eMedNY

New York State Department of Health

Office of Health Insurance Programs

Managed Care Capitation Premium

Pended and Denied Claims Report: Specification

Version: 1.3

Publication: 6/22/2020
Trading Partner: eMedNY

Pended and Denied Claims – Enhanced Reporting

INTRODUCTION

The standard transaction for reporting Managed Care Capitation premium payments is the ASC X12 820 Payroll Deducted and Other Group Premium Payment for Insurance Products. In order to better serve Managed Care Organizations contracted by NYSDOH for Medicaid Managed Care insurance products, a proprietary transaction has been developed to report information about pended and denied claims for capitation premiums.

Pended claim data is NOT reported on the ASC X12N 820 transaction. Additionally, limited claim detail is reported on the 820 for denied claims. However, the Plan will receive supplementary proprietary information that will provide Pended and Denied claim detail in a format similar to the former proprietary remittance. Furthermore, when applicable, providers will receive detailed supplementary proprietary information for the following types of approved claims: State-submitted Adjustment/Void claims, Retroactive Rate Adjustments, Kick Newborn/Maternal and Stop/Loss claims where the charge amount does not equal the payment amount, and approved claims where the rate code is changed during adjudication (please review the Record Layout for more detailed information regarding these claim types).

Pended claim reporting: Providers must contact eMedNY Call Center at 1-800-343-9000 (select Provider Enrollment) to set up the frequency of “old-day” pend reporting (initially, the transmission of “old-day” pends will be set to none).

Please note that this file will be transmitted automatically when applicable.

A Managed Care Capitation Premium Pended and Denied Claims Report will be created using the New York State Department of Health (NYSDOH) Supplementary Proprietary File format (i.e. Record Layout) defined in Attachment A. The proprietary supplementary file contains:

- Fixed-length, asterisk-delimited (*) fields. Fields not applicable to a particular claim will be space filled.
- The logical and physical record length is 600. The record length includes the tilde at the end of the record.
- There is no block-size (records are not blocked).
- The tilde at the end of the last record in the file will serve as the end-of-file indicator.
- The file will not contain header or trailer records.
- The format supplied in Attachment A contains a detailed claim record layout.
- The file will be transmitted with the 820 transaction when applicable.
- Please refer to the eMedNY Trading Partner Information Standard Companion Guide, eMedNY Transaction Information Standard Companion Guide X12, and eMedNY Transaction Information Standard Companion Guide CAQH – CORE X12 for more information about HIPAA Electronic Data Interchange with eMedNY.

DISCLAIMER:

The New York State Department of Health (NYSDOH) has provided this document and the data specification described herein to assist its contracted Managed Care Organizations, Clearinghouses, and Business Associates in processing/receiving a Managed Care Capitation Premium Pended and Denied Claims Report. This document was prepared using a proprietary record format as the vehicle for reporting pended claim information and enhanced denied claim information. NYSDOH has focused primarily on the rules and policies regulating the transmission of NYS Medicaid data that are provided within this document. NYSDOH has provided the information on http://www.emedny.org/HIPAA as a tool to make the Plan’s job easier in processing/receiving electronic transactions.

NOTE: 'National Provider ID' (NPI): Managed Care Organizations, (MCOs) are not Health Care Providers under HIPAA and are not eligible to receive a National Provider Identifier. Therefore the requirement to send the NPI on claims or to receive NPI on payments does not apply to MCOs.

The information provided herein is believed to be true and correct based on NYSDOH policy and all other applicable regulations. These regulations are continuing to evolve, therefore NYSDOH makes no guarantee, expressed or implied, as to the accuracy of the information provided herein. Furthermore, this is a living document and the information provided herein is subject to change as NYSDOH policy changes or as HIPAA legislation or other applicable State of Federal regulation is updated or revised.

MODIFICATION TRACKING:

>V1.0 – Initial publication
>V1.1 – Update email address and URLs.
>V1.2 – Updated email address to @csra.com
>V1.3 – Updated email address to @gdit.com

NYS MEDICAID NOTE:

The Managed Care Capitation Premium Pended and Denied Claims Report has been established by NYSDOH as the format for reporting pended claims, and for providing enhanced information about denied claims to its contracted Managed Care Organizations.

This document which is provided by the New York State Department of Health (NYSDOH) outlines the specification for a proprietary

report that is sent to Managed Care Organizations as an electronic transaction when Managed Care Capitation Premium claims have been pended or denied. It is important that Plans study this document and become familiar with the specification that it defines. Managed Care Plans (MCOs) may choose to focus their efforts on pended claims when using the Pended and Denied Claims Report.

NYSDOH has provided "NYS MEDICAID NOTE(s)" clarifying the usage of all data elements that will be transmitted in this file.

SUPPORT:
Please refer to the eMedNY Trading Partner Information Companion Guide for information about transaction header structures, transaction size limits, electronic communications methods, and enrollment as a Trading Partner. This document is available for download at eMedNY.org/HIPAA.

NYSDOH and its fiscal agent encourage trading partners and providers to visit http://www.emedny.org/HIPAA. Information under the "eMEDNY HIPAA Support" tab, "Transaction Instructions", will provide Companion Guide updates and other pertinent information. Questions may be sent to the NYSDOH Fiscal Agent's Support Team at emednyhipaasupport@gdit.com.

Providers with questions may call the eMedNY Call Center at: 1-800-343-9000. Please be advised that Unit representatives will only answer questions related to New York Medicaid requirements.

The ASC X12N Implementation Guides and their associated Addenda are available in electronic format at: http://store.x12.org/store/.

Re-association of Supplementary Information to the 820 Transaction:
In order for the Plan to re-associate the detail information provided in the Pended and Denied Claims report to the 820 Transaction, the following crosswalk is provided:

Pended and Denied Claims Report Field	ASC X12N 820 Transaction Field
Patient Control Number/Office Account Number	Loop 2000B, ENT-04
Recipient ID	Loop 2100B, NM1-09
Transaction Control Number (TCN)	Loop 2300B, RMR-02

ATTACHMENT A

Supplementary Information Delimited Flat File

(Fixed-length fields, asterisk (*) delimited)

Field Name	Format	Position	eMedNY Description	NYS Medicaid Note
ETIN	X(4)	1-4	Electronic Transmitter Identification Number – a unique number assigned to service bureau(s), Plans or Providers submitting or receiving electronic transactions.	NYSDOH will provide information as supplied on input transaction.
Group Provider ID	X(8)	6-13	Not applicable to Managed Care Plans.	NA
Individual Provider ID Number	X(8)	15-22	Provider/Plan Identification Number – the unique number assigned by NYSDOH to each provider/plan of services applying for enrollment in the Medicaid Program.	NYSDOH will provide information as supplied on input transaction.
Location of Service	X(3)	24-26	Location of Service – (Locator Code) As assigned by NYSDOH, the locater code is used in conjunction with the rate code.	NYSDOH will provide information as supplied on input transaction.
Status of Claim	X(4)	28-31	Claim Line Type – Shows actual claim status on remittance for the provider's reference.	NYSDOH will provide values ' PEND', 'DENY', 'VOID' (NYS submitted voids), 'ADJ' (NYS submitted adjustments). NYSDOH will provide value 'PAID' for NYS initiated retroactive rate adjustments and for approved claims, where rate code is changed during the adjudication process, as well as stop loss and kick newborn/maternal claims for which the claim charge does not equal claim payment. **Note:** A status of **DENY** provides an alternate record format for reporting **27** Error Reason Codes determined through adjudication. All others default to the prior record format. **Review format starting at position 293 for alternate and prior record formats.**
Patient Account Number	X(20)	33-52	Office Control Number – any number assigned by a plan to a recipient or a claim for reference purposes. Used by the plan to tie a particular claim to a particular payment.	NYSDOH will provide information as submitted in field CLM01 (Claim Submitter's Identifier) on the 837 Institutional.
Transaction Control Number (TCN)	X(16)	54-69	Transaction Control Number (TCN) – a unique number serving to identify each claim transaction received. (Formerly known as CRN.)	This is a unique identifier assigned to each claim line input which NYSDOH will use, if necessary, to adjust or void the claim. Format = YYDDDNNNNNNNNNMA (YY = Year, DDD = Julian day, NNNNNNNNN = Sequence Number, M = Media type (0 = Paper, 2 = Electronic, 3 = POS), A = Claim type (0= original, 1 = Credit Adjustment or Credit Void, 2 = Debit Adjustment)).
Remittance Number	X(11)	71-81	Sequential number generated for remittances during the payment cycle.	NYSDOH will provide the six-character date of the remittance (YYMMDD), followed by a 5-digit sequence number.
Invoice Type	X(2)	83-84	Invoice Type - code indicating the type of invoice that generated the adjudicated claims record.	NYSDOH will provide the Invoice Type as generated by the system.
Claim Line Number	X(30)	86-115	Specifies the line number for service on an invoice. It identifies service lines that can be adjudicated separately.	NYSDOH will provide information as submitted on input.
Medical Record Number	X(30)	117-146	Medical Record Number – number assigned to a patient's medical record by the hospital. Unique to each patient.	NYSDOH will provide information as supplied on input (Loop ID 2300, REF02 on 837 Institutional).
Adjudication Date	X(8)	148-155	Date Adjudicated – date upon which a claim transaction was processed.	NYSDOH will provide information in the following format: CCYYMMDD.

Field Name	Format	Position	eMedNY Description	NYS Medicaid Note
Bill Date	X(8)	157-164	Billing Date/Invoice Date – The date a provider enters on a claim indicating when it was prepared.	NYSDOH will provide information as supplied on input.
Client ID Number	X(11)	166-176	Recipient Identifier – a unique identifier that serves to identify data pertaining to that individual.	NYSDOH will provide information as supplied on input.
Client Last Name	X(17)	178-194	Recipient Name – the name of an individual as provided on the application for assistance of care. Needed for individual identification.	NYSDOH will provide information as supplied on input. If unavailable from input, this field will contain client last name from the NYSDOH Client File, which corresponds to the client ID number submitted.
Client First Name	X(10)	196-205	Recipient Name – the name of an individual as provided on the application for assistance of care. Needed for individual identification.	NYSDOH will provide information as supplied on input. If unavailable from input, this field will contain client first name from the NYSDOH Client File, which corresponds to the client ID number submitted.
Client Middle Initial	X	207	Recipient Name – the name of an individual as provided on the application for assistance of care. Needed for individual identification.	NYSDOH will provide information as supplied on input. If unavailable from input, this field will contain client middle initial from the NYS DOH Client File, which corresponds to the client ID number submitted.
Recycle Number	X(4)	209-212	Number of Times Recycled – the number of times a claim has been recycled through the Daily adjudication cycle.	NYSDOH will provide a figure indicating the number of times a claim has been recycled through the Daily adjudication cycle because it pended for edits.
Date of Service/From Date	X(8)	214-221	Service Date – the date upon which the service covered by a claim was rendered.	NYSDOH will provide information in the following format: CCYYMMDD.
Through Date of Service	X(8)	223-230	End Service Date – the date upon which the service covered by a claim was ended.	NYSDOH will provide information in the following format: CCYYMMDD.
Procedure Code/ NCPDP Code	X(11)	232-242	Not Applicable to Managed Care Plans.	NA
Rate Code	X(4)	244-247	Rate Code – a code identifying a medical service or product that utilizes a rate reimbursement technique under MMIS.	NYSDOH will provide information as submitted on input or system generated.
Units of Service /Times Performed	-9(7).9(3)	249-260	Quantity – the units (e.g., days, visits, miles, injections) of a procedure rendered to a recipient.	Units of Service. This is a signed field. **Note: Decimal will be transmitted.** **Negative sign will be transmitted in the high order field position.**
Amount Charged/Billed	-9(8).99	262-273	The amount billed by the plan for each service.	NYSDOH will provide information as submitted on input. This is a signed field. **Note: Decimal will be transmitted.** **Negative sign will be transmitted in the high order field position.**
Amount Paid	-9(8).99	275-286	Amount Paid for Claim – the amount paid by Medicaid for this service.	Total claim approved amount. A signed field. **Note: Decimal will be transmitted.** **Negative sign will be transmitted in the high order field position.**
Medicaid Covered Actual Days	9(4)	288-291	Not Applicable to Managed Care Plans.	NA
			Status of Claim "DENY" record format follows.	

Field Name	Format	Position	eMedNY Description	NYS Medicaid Note
			Positions 293 to 526 of this record layout shall be used to provide edit information depending on the status of the claim. If the claim is DENIED, the area shall contain up to twenty-seven (27) edit numbers and no descriptions.	Please refer to the Edit/Error Knowledge Base for edit descriptions with resolutions: https://www.emedny.org/HIPAA/5010/edit_error/index.aspx
Error Reason Code1	X(5)	293-297	Error Reason Code – the edit result code put on a claim during an adjudication cycle.	NYSDOH will provide the five-digit code that specifies the reason for the claim being denied and up to 27 reason codes may be reported.
Error Reason Code2	X(5)	299-303	See Error Reason Code1.	See Error Reason Code1.
Error Reason Code3	X(5)	305-309	See Error Reason Code1.	See Error Reason Code1.
Error Reason Code4	X(5)	311-315	See Error Reason Code1.	See Error Reason Code1.
Error Reason Code5	X(5)	317-321	See Error Reason Code1.	See Error Reason Code1.
Error Reason Code6	X(5)	323-327	See Error Reason Code1.	See Error Reason Code1.
Error Reason Code7	X(5)	329-333	See Error Reason Code1.	See Error Reason Code1.
Error Reason Code8	X(5)	335-339	See Error Reason Code1.	See Error Reason Code1.
Error Reason Code9	X(5)	341-345	See Error Reason Code1.	See Error Reason Code1.
Error Reason Code10	X(5)	347-351	See Error Reason Code1.	See Error Reason Code1.
Error Reason Code11	X(5)	353-357	See Error Reason Code1.	See Error Reason Code1.
Error Reason Code12	X(5)	359-363	See Error Reason Code1.	See Error Reason Code1.
Error Reason Code13	X(5)	365-369	See Error Reason Code1.	See Error Reason Code1.
Error Reason Code14	X(5)	371-375	See Error Reason Code1.	See Error Reason Code1.
Error Reason Code15	X(5)	377-381	See Error Reason Code1.	See Error Reason Code1.
Error Reason Code16	X(5)	383-387	See Error Reason Code1.	See Error Reason Code1.
Error Reason Code17	X(5)	389-393	See Error Reason Code1.	See Error Reason Code1.
Error Reason Code18	X(5)	395-399	See Error Reason Code1.	See Error Reason Code1.
Error Reason Code19	X(5)	401-405	See Error Reason Code1.	See Error Reason Code1.
Error Reason Code20	X(5)	407-411	See Error Reason Code1.	See Error Reason Code1.
Error Reason Code21	X(5)	413-417	See Error Reason Code1.	See Error Reason Code1.
Error Reason Code22	X(5)	419-423	See Error Reason Code1.	See Error Reason Code1.
Error Reason Code23	X(5)	425-429	See Error Reason Code1.	See Error Reason Code1.

Field Name	Format	Position	eMedNY Description	NYS Medicaid Note
Error Reason Code24	X(5)	431-435	See Error Reason Code1.	See Error Reason Code1.
Error Reason Code25	X(5)	437-441	See Error Reason Code1.	See Error Reason Code1.
Error Reason Code26	X(5)	443-447	See Error Reason Code1.	See Error Reason Code1.
Error Reason Code27	X(5)	449-453	See Error Reason Code1.	See Error Reason Code1.
Filler	X(31)	455-485		
State Adjustment/ Void Message/ Retro Indicator	X(40)	487-526	State Adjustment/Void Message – message to indicate a State-submitted Adjustment or Void. Or, message to indicate Retro Rate Reversal or Retro Rate Correction.	NYSDOH will provide a message to indicate a State-submitted Adjustment or Void. For Retroactive Rate changes that are reported on the 820 transaction, the following messages will be placed in this field to identify these adjustments to Providers: 'Retro Rate Reversal' for retroactive rate adjustment reversal (credit adjustment). 'Retro Rate Correction' for retroactive rate adjustment correction (debit adjustment).
			Status of Claim "PEND" record format follows. **All other Status of Claims, default to prior format.**	
			Positions 293 to 526 of this record layout shall be used to provide edit information depending on the status of the claim. If the claim is PENDED, the area shall contain up to two (2) edit numbers and their description.	Please refer to the Edit/Error Knowledge Base for edit descriptions with resolutions: https://www.emedny.org/HIPAA/5010/edit_error/index.aspx
Error Reason Code1	X(5)	293-297	Error Reason Code – the edit result code put on a claim during an adjudication cycle.	NYSDOH will provide the five-digit code that specifies the reason for the claim being pended; the description of the code is found in the Error Reason Message (see next row). Up to 2 reason codes may be reported.
Error Reason Message1	X(90)	299-388	Remittance Message – pend message on the remittance line that corresponds to the reason code. See note at right for kick newborn/maternal or stop loss message.	NYSDOH will provide the pend message that corresponds to the Error Reason Code. In the instance of reporting kick newborn/maternal or stop loss claims when the claim charge amount is not equal to the claim payment amount, this field will contain "Charges exceed contracted/legislated fee".
Error Reason Code2	X(5)	390-394	See Error Reason Code1.	See Error Reason Code1.
Error Reason Message2	X(90)	396-485	See Error Reason Message1.	See Error Reason Message1.
State Adjustment/ Void Message/ Retro Indicator	X(40)	487-526	State Adjustment/Void Message – message to indicate a State-submitted Adjustment or Void. Or, message to indicate Retro Rate Reversal or Retro Rate Correction.	NYSDOH will provide a message to indicate a State-submitted Adjustment or Void. For Retroactive Rate changes that are reported on the 820 transaction, the following messages will be placed in this field to identify these adjustments to Providers: 'Retro Rate Reversal' for retroactive rate adjustment reversal (credit adjustment). 'Retro Rate Correction' for retroactive rate adjustment correction (debit adjustment).
			Record Expansion **(See Record Layout below)**	
NPI	X(10)	528-537	Not reported with the 820	This field will be space filled.

Field Name	Format	Position	eMedNY Description	NYS Medicaid Note
Bill NPI	X(10)	539-548	Not reported with the 820	This field will be space filled.
Filler	X(50)	550-599	Space filled	
End of Record/File Indicator	X(1)	600	End of Record / File Indicator is a Tilde: ~	