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FEBRUARY 2011
SPECIAL EDITION
VOLUME 27 - NUMBER 2

New York State Medicaid Update

THE OFFICIAL NEWSLETTER OF THE NEW YORK MEDICAID PROGRAM

Special Edition: Prepare for HIPAA 5010 today!

PREPARATION, IMPLEMENTATION & COMPLIANCE RESOURCE GUIDE

We are committed to helping providers prepare for 5010

BACKGROUND

On January 16, 2009, the Office of the Secretary of the Department of Health and Human Services (DHHS) published a Final Rule adopting updated versions of the standards for electronic transactions previously adopted under the Administrative Simplification subtitle of the Health Insurance Portability and Accountability Act (HIPAA). Since the mandate and subsequent implementation of the original transactions in October 2003, industry stakeholders submitted many comments to DHHS and change requests to the Designated Standards Maintenance Organizations (DSMOs). This resulted in the development of updated specifications for the existing transactions, which all covered entities are mandated to implement by January 1, 2012.

- **These changes will impact ALL providers.**
- **Payers' and Providers' systems and business processes will be affected and require remediation.**

5010/D.0 IMPLEMENTATION

To meet the mandated deadline, the New York State Department of Health (NYSDOH) will implement substantial changes to Medicaid processing beginning the summer of 2011. This will begin the transition period. During transition, eMedNY will process both 5010/D.0 and 4010/5.1 transactions. **This will not be a phased approach.** All mandated transactions will be supported at the same time.

Unlike the previous 4010 Companion Guides (CG), the 5010 and D.0 versions do not provide the same level of detail due to copyright limitations. Developers will need to obtain the official Implementation Guides along with the Companion Guides as outlined below.

- **X12 Implementation Guides are available at: store.x12.org.**
- **NCPDP D.0 Implementation Guides are available at: www.NCPDP.org.**
- **eMedNY Companion Guides are available at: www.eMedNY.org under eMedNY HIPAA SUPPORT.**

The 5010/D.0 implementation will impact existing 4010/5.1 business processes. These impacts will be discussed in separate, more detailed articles. The following is a summary of some of the business and technical impacts:

- **eMedNY will implement new and improved acknowledgment files for 5010 submissions.**
- **Enhanced Batch File Tracking will be introduced to allow submitters to track files throughout the adjudication process. This new "dashboard" will be available for all files submitted for batch processing.**
- **Process time from file submission to acknowledgement will be greatly reduced.**
- **Users of the Bulletin Board System (BBS) submission method are required to migrate to another method (FTP, eXchange, etc) as the BBS is scheduled to be retired as of April 2011.**
- **Some claims editing currently performed in the claims adjudication system and reported on providers' remittances will be moved to the "pre-adjudication" process to provide more timely notification about these errors (list of edits will be announced at a later date).**
- **The 835 Supplemental Remittance file sent with electronic remittances will no longer contain denied claims (it will consist of only pended claims).**
- **POS devices will require a new software version to support 5010 transactions (download instructions are forth coming).**
- **5010 response requirements result in significant changes to eligibility responses and the associated business processes to both 4010 and 5010 implementations.**
- **The 278 Service Authorization transaction will be eliminated.**
- **ePACES screens will change (information and training will be available at a later date).**

Providers are urged to contact their vendors to ensure systems and business process changes that result from this implementation do not interrupt providers' New York Medicaid payments.

TRANSACTION ACKNOWLEDGMENTS

NYSDOH will implement acknowledgement transactions expected to be consistent with implementations of many other payers and future HIPAA mandates.

OUTBOUND TRANSACTION FORMATS

During the transition period, NYSDOH response transactions will be versioned according to submitter readiness. Submitter readiness will be communicated in two ways.

- Request/Response transactions (270/271, 276/277, 278 Request/278 Response) will be based upon the format the request is received. In other words, if an eligibility request is in the 4010 format, the response will be in the 4010 format. If the request is in 5010 format, the response will be in 5010 format.

- Transition of 820 and 835 remittance advice transactions will be managed using a new form that must be submitted advising eMedNY when a receiver is ready to receive the 5010 format. The version used for the Remittance Advice is totally independent of the inbound claims.

  The format of paper remittances will not change.

PROVIDER TEST ENVIRONMENT (PTE)

It is anticipated the PTE will be ready for testing of 5010 and D.0 transactions prior to the production release. This will allow providers and vendors to submit test transactions and receive responses as early as possible. Specific dates will follow in subsequent communications.

ENHANCED SUBMISSION RESPONSE FILES FOR 5010

With the implementation of 5010, the efficiency of processing submitted transactions has been greatly enhanced resulting in more timely acknowledgement reporting and final adjudication of files. Under the current process, excessive delays have occurred due to large volumes.

Because the current process does not acknowledge the files until full adjudication is complete, these delays have caused submitters to resubmit the same file under the assumption there was a processing/corruption issue. In most cases, this added to the processing backlog and generated duplicate claim denials.

For 5010 transactions, many technical improvements have been made to accelerate file processing throughout the system. As part of the newly devised architecture, new acknowledgement transactions will be returned as the associated processes complete. The response transactions and expected timelines are outlined in the table below.

Acknowledgement Transaction	Editing Parameters	Expected Response Times (under NORMAL operating conditions)
TA1	X12 Envelope and Functional Group validation	< 2 hours – only sent when there are errors and requested by the submitter in ISA14
999	Verifies compliance with X12 syntax and HIPAA Implementation Guide	2 hours
277CA	Detailed Claim Acknowledgment	4 hours

TA1 – Interchange Acknowledgement: Validates proper syntax and format of the outer envelope and functional groups.

999 – Implementation Acknowledgement for Health Care Insurance: Validates transaction structure and syntax as defined by the mandated Implementation Guides.

277CA – Health Care Claim Acknowledgement: Provides certain claim specific accept/reject status.

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- **In addition to the few provider related pre-adjudication edits that already exist, several validation edits have been added. These edits will provide immediate feedback for claims that would deny if passed to the system. The way files are processed today, these denials would not be seen until weeks later when the remittance advice is received.**
- **No further processing, or reporting, will be performed on rejected claims. They will not appear on a remittance advice.**
- **Accepted for further processing means the claim has passed all "pre-adjudication" edits and will be reported on a future remittance advice with the associated final disposition.**
- **The transaction includes batch totals of: Total Claims Submitted, Total Claims Rejected, and Total Claims Accepted for further processing.**

A complete list of pre-adjudication edits and associated claim status codes will be posted to www.emedny.org, in the eMedNY HIPAA SUPPORT area.

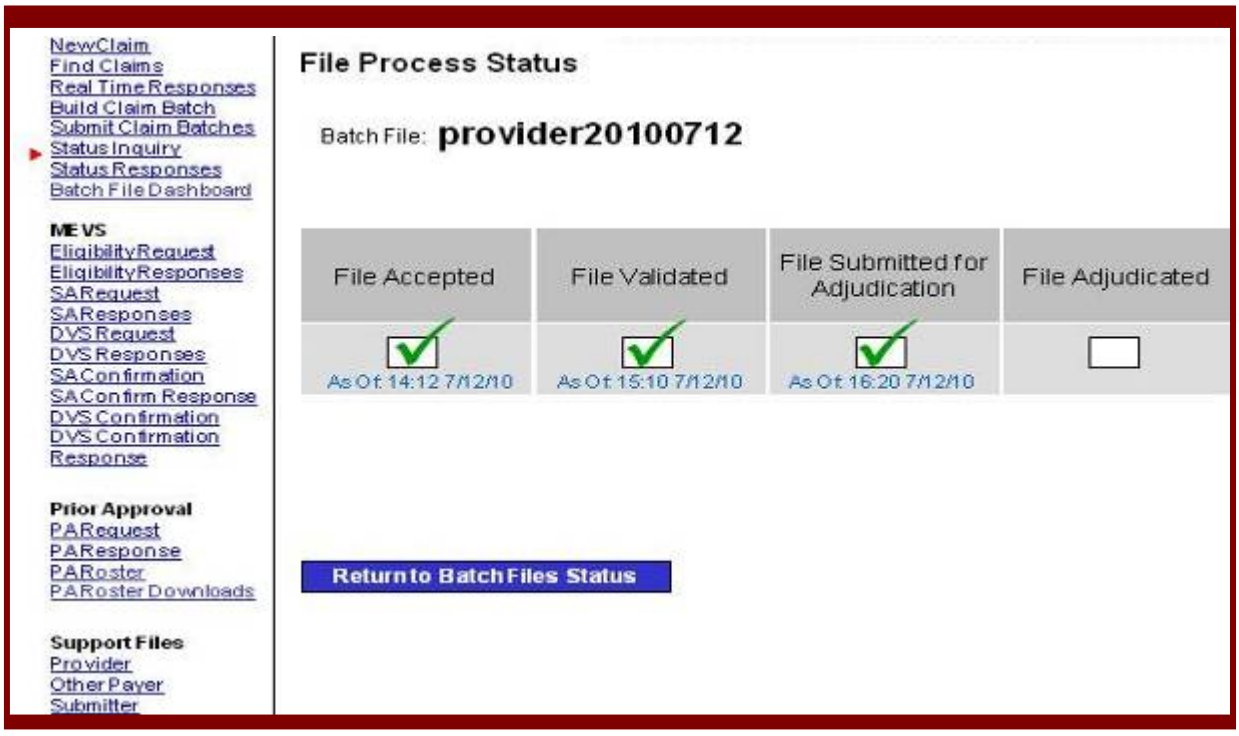
Note: The above response files will be new to the Medicaid processing system and will be implemented as providers submit the upgraded 5010 version. During the transition period submitters of 4010 transactions will continue to receive the "F" file, 997, and U277.

The U277 will be enhanced to include the front-end edits that will be implemented for the 5010 277CA.

NYSDOH TO INTRODUCE THE SUBMITTER DASHBOARD FOR ENHANCED FILE TRACKING AT EMEDNY

In response to submitter requests, NYSDOH is pleased to announce a new online "dashboard" that allows submitters to track the status of files from the moment they are received to the point of final adjudication.

The dashboard will be accessed from the www.eMedNY.org home page for all users of eXchange, FTP, iFTP and SOAP. Batches will only be viewable by the actual submitter ID used to submit the files. Users will use the same User ID and password used for transaction submission.



MEDICAID ELIGIBILITY VERIFICATION SYSTEM (MEVS) CHANGES

Substantial changes will be made to the Medicaid Eligibility Verification System (MEVS) as part of the 5010 implementation. These changes will be seen by all providers regardless of the version submitted. The changes will impact all methods of accessing MEVS, including:

- **Telephone Audio Response Unit (ARU) Verification**
- **MEVS Point of Service (POS) Terminals**
- **ePACES**
- **ASC X12 270 or 278 requests.**

Many of the changes are outlined in the following two articles:

- **Electronic Eligibility Transactions**
- **Changes to the Utilization Threshold Program and Elimination of Service Authorization Requests.**

Providers are strongly encouraged to download the new MEVS Provider Manual from www.eMedNY.org for details regarding the changes. Watch the eMedNY HIPAA Support page for availability of the revised MEVS Provider Manual.

Providers sending X12 270 and/or 278 requests can find the eMedNY Companion Guides at: http://www.emedny.org/HIPAA/5010/index.html.

ELECTRONIC ELIGIBILITY TRANSACTIONS

The magnitude of the changes necessary to meet the requirements of the 5010 eligibility response has forced modifications to both the 4010 and 5010 transactions within eMedNY. The following changes impact both formats except where specified.

- **The card sequence number will no longer be required.**
- **All eligibility requests will be treated as a generic request. This means that although a provider request may specify particular service types, eMedNY will respond with information about all service types that exist for the Medicaid member.**
- **The coverage code description will be returned in field EB05. (See the MEVS Provider Manual for coverage code benefits information).**
- **The eligibility responses must address each of the following Service Type codes when coverage exists:**

1 – Medical Care	33 – Chiropractic
35 – Dental Care	86 – Emergency Services
88 – Pharmacy	98 – Professional Physician Office
MH – Mental Health	UC – Urgent Care
AL – Vision (Optometry)	47 – Hospital

If one or more of the above Service Types are not returned in response – this indicates those services are not covered by Medicaid.

- **Service Types will also be returned to indicate specific exclusions or inclusions of coverage. For example, the following service types may be returned with an indication of Non-Covered (this indicator is reported in EB01).**

48 – Hospital Inpatient	54 – Long Term Care

- **The Hospital Inpatient example can create confusion if not properly considered. Receivers must understand there are instances where Service Type '47 – Hospital' will receive an active coverage response AND a '48 – Hospital Inpatient' Non-Covered response. This means that the patient has coverage for outpatient (including ER, lab, and X-ray) hospital services only.**

Co-pay Changes

- **Providers will no longer be asked to submit the co-pay units while entering an eligibility request into the ARU.**
- **It will no longer be necessary to indicate if a service is co-pay exempt in the eligibility request.**
- **The co-pay amount reported in the eligibility response will be the remaining amount of the member's annual maximum (no change from current process).**

Restricted Member Changes

Today, if a member has a provider restriction, the eligibility response states "Provider Not Primary Physician." After 5010 implementation, when a member has provider restrictions, the restricted Service Types will be returned in the response along with the provider name and NPI that the member is restricted to. The requesting provider will be responsible for determining the applicability of the restriction based on the type of service to be provided.

Managed Care Responses

- **Responses will no longer include scope of benefits information and providers will need to contact the plan to determine services covered by the plan.**
- **Service Type codes will be used to identify carved-out services where possible.**
- **In the 4010 transaction, Category of Assistance (COA) code 'S' is used to indicate Mental Health services are carved-out of the managed care plan. In 5010, the carve-out will be indicated using the MH service type and the COA will not be returned.**

Technical Notes: EB01 = U indicates the member is enrolled in a managed care or Family Health Plus (FHP) plan. The name and available contact information of the plan will be included in the response. The Coverage Code description reported in EB05 will indicate whether the plan is Managed Care or FHP.

Third Party Payers

- **All payers on file for a member will be returned with Plan Name.**
- **The plan name and available contact information of the plan will be included in the response.**
    - **When the member has Medicare coverage, the name will indicate the type of Medicare coverage. See below:**
        - **MEDICARE A**
        - **MEDICARE B**
        - **MEDICARE AB**
        - **MEDICARE ABDQMB**

Technical Note: EB01 = R indicates the member has another Payer, such as Medicare or a commercial insurance, that must be considered before submitting claims.

CHANGES TO THE UTILIZATION THRESHOLD PROGRAM AND ELIMINATION OF SERVICE AUTHORIZATION REQUESTS

This article pertains to services subject to Utilization Threshold (UT) in order to be reimbursed for services by New York Medicaid. The service categories subject to UT are as follows:

- **Physicians**
- **Medical clinics and hospital outpatient departments**
- **Laboratories**
- **Dental clinics**
- **Mental Health clinics**
- **Pharmacy**

With the implementation of the 5010 and D.0 transactions, NYSDOH will be eliminating the current Service Authorization (SA) process.

SA (278) transactions will no longer be supported. Instead, services subject to UT will be administered based upon the member's status at the time the claim is processed and information reported in the eligibility response.

- **If the member is "At Limits" for any service category, the eligibility response will return an indication of "Limitations" for the applicable Service Type(s). If a "Limitations" message is returned, a Threshold Override Application (TOA) must be submitted to request an increase in the member's allowed services as is done today.**
    - ***Technical Note: A "Limitations" Message is indicated by EB01 = 'F'.***
- **If during claim adjudication the client is "At Limits", the claim will pay if the SA units were available for that DOS when the eligibility request was processed.**
- **If the provider did not perform an eligibility request for the date of service on the claim AND the member is "At Limits", the claim will be denied.**

In addition, the member's service counts for each service category will now be incremented based on claim adjudication instead of reservation of units by the SA.

The provider number used when performing the eligibility request must match the provider number on the claim. The exception to this is for providers who submit claims with a group and rendering provider number. If either the group or rendering provider number was used to obtain the eligibility information and at least one of them match the claim, the UT edit will be bypassed.

POINT-OF-SERVICE (POS) CARD-SWIPE TERMINALS WILL REQUIRE SOFTWARE UPGRADE

To support the 5010/D.0 changes, a software upgrade will be required for all POS devices on the eMedNY implementation date. Computer Sciences Corporation (CSC) will attempt to make this transition as easy as possible by setting your device to automatically download the software upgrade during non-business hours.

In order for the upgrade to be successful, it is imperative the POS devices are:

- **connected to a phone line.**
- **turned on the evening of the planned upgrade.**

If the devices are not left on and connected to a telephone line, the upgrade will not install, and the devices will not work until the provider performs a manual download of the new software. This may cause further operational delays.

Prior to implementation, CSC will send individual notifications to all providers who possess POS devices. The notification will include information on how to verify your POS device was properly loaded with the HIPAA 5010 software and how to perform a manual download should the automatic download not be successful.

CHANGES TO PRIOR APPROVAL (PA) PROCESSING

eMedNY will allow providers to request changes for existing PAs through a 278 transaction. These changes will allow providers to request extensions, cancellations or revisions to existing PAs.

- **Extensions - will enable the requester to ask for an extended period of time to perform services previously approved. Requests for extensions will be sent for review and processing through the appropriate reviewing personnel for adjudication.**

- **Cancellations - will be an "all or nothing" proposition, meaning that if a cancellation is sent at the header level, all lines will be canceled. Note that if only one line of a PA needs to be canceled a "revision" should be submitted.**

- **Revisions - are any other types of changes not covered by extensions or cancellations, for example changes for one or more procedure codes etc.**

CLAIMS PROCESSING CHANGES

Implementation of version 5010 and D.0 claims transactions requires the following eMedNY specific changes.

837 Professional & Dental claims

- **The Pay-to loop (2010AB) will no longer be used.**
- **The Group's NPI must be reported as the Billing Provider (2010AA).**
- **The Individual's NPI must be reported as the Rendering NPI (2310B) when submitting claims as a member of a group.**

837 Professional claims

- **Abortion/Sterilization codes will be reported using Condition Codes. For those who are unfamiliar with condition codes, the list applicable to professional claims is available at: http://nucc.org/index.php?option=com_content&task=view&id=20&Itemid=38.**

837 Institutional claims

- **Providers billing for atypical services (those not requiring NPI's) must report the MMIS ID and Locator Code as a concatenated value into a single element (Loop 2010BB - REF02)**
  - **Example: If MMIS=12345678 and Locator Code=003 - the field would contain an 11 digit number 12345678003**
- **The information for the following fields will now be reported as Value Codes:**
  - **Covered Days 80**
  - **Non-covered Days 81**
  - **Coinsurance Days. 82**
  - **LTR Days 83**
  - **Patient Paid Amount FC**

NCPDP

- **The card sequence number will no longer be required.**

Applicable to all claims (837PDI):

- **For 5010, the "0FILL" designation no longer applies to the entire claim. The indication of "0FILL" will be payer specific.**
- **"0FILL" may only be indicated when the prior payer has not adjudicated the claim. *It is no longer permissible for "0FILL" to be used when a denial is received for claims submitted in either 4010 or 5010 formats.***

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- **The literal "0FILL" reported as a Group Name will not be used for 5010 claims. Instead, the Total Charge Amount (CLM02) will be reported in the Non-Covered Amount field (Loop 2320, AMT 02 where AMT01 = A8) to indicate a specific prior payer has not adjudicated the claim.**

- **When the prior payer has adjudicated the claim, providers are required to submit all Claim Adjustment Reason Codes (CARC) as reported to the provider in the prior payer(s) EOB. The submitted CARC(s) will then determine whether the COB claim will be processed as a primary or secondary claim.**

- **Partial co-pays will be applied if the patient's annual remaining co-pay balance is less than the co-pay amount due.**

CLAIM BALANCING TO BE ENFORCED

Claim balancing is a HIPAA requirement within the Version 4010 implementation. New York State Medicaid opted not to enforce the balancing requirement because the 4010 Implementation Guides do not provide clear and precise instructions. Analysis of submitted claims has confirmed that the balancing calculations within Version 4010 are not widely understood and many Coordination of Benefits (COB) claims would fail a true claim balancing edit if we enforced the requirement today.

The Version 5010 Implementation Guides (IG) describe in much greater detail how to create a balanced 837 transaction (Section 1.4.4 of any 837). As such, **with implementation of 5010 NYS Medicaid will begin strict enforcement of claim balancing.** Claim balancing compliance will allow the program to receive more qualitative and measurable information. The claim balancing edits will be checked as part of the front end pre-adjudication process. The following sections articulate the balancing equations that will be enforced.

Claim Charge Amount:

The total of all Line Item Charge Amount (Loop 2400; 837P SV102, 837I SV203 or 837D SV302) must equal the Total Claim Charge Amount Loop 2300, CLM02).

Claim Payment Amounts - Coordination of Benefits (COB):

This is only applicable to claims that have been adjudicated by prior payer(s). The balancing verification is performed on a payer by payer basis, starting with loop 2320. When the claim was adjudicated at the line level by the specific payer, line level balancing is performed first:

Line Level Balancing:

Each line (Loops 2400 through 2430) is balanced independently by adding the Service Line Paid Amount (SVD02) to the sum of all CAS Adjustment Amount(s) within the specific line and comparing the total to the Line Item Charge Amount (837P SV102, 837I SV203 or 837D SV302).

Claim Level Balancing:

A pointer in SVD01 joins the line information to the specific payer's claim level information by matching the value from SVD01 to the value in NM109 from loop 2330B, which is nested within the 2320 loop.

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For each payer, eMedNY adds all Service Line Paid Amounts (Loop ID-2430, SVD02) and subtracts any claim level adjustment amounts (Loop ID-2320, CAS Adjustment Amount(s)). Please Note that in adjustment segments, a positive amount decreases the payment, while negative amounts increase it. The result must equal the Payer Paid Amount (AMT02), as reported in AMT Segment (Coordination of Benefits (COB) Payer Paid Amount), in Loop ID-2320. This amount is identified by Qualifier "D" (Payer Amount Paid), in AMT01.

Please refer to Section 1.4.4 (Balancing) in any 837 Implementation Guide for additional information.

Claims that fail balancing compliance at any level, including line level, will be rejected and reported in the 277CA (Health Care Claim Acknowledgment) with the following Claim Status Category Code | Claim Status Code | Entity Code:

Claim Charge Amounts:	**A3|400|85**
Claim Payment Amounts:	**A3|400|PR**

It is extremely important that providers, as well as the vendors that service the eMedNY provider community, react to the front end responses sent by eMedNY. Claims rejected by the front end process are not reported in the Remittance Advice or any other transaction.

For those familiar with X12 formatting, please see the following link for an example of how claim balancing will be computed:

http://www.emedny.org/HIPAA/5010/transactions/5010_Claim_Balancing_Example.pdf

PHARMACY BILLING CHANGES FOR NCPDP D.0

Pharmacies will be required to implement the NCPDP D.0 format. The following are the primary changes that pharmacies will notice.

Expanded Prescription Service Reference Number

The Prescription Service Reference Number field 402-D2 will be expanded from 7 to 12 positions.

New Delay Reason Code field

Providers submitting via electronic NCPDP D.0 format real-time will now be able to submit over 90 day claims up to two years old from the date of service with a valid over 90 day reason in the new field 357-NV (Delay Reason Code) for claims capture and adjudication. Claims that are over 90 days submitted real-time via NCPDP D.0 with the Processor Control Number field completed and without a valid over 90 day Reason code will no longer become a non-capture transaction but instead will be denied.

Providers submitting electronic batch NCPDP D.0 claims that are over 90 days must use the new field (357-NV) to submit a valid over 90 day reason code. The current batch process will be disabled for version D.0.

Compound Drug Billing

For Compound drug billing, providers will be able to submit up to 25 ingredients (NDC's) using the Compound Segment via the NCPDP D.0 format. Compound drugs will be returned on the 835 Remittance Advice using the first ingredient's NDC Code of the Compound drug in SVC01-2 (Procedure Code) with an "N4" Qualifier in SVC01-1.

The Compound Code 99999999999 will not be allowed to be submitted on the NCPDP D.0 format. However, it will still be accepted on NCPDP 5.1 and paper claims prior to January 2012.

Card Sequence Numbers

The Card Sequence Number field 303-C3-(Person Code) will not be required in either the NCPDP D.0 or 5.1 format.

Coordination of Benefits (COB)

Providers submitting claims involving TPL- (Third Party Liability), Medicare Part B and Medicare MCO- (Medicare Managed Care Organization) via NCPDP D.0 will use new fields to report Patient Responsibility Amounts in the COB Segment:

- **Field 351-NP- (Other Payer Patient Responsibility Amount Qualifier)**
- **Field 352-NQ- (Other Payer Patient Responsibility Amount)**

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Post & Clear

Post & Clear processing will be discontinued, however, pharmacies who are designated swipers must continue to "swipe" the client card through the POS terminal using Tran Type 5 prior to submitting the pharmacy claim online.

DUR Overrides

Current eMedNY processing recognizes up to three drug conflict codes. They are provided in order of severity. An override claim may be submitted with a single override code that is appropriate for the first error and the claim will pay. Any warning errors must be omitted from the override claim.

In D.0, eMedNY will process up to nine drug conflict codes. If there is more than one DUR conflict type (DD, TD, and ER), an override for each type is required. If a warning code is received in the override, the claim will no longer be rejected because of the warning code.

REMITTANCE AND CHECK/ EFT PROCESSING

When the 5010 software is promoted:

- **Providers will continue to receive 835 remittance files in 4010 format until the receiver has submitted a form specifying they are ready to receive the 5010 format. Providers who have not voluntarily migrated to 5010 when the mandate date arrives will be automatically switched to the 5010 format.**
- **Supplemental files will report pended claims only. Denied claims with their proprietary edits are no longer available.**
- **The EFT Effective Date (BPR16) for EFT Remittance Advices will reflect the date funds are released. (Note: There are no changes to the existing funds release process or payment lag.)**
- **The reported prior payer amount (OA23) will reflect the prior payer payment plus any patient responsibility. This should eliminate credit balance issues impacting some providers' patient accounting systems.**
- **Checks that are reissued will contain the original check number on the stub portion of the check.**
- **For audit related recoveries of providers' funds, the audit number assigned by NYSDOH will be reported in PLB03-2 and will contain a prefix of "FMG#".**
    - ***The audit number will be reported only on the first remittance when the recovery begins.***
    - ***Subsequent remittances will report the remittance number associated with the first remittance the audit number was reported and will report a prefix of "RA#".***
    - ***If no audit number is assigned the financial control number will be reported in PLB03-2 with the prefix "FCN#".***

Other changes to remittance processing that will only impact the 5010 version include:

- **Claims that fail as duplicates of previously paid claims will contain the Transaction Control Number (TCN) of the conflicting claim.**
- **EFT transactions will be submitted using 'ACH' rather than 'FWT' in BPR04.**

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- **In today's process Claim Status Code (CLP02) code "4" is returned for all denied claims. For 5010 ONLY: CLP02 will report a "4" only when the client is not known. The following MMIS edits will trigger the "4" in CLP02:**

    - **00074 – Recipient ID Number Invalid**
    - **00140 – Recipient ID Number Not On File**
    - **01337 – Information Inconsistent For Family Health Plus Program**
    - **01496 – No Coverage Pending Family Health Plus**
    - **01497 – Family Health Plus Claim Not Covered**

If the claim does not fail one of these edits, CLP02 will be populated for paid and denied claims with the following codes:

- 1 – Paid As Primary
- 2 – Paid As Secondary
- 3 – Paid As Tertiary

All other denials will be represented by the Claim Adjustment Reason Codes and amounts reported in the CAS segments.

- There are no changes to the paper remittance except for pharmacy remittances where the prescription number will expand from 7 to 12 characters.

5010 IMPLEMENTATION WILL BRING ABOUT SUBSTANTIAL CHANGES TO ePACES

The 5010 implementation will also result in substantial changes to ePACES. The day following implementation, you will notice new screens and updated functionality.

Due to these changes all batches (claims, eligibility, etc.) begun prior to the implementation MUST be submitted prior to the implementation date. If batches are not submitted before the implementation date, they will be deleted due to the format and data content differences required after that date.

CSC will provide additional information and training for the new ePACES prior to implementation. Please continue to check www.emedny.org for additional information.

Note: ePACE users do not need to re-enroll.

eMedNY GATEWAY TO BE ELIMINATED

The eMedNY Gateway will be eliminated effective April 1, 2011. In order to be prepared for this implementation, eMedNY Gateway submitters are strongly encouraged to consider the alternative options currently available.

eMedNY eXchange

- Internet accessible.
- Easy to use – works just like an e-mail mailbox.
- No special scripting or software necessary to upload or download files.
- Files retained for 28 days after submission.
- ePACES User ID is used to access your eMedNY eXchange mailbox.
- All HIPAA x12 and NCPDP batch files supported.
- Can receive 835 Electronic Remits, PDF remits, PA Rosters.
- Provider test files supported.

FTP (Dial-up)

- For those without high speed internet access who wish to continue to use a dial-up method.
- Login and file transmission is fully scriptable.
- All HIPAA x12 and NCPDP Batch files supported.
- 835 electronic remits supported.
- Provider test files supported.
- **Note:** FTP does not support submission of Pharmacy (NCPDP 5.1) over 90 day old claims. These will be supported in the NCPDP D.0 format.

eMedNY Simple Object Access Protocol (SOAP) – Batch, Real-Time

- Trading Partners may use SOAP, and the underlining Service Oriented Architecture (SOA) for exchange of batch files with eMedNY.
- eMedNY SOAP is an XML based protocol which enables applications to exchange. information over Hyper Text Transfer Protocol (HTTP).
- The interface for this access method is completely user defined. Trading partners should discuss this option with their software vendor/programmer.
- Uses an existing FTP or ePACES user ID.
- All HIPAA x12 and NCPDP batch files are supported.
- 270 Eligibility and Meds History (NCPDP) are supported with Real-Time submission.
- **Note:** SOAP does not support submission of Pharmacy (NCPDP 5.1) over 90 day old claims. These will be supported in the NCPDP D.0 format.

Technical guides for each of these methods are posted in the Companion Guide section of the New York HIPAA Desk Support pages at: www.emedny.org. Software vendor listings are also available on the New York HIPAA Desk Support pages.

PROVIDER DIRECTORY

Provider Manuals/Companion Guides, Enrollment Information/Forms/Training Schedules:
Please visit the eMedNY Website at: www.emedny.org.

Questions about billing and performing MEVS transactions?
Please call the eMedNY Call Center at (800) 343-9000.

Provider Training:
To sign up for a provider seminar in your area, please enroll online at: http://www.emedny.org/training/index.aspx. For individual training requests, call (800) 343-9000 or e-mail: emednyproviderrelations@csc.com.

Enrollee Eligibility:
Call the Touchtone Telephone Verification System at any of the following numbers: (800) 997-1111, (800) 225-3040, (800) 394-1234.

Address Change?
Address changes should be directed to the eMedNY Call Center at: (800) 343-9000.

Fee-for-Service Providers: A change of address form is available at: http://www.emedny.org/info/ProviderEnrollment/allforms.html.

Rate-Based/Institutional Providers: A change of address form is available at: http://www.emedny.org/info/ProviderEnrollment/allforms.html.

Does your enrollment file need to be updated because you've experienced a change in ownership?
Fee-for-Service Providers please call (518) 402-7032.
Rate-Based/Institutional Providers please call (518) 474-3575.