INITIAL ePACES SCREEN

Select New Claim.
GENERAL CLAIM INFORMATION

Submission Reason: Choose *Original* if you are submitting a new claim or the resubmission of a previously denied claim. Choose *Replace* if you are submitting an Adjustment. Choose *Void* if you are voiding a claim.

If you choose Replace or Void, you must enter the Payer Claim Control Number of the paid claim.

Payer Claim Control Number: Enter the payer claim control number (also called a TCN), if you are submitting an Adjustment or Void to a previously processed claim. **Note:** This field will only appear if doing an adjustment or void.

Patient Control Number: Enter up to 20 characters (letters and/or numbers). For example, enter a student’s school ID number for your record-keeping purposes. This information will be returned on the Medicaid Remittance.

Location Information: Enter the address of the service location including the Zip + 4. The billing provider must submit the 9-digit zip code of the service location address listed on their provider enrollment file.

Client Information: Enter the MMIS client identification number (CIN), then click on *Go.*
Client Information: Will display the client name, address, date of birth and gender of the client identification number (CIN) entered on the previous screen.

Type of Claim: Select – Institutional and click on Next.
**INSTITUTIONAL CLAIM INFORMATION TAB**

**New Claim - 837 Institutional**

**Facility Type:** Enter the facility type - 89.

**Assignments of Benefits:** Enter Y for Yes

**Release of Information:** Choose the correct option from the drop down list. Y for Yes, Provider has a signed Parental Consent giving permission to bill Medicaid for the provision of services. Without Parental Consent, Medicaid cannot be billed.

**Accept Assignment:** Enter A to indicate the provider is enrolled in Medicaid.

**Admission Type:** Enter the Admission Type – 9 (Information not available).

**Patient Status:** Enter the Patient Status - 30.

**Statement Covers:** ePACES requires a date on this tab.

*From* / *To* - Enter the From and To dates of the claim here. Billing should be done for ONE day, that date should be entered as BOTH the From and the To date. **Note:** The individual date of service entered on the service line level MUST match the date specified here on the claim level.
**Value Codes:** In the **Code** enter 24 then in **Value** enter the 4-digit **Rate Code** (NOTE: *Only one rate code may be entered per claim.*)

**Sample SSHSP Rate Codes:**

<table>
<thead>
<tr>
<th>SERVICE TYPE</th>
<th>CPT Code</th>
<th>Rate Code</th>
<th>DESCRIPTION</th>
<th>Session Time / Units</th>
<th>Payment Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychological Counseling</td>
<td>90832</td>
<td>2008</td>
<td>PSYCHOTHERAPY, 30 MINUTES WITH PATIENT AND/OR FAMILY MEMBER</td>
<td>30 minutes</td>
<td>$48.30</td>
</tr>
<tr>
<td>Psychological Counseling</td>
<td>90833</td>
<td>2009</td>
<td>PSYCHOTHERAPY, 30 MINUTES WITH PATIENT AND/OR FAMILY MEMBER WHEN PERFORMED WITH AN EVALUATION AND MANAGEMENT SERVICES (LIST SEPARATELY IN ADDITION TO THE CODE FOR PRIMARY PROCEDURE)</td>
<td>30 minutes</td>
<td>$31.82</td>
</tr>
<tr>
<td>Psychological Counseling</td>
<td>90834</td>
<td>2010</td>
<td>PSYCHOTHERAPY, 45 MINUTES WITH PATIENT AND/OR FAMILY MEMBER</td>
<td>45 minutes</td>
<td>$61.83</td>
</tr>
<tr>
<td>Psychological Counseling</td>
<td>90836</td>
<td>2011</td>
<td>PSYCHOTHERAPY, 45 MINUTES WITH PATIENT AND/OR FAMILY MEMBER WHEN PERFORMED WITH AN EVALUATION AND MANAGEMENT SERVICE (LIST SEPARATELY IN ADDITION TO THE CODE FOR PRIMARY PROCEDURE)</td>
<td>45 minutes</td>
<td>$51.63</td>
</tr>
</tbody>
</table>

Complete list of Rate Codes and Procedure (CPT) Codes are found at:


**Condition Codes:** Leave blank
**Occurrence Span**: Leave blank

**Service Authorization Exception Code**: Leave blank

**Delay Reason**: SSHSP claims submitted more than 90 days after the date of service must include a delay reason code of 3.

**Note**: Do not use a delay reason code for claims submitted timely (within 90 days of the date of service).
PROVIDER INFORMATION TAB

New Claim - 837 Institutional

Attending/Servicing Physician: Enter the attending provider’s (e.g., physical therapist, occupational therapist, speech language pathologist) information. (Medicaid Alert 14-01)

Referring Physician: Enter the referring provider’s information. (Medicaid Alert 14-01)
**DIAGNOSIS / PROCEDURE TAB**

- **New Claim - 837 Institutional**

![Image of the DIAGNOSIS / PROCEDURE TAB]

**ICD-9/ICD-10**: Click the radio button that applies to the type of diagnosis code being submitted. Select ICD-9 for service dates prior to October 1, 2015 or select ICD-10 for service dates on or after October 1, 2015.

**Principal Diagnosis**: Enter the principal diagnosis code **without** the decimal.
OTHER PAYERS TAB

New Claim - 837 Institutional

This tab may be used to report Medicare payer information, if applicable.
Other Payer Details

- New Claim - 837 Institutional

Other Payer Details

- Other Payer Information
  - Other Payer Name:
  - Payer Sequence Number:
  - Other Payer Paid Amount:
  - Other Payer Claim Control Number:
  - Remaining Patient Responsibility:
  - Total Non Covered Amount:
  - Date Claim Paid:
  - Covered Days:

- Other Subscriber
  - Last Name:
  - First Name:
  - Member ID:
  - Address Line 1:
  - Address Line 2:
  - City:
  - State:
  - Zip Code:
  - Country:

- Other Subscriber Information
  - Relationship:
  - Payer Type:
  - Group Number:
  - Group Name:

Other Payer Name: Select Medicare Part B or the name of the Medicare managed care plan from the drop down list of payers previously added to the Other Payer support file.

Payer Sequence Number: Choose - Primary.

Total Non Covered Amount: The amount entered must equal the Total Claim Charge Amount.

Other Subscriber: Enter the Name, Primary ID, Address, and other demographic information pertaining to the subscriber of the Other Payer.

Relationship: Pick the appropriate entry from the drop down list. For example, 18 = Self.

Payer Type: Enter the Code representing the Other Payer from the drop down list. Medicare Part B = MB or Medicare managed care plan = 16.
Assignment of Benefits: Enter Y for Yes.

Release of Information: Pick an entry from the drop down list.
**SERVICE LINE TAB**

Date of Service: Enter the date of service in the **From:** field.

Rev Code: Enter revenue code – 0240.

Procedure Codes & Mod: Enter the CPT procedure code. If applicable, enter a modifier. Procedure code modifier GN identifies a CPT code for speech therapy, GO is used for occupational therapy and GP is used for physical therapy.

Charge Amount: Enter the amount charged.

Service Count: Enter the applicable service count.
Add: Click Add to attach the service line to the claim, the service line will then display above.

Click Finish to finalize and save the claim.
CLAIM ENTRY CONFIRMATION WINDOW

This is the response page displayed when you click on the Finish button.

From this page, if necessary, you can click on the appropriate button to perform the following options:

• **Edit Current Claim**: Can be used to edit the claim.
• **Enter Another New Claim**: Can be used to add another institutional claim.
• **Validate Current Claim**: Can be used to check for errors
**BUILD CLAIM BATCH**

Claims that have been successfully entered into the ePACES System must be batched before they can be submitted for processing. Only claims with a status of Complete may be batched.

Click on the *Build Batch* button to build the batch of claims that have been checked and selected for submission.
**Build Claim Batch**

Claim(s) by User ID: PREP05  Go

Select which claim(s) you want to batch and build the batch.

<table>
<thead>
<tr>
<th>UnCheck All</th>
<th>Check All</th>
<th>Add to Batch</th>
<th>Patient Control #</th>
<th>Entry Status</th>
<th>Client ID</th>
<th>Client Name</th>
<th>Type of Claim</th>
<th>Total Charges</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>12345</td>
<td>Complete</td>
<td>Institutional</td>
<td></td>
<td>$872.34</td>
<td></td>
</tr>
</tbody>
</table>

**SUBMIT CLAIM BATCHES**

The New York State Department of Health invites you to use the ePACES application to request and receive a variety of HIPAA-compliant Medicaid transactions. Using the links in the menu bar on the left and the Help link on the top right of each page, you will be able to easily navigate through all the available functionality. If you do not see the necessary links in the menu at the left, please contact your Primary Administrator.

Please make sure your Provider Name is displayed at the top of the page before continuing. If your Provider Name is incorrect or not available in the “Change Provider” drop-down box at the top of the page, please contact the CSC HelpDesk at 800-343-9000.

For further information, please visit these sites:
- eMedNY
- ePACES
**SUBMIT CLAIM BATCHES WINDOW**

Click on the *Submit All Selected Batches* button to submit all of the batches that are checked and selected for submission.

### Submit Claim Batches

```
Claim(s) by User ID: [PREP05]  Go

View
Previously
Submitted
Batches

<table>
<thead>
<tr>
<th>Check All</th>
<th>Batch Number</th>
<th>Batch Date</th>
<th>Type Of Claim</th>
<th>Total Claims</th>
<th>Total Batch Charges</th>
<th>Remove</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1200002015</td>
<td>10/6/2015</td>
<td>Institutional</td>
<td>1</td>
<td>$872.34</td>
<td></td>
</tr>
</tbody>
</table>
```

### VIEW PREVIOUSLY SUBMITTED BATCHES

Click on *View Previously Submitted Batches*. The screen will display a list of all previously submitted batches in Batch Number order.

### Submit Claim Batches

```
Claim(s) by User ID: [PREP05]  Go

View
Previously
Submitted
Batches

The following claim batches have been submitted:

<table>
<thead>
<tr>
<th>Batch Number</th>
<th>Submit Date</th>
<th>Type Of Claim</th>
<th>Total Claims</th>
<th>Total Batch Charges</th>
<th>Total Rejected</th>
</tr>
</thead>
<tbody>
<tr>
<td>1200002015</td>
<td>10/6/2015</td>
<td>Institutional</td>
<td>1</td>
<td>$872.34</td>
<td></td>
</tr>
</tbody>
</table>
```

Click on the Batch Number and the batch will be displayed.
Click on Details under Initial Claim Status/Response to access the Claim Status Response.

**Batch # 1200002015**

A Claim Status Response Details screen will be displayed with claim adjudication information.
Paid Claim Response

Payer Claim Control # - returned on the remittance and may be used for Voiding & Replacing paid Claims
Rejected Claim Response

For clarification of rejected claims consult the Pre-Adjudication Crosswalk at eMedNY.org

REJECTED claim response example - Review the combination of errors shown in the Claim Level Status to determine why the claim was rejected. Rejected claims will not appear on the remittance statement.
Refer to the Pre-Adjudication Crosswalk found at [www.emedny.org](http://www.emedny.org) under the eMedNY HIPAA Support Tab/Crosswalks for descriptions of claim rejection responses.

### NYS Medicaid Pre-Adjudication Crosswalk for Health Care Claims

#### NYS Medicaid Conditions

- **A3 121**: Maximum lines (50) exceeded in claim.
- **A3 156 QC**: Patient Hierarchical Level (dependent loop) present.
- **A3 400 85**: Claim is out-of-balance (charges).
- **A3 400 PR**: Claim is out-of-balance (Coordination of Benefits).
- **A3 479 P4**: Coordination of Benefits payer at line level (loop 2430 SVD01) not matched to claim level (loop 23308 NM109).
- **A3 479 PR**: Coordination of Benefits payer at line level (loop 2430 SVD01) not matched to claim level (loop 23308 NM109).
- **A3 742**: Invalid or repeated Payer Responsibility Sequence Number Code (same code occurred more than once in a claim or code "U" in non-crosswalk claim).
- **A7 33 IL**: Invalid client ID (CIN#).
- **A7 96 41**: ETIN Not Certified for Use.
- **A7 96 44**: ETIN Not Certified for Use.
- **A7 132 85**: Invalid NYS Medicaid Provider ID for Billing Provider (Identified by NPI or Medicaid ID) not on file or not active on date of service (for Inpatient claims with Rate Codes 2940 or 2953 the "Through" Statement Date is used).
- **A7 132 71**: Invalid NYS Medicaid Provider ID for Attending Provider.
- **A7 132 82**: Invalid NYS Medicaid Provider ID for Rendering Provider.
- **A7 132 DN**: Invalid NYS Medicaid Provider ID for Referring Provider.
- **A7 187**: Statement Dates failed “reasonability” validation (within 6 years of processing date).
- **A7 228**: Invalid Uniform Billing Claim Form Bill Type.
- **A7 229**: Invalid NUBC Admission Source Code (Point of Origin).
Denied Claim Response

Refer to the Edit Error Knowledge Base for information regarding denial messages returned in the claim status response. Go to www.emedny.org and select the eMedNY HIPAA Support tab, and select Edit/Error Knowledge Base (EEKB) Search Tool.