# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>INITIAL SCREEN</td>
<td>2</td>
</tr>
<tr>
<td>INSTITUTIONAL CLAIM INFORMATION</td>
<td>7</td>
</tr>
<tr>
<td>PROVIDER INFORMATION TAB</td>
<td>13</td>
</tr>
<tr>
<td>DIAGNOSIS / PROCEDURE TAB</td>
<td>15</td>
</tr>
<tr>
<td>OTHER PAYERS TAB</td>
<td>18</td>
</tr>
<tr>
<td>OTHER PAYER DETAILS</td>
<td>19</td>
</tr>
<tr>
<td>SERVICE LINE TAB</td>
<td>22</td>
</tr>
<tr>
<td>EXPORT FUNCTION</td>
<td>23</td>
</tr>
<tr>
<td>EDITING A SERVICE LINE</td>
<td>23</td>
</tr>
<tr>
<td>CLAIM ENTRY CONFIRMATION WINDOW</td>
<td>27</td>
</tr>
<tr>
<td>BUILD CLAIM BATCH WINDOW</td>
<td>28</td>
</tr>
<tr>
<td>CLAIM BATCH BUILT CONFIRMATION WINDOW</td>
<td>29</td>
</tr>
<tr>
<td>SUBMIT CLAIM BATCHES</td>
<td>30</td>
</tr>
<tr>
<td>CLAIM BATCHES SUBMITTED</td>
<td>31</td>
</tr>
<tr>
<td>VIEW BATCH</td>
<td>32</td>
</tr>
<tr>
<td>EDIT CLAIM - DRAFT, ERRORS OR COMPLETE</td>
<td>33</td>
</tr>
<tr>
<td>EDIT A SENT CLAIM</td>
<td>34</td>
</tr>
<tr>
<td>ROSTER BILLING</td>
<td>36</td>
</tr>
</tbody>
</table>
INITIAL SCREEN

Choose **New Claim**.
GENERAL CLAIM INFORMATION TAB

Submission Reason: Choose Original if you are submitting a new claim or the resubmission of a previously denied or rejected claim. Choose Replace if you are submitting an Adjustment to a previously paid claim and choose Void if you are voiding a paid claim. If you choose Replace or Void, you must enter the Payer Claim Control Number of the paid claim.

Effective 4/1/12, Certified Home Health Agencies will indicate the type of Episodic Payment System claim they are submitting in this field. Choose Interim if you are a Certified Home Health Agency submitting an Episodic Payment System claim that is Interim. Choose Final if you are a Certified Home Health Agency submitting an Episodic Payment System claim that is Final or Partial. The Payer Claim Control Number field will also appear when selecting Interim or Final.

Note: The Payer Claim Control Number field will only appear if you select Replace, Void, Interim or Final from the drop down. This number was reported on the provider’s remittance as the Transaction Control Number (TCN). This is not a required field for the Interim and Final options and should only be completed when adjusting a paid CHHA EPS claim.

NPI Number: The NPI in this field defaults to the current NPI for the MMIS provider ID currently assigned. If you are billing for a date of service when the NPI for the same MMIS provider ID is different, enter the old NPI in this field.

* Payer Claim Control Number: Enter the payer claim control number (also called a TCN), if you are submitting an Adjustment or Void to a previously paid claim.

* Patient Control Number: Enter the Patient Control Number. This is also referred to as the Office Account number. You may enter up to 20 characters and each number should be unique to the patient for which you are submitting the claim. This field is required on all claims.
* **Location Information:** Institutional providers that are required to submit with an NPI must enter the address of the service location including the Zip + 4.

Some provider types do not meet the HIPAA standard’s definition of a ‘Health Care Provider’. These providers are exempt from using a NPI and should continue to use location code 003 or higher.

**Note:** The Location Code field will only appear if the billing provider is exempt from having an NPI.

* **Client Information:** Enter the client ID, then click on Go.
If the client ID you have entered is a valid ID, the system will present you with this page.

The client’s name, address, DOB, and gender will automatically populate. The DOB and gender fields have options to allow you to change the DOB and gender if necessary. If the client displayed is not correct because you entered the wrong ID, you may enter a new client ID and click on Go.
Type of Claim: Enter the type of claim you want to submit and click on Next. The types of claims allowed are:

- Dental
- Professional
- Professional Real Time
- Institutional

In order for this to be submitted as an Institutional Claim, select *Institutional* from the drop down.

**Note:** Orthodontics in a Clinic setting MUST be billed as Dental only.

Click on *Next.*
Once you have chosen the Claim Type and this page is displayed, you cannot change the Claim Submission Reason, Patient Control Number, Client ID, or Claim Type.

* **Facility Type:** Enter the facility type that most appropriately describes the visit.

* **Assignments of Benefits:** Always YES

* **Release of Information:** Choose the correct option from the drop down list.

* **Accept Assignment:** Must be A to indicate the provider is enrolled in Medicaid.

**Auto Accident State:** When the claim is the result of an auto accident, enter the state in which the accident occurred.

* **Admission Type:** This is a required field. Pick the appropriate Admission Type code from the list.

* **Patient Status:** This is a required field. Pick the appropriate status code from the list.

**Admission Source:** For Inpatient claims ONLY, pick a code from the list. Admission Source may be required depending on the Admission Type selected.
**Statement Covers:** ePACES requires a date on this tab.

**From - / To -** Enter the From and To dates of the claim here. If billing for ONE day, that date should be entered as BOTH the From and the To date.

**Note:** Individual dates of service entered on the service line level MUST fall within the date range specified here on the claim level.

**Admission Date:** For inpatient claims only, enter the date the patient was admitted.

**Admission Hour:** For Inpatient claims only, enter the admission hour in 24-hour (military) time. Ex: 3:00 PM is 1500 hours.

**Discharge Hour:** For Inpatient claims only enter the discharge hour using 24-hour (military) time.

**Note:** When the discharge date is different than the To Date of the claim, it is entered as an Occurrence Span code in the Occurrence Span section of the claim.

**Medical Record Number:** Required on all Inpatient claims.

**Prior Authorization Number:** If the claim requires a Prior Approval, enter the PA number here.

**Note:** If there are multiple prior approvals for rehab therapy for this claim, enter the prior approval number (DVS number) for the first date of service here.

**Certificate Category:** If billing for a well care visit for a child, please select option from the drop down.

**Condition Codes:** Enter the appropriate condition code for EPSDT billing.
Value Codes: Value Codes are used to enter a variety of information. The Code identifies the type of entry made in the Value field and the corresponding information is entered in the value field.

- **Code 24** = Rate Code and the Value entry is the NYS Medicaid assigned 4-digit rate code.
- **Code 23** = NAMI amount and the Value entry is the client’s NAMI.
- **Code 54** = Birth Weight and the Value is the birth weight of a baby in grams which is needed on all DRG Inpatient claims if the baby is 28 days old or less.
- **Code 80** = Used to show Medicaid Covered days on Inpatient (not OMH clinics) claims. The Value is the number of Medicaid Covered days.
  
  **Note:** Used for hospital and therapeutic days for Nursing Home and ICF Claims, where hourly or daily services are entered with BOTH the service line and Value Code 80.

  **Note:** The Medicare Covered Days are entered in the Other Insurance tab and INCLUDES the number of LTR and Coinsurance days.

- **Code 81** = Used to show Non-covered days on Inpatient claims. The Value is the number of Non-covered days.
  
  **Note:** Only applies to the same providers whom reported Medicaid Covered days.

- **Code 82** = Used to show Coinsurance Days on Inpatient claims. The Value is the number of Coinsurance days. **Note:** Included in the Medicaid covered days on the Other Insurance tab.

- **Code 83** = Used to show LTR (Lifetime Reserve) Days on Inpatient claims. **Note:** Included in the Medicare Covered days on the Other Insurance tab.

- **Code FC** = Used to show Patient Paid amount on the claim. The value is the sum of all the amounts paid by the Patient.
Condition Codes
Not all claims require a condition code. Condition codes include the Abortion/Sterilization, Copay exception, EPSDT/CHAP, and the condition code 61 for inpatient cost outliers.

**Note:** If no condition codes apply then do not enter a code and the system will default to not applicable.

**Note:** The Cost Outlier charges are entered on the service line with revenue codes.
ePACES Institutional Claim
REFERENCE GUIDE

Occurrence Span Codes
Used on Hospital Inpatient claims to indicate the Discharge Date of the patient, shown with code 42 with the Discharge date in the From field.

- The code 75 may be entered multiple times on a claim (usually for ALC periods). The dates for code 75 will show the From and To dates of each ALC period.
- If the claim is being submitted for Workman’s Comp/Auto Accident, the Accident Occurrence code 02 is reported here.

**Note:** The most commonly used Occurrence codes for an Institutional claim are:

**Occurrence code: 02** = No Fault/ Auto Accident
**Occurrence code: 55** = Hospice Date of Death
**Occurrence code: 75** = ALC Date spans (SNF Level of Care)
ePACES Institutional Claim
REFERENCE GUIDE

**Service Authorization Exception Code:** This code indicates that the procedure(s) are exempt from the Utilization Threshold Program or an Emergency. Enter the Service Authorization Code if the service you are billing is exempt from utilization threshold. If billing for an enhanced fee program or a clinic is billing for any exempt specialty then SA Exception Code 7 must be entered to ensure an exempt Specialty Code is derived. The following list shows the acceptable HIPAA SA Exception Codes:

1 = Immediate/Urgent Care  
2 = Services Rendered in a Retroactive Period  
3 = Emergency Care  
4 = Client has Temporary Medicaid  
5 = Request from County for Second Opinion to Determine if Recp can work  
6 = Request for Override Pending  
7 = Special Handling

**Delay reason:** This field is the Over 90 Day indicator. One of the following codes is used to indicate why the claim is being submitted over 90 days from the service date.

1 = Proof of Eligibility Unknown or Unavailable  
2 = Litigation  
3 = Authorization Delays  
4 = Delay in Certifying Provider  
5 = Delay in Supplying Billing Forms (not allowed for electronic claims including ePACES)  
7 = Third Party Processing Delay  
8 = Delay in Eligibility Determination  
9 = Original Claim Rejected or Denied Due to a Reason Unrelated to the Billing Limitation Rules  
10 = Administrative Delay in the Prior Approval Process  
11 = Other  
15 = Natural Disaster
**Attending/Servicing Physician:** The Attending Physician is required. The attending provider is defined as the physician who is primarily responsible for the episode of care included within the claim.
To use an Existing Provider - If the Attending/Service provider is already entered in the support file as a Medicaid provider, you can pick the name of the provider from the drop down list in that section. Then click on GO.

The information for that provider is automatically entered. OMH, OPWDD and OASAS providers should enter the MMIS ID for unlicensed service providers here.

To enter a New Non-Medicaid Provider – Enter the NPI of the non-Medicaid provider. Then click on GO.

**Operating Physician:** The Operating Physician is the Physician performing surgical procedures on the claim.

**Referring Physician:** If a referring provider is required, then enter the referring provider’s information here in the same manner as described above. In the case of a restricted recipient, the provider that the recipient is restricted to MUST be the Referring provider.
**DIAGNOSIS / PROCEDURE TAB**

**ICD-9/ICD-10:** This defaults to ICD-10.

* **Principal Diagnosis:** Enter the Principal Diagnosis Code without the decimal.
  
  **Note:** If submitting an Inpatient claim, include a POA (Present on Admission) code (in upper case letters).

**Reason for Visit Diagnosis:** The Reason for Visit Diagnosis Code contains the diagnosis information on why a patient visited the provider.

**Admitting Diagnosis:** For inpatient claims, enter the Admitting Diagnosis code without the decimal.

**Other Diagnosis:** If there are any other diagnosis codes, enter the code without the decimal.
  
  **Note:** If submitting an Inpatient claim, include a POA code.
### External Cause of Injury Code

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<thead>
<tr>
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</tr>
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<tbody>
<tr>
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**External Cause of Injury Code:** Enter “E-Codes” when applicable.
**Principal Procedure:** Principal Procedure is used on Inpatient claims ONLY. Use the ICD Principal Procedure codes if a *Surgical* Procedure was performed.

**Note:** Not all Inpatient claims will have a principal procedure code.

**Principal Procedure Date:** Enter a date only if the Principal Procedure field has an entry.

**Other Procedures Code:** Only Inpatient claims use ICD-10 procedure codes for the Other Procedure Code field. NO other claims use this entry. If a procedure code is entered, the date the procedure was performed must also be entered.

**Other Procedures Date:** Enter a date only if the Other Procedure Code field has an entry.

Click on **Next** to go to the next tab.
OTHER PAYERS TAB

This tab may be used to report payments received from Medicare and/or Third Party Insurance.

**Note:** Providers are required to report other payer payments and adjustments as they were reported by the other payer. If the other payer provided line level payments and adjustments, then providers are required to report those payments and adjustments at the line level. If the other payer provided claim level payments and adjustments, then providers are required to report those payments and adjustments at the claim level.
OTHER PAYER DETAILS

* Other Payer Name: If the Other Payer Support File has already been populated with the Other Payer, you may choose it from the drop down list. If the other payer is not in the dropdown list, you can add it by clicking on the Other Payer link under Support Files on the left hand side.

* Payer Sequence Number: The coverage sequence of the other payer (i.e. where in the sequence of submissions does this payer fall), choose Primary, Secondary or Tertiary.

Other Payer Paid Amount: Enter the total amount paid by the other insurance for the entire claim.

Other Provider Claim Control Number: If available, enter the claim control number from the other payer.

Remaining Patient Liability: Leave this field blank. The remaining patient liability is entered using claim adjustment reason codes.

Total Non Covered Amount: Only enter an amount in this field if there is documentation stating that the other payer will not cover this service and you are not billing the other payer. The amount entered must equal the Total Claim Charge Amount.

Date Claim Paid: The date that the other carrier paid or denied the claim, found on the other payer’s explanation of benefits.

Covered Days: This entry is used to indicate the number of days covered by the Other Payer (either Medicare or Commercial Insurance).

Note: Sometimes a Commercial payer will pay a lump sum and not an amount associated with a number of days.

- If Medicare Part B covered the claim, no days should be entered.
- If Medicare Part A covered the claim using Part A days, Coinsurance days and/or Lifetime Reserve days, the covered days entry should include the sum of all the days covered by Medicare.
* Other Subscriber: Enter the Name, Primary ID, Address, and other demographic information pertaining to the subscriber of the Other Payer.

Other Subscriber Information:

* Relationship: Pick the appropriate entry from the drop down list.

Payer Type: Enter the Code representing the Other Payer from the drop down list.

Note: If code 16 is entered on a claim, that claim cannot have Medicare Part A and/or Medicare Part B. The 16 code indicates the client is enrolled in a Medicare Managed Care plan and no longer has traditional Medicare coverage.

Group Number: Enter the Subscriber’s group number for the other payer when applicable.

Group Name: Enter the Subscriber’s group name for the other payer when a group number is not present, but the group name is.
**Claim Adjustments**: If the other payer reported claim adjustments at the claim level, enter the adjustment information here.

- **Claim Adjustment Group**: Enter the Group Code as received from the other payer.
- **Reason Code**: Enter the Claim Adjustment Reason Code as received from the other payer.
- **Adjustment Amount**: Enter the adjustment amount as received from the other payer.
- **Adjustment Quantity**: Enter the quantity as received from the other payer.

**Other Insurance Coverage Information**

- **Assignment of Benefits**: Always YES.
- **Release of Information**: Pick an entry from the drop down list.

Click on Next Other Payer to add another payer or Next to go to the next tab.
ePACES Institutional Claim  
REFERENCE GUIDE

SERVICE LINE TAB

**Line Item Ctl #** - Not required. When used, the value provided will be returned on the 835 (electronic remittance advice) and may be used as an index to your system.

**Date of Service:** Only use this field for outpatient services or Certified Home Health Agency EPS claims when the From and Thru dates entered at the claim level are more than one day. Otherwise, leave blank.

**Rev Code:** Enter the applicable revenue code for the type of claim submitted.

**Procedure Codes & Mod:** If applicable, enter the procedure code and modifier combinations that accurately reflect the services performed.

**Charge Amount:** Enter the amount charged.

**Service Count:** Enter the applicable service count for the procedure/modifier combination. Providers billing for a number of units (PCA, home health, case management) must enter an appropriate revenue code with the number of units entered in the service count.

**Add:** Click **Add** to attach the service line to the claim, the service line will then display above. Continue entering service line information and adding as needed.
**EXPORT FUNCTION**

Export to Excel will display the list of service lines entered on the claim with the total charges in an Excel document.

Export to Word will display the list of service lines entered on the claim with the total charges in a Word document.

**EDITING A SERVICE LINE**

Click the **Edit** icon that corresponds to the service line which will be updated. This will open the service line to allow changes.
Click **Finish** to save the changes made on the edited service line. Click **Cancel** to close out of Edit option for the service line. No changes will be saved to the line when **Cancel** is selected.

**More:** This option allows a provider to enter additional line specific information. Use the **More** button to report the prior payer's line adjudication information, National Drug Code (NDC) and National Drug Unit Count. NDC information is required for Ordered Ambulatory providers billing for physician-administered drugs.
Enter the NDC information in the *Drug Identification* section.

![Drug Identification Section](image)
If a client has Medicare and/or a Third Party Insurance, the payment information may be entered on the claim line level using the More button.
CLAIM ENTRY CONFIRMATION WINDOW

This is the response page displayed when you click on the Finish button.

From this page you can click on the appropriate button to perform the following options:

- **Edit Current Claim**: Can be used to edit the claim.
- **Enter Another New Claim**: Can be used to add another institutional claim.
- **Validate Current Claim**: Can be used to check for errors.

Click on the **Build a Claim Batch** option on the Main Menu in order to batch the claims. This will bring you to the Build Claim Batch window.
BUILD CLAIM BATCH WINDOW

Claims that have been successfully entered into the ePACES System must be Batched before they can be submitted for processing. Only claims with a status of Complete may be batched.

The claims in a Complete status that are eligible for batching will have a check mark in the box to the left of the line. If you want to batch all the claims that are checked, click on the Build Batch button. You also have the option of unchecking claims so that they will not be included in the current batch. Once you have done so, click on the Build Batch button in order to build a batch with the selected claims.
CLAIM BATCH BUILT CONFIRMATION WINDOW

This window will be displayed to confirm that the batch has been built.

![Claim Batch Built](image)

This confirmation window displays the Claim Type, assigns the Batch Number and gives the total number of claims and batch charges.

Choose the **Submit Claim Batches** option from the Main Menu to submit the batch.
SUBMIT CLAIM BATCHES

Click on the **Submit All Selected Batches** button to submit all of the batches that are checked and selected for submission. You also have the option of unchecking claim batches so they will not be submitted at this time. Batches that are unchecked will remain batched together and can be submitted at a later date.

You will receive a message that states “The following claim batches have been submitted” and the batches will be displayed. To check to see if the batch was received, click on the “View Previously Submitted Batches” link.
CLAIM BATCHES SUBMITTED

This screen will display a list of all previously submitted batches in Batch Number order. The Submit Date and the Total Claims (in the batch) and the Total Rejected will be provided.

Once a number appears in the Total Rejected column, Click on the link in the Batch Number column and the claims submitted within the batch will be displayed.
VIEW BATCH

This screen will display each individual claim within the batch. Click on the **Details** link in the Initial Claim Status/Response column to check the status of the claim.

If the claim status is denied or rejected, click the **Close** button at the bottom of the response screen to return to the view batch screen. Clicking the link provided in the Patient Control Number column will open the claim for editing.
EDIT CLAIM - DRAFT, ERRORS OR COMPLETE

There are many reasons why you may need to edit an existing claim. For example, you may not have had all of the information when initially entering the claim and therefore saved it in Draft status. You may also have finished the claim, but when it went through the validation process, errors were found that need to be fixed in order to successfully submit the claim for processing. Additionally, you now have the ability to edit and resend a claim that is in a Sent status.

When in edit mode, all data on the claim may be edited except for the Submission Type, Client ID and Date of Birth, Gender, and Type of Claim which are located on the General Information Tab. The process of editing a claim and entering a claim are very similar in navigation.

Depending on the status of the claim, the editing process differs slightly.

- **DRAFT**: Editing a claim that has been saved as a Draft is a continuation of the Claim Entry process. If a claim is saved as a draft, no validation has been done to the data entered. Once you complete entering information and click Finish, the data will be sent through the standard claim validation and will either have a status of "Complete" or "Errors", depending on the outcome.

- **ERRORS**: A claim in Error status has been entered and Finished, thus triggering the validation process. When errors exist, a table will be displayed on the confirmation page indicating the error and its location on the claim. Once the errors have been fixed and you click Finish, the claim will be sent through the validation process again to confirm the errors have been resolved.

- **COMPLETE**: Editing a claim that has been fully entered and passed all validation, therefore has a status of Complete, is similar to editing a claim in Draft. You may change any data on any of the tabs, with the exception of the General Information Tab, and then click Finish to complete the claim thereby initiating the validation process. Assuming all changes made were valid, the claim will once again have a status of Complete, awaiting the batching process; otherwise, it will be placed in Error status.

- **BATCHED**: A Batched claim MAY NOT be edited. In order to edit a claim that has been batched, you must find the batch containing the claim and delete the batch, which will reset all the status of all the claims in that batch to Complete. You may then edit the claim as it is now in a Complete status. Once you have completed the editing of the claim, you may re-batch the claims.

- **SENT**: If a sent claim must be replaced, clicking the Replace Claim button will generate a new claim with a Claim Submission Reason of "Replacement". You may then make any edits necessary to the new claim. A Replacement claim requires the Payer Claim Control Number to be populated. These new claims will go through the standard validation, batching, and submittal process to be sent to the Payer. 

  **Note**: If a sent claim must be edited and resent, clicking the Edit Claim button will generate a new claim with a Claim Submission Reason of "Original". You may then make any edits necessary to the new claim and it does not require the Payer Claim Control Number to be populated. (See below for expanded instructions for editing a sent claim.)

- **REPLACED**: Once a Replacement claim has been generated to replace a Sent claim, the Sent claim will then have a status of Replaced. A Replaced claim may not be edited, it may only be viewed.

- **VOIDED**: Once a Void claim has been generated to replace a Sent claim, the Sent claim will then have a status of Voided. A Voided claim may not be edited, it may only be viewed.
EDIT A SENT CLAIM

The Edit Claim button only appears on claims in a Sent status at the bottom of the screen next to the Void Claim and Replace Claim buttons. Sent claims may be accessed through the Find Claims function. This function allows you to edit and resubmit a claim that was previously sent for processing.

When the Edit Claim function is selected, the Submission Reason will change to Original. All of the information on the claim may be modified except for the Submission Reason, Client ID, DOB and Gender. Unlike a void or an adjustment, there is no association to the previously sent claim. You will not need the Payer Claim Control number (TCN) to re-submit the claim. All of the information on the sent claim is copied to the new claim except for the More Details information on the Service Lines. However, any line adjudication information will be copied over to the new claim.
This screen will display once the provider clicks the **Edit Claim** button. The provider will need to click **YES** to edit the claim. Clicking on **NO** returns the provider to the previous screen.

Again, the following fields **cannot** be changed:
- Submission Reason
- Client ID
- Date Of Birth
- Gender
- Type of Claim (e.g. Professional, Institutional & Dental)
A provider can use one claim repeatedly for the same client to save time. As long as he/she changes the appropriate information such as Date of Service and Procedure codes. It is also the provider’s responsibility to make sure the eligibility information, such as other insurance, is still the same.

**ROSTER BILLING**

Roster billing is used for when a provider sees many clients for the same procedure on the same date of service, such as administering the Flu Vaccine.

**Replicate Claim For New Client:** You will enter one claim. To replicate the claim, go to **Find Claims** and click on the claim you wish to use. Once you click on the claim, the **Replicate Claim for New Client** button will appear on the General Claim Information Tab.

Clicking on this button will allow the provider to erase the old client ID and enter the new client ID and patient control number.
Once you enter this information, click on Go next to the client ID. This will change the client information. Then you can click on Next at the bottom of the screen. You can then click on Finish on the bottom of the screen to complete the claim.