NEW YORK STATE
MEDICAID PROGRAM

INPATIENT HOSPITAL

BILLING GUIDELINES

TABLE OF CONTENTS

Section I – Purpose Statement

The purpose of this document is to assist the provider community in understanding and complying with the New York State Medicaid (NYS Medicaid) requirements and expectations for:

- Billing and submitting claims

- Interpreting and using the information returned in the Medicaid Remittance Advice

This document is customized for Inpatient Hospital providers and should be used by the provider as an instructional as well as a reference tool.

Inpatient Hospital providers can submit their claims to NYS Medicaid in only an electronic format. Because there are a variety of different types of inpatient claiming situations and a variety of electronic billing systems used by providers, the billing instructions included in this manual are intended to give providers an understanding of New York Medicaid's billing procedures in as much detail as practical.

Questions about how this information relates to individual providers' billing software and systems should be directed to the appropriate programming or software development personnel for the hospital or vendor that developed the providers' billing program.

Section II – Claims Submission

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.

Inpatient Hospital providers are required to use the HIPAA 837 Institutional (837I) transaction. In addition to this document, direct billers may also refer to the sources listed below to comply with the NYS Medicaid requirements.

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

- **NYS Medicaid 837I Companion Guide (CG)** is a subset of the IG which provides specific instructions on the NYS Medicaid requirements for the 837I transaction.

- **837 Institutional Supplemental CG** provides instruction specific to providers who utilize the 837I transaction. It includes information about various codes sets relevant to NYS Medicaid Institutional providers.

- **NYS Medicaid Technical Supplementary CG** provides technical information needed to successfully transmit and receive electronic data. Some of the topics put forth in this CG are enrollment process, header information, response documents and communication specifications.

These documents are available at www.emedny.org by clicking on the link to the web page below:

eMedNY Companion Guides and Sample Files

Pre-requirements for the Submission of Electronic Claims

Before being able to start submitting electronic claims to NYS Medicaid, providers need the following:

- An Electronic/Paper Transmitter Identification Number (ETIN)

- A Certification Statement

- A User ID and Password

- A Trading Partner Agreement

- Testing

ETIN
This is a submitter identifier issued by the eMedNY Contractor. All providers are required to have an active ETIN on file with the eMedNY Contractor prior to the submission of claims. 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 billed 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 test transactions to CSC before they start submitting Medicaid claims for the first time after enrollment, and 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 837I. ePACES, which is provided free of charge, is ideal for providers with small-to-medium claim volume.

The requirements for using ePACES include:

* An ETIN and Certification Statement should be obtained prior to enrollment

* Internet Explorer 4.01 and above or Netscape 4.7 and above

* Internet browser that supports 128-bit encryption and cookies

* Minimum connection speed of 56K

* An accessible email address

The following transactions can be submitted via ePACES:

* 270/271 - Eligibility Benefit Inquiry and Response

* 276/277 - Claim Status Request and Response

* 278 – Prior Approval/Prior Authorization/Service Authorization Request and Response

* 837 - Dental, Professional, and Institutional Claims

To take advantage of ePACES, providers need to follow an enrollment process. Additional enrollment information is available at www.emedny.org by clicking on the link to the web page below:

Self Help

eMedNY eXchange

The eMedNY eXchange works like email; users are assigned an inbox and they are able to send and receive transaction files in an email-like fashion. Transaction files are attached and sent to eMedNY for processing and the responses are delivered to the user's inbox so they can be detached and saved on the user's computer. **For security reasons, the eMedNY eXchange is accessible only through the eMedNY website at www.emedny.org**.

The eMedNY eXchange only accepts HIPAA-compliant transactions.

Access to the eMedNY eXchange is obtained through an enrollment process. To enroll in eXchange, you must first complete enrollment in ePACES and at least one login attempt must be successful.

FTP

File Transfer Protocol (FTP) is the standard process for batch authorization transmissions. FTP allows users to transfer files from their computer to another computer. FTP is strictly a dial-up connection.

FTP access is obtained through an enrollment process.   To obtain a user name and password, you must complete and return a Security Packet B. The Security Packet B 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, 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.

Inpatient Billing Procedures

The following information details billing instructions and related information for hospital inpatient claims in the following main categories:

- General Inpatient Billing Procedures

- Reporting Present on Admission (POA) Information

- Diagnosis Related Groups (DRG) Claims

- Non-DRG (DRG-Exempt) Claims

- Medicaid – Payer of Last Resort

- Special Instructions for Other Inpatient Claims

- Supplemental Inpatient Billing Information

General Inpatient Billing Procedures

When calculating the number of days to be reported on a claim, Medicaid counts the date of admission, but not the date of discharge, transfer or death.

The calculation of the number of days in the billing period is impacted by the status of the patient on the statement through date. When the patient status is "30" – Still A Patient, the through date is included in the calculation of days. When the status is a "Discharged" on the through date of service, the through date is not included in the calculation of the number of days. See status codes at the end of this section of the manual.

The sum of the days reported in the following fields **must** equal the days in the statement from-through period of the claim or one less day if the status is discharged as described above:

- Medicare Full Days

- Medicaid Full Days

- Medicaid Non Covered Days and

- Other Insurance Covered Days

Days billed as covered and non-covered, by the various payers, are reported in the 837 Institutional Segments with appropriate qualifiers. The segment and qualifier information below may be useful to providers' programming or software development personnel.

Type of Days	837I Segment Name	Qualifier
Medicare Full Days	MIA Segment	Not Applicable
Medicare Coinsurance Days	QTY Segment	CD
Medicare Life Time Reserve Days	QTY Segment	LA
Medicaid Full Days	QTY segment	CA
Medicaid Non Covered Days	QTY segment	NA
Other Insurance Covered Days	MIA Segment	Not Applicable

Notes:

- **Medicare Life Time Reserve (LTR) Days may also be reported in the MIA Segment. If LTR days are reported in the MIA Segment, they would override any LTR days that may also have been reported in the QTY Segment.**

- **The maximum number of days cannot exceed 9999 on any inpatient claim.**

The two basic types of inpatient hospital claims are Diagnosis-Related Group (DRG) and Non-DRG (DRG-exempt) claims.

Reporting Present on Admission (POA) Information

NYSDOH requires this information to be reported for all reported diagnoses on all hospital inpatient claims. Present On Admission is defined as the diagnosis that is present at the time the order for inpatient admission occurred. Additional information on reporting this information can be found in the 837I Companion Guide at www.emedny.org.

One of the following POA Codes must be submitted with the Primary Diagnosis and each succeeding diagnosis.   However, the admitting diagosis code does **not** require a POA.

- **Y – Yes:** Present at the time of inpatient admission

- **N – No:** Not present at the time of inpatient admission

- **U – Unknown:** Documentation is insufficient to determine if condition is present at time of inpatient admission

- **W – Clinically undetermined:** Provider is unable to clinically determine whether condition was present at time of inpatient admission or not

- **1 – Unreported/Not used:** Exempt from POA reporting

Note: A blank cannot be used. If a code does not require a POA code then a 1 must be entered.

DRG Claims

Diagnosis-Related Group (**DRG**) billing classifies inpatient hospital stays into one of approximately 800 groups, also referred to as DRGs. A "grouper" program assigns a DRG by utilizing data submitted on the claim such as ICD-9-CM diagnoses, procedures, patient age, sex, and other information.

Associated with each DRG is an average length of stay, high trim point (threshold), service intensity weight and low trim point. See definitions that follow:

TERM	DEFINITION
High Trim	**Maximum** number of days the patient is expected to be hospitalized based on the assigned DRG
Low Trim	**Minimum** number of day the patient is expected to be hospitalized for the assigned DRG
Inlier	Portion of the inpatient stay from the date of admission through and including the high trim point
Outlier	Portion of the inpatient stay from the day after the high trim point to date of discharge (also referred to as long stay outlier)
Short Stay Outlier	Portion of the stay from admission to **before** the low trim point
Cost Per Discharge (CPD)	Dollar amount on file for a hospitals DRG rate code

TERM	DEFINITION
Service Intensity Weight (SIW)	A weighting factor assigned to each DRG
Average Length of Stay (ALOS)	Average length of a hospital stay for the DRG assigned

DRG Rate Codes

A claim is classified as a DRG claim based on the submitted rate code. The rate code is sent in the 837 Institutional Claim in loop 2300, in the Value Information Segment. DRG claims are identified by the following Rate Codes:

Type of Claim	Rate Code
New York State Inlier	2946
New York State Outlier	2956
Out-of-state Inlier	2953
Out-of-state Outlier	2958

DRG Payment Calculations

The following describes the calculations used to price Inpatient DRG claims for New York State hospitals by Medicaid.

The **Inlier** claim calculation is as follows:

> CPD (x) SIW (+) Capital add on = payment amount

The **Long Stay Outlier** claim calculation is as follows:

> $\frac{\text{CPD (x) SIW}}{\text{ALOS}}$ (x) .275 (x) number of days = payment amount

There are two types of Short Stay claims: Transfers and Non-transfers.

The **Short Stay Non-transfer** claim calculation is as follows:

> $\frac{\text{CPD (x) SIW}}{\text{ALOS}}$ (+) short cap add-on (x) # of days = payment amount

The **Short Stay Transfer** claim calculation is as follows:

> $\frac{\text{CPD (x) SIW}}{\text{ALOS}}$ (x) 1.200% (+) cap add (x) number of days = payment amount

Split-Billing DRG Claims

Rule 1 – Split-Billing
DRG claims can be billed from Admission to Discharge and do not have to be split-billed according to the high trim point, which is the date that separates Inlier and Outlier segments. The rate code billed would be 2946 or 2953. The eMedNY system will calculate one payment combining the appropriate payment for the inlier and outlier period.

Note: There are exceptions to this rule in the "Special Instructions for Other Inpatient Claims" section of this manual under ALC instructions.

DRG claims can also be split-billed at the high trim point for the DRG, i.e., one claim for the inlier period and a separate claim for the outlier period. In this case, each claim must be billed (and will be processed) using the appropriate Inlier and Outlier rate codes.

The inlier claim cannot be split at a date that is before the high trim day for the DRG unless the patient is transferred to ALC and continues on ALC on or after the day of high trim. See information on billing procedures for ALC in the section of this manual entitled "Special Instructions for Other Inpatient Claims".

If the DRG claim is split-billed at the high trim then status code 30 must be used, and the discharge date must be on the inlier claim.

If the discharge occurs after the high trim point, DRG claims have to be billed, at a minimum, up to the high trim point for the DRG assigned. When billing on separate claims for the inlier and outlier periods, the high trim day itself is included in the Inlier claim.

Rule 2 – Timely Submission of claims
For DRG claims, the NYS Medicaid 90-day timely submission requirement is based on the Through Date of Service reported on the claim.

Rule 3 – Discharge Date
A DRG claim cannot be billed until the patient is discharged. All DRG claims **must** have the actual discharge date regardless of the status code of the patient. The discharge date will not match the end date of service if the patient status is 30 – Still A Patient.

Rule 4 - Newborns
DRG claims for newborns, 28 days or younger, must contain the birth weight in grams.

Rule 5 – Transfers in the Outlier Period

Transfers in the Outlier period (days after the high trim) are not payable. If the claim is billed as an Admission to Discharge claim, no payment will be made for outlier days. If the outlier claim is billed separately with patient status code 02 - Discharged/transferred to a short-term general hospital for inpatient care, the claim will be denied for Edit 00794, "Outlier Payment Not Allowed for Transfer".

Outlier claims billed with a patient status code 05 - Discharged/transferred to a non-Medicare PPS children's hospital or non-Medicare PPS cancer hospital for inpatient care, will be paid at $0.00 if the DRG Code assigned is one of the following: 0602 through 0630, 0635 or 0641.

DRG Admission Day Claims

Providers have the option of submitting a claim as an Admission Day claim. Admission Day claims are submitted to receive some form of payment in lieu of the DRG payment, which cannot be made until the patient is discharged.

Admission Day claims **must** be replaced (adjusted) as a DRG claim within 90 days of the payment. If the patient has not been discharged after the 90-day period, the claim should be submitted as an adjusted Admission day claim. All the data will remain the same but the adjudication date of the adjustment will cause the 90-day limitation to be extended for another 90 days. If no adjustment is received, the Admission Day payment will be automatically voided by the system and the admission payment recovered.

Follow these procedures for submission of Admission Day claims:

- The rate code billed on the claim is 2960

- The Admission date is also submitted as the from and through date of service

- The patient status code is billed is 30

- No discharge date is reported and

- One day is entered as the Medicaid Covered Days

- The payment amount for an Admission Day claim is the rate associated with the 2960 rate code.

Non-DRG Claim Procedures

For non-DRG claims the 90-day regulation applies to the statement through date entered on the claim.

Non-DRG claims can be billed from admission to discharge or they can be billed as interim claims. If a Non-DRG claim is billed as an interim bill the patient status code submitted is 30 – Still A Patient, and no discharge date is entered on the claim.

Medicaid as Payer of Last Resort

All other sources of payments must be exhausted before billing Medicaid. The following section of the manual explains billing procedures for patients with other sources of coverage. The main topics are as follows:

- Medicaid Only (No involvement from any other payer)

- Medicare as Primary – Medicaid as Secondary

- Other Third party Insurance as Primary – Medicaid as Secondary

Medicaid Only (No involvement from any other payer)

The claim can be billed from Admission to Discharge under rate code 2946 regardless of the high trim. eMedNY will calculate the appropriate payment for both the inlier and outlier portions of the hospital stay and pay the claim with one payment amount with rate code 2946.

The claim can also be submitted on two separate claims for the Inlier and Outlier periods using the appropriate rate codes.

The days are reported as Medicaid Full Covered Days.

Medicare as Primary – Medicaid as Secondary

If Medicare covered the entire stay (and there is no ALC), the only payment due is the Deductible/Coinsurance or Life Term Reserve (LTR) amounts – the claim can be billed from Admission to Discharge regardless of the high trim point.

All the days are reported as Full-Covered Medicare days.

If some or all the days are covered as Coinsurance Days or Life Time Reserved (LTR) Days, then those Coinsurance and/or LTR days are included in the Total Covered Medicare Days and are repeated in the Coinsurance or LTR day's fields.

The system will pay the reported Part A deductible, which is entered in the CAS Segment and the Coinsurance and/or LTR amounts.

Note: While the Coinsurance amount is reported in the CAS Segment, there is no LTR amount entered in the CAS Segment. eMedNY will calculate the LTR amount from the number of LTR day's reported on the claim.

- If Medicare **Part A** <u>has covered</u> the claim, the **Part B patient responsibility** can be claimed. In this instance the **Part B payment** should not be reported on the claim and, if reported, will be ignored.

- If Medicare **Part A** <u>has not covered</u> the claim, **Medicare Part B patient responsibility** will <u>not be paid</u> and the **Medicare Part B payment** must be <u>reported and deducted</u> from the Medicaid payment.

Medicare Part A	Part B Patient Responsibility	Medicare Part B Payment
Covered the stay	Claim to Medicaid	Do not report on claim
Did not cover the stay	Do not report on claim	Must be reported on claim

Medicare Exhausts in the Outlier Period
If Medicare exhausts in the outlier period, then the inlier claim is billed from the day of admission to the last Medicare covered day with patient status code 30 and the actual discharge date. See the rules for reporting Medicare deductible, Coinsurance and/or LTR above.

The period that Medicare did not cover is billed to Medicaid as a separate outlier claim. The outlier claim must contain the appropriate admission date and outlier rate code. The outlier claim must indicate Medicare Full Covered days as zero and zero amounts paid. Additionally, the 0FILL option must be indicated.

Medicare Exhausts Before the High Trim Point
If Medicare exhausts before the high trim, then the inlier claim is billed from the day of admission to the high trim point. The inlier claim must contain the days Medicare covered and the remaining days (Medicare non-covered) are reported as Medicaid Non Covered days.

A separate claim must be submitted for any days after the high trim point with the outlier rate code.

Medicare Coverage Begins After the Admission Date
For billing instruction in this scenario, please see the Policy Guidelines section of the Inpatient Manual.

Other Third party Insurance as Primary – Medicaid as Secondary

The claim is submitted as a Medicaid Secondary claim. The days covered by the other insurance are reported as covered by the insurance and the payment received from the other insurance must be reported on the claim.

If another insurance deductible is being claimed it is entered in the CAS Segment of the electronic claim record. eMedNY will calculate the Medicaid payment and, subtract the reported other Insurance payment, then compare that balance to the deductible claimed. eMedNY will pay the lower of the reported deductible or the balance after subtracting the other insurance payment from the amount Medicaid would pay.

Only bill if there is a patient responsibility, i.e., deductible, coinsurance, copay.

Special Instructions for Other Inpatient Claims

This section of the manual explains billing requirements for the following types of claims:

- Alternate Level of Care (ALC) Claims

- Alternate Level of Care - Medicare Non-covered

- Graduate Medical Expense (GME) Claims

- Pass Days Claims

- Cost Outlier Claims

Alternate Level of Care (ALC)

ALC Rule 1 – Patient Admitted on ALC
All patients MUST be admitted as acute care patients. A claim submitted indicating the patient was admitted on ALC will be denied. However, if the patient is admitted as ALC and subsequently goes to acute care, the provider can contact the Island Peer Review Organization (IPRO). If IPRO approves the stay, then the admission date can be changed to be the date acute care started. The provider cannot submit the ALC portion, but can submit the acute care claim with the new admission date.

ALC Rule 2 – Split-Billing
ALC claims are Non-DRG (per diem) claims. The ALC claims can be split-billed. Split-billing means submitting separate multiple claims that can be submitted prior to the discharge (except for the discharge claim).

ALC Rule 3 – Discharge Date
The discharge date and time of discharge is only reported on an ALC claim if the patient status is a discharge or transfer status code.

ALC Rule 4 – Occurrence Span Code
The claims for ALC must contain Occurrence Span Code 75 with the date range the patient was on ALC.

ALC Rule 5 – Admission Date
The admission date on the ALC claim will be the actual acute care admission date.

ALC Rule 6 – Transferred and Discharged on ALC
If the patient is transferred to ALC and is discharged while on ALC, then the DRG claim is billed from the date of admission to the last day the patient was acute care, with status code 30 – Still A Patient. The DRG claim must include the discharge date and occurrence span code 75 with the date span the patient was on ALC. (See billing examples that follow).

ALC Rule 7 – Transferred To and From ALC Multiple Times
If the patient is transferred to and from ALC multiple times during the stay, each ALC time period is a separate claim, with no discharge date and a patient status code 30 – Still A Patient; except for the discharge claim.

The occurrence span code 75 with the date span the patient was on ALC must be reported.

The date range used as the statement-covered period in the header on the DRG claim will include the dates of service the patient was on ALC.

The DRG claim will have an occurrence span code 75 with the date range of each of the ALC time periods.

Please review the examples that follow that describe the submission of ALC and DRG claims for various scenarios.

DRG AND ALC BILLING EXAMPLES

SCENARIO 1 - ALC period occurs prior to high trim (HT)

DRG Timelines
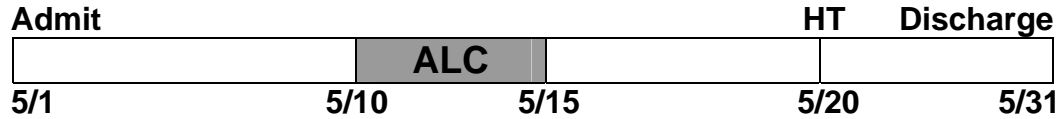
Admit				HT	Discharge

		ALC			
5/1	5/10	5/15		5/20	5/31

CLAIM 1
The DRG Inlier claim can be billed in one of two ways:

a) Submit with from – through dates (5/01 to 5/20) and a patient status code of 30 - Still A Patient, or

b) Submit with from – through dates (5/1 to 5/31) with an appropriate discharge status code.

Either way, the claim must include an occurrence span code 75 and the date span the patient was on ALC.

CLAIM 2
If the Inlier claim was submitted using method above, the DRG Outlier claim (the days after HT) must be submitted with from – through dates (5/21 to 5/31), with a patient status of discharged.

CLAIM 3
The ALC claim must be submitted with from – through dates (5/10 to 5/15). The claim **MUST** have a patient status code of 30 and occurrence span code 75 and the date span the patient was on ALC.

Note: No discharge date should be reported on this claim.

SCENARIO 2 - ALC period ends on or after the HT
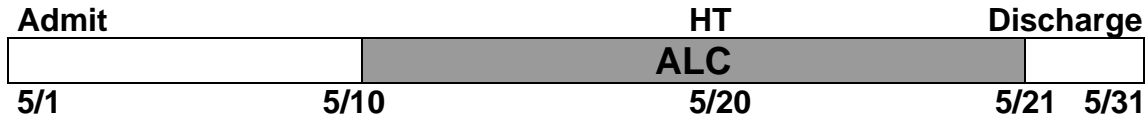
DRG Timelines

Admit		HT		Discharge
	ALC			
5/1	5/10	5/20	5/21	5/31

CLAIM 1
The DRG Inlier claim can be billed in one of two ways:

a) Submit with from – through dates (5/01 to 5/9) 5/9 is the last day of acute care prior to the HT. The claim must contain patient status code of 30 - Still A Patient, or

b) Submit with from – through dates (5/1 to 5/31) with an appropriate discharge status code.

Either way, the claim must include an occurrence span code 75 and the date span the patient was on ALC.

CLAIM 2
The ALC claim must be submitted with from – through dates (5/10 to 5/21). The ALC claim must also contain the occurrence span code 75 with the date span the patient was on ALC.

CLAIM 3
If the Inlier claim was submitted using method above, the DRG Outlier claim (the days after the HT) must be submitted with from – through dates (5/22 to 5/31) with a patient status of discharged.

SCENARIO 3 - Multiple ALC periods ends on or after the HT
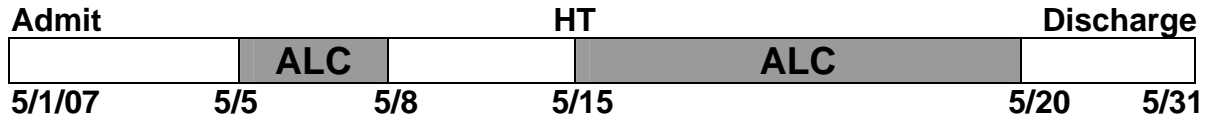
DRG Timelines

Admit			HT		Discharge

	ALC			ALC	

| 5/1/07 | 5/5 | 5/8 | 5/15 | 5/20 | 5/31 |

CLAIM 1
The DRG Inlier claim can be billed in one of two ways:

a) Submit with from – through dates (5/01 to 5/14) 5/14 is the last day of acute care prior to the HT. The claim must contain patient status code of 30 - Still A Patient, or

b) Submit with from – through dates (5/1 to 5/31) with an appropriate discharge status code.

Either way, the claim must include an occurrence span code 75 and the date span the patient was on ALC.

CLAIMS 2 and 3
The 2nd claim for ALC must be submitted with from – through dates (5/5 to 5/8), and must contain a patient status code of 30.

The 3rd claim for ALC must be submitted with from – through dates (5/15 to 5/20), and must contain a patient status code of 30.

Both ALC claims must contain occurrence span code 75 and the date span the patient was on ALC for each claim.

CLAIM 4
If the Inlier claim was submitted using method a above, the DRG Outlier claim (the days after the HT) must be submitted with from - through dates (5/21 to 5/31) and must contain a patient status of discharged.

Alternate Level of Care After Medicare

The scenarios below explain billing requirements when ALC occurs during the inpatient hospital stay and **Medicare does not cover the ALC period(s)**.

Scenario 1 - Patient Discharged On ALC

The **DRG Inlier claim** is submitted with the following information:

- Dates of service would be submitted from the admission day to the last day the patient was on an acute care status.

- Patient Status Code would be 30 – Still A Patient.

- Occurrence Code 75 and the date range the patient was on ALC must be reported.

- Days covered by Medicare are submitted with the applicable Medicare Deductible, Coinsurance or LTR amounts.

The **ALC claim** is submitted with the following information:

- Admission date would be the actual acute care admission date.

- Dates of service would be submitted for the dates the patient was on ALC.

- Occurrence Code 75 must be entered

- Occurrence Span dates should be the dates the patient was on ALC.

- The "0FILL" indicator must be submitted.

Note for programmers and software developers: 0FILL is an indicator submitted in the electronic claim in Loop 2000B, SBR04.

Scenario 2 - ALC Begins After the High Trim Point

The **DRG Inlier claim** is submitted with the following information:

- Dates of service would be submitted from the admission day to the last day the patient was acute care.

- Patient status code must be 30 – Still A Patient.

- Occurrence Code 75 with the occurrence span dates the patient was on ALC.

- Days covered by Medicare are submitted with the applicable Medicare Deductible, Coinsurance and/or LTR amounts.

The **ALC claim** is submitted with the following information:

- Admission date would be the actual acute care admission date.

- Dates of service would be the time period the patient was on ALC.

- Occurrence Code 75 must be submitted.

- Occurrence span dates should be the dates the patient was on ALC.

- The "0FILL" indicator must be submitted.

Note for programmers and software developers: 0FILL is an indicator submitted in the electronic claim in Loop 2000B, SBR04.

Scenario 3 - Patient level of Care Changes from Acute to ALC and Back to Acute

The **DRG Inlier claim** is submitted with the following information:

- Dates of service would be submitted from admission to discharge.

- Medicare covered days are submitted with the applicable Medicare Deductible, Coinsurance and/or LTR amounts.

- ALC days occurring in this period are submitted as Medicaid non-covered days.

- Occurrence Span Code 75 must be submitted.

- Occurrence span dates should be the dates the patient was on ALC.

Note: If there are numerous ALC periods, the Inlier claim will have the Occurrence Span Code 75 and the dates the patient was on ALC for each of the ALC periods include in the date range billed. So there will be multiple Occurrence Codes 75 reported.

The **ALC claim** is submitted with the following information:

- Admission date would be the actual acute care admission date.

- Dates of service would be the time period the patient was on ALC.

- Occurrence Code 75 must be submitted.

- Occurrence Span dates would be the dates the patient was on ALC.

- The "0FILL" indicator must be submitted.

Note for programmers and software developers: 0FILL is an indicator submitted in the electronic claim in Loop 2000B, SBR04.

Graduate Medical Education (GME) Claims

GME payments are made to cover the GME expenses related to an Inpatient stay on behalf of a Medicaid client enrolled in a Medicaid Managed Care plan on the Date of Admission.

GME claims are billed with all the information required on an Inpatient claim with a few modifications such as:

- Discharge date is required.

- Discharge date is repeated as the dates of service from – through.

- Patient status code is the final discharge status code.

- Medicaid full-covered day is one.

The GME payment is determined by the GME rate code entered on the claim. (GME rate codes range from 3130 thru 3137.)

Pass Days Claims

Pass day claims are submitted when the patient was readmitted within 31 days of the original discharge for the same or a related condition in accordance with 10NYCRR, Section 86-1.54(m). Claims should be submitted as follows:

- Admission date submitted is from the first stay.

- Discharge date submitted is from the second stay.

- Date of service "From" is the first Admission date.

- Dates between the first discharge and 2nd admission are included in the dates of service.

- Days between the first discharge and 2nd admission are submitted as Medicaid Non-covered days.

Cost Outlier Claims

Hospitals can request additional reimbursement for an inpatient, DRG hospitalization by requesting Cost Outlier consideration. Each cost outlier case must undergo Peer Review. The 837I must include rate code 2946 or 2953 (whichever code appears on the provider's file) and condition code 61 in the 2300 loop.

PLEASE NOTE: (1) Medicaid must be the primary inpatient coverage to qualify for a cost outlier consideration, and (2) transfer cases, as defined in 10NYCRR, Section 86-1.50, do not qualify for cost outlier consideration.

Notes:

- **The Cost Outlier payment is for the entire acute care stay. No long stay outlier portion can be billed separately.**

- **ALC periods are not paid as part of the Cost Outlier, therefore ALC claims can be billed in addition to the Cost Outlier claim.**

- **If a case receives two technical denials it will be closed to cost outlier consideration.**

- **Other rules may apply. Questions should be referred to the hospital's IPRO Liaison.**

Medicaid Policy when Medicare Coverage Begins During an Inpatient Admission

Refer to the Inpatient Policy Guidelines Manual for details.

Supplemental Inpatient Billing Information

This section of the manual puts forth information on the following topics:

- Inpatient Services Paid "Offline"

- Replacement/Void of Previously Paid Claims

- Medicaid Managed Care Clients

- Hospital Responsibility For Outside Care

Inpatient Services Paid "Off-Line"

Information about Inpatient Services Paid "Off-Line" can be found in the Policy Guidelines section of the Inpatient Manual.

Replacement/Void of Previously Paid Claims

If submitting an **Adjustment (Replacement)** or a **Void** to a previously paid claim, enter the 16 digit **TCN** assigned to the claim to be adjusted or voided. The TCN is the claim identifier and is listed in the Remittance Advice. If a TCN is entered in the Original Reference Number Segment (Loop 2300), the Claim Frequency Type Code entered in the Claim Information Segment (Loop 2300 – CLM05-3) must be 7 for a replacement or 8 for a void. When submitting an original claim or the resubmission of a previously denied claim, this information is not to be entered on the claim as resubmissions are considered original claims by eMedNY. Adjustments and voids are <u>not</u> subject to Medicaid's 90 day timeliness policy.

Note: Once a claim is voided, any rebilled claim is subject to the 90 day timeliness policy. Claims with a discharge date (DRG claims) or a though date (Non-DRG claims) over 6 years old can not be adjusted or voided.

Adjustments
An adjustment is submitted to correct one or more data items of a previously paid claim. Any field, except the **Provider ID number,** the **Patient's Medicaid ID number**, or **Bill Type** can be adjusted. Adjustments cause the correction of the adjusted information in the claim history records as well as the cancellation of the original claim payment and the re-pricing of the claim based on the adjusted information.

Voids
A void is submitted to nullify a paid claim. Voids cause the cancellation of the original claim history records and payment.

Medicaid Managed Care Clients

If a patient is enrolled in a Medicaid Managed Care Plan on the day of admission, the managed care plan should be billed and is responsible to pay the claim. Even in cases where the patient is disenrolled from the managed care plan during the stay, the managed care plan is responsible for payment.

Hospital Responsibility For Outside Care: Reimbursement Policy

Please see the Policy Guidelines section of the Inpatient manual for information.

Patient Status Codes

01   Discharged to home or self-care (routine discharge)

02   Discharged/transferred to another short-term general hospital for inpatient care

03   Discharged/transferred to skilled nursing facility (SNF)

04   Discharged/transferred to an intermediate care facility (ICF)

05   Discharged/transferred to a non-Medicare PPS children's hospital or non-Medicare cancer hospital for inpatient care

06   Discharged/transferred to home under care of organized home health service organization

20   Expired

30   Still Patient

40   Expired at home

41   Expired in a medical facility (e.g. hospital, SNF, ICF or free standing hospice)

42   Expired place unknown

50   Hospice – Home

51   Hospice – Medical Facility

61   Discharged/Transferred within this institution to hospital-based Medicare approved swing bed

62   Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part units of a hospital

63   Discharged/transferred to a Medicare certified long term care hospital (LTCH)

64   Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare

65   Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital

66   Discharged/transferred to critical access hospital

Section III – Remittance Advice

The purpose of this section is to familiarize the provider with the design and contents of the paper 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 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 (EFT)

  - ► Summout (no claims paid)

- Section Two: Provider Notification (special messages)

- Section Three: Claim Detail

- Section Four:

  - ► Financial Transactions (recoupments)

  - ► Accounts Receivable (cumulative financial information)

- Section Five: Edit (Error) Description

Explanation of Remittance Advice Sections

The next pages present a sample of each section of the remittance advice for Inpatient Hospital services followed by an explanation of the elements contained in the section.

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

Section One – Medicaid Check

For providers who have selected to be paid by check, a Medicaid check is issued when the provider has claims approved for the cycle and the approved amount is greater than the recoupments, if any, scheduled for the cycle. This section contains the check stub and the actual Medicaid check (payment).

MEDICAID
MANAGEMENT
INFORMATION SYSTEM

TO: DOWNTOWN HOSPITAL

DATE: 2007-08-06
REMITTANCE NO: 07080600001
PROV ID: 00234567/0123456789

00234567/0123456789 2007-08-06
DOWNTOWN HOSPITAL
123 FIRST ST
ANYTOWN   NY   11111

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

- -

$\frac{29}{2}$

DATE	REMITTANCE NUMBER	PROVIDER ID NO.		DOLLARS/CENTS
2007-08-06 VOID AFTER 90 DAYS	07080600001	0123456789	PAY	$****12000.00

TO
THE
ORDER
OF

DOWNTOWN HOSPITAL
123 FIRST ST
ANYTOWN   NY   11111

MEDICAID
MANAGEMENT
INFORMATION SYSTEM

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

John Smith
AUTHORIZED SIGNATURE

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
*PROV ID: This field will contain the Medicaid Provider ID and the NPI (if applicable)

CENTER
*Medicaid Provider ID/NPI/Date
Provider's name/Address

Medicaid Check

LEFT SIDE
Table
  Date on which the check was issued
  Remittance number
  *Provider ID No.: This field will contain the NPI **or** the Medicaid Provider ID (if applicable)

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: DOWNTOWN HOSPITAL

MEDICAID
MANAGEMENT
INFORMATION SYSTEM

DATE: 08-06-2007
REMITTANCE NO: 07080600001
PROV ID: 00234567/0123456789

00234567/0123456789 08-06-2007
DOWNTOWN HOSPITAL
123 FIRST ST
ANYTOWN   NY   11111

DOWNTOWN HOSPITAL $12000.00

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
*PROV ID: This field will contain the Medicaid Provider ID and the NPI (if applicable)

CENTER
*Medicaid Provider ID/NPI/Date: This field will contain the Medicaid Provider ID and the NPI (if applicable)
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: DOWNTOWN HOSPITAL   DATE: 08/06/2007
                                                               REMITTANCE NO: 07080600001
                                                               PROV ID: 00234567/0123456789

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

DOWNTOWN HOSPITAL
123 FIRST ST
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
*PROV ID: This field will contain the Medicaid Provider ID and the NPI (if applicable)

CENTER
Notification that no payment was made for the cycle (no claims were approved)
Provider name and address

Section Two – Provider Notification

This section is used to communicate important messages to providers.

MEDICAID
MANAGEMENT INFORMATION SYSTEM

PAGE   01
DATE   08/06/07
CYCLE   1563

MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

TO: DOWNTOWN HOSPITAL   ETIN:
      BUSINESS OFFICE   PROVIDER NOTIFICATION
      123 FIRST STREET   PROV ID: 00234567/0123456789
      ANYTOWN, NEW YORK 11111   REMITTANCE NO   07080600001

REMITTANCE ADVICE MESSAGE TEXT

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

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

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

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

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

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

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

Information on the Provider Notification Page

UPPER LEFT CORNER
Provider's name and address

UPPER RIGHT CORNER
Remittance page number
Date on which the remittance advice was issued
Cycle number

ETIN (not applicable)
Name of section: **PROVIDER NOTIFICATION**
*PROV ID: This field will contain the Medicaid Provider ID and the NPI (if applicable)
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 claims that pended previously.

PAGE   02
DATE   08/06/07
CYCLE   1563

MEDICAID
MANAGEMENT
INFORMATION SYSTEM

TO: DOWNTOWN HOSPITAL
       BUSINESS OFFICE
       123 FIRST STREET
       ANYTOWN, NEW YORK 11111

MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

ETIN:
INPATIENT
PROV ID: 00234567/0123456789
REMITTANCE NO: 07080600001
LOCATOR CD: 003

PATIENT CONTROL NO DATE	CLIENT NAME ID NUMBER	TCN MEDICAL RECORD NUMBER	SERVICE DATES FROM THRU	COV'D DAYS RATE CODE	OUT DAYS PAY TYPE	TOT DAYS DRG CODE	COVERAGE BASE	CO-PAY	OTHER INSURANCE PAID	STATUS	ERRORS
CPIC1008432 05/25/07	SMITH ZZ22222T	07230-000000315-2-0 000000585555IH03	05/25/07 05/29/07	0 2946	0 C	0 0122	4000.00	25.00	0.00 0.00	DENY	00805 00806 00848
CPIC1088777 05/25/07	TAYLOR AB12345C	07231-000000441-2-0 000000586555IH03	05/25/07 05/30/07	0 2946	0 C	0 0195	4000.00	25.00	0.00 0.00	DENY	00162
CPIC1005432 05/27/07	BOWN FF33333T	07245-000000049-2-0 000000587672IH03	05/27/07 05/30/07	0 2946	0 C	0 0127	4000.00	0.00	0.00 0.00	DENY	00848

* = PREVIOUSLY PENDED CLAIM
** = NEW PEND

TOTAL AMOUNT ORIGINAL CLAIMS	DENIED	12000.00	NUMBER OF CLAIMS	3
NET AMOUNT ADJUSTMENTS	DENIED	0.00	NUMBER OF CLAIMS	0
NET AMOUNT VOIDS	DENIED	0.00	NUMBER OF CLAIMS	0
NET AMOUNT VOIDS – ADJUSTS		0.00	NUMBER OF CLAIMS	0

MEDICAID MANAGEMENT INFORMATION SYSTEM

**MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT**

TO: DOWNTOWN HOSPITAL
BUSINESS OFFICE
123 FIRST STREET
ANYTOWN, NEW YORK 11111

ETIN:
INPATIENT
PROV ID: 00234567/0123456789
REMITTANCE NO: 07080600001
LOCATOR CD: 003

PATIENT CONTROL NO DATE	CLIENT NAME ID NUMBER	TCN MEDICAL RECORD NUMBER	SERVICE DATES FROM THRU	COV'D DAYS RATE CODE	OUT DAYS PAY TYPE	TOT DAYS DRG CODE	COVERAGE BASE	CO-PAY	OTHER INSURANCE PAID	STATUS	ERRORS
CPIC1563324 05/25/07	WAYTKUS SS44444P	07230-000000315-2-0 000000587672IH03	05/25/07 05/27/07	2 2946	0 C	0 0311	4000.00	25.00	0.00 4000.00	PAID	
CPIC1768935 05/25/07	GOUGH GG44444L	07231-000000441-2-0 000000587672IH03	05/25/07 05/30/07	5 2946	0 C	0 0079	4000.00	25.00	0.00 4000.00	PAID	
CPIC1667792 05/25/07	ABRAHAM BB88888S	07245-000000049-2-0 000000587672IH03	05/25/07 05/30/07	5 2946	0 C	0 0140	4000.00	0.00	0.00 4000.00	PAID	

* = PREVIOUSLY PENDED CLAIM
** = NEW PEND

TOTAL AMOUNT ORIGINAL CLAIMS	PAID	12000.00	NUMBER OF CLAIMS	3
NET AMOUNT ADJUSTMENTS	PAID	0.00	NUMBER OF CLAIMS	0
NET AMOUNT VOIDS	PAID	0.00	NUMBER OF CLAIMS	0
NET AMOUNT VOIDS – ADJUSTS		0.00	NUMBER OF CLAIMS	0

MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

TO: DOWNTOWN HOSPITAL
BUSINESS OFFICE
123 FIRST STREET
ANYTOWN, NEW YORK 11111

ETIN:
INPATIENT
PROV ID: 00234567/0123456789
REMITTANCE NO: 07080600001
LOCATOR CD: 003

PATIENT CONTROL NO DATE	CLIENT NAME ID NUMBER	TCN MEDICAL RECORD NUMBER	SERVICE DATES FROM THRU	COV'D DAYS RATE CODE	OUT DAYS PAY TYPE	TOT DAYS DRG CODE	COVERAGE BASE	CO-PAY	OTHER INSURANCE PAID	STATUS	ERRORS
CPIC156565633	PROUST	07230-000000315-2-0	05/25/07	0	0	0	4000.00	25.00	0.00	PEND	00162
05/25/07	XX99999V	000000587672IH03	05/26/07	2959	C	0122			0.00		
CPIC196969685	WELBY	07231-000000441-2-0	05/25/07	0	0	0	4000.00	25.00	0.00	PEND	00142
05/25/07	KK99999N	000000587672IH03	05/30/07	2959	C	0088			0.00		
CPIC183211677	SHEEHAN	07245-000000049-2-0	05/25/07	0	0	0	4000.00	0.00	0.00	PEND	00144
05/25/07	WW66666G	000000587672IH03	05/30/07	2959	C	0296			0.00		

* = PREVIOUSLY PENDED CLAIM
** = NEW PEND

TOTAL AMOUNT ORIGINAL CLAIMS	PEND	12000.00	NUMBER OF CLAIMS	3
NET AMOUNT ADJUSTMENTS	PEND	0.00	NUMBER OF CLAIMS	0
NET AMOUNT VOIDS	PEND	0.00	NUMBER OF CLAIMS	0
NET AMOUNT VOIDS – ADJUSTS		0.00	NUMBER OF CLAIMS	0

LOCATOR 003 TOTALS – INPATIENT

VOIDS – ADJUSTS	0.00	NUMBER OF CLAIMS	0
TOTAL PENDS	12000.00	NUMBER OF CLAIMS	3
TOTAL PAID	12000.00	NUMBER OF CLAIMS	3
TOTAL DENY	12000.00	NUMBER OF CLAIMS	3
NET TOTAL PAID	12000.00	NUMBER OF CLAIMS	3

REMITTANCE TOTALS – INPATIENT

VOIDS – ADJUSTS	0.00	NUMBER OF CLAIMS	0
TOTAL PENDS	12000.00	NUMBER OF CLAIMS	3
TOTAL PAID	12000.00	NUMBER OF CLAIMS	3
TOTAL DENY	12000.00	NUMBER OF CLAIMS	3
NET TOTAL PAID	12000.00	NUMBER OF CLAIMS	3

MEMBER ID: 00234567

VOIDS – ADJUSTS	0.00	NUMBER OF CLAIMS	0
TOTAL PENDS	12000.00	NUMBER OF CLAIMS	3
TOTAL PAID	12000.00	NUMBER OF CLAIMS	3
TOTAL DENY	12000.00	NUMBER OF CLAIMS	3
NET TOTAL PAID	12000.00	NUMBER OF CLAIMS	3

MEDICAID

MANAGEMENT
INFORMATION SYSTEM

PAGE: 05
DATE: 08/06/07
CYCLE: 1563

MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

TO: DOWNTOWN HOSPITAL
      BUSINESS OFFICE
      123 FIRST STREET
      ANYTOWN, NEW YORK 11111

ETIN:
INPATIENT
GRAND TOTALS
PROV ID: 00234567/0123456789
REMITTANCE NO: 07080600001

REMITTANCE TOTALS – GRAND TOTALS

VOIDS – ADJUSTS	0.00	NUMBER OF CLAIMS	0
TOTAL PENDS	12000.00	NUMBER OF CLAIMS	3
TOTAL PAID	12000.00	NUMBER OF CLAIMS	3
TOTAL DENY	12000.00	NUMBER OF CLAIMS	3
NET TOTAL PAID	12000.00	NUMBER OF CLAIMS	3

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: **INPATIENT**
*PROV ID: This field will contain the Medicaid Provider ID and the NPI (if applicable)
Remittance number
Locator Code (providers who have more than one locator code will receive separate Claim Detail sections for each locator code)

Explanation of the Claim Detail Columns

PATIENT CONTROL NUMBER/DATE
This column indicates the Patient Control Number assigned to the patient by the hospital at the time of admission (first line) and the admission date (second line).

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

TCN/MEDICAL RECORD NUMBER
The TCN (first line) is a unique identifier assigned to each claim.

The Medical Record Number will be indicated below the TCN in this column.

SERVICE DATES – FROM/THROUGH
The first date of service covered by the claim (From date) appears on the first line; the last date of service (Through date) appears on the second line.

COV'D (COVERED) DAYS/RATE CODE
The number of full covered days (first line) and the four-digit rate code (second line) that were entered in the claim appear under this column.

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

Inpatient Payment Type Codes – One of the following type codes appears in the Pay Type field on the Medicaid remittance advice and indicates the type of payment (code) generated by the claim.

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

TOT (TOTAL) DAYS/DRG CODE

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

The DRG code assigned to the claim based on pertinent data submitted on the claim will appear below the Total Days.

COVERAGE BASE

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

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

CO-PAY

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

OTHER INSURANCE/PAID

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

STATUS

This column indicates the status (DENY, PAID/ADJT/VOID, PEND) of each 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 cancelling a previously paid claim. A void lists the credit transaction (previously paid claim) only.

Pending Claims

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

- New York State Medical Review required

- Procedure requires manual pricing

- No match found in the Medicaid files for certain information submitted on the claim. For example: Recipient ID, Prior Approval, or Service Authorization. These claims are recycled for a period of time during which the Medicaid files may be updated to match the information on the claim.

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

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

ERRORS

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

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

- Adjustments/voids (combined)

- Pends

- Paid

- Denied

- Net total paid (for the specific combination)

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

- Adjustments/voids (combined)

- Pends

- Paid

- Deny

- Net total paid (for the specific service classification)

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

- Adjustments/voids (combined)

- Pends

- Paid

- Deny

- Net total paid (entire remittance)

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.

							PAGE	07
							DATE	08/06/07
			MEDICAID				CYCLE	1563

MANAGEMENT INFORMATION SYSTEM

TO: DOWNTOWN HOSPITAL   **MEDICAL ASSISTANCE (TITLE XIX) PROGRAM**   ETIN:
BUSINESS OFFICE   **REMITTANCE STATEMENT**   FINANCIAL TRANSACTIONS
123 FIRST STREET   PROV ID: 00234567/0123456789
ANYTOWN, NEW YORK 11111   REMITTANCE NO: 07080600001

	FINANCIAL	FISCAL		
FCN	REASON CODE	TRANS TYPE	DATE	AMOUNT
200705060236547	XXX	RECOUPMENT REASON DESCRIPTION	08 01 07	$$.$$

NET FINANCIAL AMOUNT $$$.$$ NUMBER OF FINANCIAL TRANSACTIONS   XXX

Explanation of the Financial Transactions Columns

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

FINANCIAL REASON CODE
This code is for DOH/CSC use only; it has no relevance to providers. It identifies the reason for the recoupment.

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

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

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

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

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

Accounts Receivable

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

```
                                                                    PAGE    08
                                                                    DATE    08/06/07
                          MEDICAID                                  CYCLE   1563
                          MANAGEMENT
                          INFORMATION SYSTEM
TO:  DOWNTOWN HOSPITAL                                              ETIN:
     BUSINESS OFFICE                                                ACCOUNTS RECEIVABLE
     123 FIRST STREET     MEDICAL ASSISTANCE (TITLE XIX) PROGRAM    PROV ID:  00234567/0123456789
     ANYTOWN, NEW YORK 11111      REMITTANCE STATEMENT              REMITTANCE NO:  07080600001


REASON CODE DESCRIPTION            ORIG BAL        CURR BAL      RECOUP %/AMT
                                   $XXX.XX-        $XXX.XX-         999
                                   $XXX.XX-        $XXX.XX-         999



TOTAL AMOUNT DUE THE STATE $XXX.XX
```

Explanation of the Accounts Receivable Columns

If a provider has negative balances of different natures (for example, the result of adjustments/voids; the result of retro-adjustments, etc.) or negative balances created at different times, each negative balance will be listed on a different line.

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

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

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

RECOUPMENT % AMOUNT
The deduction (recoupment) scheduled for each cycle.

Total Amount Due the State
This amount is the sum of all the **Current Balances** listed above.

Section Five – Edit Descriptions

The last section of the Remittance Advice features the description of each of the edit codes (including approved codes) failed by the claims listed in Section Three.

MEDICAID
MANAGEMENT
INFORMATION SYSTEM

PAGE 06
DATE 08/06/07
CYCLE 1563

MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

TO: DOWNTOWN HOSPITAL
     BUSINESS OFFICE
     123 FIRST STREET
     ANYTOWN, NEW YORK 11111

ETIN:
INPATIENT
EDIT DESCRIPTIONS
PROV ID: 00234567/0123456789
REMITTANCE NO: 07080600001

THE FOLLOWING IS A DESCRIPTION OF THE EDIT REASON CODES THAT APPEAR ON THE CLAIMS FOR THIS REMITTANCE:
    00142   RECIPIENT YOB NOT EQUAL TO FILE
    00144   RECIPIENT SEX NOT EQUAL TO FILE
    00162   RECIPIENT INELIGIBLE ON DATE OF SERVICE
    00805   MEDICARE CO-INS / LTR DAYS PRESENT–TOTAL MDCR DAYS BLANK
    00806   CO-INSURANCE AND LTR DAYS GREATER THAN PART-A DAYS
    00848   THIRD PARTY DAYS NOT EQUAL TO BILLING PERIOD

Appendix A – Edit Information and Explanations

Providers who perform reconciliation of pended or denied claims should visit the Edit/ Error Knowledge Base located on www.emedny.org to find explanations for denied or pended claims. This document provides valuable detailed information about what corrective action may be needed to resolve unpaid claims.

If you wish to research denied/pended claims by eMedNY Edit number, please follow the procedures below.

If you are receiving a paper remittance, the eMedNY Edit Number is reported in the last column of the remittance statement (titled ERRORS) where the denied and pended claims are detailed. At the end of each paper remittance, the edits that claims have failed for any given remittance are listed in numeric order along with a description of the reason.

If a provider needs more detailed information about the reason for denial or pending of a claim, visit the Edit/Error Knowledge Base for potential causes and detailed solutions for each eMedNY edit. The Edit/Error Knowledge Base is available at www.emedny.org by clicking on the link to the web page below:

<p align="center">**Edit / Error Knowledge Base**</p>

If you wish to research denied/pended claims by HIPAA Claim Adjustment Reason Code and Remittance Advice Remark Code, please follow the procedures below.

If you are receiving an electronic remittance, the HIPAA remittance advice provides Claim Adjustment Reason Codes and the Remittance Advice Remark Codes to explain claim denials. (Please see the eMedNY Companion Guides for the 835 or 820 remittances located at www.emedny.org for the placement of these codes within the remittance file.)

If a provider is seeking further explanation about the reason for denial or pending of a claim, visit the Edit Mapping Crosswalk located at www.emedny.org by clicking on the link to the web page below. This crosswalk will assist a provider to determine the eMedNY edit for any given HIPAA adjustment reason code and remittance advice remark code combination.

<p align="center">**eMedNY Crosswalk**</p>

Once you have determined the eMedNY edit number, more detailed information about the reason for denial or pending of a claim can be found in the Edit/Error Knowledge Base. The Edit/Error Knowledge Base is available on www.emedny.org by clicking on the link to the web page below:

Edit / Error Knowledge Base

Below are direct links to the explanations on the Edit/Error Knowledge Base for some of the most common inpatient edits:

Edit 00782   For acute DRG claims the discharge date must be after the end date of service

Edit 00784   Subsequent DRG Bills Must Be After The Threshold Date

Edit 00785   Alternate Level care (ALC) Claims Require an ALC Date

Edit 00789   Statement From date Not Equal to Admission date for DRG Claim

Edit 00790   Days Less Than Threshold in Inlier period and patient Discharged In Outlier Period

Edit 00791   DRG Equals 470- Grouper Was Unable To Determine A Valid DRG

Edit 00793   Part A Days With Medicaid Days Not Allowed One DRG Claims

Edit 00795   Claim Does Not Qualify As A Cost Outlier

Edit 00808   Patient Has Already Met Medicare Deductible- Review Medicare Data

Edit 00843   Calculated Payment Amount less than Zero

Edit 00847   Billing For Deductible But No Medicare Days Present

Edit 00848   Total Third Party Covered and Noncovered Days must equal Total Days in the Billing Period

Edit 00850   Medicare-A Co-Insurance Amount Present/Co-Insurance Days Missing

Appendix B – Sterilization Consent Form – DSS-3134

A Sterilization Consent Form, DSS-3134, must be completed for each sterilization procedure. **No other form can be used in place of the DSS-3134.** A supply of these forms, available in English and in Spanish [DSS-3134(S)], can be obtained from the New York State Department of Health's website by clicking on the link to the web page below:

Local Districts Social Service Forms

For electronic claim submissions, the completed and signed DSS-3134 [or DSS-3134(S)] must be kept in the patient's file. If upon audit and examination, it is found that the consent form is not present or is defective, the Department will recoup any and all payments associated with the sterilization procedure.

When completing the DSS-3134, please follow the guidelines below:

- Be certain that the form is completed so it can be read easily. An illegible or altered form is unacceptable. Also, the persons completing the form should check to see that all five copies are legible.

- Each required field or blank must be completed in order to ensure payment.

- If a woman is not currently Medicaid eligible at the time she signs the DSS-3134 [or 3134(S)] form but becomes eligible prior to the procedure and if she is 21 years of age when the form was signed, the 30 day waiting period starts from the date the DSS form was signed regardless of the date the woman becomes Medicaid eligible.

A sample Sterilization Consent Form and step-by-step instructions follow on the next pages.

Inpatient Hospital Billing Guidelines: Appendix B

DSS-3134 **(Rev.5/82)**	PATIENT NAME 1.	CHART NO.	RECIPIENT ID NO.
STERILIZATION CONSENT FORM	HOSPITAL/CLINIC		

NOTICE: YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.

■ CONSENT TO STERILIZATION ■

I have asked for and received information about sterilization from ____2.____ . When I first asked for
(doctor or clinic)
the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as A.F.D.C. or Medicaid that I am now getting or for which I may become eligible.
I UNDERSTAND THAT THE STERILIZATION MUST BE CONSIDERED **PERMANENT** AND **NOT REVERSIBLE**. I HAVE DECIDED THAT I DO NOT WANT TO BECOME PREGNANT, BEAR CHILDREN OR FATHER CHILDREN.
I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.
I understand that I will be sterilized by an operation known as a ____3.____ . The discomforts, risks and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.
I understand that the operation will not be done until at least thirty days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by federally funded programs.
I am at least 21 years of age and was born on ____4.____ .
Month Day Year

I, ____5.____ , hereby consent of my own free will to be sterilized by ____6.____
(doctor)
by a method called ____7.____ . My consent expires 180 days from the date of my signature below.

I also consent to the release of this form and other medical records about the operation to:
Representatives of the Department of Health, Education, and Welfare or Employees of programs or projects funded by the Department but only for determining if Federal laws were observed.
I have received a copy of this form.

____8.____   Date: ____9.____
Signature   *Month Day Year*

10. You are requested to supply the following information, but it is not required:
Race and ethnicity designation (please check)

☐₁ American Indian or   ☐₃ Blank (not of Hispanic origin)
  Alaska Native   ☐₄ Hispanic
☐₂ Asian or Pacific Islander ☐₅ White (not of Hispanic origin)

■ INTERPRETER'S STATEMENT ■

If an interpreter is provided to assist the individual to be sterilized:
I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form in ____11.____ language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

____12.____
Interpreter   *Date*

■ STATEMENT OF PERSON OBTAINING CONSENT ■

Before ____13.____ signed the
name of individual
consent form, I explained to him/her the nature of the sterilization operation ____14.____ , the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.
I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.
I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.
To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequence of the procedure.

____15.____
Signature of person obtaining consent   *Date*
____16.____
Facility
____16.____
Address

■ PHYSICIAN'S STATEMENT ■

Shortly before I performed a sterilization operation upon ____17.____
on ____18.____
Name of individual to be sterilized   *Date of sterilization*
 ____18. (Con't)____ , I explained to him/her the nature of the *operation*
sterilization operation ____19.____ , The fact that
specify type of operation
it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.
I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.
I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds.
To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the pro- cedure.

(Instructions for use of alternative final paragraphs: Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraph which is not used.)
(1)   At least thirty days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.
(2)   This sterilization was performed less than 30 days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable box and fill in information requested):
☐ 1 Premature delivery 20.
22. Individual's expected date of delivery: ____21.____
☐ 2 Emergency abdominal surgery: ____23.____
(describe circumstances): ____23.(Con't)____
____24.____
Physician
Date ____25.____

THE FOLLOWING MUST BE COMPLETED FOR STERILIZATIONS PERFORMED IN NEW YORK CITY
WITNESS CERTIFICATION

I, ____26.____ do certify that on ____27.____ , 19___ I was present while the counselor read and explained the consent form to ____28.____ and saw the patient sign the consent form in his/her own handwriting. *(patient's name)*		
SIGNATURE OF WITNESS X 29.	TITLE 30.	DATE 31.

REAFFIRMATION (to be signed by the patient on admission for Sterilization)

I certify that I have carefully considered all the information, advice and explanations given to me at the time I originally signed the consent form. I have decided that I still want to be sterilized by the procedure noted in the original consent form, and I hereby affirm that decision.			
SIGNATURE OF PATIENT X 32.	DATE 33.	SIGNATURE OF WITNESS X 34.	DATE 35.

DISTRIBUTION: 1 - Medical Record File 2 - Hospital Claim 3 - Surgeon Claim 4 - Anesthesiologist Claim 5 - Patient

Field-by-Field Instructions for Completing the Sterilization Consent Form – DSS-3134 and 3134(S)

Patient Identification

<u>Field 1</u>

Enter the patient's name, Medicaid ID number, and chart number; name of hospital or clinic is optional.

Consent To Sterilization

<u>Field 2</u>

Enter the name of the individual or clinic obtaining consent. If the sterilization is to be performed in New York City, the physician who performs the sterilization (24) cannot obtain the consent.

<u>Field 3</u>

Enter the name of sterilization procedure to be performed.

<u>Field 4</u>

Enter the patient's date of birth. Check to see that the patient is at least 21 years old. If the patient is not 21 on the date consent is given (9), Medicaid will not pay for the sterilization.

<u>Field 5</u>

Enter the patient's name.

<u>Field 6</u>

Enter the name of doctor who will probably perform the sterilization. It is understood that this might not be the doctor who eventually performs the sterilization (24).

<u>Field 7</u>

Enter the name of sterilization procedure.

<u>Field 8</u>

The patient must sign the form.

Field 9

Enter the date of patient's signature. This is the date on which the consent was obtained. The sterilization procedure must be performed no less than 30 days nor more than 180 days from this date, except in instances of premature delivery (20, 21), or emergency abdominal surgery (22, 23) when at least 72 hours (three days) must have elapsed.

Field 10

Completion of the race and ethnicity designation is optional.

Interpreter's Statement

Field 11

If the person to be sterilized does not understand the language of the consent form, the services of an interpreter will be required. Enter the language employed.

Field 12

The interpreter must sign and date the form.

Statement of Person Obtaining Consent.

Field 13

Enter the patient's name.

Field 14

Enter the name of the sterilization operation.

Field 15

The person who obtained consent from the patient must sign and date the form. If the sterilization is to be performed in New York City, this person cannot be the operating physician (24).

Field 16

Enter the name and address of the facility with which the person who obtained the consent is associated. This may be a clinic, hospital, Midwife's, or physician's office.

Physician's Statement

The physician should complete and date this form after the sterilization procedure is performed.

Field 17

Enter the patient's name.

Field 18

Enter the date the sterilization procedure was performed.

Field 19

Enter the name of the sterilization procedure.

Instructions for Use of Alternative Final Paragraphs
If the sterilization was performed at least 30 days from the date of consent (9), then cross out the second paragraph and sign (24) and date (25) the consent form.

If less than 30 days but more than 72 hours has elapsed from the date of consent as a consequence of either premature delivery or emergency abdominal surgery, proceed as follows:

Field 20

If the sterilization was scheduled to be performed in conjunction with delivery but the delivery was premature, occurring within the 30-day waiting period, check box one and (21) enter the expected date of delivery.

Field 21

If the patient was scheduled to be sterilized but within the 30-day waiting period required emergency abdominal surgery and the sterilization was performed at that time, then check box two and (23) describe the circumstances.

Field 24

The physician who performed the sterilization must sign and date the form.

Field 25

The date of the physician's signature should indicate that the physician's statement was signed after the procedure was performed, that is, on the day of or a day subsequent to the sterilization.

For Sterilizations Performed In New York City
New York City local law requires the presence of a witness chosen by the patient when the patient consents to sterilization. In addition, upon admission for sterilization, in New York City, the patient is required to review his/her decision to be sterilized and to reaffirm that decision in writing.

Witness Certification

Field 26

Enter the name of the witness to the consent to sterilization.

Field 27

Enter the date the witness observed the consent to sterilization. This date will be the same date of consent to sterilization (9).

Field 28

Enter the patient's name.

Field 29

The witness must sign the form.

Field 30

Enter the title, if any, of the witness.

Field 31

Enter the date of witness's signature.

Reaffirmation

Field 32

The patient must sign the form.

Field 33

Enter the date of the patient's signature. This date should be shortly prior to or same as date of sterilization in field 18.

Field 34

The witness must sign the form for reaffirmation. This witness need not be the same person whose signature appears in field 29.

Field 35

Enter the date of witness's signature.

Appendix C – Acknowledgment of Receipt of Hysterectomy Information Form – DSS-3113

An Acknowledgment of Receipt of Hysterectomy Information Form, DSS-3113, must be completed for each hysterectomy procedure. **No other form can be used in place of the DSS-3113.** A supply of these forms, available in English and in Spanish, can be obtained from the New York State Department of Health's website by clicking on the link to the web page below:

Local Districts Social Service Forms

For electronic claim submissions, the completed and signed DSS-3113 must be kept in the patient's file. If upon audit and examination, it is found that the acknowledgment of hysterectomy form is not present or is defective, the Department will recoup any and all payments associated with the hysterectomy procedure.

When completing the DSS-3113, please follow the guidelines below:

- Be certain that the form is completed so it can be read easily. An illegible or altered form is unacceptable.

- Each required field or blank must be completed in order to ensure payment.

A sample Hysterectomy Consent Form and step-by-step instructions follow on the next pages.

DSS-3113 (Rev. 4/84)

ACKNOWLEDGEMENT OF RECEIPT OF HYSTERECTOMY INFORMATION
 (NYS MEDICAID PROGRAM)

EITHER PART I OR PART II MUST BE COMPLETED

1. RECIPIENT ID NO.	2. SURGEON'S NAME

Part I: RECIPIENT'S ACKNOWLEDGEMENT STATEMENT AND SURGEON'S CERTIFICATION
RECIPIENT'S ACKNOWLEDGEMENT STATEMENT

It has been explained to me, __3._____, that the hysterectomy to be performed on me will
(RECIPIENT NAME)
make it impossible for me to become pregnant or bear children. I understand that a hysterectomy is a permanent operation. The reason for performing the hysterectomy and the discomforts, risks and benefits associated with the hysterectomy have been explained to me, and all my questions have been answered to my satisfaction prior to the surgery.

4. RECIPIENT OR REPRESENTATIVE SIGNATURE X	5. DATE	6. INTERPRETER'S SIGNATURE (If required) X	7. DATE

SURGEON'S CERTIFICATION

The hysterectomy to be performed for the above mentioned recipient is solely for medical indications. The hysterectomy is not primarily or secondarily for family planning reasons, that is, for rendering the recipient permanently incapable of reproducing.

	8. SURGEON'S SIGNATURE X	9. DATE

Part II: WAIVER OF ACKNOWLEDGEMENT AND SURGEON'S CERTIFICATION

The hysterectomy performed on _10._____ was solely for medical reasons.   The
(RECIPIENT NAME)
hysterectomy was not primarily or secondarily for family planning reasons, that is, for rendering the recipient permanently incapable of reproducing. I did not obtain Acknowledgement of Receipt of Hysterectomy information from her and have her complete Part I of this form because (please check the appropriate statement and describe the circumstances where indicated):

11   1.   She was sterile prior to the hysterectomy.
       (briefly describe the cause of sterility)_____

12   2.   The hysterectomy was performed in a life threatening emergency in which prior acknowledgement was not possible. (briefly describe the nature of the emergency)

13   3.   She was not a Medicaid recipient at the time the hysterectomy was performed but I did inform her prior to surgery that the procedure would make her permanently incapable of reproducing.

	14. SURGEON'S SIGNATURE X	15. DATE

DISTRIBUTION: File patient's medical record; hospital submit with claim for payment; surgeon and anesthesiologist submit
with claims for payment; patient

*Field-by-Field Instructions for Completing Acknowledgement
Receipt of Hysterectomy Information Form – DSS-3113*

Either Part I or Part II must be completed, depending on the circumstances of the operation. In all cases, Fields 1 and 2 must be completed.

Field 1

Enter the recipient's Medicaid ID number.

Field 2

Enter the surgeon's name.

Part I: Recipient's Acknowledgement Statement and Surgeon's Certification
This part must be signed and dated by the recipient or her representative unless one of the following situations exists:

- The recipient was sterile prior to performance of the hysterectomy;

- The hysterectomy was performed in a life-threatening emergency in which prior acknowledgment was not possible; or

- The patient was not a Medicaid recipient on the day the hysterectomy was performed.

Field 3

Enter the recipient's name.

Field 4

The recipient or her representative must sign the form.

Field 5

Enter the date of signature.

Field 6

If applicable, the interpreter must sign the form.

Field 7

If applicable, enter the date of interpreter's signature.

Field 8

The surgeon who performed or will perform the hysterectomy must sign the form to certify that the procedure was for medical necessity and not primarily for family planning purposes.

Field 9

Enter the date of the surgeon's signature.

Part II: Waiver of Acknowledgment
The surgeon who performs the hysterectomy must complete this Part of the claim form if Part I, the recipient's Acknowledgment Statement, has not been completed for one of the reasons noted above. This part need not be completed before the hysterectomy is performed.

Field 10

Enter the recipient's name.

Field 11

If the recipient's acknowledgment was **not** obtained because she was sterile prior to performance of the hysterectomy, check this box and briefly describe the cause of sterility, e.g., postmenopausal. This waiver may apply to cases in which the woman was not a Medicaid recipient at the time the hysterectomy was performed.

Field 12

If the recipient's Acknowledgment was **not** obtained because the hysterectomy was performed in a life-threatening emergency in which prior acknowledgment was not possible, check this box and briefly describe the nature of the emergency. This waiver may apply to cases in which the woman was not a Medicaid recipient at the time the hysterectomy was performed.

Field 13

If the patient's Acknowledgment was **not** obtained because she was not a Medicaid recipient at the time a hysterectomy was performed, but the performing surgeon did inform her before the procedure that the hysterectomy would make her permanently incapable of reproducing, check this box.

Field 14

The surgeon who performed the hysterectomy must sign the form to certify that the procedure was for medical necessity and not primarily or secondarily for family planning purposes and that one of the conditions indicated in Fields 11, 12, and 13 existed.

Field 15

Enter the date of the surgeon's signature.

Appendix D – INPATIENT GLOSSARY OF TERMS

Adjustment/Replacement	An adjustment transaction is submitted to replace a previously paid claim.
Admission Day Claim	Admission Day claims are submitted to receive some form of payment in lieu of the DRG payment, which cannot be made until the patient is discharged. Admission Day claims **must** be adjusted as a DRG claim within 90 days of the payment.
Admission Type	Indicates the type of admission, e. g. emergency, urgent, elective, and newborn.
ALC	ALC – Alternate Level of Care (not acute care level).
Capital Add-on	A set rate amount added to payment of DRG inlier claims for capital expenses. The amount is added after the calculation of the DRG payment.
CAS	Claim Adjustment Segment of an electronic HIPAA claim where other payer payment information is reported.
Co Payment (Medicaid)	Amount due from the patient that is automatically deducted from the claim.
Co Insurance Days	Medicare covered days at a Co-insurance rate.
Companion Guide	A document that provides detailed instructions for submitting HIPAA-compliant transactions to NY Medicaid. Companion Guides are located at www.emedny.org, select NYHIPAADESK, then select Companion Guides and Sample Files.
Condition Code	Code used to identify conditions relating to a claim. Medicaid uses conditions codes to report day outliers, cost outliers, family planning, abortion/sterilization codes and co-pay exemption.
Cost Outlier	Cost outlier claims can occur when the cost of the hospital stay is much higher than the normal DRG payment would reimburse.
Cost Per Discharge	The base rate used in the calculation of a DRG claim.
Day Outlier	Days that are beyond the high trim point for the assigned DRG.
Delay Reason Code/90 Day Indicator	A code that defines one of the valid reasons for submitting a claim after 90 days from the discharge date (DRG claims) or the through date of service (per diem claims).

DRG	Diagnosis Related Group – A code assigned to a claim based on diagnosis, procedures and other claim information.
Edit (Edit Number)	A NYS Medicaid reason for a claim to be denied and/or pended. The associated Edit number and reason are detailed on a provider's paper remittance statement.
ePACES	electronic Provider Assisted Claim Entry System - A web-based application that allows enrolled providers to submit and receive electronic claims, claim status request and responses and eligibility requests and responses.
GME	Graduate Medical Expense - Payments made to cover the GME expenses related to an Inpatient stay on behalf of a Medicaid recipient enrolled in a Medicaid Managed Care plan on the Date of Admission.
Grouper	System used to assign a DRG code based on diagnosis, procedure and other claim information.
High Trim Point	Same as threshold. Maximum number of days a patient is expected to be hospitalized for the assigned DRG.
HIPAA 835 Transaction	The name given to the format of a HIPAA-compliant electronic remittance statement.
HIPAA 837 Institutional	The name given to the accepted format for HIPAA-compliant electronic claim submissions for institutional services.
Inlier	Days less that the high trim point for the assigned DRG.
IPRO	IPRO - Island Peer Review Organization grants prior approval for certain types of inpatient stays.
Low Trim Point	Minimum number of days a patient is expected to be hospitalized for the assigned DRG.
LTR Days	Medicare covered days at a Life Time Reserved rate.
Non-DRG	Claim processed as a per diem claim.
NYHIPAADESK	Section of the eMedNY website that contains information related to electronic transactions for NYS Medicaid.
Occurrence Codes	Code defining a significant event relating to a claim. Submitted on DRG claims to indicate alternate level of care portions of the hospital stay.

Occurrence Span	Dates of a significant event relating to a claim. Submitted on DRG claims to indicate dates (from – through) for alternate level of care portions of the hospital stay.
Off Line Payment	Special claims payment processing that occurs outside of systems claims processing.
Outlier	Days after the high trim point for the assigned DRG.
Pass Days	Claims where the patient was admitted to the same hospital twice for the same diagnosis and the admission date of the second stay was close to the discharge date of the first stay.
Patient Control Number	Number assigned by a provider to track and reconcile adjudicated claims.
Patient Status	Status of the patient as of the through date of service on a claim.
Per Diem	A claim paid at a single daily rate amount.
Rate Code	Assigned by OHIP to facilitate correct payment of claims.
Revenue Code	Code that identifies a specific accommodation, ancillary service or billing calculation. Required for inpatient claims. Consult the UB-92 manual or its successor UB-04 for an appropriate code. Consult the 837 Institutional Supplemental Guide at www.emedny.org for Medicaid business rules.
Service Intensity Weight	A weighting factor assigned to each DRG. Used in the payment calculation.
Short Stay	A hospital stay that is less number of days for the minimum (low trim point) for the assigned DRG.
Spend Down	A monthly amount a patient must contribute to his/her medical expenses to be qualified as Medicaid eligible.
Stay Denied Date	Date on which hospital peer review deems the hospital stay as not acute.
Surplus	An amount a patient must contribute toward the hospital bill.
Swing Bed	A hospital bed that can be billed as acute care or at a nursing home level if approved by DOH.
Third Party	A Payer other than Medicare and Medicaid.
Threshold	Same as high trim point. The threshold is the number of days a patient is expected to be hospitalized based on the DRG code assigned.
Type of Bill	A code describing the type of facility where services were rendered.

Value Code	A Value Code is a qualifier submitted on a claim to define data that follows in the billing record such as a rate code.
Void	A Void is submitted to negate a previously paid claim.