New York State Electronic Medicaid System eMedNY 000301 Billing Guidelines

PHARMACY

Version 2010 - 01

9/21/2010

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***For eMedNY Billing Guideline questions, please contact the eMedNY Call Center** 1-800-343-9000.*

1. Purpose Statement

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

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

This document is customized for Pharmacies and should be used by the provider as an instructional, as well as a reference tool. For providers new to NYS Medicaid, it is required to read the All Providers General Billing Guideline Information available at www.emedny.org by clicking on the link to the webpage as follows: Information for All Providers.

2. Claims Submission

Pharmacies are required to submit most of their claims to NYS Medicaid electronically. However, certain types of claims are allowed to be submitted in electronic or paper formats. Examples of these types of claims are: claims requiring attachments, such as manufacturers' invoices for manual review and pricing, and claims exempt from the Drug Utilization Review (DUR) requirement.

Providers are required to submit an Electronic/Paper Transmitter Identification Number (ETIN) Application and Certification Statement before submitting claims to NYS Medicaid. Certification Statements remain in effect and apply to all claims until superseded by another properly executed Certification Statement.

Providers will be asked to update their Certification Statement on an annual basis. Providers will be provided with renewal information when their Certification Statement is near expiration. Information about these requirements is available at www.emedny.org by clicking on the link to the webpage as follows: Information for All Providers.

2.1 Electronic Claims

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

Pharmacies are required to use the HIPAA-compliant National Council for Prescription Drugs Program (NCPDP) 5.1 electronic format. Direct billers should also refer to the sources listed below to comply with the NYS Medicaid requirements:

- NCPDP Standard Version 5.1 Implementation Guide explains the proper use of the standards and program specifications. This document is available at www.ncpdp.org.
- NYS Medicaid NCPDP 5.1 Request and Response Companion Guides (CGs) provide instructions for the specific requirements of NYS Medicaid for the NCPDP 5.1. This document is available at www.emedny.org by clicking on the link to the web page as follows: Companion Guides and Sample Files.
- NYS Medicaid Technical Supplementary Companion Guide provides technical information needed to successfully transmit and receive electronic data. Some of the topics put forth in this CG are testing requirements, error report information, and communication specifications. This document is available at www.emedny.org by clicking on the link to the web page as follows: Companion Guides and Sample Files.

Further information about electronic claim pre-requirements is available at www.emedny.org by clicking on the link to the webpage as follows: Information for All Providers.

2.2 Paper Claims

For paper submissions, Pharmacies must use the New York State eMedNY-000301 claim form (Pharmacy Claim Form). To view the eMedNY-000301 claim form, see Appendix A. The displayed claim form is a sample and the information it contains is for illustration purposes only.

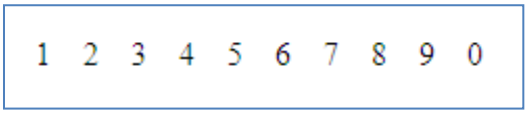
An Electronic Transmission Identification Number (ETIN) and a Certification Statement are required to submit paper claims. Providers who have a valid ETIN for the submission of electronic claims do not need an additional ETIN for paper submissions. The ETIN and the associated certification qualify the provider to submit claims in both electronic and paper formats. Information about these requirements is available at www.emedny.org by clicking on the link to the webpage as follows: Information for All Providers.

2.2.1 General Instructions for Completing Paper Claims

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

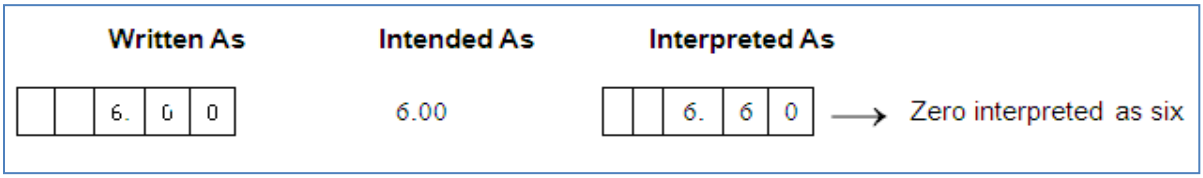
- All information should be typed or printed.
- Alpha characters (letters) should be capitalized.
- Numbers should be written as close to the example below in Exhibit 2.2.1-1 as possible:

Exhibit 2.2.1-1



- Circles (the letter O, the number 0) must be closed.
- Avoid unfinished characters. See the example in Exhibit 2.2.1-2.

Exhibit 2.2.1-2



- When typing or printing, stay within the box provided; ensure that no characters (letters or numbers) touch the claim form lines. See the example in Exhibit 2.2.1-3.

Exhibit 2.2.1-3

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

- Characters should not touch each other as seen in Exhibit 2.2.1-4.

Exhibit 2.2.1-4

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

- Do not write between lines.
- Do not use arrows or quotation marks to duplicate information.
- Do not use the dollar sign ($) to indicate dollar amounts; do not use commas to separate thousands. For example, three thousand should be entered as 3000, not as 3,000.
- For writing, it is best to use a felt tip pen with a fine point. Avoid ballpoint pens that skip; do not use pencils, highlighters, or markers. Only blue or black ink is acceptable.
- If filling in information through a computer, ensure that all information is aligned properly, and that the printer ink is dark enough to provide clear legibility.
- Do not submit claim forms with corrections, such as information written over correction fluid or crossed out information. If mistakes are made, a new form should be used.
- Separate forms using perforations; do not cut the edges.
- Do not fold the claim forms.
- Do not use adhesive labels (for example for address); do not place stickers on the form.
- Do not write or use staples on the bar-code area.

The address for submitting claim forms is:

COMPUTER SCIENCES CORPORATION
P.O. Box 4601
Rensselaer, NY 12144-4601

2.3 Claim Form A – eMedNY-000301

The eMedNY-000301 claim form is a New York State Medicaid form that can be obtained through the financial contractor (CSC). To order the forms, please contact the eMedNY call center at 1-800-343-9000.

To view the eMedNY-000301 claim form, see Appendix A. The displayed claim form is a sample and the information it contains is for illustration purposes only.

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

2.4 Pharmacy Services Billing Instructions

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

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

2.4.1 Claim Form – eMedNY-00301 Field Instructions

Header Section: Fields 1 through 13A

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

Provider ID Number (Field 1)

Enter the provider's 10-digit National Provider Identifier (NPI), name and address in this field using the following rules for submitting the ZIP code:

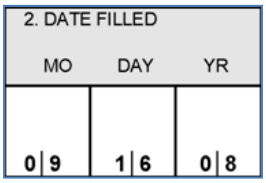
- Paper claim submissions: Enter the five-digit ZIP code or the ZIP plus four.
- Electronic claim submissions: Enter the nine-digit ZIP code.

NOTE: It is the responsibility of the provider to notify Medicaid of any change of address or other pertinent information within 15 days of the change. For information on where to direct address change requests, please refer to Information for All Providers, Inquiry on the web page for this manual, which can be found at www.emedny.org by clicking on the link to the webpage as follows: Pharmacy Manual.

Date Filled (Field 2)

Enter the date on which the prescription/order is filled in the format MM/DD/YY. See Exhibit 2.4.1-1 for an example.

Exhibit 2.4.1-1



SA EXCP Code [Service Authorization Exception Code] (Field 3)

For Dental Clinic Claims Only

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

For more information on the UT Program, please refer to Information for All Providers, General Policy, ***which can be found at www.emedny.org by clicking on the link to the webpage as follows:*** Pharmacy Manual.

If not applicable, leave this field blank.

Adjustment/Void Code (Field 4)

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

If submitting a ***void*** to a previously paid claim, enter ***X*** or the value ***8*** in the V box.

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

Original Claim Reference Number (Field 4A)

Leave this field blank when submitting an original claim or resubmission of a denied claim.

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

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

2.4.1.1 Adjustment

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

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

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

Exhibit 2.4.1.1-1 and Exhibit 2.4.1.1-2 illustrate an example of a claim with an adjustment being made. TCN 0826019876543200 is shared by three individual claim lines. TCN 0826067890123456 was paid on October 1, 2008. After receiving payment, the provider determines that an incorrect item code has been reported. An adjustment must be submitted to correct the claim records. Exhibit 2.4.1.1-1 shows the claim as it was originally submitted and Exhibit 2.4.1.1-2 shows the claim as it appears after the adjustment has been made.

Exhibit 2.4.1.1-1

NYS MEDICAL ASSISTANCE (TITLE XIX) PHARMACY CLAIM FORM

1. PROVIDER ID NUMBER: 0 1 2 3 4 5 6 7 8 9

City Pharmacy
111 Park Avenue
Anytown, NY 11111-1111

2. DATE FILLED: MO 0 9 DAY 1 6 YR 0 8

3. SA EXCP CODE:

ONLY TO BE USED TO ADJUST OR VOID A PAID CLAIM
4 CODE: A
4A. ORIGINAL CLAIM NUMBER: V

5. RECIPIENT ID NUMBER: A A 1 2 3 4 5 W
6. DATE OF BIRTH: 0 4 1 9 1 9 5 5
7. SEX: X 1 (F 2)
8. OTHER RECIPIENT INSURANCE CODE:
9. RECIPIENT NAME: LAST Brandon FIRST John

10. PROF CD:
10A. ORDERING/PRESCRIBING PROVIDER ID/LICENSE NUMBER: 0 0 1 2 3 4 5 6
10B. NAME: Peter Smith

11. PROF CD:
11A. OTHER REFERRING/ORDERING PROVIDER ID/LICENSE NUMBER:
11B. NAME:

PRIOR APPROVAL/AUTHORIZATION NO. | LINE
12. | 12A. | FOR OFFICE USE ONLY
13. | 13A. | 14

LINE	15. PRESCRIPTION/ ORDER NUMBER	16. DATE ORDERED MO DAY YR	17. DRUG SUPPLY CODE	18. QUANTITY DISPENSED	19. DAYS SUPPLY	20. NEW REFILL NUMBER	20A. NO OF REFILLS AUTHOR-IZED	21. BRAND NECES-SARY	22. AMOUNT CHARGED	MEDICARE 23. CO-INSURANCE	23A. DEDUCT-ABLE	23B. CO-PAY	23C. PAID	24. OTHER INSURANCE PAID
1	6 0 0 0 1 0 0	0 9 1 6 0 8	5 1 0 7 9 0 2 0 0 2 0	6 0.0 0	3 0	1	5	Y 1 X	1 5.0 0					
2	6 0 0 0 6 0 0	0 9 1 6 0 8	B 4 1 8 9	1.0 0	1 0	1	0	Y 1 X	7 5.0 0					
3	6 0 0 0 1 6 0	0 9 1 6 0 8	A 6 2 4 7	6 0.0 0	3 0	0	0	Y 1 X	2 0.0 0					
4								Y 1 N						
5								Y 1 N						

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

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

29. SIGNATURE: James Strong
30. COUNTY*:
31. BILLING DATE: MO 0 9 DAY 1 6 YR 0 8

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

DO NOT WRITE IN BARCODE AREA

[redacted]

EMEDNY – 000301 (01/04) 1-11-0071 (12/03)

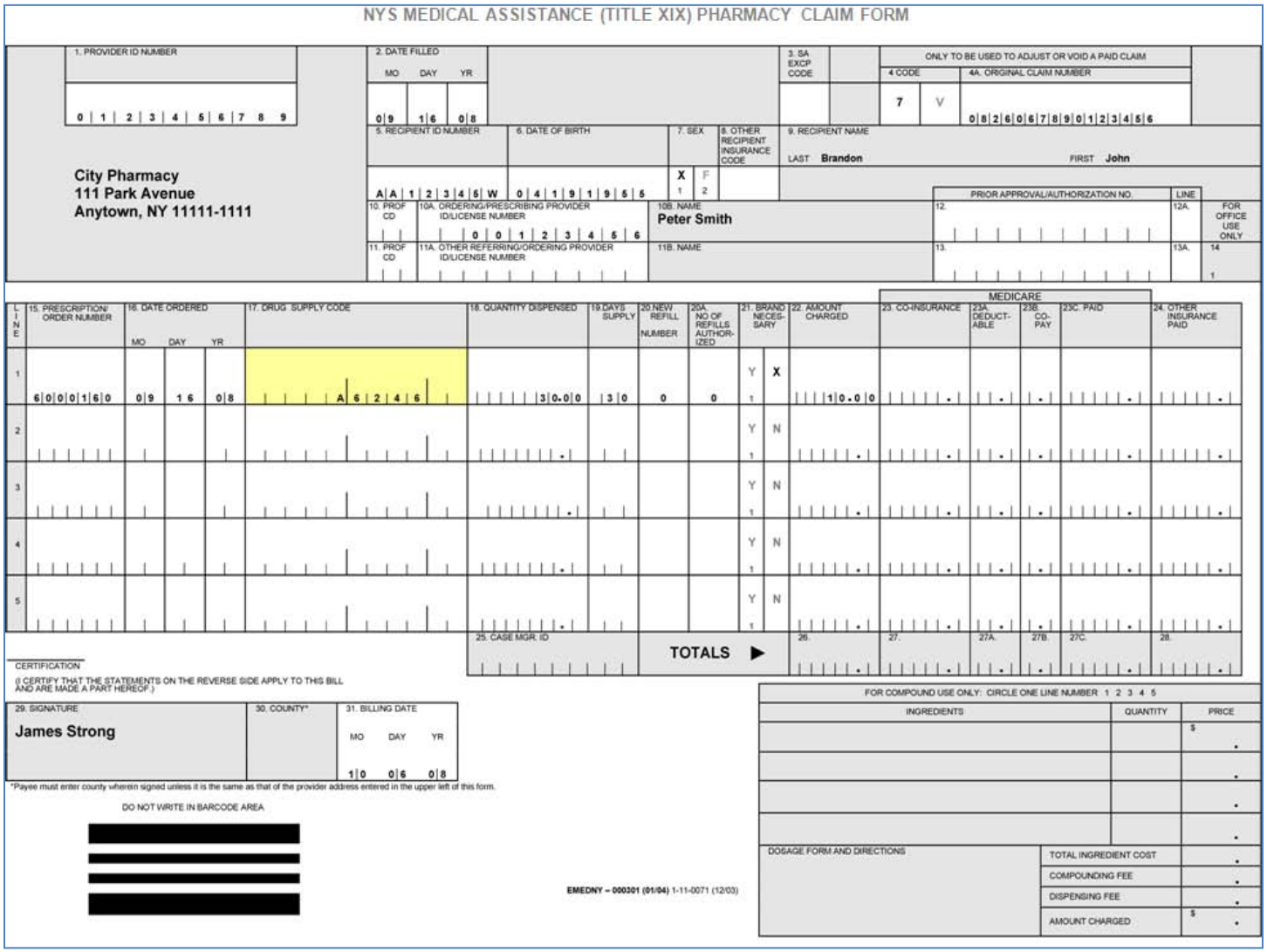
FOR COMPOUND USE ONLY: CIRCLE ONE LINE NUMBER 1 2 3 4 5

INGREDIENTS	QUANTITY	PRICE
		$.
		.
		.
		.

DOSAGE FORM AND DIRECTIONS

TOTAL INGREDIENT COST	.
COMPOUNDING FEE	.
DISPENSING FEE	.
AMOUNT CHARGED	$.

Exhibit 2.4.1.1-2



NYS MEDICAL ASSISTANCE (TITLE XIX) PHARMACY CLAIM FORM

1. PROVIDER ID NUMBER: 0 1 2 3 4 5 6 7 8 9

City Pharmacy
111 Park Avenue
Anytown, NY 11111-1111

2. DATE FILLED: MO 0 9 DAY 1 6 YR 0 8

3. SA EXCP CODE:

ONLY TO BE USED TO ADJUST OR VOID A PAID CLAIM
4 CODE: 7 V
4A. ORIGINAL CLAIM NUMBER: 0 8 2 6 0 6 7 8 9 0 1 2 3 4 5 6

5. RECIPIENT ID NUMBER: A A 1 2 3 4 5 W
6. DATE OF BIRTH: 0 4 1 9 1 9 5 5
7. SEX: X 1 F 2
8. OTHER RECIPIENT INSURANCE CODE:
9. RECIPIENT NAME: LAST Brandon FIRST John

PRIOR APPROVAL/AUTHORIZATION NO.: LINE:

10. PROF CD:
10A. ORDERING/PRESCRIBING PROVIDER ID/LICENSE NUMBER: 0 0 1 2 3 4 5 6
10B. NAME: Peter Smith
11. PROF CD:
11A. OTHER REFERRING/ORDERING PROVIDER ID/LICENSE NUMBER:
11B. NAME:
12.
12A.
FOR OFFICE USE ONLY
13.
13A.
14 1

LINE	15. PRESCRIPTION/ ORDER NUMBER	16. DATE ORDERED MO DAY YR	17. DRUG SUPPLY CODE	18. QUANTITY DISPENSED	19. DAYS SUPPLY	20. NEW REFILL NUMBER	20A. NO OF REFILLS AUTHORIZED	21. BRAND NECESSARY	22. AMOUNT CHARGED	MEDICARE 23. CO-INSURANCE	23A. DEDUCTABLE	23B. CO-PAY	23C. PAID	24. OTHER INSURANCE PAID
1	6 0 0 0 0 1 6 0	0 9 1 6 0 8	A 6 2 4 6	3 0.0 0	3 0	0	0	Y 1 X	1 0.0 0					
2								Y 1 N						
3								Y 1 N						
4								Y 1 N						
5								Y 1 N						
				25. CASE MGR. ID	TOTALS ▶				26.	27.	27A.	27B.	27C.	28.

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

29. SIGNATURE: James Strong
30. COUNTY*:
31. BILLING DATE: MO 1 0 DAY 0 6 YR 0 8

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

DO NOT WRITE IN BARCODE AREA

[redacted]

EMEDNY – 000301 (01/04) 1-11-0071 (12/03)

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

INGREDIENTS	QUANTITY	PRICE
		$.
		.
		.
		.

DOSAGE FORM AND DIRECTIONS

TOTAL INGREDIENT COST	.
COMPOUNDING FEE	.
DISPENSING FEE	.
AMOUNT CHARGED	$.

2.4.1.2 Void

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

Exhibit 2.4.1.2-1 and Exhibit 2.4.1.2-2 illustrate an example of a claim being voided. TCN 082609865432123 was paid on October 1, 2008. Later, the provider became aware that the patient was covered by other insurance. The other insurance was billed, and the provider received full payment from that payer. Medicaid must be reimbursed by submitting a void to the previously paid claim. Exhibit 2.4.1.2-1 shows the claim as it was originally submitted and Exhibit 2.4.1.2-2 shows the claim being submitted as voided.

Exhibit 2.4.1.2-1

NYS MEDICAL ASSISTANCE (TITLE XIX) PHARMACY CLAIM FORM

1. PROVIDER ID NUMBER: 0 1 2 3 4 5 6 7 8 9

City Pharmacy
111 Park Avenue
Anytown, NY 11111-1111

2. DATE FILLED: MO 0 9 DAY 1 6 YR 0 8

3. SA EXCP CODE:

ONLY TO BE USED TO ADJUST OR VOID A PAID CLAIM
4 CODE: A
4A. ORIGINAL CLAIM NUMBER: V

5. RECIPIENT ID NUMBER: A A 1 2 3 4 5 W
6. DATE OF BIRTH: 0 4 1 9 1 9 5 5
7. SEX: X 1 (F 2)
8. OTHER RECIPIENT INSURANCE CODE:
9. RECIPIENT NAME: LAST Brandon FIRST John

10. PROF CD:
10A. ORDERING/PRESCRIBING PROVIDER ID/LICENSE NUMBER: 0 0 1 2 3 4 5 6
10B. NAME: Peter Smith

11. PROF CD:
11A. OTHER REFERRING/ORDERING PROVIDER ID/LICENSE NUMBER:
11B. NAME:

PRIOR APPROVAL/AUTHORIZATION NO. 12.
LINE 12A.
FOR OFFICE USE ONLY
13.
13A.
14 1

MEDICARE

LINE	15. PRESCRIPTION/ ORDER NUMBER	16. DATE ORDERED MO DAY YR	17. DRUG SUPPLY CODE	18. QUANTITY DISPENSED	19.DAYS SUPPLY	20.NEW REFILL NUMBER	20A. NO OF REFILLS AUTHOR-IZED	21. BRAND NECES-SARY	22. AMOUNT CHARGED	23. CO-INSURANCE	23A. DEDUCT-ABLE	23B. CO-PAY	23C. PAID	24. OTHER INSURANCE PAID
1	6 0 0 0 1 0 0	0 9 1 6 0 8	5 1 0 7 9 0 2 0 0 2 0	6 0.0 0	3 0	1	5	Y X	1 5.0 0					
2								Y N						
3								Y N						
4								Y N						
5								Y N						
				25. CASE MGR. ID	TOTALS ▶				26.	27.	27A.	27B.	27C.	28.

CERTIFICATION
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29. SIGNATURE: James Strong
30. COUNTY*:
31. BILLING DATE: MO 0 9 DAY 1 6 YR 0 8

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

DO NOT WRITE IN BARCODE AREA

[redacted]

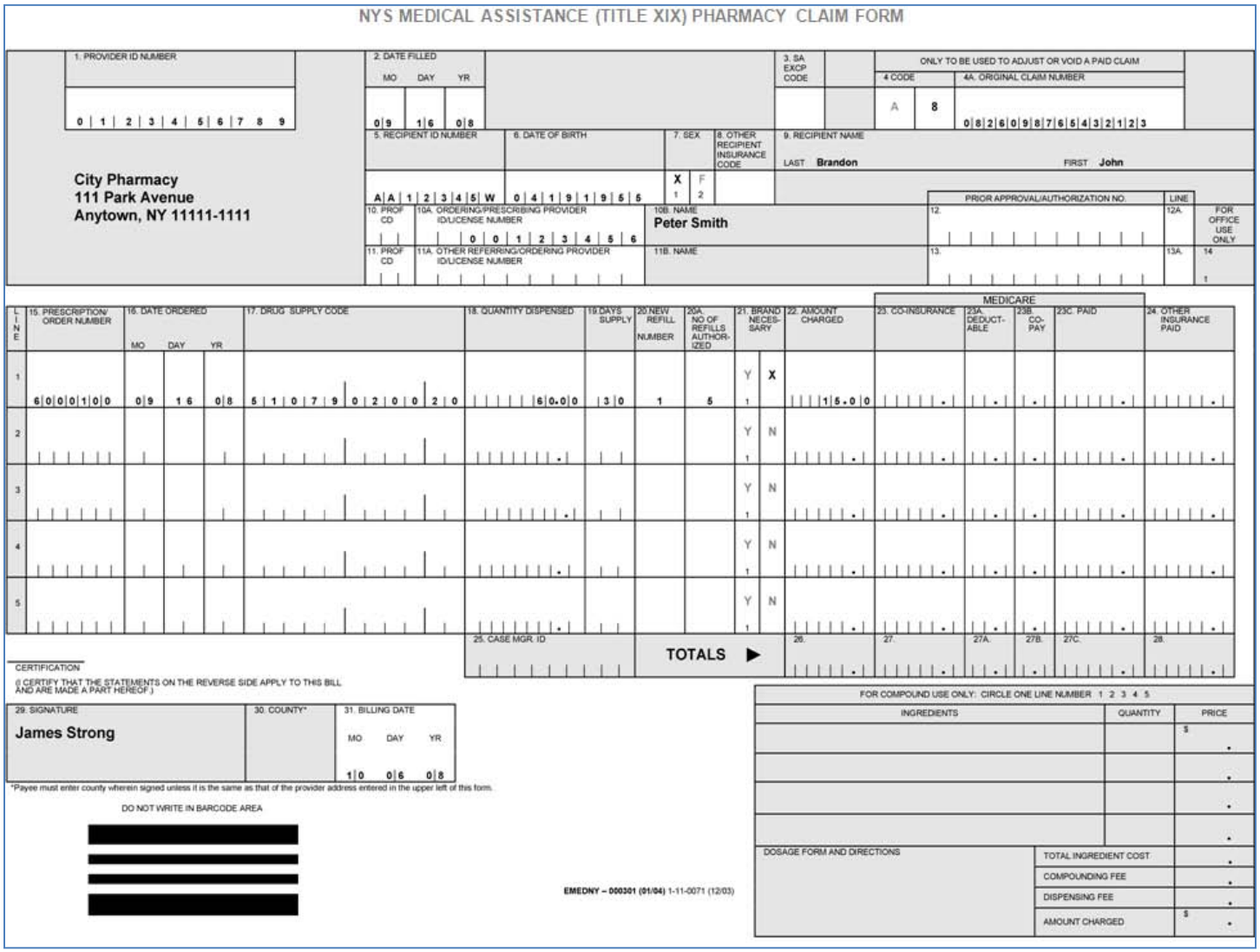
EMEDNY – 000301 (01/04) 1-11-0071 (12/03)

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

INGREDIENTS	QUANTITY	PRICE
		$.
		.
		.
		.

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

Exhibit 2.4.1.2-2



NYS MEDICAL ASSISTANCE (TITLE XIX) PHARMACY CLAIM FORM

1. PROVIDER ID NUMBER: 0 1 2 3 4 5 6 7 8 9

City Pharmacy
111 Park Avenue
Anytown, NY 11111-1111

2. DATE FILLED: MO 0 9 DAY 1 6 YR 0 8

3. SA EXCP CODE:

ONLY TO BE USED TO ADJUST OR VOID A PAID CLAIM
4 CODE: A 8
4A. ORGINAL CLAIM NUMBER: 0 8 2 6 0 9 8 7 6 5 4 3 2 1 2 3

5. RECIPIENT ID NUMBER: A A 1 2 3 4 5 W
6. DATE OF BIRTH: 0 4 1 9 1 9 5 5
7. SEX: X 1 F 2
8. OTHER RECIPIENT INSURANCE CODE:
9. RECIPIENT NAME: LAST Brandon FIRST John

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

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

MEDICARE

LINE	15. PRESCRIPTION/ ORDER NUMBER	16. DATE ORDERED MO DAY YR	17. DRUG SUPPLY CODE	18. QUANTITY DISPENSED	19. DAYS SUPPLY	20. NEW REFILL NUMBER	20A. NO OF REFILLS AUTHORIZED	21. BRAND NECESSARY	22. AMOUNT CHARGED	23. CO-INSURANCE	23A. DEDUCTABLE	23B. CO-PAY	23C. PAID	24. OTHER INSURANCE PAID
1	6 0 0 0 1 0 0	0 9 1 6 0 8	5 1 0 7 9 0 2 0 0 2 0	6 0.0 0	3 0	1	5	Y 1 X	1 5.0 0					
2								Y 1 N						
3								Y 1 N						
4								Y 1 N						
5								Y 1 N						
			25. CASE MGR. ID	TOTALS ▶					26.	27.	27A.	27B.	27C.	28.

CERTIFICATION
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30. COUNTY*:
31. BILLING DATE: MO 1 0 DAY 0 6 YR 0 8

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DO NOT WRITE IN BARCODE AREA

[redacted]

EMEDNY – 000301 (01/04) 1-11-0071 (12/03)

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

INGREDIENTS	QUANTITY	PRICE
		$.
		.
		.
		.

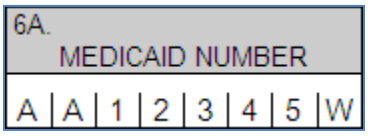
DOSAGE FORM AND DIRECTIONS

TOTAL INGREDIENT COST	.
COMPOUNDING FEE	.
DISPENSING FEE	.
AMOUNT CHARGED	$.

Recipient ID Number (Field 5)

Enter the patient's ID number (Client ID number). This information may be obtained from the Client's (Patient's) Common Benefit ID Card. Medicaid Client ID numbers are assigned by NYS Medicaid and are composed of 8 characters in the format AANNNNNA, where A = alpha character and N = numeric character as shown in Exhibit 2.4.1-2.

Exhibit 2.4.1-2

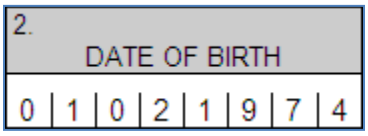


6A. MEDICAID NUMBER							
A	A	1	2	3	4	5	W

Date of Birth (Field 6)

Enter the patient's birth date. This information may be obtained from the Client's (Patient's) Common Benefit ID Card. The birth date must be in the format MMDDYYYY as shown in Exhibit 2.4.1-3.

Exhibit 2.4.1-3



Sex (Field 7)

Place an 'X' in the appropriate box to indicate the patient's sex. This information may be obtained from the Client's (Patient's) Common Benefit ID Card.

Recipient Other Insurance Code (Field 8)

If the recipient is exempt from co-pay, enter the value Z9 in this field. For information on co-pay exemptions, refer to the Policy Guidelines which can be found at www.emedny.org by clicking on the link to the webpage as follows: Pharmacy Manual.

Recipient Name (Field 9)

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

PROF Code [Profession Code – Ordering/Prescribing Provider] (Field 10)

Leave this field blank.

Ordering/Prescribing Provider ID/License Number (Field 10A)

Prescriptions from Practitioners

Enter the NPI of the ordering/prescribing provider.

Prescriptions from Facilities

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

When a prescription is written by an unlicensed intern or resident, the supervising physician's NPI should be entered in this field.

Prescriptions from Physician's Assistants

When prescriptions have been written by a Physician's Assistant, the supervising physician's NPI should be entered in this field.

Prescriptions from Nurse Practitioners

Licenses issued to Nurse Practitioners certified to write prescriptions have seven characters which includes the letter “F” followed by six digits. For example: F012346.

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

If the prescribing provider is a Nurse Practitioner certified to write prescriptions, enter his/her NPI in this field.

NOTE: If the NPI of an authorized prescriber is not on the prescription, it is the pharmacist's responsibility to obtain it.

Prescriptions for Restricted Recipients

When filling prescriptions/orders for a recipient who is restricted to a primary provider (physician, clinic, podiatrist or dentist) and the primary provider is the prescribing/ordering provider, the NPI of this provider must be entered in this field.

If the restricted recipient was referred by his/her primary provider to another provider and the referred provider is the ordering/prescribing provider, the pharmacy provider must enter the referred provider’s NPI in this field. The primary provider’s NPI must be entered in field 11A.

DIAGNOSIS CODE

New York Medicaid policy requires the prescriber to provide a valid diagnosis code on all fiscal orders for durable medical equipments, prosthetics, orthotics, and supplies (DMEPOS).

A valid diagnosis code is a minimum requirement for all DMEPOS fiscal orders.

The diagnosis code must be submitted on all NCPDP pharmacy DMEPOS claims. The diagnosis code on the fiscal order must match the diagnosis code reported on the claim. Providers that bill using the 837 form should already be submitting the diagnosis code on all DMEPOS claims.

Exhibit 2.4.1-4 contains the NCPDP 5.1 fields utilized to report diagnosis code:

Exhibit 2.4.1-4

NCPDP FIELD	DESCRIPTION
Diagnosis Code Count (491-VE)	Count of diagnosis occurrences. 1-5 'Diagnosis Codes' may be sent.
Diagnosis Code Qualifier (492-WE)	Code qualifying the 'Diagnosis Code' sent. '01'= International Classification of Diseases (ICD-9).
Diagnosis Code (424-DO)	Code Identifying the diagnosis of the patient.

NOTE: Diagnosis Code can only be reported on NCPDP format.

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

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

PROF CD [Profession Code – Other Referring/Ordering Provider] (Field 11)

Leave this field blank.

Other Referring/Ordering Provider ID/License Number (Field 11A)

Prescriptions for Restricted Recipients

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

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

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

Prior Approval/Authorization No. (Field 12)

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

Line (Field 12A)

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

Prior Approval/Authorization No. (Field 13)

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

Line (Field 13A)

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

NOTES:

- ***For information regarding how to obtain Prior Approval/Prior Authorization for specific services, please refer to the Information for All Providers, Inquiry section on the web page for this manual.***
- ***For information on how to submit a DVS transaction, please refer to the MEVS Manual available at www.emedny.org by clicking on the link to the webpage as follows:*** Provider Manuals***.***
- ***For information regarding procedures that require prior approval, please consult the Procedure Codes and Fee Schedules for this manual.***
- ***All items listed above are available at www.emedny.org by clicking on the link to the webpage as follows:*** Pharmacy Manual.

Encounter Section: Fields 15 to 24

Prescription/Order Number (Field 15)

Enter the pharmacy prescription/order number in this field.

Date Ordered (Field 16)

Enter the original date on which the prescription/order was written as it appears on the prescription/order note signed by the prescribing/ordering provider. The date should be entered in the format MM/DD/YY. For example, if a drug was originally prescribed for a patient on 04/03/10 and is being refilled on 05/03/10, enter 04/03/10 in Field 16.

Drug/Supply Code (Field 17)

For Prescription Drugs

Enter in this field the National Drug Code (NDC) of the drug displayed on the package.

For OTC Drugs

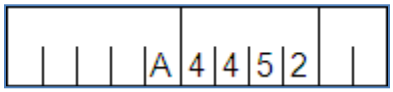
Bill using the 11-digit NDC code.

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

For Supplies

Leave the first four spaces of this field blank. Enter the five-character code from the Procedure Code and Fee Schedule Section in the next five spaces and leave the next two spaces of this field blank unless a modifier is required. When a modifier is required, enter the two-character modifier in the last two spaces of this field. See exhibit 2.4.1-5 for an example of proper entry for Medical/Surgical supply items.

Exhibit 2.4.1-5



Procedure Code and Fee Schedule available e at www.emedny.org by clicking on the link to the webpage as follows: Pharmacy Manual.

Quantity Dispensed (Field 18)

To determine units pricing, use the rules that follow:

Legend Drugs

- When applicable, units must be expressed in the metric system. Examples:
  - A pint bottle of a liquid is billed as milliliters and the quantity supplied should be “473.”
  - A 2 oz. bottle of a liquid is billed as milliliters and the quantity supplied should be “60.”
  - A 2 oz. unit of a solid or semi-solid is billed as grams and the quantity supplied should be “60.”
- All liquid preparations that are dispensed in unbroken bottles must be billed for the same number of units (mls) indicated on the label. (e.g. Cough Preparation, 472.8 mls. bottle, is billed as a quantity of “472.8.”).
- All reconstituted medications must be expressed in terms of milliliters.
  - Oral penicillin’s and penicillin derivatives are priced by the number of mls. dispensed (e.g. Ampicillin Suspension, 5 ml. - 125 mg., 100 ml, is billed as a quantity of “100.”)

- Powders for rectal administration are priced by the number of mls. dispensed (e.g. Cortenema, 100mg/60ml., is billed as a quantity of "60.")

- All legend drugs are billed by the appropriate unit (e.g.: Caps, Tabs, Packets, Suppositories, etc.) with the following exceptions:
  - Ampules are billed in ml. units (e.g.: Lasix Ampules, 20 mg/cc, five 2 ml. ampules are billed as a quantity of "10.")
  - Vials are billed as number of ml. (e.g.: Demerol, 100mg/ml, one 20 ml. vial is billed as a quantity of "20.")

- **For birth control pills and OTC drugs, please carefully comply with the instructions that follow:**
  - Birth control pills are billed as tablet units. (e.g.: Ovral-21 is billed as a quantity of "21.").
  - Over-the-counter (OTC) drugs are billed in the same manner as legend drugs.

For medical/surgical supplies please refer to the Procedure Codes and the Fee Schedules available at www.emedny.org by clicking on the link to the webpage as follows: Pharmacy Manual.

NOTES:

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

Days Supply (Field 19)

Enter the number of days for which the quantity supplied should last as written on the prescription/order. Exhibit 2.4.1-6 shows an example of a proper entry of a 30-day supply.

Exhibit 2.4.1-6

19. DAYS SUPPLY		
	3	0

If the prescription/order directs the patient "to take when necessary," enter ***180*** in this field as shown in Exhibit 2.4.1-7.

Exhibit 2.4.1-7

19. DAYS SUPPLY		
1	8	0

New /Refill Number (Field 20)

Original Prescription/Order

Enter 0 in this field.

Refill

Indicate the number of the refill. For example, enter 1 for first refill. Enter 5 for fifth refill.

Enteral Formula

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

Number of Refills Authorized (Field 20A)

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

Brand Necessary (Field 21)

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

Amount Charged (Field 22)

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

Medicare Co-Insurance (Field 23)

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

NOTES:

- ***Fields 23, 23A, 23B, and 23C are only applicable if the recipient is also a Medicare beneficiary.***
- ***It is the responsibility of the provider to determine whether Medicare covers the service being billed for. If the service is covered or if the provider does not know if the service is covered, the provider must first submit a claim to Medicare, as Medicaid is always the payer of last resort.***
- ***If the provider knows that the service rendered is not covered by Medicare, enter zero in field 23C.***

Medicare Deductible (Field 23A)

If applicable, enter the Medicare deductible amount for this drug/supply. Otherwise, leave this field blank.

Medicare Co-Pay (Field 23B)

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

Medicare Paid (Field 23C)

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

Other Insurance Paid (Field 24)

This field must be completed if the patient is covered by insurance other than Medicare.

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

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

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

Leave this field blank if the recipient has no other insurance coverage.

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

Pharmacy Claim Form-Certification Section: Fields 29 to 31

Signature (Field 29)

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

County (Field 30)

Enter the name of the county wherein the claim form is signed. The county may be left blank ***only*** when the provider's address, entered in Field 1, is within the county wherein the claim form is signed.

Date (Field 31)

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

NOTE: In accordance with New York State regulations, claims must be submitted within 90 days of the Date of Service unless acceptable circumstances for the delay can be documented. For more information about billing claims over 90 days or two years from the Date of Service, refer to Information for All Providers, General Billing section, which can be found at www.emedny.org by clicking on the link to the webpage as follows: Pharmacy Manual.

For Compound Use Only (Field 35)

Electronic Claims (NCPDP 5.1)

Please refer to the Procedure Codes, which can be found at www.emedny.org by clicking on the link to the webpage as follows: Pharmacy Manual.

Paper Claims

- Ingredients

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

- Quantity

  Enter the metric quantity of each ingredient.

- Price

  Enter the cost of each ingredient.

- Dosage Form and Directions

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

- Total Ingredient Cost

  Enter the total cost of the compound prescription.

- Compounding Fee

  Enter the fee for compounding a prescription.

- Dispensing Fee

  Enter the fee for dispensing a prescription.

- Amount Charged

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

3. Explanation of Paper Remittance Advice Sections

This Section present a sample of each section of the remittance advice for Pharmacy providers followed by an explanation of the elements contained in the section.

The information displayed in the remittance advice samples is for illustration purposes only. The following information applies to a remittance advice with the default sort pattern.

General Remittance Advice Information is available in the All Providers General Billing Guideline Information section available at www.emedny.org by clicking on the link to the webpage as follows: Information for All Providers.

The remittance advice is composed of five sections.

Section One may be one of the following:

- Medicaid Check
- Notice of Electronic Funds Transfer
- Summout (no claims paid)

Section Two: Provider Notification (special messages)

Section Three: Claim Detail

Section Four:

- Financial Transactions (recoupments)
- Accounts Receivable (cumulative financial information)

Section Five: Edit (Error) Description

3.1 Section One – Medicaid Check

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

Exhibit 3.1-1

MEDICAID MANAGEMENT INFORMATION SYSTEM

TO: CITY PHARMACY

DATE: 2010-05-31
REMITTANCE NO: 070806000006
PROV ID: 00123456/1123456789

00123456/1123456789 2010-05-31
CITY PHARMACY
111 PARKAVENUE
ANYTOWN NY 11111

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

29/2

DATE	REMITTANCE NUMBER	PROVIDER ID NO.
2010-05-31 VOID AFTER 90 DAYS	070806000006	00123456/1123456789

PAY	DOLLARS/CENTS
	$*****104.88

TO THE ORDER OF
CITY PHARMACY
111 PARKAVENUE
ANYTOWN NY 11111

MEDICAID MANAGEMENT INFORMATION SYSTEM

John Smith
AUTHORIZED SIGNATURE

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

3.1.1 Medicaid Check Stub Field Descriptions

Upper Left Corner

Provider's Name (as recorded in the Medicaid files)

Upper Right Corner

Date on which the remittance advice was issued

Remittance Number

PROV ID: This field will contain the Medicaid Provider ID and the NPI

Center

Medicaid Provider ID/NPI/Date

Provider's Name/Address

3.1.2 Medicaid Check Field Descriptions

Left Side

Table

Date on which the check was issued
Remittance Number
Provider ID No.: This field will contain the Medicaid Provider ID and the NPI

Provider's Name/Address

Right Side

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

3.2 Section One – EFT Notification

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

Exhibit 3.2-1

TO: CITY PHARMACY

MEDICAID MANAGEMENT INFORMATION SYSTEM

DATE: 2010-05-31
REMITTANCE NO: 070806000006
PROV ID: 00123456/1123456789

00123456/1123456789 2010-05-31
CITY PHARMACY
111 PARK AVENUE
ANYTOWN NY 11111

CITY PHARMACY $104.88

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

3.2.1 EFT Notification Page Field Descriptions

Upper Left Corner

Provider's Name (as recorded in the Medicaid files)

Upper Right Corner

Date on which the remittance advice was issued

Remittance Number

PROV ID: This field will contain the Medicaid Provider ID and the NPI

Center

Medicaid Provider ID/NPI/Date

Provider's Name/Address

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

3.3 Section One – Summout (No Payment)

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

Exhibit 3.3-1

TO: ABC PHARMACY

MEDICAID MANAGEMENT INFORMATION SYSTEM

DATE: 05/31/2010
REMITTANCE NO: 070806000006
PROV ID: 00123456/1123456789

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

CITY PHARMACY
111 PARK AVENUE
ANYTOWN NY 11111

3.3.1 Summout (No Payment) Field Descriptions

Upper Left Corner

Provider's Name (as recorded in the Medicaid files)

Upper Right Corner

Date on which the remittance advice was issued

Remittance Number

PROV ID: This field will contain the Medicaid Provider ID and the NPI

Center

Notification that no payment was made for the cycle (no claims were approved)

Provider Name and Address

3.4 Section Two – Provider Notification

This section is used to communicate important messages to providers.

Exhibit 3.4-1

MEDICAID MANAGEMENT INFORMATION SYSTEM

PAGE 01
DATE 05/31/10
CYCLE 1710

MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

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

ETIN:
PROVIDER NOTIFICATION
PROV ID: 00123456/1123456789
REMITTANCE NO: 070806000006

REMITTANCE ADVICE MESSAGE TEXT

*** ELECTRONIC FUNDS TRANSFER (EFT) FOR PROVIDER PAYMENTS IS NOW AVAILABLE ***

PROVIDERS WHO ENROLL IN EFT WILL HAVE THEIR MEDICAID PAYMENTS DIRECTLY DEPOSITED INTO THEIR CHECKING OR SAVINGS ACCOUNT.

THE EFT TRANSACTIONS WILL BE INITIATED ON WEDNESDAYS AND DUE TO NORMAL BANKING PROCEDURES, THE TRANSFERRED FUNDS MAY NOT BECOME AVAILABLE IN THE PROVIDER'S CHOSEN ACCOUNT FOR UP TO 48 HOURS AFTER TRANSFER. PLEASE CONTACT YOUR BANKING INSTITUTION REGARDING THE AVAILABILITY OF FUNDS.

PLEASE NOTE THAT EFT DOES NOT WAIVE THE TWO-WEEK LAG FOR MEDICAID DISBURSEMENTS.

TO ENROLL IN EFT, PROVIDERS MUST COMPLETE AN EFT ENROLLMENT FORM THAT CAN BE FOUND AT WWW.EMEDNY.ORG. CLICK ON PROVIDER ENROLLMENT FORMS WHICH CAN BE FOUND IN THE FEATURED LINKS SECTION. DETAILED INSTRUCTIONS WILL ALSO BE FOUND THERE.

AFTER SENDING THE EFT ENROLLMENT FORM TO CSC, PLEASE ALLOW A MINIMUM TIME OF SIX TO EIGHT WEEKS FOR PROCESSING. DURING THIS PERIOD OF TIME YOU SHOULD REVIEW YOUR BANK STATEMENTS AND LOOK FOR AN EFT TRANSACTION IN THE AMOUNT OF $0.01 WHICH CSC WILL SUBMIT AS A TEST. YOUR FIRST REAL EFT TRANSACTION WILL TAKE PLACE APPROXIMATELY FOUR TO FIVE WEEKS LATER.

IF YOU HAVE ANY QUESTIONS ABOUT THE EFT PROCESS, PLEASE CALL THE EMEDNY CALL CENTER AT 1-800-343-9000.

NOTICE: THIS COMMUNICATION AND ANY ATTACHMENTS MAY CONTAIN INFORMATION THAT IS PRIVILEGED AND CONFIDENTIAL UNDER STATE AND FEDERAL LAW AND IS INTENDED ONLY FOR THE USE OF THE SPECIFIC INDIVIDUAL(S) TO WHOM IT IS ADDRESSED. THIS INFORMATION MAY ONLY BE USED OR DISCLOSED IN ACCORDANCE WITH LAW, AND YOU MAY BE SUBJECT TO PENALTIES UNDER LAW FOR IMPROPER USE OR FURTHER DISCLOSURE OF INFORMATION IN THIS COMMUNICATION AND ANY ATTACHMENTS. IF YOU HAVE RECEIVED THIS COMMUNICATION IN ERROR, PLEASE IMMEDIATELY NOTIFY NYHIPPADESK@CSC.COM OR CALL 1-800-541-2831. PROVIDERS WHO DO NOT HAVE ACCESS TO E-MAIL SHOULD CONTACT 1-800-343-9000.

3.4.1 Provider Notification Field Descriptions

Upper Left Corner

Provider's Name (as recorded in the Medicaid files)

Upper Right Corner

Remittance page number

Date on which the remittance advice was issued

Cycle Number

ETIN (not applicable)

Name of section: **PROVIDER NOTIFICATION**

PROV ID: This field will contain the Medicaid Provider ID and the NPI

Remittance number

Center

Message text

3.5 Section Three – Claim Detail

This section provides a listing of all new claims that were processed during the specific cycle plus claims that were previously pended and denied during the specific cycle. This section may also contain claims that pended previously.

Exhibit 3.5-1

MEDICAID MANAGEMENT INFORMATION SYSTEM

PAGE 02
DATE 05/31/2010
CYCLE 1710

MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

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

ETIN:
PHARMACY
PROV ID: 00123456/1123456789
REMITTANCE NO: 070806000006

PRESCRIPTION NO.	ITEM CODE	QUANTITY	CLIENT ID NUMBER	CLIENT NAME	SERVICE DATE	TCN	CHARGED	PAID	STATUS	ERRORS
4267229	00173044100	54.000	XX12345X	DOE	05/01/10	07267-000000605-0-2	100.00	0.00	DENY	00162
4267240	00904391660	5.000	XX23456X	SAMPLE	05/15/10	07267-000000614-0-1	50.00	0.00	DENY	00162
0426722	00904391660	5.000	XX34567X	EXAMPLE	05/25/10	07267-000000573-0-1	30.00	0.00	DENY	00142 00144
0042664	00002411260	1.000	XX45678X	SPECIMEN	05/01/10	07267-000000453-2-2	60.00	0.00	DENY	00142 00144

* = PREVIOUSLY PENDED CLAIM
** = NEW PEND

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

Exhibit 3.5-2

MEDICAID MANAGEMENT INFORMATION SYSTEM

PAGE 03
DATE 05/31/2010
CYCLE 1710

MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

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

ETIN:
PHARMACY
PROV ID: 00123456/1123456789
REMITTANCE NO: 070806000006

PRESCRIPTION NO.	ITEM CODE	QUANTITY	CLIENT ID NUMBER	CLIENT NAME	SERVICE DATE	TCN	CHARGED	PAID	STATUS	ERRORS
0042663	00002411260	5.000	XX56789X	STANDARD	05/05/10	07267-000000437-2-1	100.00	100.00	PAID	
0042663	00002411260	5.000	XX56789X	STANDARD	05/05/10	07188-000000437-2-2	10.00	80.00-	ADJT	ORIGINAL CLAIM AS PAID 05/20/10
0426722	00904391660	1.000	XX56789X	STANDARD	05/25/10	07267-000000562-0-0	5.91	5.91	PAID	
0426711	00002411260	1.000	XX87654X	EXAMPLE	05/10/10	07267-000000260-0-0	28.97	28.97	PAID	
0426712	00002411260	1.000	XX87654X	EXAMPLE	05/20/10	07267-000000263-0-0	50.00	50.00	PAID	

* = PREVIOUSLY PENDED CLAIM
** = NEW PEND

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

Exhibit 3.5-3

MEDICAID MANAGEMENT INFORMATION SYSTEM

PAGE 04
DATE 05/31/2010
CYCLE 1710

MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

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

ETIN:
PHARMACY
PROV ID: 00123456/1123456789
REMITTANCE NO: 070806000006

PRESCRIPTION NO.	ITEM CODE	QUANTITY	CLIENT ID NUMBER	CLIENT NAME	SERVICE DATE	TCN	CHARGED	PAID	STATUS	ERRORS
4267241	00904391660	5.000	XX12345X	DOE	05/01/10	07272-000000027-0-1	56.00	0.00	PEND	00162 00127
4267241	00904391660	5.000	XX23456X	SAMPLE	05/15/10	07272-000000028-0-2	55.00	0.00	PEND	00162 00127
4267242	00904391660	5.000	XX34567X	EXAMPLE	05/25/10	07272-000000035-0-1	20.00	0.00	PEND	01154
4267243	00904391660	5.000	XX45678X	SPECIMEN	05/01/10	07272-000000044-0-2	40.00	0.00	PEND	01154

* = PREVIOUSLY PENDED CLAIM
** = NEW PEND

TOTAL AMOUNT ORIGINAL CLAIMS	PEND	171.00	NUMBER OF CLAIMS	4
NET AMOUNT ADJUSTMENTS	PEND	00.00	NUMBER OF CLAIMS	0
NET AMOUNT VOIDS	PEND	00.00	NUMBER OF CLAIMS	0
NET AMOUNT VOIDS – ADJUSTS		00.00	NUMBER OF CLAIMS	0
REMITTANCE TOTALS – PHARMACY				
VOIDS – ADJUSTS		20.00	NUMBER OF CLAIMS	1
TOTAL PENDS		171.00	NUMBER OF CLAIMS	4
TOTAL PAID		84.88	NUMBER OF CLAIMS	3
TOTAL DENIED		240.00	NUMBER OF CLAIMS	4
NET TOTAL PAID		64.88	NUMBER OF CLAIMS	4
MEMBER ID: 00123456				
VOIDS – ADJUSTS		20.00	NUMBER OF CLAIMS	1
TOTAL PENDS		171.00	NUMBER OF CLAIMS	4
TOTAL PAID		84.88	NUMBER OF CLAIMS	3
TOTAL DENIED		240.00	NUMBER OF CLAIMS	4
NET TOTAL PAID		64.88	NUMBER OF CLAIMS	4

Exhibit 3.5-4

MEDICAID MANAGEMENT INFORMATION SYSTEM

PAGE: 05
DATE: 05/31/10
CYCLE: 1710

MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

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

ETIN:
PHARMACY
GRAND TOTALS
PROV ID: 00123456/1123456789
REMITTANCE NO: 070806000006

REMITTANCE TOTALS – GRAND TOTALS

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

3.5.1 Claim Detail Page Field Descriptions

Upper Left Corner

Provider's Name/Address

Upper Right Corner

Remittance page number

Date: The date on which the remittance advice was issued

Cycle Number: The cycle number should be used when calling the eMedNY Call Center with questions about specific processed claims or payments.

ETIN (not applicable)

Provider Service Classification: **PHARMACY**

PROV ID: This field will contain the Medicaid Provider ID and the NPI

Remittance Number

3.5.2 Explanation of Claim Detail Columns

Prescription No. (Line Number)

This column indicates the prescription number as it appears on the claim form.

Item Code

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

Quantity

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

Client Number

The client's Medicaid ID number appears under this column.

Client Name

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

Service Date

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

TCN

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

Charged

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

Paid

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

Status

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

Denied Claims

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

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

Approved Claims

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

Paid Claims

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

Adjustments

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

Voids

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

Pending Claims

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

- New York State Medical Review required.
- Procedure requires manual pricing.
- No match found in the Medicaid files for certain information submitted on the claim, for example: Patient ID, Prior Approval, Service Authorization. These claims are recycled for a period of time during which the Medicaid files may be updated to match the information on the claim.

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

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

Errors

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

3.5.3 Subtotals/Totals/Grand Totals

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

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

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

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

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

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

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

Grand Totals for the entire provider remittance advice, which include all the provider's service classifications, appear on a separate page following the page containing the ***totals by service classification***. The grand total is broken down by:

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

3.6 Section Four – Financial Transactions and Accounts Receivable

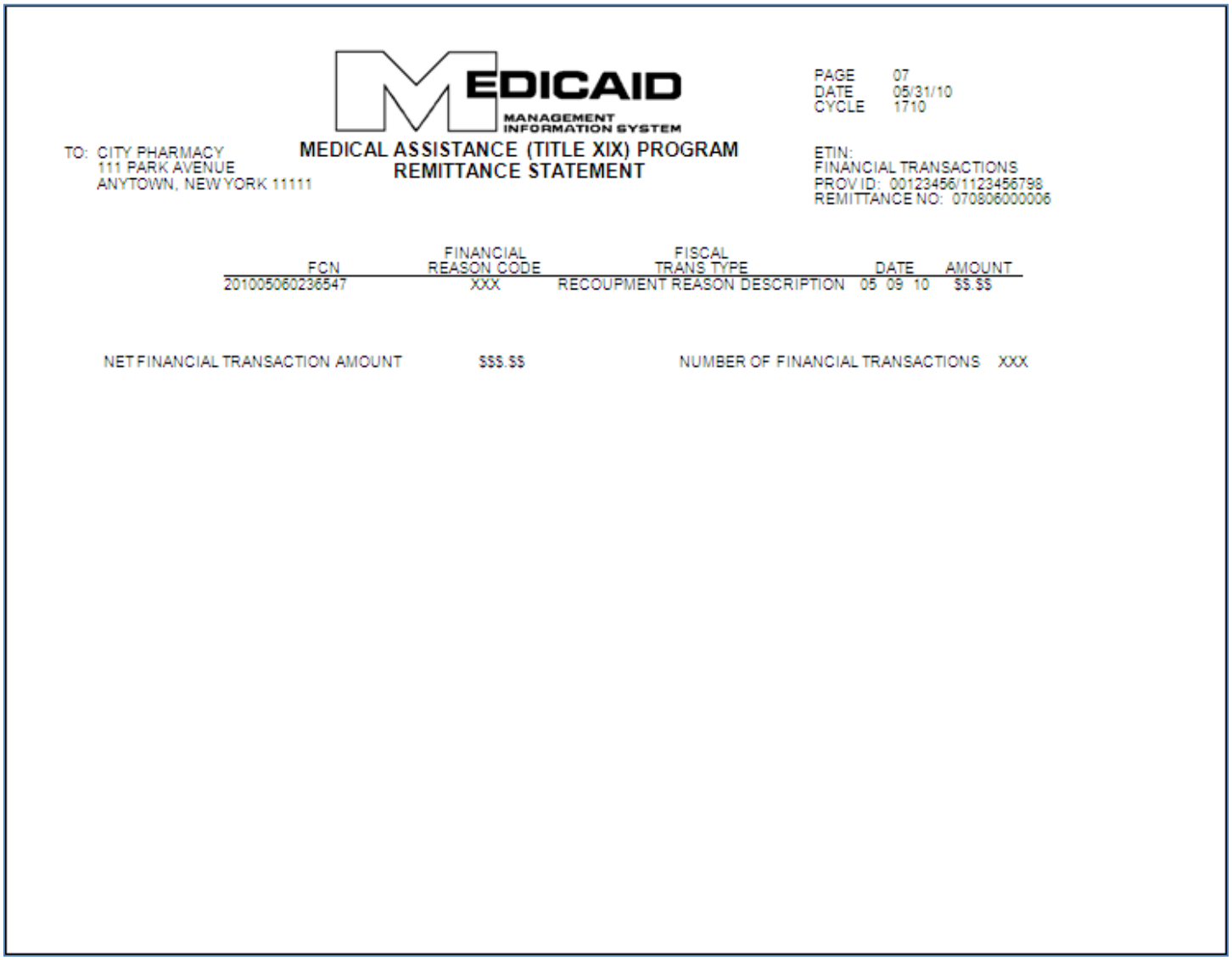
This section has two subsections:

- Financial Transactions
- Accounts Receivable

3.6.1 Financial Transactions

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

Exhibit 3.6.1-1



MEDICAID
MANAGEMENT INFORMATION SYSTEM

PAGE 07
DATE 05/31/10
CYCLE 1710

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

MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

ETIN:
FINANCIAL TRANSACTIONS
PROV ID: 00123456/1123456798
REMITTANCE NO: 070806000006

FCN	FINANCIAL REASON CODE	FISCAL TRANS TYPE	DATE	AMOUNT
201005060236547	XXX	RECOUPMENT REASON DESCRIPTION	05 09 10	$$.$$

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

3.6.1.1 Explanation of Financial Transactions Columns

FCN

The Financial Control Number (FCN) is a unique identifier assigned to each financial transaction.

Financial Reason Code

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

Financial Transaction Type

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

Date

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

Amount

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

3.6.1.2 Explanation of Totals Section

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

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

3.6.2 Accounts Receivable

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

Exhibit 3.6.2-1

PAGE 08
DATE 05/31/10
CYCLE 1710

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

MEDICAID MANAGEMENT INFORMATION SYSTEM
MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

ETIN:
ACCOUNTS RECEIVABLE
PROV ID: 00123456/1123456789
REMITTANCE NO: 070806000006

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

TOTAL AMOUNT DUE THE STATE $XXX.XX

3.6.2.1 Explanation of Accounts Receivable Columns

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

Reason Code Description

This is the description of the Financial Reason Code. For example, Third Party Recovery.

Original Balance

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

Current Balance

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

Recoupment % Amount

The deduction (recoupment) scheduled for each cycle.

Total Amount Due the State

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

3.7 Section Five – Edit (Error) Description

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

Exhibit 3.7-1

MEDICAID MANAGEMENT INFORMATION SYSTEM

MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

PAGE 06
DATE 05/31/10
CYCLE 1710

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

ETIN:
PHARMACY
EDIT DESCRIPTIONS
PROV ID: 00123456/1123456789
REMITTANCE NO: 070806000006

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

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

APPENDIX A
CLAIM SAMPLES

The eMedNY Billing Guideline Appendix A: Claim Samples contains images of claims with sample data.

Pharmacy – Sample Claim
NYS MEDICAL ASSISTANCE (TITLE XIX)
PHARMACY CLAIM FORM

1. PROVIDER ID NUMBER: 1 2 3 4 5 6 7 8 9 0

2. DATE FILLED: MO 0 5 DAY 1 3 YR 0 7

3. SA EXCP CODE:

ONLY TO BE USED TO ADJUST OR VOID A PAID CLAIM
4 CODE: A V
4A. ORIGINAL CLAIM NUMBER:

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

6. DATE OF BIRTH: 0 4 1 9 1 9 5 5

7. SEX: X 1 (M) F 2

8. OTHER RECIPIENT INSURANCE CODE:

9. RECIPIENT NAME: LAST Brandon FIRST John

City Pharmacy
111 Park Avenue
Anytown, NY 11111

10. PROF CD:
10A. ORDERING/PRESCRIBING PROVIDER ID/LICENSE NUMBER: 1 2 3 4 5 6 7 8 9 0
10B. NAME: Peter Smith
11. PROF CD:
11A. OTHER REFERRING/ORDERING PROVIDER ID/LICENSE NUMBER:
11B. NAME:

PRIOR APPROVAL/AUTHORIZATION NO.:
12.
12A. LINE:
13.
13A.
FOR OFFICE USE ONLY 14 1

LINE	15. PRESCRIPTION/ ORDER NUMBER	16. DATE ORDERED MO	DAY	YR	17. DRUG SUPPLY CODE	18. QUANTITY DISPENSED	19. DAYS SUPPLY	20. NEW REFILL NUMBER	20A. NO OF REFILLS AUTHORIZED	21. BRAND NECESSARY	22. AMOUNT CHARGED	MEDICARE 23. CO-INSURANCE	23A. DEDUCTABLE	23B. CO-PAY	23C. PAID	24. OTHER INSURANCE PAID
1	6 0 0 0 0 1 0 0	0 5	0 3	0 7	5 1 0 7 9 0 2 0 0 2 0	6 0 . 0 0	3 0	1	5	Y 1 X	1 5 . 0 0					
2	6 0 0 0 0 6 0 0	0 5	0 3	0 7	B 4 1 8 9	1 0 . 0 0	1 0	1	0	Y 1 X	7 0 . 0 0					
3	6 0 0 0 0 1 6 0	0 5	0 3	0 7	A 6 2 4 7	3 0 . 0 0	3 0	0	0	Y 1 X	2 0 . 0 0					
4										Y 1 N						
5										Y 1 N						

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

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

29. SIGNATURE: James Strong
30. COUNTY*:
31. BILLING DATE: MO 0 5 DAY 1 3 YR 0 7

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

DO NOT WRITE IN BARCODE AREA

[redacted]

EMEDNY – 000301 (01/04) 1-11-0071 (12/03)

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

INGREDIENTS	QUANTITY	PRICE
		$.
		.
		.

DOSAGE FORM AND DIRECTIONS

TOTAL INGREDIENT COST	.
COMPOUNDING FEE	.
DISPENSING FEE	.
AMOUNT CHARGED	$.

APPENDIX B
CODE SETS

The eMedNY Billing Guideline Appendix B: Code Sets contains a list of SA Exception Codes.

SA Exception Codes

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

eMedNY is the name of the electronic New York State Medicaid system. The eMedNY system allows New York Medicaid providers to submit claims and receive payments for Medicaid-covered services provided to eligible clients.

eMedNY offers several innovative technical and architectural features, facilitating the adjudication and payment of claims and providing extensive support and convenience for its users. CSC is the eMedNY contractor and is responsible for its operation.

The information contained within this document was created in concert by eMedNY DOH and eMedNY CSC. More information about eMedNY can be found at www.emedny.org.