ePACES Help

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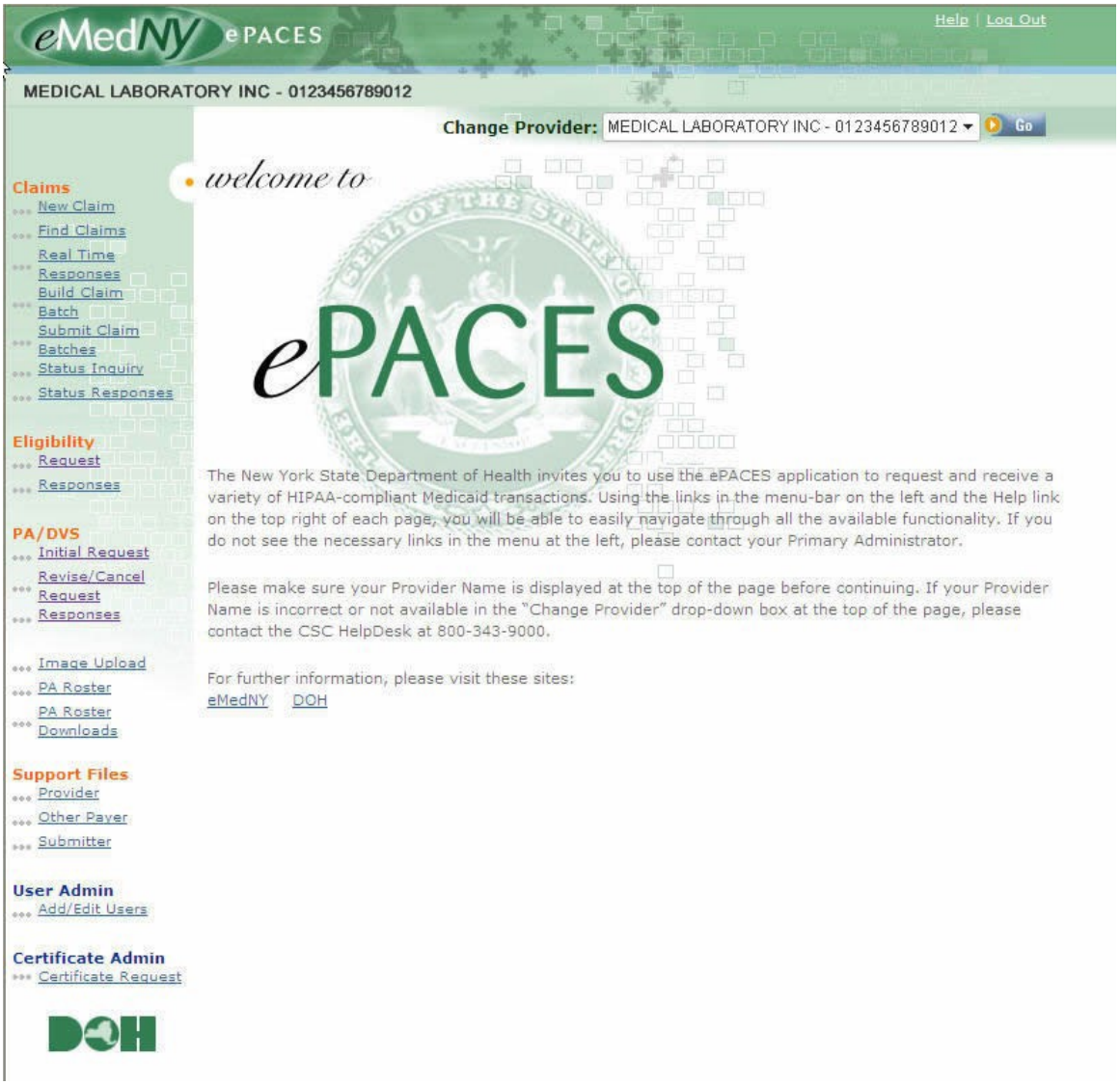
What is ePACES?



The electronic Provider Assisted Claim Entry System (ePACES) was developed by eMedNY, on behalf of the New York State (NYS) Department of Health (DOH). ePACES is a web- based application that allows providers to request and receive HIPAA-compliant Claim, Eligibility, Claim Inquiry and Prior Approval/ Dispensing Validation System (DVS) transactions.

Providers log onto ePACES over the Internet and ePACES automatically submits transactions for processing, eliminating the need to mail files on diskettes and tapes. The HIPAA-compliant transactions are electronically transferred to the NYS eMedNY Medicaid Management Information System (MMIS) mainframe. ePACES integrates with the eMedNY system via a Translator, which reformats the data being transferred to a structure expected by the receiving system.

Because ePACES is a web-based application, it is not necessary to distribute application software for provider installation. The most current version of the ePACES application will be delivered to the client PC each time providers access it over the Internet. Providers will need only a PC, browser and connection to the Internet to access ePACES. Providers do not need to install any custom software. The most recent enhancements to the system are outlined in the What's New in ePACES section of this document.

System Requirements

- Cookie-enabled and Javascript-enabled browser:
  - Internet Explorer 10+
  - Chrome
  - Firefox
  - Safari
- Broadband connection

Key Features

- HIPAA-compliant claims: Institutional, Professional, Dental
- Prior Approval Request and Response processing
- Real Time Professional Claims Request and Response processing
- Context-sensitive selection lists speed claim entry and enhance accuracy
- Real-time Client Eligibility Request and Response processing
- Automated Real-time Claim Status Inquiry for single or multiple claims
- Real-time Dispensing Validation System processing
- Automated Claim batch and submit for adjudication
- Comprehensive On-line Help documentation
- On-Line maintenance of provider and payer information

What's New in ePACES

September 2018

Eligibility Response Details

- ☐ The Health Insurance Claim Number (HICN) field has been replaced with Medicare Identifier.

June 2016

Login Security

- ☐ A secondary level of login security added utilizing the reCAPTCHA security service.
  - o Users are challenged to prove they are not robots by completing visual or audio recognition tasks.
  - o Login cannot proceed without successful completion of challenge.
  - o Browser version of IE10+ or latest two versions of Chrome, Firefox and Safari required to support reCAPTCHA.

January 2015

PA-DVS Requests

- A new submission function—Enter Another DVS For This Client—has been added that preserves the client information from request to request.
  - o The client information is retained but the service information is cleared to support submitting repeat requests for the same client.
  - o It is only available for Dental - DVS and Non Dental - DVS requests.

June 2014

ICD-10

- ☐ ICD-10 codes have been made active.
  - o ICD-10 codes may be entered where previously only ICD-9 codes were allowed.
  - o Users select either the ICD-9 or ICD-10 control to indicate the type of code being entered.

June 2013

Eligibility Requests

- ☐ The Request page layout has been reorganized for readability and to accommodate the addition of the Service Types parameters.
- ☐ The Client ID and Client Information fields are mutually exclusive. Entering a value in one side locks the other side until either a search is performed or the initial entry field is cleared. This prevents submitting both sets of search criteria for a single search.
- ☐ One or more Service Types may be specified as a search parameter.
- ☐ The Calendar control for selecting Date of Service and Date of Birth has been upgraded.
- ☐ The SSN field is divided into subfields separated by hyphens (xxx-xx-xxxx) to simplify entry of Social Security numbers.

Eligibility Response

- ☐ The search criteria parameters for Result and Status have been removed and To Date has been added.
- ☐ The Responses page layout has been reorganized for readability.
- ☐ The Response listing has been improved for readability and navigation:
  - o The displayed fields have been reduced to Client ID, Name and Dates of Service.
  - o The layout has been converted from a block cell look to continuous rows with alternating grayscale background.
  - o Paging controls have been added to set number of displayed results (10–50 by 10s) and to navigate sequentially among pages or directly to a page.

Eligibility Response Details

- ☐ The Response Details page layout has been reorganized to put the client information at the top and separate the information into bordered sections to increase readability.
- ☐ Within each section, the fields have been brought closer and aligned.
- ☐ The Medicaid Eligibility section has been has been improved for readability:
  - o Eligibility and exceptions are written out.
  - o Eligible and Non-eligible codes have been converted to side-by-side listings of the codes and descriptions labeled as Covered Services and Non-covered Services, respectively.

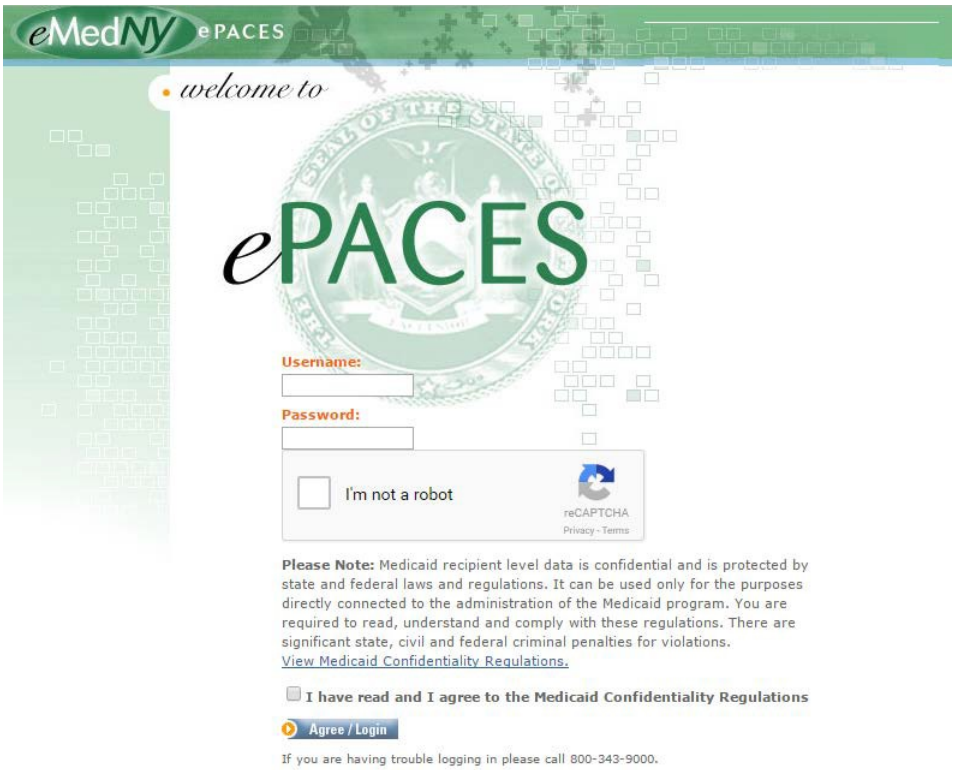
January 2012

There are a number of enhancements that have been added to the ePACES application that you should keep in mind while working in the system:

- ☐ The Claim Status Inquiry requests will now process in real-time, providing a response within a few moments that may be viewed in the Status Response worklist.
- ☐ The concept of a Temporary TSN has transitioned to a MEVS Only TSN. This type of TSN
- ☐ may be used for submitting all non-claims transactions and will not expire.
- ☐ Announcement page added for the important announcements when a user first logs into ePACES.
- ☐ POA (Present on Admission) Indicator required for All Diagnosis if Type of Bill is 11 or 12.

Accessing ePACES

ePACES is accessed from the vertical application bar (*Login ePACES*) on the right side of the eMedNY.org homepage or directly from https://emedny.org/epaces/. The ePACES login page is shown below.



ePACES Security

ePACES has two levels of security:

- Primary—Login credentials
- Secondary—Robot challenge

Login Credentials

Users must have valid login credentials consisting of a username and password combination in order to log into ePACES. The credentials are not obtained by individual users, but rather through their facilities:

- If your facility is new to the ePACES system, you must contact Provider Relations to receive an Electronic Transmittal Identification Number (ETIN or TSN) as well as instructions for the ePACES Activation process. A MEVS Only TSN may be issued to allow for submission of all non-Claims transactions, including Prior Approval, Eligibility, Claim Inquiry and Dispensing Validation System (DVS) transactions.

- If your facility has already been registered in the ePACES system, your on-site ePACES Administrator is responsible for setting up individual user accounts with the proper access privileges.

If you do not have a User ID or have forgotten your password, please contact your ePACES System Administrator or Provider Relations.

> **Warning:** Per the Health Insurance Portability and Accountability Act (HIPAA), eMedNY or the on-site ePACES Administrator is required to assign unique usernames and passwords for identifying and tracking a user's identity [Ref: § 164.312(a)(2)(i)]. Users that share their ePACES username and password are in violation of the HIPAA Security Regulation. If this practice is detected, the user's access will be revoked and other sanctions may apply.

Robot Challenge—reCAPTCHA

ePACES requires users to prove they are not robots (automated login applications) by utilizing the reCAPTCHA security service to present them with a recognition challenge task. Successfully completing the task allows a user to prove *I'm not a robot*. Failure to complete the task prevents the user from being able to log into ePACES.

An area under the login credential fields contains reCAPTCHA. Users initiate the challenge by clicking in the box next to *I'm not a robot* to display the reCAPTCHA popup window. Successfully completing the robot challenge closes the window and replaces the box with a green checkmark to indicate the user is not a robot.

Challenge Tasks

ePACES has two types of recognition challenge tasks:

- Visual
- Audio

Visual is the default challenge task. Audio is selected by clicking on the headphone icon at the bottom of the reCAPTCHA window. When in audio recognition mode, visual is selected by clicking on the eye icon.

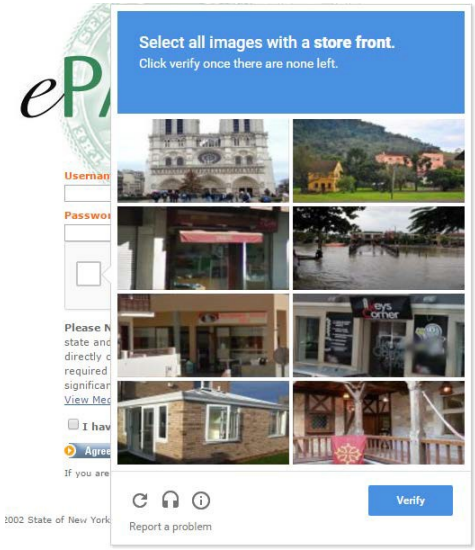
Additional Functions

Two additional functions are available at the bottom of the reCAPTCHA window. The first is refresh which is indicated by a almost closed clockwise circle with an arrow at one end. Clicking refresh brings a fresh challenge. The second function is help which is indicated by a circle with the letter i in it. Clicking help opens an area at the bottom of the window containing help for the challenge.

Visual Recognition

The visual recognition task challenges a user to select one or more images containing a specified element such as a pizza or a big blue box. Each time an image is selected, reCAPTCHA records the selection and replaces it with another image that may contain the specified element. Users must continue selecting images until there are no images remaining with the specified element.

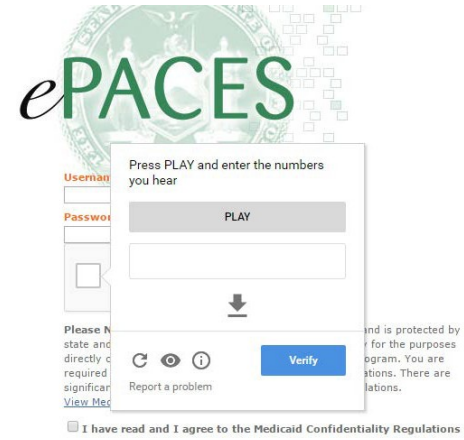
Clicking the Verify button indicates the challenge is complete upon which reCAPTCHA evaluates the selected images. If the user successfully met the challenge, the window closes. If not, reCAPTCHA displays a message under the images to indicate what the user must do.



Audio Recognition

The audio recognition task challenges a user to enter a set of spoken numbers. The numbers are played after the user clicks the Play button and entered in the field under the Play button. There is no fixed amount of numbers so users must continue listening until there is prolonged silence. Users may press the R key to replay the numbers.

Clicking the Verify button indicates the challenge is complete upon which reCAPTCHA evaluates the entered numbers. If the user successfully met the challenge, the window closes. If not, reCAPTCHA displays a message at the top of the window to indicate what the user must do.



Logging Into ePACES

Logging into ePACES requires users to perform three actions:

- Enter valid login credentials
- Successfully complete the robot challenge
- Agree to the Medicaid Confidentiality Regulations

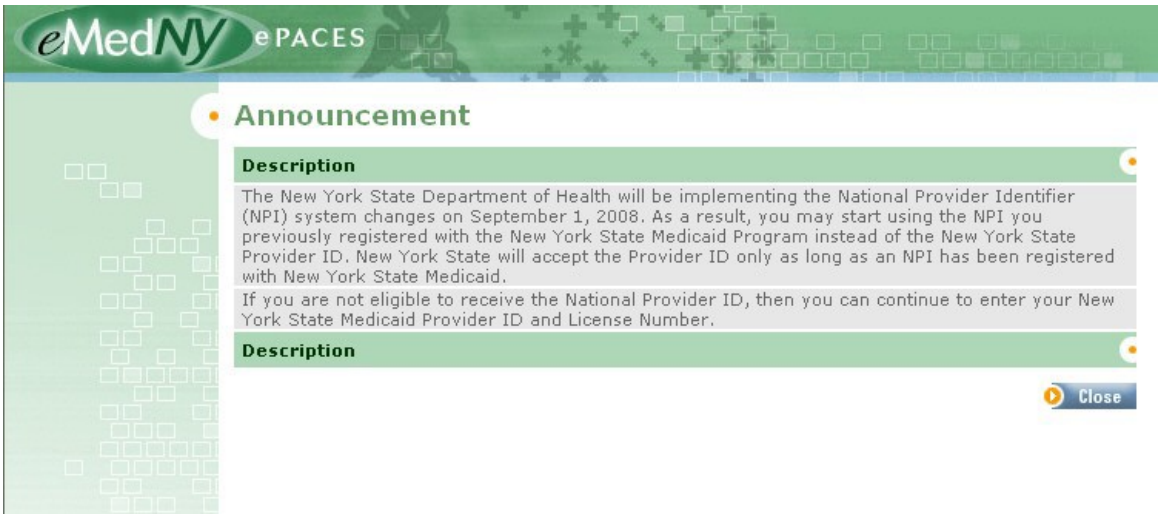
These actions must be done each time to enter ePACES.

First Time Logins and Password Resets/Expirations

First time users who log into ePACES or users who had their passwords reset by the System Administrator or had their passwords expire, are automatically prompted to create a permanent password immediately upon logging in. ePACES will not allow users to proceed until this is done.

Announcement Page

The ePACES Announcement page is displayed whenever DOH has important information to share with providers.



The Announcement page is accessible only upon logging in and cannot be reopened unless the user logs out and logs back in.

Login Instructions

1. Enter a valid username and password.
2. Click *I'm not a robot* to initiate reCAPTCHA.
3. Follow the instructions on the reCAPTCHA popup and click Verify to complete the challenge.
4. Click *I have read and I agree to the Medicaid Confidentiality Regulation* to accept the Medicaid confidentiality regulations.
5. Click the Agree/Login button to log into ePACES.

Navigational Tips

The ePACES application has been designed to be intuitive and user-friendly. The Claim Entry process may be navigated using the keyboard, however at times you will be required to use the mouse to assist. Listed below are some hints and tips for navigating the ePACES system. Each special key responds differently depending on which type of control has the focus.

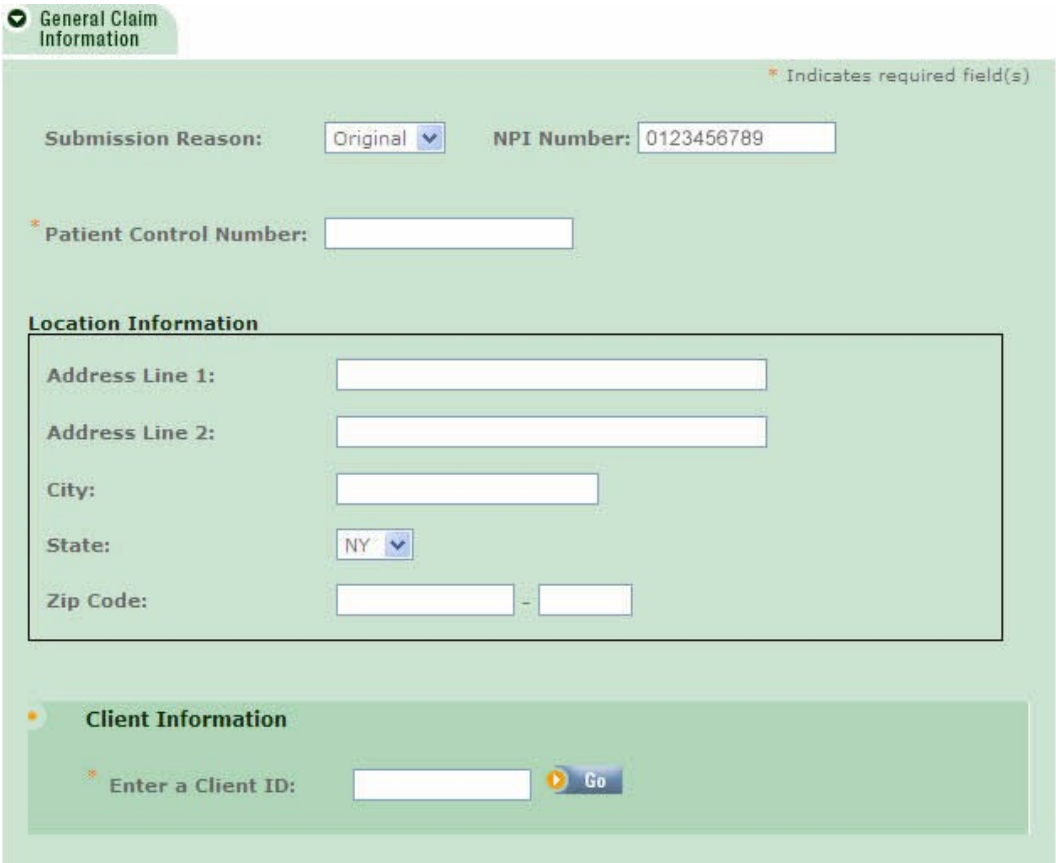
Arrow Keys

- If focus is on a basic data entry field or text box , the up and down arrow keys will not do anything, but the left and right arrow keys will move you through the text entered in the field.
- If focus is on a list box , the up and down arrow keys will scroll through the options in the list while the left and right keys will not do anything.
- If focus is on a set of radio buttons

, the left and up arrow keys will move focus from the option on the right to the option on the left and conversely the right and down arrow keys will move the focus from the option on the left to the option on the right.
- If focus is on a button, whether a list , calendar or general button, the left and right arrow keys will not do anything but the up and down arrow keys will scroll the page, if applicable.
- If focus is on hyperlinked text, the left and right arrow keys will not do anything but the up and down arrow keys will scroll the page, if applicable.
- If focus is on a tab, the left and right arrow keys will not do anything but the up and down arrow keys will scroll the page, if applicable.

TAB Key

- Radio Buttons have their own unique way of reacting to <TAB> and the arrow keys. When navigating using the <TAB> key, if you encounter a set of Radio Buttons the focus will be placed on the option which is selected. If neither option is selected, the first one listed will receive the focus. You may alternate between the options by using the arrow keys.
- The <TAB> key is the main key used to move around the pages. Pressing the <TAB> key will move the cursor or focus through the controls on a page starting at the top and moving left to right and top to bottom. All data entry fields, radio buttons, check boxes, hyperlinks, and buttons are included in this path.



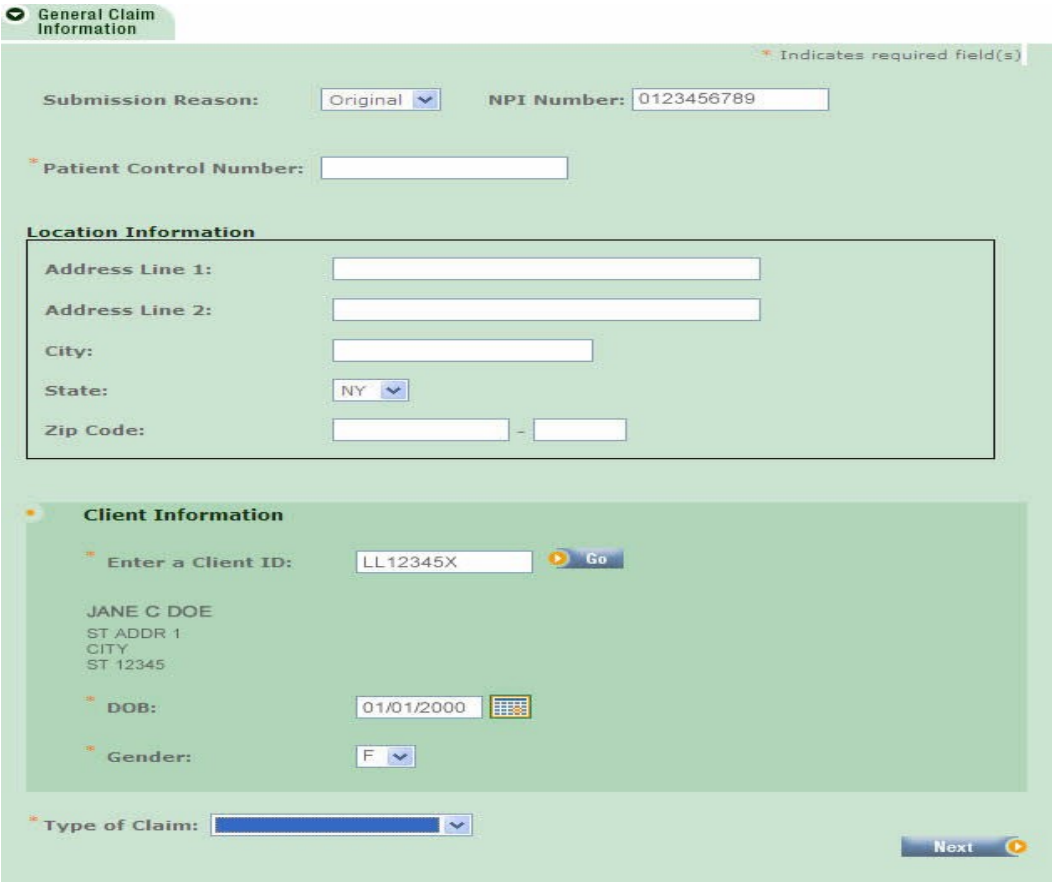
For example, on the General Claim Information tab, you will enter the Patient Control Number and Location Information, then click the key to move to the Client ID field. Once you enter a Client ID, you may click again to move focus to the Go button. Notice, when a button has focus there is a dotted box surrounding the button.

- The <SHIFT>+<TAB> key combination will navigate through the controls on a page in reverse order, therefore right to left and bottom to top. This is useful if you have pressed the <TAB> key too many times and passed your desired field or button.

Enter Key

- When a button has focus, indicated by the dotted box surrounding the button, pressing the <ENTER> key will simulate a mouse click on the button.

- After clicking a button or link, via a mouse click or pressing <ENTER>, which causes the page to refresh or change for any reason, it is necessary to use the mouse rather than the <TAB> key to place your cursor where desired.



An example of this is entering the Client ID on the General Claim Information tab and then clicking Go. This will cause the page to be expanded to allow for the selection of the Claim Type. Even though logically this is the same page, technically it is a new page and therefore you need to redirect focus to the Claim Type field as the page has no memory of where you were located on the page prior to clicking Go.

Change Provider

ePACES users are identified with a NPI/Provider ID. Each NPI/Provider ID is associated with an ETIN. Depending upon the model used during setup, the ETIN may have a one-to-one relationship with the NPI/Provider ID or there may be multiple NPI/Provider IDs assigned to the ETIN. Each user may have Access Privileges to one, all, or a combination of the Provider Numbers under the ETIN.

If your user has Access Privileges to multiple NPI/Provider IDs, you will see a Change Provider drop down at the top of each page within the ePACES application. This value will default to the provider name followed by the NPI (if application set to show NPI) its sorted by Name in alphabetically order, however, you may select a different Provider Name from the list by clicking on their name. Then, click on the "Go" button to refresh the screen to the NPI/Provider ID you selected.

Conversely, if your user has Access Privileges to just a single NPI/Provider ID, you will not see a Change Provider drop down as there is no other Provider Name to change to.

In any case, be sure the Provider Name and ID (National Provider ID or MMIS ID) displayed above the menu on the left-hand side of the page is correct for the transactions which you are performing. In the case where payment should be made to the Group rather than the Member, enter the claim for the Member and include the Group ID on the claim as the Group Provider Number located on the Claim Information page.

Enter New Claims

Entering Claims

Providers and third-party Billing Services can enter Institutional, Professional, Dental batch and Professional Real Time claims for processing by eMedNY. When you start entering a claim, you will be prompted to select the type of claim. Batch claims will not be available for processing by eMedNY until the claims have been batched using the Build Claim Batch pages and transmitted with the Submit Claim Batch pages. Professional Real Time claims are submitted one at a time and are available for viewing within moments using the Real Time Response page.

If your facility is set up to enter claim transactions for multiple Providers, be sure the Provider Name and ID displayed above the left-hand menu is correct. In the event of a Physician Group, claims must be entered under the individual provider and the Group will be entered on the Claim information tab.

Warning: ePACES provides individuals the ability to create and submit transactions to eMedNY over the Internet using their browser. Collecting multiple transactions created in ePACES, and submitting these as batches is also supported. However, automated programmatic scripting of the ePACES online access and entry process to eMedNY is expressly forbidden, and will result in your user ID being revoked.

Scripting is a process of storing transactions in a computer file and programming the computer to enter them in rapid succession expecting online responses. This can create serious performance problems in ePACES and unnecessarily inconvenience other users of the product.

If you need information about automated interfaces to eMedNY, please visit our website: www.emedny.org , and select NYHIPAADESK. If you cannot locate the answer to your question(s), call the eMedNY Call Center at 800-343-9000.

Navigating the Claim Entry Pages

When the **New Claim** link is initially selected from the left-hand menu, you will be required to enter the Patient Control Number, Location Code if Billing provider has MMIS ID, address (plus Zip+4) if Billing Provider has National Provider ID and Client ID. These items are required for all claims regardless of type. The Client ID is used to retrieve the patient information from the database and pre-populate certain parts of the claim. Following the validation of the Client Information, you must select the Claim Type (Institutional, Professional, Real Time Professional, or Dental), this will drive the contents of the subsequent pages.

The next page that is displayed will have multiple tabs across the top of the page, of which the number and names of will depend on the claim type selected on the prior page. You may enter information on these tabs in the order they are presented or click on the individual tab to enter information in an order that works for you. However, you may not move from one tab to another without entering all required fields on that tab. At the bottom of each tab are Previous and Next buttons, clicking these will bring you to the prior or following tab respectively. To clear all data entered or changed on the claim since the last time it was saved, you may Cancel these changes. Note that the claim information is saved automatically as you navigate through the pages.

Some data fields will provide you with a listing of possible options from which to choose. These are available through either drop-down list boxes ( ) or a separate pop-up listing ( ) of values and descriptions. In either case, simply enter or select the value and the field will be populated accordingly.

Once all the necessary and/or available information is filled in on all tabs, you may click Finish at the bottom of any tab. If all data entered passes validation, a message confirming the completion of the claim will be displayed along with a button to enter another new claim. If the claim just completed was a Real Time Professional claim, a Real Time Claim Confirmation message is displayed and you are prompted to submit the claim for processing. However, if any data entered does not pass the validation process, a table containing the field in error along with the tab on which the

error is located is displayed. If errors exist you may elect to return to the claim and make the necessary changes or continue on to enter another new claim and return to this claim at a later time, in which case you may wish to print out this page for reference.

If at any time during the entry process you decide not to complete the entry of a batch claim, you may either Save As Draft or Delete the claim. Saving the claim as a draft will not initiate the validation process which is done upon finishing a claim.

If you click more than once on a different tab to get off the page (before allowing the page to load) OR if you are entering a claim, click back on the browser to leave a tab and then try to save it you may receive this message: " The information on this claim has been updated while you were viewing the claim. Leave this tab and return to it to view any updated information. Your changes have not been made to this claim.". You must refresh the page or go to find claims to continue working on that claim.

Tab Controls

Located at the bottom of each tab throughout the Claim Entry process are a few controls, which are helpful when navigating through the process.

Previous / Next When available, these controls will navigate you back to the previous tab or forward to the next tab as visually indicated at the top of the page.

Delete Claim All claims that have not been Batched or Sent may be deleted. Deleting a claim will remove all references to this claim from the system. There is no way to recover this information once you have confirmed the deletion. The button is available on claims that have not been Batched or Sent for processing.

Void Claim If a claim has been submitted for processing, either through ePACES or another source, and it is necessary to stop processing, you must void the claim to prevent payment. Voiding the claim requires the population of the Claim Original Reference Number to allow the Payer to identify and cross-reference the claims. The button is available only on claims that have been Sent for processing. The newly created claim will have a Submission Reason of "Void" and the original claim will have an Entry Status of "Voided".

Replace Claim Similar to a voided claim, there may be a need to edit or revise a claim once it has been submitted for processing. This would require you to create a Replacement Claim by clicking this button and entering the Claim Original Reference Number to allow the Payer to identify and cross-reference the claims. The button is available only on claims that have been Sent for processing. The newly created claim will have a Submission Reason of "Replacement" and the original claim will have an Entry Status of "Replaced".

Save As Draft Saving the claim in a draft form is a convenient way to allow a user stop midway through the claim entry process, due to the need to collect further information or a simple distraction, without losing any of the information that has already been entered. Saving the claim as a draft will also prevent the claim from potentially being submitted in error. A claim that has an entry status of Draft does not go through any sort of validation but the user has the option to resume claim entry at a later time. The button is available on claims that have not been Batched or Sent for processing.

Edit Claim 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. These new claims will go through the standard validation, batching, and submittal process to be sent to the Payer.

Return to Errors If validation errors were discovered upon completion of the claim, returning to the table of errors during the editing process may be beneficial. The errors displayed on the page are valid as of the date stamp and therefore are not impacted by any corrections or changes you may have done. You must revalidate the claim by clicking Finish in order to display the current and accurate set of errors, if any exist.

Finish If at any time during the Claim Entry process, you feel you have completed all the necessary information and would like to save and validate the claim, making it eligible for the next batch, clicking this button will do so. The button is available on claims that have not been Batched or Sent for processing. If errors are found, a page will be displayed with a list of the location and description of the error.

Cancel Clicking Cancel at any point during the Claim Entry process will return you to the previously saved version of the claim, deleting any information entered since the last save. Claim information is saved upon transition from tab to tab. The button is available on claims that have not been Batched or Sent for processing.

Dental Claims

The process of entering a Dental Claim is simplified by the user-friendly tab layout of the pages, grouping data elements to be entered into logical sets.

The tabs of information are as follows:

General Claim Information: The General Claim Information tab is identical for all Claim Types. It contains client specific information for the claim, and once data has been entered, is view only as the client personal information may not be modified.

Dental Claim Information: This tab is specific to Dental Claims. Just over half the data elements included on this page are unique to Dental Claims.

Provider Information: All information pertaining to the Referring, Rendering or Supervising Provider is entered on this tab.

Other Payers: The Other Payer tab allows for the entry of payers and the related subscriber information who, in addition to NY Medicaid, are responsible for the payment of the claim being entered.

Service Line(s): Multiple Service Lines may be entered to provide detailed information regarding the services rendered and associated with this claim.

Diagnosis: Currently, this tab will not be used.

Institutional Claims

The process of entering an Institutional Claim is simplified by the user-friendly tab layout of the pages, grouping data elements to be entered into logical sets.

The tabs of information are as follows:

General Claim Information: The General Claim Information tab is identical for all Claim Types. It contains client specific information for the claim, and once data has been entered, is view only as the client personal information may not be modified.

Institutional Claim Information: This tab is specific to Institutional Claims. Just over half the data elements included on this page are unique to Institutional Claims.

Provider Information: All information pertaining to the Attending, Operating, or Referring Physician is entered on this tab.

Diagnosis/Procedure: Diagnosis and Procedure codes are entered here to allow charges to be properly assigned. Multiple diagnosis codes and multiple procedure codes may be entered.

Other Payers: The Other Payer tab allows for the entry of payers and the related subscriber information who, in addition to NY Medicaid, are responsible for the payment of the claim being entered.

Service Line(s): Multiple Service Lines may be entered to provide detailed information regarding the services rendered and associated with this claim.

Professional Claims

The process of entering a Professional Claim is simplified by the user-friendly tab layout of the pages, grouping data elements to be entered into logical sets.

The tabs of information are as follows:

General Claim Information: The General Claim Information tab is identical for all Claim Types. It contains client specific information for the claim, and once data has been entered, is view only as the client personal information may not be modified.

Professional Claim Information: This tab is specific to Professional Claims. Just over half the data elements included on this page are unique to Professional Claims.

Provider Information: All information pertaining to the Rendering, Referring, Primary Care, or Supervising Provider is entered on this tab.

Diagnosis: Diagnosis codes are entered here to allow charges to be properly assigned. Multiple diagnosis codes may be entered.

Other Payers: The Other Payer tab allows for the entry of payers and the related subscriber information who, in addition to NY Medicaid, are responsible for the payment of the claim being entered.

Service Line(s): Multiple Service Lines may be entered to provide detailed information regarding the services rendered and associated with this claim.

Real Time Professional Claims

Real Time Professional Claims differ from batch Professional Claims in that you will receive an immediate claim status response for each claim entered. The process of entering a Real Time Professional Claim is simplified by the user-friendly tab layout of the pages, grouping data elements to be entered into logical sets.

The tabs of information are as follows:

General Claim Information: The General Claim Information tab is identical for all Claim Types. It contains client specific information for the claim, and once data has been entered, is view only as the client personal information may not be modified.

Professional Claim Information: This tab is specific to Professional Claims. Just over half the data elements included on this page are unique to Professional Claims.

Provider Information: All information pertaining to the Rendering, Referring, Primary Care, or Supervising Provider is entered on this tab.

Diagnosis: Diagnosis codes are entered here to allow charges to be properly assigned. Multiple diagnosis codes may be entered.

Other Payers: The Other Payer tab allows for the entry of payers and the related subscriber information who, in addition to NY Medicaid, are responsible for the payment of the claim being entered.

Service Line(s): May be entered to provide detailed information regarding the services rendered and associated with this claim.

General Claim Information

General Claim Information

* Indicates required field(s)

Submission Reason: Original NPI Number: 0123456789

* Patient Control Number:

Location Information

Address Line 1:

Address Line 2:

City:

State: NY

Zip Code: -

Client Information

* Enter a Client ID: Go

When **New Claim** is selected from the left-hand menu, the page you initially see is the General Claim Information tab, part of the overall claim entry process. This tab is the same regardless of claim type. This tab contains the patient related information for the claim being entered. This includes the Patient Control Number specific to this claim and the Client ID, which provides the Patient's personal information.

If you are an a-typical provider (billing with a MMIS ID) please enter your three digit locator code in the location code field. This field will only appear if an a-typical provider is billing.

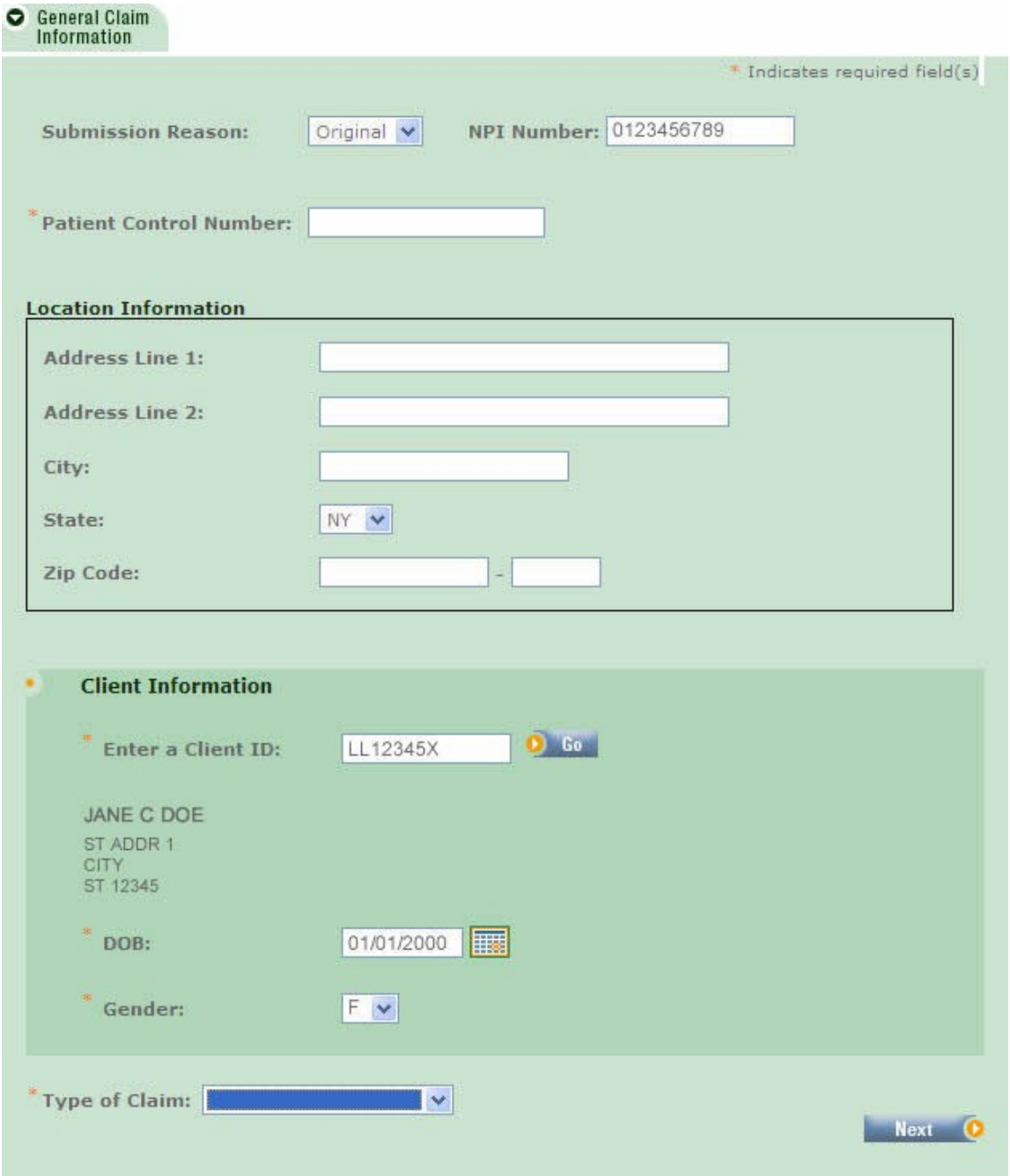
Submission Reason: Indicates if the claim is an Original, Replacement, or Void claim. This field will default to Original for all new claims, however you may select Void or Replace. Selecting the Edit Claim button, will change the claim reason to Original and allow the claim to be edited and resent. If a value other than Original is selected, the Claim Original Reference Number must be entered. Selecting Void or Replace and entering the Transaction Control Number will allow you to void or replace a claim which was not submitted via ePACES but is currently in the eMedNY system for adjudication processing or has been purged from the ePACES system. If a claim is still in the ePACES system and needs to be voided or replaced, it is recommended to do so with the appropriate button from within the claim, as this will remove the need to re-enter all the required information, the system will automatically make a copy of the original claim and then you may proceed with the necessary modifications.

NPI Number: The NPI or MMIS ID of the provider in the upper right hand corner of the screen is pre-populated in this field based upon the provider information selected from the drop down menu.

Patient Control Number: You must enter a value in this field for every claim, regardless of Submission Reason. The value entered may be no longer than 20 alphanumeric characters and should be unique for each individual claim. Individual Patient Control Numbers are usually assigned to each visit a client makes to a provider. This may also be referred to as the Patient Account Number in the provider's billing system.

Location Information: The address the service was rendered (including the zip+4) should be entered here.

Client ID: This is the 8-digit alphanumeric Medicaid assigned ID for the patient. Based on the value entered here, ePACES will retrieve the patient information from the database and display it for confirmation that the correct value was entered.



Once the required data elements are entered and you click Go, the Client Information grouping will be populated with the client's most recent personal information (Name, Address, Date of Birth , and Gender). Entering a new Date of Birth or Gender for a client will only update those elements on the claim itself. Assuming this is the correct client, you are now able to continue with the entry of the claim. If the client returned is not correct, edit the Client ID and click Go.

Type of Claim: This field alone determines the type of claim that is going to be generated and what data elements will be requested and required on the subsequent pages. The predefined values available to you are: Dental, Professional, Professional Real Time and Institutional. You may either choose from the drop-down list or type the first character to highlight the type in the list and hit the Enter key to select.

To begin entering the new claim, choose the claim type and click Next. When this page is viewed following the initial entry of data, the Claim Submission Reason, Patient Control Number, Client ID, and Claim Type may not be modified. The Original Claim Reference Number may only be maintained on Replacement and Void claims.

Dental Claims

The process of entering a Dental Claim is simplified by the user-friendly tab layout of the pages, grouping data elements to be entered into logical sets.

The tabs of information are as follows:

General Claim Information: The General Claim Information tab is identical for all Claim Types. It contains client specific information for the claim, and once data has been entered, is view only as the client personal information may not be modified.

Dental Claim Information: This tab is specific to Dental Claims. Just over half the data elements included on this page are unique to Dental Claims.

Provider Information: All information pertaining to the Referring, Rendering or Supervising Provider is entered on this tab.

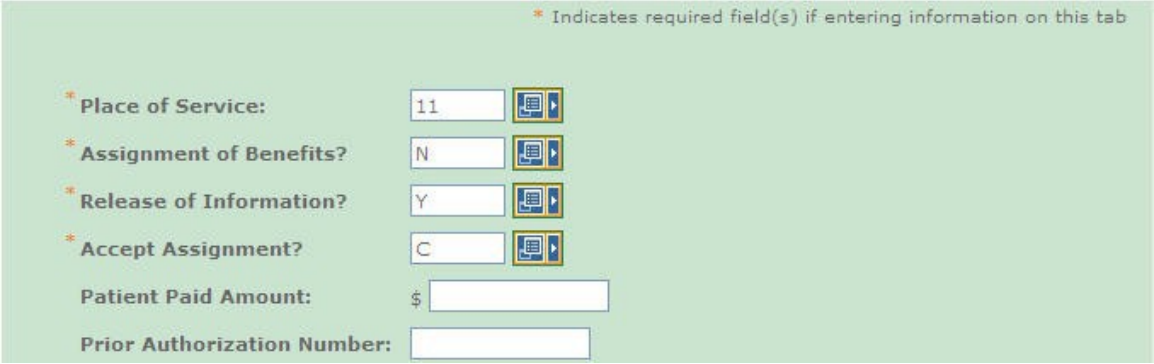
Other Payers: The Other Payer tab allows for the entry of payers and the related subscriber information who, in addition to NY Medicaid, are responsible for the payment of the claim being entered.

Service Line(s): Multiple Service Lines may be entered to provide detailed information regarding the services rendered and associated with this claim.

Diagnosis: Currently, this tab will not be used.

Dental Claim Information

Information specific to a Dental Claim is entered on this tab. A portion of the data elements is unique to this claim type and will not be seen on the tabs when entering other types of claims. The page is visually separated into sections using different shading. Each section/field is discussed below .



Place of Service: Enter the code from the CMS Place of Service code list that is most appropriate for the service location type. Required for all Dental claims.

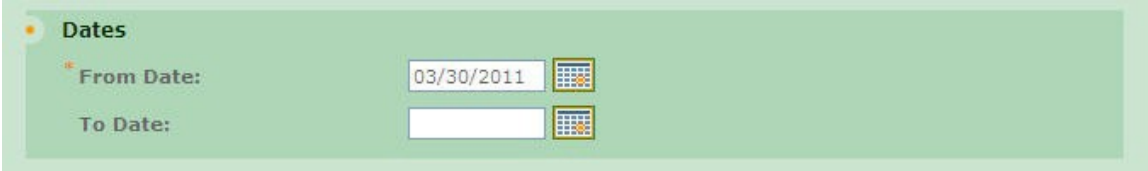
Assignment of Benefits? Select 'Yes' if the insured or authorized person authorizes benefits to be assigned to the provider. Select 'No' if benefits have not been assigned to the provider. Required for all dental claims. Defaults to 'Yes'.

Release of Information? Enter or select the code indicating whether the provider has on file a signed statement by the patient authorizing the release of medical data to other organizations. Required for all dental claims. Defaults to 'Y'.

Accept Assignment? Enter or select the appropriate value from the provided list to indicate whether the provider has a participation agreement with the payer. This field is required on all claims.

Patient Paid Amount: The sum of all amounts paid on the claim by the patient or his/her representative, if any.

Prior Authorization Number: If Prior Authorization has been received for the services associated with this claim, enter the prior approval number in the field. Prior Authorization numbers are assigned by the payer to authorize a service prior to its being performed.



Dates

While not enforced with validation in ePACES, the Service Date information entered should be inclusive of all service dates reported at the line level.

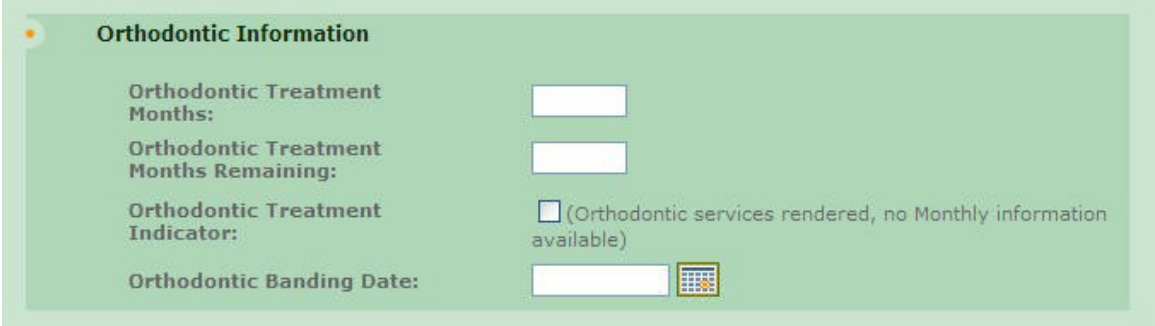
From Date: The first date on which the procedures covered by this claim were rendered. The date may not be greater than the current date. The format for the date is: MM/DD/YYYY and may either be entered in the field or selected from the calendar available by pressing the button to the right of the field.

To Date : The last date on which the procedures covered by this claim were rendered. The date may not be greater than the current date and must be equal to or greater than the From Date. The format for the date is: MM/DD/YYYY and may either be entered in the field or selected from the calendar available by pressing the button to the right of the field.

Related Causes Information

Related Causes: You may select up to two related causes for this claim. If one or more of the options applies to the situation, mark the appropriate check box(es) and enter the Accident Date. If Auto Accident is selected as a Related Cause, enter the state and country in which the accident occurred. 'NY' and 'USA' are the default values.

Accident Date: If either the Other Accident or Auto Accident boxes are checked, the date of the accident must be entered. When the Employment box is checked and the services are caused by an accident, enter the accident date. The date may not be greater than the current date. The format of the date is: MM/DD/YYYY and may either be entered in the field or selected from the calendar available by pressing the button to the right of the field.



Orthodontic Information

Orthodontic Treatment Months: Enter the total months, whole or partial, of orthodontic treatment.

Orthodontic Treatment Months Remaining: Enter the number of months, whole or partial, of orthodontic treatment remaining. If entered, this value must be less than the Orthodontic Treatment Months Count entered above.

Orthodontic Treatment Indicator: Click on the box if there are Orthodontic services rendered, but no Monthly information is available.

Orthodontic Banding Date: A maximum of 5 Orthodontic Banding Dates may be entered. The format of the date is: MM/DD/YYYY and may either be entered in the field or selected from the calendar available by pressing the button to the right of the field.

Tooth Information

Tooth Number/Tooth Status: Enter or select the number and status of each tooth missing tooth or tooth to be extracted. If a tooth number is selected, an associated status must also

be selected. While up to 35 tooth number/status combinations may be entered on a single claim, a tooth number may not be duplicated. If more than six values need to be entered, click Enter More Tooth Numbers...and additional lines will be displayed.

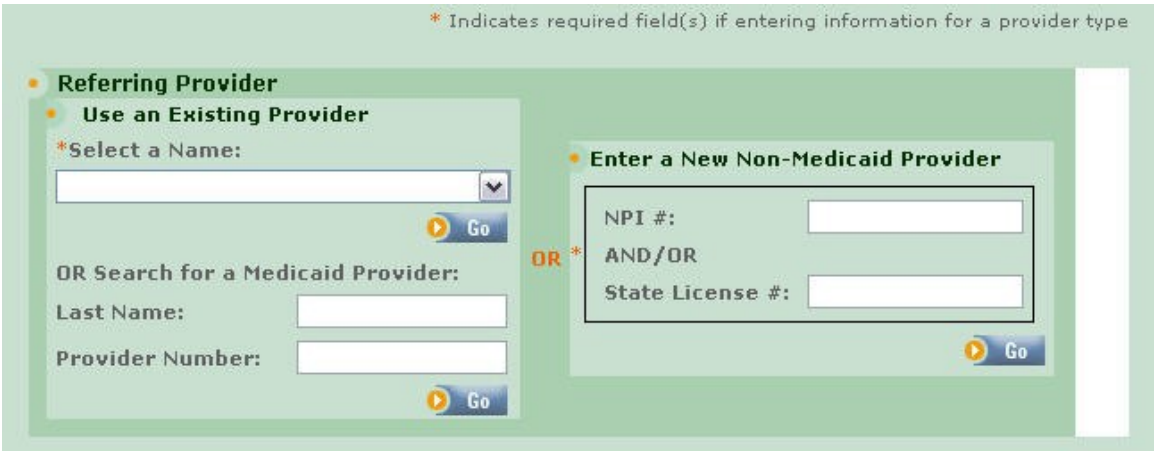
Group Provider

Group Provider Number: If there is a Group Provider which is different than the Billing Entity for this claim, enter the 10-digit National Provider ID and click Go. This will retrieve the Provider's contact information from the database and display it.

Provider Information

For Dental Claims, there may be up to 3 providers listed. The providers may be the Referring, Rendering, Assistant Surgeon or Supervising. Each will be handled in the same manner, however in their own individual sections. You may not enter a Rendering Provider and Assistant Surgeon on the same claim; in this section, you must select which type of physician you are entering using the radio buttons provided.

For Referring, Rendering, Assistant Surgeon and Supervising there are three ways in which to enter the name onto the claim, you may select an existing provider, search for a Medicaid provider, or enter a new Non-Medicaid provider. See Appendix for details. The Service Facility however is entered in a different manner.



Referring Provider

If the service you are billing for was referred by another provider, enter that provider here. There are three ways in which to enter the name onto the claim, you may select an existing provider, search for a Medicaid provider, or enter a new non-Medicaid provider. See Appendix for details.

Use an Existing Provider

Select a Name: If using an existing provider, you can select the name of the provider in the list.

Last Name: You can also enter the last name of the provider and click "Go".

Provider Number: You can also enter the provider's MMIS ID and click "Go".

Enter a New Non-Medicaid Provider

If you are entering a new non-Medicaid provider, you can enter the **NPI #** and/or the **State License #** here.

Rendering Provider or Assistant Surgeon

Rendering Provider: Cannot be entered in conjunction with the Assistant Surgeon. In the case of a dental school, the teacher in charge should be listed as the Supervising Physician. The Rendering Provider will be the student.

Assistant Surgeon: Cannot be entered together with a Rendering Physician as the Assistant Surgeon will be processed as the Service Provider for the claim.

Use an Existing Provider

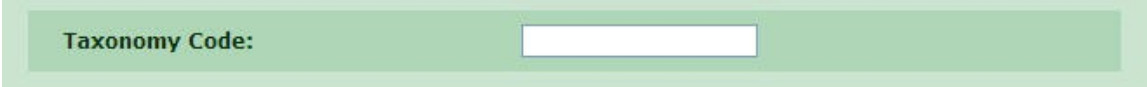
Select a Name: If using an existing provider, you can select the name of the provider in the list.

Last Name: You can also enter the last name of the provider and click "Go".

Provider Number: You can also enter the provider's MMIS ID and click "Go".

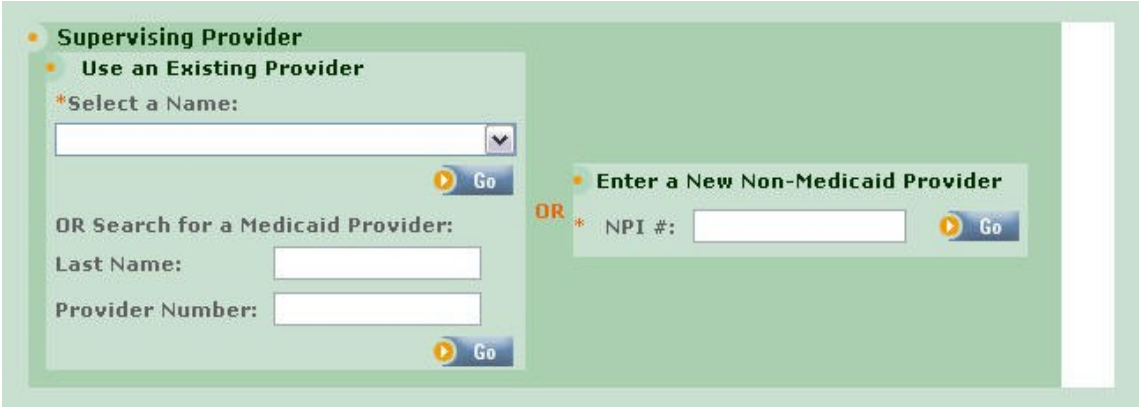
Enter a New Non-Medicaid Provider

NPI: If you are entering a new non-Medicaid provider, you can enter the NPI of the provider here.



Taxonomy Code

Taxonomy Code: If applicable, enter the taxonomy code in this field.



Supervising Provider

If you are entering rendering provider that has non-billable category of service, enter the billing provider as the supervising provider. In the case of a dental school, the teacher in charge should be listed as the Supervising Physician.

Use an Existing Provider

Select a Name: If using an existing provider, you can select the name of the provider in the list.

Last Name: You can also enter the last name of the provider and click "Go".

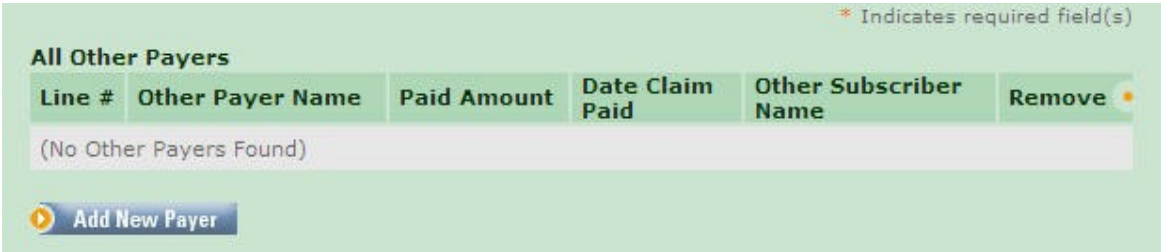
Provider Number: You can also enter the provider's MMIS ID and click "Go".

Enter a New Non-Medicaid Provider

NPI: If you are entering a new non-Medicaid provider, you can enter the NPI of the provider here.

Other Payers

The Other Payers tab is not required to enter a claim. You only need to access this tab if there are payers in addition to NY Medicaid to be applied to the claim being entered. However, if you do access the tab and start the process of entering an Other Payer, you must complete all the required information or delete all data entered before continuing to another tab.



All Other Payers

Line #: This is a line number identifying the order in which the Other Payers were entered on the claim. Clicking this hyperlinked value will open the Details Page for that Payer. Removing a Payer will change the Line # of payers entered after that payer. For example, if you delete Line # 2, then Line # 3 and Line # 4 become 2 and 3 respectively. Payers may be entered in any sequence, and are displayed here in that sequence. The Line # is not related to the order of responsibility for paying this claim, that is handled by the Payer Sequence Number.

Other Payer Name: The Payer name as selected when entering the Other Payer onto the claim.

Paid Amount: The dollar amount paid by the Payer towards this claim.

Date Claim Paid: The date on which a payment was received from this Payer for this claim.

Other Subscriber Name: The full name (Last Name, First Name, Middle Initial) of the Subscriber associated with this Payer.

Upon initially opening this tab, you will see the Summary level of all Other Payers entered for this claim. If no Payers exist, the table will be empty and you may Add Another Payer at this time. If Other Payers have already been entered for this claim, you may view the details associated with each payer from this table or add Other Payers.

Enter Other Payer

In addition to NY Medicaid, you may enter additional payers who are responsible for this claim. Remember that all elements marked with an asterisk (*) are required when entering a Payer. Not all claims will have Other Payer information. Note: A maximum of 10 Other Payer records may be entered per claim.

Other Payer Information

Other Payer Name: Select the name of the desired payer from the provided list. If the Other Payer you are looking for is not listed, contact your Administrator to add the Payer to the Support File of valid Payers. Required for all Other Payers.

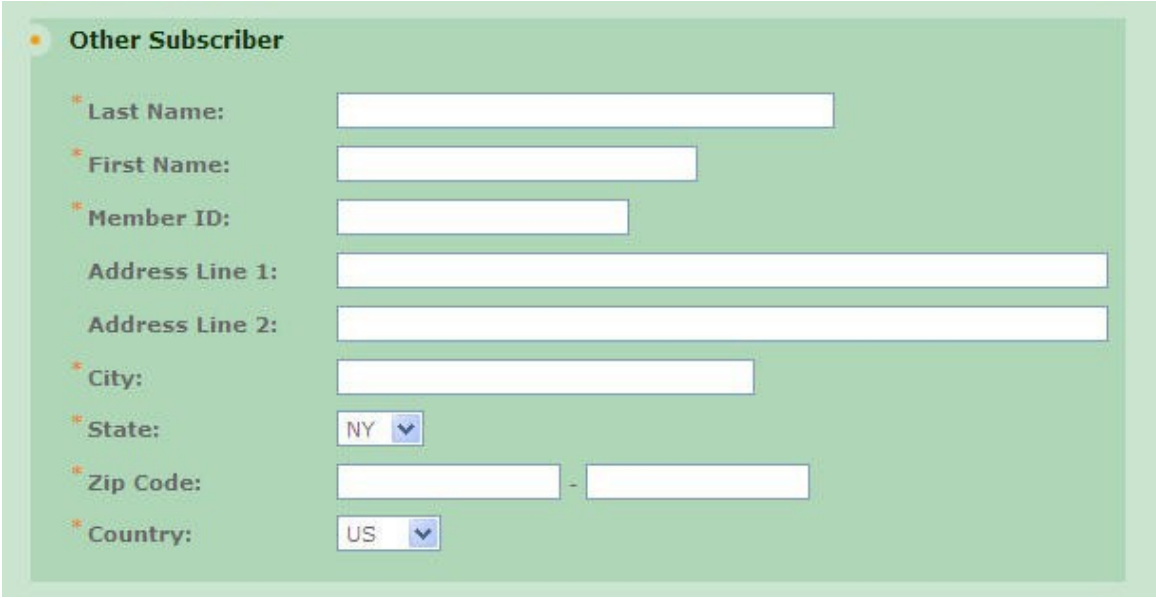
Payer Sequence Number : Select the value that represents the order in which payment was received from other payers. This will determine in what order the payer is applied to the value of the claim. Payers may be entered in any sequence and displayed in any sequence. Required for all Other Payers.

Payer Type: A code identifying the type of Payer. Enter or select a value from the list of available codes.

Other Payer Paid Amount: The amount this payer has paid to the provider towards this bill. This field is required when this payer has adjudicated the claim. If the Other Payer denied the claim, enter 0. If the Other Payer has not adjudicated the claim, leave blank. If a value is entered, the Date Claim Paid must be entered as well.

Other Payer Claim Control Number: Enter the claim control number assigned by the other payer.

Date Claim Paid: Date on which the Other Payer Paid Amount was received. This date may not be greater than the current date. The format is: MM/DD/YYYY and may either be entered in the field or selected from the calendar available by pressing the button to the right of the field.



Other Subscriber

Last Name/First Name: If entering an Other Payer, you must enter the First and Last Name of the Subscriber for the Payer. The Subscriber may or may not be the Client.

Member ID: The Subscriber's Member ID as assigned by the Payer. This is required when entering the Subscriber for the Other Payer.

Address Line 1/2: The street address of the Subscriber, if known.

City: Enter city name of the Subscriber.

State: State in which the Subscriber lives. Select value from the list of available valid state abbreviations, defaults to 'NY'.

Zip Code: Enter the postal Code associated with the Subscriber's address.

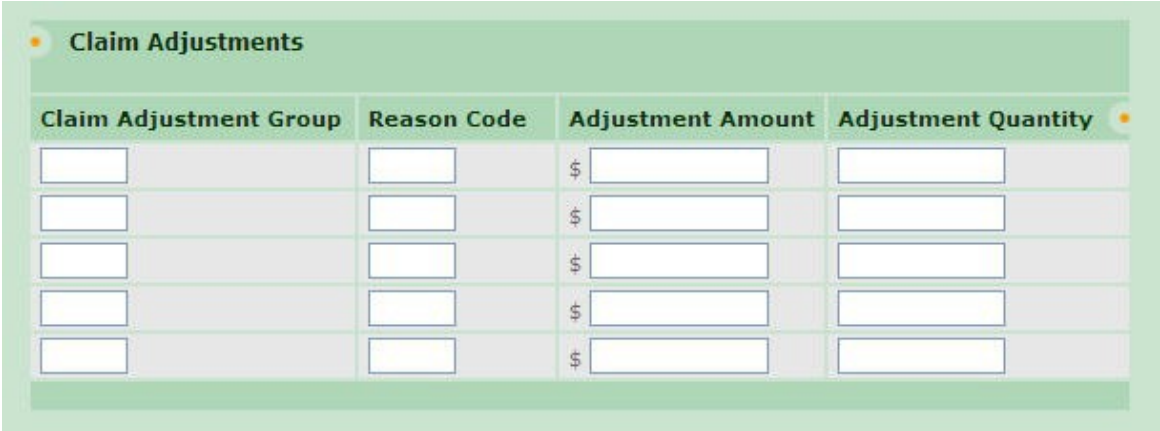
Country: Country in which the Subscriber lives. Select value from the list of available countries, defaults to 'US'.

Other Subscriber Information

Relationship: Code indicating the relationship between the Client/Patient and the Subscriber for this Payer must be selected if a Subscriber is entered. Enter or select a value from the list of available codes.

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. Otherwise, this information will be blank. Claim adjustment group codes and reason codes are from the remittance of the other payer.

Claim Adjustment Group: Enter the Group Code as received from the other payer. Enter a maximum of 5 Claim Adjustment Groups per claim.

Reason Code: Enter the Claim Adjustment Reason Code as received from the other payer. The Claim Adjustment Group/Reason Code combination may not be entered more than once. If an Adjustment Amount or Adjustment Quantity is entered, a Reason Code must be entered.

Adjustment Amount: Enter the Adjustment Amount as received from the other payer. An Adjustment Amount is required when a Reason Code is entered.

Adjustment Quantity: Enter the Quantity Adjusted as received from the other payer.

Other Insurance Coverage Information

Assignment of Benefits?: The Benefits Assignment Certification Indicator. 'Yes' indicates insured or authorized person authorizes benefits to be assigned to the provider while 'No' indicates that no authorization has been given. This value will default to 'Yes' and is required if an Other Payer Name is selected.

Release of Information?: Indicates whether the provider has a signed statement by the patient authorizing the release of medical data to other organizations. This value will default to ' Y', and is required if an Other Payer Name is selected.

Amounts

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

Non-Covered Charge Amount: Enter the dollar value of the claim in this field if the other payer was not billed, and documentation is on file that the other payer would not have paid the claim.

Once all the information for the Payer has been entered, you may add another payer by clicking the Next Payer>> control at the top or bottom of the tab. This will return you to the top of the page with all the values cleared out and a new Payer Number listed at the top of the page. Clicking View All Other Payers will display the Other Payers Summary page.

View Other Payers

Viewing All Other Payers is a quick and easy way to see what payers, in addition to NY Medicaid, have a responsibility for this claim. The easy to read table displays a snapshot of information about each Payer.

* Indicates required field(s)

All Other Payers

Line #	Other Payer Name	Paid Amount	Date Claim Paid	Other Subscriber Name	Remove *
1	OT PAYER	24.00	11/1/2002	OT SUBSCRIBER	

Line #: This is a line number identifying the order in which the Other Payers were entered on the claim. Clicking this hyperlinked value will open the Details Page for that Payer. Removing a Payer will change the Line # of payers entered after that payer. For example, if you delete Line # 2, then Line # 3 and Line # 4 become 2 and 3 respectively. Payers may be entered in any sequence, and are displayed here in that sequence. The Line # is not related to the order of responsibility for paying this claim, that is handled by the Payer Sequence Number.

Other Payer Name: The Payer name as selected when entering the Other Payer onto the claim.

Paid Amount: The dollar amount paid by the Payer towards this claim.

Date Claim Paid: The date on which a payment was received from this Payer for this claim.

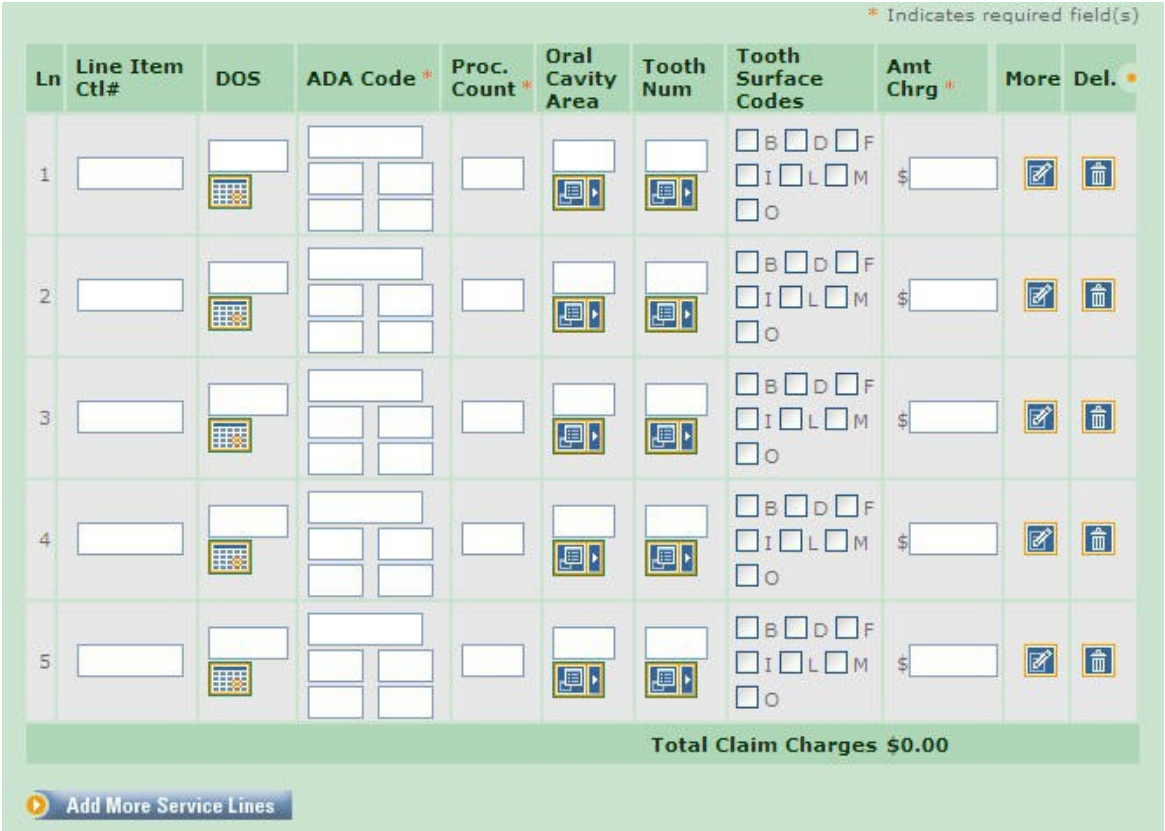
Other Subscriber Name: The full name (Last Name, First Name Middle Initial) of the Subscriber associated with this Payer.

If a specific Third Party or Managed Care Plan is required but not listed, you may Add Another Payer. If a Payer was erroneously added to this claim and must be removed, click the Remove icon and confirm the deletion.

Service Line(s)

A Service Line is listed on a claim for each procedure or item that is to be reported to the Payer(s) for claim adjudication. Each claim must contain at least one Service Line.

The main view of the Service Line(s) tab contains the basic information for the line as it relates to NY Medicaid. Additional information and adjudication details from Other Payers are available on subsequent pages. As a default, 5 Service Lines are displayed on the main page, however you may add as many as needed, up to a maximum of 50, simply by clicking Add More Service Lines. You may remove any single Service Line by clicking the Remove icon on that line. In addition, the total of all the submitted charges for the Service Lines is listed below all the Service Lines that have been entered.



Ln (Line): This is a system generated value to uniquely identify the Service Line on the claim. The counter will start with 1 and increment with each new Service Line entered. A minimum of 1 Service Line is required on all claims.

Line Item Ctl#: This field can be used to enter a line number that corresponds with your records if it is different than the line number given. This field is not required.

Date of Service (DOS): The date on which the service was rendered. The date may not be greater than the current date. The format is: MM/DD/YYYY and may either be entered in the field or selected from the calendar available by pressing the button to the right of the field. When finding this claim on the Find Claims page, the Begin Date corresponds to the Date of Service on Line 1 of this claim.

ADA Code: An American Dental Association (ADA) Procedure Code is required on all Service Lines.

Proc. Count: The number of procedures associated with the Service Line, required when an ADA Code is entered.

Oral Cavity Area: Enter the 2-digit code to identify the area of the oral cavity if the procedure billed requires quadrant or arch identification. Additional codes may be entered by clicking the More icon.

Tooth Num: Enter the tooth identification (or choose from the drop down box) if the procedure being billed requires tooth identification. If multiple teeth are affected by the procedure, additional Tooth Numbers may be entered by clicking the More icon. A Tooth Number may not be repeated on a single service line.

Tooth Surface Codes: Select the boxes for the corresponding surfaces that were affected by the procedure. A maximum of 5 surfaces may be selected. "I" and "O" may not be selected at the same time; and "B" and "F" may not be selected at the same time.

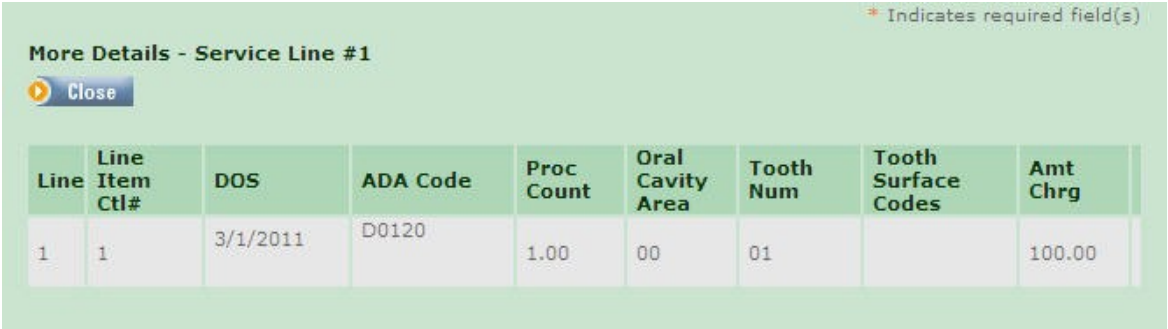
Amt Chrg: The submitted charge amount for this procedure/service must be entered. Note: Zero dollars is a valid charge amount.

Total Claim Charges: At the bottom of the table of Service Lines, all charges for all Service Lines on the claim will be summed and displayed, once the Service Line Information is saved.

For each Service Line, you may view/enter additional details by clicking the More icon. However you may only view these additional details once all required elements have been entered. Navigating off this summary page, either by clicking the More icon or moving to another tab, will trigger validation of the data entered on this page. Validation is done one line at a time, so if there are errors on multiple lines you will have to fix each line before seeing the next set of errors. If a Service Line must be removed for any reason, clicking the Delete icon will remove the line and re-sequence the remaining Service Lines.

Service Line Details

Each service line on a Dental Claim will have information available in addition to what is displayed in summary on the main page. This information is accessed by clicking the More icon on the main Service Line(s) page.



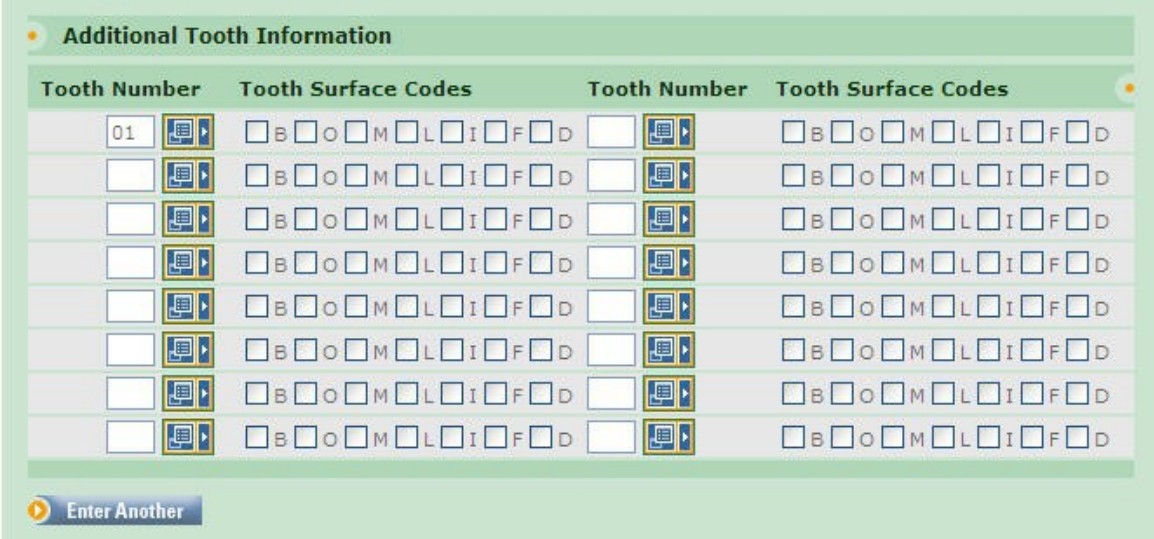
Line	Line Item Ctl#	DOS	ADA Code	Proc Count	Oral Cavity Area	Tooth Num	Tooth Surface Codes	Amt Chrg
1	1	3/1/2011	D0120	1.00	00	01		100.00

More Details

The top of the screen will display information on what service line more button you are on. This includes, Line Number, Line Item CTL #, DOS, ADA Code, Proc Count, Oral Cavity Area, Tooth Num, Tooth Surface Codes and Amt Chrg that was enter on the service line.

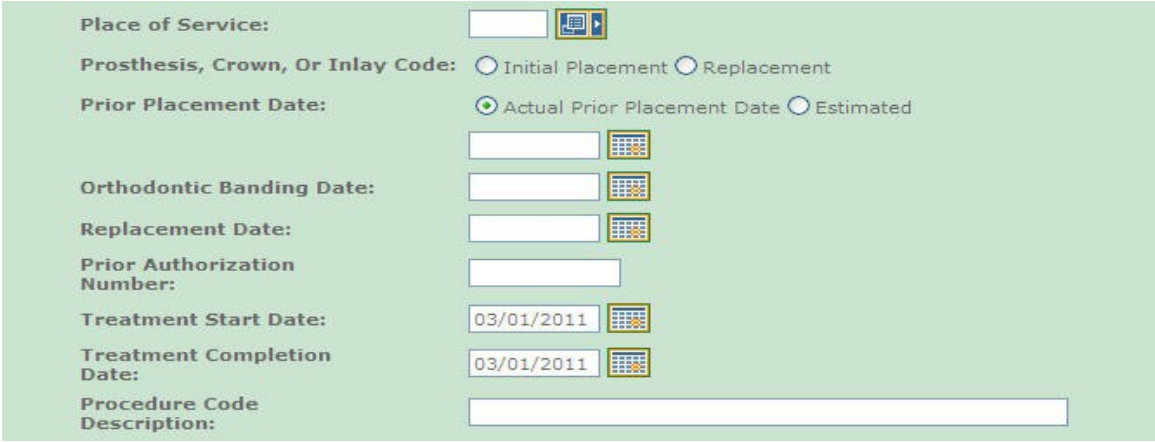
DX Pointer

Currently, the dx pointer is not used for dental.



Additional Tooth Information

Tooth Number/Tooth Surface Codes: A single Tooth Number and associated Surface Code may be entered/viewed on the main Service Line Summary page; you may add/view a maximum of 32 Tooth Number/Surface Code combinations, however a Tooth Number may not be repeated on an individual Service Line. If a Tooth Number or Surface Information was entered on the main Service Line page, the values will default to the first corresponding field on this page.



Place of Service: A two-digit code representing the Place of Service Code where the particular Service Line procedure was rendered. Enter or select the desired code from the provided list of valid values. If entered, this value should be different than the value entered on the Dental Claim Information tab.

Prosthesis, Crown, or Inlay Code: If this procedure involved the placement of a prosthetic, select the proper button to indicate if this was an 'Initial Placement' or a 'Replacement'. If this is a 'Replacement', the Prior Placement Date is required.

Prior Placement Date: Choose whether the placement date is "Actual Prior Placement Date" or "Estimated" date. The Date on which the prosthetic was previously placed must be entered if the "Prosthesis, Crown, or Inlay Code" indicates that this is a 'Replacement' procedure. The format of the date is: MM/DD/YYYY and may either be entered in the field or selected from the calendar available by pressing the button to the right of the field.

Orthodontic Banding Date: The date on which the Orthodontic Banding occurred. The format of the date is: MM/DD/YYYY and may either be entered in the field or selected from the calendar available by pressing the button to the right of the field.

Replacement Date: Date on which the orthodontic appliance was replaced. The format of the date is: MM/DD/YYYY and may either be entered in the field or selected from the calendar available by pressing the button to the right of the field.

Prior Authorization Number: If Prior Authorization has been received for the procedures associated with this Service Line and the number is different from that entered on the Dental Claim Information tab, enter the number in the field. Prior Authorization numbers are assigned by the payer to authorize a service prior to its being performed. This number is specific to NY Medicaid.

Treatment Start Date: Enter the date the treatment started.

Treatment Completion Date: Enter the date the treatment completed.

Procedure Code Description: Use to provide additional information about the procedures on the Service Line.

Line Adjudication Information

Other Payer Name: The Payer Name selected must match one of those entered on the Other Payer tab. All subsequent data entered applies to the Adjudication for this Service Line and Payer combination.

Service Line Paid Amount: The dollar amount paid towards this Service Line by this Payer.

Paid ADA Code: This is the ADA Procedure code processed by the payer.

Paid Service Unit Count: The Units of Service paid by the other payer.

Bundled Line Number: If applicable, enter the number of the line bundled or unbundled by the other payer.

Date Claim Paid: Service adjudication or payment date must be entered. The date may not be greater than the current date. The format is: MM/DD/YYYY and may either be entered in the field or selected from the calendar available by pressing the button to the right of the field.

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

Claim Adjustment

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. The Claim Adjustment Group/Reason Code combination may not be entered more than once. If an Adjustment Amount or Adjustment Quantity is entered, a Reason Code is required.

Adjustment Amount: Enter the Adjustment Amount as received from the other payer. An Adjustment Amount is required when a Reason Code is entered.

Adjustment Quantity: Enter the Quantity Adjusted as received from the other payer.

If Other Payers have been included on the claim and they have adjudicated this line or you need to maintain the adjudication details, you may view/maintain the individual Line Adjudication Information or view a summary of all adjudication information for this line.

Claim Confirmation

Upon completion of a claim, which is indicated by clicking Finish, the claim will be placed into one of two states. If there are no validation errors and the claim is ready to be submitted for adjudication, then it will be set to Complete.

Claim Entered

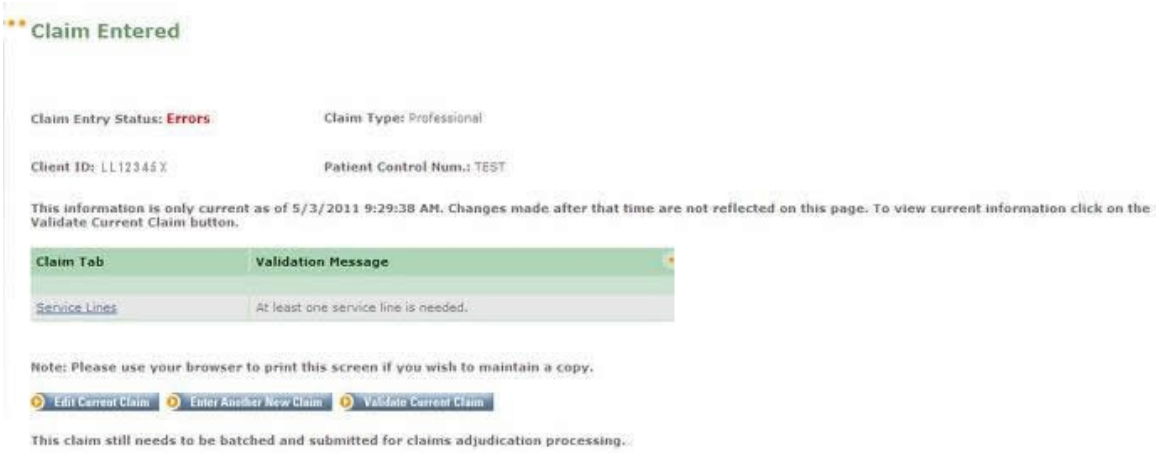
Claim Entry Status: Complete **Claim Type:** Professional Real Time

Client ID: LL12345X **Patient Control Num.:** ABC123

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

However, if errors exist, a table will be displayed informing you of each error and its location in the claim. The tab location of the error will be a hyperlink, which when clicked will take you directly to that tab so that you may make any necessary edits. Click on Edit Current Claim to return to the General Claim Information tab of the current claim or click Enter Another New Claim to leave this claim in Error status and enter a new claim. If you are viewing a claim with errors that was previously processed and you wish to determine if the errors displayed are still accurate, click Validate Current Claim, which will re-validate the claim and display an updated Confirmation page.



Claim Entered

Claim Entry Status: Errors Claim Type: Professional

Client ID: LL12345X Patient Control Num.: TEST

This information is only current as of 5/3/2011 9:29:38 AM. Changes made after that time are not reflected on this page. To view current information click on the Validate Current Claim button.

Claim Tab	Validation Message
Service Lines	At least one service line is needed.

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

This claim still needs to be batched and submitted for claims adjudication processing.

The Submit Real Time Claim button only displays if you selected Professional Real Time as the claim type when you initially began creating the claim. Choosing Submit Real Time displays a confirmation page.

' • Claim Entered

Claim Entry Status: Sent

Claim Type: Professional (RT)

Client 10: LL12345X

Patient Control Num.: TtST CLAIM

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 R"alTime Responses link In th" Idt hand navigationalmenu to view the corresponding Claim Acknowledgement response.

Institutional Claims

Institutional Claims

The process of entering an Institutional Claim is simplified by the user-friendly tab layout of the pages, grouping data elements to be entered into logical sets.

The tabs of information are as follows:

General Claim Information: The General Claim Information tab is identical for all Claim Types. It contains client specific information for the claim, and once data has been entered, is view only as the client personal information may not be modified.

Institutional Claim Information: This tab is specific to Institutional Claims. Just over half the data elements included on this page are unique to Institutional Claims.

Provider Information: All information pertaining to the Attending, Operating, or Referring Physician is entered on this tab.

Diagnosis/Procedure: Diagnosis and Procedure codes are entered here to allow charges to be properly assigned. Multiple diagnosis codes and multiple procedure codes may be entered.

Other Payers: The Other Payer tab allows for the entry of payers and the related subscriber information who, in addition to NY Medicaid, are responsible for the payment of the claim being entered.

Service Line(s): Multiple Service Lines may be entered to provide detailed information regarding the services rendered and associated with this claim.

Institutional Claim Information

The information specific to an Institutional claim is entered on this tab. Approximately half the data elements are unique to this claim type and will not be seen on the tabs when entering other types of claims. The page is visually separated into sections using different shading. Each section/field is discussed below, click on the section name to view the details of the fields in that section.

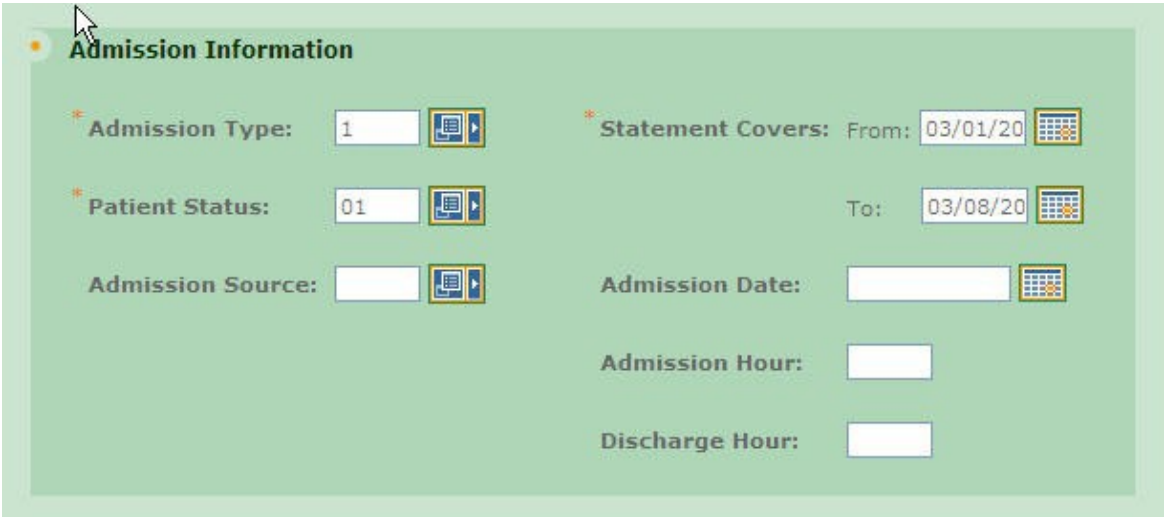
Facility Type: Enter the Type of Facility and Bill Classification. This value identifies the type of facility where services were performed. The Claim Frequency is defaulted for all claims by ePACES and therefore is not entered as a part of this code. Required for all claims.

Assignment of Benefits?: Select 'Yes' if the insured or authorized person authorizes benefits to be assigned to the provider. Select 'No' if benefits have not been assigned to the provider. This will default to 'Yes'.

Release of Information?: Enter or select the code indicating whether the provider has on file a signed statement by the patient authorizing the release of medical data to other organizations.

Accept Assignment?: Enter or select the appropriate value from the provided list to indicate whether the provider has a participation agreement with the payer. This field is required on all claims.

Auto Accident State: If this claim is related to a vehicular accident please choose the state the accident occurred in.



Admission Information

At a minimum, the admission type, patient status and the date range that is covered by the statement must be entered.

Admission Type: Please select an admission type.

Patient Status : Code representing the patient status as of the 'Statement Covers To' or Discharge date. Enter or select the appropriate value from the list of available codes. This a required field.

Admission Source: Indicates the source of the admission covered by this claim. Enter or select the appropriate Admission Source Code from the list. A value must be selected for all inpatient services.

Statement Covers (From / To): The date range that is being billed for in the claim. The dates may not be greater than the current date. The format for each date is: MM/DD/YYYY and may either be entered in the field or selected from the calendar available by pressing the button to the right of the field. A date range must be entered for all claims.

Admission Date : The date on which the patient was admitted to the facility. The date may not be greater than the current date. The format for the date is: MM/DD/YYYY and may either be entered in the field or selected from the calendar available by pressing the button to the right of the field. An Admission Date is required for all inpatient.

Admission Hour : The 4-digit military time, HHMM, associated with the time the patient was admitted to the facility. The value must be between 0001 and 2400 and must be entered directly into the field. An Admission Hour must be entered for all hospital inpatient services.

Discharge Hour : The 4-digit military time, HHMM, associated with the time the patient was discharged from the facility. The value must be between 0001 and 2400 and must be entered directly into the field. The Discharge Hour is required for all final inpatient claims. If a Discharge Hour is entered, the Discharge Date must also be captured when the discharge date is different than the statement through date.

Medical Record Number: Allows the provider to identify the actual medical record of the patient. Free-form text field, used as reference only for Hospital Inpatient claims.

Prior Authorization Number : If Prior Authorization has been received for the services associated with this claim, enter the prior approval number in the field. Prior Authorization numbers are assigned by the payer to authorize a service prior to its being performed. This number is specific to NY Medicaid.

Certification Information

Certification Category: If billing for a well care visit for a child, please select EPSDT-Referral Mutual in the drop down.

Condition Codes: Enter the appropriate condition code for EPSDT billing.

Value Codes

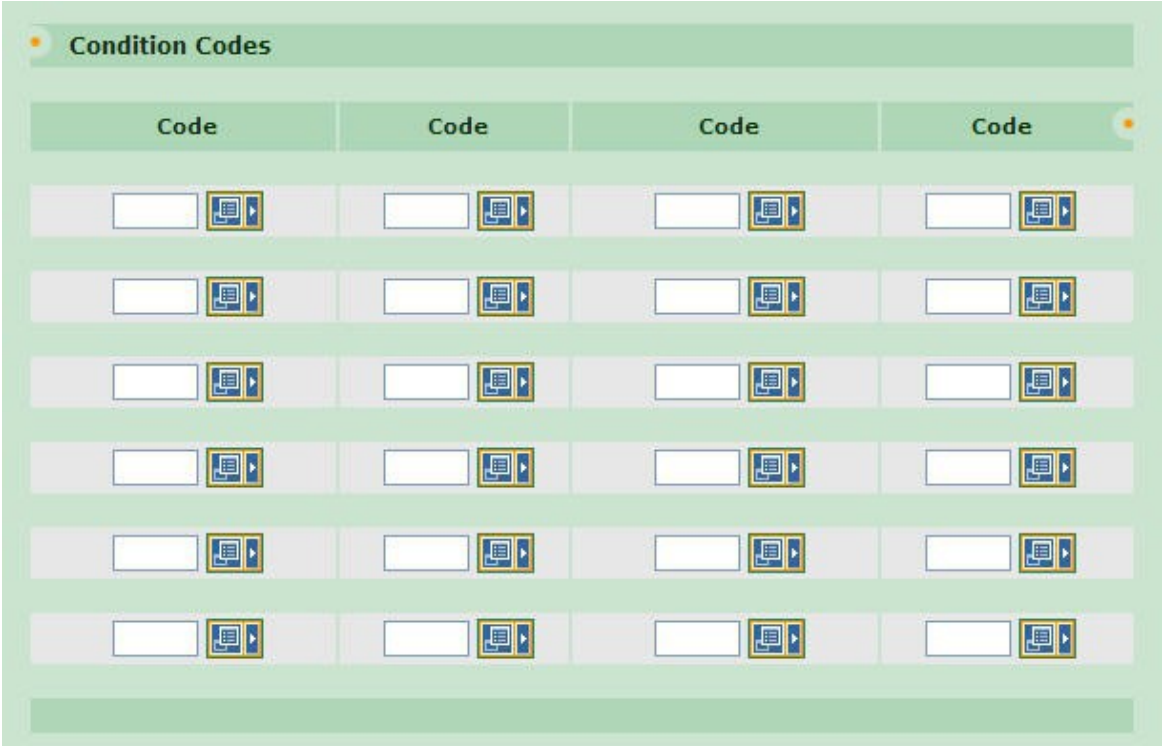
Rate Codes (24), Birth Weight (54), LTR Amounts (08 or 10), Surplus Amount (22), Catastrophic Amount (21), Net Available Monthly Income (NAMI) (23), Covered Days (80), Non-covered Days (81), Coinsurance Days (82), LTR Days (83) and Patient Paid Amount (FC) are

If it is necessary to enter Value codes and their corresponding values, you will notice there are 6 sets of fields visible in which to enter the information. If more than 6 Value Codes need to be entered, simply click 'Add'... and you will be able to enter an additional six Value Codes.

NOTE: You may not enter the same code multiple times, even if the corresponding values are different.

Code: Enter or select the desired code from the provided list of valid values. You may either type the code directly into the field or select the value from the pop-up window.

Value: This is a free-form field and becomes required if a corresponding code is selected. Depending on the code selected, the value entered may be an integer or a decimal value, however it must always be numeric.

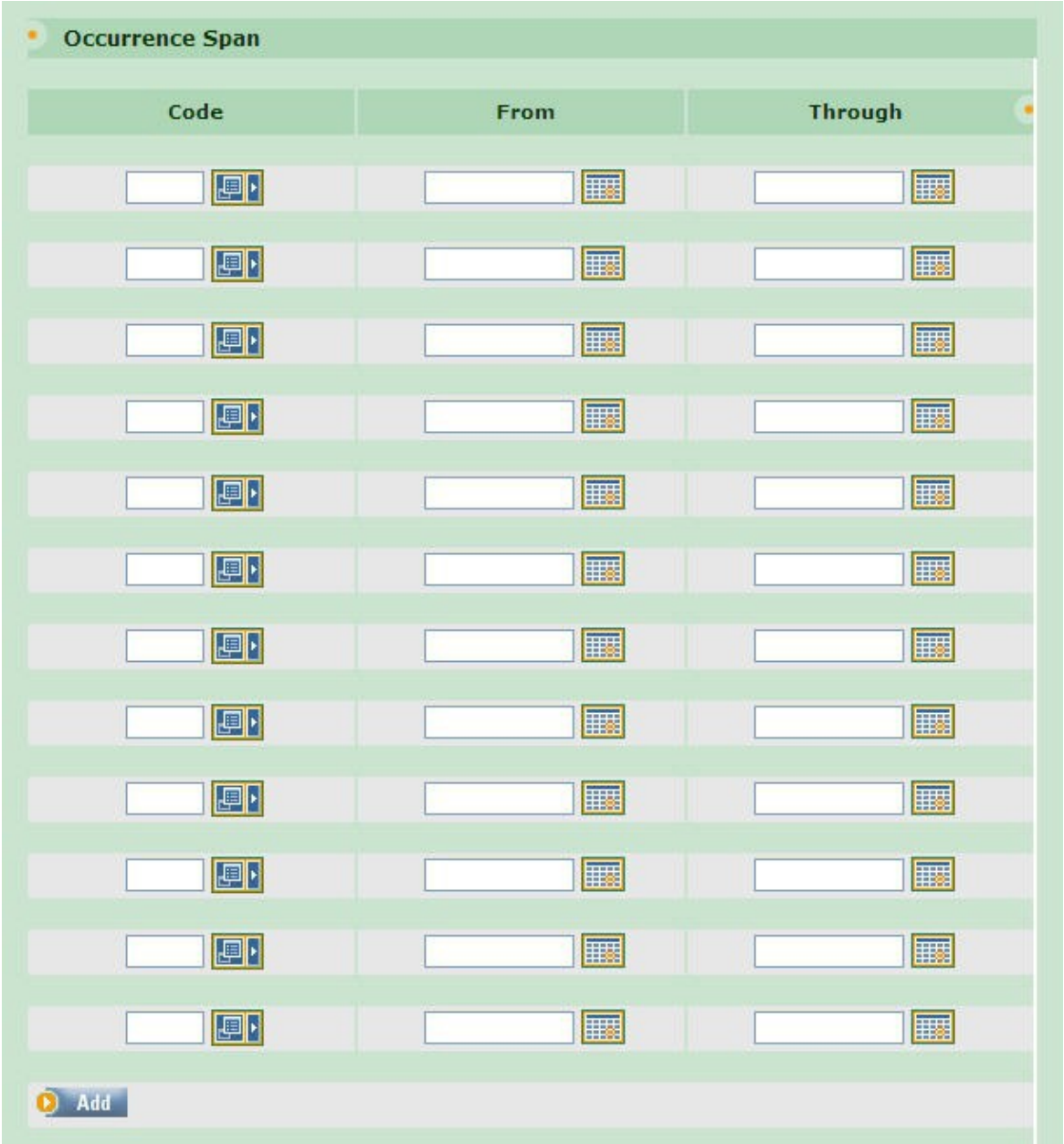


Condition Codes

Up to 24 Condition Codes may be selected for an individual Institutional Claim.

NOTE: You may not select the same Condition Code multiple times.

Code: Enter or elect the desired code value from the provided list of valid values. You may either type the code directly into the field or select the value from the pop-up window.



Occurrence Span

If it is necessary to enter Occurrence Spans or Codes for this claim, you are able to enter 12 values. The tab displays 12 sets of codes and corresponding dates, however clicking 'Add'... will allow you to enter an additional 12 values if needed. Occurrence Codes are used on Hospital Inpatient claims to indicate the Discharge Date (code = 42). The Stay Deny Effective Date is now reported as the Date Active Care Ended (code = 22).

NOTE: You **may** select the Code 75 multiple times for the same claim. For all other codes, you **may not** select the same code multiple times, even if the date ranges associated with the codes differ.

Code: Enter or select the desired value from the provided list of valid values. You may either type the code directly into the field or select the value from the pop-up window.

From / Through: If an Occurrence Code is entered (code values 01-69 and A0-L9), only a From date may be entered. However if an Occurrence Span is entered (code values 70-99 and M0-Z9), then both a From and Through date must be entered. If a Through date is entered, it must be greater than the From date entered. The date(s) may not be greater than the current date. The format is: MM/DD/YYYY and may either be entered in the field or selected from the calendar available by pressing the button to the right of the field.

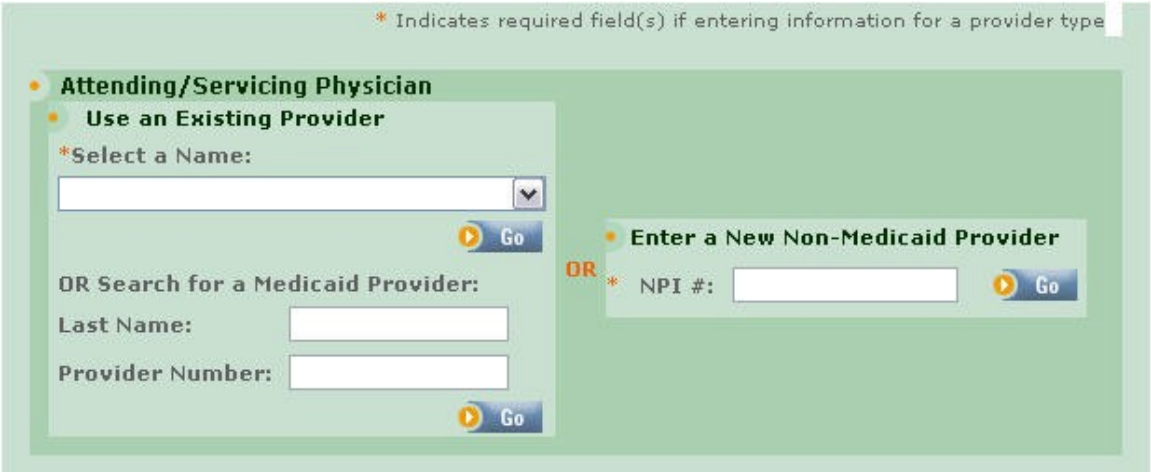
Service Authorization Exception Code: Enter the Service Authorization Code if the service you are billing is exempt from utilization threshold. You may either type the code directly into the field or select the value by pressing the button to the right of the field.

Delay Reason: If a claim will be submitted beyond the 90-day filing limitations, enter or select a reason code from the available list of valid values. If the delay reason is for interrupted maternity care or an IPRO denial/reversal, use "11 - Other".

Physician Information

For an Institutional Claim, there may be up to 3 Physicians listed. These would be the Attending/Servicing, Operating, and Referring. Each will be handled in the same manner, however in their own individual sections. **NOTE:** NYS expects to receive the referring provider for all claims that are the result of a referral. In the case of a restricted recipient, the recipient's primary care provider must be reported.

For each type of Physician, there are three ways in which to enter the name onto the claim, you may select an existing provider, search for a Medicaid provider, or enter a new non-Medicaid provider. See Appendix for details.



Attending/Servicing Physician

An Attending/Servicing Physician is required on all Claims.

Use an Existing Provider

Select a Name: If using an existing provider, you can select the name of the provider in the list.

Last Name: You can also enter the last name of the provider and click "Go".

Provider Number: You can also enter the provider's MMIS ID and click "Go".

Enter a New Non-Medicaid Provider

NPI: If you are entering a new non-Medicaid provider, you can enter the NPI of the provider here.

Operating Physician

Use an Existing Provider

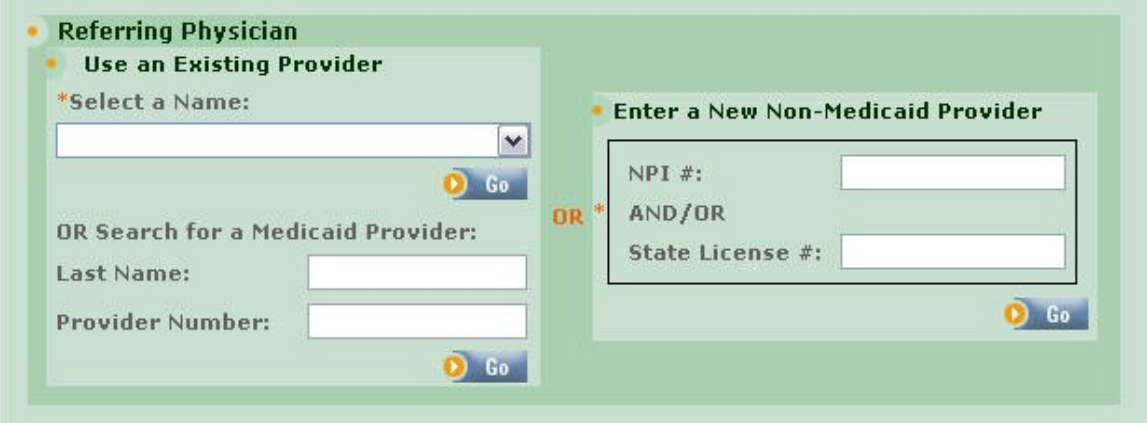
Select a Name: If using an existing provider, you can select the name of the provider in the list.

Last Name: You can also enter the last name of the provider and click "Go".

Provider Number: You can also enter the provider's MMIS ID and click "Go".

Enter a New Non-Medicaid Provider

NPI: If you are entering a new non-Medicaid provider, you can enter the NPI of the provider here.



Referring Physician

Use an Existing Provider

Select a Name: If using an existing provider, you can select the name of the provider in the list.

Last Name: You can also enter the last name of the provider and click "Go".

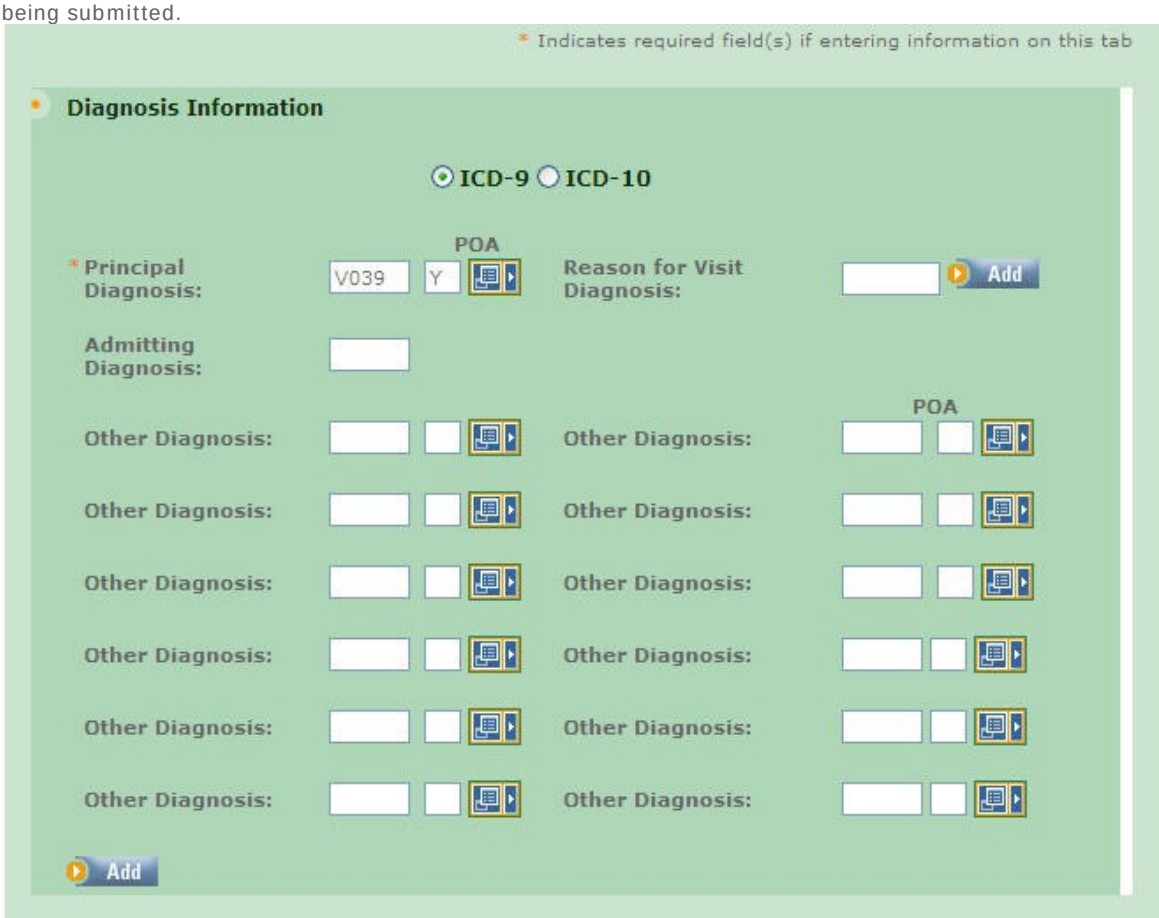
Provider Number: You can also enter the provider's MMIS ID and click "Go".

Enter a New Non-Medicaid Provider

If you are entering a new non-Medicaid provider, you can enter the **NPI #** and/or the **State License #** here.

Diagnosis / Procedure

Diagnosis and Procedure information must be entered on the claim to inform the payer of why the claim is being submitted.



Diagnosis Information

ICD-9 / ICD-10: Select the appropriate code type for the diagnosis.

Principal Diagnosis : A principal diagnosis is required for all institutional claims.

Admitting Diagnosis: The Admitting Diagnosis is required on inpatient claims only. Cannot be entered in combination with Reason for Visit.

Reason for Visit Diagnosis: If applicable, enter the diagnosis code that is being used for the reason for the visit.

Other Diagnosis: Other Diagnosis codes may be entered when other condition(s) co-exist with the principal diagnosis, co-exist at the time of admission, or develop subsequently during the patient's treatment. Up to 24 Other Diagnosis codes may be entered on a single claim and may not be duplicated.

POA: Present on Admission code is required for all inpatient claims. It is used to indicate whether a Principal/Other Diagnosis code was present at the time of admission, to distinguish it from a diagnosis that occurred after the admission but during the stay. Select the appropriate Present on Admission code.

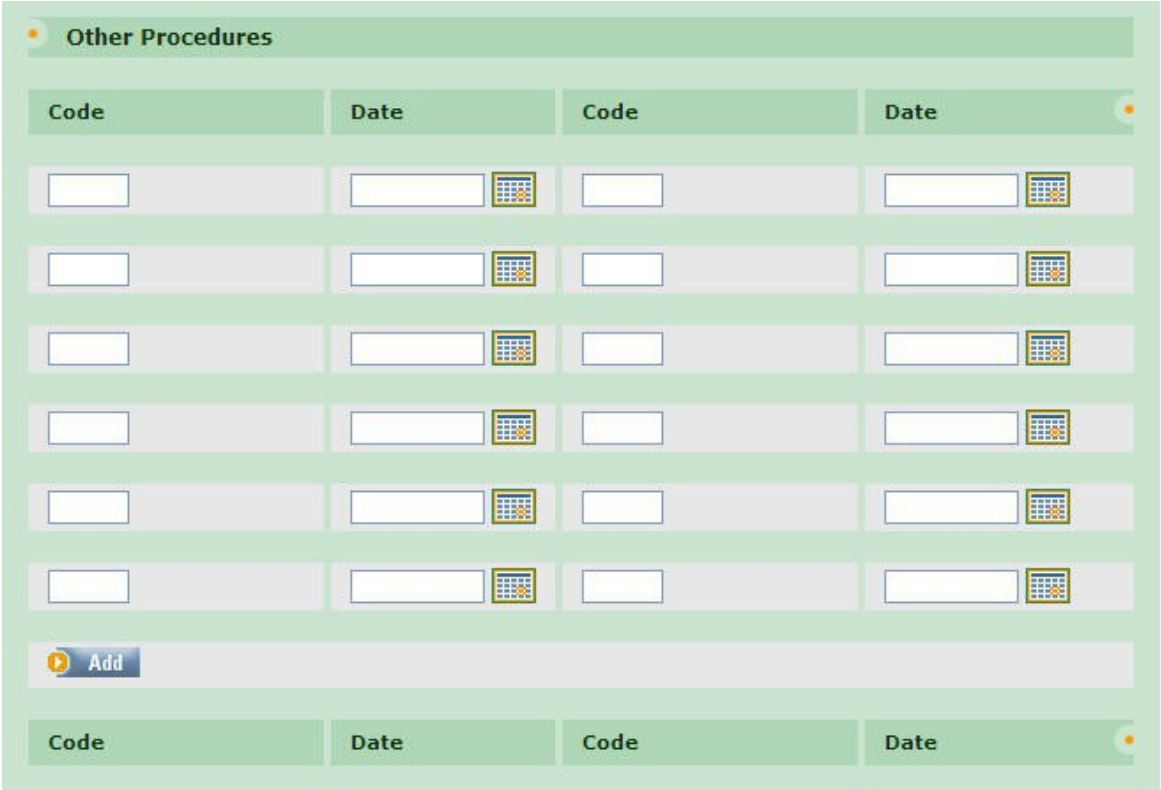
External Cause of Injury

Code: This field is used when an external Cause of Injury is needed to describe an injury, poisoning, or adverse effect.

Principal Procedure

Principal Procedure : A Principal Procedure must be entered on inpatient claims where a procedure was performed.

Principal Procedure Date: Required if a Principal Procedure is entered. The date may not be greater than the current date. The format is: MM/DD/YYYY and may either be entered in the field or selected from the calendar available by pressing the button to the right of the field.



Other Procedures

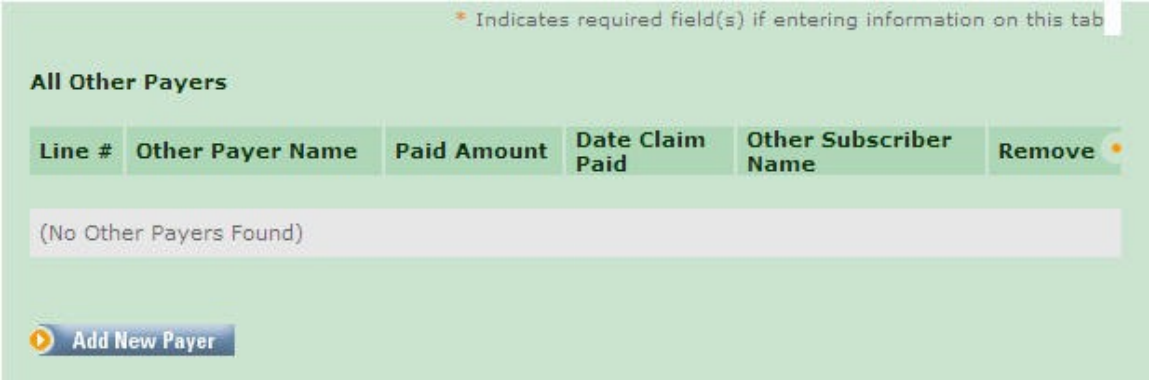
Code: Only Inpatient claims use ICD-9 or ICD-10 procedure codes for the Other Procedure Code field. NO other claims use this entry. If a procedure code is entered, the date the procedure was performed must also be entered.

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

Other Payers

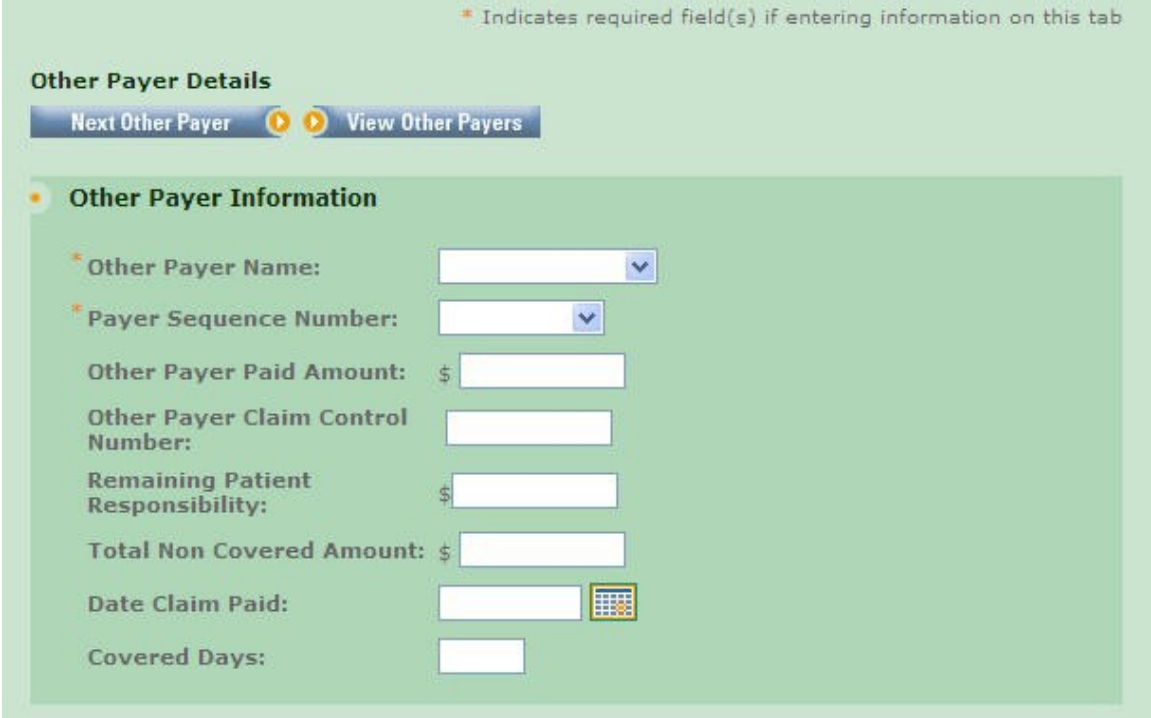
The Other Payers tab is not required to enter a claim. You only need to access this tab if there are payers in addition to NY Medicaid to be applied to the claim being entered. However, if you do access the tab and start the process of entering an Other Payer, you must complete all the required information or delete all data entered before continuing to another tab.

Upon initially opening this tab, you will see the Summary level of all Other Payers entered for this claim. If no Payers exist, the table will be empty and you may Add Another Payer at this time. If Other Payers have already been entered for this claim, you may view the details associated with each payer from this table or add Other Payers.



Enter Other Payer

In addition to NY Medicaid, you may enter additional payers who are responsible for this claim. Remember that all elements marked with an asterisk (*) are required when entering a Payer. Not all claims will have Other Payer information. Note: A maximum of 10 Other Payer records may be entered per claim.



Other Payer Information

Other Payer Name: Select the name of the desired payer from the provided list. If the Other Payer you are looking for is not listed, contact your Administrator to add the Payer to the Support File of valid Payers. Required for all Other Payers.

Payer Sequence Number: Select the value that represents the order in which payment was received from other payers. This will determine in what order the payer is applied to the value of the claim. Payers may be entered in any sequence and displayed in any sequence. Required for all Other Payers.

Other Payer Paid Amount: The amount this payer has paid to the provider towards this bill. This field is required when this payer has adjudicated the claim. If the Other Payer denied the claim, enter 0. If the Other Payer has not adjudicated the claim, leave blank. If a value is entered, the Date Claim Paid must be entered as well.

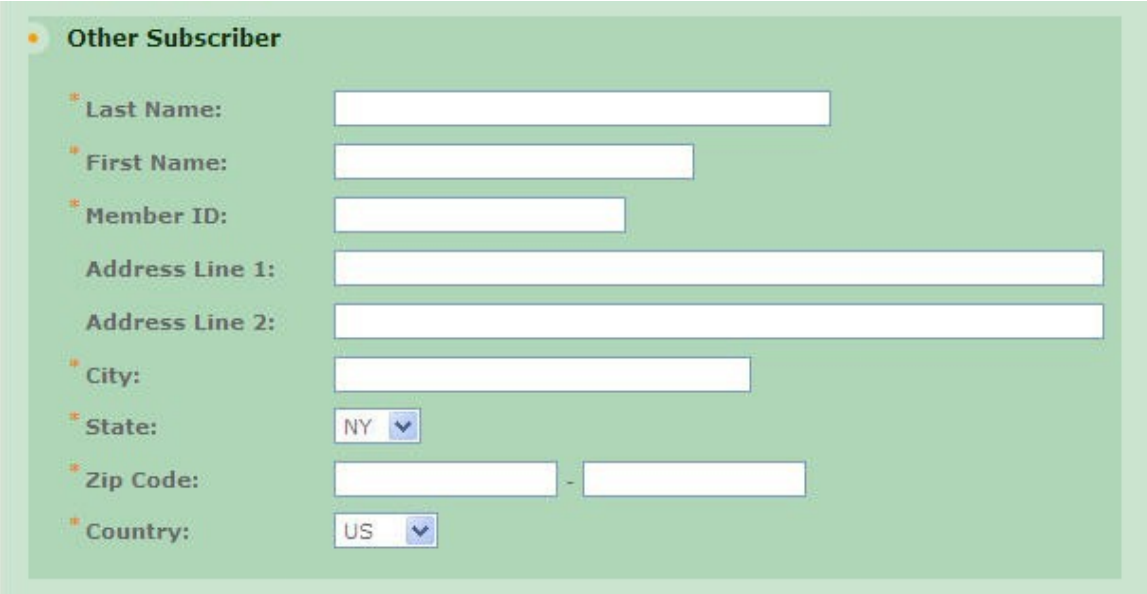
Other Payer Claim Control Number: Enter the claim identification number this payer has assigned to the claim.

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

Total Non-Covered Amount: Enter the dollar value of the claim in this field if the other payer was not billed, because documentation is on file that the other payer would not have paid the claim.

Date Claim Paid: Date on which the Other Payer Paid Amount was received. This date may not be greater than the current date. The format is: MM/DD/YYYY and may either be entered in the field or selected from the calendar available by pressing the button to the right of the field.

Covered Days: The number of full days that are eligible for reimbursement by the Other Payer.



Other Subscriber

Last Name/First Name: If entering an Other Payer, you must enter the First and Last Name of the Subscriber for the Payer. The Subscriber may or may not be the Client.

Member ID: The Subscribers ID as assigned by the Payer. This is required when entering the Subscriber for the Other Payer.

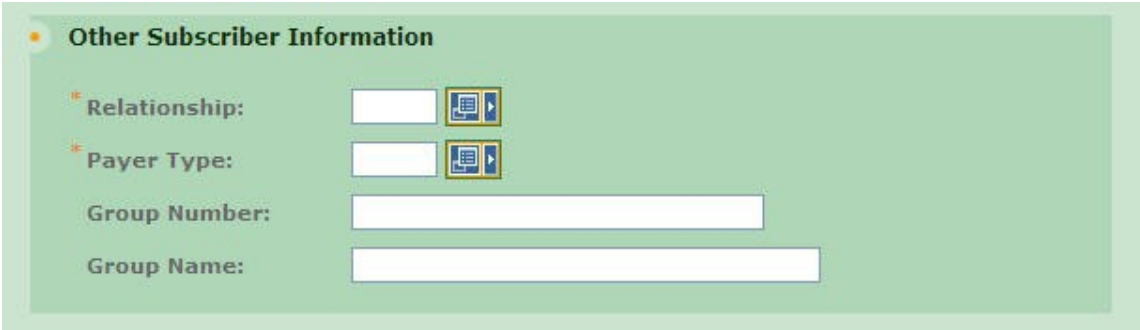
Address Line 1/2: Enter the street address of the subscriber.

City: Enter the city name of the subscriber.

State: Enter the state of the subscriber.

Zip Code: Enter the Zip of the subscriber.

Country: Country in which the Subscriber lives, if known. Select value from the list of available countries, defaults to 'US'.



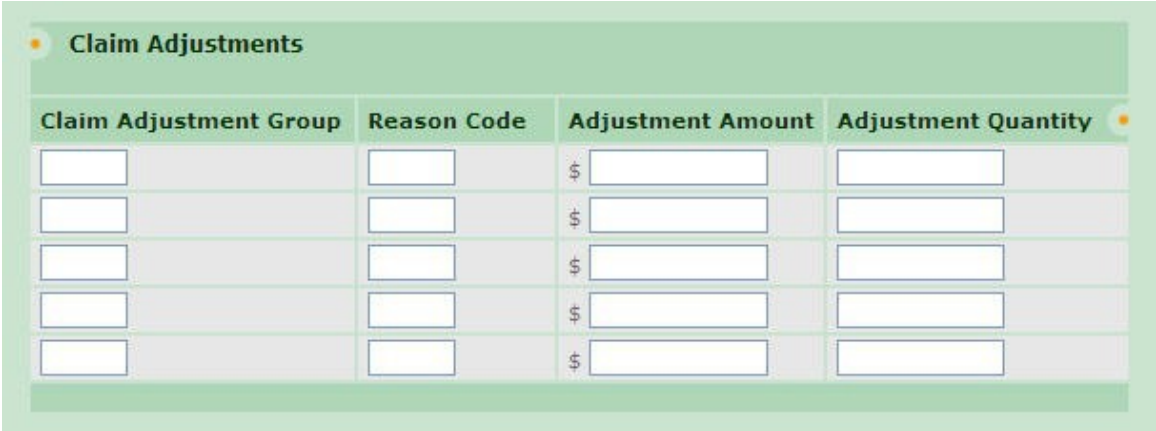
Other Subscriber Information

Relationship: Code indicating the relationship between the Client/Patient and the Subscriber for this Payer. Enter or select a value from the list of available codes. A relationship is required if a Subscriber is entered.

Payer Type: Code identifying the type of payer. Enter or select a value from the list of available codes. A Claim Filing Indicator is required if a Subscriber is entered.

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

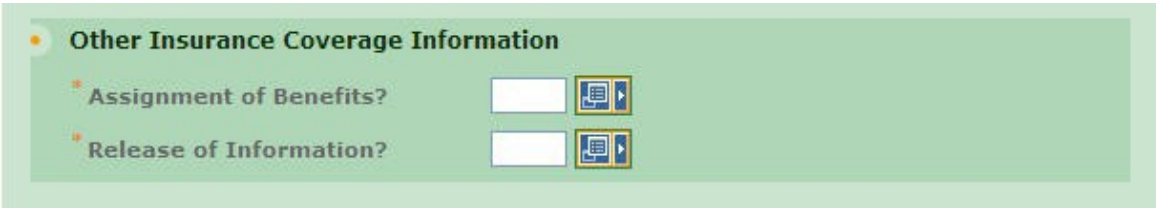
If the other payer reported claim adjustments at the claim level, enter the adjustment information here. Otherwise, this information will be blank.

Claim Adjustment Group: Enter the Group Code as received from the other payer. A maximum of 5 Claim Adjustment Groups are allowed per claim and the values are to be entered.

Reason Code: Enter the Claim Adjustment Reason Code as received from the other payer. This is directly correlated to the Claim Adjustment Group. The Claim Adjustment Group/Reason Code combination may not be entered more than once. If an Adjustment Amount or Adjustment Quantity is entered, a Reason Code is required.

Adjustment Amount: Enter the Adjustment Amount as received from the other payer. An Adjustment Amount is required when a Reason Code is entered.

Adjustment Quantity: Enter the Quantity Adjusted as received from the other payer.



Other Insurance Coverage Information

Assignment of Benefits?: The Benefits Assignment Certification Indicator. 'Yes' indicates insured or authorized person authorizes benefits to be assigned to the provider while 'No' indicates that no authorization has been given. This value will default to 'Yes' and is required if an Other Payer Name is selected.

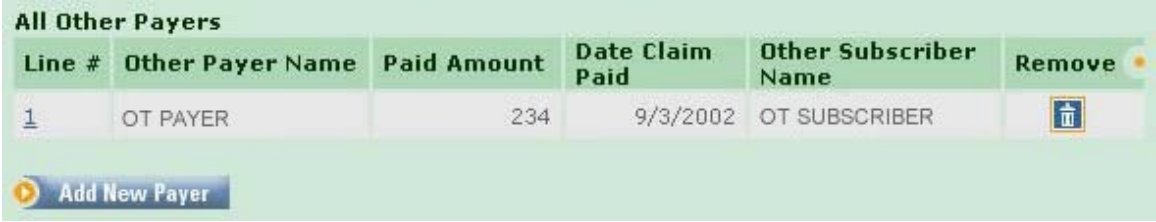
Release of Information?: Indicates whether the provider has a signed statement by the patient authorizing the release of medical data to other organizations. You must enter or

select a value if an Other Payer Name is selected.

Once you have entered all the information for the Payer, you may add another payer by clicking the Next Payer>> control at the top or bottom of the tab. This will return you to the top of the page with all the values cleared out and a new Payer Sequence Number listed at the top of the page. Clicking View All Other Payers will display the Other Payers Summary page.

View Other Payers

Viewing All Other Payers is a quick and easy way to see what payers, in addition to NY Medicaid, have a responsibility for this claim. The easy to read table displays a snapshot of information about each Payer.



All Other Payers

Line #	Other Payer Name	Paid Amount	Date Claim Paid	Other Subscriber Name	Remove
1	OT PAYER	234	9/3/2002	OT SUBSCRIBER	

Add New Payer

Line #: This is a line number identifying the order in which the Other Payers were entered on the claim. Clicking this hyperlinked value will open the Details Page for that Payer. Removing a Payer will change the Line # of payers entered after that payer. For example, if you delete Line # 2, then Line # 3 and Line # 4 become 2 and 3 respectively. Payers may be entered in any sequence, and are displayed here in that sequence. The Line # is not related to the order of responsibility for paying this claim, that is handled by the Payer Sequence Number.

Other Payer Name: The Payer name as selected when entering the Other Payer onto the claim.

Paid Amount: The dollar amount paid by the Payer towards this claim.

Date Claim Paid: The date on which a payment was received from this Payer for this claim.

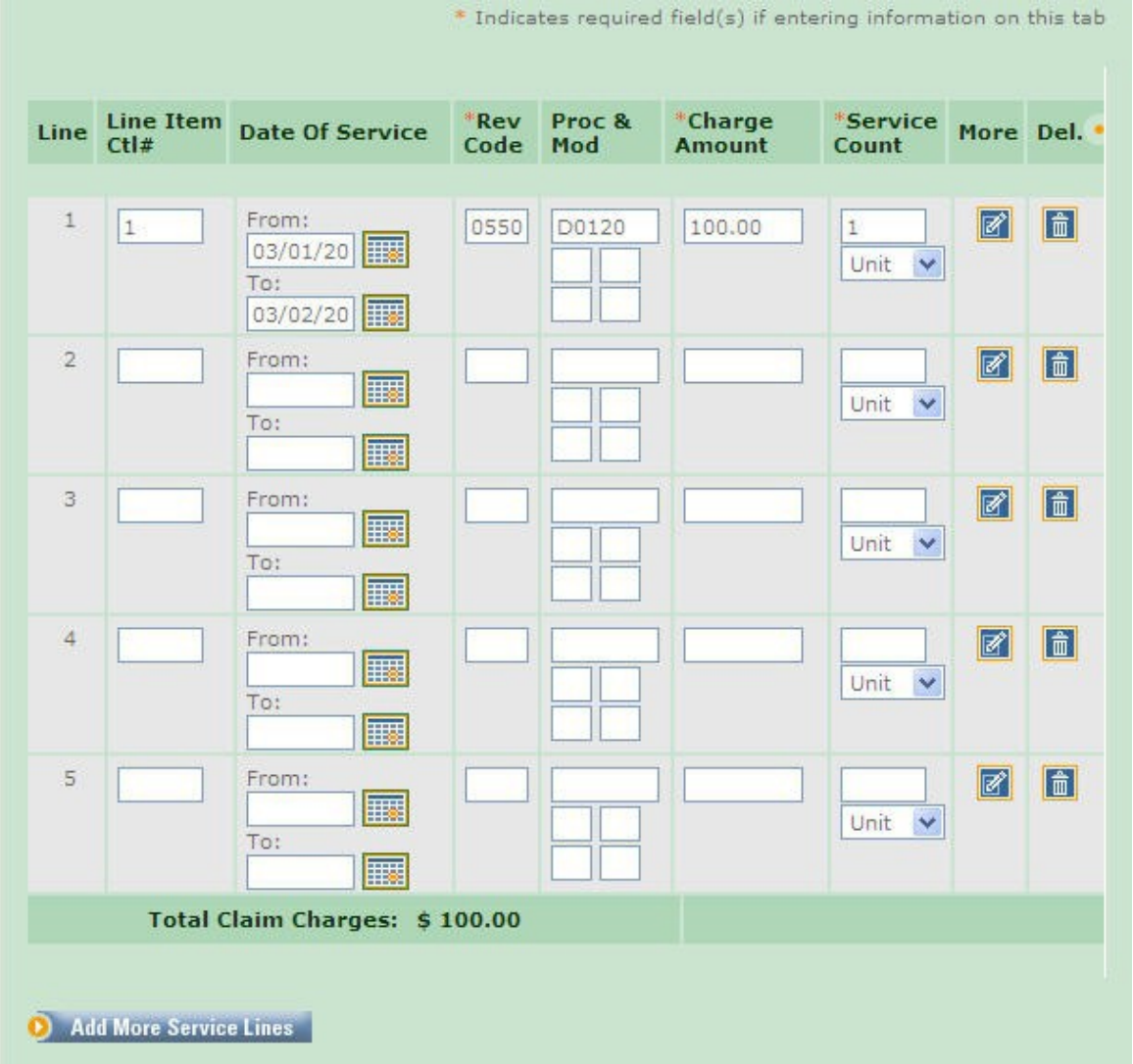
Other Subscriber Name: The full name (Last Name, First Name Middle Initial) of the Subscriber associated with this Payer.

If a specific Third Party or Managed Care Plan is required but not listed, you may Add Another Payer. If a Payer was erroneously added to this claim and must be removed, click the Remove icon and confirm the deletion.

Service Line(s)

A Service Line is listed on a claim for each procedure or item that is to be reported to the Payer(s) for claim adjudication. Each claim must contain at least one Service Line.

The main view of the Service Line(s) tab contains the basic information for the line as it relates to NY Medicaid. Additional information and adjudication details from Other Payers are available on subsequent pages. As a default, 5 Service Lines are displayed on the main page, however you may add as many as needed, up to a maximum of 999, simply by clicking Add More Service Lines. You may remove any single Service Line by clicking the Remove icon on that line. In addition, the total of all the submitted charges for the Service Lines is listed below all the Service Lines that have been entered.



Line: This is a system generated value to uniquely identify the Service Line on the claim. The counter will start with 1 and increment with each new Service Line entered. A minimum of 1 Service Line is required on all claims.

Line Item Ctl#: This field can be used to enter a line number that corresponds with your records if it is different than the line number given. When used, the value provided will be returned on the 835 (electronic remittance advice) and may be used as an index to your system. This field is not required.

Date of Service: For a procedure/service rendered on a single date, enter this date in the From Date. However, if the procedure/service transpired over a period of time, enter the start

and end dates in the From and To fields respectively. The date(s) may not be greater than the current date. The format is: MM/DD/YYYY and may either be entered in the field or selected from the calendar available by pressing the button to the right of the field.

Rev Code: The Revenue code associated with the procedure/service. This value is required and will be validated against the Revenue Codes in the database.

Proc & Mod: The Health Care Financing Administration Common Procedural Coding System identifier for the product/service. This code value is required for all Outpatient Claims. Optionally, up to four modifiers identifying special circumstances related to the performance of the service may be entered for each code. Note: If entered, the Modifier must be a 2 character code.

Charge Amount: The submitted charge amount for this procedure/service must be entered. Note: Zero dollars is a valid charge amount.

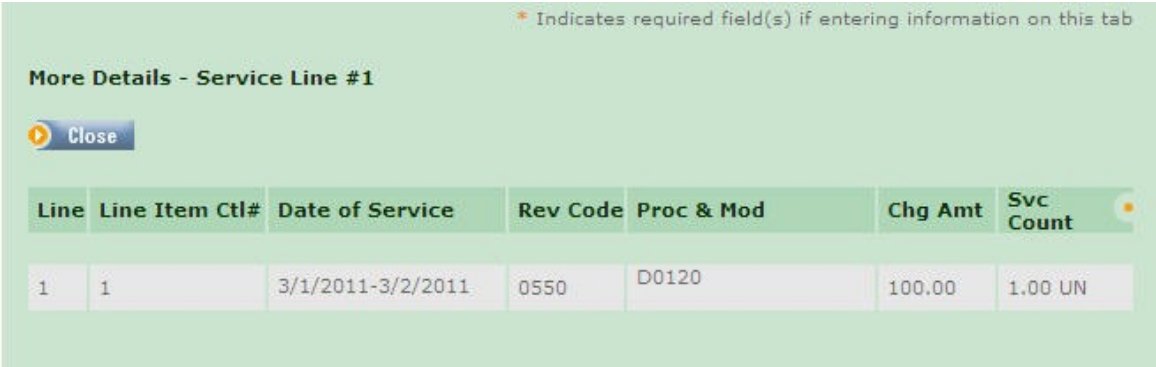
Service Count: The number of days or units in which the procedure/service is to be billed. A drop down is available to indicate the unit of measure for the Service Unit. Valid units of measure are 'Units' and 'Days'.

Total Claim Charges: At the bottom of the table of Service Lines, all charges for all Service Lines on the claim will be summed and displayed, once the Service Line Information is saved.

For each Service Line, you may view/enter additional details by clicking the More icon. However you may only view these additional details once all required elements have been entered. Navigating off this summary page, either by clicking the More icon or moving to another tab, will trigger validation of the data entered on this page. Validation is done one line at a time, so if there are errors on multiple lines you will have to fix each line before seeing the next set of errors. If a Service Line must be removed for any reason, clicking the Delete icon will remove the line and re-sequence the remaining Service Lines.

Service Line Details

Each service line on an Institutional Claim will have information available in addition to what is displayed in summary on the main page. This information is accessed by clicking the More icon on the main Service Line(s) page.



More Details

The top of the screen will display information on what service line more button you are on. This includes, Line Number, Line Item CTL #, DOS, Rev Code, Proc & Mod, Charge Amount and Service Count that was enter on the service line.

Drug Identification

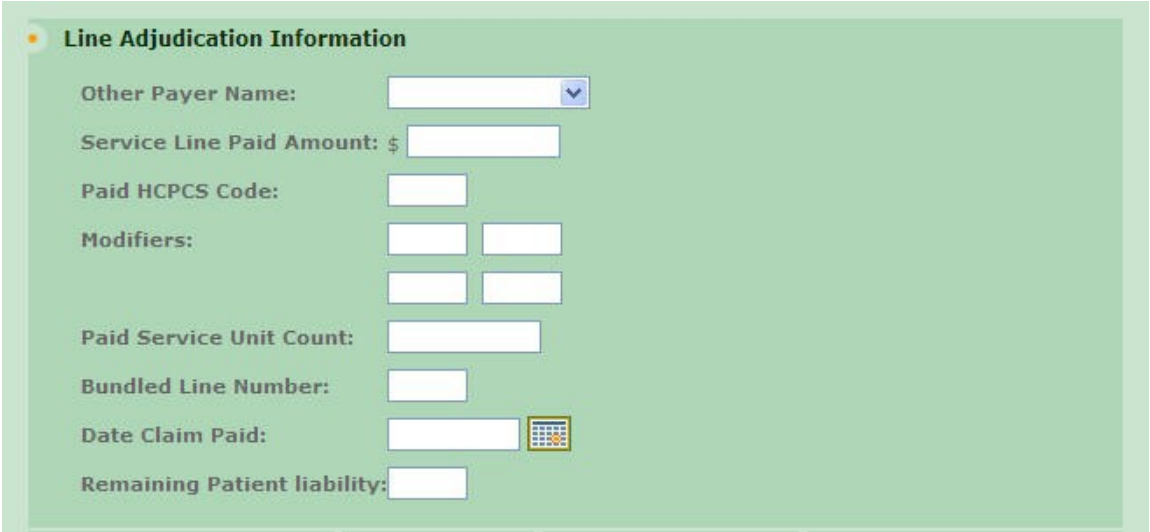
If any information is entered into this section, all pieces of data must be populated.

National Drug Code: Enter the NDC for the drug associated with this Service Line. The value entered must be 11 digits with no hyphens.

National Drug Unit Count: Enter the number of units dispensed of this medication. Also, select the proper Unit of Measure to be associated with this value. Defaults to 'Unit' but any valid value may be selected.

Pharmacy Prescription Number/Link Sequence Number: Pick whether you are entering a Prescription Number or Link Sequence Number.

Prescription/Compound Number(s): The Prescription/Compound Number associated with the drug may be entered here.



Line Adjudication Information

Other Payer Name: Select the name of the desired payer from the provided list.

Service Line Paid Amount: The dollar amount paid by the Payer towards this service line.

Paid HCPCS Code: The HCPCS code paid by the other payer.

Modifiers: The modifiers associated with the HCPCS above paid by the other payer.

Paid Service Unit Count: The amount of service units paid by the other payer.

Bundled Line Number: If applicable, enter the number of the line bundled or unbundled by the other payer.

Date Claim Paid: Date on which the Other Payer Paid Amount was received. This date may not be greater than the current date. The format is: MM/DD/YYYY and may either be entered in the field or selected from the calendar available by pressing the button to the right of the field.

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

Claim Adjustment

Claim Adjustment Group: Enter the Group Code as received from the other payer. The general category of the payment adjustment. A maximum of 5 Claim Adjustment Groups are allowed per claim and the values are to be entered.

Reason Code: Enter the Claim Adjustment Reason Code as received from the other payer. This is directly correlated to the Claim Adjustment Group. The Claim Adjustment

Group/Reason Code combination may not be entered more than once. If an Adjustment Amount or Adjustment Quantity is entered, a Reason Code is required.

Adjustment Amount: Enter the Adjustment Amount as received from the other payer. An Adjustment Amount is required when a Reason Code is entered.

Adjustment Quantity: Enter the Quantity Adjusted as received from the other payer.

If Other Payers have been included on the claim and they have adjudicated this line or you need to maintain the adjudication details, you may view/maintain the individual Line Adjudication Information or view a summary of all adjudication information for this line.

Service Line Adjudication Summary

If there are multiple Other Payers defined for a claim, each Service Line may have multiple Line Adjudication records. Viewing the Line Adjudication Summary for a particular Service Line will provide quick visibility to the payments which have been made against the particular Service Line.

Line #	Other Payer Name	Service Line Paid Amount	HCPCS Code	Date Claim Paid	Remove
1	MCMS OF ST	1526.45	V5200	10/1/2003	
2	SELF	25.50	V5500	9/29/2003	

From this page, you may Add Another Line Adjudication or review the individual Line Adjudications. The table displayed contains the following summary information:

Line #: An incremental counter to track the adjudication records for each line.

Other Payer Name: The Third-Party or Managed Care payer responsible for payment on this claim. All subsequent data entered applies to the Adjudication for this Service Line and Payer combination. Any Payer entered here must also be entered on the Other Payer tab for the claim.

Service Line Paid Amount: The dollar amount paid towards this Service Line by the Payer. The total of all the Service Line Paid Amounts on this claim must add up to the total Other Payer Paid Amount on the Other Payer tab.

HCPCS Code: The Health Care Financing Administration Common Procedural Coding System identifier for the product/service. This code value is required for all Outpatient Claims.

Date Claim Paid: Service adjudication or payment date. The format is: MM/DD/YYYY.

Remove a Line Adjudication

Clicking the Remove icon for a particular Line Adjudication record will prompt you to confirm the deletion. Removing a record will permanently delete the data from the claim and adjust Line Paid amounts accordingly.

Claim Confirmation

Upon completion of a claim, which is indicated by clicking Finish, the claim will be placed into one of two states. If there are no validation errors and the claim is ready to be submitted for adjudication, then it will be set to Complete.

Claim Entered

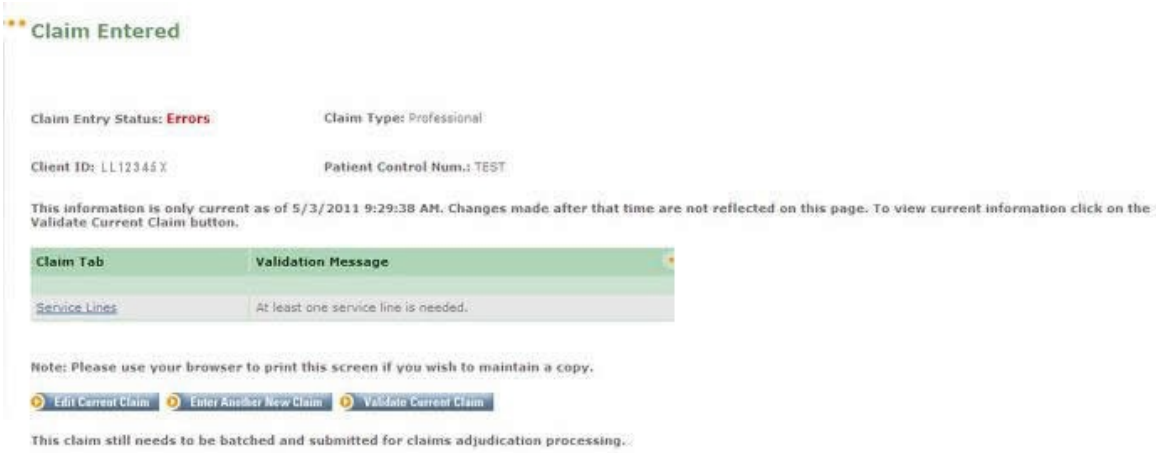
Claim Entry Status: Complete **Claim Type:** Professional Real Time

Client ID: LL12345X **Patient Control Num.:** ABC123

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

However, if errors exist, a table will be displayed informing you of each error and its location in the claim. The tab location of the error will be a hyperlink, which when clicked will take you directly to that tab so that you may make any necessary edits. Click on Edit Current Claim to return to the General Claim Information tab of the current claim or click Enter Another New Claim to leave this claim in Error status and enter a new claim. If you are viewing a claim with errors that was previously processed and you wish to determine if the errors displayed are still accurate, click Validate Current Claim, which will re-validate the claim and display an updated Confirmation page.



Claim Entered

Claim Entry Status: Errors Claim Type: Professional

Client ID: LL12345X Patient Control Num.: TEST

This information is only current as of 5/3/2011 9:29:38 AM. Changes made after that time are not reflected on this page. To view current information click on the Validate Current Claim button.

Claim Tab	Validation Message
Service Lines	At least one service line is needed.

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

This claim still needs to be batched and submitted for claims adjudication processing.

The Submit Real Time Claim button only displays if you selected Professional Real Time as the claim type when you initially began creating the claim. Choosing Submit Real Time displays a confirmation page.

' • Claim Entered

Claim Entry Status: Sent

Claim Type: Professional (RT)

Client 10: LL12345X

Patient Control Num.: TtST CLAIM

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 R"alTime Responses link In th" Idt hand navigationalmenu to view the corresponding Claim Acknowledgement response.

Professional Claims

Professional Claims

The process of entering a Professional Claim is simplified by the user-friendly tab layout of the pages, grouping data elements to be entered into logical sets.

The tabs of information are as follows:

General Claim Information: The General Claim Information tab is identical for all Claim Types. It contains client specific information for the claim, and once data has been entered, is view only as the client personal information may not be modified.

Professional Claim Information: This tab is specific to Professional Claims. Just over half the data elements included on this page are unique to Professional Claims.

Provider Information: All information pertaining to the Rendering, Referring, Primary Care, or Supervising Provider is entered on this tab.

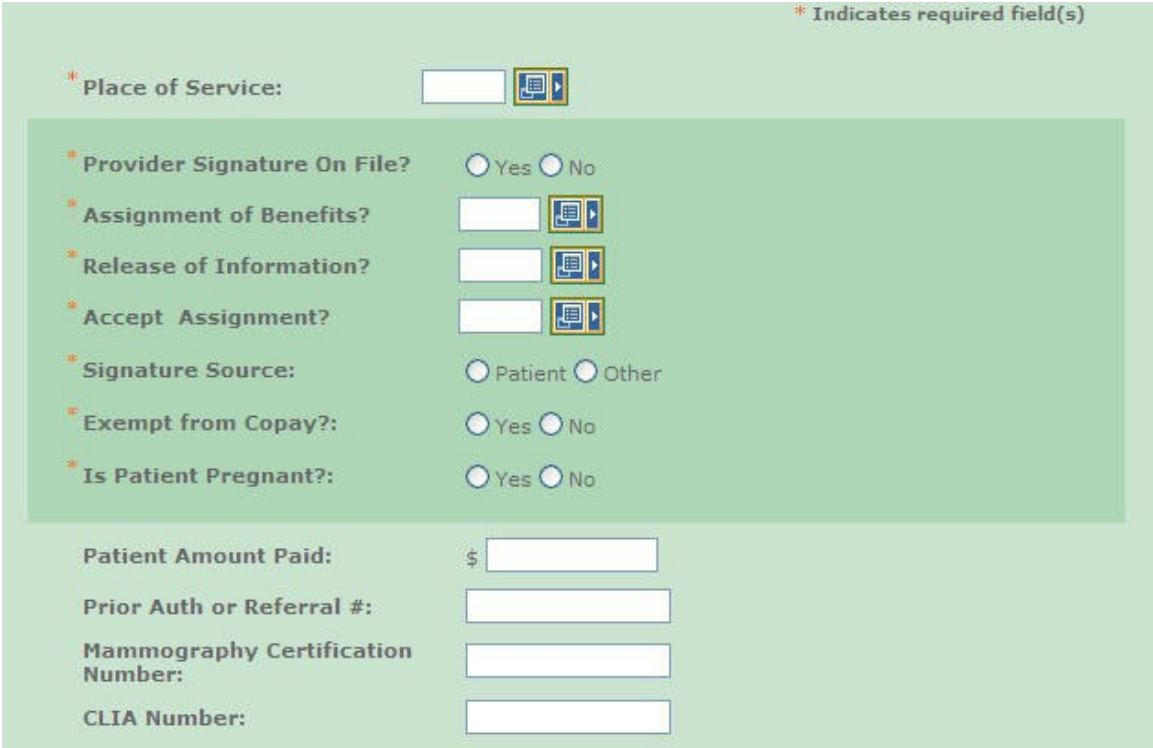
Diagnosis: Diagnosis codes are entered here to allow charges to be properly assigned. Multiple diagnosis codes may be entered.

Other Payers: The Other Payer tab allows for the entry of payers and the related subscriber information who, in addition to NY Medicaid, are responsible for the payment of the claim being entered.

Service Line(s): Multiple Service Lines may be entered to provide detailed information regarding the services rendered and associated with this claim.

Professional Claim Information

The information specific to a Professional claim is entered on this tab. Approximately one-third of the data elements are unique to this claim type and will not be seen on other tabs when entering other types of claims. The page is visually separated into sections using different shading. Each section/field is discussed below, click on the section name to view the details of the fields in that section.



Place of Service: Enter the Place of Service from the CMS Place of Service code list that is most appropriate for the service location type.

Provider Signature on File?: Select 'Yes' or 'No' depending on whether or not the Provider Signature is on file with the Payer. This field is required for all Professional claims.

Assignment of Benefits?: Select 'Yes' if the insured or authorized person authorizes benefits to be assigned to the provider. Select 'No' if benefits have not been assigned to the provider. This will default to 'Yes'.

Release of Information?: Enter or select the code indicating whether the provider has on file a signed statement by the patient authorizing the release of medical data to other organizations.

Accept Assignment? Enter or select the appropriate value from the provided list to indicate whether the provider has a participation agreement with the payer. This field is required on all claims.

Signature Source: Select either patient or other on how subscriber authorization signature was obtained.

Exempt from Copay? Select Yes or No on whether the member is exempt from copay.

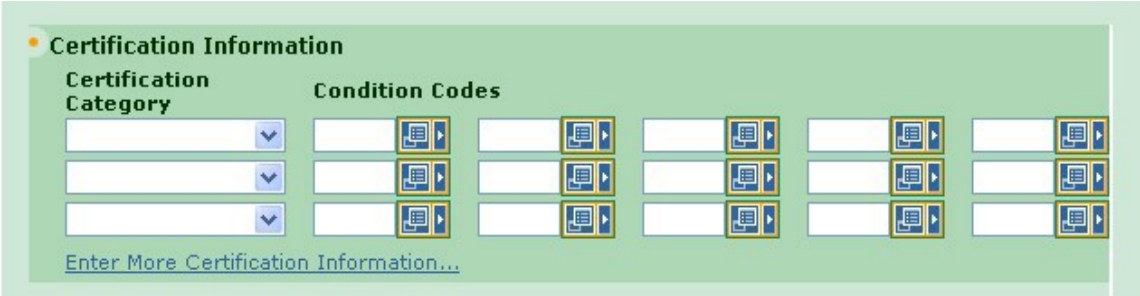
Is Patient Pregnant? Select Yes or No on whether the member is pregnant.

Patient Amount Paid: The sum of all amounts paid, if any, on the claim by the patient or his/her representative.

Prior Authorization: If Prior Authorization has been received for the services associated with this claim, enter the prior approval number in the field. Prior Authorization numbers are assigned by the payer to authorize a service prior to its being performed. This number is specific to NY Medicaid and should not be used for Predetermination of Benefits.

Mammography Certification Number: When entering a claim where mammography services were rendered, the Mammography Certification Number must be entered.

CLIA Number: The Clinical Laboratory Improvement Amendment Number is required on all claims containing laboratory tests covered by the CLIA Act.



Certification Information

Certification Category: If applicable, select the appropriate certification category. Options are: Homebound-Functional, Vision-Spectacle Lense, Vision-Contact Lense, Vision Spectacle Frame or EPSDT Referral.

Condition Codes: Enter the appropriate condition code based on the certification category selected.

The format for all date values is MM/DD/YYYY and may be entered in the field or selected from the calendar available by pressing the button to the right of the field.

Dates

Admission Date: If applicable, enter the date of admission.

Discharge Date: If applicable, enter the discharge date.

Onset of Current Illness or Injury Date: If applicable, enter the date the illness/injury began.

Last X-Ray Date: If applicable, enter the date of the last x-ray.

Last Menstrual Period Date: If applicable, enter the last menstrual period date.

Hearing and Vision Prescription Date: If applicable, enter date for hearing or vision prescription.

Disability From Date: If applicable, enter date member started disability.

Disability Through Date: If applicable, enter date member stopped disability.

Assumed Care Date: If applicable, enter date care was assumed.

Relinquished Care Date: If applicable, enter date care was relinquished.

Acute Manifestation Date: If applicable, enter date of acute manifestation.

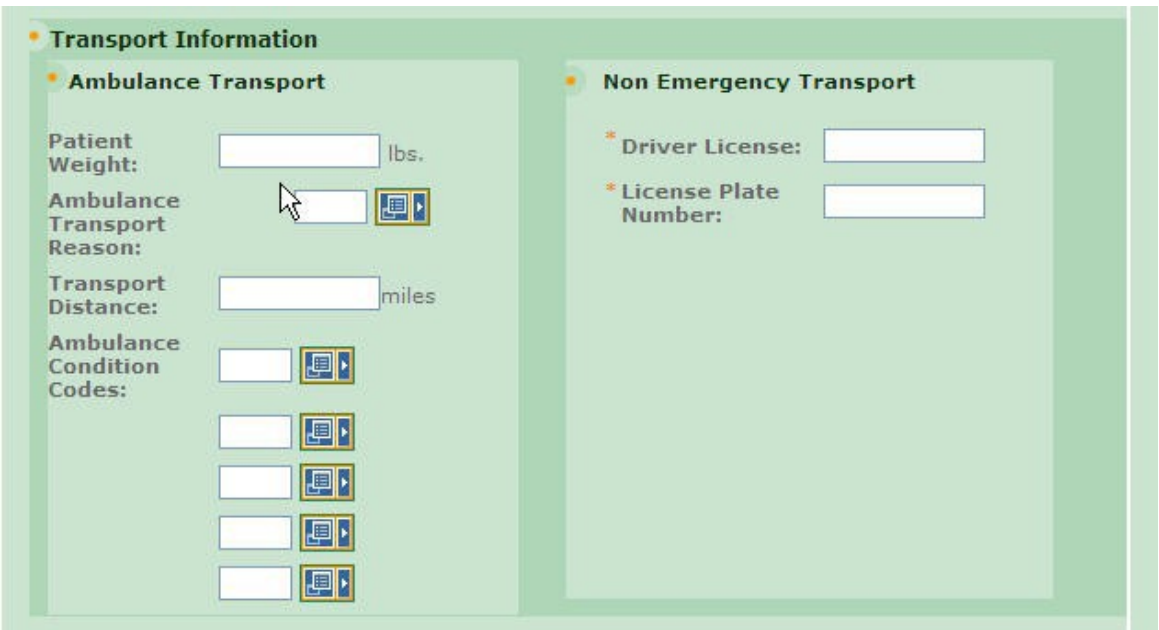
Initial Treatment Date: If applicable, enter date initial treatment started. **Last**

Seen Date: If applicable, enter date member was last seen.

Related Causes Information

Related Causes: You may select up to two related causes for this claim. If one or more of the options applies to the situation, mark the appropriate check box(es) and enter the Accident Date. If Auto Accident is selected as a Related Cause, enter the state and country in which the accident occurred, 'NY' and 'USA' are the corresponding default values.

Accident Date: If any of the Related Causes boxes are checked, the date of the accident must be entered. The date may not be greater than the current date. The format of the date is: MM/DD/YYYY and may either be entered in the field or selected from the calendar available by pressing the button to the right of the field.



Transport Information

Ambulance Transport

Patient Weight: The weight, in pounds, of the patient at the time of transport via ambulance.

Ambulance Transport Reason: Enter or select a Transport Reason Code from the provided list of valid values. If any information is entered in the "Ambulance Transport Information" section, this data element is required.

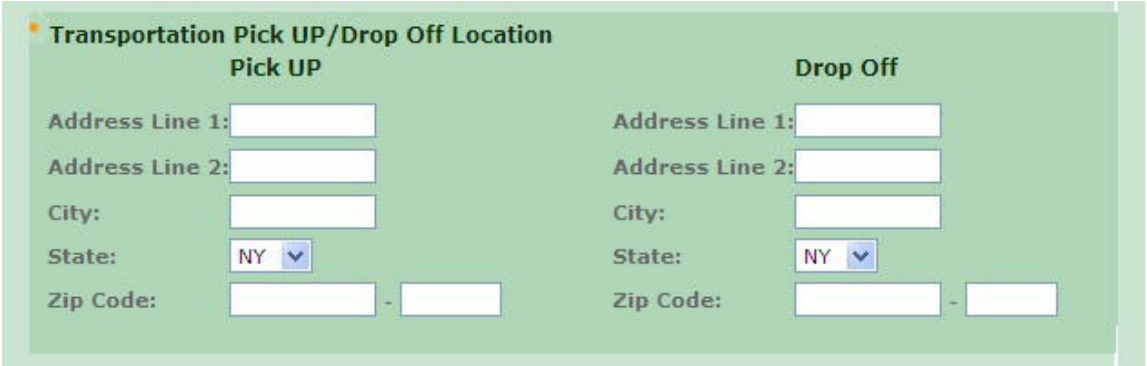
Transport Distance: Enter the distance, in miles, traveled during transport of the patient. If any information is entered in the "Ambulance Transport Information" section, this data element is required.

Ambulance Condition Codes: Up to 5 Condition Codes may be entered for an individual claim, however if any information is entered in the "Ambulance Transport Information" section at least 1 Condition Code must be entered. Select the desired code value from the provided list of valid values. You may either select from the available list or type the code directly into the field. Note: Condition Code values may not be entered more than once on an individual claim.

Non-Emergency Transport

Driver License: If billing for non-emergency transportation (Ambulette), enter the driver license of the driver.

License Plate Number: If billing for non-emergency transportation (Ambulette), enter the license plate number of the vehicle.



Transportation Pick UP/Drop Off Location

If billing for transportation, enter the drop off and pick up locations of the trip.

Pick UP

Address Line 1/Line 2: Enter the street address of where the member was picked up.

City: Enter the city where the member was picked up.

State: Enter the state where the member was picked up.

Zip Code: Enter the zip code where the member was picked up.

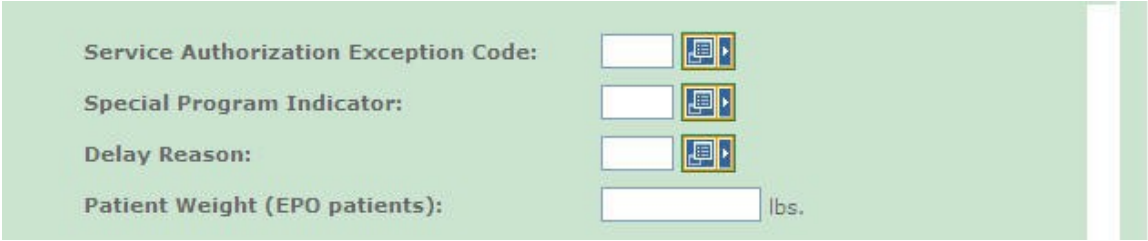
Drop Off

Address Line 1/Line 2: Enter the street address of where the member was dropped off.

City: Enter the city where the member was dropped off.

State: Enter the state where the member was dropped off.

Zip Code: Enter the zip code where the member was dropped off.



Other Information

Service Authorization Exception Code: Enter an exception code if service is exempt from utilization threshold.

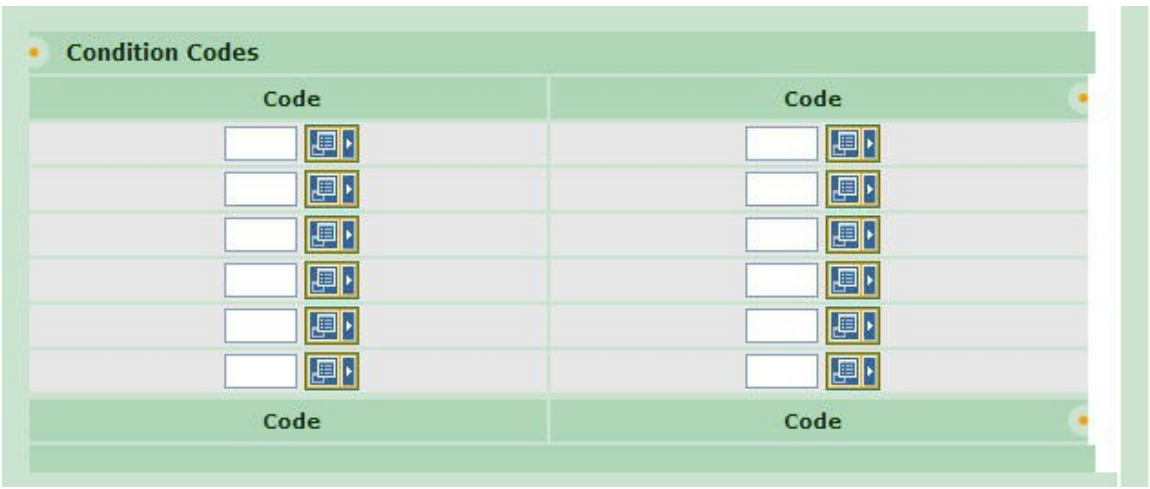
Special Program Indicator: If applicable, enter a special program indicator. Options are:

- 02 Physically Handicapped Children's Program
- 03 Special Federal Funding
- 05 Disability
- 09 Second Opinion or Surgery

Delay Reason: If claim is over the timely filing limits, enter the appropriate delay reason for the claim. Options are:

- 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 Administration Delay in the Prior Approval Process
- 11 Other
- 15 Natural Disaster

Patient Weight (EPO patients): If applicable, enter the weight of the patient.



Condition Codes

Code: If billing for a sterilization or abortion, select the appropriate condition code from the list.

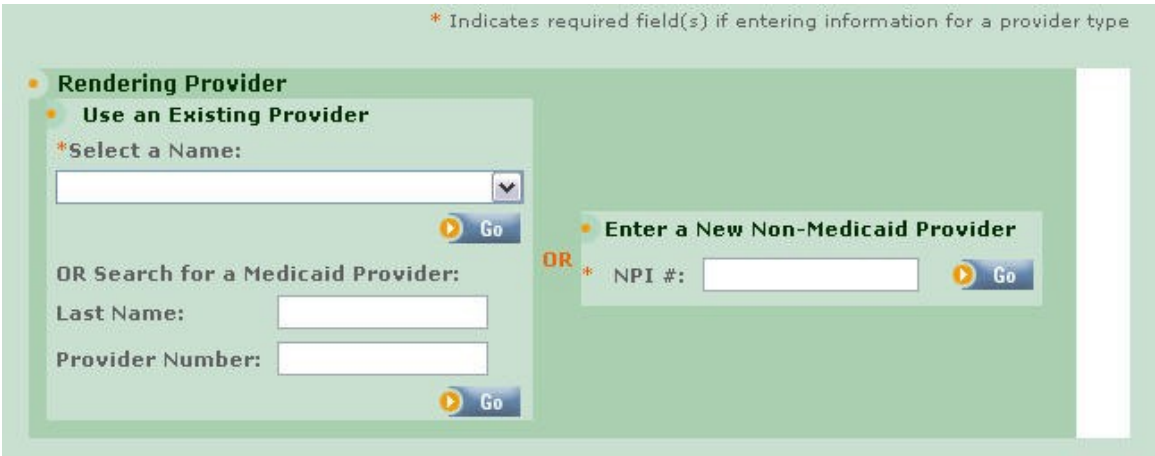
Group Provider

Group Provider Number: If payment is to go to the group, enter the group NPI in this field.

Provider Information

All information pertaining to the Rendering, Referring, Primary Care, or Supervising Provider is entered on this tab.

There are three ways in which to enter the name onto the claim, you may select an existing provider, search for a Medicaid provider, or enter a new non-Medicaid provider. See Appendix for details.



Rendering Provider: Select a Rendering Provider from the drop down. If the provider you want to select does not exist in the drop down, you can search for a Medicaid provider by entering the last name or Provider Number/NPI number. If the provider you want to enter is a non-Medicaid provider, then the user can enter a new Provider on the right side by entering the provider's NPI.

Rendering Provider

Use an Existing Provider

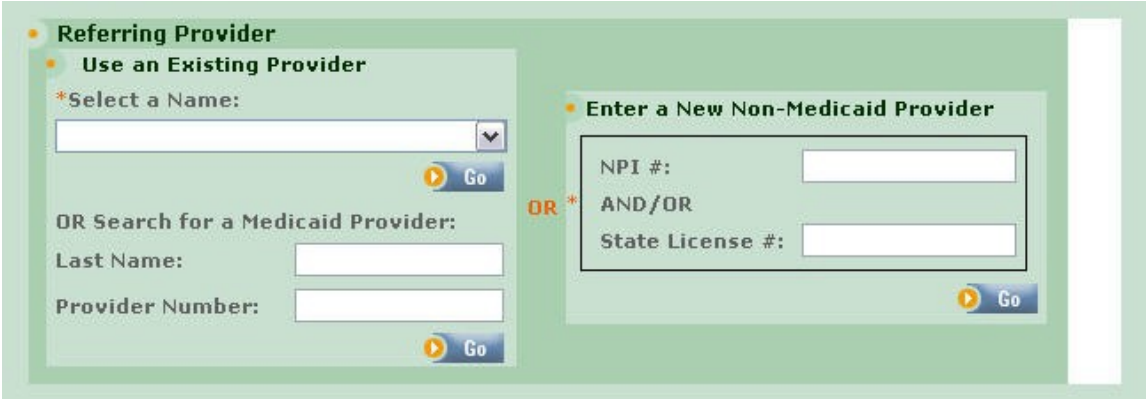
Select a Name: If using an existing provider, you can select the name of the provider in the list.

Last Name: You can also enter the last name of the provider and click "Go".

Provider Number: You can also enter the provider's MMIS ID and click "Go".

Enter a New Non-Medicaid Provider

NPI: If you are entering a new non-Medicaid provider, you can enter the NPI of the provider here.



Referring Provider: If the service you are billing for was referred by another provider, enter that provider here. There are three ways in which to enter the name onto the claim, you may select an existing provider, search for a Medicaid provider, or enter a new non-Medicaid provider. See Appendix for details.

Referring Provider

Use an Existing Provider

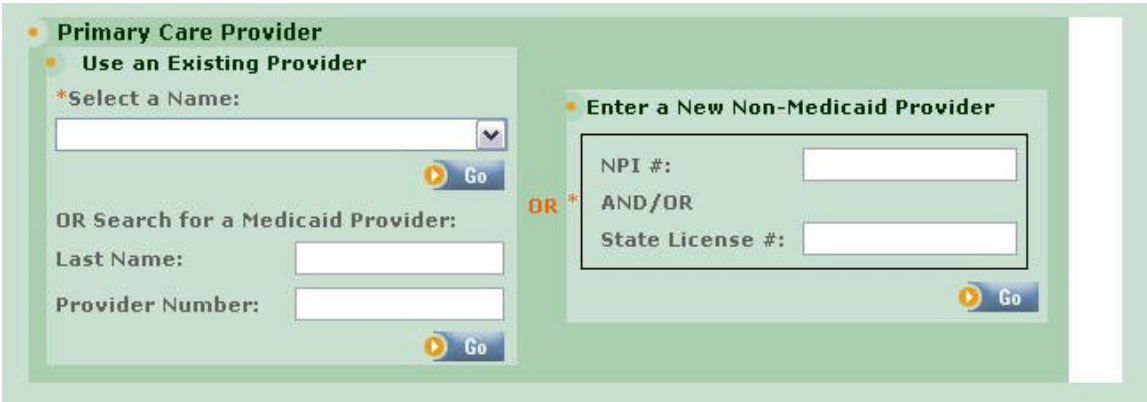
Select a Name: If using an existing provider, you can select the name of the provider in the list.

Last Name: You can also enter the last name of the provider and click "Go".

Provider Number: You can also enter the provider's MMIS ID and click "Go".

Enter a New Non-Medicaid Provider

If you are entering a new non-Medicaid provider, you can enter the **NPI #** and/or the **State License #** here.



Primary Care Provider: May be used if more than one referral exists and there is a requirement to report the additional referral. The Primary Care Provider indicates the source of the initial referral for this client's episode of care being billed/reported on this claim. NOTE: A Referring Provider must be selected if the Primary Care Provider is selected.

Primary Care Provider

Use an Existing Provider

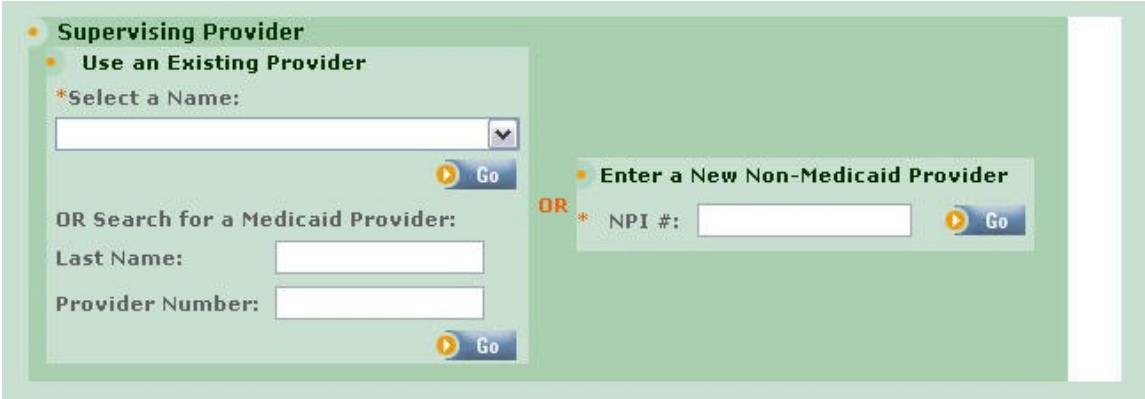
Select a Name: If using an existing provider, you can select the name of the provider in the list.

Last Name: You can also enter the last name of the provider and click "Go".

Provider Number: You can also enter the provider's MMIS ID and click "Go".

Enter a New Non-Medicaid Provider

If you are entering a new non-Medicaid provider, you can enter the **NPI #** and/or the **State License #** here.



Supervising Provider: Select a Supervising Provider from the drop down. If the provider you want to select does not exist in the drop down, you can search for a Medicaid provider by entering the last name or Provider Number/NPI number. If the provider you want to enter is a non-Medicaid provider, then the user can enter a new Provider on the right side by entering the provider's NPI.

Supervising Provider

Use an Existing Provider

Select a Name: If using an existing provider, you can select the name of the provider in the list.

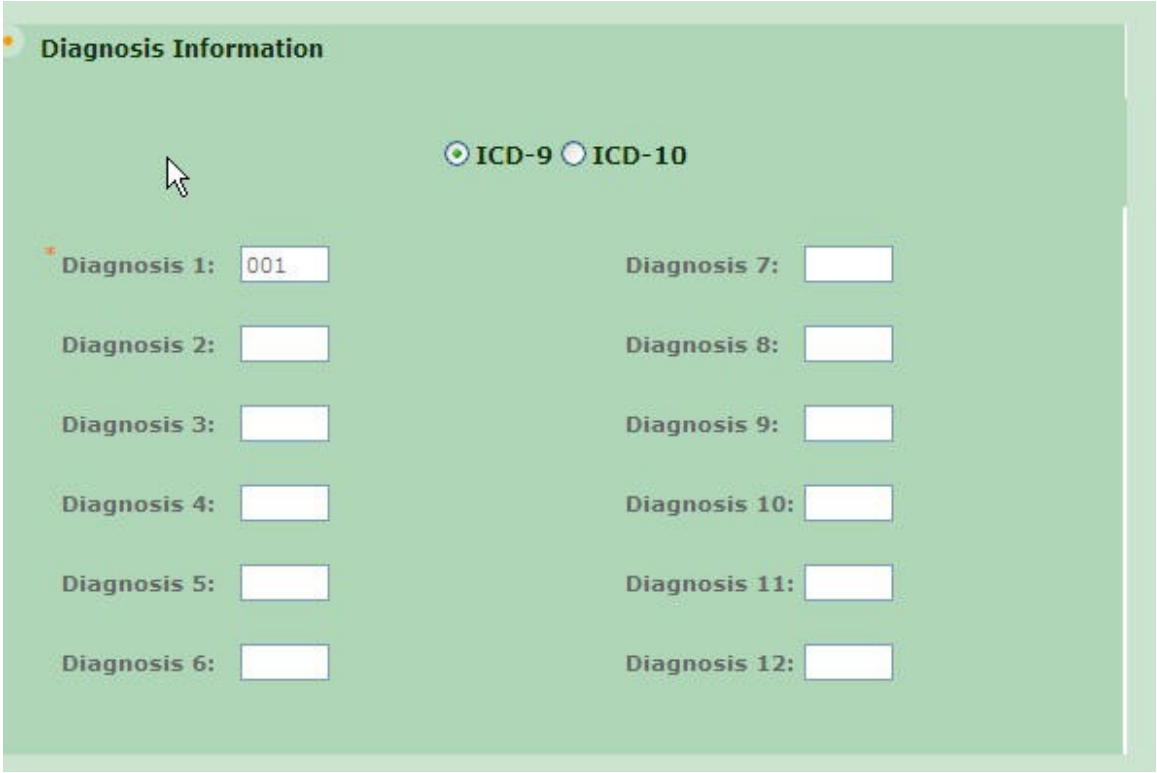
Last Name: You can also enter the last name of the provider and click "Go".

Provider Number: You can also enter the provider's MMIS ID and click "Go".

Enter a New Non-Medicaid Provider

NPI: If you are entering a new non-Medicaid provider, you can enter the NPI of the provider here.

Diagnosis



Diagnosis Information

Enter at least one diagnosis code. Up to 12 Diagnosis codes may be entered on a single claim and may not be duplicated.

All other codes entered will be treated as Other Diagnosis codes. All codes entered should be valid ICD-9-CM or ICD-10-CM codes.

ICD-9 / ICD-10: Select the appropriate code type for the diagnosis.

Diagnosis 1 - 12: Enter up to 12 applicable diagnosis codes in these fields.

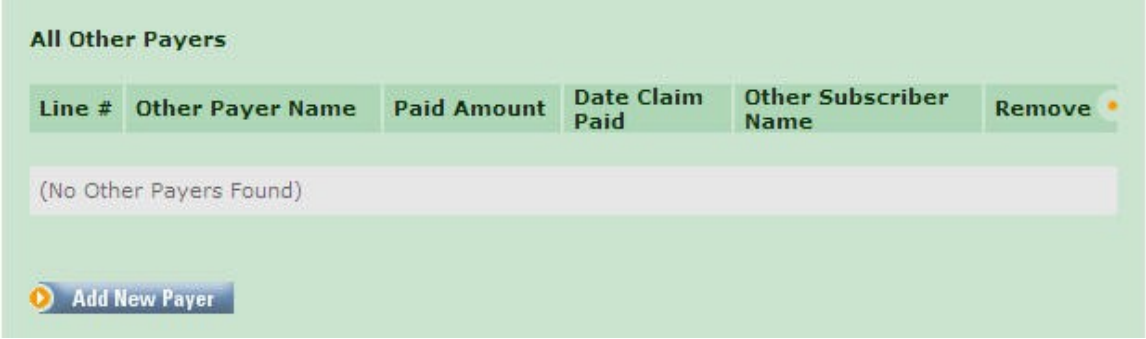
Anesthesia Related Procedure

Anesthesia Related Procedure Code 1: If billing for anesthesia services, enter the procedure code for the surgery in this field.

Anesthesia Related Procedure Code 2: If applicable, enter the second procedure code for the surgery in this field if billing for anesthesia services.

Other Payers

The Other Payers tab is not required to enter a claim. You only need to access this tab if there are payers in addition to NY Medicaid to be applied to the claim being entered. However, if you do access the tab and start the process of entering an Other Payer, you must complete all the required information or delete all data entered before continuing to another tab.



Upon initially opening this tab, you will see the Summary level of all Other Payers entered for this claim. If no Payers exist, the table will be empty and you may Add Another Payer at this time. If Other Payers have already been entered for this claim, you may view the details associated with each payer from this table or add Other Payers.

All Other Payers

Line #: This is a line number identifying the order in which the Other Payers were entered on the claim. Clicking this hyperlinked value will open the Details Page for that Payer. Removing a Payer will change the Line # of payers entered after that payer. For example, if you delete Line # 2, then Line # 3 and Line # 4 become 2 and 3 respectively. Payers may be entered in any sequence, and are displayed here in that sequence. The Line # is not related to the order of responsibility for paying this claim, that is handled by the Payer Sequence Number.

Other Payer Name: The Payer name as selected when entering the Other Payer onto the claim.

Paid Amount: The dollar amount paid by the Payer towards this claim.

Date Claim Paid: The date on which a payment was received from this Payer for this claim.

Other Subscriber Name: The full name (Last Name, First Name, Middle Initial) of the Subscriber associated with this Payer.

Remove: Click this button to delete the other payer information.

Enter Other Payer

In addition to NY Medicaid, you may enter additional payers who are responsible for this claim. Remember that all elements marked with an asterisk (*) are required when entering a Payer. Not all claims will have Other Payer information. Note: A maximum of 10 Other Payer records may be entered per claim.

Other Payer Information

Other Payer Name: Select the name of the desired payer from the provided list. If the Other Payer you are looking for is not listed, contact your Administrator to add the Payer to the Support File of valid Payers. Required for all Other Payers.

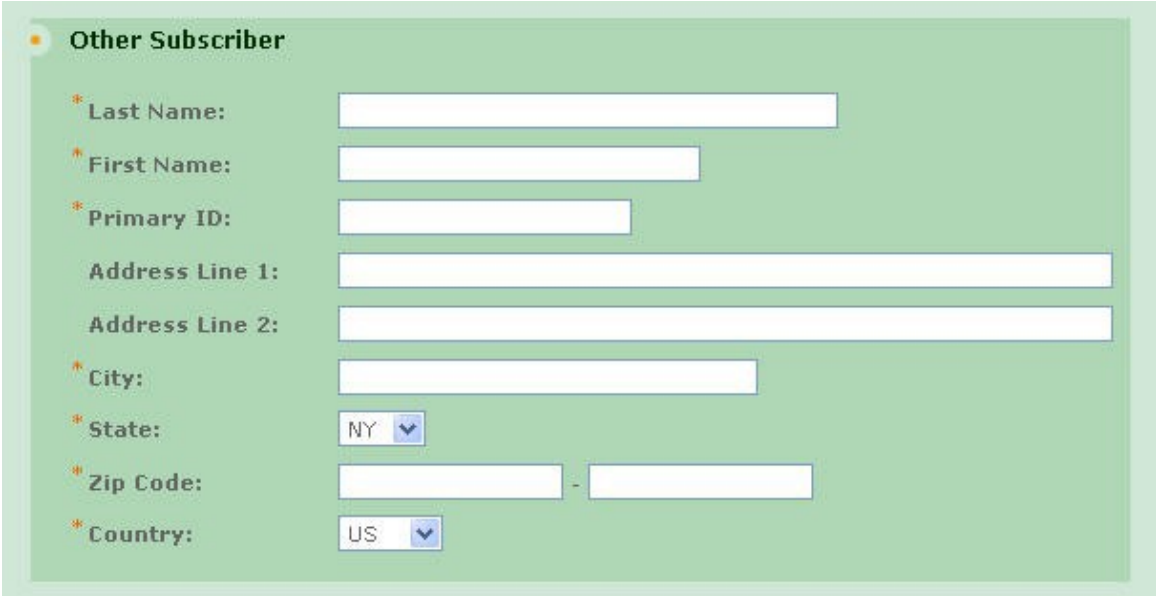
Payer Sequence Number: Select the value that represents the order in which payment was received from other payers. Payers may be entered in any sequence and displayed in any sequence. Required for all Other Payers.

Payer Type: A code identifying the type of Payer. Enter or select a value from the list of available codes.

Other Payer Paid Amount: This field is required when this payer has adjudicated the claim. If the Other Payer denied the claim, enter 0. If the Other Payer has not adjudicated the claim, leave blank. If a value is entered, the Date Claim Paid must be entered as well.

Other Payer Claim Control Number: Enter the claim control number of the other payer.

Date Claim Paid: Date on which the Other Payer Paid Amount was received. This date may not be greater than the current date. The format is: MM/DD/YYYY and may either be entered in the field or selected from the calendar available by pressing the button to the right of the field.



Other Subscriber

Last Name/First Name: If entering an Other Payer, you must enter the First and Last Name of the Subscriber for the Payer. The Subscriber may or may not be the Client.

Primary ID: The Other Insured Identifier as assigned by the Payer. This is required when entering the Subscriber for the Other Payer.

Address Line 1/2: The street address of the Subscriber, if known.

City: Enter city name of the Subscriber.

State: State in which the Subscriber lives. Select value from the list of available valid state abbreviations, defaults to 'NY'.

Zip Code: Enter the postal Code associated with the Subscriber's address.

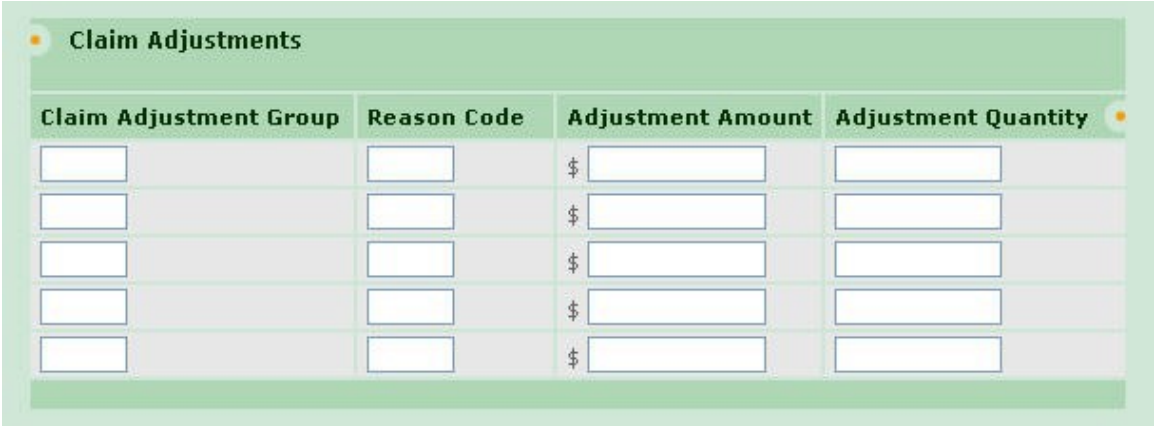
Country: Country in which the Subscriber lives. Select value from the list of available countries, defaults to 'US'.

Other Subscriber Information

Relationship: Code indicating the relationship between the Client/Patient and the Subscriber for this Payer. Enter or select a value from the list of available codes. A relationship is required if a Subscriber is entered.

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

Group Name: The Group Name associated with the Group Number above.



Claim Adjustments

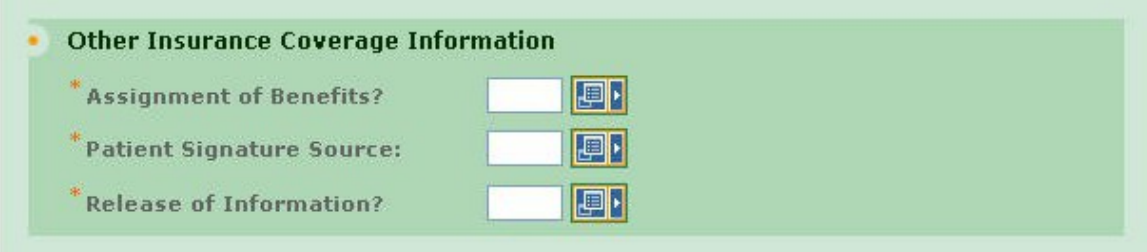
If the other payer reported claim adjustments at the claim level, enter the adjustment information here. Otherwise, this information will be blank. Claim adjustment group codes and reason codes are from the remittance of the other payer.

Claim Adjustment Group: Enter the Group Code as received from the other payer. A maximum of 5 Claim Adjustment Groups are allowed per claim and the values are to be entered.

Reason Code: Enter the Claim Adjustment Reason Code as received from the other payer. The Claim Adjustment Group/Reason Code combination may not be entered more than once. If an Adjustment Amount or Adjustment Quantity is entered, a Reason Code is required.

Adjustment Amount: Enter the Adjustment Amount as received from the other payer.

Adjustment Quantity: Enter the Quantity Adjusted as received from the other payer.



Other Insurance Coverage Information

Assignment of Benefits?: The Benefits Assignment Certification Indicator. 'Yes' indicates insured or authorized person authorizes benefits to be assigned to the provider while 'No' indicates that no authorization has been given. This value will default to 'Yes' and is required if an Other Payer Name is selected.

Patient Signature Source: Enter or select the Patient Signature Source Code, indicating how the patient or subscriber authorization signatures were obtained and how they are being retained by the provider. An entry is required if an Other Payer Name is selected.

Release of Information?: Indicates whether the provider has a signed statement by the patient authorizing the release of medical data to other organizations. This value is required if an Other Payer Name is selected.

Amounts

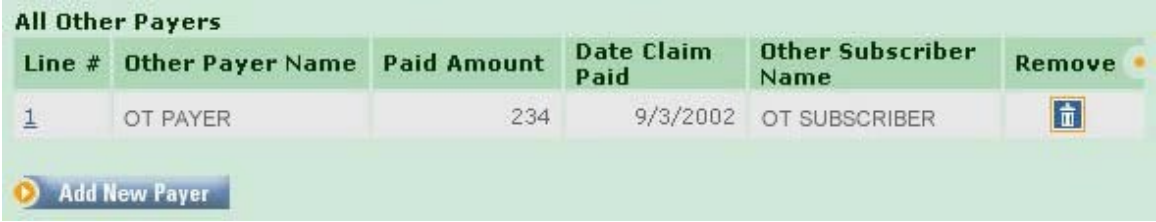
Remaining Patient Liability: This is the amount the provider believes is due and owing after the Other Payer's adjudication.

Non-Covered Charge Amount: Enter the dollar value of the claim in this field if the other payer was not billed, and documentation is on file that the other payer would not have paid the claim.

Once all the information for the Payer has been added, another payer may be added by clicking the Next Payer>> control at the top or bottom of the tab. This will return you to the top of the page with all the values cleared out and a new Payer Number listed at the top of the page. Clicking View All Other Payers will display the Other Payers Summary page.

View Other Payers

Viewing All Other Payers is a quick and easy way to see what payers, in addition to NY Medicaid, have a responsibility for this claim. The easy to read table displays a snapshot of information about each Payer.



All Other Payers

Line #	Other Payer Name	Paid Amount	Date Claim Paid	Other Subscriber Name	Remove
1	OT PAYER	234	9/3/2002	OT SUBSCRIBER	

Add New Payer

Line #: This is a line number identifying the order in which the Other Payers were entered on the claim. Clicking this hyperlinked value will open the Details Page for that Payer. Removing a Payer will change the Line # of payers entered after that payer. For example, if you delete Line # 2, then Line # 3 and Line # 4 become 2 and 3 respectively. Payers may be entered in any sequence, and are displayed here in that sequence. The Line # is not related to the order of responsibility for paying this claim, that is handled by the Payer Sequence Number.

Other Payer Name: The Payer name as selected when entering the Other Payer onto the claim.

Paid Amount: The dollar amount paid by the Payer towards this claim.

Date Claim Paid: The date on which a payment was received from this Payer for this claim.

Other Subscriber Name: The full name (Last Name, First Name Middle Initial) of the Subscriber associated with this Payer.

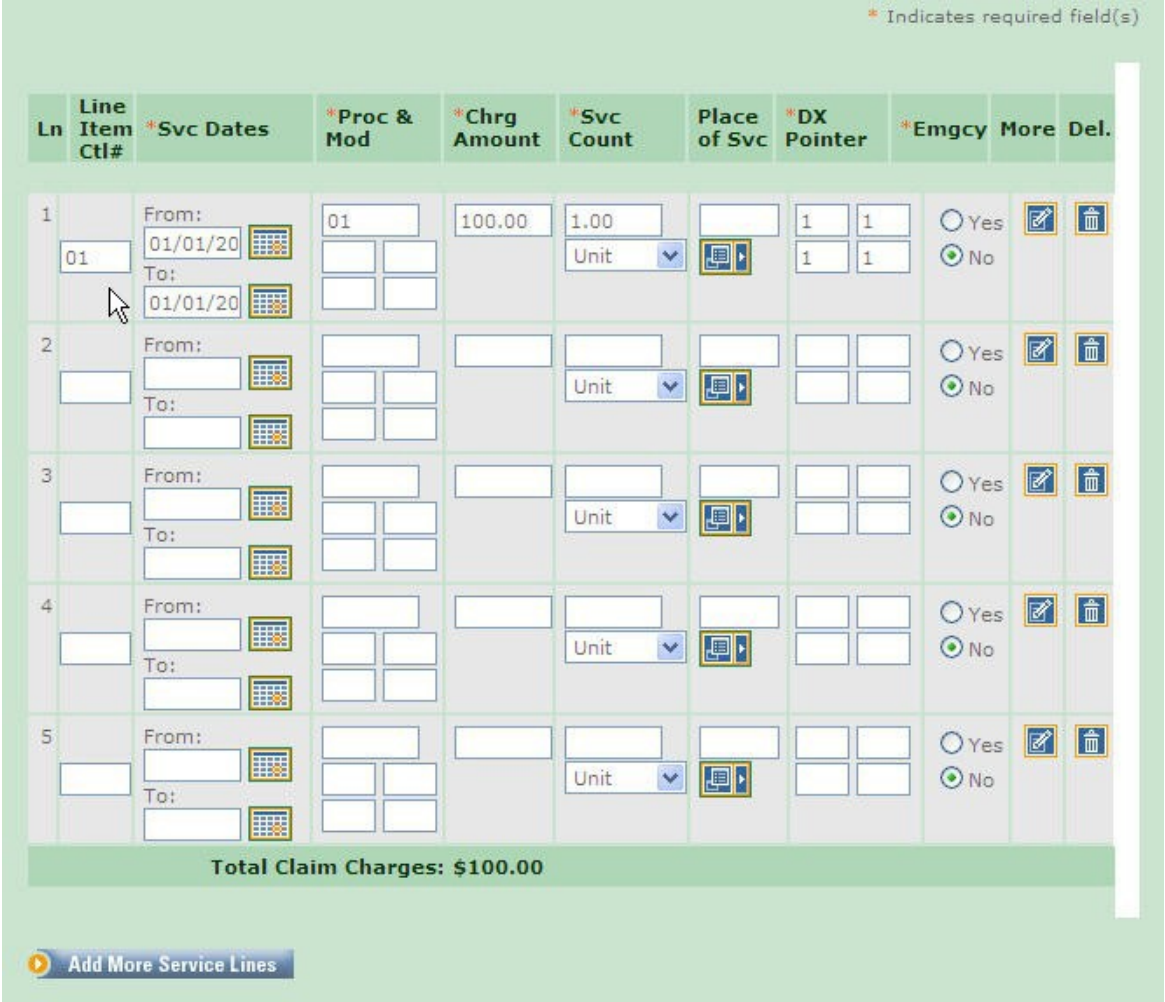
Remove: Click this button to delete the other payer information.

If a specific Third Party or Managed Care Plan is required but not listed, you may Add Another Payer. If a Payer was erroneously added to this claim and must be removed, click the Remove icon and confirm the deletion.

Service Line(s)

A Service Line is listed on a claim for each procedure or item that is to be reported to the Payer(s) for claim adjudication. Each claim must contain at least one Service Line.

The main view of the Service Line(s) tab contains the basic information for the line as it relates to NY Medicaid. Additional information and adjudication details from Other Payers are available on subsequent pages. As a default, 5 Service Lines are displayed on the main page, however you may add as many as needed, up to a maximum of 50, simply by clicking Add More Service Lines. You may remove any single Service Line by clicking the Remove icon on that line. In addition, the total of all the submitted charges for the Service Lines is listed below all the Service Lines that have been entered.



Ln (Line): This is a system generated value to uniquely identify the Service Line on the claim. The counter will start with 1 and increment with each new Service Line entered. A minimum of 1 Service Line is required on all claims.

Line Item Ctl#: This field can be used to enter a line number that corresponds with your records if it is different than the line number given. This field is not required.

Svc Dates: For a procedure/service rendered on a single date, enter this date in the From Date. However, if the procedure/service transpired over a period of time, enter the start and end dates in the From and To fields respectively. The date(s) may not be greater than the current date. The format is: MM/DD/YYYY and may either be entered in the field or selected from the calendar available by pressing the button to the right of the field. At a minimum, a From Date is required for all Service Lines.

Proc & Mod (Procedure Codes & Modifiers): The Health Care Financing Administration Common Procedural Coding System identifier for the product/service. This code value is required for all claims. Optionally, up to 4 modifiers identifying special circumstances related to the performance of the service may be entered for each code. Note: If entered, the Modifier must be a 2 character code.

Chrg Amount: The submitted charge amount for this procedure/service must be entered. Note: Zero (0) is a valid charge amount.

Svc Count: The number of units or minutes in which the procedure/service is to be billed. A drop down is available to indicate the unit of measure for the Service Unit. A default value of 'Unit' will be selected but may be changed.

Place of Svc: Enter or select the code for the facility/location where services on the current line were performed, if the facility/location differs from the Place of Service listed on the Professional Claim Information tab.

DX (Diagnosis) Pointers: If Diagnosis Codes were entered on the Diagnosis tab, you may list the top four (4) diagnosis code labels in order of priority here. Diagnosis Codes are referenced by their label number and therefore acceptable values are 1 through 12 inclusive.

Emgcy: You must select 'Yes' or 'No' to indicate whether or not the services provided were emergency related.

More: Click the more button to enter additional details about the service line.

Del.: If you want to delete a service line that has been entered, click here.

Total Claim Charges: At the bottom of the table of Service Lines, all charges for all Service Lines on the claim will be summed and displayed, once the Service Line Information is saved.

For each Service Line, you may view/enter additional details by clicking the More icon. However you may only view these additional details once all required elements have been entered. Navigating off this summary page, either by clicking the More icon or moving to another tab, will trigger validation of the data entered on this page. Validation is done one line at a time, so if there are errors on multiple lines you will have to fix each line before seeing the next set of errors. If a Service Line must be removed for any reason, clicking the Delete icon will remove the line and re-sequence the remaining Service Lines.

Service Line Details

Each service line on a Professional Claim will have information available in addition to what is displayed in summary on the main page. This information is accessed by clicking the More icon on the main Service Line(s) page.

Dates

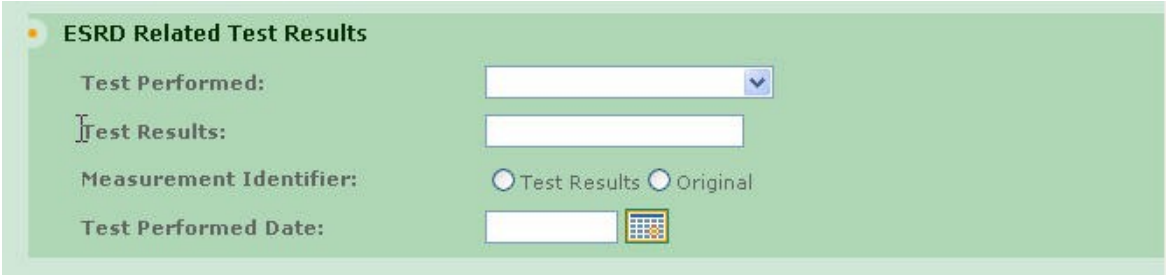
The format for all date values is: MM/DD/YYYY and may either be entered in the field or selected from the calendar available by pressing the button to the right of the field. The dates may not be greater than the current date unless otherwise specified.

Last X-Ray Date: If the claim involves spinal manipulation and an X-Ray was taken, enter the date of the X-Ray here. Not necessary if same as date entered at claim level.

Product Shipped Date: If the Service Line involves the billing/reporting of shipped goods, enter the date on which the goods were shipped.

Initial Treatment Date: If patient has previously experienced similar symptoms/illness, enter the initial treatment date here, only if it differs from the value entered at the claim level.

Prescription Date: When billing for a drug and a prescription was written, enter the date the prescription was written.



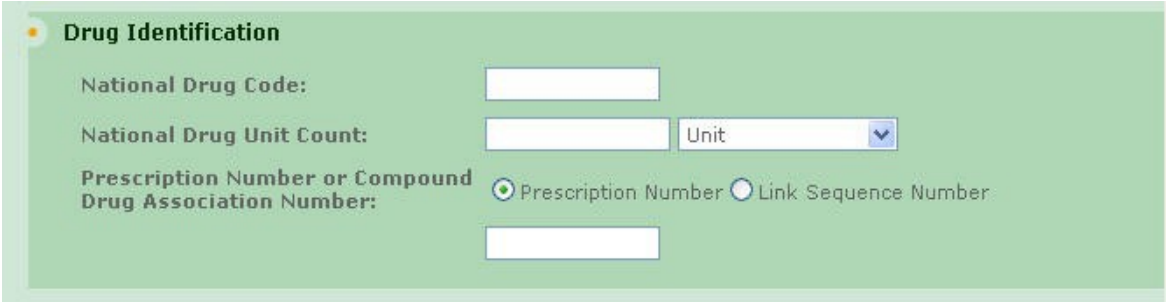
ESRD Related Test Results

Test Performed: Using the drop down, indicate what type of test was performed.

Test Results: Enter the numeric results of the specified test. If Test Results are entered, an Identifier and Qualifier must also be selected.

Measurement Identifier: Select the manner in which the results are measured. If an Identifier is selected, a Qualifier and Test Results must also be specified.

Test Performed Date: Enter the date on which the test selected above was performed. The format is: MM/DD/YYYY and may either be entered in the field or selected from the calendar available by pressing the button to the right of the field. The date may not be greater than the current date.



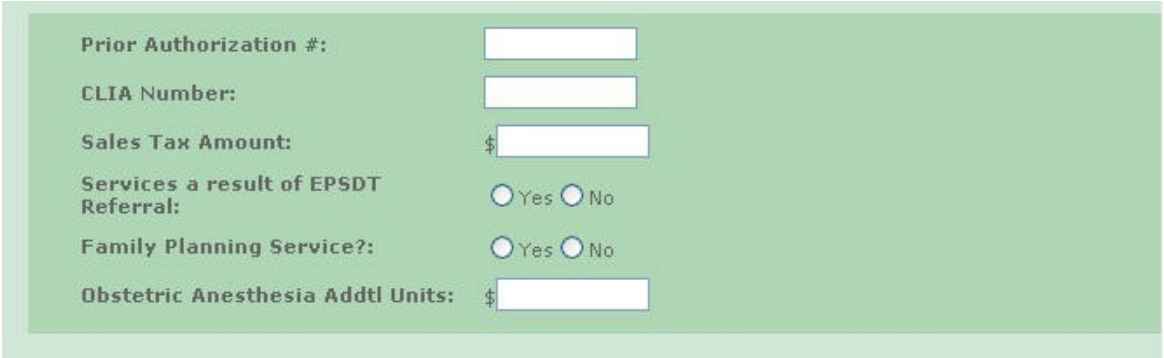
Drug Identification

If any information is entered into this section, all pieces of data must be populated.

National Drug Code: Enter the NDC for the drug associated with this Service Line. An 11 digit value must be entered without the hyphens.

National Drug Unit Count: Enter the number of units prescribed of this medication. Also, select the proper Unit of Measure to be associated with this value. Defaults to 'Unit' but any valid value may be selected.

Prescription Number or Compound Drug Association Number: Pick whether you are entering a Prescription Number or Link Sequence Number. Then enter the Prescription Number or Link Sequence Number associated with the drug in the field below.



Prior Authorization #: If Prior Authorization has been received for the procedures associated with this Service Line and the number is different from that entered on the Professional Claim Information tab, enter the number in the field. Prior Authorization numbers are assigned by the payer to authorize a service prior to its being performed. This number is specific to NY Medicaid.

CLIA Number: The Clinical Laboratory Improvement Amendment Number is required on all service lines containing laboratory tests covered by the CLIA Act, assuming the value differs from that entered at the claim level.

Sales Tax Amount: If sales tax applies to the services rendered on this line, enter the dollar value of the sales tax amount here.

Services a result of EPSDT Referral: Select 'Yes' or 'No' to indicate whether or not the procedures were related to the Early and Periodic Screen for Diagnosis and Treatment of Children.

Family Planning Service? Select 'Yes' or 'No' to indicate the involvement of Family Planning services.

Obstetric Anesthesia Addtl Units: If there are additional units for anesthesia, enter them in this field.

Purchased Service Provider

If applicable, enter the purchased service provider here. For each type of provider, there are three ways in which to enter the name onto the claim, you may select an existing provider, search for a Medicaid provider, or enter a new non-Medicaid provider. See Appendix for details.

Use an Existing Provider

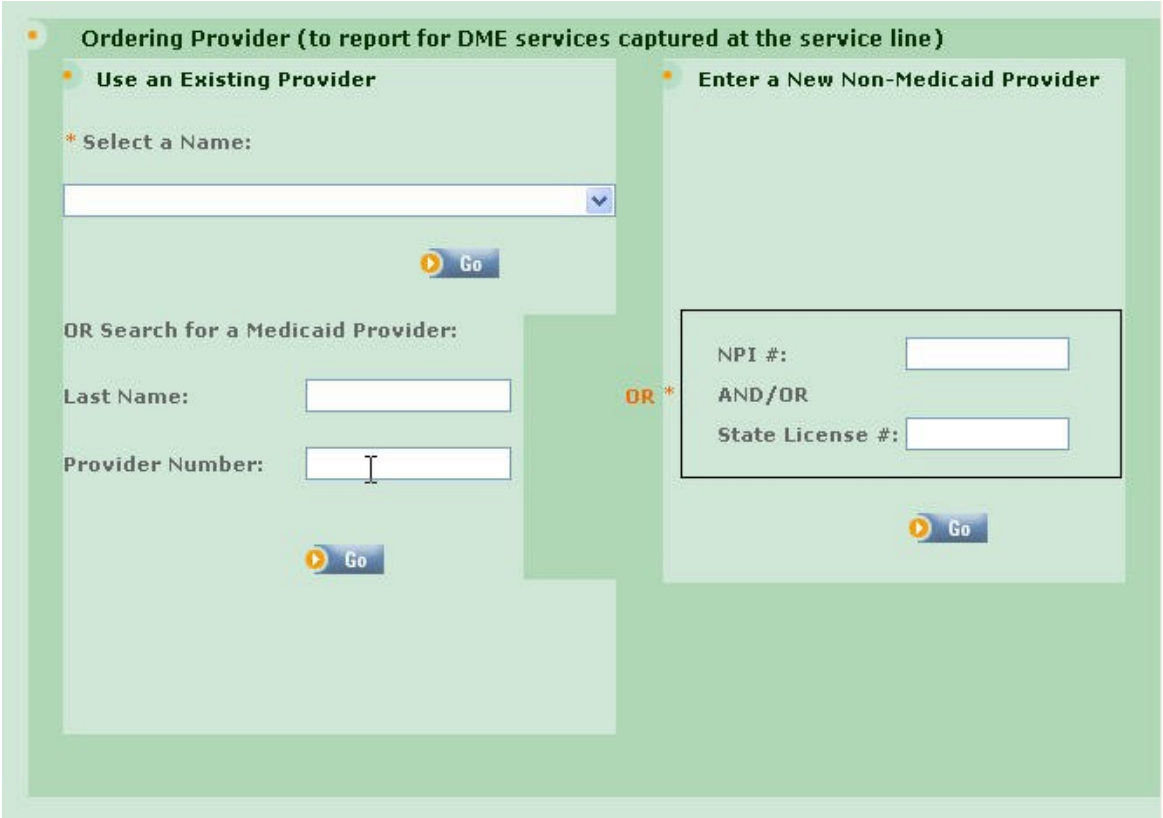
Select a Name: If using an existing provider, you can select the name of the provider in the list.

Last Name: You can also enter the last name of the provider and click "Go".

Provider Number: You can also enter the provider's MMIS ID and click "Go".

Enter a New Non-Medicaid Provider

If you are entering a new non-Medicaid provider, you can enter the **NPI #** and/or the **State License #** here.



Ordering Provider

If applicable, enter the ordering provider here. For each type of provider, there are three ways in which to enter the name onto the claim, you may select an existing provider, search for a Medicaid provider, or enter a new non-Medicaid provider. See Appendix for details. DME services require an ordering provider.

Use an Existing Provider

Select a Name: If using an existing provider, you can select the name of the provider in the list.

Last Name: You can also enter the last name of the provider and click "Go".

Provider Number: You can also enter the provider's MMIS ID and click "Go".

Enter a New Non-Medicaid Provider

If you are entering a new non-Medicaid provider, you can enter the **NPI #** and/or the **State License #** here.

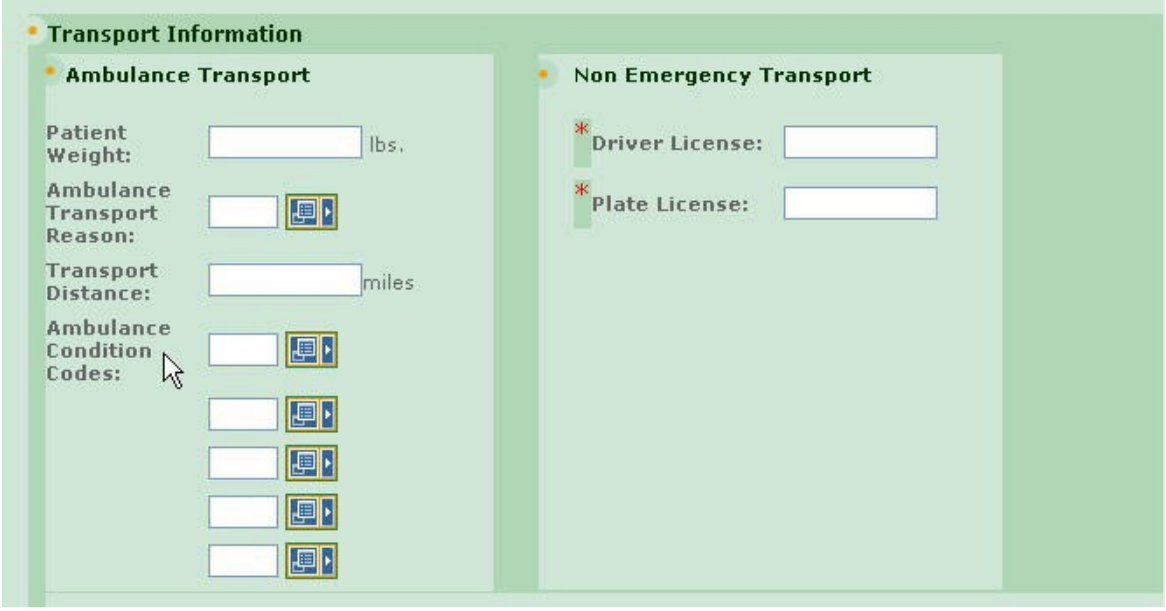
Durable Medical Equipment Rental Services

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

If Ambulance Transport Information was entered at the claim level, it does not need to be re-entered here, unless details are different, in which case all data elements are required.

<u>Ambulance Transport</u>

Patient Weight: The weight, in pounds, of the patient at the time of transport via ambulance.

Ambulance Transport Reason: Enter or select a Transport Reason Code from the provided list of valid values. If any information is entered in the Ambulance Transport Information box, this data element is required.

Transport Distance: Enter the distance, in miles, traveled during transport of the patient. If any information is entered in the Ambulance Transport Information box, this data element is required.

Ambulance Condition Codes: Up to 5 Condition Codes may be selected for an individual claim, however if any information is entered in the Ambulance Transport Information box at least 1 Condition Code must be entered. Select the desired code value from the provided list of valid values. You may either select from the available list or type the code directly into the field. Note: Condition Code values may not be entered more than once on an individual claim.

Non-Emergency Transport

Driver License: If billing for non-emergency transportation (Ambulette), enter the driver license of the driver.

Plate License: If billing for non-emergency transportation (Ambulette), enter the license plate number of the vehicle.

Transportation Pick UP/Drop Off Location

Enter the pickup and dropoff location for the transport.

Pick UP

Address Line 1/Line 2: Enter the street address of where the member was picked up.

City: Enter the city where the member was picked up.

State: Enter the state where the member was picked up.

Zip Code: Enter the zip code where the member was picked up.

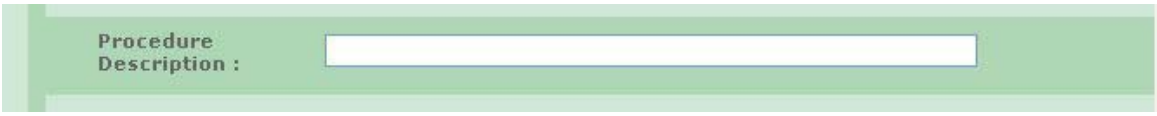
Drop Off

Address Line 1/Line 2: Enter the street address of where the member was dropped off.

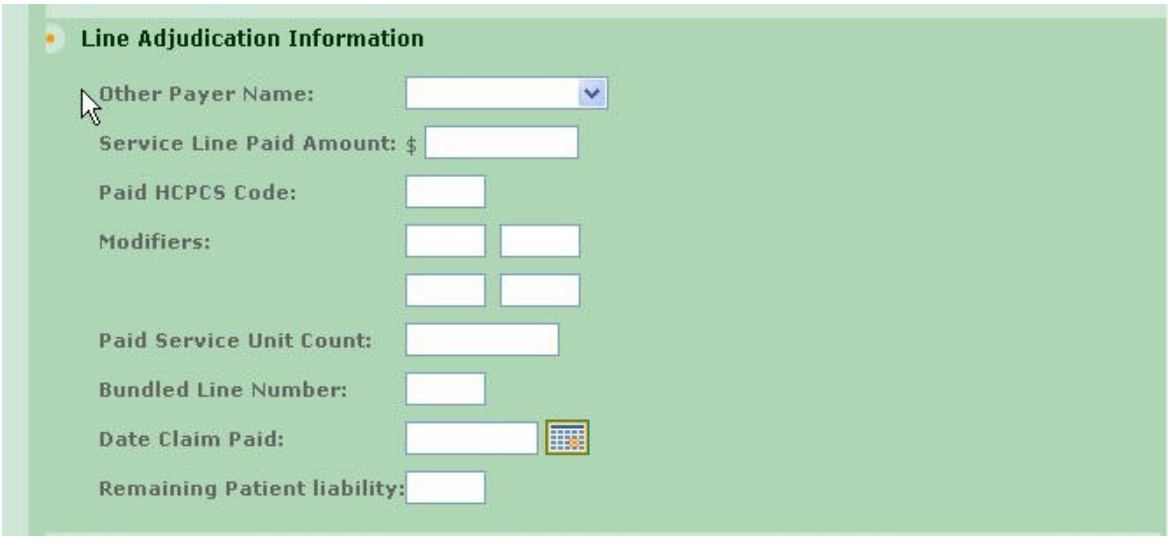
City: Enter the city where the member was dropped off.

State: Enter the state where the member was dropped off.

Zip Code: Enter the zip code where the member was dropped off.



Procedure Description: Enter additional comments on the procedure being billed.



Line Adjudication Information

Other Payer Name: The Payer Name selected must match one of those entered on the Other Payer tab. All subsequent data entered applies to the Adjudication for this Service Line and Payer combination.

Service Line Paid Amount: The dollar amount paid towards this Service Line by this Payer.

Paid HCPCS Code: This is the procedure code processed/priced by the payer.

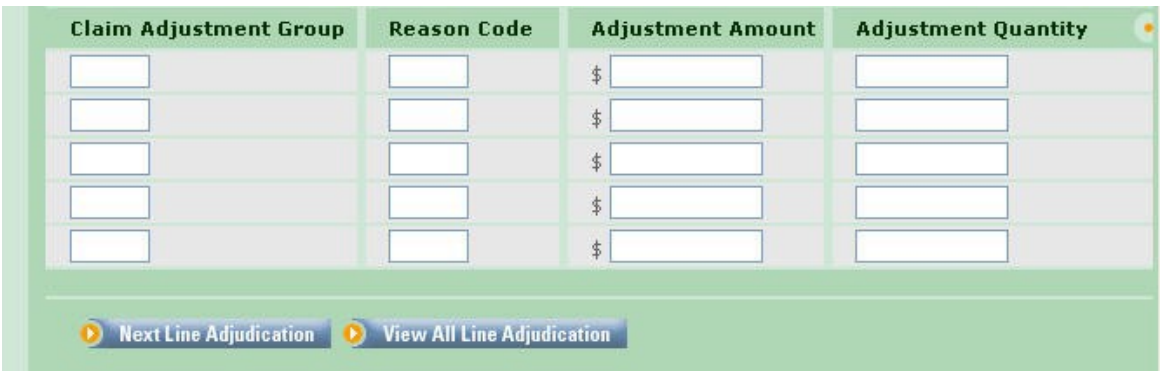
Modifiers: Optionally, up to 4 modifiers identifying special circumstances related to the performance of the service may be entered for each code. Note: If entered, the Modifier must be a 2 character code.

Paid Service Unit Count: The units of service paid by the Other Payer.

Bundled Line Number: If applicable, enter the number of the line bundled or unbundled by the other payer.

Date Claim Paid: Service adjudication or payment date must be entered. The date may not be greater than the current date. The format is: MM/DD/YYYY and may either be entered in the field or selected from the calendar available by pressing the button to the right of the field.

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



Claim Adjustment

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. The Claim Adjustment Group/Reason Code combination may not be entered more than once. If an Adjustment Amount or Adjustment Quantity is entered, a Reason Code is required.

Adjustment Amount: Enter the Adjustment Amount as received from the other payer. An Adjustment Amount is required when a Reason Code is entered.

Adjustment Quantity: Enter the Quantity Adjusted as received from the other payer.

If Other Payers have been included on the claim and they have adjudicated this line or you need to maintain the adjudication details, you may view/maintain the individual Line Adjudication Information or view a summary of all adjudication information for this line.

Service Line Adjudication Summary

If there are multiple Other Payers defined for a claim, each Service Line may have multiple Line Adjudication records. Viewing the Line Adjudication Summary for a particular Service Line will provide quick visibility to the payments which have been made against the particular Service Line.

Line #	Other Payer Name	Service Line Paid Amount	HCPCS Code	Date Claim Paid	Remove
1	MCMS OF ST	356.75	V5300	10/1/2003	
2	SELF	15.00	V5200	9/30/2003	

From this section, you may Add Another Line Adjudication, review the individual Line Adjudications, or Remove a Line Adjudication. The table displayed contains the following summary information:

Line #: An incremental counter to track the adjudication records for each line.

Other Payer Name: The Third-Party or Managed Care payer responsible for payment on this claim. All subsequent data entered applies to the Adjudication for this Service Line and Payer combination. Any Payer entered here must also be entered on the Other Payer tab for the claim.

Service Line Paid Amount: The dollar amount paid towards this Service Line by the Payer. The total of all the Service Line Paid Amounts on this claim must add up to the total Other Payer Paid Amount on the Other Payer tab.

HCPCS Code: The main HCPCS code entered for the Service Line. Multiple codes and modifiers may be associated with the line and are accessible by viewing the details for the line.

Date Claim Paid: Service adjudication or payment date. The format of the date is: MM/DD/YYYY.

Remove a Line Adjudication

Clicking the Remove icon for a particular Line Adjudication record will prompt you to confirm the deletion. Removing a record will permanently delete the data from the claim and adjust Line Paid amounts accordingly.

Claim Confirmation

Upon completion of a claim, which is indicated by clicking Finish, the claim will be placed into one of two states. If there are no validation errors and the claim is ready to be submitted for adjudication, then it will be set to Complete.

Claim Entered

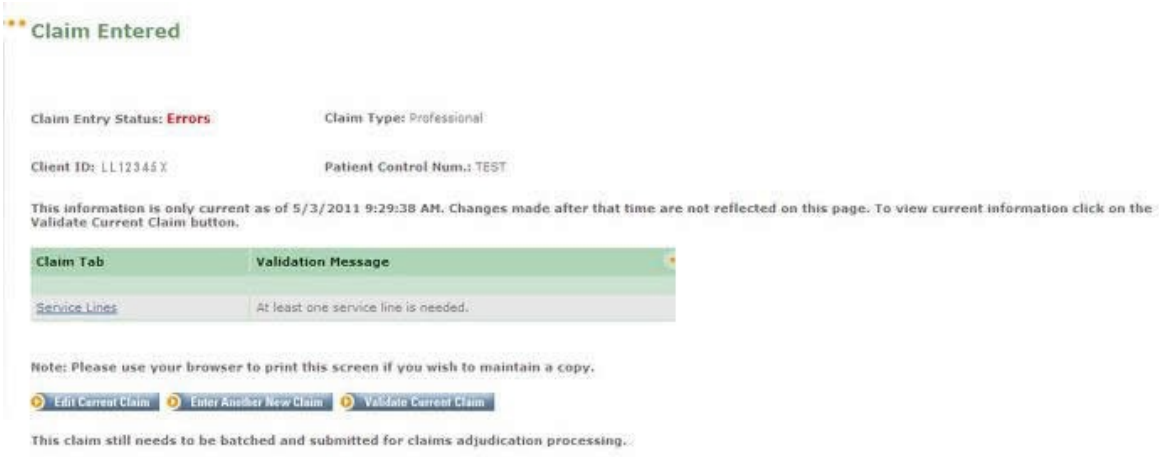
Claim Entry Status: Complete **Claim Type:** Professional Real Time

Client ID: LL12345X **Patient Control Num.:** ABC123

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

However, if errors exist, a table will be displayed informing you of each error and its location in the claim. The tab location of the error will be a hyperlink, which when clicked will take you directly to that tab so that you may make any necessary edits. Click on Edit Current Claim to return to the General Claim Information tab of the current claim or click Enter Another New Claim to leave this claim in Error status and enter a new claim. If you are viewing a claim with errors that was previously processed and you wish to determine if the errors displayed are still accurate, click Validate Current Claim, which will re-validate the claim and display an updated Confirmation page.



Claim Entered

Claim Entry Status: Errors Claim Type: Professional

Client ID: LL12345X Patient Control Num.: TEST

This information is only current as of 5/3/2011 9:29:38 AM. Changes made after that time are not reflected on this page. To view current information click on the Validate Current Claim button.

Claim Tab	Validation Message
Service Lines	At least one service line is needed.

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

This claim still needs to be batched and submitted for claims adjudication processing.

The Submit Real Time Claim button only displays if you selected Professional Real Time as the claim type when you initially began creating the claim. Choosing Submit Real Time displays a confirmation page.

' • Claim Entered

Claim Entry Status: Sent

Claim Type: Professional (RT)

Client 10: LL12345X

Patient Control Num.: TtST CLAIM

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 R"alTime Responses link In th" Idt hand navigationalmenu to view the corresponding Claim Acknowledgement response.

Real Time Professional Claims

Real Time Professional Claims

Real Time Professional Claims differ from batch Professional Claims in that you will receive an immediate claim status response for each claim entered. The process of entering a Real Time Professional Claim is simplified by the user-friendly tab layout of the pages, grouping data elements to be entered into logical sets.

The tabs of information are as follows:

General Claim Information: The General Claim Information tab is identical for all Claim Types. It contains client specific information for the claim, and once data has been entered, is view only as the client personal information may not be modified.

Professional Claim Information: This tab is specific to Professional Claims. Just over half the data elements included on this page are unique to Professional Claims.

Provider Information: All information pertaining to the Rendering, Referring, Primary Care, or Supervising Provider is entered on this tab.

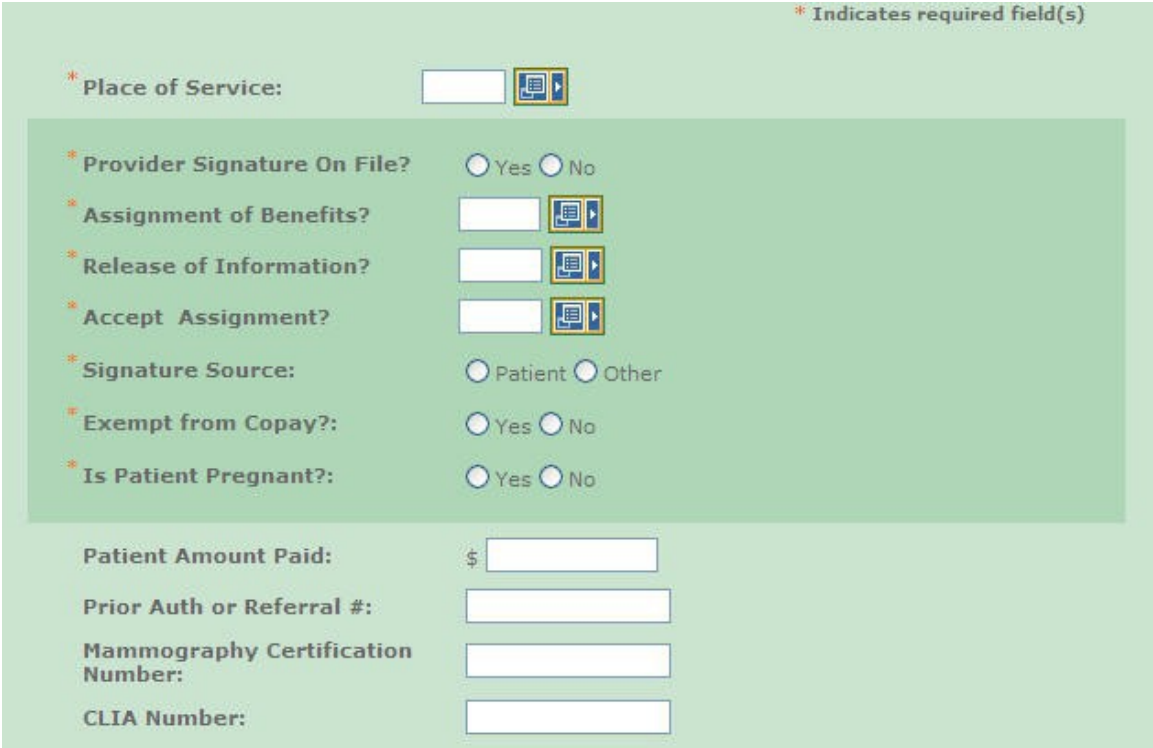
Diagnosis: Diagnosis codes are entered here to allow charges to be properly assigned. Multiple diagnosis codes may be entered.

Other Payers: The Other Payer tab allows for the entry of payers and the related subscriber information who, in addition to NY Medicaid, are responsible for the payment of the claim being entered.

Service Line(s): May be entered to provide detailed information regarding the services rendered and associated with this claim.

Professional Claim Information

The information specific to a Professional claim is entered on this tab. Approximately one-third of the data elements are unique to this claim type and will not be seen on other tabs when entering other types of claims. The page is visually separated into sections using different shading. Each section/field is discussed below, click on the section name to view the details of the fields in that section.



Place of Service: Enter the Place of Service from the CMS Place of Service code list that is most appropriate for the service location type.

Provider Signature on File?: Select 'Yes' or 'No' depending on whether or not the Provider Signature is on file with the Payer. This field is required for all Professional claims.

Assignment of Benefits?: Select 'Yes' if the insured or authorized person authorizes benefits to be assigned to the provider. Select 'No' if benefits have not been assigned to the provider. This will default to 'Yes'.

Release of Information?: Enter or select the code indicating whether the provider has on file a signed statement by the patient authorizing the release of medical data to other organizations.

Accept Assignment? Enter or select the appropriate value from the provided list to indicate whether the provider has a participation agreement with the payer. This field is required on all claims.

Signature Source: Select either patient or other on how subscriber authorization signature was obtained.

Exempt from Copay? Select Yes or No on whether the member is exempt from copay.

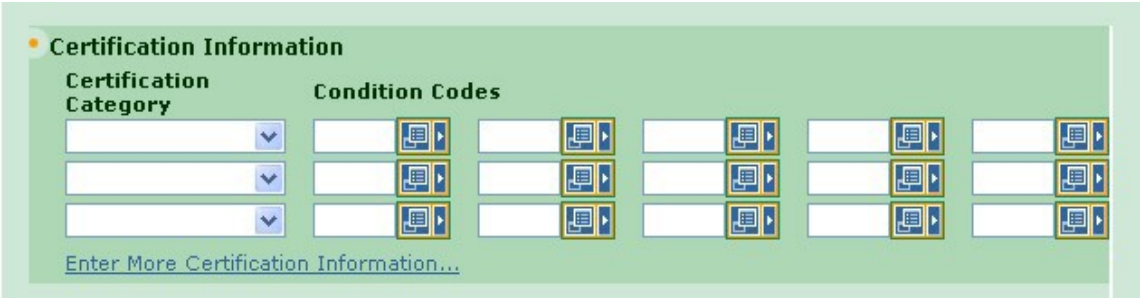
Is Patient Pregnant? Select Yes or No on whether the member is pregnant.

Patient Amount Paid: The sum of all amounts paid, if any, on the claim by the patient or his/her representative.

Prior Authorization: If Prior Authorization has been received for the services associated with this claim, enter the prior approval number in the field. Prior Authorization numbers are assigned by the payer to authorize a service prior to its being performed. This number is specific to NY Medicaid and should not be used for Predetermination of Benefits.

Mammography Certification Number: When entering a claim where mammography services were rendered, the Mammography Certification Number must be entered.

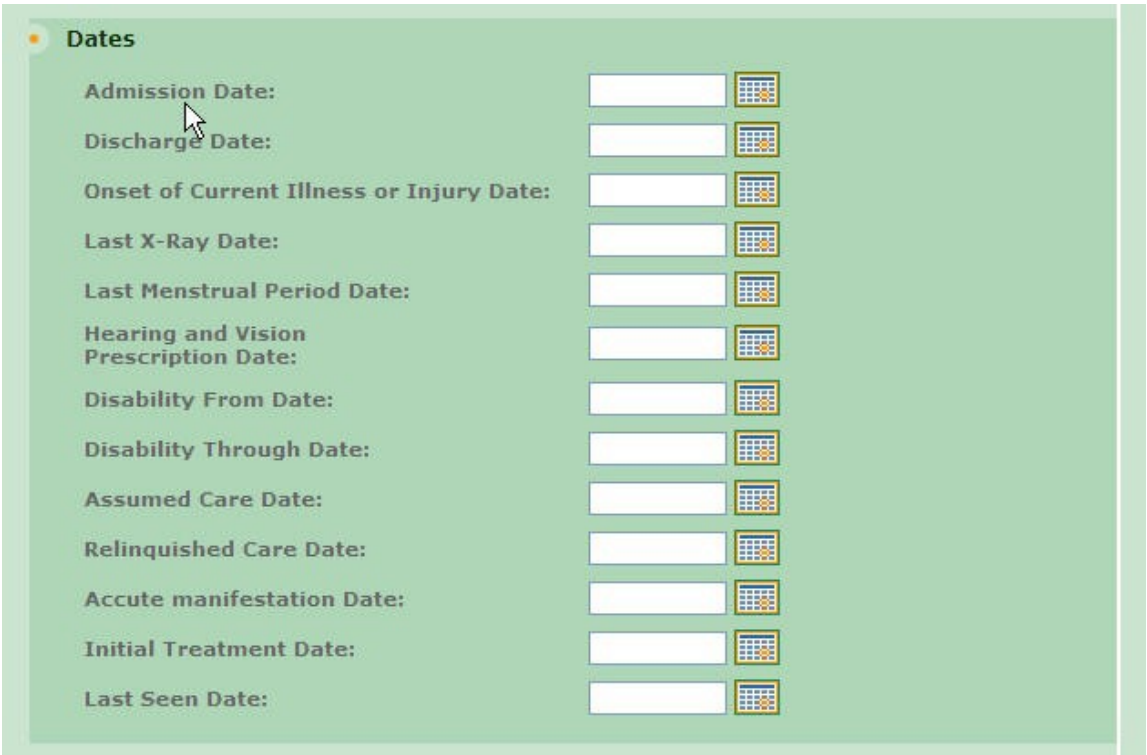
CLIA Number: The Clinical Laboratory Improvement Amendment Number is required on all claims containing laboratory tests covered by the CLIA Act.



Certification Information

Certification Category: If applicable, select the appropriate certification category. Options are: Homebound-Functional, Vision-Spectacle Lense, Vision-Contact Lense, Vision Spectacle Frame or EPSDT Referral.

Condition Codes: Enter the appropriate condition code based on the certification category selected.



The format for all date values is MM/DD/YYYY and may be entered in the field or selected from the calendar available by pressing the button to the right of the field.

Dates

Admission Date: If applicable, enter the date of admission.

Discharge Date: If applicable, enter the discharge date.

Onset of Current Illness or Injury Date: If applicable, enter the date the illness/injury

began.

Last X-Ray Date: If applicable, enter the date of the last x-ray.

Last Menstrual Period Date: If applicable, enter the last menstrual period date.

Hearing and Vision Prescription Date: If applicable, enter date for hearing or vision prescription.

Disability From Date: If applicable, enter date member started disability.

Disability Through Date: If applicable, enter date member stopped disability.

Assumed Care Date: If applicable, enter date care was assumed.

Relinquished Care Date: If applicable, enter date care was relinquished.

Acute Manifestation Date: If applicable, enter date of acute manifestation.

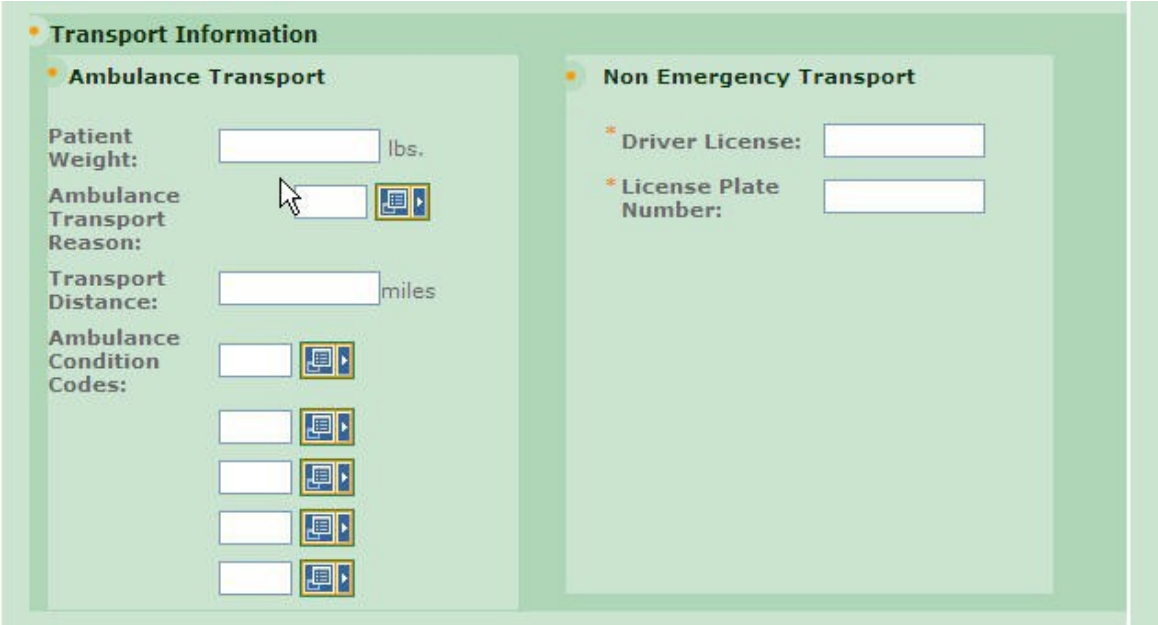
Initial Treatment Date: If applicable, enter date initial treatment started.

Last Seen Date: If applicable, enter date member was last seen.

Related Causes Information

Related Causes: You may select up to two related causes for this claim. If one or more of the options applies to the situation, mark the appropriate check box(es) and enter the Accident Date. If Auto Accident is selected as a Related Cause, enter the state and country in which the accident occurred, 'NY' and 'USA' are the corresponding default values.

Accident Date: If any of the Related Causes boxes are checked, the date of the accident must be entered. The date may not be greater than the current date. The format of the date is: MM/DD/YYYY and may either be entered in the field or selected from the calendar available by pressing the button to the right of the field.



Transport Information

Ambulance Transport

Patient Weight: The weight, in pounds, of the patient at the time of transport via ambulance.

Ambulance Transport Reason: Enter or select a Transport Reason Code from the provided list of valid values. If any information is entered in the "Ambulance Transport Information" section, this data element is required.

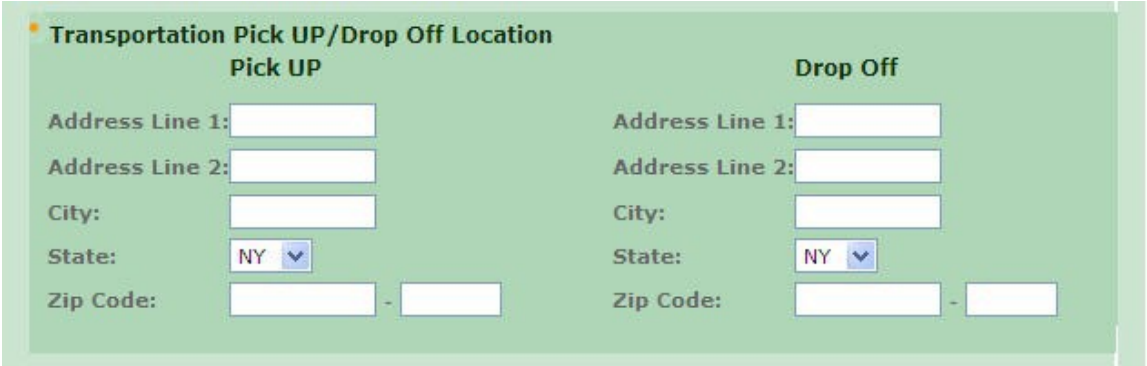
Transport Distance: Enter the distance, in miles, traveled during transport of the patient. If any information is entered in the "Ambulance Transport Information" section, this data element is required.

Ambulance Condition Codes: Up to 5 Condition Codes may be entered for an individual claim, however if any information is entered in the "Ambulance Transport Information" section at least 1 Condition Code must be entered. Select the desired code value from the provided list of valid values. You may either select from the available list or type the code directly into the field. Note: Condition Code values may not be entered more than once on an individual claim.

Non-Emergency Transport

Driver License: If billing for non-emergency transportation (Ambulette), enter the driver license of the driver.

License Plate Number: If billing for non-emergency transportation (Ambulette), enter the license plate number of the vehicle.



Transportation Pick UP/Drop Off Location

If billing for transportation, enter the drop off and pick up locations of the trip.

Pick UP

Address Line 1/Line 2: Enter the street address of where the member was picked up.

City: Enter the city where the member was picked up.

State: Enter the state where the member was picked up.

Zip Code: Enter the zip code where the member was picked up.

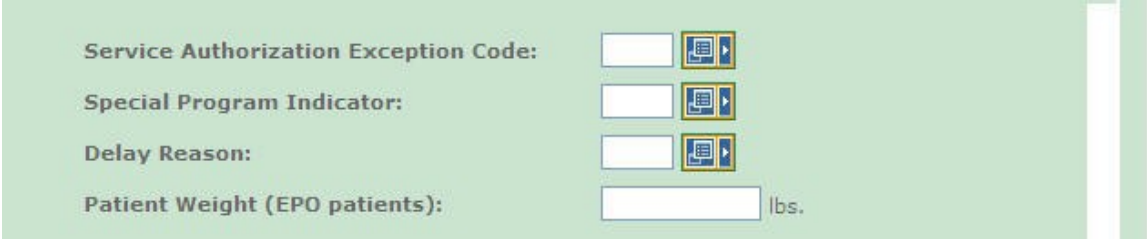
Drop Off

Address Line 1/Line 2: Enter the street address of where the member was dropped off.

City: Enter the city where the member was dropped off.

State: Enter the state where the member was dropped off.

Zip Code: Enter the zip code where the member was dropped off.



Other Information

Service Authorization Exception Code: Enter an exception code if service is exempt from utilization threshold.

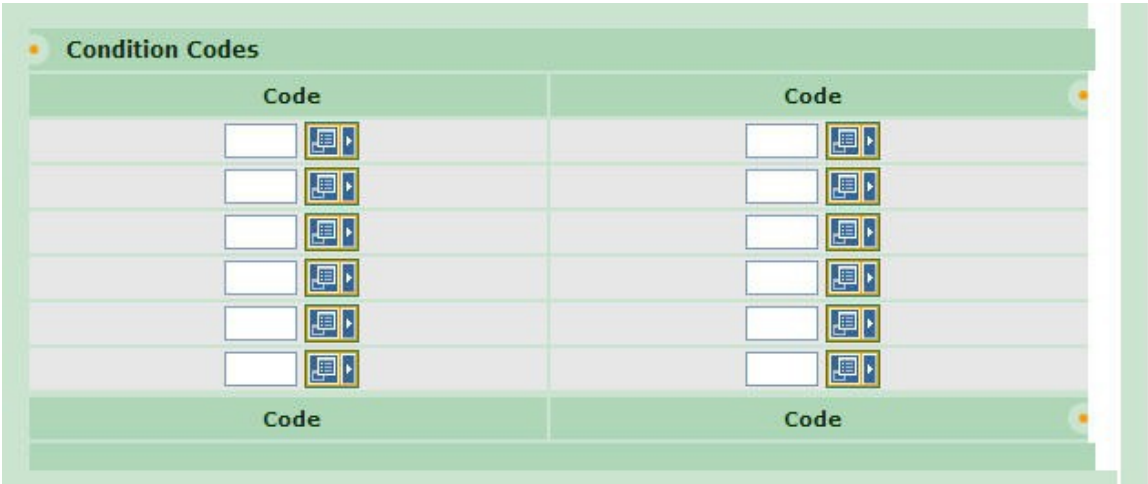
Special Program Indicator: If applicable, enter a special program indicator. Options are:

- 02 Physically Handicapped Children's Program
- 03 Special Federal Funding
- 05 Disability
- 09 Second Opinion or Surgery

Delay Reason: If claim is over the timely filing limits, enter the appropriate delay reason for the claim. Options are:

- 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 Administration Delay in the Prior Approval Process
- 11 Other
- 15 Natural Disaster

Patient Weight (EPO patients): If applicable, enter the weight of the patient.



Condition Codes

Code: If billing for a sterilization or abortion, select the appropriate condition code from the list.

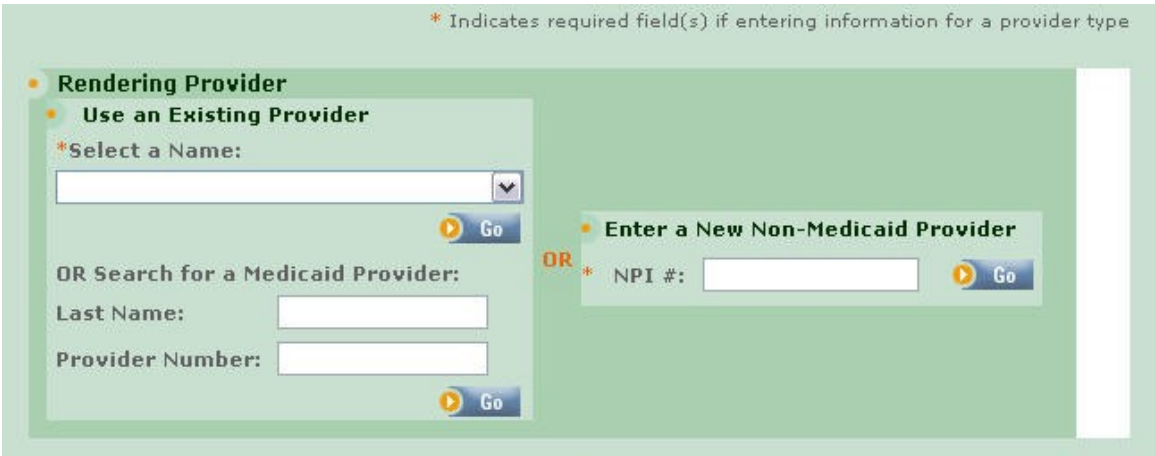
Group Provider

Group Provider Number: If payment is to go to the group, enter the group NPI in this field.

Provider Information

All information pertaining to the Rendering, Referring, Primary Care, or Supervising Provider is entered on this tab.

There are three ways in which to enter the name onto the claim, you may select an existing provider, search for a Medicaid provider, or enter a new non-Medicaid provider. See Appendix for details.



Rendering Provider: Select a Rendering Provider from the drop down. If the provider you want to select does not exist in the drop down, you can search for a Medicaid provider by entering the last name or Provider Number/NPI number. If the provider you want to enter is a non-Medicaid provider, then the user can enter a new Provider on the right side by entering the provider's NPI.

Rendering Provider

Use an Existing Provider

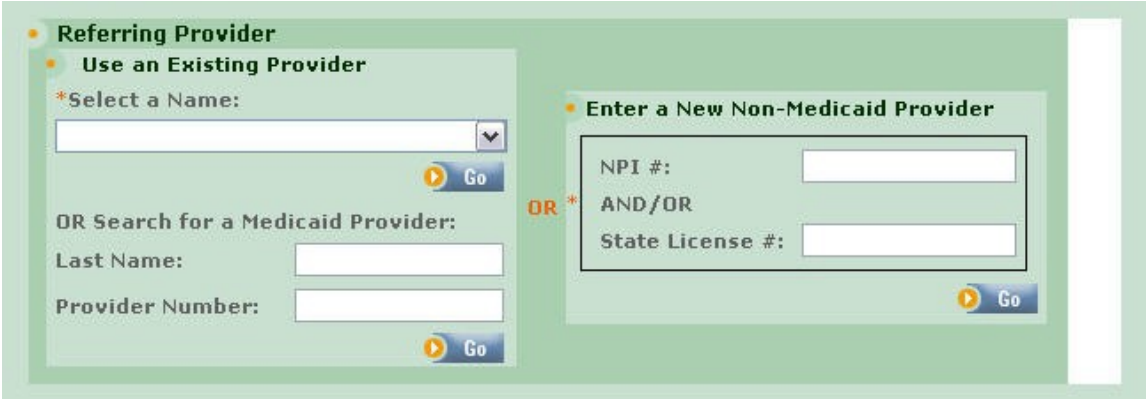
Select a Name: If using an existing provider, you can select the name of the provider in the list.

Last Name: You can also enter the last name of the provider and click "Go".

Provider Number: You can also enter the provider's MMIS ID and click "Go".

Enter a New Non-Medicaid Provider

NPI: If you are entering a new non-Medicaid provider, you can enter the NPI of the provider here.



Referring Provider: If the service you are billing for was referred by another provider, enter that provider here. There are three ways in which to enter the name onto the claim, you may select an existing provider, search for a Medicaid provider, or enter a new non-Medicaid provider. See Appendix for details.

Referring Provider

Use an Existing Provider

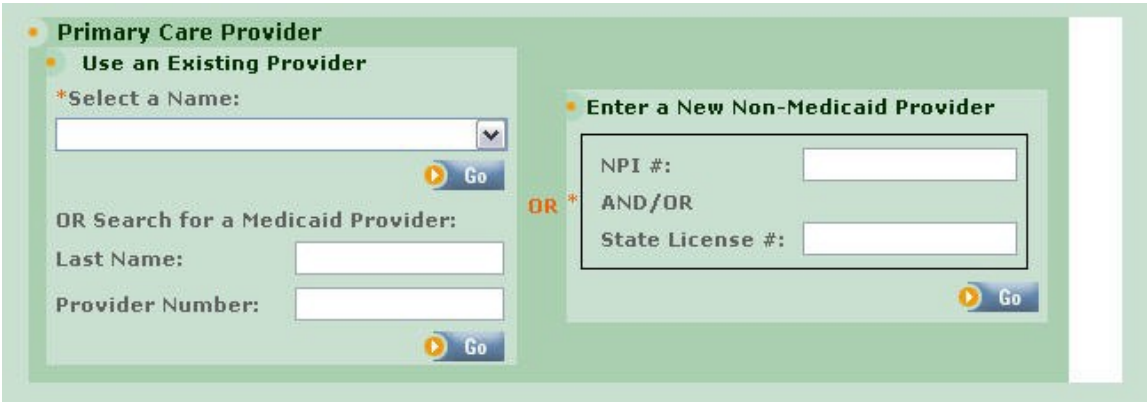
Select a Name: If using an existing provider, you can select the name of the provider in the list.

Last Name: You can also enter the last name of the provider and click "Go".

Provider Number: You can also enter the provider's MMIS ID and click "Go".

Enter a New Non-Medicaid Provider

If you are entering a new non-Medicaid provider, you can enter the **NPI #** and/or the **State License #** here.



Primary Care Provider: May be used if more than one referral exists and there is a requirement to report the additional referral. The Primary Care Provider indicates the source of the initial referral for this client's episode of care being billed/reported on this claim. NOTE: A Referring Provider must be selected if the Primary Care Provider is selected.

Primary Care Provider

Use an Existing Provider

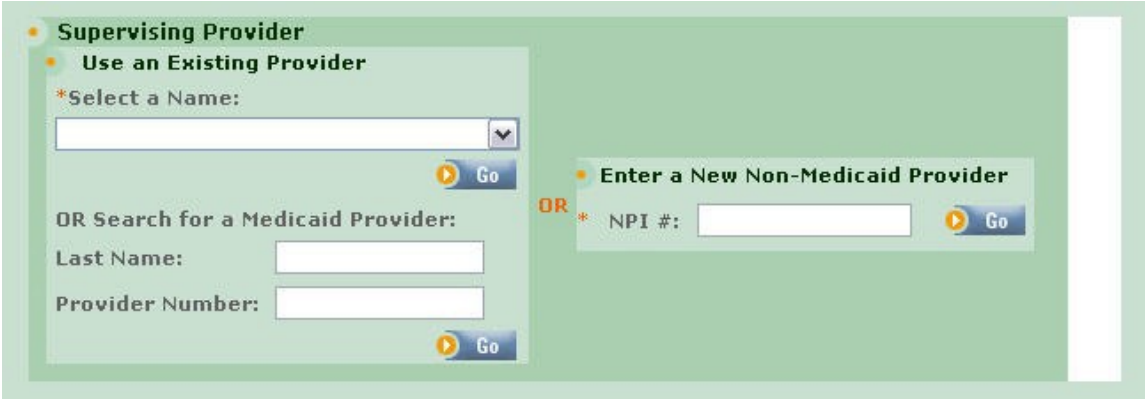
Select a Name: If using an existing provider, you can select the name of the provider in the list.

Last Name: You can also enter the last name of the provider and click "Go".

Provider Number: You can also enter the provider's MMIS ID and click "Go".

Enter a New Non-Medicaid Provider

If you are entering a new non-Medicaid provider, you can enter the **NPI #** and/or the **State License #** here.



Supervising Provider: Select a Supervising Provider from the drop down. If the provider you want to select does not exist in the drop down, you can search for a Medicaid provider by entering the last name or Provider Number/NPI number. If the provider you want to enter is a non-Medicaid provider, then the user can enter a new Provider on the right side by entering the provider's NPI.

Supervising Provider

Use an Existing Provider

Select a Name: If using an existing provider, you can select the name of the provider in the list.

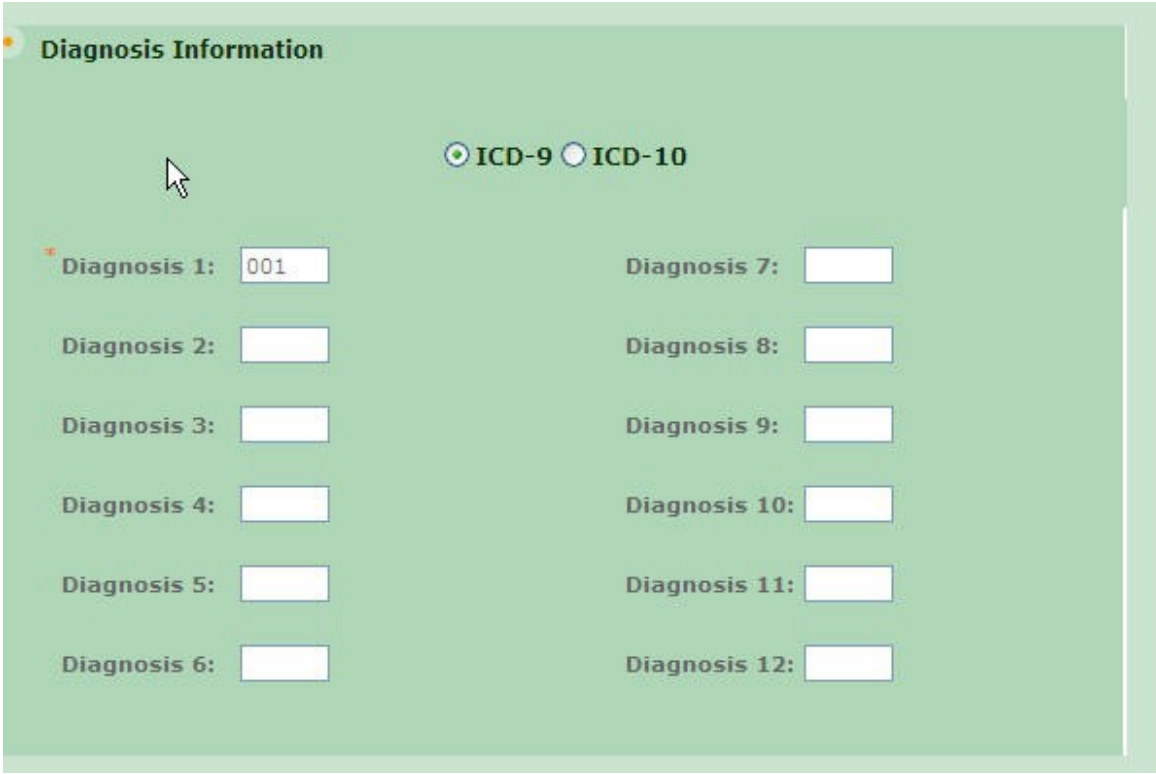
Last Name: You can also enter the last name of the provider and click "Go".

Provider Number: You can also enter the provider's MMIS ID and click "Go".

Enter a New Non-Medicaid Provider

NPI: If you are entering a new non-Medicaid provider, you can enter the NPI of the provider here.

Diagnosis



Diagnosis Information

Enter at least one diagnosis code. Up to 12 Diagnosis codes may be entered on a single claim and may not be duplicated.

All other codes entered will be treated as Other Diagnosis codes. All codes entered should be valid ICD-9-CM or ICD-10-CM codes.

ICD-9 / ICD-10: Select the appropriate code type for the diagnosis.

Diagnosis 1 - 12: Enter up to 12 applicable diagnosis codes in these fields.

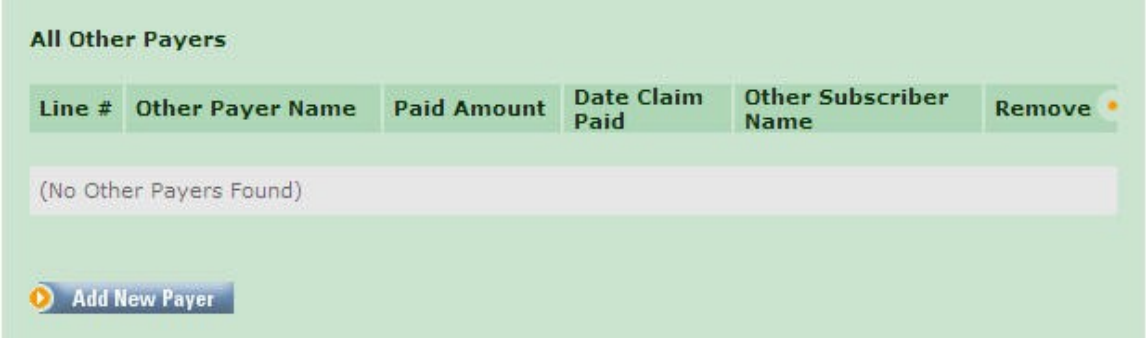
Anesthesia Related Procedure

Anesthesia Related Procedure Code 1: If billing for anesthesia services, enter the procedure code for the surgery in this field.

Anesthesia Related Procedure Code 2: If applicable, enter the second procedure code for the surgery in this field if billing for anesthesia services.

Other Payers

The Other Payers tab is not required to enter a claim. You only need to access this tab if there are payers in addition to NY Medicaid to be applied to the claim being entered. However, if you do access the tab and start the process of entering an Other Payer, you must complete all the required information or delete all data entered before continuing to another tab.



Upon initially opening this tab, you will see the Summary level of all Other Payers entered for this claim. If no Payers exist, the table will be empty and you may Add Another Payer at this time. If Other Payers have already been entered for this claim, you may view the details associated with each payer from this table or add Other Payers.

All Other Payers

Line #: This is a line number identifying the order in which the Other Payers were entered on the claim. Clicking this hyperlinked value will open the Details Page for that Payer. Removing a Payer will change the Line # of payers entered after that payer. For example, if you delete Line # 2, then Line # 3 and Line # 4 become 2 and 3 respectively. Payers may be entered in any sequence, and are displayed here in that sequence. The Line # is not related to the order of responsibility for paying this claim, that is handled by the Payer Sequence Number.

Other Payer Name: The Payer name as selected when entering the Other Payer onto the claim.

Paid Amount: The dollar amount paid by the Payer towards this claim.

Date Claim Paid: The date on which a payment was received from this Payer for this claim.

Other Subscriber Name: The full name (Last Name, First Name, Middle Initial) of the Subscriber associated with this Payer.

Remove: Click this button to delete the other payer information.

Enter Other Payer

In addition to NY Medicaid, you may enter additional payers who are responsible for this claim. Remember that all elements marked with an asterisk (*) are required when entering a Payer. Not all claims will have Other Payer information. Note: A maximum of 10 Other Payer records may be entered per claim.

Other Payer Information

Other Payer Name: Select the name of the desired payer from the provided list. If the Other Payer you are looking for is not listed, contact your Administrator to add the Payer to the Support File of valid Payers. Required for all Other Payers.

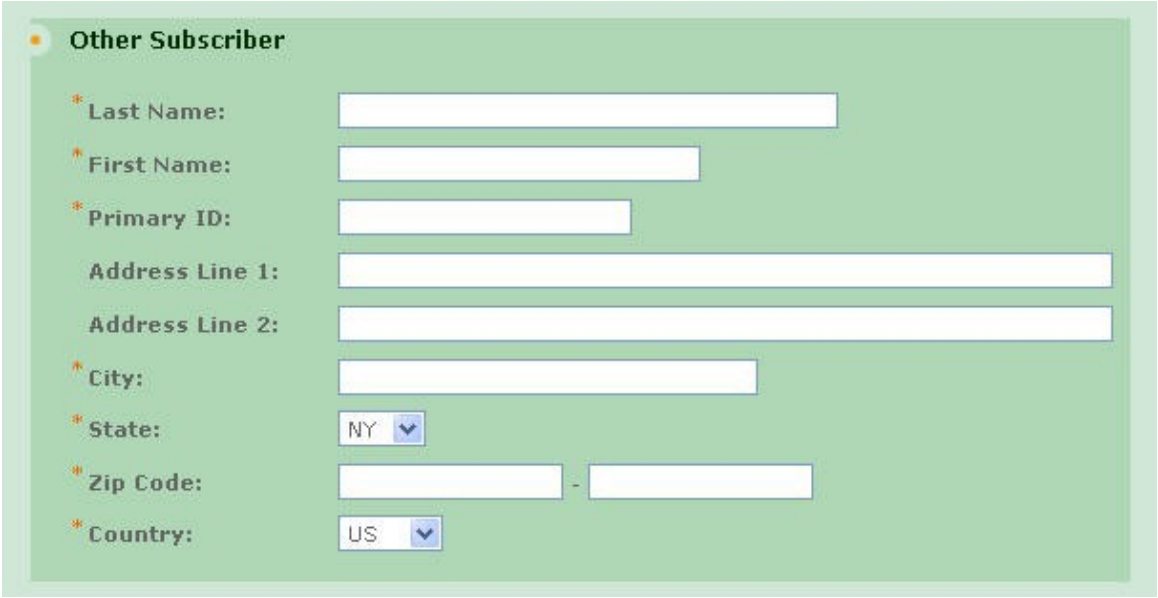
Payer Sequence Number: Select the value that represents the order in which payment was received from other payers. Payers may be entered in any sequence and displayed in any sequence. Required for all Other Payers.

Payer Type: A code identifying the type of Payer. Enter or select a value from the list of available codes.

Other Payer Paid Amount: This field is required when this payer has adjudicated the claim. If the Other Payer denied the claim, enter 0. If the Other Payer has not adjudicated the claim, leave blank. If a value is entered, the Date Claim Paid must be entered as well.

Other Payer Claim Control Number: Enter the claim control number of the other payer.

Date Claim Paid: Date on which the Other Payer Paid Amount was received. This date may not be greater than the current date. The format is: MM/DD/YYYY and may either be entered in the field or selected from the calendar available by pressing the button to the right of the field.



Other Subscriber

Last Name/First Name: If entering an Other Payer, you must enter the First and Last Name of the Subscriber for the Payer. The Subscriber may or may not be the Client.

Primary ID: The Other Insured Identifier as assigned by the Payer. This is required when entering the Subscriber for the Other Payer.

Address Line 1/2: The street address of the Subscriber, if known.

City: Enter city name of the Subscriber.

State: State in which the Subscriber lives. Select value from the list of available valid state abbreviations, defaults to 'NY'.

Zip Code: Enter the postal Code associated with the Subscriber's address.

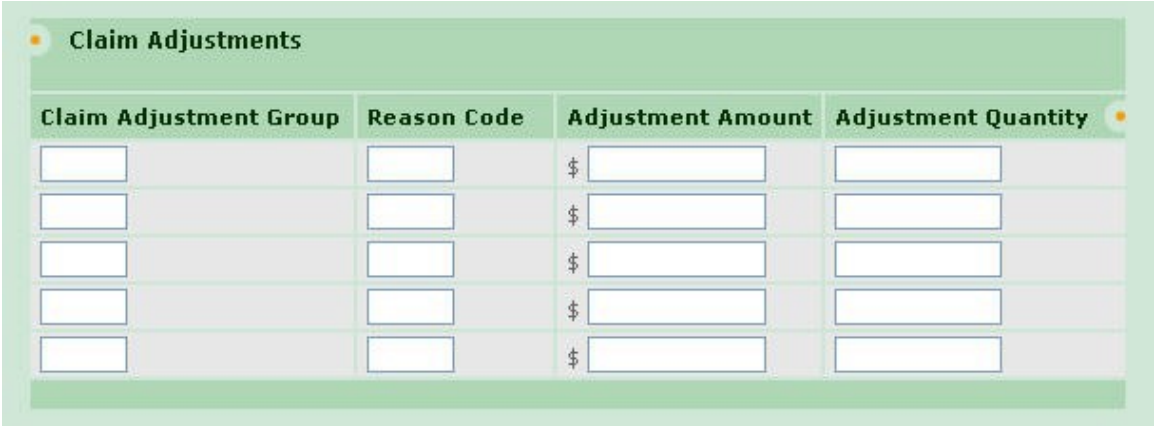
Country: Country in which the Subscriber lives. Select value from the list of available countries, defaults to 'US'.

Other Subscriber Information

Relationship: Code indicating the relationship between the Client/Patient and the Subscriber for this Payer. Enter or select a value from the list of available codes. A relationship is required if a Subscriber is entered.

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

Group Name: The Group Name associated with the Group Number above.



Claim Adjustments

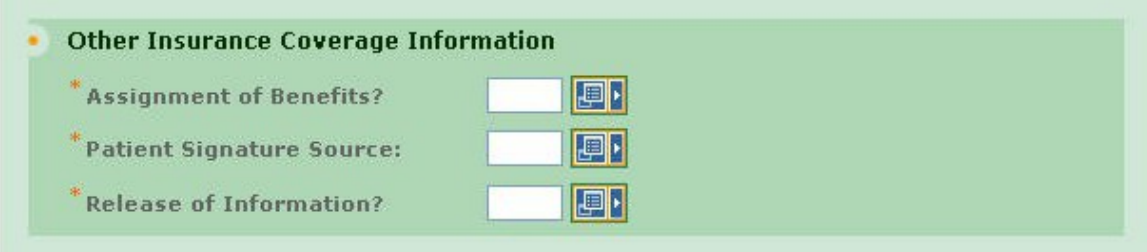
If the other payer reported claim adjustments at the claim level, enter the adjustment information here. Otherwise, this information will be blank. Claim adjustment group codes and reason codes are from the remittance of the other payer.

Claim Adjustment Group: Enter the Group Code as received from the other payer. A maximum of 5 Claim Adjustment Groups are allowed per claim and the values are to be entered.

Reason Code: Enter the Claim Adjustment Reason Code as received from the other payer. The Claim Adjustment Group/Reason Code combination may not be entered more than once. If an Adjustment Amount or Adjustment Quantity is entered, a Reason Code is required.

Adjustment Amount: Enter the Adjustment Amount as received from the other payer.

Adjustment Quantity: Enter the Quantity Adjusted as received from the other payer.



Other Insurance Coverage Information

Assignment of Benefits?: The Benefits Assignment Certification Indicator. 'Yes' indicates insured or authorized person authorizes benefits to be assigned to the provider while 'No' indicates that no authorization has been given. This value will default to 'Yes' and is required if an Other Payer Name is selected.

Patient Signature Source: Enter or select the Patient Signature Source Code, indicating how the patient or subscriber authorization signatures were obtained and how they are being retained by the provider. An entry is required if an Other Payer Name is selected.

Release of Information?: Indicates whether the provider has a signed statement by the patient authorizing the release of medical data to other organizations. This value is required if an Other Payer Name is selected.

Amounts

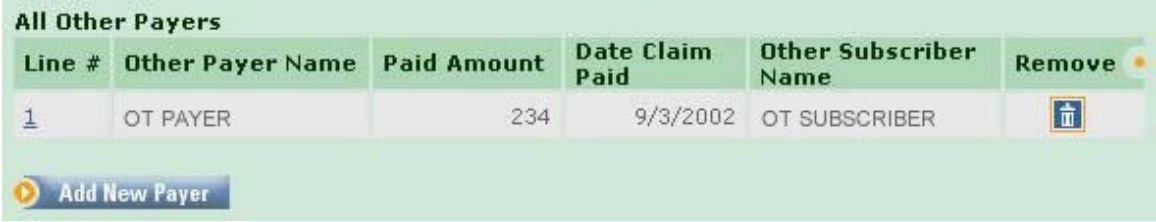
Remaining Patient Liability: This is the amount the provider believes is due and owing after the Other Payer's adjudication.

Non-Covered Charge Amount: Enter the dollar value of the claim in this field if the other payer was not billed, and documentation is on file that the other payer would not have paid the claim.

Once all the information for the Payer has been added, another payer may be added by clicking the Next Payer>> control at the top or bottom of the tab. This will return you to the top of the page with all the values cleared out and a new Payer Number listed at the top of the page. Clicking View All Other Payers will display the Other Payers Summary page.

View Other Payers

Viewing All Other Payers is a quick and easy way to see what payers, in addition to NY Medicaid, have a responsibility for this claim. The easy to read table displays a snapshot of information about each Payer.



All Other Payers

Line #	Other Payer Name	Paid Amount	Date Claim Paid	Other Subscriber Name	Remove
1	OT PAYER	234	9/3/2002	OT SUBSCRIBER	

Add New Payer

Line #: This is a line number identifying the order in which the Other Payers were entered on the claim. Clicking this hyperlinked value will open the Details Page for that Payer. Removing a Payer will change the Line # of payers entered after that payer. For example, if you delete Line # 2, then Line # 3 and Line # 4 become 2 and 3 respectively. Payers may be entered in any sequence, and are displayed here in that sequence. The Line # is not related to the order of responsibility for paying this claim, that is handled by the Payer Sequence Number.

Other Payer Name: The Payer name as selected when entering the Other Payer onto the claim.

Paid Amount: The dollar amount paid by the Payer towards this claim.

Date Claim Paid: The date on which a payment was received from this Payer for this claim.

Other Subscriber Name: The full name (Last Name, First Name Middle Initial) of the Subscriber associated with this Payer.

Remove: Click this button to delete the other payer information.

If a specific Third Party or Managed Care Plan is required but not listed, you may Add Another Payer. If a Payer was erroneously added to this claim and must be removed, click the Remove icon and confirm the deletion.

Service Line(s)

A Service Line is listed on a claim for each procedure or item that is to be reported to the Payer(s) for claim adjudication. Each claim must contain at least one Service Line.

The main view of the Service Line(s) tab contains the basic information for the line as it relates to NY Medicaid. Additional information and adjudication details from Other Payers are available on subsequent pages. You may remove any single Service Line by clicking the Remove icon on that line. In addition, the total of all the submitted charges for the Service Lines is listed below all the Service Lines that have been entered.

Line: This is a system generated value to uniquely identify the Service Line on the claim. The counter will start with 1 and increment with each new Service Line entered. A minimum of 1 Service Line is required on all claims.

Svc Dates: For a procedure/service rendered on a single date, enter this date in the From Date. However, if the procedure/service transpired over a period of time, enter the start and end dates in the From and To fields respectively. The date(s) may not be greater than the current date. The format is: MM/DD/YYYY and may either be entered in the field or selected from the calendar available by pressing the button to the right of the field. At a minimum, a From Date is required for all Service Lines.

HCPCS & Mod: The Health Care Financing Administration Common Procedural Coding System identifier for the product/service. This code value is required for all claims. Optionally, up to 4 modifiers identifying special circumstances related to the performance of the service may be entered for each code. Note: If entered, the Modifier must be a 2 character code.

Chrg Amount: The submitted charge amount for this procedure/service must be entered. Note: Zero (0) is a valid charge amount.

Svc Count: The number of units or minutes in which the procedure/service is to be billed. A drop down is available to indicate the unit of measure for the Service Unit. A default value of 'Unit' will be selected but may be changed.

Place of Svc: Enter or select the code for the facility/location where services on the current line were performed, if the facility/location differs from the Place of Service listed on the Professional Claim Information tab.

DX (Diagnosis) Pointer: If Diagnosis Codes were entered on the Diagnosis tab, you may list the top four (4) diagnosis code labels in order of priority here. Diagnosis Codes are referenced by their label number and therefore acceptable values are 1 through 12 inclusive.

Emgcy: You must select 'Yes' or 'No' to indicate whether or not the services provided were emergency related.

Total Claim Charges: At the bottom of the table of Service Lines, all charges for all Service Lines on the claim will be summed and displayed, once the Service Line Information is saved.

For each Service Line, you may view/enter additional details by clicking the More icon. However you may only view these additional details once all required elements have been entered. Navigating off this summary page, either by clicking the More icon or moving to another tab, will trigger validation of the data entered on this page. Validation is done one line at a time, so if there are errors on multiple lines you will have to fix each line before seeing the next set of errors. If a Service Line must be removed for any reason, clicking the Delete icon will remove the line and re-sequence the remaining Service Lines.

Service Line Details

Each service line on a Professional Claim will have information available in addition to what is displayed in summary on the main page. This information is accessed by clicking the More icon on the main Service Line(s) page.

Dates

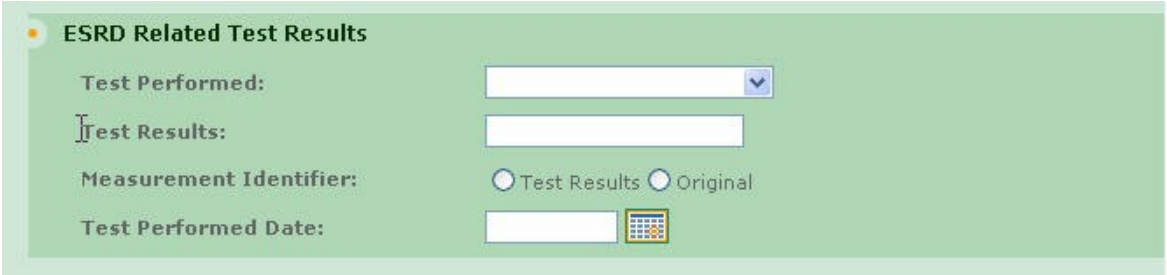
The format for all date values is: MM/DD/YYYY and may either be entered in the field or selected from the calendar available by pressing the button to the right of the field. The dates may not be greater than the current date unless otherwise specified.

Last X-Ray Date: If the claim involves spinal manipulation and an X-Ray was taken, enter the date of the X-Ray here. Not necessary if same as date entered at claim level.

Product Shipped Date: If the Service Line involves the billing/reporting of shipped goods, enter the date on which the goods were shipped.

Initial Treatment Date: If patient has previously experienced similar symptoms/illness, enter the initial treatment date here, only if it differs from the value entered at the claim level.

Prescription Date: When billing for a drug and a prescription was written, enter the date the prescription was written.



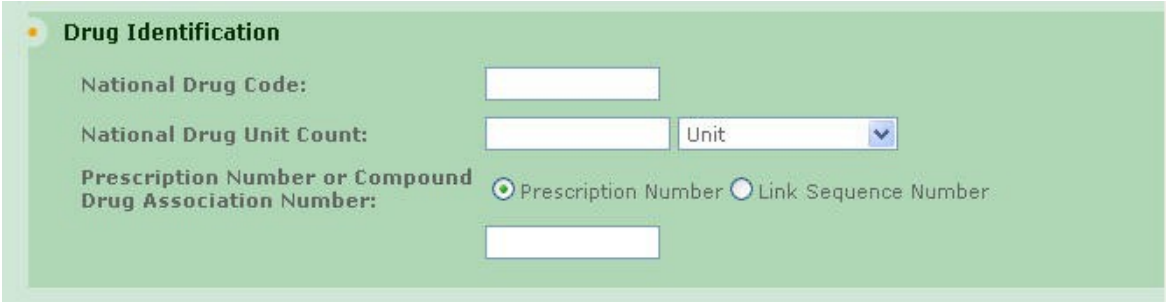
ESRD Related Test Results

Test Performed: Using the drop down, indicate what type of test was performed.

Test Results: Enter the numeric results of the specified test. If Test Results are entered, an Identifier and Qualifier must also be selected.

Measurement Identifier: Select the manner in which the results are measured. If an Identifier is selected, a Qualifier and Test Results must also be specified.

Test Performed Date: Enter the date on which the test selected above was performed. The format is: MM/DD/YYYY and may either be entered in the field or selected from the calendar available by pressing the button to the right of the field. The date may not be greater than the current date.



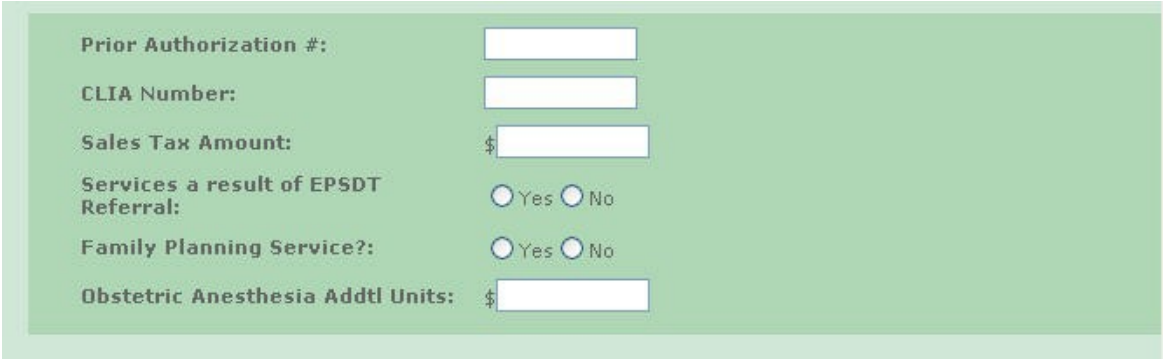
Drug Identification

If any information is entered into this section, all pieces of data must be populated.

National Drug Code: Enter the NDC for the drug associated with this Service Line. An 11 digit value must be entered without the hyphens.

National Drug Unit Count: Enter the number of units prescribed of this medication. Also, select the proper Unit of Measure to be associated with this value. Defaults to 'Unit' but any valid value may be selected.

Prescription Number or Compound Drug Association Number: Pick whether you are entering a Prescription Number or Link Sequence Number. Then enter the Prescription Number or Link Sequence Number associated with the drug in the field below.



Prior Authorization #: If Prior Authorization has been received for the procedures associated with this Service Line and the number is different from that entered on the Professional Claim Information tab, enter the number in the field. Prior Authorization numbers are assigned by the payer to authorize a service prior to its being performed. This number is specific to NY Medicaid.

CLIA Number: The Clinical Laboratory Improvement Amendment Number is required on all service lines containing laboratory tests covered by the CLIA Act, assuming the value differs from that entered at the claim level.

Sales Tax Amount: If sales tax applies to the services rendered on this line, enter the dollar value of the sales tax amount here.

Services a result of EPSDT Referral: Select 'Yes' or 'No' to indicate whether or not the procedures were related to the Early and Periodic Screen for Diagnosis and Treatment of Children.

Family Planning Service? Select 'Yes' or 'No' to indicate the involvement of Family Planning services.

Obstetric Anesthesia Addtl Units: If there are additional units for anesthesia, enter them in this field.

Purchased Service Provider

If applicable, enter the purchased service provider here. For each type of provider, there are three ways in which to enter the name onto the claim, you may select an existing provider, search for a Medicaid provider, or enter a new non-Medicaid provider. See Appendix for details.

Use an Existing Provider

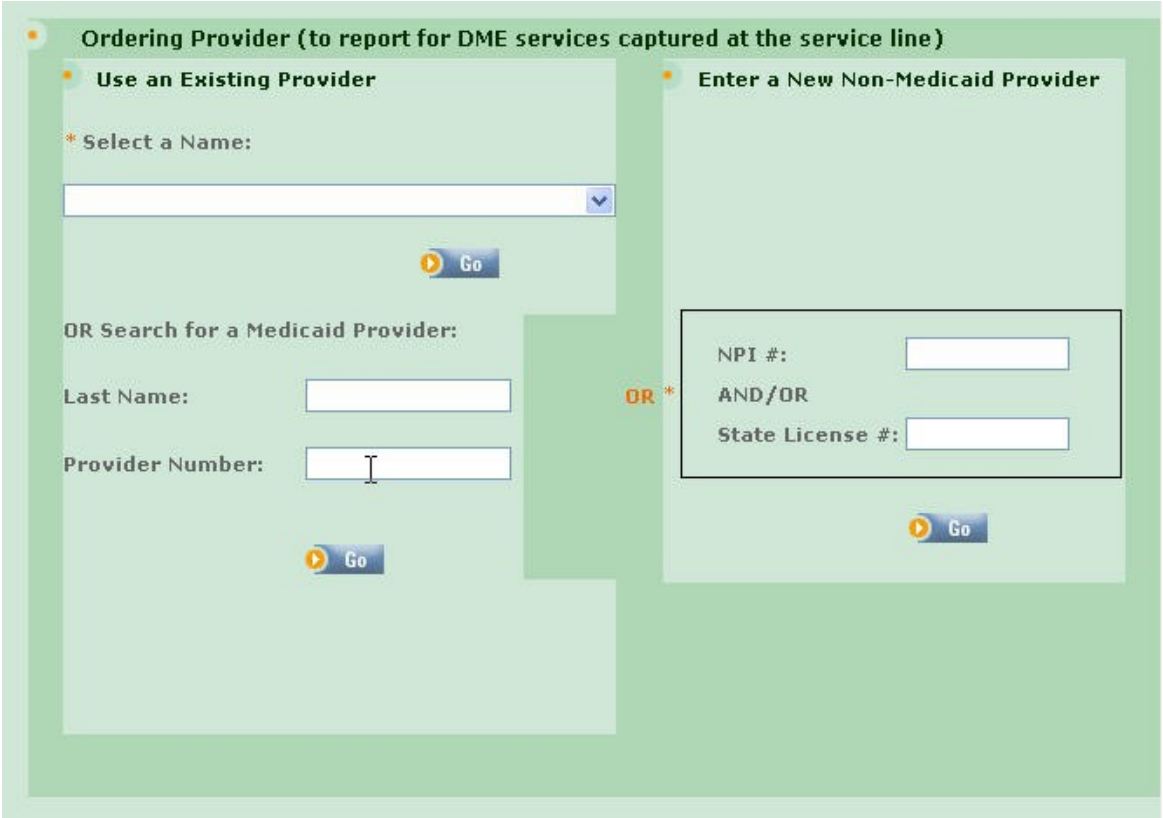
Select a Name: If using an existing provider, you can select the name of the provider in the list.

Last Name: You can also enter the last name of the provider and click "Go".

Provider Number: You can also enter the provider's MMIS ID and click "Go".

Enter a New Non-Medicaid Provider

If you are entering a new non-Medicaid provider, you can enter the **NPI #** and/or the **State License #** here.



Ordering Provider

If applicable, enter the ordering provider here. For each type of provider, there are three ways in which to enter the name onto the claim, you may select an existing provider, search for a Medicaid provider, or enter a new non-Medicaid provider. See Appendix for details. DME services require an ordering provider.

Use an Existing Provider

Select a Name: If using an existing provider, you can select the name of the provider in the list.

Last Name: You can also enter the last name of the provider and click "Go".

Provider Number: You can also enter the provider's MMIS ID and click "Go".

Enter a New Non-Medicaid Provider

If you are entering a new non-Medicaid provider, you can enter the **NPI #** and/or the **State License #** here.

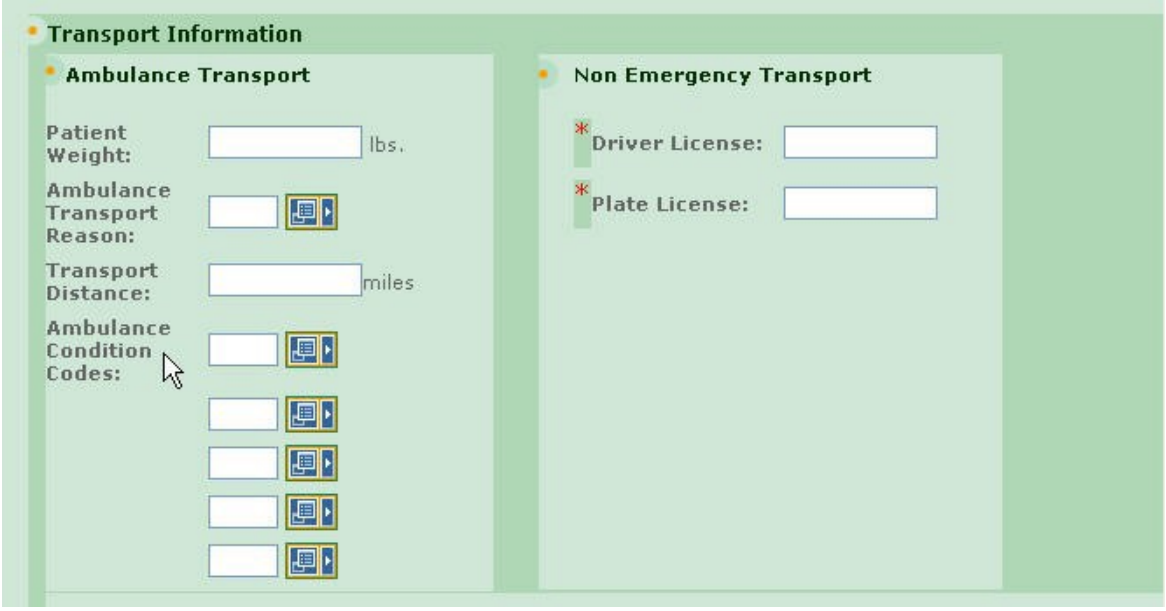
Durable Medical Equipment Rental Services

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

If Ambulance Transport Information was entered at the claim level, it does not need to be re-entered here, unless details are different, in which case all data elements are required.

<u>Ambulance Transport</u>

Patient Weight: The weight, in pounds, of the patient at the time of transport via ambulance.

Ambulance Transport Reason: Enter or select a Transport Reason Code from the provided list of valid values. If any information is entered in the Ambulance Transport Information box, this data element is required.

Transport Distance: Enter the distance, in miles, traveled during transport of the patient. If any information is entered in the Ambulance Transport Information box, this data element is required.

Ambulance Condition Codes: Up to 5 Condition Codes may be selected for an individual claim, however if any information is entered in the Ambulance Transport Information box at least 1 Condition Code must be entered. Select the desired code value from the provided list of valid values. You may either select from the available list or type the code directly into the field. Note: Condition Code values may not be entered more than once on an individual claim.

Non-Emergency Transport

Driver License: If billing for non-emergency transportation (Ambulette), enter the driver license of the driver.

Plate License: If billing for non-emergency transportation (Ambulette), enter the license plate number of the vehicle.

Transportation Pick UP/Drop Off Location

Enter the pickup and dropoff location for the transport.

Pick UP

Address Line 1/Line 2: Enter the street address of where the member was picked up.

City: Enter the city where the member was picked up.

State: Enter the state where the member was picked up.

Zip Code: Enter the zip code where the member was picked up.

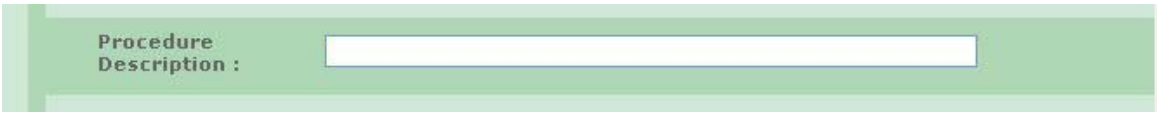
Drop Off

Address Line 1/Line 2: Enter the street address of where the member was dropped off.

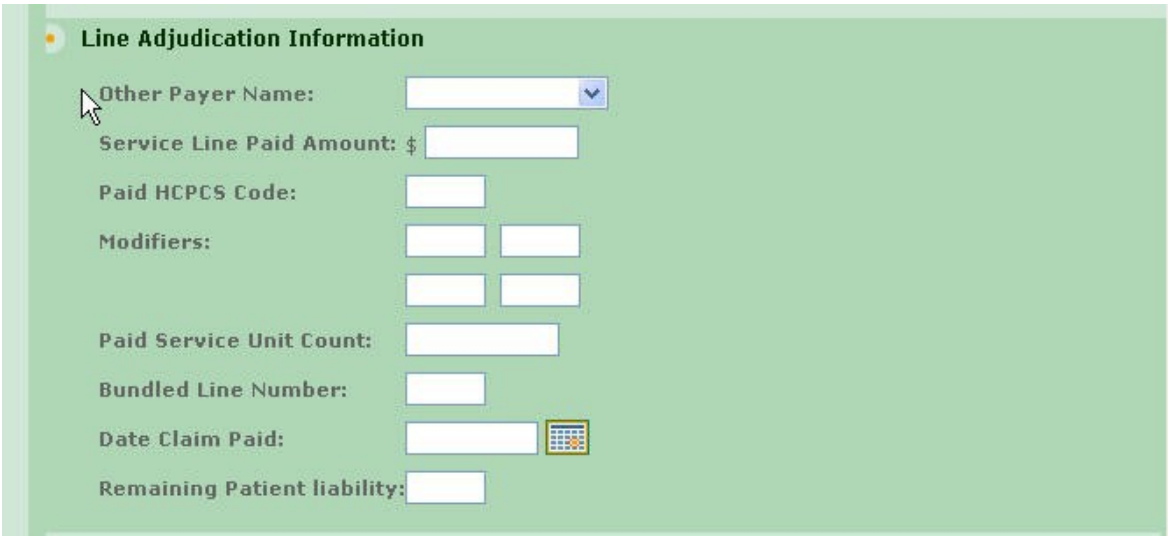
City: Enter the city where the member was dropped off.

State: Enter the state where the member was dropped off.

Zip Code: Enter the zip code where the member was dropped off.



Procedure Description: Enter additional comments on the procedure being billed.



Line Adjudication Information

Other Payer Name: The Payer Name selected must match one of those entered on the Other Payer tab. All subsequent data entered applies to the Adjudication for this Service Line and Payer combination.

Service Line Paid Amount: The dollar amount paid towards this Service Line by this Payer.

Paid HCPCS Code: This is the procedure code processed/priced by the payer.

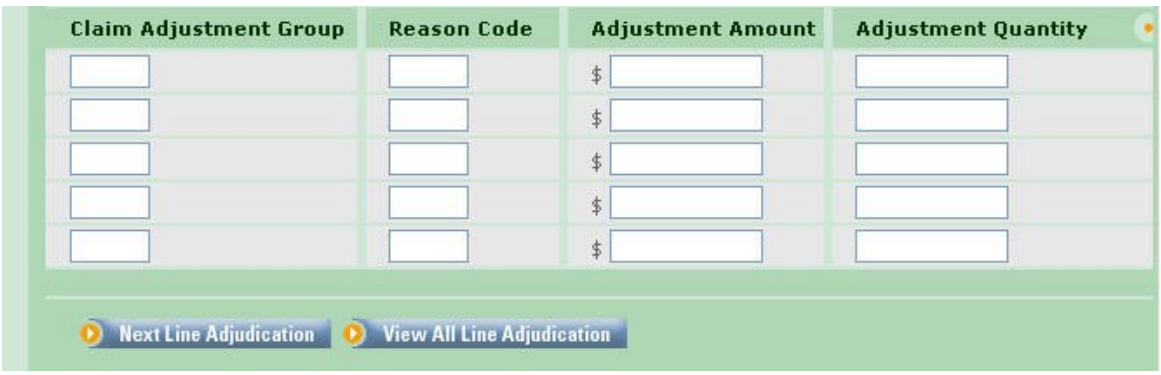
Modifiers: Optionally, up to 4 modifiers identifying special circumstances related to the performance of the service may be entered for each code. Note: If entered, the Modifier must be a 2 character code.

Paid Service Unit Count: The units of service paid by the Other Payer.

Bundled Line Number: If applicable, enter the number of the line bundled or unbundled by the other payer.

Date Claim Paid: Service adjudication or payment date must be entered. The date may not be greater than the current date. The format is: MM/DD/YYYY and may either be entered in the field or selected from the calendar available by pressing the button to the right of the field.

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



Claim Adjustment

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. The Claim Adjustment Group/Reason Code combination may not be entered more than once. If an Adjustment Amount or Adjustment Quantity is entered, a Reason Code is required.

Adjustment Amount: Enter the Adjustment Amount as received from the other payer. An Adjustment Amount is required when a Reason Code is entered.

Adjustment Quantity: Enter the Quantity Adjusted as received from the other payer.

If Other Payers have been included on the claim and they have adjudicated this line or you need to maintain the adjudication details, you may view/maintain the individual Line Adjudication Information or view a summary of all adjudication information for this line.

Service Line Adjudication Summary

If there are multiple Other Payers defined for a claim, each Service Line may have multiple Line Adjudication records. Viewing the Line Adjudication Summary for a particular Service Line will provide quick visibility to the payments which have been made against the particular Service Line.

Line #	Other Payer Name	Service Line Paid Amount	HCPCS Code	Date Claim Paid	Remove
1	MCMS OF ST	356.75	V5300	10/1/2003	
2	SELF	15.00	V5200	9/30/2003	

From this section, you may Add Another Line Adjudication, review the individual Line Adjudications, or Remove a Line Adjudication. The table displayed contains the following summary information:

Line #: An incremental counter to track the adjudication records for each line.

Other Payer Name: The Third-Party or Managed Care payer responsible for payment on this claim. All subsequent data entered applies to the Adjudication for this Service Line and Payer combination. Any Payer entered here must also be entered on the Other Payer tab for the claim.

Service Line Paid Amount: The dollar amount paid towards this Service Line by the Payer. The total of all the Service Line Paid Amounts on this claim must add up to the total Other Payer Paid Amount on the Other Payer tab.

HCPCS Code: The main HCPCS code entered for the Service Line. Multiple codes and modifiers may be associated with the line and are accessible by viewing the details for the line.

Date Claim Paid: Service adjudication or payment date. The format of the date is: MM/DD/YYYY.

Remove a Line Adjudication

Clicking the Remove icon for a particular Line Adjudication record will prompt you to confirm the deletion. Removing a record will permanently delete the data from the claim and adjust Line Paid amounts accordingly.

Claim Confirmation

Upon completion of a claim, which is indicated by clicking Finish, the claim will be placed into one of two states. If there are no validation errors and the claim is ready to be submitted for adjudication, then it will be set to Complete.

Claim Entered

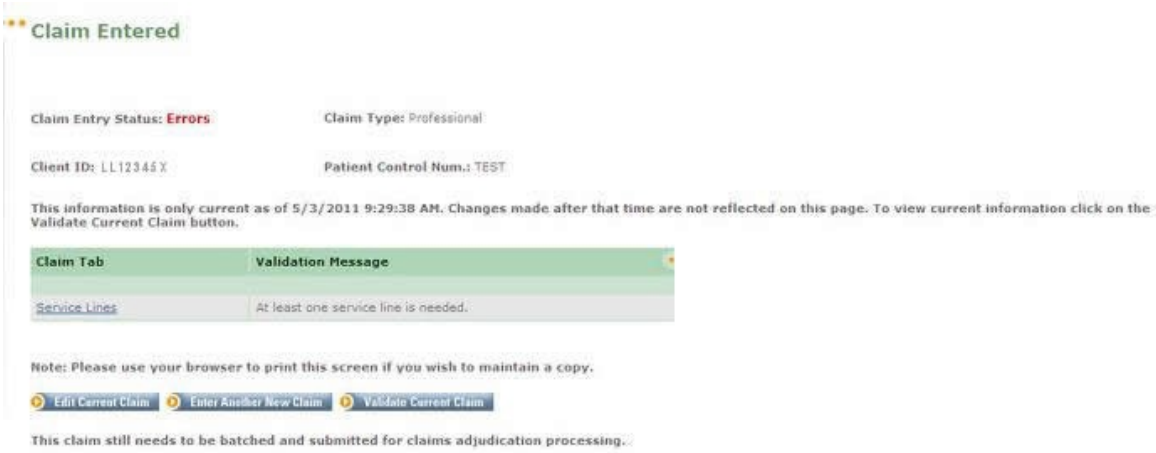
Claim Entry Status: Complete **Claim Type:** Professional Real Time

Client ID: LL12345X **Patient Control Num.:** ABC123

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

However, if errors exist, a table will be displayed informing you of each error and its location in the claim. The tab location of the error will be a hyperlink, which when clicked will take you directly to that tab so that you may make any necessary edits. Click on Edit Current Claim to return to the General Claim Information tab of the current claim or click Enter Another New Claim to leave this claim in Error status and enter a new claim. If you are viewing a claim with errors that was previously processed and you wish to determine if the errors displayed are still accurate, click Validate Current Claim, which will re-validate the claim and display an updated Confirmation page.



Claim Entered

Claim Entry Status: Errors Claim Type: Professional

Client ID: LL12345X Patient Control Num.: TEST

This information is only current as of 5/3/2011 9:29:38 AM. Changes made after that time are not reflected on this page. To view current information click on the Validate Current Claim button.

Claim Tab	Validation Message
Service Lines	At least one service line is needed.

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

This claim still needs to be batched and submitted for claims adjudication processing.

The Submit Real Time Claim button only displays if you selected Professional Real Time as the claim type when you initially began creating the claim. Choosing Submit Real Time displays a confirmation page.

' • Claim Entered

Claim Entry Status: Sent

Claim Type: Professional (RT)

Client 10: LL12345X

Patient Control Num.: TtST CLAIM

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 R"alTime Responses link In th" Idt hand navigationalmenu to view the corresponding Claim Acknowledgement response.

Find Claims

Find Existing Claim

Once a claim has been Finished or Saved as Draft, you may use the Find Claim pages to view, edit or delete the claim. Opening the main Find Claim page will display all the claims in the system, which have not been sent for processing, or have been sent within the past 90 days.

By selecting a User ID from the Claim(s) by User ID list, an Administrator or Supervisor may have visibility to all claims entered for the selected provider by the selected user. General Users do not have visibility to claims entered by anyone other than themselves and therefore will not have this option.

By default, the claims will be displayed in the order they were entered into the ePACES system, with the newest claim at the top of the list. You may sort the displayed records by any data element simply by clicking on the arrow in the column header; if the arrow is white that is the column by which the table is currently sorted. Clicking on the Back button or Find Claims will return the data to the default sort order.

To find the claim in which you are interested, you may either navigate through the list using the <<Previous Page and Next Page>> controls located at the top and bottom of the table or you may filter the claims displayed based on any of the six data elements in the table: Patient Control Number , Entry Status, Client ID , Client Name, Type of Claim , or Begin Date.

Patient Control #: The hyperlinked Patient Control Number, also known as the Patient Account Number, will bring you to the corresponding claim. The status of the claim will determine how the claim is displayed: view-only or editable.

Entry Status: The status of the claim is displayed for informational purposes. A claim may be in one of 7 states: Draft, Errors, Complete, Batched, Sent, Replaced, or Voided. Clicking the hyperlinked Errors will open the page of errors for the selected claim.

Client ID: The Client ID associated with the claim is displayed and may be used as a filter to find a specific claim.

Client Name: The Full client name will be displayed (First Name, Middle Initial, Last Name) however when applying the Client Name filter, only the Last Name will be used.

Type of Claim: A claim may be one of four types: Institutional, Professional, Real Time Professional or Dental, and may be used to filter the list. You may enter either the complete word or just the first letter of the claim type to filter the list of claims.

Begin Date: For Institutional and Professional claims for which Service Lines may have a Service Date Range, this value represents the From Date on the first Service Line. For Dental claims that only have a single Service Date for each Line, this represents the Service Date of the first Service Line. The format of the date is: MM/DD/YYYY.

NOTE: When applying a filter to the list of claims, for all fields other than Type of Claim, whatever value is entered in the text field is matched exactly to the values in the data type field selected. Therefore, if "Client Last Name" is selected and "Jeff" is entered into the text box, the results page will be opened with only claims where the Client's last name is "Jeff", variations such as "Jeffries", "Jefferson", or "Jeffers" will not be displayed.

Clicking on Clear Results will clear out the filter and return all claims in the system in the default sort order.

View Claim - Batched, Sent, Replaced, or Voided

The first step in viewing a Batched, Sent, Replaced, or Voided claim is Finding the Claim. Once you have found the claim and clicked on the Patient Control # hyperlink, you will see pages which are very similar to those used to Enter a New Claim. The basic difference is the fact that all the tabs are view-only, meaning no changes can be made. You are able to navigate through the tabs in the same manner as during the entry process with very few differences.

Differences between the Claim Entry view and the View/Edit views:

- Unable to Add Service Lines
- Unable to Add Line Adjudication details
- All Value, Condition, and Occurrence codes on Institutional claims will be displayed without the need for expansion
- All Tooth Numbers on Dental claims will be displayed without the need for expansion

Depending on the status of the claim, there are various actions which may be taken.

- **DRAFT:** A claim in Draft status may be edited or deleted and therefore will never be opened in View Only mode. See Edit Existing Claim for details.
- **ERRORS:** A claim in Error status may be edited or deleted and therefore will never be opened in View Only mode. See Edit Existing Claim for details.
- **COMPLETE:** A claim in Complete status may be edited or deleted and therefore will never be opened in View Only mode. See Edit Existing Claim for details.
- **BATCHED:** A Batched claim MAY NOT be edited and MAY NOT be deleted and therefore will always be opened in View Only mode.
- **SENT:** A claim that has already been sent for processing and therefore has a status of Sent may be replaced or voided however will be opened in View Only mode. See Edit Existing Claim or Delete Existing Claim for more information.
- **REPLACED:** A Replaced claim may not be edited or deleted and therefore will always be opened in View Only mode.
- **VOIDED:** A Voided claim may not be edited or deleted and therefore will always be opened in View Only mode.

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 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 Patient Control Number, Client ID 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 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.

- **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:** 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. These new claims will go through the standard validation, batching, and submittal process to be sent to the Payer.

- **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) the Sent claim will then have a status of Voided. A Voided claim may not be edited, it may only be viewed.

Delete Existing Claim

If a claim must be deleted from the system, it may have been entered in error or duplicated, you may do so with the click of a button. However, be cautious when deleting a claim as there is no way to undo the deletion or retrieve the information. Once you confirm the deletion, the data is gone.

Clicking Delete Claim while entering or editing the claim will prompt you for confirmation of the deletion. If you click Yes, then the data will be removed from the ePACES system. If you click No, the claim will remain unaffected and you will be returned to the claim.

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

- **DRAFT:** Throughout both the Claim Entry process and the editing of a "Draft" claim, the Delete Claim button is available to you. Clicking this button will prompt for confirmation of the deletion, which if confirmed, will remove the claim information from the ePACES system.

- **ERRORS:** When editing a claim that has a status of "Errors", the Delete Claim button is available to you. Clicking this button will prompt for confirmation of the deletion, which if confirmed, will remove the claim information from the ePACES system.

- **COMPLETE:** When editing a claim that has a status of "Complete", the Delete Claim button is available to you. Clicking this button will prompt for confirmation of the deletion, which if confirmed, will remove the claim information from the ePACES system.

- **BATCHED:** A "Batched" claim MAY NOT be deleted. In order to delete 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. Then you may delete the claim as it is now in "Complete" status. Once you have deleted the claim, you may re-batch the claims.

- **SENT:** A claim that has already been sent for processing and therefore has a status of "Sent" may not be deleted. It may, however be voided. If a sent claim must be voided, clicking the Void Claim button will generate a new claim with a Claim Submission Reason of "Void". A Void claim requires the Claim Original Reference Number to be populated indicating to the payer that the claim is not new but the previously received claim is void and should not be processed. These new claims will go through the standard validation, batching, and submittal process to be sent to the Payer.

- **REPLACED:** Once a Replacement claim has been generated to replace a Sent claim, see Editing a Sent Claim for more details, the Sent claim will then have a status of "Replaced". A "Replaced" claim may not be deleted, 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 deleted, it may only be viewed.

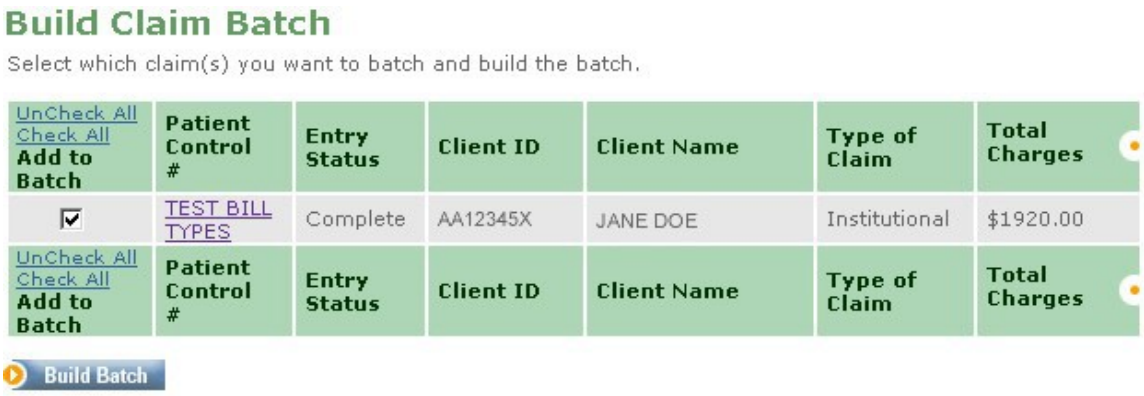
Batch Claims for Submission

Build Batch

Claims that have been successfully entered into the ePACES system must be transmitted to the eMedNY to allow for the processing and payment of the claims. In ePACES, unless the claim type is Real Time Professional, this is called Building and Submitting Claim Batches. Real Time Professional Claims are sent directly to eMedNY without having to go through the batch process. Only claims that are in a status of "Complete" may be batched and sent to eMedNY for processing.

The Build Claim Batch page, which is accessed by clicking **Build Claim Batch** on the left-hand menu, consists of a table containing all non-Real Time claims that have a status other than "Replaced", "Voided", "Batched" or "Sent".

By selecting a User ID from the Claim(s) by User ID list, an Administrator or Supervisor has the ability to batch claims entered for the selected provider by the selected user. General Users who have the ability to Batch Claims do not have access to claims entered by anyone other than themselves and therefore will not have this option.



Add to Batch: This column contains the check boxes for each claim, which need to be marked in order to indicate the claim should be batched. Only claims with an Entry Status of "Complete" will have a check box, as they are the only claims eligible for batching. Clicking Check All in the header/footer of the table will mark all claims in "Complete" status to be included in the batch, while clicking Uncheck All will remove the checkmark from all claims indicating they are not to be included in the batch. This field will default to checked for all eligible claims.

Patient Control #: The Patient Control # associated with the claim will be a hyperlink to the contents of the claim in View Mode. If you click the link and view the claim, you must select the Build Claim Batch menu item again to return to this page.

Entry Status: Claims which have gone through, either completely or partially, the entry process and have an Entry Status of "Complete", "Draft", or "Errors" will be displayed. Claims with an Entry Status of "Replaced", "Voided", "Batched", or "Sent" will not be included in the list as they have already been through the complete claim batching process.

Client ID/Client Name: This information is included for reference purpose only to ensure you are selecting the proper claim.

Type of Claim: You may select any combination of claim types, Institutional, Professional, and Dental. When a batch is built, the ePACES system will separate the claims into individual batches based on the claim type and Location Information. Therefore, if you select 10 Institutional and 5 Professional claims and click Build Batch, the end result will be 2 separate batches of 10 institutional and 5 Professional claims, assuming the location information on each claim is the same.

Total Charges: Formatted with commas and a dollar sign, the sum of all Service Line charges for the Completed claim. Claims which do not have an Entry Status of "Complete" will not have a value displayed.

Once all desired claims have been marked, click the Build Batch button. This will open the Confirmation page, summarizing the batches that were built.

Confirm Batch

After building the claim batches, the confirmation page is displayed containing the information on the batches built. Each click of the Build Batch button on the Build Claim Batch page may create any number of batches depending on the types of claims selected (Institutional, Dental, Professional) and variety of Location Information, as each claim batch may only contain claims of a single type.

Claim Batch Built

TSN:

Claim Type	Batch Number	Total Claims	Total Batch Charges
Professional	0000055	2	$2308

Claim Type: The type of claims included in the specified batch. May be Dental, Institutional, or Professional.

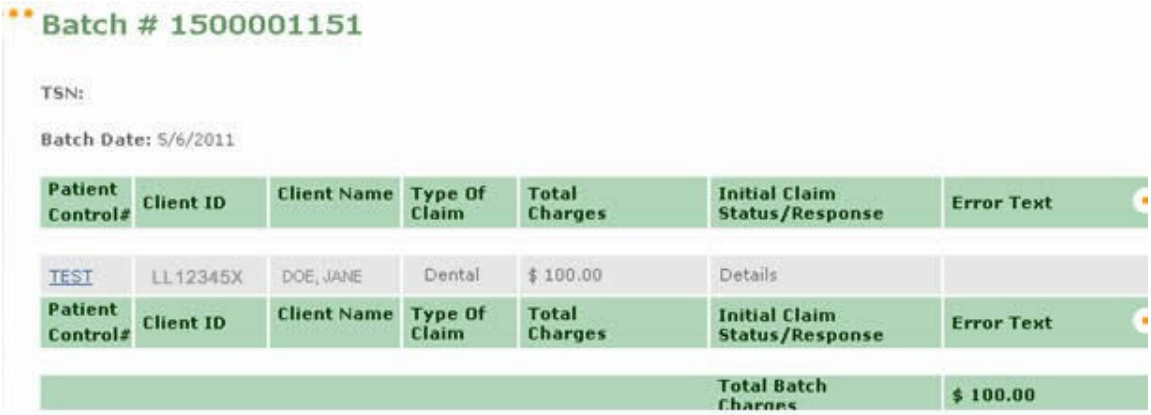
Batch Number: This is a unique, sequential number and batches will be displayed in descending order of Batch Number to allow the newest batches to be located at the top of the list. Clicking this hyperlink will open the View Batch page allowing you to see the details of the claims contained within the batch. The Initial Claim Status/Response will now show Details as a hyperlink. A corresponding error message for rejected claims within the batch will be displayed.

Total Claims: The Total Claims is a count of the number of claims included in the specified batch.

Total Batch Charges: Total Batch Charges is the sum of all Claim Charges.

Review Batch Details

Once a batch has been built, it may be necessary to view exactly which claims are contained in a specific batch. In addition, if you need to edit or delete a claim that has a status of "Batched" it is necessary to review the batches and determine which batch is the correct one to be deleted in order to maintain the claim.



Batch # 1500001151

TSN:

Batch Date: 5/6/2011

Patient Control#	Client ID	Client Name	Type Of Claim	Total Charges	Initial Claim Status/Response	Error Text
TEST	LL12345X	DOE, JANE	Dental	$ 100.00	Details	
Patient Control#	Client ID	Client Name	Type Of Claim	Total Charges	Initial Claim Status/Response	Error Text
					Total Batch Charges	$ 100.00

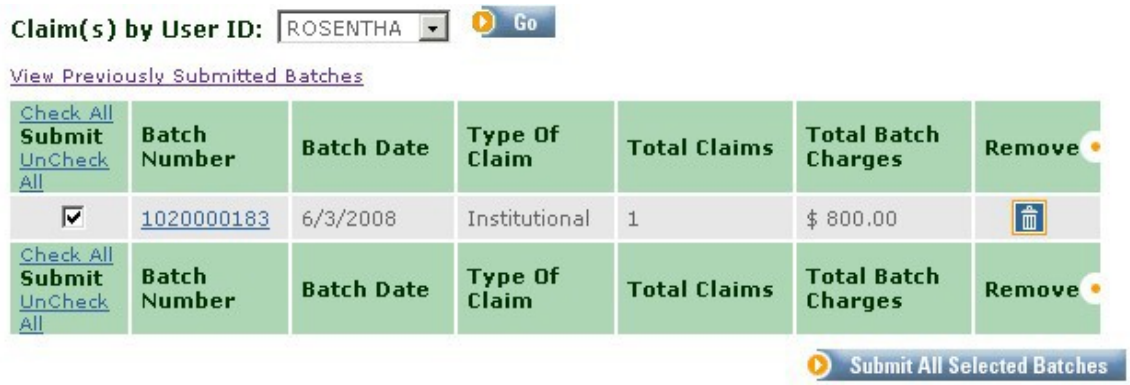
Clicking on the Batch Number hyperlink on the Build Claim Batch Confirmation, the Submit Claim Batch, or the Submit Claim Batch Confirmation page will open the View Batch page. The page will display the Batch Number, along with the date on which the batch was created and the TSN/ETIN for which the batch is being submitted. Below this information is a table containing the claims included in the batch sorted in descending order of when they were entered into the ePACES system.

For each claim in the batch, the Patient Control # , Client ID , Client Name, Type of Claim , and Total Charges are displayed. As with the Build Claim Batch page, the Patient Control # is a hyperlink to the View Claim page. Total Batch Charges, displayed at the bottom of the table, summarizes the Total Charges of the individual claims contained within the batch. The Initial Claims Status/Response column will contain the word Details. Details will not be hyperlinked until the batch has been sent and received for processing. The Error Text column will not be populated until the batch has been sent and received for processing.

Submit Batch

Submit Claim Batches on the left-hand menu will open a page displaying a list of all Claim Batches that are ready and waiting to be submitted to eMedNY. Batching the claims and not proceeding to the step of actually submitting them will not allow the claim to get processed and paid; the claim batches must be submitted to eMedNY. On this page, you will select the batches, all or a select few, to be submitted for processing. If it is necessary to delete a batch, you may do this here as well. Clicking View Previously Submitted Batches will display a table containing all the batches that have been submitted within the last 90 days. The batches will be listed in reverse chronological order.

By selecting a User ID from the Claim(s) by User ID list, an Administrator or Supervisor may have the ability to submit batches created for the selected provider by the selected user. General Users who have the ability to Submit Claims do not have visibility to batches created by anyone other than themselves and therefore will not have this option.



To submit a Claim Batch for processing:

1. Review the batches contained in the *table*,

   Submit: Each claim will have a checkbox. To select a batch to be submitted, mark the box with a check, otherwise clear the mark. By default, all batches displayed will be marked for submission upon opening this page. You may easily "Uncheck All" or "Check All" using the controls at the top of the column.

   Batch Number: This is a unique, sequential number and batches will be displayed in descending order of Batch Number to allow the newest batches to be located at the top of the list. Clicking this hyperlink will open the View Batch page allowing you to see the details of the claims contained within the batch.

   Batch Date: The date on which the batch was created. Displayed in the MM/DD/YYYY format.

   Type of Claim: For informational purposes only, the type for all claims contained within the batch. Each batch may contain claims of a single claim type.

   Total Claims: The total number of claims contained in the batch.

   Total Batch Charges: The total dollar value of charges for all claims contained in the batch.

   Remove: Clicking this icon will delete the batch and set the status of all claims contained within the batch back to "Complete".

2. clear the Submit box for any batches which you do not wish to submit at this time,

3. click Submit All Selected Batches,

4. review the Submit Claim Batch Confirmation page.

Confirm Claim Batch Submission

Upon submitting batches to eMedNY, a confirmation page will be displayed containing the details of the batches which were just submitted. Clicking View Previously Submitted Batches will display a table containing all the batches that have been submitted within the last 90 days. The batches will be listed in reverse chronological order by Submit Date.

Confirmation of Current Submission of Batches:

Claim(s) by User ID: ROSENTHA Go

View Previously Submitted Batches

The following claim batches have been submitted:

Batch Number	Submit Date	Type Of Claim	Total Claims	Total Batch Charges	Total Rejected
1020000182	06/03/2008	Institutional	1	$ 1920.00	
Batch Number	Submit Date	Type Of Claim	Total Claims	Total Batch Charges	Total Rejected

Confirmation of Previously Submitted Batches:

Claim(s) by User ID: ROSENTHA Go

The following table lists all claim batches that you have submitted:

Batch Number	Submit Date	Type Of Claim	Total Claims	Total Batch Charges	Total Rejected
1020000182	06/03/2008	Institutional	1	$ 1920.00	
1020000181	05/29/2008	Institutional	1	$ 800.00	0
1020000180	05/29/2008	Institutional	1	$ 800.00	0
1020000010	03/28/2008	Institutional	1	$ 1920.00	0
Batch Number	Submit Date	Type Of Claim	Total Claims	Total Batch Charges	Total Rejected

Click the View Previously Submitted Batches link and a table of information for previously submitted batches will be displayed. For each batch listed, the following data will be displayed:

Batch Number: This is a unique, sequential number and batches will be displayed in descending order of Batch Number to allow the newest batches to be located at the top of the list. Clicking this hyperlink will open the View Batch page allowing you to see the details of the claims contained within the batch. A corresponding error message for rejected claims within the batch will be displayed.

Submit Date: The date on which the batch was submitted. Displayed in the MM/DD/YYYY format.

Type of Claim: For informational purposes only, the type for all claims contained within the batch. Each batch may only contain claims of a single claim type.

Total Claims: The total number of claims contained in the batch.

Total Batch Charges: The total dollar value of charges for all claims contained in the batch.

Total Rejected: Once the 997 response is received from eMedNY for a batch submission, the total number of claims that were rejected in the batch will be displayed. This will allow you to determine if the batch has been received for processing.

The following View Batch screen will display when clicking the Batch Number hyperlink under View Previously Submitted Claim Batches:

Batch # 1500001151

TSN:

Batch Date: 5/6/2011

Patient Control#	Client ID	Client Name	Type Of Claim	Total Charges	Initial Claim Status/Response	Error Text
TEST	LL12345X	DOE, JANE	Dental	$ 100.00	Details	
Patient Control#	Client ID	Client Name	Type Of Claim	Total Charges	Initial Claim Status/Response	Error Text
					Total Batch Charges	$ 100.00

The following screen will display when the Details hyperlink is clicked:

Claim Status Response Details

Client Information

Client ID: LL12345X Name: JOHN DOE

Claim Level Status

(A7) - Acknowledgement/Rejected for Invalid Information - The claim/encounter has invalid information as specified in the Status details and has been rejected (New as of 10/02) - (725)

Bill Type:

Patient Control #: TEST

Pharmacy Control #:

Payer Claim Control #	Total Claim Charge Amount	Paid Amount	Dates of Service	Status Effective Date
1113900000206930	1132.00	0.00	4/1/2011 - 4/15/2011	5/19/2011

Line Level Status

Line	Status	Service Line Dates	Proc/NDC Code & Mod	Line Charge Amount	Paid Amount	Units.	Status Date

Close Worked

This will return any initial response for front end edits. If there is no Initial rejection the screen will display a message of: No Responses Found, Please Submit a Status Inquiry. This means that normal processing time should be allowed and then proceed to check status inquiry/status response for the claim(s). If there was an initial rejection, the fields on this screen will be populated. You will need to click on Details for each claim within the batch in order to see if there was a front end edit for any of the claims.

Client ID/Name: This information is included for reference purposes only to ensure you are selecting the proper claim.

Claim Level Status: This field will show Pre-adjudication editing at the claim level.

Bill Type: This value identifies the type of facility where services were performed.

Patient Control #: The Patient Control Number as it was entered on the claim.

Pharmacy Control #: If there was a pharmacy claim control # on the claim, it will display here.

Payer Claim Control #: The payer assigned number used to uniquely identify each claim. This will still be assigned even though the claim contains an initial rejection and did not process as paid/pended/denied.

Total Claim Charge Amount: This field reflects the total charges on the claim.

Paid Amount: If the claim has not been finalized for payment or payment has not been authorized, this field will remain at $0.00.

Dates of Service: This field reflects the date(s) of service entered on the claim.

Status Effective Date: This date represents the effective date for the associated initial claim status.

Line Level Status: These fields will remain blank if any Initial Claim Status/Response will apply to the claim level. If there is Pre-adjudication editing on the line level, it will display here.

Delete Batch

If for any reason you must delete a batch, for example one of the claims contained in the batch must be edited or deleted, follow these steps:

1. Click **Submit Claim Batches** in the left-hand menu
2. If you know the batch number which must be deleted skip to step 6 otherwise continue to step 3
3. If you are looking for a batch which contains a specific claim, use the claim type and an approximation of when the claim may have been batched to determine the Batch Number
4. Click the Batch Number hyperlink to view the claims which are contained in the batch
5. Once you have determined the batch number or if you know the number
6. Click the Remove icon for the batch which is to be deleted

Real Time Responses

Real Time Responses

Real Time Responses is a tool used to inquire on the results of Professional Real Time claims submitted to the NY State Medicaid adjudication process. Real Time claim results are available within moments after submitting the claim. There are two steps in the process of inquiring on the results of a Real Time claim: selecting the claim and viewing the response.

Real Time Claim Status Response Details

The details of an individual claim which satisfied the inquiry parameters are displayed on this page, which may be accessed directly from the Claim Status Activity Worklist or via the Claim Status Response page. The top portion of the page will contain the ID and the Last Name of the Client. The lower portion of the page however is visually separated into a couple of different sections, Claim Level and Line Level.

Claim Level Information

The contents of this portion reflect the overall claim, not just this one line of the claim. All lines of a single claim will have identical data in this portion.

Claim Level Status: Claim Status and Claim Status Category Codes and descriptions.

Bill Type: This value identifies the type of facility where services were performed. It reflects the value that had been entered in the Place of Service field on the Real Time Professional Claim.

Patient Control #: This value represents the unique number assigned to this visit. This may be referred to the Patient Account Number in the provider's billing system.

Pharmacy Control #: If a pharmacy control number was entered on the claim, it will display here.

Payer Claim Control #: The payer assigned number used to uniquely identify each claim.

Total Claim Charge Amount: This value represents the total claim charge amount.

Paid Amount: This value represents the total claim payment amount. If the claim has not been finalized for payment or payment has not been authorized, this field will remain at 0.00.

Dates of Service: This date range represents different data elements for different claim types. For Institutional claims, the date range represents the statement period. Similarly, for Professional claims, the range is the Claim From and Through Dates. However, Dental claims have a single Service Date and not a date range.

Status Effective Date: This date represents the effective date for the associated claim status.

Line Level Status

Line	Status	Service Line Dates	Proc/NDC Code & Mod	Line Charge Amount	Paid Amount	Units.	Status Date
1	(A7) - Acknowledgement/Rejected for Invalid Information - The claim/encounter has invalid information as specified in the Status details and has been rejected (New as of 10/02) (454) - Procedure code for services rendered. (Note: New as of 2/97)	5/11/2011-5/11/2011	99999	345.00	0.00	1.00	5/13/2011

Close Worked

Service Line Information

Line: The number uniquely identifying a line on a claim.

Status: The codes and descriptions for the Claim Status and Claim Status Category codes.

Service Line Dates: The date(s) of service for that particular line.

Proc/NDC Code & Mod: The value(s) shown reflect the Procedure Code, National Drug Code and/or Modifiers (up to 4) for that specific line.

Line Charge Amount: The original dollar value submitted by the Provider for this line of the claim.

Paid Amount: If claim/line has been authorized for payment, the dollar value which has been paid by the payer.

Units: The original submitted units of service.

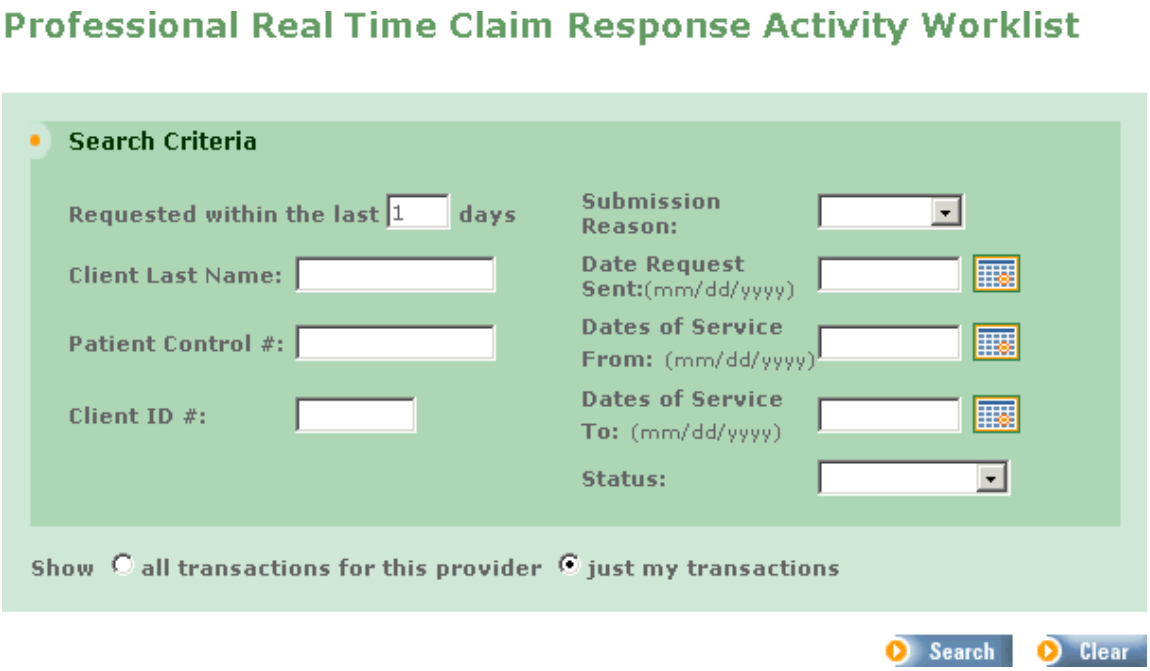
Status Date: This date represents the effective date for the associated line status.

Once you have reviewed the information displayed on the page, you have two options. You may click the Close button which will set the status of the response to "Viewed" or you may click Worked to mark the response as such, indicating that follow-up has been completed. Both buttons will close the details page and return you to the Claim Status Activity Worklist.

Real Time Professional Claim Response Activity Worklist

Search Criteria Region

This section of the page contains multiple fields that you may use to filter the pool of submitted Professional Real Time claims. When the page is initially accessed from the menu, inquiries made within the past 24 hours or 1 day is defaulted in order to display the most recent inquiries made. Changing any of the values in the fields and clicking Search will refresh the page with the new list of claims displayed in the lower portion.



Requested within the last_____days: Entering a value in this field will limit the returned claims to only those created within the specified number of 24 hour periods. For example, if you open this page at 9:00 AM Friday and enter '2' in this field then click Search, the results will display claims entered in the past 48 hours which translates to claims entered after 9:00 AM on Wednesday. The value entered in this field must be greater than '0', and will be defaulted to '1'. NOTE: This field cannot be used in combination with the "Date Request Sent" field.

Client Last Name: Entering the last name of a client will limit the returned claims to only claims entered for clients where the last name in the database exactly matches what was typed. For example, to find "JOHN SMITH JR." you would need to enter "SMITH JR." in this search field.

Patient Control Number : Entering the Patient Control Number will limit the returned claims to only those where the Patient Control Number exactly matches what was typed.

Client ID : Entering the Client ID will limit the returned claims to only claims entered made for that exact value.

Submission Reason: Selecting a Submission Reason (Original, Replaced, or Void) will limit the returned claims to only claims with the exact value.

Date Request Sent: To retrieve claims entered on a specific date, enter the date here. The format should be: MM/DD/YYYY or may be selected from a calendar by clicking the calendar pop-up button. NOTE: this field cannot be used in combination with the "Requested within the last____days" field.

Dates of Service (From / To): Entering both a From and To date will return all claims where the services were rendered on or between the From and To date values. Entering solely a From Date will result in a subset of claims where services were rendered on that date only. The format for each date should be: MM/DD/YYYY or may be selected from a calendar by clicking the calendar pop-up button.

Status: Select one of the available values (Sent, Received, Viewed, Worked) to limit the returned claims. SENT = Claim has been sent but no response received from the payer. RECEIVED = Claim has been received from the payer but not viewed by the user. VIEWED = Response has been viewed by the user. WORKED = Response has been viewed and any necessary follow-up has been completed.

Show all transactions/Show just my transactions: Selecting "all transactions" will return all Professional Real Time Claim Claims entered for users of your facility(s). Selecting "just my transactions" will return only the Professional Real Time Claims entered by you, the current user.

Inquiry/Response Region

This section of the page contains a table listing the Professional Real Time Claims that match the filtering criteria as defined in the above section. With minimal criteria, this list could become quite lengthy which is why there is a default of displaying claims entered within the past 24 hours. Claims are displayed in descending order of when they were submitted.

Name	Patient Control #	Client ID	Submission Reason	Date Sent	Dates of Service	Status
DOE, JANE	PRE ADJUD 10	LL12345X	Original	5/19/2011 8:21:36 AM	5/11/2011 - 5/11/2011	Viewed
DOE, JOHN	PRE ADJUD 3 POINT 5	LL23456X	Original	5/19/2011 8:06:08 AM	5/11/2011 - 5/11/2011	Received
Name	Patient Control #	Client ID	Submission Reason	Date Sent	Dates of Service	Status

Name: This value is the Client Name in the following format: "Last Name, First Name Middle Initial". The name is underlined as a hyperlink. Clicking the hyperlink opens the details of that response.

Patient Control #: The Patient Control Number as entered on the claim.

Client ID: The Client ID associated with the Client name for which the claim was created.

Submission Reason: The Submission Reason (Original, Replaced, or Void) of the claim.

Date Sent: The date and time when the claim was sent to the payer.

Dates of Service: The claim's "From" and "To" dates of service.

Status: SENT = Claim has been sent but no response received from the payer. RECEIVED = Response has been received from the payer but not viewed by the user. VIEWED = Response has been viewed by the user. WORKED = Response has been viewed and necessary follow-up has been completed.

Claim Status Inquiry

Claim Status Inquiry/Response

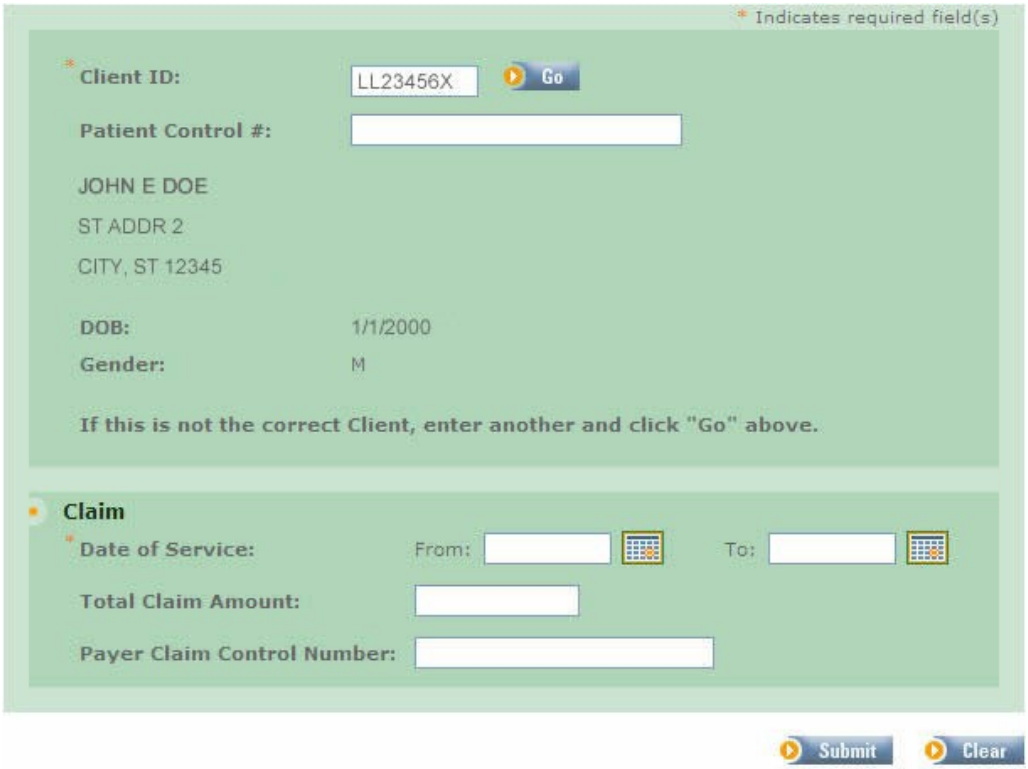
Claim Status Inquiry is a tool used to inquire on the current status of claims within the NY State Medicaid adjudication process. Responses are received indicating the current status of the claim. When the claim status inquiry does not uniquely identify the claim within the NY State Medicaid adjudication process, the response will be for the first claim that meets the identification parameters supplied by the requester.

There are two steps in the process of inquiring on the status of a claim: submitting a request and viewing the response.

Claim Status Inquiry

To submit a claim status inquiry:

1. Access the Claim Status Inquiry page by clicking on **Status Inquiry** on the left-hand menu



2. To *submit an individual inquiry* for a claim submitted through ePACES or any other media:

   - enter the Client ID and click Go - if the value is not valid, an error message will be displayed. Otherwise the Full Name , Date of Birth , Address, and Gender of the client will be displayed,

- at a minimum, you are required to enter the From Date of Service. You may also enter the To Date of Service, Claim Amount and/or Payer Claim Control Number to help narrow the search and ensure you receive a response on the desired claim,

- clicking Submit will send the request to NYS Medicaid and return you to the main Claim

3. Status Inquiry page to allow for the entry of another inquiry.

Select which claims you want to include in your Claim Status Inquiry. When you are finished, click on "Submit Claim Status Inquiry" below.

Find Claim(s) by: Go

Add to Inquiry Uncheck All	Patient Control #	Client ID	Client Name	Type of Claim	Total Claim Amount	Batch Submit Date	Last Inquiry Date
☐	001	LL12345X	DOE, JANE	Institutional	$ 23.00	12/22/2005	7/30/2007
☐	002	LL23456X	DOE, JOHN	Professional	$ 34.00	12/22/2005	7/30/2007
☐	003	LL12345X	DOE, JANE	Dental	$ 234.00	12/22/2005	
☐	004	LL12345X	DOE, JANE	Professional	$ 11.00	12/22/2005	
☐	005	LL12345X	DOE, JANE	Professional	$ 111.00	12/22/2005	
☐	006	LL23456X	DOE, JOHN	Professional	$ 160.00	12/22/2005	
☐	007	LL23456X	DOE, JOHN	Professional	$ 100.00	3/28/2007	3/30/2007
☐	008	LL23456X	DOE, JOHN	Professional	$ 100.00	3/30/2007	3/30/2007
Uncheck All Add to Inquiry	Patient Control #	Client ID	Client Name	Type of Claim	Total Claim Amount	Batch Submit Date	Last Inquiry Date

Submit Cancel

To *submit requests for multiple claims* by selecting from a list of ePACES claims which have been sent for processing:

- click Find and select multiple claims to check on the main Inquiry page,

- a page displaying a table of claims which have been sent for processing by the NY State MMIS will open,

- Administrators and Supervisors may inquire on all claims entered by any user for the selected provider by selecting a User ID from the Claim(s) by User ID list. General Users with the ability to submit Claim Status Inquiry requests do not have visibility to claims entered by anyone other than themselves and therefore will not have this option.

- mark the desired claims to be included in the inquiry,

  - filter the complete list by Patient Control Number, Client ID , Client Last Name, Type of Claim , or Batch Submit Date ,

    NOTE: When applying a filter to the list of claims, for all fields other than Type of Claim, whatever value is entered in the text field is matched exactly to the values in the data type field selected. Therefore, if "Client Last Name" is selected and "Jeff" is entered into the text box, the results page will be opened with only claims where the Client's last name is "Jeff", variations such as "Jeffries", "Jefferson", or "Jeffers" will not be displayed.

  - sort the list by one of the column headings to ease the manual search process,

- once all the claims in which you are interested have been marked, click Submit Claim Status Inquiry,

  - NOTE: No more than 99 Claims may be inquired upon at once.

- a confirmation page will be displayed indicating the number of Claim Status Inquiries you just submitted.

4. Check the Status Responses page to view the results of the Inquiries.

Claim Status Response

Clicking **Status Responses** on the left-hand menu will open the main Claim Status Activity Worklist page. When initially opened, the lower portion of the page is populated with the inquiries that were made within the past 24 hours. However, using the Search Criteria at the top of the page, you may retrieve any subset of all the inquiries in the system for your Provider.

This page is used as the driver for viewing the status of a submitted Claim Status Inquiry. There are two distinct sections contained on this page: the Search Criteria Region which is used to apply filters to the pool of inquiries, and the Inquiry/Response Region which contains the results of the applied filtering.

Claim Status Activity Worklist

Search Criteria Region

This section of the page contains multiple fields that you may use to filter the pool of submitted Claim Status Inquiries. When the page is initially accessed from the menu, inquiries made within the past 24 hours or 1 day is defaulted in order to display the most recent inquiries made. Changing any of the values in the fields and clicking Search will refresh the page with the new list of inquiries displayed in the lower portion.

Requested within the last_____days: Entering a value in this field will limit the returned inquiries to only inquiries made within the specified number of 24 hour periods. For example, if you open this page at 9:00 AM Friday and enter 2 in this field then click Search, the results will display inquiries made in the past 48 hours which translates to inquiries made after 9:00 AM on Wednesday. The value entered in this field must be greater than 0, and will be defaulted to 1. NOTE: this field cannot be used in combination with the "Date Inquiry Sent" field.

Client Last Name: Entering the last name of a client will limit the returned requests to only inquiries made for clients where the last name in the database exactly matches what was typed. For example, to find "JOHN SMITH JR." you would need to enter "SMITH JR." in this search field.

Patient Control Number : Entering the Patient Control Number will limit the returned inquiries to only those where the Patient Control Number exactly matches what was typed. Since this is not a required value when submitting an inquiry, this may not be a useful field to return the desired inquiries.

Client ID : Entering the Client ID will limit the returned inquiries to only inquiries made for that exact value.

Date Inquiry Sent: To retrieve inquiries made on a specific date, enter the date here. The format should be: MM/DD/YYYY or may be selected from a calendar by clicking the calendar drop-down button. NOTE: this field cannot be used in combination with the "Requested within the last_____days" field.

Dates of Service (From/To): Entering both a From and To date will return all inquiries where the services were rendered on or between the From and To date values. Entering solely a From Date will result in a subset of claim inquiries where services were rendered on that date only. The format for each date should be: MM/DD/YYYY or may be selected from a calendar by clicking the calendar drop-down button.

Status: Select one of the available values (Sent, Received, Viewed, Worked) to limit the returned requests. SENT = Request has been sent but no response received from the payer. RECEIVED = Response has been received from the payer but not viewed by the user. VIEWED = Response has been viewed by the user. WORKED = Response has been viewed and any necessary follow-up has been completed.

Show all transactions/Show just my transactions: Selecting "all transactions" will return all Claim Status Inquiries for users of your facility(s). Selecting "just my transactions" will return only the Claim Status Inquiries created by you, the current user.

Inquiry/Response Region

This section of the page contains a table listing the Claim Status Inquiries that match the filtering criteria as defined in the above section. With minimal criteria, this list could become quite lengthy. Therefore, the default displays inquiries made within the past 24 hours. As soon as an Inquiry is submitted, it will be displayed at the top of this list with a Status of 'Sent', as inquiries are displayed in descending order of when they were submitted.

Record 1 of 1

Name	Patient Control #	Client ID	Date Sent	Dates of Service	Status
DOE, JANE	GP TEST	LL12345X	2/8/2005 3:18:44 PM	2/1/2005 - 2/2/2005	Sent
Name	Patient Control #	Client ID	Date Sent	Dates of Service	Status

Record 1 of 1

Name: This value is the Client Name in the following format: "Last Name, First Name Middle Initial". Once a response has been received for an inquiry, the name will be underlined as a hyperlink. Clicking the hyperlink will open the details of that response.

Patient Control #: If the Patient Control Number was entered at the time of the inquiry, it will be displayed here; otherwise, the field will remain blank.

Client ID: The Client ID associated with the Client name for which the inquiry was made.

Date Sent: The date and time when the Inquiry was sent to the Payer.

Dates of Service: Each inquiry must have a range of dates on which services were rendered. If only a From Date was entered, it will be displayed as both ends of the date range. For example, if the inquiry were entered for 8/30/2002, this field would contain "08/30/2002 - 08/30/2002".

Status: SENT = Request has been sent but no response received from the payer. RECEIVED = Response has been received from the payer but not viewed by the user. VIEWED = Response has been viewed by the user. WORKED = Response has been viewed and necessary follow-up has been completed.

Claim Status Response Details

The details of an individual claim which satisfied the inquiry parameters are displayed on this page. It may be accessed directly from the Claim Status Activity Worklist or via the Claim Status Response page. The top portion of the page will contain the ID and the Last Name of the Client. The lower portion of the page, however is visually separated into Claim Level and Line Level sections.

Claim Level Information

The contents of this portion reflect the overall claim, not just this one line of the claim. All lines of a single claim will have identical data in this portion. You may receive up to 10 claim status responses for a single claim inquiry. Clicking the hyperlink of the Payer Claim ID will display the service line information for that Payer Claim ID. The first Payer Claim Id's service line information is initially displayed.

Payer Claim Control #: The payer assigned number used to uniquely identify each claim.

Total Claim Charge Amount: This value represents the total claim charge amount.

Paid Amount: This value represents the total claim payment amount. If the claim has not been finalized for payment or payment has not been authorized, this field will remain blank.

Dates of Service: This date range represents different data elements for different claim types. For Institutional claims, the date range represents the statement period. Similarly, for Professional claims, the range is the Claim From and Through Dates. However, Dental claims have a single Service Date and not a date range.

Status Effective Date: This date represents the effective date for the associated claim status.

Remittance Trace #: The corresponding remittance number.

Remittance Date: The date the remittance was generated.

Claim Level Status: Claim Status and Claim Status Category Codes and descriptions.

Bill Type: This value identifies the type of facility where services were performed.

Patient Control #: This value represents the unique number assigned to this visit. This may be referred to the Patient Account Number in the provider's billing system.

Pharmacy Control #: If a pharmacy control number was entered on the claim, it will display here.

Line Level Status

Line	Status	Service Line Dates	Proc/NDC Code & Mod	Line Charge Amount	Paid Amount	Units	Status Date
1	(F2) - Finalized/Denial-The claim/line has been denied. (91) - Entity not eligible/not approved for dates of service. (DJ) - Consulting Physician (F2) - Finalized/Denial-The claim/line has been denied. (153) - Entity's id number. (DK) - Ordering Physician (F2) - Finalized/Denial-The claim/line has been denied. (486) - Principle Procedure Date(Note: New as of 10/01)	4/20/2011 -4/20/2011	E1340	$75.00	$0.00	1.00	5/9/2011
2	(F2) - Finalized/Denial-The claim/line has been denied. (91) - Entity not eligible/not approved for dates of service. (DJ) - Consulting Physician (F2) - Finalized/Denial-The claim/line has been denied. (153) - Entity's id number. (DK) - Ordering Physician	4/20/2011 -4/20/2011	E2365	$35.00	$0.00	1.00	5/9/2011
3	(F2) - Finalized/Denial-The claim/line has been denied. (91) - Entity not eligible/not approved for dates of service. (DJ) - Consulting Physician (F2) - Finalized/Denial-The claim/line has been denied. (153) - Entity's id number. (DK) - Ordering Physician (F2) - Finalized/Denial-The claim/line has been denied. (84) - Service not authorized.	4/20/2011 -4/20/2011	E2386	$15.00	$0.00	1.00	5/9/2011

Service Line Information

Line: The number uniquely identifying a line on a claim.

Status: The codes and descriptions for the Claim Status and Claim Status Category codes.

Service Line Dates: The date(s) of service for that particular line.

Proc/NDC Code & Mod: The value(s) shown reflect the Procedure Code, National Drug Code and/or Modifiers (up to 4) for that specific line.

Line Charge Amount: The original dollar value submitted by the Provider for this line of the claim.

Paid Amount: If claim/line has been authorized for payment, the dollar value which has been paid by the payer.

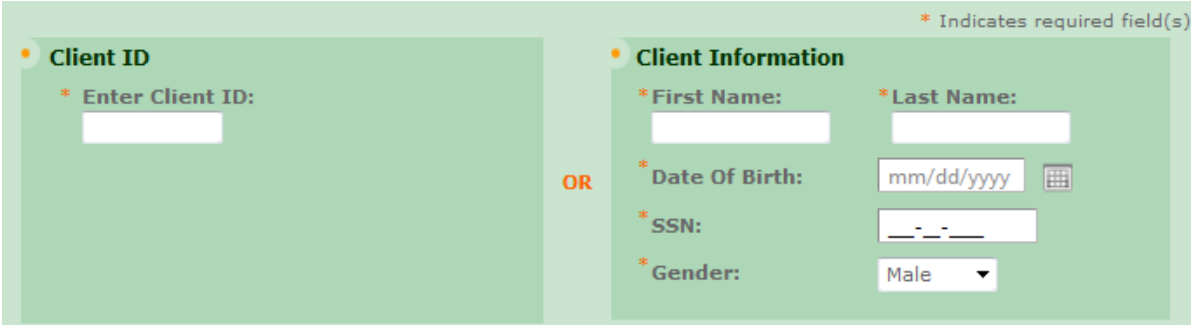
Units: The original submitted units of service.

Status Date: This date represents the effective date for the associated line status.

Once you have reviewed the information displayed on the page, you have two options. You may click the Close button which will set the status of the response to "Viewed" or you may click Worked to mark the response as such, indicating that follow-up has been completed. Both buttons will close the details page and return you to the Claim Status Activity Worklist.

Client Eligibility

Determine Eligibility



Clicking Request in the menu under Eligibility allows you to submit a request for a client's eligibility details. The requests may be submitted for an individual Provider or a Provider Group. Requests are made directly to NY Medicaid and, therefore, Eligibility Responses may be considered real-time transactions.

There are two eligibility request types:

- Client ID—Search using client ID.
- Client Information—Search using client information such as name and Social Security number.

Entering the value for one type of request locks out the other request type until either a search is performed or the initial entry field is cleared. For example, entering a value in the Client ID field locks out the Client Information fields. This prevents submitting both sets of request criteria for a single search.

Regardless of the specific eligibility request used, the Date of Service must always be specified. There is also the option to specify the Ordering or Referring Provider NPI, and one or more Service Types to narrow the results

Client ID Eligibility Request

Client ID Eligibility Requests are the simplest of the two requests because they require only one field.

Enter Client ID: The Client ID of the individual.

Client Information Eligibility Request

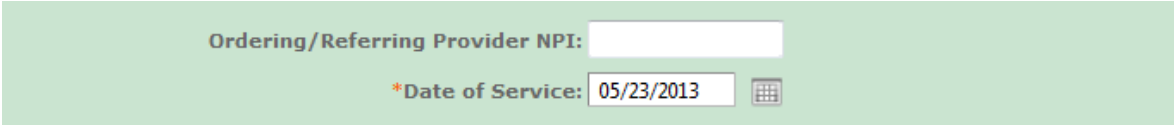
Client Information Eligibility Requests are used when the Client ID is not available. All five fields are required.

Last Name/First Name: Enter the client's full name as only complete matches will be successfully processed. Valid values are: A–Z, hyphen (-), period (.), and apostrophe (').

Date of Birth: The Date of Birth entry format is mm/dd/yyyy and may be directly specified or selected using the Calendar control to the right of the field.

Gender: Select Male or Female from the drop-down.

SSN: The Social Security number field is set up to match the standard format of three digits, hypen, two digits, hyphen, four digits (xxx-xx-xxxx) to aid in entering the value.



Required Information

The Date of Service field must always be specified.

Date of Service: The date of service defaults to the current date, but may be changed. However, the date entered may not be in the future nor be greater than 2 years prior to the current date. The accepted entry format is mm/dd/yyyy and may be directly specified or selected using the Calendar control to the right of the field.

Optional Information

The Ordering/Referring Provider NPI and Service Types fields may be optionally specified.

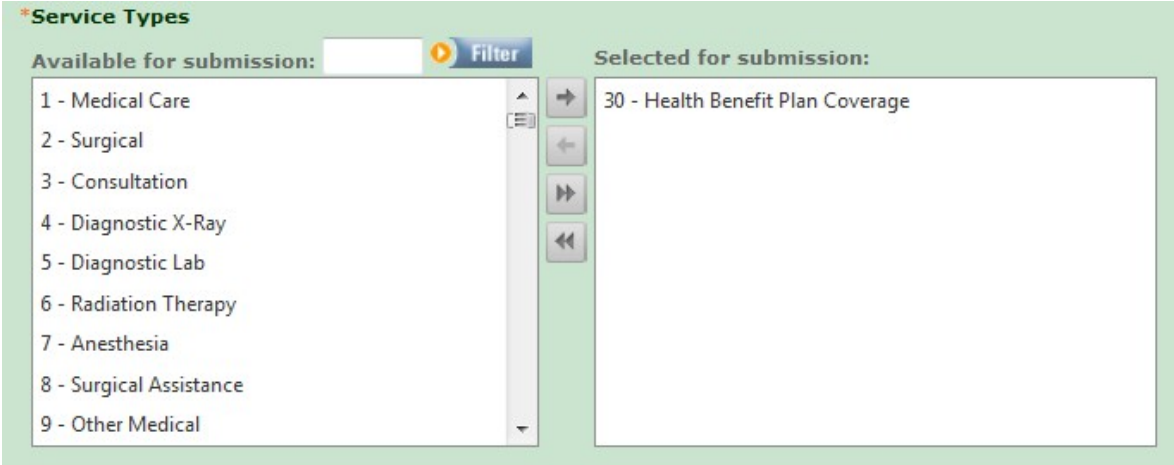
Ordering Provider NPI: The 10-digit National Provider ID.

Service Types: The applicable Service Type(s) selected from the full list of service types. If no Service Type is specified, the default value of 30 - Health Benefit Plan Coverage is used.

Service Types

Services Types are specified using the Services Types control. The control consists of two lists—*Available for Submission* and *Selected for Submission*—separated by arrow buttons for moving the types between the two lists. The single arrows move one or more types; the double arrow buttons move all members of a list.

Moving a Service Type to the Selected list makes it an addtional field that must be matched for the eligibility request.



Selecting and Removing Service Types for Submission

Services Types can be selected individually for submission by clicking on a type in the Available list and using the right pointing arrow button. The reverse for removing a service type is done by selecting the service type from the Selected list and using the left facing arrow button.

Multiple types can be selected continuously using the Shift key while clicking the types to select an inclusive range or discontinuously using the Ctrl key to select individual types that will moved together.

The Filter function allows the Available types to be limited by entering a value that must appear in a type's description. Only types containing that value will be displayed for selection. For example, entering medi limits the displayed types to those containing medi such as *1 - Medical Care* and *55 - Major Medical*.

Submission and Results

Clicking Submit at the bottom of the page transmits the selected Eligibility Request fields along with any of the optional fields to the NY Medicaid system. A message Request has been submitted. displays above the request fields to indicate the request is complete. Once submitted, the fields are cleared to allow for another request.

The result of the request is available by clicking Responses in the menu under Eligibility.

Eligibility Activity Worklist

You may view the list of Eligibility Activity Worklist by clicking Eligibility Responses on the left menu. This page has two sections the top contains the Search Criteria which you enter to filter the pool of all Eligibility Requests in the system, and the lower portion is the filtered list of Responses. The results may be sorted based on any of the columns by clicking the header of the column.

Search Criteria Region

This section of the page contains multiple fields that you may use to filter the pool of Eligibility Requests. When the page is initially accessed from the menu, inquiries made within the past 24 hours or 1 day is defaulted in order to display the most recent inquiries made. Changing any of the values in the fields and clicking Search will refresh the page with the new list of requests displayed in the lower portion.

Requested within the last_____days: Entering a value in this field will limit the returned requests to only requests made within the specified number of 24 hour periods. For example, if you open this page at 9:00 AM Friday and enter 2 in this field then click Search, the results will display requests made in the past 48 hours which translates to requests made after 9:00 AM on Wednesday. The value entered in this field must be greater than 0. NOTE: this field cannot be used in combination with the "Date Sent" field.

Client Last Name: Entering the last name of a client will limit the returned requests to only inquiries made for clients where the last name in the database exactly matches what was typed. For example, to find "JOHN SMITH JR." you would need to enter "SMITH JR." in this search field.

Client ID : Entering the Medicaid Client ID will limit the returned requests to only those made for that exact value.

From Date / To Date: To retrieve requests made during a range of dates, enter the beginning and ending date of the range. The entry format is mm/dd/yyyy and may be directly specified or selected using the Calendar control to the right of the fields. NOTE: This field cannot be used in combination with the "Requested within the last_____days" field..

Show Just my Transactions / All Tranasctions for this provider: Selecting Show just my transactions returns only the Eligibility Requests created by the current user. Selecting Show all Transactions for this provider returns all Eligibility Requests for users of your facility(s).

Response Region

Responses: Records 1-3 of 3

Client ID	Name	Date Submitted
ZZ99999A	PATIENS, NONO	5/22/2013
ZZ99999R	MCPATIENS, ANO N	5/22/2013
ZZ99999G	DIPATIENS, UNKN	5/22/2013

Page size: 10 Page: 1 of 1 1

This section of the page contains a table listing the Eligibility Requests that match the filtering criteria as defined in the above section. With minimal criteria, this list could become quite lengthy which is why there is a default of displaying requests made within the past 72 hours. As soon as a Request is submitted, it will be displayed at the top of this list, as requests are displayed in descending order of when they were submitted.

Client ID: The Medicaid Client ID for an Eligibility Request by Client ID. If an Eligibility Request by Name Search was submitted, the word "Details" will appear in place of a Client ID. Once a response has been received for this request, the ID or "Details" will be underlined as a hyperlink to open the Eligibility Response Details page.

Name: This value is the Client Name in the following format: "LastName, FirstName MiddleInitial". The Client Name will only be displayed if an Eligibility Request by Name Search is submitted.

Date Submitted: The date and time when the Request was sent to NY Medicaid.

Paging Controls: The paging controls allow the number of displayed results to be set (10–50 by 10s using the Page size drop-down) and also allow navigation sequentially or directly among the results pages.

NOTE: A transaction which has somehow failed in the transmission to eMedNY will be marked with a Status of *Retry*, and will not have a hyperlinked response. If this is the case, you must resubmit the Eligibility Request.

Review Eligibility Details

The Eligibility Response Details page contains the information that was received from NY Medicaid. The amount of information contained in the response is dependent on the specific plan in which the client is enrolled.

The information presented is divided into sections. Any or all of these sections may be blank depending upon the level of information supplied by NY Medicaid.

Client Information - Includes the Client ID, Client Name, Address, Date of Birth and Gender to assist in ensuring Eligibility was requested for the proper individual. Additional information displayed includes SSN, Anniversary Date, Plan Date and Recertification month.

Client Information:

Client ID:	ZZ99999G	**Client Name:**	DIPATIENS, UNKN
Gender:	F	**SSN:**	
Date of Birth:	1/23/1818	**Address 1:**	1138 AVENUE L
Anniversary Date:	03/2/2012	**Address 2:**	
Recertification:	May	**City, State Zip:**	XILTON, NY 15598
County:	Possum	**Office:**	
Date of Service:	3/11/2013	**Plan Date:**	3/1/2013

Medicaid Eligibility Information - The client's status with NY Medicaid for the Date of Service submitted along with Plan Date and Co-pay Remaining. Covered Services and Non-Covered Services are listed in side-by-side tables. Refer to the MEVS manual for guidance on interpreting service type information.

Medicaid Eligibility Information:

Eligible Except Nursing Facility Services

Co-pay Remaining: $0.00

Covered Services

Code	Description
AL	Vision (Optometry)
MH	Mental Health
UC	Urgent Care
1	Medical Care
35	Dental Care
47	Hospital
48	Hospital - Inpatient
50	Hospital - Outpatient
86	Emergency Services
88	Pharmacy
98	Professional (Physician) Visit - Office

Non-Covered Services

Code	Description
54	Long Term Care

Medicare Information - The Payer Name and Medicare Identifier will be returned.

Medicare Information:

Other Payer Name: MEDICARE BD
Medicare Identifier: XXXXXXXXXXXX

Third Party Insurance - Up to nine third party insurance policies can be returned. For each policy, the following will be returned (if available): Other Payer Name, Carrier Code, Other Payer Address, Phone Number, Policy Number and Group Number.

Third Party Insurance:

Other Payer Name:	UNITED HEALTH CARE
Carrier Code:	F7
Other Payer Address:	PO BOX 740800 ATLANTA , GA 30374-0800
Phone Number:	(800) 705-1691
Policy Number:	314159265
Group Number:	27182

Medicaid Managed Care: The Name, Address, Phone Number and Plan Code will be returned for the Managed Care Plan when the Medicaid Eligibility Information displays Eligible PCP.

Family Health Plus: The Name, Address, Phone Number and Plan Code of the Family Health Plus participating Managed Care Plan will be returned when the Medicaid Eligibility Information displays Family Health Plus.

Once you have reviewed the information displayed on the page, you may click the Close button which sets the status of the response to *Viewed*, closes the Details page and returns to the Eligibility Activity Worklist.

PA / DVS

PA / DVS Request

A DVS Request may be submitted by either an individual Provider or a Provider Group. If submitted for a Group, the ID must be entered on the claim which applies to the request. A Prior Approval (non-DVS) request must be submitted under an individual provider.

Submitting Requests-Single and Repeated (DVS Only)

DVS Requests have two submission functions:

- **Submit** for single submissions for different clients
- **Enter Another DVS For This Client** for repeated submissions for the same client

Repeated submissions retain the client's information in between submissions.

> **NOTE:** The Enter Another DVS For This Client function is only available for DVS transaction types (Dental - DVS and Non Dental - DVS).

Single Requests

Single requests use the Submit button. The function submits the request and clears the entire request form in preparation for submitting a new request for a different client.

Use the Submit button when the next request is for a different client.

Repeated Requests

Repeated requests use the Enter Another DVS For This Client button. The function submits the request, but clears only the service information leaving the client information intact in preparation for submitting another request for the same client. Requests may continue being submitted for the same client for each use of the button.

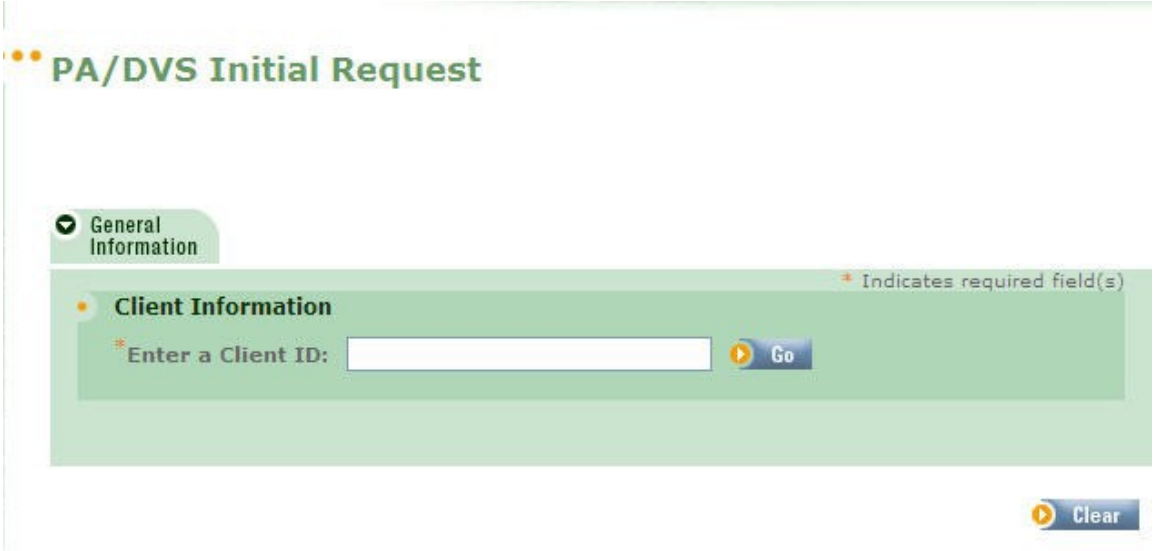
Use the Enter Another DVS For This Client button when the next request is for the same client.

Ending Repeated Requests

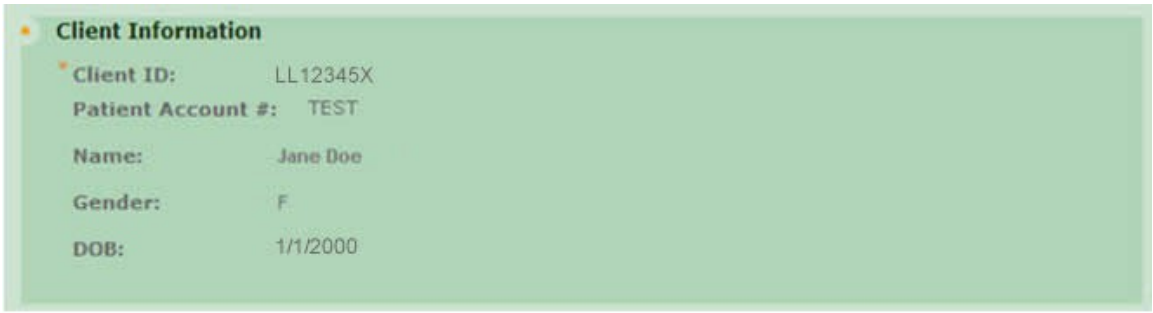
Repeated requests are ended by using the Submit button instead of the Enter Another DVS For This Client button. Using the Submit button submits the request and clears the entire form so that a new request may be made for a different client.

Data For DVS and Non-DVS Requests

A Prior Approval (non-DVS) request must be submitted under an individual provider. The following data may be entered when generating a DVS or Non-DVS request.



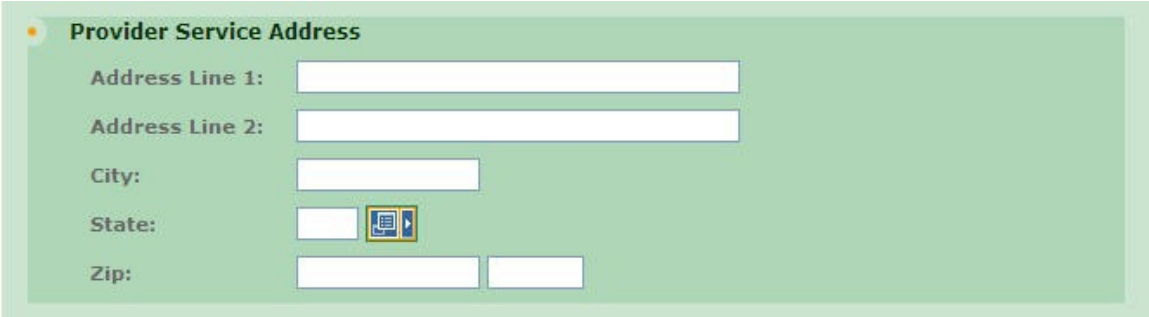
Enter the desired Client ID and click Go, this will return the associated Client information below the prompt. The client's full name, gender, and birth date will be displayed as confirmation that the correct ID was entered. If this is not the desired client, re-enter the ID and search again.



Patient Control #: Individual Patient Control Numbers are usually assigned to each visit a client makes to a provider. This may also be referred to as the Patient Account Number in the provider's billing system.

Transaction Type

Transaction Type: Select the appropriate transaction type from the drop down. The following options are available Dental -DVS; Dental - Non DVS; Non Dental - DVS; or Non Dental - Non DVS.



Provider Service Address

Address Line 1/line 2: Address Line 1/line 2: The street and, optionally, building name in the provider's service address.

City: The city or town name in the provider's address.

State: The state name in the provider's address.

Zip: Enter the postal code (Zip + 4) associated with the provider's service address being entered.

Contact Information

Contact Name: An optional name, normally identifying clerical or technical staff.

Telephone: The contact's telephone number.

Ext: The contact's extension number.

E-Mail: The contact's e-mail address.

Fax #: The contact's fax number.

Referring Provider

Use an Existing Provider

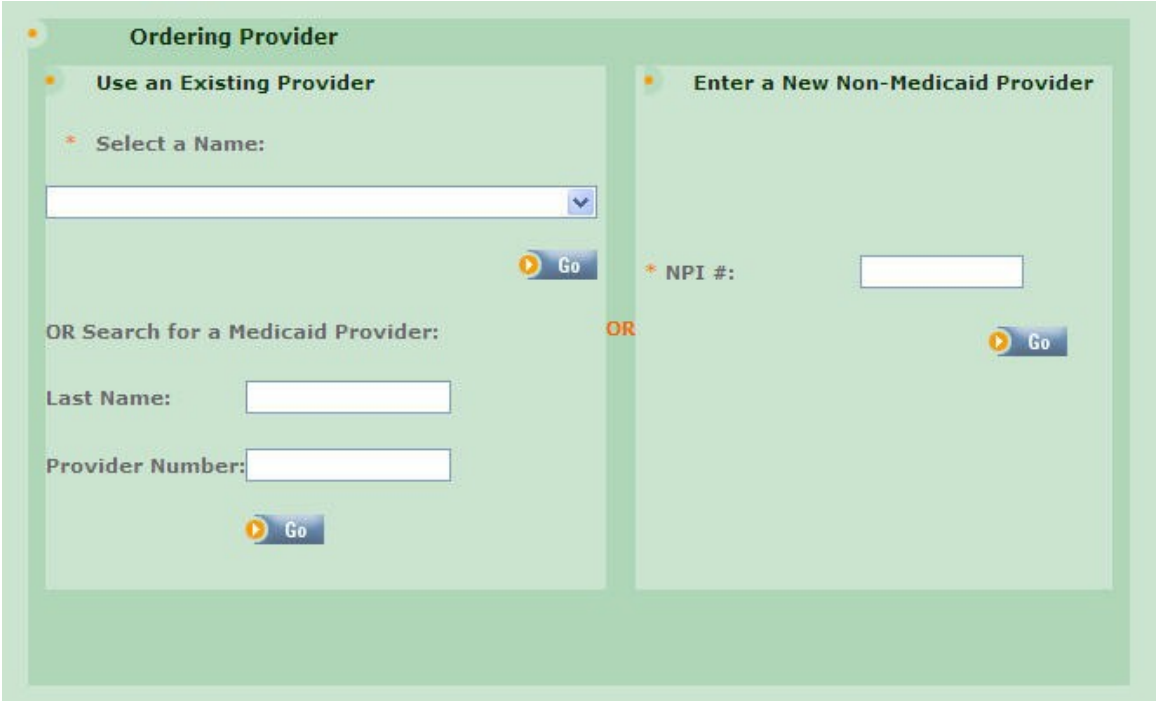
Select a Name: From the available drop-down list, select a name of a previously used provider available in the support file to indicate a Referring provider.

Last Name: Enter a Last Name to search for an existing Medicaid provider. This will return a list of providers that match the search criteria. Click the radio button for the desired provider.

Provider Number: Enter the provider number to search for an existing Medicaid provider.

Enter a New Non-Medicaid Provider

NPI #: Enter the NPI to indicate a New Non-Medicaid provider that is not listed as an option in the Select a Name drop down.



Ordering Provider

Use an Existing Provider

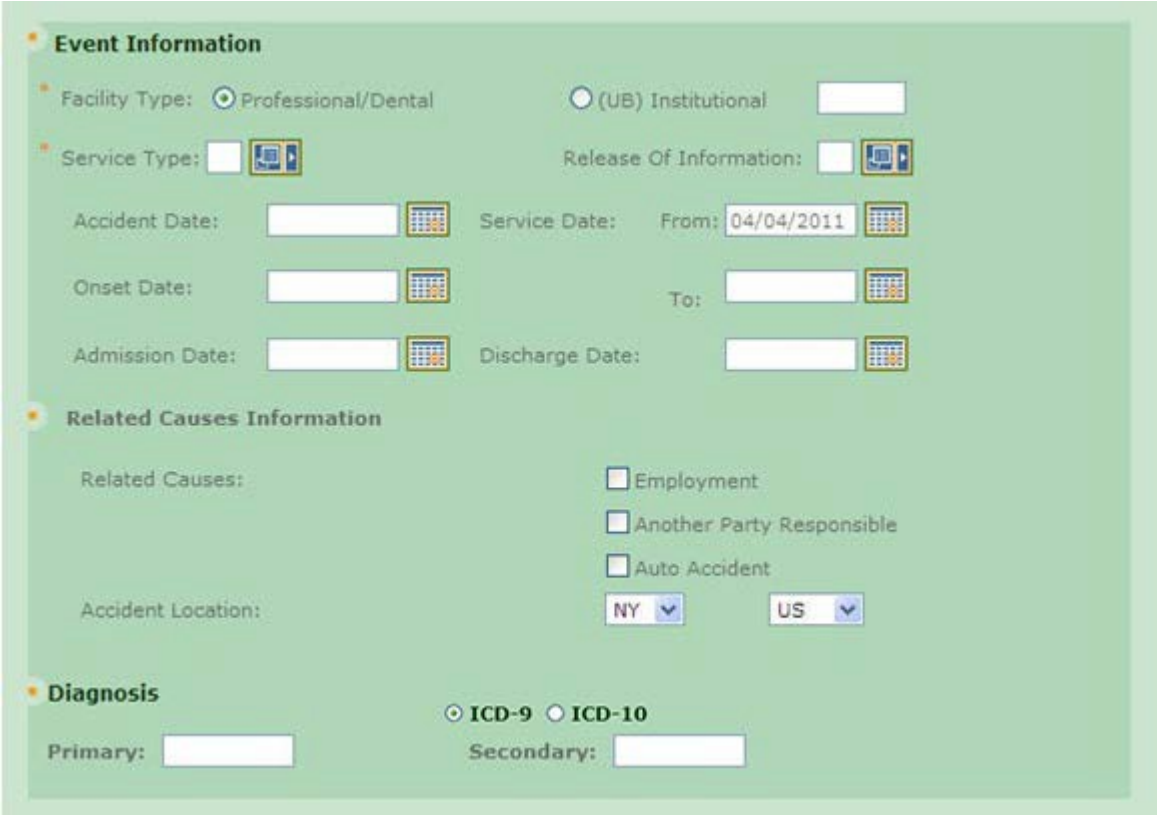
Select a Name: From the available drop-down list, select a name of a previously used provider available in the support file to indicate an Ordering provider.

Last Name: Enter a Last Name to search for an existing Medicaid provider. This will return a list of providers that match the search criteria. Click the radio button for the desired provider.

Provider Number: Enter the provider number to search for an existing Medicaid provider.

Enter a New Non-Medicaid Provider

NPI #: Enter the NPI to indicate a New Non-Medicaid provider that is not listed as an option in the Select a Name drop down.



Event Information

Facility Type: Select appropriate Facility Type radio button of either Professional/Dental or (UB) Institutional.

Service Type: Enter the appropriate service type for what service you are getting a PA/DVS for. Please pick an option from the list.

Release of Information: Pick the appropriate option to indicate whether the provider has on file a signed statement by the patient authorizing the release of medical data to other organizations.

Accident Date: If any of the Related Causes boxes will be checked, the date of the accident must be entered. The date may not be greater than the current date. The format of the date is: MM/DD/YYYY and may either be entered in the field or selected from the calendar available by pressing the button to the right of the field.

Service Date From: Enter proposed or actual begin date of service.

Service Date To: Service Date To: Enter proposed or actual end date of service.

Onset Date: If the onset date differs from the date of service, enter the date here. The date may not be greater than the current date.

Admission Date: If applicable, enter the date of admission.

Discharge Date: If applicable, enter the date of discharge.

Related Causes Information

Related Causes: You may select up to three related causes for this claim. If one or more of the options applies to the situation, mark the appropriate check box(es) and enter the Accident Date.

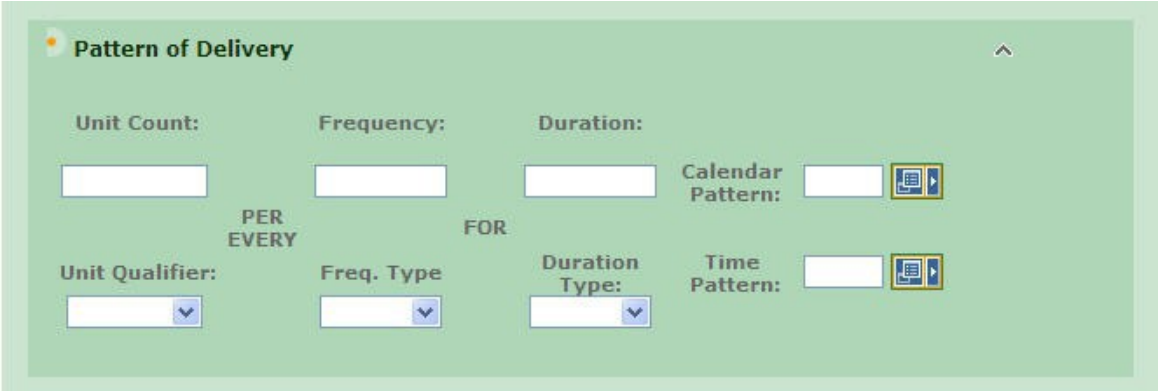
Accident Location: If Auto Accident is selected as a Related Cause, enter the state and country in which the accident occurred, 'NY' and 'USA' are the corresponding default values.

Diagnosis

ICD-9 / ICD-10: Select the appropriate code type for the diagnosis.

Primary: Enter the Primary Diagnosis code.

Secondary: Enter the Secondary Diagnosis code.



Pattern of Delivery

*** Private Duty Nursing (PDN) providers should not enter any information in these fields. Entering information in these fields prohibits the ability to make future adjustments to the prior approval.**

The Pattern of Delivery section contains fields used to define units of service to be provided over specific periods of time. The following fields are provided:

Unit Count: These fields include a units value on the top and a type field on the bottom. The type field is a drop-down that allows you to choose either Days, Units, Hours, Month, or Visits.

Frequency: These fields include a frequency value on the top and a frequency type field on the bottom. The type field is a drop-down that allows you to choose either Days, Months, or Weeks.

Duration: These fields include a duration value on the top and a duration type field on the bottom. The type field is a drop-down that allows you to choose either Hour, Day, Years, Episode, Visit, Month, Week.

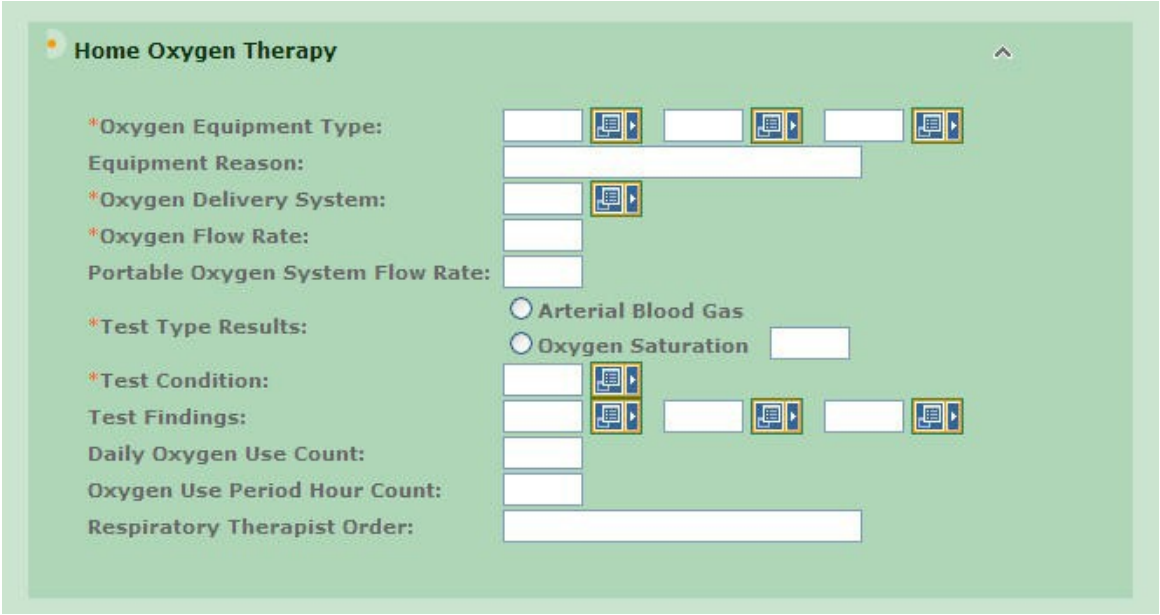
Calendar Pattern: This field establishes the frequency (e.g., 1st Week of the Month) that the requested service is to be rendered as it relates to calendar days/weeks.

Unit Qualifier: This field is a drop-down that allows you to choose either Days, Units, Hours, Month, or Visits.

Freq. Type: This field is a drop-down that allows you to choose either Days, Months, or Weeks.

Duration Type: This field is a drop-down that allows you to choose either Hour, Day, Years, Episode, Visit, Month, Week.

Time Pattern: This field establishes the time (e.g., 2nd Shift) that the requested service is to be rendered.



Home Oxygen Therapy

Oxygen Equipment type: These fields allow you to identify the requested equipment type. You must populate at least one of these fields using the adjacent pop-up.

Equipment Reason: Allows you to enter optional free form text that justifies the use of the equipment.

Oxygen Delivery System: This required field can only be populated by the associated pop-up and identifies the method of oxygen delivery.

Oxygen Flow Rate: This required field specifies a patient's oxygen flow rate in liters per hour.

Portable Oxygen System Flow Rate: This optional field specifies a device's oxygen flow rate in liters per hour.

Test Type Results: These required fields include a radio button set that establishes the test type and a text field used to record the test results.

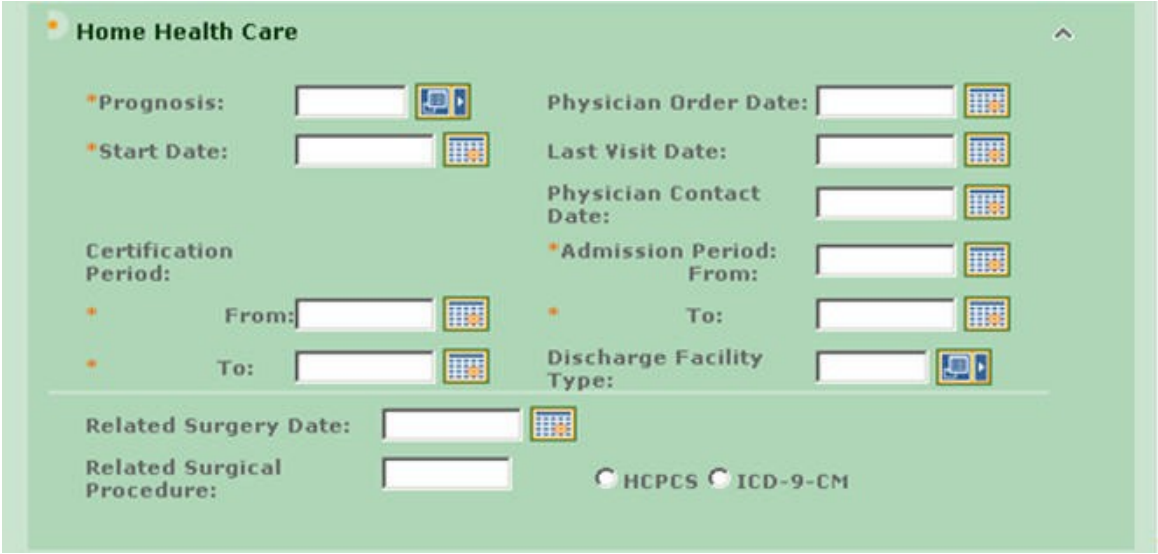
Test Condition: These fields allow you to identify the condition in which the test was administered. At least one of these fields must be populated using the associated popup.

Test Findings: These fields allow you to identify the test findings. At least one of these fields must be populated using the associated pop-up.

Daily Oxygen Use count: The number of times per day a patient must use oxygen.

Oxygen Use Period Hour Count: The number of hours in a period of oxygen use.

Respiratory Therapist Order: Optional free form text describing treatment to be provided by the respiratory therapist.



Home Health Care

Prognosis: This field captures the patient's prognosis (Good, Fair, etc.) and can be populated by the associated pop-up.

Physician Order Date: The date that a physician ordered the home health care.

Start Date: The date that the home health care is to begin.

Last Visit Date: The date that the physician last saw the patient.

Physician Contact Date: The date that contact was last made with the physician.

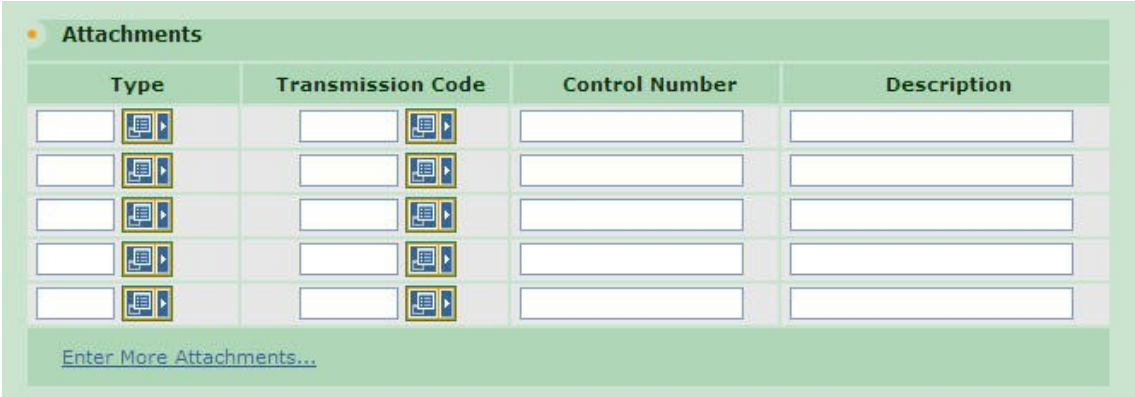
Certification Period From / To: These From and To dates establish the period within which the home health care is certified.

Admission Period From / To: These From and To dates establish admission and discharge dates, if any, from a facility prior to start of home health care.

Discharge Facility Type: The type of facility (e.g., Acute Care Facility) from which the patient was or will be discharged prior to the home health care.

Related Surgery Date: The date of a surgery, if any, related to the home health care.

Related Surgical Procedure: These radio buttons and related text field capture whether the procedure is an HCPCS or an ICD-9-CM or an ICD-10-CM procedure and the procedure code, respectively.



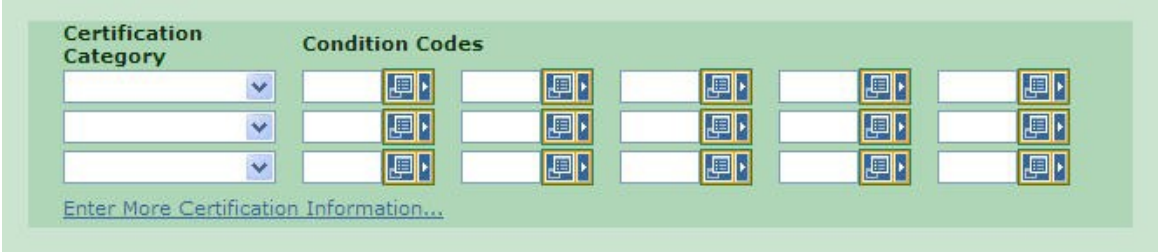
Attachments

Type: This field can only be populated by the associated pop-up and identifies the type of attachment.

Transmission Code: This field can only be populated by the associated pop-up and identifies the method by which the attachment will be transmitted to eMedNY.

Control Number: This field identifies the attachment's control number in your records. It is an internal number that is for the provider's office use only and does not correspond to the subsequent PA number issued by NYS Medicaid.

Description: This field describes the attachment.

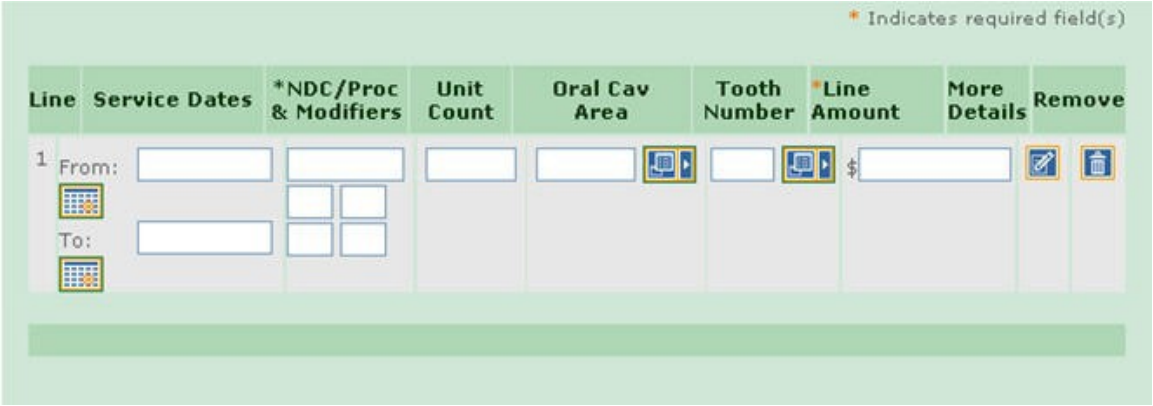


Certification Category: This field is required if when health care services review is requesting Ambulance Certification, Chiropractic Certification, Durable Medical Equipment, Oxygen Therapy, Functional Limitations, Activities Permitted or Mental Status when relevant to review.

Condition Codes: If entering a certification category, select the appropriate condition code in the list.

Comments: Allows you to enter free form text that clarifies the request.

Once all the necessary information has been entered, click the "next" button.



Prior Approval Items (Dental)

Line: This is a system generated value to uniquely identify the Service Line on the claim. The counter will start with 1 and increment with each new Service Line entered. A minimum of 1 Service Line is required on all claims. Note: If requesting a DVS, only one line will display. If requesting a Non DVS, 5 lines will display.

Service Dates: If requesting a procedure/service on a single date, enter this date in the From Date. However, if the procedure/service will transpire over a period of time, enter the start and end dates in the From and To fields respectively. The date(s) may not be greater than the current date. The format is: MM/DD/YYYY and may either be entered in the field or selected from the calendar available by pressing the button to the right of the field. At a minimum, a From Date is required for all Service Lines.

NDC/Proc & Modifiers: Enter the Health Care Financing Administration Common Procedural Coding System identifier(or National Drug Code) for the product/service. This code value is required. Optionally, up to 4 modifiers identifying special circumstances related to the performance of the service may be entered for each code. Note: If entered, the Modifier must be a 2 character code.

Unit Count: Enter the service quantity in this field.

Oral Cav Area: A two-digit code may be entered or selected to identify the area of the oral cavity in which the indicated service is rendered. Additional codes may be entered by clicking the More icon.

Tooth Number: Enter or select the tooth number/code for the tooth related to this service. If multiple teeth are affected by the procedure, additional Tooth Numbers may be entered by clicking the More icon. A Tooth Number may not be repeated on a single line.

Line Amount: The submitted charge amount for this procedure/service must be entered. Note: Zero dollars is a valid charge amount.

More Details: For each Prior Approval Item Line, you may view/enter additional details by clicking the More icon. However you may only view these additional details once all required elements have been entered. Navigating off this summary page, either by clicking the More icon or moving to another tab, will trigger validation of the data entered on this page. Validation is done one line at a time, so if there are errors on multiple lines you will have to fix each line before seeing the next set of errors.

Remove: If a Prior Approval Line must be removed for any reason, clicking the Delete icon will remove the line and re-sequence the remaining Prior Approval Lines.

* Indicates required field(s)

More Details - PA Item #1

Close Clear

Line	Service Dates	*NDC/Proc & Modifiers	Unit Count	*Line Amount
1	From: 06/01/2011 To:	D5220	1.000	$500.00

Oral Cavity Areas

Tooth Information

Tooth Number	Tooth Surface Codes	Tooth Number	Tooth Surface Codes
	O M B L I F D		O M B L I F D
	O M B L I F D		O M B L I F D
	O M B L I F D		O M B L I F D
	O M B L I F D		O M B L I F D
	O M B L I F D		O M B L I F D
	O M B L I F D		O M B L I F D
	O M B L I F D		O M B L I F D
	O M B L I F D		O M B L I F D

Enter Another

Attachments

Copy attachments from Line

Type	Transmission Code	Control Number	Description

Enter more Attachments

Comments

Copy comments from Line

More Details (Dental)

The top of the screen will display information on what service line more button you are on. This includes: Line Number, Service Dates, NDC/Proc & Modifiers, Unit Count, and Line Amount that was enter on the Prior Approval Items line.

Oral Cavity Areas: A two-digit code may be entered or selected to identify the area of the oral cavity in which the indicated service is rendered.

Tooth Information: Tooth Number/Tooth Surface Codes: A single Tooth Number and associated Surface Code may be entered/viewed on the main Service Line Summary page; you may add/view a maximum of 32 Tooth Number/Surface Code combinations, however a Tooth Number may not be repeated on an individual Service Line. If a Tooth Number or Surface Information was entered on the Prior Approval Items page, the values will default to the first corresponding field on this page.

Attachments: This group allows you to apply attachments to the line. The Enter More Attachments link allows for the entry of 5 additional attachment fields.

Copy Attachments from line: If you want to copy attachments from a previous line, enter the line number here.

Type: This field may be populated by using the associated pop-up and identifies the type of attachment.

Transmission Code: This field may be populated by using the associated pop-up and identifies the method by which the attachment will be transmitted or sent to eMedNY.

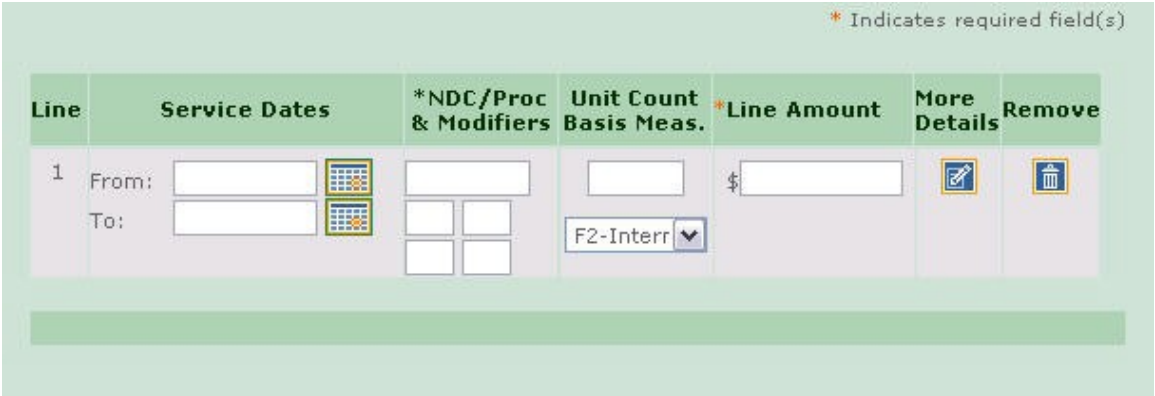
Control Number: This field identifies the attachment's control number in your records. It is an internal number that is for the provider's office use only and does not correspond to the subsequent PA number issued by NYS Medicaid.

Description: This field describes the attachment.

Copy Comments from line: If you want to copy comments from a previous line, enter the line number here.

Comments: The Comments field allows you to enter free form text that clarifies the request. You may copy comments into the current line from another line in the current PA.

Close: After you have completed the additional items for the current line, choose Close to save the information and return to the previous page. If you wish to abandon the additional items for the current line, choose Clear and you will return to the previous page.



Prior Approval Items (Non-Dental)

Line: This is a system generated value to uniquely identify the Service Line on the claim. The counter will start with 1 and increment with each new Service Line entered. A minimum of 1 Service Line is required on all claims. Note: If requesting a DVS, only one line will display. If requesting a Non DVS, 5 lines will display.

Service Dates: If requesting a procedure/service on a single date, enter this date in the From Date. However, if the procedure/service will transpire over a period of time, enter the start and end dates in the From and To fields respectively. The date(s) may not be greater than the current date. The format is: MM/DD/YYYY and may either be entered in the field or selected from the calendar available by pressing the button to the right of the field. At a minimum, a From Date is required for all Service Lines.

NDC/Proc & Modifiers: Enter the Health Care Financing Administration Common Procedural Coding System identifier(or National Drug Code) for the product/service. This code value is required. Optionally, up to 4 modifiers identifying special circumstances related to the performance of the service may be entered for each code. Note: If entered, the Modifier must be a 2 character code.

Unit Count Basis Meas.: Enter the service quantity in this field.

Line Amount: The submitted charge amount for this procedure/service must be entered. Note: Zero dollars is a valid charge amount.

More Details: For each Prior Approval Item Line, you may view/enter additional details by clicking the More icon. However you may only view these additional details once all required elements have been entered. Navigating off this summary page, either by clicking the More icon or moving to another tab, will trigger validation of the data entered on this page. Validation is done one line at a time, so if there are errors on multiple lines you will have to fix each line before seeing the next set of errors.

Remove: If a Prior Approval Line must be removed for any reason, clicking the Delete icon will remove the line and re-sequence the remaining Prior Approval Lines.

* Indicates required field(s)

More Details - Item #1

Close Clear

Line	Service Dates	*NDC/Proc & Modifiers	Unit Count Basis Meas.	*Line Amount
1	From: 06/01/2011 To: 09/01/2011	S9124	1.000 UN-Unit	$20000.00

DX Pointer

Pattern of Delivery

Unit Count:	Frequency:	Duration:	Calendar Pattern:
			Time Pattern:

Health Care Services Review Information

Facility Type Code: Professional/Dental UB(Institutional)

Attachments

Copy attachments from Line

Type	Transmission Code	Control Number	Description

Enter more Attachments

Comments

Copy comments from Line

More Details (Non-Dental)

The top of the screen will display information on what service line more button you are on. This includes: Line Number, Service Dates, NDC/Proc & Modifiers, Unit Count, and Line Amount that was enter on the Prior Approval Items line.

DX Pointer: Enter the applicable DX pointer

Pattern of Delivery

*** Private Duty Nursing (PDN) providers should not enter any information in these fields. Entering information in these fields prohibits the ability to make future adjustments to the prior approval.**

Unit Count: These fields include a units value on the top and a type field on the bottom. The type field is a drop-down that allows you to choose either Days, Units, Hours, Month, or Visits.

Frequency: These fields include a frequency value on the top and a frequency type field on the bottom. The type field is a drop-down that allows you to choose either Days, Months, or Weeks.

Duration: These fields include a duration value on the top and a duration type field on the bottom. The type field is a drop-down that allows you to choose either Hour, Day, Years, Episode, Visit, Month, Week.

Calendar Pattern: This field establishes the frequency (e.g., 1st Week of the Month) that the requested service is to be rendered as it relates to calendar days/weeks.

Time pattern: This field establishes the time (e.g., 2nd Shift) that the requested service is to be rendered.

Facility Type Code: Select appropriate Facility Type radio button of either Professional/Dental or (UB) Institutional.

Attachments: This group allows you to apply attachments to the line. The Enter More Attachments link allows for the entry of 5 additional attachment fields.

Copy Attachments from line: If you want to copy attachments from a previous line, enter the line number here.

Type: This field may be populated by using the associated pop-up and identifies the type of attachment.

Transmission Code: This field may be populated by using the associated pop-up and identifies the method by which the attachment will be transmitted or sent to eMedNY.

Control Number: This field identifies the attachment's control number in your records. It is an internal number that is for the provider's office use only and does not correspond to the subsequent PA number issued by NYS Medicaid.

Description: This field describes the attachment.

Copy Comments from line: If you want to copy comments from a previous line, enter the line number here.

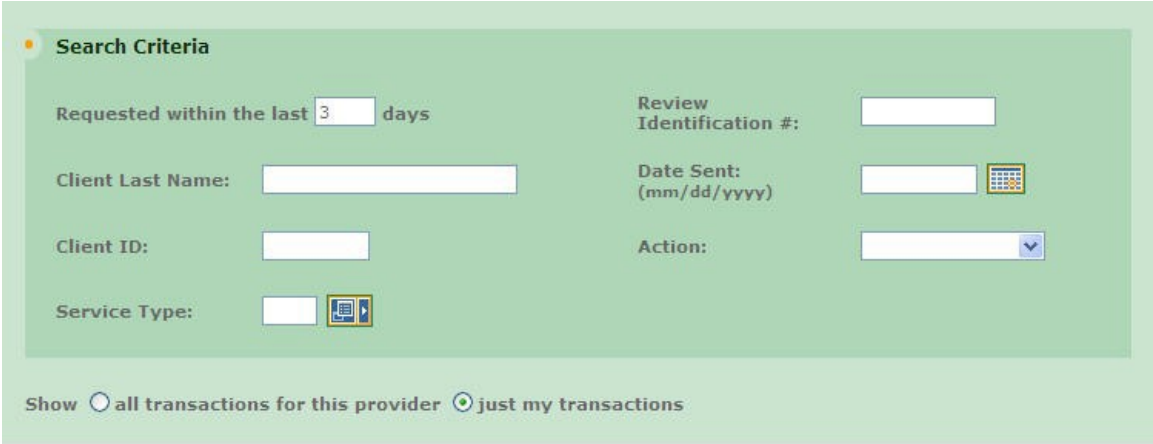
Comments: The Comments field allows you to enter free form text that clarifies the request. You may copy comments into the current line from another line in the current PA.

Close: After you have completed the additional items for the current line, choose Close to save the information and return to the previous page. If you wish to abandon the additional items for the current line, choose Clear and you will return to the previous page.

PA/DVS Activity Worklist

You may view the list of PA DVS Requests by clicking Responses under PA DVS on the left-hand menu. This page has two sections, the top contains the Search Criteria which you enter to filter the pool of all PA DVS Requests in the system. The lower portion is the filtered list of PA DVS Requests/Responses. The results may be sorted based on any of the columns by clicking the arrow located in the header of the column.

Search Criteria Region



This section of the page contains multiple fields that you may use to filter the pool of submitted PA DVS Requests. When the page is initially accessed from the menu, requests made within the past 3 days are defaulted to display the most recent requests made. Changing any of the values in the fields and clicking Search will refresh the page with the new list of inquiries displayed in the lower portion.

Requested within the last_____days: Requested with in the Last_ Days: Entering a value in this field will limit the displayed requests to only requests made within the specified number of 24 hour periods. For example, if you open this page at 9:00 AM Friday and enter 2 in this field then click Search, the results will display requests made in the past 48 hours which translates to requests made after 9:00 AM on Wednesday in this example. The value entered in this field must be greater than 0, and will be defaulted to 3. NOTE: this field cannot be used in combination with the "Date Sent" field.

Client Last Name: Entering the last name of a client will limit the returned requests to only inquiries made for clients where the last name in the database exactly matches what was typed. For example, to find "JOHN SMITH JR." you would need to enter "SMITH JR." in this search field.

Client ID : Entering the Client ID will limit the returned requests to only requests made for that exact value.

Service Type: Enter the service type using the associated pop-up.

Review Identification #: The PA DVS number assigned will display here.

Date Sent: To retrieve requests made on a specific date, enter the date here. The format should be: MM/DD/YYYY or may be selected from a calendar by clicking the calendar drop-down button. NOTE: this field cannot be used in combination with the "Requested within the last_____days" field.

Result: Action: Enter or select a desired code by which to filter the PA DVS Requests to be displayed. The provided list will include all valid Action codes.

Show all transactions/Show just my transactions: Selecting "all transactions" will return all PA DVS Confirmation Requests made by users of your facility(s). Selecting "just my transactions" will return only the PA DVS Confirmation Requests created by you, the current user.

Request / Response Region

Records 1-2 of 2

Client ID	Name	Date Sent	Service Type	Review ID Number	Action	Response Descriptive Text	Image Upload
LL12345X		5/3/2011 9:26:42 AM	5	DOE, JANE	A3	Not Certified	
LL23456X		5/4/2011 11:23:41 AM	35	DOE, JOHN	C	95-Patient Not Eligible	

Client ID	Name	Date Sent	Service Type	Review ID Number	Action	Response Descriptive Text	Image Upload

This section of the page contains a table listing the PA DVS Confirmation Requests that match the filtering criteria as defined in the above section. With minimal criteria, this list could become quite lengthy which is why there is a default of displaying requests made within the past 3 days. As soon as a Request is submitted, it will be displayed at the top of this list as requests are displayed in descending order of when they were submitted.

Client ID: The Client ID for which the request was made. Once a response has been received for a request, the Client ID will become a hyperlink. Clicking the hyperlink will open the details of that response.

Name: This value is the Client Name in the following format: "LastName, FirstName MiddleInitial".

Date Sent: The date when the Request was sent to NY Medicaid. The format will be: MM/DD/YYYY.

Service Type: The service type selected will display here.

Reviewer ID Number: The PA DVS number assigned will display here.

Action: The Action Code received in the DVS Response from NY Medicaid.

Response Descriptive Text: The Action Code or Reject Reason description associated with the Action in the adjacent column.

Image Upload: User can upload Image for desired PA by clicking Image upload button from the PA Activity Worklist Page. It will open separate window to upload image for desired PA.

* indicates required fields

Image Upload

PA Number: 53000018549

* Image Type: MR - MRI

* File Type: gif jpg png tif

* File Upload: Browse...

Upload

(Once all required fields are populated and local image file is selected, click upload button.)

Image Activity List

User	Local Image Name	Document Name	Sent Date	Status	Source	Image Type

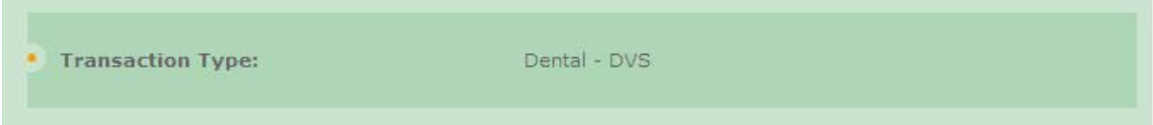
NOTE: A transaction which has somehow failed in the transmission to eMedNY will be marked with a Status of "Retry", and will not have a hyperlinked response. If this is the case, you must resubmit your DVS Request.

PA/DVS Response Details

The PA/DVS Response Details page contains the information that was received from NY Medicaid. The information transmitted in the Request will be returned and displayed along with a textual response message from NY Medicaid.

The information presented is divided into sections. Any or all of these sections may be blank depending upon the level of information supplied by NY Medicaid.

Client Information - Includes the client ID, patient account #, name, gender and date of birth to assist in ensuring confirmation was requested for the proper individual.



Transaction Type

Transaction Type: Displays the Transaction Type that was selected for the PA or DVS Initial request.

Response

Response - NY Medicaid's response to the request for PA/DVS. Responses indicating approval will be displayed in Black; while denial and error responses will be displayed in Red.

Action Code: This is explains the actions taken by the reviewer.

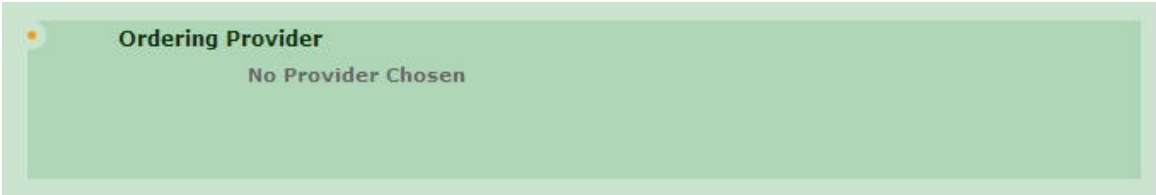
Issue Date: This will display the date the PA/DVS is issued.

Reviewer ID Number: The PA/DVS number assigned will display here.

Effective Date: This is the date the PA/DVS is effective.

Expiration Date: This is the date the PA/DVS is expired.

Prescribing Provider: If a prescribing provider was entered on the request, it will be displayed here.



Ordering Provider

If an ordering provider was entered on the request, it will be displayed here.

Event Information

If fields were entered under Event Information in the request, they will display here on the response.

Facility Type: This will display the code identifying the type of facility where services were performed. Either Professional/Dental or (UB) Institutional.

Service Type: This will display the service type selected on the request.

Release of Information: This will display the option chosen for release of information.

Accident Date: If an accident date was given in the request, it will display here.

Service Date From / To: The service date(s) entered on the request will display here.

Onset Date: If an onset date was given on the request, it will display here.

Admission Date: If an admission date was given on the request, it will display here.

Discharge Date: If a discharge date was given on the request, it will display here.

Related Causes Information

If fields were entered under Related Causes Information in the request, they will display here on the response.

Related Causes: If any related causes was entered on the request, it will display here.

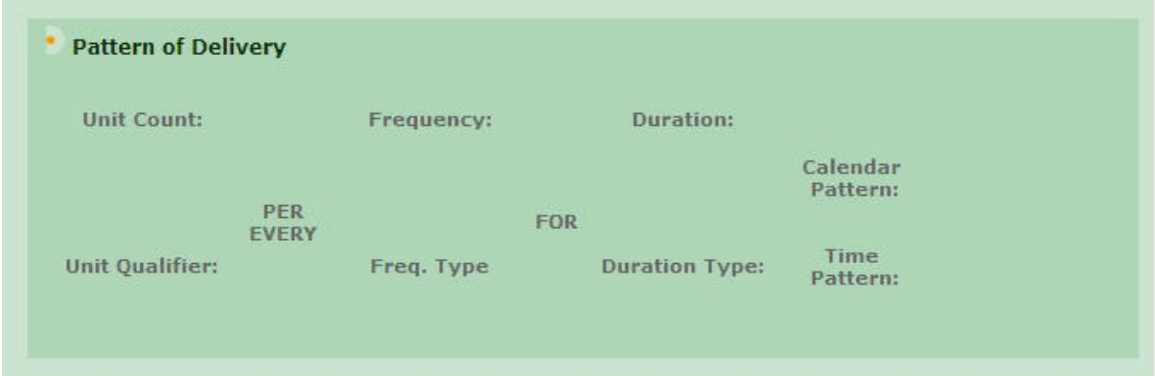
Accident Location: If an accident location was given in the request, it will display here.

Diagnosis

ICD-9 / ICD-10 (not labeled): The applicable diagnosis code type—ICD-9 or ICD-10—displays above the Primary and Secondary diagnosis codes.

Primary: The primary diagnosis given on the request will display here.

Secondary: If a secondary diagnosis was given on the request, it will display here.



Pattern of Delivery

If fields were entered under Pattern of Delivery in the request, they will display here on the response.

Unit Count: The number of units entered on the request.

Frequency: The frequency entered on the request.

Duration: The duration entered on the request.

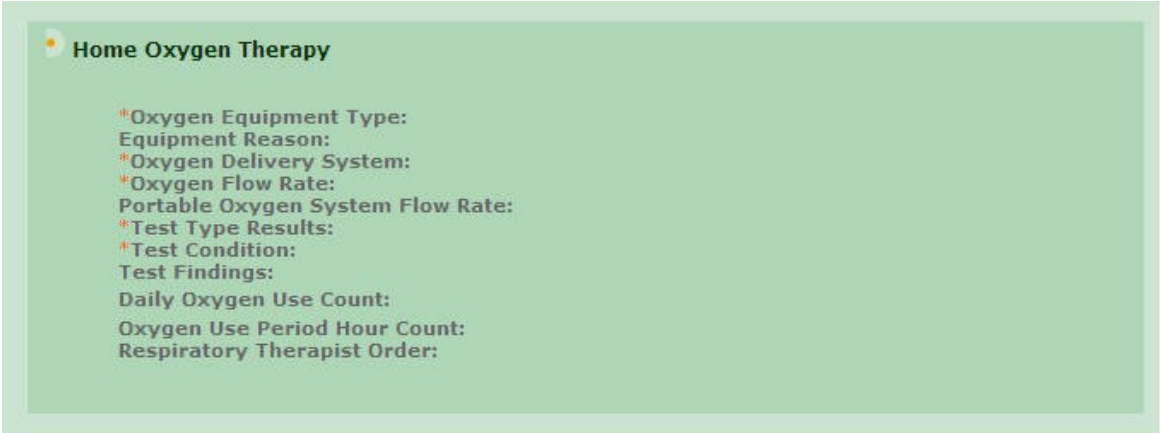
Calendar Pattern: The calendar pattern entered on the request.

Unit Qualifier: The unit qualifier pattern entered on the request.

Freq. Type: The frequency type entered on the request.

Duration Type: The duration type entered on the request.

Time Pattern: The time pattern entered on the request.



Home Oxygen Therapy

If fields were entered under Home Oxygen Therapy in the request, they will display here on the response.

Oxygen Equipment type: The equipment type on the request.

Equipment Reason: The equipment reason on the request.

Oxygen Delivery System: The oxygen delivery system on the request.

Oxygen Flow Rate: The oxygen flow rate on the request.

Portable Oxygen System Flow Rate: The portable oxygen flow rate on the request.

Test Type Results: The test type results on the request.

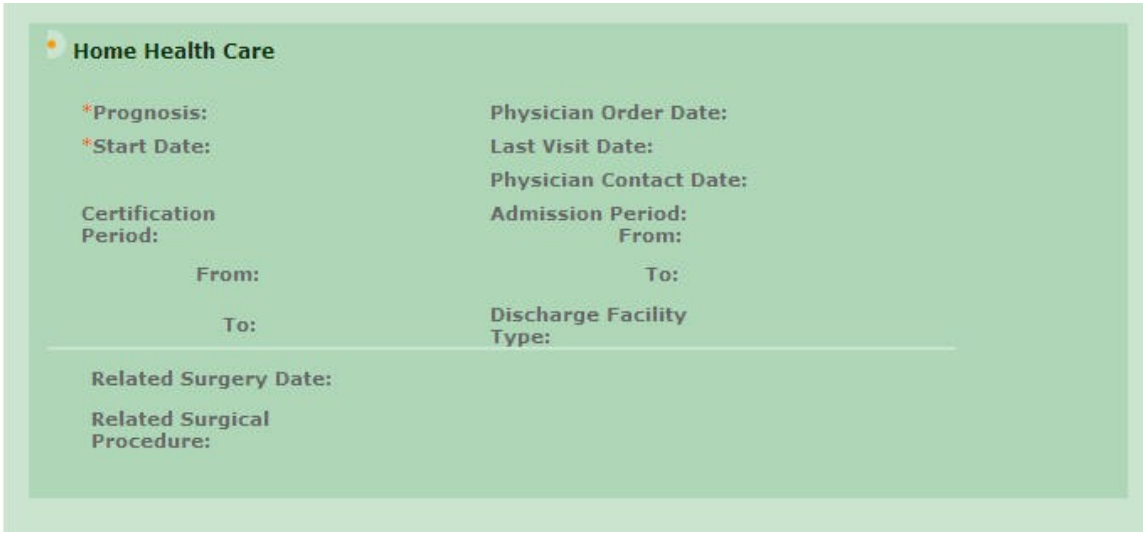
Test Condition: The test condition on the request.

Test Findings: The test findings on the request.

Daily Oxygen Use count: The daily oxygen count on the request.

Oxygen Use Period Hour Count: The oxygen use period count on the request.

Respiratory Therapist Order: The respiratory therapist order on the request.



Home Health Care

If fields were entered under Home Health Care in the request, they will display here on the response.

Prognosis: The prognosis entered on the request.

Physician Order Date: The physician order date entered on the request.

Start Date: The start date entered on the request.

Last Visit Date: The last visit date entered on the request.

Physician Contact Date: The physician contact date entered on the request.

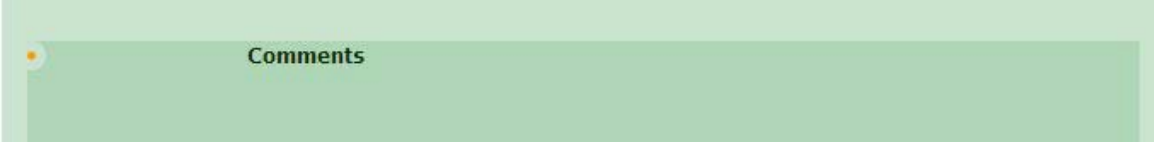
Certification Period From / To: The certification period entered on the request.

Admission Period From / To: The admission period entered on the request.

Discharge Facility Type: The discharge facility type entered on the request.

Related Surgery Date: The related surgery date entered on the request.

Related Surgical Procedure: The related surgical procedure entered on the request.



Comments

Comments: Any additional comments that were entered on the request.

Once you have reviewed the information displayed on the page, you have two options. You may click the Close button which will set the status of the response to "Viewed" or you may click Worked to mark the response as such, indicating that follow-up has been completed. Both buttons will close the details page and return you to the DVS Activity Worklist.

PA/DVS Cancel or Revise Request

A PA/DVS Cancel or Revise Request may be submitted by either an individual Provider or a Provider Group. If submitted for a Group, the ID must be entered on the claim which applies to the request. A Prior Approval (non-DVS) request must be submitted under an individual provider. The following data may be entered when generating a DVS or Non-DVS Cancel or Revise request.

Revise/Cancel Request

Enter the desired Review ID Number and click Go, this will return a previously entered PA/DVS that was entered within the ePACES application based on the Review ID Number. If the Review ID was not found the screen will allow a user to enter all header and detail information as generated through an initial Request.

If the Prior Approval/DVS was originally entered in ePACES the information should be pre-filled in. If the PA/DVS was not entered through ePACES the user must enter all of the PA data necessary to complete the revise or cancel transaction before submission.

A selection of **Revise Service Request** or **Cancel Service Request** must be selected for the transactions to be processed.

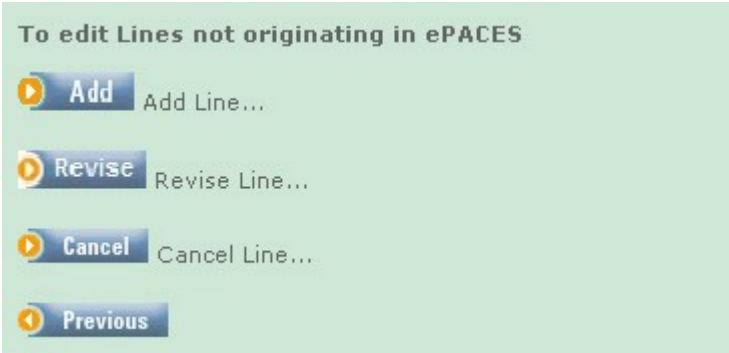
The entry of the PA/DVS information can be entered – similar to an initial Request. Header and line information may be revised or cancelled in this manner.

Prior Approval Items

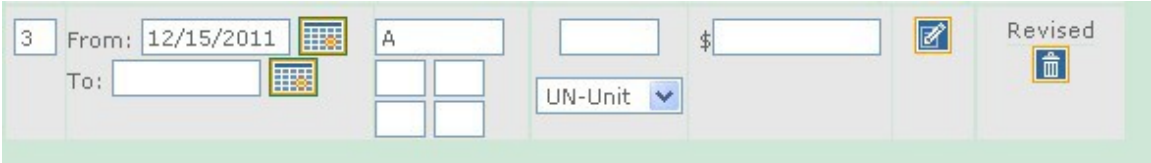
Line	Service Dates	*NDC/Proc & Modifiers	Unit Count Basis Meas.	Line Amount	More Details	Revise/ Cancel
4	From: 12/15/2011 To:	A8004	1.000 UN-Unit	$200.00		Revise Cancel

Line items previously entered in ePACES will be displayed to the user in a non-editable format. If the user needs to revise or cancel, buttons are available on left side to Revise or Cancel the line item. The user will be allowed to edit the line item as they would with an Initial Request Item.

Add / Revise / Cancel New Line Items



To add new lines three buttons below the line listing will allow the user to **Add**, **Revise**, or **Cancel** new lines that were not previously entered in the PA/DVS in ePACES.



If the PA/DVS was not entered in ePACES the user will need to enter the line number for canceling or revising an existing line of the PA.

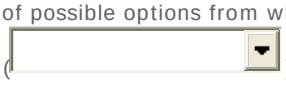
Prior Approval

PA Rosters

Prior Approval Roster Search

Providers and third-party Billing Services can search for Prior Approval (PA) Rosters through ePACES **for Transportation rosters ONLY**. If your facility is set up to enter transactions for multiple Providers, be sure that the Provider Name and ID displayed above the left-hand menu is correct for the transaction that you are searching for.

Navigating the PA Roster Search Page

When the **PA Roster** link is selected from the left-hand menu, you will be required to enter the criteria of your search for the PA Rosters where the provider selected is either the Billing/Requesting Provider or Ordering/Prescribing Provider. After selecting the Provider type, you can filter the PA Rosters by entering the additional criteria before submitting the search request. Some data fields will provide you with a listing of possible options from which to choose. These are available through drop-down list boxes ().

You can enter a Prior Approval Number in the **PA Number** text box and submit the search by clicking the Search button. This will bring up the PA Roster in the result table if the provider you selected is either the Billing/Requesting Provider or the Ordering/Prescribing Prover. If you do not know the PA Number you can also filter your search request by the additional fields.

- **PA Number**: The Prior Approval Number for the Roster.
- **Client ID**: This is the 8-digit alphanumeric Medicaid assigned ID for the patient. Based on the value entered here, ePACES will retrieve the patient information from the database and display it for confirmation that the correct value was entered.
- **PA Type**: The Type of Prior Approval Roster.
- **Status (Header)**: The Prior Approval Roster Final Status.

- **Item/Procedure Code**: Identifying the services that are being requested for the patient.
- **Rate Code**: The Rate Code used on the Prior Approval Roster.
- **Submitted Date Range (To/From)**: The Range of dates to begin and end the search of Prior Approval Rosters.
- **Effective Dates (To/From)**: The date range for the approved period of service.
- **Provider Number**: This is the 8-digit numeric New York State Medicaid ID and the 10-digit National Provider ID (If registered with New York State Medicaid). If you have selected Billing/Requesting Provider above then this would be the Ordering/Prescribing Provider on the PA Roster otherwise if you've selected the Ordering/Prescribing Provider this will be the Billing/Requesting Provider on the PA Rosters.
- **License Number**: This is the numeric license number of the Provider. If you have selected Billing/Requesting Provider above then this would be the Ordering/Prescribing Provider on the PA Roster otherwise if you've selected the Ordering/Prescribing Provider this will be the Billing/Requesting Provider on the PA Rosters.
- **Sort Field**: This is the field that sorts the resulting list of Prior Approval Rosters that are returned when the Search button is clicked.

Search Results

Records 1- 9 of 9 out of 9

Client ID	PA Number	Billing/ Requesting	Ordering/ Prescribing	PA Type	Header Status	Submit Date	Effective Date	Image Upload
LL12345X	0025906901X	12345678 1234567890	12345678	Physician	Rejected	03/27/08	01/01/01	
LL12345X	0036896901X	12345678 1234567890		Hearing Aid	Rejected	03/28/08	01/01/01	
LL12345X	0125906901X	12345678 1234567890		Bed Nursing	Suspended	03/31/08	01/01/01	
LL12345X	1234259069X	12345678 1234567890	12345678 1234567890	Hearing Aid	Rejected	04/16/08	01/01/01	
LL12345X	2333259069Y	12345678 1234567890	12345678 1234567890	Physician	Suspended	03/27/08	01/01/01	
LL12345X	3101126869B	12345678 1234567890		Bed Nursing	Suspended	03/31/08	01/01/01	
LL12345X	1425906901X	12345678 1234567890		Bed Nursing	Rejected	03/31/08	01/01/01	
LL12345X	1234256901X	12345678 1234567890	12345678 1234567890	Eye Care	Rejected	04/16/08	01/01/01	
LL12345X	1235906901X	12345678 1234567890		Physician	Rejected	03/27/08	01/01/01	
Client ID	PA Number	Billing/ Requesting	Ordering/ Prescribing	PA Type	Header Status	Submit Date	Effective Date	Image Upload

Records 1- 9 of 9 out of 9

Download Roster

The resulting list will show based on the criteria entered by clicking the submit button. By default the list will be sorted by Sort Field that was selected in the criteria. The table will initially show up to the first 10 items with a maximum return of 500 records.

The << Previous and Next >> buttons will allow you to page between the list of records if more than 10 records have been returned.

The **Download Roster** button

will place a request to receive comma delimited files to be retrieved from the Prior Approval Downloads page. This will create file(s) based on the same criteria that was used to select the list displayed.

When clicking on a Client ID that has a link a new window will open with a detailed view of the PA Roster. The detail views available are:

Transportation (Billing)

```
REPORT: AM07020-R0602                          NEW YORK STATE DEPARTMENT OF HEALTH                          PROCESS DATE: 06/06/2008
                                                              EMEDNY                                         PROCESS TIME: 16:40:24
PROVIDER: 12345678
                        TRANSPORTATION - ROSTER FOR BILLING PROVIDER12345678 CITY PHARMACY


CLIENT ID/NAME LL12345X JANE C DOE                          DATE OF BIRTH 01/01/2000              SEX F    CNTY FISC RESP 99

   ORDERING PROVIDER ID          PROCEDURE CODE       PRIOR APPROVAL NUMBER 0263316600X              DETERMINATION/RSN         APPROVED/
   APPROVED - QUANTITY               120.000   TIMES 0    AMOUNT   0.00                        PERIOD OF SERVICE FROM/TO 04/21/2004 10/28/2004
   RENDERED - QUANTITY               120.000   TIMES 0    AMOUNT   0.00


  TOTAL NUMBER OF ENTRIES ON THIS ROSTER :  2
```

Transportation (Ordering)

```
REPORT: AM07030-R0603                          NEW YORK STATE DEPARTMENT OF HEALTH                          PROCESS DATE: 06/06/2008
                                                              EMEDNY                                         PROCESS TIME: 16:41:51
PROVIDER:
                        TRANSPORTATION - ROSTER FOR ORDERING PROVIDER


                                 DATE        S PRIOR              CNTY        APPRVD PERIOD      BILLING
CLIENT                           OF          E APPROVAL     PROC  FISC         OF SERVICE        PROV          APPROVED      LINED     DETER
ID        CLIENT NAME            BIRTH       X NUMBER       CODE  RESP     FROM:        TO:     ID        QTY  TIMES  AMNT DETER     RSN

LL12345X  JANE C DOE             01/01/2000  F 0263316600X         99     04/21/2004   10/28/2004  12345678  120   000   0.00 APPROVED


  TOTAL NUMBER OF ENTRIES ON THIS ROSTER :  1
```

PA Roster Downloads Status

Providers and third-party Billing Services can search for Prior Approval (PA) Rosters through ePACES. If your facility is set up to enter transactions for multiple Providers, be sure that the Provider Name and ID displayed above the left-hand menu is correct for the transaction that you are searching for.

Navigating the PA Roster DownloadsPage

Download Request(s) by User ID: ROSENTHA Go

Records 21- 30 of 43 | << Previous | Next >>

Request ID	Status	Request Date	Reset Priority	Cancel Request
50000120	Download	07/17/07		
50000121	Download	07/17/07		
50000122	Download	07/17/07		
50000123	Download	07/17/07		
50000124	Download	07/17/07		
50000125	Download	07/17/07		
50000126	Download	07/17/07		
50000128	Pending	07/20/07	◉	☐
50000129	Pending	07/20/07	○	☐
50000130	Pending	07/20/07	○	☐
Request ID	Status	Request Date	Reset Priority	Cancel Request

Records 21- 30 of 43 | << Previous | Next >>

Update Selected Requests

When the **PA Roster Downloads** link is selected from the left-hand menu, a list of Download Requests will displayed.

Administrator Review

For Administrators there will be a Drop Down List of Users to review the requests users have submitted. The users can be selected by clicking on the Drop Down List ( ) and when the user is selected click the Go Go) button. This will show the requests submitted by the user.

Paging through Requests

The table will initially show up to the first 10 requests of the user and if there are more will display a Next (Next >>) and/or Previous << Previous) link to view the additional requests.

Setting High Priority

To place one of the requests ahead of the others, select the request by choosing the option button ◉) in the Reset Priority column and clicking the Update Selected Requests button (Update Selected Requests).

Cancelling Requests

To Cancel a request select the request by clicking the check box button (☐) in the Cancel Request Column and clicking the Update Selected Requests button (Update Selected Requests).

Reviewing the Criteria of Request

Search Criteria

Billing/Requesting Provider Number:	NPI: 1234567891 MMIS: 87654321	**Ordering/Prescribing Provider Number:**	
PA Number:	**Client ID:**	**Sort Field:**	PA Number
PA Type:	**Status** All		
Item/Proc Code:	**NDC Code:**	**Rate Code:**	
Submitted Date Range:	**From:** 01/01/2005	**To:**	01/15/2005
Effective Date Range:	**From:**	**To:**	

The criteria of the search is based on the information supplied on the PA Roster Search page when the Download Roster button (Download Roster) was clicked. This information will be used to create the download text files.

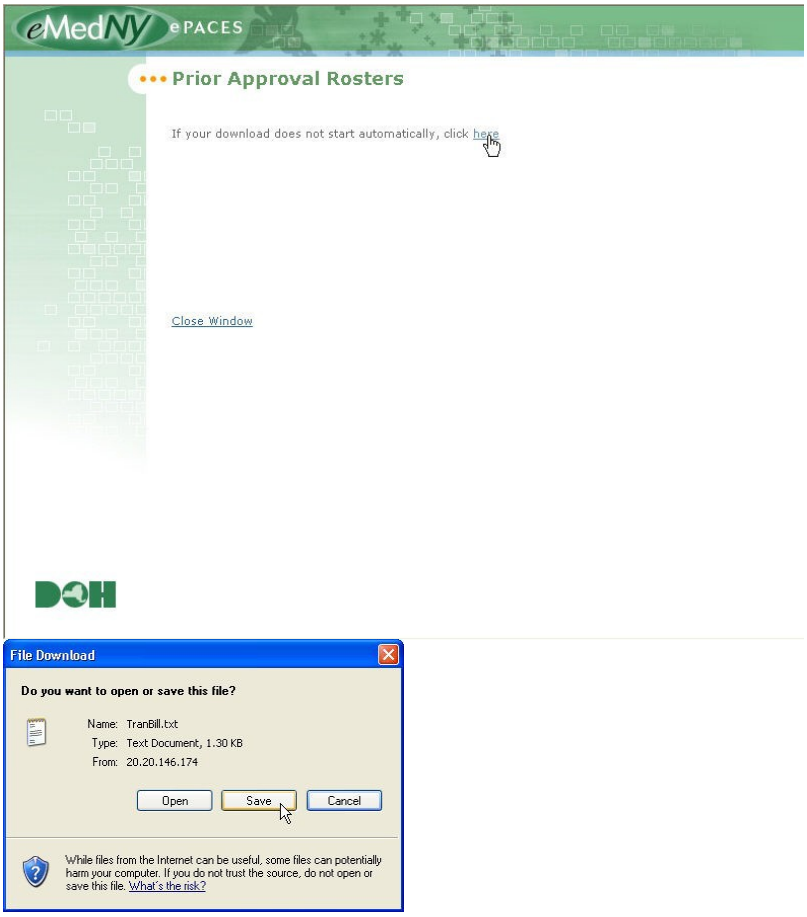
Downloading Files

Results

PA Type	Status	Downloaded By
PDN	Download	ROSENTHA
PCA	Download	ROSENTHA
Transportation	Download	
Prescription Drugs/OTCs	Download	
Dental	Download	
Eye Care	Download	
Hearing Aid	Download	
DME/Supplies	Download	
Radiology	Download	

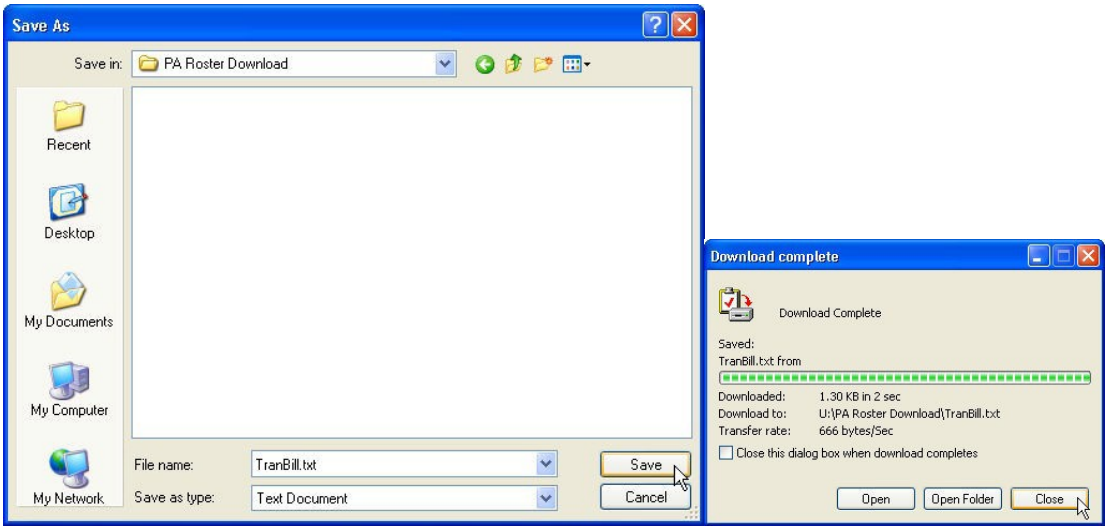
When the Status of the request is "Download" and you click on the Request ID link. A list of 1 or more comma-delimited text files should be visible for downloading. To download each file click the Download link under the Status column.

Download Screen



Once selected a new window will appear to download the text file locally. If the File Download Dialog box doesn't appear automatically you can select it manually by clicking on the here link. You can then save the file at a locally specified location.

Saving Locally



When the Save As dialog box appears click the Save button to store the comma-delimited text file to your local storage device.

Maintain Provider Information

Maintain Provider Information

The provider function is designed to operate with the ePACES claim and MEVS processing. Once entered, the provider information will be available within subsequent ePACES pages through a scrollable pick-list. The provider function is provided as a convenience to you and does not have to be utilized to generate a claim or a MEVS request.

Within this section of the ePACES application, you are able to view an alphabetic listing of all providers in your support file, edit the details of an existing Non-Medicaid provider, add a new Medicaid or Non-Medicaid provider to your support file, or remove a provider from your support file.

Medicaid provider information is copied from the main database of providers to your local support file and therefore no information may be edited. Non-Medicaid providers however, are to be entered into your support file and therefore may be maintained by you, or any user associated with your TSN/ETIN.

Review Providers

Selecting **Provider** from the **Support Files** topic on the menu will display a listing of all providers existing in the Support File for your TSN/ETIN sorted alphabetically by Last Name. This view lets you page through the resulting table, quickly viewing the name, State License Number, Provider Type, and contact information of each provider. Clicking on the green arrow in the header of one of the columns, Name, License Number or Provider Type, will sort the Providers in ascending order by the values in that column.

This page is the primary source of interacting with the Provider Support File. From this page it is possible to navigate through this complete list of providers by using the Next Page>> and <<Previous Page controls available above and below the table.

You may add new Medicaid and Non-Medicaid Providers to the Support File by clicking the Add New Provider button. You may edit Non-Medicaid Providers by clicking the corresponding Edit icon; Medicaid Provider information cannot be modified and therefore will not have an Edit icon. You may also delete existing Medicaid and Non-Medicaid Providers from the Support File by clicking the Delete icon for the desired Provider. NOTE: Deleting a Medicaid Provider will only remove it from this Support File, not the database.

Add New Provider

To add a new provider to the local provider file:

1. click on Add New Provider on the main Provider Support File page,
2. *if the provider to be added is an existing Medicaid provider*:
   - enter the last name **OR** Provider Number (8 digit Medicaid ID or 10 digit National Provider ID) in the corresponding fields under the heading **Add an existing Provider**,
     - Entering the Last Name followed by a single space and the First Name will narrow the list of returned Provider Names.
     - If both Last Name and Provider Number are entered, Number will be used alone as it will ensure a unique match.
   - click Go,
   - if a Last Name or name combination (LastName <space> FirstName) is entered and matches one or more existing records in the provider master file, the records will be displayed on the resulting page,
   - review the retrieved record(s) and select the desired provider to be added to the local file,
   - click Submit to add the record to the file and return to the main Provider Support File page,
   - if the desired provider is not returned in the result set, click <<Back to return to the main Add New Provider Page.

3. *if the provider to be added is a Non-Medicaid provider*:
   - Select the proper entity type, Person or Non-Person, for the Provider to be entered,
   - enter the complete name of the provider, either the Employer Identification Number (EIN) or Social Security Number (SSN) of the provider, and the National Provider ID and/or State License.
     - EIN/SSN: valid values must be 9 digits and may or may not contain dashes
     - State License Number: Enter the 3-digit Profession Code, 2-character State Code (out of state providers) or Privilege Code (in state providers) and 6-digit license for a total of 11 characters. If the license number does not equal 6-digits, zero-fill the appropriate positions preceding the license number.
     - NPI# : Enter 10 digit National Provider ID
   - if known, you may also enter the following Optional Information:

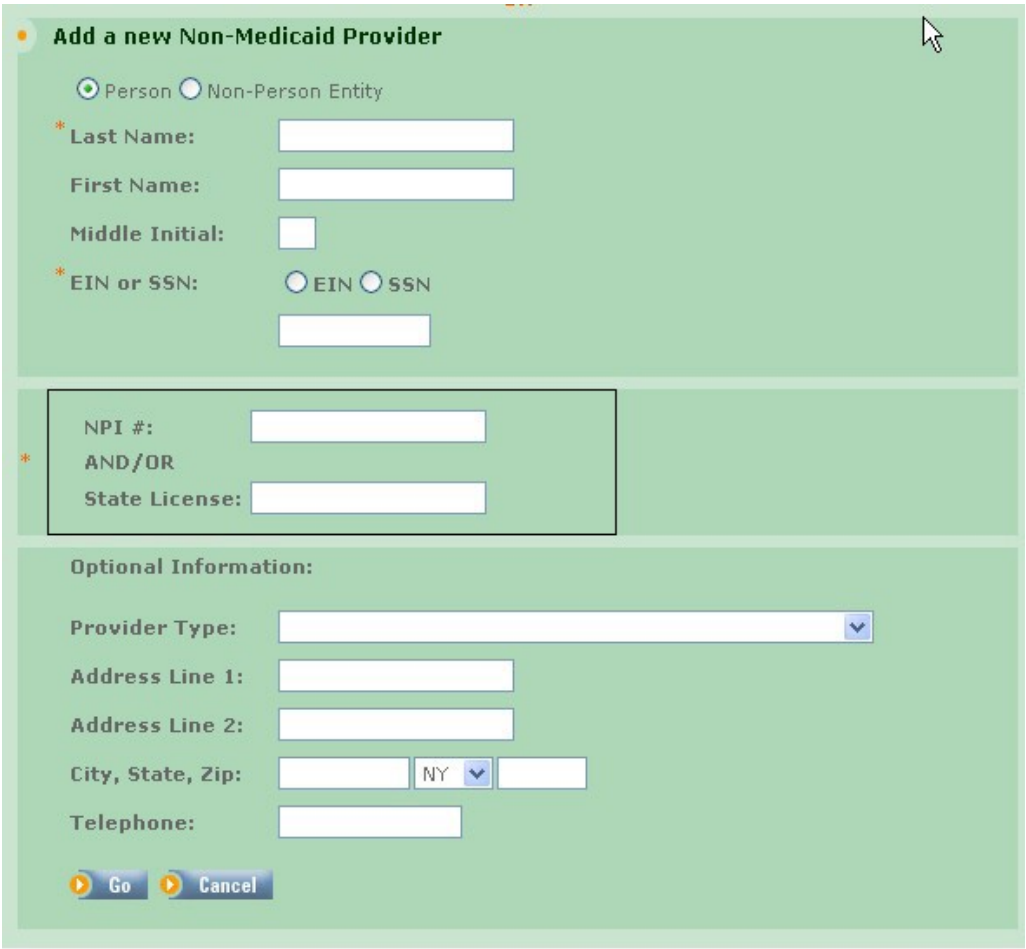
     Provider Type: Select the Provider Type to be used and displayed along with the Provider Name to differentiate Providers who may have the same name.

     Address: If entered, the address information will be displayed as Contact Information when selecting a Provider during the Claim Entry,

SA/DVS/Eligibility or Prior Approval Request process.

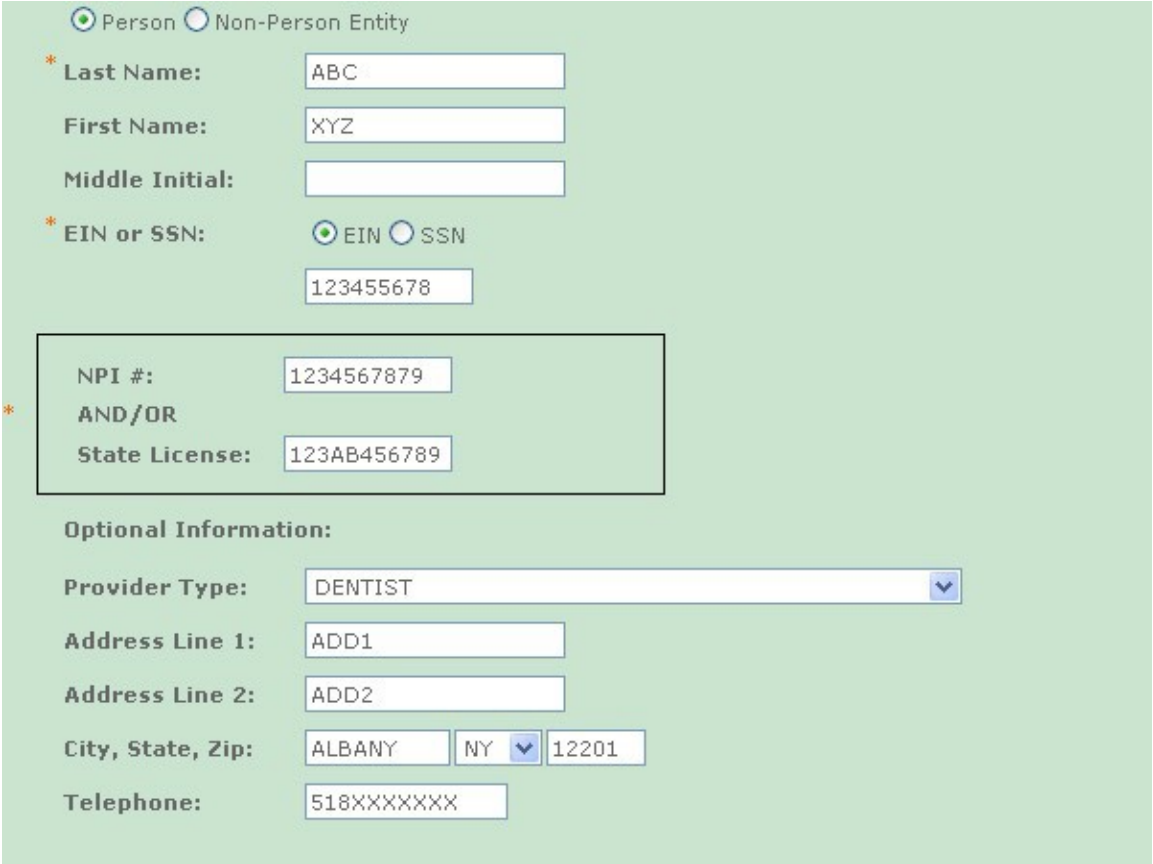
Telephone: As with the Address, if entered, the telephone number will be displayed as part of the Provider's Contact Information.

- click Go and the provider will be added to the local provider file, therefore available for selection when entering other claims or prior approvals.
- If the State License Number, National Provider ID or SSN entered already exists in your local Provider Support File, an error will be displayed informing you of the duplication.



NOTE: If the provider being added is a Non-Person Entity, the organization or facility name should be entered into the Last Name field and the First Name/Middle Initial fields should remain blank.

Edit Existing Provider



To edit an existing Non-Medicaid Provider, find the provider and click on the corresponding Edit icon. This will open a page with the provider's information displayed in a form to allow for editing of all displayed information. NOTE: Medicaid Provider information may not be edited, and therefore will not have an Edit icon.

Radio Buttons: Select the entity type for the Provider, either Person or Non-Person.

Last Name: The last name of the Provider, if the entity is a Person, or the Organization Name for all Non-Person Entities.

First Name: This field should remain blank for all Non-Person Entities.

Middle Initial: This field should remain blank for all Non-Person Entities.

EIN or SSN: Either the EIN or the SSN is required for all Providers. The setting of the radio button will determine which is to be entered. Valid entries must be 9 digits and may be entered with or without the appropriate dashes.

NPI#: Enter 10 digit assigned National Provider ID . Enter either National Provider ID or State License Number or both.

State License Number: Enter the 3-digit Profession Code, 2-character State Code (out of state providers) or Privilege Code (in state providers) and 6-digit license for a total of 11 characters. If the license number does not equal 6-digits, zero-fill the appropriate positions preceding the license number. Enter either National Provider ID or State License Number or both.

Provider Type: Select the value to be used and displayed along with the Provider Name to differentiate Providers who may have the same name.

Address: If entered, the address information will be displayed as Contact Information when selecting a Provider during the Claim Entry, SA/DVS/Eligibility or Prior Approval Request process.

Telephone: As with the Address, if entered, the telephone number will be displayed as part of the Provider's Contact Information.

Clicking Close will save the changes and return you to the main Provider Support page. Depending on the quality of the information in the provider record, it may be more beneficial to simply delete the provider. Clicking on the Remove from Support File link at the top of the page will allow you to delete the provider

Remove Provider

Remove from Support File

Person

* **Last Name:** DOE

First Name: JOHN

Middle Initial: E

* **NPI #:** 0123456789

State License: NY123456789

Optional Information:

Provider Type: DENTIST

Address Line 1: ST ADDR1

Address Line 2: ST ADDR2

City, State, Zip: CITY ST 12345

Telephone: 999-999-9999

Are you sure you want to remove this Provider from the Support File?

Yes No

Selecting the Delete icon from the Provider Summary page or clicking the Remove from Support File link on the Provider Edit page will prompt the user to confirm the permanent deletion of the provider record from the local Support File. This will prevent the selected Provider from appearing in any list when entering claims or making requests.

To remove a Provider:

1. select the Delete icon on the Provider Summary page OR click Remove from Support File link on the Provider Edit page,

2. confirm the Provider displayed is the correct item to bedeleted.

Maintain Payer Information

Maintain Payer Information

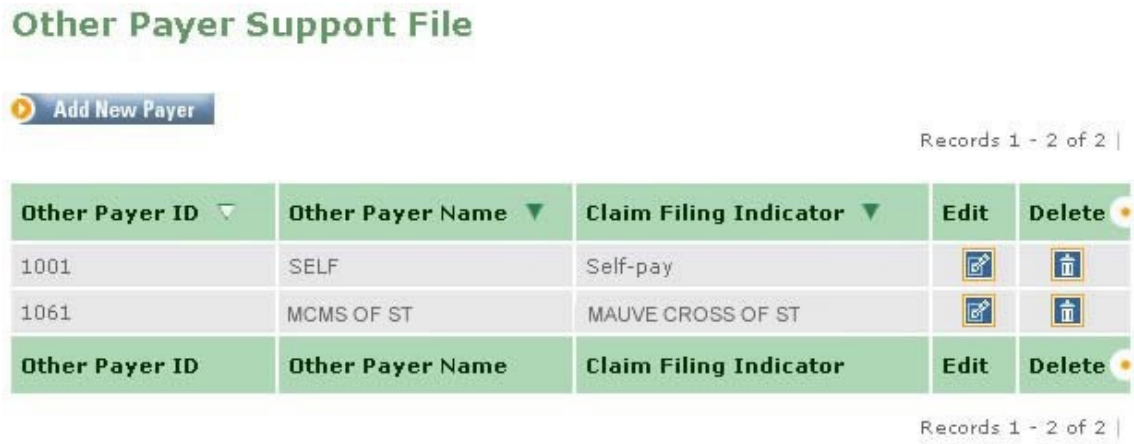
Submitters are required to send Other Payer information for Coordination of Benefits (COB) purposes. Payer data may be used when submitting claims on the Other Payer tab. In order to have this information available to the users, the data must be defined in the proper Support File. The IDs for Payers are maintained in support files which are TSN/ETIN specific, thereby allowing all Providers associated with an TSN/ETIN to use the same IDs for the same Payers.

Payer Information consists of an identification number, the Payer Name, and a claim filing indicator. The identification number is a value assigned by the ePACES system to uniquely identify the payer within the system. From the main page, users may review the information of the payers existing in the system, add a new payer to the system, edit the information of a payer existing in the system, or delete an existing payer from the system.

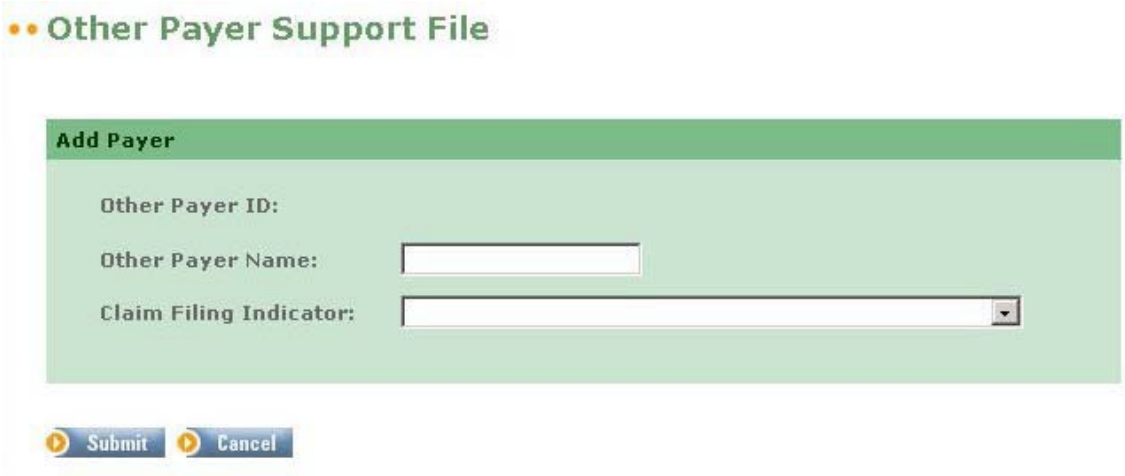
Review Payers

The main summary page for the Other Payer Support File contains a listing of all payers existing in the system in a tabular format. Information displayed includes the Other Payer ID Number, the Other Payer Name, and the Claim Filing Indicator for that Other Payer. You may navigate through the list of Other Payers using the links above and below the table. Clicking on the green triangle in the heading of a particular column will sort the Payers by that information.

From this page, you may also select to edit or delete an existing payer, or add a new payer if you are unable to find the payer for which you are looking.



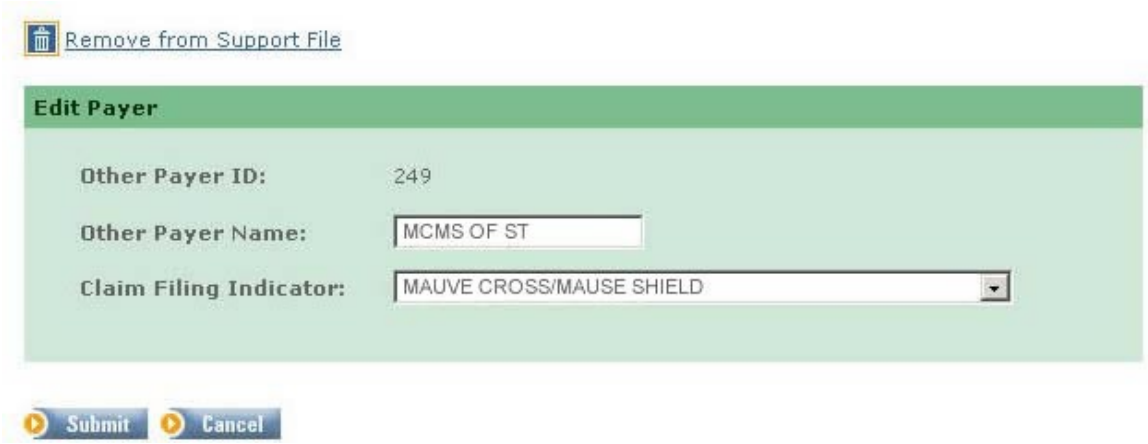
Add Payer



Adding a new payer to the system is a simple process, yet critical to the accurate entering and processing of claims. To add a new payer to the system:

1. click the Add New Payer button at the top of the Other Payer Summary page,
2. enter the organization name as the Other Payer Name,
3. select the appropriate claim filing indicator for the payer,
4. to accept the new payer, click Submit,
5. upon confirmation, you will be returned to the main Other Payer Summary page.

Edit Payer



To edit an existing payer:

1. find the payer in the list by paging through the available data,
2. select the check box in the Edit column in the row for the desired payer to be edited,
3. make the necessary changes to either the payer name or the claim filing indicator,
    - NOTE: the Other Payer ID displayed may not be changed, as this value is automatically generated by the ePACES system to ensure it uniquely identifies the payer.
4. click the Submit button to save changes and return to the Other Payer Summary page.

The user may also delete a payer from the system by clicking the Remove from Support File link.

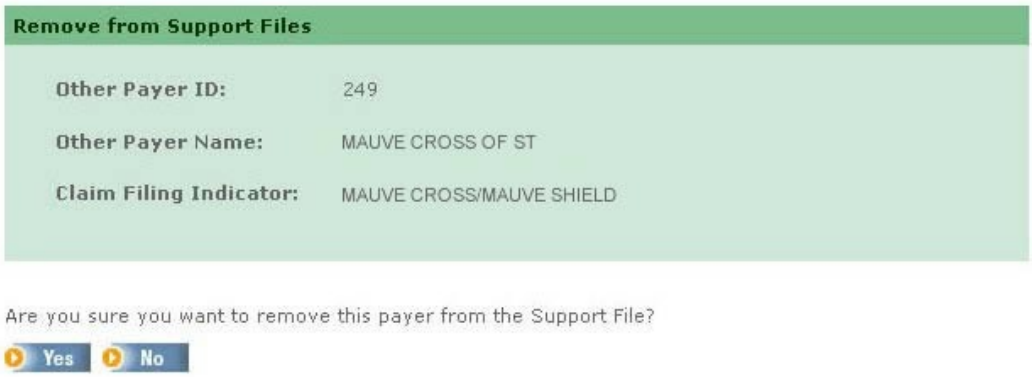
Remove Payer

Selecting the Delete icon from the Other Payer Summary page or clicking the Remove from Support File link on the Other Payer Edit page will prompt the user to confirm the permanent deletion of the payer record from the file. This will prevent the selected Other Payer ID from being entered on any claims.

To remove an Other Payer:

1. select the Delete icon on the Other Payer Summary page **OR** click Remove from Support File link on the Other Payer Edit page,

2. confirm the Other Payer displayed is the correct item to be deleted.



Maintain Submitter Information

Maintain Submitter Information

The submitter function is designed to operate with the Build Claim Batch function in ePACES. Each time a batch of claims is built, it must be linked to a submitting Tape Supplier Number (TSN) or Electronic Transmitter Identification Number (ETIN). Since a User ID may be associated with a single TSN/ETIN, there is no need to Add new TSN/ETIN or remove any from the local file. Therefore, the only function this page serves is to view the TSN/ETIN for reference.

Review Submitter

Submitter Information

Transmission Supplier Number (TSN):	686

The following data elements are displayed for the TSN/ETIN associated with the user ID:

TSN/ETIN: The Tape Supplier Number (TSN) or Electronic Transmitter Identification Number (ETIN) for the submitter. Required for the submission of claim batches and must be unique within the ePACES system.

User Maintenance

User Maintenance

In order to log onto and use the ePACES system, each individual must have a User ID. The User ID and access privileges are created and maintained by the System Administrator.

Clicking the **Add/Edit Users** link below the **User Admin** heading in the left hand menu will allow the System Administrator to perform various maintenance functions. The System Administrator may add new users, review and edit the privileges of existing users, change the password of existing users, unlock existing user accounts, promote existing users, and inactivate existing users.

The ePACES application is grouped into six general areas. Each of these areas has an access level associated with it for each user or user group. There are three groups of users, each with specific levels of access privileges. Administrators and Supervisors cannot have their access levels edited however General Users may.

Update Provider List

If additional Providers become enrolled under a specific TSN/ETIN after the initial enrollment and setup of a Primary Administrator, it becomes necessary to update the Provider list in ePACES. The Administrator for the TSN/ETIN must update the list and then set the necessary privileges for all associated users.

To do this:

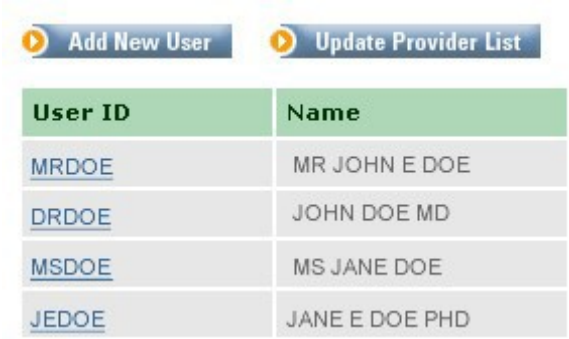
1. Click **Add/Edit Users** link under the **User Admin** menu,
2. On the resulting page, click the Update Provider List button,

3. Once confirmation is received indicating the update is complete, you may either edit the necessary users or add users for the new providers.

Add New User

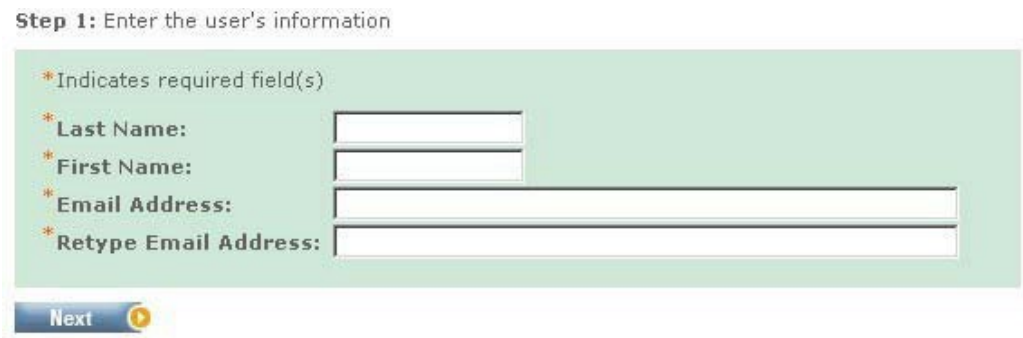
Before a System Administrator adds a new user to the system, it is important to review the list of existing users and User IDs to verify that the individual actually needs to be added. Review the list of users associated with your TSN/ETIN. If the user in question is not found, continue through the process of Adding a New User; otherwise, the user privileges may simply need to be edited.

Select the **Add / Edit User** link from the System Administrator's **User Admin** menu.



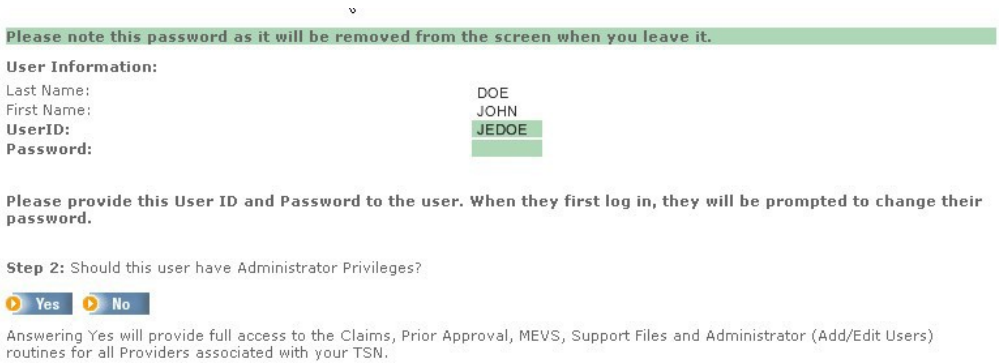
Click the Add New User button to begin the process.

Step 1:



The first step in adding a new user to the system is to enter the user's complete first and last names along with their complete email address. This information will be used to automatically determine the ID for the user. Any special characters in the first or last name will be ignored when creating the User ID. Clicking Next will bring you to Step 2.

Step 2:



Once you have entered the user's name and email, it is important to determine if the user

should have administrative rights to all the providers associated with the TSN/ETIN. Administrative rights allow the user to add and maintain users, in addition to having access to all the standard ePACES functionality.

Clicking Yes will automatically set the Access Privileges for the user to be Secondary Administrator in all Providers, and therefore will skip Step 3 and go right to the Confirmation page. Please make note of the password displayed at this time. Otherwise, clicking No will bring you to Step 3 where you can manually set the Access Groups and Privileges for each provider.

NOTE: Users associated with a MEVS Only TSN/ETIN will not have permission to access any claim related pages regardless of their Access Group or privileges. Contact Provider Relations to obtain a permanent TSN/ETIN if your organization wishes to process claims via ePACES.

Step 3:

Answering No in Step 2 means that this user is either a Supervisor or a General User. Users are defaulted to be General Users upon set up with no access privileges for each provider. Therefore, each provider listed must be edited by clicking on the Add/Edit Access Privileges icon to set the Access Group and/or Privileges. The providers available are determined based upon the TSN/ETIN under which the Administrator is logged in.

Step 3:
For each Provider Number the user is associated with add a set of Access Privileges.

Provider Number	Provider Type	Name	Access Group	Add/Edit Access Privileges
9999999996	046 PHYSICIAN	JANE DOE	General	
99999997	046 PHYSICIAN	JOHN DOE	General	

Finish

Clicking the Add/Edit Access Privileges icon will display a table where you can mark if the user should be a Supervisor or a General User. Note: A Supervisor has Full Access to all areas of ePACES other than User Administration, whereas a General User may have Full Access to some areas and No Access to others. If a User has No Access to a specific group of functionality, those associated menu options will not be available to them in the ePACES application.

NOTE: Users associated with a MEVS Only TSN/ETIN will not have permission to access any claim related pages regardless of their Access Group or privileges. Contact Provider Relations to obtain a permanent TSN/ETIN if your organization wishes to process claims via ePACES.

User Information:

Last Name: DOE
First Name: JANE
User ID: JEDOE

Provider Number: 12345678 **Provider Type:** 046 PHYSICIAN **Provider Name:** DOE JANE

	Supervisor	General User
Access Group	○	◉
Enter Claims, Build Claim Batches	**Full Access**	No Access
Claim Status Inquiries	**Full Access**	No Access
Support Files	**Full Access**	No Access
Submit Claim Batches	**Full Access**	No Access
MEVS	**Full Access**	No Access
Prior Approval	**Full Access**	No Access
PA Roster	**Full Access**	No Access
User Administration	**No Access**	**No Access**

Submit Cancel

Click Submit to return to the listing of Providers for the User you are adding. You may then continue editing the Access Privileges for any additional Providers. Once all Access Groups and Privileges have been defined, click Finish which will display the Confirmation page and complete the process.

Confirmation

The final step in the process of adding a new user is the Confirmation Page. Clicking Back to Add/Edit Users will return you to the main User Maintenance page where you may either edit an existing user or add another.

New User Added

The new user has been created. Please provide them with their User ID and Password. When they first log in, they will be prompted to change their password.

Back to Add / Edit Users

Edit Existing User

When editing an existing user, you may change the Access Group and Privileges associated with the User and specific Provider IDs, change the user's password, inactivate the User ID, unlock the user's account, or promote the user to an Administrator.

To edit the Access Group or Privileges of an existing user:

- Find the name of the User to be modified and click the hyperlinked name. NOTE: An inactivated User ID will not be displayed as a hyperlink.

- on the resulting page, confirm the first name, last name and user id are those of the desired user,

- in the listing of Provider IDs/Names and Access Groups available for the selected user, determine the combination to be maintained and click the Add/Edit Access Privileges icon,

- you may change the Access Group for a user simply by selecting the button for another group,
    - NOTE: the access privileges for Supervisor are predetermined and therefore may not be modified.
- the access privileges for a General User may be modified to grant either "Full Access" or "No Access" to certain areas of the application,

User Information:

Last Name: DOE
First Name: JANE
User ID: JEDOE

Provider Number: 12345678 **Provider Type:** 046 PHYSICIAN **Provider Name:** DOE JANE

	Supervisor	General User
Access Group	○	◉
Enter Claims, Build Claim Batches	**Full Access**	No Access
Claim Status Inquiries	**Full Access**	No Access
Support Files	**Full Access**	No Access
Submit Claim Batches	**Full Access**	No Access
MEVS	**Full Access**	No Access
Prior Approval	**Full Access**	No Access
PA Roster	**Full Access**	No Access
User Administration	**No Access**	**No Access**

Submit Cancel

- click Cancel if you do not wish to save your changes or click Submit to save changes and return to the Edit Users page.
- Once all necessary access levels have been defined for the Providers, click Close to return to the Add/Edit Users page.

Change User Password

The System Administrator has the ability to change the password of a user account. The new password must comply with standards, and the user must change it immediately upon their next login to ePACES.

If the Primary Administrator password must be reset and there are no other Administrators defined, contact the EMC Group at 518-477-9256 to reset the password.

To change a user's password:

- Find the name of the User to be modified and click the hyperlinked name. NOTE: An inactivated User ID will not be displayed as a hyperlink.

- on the resulting page, confirm the first name, last name and user id are those of the desired user,

- click the Change Password link,

- enter and confirm the new password which must comply with the following standards: 8-16 characters in length with at least 1 number, 1 lower case letter, and 1 upper case letter

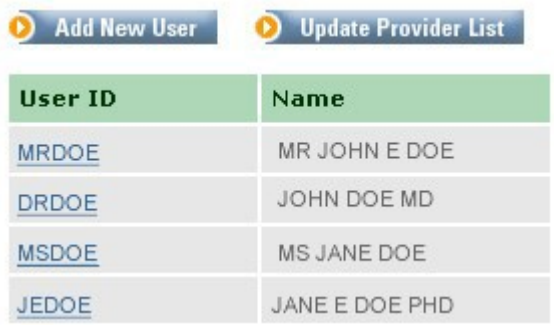
- provide this new password to the user and inform them that, for security reasons, the first time they log into ePACES with this new password they will be prompted to change it.

Inactivate User

Inactivating a user will prevent that user from logging into the ePACES application. In addition, all transactions associated with the inactivated user will be purged from the system 120 days following the inactivation, including claims that may have not been batched and submitted by that time.

To inactivate a user completely in all Provider IDs:

- Find the name of the User to be modified and click the hyperlinked name. NOTE: An inactivated User ID will not be displayed as a hyperlink.



- on the resulting page, confirm the first name, last name and user id are those of the desired user,

- click the Inactivate User link,

NOTE: Primary Administrators will not have an Inactivate User link as their accounts may never be inactivated.

- confirm the inactivation.

User Information:

Last Name: DOE
First Name: JOHN
User ID: JDOE001

The user you are inactivating may be using Exchange to receive financial remittances for your organization. Are you sure you want to inactivate this user?

User Access Privileges

Provider Type	Provider Number.	Name	Access Group
1234567893	010 CHILD CARE INSTITUTION	CITYCHILDCARE	General
12345678	012 PHYSICIAN	CITY PHYSICIAN 001	General
23456789	012 PHYSICIAN	CITY PHYSICIAN 002	General
34567890	012 HOSPITAL	CITY MEMORIAL HOSP	General

Data associated with this user will purge after 120 days.

Unlock User Account

The System Administrator has the ability to unlock a user account in the case where they have attempted to login multiple times unsuccessfully. This may often be combined with changing the user's password.

To unlock a user's account:

- Find the name of the User to be modified and click the hyperlinked name. NOTE: An inactivated User ID will not be displayed as a hyperlink.

- on the resulting page, confirm the first name, last name and user id are those of the desired user,

- click the Unlock User link,

- confirm the unlocking of the account.

- Once the user account has been successfully unlocked, the confirmation message 'This user has been unlocked' will appear.

Promote User to Administrator

The System Administrator has the ability to promote a Supervisor or General User to the role of Administrator for a TSN/ETIN. If a user is set to an Administrator, they have Full Access to all areas of the ePACES application including the User Maintenance section, for all Providers assigned to their TSN/ETIN. Once a user is promoted to an Administrator, they are unable to be changed back to a Supervisor or General User.

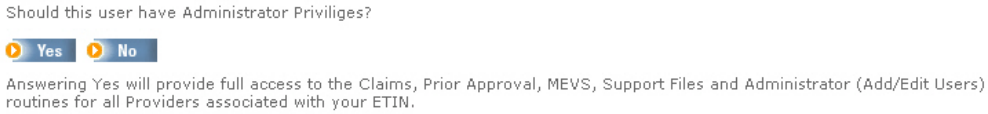
To promote a Supervisor or General User to an Administrator role:

- Find the name of the User to be modified and click the hyperlinked name. NOTE: An inactivated User ID will not be displayed as a hyperlink.

- on the resulting page, confirm the first name, last name and user id are those of the desired user,

- click the Promote User to Administrator link,

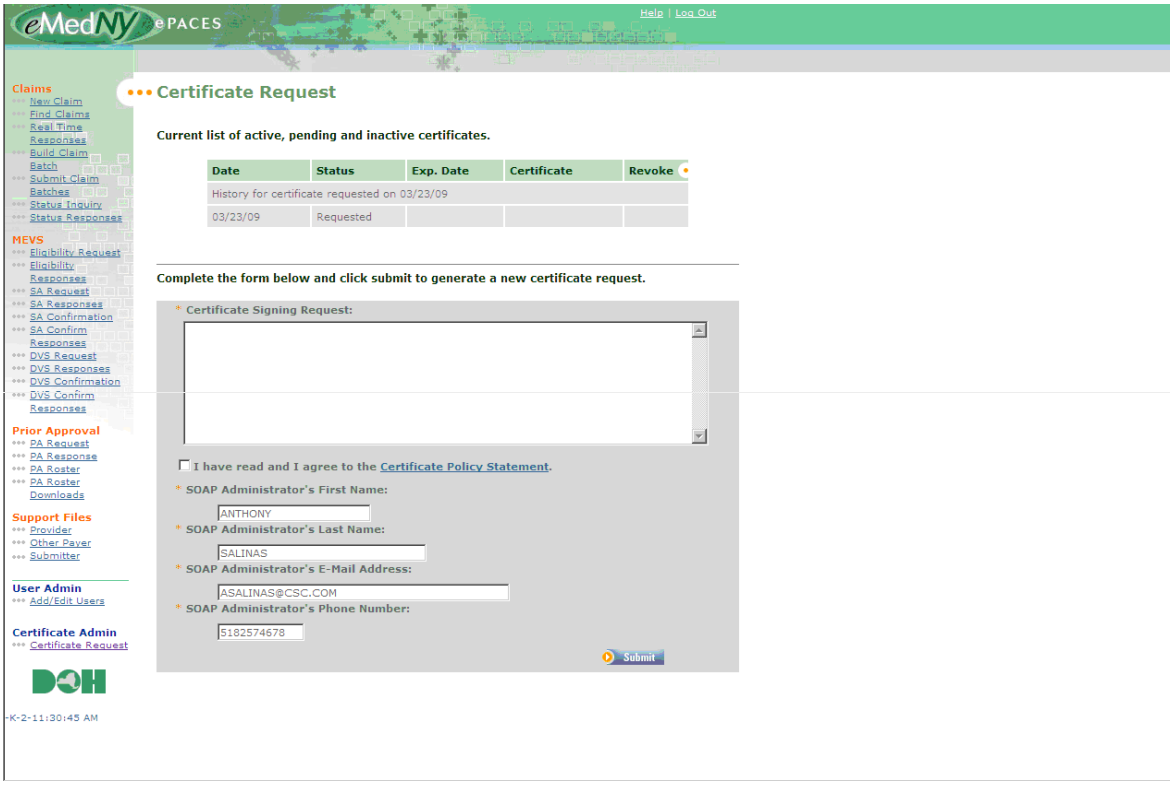
- confirm that the selected user should have Administrator privileges to all Providers listed,



- the user will now have an Access Group of Administrator and no Add/Edit Access Privileges icon for all Providers on the Edit Current Users page.

SOAP Certificate Request

Soap Certificate Request



The ePACES menu will show "Certificate Request" menu option for the System Administrators enrolled in the Certificate Request Process. The "Certificate Request" page is for enrolled users to request a SOAP certificate. By clicking **Certificate Request** on the left-hand menu admin can access the request page, it will allow a primary system administrator to submit a Soap Certificate Request. There are variety of data that may be entered to get Soap certificate (acceptable character are a-z, A-Z,0-9 and +,/).

Current list of active, pending and inactive certificates list detail.

30 days worth of Certificate History will be displayed at the top of the page containing : -

Date: Show the Date of certificate requested.

Status of Request: Status of request field shows the status of request. Type of the Status

Expiration Date: Date of expiration of certificate if applicable.

Certificate Download: Its link to download certificate, Once request get precessed it will become a link and user can click and see its certificate in the bottom part of the page.

Revocation: When applicable

The second half of the page is for the Soap certificate request. User needs to enter a Certificate Signing Request (CSR) field and the SOAP admin fields (Name, Phone Number, and E-Mail address) from the enrollment process that may be changed.
To Submit the Soap Certificate Request, Click the "Submit Certificate Request" button it will open a request page and after entering all the request field click the submit button the bottom of the page.

Submission without all the proper information will result in an error message stating, "Please fill out all mandatory fields and try again."

Certificate Response

Once the request is approved its status will updated to "Available" and the user can see the download link on the list at the top of the page. To download the certificate the user must click the download now link on the list afterwards, the Soap Certificate will be displayed.

Date	Status	Exp. Date	Certificate	Revoke
History for certificate requested on 03/13/09				
03/13/09	Requested	09/13/09		
03/13/09	Available	09/13/09	Download Now	

Here's your Certificate. Please cut and paste it to a file.

eMedNY SOAP Certificate:

-----BEGIN CERTIFICATE-----
MIIGKQYJ!<oZwcNAQcCo GGjCC3hYCAQExADALBgkq;,k G9•,,033•G gggX+l1D
jzCCAvigAwI3P.gI33TANOgkqkiG9r,103AQUFADA2HQSTtiDQYDVQQ?CEvi21IlPlki1kx
zA:>BgNV3AsTGm1EZXYgQ2VydGImaWNtOdGUgQXVOaG9yaXR5!13 XDTA5!1DHxl1zAO
l1DAvll1FcXDTA5!1DkxNDAzNTk1OVo•nYDEPHAOGA1UEC:o!1GZU11ZE5Zl1RlLVIEQYDVQQL
'::qp TiWkT1ktREVWMQ8•,DQYDVQQLEoZlUGFj ZX11xFTAT3gNV3AsTDGVQYWNtly3D
ZXJOc zEQ!1A9GA1UEAxl13RVB3QOVT!1TCCASio,;DQYJ!<oZ ;,vcNAQE33QADggEPADCC
AQoCggE3AVGwY5rn31LRZh3Hu7z007iW:indZE9Sm//4r7 fDYOU1 ZneIl1k gZ
Ayz
C6ccCVlEvOy/8ZifpGHzEY;,9EoeRalrJt2fi IS15e1i:ijZOqVr99geRI2+Nc?<+ea
f6U8mzt i::T8vN11<oyQSnCl17UrE+EUdHNGaR9NOLuqdS/FFl1xtYpUxv1 JvL9oVe
Yx zbjSd+5Afox H::nyz qpnaU2Wg ZUuVORpr,qvxLh82 vgn-lov Rg jClUx
sKX!:+p atToOvB+gykk37fu7Qu+x5uUR8fYC1GHp+9+yVcdVQ+EEV\RXT5dn
ysz 3KG
jBcciU:i+dRC kKs9h:iS41U3CZAyt/13kCAwEAAa03/jC3+zAOBg NV:1Q83Af8E3Al1C
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3Jpd:1kxDIALOgNV3ANI3!:NSIDEvlN6A1oDOGHWh0d:1E6Ly8yHCyHCxNicuNDU6
ODA9!159QSO T ZXJ2L2N:>Y2Vyd3!1vQ1J1lHS5jcmo,l3QYDVROO33YEFL 1<p!<eAc
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i.b3i.DYo BooOQU67Ci.e
K cqr RLkTe3YmqF1<CCpbZtNWk:Oc q8L8fNF+P+UDI005XJgmsPs37+9 A5X6UPA
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HIICZzCCAdCgAvii3P.gi3ADAN3gkqkiG9•,i03AQUFADA2HQ8wDQYDVQQ?CEviZlilYVk
T kx zA:>BgN3lAsTGm1EZXYgQ2VydGImaio1NOdGUgQXVOaG9yaXR5!2 XDTA5!Diy
NzA1!1DAvll1FcXDT xl1D xl1LDAONTk1OVo•,INjEP!1AOGA1UEC:o!1GZU11ZE5Zl1Sl1VQQYD
VQQLExptRGV2
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jQAv;gYkCgYEAss2jj3kOvrvWt!<12vpN;,CdEA9jkx qksOjd8rub+O/:0RU5
NErzVJO z42x/niEmZGiP0miYeWoG616oHiv3vC30VgsSr/DW+0ArY09ZFcnrs3
bCUJvVLlH76a5+tVn076k129Gfqz1Soli>biZceuk:11V9j1yDyJH:1ivdV3nlsCAwEA Aa03hDC3giA/
3gig kg3hvhCAQOEMt-IR2VuZXJdGVkiGJ5IRoZS3IZi-1N1cmlO
eS3TZXJ2ZX gZm9y3lovT1!1gKFJ3QOYpH1!9GA1UdDv E3/VIQEAVB3jAP3gNV3RI 2

Af8E3TADAQH/!120GA1UdDgQW33R3tcmjdnV!1H> QuvqI:lZt5FnNsUjA."B

gkq;,k G

9•,i03AQUFAAOBgQ3QhDoquOdZCvtd3Jlj9byfJ0savF3JHp+ yHLqigaHbAGWi1
6RS5;T;,N21<2E699iR;xuA!1PyHkVviFC01CJ::8T•,;r.;-lttbUT5 Yncp3XLdmerU1<fQ
3I8v3s3XOQn;13CuNpiVIAti39Z/PSSDor,idsiOo9113?C+wY2 duigwj2gNIEA
-----END CERTIFICATE-----

Appendices

Provider Search & Selection

Select an Existing Provider

1. Select a name from the available drop-down list of previously used providers available in the support file. Due to space constraints, only the first 15 characters of the " LastName, FirstName MiddleName" will be displayed.

2. Confirm the correct physician was selected by reviewing the Contact Information and Provider Type displayed.

3. If the provider is not correct, click <<Change Provider and either select a different provider from the list or search for the provider in the master provider file (see Search for a Medicaid Provider below).

4. If the provider is correct, either continue on to the next Provider type or the next tab.

Search for a Medicaid Provider

1. Enter the physician's full Last Name **OR** National Provider ID or the Medicaid ID into the appropriate fields and click Go to search the database of NY Medicaid Providers. NOTE: Entering the provider's Last Name followed by a single space and the provider's first name will help narrow the list of providers with a common last name.

2. If multiple providers are returned, a table will display containing all the matches, select the desired physician and click Select Provider.

3. If a single provider matches the name or ID entered, the single record will display, click Select Provider and continue.

4. If no providers match the name or ID entered, the error message "**Provider Not Found**" will be displayed.

5. If providers were returned but none are the desired physician or if no providers match the name or ID entered, this may be due to a typographical error in the search criteria, if so click Change Provider and try again, otherwise you will need to Enter a New Non-Medicaid Provider.

Enter a New Non-Medicaid Provider

Fill out the fields with the appropriate amount of information that you have for the physician. This data will be validated against the support file for potential matches based on the information that you enter, to avoid duplication of data. Duplication is based on the State License Number and SSN, if entered.

Last Name: A last name must be entered when entering any type of physician, Person or Non-Person. If the Provider is identified as a Non-Person Entity, such as an organization, then the entire Organization name will be entered here and the First Name and Middle Initial fields will remain blank.

First Name: This is the first name of the selected physician, however is only required if the Person radio button was selected.

Middle Initial: The middle initial is optional for all physician types; if entered, it will assist in differentiating multiple physicians with common first and last names.

EIN or SSN: Either the EIN or the SSN is required if a Last Name is entered. The setting of the radio button will determine which is to be entered. Valid entries must be 9 digits and may be entered with or without the appropriate dashes.

NPI# AND/OR State License #: NPI# AND/OR State License # is required if Last name entered. Enter either the National Provider ID or the State License #, or enter Both. For State License Number : Enter the 3-digit Profession Code, 2-character State Code (out of state providers) or Privilege Code (in state providers) and 6-digit license for a total of 11 characters. If the license number does not equal 6-digits, zero-fill the appropriate positions preceding the license number.

Category of Service

The Category of Service is a 4-digit code used to distinguish the type of claim to be entered. In ePACES, rather than enter the code, you will need to select the claim type from a list (Institutional, Dental, Professional). Therefore, this mapping is provided as a reference.

Category of Service	Claim Type	Provider Type
0001	Professional	Chain DME Dealer
0002	Professional	Chain Nursing Registry
0010	Professional	Shared Health Facility
0020	Dental	Dental Group
0046	Professional	Physician Group
0050	Professional	Podiatrist Group
0052	Professional	Nurse-Midwife Group
0056	Professional	Clinical Social Worker Group
0058	Professional	Clinical Psychologist
0062	Professional	Therapy Group Services
0090	Professional	Multi Type Group Services
0121	Institutional	Child Care Agencies - Medical Per Diem
0122	Institutional	Child Care Agencies - Not Medical Per Diem
0123	Institutional	Residential Treatment Facility
0140	Professional	Chiropractic Services
0160	Institutional	Diagnostic & Treatment Center Services
0160	Institutional	Day Treatment
0162	Institutional	Laboratory Ordered Ambulatory
0163	Institutional	Ordered Ambulatory (other than labs)
0164	Institutional	Supportive Health Services
0165	Institutional	Hospice
0166	Institutional	Pre-School Supportive Health Program
0180	Dental	Dental School Clinic Services
0200	Dental	Dental Services
0220	Institutional	Capitation Provider
0260	Institutional	Home Health Agency
0261	Professional	HHA Medical/Surgical Supply and DME Equipment
0263	Institutional	Traumatic Brain Injury
0264	Institutional	Vendor Personal Care Services
0264	Institutional	Limited Licensed Home Care Services
0265	Institutional	Case Management Services
0266	Institutional	Personal Emergency Response Services
0267	Institutional	Assisted Living Program
0268	Institutional	OMH Rehabilitative Services
0269	Institutional	OMRDD Waiver Services
0281	Institutional	Laboratory (Hospital-based) Ordered Ambulatory
0282	Institutional	Ordered Ambulatory Other Than Labs
0284	Institutional	Home Care Program
0285	Institutional	Inpatient
0286	Institutional	Skilled Nursing Facility
0287	Institutional	Hospital Based Outpatient Services
0287	Institutional	Day Treatment
0321	Professional	Durable Medical Equipment
0322	Professional	Hearing Aid Dispenser
0323	Professional	Oxygen and Related Equipment Dealer
0324	Professional	Audiologist/Hearing Aid Dealer

0325	Professional	Audiologist
0381	Institutional	Skilled Nursing Facility
0383	Institutional	Day Care
0384	Institutional	Intermediate Care Facility/Developmentally Disabled
0385	Institutional	Mental Retardation, Outpatient Services
0386	Institutional	HHA Professional Services
0388	Institutional	Long Term Home Health Care
0389	Institutional	Ordered Ambulatory Other Than Labs
0401	Professional	Optical Establishment with Salaried Optometrist
0402	Professional	Optical Establishment without Salaried Optometrist
0403	Professional	Optician (Ophthalmic Dispenser) Salaried
0404	Professional	Optician (Ophthalmic Dispenser) Self-Employed
0405	Professional	Eye Prosthesis Fitter
0421	Professional	Optometrist (Salaried)
0422	Professional	Optometrist (Self Employed)
0423	Professional	Optometrist Who Employs Other Optometrists or an Optician
0442	Professional	Pharmacy Medical Supplies, Equipment and Appliances
0443	Professional	Pharmacy Hearing Aid Dispenser
0460	Professional	Physician Services
0461	Professional	Chap Prac.
0462	Professional	Physicians Assistants
0463	Professional	High Ordering Provider
0469	Professional	Nurse Prac.
0500	Professional	Podiatry Services
0521	Professional	LPN
0522	Professional	RN
0523	Professional	Hospital Registry LPN
0524	Professional	Hospital Registry RN
0525	Professional	Nurse-Midwife
0560	Professional	Clinical Social Worker Services
0580	Professional	Clinical Psychology Services
0601	Professional	Ambulance
0602	Professional	Invalid Coach
0603	Professional	Taxi
0604	Professional	Trans-Medical/Surgical Supplies
0605	Professional	Livery Services
0606	Professional	Trans Day Treatment
0609	Professional	Transportation (Other)
0621	Professional	Occupational Therapist
0622	Professional	Physical Therapist
0623	Professional	Speech Pathologist
1000	Professional	Laboratory (Free Standing)
1001	Professional	Laboratory Director

Facility Code Structure

The Facility code on Institutional claims represent the type of facility where the services were performed and are the first two digits of the Type of Bill. For a list of Bill Types use the separate pop up list as shown in the table below or refer to NUBC.org.

Code	Description
11	Hospital - Inpatient Including Medicare Part A
12	Hospital - Inpatient Medicare Part B only
13	Hospital - Outpatient
14	Hospital - Other (for hospital referenced diagnostic services, or home health not under a plan of treatment)
15	Hospital - Intermediate Care Level I
16	Hospital - Intermediate Care Level II
17	Hospital - Subacute Inpatient (Revenue Code 19X Required when this type of bill is used)
18	Hospital - Swing Beds
21	Skilled Nursing - Inpatient Including Medicare Part A
22	Skilled Nursing - Inpatient Medicare Part B only
23	Skilled Nursing - Outpatient
24	Skilled Nursing - Other (for hospital referenced diagnostic services, or home health not under a plan of treatment)
25	Skilled Nursing - Intermediate Care Level I
26	Skilled Nursing - Intermediate Care Level II
27	Skilled Nursing - Subacute Inpatient (Revenue Code 19X Required when this type of bill is used)
28	Skilled Nursing - Swing Beds
32	Home Health - Inpatient Medicare Part B only
33	Home Health - Outpatient
34	Home Health - Other (for hospital referenced diagnostic services, or home health not under a plan of treatment)
41	Religious Non-medical Health Care Institutions - Hospital Inpatient - Inpatient Including Medicare Part A
42	Religious Non-medical Health Care Institutions - Hospital Inpatient - Inpatient Medicare Part B only
43	Religious Non-medical Health Care Institutions - Hospital Inpatient - Outpatient
44	Religious Non-medical Health Care Institutions - Hospital Inpatient - Other (for hospital referenced diagnostic services, or home health not under a plan of treatment)
45	Religious Non-medical Health Care Institutions - Hospital Inpatient - Intermediate Care Level I
46	Religious Non-medical Health Care Institutions - Hospital Inpatient -

	Intermediate Care Level II
47	Religious Non-medical Health Care Institutions - Hospital Inpatient - Subacute Inpatient (Revenue Code 19X Required when this type of bill is used)
48	Religious Non-medical Health Care Institutions - Hospital Inpatient - Swing Beds
51	Religious Non-medical Health Care Institutions - Post-hospital Extended Care Services - Inpatient Including Medicare Part A
52	Religious Non-medical Health Care Institutions - Post-hospital Extended Care Services - Inpatient Medicare Part B only
53	Religious Non-medical Health Care Institutions - Post-hospital Extended Care Services - Outpatient
54	Religious Non-medical Health Care Institutions - Post-hospital Extended Care Services - Other (for hospital referenced diagnostic services, or home health not under a plan of treatment)
55	Religious Non-medical Health Care Institutions - Post-hospital Extended Care Services - Intermediate Care Level I
56	Religious Non-medical Health Care Institutions - Post-hospital Extended Care Services - Intermediate Care Level II
57	Religious Non-medical Health Care Institutions - Post-hospital Extended Care Services - Subacute Inpatient (Revenue Code 19X Required when this type of bill is used)
58	Religious Non-medical Health Care Institutions - Post-hospital Extended Care Services - Swing Beds
61	Intermediate Care - Inpatient Including Medicare Part A
62	Intermediate Care - Inpatient Medicare Part B only
63	Intermediate Care - Outpatient
64	Intermediate Care - Other (for hospital referenced diagnostic services, or home health not under a plan of treatment)
65	Intermediate Care - Intermediate Care Level I
66	Intermediate Care - Intermediate Care Level II
67	Intermediate Care - Subacute Inpatient (Revenue Code 19X Required when this type of bill is used)
68	Intermediate Care - Swing Beds
71	Clinic - Rural Health
72	Clinic - Hospital Based or Independent Renal Dialysis Center
73	Clinic - Free Standing
74	Clinic - Outpatient Rehabilitation Facility (ORF)
75	Clinic - Comprehensive Outpatient Rehabilitation Facility (CORF)
76	Clinic - Community Mental Health Center
79	Clinic - Other
81	Special Facility - Hospice (non-hospital based)

82	Special Facility - Hospice (hospital based)
83	Special Facility - Ambulatory Surgery Center
84	Special Facility - Free Standing Birthing Center
85	Special Facility - Critical Access Hospital
86	Special Facility - Residential Facility
89	Special Facility - Other

Taxonomy and Service Type Codes

To ensure correct Utilization Threshold processing, use the appropriate Taxonomy Code/Service Type Code Combinations.

NYS Providers

If you are...	And your Specialty Code is	Use Taxonomy Code	Service Type Code
AIDS Clinic Freestanding	249, 355		85 - AIDS
Clinic - Freestanding	300, 301, 302, 303, 304, 305, 308, 309, 320, 900, 904, 908, 913, 934, 936, 937, 938, 939, 940, 941, 942, 943, 944, 949, 960, 961, 962, 967, 968, 970, 975, 976, 983, 984, 985, 986, 987, 988, 989, 990, 991, 993, 994, 995, 996, 997, 998		1 - Medical Care 6 - Radiation Therapy 15 - Alternate Method Dialysis 53 - Hospital – Ambulatory Surgical 65 - Newborn Care 68 - Well Baby Care 69 – Maternity 76 - Dialysis 78 - Chemotherapy A9 - Rehabilitation AJ - Alcoholism AK - Drug Addiction
Clinic - Hospital Based	300, 301, 302, 303, 304, 305, 308, 309, 320, 904, 908, 913, 934, 936, 937, 938, 939, 940, 941, 942, 943, 944, 949, 969, 961, 962, 967, 968, 970, 972, 973, 975, 976, 979, 983, 984, 985, 986, 987, 988, 989, 990, 991, 993, 994, 995, 996, 997, 998		1 - Medical Care 6 - Radiation Therapy 15 - Alternate Method Dialysis 53 - Hospital – Ambulatory Surgical 65 - Newborn Care 68 - Well Baby Care 69 – Maternity 76 - Dialysis 78 - Chemotherapy A9 - Rehabilitation AJ - Alcoholism AK - Drug Addiction
Clinic - Hospital Based	740		56 - Medically Related Transportation
Clinic - Hospital Based or Freestanding	902, 903, 905, 909, 914, 915, 916, 917, 925, 926, 927, 928, 929, 930, 931, 932, 933, 950, 951, 952, 953, 954, 955, 956, 957, 965, 966, 999		2 - Surgical 3 – Consultation 17 - Pre-Admission Testing 20 - Second Surgical Opinion 21 - Third Surgical Opinion 50 - Hospital - Outpatient 64 - Acupuncture 67 - Smoking Cessation 71 - Audiology Exam (Non-DVS) 72 - Inhalation Therapy 73 - Diagnostic Medical 79 - Allergy Testing 80 - Immunizations 98 - Professional (Physician) Visit - Office 99 – Professional (Physician) Visit - Inpatient A0 - Professional (Physician) Visit - Outpatient A1 - Professional (Physician) Visit - Nursing Home A2 - Professional (Physician)

			Visit - Skilled Nursing Facility A3 - Professional (Physician) Visit - Home BD - Cognitive Therapy BE - Massage Therapy BF - Pulmonary Rehabilitation
Clinic - Hospital Based or Freestanding	918		BG - Cardiac Rehabilitation BS - Invasive Procedures - Podiatry - Podiatry - Office Visits
Clinic - Freestanding	919 920, 921, 923, 924, 958	261Q00000X ---------- or No Taxonomy	95 - Podiatry - Nursing Home Visits 50 - Hospital - Outpatient ---------- or AC - Rehabilitation - Outpatient AD - Occupational Therapy AE - Physical Medicine
Clinic - Hospital Based	919 920, 921, 923, 924, 958	282N00000X ---------- or No Taxonomy	AF - Speech Therapy AL - Vision (Optometry) 50 - Hospital - Outpatient ---------- or AC - Rehabilitation - Outpatient AD - Occupational Therapy AE - Physical Medicine
			AF - Speech Therapy AL - Vision (Optometry)
Clinic - Hospital Based or Freestanding	922		AI - Substance Abuse
Clinic - Hospital Based or Freestanding	935		77 - Otological Exam
Clinic - Hospital Based or Freestanding	969		75 - Prosthetic Device
Clinic - Hospital Based or Freestanding - DVS Clinic Abortion -	967 907		71 - Audiology Exam 84 - Abortion
Hospital Based or Freestanding Clinic Family Planning	906		82 - Family Planning
- Hospital Based or Freestanding Clinic Pharmacy -	760		88 - Pharmacy
Hospital Based or Freestanding Clinic Radiology -	998		4 - Diagnostic X-Ray
Hospital Based or Freestanding			62 - MRI/CAT Scan
Clinic/Center	321	261QM1300X	
Multispecialty -			
Hospital Based or Freestanding Clinic/Center -	306, 325	261QS1000X	

Student Health - Freestanding Dental Clinic -	350, 351	261QD0000X	35 - Dental Care
Hospital Based or Freestanding Dental Clinic -	910, 911		40 - Oral Surgery
Hospital Based or Freestanding Dental Clinic - Hospital Based or Freestanding	911		23 - Diagnostic Dental 24 - Periodontics 25 - Restorative - Endodontics 27 - Maxofocial Prosthetics 28 - Adjunctive Dental Services 35 - Dental Care 36 - Dental Crowns
Dental Clinic -	912		37 - Dental Accident 39 - Prosthodontics 38 - Orthodontics
Hospital Based or Freestanding DME Dealer - DVS Only			12 - Durable Medical Equipment Purchase
Emergency Room - Hospital Based or Freestanding	901		18 - Durable Medical Equipment Rental 51 - Hospital - Emergency Accident 52 - Hospital - Emergency
Home Health DME - DVS			Medical 86 - Emergency Services 12 - Durable Medical Equipment Purchase
Hospital General	060, 110, 181, 730	282N00000X	18 - Durable Medical Equipment Rental
Acute Care - Special Use Hospital Inpatient - Non-DVS	899		48 - Hospital - Inpatient 63 - Donor Procedures 70 - Transplants A7 - Psychiatric - Inpatient
Hospital Inpatient - DVS	COS 0285		AB - Rehabilitation - Inpatient 48 - Hospital - Inpatient 63 - Donor Procedures 70 - Transplants A7 - Psychiatric - Inpatient
Lab	411, 412, 413, 414, 415, 416, 419, 420, 421, 422, 423, 427, 430, 431, 432, 435, 436, 438, 439, 440, 441, 442, 450, 451, 460, 470, 481, 482, 483, 484, 485, 486, 491, 510, 511, 512, 513, 514, 515, 516, 518, 521, 523, 524, 531, 540, 550, 551, 552, 553, 560, 570, 572, 573, 580, 599		AB - Rehabilitation - Inpatient 5 - Diagnostic Lab
Clinic Pharmacy - Hospital Based or Freestanding	760	333600000X	

Pharmacy DME	307		12 - Durable Medical Equipment Purchase 18 - Durable Medical Equipment Rental
Physician	010, 030, 040, 041, 050, 060, 062, 063, 064, 065, 066, 067, 068, 069, 070, 080, 089, 092, 093, 100, 110, 120, 131, 135, 136, 137, 138, 139, 141, 142, 143, 146, 148, 160, 162, 170, 182, 183, 184, 185, 194, 200, 201, 202, 210, 220, 230, 241, 242, 402, 403, 404, 777		A0 - Professional (Physician) Visit - Outpatient
Physician	020, 130, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 161, 163, 169, 186, 191, 192, 193, 195, 196, 205, 247, 249, 252, 253, 254, 270 ,306, 401, 751		98 - Professional (Physician) Visit - Office
Physician			86 - Emergency Services
Physician	750		AK - Drug Addiction
Physician Abortion			84 - Abortion
Physician Group	010, 060, 063, 089, 100, 150, 158, 159, 161, 750	193400000X	
Physician Radiology	081, 206, 207, 208		04 - Diagnostic X-Ray
Psychiatric Clinic - Hospital Based	310, 311, 315, 316, 322, 945, 946, 947, 948, 963, 964, 971, 974		A4 - Psychiatric A6 - Psychotherapy BC - Day Care (Psychiatric)
Psychiatric Clinic - Freestanding	310, 311, 315, 316, 322, 945, 946, 947, 948, 963, 964, 974		A4 - Psychiatric A6 - Psychotherapy BC - Day Care (Psychiatric)
Psychiatric Clinic - Hospital Based or Freestanding	312, 313, 314, 317, 318, 319, 323, 352, 353, 354, 959, 978, 980, 982, 992		A8 - Psychiatric - Outpatient BB - Partial Hospitalization (Psychiatric)
Transportation DME - DVS Only			12 - Durable Medical Equipment Purchase 18 - Durable Medical Equipment Rental

Out-of-State Providers

If you are an Out of State Provider of one of the types listed blow, use the Taxonomy Code provided for all MEVS transactions (Eligibility and DVS Requests).

If you are...	And your Specialty Code is	Use Taxonomy Code	Service Type Code
Clinical Psychologist		103GC0700X	
Licensed Practical Nurse		164W00000X	
Midwife/Certified Nurse		367A00000X	
Nurse Practitioner		363L00000X	
Occupational Therapist		225X00000X	
Physical Therapist		225100000X	
Physician - General Practice		208D00000X	
Registered Nurse - General Practice		163WG0000X	
Speech/Language Pathologist		235Z00000X	

Claim Status Codes

Claim Status codes are used in the Health Care Claim Status Notification (277) transaction. They indicate the detail about the general status communicated in the Claim Status Category Codes. Claim status codes communicate information about the status of a claim, i.e., whether it's been received, pended, or paid. The Claim Status transaction is not used as a financial transaction.

Code	Description
0	Cannot provide further status electronically.
1	For more detailed information, see remittance advice.
2	More detailed information in letter.
3	Claim has been adjudicated and is awaiting payment cycle.
4	This is a subsequent request for information from the original request.
5	This is a final request for information.
6	Balance due from the subscriber.
7	Claim may be reconsidered at a future date.
8	No payment due to contract/plan provisions.
9	No payment will be made for this claim.
10	All originally submitted procedure codes have been combined.
11	Some originally submitted procedure codes have been combined.
12	One or more originally submitted procedure codes have been combined.
13	All originally submitted procedure codes have been modified.
14	Some all originally submitted procedure codes have been modified.
15	One or more originally submitted procedure codes have been modified.
16	Claim/encounter has been forwarded to entity.
17	Claim/encounter has been forwarded by third party entity to entity.
18	Entity received claim/encounter, but returned invalid status.
19	Entity acknowledges receipt of claim/encounter.
20	Accepted for processing.
21	Missing or invalid information.
22	... before entering the adjudication system.
23	Returned to entity.
24	Entity not approved as an electronic submitter.
25	Entity not approved.

Code	Description
26	Entity not found.
27	Policy canceled.
28	Claim submitted to wrong payer.
29	Subscriber and policy number/contract number mismatched.
30	Subscriber and subscriber id mismatched.
31	Subscriber and policyholder name mismatched.
32	Subscriber and policy number/contract number not found.
33	Subscriber and subscriber id not found.
34	Subscriber and policyholder name not found.
35	Claim/encounter not found.
37	Predetermination is on file, awaiting completion of services.
38	Awaiting next periodic adjudication cycle.
39	Charges for pregnancy deferred until delivery.
40	Waiting for final approval.
41	Special handling required at payer site.
42	Awaiting related charges.

44	Charges pending provider audit.
45	Awaiting benefit determination.
46	Internal review/audit.
47	Internal review/audit - partial payment made.
48	Referral/authorization.
49	Pending provider accreditation review.
50	Claim waiting for internal provider verification.

Code	Description
51	Investigating occupational illness/accident.
52	Investigating existence of other insurance coverage.
53	Claim being researched for Insured ID/Group Policy Number error.
54	Duplicate of a previously processed claim/line.
55	Claim assigned to an approver/analyst.
56	Awaiting eligibility determination.
57	Pending COBRA information requested.
59	Non-electronic request for information.
60	Electronic request for information.
61	Eligibility for extended benefits.
64	Re-pricing information.
65	Claim/line has been paid.
66	Payment reflects usual and customary charges.
67	Payment made in full.
68	Partial payment made for this claim.
69	Payment reflects plan provisions.
70	Payment reflects contract provisions.
71	Periodic installment released.
72	Claim contains split payment.
73	Payment made to entity, assignment of benefits not on file.

Code	Description
78	Duplicate of an existing claim/line, awaiting processing.
81	Contract/plan does not cover pre-existing conditions.
83	No coverage for newborns.
84	Service not authorized.
85	Entity not primary.
86	Diagnosis and patient gender mismatch.
87	Denied: Entity not found.
88	Entity not eligible for benefits for submitted dates of service.
89	Entity not eligible for dental benefits for submitted dates of service.
90	Entity not eligible for medical benefits for submitted dates of service.
91	Entity not eligible/not approved for dates of service.
92	Entity does not meet dependent or student qualification.
93	Entity is not selected primary care provider.
94	Entity not referred by selected primary care provider.
95	Requested additional information not received.
96	No agreement with entity.
97	Patient eligibility not found with entity.
98	Charges applied to deductible.
99	Pre-treatment review.
100	Pre-certification penalty taken.

Code	Description
101	Claim was processed as adjustment to previous claim.
102	Newborn's charges processed on mother's claim.
103	Claim combined with other claim(s).
104	Processed according to plan provisions.
105	Claim/line is capitated.
106	This amount is not entity's responsibility.
107	Processed according to contract/plan provisions.
108	Coverage has been canceled for this entity.
109	Entity not eligible.
110	Claim requires pricing information.
111	At the policyholder's request these claims cannot be submitted electronically.
112	Policyholder processes their own claims.
113	Cannot process individual insurance policy claims.
114	Should be handled by entity.
115	Cannot process HMO claims.
116	Claim submitted to incorrect payer.
117	Claim requires signature-on-file indicator.
118	TPO rejected claim/line because payer name is missing.
119	TPO rejected claim/line because certification information is missing.
120	TPO rejected claim/line because claim does not contain enough information.
121	Service line number greater than maximum allowable for payer.
122	Missing/invalid data prevents payer from processing claim.
123	Additional information requested from entity.
124	Entity's name, address, phone and id number.
125	Entity's name.

Code	Description
126	Entity's address.
127	Entity's phone number.
128	Entity's tax id.
129	Entity's Blue Cross provider id.
130	Entity's Blue Shield provider id.
131	Entity's Medicare provider id.
132	Entity's Medicaid provider id.
133	Entity's UPIN.
134	Entity's CHAMPUS provider id.
135	Entity's commercial provider id.
136	Entity's health industry id number.
137	Entity's plan network id.
138	Entity's site id .
139	Entity's health maintenance provider id (HMO).
140	Entity's preferred provider organization id (PPO).
141	Entity's administrative services organization id (ASO).
142	Entity's license/certification number.
143	Entity's state license number.
144	Entity's specialty license number.
145	Entity's specialty code.
146	Entity's anesthesia license number.
147	Entity's qualification degree/designation (e.g. RN, PhD,MD).

148	Entity's social security number.
149	Entity's employer id.
150	Entity's drug enforcement agency (DEA) number.

Code	Description
152	Pharmacy processor number.
153	Entity's id number.
154	Relationship of surgeon & assistant surgeon.
155	Entity's relationship to patient.
156	Patient relationship to subscriber.
157	Entity's Gender.
158	Entity's date of birth.
159	Entity's date of death.
160	Entity's marital status.
161	Entity's employment status.
162	Entity's health insurance claim number (HICN).
163	Entity's policy number.
164	Entity's contract/member number.
165	Entity's employer name, address and phone.
166	Entity's employer name.
167	Entity's employer address.
168	Entity's employer phone number.
169	Entity's employer id.
170	Entity's employee id.
171	Other insurance coverage information (health, liability, auto, etc.).
172	Other employer name, address and telephone number.
173	Entity's name, address, phone, gender, DOB, marital status, employment status and relation to subscriber.
174	Entity's student status.
175	Entity's school name.

Code	Description
176	Entity's school address.
177	Transplant recipient's name, date of birth, gender, relationship to insured.
178	Submitted charges.
179	Outside lab charges.
180	Hospital s semi-private room rate.
181	Hospital s room rate.
182	Allowable/paid from primary coverage.
183	Amount entity has paid.
184	Purchase price for the rented durable medical equipment.
185	Rental price for durable medical equipment.
186	Purchase and rental price of durable medical equipment.
187	Date(s) of service.
188	Statement from-through dates.
189	Hospital admission date.
190	Hospital discharge date.
191	Date of Last Menstrual Period (LMP)
192	Date of first service for current series/symptom/illness.
193	First consultation/evaluation date.
194	Confinement dates.
195	Unable to work dates.

196	Return to work dates.
197	Effective coverage date(s).
198	Medicare effective date.
199	Date of conception and expected date of delivery.
200	Date of equipment return.

Code	Description
201	Date of dental appliance prior placement.
202	Date of dental prior replacement/reason for replacement.
203	Date of dental appliance placed.
204	Date dental canal(s) opened and date service completed.
205	Date(s) dental root canal therapy previously performed.
206	Most recent date of curettage, root planing, or periodontal surgery.
207	Dental impression and seating date.
208	Most recent date pacemaker was implanted.
209	Most recent pacemaker battery change date.
210	Date of the last x-ray.
211	Date(s) of dialysis training provided to patient.
212	Date of last routine dialysis.
213	Date of first routine dialysis.
214	Original date of prescription/orders/referral.
215	Date of tooth extraction/evolution.
216	Drug information.
217	Drug name, strength and dosage form.
218	NDC number.
219	Prescription number.
220	Drug product id number.
221	Drug days supply and dosage.
222	Drug dispensing units and average wholesale price (AWP).
223	Route of drug/ myelogram administration.
224	Anatomical location for joint injection.
225	Anatomical location.

Code	Description
226	Joint injection site.
227	Hospital information.
228	Type of bill for UB-04 claim.
229	Hospital admission source.
230	Hospital admission hour.
231	Hospital admission type.
232	Admitting diagnosis.
233	Hospital discharge hour.
234	Patient discharge status.
235	Units of blood furnished.
236	Units of blood replaced.
237	Units of deductible blood.
238	Separate claim for mother/baby charges.
239	Dental information.
240	Tooth surface(s) involved.
241	List of all missing teeth (upper and lower).
242	Tooth numbers, surfaces, and/or quadrants involved.

243	Months of dental treatment remaining.
244	Tooth number or letter.
245	Dental quadrant/arch.
246	Total orthodontic service fee, initial appliance fee, monthly fee, length of service.
247	Line information.
248	Accident date, state, description and cause.
249	Place of service.
250	Type of service.

Code	Description
251	Total anesthesia minutes.
252	Authorization/certification number.
253	Procedure/revenue code for service(s) rendered. Please use codes 454 or 455.
254	Primary diagnosis code.
255	Diagnosis code.
256	DRG code(s).
257	ADSM-III-R code for services rendered.
258	Days/units for procedure/revenue code.
259	Frequency of service.
260	Length of medical necessity, including begin date.
261	Obesity measurements.
262	Type of surgery/service for which anesthesia was administered.
263	Length of time for services rendered.
264	Number of liters/minute & total hours/day for respiratory support.
265	Number of lesions excised.
266	Facility point of origin and destination - ambulance.
267	Number of miles patient was transported.
268	Location of durable medical equipment use.
269	Length/size of laceration/tumor.
270	Subluxation location.
271	Number of spine segments.
272	Oxygen contents for oxygen system rental.
273	Weight.
274	Height.
275	Claim.

Code	Description
276	UB-04/HCFA-1450/HCFA-1500 claim form.
277	Paper claim.
278	Signed claim form.
279	Itemized claim.
280	Itemized claim by provider.
281	Related confinement claim.
282	Copy of prescription.
283	Medicare worksheet.
284	Copy of Medicare ID card.
285	Vouchers/explanation of benefits (EOB).
286	Other payer's Explanation of Benefits/payment information.
287	Medical necessity for service.
288	Reason for late hospital charges.
289	Reason for late discharge.
290	Pre-existing information.
291	Reason for termination of pregnancy.
292	Purpose of family conference/therapy.
293	Reason for physical therapy.
294	Supporting documentation.
295	Attending physician report.
296	Nurse's notes.
297	Medical notes/report.
298	Operative report.
299	Emergency room notes/report.
300	Lab/test report/notes/results.

Code	Description
301	MRI report.
302	Refer to codes 300 for lab notes and 311 for pathology notes.
303	Physical therapy notes. Please use code 297:6O (6 'OH' - not zero).
304	Reports for service.
305	X-ray reports/interpretation.
306	Detailed description of service.
307	Narrative with pocket depth chart.
308	Discharge summary.
309	Code was a duplicate of code 299.
310	Progress notes for the six months prior to statement date.
311	Pathology notes/report.
312	Dental charting.
313	Bridgework information.
314	Dental records for this service.
315	Past perio treatment history.
316	Complete medical history.
317	Patient's medical records.
318	X-rays.
319	Pre/post-operative x-rays/photographs.
320	Study models.

321	Radiographs or models.
322	Recent fm x-rays.
323	Study models, x-rays, and/or narrative.
324	Recent x-ray of treatment area and/or narrative.
325	Recent fm x-rays and/or narrative.

Code	Description
326	Copy of transplant acquisition invoice.
327	Periodontal case type diagnosis and recent pocket depth chart with narrative.
328	Speech therapy notes. Please use code 297:6R.
329	Exercise notes.
330	Occupational notes.
331	History and physical.
332	Authorization/certification (include period covered).
333	Patient release of information authorization.
334	Oxygen certification.
335	Durable medical equipment certification.
336	Chiropractic certification.
337	Ambulance certification/documentation.
338	Home health certification. Please use code 332:4Y.
339	Enteral/ parenteral certification.
340	Pacemaker certification.
341	Private duty nursing certification.
342	Podiatric certification.
343	Documentation that facility is state licensed and Medicare approved as a surgical facility.
344	Documentation that provider of physical therapy is Medicare Part B approved.
345	Treatment plan for service/diagnosis.
346	Proposed treatment plan for next 6 months.
347	Refer to code 345 for treatment plan and code 282 for prescription.
348	Chiropractic treatment plan.
349	Psychiatric treatment plan. Please use codes 345:5I, 5J, 5K, 5L, 5M, 5N, 5O (5 'OH' - not zero), 5P.
350	Speech pathology treatment plan. Please use code 345:6R.

Code	Description
351	Physical/occupational therapy treatment plan. Please use codes 345:6O (6 'OH' - not zero), 6N.
352	Duration of treatment plan.
353	Orthodontics treatment plan.
354	Treatment plan for replacement of remaining missing teeth.
355	Has claim been paid?
356	Was blood furnished?
357	Has or will blood be replaced?
358	Does provider accept assignment of benefits?
359	Is there a release of information signature on file?
360	Is there an assignment of benefits signature on file?
361	Is there other insurance?
362	Is the dental patient covered by medical insurance?

363	Will worker's compensation cover submitted charges?
364	Is accident/illness/condition employment related?
365	Is service the result of an accident?
366	Is injury due to auto accident?
367	Is service performed for a recurring condition or new condition?
368	Is medical doctor (MD) or doctor of osteopath (DO) on staff of this facility?
369	Does patient condition preclude use of ordinary bed?
370	Can patient operate controls of bed?
371	Is patient confined to room?
372	Is patient confined to bed?
373	Is patient an insulin diabetic?
374	Is prescribed lenses a result of cataract surgery?
375	Was refraction performed?

Code	Description
376	Was charge for ambulance for a round-trip?
377	Was durable medical equipment purchased new or used?
378	Is pacemaker temporary or permanent?
379	Were services performed supervised by a physician?
380	Were services performed by a CRNA under appropriate medical direction?
381	Is drug generic?
382	Did provider authorize generic or brand name dispensing?
383	Was nerve block used for surgical procedure or pain management?
384	Is prosthesis/crown/inlay placement an initial placement or a replacement?
385	Is appliance upper or lower arch & is appliance fixed or removable?
386	Is service for orthodontic purposes?
387	Date patient last examined by entity.
388	Date post-operative care assumed.
389	Date post-operative care relinquished.
390	Date of most recent medical event necessitating service(s).
391	Date(s) dialysis conducted.
392	Date(s) of blood transfusion(s).
393	Date of previous pacemaker check.
394	Date(s) of most recent hospitalization related to service.
395	Date entity signed certification/ recertification.
396	Date home dialysis began.
397	Date of onset/exacerbation of illness/condition.
398	Visual field test results.
399	Report of prior testing related to this service, including dates.
400	Claim is out of balance.

Code	Description
401	Source of payment is not valid.
402	Amount must be greater than zero.
403	Entity referral notes/orders/prescription.
404	Specific findings, complaints, or symptoms necessitating service.
405	Summary of services.
406	Brief medical history as related to service(s).

407	Complications/mitigating circumstances.
408	Initial certification.
409	Medication logs/records (including medication therapy).
410	Explain differences between treatment plan and patient's condition.
411	Medical necessity for non-routine service(s).
412	Medical records to substantiate decision of non-coverage.
413	Explain/justify differences between treatment plan and services rendered.
414	Need for more than one physician to treat patient.
415	Justify services outside composite rate.
416	Verification of patient's ability to retain and use information.
417	Prior testing, including result(s) and date(s) as related to service(s).
418	Indicating why medications cannot be taken orally.
419	Individual test(s) comprising the panel and the charges for each test.
420	Name, dosage and medical justification of contrast material used for radiology procedure.
421	Medical review attachment/information for service(s).
422	Homebound status.
423	Prognosis.
424	Statement of non-coverage including itemized bill.
425	Itemize non-covered services.

Code	Description
426	All current diagnoses.
427	Emergency care provided during transport.
428	Reason for transport by ambulance.
429	Loaded miles and charges for transport to nearest facility with appropriate services.
430	Nearest appropriate facility.
431	Provide condition/functional status at time of service.
432	Date benefits exhausted.
433	Copy of patient revocation of hospice benefits.
434	Reasons for more than one transfer per entitlement period.
435	Notice of Admission.
436	Short term goals.
437	Long term goals.
438	Number of patients attending session.
439	Size, depth, amount, and type of drainage wounds.
440	why non-skilled caregiver has not been taught procedure.
441	Entity professional qualification for service(s).
442	Modalities of service.
443	Initial evaluation report.
444	Method used to obtain test sample.
445	Explain why hearing loss not correctable by hearing aid.
446	Documentation from prior claim(s) related to service(s).
447	Plan of teaching.
448	Invalid billing combination. See STC12 for details. This code should only be used to indicate an inconsistency between two or more data elements on the claim. A detailed explanation is required in STC12 when this code is used.
449	Projected date to discontinue service(s).

450	Awaiting spend down determination.

Code	Description
451	Preoperative and post-operative diagnosis.
452	Total visits in total number of hours/day and total number of hours/week.
453	Procedure Code Modifier(s) for Service(s) Rendered.
454	Procedure code for services rendered.
455	Revenue code for services rendered.
456	Covered Day(s).
457	Non-Covered Day(s).
458	Coinsurance Day(s).
459	Lifetime Reserve Day(s).
460	NUBC Condition Code(s).
461	NUBC Occurrence Code(s) and Date(s).
462	NUBC Occurrence Span Code(s) and Date(s).
463	NUBC Value Code(s) and/or Amount(s).
464	Payer Assigned Control Number.
465	Principal Procedure Code for Service(s) Rendered.
466	Entities Original Signature.
467	Entity Signature Date.
468	Patient Signature Source.
469	Purchase Service Charge.
470	Was service purchased from another entity?
471	Were services related to an emergency?
472	Ambulance Run Sheet.
473	Missing or invalid lab indicator.
474	Procedure code and patient gender mismatch.
475	Procedure code not valid for patient age.

Code	Description
476	Missing or invalid units of service.
477	Diagnosis code pointer is missing or invalid.
478	Claim submitter's identifier (patient account number) is missing.
479	Other Carrier payer ID is missing or invalid.
480	Other Carrier Claim filing indicator is missing or invalid.
481	Claim/submission format is invalid.
482	Date Error, Century Missing.
483	Maximum coverage amount met or exceeded for benefit period.
484	Business Application Currently Not Available.
485	More information available than can be returned in real time mode. Narrow your current search criteria.
486	Principle Procedure Date.
487	Claim not found, claim should have been submitted to/through 'entity'.
488	Diagnosis code(s) for the services rendered.
489	Attachment Control Number.
490	Other Procedure Code for Service(s) rendered.
491	Entity not eligible for encounter submission.
492	Other Procedure date.
493	Version/Release/Industry ID code not currently supported by information holder.

494	Real-Time requests not supported by the information holder, resubmit as batch request.
495	Requests for re-adjudication must reference the newly assigned payer claim control number for this previously adjusted claim. Correct the payer claim control number and re-submit.
496	Submitter not approved for electronic claim submissions on behalf of this entity.
497	Sales tax not paid.
498	Maximum leave days exhausted.
499	No rate on file with the payer for this service for this entity.
500	Entity's Postal/Zip Code.
501	Entity's State/Province.
502	Entity's City.
503	Entity's Street Address.
504	Entity's Last Name.
505	Entity's First Name.
506	Entity is changing processor/clearinghouse. This claim must be submitted to the new processor/clearinghouse.
507	HCPCS
508	ICD9
509	E-Code
510	Future date
511	Invalid character
512	Length invalid for receiver's application system.
513	HIPPS Rate Code for services Rendered.
514	Entities Middle Name.
515	Managed Care review.
516	Adjudication or Payment Date.
517	Adjusted Repriced Claim Reference Number.
518	Adjusted Repriced Line item Reference Number .
519	Adjustment Amount.
520	Adjustment Quantity.
521	Adjustment Reason Code.
522	Anesthesia Modifying Units.
523	Anesthesia Unit Count.
524	Arterial Blood Gas Quantity.
525	Begin Therapy Date.
526	Bundled or Unbundled Line Number.
527	Certification Condition Indicator.
528	Certification Period Projected Visit Count.
529	Certification Revision Date.
530	Claim Adjustment Indicator.
531	Claim Disproportionate Share Amount.
532	Claim DRG Amount.
533	Claim DRG Outlier Amount.
534	Claim ESRD Payment Amount.
535	Claim Frequency Code.
536	Claim Indirect Teaching Amount.
537	Claim MSP Pass-through Amount.
538	Claim or Encounter Identifier.

539	Claim PPS Capital Amount.
540	Claim PPS Capital Outlier Amount.
541	Claim Submission Reason Code .
542	Claim Total Denied Charge Amount.
543	Clearinghouse or Value Added Network Trace.
544	Clinical Laboratory Improvement Amendment.
545	Contract Amount.
546	Contract Code.
547	Contract Percentage.
548	Contract Type Code.
549	Contract Version Identifier.
550	Coordination of Benefits Code.
551	Coordination of Benefits Total Submitted Charge.
552	Cost Report Day Count.
553	Covered Amount.
554	Date Claim Paid.
555	Delay Reason Code.
556	Demonstration Project Identifier.
557	Diagnosis Date.
558	Discount Amount.
559	Document Control Identifier.
560	Entity's Additional/Secondary Identifier.
561	Entity's Contact Name.
562	Entity's National Provider Identifier (NPI).
563	Entity's Tax Amount.
564	EPSDT Indicator.
565	Estimated Claim Due Amount.
566	Exception Code.
567	Facility Code Qualifier.
568	Family Planning Indicator.
569	Fixed Format Information.
570	Free Form Message Text.
571	Frequency Count.
572	Frequency Period.
573	Functional Limitation Code.
574	HCPCS Payable Amount Home Health.
575	Homebound Indicator.
576	Immunization Batch Number.
577	Industry Code.
578	Insurance Type Code.
579	Investigational Device Exemption Identifier.
580	Last Certification Date.
581	Last Worked Date.
582	Lifetime Psychiatric Days Count.
583	Line Item Charge Amount.
584	Line Item Control Number.
585	Line Item Denied Charge or Non-covered Charge.
586	Line Note Text.

587	Measurement Reference Identification Code.
588	Medical Record Number.
589	Medicare Assignment Code.
590	Medicare Coverage Indicator.
591	Medicare Paid at 100% Amount.
592	Medicare Paid at 80% Amount
593	Medicare Section 4081 Indicator.
594	Mental Status Code.
595	Monthly Treatment Count.
596	Non-covered Charge Amount.
597	Non-payable Professional Component Amount.
598	Non-payable Professional Component Billed Amount.
599	Note Reference Code.
600	Oxygen Saturation Qty.
601	Oxygen Test Condition Code.
602	Oxygen Test Date.
603	Old Capital Amount.
604	Originator Application Transaction Identifier.
605	Orthodontic Treatment Months Count.
606	Paid From Part A Medicare Trust Fund Amount.
607	Paid From Part B Medicare Trust Fund Amount.
608	Paid Service Unit Count.
609	Participation Agreement.
610	Patient Discharge Facility Type Code.
611	Peer Review Authorization Number.
612	Per Day Limit Amount.
613	Physician Contact Date.
614	Physician Order Date.
615	Policy Compliance Code.
616	Policy Name.
617	Postage Claimed Amount.
618	PPS-Capital DSH DRG Amount.
619	PPS-Capital Exception Amount.
620	PPS-Capital FSP DRG Amount.
621	PPS-Capital HSP DRG Amount.
622	PPS-Capital IME Amount.
623	PPS-Operating Federal Specific DRG Amount.
624	PPS-Operating Hospital Specific DRG Amount.
625	Predetermination of Benefits Identifier.
626	Pregnancy Indicator.
627	Pre-Tax Claim Amount.
628	Pricing Methodology.
629	Property Casualty Claim Number.
630	Referring CLIA Number.
631	Reimbursement Rate.
632	Reject Reason Code.
633	Related Causes Code.

634	Remark Code.
635	Repriced Approved Ambulatory Patient Group.
636	Repriced Line Item Reference Number.
637	Repriced Saving Amount.
638	Repricing Per Diem or Flat Rate Amount.
639	Responsibility Amount.
640	Sales Tax Amount.
641	Service Adjudication or Payment Date.
642	Service Authorization Exception Code.
643	Service Line Paid Amount.
644	Service Line Rate.
645	Service Tax Amount.
646	Ship, Delivery or Calendar Pattern Code.
647	Shipped Date.
648	Similar Illness or Symptom Date.
649	Skilled Nursing Facility Indicator.
650	Special Program Indicator.
651	State Industrial Accident Provider Number.
652	Terms Discount Percentage.
653	Test Performed Date.
654	Total Denied Charge Amount.
655	Total Medicare Paid Amount.
656	Total Visits Projected This Certification Count.
657	Total Visits Rendered Count.
658	Treatment Code.
659	Unit or Basis for Measurement Code.
660	Universal Product Number .
661	Visits Prior to Recertification Date Count CR702.
662	X-ray Availability Indicator.
663	Entity's Group Name.
664	Orthodontic Banding Date.
665	Surgery Date.
666	Surgical Procedure Code.

Claim Status Category Codes

Claim Status Category codes are used in the Health Care Claim Status Notification (277) transaction. They indicate the general category of the status (accepted, rejected, additional information requested, etc.) which is then further detailed in the Claim Status Codes. Claim status codes communicate information about the status of a claim. The Claim Status transaction is not used as a financial transaction.

Code	Description
	Supplemental
X0	Supplemental Messages
	Acknowledgements
A0	Acknowledgement/Forwarded-The claim/encounter has been forwarded to another entity.
A1	Acknowledgement/Receipt-The claim/encounter has been received. This does not mean that the claim has been accepted for adjudication.
A2	Acknowledgement/Acceptance into adjudication system-The claim/encounter has been accepted into the adjudication system.
A3	Acknowledgement/Returned as unprocessable claim-The claim/encounter has been rejected and has not been entered into the adjudication system.
A4	Acknowledgement/Not Found-The claim/encounter can not be found in the adjudication system.
A5	Acknowledgement/Split Claim-The claim/encounter has been split upon acceptance into the adjudication system.
A6	Acknowledgement/Rejected for Missing Information- The claim/encounter is missing the information specified in the Status Details and has been rejected.
A7	Acknowledgement/Rejected for Invalid Information- The claim/encounter has invalid information as specified in the Status Details and has been rejected.
A8	Acknowledgement/Rejected for relational field in error.
	Pending
P0	Pending: Adjudication/Details-This is a generic message about a pended claim. A pended claim is one for which no remittance advice has been issued, or only part of the claim has been paid.
P1	Pending/In Process-The claim or encounter is in the adjudication system.
P2	Pending/In Review-The claim/encounter is suspended pending review.
P3	Pending/Requested Information-The claim or encounter is waiting for information that has already been requested.
P4	Pending/Patient Requested Information.
	Finalized
F0	Finalized-The claim/encounter has completed the adjudication cycle and no more action will be taken.
F1	Finalized/Payment-The claim/line has been paid.
F2	Finalized/Denial-The claim/line has been denied.
F3	Finalized/Revised - Adjudication information has been changed.
F3F	Finalized/Forwarded-The claim/encounter processing has been completed. Any applicable payment has been made and the claim/encounter has been forwarded to a Subsequent entity as identified on the original claim or in this payer's records.
F3N	Finalized/Not Forwarded-The claim/encounter processing has been completed. Any applicable payment has been made. The claim/encounter has NOT been forwarded to any subsequent entity identified on the original claim.
F4	Finalized/Adjudication Complete - No payment forthcoming-The claim/encounter has been adjudicated and no further payment is forthcoming.

F5	Finalized/Cannot Process.
	Requests for additional information
R0	Requests for additional information/General Requests-Requests that don't fall into other R-type categories.
R1	Requests for additional information/Entity Requests-Requests for information about specific entities (subscribers, patients, various providers).
R3	Requests for additional information/Claim/Line-Requests for information that could normally be submitted on a claim.
R4	Requests for additional information/Documentation-Requests for additional supporting documentation. Examples: certification, x-ray, notes.
R5	Request for additional information/more specific detail-Additional information as a follow up to a previous request is needed. The original information was received but is inadequate. More specific/detailed information is requested.
	General
RQ	General Questions (Yes/No Responses)-Questions that may be answered by a simple "yes" or "no".
	Error
E0	Response not possible - error on submitted request data
E1	Response not possible - System Status
E2	Information Holder is not responding; Resubmit at a later time.
	Searches
D0	Entity not found - change search criteria

Entity Identifier Codes

Entity Identifier codes are used in the Health Care Claim Status Notification (277) transaction. They identify an organizational entity, a physical location, property or an individual. The Claim Status transaction is not used as a financial transaction.

Code	Description
13	Contracted Service Provider
17	Consultant's Office
1E	Health Maintenance Organization (HMO)
1G	Oncology Center
1H	Kidney Dialysis Unit
1I	Preferred Provider Organization (PPO)
1O	Acute Care Hospital
1P	Provider
1Q	Military Facility
1R	University, College or School
1S	Outpatient Surgicenter
1T	Physician, Clinic or Group Practice
1U	Long Term Care Facility
1V	Extended Care Facility
1W	Psychiatric Health Facility
1X	Laboratory
1Y	Retail Pharmacy
1Z	Home Health Care

Code	Description
28	Subcontractor
2A	Federal, State, County or City Facility
2B	Third-Party Administrator
2D	Miscellaneous Health Care Facility
2E	Non-Health Care Miscellaneous Facility
2I	Church Operated Facility
2K	Partnership
2P	Public Health Service Facility
2Q	Veterans Administration Facility
2S	Public Health Service Indian Service Facility
2Z	Hospital Unit of an Institution (prison hospital, college infirmary, etc.)
30	Service Supplier
36	Employer
3A	Hospital Unit Within an Institution for the Mentally Retarded
3C	Tuberculosis and Other Respiratory Diseases Facility
3D	Obstetrics and Gynecology Facility
3E	Eye, Ear, Nose and Throat Facility
3F	Rehabilitation Facility
3G	Orthopedic Facility
3H	Chronic Disease Facility
3I	Other Specialty Facility
3J	Children's General Facility
3K	Children's Hospital Unit of an Institution
3L	Children's Psychiatric Facility
3M	Children's Tuberculosis and Other Respiratory Diseases Facility
3N	Children's Eye, Ear, Nose and Throat Facility

3O	Children's Rehabilitation Facility
3P	Children's Orthopedic Facility
3Q	Children's Chronic Disease Facility
3R	Children's Other Speciality Facility
3S	Institution for Mental Retardation
3T	Alcoholism and Other Chemical Dependency Facility
3U	General Inpatient Care the AIDS/ARC Facility
3V	AIDS/ARC Unit
3W	Specialized Outpatient Program for AIDS/ARC
3X	Alcohol/Drug Abuse or Dependency Inpatient Unit
3Y	Alcohol/Drug Abuse or Dependency Outpatient Services
3Z	Arthritis Treatment Center

Code	Description
40	Receiver
43	Claimant Authorized Representative
44	Data Processing Service Bureau
4A	Birthing Room/LDRP Room
4B	Burn Care Unit
4C	Cardiac Catheterization Laboratory
4D	Open-Heart Surgery Facility
4E	Cardiac Intensive Care Unit
4F	Angioplasty Facility
4G	Chronic Obstructive Pulmonary Disease Service Facility
4H	Emergency Department
4I	Trauma Center (Certified)
4J	Extracorporeal Shock-Wave Lithotripter (ESWL) Unit
4L	Genetic Counseling/Screening Services
4M	Adult Day Care Program Facility
4N	Alzheimer's Diagnostic/Assessment Services
4O	Comprehensive Geriatric Assessment Facility
4P	Emergency Response (Geriatric) Unit
4Q	Geriatric Acute Care Unit
4R	Geriatric Clinics
4S	Respite Care Facility
4U	Patient Education Unit
4V	Community Health Promotion Facility
4W	Worksite Health Promotion Facility
4X	Hemodialysis Facility
4Y	Home Health Services
4Z	Hospice

Code	Description
5A	Medical Surgical or Other Intensive Care Unit
5B	Histopathology Laboratory
5C	Blood Bank
5D	Neonatal Intensive Care Unit
5E	Obstetrics Unit

5F	Occupational Health Services
5G	Organized Outpatient Services
5H	Pediatric Acute Inpatient Unit
5I	Psychiatric Child/Adolescent Services
5J	Psychiatric Consultation-Liaison Services
5K	Psychiatric Education Services
5L	Psychiatric Emergency Services
5M	Psychiatric Geriatric Services
5N	Psychiatric Inpatient Unit
5O	Psychiatric Outpatient Services
5P	Psychiatric Partial Hospitalization Program
5Q	Megavoltage Radiation Therapy Unit
5R	Radioactive Implants Unit
5S	Therapeutic Radioisotope Facility
5T	X-Ray Radiation Therapy Unit
5U	CT Scanner Unit
5V	Diagnostic Radioisotope Facility
5W	Magnetic Resonance Imaging (MRI) Facility
5X	Ultrasound Unit
5Y	Rehabilitation Inpatient Unit
5Z	Rehabilitation Outpatient Services

Code	Description
61	Performed At
6A	Reproductive Health Services
6B	Skilled Nursing or Other Long-Term Care Unit
6C	Single Photon Emission Computerized Tomography (SPECT) Unit
6D	Organized Social Work Service Facility
6E	Outpatient Social Work Services
6F	Emergency Department Social Work Services
6G	Sports Medicine Clinic/Services
6H	Hospital Auxiliary Unit
6I	Patient Representative Services
6J	Volunteer Services Department
6K	Outpatient Surgery Services
6L	Organ/Tissue Transplantation Unit
6M	Orthopedic Surgery Facility
6N	Occupational Therapy Services
6O	Physical Therapy Services
6P	Recreational Therapy Services
6Q	Respiratory Therapy Services
6R	Speech Therapy Services
6S	Women's Health Center/Services
6U	Cardiac Rehabilitation Program Facility
6V	Non-Invasive Cardiac Assessment Services
6W	Emergency Medical Technician
6X	Disciplinary Contact
6Y	Case Manager

71	Attending Physician
72	Operating Physician
73	Other Physician
74	Corrected Insured
77	Service Location
7C	Place of Occurrence

Code	Description
80	Hospital
82	Rendering Provider
84	Subscriber's Employer
85	Billing Provider
87	Pay-to Provider
95	Research Institute
CK	Pharmacist
CZ	Admitting Surgeon
D2	Commercial Insurer
DD	Assistant Surgeon
DJ	Consulting Physician
DK	Ordering Physician
DN	Referring Provider
DO	Dependent Name
DQ	Supervising Physician
E1	Person or Other Entity Legally Responsible for a Child
E2	Person or Other Entity With Whom a Child Resides
E7	Previous Employer
E9	Participating Laboratory
FA	Facility
FD	Physical Address
FE	Mail Address

Code	Description
G0	Dependent Insured
G3	Clinic
GB	Other Insured
GD	Guardian
GI	Paramedic
GJ	Paramedical Company
GK	Previous Insured
GM	Spouse Insured
GY	Treatment Facility
HF	Healthcare Professional Shortage Area (HPSA) Facility
HH	Home Health Agency
I3	Independent Physicians Association (IPA)
IJ	Injection Point
IL	Insured or Subscriber
IN	Insurer
LI	Independent Lab

LR	Legal Representative
MR	Medical Insurance Carrier
OB	Ordered By
OD	Doctor of Optometry
OX	Oxygen Therapy Facility
P0	Patient Facility
P2	Primary Insured or Subscriber
P3	Primary Care Provider
P4	Prior Insurance Carrier
P6	Third Party Reviewing Preferred Provider Organization (PPO)
P7	Third Party Repricing Preferred Provider Organization (PPO)
PT	Party to Receive Test Report
PV	Party performing certification
PW	Pick up Address

Code	Description
QA	Pharmacy
QB	Purchase Service Provider
QC	Patient
QD	Responsible Party
QE	Policyholder
QH	Physician
QK	Managed Care
QL	Chiropractor
QN	Dentist
QO	Doctor of Osteopathy
QS	Podiatrist
QV	Group Practice
QY	Medical Doctor
RC	Receiving Location
RW	Rural Health Clinic
S4	Skilled Nursing Facility
SJ	Service Provider
SU	Supplier/Manufacturer
T4	Transfer Point - Used to identify the geographic location where a patient is transferred or diverted
TQ	Third Party Reviewing Organization (TPO)
TT	Transfer To
TU	Third Party Repricing Organization (TPO)
UH	Nursing Home
X3	Utilization Management Organization
X4	Spouse
X5	Durable Medical Equipment Supplier
ZZ	Mutually Defined

Security Areas

The ePACES application has been divided into six (6) major areas which each may be secured at a different level of privilege for individual users or user groups.

Enter Claims, Build Claim Batches*Includes all pages accessed from the following links in the left hand menu: New Claim, Find Claims, Build Claim Batch, Real Time Responses.*

Claim Status Inquiries*Includes all pages accessed from the following links in the left hand menu: Status Inquiry, Status Responses.*

Support Files*Includes all pages accessed from the following links in the left hand menu: Provider, Other Payer, Submitter.*

Submit Claim Batches*Includes all pages accessed from the following links in the left hand menu: Submit Claim Batches.*

MEVS*Includes all pages accessed from the following links in the left hand menu: Eligibility Request, Eligibility Responses, SA Request, SA Responses, DVS Request, DVS Responses, SA Confirmation Request, SA Confirmation Responses, DVS Confirmation Request, DVS Confirmation Response.*

User Administration*Includes all pages accessed from the following links in the left hand menu: Add /Edit Users.*

Prior Approval*Includes all pages accessed from the following links in the left hand menu: PA Request, PA Response.*

Glossary

A

Adjustment: A transaction initiated by the provider which corrects/changes a previously paid or submitted claim for all elements except the Provider ID, Client ID, and Group ID.

Admission Date: The date on which the patient was first admitted.

Admission Hour: Indicates the hour when the patient was admitted. For further information, see the appropriate provider billing manual.

Admission Type: The type of admission.

Admitting Diagnosis: The diagnosis code indicating the condition established after study to be chiefly responsible for occasioning admission to the hospital.

Attending Physician: The physician who is primarily responsible for the patient's medical care. This may be the patient's private physician or one assigned responsibility by the hospital.

B

Batch Submit Date: Date on which the claim was batched and sent to the Payer. If this field is blank, the claim may have been batched, but has not been sent to the Payer.

C

Claim Amount: Dollar value of the claim.

Claim Reference Number: A unique number assigned by the eMedNY Contractor serving to identify each claim transaction received.

Client ID: A unique 8-digit Medicaid assigned recipient identifier serving to permanently identify data pertaining to an individual. Format: AANNNNNA, where A is alphabetic and N is numeric.

Co-Insured Days: The number of days which are considered reimbursable by the patient at the coinsurance rate for Medicare Days.

Covered Days: Covered Days are fully reimbursable by Medicaid.

D

Date of Birth: The birth date of the individual, e.g. 04/15/1995.

Date(s) of Service: The date on which the service was rendered. If a date range is displayed, the service must have been rendered between or on the specified dates.

Discharge Date: The date on which the patient was released from the hospital.

Discharge Hour: The hour when the patient was discharged. For further information, see the appropriate provider billing manual.

E

ePACES: electronic Provider Assisted Claim Entry System. A web-based application which allows users to request and receive HIPAA-compliant Claim, Eligibility, Claim Inquiry, and DVS transactions.

ETIN: The ETIN or Electronic Transmittal Identification Number was formerly known as the Tape Supplier Number or TSN.

F

Full Name: The complete name (First Name, Middle Initial, Last Name) of an individual. May be

used to display information for a client, provider, or submitter.

L

Lifetime Reserve Days: The number of lifetime reserve days used in the specified billing period.

N

National Provider Number: The National Provider Identifier (NPI) is a unique, government-issued, standard identification number for individual health care providers and provider organizations like clinics,hospitals, schools and group practices. The 10-digit number is used by all health plans and does not expire or change.

O

Operating Physician: Physician performing surgical procedures.

Organization Name/Last Name: When displaying an organization Name, as opposed to the name of an individual, only the Last Name field will be displayed, as that is where the name of the organization is stored.

Original Claim Reference Number: When submitting an adjustment or void to a sent/paid claim, enter the Claim Reference Number of the original claim as shown on the remittance statement. Note that the CRN is not the invoice number, but a unique identifier assigned to each claim.

Other Diagnosis: The diagnosis code(s) for any additional conditions that coexist at the time of admission, or develop subsequently, which affect the treatment received and/or the length of stay. Diagnoses that relate to an earlier episode which have no bearing on this hospital stay are to be excluded.

Other Physician: Used when another referring Provider ID is necessary. May be any type of Physician.

P

Patient Control Number: An identifier used in provider's billing which uniquely identifies a patient visit.

Patient Status: A code describing a specific condition or status of the patient as of the last date of service. For further information, see the appropriate provider manual.

Payer Claim ID: An ID assigned to the claim by the Payer's system, may differ from the ID assigned by the Provider.

Payer Sequence Number: A code identifying the payer's level of responsibility for payment of a claim.

Primary Administrator: Defined by Provider Relations only. User role which has access to all functions within the ePACES application for all Providers associated with the assigned ETIN. There is a one-to-one relationship between the Primary Administrator and the ETIN, therefore there may only be one Primary Administrator defined for a single ETIN. A Primary Administrator may not be maintained or inactivated.

Primary Diagnosis: The diagnosis code for the principle condition requiring medical attention.

Principal Diagnosis: The diagnosis code indicating the condition established after study to be chiefly responsible for occasioning admission to the hospital.

Principal Procedure: The procedure code indicating the performed procedure most closely related to the principal diagnosis.

Prior Authorization Number: If the provider is billing for a service that requires prior authorization, the 8-digit prior authorization number which was assigned by the NYS Department of Health Area Office.

Provider ID: An ePACES generated number, which facilitates provider uniqueness within the application. The provider is an individual or organization that provides some type of medical related service to the client. Examples are: dentists, hospitals, out-patient clinics, pediatricians, etc.

S

Service Authorization Exception Code: Indicates the service billed is exempt from utilization threshold.

State License Number: The physician must be licensed to practice medicine in the state in which the services are performed. The value will be entered as the 6-character State License Number for the physician preceded by the 2-digit license type.

T

TSN: The Tape Supplier Number is now known as the Electronic Transmittal Identification Number (ETIN) in ePACES.

Type of Claim: A claim may be one of the following: Professional, Institutional, or Dental. The type of claim will drive the fields displayed and required when entering claims. Companion Guides, Trading Partner Agreements, On-Line Help, and Provider Relations training will guide the user in selecting the correct claim type.

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