NEW YORK STATE
MEDICAID PROGRAM

INFORMATION FOR ALL PROVIDERS

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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:

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/](http://www.emedny.org/)
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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;

• 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:


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:


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:


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 event 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:


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.
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.

Recoulement

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:
  
  o the Offices of Mental Health, Mental Retardation and Developmental Disabilities, Alcoholism and Substance Abuse Services, Temporary Disability Assistance, and Children and Family Services;
  
  o the Department of Education;
  
  o the eMedNY Contractor, Computer Sciences Corporation (CSC), employed to operate the Medicaid Management Information System;
  
  o the State Attorney General for Medicaid Fraud Control; and,
  
  o the State Comptroller;

➢ pursing 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:
  
  o 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](http://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](http://www.emedny.org/ProviderManuals/Transportation/index.html) for telephone numbers of DSS staff.

New York City practitioners and facilities should refer to the [Prior Authorization Guidelines](http://www.emedny.org/ProviderManuals/Transportation/index.html) 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:

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](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](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
Information for All Providers – General Policy

- 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:

or
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:

<table>
<thead>
<tr>
<th>Service</th>
<th>Number of Visits, Items or Lab Tests Allowed per Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pharmacy (prescription drugs including initial prescriptions, refills, over-the-counter medicine and medical/surgical supplies)</td>
<td>40 items if the enrollee is:</td>
</tr>
<tr>
<td></td>
<td>• Under 21</td>
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<tr>
<td></td>
<td>• 65 or over</td>
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<tr>
<td></td>
<td>• Certified blind or disabled</td>
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<td></td>
<td>• Single caretaker of a child under 18</td>
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<tr>
<td></td>
<td>43 items if the enrollee is:</td>
</tr>
<tr>
<td>Service</td>
<td>Number of Visits, Items or Lab Tests Allowed per Year</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>-----------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td>• 21 to 65</td>
</tr>
<tr>
<td></td>
<td>• Not certified blind or disabled</td>
</tr>
<tr>
<td></td>
<td>• Not a single caretaker of a child under 18</td>
</tr>
<tr>
<td>Physician and Medical Clinic</td>
<td>10 visits</td>
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<tr>
<td>Dental Clinic</td>
<td>3 visits</td>
</tr>
<tr>
<td>Laboratory</td>
<td>18 procedures</td>
</tr>
<tr>
<td>Mental Health Clinic</td>
<td>40 visits</td>
</tr>
</tbody>
</table>

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 through 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
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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](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?

<table>
<thead>
<tr>
<th>Roster Date</th>
<th>Patient Name</th>
<th>Billing Provider Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>PA Number</td>
<td>Patient Medicaid ID</td>
<td>Billing Provider ID</td>
</tr>
<tr>
<td>Procedure/Rate Code</td>
<td>Patient Gender</td>
<td>Ordering Provider ID</td>
</tr>
<tr>
<td>Approved Quantity</td>
<td>Patient Date of Birth</td>
<td>Dates of Service</td>
</tr>
<tr>
<td>Approved Times</td>
<td>Patient County</td>
<td>Approved Amount</td>
</tr>
</tbody>
</table>

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 ($8\frac{1}{2} \times 11$) 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:


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:


**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:


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:
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
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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:

<table>
<thead>
<tr>
<th>If your question is concerning:</th>
<th>Choose:</th>
</tr>
</thead>
<tbody>
<tr>
<td>➢ New Enrollment;</td>
<td>Sub-option 1</td>
</tr>
<tr>
<td>➢ ePACES Enrollment;</td>
<td></td>
</tr>
<tr>
<td>➢ TSN/ETIN applications.</td>
<td></td>
</tr>
<tr>
<td>➢ Explanation of eligibility response;</td>
<td>Sub-option 2</td>
</tr>
<tr>
<td>➢ UT service authorization;</td>
<td></td>
</tr>
<tr>
<td>➢ POS Device Support.</td>
<td></td>
</tr>
<tr>
<td>➢ Obtaining NYC Transportation Prior Authorizations</td>
<td>Sub-option 3</td>
</tr>
<tr>
<td>➢ Claims;</td>
<td>Sub-option 4</td>
</tr>
<tr>
<td>➢ Billing;</td>
<td></td>
</tr>
<tr>
<td>➢ Remittance;</td>
<td></td>
</tr>
<tr>
<td>➢ Form orders; and</td>
<td></td>
</tr>
<tr>
<td>➢ Prior approval.</td>
<td></td>
</tr>
</tbody>
</table>
If you are a:

- Pharmacy Provider

Call (800) 343-9000
Option 2

Then, depending on your question:

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

<table>
<thead>
<tr>
<th>If your question is concerning:</th>
<th>Choose:</th>
</tr>
</thead>
<tbody>
<tr>
<td>➢ New Enrollment; ➢ ePACES Enrollment; ➢ TSN/ETIN applications.</td>
<td><strong>Sub-option 1</strong></td>
</tr>
<tr>
<td>➢ Explanation of eligibility response; ➢ UT service authorization; ➢ POS Device Support.</td>
<td><strong>Sub-option 2</strong></td>
</tr>
<tr>
<td>➢ Obtaining NYC Transportation Prior Authorizations</td>
<td><strong>Sub-option 3</strong></td>
</tr>
<tr>
<td>➢ Claims; ➢ Billing; ➢ Remittance; ➢ Form orders; and ➢ Prior approval questions.</td>
<td><strong>Sub-option 4</strong></td>
</tr>
</tbody>
</table>
If you are a:

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

Call (800) 343-9000
Option 4

Then, depending on your question:

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

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.

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

<table>
<thead>
<tr>
<th>For questions concerning:</th>
<th>Contact:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Check Amounts</strong></td>
<td>Department of Health</td>
</tr>
<tr>
<td>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.</td>
<td>(866) 307-5549</td>
</tr>
<tr>
<td><strong>Child Health Plus</strong></td>
<td>(800) 698-4KIDS</td>
</tr>
<tr>
<td><strong>Claim Response Status for ePACES Users</strong></td>
<td><a href="http://www.emedny.org/hipaa/Crosswalk/index.html">http://www.emedny.org/hipaa/Crosswalk/index.html</a></td>
</tr>
<tr>
<td><strong>Dental/Orthodontia Services</strong></td>
<td>Dental Review Unit</td>
</tr>
<tr>
<td><strong>Dental Pended Claims</strong></td>
<td>(800) 342-3005 Option #2</td>
</tr>
<tr>
<td><strong>Diagnosis Codes</strong></td>
<td><a href="http://www.cms.hhs.gov/icd9providerdiagnosticcodes/">http://www.cms.hhs.gov/icd9providerdiagnosticcodes/</a></td>
</tr>
<tr>
<td></td>
<td>The list of diagnosis codes is also available through publishing houses.</td>
</tr>
<tr>
<td><strong>Durable Medical Equipment</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Prior Approval</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Non-DVS/DiRad – Except Buffalo Area Counties</strong></td>
<td>(800) 342-3005</td>
</tr>
<tr>
<td><strong>Non-DVS/DiRad – Buffalo Area Counties (Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans and Wyoming)</strong></td>
<td>(800) 462-8407</td>
</tr>
<tr>
<td><strong>PA Overrides of DVS/DiRad (Statewide)</strong></td>
<td>(800) 342-3005</td>
</tr>
<tr>
<td><strong>Elderly Pharmaceutical Insurance Coverage Program (EPIC)</strong></td>
<td>(800) 634-1340</td>
</tr>
<tr>
<td><strong>Electronic Funds Transfer Provider Enrollment Form</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Electronic Prior Approval Request Form</strong></td>
<td><a href="http://www.emedny.org/info/ProviderEnrollment/index.html">http://www.emedny.org/info/ProviderEnrollment/index.html</a></td>
</tr>
<tr>
<td><strong>Electronic Transmitter Identifier Number (ETIN)</strong></td>
<td></td>
</tr>
<tr>
<td>For questions concerning:</td>
<td>Contact:</td>
</tr>
<tr>
<td>-------------------------------------------------------</td>
<td>-----------------------------------------------</td>
</tr>
<tr>
<td>eMedNY</td>
<td><a href="http://www.emedny.org">http://www.emedny.org</a></td>
</tr>
<tr>
<td><strong>Enrollee Eligibility Determination</strong></td>
<td>Department of Health</td>
</tr>
<tr>
<td>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.</td>
<td>(866) 307-5549</td>
</tr>
<tr>
<td>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.</td>
<td>(518) 472-1550</td>
</tr>
<tr>
<td><strong>Family Health Plus</strong></td>
<td>(877) 9FHPLUS</td>
</tr>
<tr>
<td><strong>Managed Care</strong></td>
<td>(518) 486-9015</td>
</tr>
<tr>
<td></td>
<td>(800) 206-8125</td>
</tr>
<tr>
<td></td>
<td><a href="mailto:omcmail@health.state.ny.us">omcmail@health.state.ny.us</a></td>
</tr>
<tr>
<td><strong>Medicaid Inspector General</strong></td>
<td><a href="http://www.omig.state.ny.us">www.omig.state.ny.us</a></td>
</tr>
<tr>
<td>Fraud Referrals</td>
<td><a href="http://www.nysomig.org/data/component/option.com_facileforms/Itemid.47/">http://www.nysomig.org/data/component/option.com_facileforms/Itemid.47/</a></td>
</tr>
<tr>
<td></td>
<td>(877) 87FRAUD</td>
</tr>
<tr>
<td><strong>Medical Pended Claims</strong></td>
<td>In State</td>
</tr>
<tr>
<td>Two-Year Old Claims</td>
<td>(800) 342-3005 Option #3</td>
</tr>
<tr>
<td></td>
<td>Out of State</td>
</tr>
<tr>
<td></td>
<td>(518) 474-3575</td>
</tr>
<tr>
<td>For questions concerning:</td>
<td>Contact:</td>
</tr>
<tr>
<td>-----------------------------------------</td>
<td>----------------------------------------------------</td>
</tr>
<tr>
<td><strong>Medicaid Policy</strong></td>
<td><a href="mailto:medicaid@health.state.ny.us">medicaid@health.state.ny.us</a></td>
</tr>
<tr>
<td>Call Center Help Line/Co-Pay Hotline</td>
<td>(800) 541-2831</td>
</tr>
<tr>
<td>Fraud/Forgery Hotline</td>
<td>(877) 891-7283</td>
</tr>
<tr>
<td>Medical/Dental Prior Approval</td>
<td>(800) 342-3005</td>
</tr>
<tr>
<td>Restricted Recipients/Utilization Threshold</td>
<td>(518) 474-6866</td>
</tr>
<tr>
<td>Two-year billing regulations</td>
<td>(800) 562-0856 menu #4</td>
</tr>
<tr>
<td><strong>Medical Prior Approval</strong></td>
<td>(800) 342-3005 Option #1</td>
</tr>
<tr>
<td>➢ Nursing</td>
<td></td>
</tr>
<tr>
<td>➢ Out-of-State Inpatient Hospital Services</td>
<td></td>
</tr>
<tr>
<td>➢ Audiology</td>
<td></td>
</tr>
<tr>
<td><strong>Medicaid Update</strong></td>
<td><a href="http://www.nyhealth.gov/health_care/medicaid/program/update/main.htm">http://www.nyhealth.gov/health_care/medicaid/program/update/main.htm</a></td>
</tr>
<tr>
<td>• Missing issues</td>
<td>Email: <a href="mailto:medicaidupdate@health.state.ny.us">medicaidupdate@health.state.ny.us</a></td>
</tr>
<tr>
<td>• Request to receive electronic version</td>
<td>(518) 474-5187</td>
</tr>
<tr>
<td><strong>New York State Department of Health</strong></td>
<td><a href="http://www.nyhealth.gov">www.nyhealth.gov</a></td>
</tr>
<tr>
<td><strong>Newborn Screening Program</strong></td>
<td>(518) 473-7552</td>
</tr>
<tr>
<td><strong>Personal Care Services</strong></td>
<td>Local Department of Social Services</td>
</tr>
<tr>
<td>Prior Authorization</td>
<td></td>
</tr>
<tr>
<td><strong>Pharmacy Policy and Operations</strong></td>
<td><a href="mailto:ppno@health.state.ny.us">ppno@health.state.ny.us</a></td>
</tr>
<tr>
<td></td>
<td>(518) 486-3209</td>
</tr>
<tr>
<td><strong>Private Duty Nursing Services</strong></td>
<td></td>
</tr>
<tr>
<td>Broome</td>
<td>(607) 778-2707</td>
</tr>
<tr>
<td>Chemung</td>
<td>(607) 737-5487</td>
</tr>
<tr>
<td>Erie</td>
<td>(716) 858-2375</td>
</tr>
<tr>
<td>Oneida</td>
<td>(315) 798-5456</td>
</tr>
<tr>
<td>Schenectady</td>
<td>(518) 386-2253</td>
</tr>
<tr>
<td>Tompkins</td>
<td>(607) 274-5278</td>
</tr>
<tr>
<td>Westchester</td>
<td>(914) 813-5440</td>
</tr>
<tr>
<td>All others not listed</td>
<td>(800) 342-3005</td>
</tr>
<tr>
<td><strong>Restricted Recipient Program</strong></td>
<td></td>
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<tr>
<td>NYC</td>
<td>(212) 630-1081</td>
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<td></td>
<td>(212) 630-1087</td>
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<tr>
<td></td>
<td>(212) 630-1089</td>
</tr>
<tr>
<td>Outside NYC</td>
<td>(518) 474-6866</td>
</tr>
<tr>
<td>For questions concerning:</td>
<td>Contact:</td>
</tr>
<tr>
<td>--------------------------</td>
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</tr>
<tr>
<td>Sterilization &amp; Hysterectomy Consent Forms</td>
<td><a href="http://www.health.state.ny.us/health_care/medicaid/publications/ldssforms">http://www.health.state.ny.us/health_care/medicaid/publications/ldssforms</a></td>
</tr>
<tr>
<td>- DSS-3113 Hysterectomy Receipt of Information</td>
<td></td>
</tr>
<tr>
<td>- DSS-3113S Hysterectomy Receipt of Information (Spanish)</td>
<td></td>
</tr>
<tr>
<td>- DSS-3134 Sterilization Consent</td>
<td></td>
</tr>
<tr>
<td>- DSS-3134S Sterilization Consent (Spanish)</td>
<td></td>
</tr>
<tr>
<td>Transportation</td>
<td>(518) 474-5187 or (518) 473-2160</td>
</tr>
<tr>
<td></td>
<td><a href="mailto:MedTrans@health.state.ny.us">MedTrans@health.state.ny.us</a></td>
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<td></td>
<td>Outside NYC</td>
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<td></td>
<td>Local Department of Social Services</td>
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<tr>
<td></td>
<td>Obtain NYC Prior Authorization</td>
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<td></td>
<td>(800) 343-9000</td>
</tr>
</tbody>
</table>
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
- Case Management
- Clinic
- Diagnostic & Treatment Center
- HCBS/TBI Waiver Provider
- Hospice
- Hospital
- Long Term Home Health Care Program
- Personal Care Provider
- Prepaid Capitation Group
- Intermediate Care Facility for the Developmentally Disabled (ICF/DD)
- Assisted Living Program
- Child Care Agency
- Community Residence
- Emergency Room
- Home Health Agency
- HMO
- Nursing Service (Registry)
- Personal Emergency Response System Provider
- Residential Health Care Facility (Nursing Home)
- School Supportive Health Service

<table>
<thead>
<tr>
<th>Provider Change of Address</th>
<th><a href="http://www.emedny.org/info/ProviderEnrollment/index.html">http://www.emedny.org/info/ProviderEnrollment/index.html</a></th>
</tr>
</thead>
</table>

To receive the form:

Call (800) 342-3005 Option # 4

or write to:

[RBU@health.state.ny.us](mailto: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._

<table>
<thead>
<tr>
<th>For questions concerning:</th>
<th>Contact:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prior authorization worksheet/fax form</td>
<td><a href="https://newyork.fhsc.com/providers/PDP_forms.asp">https://newyork.fhsc.com/providers/PDP_forms.asp</a></td>
</tr>
<tr>
<td>Request email notification of changes to Preferred Drug List</td>
<td><a href="mailto:NYPDPNotices@firsthealth.com">NYPDPNotices@firsthealth.com</a></td>
</tr>
<tr>
<td>To obtain a supply of Preferred Drug Program educational materials for Medicaid enrollees</td>
<td>(518) 951-2040</td>
</tr>
<tr>
<td>Clinical concerns Preferred Drug Program questions</td>
<td>(877) 309-9493</td>
</tr>
<tr>
<td>Billing</td>
<td>(800) 343-9000</td>
</tr>
</tbody>
</table>
## Local Departments of Social Services

<table>
<thead>
<tr>
<th>County</th>
<th>Department of Social Services</th>
<th>Address</th>
<th>Phone</th>
<th>Website</th>
</tr>
</thead>
<tbody>
<tr>
<td>Broome County</td>
<td>Department of Social Services</td>
<td>36-42 Main Street, Binghamton, New York 13905-3199</td>
<td>(607) 778-8850</td>
<td><a href="http://www.gobroomecounty.com/dss/">http://www.gobroomecounty.com/dss/</a></td>
</tr>
<tr>
<td>Cattaraugus County</td>
<td>Department of Social Services</td>
<td>One Leo Moss Drive, Suite 6010, Olean, New York 14760</td>
<td>(716) 373-8070</td>
<td><a href="http://www.co.cattaraugus.ny.us/dss/">http://www.co.cattaraugus.ny.us/dss/</a></td>
</tr>
<tr>
<td>Cayuga County</td>
<td>Department of Social Services</td>
<td>County Office Building, Auburn, New York 13021-3433</td>
<td>(607) 737-5309</td>
<td><a href="http://cayugacounty.us/hhs/index.html">http://cayugacounty.us/hhs/index.html</a></td>
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<tr>
<td>Chautauqua County</td>
<td>Department of Social Services</td>
<td>H.R. Clothier Building, Mayville, New York 14757</td>
<td>(716) 753-4421</td>
<td><a href="http://www.co.chautauqua.ny.us/hservframe.htm">http://www.co.chautauqua.ny.us/hservframe.htm</a></td>
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<tr>
<td>Chenango County</td>
<td>Department of Social Services</td>
<td>County Office Building, Norwich, New York 13815</td>
<td>(607) 337-1500</td>
<td><a href="http://www.cny.ny.gov/hservframe.htm">http://www.cny.ny.gov/hservframe.htm</a></td>
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<tr>
<td>Columbia County</td>
<td>Department of Social Services</td>
<td>P.O. Box 458, 25 Railroad Avenue, Hudson, New York 12534-2514</td>
<td>(518) 828-9411</td>
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<tr>
<td>County</td>
<td>Department of Social Services</td>
<td>Address</td>
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<td>Zip Code</td>
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<td>County Office Building</td>
<td>Cortland</td>
<td>13045</td>
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<tr>
<td>Delaware County</td>
<td>Department of Social Services</td>
<td>111 Main Street</td>
<td>Delhi</td>
<td>12601</td>
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<tr>
<td>Dutchess County</td>
<td>Department of Social Services</td>
<td>60 Market Street</td>
<td>Poughkeepsie</td>
<td>12601</td>
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<tr>
<td>Erie County</td>
<td>Department of Social Services</td>
<td>95 Franklin Street</td>
<td>Buffalo</td>
<td>14202</td>
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<tr>
<td>Essex County</td>
<td>Department of Social Services</td>
<td>7551 Court Street, P.O. Box 217</td>
<td>Elizabethtown</td>
<td>12932</td>
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<tr>
<td>Franklin County</td>
<td>Department of Social Services</td>
<td>Court House</td>
<td>Malone</td>
<td>12953</td>
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<td>Fulton County</td>
<td>Department of Social Services</td>
<td>P.O. Box 549</td>
<td>Johnstown</td>
<td>12095</td>
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<tr>
<td>Genesee County</td>
<td>Department of Social Services</td>
<td>5130 East Main Street, Suite 3</td>
<td>Batavia</td>
<td>14020</td>
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<td>Greene County</td>
<td>Department of Social Services</td>
<td>411 Main Street</td>
<td>Catskill</td>
<td>12414</td>
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<tr>
<td>Hamilton County</td>
<td>Department of Social Services</td>
<td>P.O. Box 725- White Birch Lane</td>
<td>Indian Lake</td>
<td>12842</td>
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<tr>
<td>Herkimer County</td>
<td>Jefferson County</td>
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<tr>
<td>Department of Social Services</td>
<td>Department of Social Services</td>
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<td></td>
</tr>
<tr>
<td>301 North Washington Street, Suite 2110</td>
<td>Human Services Building</td>
<td></td>
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</tr>
<tr>
<td>Herkimer, New York 13350</td>
<td>250 Arsenal Street</td>
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<td></td>
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<tr>
<td>(315) 867-1291</td>
<td>Watertown, New York 13601</td>
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<tr>
<td><a href="http://herkimercounty.org/content/Departments/View/10">link</a></td>
<td>(315) 782-9030</td>
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<tr>
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<tr>
<td>Department of Social Services</td>
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<tr>
<td>P.O. Box 193</td>
<td>3 Murray Hill Drive</td>
</tr>
<tr>
<td>Lowville, New York 13367</td>
<td>Mount Morris, New York 14510</td>
</tr>
<tr>
<td>(315) 376-5400</td>
<td>(585) 243-7300</td>
</tr>
<tr>
<td><a href="http://lewiscountyny.org/content/Departments/View/30">link</a></td>
<td><a href="http://www.co.livingston.state.ny.us/dss.htm">link</a></td>
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<tr>
<td>Department of Social Services</td>
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<tr>
<td>Madison County Complex</td>
<td>111 Westfall Road, Room 660</td>
</tr>
<tr>
<td>P.O. Box 637</td>
<td>Rochester, New York 14620-4686</td>
</tr>
<tr>
<td>Wampsville, New York 13163</td>
<td>(585) 274-6000</td>
</tr>
<tr>
<td>(315) 366-2211</td>
<td><a href="http://www.monroecounty.gov/hs-index.php">link</a></td>
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<td><a href="http://www.madisoncounty.org">link</a></td>
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<tr>
<th>Montgomery County</th>
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<tr>
<td>Department of Social Services</td>
<td>Department of Social Services</td>
</tr>
<tr>
<td>County Office Building</td>
<td>101 County Seat Drive</td>
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<tr>
<td>P.O. Box 745</td>
<td>Mineola, New York 11501</td>
</tr>
<tr>
<td>Fonda, New York 12068</td>
<td>(516) 571-4444</td>
</tr>
<tr>
<td>(518) 853-4646</td>
<td><a href="http://www.nassaucountyny.gov/agencies/dss/DSSHome.htm">link</a></td>
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<tr>
<th>New York City</th>
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<tr>
<td>Human Resources Administration</td>
<td>Department of Social Services</td>
</tr>
<tr>
<td>180 Water Street</td>
<td>P.O. Box 506, 20 East Avenue</td>
</tr>
<tr>
<td>New York, New York 10038</td>
<td>Lockport, New York 14095-3394</td>
</tr>
<tr>
<td>(877) 472-8411 within the 5 boroughs</td>
<td>(716) 439-7602</td>
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<tr>
<td>County</td>
<td>Department of Social Services</td>
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<tr>
<td>Oneida County</td>
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<td>Onondaga County</td>
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<td>Ontario County</td>
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<td>Orange County</td>
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<td>Orleans County</td>
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<td>Oswego County</td>
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<td>Otsego County</td>
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<td>Putnam County</td>
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<td>Rensselaer County</td>
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<td>Rockland County</td>
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<td>St. Lawrence County</td>
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<td>Saratoga County</td>
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<td>Schoharie County</td>
<td>Department of Social Services</td>
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<td>Schuyler County</td>
<td>Department of Social Services</td>
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<td>Seneca County</td>
<td>Department of Social Services</td>
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<tr>
<td>Steuben County</td>
<td>Department of Social Services</td>
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<td>Sullivan County</td>
<td>Department of Social Services</td>
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<td>Tioga County</td>
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<td>Ulster County</td>
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<td>County</td>
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<td>Warren County</td>
<td>Department of Social Services</td>
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<td>Washington County</td>
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<td>Wayne County</td>
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<td>Westchester County</td>
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<td>Wyoming County</td>
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<tr>
<td>Yates County</td>
<td>Department of Social Services</td>
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</table>
NEW YORK STATE
MEDICAID PROGRAM

INFORMATION FOR ALL PROVIDERS

THIRD PARTY INFORMATION
# Table of Contents

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- INSURANCE COVERAGE CODES ................................................................. 3
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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.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Inpatient Hospital</td>
<td>All inpatient services are covered except psychiatric care.</td>
</tr>
<tr>
<td>B</td>
<td>Physician In-Office</td>
<td>Services provided in the physician’s office are generally covered.</td>
</tr>
<tr>
<td>C</td>
<td>Emergency Room</td>
<td>Self-Explanatory.</td>
</tr>
<tr>
<td>D</td>
<td>Clinic</td>
<td>Both hospital-based and free-standing clinic services are covered.</td>
</tr>
<tr>
<td>E</td>
<td>Psychiatric Inpatient</td>
<td>Self-Explanatory.</td>
</tr>
<tr>
<td>F</td>
<td>Psychiatric Outpatient</td>
<td>Self-Explanatory.</td>
</tr>
<tr>
<td>G</td>
<td>Physician In-Hospital</td>
<td>Physician services provided in a hospital or nursing home are covered.</td>
</tr>
<tr>
<td>H</td>
<td>Drugs No Card</td>
<td>Drug coverage is available but a drug card is not needed.</td>
</tr>
<tr>
<td>I</td>
<td>Lab/X-ray</td>
<td>Laboratory and X-ray services are covered.</td>
</tr>
<tr>
<td>J</td>
<td>Dental</td>
<td>Self-Explanatory.</td>
</tr>
<tr>
<td>K</td>
<td>Drugs Co-pay</td>
<td>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.</td>
</tr>
<tr>
<td>L</td>
<td>Nursing Home</td>
<td>Some nursing home coverage is available. You must bill until benefits are exhausted.</td>
</tr>
<tr>
<td>M</td>
<td>Drugs Major Medical</td>
<td>Drug coverage is provided as part of a major medical policy.</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
<td>Explanation</td>
</tr>
<tr>
<td>------</td>
<td>----------------------------------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>N</td>
<td>All Physician Services</td>
<td>Physician services, without regard to where they were provided, are covered.</td>
</tr>
<tr>
<td>O</td>
<td>Drugs</td>
<td>Self-Explanatory.</td>
</tr>
<tr>
<td>P</td>
<td>Home Health</td>
<td>Some home health benefits are provided. Continue to bill until benefits are exhausted.</td>
</tr>
<tr>
<td>Q</td>
<td>Psychiatric Services</td>
<td>All psychiatric services, inpatient and outpatient, are covered.</td>
</tr>
<tr>
<td>R</td>
<td>ER and Clinic</td>
<td>Self-Explanatory.</td>
</tr>
<tr>
<td>S</td>
<td>Major Medical</td>
<td>The following services are covered: physician, clinic, emergency room, inpatient, laboratory, referred ambulatory, transportation and durable medical equipment.</td>
</tr>
<tr>
<td>T</td>
<td>Transportation</td>
<td>Medically necessary transportation is covered.</td>
</tr>
<tr>
<td>U</td>
<td>Coverage to Complement Medicare</td>
<td>All services paid by Medicare, which require a coinsurance or deductible payment, should be billed to the insurance carrier prior to billing Medicaid.</td>
</tr>
<tr>
<td>V</td>
<td>Substance Abuse Services</td>
<td>All substance abuse services, regardless of where they are provided, are covered.</td>
</tr>
<tr>
<td>W</td>
<td>Substance Abuse Outpatient</td>
<td>Self-Explanatory.</td>
</tr>
<tr>
<td>X</td>
<td>Substance Abuse Inpatient</td>
<td>Self-Explanatory.</td>
</tr>
<tr>
<td>Y</td>
<td>Durable Medical Equipment</td>
<td>Self-Explanatory.</td>
</tr>
<tr>
<td>Z</td>
<td>Optical</td>
<td>Self-Explanatory.</td>
</tr>
<tr>
<td>All</td>
<td>All of the above</td>
<td>All services are covered.</td>
</tr>
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Recipient Other Insurance Codes

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

<table>
<thead>
<tr>
<th>Ins Cd</th>
<th>Description</th>
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<tbody>
<tr>
<td>02</td>
<td>HIP Outpatient</td>
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<tr>
<td>05</td>
<td>Other Insurance Inpt/Outpt</td>
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<tr>
<td>06</td>
<td>Group Health Inc (GHI)</td>
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<tr>
<td>09</td>
<td>Union Inpt/Outpt</td>
</tr>
<tr>
<td>10</td>
<td>HIP/HMO</td>
</tr>
<tr>
<td>12</td>
<td>BC/BS Empire</td>
</tr>
<tr>
<td>14</td>
<td>A&amp;P Health And Welfare</td>
</tr>
<tr>
<td>18</td>
<td>Administrative Services Co</td>
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<tr>
<td>20</td>
<td>Aftra Health And Retirement</td>
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<td>22</td>
<td>AIG</td>
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<tr>
<td>23</td>
<td>Empire BC</td>
</tr>
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<td>25</td>
<td>Airfreight Warehouse Corp</td>
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<tr>
<td>27</td>
<td>Albany International</td>
</tr>
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<td>28</td>
<td>Allied International Union</td>
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<tr>
<td>29</td>
<td>Allied Security Health &amp; Welfare</td>
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<td>30</td>
<td>Amalgamated Services</td>
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<td>31</td>
<td>Amerco</td>
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<td>32</td>
<td>American Medical Life Ins</td>
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<tr>
<td>34</td>
<td>America’s Choice Health Plan</td>
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<td>35</td>
<td>Amerihealth Administrators</td>
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<td>36</td>
<td>Atlantis Health</td>
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<td>38</td>
<td>BAC5NY Welfare Fund</td>
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<td>Bakers Local 3</td>
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<td>40</td>
<td>Bakery Drivers Local 802</td>
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<td>41</td>
<td>BC/BS Carefirst</td>
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<td>42</td>
<td>BC/BS Healthflex Now</td>
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<td>43</td>
<td>BC/BS of Alabama</td>
</tr>
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<td>44</td>
<td>BC/BS of Greater NY</td>
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<td>45</td>
<td>Empire BS</td>
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<td>47</td>
<td>BC/BS of Iowa-Wellmark</td>
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<td>BC/BS of Minnesota</td>
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<td>BC/BS of North Dakota</td>
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<td>BC/BS of Rhode Island</td>
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<td>51</td>
<td>BC/BS through SSA</td>
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<tr>
<td>52</td>
<td>Benefit Concepts</td>
</tr>
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<td>53</td>
<td>Benesight PCHS</td>
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<td>54</td>
<td>Better Health Advantage</td>
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<td>55</td>
<td>BC/BS PP</td>
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<td>56</td>
<td>BC of NY</td>
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<td>58</td>
<td>Capitol Administrators</td>
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<td>Carpenters Healthcare Plan</td>
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<td>CBSA</td>
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<td>Central States</td>
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<td>CENTRUS</td>
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<td>Chatwins Healthcare Administrators</td>
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<tr>
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<tr>
<td>66</td>
<td>Christian Brothers Employees</td>
</tr>
<tr>
<td>67</td>
<td>Citywide Central Ins Program</td>
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<tr>
<td>69</td>
<td>Coalition for Care</td>
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<td>70</td>
<td>Cole Managed Vision</td>
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<td>71</td>
<td>Combined Welfare Fund</td>
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<td>72</td>
<td>Coresource Inc.</td>
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<td>74</td>
<td>Custom Coverage</td>
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<td>88</td>
<td>Elderplan</td>
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<td>90</td>
<td>Davis Vision</td>
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<tr>
<td>99</td>
<td>New HIP</td>
</tr>
</tbody>
</table>

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
<table>
<thead>
<tr>
<th>Ins Cd</th>
<th>Description</th>
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### 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

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## County/District Codes

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<tr>
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NEW YORK STATE
MEDICAID PROGRAM

HEARING AID/AUDIOLOGY
MANUAL

POLICY GUIDELINES
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Section I - Requirements for Participation in Medicaid

Services Provided to Patients Under 21 Years of Age

Audiology services and hearing aid services for eligible patients under 21 years of age may be provided

- in a speech and hearing center certified by the Physically Handicapped Children's Program (PHCP),
- in an Article 28 facility,
- by a self-employed or salaried audiologist or audiologist/hearing aid dealer, or
- by audiologists in a group practice.

Hearing aid services ordered or recommended by the above providers must be provided by a qualified hearing aid dealer or audiologist/hearing aid dealer.

Newborn Hearing Screening

In New York State, newborn hearing screening is mandated. Maternity hospitals and birthing centers must screen newborns for hearing loss before discharge. Infants who fail screening tests must be referred for audiological evaluation as soon as possible.

Timely follow-up is important for infants who do not pass their initial hearing screening and for those infants who fail two initial newborn screenings. Referral to the Early Intervention Program in the infant’s county of residence can take place at two main junctures in the newborn hearing process:

- After an infant fails two hearing screenings, the infant may be referred to early intervention for a confirmatory (diagnostic) test; or
- If an infants who has failed his/her initial screening does not receive follow-up screening within 75 days post-discharge, the facility responsible for reporting data to the Department (usually the birth facility) may refer the family to early intervention for the purpose of facilitating a second hearing screening.

Hearing Screening for Children Under Three Years of Age

For children less than three years of age, follow the most recent version of American Academy of Pediatrics’ (AAP) Recommendations for Preventive Pediatric Health Care for age-specific intervals at which subjective history and/or routine standardized hearing testing should be performed.

Children less than three years of age who have test findings indicative of hearing loss, or are deemed to be at increased risk for hearing problems should be referred for age-appropriate hearing testing.
It is recommended that providers refer the child to a speech and hearing center certified by the Physically Handicapped Children’s Program (PHCP) or other appropriately licensed or credentialed providers. These children may also be referred to the Early Intervention Program in the child’s county of residence.

**Children Between the Ages of Three and 21 Years**

Pure tone screening should be performed at ages specified in the current version of AAP’s Recommendations for Preventive Pediatric Health. If a hearing impairment is suspected at any age, the child should be referred for age-appropriate hearing testing. It is recommended that providers refer the child to a speech and hearing center certified by the Physically Handicapped Children’s Program or other appropriately licensed or credentialed providers.

Providers serving children under 21 years, should refer to the Hearing Section in the EPSDT/CTHP Manual for Child Health Plus A (Medicaid)

[http://www.emedny.org/ProviderManuals/EPSDTCTHP/index.html](http://www.emedny.org/ProviderManuals/EPSDTCTHP/index.html).

**Services Provided to Patients 21 Years of Age and Over**

*Audiology services* to eligible patients **21 years of age and over** may be provided:

- in an approved speech and hearing center,
- in an Article 28 facility, or
- by a self-employed or salaried audiologist or audiologist/hearing aid dealer or
- by audiologists in group practice.

*Hearing aid services* to eligible patients **21 years of age and over** may be provided:

- in an approved speech and hearing center,
- in an Article 28 facility, or
- by a hearing aid dealer or audiologist/hearing aid dealer.

**Written Statements Required**

1. Audiology services shall be supported by a written statement of a physician referring the patient to a qualified audiologist.

   *The written referral must be maintained with the patient record.*

2. Hearing aid services shall be supported by written results of audiometry or equivalent testing as required by a hearing aid recommendation or prescription signed by a qualified audiologist or licensed otolaryngologist.
At the end of the trial period, a statement of an audiologist, primary care giver or the patient himself/herself, providing verification of benefit from use of the hearing aid is required.

Should the patient fail to return and provide such written confirmation, a written explanation from the dispenser may be used in lieu of this confirmation-of-benefit to support billing and for entry into the patient record.

_These documents must be maintained with the patient record._

3. A statement of patient rights and obligations shall be provided to the patient by the hearing aid dispenser at the time the hearing aid is dispensed.

_This statement shall be signed by the patient, with a copy maintained in the records and shall explain that the thirty days immediately subsequent to dispensing of the hearing aid constitutes a trial period for that aid._

Such statement shall explain the patient’s obligation to return to the dispenser:

► for all necessary adjustments and calibrations of the hearing aid during the 45-day trial period and
► to provide written confirmation of benefit from use of the hearing aid; or
► to ultimately return an unsatisfactory hearing aid.

**Record Keeping Requirements**

Hearing aid dealers must meet the record-keeping requirements outlined in **Information For All Providers, General Policy**, available online at:

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

Hearing aid dealers must maintain at each of their business locations the records specified in the Official Codes, Rules and Regulations of the New York State (NYS) Department of State available at:


**Out-of-State Prescribers**

For persons _21 years of age and older_, out-of-state audiologist, otolaryngologists and health care facilities licensed by the appropriate agency in that state may issue written recommendations for hearing aids for Medicaid recipients. _All such recommendations however, are subject to the prior approval._

For persons _under 21 years of age_, all hearing aid recommendations must originate from a PHCP approved speech and hearing center or other New York State appropriately licensed or credentialed provider.
Out-of-State Dispensers

In order to participate in the New York Medicaid Program, out-of-state hearing aid dispensers must be enrolled in the New York State Medicaid Program.
Section II - Hearing Aid/Audiology Services

The Medicaid Program provides payment for:

- audiology services,
- audiometric screening, and
- hearing aid services and products

that are furnished to eligible patients, when medically necessary, to alleviate disability caused by the loss or impairment of hearing.

In order to assure that a patient receives maximum and continuing benefit from the use of a hearing aid, there must be a written recommendation from an otolaryngologist or an audiologist for a hearing aid which conforms to the requirements outlined in this Policy Manual.

The Program also provides payment for hearing aid repairs and replacement of accessories when necessary to maintain a patient's hearing aid in functional order.

1. Audiology services shall be made available by a qualified audiologist upon referral of a licensed physician for audiometric examination and testing and, if necessary, a hearing aid evaluation.

   *A referral is not required for a conformity evaluation.*

2. For children **less than three years of age**, follow the most recent version of American Academy of Pediatrics’ (AAP’s) Recommendations for Preventive Pediatric Health Care for age-specific intervals at which subjective history and/or routine standardized hearing testing should be performed.

Children less than three years of age who have test findings indicative of hearing loss, or are deemed to be at increased risk for hearing problems should be referred for age-appropriate hearing testing.

It is recommended that providers refer the child to a speech and hearing center certified by the Physically Handicapped Children’s Program (PHCP) or other appropriately licensed or credentialed providers. These children may also be referred to the Early Intervention Program in the child’s county of residence.

3. Pure tone screening should be performed for **children from age three to 21 years** as specified in the current version of AAP’s *Recommendations for Preventive Pediatric Health*.

   If a hearing impairment is suspected at any age, the child should be referred for age-appropriate hearing testing. It is recommended that providers refer the child to a speech and hearing center certified by the Physically Handicapped Children’s Program or other appropriately licensed or credentialed providers.
4. Hearing aids shall be made available based upon the results of an audiometric examination or testing by a qualified audiologist or otolaryngologist.

Providers serving children under 21 years, should refer to the Hearing Section in the EPSDT/CTHP Manual for Child Health Plus A (Medicaid) found at http://www.emedny.org/ProviderManuals/EPSDTCTHP/index.html.

Hearing Aid Recommendation Requirements

All recommendations for hearing aids for Medicaid-eligible patients must be in compliance with Article 37 of the NYS General Business Law.

The written recommendation must indicate that the recipient is in need of a hearing aid and include the results of pure tone and speech (clinical) audiometry conducted in a sound treated room and/or test suite meeting the American National Standard Institute's specifications.

The otolaryngologist or qualified audiologist may either write a general recommendation for a hearing aid, or prescribe a specific device by indicating manufacturer and model required.

In support of a prescription for a specific hearing aid, sound field speech audiometry or equivalent testing methods must be performed. These tests must be conducted by or under the direction and personal supervision of an otolaryngologist or licensed audiologist. When a specific device is prescribed, the dealer must dispense as written.

When a general recommendation is made, the hearing aid dealer may perform hearing measurements by means of an audiometer or other testing equipment used solely for the purpose of selecting, fitting or dispensing an instrument designed to aid or improve human hearing.

Hearing aids must be dispensed within six months of the date of the recommendation.

Source of Recommendations for Persons Under 21

All written recommendations for hearing aids for Medicaid patients under 21 years of age may come from a PHCP approved speech and hearing centers or other appropriately licensed or credentialed providers.

The written recommendation must be signed by an otolaryngologist or qualified audiologist.

Note: For persons under 21 residing in New York State Developmental Centers or OMRDD-certified residences, the recommendation for a hearing aid may come from a Developmental Center’s employed or consultant audiologist.
Source of Recommendations for Persons 21 Years of Age and Older

A written recommendation from a PHCP approved speech and hearing center, an otolaryngologist, or qualified audiologist in private practice, group practice, employed by a hearing aid dealer or employed by an Article 28 Facility that is certified to render speech and hearing or audiology service is sufficient in cases involving adults.

Who May Dispense Hearing Aids – For-Profit Providers

A person, partnership, association, organization, or corporation formally registered under the provisions of Article 37 of the General Business Law, with the NYS Department of State as a hearing aid dealer, and enrolled in the Medicaid program, may dispense hearing aids to recipients in accordance with the Hearing Aid/Audiology Services Fee Schedule, available online at:

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

The Secretary of State's approval of an application is contingent upon the applicant's compliance with specific standards. While this Manual elaborates on some, it does not discuss all of these requirements in detail. They may be found in their entirety in the Official Codes, Rules and Regulations of the Department of State, available at:


Hearing aid dealers must continue to comply with these regulations. Failure to abide by these regulations will cause a hearing aid dealer to have his/her certificate of registration revoked. When this occurs, the hearing aid dealer automatically forfeits the right to participate in the Medicaid Program.

Who May Dispense Hearing Aids - Not-for-Profit Providers

Under the Medicaid Program, hearing aid devices and accessories may be dispensed on a not-for-profit basis by a licensed otolaryngologist or certified speech and hearing center which is approved to render services under the PHCP, or by an Article 28 Facility that is eligible to participate under Title XVIII of the Social Security Act (Medicare) and is certified to render speech and hearing or audiology services.

When the costs are not included in the facility's rate, reimbursement for hearing aids will be made at the lower of the price charged by the facility to the general public or the acquisition cost.

Reimbursement for accessories, earmolds and hearing aid batteries will be made at the lowest of the price charged by the facility to the general public or the facility's acquisition cost or the State Maximum Fee Schedule amount.

The administrative and dispensing fees contained in the State Fee Schedule will not be paid to not-for-profit facilities.
Facilities may bill for visits at the established clinic rate to cover reasonable and necessary costs for the dispensing of the aid.

**Physically Handicapped Children's Program**

For Medicaid eligible persons **under age 21** who are receiving care under the auspices of the PHCP, the provider of care is required to comply with PHCP policies.
Section III - Basis of Payment for Services Provided

Audiology services and audiometric screening and hearing aid services shall be reimbursed in accordance with the fee schedule set forth in the NYS Fee Schedule for Hearing Aid/Audiology Supplies and Services.

The fee schedule is available online at:
http://www.emedny.org/ProviderManuals/HearingAid/index.html.

Dispensing Fee

The dispensing fee includes, but is not limited to the following, for the life of the hearing aid under normal use:

- all repairs and/or replacement of defective parts plus labor,
- cleaning by original dispenser,
- all fittings,
- all adjustments,
- all instructions to the recipient in the use of the device,
- a garment bag, if applicable, and
- a one month supply of batteries.

The dispensing fee, as listed on the fee schedule shall be payable to all qualified hearing aid dispensers.

Claims

The claim for the hearing aid, dispensing fees may be submitted upon provision of the aid.

If it is determined during the trial period that the patient will not keep the aid, the claim for the returned aid must be voided and the claim for the dispensing fee code must be adjusted to deduct the amount indicated as “dispensing” in the description of the dispensing fee procedure code.

The dispenser is entitled to retain the payment for the fee portion in such circumstances. The dispensing fee is applicable for the initial or replacement aid and may only be billed by a for-profit dealer.

*Only the administrative fee (not the dispensing fee) is applicable for replacement of lost or stolen aids within the manufacturer’s warranty.*
Reimbursement

Reimbursement shall be made for the acquisition cost of hearing aid(s), supported by a copy of the invoice.

- The invoice supporting the acquisition cost of a hearing aid shall list the following information for the hearing aid for which reimbursement is requested:
  - the brand name,
  - the model number, and
  - the serial number.

Reimbursement as listed on the fee schedule shall be made to qualified audiologists for a hearing aid evaluation and hearing aid check to confirm benefit from the aid, provided that the audiologist is not the dispenser of the aid and, therefore, ineligible for a dispensing fee (which includes payment for these services).

When benefit of a hearing aid cannot be confirmed and the aid is returned to the dispenser, payment for that aid and the dispensing fee is forfeited.

When benefit can not be confirmed because the patient does not return the aid to the dispenser, the dispensing fee is forfeited and the acquisition cost of the aid may be reimbursable when requests are supported by documentation of reasonable attempts by the dispenser to provide continuity of service.

Should a patient lose eligibility after an earmold(s) and/or hearing aid is ordered but before it is dispensed, Medicaid reimbursement will be made only for the earmold(s).

Hearing Aid Coverage Criteria

Medicaid reimbursement for hearing aids is dependent upon the following criteria, regardless of order source:

- Monaural Hearing Aid
  - Hearing loss in the better ear of 30 dBHL or greater (re - ANSI 1969) for the pure tone average of 500, 1000 and 2000Hz.
  - A spondee threshold in the better ear of 30 dBHL or greater when pure tone thresholds cannot be established.
  - Hearing loss in each ear is less than 30 dBHL at the frequencies below 2,000 Hz and thresholds in each ear are greater than 40 dBHL at 2,000 Hz and higher.
  - Documentation of communication need and a statement that the patient is alert and oriented and able to utilize their aid appropriately.
Binaural Hearing Aid

Same as the criteria for Monaural Hearing Aid plus one or more of the following:

- significant social, vocational or educational demands;
- previous user of binaural hearing aids;
- significant visual impairment; and
- children.

*FM Systems are not reimbursable by Medicaid.*

Prior Approval/Authorization Requirements for Persons Under 21 Years of Age

Prior approval of the local PHCP Medical Director is required for all hearing aid services furnished to patients **under 21 years of age** who are receiving care under the auspices of the PHCP.

When recommended by an otolaryngologist, a qualified audiologist or a facility licensed and certified under Article 28 of the Public Health Law to provide speech and hearing or audiology services, prior approval shall be required for all:

- administrative fees,
- hearing aid(s),
- dispensing fees,
- special fittings and
- repairs costing $70 or more.

When hearing aids and special fittings are recommended by a speech and hearing center certified by the PHCP, prior approval is not required for these items or for the administrative and dispensing fees.

Repairs costing $70 or more and batteries not listed in the Fee Schedule shall require prior approval regardless of the source of the order.

**Note:** For patients **under 21 residing in New York State Developmental Centers**, the recommendation for a hearing aid may come from the Developmental Center.

How to Obtain Prior Approval for Persons Under 21 Years of Age

For information, contact the PHCP at the address/telephone number indicated in Information For All Providers, Inquiry, available online at:

[http://www.emedny.org/ProviderManuals/AllProviders/index.html](http://www.emedny.org/ProviderManuals/AllProviders/index.html)
Prior approvals may be obtained by submitting eMedNY form 283201 to Computer Sciences Corporation. For complete instructions, see Prior Approval Guidelines available at:

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

Prior Approval/Authorization Requirements for Persons 21 Years of Age and Older

When recommended by an otolaryngologist, qualified audiologists, out-of-state prescribers or facilities licensed and certified under Article 28 of the Public Health Law to provide speech and hearing or audiology services, prior approval shall be required for all:

- administrative fees,
- hearing aid(s),
- dispensing fees,
- special fittings and
- repairs costing $70 or more.

When hearing aids and special fittings are recommended by speech and hearing centers certified by the PHCP, prior approval is not required for these items or for the administrative and dispensing fees.

Repairs costing $70 or more and batteries not listed in the Fee Schedule shall require prior approval regardless of the source of the order.

How to Obtain Prior Approval for Persons 21 Years of Age and Older

Prior approvals are obtained by submitting eMedNY form 283201 to Computer Sciences Corporation. For complete instructions, see Prior Approval Guidelines available at:

http://www.emedny.org/ProviderManuals/HearingAid/index.html.
Section IV – Documentation Required with Prior Approval Requests

Hearing Aid Requests

The following documentation is required when requesting prior approval for hearing aids:

- Completed prior approval form eMedNY 283201. The form is not required if the request is submitted online via ePACES or other HIPAA-compliant transaction.

  If the PA request is submitted online, all supporting medical documentation must be submitted by mail to Computer Sciences Corporation, utilizing the electronic transaction attachment scanning form available for download at:

  http://www.emedny.org/info/phase2/paper.html;

- Audiogram dated within the previous year of order date that includes air conduction for both ears, bone conduction, and speech discrimination results;

- Medical clearance;

- Psycho-social statement indicating the recipient’s ability to use and care for hearing aids, and indication if the recipient will be assisted by a care-giver;

- Hearing aid history, including:
  - make,
  - model,
  - serial number,
  - ear worn,
  - year dispensed and
  - status of current hearing aid(s);

  **Note:** If hearing aid is lost, provide letter from recipient or care-giver describing circumstances of the loss and what will be done to prevent future loss.

- If requesting **monaural** fit, indicate which ear is being fit;

- If requesting **binaural** fit, provide supporting documentation to verify recipient’s qualification for binaural use as indicated in this Manual; and

- If hearing aid is under 5 years old, indicate why the request is for replacement rather than repair.
**Repair Requests**

If requesting prior approval for the repair of hearing aids, the following documentation is required:

- Completed prior approval form eMedNY 283201. The form is not required if the request is submitted online via ePACES or other HIPAA-compliant transaction.

If the PA request is submitted online, all supporting medical documentation must be submitted by mail to Computer Sciences Corporation, utilizing the electronic transaction attachment scanning form available for download at:

http://www.emedny.org/info/phase2/paper.html;

- Audiogram dated within the past two years;
  - If information is available, indicate if hearing loss remains stable or if there has been a significant change in hearing since original fitting which may require new amplification;

- Make, model, serial number, ear worn, and year dispensed of aid to be repaired;

- Description of the current condition of hearing aid and what repairs are being done;

- Indication of the cost of repair showing Medicaid’s twenty percent discount; and

- If hearing aid is over 5 years old, indicate why the request is for repair rather than replacement.
Section V - Definitions

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

**Article 28 Facility**

An Article 28 facility is a health facility as defined under Article 28, Section 2805 of the Public Health Law.

In the context of this Manual, the Article 28 facility must be certified to provide speech and hearing services or audiology services.

**Audiologist/Hearing Aid Dealer**

An audiologist/hearing aid dealer is an individual who, in addition to being licensed to practice audiology, is also duly registered with the NYS Department of State, pursuant to Article 37, Section 781(a) of the General Business Law.

Audiologist/hearing aid dealer also refers to a qualified hearing aid dealer who employs a qualified audiologist(s).

**Audiology Services**

Audiology services refer to and include:

- audiometric examination or testing,
- hearing aid evaluation,
- conformity evaluation and
- hearing aid prescription or recommendation if indicated.

**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 New York State Department of Health, and generally follow the recommendations of the Committee on Standards of Child Health, American Academy of Pediatrics.

The CTHP includes a full range of comprehensive, primary health care services for Medicaid-eligible youth from birth up until age 21 years. In line with the federal EPSDT mandate, 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.

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

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

Hearing Aid Services and Products

Hearing aid services and products shall be provided in compliance with Article 37 of the General Business Law.

Services shall include hearing aid:

- selection,
- fitting,
- dispensing,
- checks following dispensing, and
- repairs.

Products shall include:

- hearing aids,
- earmolds,
- batteries,
- special fittings and
- replacement parts.

Otolaryngologist

An otolaryngologist is a licensed physician who is qualified to engage in the practice of otolaryngology by reason of having passed, or received training acceptable for admission to the examination of the American Board of Otolaryngology.

Such a physician normally confines his/her practice to the problems of the ears, pharynx, larynx, nasopharynx, and the tracheo-bronchial tree.

Qualified Audiologist

To participate in the Medicaid Program, an audiologist must be licensed and currently registered to practice audiology in by the NYS Education Department.

Audiology services provided to Medicaid-eligible patients while temporarily out-of-state shall be provided by audiologists qualified to practice audiology by the appropriate licensing agency of the state in which the audiology services are provided.
Qualified Hearing Aid Dealer

A qualified hearing aid dealer is any person, partnership, association or corporation engaged in the selecting, fitting and dispensing of hearing aids and currently registered in NYS by the Department of State pursuant to Article 37, Section 781(a) of the General Business Law may be qualified to participate in the Medicaid Program.

Hearing aids and related services provided to Medicaid-eligible patients while temporarily out-of-state shall be provided by hearing aid dealers properly meeting the registration requirements of the appropriate agency of the state in which the hearing aids and related services are provided.

Replacement Hearing Aid

A replacement hearing aid is a device that is recommended because a recipient attests to the fact that his original device was:

- lost, stolen, or damaged and
- is outside the manufacturer’s warranty; or
- to a device that is recommended due to a measurable change in the recipient’s hearing loss.

Speech and Hearing Centers Approved by the NYS Physically Handicapped Children’s Program

Pursuant to Title V, Article 25 of the Public Health Law, Section 2580, Physically Handicapped Children, the DOH is authorized to approve speech and hearing services in health facilities and to designate facilities meeting the highest professional standards as eligible to provide services to children in the PHCP.

Because of the scope of services in these facilities and the professional staff available through these facilities, their use is recommended as the referral agency under the Medicaid Program.

A list of these approved centers may be obtained by calling the Growing Up Healthy Hotline at (800) 522-5006.
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<td>V5230</td>
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<td>DESCRIPTION</td>
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<td>BR</td>
<td>PA</td>
<td>CHANGE</td>
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<td>3 prong Y cord</td>
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<td></td>
<td>garment bag - binaural w/straps</td>
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<td>temple tip - eyeglasses</td>
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<td></td>
<td>dummy temple - eyeglasses</td>
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</table>
**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 (e.g., operative report, procedure description, and/or itemized invoices) should accompany all claims submitted.

**BR SC:** For specialty 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.
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.
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F. REPLACEMENT PARTS------------------------------- 8
G. REPAIRS------------------------------------------ 9
GENERAL INFORMATION AND INSTRUCTIONS

1. “For Profit Dispensers”

At the commencement of the trial period, (which is the date the aid is dispensed to the recipient), the for-profit dispenser may bill for:

(a) Earmolds
(b) Hearing aid device
(c) Accessories, provided the price of the accessory is not already included in the price of the aid
(d) Dispensing fee

2. “Not-for-Profit Dispensers”

When billing for the initial and/or replacement hearing aid device, the not-for-profit dispenser may bill for:

(a) Accessories, provided the price of the accessory is not already included in the price of the aid
(b) Earmolds
(c) Batteries
(d) Visits at the clinic rate of the facility to cover reasonable and necessary costs for the dispensing of the aid. Not-for-profit providers may not bill the Dispensing fee separately.

NOTE: When the costs are not included in the facility’s rate, reimbursement for accessories and earmolds will be made at the lower of the price charged by the facility to the general public or the State Maximum Fee Schedule amount. Reimbursement for hearing aid batteries will be made at the lowest of the price charged by the facility to the general public, the facility’s acquisition cost or the State Maximum Fee Schedule amount. The Dispensing fee contained in the State Fee Schedule will not be paid to not-for-profit facilities.

3. The Administrative fee includes reimbursement for all fittings, adjustments, instructions to the recipient in use of the device, a garment bag and/or body harness/strap if applicable, regardless of the length of the trial period and a one-month supply of batteries. Effective for dispensing dates on and after July 1, 2003, the “administration fee” is a component of the Dispensing fee code. There is no longer a separate billing code for “administrative fee”.

4. Dispensing fee includes, but is not limited to, reimbursement for all repairs and/or replacement of defective parts plus labor and cleaning for the life of the hearing aid under normal use. Effective for dispensing dates on and after July 1, 2003, Dispensing fee codes also include reimbursement for the administrative component defined in Rule 3. If it is determined during the trial period that the recipient will not keep the aid, the claim for the aid must be voided and the claim
for the Dispensing fee code must be adjusted to deduct the amount indicated as "dispensing" in the description of the Dispensing Fee Code.

5. Assessment for hearing aid (Hearing aid evaluation test, free field testing) evaluates the interaction between amplification and a given auditory system with a goal of minimizing a communication handicap caused by an auditory dysfunction.

6. Conformity evaluation is a hearing aid check performed following the receipt of a hearing aid for the purpose of evaluating the performance of the hearing aid and its benefit to the wearer to insure that the unit and its benefit meet expectations.

7. Hearing aids will be reimbursed at acquisition cost (by invoice) to the dispenser.

8. Batteries will be priced on a periodic basis in accordance with a statewide average retail price, less 20%. Changes to the prices will be provided by the appropriate State agency responsible for such notification.

9. In those instances where a recipient requires two hearing aids, but the type of aids prescribed are different (e.g., behind the ear and body), the provider should bill the appropriate monaural fee codes for the aid(s) along with the binaural Dispensing fee, where appropriate.

10. "_____________" Underlined codes require prior approval if the recipient is 21 years of age or older. However, hearing aids and special fittings recommended by an Approved Speech and Hearing Center do not require prior approval.

If the recipient is less than 21 years of age, recommendation by an Approved Speech and Hearing Center and prior approval from the Local Physically Handicapped Children’s Program Director are required for all services.

NOTE: For persons under 21 residing in New York State Developmental Centers, the recommendation for a hearing aid may come from either an Approved Speech and Hearing Center or from the Developmental Center.

All repairs due to damages for $70 or more require prior approval regardless of the age of the recipient. The provider should indicate their cost minus 20%.

Prior Approval contact information is identified in the Inquiry Section under Information For All Providers.

11. " * " Asterisked codes require appropriate documentation (e.g., itemized invoice) to accompany claims.

12. Modifier ‘-RP Replacement and Repair should be used to indicate repair of a hearing aid, special fitting, earmold or part which has been in use for some time. The claim should show the code for the part followed by the Modifier ‘-RP and the charge.
13. Recipient rights and obligations statement shall be provided to the recipient at the time the hearing aid is dispensed and a copy must be maintained in the recipient’s record as per Section 2.2.7(3) of this Manual. (See sample form below.)

**RECIPIENT RIGHTS AND OBLIGATIONS**

Minimum Hearing Aid Trial Period: _____________________ (date dispensed) to _____________________ (45 days immediately subsequent to dispensing).

During Trial Period _____________________________ (Recipient Name) must return to the dealer for all necessary adjustments and calibrations of the hearing aid or to return the hearing aid.

At the end of the trial period the recipient must return to the dispenser and provide written confirmation of benefit of use of the hearing aid.

__________________________________________  ________________________________________
Dispenser Name                                  Recipient Signature

__________________________________________  ________________________________________
MMIS Provider ID #                             Recipient Name (Please Print)

__________________________________________
Recipient Medicaid ID #
14. Confirmation of benefit statement documents the assessment of the accuracy and the efficacy of the hearing aid fitting and verifies that the proper hearing aid fitting was dispensed as recommended; and that the aid(s) function according to specifications, based on audiological data, behavioral observations, or recipient statement of benefit. This statement must be completed at the end of the trial period (present requirement is a 45-day trial period) and maintained in the recipients’ record. (See sample form below)

HEARING AID CONFIRMATION OF BENEFIT STATEMENT

This is to verify that the ____________________________ (brand, model and serial #) hearing aid(s) provided to __________________________ (recipient name), __________________________ (Recipient Medicaid ID #)

and delivered ___________________________ (month/year) is/are providing benefit and purchase is recommended. The following information is offered in support of this statement of hearing aid benefit:

_________________________________________________________________

____________________________
Signature

Please Print:

____________________________  _____________________________
Name                          Relationship to Recipient

____________________________  _____________
Address                      Date

____________________________
Phone #
15. Hearing Aid Coverage Criteria

Medicaid reimbursement for hearing aids is dependent upon the following criteria, regardless of order source:

A. Monaural Hearing Aid:

Hearing loss in the better ear of 30 dB HL or greater (re-ANSI 1969) for the pure tone average of 500, 1,000 and 2,000 Hz. The better ear must be fitted unless medical justification to the contrary can be documented.

A spondee threshold in the better ear of 30 dBHL or greater when pure tone thresholds cannot be established.

Hearing loss in each ear is less than 30 dBHL at the frequencies below 2,000 Hz and thresholds in each ear are greater than 40 dBHL at 2,000 Hz and higher.

Documentation of communication need and a statement that the patient is alert and oriented and able to utilize their aid appropriately.

B. Binaural Hearing Aids:

Same as the criteria for Monaural Hearing Aid plus one or more of the following:

- Significant social, vocational or educational demands;
- Previous user of binaural hearing aids;
- Significant visual impairment;
- Children

C. Covered Hearing Aids:

All providers are responsible for assuring that an adequate and least costly analog, digital and/or programmable hearing aid has been explored and, where appropriate and cost effective, is provided. The types of covered hearing aids are limited to those described by the codes listed in the fee schedule.

The patient’s medical record must contain documentation of (in the ordering practitioner’s best professional judgement) medical necessity supporting the type (analog, digital and/or programmable) of hearing aid to be dispensed. This includes a face to face clinical evaluation(s) of the patient by the ordering practitioner and additional documentation from other licensed healthcare professionals which supports the medical necessity of the specific hearing aid (see A, B and C above).

Only licensed healthcare professionals can evaluate and document the medical need for hearing aids. Dispensing providers must collect this documentation from the ordering practitioner and other licensed healthcare professionals, maintain it in their files, and provide it to the Department upon request.

NOTE: FM Systems are not reimbursable.

16. Fees, if applicable, are published in the Fee Schedule, available at: http://www.emedny.org/ProviderManuals/HearingAid/index.html
## CODE DESCRIPTION

### A. DIAGNOSTIC SERVICES

Reimbursement limited to qualified audiologist

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<td>Conformity evaluation (Hearing aid check) (May only be billed by non-dispensing audiologist.)</td>
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<td>92551</td>
<td>Screening test, pure tone, air only (C/THP only)</td>
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<td>92552</td>
<td>Pure tone audiometry (threshold); air only</td>
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<td>92553</td>
<td>air and bone</td>
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<td>92555</td>
<td>Speech audiometry threshold;</td>
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<tr>
<td>92556</td>
<td>with speech recognition</td>
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<td>92557</td>
<td>Comprehensive audiometry threshold evaluation and speech recognition (92553 and 92556 combined) (including the measuring of hearing acuity and tests relating to air conduction, bone conduction, speech reception, threshold and speech discrimination.)</td>
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<td>92563</td>
<td>Tone decay test</td>
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<td>Short increment sensitivity index (SISI)</td>
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<td>92565</td>
<td>Stenger test, pure tone</td>
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<td>92567</td>
<td>Tympanometry (impedance testing)</td>
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<td>92568</td>
<td>Acoustic reflex testing</td>
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<td>Acoustic reflex decay test</td>
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<td>92571</td>
<td>Filtered speech test</td>
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<td>92585</td>
<td>Auditory evoked potentials for evoked response audiometry and/or testing of the central nervous system; comprehensive limited (use for newborn hearing screening)</td>
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### B. DISPENSING FEES for HEARING AIDS

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<td>Dispensing fee, CROS (administrative=$67/dispensing=$133)</td>
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<td>V5240</td>
<td>Dispensing fee, BICROS (administrative=$67/dispensing=$133)</td>
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<tr>
<td>V5241</td>
<td>Dispensing fee, monaural hearing aid (administrative=$45/dispensing=$90)</td>
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### C. HEARING AIDS

Reimbursed at acquisition cost (by invoice).

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<tr>
<td>V5040*</td>
<td>Hearing aid, monaural, body worn, bone conduction</td>
</tr>
<tr>
<td>V5050*</td>
<td>Hearing aid, monaural, in the ear</td>
</tr>
<tr>
<td>V5060*</td>
<td>Hearing aid, monaural, behind the ear</td>
</tr>
<tr>
<td>V5070*</td>
<td>Glasses, air conduction</td>
</tr>
<tr>
<td>V5080*</td>
<td>Glasses, bone conduction</td>
</tr>
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<td>V5120*</td>
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<tr>
<td>CODE</td>
<td>DESCRIPTION</td>
</tr>
<tr>
<td>-------</td>
<td>-------------</td>
</tr>
<tr>
<td>V5140*</td>
<td>Binaural, behind the ear</td>
</tr>
<tr>
<td>V5150*</td>
<td>Binaural, glasses</td>
</tr>
<tr>
<td>V5170*</td>
<td>Hearing aid, CROS, in the ear</td>
</tr>
<tr>
<td>V5180*</td>
<td>Hearing aid, CROS, behind the ear</td>
</tr>
<tr>
<td>V5190*</td>
<td>Hearing aid, CROS, glasses</td>
</tr>
<tr>
<td>V5210*</td>
<td>Hearing aid, BICROS, in the ear</td>
</tr>
<tr>
<td>V5220*</td>
<td>Hearing aid, BICROS, behind the ear</td>
</tr>
<tr>
<td>V5230*</td>
<td>Hearing aid, BICROS, glasses</td>
</tr>
<tr>
<td>V5246*</td>
<td>Hearing aid, digitally programmable analog, monaural, ITE (in the ear)</td>
</tr>
<tr>
<td>V5247*</td>
<td>Hearing aid, digitally programmable analog, monaural, BTE (behind the ear)</td>
</tr>
<tr>
<td>V5252*</td>
<td>Hearing aid, digitally programmable, binaural, ITE</td>
</tr>
<tr>
<td>V5253*</td>
<td>Hearing aid, digitally programmable, binaural, BTE</td>
</tr>
<tr>
<td>V5256*</td>
<td>Hearing aid, digital, monaural, ITE</td>
</tr>
<tr>
<td>V5257*</td>
<td>Hearing aid, digital, monaural, BTE</td>
</tr>
<tr>
<td>V5260*</td>
<td>Hearing aid, digital, binaural, ITE</td>
</tr>
<tr>
<td>V5261*</td>
<td>Hearing aid, digital, binaural, BTE</td>
</tr>
</tbody>
</table>

**D. BATTERIES**

The dispensing fee for a hearing aid device includes a one-month supply of batteries. Batteries should be billed individually; therefore, the “quantity” field on the claim form should reflect the **NUMBER OF BATTERIES** dispensed rather than the number of packages. Prices will be periodically updated by the State at retail less 20 percent. No invoice attachment is necessary since these are maximum reimbursable amounts.

- V5266 Battery for use in hearing device (**any type**) (up to 24) (up to a two-month supply may be dispensed on one date of service)
- L8621 Zinc air battery for use with cochlear implant device, replacement, each (up to 60 per month)

**E. EAR MOLDS**

- V5264 Ear mold/insert, not disposable, any type

**F. REPLACEMENT PARTS**

Payment for cochlear implant replacement parts is limited to cochlear implant manufacturers enrolled as Medicaid providers.

- L8615 Headset/headpiece for use with cochlear implant device, replacement
- L8616 Microphone for use with cochlear implant device, replacement
- L8617 Transmitting coil for use with cochlear implant device, replacement
- L8618 Transmitter cable for use with cochlear implant device, replacement
- L8619* Cochlear implant external speech processor, replacement
<table>
<thead>
<tr>
<th>CODE</th>
<th>DESCRIPTION</th>
</tr>
</thead>
</table>
| V5267 | Hearing aid supply/accessories  
        (Limited to the following items and amounts listed in the Fee Schedule)  
        (Replacement; bone band)  
        (2 prong cord)  
        (3 prong cord)  
        (2 prong Y cord)  
        (3 prong Y cord)  
        (garment bag - monaural w/straps)  
        (garment bag - binaural w/straps)  
        (garment bag - pin on type)  
        (temple tip - eyeglasses)  
        (dummy temple - eyeglasses) |

**G. REPAIRS**

Repair/replacement of defective parts is included in the Dispensing fee.

V5014  Repair/modification of a hearing aid  
        (Repairs due to damages $70 and over require Prior Approval)

V5299  Hearing service, miscellaneous  
        (Limited to cleaning once per year)  
        (Not reimbursable to original dispenser)
NEW YORK STATE
MEDICAID PROGRAM

HEARING AID/AUDIOLOGY
SERVICES

BILLING GUIDELINES
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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 Hearing Aid/Audiology Services providers and should be used by the provider as an instructional as well as a reference tool.
Section II – Claims Submission

Hearing Aid/Audiology Services providers can submit their claims to NYS Medicaid in electronic or paper formats.

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.

Hearing Aid/Audiology Services providers who choose to submit their Medicaid claims electronically are required to use the HIPAA 837 Professional (837P) transaction. In addition to this document, direct billers may also refer to the sources listed below to comply with the NYS Medicaid requirements.

- **HIPAA 837P Implementation Guide (IG)** explains the proper use of the 837P standards and program specifications. This document is available at [www.wpc-edi.com/hipaa](http://www.wpc-edi.com/hipaa).

- **NYS Medicaid 837P Companion Guide (CG)** is a subset of the IG which provides specific instructions on the NYS Medicaid requirements for the 837P 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](http://www.emedny.org) by clicking on the link to the web page below:

**eMedNY Companion Guides and Sample Files**
Pre-requisites 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 a HIPAA-compliant, web-based application that is customized for specific transactions, including the 837P. 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
ePACES also features the **real time claim submission** functionality under the 837 Professional transaction, which allows immediate adjudication of the claim. When this functionality is used, a claim adjudication status response is sent to the submitter shortly after submission.

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 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 is available 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 is available 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

Hearing Aid/Audiology Services providers who choose to submit their claims on paper forms must use the New York State eMedNY-150001 claim form. To view the eMedNY-150001 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.

Hearing Aid – 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:

<table>
<thead>
<tr>
<th>Written As</th>
<th>Intended As</th>
<th>Interpreted As</th>
</tr>
</thead>
<tbody>
<tr>
<td>6. 0 0</td>
<td>6.00</td>
<td>6.00</td>
</tr>
</tbody>
</table>

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:

<table>
<thead>
<tr>
<th>Written As</th>
<th>Intended As</th>
<th>Interpreted As</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>3</td>
<td>3</td>
<td>2</td>
</tr>
</tbody>
</table>

Two interpreted as seven
Three interpreted as two

• Characters should not touch each other. Example:

<table>
<thead>
<tr>
<th>Written As</th>
<th>Intended As</th>
<th>Interpreted As</th>
</tr>
</thead>
<tbody>
<tr>
<td>23</td>
<td>23</td>
<td>illegible</td>
</tr>
</tbody>
</table>

Entry cannot be interpreted properly

• Do not write 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, such as 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 eMedNY-150001

To view the eMedNY-150001 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.

Hearing Aid – Sample Claim

General Information About the eMedNY-150001

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 Hearing Aid/Audiology Services

This subsection of the Billing Guidelines covers the specific NYS Medicaid billing requirements for Hearing Aid/Audiology Services providers. Although the instructions that follow are based on the eMedNY-150001 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 eMedNY-150001

Header Section: Fields 1 through 23B

The information entered in the Header Section of the claim form (fields 1 through 23B) must apply to all claim lines entered in the Encounter Section of the form.

The following two fields (unnumbered) 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 (Upper right corner of the form)

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 (Upper Right Corner Of The Form)

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 units 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.
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

**Patient and Insured (Subscriber) Information**

<table>
<thead>
<tr>
<th>1. Patient’s Name. (First, middle, last)</th>
<th>Jane Smith</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Date of Birth</td>
<td>05/20/90</td>
</tr>
<tr>
<td>3. Insured’s Name (First name, middle initial, last name)</td>
<td>[Redacted]</td>
</tr>
<tr>
<td>4. Patient’s Address (Street, City, State, Zip Code)</td>
<td>[Redacted]</td>
</tr>
<tr>
<td>5. Insured’s Sex</td>
<td>Female</td>
</tr>
<tr>
<td>6. Medicare Number</td>
<td>[Redacted]</td>
</tr>
<tr>
<td>7. Patient’s Telephone Number</td>
<td>[Redacted]</td>
</tr>
<tr>
<td>8. Insured’s Employer or Occupation</td>
<td>[Redacted]</td>
</tr>
<tr>
<td>9. Other Health Insurance Coverage – Enter name of Polyclinic, Plan Name and Address, and Policy or Private Insurance Number</td>
<td>[Redacted]</td>
</tr>
<tr>
<td>10. Was Condition Related To</td>
<td>[Redacted]</td>
</tr>
<tr>
<td>11. Insured’s Address (Street, City, State, Zip Code)</td>
<td>[Redacted]</td>
</tr>
</tbody>
</table>

**Physician or Supplier Information (Refer to reverse before completing and signing)**

| 14. Date of Onset of Condition | [Redacted] |
| 15. First Consultation For Condition | [Redacted] |
| 16. Name of Referring Physician or Other Source | [Redacted] |
| 17. Name of Hospital Where Services Rendered (Other than own or office) | [Redacted] |
| 18. Address or Facility Where Services Rendered (Other than own or office) | [Redacted] |
| 19. Name of Service Provider | [Redacted] |
| 20. Service Provider Name | [Redacted] |
| 21. Service Provider Signature | [Redacted] |

**Diagnosis or Nature of Illness**

| 22A. Procedure Code | [Redacted] |
| 22B. Procedure Date of Service | [Redacted] |
| 22C. Procedure Place | [Redacted] |
| 22D. Procedure Diagnosis Code | [Redacted] |
| 22E. Procedure Charges | [Redacted] |

**Diagnosis**

<table>
<thead>
<tr>
<th>Diagnosis Code</th>
<th>Charge Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>[Redacted]</td>
<td>[Redacted]</td>
</tr>
</tbody>
</table>

**Employer Identification Number**

| 23A. First Name | [Redacted] |
| 23B. Middle Initial | [Redacted] |
| 23C. Last Name | [Redacted] |
| 23D. Social Security Number | [Redacted] |

**Claim**

| 24A. Provider Identification Number | [Redacted] |
| 24B. Medicaid Group Identification Number | [Redacted] |
| 24C. LOCATOR CODE | [Redacted] |
| 24D. EXCP CODE | [Redacted] |

**Other**

| 31. Physician’s or Supplier’s Name, Address, Zip Code | [Redacted] |
| 32. Telephone Number | [Redacted] |

**Signature of Physician or Supplier**

James Strong
ABC Hearing Aid
312 Main Street
Anytown, New York 11111
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 the provider was 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.
Fields 1, 2, 5A, and 6A require information obtained from the Client’s (Patient’s) Common Benefit Identification Card.

**PATIENT'S NAME (Field 1)**

Enter the patient’s first name, followed by the last name.

**DATE OF BIRTH (Field 2)**

Enter the patient’s birth date. The birth date must be in the format MMDDYYYY.

**Example:** Mary Brandon was born on January 2\(^{nd}\), 1974.

<table>
<thead>
<tr>
<th>2. DATE OF BIRTH</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
</tr>
</tbody>
</table>

**PATIENT'S SEX (Field 5A)**

Place an ‘X’ in the appropriate box to indicate the patient’s sex.

**MEDICAID NUMBER (Field 6A)**

Enter the patient’s ID 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:**

<table>
<thead>
<tr>
<th>6A. MEDICAID NUMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td>A A 1 2 3 4 5 W</td>
</tr>
</tbody>
</table>

**WAS CONDITION RELATED TO (Field 10)**

If applicable, place an ‘X’ in the appropriate box to indicate that the service rendered to the patient was for a condition resulting from an accident or a crime. Select the boxes in accordance to the following:

- **Patient’s Employment**
  
  Use this box to indicate Worker’s Compensation. Leave this box blank if condition is related to patient’s employment, but not to Worker’s Compensation.

- **Crime Victim**
  
  Use this box to indicate that the condition treated was the result of an assault or crime.
• **Auto Accident**
  Use this box to indicate Automobile No-Fault. Leave this box blank if condition is related to an auto accident other than no-fault or if no-fault benefits are exhausted.

• **Other Liability**
  Use this box to indicate that the condition was an accident-related injury of a different nature from those indicated above.

If the condition being treated is not related to any of these situations, leave these boxes blank.

**EMERGENCY RELATED (Field 16A)**
Leave this field blank.

**NAME OF REFERRING PHYSICIAN OR OTHER SOURCE (Field 19)**
Enter the ordering provider’s name in this field.

**ADDRESS [Or Signature - SHF Only] (Field 19A)**
If the ordering provider and the Hearing Aid dispenser or Audiologist are part of the same **Shared Health Facility**, obtain the ordering provider’s signature in this field.

**PROF CD [Profession Code - Ordering /Referring Provider] (Field 19B)**
If a license number is indicated in Field 19C, the Profession Code that identifies the ordering/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**](#)

If an audiometric examination is recommended by a physician with a specialty other than otolaryngology, enter the appropriate Profession Code for the specialty.

**IDENTIFICATION NUMBER [Ordering/Referring Provider] (Field 19C)**
Enter the Medicaid ID number of the physician or Audiologist ordering the hearing aid or the physician recommending the patient for audiology services in this field. If the ordering/referring provider is not enrolled in Medicaid, enter his/her license number. If a license number (or State Certification 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.
DX CODE (Field 19D)
Leave this field blank.

NAME OF FACILITY WHERE SERVICES RENDERED (Field 21)
Leave this field blank.

ADDRESS OF FACILITY (Field 21A)
Leave this field blank.

SERVICE PROVIDER NAME (Field 22A)
Leave this field blank.

PROF CD [Profession Code - Service Provider] (Field 22B)
Leave this field blank.

IDENTIFICATION NUMBER [Service Provider] (Field 22C)
Leave this field blank.

STERILIZATION/ABORTION CODE (Field 22D)
Leave this field blank.

STATUS CODE (Field 22E)
Leave this field blank.

POSSIBLE DISABILITY (Field 22F)
Place an ‘X’ in the Y box for YES or an ‘X’ in the N box for NO to indicate whether the service was for treatment of a condition which appeared to be of a disabling nature (the inability to engage in any substantial or gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or has lasted or can be expected to last for a continuous period of not less than 12 months).

EPSDT C/THP (Field 22G)
Leave this field blank.
FAMILY PLANNING (Field 22H)

Leave this field blank.

PRIOR APPROVAL NUMBER (Field 23A)

If the provider is billing for a service or item that requires Prior Approval/Prior Authorization, enter in this field the eleven-digit prior approval number assigned for the service or item by the appropriate agency of the New York State Department of Health. Items that are covered by different prior approval numbers cannot be billed on the same claim form; a separate claim form needs 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 Hearing Aid/Audiology Manual, Procedure Codes and Fee Schedules for this manual.

PAYMENT SOURCE CODE [Box M and Box O] (Field 23B)

This field has two components: Box M and Box O. Both boxes need to be filled as follows:

Box M
The values entered in this box define the nature of the amounts entered in fields 24J and 24K. Box M is used to indicate whether the patient is covered by Medicare, and whether Medicare approved or denied payment. Enter the appropriate numeric indicator from the following list.

- No Medicare involvement – Source Code Indicator = 1
  This code indicates that the patient does not have Medicare coverage.

- Patient has Medicare Part B; Medicare paid for the service – Source Code Indicator = 2
  This code indicates that the service is covered by Medicare and that Medicare approved the service and made a payment. Medicaid is responsible for reimbursing the Medicare deductible and/or (full or partial) coinsurance.
• **Patient has Medicare Part B; Medicare denied payment – Source Code Indicator = 3**
  This code indicates that Medicare denied payment or did not cover the service billed.

**Box O**
Box O is used to indicate whether the patient has insurance coverage other than Medicare or Medicaid, or whether the patient is responsible for a pre-determined amount of his/her medical expenses. The values entered in this box define the nature of the amount entered in field 24L. Enter the appropriate indicator from the following list.

• **No Other Insurance involvement – Source Code Indicator = 1**
  This code indicates that the patient does not have other insurance coverage.

• **Patient has Other Insurance coverage – Source Code Indicator = 2**
  This code indicates that the patient has other insurance regardless of the fact that the insurance carrier(s) paid or denied payment or that the service was covered or not by the other insurance. When the value 2 is entered in Box O, the two-character code that identifies the other insurance carrier must be entered in the space following Box O. If more than one insurance carrier is involved, enter the code of the insurance carrier who paid the largest amount. For the appropriate Other Insurance codes, refer to Information for All Providers, Third Party Information on the web page for this manual.

• **Patient Participation – Source Code Indicator = 3**
  This code indicates that the patient has incurred a pre-determined amount of medical expenses, which qualify him/her to become eligible for Medicaid.

The following chart provides a full illustration of how to complete field 23B and the relationship between this field and fields 24J, 24K, and 24L.
<table>
<thead>
<tr>
<th></th>
<th>BOX M</th>
<th>BOX O</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>23B. PAYM'T SOURCE CO</strong></td>
<td>Code 1 – No Medicare involvement. Field 24J should contain the amount charged and field 24K must be left blank.</td>
<td>Code 1 – No Other Insurance involvement. Field 24L must be left blank.</td>
</tr>
<tr>
<td>1 / 1 / /</td>
<td>Code 1 – No Medicare involvement. Field 24J should contain the amount charged and field 24K must be left blank.</td>
<td>Code 2 – Other Insurance involved. Field 24L should contain the amount paid by the other insurance or $0.00 if the other insurance did not cover the service or denied payment.</td>
</tr>
<tr>
<td>1 / 2 / /</td>
<td>Code 1 – No Medicare involvement. Field 24J should contain the amount charged and field 24K must be left blank.</td>
<td>Code 3 – Indicates patient's participation. Field 24L should contain the patient's participation amount. If Other Insurance is also involved, enter the total payments in 24L.</td>
</tr>
<tr>
<td>1 / 3 / /</td>
<td>Code 2 – Medicare Approved Service. Field 24J should contain the Medicare Approved amount and field 24K should contain the Medicare payment amount.</td>
<td>Code 1 – No Other Insurance involvement. Field 24L must be left blank.</td>
</tr>
<tr>
<td>2 / 1 / /</td>
<td>Code 2 – Medicare Approved Service. Field 24J should contain the Medicare Approved amount and field 24K should contain the Medicare payment amount.</td>
<td>Code 2 – Other Insurance involved. Field 24L should contain the amount paid by the other insurance or $0.00 if the other insurance did not cover the service or denied payment.</td>
</tr>
<tr>
<td>2 / 2 / /</td>
<td>Code 2 – Medicare Approved Service. Field 24J should contain the Medicare Approved amount and field 24K should contain the Medicare payment amount.</td>
<td>Code 3 – Indicates patient's participation. Field 24L should contain the patient's participation amount. If Other Insurance is also involved, enter the total payments in 24L.</td>
</tr>
<tr>
<td>2 / 3 / /</td>
<td>Code 3 – Medicare denied payment or did not cover the service. Field 24J should contain the amount charged and field 24K should contain $0.00.</td>
<td>Code 1 – No Other Insurance involvement. Field 24L must be left blank.</td>
</tr>
<tr>
<td>3 / 1 / /</td>
<td>Code 3 – Medicare denied payment or did not cover the service. Field 24J should contain the amount charged and field 24K should contain $0.00.</td>
<td>Code 2 – Other Insurance involved. Field 24L should contain the amount paid by the other insurance or $0.00 if the other insurance did not cover the service or denied payment.</td>
</tr>
<tr>
<td>3 / 2 / /</td>
<td>Code 3 – Medicare denied payment or did not cover the service. Field 24J should contain the amount charged and field 24K should contain $0.00.</td>
<td>Code 3 – Indicates patient's participation. Field 24L should contain the patient's participation amount. If Other Insurance is also involved, enter the total payments in 24L.</td>
</tr>
<tr>
<td>3 / 3 / /</td>
<td>Code 3 – Medicare denied payment or did not cover the service. Field 24J should contain the amount charged and field 24K should contain $0.00.</td>
<td>Code 3 – Indicates patient's participation. Field 24L should contain the patient's participation amount. If Other Insurance is also involved, enter the total payments in 24L.</td>
</tr>
</tbody>
</table>
Encounter Section: Fields 24A through 24O

The claim form can accommodate up to seven encounters with a single patient, plus a block of encounters in a hospital setting, if all the information in the Header Section of the claim (Fields 1–23B) applies to all the encounters.

DATE OF SERVICE (Field 24A)

Enter the date on which the item was supplied or the service was rendered in the format MM/DD/YY.

Example: April 1, 2007 = 04/01/07

Notes:

- A service date must be entered for each Procedure Code listed.
- In accordance with New York State policy, hearing aids must be dispensed within six months of the Ordering date. A claim form must be submitted within 90 days from the Date of Service entered on the claim form.
- When billing for an earmold subsequent to a patient’s loss of eligibility under the circumstances outlined in the Policy Guidelines section of this manual, the Date of Service should be the date on which the earmold impression was taken.

PLACE [of Service] (Field 24B)

This two-digit code indicates the type of location from where the item was dispensed or the service was rendered. Please note that the Place of Service Code is different from the Locator Code. Select the appropriate codes from Appendix A-Code Sets.

Note: If Code 99 (Other Unlisted Facility) is entered in this field for any claim line, the exact address where the item was dispensed must be entered in Fields 21 and 21A.

PROCEDURE CODE (Field 24C)

This code identifies the item dispensed or the service rendered to the patient. Enter the appropriate five-character item/procedure code in this field.
Note: Item/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.

**Hearing Aid Manual**

**MOD [Modifier] (Fields 24D, 24E, 24F and 24G)**

Under certain circumstances, the procedure code must be expanded by a two-digit modifier to further explain or define the nature of the procedure. If the Procedure Code requires the addition of modifiers, enter one or more (up to four) modifiers in these fields.

**Special Instructions for Claiming Medicare Deductible:**

When billing for the Medicare deductible, modifier “U2” must be used in conjunction with the Procedure Code for which the deductible is applicable. **Do not enter** the “U2” modifier if billing for Medicare coinsurance.

Note: Modifier values and their definitions are available at www.emedny.org by clicking on the link to the web page below under Procedure Codes and Fee Schedule.

**Hearing Aid Manual**

**DIAGNOSIS CODE (Field 24H)**

Using the International Classification of Diseases, Ninth Edition, Clinical Modification (ICD-9-CM) coding system, enter the appropriate code which describes the main condition or symptom of the patient. The ICD-9-CM code must be entered exactly as it is listed in the manual in the correct spaces of this field and in relation to the decimal point.

**Note:** A three-digit Diagnosis Code (no entry following the decimal point) will only be accepted when the Diagnosis Code has no subcategories. Diagnosis Codes with subcategories MUST be entered with the subcategories indicated after the decimal point.

The following is an example of an ICD-9-CM Diagnosis Code properly entered in Field 24H:

**Example:**

```
24H. DIAGNOSIS CODE
    | 3 | 8 | 9 . 9 |
```
**DAYS OR UNITS (Field 24I)**

Enter the quantity of each item dispensed or units of service rendered. If only one unit of an item was dispensed, this field may be left blank.

**Note:** Batteries should be billed individually; therefore when billing for batteries, this field should reflect the number of batteries dispensed rather than the number of battery packages.

The entries in Fields 24J, 24K, and 24L are determined by the entries in Field 23B, Payment Source Code.

**CHARGES (Field 24J)**

This field must contain either the Amount Charged or the Medicare Approved Amount.

**Amount Charged**
When Box M in field 23B has an entry value of 1 or 3, enter the amount charged in this field. The Amount Charged may not exceed the provider's customary charge for the procedure.

**Medicare Approved Amount**
When Box M in field 23B has an entry value of 2, enter the Medicare Approved Amount in field 24J. The Medicare Approved amount is determined as follows:

- If billing for the Medicare **deductible**, the Medicare Approved amount should equal the Deductible amount claimed, which must not exceed the established amount for the year in which the service was rendered.

- If billing for the Medicare **coinsurance**, the Medicare Approved amount should equal the sum of: the amount paid by Medicare plus the Medicare co-insurance amount plus the Medicare deductible amount, if any.

**Notes:**

- Field 24J must never be left blank or contain 0.00. If the Medicare Approved amount from the EOMB equals zero, then Medicaid should not be billed.

- 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.
UNLABELED (Field 24K)

This field is used to indicate the Medicare Paid Amount and must be completed if Box M in field 23B has an entry value of 2 or 3.

The value in Box M is 2
• When billing for the Medicare deductable, enter 0.00 in this field.
• When billing for the Medicare coinsurance, enter the Medicare Paid amount as the sum of the actual Medicare paid amount and the Medicare deductible, if any.

The value in Box M is 3
• When Box M in field 23B contains the value 3, enter 0.00 in this field to indicate that Medicare denied payment or did not cover the service.

If none of the above situations are applicable, leave this field blank.

UNLABELED (Field 24L)

This field must be completed when Box O in field 23B has an entry value of 2 or 3.

• When Box O has an entry value of 2, enter the Other Insurance payment in this field. If more than one insurance carrier contributes to payment of the claim, add the payment amounts and enter the total amount paid by all other insurance carriers in this field.

• When Box O has an entry value of 3, enter the Patient Participation amount. If the patient is covered by other insurance and the insurance carrier(s) paid for the service, add the Other Insurance payment to the Patient Participation amount and enter the sum in this field.

If none of the above situations are applicable, leave this field blank.

Note: It is the responsibility of the provider to determine whether the patient’s Other Insurance carrier covers the service being billed for, as Medicaid is always the payer of last resort.

If the other insurance carrier denied payment enter 0.00 in field 24L. 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 for 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 the provider to zero-fill other insurance payment for 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 them 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 patient 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 patient or absent parent.

The provider is instructed to zero-fill by the LDSS for circumstances not listed above.

*Fields 24M through 24O (INPATIENT HOSPITAL VISITS) may be used for block-billing CONSECUTIVE visits within the SAME MONTH/YEAR made to a patient in a hospital inpatient status.*

**INPATIENT HOSPITAL VISITS [From/Through Dates] (Field 24M)**

Leave this field blank.
PROC CD [Procedure Code] (Field 24N)
Leave this field blank.

MOD [Modifier] (Field 24O)
Leave this field blank.

Note: Leave the last row of Fields 24H, 24J, 24K, and 24L blank.

Trailer Section: Fields 25 through 34

The information entered in the Trailer Section of the claim form (fields 25 through 34) must apply to all claim lines entered in the Encounter Section of the form.

CERTIFICATION [Signature of Physician or Supplier] (Field 25)
The billing provider or an authorized representative must sign the claim form. Rubber stamp signatures are not acceptable. Please note that the certification statement is on the back of the form.

PROVIDER IDENTIFICATION NUMBER (Field 25A)
Enter the Medicaid Provider ID number which is the eight-digit identification number assigned to providers at the time of enrollment in the Medicaid program.

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.

MEDICAID GROUP IDENTIFICATION NUMBER (Field 25B)
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 case, the Medicaid Provider ID number of the group member that rendered the service must be entered in field 25A.

For a Shared Health Facility, enter in this field the 8-digit identification number 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.

**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 25C)**

Locator codes are assigned to the provider for each service address registered at the time of enrollment in the Medicaid program or at anytime, afterwards, 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 patients 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 25D)**

Leave this field blank.

**COUNTY OF SUBMITTAL (Unnumbered Field)**

Enter the name of the county wherein the claim form is signed. The County may be left blank only when the provider's address, is within the county wherein the claim form is signed.

**DATE SIGNED (Field 25E)**

Enter the date on which the provider or an authorized representative 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, which can be found on the web page for this manual.
PHYSICIAN’S OR SUPPLIER’S NAME, ADDRESS, ZIP CODE (Field 31)

Enter the provider's name and correspondence address in this field.

Note: It is the responsibility of the provider to notify Medicaid of any change of address or other pertinent information within 15 days of the change. For information on where to direct address change requests, please refer to Information for All Providers, Inquiry section which can be found on the web page for this manual.

PATIENT’S ACCOUNT NUMBER (Field 32)

For record-keeping purposes, the provider may choose to identify a patient 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 patient identification.

OTHER REFERRING/ORDERING PROVIDER ID/LICENSE NUMBER (Field 33)

Leave this field blank.

PROF CD [Profession Code - Other Referring/Ordering Provider] (Field 34)

Leave this field blank.
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, locator code 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 must 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 who submit claims under multiple ETINs receive a separate 835 for each ETIN and a separate check for each 835. Also, any 835 transaction can contain a maximum of ten thousand (10,000) claim lines; any overflow will generate a separate 835 and a separate check.

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 also 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
  - 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 Hearing Aid/Audiology 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).
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: ABC HEARING AID

DATE: 2007-08-06
REMITTANCE NO: 07080600006
PROVIDER ID/NPI: 00112233/0123456789

07080600006  2007-08-06
ABC HEARING AID
100 BROADWAY
ANYTOWN                     NY                  11111

ABC HEARING AID       $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: ABC HEARING AID
DATE: 08/06/2007
REMITTANCE NO: 07080600006
PROVIDER ID/NPI: 00112233/0123456789

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

ABC HEARING AID
100 BROADWAY
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.

*** 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 denied during the specific cycle. This section may also contain pending claims from previous cycles that remain in a pend status.

<table>
<thead>
<tr>
<th>LN.</th>
<th>PROC NO.</th>
<th>CODE</th>
<th>QUANTITY</th>
<th>CLIENT NUMBER</th>
<th>CLIENT NAME</th>
<th>OFFICE ACCT NUMBER</th>
<th>SERVICE DATE</th>
<th>TCN</th>
<th>AMOUNT CHARGED</th>
<th>AMOUNT PAID</th>
<th>STATUS</th>
<th>ERRORS</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>92585</td>
<td>1.000</td>
<td>UU44444R</td>
<td>DAVIS CP343444</td>
<td>07/11/07</td>
<td>07206-00000227-0-0</td>
<td>52.80</td>
<td>0.00</td>
<td>DENY</td>
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* = 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
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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

* = PREVIOUSLY PENDED CLAIM
** = NEW PEND
### MEDICAL ASSISTANCE (TITLE XIX) PROGRAM REMITTANCE STATEMENT

**TO:** ABC HEARING AID  
100 BROADWAY  
ANYTOWN, NEW YORK 11111  

**ETIN:**  
00112233/0123456789  

**REMITTANCE NO:** 07080600006  

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* = PREVIOUSLY PENDED CLAIM  
** = NEW PEND  

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

**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**  
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NUMBER OF CLAIMS 1  

**TOTAL PENDS**  
168.94  
NUMBER OF CLAIMS 4  

**TOTAL PAID**  
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NUMBER OF CLAIMS 4  

**TOTAL DENIED**  
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NUMBER OF CLAIMS 4  

**NET TOTAL PAID**  
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NUMBER OF CLAIMS 5
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**MEDICAL ASSISTANCE (TITLE XIX) PROGRAM**

**REMITTANCE STATEMENT**
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: DME

* Provider ID/NPI
Remittance number

Explanations 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.

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

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

CLIENT ID NUMBER
The client’s Medicaid ID number appears under this column.

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

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

SERVICE DATE
This column lists the service date as entered in the claim form.
**TCN**
The TCN is a unique identifier assigned to each 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.

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

**PAID**
If the claim 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: Client 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.
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.

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<th>REASON CODE</th>
<th>DESCRIPTION</th>
<th>ORIG BAL</th>
<th>CURR BAL</th>
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<td>$XXX.XX-</td>
<td>999</td>
<td>999</td>
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</table>

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.

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

00131  RECIPIENT HAS OTHER INSURANCE BILL PRIMARY CARRIER
00142  RECIPIENT YEAR OF DIFFERS FROM FILE
00162  RECIPIENT INELIGIBLE ON DATE OF SERVICE
00244  PA NOT ON OR REMOVED FROM FILE
### Appendix A – Code Sets

**Place of Service**

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<td>06</td>
<td>Indian health service provider-based facility</td>
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<td>07</td>
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<td>Tribal 638 provider-based facility</td>
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<th>American Territories</th>
<th>Abbrev.</th>
</tr>
</thead>
<tbody>
<tr>
<td>American Samoa</td>
<td>AS</td>
</tr>
<tr>
<td>Canal Zone</td>
<td>CZ</td>
</tr>
<tr>
<td>Guam</td>
<td>GU</td>
</tr>
<tr>
<td>Puerto Rico</td>
<td>PR</td>
</tr>
<tr>
<td>Trust Territories</td>
<td>TT</td>
</tr>
<tr>
<td>Virgin Islands</td>
<td>VI</td>
</tr>
</tbody>
</table>

Note: Required only when reporting out-of-state license numbers.
NEW YORK STATE
MEDICAID PROGRAM

HEARING AID

PRIOR APPROVAL GUIDELINES
TABLE OF CONTENTS

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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 283201)

This document is customized for Hearing Aid 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 are 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 Order/Prior Approval Request Form (eMedNY 283201). 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 payments. Payment is subject to client’s eligibility and other guidelines.

Requests for prior approval should be submitted before the date of service or dispensing date. 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 item was dispensed/service was provided before the prior approval request was approved.

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 283201)

NYS MEDICAL ASSISTANCE – TITLE XIX PROGRAM

HEARING AID – ORDER/PRIOR APPROVAL REQUEST

1 ORDER SRC
2 ORDER DATE
3 ID/LICENSE NUMBER
4 PROF CODE
5 ORDERED BY (NAME)
6 CLIENT ID
7 ADDRESS
8 DATE OF BIRTH
9 CLIENT NAME
10 ADDRESS

11 DATE OF BIRTH
12 SEX
13 SRC CODE
14 PRIMARY DIAGNOSIS
15 SECONDARY DIAGNOSIS
16 AIR CONDUCTION PURE TONE AVERAGE
17 RECEPTION THRESHOLD
18 SPEECH DISCRIMINATION
19 REPLACEMENT
20 REPLACEMENT THROUGH MEDICAID

21 BONE CONDUCTION
22 RECEPTION THRESHOLD
23 DISCRIMINATION @ 35dBHL
24 DISCRIMINATION @ 60dBHL
25 DISC. IN NOISE
26 EAR(S) FITTED
27 DISTANT IN NOISE

28 AIR CONDUCTION
29 SPEECH DISCRIMINATION
30 EXAMINER/Dispenser
31 TWO ROOM SOUND SUITE
32 OTOLOGYNGOLOGIST

33 CHANGE IN CLINICAL STATUS
34 RECOMMENDATION
35 POSSIBLE DISABILITY
36 ACCIDENT

37 REPLACEMENT
38 SINGLE SOUND TREATED ROOM
39 TWO ROOM SOUND SUITE
40 SERVICING PROVIDER NAME
41 PROVIDER SIGNATURE
42 PROVIDER ADDRESS
43 LOC CODE
44 D/LICENSE NUMBER
45 EXAMINER SIGNATURE

46 ITEM CODE
47 DESCRIPTION
48 QUANTITY REQUESTED
49 TOTAL AMOUNT REQUESTED

50 PA REVIEW OFFICE CODE
Section III - Field by Field (eMedNY 283201)

Instructions

ORDER SRC (Field 1)

Enter the code letter from the list below, indicating where the test was done:

<table>
<thead>
<tr>
<th>CODE</th>
<th>ORDER SOURCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Hospital Outpatient Department</td>
</tr>
<tr>
<td>B</td>
<td>Inpatient Hospital Service</td>
</tr>
<tr>
<td>C</td>
<td>Treatment and Diagnostic Center</td>
</tr>
<tr>
<td>D</td>
<td>Residential Health Care Facility</td>
</tr>
<tr>
<td>E</td>
<td>Adult Home</td>
</tr>
<tr>
<td>G</td>
<td>Practitioner’s (Prescriber’s) Office</td>
</tr>
<tr>
<td>H</td>
<td>Patient’s Home</td>
</tr>
<tr>
<td>J</td>
<td>P.H.C.P. Approved Speech and Hearing Center</td>
</tr>
<tr>
<td>K</td>
<td>P.H.C.P. Approved Amputee Center</td>
</tr>
</tbody>
</table>

ORDER DATE (Field 2)

Indicate the month, day, and year on which the hearing evaluation tests were conducted.

Example: October 7, 2005 = 10072005

<table>
<thead>
<tr>
<th>ORDER DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 0 0 7 2 0 0 5</td>
</tr>
</tbody>
</table>

ID/LICENSE NUMBER (Field 3)

Enter the ordering provider’s MMIS provider number as shown in the example below. Right justify the information in this field.

Example:

<table>
<thead>
<tr>
<th>ID/LICENSE NO.</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 1 2 3 4 5 6 7</td>
</tr>
</tbody>
</table>
When the ordering provider is a non-enrolled, private-practicing otolaryngologist or audiologist, enter the orderer’s state license number. When entering the license number, leave the first two spaces at the left side of the box blank, enter two zeros then begin the license number. Right justify the information in this field as shown 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 CODE (Field 4)**

When the ordering provider is a non-enrolled private practicing otolaryngologist or audiologist, enter the three-digit code from below to indicate the profession of the orderer who performed the testing and completed the recommendation/prescription.

<table>
<thead>
<tr>
<th>CODE</th>
<th>Otolaryngologist</th>
<th>060</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Audiologist</td>
<td>057</td>
</tr>
</tbody>
</table>

**ORDERED BY (NAME) (Field 5)**

Enter the last name followed by the first name of the prescribing provider. For PHCP Centers and Article 28 facilities, this will be the name the facility enrolled under for MMIS.

**TELEPHONE NUMBER (Field 6)**

Enter the ordering provider’s telephone number.

**ADDRESS (Field 7)**

Enter the provider's address including name of facility, where appropriate.
CLIENT ID (Field 8)

For a district of fiscal responsibility, including County Code 97 (OMH Administered) and County Code 98 (OMR/DD Administered), enter the client's eight-character alphanumeric Welfare Management System (WMS) ID number.

Example:

CLIENT ID NUMBER
A A 1 2 3 4 5 X

CLIENT NAME (Field 9)

Enter the last name followed by the first name of the client as it appears on the Medicaid ID Card.

ADDRESS (Field 10)

Enter the client's street number, P.O. Box number, city, state, and zip code.

DATE OF BIRTH (Field 11)

Enter the month, day, and year of the client's birth.

Example: April 5, 1940 = 04051940

SEX (Field 12)

Place an X on M for Male or F for Female to indicate the client’s gender.

PURE TONE AUDIOGRAM (Field 13)

The ordering provider or the audiologist completes the audiogram that represents test results of air conduction and bone conduction thresholds of the right ear and left ear. Masked threshold levels shall also be recorded where appropriate. Enter on the audiogram the applicable symbols from the legend.
PRIMARY DIAGNOSIS (Field 14)

Enter the ICD-9-CM diagnosis code that represents the condition or symptom which establishes the need for the service requested. ICD-9-CM is the *International Classification of Diseases - 9th Revision - Clinical Modification Coding System*.

Example:

<table>
<thead>
<tr>
<th>CODE</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 8 9 9</td>
</tr>
</tbody>
</table>

SECONDARY DIAGNOSIS (Field 15)

Enter the appropriate ICD-9-CM diagnosis code that represents a secondary condition or symptom affecting treatment. Leave blank if there is no secondary diagnosis.

AIR CONDUCTION PURE TONE AVERAGE (Field 16)

The ordering provider or the audiologist completes the test and enters the average of the air conduction threshold levels in decibels of 500, 1000, and 2000 Hz for each ear. In the case of precipitous high frequency hearing loss, enter the two-frequency average that is in agreement with the speech reception threshold for each ear.

RECEPTION THRESHOLD (Field 17)

The ordering provider or the audiologist completes the test and enters the threshold level in decibels of the speech reception for each ear.

SPEECH DISCRIMINATION (Field 18)

The ordering provider or the audiologist completes the test and enters the discrimination percentage score for each ear and enters the decibel presentation level for each ear.

NOTE: The tests listed above represent the minimum tests the ordering provider or the ordering provider’s authorized employee must perform, but they are not necessarily exclusive. Results from administering tests not listed in these instructions, which assist in substantiating the need for a hearing aid, may be forwarded as attachments.

REPLACEMENT / THROUGH MEDICAID (Field 19)

If the client is currently in possession of a hearing aid, check the box Replacement and indicate the manufacturer and model. If the client is not in possession of an aid, leave this field blank.
If the hearing aid was obtained through the Medicaid Program, check the box Through Medicaid and enter the approximate date obtained and the dispenser's name and address. If the hearing aid was not obtained through Medicaid, leave this box blank and enter the approximate date obtained and the dispenser's name and address.

**PURE TONE AUDIOGRAM**

The ordering provider or the audiologist completes the audiogram which represents test results of air conduction and bone conduction thresholds of the right ear and left ear. Masked threshold levels shall also be recorded where appropriate. Enter on the audiogram the applicable symbols from the legend. (Field 20 and 21.)

**RECEPTION THRESHOLD (Field 22)**

The ordering provider or the audiologist tests and enters in decibels the threshold levels of speech reception as presented in sound field through the loudspeaker.

**DISCRIMINATION AT 35dB HL; 50dB HL (Fields 23 and 24)**

The ordering provider or the audiologist tests and enters, if obtainable, percentage scores at 35dB and 50dB hearing levels. When the unaided speech reception level exceeds 50dB, enter the presentation level and the percentage score.

**DISC. IN NOISE (Field 25)**

The ordering provider or the audiologist tests and enters the percentage score of discrimination ability within a recorded signal-to-noise ratio. This field is optional.

**EAR(S) FITTED (Field 26)**

The ordering provider or the audiologist indicates which ear is being fitted; right, left or both.

**SPEECH RECEPTION THRESHOLD WITH RECOMMENDED AID (Field 27)**

The ordering provider or the audiologist tests and enters threshold level in decibels of aided speech reception.

**SPEECH DISCRIMINATION WITH RECOMMENDED AID (Fields 28 and 29)**

The ordering provider or the audiologist tests and enters, if obtainable, the percentage scores at 35dB and 50dB hearing levels.
SPEECH DISC. IN NOISE WITH RECOMMENDED AID (Field 30)

The ordering provider or the audiologist tests and enters the percentage score of discrimination ability within recorded signal to noise ratio.

WHERE PERFORMED (Field 31)

Check the appropriate box.

PERFORMED BY (Field 32)

Check the appropriate box.

REPLACEMENT HEARING AID (Field 33)

Check box for yes, leave blank for no. Enter a check for a change in clinical status, lost, stolen, or damaged hearing aid, as applicable. In the case of a lost or stolen hearing aid, a written statement shall be attached by the client's caseworker or facility's social services department that includes the time, place, and reason for the loss of the device. For damaged hearing aids, a written statement from the dispenser is required regarding the extent of damage and reason for not repairing the device.

RECOMMENDATION (Field 34)

The ordering provider checks YES to indicate that while the client is in need of a hearing aid, the provider is making a general recommendation and is not prescribing a specific model. The ordering provider checks NO to indicate that a specific aid is being prescribed and a general recommendation is not being made.

POSSIBLE DISABILITY (Field 35)

Indicate whether the service was for treatment of a condition which appears to be of a disabling nature (the inability to engage in any substantial or gainful activity by reason of any medically determinable physical or mental impairment that can be expected to result in death, or has lasted or can be expected to last for a continuous period of not less than 12 months). Place an X on Y for Yes or N for No.

ACCIDENT (Field 36)

Indicate whether the service is rendered for a condition that is a result of an accident or a crime. Place an X on Y for Yes or N for No.

EAR MOLD (Field 37)

Check appropriate box for ear to be fitted or check both when applicable.
SERVICING PROVIDER NAME (Field 38)
Enter the servicing provider's name.

TELEPHONE NUMBER (Field 39)
Enter the servicing provider's telephone number.

SERVICING PROVIDER ID (Field 40)
Enter the servicing provider's ID assigned by New York State at the time of enrollment. This should be the ID number of the provider who will supply the item and bill Medicaid. Right justify the information as shown in the example below.

Example:

<table>
<thead>
<tr>
<th>SERVICING PROVIDER ID</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 1 2 3 4 5 6 7</td>
</tr>
</tbody>
</table>

PROVIDER ADDRESS (Field 41)
Enter the servicing provider's address.

PROVIDER SIGNATURE (Field 42)
The signature of the ordering provider or his/her authorized agent must be in this field.

LOC CODE (Field 43)
Enter the three-digit locator code assigned to the service provider (Example 003).

ID/LICENSE NUMBER (Field 44)
Enter the New York State license number of the examiner (if different from the ordering provider.)

EXAMINER'S SIGNATURE AND LICENSE (Field 45)
Enter the signature of the person authorized by the ordering provider (licensed physician) to perform the audiometric tests. This may be the otolaryngologist or the audiologist.
ITEM CODE (Field 46)

This code indicates the service to be rendered to the client. Refer to the New York State Procedure Code section of this manual. Enter the appropriate 5-character code of the item ordered. For those items not listed in the MMIS Manual, call the Bureau of Medical Review and Payment at (800) 342-3005.

DESCRIPTION (Field 47)

The prescriber, when prescribing a specific hearing aid, must enter the manufacturer’s name and model number of the device. The vendor must enter this information when a general recommendation has been made.

QUANTITY REQUESTED (Field 48)

Enter 1 in this field except when ordering duplicate devices for binaural fittings.

Example: Quantity of 32

<table>
<thead>
<tr>
<th>QUANTITY REQUESTED</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
</tr>
</tbody>
</table>

Example: Quantity of 1

<table>
<thead>
<tr>
<th>QUANTITY REQUESTED</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
</tr>
</tbody>
</table>

TOTAL AMOUNT REQUESTED (Field 49)

The dispenser enters in this field the total amount requested for the item.

PA REVIEW OFFICE CODE (Field 50)

This field is used to identify the state agency responsible for reviewing and issuing the prior approval. Enter code A1.

A1 – Bureau of Medical Review and Payment, Office of Medicaid Management, NYS Department of Health
<table>
<thead>
<tr>
<th>Service</th>
<th>Location</th>
<th>Area</th>
<th>Phone Numbers</th>
</tr>
</thead>
<tbody>
<tr>
<td>PHYSICIAN</td>
<td>A1 (Albany)</td>
<td>Statewide</td>
<td>800-342-3005, 518-474-3575</td>
</tr>
<tr>
<td>HEARING AID</td>
<td>A1 (Albany)</td>
<td>Statewide</td>
<td>800-342-3005, 518-474-3575</td>
</tr>
<tr>
<td>EYE CARE</td>
<td>A1 (Albany)</td>
<td>Statewide</td>
<td>800-342-3005, 518-474-3575</td>
</tr>
<tr>
<td>DME (Non-DVS/DiRad)</td>
<td>A1 (Albany)</td>
<td>For all counties except the Buffalo office area*</td>
<td>800-342-3005, 518-474-3575</td>
</tr>
<tr>
<td></td>
<td>B1 (Buffalo)</td>
<td>For all Buffalo office counties*</td>
<td>800-462-8407</td>
</tr>
<tr>
<td>DME (PA Overrides of DVS/DiRad)</td>
<td>A1 (Albany)</td>
<td>Statewide</td>
<td>800-342-3005, 518-474-3575</td>
</tr>
<tr>
<td>PHARMACY (Rx Drugs/OTC)</td>
<td>A2 (Albany)</td>
<td>Statewide</td>
<td>518-486-3209</td>
</tr>
<tr>
<td>DENTAL</td>
<td>A1 (Albany)</td>
<td>Statewide</td>
<td>800-342-3005, 518-474-3575</td>
</tr>
<tr>
<td>Orthodontia</td>
<td>A1 (Albany)</td>
<td>Statewide EXCEPT for NYC</td>
<td>800-342-3005, 518-474-3575</td>
</tr>
<tr>
<td>PRIVATE DUTY NURSING</td>
<td>03 (Broome)</td>
<td>For Broome county clients</td>
<td>607-778-2707</td>
</tr>
<tr>
<td></td>
<td>07 (Chemung)</td>
<td>For Chemung county clients</td>
<td>607-737-5487</td>
</tr>
<tr>
<td></td>
<td>14 (Erie)</td>
<td>For Erie county clients</td>
<td>716-858-2375</td>
</tr>
<tr>
<td></td>
<td>30 (Oneida)</td>
<td>For Oneida county clients</td>
<td>315-798-5456</td>
</tr>
<tr>
<td></td>
<td>42 (Schenectady)</td>
<td>For Schenectady county clients</td>
<td>518-386-2253</td>
</tr>
<tr>
<td></td>
<td>50 (Tompkins)</td>
<td>For Tompkins county clients</td>
<td>607-274-5278</td>
</tr>
<tr>
<td></td>
<td>55 (Westchester)</td>
<td>For Westchester county clients</td>
<td>914-813-5440</td>
</tr>
<tr>
<td></td>
<td>A1 (Albany)</td>
<td>For clients from all other counties not listed above.</td>
<td>800-342-3005, 518-474-3575</td>
</tr>
<tr>
<td>OUT OF STATE INPATIENT HOSPITAL SERVICES</td>
<td>A1 (Albany)</td>
<td>Statewide</td>
<td>800-342-3005, 518-474-3575</td>
</tr>
</tbody>
</table>

*B1 Buffalo Office Counties – Allegghany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans and Wyoming