NEW YORK STATE
MEDICAID PROGRAM

MANAGED CARE REFERENCE GUIDE:
CLAIM SUBMISSION

TABLE OF CONTENTS

Section I – Purpose Statement

The purpose of this document is to assist participating managed care organizations in understanding and complying with the New York State Medicaid (NYS-Medicaid) requirements and expectations for billing.

The guide addresses the following subjects:

- Pre-paid Capitation Billing
- Remittance Statements

This document is customized for managed care providers as an instructional as well as a reference tool.

Section II –Claim Submission

Managed care organizations can submit their claims to NYS-Medicaid in electronic or paper formats.

Electronic Claims

The New York State Department of Health, Office of Medicaid Management has mandated the use of the HIPAA compliant ASC X12N 837 Institutional (837I) for premium billing to NYS Medicaid by Managed Care Organizations (MCOs).

In addition to this Reference Guide, it is recommended that managed care organizations obtain the following documents, all of which are available for free download.

- HIPAA 837I Implementation Guide (IG) – A document that 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) – A subset of the IG, which provides instructions for the specific requirements of NYS Medicaid for the 837I. This document is available at www.emedny.org.

✓ Select **NYHIPAADESK** from the menu

✓ Click on **eMedNY Phase II HIPAA Transactions**

✓ Look for the box labeled “837 Institutional Health Care Claim Transaction” and click on the link for the **837 Institutional Companion Guide**

- NYS Medicaid Technical Supplementary Companion Guide – This document provides technical information needed to successfully transmit and receive electronic data. Some of the topics put forth in this CG are testing requirements, error report information, and communication specifications. The Technical Supplementary CG is available at www.emedny.org.

✓ Select **NYHIPAADESK** from the menu

✓ Click on **eMedNY Phase II HIPAA Transactions**

✓ Look for the box labeled “Technical Guides” and click on the link for the **Technical Supplementary CG**

Pre-requirements for Submission of Electronic Claims

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

- An Electronic Transmitter Identification Number (ETIN)
- A Certification Statement
- A User ID and Password
- A Trading Partner Agreement
- Testing

ETIN
This is a four-character submitter identifier, issued by the NYS Medicaid Fiscal Agent, Computer Sciences Corporation (CSC), upon application and 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.

ETIN applications are available at www.emedny.org.

✓ Click on **Provider Enrollment Forms** under "Information"

✓ Click on **Electronic Transmitter Identification Number**

Certification Statement
Managed care organizations, 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 at www.emedny.org together with the ETIN application.

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.

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 under HIPAA.

Testing

Direct billers are encouraged to submit production tests to CSC before they start submitting Medicaid claims for the first time after enrollment or any time they update their systems or start using a new system. This testing will assist providers in identifying errors in their system and allow for corrections before they submit actual claims.

Information and instructions regarding testing are available at www.emedny.org.

✓ Click on **eMedNY Phase II** under "Information"

✓ Click on **eMedNY Provider Testing User Guide**

Communication Methods

The following communication methods are available for submission of electronic claims to NYS-Medicaid:

- eMedNY eXchange
- FTP
- eMedNY Gateway

eMedNY eXchange

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

The eMedNY eXchange accepts files no larger than 10 megabytes. Options for managed care plans submitting files larger than 10 MB are to:

✓ Send them as multiple, smaller files through the eMedNY eXchange,

or

✓ Send files using file transfer protocol (FTP). Plans that want to use FTP must contact CSC to sign up for FTP: 800-343-9000.

Access to the eMedNY eXchange is obtained through an enrollment process. Procedures and instructions regarding how to enroll into the eMedNY eXchange are available at www.emedny.org.

FTP
FTP allows for direct or dialup connection.

eMedNY Gateway
This is a dialup access method. It requires the use of the User ID assigned at the time of enrollment and a password.

Note: For questions regarding FTP or eMedNY Gateway connections call CSC-Provider Enrollment Support at 800-343-9000.

ePACES
Additionally, NYS-Medicaid provides ePACES, 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.

To use ePACES, managed care organizations must complete an enrollment process, which is available at www.emedny.org. Managed care organizations that enroll in ePACES will be automatically enrolled in eMedNY eXchange.

The requirements for using ePACES include:

- An ETIN and Certification Statement are required for enrollment.
- Internet Explorer 4.01 or above or Netscape 4.7 or 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
- 837 – Dental, Professional and Institutional Claims

NYS Medicaid Premium Billing Using the 837 Institutional

Electronic Claims
The 837 Institutional as used for billing consists of a subset of the loops, segments, and data elements supported by the full implementation. Included in this Guide are a sample de-identified transaction and a mapping matrix in Appendices A and B.

Rate Codes and Revenue Codes
The format of an 837 Institutional claim submitted by a Managed Care Plan is the same as for any other Rate Based claim. The Rate Code, reported in loop 2300, Value Information HI segment, determines the payment amount.

The example provided below uses a Capitation Rate Code of 2210. This is the default Rate Code for premium billing. There are several other Capitation Rate Codes. Only the Rate Code assigned by the New York State Department of Health, Office of Medicaid Management may be used.

HI*BE:24:::2210~
The 837 Institutional requires a Revenue Code in loop 2400, SV2 segment.

Using the Rate Code 2210 requires a Revenue Code in the 010X range and this in turn requires the SV206 element. Because capitation is for a full month, the units reported in SV205 should be '1'. The SV206 Service Line Rate (Unit Charge Amount) and SV203 Line Charge Amount should be equal.

To be completely accurate, managed care plans should populate SV206 with the rate they receive for the Rate Code used. However, since reimbursement is determined by the Rate Code itself and not by the charge amount this is not critical as long as SV203 divided by SV205 equals SV206 (line charge divided by units = unit charge).

Administratively, each plan submits a claim (one per every client enrolled in the plan) at the beginning of each month with a Date of Service of the 1st of the month. This is paid at the monthly premium payment due rate.

Additionally, managed care plans can submit Stop Loss and Newborn Delivery Charge rate codes, as needed.

- Stop Loss claims have Rate Codes, which cause claims to be pended to NYSDOH for pricing.

- Newborn Delivery Charge claims have a unique Rate Code, which pays according to the associated rate on file. No pricing is necessary.

Please refer for further information to the following FAQ documents, located at www.emedny.org. Click on NYHIPAADESK, where you will find:

- "Rate Codes and Rate-Based Claims"
- The updated "Rate Code Crosswalk"

Diagnosis Code
The Principal, Admitting, or E-Diagnosis segment (HI*BK in loop 2300) is required by the HIPAA implementation as described in the 837I Implementation Guide. It is an optional segment in a non-HIPAA-regulated transaction. It is permissible to use ICD-9 code 799.9 - Other Unknown and Unspecified Cause. Because the decimal point is not sent in the 837, populate the HI01-2 sub-element with a value of '7999'.

Procedure Code
The Procedure Code in loop 2400, SV202-2 is not needed for capitation premium billing. The Principal Procedure Code segment (HI*BR) in loop 2300 is also not needed.

Type of Bill
There is no value from the Type of Bill code list published in the UB-92 manual by the National Uniform Billing Committee that accurately describes a Managed Care Capitation claim. It is permissible to use a value of 89, Special Facility, Other in this data element.

ISA-IEA and GS-GE Envelopes

- ISA08 and GS03 should contain 'EMEDNYBAT'.
- ISA06 and GS02 should contain the plan's ETIN.

NYSDOH has posted a Frequently Asked Question (FAQ) document. This document, available at www.emedny.org, is entitled, "ISA and GS Segments – How do I create the X12 envelope information for NYSDOH?"

Coordination of Benefits and Prior Payers
Because premium billing for capitation is not a bill for a specific medical service, the Coordination of Benefits loops and segments are not relevant. Loops 2320, 2330A, 2330B, and 2430 are not needed. Similarly, the Patient Participation amount is not needed (loop 2300, AMT*F5).

Additional Resources
A mapping of Claim Form A for managed care organization billing to the 837 Institutional is included in Appendix B of this Guide. The mapping shows the relationship of the data in Claim Form A to data in the 837I relevant to billing NYS-Medicaid managed care claims.

Paper Claims

Managed care organizations that choose to submit their claims on paper forms must use the CMS- standard UB-92 claim form. A link to this form appears at the end of this subsection.

General Instructions for Completing Paper Claims
Since the information entered on the claim form is captured via an automated data collection process (imaging), it is imperative that it be legible and placed appropriately in the required fields. The following guidelines will help ensure the accuracy of the imaging output:

- All information should be typed or printed.
- Alpha characters (letters) should be capitalized.
- Numbers should be written as close to the example below as possible:

1 2 3 4 5 6 7 8 9 0

- Circles (the letter O, the number 0) must be closed.
- Avoid unfinished characters. For example:

Written As	Intended As	Interpreted As	
6.00	6.00	6.60	Zero interpreted as six

- When typing or printing, stay within the box where provided; ensure that no characters (letters or numbers) touch the claim form lines. For example:

Written As	Intended As	Interpreted As	
2	2	7	Two interpreted as seven
3	3	2	Three interpreted as two

- Characters should not touch each other. Example:

Written As	Intended As	Interpreted As	
	23	illegible	→ Entry cannot be interpreted properly

- Do not write between lines.
- Do not use arrows or quotation marks to duplicate information.
- Do not use the dollar sign ($) to indicate dollar amounts; do not use commas to separate thousands. For example, three thousand should be entered as 3000, not as 3,000.
- For writing, it is best to use a felt tip pen with a fine point. Avoid ballpoint pens that skip; do not use pencils, highlighters, or markers. Only blue or black ink is acceptable.
- If filling in information through a computer, ensure that all information is aligned properly, and that the printer ink is dark enough to provide clear legibility.
- Do not submit claim forms with corrections, such as information written over correction fluid or crossed out information. If mistakes are made, a new form should be used.
- Separate forms using perforations; do not cut the edges.
- Do not fold the claim forms.
- Do not use adhesive labels (for example for address); do not place stickers on the form.
- Do not write or use staples on the barcode area.

If submitting multiple claim forms, they may be batched up to 100 forms per batch. Use paper clips or rubber bands to hold the claim forms in each batch together. Do not use staples.

The address for submitting claim forms is:

COMPUTER SCIENCES CORPORATION
P.O. Box 4601
Rensselaer, NY 12144-4601

UB-92 Claim Form

To view the UB-92 claim form please click on the link provided below. The displayed claim form is a sample and the information it contains is for illustration purposes only.

Sample Claim-UB92-Managed Care

General Information About the UB-92 Form

The UB-92 HCFA-1450 is a CMS standard form; therefore CSC does not supply it. These forms can be obtained from any of the national suppliers.

The UB-92 Manual (National Uniform Billing Data Element Specifications as Developed by the National Uniform Billing Committee – Current Revision) should be used in conjunction with this Provider Manual as a reference guide for the preparation of claims to be submitted to NYS Medicaid.

The unlabeled fields in this claim form, with the exception of Fields 1 and 37, have no NYS Medicaid application; therefore instructions for using these fields (2, 11, 31, 38, 49, 56, 57, and 78) are not provided.

The labeled fields listed below have no NYS Medicaid application; therefore instructions for using these fields are not provided:

Fields 5, 10, 13, 16-18, 20, 21, 23, 36, 44, 45, 48, 52–55, 58, 59, 61, 62, 64–66, 76, 77, 79-81, and 84.

Pre-Paid Capitation Billing Instructions

This subsection of the Billing Guidelines covers the specific requirements for managed care organizations submitting capitation or premium claims to New York State Medicaid. Although the instructions that follow are based on the UB-92 paper claim form, they are also intended as a guideline for electronic billers who should refer to these instructions for information and codes they need to provide in their claims, etc.

It is important that the Plans adhere to the instructions outlined below. Claims that do not conform to the eMedNY requirements as described throughout this document may be rejected, pended, or denied.

Field-by-Field (UB-92) Instructions

PROVIDER NAME, ADDRESS, AND TELEPHONE NUMBER (Form Locator 1)

Enter the billing plan's name and correspondence address.

Note: It is the responsibility of the plan to notify Medicaid of any change of address or other pertinent information within 15 days of the change. For information on where to direct address change requests, please refer to the Inquiry section of this document.

PATIENT CONTROL NO. (Form Locator 3)

For record-keeping purposes, managed care plans may choose to identify a recipient by using an account/patient control number. This field can accommodate up to 20 alphanumeric characters. If an account/patient control number is indicated on the claim form, it will be returned on the Remittance Advice. Using an account/patient control number can be helpful for locating accounts when there is a question on recipient identification.

TYPE OF BILL (Form Locator 4)

Completion of this field is required. All entries in this field must contain three digits. Each digit identifies a different category as follows:

- 1st Digit – Type of Facility
- 2nd Digit – Bill Classification
- 3rd Digit – Frequency

Type of Facility
The source of this code is the UB-92 Manual, Form Locator 4, Type of Facility category.

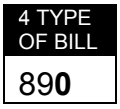
Bill Classification
The source of this code is the UB-92 Manual, Form Locator 4, Bill Classification category.

4 TYPE OF BILL
89X

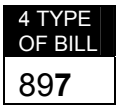
Frequency - Adjustment/Void Code

The third position of this field identifies whether the claim is an original, a replacement (adjustment), or a void.

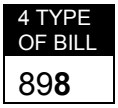
- If submitting an original claim, enter the value 0 in the third position of this field.



- If submitting an adjustment (replacement) to a previously paid claim, enter the value 7 in the third position of this field.



- If submitting a void to a previously paid claim, enter the value 8 in the third position of this field.



STATEMENT COVERS PERIOD FROM/THROUGH (Form Locator 6)

Only **one** date of service may be billed per claim form. Enter the date in the FROM box. The THROUGH box may contain the same date or be left blank. Dates must be entered in the format MMDDYY.

Note: Claims must be submitted within 90 days from the date of service entered on the claim.

COV D. [COVERED DAYS] (Form Locator 7)

Leave this field blank.

N-CD. [NON-COVERED DAYS] (Form Locator 8)

Leave this field blank.

C-ID. [COINSURANCE DAYS] (Form Locator 9)

Leave this field blank.

PATIENT NAME (Form Locator 12)

Enter the patient's last name followed by the first name.

BIRTHDATE (Form Locator 14)

Enter the patient's birth date. The birth date must be in the format MMDDYYYY.
Example: Mary Brandon was born on March 5, 1975. Enter the birth date thusly:

14 BIRTHDATE
03051975

SEX (Form Locator 15)

Enter **M** for male or **F** for female to indicate the patient's sex.

ADMISSION TYPE (Form Locator 19)

Leave this field blank.

STAT [PATIENT STATUS] (Form Locator 22)

Leave this field blank.

CONDITION CODES (Form Locators 24–30)

Leave these fields blank.

OCCURRENCE CODE/DATE (Form Locators 32–35)

Leave these fields blank.

UNLABELED [ORIGINAL CLAIM REFERENCE NUMBER] (Form Locator 37 A, B, C)

If submitting an **Adjustment (Replacement)** or a **Void** to a previously paid claim, this field must be used to enter the **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 this field, the third position of Form Locator 4, Type of Bill, must be 7 or 8.

- The TCN must be entered on line A.
- When submitting an original claim, leave this field blank.

Adjustments

An adjustment is submitted to correct one or more fields of a previously paid claim. Any field, except the **Plan ID Number** or the **Patient's Medicaid ID Number**, can be adjusted. The adjustment must be submitted in a new claim form (copy of the original form is unacceptable) and all applicable fields must be completed. An adjustment is identified by the value **7** in the **third position of Form Locator 4**, Type of Bill, and the claim to be adjusted is identified by the TCN entered in this field (Form Locator 37).

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. The void must be submitted in a new claim form (copy of the original form is unacceptable) and all applicable fields must be completed. A void is identified by the value **8** in the **third position of Form Locator 4**, Type of Bill, and the claim to be voided is identified by the TCN entered in this field (Form Locator 37)

Voids cause the cancellation of the original claim history records and payment.

VALUE CODES (Form Locators 39–41)

NYS Medicaid uses Value Codes to report the following information:

- Locator Code (required)
- Rate Code (required)

Value Codes have two components: Code and Amount. The Code component is used to indicate the type of information reported. The Amount component is used to enter the information itself. Both components are required for each entry.

Locator Code – Value Code 61
Locator Codes are assigned to the plan for each service address from which the service is rendered. Locator Codes range from 001 through 020. Locator Codes 001 and 002 are for administrative use only and are not to be entered in this field.

Value Code

Code **61** should be used to indicate that a Locator Code is entered under Amount.

Value Amount

Entry must be three digits and must be placed to the left of the dollars/cents delimiter.

Locator codes are three-digit codes. To comply with eMedNY billing requirements, plans must enter ana additional zero to the left of these two-digit codes previously used to indicate locator code. For example, Locato Code 03 must be entered as 003.

Enter Value Code 61 followed by appropriate Locator Code in the Amount field as illustrated in the example below:

	39. CODE	VALUE CODES AMOUNT	
a	61	003	.
b			.
c			.
d			.

Note: Managed Care plans are reminded of the obligations to nofity Medicaid of all service locations as well as changes to any of them. For Information on where to direct Labor Code updates,please refer to the Inquiry section.

Rate Code - Value Code 24
Rates are established by the Department of Health. At the time of enrollment in Medicaid, plans receive notification of the rate codes and rate amounts assigned to their category of service. Any time that rate codes or amounts change, providers also receive notification from the Department of Health.

Value Code
Code **24** should be used to indicate that a rate code is entered under Amount.

Value Amount
Enter the rate code that applies to the service rendered. The four-digit rate code must be entered to the left of the dollars/cents delimiter.

The example below illustrates a correct Rate Code entry.

	39. CODE	VALUE CODES AMOUNT	
a	24	2210	.
b			.
c			.
d			.

REV. CD. [REVENUE CODE] (Form Locator 42)

NYS Medicaid uses Revenue Codes to report the Total Amount Charged.

Total Amount Charged
Use Revenue Code **0001** to indicate that total charges for the services being claimed in the form are entered in Form Locator 47.

SERV. UNITS (Form Locator 46)

Leave this field blank.

TOTAL CHARGES (Form Locator 47)

Enter the total amount charged for the service(s) rendered on the lines corresponding to Revenue Code 0001. Both sections of the field (dollars and cents) must be completed; if the charges contain no cents, enter **00** in the cents box.

Example:

42 REV. CD.	43 DESCRIPTION	44 HCPCS/RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
0001					3000●00	.	

PAYER (Form Locator 50 A, B, C)

Enter the word Medicaid on line A of this field. Leave lines B and C blank.

PROVIDER NO. (Form Locator 51)

The Medicaid Plan ID Number is the eight-digit identification number assigned to Plans at the time of enrollment in the Medicaid program.

Enter the Medicaid Provider ID Number on line A.

CERT. - SSN - HIC - ID NO. (Form Locator 60)

Enter the patient's Medicaid ID number (Client ID Number) indicated on the roster compiled by the State Department of Health for the Plans. Medicaid Client ID numbers are assigned by the State of New York and are composed of eight characters in the format AANNNNNA, where A = alpha character and N = numeric character.

The Medicaid ID should be entered on line A.

TREATMENT AUTHORIZATION CODES (Form Locator 63)

Leave this field blank.

PRIN. DIAG. CD. (Form Locators 67–75)

Leave this field blank.

ATTENDING PHYS. ID (Form Locator 82)

Leave this field blank.

OTHER PHYS. ID (Form Locator 83)

Leave this field blank.

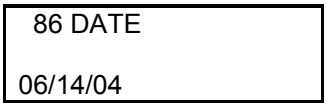
PROVIDER REPRESENTATIVE (Form Locator 85)

An authorized Plan representative must sign the claim form. Rubber-stamp signatures are not acceptable.

DATE BILL SUBMITTED (Form Locator 86)

Enter the date on which the provider's authorized representative signed the claim form. The date should be in the format MM/DD/YY.

Example: June 14, 2004



Note: In accordance with New York State regulations, claims must be submitted within 90 days of the Date of Service unless acceptable circumstances for the delay can be documented. For more information about billing claims over 90 days or two years from the Date of Service, refer to Information for All Providers, General Billing section.

Inpatient Newborn Delivery Claims

Claims for inpatient newborn delivery are processed and paid according to the usual processing cycle at CSC. Costs for inpatient newborn delivery are excluded from the monthly capitation reimbursement for newborns.

The rate code for newborn delivery claims is 2298. The service date must be the same as the date of birth.

The claim will appear on the Medicaid remittance for the cycle (week) in which it is processed.

Section III – Remittance Advice

The purpose of this section is to familiarize the provider with the design and contents of the Remittance Advice.

eMedNY produces remittance advices on a weekly (processing cycle) basis. Weekly remittance advices contain the following information:

- A listing of all claims (identified by several pieces of information as submitted on the claim) that have entered the computerized processing system during the corresponding cycle.
- The status of each claim (deny/paid/pend) after processing.
- The eMedNY edits (errors) failed by pending or denied claims.
- Subtotals (by category, status, locator code, and member ID) and grand totals of claims and dollar amounts.
- Other financial information such as recoupments, negative balances, etc.

The remittance advice, in addition to showing a record of claim transactions, can assist providers in identifying and correcting billing errors and plays an important role in the communication between the provider and the Fiscal Agent 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 HIPAA 835 Transaction Request form, which is available at www.emedny.org.

Under Information:

✓ Click on **Provider Enrollment Forms**

✓ Click on **HIPAA 835 Transaction Request Form**

For additional information, providers may also call CSC-Provider Enrollment Support at 800-343-9000.

The electronic HIPAA 820 transaction (Remittance Advice) is available via the eMedNY eXchange or FTP. To request the electronic remittance advice (820) managed care plans may call CSC-Provider Enrollment Support at 800-343-9000 or complete the HIPAA 820 Transaction Request form, which is available at www.emedny.org, and mail it to the address indicated on the form.

The NYS-Medicaid Companion Guide for the 820 transaction is available at www.emedny.org.

Plans submitting claims under multiple ETINs receive a separate 820 for each ETIN and a separate check for each 820. Also, any 820 transaction can contain a maximum of ten thousand (10,000) claim lines; any overflow will generate a separate 820 and a separate check.

Plans that choose to receive the 820 electronic remittance advice will receive adjudicated claims (paid/denied) detail for their electronic claim submissions in this format. Retro-adjustment information is also sent in the 820 transaction format. Pending claims do not appear in the 820 transaction; they are listed in the Proprietary Supplemental file.

Paper Remittance Advice

Remittance advices are also available on paper. Plans billing electronically that do not specifically request to receive the 820 transaction are sent paper remittance advices. Providers who bill all of their claims on paper forms can only receive paper remittance advices.

Remittance Sorts

The default sort for the paper remittance advice is: Claim Status (denied, paid, pending) – Patient ID – TCN. Plans 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 Remittance Sort Request form, available at www.emedny.org and mail it to the address indicated on the form.

Under Information:

✓ Click on **Provider Enrollment Forms**

✓ Click on **Paper Remittance Sort Request**

For additional information, providers may also call CSC-Provider Enrollment Support at 800-343-9000.

Remittance Advice Format

The remittance advice is composed of five sections as described below.

- Section One may be one of the following:
  - ► Medicaid Check
  - ► Notice of Electronic Funds Transfer
  - ► Summout (no claims paid)
- Section Two: Provider Notification (special messages)
- Section Three: Claim Detail
- Section Four
  - ► Financial Transactions (recoupments)
  - ► Accounts Receivable (cumulative financial information)
- Section Five: Edit (Error) Description

Explanation of Remittance Advice Sections

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

The following information applies to a remittance advice with the default sort pattern.

Section One – Medicaid Check

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

MEDICAID MANAGEMENT INFORMATION SYSTEM

TO: CITY MANAGED CARE PLAN

DATE: 2005-05-06
REMITTANCE NO: 05050900001
PROVIDER ID: 00111234

05050900001 2005-05-06
CITY MANAGED CARE PLAN
111 MAIN ST
ANYTOWN NY 11111

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

29
2

DATE	REMITTANCE NUMBER	PROVIDER ID NO.
2005-05-09 VOID AFTER 90 DAYS	05050900001	00111234

PAY

DOLLARS/CENTS
$******3306.59

TO THE ORDER OF
05050900001 2005-05-09
CITY MANAGED CARE PLAN
111 MAIN ST
ANYTOWN NY 11111

MEDICAID MANAGEMENT INFORMATION SYSTEM

John Smith
AUTHORIZED SIGNATURE

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

Section One – EFT Notification

For Plans that 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 that the recoupments (if any) scheduled for the cycle. This section indicates the amount of the EFT.

TO: CITY MANAGED CARE PLAN

DATE: 2004-08-0
REMITTANCE NO: 05050900001
PROVIDER ID: 00111234

05050900001 2005-05-09
CITY MANAGED CARE PLAN
111 MAIN STREET
ANYTOWN NY 11111

CITY MANAGED CARE PLAN $3306.59

PAYMENT IN THE ABOVE AMOUNT WILL BE DEPOSITED VIA AN ELECTRONIC FUNDS TRANSFER.

Information on the EFT Notification Page

UPPER LEFT CORNER
Plan name (as recorded in the Medicaid files)

UPPER RIGHT CORNER
Date on which the remittance advice was issued
Remittance number
Plan ID number

CENTER
Remittance number/date
Plan name/address

Plan Name – Amount transferred to the Plan'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 plan has no positive total payment for the cycle and, therefore, there is no disbursement of moneys.

TO: CITY MANAGED CARE PLAN
111 MAIN ST
ANYTOWN NY 11111

DATE: 05/06/2005
REMITTANCE NO: 05050900001
PROVIDER ID: 00111234

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

CITY MANAGED CARE PLAN
111 MAIN ST
ANYTOWN NY 11111

Information on the Summout Page

UPPER LEFT CORNER
Plan Name (as recorded in Medicaid files)

UPPER RIGHT CORNER
Date on which the remittance advice was issued
Remittance number
Plan ID number

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

Section Two – Provider Notification

This section is used to communicate important messages to providers.

MEDICAID MANAGEMENT INFORMATION SYSTEM

PAGE 01
DATE 05/06/05
CYCLE 446

MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

TO: CITY MANAGED CARE PLAN
111 MAIN STREET
ANYTOWN, NEW YORK 11111

ETIN:
PROVIDER NOTIFICATION
PROVIDER ID 00111234
REMITTANCE NO: 05050900001

REMITTANCE ADVICE MESSAGE TEXT

EMEDNY WILL BE CLOSED MONDAY, MAY 30, 2005 IN OBSERVANCE OF MEMORIAL DAY.

Information on the Provider Notification Page

UPPER LEFT CORNER
Plan 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**
Plan ID number
Remittance number

CENTER
Message text

Section Three – Claim Detail

This section provides a listing of all new claims that were processed during the specific cycle plus claims that were previously pended and denied during the specific cycle. This section may also contain claims that pended previously.

MEDICAID MANAGEMENT INFORMATION SYSTEM

MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

PAGE 02
DATE 05/06/2005
CYCLE 446

TO: CITY MANAGED CARE PLAN
111 MAIN STREET
ANYTOWN, NEW YORK 11111

ETIN:
MANAGED CARE
PROVIDER ID: 00111234
REMITTANCE NO: 05050900001
LOCATOR CD: 003

OFFICE ACCOUNT NUMBER	CLIENT NAME	CLIENT ID.	TCN	DATE OF SERVICE	RATE CODE	UNITS	CHARGED	PAID	STATUS	ERRORS
CPIC1-00974-6	JONES	AA12345W	04083-000012112-3-2	04/01/05	2210	1.000	472.37	0.00	DENY	00162 00142
CPIC1-00575-6	EVANS	BB54321X	04083-000019113-3-1	04/01/05	2210	1.000	472.37	0.00	DENY	00142

* = PREVIOUSLY PENDED CLAIM
** = NEW PEND

TOTAL AMOUNT ORIGINAL CLAIMS	DENIED	944.74	NUMBER OF CLAIMS	2
NET AMOUT ADJUSTMENTS	DENIED	0.00	NUMBER OF CLAIMS	0
NET AMOUNT VOIDS	DENIED	0.00	NUMBER OF CLAIMS	0
NET AMOUNT VOIDS – ADJUSTS		0.00	NUMBER OF CLAIMS	0

MEDICAID MANAGEMENT INFORMATION SYSTEM

PAGE 03
DATE 05/06/2005
CYCLE 446

MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

TO: CITY MANAGED CARE PLAN
111 MAIN STREET
ANYTOWN, NEW YORK 11111

ETIN:
MANAGED CARE
PROVIDER ID: 00111234
REMITTANCE NO: 05050900001
LOCATOR CD: 003

OFFICE ACCOUNT NUMBER	CLIENT NAME	CLIENT ID.	TCN	DATE OF SERVICE	RATE CODE	UNITS	CHARGED	PAID	STATUS	ERRORS
CPIC3-16774-6	DAVIS	AA11111Z	04083-000034112-0-2	02/01/05	2210	1.000	472.37	472.37	PAID	
CPIC3-22921-6	THOMAS	BB22222Y	04083-000445113-0-2	02/01/05	2210	1.000	472.37	472.37	PAID	
CPIC1-45755-6	JONES	CC33333X	04083-000466333-0-2	02/01/05	2210	1.000	472.37	472.37	PAID	
CPIC1-60775-6	GARCIA	DD44444W	04083-000445663-0-2	02/01/05	2210	1.000	472.37	472.37	PAID	
CPIC1-33733-6	BROWN	EE55555V	04083-000447654-0-2	02/01/05	2210	1.000	472.37	472.37	PAID	
CPIC1-55789-6	SMITH	GG66666U	04083-000465553-0-2	02/01/05	2210	1.000	472.37	472.37	PAID	
CPIC1-76744-6	WAGNER	HH77777T	04083-000455557-0-2	02/01/05	2210	1.000	472.37	472.37	PAID	
CPIC1-91766-6	STEVENS	KK99999R	04083-000465477-0-2	02/01/05	2210	1.000	472.37	427.37	PAID	
CPIC1-66754-6	MCNALLY	JJ88888S	04083-000544444-0-2	02/01/05	2210	1.000	0.00	472.37	VOID	
CPIC1-66754-6	MCNALLY	JJ88888S	04083-000544444-0-2	02/01/05	2210	1.000	472.37	472.37-	PAID	ORIGINAL CLAIM PAID 04/11/2005

TOTAL AMOUNT ORIGINAL CLAIMS	PAID	3778.96	NUMBER OF CLAIMS	8
NET AMOUNT ADJ.VOIDS		472.37	NUMBER OF CLAIMS	1

MEDICAID MANAGEMENT INFORMATION SYSTEM

PAGE 04
DATE 05/06/2005
CYCLE 446

MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

TO: CITY MANAGED CARE PLAN
111 MAIN STREET
ANYTOWN, NEW YORK 11111

ETIN:
MANAGED CARE
PROVIDER ID: 00111234
REMITTANCE NO: 05050900001
LOCATOR CD: 003

OFFICE ACCOUNT NUMBER	CLIENT NAME	CLIENT ID.	TCN	DATE OF SERVICE	RATE CODE	UNITS	CHARGED	PAID	STATUS	ERRORS
CPIC1-06774-6	EVANS	BB54321X	04083-000034112-3-2	04/01/05	2210	1.000	472.37	**	PEND	00162
CPIC1-00974-6	JONES	AA12345W	04083-000445113-3-1	04/01/05	2210	1.000	427.37	**	PEND	00162

* = PREVIOUSLY PENDED CLAIM
** = NEW PEND

TOTAL AMOUNT ORIGINAL CLAIMS	PEND	944.74	NUMBER OF CLAIMS	2
NET AMOUT 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			
VOIDS – ADJUSTS	472.37-	NUMBER OF CLAIMS	1
TOTAL PENDS	944.74	NUMBER OF CLAIMS	2
TOTAL PAID	3778.96	NUMBER OF CLAIMS	8
TOTAL DENIED	944.74	NUMBER OF CLAIMS	2
NET TOTAL PAID	3306.59	NUMBER OF CLAIMS	8

REMITTANCE TOTALS			
VOIDS – ADJUSTS	472.37-	NUMBER OF CLAIMS	1
TOTAL PENDS	944.74	NUMBER OF CLAIMS	2
TOTAL PAID	3779.96	NUMBER OF CLAIMS	8
TOTAL DENIED	944.74	NUMBER OF CLAIMS	2
NET TOTAL PAID	3306.59	NUMBER OF CLAIMS	8

MEMBER ID: 00111234			
VOIDS – ADJUSTS	472.37-	NUMBER OF CLAIMS	1
TOTAL PENDS	944.74	NUMBER OF CLAIMS	2
TOTAL PAID	3779.96	NUMBER OF CLAIMS	8
TOTAL DENY	944.74	NUMBER OF CLAIMS	2
NET TOTAL PAID	3306.59	NUMBER OF CLAIMS	8

MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

PAGE: 05
DATE: 05/06/2005
CYCLE: 446

TO: CITY MANAGED CARE PLAN
111 MAIN STREET
ANYTOWN, NEW YORK 11111

ETIN:
MANAGED CARE
GRAND TOTALS
PROVIDER ID: 00111234
REMITTANCE NO: 05050900001

REMITTANCE TOTALS – GRAND TOTALS

VOIDS – ADJUSTS	472.37-	NUMBER OF CLAIMS	1
TOTAL PENDS	944.74	NUMBER OF CLAIMS	2
TOTAL PAID	3779.96	NUMBER OF CLAIMS	8
TOTAL DENY	944.74	NUMBER OF CLAIMS	2
NET TOTAL PAID	3306.59	NUMBER OF CLAIMS	8

General Information on the Claim Detail Pages

UPPER LEFT CORNER
PLAN 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 CSC with questions about specific processed claims or payments.

ETIN (not applicable)
Provider Service Classification: **MANAGED CARE**
Plan ID number
Remittance number
Locator Code (Plans with have more than one locator code will receive separate Claim Detail sections for each locator code).

Explanation of the Claim Detail Columns

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

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

CLIENT ID
The patient's Medicaid ID number appears under this column.

TCN
The TCN is a unique identifier assigned to each document (claim form) that is processed. If multiple claim lines are submitted on the same claim form, all the lines are assigned the same TCN.

DATE OF SERVICE
The first date of service (From date) entered in the claim appears under this column. If a date different from the From date was entered in the Through date box, that date is not returned in the Remittance Advice.

RATE CODE
The four-digit rate code that was entered in the claim form appears under this column.

UNITS
The total number of units of service for the specific claim appears under this column.

CHARGED
The total charges entered in the claim form appear under this column.

PAID
If the claim was approved, the amount paid appears under this column. If the claim has a pend or deny status, the amount paid will be zero (0.00).

STATUS
This column indicates the status (DENY, PAID/ADJT/VOID, PEND) of the claim line.

Denied Claims
Claims for which payment is denied will be identified by the **DENY** status. A claim may be denied for the following general reasons:

- The service rendered is not covered by the New York State Medicaid Program.
- The claim is a duplicate of a prior paid claim.
- Information entered in the claim form is invalid or logically inconsistent.

Approved Claims
Approved claims will be identified by the statuses **PAID, ADJT** (adjustment), or **VOID**.

Paid Claims
The status PAID refers to **original** claims that have been approved.

Adjustments
The status ADJT refers to a claim submitted in replacement of a paid claim with the purpose of changing one or more fields. An adjustment has two components: the credit transaction (previously paid claim), and the debit transaction (adjusted claim).

Voids
The status VOID refers to a claim submitted with the purpose of canceling a previously paid claim. A void lists the credit transaction (previously paid claim) only.

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

- New York State Medical Review required.
- Claim requires manual pricing.

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

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

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

ERRORS

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

Subtotals/Totals

Subtotals of dollar amounts and number of claims are provided as follows:

Subtotals by claim **status** appear at the end of the claim listing for each status. The subtotals are broken down by:

- Original claims
- Adjustments
- Voids
- Adjustments/voids combined

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

- Adjustments/voids (combined)
- Pends
- Paid
- Denied
- Net total paid (for the specific combination)

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

- Adjustments/voids (combined)
- Pends
- Paid
- Deny
- Net total paid (for the specific service classification)

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

- Adjustments/voids (combined)
- Pends
- Paid
- Deny
- Net total paid (for the specific service classification)

Section Four

This section has two subsections:

- Financial Transactions
- Accounts Receivable

Financial Transactions

The Financial Transactions subsection lists all the recoupments that were applied to the provider during the specific cycle. If there is no recoupment activity, this subsection is not produced.

MEDICAID MANAGEMENT INFORMATION SYSTEM

PAGE 07
DATE 05/06/05
CYCLE 446

TO: CITY MANAGED CARE PLAN
111 MAIN STREET
ANYTOWN, NEW YORK 11111

MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

ETIN:
FINANCIAL TRANSACTIONS
PROVIDER ID: 00111234
REMITTANCE NO: 05050900001

FCN	FINANCIAL REASON CODE	FISCAL TRANS TYPE	DATE	AMOUNT
	XXX	RECOUPMENT REASON DESCRIPTION	05 09 05	$$.$$

NET FINANCIAL AMOUNT $$$.$$

NUMBER OF FINANCIAL TRANSACTIONS XXX

Accounts Receivable

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

PAGE 08
DATE 05/06/05
CYCLE 446

TO: CITY MANAGED CARE PLAN
111 MAIN STREET
ANYTOWN, NEW YORK 11111

MEDICAID MANAGEMENT INFORMATION SYSTEM

MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

ETIN:
ACCOUNTS RECEIVABLE
PROVIDER ID: 00111234
REMITTANCE NO: 05050900001

REASON CODE DESCRIPTION	PREV 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 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.

Explanation of the Accounts Receivable Columns

If a provider has negative balances of different nature (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 in a different line.

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

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

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

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

Total Amount Due the State

This amount is the sum of all the **Current Balances** listed above.

Section Five – Edit Descriptions

The last section of the Remittance Advice features the description of each of the edit codes (included approved codes) failed by the claims listed in Section Three. The codes are listed in ascending numeric order.

MEDICAID MANAGEMENT INFORMATION SYSTEM

MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

PAGE 06
DATE 05/06/2005
CYCLE 446

TO: CITY MANAGED CARE PLAN
111 MAIN STREET
ANYTOWN, NEW YORK 11111

ETIN:
MANAGED CARE
EDIT DESCRIPTIONS
PROVIDER ID: 00111234

REMITTANCE NO: 05050900001

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

00142 RECIPIENT YEAR OF BIRTH DIFFERS FROM FILE
00162 RECIPIENT INELIGIBLE ON DATE OF SERVICE

Section IV – Appendices

Appendix A – Sample De-Identified Managed Care 837I Transaction

ISA*00* *00* *ZZ*MCO *ZZ*EMEDNYBAT *050101*0830*U*00401*000000123*0*P*:~
GS*HC*MCO*EMEDNYBAT*20050101*0830*123*X*004010X096A1~
ST*837*0123~
BHT*0019*00*000000123*20050101*0830*CH~
REF*87*004010X096DA1~
NM1*41*2*SAMPLE NYS MEDICAID MCO*****46*MCO~
PER*IC*ANNA A ADMINISTRATIVE*TE*5181231234~
NM1*40*2*NYSDOH*****46*141797357~
HL*1**20*1~
NM1*85*2*SAMPLE NYS MEDICAID MCO*****24*987654321~
N3*100 INSURANCE ROAD~
N4*NEW YORK*NY*10025~
REF*1D*12345678~
REF*LU*01~
HL*2*1*22*0~
SBR*P*18*******MC~
NM1*IL*1*PATIENT*PATRICK*P***MI*AB12345C~
N3*999 RECIPIENT ROAD~
N4*SUBURBS*NY*10055~
DMG*D8*19500101*M~
NM1*PR*2*NYSDOH*****PI*141797357~
CLM*AB12345C050101*170.49***89:A:1*Y**Y*Y*********N~
DTP*434*D8*20050101~
HI*BK:7999~
HI*BE:24:::2200~
LX*1~
SV2*0100**170.49*UN*1*170.49~
DTP*472*RD8*20050101-20050101~
HL*3*1*22*0~
SBR*P*18*******MC~
NM1*IL*1*PATIENT*PENELOPE*P***MI*AB67890C~
N3*888 PATIENT PLACE~
N4*METRO*NY*10025~
DMG*D8*19600101*F~
NM1*PR*2*NYSDOH*****PI*141797357~
CLM*AB67890C050101*170.49***89:A:1*Y**Y*Y*********N~
DTP*434*D8*20050101~
HI*BK:7999~
HI*BE:24:::2200~
LX*1~
SV2*0100**170.49*UN*1*170.49~
DTP*472*RD8*20050101-20050101~
SE*41*0123~
GE*1*123~
IEA*1*000000123~

Appendix B – Mapping of Former Claim Form A for Managed Care Billing To 837 Institutional

Claim Form A for MCO Premium Billing to 837 Institutional Mapping
This mapping shows the relationship of the data sent in Claim Form A to data in the 837I. It is not a complete listing of the required data items in the 837I. Refer to the Phase II Companion Guides at www.nyhipaadesk.com for all required data.

Former Form A (Types: X=Alpha-Numeric N=Numeric)						837
Field Name	Start	End	Field Size	Type	Explanation	837 Institutional Related Data Item(s)
Claim Form A Record Type: T0						
Input Supplier Number	1	3	3	X	This number is assigned by CSC upon receipt of a Transmission `Supplier Number Application and a Certification Statement. It can be all numeric or alpha/numeric. Alpha characters must be upper case.	ISA06, GS02 Loop 1000A NM108 where NM101=41
Input Serial Number	4	9	6	X	This number is assigned by the submitter to each tape or diskette. Use 6 numbers for tapes. Use a "D" followed by 5 numbers for diskettes. Alpha/numeric characters are acceptable.	ISA13, IEA02 GS02, GE06 ST01, SE01
Current Year	10	11	2	N	Enter the present year in which the file is created.	ISA09, GS04, BHT04
Current Julian Date	12	14	3	N	Enter the Julian Date on which the file was created. (Example: January 1st = 001)	N/A
Provider Type	15	16	2	N	Managed Care claims – enter "TA".	N/A
Record Count	17	22	6	N	Enter the total number of records on the input. Include all records. Zero fill and right justify.	SE01
Invoice Count	23	28	6	N	Enter the total number of invoice numbers that will be equal to the total number of "D1" Records. Zero fill and right justify.	N/A
Claim Count	29	34	6	N	Enter the total number of claims which will equal the total number of "C3" Records.	N/A

Former Form A (Types: X=Alpha-Numeric N=Numeric)						837
Field Name	Start	End	Field Size	Type	Explanation	837 Institutional Related Data Item(s)
Total Charges	35	43	9	N	Enter the total amount charged. This is the sum of all "C3" Records (positions 35-41). Zero fill and right justify. Do not enter the balance due. Do not enter decimal. This field should not be signed.	N/A
Unused Area	44	44	1	N	This position must be space filled.	N/A
Certification	45	53	9	X	The word "CERTIFIED" must appear in these positions.	N/A
Unused Area	54	78	25	X	This area must be space filled.	N/A
Record Type	79	80	2	X	Enter the constant value "T0" (T-Zero).	N/A
8" Diskette Only Unused Area	81	128	48	X	Record positions greater than 80 must be space filled.	N/A
Claim Form A Record Type: D1						
Invoice Number	1	9	9	N	This is a nine digit numeric field assigned by the user. The ninth position of the invoice number must be zero. Invoice numbers must be in ascending sequence on the file.	N/A
Provider ID Number	10	17	8	N	This is an eight digit number assigned to Plans by SDOH.	Loop 2010AA, REF02 where REF01="1D"
Billing Date	18	23	6	N	This field should indicate the date the claim was prepared. Use the following format: MMDDYY. (example: April 19, 1996 is entered as 041996)	ISA09, GS04, BHT04
Group ID No.	24	31	8	X	This area must be space filled.	N/A
Locator Code	32	33	2	N	Locator codes are assigned to the provider at enrollment. Enter the code that corresponds to the service location. Codes must be 03 or greater and differ for each county. This is **not** the county code.	Loop 2010AA, REF02 where REF01="LU"
Specialty Code	34	36	3	X	This area is space filled.	N/A

Former Form A (Types: X=Alpha-Numeric N=Numeric)						837
Field Name	Start	End	Field Size	Type	Explanation	837 Institutional Related Data Item(s)
Category of Svc.	37	40	4	N	Enter 0220 for the type of provider that has rendered service.	N/A
Service Authorization Exception Code	41	41	1	X	This area is space filled.	N/A
Adjustment/ Void Code	42	42	1	X	If the purpose of the invoice being submitted is to adjust or void a previously paid claim, this field must be completed: A for adjustment or V for void. (Otherwise, space fill.)	Loop 2300, CLM03-5
Original Claim Reference Number	43	56	14	X	If submitting an adjustment or void, enter the last 14 digits of the claim reference number (CRN) that is to be adjusted or voided. This number is located on the remittance statement. (Otherwise, space fill.)	Loop 2300, REF02 where REF01=”F8”
Office Account Number	57	73	17	X	(Optional) A number may be assigned to the patient’s account for record purposes. If the account number is indicated, MMIS will report it on the Remittance Statement. (Otherwise, space fill.)	Loop 2300, CLM01
Unused Area	74	77	4	X	This area must be space filled.	N/A
Original Claim Reference Number Decade Digit	78	78	1	X	If claim is an adjustment/void, enter the 1st digit of the CRN from the paid claim line of the remittance statement. (Otherwise, space fill.)	Loop 2300, REF02 where REF01=”F8”
Record Type	79	80	2	X	For all document header 1 records, the constant value of ‘D1’ must be in this field.	N/A
(8” Diskette Only) Unused area	81	128	48	X	This area must be space filled.	N/A

Former Form A (Types: X=Alpha-Numeric N=Numeric)						837
Field Name	Start	End	Field Size	Type	Explanation	837 Institutional Related Data Item(s)
Claim Form A Record Type: D2						
Invoice Number	1	9	9	N	This number must match the Invoice Number on the previous D1 Record, positions 1-9.	N/A
Recipient ID Number	10	20	11	X	All entries are left justified. Recipient ID numbers are formatted as follows: 2 alpha, 5 numeric, and 1 alpha. Positions 18-20 must be space filled.	Loop 2010BA, NM109 where NM108=”MI”
Recipient Year of Birth	21	22	2	N	This two digit numeric field should indicate the recipients year of birth. This must always be two numbers.	Loop 2010BA, DMG02
Recipient Sex	23	23	1	X	Enter F for female and M for male.	Loop 2010BA, DMG03
Coding Method for Diagnosis	24	24	1	X	Space fill this field.	Loop 2300, HI01=”BK”
Coding Method for Procedure	25	25	1	X	Space fill this field.	N/A
Primary Diagnosis	26	31	6	X	Space fill this field.	See Companion Guide
Secondary Diagnosis	32	37	6	X	Space fill this field.	N/A
Emergency Code	38	38	1	X	Space fill this field.	N/A
Handicapped Children Program	39	39	1	X	Space fill this field.	N/A
Possible Disability	40	40	1	X	Space fill this field.	N/A

Former Form A (Types: X=Alpha-Numeric N=Numeric)						837
Field Name	Start	End	Field Size	Type	Explanation	837 Institutional Related Data Item(s)
Family Planning	41	41	1	X	Space fill this field.	N/A
Accident Code	42	42	1	N	Space fill this field.	N/A
Patient Status	43	43	1	X	Space fill this field.	N/A
CHAP Referral	44	44	1	X	Space fill this field.	N/A
Recipient Other Insurance Coverage	45	46	2	X	Space fill this field.	N/A
Abortion/ Sterilization Code	47	47	1	X	Space fill this field.	N/A
Unused Area	48	48	1	X	Space fill this field.	N/A
Prior Approval Number	49	56	8	X	Space fill this field.	N/A
Place of Service	57	57	1	X	Space fill this field.	Loop 2300, CLM05-1=”89”
Service Provider Number	58	65	8	X	Space fill this field.	N/A
Service Provider Type	66	67	2	X	Space fill this field.	N/A

Former Form A (Types: X=Alpha-Numeric N=Numeric)						837
Field Name	Start	End	Field Size	Type	Explanation	837 Institutional Related Data Item(s)
Referring Provider Number	68	75	8	X	Space fill this field.	N/A
Referring Provider Type	76	77	2	X	Space fill this field.	N/A
Over 90 day indicator	78	78	1	X	Values 1 through 5 are accepted as valid indicators. (See Below)	Loop 2300, CLM20
Record Type	79	80	2	X	A constant value of D2 must be in this field for all Document Header 2 records in the file.	N/A
(8" Diskette Only) Unused Area	81	128	48	X	This area must be space filled.	N/A
Claim Form A Record Type: C3						
Invoice Number	1	9	9	N	For each claim line in the invoice, this field should contain the same invoice number as the previous D1 and D2 records.	N/A
Line Number	10	11	2	N	This field represents the line number (order) of the claim record. If billing multiple C3 records for the same invoice number, assign line numbers as follows: 01, 02, 03, etc.	Loop 2400, LX01
Date of Service	12	17	6	N	For capitation claims, enter the date for the first of the month for which the monthly reimbursement is being claimed.	Loop 2300, DTP03 where DTP01="434" Loop 2400, DTP03 where DTP01="472"
Rate Code	18	22	5	X	Enter the appropriate rate code which identifies service rendered to the recipient. Position 22 must be zero.	Loop 2300, HI01-5 where HI01="BE" and HI01-2="24" (HI01-3 and HI01-4 are not valued)

Former Form A (Types: X=Alpha-Numeric N=Numeric)						837
Field Name	Start	End	Field Size	Type	Explanation	837 Institutional Related Data Item(s)
Unused Area	23	34	12	X	Space fill this area.	N/A
Amount Charged	35	41	7	N	Enter the established rate for the service being billed or the amount charged. Do not enter decimal.	Loop 2300, CLM02
Unused Area	42	62	21	X	Space fill this area.	N/A
Balance Due	63	69	7	N	Enter net amount due. Do not enter decimal.	N/A
Unused Area	70	78	9	X	Space fill this area.	N/A
Record Type	79	80	2	X	A constant value of 'C3' must be in this field for all claim line records in the file.	N/A
(8" Diskette Only) Unused area	81	128	48	X	Space fill this area.	N/A