



**ePACES Professional Real Time Claim**  
*REFERENCE GUIDE*



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## ePACES Professional Real Time Claim REFERENCE GUIDE



### INITIAL SCREEN

Provider 111111111

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**welcome to ePACES**

The New York State Department of Health invites you to use the ePACES application to request and receive a variety of HIPAA-compliant Medicaid transactions. Using the links in the menu-bar on the left and the Help link on the top right of each page, you will be able to easily navigate through all the available functionality. If you do not see the necessary links in the menu at the left, please contact your Primary Administrator.

Please make sure your Provider Name is displayed at the top of the page before continuing. If your Provider Name is incorrect or not available in the "Change Provider" drop-down box at the top of the page, please contact the CSC HelpDesk at 800-343-9000.

For further information, please visit these sites:  
[eMedNY](#) [DOH](#)

**DOH**

Choose New Claim.



## ePACES Professional Real Time Claim REFERENCE GUIDE



### GENERAL CLAIM INFORMATION TAB

▼
General Claim Information

\* Indicates required field(s)

Submission Reason:  NPI Number:

\* Payer Claim Control Number:

\* Patient Control Number:

**Location Information**

Address Line 1:

Address Line 2:

City:

State:

Zip Code:  -

•
Client Information

\* Enter a Client ID:

**Submission Reason:** Choose *Original* if you are submitting a new claim or resubmitting a previously denied claim. Choose *Replace* if you are submitting an Adjustment and choose *Void* if you are voiding a claim. If you choose *Replace* or *Void*, you must enter the Payer Claim Control Number of the paid claim. This number appears on the remittance statement as the Transaction Control Number (TCN). The Payer Claim Control Number field will only appear if you select *Replace* or *Void* from the drop down.

**Note:** Options *Interim* and *Final* also appear in the drop down menu. These are only for use by Certified Home Health Agencies.

**NPI Number:** The NPI in this field is defaulted to the current NPI for the MMIS provider ID to which it maps. If you are billing a date of service when the NPI for the **same** MMIS provider ID was 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 processed claim. **Note:** This field will only appear if doing an adjustment or void.

**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 whom you are submitting a claim. This field is required on all claims.

**Location Information:** Enter the address where the service was performed and your Zip + 4 postal code.

Non-emergency Transportation claims only: You may enter the 3-digit locator code assigned to the location you are billing from if you are not required to submit with an NPI. Locator codes range 003 and higher. **Note:** The Locator Code field will only appear if the provider in the drop down is an atypical provider such as a Non-emergency transportation provider.



### ePACES Professional Real Time Claim REFERENCE GUIDE



**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.

**General Claim Information**

\* Indicates required field(s)

Submission Reason:  NPI Number:

\* Patient Control Number:

**Location Information**

Address Line 1:

Address Line 2:

City:

State:

Zip Code:  -

**Client Information**

\* Enter a Client ID:

Jav Doe  
Adress Line 1  
Address Line 2  
City, State, Zip

\* DOB:

\* Gender:

\* Type of Claim:



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The client's name, address, DOB and gender are automatically populated. 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 considered for a Real Time Submission 'Professional Real Time' must be chosen, otherwise it will process as a general batched claim.

An immediate claim status response will be sent for each claim submitted.



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**PROFESSIONAL CLAIM INFORMATION TAB**

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.

▶ General Claim Information

▼ Professional Claim Information

▶ Provider Information

▶ Diagnosis

▶ Other Payers

▶ Service Line(s)

\* Indicates required field(s)

\* Place of Service:

---

\* Provider Signature On File?  Yes  No

\* Assignment of Benefits?

\* Release of Information?

\* Accept Assignment?

\* Signature Source:  Patient  Other

\* Exempt from Copay?:  Yes  No

\* Is Patient Pregnant?:  Yes  No

---

Patient Amount Paid: \$

Prior Auth or Referral #:

Mammography Certification Number:

CLIA Number:

---

**• Certification Information**

Certification Category	Condition Codes
<input type="text"/> ▼	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
<input type="text"/> ▼	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
<input type="text"/> ▼	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

[Enter More Certification Information...](#)

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**• Dates**

Admission Date:

Discharge Date:

Onset of Current Illness or Injury Date:

Last X-Ray Date:

Last Menstrual Period Date:

Hearing and Vision Prescription Date:

Disability From Date:

Disability Through Date:

Assumed Care Date:

Relinquished Care Date:

Accute manifestation Date:

Initial Treatment Date:

Last Seen Date:



## ePACES Professional Real Time Claim REFERENCE GUIDE



**Place Of Service:** Choose the Place of Service code from the drop down box. The Place of Service identifies where you saw the patient. The most common Place of Service codes are:

- |                         |                               |
|-------------------------|-------------------------------|
| 11 – Office             | 12 – Recipient Home           |
| 21 – Inpatient Hospital | 22 – Outpatient Hospital      |
| 23 – Emergency Room     | 31 – Skilled Nursing Facility |

**Provider Signature On File:** Entry must be YES to indicate that the Provider has a current certification statement on file to allow them to submit electronically.

**Assignment Of Benefits:** Entry must be Y for Yes to indicate payment will be made to the Provider.

**Release Of Information:** Enter a Y for Yes - Provider has a Signed Statement Permitting Release of Medical Billing Data Related to a Claim. Enter an 'I' for Informed Consent to Release Medical Information for Conditions or Diagnoses Regulated by Federal Statutes.

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

**Signature Source:** Choose the appropriate option of Patient or Other.

**Exempt From Copay?:** Choose Yes or No on whether the member is exempt from copay.

**Is Patient Pregnant?:** Field is defaulted No. If member is pregnant, click Yes.

**Patient Amount Paid:** This field is used to indicate the amount paid, if any, by the member.

**Prior Authorization or Referral #:** Enter in prior approval number or Referral number if applicable.

**Mammography Certification Number:** Required when billing for mammography services.

**CLIA Number:** Required for all CLIA certified facilities performing CLIA covered laboratory services.

**Certification Category:** Enter a certification category if billing for Early Periodic Screening Diagnosis and Treatment.

**Condition Codes:** If you indicated a certification category, enter the appropriate condition code:

- AV Patient refused referral.
- NU No Referral Made
- S2 Under Treatment for referred diagnostic or corrective health problem
- ST Patient is referred or scheduled for new services as a result of the screening

**Dates:** Enter the dates listed below as applicable.

- Admission Date
- Discharge Date
- Onset of Current Illness or Injury Date
- Last X-Ray Date
- Last Menstrual Period Date
- Hearing and Vision Prescription Date
- Disability From Date
- Disability Through Date
- Assumed Care Date
- Relinquished Care Date
- Acute Manifestation Date
- Initial Treatment Date
- Last Seen Date



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**Related Causes Information**

Related Causes: (select up to 2)

Employment  
 Other Accident  
 Auto Accident NY US

Accident Date:

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**Transport Information**

**Ambulance Transport**

Patient Weight:  lbs.

Ambulance Transport Reason:

Transport Distance:  miles

Ambulance Condition Codes:

**Non Emergency Transport**

\* Driver License:

\* License Plate Number:

---

**Transportation Pick UP/Drop Off Location**

Pick UP	Drop Off
Address Line 1: <input type="text"/>	Address Line 1: <input type="text"/>
Address Line 2: <input type="text"/>	Address Line 2: <input type="text"/>
City: <input type="text"/>	City: <input type="text"/>
State: NY	State: NY
Zip Code: <input type="text"/> - <input type="text"/>	Zip Code: <input type="text"/> - <input type="text"/>

Service Authorization Exception Code:

Special Program Indicator:

Delay Reason:

Patient Weight (EPO patients):  lbs.

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**Condition Codes**

Code	Code
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>

---

**Group Provider (use if a different entity than the Billing Provider)**

Group Provider Number:  Go

Previous 
Next

Delete Claim 
Finish 
Save As Draft 
Cancel





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**Related Causes Information:** This field is used to indicate that the claim is being submitted because of an accident or work related incident. If applicable, enter a check next to the appropriate cause and enter the accident date. If Auto Accident is checked, use the drop down boxes to indicate the State and Country. Leave blank if the claim is unrelated to an accident.

**Transport Information:**

**Ambulance Transport:** completed for ambulance services only

**Non-Emergency Transport:** completed for ambulette services only

**Service Authorization Exception Code:** Enter a service authorization exception code if the service you are billing is exempt from utilization threshold. 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

**Special Program Indicator:** Entry will be one of the following Special Program codes to indicate if the services are related to PHCP or Disability:

- 02 = Physically Handicapped Children's Program. This value will be processed as the PHCP indicator.
- 03 = Special Federal Funding. We will ignore this value if entered.
- 05 = Disability. This value will be processed as the Possible Disability indicator.
- 09 = Second Opinion or Surgery. We will ignore this value if entered.

**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
- 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 (Interrupted Maternity Care or IPRO Denial/Reversal)
- 15 = Natural Disaster

**Patient Weight (EPO patients):** Leave this field blank.

**Condition Codes:** If the procedure is for an Abortion/Sterilization, select the applicable code from the list. Only the following Abortion Codes may be reported in this field:

- AA = Abortion performed due to rape
- AB = Abortion performed due to incest
- AC = Abortion due to serious fetal defect or serious deformity or abnormality



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**AD** = Abortion due to life endangering physical condition caused by or arising from pregnancy  
**AE** = Abortion due to physical health of mother that is not life endangering  
**AF** = Abortion due to emotional/physiological health of mother  
**AG** = Abortion due to social or economic reasons  
**AH** = Elective Abortion  
**AI** = Sterilization

**Group Provider Number:** If you would like payment to go to the group, enter the group NPI in this field.



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## PROVIDER INFORMATION TAB

**New Claim - 837 Professional**

General Claim Information | Professional Claim Information | **Provider Information** | Diagnosis | Other Payers | Service Line(s)

\* Indicates required field(s) if entering information for a provider type

**Rendering Provider**

- Use an Existing Provider**  
\*Select a Name:    
OR Search for a Medicaid Provider:  
Last Name:   
Provider Number:
- Enter a New Non-Medicaid Provider**  
\* NPI #:

**Referring Provider**

- Use an Existing Provider**  
\*Select a Name:    
OR Search for a Medicaid Provider:  
Last Name:   
Provider Number:
- Enter a New Non-Medicaid Provider**  
NPI #:   
AND/OR  
State License #:

**Primary Care Provider**

- Use an Existing Provider**  
\*Select a Name:    
OR Search for a Medicaid Provider:  
Last Name:   
Provider Number:
- Enter a New Non-Medicaid Provider**  
NPI #:   
AND/OR  
State License #:

**Supervising Provider**

- Use an Existing Provider**  
\*Select a Name:    
OR Search for a Medicaid Provider:  
Last Name:   
Provider Number:
- Enter a New Non-Medicaid Provider**  
\* NPI #:



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**Rendering Provider:** The Rendering Provider is used to identify the actual provider of service when that person is different from the provider selected as the Billing Provider.

**Please Take Note:** If a Physician Assistant or Clinical Social Worker is entered as a Rendering Provider, the Supervising Provider field must be completed.

**Referring Provider:** This field is used to identify the Referring Provider when necessary. The Referring Provider is required in certain cases such as a Restricted Recipient, private duty nursing claims, and required Podiatry referrals for children under 21 years of age.

**Primary Care Provider:** This field is used to report additional referrals if more than one referral exists and there is a requirement to report the additional referral. If a Primary Care Provider is entered, a Referring Provider must also be entered.

**Supervising Provider:** Enter the Billing Provider's number in this section when the Rendering Provider is a Physician Assistant or Clinical Social Worker.



## ePACES Professional Real Time Claim REFERENCE GUIDE



### DIAGNOSIS TAB

**•• New Claim - 837 Professional**

▶ General Claim Information

▶ Professional Claim Information

▶ Physician Information

▼ **Diagnosis**

▶ Other Payers

▶ Service Line(s)

**• Diagnosis Information**

ICD-9     ICD-10

Diagnosis 1: <input style="width: 100%;" type="text"/>	Diagnosis 7: <input style="width: 100%;" type="text"/>
Diagnosis 2: <input style="width: 100%;" type="text"/>	Diagnosis 8: <input style="width: 100%;" type="text"/>
Diagnosis 3: <input style="width: 100%;" type="text"/>	Diagnosis 9: <input style="width: 100%;" type="text"/>
Diagnosis 4: <input style="width: 100%;" type="text"/>	Diagnosis 10: <input style="width: 100%;" type="text"/>
Diagnosis 5: <input style="width: 100%;" type="text"/>	Diagnosis 11: <input style="width: 100%;" type="text"/>
Diagnosis 6: <input style="width: 100%;" type="text"/>	Diagnosis 12: <input style="width: 100%;" type="text"/>

**• Anesthesia Related Procedure**

Anesthesia Related Procedure Code 1:

Anesthesia Related Procedure Code 2:

◀ Previous

Next ▶

▶ Delete Claim

▶ Finish

▶ Save As Draft

▶ Cancel

**ICD-9/ICD-10:** This is defaulted to ICD-9 as this is the only diagnosis type currently allowed. ICD-10 is reserved for future use.

**Diagnosis Information:** Enter the diagnosis code when applicable. Up to 12 diagnosis codes may be entered on a claim, but they cannot be duplicated. The diagnosis pointer on the claim line corresponds to the codes entered here. Do not include the decimal point when entering the diagnosis code.

**Anesthesia Related Procedure:** If billing for anesthesia services, enter the procedure code(s) for the surgery in this field.



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### OTHER PAYERS TAB

This tab may be used to report payments received from Medicare and/or Third Party Insurance if you want to report payment at the Claim Level.

• • **New Claim - 837 Professional**

\* Indicates required field(s)

**All Other Payers**

Line #	Other Payer Name	Paid Amount	Date Claim Paid	Other Subscriber Name	Remove
(No Other Payers Found)					

**All Other Payers:** If more than one other payer's information applies, click on the *Add New Payer* button.



## ePACES Professional Real Time Claim REFERENCE GUIDE



### OTHER PAYER DETAILS

This Tab is used to indicate details about the Other Payer. If you are reporting payment from a third party insurance, all required fields on this tab must be completed.

▶ General Claim Information

▶ Professional Claim Information

▶ Physician Information

▶ Diagnosis

▼ Other Payers

▶ Service Line(s)

\* Indicates required field(s) if entering information on this tab

#### Other Payer Details

Next Other Payer

▶ View Other Payers

#### Other Payer Information

- \* Other Payer Name:
- \* Payer Sequence Number:
- \* Payer Type:
- Other Payer Paid Amount: \$
- Other Payer Claim Control Number: \$
- Date Claim Paid:

#### Other Subscriber

- \* Last Name:
- \* First Name:
- \* Primary ID:
- Address Line 1:
- Address Line 2:
- \* City:
- \* State:
- \* Zip Code:
- \* Country:

#### Other Subscriber Information

- \* Relationship:
- Group Number:
- Group Name:

02/23/12



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### **Other Payer Information**

**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 support files, you can add them by clicking on the "Other Payer" link under Support Files.

**Payer Sequence Number:** Enter the sequence number as Primary, Secondary or Tertiary.

**Payer Type:** Enter the other payer type. Ex: MB for Medicare Part B.

**Other Payer Paid Amount:** If reporting Other Payer Paid information, enter the amount paid by the Other Payer in this field. Enter the total amount paid by the other insurance for the entire claim.

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

**Date Claim Paid:** Enter the date you received payment from the Other Payer.

### **Other Subscriber**

Enter the Name, Primary ID, Address, and other demographic information pertaining to the subscriber of the Other Payer.

### **Other Subscriber Information**

**Relationship:** Enter the appropriate code from the drop down list to indicate the subscriber's relationship to the member.

**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.





## ePACES Professional Real Time Claim REFERENCE GUIDE



**Claim Adjustments**

Claim Adjustment Group	Reason Code	Adjustment Amount	Adjustment Quantity
<input type="text"/>	<input type="text"/>	\$ <input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	\$ <input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	\$ <input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	\$ <input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	\$ <input type="text"/>	<input type="text"/>

[Add](#)

Claim Adjustment Group	Reason Code	Adjustment Amount	Adjustment Quantity

**Other Insurance Coverage Information**

Assignment of Benefits?

Patient Signature Source?

Release of Information?

**Amounts**

Remaining Patient Liability: \$

Non Covered Charge Amount: \$

[Next Other Payer](#) [View Other Payers](#)

[Previous](#) [Next](#)

[Delete Claim](#) [Finish](#) [Save As Draft](#) [Cancel](#)

### 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:** Enter Yes or No.



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**Patient Signature Source:** Choose the appropriate code from the drop down list.

**Release of Information:** Choose the appropriate code (Y or I) from the drop down list.

**Amounts**

**Remaining Patient Liability:** This amount the provider believes is due and owing after the Other Payer's adjudication.

**Non Covered Charge 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.



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**SERVICE LINE TAB**

**•• New Claim - 837 Professional**

\* Indicates required field(s)

Line	Line Item Ctl #	*Svc Date:	*Proc & Mod	*Chrg Amount	*Svc Count	Place of Svc	DX Pointer	*Emgcy	More	Del.
1	<input type="text"/>	From: <input type="text"/> To: <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> Unit <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="radio"/> Yes <input type="radio"/> No		
2	<input type="text"/>	From: <input type="text"/> To: <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> Unit <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="radio"/> Yes <input type="radio"/> No		
3	<input type="text"/>	From: <input type="text"/> To: <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> Unit <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="radio"/> Yes <input type="radio"/> No		
4	<input type="text"/>	From: <input type="text"/> To: <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> Unit <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="radio"/> Yes <input type="radio"/> No		
5	<input type="text"/>	From: <input type="text"/> To: <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> Unit <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="radio"/> Yes <input checked="" type="radio"/> No		

**Total Claim Charges: \$0.00**

**Line:** Indicates the line number on the claim. You can enter up to 5 service lines using this page. Click on the *Add More Services Lines* button to allow entry of an additional 5 lines. Each time you click on that button, you are given 5 more lines up to a maximum of 50 claim lines.

**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.



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**Svc Dates From/To:** Enter the service date in *From* if you are only billing for a single day for that claim line. For Physicians or Nurse Practitioners who are block billing consecutive inpatient hospital visits in the same month, the *From/To* dates may be used.

**Proc&Mod:** Enter the procedure code that describes the service you are billing. You may enter up to 4 modifiers as necessary to identify special circumstances.

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

**Svc Count:** Enter the number of units.

**Place of Svc:** Enter the Place of Service Code if the code you entered on the Professional Claim Information Tab is different. This would be done if you indicated Office Visit on the header, then needed to bill Inpatient Services as well.

**DX Pointer:** Enter the appropriate number corresponding to the diagnosis code entered on the Diagnosis Tab. The first pointer indicates which diagnosis code is considered to be the primary diagnosis for this claim line. You may enter up to 4 pointers per claim line.

**Emgcy:** Select Yes or No to indicate if the service rendered was related to an emergency.

**More:** Click on this button to add additional details pertaining to this claim line. You may use this area to indicate additional data that may be different from what was entered at the claim level. Some examples of how the *More* button may be used are:

- To indicate a paid amount from Medicare and/or Other Payers at the line level.
- To indicate a Prior Approval Number at the line level.
- To indicate EPSDT (CHAP) at the line level.
- To indicate Family Planning at the line level.
- To indicate Co-Pay Exemption at the line level.
- To indicate the NDC and National Drug Unit Count when billing physician administered drugs.



## ePACES Professional Real Time Claim REFERENCE GUIDE



### MORE BUTTON

**\*\* New Claim - 837 Professional**

General Claim Information
  Professional Claim Information
  Physician Information
  Diagnosis
  Other Payers
  Service Line(s)

\* Indicates required field(s)

**More Details - Service Line #1**

Line	Line Item Ctl #	*Svc Date	*Proc & Mod	*Chrg Amount	*Svc Count	Place of Svc	DX Pointer	* Emgcy
1		05/01/2010 05/18/2010	0123	\$1.00	2 UN			No

**Dates**

Last X-Ray Date:

Product Shipped Date:

Initial Treatment Date:

Prescription Date:

**ESRD Related Test Results**

Test Performed:

Test Results:

Measurement Identifier:  Test Results  Original Starting Dosage

Test Performed Date:

**Drug Identification**

National Drug Code:

National Drug Unit Count:  Unit

Prescription Number or Compound Drug Association Number:  Prescription Number  Link Sequence Number

Prior Authorization #:

CLIA Number:

Sales Tax Amount: \$

Services a result of EPSDT Referral?:  Yes  No

Family Planning Service?:  Yes  No

Obstetric Anesthesia Addtl Units :

**More Details - Service Line:** When clicked, the *More* button allows you to enter additional information for the claim line.

**Drug Identification:** These fields are required if billing for a drug code requiring an NDC on the claim.

**National Drug Code:** Enter NDC number.



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**National Drug Unit Count:** Enter number of units given.

**Prescription Number or Compound Drug Association Number:** Enter the prescription number or compound drug association number in this field.

**Prior Authorization #:** PA number can be entered on the *More* button if you are billing for different lines that require a different PA number on each line.

**Services a result of EPSDT Referral?** If the service was performed as the result of a screening referral, enter Yes here.

**Family Planning Service?:** If Family Planning applies for this line and is not indicated on the Professional Claim Information tab, enter Yes here.



**ePACES Professional Real Time Claim**  
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**Purchased Service Provider**

**Use an Existing Provider**

Select a Name:  Go

OR Search for a Medicaid Provider:

Last Name:

Provider Number:  Go

**Enter a New Non-Medicaid Provider**

NPI #:

AND/OR

State License #:

Go

**Ordering Provider (to report for DME services captured at the service line)**

**Use an Existing Provider**

Select a Name:  Go

OR Search for a Medicaid Provider:

Last Name:

Provider Number:  Go

**Enter a New Non-Medicaid Provider**

NPI #:

AND/OR

State License #:

Go

**Durable Medical Equipment Rental Services**

Length of Medical Necessity:  days

DME Rental Price: \$

DME Purchase Price: \$

Rental Unit Price Indicator:

**Transport Information**

**Ambulance Transport**

Patient Weight:  lbs.

Ambulance Transport Reason:  Go

Transport Distance:  miles

Ambulance Condition Codes:  Go

Go

Go

Go

**Non Emergency Transport**

Driver License:

Plate License:

**Transportation Pick UP/Drop off Location**

Pick UP	Drop Off
Address Line 1: <input type="text"/>	Address Line 1: <input type="text"/>
Address Line 2: <input type="text"/>	Address Line 2: <input type="text"/>
City: <input type="text"/>	City: <input type="text"/>
State: <input type="text" value="NY"/>	State: <input type="text" value="NY"/>
Zip Code: <input type="text"/>	Zip Code: <input type="text"/>

Procedure Description:

02/23/12



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**ePACES Professional Real Time Claim**  
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**Ordering Provider:** DME and Transportation Providers use this field to report the Ordering Provider.

**Durable Medical Equipment Rental Services**

**Length of Medical Necessity:** Enter the number of days for which the medical equipment is medically necessary to the patient. A value is required if any information is entered in the DME section.

**DME Rental Price:** If there is a rental fee involved with the DME represented on this Service Line, enter the dollar value here. If a HCPCS code is entered, either a Rental Price or Purchase Price must be entered.

**DME Purchase Price:** If the DME was purchased, enter the purchase price here. If a HCPCS code is entered, either a Rental Price or Purchase Price must be entered.

**Rental Unit Price Indicator:** If a Rental Price is entered, you must select the unit by which the Rental Price is based. Valid values are 'Daily', 'Weekly', or 'Monthly'.

**Transport Information**

**Non Emergency Transport:** You can enter license number and plate number on the *More* button instead of on the professional claim tab if a different driver or vehicle is used for different service lines.

**Line Adjudication Information and Claim Adjustment Fields**

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. Scroll to the bottom of the screen to enter the information.





## ePACES Professional Real Time Claim REFERENCE GUIDE



**Line Adjudication Information**

Other Payer Name:

Service Line Paid Amount: \$

Paid HCPCS Code:

Modifiers:

Paid Service Unit Count:

Bundled Line Number:

Date Claim Paid:

Remaining Patient Liability:

Claim Adjustment Group	Reason Code	Adjustment Amount	Adjustment Quantity
<input type="text"/>	<input type="text"/>	\$ <input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	\$ <input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	\$ <input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	\$ <input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	\$ <input type="text"/>	<input type="text"/>

Claim Adjustment Group	Reason Code	Adjustment Amount	Adjustment Quantity
<input type="text"/>	<input type="text"/>	\$ <input type="text"/>	<input type="text"/>

If the other payer reported adjustments at the line 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.

To go back to the service line tab, click on *Close*.

When you have entered the claim lines you want to submit, click on the *Finish* button.



## ePACES Professional Real Time Claim REFERENCE GUIDE



### CLAIM ENTRY CONFIRMATION WINDOW

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

### Claim Entered

<b>Claim Entry Status:</b> Complete	<b>Claim Type:</b> Professional Real Time
<b>Client ID:</b>	<b>Patient Control Num.:</b>

**Note: Please use your browser to print this screen if you wish to maintain a copy.**

▶ Edit Current Claim
▶ Enter Another New Claim
▶ Validate Current Claim
▶ Submit Real Time Claim

At this point you can choose from the 4 options displayed. If you are ready to submit the claim and want a real time response, click on the *Submit Real Time Claim* button.

This screen displays to indicate that the claim was successfully submitted. Now you must click on the Real Time Responses link from the menu to view the Claim Acknowledgement response.

### Claim Entered

<b>Claim Entry Status:</b> Sent	<b>Claim Type:</b> Professional (RT)
<b>Client ID:</b>	<b>Patient Control Num.:</b>

**Note: Please use your browser to print this screen if you wish to maintain a copy.**

▶ Enter Another New Claim

**Submit Real Time Claim Confirmation**

**Claim successfully submitted. Click the Real Time Responses link in the left hand navigational menu to view the corresponding Claim Acknowledgement response.**



## ePACES Professional Real Time Claim REFERENCE GUIDE



### REAL TIME RESPONSES

Responses to Professional Real Time claims are available within moments after submitting the claim.

• • Professional Real Time Claim Response Activity Worklist

**Search Criteria**

Requested within the last  days

Client Last Name:

Patient Control #:

Client ID #:

Submission Reason:

Date Request Sent:(mm/dd/yyyy)

Dates of Service From: (mm/dd/yyyy)

Dates of Service To: (mm/dd/yyyy)

Status:

Show  all transactions for this provider  just my transactions

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No Records

Name ▼	Patient Control # ▼	Client ID ▼	Submission Reason ▼	HCPCS & Mod	Date Sent ▼	Dates of Service ▼	Status ▼
No Results Found							
Name	Patient Control #	Client ID	Submission Reason	HCPCS & Mod	Date Sent	Dates of Service	Status
No Records							

**Search Criteria:** You can enter various search criteria to search for particular claims. The ePACES system will default the “Requested within the last (number of) days” field to 1 in order to limit the number of claims returned in the search results.

The results list will display claims that match the search criteria entered. Click on the highlighted name to open the response page for the claim you want to view.



## ePACES Professional Real Time Claim REFERENCE GUIDE



### CLAIM STATUS RESPONSE DETAILS

**Patient**

Client ID: [LL11111L](#)

Name: [Smith](#)

Address:

Date of Birth: [01/01/0001](#)

Gender: FEMALE

**Claims**

Payer Claim ID	Charge Amount	Paid Amount	Dates of Service	Status Date	Check #	Check Date
<a href="#">▶ 01234567891234567</a>	\$659.33	\$115.77	5/16/2008 - 5/16/2008	7/28/2008	12345678901234	5/26/2008

**Claim Level Status**

(F1) - Finalized/Payment-The claim/line has been paid. (65) - Claim/line has been paid.

▶ Close
▶ Worked

**Client Information:** Displays the client's demographic information.

**Claim Level Status:** Indicates the status of the claim at the Claim Level. If the claim has more than one claim line, what is reflected in the claim level status applies to the entire claim. The TCN assigned to the claim by eMedNY is provided.

**Line Level Status:** Indicates the status of the claim at the Line Level. If the claim has more than one claim line, each line will be displayed separately.

**Note:** As the Provider, you have the option to change this file to 'Worked' indicating that you have viewed the claim response.



## ePACES Professional Real Time Claim REFERENCE GUIDE



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### **EDITING A 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 also may 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 is 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 *Finish* 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.
- **SENT:** A claim that has already been sent for processing and therefore has a status of Sent may not be edited; it may however be replaced or edited as an Original claim and resent. 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 Claim Original Reference Number to be populated. These new claims will go through the standard validation, batching, and submittal process to be sent to the Payer. 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 Claim Original Reference 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 (see [Deleting a Sent Claim](#) for more details in the Help documentation) the Sent claim will then have a status of Voided. A Voided claim may not be edited, it may only be viewed.



## ePACES Professional Real Time Claim REFERENCE GUIDE



### 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 Claim Original Ref. Num. 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.

General Claim Information

Institutional Claim Information

Provider Information

Diagnosis/Procedure

Other Payers

Service Line(s)

\* Indicates required field(s)

Submission Reason: Original      NPI Number:

\* Patient Control Number: 123458

**Location Information**

Address Line 1:

Address Line 2:

City:

State: NY

Zip Code: 12143- 0023

**Client Information**

\* Enter a Client ID: AA11111A ▶ Replicate Claim For New Client

Jav Doe  
Address Line 1  
Address Line 2  
City, State, Zip

\* DOB: 01/01/0001

\* Gender: F

\* Type of Claim: Professional

▶ Next

▶ Void Claim

▶ Replace Claim

▶ Edit Claim



### ePACES Professional Real Time Claim REFERENCE GUIDE



Do you wish to edit and resend this claim?

\* Indicates required field(s)

Submission Reason: Original      NPI Number:

\* Patient Control Number: 123458

**Location Information**

Address Line 1:  
Address Line 2:  
City:  
State: NY  
Zip Code: 12143- 0023

**Client Information**

\* Enter a Client ID: AA11111A

Jav Doe  
Adress Line 1  
Address Line 2  
City, State, Zip

\* DOB: 01/01/0001

\* Gender: F

\* Type of Claim: Professional

This screen will display once the provider clicks the *Edit Claim* button. You need to click YES if you want to edit the claim. If you click NO you are brought back to the previous screen.



**ePACES Professional Real Time Claim**  
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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 recipient to save time. As long as they change the information such as Date of Service and Procedure codes. It is also their responsibility to make sure the eligibility information, such as other insurance, is still the same.





## ePACES Professional Real Time Claim REFERENCE GUIDE



### ROSTER BILLING

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

General Claim Information
Professional Claim Information
Provider Information
Diagnosis
Other Payers
Service Line(s)

\* Indicates required field(s)

Submission Reason: Original      NPI Number:

\* Patient Control Number: 123

**Location Information**

Address Line 1: 1 MAIN ST.

Address Line 2:

City: NOWHERE

State: NY

Zip Code: 11111 - 1111

**Client Information**

\* Enter a Client ID: AA11111A ▶ Replicate Claim For New Client

JOHN SMITH  
123 Street  
Nowhere, NY 12345

\* DOB: 01/01/0001

\* Gender: M

\* Type of Claim: Professional Real Time

▶ Next

▶ Void Claim
▶ Replace Claim
▶ Edit Claim

**Replicate Claim For New Client:** The provider will enter one claim. You can use this button by going to Find Claims and clicking 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.



## ePACES Professional Real Time Claim REFERENCE GUIDE



Clicking on the button will allow you to erase the old client ID, and enter the new client ID and patient control number.

General Claim Information

Professional Claim Information

Provider Information

Diagnosis

Other Payers

Service Line(s)

\* Indicates required field(s)

Submission Reason: Original      NPI Number:

\* Patient Control Number:

**Location Information**

Address Line 1:            1 MAIN ST.

Address Line 2:

City:                        NOWHERE

State:                        NY

Zip Code:                  11111 - 1111

**Client Information**

\* Enter a Client ID:  Go

JOHN SMITH  
123 Street  
Nowhere, NY 12345

\* DOB:

\* Gender:

\* Type of Claim: Professional Real Time

Next

Once you enter this information, you want to click *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.