



Managed care is defined as: A comprehensive approach to the provision of healthcare that combines clinical services and administrative procedures within an integrated coordinated system.

Medicaid managed care offers several advantages over the traditional Medicaid fee-for-service system. These advantages include:

- Improved healthcare access
- Improved quality of care
- Increased emphasis on preventive care
- Lowered long-term costs

DETERMINING ENROLLEE STATUS

Determining whether a Medicaid recipient is (or is not) enrolled in a managed care plan is critical for accurate billing and payment purposes. The provider will run the risk of receiving ***no payment*** for a patient if eligibility and conditions of coverage are not verified.

The provider is responsible for determining the Medicaid recipient's MCO (Managed Care Organization) status, including whether or not the recipient is enrolled in a plan, identifying the plan in which the recipient is enrolled, and the services (scope of benefits) provided to the recipient under that plan.

There are two methods by which a provider may easily determine a recipient's managed care status:

- MCO Identification Card
- NYS Benefit ID Card (in conjunction with MEVS)

A plan must issue an MCO identification card to each Medicaid enrollee within 14 days of enrollment. Although a card may identify an enrollee as a Medicaid recipient, the card may not do so in any way that makes the card overtly different from a commercial enrollee's ID card.

In addition to identifying the enrollee, an MCO ID card *should* include the following, which may be embossed on the card or affixed with a sticker:

- The name of the managed care plan
- The name of the enrollee's Primary Care Provider (PCP)
- The telephone number of the enrollee's PCP
- The name of the enrollee's clinic (if applicable)

METHODS OF DETERMINING ENROLLEE STATUS

MEDICAID ELIGIBILITY VERIFICATION SYSTEM (MEVS)

Four ways to access MEVS are:

- **Audio Response Unit - ARU** (touch-tone telephone method) by calling **800-997-1111**.
- **VeriFone Omni 3750 MEVS Terminal**
Information about how to obtain an Omni 3750 can be accessed on the website <http://www.emedny.org/HIPAA/SupportDocs/Omni.html> or calling **1-800-343-9000**.
- **ePACES** – Web-based application
For instructions on how to enroll in ePACES call 1-800-343-9000 or visit the website at <http://www.emedny.org/HIPAA/QuickRefDocs/index.html> and refer to document FOD 4002 ePACES Enrollment.
- **270/271 Eligibility Inquiry /Response electronic transactions** via other Alternate Access Methods
The 270/271 Eligibility Inquiry and Response Companion Guides for creating HIPAA compliant electronic transactions are available at <http://www.emedny.org>
 - ✓ select **NYHIPAADESK**
 - ✓ select **eMedNY Companion Guides and Sample Files**

MEVS manuals are available on-line at <http://www.emedny.org/providermanuals/index.html>. If the provider does not have Internet access MEVS manuals can be obtained by submitting a written request to eMedNY Provider Services.

MEVS VERIFICATION INPUT

Among the most important pieces of information MEVS communicates to the provider are the recipient's eligibility status, the plan (and plan code) in which he/she is enrolled, and the specific services covered by the managed care plan (scope of benefits).

There are two main transaction types a provider may request through MEVS:

- **Transaction Type 1**
Eligibility verification and utilization threshold service authorization
- **Transaction Type 2**
Eligibility verification only

MEVS VERIFICATION RESPONSE

MEVS eligibility responses may be displayed on the VeriFone LCD screen and print receipt, by clicking on the ePACES Eligibility Response hyperlink, or they can be heard over a touch-tone telephone (ARU). Eligibility responses may be returned via other Alternate Access methods.

MANAGED CARE TOUCH TONE TELEPHONE RESPONSES:

- **ELIGIBLE PCP** - indicates the Medicaid recipient is enrolled in a managed care plan. [In this section, PCP refers to **Prepaid Capitation Plan**, *not* Primary Care Physician.]
The provider will receive payment for *most* Medicaid-covered services from the managed care plan, but the recipient may be eligible for ***all*** Medicaid-covered services.
- **ELIGIBLE CAPITATION GUARANTEE** - indicates the Medicaid recipient is enrolled in a managed care plan, but is no longer enrolled in Medicaid.
The provider will *only* be paid for the scope of benefits covered ***specifically*** by the enrollee's managed care plan. The recipient is non-eligible for services not covered by the managed care plan, or services that are carved-out.

[See page 9 for a complete list of coverage codes.]

INSURANCE AND COVERAGE CODES

Insurance codes identify the managed care plan in which the recipient is enrolled. A list of insurance plan codes is available at www.emedny.org under Provider Manuals. The Managed Care Coordinator at the local Department of Social Services may also be contacted for a list of the managed care plans in that county.

[Note: Broome, Chemung, Erie, Schuyler, and Steuben Counties maintain contracts with Physician Case Management Plans (PCMPs) in addition to managed care organizations. PCMPs provide primary care services only. Specialty services must be referred out **while managed care organizations usually provide both primary care and specialty services through their own provider network.**

Providers billing for services referred to them by the PCMP ***must*** indicate the referring plan's ID when submitting a claim. eMedNY will deny claims that do not include the referring plan's ID.]

MANAGED CARE OMNI 3750 TICKET RESPONSES

NYS DOH OFFICE OF MEDICAID MANAGEMENT
eMedNY

TODAY'S DATE: 03/26/2004—17:24:59
 ACCESS: AB12345Z
 TRAN TYPE: 2
 DATE OF SVC: 03/25/2004
 PROVIDER NO : 00123456

PROV NO: 00123456
 DATE SVC: 03/25/04
 MEDICAID ID: AB12345Z
 DOB: 10/24/1998
 GENDER: M
 CNTY/OFF: 66/545
 ANIV DT: 09/01/2003

PLAN ELIG & BENEFITS

Plan: METROPOLITAN HEALTH PLAN
 Plan Cd: 92/AINPQRTVYZ
Elig/Ben Info: Managed Care Coordinator
 Serv Type Cd: 30
 Insr Type Cd: MC
 - End of Receipt -

MEVS Manual, Section 10.0	
RESPONSE	POSSIBLE CAUSES
MC MANAGED CARE COORDINATOR	ELIGIBLE PCP A response of “Eligible PCP” indicates coverage under a Prepaid Capitation Program (PCP). This status means the client is PCP eligible as well as eligible for limited fee-for-service benefits. To determine exactly what services are covered, review the coverage codes returned in the response. The Coverage Code definitions can be found in the Codes section of this manual. If further clarification of exact coverage is needed, contact the PCP.

NYS DOH OFFICE OF MEDICAID MANAGEMENT

eMedNY

TODAY'S DATE: 03/26/2004—17:24:59

ACCESS: AB23456C

TRAN TYPE: 2

DATE OF SVC: 03/25/2004

PROVIDER NO: 00123456

PROV NO: 00123456

DATE SVC: 03/25/04

MEDICAID ID: AB23456C

DOB: 10/24/1998

GENDER: M

CNTY/OFF: 66/545

ANIV DT: 09/01/2003

PLAN ELIG & BENEFITS

Plan: BETTER HEALTH PLAN

Plan Cd: SP/AIJNPQRTVYZ

Elig/Ben Info: Other or Additional Payor

Serv Type Cd: 30

Insr Type Cd: MC

- End of Receipt -

MEVS Manual, Section 10.0

RESPONSE	POSSIBLE CAUSES
<p>R OTHER OR ADDITIONAL PAYER</p>	<p>ELIGIBLE CAPTITATION GUARANTEE</p> <p>A response of “Eligible Capitation Guarantee” indicates guaranteed status under a Prepaid Capitation Program (PCP). The PCP provider is guaranteed the capitation rate for a period of time after a client becomes ineligible for Medicaid services. Clients enrolled in some PCPS are eligible for some fee-for-service benefits if referred by the PCP provider. To determine exactly what services are covered, contact the PCP designated in the insurance code field.</p>

- Claims**
- *** New Claim
 - *** Find Claims
 - *** Build Claim Batch
 - *** Submit Claim Batches
 - *** Status Inquiry
 - *** Status Responses

•• Eligibility Response Details

Eligibility Information:
Managed Care Coordinator



- MEVS**
- *** Eligibility Request
 - *** Eligibility Responses
 - *** SA Request
 - *** SA Responses
 - *** SA Confirmation
 - *** SA Confirm Responses
 - *** DVS Request
 - *** DVS Responses
 - *** DVS Confirmation
 - *** DVS Confirm Responses

- Support Files**
- *** Provider
 - *** Other Payer
 - *** Submitter

- User Admin**
- *** Add/Edit Users



Client Information:

Client ID:

Client Name:

Date of Birth:

Gender: M

County: Broome

Office:

Medicaid Coverage Information:

Coverage Level: IND

Insurance Type: Medicaid

Date of Service: 04/20/2004

Anniversary: 4/1/2004

Medicaid Managed Care

Plan Name:

LOURDES PRIMARY CARE

Carrier Code:

DY/AINPRY

Medicaid Restricted Recipi

Restriction Type:

Co-Payment Information

Co-Pay Remaining:

Medicaid Messages

1. Individual Exception Code
2. Category of Assistance:

Additional Payer Information

Close

Claims

- *** New Claims
- *** Find Claims
- *** Build Claims

MEVS

- *** Eligibility Request
- *** Eligibility Responses
- *** SA Request
- *** SA Responses
- *** SA Confirmation
- *** SA Confirm Responses
- *** DVS Request
- *** DVS Responses
- *** DVS Confirmation
- *** DVS Confirm Responses

Support Files

- *** Provider
- *** Other Payer
- *** Submitter

User Admin

- *** Add/Edit Users



Eligibility Response Details

**ELIGIBLE
CAPITATION
GUARANTEE**

Eligibility Information:

Other or Additional Payer (please review information at bottom of screen)

Client Information:

Client ID:

Client Name:

Date of Birth:

Gender:

M

County:

NYC

Office:

099

Medicaid Coverage Information:

Coverage Level: IND

Insurance Type: Medicaid

Date of Service: 03/25/2004

Anniversary: 9/1/2003

Medicaid Managed Care

Plan Name:

BETTER HEALTH PLAN

Carrier Code:

SP/AIJNPQRTVYZ

Medicaid Restricted Recipi

Restriction Type:

Co-Payment Information

Co-Pay Remaining:

Medicaid Messages

1. Individual Exception Code:

2. Category of Assistance:

Additional Payer Information

Close

https://www.emedny.org/enaces/MEVS/EligibilityDetailsPSO.aspx?FROM=2&UID=928... 4/20/2004

SCOPE OF BENEFITS

MEVS identifies the scope of benefits a Medicaid recipient's MCO provides through specific coverage codes. When using a touch-tone telephone you will hear the "**Description**" of each covered service. When using either the OMNI 3750 or ePACES the "**Coverage Codes**" will be displayed. If the message "**All**" appears, all services below are covered.

Note: Medicaid will **not** reimburse a provider on a fee-for-service basis if MEVS indicates that the service is covered by the plan.

COVERAGE CODE	DESCRIPTION
A	Inpatient hospital
B	Physician in-office
C	Emergency room
D	Clinic
E	Psychiatric inpatient
F	Psychiatric outpatient
G	Physician in-hospital
H	Drugs – No card
I	Lab/X-ray
J	Dental
K	Drugs – Co-pay
L	Nursing home
M	Drugs – Major Medical
N	All physician services
O	Drugs
P	Home Health
Q	Psychiatric services
R	ER & clinic
S	Major Medical
T	Transportation
U	Coverage to complement Medicare
V	Substance abuse services
W	Substance abuse outpatient
X	Substance abuse inpatient
Y	Durable Medical Equipment
Z	Optical
ZZ	More than 2 insurance codes – call Local DSS

FREE ACCESS SERVICES

Free access services are specific healthcare services, which Medicaid recipients may receive from a provider of the recipient's choice, whether or not that provider is affiliated with the recipient's MCO. Recipients do **not** need a referral for free access services.

Free access services include:

- Family planning/reproductive health
- HIV treatment services for pre-and post-test counseling, **only** when performed as part of a family planning encounter

If a free access service is rendered by a provider who is **not** affiliated with the recipient's MCO, the non-affiliated provider should bill Medicaid (CSC) directly. If the provider **is** affiliated with the recipient's MCO, he/she should bill the plan directly.

NOTE: If it is appropriate to bill eMedNY for a family planning service, the provider must enter a "yes", or an appropriate family planning code in the applicable family planning field of the paper or electronic claim.

EDITS (ERRORS)

Edit (error) numeric codes are returned on the remittance advice sent to the provider by the NYS Medicaid Fiscal Agent (CSC). An edit (error) code describes the cause of a claim denial or pend. Edit (error) code definitions are found on the last page(s) of the paper remittance advice.

Below are 2 edits associated with Managed Care which appear on the paper remittance advice and the corresponding claim adjustment reason code returned on the electronic remittance advice and the claim status code returned on the Claim Status Response:

Denial due to MCO enrollment

Paper Remit	Electronic Remit (835)	Claim Status Response (277)
Edit 01172 – Prepaid Cap Recipient Service Covered Within Plan	HIPAA Claim Adjustment Reason Code 24 – Payment for charges are covered under a capitation agreement/managed care plan	Health Care Claim Status Code 115 – Cannot process HMO claims

Medicaid denies this claim because the service billed is covered by the recipient's MCO (the specific plan is identified by the MEVS insurance code). The managed care plan is responsible for payment.

Note: This denial will also appear for recipients of Family Health Plus (FHP).

Denial due to missing PCMP referral ID

Paper Remit	Electronic Remit (835)	Claim Status Response (277)
Edit 01173 – Prepaid Cap Recipient Referral or Specialist ID Invalid	HIPAA Claim Adjustment Reason Code 38 – Services not provided or authorized by designated (network) providers	HealthCare Claim Status Code 153 – Entity's ID number

Medicaid denies this claim because the recipient is enrolled in a Physician Case Management Plan (PCMP). The billing provider did not indicate the Medicaid ID of the PCMP plan as the referring provider on the claim, or the provider is billing for primary care services covered by the plan.

For additional information about edits refer to <http://www.emedny.org>

- ✓ select **NYHIPAADESK**
- ✓ select **Edit/Error Knowledge Base**