New York State Department of Health
(NYS DOH)
Office of Health Insurance Programs
(OHIP)

Medicaid Eligibility Verification System (MEVS)

and

Dispensing Validation System (DVS)

Provider Manual

Version Number: 4.5 **HIPAA Version: 5010**
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1.0 INTRODUCTION TO THE NEW YORK STATE MEDICAID ELIGIBILITY VERIFICATION AND DISPENSING VALIDATION SYSTEM (Rev. 02/12)

A component of the eMedNY system operated by New York State serves as a Medicaid Eligibility Verification and Dispensing Validation System (DVS). This enables providers to verify member eligibility prior to provision of services and obtain authorization for specific services covered under DVS. A member must present an official Common Benefit Identification Card (CBIC) to the provider when requesting services. The issuance of an Identification Card does not constitute full authorization for provision of medical services and supplies. The member's eligibility must be verified through eMedNY to confirm the member's eligibility for services and supplies. A provider not verifying eligibility prior to provision of services will risk the possibility of nonpayment for those services.

The verification process through eMedNY can be accessed using one of the following methods:

- Telephone verification process (Audio Response Unit or ARU).
- VeriFone POS device(s).
- Other access methods: ePACES, CPU-CPU link, eMedNY eXchange, dial-up FTP, PC-Host link, and File Transfer Service using SOAP.

Eligibility information available through eMedNY will provide:

- eligibility status for a Medicaid member for a specific date (today or prior to today).
- Medicare, third party insurance or Managed Care plan contact information a member has on file for the date of service.
- limitations on coverage due to the member's Utilization Threshold (UT).
- restrictions to primary providers and/or exception codes which further clarify a member's eligibility.
- co-pay remaining.
- The county having financial responsibility for the member (used to determine the contact office for prior approval and prior authorization.)

The DVS system can be accessed using one of the following methods:

- ePACES
- VeriFone POS device(s)
- CPU-CPU link
- SOAP

DVS requests through eMedNY will provide:

- Dispensing Validation Numbers (DVS) for certain Drugs, Durable Medical Equipment, Dental Services, Physical, Occupational and Speech Therapy.
- The ability to cancel a previously obtained DVS Authorization.

This manual contains different sections discussing the Common Benefit Identification Card (CBIC), procedures for verification, a description of eligibility responses, definitions of codes, and descriptions of alternate access methods.

1.1 Other Access Methods to eMedNY (Rev. 05/11)

Alternative methods of access allow providers to use their own equipment to access eMedNY. The following is a brief description of these alternate access methods.

- **ePACES**

ePACES is a web based application that allows providers to request and receive HIPAA-compliant Claim, Prior Approval, Eligibility, Claim Inquiry, and Dispensing Validation System (DVS) transactions.

NOTE: ePACES responses are similar to POS responses and may use this manual as an additional reference. See section 5.0.

Refer to ePACES on http://www.emedny.org/selfhelp/ePACES/ePACES_Help.pdf

- **CPU-CPU LINK**

This method is for providers who want to link their computer system to eMedNY via a dedicated communication line. CPU-CPU link is suggested for trading partners with high volume (5,000 to 10,000 transactions per day).

- **eMedNY eXchange**

This method allows users to transfer files from their computer via a web-based interface. Users are assigned an inbox and are able to send and receive transaction files in an email-like fashion. Transaction files are uploaded to eMedNY for processing. Responses are delivered to the user's inbox, and can be downloaded to the user's computer.

Refer to eXchange on http://www.emedny.org/selfhelp/exchange/faq.html#enroll

- **Dial-up FTP**

FTP allows users to upload and download files between their computer and eMedNY. Each file sent to eMedNY must be completed within two hours. Any transmission exceeding two hours will be disconnected.

Refer to dial-up FTP instructions:
http://www.emedny.org/ProviderManuals/AllProviders/MEVS/MEVS_Batch_Auth/FTP%20Batch%20Instructions%20Manual.pdf

- **PC-HOST LINK**

This method requires a PC, a dial up modem, and third party software.

Verification requests are transmitted to the eMedNY contractor one transaction at a time. The PC-Host method is suggested for providers with less than 2,000 transactions per month.

For additional information contact the eMedNY Call center at 1-800-343-9000.

- **eMedNY File Transfer Service using Simple Object Access Protocol (SOAP)**

  eMedNY provides support for File Transfer Service using Simple Object Access Protocol (SOAP). File Transfer Service is available for batch file transfer.

  For additional information contact the eMedNY Call center at 1-800-343-9000.

For further information about alternate access methods and the approval process, please call 1-800-343-9000 or refer to the Technical Supplementary Companion guide: http://www.emedny.org/hipaa/emedny_transactions/Technical/TECHNICAL_SUPPLEMENTARY_CG.pdf .

2.0 COMMON BENEFIT IDENTIFICATION CARDS (CBIC)/FORMS (Rev. 05/11)

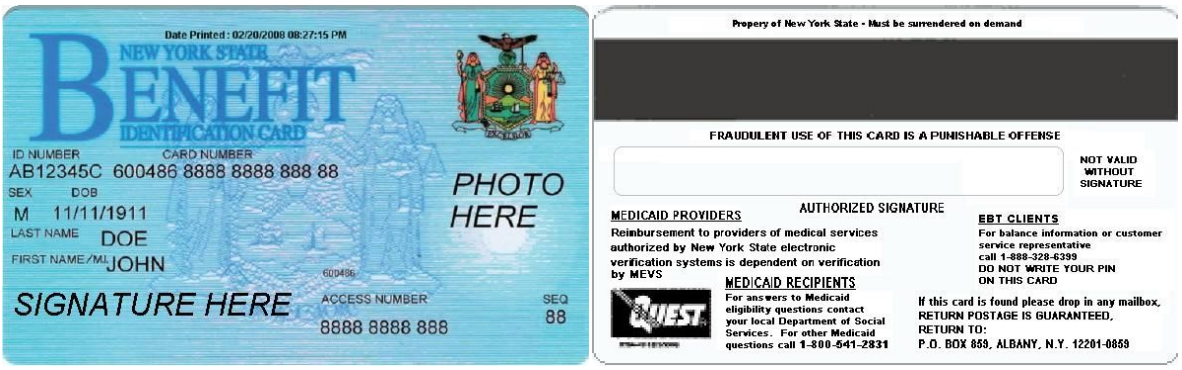
There are three types of Common Benefit Identification Cards:

- CBIC permanent plastic photo card.
- CBIC permanent plastic non-photo card.
- replacement paper card.

Presentation of a Benefit Identification Card alone is not sufficient proof that a member is eligible for services. Each of the Benefit Identification Cards must be used in conjunction with the electronic verification process. The risk of not verifying member eligibility each time services are requested creates the possibility of nonpayment for services provided.

2.1 Permanent Common Benefit Identification Photo Card (Rev. 05/11)

The Permanent Common Benefit Identification Photo Card is a permanent plastic card issued to members by the Local Department of Social Services. This permanent card has no expiration date. Eligibility must be verified using the eMedNY system.



COMMON BENEFIT IDENTIFICATION PHOTO CARD DESCRIPTION	
ID Number	Eight character identifier assigned by the State of New York which identifies each individual Medicaid member. **This is the Member Identification Number to be used for billing purposes. Member ID # must be two alphas, five numeric and one alpha.**
Card Number	The card number consists of the ISO, Access and Sequence Numbers. Please see the appropriate sections below for discussion on each of these components.
Sex	One letter character indicating the sex of the member. M = Male F = Female U = Unborn (Infant)
DOB (Date of Birth)	Member's date of birth, presented in MM/DD/CCYY format. Example: August 15, 1980 is shown as 08/15/1980. Unborns (Infants) are identified by 0000000000.
Last Name	Last name of the member who will use this card for services.
First Name/ M.I.	First name and middle initial of the person named above.
Signature Here	Digitized Signature of cardholder, parent or guardian, if applicable.
ISO#	Six-digit number assigned to the New York State Department of Health (DOH).

COMMON BENEFIT IDENTIFICATION PHOTO CARD DESCRIPTION	
Access Number	Eleven-digit number used to identify the member.
Sequence Number	Two-digits defining the uniqueness of the card.
Photo	Photograph of the individual cardholder.
Magnetic Stripe	Stripe with encoded information that is read by the eMedNY terminal.
Authorized Signature (back of card)	Must be signed by the individual cardholder, parent or guardian to be valid for services.
Date Printed	Located at top of the Benefit Card. *When multiple cards are present always use the card with the most recent date/time stamp.*

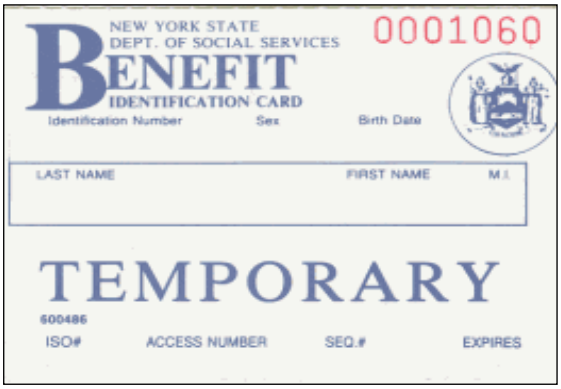
2.2 Permanent Common Benefit Identification Non-Photo Card (Rev. 05/11)

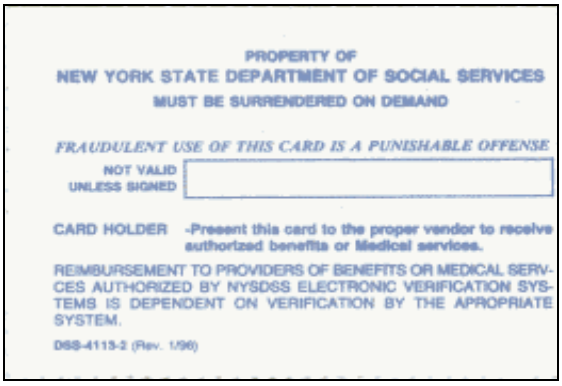
The Common Benefit Identification Non-Photo Card is a permanent plastic card issued to members as determined by the Local Department of Social Services. This permanent card has no expiration date. Eligibility must be verified using the eMedNY system.

For card field descriptions see section 2.1

2.3 Replacement Common Benefit Identification Card (Rev. 05/11)

The Replacement Common Benefit Identification Card is a temporary paper card issued by the Local Department of Social Services to a member. This card will be issued when the Permanent Common Benefit Identification Card is lost, stolen or damaged. When using the eMedNY terminal for eligibility verification, all information will need to be entered manually.





For card field descriptions see section 2.1
Note: Temporary cards have an expiration date located in the lower right hand corner.

2.4 Temporary Medicaid Authorization Form (Rev. 05/11)

In some circumstances, the member may present a Temporary Medicaid Authorization (TMA) Form DSS-2831A (not pictured). This authorization is issued by the Local Department of Social Services (LDSS) when the member has an immediate medical need and a permanent plastic card has not been received by the member. The Temporary Medicaid Authorization Form is a guarantee of eligibility and is valid for 15 days.

Providers should always make a copy of the TMA form for their records. Since an eligibility record is not sent to the eMedNY contractor until the CBIC Card is generated, the eMedNY system will not have eligibility data for a member in TMA status. Note that any claim submitted for payment may pend waiting for the eligibility to be updated. If the final adjudication of the claim results in a denial for member eligibility, please contact the New York State Department of Health, Office of Health Insurance Programs, Local District Support. The phone number for inquiries on TMA issues for members residing Upstate is (518) 474-8887. For New York City member TMA issues, the number is (212) 417-4500.

3.0 INTRODUCTION TO TELEPHONE (AUDIO RESPONSE UNIT) VERIFICATION (Rev. 02/12)

Verification requests for member eligibility may be entered into eMedNY through a touch-tone telephone. This access method is suggested for providers with very low transaction volume (less than 50 transactions per month). Providers with higher volumes should consider one of the other methods outlined in Section 1.1 - Alternate Access Methods To eMedNY.

Access to the Telephone Verification System (Rev. 05/11)

To access the system, dial **1-800-997-1111**. This is a toll free number for both New York State and Out of State Providers.

To be transferred directly to an eMedNY Call Center Representative, press “0” at any time during the first four prompts.

The following message will be heard:
“The ARU Zero Out Option” before being connected to the eMedNY Helpdesk.

If the connection is unsuccessful, call the eMedNY Call Center at **1-800-343-9000**.

3.1 Telephone Verification Using the Access Number or Medicaid Number (Rev. 05/11)

The access number is a thirteen-digit numeric identifier on the Common Benefit Identification Card. The easiest and fastest verification method is by using the access number.

The Medicaid number is an eight-character alpha/numeric identifier on the Common Benefit Identification Card. The Medicaid number can also be used to verify a member's eligibility. Convert the eight-digit identifier to an eleven-digit number by converting the alpha characters to numbers using the chart below.

For example:

A D12345Z = eight-digit Medicaid number
2131234512 = becomes an eleven-digit number

For this example, the chart indicates that the letter A = 21, D = 31 and Z = 12. Replace the letters A, D and Z with the numbers 21, 31 and 12 respectively. The converted number is 21311234512

ALPHA CONVERSION CHART

A = 21	N = 62
B = 22	O = 63
C = 23	P = 71
D = 31	Q = 11
E = 32	R = 72
F = 33	S = 73
G = 41	T = 81
H = 42	U = 82
I = 43	V = 83
J = 51	W = 91
K = 52	X = 92
L = 53	Y = 93
M = 61	Z = 12

Note: Perform the required conversion before dialing eMedNY.

3.2 Telephone Verification Input Section (Rev. 05/11)

Instructions for Completing a Telephone Transaction

• If using a Medicaid number, be sure to convert the number before dialing. Refer to the chart on the previous page.

• Dial 1-800-997-1111.

• When a connection is made, an Audio Response Unit (ARU) will prompt for the input data that needs to be entered.

• To repeat a prompt, press * (asterisk).

• To bypass a prompt, press #, (the pound key).

• To clear a mistake, press the * key and re-enter the correct information. This step is only valid if done prior to pressing the # key which registers the entry.

• To make entries without waiting for the prompts, continue to enter the data in the proper sequence. As in all transactions (prompted or unprompted), press the # key after each entry.

• For assistance or further information on input or response messages, call the Call Center staff at 1-800-343-9000.

• For some prompts, if the entry is invalid, the ARU will repeat the prompt. This allows for correction of the entry without re-keying the entire transaction.

• The call is terminated if excessive errors are made.

• To be transferred to an eMedNY Call Center Representative, press “0” on the telephone keypad at any time during the first four prompts.

The following types of transactions cannot be processed via the telephone:

- Cancel Transactions
- Dispensing Validation System Transactions

Detailed instructions for entering a transaction are in the following table. The Voice Prompt column lists the instructions voiced. The Action/Input column describes the data to be entered.

VOICE PROMPT	ACTION/INPUT
	TO BEGIN Dial 1-800-997-1111
NEW YORK STATE MEDICAID	None
IF ENTERING ALPHA/NUMERIC IDENTIFIER, ENTER NUMBER 1 **IF ENTERING NUMERIC IDENTIFIER, ENTER NUMBER 2**	Enter 1, If using converted Medicaid Number. Enter 2, If using Access Number.
ENTER IDENTIFICATION NUMBER	Enter converted alpha/numeric Medicaid number or numeric access number.
ENTER NUMBER 2 FOR ELIGIBILITY INQUIRY	Enter **2**
ENTER DATE	Press # for today's date or enter MMDDCCYY for a previous date of service.
ENTER PROVIDER NUMBER	Enter the National Provider Identifier (NPI) and press #. For atypical providers enter the eight-digit MMIS provider identification number.
ENTER ORDERING PROVIDER NUMBER	Enter the National Provider Identifier (NPI). **Press # to bypass this prompt when it is not necessary to identify a dispensing provider.**

THIS IS THE LAST PROMPT. THE eMedNY SYSTEM WILL NOW RETURN THE RESPONSE. THIS ENDS THE INPUT DATA SECTION.

3.3 Telephone Verification Response Section (Rev. 03/12)

AN ELIGIBILITY RESPONSE THAT CONTAINS NO ERRORS WILL BE RETURNED IN THE FOLLOWING SEQUENCE.

Note: Although all types of eligibility coverages are listed below, only one will be returned in the response.

MESSAGE SEQUENCE	RESPONSE	DESCRIPTION/COMMENTS
MEDICAID NUMBER	MEDICAID NUMBER AA22346D	The response begins with the member's eight-character Medicaid number.
MEMBER'S ADDRESS	MEMBER ADDRESS	Member Street address, City, State and Zip
MEMBER'S MEDICAID COVERAGE	COMMUNITY COVERAGE WITH COMMUNITY BASED LONG TERM CARE	Member is eligible to receive most Medicaid services. Member is not eligible for nursing home services in a SNF or inpatient setting except for short-term rehabilitation nursing home care in a SNF. Short-term rehabilitation nursing home care means one admission in a 12-month period of up to 29 consecutive days of nursing home care in a SNF. Member is not eligible for managed long-term care in a SNF, hospice in a SNF or intermediate care facility services. Refer to Appendix Section 7.1 for Attestation of Resources Non-Covered Services.

MESSAGE SEQUENCE	RESPONSE	DESCRIPTION/COMMENTS

MEMBER'S MEDICAID COVERAGE (Cont)	COMMUNITY COVERAGE WITHOUT LONG TERM CARE	Member is eligible for:
		• acute inpatient care,
		• care in a psychiatric center,
		• some ambulatory care,
		• prosthetics,
		• short-term rehabilitation.
		
		Short-term rehabilitation services include one admission in a 12-month period of up to 29 consecutive days of short-term rehabilitation nursing home care in a SNF, and one commencement of service in a 12-month period up to 29 consecutive days of certified home health agency services.
		
		Member is not eligible for:
		• adult day health care,
		• Assisted Living Program,
		• certified home health agency services except short-term rehabilitation,
		• hospice,
		• managed long-term care,
		• personal care,
		• consumer directed personal assistance program,
		• limited licensed home care,
		• personal emergency response services,
		• private duty nursing,
		• nursing home services in a SNF other than short-term rehabilitation,
		• nursing home services in an inpatient setting,
		• intermediate care facility services,
		• residential treatment facility services
		• services provided under the:
		  ○ Long Term Home Health Care Program
		  ○ Traumatic Brain Injury Program,
		  ○ Care at Home Waiver Program
		  ○ Office for People With Developmental Disabilities (OPWDD) Home and Community-Based Services (HCBS) Waiver Program.
		Refer to Appendix Section 7.1 for Attestation of Resources Non-Covered Services.

MESSAGE SEQUENCE	RESPONSE	DESCRIPTION/COMMENTS
MEMBER'S MEDICAID COVERAGE (Cont)	ELIGIBLE CAPITATION GUARANTEE	A response of "Eligible Capitation Guarantee" indicates guaranteed status under a Prepaid Capitation Program (PCP). Members enrolled in some PCPs are eligible for some fee-for-service benefits. To determine exactly what services are covered, contact the PCP designated in the insurance code field. Services not covered by the PCP will not be paid by Medicaid (see exception for partial plans (PCMP's) below) Plans identified as PCMP's in the Information for All Providers - Managed Care Information manual require referrals from plan participating providers.
	ELIGIBLE EXCEPT NURSING FACILITY SERVICES	Member is eligible to receive all services except nursing home services provided in an SNF or inpatient setting. All pharmacy, physician, ambulatory care services and inpatient hospital services, not provided in a nursing home, are covered.
	ELIGIBLE ONLY FAMILY PLANNING SERVICES	The Family Planning Benefit Program provides Medicaid coverage for family planning services to persons of childbearing age with incomes at or below 200% of the federal poverty level. Eligible Members (males and females) have access to all enrolled Medicaid family planning providers and family planning services available under Medicaid.
	ELIGIBLE ONLY OUTPATIENT CARE	Member is eligible for all ambulatory care, including prosthetics; no inpatient coverage.
	ELIGIBLE PCP	Indicates coverage under a pre-paid capitation program (PCP). This status means the member is PCP eligible, as well as, eligible for limited fee for service benefits. To determine exactly what services are covered, contact the PCP designated in the insurance code field.

MESSAGE SEQUENCE	RESPONSE	DESCRIPTION/COMMENTS
MEMBER'S MEDICAID COVERAGE (Cont)	ELIGIBLE PCP WITH BEHAVIORAL HEALTH SERVICES CARVE OUT	Indicates coverage under a pre-paid capitation program (PCP). This status means the member is PCP eligible, as well as, eligible for limited fee for service benefits. To determine exactly what services are covered, contact the PCP designated in the insurance code field. Behavioral Health Services are carved out of the PCP.
	ELIGIBLE PCP WITH PHARMACY CARVE OUT	Indicates coverage under a pre-paid capitation program (PCP). This status means the member is PCP eligible, as well as, eligible for limited fee for service benefits. To determine exactly what services are covered, contact the PCP designated in the insurance code field. Pharmacy Services are carved out of the PCP.
	ELIGIBLE PCP WITH BEHAVIORIAL HEALTH SERVICES AND PHARMACY CARVE OUT	Indicates coverage under a pre-paid capitation program (PCP). This status means the member is PCP eligible, as well as, eligible for limited fee for service benefits. To determine exactly what services are covered, contact the PCP designated in the insurance code field. Behavioral Health and Pharmacy Services are carved out of the PCP.
	EMERGENCY SERVICES ONLY	Member is eligible for emergency services from the first treatment for the emergency medical condition until the condition requiring emergency care is no longer an emergency. An emergency is defined as a medical condition (including emergency labor and delivery) manifesting itself by acute symptom of sufficient severity (including severe pain), such that the absence of immediate medical attention could reasonably be expected to place the patient's health in serious jeopardy, serious impairment of bodily functions or serious dysfunction of any body organ or part.

MESSAGE SEQUENCE	RESPONSE	DESCRIPTION/COMMENTS
	FAMILY HEALTH PLUS	Member is enrolled in Family Health Plus (FHP) Program and receives most services through an FHP Participating Managed Care Plan.
	FAMILY HEALTH PLUS WITH PHARMACY CARVE OUT	Member is enrolled in Family Health Plus (FHP) Program and receives most services through an FHP Participating Managed Care Plan. Pharmacy Services are carved out of the FHP.
	MEDICAID ELIGIBLE HR UTILIZATION THRESHOLD	Member is eligible to receive all services within prescribed limits for: • physician, • mental health clinic • medical clinic, • laboratory, • dental clinic • pharmacy services.
	MEDICAID ELIGIBLE	Member is eligible for all benefits.
	MEDICARE COINSURANCE AND DEDUCTIBLE ONLY	Member is eligible for payment of Medicare coinsurance and deductibles. Deductible and coinsurance payments will be made for Medicare approved services only.
MEMBER'S MEDICAID COVERAGE (Cont)	OUTPATIENT COVERAGE WITH COMMUNITY BASED LONG TERM CARE	Member is eligible for most ambulatory care, including prosthetics, Member is not eligible for inpatient care other than short-term rehabilitation nursing home care in a SNF. Short-term rehabilitation services include one admission in a 12-month period of up to 29 consecutive days of short-term rehabilitation nursing home care in a SNF. Refer to Appendix Section 7.1 for Attestation of Resources Non-Covered Services.

MESSAGE SEQUENCE	RESPONSE	DESCRIPTION/COMMENTS

MEMBER'S MEDICAID COVERAGE (Cont)	OUTPATIENT COVERAGE WITHOUT LONG TERM CARE	Member is eligible for some ambulatory care, including prosthetics, and short-term rehabilitation services.
		
		Short-term rehabilitation services include one admission in a 12-month period of up to 29 consecutive days of short-term rehabilitation nursing home care in a SNF and one commencement of service in a 12-month period of up to 29 consecutive days of certified home health agency services.
		
		Member is not eligible for:
		• inpatient coverage other than short-term rehabilitation nursing home care in a SNF.
		• adult day health care,
		• Assisted Living Program,
		• certified home health agency except short-term rehabilitation,
		• hospice,
		• managed long-term care,
		• personal care,
		• consumer directed personal assistance program,
		• limited licensed home care,
		• personal emergency response services,
		• private duty nursing,
		• waiver services provided under the:
		  ○ Long Term Home Health Care Program,
		  ○ Traumatic Brain Injury Program,
		  ○ Care at Home Waiver Program
		  ○ Office for People With Developmental Disabilities (OPWDD) Home and Community-Based Services (HCBS) Waiver Program.
		
		Refer to Appendix Section 7.1 for Attestation of Resources Non-Covered Services.

MESSAGE SEQUENCE	RESPONSE	DESCRIPTION/COMMENTS
MEMBER'S MEDICAID COVERAGE (Cont)	OUTPATIENT COVERAGE WITH NO NURSING FACILITY SERVICES	Member is eligible for all ambulatory care, including prosthetics. Member is not eligible for inpatient coverage Refer to Appendix Section 7.1 for Attestation of Resources Non-Covered Services.
	PERINATAL FAMILY	Member is eligible to receive a limited package of benefits. The following services are excluded: • podiatry, • long- term home health care, • long term care, hospice, • ophthalmic services, • DME, • therapy (physical, speech, and occupational), • abortion services, • alternate level care.
	PRESUMPTIVE ELIGIBLE LONG-TERM/HOSPICE	Member is eligible for all Medicaid services except: • hospital based clinic services, • hospital emergency room services, • hospital inpatient services, • bed reservation.
	PRESUMPTIVE ELIGIBILITY PRENATAL A	Member is eligible to receive all Medicaid services except: • inpatient care, • institutional long-term care, alternate level care, • long-term home health care.
	PRESUMPTIVE ELIGIBILITY PRENATAL B	Member is eligible to receive only ambulatory prenatal care services. The following services are excluded: • inpatient hospital, • long-term home health care, • long-term care, • hospice, • alternate level care, • ophthalmic, • DME, • therapy (physical, speech, and occupational), • abortion, • podiatry.

MESSAGE SEQUENCE	RESPONSE	DESCRIPTION/COMMENTS
MEMBER RESTRICTIONS	CLIENT HAS DENTAL RESTRICTION RESTRICTED PROVIDER NAME PROVIDER NPI	eMedNY will provide the Name and NPI of the provider services are restricted to.
	CLIENT HAS PHARMACY RESTRICTION RESTRICTED PROVIDER NAME PROVIDER NPI	
	CLIENT HAS CLINIC RESTRICTION RESTRICTED PROVIDER NAME PROVIDER NPI	
	CLIENT HAS INPATIENT RESTRICTION RESTRICTED PROVIDER NAME PROVIDER NPI	
	CLIENT HAS PHYSICIAN RESTRICTION RESTRICTED PROVIDER NAME PROVIDER NPI	
	CLIENT HAS NURSE PRACTITIONER RESTRICTION RESTRICTED PROVIDER NAME PROVIDER NPI	
	CLIENT HAS DME RESTRICTION RESTRICTED PROVIDER NAME PROVIDER NPI	

MESSAGE SEQUENCE	RESPONSE	DESCRIPTION/COMMENTS
MEMBER RESTRICTIONS (Cont)	CLIENT HAS PODIATRY RESTRICTION RESTRICTED PROVIDER NAME PROVIDER NPI	
CLIENT HAS CASE MANAGEMENT	CLIENT HAS CASE MANAGEMENT RESTRICTED PROVIDER NAME PROVIDER NPI	The member has Case Management. eMedNY will provide the Name and NPI of the provider services are restricted to.
ANNIVERSARY	ANNIVERSARY DATE	This is the anniversary date of the member's benefit year.
RECERT MONTH	RECERTIFICATION MONTH IS	This is the end month of the member's recertification year. *Recert month is omitted from the response if the member's Category of Assistance is SSI CASH.
COUNTY CODE	CLIENT COUNTY CODE XX	The two-digit code which indicates the member's county of fiscal responsibility. Refer to Section 6.6 for County/District Codes.
OFFICE CODE	CLIENT OFFICE CODE XXX	The three-digit code is returned ONLY if the member's county code is '66'. Refer to Section 6.7 for Office Codes.
PLAN DATE	PLAN DATE IS	This is the effective date of coverage, or the first day of the month eligibility information was requested.
MEDICARE DATA	MEDICARE PART A	Member has Part A Coverage.
	MEDICARE PART B	Member has Part B Coverage.
	MEDICARE PARTS A and B	Member has both Parts A and B Medicare Coverage.
	MEDICARE PARTS A & B & QMB	Member has Part A and B Medicare coverage and is a Qualified Medicare Beneficiary (QMB).
	MEDICARE PARTS A & D	Member has both Part A and Part D Medicare coverage

MESSAGE SEQUENCE	RESPONSE	DESCRIPTION/COMMENTS
MEDICARE DATA (CONT)	MEDICARE PARTS B & D	Member has both Part B and Part D Medicare coverage.
	MEDICARE PARTS A, B & D	Member has Part A, Part B and Part D Medicare coverage.
	MEDICARE PARTS A, B, D & QMB	Member has Part A, Part B and Part D and is a Qualified Medicare Beneficiary (QMB).
	HEALTH INSURANCE CLAIM NUMBER XXXXXXXXXXX	Health Insurance Claim number consisting of up to twelve characters. If a number is not available, the message "HEALTH INSURANCE CLAIM NUMBER NOT ON FILE" will be returned.
MANAGED CARE PLAN	PLAN NAME	The user will hear the plan name.
	PLAN ADDRESS	The user will hear the plan address.
	POLICY NUMBER	The policy number will be provided when known.
	GROUP NUMBER	The group number will be provided when known.
	PLAN TELEPHONE NUMBER	The telephone number will be provided when known.
THIRD PARTY INSURANCE	CARRIER CODE	The user will hear the carrier code.
	PLAN NAME	The user will hear the plan name.
	PLAN ADDRESS	The user will hear the plan address.
	POLICY NUMBER	When known, the Third Party Insurance Policy Number will be returned.
	GROUP NUMBER	When known, the Third Party Insurance Group Number will be returned.
	PLAN TELEPHONE NUMBER	When known, the Third Party Insurance Telephone Number will be returned.

<table>
<tr><th>MESSAGE SEQUENCE</th><th>RESPONSE</th><th>DESCRIPTION/COMMENTS</th></tr>
<tr><td>EXCEPTION CODES</td><td>EXCEPTION CODE</td><td>If applicable, a member's exception code will be returned. Refer to Section 6.5, for Exception Codes and descriptions.</td></tr>
<tr><td>CO-PAY DATA</td><td>CO-PAYMENT REMAINING</td><td>eMedNY will return the remaining annual co-pay amount for the member.
This message will not be heard if the member is exempt from co-payment.</td></tr>
<tr><td rowspan="5">UT LIMITS REACHED</td><td>PHYSICIAN/CLINIC AT LIMITS</td><td rowspan="5">This will be heard when a member has utilized their maximum number of service units for the given service category.</td></tr>
<tr><td>MENTAL HEALTH CLINIC AT LIMITS</td></tr>
<tr><td>PHARMACY AT LIMITS</td></tr>
<tr><td>DENTAL CLINIC AT LIMITS</td></tr>
<tr><td>LAB AT LIMITS</td></tr>
<tr><td>COVERED HIPAA SERVICE TYPES</td><td>FOR MORE DETAILED INFORMATION ON COVERED SERVICES, PRESS 1
PRESS 2 TO CONTINUE</td><td>If 1 is pressed, the user will hear the appropriate Service Type codes and descriptions.
If 2 is pressed, continue to the next prompt.
The following table identifies the most common Service Types.
<table>
<tr><th>Service Type</th><th>Service Type Description</th></tr>
<tr><td>1</td><td>Medical Care</td></tr>
<tr><td>33</td><td>Chiro Services</td></tr>
<tr><td>35</td><td>Dental Care</td></tr>
<tr><td>47</td><td>Hospital</td></tr>
<tr><td>86</td><td>Emergency Services</td></tr>
<tr><td>88</td><td>Pharmacy</td></tr>
<tr><td>98</td><td>Prof (Physician) Visit – Office</td></tr>
<tr><td>AL</td><td>Vision (Optometry)</td></tr>
<tr><td>MH</td><td>Mental Health</td></tr>
<tr><td>UC</td><td>Urgent Care</td></tr>
<tr><td>48</td><td>Hospital Inpatient</td></tr>
<tr><td>50</td><td>Hospital Outpatient</td></tr>
<tr><td>54</td><td>Long Term Care</td></tr>
</table></td></tr>
</table>

MESSAGE SEQUENCE	RESPONSE	DESCRIPTION/COMMENTS
DATE OF SERVICE	FOR DATE MMDDYY	This will be heard when the message is complete and reflects the date for which services were requested. **The message may be repeated one time by pressing the * key.**

Note: A maximum of three transactions during a single call may be performed. If less than three transactions have been completed, another transaction will automatically be prompted. If no other transactions are needed, disconnect.

3.4 Telephone Verification Error and Denial Responses (Rev. 07/11)

The next few pages contain processing error and denial messages that may be heard. Error responses are heard immediately after an incorrect or invalid entry. To change the entry, enter the correct data and press the # key. Denial responses are heard when the transaction is rejected due to the type of invalid data entered. The entire transaction must be reentered.

RESPONSE	DESCRIPTION/COMMENTS
CALL 800-343-9000	When certain failure conditions are met that cannot be appropriately communicated with one of the other listed responses, a message to call Call Center staff for information will be heard.
EXCESSIVE ERRORS, REFER TO eMedNY MANUAL OR CALL 800-343-9000 FOR ASSISTANCE	Too many invalid entries have been made during the transaction. Refer to Telephone Verification Input Section 3.2, or call the eMedNY Call Center at **800-343-9000**.
INVALID ACCESS METHOD	The received transaction is classified as a Provider Type/Transaction Type Combination that is not allowed to be submitted through the telephone.
INVALID ACCESS NUMBER	An invalid access number was entered. Check the number and retry the transaction.
INVALID DATE	An illogical date or a date which falls outside of the allowed eMedNY inquiry period was entered. The allowed period is 24 months retroactive from the entry date and/or not a future date.
INVALID IDENTIFICATION NUMBER	The member identification number entered was Non-numeric.
INVALID MEDICAID NUMBER	An invalid Medicaid number was entered. Refer to the alpha conversion chart in Section 3.1. Verify that the Medicaid number was correctly converted to an eleven-digit number.
INVALID MENU OPTION	An invalid entry was made when selecting the identifier type. Valid entries are 1 (alphanumeric identifier) or 2 (numeric identifier).
INVALID PROVIDER NUMBER	The National Provider Identifier (NPI) entered is invalid, or for atypical providers, the MMIS provider ID entered is invalid.

RESPONSE	DESCRIPTION/COMMENTS
NO COVERAGE EXCESS INCOME	Member has income in excess of the allowable levels. All other eligibility requirements have been satisfied. This individual will be considered eligible for Medicaid reimbursable services only at the point his or her excess income is reduced to the appropriate level. The individual may reduce his or her excess income by paying the amount of the excess, or submitting bills for the medical services that are at least equal to the amount of the excess income, to the Local Department of Social Services.
NO COVERAGE PENDING FHP	Member is waiting to be enrolled into a Family Health Plus Managed Care Plan. No Medicaid services are reimbursable.
NOT MEDICAID ELIGIBLE	Member is not eligible for benefits on the date requested. Contact the member's Local Department of Social Services for eligibility discrepancies.
PROVIDER INELIGIBLE FOR SERVICE ON DATE PERFORMED	The Provider number submitted in the transaction is inactive or invalid for the entered Date of Service.
PROVIDER NOT ELIGIBLE	The verification was attempted by an inactivated or disqualified provider.
PROVIDER NOT ON FILE	As entered, the provider number is not found on the provider master file.
RECIPIENT NOT ON FILE	As entered, the Member identification number is not found on the member master file.
REENTER ORDERING PROVIDER NUMBER	The National Provider Identifier (NPI) entered in the ordering provider is incorrectly formatted.
SSN ACCESS NOT ALLOWED	The provider is not authorized to access the system using a social security number. The Medicaid Number or Access Number must be entered.
SSN NOT ON FILE	The SSN entered is not on the member master file.
SYSTEM ERROR #	A network problem exists. Please call 1-800-343-9000 with the error number.
THE SYSTEM IS CURRENTLY UNAVAILABLE. PLEASE CALL 800-343-9000 FOR ASSISTANCE.	The system is currently unavailable. After this message is voiced, the connection will be terminated.

4.0 VERIFONE VERIFICATION INPUT SECTION (Rev. 05/11)

4.1 VeriFone Verification Using the Access Number or Medicaid Number (REV. 05/11)

The access number is a thirteen-digit numeric identifier on the Common Benefit Identification Card that includes the sequence number. The easiest and fastest verification method is using the Access Number by swiping the card through the terminal. The Medicaid number is an eight-character alpha/numeric identifier on the Common Benefit Identification Card.

4.2 Instructions for Completing a VeriFone Transaction (REV. 05/11)

- The **ENTER** key must be pressed after each field entry.
- For assistance or further information on input or response messages call the eMedNY Call Center at **800-343-9000**.
- To add provider numbers to the terminal, refer to instructions available here:
  http://www.emedny.org/HIPAA/SupportDocs/Omni.html
  or
  contact the eMedNY Call Center **800-343-9000**.
  (Please maintain a listing of provider numbers and corresponding shortcuts.)
- To enter a letter, press the key with the desired letter, and then press the alpha key until the letter appears in the display window.

4.2.1 Instructions for Completing Tran Type 2 (Rev. 05/11)

The Eligibility Inquiry transaction provides the following: Eligibility status, Benefit Coverage, other potential payers, Medicaid Managed Care information, Family Health Plus information, member provider restrictions, and/or if a member is at limits for any of the service categories covered by the UT program.

PROMPT DISPLAYED	ACTION/INPUT
	TO BEGIN: Press the **CANCEL**/**CLEAR** key.
ENTER CARD OR ID	Press the **F4** key, then do one of the following: • swipe the card through the reader • key the access number and press the **ENTER** key. **Note:** The access number must be entered manually if using a replacement paper Benefit Identification Card or if using a plastic card with a damaged magnetic stripe. • Enter the member number and press the **ENTER** key. The type of identification used will be displayed for one second.
ENTER TRAN TYPE	**2** Eligibility Inquiry Press the **ENTER** key.
ENTER DATE	Press the **ENTER** key for today's date. If the transaction is for a previous date of service, enter the eight-digit date, MMDDCCYY, and press the **ENTER** key.
SELECT PROVIDER	When this prompt appears, there are multiple provider numbers programmed into the terminal. Enter the appropriate shortcut code associated with the intended provider identification number. OR Enter an NPI or eight-digit MMIS Provider ID (for atypical providers ONLY) and press the **ENTER** key (To add numbers call 1-800-343-9000).
ORDERING PRV #	Enter the National Provider Identifier (NPI) and press the **ENTER** key.
THIS ENDS THE INPUT DATA SECTION. **DIALING, WAITING FOR ANSR, CONNECT XXXX, WAITING FOR ENQ, TRANSMITTING,** and **RECEIVING.**	The VeriFone will now dial into the eMedNY system and display these processing messages: These processing messages are displayed.

4.2.2 Instructions for Completing Tran Type 4 (Rev. 02/12)

The Dispensing Validation System (DVS) Cancellation transaction is used to cancel an authorization. Authorizations for DME, prescription footwear, orthotic/prosthetic devices, physical, occupational, speech therapy and dental services may be cancelled for up to 90 days. Authorizations for supplies may be cancelled only within 24 hours.

PROMPT DISPLAYED	ACTION/INPUT
	TO BEGIN: Press the **CANCEL**/**CLEAR** key.
ENTER CARD OR ID	Press the **F4** key, then do one of the following: • swipe the card through the reader • key the access number and press the **ENTER** key. **Note:** The access number must be entered manually if using a replacement paper Benefit Identification Card or if using a plastic card with a damaged magnetic stripe. • Enter the member number and press the **ENTER** key. The type of identification used will be displayed for one second.
ENTER TRAN TYPE	**4** Authorization Cancellation Press the **ENTER** key.
ENTER DATE	Press the **ENTER** key for today's date. If the transaction is for a previous date of service, enter the eight-digit date, MMDDCCYY, and press the **ENTER** key.
SELECT PROVIDER	When this prompt appears, there are multiple provider numbers programmed into the terminal. Enter the appropriate shortcut code associated with the intended provider identification number. OR Enter an NPI or eight-digit MMIS Provider ID (for atypical providers ONLY) and press the **ENTER** key (To add numbers call 1-800-343-9000).
PA Number	Enter the DVS number assigned to the approved DVS request to be canceled and press the **ENTER** key.
THIS ENDS THE INPUT DATA SECTION. The VeriFone will now dial into the eMedNY system and display these processing messages:	

PROMPT DISPLAYED	ACTION/INPUT
DIALING, WAITING FOR ANSR, CONNECT XXXX, WAITING FOR ENQ, TRANSMITTING, and **RECEIVING.**	These processing messages are displayed.

4.2.3 Instructions for Completing Tran Type 6 (Rev. 06/12)

The Dispensing Validation System (DVS) transaction allows suppliers of prescription footwear items, certain medical surgical supplies and equipment to request a DVS number (Prior approval).

This DVS transaction also allows a health care provider to request DVS numbers for Speech Therapy, Occupational Therapy and Physical Therapy, which are each limited to twenty (20) visits per benefit year.

Applies to: Physician, Free Standing Clinic and Hospital Outpatient (Article 16 or 28 Certified Only)

Does Not Apply to: Members Less than Age 21; Developmental Disabilities; Services Delivered through a Certified Home Health Agency (CHHA); Acute Care Inpatient Setting; Residents in Skilled Nursing Facility (SNF) for services in that facility; Members eligible for Medicare & Medicaid (Dual Eligible).

PROMPT DISPLAYED	ACTION/INPUT
	TO BEGIN: Press the **CANCEL**/**CLEAR** key.
ENTER CARD OR ID	Press the **F4** key, then do one of the following: • swipe the card through the reader • key the access number and press the **ENTER** key. **Note:** The access number must be entered manually if using a replacement paper Benefit Identification Card or if using a plastic card with a damaged magnetic stripe. • Enter the member number and press the **ENTER** key. The type of identification used will be displayed for one second.
ENTER TRAN TYPE	**6** Dispensing Validation System (DVS) Request Press the **ENTER** key.
ENTER DATE	Press the **ENTER** key for today's date. DVS transactions require a current date entry.
SELECT PROVIDER	When this prompt appears, there are multiple provider numbers programmed into the terminal. Enter the appropriate shortcut code associated with the intended provider identification number. OR Enter an NPI or eight-digit MMIS Provider ID (for atypical providers ONLY) and press the **ENTER** key (To add

PROMPT DISPLAYED	ACTION/INPUT
	numbers call 1-800-343-9000).
ORDERING PRV #	Enter the National Provider Identifier (NPI) and press the **ENTER** key.
ENTER ITEM/NDC #	Enter the five-character HCPCS alpha/numeric item code or the eleven-digit National Drug Code of the item being dispensed and press the **ENTER** key.
ENTER MODIFIER	Enter the appropriate/valid modifier and press the **ENTER** key. Example: For Therapy DVS, use the following Procedure Modifiers: Speech Therapy - 'GN' Occupational Therapy - 'GO' Physical Therapy - 'GP'
ENTER QUANTITY	Enter the total number of units dispensed for the current date of service only and press the **ENTER** key. Do not include refills.
THIS ENDS THE INPUT DATA SECTION. The VeriFone will now dial into the eMedNY system and display these processing messages:	
DIALING, WAITING FOR ANSR, CONNECT XXXX, WAITING FOR ENQ, TRANSMITTING, and **RECEIVING.**	These processing messages are displayed.

ENTER MODIFIER prompt will repeat up to four times, or until it is skipped.

4.2.4 Instructions for Completing Tran Type 8 (Rev. 05/11)

The Transportation/Home Health swipe transaction is performed at the beginning and end of a trip or visit to capture the begin and end times for private duty nurses and transportation providers who are required to swipe.

PROMPT DISPLAYED	ACTION/INPUT
	TO BEGIN: Press the **CANCEL**/**CLEAR** key.
ENTER CARD	Swipe the card through the reader
ENTER TRAN TYPE	**8** Transportation/Home Health swipe transaction Press the **ENTER** key.
SELECT PROVIDER	When this prompt appears, there are multiple provider numbers programmed into the terminal. Enter the appropriate shortcut code associated with the intended provider identification number. OR Enter an NPI or eight-digit MMIS Provider ID (for atypical providers ONLY) and press the **ENTER** key (To add numbers call 1-800-343-9000).
ENTER EVENT TYPE	Enter the value that defines this transactions event, and press the **ENTER** key. Valid values are: o 1 Transportation Begin o 2 Transportation End o 3 Home Health Arrive o 4 Home Health Depart
SELECT LICENSE NO	When this prompt appears, there are multiple driver's licenses programmed into your terminal. Enter the appropriate shortcut code associated with the intended license. (Transportation Only)
SELECT PLATE NO	When this prompt appears, there are multiple license plate numbers programmed into your terminal. Enter the appropriate shortcut code associated with the intended license plate number. (Transportation Only)
THIS ENDS THE INPUT DATA SECTION. The VeriFone will now dial into the eMedNY system and display these processing messages:	
DIALING, WAITING FOR ANSR,	These processing messages are displayed.

PROMPT DISPLAYED	ACTION/INPUT
CONNECT XXXX, WAITING FOR ENQ, TRANSMITTING, and **RECEIVING.**	

4.2.5 Instructions for Completing Tran Type 9 (Rev. 06/12)

The Dispensing Validation System (DVS) Dental Request transaction is used to obtain Dental DVS Numbers for selected Dental Procedure Codes. Click to see the Dental Procedure Codes manual.

PROMPT DISPLAYED	ACTION/INPUT
	TO BEGIN: Press the **CANCEL**/**CLEAR** key.
ENTER CARD OR ID	Press the **F4** key, then do one of the following: • swipe the card through the reader • key the access number and press the **ENTER** key. **Note:** The access number must be entered manually if using a replacement paper Benefit Identification Card or if using a plastic card with a damaged magnetic stripe. • Enter the member number and press the **ENTER** key. The type of identification used will be displayed for one second.
ENTER TRAN TYPE	**9** **The** Dispensing Validation System (DVS) Dental Request transaction is used to obtain Dental DVS Numbers for select Dental Procedure Codes. Press the **ENTER** key.
ENTER DATE	Press the **ENTER** key for today's date. DVS transactions require a current date entry.
SELECT PROVIDER	When this prompt appears, there are multiple provider numbers programmed into the terminal. Enter the appropriate shortcut code associated with the intended provider identification number. OR Enter an NPI or eight-digit MMIS Provider ID (for atypical providers ONLY) and press the **ENTER** key (To add numbers call 1-800-343-9000).
REFERRING PRV #	Enter the National Provider Identifier (NPI) and press the **ENTER** key.
ENTER ITEM/NDC #	Enter a procedure code and press the **ENTER** key.

PROMPT DISPLAYED	ACTION/INPUT
Oral Cavity Designation Code #	Enter an Oral Cavity Code and press the **ENTER** key. If Oral Cavity information is not applicable, press the **ENTER** key to skip the field.
ENTER QUANTITY	Enter the total number of times the procedure will be performed for the current date of service only.
Tooth #	Enter a Tooth Number and press the **ENTER** key. If Tooth Number information is not applicable, press the **ENTER** key to skip the field.
THIS ENDS THE INPUT DATA SECTION. The VeriFone will now dial into the eMedNY system and display these processing messages:	
DIALING, WAITING FOR ANSR, CONNECT XXXX, WAITING FOR ENQ, TRANSMITTING, and **RECEIVING.**	These processing messages are displayed.

ENTER Tooth # prompt will repeat up to 3 times, or until it is skipped.

4.2.6 Review Function (REV. 05/11)

The Review function allows for review of the last response received, edit the transaction data and resubmit the transaction. To begin follow the Action/Display table.

PROMPT DISPLAYED	ACTION/INPUT
Initial Screen	Press the **P4 SCROLL FORWARD/ REVIEW** key
The response from the last transaction is displayed	Press the **ENTER** key to edit the data
Each screen displays the data that was entered	Reenter new data Or Press the **ENTER** key to accept current data

5.0 VERIFONE VERIFICATION RESPONSE SECTION (Rev. 05/11)

The device will automatically display and print the response data unless specified in the setup menu to not automatically print receipts.

The eMedNY receipt presents information in two sections:

- Input: The Input section displays the member ID and transaction type submitted.
- Response: The Response section only displays fields, which contain data. The fields displayed also vary based on the Tran Type used to conduct the transaction. The Response section always starts with the PROV NO. field.

Required fields will always appear. Others will appear only when applicable.

Note: The amount of text on the screen display is limited. Use the P3 (Scroll Back) and P4 (Scroll Forward/Review) keys to navigate through the response.

TIP: To print an additional copy of the response data, press the '*' asterisk key.

5.1 Fields on eMedNY Eligibility Receipt (Rev. 02/12)

The following table describes the fields returned for an eligibility response (Tran types 2 and 8).

LABEL	DESCRIPTION
TODAYS DATE AND TIME:	
---------- INFORMATION PROVIDED ----------	
CARD OR ID ENTERED:	This is the member identifier submitted.
TRAN TYPE:	Identifies the POS transaction type processed.
---------- RESPONSE ----------	
PROVIDER NO.:	The NPI, or the MMIS Provider ID (for atypical providers ONLY).
LICENSE:	The license number entered on the request transaction. (Transaction Type 8 transportation providers only) *Only displayed for TB event type
PLATE:	The plate number entered on the request transaction. (Transaction Type 8 transportation providers only) *Only displayed for TB event type
EVENT TYPE:	The Event Type entered on the request transaction. (Transaction Type 8 only) Possible values are: o TB Transportation Begin o TE Transportation End o HA Home Health Begin o HD Home Health End
DATE OF SVC:	The date for which services were requested. (Tran Type 2 only)
MEDICAID ID:	The Medicaid number is displayed on the receipt when the member is identified. If the member cannot be identified, the information entered in the Device will be displayed.
CLIENT ADDRESS:	The member's address.
DOB:	The member's date of birth.
GENDER:	The member's gender. Values are: M = Male F = Female U = Unborn
ANNIV DT:	This is the beginning of the member's benefit year.
PLAN DATE:	This is the effective date of coverage, or the first day of the month eligibility information was requested.

LABEL	DESCRIPTION
MSG:	'CNTY CD=' The two-digit county code is displayed for member's county of fiscal responsibility. For Downstate members an additional three-digit Office code is also displayed following the county code. For a listing of County Codes, refer to Section 6.6. For a listing of Office Codes, refer to Section 6.7. If applicable, a member's exception code(s) will be returned. Refer to Section 6.5 for the definitions/descriptions of the Exception Codes. The member's Recertification Month may also be displayed here.
---------- PLAN ELIG. & BENEFITS ----------	
ELIG/BEN INFO:	Coverage Code Description – See Section 6.1 for a detailed Eligibility Benefit Descriptions.
SERVICE TYPE CD	When present, this will always be valued as 30. (Used to satisfy HIPAA eligibility response requirements.)
CO-PAYMENT AMT:	The remaining amount of the member's annual maximum out-of-pocket.

<table>
<tr><th>LABEL</th><th>DESCRIPTION</th></tr>
<tr><td>SERV TYPE CD:</td><td>eMedNY will provide Service Type Codes as applicable to the Coverage Description above. HIPAA requires the following codes be evaluated and responded to. If any of the following are omitted from the response, the member does not have that scope of coverage.

<table>
<tr><th>Service Type</th><th>Service Type Description</th></tr>
<tr><td>1</td><td>Medical Care</td></tr>
<tr><td>33</td><td>Chiropractic</td></tr>
<tr><td>35</td><td>Dental Care</td></tr>
<tr><td>47</td><td>Hospital</td></tr>
<tr><td>50</td><td>Hospital - Outpatient</td></tr>
<tr><td>86</td><td>Emergency Services</td></tr>
<tr><td>88</td><td>Pharmacy</td></tr>
<tr><td>98</td><td>Professional (Physician)</td></tr>
<tr><td>AL</td><td>Vision (Optometry)</td></tr>
<tr><td>MH</td><td>Mental Health</td></tr>
<tr><td>UC</td><td>Urgent Care</td></tr>
</table>

Service Types will also be returned to indicate specific exclusions or inclusions of coverage.

For example, the following service types may be returned with an indication of Non-Covered (This indicator is reported in EB01.)

48 – Hospital Inpatient 54 – Long Term Care</td></tr>
<tr><td></td><td></td></tr>
<tr><td colspan="2">PLAN INFORMATION – Managed Care, Medicare, and/or Other Insurance (For each known plan, the following plan information will be provided).</td></tr>
<tr><td>PLAN:</td><td>The name of the health plan.</td></tr>
<tr><td>PLAN POLICY/HIC NO.:</td><td>Policy number (Provided when known)</td></tr>
<tr><td>PLAN GROUP NUM:</td><td>Group Number (Provided when known)</td></tr>
<tr><td>PLAN CD:</td><td>Medicaid assigned Carrier Code</td></tr>
<tr><td>PLAN ADDRESS:</td><td>(Provided when known)</td></tr>
<tr><td>PLAN PHONE NUM:</td><td>(Provided when known)</td></tr>
<tr><td>EB01:</td><td>Indicates whether the plan is a payer considered primary to Medicaid, or a payer to be billed in lieu of Medicaid (i.e. Medicaid Managed Care or Family Health Plus)

A prior payer will be identified by the literal “Other or Additional Payer”
Managed Care or FHP will be identified by the literal “Managed Care or FHP”.</td></tr>
<tr><td>SERV TYPE CD:</td><td>When the plan identified is Managed Care or FHP, carved out services, when applicable, will be reported using appropriate service types.</td></tr>
<tr><td></td><td></td></tr>
</table>

LABEL	DESCRIPTION
---------- SERVICES RESTRICTED TO THE FOLLOWING PROV ----------	
SERV TYPE CD:	Identifies the restriction type • 35 – Dental Care (The provider identified will indicate whether Dental Clinic, or Dental fee for service). • 48 – Hospital - Inpatient • 50 – Hospital – Outpatient (Clinic) • 88 – Pharmacy • 93 – Podiatry • 98 – Professional (Physician/Nurse Practitioner) • CQ – Case Management • DM – Durable Medical Equipment (DME)
PROVIDER NAME:	Provider services are restricted to
PROVIDER NPI:	Provider NPI services are restricted to
---------- UT LIMITS REACHED ----------	
PHYSICIAN/CLINIC AT LIMITS	When present, the member has reached their UT Limits for the category specified. A Threshold Override Application is required to request additional services.
MENTAL HEALTH CLINIC AT LIMITS	
PHARMACY AT LIMITS	
DENTAL CLINIC AT LIMITS	
LAB AT LIMITS	
---------- ELIG REQUEST REJECT ----------	This message is displayed when the eligibility request cannot be validated. The fields listed below provide further information for the validation of the eligibility request.
REJ REASON CD:	This field displays the Reject Reason codes. Refer to Section 6.2 for Reject Reason codes.
FOLW-UP ACT CD:	Values are: C = Please Correct and Resubmit P = Please Resubmit Original Transaction
INFO #:	Telephone number to call for more information.

5.2 Fields on eMedNY Authorization Cancellation receipt

The following table describes the fields returned for an Authorization Cancellation response (Tran type 4).

LABEL	DESCRIPTION
TODAYS DATE AND TIME:	
---------- INFORMATION PROVIDED ----------	
CARD OR ID ENTERED:	This is the member identifier submitted.
TRAN TYPE:	Identifies the POS transaction type processed.
---------- RESPONSE ----------	
PROVIDER NO.:	The NPI the transaction was processed for.
MEDICAID ID:	The member ID processed.
---------- HEALTH CARE SERVICES ----------	
ACTION CD:	Values are: • C – Cancelled (Cancel was successful) • A3 – Not Certified (Cancel failed – See reject reason)
REF ID:	The authorization number of the transaction requested to be cancelled.
---------- DVS REQUEST REJECT ----------	This message is displayed when a DVS request cannot be processed or the member is ineligible. The fields listed below provide further information for the validation of the Service request or DVS.
REJ REASON CD:	This field displays the Reject Reason codes. Refer to Section 6.2 for Reject Reason codes.
FOLW-UP ACT CD:	Values are: C = Please Correct and Resubmit P = Please Resubmit Original Transaction N= Resubmission Not Allowed
INFO #:	Telephone number to call for more information.

5.3 Fields on eMedNY DVS Professional receipt

The following table describes the fields returned for a DVS Professional response (Tran type 6).

LABEL	DESCRIPTION
TODAYS DATE AND TIME:	
---------- INFORMATION PROVIDED ----------	
CARD OR ID ENTERED:	This is the member identifier submitted.
TRAN TYPE:	Identifies the POS transaction type processed.
---------- RESPONSE ----------	
PROVIDER NO.:	The NPI of the provider submitted on the request transaction.
ORDERING PRV:	This is the Ordering Provider submitted on the request transaction.
EFFECTIVE DATE	If approved, this is the DVS effective date.
EXPIRATION DATE	If approved, this is the DVS expiration date.
ITEM/NDC:	When present, this is the authorized procedure code.
HCPCS MODIFIER:	When present, the listed modifier is part of the procedure authorization.
QUANTITY:	Approved Units
MEDICAID ID:	The member ID processed.
DOB:	When present, this is the member's DOB on file.
GENDER:	When present, this is the member's Gender on file.
---------- HEALTH CARE SERVICES ----------	
ACTION CD:	Values are: A1 = Certified in total A3 = Not Certified* A6 = Modified C = Cancelled CT = Contact Payer NA = No Action Required * When 'A3' is received, the INFO # and AUTHORIZATION # fields will not display. Instead, a REJ REASON CD field will appear. Refer to Section 6.3 Decision Reason Codes for value descriptions.
INFO #:	Telephone number to call for more information.
AUTHORIZATION #:	When present, DVS Number assigned to approved transaction. The DVS approval number is to be submitted in the Prior Approval Number field of the claim.
REF ID:	When present, DVS Number assigned to disapproved transaction. This number is purely informational and may be retained at the discretion of the submitter.
---------- DVS REQUEST REJECT ----------	This message is displayed when a DVS request cannot be processed or the member is ineligible. The fields listed below provide further information for the validation of the Service request or DVS.
DVS REJ REASON CD:	This field displays the Reject Reason codes. Refer to Section 6.2 for Reject Reason codes.

LABEL	DESCRIPTION
FOLW-UP ACT CD:	Values are: C = Please Correct and Resubmit P = Please Resubmit Original Transaction
INFO #:	Telephone number to call for more information.

5.4 Fields on eMedNY DVS Dental receipt

The following table describes the fields returned for a DVS Dental response (Tran type 9).

LABEL	DESCRIPTION
TODAYS DATE AND TIME:	
---------- INFORMATION PROVIDED ----------	
CARD OR ID ENTERED:	This is the member identifier submitted.
TRAN TYPE:	Identifies the POS transaction type processed.
---------- RESPONSE ----------	
PROVIDER NO.:	The NPI of the provider submitted on the request transaction.
REFERRING PRV:	This is the Referring Provider submitted on the request transaction.
EFFECTIVE DATE	If approved, this is the DVS effective date.
EXPIRATION DATE	If approved, this is the DVS expiration date.
ITEM/NDC:	When present, this is the authorized procedure code.
ORAL CAVITY DESIGNATION CODE _#	When present, the listed Oral Cavity is part of the procedure authorization.
QUANTITY:	Approved Units
TOOTH #:	When present, the listed Tooth # is part of the procedure authorization.
MEDICAID ID:	The member ID processed.
DOB:	When present, this is the member's DOB on file.
GENDER:	When present, this is the member's Gender on file.
---------- HEALTH CARE SERVICES ----------	
ACTION CD:	Values are: A1 = Certified in total A3 = Not Certified* A6 = Modified C = Cancelled CT = Contact Payer NA = No Action Required * When 'A3' is received, the INFO # and AUTHORIZATION # fields will not display. Instead, a REJ REASON CD field will appear. Refer to Section 6.3 Decision Reason Codes for value descriptions.
INFO #:	Telephone number to call for more information.
AUTHORIZATION #:	When present, DVS Number assigned to approved transaction. The DVS approval number is to be submitted in the Prior Approval Number field of the claim.
REF ID:	When present, DVS Number assigned to disapproved transaction. This number is purely informational and may be retained at the discretion of the submitter.

LABEL	DESCRIPTION
---------- DVS REQUEST REJECT ----------	This message is displayed when a DVS request cannot be processed or the member is ineligible. The fields listed below provide further information for the validation of the Service request or DVS.
REJ REASON CD:	This field displays the Reject Reason codes. Refer to Section 6.2 for Reject Reason codes.
FOLW-UP ACT CD:	Values are: C = Please Correct and Resubmit P = Please Resubmit Original Transaction
INFO #:	Telephone number to call for more information.

6.0 REFERENCE TABLES (REV. 06/12)

The following sections provide reference tables intended to assist in clarifying messages received.

6.1 Eligibility Benefit Descriptions (Rev. 03/12)

The following table describes the Medicaid covered services in each of the benefit plans.

COMMUNITY COVERAGE WITH COMMUNITY BASED LONG TERM CARE	Member is eligible to receive most Medicaid services. Member is not eligible for nursing home services in a SNF or inpatient setting except for short-term rehabilitation nursing home care in a SNF. Short-term rehabilitation nursing home care means one admission in a 12-month period of up to 29 consecutive days of nursing home care in a SNF. Member is not eligible for managed long-term care in a SNF, hospice in a SNF or intermediate care facility services. Refer to Appendix Section 7.1 for Attestation of Resources Non-Covered Services.

COMMUNITY COVERAGE WITHOUT LONG TERM CARE	Member is eligible for:
	
	• acute inpatient care,
	• care in a psychiatric center,
	• some ambulatory care,
	• prosthetics,
	• short-term rehabilitation.
	
	Short-term rehabilitation services include one admission in a 12-month period of up to 29 consecutive days of short-term rehabilitation nursing home care in a SNF, and one commencement of service in a 12-month period up to 29 consecutive days of certified home health agency services.
	
	Member is not eligible for:
	
	• adult day health care,
	• Assisted Living Program,
	• certified home health agency services except short-term rehabilitation,
	• hospice,
	• managed long-term care,
	• personal care,
	• consumer directed personal assistance program,
	• limited licensed home care,
	• personal emergency response services,
	• private duty nursing,
	• nursing home services in a SNF other than short-term rehabilitation,
	• nursing home services in an inpatient setting,
	• intermediate care facility services,
	• residential treatment facility services
	• services provided under the:
	  ○ Long Term Home Health Care Program
	  ○ Traumatic Brain Injury Program,
	  ○ Care at Home Waiver Program

COMMUNITY COVERAGE WITHOUT LONG TERM CARE (CONT)	○ Office for People With Developmental Disabilities (OPWDD) Home and Community-Based Services (HCBS) Waiver Program. Refer to Appendix Section 7.1 for Attestation of Resources Non-Covered Services.
ELIGIBLE CAPITATION GUARANTEE	A response of "Eligible Capitation Guarantee" indicates guaranteed status under a Prepaid Capitation Program (PCP). Members enrolled in some PCPs are eligible for some fee-for-service benefits. To determine exactly what services are covered, contact the PCP designated in the insurance code field. Services not covered by the PCP will not be paid by Medicaid (see exception for partial plans (PCMP's) below) Plans identified as PCMP's in the Information for All Providers - Managed Care Information manual require referrals from plan participating providers.
ELIGIBLE EXCEPT NURSING FACILITY SERVICES	Member is eligible to receive all services except nursing home services provided in an SNF or inpatient setting. All pharmacy, physician, ambulatory care services and inpatient hospital services, not provided in a nursing home, are covered.
ELIGIBLE ONLY FAMILY PLANNING SERVICES	The Family Planning Benefit Program provides Medicaid coverage for family planning services to persons of childbearing age with incomes at or below 200% of the federal poverty level. Eligible Members (males and females) have access to all enrolled Medicaid family planning providers and family planning services available under Medicaid.
ELIGIBLE ONLY OUTPATIENT CARE	Member is eligible for all ambulatory care, including prosthetics; no inpatient coverage.
ELIGIBLE PCP * MH service type *88 Service Type	Indicates coverage under a pre-paid capitation program (PCP). This status means the member is PCP eligible, as well as, eligible for limited fee for service benefits. To determine exactly what services are covered, contact the PCP designated in the insurance code field. *Behavioral Health Services are carved out of the PCP when the member is on SSI. Previously, this was known by receipt of the COA=S. Effective 7/21/11, the presence of Service Type MH means the services are carved out. The presence of Service Type 88 means the Pharmacy Services are carved out of the PCP.
EMERGENCY SERVICES ONLY	Member is eligible for emergency services from the first treatment for the emergency medical condition until the condition requiring emergency care is no longer an emergency. An emergency is defined as a medical condition (including emergency labor and delivery) manifesting itself by acute symptom of sufficient severity (including severe pain), such that the absence of immediate medical attention could reasonably be expected to place the patient's health in serious jeopardy, serious impairment of bodily functions or

	serious dysfunction of any body organ or part.
FAMILY HEALTH PLUS *88 Service Type	Member is enrolled in Family Health Plus (FHP) Program and receives most services through an FHP Participating Managed Care Plan. *The presence of Service Type Code 88 means Pharmacy Services are carved out of the FHP.
MEDICAID ELIGIBLE HR UTILIZATION THRESHOLD	Member is eligible to receive all services within prescribed limits for: • physician, • mental health clinic • medical clinic, • laboratory, • dental clinic • pharmacy services.
MEDICAID ELIGIBLE	Member is eligible for all benefits.
MEDICARE COINSURANCE AND DEDUCTIBLE ONLY	Member is eligible for payment of Medicare coinsurance and deductibles. Deductible and coinsurance payments will be made for Medicare approved services only.
OUTPATIENT COVERAGE WITH COMMUNITY BASED LONG TERM CARE	Member is eligible for most ambulatory care, including prosthetics, Member is not eligible for inpatient care other than short-term rehabilitation nursing home care in a SNF. Short-term rehabilitation services include one admission in a 12-month period of up to 29 consecutive days of short-term rehabilitation nursing home care in a SNF. Refer to Appendix Section 7.1 for Attestation of Resources Non-Covered Services.
OUTPATIENT COVERAGE WITHOUT LONG TERM CARE	Member is eligible for some ambulatory care, including prosthetics, and short-term rehabilitation services. Short-term rehabilitation services include one admission in a 12-month period of up to 29 consecutive days of short-term rehabilitation nursing home care in a SNF and one commencement of service in a 12-month period of up to 29 consecutive days of certified home health agency services. Member is not eligible for: • inpatient coverage other than short-term rehabilitation nursing home care in a SNF. • adult day health care, • Assisted Living Program, • certified home health agency except short-term rehabilitation, • hospice, • managed long-term care, • personal care, • consumer directed personal assistance program, • limited licensed home care, • personal emergency response services, • private duty nursing,

OUTPATIENT COVERAGE WITHOUT LONG TERM CARE (CONT)	• waiver services provided under the:
	  ○ Long Term Home Health Care Program,
	  ○ Traumatic Brain Injury Program,
	  ○ Care at Home Waiver Program
	  ○ Office for People With Developmental Disabilities (OPWDD) Home and Community-Based Services (HCBS) Waiver Program.
	
	Refer to Appendix Section 7.1 for Attestation of Resources Non-Covered Services.

OUTPATIENT COVERAGE WITH NO NURSING FACILITY SERVICES	Member is eligible for all ambulatory care, including prosthetics. Member is not eligible for inpatient coverage Refer to Appendix Section 7.1 for Attestation of Resources Non-Covered Services.
PERINATAL FAMILY	Member is eligible to receive a limited package of benefits. The following services are excluded: • podiatry, • long- term home health care, • long term care, hospice, • ophthalmic services, • DME, • therapy (physical, speech, and occupational), • abortion services, • alternate level care.
PRESUMPTIVE ELIGIBLE LONG-TERM/HOSPICE	Member is eligible for all Medicaid services except: • hospital based clinic services, • hospital emergency room services, • hospital inpatient services, • bed reservation.
PRESUMPTIVE ELIGIBILITY PRENATAL A	Member is eligible to receive all Medicaid services except: • inpatient care, • institutional long-term care, alternate level care, • long-term home health care.
PRESUMPTIVE ELIGIBILITY PRENATAL B	Member is eligible to receive only ambulatory prenatal care services. The following services are excluded: • inpatient hospital, • long-term home health care, • long-term care, • hospice, • alternate level care, • ophthalmic, • DME, • therapy (physical, speech, and occupational), • abortion, • podiatry.

6.2 Reject Reason codes (REV. 06/12)

The table below displays the mapping of HIPAA codes to eMedNY codes.

REJECT REASON CODE AND DESCRIPTION		POSSIBLE CAUSES
AA	AUTHORIZATION NUMBER NOT FOUND	**PA NOT ON FILE**
		The DVS Prior Approval number that you are trying to cancel is not on file.
AG	INVALID/MISSING PROCEDURE CODES	**PROCEDURE MODIFIER NOT INPUT**
		A valid modifier was not entered for the procedure.
		INVALID HCPCS CODE
		The HCPCS code entered is not valid.
		INVALID ADA CODE
		The dental procedure code entered is not valid.
CT	CONTACT PAYER	**CALL 1-800-343-9000**
		When certain conditions are met (ex: multiple responses), call the Call Center staff for additional data.
T5	CERTIFICATION INFORMATION MISSING	**PRIOR APPROVAL NOT ON OR REMOVED FROM FILE**
		The DVS Prior Approval is not on, or has been removed from file.
15	REQUIRED APPLICATION DATA MISSING	**NO UNITS ENTERED**
		No entry was made and the units are required for this transaction.
33	INPUT ERRORS	**ITEM NOT COVERED**
		The entered Item/NDC code is not a reimbursable code on the New York State Drug Plan file or has been discontinued.
		MISSING/INVALID DVS QUANTITY
		The entered quantity's format is invalid or missing and is required.
		CURRENT DATE REQUIRED
		A DVS transaction requires a current date entry. The date entered was NOT today's date.

REJECT REASON CODE AND DESCRIPTION		POSSIBLE CAUSES
33	INPUT ERRORS (cont)	**MISSING/INVALID TOOTH/QUADRANT**
		The tooth number, tooth quadrant, or arch was not entered and is required, or was entered incorrectly. Else, the dental procedure is not allowed for the specific Dental site.
41	AUTHORIZATION/ACCESS RESTRICTIONS	**DOWNLOAD REQUIRED**
		The VeriFone software is obsolete and must be updated. This message is displayed once a day until the download is completed.
		INVALID TERMINAL ACCESS
		The received transaction is classified as a Provider Type/Transaction Type Combination that is not allowed to be submitted through the POS VeriFone terminal. Additionally, this message will be returned if a pharmacy submits a DVS transaction for an NDC code through the POS VeriFone terminal because NDC codes must be submitted through the online NCPDP DUR format. Pharmacies are only allowed to submit DVS transactions through the POS VeriFone terminal for HCPCS codes (five-digit alpha/numeric codes).
		LOST/STOLEN TERMINAL
		The terminal serial ID is indicated as being a lost or stolen terminal. Call 1-800-343-9000 for assistance.
		SSN ACCESS NOT ALLOWED
		The provider is not authorized to access the system using a social security number. The Medicaid number or Access Number must be entered.
42	UNABLE TO RESPOND AT CURRENT TIME	**RESUBMIT TRANSACTION**
43	INVALID/MISSING PROVIDER INFORMATION	**INVALID PROVIDER NUMBER**
		The Provider ID entered is not valid.
49	PROVIDER IS NOT PRIMARY CARE PHYSICIAN	**RESTRICTED MEMBER – NO AUTHORIZATION**
		The ordering/referring provider entered is not the provider the member is restricted to. (DVS Only)
50	PROVIDER INELIGIBLE FOR INQUIRIES	**PROVIDER NOT ELIGIBLE**
		The verification was attempted by an inactivated or disqualified provider.

REJECT REASON CODE AND DESCRIPTION		POSSIBLE CAUSES
51	PROVIDER NOT ON FILE	**PROVIDER NOT ON FILE**
		The provider number entered is not identified as a Medicaid enrolled provider. Either the number is incorrect or not on the provider master file.
60	DATE OF BIRTH FOLLOWS DATE(S) OF SERVICE	**SERVICE DATE PRIOR TO BIRTHDATE**
		A date which occurs before the birthdate.
62	DATE OF SERVICE NOT WITHIN ALLOWABLE INQUIRY PERIOD	**INVALID DATE**
		An illogical date or a date which falls outside the eMedNY inquiry period. (Dates up to 24 months retroactive will be supported.)
69	INCONSISTENT WITH PATIENT'S AGE	**AGE EXCEEDS MAXIMUM**
		The member's age exceeds the maximum allowable age on the NYS Drug Plan file for the item/NDC code entered.
		AGE PRECEDES MINIMUM
		The member's age is below the minimum allowable age on the NYS Drug Plan file for the item/NDC code entered.
70	INCONSISTENT WITH PATIENT'S GENDER	**ITEM/GENDER INVALID**
		The item/NDC code entered is not reimbursable for the member's gender resident on the eligibility file.
72	INVALID/MISSING SUBSCRIBER/INSURED ID	**INVALID CARD THIS MEMBER**
		Member has used an invalid card. Check the number entered against the member's Common Benefit Identification Card. If they agree, the member has been issued a new and different Benefit Identification Card and must produce the new card prior to receiving services.
		INVALID ACCESS NUMBER
		An incorrect access number was entered.
		INVALID MEDICAID NUMBER
		The Medicaid number entered is not valid.
75	SUBSCRIBER/INSURED NOT FOUND	**SOCIAL SECURITY NUMBER NOT ON FILE**
		The entered nine-digit number is not on the Member Master File.

REJECT REASON CODE AND DESCRIPTION		POSSIBLE CAUSES
75	SUBSCRIBER/INSURED NOT FOUND (cont)	**MEMBER NOT ON FILE**
		Member identification number is not on file. The number is either incorrect or the member is no longer eligible and the number is no longer on file.
		NO COVERAGE: PENDING FHP
		Member is waiting to be enrolled into a Family Health Plus Managed Care Plan. No Medicaid services are reimbursable.
		NO MATCH ON FILE
		Member is not found on file.
76	DUPLICATE SUBSCRIBER/INSURED ID NUMBER	**CALL LOCAL DISTRICT**
		When a Name Search transaction is submitted and more than one eligible member identification number is found, please contact the member's local county of fiscal responsibility**.**
84	CERTIFICATION NOT REQUIRED FOR THIS SERVICE	**PA NOT REQ/MEDIA TYPE INVALID**
		The entered item/NDC was not designated by the Dept. of Health to receive a DVS number through eMedNY or this is not the appropriate access for obtaining a Prior Approval number for this item/NDC. This response will be returned except on the OMNI 3750. For those developing their own software, refer to the NYS Medicaid HIPAA Companion Documents, 278 Request and Response.
		DVS NUMBER NOT REQUIRED
		The entered item/NDC was not designated by the Dept. of Health to receive a DVS number through eMedNY. This response will be returned for the VeriFone OMNI 3750 Terminal.
87	EXCEEDS PLAN MAXIMUMS	**AT SERVICE LIMIT**
		The member has reached his/her limit for that particular service category.

REJECT REASON CODE AND DESCRIPTION	POSSIBLE CAUSES
87 EXCEEDS PLAN MAXIMUMS (cont)	**EXCEEDS FREQUENCY LIMIT**
	The member has already received the allowable quantity limit of the item/NDC code entered in the time frame resident on the NYS Drug Plan file or the quantity you requested will exceed that limit. OR the procedure code conflicts with either the same or similar procedure code(s), or is not substantiated by previous service(s) on the Member's PA and/or Claims History File.
	MAXIMUM QUANTITY EXCEEDED
	The quantity entered exceeds the maximum allowable quantity resident on the NYS Drug Plan file. Make sure the quantity entered is for the current date of service only. (no refills).
88 NON-COVERED SERVICE	**PROCEDURE CODE NOT COVERED**
	The procedure code entered was either entered incorrectly or is not a NYS reimbursable code, or has been discontinued.
	ITEM NOT COVERED
	The entered Item/NDC code is not a reimbursable code on the New York State Drug Plan file or has been discontinued.
89 NO PRIOR APPROVAL	**NO AUTHORIZATION FOUND**
	No matching transaction found for the authorization cancellation request.
91 DUPLICATE REQUEST	**DUPLICATE DVS**
	The entered transaction is a duplicate of a previously submitted and approved DVS transaction.
95 PATIENT NOT ELIGIBLE	**NOT MEDICAID ELIGIBLE**

REJECT REASON CODE AND DESCRIPTION	POSSIBLE CAUSES
	Member is not eligible for benefits on the date of service requested.
95 PATIENT NOT ELIGIBLE (cont)	**NO COVERAGE: EXCESS INCOME**
	Member has income in excess of the allowable levels. All other eligibility requirements have been satisfied. This individual will be considered eligible for Medicaid reimbursable services only at the point his or her excess income is reduced to the appropriate level. The individual may reduce his or her excess income by paying the amount of the excess, or submitting bills for the medical services that are at least equal to the amount of the excess income, to the Local Department of Social Services.
	MEMBER MEDICARE PART D DENIAL
	DVS Requests for Pharmacy and DME Prior Approvals will be rejected for Members who have Part D Medicare coverage (prescription drugs).

6.3 Decision Reason Codes (Rev. 10/11)

When code 'A3' is received in a DVS response transaction, it is accompanied by a Health Care Decision Reason Code. The full list of these codes may be found at http://www.wpc-edi.com/content/view/769/1. The codes most used by NYS DOH are listed below.

01	**Price Authorization Expired**
04	**Authorized Quantity Exceeded**
0C	**Authorization/Access Restrictions**
0D	**Requires PCP authorization**
0H	**Certification Not Required for this Service**
0L	**Exceeds Plan Maximums**
0N	**No Prior Approval**
0Q	**Duplicate Request**
0X	**Service Inconsistent with Provider Type**
0Y	**Service inconsistent with Patient's Age**
0Z	**Service inconsistent with Patient's Gender**
10	**Product/service/procedure delivery pattern (e.g., units, days, visits, weeks, hours, months)**
12	**Patient is restricted to specific provider**
14	**Plan/contractual guidelines not followed**
21	**Transport Request Denied**
25	**Services were not considered due to other errors in the request.**
26	**Missing Provider Role**

6.4 eMedNY Terminal Messages (Rev. 05/11)

The following table lists terminal generated error messages and possible causes.

BUSY REDIALING	Indicates the telephone number is busy. You may have an incorrect dial prefix programmed.
CHECK LINE	The VeriFone terminal is not plugged in or the terminal is on the same line as a telephone, which is off the hook or in use.
CONNECT XXXX	Displayed until transmission to the host computer begins.
DOWNLOAD DONE	Displayed when the download function process is complete. Pres ENTER to continue.
IP CONNECT FAILURE	Indicates your cellular terminal is not in cellular range.
NO ANSWER	Indicates the telephone is not answering. You may have an incorrect dial prefix or telephone number programmed.
NO ENQ FROM HOST	No inquiry received from host. A problem exists with the network. Repeat the transaction. If problem persists, contact eMedNY Call Center at 1-800-343-9000 for assistance.
NO RESPONSE FROM HOST	No response received from host. A problem exists with the network. Repeat the transaction. If problem persists, contact eMedNY Call Center at 1-800-343-9000 for assistance.
PLEASE TRY AGAIN	The card swipe was unsuccessful because you partially swiped the card, the card was damaged, or the equipment malfunctioned. Re-swipe or manually enter the access number.
PROCESSING	Displayed until the host message is ready to be displayed.
RECEIVING	Displayed until the host message is received by the VeriFone.
RETRY TRANSACTION	After a successful Transaction has been completed, this message will be received during the Review Function if an invalid sequence of keys Is pressed or an Access Number is entered which differs in length from the original number.
TRANSMITTING	Displayed until the host computer acknowledges the transmission.
UNREADABLE CARD	Displayed after three unsuccessful attempts to swipe the card.
WAITING FOR ANSWER	Indicates the terminal is attempting to connect to the eMedNY system.

6.5 Exception Codes (Rev. 06/12)

Exception Codes are two-digit codes that identify a member's program exceptions or restrictions.

Code 23	This code identifies a member who is enrolled in the OMH Home and Community Based Services (HCBS) Waiver for Seriously Emotionally Disturbed (SED) children. This member is exempt from Utilization Threshold and Co-pay requirements.
Code 24	This code identifies a member who is enrolled in a Chronic Illness Demonstration Project (CIDP) program. The member's participation in a CIDP does not affect eligibility for other Medicaid services. This member is not exempt from Utilization Threshold and co-payment requirements.
Code 30	This code identifies a Medicaid member who is enrolled in the Long Term Home Health Care Program Waiver also known as the Lombardi Program/nursing home without walls. The member is authorized to receive LTHHCP services from an enrolled LTHHCP provider. This member is not exempt from Utilization Threshold and co-payment requirements.
Code 35	This member is enrolled in a Comprehensive Medicaid Case Management (CMCM) program. The member's participation in CMCM does not affect eligibility for other Medicaid services. This member is exempt from Utilization Threshold and Co-payment requirements.
Code 38	The member is resident in an ICF-DD facility. You should contact the ICF-DD to find out if the service is included in their per diem rate. If it is not, the claim can be submitted to the NYS Medicaid Program. This member is exempt from Utilization Threshold and Co-payment requirements and may be eligible for some fee-for-service Medicaid coverage.
Code 39	This code identifies a member in the Aid Continuing program. This member is subject to Utilization Threshold and exempt from Co-payment requirements.
Code 44	This code identifies a Medicaid member who is enrolled in OPWDD's Home and Community Based Services (HCBS) Waiver and is authorized to receive Non-Intensive At Home Residential Habilitation services. This member is exempt from Utilization Threshold and Co-payment requirements.
Code 45	This code identifies a Medicaid member who is enrolled in OPWDD's Home and Community Based Services (HCBS) Waiver and is authorized to receive Intensive At Home Residential Habilitation services. This member is exempt from Utilization Threshold and Co-payment requirements.
Code 46	This code identifies a Medicaid member who is enrolled in OPWDD's Home and Community Based Services (HCBS) Waiver and is authorized to receive services. This member is exempt from Utilization Threshold and Co-payment requirements.

Code 47	This code identifies a Medicaid member who is enrolled in OPWDD's Home and Community Based Service (HCBS) Waiver and resides in a *supervised* Community Residence. This member is exempt from Utilization Threshold and Co-payment requirements.
Code 48	This code identifies a Medicaid member who is enrolled in OPWDD's Home and Community Based Service (HCBS) Waiver and resides in a *supportive* Community Residence (CR) or a *supportive* Individual Residential Alternative (IRA). This member is exempt from Utilization Threshold and Co-payment requirements.
Code 49	This code identifies a Medicaid member who is enrolled in OPWDD's Home and Community Based Services (HCBS) Waiver, resides in a *supervised* Individual Residential Alternative (IRA) and is authorized to receive IRA residential habilitation services. This member is exempt from Utilization Threshold and Co-payment requirements.
Code 50	This member has Connect services, plus is eligible for the service package available to all members with Perinatal Family. For a Definition of Perinatal Family, refer to Section 3.3 on page 3.3.7 for the Eligibility Responses. This member is exempt from Utilization Threshold and Co-payment requirements.
Code 51	This member has Connect services, plus is eligible for the services described in the Eligibility Response associated with the member. For the range of possibilities, refer to Section 3.3 on page 3.3.1 for the Eligibility Responses. This member is exempt from Utilization Threshold and Co-payment requirements.
Code 54	This code designates a member whose outpatient Medicaid coverage is limited to Home Health and Personal Care Services benefits. This member is **not** exempt from Utilization Threshold and Co-payment requirements.
Code 60	This code identifies a member who is receiving Home and Community Based Services (HCBS) as part of the Nursing Home Transition and Diversion Waiver program. This member is exempt from Utilization Threshold and Co-payment requirements.
Code 62	This code identifies a member in the Care At Home I program. This member is exempt from completion of HARRI (the Long Term Home Health Care Assessment Tool), Co-payment and Utilization Threshold requirements.
Code 63	This code identifies a member in the Care At Home II program. This member is exempt from completion of HARRI (the Long Term Home Health Care Assessment Tool), Co-payment and Utilization Threshold requirements.
Code 64	This code identifies a member in the Care At Home III program. This member is exempt from completion of HARRI (the Long Term Home Health Care Assessment Tool), Co-payment and Utilization Threshold requirements.

Code 65	This code identifies a member in the Care At Home IV program. This member is exempt from completion of HARRI (the Long Term Home Health Care Assessment Tool), Co-payment and Utilization Threshold requirements.
Code 66	This code identifies a member in the Care At Home V program. This member is exempt from completion of HARRI (the Long Term Home Health Care Assessment Tool), Co-payment and Utilization Threshold requirements.
Code 67	This code identifies a member in the Care At Home VI program. This member is exempt from completion of HARRI (the Long Term Home Health Care Assessment Tool), Co-payment and Utilization Threshold requirements.
Code 68	This code identifies a member in the Care At Home VII program. This member is exempt from completion of HARRI (the Long Term Home Health Care Assessment Tool), Co-payment and Utilization Threshold requirements.
Code 69	This code identifies a member in the Care At Home VIII program. This member is exempt from completion of HARRI (the Long Term Home Health Care Assessment Tool), Co-payment and Utilization Threshold requirements.
Code 70	This code identifies a member in the Care At Home IX program. This member is exempt from completion of HARRI (the Long Term Home Health Care Assessment Tool), Co-payment and Utilization Threshold requirements.
Code 71	This code identifies a member in the Care At Home X program. This member is exempt from completion of HARRI (the Long Term Home Health Care Assessment Tool), Co-payment and Utilization Threshold requirements.
Code 72	This Restriction/Exception code identifies Medicaid Members under the age of 21 who are participants in the Bridges to Health Waiver for the Seriously Emotionally Disturbed (B2H/SED). This waiver is for children who are initially in foster care and who can remain in the waiver once discharged, if otherwise eligible. This member is exempt from Utilization Threshold and Co-payment requirements.
Code 73	This Restriction/Exception code identifies Medicaid Members under the age of 21 who are participants in the Bridges to Health Waiver for Developmentally Disabled (B2H). This waiver is for children who are initially in foster care and who can remain in the waiver once discharged, if otherwise eligible. This member is exempt from Utilization Threshold and Co-payment requirements.
Code 74	This Restriction/Exception code identifies Medicaid Members under the age of 21 who are participants in the Bridges to Health Waiver for the Medically Fragile (B2H/MedF). This waiver is for children who are initially in foster care but who can remain in the waiver after discharge, if otherwise eligible. This member is exempt from Utilization Threshold and Co-payment requirements.

Code 75	This code identifies a participant of the Partnership program who has Dollar for Dollar Asset Protection. The member may have long term care insurance benefits available for certain long term care services. You should contact the insurance to find out if the service is covered. If it is not, the claim can be submitted to the NYS Medicaid Program. Participation in the Partnership does not affect eligibility for other Medicaid services. This member is **not** exempt from Utilization Threshold and Co-payment requirements.
Code 76	This code identifies a participant of the Partnership program who has Total Asset Protection. The member may have long term care insurance benefits available for certain long term care services. You should contact the insurance to find out if the service is covered. If it is not, the claim can be submitted to the NYS Medicaid Program. Participation in the Partnership does not affect eligibility for other Medicaid services. This member is **not** exempt from Utilization Threshold and Co-payment requirements.
Code 77	This code identifies a member that may have long term care insurance benefits available for certain long term care services. You should contact the insurance to find out if the service is covered. If it is not, the claim can be submitted to the NYS Medicaid Program. This member is **not** exempt from Utilization Threshold and Co-payment requirements.
Code 81	This code identifies a member in a Home and Community Based Services (HCBS) Waiver Program for Traumatic Brain Injury (TBI). This member is exempt from Utilization Threshold and Co-payment requirements.
Code 82	This code identifies a member in the Recipient Restriction Program who is enrolled in a managed care plan. **The member is restricted to a plan network provider who is not a FFS MMIS provider.** Inquiries concerning service to recipients with Code 82 should be directed to the managed care plan. This member is not exempt from Utilization Threshold and Co-payment requirements.
Code 83	This code identifies a member who has been mandated by the local social services district to receive certain alcohol and substance abuse services as a condition of eligibility for public assistance or Medicaid as a result of welfare reform requirements. For managed care enrollees, the presence of this code allows certain substance abuse services to be paid on a fee for service basis. The code may be used to trigger prior approval requirements.
Code 84	This code identifies a Medicaid member who is enrolled in the OMH's Personalized Recovery Oriented Services (PROS) program and is authorized to receive Community Rehabilitation and Support (CRS) With Clinic Treatment. Other base and clinical PROS programs, OMH clinic, CDT, IPRT, PMHP, and ACT intensive claims will be denied payment. This member is exempt from Utilization Threshold and Co-payment requirements.
Code 85	This code identifies a Medicaid member who is enrolled in the OMH's Personalized Recovery Oriented Services (PROS) program and is authorized to receive

	Community Rehabilitation and Support (CRS) Without Clinic Treatment. Other base PROS programs, OMH CDT, IPRT, and ACT intensive claims will be denied payment. This member is exempt from Utilization Threshold and Co-payment requirements.
Code 86	This code identifies a Medicaid member who is enrolled in the OMH's Personalized Recovery Oriented Services (PROS) program and is authorized to receive Intensive Rehabilitation (IR) or Ongoing Rehabilitation and Support (ORS). Other PROS providers will be denied payment for these services. OMH IPRT claims will be denied payment. This member is exempt from Utilization Threshold and Co-payment requirements.
Code 95	This code identifies members with a mental retardation or developmental disability diagnosis who are eligible to be billed under an enhanced APG (Ambulatory Patient Groups) base rate for clinical services. It will allow for payment of the following rates codes: 1435 - MR/DD/TBI APG Base Rate 1436 - MR/DD/TBI Existing Payment for Blend 1437 - Capital and R&R Add-on This member is **not** exempt from the Utilization Threshold or Co-payment requirements.
Code AL	This code identifies a member who resides in an Assisted Living Program residence. The following services are included in the ALP's Medicaid per diem rate and cannot be billed to the Medicaid Program: 1. Adult day health care provided in a program approved by the Department of Health; 2. Home health aide services; 3. Medical supplies and equipment NOT requiring prior approval (underlined procedure codes in the DME and Pharmacy provider manuals are prior approved); 4. Nursing services; 5. Personal care services; 6. Personal emergency response services; and 7. Physical therapy, speech therapy, and occupational therapy.
Code NH	This code identifies a member in a Nursing Home facility. The majority of the member's care is provided by the Nursing Home and is included in their Medicaid per diem rate. If you provide a service to a NH member, you must contact the Nursing Home to find out if the service is included in their rate. If it is not, the claim can be submitted to the NYS Medicaid Program.

6.6 County/District Codes (Rev. 09/11)

The County/District, two-digit codes are used to identify the member's county of fiscal responsibility.

01	Albany	31	Onondaga
02	Allegany	32	Ontario
03	Broome	33	Orange
04	Cattaraugus	34	Orleans
05	Cayuga	35	Oswego
06	Chautauqua	36	Otsego
07	Chemung	37	Putnam
08	Chenango	38	Rensselaer
09	Clinton	39	Rockland
10	Columbia	40	St. Lawrence
11	Cortland	41	Saratoga
12	Delaware	42	Schenectady
13	Dutchess	43	Schoharie
14	Erie	44	Schuyler
15	Essex	45	Seneca
16	Franklin	46	Steuben
17	Fulton	47	Suffolk
18	Genesee	48	Sullivan
19	Greene	49	Tioga
20	Hamilton	50	Tompkins
21	Herkimer	51	Ulster
22	Jefferson	52	Warren
23	Lewis	53	Washington
24	Livingston	54	Wayne
25	Madison	55	Westchester
26	Monroe	56	Wyoming
27	Montgomery	57	Yates
28	Nassau	66	New York City
29	Niagara	97	OMH Administered
30	Oneida	98	OMR/DD Administered
		99	Oxford Home

6.7 New York City Office Codes (Rev. 09/11)

The office codes and descriptions listed below are only returned for **County Code 66** members. Any data returned in this field for members with other county codes may not be accurate since those counties are not required to enter an office code.

Public Assistance

Manhattan

013	Waverly
019	Yorkville
023	East End
024	Amsterdam
026	St. Nicolas
028	Hamilton
032	East Harlem
035	Dyckman
037	Roosevelt

Bronx

038	Rider
039	Boulevard
040	Melrose
041	Tremont
043	Kingsbridge
044	Fordham
045	Concourse
046	Crotona
047	Soundview
048	Bergen
049	Willis

Queens

051	Queensboro
052	Office of Treatment Monitoring
053	Queens
054	Jamaica
079	Rockaway

Brooklyn

061	Fulton
062	Clinton
063	Wyckoff
064	Dekalb
066	Bushwick
067	Linden
068	Prospect
070	Bay Ridge
071	Nevins
072	Livingston
073	Brownsville
078	Euclid
080	Fort Greene
084	Williamsburg

Staten Island

099	Richmond

Medical Assistance

500-593 34th Street Manhattan

Special Services for Children (SSC)

DOP	Division of Placement
OPA	Office of Placement and Accountability

Field Offices

071	Bronx
072	Brooklyn
073	Manhattan
074	Queens
075	Staten Island

Office of Direct Child Care Services

801	Brooklyn
802	Jamaica
806	Manhattan
810	Division of Group Homes
823	Division of Group Residence
826	Diagnostic Reception Centers

7.0 APPENDIX (Rev. 05/11)

7.1 Attestation of Resources Non-Covered Services (Rev. 05/11)

Community Coverage NO LONG TERM CARE

If the coverage code description in the Eligibility Response is COMMUNITY COVERAGE NO LONG TERM CARE, and you are providing services (as detailed below) your claims may be denied. All other Medicaid-covered services/supplies NOT listed below ARE covered by Medicaid for eligible members with this Community Coverage.

INPATIENT HOSPITAL claims will be covered with the following exceptions:

If your Category of Service is 0285 (Hospital Inpatient) and you are billing for any of the following Rate Codes: 2950, 2951, 2954, 2955, 2962 thru 2971, your claim will NOT BE COVERED.

HOME HEALTH claims will be covered with the following exceptions:

If your Category of Service is 0260 (Home Health Agency) or 0284 (Home Care Program), and you are billing any of the following Rate Codes: 2609, 2611, 2616, 2621, 2631, 2636 thru 2639, 2641, 2651, 2652, 2661, 2663 thru 2665, 2671, 2681, 2682, 2685, 2689 thru 2699, 2809, thru 2818, 2821 thru 2837, 2864, 3823 thru 3827, 9981, 9990 thru 9995, your claim will NOT BE COVERED.

If your Category of Service is 0260 (Home Health Agency) and you are billing any of the following Rate Codes: 2301 thru 2309, 2311 thru 2336, 9912 thru 9923, 9930 thru 9935, 9960 thru 9967, 9970 thru 9973, your claim will NOT BE COVERED.

If your Category of Service is one of the following: 0263 (TBI- Traumatic Brain Injury), 0264 (Personal Care Services), 0266 (Personal Emergency Response), 0269 (OPWDD Waiver Services), 0388 (Long Term Home Health Care), your claims will NOT BE COVERED.

If your Category of Service is 0268 (OMH Rehabilitative Services) and you are billing one of the following Rate Codes: 4650 thru 4667, your claim will NOT BE COVERED.

PRACTITIONER claims will be covered with the following exceptions:

If your Category of Service is 0521 (Private Duty Nursing LPN), 0522 (Private Duty Nursing RN), 0523 (Hospital Registry LPN), 0524 (Hospital Registry RN) and you are billing procedure codes S9123 or S9124, your claim will NOT BE COVERED.

RESIDENTIAL HEALTH claims will be covered with the following exceptions:

If your Category of Service is 0165 (Hospice), 0267 (Assisted Living Program ALP), 0383 (Day Care), your claims will NOT BE COVERED.

ICF DD claims will NOT be covered

Community Coverage With Community Based Long Term Care

If the coverage code description in the Eligibility Response is COMMUNITY COVERAGE WITH COMMUNITY BASED LONG TERM CARE, and you are providing services (as detailed below) your claims may be denied. All other Medicaid-covered services/supplies NOT listed below ARE covered by Medicaid for eligible members with this Community Coverage.

INPATIENT HOSPITAL claims will be covered with the following exceptions:

If your Category of Service is 0285 (Hospital Inpatient) and you are billing for any of the following Rate Codes: 2950, 2951, 2954, 2955 or 2962 thru 2971, your claim will NOT BE COVERED.

HOME HEALTH claims will be covered with the following exceptions:

If your Category of Service is 0260 (Home Health Agency) or 0284, 0388 (Home Care Program) and you are billing for the following Rate Codes: 2609, 2616, 2636 through 2639, 2663 through 2665, 2682, 2685, 2689 through 2699, 2809, 2818, 2821 through 2837, 2864, 3819, 3823 through 3829, 3831, 3858 through 3875, 9981, or 9990 through 9998, your claim will NOT BE COVERED.

If your Category of Service is 0260 (Home Health Agency) and you are billing any of the following Rate Codes 2301 through 2309, 2311, through 2336, 9912 through 9923, 9930 through 9935, 9960 through 9967, 9970 through 9973, your claim will NOT BE COVERED.

If your Category of Service is 0263 or 0269 your claim will NOT BE COVERED.

ICF DD claims will NOT be covered

PRACTITIONER claims will be covered with the following exceptions:

If your Category of Service is 0521 (Private Duty Nursing LPN), 0522 (Private Duty Nursing RN), 0523 (Hospital Registry LPN), 0524 (Hospital Registry RN) and you are billing procedure codes S9123 or S9124 and Procedure Code Modifier is "U1" (Care at Home Waiver Program, private duty nursing), your claim will NOT BE COVERED.

Outpatient Coverage With Community Based Long Term Care

If the coverage code description in the Eligibility Response is OUTPATIENT COVERAGE WITH COMMUNITY BASED LONG TERM CARE, and you are providing services (as detailed below) your claims may be denied. All other Medicaid-covered services/supplies NOT listed below ARE covered by Medicaid for eligible members with this Community Coverage.

CLINIC, NURSING HOME, HOME HEALTH, CHILD CARE, ICF DD, HMO-(Managed Care) claims will be covered with the following exceptions:

If you are billing for services included within any of these claim types and you are submitting one of the following Bill Types on your claim: 11, 12, 15 thru 18, 61 or 62, your claim will NOT BE COVERED.

RESIDENTIAL HEALTH claims will be covered with the following exceptions:

If your Category of Service is 0165 (Hospice) and you are billing Rate Code 3990, your claim will NOT BE COVERED.

HOME HEALTH claims will be covered with the following exceptions:

If your Category of Service is 0263 or 0269, your claim will NOT BE COVERED.

If your Category of Service is 0260 (Home Health Agency) or 0284, 0388 (Home Care Program) and you are billing for the following Rate Codes: 2609, 2616, 2636 through 2639, 2663 through 2665, 2682, 2685, 2689 through 2699, 2809, 2818, 2821 through 2837, 2864, 3819, 3823 through 3829, 3831, 3858 through 3875, 9981, or 9990 through 9998, your claim will NOT BE COVERED.

If your Category of Service is 0260 (Home Health Agency) and you are billing any of the following Rate Codes 2301 through 2309, 2311, through 2336, 9912 through 9923, 9930 through 9935, 9960 through 9967, 9970 through 9973, your claim will NOT BE COVERED.

PRACTITIONER claims will be covered with the following exceptions:

If your Category of Service is 0521 (Private Duty Nursing LPN), 0522 (Private Duty Nursing RN), 0523 (Hospital Registry LPN), 0524 (Hospital Registry RN) and you are billing procedure codes S9123 or S9124 and Procedure Code Modifier is "U1" (Care at Home Waiver Program, private duty nursing), your claim will NOT BE COVERED.

ICF DD claims will NOT BE COVERED

INPATIENT HOSPITAL

If your Category of Service is 0285 (Hospital Inpatient) and you are **NOT Billing** any of the following Rate Codes: 2946, 2950, 2951, 2953, 2956, 2958, 2960 or 2996, your claim will NOT BE COVERED.

If your Category of Service is 0285 (Hospital Inpatient) and you **ARE Billing** one of the following Rate Codes: 2946, 2950, 2951, 2953, 2956, 2958, 2960 or 2996 and you are submitting one of the following Bill Types on your claim- (11, 12, 15 thru 18, 61 or 62), your claim will NOT BE COVERED.

MEDICAL- (DME, TRANSPORTATION, REFERRED AMBULATORY, PRACTITIONER, LAB, EYE CARE, DENTAL) claims will be covered with the following exceptions:

If you are billing any of these services and are submitting Place of Service 21-(Inpatient) on your claim, your service will NOT BE COVERED.

Place of Service Codes, used throughout the Health Care industry, are maintained by the Center for Medicare & Medicaid Services (CMS). Refer to the CMS website for a current list of Place of Service Codes: http://www.cms.gov/Place-of-Service-Codes/

Outpatient Coverage Without Long Term Care

If the coverage code description in the Eligibility Response is OUTPATIENT COVERAGE WITHOUT LONG TERM CARE, and you are providing services (as detailed below) your claims may be denied. All other Medicaid-covered services/supplies NOT listed below ARE covered by Medicaid for eligible members with this Community Coverage.

CLINIC, NURSING HOME, HOME HEALTH, CHILD CARE, ICF DD, HMO-(Managed Care) claims will be covered with the following exceptions:

If you are billing for services included within any of these claim types and you are submitting one of the following Bill Types on your claim: 11, 12, 15 thru 18, 61 or 62, your claim will NOT BE COVERED.

RESIDENTIAL HEALTH claims will be covered with the following exceptions:

If your Category of Service is one of the following: 0165 (Hospice), 0267 (Assisted Living Program ALP) or 0383 (Day Care), your claims will NOT BE COVERED.

HOME HEALTH claims will be covered with the following exceptions:

If your Category of Service is one of the following: 0263 (TBI Traumatic Brain Injury), 0264 (Personal Care Services), 0266 (Personal Emergency Response Services), 0269 (OPWDD Waiver Services), 0388 (Long Term Home Health Care), your claims will NOT BE COVERED.

If your Category of Service is 0260 (Home Health Agency) or 0284 (Home Care Program) and you are billing for one of the following Rate Codes: 2609, 2611, 2616, 2621, 2631, 2636 thru 2639, 2641, 2651, 2652, 2661, 2663 thru 2665, 2671, 2681, 2682, 2685, 2689 thru 2699, 2809 thru 2818, 2821 thru 2837, 2864, 3823 thru 3827, 3831, 3858 thru 3875, 9981, 9990 thru 9995, your claim will NOT BE COVERED.

If your Category of Service is 0260 (Home Health Agency) and you are billing one of the following Rate Codes: 2301 thru 2309, 2311 thru 2336, 9912 thru 9923, 9930 thru 9935, 9960 thru 9967, 9970 thru 9973, your claim will NOT BE COVERED.

If your Category of Service is 0268 (OMH Rehabilitative Services) and you are billing one of the following Rate Codes: 4650 thru 4664, your claim will NOT BE COVERED.

PRACTITIONER claims will be covered with the following exceptions:

If your Category of Service is 0521 (Private Duty Nursing LPN), 0522 (Private Duty Nursing RN), 0523 (Hospital Registry LPN), 0524 (Hospital Registry RN) and you are billing procedure codes S9123 or S9124, your claim will NOT BE COVERED.

ICF DD claims will NOT be covered

INPATIENT

If your Category of Service is 0285 (Hospital Inpatient) and you are **NOT Billing** any of the following Rate Codes: 2946, 2950, 2951, 2953, 2956, 2958, 2960 or 2996, your claim will NOT BE COVERED.

If your Category of Service is 0285 (Hospital Inpatient) and you **ARE Billing** one of the following Rate Codes: 2946, 2950, 2951, 2953, 2956, 2958, 2960 or 2996 and you are submitting one of the following Bill Types on your claim- (11, 12, 15 thru 18, 61 or 62), your claim will NOT BE COVERED.

MEDICAL- (DME, TRANSPORTATION, REFERRED AMBULATORY, PRACTITIONER, LAB, EYE CARE, DENTAL) claims will be covered with the following exception:

If you are billing any of these services and are submitting Place of Service 21-(Inpatient) on your claim, your service will NOT BE COVERED.

Place of Service Codes, used throughout the Health Care industry, are maintained by the Center for Medicare & Medicaid Services (CMS). Refer to the CMS website for a current list of Place of Service Codes:
http://www.cms.gov/Place-of-Service-Codes/

Outpatient Coverage With No Nursing Facility Services

If the coverage code description in the Eligibility Response is OUTPATIENT COVERAGE WITH NO NURSING FACILITY SERVICES, and if you are providing services (as detailed below) your claims may be denied. All other Medicaid-covered services/supplies NOT listed below ARE covered by Medicaid for eligible members with this Community Coverage.

CLINIC, NURSING HOME, HOME HEALTH, CHILD CARE, ICF DD, HMO-(Managed Care) claims will be covered with the following exceptions:

If you are billing for services included within any of these claim types and you are submitting one of the following Bill Types on your claim: 11, 12, 15 thru 18, 61 or 62, your claim will NOT BE COVERED.

NURSING HOME, CHILD CARE, ICF DD

If you are billing for services included in any of these claim types and your Category of Service is NOT 0287 (Day Treatment) or 0383 (Day Care), your claims will NOT BE COVERED.

RESIDENTIAL HEALTH claims will be covered with the following exceptions:

If your Category of Service is 0165 (Hospice) and you are billing Rate Code 3990, your claim will NOT BE COVERED.

HOME HEALTH claims will be covered with the following exceptions:

If your Category of Service is 0260 (Home Health Agency) or 0284, 0388 (Home Care Program) and you are billing for the following Rate Codes: 2609, 2616, 2636 through 2639, 2663 through 2665, 2682, 2685, 2689 through 2699, 2809, 2818, 2821 through 2837, 2864, 3819, 3823 through 3829, 3831, 3858 through 3875, 9981, or 9990 through 9998, your claim will NOT BE COVERED.

If your Category of Service is 0260 (Home Health Agency) and you are billing any of the following Rate Codes 2301 through 2309, 2311, through 2336, 9912 through 9923, 9930 through 9935, 9960 through 9967, 9970 through 9973, your claim will NOT BE COVERED.

If your Category of Service is 0263 or 0269 your claim will NOT BE COVERED.

PRACTITIONER claims will be covered with the following exceptions:

If your Category of Service is 0521 (Private Duty Nursing LPN), 0522 (Private Duty Nursing RN), 0523 (Hospital Registry LPN), 0524 (Hospital Registry RN) and you are billing procedure codes S9123 or S9124 and Procedure Code Modifier is "U1" (Care at Home Waiver Program, private duty nursing), your claim will NOT BE COVERED.

INPATIENT

If your Category of Service is 0285 (Hospital Inpatient) and you are **NOT Billing** any of the following Rate Codes: 2946, 2950, 2951, 2953, 2956, 2958, 2960 or 2996, your claim will NOT BE COVERED.

If your Category of Service is 0285 (Hospital Inpatient) and you **ARE Billing** one of the following Rate Codes: 2946, 2950, 2951, 2953, 2956, 2958, 2960 or 2996 and you are submitting one of the following Bill Types on your claim- (11, 12, 15 thru 18, 61 or 62), your claim will NOT BE COVERED.

8.0 MODIFICATION TRACKING (Rev. 06/12)

02/23/2012	**[Version 4.3]** Following sections modified: 1.0 Introduction to NYS MEVS-DVS Modified to include information about Speech, Occupational, and Physical Therapy under DVS 3.0 Introduction to Telephone (ARU) Verification Section Removed information about the ARU back-up number. 4.2.2 Instructions for Completing Tran Type 4 Modified heading to include Speech Therapy, Occupational Therapy and Physical Therapy 4.2.3 Instructions for Completing Tran Type 6 Added DVS instructions for Speech Therapy, Occupational Therapy and Physical Therapy 5.1 Fields on eMedNY Eligibility Receipt Moved 'CNTY CD=' into the MSG Label.
03/15/2012	**[Version 4.4]** Following sections modified: 3.3 Telephone Verification Response Section Modified Message Sequence for Member's Medicaid Coverage to include: Eligible PCP with Pharmacy Carve out Eligible PCP with Behavioral Health Services and Pharmacy Carve Out Family Health Plus with Pharmacy Carve Out 6.1 Eligibility Benefit Descriptions Modified benefit Plan and Medicaid Covered Services for Eligible PCP and Family Health Plus
06/19/2012	**[Version 4.5]** Following sections modified: Instructions for Completing Tran Type 6 (Rev. 06/12) Modified Enter Modifier to add /valid and delete below, and added Example: preceding For Therapy DVS. Instructions for Completing Tran Type 9 (Rev. 06/12) Modified Action/Input to will be from was, and added Enter tooth number prompt at end of instructions. Reject Reason codes (Rev. 06/12)

For Reject Reason 33, added to Missing/Invalid Tooth Quadrant under Input Errors:

> Else, the dental procedure is not allowed for the specific Dental site.

For Reject Reason 87, added to Exceeds Frequency Limit under Exceeds Plan Maximums:

> OR the procedure code conflicts with either the same or similar procedure code(s), or is not substantiated by previous service(s) on the Member's PA and/or Claims History File.

Exception Codes (Rev. 06/12)

For Exception Codes 75 and 76, removed extraneous word *to* from the last sentence.

Added Exception Code 82.