and commercial payers at the same time. This is causing instances where the commercial payer and Medicaid are both paying the claim. If this occurs you are required to resubmit the Medicaid claim as an adjustment and reflect the commercial insurance payment.
Please check this notice periodically for status update.
- **Update 2/10/2010: Crossover – Referred Ambulatory on Institutional Claim to Medicare Paid Incorrectly on Crossover:**
Referred Ambulatory claims sent directly to Medicaid on an 837I without a Rate Code are currently recognized as professional and processed internally as if they were submitted on the 837P. However Medicare crossover claims received on an 837I without a Rate Code will not derive to a Referred Ambulatory claim type. If Referred Ambulatory is submitted on the 837I the Bill Type will be used to classify the claim. This means if the Clinic Bill Type is used, for example, the result would be a Clinic Co-pay deduction.
2/10/2010 Update: Previously this announcement advised that Referred Ambulatory claims for dual eligible clients should be submitted to Medicare on the Professional claim. This may not be possible for a provider due to Medicare rules. At this time such a claim must be voided and resubmitted to Medicaid.
Please check this notice periodically for status update.

Active eMedNY Issues

- **Update: 01/08/2010 – Edit 02067 Attending Provider Not Linked to Billing Provider:**
A number of facilities are submitting claims where some of the attending providers are not affiliated with Medicaid for your facility, which results in edit 02067 being reported in the 835 Supplemental file ([X12 Reason 208|N55](#)). NY Medicaid will begin denying claims where the attending provider NPI is not affiliated. New York State Medicaid requires that clinics, hospitals and other facilities register the National Provider Identifier (NPI) and licenses for all practitioners who are affiliated with the facility and might be included as an attending provider on claims submitted by the facility. NY

Medicaid provides two methods for affiliating practitioners NPIs: On the web at: <https://npi.emedny.org/Facility/>, or via batch by following the instructions on the [Facilities Practitioner's NPI Reporting](#). Please check this notice periodically for status update.

- Update: 02/22/2007 – 835 Reporting Denied Claims, But No CARCs:
This occurs when the Charged Amount is zeroes, and the claim denies. The reason is adjustments cannot be reported when the Charged Amount is zeroes because the claim will not balance since the adjustment needs to be greater than \$.00. The problem is primarily on Secondary paper claims because there is only one field to report Charged Amount and/or Deductible. When the Deductible is submitted, eMedNY copies the Deductible Amount to the Charged Amount field. However, this is currently happening towards the back-end of the eMedNY adjudication process. Claims that fail front-end edits, such as “Client not on file”, do not get a chance to get the Charged Amount populated and result in a denial without a CAS Segment. NYSDOH has initiated a project request to correct this problem. Please check this notice periodically for status update.

- Update 9/23/2005 – Edit 02001 – Enforcing Balancing Compliance for COB Claims:
This Edit was activated on 09/22/2005. As a result, Coordination of Benefit (COB) claims whose total paid-amount at the claim level did not match the sum of all the lines paid-amounts were denied. The Edit was turned off on 09/23/05. The denied claims will not be reprocessed. It is the submitter’s responsibility to resubmit those claims. The paid-amount at the claim level must equal the sum of all the paid-amounts reported at line level; otherwise the claim will be denied.
Update 10/11/2005 - Please note that this is a necessary, imminent change. However, DOH has decided to keep the Edit turned off, until further notice, due to the number of claims that will deny if this Edit is turned on at this point. It will be turned back on in the near future to ensure claim balancing, which is mandated by the HIPAA Rule, and to avoid inappropriate claim adjudication. We are currently incorrectly paying claims due to inaccurate amounts being reported.
Please check this notice periodically for updates, but start making your system changes now to avoid negative impact on your cash flow.
Update: 10/21/2005 – The Edit mapping/crosswalks, which can be now found in the [Crosswalks](#) folder in NYHIPAADESK, are being updated. The corresponding Claim Adjustment Reason Code for Edit 02001 is 125, and the Remark Code is N4.
Update: 02/06/2006 – ETA during cycle 1489, Edit 02001 (X12 Reason 125|N4) will be set to PEND for paper claims and DENY for electronic claims. Please make system changes now. On average, over 55,000 claims are failing this Edit on a cycle basis. These claims will be affected once the status of the Edit is changed.
Update: 03/09/2006 – Please note that this is a necessary, imminent change. However, DOH has decided to keep the Edit turned off, until further notice, due to the number of claims that will deny if this Edit is turned on at this point. Please check this notice periodically for updates.

Closed eMedNY Issues

- ✓ Issues resolved more than six months ago are archived [here](#).

Issues Resolved as of 01/08/2010

- Update: 12/30/2009 – 835 CLP11 Reporting Error:
An error is occurring in CLP11 - Diagnosis Related Group (DRG) Code - as of cycle 1688. eMedNY is suppressing leading zeroes from the DRG field. A change will be implemented to accommodate APR DRG reporting. For Institutional claims, NYSDOH will provide up to 4 bytes in CLP11. The first 3 bytes will be the DRG. The 4th byte will be present only when the Severity of Illness is reported. If the APR Severity of Illness is not applicable the last position will be suppressed and only the 3-byte DRG code will be sent.
Update: 01/05/2010 – A fix has been implemented.
- Update: 12/30/2009 – 835 “Paid Edits” Remark Codes Sent:
eMedNY is sending Remark Codes of “paid-edits” in the 835 Remittance Advice, which is causing confusion for providers attempting to crosswalk the edit to the CARC & RARC combination.
Update: 01/07/2010 – A fix has been implemented.
- Update: 09/30/2009 – 835 Sending CARC A2 on RETRO Claims:
CARC A2 is still being reporting for RETRO claims. A2 is discontinued code.
Update: 01/08/2010 – A fix has been implemented.
- Update 7/20/2005 – CLP02 = 2 and no CAS*CO*23 – PART 2:
CLP02 is sometimes incorrectly reporting Claim Status Code of 2 (Secondary) but not reporting Prior Payer information, which is being erroneously combined with Medicaid’s CO adjustments. However, Medicaid’s CO adjustment should be reported separately in its own CAS*CO*45, and the Prior Payer’s write-off and/or payment should be identified with CARC 23. CSC is assessing a solution.
Update: 01/23/2007 – The fix will not be implemented in January 2007, as previously scheduled. A new ETA will be provided in the future.
Update: 01/08/2010 – A fix has been implemented.

- Update 08/24/2006 – CLP02 = 1 though the claim reported a previous payer – PART 3:
In the 835 Remittance Advice, CLP02 is sometimes incorrectly reporting Claim Status Code of 1 (Processed as Primary) even though the claim reported prior payer's adjudication information. The 835-transaction is combining the prior payer's payment and adjustments with NYSDOH's CO adjustments, causing problems in the provider's Accounts Receivable. NYSDOH's CO adjustment should be reported separately in its own CAS*CO*45, and the Prior Payer's write-off and/or payment should be identified with CARC 23.
Update: 01/23/2007 – The fix will not be implemented in January 2007, as previously scheduled. A new ETA will be provided in the future.
Update: 01/08/2010 – A fix has been implemented.
- Update 10/21/2005 – Virtual Private Network (VPN) Connectivity Restrictions:
Many providers have indicated an interest in utilizing the Internet for communicating with Medicaid. CSC is investigating a solution to allow more trading partners to utilize internet-FTP submission.
Update: 01/08/2010 – CSC has implemented a new Simple Object Access Protocol (SOAP) communication method to allow trading partners to submit files via the Internet under a Service Oriented Architecture (SOA). The SOAP method is a good solution for those users who prefer to develop an automated approach to submitting files using the internet as a communications mechanism. Please note, CSC will be phasing out the current dial-up Bulletin Board System (BBS) in the near future and is currently urging BBS users to start switching to different method of file submission such as SOAP, FTP or eMedNY eXchange.
For more information, please send an email to NYHIPAADESK3@CSC.COM.