New York State Medicaid
HIPAA Transaction Standard Companion Guide

Refers to the Implementation Guides Based on ASC X12 version 005010

Based on CAQH-CORE v5010 Master Companion Guide Template
Preface
This Companion Guide to the v5010 ASC X12N Implementation Guides and associated errata adopted under HIPAA¹ clarifies and specifies the data content when performing Electronic Data Interchange (EDI) with New York State Medicaid. Transmissions based on this companion guide, used in tandem with the v5010 ASC X12N Implementation Guides (Type 3 Technical Reports or TR3s), are compliant with both ASC X12 syntax and those guides. This Companion Guide is intended to convey information that is within the framework of the ASC X12N Implementation Guides adopted for use under HIPAA. The Companion Guide is not intended to convey information that in any way exceeds the requirements or usages of data expressed in the Implementation Guides.

¹ The Health Insurance Portability and Accountability Act of 1996
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1. INTRODUCTION
This section describes how ASC X12N TR3 Implementation Guides (IGs) adopted under HIPAA will be detailed with the use of a table. Please refer to Section 10, where New York State Medicaid has provided tables to describe additional information, in addition to the information in the IGs. That information can:

- Limit the repeat of loops, or segments
- Limit the length of a simple data element
- Specify a sub-set of the IGs internal code listings
- Clarify the use of loops, segments, composite and simple data elements
- Any other information tied directly to a loop, segment, and composite or simple data element pertinent to trading electronically with New York State Medicaid.

Scope
This HIPAA Transaction Standard Companion Guide is limited to discussion of the Eligibility Inquiry and Response, the Claim Status Inquiry and Response, and the Health Care Claim Payment Advice transactions as of the publication date. This document is intended as a resource to assist providers, clearinghouses, service bureaus, and all other trading partners of the New York State Department of Health (NYSDOH) in successfully conducting Electronic Data Interchange (EDI) of administrative health care transactions. This document provides instructions for enrolling as a NYSDOH Trading Partner, obtaining technical assistance, initiating and maintaining connectivity, sending and receiving files, testing, and other related information. This document does not provide detailed data specifications, which are published separately by the industry committees responsible for their creation and maintenance.

The Transaction Instruction component of this companion guide must be used in conjunction with an associated ASC X12 Implementation Guide. The instructions in this companion guide are not intended to be stand-alone requirements documents. This companion guide conforms to all the requirements of any associated ASC X12 Implementation Guide and is in conformance with ASC X12’s Fair Use and Copyright statements.

Overview
This guide provides communications-related information a Trading Partner needs to enroll as a Trading Partner, obtain support, format the ISA and GS envelopes, and exchange test and production transactions with NYSDOH.

Providers who are not enrolled in New York State Medicaid cannot enroll as a Trading Partner until registered and credentialed with the NYSDOH. Please contact NYSDOH Enrollment at (518) 474-8161.

HIPAA includes provisions for administrative simplification. This requires the Secretary of the Department of Health and Human Services (HHS) to adopt standards to support the electronic exchange of administrative and financial health care transactions primarily between health care providers and plans. HIPAA directs the Secretary to adopt standards for transactions to enable health information to be exchanged electronically and to adopt specifications for implementing each standard. HIPAA serves to:

- Create better access to health insurance
- Limit fraud and abuse
- Reduce administrative costs

References
For billing instructions specific to practice or facility types, reference the NYSDOH Provider Manuals posted at:
Related resources such as FAQs, Crosswalks, and the complete set of eMedNY Companion Guides are available from the "eMedNY HIPAA Support tab at:
https://www.emedny.org/HIPAA/5010/index.aspx

The eMedNY website also contains links to all forms and related information for enrollment as a Trading Partner of NYSDOH. The enrollment process is described in detail in the Provider Enrollment Guide:
https://www.emedny.org/info/ProviderEnrollment/index.aspx

This table lists the X12N Implementation Guides for which specific transaction instructions apply and which are included in Section 10 of this document.

<table>
<thead>
<tr>
<th>Unique ID</th>
<th>Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>005010X279A1</td>
<td>Health Care Eligibility Benefit Inquiry and Response (270/271)</td>
</tr>
<tr>
<td>005010X212</td>
<td>Health Care Claim Status Request and Response (276/277)</td>
</tr>
<tr>
<td>005010X220</td>
<td>Benefit and Enrollment Maintenance (834)</td>
</tr>
<tr>
<td>005010X218A1</td>
<td>Health Care Claim Payment/Advice (835)</td>
</tr>
<tr>
<td>005010X223A2</td>
<td>Health Care Claim Institutional (837)</td>
</tr>
<tr>
<td>005010X222A1</td>
<td>Health Care Claim Professional (837)</td>
</tr>
<tr>
<td>005010X224A2</td>
<td>Health Care Claim Dental (837)</td>
</tr>
<tr>
<td>005010X217</td>
<td>Health Care Services Review-Request for Review and Response (278)</td>
</tr>
<tr>
<td>005010X214</td>
<td>Health Care Claim Acknowledgment (277)</td>
</tr>
<tr>
<td>005010X218</td>
<td>Payroll Deducted and Other Group Premium for Insurance Products (820)</td>
</tr>
<tr>
<td>005010X231A1</td>
<td>Implementation Acknowledgement for Health Care Insurance (999)</td>
</tr>
</tbody>
</table>

The Implementation Guides are available at:
http://store.x12.org/

Additional Information
It is assumed that the readers of this document are familiar with HIPAA and its associated Regulations and with EDI standards as developed by the Accredited Standards Committee X12 (ASCX12) and published in the implementation guides (Type 3 Technical Reports) for the included transactions.

The authors of this document address its contents to both technical and non-technical readers tasked with designing, implementing, and/or supporting EDI with New York State Medicaid.

HIPAA Privacy and Security
Trading Partners are responsible for the preservation, privacy, and security of data in their possession. While using the application the user has access to data that contains Protected Health Information (PHI). This information must be handled in accordance with federally prescribed regulations.

2. GETTING STARTED
Working with New York State Medicaid
All eMedNY support services can be accessed through the eMedNY Call Center by calling (800) 343-9000.

- Technical assistance for HIPAA/EDI related issues can also be obtained by emailing eMedNYHIPAASupport@csra.com
- Enrollment Inquiries: emedny_enrollment@csra.com

Trading Partner Registration
New York State Medicaid Program Enrollment
NYSDOH requires any entity exchanging electronic data with New York State Medicaid to be enrolled in the New York State Medicaid Program. This requirement applies to Clearinghouses and Service Bureaus as well as to Providers. New York State Medicaid Enrollment Forms and instructions are available at: https://www.emedny.org/info/ProviderEnrollment/index.aspx

Successful enrollment is required before proceeding with EDI.

Requirements for Electronic Data Interchange
Prior to establishing access with New York State Medicaid’s eMedNY system, the enrolled Medicaid provider must meet the following requirements.

ETIN (Electronic Transmitter Identification Number)
NYSDOH requires any entity that intends to exchange electronic data with New York State Medicaid to obtain an ETIN. An ETIN is used to identify a submitter. An ETIN may also be used, in conjunction with a Provider ID, to set up electronic routing of Electronic Remittance Advices (ERAs). There are two types of ETIN applications:

- Provider ETIN Application: https://www.emedny.org/info/ProviderEnrollment/ProviderMaintForms/401101_ETIN_APPL_Provider_Electronic_Paper_ETIN_Application.pdf
- Service Bureau/Billing Agency ETIN Application: https://www.emedny.org/info/ProviderEnrollment/ProviderMaintForms/403101_ETIN_SBaP_ETIN_Service_Bureau_application.pdf

Note: A service Bureau/Billing Agency ETIN Application is used only by entities that submit and/or receive transactions on behalf of an enrolled New York State Medicaid provider.

Certification Statement for Existing ETINs
A notarized Certification Statement must be submitted for each enrolled Provider ID and ETIN combination. The Certification Statement is packaged with the ETIN Application download and is also available as a standalone document at: https://www.emedny.org/info/ProviderEnrollment/ProviderMaintForms/490501_ETIN_CERT_Certification_Statement_Cert_Instructions_for_Existing_ETINs.pdf

Certification of the Provider to the ETIN is required and must be renewed annually.

Note: To add a enrolled provider to an existing ETIN only the Certification Statement is required.
TPA (Trading Partner Agreement)
All Trading Partners must have a Trading Partner Agreement on file. The TPA can be executed only upon successful enrollment into the New York State Medicaid Program and upon receiving an ETIN.

The TPA is available at:
https://www.emedny.org/info/providerenrollment/providermaintforms/801101_trdprtagr_trading_partner_agreement.pdf

UserID
A UserID must be obtained to login and exchange transactions in batch mode (other means of user authentication can be applied to real time interactive transactrions.) Requirements are specific to the means of communication selected. See Communications Protocols Information in this guide. Also refer to;
https://www.emedny.org/selfhelp/index.aspx

Default ETIN Selection Form

Note to Managed Care Organizations:
Managed Care Rosters are delivered solely based on the default ETIN in the provider's profile.

The Trading Partner must designate a Default ETIN to receive information about Medicare Crossover claims, State-submitted adjustments and voids, and claims submitted on paper in their ERA. An ERA reporting these claims will be generated only for the provider’s default ETIN. Only one Default ETIN is allowed for a provider.

If a Default ETIN was not selected on the Electronic or PDF Remittance Advice Request form, one can be selected by filing the Default Electronic Transmitter Identification Number (ETIN) Selection Form:
https://www.emedny.org/info/ProviderEnrollment/ProviderMaintForms/401103_ETINDFLT_Default_ETIN_Selection_Form.pdf.

Certification and Testing Overview
Reminder: Testers are responsible for the preservation, privacy, and security of data in their possession. While using production data that contains PHI to conduct testing, the data must be guarded and disposed of appropriately. A notarized Certification Statement for Existing ETINs, as dicussed in this guide under Payer Specific Business Rules and Limitations, is required prior to testing.

eMedNY Provider Test Environment (PTE)
The eMedNY PTE is designed to enable New York State Medicaid trading partners to test batch and real-time EDI transactions using the same validation, adjudication logic, and methods as the eMedNY production environment. Test transactions submitted to the eMedNY PTE undergo processes that verify and report on data structure and content to the same degree of stringency as live transactions sent to the eMedNY production environment, and receive, in most cases, the same system responses at each step.

For similar inquiries, the response in the PTE may not be identical to the response in the production environment. For example, edits involving duplicate and near-duplicate claims, or prior authorization submissions, are not applied in PTE, so as to allow for iterative testing. No claim or authorization requests are pended in the PTE.

PTE Enrollment and Support
• Provider Profiles
  Provider profiles in the PTE are mirrored from the eMedNY production environment. Provider enrollment occurs in the production environment and there is no separate enrollment necessary for the PTE.

• PTE Provider Support
  Email: eMedNYHIPAASupport@csra.com
  eMedNY Call Center: (800) 343-9000.

3. TESTING WITH NEW YORK STATE MEDICAID
The eMedNY PTE enables Trading Partners to conduct end-to-end testing.

PTE (Provider Testing Environment) Access Methods
eMedNY PTE can be accessed using any of your existing eMedNY Access Methods (please reference the Communication Protocol Specifications heading under Section 4 of this document) with a few exceptions (see PTE Access Exceptions below).

Since existing access methods are being used for PTE access, it is critical the test indicator is valued in the inbound/outbound transactions.

For test ASC X12 transactions, including 270 and 276: “Test Indicator” in ISA15 is set to “T”

Note: If the appropriate indicator for a transaction is not set to Test (T), the transactions will be processed through the production environment.

PTE Access Exceptions (not supported)
• ePACES
• Audio Response Unit (ARU)
• Paper

Note: Since these are internal applications maintained by eMedNY, end user testing is not necessary. User documentation has been modified for these select access methods.

PTE Availability and Submission Cutoff Times
Outside of normal system maintenance, the eMedNY PTE is available continuously for submitting test transactions and receiving associated responses.

The eMedNY PTE may experience processing delays because the production environment is given higher priority than the test environment. Although such delays are uncommon, the delay may cause submissions to be processed in the following week’s cycle.

PTE Synchronization to Production Environment
The eMedNY PTE contains essentially the same dimensional data as the eMedNY production environment; however it is not synchronized continuously. Rather, it is updated to reflect the current state of the production environment, generally on a bi-weekly basis, contingent upon system load. This means that client, provider, payment rate, and other information that is subject to update may occasionally differ between the two systems. The eMedNY PTE does not contain the same historical transaction data as the eMedNY production environment. As a result, your experience with historical edits, transaction relationship requirements, and similar transactional results may be different than in production.
PTE Financial Cycle

As is the case with the eMedNY production environment, the eMedNY Provider Test Environment has a Financial Cycle. The PTE Financial Cycle is a weekly processing event in which test Remittance Advice files are prepared. No Pended Claims Reports are generated because no claims are pended in the PTE. However, Managed Care Organizations who receive the 820 transaction will receive the Managed Care Capitation Premium Pended and Denied Claims report, listing denied claims.

The PTE cycle emulates payments for successfully adjudicated test claims using fictitious Electronic Funds Transfer (EFT) and bank account numbers. The PTE cycle cutoff is 2:00PM every Friday. Remittance advices are released by the following Monday (production processing can, as noted above, on rare occasions cause 24-48 hour delays).

EFT Emulated Payments in the PTE

The first eight positions of the “dummy” EFT transactions from the PTE cycle are all 9’s. The remaining seven positions are numeric and are system-generated. A paper EFT Notification is generated with the following notice:

“PAYMENT IN THE ABOVE AMOUNT WAS CALCULATED. NO EFTS WILL BE GENERATED IN THE PROVIDER TEST ENVIRONMENT”.

In the 835 or 820 Remittance Advice, the Routing Number and Account Number (Data Elements BPR13 and BPR14) are defaulted to all 9s.

Testing and Certification Requirements

Requirements for using the eMedNY PTE are the same as for Production. In order to utilize the eMedNY PTE the following components are required:

- An active New York State Medicaid ETIN
- A notarized Certification Statement (annual re-certification required)
- Active user account and login information for accessing eMedNY
- For HIPAA-regulated providers (health care providers) - registration of NPI
- For non-HIPAA-regulated providers (non-health care providers) - an active New York State Medicaid Provider ID
- For facilities - reporting of affiliated NPI’s

For more information about Trading Partner requirements refer to the Provider Maintenance Forms at eMedNY.org:
https://www.emedny.org/info/ProviderEnrollment/allforms.aspx

X12 Transaction Versions

The eMedNY Provider Test Environment accepts and processes only ASC X12 version 5010.

PTE Limits

Transaction size limits are set for inbound test files that differ from the eMedNY production limits.

- Real-time transactions testing in the PTE must not be used for volume testing. Trading partners are allowed to submit a maximum of fifty (50) real-time test transactions per hour in the PTE.
- Submitters are limited to sending two batch transmissions (two physical files) to the PTE per 24-hour period. Also, all electronic batch file submissions are limited to 50 records or transactions.
- The specific data item counted in each transaction:
**Transaction Loop – Segment Counting Instructions**

<table>
<thead>
<tr>
<th>Transaction</th>
<th>Loop – Segment</th>
<th>Counting Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>270</td>
<td>2100C – NM1*IL</td>
<td>Each NM1 Segment in loop 2100C constitutes a Subscriber.</td>
</tr>
<tr>
<td>276</td>
<td>2200D – TRN*</td>
<td>Each TRN Segment in loop 2200D constitutes a claim inquiry.</td>
</tr>
<tr>
<td>278</td>
<td>ST-SE (Transaction Set)</td>
<td>eMedNY limits the Subscriber count to a maximum of 1 per Transaction Set (ST – SE segment). Therefore, the number of Transaction Sets per uploaded physical file must not exceed 50.</td>
</tr>
<tr>
<td>834</td>
<td>2000 – INS</td>
<td>Each NM1 Segment in loop 2000 constitutes a Subscriber.</td>
</tr>
<tr>
<td>837</td>
<td>2300 – CLM</td>
<td>Each CLM Segment in loop 2300 constitutes a claim.</td>
</tr>
</tbody>
</table>

**Routing Test Files to PTE**

Test transactions are routed into the eMedNY PTE simply by setting the appropriate indicator on the inbound file. For ASC X12 Transactions, set the Usage Indicator (Data Element ISA15) to a value of “T”.

```
Version 5010 inbound
ISA*00*          *00*          *ZZ*ETIN           *ZZ*EMEDNYBAT      *160324*1428***00501*000000485*0*T*~
```

**PTE Response File Naming Conventions**

Response file naming in PTE is nearly identical to the file naming convention used in the production environment. The only difference is that the responses returned in PTE contain a ‘T’ for test.

- **“F-file”**
  A proprietary “F-file” is returned only in response to an unrecognized or unsupported file type or for Interchange errors when the “Acknowledgment Requested” Data Element in ISA14 is set to “0”. This file is a short text message describing the nature of the error.
  - Here is an example response filename in eMedNY eXchange:
    F-USERID-160530123456T-.020001.x12
  - Here is an example response filename in an FTP Account:
    F160328152041T.020001.txt

- **“R-files”**
  With the exception of the “F-file” as noted earlier, the filenames of all PTE system response transactions, including acknowledgments and remittance files, begin with a capital letter “R”, followed by a 12 digit date and time stamp (24-hour time, in the format YYMMDDHHMMSS). All PTE “R-files” include the character “T”, sent as an indicator in the last byte of the first “node” of the filename, except for Electronic Remittances, which have a “T” in the fourth node of the filename.
  - Here is an example of PTE “R-file” name for eXchange and FTP accounts:
    R160519112301T

**4. CONNECTIVITY WITH NY MEDICAID/COMMUNICATIONS**

**Process Flows**

Trading Partner:
- Establishes communications link
- Selects type of transaction to send
- Uploads file

eMedNY Transaction Information CG 
February 1, 2019
Front-end Validation Process for X12 Transactions (Batch Mode)

Submitter

Batch X12 Transaction

Valid Interchange?

Yes

Valid Functional Group?

Yes

Positive 999

Valid Functional Group?

Yes

Validated Claims

eMedNY Production

Validated Request or Inquiry

Preadjudication Validation

Validated Claims

Valid Functional Group?

Yes

Positive 999

Valid Functional Group?

Yes

Validated Claims

eMedNY Production

Validated Request or Inquiry

Preadjudication Validation

Validated Claims

Valid Functional Group?

Preadjudication Validation (PTE)

Validated Request or Inquiry

Validated claims

PTE (Test system)

Valid Functional Group?

Yes

Validation?

Yes

Valid Functional Group?

Yes

Validated Claims

eMedNY Production

Validated Request or Inquiry

Preadjudication Validation

Validated Claims

Valid Functional Group?

Yes

Validation?

Yes

Valid Functional Group?

Yes

Validated Claims

eMedNY Production

Validated Request or Inquiry

Preadjudication Validation

Validated Claims

Valid Functional Group?

I SA15='T' or 'P' (Test or Production)?

Yes

'P' (Production)

837?

Yes

Preadjudication Validation

Validated Claims

eMedNY Production

Validated Request or Inquiry

Preadjudication Validation (PTE)

Validated claims

PTE (Test system)

Valid Functional Group?

Yes

Validation?

Yes

Valid Functional Group?

Yes

Validated Claims

eMedNY Production

Validated Request or Inquiry

Preadjudication Validation

Validated Claims

Valid Functional Group?

Valid Interchange?

Yes

Valid Functional Group?

Yes

Validated Claims

eMedNY Production

Validated Request or Inquiry

Preadjudication Validation

Validated Claims

Valid Functional Group?

Valid Interchange?

Yes

Valid Functional Group?

Validated Claims

eMedNY Production

Validated Request or Inquiry

Preadjudication Validation

Validated Claims

Valid Functional Group?

Valid Interchange?

Yes

Valid Functional Group?

Validated Claims

eMedNY Production

Validated Request or Inquiry

Preadjudication Validation

Validated Claims

Valid Functional Group?

Valid Interchange?

Yes

Valid Functional Group?

Validated Claims

eMedNY Production

Validated Request or Inquiry

Preadjudication Validation

Validated Claims

Valid Functional Group?

Valid Interchange?

Yes

Valid Functional Group?

Validated Claims

eMedNY Production

Validated Request or Inquiry

Preadjudication Validation

Validated Claims

Valid Functional Group?

Valid Interchange?

Yes

Valid Functional Group?

Validated Claims

eMedNY Production

Validated Request or Inquiry

Preadjudication Validation

Validated Claims

Valid Functional Group?

Valid Interchange?

Yes

Valid Functional Group?

Validated Claims

eMedNY Production

Validated Request or Inquiry

Preadjudication Validation

Validated Claims

Valid Functional Group?

Valid Interchange?

Yes

Valid Functional Group?

Validated Claims

eMedNY Production

Validated Request or Inquiry

Preadjudication Validation

Validated Claims

Valid Functional Group?

Valid Interchange?

Yes

Valid Functional Group?

Validated Claims

eMedNY Production

Validated Request or Inquiry

Preadjudication Validation

Validated Claims

Valid Functional Group?

Valid Interchange?

Yes

Valid Functional Group?

Validated Claims

eMedNY Production

Validated Request or Inquiry

Preadjudication Validation

Validated Claims

Valid Functional Group?

Valid Interchange?

Yes

Valid Functional Group?

Validated Claims

eMedNY Production

Validated Request or Inquiry

Preadjudication Validation

Validated Claims

Valid Functional Group?

Valid Interchange?

Yes

Valid Functional Group?

Validated Claims

eMedNY Production

Validated Request or Inquiry

Preadjudication Validation

Validated Claims

Valid Functional Group?

Valid Interchange?

Yes

Valid Functional Group?

Validated Claims

eMedNY Production

Validated Request or Inquiry

Preadjudication Validation

Validated Claims

Valid Functional Group?

Valid Interchange?

Yes

Valid Functional Group?

Validated Claims

eMedNY Production

Validated Request or Inquiry

Preadjudication Validation

Validated Claims

Valid Functional Group?

Valid Interchange?

Yes

Valid Functional Group?

Validated Claims

eMedNY Production

Validated Request or Inquiry

Preadjudication Validation

Validated Claims

Valid Functional Group?

Valid Interchange?

Yes

Valid Functional Group?

Validated Claims

eMedNY Production

Validated Request or Inquiry

Preadjudication Validation

Validated Claims

Valid Functional Group?

Valid Interchange?

Yes

Valid Functional Group?

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eMedNY Production

Validated Request or Inquiry

Preadjudication Validation

Validated Claims

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Preadjudication Validation

Validated Claims

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Valid Interchange?

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Validated Request or Inquiry

Preadjudication Validation

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Preadjudication Validation

Validated Claims

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Valid Interchange?

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Valid Functional Group?

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eMedNY Production

Validated Request or Inquiry

Preadjudication Validation

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eMedNY Production

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Preadjudication Validation

Validated Claims

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eMedNY Production

Validated Request or Inquiry

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Preadjudication Validation

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Valid Interchange?

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Valid Functional Group?

Validated Claims

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Preadjudication Validation

Validated Claims

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Valid Interchange?

Yes

Valid Functional Group?

Validated Claims

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Validated Request or Inquiry

Preadjudication Validation

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Valid Functional Group?

Valid Interchange?

Yes

Valid Functional Group?

Validated Claims

eMedNY Production

Validated Request or Inquiry

Preadjudication Validation

Validated Claims

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Valid Interchange?

Yes

Valid Functional Group?

Validated Claims

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Validated Claims

Valid Functional Group?

Valid Interchange?

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Valid Functional Group?

Validated Claims

eMedNY Production

Validated Request or Inquiry

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Valid Interchange?

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Valid Functional Group?

Validated Claims

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Valid Functional Group?

Valid Interchange?

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Valid Functional Group?

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Validated Claims

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Valid Interchange?

Yes

Valid Functional Group?

Validated Claims

eMedNY Production

Validated Request or Inquiry

Preadjudication Validation

Validated Claims

Valid Functional Group?

Valid Interchange?

Yes

Valid Functional Group?

Validated Claims

eMedNY Production

Validated Request or Inquiry

Preadjudication Validation

Validated Claims

Valid Functional Group?

Valid Interchange?

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Valid Functional Group?

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eMedNY Production

Validated Request or Inquiry

Preadjudication Validation

Validated Claims

Valid Functional Group?

Valid Interchange?

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Valid Functional Group?

Validated Claims

eMedNY Production

Validated Request or Inquiry

Preadjudication Validation

Validated Claims

Valid Functional Group?

Valid Interchange?

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Valid Functional Group?

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Valid Interchange?

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Valid Functional Group?

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Valid Interchange?

Yes

Valid Functional Group?

Validated Claims

eMedNY Production

Validated Request or Inquiry

Preadjudication Validation

Validated Claims

Valid Functional Group?

Valid Interchange?

Yes

Valid Functional Group?

Validated Claims

eMedNY Production

Validated Request or Inquiry

Preadjudication Validation

Validated Claims

Valid Functional Group?

Valid Interchange?

Yes

Valid Functional Group?

Validated Claims

eMedNY Production

Validated Request or Inquiry

Preadjudication Validation

Validated Claims

Valid Functional Group?
Front-end EDI Validation Process for X12 Transactions (Real-time)
Production Processing – X12 837 Claims

Production Claims (ISA 15 = "P") from Front-end EDI Validation Process

Adjudication
Claims Editing
(Pay, Deny, Pend) and Pricing

Financial Cycle

Payment > 0?

Yes

EFT

NO

PDF RA (includes Pends)

ERA?

YES

ERA and pends report

NO

Receiver’s Staff

Receiver’s System

Payee’s Bank
Test Processing – X12 837 Claims

Test Claims (ISA 15 = "T") from Front-end EDI Validation Process

Test Adjudication Claims Editing (Pay, Deny)

Test Financial Cycle

Test ERA

ERAS? Yes

Test Paper RA

Mail

Test Paper RA

Receiver’s System

ERA?

No

Receiver’s Staff

Receiver’s System
Transmission Administrative Procedures
Determine if the transmission you are sending is Test or Production and is using the appropriate indicator. For details about available eMedNY Access Methods, refer to the Communication Protocol Specifications section below.

Re-transmission Procedure
In the event of an interrupted communications session the Trading Partner only has to reconnect and initiate their file transfer as they normally do.

If a file fails the pre-adjudication process, errors must be corrected before re-transmission. It is recommended that transmitted files that were rejected be assigned new Interchange, Group, and Transaction Control Numbers.

Communication Protocol Specifications
The following communication methods are available for the exchange of electronic transactions with New York State Medicaid:

- ePACES
- eMedNY eXchange
- FTP
- eMedNY File Transfer Service using SOAP
- CAQH-CORE Web Services

ePACES
ePaces is a web application provided free to NYS Medicaid Trading Partners. This method utilizes a web portal where users enter their information in a direct data entry format. Users can submit eligibility requests, prior approval requests, and all claims types (with the exception of NCPDP D.0 pharmacy claims, only real time or batch is available for this claim type.) Access is free; only an internet connection is needed to access the web application.

Please go to the following URL for more detailed information:
https://www.emedny.org/selfhelp/ePACES/epaces_generalinfo.aspx
Or contact the eMedNY Call Center at 1-800-343-9000.

eMedNY eXchange
eMedNY eXchange is a web-based access method used to exchange transaction files. The application works similarly to a typical FTP (File Transfer Protocol) interface. Users are assigned a directory and are able to upload and download transaction files. When uploaded, the files are sent to eMedNY for processing. The responses are delivered back to the user’s directory where they can be downloaded and saved locally. For security reasons, the eMedNY eXchange is accessible only through the eMedNY.org website. eMedNY eXchange is accessed using the login and password established during the ePACES enrollment process. At least one login attempt into ePACES must be successful before eXchange may be accessed.

Please go to the following URL for more detailed information:
https://www.emedny.org/selfhelp/exchange/faq.aspx
Or contact the eMedNY Call Center at 1-800-343-9000.

FTP
This method is the standard protocol for submitting batch transmissions. FTP allows users to transfer ZIP files from their computer to another computer (upload) or from another computer to their computer (download). Each batch file transmission is required to complete within two hours. Any transmission exceeding two hours will be disconnected. FTP is strictly a dial-up connection.

Please go to the following URL for more detailed information: https://www.emedny.org/selfhelp/FTP-bbs/ftp_faq.aspx

Or contact the eMedNY Call Center at 1-800-343-9000.

**SOAP**

Simple Object Access Protocol (SOAP) is a protocol for exchanging structured information in XML format used in the implementation of web services delivered over Hyper Text Transfer Protocol (HTTP) and other protocols. The structured information exchange is defined by a WSDL (Web Service Definition Language) file and XSD (XML Schema Definition) files appropriate for each service. WSDL and XSD are W3C (World Wide Web Consortium) standards.

Please go to the following URL for more detailed information: https://www.emedny.org/selfhelp/index.aspx

Or contact the eMedNY Call Center at 1-800-343-9000.

**CORE Web Services**

CORE Web Services involves using Hypertext Transfer Protocol Secure (HTTPS) over an Internet connection. X12 transactions are send in an envelope structure compliant with the HTTP MIME Multipart and SOAP/WSDL standards as per CAQH-CORE Connectivity Rule 470.

Please go to the following URL for more detailed information: https://www.emedny.org/selfhelp/CORE_Web_Services_User_Guide.pdf

Or contact Tier 2 Operations at eMedNYProviderServices@csra.com or the eMedNY Call Center at 1-800-343-9000.

**Passwords**

The ePACES and eMedNY eXchange applications both utilize the same password. These passwords require a reset every 60 days. The passwords are maintained by the external user. If a general user needs a password reset, they must contact the Administrator of the ePACES account. eMedNY Call Center representatives can only make changes to Administrator accounts.

FTP passwords are permanent until changed, by request only. If the password on an FTP account needs to be changed, the user must contact the eMedNY Call Center and provide the User ID and the Unique Identifier that was listed on the Security Packet B.

The two systems utilizing SOAP protocols use different password procedures. File Transfer System (FTS) uses the eXchange credentials to submit batch files - it therefore follows the same rules for passwords as eXchange (and ePACES.) Meds History System (MHS) uses the Certificate Administrator's login as the UserID and maintains a separate password set up through eMedNY. Providers should email emednyproviderservices@csra.com to set up or change the MHS password.

**Reminder:** Strong security precautions must be taken with passwords;
• Passwords must be sufficiently complex to not be guessable
• Passwords must not be shared
• Passwords must not be written down or stored electronically where persons other than the authorized party can access them.

5. CONTACT INFORMATION

EDI Customer Service
(See contact information below)

EDI Technical Assistance
(See contact information below)

Provider Services Number
(See contact information below)

For each of the above services or for assistance in troubleshooting rejected transactions, or for technical support regarding connectivity please contact:

eMedNY Call Center at (800) 343-9000

Send an email to: mailto:emednyproviderservices@csra.com

For all EDI syntax and/or HIPAA transaction compliance issues send an email to: emedNYHIPAASupport@csra.com

For enrollment issues send email to: emedny_enrollment@csra.com

Note: Please have the applicable provider identifier – the NPI for Health Care Providers or the NYS Medicaid Provider ID for Atypical Providers available for tracking and faster issue resolution.

Applicable Websites/e-mail

The New York State Department of Health: Resources
Publicly available information about the Medicaid Program:

The monthly publication "Medicaid Update":

New York State Medicaid Fiscal Agent – Forms and Resources
Information about a variety of topics essential to Medicaid providers and their Business Associates, including topics such as provider enrollment, training, and how to establish and use the various communication channels for exchanging electronic claims and related transactions is publicly available at: www.emedny.org.

All Provider Enrollment Forms including Maintenance Forms are available at www.emedny.org under the Provider Enrollment tab.

More details about billing guidelines may be accessed via Provider Manuals, available on the eMedNY website. Billing Guidelines are arranged by specific provider type(s):
More information about the Remittance Advice is available at:
https://www.emedny.org/ProviderManuals/AllProviders/General_Remittance_Guidelines.pdf
For additional information, providers may also contact the eMedNY Call Center at (800) 343-9000.

Other Useful Websites

- The registry for the NPI (National Provider Identifier) is the National Plan and Provider Enumeration System (NPPES), at: https://nppes.cms.hhs.gov/NPPES/Welcome.do.
- Implementation Guides and Non-medical code sets are at: http://store.x12.org/.
- The National Uniform Billing Committee: http://www.nubc.org/
- Information from CMS about ICD-10 codes: http://www.cms.gov/Medicare/Coding/ICD10/Index.html
  and https://www.cms.gov/ICD10/.
- Quarterly updates to the HCPCS code set are available from CMS at: https://www.cms.gov/Medicare/Coding/MedHCPCSGenInfo/index.html?redirect=/MedHCPCSGenInfo/ (CPT-4, or Level 1 HCPCS, is maintained and licensed by the American Medical Association and is available for purchase in various hardcopy and softcopy formats from of variety of vendors).
- Information at the Federal level about Medicaid can be found at: http://www.cms.hhs.gov/home/medicaid.asp.
- The CMS online Manuals system and Internet Only Manuals (IOM) system, including Transmittals and Program Memoranda, at: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/index.html
- Place of Service Codes are listed in the Medicare Claims Processing Manual and are maintained by (CMS), available online at: https://www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set.html.

6. CONTROL SEGMENTS/ENVELOPES

ISA-IEA

Sender and Receiver Codes:
<table>
<thead>
<tr>
<th>Transaction</th>
<th>ISA06 (Interchange Sender ID)</th>
<th>ISA08 (Interchange Receiver ID)</th>
</tr>
</thead>
<tbody>
<tr>
<td>270 interactive</td>
<td>Submitter’s ETIN</td>
<td>EmedNYREL</td>
</tr>
<tr>
<td>271 interactive</td>
<td>EMEDNYREL</td>
<td>Submitter’s ETIN</td>
</tr>
<tr>
<td>270 batch</td>
<td>Submitter’s ETIN</td>
<td>EmedNYBAT</td>
</tr>
<tr>
<td>271 batch</td>
<td>EMEDNYBAT</td>
<td>Submitter’s ETIN</td>
</tr>
<tr>
<td>276 batch</td>
<td>Submitter’s ETIN</td>
<td>EmedNYBAT</td>
</tr>
<tr>
<td>277 batch</td>
<td>EMEDNYBAT</td>
<td>Submitter’s ETIN</td>
</tr>
<tr>
<td>277 Claim Acknowledgment batch</td>
<td>EMEDNYBAT</td>
<td>Submitter’s ETIN</td>
</tr>
<tr>
<td>278 request batch</td>
<td>Submitter’s ETIN</td>
<td>EmedNYBAT</td>
</tr>
<tr>
<td>278 response batch</td>
<td>EmedNYBAT</td>
<td>Submitter’s ETIN</td>
</tr>
<tr>
<td>820 batch</td>
<td>EmedNYBAT</td>
<td>Submitter’s ETIN</td>
</tr>
<tr>
<td>834 batch</td>
<td>Submitter’s ETIN</td>
<td>EmedNYBAT</td>
</tr>
<tr>
<td>835 batch</td>
<td>EmedNYBAT</td>
<td>Submitter’s ETIN</td>
</tr>
<tr>
<td>837 batch</td>
<td>Submitter’s ETIN</td>
<td>EmedNYBAT</td>
</tr>
<tr>
<td>837 interactive</td>
<td>Submitter’s ETIN</td>
<td>EmedNYREL</td>
</tr>
<tr>
<td>999 batch</td>
<td>EmedNYBAT</td>
<td>Submitter’s ETIN</td>
</tr>
</tbody>
</table>

**GS-GE**
Sender and Receiver Codes:

<table>
<thead>
<tr>
<th>Transaction</th>
<th>GS02 (Interchange Sender ID)</th>
<th>GS03 (Interchange Receiver ID)</th>
</tr>
</thead>
<tbody>
<tr>
<td>270 interactive</td>
<td>Submitter’s ETIN</td>
<td>EmedNYREL</td>
</tr>
<tr>
<td>271 interactive</td>
<td>EmedNYREL</td>
<td>Submitter’s ETIN</td>
</tr>
<tr>
<td>270 batch</td>
<td>Submitter’s ETIN</td>
<td>EmedNYBAT</td>
</tr>
<tr>
<td>271 batch</td>
<td>EmedNYBAT</td>
<td>Submitter’s ETIN</td>
</tr>
<tr>
<td>276 batch</td>
<td>Submitter’s ETIN</td>
<td>EmedNYBAT</td>
</tr>
<tr>
<td>277 batch</td>
<td>EmedNYBAT</td>
<td>Submitter’s ETIN</td>
</tr>
<tr>
<td>277 Claim Acknowledgment batch</td>
<td>EmedNYBAT</td>
<td>Submitter’s ETIN</td>
</tr>
<tr>
<td>278 request batch</td>
<td>Submitter’s ETIN</td>
<td>EmedNYBAT</td>
</tr>
<tr>
<td>278 response batch</td>
<td>EmedNYBAT</td>
<td>Submitter’s ETIN</td>
</tr>
<tr>
<td>820 batch</td>
<td>EmedNYBAT</td>
<td>Submitter’s ETIN</td>
</tr>
<tr>
<td>834 batch</td>
<td>Submitter’s ETIN</td>
<td>EmedNYBAT</td>
</tr>
<tr>
<td>835 batch</td>
<td>EmedNYBAT</td>
<td>Submitter’s ETIN</td>
</tr>
<tr>
<td>837 batch</td>
<td>Submitter’s ETIN</td>
<td>EmedNYBAT</td>
</tr>
<tr>
<td>837 interactive</td>
<td>Submitter’s ETIN</td>
<td>EmedNYBAT</td>
</tr>
<tr>
<td>Transaction</td>
<td>GS02 (Interchange Sender ID)</td>
<td>GS03 (Interchange Receiver ID)</td>
</tr>
<tr>
<td>------------</td>
<td>-----------------------------</td>
<td>-------------------------------</td>
</tr>
<tr>
<td>837 interactive</td>
<td>Submitter’s ETIN</td>
<td>EMEDNYREL</td>
</tr>
<tr>
<td>999 batch</td>
<td>EMEDNYBAT</td>
<td>Submitter’s ETIN</td>
</tr>
</tbody>
</table>

**ST-SE**
NYSDOH has no requirements for the contents of the ST and SE segments other than those specified in the Type 3 Technical Reports published by X12N.

**7. PAYER SPECIFIC BUSINESS RULES AND LIMITATIONS**

**Data Format**
eMedNY does not support blocked data formats. Trading partners must not include Carriage Returns and/or Line Feeds in the inbound file.

**Connectivity Requirements**
NYSDOH requires and enforces all applicable Federal and State requirements to protect the security and integrity of its systems. All Trading Partners must meet these requirements to perform Electronic Data Interchange with NYSDOH and the eMedNY system. See Communications Protocol Specifications in this guide.

**Electronic Transmitter Identification Number**
An ETIN is used to identify the submitter and receiver of an EDI transmission. Every entity that exchanges administrative health care transactions with eMedNY systems must be enrolled as a Trading Partner with a unique Electronic Transmitter Identification Number (ETIN). See Section 2 Getting Started for information about the enrollment process.

The ETIN of the Trading Partner sending an Interchange is expected in the outside envelope data element ISA06, Interchange Sender ID. The ETIN of the Trading Partner sending the Functional Group is expected in data element GS02, Application Sender’s Code. These will often be the same.

An ETIN is used, in conjunction with a Provider ID, to set up electronic routing of Remittance Advices.

**Production Batch Transactions Size Limits**
NYSDOH has set a limit of 5,000 Transaction Sets (ST-SE) within a Functional Group (GS-GE). There are no limits being imposed at this time to the number of Functional Groups (GS-GE) that can be sent within an Interchange (ISA-IEA). Additionally, the following limits apply within each X12 Transaction Set (ST-SE):

**270 Eligibility Inquiry**
NYSDOH expects no more than 5000 Subscriber Levels (Loop 2000C) per Transaction Set (ST-SE).

**276 Claim Status Inquiry**
NYSDOH expects no more than 5000 Subscriber Levels (Loop 2000D) per Transaction Set (ST-SE).

**278 Health Care Services Review – Request**
Any limits within the Transaction Set (ST-SE) as specified in the ASC X12/005010X217 Health Care Services Review - Request for Review and Response (278).

**834 Benefit Enrollment and Maintenance**
NYSDOH expects no more than 5000 Member Level Detail Loops (Loop 2000)

**837 Health Care Claims**
NYSDOH expects no more than 5000 Claim Information Loops (Loop 2300) per Transaction Set (ST-SE).

Note: Transaction Sets exceeding these limits are subject to rejection.

**Institutional Provider Facility Affiliation of Practitioners**
Institutional providers must provide the NPI of all affiliated practitioners who will be reported as the Attending Provider in 837 Institutional claims. Instructions are available at:

https://npi.emedny.org/Facility/

**Ordering/Prescribing/Referring/Attending (OPRA) Providers**
All providers who order, prescribe, refer, or attend services payable by fee-for-service Medicaid are required to be enrolled in fee-for-service Medicaid even if they do not bill Medicaid. Enrollment status of these providers can be checked by using the Enrolled Providers Search at:

https://www.emedny.org/info/opra.aspx

**Instructions for Billing Atypical Services**
**NET (Non-emergency Transportation)**
Non-emergency Transportation billing is not a HIPAA-regulated function. NYSDOH has adopted the 837 Professional Health Care Claim transaction for this purpose. Please refer to the FAQ “What are some key requirements when billing for Non-emergency Ambulette Transportation, Taxi, Livery, Day Treatment and Transportation Network Company services?” at the FAQ page at eMedNY.org:

https://www.emedny.org/HIPAA/5010/FAQs/FAQs.aspx?cat=*  

**Managed Care Capitation Premium**
Managed Care Capitation Premium billing is not a HIPAA-regulated function. NYSDOH has adopted the 837 Institutional Health Care Claim transaction for this function. Please refer to the FAQ “Premium Billing - How should a Managed Care Plan submit a HIPAA 837I for premium billing?” at the FAQ page at eMedNY.org:

https://www.emedny.org/HIPAA/5010/FAQs/FAQs.aspx?cat=*  

See also the information about the Default ETIN Selector Form in this guide.

8. ACKNOWLEDGEMENTS AND/OR REPORTS

**Invalid Interchange Notifications**
A file containing one of these responses will be returned only when a negative response is necessary because the file cannot be processed any further. If produced, a submitter can expect this response within 2 hours after the file is uploaded to eMedNY. Header or envelope level errors are frequently caused by establishing a character as delimiter that is also present in the data content. To avoid these errors delimiters must not be alpha or numeric characters or space.

**Interchange Acknowledgment (TA1)**
Negative Interchange Acknowledgment (TA1) is returned only if the interchange control (ISA/IEA) structure validation fails and if a TA1 was requested (inbound ISA14 = ‘1’).
The TA1 Interchange Acknowledgment as implemented in eMedNY contains no values specific to NYS DOH requirements or processing. Specifications for the TA1 Segment are published in ASC X12C/005010X231 Implementation Guide Acknowledgment for Health Care Insurance (999).

**Negative Transfer Status (F-File and GS99)**

If a TA1 is not requested (inbound ISA14 is not set to ‘1’) and the ASC X12 interchange control structure of a batch transmission (ISA/IEA) cannot be processed, a text file is returned indicating the negative File Transfer Status (F-File). The notification consists of the string “GS99” for a real-time eligibility inquiry or interactive 837 with an unprocessable interchange structure.

**Pre-adjudication Claims Editing**

The eMedNY system uses a set of front-end edits to enforce the claims activity from each trading partner in both PTE and Production systems. This process occurs after the structure and syntax validation that causes the 999 transaction to be generated, but before claims are passed to the adjudication system. Pre-adjudication editing results are reported back to the submitter in the 277 Health Care Claim Acknowledgment transaction (277CA). For the code values reported for specific error conditions refer to the [NYS Medicaid Pre-Adjudication Crosswalk for Health Care Claims](https://www.emedny.org/HIPAA/5010/transactions/crosswalks/eMedNY%20Pre-Adjudication%20Crosswalk%20(837%20Health%20Care%20Claims).pdf).

**X12 Response Files**

eMedNY will return the appropriate X12 response to all inbound X12 transactions.

**Response File Table**

Inbound ASC X12 transactions are responded to as follows:

<table>
<thead>
<tr>
<th>REQUEST</th>
<th>BATCH RESPONSE</th>
<th>REAL-TIME RESPONSE</th>
</tr>
</thead>
<tbody>
<tr>
<td>270</td>
<td>F-FILE; TA1; 999; 271</td>
<td>GS99; TA1; 999; 271</td>
</tr>
<tr>
<td>276</td>
<td>F-FILE; TA1; 999; 277</td>
<td>N/A</td>
</tr>
<tr>
<td>278 Request</td>
<td>F-FILE; TA1; 999; 278 Response</td>
<td>N/A</td>
</tr>
<tr>
<td>834</td>
<td>F-FILE; TA1; 999</td>
<td>N/A</td>
</tr>
<tr>
<td>837</td>
<td>F-FILE; TA1; 999; 277CA</td>
<td>GS99; TA1; 999; 277CA</td>
</tr>
</tbody>
</table>

**Pended Claims Reporting**

**Pended Claims Report**

Pended claims do not appear in the 835 transaction; they are listed in the Pended Claims Report file, which will be sent along with the 835 transaction for any processing cycle that produces pended claims.

The specification for this report is at:


**Managed Care Capitation Premium Pended and Denied Claims Report**

Pended claims are not reported in the 820 transaction and only limited information is provided about denied claims. The Managed Care Capitation Premium Pended and Denied Claims Report will be sent with the 820 transaction for cycles with pended or denied claims.

The specification for this report is at:
Providers can control how information about pended claims is sent by completing the Pended Claim Recycle Request Form.

Available at: https://www.emedny.org/info/ProviderEnrollment/ProviderMaintForms/703101_PNDCLMFORM_PENDED_CLAIM_RECYCLE_REQUEST_FORM.pdf.

Either paper (PDF); or the Pended Claims Report (for receivers of the 835 Remittance Advice) or Managed Care Premium Pended and Denied Claims Report (for receivers of the 820 Premium Payment Notification) can be selected.

Electronic Remittances
A provider can choose from the 2 following pended claim delivery options:

- First Remit Only: This option would report pending claims in ONLY the first “new pend” remittance and not appear again until the status changes to a paid or denied claim, or
- Every Week: This option would report a cumulative list of all pending claims on every weekly remittance.

Paper (PDF) Remittances
Pended claims are included in the PDF remittance and no separate Pended Claims Report is produced. A provider can choose from the 3 following pended claim delivery options:

- First Remit Only: This option would report pending claims in ONLY the first “new pend” remittance and not appear again until the status changes to a paid or denied claim, or
- Cumulative Every 4th Week: This option would report pending claims in the first “new pend” remittance and again every 4th weekly cycle. The 4th cycle references weekly cycle numbers that are divisible by 4 (for example 1484, 1488, 1492 and so on). This means that every 4th cycle a provider would receive a cumulative list of all claims pending at that point in time, regardless of when a claim was first pended, or
- Every Week: This option would report a cumulative list of all pending claims on every weekly remittance.

Note: Any request to change options for electronic remittances must include the ETIN.

9. TRADING PARTNER AGREEMENTS
EDI Trading Partner Agreements ensure the integrity of the electronic transaction process. The Trading Partner Agreement is related to the electronic exchange of information, whether the agreement is conducted separately or as a part of a larger agreement, between each party to the agreement.

Trading Partners
An EDI Trading Partner is any entity (provider, billing service, software vendor, employer group, financial institution, etc.) that transmits electronic data to or receives electronic data from another entity. For the purposes of this document a Trading Partner is any entity that exchanges electronic health care data with New York State Medicaid or its agent through the eMedNY system.

10. TRANSACTION SPECIFIC INFORMATION
The tables in this section list specific transaction Instructions applicable to ASC X12 transactions:

<table>
<thead>
<tr>
<th>Unique ID</th>
<th>Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>005010X279A1</td>
<td>Health Care Eligibility Benefit Inquiry and Response (270/271)</td>
</tr>
<tr>
<td>005010X212</td>
<td>Health Care Claim Status Request and Response (276/277)</td>
</tr>
<tr>
<td>005010X214</td>
<td>Health Care Claim Acknowledgment (277)</td>
</tr>
<tr>
<td>005010X221A1</td>
<td>Health Care Claim Payment/Advice (835)</td>
</tr>
<tr>
<td>005010X223A2</td>
<td>Health Care Claim Institutional (837)</td>
</tr>
<tr>
<td>005010X222A1</td>
<td>Health Care Claim Professional (837)</td>
</tr>
<tr>
<td>005010X224A2</td>
<td>Health Care Claim Dental (837)</td>
</tr>
<tr>
<td>005010X231A1</td>
<td>Implementation Acknowledgment for Health Care Insurance (999)</td>
</tr>
</tbody>
</table>

The implementation guides (Type 3 Technical Reports) are available at: http://store.x12.org/.
### TR3: ASC X12N/005010X279A1 Health Care Eligibility Benefit Inquiry and Response (270/271) 
#### Transaction: 270 Health Care Benefit Inquiry

<table>
<thead>
<tr>
<th>Loop ID</th>
<th>Reference</th>
<th>Name</th>
<th>Codes</th>
<th>Length</th>
<th>Notes/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>63</td>
<td>BHT</td>
<td>Beginning of Hierarchical Transaction</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>64</td>
<td>BHT02</td>
<td>Transaction Set Purpose Code</td>
<td>13</td>
<td>2</td>
<td>NYSDOH expects to receive ‘13’. NYSDOH does not support Cancellation via 270 Inquiry.</td>
</tr>
<tr>
<td>69</td>
<td>2100A</td>
<td>NM1 Information Source Name</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>69</td>
<td>2100A</td>
<td>NM101 Entity Identifier Code</td>
<td>PR</td>
<td>2</td>
<td>NYSDOH expects to receive ‘PR’.</td>
</tr>
<tr>
<td>70</td>
<td>2100A</td>
<td>NM102 Entity Type Qualifier</td>
<td>2</td>
<td>1</td>
<td>NYSDOH expects to receive ‘2’.</td>
</tr>
<tr>
<td>71</td>
<td>2100A</td>
<td>NM108 Identification Code Qualifier</td>
<td>FI</td>
<td>2</td>
<td>NYSDOH expects to receive ‘FI’.</td>
</tr>
<tr>
<td>71</td>
<td>2100A</td>
<td>NM109 Information Source Primary Identifier</td>
<td></td>
<td>9</td>
<td>NYSDOH expects to receive “141797357”.</td>
</tr>
<tr>
<td>75</td>
<td>2100B</td>
<td>NM1 Information Receiver Name</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>75</td>
<td>2100B</td>
<td>NM101 Entity Identifier Code</td>
<td>1P, 2B, 80, FA, GP</td>
<td>2</td>
<td>NYSDOH only recognizes Provider, Third-Party Administrator, Hospital, Facility, or Gateway Provider.</td>
</tr>
<tr>
<td>77</td>
<td>2100B</td>
<td>NM108 Identification Code Qualifier</td>
<td>SV, XX</td>
<td>2</td>
<td>NYSDOH only recognizes Service Provider Number or Centers for Medicare and Medicaid Services National Provider Identifier</td>
</tr>
<tr>
<td>79</td>
<td>2100B</td>
<td>REF Information Receiver Additional</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>79</td>
<td>2100B</td>
<td>REF01 Reference Identification Qualifier</td>
<td>EO</td>
<td>2</td>
<td>NYSDOH only recognizes the qualifier for Submitter Identification Number.</td>
</tr>
<tr>
<td>80</td>
<td>2100B</td>
<td>REF02 Information Receiver Additional</td>
<td></td>
<td>8</td>
<td>NYSDOH expects to receive the 8-digit MMIS Identification Number of the entity identified in GS02. Note: This MMIS-ID must be currently certified with the ETIN in GS02.</td>
</tr>
<tr>
<td>92</td>
<td>2100C</td>
<td>NM1 Subscriber Name</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Page #</td>
<td>Loop ID</td>
<td>Reference</td>
<td>Name</td>
<td>Codes</td>
<td>Length</td>
</tr>
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<tr>
<td>96</td>
<td>2100C</td>
<td>NM109</td>
<td>Identification Code</td>
<td></td>
<td>8</td>
</tr>
<tr>
<td>122</td>
<td>2100C</td>
<td>DTP</td>
<td>Subscriber Date</td>
<td></td>
<td></td>
</tr>
<tr>
<td>123</td>
<td>2100C</td>
<td>DTP01</td>
<td>Date/Time Qualifier</td>
<td>291</td>
<td>3</td>
</tr>
<tr>
<td>124</td>
<td>2110C</td>
<td>EQ</td>
<td>Subscriber Eligibility or Benefit Inquiry</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Page #</td>
<td>Loop ID</td>
<td>Reference</td>
<td>Name</td>
<td>Codes</td>
<td>Length</td>
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<td>-----------</td>
<td>------------------</td>
<td>--------------------------------------------</td>
<td>--------</td>
</tr>
<tr>
<td>126</td>
<td>2110C</td>
<td>EQ01</td>
<td>Service Type Code</td>
<td>1;2;4;5;6;7;8;12;13;18;20;30;33;35;40;42;45;47;48;50;51;52;53;62;65;68;73;76;78;80;81;82;86;88;93;98;99;A0;A3;A6;A7;A8;AD;AE;AF;AG;AI;AL;BG;BH;MH;UC</td>
<td>1-2</td>
</tr>
</tbody>
</table>

| 146   | 2000D   | HL        | Dependent Level  |                                            |        | NYSDOH does not support the Dependent Loop since all NYS Medicaid patients can be uniquely identified at the Subscriber Level (loop 2000C). |
## Transaction: 271 Health Care Benefit Response

<table>
<thead>
<tr>
<th>Page #</th>
<th>Loop ID</th>
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<th>Name</th>
<th>Codes</th>
<th>Length</th>
<th>Notes/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>289</td>
<td>2110C</td>
<td>EB</td>
<td>Subscriber Eligibility or Benefit Inquiry Information</td>
<td></td>
<td></td>
<td>NYSDOH repeats the EB segment for each Service Type.</td>
</tr>
<tr>
<td>291</td>
<td>2110C</td>
<td>EB01</td>
<td>Eligibility or Benefit Information</td>
<td>1;6:B:F;i;J;N;R;U;Y</td>
<td>1</td>
<td>NYSDOH returns these codes.</td>
</tr>
<tr>
<td>291</td>
<td>2110C</td>
<td>EB01</td>
<td>Eligibility or Benefit Information</td>
<td>F</td>
<td>1</td>
<td>When EB01 = 'F', the limitation being expressed is the patient has met their Utilization Threshold (UT) for the service type identified in EB03.</td>
</tr>
<tr>
<td>292</td>
<td>2110C</td>
<td>EB01</td>
<td>Eligibility or Benefit Information</td>
<td>J</td>
<td>1</td>
<td>When EB01 = 'J', member’s Principal Provider Excess Resource amount is conveyed in EB07. This value is returned with Service Type Codes ‘AG’ or ‘48’ in EB03.</td>
</tr>
<tr>
<td>292</td>
<td>2110C</td>
<td>EB01</td>
<td>Eligibility or Benefit Information</td>
<td>N</td>
<td>1</td>
<td>When EB01 = ‘N’, the patient has provider restrictions for the service type identified in EB03. The provider the patient is restricted to is reported in Loop 2120C.</td>
</tr>
<tr>
<td>292</td>
<td>2110C</td>
<td>EB01</td>
<td>Eligibility or Benefit Information</td>
<td>R</td>
<td>1</td>
<td>When EB01 = ‘R’, another payer is expected to pay or process before NYSDOH will pay. The payer is identified in Loop 2120C.</td>
</tr>
<tr>
<td>292</td>
<td>2110C</td>
<td>EB01</td>
<td>Eligibility or Benefit Information</td>
<td>U</td>
<td>1</td>
<td>The patient’s benefits are administered by another payer. Whether this is because the patient is enrolled in a managed care plan or Family Health Plus will be indicated in EB05. The payer is identified in Loop 2120C. If any services are carved-out, additional iteration(s) of the EB segment may be returned to indicate active coverage for those covered services.</td>
</tr>
<tr>
<td>292</td>
<td>2110C</td>
<td>EB01</td>
<td>Eligibility or Benefit Information</td>
<td>Y</td>
<td>1</td>
<td>When EB01=’Y’, member’s NAMI amount is conveyed in EB07. This value is returned with Service Type Codes ‘AG’ or ‘48’ in EB03.</td>
</tr>
<tr>
<td>Page #</td>
<td>Loop ID</td>
<td>Reference</td>
<td>Name</td>
<td>Codes</td>
<td>Length</td>
<td>Notes/Comments</td>
</tr>
<tr>
<td>--------</td>
<td>---------</td>
<td>-----------</td>
<td>-----------------------------</td>
<td>----------------------------</td>
<td>--------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>293</td>
<td>2110C</td>
<td>EB03</td>
<td>Service Type Code</td>
<td>1;4;5;30;3</td>
<td>1 - 2</td>
<td>NYSDOH returns all these service type codes, when applicable, in response to a Generic Eligibility Inquiry (EQ01 = ‘30’ or any service type code which are not supported for Explicit Inquiry). NYSDOH does not repeat this data element, instead will repeat the EB segment to convey eligibility or benefit information, if available, for each Service Type Code.</td>
</tr>
<tr>
<td>299</td>
<td>2110C</td>
<td>EB05</td>
<td>Plan Coverage Description</td>
<td></td>
<td></td>
<td>When EB01='1', '6' or 'U' and EB03 = ‘30, NYSDOH may return a Plan Coverage Description. For more information refer to the Eligibility Benefits Descriptions section in the MEVS Provider Manual.</td>
</tr>
<tr>
<td>299</td>
<td>2110C</td>
<td>EB06</td>
<td>Time Period Qualifier</td>
<td>26;27;29;3</td>
<td>2</td>
<td>NYSDOH does not value this field when EB01 ='B' and EB03 = ‘4’, ‘5’, ‘88’, ‘91’ or ‘92’, although EB07 may still contain a copay amount associated with these five service types. Otherwise, NYSDOH returns one of the values in the Codes column, when there is a benefit amount in EB07.</td>
</tr>
<tr>
<td>300</td>
<td>2110C</td>
<td>EB07</td>
<td>Benefit Amount</td>
<td></td>
<td></td>
<td>When EB01 = B, the amount reported here is the copay amount. When EB01 = Y, the amount reported here is the Net Available Monthly Income (NAMI) amount. When EB01 = J, the amount reported here is the Principal Provider Excess Resource amount.</td>
</tr>
<tr>
<td>314</td>
<td>2110C</td>
<td>REF</td>
<td>Subscriber Additional Information</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>315</td>
<td>2110C</td>
<td>REF01</td>
<td>Reference Identification Qualifier</td>
<td>18, 6P</td>
<td>2</td>
<td>NYSDOH may send the Plan and/or Policy number which applies to the Subscriber Benefit Related Entity Name in Loop 2120C NM1 segment.</td>
</tr>
<tr>
<td>317</td>
<td>2110C</td>
<td>DTP</td>
<td>Subscriber Eligibility/Benefit Date</td>
<td></td>
<td></td>
<td>When applicable, NYSDOH returns date(s) associated with NAMI or Excess Resource amounts</td>
</tr>
<tr>
<td>317</td>
<td>2110C</td>
<td>DTP01</td>
<td>Date Time Qualifier</td>
<td>291</td>
<td>3</td>
<td>NYSDOH will return this code.</td>
</tr>
<tr>
<td>Page #</td>
<td>Loop ID</td>
<td>Reference</td>
<td>Name</td>
<td>Codes</td>
<td>Length</td>
<td>Notes/Comments</td>
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<td>------</td>
<td>-------</td>
<td>--------</td>
<td>----------------</td>
</tr>
<tr>
<td>318</td>
<td>2110C</td>
<td>DTP02</td>
<td>Date Time Period Format Qualifier</td>
<td>D8, RD8</td>
<td>2 – 3</td>
<td>When DTP02 = ‘D8’, NYSDOH will return the NAMI Begin Date in DTP03. When DTP02 = ‘RD8’, NYSDOH will return the Principal Provider (Excess Resource) Begin Date and End Date as a Range.</td>
</tr>
<tr>
<td>322</td>
<td>2110C</td>
<td>MSG</td>
<td>Message Text</td>
<td></td>
<td></td>
<td>NYSDOH may send multiple iterations of MSG Segment</td>
</tr>
<tr>
<td>323</td>
<td>2110C</td>
<td>MSG01</td>
<td>Free Form Message Text</td>
<td></td>
<td></td>
<td>NYSDOH may send up to 10 Exception Codes. Refer to the MEVS Provider Manual for translation of these codes. NYSDOH may also send the Client’s Recertification Month here. Example: “RECERT MONTH = 09”</td>
</tr>
<tr>
<td>329</td>
<td>2120C</td>
<td>NM1</td>
<td>Subscriber Benefit Related Entity Name</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>330</td>
<td>2120C</td>
<td>NM101</td>
<td>Entity Identifier Code</td>
<td>P3</td>
<td>2</td>
<td>When NM101 = P3, the entity being identified is the provider the patient is restricted to for the service type reported in EB03.</td>
</tr>
<tr>
<td>330</td>
<td>2120C</td>
<td>NM101</td>
<td>Entity Identifier Code</td>
<td>P4</td>
<td>2</td>
<td>When NM101 = P4, the entity being identified is a payer deemed primary to Medicaid.</td>
</tr>
<tr>
<td>330</td>
<td>2120C</td>
<td>NM101</td>
<td>Entity Identifier Code</td>
<td>PR</td>
<td>2</td>
<td>When NM101 = PR, the entity being identified is a Family Health Plus payer.</td>
</tr>
<tr>
<td>61 (A1)</td>
<td>2120C</td>
<td>NM101</td>
<td>Entity Identifier Code</td>
<td>Y2</td>
<td>2</td>
<td>When NM101 = Y2, the entity being identified is a Managed Care Plan.</td>
</tr>
<tr>
<td>333</td>
<td>2120C</td>
<td>NM108</td>
<td>Identification Code Qualifier</td>
<td>PI</td>
<td>2</td>
<td>NYSDOH will send ‘PI’ for Managed Care plans, Other payers, or Family Health Plus plans.</td>
</tr>
<tr>
<td>33</td>
<td>2120C</td>
<td>NM108</td>
<td>Identification Code Qualifier</td>
<td>XX</td>
<td>2</td>
<td>NYSDOH will send ‘XX’ when identifying a Restricted Provider.</td>
</tr>
<tr>
<td>347</td>
<td>2000D</td>
<td>HL</td>
<td>Dependent Level</td>
<td></td>
<td></td>
<td>NYSDOH does not support the Dependent Loop since all NYS Medicaid patients can be uniquely identified at the Subscriber Level (loop 2000C).</td>
</tr>
</tbody>
</table>
### TR3: ASC X12N/005010X212 Health Care Claim Status Request and Response (276/277)
#### Transaction: 276 Health Care Claim Status Request

<table>
<thead>
<tr>
<th>Page #</th>
<th>Loop ID</th>
<th>Reference</th>
<th>Name</th>
<th>Codes</th>
<th>Length</th>
<th>Notes/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>37</td>
<td>BHT</td>
<td>Beginning of Hierarchical Transaction</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>37</td>
<td>BHT03</td>
<td>Reference Identification</td>
<td></td>
<td></td>
<td></td>
<td>NYSDOH may return this information on the 277 response when the transaction cannot be processed due to an invalid provider ID or ETIN/provider ID combination.</td>
</tr>
<tr>
<td>39</td>
<td>2100A</td>
<td>NM1</td>
<td>Information Source Level</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>42</td>
<td>2100A</td>
<td>NM109</td>
<td>Identification Code</td>
<td>9</td>
<td></td>
<td>NYSDOH expects to receive '141797357'.</td>
</tr>
<tr>
<td>49</td>
<td>2100C</td>
<td>NM1</td>
<td>Provider Name</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>51</td>
<td>2100C</td>
<td>NM108</td>
<td>Identification Code Qualifier</td>
<td>SV, XX</td>
<td>2</td>
<td>NYSDOH will only recognize codes SV for atypical providers and XX for all others.</td>
</tr>
<tr>
<td>69</td>
<td>2210D</td>
<td>SVC</td>
<td>Service Line Information</td>
<td></td>
<td></td>
<td>NYSDOH does not support Service Line specific status requests. When sent, this data will be ignored and the request will be processed using the claim level data.</td>
</tr>
<tr>
<td>75</td>
<td>2000E</td>
<td>HL</td>
<td>Dependent Level</td>
<td></td>
<td></td>
<td>NYSDOH does not support the Dependent Loop since all NYS Medicaid patients can be uniquely identified at the Subscriber Level (loop 2000D).</td>
</tr>
</tbody>
</table>
**Transaction: 277 Health Care Claim Status Response**
The 277 Health Care Claim Status Response as implemented in eMedNY contains no values specific to NYSDOH requirements or processing. Readers of this document are directed to the Type 3 Technical Report ASC X12N/005010X212 Implementation Guide for Health Care Claim Status Response (277).
TR3: ASC X12N/005010X214 Health Care Claim Acknowledgment (277)

Transaction: 277 Health Care Claim Acknowledgment

Readers of this document are directed to the Type 3 Technical Report ASC X12N/005010X220 Implementation Guide for Health Care Claim Acknowledgment (277) and associated Errata.

For more information about the specific values that are returned in the STC Segment (Loop 2200D and/or Loop 2220D), refer to the NYS Medicaid Pre-adjudication Crosswalk for Health Care Claims which is located on the eMedNY.org website (move your cursor to the "eMedNY HIPAA Support" tab and select "Crosswalks").

<table>
<thead>
<tr>
<th>Page #</th>
<th>Loop ID</th>
<th>Reference</th>
<th>Name</th>
<th>Codes</th>
<th>Length</th>
<th>Notes/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>65</td>
<td>2200C</td>
<td>STC</td>
<td>Billing Provider Status Information</td>
<td></td>
<td></td>
<td>NYSDOH will not provide status at this level.</td>
</tr>
<tr>
<td>71</td>
<td>2200C</td>
<td>QTY</td>
<td>Total Accepted Quantity</td>
<td></td>
<td></td>
<td>NYSDOH will not use this segment since Billing Provider Level Status will not be reported.</td>
</tr>
<tr>
<td>72</td>
<td>2200C</td>
<td>QTY</td>
<td>Total Rejected Quantity</td>
<td></td>
<td></td>
<td>NYSDOH will not use this segment since Billing Provider Level Status will not be reported.</td>
</tr>
<tr>
<td>73</td>
<td>2200C</td>
<td>AMT</td>
<td>Total Accepted Amount</td>
<td></td>
<td></td>
<td>NYSDOH will not use this segment since Billing Provider Level Status will not be reported.</td>
</tr>
<tr>
<td>74</td>
<td>2200C</td>
<td>AMT</td>
<td>Total Rejected Amount</td>
<td></td>
<td></td>
<td>NYSDOH will not use this segment since Billing Provider Level Status will not be reported.</td>
</tr>
</tbody>
</table>
TR3: ASC X12N/005010X220 Benefit Enrollment and Maintenance (834)
Transaction: 834 Benefit Enrollment and Maintenance

The 834 Benefit Enrollment and Maintenance as implemented in eMedNY contains no values specific to NYSDOH requirements or processing. Readers of this document are directed to the Type 3 Technical Report ASC X12N/005010X220 Implementation Guide for Benefit Enrollment and Maintenance (834) and associated Addenda and Errata.
<table>
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<tr>
<th>Loop ID</th>
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<th>Name</th>
<th>Codes</th>
<th>Length</th>
<th>Notes/Comments</th>
</tr>
</thead>
<tbody>
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<td>82</td>
<td>REF</td>
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<tr>
<td>82</td>
<td>REF02</td>
<td>Receiver Identifier</td>
<td></td>
<td></td>
<td>NYSDOH will return the submitter’s ETIN (in the 837 this is the NM109 data element in Loop 1000A).</td>
</tr>
<tr>
<td>182</td>
<td>2100</td>
<td>Claim Supplemental Information</td>
<td></td>
<td></td>
<td>NYSDOH will send this segment at loop 2100 in the remittance advice for claims processed under the Health Home program.</td>
</tr>
<tr>
<td>182</td>
<td>2100</td>
<td>Amount Qualifier Code</td>
<td>ZK</td>
<td>2</td>
<td>The value of “ZK” will be sent in this location for Health Home claims.</td>
</tr>
<tr>
<td>183</td>
<td>2100</td>
<td>Monetary Amount</td>
<td></td>
<td></td>
<td>The Health Home payment amount will be reported in this location.</td>
</tr>
<tr>
<td>186</td>
<td>2110</td>
<td>Service Payment Information</td>
<td></td>
<td></td>
<td>The SVC segment will only be returned for Clinic claims processed under the APG (Ambulatory Patient Groups) methodology; and for Professional, Dental, and Pharmacy claims.</td>
</tr>
<tr>
<td>217</td>
<td>PLB</td>
<td>Provider Adjustment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>219</td>
<td>PLB03-2</td>
<td>Provider Adjustment Identifier</td>
<td></td>
<td></td>
<td>When assigned by the enforcement agency, this field will contain the Audit Number prefixed with FMG# for the first cycle a Negative Recoupment is reported. If no Audit Number is available, the Medicaid Financial Control Number prefixed with FCN# will be provided. Any subsequent cycle, in which the Negative Recoupment is reported, the original remittance advice number prefixed with RA# will be provided.</td>
</tr>
<tr>
<td>Page #</td>
<td>Loop ID</td>
<td>Reference</td>
<td>Name</td>
<td>Codes</td>
<td>Length</td>
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<td>71</td>
<td>1000A</td>
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<td>Submitter Name</td>
<td></td>
<td></td>
</tr>
<tr>
<td>72</td>
<td>1000A</td>
<td>NM109</td>
<td>Submitter Identifier</td>
<td></td>
<td></td>
</tr>
<tr>
<td>76</td>
<td>1000B</td>
<td>NM1</td>
<td>Receiver Name</td>
<td></td>
<td></td>
</tr>
<tr>
<td>77</td>
<td>1000B</td>
<td>NM103</td>
<td>Receiver Name</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>77</td>
<td>1000B</td>
<td>NM109</td>
<td>Receiver Primary Identifier</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>90</td>
<td>2010AA</td>
<td>REF</td>
<td>Billing Provider Tax Identification</td>
<td></td>
<td></td>
</tr>
<tr>
<td>90</td>
<td>2010AA</td>
<td>REF02</td>
<td>Billing Provider Tax Identification</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>129</td>
<td>2010BB</td>
<td>REF</td>
<td>Billing Provider Secondary Identification</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Page #</td>
<td>Loop ID</td>
<td>Reference</td>
<td>Name</td>
<td>Codes</td>
<td>Length</td>
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<td>-------</td>
<td>--------</td>
</tr>
</tbody>
</table>
| 129   | 2010BB   | REF01     | Reference Identification Qualifier | G2    | 2      | Billers of Atypical Provider services (those that do not require an NPI) will need to combine the NYS Medicaid Provider ID and Locator Code into element REF02 of Loop 2010BB (5010 submissions only).
<p>|       |          |           |                                   |       |        | Example…if Provider ID-12345678 and Locator Code=003, this REF segment will contain: REF<em>G2</em>12345678003~ |
| 130   | 2010BB   | REF02     | Billing Provider Secondary Identifier |       |        |                                                                                                                                            |
| 161   | 2300     | REF       | Service Authorization Exception Code |       |        | Service Authorization Exception Codes “1” – “6” are to be used in accordance with Medicaid Policy. Code “7” (Special Handling) is expected when the claim is intended to be processed using a UT exempt NYSDOH specialty code. |
| 161   | 2300     | REF02     | Service Authorization Exception Code |       | 1      |                                                                                                                                            |
| 184   | 2300     | HI        | Principal Diagnosis               |       |        |                                                                                                                                            |</p>
<table>
<thead>
<tr>
<th>Page #</th>
<th>Loop ID</th>
<th>Reference</th>
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<th>Length</th>
<th>Notes/Comments</th>
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</thead>
<tbody>
<tr>
<td>185</td>
<td>2300</td>
<td>HI01-2</td>
<td>Principal Diagnosis Code</td>
<td></td>
<td></td>
<td>For claims which may not be directly related to a diagnosis, but for which a valid codes is required to comply with the Implementation Guide, such as Child Care, Managed Care, and Waiver Services, NYSDOH will accept, for services and discharges occurring on and after October 1, 2015; ICD-10 code R69 – Illness, unspecified.</td>
</tr>
<tr>
<td>Page #</td>
<td>Loop ID</td>
<td>Reference</td>
<td>Name</td>
<td>Codes</td>
<td>Length</td>
<td>Notes/Comments</td>
</tr>
<tr>
<td>--------</td>
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<td>----------------</td>
</tr>
</tbody>
</table>
| 285    | 2300    | HI01-5    | Monetary Amount (Implementation Name: Value Code Amount) |       |        | This sub-element will contain the applicable amount or value associated with the Value Code in sub-element 4 (see previous row) of this Composite Data Element. When sub-element 4 contains “24”, the NYS Medicaid Rate Code is sent in this location (all NYS Medicaid Rate Codes are 4 numeric characters. However, because this is a “Monetary Amount” field it will be accepted and processed when sent with or without a decimal point. )

**Note:** When sending the claim to Medicare, always send it with the decimal point.

Example: HI*BE:24::99.99~

| 345    | 2310E   | N4        | Service Facility Location City, State, Zip Code |       |        | When NM109 (Laboratory or Facility Primary Identifier) is not populated, eMedNY uses the zip+4 to derive the location where the service was provided. |
| 346    | 2310E   | N403      | Postal Code | 9     |        | The process previously known as "0FILL" is now indicated by usage of this AMT segment. As a result, this indicator is now payer specific. |
| 366    | 2320    | AMT       | Coordination of Benefits (COB) Total Non-covered Amount |       |        | |

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eMedNY Transaction Information CG

February 1, 2019
### TR3: ASC X12N/005010X222A1 Health Care Claim Professional (837)
#### Transaction: 837 Health Care Claim – Professional

<table>
<thead>
<tr>
<th>Page #</th>
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<th>Name</th>
<th>Codes</th>
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<tbody>
<tr>
<td>74</td>
<td>1000A</td>
<td>NM1</td>
<td>Submitter Name</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>75</td>
<td>1000A</td>
<td>NM109</td>
<td>Submitter Identifier</td>
<td></td>
<td></td>
<td>The ETIN received here will be used to route the Electronic Remittance Advice (ERA) to an existing electronic mailbox designated by the Trading Partner. The ERA Routing occurs only if a valid mailbox has already been set up by eMedNY Provider Enrollment.</td>
</tr>
<tr>
<td>79</td>
<td>1000B</td>
<td>NM1</td>
<td>Receiver Name</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>80</td>
<td>1000B</td>
<td>NM103</td>
<td>Receiver Name</td>
<td>6</td>
<td></td>
<td>NYSDOH expects to receive &quot;NYSDOH&quot;.</td>
</tr>
<tr>
<td>80</td>
<td>1000B</td>
<td>NM109</td>
<td>Receiver Primary Identifier</td>
<td>9</td>
<td></td>
<td>NYSDOH expects to receive &quot;141797357&quot;.</td>
</tr>
<tr>
<td>94</td>
<td>2010A</td>
<td>REF</td>
<td>Billing Provider Tax Identification</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>94</td>
<td>2010A</td>
<td>REF02</td>
<td>Billing Provider Tax Identification</td>
<td>9</td>
<td></td>
<td>NYSDOH will use the tax-ID as recorded in the provider’s profile in eMedNY for 1099 reporting purposes and will not use the data sent in this location.</td>
</tr>
<tr>
<td>140</td>
<td>2010B</td>
<td>REF</td>
<td>Billing Provider Secondary Identification</td>
<td></td>
<td></td>
<td>When the Billing Provider is an Atypical Provider NYSDOH expects to receive two iterations of this segment; one with the NYS Medicaid Provider ID and one with the Locator Code.</td>
</tr>
<tr>
<td>Page #</td>
<td>Loop ID</td>
<td>Reference</td>
<td>Name</td>
<td>Codes</td>
<td>Length</td>
<td>Notes/Comments</td>
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</tr>
<tr>
<td>140</td>
<td>2010B</td>
<td>REF01</td>
<td>Reference Identification Qualifier</td>
<td>G2 LU</td>
<td>2</td>
<td>When REF01 contains “G2”, NYSDOH expects the NYS Medicaid Provider ID. When REF01 contains “LU”, NYSDOH expects the Locator Code.</td>
</tr>
<tr>
<td>141</td>
<td>2010B</td>
<td>REF02</td>
<td>Billing Provider Secondary Identifier</td>
<td></td>
<td></td>
<td>For batch transactions, please refer to the TR3 (implementation guide) requirements and limitations. For real-time processing of the Interactive 837P, NYSDOH will accept a maximum of one claim (one CLM segment).</td>
</tr>
<tr>
<td>157</td>
<td>2300</td>
<td>CLM</td>
<td>Claim Information</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>189</td>
<td>2300</td>
<td>REF</td>
<td>Service Authorization Exception Code</td>
<td></td>
<td></td>
<td>Service Authorization Exception Codes “1” – “6” are to be used in accordance with Medicaid Policy. Code “7” (Special Handling) is expected when the claim is intended to be processed using a UT exempt NYSDOH specialty code.</td>
</tr>
<tr>
<td>189</td>
<td>2300</td>
<td>REF02</td>
<td>Service Authorization Exception Code</td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>273</td>
<td>2310C</td>
<td>N4</td>
<td>Service Facility Location City, State, Zip Code</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

For batch transactions, please refer to the TR3 (implementation guide) requirements and limitations. For real-time processing of the Interactive 837P, NYSDOH will accept a maximum of one claim (one CLM segment).
<table>
<thead>
<tr>
<th>Page #</th>
<th>Loop ID</th>
<th>Reference</th>
<th>Name</th>
<th>Codes</th>
<th>Length</th>
<th>Notes/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>274</td>
<td>2310C</td>
<td>N403</td>
<td>Postal Code</td>
<td></td>
<td>9</td>
<td>When NM109 (Laboratory or Facility Primary Identifier) is not populated, eMedNY uses the zip+4 to derive the location where the service was provided.</td>
</tr>
<tr>
<td>306</td>
<td>2320</td>
<td>AMT</td>
<td>COORDINATION OF BENEFITS (COB) TOTAL NON-COVERED AMOUNT</td>
<td></td>
<td></td>
<td>The process previously known as “0FILL” is now indicated by usage of this AMT segment. As a result, this indicator is now payer specific.</td>
</tr>
<tr>
<td>350</td>
<td>2400</td>
<td>LX</td>
<td>Service Line Number</td>
<td></td>
<td></td>
<td>For real-time claims submission, NYSDOH expects a maximum of 4 lines (iterations of the LX segment).</td>
</tr>
</tbody>
</table>
## TR3: ASC X12N/005010X224A2 Health Care Claim Dental (837)
### Transaction: 837 Health Care Claim – Dental

<table>
<thead>
<tr>
<th>Page #</th>
<th>Loop ID</th>
<th>Reference</th>
<th>Name</th>
<th>Codes</th>
<th>Length</th>
<th>Notes/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>69</td>
<td>1000A</td>
<td>NM1</td>
<td>Submitter Name</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>70</td>
<td>1000A</td>
<td>NM109</td>
<td>Submitter Identifier</td>
<td></td>
<td></td>
<td>The ETIN received here will be used to route the Electronic Remittance Advice (ERA) to an existing electronic mailbox designated by the Trading Partner. The ERA Routing occurs only if a valid mailbox has already been set up by eMedNY Provider Enrollment.</td>
</tr>
<tr>
<td>74</td>
<td>1000B</td>
<td>NM1</td>
<td>Receiver Name</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>75</td>
<td>1000B</td>
<td>NM103</td>
<td>Receiver Name</td>
<td>6</td>
<td></td>
<td>NYSDOH expects to receive “NYSDOH”.</td>
</tr>
<tr>
<td>75</td>
<td>1000B</td>
<td>NM109</td>
<td>Receiver Primary Identifier</td>
<td>9</td>
<td></td>
<td>NYSDOH expects to receive “141797357”.</td>
</tr>
<tr>
<td>89</td>
<td>2010A</td>
<td>REF</td>
<td>Billing Provider Tax Identification</td>
<td></td>
<td></td>
<td>NYSDOH will use the tax-ID as recorded in the provider’s profile in eMedNY for 1099 reporting purposes and will not use the data sent in this location.</td>
</tr>
<tr>
<td>89</td>
<td>2010A</td>
<td>REF02</td>
<td>Billing Provider Tax Identification</td>
<td></td>
<td>9</td>
<td>NYSDOH does not support the predetermination business process and will ignore this segment if submitted.</td>
</tr>
<tr>
<td>165</td>
<td>2300</td>
<td>REF</td>
<td>Predetermination Identification</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>166</td>
<td>2300</td>
<td>REF</td>
<td>Service Authorization Exception Code</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Page #</td>
<td>Loop ID</td>
<td>Reference</td>
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<td>Notes/Comments</td>
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<tr>
<td>166</td>
<td>2300</td>
<td>REF02</td>
<td>Service Authorization Exception Code</td>
<td></td>
<td>1</td>
<td>Service Authorization Exception Codes “1” – “6” are to be used in accordance with Medicaid Policy. Code “7” (Special Handling) is expected when the claim is intended to be processed using a UT exempt NYSDOH specialty code.</td>
</tr>
<tr>
<td>206</td>
<td>2310C</td>
<td>N4</td>
<td>Service Facility Location City, State, Zip Code</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>207</td>
<td>2310C</td>
<td>N403</td>
<td>Postal Code</td>
<td></td>
<td>9</td>
<td>When NM109 (Laboratory or Facility Primary Identifier) is not populated, eMedNY uses the zip+4 to derive the location where the service was provided.</td>
</tr>
<tr>
<td>233</td>
<td>2320</td>
<td>AMT</td>
<td>COORDINATION OF BENEFITS (COB) TOTAL NON-COVERED AMOUNT</td>
<td></td>
<td></td>
<td>The process previously known as &quot;0FILL&quot; is now indicated by usage of this AMT segment. As a result, this indicator is now payer specific.</td>
</tr>
</tbody>
</table>
# TR3: ASC X12N/005010X217 Health Care Services Review Request for Review and Response (278)
## Transaction: 278 Health Care Service Review - Request

<table>
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<tr>
<th>Page #</th>
<th>Loop ID</th>
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<th>Codes</th>
<th>Length</th>
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<tr>
<td>67</td>
<td>BHT</td>
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<td>Beginning of Hierarchical Transaction</td>
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<td></td>
</tr>
<tr>
<td>67</td>
<td>BHT02</td>
<td></td>
<td>Transaction Set Purpose Code</td>
<td>13</td>
<td>2</td>
<td>NYSDOH expects to receive Request transaction only. NYSDOH does not support codes 01 or 36.</td>
</tr>
<tr>
<td>68</td>
<td>BHT06</td>
<td></td>
<td>Transaction Type Code</td>
<td>RU</td>
<td>2</td>
<td>NYSDOH does not support Medical Services Reservation.</td>
</tr>
<tr>
<td>71</td>
<td>2010A</td>
<td>NM1</td>
<td>UTILIZATION MANAGEMENT ORGANIZATION (UMO) NAME</td>
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<td></td>
</tr>
<tr>
<td>71</td>
<td>2010A</td>
<td>NM101</td>
<td>Entity Identifier Code</td>
<td>X3</td>
<td>2</td>
<td>NYSDOH expects to receive the code for Utilization Management Organization.</td>
</tr>
<tr>
<td>73</td>
<td>2010A</td>
<td>NM108</td>
<td>Identification Code Qualifier</td>
<td>PI</td>
<td>2</td>
<td>NYSDOH expects to receive the code for Payer Identification.</td>
</tr>
<tr>
<td>73</td>
<td>2010A</td>
<td>NM109</td>
<td>Utilization Management Organization (UMO) Identifier</td>
<td></td>
<td>9</td>
<td>NYSDOH expects to receive ‘141797357’.</td>
</tr>
<tr>
<td>76</td>
<td>2010B</td>
<td>NM1</td>
<td>Requester Name</td>
<td></td>
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</tr>
<tr>
<td>76</td>
<td>2010B</td>
<td>NM101</td>
<td>Entity Identifier Code</td>
<td>1P, FA</td>
<td>2</td>
<td>NYSDOH expects to receive a code for Provider or Facility</td>
</tr>
<tr>
<td>77</td>
<td>2010B</td>
<td>NM108</td>
<td>Identification Code Qualifier</td>
<td>XX</td>
<td>2</td>
<td>NYSDOH expects to receive the qualifier for the Submitter's CMS NPI here</td>
</tr>
<tr>
<td>Page #</td>
<td>Loop ID</td>
<td>Reference</td>
<td>Name</td>
<td>Codes</td>
<td>Length</td>
<td>Notes/Comments</td>
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<tr>
<td>78</td>
<td>2010B</td>
<td>NM109</td>
<td>Requestor Identifier</td>
<td></td>
<td></td>
<td>When the submitting entity is a provider that qualifies for an NPI, NYSDOH expects to receive the Submitter’s NPI here. For All other Submitters, see 2010B REF noted below.</td>
</tr>
<tr>
<td>79</td>
<td>2010B</td>
<td>REF</td>
<td>Requestor Supplemental Identification</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>79</td>
<td>2010B</td>
<td>REF01</td>
<td>Reference Identification Qualifier</td>
<td>ZH</td>
<td>2</td>
<td>NYSDOH expects to receive code ZH when REF02 is required as described below.</td>
</tr>
<tr>
<td>80</td>
<td>2010B</td>
<td>REF02</td>
<td>Requestor Supplemental Identifier</td>
<td></td>
<td></td>
<td>NYSDOH expects to receive the MMIS ID of the submitter transmitting the file when an NPI is not present in this loop.</td>
</tr>
<tr>
<td>81</td>
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<td>N3</td>
<td>Requester Address</td>
<td></td>
<td></td>
<td>NYSDOH does not support identifying a Requester by location.</td>
</tr>
<tr>
<td>82</td>
<td>2010B</td>
<td>N4</td>
<td>Requester City, State, Zip Code</td>
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<td></td>
<td>NYSDOH does not support identifying a Requester by location.</td>
</tr>
<tr>
<td>84</td>
<td>2010B</td>
<td>PER</td>
<td>Requester Contact Information</td>
<td></td>
<td></td>
<td>NYSDOH will direct all requests for Additional Information to the Contact Information on file for the Submitter. NYSDOH does not support the direction of requests for Additional Information to a specific Requester.</td>
</tr>
<tr>
<td>91</td>
<td>2010C</td>
<td>NM1</td>
<td>Subscriber Name</td>
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<td>103</td>
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<td>HL</td>
<td>Dependent Level</td>
<td></td>
<td></td>
<td>NYSDOH does not process the Dependent Loop since a NY Medicaid patient is never someone other than the subscriber and each patient can be uniquely identified at the Subscriber Level (loop 2000C).</td>
</tr>
<tr>
<td>120</td>
<td>2000E</td>
<td>UM</td>
<td>Health Care Services Review Information</td>
<td></td>
<td></td>
<td>NYSDOH expects to receive the code for Health Services Review.</td>
</tr>
<tr>
<td>120</td>
<td>2000E</td>
<td>UM01</td>
<td>Request Category Code</td>
<td>HS</td>
<td>2</td>
<td>In addition to Initial Inquiry, NYSDOH will recognize Revision, Extension, or Cancel on a PA request. A Cancel transaction will cancel all approved, pended or suspended detail lines when none of the requested services have been rendered. An Extension may be used to extend the Expiration Date on Approved PA’s. If the Service Detail loop is not valued, the Extension request will apply to all detail lines. If all PA detail lines are not being cancelled, NYSDOH expects to receive a Revision code at the Patient Event Level and Cancel at the Service Detail Level for the specific PA detail line(s) to be cancelled. NYSDOH does not process any other Certification Type Codes.</td>
</tr>
<tr>
<td>121</td>
<td>2000E</td>
<td>UM02</td>
<td>Certification Type Code</td>
<td>3, 4, I, S</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Page #</td>
<td>Loop ID</td>
<td>Reference</td>
<td>Name</td>
<td>Codes</td>
<td>Length</td>
<td>Notes/Comments</td>
</tr>
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<td>----------------------------------------------------</td>
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</tr>
<tr>
<td>128</td>
<td>2000E</td>
<td>REF</td>
<td>Previous Review Authorization Number</td>
<td></td>
<td></td>
<td>NYSDOH expects to receive the Prior Authorization Number in this segment when this request is to Cancel, Extend or Revise a previously approved PA request.</td>
</tr>
<tr>
<td>129</td>
<td>2000E</td>
<td>REF</td>
<td>Previous Review Administrative Reference Number</td>
<td></td>
<td></td>
<td>NYSDOH does not process data sent in this segment.</td>
</tr>
<tr>
<td>135</td>
<td>2000E</td>
<td>DTP</td>
<td>Admission Date</td>
<td></td>
<td></td>
<td>NYSDOH expects to receive the proposed Admission date, for “Bed Reservation from date”, in a Nursing Home when Service Type Code '54' is valued in UM03.</td>
</tr>
<tr>
<td>136</td>
<td>2000E</td>
<td>DTP</td>
<td>Discharge Date</td>
<td></td>
<td></td>
<td>NYSDOH expects to receive the proposed Discharge Date, “for Bed Reservation to date”, in a Nursing Home when Service Type Code '54' is valued in UM03.</td>
</tr>
<tr>
<td>155</td>
<td>2000E</td>
<td>HSD</td>
<td>Health Care Services Delivery</td>
<td></td>
<td></td>
<td>NYSDOH expects to receive this segment when requesting PAs for following services: Transportation Private Duty Nursing (PDN) DME Rentals/Supplies NYSDOH will ignore the HSD segment for Cancel and Extension transactions. For all other PA types, submit quantity in SV106 or SV306. HSD information is returned on the response only for an approved PA.</td>
</tr>
<tr>
<td>Page #</td>
<td>Loop ID</td>
<td>Reference</td>
<td>Name</td>
<td>Codes</td>
<td>Length</td>
<td>Notes/Comments</td>
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<td>--------</td>
<td>--------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>156</td>
<td>HSD01</td>
<td></td>
<td>Quantity Qualifier</td>
<td>FL, HS</td>
<td>2</td>
<td>NYSDOH expects to receive the qualifier 'FL' for DME Rentals/Supplies (Items/units) and Transportation (Trips/units). For PDN, enter ‘HS’ for Hours.</td>
</tr>
<tr>
<td>156</td>
<td>HSD02</td>
<td></td>
<td>Service Unit Count</td>
<td></td>
<td></td>
<td>For PDN and Transportation enter the number of trips/hours per day. For DME Rentals/Supplies, enter 1.</td>
</tr>
<tr>
<td>157</td>
<td>HSD03</td>
<td></td>
<td>Unit or Basis for Measurement Code</td>
<td>DA, MO</td>
<td>2</td>
<td>For PDN and Transportation, enter ‘DA’. For DME Rentals/Supplies, enter ‘MO’.</td>
</tr>
<tr>
<td>157</td>
<td>HSD04</td>
<td></td>
<td>Sample Selection Modulus</td>
<td></td>
<td></td>
<td>For PDN and Transportation, enter 1. For DME Rentals/Supplies, enter 1.</td>
</tr>
<tr>
<td>157</td>
<td>HSD05</td>
<td></td>
<td>Time Period Qualifier</td>
<td>7, 34</td>
<td>1 – 2</td>
<td>For PDN and Transportation, enter 7. For DME Rentals/Supplies, enter 34.</td>
</tr>
<tr>
<td>157</td>
<td>HSD06</td>
<td></td>
<td>Period Count</td>
<td></td>
<td></td>
<td>For PDN and Transportation, enter total number of days. For DME Rentals/Supplies, enter total number of months.</td>
</tr>
<tr>
<td>209</td>
<td>2010EA</td>
<td>NM1</td>
<td>PATIENT EVENT PROVIDER NAME</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>210</td>
<td>2010EA</td>
<td>NM101</td>
<td>Entity Identifier Code</td>
<td>DK</td>
<td>2</td>
<td>NYSDOH will interpret this as the Ordering Provider’s information.</td>
</tr>
<tr>
<td>Loop ID</td>
<td>Name</td>
<td>Codes</td>
<td>Length</td>
<td>Notes/Comments</td>
<td></td>
<td></td>
</tr>
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<td>---------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>210</td>
<td>DN</td>
<td>2</td>
<td></td>
<td>NYSDOH will interpret this as the Referring Provider’s information.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>210</td>
<td>FA</td>
<td>2</td>
<td></td>
<td>NYSDOH will interpret this as the Billing Provider’s information.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>210</td>
<td>G3</td>
<td>2</td>
<td></td>
<td>NYSDOH will interpret this as the Billing Provider’s information.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>210</td>
<td>QV</td>
<td>2</td>
<td></td>
<td>NYSDOH will interpret this as the Billing Provider’s information.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>SJ</td>
<td></td>
<td>2</td>
<td>If FA, G3 and/or QV are not valued in other iterations of Loop 2010EA then the value in NM109 will be recognized as the Billing Provider NPI</td>
<td></td>
<td></td>
</tr>
<tr>
<td>213</td>
<td>2010EA REF</td>
<td>Patient Event Provider Supplemental Information</td>
<td></td>
<td>NYSDOH expects to receive this segment only when the services to be approved are Atypical and an NPI is not to be used.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>213</td>
<td>2010EA REF01</td>
<td>Reference Identification Qualifier</td>
<td>ZH, 0B</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>214</td>
<td>2010EA REF02</td>
<td>Patient Event Provider Supplemental Identifier</td>
<td></td>
<td>When REF01 = ‘ZH’, NYSDOH expects to receive the MMIS ID. When REF01 = ‘0B’, NYSDOH expects to receive the profession code and license concatenated as follows: 1st 3 bytes = Profession Code; remaining 8 bytes = License Number.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>238</td>
<td>2000F UM</td>
<td>Health Care Services Review Information</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Loop ID</td>
<td>Referenced Name</td>
<td>Code</td>
<td>Length</td>
<td>Notes/Comments</td>
<td></td>
<td></td>
</tr>
<tr>
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<td></td>
<td></td>
</tr>
<tr>
<td>239</td>
<td>UM02 Certification Type Code</td>
<td>C</td>
<td>1</td>
<td>NYSDOH will inactivate individual detail lines of the Original PA which are not yet rendered when Loop 2000E UM02 = S (Revised).</td>
<td></td>
<td></td>
</tr>
<tr>
<td>239</td>
<td>I</td>
<td>I</td>
<td>1</td>
<td>NYSDOH will extend individual detail lines of the original PA which are not yet rendered when Loop 2000E UM02 = 4 (Extension).</td>
<td></td>
<td></td>
</tr>
<tr>
<td>244</td>
<td>REF Previous Review Authorization Number</td>
<td>If sent, NYSDOH expects to receive the line number from the original Authorization.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>247</td>
<td>SV1 Professional Service</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>250</td>
<td>SV103 Unit of Basis for Measurement Code</td>
<td>UN</td>
<td>2</td>
<td>NYSDOH expects to receive the code for Units.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Transaction: 278 Health Care Service Review – Response

<table>
<thead>
<tr>
<th>Page #</th>
<th>Loop ID</th>
<th>Reference</th>
<th>Name</th>
<th>Codes</th>
<th>Length</th>
<th>Notes/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>232</td>
<td>2010B</td>
<td>REF</td>
<td>Requester Supplemental Identification</td>
<td></td>
<td></td>
<td>Segment is only created when the 278 request contained a REF segment and REF01 = “ZH” and the request NM1 segment did not specify an NPI</td>
</tr>
<tr>
<td>323</td>
<td>2010B</td>
<td>REF01</td>
<td>Reference Identification Qualifier</td>
<td>ZH</td>
<td>2</td>
<td>Indicates that NYSDOH will return the Carrier Assigned Reference Number in REF02 (below).</td>
</tr>
<tr>
<td>324</td>
<td>2010B</td>
<td>REF02</td>
<td>Reference Identification</td>
<td>8</td>
<td></td>
<td>NYSDOH will return the submitted 8-digit MMIS ID.</td>
</tr>
<tr>
<td>355</td>
<td>2010D</td>
<td>AAA</td>
<td>Dependent Request Validation</td>
<td></td>
<td></td>
<td>If the Dependent Loop was valued on the 278 Request, then the transaction will be rejected at this level. NYSDOH does not support the Dependent Loop since all NYS Medicaid patients can be uniquely identified at the Subscriber Level (loop 2000C).</td>
</tr>
</tbody>
</table>
### Transaction: 278 Health Care Service Review - Request (Dispense Validation System - DVS)

<table>
<thead>
<tr>
<th>Page #</th>
<th>Loop ID</th>
<th>Reference</th>
<th>Name</th>
<th>Codes</th>
<th>Length</th>
<th>Notes/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>67</td>
<td></td>
<td>BHT</td>
<td>Beginning of Hierarchical Transaction</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>67</td>
<td></td>
<td>BHT01</td>
<td>Transaction Set Purpose Code</td>
<td>01, 13</td>
<td>2</td>
<td>NYSDOH expects to receive Request or Cancellation.</td>
</tr>
<tr>
<td>71</td>
<td>2010A</td>
<td>NM1</td>
<td>UTILIZATION MANAGEMENT ORGANIZATION (UMO) NAME</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>71</td>
<td></td>
<td>NM101</td>
<td>Entity Identifier Code</td>
<td>X3</td>
<td>2</td>
<td>NYSDOH expects to receive the code for Utilization Management Organization.</td>
</tr>
<tr>
<td>72</td>
<td></td>
<td>NM102</td>
<td>Entity Type Qualifier</td>
<td>2</td>
<td>2</td>
<td>NYSDOH expects to receive the code for Non-Person Entity.</td>
</tr>
<tr>
<td>73</td>
<td></td>
<td>NM108</td>
<td>Entity Identifier Code</td>
<td>PI</td>
<td>2</td>
<td>NYSDOH expects to receive the code for Payer Identification.</td>
</tr>
<tr>
<td>73</td>
<td></td>
<td>NM109</td>
<td>Utilization Management Organization (UMO) Identifier</td>
<td>9</td>
<td></td>
<td>NYSDOH expects to receive ‘141797357’.</td>
</tr>
<tr>
<td>79</td>
<td>2010B</td>
<td>REF</td>
<td>Requester Supplemental Identification</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>79</td>
<td></td>
<td>REF01</td>
<td>Reference Identification Qualifier</td>
<td>ZH</td>
<td>2</td>
<td>NYSDOH Requires the Medicaid ID of the entity</td>
</tr>
<tr>
<td>80</td>
<td></td>
<td>REF02</td>
<td>Requester Supplemental Identifier</td>
<td></td>
<td></td>
<td>When the ETIN reported in GS02 is different than the entity identified in NM109 of this loop, report the MMIS ID of the ETIN entity here.</td>
</tr>
<tr>
<td>Page #</td>
<td>Loop ID</td>
<td>Reference</td>
<td>Name</td>
<td>Codes</td>
<td>Length</td>
<td>Notes/Comments</td>
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<td>--------</td>
<td>----------------</td>
</tr>
<tr>
<td>103</td>
<td>2000D</td>
<td>HL</td>
<td>Dependent Level</td>
<td></td>
<td></td>
<td>NYSDOH does not support the Dependent Loop since all NYS Medicaid patients can be uniquely identified at the Subscriber Level (loop 2000C).</td>
</tr>
<tr>
<td>134</td>
<td>2000E</td>
<td>DTP</td>
<td>Event Date</td>
<td></td>
<td></td>
<td>NYSDOH expects to receive the Date of Service in this segment. If a date is not submitted, NYSDOH will default to current date.</td>
</tr>
<tr>
<td>134</td>
<td>DTP03</td>
<td></td>
<td>Proposed or Actual Event Date</td>
<td></td>
<td></td>
<td>If a range of dates is submitted, NYSDOH will process based upon the &quot;from&quot; date.</td>
</tr>
<tr>
<td>209</td>
<td>2010EA</td>
<td>NM1</td>
<td>PATIENT EVENT PROVIDER NAME</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>210</td>
<td>NM101</td>
<td></td>
<td>Entity Identifier Code</td>
<td>71, 72, 73 77, AAJ, DD, P3, QB</td>
<td>2-3</td>
<td>If one of the listed codes is used NYSDOH will ignore the corresponding loop information.</td>
</tr>
<tr>
<td>247</td>
<td>2000F</td>
<td>SV1</td>
<td>Professional Service</td>
<td></td>
<td></td>
<td>This segment is used when seeking approval of a “Non-Dental” service.</td>
</tr>
<tr>
<td>259</td>
<td>2000F</td>
<td>SV3</td>
<td>Dental Service</td>
<td></td>
<td></td>
<td>This segment is used when seeking approval of a “Dental” service.</td>
</tr>
<tr>
<td>264</td>
<td>2000F</td>
<td>TOO</td>
<td>Tooth Information</td>
<td></td>
<td></td>
<td>When applicable, NYSDOH expects to receive the Tooth Number in this segment.</td>
</tr>
</tbody>
</table>
### Transaction: 278 Health Care Service Review - Response (DVS)

<table>
<thead>
<tr>
<th>Page #</th>
<th>Loop ID</th>
<th>Reference</th>
<th>Name</th>
<th>Codes</th>
<th>Length</th>
<th>Notes/Comments</th>
</tr>
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<tbody>
<tr>
<td>310</td>
<td>2010A</td>
<td>NM1</td>
<td>Utilization Management Organization (UMO) Name</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>310</td>
<td></td>
<td>NM101</td>
<td>Entity Identifier Code</td>
<td>X3</td>
<td>2</td>
<td>NYSDOH will always send the code for Utilization Management Organization.</td>
</tr>
<tr>
<td>311</td>
<td></td>
<td>NM102</td>
<td>Entity Type Qualifier</td>
<td>2</td>
<td>1</td>
<td>NYSDOH will always send the code for Non-Person Entity.</td>
</tr>
<tr>
<td>311</td>
<td></td>
<td>NM108</td>
<td>Entity Identifier Code</td>
<td>PI</td>
<td>2</td>
<td>NYSDOH will always send the code for Payer Identification.</td>
</tr>
<tr>
<td>312</td>
<td></td>
<td>NM109</td>
<td>Utilization Management Organization (UMO) Identifier</td>
<td></td>
<td>9</td>
<td>NYSDOH will always send ‘141797357’.</td>
</tr>
<tr>
<td>355</td>
<td>2010DA</td>
<td>AAA</td>
<td>Dependent Request Validation</td>
<td></td>
<td></td>
<td>If the Dependent Loop is valued on the 278 Request, then the transaction will</td>
</tr>
</tbody>
</table>

If the Dependent Loop is valued on the 278 Request, then the transaction will be rejected at this level. NYSDOH does not support the Dependent Loop since all NYS Medicaid patients can be uniquely identified at the Subscriber Level (loop 2000C).
### TR3: ASC X12N/005010X218 Payroll Deducted and Other Group Premium Payment for Insurance Products (820)
Transaction: 820 Payroll Deducted and Other Group Premium Payment for Insurance Products

<table>
<thead>
<tr>
<th>Page #</th>
<th>Loop ID</th>
<th>Reference</th>
<th>Name</th>
<th>Codes</th>
<th>Length</th>
<th>Notes/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>85</td>
<td>2200A</td>
<td>ADX</td>
<td>Organization Summary Remittance Level Adjustment for Previous Payment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>86</td>
<td>2200A</td>
<td>ADX02</td>
<td>Premium Payment Adjustment Reason</td>
<td>H1</td>
<td>2</td>
<td>NYSDOH will send H1 for Information Forthcoming to identify the amounts of all fiscal (non-claim related) adjustments with additional information to be provided in the Managed Care Capitation Premium Pended and Denied Claims Report.</td>
</tr>
<tr>
<td>114</td>
<td>2300B</td>
<td>REF</td>
<td>Reference Information</td>
<td></td>
<td></td>
<td>NYS DOH will value identifiers, if available, using one or more iterations of this REF segment.</td>
</tr>
<tr>
<td>114</td>
<td>2300B</td>
<td>REF01</td>
<td>Reference Identification Qualifier</td>
<td>LU, ZZ</td>
<td>2</td>
<td>When REF01 is 'ZZ', NYS DOH will send a TCN (23-Char), HBE Member ID (12-char), and/or Variant Code (2-char of HIOS ID). When REF01 is 'LU' NYS DOH will send the member's Residential County Code (2-char).</td>
</tr>
<tr>
<td>117</td>
<td>2320B</td>
<td>ADX</td>
<td>Individual Premium Adjustment for Current Payment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Page #</td>
<td>Loop ID</td>
<td>Reference</td>
<td>Name</td>
<td>Codes</td>
<td>Length</td>
<td>Notes/Comments</td>
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<tr>
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<td>------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>118</td>
<td>2320B</td>
<td>ADX02</td>
<td>Adjustment Reason Code</td>
<td>H1</td>
<td>2</td>
<td>NYSDOH will send H1 for Information Forthcoming to identify Pended, Denied, Paid State Adjustment / Void, Paid Claims with Stop loss or Kick Payment Rate Codes, and Retro Claims for Managed Care records with additional information to be provided in the Managed Care Capitation Premium Pended and Denied Claims Report.</td>
</tr>
</tbody>
</table>
TR3: ASC X12C/005010X231A1 Implementation Acknowledgment for Health Care Insurance (999)

Transaction: 999 Implementation Acknowledgment for Health Care Insurance

The 999 Implementation Acknowledgment for Health Care Insurance as implemented in eMedNY contains no values specific to NYSDOH requirements or processing. Readers of this document are directed to the Type 3 Technical Report ASC X12C/005010X231 Implementation Guide for Implementation Acknowledgment for Health Care Insurance (999) and associated Errata.
APPENDICES

1. IMPLEMENTATION CHECKLIST
   NYSDOH does not publish a trading partner Implementation Checklist.

2. BUSINESS SCENARIOS
   NYSDOH expects NY Medicaid providers to verify client eligibility before providing services to NY Medicaid clients. When an eligibility response transaction indicates available units of service for a Medicaid client then when the services are billed the available units remain in effect, even if the units have been utilized by another claim in the interim period between the eligibility and claim transactions.

   NYSDOH encourages NY Medicaid providers to perform Claim Status Inquiry on a regular basis, generally within 48 hours of claim submission. The Claim Status Response will return useful information that will allow correction and re-submission of claims that were denied for billing errors, more timely than waiting for the remittance advice.

3. TRANSMISSION EXAMPLES
   Examples of ASC X12 files are available at https://www.emedny.org/HIPAA/5010/5010_sample_files/index.aspx

4. FREQUENTLY ASKED QUESTIONS
   https://www.emedny.org/HIPAA/5010/index.aspx

5. CHANGE SUMMARY

<table>
<thead>
<tr>
<th>Date</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>10/14/2012</td>
<td>Initial publication of Companion Guide based on CAQH-CORE Template for ASC X12 Transaction Sets as defined in; 005010X279A1 (270/271) 005010X212 (276/277) 005010X221A1 (835)</td>
</tr>
<tr>
<td>1/22/2014</td>
<td>Updated website link for Trading Partner Agreement Updated website link for Certification Statement for Existing ETINs</td>
</tr>
<tr>
<td>8/4/2015</td>
<td>V 2.1 Added CAQH-CORE Web Services to the Communications Protocols section. Updated broken links to eMedNY.org and CMS.gov online resources.</td>
</tr>
<tr>
<td>11/20/2015</td>
<td>V 2.2 Updated email addresses to @csgov.com</td>
</tr>
<tr>
<td>7/15/2016</td>
<td>V 2.3 Updated email addresses to @csra.com Updated health.ny.state.us to health.ny.gov in hyperlinks</td>
</tr>
<tr>
<td>8/25/2016</td>
<td>V 3.0 Added 278, 277CA, 820, 834, 837 and 999 in all applicable locations.</td>
</tr>
<tr>
<td>10/18/2016</td>
<td>V 3.1 Added information about; real-time (interactive) claims, negative file acknowledgments, ETIN, pended claims reporting, atypical services billing, provider affiliation and enrollment. Replaced/added data flow diagrams.</td>
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<tr>
<td>2/16/2017</td>
<td>V 3.2 Added information about the information send in the 820, loop 2300B REF segments.</td>
</tr>
<tr>
<td>6/5/2018</td>
<td>V 3.4 Updated information about billing for Non-emergency Transportation services in “Instructions for Billing Billing Atypical Services” section.</td>
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