

STATE OF NEW YORK
DEPARTMENT OF HEALTH



eMedNY
MEVS Batch Authorizations
Manual

October 8, 2003
Version 14

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1.0 OVERVIEW (Rev. 10/03)

The New York State Medicaid Eligibility Verification System (MEVS) requires the use of the HIPAA compliant Eligibility transaction formats. The formats will be accepted via File Transfer Protocol (FTP) or CPU-CPU link.

1.1 FTP

This method is the standard process for batch authorization transmissions. FTP allows users to transfer files from their computer to another computer (upload) or from another computer to their computer (download). Each batch file transmission sent to the eMedNY contractor is required to be completed within two hours. Any transmission exceeding two hours will be disconnected.

1.2 Availability of eMedNY

The eMedNY system is available 24 X 7. In the event of a system problem, you may call CSC's Provider Services Department at 800 343-9000. User support is available Monday through Friday between 7:00 AM and 10:00 PM, and 8:30 AM to 5:30 PM on Saturday, Sunday and holidays. You may contact CSC's Provider Services Department at 800 343-9000.

While the intent has been to provide sufficient concurrent telephone connections, it is possible that you may encounter a busy signal. Please try again at a later time.

2.0 OBTAINING AN eMedNY ACCESS (Rev. 10/03)

Upon completion and subsequent filing of the electronic certification statement you will be given two pieces of information. The first is your user identifier and the second is your initial password. You will be required to change your password when you access the eMedNY the first time. Make sure you record your new password and store it in a secure place.

If you lose or forget any component of your access key, or suspect an unauthorized person may have knowledge of your access key, please call the CSC Provider Services Department immediately. You are responsible for any action taken on behalf of your account.

Refer to [Security Packet B](#) containing the forms to obtain an eMedNY user access key.

3.0 File Format Specifications (Rev. 10/03)

Please refer to the Companion Guides on the eMedNY.org website for the following HIPAA Medicaid Eligibility companion guides to obtain the correct file and record formats.

Access the Companion Guides by referring to www.hipaadesk.com/?nymedicaid under the "News and Resources" tab.

- 270: 270 Eligibility Inquiry Request NYSDOH Companion Guide (4010X092A1)
- 271: 271 Eligibility Inquiry Response NYSDOH Companion Guide (4010X092A1)
- 278: 278 Services Request NYSDOH Companion Guide (4010X094A1)
- 278: 278 Services Response NYSDOH Companion Guide (4010X094A1)

The electronic specifications contain the requirements and procedures that must be followed when submitting electronic media

4.0 FTP FILE PREPARATION PROCEDURES (Rev. 11/02)

- The “Binary” option must be activated prior to sending or receiving files. Therefore, following your logon to the FTP ID, type “Binary” at the FTP prompt and hit enter.
- To *send* files type, “Send” at the FTP prompt and hit enter. To *receive* files type “Recv” at the FTP prompt and hit enter.
- Using PKZIP or WinZIP, a file must be *zipped* prior to sending files to the FTP ID.
- Using PKZIP or WinZIP, a file must be *unzipped* after downloading a response file from the FTP ID.
- When *sending* a file, the following Dataset Naming Standard for the remote file is required:

Node1.Node2.Node3

where,

Node1 = ‘P’ followed by the first seven digits of *your* provider number (i.e. P1234567)

Node2 = ZIP

Node3 = Generation/File number in the following format (G000?V00), where ? = the file you are sending for the day.

Using the example above, the completed remote file would be:

P1234567.ZIP.G0001V00 (1st file for the day)

P1234567.ZIP.G0002V00 (2nd file for the day)

P1234567.ZIP.G0003V00 (3rd file for the day)

- When *receiving* a file, the remote file will be entered using the following naming standard:

NodeA.NodeB.NodeC

where,

NodeA = ‘P’ followed by the first seven digits of *your* provider number (i.e. P1234567)

NodeB = ‘D’ followed by the date in the YYMMDD format.

NodeC = ZIP

5.0 FORMS (Rev. 10/03)

The following forms are included in the manual:

- Provider Electronic Transmission Identification Number (ETIN) Application
- AGREEMENT for eMedNY System ACCESS (Security Packet B)

Provider Electronic Transmission Identification Number (ETIN) APPLICATION

To apply for your Electronic Transmission Identification Number (ETIN), which is required in order to submit data electronically for processing by the New York State MMIS or eMedNY, please complete the items below and forward along with a Certification Statement to:

ATTN: MAGNETIC MEDIA LIAISON - FIRST FLOOR
CSC HEALTHCARE SERVICES
800 NORTH PEARL STREET
ALBANY, NY 12204

* PLEASE NOTE: If you are adding a new Provider ID Number to an existing Electronic Transmission Identification Number (ETIN) send ONLY the Certification Statement.

1. PROVIDER NAME: _____

2. PROVIDER ADDRESS: _____
(STREET)

(CITY) (STATE) (ZIP CODE + 4)

()- _____ ()- _____
(TELEPHONE NUMBER) (EXTENSION) (FAX Number)

3. ADMINISTRATOR'S NAME _____

4. CONTACT PERSON'S NAME _____

TELEPHONE NUMBER _____

5. MMIS PROVIDER NUMBER(S) _____
(NOT GROUP #)

SIGNATURE OF PERSON(S) AUTHORIZED TO SIGN PROVIDER MAGNETIC INPUT TRANSMITTALS.

(NAME PRINTED) (SIGNATURE)

(TITLE) (DATE)

(NAME PRINTED) (SIGNATURE)

(TITLE) (DATE)

**SECURITY PACKET B
AGREEMENT for eMedNY System ACCESS
Instructions for Completion**

1. Please read the Agreement. Your signature indicates acceptance to the terms and conditions of this Agreement.
2. Complete the information requested at the bottom of the Agreement form and sign the Agreement. Please print or type the following information:
 - a) **Provider Number (Only for enrolled providers or vendors with an assigned Medicaid ID number. Otherwise leave this field blank.)**
Enter your eight-digit Medicaid Provider ID Number, which was assigned by the Department of Health at the time of your enrollment in the Medicaid program.
 - b) **Provider/Vendor Name**
Enter the name of the Provider/Vendor that will be subject to the agreement. (If you have a Medicaid Provider ID, enter the name associated with the Provider ID Number entered above).
 - c) **Street Address, City, State, Zip**
Enter the address where you would like to receive correspondence from CSC. Please note that it must be a **Street Address, not a P.O. Box.**
 - d) **By**
Print the name of the authorized person who signs the Agreement.
 - e) **Title**
Print the title of the authorized person who signs the Agreement.
 - f) **Date**
Enter the date on which the Agreement is signed.

SECURITY PACKET B

AGREEMENT for eMedNY System ACCESS (Rev. 10/03)

WHEREAS, the New York State Department of Health (the "Department") and Computer Sciences Corporation ("CSC"), have entered into an agreement whereby CSC provides direct electronic access to MEDICAID eligibility verification, claims submission, and other electronic transactions, for Medical Providers/Vendors and their agents (Provider/Vendor) to the eMedNY System; and

WHEREAS, Provider/Vendor performs certain medical services and/or provides medical supplies for recipients who are eligible for MEDICAID benefits, or performs data processing services for such entities; and

WHEREAS, Provider/Vendor has requested direct electronic access to the eMedNY System;

NOW, THEREFORE, CSC and Provider/Vendor agree as follows:

- 1. CSC-eMedNY will supply to Provider/Vendor the technical specifications required to establish the link to the eMedNY System (Exhibit A). Provider/Vendor is responsible for all costs associated with complying with such requirements.
2. Provider/Vendor agrees to comply with the system requirements and any additional terms set forth on Exhibit A.
3. After Provider/Vendor has obtained initial access to the eMedNY System, Provider/Vendor agrees to re-test its link to the System in the event:
- Provider's/Vendor's link is changed or modified in any way, or
- The technical specifications change in response to Department mandated program changes
Provider/Vendor agrees to follow CSC's then current procedures for obtaining such access.
4. Provider/Vendor agrees to pay any damages that are caused by, result from, or are in any way attributable to Provider/Vendor, its employees', agents' and independent contractors' negligent use of the eMedNY System, fraud or intentional misconduct or Provider's/Vendors' failure to certify or re-certify its link to the eMedNY System.
5. Provider/Vendor agrees to exercise due diligence in protecting Provider/Vendor systems so that malicious software is not introduced to eMedNY Systems.
6. Provider/Vendor accepts and agrees to comply with the Provisions of the attached eMedNY Security Agreement.
7. This Agreement shall become effective upon approval by CSC-eMedNY, on behalf of the New York State Department of Health and shall continue thereafter until terminated by either party on 60 days notice in writing.

Provider Number By: Please print name

Provider/Vendor Name By: Signature

Street Address Title:

City, State, Zip Date:

AGREEMENT for eMedNY System ACCESS
****EXHIBIT A****

SYSTEM REQUIREMENTS

1. Interactive Host-to-Host (CPU-CPU):
 - SNA Protocol (LU6.2)
 - Compliance with Data Stream Formats
2. Batch Host-to-Host:
 - SNA Protocol
 - Compliance with File Formats
3. Interactive PC-to-Host:
 - Third Party Software:
 - VISA-2 Protocol
 - Compliance with Data Stream Formats
 - Medicaid Eligibility:
 - 233 MHz Pentium
 - 32MB RAM
 - 20 MB HDD
 - 14400 BAUD Modem
 - Windows 95
 - Analog Telephone Line
4. Batch PC-to-Host (Dial-up FTP):
 - Point-to-Point Protocol (PPP)
 - TCP/IP Protocol with File Transfer Protocol (FTP)
 - Compliance with File Formats

OTHER TERMS

1. Provider/Vendor shall order the telecommunication lines and equipment necessary to link Provider's/Vendor's system to the eMedNY System. Provider/Vendor will be responsible for monitoring, diagnosing and establishing dial backup on the telecommunication lines and equipment.
2. CSC does not provide consultation services beyond simple installation troubleshooting. For example, we cannot assist with the installation of the operating system or configuration issues involving the Provider's/Vendor's LAN, PC, modem or printer. CSC does not support Provider/Vendor hardware or software.
3. When CSC provides the State of New York Medicaid Eligibility software, the software is supplied "AS IS" AND CSC MAKES NO REPRESENTATIONS OR WARRANTIES, EXPRESSED OR IMPLIED, WITH RESPECT TO THE SOFTWARE. In no event shall CSC be responsible for any damage to Provider's/Vendor's property which arises out of or is related to Provider's/Vendor's use of the Medicaid Eligibility, claims submission, and other electronic transaction software.
4. For qualified Providers/Vendors, CSC will provide support for the Medicaid Eligibility, claims submission, and other electronic transaction software supplied by CSC, so long as CSC is the State of New York eMedNY contractor and Provider/Vendor has not altered or modified the software in any way.

**PROVIDER/VENDOR eMedNY Access Request Form
Instructions for Completion**

Please type or print all required information.

1. User Information (*User is the Provider enrolled in the New York State Medical Assistance Program [Medicaid] or the Vendor that supplies switch services to a group of providers*)

Name

- If you are an individual Provider, enter your last name, first name, and middle initial (if any)
- If the Medicaid Provider ID number applies to a business (i.e. Pharmacy, DME Supplier, Laboratory, etc.), enter the name of the individual authorized to sign the eMedNY Access Request on behalf of the provider organization.
- If you are a Vendor, enter the Company name.

Address

Enter the address where you would like to receive correspondence from CSC.

Indicate

Check the box (only one box please) that best indicate your user status. If you check the box next to **Other**, please explain.

Medicaid Provider ID (*only for enrolled providers or vendors with an assigned Medicaid ID number; otherwise, leave this field blank.*)

Enter your (or your organization's) eight-digit Medicaid Provider ID Number, which was assigned by the Department of Health at the time of enrollment in the Medicaid program.

Phone Number

Enter the phone number at which you can be contacted.

2. Alternate Access Required

Enter the reason for which you are requesting access to eMedNY.

3. Requestor Information

Requestor's Name

Enter the name of the authorized person requesting access to eMedNY.

Date

Enter the date on which the request was completed.

Phone Number

Enter the phone number at which CSC can contact you if necessary.

LEAVE SECTIONS 4 AND 5 BLANK. THESE ARE FOR CSC USE ONLY.

PROVIDER/VENDOR eMedNY Access Request Form

1. User Information			
USER INFORMATION	Last Name:		First Name:
	Position/Title:		Middle Initial:
	Address:		Phone Number:
INDICATE: Medical Provider Service Bureau Connectivity Switch Provider/Vendor Other _____		MEDICAID PROVIDER ID:	
2. Alternate Access Required (Please see exhibit A for minimum requirements)			
PLATFORM	FTP batch submission (Dial-up)		
	Business Reason / description of access required:		
3. Requestor Information			
Requestor's Name:		Date:	Phone Number:
4. Approvals (For CSC eMedNY Use Only)			
APPROVER	Approver's Name:	Signature:	Date:
	Phone number:		
APPROVER	Approver's Name:	Signature:	Date:
	Phone number:		
5. Administration (For CSC eMedNY Data Security Use Only)			
DATA SECURITY	Type of User ID assigned:		
	Comments:		
	Administrator Name:	Administrator Signature:	Date:
	New USERID		Initial password

**SECURITY AGREEMENT FOR
NEW YORK STATE-eMedNY SYSTEM
Instructions for Completion**

1. Please read the **USERID AND PASSWORD RULES**. By signing the Agreement you indicate acceptance to the terms and conditions of this Agreement.
2. Complete the information requested at the bottom of the Agreement form and sign the Agreement. Please type or print the following information:
 - a) **Provider Number (only for enrolled providers or vendors with an assigned Medicaid ID number; otherwise leave this field blank).**
Enter your eight-digit Medicaid Provider ID Number, which was assigned by the Department of Health at the time of your enrollment in the Medicaid program.
 - b) **Provider/Vendor Name**
Enter the name of the Provider/Vendor that will be subject to the agreement. (If you have a Medicaid Provider ID, enter the name associated with the Provider ID Number entered above).
 - c) **Street Address, City, State, Zip**
Enter the address where you would like to receive correspondence from CSC. Please note that it must be a **Street Address, not a P.O. Box.**
 - d) **By**
Print the name of the authorized person who signs the Agreement.
 - e) **Title**
Print the title of the authorized person who signs the Agreement.
 - f) **Date**
Enter the date on which the Agreement is signed.

**SECURITY AGREEMENT
NEW YORK STATE-eMedNY SYSTEM**

All users of Medicaid data and systems are required to affirm their understanding and agreement to comply with the following USERID and Password rules before access can be granted.

USERID AND PASSWORD RULES

A USERID and password will be provided by CSC-eMedNY Data Security upon approval of this security agreement. CSC, in accordance with the Federal Information Processing Standards and the Privacy Act of 1974, requires that all users of the system be aware of and comply with the following rules regarding USERIDS and Passwords:

- a. USERIDS and Passwords must not be shared with anyone. A USERID is assigned by CSC-eMedNY Data Security solely to an individual and the individual is responsible for all system activity related to that USERID.
- b. After four consecutive password violations (i.e., entering the wrong password) the USERID is revoked. If this occurs CSC-eMedNY Data Security Administration intervention is required to reactivate the USERID. Contact Provider Relations to activate this intervention.

I have read and fully understand the USERID and Password rules as set out above.

Please provide a unique identifier, which will be used to authenticate this Provider/Vendor when corresponding via phone. This identifier should be something only this Provider/Vendor knows and will be used to verify that the Provider/Vendor is who they indicate they are when we are asked to provide sensitive information such as account passwords.

Unique identifier

Provider Number By: _____
Please print name

Provider/Vendor Name Signature

Street Address Title: _____

City, State, Zip Date: _____