NEW YORK STATE
MEDICAID PROGRAM

INFORMATION FOR ALL PROVIDERS

INTRODUCTION

Table of Contents

Preface

The purpose of this Manual is the provision of information and guidance to those providers who participate in the New York State Medicaid Program. It is designed to provide instructions for the understanding and completion of forms and documents relating to billing procedures and to serve as a reference for additional information that may be required.

Pertinent policy statements and requirements governing the Medicaid Program have been included. The Manual has been designed to easily incorporate changes since additions and periodic clarifications will be necessary. It should serve as a central reference for updated information.

Providers are responsible for familiarizing themselves with all Medicaid procedures and regulations currently in effect and as they are issued.

The Department of Health publishes a monthly newsletter, the *Medicaid Update*, which contains information regarding Medicaid programs, policy and billing. The *Update* is sent to all active enrolled providers.

New providers need to be familiar with the past issues of *Medicaid Update* to have current policy and procedures.

Past issues of *Medicaid Update* are available at:

http://www.health.state.ny.us/health_care/medicaid/program/update/main.htm.

Foreword

The New York State Department of Health (DOH) is the single State agency responsible for the administration of the New York Medicaid Program under Title XIX of the Social Security Act.

The primary purpose of the Medicaid Program is to make covered health and medical services available to eligible individuals. As the single State agency, DOH promulgates all necessary regulations and guidelines for Program administration, as well as develops professional standards for the Program, develops rates and fees for medical services, hospital utilization review and professional consultation to local department of social service officials for determining adequacy of medical services submitted for Medicaid reimbursement.

The Department is required to maintain a Medicaid State Plan that is consistent with provisions of Federal law and regulations. Administrative functions include development of Program policy, determination of recipient eligibility, ambulatory care utilization review, detection of possible fraud and abuse, and supervision of the Fiscal Agent and all its functions.

In order to carry out aspects of the professional administration of the Program, the DOH's Office of Medicaid Management (OMM) works in conjunction with other state agencies such as the Office of Mental Health (OMH), Office of Mental Retardation and Developmental Disabilities (OMRDD), Office of Alcohol and Substance Abuse Services (OASAS) and the State Education Department (SED) to ensure that the needs of the special populations that these agencies serve are addressed within the parameters of the Medicaid Program.

> Additionally, the DOH works with New York's local departments of social services to administer and fund the Medicaid Program.

The Director of the New York State Division of the Budget promulgates all fees and rates for the Medicaid Program (with the exception of those which by statute are set by OMH, OMRDD and OASAS).

Medicaid Management Information System

Chapter 639 of the Laws of the State of New York, 1976, mandated that a statewide Medicaid Management Information System (MMIS) be designed, developed and implemented.

New York State's MMIS, called eMedNY, is a computerized system for claims processing which also provides information upon which management decisions can be made. The New York State eMedNY design is based on the recognition that Medicaid processing can be highly automated and that provider relations and claims resolution require an interface with experienced program knowledgeable people.

> This approach results in great economies through automation, yet eliminates the frustration which providers frequently encounter in dealing with computerized systems.

DOH has contracted with Computer Sciences Corporation (CSC) to be the Medicaid fiscal agent.

CSC, in its role as Fiscal Agent, maintains a Medicaid claims processing system to meet New York State and Federal Medicaid requirements, and performs the following functions:

- Receives, reviews and pays claims submitted by the providers of health care for services rendered to eligible patients (recipients).

- Interacts with the providers through its Provider Services personnel in order to train providers in what the Medicaid requirements are and how to submit claims; responds to provider mail and telephone inquiries; maintains and issues forms, and notices, to providers.

- Maintains the Medicaid Eligibility Verification System (MEVS).

Key Features

eMedNY has several key features that enable the system to achieve its objectives.

- **Claims Payment**
  This aspect of eMedNY generates prompt payment of all approved claims and prepares a Remittance Statement with each payment cycle which lists the status of all paid, denied and pended claims.

- **Flexibility**
  For rate-based providers, the system has the flexibility to process individual claim lines submitted on a single claim separately. It will not deny payment of the entire

invoice if one line is pended or requires manual pricing.
For fee-for-service providers who utilize ePACES the system can process claims (with up to 4 claim lines) in "real-time". Real time means that the claims process through adjudication within seconds.

- **Manual Review**
  All paper claims are manually screened on the day of receipt prior to computer processing. Any omissions or obvious errors will result in the return of the claim form to the provider.

- **Inquiry Procedures**
  The Fiscal Agent handles written and telephone requests for information. Detailed procedures can be found in Information for All Providers, Inquiry.

- **Service Bureaus**
  The Fiscal Agent will cooperate with the provider's computer service bureau to ensure that the automated claim input meets eMedNY requirements.

- **Provider and Recipient Eligibility**
  The DOH is responsible for the determination of eligibility of providers in the New York Medicaid Program. Local departments of social services retain the responsibility for determining recipient eligibility.

- **Service Limitations and Exclusions**
  The DOH maintains the responsibility for determining covered services and exclusions in the Medicaid Program.

- **Continuing Communications**
  To ensure a flow of information from the State and Fiscal Agent to the providers, community bulletins, newsletters and updates are mailed periodically. Additionally, most information can be found online at:

  http://www.emedny.org/.

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GENERAL POLICY

Table of Contents

Section I – Enrollee Information

The New York State Department of Health (Department, DOH) exercises overall supervision of the Medicaid Program. Enrollee eligibility, however, is handled by the fifty-eight local departments of social services (LDSS) and the New York City Human Resources Administration (HRA).

Generally, the following groups are eligible for Medicaid in New York State:

- Citizens and certain qualified persons who are:

  - eligible for Low Income Families (families with children under age 21; persons under age 21 living alone; and pregnant women); or

  - in receipt of or eligible for Supplemental Security Income (individuals who are aged, certified blind or disabled); or

  - children on whose behalf foster care maintenance payments are being made or for whom an adoption assistance agreement is in effect under Title IV-E of the Social Security Act; or

  - individuals between the ages of 21 and 65 not living with a child under the age of 21, not certified blind or disabled, and not pregnant, whose income and resources are below the Public Assistance Standard of Need.

- Citizens and certain qualified persons who meet the financial and other eligibility requirements for the State's Medically Needy Program.

  These persons have income and resources above the cash assistance levels, but their income and resources are insufficient to meet medical needs.

  These groups generally include:

  - infants up to age one and pregnant women whose family income is at or below 185% of the federal poverty level;

  - children age one through five whose family income is at or below 133% of the federal poverty level;

  - other children with family income at or below 100% of the federal poverty level, including all children under age 19;

  - families with children under age 21 who do not have two parents in the household capable of working and providing support;

- persons related to the Supplemental Security Program (i.e., aged, certified blind or disabled);

- adults in two-parent households who are capable of working and providing support to their children under age 21;

- a special limited category of Medicaid eligibility is available for individuals who are entitled to the payment of Medicare deductibles and coinsurance, as appropriate, for Medicare-approved services. An individual eligible for this coverage is called a Qualified Medicare Enrollee (QMB).

  Any individual who is fully Medicaid-eligible and has Medicare coverage, even if not a QMB, is also entitled to have Medicare coinsurance and deductibles paid for by Medicaid. An individual may also have these benefits as a supplement to other Medicaid eligibility. QMB status is identified through the Medicaid Eligibility Verification System (MEVS).

Identification of Medicaid Eligibility

It is important to determine Medicaid eligibility for each medical visit since Medicaid eligibility is date specific. Each enrollee should have only one Common Benefit Identification Card (CBIC) or Temporary Medicaid Authorization paper document. If the enrollee presents a Temporary Medicaid Authorization paper document, there should be no obstacle to payment of the claim because of the enrollee's ineligibility for Medicaid, for medical services provided within the dates of coverage listed on the form.

The Temporary Medicaid Authorization is completed by the LDSS worker and includes the enrollee's:

- Name;
- Date of Birth;
- Social Security Number;
- Case Number;
- Caseworker's name and telephone number;
- Issuing County; and
- Type of Medicaid coverage authorized;
- Any restrictions that exist;
- Authorized dates of coverage.

It is recommended that the provider make a copy of the Temporary Medicaid Authorization and return the original to the enrollee, as he or she may have further medical needs during the authorization period.

The CBIC has the capability of being activated and authorized for several assistance programs at the same time. It is important for the provider to check the actual card through the MEVS system to assure there is current, active Medicaid coverage. This card may or may not have a photograph on it, as this is not a requirement for some enrollees because of their category or circumstances.

Sometimes, an enrollee may present the provider with more than one card for the same individual. This may occur when the enrollee has reported to the district that their card is lost and is then found after the LDSS issues a replacement card. In these cases, check each card for the sequence number, which is found to the right of the access number on the bottom of the front of the card. The highest sequence number is the most recently issued card, and is usually the one that is authorized with current benefits.

The permanent, plastic CBIC does not contain eligibility dates or other eligibility information. **Therefore, presentation of a CBIC alone is not sufficient proof that an enrollee is eligible for services. Each of the Benefit Cards must be used in conjunction with the MEVS process.** Through this process, the provider must be sure to verify if the enrollee has any special limitations or restrictions.

If the provider does not verify the eligibility and extent of coverage of each enrollee each time services are requested, then the provider will risk the possibility of non-reimbursement for services provided as **the State cannot compensate a provider for a service rendered to an ineligible person.** Eligibility information for the enrollee must be determined via the MEVS.

Eligible enrollees in voluntary child care agencies and residential health care facilities are issued Medicaid ID numbers which are maintained on a roster. A CBIC is usually not issued for these enrollees. If a card is required, a non-photo CBIC will be issued by the LDSS. It is the responsibility of the voluntary child care agency or the residential health care facility to give the enrollee's Medicaid ID number to other service providers; those providers must complete the verification process via MEVS to determine the enrollee's eligibility for Medicaid services and supplies.

The MEVS Provider Manual is available online at:

http://www.emedny.org/ProviderManuals/AllProviders/index.html.

Eligible Enrollees

Swiping the Medicaid card and/or reviewing the paper authorization and making no further comment to the Medicaid enrollee concerning payment for services, leads the enrollee to assume that you, as the provider, will accept Medicaid payment for the service about to be provided.

The Department supports this assumption and expects the provider to bill Medicaid, not the enrollee, for that service.

Ineligible Patients

If you swipe the plastic card and find that the individual is not eligible, then you must inform the patient.

A provider may charge a Medicaid enrollee for services only when both parties have agreed prior to the rendering of the service that the enrollee is being seen as a private pay patient; this must be a mutual and voluntary decision. It is suggested that the provider maintain the patient's signed consent to be treated as private pay in the patient's medical record.

Emergency Situations

In emergency situations where questions regarding health insurance are not normally asked, the Department expects you to accept the patient as a Medicaid enrollee; however, the enrollee is responsible for providing both the ambulance company and the hospital emergency room billing staff with a Medicaid number when it is requested at a later time.

If the enrollee is not cooperative in providing his or her Medicaid information after the transport or emergency room visit has occurred, then the patient may be billed as private pay. The Department does, however, expect that diligent efforts will be made to obtain the Medicaid information from the patient.

Services Available Under the Medicaid Program

Under the Medicaid Program, eligible individuals can obtain a wide variety of medical care and services. To acquaint providers with the scope of services available under this Program, the following list has been developed as a general reference.

Payment may be made for necessary:

- medical care provided by qualified physicians, nurses, optometrists, and other practitioners within the scope of their practice as defined by State Law;
- preventive, prophylactic and other routine dental care services and supplies provided by dentists and others professional dental personnel;
- inpatient care in hospitals, skilled nursing facilities, infirmaries, other eligible medical institutions (except that inpatient care is not covered for individuals from age 21 to 65 in institutions primarily or exclusively for the treatment of mental illness or tuberculosis), and health related care in intermediate care facilities;
- outpatient hospital and clinic services;
- home health care by approved home health agencies;
- personal care services prior authorized by the LDSS;
- physical therapy, speech pathology and occupational therapy;

- laboratory and X-ray services;
- family planning services;
- prescription drugs per the Commissioner's List, supplies and equipment, eyeglasses, and prosthetic or orthotic devices;
- early and periodic screening, diagnosis and treatment for individuals under 21;
- transportation when essential to obtain medical care;
- care and services furnished by qualified health care organizations or plans using the prepayment capitation principle;
- services of podiatrists in private practice only for persons in receipt of Medicare or under age 21 with written referral from a physician, physician's assistant, nurse practitioner or nurse midwife.

Providers must offer the same quality of service to Medicaid enrollee that they commonly extend to the general public and may not bill Medicaid for services that are available free-of-charge to the general public.

Qualified Medicare Beneficiary

The Medicaid Program permits payment toward Medicare deductibles and coinsurance, as appropriate, for certain Medicare Part B services provided to a select group of elderly and disabled Medicare enrollees with low income and very limited assets. These individuals are known as Qualified Medicare Beneficiaries (QMBs).

Not all Medicaid enrollees who have Medicare Part B coverage are QMBs.

Entitlement to QMB benefits must be confirmed by accessing the MEVS. It is crucial to note that the mere presentation of the enrollee's CBIC or other appropriate documentation is not sufficient to confirm an individual's entitlement to QMB services. A provider must confirm an individual's current QMB eligibility by accessing the MEVS prior to the provision of each service.

Free Choice

A person covered under Medicaid is free to choose from among qualified facilities, practitioners and other providers of services who participate in the Medicaid Program.

Enrollment in Medicaid does not mandate practitioners to render services to all Medicaid enrollees who request care. If a private payment arrangement is made with a Medicaid enrollee, the enrollee should be notified in advance of the practitioner's choice

not to accept Medicaid reimbursement. The Medicaid Program cannot be billed for services rendered under these circumstances.

Guidelines that govern reasonable application of "free choice" are:

- Appropriate resources of the local medical market area should first be utilized in order to avoid unnecessary transportation costs;

- Medical "shopping around" habits should be discouraged so that continuity of care may be maintained.

Right to Refuse Medical Care

Federal and State Laws and Regulations provide for Medicaid enrollees to reject any recommended medical procedure of health care or services and prohibits any coercion to accept such recommended health care. This includes the right to reject care on the grounds of religious beliefs.

Civil Rights

In structuring their practice, practitioners must ensure that any limitations are based on criteria which are not discriminatory and continue to comply with a person's civil rights.

Public Law 88-352, the Civil Rights Act of 1964 as amended in 1972, Section 601, and Rehabilitation Act of 1973 reads as follows:

> *"No person in the United States shall, on the ground of race, color, national origin, age, sex, religion or handicap, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance."*

Confidentiality

Information, including the identity and medical records of Medicaid enrollees, is considered confidential and cannot be released without the expressed consent of the enrollee. Medical records and information which are transmitted for the purpose of securing medical care and health services are received and held under the same confidentiality.

All providers **must** comply with these confidentiality requirements.

The DOH, its various political subdivisions, LDSS and eMedNY Contractor, must also observe the confidentiality requirements and must provide safeguards against unauthorized disclosure. This policy should in no way be construed to preclude authorized access to records by the DOH which is under a very strict obligation to monitor medical practices under the Medicaid Program. Authorized representatives of

the Department, its subdivisions, LDSS and eMedNY Contractor have the right to clear access to the medical and financial Medicaid records.

This general policy does not preclude the release of information to the eMedNY Contractor, and to Federal, State and local program officials for purposes directly connected with the administration of the Medicaid Program.

When Medicaid Enrollees Cannot be Billed

This is the policy of the Medicaid Program concerning the enrollee, including those Medicaid enrollees who are enrolled in a Managed Care Plan and in Family Health Plus.

Acceptance and Agreement

When a provider accepts a Medicaid enrollee as a patient, the provider agrees to bill Medicaid for services provided or, in the case of a Medicaid Managed Care enrollee, agrees to bill the enrollee's Managed Care Plan for services covered by the contract. The provider is prohibited from requesting any monetary compensation from the enrollee, or his/her responsible relative, except for any applicable Medicaid co-payments.

Private Pay Agreement
A provider may charge a Medicaid enrollee, including a Medicaid enrollee enrolled in a Managed Care Plan, **ONLY** when both parties have agreed **PRIOR** to the rendering of the service that the enrollee is being seen as a private-pay patient. This must be a mutual and voluntary agreement. It is suggested that the provider maintain the patient's signed consent to be treated as private pay in the patient record.

A provider who participates in Medicaid fee-for-service but does not participate in the enrollee's Medicaid Managed Care Plan may not bill Medicaid fee-for-service for any services that are included in the Managed Care Plan, with the exception of family planning services. Neither may such a provider bill the enrollee for services that are covered by the enrollee's Medicaid Managed Care contract unless there is a prior agreement with the enrollee that he/she is being seen as a private patient as described above. The provider must inform the enrollee that the services may be obtained at no cost to the enrollee from a provider that participates in the enrollee's Managed Care Plan.

Claim Submission

The prohibition on charging a Medicaid enrollee applies when a participating Medicaid provider fails to submit a claim to the Department's eMedNY Contractor, Computer Sciences Corporation (CSC), or the enrollee's Managed Care Plan within the required timeframe. It also applies when a claim is submitted to CSC or the enrollee's Managed Care Plan and the claim is denied for reasons other than that the patient was not Medicaid-eligible on the date of service.

Collections

A Medicaid enrollee, including a Medicaid Managed Care Enrollee, must not be referred to a collection agency for collection of unpaid medical bills or otherwise billed, except for applicable Medicaid co-payments, when the provider has accepted the enrollee as a Medicaid patient. Providers may use any legal means to collect applicable unpaid Medicaid co-payments.

Emergency Medical Care

A hospital that accepts a Medicaid enrollee as a patient, including a Medicaid enrollee enrolled in a Managed Care Plan, accepts the responsibility of making sure that the patient receives all medically necessary care and services.

Other than for legally established co-payments, a Medicaid enrollee should never be required to bear any out-of-pocket expenses for medically-necessary inpatient services or medically-necessary services provided in a hospital-based emergency room (ER). This policy applies regardless of whether the individual practitioner treating the enrollee in the facility is enrolled in the Medicaid Program.

When reimbursing for ER services provided to Medicaid enrollees in Managed Care, health plans must apply the *Prudent Layperson Standard*, provisions of the Medicaid Managed Care Model Contract and Department directives.

Claiming Problems

If a problem arises with a claim submission, the provider must first contact CSC or, if the claim is for a service included in the Medicaid Managed Care benefit package, the enrollee's Medicaid Managed Care plan.

If CSC or the Managed Care Plan is unable to resolve an issue because some action must be taken by the enrollee's LDSS (i.e., investigation of enrollee eligibility issues), then the provider must contact the LDSS for resolution.

Prior Approval

Prior Approval is the process of evaluating the aspects of a plan of care which may be for a single service or an ongoing series of services in order to determine the medical necessity and appropriateness of the care requested.

Prior Approval determinations are made by the Local Professional Director for the district having financial responsibility for the enrollee (which is identified via MEVS). It is the providers' responsibility to verify whether the services and care rendered in their professional areas require prior approval.

Prior Approval contacts can be contacted at the telephone numbers listed in the Information for All Providers, Inquiry Manual, online at:

http://www.emedny.org/ProviderManuals/AllProviders/index.html.

When a provider determined that a service requires prior approval, he/she must obtain a prior approval number by following procedures outlined in the Billing Guidelines and Policy Guidelines sections of each provider manual. Requests for prior approval must be submitted before a service is rendered, except in cases of emergency.

Prior Approval and Payment

No payment will be made when the request for prior approval is submitted after the service is rendered, except in cases of emergency.

Prior approval does not ensure payment. Even when a service has been prior approved, the provider must verify an enrollee's eligibility via the MEVS before the service is provided and comply with all other service delivery and claims submission requirements described in each related section of the provider manual.

Services for which the provider has received prior approval are not subject to Utilization Thresholds.

On the appropriate claim form, the provider must include the prior approval number assigned to his/her request. Information on the claim form must be consistent with the information given and received during the prior approval process.

When a treatment plan has been prior approved for an enrollee, and that enrollee becomes ineligible before the plan is completed, payment for services provided outside the enrollee's eligibility period shall not be made except where:

- the enrollee is enrolled in the Physically Handicapped Children's Program and has an approved treatment plan; or
- failure to pay for services would result in undue hardship to the patient.

When a provider's treatment plan for an enrollee has been prior approved, but the provider becomes ineligible to participate in the Medicaid Program before that plan is completed, payment for services remaining to be provided will not be made unless undue hardship is placed on the enrollee.

When the reason for ineligibility is due to the provider's suspension or disqualification due to improper practices, under no circumstances will services by that provider be paid after the termination date. All efforts will be made by the LDSS to secure a new provider for the enrollee so the plan can be re-evaluated and, where indicated, completed.

Approval will not be given for providers to render services they are not ordinarily qualified to render. In the event such services are provided by a practitioner in the case of an emergency, the provider must attach to the claim form a justification of the services rendered and complete the "SA EXCP CODE" and "EMERGENCY" fields on the claim. Please refer to the Billing Guidelines section of your specific provider manual.

When a fee, rate or price change takes place on a prior approved service, the fee, rate or price in effect at the time the service is rendered must be submitted by the provider on the claim for that service.

When prior approval is granted for services to be rendered by a specific date, any extension of such services beyond the time granted must be submitted on a new prior approval request outlining a new or modified treatment plan. Additionally, should a change be necessary in an approved course of treatment, a new Prior Approval Request must be submitted.

Prior Authorization

Prior authorization is the acceptance by the Local Commissioner of Social Services, or his/her designated representative, of conditional financial liability for a service or a series of services to be rendered by the provider.

Prior authorization does not ensure payment. Even if a service has been prior authorized, the provider still must verify an enrollee's eligibility via the MEVS before rendering service and the claim must be otherwise payable in accordance with the requirements as found in each related section of the provider manual.

In instances when a prior authorized item or service has been ordered, the vendor must confirm that the orderer has not been excluded from the Medicaid Program.

There are certain services which always require prior authorization, i.e., personal care services and non-emergency transportation. Each specific provider manual indicates which services, if any, require prior authorization. Services requiring prior authorization are not subject to Utilization Thresholds.

Utilization of Insurance Benefits

The Medicaid Program is designed to provide payment for medical care and services only after all other resources available for payments have been exhausted; Medicaid is the payer of last resort.

The Medicaid Program does not require providers to enroll as Medicare providers, with few exceptions (i.e., skilled nursing facilities, general hospitals, clinics, and ambulance companies) and are not required to enter into a contract with all other payers simply because Medicaid requires providers to exhaust all existing benefits prior to the billing of

the Medicaid Program. However, if providers do not enter into an agreement with other payers (excluding Medicare), then they must follow the instructions and requirements contained in Title 18 Section 542 of New York State Code of Rules and Regulations. These guidelines are searchable online at:

http://www.health.state.ny.us/nysdoh/phforum/nycrr18.htm.

If an enrollee has third-party insurance coverage, he/she is required to inform the LDSS of that coverage and to use its benefits to the fullest extent before using Medicaid. Supplementary payments may be made by Medicaid when appropriate.

Upon verification of an enrollee's eligibility via MEVS, information specific to an enrollee's eligibility is reported. Eligibility verification responses are detailed in the **MEVS Manual** and Third Party Insurance codes are available in the Third Party Information Manual online at:

http://www.emedny.org/ProviderManuals/AllProviders/index.html.

Fair Hearing

If either the provider or enrollee feels that a service which has been recommended by the provider has been unjustifiably denied, the enrollee may request a Fair Hearing via any one of the following methods:

- Call (800) 342-3334, or
- Fax a copy of the denial notice to (518) 473-6735, or
- Online at http://www.otda.state.ny.us/oah/forms.asp; or
- In writing to:

Disability Assistance
P.O. Box 1930
Albany, New York, 12201.

Billing

Providers must bill all applicable insurance sources before submitting claims to Medicaid. Payment from those sources must be received before submitting a Medicaid claim.

Medicaid providers may not refuse to furnish services to an individual eligible to receive such services because of a third party's liability for payment for the service.

Third party insurers and corresponding coverage codes for a Medicaid-eligible enrollee can be found online in the **Information for All Providers, Third Party Information Manual** at:

http://www.emedny.org/ProviderManuals/AllProviders/index.html.

Record Keeping

Providers must maintain appropriate financial records supporting their determination of available resources, collection efforts, receipt of funds and application of monies received. Such records must be readily accessible to authorized officials for audit purposes.

Section II – Provider Information

The State of New York requires that all providers who participate in the Medicaid Program meet certain basic criteria. For most, this involves the possession of a license or operating certificate and current registration. Compliance with these basic standards is essential not only for medical institutions and facilities, but for professional practitioners as well.

In order to participate in the Medicaid Program, providers are required to enroll with the DOH. For provider enrollment contact information, please refer to the **Information for All Providers, Inquiry Manual**, available online at:

http://www.emedny.org/ProviderManuals/AllProviders/index.html.

Providers must inform DOH of any changes in their status as an enrolled provider in the Medicaid Program, i.e., change of address, change in specialty, change of ownership or control. Provider maintenance forms are available online at:

http://www.emedny.org/info/ProviderEnrollment/index.html.

Enrollment of Providers

Every person who furnishes care, services or supplies and who wishes to receive payment under the Medicaid Program must enroll as a provider of services prior to being eligible to receive such payments.

Continued participation in the Medicaid Program by providers is subject to re-enrollment upon notice by the Department.

Applications for Enrollment/Re-enrollment

Upon receipt of an application for enrollment or re-enrollment, the Department will conduct an investigation to verify or supplement information contained in the application. The Department may request further information from an applicant and may review the background and qualifications of an applicant.

The Department will complete its investigation within ninety days of receipt of the application. If the applicant cannot be fully evaluated within ninety days, the Department may extend the time for acting on the application for up to 120 days from receipt of the application.

Denial of an Application

In determining whether to contract with an applicant, the Department will consider a variety of factors as they pertain to the applicant or anyone affiliated with the applicant. These factors include, but are not limited to, the following:

- Any false representation or omission of a material fact in making the application;
- Any previous or current exclusion or involuntary withdrawal from participation in the Medicaid Program of any other state of the United States or other governmental or private medical insurance program;
- Any failure to make restitution for a Medicaid or Medicare overpayment;
- Any failure to supply further information after receiving written request;
- Any previous indictment for, or conviction of, any crime relating to the furnishing of, or billing for medical care, services or supplies;
- Any prior finding of having engaged in unacceptable practices;
- Any other factor having a direct bearing on the applicant's ability to provide high-quality medical care, services or supplies or to be fiscally responsible to the Program.

Review of Denial

If any application is denied, the applicant will be given a written notice which may be effective on the date mailed.

After denial of an application, the applicant may reapply only upon correction of the factors leading to the denial or after two years if the factors relate to the prior conduct of the applicant or an affiliate.

All persons whose applications are denied shall have an opportunity to request reconsideration of such denial. A person who wishes to appeal must submit documentation to the Department which will establish that an error of fact was made in reviewing his or her application.

Termination of Enrollment

A provider's participation in the Medicaid Program may be terminated by either the provider or the Department upon thirty (30) days written notice to the other without cause. Additionally, the provider's participation in the Medicaid Program may be terminated under the following circumstances:

- When a provider is suspended or excluded from the Medicaid Program;
- When a provider's license to practice his or her profession, or any registration or certification required to provide medical care services or supplies has been terminated, revoked or suspended, or is found to be otherwise out of compliance with local or State requirements;
- When a provider fails to maintain an up-to-date disclosure form;
- When a provider's ownership or control has substantially changed since acceptance of his/her enrollment application;
- When at any time, the Department discovers that the provider submitted incorrect, inaccurate or incomplete information on his/her application where provision of correct, accurate or complete information would have resulted in a denial of the application.

For a more extensive and precise definition of his/her rights and obligations, persons are referred to part 504, 515, 517, 518 and 519 of Title 18 of the New York Code of Rules and Regulations which are found online at:

http://www.health.state.ny.us/nysdoh/phforum/nycrr18.htm.

Duties of the Provider

By enrolling in the Medicaid Program, a provider agrees to:

- prepare and maintain contemporaneous records as required by Department regulations and law;
- notify the Department, *in writing*, of any change in Correspondence, Pay-To or Service Addresses;
- comply with the disclosure requirements of the Department with respect to ownership and controlling interests, significant business transactions and involvement with convicted persons;
- report any change in the ownership or control or a change of managing employees to the Department within fifteen (15) days of the change;
- accept payment under the Medicaid Program as payment in full for the services rendered;
- submit claims for payment for services actually furnished, medically necessary and provided to eligible persons;

- permit audits of all books and records or a sample thereof relating to services furnished and payments received under the Medicaid Program;

- comply with the rules, regulations and official directives of the Department.

Keeping Current with Policy Information

Policy information is relayed through the monthly *Medicaid Update* newsletter, which is available in hard copy and electronically; and is sent automatically to each enrolled Medicaid provider. The *Medicaid Update* is available online at:

http://www.health.state.ny.us/health_care/medicaid/program/update/main.htm.

Providers are responsible to check their Provider Manual on a *monthly basis* to ensure they are current with the latest policy information. This includes the Information for All Providers sections, which contain general Medicaid policy, general billing, inquiry and third party insurance information.

Hard copies of Provider Manuals are available for those providers who do not have access to the Internet. In these cases, the provider must call Computer Sciences Corporation at:

(800) 343-9000.

Change of Address

It is the responsibility of the provider to notify the Medicaid Program of any change in address. Keeping the provider file current will ensure the provider receives all updates and announcements. "Change of Address" forms for Rate-Based or Fee-for-Service providers are available online at:

http://www.emedny.org/info/ProviderEnrollment/index.html.

Out-of-State Medical Care and Services

Out-of-State providers must enroll in the New York State Medicaid Program in order to be reimbursed by the Program. Enrollment contact information is available in the **Information for All Providers - Inquiry Manual** at:

http://www.emedny.org/ProviderManuals/AllProviders/index.html.

Medicaid-eligible individuals normally obtain medical care and services from qualified providers located in New York State. An enrolled out-of-state provider will be reimbursed for services rendered to a New York State Medicaid enrollee only under the following circumstances:

- The provider practices within the "common medical marketing area" of the enrollee's home LDSS as determined by the Local Professional Director;

- An emergency requires that the out-of-state provider render immediate care to an enrollee who is temporarily out-of-state.

Under any of these circumstances, only providers in the United States, Canada, Puerto Rico, Guam, the American Virgin Islands, and American Samoa will be reimbursed for care provided to New York State Medicaid enrollees.

Non-Emergent Inpatient Care

The Medicaid Program provides assistance in the form of payment to enrolled, qualified out-of-state inpatient services providers when the best interest of the applicant or enrollee will be most effectively served because of his/her social situation or when the inpatient care is needed by a patient, as determined in the basis of medical advice, is more readily available in the other state.

A qualified out-of-state provider is normally a facility recognized by their home state as a Medicaid Program inpatient facility services provider (i.e., a hospital, skilled nursing or intermediate care facility, residential treatment center, etc.).

A Medicaid prior approval for the placement of a New York State Medicaid enrollee with an out-of-state medical inpatient facility is required to document that the needed services are not readily available within the State of New York. Approval is based upon a determination made by the Department of Health. Prior approval and medical review contacts are listed in the **Information for All Providers – Inquiry Manual** online at:

http://www.emedny.org/ProviderManuals/AllProviders/index.html.

Where a mentally disabled enrollee is seeking out-of-state care, approval is subject to the approval of the State office that provides services to this patient population within New York State, either the Office of Mental Health or Mental Retardation and Developmental Disabilities.

Prior Approval

For out-of-state services provided in situations other than those noted above, prior approval must be obtained for all services. For services provided in those situations noted above, prior approval requirements will be identical to those mandated for in-state providers.

Billing Procedures

Out-of-state providers enrolled in the Program will follow the regular billing procedures for Medicaid.

Record-Keeping Requirements

Federal Law and State Regulations require providers to maintain financial and health records necessary to fully disclose the extent of services, care, and supplies provided to Medicaid enrollees. Providers must furnish information regarding any payment claim to authorized officials upon request of the DOH or the LDSS.

For medical facilities subject to inspection and licensing requirements provided in Article 28 of the Public Health Law, the State Hospital Code contains specific details concerning content and maintenance of medical records. Practitioners providing diagnostic and treatment services must keep medical records on each enrollee to whom care is rendered. At a minimum, the contents of the enrollee's hospital record should include:

- enrollee information (name, sex, age, etc.);
- conditions or reasons for which care is provided;
- nature and extent of services provided;
- type of services ordered or recommended for the enrollee to be provided by another practitioner or facility;
- the dates of service provided and ordered.

The maintenance and furnishing of information relative to care included on a Medicaid claim is a basic condition for participation in the Program.

For auditing purposes, records on enrollees must be maintained and be available to authorized Medicaid officials for six years following the date of payment. Failure to conform to these requirements may affect payment and may jeopardize a provider's eligibility to continue as a Medicaid participant.

General Exclusions from Coverage Under Medicaid

In an effort to assure quality care and to contain costs under the Medicaid Program, certain restrictions have been placed on Medicaid payments to providers. As a general reference, the following list of medical care and services which do not qualify for payment is presented.

Payment will **not** be made for medical care and services:

- Which are medically unnecessary;

- Whose necessity is not evident from documentation in the enrollee's medical record;
- Which fail to meet existing standards of professional practice, are currently professionally unacceptable, or are investigational or experimental in nature;
- Which are rendered outside of the enrollee's period of eligibility;
- Which were not rendered, ordered, or referred by a restricted enrollee's primary care provider unless the service was provided in an emergency, was a methadone maintenance claim or a service provided in an inpatient setting;
- When the claim was initially received by the Department more than ninety days after the original date of service (refer to the Information for All Providers, General Billing Manual for exceptions);
- Which require prior approval or authorization, but for which such approval/authorization was not obtained or was denied;
- For which third parties (i.e., Medicare, Blue Cross/Blue Shield) are liable;
- Which are rendered out-of-state but which do not meet the qualifications outlined in the section Out-of-State Medical Care and Services;
- Which are fraudulently claimed;
- Which represent abuse or overuse;
- Which are for cosmetic purposes and are provided only because of the enrollee's personal preference;
- Which are rendered in the absence of authorization from the MEVS in accordance with Utilization Threshold requirements. Exceptions to this policy include instances when a provider uses one of the Service Authorization Exception codes on the claim. Details are found in the **Billing Guidelines** section of each specific provider manual.
- Which have already been rejected or disallowed by Medicare when the rejection was based upon findings that the services or supplies provided:
    - Were not medically necessary;
    - Were fraudulently claimed;
    - Represented abuse or overuse;
    - Were inappropriate;

- Were for cosmetic purposes; or
- Were provided for personal comfort.

➢ Which are rendered after an enrollee has reached the Utilization Threshold established for a specific provider service type unless one of the following conditions is satisfied:

- The enrollee has been exempted from the Utilization Threshold;
- The enrollee has been granted an increase in the Utilization Threshold;
- The provider certifies that the care, services or supplies were furnished pursuant to a medical emergency or when urgent medical care was necessary.

Unacceptable Practices

Examples of unacceptable practices include, but are not limited to, the following:

➢ Knowingly making a claim for an improper amount or for unfurnished, inappropriate or unnecessary care, services or supplies;

➢ Ordering or furnishing inappropriate, improper, unnecessary or excessive care, services or supplies;

➢ Billing for an item/service prior to being furnished;

➢ Practicing a profession fraudulently beyond its authorized scope, including the rendering of care, services or supplies while one's license to practice is suspended or revoked;

➢ Failing to maintain or make available for purposes of audit or investigation records necessary to fully disclose the extent of the care, services or supplies furnished;

➢ Submitting bills or accepting payment for care, services or supplies rendered by a person suspended or disqualified from practicing in the Medicaid Program;

➢ Soliciting, receiving, offering or agreeing to make any payment for the purpose of influencing a Medicaid enrollee to either utilize or refrain from utilizing any particular source of care, services or supplies;

➢ Knowingly demanding or collecting any compensation in addition to claims made under the Medicaid Program, except where permitted by law;

- Denying services to an enrollee based upon the enrollee's inability to pay a co-payment; and

- Failure to use the POS Terminal for verification, post and/or clear procedures when designated to do so.

Process for Resolving Unacceptable Practices

If the Department proposes to sanction a person, the DOH will advise that person, in writing, of the following:

- The unacceptable practice with which the person has been charged;

- The administrative action which is proposed (i.e., exclusion, or censure, and its statutory, regulatory or legal basis);

- The person's right to submit documentation or written arguments against the proposed agency action within 30 days from the date of the notice of proposed action.

Affiliated Persons

Whenever the Department sanctions a person, it may also sanction any affiliate of that person. Affiliated persons will be sanctioned on a case-by-case basis with due regard to all the relevant facts and circumstances leading to the original sanction.

> Affiliated persons are those individuals having an overt, covert or conspiratorial relationship with another such that either of them may directly or indirectly control the other or such that they are under a common control.

Some examples of affiliated persons are the following:

- persons with an ownership or controlling interest in a provider;

- agents and managing employees of a provider;

- providers who share common managing employees;

- subcontractors with whom the provider has more than $25,000 in annual business transactions.

Agency Action

If the Department determines to sanction a person, it will send a written notice of agency action advising the person of the final determination at least 20 days before the action becomes effective.

Suspension or Withholding of Payments

Upon notification to the person that he/she has engaged in an unacceptable practice, payment to that person may be withheld for current and subsequently received claims, or all payments may be suspended pending a resolution of the charges.

Hearings

A person has the right to a hearing to review a determination that he/she has engaged in an unacceptable practice. All requests for hearings must be in writing and must be made within sixty days of the date of the notice of agency action notifying the person of the unacceptable practice.

In the even that a person withdraws or abandons his/her request for a hearing, the hearing will be cancelled.

A request for a hearing will not defer any administrative action. All hearings will be conducted in accordance with the procedures contained in Part 519 of Title 18 of the Official Codes, Rules and Regulations of the State of New York which can be found by conducting a search online at:

http://www.health.state.ny.us/nysdoh/phforum/nycrr18.htm.

Administrative Sanctions

When it is determined that a person has been engaged in unacceptable practices, the DOH may take one or more of the following sanctions:

- The person may be excluded from participation in the Medicaid Program. No payments will be made to a person who is excluded from the Medicaid Program for care, services or supplies rendered to enrollees as of the date of his/her exclusion;

- No payments will be made for any medical care, services or supplies ordered by a person who is excluded or suspended from the Medicaid Program;

- The person may be censured in writing with notification to the appropriate governmental licensing and/or regulatory agencies.

A sanction designed to monitor the Program activities of a person may be imposed against anyone who has been previously suspended from the Medicaid Program or as a precondition to a person's continued participation of the Program. Such sanctions include:

- Requiring, prior to payment, a review of any care, services or supplies rendered by the person; or

- Requiring prior approval for all care, services or supplies to be rendered by the person.

The DOH may also choose to impose fiscal sanctions against persons who engage in unacceptable practices. Examples of fiscal sanctions include:

- Restitution plus interest may be collected from a person who has received payment for care, services or supplies associated with an unacceptable practice; or

- Reduction in payment may be utilized when it is determined that the person has rendered care, services or supplies not included in the scope of the Program, or that the person has billed for more costly care, services or supplies that were actually provided; or

- Payment may be denied to a person who has engaged in an unacceptable practice.

Guidelines for Sanctions

In determining the sanction to be imposed, the following factors will be considered:

- The number and nature of the Program violations or other related offenses;

- The nature and extent of any adverse impact the violations have had on enrollees;

- The amount of damages to the Program;

- Mitigating circumstances;

- Other facts related to the nature and seriousness of the violations; and

- The previous record of the person under the Medicare Program, the Medicaid Program and other Social Services Programs.

Immediate Sanctions

In the following cases, a person may be immediately sanctioned on five (5) days notice:

- When a person or an affiliate is suspended from the Medicare Program the person will be suspended from the Medicaid Program for a period of time at least equal to the period of suspension from the Medicare Program;

- When a person has been convicted of any crime relating to the rendering of, or billing for medical care, services or supplies;

- When a person has been charged with a felony offense relating to the rendering of, or billing for medical care, services or supplies;

- When a person has been the subject of administrative, judicial proceeding finding the person to have committed unprofessional misconduct or an act which would constitute an unacceptable practice under the Medicaid Program; or

- When a person's further participation in the Medicaid Program will endanger the public health, or the health, safety or welfare of any enrollee.

A person sanctioned in these cases will not be entitled to an administrative hearing under the Department's regulations. However, within 30 days of being notified of any immediate sanction, a person may submit written material to challenge any mistake of fact or the appropriateness of a sanction.

Reinstatement

A person who is sanctioned may request reinstatement, or removal of any condition or limitation on participation in the Medicaid Program, at any time after the date or time period specified in the notice of agency action, or upon the occurrence of an event specified in the notice.

A request for reinstatement or removal of any condition on participation in the Program is made as an application for enrollment under Part 504 of the Department's regulations and must be denominated as a request for reinstatement to distinguish it from an original application.

The request for reinstatement must be sent to the Enrollment Processing Unit of the Department, and must:

- Include a complete ownership and control disclosure statement;

- State whether the person has been convicted of other offenses related to participation in the Medicare Program, the Medicaid Program or other Social Services Programs which were not considered during the development of the sanction; and

- State whether any State or local licensing authorities have taken any adverse action against the person for offenses related to participation in the Medicare Program, the Medicaid Program or other Social Services Programs which were not considered during the development of the sanction.

For a more extensive and precise definition of his/her rights and obligations, persons are referred to part 504, 515, 517, 518 and 519 of Title 18 of the New York Code of Rules and Regulations which are found by doing a search at:

http://www.health.state.ny.us/nysdoh/phforum/nycrr18.htm.

Audits

The DOH is responsible for monitoring the Medicaid Program in New York State. This includes evaluating whether providers of medical care, services and supplies are in compliance with applicable State and Federal law and regulations.

The Department conducts audits of persons who submit claims for payment under the Medicaid Program, and the Department may seek recovery or restitution if payments were improperly claimed, regardless of whether unacceptable practices have occurred. The Department may either conduct an on-site field audit of a person's records or it may conduct an in-house review utilizing data processing procedures.

If overpayments are found, the Department will issue a draft audit report which will set forth any items to be disallowed and advise the person of the Department's proposed action. The person will then have 30 days to submit documents in response to the draft and/or object to any proposed action.

After considering the person's submittal, if any, the Department will issue a final audit report advising the person of the Department's final determination. The person may then request an administrative hearing to contest any adverse determination.

Recovery of Overpayments

When any person has submitted or caused to be submitted claims for medical care, services or supplies for which payment should not have been made, the Department may require repayment of the amount overpaid.

An overpayment includes any amount not authorized to be paid under the Medicaid Program, whether paid as the result of inaccurate or improper cost reporting, improper claiming, unacceptable practices, fraud, abuse or mistake.

Recoupment

Overpayments may be recovered by withholding all or part of a person's and an affiliate's payments otherwise payable, at the option of the Department.

Withholding of Payments

The Department may withhold payments in the absence of a final audit report when it has reliable information that a person is involved in fraud or willful misrepresentation

involving claims submitted to the Program, has abused the Program or committed an unacceptable practice. Reliable information may consist of:

- Preliminary findings of unacceptable practices or significant overpayments;
- Information from a State professional licensing or certifying agency of an ongoing investigation of a person involving fraud, abuse, professional misconduct or unprofessional conduct; or
- Information from a State investigating or prosecutorial agency or other law enforcement agency of an ongoing investigation of a person for fraud or criminal conduct involving the Program.

Notice of the withholding will usually be given within five days of the withholding of payments. The notice will describe the reasons for the action, but need not include specific information concerning an ongoing investigation.

The withholding may continue as follows:

- If payments are withheld prior to issuance of a draft audit report or notice of proposed agency action, the withholding will not continue for more than 90 days unless a written draft report or notice of proposed agency action is sent to the provider.
    - Issuance of the draft report or notice of proposed agency action may extend the duration of the withholding until an amount reasonably calculated to satisfy the overpayment is withheld, pending a final determination on the matter.
- If payments are withheld after issuance of a draft report or notice of proposed agency action, the withholding will not continue for more than 90 days unless a written final audit report or notice of agency action is sent to the provider.
    - Issuance of the report or notice of agency action may extend the duration of the withholding until an amount reasonably calculated to satisfy the overpayment is withheld, pending a final determination on the matter.
- When initiated by another State agency or law enforcement organization, the withholding may continue until the agency or prosecuting authority determines that there is insufficient evidence to support an action against the person, or until the agency action or criminal proceedings are completed.

Fraud

Examples of fraud include when a person knowingly:

- makes a false statement or representation which enables any person to obtain medical assistance to which he/she is not entitled;
- presents for allowance of payment any false claim for furnishing services or merchandise;
- submits false information for the purpose of obtaining greater compensation than that to which he/she is legally entitled; or
- submits false information for the purpose of obtaining authorization for the provision of services or merchandise.

Office of the Medicaid Inspector General

The Office of the Medicaid Inspector General (OMIG) is an independent fraud-fighting entity within the Department of Health whose functions include:

- conducting and supervising activities to prevent, detect and investigate Medicaid fraud, waste and abuse and, to the greatest extent possible, coordinating such activities amongst:
    - the Offices of Mental Health, Mental Retardation and Developmental Disabilities, Alcoholism and Substance Abuse Services, Temporary Disability Assistance, and Children and Family Services;
    - the Department of Education;
    - the eMedNY Contractor, Computer Sciences Corporation (CSC), employed to operate the Medicaid Management Information System;
    - the State Attorney General for Medicaid Fraud Control; and,
    - the State Comptroller;
- pursuing civil and administrative enforcement actions against those who engage in fraud, waste or abuse or other illegal or inappropriate acts perpetrated against the Medicaid Program;
- keeping the Governor and the heads of agencies with responsibility for the administration of the Medicaid Program apprised of efforts to prevent, detect, investigate, and prosecute fraud, waste and abuse within the Medicaid system;
- making information and evidence relating to potential criminal acts which we may obtain in carrying out our duties available to appropriate law enforcement and consulting with:
    - the New York State Deputy Attorney General for Medicaid Fraud Control;

  - federal prosecutors; and
  - local district attorneys to coordinate criminal investigations and prosecutions;

- receiving and investigating complaints of alleged failures of state and local officials to prevent, detect and prosecute fraud, waste and abuse; and
- performing any other functions that are necessary or appropriate to fulfill the duties and responsibilities of the office.

The OMIG also has broad subpoena powers:

- *ad testificandum* (a subpoena *ad testificandum* is a command to a named individual or corporation to appear at a specified time and place to give oral testimony under oath); and
- *duces tecum* (i.e., a writ or process of the same kind as the *subpoena ad testificandum,* including a clause requiring the witness to bring with him and produce to the court, books, papers, etc.).

The Medicaid Inspector General is headquartered in Albany with regional field offices in New York City, White Plains, Hauppauge, Syracuse, Rochester, and Buffalo.

For more information, please refer to the OMIG website:

www.omig.state.ny.us.

The OMIG website contains:

- An online complaint reporting mechanism;
- Current comprehensive listing of banned Medicaid providers;
- Significant news of OMIG initiatives and actions; and
- Useful links to State and federal resources in the Medicaid field.

Prohibition Against Reassignment of Claims: Factoring

The practice of factoring is prohibited by Federal Medicaid Regulations, which specify that no payment for any care or service provided to a Medicaid enrollee can be made to anyone other than the provider of the service.

Payment shall not be made to or through a factor either directly or by use of a power of attorney given by the provider to the factor.

Exceptions

Exceptions to the prohibition against the reassignment of Medicaid claims are allowed under the following circumstances:

- Direct payment for care or services provided to a Medicaid enrollee by physicians, dentists or other individual practitioners may be made to:
    - The employer (Article 28 facility, or other medical providers certified by State agencies) of the practitioner, if the practitioner is required to turn over fees to his/her employer as a condition of employment;
    - The facility in which the care or service was provided, if there is an arrangement whereby the facility submits the claim for other affiliated persons in its claim for reimbursement;
    - A foundation, plan, or similar organization, including a health maintenance organization which furnishes health care through an organized health care delivery system, if there is a contractual arrangement between the organization and the practitioner furnishing the service under which the organization bills or receives payments on a basis other than a percentage of the Medicaid payments for such practitioner's services.
- Payments are allowed which result from an assignment made pursuant to a court order;
- Payments may be made to a government agency in accordance with an assignment against a provider;
- Payment may be made to a business agent, such as a billing service or accounting firm, that prepares statements and receives payments in the name of a provider, if the business agent's compensation for the service is:
    - Reasonably related to the cost of services;
    - Unrelated, directly or indirectly, to the dollar amounts billed and collected; and
    - Not dependent upon the actual collection of payment.

Services Subject to Co-Payments

The following services are subject to a co-payment:

- Clinic Visits (Hospital-Based and Free-Standing Article 28 Health Department-certified facilities) - $3.00;

- Laboratory Tests performed by an independent clinical laboratory or any hospital-based/free-standing clinic laboratory - $0.50 per procedure;
- X-rays performed in hospital clinics, free-standing clinics -$1.00 per procedure;
- Medical Supplies including syringes, bandages, gloves, sterile irrigation solutions, incontinence pads, ostomy bags, heating pads, hearing aid batteries, nutritional supplements, etc. - $1.00 per claim;
- Inpatient Hospital Stays (involving at least one overnight stay – is due upon discharge) - $25.00;
- Emergency Room – for non-urgent or non-emergency services - $3.00 per visit;
- Pharmacy Prescription Drugs - $3.00 Brand Name, $1.00 Generic;
- Non-Prescription (over-the-counter) Drugs - $0.50.

There is no co-payment on private practicing physician services (including laboratory and/or X-ray services, home health services, personal care services or long term home health care services.

Co-payment Maximum

The annual co-payment maximum per enrollee per state fiscal year (April 1 through March 31) is $200.

Co-payment Exemptions

The following are exempt from all Medicaid co-payments:

- Enrollees younger than 21 years old.
- Enrollees who are pregnant.
    - Pregnant women are exempt during pregnancy and for the two months after the month in which the pregnancy ends.
- Family planning (birth control) services.
    - This includes family planning drugs or supplies like birth control pills and condoms.
- Residents of an Adult Care Facility licensed by the New York State Department of Health (**for pharmacy services only**).

- Residents of a Nursing Home.
    - Residents of an Intermediate Care Facility for the Developmentally Disabled (ICF/DD).
- Residents of an Office of Mental Health (OMH) or Office of Mental Retardation and Developmental Disabilities (OMRDD) certified Community Residence.
- Enrollees in a Comprehensive Medicaid Case Management (CMCM) or Service Coordination Program.
    - Enrollees in an OMH or OMRDD Home and Community Based Services (HCBS) Waiver Program.
- Enrollees in a Department of Health HCBS Waiver Program for Persons with Traumatic Brain Injury (TBI).
- Enrollees in a Care plan.

Enrollees who are eligible for both Medicare and Medicaid and/or receive Supplemental Security Income (SSI) payments *are not exempt* from Medicaid co-payments, unless they also fall into one of the groups listed above. Enrollees cannot be denied care and services because of their inability to pay the co-payment amount.

The potential provider of a service will be required to access the MEVS to enter the applicable co-payment amount, if any is due for the service being provided. When accessing the MEVS, the provider will be given information as to the enrollee's exemption status for co-payments. Specific instructions on the MEVS information obtained by the provider may be found in the MEVS manual.

Section III – Ordering Non-Emergency Medical Transportation

A request for prior authorization of non-emergency medical transportation must be supported by the order of a practitioner who is the Medicaid enrollee's:

- Attending physician;
- Physician's assistant;
- Nurse practitioner;
- Dentist;
- Optometrist;
- Podiatrist; or
- Other type of medical practitioner designated by the district and approved by the Department.

A diagnostic and treatment clinic, hospital, nursing home, intermediate care facility, long term home health care program, home and community based services waiver program, or managed care program may order transportation services on behalf of the ordering practitioner.

Any order practitioner or facilities/programs ordering on the practitioner's behalf, which do not meet the rules of this section, may be sanctioned according to the regulations established by the Department of Health at Title 18 Section 515.3, available online at:

http://www.health.state.ny.us/nysdoh/phforum/nycrr18.htm.

Responsibilities of the Ordering Practitioner

Ordering practitioners are responsible for ordering only necessary transportation at the medically appropriate level. A basic consideration for this should be the enrollee's current level of mobility and functional independence.

The transportation ordered should be the least specialized mode required based upon the enrollee's *current* medical condition. For example, if the orderer feels the enrollee does not require personal assistance, but cannot walk to public transportation, then livery service should be requested.

Enrollees who have reasonable access to a mode of transportation used for the normal activities of daily living; such as shopping and recreational events; are expected to use

this mode to travel to and from medical appointments when that mode is available to them. For most residents of New York City, this mode is usually mass transit.

Medicaid may restrict payment for transportation if it is determined that:

- the enrollee chose to go to a medical provider outside the CMMA when services were available within the CMMA;
- the enrollee could have taken a less expensive form of transportation but opted to take the more costly transportation.

In either case above, if the enrollee can demonstrate circumstances justifying payment, then reimbursement can be *considered*.

Non-emergency Ambulance

Generally, ambulance service is requested when a Medicaid enrollee needs to be transported in a recumbent position or is in need of medical attention while en route to their medical appointments.

A request for prior authorization of non-emergency ambulance services must be supported by the order of a practitioner who is the Medicaid enrollee's:

- Attending physician;
- Physician's assistant; or
- Nurse practitioner.

A diagnostic and treatment clinic, hospital, nursing home, intermediate care facility, long term home health care program, home and community based services waiver program, or managed care program may order non-emergency ambulance transportation on behalf of the ordering practitioner.

Ambulette

Ambulette service is door-to-door; from the enrollee's home through the door at the building where the medical appointment is to take place. Personal assistance by the staff of the ambulette company is required by the Medicaid Program in order to bill the Program for the provision of ambulette service.

> **If personal assistance is not necessary and/or not provided, then livery service should be ordered.**

Ambulettes may also provide taxi (curb-to-curb) service and will transport livery-eligible enrollees in the same vehicle as ambulette-eligible enrollees. The Medicaid Program

does not require the ambulette service to be licensed as a taxi service; but the ambulette must maintain the proper authority and license required to operate as an ambulette.

A request for prior authorization of ambulette transportation must be supported by the order of a practitioner who is the Medicaid enrollee's:

- Attending physician;
- Physician's assistant;
- Nurse practitioner;
- Dentist;
- Optometrist;
- Podiatrist; or
- Other type of medical practitioner designated by the district and approved by the Department.

A diagnostic and treatment clinic, hospital, nursing home, intermediate care facility, long term home health care program, home and community based services waiver program, or managed care program may order transportation services on behalf of the ordering practitioner.

Ambulette transportation may be ordered if any of the following conditions is present:

- The Medicaid enrollee needs to be transported in a recumbent position, needs no medical treatment en route to his or her appointment, and the ambulette service is able to accommodate a stretcher;
- The Medicaid enrollee is wheelchair-bound and is unable to use a taxi, livery service, public transportation or a private vehicle;
- The Medicaid enrollee has a disabling physical condition which requires the use of a walker or crutches and is unable to use a taxi, livery service, public transportation or a private vehicle;
- An otherwise ambulatory Medicaid enrollee requires radiation therapy, chemotherapy, or dialysis treatments which result in a disabling physical condition after treatment, making the enrollee unable to access transportation without personal assistance provided by an ambulette service;

- The Medicaid enrollee has a disabling physical condition other than one described above or a disabling mental condition requiring personal assistance provided by an ambulette services; and,

- The ordering practitioner certifies in a manner designated by and submitted to the Department that the Medicaid enrollee cannot be transported by taxi, livery service, bus or private vehicle and there is a need for ambulette service.

The ordering practitioner must note in the patient's record the condition which qualifies the use of ambulette services.

Livery Transportation

A request for prior authorization for transportation by New York City livery services must be supported by the order of a practitioner who is the Medicaid enrollee's:

- Attending physician;

- Physician's assistant;

- Nurse practitioner;

- Dentist;

- Optometrist;

- Podiatrist; or

- Other type of medical practitioner designated by the district and approved by the Department.

A diagnostic and treatment clinic, hospital, nursing home, intermediate care facility, long term home health care program, home and community based services waiver program, or managed care program may order transportation services on behalf of the ordering practitioner.

Day Treatment Transportation

Day treatment/day program transportation is unique in that this transportation can be provided by an ambulance, ambulette or livery provider. The difference is that a typical transport involves a group of individuals traveling to and from the same site, at the same time, on a daily or regular basis.

The economies of this group ride transport are reflected in a different reimbursement amount than that reimbursed for an episodic medical appointment.

Providers of transportation to day treatment/day program must adhere to the same requirements for their specific provider category.

Required Documentation

In cases where an ordering practitioner believes that a Medicaid enrollee should use a particular form of non-emergency transportation, Medicaid guidelines at Title 18 of the New York Code of Rules and Regulations Section 505.10 (c)(4) indicate that:

> *"The ordering practitioner must note in the [enrollee's] patient record the condition which justifies the practitioner's ordering of ambulette or nonemergency ambulance services."*

Making the Request for Authorization

Requests for medical transportation require the authorization of the local department of social services (DSS). Please refer to the Information for All Providers – Inquiry Manual for telephone numbers of DSS staff.

New York City practitioners and facilities should refer to the Prior Authorization Guidelines manual titled City of New York Transportation Ordering Guidelines, which is available online at:

http://www.emedny.org/ProviderManuals/Transportation/index.html.

Section IV - Family Planning Services

All Medicaid-eligible persons of childbearing age who desire family planning services, without regard to marital status or parenthood, are eligible for such services *with the exception of sterilization*.

Family planning services, including the dispensing of both prescription and non-prescription contraceptives but **excluding sterilization**, may be given to minors who wish them without parental consent.

Medicaid-eligible minors seeking family planning services may not have a Medicaid ID Card in their possession. To verify eligibility, the physician or his/her staff should obtain birth date, sex, social security number, or as much of this information as possible, before contacting the Department at:

(518) 472-1550.
If sufficient information is provided,
Department staff will verify the eligibility of the individual for Medicaid.

Medicaid patients enrolled in managed care plans (identified on MEVS as "PCP"), may obtain HIV blood testing and pre- and post-test counseling when performed as a family planning encounter from the managed care plan or from any appropriate Medicaid-enrolled provider without a referral from the managed care plan.

> *Services provided for HIV treatment may only be obtained from the managed care plan. HIV testing and counseling not performed as a family planning encounter may only be obtained from the managed care plan.*

Patient Rights

Patients are to be kept free of coercion or mental pressure to use family planning services and are free to choose their medical provider of services and the method of family planning to be used.

Standards for Providers

Family planning services can be provided by a licensed private physician, nurse practitioner, clinic, or hospital, which complies with all applicable provisions of law.

In addition, services are available through designated Family Planning Service Programs, which meet specific DOH requirements for such Programs.

Sterilizations

Medical family planning services include sterilizations. Sterilization is defined as any medical procedure, treatment or operation for the purpose of rendering an individual permanently incapable of reproducing.

The physician who performs the sterilization must discuss the information below with the patient shortly before the procedure, usually during the pre-operative examination:

Informed Consent

The person who obtains consent for the sterilization procedure must offer to answer any questions the individual may have concerning the procedure, provide a copy of the *Medicaid Sterilization Consent Form (DSS-3134)* **and provide verbally all of the following information or advice to the individual to be sterilized**:

- Advice that the individual is free to withhold or withdraw consent to the procedure at any time before the sterilization without affecting the right to future care or treatment and without loss or withdrawal of any federally-funded program benefits to which the individual might be otherwise entitled;
- A description of available alternative methods of family planning and birth control;
- Advice that the sterilization procedure is considered to be irreversible;
- A thorough explanation of the specific sterilization procedure to be performed;
- A full description of the discomforts and risks that may accompany or follow the performance of the procedure, including an explanation of the type and possible effects of any anesthetic to be used;
- A full description of the benefits or advantages that may be expected as a result of the sterilization;
- Advice that the sterilization will not be performed for at least 30 days except under the circumstances specified below under "Waiver of the 30-Day Waiting Period."

Waiting Period

The enrollee to be sterilized must have voluntarily given informed consent not less than 30 days nor more than 180 days prior to sterilization.

> *When computing the number of days in the waiting period, the day the enrollee signs the form is not to be included.*

Waiver of the 30-Day Waiting Period
The only exceptions to the 30-day waiting period are in the cases of:

- premature delivery when the sterilization was scheduled for the expected delivery date, or
- emergency abdominal surgery.

In both cases, informed consent must have been given at least 30 days before the intended date of sterilization.

Since premature delivery and emergency abdominal surgery are unexpected but necessary medical procedures, sterilizations may be performed during the same hospitalization, as long as 72 hours have passed between the original signing of the informed consent and the sterilization procedure.

Minimum Age

The enrollee to be sterilized must be at least 21 years old at the time of giving voluntary, informed consent to sterilization.

Mental Competence

The patient must be a mentally competent individual.

Institutionalized Individual

The patient to be sterilized must not be an institutionalized individual.

Restrictions on Circumstances in Which Consent is Obtained

Informed consent may not be obtained while the patient to be sterilized is:

- in labor or childbirth;
- seeking to obtain or obtaining an abortion; or
- under the influence of alcohol or other substances that affect the patient's state of awareness.

Foreign Languages

An interpreter must be provided if the patient to be sterilized does not understand the language used on the consent form or the language used by the person obtaining informed consent.

Handicapped Persons

Suitable arrangements must be made to insure that the sterilization consent information is effectively communicated to deaf, blind or otherwise handicapped individuals.

Presence of Witness

The presence of a witness is optional when informed consent is obtained, except in New York City when the presence of a witness of the patient's choice is mandated by New York City Local Law No. 37 of 1977.

Reaffirmation Statement (NYC Only)

A statement signed by the patient upon admission for sterilization, again acknowledging the consequences of sterilization and his/her desire to be sterilized, is mandatory within the jurisdiction of New York City.

Sterilization Consent Form

A copy of the *NYS Sterilization Consent Form (DSS-3134)* must be given to the patient to be sterilized and completed copies must be submitted with all surgeon, anesthesiologist and facility claims for sterilizations.

Hospitals and Article 28 clinics submitting claims electronically must maintain a copy of the completed *DSS-3134* in their files. This form, in English and in Spanish, is available online at:

http://www.health.state.ny.us/health_care/medicaid/publications/ldssforms.

New York City

New York City Local Law No. 37 of 1977 establishes guidelines to insure informed consent for sterilizations performed in New York City. Since the Medicaid Program will not pay for services rendered illegally, conformance to the New York City Sterilization Guidelines is a prerequisite for payment of claims associated with sterilization procedures performed in New York City.

Any questions relating to New York City Local Law No. 37 of 1977 should be directed to the following office:

Maternal, Infant & Reproductive Health Program
New York City Department of Health
125 Worth Street
New York, NY 10013
(212) 442-1740.

Hysterectomies

Federal regulations prohibit Medicaid reimbursement for hysterectomies which are performed solely for the purpose of rendering the patient incapable of reproducing; or, if there was more than one purpose to the procedure, it would not have been performed but for the purpose of rendering the individual permanently incapable of reproducing.

Any other hysterectomies are covered by Medicaid if the patient is informed verbally and in writing prior to surgery that the hysterectomy will make her permanently incapable of reproducing.

The patient or her representative must sign *Part I of the Acknowledgement of Receipt of Hysterectomy Information Form (DSS-3113)*. The requirement for the patient's signature on Part I of Form DSS-3113 can be waived if:

1. The woman was sterile prior to the hysterectomy;

2. The hysterectomy was performed in a life-threatening emergency in which prior acknowledgement was not possible. For Medicaid payment to be made in these two cases, the surgeon who performs the hysterectomy must certify in writing that one of the conditions existed and state the cause of sterility or nature of the emergency. For example, a surgeon may note that the woman was postmenopausal or that she was admitted to the hospital through the emergency room, needed medical attention immediately and was unable to respond to the information concerning the acknowledgement agreement;

3. The woman was not a Medicaid enrollee at the time the hysterectomy was performed but subsequently applied for Medicaid and was determined to qualify for Medicaid payment of medical bills incurred before her application. For these cases involving retroactive eligibility, payment may be made if the surgeon certifies in writing that the woman was informed before the operation that the hysterectomy would make her permanently incapable of reproducing or that one of the conditions noted above in "1" or "2" was met.

The DSS-3113 documents the receipt of hysterectomy information by the patient or the surgeon's certification of reasons for waiver of that acknowledgement. It also contains the surgeon's statement that the hysterectomy was not performed for the purpose of sterilization.

All surgeons, hospitals, clinics and anesthesiologists must submit a copy of the fully completed DSS-3113 when billing for a hysterectomy. Hospitals and Article 28 clinics submitting claims electronically, must maintain a copy of the completed DSS-3113 in their files. This form, in English and in Spanish, is available online at:

http://www.health.state.ny.us/health_care/medicaid/publications/ldssforms.

Induced Termination of Pregnancy

Performance of induced terminations of pregnancy must conform to all applicable requirements set forth in regulations of the DOH. Except in cases of medical or surgical emergencies, no pregnancy may be terminated in an emergency room.

The NYS Medicaid Program covers abortions which have been determined to be medically necessary by the attending physician. The doctor makes the determination of medical necessity and so indicates on the claim form.

Although Medicaid covers only medically necessary abortions, payment is made for both medically necessary and elective abortions provided to NYC enrollees. Payment for elective abortions is funded with 100% New York City funds.

Obstetrical Services

Obstetrical care includes prenatal care in a physician's office or dispensary, delivery in the home or hospital, postpartum care and, in addition, care for any complications that arise in the course of pregnancy and/or the puerperium. The following standards and guidelines are considered to be part of normal obstetrical care:

Antepartum Care

Under normal circumstances the physician should see the patient every 4 weeks for the first 28 weeks of pregnancy, then every 2 weeks until the 36th week and weekly thereafter, when this is feasible.

As part of complete antepartum care, provision of the following laboratory and other diagnostic procedures is encouraged:

- Papanicolaou smear,
- complete blood count,
- complete urine analysis,
- serologic examination for syphilis and hepatitis,
- chest X-ray with proper shielding of the abdomen, and
- blood grouping and Rh determination with serial antibody titers, where indicated.

Intrapartum Care

Whenever possible, delivery should be performed in a hospital. In addition to these standards, the routine attendance of a qualified anesthesiologist at the time of delivery

is recommended as an important preventive measure in promoting optimum medical care for both mother and infant.

Postpartum Care

Upon discharge from the hospital, the patient should be seen for a postpartum physical exam at 3 to 6 weeks and again in 3 to 6 months.

A Papanicolaou smear should be obtained during the postpartum period at one of the visits.

Other Medical Care

Consultation with specialists in other branches of medicine should be freely sought without delay when the condition of the patient requires such care.

Section V – Related Programs

Child/Teen Health Program

New York State's Medicaid Program (Child Health Plus A) implements federal EPSDT requirements via the Child/Teen Health Program (CTHP). The CTHP care standards and periodicity schedule are provided by the Department of Health, and generally follow the recommendations of the Committee on Standards of Child Health, American Academy of Pediatrics.

New York State's CTHP promotes early and periodic screening, diagnosis and treatment aimed at addressing any health or mental health problems identified during exams. The CTHP includes a full range of comprehensive, primary health care services for Medicaid-eligible youth from birth until age 21.

Many categories of providers directly render or contract for primary health care services for Medicaid-eligible youth services by the CTHP. For example:

- Physicians;
- Nurse Practitioners;
- Clinics;
- Hospitals;
- Nursing Homes;
- Office of Mental Health Licensed Residential Treatment Facilities;
- Office of Mental Retardation and Developmental Disabilities, Licensed Intermediate Care Facilities for the Developmentally Disabled;
- Office of Children and Family Services Authorized Child (Foster) Care Agencies;
- Medicaid Managed Care Organizations; and
- Medicaid-enrolled School-Based Health Centers.

New York State's EPSDT/CTHP Provider Manual for Child Health Plus A (Medicaid) also emphasizes recommendations of *Bright Futures* in order to guide provider practice, and improve health and mental health outcomes for Medicaid-eligible youth. The EPSDT/CTHP Provider Manual for Child Health Plus A (Medicaid) is available online at:

http://www.emedny.org/ProviderManuals/EPSDTCTHP/index.html.

Preferred Physicians and Children Program

The Preferred Physicians and Children (PPAC) program is an important part of the State's effort to assure children access to quality medical care through the Medicaid Program. The PPAC program:

- Encourages the participation of qualified practitioners;
- Increases children's access to comprehensive primary care and to other specialist physician services; and,
- Promotes the coordination of medical care between the primary care physician and other physician specialists.

Application for the Preferred Physicians and Children Program

PPAC provider enrollment applications may be obtained online at:

http://www.emedny.org/info/ProviderEnrollment/index.html.

PPAC Procedure Codes are in the Procedure Code and Fee Schedule Section of this manual, available at:

http://www.emedny.org/ProviderManuals/Physician/index.html.

Physician Eligibility and Practice Requirements

The qualified primary care physician will:

- Have an active hospital admitting privilege at an accredited hospital.

  This requirement may be waived for the physician who qualifies for hospital admitting privilege but does not have one due to such reason as the unavailability of admitting privilege at area hospitals; or nearest hospital too distant from office to be practical.

  Such physician will submit *each of the following* at the time of application:

  - a description of the circumstance that merits consideration of waiver of this requirement,
  - evidence of an agreement between the applicant and a primary care physician who is licensed to practice in New York, has an active hospital admitting privilege and will monitor and provide continuity of care to the applicant's patients who are hospitalized; and

- a curriculum vitae; proof of medical malpractice insurance; and two letters of reference, each from a physician who can attest to the applicant's qualifications as a practicing physician.

- Be board certified (or board admissible for a period of no more than five years from completion of a post graduate training program) in family practice, internal medicine, obstetrics and gynecology, or pediatrics.

  The physician who participates in the PPAC program and is board admissible must re-qualify when board admissibility reaches five years.

- Provide 24-hour telephone coverage for consultation.

  This will be accomplished by having an after-hours phone number with an on-call physician, nurse practitioner or physician's assistant to respond to patients.

  This requirement cannot be met by a recording which refers patients to emergency rooms.

- Provide medical care coordination.

  Medical care coordination will include at a minimum: the scheduling of elective hospital admissions, assistance with emergency admissions; management of and/or participation in hospital care and discharge planning, scheduling of referral appointments with written referral as necessary and with request for follow-up report, and scheduling for necessary ancillary services.

- Agree to provide periodic health assessment examination in accordance with the Child/Teen Health program (CTHP) standards of Medicaid.

- Be a provider in good standing if enrolled in the Medicaid Program at time of application to PPAC.

- Sign an agreement with the Medicaid Program, such agreement to be subject to cancellation with 30-day notice by either party.

The qualified non-primary care specialist physician will:

- Have an active hospital admitting privilege at an accredited hospital;

  This requirement may be waived for the physician who qualifies for hospital admitting privilege but does not have one because the practice of his/her specialty does not support need for admitting privilege.

  Such physician will submit at the time of application, (a) a description of the circumstance that merits consideration of waiver of this requirement, and (b) where applicable, **EITHER** a copy of a letter of active hospital appointment other than admitting **OR** evidence of an agreement between the applicant and a

primary care physician who is licensed to practice in New York, has an active hospital admitting privilege and will monitor and provide continuity of care to the applicant's patients who are hospitalized; and (c) a curriculum vitae; proof of medical malpractice insurance; and two letters of reference, each from a physician who can attest to the applicant's qualifications as a practicing physician.

- Be board certified (or board admissible for a period of not more than five years from completion of a post graduate training program) in a specialty recognized by the DOH;

  The physician who participates in PPAC and is board admissible must requalify when board admissibility reaches five years.

- Provide consultation summary or appropriate periodic progress notes to the primary care physician on a timely basis following a referral or routinely scheduled consultant visit;

- Notify the primary care physician when scheduling hospital admission;

- Be a provider in good standing if enrolled in the Medicaid Program at time of application to PPAC;

- Sign an agreement with the Medicaid Program, such agreement to be subject to cancellation with 30-day notice by either party.

Covered Services

For the PPAC participating provider the visit/examination is the only service claimed and reimbursed through PPAC. Claiming is specific to place of service, such as office.

The PPAC participating provider may NOT bill for:

- physician services provided in Article 28 clinics or

- contractual physician services in emergency rooms.

Claims for physician services other than the visit/examination will continue to be claimed and reimbursed in accordance with the instructions outlined in this Manual.

Physically Handicapped Children's Program

The Physically Handicapped Children's Program (PHCP) is a Federal Grant Program under the Social Security Act established to aid states in the provision of medical services for the treatment and rehabilitation of physically handicapped children. Administration of the Program is supervised by Department of Health.

On the local level, county health commissioners, county directors of PHCP, or the New York City Health Department's Bureau of Handicapped Children have responsibility for the Program. Providers will deal primarily with designated local officials.

Services Available and Conditions Covered

Medical services available under PHCP include diagnostic, therapeutic, and rehabilitative care by medical and paramedical personnel. Necessary hospital and related care, drugs, prosthesis, appliances, and equipment are also available under the Program.

This Program includes care for 125 categories of handicapping conditions. Care is available not only for defects and disabilities of the musculo-skeletal system, but also:

- cardiac defects,
- hearing loss,
- hydrocephalus,
- convulsive disorders,
- dento-facial abnormalities, and
- many other conditions.

Treatment for long-term diseases, i.e., cystic fibrosis, muscular dystrophy, rheumatic heart disease, which are likely to result in a handicap in the absence of treatment, is also available.

For more detailed information on covered services, the provider should contact the county health department or the local PHCP office.

Eligibility

To participate in the PHCP, a child must first be determined medically-eligible, i.e., having one of the defects or disabilities referred to above.

A child under age 21 who, in a physician's professional judgment, may be eligible for the PHCP should be referred to the local medical rehabilitation officer, the county commissioner of health, the local PHCP medical director, or the Bureau of Handicapped Children (New York City) for a determination of the child's eligibility for the Program.

Financing

A great number of PHCP cases will be financed by Medicaid. If the family of a medically-eligible child is not currently covered by Medicaid, the family will be referred by PHCP officials to the LDSS for a determination of Medicaid eligibility.

If the child is determined eligible for Medicaid, payment for services for the child will be paid with Medicaid funds. If the child is determined ineligible for Medicaid, payment for services will be paid by the PHCP and/or the child's family.

Reimbursement for services rendered to PHCP participants (either from Medicaid or PHCP funds) will not exceed the fees and rates established by the Department of Health.

Prior Approval

Prior approval is required for treatment of medical and dental conditions under the Program. Such approval is to assure that:

- The clinical conditions come under the Program;
- The physician or dentist meets the required program qualifications;
- The institution, if necessary, has been specifically approved for the service required.

Prior approval must be obtained from the county health officer or PHCP medical director. Requests for prior approval should be initiated by the attending physician by submission of an appropriate form which may be obtained from city, county, or district health offices, or the eMedNY Contractor.

Prior approval for treatment will be granted only for a specified period of time. Generally, Medicaid reimbursement will only be available for treatment rendered during that approved period of time. Reimbursement, however, will continue to be made should the child's Medicaid coverage be terminated during the treatment period. In such an instance, payment will only be made for the prior-approved treatment and will be discontinued upon completion of that treatment.

In an emergency, care may be provided without prior approval. *However, the county health officer or PHCP medical director must be promptly notified of such care.*

Family Care Program

The Family Care Program of the New York State Office of Mental Health/Office of Mental Retardation and Developmental Disabilities (OMH/OMRDD) provides supervised residence in the community for inpatients of psychiatric or developmental centers who

have responded to treatment and other persons who, though unable to function adequately in their own homes, do not require inpatient care. Individuals who have been determined able to live in the community may be placed in certified family care homes.

Each family care home must possess an OMH or an OMRDD operating certificate. Those who operate family care homes provide room and board, some non-emergency transportation, and basic support services to their residence. The OMH/OMRDD facility making the placement exercises administrative control over the family care home.

Since the emphasis of the Family Care Program is on integration into the community, the use of private practitioners is encouraged for medical care. Enrollees who have been placed in an approved family care home are eligible for the full range of services covered by Medicaid, except when OMH family-care residents require acute psychiatric hospitalization. These enrollees must return to their psychiatric centers.

State regulations also require annual medical, dental and psychiatric or psychological examinations for all family-care residents, which may be provided by practitioners in the community.

The same prior approval requirements in addition to any other Program restrictions that apply when services are provided to other Medicaid enrollees, also apply in cases involving family care residents.

Individuals in the Family Care Program must be determined Medicaid-eligible by the Department of Health in conjunction with the OMH/OMRDD. Residents determined eligible for Medicaid are issued a permanent plastic CBIC.

Family Planning Benefit Program

This program provides Medicaid coverage for family planning services to all persons of childbearing age with incomes at or below 200% of the federal poverty level. This population will have access to all enrolled Medicaid family planning providers and family planning services currently available under Medicaid.

Family planning services under this program can be provided by all Medicaid enrolled family planning providers including physicians and nurse practitioners. Covered family planning services include:

- All FDA-approved birth control methods, devices, pharmaceuticals, and supplies;
- Emergency contraceptive services and follow-up;
- Male and female sterilization in accordance with 18 NYCRR Section 505.13(e); and
- Preconception counseling and preventive screening and family planning options.

The following additional services are considered family planning only when provided during a family planning visit and when the service provided is directly related to family planning:

- Pregnancy testing and counseling;
- Counseling services related to pregnancy and informed consent, and STD/HIV risk counseling;
- Comprehensive reproductive health history and physical examination, including clinical breast exam (excluding mammography);
- Screening for STDs, cervical cancer, and genito-urinary infections;
- Screening and related diagnostic testing for conditions impacting contraceptive choice, i.e. glycosuria, proteinuria, hypertension, etc.;
- HIV counseling and testing;
- Laboratory tests to determine eligibility for contraceptive of choice; and
- Referral for primary care services as indicated.

For more information on the FPBP, please call the Bureau of Policy Development and Coverage at (518) 473-2160.

Prenatal Care Assistance Program

Prenatal Care Assistance Program (PCAP) is a comprehensive prenatal program administered by the DOH that offers complete pregnancy care and other health services to women and teens who live in New York State and meet certain income guidelines. PCAP offers:

- routine pregnancy check-ups,
- hospital care during pregnancy and delivery,
- full Medicaid coverage for the woman until at least two months after delivery, and
- full Medicaid coverage for the baby up to one year of age.

Providers interested in this Program may go online to:

http://www.health.state.ny.us/nysdoh/perinatal/en/

or

http://www.emedny.org/ProviderManuals/Prenatal/index.html.

Medicaid Obstetrical and Maternal Services Program

Obstetricians, family physicians, nurse midwives and nurse practitioners who meet certain criteria may enroll in the Medicaid Obstetrical and Maternal Service (MOMS) program and receive increased fees for obstetrical care.

Practitioners participating in the MOMS program are required to refer Medicaid-eligible pregnant women for non-medical health supportive services such as:

- nutrition and psychosocial assessment and counseling,
- health education, and
- care coordination.

Health supportive services are provided by approved agencies such as county health departments, certified home health agencies and Prenatal Care Assistance Programs (PCAP).

The interested physician, midwife or nurse practitioner may apply to participate in the MOMS program by completing the following two forms, which must be submitted together:

- the "Application for Enrollment as a Medical (or Dental) Specialist" ***and***
- the MOMS Addendum.

For additional information regarding the MOMS and Health Supportive Services programs, please call the Department at:

(518) 474-1911.

MOMS Eligibility and Practice Requirements
Physicians who participate must:

- be board certified or an active candidate for board certification by the American College of Obstetrics and Gynecologists (ACOG) or eligible for board certification by the American Academy of Family Practice Physicians for a period of no more than five years from completion of a post-graduate training period in obstetrics and gynecology or family practice;
- have active hospital-admitting privileges in an appropriately accredited hospital which includes maternity services;

- provide medical care in accordance with the practice guidelines established by the ACOG;
- have 24-hour telephone coverage;
- have an agreement with an approved health supportive service provider to provide non-medical health supportive services such as health education, nutrition, and psychosocial assessment and counseling, case management, presumptive eligibility, and acting as an authorized representative for the Medicaid application;
- provide medical care coordination and agree to participate in managed care programs if the managed care programs are operational within the physician's geographic practice area;
- be a provider in good standing;
- sign an agreement with the Medicaid Program, such agreement to be subject to cancellation with 30-day notice by either party.

For physician enrollment information, please go online to:

http://www.emedny.org/info/ProviderEnrollment/index.html

For additional information, please go to:

http://www.health.state.ny.us/nysdoh/perinatal/en/

Utilization Threshold Program

In order to contain costs while continuing to provide medically necessary care and services, Medicaid will pay for a limited number of certain health services per benefit year unless additional services have been approved. The established thresholds are:

Service	Number of Visits, Items or Lab Tests Allowed per Year
Pharmacy (prescription drugs including initial prescriptions, refills, over-the-counter medicine and medical/surgical supplies)	40 items if the enrollee is: • Under 21 • 65 or over • Certified blind or disabled • Single caretaker of a child under 18 43 items if the enrollee is:

Service	Number of Visits, Items or Lab Tests Allowed per Year
	• 21 to 65 • Not certified blind or disabled • Not a single caretaker of a child under 18
Physician and Medical Clinic	10 visits
Dental Clinic	3 visits
Laboratory	18 procedures
Mental Health Clinic	40 visits

These Utilization Thresholds have been set in accordance with historical information on service use from the Medicaid Program. The threshold limits are high enough so that most enrollees will not be affected. It will be necessary, however, for providers to verify eligibility and to obtain authorization through the MEVS for those services that they provide.

The potential provider of a service will be required to access the MEVS to receive provider/enrollee service data to ascertain whether the enrollee has reached the particular threshold for that type of service. If the enrollee has not reached his/her service limitation, the MEVS will inform the provider that the service is approved and record that approval for transmission to the eMedNY Contractor. Without such approval, the provider's claim for service will not be paid by the eMedNY Contractor. Exceptions to this are situations such as emergency or urgent care when the provider will use on the "SA EXCP CODES" on the claim as described in the **Billing Guidelines** section of each specific provider manual.

The Department recognizes that an initiative such as this must be sensitive to the needs of individual patients who require medically necessary services beyond the normal limits because of a chronic medical condition or an acute spell of illness. To accommodate these patients, the physician may request that higher limits be approved for a particular Utilization Threshold or an exemption be approved for a particular Utilization Threshold by submitting a "Threshold Override Application" form to the Medicaid Override Application System (MOAS).

In order to help avoid a disruption in an enrollee's medical care, a "nearing limits" letter will be sent to the enrollee, when the authorized services are being used at a rate that will utilize all available services, in less than the current benefit year. This letter will advise the enrollee to contact his/her provider who should submit the Threshold Override Application form to increase the enrollee's service limits. The provider will also be alerted to the fact that this letter has been sent via a message on the MEVS terminal.

When an enrollee reaches his/her Utilization Threshold, a letter will be sent to the enrollee and the provider will be alerted to this fact via a message on the MEVS terminal.

Certain Medicaid enrollees will be exempt from most Utilization Thresholds because they receive their medical care though Managed Care Programs, i.e., Health Maintenance Organizations, prepaid capitation service plans.

There are also some services which are exempt from Utilization Threshold and the enrollee's use of these services is not limited under this Program. Such services include:

- Family Planning,
- Methadone Maintenance Treatment,
- Certain obstetric services,
- Child/Teen Health Program services, and
- Kidney dialysis.

Recipient Restriction Program

The Recipient Restriction Program (RRP) is an administrative mechanism whereby selected Medicaid enrollees with a demonstrated pattern of abusive utilization of Medicaid services must receive their medical care from a designated primary provider(s). The goals of the RRP are the elimination of abusive utilization behavior and the promotion of quality care for restricted enrollees through coordination of the delivery of select medical services.

The DOH and LDSS may restrict enrollees to the following provider types:

- Physicians,
- Clinics,
- Pharmacies,
- Inpatient hospitals,
- Podiatrists,
- Dentists and
- Durable Medical Equipment providers.

These restrictions may be imposed individually or in conjunction with one another. To promote coordinated medical care, the RRP prohibits restricted enrollees from obtaining

certain ancillary services such as laboratory and transportation ordered by non-primary providers.

Billing information relating to the RRP is located in the **Billing Guidelines** of each specific provider manual.

MEVS Implications for the RRP

It is important for all providers to properly access the MEVS to ensure that the enrollee is eligible and to:

- Avoid rendering services to a patient who is restricted to another provider; and/or
- Ensure that ordered services are provided at the request of a restricted enrollee's primary provider or a provider to whom the enrollee was referred by his/her primary provider.

For instructions on MEVS transactions, please refer to the MEVS Provider Manual online at:

http://www.emedny.org/ProviderManuals/index.html.

Managed Care

Managed Care is a comprehensive and coordinated system of medical and health care service delivery encompassing ancillary services, as well as acute inpatient care. The Managed Care Organization (MCO) is responsible for assuring that enrollees have access to a comprehensive range of preventative, primary and specialty services. The MCO may provide services directly or through a network of providers. The MCO receives a monthly premium for each enrollee to provide these services.

In a MCO, each Medicaid enrollee is linked to a primary care practitioner. This provider may be a private practicing physician, on staff in a community health center or outpatient department, or may be a nurse practitioner. Regardless of the setting, the primary care provider is the focal point of the Managed Care system. This practitioner is responsible for the delivery of primary care, and also coordinates and case manages most other necessary services. Another feature of managed care is 24-hour, 7-day/week access to care.

A Medicaid enrollee enrolled with a MCO remains eligible for the full range of medical services available in the Medicaid Program. However, an enrolled enrollee is required to access most health care services through his/her MCO. When an enrollee is determined Medicaid-eligible, he/she has the opportunity to enroll with a MCO, but not all enrollees will be enrolled in a MCO.

Certain individuals are excluded from participating on Medicaid Managed Care:

- Individuals who “spend down” to obtain Medicaid eligibility;
- Foster care children whom the fiscally responsible LDSS has placed under the auspices of a voluntary child (foster) care agency;
- Medicare/Medicaid dual eligibles;
- Residents of State-operated inpatient psychiatric facilities;
- Residents of residential treatment facilities for children and youth;
- Enrollees of Mental Health Family Care services;
- Residents of residential health care facilities at the time of enrollment;
- Participants in a long term care capitation demonstration project;
- Infants of incarcerated mothers;
- Participants in the Long Term Home Health Care Program;
- Certified blind or disabled children who are living apart from their parents over 30 days;
- Individuals expected to be eligible for Medicaid less than 6 months;
- Individuals receiving hospice services;
- Individuals receiving services from a Certified Home Health Agency when it has been determined that they are not suitable for managed care enrollment;
- Individuals enrolled in the Restricted Enrollee Program with a primary physician, clinic, dental, DME, or inpatient provider;
- Enrollees who have other third party insurance so that managed care enrollment is not cost-effective.

MEVS Implications for Managed Care

Provider must check the MEVS prior to rendering services to determine the enrollee’s Medicaid eligibility and the conditions of Medicaid coverage. If the Medicaid enrollee is enrolled with a MCO, the first MEVS coverage message will indicate, “Eligible PCP”.

> **Note**: PCP stands for Prepaid Capitation Plan (or MCO). Please refer to the MEVS manual for instructions on Managed Care transactions.

While MCOs are required to provide a uniform benefit package, there may be some variations between MCOs. The MEVS coverage codes are general service categories within the general category. To avoid payment problems, providers should contact the MCO whenever possible before providing services.

Providers may bill Medicaid and receive payment for any services not covered by the MCO. However, Medicaid will deny payment for services which are covered by the MCO. If a provider is not a participating provider in the enrollee's MCO, and the provider is certain that the service is covered by the MCO, then the provider must first refer the enrollee to his/her MCO for that service, or call the MCO prior to providing service.

Section VI – Definitions

For the purposes of the Medicaid Program and as used in this Manual, the following terms are defined to mean:

Emergency

An emergency is defined as care for patients with severe, life threatening, or potentially disabling conditions that require immediate intervention.

Emergency Services

Care provided after a sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity that the absence of immediate medical treatment could reasonably result in:

- serious impairment of bodily functions;
- serious dysfunction of a bodily organ or body part; or
- would otherwise place the enrollee's health in serious jeopardy.

Factor

A person or an organization such as a collection agency, service bureau or an individual that advances money to a provider for accounts receivable in return for a fee, deduction, or discount based on the dollar amount billed or collected. The accounts receivable are transferred by the provider to the factor by means of assignment, sale or transfer, including transfer through the use of power of attorney.

Local Professional Director

The Local Professional Director (also known as the Local Medical Director or Reviewing Health Professional) is an individual who, under Section 365-b of the NYS Social Services Law, serves under the general direction of the Commissioner of Social Services and has responsibility for:

- supervising the medical aspects of the Medicaid Program,
- monitoring the professional activities related to the Program, and
- taking all steps required to ensure that such activities are in compliance with Social Services Law and Regulations and Public Health Law and Regulations.

Managed Care

Managed care is a comprehensive and coordinated system of medical and health care service delivery encompassing ancillary services, as well as acute inpatient care.

Prior Approval

Prior Approval is the process of evaluating the aspects of a plan of care which may be for a single service or an ongoing series of services in order to determine the medical necessity and appropriateness of the care requested.

Prior approval does not guarantee payment.

Prior Authorization

Prior authorization is the acceptance by the Local Commissioner of Social Services, or his/her designated representative, of conditional financial liability for a service or a series of services to be rendered by the provider.

Prior authorization does not guarantee payment.

Qualified Medicare Enrollee

Qualified Medicare Enrollees (QMBs) are individuals who have applied to Medicaid through the LDSS and have been determined eligible for Medicaid payment, as appropriate, of Medicare premiums, deductibles and coinsurance for Medicare-approved services.

QMB status is determined via the MEVS.

Unacceptable Practice

An unacceptable practice is conduct by a person which conflicts with any of the policies, standards or procedures of the State of New York as set forth in the Official Codes, Rules and Regulations of the Department of Health or any other State or Federal statute or regulation which relates to the quality of care, services and supplies or the fiscal integrity of the Medicaid Program.

Urgent Medical Care

A situation in which the patient has an acute or active problem which, if left untreated, might result in:

- an increase in the severity of symptoms;
- the development of complications;

- increase in recovery time;
- the development of an emergency situation.

NEW YORK STATE
MEDICAID PROGRAM

INFORMATION FOR ALL PROVIDERS
GENERAL BILLING

Table of Contents

Common Benefit Identification Card

There are four types of Common Benefit Identification Cards (CBIC) or documents with which you will need to become familiar;

- a photo card,
- a non-photo card,
- a paper replacement CBIC and
- a Temporary Medicaid Authorization (DSS-2831A).

The photo and non-photo cards are permanent plastic cards and each contains information needed for verifying eligibility for a single enrollee. Each card contains the following information for the enrollee:

- Medicaid identification number;
- first name;
- last name;
- middle initial;
- sex; and
- date of birth.

Additionally, each card contains an access number, a sequence number, an encoded magnetic strip and a signature panel. The photo ID card also contains a photo. Neither card contains an expiration date.

The provider must verify enrollee eligibility via the Medicaid Eligibility Verification System (MEVS) each time service is provided to be assured that an enrollee is eligible.

If an enrollee's permanent plastic ID card has been lost, stolen or damaged, the enrollee will be issued a temporary replacement paper CBIC (DSS-3713), which contains the following information for the enrollee:

- Medicaid identification number;
- first name;
- last name;
- middle initial;
- sex; and
- date of birth.

This temporary card carries an expiration date after which the card cannot be used. Verification of eligibility must be completed via MEVS whenever a temporary replacement card (DSS-3713) is presented.

In some circumstances, the enrollee may present a Temporary Medicaid Authorization (DSS-2831A). This document is issued by the local department of social services

(LDSS) when the enrollee has an immediate medical need and a permanent plastic identification card has not yet been received by the enrollee. It is a guarantee of eligibility for the authorization period indicated (maximum 15 days); therefore, verification of eligibility via MEVS is not required. Limitations and/or restrictions are listed on the Authorization. In these cases it will be necessary for some providers to place a code of "M" in the "SA EXCP CODE" field on the eMedNY billing form in order to indicate that the enrollee had a Temporary Medicaid Authorization. Please refer to the Billing Guidelines section of your specific provider manual for instructions. Questions regarding eligibility should be directed to the LDSS issuing the DSS-2831A.

Note: Each of these documents is described in greater detail in the "Common Benefit Identification Card" section of the MEVS Provider Manual.

The MEVS Provider Manual is available to Medicaid enrolled providers. This manual can be accessed at or downloaded from:

http://www.emedny.org/ProviderManuals/index.html.

Samples of the four types of CBIC are shown and detailed descriptions are provided in the **MEVS Provider Manual** section entitled, "Common Benefit Identification Cards".

Note: The sample cards shown in the **MEVS Provider Manual** are issued to New York State Medicaid enrollees whose district of fiscal responsibility is within eMedNY. Claims for patients with non-eMedNY CBIC should be sent to the Local Department of Social Services indicated in the MEVS response.

Voice Interactive Phone System

Medicaid offers the Voice Interactive Phone System (VIPS) to afford providers the opportunity to conduct a name search to locate the Client Identification Number (CIN) of Medicaid enrollees who were unable to present their cards at the time of service. This system is accessible by calling (518) 472-1550 from a touch-tone telephone and following the voice prompts. There is a charge of $.85 per minute.

Prior Approval Rosters

Prior approval/authorization rosters contain information necessary to submit claims for certain services provided to Medicaid enrollees. Rosters contain necessary billing information, including, but not limited to: prior approval/authorization number, client identification number, applicable approved/authorized procedure/rate code/s, and date/s of service.

Electronic Roster

Rosters are available electronically in Portable Document Format (pdf) via the eMedNY eXchange, at no additional expense to providers, and are delivered in advance of hard copy rosters so claims may be submitted and paid earlier. Electronic rosters are not in HIPAA-compliant format, therefore providers need not purchase additional software to read or interpret roster information.

Weekly rosters for transportation and personal care services providers are posted every Monday. For all other provider types, a roster is posted the day after prior approvals are approved.

eXchange works like email. A provider, who has requested an electronic roster, would log on to the eXchange via the eMedNY website. After entering an assigned User Identification Number and password, the provider is able to print the roster and/or detach the roster file to save it on a personal computer for future reference.

What information is included on the electronic roster?

- Roster Date
- PA Number
- Procedure/Rate Code
- Approved Quantity
- Approved Times
- Patient Name
- Patient Medicaid ID
- Patient Gender
- Patient Date of Birth
- Patient County
- Billing Provider Name
- Billing Provider ID
- Ordering Provider ID
- Dates of Service
- Approved Amount

How does a provider obtain a User Identification Number and password for eXchange?

First, the eMedNY eXchange is available only to providers who have enrolled in ePACES. Once a provider is enrolled in ePACES, then the provider is automatically enrolled in eXchange.

After successful enrollment in ePACES, the provider calls the eMedNY Call Center at (800) 343-9000 to activate their eXchange inbox.

Providers not yet enrolled in ePACES will need the following prior to contacting the Call Center to enroll:

- Computer with internet access;
- Valid email address;
- Internet browser (Explorer v.4.01, Netscape v 4.7 or higher);
- Operating system of Microsoft Windows, Macintosh or Linux; and
- NYS Medicaid Provider Identification number.

The electronic prior approval request for is available at:

http://www.emedny.org/info/ProviderEnrollment/index.html.

Billing for Medical Assistance Services

Medicaid regulations require that claims for payment of medical care, services, or supplies to eligible enrollees be initially submitted within **90 days of the date of service** to be valid and enforceable, unless the claim is delayed due to circumstances outside the control of the provider. Acceptable reasons for a claim to be submitted beyond 90 days are listed below.

If a claim is denied or returned for correction, it must be corrected and resubmitted within **60 days of the date of notification** to the provider. Claims not correctly resubmitted within 60 days, or those continuing to not be payable after the second resubmission, are neither valid nor enforceable.

All claims must be **finally** submitted to the eMedNY Contractor and be payable within two years from the date the care, services or supplies were furnished in order to be valid and enforceable against the Department or a social service district.

Claims Submitted for Stop-Loss Payments

All claims for Stop-Loss payment must be finally submitted to the Department, and be payable, within two years from the close of the benefit year in order to be valid and enforceable against the Department.

For example, calendar year 2002 payable claims must be finally submitted no later than December 31, 2004 with corresponding cutoff for future years.

Claims Over 90-Days Old, Less Than Two Years Old

Paper claims over 90 days of the date of service must be submitted with a 90-day letter attached (with the exception of Third Party Insurance Processing Delay). The reason for the delay should be indicated on a piece of paper the same size (8½ x 11) and paper quality as the invoice.

Because the claim forms do not contain an invoice number, **each** claim must have its **own** 90-day letter attached. This allows the imaging system to simultaneously track each claim and attachment.

Acceptable Delay Reasons

Claims over 90 days, and less than two years, from the date of service may be submitted if the delay is due to one or more of the following acceptable conditions. *The applicable delay reason(s) must be included on a 90-day letter attached to the claim.*

- **Proof of Eligibility Unknown or Unavailable – Delay in Medicaid Client Eligibility Determination (including Fair Hearing)**

The enrollee applied for Medicaid and their eligibility was backdated. If the claim ages over 90 days while this process is taking place, then this reason applies.

The claim must be submitted within 30 days from the time of notification.

- **Litigation**

  This means there was some kind of litigation involved and there was the possibility that payment for the claim may come from another source, such as a lawsuit.

  The claim must be submitted within thirty (30) days from the time submission came within the control of the Provider.

- **Authorization Delays/Administrative Delay (Enrollment Process, Prior Approval Process, Rate Changes, etc.) by the Department or other State Agency**

  For example: Provider enrollment may back date the effective date of a Specialty Code.

- **Delay in Certifying Provider/Administrative Delay (Enrollment Process, Prior Approval Process, Rate Changes, etc.) by the Department or other State Agency**

  For example: Provider enrollment may back date the effective date of a Specialty Code.

- **Delay in Supplying Billing Forms**

- **Third Party Processing Delay – Medicare and Other Third Party Processing Delays**

  The claim had to be submitted to Medicare or other Third Party Insurance before being submitted to Medicaid.

  The claim must be submitted within thirty (30) days from the time submission came within the control of the Provider.

- **Delay in Eligibility Determination/Delay in Medicaid Client Eligibility Determination (including Fair Hearing)**

  This means the enrollee applied for Medicaid and their eligibility date was backdated. If the claim ages over 90 days while this process is taking place, then this reason applies.

The claim must be submitted within thirty (30) days from the time of notification.

- **Original Claim Rejected or Denied Due to a Reason Unrelated to the Billing Limitation Rules**

  This means the Provider submitted the claim on time and was denied for some other reason. If the date of service is over 90 days when they rebill, this reason applies.

  The claim must be submitted within thirty (30) days from the time of notification.

- **Administration Delay in the Prior Approval Process/Administrative Delay (prior approval) by the Department of Health or other State agency**

  IPRO denial/reversal (Island Peer Review Organization) previously denied the claim, but the denial was reversed on appeal.

- **Other/Interrupted Maternity Care**

  Prenatal care claims over 90 days because delivery was performed by a different practitioner.

Claims Over Two Years Old

All claims over two years old will be denied for **edit 1292** (*DOS (date of service) Two Yrs (years) Prior to Date Received*). The Department will *only* consider claims over two years old for payment only if the provider can produce documentation verifying that the cause of the delay was the result of one or more of the following:

- Errors by the Department, the local social services district, or another agent of the Department; or

- Court-ordered payments.

If a Provider believes that claims denied for edit 1292 are payable due to one of the reasons above, they may request a review. All claims **must** be submitted **within 90 days of the date on the remittance advice** with supporting documentation to:

New York State Department of Health
Two Year Claim Review
150 Broadway, Suite 6E
Albany, New York 12204-2736.

Claims submitted for review without the appropriate documentation, or those not submitted within the 90-day time period for review, will not be considered.

When a provider **voids** a previously paid claim and now wishes to resubmit, the resubmission is treated as a **new claim** and will be subjected to the criteria above for the submission of claim(s) over two years old. All timely submission rules apply. The new claim will not be considered as an agency error and, therefore, **will not** qualify for a waiver of the two-year regulation. Adjustments, rather than voids, should always be billed to correct a paid claim(s).

Electronic Claims Submission

Most claims for payment of medical care, services and supplies may be submitted electronically, including originals, resubmissions, adjustments and voids. The only exceptions are claims that require paper attachments such as enrollee's "consent forms" or provider's procedure reports for manual pricing.

When a file is submitted to eMedNY, a series of response files are returned to the submitter to communicate the status of the transaction. Errors in transmissions may cause transactions not to be processed. eMedNY sends status files that can prevent surprises and negative impacts on cash flow. Please review the list of frequently asked questions online at:

http://www.emedny.org/hipaa/FAQs/index.html.

If you would like more information about computer generated claims submission or require the input specifications for the submission of the types of claims indicated above, please call the eMedNY Call Center at (800) 343-9000.

Claim Status Options

Medicaid offers a number of tools to assist providers seeking claim status information without having to wait for remittance statements. eMedNY Call Center staff are **not** able to perform routine claim status checks for providers and submitters waiting for their remittances to be delivered.

ePACES

To request claim status for ePACES claims, providers just need to select from a list of submitted claims. The status of ePACES claims is usually available on the same day the claim was submitted.

For claims submitted via other methods, ePACES requires the key entry of a few pieces of claim data in order to retrieve the status, including the paid amount. Availability of the claim status for claims submitted via other methods may vary depending on the submission method and the time it reached the eMedNY Contractor for processing.

ePACES Real Time

The status of claims, including the paid amount, submitted via "Real Time" is available for professional claims immediately following submission.

Electronic Claim Status Request

Electronic requests can be submitted as batch files. Submitters need a software program to produce the requests in a HIPAA-compliant format and to interpret the 277 Claim Status Response.

Electronic Claim Status Responses

These are returned via ePACES or the 277 transaction containing the HIPAA-compliant response codes. To assist providers with interpreting the response codes, an edit mapping document is available online at:

http://www.emedny.org/hipaa/Crosswalk/index.html.

Paper Remittance

Claim status information is available two and one half weeks after processing is completed.

Electronic Remittance

To receive Electronic Remittances, providers must submit a completed *Electronic Remittance Request Form,* available online at:

http://www.emedny.org/info/ProviderEnrollment/index.html.

Electronic Remittances generally include the status of electronically and paper submitted claims as well as state-submitted adjustments and voids whenever providers who have only one Electronic Transmitter Identification Number sign up for electronic remittances.

Note: State-submitted adjustments and voids are transactions submitted by New York State or one of its contractors and are based upon audit findings.

The *Electronic Remittance Request Form* is available online at:

http://www.emedny.org/info/ProviderEnrollment/index.html.

Electronic Funds Transfer

Medicaid funds issued to a provider as a result of paper or electronic claims submission can be electronically transferred to a designated bank account or accounts. Providers do not have to submit claims electronically to take advantage of the convenience of EFT. To enroll in EFT, complete the EFT Provider Enrollment Form, available online at:

http://www.emedny.org/info/ProviderEnrollment/index.html.

After submitting the *Form*, please allow four to six weeks for processing.

Claims Pended for Review by the Office of the State Comptroller

The New York State Constitution requires the Office of the State Comptroller (OSC) to audit all vouchers before payment, including claims that are submitted to the Medicaid Program. OSC will suspend certain claims from the Medicaid payment procedure in order to conduct a thorough review of those claims.

Some providers will see an edit code and reason associated with the OSC audit:

02014 – Claim Under Review by the Office of the State Comptroller.

If a provider is receiving the HIPAA-compliant error codes, then the OSC edit will be mapped to:

Claim Adjustment Reason Code 95 – Benefits Adjusted. Plan Procedures Not Followed.

If a provider has claims pending or denied for this reason, a representative from OSC will contact the provider to discuss the provider's claims. This may include scheduling an appointment to visit the provider's facility to inspect medical records and other documentation supporting the claims being reviewed.

Under the Code of Federal Regulations (45 CFR § 164.512(d)(1) (HIPAA)), medical providers are permitted to disclose protected health information to an oversight agency, for oversight activities which are authorized by law, such as audits. For these purposes, OSC is an oversight agency.

HIPAA Claim Denials

With the implementation of HIPAA-standardized claim error reasons, it can be difficult to pinpoint the specific reason for a claim denial because HIPAA requires that denied claims be assigned a *Claim Adjustment Reason Code*.

An Edit/Error Knowledgebase tool for analyzing claim edit codes and/or claim status codes is available online at:

http://www.emedny.org/hipaa/edit_error/KnowledgeBase.html.

Good Cause

Medicaid providers should always bill available health insurance unless they received authorization from the DOH that "good cause" exists not to bill the health insurance. Health insurance is only determined to be available if the Medicaid Eligibility Verification System (MEVS) indicates that the insurance covers the particular service for which the provider would be billing Medicaid.

Circumstances in which the DOH must determine "good cause" not to bill health insurance involve situations where the billing could jeopardize the emotional or physical health, safety and/or privacy of the Medicaid enrollee. These circumstances commonly arise but are not restricted to occasions on which reproductive health services such as family planning, pregnancy-related services or treatment of sexually transmitted diseases are provided.

> *When warranted, providers on behalf of their patients may request a "good cause" determination and an authorization for not billing the health insurance.*

If a particular patient wants the service to remain confidential, the provider must contact the DOH **weekdays between 8:00am and 4:45pm** at:

(800) 541-2831.

If "good cause" is granted, the provider must document the date of the call and that DOH staff gave permission not to bill the health insurance. The information obtained may be utilized as documentation for future audits or claim reviews.

Once a positive determination of "good cause" has been received, the provider must enter $0.00 in the insurance payment field of the Medicaid claim form. *Since the DOH monitors $0.00 filled claims, it is especially important to obtain the previously described approval and document that approval.*

Claim Certification Statement

Provider certifies that:

- I am (or the business entity named on this form of which I am a partner, officer or director is) a qualified provider enrolled with and authorized to participate in the New York State Medical Assistance Program and in the profession or specialties, if any, required in connection with this claim;
- I have reviewed this form;
- I (or the entity) have furnished or caused to be furnished the care, services and supplies itemized in accordance with applicable federal and state laws and regulations;
- The amounts listed are due and, except as noted, no part thereof has been paid by, or to the best of my knowledge is payable from any source other than, the Medical Assistance Program;
- Payment of fees made in accordance with established schedules is accepted as payment in full; other than a claim rejected or denied or one for adjustment, no previous claim for the care, services and supplies itemized has been submitted or paid;
- All statements made hereon are true, accurate and complete to the best of my knowledge;
- No material fact has been omitted from this form;
- I understand that payment and satisfaction of this claim will be from federal, state and local public funds and that I may be prosecuted under applicable federal and state laws for any false claims, statements or documents or concealment of a material fact;
- Taxes from which the State is exempt are excluded;
- All records pertaining to the care, services and supplies provided including all records which are necessary to disclose fully the extent of care, services and supplies provided to individuals under the New York State Medical Assistance Program will be kept for a period of six years from the date of payment, and such records and information regarding this claim and payment therefore shall be promptly furnished upon request to the local departments of social services, the DOH, the State Medicaid Fraud Control Unit of the New York State Office of Attorney General or the Secretary of the Department of Health and Human Services;

- There has been compliance with the Federal Civil Rights Act of 1964 and with section 504 of the Federal Rehabilitation Act of 1973, as amended, which forbid discrimination on the basis of race, color, national origin, handicap, age, sex and religion;

- I agree (or the entity agrees) to comply with the requirements of 42 CFR Part 455 relating to disclosures by providers; the State of New York through its eMedNY Contractor or otherwise is hereby authorized to

    - (1) make administrative corrections to this claim to enable its automated processing subject to reversal by provider, and

    - (2) accept the claim data on this form as original evidence of care, services and supplies furnished.

By making this claim I understand and agree that I (or the entity) shall be subject to and bound by all rules, regulations, policies, standards, fee codes and procedures of the DOH as set forth in Title 18 of the Official Compilation of Codes, Rules and Regulations of New York State and other publications of the Department, including Provider Manuals and other official bulletins of the Department.

I understand and agree that I (or the entity) shall be subject to and shall accept, subject to due process of law, any determinations pursuant to said rules, regulations, policies, standards, fee codes and procedures, including, but not limited to, any duly made determination affecting my (or the entity's) past, present or future status in the Medicaid Program and/or imposing any duly considered sanction or penalty.

I understand that my signature on the face hereof incorporates the above certifications and attests to their truth.

NEW YORK STATE
MEDICAID PROGRAM

INFORMATION FOR ALL PROVIDERS

INQUIRY

Table of Contents

Computer Sciences Corporation Contact Information

Computer Sciences Corporation (CSC) is the Medicaid Program's eMedNY Contractor. Contact CSC with questions concerning:

- ePACES (electronic claims);
- obtaining claim forms;
- obtaining prior approval forms;
- Medicaid enrollment;
- obtaining transportation prior authorization for New York City enrollees;
- preparing/completing claim forms;
- remittance statements/billing;
- the Medicaid Eligibility Verification System (MEVS).

Hours of Operation

For provider inquiries pertaining to non-pharmacy billing or claims, or provider enrollment:

Monday through Friday 7:00am – 6:00pm EST

For provider inquiries pertaining to eligibility, service authorizations, DVS, and pharmacy claims:

Monday through Friday 7:00am – 10:00pm EST

Weekends and Holidays 8:30am – 5:30pm EST

Telephone Directory

If you are a:

- Physician
- Private Duty Nurse
- Clinical Social Worker
- Dentist
- Nurse Practitioner; or
- Ophthalmic Provider

Call **(800) 343-9000**
Option 1

Then, depending on your question:

If your question is concerning:	Choose:
➢ New Enrollment; ➢ ePACES Enrollment; ➢ TSN/ETIN applications.	**Sub-option 1**
➢ Explanation of eligibility response; ➢ UT service authorization; ➢ POS Device Support.	**Sub-option 2**
➢ Obtaining NYC Transportation Prior Authorizations	**Sub-option 3**
➢ Claims; ➢ Billing; ➢ Remittance; ➢ Form orders; and ➢ Prior approval.	**Sub-option 4**

If you are a:

- Pharmacy Provider

Call **(800) 343-9000**
Option 2

Then, depending on your question:

If your question is concerning:	Choose:
➢ New Enrollment; ➢ ePACES Enrollment; ➢ TSN/ETIN applications.	**Sub-option 1**
➢ For all other questions including: ▪ explanation of eligibility response, ▪ claims, ▪ billing, ▪ remittance and ▪ prior approval questions including DIRAD.	**Sub-option 2**

If you are a:

- Hospital;
- Clinic;
- Long Term Care Facility;
- Nursing Agency; or
- Child Care Agency;
- Home Health Agency

Call **(800) 343-9000**
Option 3

Then, depending on your question:

If your question is concerning:	Choose:
➢ New Enrollment; ➢ ePACES Enrollment; ➢ TSN/ETIN applications.	**Sub-option 1**
➢ Explanation of eligibility response; ➢ UT service authorization; ➢ POS Device Support.	**Sub-option 2**
➢ Obtaining NYC Transportation Prior Authorizations	**Sub-option 3**
➢ Claims; ➢ Billing; ➢ Remittance; ➢ Form orders; and ➢ Prior approval questions.	**Sub-option 4**

If you are a:

- Durable Medical Equipment;
- Hearing Aid; or
- Laboratory;
- Transportation Provider

Call **(800) 343-9000**
Option 4

Then, depending on your question:

If your question is concerning:	Choose:
➢ New Enrollment; ➢ ePACES Enrollment; ➢ TSN/ETIN applications.	**Sub-option 1**
➢ Explanation of eligibility response; ➢ UT service authorization; ➢ POS Device Support.	**Sub-option 2**
➢ Claims; ➢ Billing; ➢ Remittance; ➢ Form orders; and ➢ Prior approval questions.	**Sub-option 3**

If your question concerns:

- MOAS; or
- Threshold override application provider support

Call **(800) 343-9000**
Option 5

Training Requests

Requests for individual provider training can be made by calling

(800) 343-9000

or email:

emednyproviderrelations@csc.com

Training Seminars are also available and are designed for specific provider types. Registration, locations and dates are available online at:

http://www.emedny.org/HIPAA/Provider_Training/Training.html.

Mailing Addresses for Medicaid Correspondence

Correspondence should be mailed to the following address, with the applicable P.O. Box from the table:

Computer Sciences Corporation
P.O. Box _____
Rensselaer, New York 12144.

P.O. Box	Description of Contents	Form Types
4600	Prior Approval and Prior Authorization Requests	• EMEDNY-3614 (Dental) • EMEDNY-3615 (Drugs…Physician) • EMEDNY-2832 (Hearing Aid) • EMEDNY-1260 (Level of Care) • EMEDNY-3897 (Transportation) • EMEDNY-4106 (Group Transportation) • PA Additional Information
4601	Claims	• EMEDNY-1500 (HCFA) • EMEDNY-0002 (Form A) • EMEDNY-0003 (Pharmacy) • UB-04 (Institutional)
4602	Threshold Override Applications	• EMEDNY-0001 (TOA)
4603	Provider Enrollment Applications	• All Fee-For-Service and Rate-Based Enrollment Packets
4604	Edit Review	• Provider submitted documentation to adjudicate claims

P.O. Box	Description of Contents	Form Types
4605	Remittance Retrieval	• Requests from providers for copies of remittance statements
4606	Additional Information	• Provider Enrollment Additional Information Form with attachments
4610	Provider Maintenance	• Provider maintenance (update) forms and related correspondence
4614	Electronic Form Requests	• Electronic Certifications • ETIN Applications • Security Packet A • Security Packet B • Electronic Remittance Request • Electronic Prior Approval Request • Remittance Sort Request • Pended Claim Recycle Request • Request to Disaffiliate/Delete an ETIN
4616	Electronic Funds Transfer	• Electronic Funds Transfer Enrollment Forms

Medicaid Program Contact Information

For questions concerning:	Contact:
Check Amounts To obtain check amounts prior to the release of the check, select the "Check Call" option from the menu of services offered. Only the current week's check amount will be reported.	Department of Health (866) 307-5549
Child Health Plus	(800) 698-4KIDS
Claim Response Status for ePACES Users	http://www.emedny.org/hipaa/Crosswalk/index.html
Dental/Orthodontia Services **Dental Pended Claims**	Dental Review Unit (800) 342-3005 Option #2
Diagnosis Codes	http://www.cms.hhs.gov/icd9providerdiagnosticcodes/ The list of diagnosis codes is also available through publishing houses.
Durable Medical Equipment Prior Approval	Non-DVS/DiRad – Except Buffalo Area Counties (800) 342-3005 Non-DVS/DiRad – Buffalo Area Counties (Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans and Wyoming) (800) 462-8407 PA Overrides of DVS/DiRad (Statewide) (800) 342-3005
Elderly Pharmaceutical Insurance Coverage Program (EPIC)	(800) 634-1340
Electronic Funds Transfer Provider Enrollment Form **Electronic Prior Approval Request Form** **Electronic Transmitter Identifier Number (ETIN)**	http://www.emedny.org/info/ProviderEnrollment/index.html

For questions concerning:	Contact:
Electronic Transactions Vendors	http://www.emedny.org/hipaa/vendors/index.html
eMedNY	http://www.emedny.org
eMedNY Companion Guides **Sample Files**	http://www.emedny.org/HIPAA/index.html
Enrollee Eligibility Determination Eligibility discrepancies must be reported to the enrollee's local social services district. CSC's MEVS staff cannot address these calls nor resolve eligibility issues. When the provider believes the individual is covered by Medicaid, but does not have the client identification number, assistance can be obtained by calling this number and selecting "Name Search" from the menu of services offered. There is a charge of $0.85 per minute for this optional service. A touch-tone telephone is required.	Department of Health (866) 307-5549 (518) 472-1550
Family Health Plus	(877) 9FHPLUS
Managed Care	(518) 486-9015 (800) 206-8125 omcmail@health.state.ny.us
Medicaid Inspector General Fraud Referrals	www.omig.state.ny.us http://www.nysomig.org/data/component/option,com_fileforms/Itemid,47/ **(877) 87FRAUD**
Medical Pended Claims **Two-Year Old Claims**	In State (800) 342-3005 Option #3 Out of State (518) 474-3575

For questions concerning:	Contact:
Medicaid Policy Call Center Help Line/Co-Pay Hotline Fraud/Forgery Hotline Medical/Dental Prior Approval Restricted Recipients/Utilization Threshold Two-year billing regulations	medicaid@health.state.ny.us (800) 541-2831 (877) 891-7283 (800) 342-3005 (518) 474-6866 (800) 562-0856 menu #4
Medical Prior Approval ➢ Nursing ➢ Out-of-State Inpatient Hospital Services ➢ Audiology	(800) 342-3005 Option #1
Medicaid Update • Missing issues • Request to receive electronic version	http://www.nyhealth.gov/health_care/medicaid/program/update/main.htm Email: medicaidupdate@health.state.ny.us (518) 474-5187
New York State Department of Health	www.nyhealth.gov
Newborn Screening Program	(518) 473-7552
Personal Care Services Prior Authorization	Local Department of Social Services
Pharmacy Policy and Operations	(518) 486-3209 ppno@health.state.ny.us
Private Duty Nursing Services	Broome (607) 778-2707 Chemung (607) 737-5487 Erie (716) 858-2375 Oneida (315) 798-5456 Schenectady (518) 386-2253 Tompkins (607) 274-5278 Westchester (914) 813-5440 All others not listed (800) 342-3005
Restricted Recipient Program	**NYC** (212) 630-1081 (212) 630-1087 (212) 630-1089 **Outside NYC** (518) 474-6866

For questions concerning:	Contact:
Sterilization & Hysterectomy Consent Forms ➢ DSS-3113 Hysterectomy Receipt of Information ➢ DSS-3113S Hysterectomy Receipt of Information (Spanish) ➢ DSS-3134 Sterilization Consent ➢ DSS-3134S Sterilization Consent (Spanish)	http://www.health.state.ny.us/health_care/medicaid/publications/ldssforms
Transportation	(518) 474-5187 or (518) 473-2160 MedTrans@health.state.ny.us **Outside NYC** Local Department of Social Services **Obtain NYC Prior Authorization** (800) 343-9000

Fee-for-Service Provider Enrollment File Forms

Fee-for-Service Providers:

- Chiropractor
- Clinical Social Worker
- Midwife
- Nursing Services (LPN/RN)
- Podiatrist
- Rehabilitation Services
- Durable Medical Equipment
- Laboratory
- Service Bureau
- Clinical Psychologist
- Dental/Mobile Van
- Nurse Practitioner
- Physician/Group
- Portable X-Ray Supplier
- Vision Care
- Hearing Aid
- Pharmacy
- Transportation

Enrollment Forms Maintenance Forms	http://www.emedny.org/info/ProviderEnrollment/index.html

Rate Based Provider Enrollment File Forms

Rate Based Providers:

- Adult Day Care Program
- Assisted Living Program
- Case Management
- Child Care Agency
- Clinic
- Community Residence
- Diagnostic & Treatment Center
- Emergency Room
- HCBS/TBI Waiver Provider
- Home Health Agency
- Hospice
- HMO
- Hospital
- Nursing Service (Registry)
- Long Term Home Health Care Prog.
- Personal Emergency Response System Provider
- Personal Care Provider
- Residential Health Care Facility (Nursing Home)
- Prepaid Capitation Group
- School Supportive Health Service
- Intermediate Care Facility for the Developmentally Disabled (ICF/DD)

Provider Change of Address	http://www.emedny.org/info/ProviderEnrollment/index.html
Disclosure of Ownership Form For use when ownership interest changes occur.	To receive the form: Call (800) 342-3005 Option # 4 or write to: RBU@health.state.ny.us ***Subject Line Must State: "Request Disclosure Form" and contain the name and Medicaid provider identification number of the entity.*** ***Completed*** forms should be mailed to: New York State Department of Health Office of Health Insurance Programs Division of Program Operations & Systems Rate Based Provider Unit 150 Broadway Albany, New York 12204-2736

Pharmacy Programs

To obtain prior authorization for drugs subject to the Mandatory Generic Drug Program, the Preferred Drug Program, or the Clinical Drug Review Program, or for prior authorization of non-preferred drugs, call:

(877) 309-9493
and follow the appropriate prompts:

• To validate a prior authorization **ending with "W"**	Press 1
• To validate a prior authorization that **does not end with "W"**	Press 2
• For information or technical assistance with a prior authorization	Press 3
• For a prior authorization program overview • Recent changes to the Preferred Drug Program	Option 9

Requests for prior authorization of non-preferred drugs may also be faxed to:

(800) 268-2990
Faxed requests may take up to 24 hours to process.

For questions concerning:	Contact:
Prior authorization worksheet/fax form	https://newyork.fhsc.com/providers/PDP_forms.asp
Current Preferred Drug List Preferred Drug Quick List	https://newyork.fhsc.com/downloads/providers/NYRx_PDP_PDL.pdf
Request email notification of changes to Preferred Drug List	NYPDPNotices@firsthealth.com
To obtain a supply of Preferred Drug Program educational materials for Medicaid enrollees	(518) 951-2040
Clinical concerns Preferred Drug Program questions	(877) 309-9493
Billing	(800) 343-9000

Local Departments of Social Services

Albany County Department of Social Services 162 Washington Avenue Albany, New York 12210 *(518) 447-7300* http://www.albanycounty.com/departments/dss/	Allegany County Department of Social Services 7 Court Street Belmont, New York 14813 *(585) 268-9622* http://www.alleganyco.com/default.asp?show=btn_dss
Broome County Department of Social Services 36-42 Main Street Binghamton, New York 13905-3199 *(607) 778-8850* http://www.gobroomecounty.com/dss/	Cattaraugus County Department of Social Services One Leo Moss Drive, Suite 6010 Olean, New York 14760 *(716) 373-8070* http://www.co.cattaraugus.ny.us/dss/
Cayuga County Department of Social Services County Office Building 160 Genesee Street Auburn, New York 13021-3433 http://cayugacounty.us/hhs/index.html	Chautauqua County Department of Social Services H.R. Clothier Building Mayville, New York 14757 *(716) 753-4421* http://www.co.chautauqua.ny.us/hservframe.htm
Chemung County Department of Social Services Human Resources Center P.O. Box 588 425 Pennsylvania Avenue Elmira, New York 14902-1795 *(607) 737-5309*	Chenango County Department of Social Services County Office Building P.O. Box 590, 5 Court Street Norwich, New York 13815 *(607) 337-1500*
Clinton County Department of Social Services 13 Durkee Street Plattsburgh, New York 12901 *(518) 565-3300* http://www.clintoncountygov.com/Departments/DSS/index.htm	Columbia County Department of Social Services P.O. Box 458 25 Railroad Avenue Hudson, New York 12534-2514 *(518) 828-9411*

Cortland County Department of Social Services County Office Building 60 Central Avenue Cortland, New York 13045-5590 *(607) 753-5248* http://www.cortland-co.org/dss/	Delaware County Department of Social Services 111 Main Street Delhi, New York 12601-3302 *(607) 746-2325*
Dutchess County Department of Social Services 60 Market Street Poughkeepsie, New York 12601-3302 *(845) 486-3000* http://www.co.dutchess.ny.us/CountyGov/Departments/SocialServices/SSIndex.htm	Erie County Department of Social Services 95 Franklin Street Buffalo, New York 14202-3935 *(716) 858-8000* http://www.erie.gov/depts/socialservices/
Essex County Department of Social Services 7551 Court Street, P.O. Box 217 Elizabethtown, New York 12932-0217 *(518) 873-3302*	Franklin County Department of Social Services Court House 335 West Main Street, Suite 331 Malone, New York 12953 *(518) 483-6770* http://franklincony.org/content/
Fulton County Department of Social Services P.O. Box 549 4 Daisy Lane Johnstown, New York 12095 *(518) 736-5640*	Genesee County Department of Social Services 5130 East Main Street, Suite 3 Batavia, New York 14020-9407 *(585) 344-2580* http://www.co.genesee.ny.us/dpt/socialservices/index.html
Greene County Department of Social Services 411 Main Street P.O. Box 528 Catskill, New York 12414-1716 *(518) 943-3200* http://www.greenegovernment.com/department/socialserv/	Hamilton County Department of Social Services P.O. Box 725- White Birch Lane Indian Lake, New York 12842-0725 *(518) 648-6131*

Herkimer County Department of Social Services 301 North Washington Street, Suite 2110 Herkimer, New York 13350 *(315) 867-1291* http://herkimercounty.org/content/Departments/View/10	Jefferson County Department of Social Services Human Services Building 250 Arsenal Street Watertown, New York 13601 *(315) 782-9030*
Lewis County Department of Social Services P.O. Box 193 Lowville, New York 13367 *(315) 376-5400* http://lewiscountyny.org/content/Departments/View/30?	Livingston County Department of Social Services 3 Murray Hill Drive Mount Morris, New York 14510 *(585) 243-7300* http://www.co.livingston.state.ny.us/dss.htm
Madison County Department of Social Services Madison County Complex P.O. Box 637 Wampsville, New York 13163 *(315) 366-2211* http://www.madisoncounty.org	Monroe County Department of Social Services 111 Westfall Road, Room 660 Rochester, New York 14620-4686 *(585) 274-6000* http://www.monroecounty.gov/hs-index.php
Montgomery County Department of Social Services County Office Building P.O. Box 745 Fonda, New York 12068 *(518) 853-4646*	Nassau County Department of Social Services 101 County Seat Drive Mineola, New York 11501 *(516) 571-4444* http://www.nassaucountyny.gov/agencies/dss/DSSHome.htm
New York City Human Resources Administration 180 Water Street New York, New York 10038 *(877) 472-8411 within the 5 boroughs* *(718) 557-1399 outside of NYC* http://www.nyc.gov/html/hra/html/home/home.shtml	Niagara County Department of Social Services P.O. Box 506, 20 East Avenue Lockport, New York 14095-3394 *(716) 439-7602*

Oneida County Department of Social Services County Office Building 800 Park Avenue Utica, New York 13501-2981 *(315) 798-5733* http://www.ocgov.net/oneidacty/gov/dept/socialservices/dssindex.html	Onondaga County Department of Social Services Onondaga County Civic Center 421 Montgomery Street Syracuse, New York 13202-2933 *(315) 435-2985 or (315) 425-2986* http://www.ongov.net/DSS/
Ontario County Department of Social Services 3010 County Complex Drive Canandaigua, New York 14424 *(585) 396-4060* http://www.co.ontario.ny.us/social_services/	Orange County Department of Social Services Quarry Road, Box Z Goshen, New York 10924-0678 *(845) 291-4000* http://www.co.orange.ny.us/orgMain.asp?orgid=55&storyTypeID=&sid=&
Orleans County Department of Social Services 14016 Route 31 West Albion, New York 14411-9365 *(585) 589-7004* http://orleansny.com/SocialServices/dss.htm	Oswego County Department of Social Services 100 Spring Street, P.O. Box 1320 Mexico, New York 13114 *(315) 963-5000* http://www.co.oswego.ny.us/dss/
Otsego County Department of Social Services 197 Main Street Cooperstown, New York 13326-1196 *(607) 547-7594* http://www.otsegocounty.com/depts/dss/	Putnam County Department of Social Services 110 Old Route Six Building #2 Carmel, New York 10512-2110 *(845) 225-7040* http://www.putnamcountyny.com/socialservices/
Rensselaer County Department of Social Services 133 Bloomingrove Drive Troy, New York 12180-8403 *(518) 283-2000* http://www.rensco.com/departments_socialservices.asp	Rockland County Department of Social Services Building L Sanatorium Road Pomona, New York 10970 *(845) 364-2000* http://www.co.rockland.ny.us/Social/
St. Lawrence County Department of Social Services 6 Judson Street Canton, New York 13617-1197 *(315) 379-2111* http://www.co.st-lawrence.ny.us/Social_Services/SLCSS.htm	Saratoga County Department of Social Services 152 West High Street Ballston Spa, New York 12020 *(518) 884-4140* http://www.co.saratoga.ny.us/dindex.html

Schenectady County Department of Social Services 487 Nott Street Schenectady, New York 12308-1812 *(518) 388-4470* http://www.schenectadycounty.com/default.aspx?m=2	Schoharie County Department of Social Services County Office Building P.O. Box 687 Schoharie, New York 12157 *(518) 295-8334* http://www.schohariecounty-ny.gov/CountyWebSite/index.jsp
Schuyler County Department of Social Services County Office Building 105 Ninth Street - Unit 3 Watkins Glen, New York 14891 *(607) 535-8303* http://www.schuylercounty.us/dss.htm	Seneca County Department of Social Services 1 DiPronio Drive Waterloo, New York 13165-0690 *(315) 539-1800* http://www.co.seneca.ny.us/dpt-divhumserv-children-family.php
Steuben County Department of Social Services 3 East Pulteney Square Bath, New York 14810 *(607) 776-7611* http://www.steubencony.org/dss.html	Suffolk County Department of Social Services 3085 Veterans Memorial Highway Ronkonkoma, New York 11779 *(631) 854-9700* http://www.co.suffolk.ny.us/webtemp3.cfm?dept=17&ID=617
Sullivan County Department of Social Services Box 231, 16 Community Lane Liberty, New York 12754 *(845) 292-0100*	Tioga County Department of Social Services Box 240 Owego, New York 13827 *(607) 687-8300* http://www.tiogacountyny.com/departments/health/social_services/
Tompkins County Department of Social Services 320 West State Street Ithaca, New York 14850 *(607) 274-5336* http://www.tompkins-co.org/departments/detail.aspx?DeptID=41	Ulster County Department of Social Services 1061 Development Court Kingston, New York 12401 *(845) 334-5000* http://www.co.ulster.ny.us/resources/socservices.html

Warren County Department of Social Services Municipal Annex 1340 State Route 9 Lake George, New York 12845 *(518) 761-6300* http://www.co.warren.ny.us/depts.php#SOCIALSERVICES	Washington County Department of Social Services Municipal Center 383 Broadway Fort Edward, New York 12828 *(518) 746-2300* http://www.co.washington.ny.us/Departments/Dss/dss.htm
Wayne County Department of Social Services 77 Water Street P.O. Box 10 Lyons, New York 14489-0010 *(315) 946-4881* http://www.co.wayne.ny.us/departments/dss/dss.htm	Westchester County Department of Social Services County Office Building #2 112 East Post Road White Plains, New York 10601-5272 *(914) 995-5000* http://www.westchestergov.com/health.htm
Wyoming County Department of Social Services 466 North Main Street Warsaw, New York 14569-1080 *(585) 786-8900* http://www.wyomingco.net/socialservices/main.htm	Yates County Department of Social Services County Office Building 417 Liberty Street Penn Yan, New York 14527-1118 *(315) 536-5183* http://www.yatescounty.org/upload/12/dss/frameset.html

NEW YORK STATE
MEDICAID PROGRAM

INFORMATION FOR ALL PROVIDERS

THIRD PARTY INFORMATION

Table of Contents

Third Party Health Resources

Insurance codes are used to identify Third Party Resources (TPR) other than Medicaid and Medicare, under which an enrollee has insurance coverage. Such coverage must be utilized for payment of medical services prior to submitting claims to the Medicaid Program.

Under the Medicaid Eligibility Verification System (MEVS), information specific to TPR will be reported to you when you request eligibility verification of a Medicaid enrollee.

> The MEVS response via the Verifone terminal or alternate access will be a two-digit insurance code.
>
> For **Medicaid Prepaid Capitation Plans** only, the two-digit plan code *and* up to 20 alphabetic coverage codes, or the word "ALL" indicating what services are covered, is displayed. The telephone response will be insurance and coverage codes and a two-digit insurance code and up to 20 messages, or "ALL", indicating which services are covered.

Please refer to the MEVS Provider Manual for more detailed information on eligibility verifications, which can be found at:

http://www.emedny.org/ProviderManuals/index.html.

The MEVS response will include information on a maximum of two third party insurance carriers. If a Medicaid enrollee is covered by more than two carriers, you will receive a response of "ZZ" as an insurance code. "ZZ" indicates additional insurance.

To obtain coverage information when there are more than two carriers, call Computer Sciences Corporation at:

(800) 343-9000.

Insurance Coverage Codes

The following codes are used in MEVS responses to designate the scope of benefits provided by an insurance company.

Code	Description	Explanation
A	Inpatient Hospital	All inpatient services are covered except psychiatric care.
B	Physician In-Office	Services provided in the physician's office are generally covered.
C	Emergency Room	Self-Explanatory.
D	Clinic	Both hospital-based and free-standing clinic services are covered.
E	Psychiatric Inpatient	Self-Explanatory.
F	Psychiatric Outpatient	Self-Explanatory.
G	Physician In-Hospital	Physician services provided in a hospital or nursing home are covered.
H	Drugs No Card	Drug coverage is available but a drug card is not needed.
I	Lab/X-ray	Laboratory and X-ray services are covered.
J	Dental	Self-Explanatory.
K	Drugs Co-pay	Although insurance carrier expects a co-payment, you may *not* request it from the recipient. If the insurance payment is less than the Medicaid fee, you can bill Medicaid for the balance, which may cover the co-payment.
L	Nursing Home	Some nursing home coverage is available. You must bill until benefits are exhausted.
M	Drugs Major Medical	Drug coverage is provided as part of a major medical policy.

Code	Description	Explanation
N	All Physician Services	Physician services, without regard to where they were provided, are covered.
O	Drugs	Self-Explanatory.
P	Home Health	Some home health benefits are provided. Continue to bill until benefits are exhausted.
Q	Psychiatric Services	All psychiatric services, inpatient and outpatient, are covered.
R	ER and Clinic	Self-Explanatory.
S	Major Medical	The following services are covered: physician, clinic, emergency room, inpatient, laboratory, referred ambulatory, transportation and durable medical equipment.
T	Transportation	Medically necessary transportation is covered.
U	Coverage to Complement Medicare	All services paid by Medicare, which require a coinsurance or deductible payment, should be billed to the insurance carrier *prior* to billing Medicaid.
V	Substance Abuse Services	All substance abuse services, regardless of where they are provided, are covered.
W	Substance Abuse Outpatient	Self-Explanatory.
X	Substance Abuse Inpatient	Self-Explanatory.
Y	Durable Medical Equipment	Self-Explanatory.
Z	Optical	Self-Explanatory.
All	All of the above	All services are covered.

Recipient Other Insurance Codes

These codes indicate other insurance carriers under which the enrollee may be covered.

Ins Cd	Description
02	HIP Outpatient
05	Other Insurance Inpt/Outpt
06	Group Health Inc (GHI)
09	Union Inpt/Outpt
10	HIP/HMO
12	BC/BS Empire
14	A&P Health And Welfare
18	Administrative Services Co
20	Aftra Health And Retirement
22	AIG
23	Empire BC
25	Airfreight Warehouse Corp
27	Albany International
28	Allied International Union
29	Allied Security Health & Welfare
30	Amalgamated Services
31	Amerco
32	American Medical Life Ins
34	America's Choice Health Plan
35	Amerihealth Administrators
36	Atlantis Health
38	BACL5NY Welfare Fund
39	Bakers Local 3
40	Bakery Drivers Local 802
41	BC/BS Carefirst
42	BC/BS Healthflex Now
43	BC/BS of Alabama
44	BC/BS of Greater NY
45	Empire BS
47	BC/BS of Iowa-Wellmark
48	BC/BS of Minnesota
49	BC/BS of North Dakota
50	BC/BS of Rhode Island
51	BC/BS through SSA
52	Benefit Concepts
53	Benesight PCHS
54	Better Health Advantage
55	BC/BS PP
56	BC of NY
58	Capitol Administrators
59	Carpenters Healthcare Plan
60	CBSA
61	Central States
62	CENTRUS
65	Chatwins Healthcare Administrators

Ins Cd	Description
66	Christian Brothers Employees
67	Citywide Central Ins Program
69	Coalition for Care
70	Cole Managed Vision
71	Combined Welfare Fund
72	Coresource Inc.
74	Custom Coverage
88	Elderplan
90	Davis Vision
99	New HIP
A1	Union Am Postal Workers
A2	American Psych Systems
A3	American Medical Life Ins Co
A4	Anthem Life
A5	Aetna Medicare Cost
A6	American National
A7	American Pioneer Life Ins Co
A8	Alta Health Strategies
A9	Wells Fargo
AA	Accident Insurance
AC	Aetna Life Insurance Co
AD	Aetna Variable Annuity Life Ins
AE	Countryway Insurance Company
AF	American Family Life Insurance
AG	Allstate Life Insurance Co
AH	Amalgamated Life Ins Co Inc
AI	Allstate Insurance CO
AJ	Absent Parent Responsibility
AK	Allied Benefit Administrators
AL	American Group Administrators
AM	Americorps
AO	Alta Rx Prescription Drugs
AP	AARP
AQ	American Integrity Ins Co
AS	Assoc Plan Admin Inc (APA)
AU	American Medical Ins Co
AY	Virginia Surety Company Inc
AZ	American Progressive Health Ins Co
B1	BC/BS Highmark
B2	BS of Florida
B3	BS of Massachusetts
B4	BC/BS of Tennessee
B5	BC/BS of Northeast Ohio

Ins Cd	Description
B6	BC/BS of New Jersey
B7	Blue Choice Preferred
B8	BC Utica
B9	BS Utica
BA	Banker's Life Company
BB	Banker's Multiple Life Ins Co
BB1	Regence BC/BS of Oregon
BCN	BC/BS of Nebraska
BC	BC Central NY
BE	BS Western NY
BF	Benefit Trust Life Ins Co
BG	BS Central NY
BH	BS Northeastern NY
BI	BS Western NY
BJ	BC Rochester
BK	BS Rochester
BL	BC New Jersey
BM	BS New Jersey
BN	BC/BS of Central NY–Excellus BC/BS
BO	BC/BS of Northeastern NY
BP	BC/BS of Western NY
BQ	BC/BS of Connecticut
BR	BC/BS of Florida
BS	Dental Pay
BT	BC/BS Massachusetts
BV	BC/BS of Vermont
BW	BC Florida
BY	BC of Massachusetts
BZ	BC of Northeastern PA
C1	BC Capital (Pennsylvania)
C3	Capital District Physicians Health Plan
C4	CIGNA
C5	Community Blue (Buffalo)
C6	Choicecare
C8	Confederation Life Ins
C9	Claim Management Services
CA	Tricare Region 1 Claims/CHAMPUS
CB	Colonial Penn Franklin Ins Co
CBS	Corporate Benefit Services of America
CC	Continental Assurance Co
CD	Continental Casualty Co
CE	BC/BS Michigan
CF	BC/BS California
CH	Chubb Life America
CJ	Columbian Mutual Life Ins Co
CK	Combined Life Ins Co of NY
CL	Serv Employees Welfare Fund Union
CM	Comm Travelers Mutual Ins Co
CN	Catskill School Emp Ben Fund Union
CO	Companion Life Ins Co
CR	Consolidated Mutual Ins Co

Ins Cd	Description
CS	Continental American Life Ins Co
CT	Continental Ins Co
CU	CSEA Union
CY	BC/BS Greater NY HMO
D1	BC/BS of the National Capitol Area
D2	ERISCO
D3	Pro Ins Agentents Grp
D4	Oxford Ins Co
D5	DC 37 Health & Security Plan
D6	Benefit Management of Maine
D7	BS of NE Pennsylvania
D8	Chesterfield Resources Inc
D9	Local 32 Health & Pension Fund Union
DA	Benefit Administrators Ins
DB	BC California
DC	Benefit Management Services
DE	BC/BS Delaware
DF	BC/BS Illinois
DG	Diversified Group Brokerage Corp
DH	Comprehensive Benefits Co
DI	Celtic Life Ins Co
DJ	BC/BS Missouri
DK	BC of Philadelphia
DL	Oxford Health Plan Mcare Risk
DP	Diversified Pharmaceutical Svc
DR	HIP Greater NY – Medicare Cost
DS	HIP Greater NY – Medicare Risk
DV	Caremark
DW	Blue Preferred HMO (Utica)
DX	Delta Dental
E1	Equicor
E2	Employee Security Fund
E3	Elm-Co Agency Inc
E5	Express Scripts
E7	BC/BS HMSA
EA	Empire State Mutual Life Ins Co
EB	Equitable Life Assurance Co
EC	Emp Mutual Liability Ins Co of Wis
ED	Equitable Life Ins Co of Iowa
EF	Executive Life Ins Co of NY
EJ	Self Insured
EM	Empire Plan/State Employees
ES	Empire St Carpenters Wlfr Bnft Fnd
F1	First Fortis (Medical)
F2	First Health
F3	Corporate Health Administrators
F5	Pan American Life
F6	SNL Administrators
F7	United Health Care

Ins Cd	Description
F8	Vytra Health Care
F9	First Cardinal
FB	Farmer's/Traders Live Ins Co
FE	Fidelity and Casualty Co of NY
FF	Fidelity Mutual Life Ins Co
FG	Diversified Group Administrators
FH	Fireman's Ins Co of Newark NJ
FI	Fireman's Fund American Life Ins
FJ	Eastern Benefit Systems Inc
FK	Excellus Rx
FL	Pharma Care
FM	ECPA
FN	Educator's Mutual
FQ	EOCNC/Multiplan
FR	Foundation Health Plan
FU	United American Life Ins Co
G1	Group Administrators
G2	Guardian Choice
G4	BC/BS Georgia
GA	Guardian Ins & Annuity Co Inc
GC	Gerber Life Ins Co
GE	Government Employees Health Assoc.
GF	EPOCH Group
GG	Govt Emp Life Ins Co NY (Union)
GI	Assure Care
GJ	Guardian Life Ins Co of America
GK	Genesee Valley Grp Hlth Plan (Roch)
GL	Eye med Vision Plan
GO	FCE Benefit Administrator
GW	Great West Life
GX	Longview Fibre Self Insured
GZ	Medical Claims Service
H1	Hollow Metal Trust Fund
H4	First Rehabilitation Life
H8	Gallagher Bassett Service
HA	HIP – Health Ins Plan of Greater NY
HB	BCS Insurance Company
HC	Health and Welfare Life Ins Assoc
HD	BC of Utica – Hospital Serv Corp
HE	Hartford Acc/Indem Co
HF	Hartford Life Ins Co
HG	Magna Care
HH	National Medical Health Card Systems
HI	Home Life Ins Co
HJ	Health Plan Administrators
HL	Health Care Plan (Buffalo) – Univera
HM	HIP of NJ
HN	Health Services Medical Corp
HO	BC/BS of Utica – Excellus BC/BS
HP	BC of Utica–Hsp Srv Pln Lehigh Valley

Ins Cd	Description
HQ	Health Economics Group
HS	Healthways Inc
HU	Healthnet
HV	Health Claim Services
HZ	Horizon Healthcare
IA	Int Life Investors Ins Co
IB	Genworth Financial
ID	INDECS
IF	Independent Health Assoc Inc
IG	General American Life
IH	Income Protection Policy-Inpt Assign
IJ	HMO CNY
IK	BC Independence (PA)
IT	ITT Life Ins Corp
J1	JJ Newman and Co
J2	Justo Inc
J3	Advantage Health Plan
J4	North Americare
J5	Phoenix Group Services
J8	Jardine Group Services
JA	JC Penney Ins Co
JB	John Deere Ins Co
JP	General Vision
JU	GPA
JX	Group Ins Service Center
K1	Value Behavioral Health
KC	BC/BS Kentucky
KM	BC/BS WNY Sr. Blue
KN	ASO Health Plans
KO	Integ Alternatives Comm Network
L2	Louisiana Office of Grp Benefits
LA	Liberty Mutual Life Ins Co
LB	Liberty Life Assurance Co
LC	Lincoln National Life Ins Co/NY
LD	APA Partners
LG	Lumbermans Mutual Ins Co
LH	Teamsters Local 182 – Union
LI	Life of America Ins Co
LO	Local 1199 – Union
LW	Harvard Pilgrim
M1	The Maxon Co
M3	McCrew Care
M4	BC/BS Montana
MB	Mutual of Omaha Ins Co
MC	Unicare
MD	Medi-Plan
ME	Mail Handlers Benefit Plan

Ins Cd	Description
MF	Medical Administrators
MG	Metropolitan Ins and Annuity
MH	Upstate Administration Svc
MI	United Food Workers – Union
MJ	Monarch Life Ins Co
ML	Montgomery Ward
MM	Mutual Benefit Life Ins Co
MN	Mutual Life Ins Co NY
MP	Mutual Protective/Medico Life Ins Co
MQ	Mohawk Valley Physicians Hlth Plan
MS	Milk Plant Emp Welfare Trust – Union
MT	Mid-Hudson Health Plan
MX	MGA Plan Administrators
N1	National Prescription Admin (NPA)
N2	National Benefit Life Ins Co
N3	National Prescription Svcs
N4	NYS Auto Dealers Assoc
N5	NY Farm Bureau/NYS BG
N6	North Medical Comm Hlth Plan
N7	National Assoc of Letter Carriers
N8	Nassau Co Retiree Health Plan
NA	NY Dental Svcs Group
NB	NY School Athletic Protect/Plan
NC	National Casualty Co
ND	NY Life Insurance Co
NE	Nationwide General Ins Co
NF	First Providian Life/Health Ins
NG	Northcare Partners
NH	Nippon Life Ins
NI	National Ins Svcs Inc
NJ	Partners Health Plan
NK	Nationwide Life Ins Co
NL	New England Mutual Life Ins Co
NM	Meritain Health
NO	Nova Healthcare
NR	Northwestern Nat Ins Co
NS	New Hampshire/Vermont Health Svc
NT	BC/BS of North Carolina
NY	Health Scope Benefits Inc
OA	Healthnow
OB	HEREIU – Union
OX	Hotel Association of NYC
P1	Principal Mutual Ins Co
P3	Pharm Serv Corp of NY (PSCNY)
P5	HRA
P6	Humana
PA	Prudential
PB	Paul Revere Life Ins Co
PC	Phoenix Mutual Life Ins Co

Ins Cd	Description
PD	Peerless Ins Co
PE	Healthsource Inc
PG	Penn General Srv of New England Inc
PI	Pacific Care
PJ	IAA
PK	IBOTV Health and Welfare Fund
PL	Premier Health Network
PM	Provident Life and Accident Ins
PO	Provident Mut Lf Ins Co-Philadelphia
PP	MEDCOHEALTH
PR	Preferred Care
PT	BS Pennsylvania
PU	Pomco Ins
PW	Premera Blue Cross of Washington
Q3	MDNY Healthcare
R1	Catalyst Rx
R3	Equitable Plan Services
R4	Harrington Benefit Services
RA	Insurance Design Administrators
RB	Insurance Management Services
RC	International Benefit Administrator
RD	Island Group Administration
RE	Rochester Health Network
RF	Excellus Blue Cross Blue Shield
RG	HIP Rutgers Health Plan of NJ
RM	RMSCO Insurance
RX	RX West
S1	BC/BS of South Carolina
SB	Sieba Ltd
SD	Susquehanna Administrators Inc
SE	Sears Roebuck and Company
SG	Security Mutual Life Ins Co
SH	Sentry Life Ins Co of NY
SL	St Lawrence/Lewis Schools Ins
SM	Sanus Health Plan – Medicare Risk
SO	Jockey Group Health Plan
SQ	State Farm Life and Accid Assurance
SS	State Mutual Lf Assurance Co/America
SU	Assurant Employee Benefits
SV	Security 65 Plan
SX	Sanus Health Plan
SZ	Suffolk Cty Employee Health Plan
T1	BC/BS Texas
TA	Teachers Ins and Annuity Trust-Union
TB	Travelers
TC	Transamerica Ins Co
TD	Transworld Life Ins Co of NY
TE	John Alden

Ins Cd	Description
TL277	Teamsters Local 277
TP	Prime Therapeutics Pharmacy
TR	Trademark
TU	Travelers Health Network
U1	Bakery and Confect Workers – Union
U2	US Health Care – Medicare Risk
U9	Industry Workers Local 424 – Union
UA	Union Labor Life Ins Co
UB	Union Mutual Life Ins Co
UC	Key Medical/Regence Life
UD	LMH Self Funded Medical Plan
UH	United Mutual Life Ins Co
UL	US Life Ins Co
UO	Utica Mutual Ins Co
UP	Union Fidelity Life of PA
VA	Veterans Aid
W1	Wachovia Insurance
WA	Washington Nat Life Ins Co
WB	Workers Comp
WF	Fiserv

Ins Cd	Description
WI	Whole Health Ins Network
WJ	WJ Jones Admin Svcs
WL	Westchester Gen Labor Welfare Fund
WM	WalMart Self-Ins – Union
WP	William Penn Ins Co of NY
WR	Wellpoint Next Rx
WS	Wassau (NY/NJ Wrkrs Cmp Claim Off)
WT	Wellcare
WV	BC/BS West Virginia
XR	United Concordia Co Inc
ZB	Zurich Insurance Company

Prepaid Capitation Plans (PCP)

Note:

LTC	Long Term Care
PCMP	Physician Case Management Program
FHP	Family Health Plus
SNP	Special Needs Plan
MA	Medical Assistance
ADV	Advantage

MEVS Values	PCP Provider Name	Telephone Number	Plan Type
AN	Hebrew Home Hospital, Inc. (Co-op Care Plan)	(718) 379-5020 or (888) 830-5620	Partial LTC
AR	Patel, Arjunj MD PC (Broome Max)	(607) 758-2543	PCMP
AT	Dygert, Stephen		PCMP
AW	Homefirst, Inc.	(718) 630-2560 or (877) 771-1119	Partial LTC
C2	HealthNow NY, Inc. (Community Blue)	(716) 887-6900	Mainstream
C7	Comprehensive Care Management Corporation	(718) 515-5600 or (877) 226-8500	LTC Pace
CG	Capital District Physician's Health Plan	(716) 885-2261	Mainstream
CV	Capital District Physician's Health Plan	(716) 885-2261	Mainstream
DC	United Medical Associates		PCMP
DD	Driscoll, Dan		PCMP
DY	Lourdes Primary Care Assoc. (Broome Max)	(607) 778-2707	PCMP
E4	PCMP IIA Gold Choice	(716) 898-5968	PCMP
E7	Senior Care Connection	(518) 382-3290	LTC Pace
FO	United Health Services Hospital	(607) 762-3173	PCMP
G3	Bhard-Waj, Gaur MD (Broome Max)	(607) 770-0004	PCMP
GD	Partners in Community Care	(845) 368-5943	Partial LTC
GH	Group Health, Inc. PPO	(518) 446-8010	FHP
GK	GHI HMO Select A	(518) 446-8055	Mainstream
GN	Guildnet	(212) 769-6200	Partial LTC
H1	Senior Health Partners, Inc.	(212) 870-4610	Partial LTC
H4	GHI HMO Select B	(518) 446-8055	Mainstream
HT	HIP of Greater NY	(646) 447-5000	Mainstream
HW	HIP Westchester	(646) 447-5000	Mainstream
HY	HIP Nassau	(646) 447-5000	Mainstream
IE	Independent Health Association	(716) 631-3086	Mainstream
IN	Independent Health Association	(716) 631-3086	Mainstream
IL	Independent Living for Seniors	(585) 922-2836	LTC Pace
IS	Loretto HMO	(315) 469-5570	LTC Pace
IX	Independent Care Systems	(212) 584-2500	Partial LTC
KP	Amerigroup NY, LLC	(800) 535-2814 or (800) 563-5581	Mainstream
KX	Amerigroup Community Connections	(212) 372-6942	Partial LTC
LE	LI Health Partners (Broadlawn)	(516) 336-2006	Partial LTC
M3	Health Advantage Plans, Inc. (Elant Choice)	(845) 569-0500	Partial LTC
M4	Addo, Samuel (Broome Max)	(607) 729-9327	PCMP
MO	United HealthCare of NY, Inc. (Met Life)	(212) 216-6824	Mainstream
MR	Excellus	(585) 454-1700	Mainstream
MV	MVP, Inc. (Dutchess & Ulster Counties)	(518) 388-2427	Mainstream
MZ	Senior Network Health, LLC	(888) 355-4764	Partial LTC

MEVS Values	PCP Provider Name	Telephone Number	Plan Type
N6	Total Aging in Place	(716) 250-3100	Partial LTC
NP	Neighborhood Health Provider PHSP	(800) 558-7970	Mainstream
NW	NY Presbyterian Community PHSP, Inc.	(212) 297-5510	Mainstream
OD	VidaCare, Inc. SN	(212) 337-5180	SNP
OG	NY Presbyterian System Select Health SN	(866) 469-7774	SNP
OM	Metroplus Partnership Care SN	(212) 597-8600	SNP
OZ	Univera	(716) 857-4448	Mainstream
PH	Southern Tier Priority HC	(607) 795-5215	PCMP
PQ	Preferred Care	(716) 325-3920	Mainstream
SA	TotalCare (Syracuse PHSP)	(315) 476-7921	Mainstream
SF	HealthFirst PHSP, Inc.	(800) 580-8540 or (212) 801-6000	Mainstream
SK	Suffolk Health Plan HMO	(800) 763-9132	Mainstream
SP	NYS Catholic Health Plan, Inc. (Fidelis)	(800) 749-0820	Mainstream
CW	NYS Catholic Health Plan, Inc. (Fidelis)	(800) 749-0820	Mainstream
SR	Saeed, Azmat MD	(607) 748-7355	PCMP
SL	Saeed, Azmat MD	(607) 748-7355	PCMP
SY	Southern Tier Pediatrics PC	(607) 734-3252	PCMP
TF	CCM Select	(718) 515-8600	Partial LTC
VC	VNS Choice	(212) 609-5600	Partial LTC
VG	Giordano, Vincent		PCMP
WC	Wellcare of NY, Inc.	(800) 960-2530	Mainstream
WH	Hudson Health Plan, Inc.	(914) 631-1611	Mainstream
WK	Broome County Max Program	(607) 778-2702	PCMP
WN	Wellcare of NY, Inc.		Partial LTC
WR	Ramanujan Ramanujapuram	(607) 723-1676	PCMP
WU	Wellcare of NY, Inc.		MA Adv Plus
Y2	Neighborhood Health Provider, LLC	(212) 883-0883	MA Advantage
Y4	Group Health Inc.	(866) 557-7300	MA Advantage
Y8	Managed Health, Inc.	(212) 801-1638	MA Advantage
Y9	Liberty Health Advantage	(866) 542-4269	MA Advantage
YA	Americhoice of NY	(212) 509-5999	MA Advantage
YC	HIP Health Plan of NY	(646) 447-6200	MA Advantage
YD	Fidelis Dual Advantage	(718) 896-6500	MA Advantage
YM	MetroPlus MA Advantage		MA Advantage
YQ	HealthNow of NY		MA Advantage
YR	Senior Whole Health		MA Advantage
YS	Oxford Health Plan Mosaic	(914) 467-1009	MA Advantage
YT	Touchstone HP (Prestige)	(888) 777-0350	MA Advantage
YW	Wellcare of NY, Inc.	(212) 337-5180	MA Advantage
YX	Oxford Health Plans	(914) 467-1009	MA Advantage
YY	Affinity		MA Advantage
77	Health Plus PHSP, Inc.	(718) 745-0030	Mainstream
82	Affinity Health Plan, Inc.	(800) 553-8247	Mainstream
91	Centercare, Inc. (Manhattan PHSP)	(800) 545-0571	Mainstream
92	Metroplus Health Plan, Inc.	(800) 597-3380	Mainstream
98	HIP of Greater NY	(646) 447-5000	Mainstream
99	HIP of Greater NY	(646) 447-5000	Mainstream

County/District Codes

Below is a listing of all the counties and their corresponding district codes.

01	Albany
02	Allegany
03	Broome
04	Cattaraugus
05	Cayuga
06	Chautauqua
07	Chemung
08	Chenango
09	Clinton
10	Columbia
11	Cortland
12	Delaware
13	Dutchess
14	Erie
15	Essex
16	Franklin
17	Fulton
18	Genesee
19	Greene
20	Hamilton
21	Herkimer
22	Jefferson
23	Lewis
24	Livingston
25	Madison
26	Monroe
27	Montgomery
28	Nassau
29	Niagara
30	Oneida
31	Onondaga
32	Ontario
33	Orange
34	Orleans
35	Oswego
36	Otsego
37	Putnam
38	Rensselaer
39	Rockland
40	St. Lawrence
41	Saratoga
42	Schenectady
43	Schoharie
44	Schuyler
45	Seneca
46	Steuben
47	Suffolk
48	Sullivan
49	Tioga
50	Tompkins
51	Ulster
52	Warren
53	Washington
54	Wayne
55	Westchester
56	Wyoming
57	Yates
66	New York City
97	Office of Mental Health Administered
98	Office of Mental Retardation & Developmental Disabilities
99	Breast & Cervical Cancer Treatment Program

NEW YORK STATE
MEDICAID PROGRAM

DENTAL MANUAL

POLICY GUIDELINES

Table of Contents

Section I - Requirements for Participation in Medicaid

Dentists must be licensed and currently registered by the New York State Education Department (NYSED), or, if in practice in another state, by the appropriate agency of that state, and must be enrolled as providers in the New York State Medicaid Program.

No dentist who has been suspended or disqualified from the Medicaid Program may receive reimbursement by the Medicaid Program, either directly or indirectly, while such sanctions are in effect.

Qualifications of Specialists

A specialist is one who:

- Is a diplomate of the appropriate American Board; or
- Is listed as a specialist in the section on character of practice in the American Dental Association's American Dental Directory; or
- Is listed as a specialist on the roster of approved dental specialists of the New York State Department of Health (DOH).

All dentists enrolled in the Medicaid Program are eligible for reimbursement for all types of services except for orthodontic care, examination by an oral surgeon, or dental anesthesiologist, general anesthesia, and parenteral conscious sedation. *There is no differential in levels of reimbursement between general practitioners and specialists*.

Orthodontic care is reimbursable only when provided by an orthodontist or an Article 28 facility which has met the qualifications of the DOH.

General anesthesia and parenteral conscious sedation are reimbursable only when provided by a qualified dentist who is certified in dental anesthesia by the NYSED.

Examination by an oral surgeon or dental anesthesiologist is reimbursable only when provided by a qualified individual as defined above.

Group Providers

A group of practitioners is defined in 18 NYCRR 502.2 as "…two or more health care practitioners who practice their profession at a common location (whether or not they share common facilities, common supporting staff, or common equipment)."

Regardless of the arrangement among practitioners (associates, employer-employee, principal-independent contractor), practitioners who practice in a group setting are

required to enroll as a group and to comply with the requirements associated with group practices.

Application of Free Choice

A Medicaid patient is guaranteed free choice of a dental provider in obtaining the dental care available under the New York State Medicaid program.

Credential Verification Reviews

Credential Verification Reviews (CVRs) are periodic onsite visits of a provider's place of business to ensure overall compliance with Medicaid regulations. These visits are conducted by the Medicaid Program, and assess such areas as:

- provider and staff identification and credentialing
- physical attributes of the place of business
- recordkeeping protocols and procedures regarding Medicaid claiming.

CVRs are conducted for such sites as:

- physician and dental offices
- pharmacies
- durable medical equipment retailers, and
- part time clinics.

We do not perform CVRs at hospitals, nursing homes, etc.

Every effort is made to conduct these visits in a professional and non-obtrusive manner. Investigators conducting these reviews will have a letter of introduction signed by the Regional Director for the Bureau of Investigations and Enforcement and a photo identification card.

Should providers, or their staff, have questions regarding these reviews, they can contact:

for Rockland, Westchester, Nassau, Suffolk Counties and New York City

Regional Director
Bureau of Investigations and Enforcement
Metropolitan Area Regional Office
(212) 383-4681

for all upstate counties

Upstate Regional Director
(518) 474-4911.

Section II - Dental Services

Dental Care in the Medicaid Program shall include only **essential services** rather than comprehensive care. The provider should use this Manual to determine when the Medicaid program considers dental services "essential". The application of standards related to individual services is made by the DOH when reviewing individual cases.

Dental clinics licensed under Article 28 and dental schools must follow the policies stated in this Manual and should use this Manual to determine when dental services are considered "essential" by the Medicaid program.

> *These clinics and schools are exempt from the prior approval procedure (except for orthodontia) because of internal quality assurance processes that insure their compliance with existing Medicaid policy*.

Standards of Quality

Services provided must conform to acceptable standards of professional practice.

Quality of Services Provided
Dental care provided under the Medicaid program must meet as high standards of quality as can reasonably be provided to the community-at-large. All materials and therapeutic agents used or prescribed must meet the minimum specifications of the American Dental Association, and must be acceptable to the State Commissioner of Health. Experimental procedures are not reimbursable in the Medicaid program.

Scope of Hospitalization Services

Medicaid recipients are provided a full range of necessary diagnostic, palliative and therapeutic inpatient hospital care, including but not limited to dental, surgical, medical, nursing, radiological, laboratory and rehabilitative services.

Limitations of Hospitalization
Medicaid utilization review (UR) agents are authorized to review the necessity and appropriateness of hospital admissions and lengths of stay, and to determine Medicaid benefit coverage. These review agents will be reviewing inpatient dental services both on a pre-admission and retrospective basis. Emergency admissions may be reviewed retrospectively for necessity and appropriateness.

If you have any questions regarding specific Medicaid hospital review requirements, you may contact the DOH, Bureau of Hospital and Primary Care Services at:

(518) 402-3267.

Child/Teen Health Program

Please refer to the EPSDT/CTHP Provider Manual for Child Health Plus A (Medicaid), available at the following website:

http://www.emedny.org/ProviderManuals/index.html

Child Health Plus Program

The goal of the Child Health Plus Program is to improve child health by increasing access to primary and preventive health care through a subsidized insurance program. A child eligible for Medicaid is not eligible for Child Health Plus.

For more information on benefits, contact the Child Health Plus Program at:

(800) 698-4543.

Dental Mobile Van

The use of mobile vans to provide the operatories for the provision of dental services has become more prevalent than in the past.

In recognition of this trend, additional information about the use of such vans or other movable vehicles is requested of dentists seeking to enroll into the Medicaid program for the first time.

As an enrolled dental provider, if you have obtained a van (or other movable vehicle), for the provision of dental services subsequent to your enrollment, you must update your enrollment information. Provider Maintenance Forms are available online at:

http://www.emedny.org/info/ProviderEnrollment/index.html

and must be sent to:

Computer Sciences Corporation
P.O. Box 4610
Rensselaer, New York 12144

Requirements and Expectations of Dental Clinics

General Expectations

- Dental clinics reimbursed on a rate basis (i.e., hospital outpatient departments, diagnostic and treatment centers, and dental schools) are required to follow the policies stated in the Dental Provider Manual.

- The provision of dental care and services are limited in those procedures presented in the Dental Fee Schedule, and are to be provided within the standards and criteria listed in the procedure code descriptions.

- Dental care provided under the Medicaid Program includes only *essential services* (rather than "comprehensive" services).

- When billing:

  - Certifying that the services were provided;

  - Entering the group Medicaid ID number in the Medicaid Group Identification Number field;

  - Entering the Medicaid ID number of the practitioner who actually provided the service in the "Provider Identification Number" field; and

  - Where services are provided at multiple locations, identifying the place of **actual service** on the claim form.

Services Not Within the Scope of the Medicaid Program

- Dental implants;

- Aesthetic veneers, such as porcelain fused to metal crowns (for other than anterior teeth and maxillary first bicuspids);

- Fixed bridgework, except for cleft palate stabilization, or when a removable prosthesis would be contraindicated;

- Immediate full or partial dentures;

- Molar root canal therapy for patients 21 years of age and over, except when extraction would be medically contraindicated or the tooth is a critical abutment for an existing serviceable prosthesis;

- Crown lengthening;

- Replacement of dentures prior to required time periods (currently 4 years), unless appropriately documented and justified as stated in the Manual;

- Dental work for cosmetic reasons or because of the personal preference of the patient;

- Periodontal surgery, except for procedure D4210 – gingivectomy or gingivoplasty, for the sole correction of severe hyperplasia or hypertrophy associated with drug therapy, hormonal disturbances or congenital defects;

- Adult orthodontics, except in conjunction with, or as a result of, orthognathic surgery;

- Placement of sealants for patients over 15 years old;

- Improper usage of panoramic X-rays (00330) along with intraoral complete series X-rays (00210).

Services Which Do Not Meet Existing Standards of Professional Practice

- Partial dentures provided prior to completion of Phase I restorative treatment which includes removal of all decay and subsequent fillings;

- Extraction of clinically sound teeth for the purpose of placing a partial denture;

- Infected teeth left untreated;

- Restorative fillings redone over a short time period without clinical indication;

- Restorative treatment of teeth that have a hopeless prognosis and should be extracted;

- “Unbundling” of procedures.

Miscellaneous Issues

- Patient medical histories should be updated periodically (annually at a minimum) and be maintained as part of the patient’s dental records. The treating practitioner should refer to the patient history to avoid unnecessary repetition of services.

- Non-emergency initial visits should include a cleaning, X-rays (if required), and a dental exam with a definitive treatment plan. Generally, this should be accomplished in one visit. However, in rare instances, a second visit may be needed for completion of these services. A notation in the record to indicate the necessity for a second visit should be made.

- Quadrant dentistry should be practiced, wherever practicable, and the treatment plan followed in normal sequence.

- Procedures normally requiring multiple visits (i.e., full dentures, partial dentures, root canals, etc.) should be completed in a number of visits that would be considered consistent with the dental community at large. If additional visits are required, a notation in the patient record to indicate the necessity for each additional visit should be made.

- Dental X-rays should be clear and allow for diagnostic assessment. They are performed based on need, age, prior dental history and clinical findings.

- Facilities should use the Department's PVR 292 list (providers who may not bill or order services) when checking and verifying the credentials of the dental professionals that make up their staff.

  This list is currently available on the Department's website at:

  http://www.health.state.ny.us/health_care/medicaid/fraud/dqprvpg.htm

Section III - Basis of Payment for Services Provided

Payment for dental services is limited to the lower of the usual and customary fee charged to the general public or the fee developed by the DOH and approved by the New York State Director of the Budget.

Payment for Services Not Listed on the Dental Fee Schedule

If an "essential" service is rendered that is not listed in the fee schedule, the fee will be determined by the DOH, which will use the most closely related service or procedure in the fee schedule as a base.

Payment for Orthodontic Care

Orthodontic care for severely handicapping malocclusions will be reimbursed for an eligible recipient for a maximum of three years of active orthodontic care, plus one year of retention care.

Cleft palate or approved orthognathic surgical cases may be approved for additional treatment time.

Dental Services Included in a Facility Rate

In State
Dental services are included in certain facility rates. Payment for services to residents of such facilities will not be made on a fee-for-service basis. Dental providers should seek reimbursement for services provided to Medicaid-eligible residents of all New York State Residential Health Care Facilities (RHCF) and some Intermediate Care Facilities for the Developmentally Disabled (ICF-DD) directly from such facilities. It is the responsibility of the ICF-DD to inform the provider if dental services are included in the rate.

Out of State
It is the responsibility of the out-of-state RHCF or ICF-DD to inform the provider if dental services are included in the rate.

Payment in Full

Fees paid by the Medicaid Program shall be considered full payment for services rendered. No additional charge may be made by a provider.

Limitations of Payment

Payment on a fee-for-service basis may not be made to a dentist salaried by a hospital, residential health care facility, or treatment and diagnostic center (free standing clinic)

for services performed in that facility when any portion of the salary is for direct care of patients and there is any prohibition against fee-for-service reimbursement in law, in the rules of the particular facility, or in the contractual agreement with the salaried dentist or dental group.

Medicare and Other Third-Party Insurers

Medicare and other third-party insurers provide reimbursement for various dental procedures. Since Medicaid is the payer of last resort, the dentist must bill the Recipient's third-party payers prior to requesting payment from Medicaid.

Medicaid will reimburse the **difference** only if the third party payment(s) is (are) less than the maximum Medicaid reimbursement for that specific procedure code.

Unspecified Procedure Codes

Unspecified procedure codes at the end of each section of the fee schedule are miscellaneous codes applicable to procedures within the scope of the Medicaid program, but for which suitable procedure codes do not currently exist.

Prior Approval Requirements

Procedures that require prior approval must not begin until the dentist has received approval from the DOH. When any portion of a treatment plan requires prior approval, a **complete** treatment plan listing all necessary procedures must be listed and coded on the prior approval request form. No treatment other than provision of symptomatic relief of pain/infection is to be instituted until such time as cases have been reviewed and a prior approval determination made.

Multiple restorations which are placed in teeth which are subsequently determined to need extraction as part of an approved prosthetic treatment plan are not acceptable if they were provided less than six months prior to the date of the prosthetic prior approval request.

When a treatment plan has been denied, services that were a portion of that plan will not be subsequently approved.

When Prior Approval is Required

Dental procedures that require prior approval are identified in the Procedure Code section of this Manual. All underlined procedure codes require prior approval. Prior Approval must be obtained from the DOH. When procedures are to be performed on an inpatient basis, the protocol established by the hospital for utilization review must be followed.

Emergency Prior Approval

Surgical Services
Emergency treatment is defined as care for severe, life-threatening or potentially disabling conditions that require immediate surgical intervention and a surgical procedure requiring prior approval is most appropriate. Upon completion of the procedure, it will be necessary to submit a written prior approval request to the DOH along with a description of the procedures performed and an explanation of the nature of the emergency. Without this approval the claim cannot be paid.

Non-Surgical Services
When a non-surgical procedure appears to be the definitive treatment of choice, palliative treatment should be initiated to alleviate the emergency condition until prior approval is received for the definitive treatment.

Recipient Restriction Program

Recipients who have been assigned to a designated dentist are required to receive all dental care from the selected provider as a condition of the recipient restriction program (RRP). All claims from other dentists will be denied except under the following circumstances:

- In cases where the primary dentist has referred a recipient to another dentist and the referring provider ID number field of the claim form is appropriately completed; and

- In cases where the service is provided in an inpatient setting.

RRP: Ordered Services
Restricted recipients may only receive certain ancillary services if they are ordered/prescribed by their primary provider. Primary dentists must order/prescribe the following ancillary services related to dental care for recipients restricted to their practice: laboratory, durable medical equipment and pharmacy. The only exception to this policy is when a primary dentist refers a restricted recipient to another dental provider for service. The provider to whom the recipient was referred may also order ancillary services; however, the servicing dental provider must enter the EMEDNY provider number of the patient's primary dentist on all order/prescription forms.

If the recipient is also restricted to a physician or clinic, this provider must order all non-emergency transportation services. If non-emergency transportation is necessary, dentists treating restricted recipients must contact the recipient's primary physician or clinic and request these services

RRP: Referrals

Primary providers may refer restricted recipients to other providers when necessary. When doing so, the primary dentist must give the servicing provider his/her MEDICAID provider ID number so that the servicing provider can perform the necessary EMEVS steps and properly submit claims.

Utilization Threshold

Under the Utilization Threshold Program, it is necessary for providers to obtain an authorization from the Medicaid Eligibility Verification System (MEVS) to render services for physician, clinic, laboratory, pharmacy, mental health clinic and dental clinic. This authorization to render services will be given unless a recipient has reached his/her utilization threshold limits. At this point, it will be necessary for an ordering provider to submit a special "Threshold Override Application" form in order to obtain additional services. In certain special circumstances, such as emergencies, providers do not have to receive authorization from MEVS. (See special instructions in the Billing Section of this Manual.) Arrangements have also been made to permit a provider to request a service authorization on a retroactive basis. In requesting a retroactive service authorization you risk your request being denied if the recipient has reached his/her limit in the interim. After you receive an authorization your claim may be submitted to our Fiscal Agent for processing. The regulation requiring claims to be submitted within 90 days of the date of service still applies.

- Laboratories and pharmacies may not submit a request for an increase in laboratory or pharmacy services. Such requests are to be submitted by the ordering provider. Laboratories which need to determine whether tests are needed on an emergency or urgent basis shall consult with the ordering provider, unless the order form indicates that an urgent or emergency situation exists.

- Those limited laboratory services which can be rendered by a physician or podiatrist in private practice to his/her own patients do not count toward the laboratory utilization threshold.

- Utilization Thresholds will not apply to services otherwise subject to thresholds when provided as follows:

  - "Managed care services" furnished by or through a managed care program, such as a health maintenance organization, preferred provider plan, physician case management program or other managed medical care, services and supplies program recognized by the Department to persons enrolled in and receiving medical care from such program;

  - Services otherwise subject to prior approval or prior authorization;

  - Reproductive health and family planning services including: diagnosis, treatment, drugs, supplies and related counseling furnished or prescribed by

or under the supervision of a physician for the purposes of contraception or sterilization. They also include medically necessary induced abortions, screening for anemia, cervical cancer, glycosuria, proteinuria, sexually transmissible diseases, hypertension, breast disease and pregnancy and pelvic abnormalities;

- Child/Teen Health Plan services;
- Methadone maintenance treatment services;
- Services provided by private practitioners on a fee-for-service basis to inpatients in general hospitals and residential health care facilities;
- Hemodialysis services;
- School health project services;
- Obstetrical services provided by a physician, hospital outpatient department, or free-standing treatment and diagnostic center; and
- Primary care services provided by a pediatrician or pediatric clinic.

The numbers of visits, lab procedures, medical supplies, drugs, and other items for each provider type are found in **Information For All Providers, General Policy**.

Section IV - Definitions

For the purposes of the Medicaid program and as used in this Manual, the following terms are defined to mean:

Attending Dentist

The attending dentist is the dentist who is primarily and continuously responsible for the treatment rendered.

Referral

A referral is the direction of a recipient to another practitioner for advice or treatment.

NYS Medicaid Dental Services Fee Schedule
Effective Date 2007-04-01

CODE	DESCRIPTION	FEE	BR	PA	FU DAYS	SITE	CHANGE
D0120	PERIODIC ORAL EVALUATION - ESTABLISHED P	29.00			0		
D0140	LIMITED ORAL EVALUATION - PROBLEM FOCUSE	14.00			0		
D0160	DETAILED AND EXTENSIVE ORAL EVALUATION -	29.00			0		
D0210	INTRAORAL-COMPLETE SERIES (INCLUDING BIT	58.00			0		
D0220	INTRAORAL-PERIAPICAL-FIRST FILM	14.00			0		
D0230	INTRAORAL-PERIAPICAL-EACH ADDITIONAL FIL	7.00			0		
D0240	INTRAORAL-OCCLUSAL FILM	17.00			0	ARCH	*
D0250	EXTRAORAL-FIRST FILM	29.00			0		
D0260	EXTRAORAL-EACH ADDITIONAL FILM	14.00			0		
D0270	BITEWING-SINGLE FILM	14.00			0		
D0272	BITEWINGS-TWO FILMS	17.00			0		
D0274	BITEWINGS-FOUR FILMS	29.00			0		
D0290	POSTERIOR-ANTERIOR OR LATERAL SKULL AND	72.00			0		
D0310	SIALOGRAPHY	58.00			0		
D0320	TEMPOROMANDIBULAR JOINT ARTHROGRAM, INCL	174.00			0		
D0321	OTHER TEMPOROMANDIBULAR JOINT FILMS, BY	29.00			0		
D0330	PANORAMIC FILM	40.00			0		
D0340	CEPHALOMETRIC FILM	58.00			0		
D0350	ORAL/FACIAL PHOTOGRAPHIC IMAGES	14.00			0		
D0470	DIAGNOSTIC CASTS	36.00			0		
D0999	UNSPECIFIED DIAGNOSTIC PROCEDURE, BY REP		BR		0		
D1110	PROPHYLAXIS-ADULT	58.00			0		
D1120	PROPHYLAXIS-CHILD	43.00			0		
D1203	TOPICAL APPLICATION OF FLUORIDE (PROPHYL	14.00			0		
D1204	TOPICAL APPLICATION OF FLUORIDE (PROPHYL	14.00			0		
D1351	SEALANT-PER TOOTH	43.00			0	TOOTH	
D1510	SPACE MAINTAINER-FIXED UNILATERAL	116.00			0	QUAD	
D1515	SPACE MAINTAINER-FIXED BILATERAL	174.00			0	ARCH	
D1550	RECEMENTATION OF SPACE MAINTAINER	21.00			0		
D2140	AMALGAM-ONE SURFACE, PRIMARY OR PERMANEN	55.00			0	SURF/TOOTH	
D2150	AMALGAM-TWO SURFACES, PRIMARY OR PERMANE	84.00			0	SURF/TOOTH	
D2160	AMALGAM-THREE SURFACES, PRIMARY OR PERMA	106.00			0	SURF/TOOTH	
D2161	AMALGAM-FOUR OR MORE SURFACES, PRIMARY O	142.00			0	SURF/TOOTH	
D2330	RESIN-ONE SURFACE, ANTERIOR	58.00			0	SURF/TOOTH	
D2331	RESIN-TWO SURFACES, ANTERIOR	87.00			0	SURF/TOOTH	
D2332	RESIN-THREE SURFACES, ANTERIOR	108.00			0	SURF/TOOTH	
D2335	RESIN-FOUR OR MORE SURFACES OR INVOLVING	145.00			0	SURF/TOOTH	
D2390	RESIN-BASED COMPOSITE CROWN, ANTERIOR	65.00			0	TOOTH	
D2391	RESIN-BASED COMPOSITE - ONE SURFACE, POS	55.00			0	SURF/TOOTH	
D2392	RESIN-BASED COMPOSITE - TWO SURFACES, PO	84.00			0	SURF/TOOTH	
D2393	RESIN-BASED COMPOSITE - THREE SURFACES,	106.00			0	SURF/TOOTH	
D2394	RESIN-BASED COMPOSITE - FOUR OR MORE SUR	142.00			0	SURF/TOOTH	
D2710	CROWN - RESIN-BASED COMPOSITE (INDIRECT)	290.00		1	0	TOOTH	
D2720	CROWN-RESIN WITH HIGH NOBLE METAL	493.00		1	0	TOOTH	
D2721	CROWN-RESIN WITH PREDOMINANTLY BASE META	493.00		1	0	TOOTH	
D2722	CROWN-RESIN WITH NOBLE METAL	493.00		1	0	TOOTH	
D2740	CROWN-PORCELAIN/CERAMIC SUBSTRATE	493.00		1	0	TOOTH	
D2750	CROWN-PORCELAIN FUSED TO HIGH NOBLE META	580.00		1	0	TOOTH	
D2751	CROWN-PROCELAIN FUSED TO PREDOMINANTLY B	580.00		1	0	TOOTH	
D2752	CROWN-PORCELAIN FUSED TO NOBLE METAL	580.00		1	0	TOOTH	

CODE	DESCRIPTION	FEE	BR	PA	FU DAYS	SITE	CHANGE
D2780	CROWN - 3/4 CAST HIGH NOBLE METAL	406.00		1	0	TOOTH	
D2781	CROWN - 3/4 CAST PREDOMINANTLY BASE META	406.00		1	0	TOOTH	
D2782	CROWN - 3/4 CAST NOBLE METAL	406.00		1	0	TOOTH	
D2790	CROWN-FULL CAST HIGH NOBLE METAL	435.00		1	0	TOOTH	
D2791	CROWN-FULL CAST PREDOMINANTLY BASE METAL	435.00		1	0	TOOTH	
D2792	CROWN-FULL CAST NOBLE METAL	435.00		1	0	TOOTH	
D2920	RECEMENT CROWN	43.00			0	TOOTH	
D2930	PREFABRICATED STAINLESS STEEL CROWN-PRIM	116.00			0	TOOTH	
D2931	PREFABRICATED STAINLESS STEEL CROWN-PERM	116.00			0	TOOTH	
D2932	PREFABRICATED RESIN CROWN	116.00			0	TOOTH	
D2933	PREFABRICATED STAINLESS STEEL CROWN WITH	130.00			0	TOOTH	
D2951	PIN RETENTION-PER TOOTH, IN ADDITION TO	29.00			0	TOOTH	
D2952	POST AND CORE IN ADDITION TO CROWN, INDI	145.00			0	TOOTH	
D2954	PREFABRICATED POST AND CORE IN ADDITION	145.00			0	TOOTH	
D2955	POST REMOVAL (NOT IN CONJUCTION WITH END	145.00			0	TOOTH	
D2980	CROWN REPAIR, BY REPORT		BR		0	TOOTH	
D2999	UNSPECIFIED RESTORATIVE PROCEDURE, BY RE		BR		0		
D3220	THERAPEUTIC PULPOTOMY (EXCLUDING FINAL R	87.00			0	TOOTH	
D3230	PULPAL THERAPY (RESORBABLE FILLING)-ANTE	174.00		1	0	TOOTH	
D3240	PULPAL THERAPY (RESORBABLE FILLING)-POST	240.00		1	0	TOOTH	
D3310	ANTERIOR (EXCLUDING FINAL RESTORATION)	250.00		1	0	TOOTH	
D3320	BICUSPID (EXCLUDING FINAL RESTORATION)	300.00		1	0	TOOTH	
D3330	MOLAR (EXCLUDING FINAL RESTORATION)	406.00		1	0	TOOTH	
D3346	RETREATMENT OF PREVIOUS ROOT CANAL THERA	232.00		1	0	TOOTH	
D3347	RETREATMENT OF PREVIOUS ROOT CANAL THERA	290.00		1	0	TOOTH	
D3348	RETREATMENT OF PREVIOUS ROOT CANAL THERA	406.00		1	0	TOOTH	
D3351	APEXIFICATION/RECALCIFICATION-INITIAL VI	87.00			0	TOOTH	
D3352	APEXIFICATION/RECALCIFICATION-INTERIM ME	87.00			0	TOOTH	
D3353	APEXIFICATION/RECALCIFICATION-FINAL VISI	116.00			0	TOOTH	
D3410	APICOECTOMY/PERIRADICULAR SURGERY-ANTERI	203.00		1	0	TOOTH	
D3421	APICOECTOMY/PERIRADICULAR SURGERY-BICUSP	217.00		1	0	TOOTH	
D3425	APICOECTOMY/PERIRADICULAR SURGERY-MOLAR	232.00		1	0	TOOTH	
D3426	APICOECTOMY/PERIRADICULAR SURGERY (EACH	72.00		1	0	TOOTH	
D3430	RETROGRADE FILLING-PER ROOT	58.00		1	0	TOOTH	
D3999	UNSPECIFIED ENDODONTIC PROCEDURE, BY REP		BR		0		
D4210	GINGIVECTOMY OR GINGIVOPLASTY - FOUR OR	116.00			0	QUAD	
D4341	PERIODONTAL SCALING AND ROOT PLANING - F	58.00			0	QUAD	
D4910	PERIODONTAL MAINTENANCE	58.00			0		
D4999	UNSPECIFIED PERIODONTAL PROCEDURE, BY RE		BR		0		
D5110	COMPLETE DENTURE - MAXILLARY	600.00		1	0		
D5120	COMPLETE DENTURE - MANDIBULAR	600.00		1	0		
D5211	UPPER PARTIAL-RESIN BASE (INCLUDING ANY	360.00		1	0		
D5212	LOWER PARTIAL-RESIN BASE (INCLUDING ANY	360.00		1	0		
D5213	MAXILLARY PARTIAL DENTURE - CAST METAL F	530.00		1	0		
D5214	MANDIBULAR PARTIAL DENTURE - CAST METAL	530.00		1	0		
D5510	REPAIR BROKEN COMPLETE DENTURE BASE	87.00			0	QUAD	
D5520	REPLACE MISSING OR BROKEN TEETH-COMPLETE	58.00			0	TOOTH	
D5610	REPAIR RESIN DENTURE BASE	87.00			0	QUAD	
D5620	REPAIR CAST FRAMEWORK	174.00			0		
D5630	REPAIR OR REPLACE BROKEN CLASP	174.00			0	TOOTH	

CODE	DESCRIPTION	FEE	BR	PA	FU DAYS	SITE	CHANGE
D5640	REPLACE BROKEN TEETH-PER TOOTH	87.00			0	TOOTH	
D5650	ADD TOOTH TO EXISTING PARTIAL DENTURE	87.00			0	TOOTH	
D5660	ADD CLASP TO EXISTING PARTIAL DENTURE	145.00			0	TOOTH	
D5710	REBASE COMPLETE MAXILLARY DENTURE	232.00		1	0		
D5711	REBASE COMPLETE MANDIBULAR DENTURE	232.00		1	0		
D5720	REBASE MAXILLARY PARTIAL DENTURE	174.00		1	0		
D5721	REBASE MANDIBULAR PARTIAL DENTURE	174.00		1	0		
D5730	RELINE COMPLETE MAXILLARY DENTURE (CHAIR	145.00		1	0		
D5731	RELINE LOWER COMPLETE MANDIBULAR DENTURE	145.00		1	0		
D5740	RELINE MAXILLARY PARTIAL DENTURE (CHAIRS	116.00		1	0		
D5741	RELINE MANDIBULAR PARTIAL DENTURE (CHAIR	116.00		1	0		
D5750	RELINE COMPLETE MAXILLARY DENTURE (LABOR	232.00			0		
D5751	RELINE COMPLETE MANDIBULAR DENTURE (LABO	232.00			0		
D5760	RELINE MAXILLARY PARTIAL DENTURE (LABORA	174.00			0		
D5761	RELINE MANDIBULAR PARTIAL DENTURE (LABOR	174.00			0		
D5820	INTERIM PARTIAL DENTURE (MAXILLARY)	174.00			0		
D5821	INTERIM PARTIAL DENTURE (MANDIBULAR)	174.00			0		
D5850	TISSUE CONDITIONING, MAXILLARY	29.00			0		
D5851	TISSUE CONDITIONING, MANDIBULAR	29.00			0		
D5899	UNSPECIFIED REMOVABLE PROSTHODONTIC PROC		BR		0		
D5911	FACIAL MOULAGE (SECTIONAL)	116.00			0		
D5912	FACIAL MOULAGE (COMPLETE)	174.00			0		
D5913	NASAL PROSTHESIS		BR		0		
D5914	AURICULAR PROSTHESIS		BR		0		
D5915	ORBITAL PROSTHESIS	957.00			0		
D5916	OCULAR PROSTHESIS	957.00			0		
D5919	FACIAL PROSTHESIS		BR		0		
D5922	NASAL SEPTAL PROSTHESIS		BR		0		
D5923	OCULAR PROSTHESIS, INTERIM	435.00			0		
D5924	CRANIAL PROSTHESIS		BR		0		
D5925	FACIAL AUGMENTATION IMPLANT PROSTHESIS		BR		0		
D5926	NASAL PROSTHESIS, REPLACEMENT		BR		0		
D5927	AURICULAR PROSTHESIS, REPLACEMENT		BR		0		
D5928	ORBITAL PROSTHESIS, REPLACEMENT		BR		0		
D5929	FACIAL PROSTHESIS, REPLACEMENT		BR		0		
D5931	OBTURATOR PROSTHESIS, SURGICAL		BR		0		
D5932	OBTURATOR PROSTHESIS, DEFINITIVE		BR		0		
D5933	OBTURATOR PROSTHESIS, MODIFICATION		BR		0		
D5934	MANDIBULAR RESECTION PROSTHESIS WITH GUI		BR		0		
D5935	MANDIBULAR RESECTION PROSTHESIS WITHOUT		BR		0		
D5936	OBTURATOR/PROSTHESIS, INTERIM		BR		0		
D5937	TRISMUS APPLIANCE (NOT FOR TM TREATMENT)	145.00			0		
D5951	FEEDING AID	435.00			0		
D5952	SPEECH AID PROSTHESIS, PEDIATRIC		BR		0		
D5953	SPEECH AID PROSTHESIS, ADULT		BR		0		
D5954	PALATAL AUGMENTATION PROSTHESIS		BR		0		
D5955	PALATAL LIFT PROSTHESIS, DEFINITIVE		BR		0		
D5958	PALATAL LIFT PROSTHESIS, INTERIM		BR		0		
D5959	PALATAL LIFT PROSTHESIS, MODIFICATION		BR		0		
D5960	SPEECH AID PROSTHESIS, MODIFICATION		BR		0		

CODE	DESCRIPTION	FEE	BR	PA	FU DAYS	SITE	CHANGE
D5982	SURGICAL STENT		BR		0		
D5983	RADIATION CARRIER		BR		0		
D5984	RADIATION SHIELD		BR		0		
D5985	RADIATION CONE LOCATOR		BR		0		
D5986	FLUORIDE GEL CARRIER	17.00			0	ARCH	
D5987	COMMISSURE SPLINT		BR		0		
D5988	SURGICAL SPLINT		BR		0		
D5999	UNSPECIFIED MAXILLOFACIAL PROSTHESIS, BY		BR		0		
D6210	PONTIC-CAST HIGH NOBLE METAL	290.00		1	0	TOOTH	
D6211	PONTIC-CAST PREDOMINANTLY BASE METAL	290.00		1	0	TOOTH	
D6212	PONTIC-CAST NOBLE METAL	290.00		1	0	TOOTH	
D6240	PONTIC-PORCELAIN FUSED TO HIGH NOBLE MET	435.00		1	0	TOOTH	
D6241	PONTIC-PORCELAIN FUSED TO PREDOMINANTLY	435.00		1	0	TOOTH	
D6242	PONTIC-PORCELAIN FUSED TO NOBLE METAL	435.00		1	0	TOOTH	
D6250	PONTIC-RESIN WITH HIGH NOBLE METAL	348.00		1	0	TOOTH	
D6251	PONTIC-RESIN WITH PREDOMINANTLY BASE MET	348.00		1	0	TOOTH	
D6252	PONTIC-RESIN WITH NOBLE METAL	348.00		1	0	TOOTH	
D6545	RETAINER-CAST METAL FOR RESIN BONDED FIX	145.00		1	0	TOOTH	
D6720	CROWN-RESIN WITH HIGH NOBLE METAL	493.00		1	0	TOOTH	
D6721	CROWN-RESIN WITH PREDOMINANTLY BASE META	493.00		1	0	TOOTH	
D6722	CROWN-RESIN WITH NOBLE METAL	493.00		1	0	TOOTH	
D6750	CROWN-PORCELAIN FUSED TO HIGH NOBLE META	580.00		1	0	TOOTH	
D6751	CROWN-PORCELAIN FUSED TO PREDOMINANTLY B	580.00		1	0	TOOTH	
D6752	CROWN-PORCELAIN FUSED TO NOBLE METAL	580.00		1	0	TOOTH	
D6780	CROWN-3/4 CAST HIGH NOBLE METAL	406.00		1	0	TOOTH	
D6790	CROWN-FULL CAST HIGH NOBLE METAL	435.00		1	0	TOOTH	
D6791	CROWN-FULL CAST PREDOMINANTLY BASE METAL	435.00		1	0	TOOTH	
D6792	CROWN-FULL CAST NOBLE METAL	435.00		1	0	TOOTH	
D6930	RECEMENT BRIDGE	58.00			0	QUAD	
D6970	POST AND CORE IN ADDITION TO FIXED PARTI	145.00			0	TOOTH	
D6972	PREFABRICATED POST AND CORE IN ADDITION	145.00			0	TOOTH	
D6980	BRIDGE REPAIR, BY REPORT		BR		0	QUAD	
D6999	UNSPECIFIED FIXED PROSTHODONTIC PROCEDUR		BR		0		
D7140	EXTRACTION, ERUPTED TOOTH OR EXPOSED ROO	45.00			1	TOOTH	
D7210	SURGICAL REMOVAL OF ERUPTED TOOTH REQUIR	90.00			10	TOOTH	
D7220	REMOVAL OF IMPACTED TOOTH-SOFT TISSUE	90.00		1	10	TOOTH	
D7230	REMOVAL OF IMPACTED TOOTH-PARTIALLY BONY	180.00		1	10	TOOTH	
D7240	REMOVAL OF IMPACTED TOOTH-COMPLETELY BON	300.00		1	10	TOOTH	
D7241	REMOVAL OF IMPACTED TOOTH-COMPLETELY BON		BR		30	TOOTH	
D7250	SURGICAL REMOVAL OF RESIDUAL TOOTH ROOTS	58.00			10	TOOTH	
D7260	ORAL ANTRAL FISTULA CLOSURE	348.00			14	QUAD	
D7261	PRIMARY CLOSURE OF A SINUS PERFORATION	348.00			14		
D7270	TOOTH REIMPLANTATION AND/OR STABILIZATIO	145.00			30	TOOTH	
D7272	TOOTH TRANSPLANTATION (INCLUDES REIMPLAN	174.00			30	TOOTH	
D7280	SURGICAL ACCESS OF AN UNERUPTED TOOTH	290.00			14	TOOTH	
D7285	BIOPSY OF ORAL TISSUE - HARD (BONE, TOOT	116.00			30		
D7286	BIOPSY OF ORAL TISSUE - SOFT	87.00			30		
D7290	SURGICAL REPOSITIONING OF TEETH	145.00		1	60	TOOTH	
D7310	ALVEOLOPLASTY IN CONJUNCTION WITH EXTRAC	87.00			14	QUAD	
D7320	ALVEOLOPLASTY NOT IN CONJUNCTION WITH EX	145.00			14	QUAD	

CODE	DESCRIPTION	FEE	BR	PA	FU DAYS	SITE	CHANGE
D7340	VESTIBULOPLASTY-RIDGE EXTENSION (SECOND	435.00		1	60	ARCH	
D7350	VESTIBULOPLASTY-RIDGE EXTENSION (INCLUDI	870.00			60	ARCH	
D7410	EXCISION OF BENIGN LESION UP TO 1.25 CM	101.00			30		
D7411	EXCISION OF BENIGN LESION GREATER THAN 1		BR		60		
D7412	EXCISION OF BENIGN LESION, COMPLICATED		BR		60		
D7413	EXCISION OF MALIGNANT LESION UP TO 1.25	101.00			30		
D7414	EXCISION OF MALIGNANT LESION GREATER THA		BR		60		
D7415	EXCISION OF MALIGNANT LESION, COMPLICATE		BR		60		
D7440	EXCISION OF MALIGNANT TUMOR-LESION DIAME		BR		30		
D7441	EXCISION OF MALIGNANT TUMOR-LESION DIAME		BR		60		
D7450	REMOVAL OF BENIGN ODONTOGENIC CYST OR TU	87.00			30	QUAD	
D7451	REMOVAL OF BENIGN ODONTOGENIC CYST OR TU		BR		60	QUAD	
D7460	REMOVAL OF BENIGN NONODONTOGENIC CYST OR	101.00			30		
D7461	REMOVAL OF BENIGN NONODONTOGENIC CYST OR		BR		30		
D7465	DESTRUCTION OF LESION(S) BY PHYSICAL OR		BR		60		
D7471	REMOVAL OF LATERAL EXOSTOSIS (MAXILLA OR	130.00			21		
D7472	REMOVAL OF TORUS PALATINUS		BR		21		
D7473	REMOVAL OF TORUS MANDIBULARIS		BR		21		
D7485	SURGICAL REDUCTION OF OSSEOUS TUBEROSITY		BR		21		
D7490	RADICAL RESECTION OF MAXILLA OR MANDIBLE	5,800.00			180		
D7510	INCISION AND DRAINAGE OF ABSCESS-INTRAOR	72.00			10		
D7520	INCISION AND DRAINAGE OF ABSCESS-EXTRAOR	174.00			21		
D7530	REMOVAL OF FOREIGN BODY FROM MUCOSA, SKI		BR		21		
D7540	REMOVAL OF REACTION-PRODUCING FOREIGN BO	435.00			90		
D7550	PARTIAL OSTECTOMY/SEQUESTRECTOMY FOR REM	290.00			90		
D7560	MAXILLARY SINUSOTOMY FOR REMOVAL OF TOOT	435.00			60	QUAD	
D7610	MAXILLA-OPEN REDUCTION (TEETH IMMOBILIZE	1,160.00			90		
D7620	MAXILLA-CLOSED REDUCTION (TEETH IMMOBILI	435.00			90		
D7630	MANDIBLE-OPEN REDUCTION (TEETH IMMOBILIZ	1,305.00			90		
D7640	MANDIBLE-CLOSED REDUCTION (TEETH IMMOBIL	435.00			90		
D7650	MALAR AND/OR ZYGOMATIC ARCH-OPEN REDUCTI	725.00			90		
D7660	MALAR AND/OR ZYGOMATIC ARCH-CLOSED REDUC		BR		90		
D7670	ALVEOLUS - CLOSED REDUCTION, MAY INCLUDE	203.00			60		
D7671	ALVEOLUS - OPEN REDUCTION, MAY INCLUDE S		BR		90		
D7680	FACIAL BONES-COMPLICATED REDUCTION WITH		BR		90		
D7710	MAXILLA-OPEN REDUCTION		BR		90		
D7720	MAXILLA-CLOSED REDUCTION	580.00			90		
D7730	MANDIBLE-OPEN REDUCTION		BR		90		
D7740	MANDIBLE-CLOSED REDUCTION	580.00			90		
D7750	MALAR AND/OR ZYGOMATIC ARCH-OPEN REDUCTI		BR		90		
D7760	MALAR AND/OR ZYGOMATIC ARCH-CLOSED REDUC		BR		90		
D7770	ALVEOLUS - OPEN REDUCTION STABILIZATION		BR		90		
D7771	ALVEOLUS, CLOSED REDUCTION STABILIZATION		BR		90		
D7780	FACIAL BONES-COMPLICATED REDUCTION WITH		BR		90		
D7810	OPEN REDUCTION OF DISLOCATION	1,450.00			90		
D7820	CLOSED REDUCTION OF DISLOCATION	174.00			7		
D7830	MANIPULATION UNDER ANESTHESIA	174.00			7		
D7840	CONDYLECTOMY	1,740.00			90		
D7850	SURGICAL DISCECTOMY; WITH/WITHOUT IMPLAN	870.00			90		
D7852	DISC REPAIR	1,044.00			90		

CODE	DESCRIPTION	FEE	BR	PA	FU DAYS	SITE	CHANGE
D7854	SYNOVECTOMY	812.00			90		
D7856	MYOTOMY		BR		90		
D7858	JOINT RECONSTRUCTION	2,900.00			120		
D7860	ARTHROTOMY	870.00			90		
D7865	ARTHROPLASTY	2,030.00			90		
D7870	ARTHROCENTESIS	116.00			7		
D7872	ARTHROSCOPY-DIAGNOSIS, WITH OR WITHOUT B	725.00			14		
D7873	ARTHROSCOPY-SURGICAL: LAVAGE AND LYSIS O	725.00			30		
D7874	ARTHROSCOPY-SURGICAL: DISC REPOSITIONING	1,044.00			60		
D7875	ARTHROSCOPY-SURGICAL: SYNOVECTOMY	1,044.00			60		
D7876	ARTHROSCOPY-SURGICAL: DISCECTOMY	1,044.00			60		
D7877	ARTHROSCOPY-SURGICAL: DEBRIDEMENT	1,044.00			60		
D7880	OCCLUSAL ORTHOTIC APPLIANCE		BR		10		
D7910	SUTURE OF RECENT SMALL WOUNDS UP TO 5 CM	116.00			14		
D7911	COMPLICATED SUTURE-UP TO 5 CM	145.00			30		
D7912	COMPLICATED SUTURE-GREATER THAN 5 CM		BR		60		
D7920	SKIN GRAFT (IDENTIFY DEFECT COVERED, LOC		BR		90		
D7940	OSTEOPLASTY-FOR ORTHOGNATHIC DEFORMITIES		BR		90		
D7941	OSTEOTOMY - MANDIBULAR RAMI	1,450.00			90		
D7943	OSTEOTOMY - MANDIBULAR RAMI WITH BONE GR	2,175.00			90		
D7944	OSTEOTOMY-SEGMENTED OR SUBAPICAL	1,160.00			90		
D7945	OSTEOTOMY-BODY OF MANDIBLE	1,102.00			90		
D7946	LEFORT I (MAXILLA-TOTAL)	2,175.00			90		
D7947	LEFORT I (MAXILLA-SEGMENTED)	2,900.00			90		
D7948	LEFORT II OR LEFORT III (OSTEOPLASTY OF	2,900.00			90		
D7949	LEFORT II OR LEFORT III-WITH BONE GRAFT	3,480.00			90		
D7950	OSSEOUS, OSTEOPERIOSTEAL, OR CARTILAGE G		BR		90		
D7960	FRENULECTOMY (FRENECTOMY OR FRENOTOMY)-S	203.00			14		
D7970	EXCISION OF HYPERPLASTIC TISSUE-PER ARCH	232.00			14	ARCH	
D7971	EXCISION OF PERICORONAL GINGIVA	72.00			10	TOOTH	
D7972	SURGICAL REDUCTION OF FIBROUS TUBEROSITY		BR		14	ARCH	
D7980	SIALOLITHOTOMY	290.00			14		
D7981	EXCISION OF SALIVARY GLAND, BY REPORT		BR		30		
D7982	SIALODOCHOPLASTY	826.00			30		
D7983	CLOSURE OF SALIVARY FISTULA		BR		30		
D7990	EMERGENCY TRACHEOTOMY	725.00			0		
D7991	CORONOIDECTOMY	551.00			60		
D7997	APPLIANCE REMOVAL (NOT BY DENTIST WHO PL		BR		14		
D7999	UNSPECIFIED ORAL SURGERY PROCEDURE, BY R		BR		0		
D8050	INTERCEPTIVE ORTHODONTIC TREATMENT OF TH		BR		0		
D8060	INTERCEPTIVE ORTHODONTIC TREATMENT OF TH		BR		0		
D8070	COMPREHENSIVE ORTHODONTIC TREATMENT OF T	986.00		1	0		
D8080	COMPREHENSIVE ORTHODONTIC TREATMENT OF T	986.00		1	0		
D8090	COMPREHENSIVE ORTHODONTIC TREATMENT OF T	986.00		1	0		
D8210	REMOVABLE APPLIANCE THERAPY		BR		0		
D8660	PRE-ORTHODONTIC VISIT	29.00			0		
D8670	PERIODIC ORTHODONTIC TREATMENT VISIT (AS	232.00		1	0		
D8680	ORTHODONTIC RETENTION (REMOVAL OF APPLIA	174.00		1	0		
D8690	ORTHODONTIC TREATMENT (ALTERNATIVE BILLI		BR		0		
D8692	REPLACEMENT OF LOST OR BROKEN RETAINER	145.00			0		

NYS Medicaid Dental Services Fee Schedule
Effective Date 2007-04-01

CODE	DESCRIPTION	FEE	BR	PA	FU DAYS	SITE	CHANGE
D8999	UNSPECIFIED ORTHODONTIC PROCEDURE, BY RE		BR		0		
D9110	PALLIATIVE (EMERGENCY) TREATMENT OF DENT	29.00			0		
D9220	DEEP SEDATION/GENERAL ANESTHESIA-FIRST 3	159.00			0		
D9221	DEEP SEDATION/GENERAL ANESTHESIA-EACH AD	58.00			0		
D9241	INTRAVENOUS CONSCIOUS SEDATION/ANALGESIA	159.00			0		
D9242	INTRAVENOUS CONSCIOUS SEDATION/ANALGESIA	58.00			0		
D9310	CONSULTATION - DIAGNOSTIC SERVICE PROVID	87.00			0		
D9410	HOUSE/EXTENDED CARE FACILITY CALL	87.00			0		
D9420	HOSPITAL CALL	87.00			0		
D9430	OFFICE VISIT FOR OBSERVATION (DURING REG	21.00			0		
D9440	OFFICE VISIT-AFTER REGULARLY SCHEDULED H	29.00			0		
D9610	THERAPEUTIC PARENTERAL DRUG, SINGLE ADMI		BR		0		
D9920	BEHAVIOR MANAGEMENT, BY REPORT	29.00			0		
D9940	OCCLUSAL GUARDS, BY REPORT	145.00			0		

FEE SCHEDULE COLUMN DESCRIPTIONS

Note: Not all columns or values are used in every Fee Schedule. The **Effective Date** represents the fee schedule in effect for dates of service on and after the effective date.

BY REPORT

BR: When the fee for a procedure is to be determined by **BR**, information concerning the nature, extent and need for the procedure or service, the time, the skill and the equipment necessary, is to be furnished. Appropriate documentation (eg, operative report, procedure description, and/or itemized invoices) should accompany all claims submitted.

BR SC: For speciality enterals and prescription footwear, BR rules apply when the charge is greater than the fee (screen price) listed.

CHANGE: An asterixics in the **CHANGE** column alerts providers that there has been a change in the code since the last fee schedule was posted.

CODE: Procedure codes reimbursable by Medicaid.

DESCRIPTION: Procedure description truncated to the first forty letters.

FEE: Maximum reimbursable Medicaid fee. See Procedure Code section for further explanation by provider type.

FEE OFFICE: Maximum reimbursable Medicaid fees for **"Office"** setting for Evaluation and Management codes (99201-99215).

FEE OUTPT: Maximum reimbursable Medicaid fees for **"Hospital Outpatient"** setting for Evaluation and Management codes (99201-99215).

FU DAYS: **Follow Up Days** - Listed fees for all procedures include the service and the follow-up care for the period indicated in days in the column headed **"FU DAYS"**. Necessary follow-up care beyond this listed period is to be added on a fee-for-service basis.

MAX UNITS: For medical/surgical supplies, the maximum allowed per month. If the fiscal order exceeds this amount, the provider must obtain prior approval.

FEE SCHEDULE COLUMN DESCRIPTIONS

PA: When **PA** is indicated: Payment is dependent upon obtaining the approval of the Department of Health prior to provision of service. If such prior approval is not obtained, no reimbursement will be made. When no fee is listed, the service is priced in the PA process.

- **When a 1 is indicated:** Prior Approval utilizing eMedNY form 361501 is required.
- **When a 4 is indicated:** Automated voice interactive telephone prior authorization is required. The prescriber must write the prior authorization number on the fiscal order and the dispenser completes the authorization process by calling (866) 211-1736.
- **When a 6 is indicated:** Electronic prior authorization through the Medicaid Eligibility Verification System (MEVS) Dispensing Validation (**DVS**) is required.

RENTAL FEE: Fee on file for DME items that can be rented without Prior Approval.

SITE: Certain dental procedure codes require specification of: surface (SURF), tooth (TOOTH), quadrant (QUAD) or arch (ARCH), when billing.

NEW YORK STATE
MEDICAID PROGRAM

DENTAL

PROCEDURE CODES

Table of Contents

GENERAL INFORMATION AND INSTRUCTIONS

1. A. Reimbursement for services listed in the New York State Fee Schedule for Dental Services is limited to the lower of the fee indicated for the specific service or the provider's usual and customary charge to the general public when there is a significant difference between the two fees. The Fee Schedule is available at: http://www.emedny.org/ProviderManuals/Dental/index.html

   The dental procedure codes are grouped into sections as follows:

	Section	Code Series
I.	Diagnostic	D0100-D0999
II.	Preventive	D1000-D1999
III.	Restorative	D2000-D2999
IV.	Endodontics	D3000-D3999
V.	Periodontics	D4000-D4999
VI.	Prosthodontics, removable	D5000-D5899
VII.	Maxillofacial Prosthetics	D5900-D5999
VIII.	Implant Services	D6000-D6199
IX.	Prosthodontics, fixed	D6200-D6999
X.	Oral and Maxillofacial Surgery	D7000-D7999
XI.	Orthodontics	D8000-D8999
XII.	Adjunctive General Services	D9000-D9999

   B. **"MANAGED CARE"**: If a recipient is enrolled in a managed care or other capitated program which covers the specific care or services being provided, it is inappropriate to bill such services to the Medicaid Program on a fee-for-service basis whether or not prior approval has been obtained. **It is the provider's responsibility to verify each recipient's eligibility.**

2. Article 28 facility reimbursement is based upon a rate rather than on fees for specific services rendered. Article 28 facilities use rate codes when billing. **Article 28 facilities must adhere to the Program policies as outlined.**

3. "BR": When the value of a procedure is to be determined "By Report" (BR), as indicated in the Fee Schedule, information concerning the nature, extent and need for the procedure or service, the time, the skill and the equipment necessary, must be furnished. Appropriate documentation (e.g., operative report, procedure description, and/or itemized invoices and name/dosage of therapeutic agents) must accompany all claims submitted. **Do not submit radiographs with claims for payment.** To ensure appropriate payment in the context of current Medicaid fees, bill your **usual and customary** amount on all "BR" procedure codes.

4. "OPERATIVE REPORT": To be acceptable as "By Report" documentation, the operative report must include the following information:

   a. Diagnosis (post operative)

b. Size, location and number of lesion(s) or procedure(s) where appropriate.
c. Major surgical procedure and supplementary procedure(s).
d. Whenever possible, list the nearest similar procedure by code number.
e. Estimated follow-up period.
f. Operative time.

5. "CHILDREN'S DENTAL SERVICES": Effective June 1, 2000, a child is defined as anyone under age 21 years, except where otherwise noted. For services provided on or after **April 1, 2001,** the fee published is applicable to both children and adults.

6. "PRIOR APPROVAL": Payment for those listed procedures where the procedure code number is underlined is dependent upon obtaining the approval of the Department of Health prior to performance of the procedure. If such prior approval is not obtained, no reimbursement will be made. See the billing section of this Manual for information on completion and submission of prior approval requests.

7. "SURFACE/TOOTH/QUADRANT/ARCH": Certain procedure codes require specification of surface, tooth, quadrant or arch when billing (fields 46 and/or 47). These specifications are indicated after the procedure code description by the following abbreviations:

Specify surface:	(SURF)
Specify tooth:	(TOOTH)
Specify quadrant:	(QUAD)
Specify arch:	(ARCH)

When more than one specification is required, both specifications are included, for example, (SURF/TOOTH).

See Billing Section of this Manual for surface, tooth, quadrant and arch designations.

8. "INTERRUPTED TREATMENT": The following is a list of procedures that may be billed in a case of interrupted treatment **after** the date of the decisive appointment. For example, a recipient loses Medicaid coverage **after** a decisive appointment and failure to complete the service would result in undue hardship to the recipient. Another example could be a case where treatment was interrupted for other reasons **after** a decisive appointment that **did not result in a completed service**. In a case of interrupted treatment due to loss of eligibility **before** a decisive appointment, **partial reimbursement may be considered**. When billing for interrupted treatment, use the billing code most relevant to the interrupted treatment, as indicated below. **In the "Procedure Description" field, describe location and complete details of the procedure for which payment is being requested. To receive reimbursement, the provider must use as the date of service on the claim form the date the decisive appointment was completed.**

Type of Service	Approved/ Multiple Visit Procedures	Billing Code	Decisive Appointment
Space Maintainers	D1510, D1515	D0999	Tooth Preparation
Crowns	D2710-D2792 D2952	D2999	Tooth Preparation
Root Canal Therapy	D3310-D3348 D3351-D3353	D3999 D3999	Initial Root Canal Visit Apexification/ recalcification
Complete Dentures	D5110-D5120	D5899	Final Impression
Partial Dentures	D5211-D5214	D5899	Final Impression
Denture Repairs	D5510-D5660	D5899	Acceptance of denture for repair
Denture Rebase	D5710-D5721	D5899	Final Impression
Denture Relining	D5750-D5761	D5899	Final Impression
Other Prosthetic Services	D5820-D5899	D5899	Final Impression
Maxillofacial Prosthetics	D5911-D5999	D5999	Final Impression
Bridge Pontics	D6210-D6252	D6999	Preparation of abutment teeth
Bridge Retainers	D6545-D6792	D6999	Preparation of abutment teeth
Other Fixed Prosthetic Services	D6970, D6972	D6999	Tooth preparation
Orthodontic Treatment	D8670, D8070, D8080, D8090	D8999 D8999	Placement of appliances and beginning of active treatment Date of initial appliance placement
Orthodontic Retention	D8680	D8999	Completion of active treatment
Occlusal Guards	D9940	D8999	Final Impression

CODE **DESCRIPTION**

I. DIAGNOSTIC D0100 - D0999

CLINICAL ORAL EVALUATIONS

D0120 **Periodic oral evaluation established patient**
Includes charting, history, treatment plan, and completion of forms. The initial dental examination of a new patient shall consist of a comprehensive clinical examination of the oral cavity and teeth. It shall include charting, history recording, pulp testing when indicated, and may be supplemented by appropriate radiographic studies. Recall dental examinations shall be limited to one per six-month period and shall include charting and history necessary to update and supplement initial oral examination data.

D0140 **Limited oral evaluation - problem focused** (emergency oral examination)
Refers to exams to evaluate emergency conditions. Typically patients are seen for a specific problem and/or present with dental emergencies, trauma, acute infections, etc. Not used in conjunction with a regular appointment. Cannot be billed with D0120; D0160; D9110; D9310; D9430. Not intended for follow-up care or therapeutic procedures.

D0160 **Detailed and extensive oral evaluation - problem focused**
Includes medical and dental history, evaluation of chief complaint, intra and extraoral examination, vital signs and completion of forms. This procedure will include most or all of these items and will be reimbursable no more than once per provider-patient relationship in a period of 90 days. This is the only type of examination that will be reimbursable in conjunction with the provision of services. It may be utilized only in preparation for definitive and impending treatment to be rendered by the practitioner. The procedure will not be reimbursed if performed within ninety days of a consultation or observation (code D0120, D0140, D9110, D9310 or D9430) by the same provider.

RADIOGRAPHS/DIAGNOSTIC IMAGING (Including Interpretation)

All radiographs, whether digitalized or conventional, must be of good diagnostic quality, properly **mounted**, **dated**, **positionally orientated** and **identified** with the recipient's name and provider name and address. Proper technique in taking and processing of x-ray films will reduce the need to expose patients to unnecessary, additional radiation. The cost of all materials and equipment used shall be included in the fee for the radiograph.

Medicaid claims payment decisions for types, numbers and frequency of radiographs will be related to individual patient needs, dental age, past dental history and radiographic findings, and, most importantly, clinical findings.

Radiographs must be made available for review upon request of the Department of Health. They will be returned after each review and must be retained by the provider for six years from the date of payment.

CODE **DESCRIPTION**

Minimum requirements apply to submission of radiographs with prior approval requests. The minimum number of pre-treatment radiographs needed for proper diagnosis and the evaluation of the overall dental condition must accompany all requests for prior approval. For edentulous patients, occlusal or panoramic radiographs may be used. If all extractions were performed under Medicaid or if Medicaid approved a previous full denture, it may not be necessary to submit current radiographs.

D0210 **Intraoral; complete series (including bitewings)**
Minimum of 14 films. A provider will be reimbursed only once in three years for each recipient. A provider will not be reimbursed for an intraoral complete series prior to the complete eruption of a patient's permanent second molars. Exceptions may be situations including orthodontic consultation, juvenile periodontitis, and other suspected, extensive pathological conditions, which require documentation that should accompany a claim as an attachment. An attachment should contain the clinical findings including the nature and complexity of the patient's condition indicating that additional radiographs would have high probability of affecting the diagnosis and treatment of a clinical problem.

D0220 **periapical first film**
To be billed only for the first periapical film when only periapical films are taken.

D0230 **periapical each additional film**
When periapical films are taken in conjunction with bitewing(s), occlusal films or a panoramic radiograph, use procedure code 00230 for **all** periapical films. The total fee for additional intraoral films may not exceed the total fee allowed for a complete intraoral series.

D0240 **occlusal film** (ARCH)
Reimbursable **only once in three years.** Only two are allowed per patient (maxillary and mandibular), but they may be supplemented by necessary intraoral periapical or bitewing films.

D0250 **Extraoral; first film**
Not reimbursable for temporomandibular joint radiographs.

D0260 **each additional film**
Maximum of two films, **not** reimbursable for temporomandibular joint radiographs.

D0270 **Bitewing; single film**
D0272 **two films**
D0274 **four films**

Bitewings are allowed no more than once in six months for each recipient. **The procedure code is an indication of the number of films performed. Do not fill in "Times Performed" on the claim form.**

D0290 **Posterior-anterior or lateral skull and facial bone survey film**
(3 films minimum)

CODE **DESCRIPTION**

D0310 **Sialography**
D0320 **Temporomandibular joint arthrogram**, **including injection**
D0321 **Other temporomandibular joint films** (per joint)
D0330 **Panoramic film**
Reimbursable every three years if clinically indicated. For use in routine caries determination, diagnosis of periapical or periodontal pathology **only** when supplemented by other necessary diagnostic intraoral radiographs (bitewings or periapicals), completely edentulous cases, diagnosis of impacted teeth, oral surgery treatment planning, or diagnosis of children with mixed dentition. Postoperative panoramic radiographs are reimbursable for post-surgical evaluation of fractures, dislocations, orthognathic surgery, osteomyelitis, or removal of unusually large and/or complex cysts or neoplasms. To expedite claim processing, enter the status of the condition within the "Procedure Description" field of the claim form. Panoramic radiographs are **not** reimbursable when an intraoral complete series or another panoramic radiograph has been taken within **three years,** except for diagnosis of a new condition (e.g. traumatic injury).

D0340 **Cephalometric film**
Reimbursement is limited to once per year and only to enrolled orthodontists or oral and maxillofacial surgeons for the purpose of treatment of a physically handicapping malocclusion.

D0350 **Oral/facial photographic images (includes intra and extraoral images)**
This includes both traditional photographs and images obtained by intraoral cameras. These images should be a part of the patient's clinical record. Excludes conventional radiographs. Reimbursement is limited to enrolled orthodontists or oral and maxillofacial surgeons.

D0470 **Diagnostic casts** (includes both arches when necessary*)*
Reimbursement is limited to enrolled orthodontists or oral and maxillofacial surgeons.

D0999 **Unspecified diagnostic procedure**

II. PREVENTIVE D1000 - D1999

DENTAL PROPHYLAXIS

Dental prophylaxis is reimbursable in addition to an initial dental examination and recall examinations, once per six-month period. For periodontal maintenance, see code D4910.

D1110 **Prophylaxis; adult** (13 years of age and older)
D1120 **child** (under 13 years of age)

CODE **DESCRIPTION**

TOPICAL FLUORIDE TREATMENT (OFFICE PROCEDURE)

A semi-annual topical fluoride treatment is reimbursable when professionally administered in accordance with appropriate standards. Fluoride treatments that are not reimbursable under the program include treatments that incorporate fluoride with prophylaxis paste, topical application of fluoride to the prepared portion of a tooth prior to restoration, and applications of aqueous sodium fluoride.

D1203 **Topical application of fluoride (prophylaxis not included); child** (under 21 years of age)
D1204 **adult** (21 years of age and older)
21 years of age and older: submit documentation of medical necessity with claim.

OTHER PREVENTIVE SERVICES

D1351 **Sealant – per tooth** (TOOTH) (Between 5 and 15 years of age)
Application of sealant shall be restricted to previously unrestored permanent first and second molars that exhibit no clinical or radiographic signs of occlusal or proximal caries for patients **between 5 and 15 years of age**. Buccal and lingual grooves are included in the fee. The use of opaque or tinted sealant is recommended for ease of checking bond efficacy. Reapplication if necessary is permitted **once every three years.**

SPACE MAINTENANCE (PASSIVE APPLIANCES)

Only fixed appliances are Medicaid reimbursable. Documentation including pre-treatment radiographs to justify all space maintenance appliances must be available upon request. Space maintenance should not be provided as an isolated service. All carious teeth must be restored before placement of any space maintainer. The patient should be practicing a sufficient level of oral hygiene to assure that the space maintainer will not become a source of further carious breakdown of the dentition. All permanent teeth in the area of space maintenance should be present and developing normally.

Space maintenance in the deciduous dentition (defined as prior to the interdigitation of the first permanent molars) will generally be reimbursable.

Space maintenance in the mixed dentition initiated within one month of the necessary extraction will be reimbursable on an individual basis. Space maintenance in the mixed dentition initiated more than one month after the necessary extraction, with minimum space loss apparent, may be reimbursable.

D1510 **Space maintainer - fixed; unilateral** (QUAD)
D1515 **bilateral** (ARCH)
D1550 **Recementation of space maintainer**

CODE **DESCRIPTION**

III. RESTORATIVE D2000 - D2999

Effective April 1, 2003, there is no longer a code or fee distinction between primary and permanent teeth for restorative purposes.

The maximum fee for restoring a tooth with either amalgam or composite resin material will be the fee allowed for placement of a four-surface restoration. With the exception of the placement of reinforcement pins (use code D2951), fees for amalgam and composite restorations include tooth preparation, all adhesives (including amalgam and composite bonding agents), acid etching, cavity liners, bases, curing and pulp capping.

For codes D2140, D2330 and D2391, only a single restoration will be reimbursable per surface. Occlusal surface restorations including all occlusal pits and fissures, will be reimbursed as one-surface restorations whether or not the transverse ridge of an upper molar is left intact. Codes D2150, D2160, D2161, D2331, D2332, D2335, D2781, D2392, D2393, and D2394 are compound restorations encompassing 2, 3, 4 or more contiguous surfaces.

Restoration of deciduous teeth when exfoliation is reasonably imminent will not be routinely reimbursable. Claims submitted for the restoration of deciduous cuspids and molars for children 10 years of age or older, or for deciduous incisors in children 5 years of age or older will be pended for professional review. As a condition for payment, it may be necessary to submit, upon request, radiographs and other information to support the appropriateness and necessity of these restorations.

A one-surface posterior restoration is one in which the restoration involves only one of the five surface classifications (mesial, distal, occlusal, lingual, or facial, including buccal and lingual.)

A two-surface posterior restoration is one in which the restoration extends to two of the five surface classifications.

A three-surface posterior restoration is one in which the restoration extends to three of five surface classifications.

A four-or-more surface posterior restoration is one in which the restoration extends to four or more of the five surface classifications.

A one-surface anterior proximal restoration is one in which neither the lingual nor facial margins of the restoration extend beyond the line angle.

A two-surface anterior proximal restoration is one in which either the lingual of facial margin of the restoration extends beyond the line angle.

A three-surface anterior proximal restoration is one in which both the lingual and facial margins extend beyond the line angle.

A four-or-more surface anterior restoration is one in which both the lingual and facial margins extend beyond the line angle and the incisal angle is involved. The restoration might also involve all four surfaces of an anterior tooth and not involve the incisal angle.

CODE **DESCRIPTION**

AMALGAM RESTORATIONS (INCLUDING POLISHING)

D2140 **Amalgam; one surface, primary or permanent** (SURF/TOOTH)
D2150 **two surfaces, primary or permanent** (SURF/TOOTH)
D2160 **three surfaces, primary or permanent** (SURF/TOOTH)
D2161 **four or more surfaces, primary or permanent** (SURF/TOOTH)

RESIN-BASED COMPOSITE-RESTORATIONS DIRECT

D2330 **Resin-based composite; one surface, anterior** (SURF/TOOTH)
D2331 **two surfaces, anterior** (SURF/TOOTH)
D2332 **three surfaces, anterior** (SURF/TOOTH)
D2335 **four or more surfaces or involving incisal angle (anterior)** SURF/TOOTH)
D2390 **Resin-based composite crown, anterior** (TOOTH)
D2391 **Resin-based composite; one surface, posterior** (SURF/TOOTH)
Used to restore a carious lesion into the dentin or a deeply eroded area into the dentin. Not a preventive procedure.

D2392 **two surfaces, posterior** (SURF/TOOTH)
D2393 **three or more surfaces, posterior** (SURF/TOOTH)
D2394 **four or more surfaces, posterior** (SURF/TOOTH)

CROWNS - SINGLE RESTORATIONS ONLY

Codes D2710, D2720, D2721, D2722, D2740, D2750, D2751, and D2752 will only be reimbursed for anterior teeth and maxillary first bicuspids when indicated.

Crowns will not be routinely approved when functional replacement of tooth contour with other restorative materials is possible, or for a molar tooth in those patients age 21 and over which has been endodontically treated without prior approval from the Department of Health. Also, crowns will not be routinely approved when there are eight natural or prosthetic bicuspids and/or molars (four maxillary and four mandibular teeth) **in functional contact with each other.**

D2710 **Crown – resin-based composite;** (**indirect**) (laboratory) (TOOTH)

Acrylic (processed) jacket crowns may be approved as restorations for severely fractured anterior teeth.

D2720 **with high noble metal** (TOOTH)
D2721 **with predominantly base metal** (TOOTH)
D2722 **with noble metal** (TOOTH)
D2740 **Crown; porcelain/ceramic substrate** (TOOTH)
D2750 **porcelain fused to high noble meta**l (TOOTH)
D2751 **porcelain fused to predominately base metal** (TOOTH)
D2752 **porcelain fused to noble metal** (TOOTH)
D2780 **3/4 cast high noble metal** (TOOTH)
D2781 **3/4 cast predominantly base metal**(TOOTH)

CODE	DESCRIPTION
D2782	**3/4 cast noble metal** (TOOTH)
D2790	**full cast high noble metal** (TOOTH)
D2791	**full cast predominately base metal** (TOOTH)
D2792	**full cast noble metal** (TOOTH)

OTHER RESTORATIVE SERVICES

D2920 **Recement crown** (TOOTH)
Claims for recementation of a crown by the original provider within one year of placement, or claims for subsequent recementations of the same crown, will be pended for professional review. Documentation to justify the need and appropriateness of such recementations may be required as a condition for payment. This information can be abbreviated and should be placed in the "Procedure Description" field of the claim form.

D2930 **Prefabricated stainless steel crown; primary tooth** (TOOTH)
The provider must have available adequate radiographic evidence as justification for the use of stainless steel crowns, or other documentation if radiographs do not demonstrate the need for stainless steel crowns in a particular case.

D2931 **permanent tooth** (TOOTH)
D2932 **Prefabricated resin crown** (TOOTH)
Must encompass the complete clinical crown and should be utilized with the same criteria as for full crown construction. This procedure is limited to one occurrence per tooth within two years. If replacement becomes necessary during that time, claims submitted will be pended for professional review. To justify the appropriateness of replacements, documentation must be included within the "Procedure Description" field of the claim form or as a claim attachment. Placement on deciduous anterioris is generally not reimbursable past the age of five years.

D2933 **Prefabricated stainless steel crown with resin window** (TOOTH)
Restricted to anterior teeth, bicuspids and maxillary first molars.

D2951 **Pin retention - per tooth, in addition to restoration** (TOOTH)
Reimbursement is allowed once per tooth regardless of the number of pins placed.

D2952 **Post and core in addition to crown** (TOOTH), **indirectly fabricated**
D2954 **Prefabricated post and core in addition to crown** (TOOTH)
Core is built around a prefabricated post. The procedure includes core material.

D2955 **Post removal (not in conjunction with endodontic therapy)** (TOOTH)
For removal of posts (e.g. fractured posts)

D2980 **Crown repair** (TOOTH)
Includes removal of crown, if necessary.

D2999 **Unspecified restorative procedure**

CODE **DESCRIPTION**

IV. ENDODONTICS D3000 - D3999

All radiographs taken during the course of root canal therapy and all post-treatment radiographs are included in the fee for the root canal procedure. At least one pre-treatment radiograph demonstrating the need for the procedure, and one post-treatment radiograph that demonstrates the result of the treatment, must be maintained in the patient's record.

Surgical root canal treatment or apicoectomy may be considered appropriate and covered when the root canal system cannot be acceptably treated non-surgically, there is active root resorption, or access to the canal is obstructed. Treatment may also be covered where there is gross over or under extension of the root canal filling, periapical or lateral pathosis persists, or there is a fracture of the root.

Eight posterior natural or prosthetic teeth in occlusion (four maxillary and four mandibular teeth in functional contact with each other) will be considered adequate for functional purposes. Requests for endodontic therapy will be reviewed for necessity based upon the presence/absence of eight points of natural or prosthetic occlusal contact in the mouth (bicuspid/molar contact).

In cases of emergency, use procedure code "**D9110 Palliative (emergency) treatment of dental pain – minor procedure". Only symptomatic relief is to be provided until such time as cases have been submitted for review and a prior approval determination has been made. Procedures completed without prior approval will not be reimbursable. Back dated prior approvals will not be issued.**

Provision of root canal therapy is not considered appropriate when the prognosis of the tooth is questionable or when a reasonable alternative course of treatment would be extraction of the tooth and replacement. Root canal therapy will not be approved in association with an existing or proposed prosthesis in the same arch, unless the tooth is a critical abutment, or unless its replacement by addition to an existing prosthesis is not feasible. If the total number of teeth which require, or are likely to require, root canal therapy or apical surgery would be considered excessive or when maintenance of the tooth is not considered essential or appropriate in view of the overall dental status of the patient, treatment will not be covered. Pulp capping is not reimbursable.

PULPOTOMY

D3220 **Therapeutic pulpotomy (excluding final restoration)- removal of pulp coronal to the dentinocemental junction and application of medicament** (TOOTH)

Pulpotomy is the surgical removal of a portion of the pulp with the aim of maintaining the vitality of the remaining portion by means of an adequate dressing. To be performed on primary or permanent teeth **up until the age of 21 years**.

This is not to be considered as the first stage of root canal therapy. Pulp capping (placement of protective dressing or cement over exposed or nearly exposed pulp for

CODE **DESCRIPTION**

protection from injury or as an aid in healing and repair) is not reimbursable. This procedure code may not be used when billing for an "emergency pulpotomy", which should be billed as palliative treatment.

ENDODONTIC THERAPY ON PRIMARY TEETH

Endodontic therapy on primary teeth with succedaneous teeth and placement of resorbable filling. This includes pulpectomy, cleaning, and filling of canals with resorbable material.

D3230 **Pulpal therapy (resorbable filling) – anterior, primary tooth (excluding final restoration)** (TOOTH)
Primary incisors and cuspids.

D3240 **Pulpal therapy (resorbable filling) – posterior, primary tooth (excluding final restoration)** (TOOTH)
Primary first and second molars.

ENDODONTIC THERAPY (INCLUDING TREATMENT PLAN, CLINICAL PROCEDURES AND FOLLOW-UP CARE)

Includes primary teeth without succedaneous teeth and permanent teeth. Complete root canal therapy. Pulpectomy is part of root canal therapy. Includes all appointments necessary to complete treatment; also includes intra-operative radiographs. Does not include diagnostic evaluation and necessary radiographs/diagnostic images.

D3310 **Anterior (excluding final restoration)** (TOOTH)
Multiple anterior pulpectomies will generally not be approved.

D3320 **Bicuspid (excluding final restoration)** (TOOTH)
Also for treatment on primary first and second molars with no permanent successor tooth.

D3330 **Molar (excluding final restoration)** (TOOTH)
Molar endodontics is not approvable as a routine procedure. Prior approval requests will be considered for patients under age 21 who display good oral hygiene, have healthy mouths with a full complement of natural teeth with a low caries index and/or who may be undergoing orthodontic treatment. In those patients age 21 and over, molar endodontic therapy will be considered only in those instances where the tooth in question is a critical abutment for an existing functional prosthesis.

ENDODONTIC RETREATMENT

D3346 **Retreatment of previous root canal therapy; anterior** (TOOTH)
D3347 **bicuspid** (TOOTH)
D3348 **molar** (TOOTH)

CODE **DESCRIPTION**

APEXIFICATION/RECALCIFICATION PROCEDURES

D3351 **Apexification/recalcification; initial visit (apical closure/calcific repair of perforations, root resorption, etc.)** (TOOTH)
Includes opening tooth, pulpectomy, preparation of canal spaces, first placement of medication and necessary radiographs. Includes the first phase of complete root canal therapy.

D3352 **interim medication replacement (apical closure/calcific repair of perforations, root resorption, etc.)** (TOOTH)
For visits in which the intracanal medication is replaced with new medication and necessary radiographs. There may be several of these visits. Published fee is the maximum reimbursable amount regardless of the number of visits.

D3353 **final visit (apical closure/calcific repair of perforations, root resorption, etc.)** (TOOTH)
Includes the removal of intracanal medication and procedures necessary to place final root canal filling material including necessary radiographs. Includes last phase of complete root canal therapy.

APICOECTOMY/PERIRADICULAR SERVICES

D3410 **Apicoectomy/periradicular surgery; anterior** (TOOTH) (per tooth)
Performed as a separate surgical procedure for a single rooted tooth and includes periapical curettage.

D3421 **bicuspid (first root)** (TOOTH)
D3425 **molar (first root)** (TOOTH)
D3426 **each additional root** (TOOTH)
Performed as a separate surgical procedure for multirooted teeth and includes periapical curettage.

D3430 **Retrograde filling - per root** (TOOTH)

OTHER ENDODONTIC PROCEDURES

D3999 **Unspecified endodontic procedure**

V. PERIODONTICS D4000 - D4999

SURGICAL SERVICES (INCLUDING USUAL POST-OPERATIVE CARE)

D4210 **Gingivectomy or gingivoplasty – four or more contiguous teeth or bounded teeth spaces per quadrant** (QUAD)

CODE **DESCRIPTION**

This surgical procedure is reimbursable solely for the correction of severe hyperplasia or hypertrophy associated with drug therapy, hormonal disturbances or congenital defects. Documentation to verify these conditions must accompany these claims as attachments. For fewer than four teeth, prorate the fee at 25 percent of the total for each tooth treated.

NON-SURGICAL PERIODONTAL SERVICES

D4341 **Periodontal scaling and root planing - four or more teeth per quadrant** (QUAD)(at least four teeth)

This procedure may be billed for those patients who have periodontal pockets and sub-gingival accretions on cemental surfaces in the quadrant(s) being treated. Periodontal scaling and root planing involves instrumentation of the crown and root surfaces of the teeth to remove plaque and calculus. It is indicated for patients with periodontal disease and is therapeutic, not prophylactic, in nature. Root planing is the definitive procedure designed for the removal of cementum and dentin that is rough, and/or permeated by calculus or contaminated with toxins or microorganisms. Some soft tissue removal occurs. Reimbursement is limited to no more than **two quadrants** on a single date of service with no more than **four different quadrant reimbursements within a two-year period.** Dental prophylaxis is reimbursable prior to periodontal scaling and root planing and **will not** be reimbursed on the same date as procedure code D4341. Prior approval may be requested for more frequent treatment. For fewer than four teeth, prorate the fee at 25 percent of the total for each tooth treated.

The provider must supply documentation of the need for periodontal scaling and root planing as a claim attachment. Include a copy of the pre-treatment evaluation of the periodontium, a general description of the tissues (e.g., color, shape, and consistency), the location and measurement of periodontal pockets, the description of the type and amount of bone loss, the periodontal diagnosis, the amount and location of subgingival calculus deposits, and tooth mobility.

OTHER PERIODONTIC SERVICES

D4910 **Periodontal Maintenance**

This procedure is for patients who have previously been treated for periodontal disease. Typically, maintenance starts 90 days after completion of active (surgical or non-surgical) periodontal therapy. D4910 is not billable on the same date of service as codes D1110 or D4341. Reimbursement for D4910 is limited to twice per year.

D4999 **Unspecified periodontal procedure**

VI. PROSTHODONTICS (Removable) D5000 - D5899

All prosthetic appliances such as complete dentures, partial dentures, denture duplication and relining procedures include six months of post-delivery care. Placement of immediate dentures and the use of dental implants and related services are beyond the scope of the program. Complete and/or partial dentures will be approved only when

CODE **DESCRIPTION**

existing prostheses are not serviceable or cannot be relined or rebased. Reline or rebase of an existing prostheses will not be reimbursed when such procedures are performed in addition to a new prostheses for the same arch.

If a recipient's health would be adversely affected by the absence of a prosthetic replacement, **and** the recipient could **successfully** wear a prosthetic replacement, such a replacement will be considered. In the event that the recipient has a record of not successfully wearing prosthetic replacements in the past, or has gone an extended period of time (three years or longer) without wearing a prosthetic replacement, the prognosis is poor. Mitigating factors surrounding these circumstances should be included with the prior approval request.

Partial dentures will be approved **only** when they are required to alleviate a serious health condition including one that affects employability. **Eight natural or prosthetic teeth in occlusion (four maxillary and four mandibular teeth in functional contact with each other) are generally considered adequate for functional purposes. One missing maxillary anterior tooth or two missing mandibular anterior teeth may be considered a problem that warrants a prosthetic replacement.**

Complete or partial dentures will **not** routinely be replaced when they have been provided by the Medicaid program and become unserviceable or are lost within four years, except when they become unserviceable through extensive physiological change. If the recipient can provide documentation that reasonable care has been exercised in the maintenance of the prosthetic appliance, and it did not become unserviceable or lost through negligence, a replacement may be considered. **Prior approval requests for such replacements will not be reviewed without supporting documentation.** A verbal statement by the recipient that is then included by the provider on the prior approval request would generally **not** be considered sufficient.

COMPLETE DENTURES (INCLUDING ROUTINE POST DELIVERY CARE)

D5110 **Complete denture; maxillary**
D5120 **mandibular**

PARTIAL DENTURES (INCLUDING ROUTINE POST DELIVERY CARE)

Reimbursement for **all** removable partial dentures includes a minimum of two clasps. The total number of clasps is dictated by the retentive requirements of each case, with no additional payment for necessary supplemental clasps.

D5211 **Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)**
Includes acrylic resin base denture with resin or wrought wire clasps.

D5212 **Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)**
Includes acrylic resin base denture with resin or wrought wire clasps.

CODE	DESCRIPTION
D5213	**Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)**
D5214	**Mandibular partial - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)**

REPAIRS TO COMPLETE DENTURES

D5510	**Repair broken complete denture base** (QUAD)
D5520	**Replace missing or broken teeth - complete denture (each tooth)** (TOOTH)

REPAIRS TO PARTIAL DENTURES

D5610	**Repair resin denture base** (QUAD)
D5620	**Repair cast framework**
D5630	**Repair or replace broken clasp** (TOOTH)
D5640	**Replace broken teeth - per tooth** (TOOTH)
D5650	**Add tooth to existing partial denture** (TOOTH)
D5660	**Add clasp to existing partial denture** (TOOTH)

DENTURE REBASE PROCEDURES

Rebase – process of refitting a denture by replacing the base material.

D5710	**Rebase; complete maxillary denture**
D5711	**complete mandibular denture**
D5720	**maxillary partial denture**
D5721	**mandibular partial denture**

DENTURE RELINE PROCEDURES

For cases in which it is impractical to complete a laboratory-processed reline, office (chairside or cold cure) reline of dentures may be requested with appropriate documentation. **This procedure is not reimbursable during the six months of follow-up care included in the fee for the denture.**

D5730	**Reline; complete maxillary denture** (**chairside**)
D5731	**complete mandibular denture (chairside)**
D5740	**maxillary partial denture (chairside)**
D5741	**mandibular partial denture (chairside)**
D5750	**complete maxillary denture (laboratory)**
D5751	**complete mandibular denture (laboratory)**
D5760	**maxillary partial denture (laboratory)**
D5761	**mandibular partial denture (laboratory)**

CODE **DESCRIPTION**

INTERIM PROSTHESIS

Reimbursement is limited to once per year and only for children between 5 and 15 years of age. Codes 05820 and 05821 are not to be used in lieu of space maintainers.

D5820 **Interim partial denture (maxillary)**
D5821 **Interim partial denture (mandibular)**

OTHER REMOVABLE PROSTHETIC SERVICES

Insertion of tissue conditioning liners in existing dentures will be limited to once per denture unit as a preparation for taking impressions for the relining of existing dentures or the fabrication of new dentures. This procedure should be billed one time at the completion of treatment, regardless of the number of visits involved. An explanation inserted in the "Procedure Description" field should be included if billed separately from the relining or new denture codes. Codes 05850 and 05851 are for therapeutic reline using materials designed to heal unhealthy ridges prior to more definitive final restoration and are not reimbursable for children under age 16.

D5850 **Tissue conditioning, maxillary** per denture unit
D5851 **Tissue conditioning, mandibular** per denture unit
D5899 **Unspecified removable prosthodontic procedure**

VII. MAXILLOFACIAL PROSTHETICS D5900 - D5999

D5911 **Facial moulage (sectional**)
D5912 **Facial moulage (complete)**
D5913 **Nasal prosthesis**
D5914 **Auricular prosthesis**
D5915 **Orbital prosthesis**
D5916 **Ocular prosthesis**
D5919 **Facial prosthesis**
D5922 **Nasal septal prosthesis**
D5923 **Ocular prosthesis, interim**
D5924 **Cranial prosthesis**
D5925 **Facial augmentation implant prosthesis**
D5926 **Nasal prosthesis, replacement**
D5927 **Auricular prosthesis, replacement**
D5928 **Orbital prosthesis, replacement**
D5929 **Facial prosthesis, replacement**
D5931 **Obturator prosthesis, surgical**
D5932 **Obturator prosthesis, definitive**
D5933 **Obturator prosthesis, modification**
D5934 **Mandibular resection prosthesis with guide flange**
D5935 **Mandibular resection prosthesis without guide flange**
D5936 **Obturator prosthesis, interim**
D5937 **Trismus appliance (not for TMD treatment**)

CODE	DESCRIPTION
D5951	**Feeding aid**
D5952	**Speech aid prosthesis, pediatric**
D5953	**Speech aid prosthesis, adult**
D5954	**Palatal augmentation prothesis**
D5955	**Palatal lift prosthesis, definitive**
D5958	**Palatal lift prosthesis, interim**
D5959	**Palatal lift prosthesis, modification**
D5960	**Speech aid prosthesis, modification**
D5982	**Surgical stent**
D5983	**Radiation carrier**
D5984	**Radiation shield**
D5985	**Radiation cone locator**
D5986	**Fluoride gel carrier** (per arch)(ARCH)
D5987	**Commissure splint**
D5988	**Surgical splint**
D5999	**Unspecified maxillofacial prosthesis**

VIII. IMPLANT SERVICES D6000 - D6199

Implant Services are not covered

IX. PROSTHODONTICS, FIXED (EACH RETAINER AND EACH PONTIC CONSTITUTES A UNIT IN A FIXED PARTIAL DENTURE) D6200 - D6999

Fixed bridgework is generally considered beyond the scope of the Medicaid program. The fabrication of any fixed bridge may be considered only for a patient with no recent caries activity (no initial restorations placed during the past year), no unrestored carious lesions, no significant periodontal bone loss in the same arch **and** no posterior tooth loss with replaceable space in the same arch. The replacement of a missing tooth or teeth with a fixed partial denture will not be approved under the Medicaid program when either no replacement or replacement with a removable partial denture could be considered appropriate based on Medicaid prosthetic guidelines. The fabrication of fixed and removable partial dentures in the same arch or the use of double abutments will not be approved.

The placement of a fixed prosthetic appliance will only be considered for the anterior segment of the mouth in those exceptional cases where there is a documented physical or neurological disorder that would preclude placement of a removable prosthesis, or in those cases requiring cleft palate stabilization. In cases other than for cleft palate stabilization, treatment would generally be limited to replacement of a single maxillary anterior tooth or replacement of two adjacent mandibular teeth.

CODE **DESCRIPTION**

For a patient whose pulpal anatomy allows crown preparation of abutment teeth without pulp exposure, the construction of a conventional fixed bridge will be approved only for the replacement of a single missing maxillary anterior tooth or two adjacent missing mandibular anterior teeth. Acid etched cast bonded bridges (Maryland Bridges) may be approved only for the replacement of a single missing maxillary anterior tooth, two adjacent missing maxillary anterior teeth, or two adjacent missing mandibular incisors. Approval will only be considered for a patient under the age of 21 or one whose pulpal anatomy precludes crown preparation of abutments without pulp exposure. Abutments for resin bonded fixed partial dentures (i.e. Maryland Bridges) should be billed using code D6545 and pontics using code D6251.

FIXED PARTIAL DENTURE PONTICS

D6210 **Pontic; cast high noble metal** (TOOTH)
D6211 **cast predominately base metal** (TOOTH)
D6212 **cast noble metal** (TOOTH)
D6240 **porcelain fused to high noble metal** (TOOTH)
D6241 **porcelain fused to predominately base metal (**TOOTH)
D6242 **porcelain fused to noble metal** (TOOTH)
D6250 **resin with high noble metal** (TOOTH)
D6251 **resin with predominately base metal** (TOOTH)
D6252 **resin with noble metal** (TOOTH)

FIXED PARTIAL DENTURE RETAINERS-INLAYS/ONLAYS

D6545 **Retainer - cast metal for resin bonded fixed prosthesis** (TOOTH)
Limited to abutment for resin bonded fixed partial dentures (i.e. Maryland Bridges).

FIXED PARTIAL DENTURE RETAINERS - CROWNS

D6720 **Crown; resin with high noble metal** (TOOTH)
D6721 **resin with predominately base metal** (TOOTH)
D6722 **resin with noble metal** (TOOTH)
D6750 **porcelain fused to high noble metal** (TOOTH)
D6751 **porcelain fused to predominantly base metal** (TOOTH)
D6752 **porcelain fused to noble metal** (TOOTH)
D6780 **3/4 cast high noble metal** (TOOTH)
D6790 **full cast high noble metal** (TOOTH)
D6791 **full cast predominantly base metal**
D6792 **full cast noble metal** (TOOTH)

OTHER FIXED PARTIAL DENTURE SERVICES

D6930 **Recement fixed partial denture** (QUAD)
D6970 **Post and core in addition to fixed partial denture retainer** (TOOTH), **indirectly fabricated**

CODE	DESCRIPTION
D6972	**Prefabricated post and core in addition to fixed partial denture retainer** (TOOTH)
D6980	**Fixed partial denture repair** (QUAD) (use for bridge repair and severing, per unit, per quadrant)
D6999	**Unspecified, fixed prosthodontic procedure**

X. ORAL AND MAXILLOFACIAL SURGERY D7000 - D7999

All surgical procedures include the surgery and the follow-up care for the period indicated. Necessary follow-up care beyond this listed period should be billed using codes D7999 or D9110.

When multiple surgical procedures are performed on the same quadrant or arch, the claim may be pended for professional review. When extensive multiple surgical procedures are performed at the same operative session, the total reimbursement will be based upon the value of the major procedure plus 50% of the value of the lesser procedure(s). Removal of bilateral tori or bilateral impactions and multiple extractions performed at the same operative session are examples of exceptions due to the independence of the individual procedures.

When a provider performs surgical excision and removal of tumors, cysts and neoplasms, the extent of the procedure claimed must be supported by information in the patient's record. This includes radiographs, clinical findings, and operative and histopathologic reports. To expedite review and reimbursement, this material (except radiographs) should be submitted with claims for procedures that are priced "By Report." **For removal of supernumerary tooth, use code D7999.**

EXTRACTIONS (INCLUDES LOCAL ANESTHESIA, SUTURING, IF NEEDED, AND ROUTINE POSTOPERATIVE CARE)

D7140 **Extraction, erupted tooth or exposed root (elevation and/or forceps removal)**(TOOTH)

SURGICAL EXTRACTIONS (INCLUDES LOCAL ANESTHESIA, SUTURING, IF NEEDED, AND ROUTINE POSTOPERATIVE CARE)

D7210 **Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth** (TOOTH)
Requires prior approval if done more than four times within one year. Includes cutting of gingiva and bone, removal of tooth structure, and closure.

D7220 **Removal of impacted tooth; soft tissue** (TOOTH)
Occlusal surface of tooth covered by soft tissue; requires mucoperiosteal flap elevation.

D7230 **partially bony** (TOOTH)
Part of crown covered by bone; requires mucoperiosteal flap elevation, bone removal and may require segmentalization of tooth.

CODE **DESCRIPTION**

D7240 **completely bony** (TOOTH)
Most or all of crown covered by bone; requires mucoperiosteal flap elevation, bone removal and may require segmentalization of tooth.

D7241 **completely bony, with unusual surgical complications** (TOOTH)
Most or all of crown covered by bone; usually difficult or complicated due to factors such as nerve dissection required, separate closure of maxillary sinus required or aberrant tooth position.

D7250 **Surgical removal of residual tooth roots (cutting procedure)** (TOOTH)
Includes cutting of gingiva and bone, removal of tooth structure and closure.

OTHER SURGICAL PROCEDURES

D7260 **Oroantral fistula closure** (QUAD)
D7261 **Primary closure of sinus perforation**
D7270 **Tooth re-implantation and/or stabilization of accidentally avulsed or displaced tooth and/or alveolus** (includes splinting) (TOOTH)
D7272 **Tooth transplantation (includes reimplantation from one site to another and splinting and/or stabilization)** (TOOTH)
D7280 **Surgical access of an unerupted tooth** (TOOTH)
An incision is made and the tissue is reflected and bone removed as necessary to expose the crown of an impacted tooth not intended to be extracted. (Also includes tooth exposure for orthodontic purposes, including the orthodontic attachments.)

D7285 **Biopsy of oral tissue; hard (bone, tooth)**
D7286 **soft**
Not to be used in conjunction with apicoectomy and periradicular curettage.

D7290 **Surgical repositioning of teeth** (TOOTH)

ALVEOPLASTY - SURGICAL PREPARATION OF RIDGE FOR DENTURES

D7310 **Alveoloplasty in conjunction with extractions – four or more teeth or tooth spaces, per quadrant** (QUAD)
This procedure will be reimbursed when at least four adjacent teeth are removed, and when additional surgical procedures above and beyond the removal of the teeth are required to prepare the ridge for dentures. Not reimbursable in addition to surgical extractions in the same quadrant. Bill on same invoice as extraction to expedite review.

D7320 **Alveoloplasty not in conjunction with extractions – four or more teeth or tooth spaces, per quadrant** (QUAD)
The fee for each quadrant includes the recontouring of both osseous and soft tissues in that quadrant. Procedure code D7320 will not be reimbursed in conjunction with procedure code D7310 in the same quadrant.

CODE **DESCRIPTION**

VESTIBULOPLASTY

Vestibuloplasty may be approved when a denture could not otherwise be worn.

D7340 **Vestibuloplasty - ridge extension (secondary epithelialization)** (ARCH)
D7350 **Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)**(ARCH)

SURGICAL EXCISION OF SOFT TISSUE LESIONS (INCLUDES NON-ODONTOGENIC CYSTS)

D7410 **Excision of benign lesion; up to 1.25 cm**
D7411 **greater than 1.25cm**
D7412 **complicated**
Requires extensive undermining with advancement or rotational flap closure.

D7413 **Excision of malignant lesion; up to 1.25cm**
D7414 **greater than 1.25cm**
D7415 **complicated**
Requires extensive undermining with advancement or rotational flap closure.

SURGICAL EXCISION OF INTRA-OSSEOUS LESIONS

Reimbursement for routine or surgical extractions includes removal of tooth, soft tissue associated with the root and curettage of the socket. Therefore, excision of tissue, particularly cyst removal under code D7450, requires supporting documentation **when billed as an adjunct to tooth extraction**. Periapical granulomas at the apex of decayed teeth will not be separately reimbursed in addition to the tooth extraction.

D7440 **Excision of malignant tumor; lesion diameter up to 1.25 cm**
D7441 **lesion greater than 1.25 cm**
D7450 **Removal of odontogenic cyst or**
D7451 **lesion greater than 1.25 cm** (QUAD)
D7460 **Removal of benign nonodontogenic cyst or tumor; lesion diameter up to 1.25 cm**
D7461 **greater than 1.25 cm**
D7465 **Destruction of lesion(s) by physical or chemical methods**

EXCISION OF BONE TISSUE

D7471 **Removal of lateral exostosis (maxilla or mandible)**
Indicate site on a separate sheet of paper submitted with the claim form.

D7472 **Removal of torus palatinus**
D7473 **Removal of torus mandibularis**
D7485 **Surgical reduction of osseous tuberosity**
D7490 **Radical resection of maxilla or mandible**

CODE **DESCRIPTION**

SURGICAL INCISION

Reimbursement for codes D7510 and D7520 includes insertion/removal of drains.

D7510 **Incision and drainage of abscess; intraoral soft tissue**
D7520 **extraoral soft tissue**
D7530 **Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue**
D7540 **Removal of reaction-producing foreign bodies – musculoskeletal system**
May include, but is not limited to, removal of splinters, pieces of wire, bone plates, screws, etc., from muscle and/or bone.

D7550 **Sequestrectomy for osteomyelitis includes guttering or saucerization**
D7560 **Maxillary sinusotomy for removal of tooth fragment or foreign body** (QUAD) (Includes closure of oro-antral communication when performed concurrently.)

TREATMENT OF FRACTURES – SIMPLE

D7610 **Maxilla; open reduction (teeth immobilized if present)**
D7620 **closed reduction (teeth immobilized if present)**
D7630 **Mandible; open reduction (teeth immobilized if present)**
D7640 **closed reduction (teeth immobilized if present)**
D7650 **Malar and/or zygomatic arch; open reduction**
D7660 **closed reduction**
D7670 **Alveolus: closed reduction, may include stabilization of teeth.**
Teeth may be wired, banded or splinted together to prevent movement (eg., Erich arch bars).

D7671 **open reduction, may include stabilization of teeth**
Teeth may be wired, banded or splinted together to prevent movement (eg., Erich arch bars).

D7680 **Facial bones – complicated reduction with fixation and multiple surgical approaches**

TREATMENT OF FRACTURES-COMPOUND

Reimbursement for codes D7710-D7740 includes splint fabrication when necessary.

D7710 **Maxilla; open reduction**
D7720 **closed reduction**
D7730 **Mandible; open reduction**
D7740 **closed reduction**
D7750 **Malar and/or zygomatic arch**; **Open reduction**
D7760 **closed reduction**
D7770 **Alveolus – open reduction stabilization of teeth**
D7771 **Alveolus, closed reduction stabilization of teeth**

CODE **DESCRIPTION**

D7780 **Facial bones – complicated reduction with fixation and multiple surgical approaches**

REDUCTION OF DISLOCATION AND MANAGEMENT OF OTHER TEMPOROMANDIBULAR JOINT DYSFUNCTIONS

Routine services for treatment of T.M.J. and related disorders are generally considered beyond the scope of the program. Reimbursement for temporomandibular joint dysfunctions will be permitted only in the specific conditions wherein a definitive diagnosis corroborates necessary treatment. Appropriate documentation (eg., operative report, procedure description) should accompany all claims as attachments.

D7810 **Open reduction of dislocation**
D7820 **Closed reduction of dislocation**
D7830 **Manipulation under anesthesia**
Usually done under general anesthesia or intravenous sedation.

D7840 **Condylectomy**
D7850 **Surgical discectomy; with/without implant**
D7852 **Disc repair**
D7854 **Synovectomy**
D7856 **Myotomy**
D7858 **Joint reconstruction**
D7860 **Arthrotomy**
D7865 **Arthoplasty**
D7870 **Arthrocentesis**
D7872 **Arthroscopy; diagnosis, with/without biopsy**
D7873 **surgical: lavage and lysis of adhesions**
D7874 **surgical: disc repositioning and stabilization**
D7875 **surgical: synovectomy**
D7876 **surgical: discectomy**
D7877 **surgical: debridement**
D7880 **Occlusal orthotic appliance**

REPAIR OF TRAUMATIC WOUNDS

Excludes closure of surgical incisions.

D7910 **Suture of recent small wounds up to 5 cm**

COMPLICATED SUTURING (RECONSTRUCTION REQUIRING DELICATE HANDLING OF TISSUES AND WIDE UNDERMINING FOR METICULOUS CLOSURE)

Procedure codes D7911, D7912, or D7920 are to be utilized in situations requiring unusual and time-consuming techniques of repair to obtain the maximum functional and cosmetic result. The extent of the procedure claimed must be supported by information in the patient's record, including clinical findings, and "Operative Reports.

CODE	DESCRIPTION
D7911	**Complicated suture; up to 5 cm**
D7912	**greater than 5 cm**

OTHER REPAIR PROCEDURES

D7920 **Skin graft (identify defect covered, location and type of graft)**
D7940 **Osteoplasty - for orthognathic deformities**
D7941 **Osteotomy; mandibular rami**
D7943 **mandibular rami with bone graft, includes obtaining the graft**
D7944 **segmented or subapical**
D7945 **body of mandible**
D7946 **Lefort I** ; **(maxilla-total)**
D7947 **(maxilla-segmented)**
D7948 **Lefort II or Lefort III (osteoplasty of facial bones for Midface hypoplasia or retrusion); Without bone graft** (includes obtaining autographs)
D7949 **with bone graft**
D7950 **Osseous, osteoperiosteal, or cartilage graft of the mandible or maxilla - autogenous or non autogenous, by report** (includes obtaining Autograph and/or allograph material)
D7960 **Frenulectomy (frenectomy or frenotomy)- separate procedure**
For pre-prosthetic purposes, correction of ankyloglossia, or in association with orthodontic treatment. Indication must be documented in patient record.

D7970 **Excision of hyperplastic tissue- per arch** (ARCH)
This procedure is reserved for the removal of tissue over a previous edentulous denture bearing area to improve the prognosis of a proposed prosthesis.

D7971 **Excision of pericoronal gingiva** (TOOTH)
D7972 **Surgical reduction of fibrous tuberosity**
D7980 **Sialolithotomy**
D7981 **Excision of salivary gland**
D7982 **Sialodochoplasty**
D7983 **Closure of salivary fistula**
D7990 **Emergency tracheotomy**
D7991 **Coronoidectomy**
D7997 **Appliance removal (not by dentist who placed appliance), includes removal of arch bar**
Not for orthodontics. This procedure includes both arches, if necessary.

D7999 **Unspecified oral surgical procedure**

CODE **DESCRIPTION**

XI. ORTHODONTICS D8000 - D8999

The decisive appointment for active orthodontic treatment is the time at which the total appliance(s) is/are completely activated. The placement of the component parts (e.g. brackets, bands) does not constitute complete appliance insertion or active treatment. When eligibility is lost after active orthodontic treatment has been initiated, Medicaid will continue to reimburse for orthodontia care for a period of up to six months following loss of eligibility. The treating orthodontist may decide to complete active treatment (including retention care), initiate retention care to preserve current status, or remove the appliances in cases of minimal progress during active therapy. When billing for the six-month treatment extension, submit paper claim using D8999, use the last date of eligibility for the date of service and identify the current treatment year.

INTERCEPTIVE ORTHODONTIC TREATMENT

Only orthodontists are reimbursed for codes D8050 and D8060 for rapid palatal expansion via fixed appliance. **Do not use D8050 and D8060 for removable appliance therapy** (see D8210). The key to successful interception is intervention in the incipient stages of a developing problem to lessen the severity of the malformation and eliminate its cause. Complicating factors such as skeletal disharmonies, overall space deficiency, or other conditions may require future comprehensive therapy.

D8050 **Interceptive orthodontic treatment of the primary dentition** (rapid palatal expansion via fixed appliance only)
D8060 **Interceptive orthodontic treatment of the transitional dentition** (rapid palatal expansion via fixed appliance only)

COMPREHENSIVE ORTHODONTIC TREATMENT

Reimbursement for codes D8070, D8080 **or** D8090 is limited to once in a lifetime as initial payment for an approved course of orthodontic treatment. The child's dentition will determine the **single code** to be used. May be billed when appliances have been placed and active treatment has been initiated on or after June 1, 2000 **or** on the date the first quarter of treatment has been completed **and** no reimbursement has been made for the case. For quarterly payment, see code D8670.

D8070 **Comprehensive orthodontic treatment of the transitional dentition**
D8080 **Comprehensive orthodontic treatment of the adolescent dentition**
D8090 **Comprehensive orthodontic treatment of the adult dentition** (up to age 21)

MINOR TREATMENT TO CONTROL HARMFUL HABITS

D8210 **Removable appliance therapy**
Removable indicates patient can remove; includes appliances for thumb sucking and tongue thrusting.

CODE **DESCRIPTION**

OTHER ORTHODONTIC SERVICES

D8660 **Pre-orthodontic treatment visit**
Orthodontist only. May not be reimbursed in conjunction with D0120.

D8670 **Periodic orthodontic treatment visit (as part of contract)**
This code can be billed quarterly for a maximum of 3 years and can only be billed **four (4) times** in a twelve-month period **beginning 90 days after the date of service** on which orthodontic appliances have been placed for active treatment. Claims billed more frequently than the allotted four times per year will result in an automatic systems denial.

D8680 **Orthodontic retention (removal of appliances**, **construction and placement of retainer(s)** (for post-treatment stabilization)
D8690 **Orthodontic treatment (alternative billing to a contract fee**
Services provided by orthodontist other than original treating orthodontist. This is limited to transfer care and removal of appliances.

D8692 **Replacement of lost or broken retainer**
This procedure will be reimbursed once per lifetime and includes both arches, if necessary.

D8999 **Unspecified orthodontic procedure**

XII. ADJUNCTIVE GENERAL SERVICES D9000 - D9999

UNCLASSIFIED TREATMENT

D9110 **Palliative (emergency) treatment of dental pain - minor procedure** (documentation required)

This service is not reimbursable in addition to other therapeutic services performed at the same visit or in conjunction with initial or periodic oral examinations when the procedure does not add significantly to the length of time and effort of the treatment provided during that particular visit. Cannot be billed with D0140.

When billing, the provider must document the nature of the emergency, the area and/or tooth involved and the specific treatment involved. This information should be placed on a separate sheet of paper and submitted with the claim form.

CODE **DESCRIPTION**

ANESTHESIA

The administration of general anesthesia or intravenous (parenteral) sedation will be reimbursed in conjunction with surgical and restorative procedures when performed by a qualified dentist who is certified in dental anesthesia by the New York State Education Department. **The cost of analgesic and anesthetic agents (e.g., oral conscious sedatives) is included in the reimbursement for the dental service.** The administration of nitrous oxide, with or without local anesthetic, but without other agents, is not reimbursable. Reimbursement for general anesthesia, intravenous (parenteral) sedation and anesthesia time is conditioned upon meeting the definitions listed below.

General Anesthesia is defined as a controlled state of unconsciousness, accompanied by a partial or complete loss of protective reflexes, including loss of ability to independently maintain an airway and respond purposefully to physical stimulation or verbal command.

Deep Sedation is an induced state of depressed consciousness accompanied by partial loss of protective reflexes, including the inability to continually maintain an airway independently and/or to respond purposefully to physical stimulation or verbal command.

Intravenous (**parenteral) sedation** is defined as a controlled state of depressed consciousness that is produced by the administration of medication intravenously, intramuscularly or subcutaneously.

Intravenous (parenteral) conscious sedation is defined as a minimally depressed level of consciousness produced by the administration of medication intravenously, intramuscularly, or subcutaneously in which the patient remains conscious, retains the ability to breathe continually without assistance and retains the ability to respond meaningfully to verbal commands and physical stimuli.

Anesthesia Time is defined as the period between the beginning of the administration of the anesthetic agent and the time that the anesthetist is no longer in personal attendance. Reimbursement for general anesthesia or intravenous (parenteral) sedation is dependent upon anesthesia time. Since anesthesia time is divided into units for billing purposes, the number of such units should be entered in the "Times Performed" field of the claim form for procedure codes D9220-D9242. The **first 30 minutes** of anesthesia time is billed as one unit using the appropriate code (**either** D9220 or D9241). If the procedure requires more than 30 minutes of anesthesia time, **additional time is billed in 15-minute units** (one unit = 15 minutes) using the appropriate code (either D9221 or D9242).

D9220 **Deep Sedation/general anesthesia – first 30 minutes**
D9221 **Deep Sedation/general anesthesia – each additional 15 minutes**
D9241 **Intravenous conscious sedation/analgesia – first 30 minutes** (parenteral sedation)
D9242 **Intravenous conscious sedation/analgesia – each additional 15 minutes** (parenteral sedation)

CODE **DESCRIPTION**

PROFESSIONAL CONSULTATION

D9310 **Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician**

Consultation is defined as advice and counsel from an accredited specialist, which is provided at the request of the attending dentist in regard to the further management of the case by the attending dentist. A consultation also occurs when a health practitioner in another discipline (e.g. a physician) requests the advice and counsel of any dentist in regard to the referring practitioner's further management of the case.

If the consultant provider assumes the management of the patient after the consultation, subsequent services rendered by that provider will not be reimbursed as consultation. Referral for diagnostic aids (including radiographs) does not constitute consultation but is reimbursable at the listed fees for such services. Consultation will not be reimbursed if claimed by a provider within ninety days of an examination (D0120 or D0160) or an office visit for observation (D9430). To expedite review, indication of the referring provider must be included.

PROFESSIONAL VISITS

D9410 **House/extended care facility call**

Per visit, regardless of number of patients seen (to be added to fee for service). **Fee for service reimbursement will not be made for those individuals who reside in facilities where dental services are included in the facility rate.** Reimbursement should be sought from the facility. The fee for a home visit represents the total extra charge permitted, and is not applicable to each patient seen at such a visit. Includes visits to long-term care facilities, hospice sites, or other institutions.

D9420 **Hospital call**

Per visit, per patient (to be added to fee for service). This service will be recognized only for professional visits for pre-operative or operative care. Post-operative visits are not reimbursable when related to procedures with assigned follow-up days. Hospital calls are not reimbursable for hospital-based providers.

D9430 **Office visit for observation (during regularly scheduled hours) – no other services performed**

Reimbursement includes the prescribing of medications and is subject to the limitations noted for consultation and is limited to two instances per clinical episode. First, an orthodontist may monitor the status of an **orthodontic patient** following an authorized phase or after the completion of active orthodontic treatment. Secondly, the evaluation of a **non-referred recipient** for whom treatment is not indicated is limited to the following providers: pedodontists, endodontists, prosthodontists, oral and maxillofacial surgeons and maxillofacial prosthodontists.

CODE **DESCRIPTION**

D9440 **Office visit - after regularly scheduled hours**
To be added to fee for service. This service is reimbursable only when requested and provided between 10:00 p.m. and 8:00 a.m. for emergency treatment.

DRUGS

D9610 **Therapeutic drug injection, by report**
Submit itemized invoice indicating name and dosage of drug administered.

MISCELLANEOUS SERVICES

D9920 **Behavior management by report** (OMRDD client identification form required)
This is a **per visit** incentive to compensate for the greater knowledge, skill, sophisticated equipment, extra time and personnel required to treat this population. This fee will be paid in addition to the normal fees for specific dental procedures. For purposes of the Medicaid program, the developmentally disabled population (OMRDD Clients) for which procedure code D9920 may be billed is limited to those who receive ongoing services from community programs operated or certified by the New York State Office of Mental Retardation and Developmental Disabilities (OMRDD). These include, among others, family care programs, programs operated directly by the State and programs operated by agencies such as Association for Retarded Children (ARC's) and private schools. To identify patients who are eligible for services billed under procedure code D9920, OMRDD has provided these individuals with special identification forms. In order to ensure the proper use of this procedure code, a copy of the completed OMRDD client identification letter must be attached to each claim submitted under procedure code D9920. You should maintain a copy of this form with the patient's record.

D9940 **Occlusal guard**
Removable dental appliance, which are designed to minimize the effects of bruxism (grinding) and other occlusal factors.

NEW YORK STATE
MEDICAID PROGRAM

DENTAL

BILLING GUIDELINES

TABLE OF CONTENTS

Section I – Purpose Statement

The purpose of this document is to assist the provider community in understanding and complying with the New York State Medicaid (NYS Medicaid) requirements and expectations for:

- Billing and submitting claims.
- Interpreting and using the information returned in the Medicaid Remittance Advice.

This document is customized for Dental providers and should be used by the provider as an instructional as well as a reference tool.

Section II – Claims Submission

Dental providers can submit their claims to NYS Medicaid in electronic or paper formats (except for Dental Clinics, which must only submit electronic claims).

Electronic Claims

Pursuant to the Health Insurance Portability and Accountability Act (HIPAA), Public Law 104-191, which was signed into law August 12, 1996, the NYS Medicaid Program adopted the HIPAA-compliant transactions as the sole acceptable format for electronic claim submission, effective November 2003.

Dental providers who choose to submit their Medicaid claims electronically are required to use the HIPAA 837 Dental (837D) transaction. In addition to this document, direct billers may also refer to the sources listed below to comply with the NYS Medicaid requirements:

- **HIPAA 837D Implementation Guide (IG)** explains the proper use of the 837D standards and program specifications. This document is available at www.wpc-edi.com/hipaa.

- **NYS Medicaid 837D Companion Guide (CG)** is a subset of the IG that provides specific instructions on the NYS Medicaid requirements for the 837D transaction.

- **NYS Medicaid Technical Supplementary Companion Guide** provides technical information needed to successfully transmit and receive electronic data. Some of the topics put forth in this CG are testing requirements, error report information, and communication specifications.

These documents are available at www.emedny.org by clicking on the link to the web page below:

eMedNY Companion Guides and Sample Files

Pre-requirements for the Submission of Electronic Claims

Before being able to start submitting electronic claims to NYS Medicaid, providers need the following:

- An Electronic/Paper Transmitter Identification Number (ETIN)
- A Certification Statement
- A User ID and Password
- A Trading Partner Agreement
- Testing

ETIN
This is a submitter identifier issued by the eMedNY Contractor that must be used in every electronic submission to NYS Medicaid. ETINs may be issued to an individual provider or provider group (if they are direct billers) and to service bureaus or clearinghouses.

The ETIN application is available at www.emedny.org by clicking on the link to the web page below;

Provider Enrollment Forms

Certification Statement
All providers, either direct billers or those who bill through a service bureau or clearinghouse, must file a notarized Certification Statement with NYS Medicaid for each ETIN used for the electronic billing.

The Certification Statement is good for one year, after which it needs to be renewed for electronic billing continuity under a specific ETIN. Failure to renew the Certification Statement for a specific ETIN will result in claim rejection.

The Certification Statement is available on the third page of the ETIN application at www.emedny.org or can be accessed by clicking on the link above.

User ID and Password
Electronic submitters need a user ID and password to access the NYS Medicaid eMedNY system through one of the communication methods available. The user ID and password are issued to the submitter at the time of enrollment in one of the communication methods. The method used to apply for a user ID varies depending on the communication method chosen by the provider. For example: An ePACES user ID is assigned systematically via email while an FTP user ID is assigned after the submission of a Security Packet B.

Trading Partner Agreement
This document addresses certain requirements applicable to the electronic exchange of information and data associated with health care transactions. The NYS Medicaid Trading Partner Agreement is available at www.emedny.org by clicking on the link to the web page below:

Provider Enrollment Forms

Testing
Direct billers (either individual providers or service bureaus/clearinghouses that bill for multiple providers) are encouraged to submit production tests to CSC before they start submitting Medicaid claims for the first time after enrollment or any time they update their systems or start using a new system. This testing will assist providers in identifying errors in their system and allow for corrections before they submit actual claims. Information and instructions regarding testing are available at www.emedny.org by clicking on the link to the web page below:

eMedNY Companion Guides and Sample Files

Communication Methods

The following communication methods are available for submission of electronic claims to NYS Medicaid:

- ePACES
- eMedNY eXchange
- FTP
- CPU to CPU
- eMedNY Gateway

ePACES

NYS Medicaid provides ePACES, a HIPAA-compliant web-based application that is customized for specific transactions, including the 837D. ePACES, which is provided free of charge, is ideal for providers with small to medium claim volume.

The requirements for using ePACES include:

- An ETIN and Certification Statement should be obtained prior to enrollment
- Internet Explorer 4.01 and above or Netscape 4.7 and above
- Internet browser that supports 128-bit encryption and cookies
- Minimum connection speed of 56K
- An accessible email address

The following transactions can be submitted via ePACES:

- 270/271 - Eligibility Benefit Inquiry and Response
- 276/277 - Claim Status Request and Response
- 278 - Prior Approval/Prior Authorization/Service Authorization Request and Response
- 837 - Dental, Professional, and Institutional Claims

To take advantage of ePACES, providers need to follow an enrollment process. Additional enrollment information is available at www.emedny.org by clicking on the link to the web page below:

Self Help

eMedNY eXchange

The eMedNY eXchange works like email; users are assigned an inbox and they are able to send and receive transaction files in an email-like fashion. Transaction files are attached and sent to eMedNY for processing, and the responses are delivered to the user's inbox so they can be detached and saved on the user's computer. **For security reasons, the eMedNY eXchange is accessible only through the eMedNY website at** www.emedny.org.

The eMedNY eXchange only accepts HIPAA-compliant transactions.

Access to the eMedNY eXchange is obtained through an enrollment process. To enroll in eXchange, you must first complete enrollment in ePACES and at least one login attempt must be successful.

FTP

File Transfer Protocol (FTP) is the standard process for batch authorization transmissions. FTP allows users to transfer files from their computer to another computer. FTP is strictly a dial-up connection.

FTP access is obtained through an enrollment process. To obtain a user name and password, you must complete and return a Security Packet B. The Security Packet B can be found at www.emedny.org by clicking on the link to the web page below:

Provider Enrollment Forms

CPU to CPU

This method consists of a direct connection established between the submitter and the processor, and it is most suitable for high volume submitters. For additional information regarding this access method, please contact the eMedNY Call Center at 800-343-9000.

eMedNY Gateway

This is a dial-up access method. It requires the use of the user ID assigned at the time of enrollment and a password. eMedNY Gateway access is obtained through an enrollment process. To obtain a user name and password you must complete and return a Security Packet B. The Security Packet B can be found at www.emedny.org by clicking on the link to the web page below:

Provider Enrollment Forms

Note: For questions regarding ePACES, eXchange, FTP, CPU to CPU, or eMedNY Gateway connections, call the eMedNY Call Center at 800-343-9000.

Paper Claims

Dental providers who choose to submit their claims on paper forms must use the New York State eMedNY-000201 claim form (Form A). To view the eMedNY-000201 claim form, please click on the link provided below. The displayed claim form is a sample and the information it contains is for illustration purposes only.

Dental - Sample Claim

General Instructions for Completing Paper Claims

Since the information entered on the claim form is captured via an automated data collection process (imaging), it is imperative that it be legible and placed appropriately in the required fields. The following guidelines will help ensure the accuracy of the imaging output:

- All information should be typed or printed.
- Alpha characters (letters) should be capitalized.
- Numbers should be written as close to the example below as possible:

1 2 3 4 5 6 7 8 9 0

- Circles (the letter O, the number 0 must be closed.
- Avoid unfinished characters. For example:

Written As	Intended As	Interpreted As
6.00	6.00	6.60 → Zero interpreted as six

- When typing or printing, stay within the box provided; ensure that no characters (letters or numbers) touch the claim form lines. For example:

Written As	Intended As	Interpreted As
2	2	7 → Two interpreted as seven
3	3	2 → Three interpreted as two

- Characters should not touch each other. For example:

Written As	Intended As	Interpreted As	
	23	illegible	→ Entry cannot be interpreted properly

- Do not write in between lines.
- Do not use arrows or quotation marks to duplicate information.
- Do not use the dollar sign ($) to indicate dollar amounts; do not use commas to separate thousands. For example, three thousand should be entered as 3000, not as 3,000.
- For writing, it is best to use a felt tip pen with a fine point. Avoid ballpoint pens that skip; do not use pencils, highlighters, or markers. Only blue or black ink is acceptable.
- If filling in information through a computer, ensure that all information is aligned properly, and that the printer ink is dark enough to provide clear legibility.
- Do not submit claim forms with corrections (i.e. information written over correction fluid or crossed out information). If mistakes are made, a new form should be used.
- Separate forms using perforations; do not cut the edges.
- Do not fold the claim forms.
- Do not use adhesive labels (for example for address); do not place stickers on the form.
- Do not write or use staples on the bar-code area.

The address for submitting claim forms is:

COMPUTER SCIENCES CORPORATION
P.O. Box 4601
Rensselaer, NY 12144-4601

Claim Form A-eMedNY-000201

To view the eMedNY-000201 claim form, please click on the link provided below. The displayed claim form is a sample and the information it contains is for illustration purposes only.

Dental - Sample Claim

General Information About the eMedNY-000201

Shaded fields are not required to be completed **unless noted otherwise**. Therefore, shaded fields that are not required to be completed in any circumstance are not listed in the instructions that follow.

Most claim form fields have been sized to contain the exact number of characters for the required information. However, some fields have been sized to accommodate potential future changes. For example, the Provider ID number has more spaces than the current number of characters for the required information. In this case, the entry must be **right justified (unless otherwise noted in the field instructions)**; that is, the extra spaces must be left blank at the left side of the box. For example, Provider ID number 02345678 should be entered as follows:

		0	2	3	4	5	6	7	8

Billing Instructions for Dental Services

This subsection of the Billing Guidelines covers the specific NYS Medicaid billing requirements for Dental providers. Although the instructions that follow are based on the eMedNY-000201 paper claim form, they are also intended as a guideline for electronic billers who should refer to these instructions for finding out what information they need to provide in their claims, what codes they need to use, etc.

It is important that providers adhere to the instructions outlined below. Claims that do not conform to the eMedNY requirements as described throughout this document may be rejected, pended, or denied.

Field by Field Instructions for Claim Form A-eMedNY-000201

Header Section: Fields 1 through 24B

The information entered in the Header Section of the claim form (fields 1 through 24B) must apply to all of the claim lines entered in the Encounter Section of the form.

PROVIDER ID NUMBER (Field 1)

The Provider ID number is the eight-digit identification number assigned to providers at the time of enrollment in the Medicaid program.

Enter the provider's ID number and the provider's name and correspondence address in this field.

Note: Until NYS Medicaid is able to accept and process claims using the National Provider ID (NPI), providers must continue to report their assigned NYS Medicaid Provider ID number. Providers will be notified by NYS Medicaid when to begin reporting NPI information.

BILLING DATE (Field 2)

Leave this field blank.

GROUP ID NUMBER (Field 3)

The Medicaid Group ID number is the eight-digit identification number assigned to the group at the time of enrollment in the Medicaid program.

For a **Group Practice**, enter the Group ID number in this field. A claim should be submitted under the Group ID **only** if payment for the service(s) being claimed is to be made to the group. In such a case, the Medicaid Provider ID number of the group member that rendered the service must be entered in Field 1.

For a **Shared Health Facility**, enter in this field the eight-digit identification number that was assigned to the facility by the New York State Department of Health at the time of enrollment in the Medicaid program.

If the provider or the service(s) rendered is not associated with a Group Practice or a Shared Health Facility, leave this field blank.

Dental Schools and Orthodontic Clinics
Leave this field blank.

Note: Until NYS Medicaid is able to accept and process claims using the National Provider ID (NPI), providers must continue to report their assigned NYS Medicaid Provider ID number. Providers will be notified by NYS Medicaid when to begin reporting NPI information.

LOCATOR CODE (Field 4)

Locator codes are assigned to the provider for each service address registered at the time of enrollment in the Medicaid program or at anytime afterward that a new location is added.

Locator codes 001 and 002 are for administrative use only and are not to be entered in this field. If the provider renders services at one location only, enter locator code 003. If the provider renders service to Medicaid recipients at more than one location, the entry may be 003 or a higher locator code. Enter the locator code that corresponds to the address where the service was performed.

Note: The provider is reminded of the obligation to notify Medicaid of all service locations as well as changes to any of them. For information on where to direct locator code updates, please refer to Information for All Providers, Inquiry section on the web page for this manual.

SA EXCP CODE [Service Authorization Exception Code] (Field 5)

For Dental Clinic Claims Only
If it was necessary to provide a service covered under the Utilization Threshold (UT) program and Service Authorization (SA) could not be obtained, enter the SA exception code that best describes the reason for the exception. For valid SA exception codes, please refer to Appendix A - Code Sets.

For more information on the UT Program, please refer to Information for All Providers, General Policy, which can be found on the web page for this manual.

If not applicable, leave this field blank.

Fields 6 and 6A should only be used to adjust or void a paid claim. Do not write in these fields when preparing an original claim form.

ADJUSTMENT/VOID CODE (Field 6)

Leave this field blank when submitting an original claim or resubmission of a denied claim.

- If submitting an **adjustment** (replacement) to a previously paid claim, enter **X** or the value **7** in the A box.

- If submitting a **void** to a previously paid claim, enter **X** or the value **8** in the V box.

ORIGINAL CLAIM REFERENCE NUMBER (Field 6A)

Leave this field blank when submitting an original claim or resubmission of a denied claim.

If submitting an adjustment or a void, enter the appropriate **Transaction Control Number (TCN)** in this field. A TCN is a 16-digit identifier that is assigned to each claim document or electronic record regardless of the number of individual claim lines (service date/procedure combinations) submitted in the document or record. For example, a document/record containing a single service date/procedure combination will be assigned a unique, single TCN; a document/record containing five service date/procedure combinations will be assigned a unique, single TCN, which will be shared by all the individual claim lines submitted under that document/record.

Adjustment
An adjustment may be submitted to accomplish any of the following purposes:

- To change information contained in one or more claims submitted on a previously paid TCN

- To cancel one or more claim lines submitted on a previously paid TCN (except if the TCN contained one single claim line or if all the claim lines contained in the TCN are to be voided)

Adjustment to Change Information

If an adjustment is submitted to correct information on one or more claim lines sharing the same TCN, follow the instructions below:

- The **Provider ID number**, the **Group ID number**, and the **Patient's Medicaid ID number** must not be adjusted.

- The adjustment must be submitted in a new claim form (copy of the original form is unacceptable).

- The adjustment must contain all claim lines originally submitted in the same document/record (all claim lines with the same TCN), and all applicable fields must be completed with the necessary changes.

The adjustment will cause the correction of the adjusted information in the TCN history records as well as the cancellation of the original TCN payment and the re-pricing of the TCN based on the adjusted information.

Example:

TCN 0709819876543200 is shared by three individual claim lines. This TCN was paid on April 18, 2007. After receiving payment, the provider determines that the service date of one of the claim line records is incorrect. An adjustment must be submitted to correct the records. Refer to Figures 1A and 1B for an illustration of this example.

Figure 1A: Original Claim Form
NYS MEDICAL ASSISTANCE (TITLE IX) PROGRAM CLAIM FORM A

1. PROVIDER ID NUMBER: 01234567

2. BILLING DATE: MO | DAY | YR

3. GROUP ID NUMBER

4. LOCATOR CODE: 003

5. SA EXCP CODE

ONLY TO BE USED TO ADJUST OR VOID A PAID CLAIM

6. CODE: A V

6A. ORIGINAL CLAIM REFERENCE NUMBER

James Strong, DDS
312 Main Street
Anytown, New York 11111

7. RECIPIENT ID NUMBER: AB123456C

8. DATE OF BIRTH: 05201990

8A. SEX: M F X

9. RECIPIENT NAME – FIRST: Jane

9A. RECIPIENT NAME – LAST: Smith

10. OFFICE ACCOUNT NUMBER (OPTIONAL): AB123456

11. OFFICE USE ONLY

DIAGNOSIS CODE
12. PRIMARY
12A. SECONDARY

EMER-GENCY? 13. Y N
POSSIBLE DISABILITY? 13A. Y N
FAMILY PLANNING 13B. Y N
ACCIDENT CODE 14.
PATIENT STATUS CODE 15.
EPSDT/ C/THP 16. Y N
RECIPIENT OTHER INSURANCE CODE 17.
ABORT STER CODE 18.
19. PRIOR APPROVAL NUMBER

PLACE OF SERVICE
20. CODE: 11
20A. ADDRESS

21. SERVICE PROVIDER ID/LICENSE NUMBER
21A. PROF CD
21B. NAME

22. OTHER IREFERRING/ORDERING PROVIDER ID/LICENSE NUMBER
22A. PROF CD
22B. NAME

23. ORDERING/REFERRING PROVIDER ID/LICENSE NUMBER
23A. PROF CD
23B. NAME

24.SHARED HEALTH FACILITY ONLY ▶
24A. SIGNATURE
24B. DIAGNOSIS

	25. DATE OF SERVICE MO	DAY	YR	26. PROCEDURE CODE	27. TIMES PERFORMED	28. ORAL CAVITY	DENTAL 29. TOOTH	29A. SURFACE M	I/O	D	F/B	L	30. AMOUNT CHARGED	MEDICARE 31. CO-INSURANCE	31A. DEDUCTIBLE	31B. CO-PAY	31C. PAID	32. OTHER INSURANCE PAID
	04	04	07	D3220			01						87.00					
	04	04	07	D2933			02						130.00					
	04	04	07	D3351			04						67.00					

33. CASE MGR | TOTALS | 34. | 35. | 35A. | 35B. | 35C. | 36.

DO NOT STAPLE IN BARCODE AREA

[redacted]

CERTIFICATION
(I CERTIFY THAT THE STATEMENTS ON THE REVERSE SIDE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.)

37. SIGNATURE	37A. COUNTY*	38. DATE MO	DAY	YR
James Strong		04	05	07

***Payee must enter county wherein signed unless it is the same as that of the provider address entered in the upper left of this form.**

Figure 1B: Adjustment
NYS MEDICAL ASSISTANCE (TITLE IX) PROGRAM CLAIM FORM A

1. PROVIDER ID NUMBER	2. BILLING DATE MO	DAY	YR	3. GROUP ID NUMBER	4. LOCATOR CODE	5. SA EXCP CODE	ONLY TO BE USED TO ADJUST OR VOID A PAID CLAIM 6. CODE	6A. ORIGINAL CLAIM REFERENCE NUMBER
0 1 2 3 4 5 6 7					0 0 3		7A V	0 7 0 9 8 1 9 8 7 6 5 4 3 2 0 0

7. RECIPIENT ID NUMBER	8. DATE OF BIRTH	8A. SEX M	F	9. RECIPIENT NAME – FIRST	10. OFFICE ACCOUNT NUMBER (OPTIONAL)	11. OFFICE USE ONLY
A B 1 2 3 4 5 C	0 5 2 0 1 9 9 0		X	Jane		
				9A. RECIPIENT NAME – LAST: Smith	A B 1 2 3 4 5	

James Strong, DDS
312 Main Street
Anytown, New York 11111

DIAGNOSIS CODE 12. PRIMARY	12A. SECONDARY	EMER-GENCY? 13. Y N	POSSIBLE DISABILITY? 13A. Y N	FAMILY PLANNING 13B. Y N	ACCIDENT CODE 14.	PATIENT STATUS CODE 15.	EPSDT/ C/THP 16. Y N	RECIPIENT OTHER INSURANCE CODE 17.	ABORT STER CODE 18.	19. PRIOR APPROVAL NUMBER
.	.									

PLACE OF SERVICE 20. CODE	20A. ADDRESS	21. SERVICE PROVIDER ID/LICENSE NUMBER	21A. PROF CD	21B. NAME	23. ORDERING/REFERRING PROVIDER ID/LICENSE NUMBER	23A. PROF CD	23B. NAME
1 1							
		22. OTHER IREFERRING/ORDERING PROVIDER ID/LICENSE NUMBER	22A. PROF CD	22B. NAME	24.SHARED HEALTH FACILITY ONLY ▶	24A. SIGNATURE	24B. DIAGNOSIS

	25. DATE OF SERVICE MO	DAY	YR	26. PROCEDURE CODE	27. TIMES PERFORMED	28. ORAL CAVITY	DENTAL 29. TOOTH	29A. SURFACE M	I/O	D	F/B	L	30. AMOUNT CHARGED	MEDICARE 31. CO-INSURANCE	31A. DEDUCTIBLE	31B. CO-PAY	31C. PAID	32. OTHER INSURANCE PAID
	0 4	0 4	0 7	D 3 2 2 0			0 1						8 7.0 0					
	0 4	0 4	0 7	D 2 9 3 3			0 2						1 3 0.0 0					
	0 4	0 1	0 7	D 3 3 5 1			0 4						8 7.0 0					
	33. CASE MGR			TOTALS									34.	35.	35A.	35B.	35C.	36.

DO NOT STAPLE IN BARCODE AREA

[redacted]

CERTIFICATION
(I CERTIFY THAT THE STATEMENTS ON THE REVERSE SIDE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.)

37. SIGNATURE	37A. COUNTY*	38. DATE MO	DAY	YR
James Strong		06	05	07

***Payee must enter county wherein signed unless it is the same as that of the provider address entered in the upper left of this form.**

Adjustment to Cancel One or More Claims Originally Submitted on the Same Document/Record (TCN)

An adjustment should be submitted to cancel or void one or more individual claim lines that were originally submitted on the same document/record and share the same TCN. The following instructions must be followed:

- The adjustment must be submitted in a new claim form (copy of the original form is unacceptable).

- The adjustment must contain all claim lines submitted in the original document (all claim lines with the same TCN) **except for the claim(s) line(s) to be voided**; these claim lines must be omitted in the adjustment. All applicable fields must be completed.

The adjustment will cause the cancellation of the omitted individual claim lines from the TCN history records as well as the cancellation of the original TCN payment and the re-pricing of the new TCN (Adjustment) based on the adjusted information.

Example:

TCN 0709818765432100 contained three individual claim lines, which were paid on April 18, 2007. Later it was determined that one of the claims was incorrectly billed since the service was never rendered. The claim line for that service must be cancelled to reimburse Medicaid for the overpayment. An adjustment should be submitted. Refer to Figures 2A and 2B for an illustration of this example.

Figure 2A: Original Claim Form
NYS MEDICAL ASSISTANCE (TITLE IX) PROGRAM CLAIM FORM A

1. PROVIDER ID NUMBER: 0 1 2 3 4 5 6 7

2. BILLING DATE: MO | DAY | YR

3. GROUP ID NUMBER

4. LOCATOR CODE: 0 0 3

5. SA EXCP CODE

ONLY TO BE USED TO ADJUST OR VOID A PAID CLAIM

6. CODE: A V

6A. ORIGINAL CLAIM REFERENCE NUMBER

James Strong, DDS
312 Main Street
Anytown, New York 11111

7. RECIPIENT ID NUMBER: A B 1 2 3 4 5 C

8. DATE OF BIRTH: 0 5 2 0 1 9 9 0

8A. SEX: M | F X

9. RECIPIENT NAME – FIRST: Jane

9A. RECIPIENT NAME – LAST: Smith

10. OFFICE ACCOUNT NUMBER (OPTIONAL): A B 1 2 3 4 5

11. OFFICE USE ONLY

DIAGNOSIS CODE
12. PRIMARY: .
12A. SECONDARY: .

13. EMER-GENCY?	13A. POSSIBLE DISABILITY?	13B. FAMILY PLANNING	14. ACCIDENT CODE	15. PATIENT STATUS CODE	16. EPSDT/ C/THP	17. RECIPIENT OTHER INSURANCE CODE	18. ABORT STER CODE	19. PRIOR APPROVAL NUMBER
Y N	Y N	Y N			Y N			

PLACE OF SERVICE
20. CODE: 1 1
20A. ADDRESS

21. SERVICE PROVIDER ID/LICENSE NUMBER
21A. PROF CD
21B. NAME

22. OTHER IREFERRING/ORDERING PROVIDER ID/LICENSE NUMBER
22A. PROF CD
22B. NAME

23. ORDERING/REFERRING PROVIDER ID/LICENSE NUMBER
23A. PROF CD
23B. NAME

24.SHARED HEALTH FACILITY ONLY ▶
24A. SIGNATURE
24B. DIAGNOSIS: .

	25. DATE OF SERVICE MO	DAY	YR	26. PROCEDURE CODE	27. TIMES PERFORMED	28. ORAL CAVITY	DENTAL 29. TOOTH	29A. SURFACE M	I/O	D	F/B	L	30. AMOUNT CHARGED	MEDICARE 31. CO-INSURANCE	31A. DEDUCTIBLE	31B. CO-PAY	31C. PAID	32. OTHER INSURANCE PAID
	0 4	0 4	0 7	D 3 2 2 0			0 1						8 7.0 0	.	.	.	.	.
	0 4	0 4	0 7	D 2 9 3 3			0 2						1 3 0.0 0	.	.	.	.	.
	0 4	0 4	0 7	D 3 3 5 1			0 4						6 7.0 0	.	.	.	.	.
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	33. CASE MGR			TOTALS									34. .	35. .	35A. .	35B. .	35C. .	36. .

DO NOT STAPLE IN BARCODE AREA

[redacted]

CERTIFICATION
(I CERTIFY THAT THE STATEMENTS ON THE REVERSE SIDE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.)

37. SIGNATURE	37A. COUNTY*	38. DATE MO	DAY	YR
James Strong		04	05	07

***Payee must enter county wherein signed unless it is the same as that of the provider address entered in the upper left of this form.**

Version 2008 – 1 (01/16/08)

Figure 2B: Adjustment
NYS MEDICAL ASSISTANCE (TITLE IX) PROGRAM CLAIM FORM A

1. PROVIDER ID NUMBER	2. BILLING DATE MO	DAY	YR	3. GROUP ID NUMBER	4. LOCATOR CODE	5. SA EXCP CODE	ONLY TO BE USED TO ADJUST OR VOID A PAID CLAIM: 6. CODE	6A. ORIGINAL CLAIM REFERENCE NUMBER
01234567					003		7 A / V	07098187654321000

7. RECIPIENT ID NUMBER	8. DATE OF BIRTH	8A. SEX M	F	9. RECIPIENT NAME – FIRST	9A. RECIPIENT NAME – LAST	10. OFFICE ACCOUNT NUMBER (OPTIONAL)	11. OFFICE USE ONLY
AB123456C	05201990		X	Jane	Smith	AB123456	

James Strong, DDS
312 Main Street
Anytown, New York 11111

DIAGNOSIS CODE 12. PRIMARY	12A. SECONDARY	EMER-GENCY? 13. Y	N	POSSIBLE DISABILITY? 13A. Y	N	FAMILY PLANNING 13B. Y	N	ACCIDENT CODE 14.	PATIENT STATUS CODE 15.	EPSDT/ C/THP 16. Y	N	RECIPIENT OTHER INSURANCE CODE 17.	ABORT STER CODE 18.	19. PRIOR APPROVAL NUMBER
.	.													

PLACE OF SERVICE 20. CODE	20A. ADDRESS	21. SERVICE PROVIDER ID/LICENSE NUMBER	21A. PROF CD	21B. NAME	23. ORDERING/REFERRING PROVIDER ID/LICENSE NUMBER	23A. PROF CD	23B. NAME
11							

22. OTHER IREFERRING/ORDERING PROVIDER ID/LICENSE NUMBER	22A. PROF CD	22B. NAME	24.SHARED HEALTH FACILITY ONLY ▶	24A. SIGNATURE	24B. DIAGNOSIS
					.

	25. DATE OF SERVICE MO	DAY	YR	26. PROCEDURE CODE	27. TIMES PERFORMED	28. ORAL CAVITY	DENTAL 29. TOOTH	29A. SURFACE M	I/O	D	F/B	L	30. AMOUNT CHARGED	MEDICARE 31. CO-INSURANCE	31A. DEDUCTIBLE	31B. CO-PAY	31C. PAID	32. OTHER INSURANCE PAID
	04	04	07	D2933			02						130.00	.	.	.	.	.
	04	04	07	D3351			04						67.00	.	.	.	.	.
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33. CASE MGR	TOTALS	34.	35.	35A.	35B.	35C.	36.
		.	.	.	.	.	.

DO NOT STAPLE IN BARCODE AREA

[redacted]

CERTIFICATION
(I CERTIFY THAT THE STATEMENTS ON THE REVERSE SIDE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.)

37. SIGNATURE	37A. COUNTY*	38. DATE MO	DAY	YR
James Strong		06	05	07

***Payee must enter county wherein signed unless it is the same as that of the provider address entered in the upper left of this form.**

Void

A void is submitted to nullify **all** individual claim lines originally submitted on the same document/record and sharing the same TCN.

When submitting a void, please follow the instructions below:

- The void must be submitted on a new claim form (copy of the original form is unacceptable).

- The void must contain all the claim lines to be cancelled and all applicable fields must be completed.

Voids cause the cancellation of the original TCN history records and payment.

Example:

TCN 0709811234567800 contained two claim lines, which were paid on April 18, 2007. Later, the provider became aware that the patient had another insurance coverage. The other insurance was billed and paid in full for all the services. Medicaid must be reimbursed by submitting a void for the two claim lines paid in the specific TCN. Refer to Figures 3A and 3B for an illustration of this example.

Figure 3A: Original Claim Form
NYS MEDICAL ASSISTANCE (TITLE IX) PROGRAM CLAIM FORM A

1. PROVIDER ID NUMBER: 01234567

2. BILLING DATE: MO | DAY | YR

3. GROUP ID NUMBER

4. LOCATOR CODE: 003

5. SA EXCP CODE

ONLY TO BE USED TO ADJUST OR VOID A PAID CLAIM
6. CODE: A V
6A. ORIGINAL CLAIM REFERENCE NUMBER

James Strong, DDS
312 Main Street
Anytown, New York 11111

7. RECIPIENT ID NUMBER: AB123456C
8. DATE OF BIRTH: 05201990
8A. SEX: M F X
9. RECIPIENT NAME – FIRST: Jane
9A. RECIPIENT NAME – LAST: Smith
10. OFFICE ACCOUNT NUMBER (OPTIONAL): AB123456
11. OFFICE USE ONLY

DIAGNOSIS CODE
12. PRIMARY
12A. SECONDARY
EMER-GENCY? 13. Y N
POSSIBLE DISABILITY? 13A. Y N
FAMILY PLANNING 13B. Y N
ACCIDENT CODE 14.
PATIENT STATUS CODE 15.
EPSDT/ C/THP 16. Y N
RECIPIENT OTHER INSURANCE CODE 17.
ABORT STER CODE 18.
19. PRIOR APPROVAL NUMBER

PLACE OF SERVICE
20. CODE: 11
20A. ADDRESS
21. SERVICE PROVIDER ID/LICENSE NUMBER
21A. PROF CD
21B. NAME
22. OTHER IREFERRING/ORDERING PROVIDER ID/LICENSE NUMBER
22A. PROF CD
22B. NAME
23. ORDERING/REFERRING PROVIDER ID/LICENSE NUMBER
23A. PROF CD
23B. NAME
24.SHARED HEALTH FACILITY ONLY ▶
24A. SIGNATURE
24B. DIAGNOSIS

	25. DATE OF SERVICE MO	DAY	YR	26. PROCEDURE CODE	27. TIMES PERFORMED	28. ORAL CAVITY	DENTAL 29. TOOTH	29A. SURFACE M	I/O	D	F/B	L	30. AMOUNT CHARGED	MEDICARE 31. CO-INSURANCE	31A. DEDUCTIBLE	31B. CO-PAY	31C. PAID	32. OTHER INSURANCE PAID
	04	04	07	D3220			01						87.00					
	04	04	07	D2933			02						130.00					

33. CASE MGR | TOTALS | 34. | 35. | 35A. | 35B. | 35C. | 36.

DO NOT STAPLE IN BARCODE AREA

[redacted]

CERTIFICATION
(I CERTIFY THAT THE STATEMENTS ON THE REVERSE SIDE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.)

37. SIGNATURE	37A. COUNTY*	38. DATE MO	DAY	YR
James Strong		04	05	07

***Payee must enter county wherein signed unless it is the same as that of the provider address entered in the upper left of this form.**

Figure 3B: Void
NYS MEDICAL ASSISTANCE (TITLE IX) PROGRAM CLAIM FORM A

1. PROVIDER ID NUMBER	2. BILLING DATE MO	DAY	YR	3. GROUP ID NUMBER	4. LOCATOR CODE	5. SA EXCP CODE	ONLY TO BE USED TO ADJUST OR VOID A PAID CLAIM: 6. CODE	6A. ORIGINAL CLAIM REFERENCE NUMBER
0 1 2 3 4 5 6 7					0 0 3		A 8	0 7 0 9 8 1 1 2 3 4 5 6 7 8 0 0

7. RECIPIENT ID NUMBER	8. DATE OF BIRTH	8A. SEX M	F	9. RECIPIENT NAME – FIRST	10. OFFICE ACCOUNT NUMBER (OPTIONAL)	11. OFFICE USE ONLY
A B 1 2 3 4 5 C	0 5 2 0 1 9 9 0		X	Jane		
				9A. RECIPIENT NAME – LAST: Smith	A B 1 2 3 4 5	

James Strong, DDS
312 Main Street
Anytown, New York 11111

DIAGNOSIS CODE 12. PRIMARY	12A. SECONDARY	EMERGENCY? 13. Y	N	POSSIBLE DISABILITY? 13A. Y	N	FAMILY PLANNING 13B. Y	N	ACCIDENT CODE 14.	PATIENT STATUS CODE 15.	EPSDT/ C/THP 16. Y	N	RECIPIENT OTHER INSURANCE CODE 17.	ABORT STER CODE 18.	19. PRIOR APPROVAL NUMBER

PLACE OF SERVICE 20. CODE	20A. ADDRESS	21. SERVICE PROVIDER ID/LICENSE NUMBER	21A. PROF CD	21B. NAME	23. ORDERING/REFERRING PROVIDER ID/LICENSE NUMBER	23A. PROF CD	23B. NAME
1 1							

22. OTHER IREFERRING/ORDERING PROVIDER ID/LICENSE NUMBER	22A. PROF CD	22B. NAME	24.SHARED HEALTH FACILITY ONLY	24A. SIGNATURE	24B. DIAGNOSIS

	25. DATE OF SERVICE MO	DAY	YR	26. PROCEDURE CODE	27. TIMES PERFORMED	28. ORAL CAVITY	DENTAL 29. TOOTH	29A. SURFACE M	I/O	D	F/B	L	30. AMOUNT CHARGED	MEDICARE 31. CO-INSURANCE	31A. DEDUCTIBLE	31B. CO-PAY	31C. PAID	32. OTHER INSURANCE PAID
	0 4	0 4	0 7	D 3 2 2 0			0 1						8 7.0 0					
	0 4	0 4	0 7	D 2 9 3 3			0 2						1 3 0.0 0					

33. CASE MGR	TOTALS	34.	35.	35A.	35B.	35C.	36.

DO NOT STAPLE IN BARCODE AREA

[redacted]

CERTIFICATION
(I CERTIFY THAT THE STATEMENTS ON THE REVERSE SIDE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.)

37. SIGNATURE	37A. COUNTY*	38. DATE MO	DAY	YR
James Strong		06	05	07

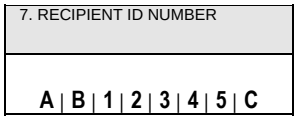
***Payee must enter county wherein signed unless it is the same as that of the provider address entered in the upper left of this form.**

Fields 7-9A require information obtained from the Client's (Recipient's) Medicaid Common Benefit Identification Card.

RECIPIENT ID NUMBER (Field 7)

Enter the patient's identification number (Client ID number). Medicaid Client ID numbers are assigned by NYS Medicaid and are composed of eight characters in the format AANNNNNA, where A = alpha character and N = numeric character.

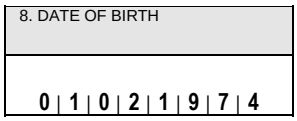
Example:



DATE OF BIRTH (Field 8)

Enter the patient's birth date. The birth date must be in the format MMDDYYYY.

Example: Mary Brandon was born on January 2, 1974.



SEX (Field 8A)

Place an 'X' in the appropriate box to indicate the patient's sex.

RECIPIENT NAME (Fields 9 and 9A)

Enter the patient's first name in Field 9 and the last name in Field 9A.

OFFICE ACCOUNT NUMBER (OPTIONAL) (Field 10)

For record-keeping purposes, the provider may choose to identify a recipient by using an Office Account number. This field can accommodate up to 20 alphanumeric characters. If an Office Account number is indicated on the claim form, it will be returned on the Remittance Advice. Using an Office Account number can be helpful for locating accounts when there is a question on the recipient identification.

DIAGNOSIS CODE [Primary/Secondary] (Fields 12 and 12A)

Leave this field blank.

EMERGENCY (Field 13)

Enter an X in the Yes box only when the condition being treated is related to an emergency (the patient requires immediate intervention as a result of severe, life-threatening, or potentially disabling condition); otherwise leave this field blank.

POSSIBLE DISABILITY (Field 13A)

Leave this field blank.

FAMILY PLANNING (Field 13B)

Leave this field blank.

ACCIDENT CODE (Field 14)

If applicable, enter the appropriate code from Appendix A-Code Sets to indicate whether the service rendered to the recipient was for a condition resulting from an accident or a crime.

PATIENT STATUS CODE (Field 15)

Leave this field blank.

EPSDT C/THP CODE (Field 16)

Leave this field blank.

RECIPIENT OTHER INSURANCE CODE (Field 17)

Leave this field blank.

ABORTION/STERILIZATION CODE (Field 18)

Leave this field blank.

PRIOR APPROVAL NUMBER (Field 19)

If the provider is billing for a service that requires Prior Approval/Prior Authorization, enter in this field the 11-digit prior approval number assigned for this service by the appropriate agency of the New York State Department of Health. If several service dates and/or procedures need to be claimed and they are covered by different prior approvals, a separate claim form has to be submitted for each prior approval.

Notes:

- **For information regarding how to obtain Prior Approval/Prior Authorization for specific services, please refer to the Information for All Providers, Inquiry section on the web page for this manual.**

- **For information on how to complete the prior approval form, please refer to the Prior Approval Guidelines for this manual.**

- **For information regarding procedures that require prior approval, please consult the Procedure Codes and Fee Schedules for this manual.**

PLACE OF SERVICE CODE (Field 20)

This **two-digit** code indicates the type of location where the service was rendered. Please note that the Place of Service Code is different from the locator code. Select the appropriate code from Appendix A-Code Sets.

Dental Schools
Enter 99 (Other) in this field and complete Field 20A.

PLACE OF SERVICE ADDRESS (Field 20A)

Dental Schools
Enter the exact address of the location where the service was performed.

SERVICE PROVIDER [Medicaid] ID/LICENSE NUMBER (Field 21)

Dental Schools
Enter the Medicaid ID number or the license number of the supervising dentist.

Orthodontic Clinics
Enter the Medicaid ID number or the license number of the dentist who rendered the service. If more than one dentist rendered the service, enter the Medicaid ID number or the license number of the principal dentist.

Dental Practitioners
Leave this field blank.

Instructions for Entering a License Number
If a license number is used, it must be preceded by two zeroes (00) if it is a NY State license or by the standard Post Office abbreviation of the state of origin if it is an out-of-state license. Please refer to Appendix A-Code Sets for the Post Office state abbreviations.

PROF CD [Profession Code - Service Provider] (Field 21A)

Orthodontic Clinics and Dental Schools
If a license number is indicated in Field 21, the Profession Code that identifies the service provider's profession must be entered in this field. Profession Codes are available at www.emedny.org by clicking on the link to the web page below:

eMedNY Crosswalks

Dental Practitioners
Leave this field blank.

NAME [Service Provider] (Field 21B)

Orthodontic Clinics and Dental Schools
If a license is entered in Field 21 because the service provider is not enrolled in the Medicaid Program, the service provider's name must be entered in this field.

OTHER REFERRING/ORDERING PROVIDER ID/LICENSE NUMBER (Field 22)

Leave this field blank.

PROF CD [Profession Code - Other Referring/Ordering Provider] (Field 22A)

Leave this field blank.

NAME [Other Referring/Ordering Provider] (Field 22B)

Leave this field blank.

Fields 23, 23A, and 23B must be completed when the recipient has been referred by another provider.

ORDERING/REFERRING PROVIDER ID/LICENSE NUMBER (Field 23)

If the patient was referred for treatment by another provider, enter the referring provider's Medicaid ID number in this field. If the referring dentist is not enrolled in Medicaid, enter his/her license number. If no referral was involved, leave this field blank.

If the patient is restricted to another dental provider, the dentist rendering services must enter the **Medicaid ID** number of the patient's primary dental provider in this field. **The license number of the primary dental provider is not acceptable in this case.**

Instructions for Entering a License Number
If a license number is used, it must be preceded by two zeroes (00) if it is a NY State license or by the standard Post Office abbreviation of the state of origin if it is an out-of-state license. Please refer to Appendix A-Code Sets for the Post Office state abbreviations.

PROF CD [PROFESSION CODE - Ordering/Referring Provider] (Field 23A)

If a license number is indicated in Field 23, the Profession Code that identifies the referring provider's profession must be entered in this field. Profession Codes are available at www.emedny.org by clicking on the link to the web page below:

eMedNY Crosswalks

NAME [Ordering/Referring Provider] (Field 23B)

If the patient was referred by another provider, enter the referring provider's name in this field.

SHARED HEALTH FACILITY ONLY (Field 24A)

If services were rendered in a Shared Health Facility and the patient was referred by another provider in the same Shared Health Facility, obtain the referring provider's signature in this field.

Encounter Section: Fields 25 through 32

The claim form can accommodate up to nine encounters with a single patient if all the information in the Header Section of the claim (Fields 1–24B) applies to all the encounters.

DATE OF SERVICE (Field 25)

Enter the date on which the service was rendered in the format MM/DD/YY.

Example: July 1, 2007 = 07/01/07

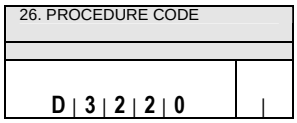
Orthodontists and Orthodontic Clinics
Enter only the last date of service in the quarter for which you are billing.

Note: A service date must be entered for each procedure code listed.

PROCEDURE CODE (Field 26)

This code identifies the type of service that was rendered to the patient. Enter the appropriate five-character Procedure Code in this field. Leave the two spaces to the right of the solid line blank as in the sample below.

Example:



Note: Procedure codes, definitions, prior approval requirements (if applicable), fees, etc. are available at www.emedny.org by clicking on the link below under Procedure Codes and Fee Schedule:

Dental Manual

TIMES PERFORMED (Field 27)

If a procedure was performed more than one time on the same date of service, enter the number of times in this field. If the procedure was performed only one time or the procedure code requires completion of Fields 28 and 29, this field may be left blank.

ORAL CAVITY (Field 28)

If applicable, enter the appropriate Oral Cavity Code from Appendix A- Code Sets.

Procedures requiring an entry in this field are marked accordingly in the Procedure Code and Fee Schedule available at www.emedny.org by clicking on the link below under Procedure Codes and Fee Schedule:

Dental Manual

TOOTH CODE (Field 29)

When appropriate, enter the number(s) or letter(s) that identify the tooth on which the procedure was performed. Tooth Codes can be found in Appendix A-Code Sets.

Procedures requiring an entry in this field are marked accordingly in the Procedure Code and Fee Schedule available at www.emedny.org by clicking on the link below under Procedure Codes and Fee Schedule:

Dental Manual

Notes:

- **A permanent tooth is identified by a two-digit number. For example: 01.**
- **A primary tooth is identified by a capital letter. For example: F.**

SURFACE (Field 29A)

If applicable, enter the code that indicates the tooth surface being restored. Please **write the letter code** in the appropriate column; **do not enter an X**. An entry in this field requires a Tooth Code in Field 29. Surface Codes can be found in Appendix A-Code Sets.

Procedures requiring an entry in this field are marked accordingly in the Procedure Code and Fee Schedule available at www.emedny.org by clicking on the link to the web page below:

Dental Manual

AMOUNT CHARGED (Field 30)

Enter the total amount charged for each service rendered. The amount may not exceed the provider's usual charge.

Fields 31, 31A, 31B, and 31C are only applicable if the recipient is also a Medicare beneficiary.

Notes:

- **It is the responsibility of the provider to determine whether Medicare covers the service being billed for. If the service is covered or if the provider does not know if the service is covered, the provider must first submit a claim to Medicare, as Medicaid is always the payer of last resort.**

- **If the provider knows that the service rendered is not covered by Medicare, enter zero in field 31C.**

MEDICARE CO INSURANCE (Field 31)

If applicable, enter the Medicare co-insurance amount for the specific procedure.

MEDICARE DEDUCTIBLE (Field 31A)

If applicable, enter the Medicare deductible amount for the specific procedure.

MEDICARE CO-PAY (Field 31B)

If applicable, enter the Medicare co-pay amount for the specific procedure.

MEDICARE PAID (Field 31C)

If applicable, enter the amount actually paid by Medicare for the specific procedure. If Medicare denies payment, enter 0.00.

OTHER INSURANCE PAID (Field 32)

This field must be completed if the patient is covered by insurance other than Medicare. Leave this field blank if the recipient has no other insurance coverage.

Note: It is the responsibility of the provider to determine whether the patient is covered by other insurance and whether the insurance carrier covers the service being billed for. If the service is covered or if the provider does not know if the service is covered, the provider must submit a claim to the other insurance carrier prior to billing Medicaid, as Medicaid is the payer of last resort.

If applicable, enter the amount actually paid by the other insurance carrier in this field.

If the other insurance carrier denied payment, enter 0.00 in this field. Proof of denial of payment must be maintained in the patient's billing record. Zeroes must also be entered in this field if any of the following situations apply:

- Prior to billing the insurance company, the provider knows that the service will not be covered because:
  - ► The provider has had a previous denial of payment for the service from the particular insurance policy. However, the provider should be aware that the service should be billed if the insurance policy changes. Proof of denials must be maintained in the patient's billing record. Prior claims denied due to deductibles not being met are not to be counted as denials for subsequent billings.
  - ► In very limited situations, the Local Department of Social Services (LDSS) has advised providers to zero-fill other insurance payment for the same type of service. This communication should be documented in the patient's billing record.
- The provider bills the insurance company and receives a rejection because:
  - ► The service is not covered; or
  - ► The deductible has not been met.
- The provider cannot directly bill the insurance carrier and the policyholder is either unavailable to or uncooperative in submitting claims to the insurance company. In these cases, the LDSS must be notified prior to zero-filling. LDSS has subrogation rights enabling it to complete claim forms on behalf of uncooperative policyholders who do not pay the provider for the services. The LDSS office can direct the insurance company to pay the provider directly for the service whether or not the provider participates with the insurance plan. The provider should contact the third-party worker in the local social services office whenever he/she encounters policyholders who are uncooperative in paying for covered services received by their dependents who are on Medicaid. In other cases, the provider will be instructed to zero-fill the Other Insurance Payment in the Medicaid claim and the LDSS will retroactively pursue the third-party resource.
- The recipient or an absent parent collects the insurance benefits and fails to submit payment to the provider. The LDSS must be notified so that sanctions and/or legal action can be brought against the recipient or absent parent.
- The provider is instructed to zero-fill by the LDSS for circumstances not listed above.

Certification Section: Fields 37 through 38

SIGNATURE (Field 37)

The provider or an authorized representative of a dental school must sign the claim form. Rubber stamp signatures are not acceptable. Please note that the certification statement is on the back of the form.

COUNTY (Field 37A)

Enter the name of the county wherein the claim form is signed. The county may be left blank **only** when the provider's address, entered in Field 1, is within the county wherein the claim form is signed.

DATE (Field 38)

Enter the date on which the provider or an authorized representative of the dental provider signed the claim form. The date should be in the format MM/DD/YY.

Note: In accordance with New York State regulations, claims must be submitted within 90 days of the Date of Service unless acceptable circumstances for the delay can be documented. For more information about billing claims over 90 days or two years from the Date of Service, refer to Information for All Providers, General Billing section on the web page for this manual.

Section III – Remittance Advice

The purpose of this section is to familiarize the provider with the design and contents of the Remittance Advice.

eMedNY produces remittance advices on a weekly (processing cycle) basis. Weekly 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** (by category, status, and member ID) 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, can assist providers in identifying and correcting billing errors and plays an important role in the communication between the provider and the eMedNY Contractor for resolving billing or processing issues.

Remittance advices are available in electronic and paper formats.

Electronic Remittance Advice

The electronic HIPAA 835 transaction (Remittance Advice) is available via the eMedNY eXchange or FTP. To request the electronic remittance advice (835), providers may complete the Electronic Remittance Request Form, which is available at www.emedny.org by clicking on the link to the web page below:

Provider Enrollment Forms

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

The NYS Medicaid Companion Guides for the 835 transaction are available at www.emedny.org by clicking on the link to the web page below:

eMedNY Companion Guides and Sample Files

Providers with multiple ETINs who choose to receive the 835 electronic remittance advice may elect to receive the status of paper claim submissions and state-submitted adjustments/voids in the 835 format. The request must be submitted using the Electronic Remittance Request Form located at www.emedny.org. If this option is chosen, no paper remittance will be produced and the status of claims will appear on the electronic 835 remittance advice for the ETIN indicated on the request form. Retro-adjustment information is also sent in the 835 transaction format. Pending claims do not appear in the 835 transaction; they are listed in the Supplemental file, which will be sent along with the 835 transaction for any processing cycle that produces pends.

Note: Providers with only one ETIN who elect to receive an electronic remittance will have the status of any claims submitted via paper forms and state-submitted adjustments/voids reported on that electronic remittance.

Paper Remittance Advice

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.

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 below:

Provider Enrollment Forms

For additional information, providers may call the eMedNY Call Center at 800-343-9000.

Remittance Advice Format

The remittance advice is composed of five sections as described below.

- Section One may be one of the following:
  - Medicaid Check
  - Notice of Electronic Funds Transfer (EFT)
  - Summout (no claims paid)
- Section Two: Provider Notification (special messages)
- Section Three: Claim Detail
- Section Four:
  - Financial Transactions (recoupments)
  - Accounts Receivable (cumulative financial information)
- Section Five: Edit (Error) Description

Explanation of Remittance Advice Sections

The next pages present a sample of each section of the remittance advice for Dental services followed by an explanation of the elements contained in the section.

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.

Section One – Medicaid Check

For providers who have selected to be paid by check, a Medicaid check is issued when the provider has claims approved for the cycle and the approved amount is greater than the recoupments, if any, scheduled for the cycle. This section contains the check stub and the actual Medicaid check (payment).

MEDICAID MANAGEMENT INFORMATION SYSTEM

TO: JAMES STRONG, DDS

DATE: 2007-08-06
REMITTANCE NO: 07080600006
PROVIDER ID/NPI: 00112233/0123456789

07080600006 2007-08-06
JAMES STRONG, DDS
312 MAIN STREET
ANYTOWN NY 11111

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

29
2

DATE	REMITTANCE NUMBER	PROVIDER ID/NPI
2007-08-06 VOID AFTER 90 DAYS	07080600006	00112233/0123456789

PAY

DOLLARS/CENTS
$*****143.80

TO THE ORDER OF

07080600006 2007-08-06
JAMES STRONG, DDS
312 MAIN STREET
ANYTOWN NY 11111

MEDICAID MANAGEMENT INFORMATION SYSTEM

John Smith
AUTHORIZED SIGNATURE

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

Check Stub Information

UPPER LEFT CORNER
Provider's name (as recorded in the Medicaid files)

UPPER RIGHT CORNER
Date on which the remittance advice was issued
Remittance number
* Provider ID/NPI

CENTER
Remittance number/date
Provider's name/address

Medicaid Check

LEFT SIDE
Table
Date on which the check was issued
Remittance number
* Provider ID/NPI

Remittance number/date
Provider's name/address

RIGHT SIDE
Dollar amount. This amount must equal the Net Total Paid Amount under the Grand Total subsection plus the total sum of the Financial Transaction section.

*** Note: NPI has been included on all examples and is pending NPI implementation by NYS Medicaid.**

Section One – EFT Notification

For providers who have selected electronic funds transfer (or direct deposit), an EFT transaction is processed when the provider has claims approved during the cycle and the approved amount is greater than the recoupments, if any, scheduled for the cycle. This section indicates the amount of the EFT.

TO: JAMES STRONG, DDS

DATE: 2007-08-06
REMITTANCE NO: 07080600006
PROVIDER ID/NPI: 00112233/0123456789

07080600006 2007-08-06
JAMES STRONG, DDS
312 MAIN STREET
ANYTOWN NY 11111

JAMES STRONG, DDS $143.80

PAYMENT IN THE ABOVE AMOUNT WILL BE DEPOSITED VIA AN ELECTRONIC FUNDS TRANSFER.

Information on the EFT Notification Page

UPPER LEFT CORNER
Provider's name (as recorded in the Medicaid files)

UPPER RIGHT CORNER
Date on which the remittance advice was issued
Remittance number
* Provider ID/NPI

CENTER
Remittance number/date
Provider's name/address

Provider's Name – Amount transferred to the provider's account. This amount must equal the Net Total Paid Amount under the Grand Total subsection plus the total sum of the Financial Transaction section.

Section One – Summout (No Payment)

A summout is produced when the provider has no positive total payment for the cycle and, therefore, there is no disbursement of moneys.

TO: JAMES STRONG, DDS

DATE: 08/06/2007
REMITTANCE NO: 07080600006
PROVIDER ID/NPI: 00112233/0123456879

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

JAMES STRONG, DDS
312 MAIN STREET
ANYTOWN NY 11111

Information on the Summout Page

UPPER LEFT CORNER
Provider Name (as recorded in Medicaid files)

UPPER RIGHT CORNER
Date on which the remittance advice was issued
Remittance number
* Provider ID/NPI

CENTER
Notification that no payment was made for the cycle (no claims were approved)
Provider name and address

Section Two – Provider Notification

This section is used to communicate important messages to providers.

MEDICAID MANAGEMENT INFORMATION SYSTEM

MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

PAGE 01
DATE 08/06/07
CYCLE 1563

TO: JAMES STRONG, DDS
312 MAIN STREET
ANYTOWN, NEW YORK 11111

ETIN:
PROVIDER NOTIFICATION
PROVIDER ID/NPI 00112233/0123456789
REMITTANCE NO 07080600006

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.

Information on the Provider Notification Page

UPPER LEFT CORNER
Provider's name and address

UPPER RIGHT CORNER
Remittance page number
Date on which the remittance advice was issued
Cycle number

ETIN (not applicable)
Name of section: **PROVIDER NOTIFICATION**
* Provider ID/NPI
Remittance number

CENTER
Message text

Section Three – Claim Detail

This section provides a listing of all new claims that were processed during the specific cycle plus claims that were previously pended and adjudicated (paid or denied) during the specific cycle. This section may also contain pending claims from previous cycles that still remain in a pend status.

MEDICAID MANAGEMENT INFORMATION SYSTEM

MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

PAGE 02
DATE 08/06/2007
CYCLE 1563

TO: JAMES STRONG, DDS
312 MAIN STREET
ANYTOWN, NEW YORK 11111

ETIN:
DENTAL
PROVIDER ID/NPI: 00112233/0123456789
REMITTANCE NO: 07080600006

LN. NO	OFFICE ACCOUNT NUMBER	CLIENT NAME	CLIENT ID NUMBER	TCN	DATE OF SERVICE	PROC. CODE	UNITS	CHARGED	PAID	STATUS	ERRORS
01	CP343444	DAVIS	UU44444R	07206-000000227-0-0	07/11/07	D0120	1.000	52.80	0.00	DENY	00162 00244
01	CP443544	BROWN	PP88888M	07206-000011334-0-0	07/11/07	D0272	1.000	17.60	0.00	DENY	00244
01	CP766578	MALONE	SS99999L	07206-000013556-0-0	07/19/07	D1204	1.000	14.30	0.00	DENY	00162
01	CP999890	SMITH	ZZ22222T	07206-000032456-0-0	07/20/07	D0290	1.000	77.50	0.00	DENY	00131

* = 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

MEDICAID MANAGEMENT INFORMATION SYSTEM

PAGE 03
DATE 08/06/2007
CYCLE 1563

MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

TO: JAMES STRONG, DDS
312 MAIN STREET
ANYTOWN, NEW YORK 11111

ETIN:
DENTAL
PROVIDER ID/NPI: 00112233/0123456879
REMITTANCE NO: 07080600006

LN. NO	OFFICE ACCOUNT NUMBER	CLIENT NAME	CLIENT ID NUMBER	TCN	DATE OF SERVICE	PROC. CODE	UNITS	CHARGED	PAID	STATUS	ERRORS
01	CP112346	DAVIS	UU44444R	07206-000033667-0-0	07/11/07	D1203	1.000	14.30	14.30	PAID	
02	CP112345	DAVIS	UU44444R	07206-000033667-0-0	07/12/07	D1204	1.000	14.30	14.30	PAID	
01	CP113433	CRUZ	LL11111B	07206-000045667-0-0	07/14/07	D0320	1.000	52.80	52.80	PAID	
01	CP445677	JONES	YY33333S	07206-000056767-0-0	07/15/07	D3220	1.000	66.00	66.00	PAID	
01	CP113487	WAGER	ZZ98765R	07206-000067767-0-0	06/05/07	D0272	1.000	17.60	17.60-	ADJT	ORIGINAL CLAIM PAID 06/24/07
01	CP744495	PARKER	VZ45678P	07206-000088767-0-0	06/05/07	D1204	1.000	14.30	14.00	ADJT	

* = 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		3.60-	NUMBER OF CLAIMS	1

MEDICAID MANAGEMENT INFORMATION SYSTEM

PAGE 04
DATE 08/06/2007
CYCLE 1563

MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

TO: JAMES STRONG, DDS
312 MAIN STREET
ANYTOWN, NEW YORK 11111

ETIN:
DENTAL
PROVIDER ID/NPI: 00112233/0123456789
REMITTANCE NO: 07080600006

LN. NO	OFFICE ACCOUNT NUMBER	CLIENT NAME	CLIENT ID NUMBER	TCN	DATE OF SERVICE	PROC. CODE	UNITS	CHARGED	PAID	STATUS	ERRORS
01	CP8765432	CRUZ	LL11111B	07206-000033467-0-0	07/13/07	D3220	1.000	69.30	0.00	**PEND	00162
02	CP4555557	CRUZ	LL11111B	07206-000033468-0-0	07/14/07	D7450	1.000	71.04	0.00	**PEND	00162
01	CP8876543	TAYLOR	GG43210D	07206-000035665-0-0	07/14/07	D1204	1.000	14.30	0.00	**PEND	00142
01	CP0009765	ESPOSITO	FF98765C	07206-000033660-0-0	07/12/07	D1204	1.000	14.30	0.00	**PEND	00131

* = PREVIOUSLY PENDED CLAIM
** = NEW PEND

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
NET AMOUNT VOIDS – ADJUSTS		0.00	NUMBER OF CLAIMS	0

REMITTANCE TOTALS – DENTAL			
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: 00112233			
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

MEDICAID MANAGEMENT INFORMATION SYSTEM

PAGE: 05
DATE: 08/06/07
CYCLE: 1563

MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

TO: JAMES STRONG, DDS
312 MAIN STREET
ANYTOWN, NEW YORK 11111

ETIN:
DENTAL
GRAND TOTALS
PROVIDER ID/NPI: 00112233/0123456789
REMITTANCE NO: 07080600006

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

General Information on the Claim Detail Pages

UPPER LEFT CORNER
Provider's name and address

UPPER RIGHT CORNER
Remittance page number
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: **DENTAL**
* Provider ID/NPI
Remittance number

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

CLIENT ID NUMBER
The client's Medicaid ID number appears under this column.

TCN
The TCN is a unique identifier assigned to each document (claim form) 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
This column lists the service date as entered in the claim form.

PROCEDURE CODE
The five-digit procedure 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. The units are indicated with three (3) decimal positions. Since Dental 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.

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

PAID
If the claim is 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: Recipient 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, which 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.

Subtotals/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 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)

Section Four

This section has two subsections:

- Financial Transactions
- Accounts Receivable

Financial Transactions

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

MEDICAID MANAGEMENT INFORMATION SYSTEM

PAGE 07
DATE 08/06/07
CYCLE 1563

MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

TO: JAMES STRONG, DDS
312 MAIN STREET
ANYTOWN, NEW YORK 11111

ETIN:
FINANCIAL TRANSACTIONS
PROVIDER ID/NPI: 00112233/0123456789
REMITTANCE NO: 07080600006

FCN	FINANCIAL REASON CODE	FISCAL TRANS TYPE	DATE	AMOUNT
200705060236547	XXX	RECOUPMENT REASON DESCRIPTION	05 09 07	$$.$$

NET FINANCIAL AMOUNT $$$.$$ NUMBER OF FINANCIAL TRANSACTIONS XXX

Explanation of the Financial Transactions Columns

FCN (FINANCIAL CONTROL NUMBER)
This is a unique identifier assigned to each financial transaction.

FINANCIAL REASON CODE
This code is for DOH/CSC use only; it has no relevance to providers. It identifies the reason for the recoupment.

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

DATE
The date on which the recoupment was applied. Since all the recoupments listed on this page pertain to the current cycle, all the 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.

Totals

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.

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.

PAGE 08
DATE 08/06/07
CYCLE 1563

MEDICAID MANAGEMENT INFORMATION SYSTEM

TO: JAMES STRONG, DDS
312 MAIN STREET
ANYTOWN, NEW YORK 11111

MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

ETIN:
ACCOUNTS RECEIVABLE
PROVIDER ID/NPI: 00112233/0123456789
REMITTANCE NO: 07080600006

REASON CODE DESCRIPTION	ORIG BAL	CURR BAL	RECOUP %/AMT
	$XXX.XX-	$XXX.XX-	999
	$XXX.XX-	$XXX.XX-	999

TOTAL AMOUNT DUE THE STATE $XXX.XX

Explanation of the 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.

Section Five – Edit Descriptions

The last section of the Remittance Advice features the description of each of the edit codes (including approved codes) failed by the claims listed in Section Three.

MEDICAID MANAGEMENT INFORMATION SYSTEM

MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

PAGE 06
DATE 08/06/07
CYCLE 1563

TO: JAMES STRONG, DDS
312 MAIN STREET
ANYTOWN, NEW YORK 11111

ETIN:
DENTAL
EDIT DESCRIPTIONS
PROVIDER ID/NPI: 00112233/0123456789
REMITTANCE NO: 07080600006

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

00131 PROVIDER NOT APPROVED FOR SERVICE
00142 SERVICE CODE NOT EQUAL TO PA
00162 RECIPIENT INELIGIBLE ON DATE OF SERVICE
00244 PA NOT ON OR REMOVED FROM FILE

Appendix A – Code Sets

Accident Codes

Code	Description
0/Blank	Not Applicable
1	Auto Accident
2	Employment
3	Another Party Responsible
4	Other Accident

Oral Cavity Designations

Code	Description
00	Entire Oral Cavity
01	Maxillary Area
02	Mandibular Area
09	Other Area of Oral Cavity
10	Upper Right Quadrant
20	Upper Left Quadrant
30	Lower Left Quadrant
40	Lower Right Quadrant
L	Left
R	Right

Place of Service Codes

Code	Description
03	School
04	Homeless shelter
05	Indian health service free-standing facility
06	Indian health service provider-based facility
07	Tribal 638 free-standing facility
08	Tribal 638 provider-based facility
11	Doctor's office
12	Home
13	Assisted living facility
14	Group home
15	Mobile unit
20	Urgent care facility
21	Inpatient hospital
22	Outpatient hospital
23	Emergency room-hospital
24	Ambulatory surgical center
25	Birthing center
26	Military treatment facility
31	Skilled nursing facility
32	Nursing facility
33	Custodial care facility
34	Hospice
41	Ambulance-land
42	Ambulance-air or water
49	Independent clinic
50	Federally qualified health center
51	Inpatient psychiatric facility
52	Psychiatric facility partial hospitalization
53	Community mental health center
54	Intermediate care facility/mentally retarded
55	Residential substance abuse treatment facility
56	Psychiatric residential treatment center
57	Non-residential substance abuse treatment facility
60	Mass immunization center
61	Comprehensive inpatient rehabilitation facility
62	Comprehensive outpatient rehabilitation facility
65	End stage renal disease treatment facility
71	State or local public health clinic
72	Rural health clinic
81	Independent laboratory
99	Other unlisted facility

SA Exception Codes

Code	Description
1	Immediate/urgent care
2	Services rendered in retroactive period
3	Emergency care
4	Client has temporary Medicaid
5	Request from county for second opinion to determine if recipient can work
6	Request for override pending
7	Special handling

Tooth Codes

Code	Description
01	Permanent Third Molar – Upper Right
02	Permanent Second Molar – Upper Right
03	Permanent First Molar – Upper Right
04	Permanent Second Premolar – Upper Right
05	Permanent First Premolar – Upper Right
06	Permanent Canine – Upper Right
07	Permanent Lateral Incisor – Upper Right
08	Permanent Central Incisor – Upper Right
09	Permanent Central Incisor – Upper Left
10	Permanent Lateral Incisor – Upper Left
11	Permanent Canine – Upper Left
12	Permanent First Premolar- Upper Left
13	Permanent Second Premolar – Upper Left
14	Permanent First Molar – Upper Left
15	Permanent Second Molar – Upper Left
16	Permanent Third Molar – Upper Left
17	Permanent Third Molar – Lower Left
18	Permanent Second Molar – Lower Left
19	Permanent First Molar – Lower Left
20	Permanent Second Premolar – Lower Left
21	Permanent First Premolar – Lower Left
22	Permanent Canine – Lower Left
23	Permanent Lateral Incisor – Lower Left
24	Permanent Central Incisor – Lower Left
25	Permanent Central Incisor – Lower Right
26	Permanent Lateral Incisor – Lower Right
27	Permanent Canine- Lower Right
28	Permanent First Premolar – Lower Right
29	Permanent Second Premolar – Lower Right
30	Permanent First Molar – Lower Right
31	Permanent Second Molar – Lower Right
32	Permanent Third Molar – Lower Right
51	Supernumerary 01
52	Supernumerary 02
53	Supernumerary 03
54	Supernumerary 04
55	Supernumerary 05
56	Supernumerary 06
57	Supernumerary 07
58	Supernumerary 08
59	Supernumerary 09

Tooth Codes (cont.)

Code	Description
60	Supernumerary 10
61	Supernumerary 11
62	Supernumerary 12
63	Supernumerary 13
64	Supernumerary 14
65	Supernumerary 15
66	Supernumerary 16
67	Supernumerary 17
68	Supernumerary 18
69	Supernumerary 19
70	Supernumerary 20
71	Supernumerary 21
72	Supernumerary 22
73	Supernumerary 23
74	Supernumerary 24
75	Supernumerary 25
76	Supernumerary 26
77	Supernumerary 27
78	Supernumerary 28
79	Supernumerary 29
80	Supernumerary 30
81	Supernumerary 31
82	Supernumerary 32
A	Primary Second Molar – Upper Right
AS	Supernumerary A
B	Primary First Molar – Upper Right
BS	Supernumerary B
C	Primary Canine – Upper Right
CS	Supernumerary C
D	Primary Lateral Incisor – Upper Right
DS	Supernumerary D
E	Primary Central Incisor – Upper Right
ES	Supernumerary E
F	Primary Central Incisor – Upper Left
FS	Supernumerary F
G	Primary Lateral Incisor – Upper Left
GS	Supernumerary G
H	Primary Canine – Upper Left
HS	Supernumerary H
I	Primary First Molar – Upper Left
IS	Supernumerary I

Tooth Codes (cont.)

Code	Description
J	Primary Second Molar – Upper Left
JS	Supernumerary J
K	Primary Second Molar – Lower Left
KS	Supernumerary K
L	Primary First Molar – Lower Left
LS	Supernumerary L
M	Primary Canine – Lower Left
MS	Supernumerary M
N	Primary Lateral Incisor – Lower Left
NS	Supernumerary N
O	Primary Central Incisor – Lower Left
OS	Supernumerary O
P	Primary Central Incisor – Lower Left
PS	Supernumerary P
Q	Primary Lateral Incisor – Lower Left
QS	Supernumerary Q
R	Primary Canine – Lower Right
RS	Supernumerary R
S	Primary First Molar – Lower Right
SS	Supernumerary S
T	Primary Second Molar – Lower Right
TS	Supernumerary T

Surface Codes

Code	Description
B	Buccal
D	Distal
F	Facial
I	Incisal
L	Lingual
M	Mesial
O	Occlusal

United States Standard Postal Abbreviations

State	Abbrev.	State	Abbrev.
Alabama	AL	Missouri	MO
Alaska	AK	Montana	MT
Arizona	AZ	Nebraska	NE
Arkansas	AR	Nevada	NV
California	CA	New Hampshire	NH
Colorado	CO	New Jersey	NJ
Connecticut	CT	New Mexico	NM
Delaware	DE	North Carolina	NC
District of Columbia	DC	North Dakota	ND
Florida	FL	Ohio	OH
Georgia	GA	Oklahoma	OK
Hawaii	HI	Oregon	OR
Idaho	ID	Pennsylvania	PA
Illinois	IL	Rhode Island	RI
Indiana	IN	South Carolina	SC
Iowa	IA	South Dakota	SD
Kansas	KS	Tennessee	TN
Kentucky	KY	Texas	TX
Louisiana	LA	Utah	UT
Maine	ME	Vermont	VT
Maryland	MD	Virginia	VA
Massachusetts	MA	Washington	WA
Michigan	MI	West Virginia	WV
Minnesota	MN	Wisconsin	WI
Mississippi	MS	Wyoming	WY

American Territories	Abbrev.
American Samoa	AS
Canal Zone	CZ
Guam	GU
Puerto Rico	PR
Trust Territories	TT
Virgin Islands	VI

Note: Required only when reporting out-of-state license numbers.

NEW YORK STATE
MEDICAID PROGRAM

DENTAL

PRIOR APPROVAL GUIDELINES

TABLE OF CONTENTS

Section I - Purpose Statement

The purpose of this document is to assist the provider community to understand and comply with the New York State Medicaid (NYS-Medicaid) requirements and expectations for:

- Obtaining Prior Approval
- Field by Field Instructions for Prior Approval Form (eMedNY 361401)

This document is customized for Dental providers and it should be used by the provider's billing staff as an instructional as well as a reference tool.

Section II - Instructions for Obtaining Prior Approval

Electronic prior approval requests and responses can be submitted on the HIPAA 278 transaction. The Companion Guide for the HIPAA 278 is available on the www.nyhipaadesk.com website. Click on eMedNY Companion Guides and Sample Files. Access to the final determinations will be available though eMedNY eXchange messages or by mail. To sign up for eXchange visit www.emedny.org.

Prior approval requests can also be requested via ePACES. ePACES is an internet-based program available to enrolled Medicaid providers. For information about enrolling in ePACES, contact CSC at (800) 343-9000. A reference number will be returned to your ePACES screen, which can be later used to check the approval status on ePACES. Visit www.emedny.org for more information.

Paper prior approval forms, with appropriate attachments, should be sent to Computer Sciences Corporation, PO Box 4600, Rensselaer, NY 12144-4600. A supply of the new Prior Approval forms is available by contacting CSC at the number above.

This section of the manual describes the preparation and submission of the New York State Medical Assistance (Title XIX) Program Prior Approval Request Form (eMedNY 361401). It is imperative that these procedures are used when completing the forms. Request forms that do not conform to these requirements will not be processed by eMedNY.

Services that require Prior Approval are indicated by a line under the respective Procedure Code in the New York State Procedure Code and Fee Schedule Section of this Manual.

Receipt of prior approval does NOT guarantee payment. Payment is subject to client's eligibility and other guidelines.

Requests for prior approval should be submitted, and a determination received, before services are rendered. However, sometimes unforeseen circumstances arise that delay the submission of the prior approval request until after the service is provided. If this occurs, the prior approval request must be received by the department within 90 days of the date of service, accompanied by an explanation of why the service was provided without prior approval.

A prior approval request will not be processed after 90 days from the date of service unless the provider's request is delayed due to circumstances outside of the control of the provider. Such circumstances include the following:

- Litigation
- Medicare/third party insurer processing delays

- Delay in the Client's Medicaid eligibility determination
- Administrative delay by the department or other State agency

The request must give a detailed explanation for the delay. Requests submitted without an explanation will be returned, without action, to the provider.

To reduce processing errors (and subsequent processing delays), please do not run-over writing or typing from one field (box) into another. The displayed sample Prior Approval Request Form is numbered in each field to correspond with the instructions for completing the request.

Prior Approval Form (eMedNY 361401)

NYS MEDICAL ASSISTANCE TITLE XIX PROGRAM
ORDER/PRIOR APPROVAL REQUEST DENTAL SERVICES

1 ORDER DATE	2 CLIENT ID
M M D D C C Y Y	

DO NOT STAPLE IN BARCODE AREA

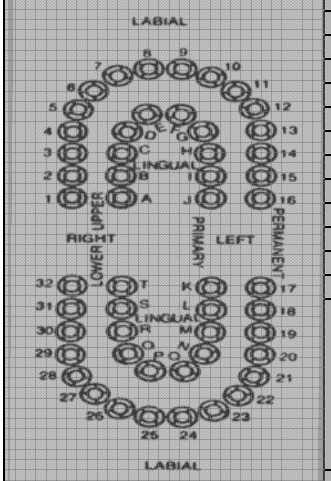
3 CLIENT NAME	4 CLIENT ADDRESS	5 CLIENT TELEPHONENUMBER	6 SEX	7 DATE OF BIRTH
			M F	M M D D C C Y Y

8 REFERRING PROVIDER NAME	9 REFERRING ID/LICENSE NUMBER	10 PROF CD	11 REFERRING PROVIDER ADDRESS/TELEPHONE

12 REQUESTING PROVIDER NAME	13 REQUESTING ID/LICENSE NUMBER	14 LOC CD	15 REQUESTING PROVIDER ADDRESS/TELEPHONE

16 SERVICING PROVIDER NAME	17 SERVICING ID/LICENSE NUMBER	18 PROF CD	19 SERVICING PROVIDER ADDRESS/TELEPHONE

20



Examination and treatment plan. List in order from tooth no. 1 through tooth no. 32. See charting system shown.

	21 PROCEDURE CODE	22 TOOTH NO. OR LETTER	23 SURFACE	24 DESCRIPTION	25 TIMES REQ.	26 AMT. REQ.
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						

27 ARE X-RAYS INCLUDED?
☐ YES ☐ NO
☐ F.M.S. ☐ PANOREX
BITEWINGS
How many? _____
PERIAPICALS
How many? _____

28 If Prosthesis is this initial placement?
☐ YES ☐ NO
If no, enter date of prior placement
M M / D D / C C Y Y

29 REMARKS FOR UNUSUAL SERVICES

	30 PROCEDURE CODE	31 MOD	32 DENT SITE	33 TIMES REQ.	34 TOTAL AMOUNT REQUESTED		PROCEDURE CODE	MOD	DENT SITE	TIMES REQ.	TOTAL AMOUNT REQUESTED		PROCEDURE CODE	MOD	DENT SITE	TIMES REQ.	TOTAL AMOUNT REQUESTED
1					.	13					.	25					.
2					.	14					.	26					.
3					.	15					.	27					.
4					.	16					.	28					.
5					.	17					.	29					.
6					.	18					.	30					.
7					.	19					.	31					.
8					.	20					.	32					.
9					.	21					.	33					.
10					.	22					.	34					.
11					.	23					.	35					.
12					.	24					.	36					.

35 PA REVIEW OFFICE CODE

↑
← ALIGN TOP AND LEFT EDGES OF STICKER
ATTACHMENT NUMBER

Section III - Field by Field (eMedNY 361401) Instructions

ORDER DATE (Field 1)

Indicate the month, day and year on which the request is submitted.

Example: October 7, 2005 = 10072005

ORDER DATE							
1	0	0	7	2	0	0	5

CLIENT ID (Field 2)

Enter the Client's eight-character alphanumeric Welfare Management System (WMS) ID number.

Example:

CLIENT ID NUMBER							
A	A	1	2	3	4	5	W

Note: WMS ID numbers are composed of eight characters. The first two are alpha, the next five are numeric and the last is an alpha.

CLIENT NAME (Field 3)

Enter the last name followed by the first name of the client as it appears on the Medicaid ID Card.

CLIENT ADDRESS (Field 4)

Enter client's address including name of facility, where appropriate.

CLIENT TELEPHONE NUMBER (Field 5)

Enter client's telephone number, including the Area Code.

SEX (Field 6)

Place an X on M for Male or F for Female to indicate the client's gender.

DATE OF BIRTH (Field 7)

Indicate the month, day and year of the Client's birth.

Example: April 5, 1940 = 04051940

DATE OF BIRTH
0 4 0 5 1 9 4 0

REFERRING PROVIDER NAME (Field 8)

If the Client was referred by another Provider, enter the referring Provider's name in this field. Otherwise, leave blank.

REFERRING ID/LICENSE NUMBER (Field 9)

If the Client was referred by another Provider, enter the referring Provider's Medicaid ID Number as in the example below. Right justify the information in the field. Otherwise, leave blank.

Example:

ID/ LICENSE NUMBER
0 1 2 3 4 5 6 7

If the referring provider is not enrolled in Medicaid, enter his/her license number.
If entering a NYS license number, the license number must be preceded by two zeros as in the example below.

Example:

ID/ LICENSE NUMBER
0 0 2 3 4 5 6 7

If entering an out-of-state license number, the two-digit United States Post Office state abbreviation should be entered in place of the two zeros as in the example below.

Example:

ID/ LICENSE NUMBER
N J 2 3 4 5 6 7

PROF CD (Field 10)

If the license number of the Referring Provider has been entered in Field 9, enter the Profession Code from the list below which identifies the type of license:

Dentist	**050**
Physician	**060**

REFERRING PROVIDER ADDRESS/TELEPHONE (Field 11)

If a Referring Provider number is indicated in Field 9, indicate the referring provider's address and telephone number in this field.

REQUESTING PROVIDER NAME (Field 12)

Enter the name of the individual provider or group who is requesting Prior Approval. Fill in first name, last name and degree.

Example: John Smith, D.D.S.

For a group, enter the name of the group in this field and the name of the practitioner rendering services in the "Servicing Provider Name" area (field 16).

REQUESTING ID/LICENSE NUMBER (Field 13)

Enter the Medicaid ID of the individual provider or group who is requesting Prior Approval. For a group, enter the Medicaid ID of the group in this field and the Medicaid ID of the practitioner rendering services in the "Servicing ID" area (field 17).

Note: A license number must not be entered in this field

LOC CD (Field 14)

Enter the Requesting Provider's 3-digit location code (example 003). This could be the service location where the client will be treated, but **MUST** be the location where the prior approval roster will be sent. If this is not completed, the default is the correspondence address on file for the Provider.

REQUESTING PROVIDER ADDRESS/TELEPHONE (Field 15)

Enter the full mailing address and telephone number, including zip code and area code, of the Requesting Provider, and where correspondence related to this request will be sent.

For a group, enter the address and telephone number of the group in this field and the address and telephone number of the practitioner rendering services in the "Servicing Provider Address/Telephone" area (field 19).

SERVICING PROVIDER NAME (Field 16)

For a group, enter the name of the provider that will actually be rendering services. Otherwise, leave blank.

SERVICING ID/LICENSE NUMBER (Field 17)

For a group, enter the Medicaid ID number of the provider that will actually be rendering services. Otherwise, leave blank.

Note: A license number must not be entered in this field.

PROF CD (Field 18)

Leave this field blank.

SERVICING PROVIDER ADDRESS/TELEPHONE (Field 19)

For a group, enter the address and telephone number of the provider that will actually be rendering services. Otherwise, leave blank.

TOOTH DIAGRAM (Field 20)

To be used to describe **PRESENT** oral conditions. Identify missing teeth with an X. Crowns are indicated by circling the correct tooth or teeth. Restorations are shown by shading in the correct surfaces of any teeth affected.

PROCEDURE CODE (Field 21)

Enter in this field the procedure codes(s) from the Dental Procedure Codes and Fee Schedule which **DO NOT REQUIRE PRIOR APPROVAL**, but relate to the overall treatment plan. Please be concise, but be sure to provide a COMPLETE TREATMENT PLAN for all procedures not requiring prior approval.

TOOTH NO. OR LETTER (Field 22)

For procedures requiring a tooth number: use the tooth-numbering system specified on the tooth diagram of the Prior Approval request form to identify the tooth number or letter to which each procedure code applies.

For procedures requiring a quadrant identification: use the two-letter designations 10 = Upper Right; 20 = Upper Left; 30 = Lower Left; 40 = Lower Right.

For procedures requiring an arch identification: use 01 = Upper; 02 = Lower.

SURFACE (Field 23)

For those procedures where tooth surface designation is applicable, indicate within this field each surface (M, I/O, D, F/B, L) to which the procedure will apply.

DESCRIPTION (Field 24)

Enter the description of the service requested. This description should be the same as found in the Procedure Code Section of this Manual as it relates to the appropriate procedure code.

For multiple extractions not requiring prior approval:
List each of the applicable procedure code(s) for the extraction(s) only once per request.

Enter the appropriate tooth numbers in the DESCRIPTION field to indicate that the procedure code will apply to more than one tooth.

Attempt to confine all numbers to one line of the DESCRIPTION.

When it is necessary to use more than one line to list all tooth numbers, DO NOT repeat the procedure code, times requested, and amount requested on the subsequent lines. DO NOT let tooth numbers run over from the DESCRIPTION into the TIMES REQUESTED column.

Example of correct listings of extractions:

	Procedure Code	Teeth No.or Letter	Surface	Description	Times Req.	Amount Requested
	D7140			Routine Extraction #6, 7, 8, 9, 10, 11,	10	450.00
				22, 23, 26, 27		

TIMES REQ. (Field 25)

Indicate with two digits the number of times the requested procedure is to be performed as part of this treatment plan (e.g., one occurrence = 01).

AMOUNT REQ. (Field 26)

Enter the total dollar amount requested for the specific procedure. The dollar amount should be sufficient to cover the total units requested.

ARE X-RAYS INCLUDED? (Field 27)

Check the box that indicates whether or not x-rays in support of the prior approval request are included. Also, indicate the type and, if appropriate, the number of x-rays included.

PROSTHESIS (Field 28)

Complete this field for any Client who requires a dental prosthesis. When the requested information does not apply, leave blank.

If a replacement for an existing prosthesis is being requested, enter the month, day and year the current prosthesis was placed, e.g., 01/15/1992. If the exact date of placement is not known, enter as much information as you have available. Describe the condition of the current prosthesis and document why it needs to be replaced in the "Remarks for Unusual Services" or on a separate sheet of paper.

REMARK FOR UNUSUAL SERVICES (Field 29)

Enter any prosthetic comments or other extenuating circumstances in support of the treatment plan in this area or on a separate sheet of paper. If there are separate attachments, indicate the type and number in this area.

PROCEDURES THAT REQUIRE PRIOR APPROVAL SECTION (Lines 1 – 36)

This section is used to indicate ALL procedure codes related to the treatment plan that require prior approval. Enter the procedure code, the site information (if appropriate), the times requested and amount requested. Each procedure must be listed separately. **ONLY PROCEDURES REQUIRING PRIOR APPROVAL SHOULD BE ENTERED IN THIS SECTION**. Procedures that DO NOT require prior approval, but are part of the overall treatment plan should be entered in the "Examination and Treatment Plan" Section.

Up to 36 procedures can be accommodated on one prior approval request. If more than 36 procedures codes requiring prior approval need to be listed, attach additional prior approval requests with the Client's and Requesting Provider's information filled out and a notation in the "Remarks for Unusual Services" indicating the number and type of additional attachments.

Only those procedure codes entered in this section will be reviewed. If no procedure codes are entered, or none of the procedure codes listed requires prior

approval, the request will automatically be rejected.

PROCEDURE CODE (Field 30)

Enter in this field the procedure codes(s) from the Dental Procedure Codes and Fee Schedule which REQUIRE PRIOR APPROVAL. Procedure codes requiring prior approval are indicated by a line below the procedure code (e.g.: **D1234**).

MOD (Field 31)

Used to indicate HIPAA "modifiers". Leave blank

DENT SITE (Field 32)

Enter the dental site information (tooth, quadrant, arch, etc.) associated with that procedure code, if applicable. Required site information is indicated in parenthesis following the procedure description in Dental Procedure Codes and Fee Schedule section.

TIME REQ (Field 33)

Indicate with ONE digit the number of times the requested procedure is to be performed.

TOTAL AMOUNT REQUESTED (Field 34)

Enter the total dollar amount requested for the specific procedure. The dollar amount should be sufficient to cover the total units requested and should be the "usual and customary" fee for the procedure.

PA REVIEW OFFICE CODE (Field 35)

Enter the appropriate code to ensure that the prior approval request is routed to the appropriate Business Location for review. This field is critical when a non-scannable attachment, such as x-rays or photographs, is submitted.

Enter code 'A1' for all dental prior approval requests.

For orthodontia, enter code 'A1' for all counties except New York City.

Prior Approval Business Location Chart

PHYSICIAN	A1 (Albany)	Statewide	800-342-3005, 518 474-3575
HEARING AID	A1 (Albany)	Statewide	800-342-3005, 518-474-3575
EYE CARE	A1 (Albany)	Statewide	800-342-3005, 518-474-3575
DME (Non-DVS/DiRad).	A1 (Albany)	For all counties except the Buffalo office area*	800-342-3005, 518-474-3575
	B1 (Buffalo)	For all Buffalo office counties*	800-462-8407
DME (PA Overrides of DVS/DiRad)	A1 (Albany)	Statewide	800-342-3005, 518-474-3575
PHARMACY (Rx Drugs/OTC)	A2 (Albany)	Statewide	518-486-3209
DENTAL	A1 (Albany)	Statewide	800-342-3005, 518-474-3575
Orthodontia	A1 (Albany)	Statewide EXCEPT for NYC	800-342-3005, 518-474-3575
PRIVATE DUTY NURSING	03 (Broome)	For Broome county clients	607-778-2707
	07 (Chemung)	For Chemung county clients	607-737-5487
	14 (Erie)	For Erie county clients	716-858-2375
	30 (Oneida)	For Oneida county clients	315-798-5456
	42 (Schenectady)	For Schenectady county clients	518-386-2253
	50 (Tompkins)	For Tompkins county clients	607-274-5278
	55 (Westchester)	For Westchester county clients	914-813-5440
	A1 (Albany)	For clients from all other counties not listed above.	800-342-3005, 518-474-3575
OUT OF STATE INPATIENT HOSPITAL SERVICES	A1 (Albany)	Statewide	800-342-3005, 518-474-3575

*B1 Buffalo Office Counties – Alleghany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans and Wyoming