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

eMedNY

Medicaid Eligibility Verification System (MEVS)

and

Dispensing Validation System (DVS)

Provider Manual

Version Number: 4.38 **HIPAA Version: 5010**
July 2019

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TABLE OF CONTENTS

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1.0 INTRODUCTION TO THE NEW YORK STATE MEDICAID ELIGIBILITY VERIFICATION AND DISPENSING VALIDATION SYSTEM (Rev. 01/19)

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).
- Other access methods: ePACES, CPU-CPU link, eMedNY eXchange, dial-up FTP, 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).
- Standard Medicaid Co-pay amounts.
- Explicit service types.
- Excess resource and NAMI amounts.

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

- ePACES
- CPU-CPU link

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. 11/12)

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 Sections 4.1 and 4.2.

Refer to ePACES:
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:
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

- **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 Trading Partner Information Companion Guide:
https://www.emedny.org/HIPAA/5010/transactions/eMedNY_Trading_Partner_Information_CG.pdf

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

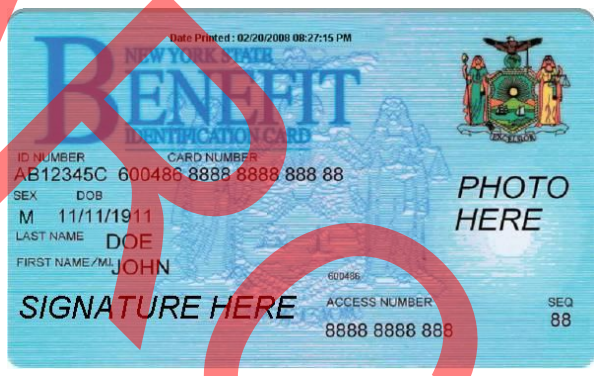
There are three types of Common Benefit Identification Cards:

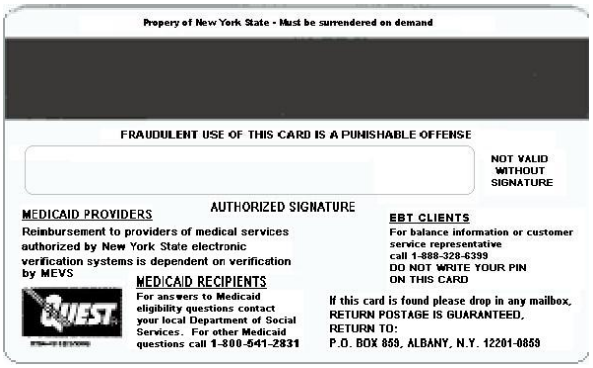
- CBIC permanent plastic photo card.
- CBIC permanent plastic non-photo card.
- Replacement paper card.

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. 01/19)

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.
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.*

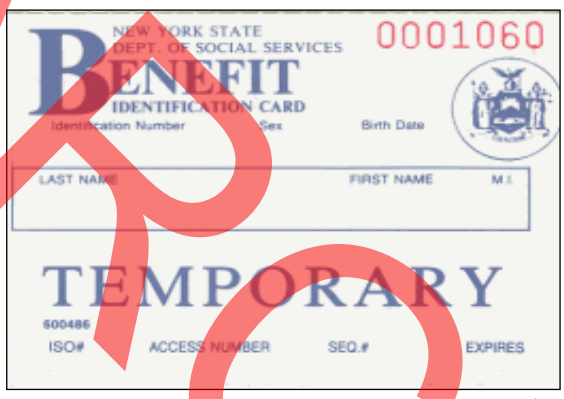
2.2 Permanent Common Benefit Identification Non-Photo Card (Rev. 05/11)

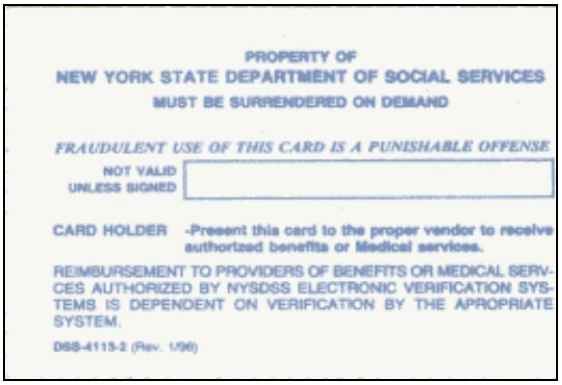
The Common Benefit Identification Non-Photo Card is a permanent plastic card issued to members as determined by the Local Department of Social Services. This permanent card has no expiration date. Eligibility must be verified using the eMedNY system.

For card field descriptions see section 2.1

2.3 Replacement Common Benefit Identification Card (Rev. 01/19)

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.





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. 01/16)

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 alphanumeric 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:

AD12345Z = Eight-digit Medicaid number
21311234512 = Converted 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 **2131**1234**512**

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. 06/13)

3.2.1 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 alphanumeric 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 or up to the end of the current month.
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.**
IF EXPLICIT SERVICE TYPE INFORMATION IS DESIRED, PLEASE ENTER SERVICE TYPE CODE	To verify if a specific service for the member is a covered benefit, enter up to a maximum of one Explicit HIPAA Service Type code.

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. 07/19)

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 5.1 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 an 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 5.1 for Attestation of Resources Non-Covered Services.

MESSAGE SEQUENCE	RESPONSE	DESCRIPTION/COMMENTS
MEMBER'S MEDICAID COVERAGE (Cont)	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 INPATIENT SERVICES	Member is eligible to receive hospital inpatient services only.
	ELIGIBLE ONLY FAMILY PLANNING SERVICES	The Family Planning Benefit Program provides Medicaid coverage for family planning services to persons of any age who reside in NYS, and are U.S. Citizens or have satisfactory immigration status, and whose incomes are 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 FAMILY PLANNING SERVICES NO TRANSPORTATION	The Family Planning Extension Program provides 24 months of family planning services coverage for women who were pregnant while in receipt of Medicaid and subsequently not eligible for Medicaid or Family Health Plus due to failure to renew, or who do not have U. S. Citizenship or satisfactory immigration status, or who have income over 200% of the federal poverty level. This coverage begins once the 60 day postpartum period of coverage ends. Eligible Members (females) have access to all enrolled Medicaid family planning providers and family planning services available under Medicaid except for transportation.
	ELIGIBLE ONLY OUTPATIENT CARE	Member is eligible for all ambulatory care, including prosthetics; no inpatient coverage.

MESSAGE SEQUENCE	RESPONSE	DESCRIPTION/COMMENTS
MEMBER'S MEDICAID COVERAGE (Cont)	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.
	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.
	ELIGIBLE PCP WITH FAMILY PLANNING CARVE OUT (ONLY)	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 what services are covered, contact the PCP designated in the insurance code field. Family Planning services are carved out of the PCP.

MESSAGE SEQUENCE	RESPONSE	DESCRIPTION/COMMENTS
MEMBER'S MEDICAID COVERAGE (Cont)	ELIGIBLE PCP WITH MENTAL HEALTH AND FAMILY PLANNING 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 what services are covered, contact the PCP designated in the insurance code field. Mental Health and Family Planning services are carved out of the PCP.
	ELIGIBLE PCP WITH MENTAL HEALTH, FAMILY PLANNING, 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 what services are covered, contact the PCP designated in the insurance code field. Mental Health, Family Planning and Pharmacy services are carved out of the PCP.
	ELIGIBLE PCP WITH FAMILY PLANNING 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 what services are covered, contact the PCP designated in the insurance code field. Family Planning 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
MEMBER'S MEDICAID COVERAGE (Cont)	ESSENTIAL PLAN – FAMILY PLANNING BENEFIT AND NON-EMERGENCY TRANSPORTATION	Member is eligible to receive Essential Plan benefits as well as Family Planning services and Non-Emergency Transportation.
	FAMILY PLANNING BENEFIT AND MEDICARE COINSURANCE AND DEDUCTIBLE ONLY	The Family Planning Benefit Program provides Medicaid coverage for family planning services to persons of any age who reside in NYS, and are U.S. Citizens or have satisfactory immigration status, and whose incomes are 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. Member is eligible for payment of Medicare coinsurance and deductibles. Deductible and coinsurance payments will be made for Medicare approved services only.
	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.

MESSAGE SEQUENCE	RESPONSE	DESCRIPTION/COMMENTS
MEMBER'S MEDICAID COVERAGE (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.
	NO COVERAGE EXCESS INCOME, NO NURSING HOME SERVICES	Member has income in excess of allowable levels. Excess income may be reduced by paying excess or incurring bills for medical services at least equal to the amount of excess income. Resources verified. Member is resource eligible for community based long term care services. Member is not eligible for Nursing Home services.
	NO COVERAGE EXCESS INCOME, RESOURCES VERIFIED	Member has income in excess of allowable levels. Excess income may be reduced by paying excess or incurring bills for medical services at least equal to the amount of excess income. Resources verified. Member is resource eligible for community based long term care services.
	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 5.1 for Attestation of Resources Non-Covered Services.

MESSAGE SEQUENCE	RESPONSE	DESCRIPTION/COMMENTS
MEMBER'S MEDICAID COVERAGE (Cont)	OUTPATIENT COVERAGE WITHOUT LONG TERM CARE (Cont)	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 5.1 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 5.1 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.

MESSAGE SEQUENCE	RESPONSE	DESCRIPTION/COMMENTS
MEMBER'S MEDICAID COVERAGE (Cont)	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.
	(SERVICE TYPE CODE DESCRIPTION) COVERED	Will voice when an explicit Service Type requested and is covered. • If Service Type "47 (Hospital)" is requested and covered, Service Types 47, 48-(hospital inpatient) and 50-(hospital outpatient) will be voiced.
	CLIENT HAS DENTAL RESTRICTION RESTRICTED PROVIDER NAME PROVIDER NPI	eMedNY will provide the Name and NPI of the provider services are restricted to.
MEMBER RESTRICTIONS	CLIENT HAS PHARMACY RESTRICTION RESTRICTED PROVIDER NAME PROVIDER NPI	eMedNY will provide the Name and NPI of the provider services are restricted to.
	CLIENT HAS CLINIC RESTRICTION RESTRICTED PROVIDER NAME PROVIDER NPI	
	CLIENT HAS INPATIENT RESTRICTION RESTRICTED PROVIDER NAME PROVIDER NPI	

MESSAGE SEQUENCE	RESPONSE	DESCRIPTION/COMMENTS
MEMBER RESTRICTIONS (Cont)	CLIENT HAS PHYSICIAN RESTRICTION RESTRICTED PROVIDER NAME PROVIDER NPI	eMedNY will provide the Name and NPI of the provider services are restricted to.
	CLIENT HAS NURSE PRACTITIONER RESTRICTION RESTRICTED PROVIDER NAME PROVIDER NPI	
	CLIENT HAS DME RESTRICTION RESTRICTED PROVIDER NAME PROVIDER NPI	
	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. Note: The provider Name and NPI will not be returned for exception code 35.
EXCEPTION CODE "A1"	CLIENT IN OUTREACH OR ENROLLED WITH A CARE MANAGEMENT AGENCY CARE MANAGEMENT AGENCY NAME CARE MANAGEMENT AGENCY NPI OR CARE MANAGEMENT AGENCY MMIS ID	Client in outreach or enrolled with a Care Management Agency, eMedNY will provide Provider NPI or Provider MMIS ID and Name.
EXCEPTION CODE "A2"	CLIENT IN OUTREACH OR ENROLLED WITH A HEALTH HOME	Client in outreach or enrolled with a Health Home, eMedNY will provide Provider NPI or MMIS ID and Name

MESSAGE SEQUENCE	RESPONSE	DESCRIPTION/COMMENTS
EXCEPTION CODE "A2" (Cont)	HEALTH HOME NAME HEALTH HOME NPI OR HEALTH HOME MMIS ID	
EXCEPTION CODES "I5", "I6", "I7", "I8"	CLIENT ENROLLED WITH CARE COORDINATION ORGANIZATION (CCO) HEALTH HOME PROVIDER NAME PROVIDER NPI OR PROVIDER MMIS ID	These codes identify a Medicaid member who is enrolled in an OPWDD Care Coordination Organization/Health Home (CCO/HH).
EXCEPTION CODE "I9"	CLIENT ENROLLED IN OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES (OPWDD) BASIC HOME AND COMMUNITY BASED SERVICES (HCBS) PLAN SUPPORT CARE MANAGEMENT CCO PROVIDER NAME PROVIDER NPI OR PROVIDER MMIS ID	Code "I9" identifies a Medicaid member who is eligible for OPWDD CCO/HH services, but has instead opted for basic HCBS plan support in lieu of full health home services. Although not a health home service itself, this option is also delivered by CCO/HH provider agencies.
CLIENT HEALTH HOME SERVICES	CLIENT ASSIGNED, IN OUTREACH OR ENROLLED WITH A CARE MANAGEMENT AGENCY HEALTH HOME PROVIDER NAME PROVIDER NPI	Client assigned, in outreach or enrolled with a Care Management Agency, eMedNY will provide Provider NPI and Name.
	CLIENT ASSIGNED TO OR ENROLLED IN THE HEALTH HOME PROGRAM HEALTH HOME PROVIDER NAME PROVIDER NPI	Client assigned, in outreach or enrolled with Health Home Program, Provider eMedNY will provide NPI and Name.
ANNIVERSARY	ANNIVERSARY DATE	This is the anniversary date of the member's benefit year.

MESSAGE SEQUENCE	RESPONSE	DESCRIPTION/COMMENTS
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 4.5 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 4.6 for Office Codes. The three-digit Office Code 'H78' is returned for members who have coverage through the NY Health Benefit Exchange. The phone number for inquiries pertaining to eligibility issues for members enrolled through the NY Health Benefit Exchange is 855-355-5777.
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
	MEDICARE PARTS B & D	Member has both Part B and Part D Medicare coverage.
MEDICARE DATA (cont)	MEDICARE PARTS A, B & D	Member has Part A, Part B and Part D Medicare coverage.
	MEDICARE PARTS A, B, D &	Member has Part A, Part B and Part D

MESSAGE SEQUENCE	RESPONSE	DESCRIPTION/COMMENTS
	QMB	and is a Qualified Medicare Beneficiary (QMB).
	MEDICARE IDENTIFIER XXXXXXXXXXX	Medicare Identifier consisting of eleven characters. If a number is not available, the message "MEDICARE IDENTIFIER 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.
	CARRIER CODE	The user will hear the carrier code.
THIRD PARTY INSURANCE	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.
EXCEPTION CODES	EXCEPTION CODE	If applicable, a member's exception code will be returned. Refer to Section 4.4 for Exception Codes and descriptions.
CO-PAY DATA	CO-PAYMENT REMAINING	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.
EXCESS RESOURCE	EXCESS RESOURCE ($X.XX)	The amount of excess resource that may be applied to an inpatient claim, if

<table>
<tr><th>MESSAGE SEQUENCE</th><th>RESPONSE</th><th>DESCRIPTION/COMMENTS</th></tr>
<tr><td></td><td></td><td>appropriate.</td></tr>
<tr><td></td><td>EXCESS RESOURCE BEGIN DATE (MMDDCCYY)
END DATE (MMDDCCYY)</td><td>The Begin and End Date for which the excess resource amount may be applied to inpatient claim, if appropriate.</td></tr>
<tr><td>NAMI</td><td>NAMI AMOUNT ($X.XX)</td><td>The amount that may be applied to inpatient claims or nursing home claims, if appropriate.</td></tr>
<tr><td></td><td>NAMI BEGIN DATE</td><td>The begin date of the NAMI.</td></tr>
<tr><td>UT LIMITS REACHED</td><td>PHYSICIAN/CLINIC AT LIMITS
MENTAL HEALTH CLINIC AT LIMITS
PHARMACY AT LIMITS
DENTAL CLINIC AT LIMITS
LAB AT LIMITS
FOR MORE DETAILED INFORMATION ON COVERED SERVICES, PRESS 1
PRESS 2 TO CONTINUE</td><td>This will be heard when a member has utilized their maximum number of service units for the given service category.
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>
<tr><td>COVERED HIPAA SERVICE TYPES</td><td>FOR MORE DETAILED INFORMATION ON COVERED SERVICES, PRESS 1
PRESS 2 TO CONTINUE</td><td>The following table identifies the 39 explicit Service Types.
<table>
<tr><th>Explicit Service Type</th><th>Service Type Description</th></tr>
<tr><td>2</td><td>Surgical</td></tr>
<tr><td>4</td><td>Diagnostic X-ray</td></tr>
<tr><td>5</td><td>Diagnostic Lab</td></tr>
</table></td></tr>
</table>

MESSAGE SEQUENCE	RESPONSE	DESCRIPTION/COMMENTS
		6 Radiation Therapy 7 Anesthesia 8 Surgical Assistance 12 Durable Medical Equipment Purchase 13 Ambulatory Service Center Facility 18 Durable Medical Equipment Rental 20 Second Surgical Opinion 40 Oral Surgery 42 Home Health Care 45 Hospice 51 Hospital - Emergency Accident 52 Hospital - Emergency Medical 53 Hospital - Ambulatory Surgical 62 MRI/CAT Scan 65 Newborn Care 68 Well Baby Care 73 Diagnostic Medical 76 Dialysis 78 Chemotherapy 80 Immunizations 81 Routine Physical 82 Family Planning 93 Podiatry 99 Professional (Physician) Visit - Inpatient A0 Professional (Physician) Visit - Outpatient A3 Professional (Physician) Visit - Home A6 Psychotherapy A7 Psychiatric - Inpatient A8 Psychiatric - Outpatient AD Occupational Therapy AE Physical Medicine AF Speech Therapy AG Skilled Nursing Care AI Substance Abuse BG Cardiac Rehabilitation BH Pediatric
COVERED HIPAA SERVICE TYPES (Cont)	FOR MORE DETAILED INFORMATION ON STANDARD COPAY AMOUNTS PRESS “1” PRESS “2” TO CONTINUE	The standard Medicaid Copay amounts will only be voiced if the member has copay remaining.
STANDARD COPAY	FOR MORE DETAILED	Diagnostic X-Ray Co-pay- $1.00

MESSAGE SEQUENCE	RESPONSE	DESCRIPTION/COMMENTS
AMOUNTS	INFORMATION ON STANDARD COPAY AMOUNTS PRESS "1" PRESS "2" TO CONTINUE FOR DATE MMDDYY	Diagnostic Lab Co-Pay- $0.50
		Hospital – Inpatient Visit Co-Pay- $25.00
		Hospital-Outpatient Visit Co-pay- $3.00
		Emergency Room Visit Co-Pay-$3.00
		Pharmacy Co-Pay- $3.00
		Brand Drug Co-Pay-$3.00
		Generic Drug Co-Pay-$1.00
		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.**
DATE OF SERVICE		

Note: A maximum of three transactions during a single call may be performed. If fewer 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. 09/13)

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 that falls outside of the allowed eMedNY inquiry period was entered. The allowed period is the current month and 24 months retroactive from the entry 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.
MMIS ID IS NOT ON FILE FOR SUBMITTED ORDERING NPI	The National Provider Identifier (NPI) entered for the Ordering Provider does not have a valid MMIS ID on file.
NO COVERAGE- (SERVICE TYPE CODE DESCRIPTION)	The Explicit Service Type requested for the member is not covered by Medicaid.

RESPONSE	DESCRIPTION/COMMENTS
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 REFERENCE TABLES (REV. 02/19)

Effective 02/01/2019 eMedNY no longer supports the Verifone Vx570 Point of Sale (POS) terminal or any other devices, as they are no longer in compliance with the data privacy and security requirements and cannot be remediated. For other alternate access methods, please see Section 1.1 (Other Access Methods to eMedNY)

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

4.1 Eligibility Benefit Descriptions (Rev. 05/16)

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

ePACES Users: Eligibility Benefit responses and descriptions are similar and may be used as an additional reference.

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 5.1 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 an 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 5.1 for Attestation of Resources Non-Covered Services.
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 FAMILY PLANNING SERVICES NO TRANSPORTATION	The Family Planning Extension Program provides 24 months of family planning services coverage for women who were pregnant while in receipt of Medicaid and subsequently not eligible for Medicaid or Family Health Plus due to failure to renew, or who do not have U.S. Citizenship or satisfactory immigration status, or who have income over 200% of the federal poverty level. This coverage begins once the 60 day postpartum period of coverage ends. Eligible Members (females) have access to all enrolled Medicaid family planning providers and family planning services available under Medicaid except for transportation.
ELIGIBLE ONLY INPATIENT SERVICES	Member is eligible to receive hospital inpatient services only.
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. The presence of Service Type MH means Behavioral Health services are carved out of the PCP. The presence of Service Type 88 means the Pharmacy Services are carved out of the PCP.
ELIGIBLE PCP WITH FAMILY PLANNING CARVE OUT (ONLY)	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 what services are covered, contact the PCP designated in the insurance code field. Family Planning services are carved out of the PCP.
ELIGIBLE PCP WITH MENTAL HEALTH AND FAMILY PLANNING	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 what services are covered,

CARVE OUT	contact the PCP designated in the insurance code field. Mental Health and Family Planning services are carved out of the PCP.
ELIGIBLE PCP WITH MENTAL HEALTH, FAMILY PLANNING, 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 what services are covered, contact the PCP designated in the insurance code field. Mental Health, Family Planning and Pharmacy services are carved out of the PCP.
ELIGIBLE PCP WITH FAMILY PLANNING 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 what services are covered, contact the PCP designated in the insurance code field. Family Planning 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.
EP – FAMILY PLANNING AND NON-EMERGENCY TRANSPORTATION ONLY	Member is eligible to receive Essential Plan benefits as well as Family Planning services and Non-Emergency Transportation.
FAMILY PLANNING BENEFIT AND MEDICARE COINSURANCE AND DEDUCTIBLE ONLY	The Family Planning Benefit Program provides Medicaid coverage for family planning services to persons of any age who reside in NYS, and are U.S. Citizens or have satisfactory immigration status, and whose incomes are 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. Member is eligible for payment of Medicare coinsurance and deductibles. Deductible and coinsurance payments will be made for Medicare approved services only.
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.
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: EXCESS INCOME, NO NURSING HOME SERVICES	Member has income in excess of allowable levels. Excess income may be reduced by paying excess or incurring bills for medical services at least equal to the amount of excess income. Resources verified. Member is resource eligible for community based long term care services. Member is not eligible for Nursing Home services.
NO COVERAGE: EXCESS INCOME, RESOURCES VERIFIED	Member has income in excess of allowable levels. Excess income may be reduced by paying excess or incurring bills for medical services at least equal to the amount of excess income. Resources verified. Member is resource eligible for community based long term care services.
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 5.1 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,
	• 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 5.1 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 5.1 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.

4.2 Reject Reason Codes (Rev. 01/19)

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

ePACES Users: Reject Reason codes returned on ePACES responses are similar and may be used as an additional reference.

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

REJECT REASON CODE AND DESCRIPTION	POSSIBLE CAUSES
	A DVS transaction requires a current date entry. The date entered was NOT today's date.
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	**COUNTY CODE ACCESS NOT ALLOWED**
	The provider is not authorized to access the system to perform a county code name search eligibility inquiry. For School Supportive Health Services (SSHSP) enrolled providers ONLY, who need to obtain the member's CIN, a county code name search eligibility transaction may be submitted via EPACES or X12 270/271 transaction. Once the CIN is obtained, SSHSP providers should use the CIN for any subsequent eligibility verifications.
	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.
	MMIS ID IS NOT ON FILE FOR SUBMITTED ORDERING NPI
	The National Provider Identifier (NPI) entered for the Ordering Provider does not have a valid MMIS ID on file
43 INVALID/MISSING PROVIDER INFORMATION (cont)	**MMIS ID IS NOT ON FILE FOR SUBMITTED REFERRING NPI**
	The National Provider Identifier (NPI) entered for the Referring Provider does not have a valid MMIS ID on file.
45 INVALID/MISSING PROVIDER SPECIALTY CODE	**DENIABLE PROVIDER MISSING SPECIALTY**
	The requesting provider number is not enrolled with the specialty code required for the procedure code entered.

REJECT REASON CODE AND DESCRIPTION	POSSIBLE CAUSES
48 INVALID/MISSING PROVIDER IDENTIFICATION NUMBER	**MMIS ID IS NOT ON FILE FOR SUBMITTED ORDERING NPI**
	The National Provider Identifier (NPI) entered for the Ordering Provider does not have a valid MMIS ID on file.
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.
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 that falls outside the eMedNY inquiry period. The allowable inquiry period is up to the end of the current month and 24 months retroactive from the entry date.
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.
69 INCONSISTENT WITH PATIENT'S AGE (cont)	**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.

REJECT REASON CODE AND DESCRIPTION	POSSIBLE CAUSES
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.
	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 MATCH ON FILE
	Member is not found on file
	NO RECORD FOUND/NO INFORMATION AVAILABLE
	For School Supportive Health Services Program (SSHSP) enrolled providers, who are submitting a county code name search eligibility transaction via EPACES or X12 270/271 transaction, and are receiving this rejection, this means that there is no exact match found, or multiple Client IDs are found to be an exact match, or the county code that you have entered is invalid.
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.

REJECT REASON CODE AND DESCRIPTION	POSSIBLE CAUSES
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. 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.
87 EXCEEDS PLAN MAXIMUMS	**AT SERVICE LIMIT**
	The member has reached his/her limit for that particular service category.
	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.

REJECT REASON CODE AND DESCRIPTION	POSSIBLE CAUSES
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**
	Member is not eligible for benefits on the date of service requested.
	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).
	ELIGIBLE ONLY INPATIENT SERVICES
	Member is eligible to receive hospital inpatient services only.
	NO COVERAGE: EXCESS INCOME, NO NURSING HOME SERVICES
	Member has income in excess of allowable levels. Excess income may be reduced by paying excess or incurring bills for medical services at least equal to the amount of excess income. Resources verified. Member is resource eligible for community based long term care services. Member is not eligible for Nursing Home services.
	NO COVERAGE: EXCESS INCOME, RESOURCES VERIFIED
	Member has income in excess of allowable levels. Excess income may be reduced by paying excess or incurring bills for medical services at least equal to the amount of excess income. Resources verified. Member is resource eligible for community based long term care services.

4.3 Decision Reason Codes (Rev. 03/14)

When code 'A3' is received in a DVS response transaction, it is accompanied by a Health Care Services Decision Reason Code. The full list of these codes may be found at http://www. wpc-edi. com/reference/codelists/healthcare/health-care-services-decision-reason-codes/. 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

4.4 Exception Codes (Rev. 07/19)

Exception Codes are two-character 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. *This code will be inactivated to prevent use after January 1, 2019*
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. *This code will be inactivated to prevent use after January 1, 2019*
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. *This code will be inactivated to prevent use after January 1, 2019*
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. *This code will be inactivated to prevent use after January 1, 2019*
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. *This code will be inactivated to prevent use after January 1, 2019*
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. *This code will be inactivated to prevent use after January 1, 2019*
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. *This code will be inactivated to prevent use after January 1, 2019*
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. *This code will be inactivated to prevent use after January 1, 2019*
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 89	This code identifies a Medicaid member who is enrolled in the Money Follows The Person (MFP) Rebalancing Demonstration program. The member's participation in MFP does not affect eligibility for other Medicaid services.
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: 1425- MR/DD/TBI APG Base Rate (Episode) 1435- MR/DD/TBI APG Base Rate (Visit) 1489- MR/DD/TBI APG Base Rate (Episode) 1501- MR/DD/TBI APG Base Rate (Visit) This member is **not** exempt from the Utilization Threshold or Co-payment requirements. This member is exempt for annual visit caps for OT, PT, and SLP services delivered by clinics and independent practitioners. This member is eligible for the OPWDD Independent Practitioner Services for Individuals with Developmental Disabilities (IPSIDD) enhanced reimbursement.
Code A1	Client in outreach or enrolled with a Care Management Agency, eMedNY will provide Provider NPI or Provider MMIS ID and Name. This member is exempt from Utilization Threshold and Co-payment requirements
Code A2	Client in outreach or enrolled with a Health Home, eMedNY will provide Provider NPI or MMIS ID and Name. This member is exempt from Utilization Threshold and 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 B7	Non-EP Aliessa Immigrant
Code C1	Copay Exempt (Hospice) – Exempt individuals receiving Hospice Care from copay by recognizing Hospice Rate Codes.
Code CF	Clients who qualify for Community First Choice Options services who are not enrolled in OPWDD. This code identifies the person who has met the eligibility requirements for receiving these services
Code CH	This code identifies a Medicaid member who is enrolled in the Care Restructuring Enhancement Program (CREP), HCBS – Home and Community Based Services. This member is not exempt from Utilization Threshold and Co-payment requirements.
Code CM	This code identifies a Medicaid member who is enrolled in the Care Restructuring Enhancement Program (CREP), MLTC- Managed Long Term Care. This member is not exempt from Utilization Threshold and Co-payment requirements.
Code CO	Clients who qualify for Community First Choice Options services who are enrolled in OPWDD. This code identifies the person who has met the eligibility requirements for receiving these services.
Code G1	(Transgender Individual Male to Female) Individual has or is in the process of transitioning from a Male to a Female.
Code G2	(Transgender Individual Female to Male) Individual has or is in the process of transitioning from a Female to a Male.
Code H1	HARP enrolled without HCBS eligibility- This code identifies the person as enrolled in a HARP (Health and Recovery Plan). It also indicates that the person is NOT eligible for the special HARP wrap-around Home and Community Based Services (HCBS).
Code H2	HARP enrolled with Tier 1 HCBS eligibility- This code identifies the person as enrolled in a HARP. It also indicates that the person has been assessed and determined to be eligible for Tier 1 HCBS services (peer supports, employment supports, education supports).
Code H3	HARP enrolled with Tier 2 HCBS eligibility- This code identifies the person as enrolled in a HARP. It also indicates that the person has been assessed and determined to be eligible for Tier 2 HCBS services (which includes all Tier 1 services listed under H2, plus psychosocial rehab, community psychiatric supports and treatment, etc.).
Code H4	HIV SNP HARP – eligible without HCBS eligibility- This code identifies the person as HARP eligible, but with enrollment in an HIV SNP. They have NOT been determined

	to be eligible for the special HCBS benefit package associated with some HARP eligible.
Code H5	HIV SNP HARP – eligible with Tier 1 HCBS eligibility- This code identifies the person as HARP eligible, but with enrollment in an HIV SNP. It also indicates they have been assessed and determined to be eligible for the Tier 1 HCBS services, which will be administered by their HIV SNP.
Code H6	HIV SNP HARP – eligible with Tier 2 HCBS eligibility- This code identifies the person as HARP eligible, but with enrollment in an HIV SNP. It also indicates they have been assessed and determined to be eligible for the Tier 2 HCBS services, which will be administered by their HIV SNP.
Code H7	Opted Out of HARP- This indicates a person was HARP- eligible but who, when given the option to enroll, declined enrollment.
Code H8	HARP ELIG COMMUNITY REFERRAL - This code indicates the person has been identified by OMH, OASIS, DOH, or another designated entity as potentially HARP eligible. An assessment will need to be done on the person and if the results of the assessment show the person to be HARP eligible they will be given the choice of joining a HARP (and given code H1, with the potential for H2 or H3 based on the results of a detailed assessment). If this person is already in an HIV SNP they can remain in the HIV SNP. They will receive code H4 and, based on the results of a more in depth assessment, possibly qualify for HCBS services under codes H5 or H6.
Code H9	HARP ELIG STATE IDENTIFIED - This person has been determined to be “categorically eligible” for a HARP. They will be given the option of moving to a HARP (where they will be given code H1, with the potential for H2 or H3 based on the results of a detailed assessment). If this person were already in an HIV SNP they would not have been given code H9, but rather code H4. They can choose to remain in the HIV SNP or move to a HARP. If they remain in the HIV SNP they could potentially, based on the results of a more in depth assessment, qualify for HCBS services under codes H5 or H6.
Code I1	This code identifies a Medicaid member who is enrolled in OPWDD MC CLASS 1. This member is not exempt from Utilization Threshold and co-payment requirements.
Code I2	This code identifies a Medicaid member who is enrolled in OPWDD MC CLASS 2. This member is not exempt from Utilization Threshold and co-payment requirements.
Code I3	This code identifies a Medicaid member who is enrolled in OPWDD MC CLASS 3. This member is not exempt from Utilization Threshold and co-payment requirements.
Code I4	This code identifies a Medicaid member who is enrolled in OPWDD MC WILLOWBROOK. The member is not exempt from Utilization Threshold and co-payment requirements.
Code I5	This code identifies a Medicaid member who is enrolled in an OPWDD Care Coordination Organization/Health Home (CCO/HH) at level one acuity. The member is exempt from Utilization Threshold and Co-pay requirements.
Code I6	This code identifies a Medicaid member who is enrolled in an OPWDD Care Coordination Organization/Health Home (CCO/HH) at level two acuity.

	The member is exempt from Utilization Threshold and Co-pay requirements.
Code I7	This code identifies a Medicaid member who is enrolled in an OPWDD Care Coordination Organization/Health Home (CCO/HH) at level three acuity. The member is exempt from Utilization Threshold and Co-pay requirements.
Code I8	This code identifies a Medicaid member who is enrolled in an OPWDD Care Coordination Organization/Health Home (CCO/HH) at level four acuity. The member is exempt from Utilization Threshold and Co-pay requirements.
Code I9	This code identifies a Medicaid member who is eligible for OPWDD CCO/HH services, but has instead opted for basic HCBS plan support in lieu of full health home services. Although not a health home service itself, this option is also delivered by CCO/HH provider agencies. The member is exempt from Utilization Threshold and Co-pay requirements.
Code K1	This code identifies a consumer who is under 21 and meets a Level of Care HCBS Eligibility Determination. Consumer is exempt from Utilization Threshold and Co-payment requirements
Code K2	This code identifies a consumer who is under 21 and meets a Level of Need HCBS Eligibility Determination. Consumer is exempt from Utilization Threshold and Co-payment requirements.
Code K3	This code identifies a consumer who is under age 21 and has a serious emotional disturbance as defined by the CANS-NY. Consumer is exempt from Utilization Threshold and Co-payment requirements
Code K4	This code identifies a consumer who is under age 21 and is medically fragile as defined by the CANS-NY. Consumer is exempt from Utilization Threshold and Co-payment requirements.
Code K5	This code identifies a consumer who is under age 21 and a child in foster care with developmental disability as defined by the OPWDD. Consumer is exempt from Utilization Threshold and Co-payment requirements.
Code K6	This code identifies a consumer who is under age 21 and has co-occurring developmental disability and medical fragility as defined by the CANS-NY. Consumer is exempt from Utilization Threshold and Co-payment requirements.
Code K7	This code identifies a consumer who is under age 21 and has experienced physical, emotional, or sexual abuse or neglect, or maltreatment defined by the CANS-NY. Consumer is exempt from Utilization Threshold and Co-payment requirements.
Code K8	This code identifies a consumer who is under age 21 and has foster care placement through a voluntary foster care agency. Consumer is exempt from Utilization Threshold and Co-payment requirements.
Code K9	This code identifies a consumer who is under age 21 and has any foster care placement, either through a voluntary foster care agency or the local district of social

	services. Consumer is exempt from Utilization Threshold and Co-payment requirements.
Code KK	This code identifies a consumer who is under age 18 and is Medicaid-eligible using Family of One budgeting. Consumer is exempt from Utilization Threshold and Co-payment requirements.
Code M1	This code identifies a Medicaid member who is eligible in a MAGI (Modified Adjusted Gross Income) category and is receiving services only available through LDSS. This member is excluded from transition to NYSOH (NY State of Health).
Code N1	This code identifies a regular Nursing Home bed type of a Medicaid managed care enrollee to the managed care health plan. Entry of this code will allow Medicaid managed care plans to receive an adjusted premium due to long term Nursing Home placement.
Code N2	This code identifies an AIDS Nursing Home bed type of a Medicaid managed care enrollee to the managed care health plan. Entry of this code will allow Medicaid managed care plans to receive an adjusted premium due to long term Nursing Home placement.
Code N3	This code identifies a Neuro-Behavioral Nursing Home bed type of a Medicaid managed care enrollee to the managed care health plan. Entry of this code will allow Medicaid managed care plans to receive an adjusted premium due to Nursing Home placement.
Code N4	This code identifies a Traumatic Brain Injury (TBI) Nursing Home bed type of a Medicaid managed care enrollee to the managed care health plan. Entry of this code will allow Medicaid managed care plans to receive an adjusted premium due to long term Nursing Home placement.
Code N5	This code identifies a Ventilator Dependent Nursing Home bed type of a Medicaid managed care enrollee to the managed care health plan. Entry of this code will allow Medicaid managed care plans to receive an adjusted premium due to long term Nursing Home placement.
Code N6	This code identifies a MLTC partial cap/MAP enrollee who has been permanently placed in a nursing facility.
Code N7	This code identifies a fee for service consumer who has been determined eligible for nursing facility services and is required to enroll in a managed care health plan. Consumer will need to enroll in a managed care health plan within 60 days or will be auto assigned. This code triggers Enrollment Broker outreach/enrollment activities.
Code N8	This code is for local districts to enter a transfer penalty period for consumers who have been permanently placed in a nursing facility but are not eligible for Medicaid payment nursing facility services due to a transfer penalty.
Code N9	This code will identify fee-for-service consumers and managed care plan enrollees who are pending nursing home eligibility determination. This member is not exempt from Utilization Threshold and Co-payment requirements.
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.
Code PL	(Upstate) Pre-release from NYS Department of Corrections and Community Supervision (NYS DOCCS) facility, Managed Care Ineligible.
Code PR	(Downstate) Pre-release from NYS Department of Corrections and Community Supervision (NYS DOCCS) facility, Managed Care Ineligible.
Code S1	Surplus Client not Eligible for Medicaid Managed Care or Medicaid Advantage Enrollment.

4.5 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
02	Allegany
03	Broome
04	Cattaraugus
05	Cayuga
06	Chautauqua
07	Chemung
08	Chenango
09	Clinton
10	Columbia
11	Cortland
12	Delaware
13	Dutchess
14	Erie
15	Essex
16	Franklin
17	Fulton
18	Genesee
19	Greene
20	Hamilton
21	Herkimer
22	Jefferson
23	Lewis
24	Livingston
25	Madison
26	Monroe
27	Montgomery
28	Nassau
29	Niagara
30	Oneida
31	Onondaga
32	Ontario
33	Orange
34	Orleans
35	Oswego
36	Otsego
37	Putnam
38	Rensselaer
39	Rockland
40	St. Lawrence
41	Saratoga
42	Schenectady
43	Schoharie
44	Schuyler
45	Seneca
46	Steuben
47	Suffolk
48	Sullivan
49	Tioga
50	Tompkins
51	Ulster
52	Warren
53	Washington
54	Wayne
55	Westchester
56	Wyoming
57	Yates
66	New York City
97	OMH Administered
98	OMR/DD Administered
99	Oxford Home

4.6 New York City Office Codes (Rev. 01/15)

For members who have coverage through the NY Health Benefit Exchange, an additional three-digit Office Code 'H78' will be displayed following the county code. The phone number for inquiries pertaining to eligibility issues for members enrolled through the NY Health Benefit Exchange is 855-355-5777.

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.

4.6.1 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

4.6.2 MEDICAL ASSISTANCE

500-593 34th Street Manhattan

4.6.3 SPECIAL SERVICES FOR CHILDREN (SSC)

DOP Division of Placement
OPA Office of Placement and Accountability

4.6.4 FIELD OFFICES

071 Bronx
072 Brooklyn
073 Manhattan
074 Queens
075 Staten Island

4.6.5 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

5.0 APPENDIX (Rev. 10/14)

5.1 Attestation of Resources Non-Covered Services (Rev. 10/14)

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/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c26. Pdf

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 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.

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/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c26. Pdf

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.

6.0 MODIFICATION TRACKING (Rev. 07/19)

02/23/2012 **[Version 4.3]**

6.1 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.

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]**

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]**

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 general procedure not allowed cause to Missing/Invalid Tooth Quadrant under Input Errors. For Reject Reason 87, added procedure code conflict and no previous service or claim to Exceeds Frequency Limit under Exceeds Plan Maximums. Exception Codes (Rev. 06/12) For Exception Codes 75 and 76, removed extraneous word *to* from the last sentence. Added Exception Code 82.
09/18/2012	**[Version 4.6]** Other Access Methods to eMedNY (Rev. 09/12) Updated Companion Guide name and link. Exception Codes (Rev. 09/12) Added Exception Codes 79, 80, 87 and 88.
10/30/2012	**[Version 4.7]** Telephone Verification Response Section (Rev. 10/12) Updated Eligible Only Family Planning Services response and added Eligible Only Family Planning Services No Transportation response under Member's Medicaid Coverage message sequence.
11/20/2012	**[Version 4.8]** Introduction To The New York State Medicaid Eligibility Verification And Dispensing Validation System (Rev. 11/12) Removed references to PC to Host and use of SOAP for DVS transactions. Other Access Methods to eMedNY (Rev. 11/12) Removed references to PC to Host. Attestation of Resources Non-Covered Services (Rev. 11/12) Updated link to CMS Place of Service Codes location in Outpatient Coverage With Community Based Long Term Care and Outpatient Coverage Without Long Term Care sections.
12/18/2012	**[Version 4.9]** Exception Codes (Rev. 12/12) Added Exception Code 78.

01/24/2013	**[Version 4.10]** Telephone Verification Response Section (Rev. 01/13) Added Eligible Only Inpatient Services under Member's Medicaid Coverage. Eligibility Benefit Descriptions (Rev. 01/13) Added Eligible Only Inpatient Services. Reject Reason Codes (Rev. 01/13) Added Eligible Only Inpatient Services under 95 Patient Not Eligible.
04/18/2013	**[Version 4.11]** Exception Codes (Rev. 4/13) Removed Exception Codes 78, 79, 80, 87, and 88.
06/20/2013	**[Version 4.12]** Introduction To The New York State Medicaid Eligibility Verification And Dispensing Validation System (Rev. 06/13) Added copay, explicit service types, excess resource and NAMI to eligibility information provided list. Telephone Verification Input Section (Rev. 06/13) Updated Date action and added explicit service type prompt. Telephone Verification Response Section (Rev. 06/13) Added family planning and explicit service type responses under Member's Medicaid Coverage. Added message sequences for Excess Resource and NAMI. Added list of explicit service types under Covered HIPAA Service Types. Added message sequences for Standard Copay Amounts. Telephone Verification Error and Denial Responses (Rev. 06/13) Updated Invalid Date description. Added No Coverage response for explicit service types. Instructions for Completing Tran Type 2 (Rev. 06/13) Added excess resource, NAMI, copay and explicit service types to eligibility inquiry transaction explanation. Added Explicit Service Type prompt.

Fields on eMedNY Eligibility Receipt (Rev. 06/13)

Added co-pay fields.

Added list of explicit service types under Serv Type CD.

Added Excess Resource and NAMI fields.

Added co-pay fields.

Eligibility Benefit Descriptions (Rev. 06/13)

Added family planning covered services.

Reject Reason Codes (Rev. 06/13)

Updated Invalid Date description under code 62.

07/24/2013 **[Version 4.13]**

Telephone Verification Response Section (Rev. 07/13)

Added No Coverage Excess Income.

Added No Coverage Pending FHP.

Telephone Verification Error and Denial Responses (Rev. 07/13)

Removed No Coverage Excess Income.

Removed No Coverage Pending FHP.

Reject Reason Codes (Rev. 07/13)

Removed No Coverage Excess Income.

Removed No Coverage Pending FHP.

Eligibility Benefit Descriptions (Rev. 07/13)

Added No Coverage Excess Income.

Added No Coverage Pending FHP.

09/24/2013 **[Version 4.14]**

Telephone Verification Error and Denial Responses (Rev. 09/13)

Added MMIS ID not on file response.

Reject Reason Codes (Rev. 09/13)

Added causes to Invalid Missing Provider Information code and added Invalid/Missing Provider Identification Number code.

10/14/2013 **[Version 4.15]**

Exception Codes (Rev. 10/13)

Added code for Money Follows the Person Demo program.

01/31/2014	**[Version 4.16]** Reject Reason Codes (Rev. 01/14) Added code for Invalid/Missing Provider Specialty Code.
03/25/2014	**[Version 4.17]** Telephone Verification Response Section (Rev. 03/14) Added No Coverage Excess Income, No Nursing Home Services and No Coverage Excess Income, Resources Verified under Member's Medicaid Coverage. Eligibility Benefit Descriptions (Rev. 03/14) Added No Coverage Excess Income, No Nursing Home Services and No Coverage Excess Income, Resources Verified. Reject Reason Codes (Rev. 03/14) Added No Coverage Excess Income, No Nursing Home Services and No Coverage Excess Income, Resources Verified under code 95. Decision Reason Codes (Rev. 03/14) Updated URL for the Health Care Services Decision Reason Code online reference.
10/06/2014	**[Version 4.18]** Attestation of Resources Non-Covered Services (Rev. 10/14) Updated Rate Code listing for Home Health claims.
01/21/2015	**[Version 4.19]** Telephone Verification Response Section (Rev. 01/15) Added contact number for NY Health Benefit Exchange eligibility issues. Fields on eMedNY Eligibility Receipt (Rev. 01/15) Added contact number for NY Health Benefit Exchange eligibility issues under MSG. New York City Office Codes (Rev. 01/15) Added contact number for NY Health Benefit Exchange eligibility issues.
03/24/2015	**[Version 4.20]** Exception Codes (Rev. 03/15) Added Exception Codes H1–H9.

08/27/2015	**[Version 4.21]** Instructions for Completing Tran Type 6 (Rev. 08/15) Added use of past date for retroactive Therapy DVS transactions to Enter Date and Enter Quantity. Exception Codes (Rev. 08/15) Added Exception Codes N1–N7.
09/24/2015	**[Version 4.22]** Exception Codes (Rev. 09/15) Added Exception Codes G1–G2, and N8.
11/19/2015	**[Version 4.23]** Telephone Verification Response Section (Rev. 11/15) Added Essential Plan – Family Planning Benefit And Non-Emergency Transportation response. Eligibility Benefit Descriptions (Rev. 11/15) Added EP – Family Planning Benefit And Non-Emergency Transportation Only.
12/17/2015	**[Version 4.24]** Eligibility Benefit Descriptions (Rev. 12/15) Updated description of MH Service Type under ELIGIBLE PCP.
01/21/2016	**[Version 4.25]** Telephone Verification Response Section (Rev. 01/16) Added Family Planning Benefit And Medicare Coinsurance And Deductible Only telephone response. Eligibility Benefit Descriptions (Rev. 01/16) Added Family Planning Benefit And Medicare Coinsurance And Deductible Only benefit description. Exception Codes (Rev. 01/16) Added Exception Code B7.

05/12/2016	**[Version 4.26]** Telephone Verification Response Section (Rev 05/16) Removed Eligible Capitation Guarantee; Family Health Plus; Family Health Plus with Pharmacy Carve out; Family Health Plus with Family Planning Carve Out (Only); Family Health Plus with Family Planning and Pharmacy Carve out; No Coverage Pending FHP. Fields on eMedNY Eligibility Receipt (Rev 05/16)l Removed references to Family Health Plus and FHP from EB01, Serv Type Cd, Co-Pay Remaining Amt. Removed FHP Co-Pay for Pharmacy Co-Pay, Brand Drug Co-Pay, and Generic Drug Co-Pay Eligibility Benefit Descriptions (Rev. 05/16) Removed Eligible Capitation Guarantee; Family Health Plus; Family Health Plus with Pharmacy Carve out; Family Health Plus with Family Planning Carve Out (Only); Family Health Plus with Family Planning and Pharmacy Carve out; No Coverage: Pending FHP.
05/26/2016	**[Version 4.27]** Exception Codes (Rev. 05/16) Modified Exception Code 95, and added Exception Codes C1 and S1.
08/26/2016	**[Version 4.28]** Exception Codes (Rev. 08/16) Added Exception Codes I1–I4, and N9.
10/27/2016	**[Version 4.29]** Exception Codes (Rev. 10/16) Added Exception Codes CF, CO, and M1.
11/17/2016	**[Version 4.30]** Telephone Verification Response Section (Rev. 11/16) Added Client Health Home Services. Exception Codes (Rev. 11/16) Added Exception Codes A1 and A2.

03/23/2017	**[Version 4.31]** Exception Codes (Rev. 03/17) Added Exception Codes PL and PR.
10/12/2017	**[Version 4.32]** Exception Codes (Rev. 10/17) Added Exception Codes CH and CM.
06/28/2018	**[Version 4.33]** Exception Codes (Rev. 06/18) Added Codes K1 - K9, KK Added Codes I5 – I9 Added disclaimer to Codes 23, 62 - 65, 72 - 74
08/23/2018	**[Version 4.34]** Exception Codes (Rev. 08/18) Modified descriptive label for Codes H8 and H9
09/20/2018	**[Version 4.35]** Medicare Data (Rev. 09/18) Replaced Health Insurance Claim Number with Medicare Identifier.
01/25/2019	**[Version 4.36]** Exception Codes (Rev. 01/19) Added County Code Access Not Allowed – ref. Code 41 Added No Record Found/No Information Available – ref. Code 75
02/01/2019	**[Version 4.37]** Termination of Support for Verifone Vx570 Point of Sale (POS) terminal or similar devices

07/25/2018	**[Version 4.38]** Telephone Verification Response Section Added Codes A1, A2, I5 – I8, I9 Exception Codes (Rev. 07/19) Revised Codes A1, A2, I9