

**NEW YORK STATE
MEDICAID PROGRAM**

INFORMATION FOR ALL PROVIDERS

INTRODUCTION

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Preface

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

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

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

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

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

Past issues of *Medicaid Update* are available at:

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

Foreword

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

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

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

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

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

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

Medicaid Management Information System

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

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

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

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

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

- Receives, reviews and pays claims submitted by the providers of health care for services rendered to eligible patients (recipients).
- Interacts with the providers through its Provider Services personnel in order to train providers in what the Medicaid requirements are and how to submit claims; responds to provider mail and telephone inquiries; maintains and issues forms, and notices, to providers.
- Maintains the Medicaid Eligibility Verification System (MEVS).

Key Features

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

- **Claims Payment**
This aspect of eMedNY generates prompt payment of all approved claims and prepares a Remittance Statement with each payment cycle which lists the status of all paid, denied and pended claims.
- **Flexibility**
For rate-based providers, the system has the flexibility to process individual claim lines submitted on a single claim separately. It will not deny payment of the entire

invoice if one line is pended or requires manual pricing.

For fee-for-service providers who utilize ePACES the system can process claims (with up to 4 claim lines) in “real-time”. Real time means that the claims process through adjudication within seconds.

➤ **Manual Review**

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

➤ **Inquiry Procedures**

The Fiscal Agent handles written and telephone requests for information. Detailed procedures can be found in [Information for All Providers, Inquiry](#).

➤ **Service Bureaus**

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

➤ **Provider and Recipient Eligibility**

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

➤ **Service Limitations and Exclusions**

The DOH maintains the responsibility for determining covered services and exclusions in the Medicaid Program.

➤ **Continuing Communications**

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

<http://www.emedny.org/>.

**NEW YORK STATE
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INFORMATION FOR ALL PROVIDERS

GENERAL POLICY

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Section I – Enrollee Information

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

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

- Citizens and certain qualified persons who are:
 - eligible for Low Income Families (families with children under age 21; persons under age 21 living alone; and pregnant women); or
 - in receipt of or eligible for Supplemental Security Income (individuals who are aged, certified blind or disabled); or
 - children on whose behalf foster care maintenance payments are being made or for whom an adoption assistance agreement is in effect under Title IV-E of the Social Security Act; or
 - individuals between the ages of 21 and 65 not living with a child under the age of 21, not certified blind or disabled, and not pregnant, whose income and resources are below the Public Assistance Standard of Need.
- Citizens and certain qualified persons who meet the financial and other eligibility requirements for the State's Medically Needy Program.

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

These groups generally include:

- infants up to age one and pregnant women whose family income is at or below 185% of the federal poverty level;
- children age one through five whose family income is at or below 133% of the federal poverty level;
- other children with family income at or below 100% of the federal poverty level, including all children under age 19;
- families with children under age 21 who do not have two parents in the household capable of working and providing support;

- persons related to the Supplemental Security Program (i.e., aged, certified blind or disabled);
- adults in two-parent households who are capable of working and providing support to their children under age 21;
- a special limited category of Medicaid eligibility is available for individuals who are entitled to the payment of Medicare deductibles and coinsurance, as appropriate, for Medicare-approved services. An individual eligible for this coverage is called a Qualified Medicare Enrollee (QMB).

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

Identification of Medicaid Eligibility

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

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

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

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

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

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

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

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

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

The MEVS Provider Manual is available online at:

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

Eligible Enrollees

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

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

Ineligible Patients

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

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

Emergency Situations

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

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

Services Available Under the Medicaid Program

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

Payment may be made for necessary:

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

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

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

Qualified Medicare Beneficiary

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

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

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

Free Choice

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

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

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

Guidelines that govern reasonable application of “free choice” are:

- Appropriate resources of the local medical market area should first be utilized in order to avoid unnecessary transportation costs;
- Medical “shopping around” habits should be discouraged so that continuity of care may be maintained.

Right to Refuse Medical Care

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

Civil Rights

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

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

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

Confidentiality

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

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

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

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

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

When Medicaid Enrollees Cannot be Billed

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

Acceptance and Agreement

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

Private Pay Agreement

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

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

Claim Submission

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

Collections

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

Emergency Medical Care

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

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

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

Claiming Problems

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

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

Prior Approval

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

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

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

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

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

Prior Approval and Payment

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

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

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

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

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

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

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

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

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

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

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

Prior Authorization

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

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

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

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

Utilization of Insurance Benefits

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

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

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

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

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

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

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

Fair Hearing

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

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

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

Billing

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

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

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

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

Record Keeping

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

Section II – Provider Information

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

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

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

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

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

Enrollment of Providers

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

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

Applications for Enrollment/Re-enrollment

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

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

Denial of an Application

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

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

Review of Denial

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

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

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

Termination of Enrollment

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

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

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

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

Duties of the Provider

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

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

- permit audits of all books and records or a sample thereof relating to services furnished and payments received under the Medicaid Program;
- comply with the rules, regulations and official directives of the Department.

Keeping Current with Policy Information

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

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

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

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

(800) 343-9000.

Change of Address

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

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

Out-of-State Medical Care and Services

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

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

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

- The provider practices within the “common medical marketing area” of the enrollee’s home LDSS as determined by the Local Professional Director;
- An emergency requires that the out-of-state provider render immediate care to an enrollee who is temporarily out-of-state.

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

Non-Emergent Inpatient Care

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

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

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

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

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

Prior Approval

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

Billing Procedures

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

Record-Keeping Requirements

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

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

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

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

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

General Exclusions from Coverage Under Medicaid

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

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

- Which are medically unnecessary;

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

- Were for cosmetic purposes; or
 - Were provided for personal comfort.
- Which are rendered after an enrollee has reached the Utilization Threshold established for a specific provider service type unless one of the following conditions is satisfied:
- The enrollee has been exempted from the Utilization Threshold;
 - The enrollee has been granted an increase in the Utilization Threshold;
 - The provider certifies that the care, services or supplies were furnished pursuant to a medical emergency or when urgent medical care was necessary.

Unacceptable Practices

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

- Knowingly making a claim for an improper amount or for unfurnished, inappropriate or unnecessary care, services or supplies;
- Ordering or furnishing inappropriate, improper, unnecessary or excessive care, services or supplies;
- Billing for an item/service prior to being furnished;
- Practicing a profession fraudulently beyond its authorized scope, including the rendering of care, services or supplies while one's license to practice is suspended or revoked;
- Failing to maintain or make available for purposes of audit or investigation records necessary to fully disclose the extent of the care, services or supplies furnished;
- Submitting bills or accepting payment for care, services or supplies rendered by a person suspended or disqualified from practicing in the Medicaid Program;
- Soliciting, receiving, offering or agreeing to make any payment for the purpose of influencing a Medicaid enrollee to either utilize or refrain from utilizing any particular source of care, services or supplies;
- Knowingly demanding or collecting any compensation in addition to claims made under the Medicaid Program, except where permitted by law;

- Denying services to an enrollee based upon the enrollee's inability to pay a co-payment; and
- Failure to use the POS Terminal for verification, post and/or clear procedures when designated to do so.

Process for Resolving Unacceptable Practices

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

- The unacceptable practice with which the person has been charged;
- The administrative action which is proposed (i.e., exclusion, or censure, and its statutory, regulatory or legal basis);
- The person's right to submit documentation or written arguments against the proposed agency action within 30 days from the date of the notice of proposed action.

Affiliated Persons

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

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

Some examples of affiliated persons are the following:

- persons with an ownership or controlling interest in a provider;
- agents and managing employees of a provider;
- providers who share common managing employees;
- subcontractors with whom the provider has more than \$25,000 in annual business transactions.

Agency Action

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

Suspension or Withholding of Payments

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

Hearings

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

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

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

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

Administrative Sanctions

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

- The person may be excluded from participation in the Medicaid Program. No payments will be made to a person who is excluded from the Medicaid Program for care, services or supplies rendered to enrollees as of the date of his/her exclusion;
- No payments will be made for any medical care, services or supplies ordered by a person who is excluded or suspended from the Medicaid Program;
- The person may be censured in writing with notification to the appropriate governmental licensing and/or regulatory agencies.

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

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

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

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

- Restitution plus interest may be collected from a person who has received payment for care, services or supplies associated with an unacceptable practice; or
- Reduction in payment may be utilized when it is determined that the person has rendered care, services or supplies not included in the scope of the Program, or that the person has billed for more costly care, services or supplies that were actually provided; or
- Payment may be denied to a person who has engaged in an unacceptable practice.

Guidelines for Sanctions

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

- The number and nature of the Program violations or other related offenses;
- The nature and extent of any adverse impact the violations have had on enrollees;
- The amount of damages to the Program;
- Mitigating circumstances;
- Other facts related to the nature and seriousness of the violations; and
- The previous record of the person under the Medicare Program, the Medicaid Program and other Social Services Programs.

Immediate Sanctions

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

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

- When a person has been convicted of any crime relating to the rendering of, or billing for medical care, services or supplies;
- When a person has been charged with a felony offense relating to the rendering of, or billing for medical care, services or supplies;
- When a person has been the subject of administrative, judicial proceeding finding the person to have committed unprofessional misconduct or an act which would constitute an unacceptable practice under the Medicaid Program; or
- When a person's further participation in the Medicaid Program will endanger the public health, or the health, safety or welfare of any enrollee.

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

Reinstatement

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

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

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

- Include a complete ownership and control disclosure statement;
- State whether the person has been convicted of other offenses related to participation in the Medicare Program, the Medicaid Program or other Social Services Programs which were not considered during the development of the sanction; and
- State whether any State or local licensing authorities have taken any adverse action against the person for offenses related to participation in the Medicare Program, the Medicaid Program or other Social Services Programs which were not considered during the development of the sanction.

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

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

Audits

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

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

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

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

Recovery of Overpayments

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

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

Recoupment

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

Withholding of Payments

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

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

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

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

The withholding may continue as follows:

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

Fraud

Examples of fraud include when a person knowingly:

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

Office of the Medicaid Inspector General

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

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

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

The OMIG also has broad subpoena powers:

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

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

For more information, please refer to the OMIG website:

www.omig.state.ny.us.

The OMIG website contains:

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

Prohibition Against Reassignment of Claims: Factoring

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

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

Exceptions

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

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

Services Subject to Co-Payments

The following services are subject to a co-payment:

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

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

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

Co-payment Maximum

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

Co-payment Exemptions

The following are exempt from all Medicaid co-payments:

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

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

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

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

Section III – Ordering Non-Emergency Medical Transportation

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

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

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

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

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

Responsibilities of the Ordering Practitioner

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

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

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

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

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

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

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

Non-emergency Ambulance

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

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

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

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

Ambulette

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

If personal assistance is not necessary and/or not provided, then [livery](#) service should be ordered.

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

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

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

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

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

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

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

- The Medicaid enrollee has a disabling physical condition other than one described above or a disabling mental condition requiring personal assistance provided by an ambulette services; and,
- The ordering practitioner certifies in a manner designated by and submitted to the Department that the Medicaid enrollee cannot be transported by taxi, livery service, bus or private vehicle and there is a need for ambulette service.

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

Livery Transportation

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

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

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

Day Treatment Transportation

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

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

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

Required Documentation

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

“The ordering practitioner must note in the [enrollee’s] patient record the condition which justifies the practitioner’s ordering of ambulance or nonemergency ambulance services.”

Making the Request for Authorization

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

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

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

Section IV - Family Planning Services

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

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

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

(518) 472-1550.

*If sufficient information is provided,
Department staff will verify the eligibility of the individual for Medicaid.*

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

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

Patient Rights

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

Standards for Providers

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

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

Sterilizations

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

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

Informed Consent

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

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

Waiting Period

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

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

Waiver of the 30-Day Waiting Period

The only exceptions to the 30-day waiting period are in the cases of:

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

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

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

Minimum Age

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

Mental Competence

The patient must be a mentally competent individual.

Institutionalized Individual

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

Restrictions on Circumstances in Which Consent is Obtained

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

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

Foreign Languages

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

Handicapped Persons

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

Presence of Witness

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

Reaffirmation Statement (NYC Only)

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

Sterilization Consent Form

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

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

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

New York City

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

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

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

Hysterectomies

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

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

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

1. The woman was sterile prior to the hysterectomy;
2. The hysterectomy was performed in a life-threatening emergency in which prior acknowledgement was not possible. For Medicaid payment to be made in these two cases, the surgeon who performs the hysterectomy must certify in writing that one of the conditions existed and state the cause of sterility or nature of the emergency. For example, a surgeon may note that the woman was postmenopausal or that she was admitted to the hospital through the emergency room, needed medical attention immediately and was unable to respond to the information concerning the acknowledgement agreement;
3. The woman was not a Medicaid enrollee at the time the hysterectomy was performed but subsequently applied for Medicaid and was determined to qualify for Medicaid payment of medical bills incurred before her application. For these cases involving retroactive eligibility, payment may be made if the surgeon certifies in writing that the woman was informed before the operation that the hysterectomy would make her permanently incapable of reproducing or that one of the conditions noted above in "1" or "2" was met.

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

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

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

Induced Termination of Pregnancy

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

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

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

Obstetrical Services

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

Antepartum Care

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

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

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

Intrapartum Care

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

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

Postpartum Care

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

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

Other Medical Care

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

Section V – Related Programs

Child/Teen Health Program

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

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

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

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

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

<http://www.emedny.org/ProviderManuals/EPSTDCTHP/index.html>.

Preferred Physicians and Children Program

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

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

Application for the Preferred Physicians and Children Program

PPAC provider enrollment applications may be obtained online at:

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

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

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

Physician Eligibility and Practice Requirements

The qualified primary care physician will:

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

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

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

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

- ▶ a curriculum vitae; proof of medical malpractice insurance; and two letters of reference, each from a physician who can attest to the applicant's qualifications as a practicing physician.
- Be board certified (or board admissible for a period of no more than five years from completion of a post graduate training program) in family practice, internal medicine, obstetrics and gynecology, or pediatrics.

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

- Provide 24-hour telephone coverage for consultation.

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

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

- Provide medical care coordination.

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

- Agree to provide periodic health assessment examination in accordance with the Child/Teen Health program (CTHP) standards of Medicaid.
- Be a provider in good standing if enrolled in the Medicaid Program at time of application to PPAC.
- Sign an agreement with the Medicaid Program, such agreement to be subject to cancellation with 30-day notice by either party.

The qualified non-primary care specialist physician will:

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

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

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

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

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

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

- Provide consultation summary or appropriate periodic progress notes to the primary care physician on a timely basis following a referral or routinely scheduled consultant visit;
- Notify the primary care physician when scheduling hospital admission;
- Be a provider in good standing if enrolled in the Medicaid Program at time of application to PPAC;
- Sign an agreement with the Medicaid Program, such agreement to be subject to cancellation with 30-day notice by either party.

Covered Services

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

The PPAC participating provider may NOT bill for:

- physician services provided in Article 28 clinics or
- contractual physician services in emergency rooms.

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

Physically Handicapped Children's Program

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

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

Services Available and Conditions Covered

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

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

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

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

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

Eligibility

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

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

Financing

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

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

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

Prior Approval

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

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

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

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

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

Family Care Program

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

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

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

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

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

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

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

Family Planning Benefit Program

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

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

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

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

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

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

Prenatal Care Assistance Program

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

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

Providers interested in this Program may go online to:

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

or

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

Medicaid Obstetrical and Maternal Services Program

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

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

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

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

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

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

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

(518) 474-1911.

MOMS Eligibility and Practice Requirements

Physicians who participate must:

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

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

For physician enrollment information, please go online to:

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

For additional information, please go to:

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

Utilization Threshold Program

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

Service	Number of Visits, Items or Lab Tests Allowed per Year
Pharmacy (prescription drugs including initial prescriptions, refills, over-the-counter medicine and medical/surgical supplies)	40 items if the enrollee is: <ul style="list-style-type: none"> • Under 21 • 65 or over • Certified blind or disabled • Single caretaker of a child under 18 43 items if the enrollee is:

Service	Number of Visits, Items or Lab Tests Allowed per Year
	<ul style="list-style-type: none"> • 21 to 65 • Not certified blind or disabled • Not a single caretaker of a child under 18
Physician and Medical Clinic	10 visits
Dental Clinic	3 visits
Laboratory	18 procedures
Mental Health Clinic	40 visits

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

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

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

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

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

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

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

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

Recipient Restriction Program

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

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

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

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

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

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

MEVS Implications for the RRP

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

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

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

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

Managed Care

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

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

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

Certain individuals are excluded from participating on Medicaid Managed Care:

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

MEVS Implications for Managed Care

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

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

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

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

Section VI – Definitions

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

Emergency

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

Emergency Services

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

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

Factor

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

Local Professional Director

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

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

Managed Care

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

Prior Approval

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

Prior approval does not guarantee payment.

Prior Authorization

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

Prior authorization does not guarantee payment.

Qualified Medicare Enrollee

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

QMB status is determined via the MEVS.

Unacceptable Practice

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

Urgent Medical Care

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

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

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

**NEW YORK STATE
MEDICAID PROGRAM**

**INFORMATION FOR ALL PROVIDERS
GENERAL BILLING**

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Common Benefit Identification Card

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Voice Interactive Phone System

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

Prior Approval Rosters

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

Electronic Roster

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

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

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

What information is included on the electronic roster?

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

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

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

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

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

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

The electronic prior approval request for is available at:

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

Billing for Medical Assistance Services

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

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

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

Claims Submitted for Stop-Loss Payments

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

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

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

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

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

Acceptable Delay Reasons

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

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

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

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

➤ **Litigation**

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

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

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

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

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

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

➤ **Delay in Supplying Billing Forms**

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

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

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

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

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

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

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

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

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

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

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

➤ **Other/Interrupted Maternity Care**

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

Claims Over Two Years Old

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

- Errors by the Department, the local social services district, or another agent of the Department; or
- Court-ordered payments.

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

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

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

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

Electronic Claims Submission

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

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

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

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

Claim Status Options

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

ePACES

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

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

ePACES Real Time

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

Electronic Claim Status Request

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

Electronic Claim Status Responses

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

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

Paper Remittance

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

Electronic Remittance

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

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

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

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

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

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

Electronic Funds Transfer

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

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

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

Claims Pended for Review by the Office of the State Comptroller

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

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

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

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

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

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

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

HIPAA Claim Denials

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

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

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

Good Cause

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

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

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

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

(800) 541-2831.

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

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

Claim Certification Statement

Provider certifies that:

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

- There has been compliance with the Federal Civil Rights Act of 1964 and with section 504 of the Federal Rehabilitation Act of 1973, as amended, which forbid discrimination on the basis of race, color, national origin, handicap, age, sex and religion;
- I agree (or the entity agrees) to comply with the requirements of 42 CFR Part 455 relating to disclosures by providers; the State of New York through its eMedNY Contractor or otherwise is hereby authorized to
 - (1) make administrative corrections to this claim to enable its automated processing subject to reversal by provider, and
 - (2) accept the claim data on this form as original evidence of care, services and supplies furnished.

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

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

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

**NEW YORK STATE
MEDICAID PROGRAM**

INFORMATION FOR ALL PROVIDERS

INQUIRY

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Computer Sciences Corporation Contact Information

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

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

Hours of Operation

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

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

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

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

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

Telephone Directory

If you are a:

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

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

Then, depending on your question:

If your question is concerning:	Choose:
<ul style="list-style-type: none">➤ New Enrollment;➤ ePACES Enrollment;➤ TSN/ETIN applications.	Sub-option 1
<ul style="list-style-type: none">➤ Explanation of eligibility response;➤ UT service authorization;➤ POS Device Support.	Sub-option 2
<ul style="list-style-type: none">➤ Obtaining NYC Transportation Prior Authorizations	Sub-option 3
<ul style="list-style-type: none">➤ Claims;➤ Billing;➤ Remittance;➤ Form orders; and➤ Prior approval.	Sub-option 4

If you are a:

- Pharmacy Provider

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

Then, depending on your question:

If your question is concerning:	Choose:
<ul style="list-style-type: none">➤ New Enrollment;➤ ePACES Enrollment;➤ TSN/ETIN applications.	Sub-option 1
<ul style="list-style-type: none">➤ For all other questions including:<ul style="list-style-type: none">▪ explanation of eligibility response,▪ claims,▪ billing,▪ remittance and▪ prior approval questions including DIRAD.	Sub-option 2

If you are a:

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

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

Then, depending on your question:

If your question is concerning:	Choose:
<ul style="list-style-type: none">➤ New Enrollment;➤ ePACES Enrollment;➤ TSN/ETIN applications.	Sub-option 1
<ul style="list-style-type: none">➤ Explanation of eligibility response;➤ UT service authorization;➤ POS Device Support.	Sub-option 2
<ul style="list-style-type: none">➤ Obtaining NYC Transportation Prior Authorizations	Sub-option 3
<ul style="list-style-type: none">➤ Claims;➤ Billing;➤ Remittance;➤ Form orders; and➤ Prior approval questions.	Sub-option 4

If you are a:

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

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

Then, depending on your question:

If your question is concerning:	Choose:
<ul style="list-style-type: none">➤ New Enrollment;➤ ePACES Enrollment;➤ TSN/ETIN applications.	Sub-option 1
<ul style="list-style-type: none">➤ Explanation of eligibility response;➤ UT service authorization;➤ POS Device Support.	Sub-option 2
<ul style="list-style-type: none">➤ Claims;➤ Billing;➤ Remittance;➤ Form orders; and➤ Prior approval questions.	Sub-option 3

If your question concerns:

- MOAS; or
- Threshold override application provider support

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

Training Requests

Requests for individual provider training can be made by calling

(800) 343-9000

or email:

emednyproviderrelations@csc.com

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

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

Mailing Addresses for Medicaid Correspondence

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

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

P.O. Box	Description of Contents	Form Types
4600	Prior Approval and Prior Authorization Requests	<ul style="list-style-type: none"> • EMEDNY-3614 (Dental) • EMEDNY-3615 (Drugs...Physician) • EMEDNY-2832 (Hearing Aid) • EMEDNY-1260 (Level of Care) • EMEDNY-3897 (Transportation) • EMEDNY-4106 (Group Transportation) • PA Additional Information
4601	Claims	<ul style="list-style-type: none"> • EMEDNY-1500 (HCFA) • EMEDNY-0002 (Form A) • EMEDNY-0003 (Pharmacy) • UB-04 (Institutional)
4602	Threshold Override Applications	<ul style="list-style-type: none"> • EMEDNY-0001 (TOA)
4603	Provider Enrollment Applications	<ul style="list-style-type: none"> • All Fee-For-Service and Rate-Based Enrollment Packets
4604	Edit Review	<ul style="list-style-type: none"> • Provider submitted documentation to adjudicate claims

Information for All Providers - Inquiry

P.O. Box	Description of Contents	Form Types
4605	Remittance Retrieval	<ul style="list-style-type: none"> • Requests from providers for copies of remittance statements
4606	Additional Information	<ul style="list-style-type: none"> • Provider Enrollment Additional Information Form with attachments
4610	Provider Maintenance	<ul style="list-style-type: none"> • Provider maintenance (update) forms and related correspondence
4614	Electronic Form Requests	<ul style="list-style-type: none"> • Electronic Certifications • ETIN Applications • Security Packet A • Security Packet B • Electronic Remittance Request • Electronic Prior Approval Request • Remittance Sort Request • Pended Claim Recycle Request • Request to Disaffiliate/Delete an ETIN
4616	Electronic Funds Transfer	<ul style="list-style-type: none"> • Electronic Funds Transfer Enrollment Forms

Medicaid Program Contact Information

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

Information for All Providers - Inquiry

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

Information for All Providers - Inquiry

For questions concerning:	Contact:																
<p>Medicaid Policy</p> <p>Call Center Help Line/Co-Pay Hotline Fraud/Forgery Hotline Medical/Dental Prior Approval Restricted Recipients/Utilization Threshold Two-year billing regulations</p>	<p>medicaid@health.state.ny.us</p> <p>(800) 541-2831 (877) 891-7283 (800) 342-3005 (518) 474-6866 (800) 562-0856 menu #4</p>																
<p>Medical Prior Approval</p> <ul style="list-style-type: none"> ➤ Nursing ➤ Out-of-State Inpatient Hospital Services ➤ Audiology 	<p>(800) 342-3005 Option #1</p>																
<p>Medicaid Update</p> <ul style="list-style-type: none"> • Missing issues • Request to receive electronic version 	<p>http://www.nyhealth.gov/health_care/medicaid/program/update/main.htm</p> <p>Email: medicaidupdate@health.state.ny.us</p> <p>(518) 474-5187</p>																
<p>New York State Department of Health</p>	<p>www.nyhealth.gov</p>																
<p>Newborn Screening Program</p>	<p>(518) 473-7552</p>																
<p>Personal Care Services Prior Authorization</p>	<p>Local Department of Social Services</p>																
<p>Pharmacy Policy and Operations</p>	<p>(518) 486-3209</p> <p>ppno@health.state.ny.us</p>																
<p>Private Duty Nursing Services</p>	<table border="1"> <tbody> <tr> <td>Broome</td> <td>(607) 778-2707</td> </tr> <tr> <td>Chemung</td> <td>(607) 737-5487</td> </tr> <tr> <td>Erie</td> <td>(716) 858-2375</td> </tr> <tr> <td>Oneida</td> <td>(315) 798-5456</td> </tr> <tr> <td>Schenectady</td> <td>(518) 386-2253</td> </tr> <tr> <td>Tompkins</td> <td>(607) 274-5278</td> </tr> <tr> <td>Westchester</td> <td>(914) 813-5440</td> </tr> <tr> <td>All others not listed</td> <td>(800) 342-3005</td> </tr> </tbody> </table>	Broome	(607) 778-2707	Chemung	(607) 737-5487	Erie	(716) 858-2375	Oneida	(315) 798-5456	Schenectady	(518) 386-2253	Tompkins	(607) 274-5278	Westchester	(914) 813-5440	All others not listed	(800) 342-3005
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For questions concerning:	Contact:
<p>Sterilization & Hysterectomy Consent Forms</p> <ul style="list-style-type: none">➤ DSS-3113 Hysterectomy Receipt of Information➤ DSS-3113S Hysterectomy Receipt of Information (Spanish)➤ DSS-3134 Sterilization Consent➤ DSS-3134S Sterilization Consent (Spanish)	<p>http://www.health.state.ny.us/health_care/medicaid/publications/ldssforms</p>
<p>Transportation</p>	<p>(518) 474-5187 or (518) 473-2160</p> <p>MedTrans@health.state.ny.us</p> <p>Outside NYC Local Department of Social Services</p> <p>Obtain NYC Prior Authorization (800) 343-9000</p>

Fee-for-Service Provider Enrollment File Forms

Fee-for-Service Providers:

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

Enrollment Forms Maintenance Forms	http://www.emedny.org/info/ProviderEnrollment/index.html
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Rate Based Provider Enrollment File Forms

Rate Based Providers:

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

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

Pharmacy Programs

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

(877) 309-9493

and follow the appropriate prompts:

<ul style="list-style-type: none"> To validate a prior authorization ending with “W” 	Press 1
<ul style="list-style-type: none"> To validate a prior authorization that does not end with “W” 	Press 2
<ul style="list-style-type: none"> For information or technical assistance with a prior authorization 	Press 3
<ul style="list-style-type: none"> For a prior authorization program overview Recent changes to the Preferred Drug Program 	Option 9

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

(800) 268-2990

Faxed requests may take up to 24 hours to process.

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

Local Departments of Social Services

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

Information for All Providers - Inquiry

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

Information for All Providers - Inquiry

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

Information for All Providers - Inquiry

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

Information for All Providers - Inquiry

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

Information for All Providers - Inquiry

Warren County
Department of Social Services
Municipal Annex
1340 State Route 9
Lake George, New York 12845
(518) 761-6300
<http://www.co.warren.ny.us/depts.php#SOCIALSERVICES>

Washington County
Department of Social Services
Municipal Center
383 Broadway
Fort Edward, New York 12828
(518) 746-2300
<http://www.co.washington.ny.us/Departments/Dss/dss.htm>

Wayne County
Department of Social Services
77 Water Street
P.O. Box 10
Lyons, New York 14489-0010
(315) 946-4881
<http://www.co.wayne.ny.us/departments/dss/dss.htm>

Westchester County
Department of Social Services
County Office Building #2
112 East Post Road
White Plains, New York 10601-5272
(914) 995-5000
<http://www.westchestergov.com/health.htm>

Wyoming County
Department of Social Services
466 North Main Street
Warsaw, New York 14569-1080
(585) 786-8900
<http://www.wyomingco.net/socialservices/main.htm>

Yates County
Department of Social Services
County Office Building
417 Liberty Street
Penn Yan, New York 14527-1118
(315) 536-5183
<http://www.yatescounty.org/upload/12/dss/frameset.html>

**NEW YORK STATE
MEDICAID PROGRAM**

INFORMATION FOR ALL PROVIDERS

THIRD PARTY INFORMATION

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Third Party Health Resources

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

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

The MEVS response via the Verifone terminal or alternate access will be a two-digit insurance code.

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

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

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

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

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

(800) 343-9000.

Insurance Coverage Codes

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

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

Information for All Providers – Third Party Information

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

Recipient Other Insurance Codes

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

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

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

Information for All Providers – Third Party Information

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

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

Information for All Providers – Third Party Information

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

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

Information for All Providers – Third Party Information

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

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

Prepaid Capitation Plans (PCP)

Note:

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

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

Information for All Providers – Third Party Information

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

County/District Codes

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

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

**NEW YORK STATE
MEDICAID PROGRAM**

**INPATIENT MANUAL
POLICY GUIDELINES**

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Section I - Requirements for Participation in Medicaid

Among other services, a [hospital](#) must:

- provide diagnostic and therapeutic services for medical diagnosis, treatment and care of sick and injured persons;
- have laboratory and radiology services and organized departments of medicine and surgery;
- have an organized medical staff which may include in addition to doctors of medicine, doctors of osteopathy and dentistry;
- have rules, by-laws, and regulations which outline standards of medical care and services rendered by the medical staff;
- maintain medical records for each patient;
- require that every patient be under the care of a medical staff member;
- provide 24 hour patient services;
- have, in effect, a quality assurance program which meets all Federal statute regulations and is not limited to New York State Department of Health (NYSDOH) regulation 405.6 "Quality Assurance", available online at <http://www.health.state.ny.us/nysdoh/phforum/nycrr10.htm>;
- have, in effect, an agreement with a home health agency for referral and transfer of patients to home health agency care when such service should be appropriate to meet the patient's needs.

Inpatient hospital services may be provided in public, incorporated (non-profit) or proprietary hospitals which meet the criteria as defined in [Section IV - Definitions](#), and:

- possess valid operating certificates issued in accordance with the provisions of Article 28 of the Public Health Law;
- are qualified to participate under Title 18 of the Federal Social Security Act or are determined to meet the requirements for such participation;
- have, in effect, hospital utilization review plans applicable to all patients; and
- meet all applicable provisions of Federal and State law and regulation.

Emergency hospital services may be provided in a hospital which does not currently meet Title 18 requirements when such services are necessary to prevent the death or serious impairment of the health of an individual and when the threat to life or health necessitates the use of the most accessible hospital available.

An individual hospitalized under such circumstances must, however, be transferred to a Title 18 participating hospital as soon as the transfer would not be medically hazardous for the individual.

Inpatient Care Provided Outside of New York State

Medicaid-eligible individuals should obtain medical care and services from qualified providers located within New York State. Should an out-of-state qualified hospital be utilized, prior approval is required for admission.

Prior approval requests should be made in written letter format from the individual's in-state referring physician and include both a list of in-state hospital contacts and reasons why in-state admission could not be arranged.

Please direct prior approval requests as follows:

Fiscally Responsible Counties	NYSDOH Office
Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans and Wyoming	Western Regional Office 584 Delaware Avenue Buffalo, New York 14202-1203
All Others Not Listed Above	Bureau of Medical Review & Payment Medical Prior Approval Unit 150 Broadway, Suite 6E Albany, New York 12204-2736

Upon approval, the out-of-state hospital provider will receive a prior approval number, which will need to be included on any subsequent claim submissions associated with the services provided.

An out-of-state provider will be reimbursed for services rendered to an eligible New York State Medicaid patient without prior approval **only** under the following circumstances:

- the provider practices in the “common medical marketing area” (CMMA) of the patient’s home social services district as defined by the NYSDOH;
- an emergency requires that immediate care be provided to a patient who is temporarily located out-of-state;
- care is provided to a patient who is an approved out-of-state placement such as for nursing home or foster care services in another state;
- the patient is Medicare approved.

Reporting Births via Electronic Birth Certificate

Within five business days of live birth to a woman in receipt of Medicaid or Family Health Plus, the hospital must report the birth to the DOH. This requirement is met by reporting the birth via the existing *Electronic Birth Certificate* (EBC).

The birth registrar should indicate the code for Medicaid in one of the payor fields which will allow the NYSDOH to review the birth information and, if appropriate, create Medicaid eligibility for the infant.

Determinations of Eligibility

Certain State regulations require hospitals and all-approved Medicaid providers to conduct a Medicaid eligibility verification clearance on each person who presents himself as a Medicaid patient in order to determine Medicaid eligibility status and medical coverage.

For an individual who has been determined to be eligible for Medicaid prior to hospitalization and who presents, upon admission, a Common Benefit Identification Card (CBIC) or a Temporary Medicaid Authorization, the hospital is responsible for taking reasonable steps to insure that:

- the individual is presenting a valid CBIC or letter,
- the bearer of the card/letter is who he claims to be, and
- the CBIC/letter indicates he is eligible for inpatient care on the date(s) of service.

For more information, please consult the [Information for All Providers, General Policy Manual](#) online at:

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

For a patient who has not been determined eligible for Medicaid at the time of his admission but who wishes to apply for Medicaid in order to cover the hospitalization, a completed Medicaid application and required documentation must be submitted to the recipient's local department of social services (LDSS).

For the appropriate LDSS office, please consult [Information for All Providers, Inquiry](#) online at:

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

Medicaid eligibility can be retroactively determined for the three-month period prior to the month of application. The application must be submitted to the LDSS within three months following the month of the patient's admission to allow for retroactive Medicaid coverage for inpatient hospital care from the date of admission.

For patients between 21 and 65 years of age who reasonably appear to be medically disabled for a minimum period of 12 months, the hospital or physician should submit to the LDSS a *Medical Report for Determination of Disability* (Form *DSS-486T*). Submission of this form in a timely manner will facilitate the determination of Medicaid eligibility. The LDSS will make a determination regarding the individual's eligibility and then notify the hospital and the patient of the determination.

Eligible with Surplus

A surplus ("spend-down") is the amount for which a Medicaid client is financially responsible before Medicaid will cover the client's healthcare.

If the LDSS determines that the patient is eligible with a surplus, that patient will be eligible for Medicaid coverage of appropriate care, supplies and services (inpatient and outpatient) when the patient has incurred or paid an amount of medical bills equal to their monthly surplus (excess income) amount for six months.

The patient is financially responsible for the amount of the surplus. The hospital may bill Medicaid for the amount of the remaining care in accordance with established Medicaid rates.

In some cases, the total hospital bill will be less than the patient's surplus. In such instances, after any third party insurances have paid, the hospital is to bill the patient for the remaining total amount and then notify the LDSS of the amount of the bill and the date(s) of service.

Enrollment of Newborns into Medicaid

Newborns born to women receiving Medicaid or Family Health Plus (FHPlus) on the date of birth are automatically Medicaid-eligible for one year.

Chapter 412 of the Laws of 1999 mandates that the NYSDOH, or its designee:

- enroll into the Medicaid Program infants born to women who are receiving Medicaid,
- assign a client identification number (CIN), and
- issue an active Medicaid identification card as soon as possible, but no later than ten (10) business days from the notification of the birth by the hospital.

If the mother is enrolled in a Medicaid Managed Care plan, the newborn will be enrolled in the same plan from the date of birth. Women who are in receipt of FHPlus at the time they give birth are treated in the same manner as women in receipt of Medicaid for purposes of hospital reporting and the infant's Medicaid eligibility.

Providers must not bill Medicaid fee-for-service, but rather must bill the Managed Care plan for the infant's hospital stay.

- If the mother's FHPlus plan also participates in Medicaid Managed Care, the newborn will be automatically enrolled in that Medicaid Managed Care plan.
- If the mother's FHPlus plan does not participate in Medicaid Managed Care, the mother will be asked to select a Medicaid Managed Care plan for the unborn child if she resides in a mandatory county.

If the mother does not have her unborn child pre-enrolled, the automated newborn enrollment process will put the infant in fee-for-service Medicaid and she may choose a Medicaid Managed Care plan for the newborn thereafter.

- If the mother resides in a voluntary county and her FHPlus plan does not participate in Medicaid Managed Care, the automated newborn enrollment process will put the infant in fee-for-service Medicaid and she may choose a

Medicaid Managed Care plan or Medicaid fee-for-service for the newborn thereafter.

- The only exceptions to the automatic enrollment of a newborn into the same Managed Care plan as the mother are:
 - when a baby is born weighing less than 1200 grams (2 lbs. 10 oz.), or
 - a newborn under age six months is determined eligible for the SSI-related category, or
 - the mother is enrolled in certain special needs for partial capitation plans.

The child may subsequently be disenrolled to fee-for-service Medicaid, or be transferred to another health plan at the mother's request.

Questions regarding FHPlus or Medicaid eligibility for newborns should be referred to the toll-free Newborn Helpline at:

(877) 463-7680.

Mother Enrolled In Medicaid Managed Care or Family Health Plus

Hospitals must determine the newborn's Managed Care status by checking the mother's status on the electronic Medicaid eligibility verification system (EMEVs). The hospital must check:

- Medicaid eligibility status;
- Medical coverage – Eligible Prepaid Capitation Plan (PCP) or FHPlus and an Insurance Code indicate enrollment in Managed Care or FHPlus plan and the specific Managed Care or FHPlus provider; and
- Benefit coverage codes to determine whether the patient has 'inpatient hospital' (letter 'A') and other relevant coverage included in the Managed Care benefit package.

It is possible that a pregnant managed care enrollee may present herself at an out-of-network hospital and need to be admitted for delivery. In this case, that hospital must notify the Managed Care plan promptly and bill the Managed Care plan for the newborn's and mother's inpatient costs associated with the birth.

The hospital should not bill the Medicaid Program; rather, Managed Care plans will reimburse the hospital at the Medicaid rate or at another rate if agreed to between the Managed Care plan and the hospital. If a hospital bills eMedNY and is paid, the State will recover the erroneous payment.

The Managed Care plan may not deny inpatient hospital costs if billing or notification is not timely except as otherwise provided by contractual agreement between the plan and the hospital.

Providers must continue to determine whether the newborn and/or mother is enrolled in a Managed Care plan. If either is enrolled and the service to be provided is a covered service by the Managed Care plan, the provider should contact the plan before rendering service, except in an emergency.

Hospitals must report live births to women in receipt of Medicaid or FHPlus to DOH, or its designee, within **five** business days of birth.

Hospitals may face a financial penalty if they fail to report within the established timeframes.

Hospitals must notify the mother, in writing upon discharge, that her newborn is deemed to be enrolled in the Medicaid Program and that she may access care, services, and supplies available under Medicaid for her baby, provided that she was in receipt of Medicaid or FHPlus at the time of the birth. The letter must indicate that the child is eligible to obtain Medicaid services even without a CIN or common benefit identification card.

Questions regarding Medicaid Managed Care should be referred to the Office of Managed Care at:

(518) 486-9015

or via email to omcmail@health.state.ny.us.

Choice of Physician on the Medical Staff

A Medicaid patient must be given the right to choose a qualified physician on the medical staff of the hospital regardless of the type of bed accommodation assigned to him. However, if the patient has been referred for hospitalization by the emergency room or the hospital's outpatient department, the physician providing inpatient services may be selected by the hospital to assure continuity of care.

Record Keeping Requirements

Hospitals must meet the general Medicaid record-keeping requirements outlined in the [Information for All Providers - General Policy Manual](#) and in the State Regulations, as well as Medicare requirements established in accordance with Title 18 of the Social Security Act.

Additionally, hospitals must maintain adequate, complete and up-to-date medical records containing the information necessary to make required determinations of Medicaid coverage.

Hospital utilization review, quality assurance and improvement activities must provide for the identification of individual patients by means which assure confidentiality.

Section II – Inpatient Services

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

Hospitals with Approved Residency

- A patient must be assigned to a member of a medical staff, who shall be the personal attending physician to the individual and assume professional responsibility for his care.
- Proper follow-up care after discharge, when the personal attending physician does not continue out-of-hospital care, must be given in the outpatient department by:
 - the personal attending physician;
 - members of the service or department which was responsible for the inpatient care; or,
 - if appropriate, members of another service or department; or
 - by a physician who, prior to the hospital admission, had been designated as the physician responsible for the care of the patient in the outpatient department.
- The patient must be referred to his/her own physician if medically feasible.
- In any specialty, physicians on the hospital staff must be organized as a group, firm, or service which is the same for inpatient and outpatient services.
- Personal and identifiable services must be given by the attending physician or the resident with oversight by the attending physician to the Medicaid patient, including:
 - review of the patient's history and physical examination, and
 - personal examination of the patient within a reasonable period after admission;
 - confirmation or revision of the diagnosis; determination of the course of treatment to be followed;
 - assurance that any supervision needed by interns and residents was furnished; and frequent review of the patient's progress.
- Personal and identifiable services provided to a patient by the attending physician must be identified in the patient's medical record; as well as evidence of ongoing supervision and oversight by the attending physician.
- Surgical residents must have personal supervision by the attending physician.

- The medical staff shall, based on written criteria, recommend privileges that are specific to treatments/procedures for each individual in such program prior to delivery of patient care services.

Psychiatric Care

Article 28 hospitals which admit patients in emergencies for immediate care, observation and treatment under Section 9.39 of the Mental Hygiene Law must be approved for such services by the Office of Mental Health.

Psychiatric Hospitals

For hospital care in institutions or facilities primarily or exclusively for treatment of the mentally ill, Medicaid reimbursement is available only for individuals under 21 years of age or over 65 years of age.

In the case of a person who attains the age of 21 during the course of hospitalization, reimbursement for hospital services may continue until that person reaches the age of 22.

Induced Termination of Pregnancy

Performance of induced terminations of pregnancy must conform to all applicable requirements set forth in regulations of the NYSDOH.

Except in cases of medical or surgical emergencies, no pregnancy may be terminated in an emergency room.

The Medicaid Program covers abortions which **have been determined to be medically necessary by the attending physician**. Social Services Law 365-a specifies the types of medically necessary care, including medically necessary abortions, which may be provided under the Medicaid Program.

Medically necessary services are those:

"...necessary to prevent, diagnose, correct or cure conditions in the person that cause acute suffering, endanger life, result in illness or infirmity, interfere with his/her capacity for normal activity or threaten some significant handicap and which are furnished to an eligible person in accordance with this title and the regulations of the Department."

Medicaid also relies on the language from the federal Supreme Court decision *Doe V. Bolton*, to further refine the definition for medically necessary abortions.

Doe v. Bolton held that the determination that an abortion is medically necessary "is a professional judgment that may be exercised in the light of all factors - physical, emotional, psychological, familial and the woman's age - relevant to the well-being of the patient. All these factors may relate to health."

The doctor makes the determination of medical necessity and so indicates on the claim.

Although Medicaid covers only medically necessary abortions, payment is made for both medically necessary and elective abortions provided to New York City patients.

Sterilization Requirements

Medical family planning services include sterilizations.

Sterilization is defined as any medical procedure, treatment or operation for the purpose of rendering a client permanently incapable of reproducing.

In addition to provision of information at the initial counseling session, the physician who performs the sterilization must discuss the information below with the patient shortly before the procedure, usually during the pre-operative examination.

Medicaid reimbursement is available for sterilization only if the following requirements are met:

Informed Consent

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

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

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

- in labor or childbirth;
- seeking to obtain or obtaining an abortion; or

- under the influence of alcohol or other substances that affect the patient's state of awareness.

Waiting Period

The patient to be sterilized must have voluntarily given informed consent not less than 30 days or more than 180 days prior to sterilization.

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

The only exceptions to the 30-day waiting period are in the cases of:

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

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

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

Minimum Age

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

Mental Competence

The patient must not be a [mentally incompetent individual](#).

Institutionalized Individual

The patient to be sterilized must not be an [institutionalized individual](#).

Foreign Languages

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

Persons With Disabilities

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

Presence of Witness

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

Sterilization Consent Form

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

The physician who performs the sterilization must sign the *Sterilization Consent Form* after the procedure has been performed, certifying that all Federal requirements have been met.

Hospitals and Article 28 clinics submitting claims electronically must maintain a copy of the completed *DSS-3134* in their files.

To obtain the *DSS-3134* form at no charge in English and/or Spanish, write to:

New York State Department of Health
Office of Health Insurance Programs
Governor Nelson A. Rockefeller Empire State Plaza
Corning Tower, Room 2029
Albany, New York 12237
Re: *DSS-3134 Form*

There is no order form to complete.

Your request should be on official letterhead and include the provider's name, address and the quantity of forms needed.

New York City

New York City (NYC) Local Law No. 37 of 1977 establishes guidelines to insure informed consent for sterilizations performed in New York City.

Conformance to the NYC Sterilization Guidelines is a prerequisite for payment of claims associated with sterilization procedures performed in NYC.

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

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

Reaffirmation Statement (NYC Only)

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

Hysterectomies

Federal regulations prohibit Medicaid reimbursement for hysterectomies which are:

- performed solely for the purpose of rendering the patient incapable of reproducing; or,
- if there was more than one purpose to the procedure, it would not have been performed but for the purpose of rendering the individual permanently incapable of reproducing.

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

The patient or her representative must sign Part I of the *Acknowledgement of Receipt of Hysterectomy Information Form (DSS-3113)*.

The requirement for the patient's signature on Form *DSS-3113* can be waived if:

- the woman was sterile prior to the hysterectomy;
- the hysterectomy was performed in a life-threatening emergency in which prior acknowledgement was not possible;
- the woman was not a Medicaid patient at the time the hysterectomy was performed but subsequently applied for Medicaid and was determined to qualify for Medicaid payment of medical bills incurred before her application.

For Medicaid payment to be made in these cases, the surgeon who performs the hysterectomy must certify in writing that one of the conditions existed and state the cause of sterility or nature of the emergency.

For example, a surgeon may note that the woman was postmenopausal or that she was admitted to the hospital through the emergency room, needed medical attention immediately and was unable to respond to the information concerning the acknowledgement agreement;

In cases involving retroactive eligibility, payment may be made if the surgeon certifies in writing that the woman was informed before the operation that the hysterectomy would make her permanently incapable of reproducing or that one of the conditions noted above was met.

Laboratory Services: Reimbursement Policy

Medicaid payment regulations at Title 18 NYCRR 505.7(g)(7) state that *no payment will be made on a fee-for-service basis for laboratory services when the cost of providing such services has been included in the Medicaid rate of payment for the provider of the patient care.*

Such providers include Article 28 hospitals (including hospital out-patient clinics) and free standing diagnostic and treatment centers.

Billing on a fee-for-service basis for tests already included in a facility's rate structure is considered to be a duplicate payment and, as such, will be recouped by Medicaid.

When a lab enters into an agreement or arrangement with a facility, the agreement must include the use of a system of internal controls to allow determination of whether services are billable to Medicaid or billable back to the Article 28 facility.

There are situations where one laboratory must refer specialized testing for inpatient, clinic, or ambulatory surgery patients to another lab.

In these cases, the lab making the referral must identify hospital-based patients so that the testing lab knows which services are not to be billed to Medicaid.

Finally, audits of laboratories have found that the ordering identification numbers on claims do not match those on the fiscal order forms. There have been situations where only one ordering provider identification number is indicated for all claims submitted by a laboratory.

This practice is incorrect and claims submitted in this manner may be disallowed on audit.

For proper billing procedures, please refer to the billing information section of the Laboratory Provider Manual online at

<http://www.emedny.org/ProviderManuals/Laboratory/index.html>.

Outside Care: Reimbursement Policy

When an original admitting hospital sends a Medicaid inpatient to another hospital for purposes of obtaining a diagnostic or therapeutic service not available in the admitting hospital, the original admitting hospital is responsible for the provision of those services.

Neither hospital may bill the Medicaid Program separately for these services.

The Medicaid payment for inpatient care is considered to include all procedures and services regardless of where they were performed.

The original hospital is responsible for reimbursing all other hospitals, clinics or ambulatory surgery centers which provide the services not available at the admitting hospital.

Transportation

When a Medicaid patient is admitted to a hospital, the hospital is reimbursed in their inpatient rate for all transportation services for the patient.

If the admitting hospital sends a Medicaid inpatient (round-trip) to another hospital for the purposes of obtaining a diagnostic or therapeutic service, the original admitting hospital is responsible for the provision of the transportation services and the reimbursement of the ambulance or other transportation service for the transport of the patient.

The transport will not be authorized by the local social services district. The costs of transportation are to be incurred by the hospital.

For example, Hospital A arranges for the round-trip transport to Hospital B of a Medicaid inpatient by an ambulance for a diagnostic, magnetic resonance imaging test. Hospital A should reimburse the transportation provider for the transport of the inpatient.

Section III - Basis of Payment for Services Provided

Diagnosis Related Groups: 20 Most Frequently Billed

Annually, the Bureau of Health Economics determines the 20 most frequently billed Diagnosis Related Groups (DRGs). Below is the new DRG table for Medicaid payments to New York State hospitals.

The new table is effective for discharges beginning January 1, 2007.

When payment for one of these DRGs is indicated, the remittance statement will list rate code 2996 rather than 2946.

The **Service Intensity Weight** table for New York State hospitals can be found at:

www.health.state.ny.us/nysdoh/hospital/drg/drgs.htm

Top 20 Diagnosis Related Groups: Effective discharge date January 1, 2007

DRG #	DIAGNOSIS RELATED GROUP NAME
88	CHRONIC OBSTRUCTIVE PULMONARY DISEASE
89	SIMPLE PNEUMONIA & PLEURISY AGE >17 W CC
127	HEART FAILURE & SHOCK
143	CHEST PAIN
183	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORD AGE>17 W/O CC
209	MAJ JOINT & LIMB REATTACHMENT PROCEDURE OF LOW EXT, EXC HIP, EXC FOR COMP
359	UTERINE & ADNEXA PROC FOR CA IN SITU & NONMALIGNANT W/O CC
370	CESAREAN SECTION W CC
371	CESAREAN SECTION W/O CC
372	VAGINAL DELIVERY W COMPLICATING DIAGNOSES
373	VAGINAL DELIVERY W/O COMPLICATING DIAGNOSES
494	LAPAROSCOPIC CHOLECYSTECTOMY W/O CDE W/O CC
627	NEONATE, BWT >2499G, W/O SIGNIF OR PROC, W MAJOR PROB
628	NEONATE, BWT >2499G, W/O SIGNIF OR PROC, W MINOR PROB
629	NEONATE, BWT >2499G, W/O SIGN OR PROC, W NORM NEWB DIAG
775	BRONCHITIS & ASTHMA AGE <18 W/O CC
814	NONBACTERIAL GASTROENTERITIS & ABDOMINAL PAIN AGE >17 W/O CC
854	PERCUTANEOUS CARDIOVASCULAR PROCEDURE W DRUG-ELUTING STENT W/O AMI
883	LAPAROSCOPIC APPENDECTOMY
886	OTHER ANTEPARTUM DIAGNOSES W/O O.R. PROCEDURE

Questions? Contact the Division of Medical Review and Provider Enrollment, Rate Based Provider Unit at (518) 474-8161.

Other Third Party Insurance Involved

Any third party health insurance the patient has must be billed prior to billing the Medicaid Program.

Maximum reimbursable charges will be determined by the New York State Department of Health (NYSDOH) for each voluntary, proprietary, and public hospital which is qualified to participate in the Medicaid Program. These charges are all-inclusive rates.

No extra charges will be allowed unless, under extraordinary circumstances, special items were omitted from the hospital cost statement which was used to determine the reimbursable charge.

Hospitals may only bill for days of service which were determined to be appropriate by the authorized utilization review agent.

If a patient is seen in the hospital's emergency room or outpatient clinic and is subsequently admitted to the hospital on the same day, Medicaid reimbursement will be limited to the hospital's inpatient rate. The hospital may not bill for the emergency room or clinic services provided on the day of admission.

For reimbursement purposes the date of admission, but not the date of discharge, may be counted as a day of care. In no instance will the date of discharge be reimbursable.

Out-of-State Facilities

For inpatient care provided by a hospital outside of New York State, Medicaid will reimburse for charges as billed by the hospital.

Reimbursement, however, will not exceed the Medicaid rate established for that hospital by the agency in which the hospital is located.

Payment to Salaried Physicians

Medicaid reimbursement for inpatient care by a hospital-based physician on salary is authorized if the portion of the physician's salary allocated for patient care is excluded as a cost element in the determination of the hospital's Medicaid rate.

Medicaid reimbursement to the physician for direct patient care is available if the physician is paid by the hospital for his responsibilities in such areas as research, teaching, or administration, but not for direct patient care.

In such cases, the determination of the hospital's rate should not reflect any cost for patient care by that physician.

The physician's contract with the hospital should clearly indicate that his responsibilities do not include direct patient care but are limited to other areas.

If a physician utilizes hospital resources (e.g., office equipment, personnel) to earn income from private practice, the cost of such resources should be excluded in the rate calculation.

Medicare Liability for Patients in Alternative Level of Care

Under certain circumstances, Medicare is obliged to pay for a hospitalized Medicare patient's stay when that patient is waiting for a bed to become available in a Medicare-participating skilled nursing facility (SNF).

When the Medicare patient is also Medicaid-eligible, Medicare should pay for part of the patient's care for those days during which the individual is awaiting placement in a qualified SNF.

The only exception to Medicare participation in reimbursement occurs when:

- the patient remains hospitalized while awaiting placement in a level of care other than SNF care; or
- the patient has exhausted all available Medicare days.

In these cases, Medicaid will be liable for the alternate level of care for the Medicare-Medicaid payment, if the patient has Medicaid coverage of covered medical care and services, including nursing facility services.

Hospital bills will be reviewed to determine whether an inpatient was eligible for Medicare at the time of hospitalization and that Medicare was billed for its maximum share. On all claims for patients in alternate level of care, the hospital must submit the appropriate level of care information on the electronic claim.

Medicare Payment for Non-Physician Services

Non-physician services provided to Medicare-eligible patients by entities other than the inpatient hospital must be provided by the hospital as a Part A benefit when the patient has Part A coverage.

The ancillary service provider must bill the hospital directly for any non-physician services provided to the patient.

Sometimes a Medicaid patient is not eligible for Part A or has exhausted Part A benefits but has Part B coverage. Medicaid would be billed in these cases but Medicare must also be billed for any Part B covered ancillary services.

The ancillary service provider must bill the inpatient hospital for his services and accept the hospital's payment as payment in full.

The inpatient hospital must bill Medicare for the Part B services.

If the ancillary services are included in the Medicaid per diem, Part B payments received by the hospital must be reported.

In those rare instances when the Part B service is not included in the Medicaid per diem, the hospital may bill Medicaid for the co-insurance and deductible.

Medicare Liability and Use of Medicare Lifetime Reserve

If a Medicaid/Medicare patient chooses not to use his/her lifetime reserve days, the patient is then completely responsible for payment of these days.

Reserved Bed Policies

Medicaid payments are available to reserve the bed of a patient in a SNF, health related facility (HRF) or intermediate care facility for the mentally retarded (ICF/DD) during hospitalization of that patient.

For bed reservation purposes, "hospitalization" refers to temporary stays in acute care, psychiatric or rehabilitation hospitals as a result of acute episodes in a patient's condition which cannot be treated in the SNF, HRF, ICF/DD in which the patient resides.

Hospital responsibilities under bed reservation policy during hospitalization of a SNF, HRF, or ICF/DD resident are outlined in *Hospital Memoranda 78-96* and *79-47*.

Form DSS-3074, *Status of Bed Reservation*, must be prepared for each SNF, HRF or ICF/DD patient being hospitalized. Instructions for completion of this form may be found in *Health Facilities Memorandum 79-72*.

The bed of a patient in a certified psychiatric or rehabilitation unit of a general hospital may be reserved for therapeutic leave purposes **only**. It may not be reserved in the unit if the patient is temporarily absent overnight while receiving another acute level of care service elsewhere within the same general hospital or in another medical inpatient facility.

A general hospital may claim reimbursement for bed reservation fees only for patients being cared for in psychiatric/rehabilitative units of the hospital during a therapeutic leave, but only when the requirements outlined in *Health Facilities Memorandum 78-96* are met. This document is available at the regional office of the Office of Health Systems Management, and online at:

http://www.health.state.ny.us/health_care/medicaid/publications/docs/adm/96adm1.pdf.

Policy questions regarding this matter and concerning hospital payments for SNF and HRF patients should be addressed to the New York State Office of Health Insurance Programs Division of Medical Review and Provider Enrollment.

Policy questions concerning hospitalized ICF/DD patients should be addressed to the appropriate County Service Group Office of the State Office of Mental Retardation and Developmental Disabilities.

Reimbursement for Newborn Hearing Screening Program Services

Hearing loss is the most common congenital disorder in newborns. Early detection of hearing loss during infancy, followed with appropriate early intervention, can greatly enhance the language, cognitive and social development of these infants so that they may be on par with their hearing peers.

To identify newborns with significant hearing impairment, the NYSDOH has implemented a statewide comprehensive [Newborn Hearing Screening Program](#).

Subpart 69-8 of Title 10 of the New York Codes, Rules, and Regulations was developed to implement the Program and requires all Article 28 birth institutions with more than 400 births annually to directly administer a program to screen all newborns prior to discharge.

Facilities with 400 births per year or fewer have the option to directly administer the program or refer infants born in their facility to qualified providers in their communities.

This regulation can be found at:

<http://www.health.state.ny.us/nysdoh/phforum/nycrr10.htm>.

Enhanced Reimbursement

For facilities that directly administer the Newborn Hearing Screening Program, enhanced reimbursement for Medicaid-eligible infants has been established to compensate for additional costs related to this mandated Program.

Facilities directly administering the Program may bill for the enhanced reimbursement *in addition to* the inpatient newborn DRG rate or birthing center rate.

The newborn hearing screening rate will also be available for missed initial or re-screens provided to the facility's newborns in their outpatient clinic.

Where the infant is a registered clinic patient and receives additional outpatient services, such as a well baby visit, on the same day that the outpatient newborn hearing screen is provided, same-day billings will be permitted for the newborn hearing screening rate in addition to the general clinic visit rate.

The facility may also issue a prescription for the infant to obtain the missed initial or re-screening service from another provider in the community authorized to provide infant hearing screening services.

In such circumstances, the actual provider of the referred newborn hearing screening service will be reimbursed based on the applicable New York State Medicaid Fee Schedule amount.

The rate codes will initially be made available to all Article 28 hospitals/birthing centers certified for maternity beds/maternity services and will be added only to the specific locator code site(s) where maternity services are provided.

Rate codes for facilities with 400 or fewer births per year that **elect the referral option** will subsequently be zeroed-out upon receipt of verification from the NYSDOH Early Intervention Program that the facility will not be directly administering the Program.

Such facilities will issue prescriptions for the newborn to receive the service from a qualified provider in their communities and are not eligible for the enhanced reimbursement.

The actual provider of the referred newborn hearing screen will bill for their service based on the appropriate NYS Medicaid Fee Schedule and applicable Current Procedural Terminology (CPT) code for the newborn screening service.

Any questions or concerns related to the enhanced reimbursement for newborn hearing screening services should be directed to the Bureau of Primary and Acute Care Reimbursement at:

(518) 474-3267.

Unique Situations Requiring Special Billing Procedures

The Medicaid payment system cannot process electronic claims when certain conditions apply. In these situations, the hospital can receive payment by submitting a paper claim form, Medicare and/or other third party benefit statements, and a cover letter to the Medicaid Program for processing. If approved, a separate check will be mailed to the hospital. The two-year billing rules, as described in the [Information for All Providers – General Billing Manual](#), also apply in this circumstance.

Following are situations where an "offline" payment will be processed for care provided to eligible clients:

- Patient is granted Medicaid eligibility during the inpatient stay, and the case will be paid on a DRG (diagnosis-related group) basis. In this case, a pro-rated (partial) DRG payment will be made.
- Patient is Medicaid eligible at admission and becomes Medicare eligible during the stay. In this case, Medicare will make a DRG payment based on services rendered from the first day of Medicare entitlement.
 - Medicaid will compare the Medicare-paid DRG to the Medicaid DRG (which is based on the entire stay).
 - If the DRGs differ, and the Medicaid-only payment exceeds the Medicare payment, Medicaid will pay the difference plus any Part A deductibles, coinsurance and LTR days that may be appropriate. (Please note: it may be appropriate to bill a portion of the stay electronically. You will be advised at the time your case is reviewed.)
- Partial Part A payment is denied because another partial Part A payment was made for the same spell of illness (remittance denial message 01129).

- Patient is covered by a Medicare managed care plan, and the plan leaves a patient responsibility that is greater than traditional Medicare deductibles or coinsurance amounts.

The documentation noted above should be mailed to:

New York State Department of Health
Office of Health Insurance Programs
Division of Medical Review and Provider Enrollment
150 Broadway
Albany, New York 12204

Utilization Review, Alternate Care Placement and Discharge Review Program

Hospitals shall comply with the Federal regulations regarding utilization review, including 42 CFR Part 482 and NYSDOH Regulation 405.26.

All patients admitted to units having an operating certificate granted by the New York State Division of Alcoholism and Alcohol Abuse for the operation of an acute care alcoholism program or inpatient rehabilitation program shall be subject to the admission, continuation of stay, care plan, staffing, services and discharge requirements of applicable State regulations, including 14 NYCRR Parts 374 and 381.

Hospitals are required to meet the requirements of the Hospital Discharge Review Program which provides a discharge appeal by the Independent Review Agent or (IPRA). The IPRA for Medicaid Hospital patients is the Island Peer Review Organization (IPRO).

Questions concerning utilization review, alternate level of care policies and Hospital Discharge Review Program should be directed to the NYSDOH's contracted entity, IPRO at:

IPRO (Island Peer Review Organization)
Medicaid/State Healthcare Assessment Department
1979 Marcus Avenue
Lake Success, New York 10042-1002

Telephone
(516) 326-7767 ext. 361

Section IV - Definitions

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

Hospital

A hospital is a facility or institution engaged principally in providing services by or under the supervision of a physician, for the prevention, diagnosis or treatment of human disease, pain, injury, deformity or physical condition.

The term hospital does **not** include:

- an institution, sanitarium or facility engaged principally in providing services for the prevention, diagnosis or treatment of mental disability and which is subject to the powers of visitation, examination, inspection and investigation of the Office of Mental Health except for those distinct parts of such a facility which provide hospital service; nor
- a facility or institution engaged principally in providing services by or under the supervision of the bona fide members and adherents of a recognized religious organization whose teachings include reliance on spiritual means through prayer alone for healing in the practice of the religion of such organization and where services are provided in accordance with those teachings.

Hospital Discharge

For purposes of payment under the case-based payment system, an inpatient shall be defined as discharged when the patient's admission to the facility occurred on or after January 1, 1988, and:

- the patient is released from the facility to a non-acute care setting;
- the patient dies in the facility;
- the patient is transferred to a facility or unit that is exempt from the case-based payment system, except when the patient is a newborn transferred to an exempt hospital for neonatal services. Such infants shall be classified as transfer patients; or
- it is a neonate being released from a hospital providing neonatal specialty services back to the community hospital of birth for weight gain.

Hospital Transfers

A transfer patient shall be defined for purposes of transfer payments as a patient who:

- is not discharged;
- is not transferred among two or more divisions of merged or consolidated facilities;

- is not assigned to a Diagnosis Related Group (DRG) specifically identified as a DRG for transferred patients only, and
- who meets one of the following conditions:
 - is transferred from an acute care facility reimbursed under the DRG case-based payment system to another acute care facility reimbursed under this system;
 - is transferred to an out-of-state acute care facility; or
 - is a neonate who is being transferred to an exempt hospital for neonatal services.

Transfers shall include, but not be limited to, transfers between more than two acute care facilities, and transfers from those hospitals excluded from the DRG case-based payment system because of participation in an approved Medicaid cost control program or demonstration, to a hospital reimbursed pursuant to the DRG case-based payment system.

Inpatient

An inpatient is an individual who has been admitted to a hospital on the recommendation of a physician or dentist and is receiving room, board, and professional services in the hospital where patients generally stay overnight.

Inpatient Hospital Services

Inpatient hospital services are those items and services, provided under the direction of a physician or dentist, ordinarily furnished by the hospital for the care and treatment of inpatients. Included in such services are:

- the room,
- dietary and nursing services,
- minor medical and surgical supplies and
- the use of certain equipment and facilities for which the hospital does not customarily make a separate charge.

Institutionalized Individual

An institutionalized individual refers to one who is either:

- involuntarily confined or detained under a civil or criminal statute, in a correctional or rehabilitative facility, including a mental hospital or other facility for the care and treatment of a mental illness; or

- confined under a voluntary commitment, in a mental hospital or other facility for the care and treatment of mental illness.

Medically Incompetent Individual

A mentally incompetent individual refers to an individual who has been declared mentally incompetent by a Federal, State or Local court of competent jurisdiction for any purposes unless the individual has been declared competent for purposes which include the ability to consent to sterilization.

Medically Necessary Services

Medically necessary services are those necessary to prevent, diagnose, correct or cure conditions in a person that:

- cause acute suffering,
- endanger life,
- result in illness or infirmity,
- interfere with his/her capacity for normal activity or threaten some significant handicap and
- which are furnished an eligible person in accordance with the regulations of the Department.

**NEW YORK STATE
MEDICAID PROGRAM**

INPATIENT HOSPITAL

BILLING GUIDELINES

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Section I – Purpose Statement

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

- Billing and submitting claims
- Interpreting and using the information returned in the Medicaid Remittance Advice

This document is customized for 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 that **must** be used in every electronic transaction submitted to NYS Medicaid. ETINs may be issued to an individual provider or provider group (if they are direct billers) and to service bureaus or clearinghouses.

The ETIN application is available at www.emedny.org by clicking on the link to the web page below:

[Provider Enrollment Forms](#)

Certification Statement

All providers, either direct billers or those who 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
- 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.

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)

Inpatient Hospital Billing Guidelines

TERM	DEFINITION
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
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:

$$\text{CPD (x) SIW (+) Capital add on} = \text{payment amount}$$

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

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

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

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

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

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

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

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** has covered 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** has not covered the claim, **Medicare Part B patient responsibility** will not be paid and the **Medicare Part B payment** must be reported and deducted 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.

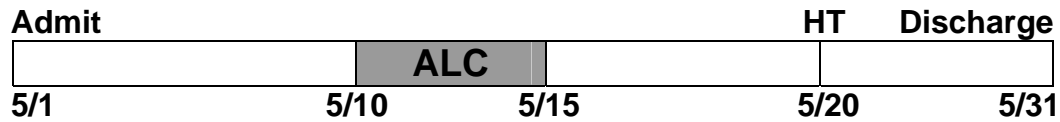
The DRG claim will have an occurrence span code 75 with the date range of each of the ALC time periods.

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



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



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

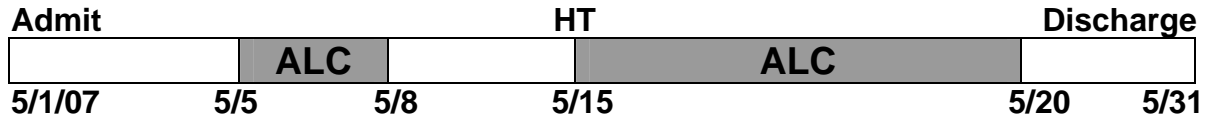
The ALC claim must be submitted with from – through dates (5/10 to 5/21). The ALC claim must also contain the occurrence span code 75 with the date span the patient was on ALC.

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



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 not 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)

Inpatient Hospital Billing Guidelines

- 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).



TO: DOWNTOWN HOSPITAL

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

07080600001 2007-08-06
 DOWNTOWN HOSPITAL
 123 FIRST ST
 ANYTOWN NY 11111

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

29
2

DATE	REMITTANCE NUMBER	PROVIDER ID/NPI
2007-08-06 <small>VOID AFTER 90 DAYS</small>	07080600001	00234567/0123456789

DOLLARS/CENTS
PAY \$****12000.00

TO
THE
ORDER
OF

07080600001 2007-08-06
 DOWNTOWN HOSPITAL
 123 FIRST ST
 ANYTOWN NY 11111



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

* Provider ID/NPI

CENTER

Remittance number/date

Provider's name/address

Medicaid Check

LEFT SIDE

Table

Date on which the check was issued

Remittance number

* Provider ID/NPI

Remittance number/date

Provider's name/address

RIGHT SIDE

Dollar amount. This amount must equal the Net Total Paid Amount under the Grand Total subsection plus the total sum of the Financial Transaction section.

*** Note: NPI has been included on all examples and is pending NPI implementation by NYS Medicaid.**

Section One – EFT Notification

For providers who have selected electronic funds transfer (or direct deposit), an EFT transaction is processed when the provider has claims approved during the cycle and the approved amount is greater than the recoupments, if any, scheduled for the cycle. This section indicates the amount of the EFT.

TO: DOWNTOWN HOSPITAL



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

07080600001 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

* Provider ID/NPI

CENTER

Remittance number/date

Provider's name/address

Provider's Name – Amount transferred to the provider's account. This amount must equal the Net Total Paid Amount under the Grand Total subsection plus the total sum of the Financial Transaction section.

Section One – Summout (No Payment)

A summout is produced when the provider has no positive total payment for the cycle and, therefore, there is no disbursement of moneys.



TO: DOWNTOWN HOSPITAL

DATE: 08/06/2007
REMITTANCE NO: 07080600001
PROVIDER ID/NPI: 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

* Provider ID/NPI

CENTER

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

Provider name and address

Section Two – Provider Notification

This section is used to communicate important messages to providers.



PAGE 01
DATE 08/06/07
CYCLE 1563

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

ETIN:
PROVIDER NOTIFICATION
PROVIDER ID/NPI 00234567/0123456789
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**

* Provider ID/NPI

Remittance number

CENTER

Message text

Inpatient Hospital Billing Guidelines

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

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

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

ETIN:
INPATIENT
PROVIDER ID/NPI: 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	OUT	TOT	COVERAGE BASE	CO-PAY	OTHER INSURANCE PAID	STATUS	ERRORS
				RATE CODE	PAY TYPE	DAYS DRG CODE					
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 00162
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

Inpatient Hospital Billing Guidelines



PAGE 03
DATE 08/06/07
CYCLE 1563

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

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

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

PATIENT CONTROL NO DATE	CLIENT NAME ID NUMBER	ICN MEDICAL RECORD NUMBER	SERVICE DATES FROM THRU	COV'D	OUT	TOT	COVERAGE BASE	CO-PAY	OTHER INSURANCE PAID	STATUS	ERRORS
				DAYS	DAYS	DAYS					
				RATE	PAY	DRG					
				CODE	TYPE	CODE					
CPIC1563324 05/25/07	WAYTKUS SS44444P	07230-00000315-2-0 00000587672IH03	05/25/07 05/27/07	2	0	0	4000.00	25.00	0.00	PAID	
CPIC1768935 05/25/07	GOUGH GG44444L	07231-00000441-2-0 00000587672IH03	05/25/07 05/30/07	5	0	0	4000.00	25.00	0.00	PAID	
CPIC1667792 05/25/07	ABRAHAM BB88888S	07245-00000049-2-0 00000587672IH03	05/25/07 05/30/07	5	0	0	4000.00	0.00	0.00	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	PAID	0.00	NUMBER OF CLAIMS	0

Inpatient Hospital Billing Guidelines



PAGE 04
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
PROVIDER ID/NPI: 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 05/25/07	PROUST XX99999V	07230-000000315-2-0 000000587672IH03	05/25/07 05/26/07	0 2959	0 C	0 0122	4000.00	25.00	0.00	PEND	00162
CPIC196969685 05/25/07	WELBY KK99999N	07231-000000441-2-0 000000587672IH03	05/25/07 05/30/07	0 2959	0 C	0 0088	4000.00	25.00	0.00	PEND	00142
CPIC183211677 05/25/07	SHEEHAN WW66666G	07245-000000049-2-0 000000587672IH03	05/25/07 05/30/07	0 2959	0 C	0 0296	4000.00	0.00	0.00	PEND	00144

* = 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

Inpatient Hospital Billing Guidelines



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

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

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

ETIN:
INPATIENT
GRAND TOTALS
PROVIDER ID/NPI: 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**

* Provider ID/NPI

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)

Inpatient Hospital Billing Guidelines

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 CYCLE 1563		
TO: DOWNTOWN HOSPITAL BUSINESS OFFICE 123 FIRST STREET ANYTOWN, NEW YORK 11111	MEDICAL ASSISTANCE (TITLE XIX) PROGRAM REMITTANCE STATEMENT	ETIN: FINANCIAL TRANSACTIONS PROVIDER ID/NPI: 00234567/0123456789 REMITTANCE NO: 07080600001		
FCN	FINANCIAL REASON CODE	FISCAL 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.

Inpatient Hospital Billing Guidelines

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.



MANAGEMENT
INFORMATION SYSTEM

MEDICAL ASSISTANCE (TITLE XIX) PROGRAM REMITTANCE STATEMENT

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

PAGE 08
DATE 08/06/07
CYCLE 1563

ETIN:
ACCOUNTS RECEIVABLE
PROVIDER ID/NPI: 00234567/0123456789
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.



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DATE 08/06/07
CYCLE 1563

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

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

ETIN:
INPATIENT
EDIT DESCRIPTIONS
PROVIDER ID/NPI: 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:

[Edit / Error Knowledge Base](#)

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.

[eMedNY Crosswalk](#)

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.

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

Patient Identification

Field 1

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

Consent To Sterilization

Field 2

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.

Field 3

Enter the name of sterilization procedure to be performed.

Field 4

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.

Field 5

Enter the patient's name.

Field 6

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).

Field 7

Enter the name of sterilization procedure.

Field 8

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.

Inpatient Hospital Billing Guidelines: Appendix C

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	5. DATE	6. INTERPRETER'S SIGNATURE (If required)	7. DATE
X		X	

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	9. DATE
X	

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	15. DATE
X	

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).

Inpatient Hospital Billing Guidelines: Appendix D

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 than 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.

Inpatient Hospital Billing Guidelines: Appendix D

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.

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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.

Out-of-State Hospital Admissions Require Prior Approval

Admission to out-of-state hospitals and facilities for non-emergency services for New York State Medicaid clients require prior approval. Otherwise, Medicaid eligible individuals should obtain medical care and services from qualified providers located in New York State. There is no standard request form. Requests should be made in written letter format and sent to the State Health Department. The letter should be from the client's in-state referring physician and include a list of in-state hospitals contacted and reasons why in-state admission could not be arranged. Upon approval, the out-of-state hospital provider will receive a prior approval number, which will need to be included on any subsequent claim submissions associated with the service provided. Please direct prior approval requests as follows:

NYSDOH Bureau of Medical Review and Payment
Medical Prior Approval Unit
150 Broadway, Suite 6E
Albany, NY 12204-2736

(800) 342-3005
(518) 473-6708 (fax)