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REMITTANCE ADVICE

Version 2013 - 01  
7/31/2013
For eMedNY Billing Guideline questions, please contact the eMedNY Call Center 1-800-343-9000.
1. Purpose Statement

The purpose of this document is to familiarize the provider with the contents of the Remittance Advice. Remittance advices contain the following information:

- A listing of all claims (identified by several pieces of information as submitted on the claim) that have entered the computerized processing system during the corresponding cycle
- The status of each claim (deny/paid/pend) after processing
- The eMedNY edits (errors) failed by pending or denied claims
- Subtotals and grand totals of claims and dollar amounts
- Other financial information such as recoupments, negative balances, etc.

The remittance advice, in addition to showing a record of claim transactions and assisting providers in identifying and correcting billing errors, plays an important role in the communication between the provider and the eMedNY Contractor for resolving billing or processing issues.
2. Remittance Advice Formats

Providers may receive remittance advice information in one of three formats:

- The electronic HIPAA 835/820 transaction
- PDF Remittance Advice
- Paper Remittance Advice

Remittance Advices contain a maximum of ten thousand (10,000) claim lines; any overflow will generate a separate 835 and a separate check.

Providers who submit claims under multiple ETINs will receive a separate remittance advice for each ETIN, regardless of advice format.

2.1 Electronic HIPAA 835/820 Transaction

The electronic HIPAA 835/820 transaction (Remittance Advice) is available via the eMedNY eXchange or FTP. For institutional providers, retro-adjustment information is also sent in the 835/820 transaction format. Pending claims are listed in the Supplemental file that is delivered with the 835/820.

To request the electronic remittance advice, providers must complete the Electronic Remittance Request Form, which is available at www.emedny.org by clicking on the link to the web page as follows: Electronic Remittance Request Form.

Providers with only one ETIN receiving an electronic remittance will have the status of any claims submitted via paper forms, state-submitted adjustments/voids and Medicare Crossover claims reported on that electronic remittance. The Default Electronic Transmitter Identification Number (ETIN) Selection Form is available on emedny.org by clicking on the link: Default ETIN Selection Form.

Providers with multiple ETINs who receive the 835/820 electronic remittance advice may elect to receive the status of paper claim submissions, state-submitted adjustments/voids and Medicare Crossover claims in the 835 format. The request must be submitted using the Default ETIN Selection Form which is available at www.emedny.org by clicking on the link to the web page as follows: Default ETIN Selection Form.

Further information on the 835 transaction is available at www.emedny.org by clicking on the link to the web page that follows: eMedNY Transaction Information Standard Companion Guide.

For additional information, providers may also call the eMedNY Call Center at 800-343-9000.
2.2 PDF Remittance Advice

The PDF Remittance Advice may be received electronically via the eMedNY eXchange or FTP and may opened with Adobe Reader® (6.0 release or higher required). This may be downloaded from www.adobe.com.

The PDF itself contains the same layout and fields found in the paper remittance advice that described in section 3 below. Additionally, the remittance can be downloaded and stored electronically for ease of retrieval and you can still print a hard copy.

PDF remittances are not held with the Medicaid check for two weeks but released two weeks earlier.

To request the PDF Remittance Advice, providers must complete the PDF Paper Remittance Request Form which is available at www.emedny.org by clicking on the link: PDF Paper Remittance Request Form.

2.3 Paper Remittance Advice

Note: Paper remittance advices are being phased out.

Remittance advices are also available on paper.

Providers who bill electronically but do not specifically request to receive the 835 transaction are sent paper remittance advices.

2.3.1 Remittance Sorts

The default sort for the paper remittance advice is:

Claim Status (denied, paid, pending) – Patient ID – TCN

Providers can request other sort patterns that may better suit their accounting systems. The additional sorts available are as follows:

- TCN – Claim Status – Patient ID – Date of Service
- Patient ID – Claim Status – TCN
- Date of Service – Claim Status – Patient ID

To request a sort pattern other than the default, providers must complete the Paper Remittance Sort Request Form which is available at www.emedny.org by clicking on the link to the web page as follows: Paper Remittance Sort Request Form.

For additional information, providers may also call the eMedNY Call Center at 800-343-9000.
3. Paper/PDF Remittance Advice Sections

This section presents samples of provider remittance advices, followed by an explanation of the elements contained in the section. Unless otherwise noted, the remittance sections are the same for all provider types.

The information displayed in the remittance advice samples is for illustration purposes only. The following information applies to a remittance advice with the default sort pattern.

The remittance advice is composed of five sections.

- **Section One** may contain one of the following documents:
  - Medicaid Check
  - Notice of Electronic Funds Transfer
  - Summout (no claims paid)

- **Section Two**: Provider Notification (special messages)
- **Section Three**: Claim Detail

The layouts and field descriptions for each of the following remittance types will be described in this section.

- Child Care
- Clinic APG
- Dental
- Durable Medical Equipment (DME)
- Home Health
- Inpatient
- Nursing Home
- Pharmacy
- Practitioner
- Transportation

- **Section Four** may contain any of the following documents:
  - Financial Transactions (recoupments)
  - Accounts Receivable (cumulative financial information)

- **Section Five**: Edit (Error) Description
3.1 Section One – Medicaid Check

This section contains the check stub and the Medicaid check (payment). A Medicaid check is issued when the provider has claims approved for the cycle and the paid amount is greater than any recoupment amounts scheduled for the cycle.

Exhibit 3.1-1

TO: CITY PHARMACY
DATE: 2007-08-06
REMITTANCE NO: ############
PROV ID: ##################

MEDICAID
MANAGEMENT INFORMATION SYSTEM

#000000000000 2007-08-06
CITY PHARMACY
111 PARK AVENUE
ANYTOWN NY 11111

YOUR CHECK IS BELOW – TO DETACH, TEAR ALONG PERFORATED DASHED LINE

<table>
<thead>
<tr>
<th>DATE</th>
<th>REMITTANCE NUMBER</th>
<th>PROVIDER ID NO.</th>
<th>PAY DOLLARS/CENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>2007-08-06</td>
<td>#000000000000</td>
<td>#000000000000</td>
<td>$*****104.88</td>
</tr>
</tbody>
</table>

MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
CHECKS DRAWN ON
KEY BANK N.A.
60 STATE STREET, ALBANY, NEW YORK 12207

FIRSTNAME LASTNAME
AUTHORIZED SIGNATURE

REMITTANCE ADVICE
3.1.1 Medicaid Check Stub Field Descriptions

**Upper Left Corner**

Provider’s Name (as recorded in the Medicaid files)

**Upper Right Corner**

Date the remittance advice was issued

Remittance Number

PROV ID: This field will contain the Medicaid Provider ID and the NPI, when applicable

*Note: For reissued checks, the original check number will be displayed beneath the PROV ID.*

**Center**

Medicaid Provider ID/NPI/Date

Provider’s Name/Address

3.1.2 Medicaid Check Field Descriptions

**Left Side**

Table

- Date the check was issued
- Remittance Number
- Provider ID No.: This field will contain the Medicaid Provider ID and the NPI, when applicable

Provider’s Name/Address

**Right Side**

Dollar/Check Amount: This amount is the:

- the Net Total Paid Amount under the Grand Total subsection
- + the total sum of the Financial Transaction section.
3.2 Section One – EFT Notification

This section indicates the amount of the EFT. An EFT transaction is processed when the provider has claims approved for the cycle and the paid amount is greater than any recoupment amounts scheduled for the cycle.

Exhibit 3.2-1

<table>
<thead>
<tr>
<th>TO:  CITY PHARMACY</th>
<th>DATE:  2007-08-06</th>
</tr>
</thead>
<tbody>
<tr>
<td>REMITTANCE NO:</td>
<td>********************</td>
</tr>
<tr>
<td>PROV ID:</td>
<td>********************</td>
</tr>
<tr>
<td>2007-08-06</td>
<td>CITY PHARMACY</td>
</tr>
<tr>
<td>111 PARK AVENUE</td>
<td>ANYTOWN</td>
</tr>
<tr>
<td></td>
<td>NY 11111</td>
</tr>
<tr>
<td>CITY PHARMACY</td>
<td>$104.88</td>
</tr>
<tr>
<td>PAYMENT IN THE ABOVE AMOUNT WILL BE DEPOSITED VIA AN ELECTRONIC FUNDS TRANSFER.</td>
<td></td>
</tr>
</tbody>
</table>
## 3.2.1 EFT Notification Page Field Descriptions

<table>
<thead>
<tr>
<th>Upper Left Corner</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider’s Name (as recorded in the Medicaid files)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Upper Right Corner</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date: The date on which the remittance advice was issued</td>
</tr>
<tr>
<td>Remittance Number</td>
</tr>
<tr>
<td>PROV ID: This field contains the Medicaid Provider ID and the NPI, when applicable</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Center</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid Provider ID/NPI/Date</td>
</tr>
<tr>
<td>Provider’s Name/Address</td>
</tr>
<tr>
<td>Provider’s Name – Amount transferred to the provider’s account.</td>
</tr>
</tbody>
</table>

This amount is the:

- Net Total Paid Amount from the Grand Total subsection
- + the total sum of the Financial Transaction section.
3.3 Section One – Summout (No Payment)

A summout is produced when the provider has no positive total payment. This may happen when the provider has claims approved for the cycle and the expected paid amount is less than or equal to any recoupment amounts scheduled for the cycle.

Exhibit 3.3-1

TO: ABC PHARMACY

DATE: 08/06/2007

REMITTANCE NO: ###########

NO PAYMENT WILL BE RECEIVED THIS CYCLE. SEE REMITTANCE FOR DETAILS.

CITY PHARMACY
111 PARK AVENUE
ANYTOWN NY 11111

3.3.1 Summout (No Payment) Field Descriptions

Upper Left Corner

Provider’s Name (as recorded in the Medicaid files)

Upper Right Corner

Date the remittance advice was issued

Remittance Number

PROV ID: This field contains the Medicaid Provider ID and the NPI, when applicable

Center

Notification that no payment was made for the cycle (no claims were approved)

Provider’s Name/Address
3.4 Section Two – Provider Notification

This section is used to communicate important messages to providers.

Exhibit 3.4-1

---

TO: ABC CHILD CARE
123 MAIN STREET
ANYTOWN, NEW YORK 11111

ETIN:

TO: ABC CHILD CARE
123 MAIN STREET
ANYTOWN, NEW YORK 11111

ETIN:

PROVIDER NOTIFICATION

REMITTANCE ADVICE MESSAGE TEXT

*** ELECTRONIC FUNDS TRANSFER (EFT) FOR PROVIDER PAYMENTS IS NOW AVAILABLE ***

PROVIDERS WHO ENROLL IN EFT WILL HAVE THEIR MEDICAID PAYMENTS DIRECTLY DEPOSITED INTO THEIR CHECKING OR SAVINGS ACCOUNT.

THE EFT TRANSACTIONS WILL BE INITIATED ON WEDNESDAYS AND DUE TO NORMAL BANKING PROCEDURES, THE TRANSFERRED FUNDS MAY NOT BECOME AVAILABLE IN THE PROVIDER’S CHOSEN ACCOUNT FOR UP TO 48 HOURS AFTER TRANSFER. PLEASE CONTACT YOUR BANKING INSTITUTION REGARDING THE AVAILABILITY OF FUNDS.

PLEASE NOTE THAT EFT DOES NOT WAIVE THE TWO-WEEK LAG FOR MEDICAID DISBURSEMENTS.

TO ENROLL IN EFT, PROVIDERS MUST COMPLETE AN EFT ENROLLMENT FORM THAT CAN BE FOUND AT WWW.EMEDNY.ORG. CLICK ON PROVIDER ENROLLMENT FORMS WHICH CAN BE FOUND IN THE FEATURED LINKS SECTION. DETAILED INSTRUCTIONS WILL ALSO BE FOUND THERE.

AFTER SENDING THE EFT ENROLLMENT FORM TO CSC, PLEASE ALLOW A MINIMUM TIME OF SIX TO EIGHT WEEKS FOR PROCESSING. DURING THIS PERIOD OF TIME YOU SHOULD REVIEW YOUR BANK STATEMENTS AND LOOK FOR AN EFT TRANSACTION IN THE AMOUNT OF $0.01 WHICH CSC WILL SUBMIT AS A TEST. YOUR FIRST REAL EFT TRANSACTION WILL TAKE PLACE APPROXIMATELY FOUR TO FIVE WEEKS LATER.

IF YOU HAVE ANY QUESTIONS ABOUT THE EFT PROCESS, PLEASE CALL THE EMEDNY CALL CENTER AT 1-800-343-9000.

NOTICE: THIS COMMUNICATION AND ANY ATTACHMENTS MAY CONTAIN INFORMATION THAT IS PRIVILEGED AND CONFIDENTIAL UNDER STATE AND FEDERAL LAW AND IS INTENDED ONLY FOR THE USE OF THE SPECIFIC INDIVIDUAL(S) TO WHOM IT IS ADDRESSED. THIS INFORMATION MAY ONLY BE USED OR DISCLOSED IN ACCORDANCE WITH LAW, AND YOU MAY BE SUBJECT TO PENALTIES UNDER LAW FOR IMPROPER USE OR FURTHER DISCLOSURE OF INFORMATION IN THIS COMMUNICATION AND ANY ATTACHMENTS. IF YOU HAVE RECEIVED THIS COMMUNICATION IN ERROR, PLEASE IMMEDIATELY NOTIFY NYHIPPADESK@CSC.COM OR CALL 1-800-541-2831. PROVIDERS WHO DO NOT HAVE ACCESS TO E-MAIL SHOULD CONTACT 1-800-343-9000.

---

REMITTANCE ADVICE

Version 2013 - 01

7/31/2013

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### 3.4.1 Provider Notification Field Descriptions

#### Upper Left Corner

Provider’s Name/Address (as recorded in the Medicaid files)

#### Upper Right Corner

- **Remittance Page Number**
- **Date the remittance advice was issued**

**Cycle Number:** The pre-assigned number for the claims processing period. It is helpful to have the cycle number available when calling the eMedNY Call Center with questions about specific processed claims or payments.

**ETIN (not applicable)**

#### Name of Section: PROVIDER NOTIFICATION

**PROV ID:** This field contains the Medicaid Provider ID and the NPI, when applicable

#### Remittance Number

#### Center

**Message Text**
3.5 Section Three – Claim Detail

This section provides a listing of all claims processed during the specific cycle.

There are nine unique Claim Detail types.

- Child Care
- Dental
- Durable Medical Equipment (DME)
- Home Health
- Inpatient
- Nursing Home
- Pharmacy
- Practitioner
- Transportation
### 3.5.1 Child Care Claim Detail

The Child Care Claim Detail section is used by Child Care provider type.

#### Exhibit 3.5.1-1

<table>
<thead>
<tr>
<th>TCN</th>
<th>PATIENT ACCOUNT NUMBER</th>
<th>SERVICE FROM</th>
<th>TO</th>
<th>DAYS</th>
<th>REPTED CALC'ED DAYS</th>
<th>RATE CODE</th>
<th>PATIENT PARTICIPATION REPORTED</th>
<th>OTHER INSURANCE</th>
<th>AMOUNT CHARGED</th>
<th>AMOUNT PAID</th>
<th>STATUS</th>
<th>AMS</th>
<th>ERRORS</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABC CHILD CARE</td>
<td>123 MAIN STREET</td>
<td>ANYTOWN, NEW YORK 11111</td>
<td>ETIN:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>PAGE 02</td>
<td>DATE 08/06/07</td>
<td>CYCLE 1563</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>LASTNAME</th>
<th>ID NUMBER</th>
<th>TCN</th>
<th>PATIENT ACCOUNT NUMBER</th>
<th>SERVICE FROM</th>
<th>TO</th>
<th>DAYS</th>
<th>REPTED CALC'ED DAYS</th>
<th>RATE CODE</th>
<th>PATIENT PARTICIPATION REPORTED</th>
<th>OTHER INSURANCE</th>
<th>AMOUNT CHARGED</th>
<th>AMOUNT PAID</th>
<th>STATUS</th>
<th>AMS</th>
<th>ERRORS</th>
</tr>
</thead>
<tbody>
<tr>
<td>LL#####L</td>
<td>XXXX-XXXXXXXX-X-X</td>
<td>CPIx-xxxxx-x</td>
<td>MM/DD/YY</td>
<td>MM/DD/YY</td>
<td>1210</td>
<td>5</td>
<td>0</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>387.81</td>
<td>0.00</td>
<td>DENY</td>
<td>01023 01035</td>
<td></td>
</tr>
<tr>
<td>LL#####L</td>
<td>XXXX-XXXXXXXX-X-X</td>
<td>CPIx-xxxxx-x</td>
<td>MM/DD/YY</td>
<td>MM/DD/YY</td>
<td>1210</td>
<td>5</td>
<td>0</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>387.81</td>
<td>0.00</td>
<td>DENY</td>
<td>01023</td>
<td></td>
</tr>
</tbody>
</table>

* = PREVIOUSLY PENDED CLAIM  
** = NEW PEND

| TOTAL AMOUNT ORIGINAL CLAIMS | DENIED | NUMBER OF CLAIMS | 2 |
| NET AMOUNT ADJUSTMENTS | DENIED | NUMBER OF CLAIMS | 0 |
| NET AMOUNT VOIDS | DENIED | NUMBER OF CLAIMS | 0 |
| NET AMOUNT VOIDS – ADJUSTS | 0.00 | NUMBER OF CLAIMS | 0 |
Exhibit 3.5.1-2

<table>
<thead>
<tr>
<th>LASTNAME</th>
<th>TCN</th>
<th>SERVICE DATES FROM THRU</th>
<th>RATE CODE</th>
<th>FULL DAYS</th>
<th>REPTED CALC'ED DAYS</th>
<th>CO-INSURANCE DAYS</th>
<th>PATIENT PARTICIPATION REPORTED DEDUCTED</th>
<th>OTHER INSURANCE</th>
<th>AMOUNT CHARGED</th>
<th>AMOUNT PAID</th>
<th>STATUS</th>
<th>ERRORS</th>
</tr>
</thead>
<tbody>
<tr>
<td>LL-------</td>
<td>PICX-xxxxx-X</td>
<td>MM/DD/YY 1210</td>
<td>5</td>
<td>0</td>
<td>387.81</td>
<td>0.00</td>
<td>0.00</td>
<td>387.81</td>
<td>PAID</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>LL-------</td>
<td>PICX-xxxxx-x</td>
<td>MM/DD/YY 1210</td>
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<td>0</td>
<td>387.81</td>
<td>0.00</td>
<td>0.00</td>
<td>387.81</td>
<td>PAID</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>LL-------</td>
<td>PICX-xxxxx-x</td>
<td>MM/DD/YY 1210</td>
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<td>0</td>
<td>387.81</td>
<td>0.00</td>
<td>0.00</td>
<td>387.81</td>
<td>PAID</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>LL-------</td>
<td>PICX-xxxxx-x</td>
<td>MM/DD/YY 1210</td>
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<td>0</td>
<td>387.81</td>
<td>0.00</td>
<td>0.00</td>
<td>387.81</td>
<td>PAID</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>LL-------</td>
<td>PICX-xxxxx-x</td>
<td>MM/DD/YY 1210</td>
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<td>0</td>
<td>387.81</td>
<td>0.00</td>
<td>0.00</td>
<td>387.81-</td>
<td>ADJT</td>
<td>ORIGINAL CLAIM</td>
<td></td>
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<tr>
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<td>298.77</td>
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<td>0.00</td>
<td>298.77</td>
<td>ADJT</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* = PREVIOUSLY PENDED CLAIM
** = NEW PEND

TOTAL AMOUNT ORIGINAL CLAIMS PAID 1551.24
NET AMOUNT ADJUSTMENTS PAID 89.04
NET AMOUNT VOIDS PAID 0.00
NET AMOUNT VOIDS – ADJUSTS 89.04
TO: ABC CHILD CARE  
123 MAIN STREET  
ANYTOWN, NEW YORK 11111  

ETIN:  
CHILD CARE  
PROV ID:  
REMITTANCE NO:  

<table>
<thead>
<tr>
<th>CLIENT NAME ID NUMBER</th>
<th>TCN PATIENT ACCOUNT NUMBER</th>
<th>SERVICE DATES FROM TO</th>
<th>RATE CODE</th>
<th>REP'TED CALCED DAYS</th>
<th>FULL DAYS</th>
<th>CO-INSURANCE DAYS PAYMENT</th>
<th>PATIENT PARTICIPATION REPORTED DEDUCTED</th>
<th>OTHER INSURANCE</th>
<th>AMOUNT CHARGED</th>
<th>AMOUNT PAID</th>
<th>STATUS ERRORS</th>
</tr>
</thead>
<tbody>
<tr>
<td>LASTNAME ###-########-#-# MM/DD/YY 1210 5 0 0.00 0.00 0.00 387.81 **PEND 00162 00971</td>
<td>CPICX-XXXXX-X MM/DD/YY</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>LASTNAME ###-########-#-# MM/DD/YY 1210 5 0 0.00 0.00 0.00 387.81 **PEND 01131</td>
<td>CPICX-XXXXX-X MM/DD/YY</td>
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<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* = PREVIOUSLY PENDED CLAIM  
** = NEW PEND  

TOTAL AMOUNT ORIGINAL CLAIMS PEND 775.62 NUMBER OF CLAIMS 2  
NET AMOUNT ADJUSTMENTS PEND 0.00 NUMBER OF CLAIMS 0  
NET AMOUNT VOIDS PEND 0.00 NUMBER OF CLAIMS 0  
NET AMOUNT VOIDS – ADJUSTS 0.00 NUMBER OF CLAIMS 0  

REMITTANCE TOTALS – CHILD CARE  
VOIDS – ADJUSTS 89.04- NUMBER OF CLAIMS 1  
TOTAL PENDS 775.62 NUMBER OF CLAIMS 2  
TOTAL PAID 1551.24 NUMBER OF CLAIMS 5  
TOTAL DENY 775.62 NUMBER OF CLAIMS 2  
NET TOTAL PAID 1462.20 NUMBER OF 5 CLAIMS  

MEMBER ID:  
VOIDS – ADJUSTS 89.04- NUMBER OF CLAIMS 1  
TOTAL PENDS 775.62 NUMBER OF CLAIMS 2  
TOTAL PAID 1551.24 NUMBER OF CLAIMS 5  
TOTAL DENY 775.62 NUMBER OF CLAIMS 2  
NET TOTAL PAID 1462.20 NUMBER OF CLAIMS 5  

PAGE 02  
DATE 08/06/07  
CYCLE 1563  

EXHIBIT 3.5.1-3  

REMITTANCE ADVICE  
Version 2013 - 01  
7/31/2013  
Page 18 of 108
<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
<th>Number of Claims</th>
</tr>
</thead>
<tbody>
<tr>
<td>Voids - Adjusts</td>
<td>89.04</td>
<td>1</td>
</tr>
<tr>
<td>Total Pends</td>
<td>775.62</td>
<td>2</td>
</tr>
<tr>
<td>Total Paid</td>
<td>1551.24</td>
<td>5</td>
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### 3.5.1.1 Claim Detail Page Field Descriptions

**Upper Left Corner**

Provider’s Name/Address

**Upper Right Corner**

Remittance page number

Date the remittance advice was issued

Cycle Number: The pre-assigned number for the claims processing period. It is helpful to have the cycle number available when calling the eMedNY Call Center with questions about specific processed claims or payments.

ETIN (not applicable)

Provider Service Classification: **CHILD CARE**

PROV ID: This field contains the Medicaid Provider ID

Remittance Number

### 3.5.1.2 Explanation of Claim Detail Columns

**Client Name/ID Number**

This column indicates the last name of the member (first line) and the Medicaid Member ID (second line). If an invalid Medicaid Member ID was entered in the claim form, the ID will be listed as it was submitted but no name will appear in this column.

**TCN/Patient Account Number**

The TCN (first line) is a unique identifier assigned to each claim that is processed.

Up to 20 characters of the Patient/Office Account Number is provided in this column (second line).

**Service Dates – From/Through**

The first date of service covered by the claim (From date) appears on the first line; the last date of service (Through date) appears on the second line.

**Rate Code**

The four-digit rate code that was entered in the claim form appears under this column.
Reported/Calculated Days

This column has two sub-columns: one is labeled **F (full days)** and the other is labeled **C (co-insurance days)**.

The number of days within the reported first (FROM) service date and the last (THROUGH) service date appear in the first line under the F sub-column. The number of full days calculated by the system appears in the second line under the F sub-column.

The number of co-insurance days reported on the claim form appears under the C sub-column. There are no calculated co-insurance days.

Patient Participation – Reported/Deducted

This column shows the patient participation amount (NAMI) as it was reported (first line) and as it was deducted (second line). If no patient participation is applicable, this column will show 0.00 amount.

Other Insurance

If applicable, the amount paid by the member’s Other Insurance carrier, as reported on the claim form, is shown in this column. If no Other Insurance payment is applicable, this column will show 0.00 amount.

Amount Charged/Amount Paid

The total charges entered in the claim form appear first under this column. If the claim was approved, the amount paid appears underneath the charges. If the claim has a pend or deny status, the amount paid will be zero (0.00).

Status

This column indicates the status (DENY, PAID/ADJT/VOID, PEND) of the claim line.

Denied Claims

Claims for which payment is denied will be identified by the **DENY** status. The following are examples of circumstances that commonly cause claims to be denied:

- The service rendered is not covered by the New York State Medicaid Program.
- The claim is a duplicate of a prior paid claim.
- The required Prior Approval has not been obtained.
- Information entered in the claim form is invalid or logically inconsistent.

Approved Claims

Approved claims will be identified by the statuses **PAID, ADJT** (adjustment), or **VOID**.

Paid Claims

The status PAID refers to original claims that have been approved.
Adjustments

The status ADJT refers to a claim submitted in replacement of a paid claim with the purpose of changing one or more fields. An adjustment has two components: the credit transaction (previously paid claim), and the debit transaction (adjusted claim).

VOIDs

The status VOID refers to a claim submitted with the purpose of canceling a previously paid claim. A void lists the credit transaction (previously paid claim) only.

Pending Claims

Claims that require further review or recycling will be identified by the PEND status. The following are examples of circumstances that commonly cause claims to be pended:

- New York State Medical Review required.
- Procedure requires manual pricing.
- No match found in the Medicaid files for certain information submitted on the claim, for example: Member ID, Prior Approval. These claims are recycled for a period of time during which the Medicaid files may be updated to match the information on the claim.

In order for a claim to be removed from Pend status, one of the following must occur:

- manual review is completed,
- a successful match is found
- the recycling time expires.

A new pend is signified by two asterisks (**). A previously pended claim is signified by one asterisk (*).

Errors

For claims with a DENY or PEND status, this column indicates the NYS Medicaid edit (error) number(s) that caused the claim to deny or pend. Up to twenty-five (25) edit codes, including approved edits, may be listed for each claim. Edit code definitions are listed at the end of the claim detail section.
3.5.1.3 Subtotals/Totals/Grand Totals

Subtotals of dollar amounts and number of claims are provided as follows:

Subtotals by claim **status** appear at the end of the claim listing for each status. The subtotals are broken down by:

- Original claims
- Adjustments
- Voids
- Adjustments/voids combined

Totals by **service classification and by member ID** are provided next to the subtotals for service classification/locator code. These totals are broken down by:

- Adjustments/voids (combined)
- Pends
- Paid
- Deny
- Net total paid (for the specific service classification)

**Grand Totals** for the entire provider remittance advice, which include all the provider’s service classifications, appear on a separate page following the page containing the **totals by service classification**. The grand total is broken down by:

- Adjustments/voids (combined)
- Pends
- Paid
- Deny
- Net total paid (entire remittance)
### 3.5.2 Clinic APG Claim Detail

#### Exhibit 3.5.2-1

**TO:** ABC CLINIC  
123 MAIN STREET  
ANYTOWN, NEW YORK 11111

**ETIN:**  
PROV ID: #######/########

**REMITTANCE NO:** ############

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<td>00142, 00144</td>
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</table>

* = PREVIOUSLY PENDED CLAIM  
** = NEW PEND

---

**TOTAL AMOUNT ORIGINAL CLAIMS**  
DENIED 380.00

**NET AMOUNT ADJUSTMENTS**  
DENIED 0.00

**NET AMOUNT voids**  
DENIED 0.00

**NET AMOUNT voids – ADJUSTS**  
0.00

**NUMBER OF CLAIMS**  
4

**NUMBER OF CLAIMS**  
4

**NUMBER OF CLAIMS**  
0

**NUMBER OF CLAIMS**  
0

---

**REMITTANCE ADVICE**  
Version 2013 - 01  
7/31/2013  
Page 24 of 108
# Exhibit 3.5.2-2

**Medicaid Remittance Statement**

**To:** ABC Clinic  
123 Main Street  
Anytown, New York 11111

**From:** PROV ID: ************  
ETIN: ************  
CLINIC: ANYTOWN NEW YORK

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**Total Amount Original Claims Paid:** 475.00  
**Number of Claims:** 5

**Net Amount Adjustments Paid:** 45.00  
**Number of Claims:** 1

**Net Amount Voids Paid:** 0.00  
**Number of Claims:** 0

**Net Amount Voids - Adjusts:** 45.00  
**Number of Claims:** 1

---

* = PREVIOUSLY PENDED CLAIM  
** = NEW PEND

---

**Date:** 08/06/07  
**Cycle:** 1563

---

**Version 2013 - 01  
Page 25 of 108  
7/31/2013**
### Exhibit 3.5.2-3

**REMITTANCE ADVISE SECTIONS**

**EXHIBIT 3.5.2-3**

**ANYTOWN, NEW YORK 11111**

**TO:** ABC CLINIC  
123 MAIN STREET  
ANYTOWN, NEW YORK 11111

**ETIN:** 
**TO:** ABC CLINIC  
123 MAIN STREET  
ANYTOWN, NEW YORK 11111

**DATE:** 08/06/07  
**CYCLE:** 1563

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<td></td>
</tr>
</tbody>
</table>

* = PREVIOUSLY PENDED CLAIM  
** = NEW PEND

**TOTAL AMOUNT ORIGINAL CLAIMS**

PEND 38 NUMBER OF CLAIMS 4

**NET AMOUNT ADJUSTMENTS**

PEND 0.00 NUMBER OF CLAIMS 0

**NET AMOUNT VOIDS**

PEND 0.00 NUMBER OF CLAIMS 0

**NET AMOUNT VOIDS – ADJUSTS**

PEND 0.00 NUMBER OF CLAIMS 0

**REMITTANCE TOTALS – CLINIC**

VOIDS – ADJUSTS 45.00– NUMBER OF CLAIMS 1

**TOTAL PENDS**

PEND 4.00– NUMBER OF CLAIMS 0

**TOTAL PAID**

47 NUMBER OF CLAIMS 5

**TOTAL DENIED**

PEND 38 NUMBER OF CLAIMS 4

**NET TOTAL PAID**

PEND 43 NUMBER OF CLAIMS 6

**MEMBER ID:** #######

**VOIDS – ADJUSTS**

45.00– NUMBER OF CLAIMS 1

**TOTAL PENDS**

PEND 4.00– NUMBER OF CLAIMS 0

**TOTAL PAID**

47 NUMBER OF CLAIMS 5

**TOTAL DENIED**

PEND 38 NUMBER OF CLAIMS 4

**NET TOTAL PAID**

PEND 43 NUMBER OF CLAIMS 6
3.5.3 Claim Detail Page Field Descriptions

Upper Left Corner

Provider’s Name/Address

Upper Right Corner

Remittance page number

Date the remittance advice was issued

Cycle Number: The pre-assigned number for the claims processing period. It is helpful to have the cycle number available when calling the eMedNY Call Center with questions about specific processed claims or payments.

ETIN (not applicable)

Provider Service Classification: CLINIC

PROV ID: This field contains the Medicaid Provider ID and NPI, when applicable

Remittance Number

3.5.3.1 Explanation of Claim Detail Columns

Office Account Number/CPT

Up to 20 characters of the Patient/Office Account Number entered in the claim form is provided in this column (first line) and the reported procedure code (second line).

Client Name/APG

The Client Name (first line) indicates the last name of the member. If an invalid Medicaid Client ID was entered in the claim form, the ID will be listed as it was submitted but no name will appear in this column. The APG Code (second line) assigned by the grouper appears in this column for the service line on the claim.

Client ID/Combined with CPT

The member’s Medicaid ID number appears in the Client ID column (first line). The Combined CPT (second line) notes procedures on the claim that caused the APG packaging and zero payment on the line.
TCN/Full Weight APG Amount

The TCN (first line) is a unique identifier assigned to each claim that is processed. If multiple claim lines are submitted on the same claim, all the lines are assigned the same TCN. The Full Weight APG Amount (second line) is the assigned grouper weight used in pricing the APG Code based on the procedure code and diagnosis codes for the submitted claims.

Date of Service/PCT APG Weight

The first date of service (From date) entered in the claim appears in the first line this column. If a date different from the From date was entered in the Through date box, that date is not returned in the Remittance Advice. The APG Paid Percentage (second line) is related to grouper assigned Payment Action Code. This is the additional weight factor applied to Full Weight.

Rate Code/APG Paid

The four-digit rate code (first line) that was entered on line one of the claim appears under this column. The APG Paid Amount (second line) is the amount after the 25%, 50% or 75% is applied over each of the first three years.

Charged/Capital Add On

The total charges entered on the claim line appear in this column (first line). The Capital Add On (second line) is the amount that was added to the payment.

Total Paid/Existing Operating Component

If the claim was approved, the amount paid appears in this column (first line). If the claim was approved, the amount paid for the service line appears in this column. Total line payment includes reductions for Medicaid co-payments, reported or prorated/bundled other insurance payments and prorated spend downs, if any. Total line payments will equal Total TCN paid amount. The Existing Operating Component (second line) is the amount added to clinic payments after the 75%, 50%, 25% is applied over each of the first 3 years and disbursed over paid lines.

Status

This column indicates the status (DENY, PAID/ADJT/VOID, PEND) of the claim line.

Denied Claims

Claims for which payment is denied will be identified by the DENY status. The following are examples of circumstances that commonly cause claims to be denied:

The service rendered is not covered by the New York State Medicaid Program.
Approved Claims

Approved claims will be identified by the statuses **PAID**, **ADJT** (adjustment), or **VOID**.

Paid Claims

The status **PAID** refers to original claims that have been approved.

Adjustments

The status **ADJT** refers to a claim submitted in replacement of a paid claim with the purpose of changing one or more fields. An adjustment has two components: the credit transaction (previously paid claim), and the debit transaction (adjusted claim).

Voids

The status **VOID** refers to a claim submitted with the purpose of canceling a previously paid claim. A void lists the credit transaction (previously paid claim) only.

Pending Claims

Claims that require further review or recycling will be identified by the **PEND** status. The following are examples of circumstances that commonly cause claims to be pended:

- New York State Medical Review required.
- Procedure requires manual pricing.
- No match found in the Medicaid files for certain information submitted on the claim, for example: Member ID, Prior Approval. These claims are recycled for a period of time during which the Medicaid files may be updated to match the information on the claim.

In order for a claim to be removed from Pend status, one of the following must occur:

- manual review is completed,
- a successful match is found
- the recycling time expires

A new pend is signified by two asterisks (**). A previously pended claim is signified by one asterisk (*).
Errors

For claims with a DENY or PEND status, this column indicates the NYS Medicaid edit (error) number(s) that caused the claim to deny or pend. Up to twenty-five (25) edit codes, including approved edits, may be listed for each claim. Edit code definitions are listed at the end of the claim detail section.

Total Paid TCN

Total Claim Payment.

3.5.3.2 Subtotals/Totals/Grand Totals

Subtotals of dollar amounts and number of claims are provided as follows:

Subtotals by claim status appear at the end of the claim listing for each status. The subtotals are broken down by:

- Original claims
- Adjustments
- Voids
- Adjustments/voids combined

Subtotals by provider type are provided at the end of the claim detail listing. These subtotals are broken down by:

- Adjustments/voids (combined)
- Pends
- Paid
- Deny
- Net total paid (for the specific service classification)

Totals by member ID are subtotals for the individual practitioners these who provided services as part of the group being paid: These subtotals are broken down by:

- Adjustments/voids (combined)
- Pends
- Paid
- Deny
- Net total paid (sum of approved adjustments/voids and paid original claims)

Grand Totals for the entire provider remittance advice appear on a separate page following the page containing the totals by provider type and member ID. The grand total is broken down by:

- Adjustments/voids (combined)
- Pends
- Paid
- Deny
- Net total paid (entire remittance)
3.5.4 Dental Claim Detail

The Child Care Claim Detail section is used by the Dental provider type.

### Exhibit 3.5.4-1

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TOTAL AMOUNT ORIGINAL CLAIMS: DENIED 162.20
NET AMOUNT ADJUSTMENTS: DENIED 0.00
NET AMOUNT Voids: DENIED 0.00

* = PREVIOUSLY PENDED CLAIM
** = NEW PEND

** = REMITTANCE NO: 000000
Exhibit 3.5.4-2

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*PREVIOUSLY PENDED CLAIM
**NEW PEND

TOTAL AMOUNT ORIGINAL CLAIMS PAID 147.40 NUMBER OF CLAIMS 4
NET AMOUNT ADJUSTMENTS PAID 3.60 - NUMBER OF CLAIMS 1
NET AMOUNT VOIDS PAID 0.00 NUMBER OF CLAIMS 0
NET AMOUNT VOIDS – ADJUSTS PAID 3.60 - NUMBER OF CLAIMS 1

REMITTANCE ADVICE

Version 2013 - 01  7/31/2013

Page 33 of 108
## Exhibit 3.5.4-3

**To:** ABC DENTAL  
123 MAIN STREET  
ANYTOWN, NEW YORK 11111

**To:** ABC DENTAL  
123 MAIN STREET  
ANYTOWN, NEW YORK 11111

**Date:** 08/06/07  
**Cycle:** 1563

**ETIN:**  
**To:** ABC DENTAL  
123 MAIN STREET  
ANYTOWN, NEW YORK 11111

**Client Account:**  
**Client ID:**  
**Date of Proc.:**

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**Total Amount Original Claims:** 168.94  
**Number of Claims:** 4

**Net Amount Adjustments:** 0.00  
**Number of Claims:** 0

**Net Amount Voided:** 0.00  
**Number of Claims:** 0

**Remittance Totals – Dental**

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**Member ID:** ########

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<th>Number of Claims</th>
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<table>
<thead>
<tr>
<th>Net Total Paid</th>
<th>Number of Claims</th>
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</thead>
<tbody>
<tr>
<td>143.80</td>
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</table>
Exhibit 3.5.4-4

TO: ABC DENTAL
123 MAIN STREET
ANYTOWN, NEW YORK 11111

ETIN:
DENTAL
GRAND TOTALS
PROV ID:  ###############
REMITTANCE NO:  ###############

REMITTANCE TOTALS – GRAND TOTALS
VOIDS – ADJUSTS 3.60 - NUMBER OF CLAIMS 1
TOTAL PENDS 168.94 NUMBER OF CLAIMS 4
TOTAL PAID 147.40 NUMBER OF CLAIMS 4
TOTAL DENY 162.20 NUMBER OF CLAIMS 4
NET TOTAL PAID 143.80 NUMBER OF CLAIMS 5
3.5.4.1 Claim Detail Page Field Descriptions

**Upper Left Corner**

Provider’s Name/Address (as recorded in the Medicaid files)

**Upper Right Corner**

Remittance page number

Date the remittance advice was issued

Cycle number: The pre-assigned number for the claims processing period. It is helpful to have the cycle number available when calling the eMedNY Call Center with questions about specific processed claims or payments.

ETIN (not applicable)

Provider Service Classification: **DENTAL**

PROV ID: This field contains the Medicaid Provider ID and the NPI

Remittance Number

---

3.5.4.2 Explanation of Claim Detail Columns

**Ln. No. (Line Number)**

This column indicates the claim number as it corresponds to the procedure lines on the claim form.

**Office Account Number**

Up to 20 characters of the Patient/Office Account Number entered in the claim form is provided in this column.

**Client Name**

This column indicates the last name of the member. If an invalid Medicaid Client ID was entered in the claim form, the ID will be listed as it was submitted but no name will appear in this column.

**Client ID**

The member’s Medicaid ID number appears in this column.
TCN

The TCN is a unique identifier assigned to each claim that is processed. If multiple claim lines are submitted on the same claim form, all the lines are assigned the same TCN.

Date of Service

The first date of service (From date) entered in the claim appears in this column. If a date different from the From date was entered in the Through date box, that date is not returned in the Remittance Advice.

Procedure Code

The five-digit procedure code entered in the claim form appears in this column.

Units

The total number of units of service for the specific claim appears in this column.

Charged

The total charges entered in the claim form appear in this column.

Paid

If the claim was approved, the amount paid appears in this column. If the claim has a pend or deny status, the amount paid will be zero (0.00).

Status

This column indicates the status (DENY, PAID/ADJT/VOID, PEND) of the claim line.

Denied Claims

Claims for which payment is denied will be identified by the DENY status. The following are examples of circumstances that commonly cause claims to be denied:

- The service rendered is not covered by the New York State Medicaid Program.
- The claim is a duplicate of a prior paid claim.
- The required Prior Approval has not been obtained.
- Information entered in the claim form is invalid or logically inconsistent.
Approved Claims
Approved claims will be identified by the statuses \textit{PAID}, \textit{ADJT} (adjustment), or \textit{VOID}.

Paid Claims
The status PAID refers to \textit{original} claims that have been approved.

Adjustments
The status \textit{ADJT} refers to a claim submitted in replacement of a paid claim with the purpose of changing one or more fields. An adjustment has two components: the credit transaction (previously paid claim), and the debit transaction (adjusted claim).

VOIDs
The status \textit{VOID} refers to a claim submitted with the purpose of canceling a previously paid claim. A void lists the credit transaction (previously paid claim) only.

Pending Claims
Claims that require further review or recycling will be identified by the \textit{PEND} status. The following are examples of circumstances that commonly cause claims to be pended:

- New York State Medical Review required.
- Procedure requires manual pricing.
- No match found in the Medicaid files for certain information submitted on the claim, for example: Member ID, Prior Approval. These claims are recycled for a period of time during which the Medicaid files may be updated to match the information on the claim.

In order for a claim to be removed from Pend status, one of the following must occur:

- manual review is completed,
- a successful match is found
- the recycling time expires

A new pend is signified by two asterisks (**). A previously pended claim is signified by one asterisk (*).

Errors
For claims with a DENY or PEND status, this column indicates the NYS Medicaid edit (error) number(s) that caused the claim to deny or pend. Up to twenty-five (25) edit codes, including approved edits, may be listed for each claim. Edit code definitions are listed at the end of the claim detail section.
3.5.4.3 Subtotals/Totals/Grand Totals

Subtotals of dollar amounts and number of claims are provided as follows:

Subtotals by claim status appear at the end of the claim listing for each status. The subtotals are broken down by:

- Original claims
- Adjustments
- Voids
- Adjustments/voids combined

Totals by service classification and by member ID (See definition above) are provided next to the subtotals for service classification/locator code. Totals by Member ID are subtotals for the individual practitioners who provided services as part of the group being paid. These totals are broken down by:

- Adjustments/voids (combined)
- Pends
- Paid
- Deny
- Net total paid (for the specific service classification)

Grand Totals for the entire provider remittance advice, which include all the provider’s service classifications, appear on a separate page following the page containing the totals by service classification. The grand total is broken down by:

- Adjustments/voids (combined)
- Pends
- Paid
- Deny
- Net total paid (entire remittance)
3.5.5 DME Claim Detail

The DME Claim Detail section is used by the following provider types:

- DME
- Hearing Aid

Exhibit 3.5.5-1

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* = PREVIOUSLY PENDED CLAIM
** = NEW PEND

TOTAL AMOUNT ORIGINAL CLAIMS DENIED 162.20 NUMERO CLAIMS 4
NET AMOUNT ADJUSTMENTS DENIED 0.00 NUMERO CLAIMS 0
NET AMOUNT VOIDS DENIED 0.00 NUMERO CLAIMS 0
NET AMOUNT VOIDS – ADJUSTS 0.00 NUMERO CLAIMS 0
### Exhibit 3.5.5-2

**TO:** ABC DENTAL  
123 MAIN STREET  
ANYTOWN, NEW YORK 11111  

**ETIN:**  
DME:  
PROV ID:  
REMITTANCE NO:  

---

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* = PREVIOUSLY PENDED CLAIM  
** = NEW PEND  

**TOTAL AMOUNT ORIGINAL CLAIMS PAID** 147.40  
**NET AMOUNT ADJUSTMENTS PAID** 3.60-  
**NET AMOUNT VOIDS PAID** 0.00  
**NET AMOUNT VOIDS – ADJUSTS** 3.60-
**Exhibit 3.5.5-3**

TO: **ABC DENTAL**  
123 MAIN STREET  
ANYTOWN, NEW YORK 11111

**DATE** 08/06/07  
**CYCLE** 1563

**ETIN:**  
**TO:** ABC DENTAL  
123 MAIN STREET  
ANYTOWN, NEW YORK 11111

**REMITTANCE NO:**  
**ANYTOWN, NEW YORK 11111

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**NOTE:**  
* = PREVIOUSLY PENDED CLAIM  
** = NEW PEND

**TOTAL AMOUNT ORIGINAL CLAIMS**  
PEND 168.94

**NET AMOUNT ADJUSTMENTS**  
PEND 0.00

**NET AMOUNT VOIDS**  
PEND 0.00

**NET AMOUNT VOIDS – ADJUSTS**  
0.00

**REMITTANCE TOTALS – DME**

| VOIDS – ADJUSTS | 3.60 | - NUMBER OF CLAIMS | 1 |
| TOTAL PENDS     | 168.94 | NUMBER OF CLAIMS | 4 |
| TOTAL PAID      | 143.80 | NUMBER OF CLAIMS | 4 |
| TOTAL DENIED    | 162.20 | NUMBER OF CLAIMS | 4 |
| NET TOTAL PAID  | 143.80 | NUMBER OF CLAIMS | 5 |

**MEMBER ID:**  
VOIDS – ADJUSTS  
TOTAL PENDS  
TOTAL PAID  
TOTAL DENIED  
NET TOTAL PAID

**MEMBER ID:**  
VOIDS – ADJUSTS  
TOTAL PENDS  
TOTAL PAID  
TOTAL DENIED  
NET TOTAL PAID

**MEMBER ID:**  
VOIDS – ADJUSTS  
TOTAL PENDS  
TOTAL PAID  
TOTAL DENIED  
NET TOTAL PAID

**REMITTANCE ADVICE**  
Version 2013 - 01  
7/31/2013

Page 42 of 108
Exhibit 3.5.5-4

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</tr>
<tr>
<td>TOTAL DENY</td>
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<td>4</td>
</tr>
<tr>
<td>NET TOTAL PAID</td>
<td>143.80</td>
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</table>
3.5.5.1 Claim Detail Page Field Descriptions

**Upper Left Corner**

Provider’s Name/Address (as recorded in the Medicaid files)

**Upper Right Corner**

Remittance Page Number

Date: The date on which the remittance advice was issued

Cycle Number: The cycle number should be used when calling the eMedNY Call Center with questions about specific processed claims or payments.

ETIN (not applicable)

Provider Service Classification: **DME**

PROV ID: This field will contain the Medicaid Provider ID and the NPI

Remittance Number

3.5.5.2 Explanation of Claim Detail Columns

**LN. NO. (Line Number)**

This column indicates the line number of each claim as it appears on the claim form.

**PROC (Procedure) Code**

The five-digit procedure/item code that was entered in the claim form appears under this column.

**Quantity**

The quantity of each item dispensed as entered in the claim form appears under this column. The units are indicated with three (3) decimal positions. Since DME providers must only report whole units of service, the decimal positions will always be 000. For example: 3 units will be indicated as 3.000.

**Client ID Number**

The patient’s Medicaid ID number appears under this column.
**Client Name**

This column indicates the last name of the patient. If an invalid Medicaid Client ID was entered in the claim form, the ID will be listed as it was submitted but no name will appear in this column.

**Office Account Number**

If a Patient/Office Account Number was entered in the claim form, that number (up to 20 characters) will appear under this column.

**Service Date**

This column lists the service date as entered in the claim form.

**TCN**

The TCN is a unique identifier assigned to each claim that is processed. If multiple claim lines are submitted on the same claim form, all the lines are assigned the same TCN.

**Amount Charged**

This column lists either the amount the provider charged for the claim or the Medicare Approved amount if applicable.

**Paid**

If the claim was approved, the amount paid appears under this column. If the claim has a pend or deny status, the amount paid will be zero (0.00).

**Status**

This column indicates the status (DENY, PAID/ADJT/VOID, PEND) of the claim line.

**Denied Claims**

Claims for which payment is denied will be identified by the *DENY* status. A claim may be denied for the following general reasons:

- The service rendered is not covered by the New York State Medicaid Program.
- The claim is a duplicate of a prior paid claim.
- The required Prior Approval has not been obtained.
- Information entered in the claim form is invalid or logically inconsistent.
Approved Claims

Approved claims will be identified by the statuses PAID, ADJT (adjustment), or VOID.

Paid Claims

The status PAID refers to original claims that have been approved.

Adjustments

The status ADJT refers to a claim submitted in replacement of a paid claim with the purpose of changing one or more fields. An adjustment has two components: the credit transaction (previously paid claim), and the debit transaction (adjusted claim).

Voids

The status VOID refers to a claim submitted with the purpose of canceling a previously paid claim. A void lists the credit transaction (previously paid claim) only.

Pending Claims

Claims that require further review or recycling will be identified by the PEND status. The following are examples of circumstances that commonly cause claims to be pended:

- New York State Medical Review required.
- Procedure requires manual pricing.
- No match found in the Medicaid files for certain information submitted on the claim, for example: Patient ID, Prior Approval, Service Authorization. These claims are recycled for a period of time during which the Medicaid files may be updated to match the information on the claim.

After manual review is completed, a match is found in the Medicaid files or the recycling time expires, pended claims may be approved for payment or denied.

A new pend is signified by two asterisks (**). A previously pended claim is signified by one asterisk (*).

Errors

For claims with a DENY or PEND status, this column indicates the NYS Medicaid edit (error) numeric code(s) that caused the claim to deny or pend. Some edit codes may also be indicated for a PAID claim. These are approved edits, which identify certain errors found in the claim and that do not prevent the claim from being approved. Up to twenty-five (25) edit codes, including approved edits, may be listed for each claim. Edit code definitions will be listed on the last page(s) of the remittance advice.
3.5.5.3 Subtotals/Totals/Grand Totals

Subtotals of dollar amounts and number of claims are provided as follows:

Subtotals by claim status appear at the end of the claim listing for each status. The subtotals are broken down by:

- Original claims
- Adjustments
- Voids
- Adjustments/voids combined

Subtotals by provider type are provided at the end of the claim detail listing. These subtotals are broken down by:

- Adjustments/voids (combined)
- Pends
- Paid
- Deny
- Net total paid (for the specific service classification)

Totals by member ID are provided next to the subtotals for provider type. For individual practitioners these totals are exactly the same as the subtotals by provider type. For practitioner groups, this subtotal category refers to the specific member of the group who provided the services. These subtotals are broken down by:

- Adjustments/voids (combined)
- Pends
- Paid
- Deny
- Net total paid (sum of approved adjustments/voids and paid original claims)

Grand Totals for the entire provider remittance advice appear on a separate page following the page containing the totals by provider type and member ID. The grand total is broken down by:

- Adjustments/voids (combined)
- Pends
- Paid
- Deny
- Net total paid (entire remittance)
3.5.6 Home Health Claim Detail

The Home Health Claim Detail section is used by the following provider types:

- Bridges to Health
- Case Management (CMCM)
- Clinic (Non-APG)
- Home and Community Based Services (HCBS Waiver)
- Home Health
- Limited Licensed Home Care
- Long Term Home Healthcare
- Managed Care
- OMH Certified Rehabilitation Services
- PERS
- Personal Care
- TBI Waiver
- School Supportive Health Services Program (SSHSP)
### Exhibit 3.5.6-1

**MEDICAID**

**MEDICAL ASSISTANCE (TITLE XIX) PROGRAM**

**REMITTANCE STATEMENT**

**TO:** ABC HOME HEALTH  
123 MAIN STREET  
ANYTOWN, NEW YORK 11111

**ETIN:**  
HOME HEALTH

**PROV ID:**  
########

**REMITTANCE NO.:**  
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* = PREVIOUSLY PENDED CLAIM  
** = NEW PEND

---

**TOTAL AMOUNT ORIGINAL CLAIMS**  
DENIED 272.19  
NUMBER OF CLAIMS 2

**NET AMOUNT ADJUSTMENTS**  
DENIED 0.00  
NUMBER OF CLAIMS 0

**NET AMOUNTVOIDS**  
DENIED 0.00  
NUMBER OF CLAIMS 0

**NET AMOUNTVOIDS – ADJUSTS**  
0.00  
NUMBER OF CLAIMS 0

---

**REMITTANCE ADVICE**

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**Exhibit 3.5.6-2**

TO: ABC HOME HEALTH  
123 MAIN STREET  
ANYTOWN, NEW YORK 11111  

ETIN:  
TO: ABC HOME HEALTH  
123 MAIN STREET  
ANYTOWN, NEW YORK 11111  

**OFFICE ACCOUNT**  
**CLIENT NAME**  
**CLIENT ID.**  
**TCN**  
**DATE OF SERVICE**  
**RATE CODE**  
**UNITS**  
**CHARGED**  
**PAID**  
**STATUS**  
**ERRORS**

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**TOTAL AMOUNT ORIGINAL CLAIMS PAID** 2026.41  
**NUMBER OF CLAIMS** 8  
**NET AMOUNT ADJUSTMENTS PAID** 49.30  
**NUMBER OF CLAIMS** 1  
**NET AMOUNT voids PAID** 0.00  
**NUMBER OF CLAIMS** 0  
**NET AMOUNT voids – ADJUSTS PAID** 149.30  
**NUMBER OF CLAIMS** 1

* = PREVIOUSLY PENDED CLAIM  
** = NEW PEND
**Exhibit 3.5.6-3**

---

## Medical Assistance (Title XIX) Program Remittance Statement

**TO:** ABC HOME HEALTH  
123 MAIN STREET  
ANYTOWN, NEW YORK 11111

**ETIN:** HOME HEALTH  
**PROV ID:** ########

**REMITTANCE NO:** ###########

### Office Account

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<tr>
<th>OCN</th>
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<th>TCN</th>
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<td>**</td>
<td>PEND</td>
<td>00162 00244</td>
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<td>188.41</td>
<td>**</td>
<td>PEND</td>
<td>00162 00244</td>
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</table>

---

### Claims

- **Total Amount Original PEND:** 488.61  
- **Number of Claims:** 2
- **Net Amount Adjustments PEND:** 0.00  
- **Number of Claims:** 0
- **Net Amount Void PEND:** 0.00  
- **Number of Claims:** 0
- **Net Amount Void - Adjusts:** 0.00  
- **Number of Claims:** 0

### Remittance Totals – Home Health

- **Total Pends:** 488.61  
- **Number of Claims:** 2
- **Total Paid:** 2026.41  
- **Number of Claims:** 8
- **Total Denied:** 272.19  
- **Number of Claims:** 2

**Net Total Paid:** 1877.11  
**Number of Claims:** 8

---

* = PREVIOUSLY PENDED CLAIM  
** = NEW PEND

---

**MEMBER ID:** 4

**VOIDS – ADJUSTS:** 149.30  
**NUMBER OF CLAIMS:** 1

**TOTAL PENDS:** 488.61  
**NUMBER OF CLAIMS:** 2

**TOTAL PAID:** 2026.41  
**NUMBER OF CLAIMS:** 8

**TOTAL DENY:** 272.19  
**NUMBER OF CLAIMS:** 2

**NET TOTAL PAID:** 1877.11  
**NUMBER OF CLAIMS:** 8

---

**REMITTANCE ADVICE**

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7/31/2013

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**Exhibit 3.5.6-4**

**TO:** ABC HOME HEALTH  
123 MAIN STREET  
ANYTOWN, NEW YORK 11111  

**ETIN:**  
HOME HEALTH  
GRAND TOTALS  
PROV ID: #######  
REMITTANCE NO: #######

**REMITTANCE TOTALS – GRAND TOTALS**

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<td>Total Paid</td>
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<tr>
<td>Total Deny</td>
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</tr>
<tr>
<td>Net Total Paid</td>
<td>1877.11</td>
<td>8</td>
</tr>
</tbody>
</table>
### 3.5.6.1 Claim Detail Page Field Descriptions

#### Upper Left Corner

Provider’s Name/Address

#### Upper Right Corner

Remittance page number

Date the remittance advice was issued

Cycle Number: The pre-assigned number for the claims processing period. It is helpful to have the cycle number available when calling the eMedNY Call Center with questions about specific processed claims or payments.

ETIN (not applicable)

Provider Service Classification: **HOME HEALTH**

PROV ID: This field will contain the Medicaid Provider ID and NPI, when applicable.

Remittance Number

### 3.5.6.2 Explanation of Claim Detail Columns

#### Office Account Number

Up to 20 characters of the Patient/Office Account Number entered in the claim form is provided in this column.

#### Client Name

This column indicates the last name of the member. If an invalid Medicaid Member ID was entered in the claim form, the ID will be listed as it was submitted but no name will appear in this column.

#### Client ID

The Member ID number appears under this column.

#### TCN

The Transaction Control Number (TCN) is a unique identifier assigned to each claim that is processed. If multiple claim lines are submitted on the same claim form, all the lines are assigned the same TCN.
Date of Service

The first date of service (From date) entered in the claim appears in this column. If a date different from the From date was entered in the Through date box, that date is not returned in the Remittance Advice.

Rate Code

The four-digit rate code that was entered in the claim form appears under this column.

Units

The total number of units of service for the specific claim appears under this column.

Charged

The total charges entered in the claim form appear under this column.

Paid

If the claim was approved, the amount paid appears under this column. If the claim has a pend or deny status, the amount paid will be zero (0.00).

Status

This column indicates the status (DENY, PAID/ADJT/VOID, PEND) of the claim line.

Denied Claims

Claims for which payment is denied will be identified by the DENY status. The following are examples of circumstances that commonly cause claims to be denied:

- The service rendered is not covered by the New York State Medicaid Program.
- The claim is a duplicate of a prior paid claim.
- The required Prior Approval has not been obtained.
- Information entered in the claim form is invalid or logically inconsistent.

Approved Claims

Approved claims will be identified by the statuses PAID, ADJT (adjustment), or VOID.

Paid Claims

The status PAID refers to original claims that have been approved.
Adjustments

The status **ADJT** refers to a claim submitted in replacement of a paid claim with the purpose of changing one or more fields. An adjustment has two components: the credit transaction (previously paid claim), and the debit transaction (adjusted claim).

VOIDs

The status **VOID** refers to a claim submitted with the purpose of canceling a previously paid claim. A void lists the credit transaction (previously paid claim) only.

Pending Claims

Claims that require further review or recycling will be identified by the **PEND** status. The following are examples of circumstances that commonly cause claims to be pended:

- New York State Medical Review required.
- Procedure requires manual pricing.
- No match found in the Medicaid files for certain information submitted on the claim, for example: Member ID, Prior Approval. These claims are recycled for a period of time during which the Medicaid files may be updated to match the information on the claim.

In order for a claim to be removed from Pend status, one of the following must occur:

- manual review is completed,
- a successful match is found
- the recycling time expires

A new pend is signified by two asterisks (**). A previously pended claim is signified by one asterisk (*).

Errors

For claims with a DENY or PEND status, this column indicates the NYS Medicaid edit (error) number(s) that caused the claim to deny or pend. Up to twenty-five (25) edit codes, including approved edits, may be listed for each claim. Edit code definitions are listed at the end of the claim detail section.
3.5.6.3 Subtotals/Totals/Grand Totals

Subtotals of dollar amounts and number of claims are provided as follows:

Subtotals by claim status appear at the end of the claim listing for each status. The subtotals are broken down by:

- Original claims
- Adjustments
- Voids
- Adjustments/voids combined

Totals by service classification and by member ID for the individual practitioners these who provided services as part of the group being paid are provided next to the subtotals for service classification/locator code. These totals are broken down by:

- Adjustments/voids (combined)
- Pends
- Paid
- Deny
- Net total paid (for the specific service classification)

Grand Totals for the entire provider remittance advice, which include all the provider’s service classifications, appear on a separate page following the page containing the totals by service classification. The grand total is broken down by:

- Adjustments/voids (combined)
- Pends
- Paid
- Deny
- Net total paid (entire remittance)
### 3.5.7 Inpatient Claim Detail

**Exhibit 3.5.7-1**

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<th>DATE THRU</th>
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<th>OUT DAYS</th>
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* = PREVIOUSLY PENDED CLAIM  
** = NEW PEND

**TOTAL AMOUNT ORIGINAL CLAIMS**  
DENIED 12000.00  NUMBER OF CLAIMS 3

**NET AMOUNT ADJUSTMENTS**  
DENIED 0.00  NUMBER OF CLAIMS 0

**NET AMOUNT VOIDS**  
DENIED 0.00  NUMBER OF CLAIMS 0

**NET AMOUNT VOIDS - ADJUSTS**  
0.00  NUMBER OF CLAIMS 0
**Exhibit 3.5.7-2**

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* = PREVIOUSLY PENDED CLAIM
** = NEW PEND

**Net Amount Adjustments**

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**Net Amount Void**

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### Exhibit 3.5.7-3

**TO:** ABC INPATIENT  
123 MAIN STREET  
ANYTOWN, NEW YORK 11111

**ETIN:**  
INPATIENT  
PROV ID: ###########  
REMITTANCE NO ###########

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* = PREVIOUSLY PENDED CLAIM  
** = NEW PEND

**TOTAL AMOUNT ORIGINAL CLAIMS**  
PEND 12000.00  
NUMBER OF CLAIMS 3

**NET AMOUNT ADJUSTMENTS**  
PEND 0.00  
NUMBER OF CLAIMS 0

**NET AMOUNTVOIDS**  
PEND 0.00  
NUMBER OF CLAIMS 0

**NET AMOUNTVOIDS – ADJUSTS**  
0.00  
NUMBER OF CLAIMS 0

**REMITTANCE TOTALS – INPATIENT**

**VOIDS – ADJUSTS**  
0.00  
NUMBER OF CLAIMS 0

**TOTALPENDS**  
12000.00  
NUMBER OF CLAIMS 3

**TOTALPAID**  
12000.00  
NUMBER OF CLAIMS 3

**TOTALDENY**  
12000.00  
NUMBER OF CLAIMS 3

**NET TOTALPAID**  
12000.00  
NUMBER OF CLAIMS 3

**MEMBER ID: ####**

**VOIDS – ADJUSTS**  
0.00  
NUMBER OF CLAIMS 0

**TOTALPENDS**  
12000.00  
NUMBER OF CLAIMS 3

**TOTALPAID**  
12000.00  
NUMBER OF CLAIMS 3

**TOTALDENY**  
12000.00  
NUMBER OF CLAIMS 3

**NET TOTALPAID**  
12000.00  
NUMBER OF CLAIMS 3
Exhibit 3.5.7-4

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<tr>
<td>Total Paid</td>
<td>12000.00</td>
<td>3</td>
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<tr>
<td>Total Deny</td>
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</tr>
<tr>
<td>Net Total Paid</td>
<td>12000.00</td>
<td>3</td>
</tr>
</tbody>
</table>
3.5.7.1 Claim Detail Page Field Descriptions

**Upper Left Corner**

Provider’s Name/Address

**Upper Right Corner**

Remittance page number

Date the remittance advice was issued

Cycle Number: The pre-assigned number for the claims processing period. It is helpful to have the cycle number available when calling the eMedNY Call Center with questions about specific processed claims or payments.

ETIN (not applicable)

Provider Service Classification: **INPATIENT**

PROV ID: This field contains the Medicaid Provider ID and the NPI

Remittance Number

3.5.7.2 Explanation of Claim Detail Columns

**Patient Control Number/Date**

Up to 20 characters of the Patient/Office Account Number entered in the claim form is provided in this column (first line) and the admission date (second line).

**Client Name/ID Number**

This column indicates the last name of the member (first line) and the Member ID (second line). If an invalid Medicaid Member ID was entered in the claim form, the ID will be listed as it was submitted but no name will appear in this column.

**TCN/Medical Record Number**

The Transaction Control Number (TCN) is a unique identifier assigned to each claim that is processed. If multiple claim lines are submitted on the same claim form, all the lines are assigned the same TCN.

The Medical Record Number will be indicated below the TCN in this column.
Service Dates – From/Through

The first date of service covered by the claim (From date) appears on the first line; the last date of service (Through date) appears on the second line.

Cov’d (Covered) Days/Rate Code

The number of full covered days (first line) and the four-digit rate code (second line) that were entered in the claim appear in this column.

Out Days/Pay Type

This column will show the number of outlier days, if any, and the type of payment (code) generated by the claim.

Inpatient Payment Type Codes

One of the type codes in Exhibit 3.5.2-1 will appear in the Pay Type field on the Medicaid remittance advice and indicates the type of payment (code) generated by the claim.

Exhibit 3.5.2-1

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Non DRG</td>
</tr>
<tr>
<td>A</td>
<td>Medicare Deductible/Coinsurance/LTR</td>
</tr>
<tr>
<td>B</td>
<td>Full DRG</td>
</tr>
<tr>
<td>C</td>
<td>Admission Day Claim</td>
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<tr>
<td>D</td>
<td>Short Stay *</td>
</tr>
<tr>
<td>E</td>
<td>Outlier Only *</td>
</tr>
<tr>
<td>F</td>
<td>ALC Claim</td>
</tr>
<tr>
<td>G</td>
<td>Transfer – Paid as Per Diem</td>
</tr>
<tr>
<td>H</td>
<td>Transfer – Paid as DRG</td>
</tr>
<tr>
<td>I</td>
<td>Transfer – Full DRG Plus Outlier *</td>
</tr>
<tr>
<td>J</td>
<td>Cost Outlier</td>
</tr>
<tr>
<td>K</td>
<td>DRG Paid as Inlier/Outlier Combined</td>
</tr>
<tr>
<td>L</td>
<td>Transfer – Inlier/Outlier *</td>
</tr>
</tbody>
</table>

NOTE: Inpatient Payment Type Codes with an asterisk (*) are only valid for claims with discharge dates prior to December 1, 2009.
### TOT (Total) Days/DRG Code [and Severity of Illness Code]

The first line under this column indicates the number of days for which the DRG payment was made.

The DRG code assigned to the claim based on pertinent data submitted on the claim will appear below the Total Days as the first three digits of the second line.

The Severity of Illness Code will be returned from the APR Grouper and used to determine the APR DRG weight. The Code is represented by the fourth digit of the second line.

*NOTE: If the information on the second line of this column is three digits in length, the DRG Code is being returned for the corresponding Patient Control Number without a Severity of Illness Code.*

### Coverage Base

For *non-DRG hospitals*, the coverage base is obtained by multiplying the hospital's rate by the number of covered days.

For *DRG hospitals*, this column indicates the gross DRG calculation prior to other coverage and other payments.

### Co-Pay

The co-pay amount for which the member is responsible and that is deducted from the claim payment appears in this column.

### Other Insurance/Paid

If applicable, the amount paid by any third party insurance other than Medicare appears on the first line of this column. The second line indicates the amount paid by Medicaid for the specific claim.

### Status

This column indicates the status (DENY, PAID/ADJT/VOID, PEND) of the claim line.

### Denied Claims

Claims for which payment is denied will be identified by the *DENY* status. A claim may be denied for the following general reasons:

- The service rendered is not covered by the New York State Medicaid Program.
- The claim is a duplicate of a prior paid claim.
- The required Prior Approval has not been obtained.
- Information entered in the claim form is invalid or logically inconsistent.
Approved Claims

Approved claims will be identified by the statuses **PAID**, **ADJT** (adjustment), or **VOID**.

Paid Claims

The status **PAID** refers to *original* claims that have been approved.

Adjustments

The status **ADJT** refers to a claim submitted in replacement of a paid claim with the purpose of changing one or more fields. An adjustment has two components: the credit transaction (previously paid claim), and the debit transaction (adjusted claim).

VOIDs

The status **VOID** refers to a claim submitted with the purpose of canceling a previously paid claim. A void lists the credit transaction (previously paid claim) only.

Pending Claims

Claims that require further review or recycling will be identified by the **PEND** status. The following are examples of circumstances that commonly cause claims to be pended:

- New York State Medical Review required.
- Procedure requires manual pricing.
- No match found in the Medicaid files for certain information submitted on the claim, for example: Member ID, Prior Approval. These claims are recycled for a period of time during which the Medicaid files may be updated to match the information on the claim.

In order for a claim to be removed from Pend status, one of the following must occur:

- manual review is completed
- a successful match is found
- the recycling time expires.

A new pend is signified by two asterisks (**). A previously pended claim is signified by one asterisk (*).

Errors

For claims with a **DENY** or **PEND** status, this column indicates the NYS Medicaid edit (error) number(s) that caused the claim to deny or pend. Up to twenty-five (25) edit codes, including approved edits, may be listed for each claim. Edit code definitions are listed at the end of the claim detail section.
3.5.7.3 **Subtotals/Totals/Grand Totals**

Subtotals of dollar amounts and number of claims are provided as follows:

Subtotals by claim *status* appear at the end of the claim listing for each status. The subtotals are broken down by:

- Original claims
- Adjustments
- Voids
- Adjustments/voids combined

Subtotals by *service classification/locator code* combination are provided at the end of the claim detail listing for each service classification/locator code combination. These subtotals are broken down by:

- Adjustments/voids (combined)
- Pends
- Paid
- Deny
- Net total paid (for the specific service classification)

Totals by *service classification* and by *Member ID* (the individual practitioners these who provided services as part of the group) are provided next to the subtotals for service classification/locator code. These totals are broken down by:

- Adjustments/voids (combined)
- Pends
- Paid
- Deny
- Net total paid (for the specific service classification)

**Grand Totals** for the entire provider remittance advice, which include all the provider’s service classifications, appear on a separate page following the page containing the *totals by service classification*. The grand total is broken down by:

- Adjustments/voids (combined)
- Pends
- Paid
- Deny

Net total paid (entire remittance)
3.5.8 Nursing Home Claim Detail

The Nursing Home Claim Detail section is used by the following provider types:

- Intermediate Care Facility/Developmentally Disabled (ICF/DD)
- Assisted Living (ALP)
- Day Treatment
- Hospice
- Residential Health
# Exhibit 3.5.8-1

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<th>LASTNAME</th>
<th>TCN ID NUMBER</th>
<th>PATIENT ACCOUNT NUMBER</th>
<th>SERVICE CODE</th>
<th>SERVICE FROM</th>
<th>SERVICE THRU</th>
<th>RATED CODE</th>
<th>REPEATED CODE</th>
<th>FULL DAYS</th>
<th>DAYS PAYMENT</th>
<th>DAYS REPORTED</th>
<th>DEDUCTED</th>
<th>AMOUNT CHARGED</th>
<th>AMOUNT PAID</th>
<th>INSURANCE</th>
<th>TOTAL AMOUNT ORIGINAL CLAIMS</th>
<th>NET AMOUNT ADJUSTMENTS</th>
<th>NET AMOUNT VOIDS</th>
<th>NET AMOUNT VOIDS – ADJUSTS</th>
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</thead>
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* = PREVIOUSLY PENDED CLAIM
** = NEW PEND

TOTAL AMOUNT ORIGINAL CLAIMS: DENIED 775.62
NUMBER OF CLAIMS: 2

NET AMOUNT ADJUSTMENTS: DENIED 0.00
NUMBER OF CLAIMS: 0

NET AMOUNT VOIDS: DENIED 0.00
NUMBER OF CLAIMS: 0

NET AMOUNT VOIDS – ADJUSTS: 0.00
NUMBER OF CLAIMS: 0

---

TO: ABC NURSING HOME
123 MAIN STREET
ANYTOWN, NEW YORK 11111

ETIN: NURSING HOME
PROV ID: #############
REMITTANCE NO: ############

PAGE 02
DATE: 08/06/07
CYCLE: 1563
### Exhibit 3.5.8-2

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<th>SERVICE DATES FROM TO</th>
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<th>FULL DAYS CO-INSURANCE DAYS PAYMENT</th>
<th>PATIENT PARTICIPATION DEDUCTED</th>
<th>OTHER INSURANCE AMOUNT CHARGED</th>
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</tbody>
</table>

* = PREVIOUSLY PENDED CLAIM
** = NEW PEND

- TOTAL AMOUNT ORIGINAL CLAIMS PAID: 1551.24
- NUMBER OF CLAIMS: 5
- NET AMOUNT ADJUSTMENTS PAID: 89.04
- NUMBER OF CLAIMS: 1
- NET AMOUNT VOIDS PAID: 0.00
- NUMBER OF CLAIMS: 0
- NET AMOUNT VOIDS – ADJUSTS: 89.04
- NUMBER OF CLAIMS: 1

**PAGE 03**
**DATE** 08/06/07
**CYCLE** 1563
Exhibit 3.5.8-3

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<th>CLIENT NAME</th>
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<th>PATIENT ACCOUNT NUMBER</th>
<th>SERVICE DATE</th>
<th>RATE</th>
<th>CALC'ED DAYS</th>
<th>FULL DAYS</th>
<th>CO-INSURANCE DAYS</th>
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<th>AMOUNT</th>
<th>AMOUNT</th>
<th>AMOUNT</th>
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<th>ERRORS</th>
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* = PREVIOUSLY PENDED CLAIM  
** = NEW PEND  

**Remittance Totals**  

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<td>Net Amount Adjustments</td>
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**Remittance Totals – Nursing Home**  

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</tr>
<tr>
<td>Total Paid</td>
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<tr>
<td>Total Deny</td>
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<td>Net Total Paid</td>
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**Member ID: ####**  

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<tbody>
<tr>
<td>Total Pends</td>
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<tr>
<td>Total Paid</td>
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<td>Net Total Paid</td>
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Exhibit 3.5.8-4

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<tr>
<td>123 MAIN STREET</td>
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<tr>
<td>ANYTOWN, NEW YORK 11111</td>
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<td>NURSING HOME</td>
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<td>PROVID: #######/####::::::</td>
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<tr>
<td>GRAND TOTALS</td>
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<tr>
<td>REMITTANCE TOTALS – GRAND TOTALS</td>
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<tr>
<td>Voids – Adjusts</td>
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<td>Net Total Paid</td>
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</tr>
</tbody>
</table>
3.5.8.1 Claim Detail Page Field Descriptions

Upper Left Corner

Provider’s Name/Address

Upper Right Corner

Remittance page number

Date the remittance advice was issued

Cycle number: The pre-assigned number for the claims processing period. It is helpful to have the cycle number available when calling the eMedNY Call Center with questions about specific processed claims or payments.

ETIN (not applicable)

Provider Service Classification: NURSING HOME

PROV ID: This field contains the Medicaid Provider ID and the NPI

Remittance Number

3.5.8.2 Explanation of Claim Detail Columns

Client Name/ID Number

This column indicates the last name of the member (first line) and the Member ID (second line). If an invalid Member ID was entered in the claim form, the ID will be listed as it was submitted but no name will appear.

TCN/Patient Account Number

The TCN (first line) is a unique identifier assigned to each claim that is processed.

If a Patient Account Number was entered in the claim form, up to 20 characters will appear in this column (second line).

Service Dates – From/Through

The first date of service covered by the claim (From date) appears on the first line; the last date of service (Through date) appears on the second line.
### Rate Code

The four-digit rate code that was entered in the claim form appears in this column.

### Reported/Calculated Days

This column has two sub-columns: one is labeled F (full days) and the other is labeled C (co-insurance days).

The number of days within the reported first (FROM) service date and the last (THROUGH) service date appear in the first line under the F sub-column. The number of full days calculated by the system appears in the second line under the F sub-column.

The number of co-insurance days reported on the claim form appears in the C sub-column. There are no calculated co-insurance days.

### Patient Participation – Reported/Deducted

This column shows the member participation amount (NAMI) as it was reported (first line) and as it was deducted (second line). If no member participation is applicable, this column will show 0.00 amount.

### Other Insurance

If applicable, the amount paid by the member’s Other Insurance carrier, as reported on the claim form, is shown in this column. If no Other Insurance payment is applicable, this column will show 0.00 amount.

### Amount Charged/Amount Paid

The total charges entered in the claim form appear first in this column. If the claim was approved, the amount paid appears underneath the charges. If the claim has a pend or deny status, the amount paid will be zero (0.00).

### Status

This column indicates the status (DENY, PAID/ADJT/VOID, PEND) of the claim line.

### Denied Claims

Claims for which payment is denied will be identified by the **DENY** status. The following are examples of circumstances that commonly cause claims to be denied:

- The service rendered is not covered by the New York State Medicaid Program.
- The claim is a duplicate of a prior paid claim.
- The required Prior Approval has not been obtained.
- Information entered in the claim form is invalid or logically inconsistent.
Approved Claims

Approved claims will be identified by the statuses PAID, ADJT (adjustment), or VOID.

Paid Claims

The status PAID refers to original claims that have been approved.

Adjustments

The status ADJT refers to a claim submitted in replacement of a paid claim with the purpose of changing one or more fields. An adjustment has two components: the credit transaction (previously paid claim), and the debit transaction (adjusted claim).

Voids

The status VOID refers to a claim submitted with the purpose of canceling a previously paid claim. A void lists the credit transaction (previously paid claim) only.

Pending Claims

Claims that require further review or recycling will be identified by the PEND status. The following are examples of circumstances that commonly cause claims to be pended:

- New York State Medical Review required.
- Procedure requires manual pricing.
- No match found in the Medicaid files for certain information submitted on the claim, for example: Member ID, Prior Approval. These claims are recycled for a period of time during which the Medicaid files may be updated to match the information on the claim.

In order for a claim to be removed from Pend status, one of the following must occur:

- manual review is completed,
- a successful match is found
- the recycling time expires

A new pend is signified by two asterisks (**). A previously pended claim is signified by one asterisk (*).

Errors

For claims with a DENY or PEND status, this column indicates the NYS Medicaid edit (error) number(s) that caused the claim to deny or pend. Some edit codes may also be indicated for a PAID claim. Up to twenty-five (25) edit codes, including approved edits, may be listed for each claim. Edit code definitions are listed at the end of the claim detail section.
3.5.8.3 Subtotals/Totals/Grand Totals

Subtotals of dollar amounts and number of claims are provided as follows:

Subtotals by claim status appear at the end of the claim listing for each status. The subtotals are broken down by:

- Original claims
- Adjustments
- Voids
- Adjustments/voids combined

Totals by service classification and by member ID are provided next to the subtotals for service classification/locator code. These totals are broken down by:

- Adjustments/voids (combined)
- Pends
- Paid
- Deny
- Net total paid (for the specific service classification)

Grand Totals for the entire provider remittance advice, which include all the provider’s service classifications, appear on a separate page following the page containing the totals by service classification. The grand total is broken down by:

- Adjustments/voids (combined)
- Pends
- Paid
- Deny

Net total paid (entire remittance)
### Pharmacy Claim Detail

**Exhibit 3.5.9-1**

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<th>ITEM CODE</th>
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**TOTAL AMOUNT ORIGINAL CLAIMS**
- **DENIED**: 240.00
- **NUMBER OF CLAIMS**: 4

**NET AMOUNT ADJUSTMENTS**
- **DENIED**: 0.00
- **NUMBER OF CLAIMS**: 0

**NET AMOUNT VOIDS**
- **DENIED**: 0.00
- **NUMBER OF CLAIMS**: 0

**NET AMOUNT VOIDS – ADJUSTS**
- **0.00**
- **NUMBER OF CLAIMS**: 0
**Exhibit 3.5.9-2**

### Medical Assistance (Title XIX) Program Remittance Statement

**To:** ABC Pharmacy  
123 Main Street  
Anytown, New York 11111

**From:**  

**ETIN:**  

**To:** ABC Pharmacy  
123 Main Street  
Anytown, New York 11111  

**Remittance No:**  

---

**Date:** 08/06/07  
**Cycle:** 1563  

**Exhibit 3.5.9-2**

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<td>00162 00162 00142 00142 00162</td>
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</tr>
</tbody>
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**Total Amount Original Claims Paid:** 84.88  
**Number of Claims:** 3

**Net Amount Adjustments Paid:** 90.00  
**Number of Claims:** 1

**Net Amount Voids Paid:** 0.00  
**Number of Claims:** 0

**Net Amount Voids – Adjusts:** 20.00  
**Number of Claims:** 1

---

*PREVIOUSLY PENDED CLAIM  
**NEW PEND*
**Exhibit 3.5.9-3**

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</table>

**TOTAL AMOUNT ORIGINAL CLAIMS**  
PEND 171.00  
NUMBER OF CLAIMS 4

**NET AMOUNT ADJUSTMENTS**  
PEND 00.00  
NUMBER OF CLAIMS 0

**NET AMOUNT VOIDS**  
PEND 00.00  
NUMBER OF CLAIMS 0

**NET AMOUNT VOIDS – ADJUSTS**  
PEND 00.00  
NUMBER OF CLAIMS 0

**REMITTANCE TOTALS – PHARMACY**

| VOIDS – ADJUSTS | 20.00  | NUMBER OF CLAIMS 1 |
| TOTAL PENDS     | 171.00 | NUMBER OF CLAIMS 4  |
| TOTAL PAID      | 84.88  | NUMBER OF CLAIMS 3  |
| TOTAL DENIED    | 240.00 | NUMBER OF CLAIMS 4  |
| NET TOTAL PAID  | 64.88  | NUMBER OF CLAIMS 4  |

**MEMBER ID:**  

| VOIDS – ADJUSTS | 20.00  | NUMBER OF CLAIMS 1 |
| TOTAL PENDS     | 171.00 | NUMBER OF CLAIMS 4  |
| TOTAL PAID      | 84.88  | NUMBER OF CLAIMS 3  |
| TOTAL DENIED    | 240.00 | NUMBER OF CLAIMS 4  |
| NET TOTAL PAID  | 64.88  | NUMBER OF CLAIMS 4  |
**Exhibit 3.5.9-4**

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<tr>
<td>Net Total Paid</td>
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</table>
3.5.9.1 Claim Detail Page Field Descriptions

Upper Left Corner

Provider’s Name/Address

Upper Right Corner

Remittance page number

Date the remittance advice was issued

Cycle Number: The pre-assigned number for the claims processing period. It is helpful to have the cycle number available when calling the eMedNY Call Center with questions about specific processed claims or payments.

ETIN (not applicable)

Provider Service Classification: PHARMACY

PROV ID: This field contains the Medicaid Provider ID and the NPI

Remittance Number

3.5.9.2 Explanation of Claim Detail Columns

Prescription No. (Line Number)

This column indicates the prescription number as it appears on the claim form.

Item Code

This column shows the code that identifies the drug or supply that was dispensed (NDC code or HCPCS CODE).

Quantity

The quantity dispensed appears in this column. The quantity is indicated with three (3) decimal positions.

Client Number

The Member ID number appears in this column.
Client Name

This column indicates the last name of the member. If an invalid Medicaid Member ID was entered in the claim form, the ID will be listed as it was submitted, but no name will appear in this column.

Service Date

This column lists the service date as entered in the claim form.

TCN

The Transaction Control Number (TCN) is a unique identifier assigned to each claim that is processed. If multiple claim lines are submitted on the same claim form, all the lines are assigned the same TCN.

Charged

This column lists either the amount the provider charged for the claim or the Medicare Approved amount if applicable.

Paid

If the claim was approved, the amount paid appears in this column. If the claim has a pend or deny status, the amount paid will be zero (0.00).

Status

This column indicates the status (DENY, PAID/ADJT/VOID, PEND) of the claim line.

Denied Claims

Claims for which payment is denied will be identified by the DENY status. The following are examples of circumstances that commonly cause claims to be pended:

- The service rendered is not covered by the New York State Medicaid Program.
- The claim is a duplicate of a prior paid claim.
- The required Prior Approval has not been obtained.
- Information entered in the claim form is invalid or logically inconsistent.

Approved Claims

Approved claims will be identified by the statuses PAID, ADJT (adjustment), or VOID.

Paid Claims

The status PAID refers to original claims that have been approved.
Adjustments

The status **ADJT** refers to a claim submitted in replacement of a paid claim with the purpose of changing one or more fields. An adjustment has two components: the credit transaction (previously paid claim), and the debit transaction (adjusted claim).

VOIDs

The status **VOID** refers to a claim submitted with the purpose of canceling a previously paid claim. A void lists the credit transaction (previously paid claim) only.

Pending Claims

Claims that require further review or recycling will be identified by the **PEND** status. The following are examples of circumstances that commonly cause claims to be pended:

- New York State Medical Review required.
- Procedure requires manual pricing.
- No match found in the Medicaid files for certain information submitted on the claim, for example: Patient ID, Prior Approval, Service Authorization. These claims are recycled for a period of time during which the Medicaid files may be updated to match the information on the claim.

In order for a claim to be removed from Pend status, one of the following must occur:

- manual review is completed,
- a successful match is found
- the recycling time expires.

A new pend is signified by two asterisks (**). A previously pended claim is signified by one asterisk (*).

Errors

For claims with a DENY or PEND status, this column indicates the NYS Medicaid edit (error) number(s) that caused the claim to deny or pend. Up to twenty-five (25) edit codes, including approved edits, may be listed for each claim. Edit code definitions are listed at the end of the claim detail section.
3.5.9.3 Subtotals/Totals/Grand Totals

Subtotals of dollar amounts and number of claims are provided as follows:

Subtotals by claim status appear at the end of the claim listing for each status. The subtotals are broken down by:

- Original claims
- Adjustments
- Voids
- Adjustments/voids combined

Subtotals by provider type are provided at the end of the claim detail listing. These subtotals are broken down by:

- Adjustments/voids (combined)
- Pends
- Paid
- Denied
- Net total paid (sum of approved adjustments/voids and paid original claims)

Totals by Member ID are subtotals for the individual practitioners these who provided services as part of the group being paid. These subtotals are broken down by:

- Adjustments/voids (combined)
- Pends
- Paid
- Denied
- Net total paid (sum of approved adjustments/voids and paid original claims)

Grand Totals for the entire provider remittance advice, which include all the provider’s service classifications, appear on a separate page following the page containing the totals by service classification. The grand total is broken down by:

- Adjustments/voids (combined)
- Pends
- Paid
- Denied

Net total paid (entire remittance)
3.5.10  Practitioner Claim Detail

The Practitioner Claim Detail section is used by the following provider types:

- Chiropractor/Portable X-Ray
- Clinical Psychology
- Clinical Social Worker
- Hospital Ordered Ambulatory
- Laboratory
- Midwife
- Nurse Practitioner
- Physician
- Podiatry
- Private Duty Nursing
- Rehabilitation Services
- Vision Care
### Exhibit 3.5.10-1

**TO:** ABC PRACTITIONER  
**123 MAIN STREET**  
**ANYTOWN, NEW YORK 11111**

**ETIN:**  
**PRACTITIONER**  
**PROV ID:**  
**REMITTANCE NO:**

<table>
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*=PREVIOUSLY PENDED CLAIM*  
**NET AMOUNT VOIDS – ADJUSTS**

**TOTAL AMOUNT ORIGINAL CLAIMS**  
**DENIED**  
**NUMBER OF CLAIMS**  
**4**

**NET AMOUNT ADJUSTMENTS**  
**DENIED**  
**NUMBER OF CLAIMS**  
**0**

**NET AMOUNT VOIDS**  
**DENIED**  
**NUMBER OF CLAIMS**  
**0**

**NET AMOUNT VOIDS – ADJUSTS**  
**0.00**  
**NUMBER OF CLAIMS**  
**0**

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**REMITTANCE ADVICE**

**Version 2013 - 01**  
**7/31/2013**

Page 84 of 108
**Exhibit 3.5.10-2**

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TOTAL AMOUNT ORIGINAL CLAIMS
PAID 147.40

NET AMOUNT ADJUSTMENTS
PAID 3.60

NET AMOUNT VOIDS
PAID 0.00

NET AMOUNT VOIDS – ADJUSTS
PAID 3.60

**TOTAL AMOUNT ORIGINAL CLAIMS PAID:** 147.40
**NUMBER OF CLAIMS:** 4
**TOTAL AMOUNT ADJUSTMENTS PAID:** 3.60
**NUMBER OF CLAIMS:** 1
**TOTAL AMOUNT VOIDS PAID:** 0.00
**NUMBER OF CLAIMS:** 0
**TOTAL AMOUNT VOIDS – ADJUSTS PAID:** 3.60
**NUMBER OF CLAIMS:** 1

*=PREVIOUSLY PENDED CLAIM  
**=NEW PEND
**Exhibit 3.5.10-3**

**TO:** ABC PRACTITIONER  
**ANYTOWN, NEW YORK 11111**

**ETIN:**  
**TO:**  
**ANYTOWN, NEW YORK 11111**

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**TOTAL AMOUNT ORIGINAL CLAIMS**  
PEND 168.94 NUMBER OF CLAIMS 4

**NET AMOUNT ADJUSTMENTS**  
PEND 0.00 NUMBER OF CLAIMS 0

**NET AMOUNT VOIDS**  
PEND 0.00 NUMBER OF CLAIMS 0

**REMITTANCE TOTALS – PRACTITIONER**

VOIDS – ADJUSTS 3.60 - NUMBER OF CLAIMS 1
TOTAL PENDS 168.94 NUMBER OF CLAIMS 4
TOTAL PAID 147.40 NUMBER OF CLAIMS 4
TOTAL DENIED 162.20 NUMBER OF CLAIMS 4
NET TOTAL PAID 143.80 NUMBER OF CLAIMS 5

**MEMBER ID:**  
VOIDS – ADJUSTS 3.60 - NUMBER OF CLAIMS 1
TOTAL PENDS 168.94 NUMBER OF CLAIMS 4
TOTAL PAID 147.40 NUMBER OF CLAIMS 4
TOTAL DENIED 162.20 NUMBER OF CLAIMS 4
NET TOTAL PAID 143.80 NUMBER OF CLAIMS 5

**PAGE 04**  
**DATE 08/06/07**  
**CYCLE 1563**
**Exhibit 3.5.10-4**

TO: ABC PRACTITIONER  
123 MAIN STREET  
ANYTOWN, NEW YORK 11111

ETIN:  
PRACTITIONER  
PROVID: ########/#########  
REMITTANCE NO: ########

---

**Remittance Totals – Grand Totals**

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<td>TOTAL PENDS</td>
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<td>NUMBER OF CLAIMS</td>
<td>4</td>
</tr>
<tr>
<td>TOTAL PAID</td>
<td>147.40</td>
<td>NUMBER OF CLAIMS</td>
<td>4</td>
</tr>
<tr>
<td>TOTAL DENY</td>
<td>162.20</td>
<td>NUMBER OF CLAIMS</td>
<td>4</td>
</tr>
<tr>
<td>NET TOTAL PAID</td>
<td>143.80</td>
<td>NUMBER OF CLAIMS</td>
<td>5</td>
</tr>
</tbody>
</table>

**Date:** 08/06/07  
**Cycle:** 1563  
**Page:** 05  
**Cycle:** 1563
3.5.10.1 Claim Detail Page Field Descriptions

**Upper Left Corner**

Provider’s Name/Address (as recorded in the Medicaid files)

**Upper Right Corner**

Remittance Page Number

Date the remittance advice was issued

Cycle Number: The pre-assigned number for the claims processing period. It is helpful to have the cycle number available when calling the eMedNY Call Center with questions about specific processed claims or payments.

ETIN (not applicable)

Provider Service Classification: **PRACTITIONER**

PROV ID: This field contains the Medicaid Provider ID and the NPI

Remittance Number

3.5.10.2 Explanation of Claim Detail Columns

**LN. NO. (Line Number)**

This column indicates the line number of each claim as it appears on the claim form.

**Office Account Number**

Up to 20 characters of the Patient/Office Account Number entered in the claim form is provided in this column.

**Client Name**

This column indicates the last name of the member. If an invalid Medicaid Member ID was entered in the claim form, the ID will be listed as it was submitted but no name will appear in this column.

**Client ID Number**

The Member ID number appears in this column.
TCN

The Transaction Control Number (TCN) is a unique identifier assigned to each claim that is processed. If multiple claim lines are submitted on the same claim form, all the lines are assigned the same TCN.

Date of Service

The first date of service (From date) entered in the claim appears in this column. If a date different from the From date was entered in the Through date box, that date is not returned in the Remittance Advice.

Procedure Code

The five-digit procedure code entered in the claim form appears in this column.

Units

The total number of units of service for the specific claim appears in this column.

Charged

This column lists either the amount the provider charged for the claim.

Paid

If the claim was approved, the amount paid appears in this column. If the claim has a pend or deny status, the amount paid will be zero (0.00).

Office–based practitioners and clinics participating in the Patient Centered Medical Home Program may receive enhanced payments for qualifying services. A payment line on the remittance will appear as shown in Exhibit 3.5.10.2-1:

Exhibit 3.5.10.2-1

<table>
<thead>
<tr>
<th>LN. NO</th>
<th>OFFICE ACCOUNT NUMBER</th>
<th>CLIENT NAME</th>
<th>CLIENT ID NUMBER</th>
<th>TCN</th>
<th>DATE OF SERVICE</th>
<th>PROC. CODE</th>
<th>UNITS</th>
<th>CHARGED</th>
<th>PAID</th>
<th>STATUS</th>
<th>ERRORS</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>CPXXXXXX</td>
<td>LASTNAME LLC</td>
<td>1234567</td>
<td>89012</td>
<td>9/8/2023</td>
<td>35</td>
<td>50</td>
<td>50.00</td>
<td>50.00</td>
<td>PEND</td>
<td></td>
</tr>
<tr>
<td></td>
<td>MEDICAL HOME ADD. ON</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Information about this program is available by clicking on the link to the webpage as follows: New York’s Medicaid Statewide Patient-Centered Medical Home Incentive Program

Status

This column indicates the status (DENY, PAID/ADJT/VOID, PEND) of the claim line.
Denied Claims

Claims for which payment is denied will be identified by the DENY status. The following are examples of circumstances that commonly cause claims to be denied:

- The service rendered is not covered by the New York State Medicaid Program.
- The claim is a duplicate of a prior paid claim.
- The required Prior Approval has not been obtained.
- Information entered in the claim form is invalid or logically inconsistent.

Approved Claims

Approved claims will be identified by the statuses PAID, ADJT (adjustment), or VOID.

Paid Claims

The status PAID refers to original claims that have been approved.

Adjustments

The status ADJT refers to a claim submitted in replacement of a paid claim with the purpose of changing one or more fields. An adjustment has two components: the credit transaction (previously paid claim), and the debit transaction (adjusted claim).

Voids

The status VOID refers to a claim submitted with the purpose of canceling a previously paid claim. A void lists the credit transaction (previously paid claim) only.

Pending Claims

Claims that require further review or recycling will be identified by the PEND status. The following are examples of circumstances that commonly cause claims to be pended:

- New York State Medical Review required.
- Procedure requires manual pricing.
- No match found in the Medicaid files for certain information submitted on the claim, for example: Member ID, Prior Approval. These claims are recycled for a period of time during which the Medicaid files may be updated to match the information on the claim.
In order for a claim to be removed from Pend status, one of the following must occur:

- manual review is completed,
- a successful match is found
- the recycling time expires

A new pend is signified by two asterisks (**). A previously pended claim is signified by one asterisk (*)

### Errors

For claims with a DENY or PEND status, this column indicates the NYS Medicaid edit (error) number(s) that caused the claim to deny or pend. Up to twenty-five (25) edit codes, including approved edits, may be listed for each claim. Edit code definitions are listed at the end of the claim detail section.

#### 3.5.10.3 Subtotals/Totals/Grand Totals

Subtotals of dollar amounts and number of claims are provided as follows:

Subtotals by claim **status** appear at the end of the claim listing for each status. The subtotals are broken down by:

- Original claims
- Adjustments
- Voids
- Adjustments/voids combined

Subtotals by **provider type** are provided at the end of the claim detail listing. These subtotals are broken down by:

- Adjustments/voids (combined)
- Pends
- Paid
- Deny
- Net total paid (for the specific service classification)

Totals by **member ID** are subtotals for the individual practitioners these who provided services as part of the group being paid: These subtotals are broken down by:

- Adjustments/voids (combined)
- Pends
- Paid
- Deny
- Net total paid (sum of approved adjustments/voids and paid original claims)
Grand Totals for the entire provider remittance advice appear on a separate page following the page containing the totals by provider type and member ID. The grand total is broken down by:

- Adjustments/voids (combined)
- Pends
- Paid
- Deny
- Net total paid (entire remittance)
### 3.5.11 Transportation Claim Detail

#### Exhibit 3.5.11-1

---

<table>
<thead>
<tr>
<th>LN. NO</th>
<th>OFFICE ACCOUNT NUMBER</th>
<th>CLIENT NAME</th>
<th>CLIENT ID NUMBER</th>
<th>TCN</th>
<th>DATE OF SERVICE</th>
<th>PROC. CODE</th>
<th>UNITS CHARGED</th>
<th>PAID</th>
<th>STATUS</th>
<th>ERRORS</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>CPXXXXXX</td>
<td>LASTNAME</td>
<td>LL#####L</td>
<td>MM/DD/YY NY211</td>
<td>48.000</td>
<td>52.80</td>
<td>0.00</td>
<td>DENY</td>
<td>00162</td>
<td>00244</td>
</tr>
<tr>
<td>01</td>
<td>CPXXXXXX</td>
<td>LASTNAME</td>
<td>LL#####L</td>
<td>MM/DD/YY NY211</td>
<td>16.000</td>
<td>17.60</td>
<td>0.00</td>
<td>DENY</td>
<td>00244</td>
<td></td>
</tr>
<tr>
<td>01</td>
<td>CPXXXXXX</td>
<td>LASTNAME</td>
<td>LL#####L</td>
<td>MM/DD/YY NY211</td>
<td>13.000</td>
<td>14.30</td>
<td>0.00</td>
<td>DENY</td>
<td>00162</td>
<td></td>
</tr>
<tr>
<td>01</td>
<td>CPXXXXXX</td>
<td>LASTNAME</td>
<td>LL#####L</td>
<td>MM/DD/YY NY211</td>
<td>63.000</td>
<td>77.50</td>
<td>0.00</td>
<td>DENY</td>
<td>00131</td>
<td></td>
</tr>
</tbody>
</table>

* = PREVIOUSLY PENDED CLAIM  
** = NEW PEND

---

**Total Amount Original Claims**  
DENIED 162.20 NUMBER OF CLAIMS 4

**Net Amount Adjustments**  
DENIED 0.00 NUMBER OF CLAIMS 0

**Net Amount Voids**  
DENIED 0.00 NUMBER OF CLAIMS 0

**Net Amount Voids – Adjusts**  
0.00 NUMBER OF CLAIMS 0

---

**TO:** ABC TRANSPORTATION  
123 MAIN STREET  
ANYTOWN, NEW YORK 11111

**ETIN:** TRANSPORTATION  
PROV ID: #######

**REMITTANCE NO:** #######
### Exhibit 3.5.11-2

**TO:** ABC TRANSPORTATION  
123 MAIN STREET  
ANYTOWN, NEW YORK 11111

**ETIN:**  
TRANSPORTATION  
Anytown, New York 11111  
**PROV ID:** ########/#########

**DATE** 08/06/07  
**CYCLE** 1563

---

**LN.** | **OFFICE ACCOUNT** | **CLIENT** | **CLIENT ID** | **DATE OF** | **PROC.** | **NO** | **NUMBER** | **NAME** | **NUMBER** | **TCN** | **SERVICE** | **CODE** | **UNITS** | **CHARGED** | **PAID** | **STATUS** | **ERRORS** |
---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
01 | CPXXXXX | LASTNAME | LL#####L | MM/DD/YY | NY211 | 13.000 | 14.30 | 14.30 | PAID | 01 CPXXXXX | LASTNAME | LL#####L | MM/DD/YY | NY211 | 13.000 | 14.30 | 14.30 | PAID |
02 | CPXXXXX | LASTNAME | LL#####L | MM/DD/YY | NY211 | 13.000 | 14.30 | 14.30 | PAID | 01 CPXXXXX | LASTNAME | LL#####L | MM/DD/YY | NY211 | 48.000 | 52.80 | 52.80 | PAID |
01 | CPXXXXX | LASTNAME | LL#####L | MM/DD/YY | NY211 | 66.000 | 66.00 | 66.00 | PAID | 01 CPXXXXX | LASTNAME | LL#####L | MM/DD/YY | NY211 | 17.000 | 17.60 | 17.60 | ADJT |
01 | CPXXXXX | LASTNAME | LL#####L | MM/DD/YY | NY211 | 13.000 | 14.30 | 14.00 | ADJT | 01 CPXXXXX | LASTNAME | LL#####L | MM/DD/YY | NY211 | 13.000 | 14.30 | 14.00 | ADJT |

**TOTAL AMOUNT ORIGINAL CLAIMS** | **PAID** | 147.40 | **NUMBER OF CLAIMS** | 4
**NET AMOUNT ADJUSTMENTS** | **PAID** | 3.60 | **NUMBER OF CLAIMS** | 1
**NET AMOUNT VOIDS** | **PAID** | 0.00 | **NUMBER OF CLAIMS** | 0
**NET AMOUNT VOIDS – ADJUSTS** | **PAID** | 3.60 | **NUMBER OF CLAIMS** | 1

*PREVIOUSLY PENDED CLAIM  
***NEW PEND*
Exhibit 3.5.11-3

<table>
<thead>
<tr>
<th>LN.</th>
<th>OFFICE ACCOUNT</th>
<th>CLIENT NAME</th>
<th>CLIENT ID</th>
<th>TCN</th>
<th>DATE OF PROC.</th>
<th>SERVICE CODE</th>
<th>UNITS CHARGED</th>
<th>UNITS PAID</th>
<th>STATUS</th>
<th>ERRORS</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>CPXXXXX</td>
<td>LASTNAME</td>
<td>LLLLLLL</td>
<td>MM/DD/YY2</td>
<td>08/06/07 NY211</td>
<td>60.000 69.30</td>
<td>0.00</td>
<td><strong>PEND</strong></td>
<td>00162</td>
<td></td>
</tr>
<tr>
<td>02</td>
<td>CPXXXXX</td>
<td>LASTNAME</td>
<td>LLLLLLL</td>
<td>MM/DD/YY2</td>
<td>08/06/07 NY211</td>
<td>63.000 71.04</td>
<td>0.00</td>
<td><strong>PEND</strong></td>
<td>00162</td>
<td></td>
</tr>
<tr>
<td>03</td>
<td>CPXXXXX</td>
<td>LASTNAME</td>
<td>LLLLLLL</td>
<td>MM/DD/YY2</td>
<td>08/06/07 NY211</td>
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<td>0.00</td>
<td><strong>PEND</strong></td>
<td>00142</td>
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</tr>
<tr>
<td>03</td>
<td>CPXXXXX</td>
<td>LASTNAME</td>
<td>LLLLLLL</td>
<td>MM/DD/YY2</td>
<td>08/06/07 NY211</td>
<td>13.000 14.30</td>
<td>0.00</td>
<td><strong>PEND</strong></td>
<td>00131</td>
<td></td>
</tr>
</tbody>
</table>

TOTAL AMOUNT ORIGINAL CLAIMS: 168.94
NET AMOUNT ADJUSTMENTS: 0.00
NET AMOUNT VOIDS: 0.00
NET AMOUNT VOIDS – ADJUSTS: 0.00

REMITTANCE TOTALS – TRANSPORTATION

VOIDS – ADJUSTS: 3.60 - NUMBER OF CLAIMS: 1
TOTAL PENDS: 168.94 - NUMBER OF CLAIMS: 4
TOTAL PAID: 147.40 - NUMBER OF CLAIMS: 4
TOTAL DENIED: 162.20 - NUMBER OF CLAIMS: 4
NET TOTAL PAID: 143.80 - NUMBER OF CLAIMS: 5

MEMBER ID: ########

VOIDS – ADJUSTS: 3.60 - NUMBER OF CLAIMS: 1
TOTAL PENDS: 168.94 - NUMBER OF CLAIMS: 4
TOTAL PAID: 147.40 - NUMBER OF CLAIMS: 4
TOTAL DENIED: 162.20 - NUMBER OF CLAIMS: 4
NET TOTAL PAID: 143.80 - NUMBER OF CLAIMS: 5
### Exhibit 3.5.11-4

**TO:** ABC TRANSPORTATION  
123 MAIN STREET  
ANYTOWN, NEW YORK 11111

**ETIN:**  
TRANSPORTATION  
GRAND TOTALS  
PROV ID: ########/#########

**REMITTANCE NO:** ########

<table>
<thead>
<tr>
<th>DESCRIPTION</th>
<th>VALUE</th>
<th>NUMBER OF CLAIMS</th>
</tr>
</thead>
<tbody>
<tr>
<td>REMITTANCE TOTALS – GRAND TOTALS</td>
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<td></td>
</tr>
<tr>
<td>Voids – Adjusts</td>
<td>3.60</td>
<td>1</td>
</tr>
<tr>
<td>Total Pends</td>
<td>168.94</td>
<td>4</td>
</tr>
<tr>
<td>Total Paid</td>
<td>147.40</td>
<td>4</td>
</tr>
<tr>
<td>Total Deny</td>
<td>162.20</td>
<td>4</td>
</tr>
<tr>
<td>Net Total Paid</td>
<td>143.80</td>
<td>5</td>
</tr>
</tbody>
</table>

**DATE:** 08/06/07  
**CYCLE:** 1563
3.5.11.1 Claim Detail Page Field Descriptions

Upper Left Corner

Provider’s Name/Address (as recorded in the Medicaid files)

Upper Right Corner

Remittance page number

Date the remittance advice was issued

Cycle number: The pre-assigned number for the claims processing period. It is helpful to have the cycle number available when calling the eMedNY Call Center with questions about specific processed claims or payments.

ETIN (not applicable)

Provider Service Classification: TRANSPORTATION

PROV ID: This field contains the Medicaid Provider ID and the NPI, as applicable.

Remittance Number

3.5.11.2 Explanation of Claim Detail Columns

Ln. No. (Line Number)

This column indicates the claim number as it corresponds to the procedure lines on the claim form.

Office Account Number

Up to 20 characters of the Patient/Office Account Number entered in the claim form is provided in this column.

Client Name

This column indicates the last name of the member. If an invalid Medicaid Client ID was entered in the claim form, the ID will be listed as it was submitted but no name will appear in this column.

Client ID

The member’s Medicaid ID number appears in this column.
**TCN**

The TCN is a unique identifier assigned to each claim that is processed. If multiple claim lines are submitted on the same claim form, all the lines are assigned the same TCN.

**Date of Service**

The first date of service (From date) entered in the claim appears in this column. If a date different from the From date was entered in the Through date box, that date is not returned in the Remittance Advice.

**Procedure Code**

The five-digit procedure code entered in the claim form appears in this column.

**Units**

The total number of units of service for the specific claim appears in this column.

**Charged**

The total charges entered in the claim form appear in this column.

**Paid**

If the claim was approved, the amount paid appears in this column. If the claim has a pend or deny status, the amount paid will be zero (0.00).

**Status**

This column indicates the status (DENY, PAID/ADJT/VOID, PEND) of the claim line.

**Denied Claims**

Claims for which payment is denied will be identified by the *DENY* status. The following are examples of circumstances that commonly cause claims to be denied:

- The service rendered is not covered by the New York State Medicaid Program.
- The claim is a duplicate of a prior paid claim.
- The required Prior Approval has not been obtained.
- Information entered in the claim form is invalid or logically inconsistent.
Approved Claims

Approved claims will be identified by the statuses PAID, ADJT (adjustment), or VOID.

Paid Claims

The status PAID refers to original claims that have been approved.

Adjustments

The status ADJT refers to a claim submitted in replacement of a paid claim with the purpose of changing one or more fields. An adjustment has two components: the credit transaction (previously paid claim), and the debit transaction (adjusted claim).

Voids

The status VOID refers to a claim submitted with the purpose of canceling a previously paid claim. A void lists the credit transaction (previously paid claim) only.

Pending Claims

Claims that require further review or recycling will be identified by the PEND status. The following are examples of circumstances that commonly cause claims to be pended:

- New York State Medical Review required.
- Procedure requires manual pricing.
- No match found in the Medicaid files for certain information submitted on the claim, for example: Member ID, Prior Approval. These claims are recycled for a period of time during which the Medicaid files may be updated to match the information on the claim.

In order for a claim to be removed from Pend status, one of the following must occur:

- manual review is completed,
- a successful match is found
- the recycling time expires

A new pend is signified by two asterisks (**). A previously pended claim is signified by one asterisk (*).

Errors

For claims with a DENY or PEND status, this column indicates the NYS Medicaid edit (error) number(s) that caused the claim to deny or pend. Up to twenty-five (25) edit codes, including approved edits, may be listed for each claim. Edit code definitions are listed at the end of the claim detail section.
3.5.11.3 Subtotals/Totals/Grand Totals

Subtotals of dollar amounts and number of claims are provided as follows:

Subtotals by claim status appear at the end of the claim listing for each status. The subtotals are broken down by:

- Original claims
- Adjustments
- Voids
- Adjustments/voids combined

Subtotals by provider type are provided at the end of the claim detail listing. These subtotals are broken down by:

- Adjustments/voids (combined)
- Pends
- Paid
- Denied
- Net total paid (for the specific provider classification)

Totals by Member ID are subtotals for the individual practitioners who provided services as part of the group being paid. These subtotals are broken down by:

- Adjustments/voids (combined)
- Pends
- Paid
- Denied
- Net total paid (sum of approved adjustments/voids and paid original claims)

Grand Totals for the entire provider remittance advice, which include all the provider’s service classifications, appear on a separate page following the page containing the totals by provider type and member ID (See definition above). The grand total is broken down by:

- Adjustments/voids (combined)
- Pends
- Paid
- Denied

Net total paid (entire remittance)
3.6 Section Four – Financial Transactions and Accounts Receivable

This section has two subsections:

- Financial Transactions
- Accounts Receivable

3.6.1 Financial Transactions

The Financial Transactions subsection lists all the recoupments applied to the provider during the specific cycle. If there is no recoupment activity, this subsection is not produced.

Exhibit 3.6.1-1
### 3.6.1.1 Explanation of Financial Transactions Columns

#### FCN

The Financial Control Number (FCN) is a unique identifier assigned to each financial transaction.

#### Financial Reason Code

This code identifies the reason for the recoupment.

#### Financial Transaction Type

This is the description of the Financial Reason Code. For example: Third Party Recovery.

#### Date

The date the recoupment was applied. Since all the recoupments listed on this page pertain to the current cycle, all recoupments will have the same date.

#### Amount

The dollar amount corresponding to the particular fiscal transaction. This amount is deducted from the provider’s total payment for the cycle.

### 3.6.1.2 Explanation of Totals Section

The total dollar amount of the financial transactions (*Net Financial Transaction Amount*) and the total number of transactions (*Number of Financial Transactions*) appear below the last line of the transaction detail list.

The Net Financial Transaction Amount added to the Claim Detail-Grand Total must equal the Medicaid Check or EFT amounts.
3.6.2 Accounts Receivable

This subsection displays the original amount of each of the outstanding Financial Transactions and their current balance after the cycle recoupments were applied. If there are no outstanding negative balances, this section is not produced.

Exhibit 3.6.2-1

<table>
<thead>
<tr>
<th>REASON CODE</th>
<th>DESCRIPTION</th>
<th>ORIG BAL</th>
<th>CURR BAL</th>
<th>RECOUP %/AMT</th>
</tr>
</thead>
<tbody>
<tr>
<td>$XXX.XX-</td>
<td></td>
<td>$XXX.XX-</td>
<td>$XXX.XX-</td>
<td>999</td>
</tr>
<tr>
<td>$XXX.XX-</td>
<td></td>
<td>$XXX.XX-</td>
<td>$XXX.XX-</td>
<td>999</td>
</tr>
</tbody>
</table>

TOTAL AMOUNT DUE THE STATE $XXX.XX
3.6.2.1 Explanation of Accounts Receivable Columns

If a provider has negative balances of different types or negative balances created at different times, each negative balance will be listed in a different line.

**Reason Code Description**

This is the description of the Financial Reason Code. For example, Third Party Recovery.

**Original Balance**

The original amount (or starting balance) for any particular financial reason.

**Current Balance**

The current amount owed to Medicaid (after the cycle recoupments, if any, were applied). This balance may be equal to or less than the original balance.

**Recoupment % Amount**

The deduction (recoupment) scheduled for each cycle.

**Total Amount Due the State**

This amount is the sum of all the Current Balances listed above.
3.7 Section Five – Edit (Error) Description

The last section of the Remittance Advice features the description of each of the edit codes that appear in Section Three.

Exhibit 3.7-1

<table>
<thead>
<tr>
<th>PAGE 05</th>
<th>DATE</th>
<th>CYCLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>DATE 08/06/07</td>
<td>CYCLE 1563</td>
<td></td>
</tr>
</tbody>
</table>

TO: ABC TRANSPORTATION
123 MAIN STREET
ANYTOWN, NEW YORK 11111

ETIN: TRANSPORTATION
EDIT DESCRIPTIONS
PROV ID: **************
REMITTANCE NO: ***********

THE FOLLOWING IS A DESCRIPTION OF THE EDIT REASON CODES THAT APPEAR ON THE CLAIMS FOR THIS REMITTANCE:

00127 MEDICARE PAID AMOUNT LESS THAN REASONABLE
00142 SERVICE CODE NOT EQUAL TO PA
00144 RECIPIENT SEX NOT EQUAL TO FILE
00162 RECIPIENT INELIGIBLE ON DATE OF SERVICE
01154 NO UT SERVICE AUTHORIZATION ON FILE
4. The Status of Claims

The eMedNY system applies two levels of editing for all incoming claims/files:

- Pre-adjudication editing
- Mainframe adjudication editing

Rejected Claims

During the pre-adjudication, claims can be either accepted or rejected. For electronic claims eMedNY provides the front-end edit report, referred to as 277CA, to inform the providers of accepted or rejected claims. A rejection means the claim will not enter the claims processing system. Providers must review the front-end edit report in order to make corrections for rejected claims and resubmit them for processing in a timely manner. Rejected claims will not appear on the submitter’s remittance statement.

Providers can also use the Submitter Dashboard tool to check if claims were accepted or rejected. The eMedNY Submitter Dashboard is designed to assist Trading Partners in tracking the status of batch submissions made to New York Medicaid. Trading Partners can follow the progress of their batch submissions here. For additional information on the Dashboard please see the Submitter Dashboard button on the home page on emedny.org

Rejections for electronic claims can be caused by various errors in submitted information. You can find a list of those rejection reasons here: https://www.emedny.org/HIPAA/5010/transactions/crosswalks/eMedNY%20Pre-Adjudication%20Crosswalk%20(837%20Health%20Care%20Claims).pdf

For ePACES claims providers can view the claims status either by checking the ‘Real Time Responses’ link for Professional Real Time claims or ‘View Previously Submitted claims’ link for all other types of claims.

For paper claims missing critical data or having an invalid attachment, the paper claim will be mailed back to the submitter with a rejection explanation.

Accepted Claims

Once a claim is accepted into the eMedNY claims processing system it will appear on a remittance with one of the following statuses:

- Adjustments/Void to a previous claim
- Pending
- Paid
- Denied
Information on Pending Claims

A claim may be pending final adjudication if it contains erroneous information, does not match the New York State Department of Health’s records, or requires manual review to be resolved. The New York State Department of Health’s fiscal agent, Computer Sciences Corporation (CSC) reviews some pending claim. While some other pending claims are resolved by the Department of Health because of the nature of the pended claim, for instance manual pricing.

The majority of pending claims are recycling for either 30, 60 or 90 days to verify if new client information has been received from the county that would allow the claim to be released for payment. An example of a recycling pending claim would be: Recipient Not Eligible on Date of Service. These claims are recycled for 30 days. If no new information is received at the end of this time period, the claim will be denied.

Any claim pending will appear on the weekly remittance for the first week it is pending. Depending on how the provider has set up their choice of how he/she wishes to see pending claims on the remittance and whether the provider receives a paper or an electronic remittance, the pending claim may be reported on the first weekly cycle and when paid or denied, every week or once every 4 weeks. A message will appear on the remittance statement with a description of why the claim is pending.

Pending claims may ultimately be approved for payment, reduced or denied. Some common reasons for pending a claim are:

- New York State Medical Review required
- Procedure requires manual pricing
- Recipient Ineligible on Date of Service

Denied Claims

Claims for which payment is denied will be identified by the DENY status. The following are examples of circumstances that commonly cause claims to be denied:

- The service rendered is not covered by the New York State Medicaid Program.
- The claim is a duplicate of a prior paid claim.
- The required Prior Approval has not been obtained.
- Information entered in the claim form is invalid or logically inconsistent.

Please refer to the Billing Section of your MMIS Provider Manual for details. Providers should review the denied claim on their remittance statement and resubmit on a new claim as described within the Billing Section of your Provider Manual or the HIPAA Companion Guides available on www.emedny.org. Please call the eMedNY Call Center at 800 343-9000 for assistance in understanding the reason why a claim is denied.

Information about re-submitting previously rejected or denied claims may be found here:
eMedNY is the name of the electronic New York State Medicaid system. The eMedNY system allows New York Medicaid providers to submit claims and receive payments for Medicaid-covered services provided to eligible clients.

eMedNY offers several innovative technical and architectural features, facilitating the adjudication and payment of claims and providing extensive support and convenience for its users. CSC is the eMedNY contractor and is responsible for its operation.

The information contained within this document was created in concert by eMedNY DOH and eMedNY CSC. More information about eMedNY can be found at www.emedny.org.