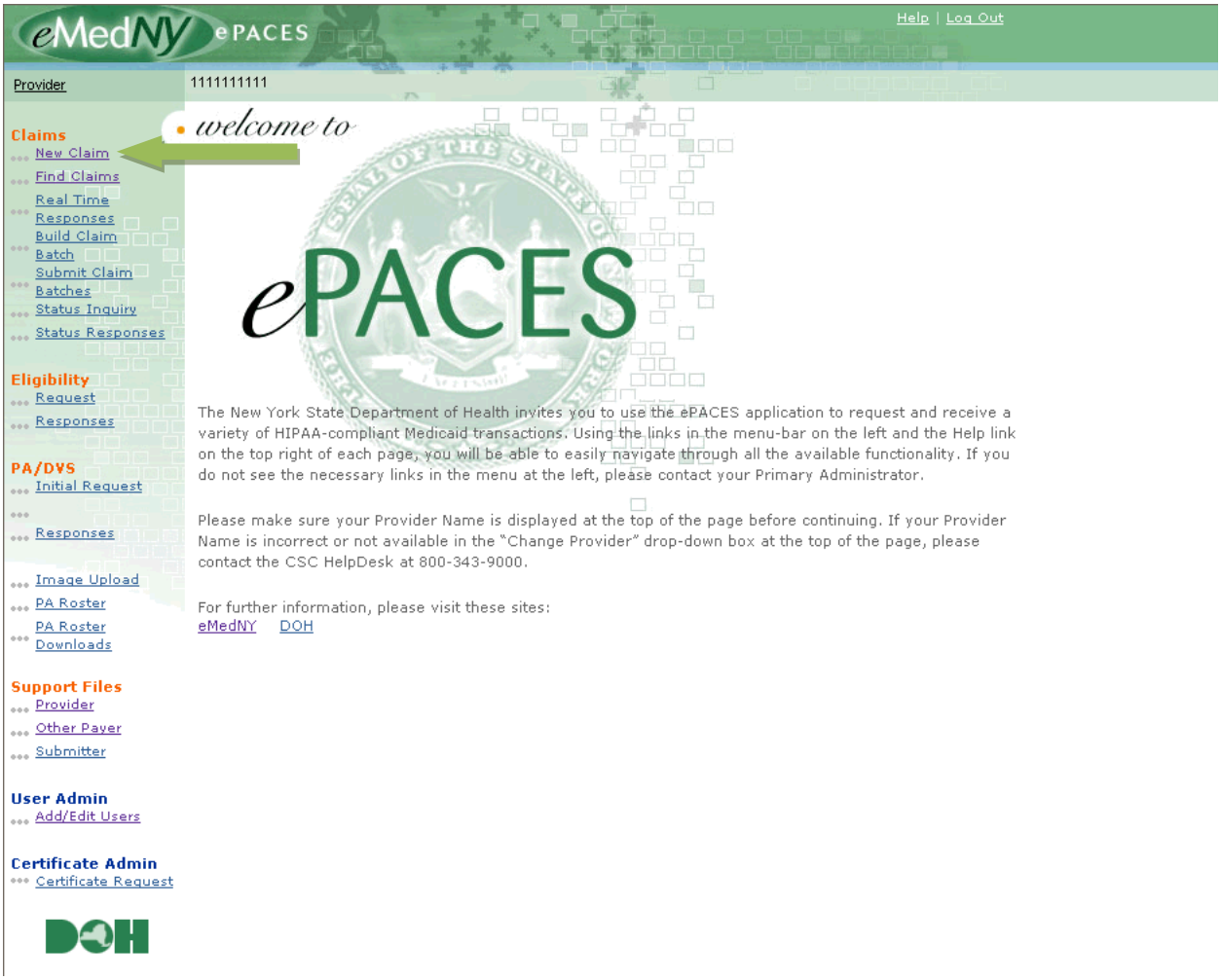
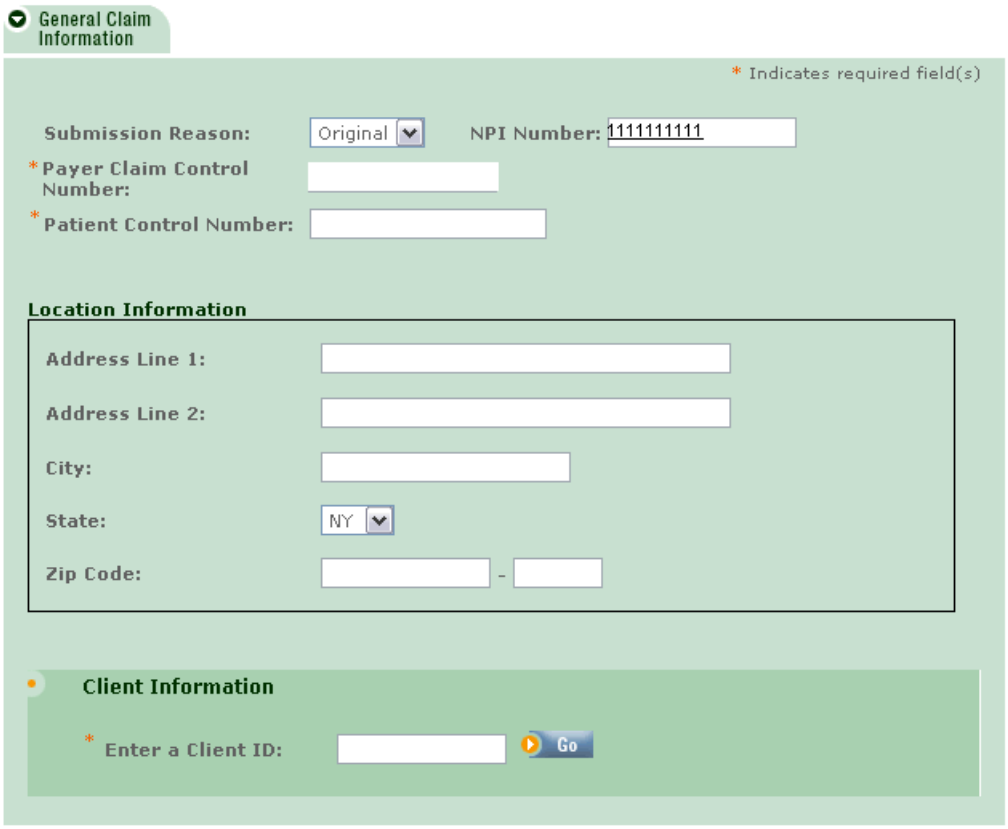
INITIAL ePACES SCREEN

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.

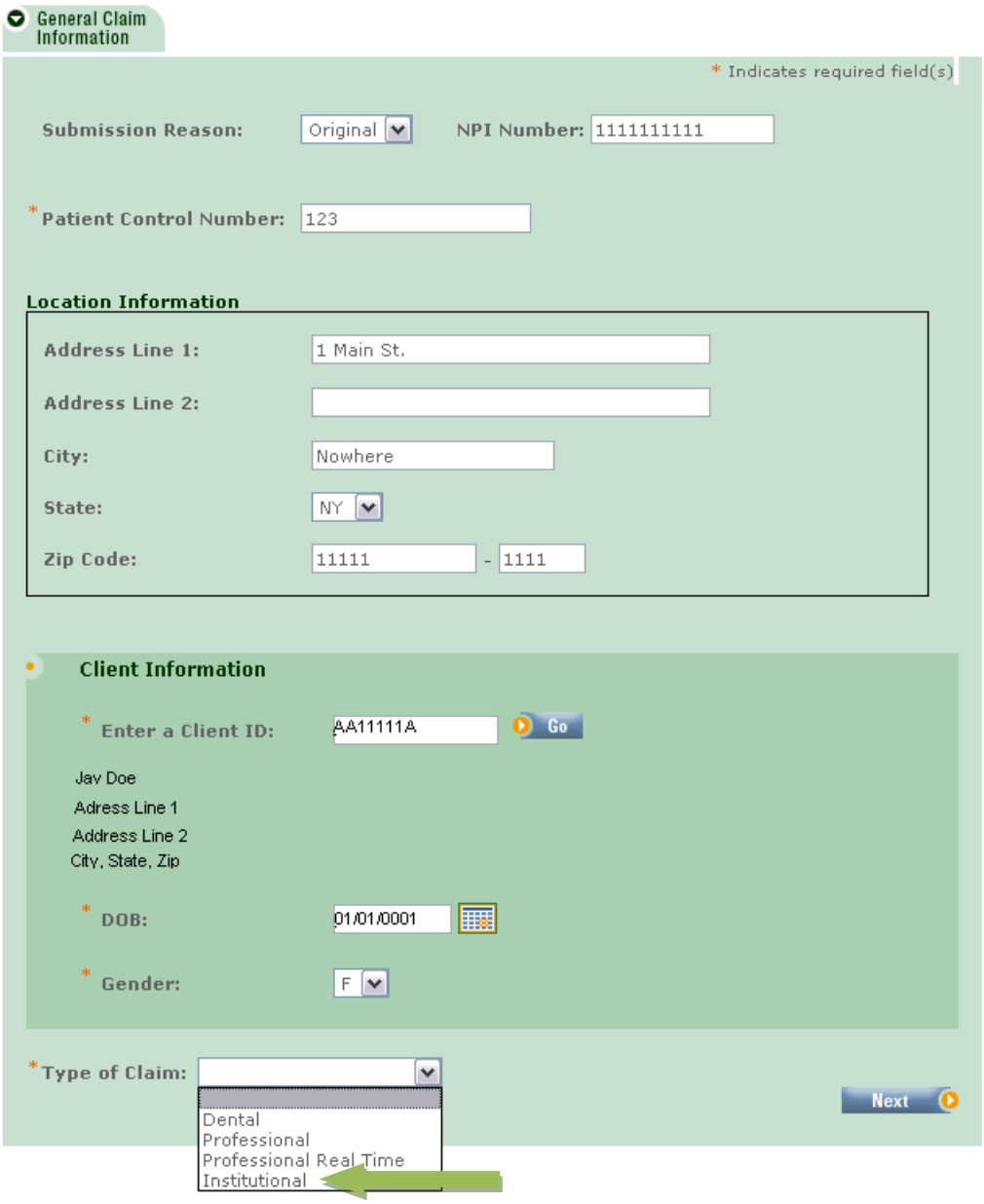
If you choose Replace or Void, you must enter the Payer Claim Control Number of the paid claim.

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*.

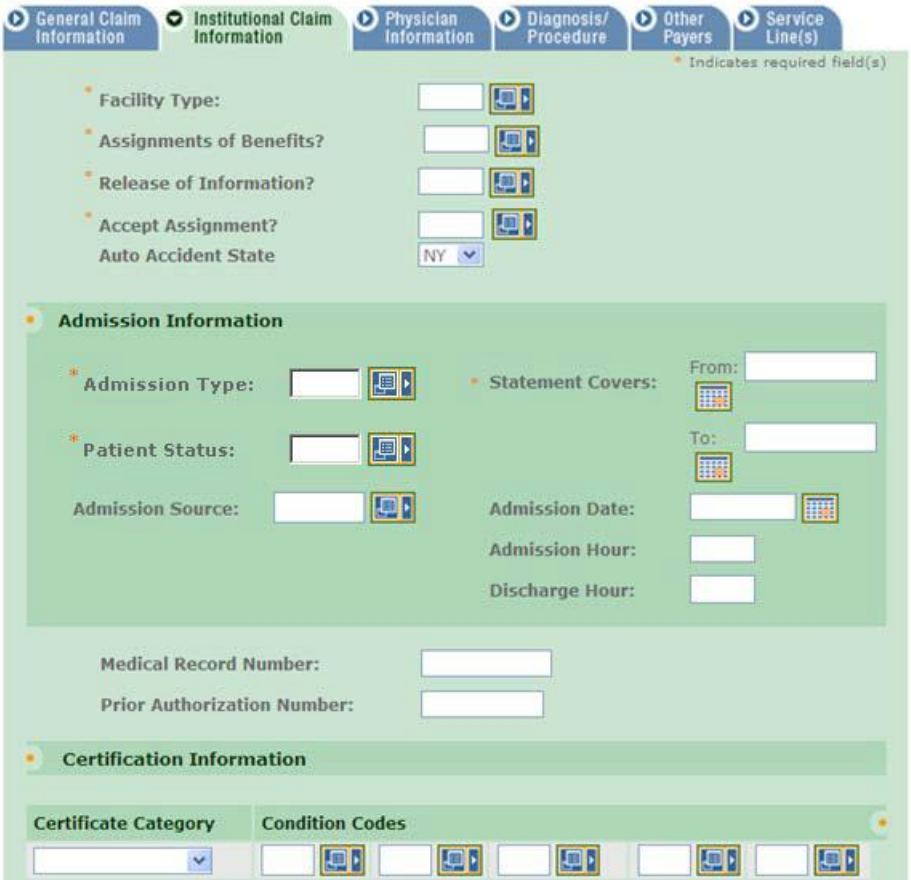


Client Information: Will display the client name, address, date of birth and gender of the client identification number (CIN) entered on the previous screen.

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.

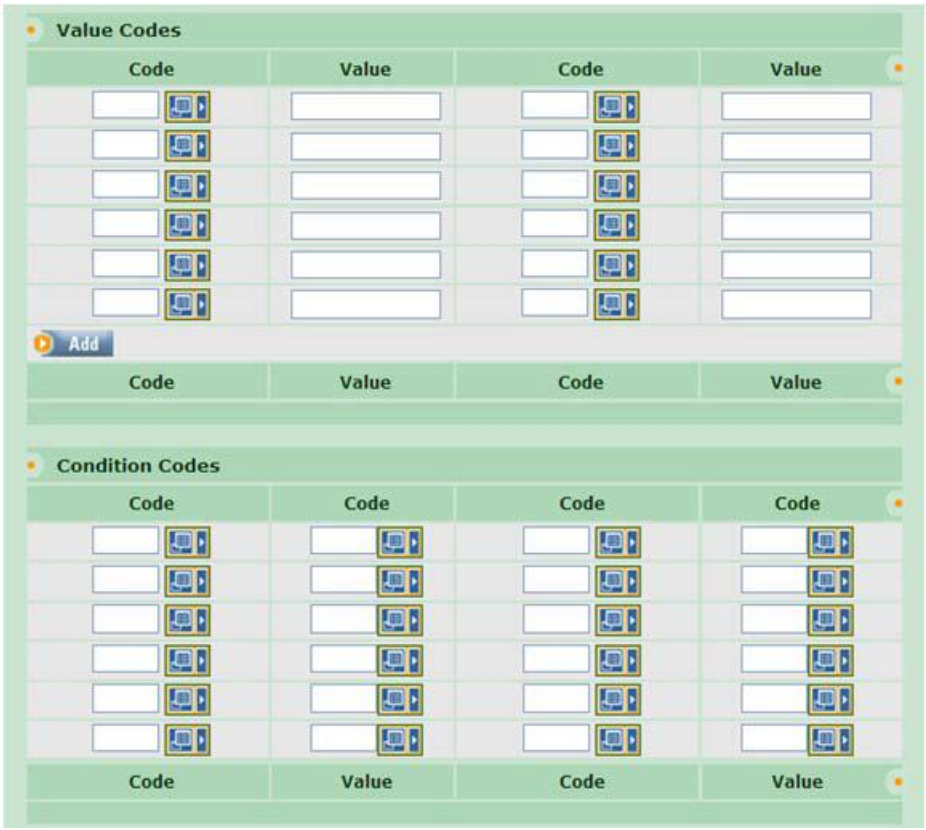
Accept Assignment: Enter **A** to indicate the provider is enrolled in Medicaid.

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.)*

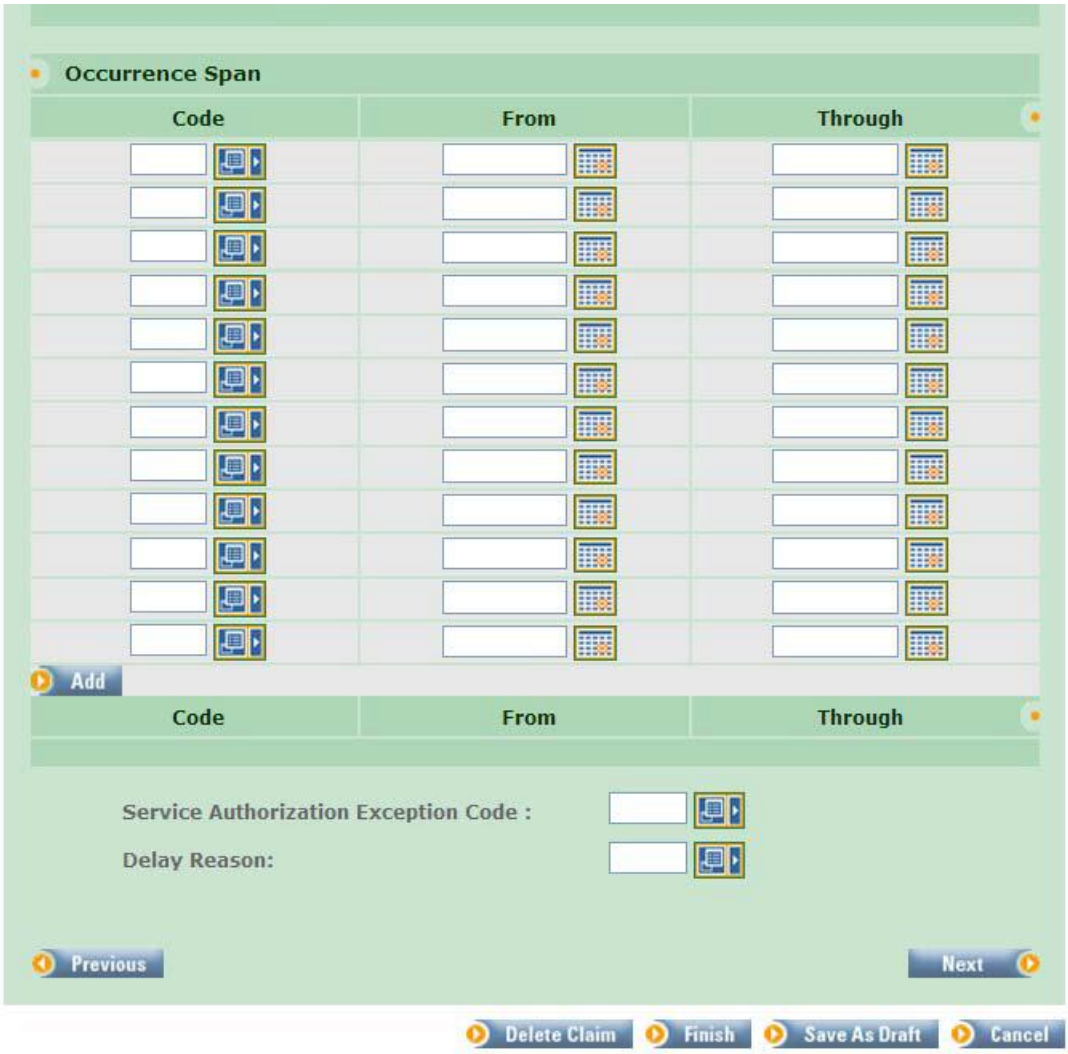
Sample SSHSP **Rate Codes**:

SERVICE TYPE	CPT Code	Rate Code	DESCRIPTION	Session Time /Units	Payment Rate
Psychological Counseling	90832	2008	PSYCHOTHERAPY, 30 MINUTES WITH PATIENT AND/OR FAMILY MEMBER	30 minutes	$48.30
Psychological Counseling	90833	2009	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)	30 minutes	$31.82
Psychological Counseling	90834	2010	PSYCHOTHERAPY, 45 MINUTES WITH PATIENT AND/OR FAMILY MEMBER	45 minutes	$61.83
Psychological Counseling	90836	2011	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)	45 minutes	$51.63

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

http://www.oms.nysed.gov/medicaid/resources/CPT_codes/handout_5_sshsp_cpt_codes_7_31_14.pdf

Condition Codes: Leave blank



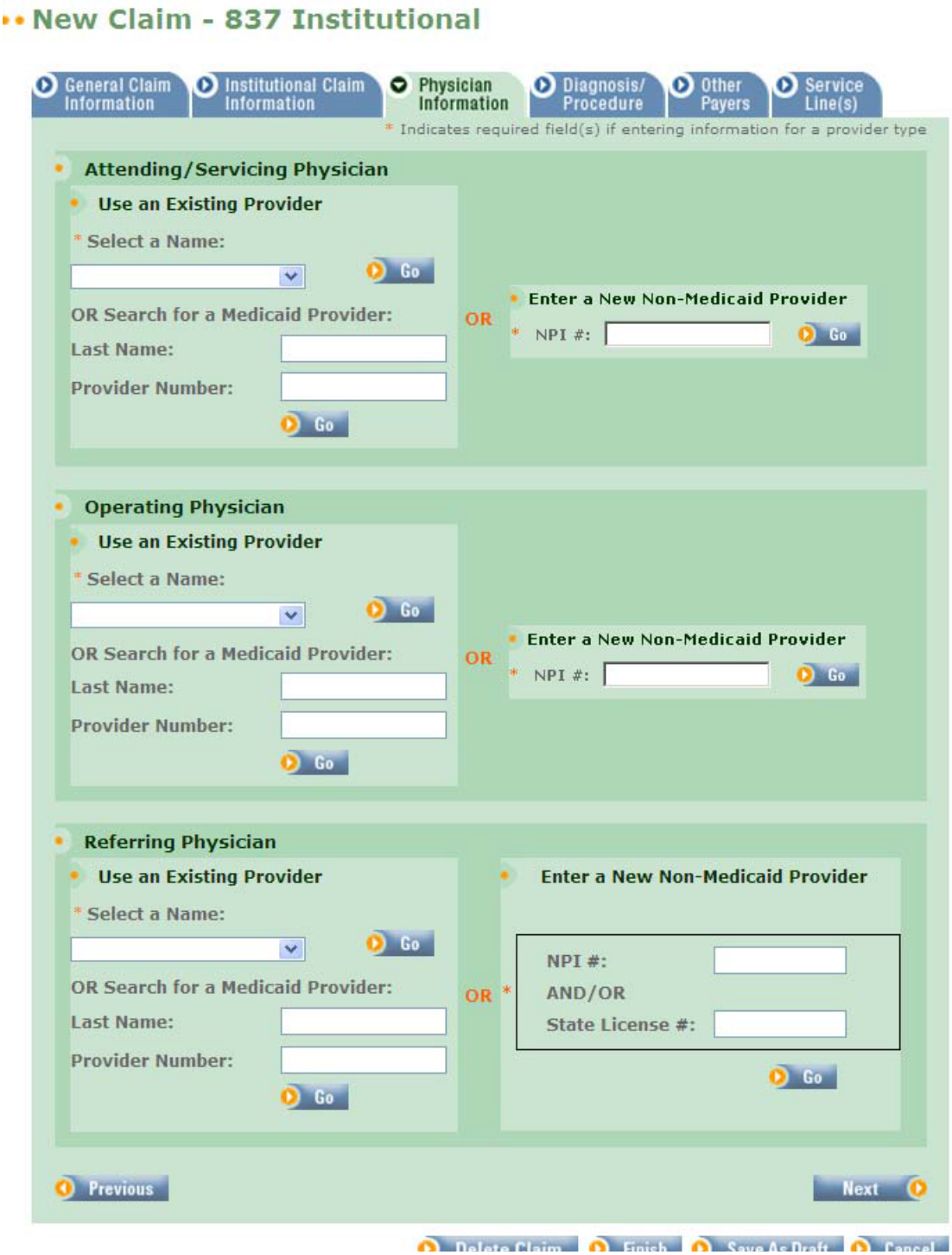
Occurrence Span: Leave blank

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).

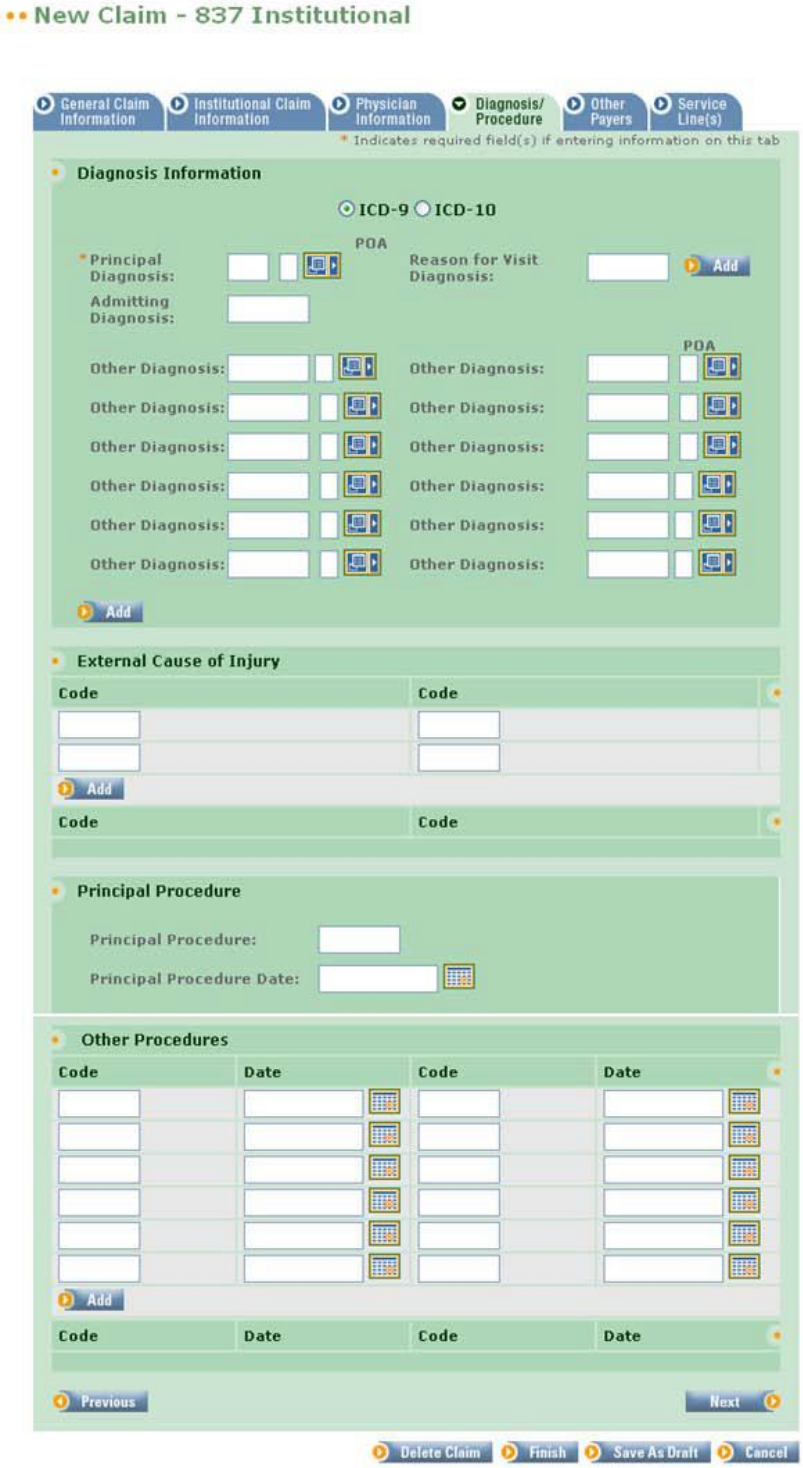
PROVIDER INFORMATION TAB



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)

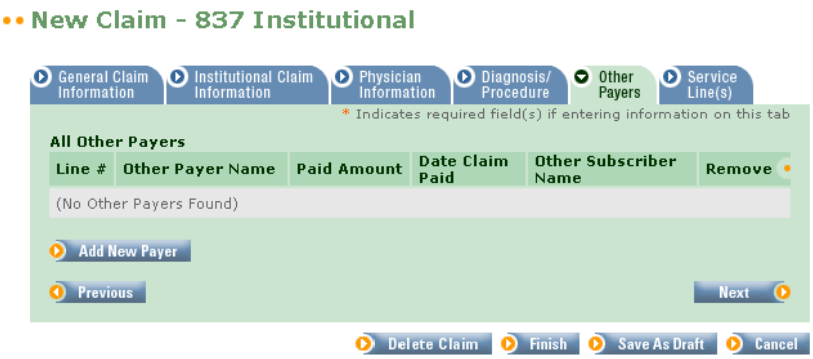
DIAGNOSIS / PROCEDURE TAB



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.

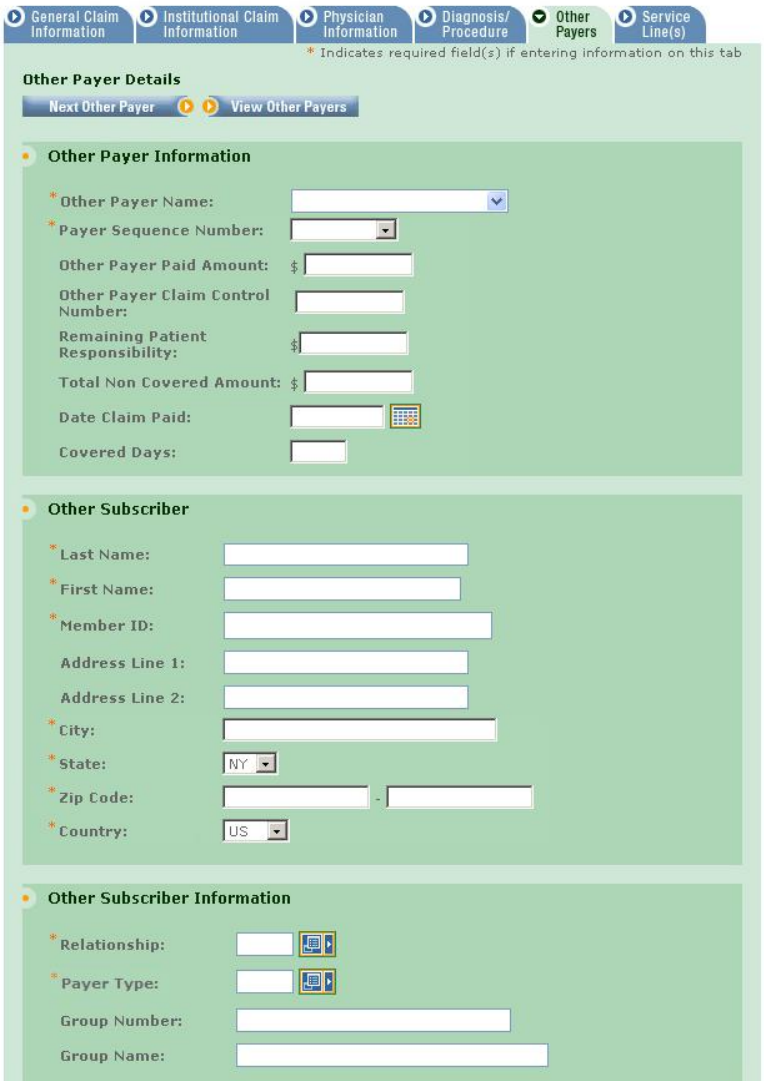
OTHER PAYERS TAB



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

OTHER PAYER DETAILS

- New Claim - 837 Institutional



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.

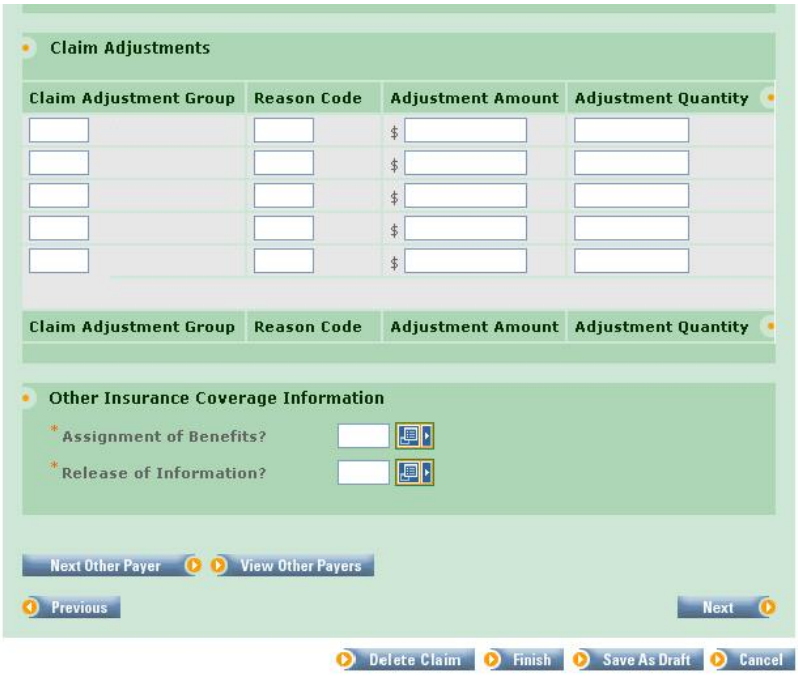
Payer Sequence Number: Choose - **Primary**.

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.

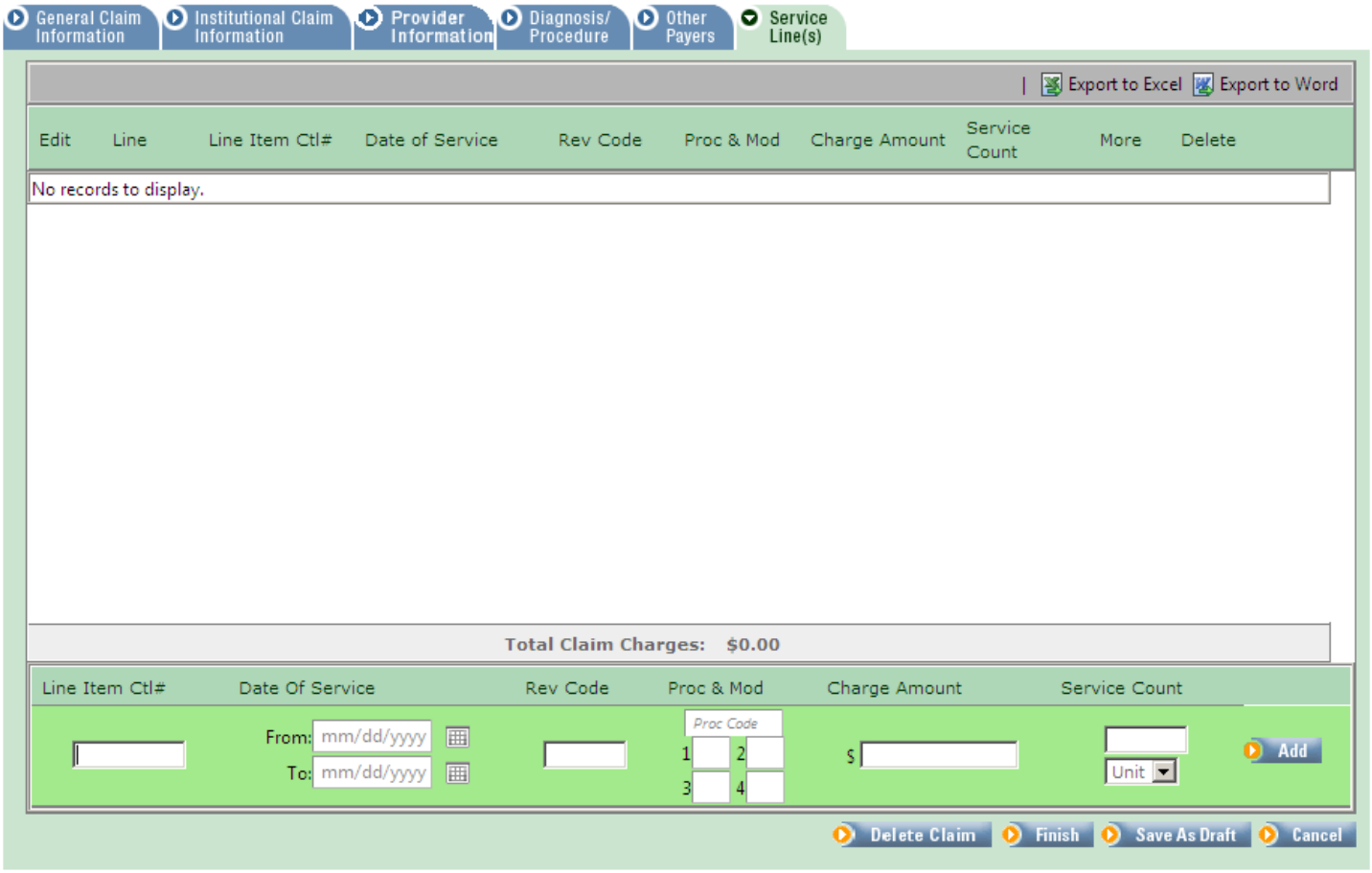
Payer Type: Enter the Code representing the Other Payer from the drop down list. Medicare Part B = **MB** or Medicare managed care plan = **16.**



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.

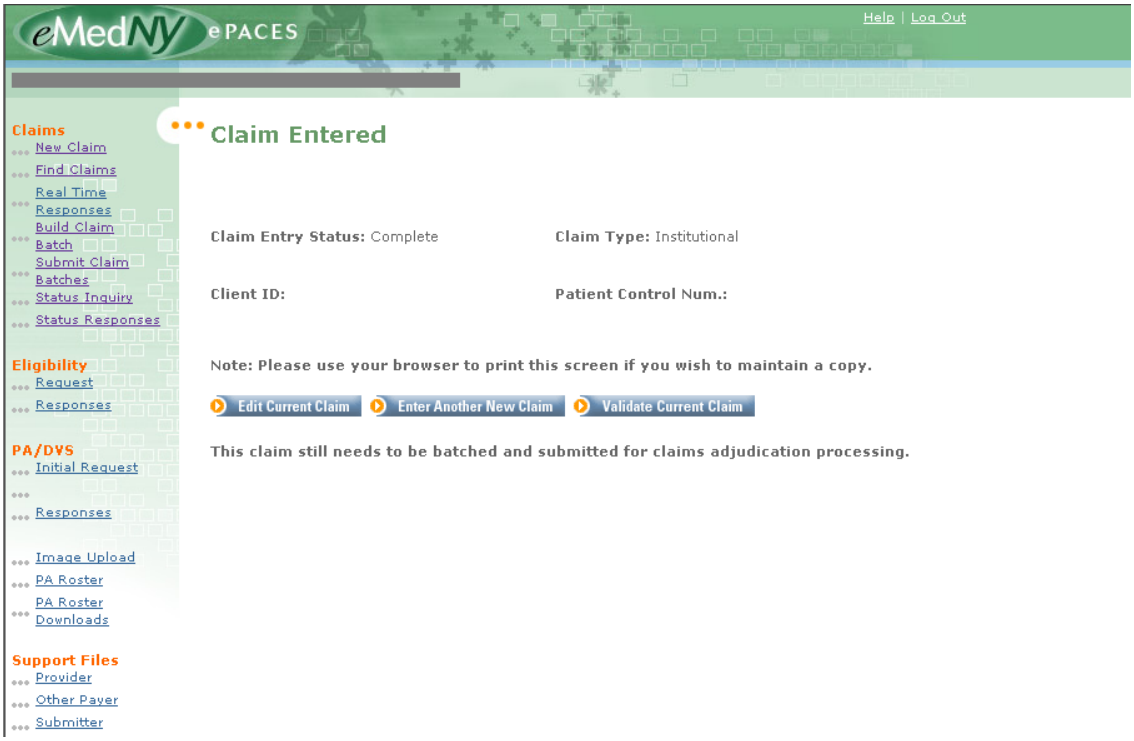
Charge Amount: Enter the amount charged.

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.



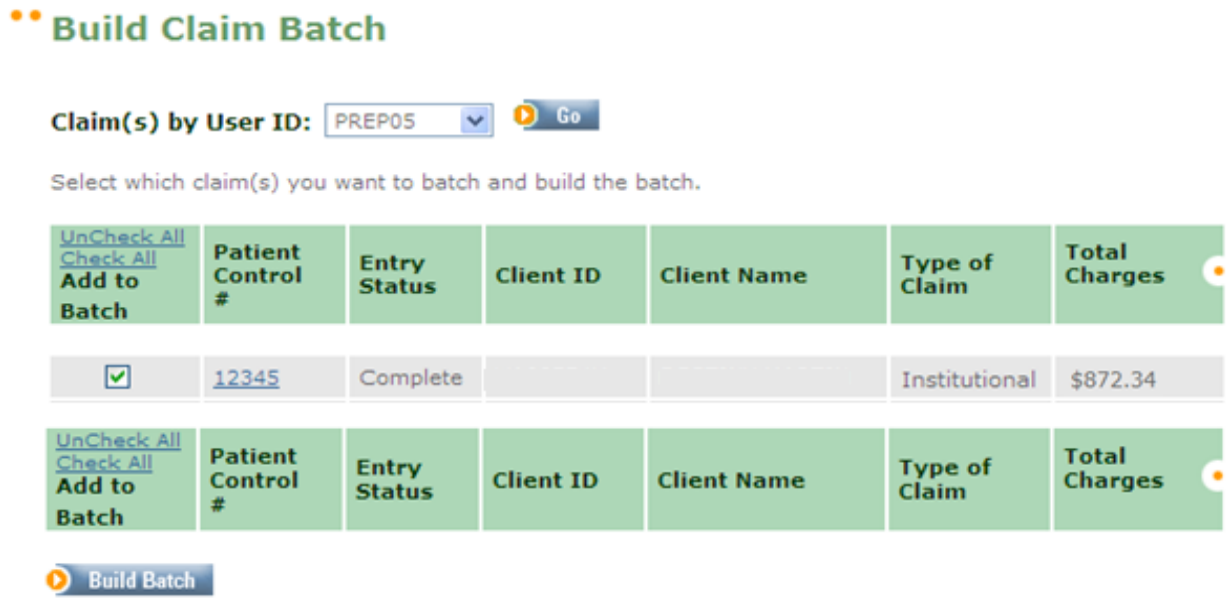
From this page, if necessary, you can click on the appropriate button to perform the following options:
- **Edit Current Claim:** Can be used to edit the claim.
- **Enter Another New Claim:** Can be used to add another institutional claim.
- **Validate Current Claim:** Can be used to check for errors

BUILD CLAIM BATCH

BUILD CLAIM BATCH WINDOW

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.

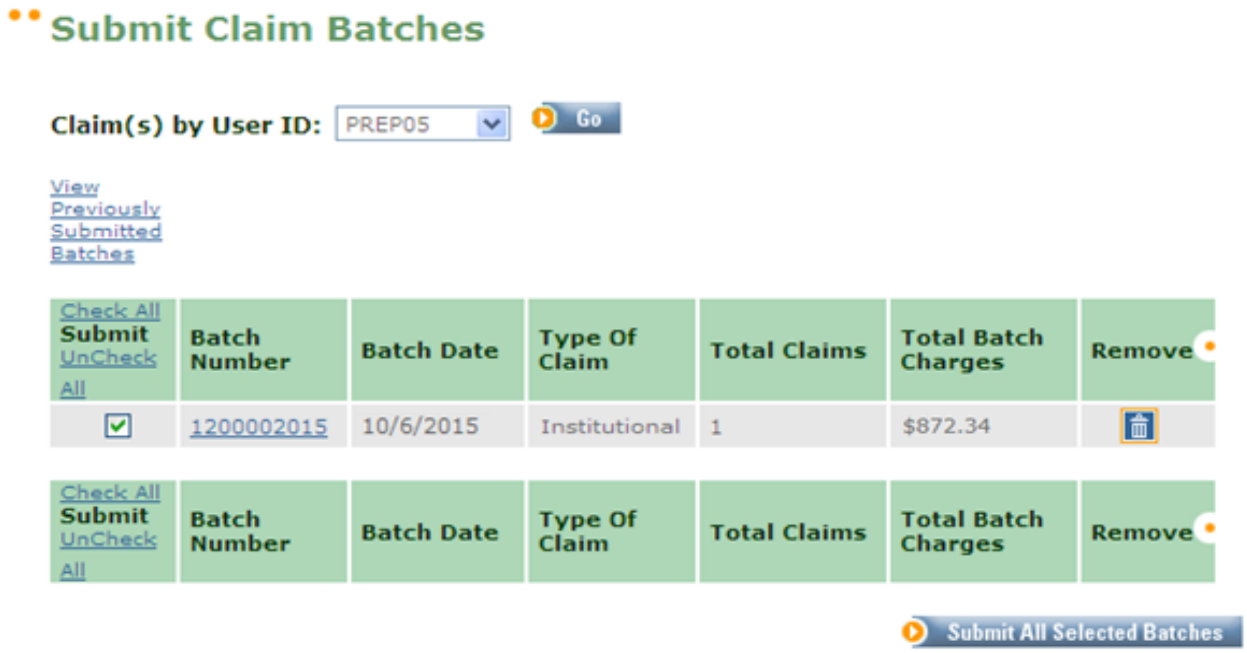
Click on the *Build Batch* button to build the batch of claims that have been checked and selected for submission.



SUBMIT CLAIM BATCHES

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.

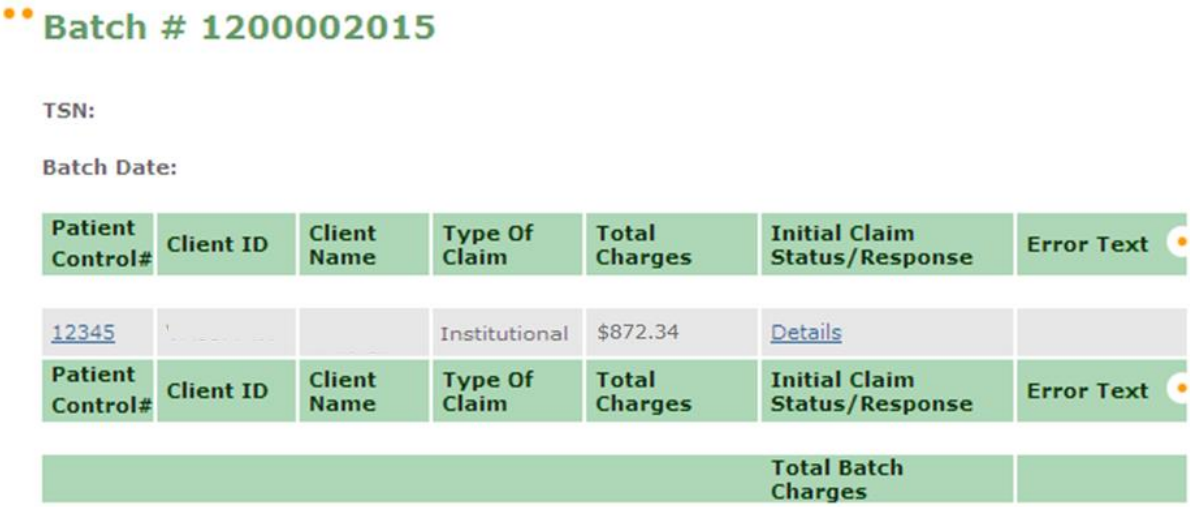


VIEW PREVIOUSLY SUBMITTED BATCHES

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

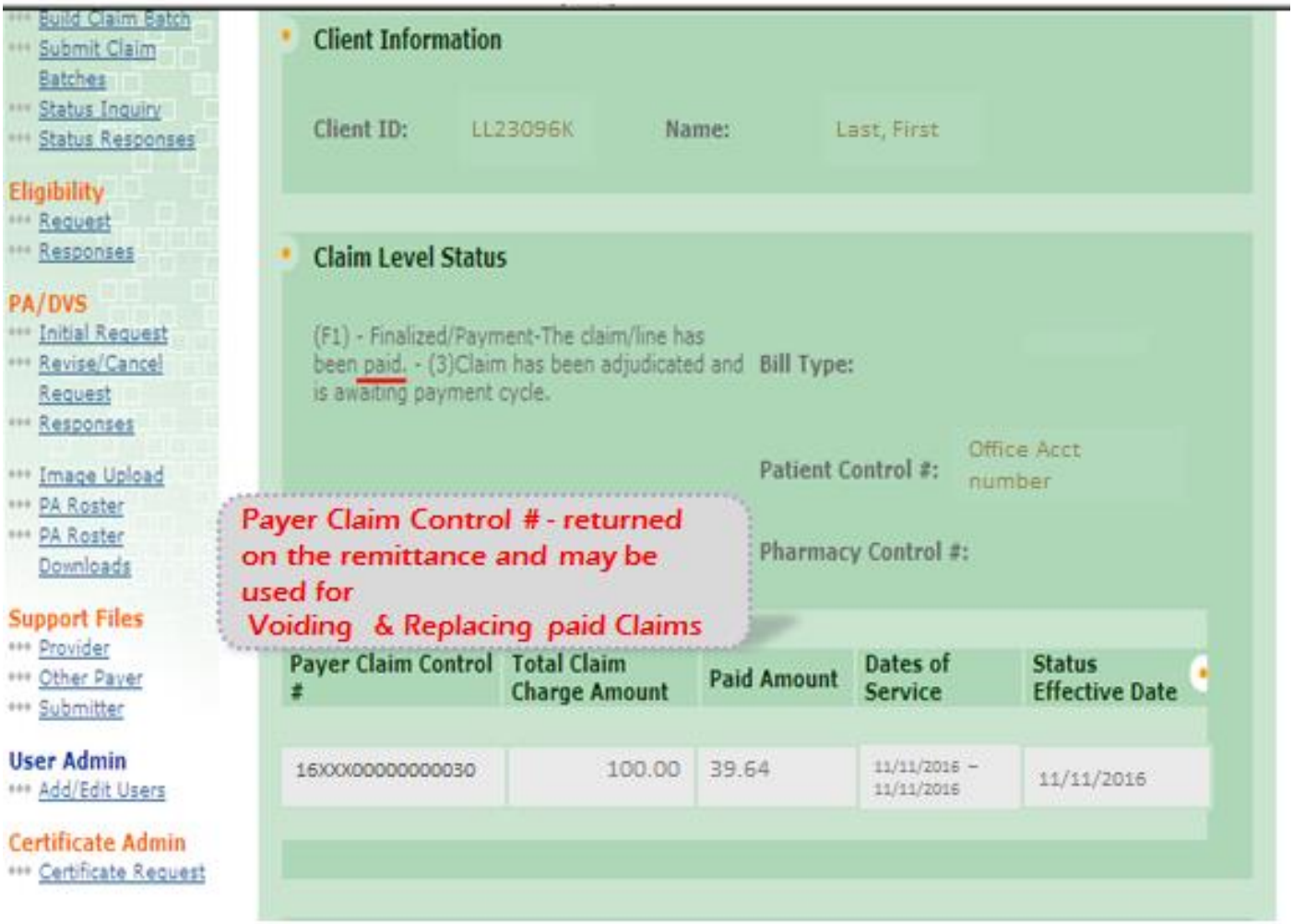
Click on the Batch Number and the batch will be displayed.

Click on **Details** under Initial Claim Status/Response to access the Claim Status Response.

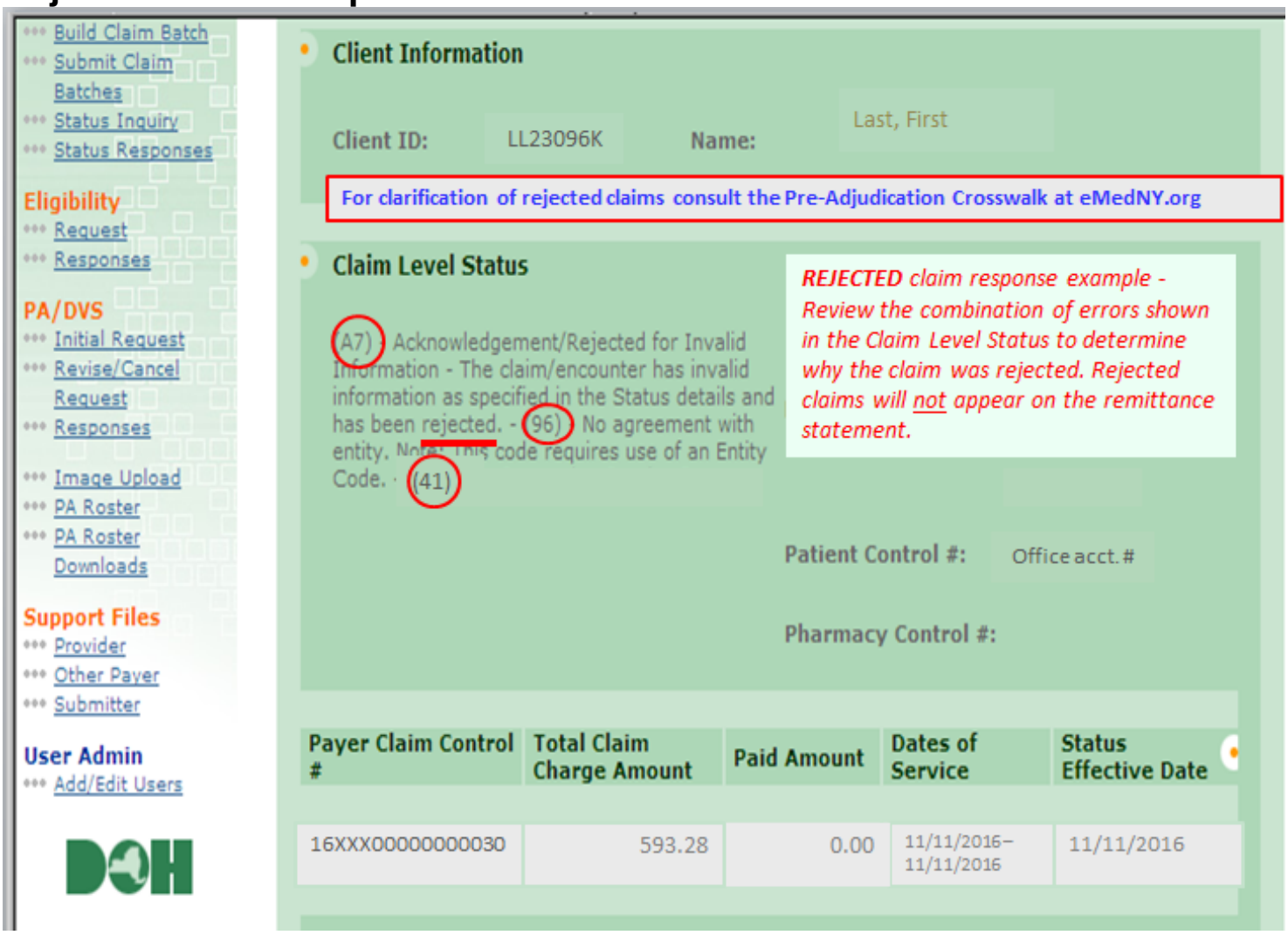


A Claim Status Response Details screen will be displayed with claim adjudication information.

Paid Claim Response



Rejected Claim Response



Refer to the Pre-Adjudication Crosswalk found at 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

VERSION 5010 (BATCH AND REAL-TIME)

277CA (OUTBOUND RESPONSE TO CLAIMS)									https://www.emedny.org/HIPAA/5010/transactions/crosswalks/eMedNY%20Pre-Adjudication%20Crosswalk%20837%20Health%20Care%20Claims.pdf	INBOUND CLAIM (VERSION 5010)			
CLAIM LEVEL (LOOP 2200D)						LINE LEVEL (LOOP 2220D)				BATCH			REAL-TIME
STC01-			STC10-			STC01-				837-			837-
-1	-2	-3	-1	-2	-3	-1	-2	-3	NYS Medicaid Conditions	INST	PROF	DENT	PROF
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	P4							Claim is out-of-balance (Coordination of Benefits)				✓
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 2330B NM109)				✓
A3	479	PR							Coordination of Benefits payer at line level (loop 2430 SVD01) not matched to claim level (loop 2330B 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-crossover claim)	✓	✓	✓	✓
A7	33	IL							Invalid client ID (CIN#)	✓	✓	✓	✓
A7	33	IL							Client is not on file	✓	✓	✓	✓
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, or Billing Provider (identified by NPI or Medicaid ID) not on file or not active on date of service (for Inpatient claims with Rate Codes 2946 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.