NEW YORK STATE
MEDICAID PROGRAM

PHARMACY MANUAL

BILLING GUIDELINES

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Section I – Purpose Statement

The purpose of this document is to assist the provider community in understanding and complying with the New York State Medicaid (NYS Medicaid) requirements and expectations for:

- Billing and submitting claims.
- Interpreting and using the information returned in the Medicaid Remittance Advice.

This document is customized for Pharmacies and should be used by the provider's billing staff as an instructional as well as a reference tool.

Section II – Claims Submission

Pharmacies are required to submit most of their claims to NYS Medicaid electronically. However, special submissions, for example, claims requiring attachments such as manufacturers invoices for manual review and pricing, and claims exempt from the Drug Utilization Review (DUR) requirement are allowed to be submitted on electronic or paper formats.

Electronic Claims

Pursuant to the Health Insurance Portability and Accountability Act (HIPAA), Public Law 104-191, which was signed into law August 12, 1996, the NYS Medicaid Program adopted the HIPAA-compliant transactions as the sole acceptable format for electronic claim submission, effective November 2003.

Pharmacies are required to use the HIPAA-compliant National Council for Prescription Drugs Program (NCPDP) 5.1 electronic format. In addition to this document, direct billers may also refer to the sources listed below to comply with the NYS Medicaid requirements:

- NCPDP Standard Version 5.1 Implementation Guide – A document that explains the proper use of the standards and program specifications. This document is available at www.ncpdp.org.

- NYS Medicaid NCPDP 5.1 (Request and Response) Companion Guides (CG) – These documents provide instructions for the specific requirements of NYS Medicaid for the NCPDP 5.1. These documents are available at www.emedny.org.

  ✓ Select **NYHIPAADESK** from the main menu

  ✓ Select **eMedNY Phase II HIPAA Transactions**

  ✓ In the transaction chart look for the section called “National Council for Prescription Drug Programs.” Select the appropriate document to the right, “NCPDP Request Phase II Companion Guide” or NCPDP “Response Phase II Companion Guide.”

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

  ✓ Select **NYHIPAADESK** from the menu

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

- ✓ Look for the box labeled "Technical Guides" and click on the link **TECHNICAL SUPPLEMENTARY Companion Guide**

Pre-requirements for the Submission of Electronic Claims

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

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

ETIN
This is a four-character submitter identifier, issued by the NYS Medicaid Fiscal Agent upon application and must be used in every electronic transaction submitted to NYS Medicaid. ETINs may be issued to an individual provider or provider group (if they are direct billers) and to service bureaus or clearinghouses.

ETIN applications are available at www.emedny.org.

Under **Information**:

- ✓ Click on Provider Enrollment Forms

- ✓ Click on Electronic Transmitter Identification Number

Certification Statement
All providers, either direct billers or those who billed through a service bureau or clearinghouse, must file a notarized Certification Statement with NYS Medicaid for each ETIN used for the electronic billing.

The Certification Statement is good for one year, after which it needs to be renewed for electronic billing continuity under a specific ETIN. Failure to renew the Certification Statement for a specific ETIN will result in claim rejection.

The Certification Statement is available at www.emedny.org together with the ETIN application.

User ID and Password
Electronic submitters need a user ID and password to access the NYS Medicaid eMedNY system through one of the communication methods available. The user ID and password are issued to the submitter at the time of enrollment in one of the communication methods.

Trading Partner Agreement
This document addresses certain requirements applicable to the electronic exchange of information and data associated with health care transactions. The NYS Medicaid Trading Partner Agreement is available at www.emedny.org.

From the **Menu**:

✓ Select **NYHIPAADESK**

✓ Click on **Registration Information Trading Partner Resources**

✓ Click on **Trading Partner Agreement**

Testing
Direct billers (either individual providers or service bureaus/clearinghouses that bill for multiple providers) are encouraged to submit production tests to eMedNY before they start submitting Medicaid claims for the first time after enrollment or any time they update their systems or start using a new system. This testing will assist providers in identifying errors in their system and allow for corrections before they submit actual claims. Information and instructions regarding testing are available at www.emedny.org.

Under **Information**:

✓ Click on **eMedNY Phase II**

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

Communication Methods

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

- eMedNY eXchange
- FTP
- CPU to CPU
- eMedNY Gateway

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

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

Under **Information**:

- ✓ Click on eMedNY Phase II
- ✓ Click on eMedNY Provider Testing User Guide
- ✓ On the Table of Contents, click on Overview
- ✓ Scroll down to Access Methods

FTP
FTP allows for direct or dial-up connection.

CPU to CPU (FTP)
This method consists of an established direct connection between the submitter and the processor, and it is most suitable for high volume submitters.

eMedNY Gateway
This is a dial-up access method. It requires the use of the user ID assigned at the time of enrollment and a password.

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

Paper Claims

For paper submissions, Pharmacies must use the New York State eMedNY-000301 claim form (Pharmacy Claim Form). A link to this form appears at the end of this subsection.

General Instructions for Completing Paper Claims

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

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

1 2 3 4 5 6 7 8 9 0

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

Written As	Intended As	Interpreted As	
| | | 6. | ℧ | 0 |	6.00	| | | 6. | 6 | 0 |	→ Zero interpreted as six

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

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

- Characters should not touch each other. For example:

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

- Do not write in between lines.
- Do not use arrows or quotation marks to duplicate information.

- Do not use the dollar sign ($) to indicate dollar amounts; do not use commas to separate thousands. For example, three thousand should be entered as 3000, not as 3,000.

- For writing, it is best to use a felt tip pen with a fine point. Avoid ballpoint pens that skip; do not use pencils, highlighters, or markers. Only blue or black ink is acceptable.

- If filling in information through a computer, ensure that all information is aligned properly, and that the printer ink is dark enough to provide clear legibility.

- Do not submit claim forms with corrections, such as information written over correction fluid or crossed out information. If mistakes are made, a new form should be used.

- Separate forms using perforations; do not cut the edges.

- Do not fold the claim forms.

- Do not use adhesive labels (for example for address); do not place stickers on the form.

- Do not write or use staples on the bar-code area.

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

For mailing completed claim forms, use the self-addressed envelopes provided by eMedNY for this purpose. For information on how to order envelopes, please refer to Information for All Providers, Inquiry section on this web page. The address for submitting claim forms is:

eMedNY
P.O. Box 4601
Rensselaer, NY 12144-4601

Pharmacy Claim Form - eMedNY-000301

To view the eMedNY-000301 claim form, please click on the link provided below. The displayed claim form is a sample and the information it contains is for illustration purposes only.

Claim Sample-Pharmacy

General Information About the eMedNY-000301

Shaded fields are not required to be completed **unless noted otherwise**. Therefore, shaded fields that are not required to be completed in any circumstance are not listed in the instructions that follow.

Most claim form fields have been sized to contain the exact number of characters for the required information. However, some fields have been sized to accommodate potential future changes, for example the Provider ID number, and therefore have more spaces than the current number of characters for the required information. In this case, the entry must be **right justified (unless otherwise noted in the field instructions)**; that is, the extra spaces must be left blank at the left side of the box. For example, Provider ID number 02345678 should be entered as follows:

		0	2	3	4	5	6	7	8

Billing Instructions for Pharmacy Services

This subsection of the Billing Guidelines covers the specific NYS Medicaid billing requirements for Pharmacies. Although the instructions that follow are based on the eMedNY-000301 paper claim form, they are also intended as a guideline for electronic billers who should refer to these instructions for finding out what information they need to provide in their claims, what codes they need to use, etc.

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

Field by Field Instructions for Pharmacy Claim Form-eMedNY-000301

Header Section: Fields 1 through 13A

The information entered in the Header Section of the claim form (fields 1 through 13A) must apply to all of the claim lines entered in the Encounter Section of the form.

<u>PROVIDER ID NUMBER (Field 1)</u>

The Provider ID number is the eight-digit identification number assigned to providers at the time of enrollment in the Medicaid program.

The provider's ID number and the provider's name and correspondence address are pre-printed in this field for all providers.

Note: It is the responsibility of the provider to notify Medicaid of any change of address or other pertinent information within 15 days of the change. For information on where to direct address change requests, please refer to Information for All Providers, Inquiry on this web page.

DATE FILLED (Field 2)

Enter the date on which the prescription/order is filled in the format MM/DD/YY.

Example: June 13, 2005 = 06/13/05

SA EXCP CODE (SERVICE AUTHORIZATION EXCEPTION CODE) (Field 3)

If it was necessary to provide a service covered under the Utilization Threshold program and Service Authorization (SA/UT) could not be obtained, enter the SA exception code that best describes the reason for the exception. For valid SA exception codes, please refer to Appendix A - Codes.

For more information on the Utilization Threshold Program, please refer to Information for All Providers, General Policy, which can be found on this web page.

If not applicable, leave this field blank.

Fields 4 and 4A should only be used to adjust or void a paid claim. Do not write in these fields when preparing an original claim form.

ADJUSTMENT/VOID CODE (Field 4)

- If submitting an **adjustment** (replacement) to a previously paid claim, enter **X** or the value **7** in the A box.
- If submitting a **void** to a previously paid claim, enter **X** or the value **8** in the V box.

ORIGINAL CLAIM REFERENCE NUMBER (Field 4A)

If submitting an adjustment or a void, enter the appropriate **Transaction Control Number (TCN)** in this field. A TCN is a 16-digit identifier that is assigned to each claim and listed in the Remittance Advice. **When submitting an original claim, leave this field blank.**

Adjustments

An adjustment is submitted to correct one or more fields of a previously paid claim. Any field, except the **Provider ID Number** or the **Patient's Medicaid ID Number**, can be adjusted. The adjustment must be submitted in a new claim form (a copy of the original form is unacceptable) and all applicable fields must be completed. If multiple claim lines originally submitted on the same claim form need to be adjusted, a separate claim form

must be submitted for each claim line to be adjusted. An adjustment is identified by the value **7** or **X** in the "A" box of field 4 and the claim to be adjusted is identified by the TCN entered in this field.

Adjustments cause the correction of the adjusted information in the claim history records as well as the cancellation of the original claim payment and the re-pricing of the claim based on the adjusted information.

Example:
TCN 0509567890123020 was paid on June 18, 2005. After receiving payment, the provider determines that an incorrect item code has been reported. An adjustment must be submitted to correct the claim records. Refer to Figures 1A and 1B for an illustration of this situation.

Figure 1A
NYS MEDICAL ASSISTANCE (TITLE XIX) PHARMACY CLAIM FORM

1. PROVIDER ID NUMBER: 0 1 2 3 4 5 6 7

2. DATE FILLED: MO 05 DAY 13 YR 05

3. SA EXCP CODE

ONLY TO BE USED TO ADJUST OR VOID A PAID CLAIM — 4. CODE (A / V) — 4A. ORIGINAL CLAIM NUMBER

City Pharmacy
111 Park Avenue
Anytown, NY 11111

5. RECIPIENT ID NUMBER: AA12345W

6. DATE OF BIRTH: 04191955

7. SEX: M (1) X / F (2)

8. RECIPIENT OTHER INSURANCE CODE

9. RECIPIENT NAME: LAST Brandon FIRST John

PRIOR APPROVAL/AUTHORIZATION NO. — LINE

10. PROF CD — 10A. ORDERING/PRESCRIBING PROVIDER ID/LICENSE NUMBER: 00123456 — 10B. NAME: Peter Smith — 12. — 12A. — FOR OFFICE USE ONLY

11. PROF CD — 11A. OTHER REFERRING/ORDERING PROVIDER ID/LICENSE NUMBER — 11B NAME — 13. — 13A. — 14. 1

LINE	15. PRESCRIPTION/ ORDER NUMBER	16. DATE ORDERED MO	DAY	YR	17. DRUG/SUPPLY CODE	18. QUANTITY DISPENSED	19. DAYS SUPPLY	20. NEW REFILL NUMBER	20A. NO OF REFILLS AUTHOR-IZED	21. BRAND NECES-SARY (Y 1 / N)	22. AMOUNT CHARGED	MEDICARE 23. CO-INSURANCE	23A. DEDUCT-IBLE	23B. CO-PAY	23C. PAID	24. OTHER INSUR-ANCE PAID
1	6000100	05	03	05	51079 0200 20	60.00	30	1	5	N X	15.00	.	.	.	.	.
2	6000600	05	03	05	B 4189	1.00	10	1	0	N X	70.00	.	.	.	.	.
3	6000160	05	03	05	A 6247	30.00	30	0	0	N X	20.00	.	.	.	.	.
4						.				Y 1 / N	.	.	.	.	.	.
5						.				Y 1 / N	.	.	.	.	.	.

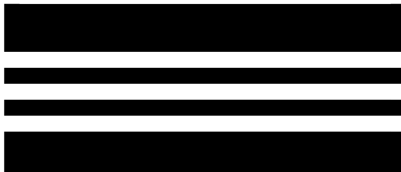
25. CASE MGR — **TOTALS** ▶ 26. . — 27. . — 27A. . — 27B. . — 27C. . — 28. .

CERTIFICATION
(I CERTIFY THAT THE STATEMENTS ON THE REVERSE SIDE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.)

29. SIGNATURE: James Strong — 30. COUNTY* — 31. BILLING DATE: MO 05 DAY 13 YR 05

*Payee must enter county wherein signed unless it is the same as that of the provider address entered in the upper left of this form.

DO NOT WRITE IN BARCODE AREA



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FOR COMPOUND USE ONLY: CIRCLE ONE LINE NUMBER 1 2 3 4 5

INGREDIENTS	QUANTITY	PRICE
		$.
		.
		.
		.

DOSAGE FORM AND DIRECTIONS		
	TOTAL INGREDIENT COST	.
	COMPOUNDING FEE	.
	DISPENSING FEE	.
	AMOUNT CHARGED	$.

Figure 1B
NYS MEDICAL ASSISTANCE (TITLE XIX) PHARMACY CLAIM FORM

Field	Value
1. PROVIDER ID NUMBER	01234567
2. DATE FILLED (MO DAY YR)	05 13 05
3. SA EXCP CODE	
ONLY TO BE USED TO ADJUST OR VOID A PAID CLAIM — 4. CODE	7 (A / V)
4A. ORIGINAL CLAIM NUMBER	0509567890123456
5. RECIPIENT ID NUMBER	AA12345W
6. DATE OF BIRTH	04191955
7. SEX	X (1) / F (2)
8. RECIPIENT OTHER INSURANCE CODE	
9. RECIPIENT NAME	LAST Brandon FIRST John
PRIOR APPROVAL/AUTHORIZATION NO. / LINE — 12. / 12A.	
13. / 13A.	
10. PROF CD	
10A. ORDERING/PRESCRIBING PROVIDER ID/LICENSE NUMBER	00123456
10B. NAME	Peter Smith
11. PROF CD	
11A. OTHER REFERRING/ORDERING PROVIDER ID/LICENSE NUMBER	
11B NAME	
14. FOR OFFICE USE ONLY	1

City Pharmacy
111 Park Avenue
Anytown, NY 11111

LINE	15. PRESCRIPTION/ ORDER NUMBER	16. DATE ORDERED MO	DAY	YR	17. DRUG/SUPPLY CODE	18. QUANTITY DISPENSED	19. DAYS SUPPLY	20. NEW REFILL NUMBER	20A. NO OF REFILLS AUTHOR-IZED	21. BRAND NECES-SARY (Y 1 / N)	22. AMOUNT CHARGED	MEDICARE 23. CO-INSURANCE	23A. DEDUCT-IBLE	23B. CO-PAY	23C. PAID	24. OTHER INSUR-ANCE PAID
1	6000160	05	03	05	A 62446	30.00	30	0	0	N (X)	10.00					
2																
3																
4																
5																

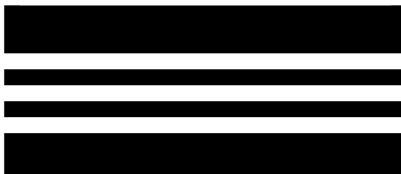
25. CASE MGR	TOTALS ▶	26.	27.	27A.	27B.	27C.	28.

CERTIFICATION
(I CERTIFY THAT THE STATEMENTS ON THE REVERSE SIDE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.)

29. SIGNATURE	30. COUNTY*	31. BILLING DATE MO	DAY	YR
James Strong		06	13	05

*Payee must enter county wherein signed unless it is the same as that of the provider address entered in the upper left of this form.

DO NOT WRITE IN BARCODE AREA



FOR COMPOUND USE ONLY: CIRCLE ONE LINE NUMBER 1 2 3 4 5

INGREDIENTS	QUANTITY	PRICE
		$.
		.
		.
		.

DOSAGE FORM AND DIRECTIONS		
	TOTAL INGREDIENT COST	.
	COMPOUNDING FEE	.
	DISPENSING FEE	.
	AMOUNT CHARGED	$.

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Void

A void is submitted to nullify a paid claim. A void must be submitted in a new claim form (a copy of the original form is unacceptable) and all applicable fields must be completed. If multiple claim lines originally submitted on the same claim form need to be voided, a separate claim form must be submitted for each claim line to be voided. A void is identified by the value **8** or **X** in the “A” box of field 4, and the claim to be voided is identified by the TCN entered in this field.

Example:

The claim with TCN 0509698765432020 was paid on June 18, 2005. Later, the provider became aware that the patient was covered by another insurance. The other insurance was billed, and the provider received full payment from that payor. Medicaid must be reimbursed by submitting a void to the previously paid claim. Refer to figures 2A and 2B for an illustration of this situation.

Figure 2A

NYS MEDICAL ASSISTANCE (TITLE XIX) PHARMACY CLAIM FORM

1. PROVIDER ID NUMBER	2. DATE FILLED (MO / DAY / YR)	3. SA EXCP CODE	ONLY TO BE USED TO ADJUST OR VOID A PAID CLAIM: 4. CODE (A / V)	4A. ORIGINAL CLAIM NUMBER
0 1 2 3 4 5 6 7	05 13 05			

City Pharmacy
111 Park Avenue
Anytown, NY 11111

5. RECIPIENT ID NUMBER	6. DATE OF BIRTH	7. SEX (M 1 / F 2)	8. RECIPIENT OTHER INSURANCE CODE	9. RECIPIENT NAME
AA12345W	04191955	X (M 1)		LAST Brandon FIRST John

10. PROF CD	10A. ORDERING/PRESCRIBING PROVIDER ID/LICENSE NUMBER	10B. NAME	PRIOR APPROVAL/AUTHORIZATION NO. 12.	LINE 12A.	FOR OFFICE USE ONLY
	0 0 1 2 3 4 5 6	Peter Smith			

11. PROF CD	11A. OTHER REFERRING/ORDERING PROVIDER ID/LICENSE NUMBER	11B NAME	13.	13A.	14.
					1

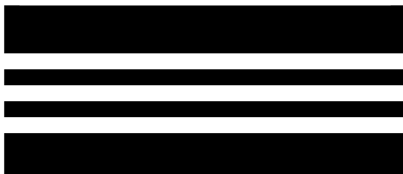
LINE	15. PRESCRIPTION/ ORDER NUMBER	16. DATE ORDERED MO	DAY	YR	17. DRUG/SUPPLY CODE	18. QUANTITY DISPENSED	19. DAYS SUPPLY	20. NEW REFILL NUMBER	20A. NO OF REFILLS AUTHOR-IZED	21. BRAND NECES-SARY (Y 1 / N)	22. AMOUNT CHARGED	MEDICARE 23. CO-INSURANCE	23A. DEDUCT-IBLE	23B. CO-PAY	23C. PAID	24. OTHER INSUR-ANCE PAID
1	6000100	05	03	05	51079 0200 20	60.00	30	1	5	X (N)	15.00	.	.	.	.	.
2						.				Y 1 / N	.	.	.	.	.	.
3						.				Y 1 / N	.	.	.	.	.	.
4						.				Y 1 / N	.	.	.	.	.	.
5						.				Y 1 / N	.	.	.	.	.	.
						25. CASE MGR		TOTALS ▶			26. .	27. .	27A. .	27B. .	27C. .	28. .

CERTIFICATION
(I CERTIFY THAT THE STATEMENTS ON THE REVERSE SIDE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.)

29. SIGNATURE	30. COUNTY*	31. BILLING DATE MO	DAY	YR
James Strong		05	13	05

*Payee must enter county wherein signed unless it is the same as that of the provider address entered in the upper left of this form.

DO NOT WRITE IN BARCODE AREA



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FOR COMPOUND USE ONLY: CIRCLE ONE LINE NUMBER 1 2 3 4 5		
INGREDIENTS	QUANTITY	PRICE
		$.
		.
		.
		.
DOSAGE FORM AND DIRECTIONS	TOTAL INGREDIENT COST	.
	COMPOUNDING FEE	.
	DISPENSING FEE	.
	AMOUNT CHARGED	$.

Figure 2B
NYS MEDICAL ASSISTANCE (TITLE XIX) PHARMACY CLAIM FORM

Field	Entry
1. PROVIDER ID NUMBER	0 1 2 3 4 5 6 7
2. DATE FILLED (MO DAY YR)	05 13 05
3. SA EXCP CODE	
ONLY TO BE USED TO ADJUST OR VOID A PAID CLAIM — 4. CODE (A / V)	8
4A. ORIGINAL CLAIM NUMBER	0 5 0 9 6 9 8 7 6 5 4 3 2 1 2 3
5. RECIPIENT ID NUMBER	AA12345W
6. DATE OF BIRTH	04191955
7. SEX (M 1 / F 2)	X (M)
8. RECIPIENT OTHER INSURANCE CODE	
9. RECIPIENT NAME	LAST Brandon FIRST John
10. PROF CD	
10A. ORDERING/PRESCRIBING PROVIDER ID/LICENSE NUMBER	0 0 1 2 3 4 5 6
10B. NAME	Peter Smith
11. PROF CD	
11A. OTHER REFERRING/ORDERING PROVIDER ID/LICENSE NUMBER	
11B NAME	
PRIOR APPROVAL/AUTHORIZATION NO. 12.	
LINE 12A.	
13.	
13A.	
FOR OFFICE USE ONLY 14.	1

City Pharmacy
111 Park Avenue
Anytown, NY 11111

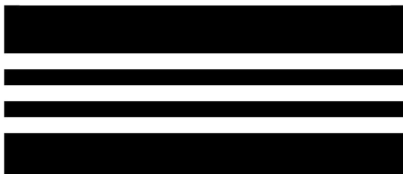
LINE	15. PRESCRIPTION/ ORDER NUMBER	16. DATE ORDERED (MO DAY YR)	17. DRUG/SUPPLY CODE	18. QUANTITY DISPENSED	19. DAYS SUPPLY	20. NEW REFILL NUMBER	20A. NO OF REFILLS AUTHOR-IZED	21. BRAND NECES-SARY (Y 1 / N)	22. AMOUNT CHARGED	MEDICARE 23. CO-INSURANCE	23A. DEDUCT-IBLE	23B. CO-PAY	23C. PAID	24. OTHER INSUR-ANCE PAID
1	6000100	05 03 05	51079 0200 20	60.00	30	1	5	X (N)	15.00	.	.	.	.	.
2				.				Y 1 N	.	.	.	.	.	.
3				.				Y 1 N	.	.	.	.	.	.
4				.				Y 1 N	.	.	.	.	.	.
5				.				Y 1 N	.	.	.	.	.	.
				25. CASE MGR		TOTALS ▶			26. .	27. .	27A. .	27B. .	27C. .	28. .

CERTIFICATION
(I CERTIFY THAT THE STATEMENTS ON THE REVERSE SIDE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.)

29. SIGNATURE	30. COUNTY*	31. BILLING DATE (MO DAY YR)
James Strong		06 13 05

*Payee must enter county wherein signed unless it is the same as that of the provider address entered in the upper left of this form.

DO NOT WRITE IN BARCODE AREA



FOR COMPOUND USE ONLY: CIRCLE ONE LINE NUMBER 1 2 3 4 5		
INGREDIENTS	QUANTITY	PRICE
		$.
		.
		.
		.
DOSAGE FORM AND DIRECTIONS	TOTAL INGREDIENT COST	.
	COMPOUNDING FEE	.
	DISPENSING FEE	.
	AMOUNT CHARGED	$.

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Fields 5-7 require information that should be obtained from the Client's (Recipient's) Common Benefit ID Card.

RECIPIENT ID NUMBER (Field 5)

Enter the recipient's ID number (Client ID Number) as it appears in the Common Benefit Identification Card. Medicaid Client ID numbers are assigned by the State of New York and are composed of eight characters in the format AANNNNNA, where A = alpha character and N = numeric character.

Example:

5. RECIPIENT ID NUMBER							
A	A	1	2	3	4	5	W

DATE OF BIRTH (Field 6)

Enter the recipient's birth date indicated in the Common Benefit ID Card. The birth date must be in the format MMDDYYYY.

Example: Mary Brandon was born on January 2nd, 2004.

6. DATE OF BIRTH							
0	1	0	2	2	0	0	4

SEX (Field 7)

Place an 'X' in the appropriate box to indicate the patient's sex.

RECIPIENT OTHER INSURANCE CODE (Field 8)

If the recipient is exempt from co-pay, enter the value Z9 in this field. For information on co-pay exemptions, refer to the Policy Guidelines section of this manual.

RECIPIENT NAME (Field 9)

Enter the recipient's last name followed by the first name as they appear on the Common Benefit Identification Card.

PROF CD (PROFESSION CODE) [Ordering/Prescribing Provider] (Field 10)

If a license number is indicated in field 10A, the Profession Code that identifies the ordering/prescribing provider's profession must be entered in this field. Profession Codes are listed at www.emedny.org.

✓ Select **NYHIPAADESK** from the menu

- ✓ Click on **eMedNY Phase II News**
- ✓ Look for the box labeled “Using License Number in Phase II” and click on **Provider License Type to Profession Code Mapping**

ORDERING/PRESCRIBING PROVIDER ID/LICENSE NUMBER (Field 10A)

Prescriptions from Practitioners
Enter the Medicaid ID Number of the ordering/prescribing provider. If the orderer/prescriber is not enrolled in the Medicaid program, enter his/her License number.

Prescriptions from Facilities
For orders originating in a hospital, clinic, or other health care facility, the following rules apply:

When a prescription is written by an unlicensed intern or resident, the supervising physician's Medicaid ID number or license number should be entered in this field. The facility's Medicaid ID number may be entered **only** when the prescriber's or the supervising physician’s Medicaid ID or License number is unavailable.

Prescriptions from Physician's Assistants
When prescriptions have been written by a Physician's Assistant, the supervising physician's Medicaid ID number or license number should be entered in this field.

Prescriptions from Nurse Practitioners
Licenses issued to Nurse Practitioners certified to write prescriptions have seven characters which includes the letter "F" followed by six digits.

Example: F012346

Certified Nurse Practitioners with licenses that contain six digits not preceded by the letter F can only write fiscal orders.

If the prescribing provider is a Nurse Practitioner certified to write prescriptions, enter his/her Medicaid ID number or license number in this field.

Note: If the Medicaid ID or State License number of an authorized prescriber is not on the prescription, it is the pharmacist's responsibility to obtain it.

Prescriptions for Restricted Recipients
When filling prescriptions/orders for a recipient who is restricted to a primary provider (physician, clinic, podiatrist or dentist) and the primary provider is the prescribing/ordering provider, the Medicaid ID number of this provider must be entered in this field. **The license number of the primary provider is not acceptable in this case.**

If the restricted recipient was referred by his/her primary provider to another provider and this provider is the prescriber/orderer, the pharmacy provider must enter this provider's Medicaid ID number or license number in this field; then, the primary provider's Medicaid ID number must be entered in field 11A.

Instructions for Entering a License Number
If a license number is used, it must be preceded by two zeroes (00) if it is a NY State license or by the standard Post Office abbreviation of the state of origin if it is an out-of-state license. Please refer to Appendix A – Codes for the Post Office state abbreviations.

NAME [Ordering/Prescribing Provider] (Field 10B)

Enter the name of the individual whose name appears as the prescriber on the prescription or fiscal order.

PROF CD (PROFESSION CODE) [Other Referring/Ordering Provider] (Field 11)

Leave this field blank.

OTHER REFERRING/ORDERING PROVIDER ID/LICENSE NUMBER (Field 11A)

Prescriptions for Restricted Recipients
If a restricted recipient was referred by his/her primary provider to another provider and this provider is the prescriber/orderer, enter the recipient's primary provider's Medicaid ID number in this field. The license number of the primary provider is not acceptable in this case.

NAME [Other Referring/Ordering Provider] (Field 11B)

Enter the name of the recipient's primary provider if a provider has been entered in field 11A.

PRIOR APPROVAL/AUTHORIZATION NO. (Field 12)

If the provider is billing for a prescription/order that requires prior approval or prior authorization, enter in this field the prior approval/authorization number assigned for the prescription/order.

LINE (Field 12A)

Enter the claim line number to which the prior approval/authorization entered in field 12 applies. If the prior approval/authorization number entered in field 12 applies to **all** claim lines, enter an "A" in this field.

PRIOR APPROVAL/AUTHORIZATION NO. (Field13)

If a prior approval/authorization number different from the one entered in field 12 applies to another claim line in the same claim form, enter the other prior approval/authorization number in this field.

LINE (Field 13A)

Enter the claim line number to which the prior approval/authorization entered in field 13 applies.

Notes:

- **For information regarding how to obtain Prior Approval/Prior Authorization for specific services, please refer to the Information for All Providers, Inquiry section on this web page.**
- **For information on how to complete the prior approval form, please refer to the Prior Approval Guidelines for this manual.**
- **For information on how to submit a DVS transaction, refer to the MEVS manual.**
- **For information regarding procedures that require prior approval, please consult the Procedure Codes and Fee Schedules for this manual.**

Pharmacy Claim Form-Encounter Section: Fields 15 Through 24

PRESCRIPTION/ORDER NUMBER (Field 15)

Enter the pharmacy prescription/order number in this field.

DATE ORDERED (Field 16)

Enter the original date on which the prescription/order was written as it appears on the prescription/order note signed by the prescribing/ordering provider. The date should be entered in the format MM/DD/YY.

> **Example**: A drug was originally prescribed for a patient on 05/03/05. The prescription is being refilled on 06/03/05. Enter 05/03/05 in field 16.

DRUG/SUPPLY CODE (Field 17)

For prescription drugs, enter in this field the National Drug Code (NDC) of the drug displayed on the package.

For OTC drugs bill using the 11-digit NDC code.

Note: Do not use the UPC code found on packaging.

For supplies and compounds, leave the first four spaces of this field blank. Enter the five-character code from the Procedure Code and Fee Schedule Section of this manual in the next five spaces and leave the next two spaces of this field blank unless a modifier is required. When a modifier is required, enter the two-character modifier in the last two spaces of this field.

Example: Medical/Surgical supply item should be entered as follows:

				A	4	4	5	2		

QUANTITY DISPENSED (Field 18)

Notes:

- **Quantities with decimals should not be rounded off.**
- **When completing this field, enter only the appropriate numbers; do not enter a quantity abbreviation, e.g., "mls."**

To determine units pricing, use the rules that follow:

Legend Drugs

- When applicable, units must be expressed in the metric system. Examples:
  - ► A pint bottle of a liquid is billed as milliliters and the quantity supplied should be "473."
  - ► A 2 oz. bottle of a liquid is billed as milliliters and the quantity supplied should be "60."
  - ► A 2 oz. unit of a solid or semi-solid is billed as grams and the quantity supplied should be "60."
- All liquid preparations that are dispensed in unbroken bottles must be billed for the same number of units (mls) indicated on the label. (e.g. Cough Preparation, 472.8 mls. bottle, is billed as a quantity of "472.8.")

- All reconstituted medications must be expressed in terms of milliliters.
  - ► Oral penicillins and penicillin derivatives are priced by the number of mls. dispensed (e.g. Ampicillin Suspension, 5 ml. - 125 mg., 100 ml, is billed as a quantity of "100.")
  - ► Powders for rectal administration are priced by the number of mls. dispensed (e.g. Cortenema, 100mg/60ml., is billed as a quantity of "60.")
- All legend drugs are billed by the appropriate unit (e.g.: Caps, Tabs, Packets, Suppositories, etc.) with the following exceptions:
  - ► Ampules are billed in ml. units (e.g.: Lasix Ampules, 20 mg/cc, five 2 ml. ampules are billed as a quantity of "10.")
  - ► Vials are billed as number of ml. (e.g.: Demerol, 100mg/ml, one 20 ml. vial is billed as a quantity of "20.")

For birth control pills and OTC drugs, please carefully comply with the instructions that follow:

- Birth control pills are billed as tablet units. (e.g.: Ovral-21 is billed as a quantity of "21.").
- Over-the-counter (OTC) drugs are billed in the same manner as legend drugs.

For medical/surgical supplies please refer to the Procedure Codes and the Fee Schedule for this manual.

DAYS SUPPLY (Field 19)

Enter the number of days for which the quantity supplied should last as written on the prescription/order.

Example: Enter 30-day supply as:

19. DAYS SUPPLY		
	3	0

If the prescription/order directs the patient "to take when necessary," enter **180** in this field.

Example:

19. DAYS SUPPLY		
1	8	0

NEW/REFILL NUMBER (Field 20)

Original Prescription/Order
Enter **0** in this field.

Refill
Indicate the number of the refill.

> **Example**: Enter **1** for first refill. Enter **5** for fifth refill.

Enteral Formula
Prior authorizations for enteral formula are issued based on "times approved" rather than refills. When billing for enteral formula products enter **0** in this field always.

NUMBER OF REFILLS AUTHORIZED (Field 20A)

Enter the number of refills indicated on the prescription/order form for the particular drug/supply. This number of refills may not exceed 5. If no refills are indicated on the prescription or if billing for enteral formula, enter **0** in this field.

BRAND NECESSARY (Field 21)

If the prescription form indicates "daw" in the "Dispense As Written" box and the ordering/prescribing provider wrote "brand necessary" or "brand medically necessary" in their own handwriting on the face of the order/prescription, place an X on Y for Yes in the proper field to indicate the brand drug was dispensed. This indicator will cause the claim to be paid at the EAC price when multiple source generic drugs affected by Upper Payment Limits are available. Otherwise, place an X on N for No.

Note: On November 17, 2002, the New York State Medicaid Program implemented the Medicaid Mandatory Generic Drug Program as a result of State legislation. For information regarding this program, please refer to the Medicaid Update, Special Edition, October 2002 Vol. 17, No. 11.

AMOUNT CHARGED (Field 22)

Enter the total amount charged for each service rendered. The amount must not exceed the provider's usual and customary charge.

Fields 23, 23A, 23B, and 23C are only applicable if the recipient is also a Medicare beneficiary.

Notes:

- **It is the responsibility of the provider to determine whether Medicare covers the service being claimed. If the service is covered or if the provider does not know if the service is covered, the provider must first submit a claim to Medicare, as Medicaid is always the payer of last resort.**

- **If the provider knows that the service rendered is not covered by Medicare, enter zero in field 23C.**

MEDICARE CO-INSURANCE (Field 23)

If applicable, enter the Medicare co-insurance amount for this drug/supply.

MEDICARE DEDUCTIBLE (Field 23A)

If applicable, enter the Medicare deductible amount for this drug/supply.

MEDICARE CO-PAY (Field 23B)

If applicable, enter the Medicare co-pay amount for this drug/supply.

MEDICARE PAID (Field 23C)

If applicable, enter the amount actually paid by Medicare for the drug/supply. If Medicare denies payment, enter $0.00 in this field.

OTHER INSURANCE PAID (Field 24)

This field must be completed if the patient is covered by insurance other than Medicare. Leave this field blank if the recipient has no other insurance coverage.

Note: It is the responsibility of the provider to determine whether the patient is covered by other insurance and whether the insurance carrier covers the service being claimed. If the service is covered or if the provider does not know if the service is covered, the provider must submit a claim to the other insurance carrier prior to billing Medicaid, as Medicaid is the payer of last resort.

If applicable, enter the amount actually paid by the other insurance carrier in this field.

If the other insurance carrier denied payment, enter 0.00 in this field. Proof of denial of payment must be maintained in the patient’s billing record. Zeroes must also be entered in this field if any of the following situations apply:

- Prior to billing the insurance company, the provider knows that the service will not be covered because:
  - The provider has had a previous denial of payment for the service from the particular insurance policy. However, the provider should be aware that the service should be billed if the insurance policy changes. Proof of denials must be maintained in the patient's billing record. Prior claims denied due to deductibles not being met are not to be counted as denials for subsequent billings.
  - In very limited situations, the Local Department of Social Services (LDSS) has advised providers to zero-fill other insurance payment for the same type of service. This communication should be documented in the patient's billing record.
- The provider bills the insurance company and receives a rejection because:
  - The service is not covered; or
  - The deductible has not been met.
- The provider cannot directly bill the insurance carrier and the policyholder is either unavailable to or uncooperative in submitting claims to the insurance company. In these cases, the LDSS must be notified prior to zero-filling. Since June 1, 1992, the LDSS has subrogation rights enabling it to complete claim forms on behalf of uncooperative policyholders who do not pay the provider for the services. The LDSS office can direct the insurance company to pay the provider directly for the service whether or not the provider participates with the insurance plan. The provider should contact the third-party worker in the local social services office whenever he/she encounters policyholders who are uncooperative in paying for covered services received by their dependents who are on Medicaid. In other cases, the provider will be instructed to zero-fill the Other Insurance Payment in the Medicaid claim and the LDSS will retroactively pursue the third-party resource.
- The recipient or an absent parent collects the insurance benefits and fails to submit payment to the provider. The LDSS must be notified so that sanctions and/or legal action can be brought against the recipient or absent parent.
- The provider is instructed to zero-fill by the LDSS for circumstances not listed above.

Pharmacy Claim Form-Certification: Fields 29 and 31

SIGNATURE (Field 29)

The provider or an authorized representative must sign the claim form. Rubber stamp signatures are not acceptable. Please note that the certification statement is on the back of the form.

COUNTY (Field 30)

Enter the name of the county wherein the claim form is signed. The county may be left blank **only** when the provider's address, as preprinted in the upper left corner of the claim form, is within the county wherein the claim form is signed.

BILLING DATE (Field 31)

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

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

FOR COMPOUND USE ONLY (Field 35)

Electronic Claims (NCPDP 5.1)
Please refer to the Procedure Codes and Fee Schedule section of this manual.

Paper Claims
Ingredients: Indicate each ingredient (as specified on the prescription) on a separate line. Indicate the manufacturer's name.

Quantity: Enter the metric quantity of each ingredient.

Price: Enter the cost of each ingredient.

Dosage Form and Directions: Indicate the form of the final preparation, i.e. cream, capsules, ointment, etc. Also, state the physician's directions in this box.

Total Ingredient Cost: Enter the total cost of the compound prescription.

Compounding Fee: Enter the fee for compounding a prescription.

Dispensing Fee: Enter the fee for dispensing a prescription.

Amount Charged: Enter the total amount charge. Also, be sure to enter this total amount in field 22 on the appropriate claim line.

Section III – Remittance Advice

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

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

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

The remittance advice, in addition to showing a record of claim transactions, can assist providers in identifying and correcting billing errors and plays an important role in the communication between the provider and the Fiscal Agent for resolving billing or processing issues.

Remittance advices are available in electronic and paper formats.

Electronic Remittance Advice

The electronic HIPAA 835 transaction (Remittance Advice) is available via the eMedNY eXchange or FTP. To request the electronic remittance advice (835), providers may call eMedNY-Provider Enrollment Support at 800-343-9000 or complete the HIPAA 835 Transaction Request form, which is available at www.emedny.org.

Under **Information**:

✓ Click on **Provider Enrollment Forms**

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

The NYS Medicaid Companion Guides for the 835 transaction are available at www.emedny.org.

✓ Select **NYHIPAADESK** from the menu

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

✓ Look for the box labeled "835 Health Care Claim Payment Advice Transaction" and select **835 Companion Guide Phase II**

Providers who submit claims under multiple ETINs receive a separate 835 for each ETIN and a separate check for each 835. Also, any 835 transaction can contain a maximum of ten thousand (10,000) claim lines; any overflow will generate a separate 835 and a separate check.

Providers who choose to receive the 835 electronic remittance advice will receive adjudicated claims (paid/denied) detail for their electronic and paper claim submissions on this format. Pending claims do not appear in the 835 transaction; they are listed in the Supplemental file, which will be sent along with the 835 transactions for any processing cycle that produces pends.

Paper Remittance Advice

Remittance advices are also available on paper. Providers who bill electronically but do not specifically request to receive the 835 transaction are sent paper remittance advices. Providers who bill all of their claims on paper forms can only receive paper remittance advices.

Remittance Sorts

The default sort for the paper remittance advice is:
Claim Status (denied, paid, pending) – Patient ID – TCN

Providers can request other sort patterns that may better suit their accounting systems. The additional sorts available are as follows:

- TCN – Claim Status – Patient ID – Date of Service
- Patient ID – Claim Status – TCN
- Date of Service – Claim Status – Patient ID

To request a sort pattern other than the default, please call Provider Enrollment Support at 800-343-9000 or complete the Remittance Sort Request Form, which is available at www.emedny.org. Under **Information**:

✓ Click on **Provider Enrollment Forms**

✓ Click on **Paper Remittance Sort Request**

Remittance Advice Format

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

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

Explanation of Remittance Advice Sections

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

The information displayed in the remittance advice samples is for illustration purposes only.

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

Section One – Medicaid Check

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

TO: CITY PHARMACY

DATE: 2005-08-01
REMITTANCE NO: 05080100001
PROVIDER ID: 00123456

05080100001 2005-08-01
CITY PHARMACY
111 PARK AVENUE
ANYTOWN NY 11111

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

29
2

DATE	REMITTANCE NUMBER	PROVIDER ID NO.
2005-08-01 VOID AFTER 90 DAYS	05080100001	00123456

PAY

DOLLARS/CENTS
$*****104.88

TO THE ORDER OF

05080100001 2005-08-01
CITY PHARMACY
111 PARK AVENUE
ANYTOWN NY 11111

John

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

Check Stub Information

UPPER LEFT CORNER
Provider's name (as recorded in the Medicaid files)

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

CENTER
Remittance number/date
Provider's name/address

Medicaid Check

LEFT SIDE
Table
Date on which the check was issued
    Remittance number
    Provider ID number
Remittance number/date
Provider's name/address

RIGHT SIDE
Dollar amount. This amount must equal the Net Total Paid Amount under the Grand Total subsection plus the total sum of the Financial Transaction section.

Section One – EFT Notification

For providers who have selected electronic funds transfer (or direct deposit), an EFT transaction is processed when the provider has claims approved during the cycle and the approved amount is greater than the recoupments, if any, scheduled for the cycle. This section indicates the amount of the EFT.

TO: CITY PHARMACY

05080100001

DATE: 2005-08-01
REMITTANCE NO:

PROVIDER ID: 00123456

05080100001 2005-08-01
CITY PHARMACY
111 PARK AVENUE
ANYTOWN NY 11111

CITY PHARMACY $104.88

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

Information on the EFT Notification Page

UPPER LEFT CORNER
Provider's name (as recorded in the Medicaid files)

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

CENTER
Remittance number/date
Provider's name/address

Provider's Name – Amount transferred to the provider's account. This amount must equal the Net Total Paid Amount under the Grand Total subsection plus the total sum of the Financial Transaction section.

Section One – Summout (No Payment)

A summout is produced when the provider has no positive total payment for the cycle and, therefore, there is no disbursement of moneys.

TO: ABC PHARMACY

DATE: 08/01/2005
REMITTANCE NO: 05080100001
PROVIDER ID: 00123456

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

CITY PHARMACY
111 PARK AVENUE
ANYTOWN NY 11111

Information on the Summout Page

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

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

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

Section Two – Provider Notification

This section is used to communicate important messages to providers.

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DATE 08/01/05
CYCLE 1458

MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

TO: CITY PHARMACY
111 PARK AVENUE
ANYTOWN, NEW YORK 11111

ETIN:
PROVIDER NOTIFICATION
PROVIDER ID 00123456
REMITTANCE NO
05080100001

REMITTANCE ADVICE MESSAGE TEXT

EMEDNY WILL BE CLOSED MONDAY, SEPTEMBER 5, 2005 IN OBSERVANCE OF LABOR DAY.

Information on the Provider Notification Page

UPPER LEFT CORNER
Provider's name and address

UPPER RIGHT CORNER
Remittance page number
Date on which the remittance advice was issued
Cycle number

ETIN (not applicable)
Name of section: **Provider Notification**
Provider ID number
Remittance number

CENTER
Message text

Section Three – Claim Detail

This section provides a listing of all new claims that were processed during the specific cycle plus claims that were previously pended and adjudicated (paid or denied) during the specific cycle. This section may also contain pending claims from previous cycles that still remain in a pend status.

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DATE 08/01/2005
CYCLE 1458

MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

TO: CITY PHARMACY
111 PARK AVENUE
ANYTOWN, NEW YORK 11111

ETIN:
PHARMACY
PROVIDER ID: 00123456
REMITTANCE NO: 05080100001

PRESCRIP TION NO.	ITEM CODE	QUANTITY	CLIENT ID NUMBER	CLIENT NAME	SERVICE DATE	TCN	CHARGED	PAID	STATUS	ERRORS
4267229	00173044100	54.000	BZ12345K	NICHOLS	05/01/05	05267-000000605-0-2	100.00	0.00	DENY	00162
4267240	00904391660	5.000	BZ12345K	NICHOLS	05/15/05	05267-000000614-0-1	50.00	0.00	DENY	00162
0426722	00904391660	5.000	CD54321J	RYDER	05/25/05	05267-000000573-0-1	30.00	0.00	DENY	00142 00144
0042664	00002411260	1.000	CD54321J	RYDER	05/01/05	05267-000000453-2-2	60.00	0.00	DENY	00142 00144

* = PREVIOUSLY PENDED CLAIM
** = NEW PEND

TOTAL AMOUNT ORIGINAL CLAIMS	DENIED	240.00	NUMBER OF CLAIMS	4
NET AMOUT ADJUSTMENTS	DENIED	0.00	NUMBER OF CLAIMS	0
NET AMOUNT VOIDS	DENIED	0.00	NUMBER OF CLAIMS	0
NET AMOUNT VOIDS – ADJUSTS		0.00	NUMBER OF CLAIMS	0

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DATE 08/01/2005
CYCLE 1458

MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

TO: CITY PHARMACY
111 PARK AVENUE
ANYTOWN, NEW YORK 11111

ETIN:
PHARMACY
PROVIDER ID: 00123456
REMITTANCE NO: 05080100001

PRESCRIP TION NO.	ITEM CODE	QUANTITY	CLIENT ID NUMBER	CLIENT NAME	SERVICE DATE	TCN	CHARGED	PAID	STATUS	ERRORS
0042663	00002411260	5.000	BB12345K	FREDERICKS	04/15/04	05267-000000437-2-1	100.00	100.00	PAID	
0042663	00002411260	5.000	BB12345K	FREDERICKS	04/15/04	05188-000000437-2-2	10.00	80.00-	ADJT	ORIGINAL CLAIM AS PAID 05/20/05
0426722	00904391660	1.000	BB12345K	FREDERICKS	05/25/04	05267-000000562-0-0	5.91	5.91	PAID	
0426711	00002411260	1.000	CG54321J	CARRS	05/10/04	05267-000000260-0-0	28.97	28.97	PAID	
0426712	00002411260	1.000	CG54321J	CARRS	05/20/04	05267-000000263-0-0	50.00	50.00	PAID	

* = PREVIOUSLY PENDED CLAIM
** = NEW PEND

TOTAL AMOUNT ORIGINAL CLAIMS	PAID	84.88	NUMBER OF CLAIMS	3
NET AMOUT ADJUSTMENTS	PAID	90.00	NUMBER OF CLAIMS	1
NET AMOUNT VOIDS	PAID	0.00	NUMBER OF CLAIMS	0
NET AMOUNT VOIDS – ADJUSTS		20.00	NUMBER OF CLAIMS	1

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DATE 08/01/2005
CYCLE 1458

MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

TO: CITY PHARMACY
111 PARK AVENUE
ANYTOWN, NEW YORK 11111

ETIN:
PHARMACY
PROVIDER ID: 00123456
REMITTANCE NO: 05080100001

PRESCRIP TION NO.	ITEM CODE	QUANTITY	CLIENT ID NUMBER	CLIENT NAME	SERVICE DATE	TCN	CHARGED	PAID	STATUS	ERRORS
4267241	00904391660	5.000	BZ12345G	CARTER	05/20/05	05272-000000027-0-1	56.00	0.00	PEND	00162 00127
4267241	00904391660	5.000	BZ12345G	CARTER	05/20/05	05272-000000028-0-2	55.00	0.00	PEND	00162 00127
4267242	00904391660	5.000	FR54321J	DUNNSON	05/05/05	05272-000000035-0-1	20.00	0.00	PEND	01154
4267243	00904391660	5.000	FR54321J	DUNNSON	05/10/05	05272-000000044-0-2	40.00	0.00	PEND	01154

* = PREVIOUSLY PENDED CLAIM
** = NEW PEND

TOTAL AMOUNT ORIGINAL CLAIMS	PEND	171 .00	NUMBER OF CLAIMS	4
NET AMOUT ADJUSTMENTS	PEND	00.00	NUMBER OF CLAIMS	0
NET AMOUNT VOIDS	PEND	00.00	NUMBER OF CLAIMS	0
NET AMOUNT VOIDS – ADJUSTS		00.00	NUMBER OF CLAIMS	0

REMITTANCE TOTALS – PHARMACY

VOIDS – ADJUSTS	20.00	NUMBER OF CLAIMS	1
TOTAL PENDS	171.00	NUMBER OF CLAIMS	4
TOTAL PAID	84.88	NUMBER OF CLAIMS	3
TOTAL DENIED	240.00	NUMBER OF CLAIMS	4
NET TOTAL PAID	64.88	NUMBER OF CLAIMS	4

MEMBER ID: 00123456

VOIDS – ADJUSTS	20.00	NUMBER OF CLAIMS	1
TOTAL PENDS	171.00	NUMBER OF CLAIMS	4
TOTAL PAID	84.88	NUMBER OF CLAIMS	3
TOTAL DENIED	240.00	NUMBER OF CLAIMS	4
NET TOTAL PAID	64.88	NUMBER OF CLAIMS	4

MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

PAGE: 05
DATE: 08/01/05
CYCLE: 1458

TO: CITY PHARMACY
111 PARK AVENUE
ANYTOWN, NEW YORK 11111

ETIN:
PHARMACY
GRAND TOTALS
PROVIDER ID: 00123456
REMITTANCE NO: 05080100001

REMITTANCE TOTALS – GRAND TOTALS

VOIDS – ADJUSTS	20.00	NUMBER OF CLAIMS	1
TOTAL PENDS	171.00	NUMBER OF CLAIMS	4
TOTAL PAID	84.88	NUMBER OF CLAIMS	3
TOTAL DENY	240.00	NUMBER OF CLAIMS	4
NET TOTAL PAID	64.88	NUMBER OF CLAIMS	4

General Information on the Claim Detail Pages

UPPER LEFT CORNER
Provider's name and address

UPPER RIGHT CORNER
Remittance page number
Date on which the remittance advice was issued
Cycle number. The cycle number should be used when calling eMedNY with questions about specific processed claims or payments.

ETIN (not applicable)
Provider Service Classification: **PHARMACY**
Provider ID number
Remittance number

Explanation of the Claim Detail Columns

PRESCRIPTION NO.
This column indicates the prescription number as it appears on the claim form.

ITEM CODE
This column shows the code that identifies the drug or supply that was dispensed (NDC code or HCPCS CODE).

QUANTITY
The quantity dispensed appears under this column. The quantity is indicated with three (3) decimal positions.

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

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

SERVICE DATE
This column lists the service date as entered in the claim form.

TCN
The TCN is a unique identifier assigned to each claim line that is processed.

CHARGED
This column lists either the amount the provider charged for the claim or the Medicare Approved amount if applicable.

PAID

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

STATUS

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

Denied Claims

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

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

Approved Claims

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

Paid Claims

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

Adjustments

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

Voids

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

Pending Claims

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

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

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

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

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

ERRORS

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

Subtotals/Totals

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

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

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

Subtotals by **provider type** are provided at the end of the claim detail listing. These subtotals are broken down by:

- Adjustments/voids (combined)
- Pends
- Paid
- Denied
- Net total paid (sum of approved adjustments/voids and paid original claims)

Totals by **member ID** are provided next to the subtotals for provider type. For pharmacies, these totals are exactly the same as the subtotals by provider type. These subtotals are broken down by:

- Adjustments/voids (combined)
- Pends
- Paid
- Deny
- Net total paid (sum of approved adjustments/voids and paid original claims)

Grand Totals for the entire provider remittance advice appear on a separate page following the page containing the **totals** by **provider type and member ID**. The grand total is broken down by:

- Adjustments/voids (combined)
- Pends
- Paid
- Deny
- Net total paid (entire remittance)

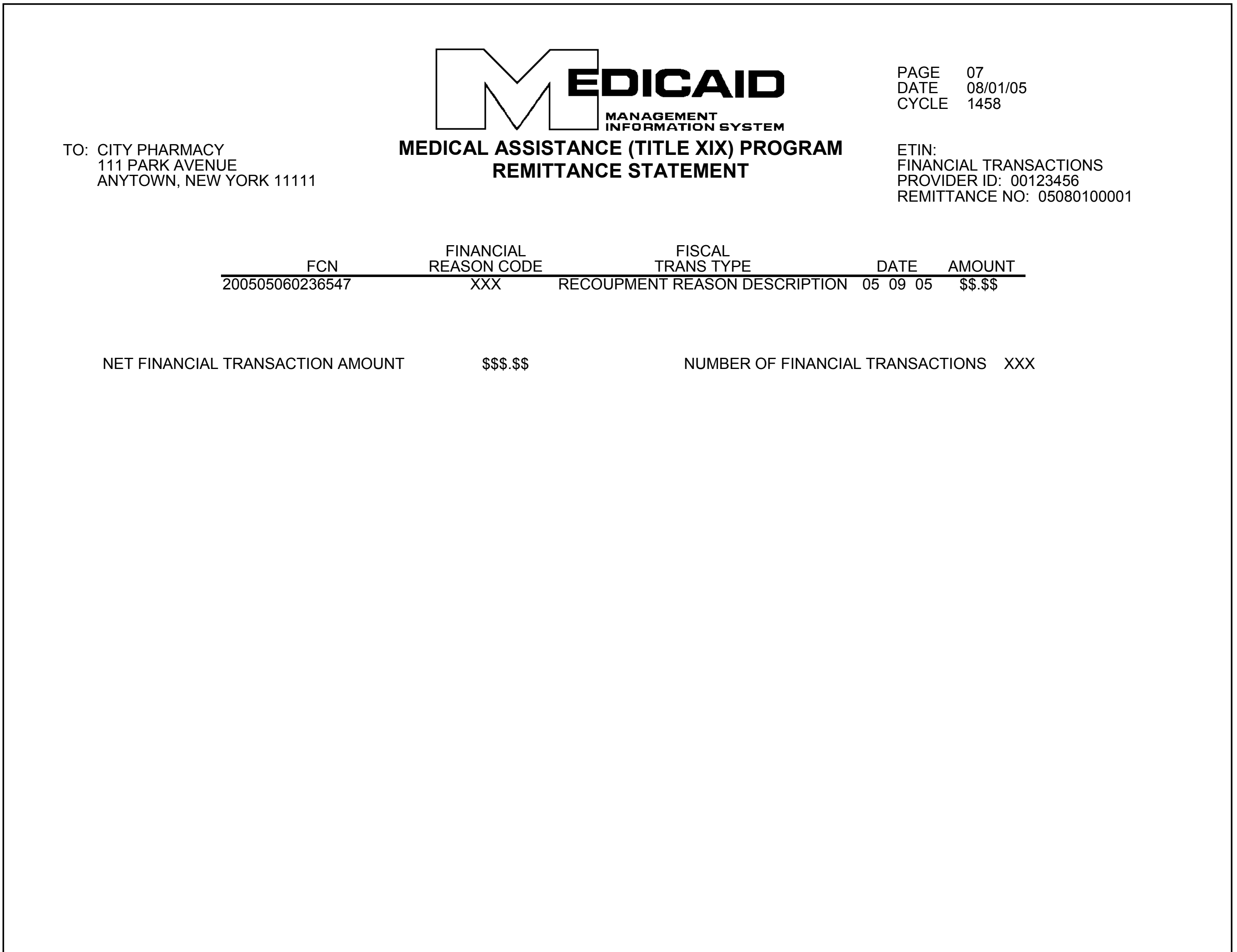
Section Four

This section has two subsections:

- Financial Transactions
- Accounts Receivable

Financial Transactions

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



MEDICAID MANAGEMENT INFORMATION SYSTEM

PAGE 07
DATE 08/01/05
CYCLE 1458

TO: CITY PHARMACY
111 PARK AVENUE
ANYTOWN, NEW YORK 11111

MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

ETIN:
FINANCIAL TRANSACTIONS
PROVIDER ID: 00123456
REMITTANCE NO: 05080100001

FCN	FINANCIAL REASON CODE	FISCAL TRANS TYPE	DATE	AMOUNT
200505060236547	XXX	RECOUPMENT REASON DESCRIPTION	05 09 05	$$.$$

NET FINANCIAL TRANSACTION AMOUNT $$$.$$ NUMBER OF FINANCIAL TRANSACTIONS XXX

Explanation of the Financial Transactions Columns

FCN (FINANCIAL CONTROL NUMBER)
This is a unique identifier assigned to each financial transaction.

FINANCIAL REASON CODE
This code is for DOH/eMedNY use only; it has no relevance to providers. It identifies the reason for the recoupment.

FISCAL TRANSACTION TYPE
This is the description of the Financial Reason Code. For example: Third-Party Recovery.

DATE
The date on which the recoupment was applied. Since all the recoupments listed on this page pertain to the current cycle, all the recoupments will have the same date.

AMOUNT
The dollar amount corresponding to the particular fiscal transaction. This amount is deducted from the provider's total payment for the cycle.

Totals

The total dollar amount of the financial transactions (**Net Financial Transaction Amount**) and the total number of transactions (**Number of Financial Transactions**) appear below the last line of the transaction detail list.

The Net Financial Transaction Amount added to the Claim Detail-Grand Total must equal the Medicaid Check or EFT amounts.

Accounts Receivable

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

PAGE 08
DATE 08/01/05
CYCLE 1458

TO: CITY PHARMACY
111 PARK AVENUE
ANYTOWN, NEW YORK 11111

MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

ETIN:
ACCOUNTS RECEIVABLE
PROVIDER ID: 00123456
REMITTANCE NO: 05080100001

REASON CODE	DESCRIPTION	ORIG BAL	CURR BAL	RECOUP %/AMT
		$XXX.XX-	$XXX.XX-	999
		$XXX.XX-	$XXX.XX-	999

TOTAL AMOUNT DUE THE STATE $XXX.XX

Explanation of the Accounts Receivable Columns

If a provider has negative balances of different types or negative balances created at different times, each negative balance will be listed in a different line.

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

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

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

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

Total Amount Due the State

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

Section Five – Edit Descriptions

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

MEDICAID MANAGEMENT INFORMATION SYSTEM

MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

PAGE 06
DATE 08/01/05
CYCLE 1458

TO: CITY PHARMACY
111 PARK AVENUE
ANYTOWN, NEW YORK 11111

ETIN:
PHARMACY
EDIT DESCRIPTIONS
PROVIDER ID: 00123456
REMITTANCE NO: 05080100001

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

00127 MEDICARE PAID AMOUNT LESS THAN REASONABLE
00142 SERVICE CODE NOT EQUAL TO PA
00144 RECIPIENT SEX NOT EQUAL TO FILE
00162 RECIPIENT INELIGIBLE ON DATE OF SERVICE
01154 NO UT SERVICE AUTHORIZATION ON FILE

Appendix A – Code Sets

SA EXCEPTION CODE

Code	Description
1	Immediate/urgent care
2	Services rendered in retroactive period
3	Emergency care
4	Client has temporary Medicaid
5	Request from county for second opinion to determine if recipient can work
6	Request for override pending
7	Special handling

United States Standard Postal Abbreviations

State	Abbrev.	State	Abbrev.
Alabama	AL	Missouri	MO
Alaska	AK	Montana	MT
Arizona	AZ	Nebraska	NE
Arkansas	AR	Nevada	NV
California	CA	New Hampshire	NH
Colorado	CO	New Jersey	NJ
Connecticut	CT	North Carolina	NC
Delaware	DE	North Dakota	ND
District of Columbia	DC	Ohio	OH
Florida	FL	Oklahoma	OK
Georgia	GA	Oregon	OR
Hawaii	HI	Pennsylvania	PA
Idaho	ID	Rhode Island	RI
Illinois	IL	South Carolina	SC
Iowa	IA	South Dakota	SD
Kansas	KS	Tennessee	TN
Kentucky	KY	Texas	TX
Louisiana	LA	Utah	UT
Maine	ME	Vermont	VT
Maryland	MD	Virginia	VA
Massachusetts	MA	Washington	WA
Michigan	MI	West Virginia	WV
Minnesota	MN	Wisconsin	WI
Mississippi	MS	Wyoming	WY

American Territories	Abbrev.
American Samoa	AS
Canal Zone	CZ
Guam	GU
Puerto Rico	PR
Trust Territories	TT
Virgin Islands	VI

Note: Required only when reporting out-of-state license numbers.