

## INITIAL ePACES SCREEN

Select *New Claim*.

Provider 111111111

Help | Log Out

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welcome to

**ePACES**

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](#) [DOH](#)

**DOH**

## GENERAL CLAIM INFORMATION

**General Claim Information**

\* Indicates required field(s)

Submission Reason:  NPI Number:

\* Payer Claim Control Number:

\* Patient Control Number:

**Location Information**

Address Line 1:

Address Line 2:

City:

State:

Zip Code:  -

**Client Information**

\* Enter a Client ID:

**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*.

General Claim Information

\* Indicates required field(s)

Submission Reason: Original NPI Number: 1111111111

\* Patient Control Number: 123

Location Information

Address Line 1: 1 Main St.  
Address Line 2:  
City: Nowhere  
State: NY  
Zip Code: 11111 - 1111

Client Information

\* Enter a Client ID: AA11111A Go

Jav Doe  
Address Line 1  
Address Line 2  
City, State, Zip

\* DOB: 01/01/0001

\* Gender: F

\* Type of Claim: Dental  
Professional  
Professional Real Time  
Institutional

Next

**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**

Code	Value	Code	Value
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

**Add**

Code	Value	Code	Value
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

**Condition Codes**

Code	Code	Code	Code
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Code	Value	Code	Value
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

**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](http://www.oms.nysed.gov/medicaid/resources/CPT_codes/handout_5_sshsp_cpt_codes_7_31_14.pdf)

**Condition Codes:** Leave blank

Code	From	Through
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>

Service Authorization Exception Code :

Delay Reason:

**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**

General Claim Information
Institutional Claim Information
Physician Information
Diagnosis/Procedure
Other Payers
Service Line(s)

\* Indicates required field(s) if entering information for a provider type

**Attending/ Servicing Physician**

**Use an Existing Provider**

\* Select a Name:  Go

OR Search for a Medicaid Provider:

Last Name:

Provider Number:  Go

**Enter a New Non-Medicaid Provider**

\* NPI #:  Go

**Operating Physician**

**Use an Existing Provider**

\* Select a Name:  Go

OR Search for a Medicaid Provider:

Last Name:

Provider Number:  Go

**Enter a New Non-Medicaid Provider**

\* NPI #:  Go

**Referring Physician**

**Use an Existing Provider**

\* Select a Name:  Go

OR Search for a Medicaid Provider:

Last Name:

Provider Number:  Go

**Enter a New Non-Medicaid Provider**

NPI #:

AND/OR

State License #:

Go

Previous
Next

Delete Claim
Finish
Save As Draft
Cancel

**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

General Claim Information
  Institutional Claim Information
  Physician Information
  **Diagnosis/ Procedure**
 Other Payers
  Service Line(s)

\* Indicates required field(s) if entering information on this tab

**Diagnosis Information**

ICD-9
  ICD-10

\* Principal Diagnosis:   Reason for Visit Diagnosis:

Admitting Diagnosis:

Other Diagnosis:   Other Diagnosis:

Other Diagnosis:   Other Diagnosis:

Other Diagnosis:   Other Diagnosis:

Other Diagnosis:   Other Diagnosis:

Other Diagnosis:   Other Diagnosis:

**External Cause of Injury**

Code	Code
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>

Code	Code
<input type="text"/>	<input type="text"/>

**Principal Procedure**

Principal Procedure:

Principal Procedure Date:

**Other Procedures**

Code	Date	Code	Date
<input type="text"/>	<input type="text"/> <input type="button" value="Calendar"/>	<input type="text"/>	<input type="text"/> <input type="button" value="Calendar"/>
<input type="text"/>	<input type="text"/> <input type="button" value="Calendar"/>	<input type="text"/>	<input type="text"/> <input type="button" value="Calendar"/>
<input type="text"/>	<input type="text"/> <input type="button" value="Calendar"/>	<input type="text"/>	<input type="text"/> <input type="button" value="Calendar"/>
<input type="text"/>	<input type="text"/> <input type="button" value="Calendar"/>	<input type="text"/>	<input type="text"/> <input type="button" value="Calendar"/>
<input type="text"/>	<input type="text"/> <input type="button" value="Calendar"/>	<input type="text"/>	<input type="text"/> <input type="button" value="Calendar"/>

Code	Date	Code	Date
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

**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

\* Indicates required field(s) if entering information on this tab

Line #	Other Payer Name	Paid Amount	Date Claim Paid	Other Subscriber Name	Remove
(No Other Payers Found)					

Buttons: Add New Payer, Previous, Next, Delete Claim, Finish, Save As Draft, Cancel

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

## OTHER PAYER DETAILS

### New Claim - 837 Institutional

General Claim Information
Institutional Claim Information
Physician Information
Diagnosis/Procedure
Other Payers
Service Line(s)

\* Indicates required field(s) if entering information on this tab

#### Other Payer Details

Next Other Payer
View Other Payers

##### 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**.

Claim Adjustments

Claim Adjustment Group	Reason Code	Adjustment Amount	Adjustment Quantity
<input type="text"/>	<input type="text"/>	\$ <input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	\$ <input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	\$ <input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	\$ <input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	\$ <input type="text"/>	<input type="text"/>

Other Insurance Coverage Information

\* Assignment of Benefits?

\* Release of Information?

**Assignment of Benefits:** Enter Y for Yes.

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

**SERVICE LINE TAB**

Edit	Line	Line Item Ctl#	Date of Service	Rev Code	Proc & Mod	Charge Amount	Service Count	More	Delete
No records to display.									
<b>Total Claim Charges: \$0.00</b>									
Line Item Ctl#	Date Of Service		Rev Code	Proc & Mod		Charge Amount	Service Count		
<input type="text"/>	From: <input type="text" value="mm/dd/yyyy"/>	<input type="text"/>	<input type="text"/>	Proc Code		\$ <input type="text"/>	<input type="text"/>	<input type="button" value="Add"/>	
	To: <input type="text" value="mm/dd/yyyy"/>			1 <input type="text"/>	2 <input type="text"/>		Unit <input type="text"/>		
				3 <input type="text"/>	4 <input type="text"/>				

**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.

**Claim Entered**

Claim Entry Status: Complete      Claim Type: Institutional

Client ID:      Patient Control Num.:

Note: Please use your browser to print this screen if you wish to maintain a copy.

[▶ Edit Current Claim](#)  
 [▶ Enter Another New Claim](#)  
 [▶ Validate Current Claim](#)

This claim still needs to be batched and submitted for claims adjudication processing.

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

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welcome to ePACES

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## 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.



## Build Claim Batch

Claim(s) by User ID:

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

<a href="#">UnCheck All</a> <a href="#">Check All</a> Add to Batch	Patient Control #	Entry Status	Client ID	Client Name	Type of Claim	Total Charges
---	-------------------------	-----------------	-----------	-------------	------------------	------------------

<input checked="" type="checkbox"/>	<a href="#">12345</a>	Complete			Institutional	\$872.34
-------------------------------------	-----------------------	----------	--	--	---------------	----------

<a href="#">UnCheck All</a> <a href="#">Check All</a> Add to Batch	Patient Control #	Entry Status	Client ID	Client Name	Type of Claim	Total Charges
---	-------------------------	-----------------	-----------	-------------	------------------	------------------

## SUBMIT CLAIM BATCHES

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[eMedNY](#) [DOH](#)

## 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:

[View Previously Submitted Batches](#)

<a href="#">Check All</a> <a href="#">Submit</a> <a href="#">UnCheck</a> All	Batch Number	Batch Date	Type Of Claim	Total Claims	Total Batch Charges	Remove
<input checked="" type="checkbox"/>	<a href="#">1200002015</a>	10/6/2015	Institutional	1	\$872.34	

<a href="#">Check All</a> <a href="#">Submit</a> <a href="#">UnCheck</a> All	Batch Number	Batch Date	Type Of Claim	Total Claims	Total Batch Charges	Remove

## 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:

[View Previously Submitted Batches](#)



The following claim batches have been submitted:

Batch Number	Submit Date	Type Of Claim	Total Claims	Total Batch Charges	Total Rejected
<a href="#">1200002015</a>	10/6/2015	Institutional	1	\$872.34	

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

## Claim Batches Submitted

Claim(s) by User ID:

The following table lists all claim batches that you have submitted:

Batch Number	Submit Date	Type Of Claim	Total Claims	Total Batch Charges	Total Rejected
<a href="#">1200002015</a>	10/6/2015	Institutional	1	\$872.34	



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

## Batch # 1200002015

TSN:

Batch Date:

Patient Control#	Client ID	Client Name	Type Of Claim	Total Charges	Initial Claim Status/Response	Error Text
<a href="#">12345</a>			Institutional	\$872.34	<a href="#">Details</a>	
Patient Control#	Client ID	Client Name	Type Of Claim	Total Charges	Initial Claim Status/Response	Error Text
				<b>Total Batch Charges</b>		

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

## Paid Claim Response

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**Client Information**

Client ID: LL23096K      Name: Last, First

**Claim Level Status**

(F1) - Finalized/Payment-The claim/line has been paid. - (3)Claim has been adjudicated and is awaiting payment cycle.

Bill Type:

Patient Control #:      Office Acct number

Pharmacy Control #:

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

Payer Claim Control #	Total Claim Charge Amount	Paid Amount	Dates of Service	Status Effective Date
16XXX00000000030	100.00	39.64	11/11/2016 - 11/11/2016	11/11/2016

## Rejected Claim Response

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\*\*\* [Submit Claim Batches](#)

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**User Admin**

\*\*\* [Add/Edit Users](#)



**Client Information**

Client ID: LL23096K      Name: Last, First

For clarification of rejected claims consult the [Pre-Adjudication Crosswalk at eMedNY.org](#)

**Claim Level Status**

**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.**

(A7) Acknowledgement/Rejected for Invalid Information - The claim/encounter has invalid information as specified in the Status details and has been rejected. - (96) No agreement with entity. Note: This code requires use of an Entity Code. (41)

Patient Control #:      Office acct. #

Pharmacy Control #:

Payer Claim Control #	Total Claim Charge Amount	Paid Amount	Dates of Service	Status Effective Date
16XXX00000000030	593.28	0.00	11/11/2016–11/11/2016	11/11/2016



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**  
**VERSION 5010 (BATCH AND REAL-TIME)**

277CA (OUTBOUND RESPONSE TO CLAIMS)									<a href="https://www.emedny.org/HIPAA/2010/transactions/crosswalks/eMedNY%20Pre-Adjudication%20Crosswalk%20837%20Health%20Care%20Claims.pdf">https://www.emedny.org/HIPAA/2010/transactions/crosswalks/eMedNY%20Pre-Adjudication%20Crosswalk%20837%20Health%20Care%20Claims.pdf</a>				INBOUND CLAIM (VERSION 5010)			
CLAIM LEVEL (LOOP 2200D)			LINE LEVEL (LOOP 2220D)										BATCH			REAL-TIME
STC01-			STC10-			STC01-			837-							
-1	-2	-3	-1	-2	-3	-1	-2	-3	INST	PROF	DENT	PROF				
NYS Medicaid Conditions																
A3	121										✓	✓				
A3	156	QC							✓	✓	✓	✓				
A3	400	85							✓	✓	✓	✓				
A3	400	P4											✓			
A3	400	PR							✓	✓	✓					
A3	479	P4											✓			
A3	479	PR							✓	✓	✓					
A3	742								✓	✓	✓	✓				
A7	33	IL							✓	✓	✓	✓				
A7	33	IL							✓	✓	✓	✓				
A7	96	41							✓	✓	✓					
A7	96	44											✓			
A7	132	85							✓	✓	✓	✓				
A7	132	71							✓							
A7	132	82								✓		✓				
A7	132	DN								✓		✓				
A7	187								✓		✓					
A7	228								✓							
A7	229								✓							



## Denied Claim Response

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**PA/DVS**

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### Claim Status Response Details

**Client Information**

Client ID: 1112345L      Name: Last, First

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**Claim Level Status**

(F2) – Finalized/Denial – The claim/line has been denied.  
 (88) Entity not eligible for benefits for submitted dates of service. Note: This code requires use of an Entity Code: (QC) - Patient      Bill Type: 131

Payer Claim Control #	Total Claim Charge Amount	Paid Amount	Dates of Service	Status Effective Date
16XXX00000000030	559.00	0.00	11/11/2016 – 11/11/2016	11/11/2016

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