NEW YORK STATE
MEDICAID PROGRAM

INFORMATION FOR ALL PROVIDERS

GENERAL BILLING

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Common Benefit Identification Card

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

The photo and non-photo cards are permanent plastic cards and each contains information needed for eligibility verification for a single recipient. Each card contains the following information for the recipient:

- Medicaid number,
- first name,
- last name,
- middle initial,
- sex and date of birth.

In addition, each card contains an access number, a sequence number, an encoded magnetic strip and a signature panel. The photo ID card also contains a photo and neither card contains an expiration date.

The provider must verify recipient eligibility via the Medicaid Eligibility Verification System (MEVS) each time service is provided to be assured that a recipient is eligible.

If a recipient's permanent plastic ID card has been lost, stolen or damaged, the recipient will be issued a temporary replacement paper CBIC (DSS-3713), which contains the following information for the recipient:

- Medicaid number,
- first name,
- last name,
- middle initial,
- sex and date of birth.

This temporary card carries an expiration date after which the card cannot be used. Verification of eligibility must be completed via MEVS whenever a temporary replacement card (DSS-3713) is presented.

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

of your specific provider manual for instructions. Questions regarding eligibility should be directed to the LDSS issuing the DSS-2831A.

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

There is a separate MEVS Provider Manual that is available to Medicaid enrolled providers. This manual can be accessed/downloaded at the eMedNY website:

http://www.emedny.org/ProviderManuals/AllProviders/MEVS/MEVS_Provider_Manual/1_10/MEVS%20Provider%20Manual.pdf

Voice Interactive Phone System

Medicaid offers the Voice Interactive Phone System (VIPS) to afford providers the opportunity to conduct a name search to locate the Client Identification Number (CIN) of Medicaid patients who were unable to present their cards at the time of service. This system is accessible by calling (518) 472-1550 from a touch-tone telephone and following the voice prompts. There is a charge of $.85 per minute.

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

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

Claims for patients with these cards should be sent to:

Computer Sciences Corporation
P.O. Box 4601
Rensselaer, NY 12144-4601

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

Local Department of Social Services of Fiscal Responsibility

available in the Information for All Providers, Inquiry Manual online at

http://www.emedny.org/ProviderManuals/AllProviders/PDFS/Information_for_All_Providers-Inquiry.pdf

Billing for Medical Assistance Services

Timely Submission of Claims to Medicaid

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

If a claim is denied or returned for correction, it must be corrected and resubmitted within **60 days of the date of notification** to the provider. Claims not correctly resubmitted within 60 days, or those continuing to not be payable after the second resubmission, are neither valid nor enforceable.

In addition, all claims must be **finally** submitted to the fiscal agent and be payable within two years from the date the care, services or supplies were furnished in order to be valid and enforceable against the Department or a social service district.

Claims Submitted for Stop-Loss Payments

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

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

Paper claims over 90 days of the date of service must be submitted with a 90-day letter attached (with the exception of Third Party Insurance Processing Delay). The applicable Delay Reason should be indicated on a piece of paper the same size (8 ½ x 11) and paper quality as the invoice.

Because the claim forms do not contain an invoice number, each claim must have its own 90-day letter attached. This allows the imaging system to track each claim and attachment together.

Acceptable Delay Reason Codes

Claims over 90 days, and less than two years, from the date of service may be submitted if the delay is due to one or more of the following acceptable conditions. *The applicable delay reason(s) must be included on a 90-day letter attached to the claim.*

- **Proof of Eligibility Unknown or Unavailable – Delay in Medicaid Client Eligibility Determination (including Fair Hearing)**

  The recipient applied for Medicaid and their eligibility was backdated. If the claim ages over 90 days while this process is taking place, then this reason applies.

  The claim must be submitted within 30 days from the time of notification.

- **Litigation**

  This means there was some kind of litigation involved and there was the possibility that payment for the claim may come from another source, such as a lawsuit.

  The claim must be submitted within thirty (30) days from the time submission came within the control of the Provider.

- **Authorization Delays/Administrative Delay (Enrollment Process, Prior Approval Process, Rate Changes, etc.) by the Department or other State agency**

  For example: Provider enrollment may back date the effective date of a Specialty Code.

- **Delay in Certifying Provider/Administrative Delay (Enrollment Process, Prior Approval Process, Rate Changes, etc.) by the Department or other State agency**

  For example: Provider enrollment may back date the effective date of a Specialty Code.

- **Delay in Supplying Billing Forms**

- **Third Party Processing Delay – Medicare and Other Third Party Processing Delays**

  The claim had to be submitted to Medicare or other Third Party Insurance before being submitted to Medicaid.

  The claim must be submitted within thirty (30) days from the time submission came within the control of the Provider.

- **Delay in Eligibility Determination/Delay in Medicaid Client Eligibility Determination (including Fair Hearing)**

  This means the recipient applied for Medicaid and their eligibility date was backdated. If the claim ages over 90 days while this process is taking place, then this reason applies.

The claim must be submitted within thirty (30) days from the time of notification.

- **Original Claim Rejected or Denied Due to a Reason Unrelated to the Billing Limitation Rules**

  This means the Provider submitted the claim on time and was denied for some other reason. If the date of service is over 90 days when they rebill, this reason applies.

  The claim must be submitted within thirty (30) days from the time of notification.

- **Administration Delay in the Prior Approval Process/Administrative Delay (prior approval) by the Department of Health or other State agency**

  IPRO denial/reversal (Island Peer Review Organization) previously denied the claim, but the denial was reversed on appeal.

- **Other/Interrupted Maternity Care**

  Prenatal care claims over 90 days because delivery was performed by a different practitioner.

Claims Over Two Years Old

All claims over two years old will be denied for **edit 1292** (*DOS (date of service) Two Yrs (years) Prior to Date Received*).

The Department will *only* consider claims over two years old for payment only if the provider can produce documentation verifying that the cause of the delay was the result of one or more of the following:

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

If a Provider believes that claims denied for edit 1292 are payable due to any of the reasons above, they may request a review.

All claims **must** be submitted **within 90 days of the date on the remittance advice** with supporting documentation to:

New York State Department of Health
Two Year Claim Review
150 Broadway, Suite 6E
Albany, New York 12204-2736

Claims submitted for review without the appropriate documentation, or those not submitted within the 90-day time period for review, will not be considered.

Electronic Claims Submission

Claims for payment of medical care, services and supplies may be submitted electronically. Most claims (originals, resubmissions, adjustments and voids) can be submitted electronically. The only exceptions are claims that require paper attachments such as recipient's "consent forms" or provider's procedure reports for manual pricing.

If you would like more information about computer generated claims submission or require the input specifications for the submission of the types of claims indicated above, please call the Provider Services Department at CSC at (800) 522-5518.

Claim Certification Statement

Provider certifies that:

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

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

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

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

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

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