NEW YORK STATE
MEDICAID PROGRAM

INFORMATION FOR ALL PROVIDERS

GENERAL BILLING

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Common Benefit Identification Card

There are four types of Common Benefit Identification Cards (CBIC) or documents with which you will need to become familiar; a photo card, a non-photo card, a paper replacement CBIC and a Temporary Medicaid Authorization (DSS-2831A).

The photo and non-photo cards are permanent plastic cards and each contains information needed for eligibility verification for a single recipient. Each card contains the following information for the recipient: Medicaid number, first name, last name, middle initial, sex and date of birth. In addition, each card contains an access number, a sequence number, an encoded magnetic strip and a signature panel. The photo ID card also contains a photo and neither card contains an expiration date. The provider must verify recipient eligibility via the Medicaid Eligibility Verification System (MEVS) each time service is provided to be assured that a recipient is eligible.

If a recipient's permanent plastic ID card has been lost, stolen or damaged, the recipient will be issued a replacement paper CBIC (DSS-3713), which contains the following information for the recipient: Medicaid number, name, sex and date of birth. In addition, the card contains an access number, a sequence number and an expiration date. This temporary card carries an expiration date after which the card cannot be used. Verification of eligibility must be completed via MEVS whenever a temporary replacement card (DSS-3713) is presented.

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

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

There is a separate MEVS Provider Manual that is available to MMIS enrolled providers. This manual can be accessed/downloaded at the eMedNY website: emedny.org (click on Manuals).

Voice Interactive Phone System
Medicaid offers the Voice Interactive Phone System (VIPS) to afford providers the opportunity to conduct a name search to locate the Client Identification Number (CIN) of

Medicaid patients who were unable to present their cards at the time of service. This system is accessible by calling 1-518-472-1550 from a touch-tone telephone and following the voice prompts. There is a charge of $.85 per minute.

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

Note: The sample cards shown in the MEVS Provider Manual are issued to residents of New York State whose districts of fiscal responsibility are within the MMIS.

Claims for patients with these cards should be sent to:

Computer Sciences Corporation
P.O. Box 4444
Albany, NY 12204-0444

Claims for patients with non-MMIS CBIC should be sent to:

Local Department of Social Services of Fiscal Responsibility
(see Information For All Providers, Inquiry)

Timely Submission of Claims to Medicaid

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

- Litigation;
- Medicare and other insurance processing delays;
- Delay in Medicaid eligibility determinations;
- Rejection or denial of the original claim for reason(s) other than the 90-days rule;
- Administrative delay in the prior approval process;
- Interrupted maternity care;
- IPRO denial/reversal.

If a claim is denied or returned for correction, it must be corrected and resubmitted within **60 days of the date of notification** to the provider. Claims not correctly resubmitted within 60 days, or those continuing to not be payable after the second resubmission, are neither valid nor enforceable. In addition, all claims must be **finally** submitted to the fiscal agent and be payable within two years from the date the care, services or supplies were furnished in order to be valid and enforceable against the Department or a social service district.

Claims Submitted for Stop-Loss Payments

All claims for Stop-Loss payment must be finally submitted to the Department, and be payable, within two years from the close of the benefit year in order to be valid and enforceable against the Department. That is, 2002 payable claims must be finally submitted no later than December 31, 2004 with corresponding cutoff for future years.

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

All claims initially delayed over 90 days must be submitted within 30 days from the time submission came within control of the provider. For paper claims, a cover letter must be attached which specifies one or more of the acceptable reasons noted above.

Resubmitted paper claim forms should be typed or printed legibly in order to reduce delays in processing. Claim forms including attachment(s) or required documentation may be submitted in batches (50 forms or less) and enclosed in a single envelope or package. The invoice number of each claim form in the batch must be specified on the cover letter.

Please send all paper claims **less than two years old** directly to:

CSC Healthcare Systems
P.O. Box 4444
Albany, New York 12204-0444

Be sure to send the original claim form and retain a photocopy for your files. Claims submitted via tape, diskette or modem must specify the appropriate late submission reason code. Refer to the MMIS electronic billing instructions issued by the Fiscal Agent or the HIPAA 837 Companion Documents available at: https://www.nyhipaadesk.com, for valid coding.

Claims Over Two Years Old and Procedures for Requesting a Waiver of the Two Year Billing Regulation

Effective January 1, 2003, all claims **over two years** old must be submitted directly to Computer Sciences Corporation within 90 days of the date control was passed to the provider. As part of the process, those claims will be automatically denied. A denial message (Edit 01292, DOS Two Yrs Prior to Date Received) will appear on the provider's remittance statement. The Department will consider claims over two years old for payment only if the provider can produce documentation verifying that the cause of the delay was the result of one or more of the following:

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

Requests for waiver of the regulation regarding submission of claims greater than two years from the date of service must then be **received** at the address below within 90 days of the release of the Medicaid Remittance Statement confirming the Edit 01292 denial.

New York State Department of Health
Bureau of Medical Review and Payment
Two Year Review Unit
150 Broadway, Suite 6E
Albany, New York 12204-2736

Supporting documentation (cover letter of explanation, remittance statements, notice of eligibility, fair hearing decision, evidence of agency error, etc.) and a copy of the remittance statement documenting an Edit 01292 denial must accompany your written request. Any waiver requests received without the required information will be returned without further processing.

For questions on the processing, review or disposition of claims over two years old, call (800) 562-0856, menu #4.

Magnetic Media Claims Submission

Claims for payment of medical care, services and supplies may be submitted on a computer tape, diskette or modem. Most claims (originals, resubmissions, adjustments and voids) can be submitted on magnetic media; the only exceptions are claims that require paper attachments such as recipient's "consent forms" or provider's procedure reports for manual pricing.

If you would like more information about computer generated claims submission or require the input specifications for the submission of the types of claims indicated above, please call the Provider Relations Department at CSC. The telephone numbers are listed in **Information for All Providers, Inquiry**.

Claim Certification Statement

Provider certifies that:

- I am (or the business entity named on this form of which I am a partner, officer or director is) a qualified provider enrolled with and authorized to participate in the New York State Medical Assistance Program and in the profession or specialties, if any, required in connection with this claim;
- I have reviewed this form;
- I (or the entity) have furnished or caused to be furnished the care, services and supplies itemized in accordance with applicable federal and state laws and regulations;
- The amounts listed are due and, except as noted, no part thereof has been paid by, or to the best of my knowledge is payable from any source other than, the Medical Assistance Program;
- Payment of fees made in accordance with established schedules is accepted as payment in full; other than a claim rejected or denied or one for adjustment, no previous claim for the care, services and supplies itemized has been submitted or paid;
- All statements made hereon are true, accurate and complete to the best of my knowledge;
- No material fact has been omitted from this form;
- I understand that payment and satisfaction of this claim will be from federal, state and local public funds and that I may be prosecuted under applicable federal and state laws for any false claims, statements or documents or concealment of a material fact;
- Taxes from which the State is exempt are excluded;
- All records pertaining to the care, services and supplies provided including all records which are necessary to disclose fully the extent of care, services and supplies provided to individuals under the New York State Medical Assistance Program will be kept for a period of six years from the date of payment, and such records and information regarding this claim and payment therefore shall be promptly furnished upon request to the local departments of social services, the DOH, the State Medicaid Fraud Control Unit of the New York State Office of Attorney General or the Secretary of the Department of Health and Human Services;
- There has been compliance with the Federal Civil Rights Act of 1964 and with section

504 of the Federal Rehabilitation Act of 1973, as amended, which forbid discrimination on the basis of race, color, national origin, handicap, age, sex and religion;

- I agree (or the entity agrees) to comply with the requirements of 42 CFR Part 455 relating to disclosures by providers; the State of New York through its fiscal agent or otherwise is hereby authorized to (1) make administrative corrections to this claim to enable its automated processing subject to reversal by provider, and (2) accept the claim data on this form as original evidence of care, services and supplies furnished.

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

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

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