Unit 8:
Provider - Invoicing

Version 4.6

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Document Revision History

Date	Release	Description
6/14/2016	4.6	• No Changes
10/27/2015	4.4	• Updated Same SA/New Claim functionality relating to Referring Provider NPI. The Referring Provider NPI entered on a claim will pre-populate on a subsequent claim, when using the Same SA/New Claim button.
9/22/2015	4.3	• Updated ICD Diagnosis Code information throughout. ICD-10 Codes are required for claiming services provided on or after 10/1/2015.
7/2015	4.2	• To support the Ordering/Prescribing/Referring/Attending (OPRA) requirements, the Referring Provider NPI is now required to be submitted with all non-vendor based claims. Non-vendor based claims include General Service, Service Coordination, and Evaluation claims. For electronically submitted claims, the Referring Provider NPI should be recorded in loop 2310A (see the NYEIS Companion Guide for further details). o Updated claim creation steps to account for new required Referring Provider NPI for General Service, Evaluation, and Service Coordination billing. Removed ABA Aide Services. o Updated Upload 837 and Submit Invoice steps to account for new language on invoice submission pages o Updated F-File "Pre-Invoice" Error Guidance to account for new rejections for missing and invalid referring provider NPI on submitted 837 files • Removed all mention of HIPAA 4010 standard for 837 billing • Removed Provider Notified of Rejected Claims
11/4/2014	4.01	• No Changes
1/16/2014	3.2.1	• No Changes
4/15/2013	2.1	• Updated sections detailing claim statuses to reflect new Status of 'System Approved' for claims that pass NYEIS invoicing rules. • Updated chapter to reflect further processing of post 4/1/13 submitted provider claims by SFA • Removed the steps pertaining to Municipal Review process for Provider claims
4/1/2013	2.0	• Based on changes to Public Health Law, a provider now enters into an Agreement with the Department in order to deliver and bill for services rendered. o Provider claim rules were modified to account for contracts ending 3/31/2013 and Provider Agreements effective 4/1/2013.

		○ Multiple updates to this unit to reflect the differences in Provider/Vendor invoice/claim statuses and processing, depending on claim submission date ○ Updated 837 billing section with revised steps for obtaining an ETIN to a given county
3/4/2013	1.6.2.1	• No changes
2/14/2013	1.6.2	• No Changes
7/19/2012	1.6.1	• No Changes
6/5/2012	1.6	• Updated Creating Invoices Section. • Modified Provider 837 (Electronic) Claiming Section to include information about the new HIPAA 5010 file format standards • Modified F-File Error Guidance Section • Added Tips for Reading the 999 Response File Section
10/21/2011	1.5	• Modified Submit Invoice Process • Added Muni Review Provider Invoice Section • Added Provider Notified of Rejected Claims Section • Enhanced documentation for Provider 837 Invoicing • Updated Claims Homepage screen shots • Updated statuses for Claims and Invoices
6/24/2011	1.4	• Corrected Service Coordination claiming minutes / units guide • Added Important Information box to Rendering Provider section in **Entering Invoices** subtopic. • Updated General Services Create Claim page screen shots
3/31/2011	1.3	• Updated Service Coordination Claim Home page screen shots in the **Creating Invoices**, **Invoice- SERVICE COORDINATION** subtopics.
1/31/2011	1.2	• Added **Provider Electronic (837) Clai**ming section.
11/22/2010	1.1	• Added **Request Provider Recoupment** section.
10/1/2010	1.0	• October 2010 NYEIS launch.

Table of Contents

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Provider Invoicing

Unit Overview

This unit describes the process of creating Invoices. Within the invoice are claims that contain details for each date a service is provided, and within that claim are service lines which supply the details about the procedure(s) performed during the service delivered. Invoices are created for all authorized services, such as Physical Therapy, Special Instruction, Respite, Transportation, Service Coordination and Assistive Technology Devices. Users will learn how to create, submit and search for Invoices and Claims as well as how to review the status of each. In addition, users will learn how to edit, delete or void Invoices and Claims.

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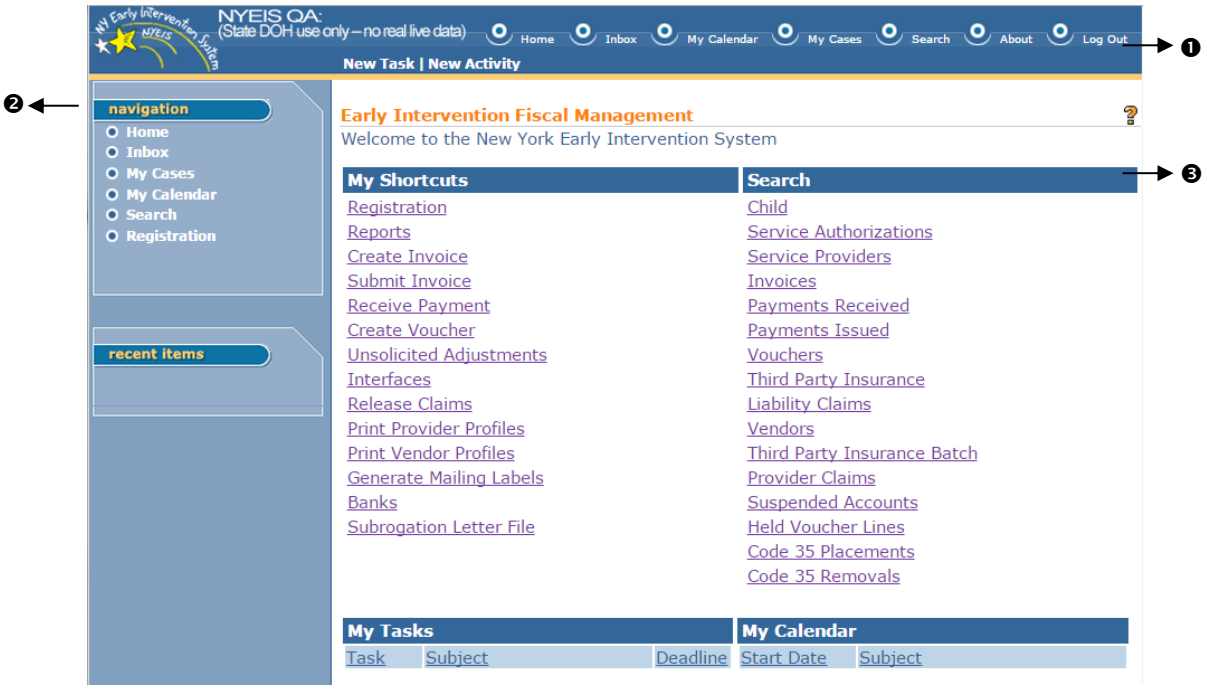
FINANCIAL HOME PAGE REVIEW



❶ **Menu Bar** - allows User to access frequently used shortcuts.

Home - returns User to personal Home Page (the first page a User comes to when logged in to NYEIS).

Inbox - navigates User to a page containing personal tasks.

My Calendar - navigates User to calendar where new or recurring activities are entered.

My Cases - navigates Service Coordinators and EIO/Ds to assigned Cases.

Search - displays a search page. *Use the **%** symbol in any of the search fields if the information to search for is unknown (e.g., if the first two letters of the individual's last name start with "SM", enter **sm%** and view results).*

About - displays NYEIS release version.

Log Out - exits NYEIS.

❷ **Navigation Bar** - directs User to different areas of the Application. The buttons or links will be different depending on the displayed page or the role of the User. The lower portion of the Navigation Bar contains a section called **Recent Items**. This section provides quick links to pages recently visited.

❸ **Body** - contains the following sections:

My Shortcuts - navigates User to different areas of the Application.

Search - navigates User to a specific Search page.

My Tasks - displays a list of the User's Tasks as links that navigate the User to the Task specific page. Tasks are work activities that have to be completed.

My Calendar - displays a list of events as links that navigate the User to the event.

INVOICES

This subgroup describes the process of creating an Invoice. Invoices are defined as the master document in which claims are contained for submission and payment.

Invoice
Top Level of Invoice that is unique by Provider of Record. The Provider of Record is the Provider that is assigned the Service Authorization.

Provider Claim
The second Level of Invoicing is the Provider Claim. Each Invoice can contain one or many Provider Claims. The Provider Claim is where the Child, Rendering Provider, Service Authorization and Date of Service are captured. Provider Claims are at the Visit Level and only one visit per Provider Claim is allowed. All Provider Claims within an Invoice *must* belong to the same Provider of Record. However, Provider Claims can be for different Children, Services, dates of service, or Rendering Providers.

Service Line
The third Level of an Invoice is the Service Line. Procedure Codes (HCPS, CPT, etc.) and their corresponding Units are captured at this Level. Only one visit per Claim can be captured at the above Provider Claim Level in order to allow for reimbursement by Commercial Insurance at the Procedure Code Level.

The flow for creating an Invoice is the same for either a Provider entering an Invoice online or a Municipality Financial User entering an Invoice that was submitted by a provider into NYEIS. The one difference is the Provider entering an Invoice will have the Provider of Record defaulted to themselves.

Important Information
The unique Invoice types such as Respite, Transportation and AT Device are typically provided by Vendors and not Providers. Some vendors may also be state-approved providers. These providers will also need to be entered into NYEIS as Vendors in order to be available to select when creating a vendor invoice. Vendors who are not state-approved providers do not have access to NYEIS; therefore, the Municipality must enter their Invoices into NYEIS. 📖 *See* **Unit 10: Municipal Administration, *Registering Vendors*** for further information.

A Provider that is also registered as a Vendor can enter both provider claims (General Service, Evaluation, Service Coordination) and vendor claims (AT Device, Transportation, Respite) in one invoice.

Creating Invoices

This process is followed when creating an Invoice.

- Invoice data can *only* be edited if the **Status** is **Draft**. Draft is defined as an Invoice that has not been submitted for approval into NYEIS. If a change is needed after an Invoice is submitted, then the Invoice *must* be voided and a new one created. If an Invoice is voided, all Claims associated with that Invoice will also be voided.

- A Provider Claim for each Service Authorization visit is submitted separately within an Invoice.

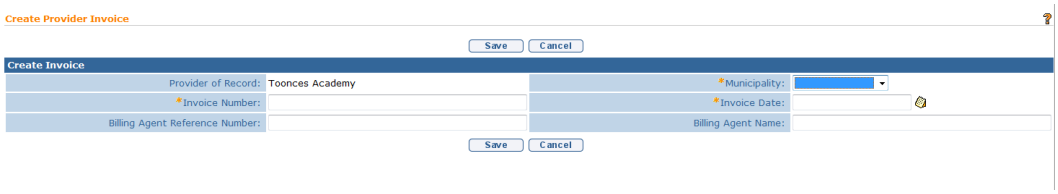
- Be aware that clicking the **Back** icon of Internet Browser during the creation of an invoice may cause the System to not capture the data properly and display an Error on the page. If this happens, the User should search for the Invoice and then check to see if the current Claim being entered displays in the list. If not, then the User should reenter the Claim and continue data entry. If the current Claim is displayed on the list, then the User can continue entering the next Claim.

- Only Service Authorizations that have been accepted are available for claiming. 🕮 *See* **Unit 6: IFSP & SA, *Accept/Reject Service Authorization*** for further information.

Important Information
A Provider may be eligible to submit Invoices for services rendered in multiple Municipalities. It is *important* that the Municipality entered for an Invoice *match* that of the specific Child's Municipality of Residence. **Municipality** *must* be selected.

1. Log in to NYEIS. User Home Page displays.

2. Click **Create Invoice** link under **My Shortcuts** section. **Create Provider Invoice** page displays.



3. Select **Provider** from the **Provider of Record** drop down. *If Provider is creating the Invoice, some field information will automatically be populated and the Search step below is not required.*

   Click **Search** icon for **Provider of Record** to identify Provider. **Provider Search** page displays. Type all known information in **Search Criteria** section. Click **Search** button. Records matching criteria display in **Search Results** section. *To search again, click **Reset** button.* Click **Select** link under **Action** column for Provider. **Create Provider Invoice** page displays.

4. Type unique **Invoice Number.** Invoice numbers are alpha-numeric and case sensitive; duplicates are not allowed. ***Invoice number** must be entered. Be sure to write down Invoice Number to search for at a later time.* **Municipality** defaults if the user is the Municipality.

Important Information
If the **Invoice Number** is unknown, the Provider name and the date the Invoice was created can be searched using the **Invoice Search** page. 🕮 *See* **Searching/Viewing Invoices** for further information.

Invoice numbers are case sensitive. Be sure to note the upper and lowercase letters when documenting an invoice number.

A Provider may be eligible to submit Invoices for services rendered in multiple Municipalities. It is *important* that the Municipality entered for an Invoice *match* that of the specific Child's Municipality of Residence. **Municipality** *must* be selected.

5. Select the **Municipality** from the drop-down that is associated with the Child/Children that the service(s) was/were provided to.

Important Information
A separate Invoice needs to be created for each Municipality that the Provider intends to bill. The Invoice can only include claims for services provided to Children associated with the same Municipality.

If the invoice is being created by a Municipal user, the Municipality billed will be set to the Municipality associated with the user entering the invoice.

6. Type **Invoice Date**. ***Invoice Date*** *must be entered. Date fields must be formatted as* ***mm/dd/yyyy*** *format.*

7. Click **Save** button. **Search Service Authorizations** page displays with the following sections: **Search Criteria** and **Search Results**.

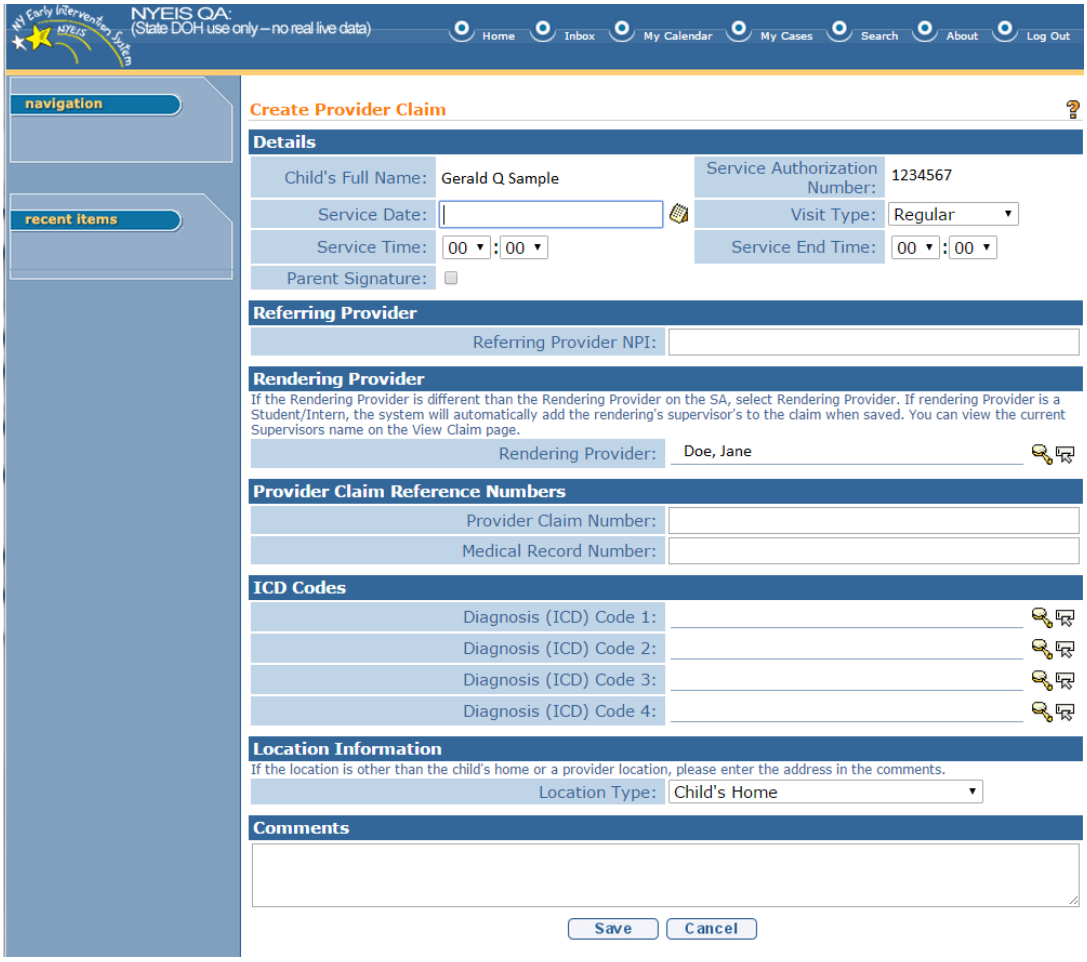
   To search for a specific Service Authorization for invoicing, type all known information in **Search Criteria** section. Click **Search** button. Records matching criteria display in **Search Results** section. *To search again, click* ***Reset*** *button.*

   To view a Service Authorization, click **View** link under **Action** column for Service Authorization. The Service Authorization can be reviewed to verify remaining visits, effective dates and availability of co-visits and/or make up visits, etc. After reviewing, click **Close** button. 🕮 *See* **Unit 6: IFSP & SA** for further information regarding Service Authorizations.

   To select a specific Service Authorization, click **Select** link under **Action** column for Service Authorization. **Create Provider Claim** page displays with the following sections: **Details**, **Referring Provider**, **Rendering Provider**,

Provider Claim Reference Numbers, **ICD Codes**, **Location Information** and **Comments**.

*In the **Details** section, the **Child's Full Name** and **Service Authorization Number** selected displays. In the **Rendering Provider** section, the name of the Rendering Provider displays.*



8. Navigate from field-to-field in **Create Provider Claim** page using **Tab** key; enter information. *Date fields must be formatted as **mm/dd/yyyy** format.*

   Service Date, **Service Time**, **Service End Time** and **Diagnosis (ICD) Code** are *required* fields.

   Details section:

   - **Service Date** is the date the service is delivered and is validated against the **Service Authorization Start/End Date**.

   - **Service Start/End Time** are in 24 hour time format.

- **Visit Type** *must* be provided by the Provider to indicate type of service being billed. Options are: **Regular** (for any regularly scheduled visit), **Co-Visit** (if agreed to authorized on the IFSP) or **Makeup Visit** (if agreed to and authorized on the IFSP). The number of visits is authorized on the Service Authorization. NYEIS will automatically reduce the total visits each time a visit is billed.

- **Parent Signature** checkbox indicates that a Parent Signature is on file with the Provider. The delivery of some EI services does not require a parent signature (for example Service Coordination). If the service delivered does not require the provider to maintain a parent signature, this box does not need to be checked.

Referring Provider section:

- **The Referring Provider NPI** is required for all General Service, Evaluation, and Service Coordination billing. A claim will not save with a missing or invalid referring provider NPI.

Rendering Provider section:

➲ **The Rendering Provider** is auto populated with the Rendering Provider assigned on the Service Authorization. If the Rendering Provider that delivered the service is different than the Rendering Provider assigned on the Service Authorization, the appropriate Rendering Provider should be selected on the claim.

Important Information

➲ For Core Evaluation claims, the Rendering Provider field is auto-populated with the name of only one of the Rendering Providers that conducted the MDE.

Provider Claim Reference Numbers section:

- **Provider Claim Number** is the unique internal tracking number assigned to a Claim by the Provider of Record. If this number is not assigned by the Provider of Record, NYEIS will automatically generate a claim number.

- **Medical Record Number** can be used for the Provider's internal use. It is not required.

ICD Codes section:

- **ICD Codes** allows the Provider to enter three ICD Codes (which have previously been entered on the child's record) and one additional ICD Code (which may or may not have been previously entered on the child's record).

- To add data for the **Diagnosis (ICD) Code 1** field, select the **Search** icon. Type all known information in **Search Criteria** section. (ICD Codes, if available, will be one or more previously documented ICD Codes in the child's case.) Click **Search** button. Records matching the search criteria display in **Search Results** section. If applicable, select the most appropriate code for *the service delivered.*

  *Click **Select** link under **Action** column to* identify **ICD Code**. **Create Provider Claim** page displays.

- To add data for the **Diagnosis (ICD) Codes 2 and 3** fields, repeat the above step.

- To add data for the **Diagnosis (ICD) Code 4** field, select the **Search** icon. Type all known information in **Search Criteria** section. (**Diagnosis (ICD) Code 4** can be selected from the list of all available ICD Codes.) Click **Search** button. Records matching the search criteria display in **Search Results** section. If applicable, select the most appropriate code *for the service delivered*. *To search again, click **Reset** button.*

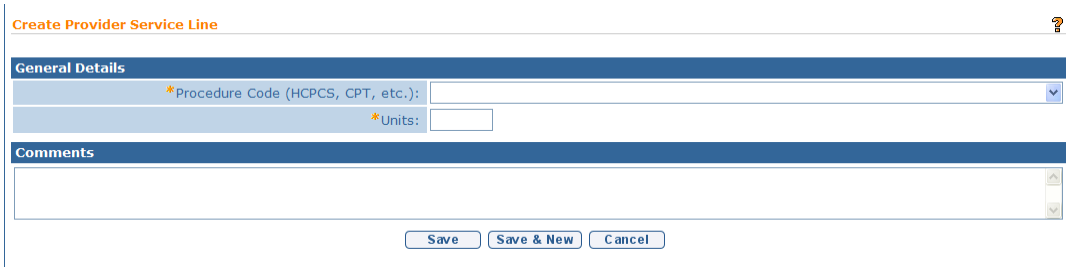
  *Click **Select** link under **Action** column to identify* **ICD Code**. **Create Provider Claim** page displays.

Important Information
If the EIP provider determines that there is no appropriate ICD code applicable to the service(s) being delivered in the child's record (e.g., child's health assessment or child's multidisciplinary evaluation, prescriptions, written orders, written recommendations, or referrals), the EIP provider is responsible for securing and providing accurate and appropriate diagnosis codes for Early Intervention services provided to children and families in the EIP, consistent with the scope of practice of his or her professional license, certification, or registration. Users with access rights can add these ICD codes to the child's record in NYEIS via the **Health Assessments** link found on the child's integrated case homepage.

Location Information section:

- **Location Information** currently displays the location defined from the Service Authorization. If services were performed in a location different than what was originally specified in the Service Authorization, select the location of services.

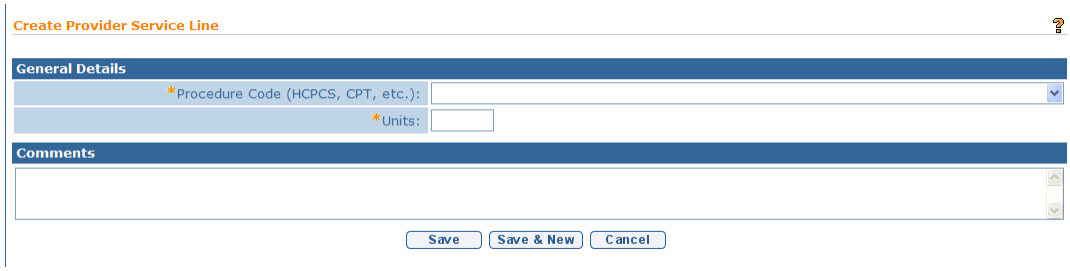
9. Click **Save** button. **Create Provider Service Line** page displays.



10. Select the **Procedure Code (HCPCS, CPT, etc.)** from the drop down and enter the number of **Units** for Service Line. *The **Procedure Code (HCSPC, CPT, etc.)** field and **Units** field must be entered.*

    Some Procedure Codes (HCPCS, CPT, etc.) have a number of minutes associated with them. Based on the code reported by the Provider, the number of units billed for that Procedure Code *must* be indicated. For example, if a Provider uses a code with a 15 minute association, and the Provider worked with the Child for 30 minutes, the units on the Claim would be two. NYEIS does not validate whether the number of units entered for a Procedure Code is appropriate based on the length of the visit. It is the Provider's responsibility to enter the correct number of units for a claim.

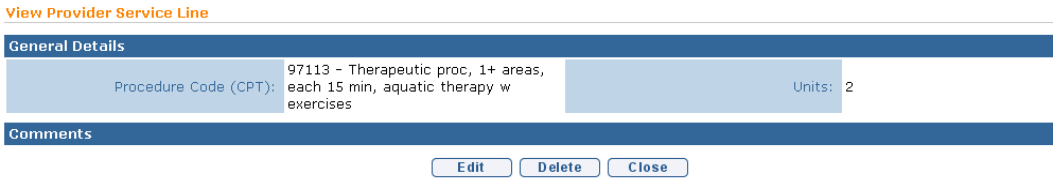
Important Information
Claims that require a Procedure Code will be denied if they are submitted without a Procedure Code selected. 🕮 *See* **Claims** for more information.



11. Click **Save** button. **Provider Claim Home** page displays. *Click **Save & New** button from the **Create Provider Service Line** page to add additional Procedure Codes.*

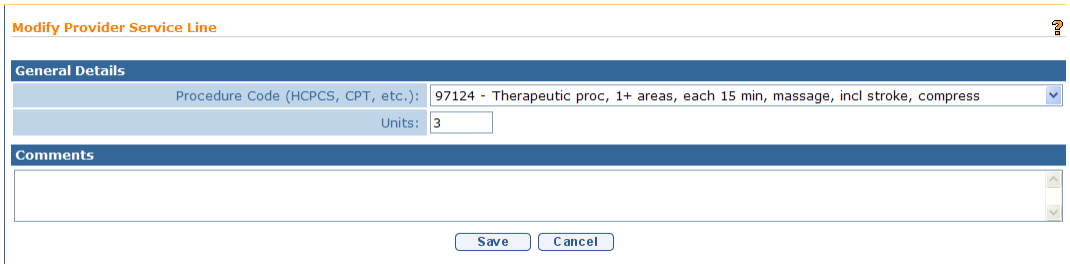
    The following options are available for **Service Lines** section:

    ➲ Click **View** link under **Action** column. **View Provider Service Line** page displays. *This page also gives the capability to **Edit** or **Delete** a Provider Service Line.*



    OR

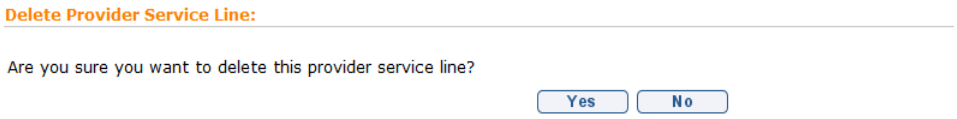
    ➲ Click **Edit** link under **Action** column. **Modify Provider Service Line** page displays.



    Edit **Procedure Code (HCPCS, CPT, etc.)**. Edit **Comments** as needed. Click **Save** button. **Provider Claim Home** page displays.

    OR

    ➲ Click **Delete** link under **Action** column. **Delete Provider Service Line** page displays the message ***Are you sure you want to delete this provider service line?*** Click **Yes** button. **Provider Claim Home** page displays.



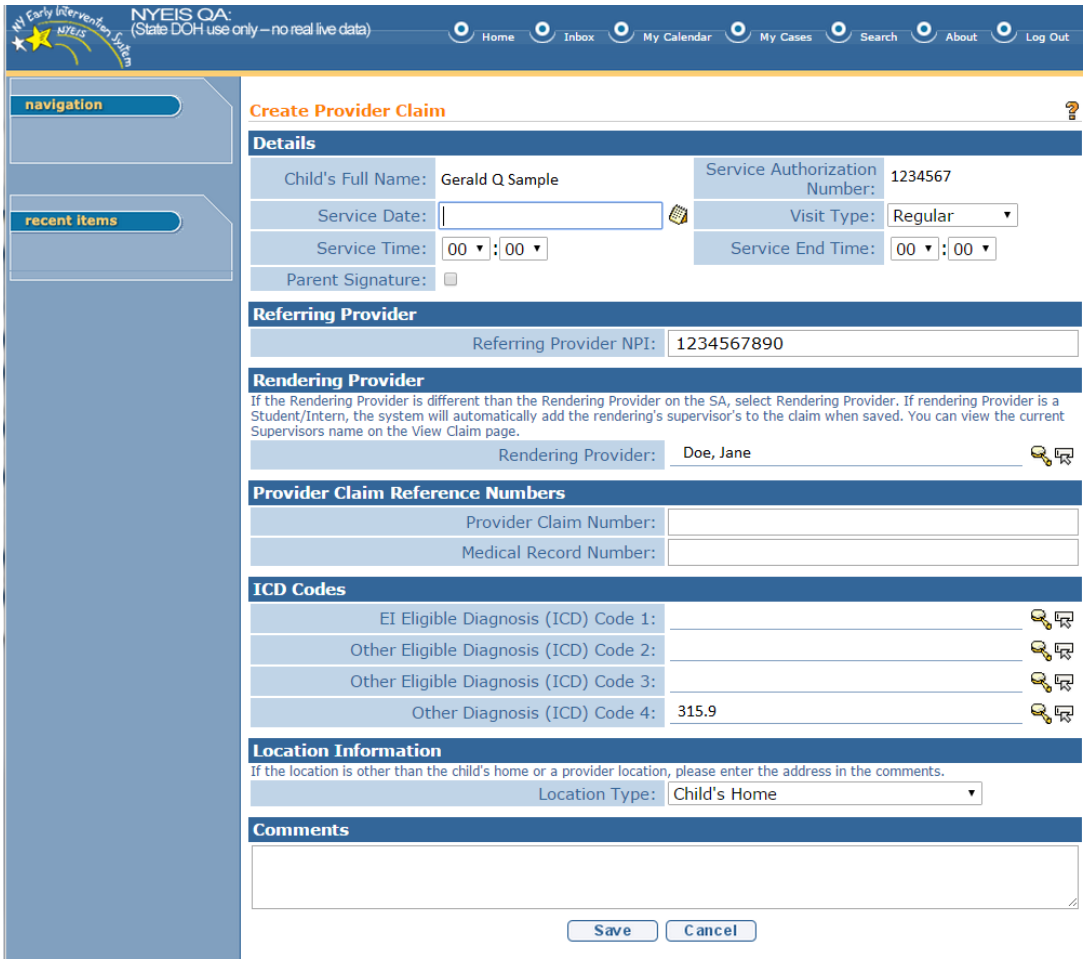
Important Information
Claims that require a Procedure Code will be denied if they are submitted with no Procedure code selected.

Notes:

- **Rate Codes** and **Rate Amounts** are generated by NYEIS and are *read-only*.
- The **Claim Status** field is in **Open** status until the Invoice has been submitted and processed in the nightly batch. The system will determine if the claim passes the billing rules during the nightly batch. The **Claim Status** field is then updated.
- The **Claim Status** is set to **System Approved** if a claim is submitted and passes the billing rules.
- The **Claim Status** is set to **Pending** if a Claim is submitted and it violates a billing rule for which an upfront waiver has been denied and requires the provider to submit a justification. 🕮 *See* **Waivers** for further information.
- The **Claim Status** is set to **Denied** if a Claim will not be paid due to a billing rule violation.
- If a claim is submitted where the time overlaps with another claim from another provider by more than 9 minutes, the claim will be denied. Visits that will overlap for more than 9 minutes must be authorized on the SA as co-visits and claimed as co-visits. 🕮 *See* **Unit 6: IFSP & SA, *Adding Service Authorizations to Individualized Family Service Plans*** for further information.

Same SA/New Claim

1. Click **Same SA/New Claim** button for another Claim visit with the same Service Authorization. **Create Provider Claim** page displays with the following sections: **Details**, **Referring Provider, Rendering Provider**, **Provider Claim Reference Numbers**, **ICD Codes**, **Location Information** and **Comments**.



2. Navigate from field-to-field using **Tab** key; enter information. *Date fields must be formatted as **mm/dd/yyyy** format.*

   Child's Full Name, **Service Authorization Number**, **Referring Provider NPI, Rendering Provider, Diagnosis (ICD) Codes** and **Location Information** are entered from the prior Claim. **Referring Provider NPI**, **Rendering Provider, Diagnosis (ICD) Codes** and **Location Information** may be edited.

   - A **Referring Provider NPI** is *required*. Claims with missing or invalid referring provider NPI will not be allowed to save. The Referring Provider NPI pre-populated from the prior claim may be edited.

   - To add data for the **Diagnosis (ICD) Code 1** field, select the **Search** icon. Type all known information in **Search Criteria** section. (ICD Codes, if available, will be one or more previously documented ICD Codes in the child's case.) Click **Search** button. Records matching the search criteria display in **Search Results** section. If applicable, select the most appropriate code for *the service delivered.*

*Click **Select** link under **Action** column to* identify **ICD Code**. **Create Provider Claim** page displays.

- To add data for the **Diagnosis (ICD) Codes 2 and 3** fields, repeat the above step.

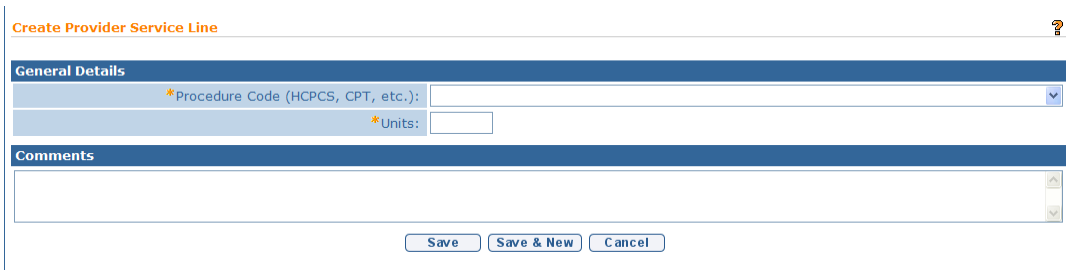
- To add data for the **Diagnosis (ICD) Code 4** field, select the **Search** icon. Type all known information in **Search Criteria** section. (**Diagnosis (ICD) Code 4** can be selected from the list of all available ICD Codes.) Click **Search** button. Records matching the search criteria display in **Search Results** section. If applicable, select the most appropriate code *for the service delivered*. *To search again, click **Reset** button.*

  *Click **Select** link under **Action** column to identify* **ICD Code**. **Create Provider Claim** page displays.

Important Information
If the EIP provider determines that there is no appropriate ICD code applicable to the service(s) being delivered in the child's record (e.g., child's health assessment or child's multidisciplinary evaluation, prescriptions, written orders, written recommendations, or referrals), the EIP provider is responsible for securing and providing accurate and appropriate diagnosis codes for Early Intervention services provided to children and families in the EIP, consistent with the scope of practice of his or her professional license, certification, or registration. Users with access rights can add these ICD codes to the child's record in NYEIS via the **Health Assessments** link found on the child's integrated case homepage.

Service Date, **Service Time**, **Service End Time**, **Visit Type, Referring Provider NPI, Rendering Provider** and **Diagnosis (ICD) Code** are *required* fields.

3. Click **Save** button. **Create Provider Service Line** page displays.



4. Select the **Procedure Code** (**HCPCS**, **CPT, etc.**) and **Units** for Service Line. *The **Procedure Code (HCPCS, CPT, etc.)** field and **Units** field must be entered.*

   Some Procedure Codes have a number of minutes associated with them. Based on the code reported by the Provider, the number of units billed for that Procedure Code *must* be indicated. For example, if a Provider uses a code with a 15 minute association, and the Provider worked with the Child for 30 minutes, the units on the Claim would be two. NYEIS does not validate whether the number of units entered for a Procedure Code is appropriate based on the length of the visit. It is the provider's responsibility to enter the correct number of units for a claim.

   Important Information
   Claims that require a Procedure Code will be denied if they are submitted with no Procedure code selected. 🕮 *See* **Claims** for more information.

5. Click **Save** button. **Provider Claim Home** page displays with the Procedure Code previously entered automatically populated in the field. *Click **Save & New** button from the **Create Provider Service Line** page to add additional Procedure Codes (HCPCS, CPT, etc.).*

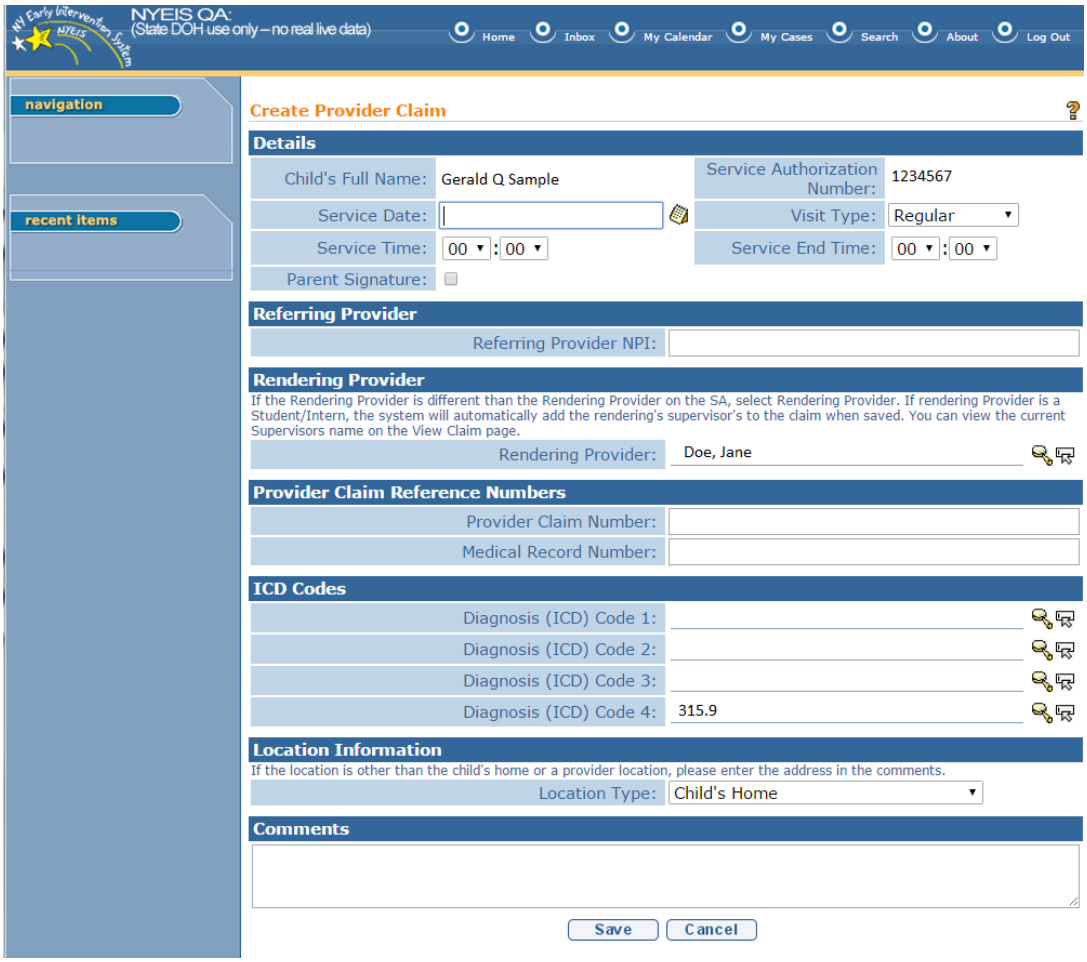
New SA/New Claim

1. Click **New SA/New Claim** button for a Claim visit with a new Service Authorization. **Search Service Authorizations** page displays with the following sections: **Search Criteria and Search Results**.

   To search for a specific Service Authorization for invoicing, type all known information in **Search Criteria** section. Click **Search** button. Records matching criteria display in **Search Results** section. To search again, click **Reset** button.
   To view a Service Authorization, click **View** link under **Action** column for Service Authorization. The Service Authorization can be reviewed to verify remaining visits, effective dates, and availability of co-visits and/or make up visits, etc. After reviewing, click **Close** button. 🕮 *See* **Unit 6: IFSP & SA** for further information regarding Service Authorizations.

   To select a specific Service Authorization, click **Select** link under **Action** column for Service Authorization. **Create Provider Claim** page displays with the following sections: **Details**, **Referring Provider**, **Rendering Provider**, **Provider Claim Reference Numbers**, **ICD Codes**, **Location Information** and **Comments**.

*In the **Details** section, the **Child's Full Name** and **Service Authorization Number** selected displays.*



2. Navigate from field-to-field in **Create Provider Claim** page using **Tab** key; enter information. *Date fields must be formatted as **mm/dd/yyyy** format.*

   Service Date, Service Time, **Service End Time**, and **Diagnosis (ICD) Code** are *required* fields**.**

   - **Check Parent Signature check box to indicate parent signature is on file for the services as delivered.** The delivery of some EI services does not require a parent signature (for example Service Coordination). If the service delivered does not require the provider to maintain a parent signature, this box does not need to be checked.

   Details section:

   - **Service Date** is the date the service is delivered and is validated against the **Service Authorization Start/End Date**.

- **Service Start/End Time** are in 24 hour time format.

- **Visit Type** *must* be provided by the Provider to indicate type of service being billed. Options are: **Regular** (for any regularly scheduled visit), **CoVisit** (if agreed to authorized on the IFSP) or **Makeup Visit** (if agreed to and authorized on the IFSP). Number of visits is authorized on Service Authorization. NYEIS will automatically reduce the total visits each time a visit is billed.

- **Parent Signature** checkbox indicates that a Parent Signature is on file with the Provider. The delivery of some EI services does not require a parent signature (for example Service Coordination). If the service delivered does not require the provider to maintain a parent signature, this box does not need to be checked.

Referring Provider section:

- **The Referring Provider NPI** is required for all General Service, Evaluation, and Service Coordination billing. A claim will not save with a missing or invalid referring provider NPI.

Rendering Provider section:

- ➲ **The Rendering Provider** is auto populated with the Rendering Provider assigned on the Service Authorization. If the Rendering Provider that delivered the service is different than the Rendering Provider assigned on the Service Authorization, the appropriate Rendering Provider should be selected on the claim.

Provider Claim Reference Numbers section:

- **Provider Claim Number** is the unique internal tracking number assigned to a Claim by the Provider of Record. If this number is not assigned by the Provider of Record, NYEIS will automatically generate a claim number.

- **Medical Record Number** can be used for the Provider's internal use. It is not required.

ICD Codes section:

- **ICD Codes** allows the Provider to enter three ICD Codes (which have previously been entered on the child's record) and one additional ICD Code (which may or may not have been previously entered on the child's record).

- To add data for the **Diagnosis (ICD) Code 1** field, select the **Search** icon. Type all known information in **Search Criteria** section. (ICD Codes, if available, will be one or more previously documented ICD Codes in the child's case.) Click **Search** button. Records matching the search criteria display in **Search Results** section. If applicable, select the most appropriate code for *the service delivered.*

  *Click **Select** link under **Action** column to* identify **ICD Code**. **Create Provider Claim** page displays.

- To add data for the **Diagnosis (ICD) Codes 2 and 3** fields, repeat the above step.

- To add data for the **Diagnosis (ICD) Code 4** field, select the **Search** icon. Type all known information in **Search Criteria** section. (**Diagnosis (ICD) Code 4** can be selected from the list of all available ICD Codes.) Click **Search** button. Records matching the search criteria display in **Search Results** section. If applicable, select the most appropriate code *for the service delivered*. *To search again, click **Reset** button.*

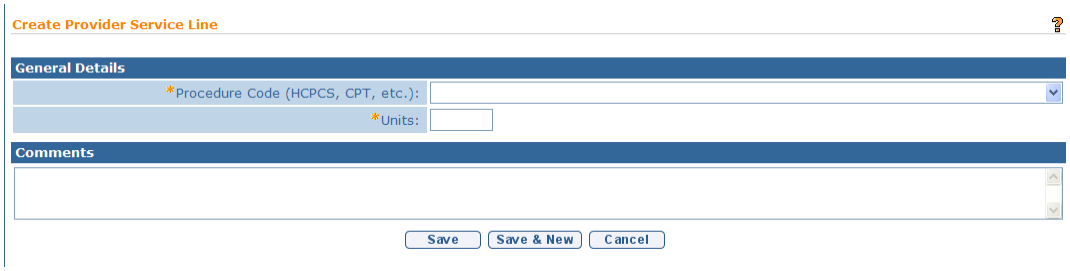
  *Click **Select** link under **Action** column to identify* **ICD Code**. **Create Provider Claim** page displays.

Important Information
If the EIP provider determines that there is no appropriate ICD code applicable to the service(s) being delivered in the child's record (e.g., child's health assessment or child's multidisciplinary evaluation, prescriptions, written orders, written recommendations, or referrals), the EIP provider is responsible for securing and providing accurate and appropriate diagnosis codes for Early Intervention services provided to children and families in the EIP, consistent with the scope of practice of his or her professional license, certification, or registration. Users with access rights can add these ICD codes to the child's record in NYEIS via the **Health Assessments** link found on the child's integrated case homepage.

Location Information section:

- **Location Information** currently displays the location defined from the Service Authorization. If services were performed in a location different than what was originally specified in the Service Authorization, select the location of services.

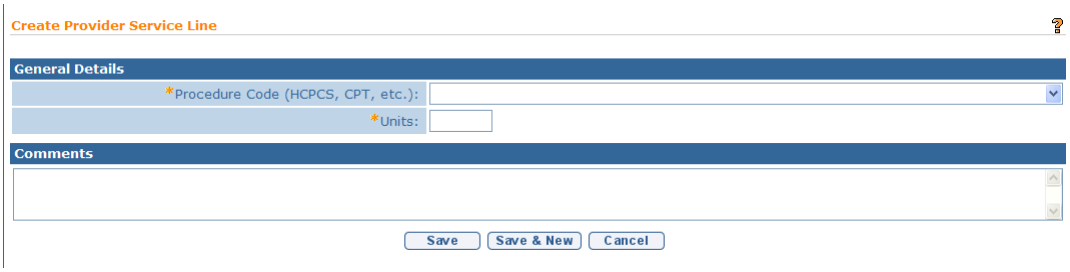
3. Click **Save** button. **Create Provider Service Line** page displays.



4. Select the **Procedure Code (HCPCS, CPT, etc.)** from the drop down and **Units** for Service Line. *The **Procedure Code (HCPCS, CPT, etc.)** field and **Units** field must be entered.*

   Some Procedure Codes have a number of minutes associated with them. Based on the code reported by the Provider, the number of units billed for that Procedure Code *must* be indicated. For example, if a Provider uses a code with a 15 minute association, and the Provider worked with the Child for 30 minutes, the units on the Claim would be two. NYEIS does not validate whether the number of units entered for a Procedure Code is appropriate based on the length of the visit. It is the provider's responsibility to enter the correct number of units for a claim.

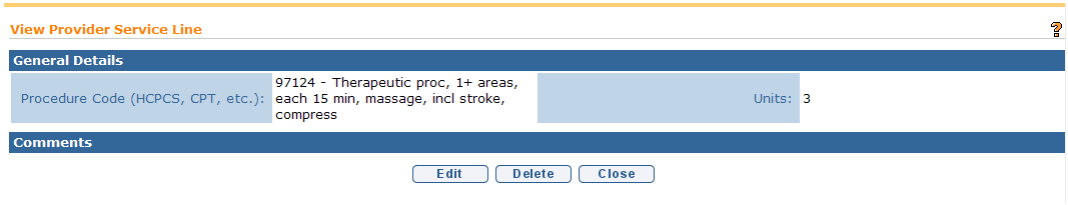
Important Information
Claims that require a Procedure Code will be denied if they are submitted with no Procedure code selected. 🕮 *See* **Claims** for more information.



5. Click **Save** button. **Provider Claim Home** page displays. *Click **Save & New** button from the **Create Provider Service Line** page to add additional Procedure Codes.*

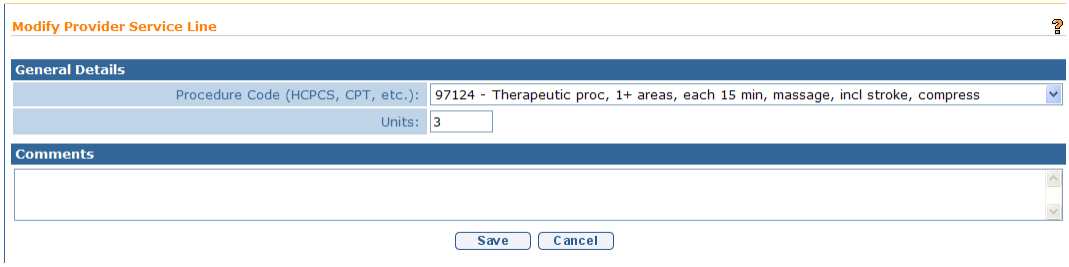
   The following options are available for **Service Lines** section:

   ➲ Click **View** link under **Action** column. **View Provider Service Line** page displays. *This page also gives the capability to **Edit** or **Delete** a Provider Service Line.*



   OR

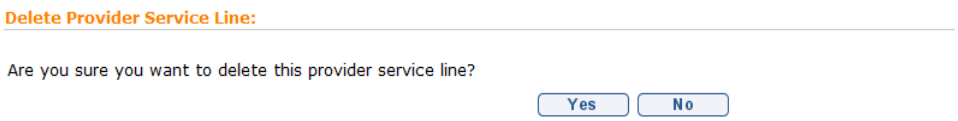
   ➲ Click **Edit** link under **Action** column. **Modify Provider Service Line** page displays.



Edit **Procedure Code (HCPCS, CPT, etc.)**. Edit **Comments** as needed. Click **Save** button. **Provider Claim Home** page displays.

OR

➲ Click **Delete** link under **Action** column. **Delete Provider Service Line** page displays the message ***Are you sure you want to delete this provider service line?*** Click **Yes** button. **Provider Claim Home** page displays.



Notes:

- **Rate Codes** and **Rate Amounts** are generated by NYEIS and are *read-only*.
- The **Claim Status** field is in **Open** status until the Invoice has been submitted and processed in the nightly batch. The system will determine if the claim passes the billing rules during the nightly batch. The **Claim Status** field is then updated.
- The **Claim Status** is set to **System Approved** if a claim is submitted and passes the billing rules.
- The **Claim Status** is set to **Pending** if a Claim is submitted and it violates a billing rule for which an upfront waiver has been denied and requires the provider to submit a justification. 🕮 *See* **Waivers** for further information.
- The **Claim Status** is set to **Denied** if a Claim will not be paid due to a billing rule violation.
- If a claim is submitted where the time overlaps with another claim from another provider by more than 9 minutes, the claim will be denied. Visits that will overlap for more than 9 minutes must be authorized on the SA as co-visits and claimed as co-visits. 🕮 *See* **Unit 6: IFSP & SA, *Adding Service Authorizations to Individualized Family Service Plans*** for further information.

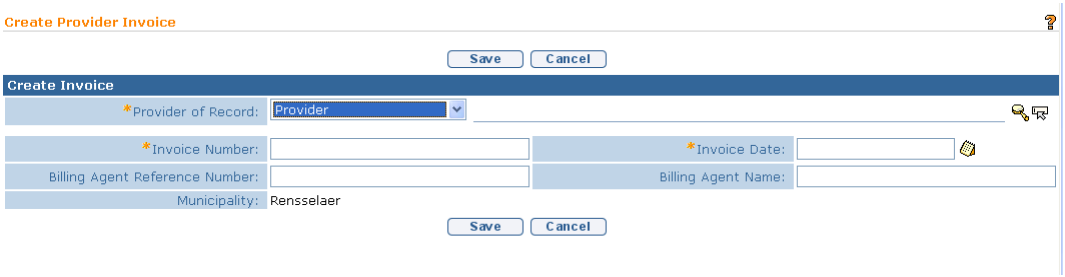
Invoice – SERVICE COORDINATION

A specific process is followed when creating an Invoice(s) for ***Service Coordination*** Claims.

Invoice data can *only* be edited if the **Status** is **Draft**. Draft is defined as an Invoice that has not been submitted for approval into NYEIS. If a change is needed after an Invoice is submitted, then the Invoice *must* be voided and a new one created.

1. Log in to NYEIS. User Home Page displays.

2. Click **Create Invoice** link under **My Shortcuts** section. **Create Provider Invoice** page displays.



3. Select **Provider** from the **Provider of Record** drop down. *If Provider is creating the Invoice, some field information will automatically be populated and the Search step below is not required.*

   Click **Search** icon for **Provider of Record** to identify Provider. **Provider Search** page displays. Type all known information in **Search Criteria** section. Click **Search** button. Records matching criteria display in **Search Results** section. *To search again, click **Reset** button.* Click **Select** link under **Action** column for Provider. **Create Provider Invoice** page displays.

4. Type unique **Invoice Number.** Invoice numbers are alpha-numeric and case sensitive; duplicates are not allowed. ***Invoice number** must be entered. Be sure to write down Invoice Number to search for at a later time.* **Municipality** defaults if the user is the Municipality.

Important Information
If the **Invoice Number** is unknown, the Provider name and the date the Invoice was created can be searched using the **Invoice Search** page. 🕮 *See* **Searching/Viewing Invoices** for further information.

Invoice numbers are case sensitive. Be sure to note the upper and lowercase letters when documenting an invoice number.

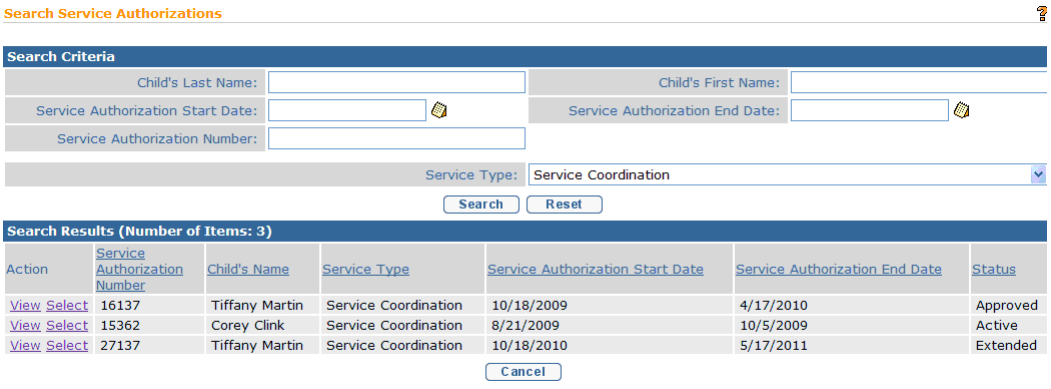
A Provider may be eligible to submit Invoices for services rendered in multiple Municipalities. It is *important* that the Municipality entered for an Invoice *match* that of the specific Child's Municipality of Residence. **Municipality** *must* be selected.

5. Select the **Municipality** from the drop-down that is associated with the Child/Children that the service(s) was/were provided to.

Important Information
A separate Invoice needs to be created for each Municipality that the Provider intends to bill. The Invoice can only include claims for services provided to Children associated with the same Municipality.

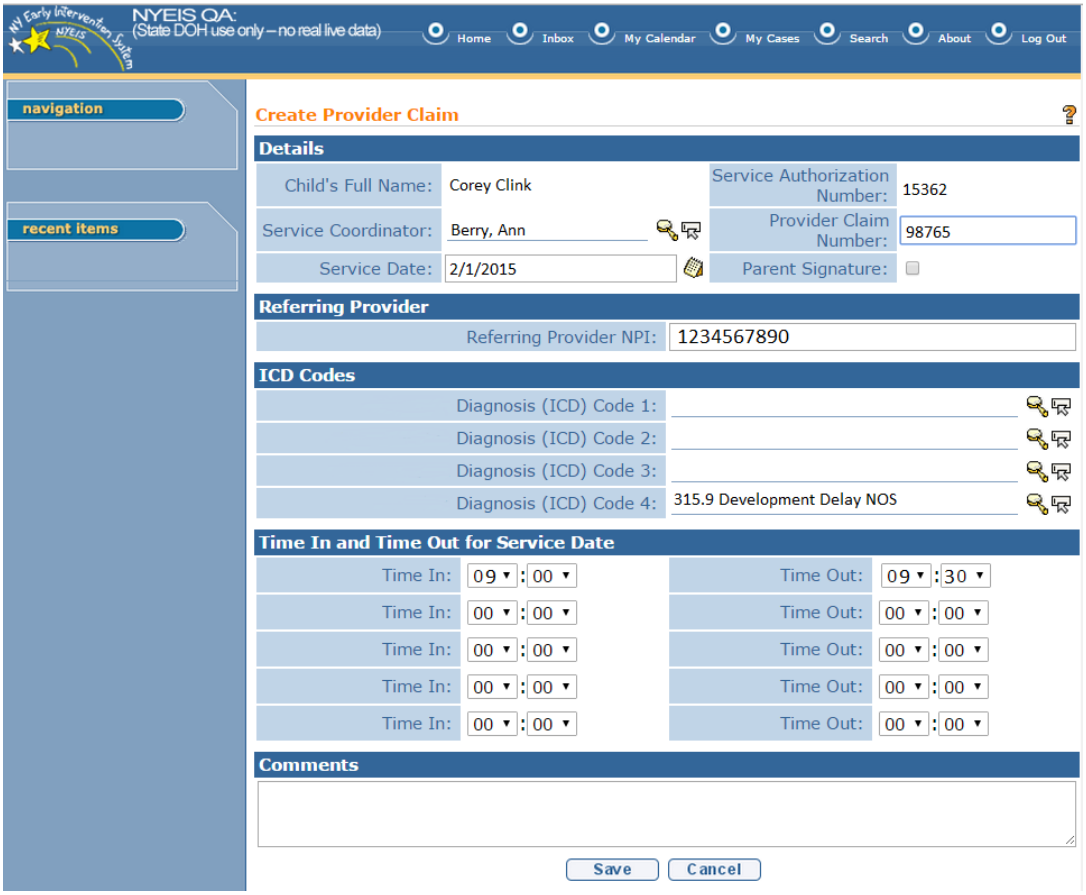
6. Type **Invoice Date**. ***Invoice Date*** *must be entered. Date fields must be formatted as* ***mm/dd/yyyy*** *format.*

7. Click **Save** button. **Search Service Authorization Number** page displays.



8. Review the list of **Available Service Authorizations**. Click **Select** link under **Action** column for the Service Authorization of choice. **Create Provider Claim** page displays.

To view a Service Authorization, click **View** link under **Action** column for Service Authorization. The Service Authorization can be reviewed to verify remaining visits, effective dates and availability of co-visits and/or make up visits, etc. After reviewing, click **Close** button. *See* **Unit 6: IFSP & SA** for further information regarding Service Authorizations.



9. Record the **Service Date** and **Provider Claim Number** in the Details cluster. Check Parent Signature check box to indicate parent signature is on file on the IFSP agreeing to the SC services as outlined. The delivery of some EI services does not require a parent signature (for example Service Coordination). If the service delivered does not require the provider to maintain a parent signature, this box does not need to be checked.

10. Enter **Referring Provider NPI Number.** The Referring Provider NPI is required for all General Service, Evaluation, and Service Coordination billing. A claim will not save with a missing or invalid referring provider NPI.

11. ICD Codes

- **ICD Codes** allows the Provider to enter three ICD Codes (which have previously been entered on the child's record) and one additional ICD Code (which may or may not have been previously entered on the child's record).

- To add data for the **Diagnosis (ICD) Code 1** field, select the **Search** icon. Type all known information in **Search Criteria** section. (ICD Codes, if available, will be one or more previously documented ICD Codes in the child's case.) Click **Search** button. Records matching the search criteria display in **Search Results** section. If applicable, select the most appropriate code for *the service delivered.*

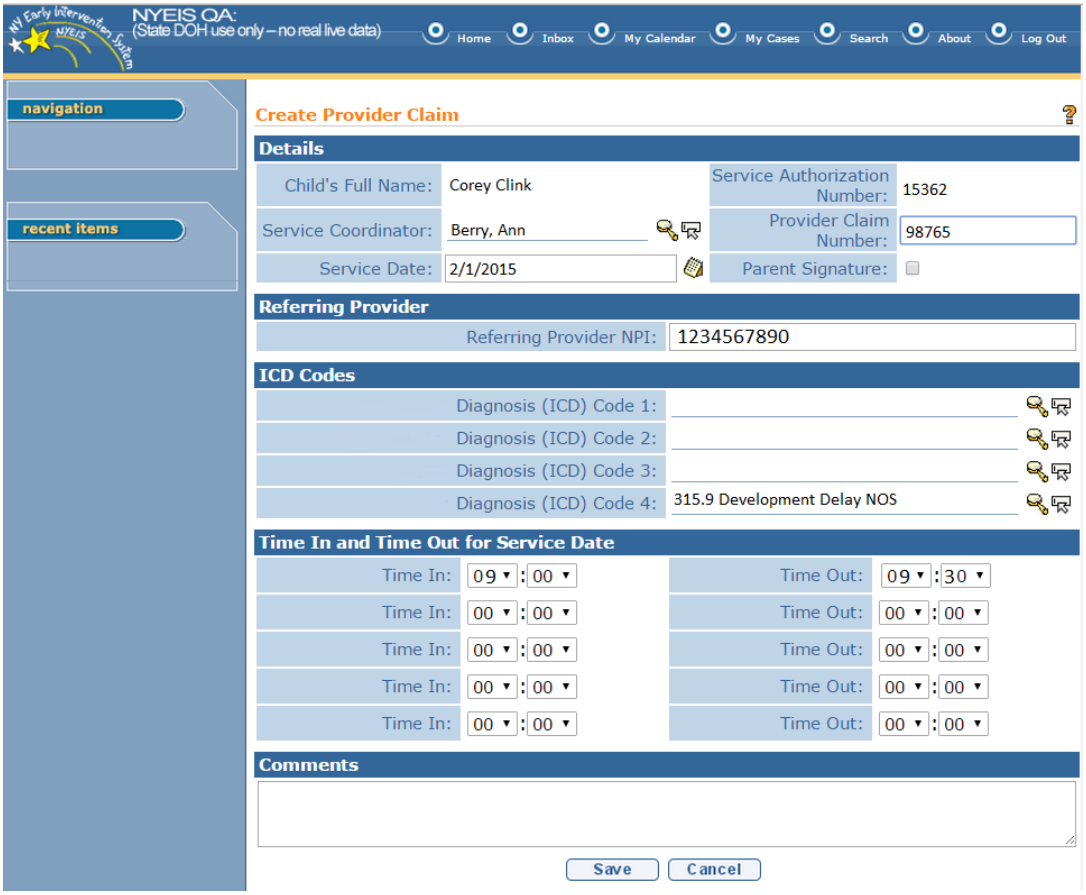
  *Click **Select** link under **Action** column to* identify **ICD Code**. **Create Provider Claim** page displays.

- To add data for the **Diagnosis (ICD) Codes 2 and 3** fields, repeat the above step.

- To add data for the **Diagnosis (ICD) Code 4** field, select the **Search** icon. Type all known information in **Search Criteria** section. (**Diagnosis (ICD) Code 4** can be selected from the list of all available ICD Codes.) Click **Search** button. Records matching the search criteria display in **Search Results** section. If applicable, select the most appropriate code *for the service delivered*. *To search again, click **Reset** button.*

  *Click **Select** link under **Action** column to identify* **ICD Code**. **Create Provider Claim** page displays.

Important Information
If the EIP provider determines that there is no appropriate ICD code applicable to the service(s) being delivered in the child's record (e.g., child's health assessment or child's multidisciplinary evaluation, prescriptions, written orders, written recommendations, or referrals), the EIP provider is responsible for securing and providing accurate and appropriate diagnosis codes for Early Intervention services provided to children and families in the EIP, consistent with the scope of practice of his or her professional license, certification, or registration. Users with access rights can add these ICD codes to the child's record in NYEIS via the **Health Assessments** link found on the child's integrated case homepage.



12. Select/Enter the **Time In** and **Time Out** for the service. Click **Save** button. **Provider Claim Home** page displays.

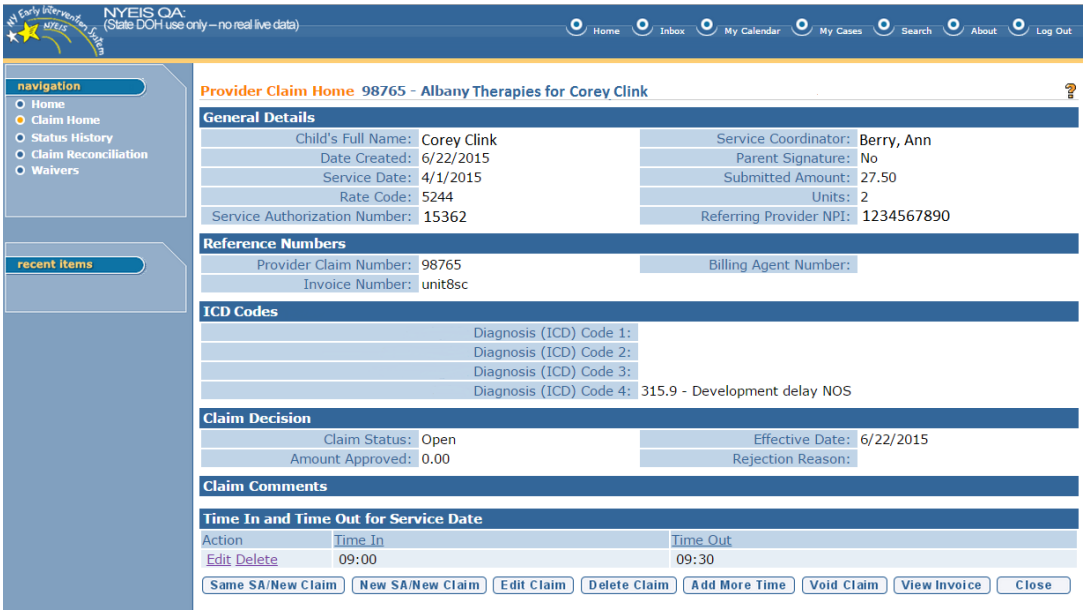
    At least one **Time In** and **Time Out** pair must be entered and the total time entered must be greater than or equal to 6 minutes. NYEIS calculates the number of units based on the total number of minutes for the service date. All of the service time for a day must be entered on one claim. An error will be presented if more than one claim is entered for the same date.

> **Important Information**
> If there is only one activity on a date and it does not exceed 5 minutes, it is not billable and should not be entered into NYEIS. However, if either one activity exceeds 5 minutes or all activities for one date exceed a total of 5 minutes, each activity must be entered individually and the total units are calculated by NYEIS and billable.

Please refer to the following chart for cross-reference from minutes to units.

0 – 5 minutes	0 units
6 -15 minutes	1 unit
16-30 minutes	2 units
31-45 minutes	3 units
46-60 minutes	4 units
61-75 minutes	5 units

13. Click **Save** button. **Provider Claim Home** page displays. The following additional functions for Provider Claims are available from the **Provider Claim Home** page: **Same SA/New Claim**, **New SA/New Claim**, **Edit Claim**, **Delete Claim**, **Add More Time**, **Void Claim** and **View Invoice**. 🕮 *See* **Claims** for further information.



Notes:

- To add more time for a service date click the **Add More Time** button and enter data for additional service time.

- The **Claim Status** field is in **Open** status until the Invoice has been submitted and processed in the nightly batch. The system will determine if the claim passes the billing rules during the nightly batch. The **Claim Status** field is then updated.

- The **Claim Status** is set to **System Approved** if a claim is submitted and passes the billing rules.

- The **Claim Status** is set to **Denied** if a Claim will not be paid due to a billing rule violation.

- Overlap of Service Coordination claims with other types of claims does not cause claims to be denied.

Invoice - ASSISTIVE TECHNOLOGY DEVICE (ATD)

During 2014 and early 2015, the New York State Department of Health (NYSDOH) and the State Fiscal Agent (SFA) began implementing a new process for the acquisition of Assistive Technology Devices (ATD). This new process was rolled out incrementally to all municipalities.

The new process affects all ATDs placed on a child's Individualized Family Service Plan (IFSP) with an ATD Service Authorization start date on or after the date in which your region began this new ATD procurement process.

Therefore, there should be no ATD claims entered in NYEIS for ATD SAs with a start date on or after the date your region began the new ATD process. ATD claims for service authorizations with these dates are processed by the State Fiscal Agent (SFA). If claims are entered for SAs **after your region began the new ATD process,** the claim must be voided.

For more information on the ATD claiming process, contact the SFA.

A specific process is followed when creating an Invoice(s) for Assistive Technology Devices (ATD).

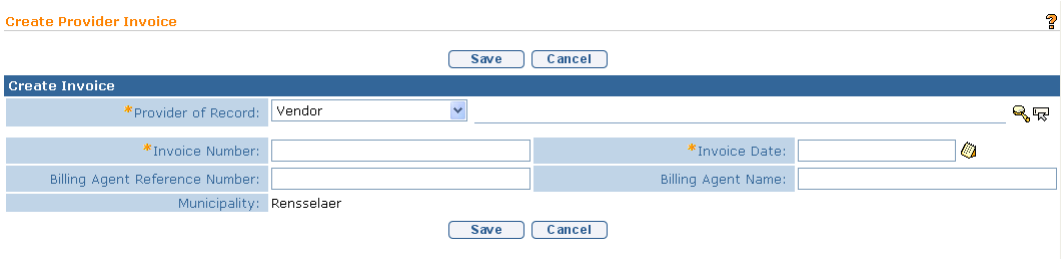
Invoice data can *only* be edited if the **Status** is **Draft**. Draft is defined as an Invoice that has not been submitted for approval into NYEIS. If a change is needed after an Invoice is submitted, then the Invoice *must* be voided and a new one created. If an Invoice is voided, all Claims associated with that Invoice will also be voided.

A Claim for each AT Device *must* be separately submitted.

A Vendor, rather than a Provider, is entered for **Assistive Technology Device (ATD)** Invoices.

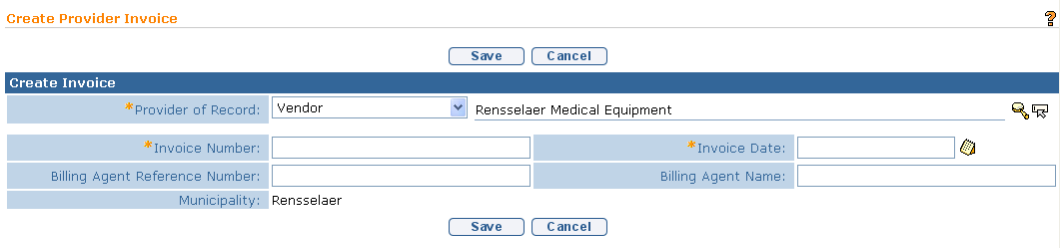
1. Log in to NYEIS. User Home Page displays.

2. Click **Create Invoice** link under **My Shortcuts** section. Select **Create Provider Invoice** page displays.



3. Select **Vendor** from the **Provider of Record** drop down.

4. Click **Search** icon for **Provider** *(Vendor)* **of Record** to identify Vendor. **Vendor Search** page displays. Type all known information in **Search Criteria** section. Click **Search** button. Records matching criteria display in **Search Results** section. *To search again, click **Reset** button.* Click **Select** link under **Action** column for Vendor of choice. **Create Provider Invoice** page displays.

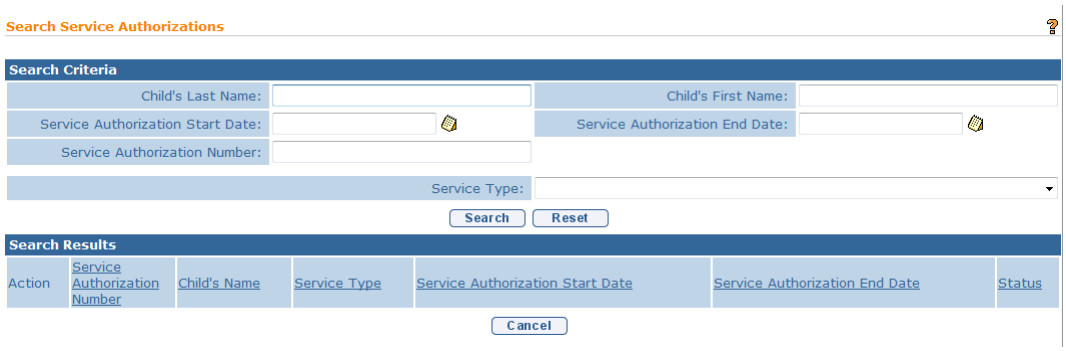


5. Type unique **Invoice Number.** Invoice numbers are alpha-numeric and case sensitive; duplicates not allowed. ***Invoice Number** must be entered. Be sure to write down Invoice Number to search for at a later time.* **Municipality** defaults if the user is the Municipality. .

> **Important Information**
> If the **Invoice Number** is unknown, the Vendor name and the date the Invoice was created can be searched using the **Invoice Search** page. 🕮 *See* **Searching/Viewing Invoices** for further information.
>
> **Invoice numbers are case sensitive**. Be sure to note the upper and lowercase letters when documenting an invoice number.

6. Type **Invoice Date**. ***Invoice Date*** *must be entered. Date fields must be formatted as* ***mm/dd/yyyy*** *format.*

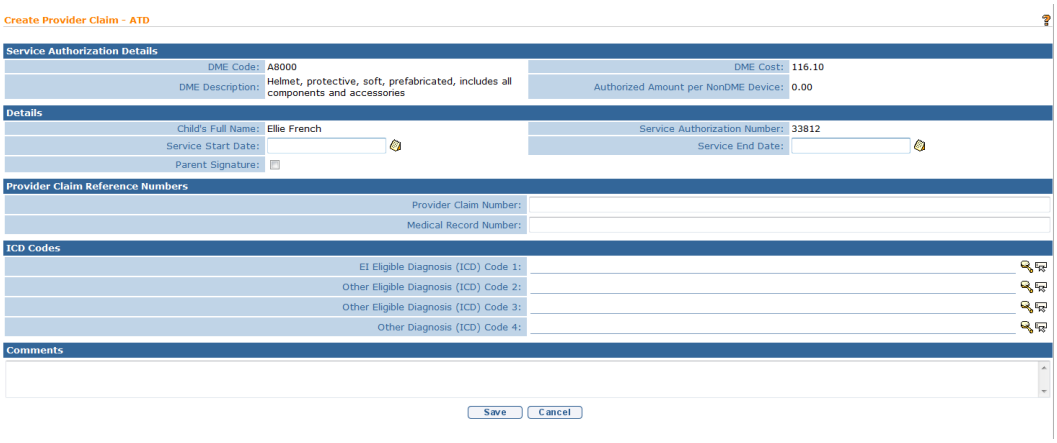
7. Click **Save** button. **Search Service Authorizations** page displays with the following sections: **Search Criteria** and **Search Results.**



8. Type all known information in **Search Criteria** section. Select **ATD** from **Service Type** field. Click **Search** button. Records matching criteria display in **Search Results** section. To search again, click **Reset** button.

   To view a Service Authorization, click **View** link under **Action** column for Service Authorization. The Service Authorization can be reviewed to verify remaining units. Click on the **Service Delivery Summary** link from the left hand navigation bar after reviewing, click **Close** button. *See* **Service Authorization Details/Unit 6 IFSP & SA** for further information.

   To select a specific Service Authorization, click **Select** link under **Action** column for Service Authorization. **Create Provider Claim - ATD** page displays with the following sections: **Service Authorization Details**, **Details**, **Provider Claim Reference Numbers**, **ICD Codes** and **Comments**.



9. Navigate from field-to-field in **Create Provider Claim - ATD** page using **Tab** key; enter information. *Date fields must be formatted as **mm/dd/yyyy** format.*

   Child's Full Name and **Service Authorization Number** are entered from the Service Authorization.

   Service Start Date and **Diagnosis (ICD) Codes** are *required* fields.

   Details section:
   - **Service Start/End Date** are dates the service is delivered and are validated against the **Service Authorization Start/End Date**.
   - **Parent Signature** checkbox indicates that a Parent Signature is on file with the Provider. The delivery of some EI services does not require a parent signature (for example Service Coordination). If the service delivered does not require the provider to maintain a parent signature, this box does not need to be checked.

   Provider Claim Reference Numbers section:
   - **Provider Claim Number** is the unique internal tracking number assigned to a Claim by the Provider of Record. If this number is not assigned by the Provider of Record, NYEIS will automatically generate a claim number.
   - **Medical Record Number** can be used for the Provider's internal use. It is not required.

   ICD Codes section:
   - **ICD Codes** allows the Provider to enter three ICD Codes (which have previously been entered on the child's record) and one additional ICD Code (which may or may not have been previously entered on the child's record).
   - To add data for the **EI Eligible Diagnosis (ICD) Code 1** field, select the **Search** icon. Type all known information in **Search Criteria** section. (ICD Codes, if available, will be one or more previously documented ICD Codes in the child's case.) Click **Search** button. Records matching the search criteria display in **Search Results** section. If applicable, select the most appropriate code for *the service delivered.*

     *Click **Select** link under **Action** column to* identify **ICD Code**. **Create Provider Claim** page displays.

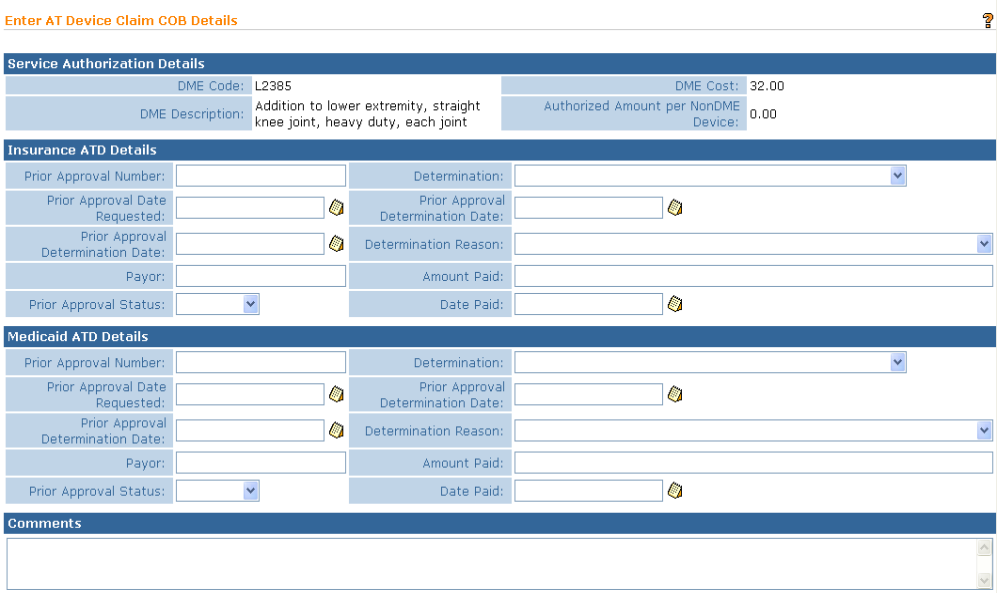
- To add data for the **Other Eligible Diagnosis (ICD) Codes 2 and 3** fields, repeat the above step.

- To add data for the **Other Diagnosis (ICD) Code 4** field, select the **Search** icon. Type all known information in **Search Criteria** section. (**Diagnosis (ICD) Code 4** can be selected from the list of all available ICD Codes.) Click **Search** button. Records matching the search criteria display in **Search Results** section. If applicable, select the most appropriate code *for the service delivered*. *To search again, click **Reset** button.*

  *Click **Select** link under **Action** column to identify* **ICD Code**. **Create Provider Claim** page displays.

Important Information
If the EIP provider determines that there is no appropriate ICD code applicable to the service(s) being delivered in the child's record (e.g., child's health assessment or child's multidisciplinary evaluation, prescriptions, written orders, written recommendations, or referrals), the EIP provider is responsible for securing and providing accurate and appropriate diagnosis codes for Early Intervention services provided to children and families in the EIP, consistent with the scope of practice of his or her professional license, certification, or registration. Users with access rights can add these ICD codes to the child's record in NYEIS via the **Health Assessments** link found on the child's integrated case homepage.

10. Click **Save** button. **Enter AT Device Claim COB Details** page displays with the following sections: **Service Authorization Details**, **Insurance ATD Details**, **Medicaid ATD Details** and **Comments**.



Important Information
If a Child has commercial insurance and Medicaid or Medicaid only, the vendor is responsible for claiming to commercial insurance and/or Medicaid and must seek payment and provide documentation to the municipality.

Service Authorization Details section:

- This section is read-only and is pre-populated from the data from the Service Authorization.

Insurance ATD Details section:

- Information in this section captures Commercial Insurance Details. The left column pertains to Prior Approval information for that Claim such as **Prior Approval Number**, **Prior Approval Date Requested**, **Prior Approval Determination Date**, **Payor** and **Prior Approval Status**. If a Prior Approval was captured for this Claim, enter data.

- The right column pertains to the Determination by the Payor on whether to pay or deny the Claim. If the Claim is paid, the **Amount Paid** and **Date Paid** should be entered. If the Claim is denied, the **Determination Reason** should be entered.

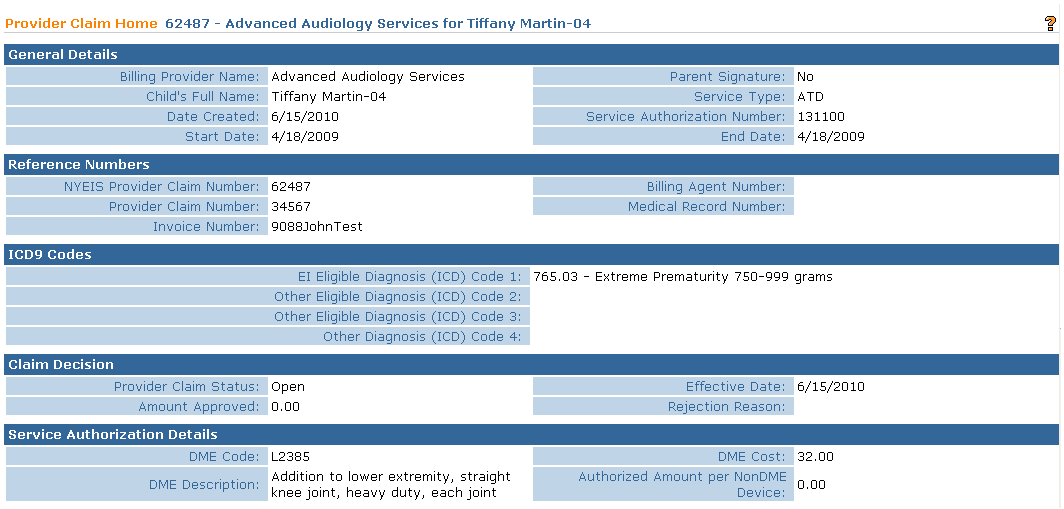
Important Information
The 'Payor' is the Insurance Company that paid the Claim.

Medicaid ATD Details section:

- Information in this section captures Medicaid Details. Field definitions for this section are similar to details in the **Insurance ATD Details** section.

11. Navigate from field-to-field using **Tab** key; enter information. *Date fields must be formatted as **mm/dd/yyyy** format.*

12. Click **Save** button. **Provider Claim Home** page displays. The following additional functions for Provider Claims are available from the **Provider Claim Home** page: **Same SA/New Claim**, **New SA/New Claim**, **Edit Claim**, **Delete Claim**, **Void Claim** and **View Invoice**. 🕮 *See* **Claims** for further information.



Provider Claim Home 62487 - Advanced Audiology Services for Tiffany Martin-04

General Details

Billing Provider Name:	Advanced Audiology Services	Parent Signature:	No
Child's Full Name:	Tiffany Martin-04	Service Type:	ATD
Date Created:	6/15/2010	Service Authorization Number:	131100
Start Date:	4/18/2009	End Date:	4/18/2009

Reference Numbers

NYEIS Provider Claim Number:	62487	Billing Agent Number:	
Provider Claim Number:	34567	Medical Record Number:	
Invoice Number:	9088JohnTest		

ICD9 Codes

EI Eligible Diagnosis (ICD) Code 1:	765.03 - Extreme Prematurity 750-999 grams
Other Eligible Diagnosis (ICD) Code 2:	
Other Eligible Diagnosis (ICD) Code 3:	
Other Diagnosis (ICD) Code 4:	

Claim Decision

Provider Claim Status:	Open	Effective Date:	6/15/2010
Amount Approved:	0.00	Rejection Reason:	

Service Authorization Details

DME Code:	L2385	DME Cost:	32.00
DME Description:	Addition to lower extremity, straight knee joint, heavy duty, each joint	Authorized Amount per NonDME Device:	0.00

Notes:

- The **Claim Status** field is in **Open** status until the Invoice has been submitted and processed in the nightly batch. The system will determine if the claim passes the billing rules during the nightly batch. The **Claim Status** field is then updated.

- The **Claim Status** is set to **System Approved** if a claim is submitted and passes the billing rules. The status will then become **Approved** overnight. The municipality will then be able to release claim for vendor payment**.**

- The **Claim Status** is set to **Denied** if a Claim will not be paid due to a billing rule violation.

- **Approved Amount** is calculated based on the Rate associated with DME Amount on the Service Authorization less any amounts paid by 3rd Party Insurance.

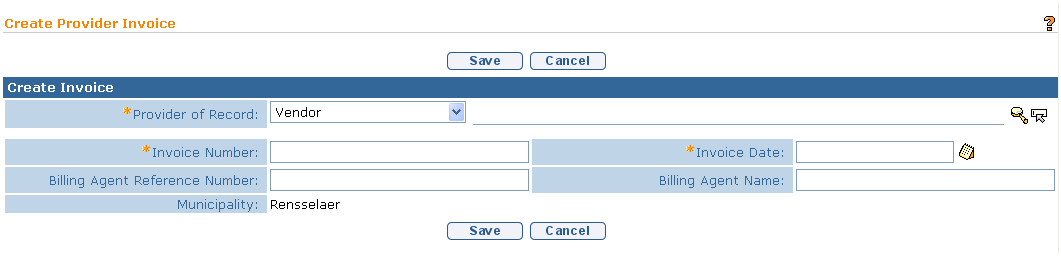
Invoice - RESPITE

When creating an Invoice for ***Respite Claims***, *follow this process.*

Invoice data can *only* be edited if the **Status** is **Draft**. Draft is defined as an Invoice that has not been submitted for approval into NYEIS. If a change is needed after an Invoice is submitted, then the Invoice *must* be voided and a new one created.

1. Log in to NYEIS. User Home Page displays.

2. Click **Create Invoice** link under **My Shortcuts** section. **Create Provider Invoice** page displays.

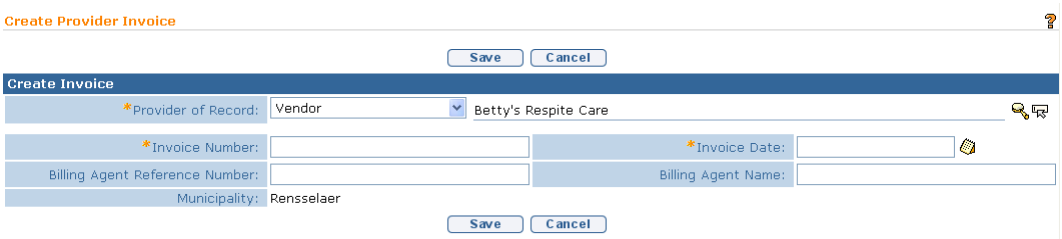


3. Select **Vendor** from the **Provider of Record** drop down.

4. Click **Search** icon for **Provider** *(Vendor)* **of Record** to identify Vendor. **Vendor Search** page displays.

> **Important Information**
> If the Parent is responsible for the Respite on the Service Authorization, the Parent is the Vendor.

Type all known information in **Search Criteria** section. Click **Search** button. Records matching criteria display in **Search Results** section. *To search again, click **Reset** button.* Click **Select** link under **Action** column for Vendor of choice. **Create Provider Invoice** page displays.



Important Information:

Respite includes the following types:

Family/Caregiver – A family member or designated caregiver provides the respite service. Before a family member or caregiver can be assigned as a provider, they must first be registered 🕮 *See* **Unit 10 – Municipal Administration** for more information on registering a Parent or caregiver for respite services.

Respite Provider – Respite services are performed by a providing agency

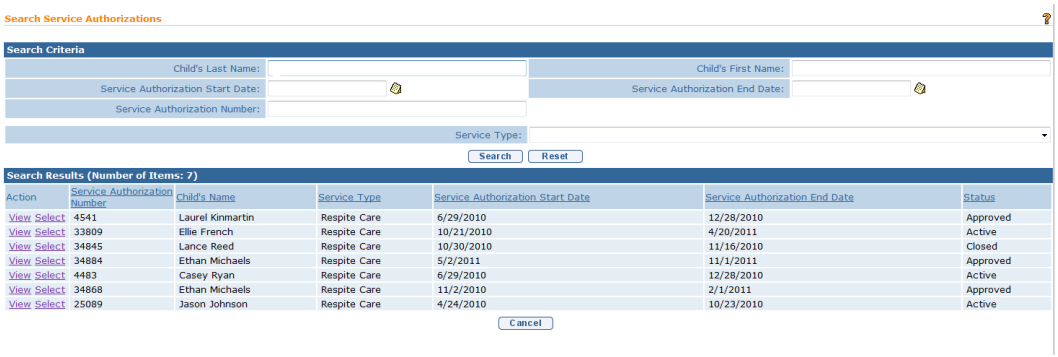
5. Type unique **Invoice Number.** Invoice numbers are alpha-numeric and case sensitive; duplicates are not allowed. ***Invoice Number*** *must be entered. Be sure to write down Invoice Number to search for at a later time.* **Municipality** defaults to Municipality of the User.

Important Information
If the **Invoice Number** is unknown, the Vendor name and the date the Invoice was created can be searched using the **Invoice Search** page. 🕮 *See* **Searching/Viewing Invoices** for further information.

Invoice numbers are case sensitive. Be sure to note the upper and lowercase letters when documenting an invoice number.

6. **Date**. ***Invoice Date*** *must be entered. Date fields must be formatted as* ***mm/dd/yyyy*** *format.*

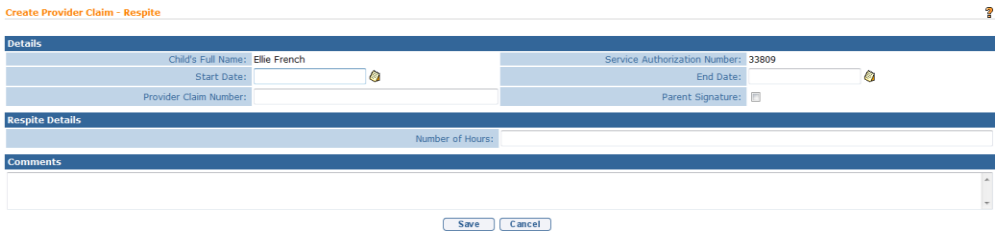
7. Click **Save** button. **Search Service Authorizations** page displays with the following sections: **Search Criteria** and **Search Results**.



8. Type all known information in **Search Criteria** section. Select **Respite Care** from **Service Type** field. Click **Search** button. Records matching criteria display in **Search Results** section. To search again, click **Reset** button.

   To view a Service Authorization, click **View** link under **Action** column for Service Authorization. The Service Authorization can be reviewed. After reviewing, click **Close** button. 🕮 *See* **Unit 6: IFSP & SA** for further information regarding Service Authorizations.

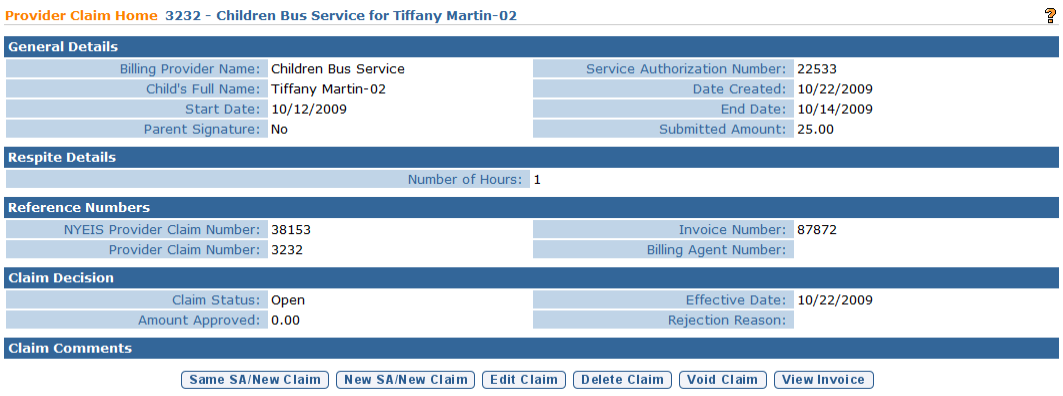
   To select a specific Service Authorization, click **Select** link under **Action** column for Service Authorization. **Create Provider Claim - Respite** page displays with the following sections: **Details**, **Respite Details** and **Comments**.



   Navigate from field-to-field using **Tab** key; enter information. *Date fields must be formatted as **mm/dd/yyyy** format.* **Start Date**, **End Date** and **Number of Hours** are *required* fields. **Parent Signature** box check is used to indicate that parent signature is on file for Respite services delivered.

> **Important Information**
> The System calculates the **Claim Amount** based *on the **Number of Hours** multiplied by the **Respite Cost Per** **Hour on the Service Authorization**.*

9. Click **Save** button. **Provider Claim Home** page displays. The following additional functions for Provider Claims are available from the **Provider Claim Home** page: **Same SA/New Claim**, **New SA/New Claim**, **Edit Claim**, **Delete Claim**, **Void Claim** and **View Invoice**. 🕮 *See* **Claims** for further information.



Notes:

- The **Claim Status** field is in **Open** status until the Invoice has been submitted and processed in the nightly batch. The system will determine if the claim passes the billing rules during the nightly batch. The **Claim Status** field is then updated.

- The **Claim Status** is set to **System Approved** if a claim is submitted and passes the billing rules. The status will then become **Approved** overnight. The municipality will then be able to release claim for vendor payment**.**

- The **Claim Status** is set to **Denied** if a Claim will not be paid due to a billing rule violation.

Invoice - TRANSPORTATION - CAREGIVER

Caregivers do not have user access to NYEIS and therefore cannot create and submit an Invoice for services provided. Transportation – Caregiver claims are processed by the Municipality.

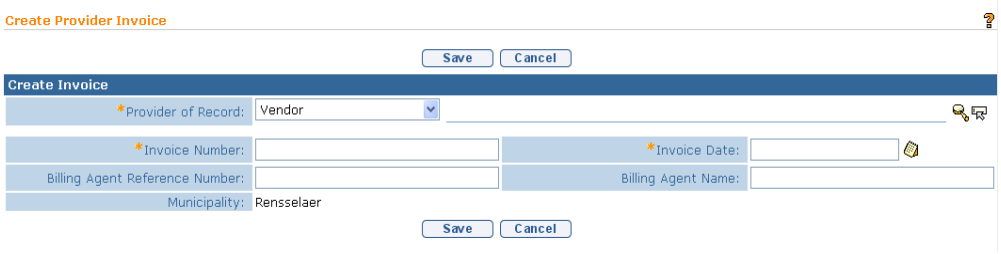
A specific process is followed when creating an Invoice for ***Transportation – Caregiver*** Claims.

Invoice data can *only* be edited if the **Status** is **Draft**. Draft is defined as an Invoice that has not been submitted for approval into NYEIS. If a change is needed after an Invoice is submitted, then the Invoice *must* be voided and a new one created.

A Vendor, rather than a Provider, is entered for **Transportation – Caregiver** type Invoices.

1. Log in to NYEIS. User Home Page displays.

2. Click **Create Invoice** link under **My Shortcuts** section. **Create Provider Invoice** page displays.

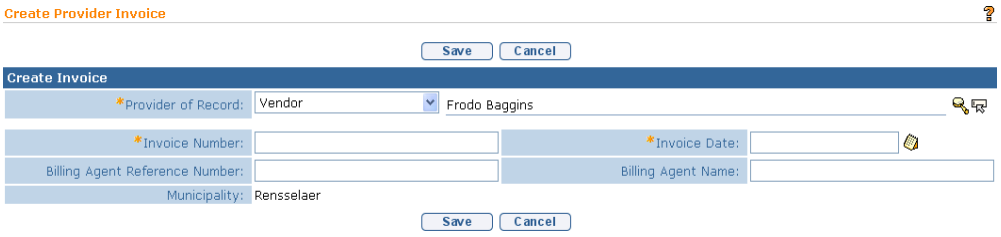


3. Select **Vendor** from the **Provider of Record** drop down.

4. Click **Search** icon for **Provider** *(Vendor)* **of Record** to identify Vendor. **Vendor Search** page displays.

> **Important Information**
> In NYEIS, the Caregiver providing the transportation is the **Vendor Name**.

5. Type all known information in **Search Criteria** section. Click **Search** button. Records matching criteria display in **Search Results** section. *To search again, click **Reset** button.* Click **Select** link under **Action** column for Vendor of choice. **Create Provider Invoice** page displays.

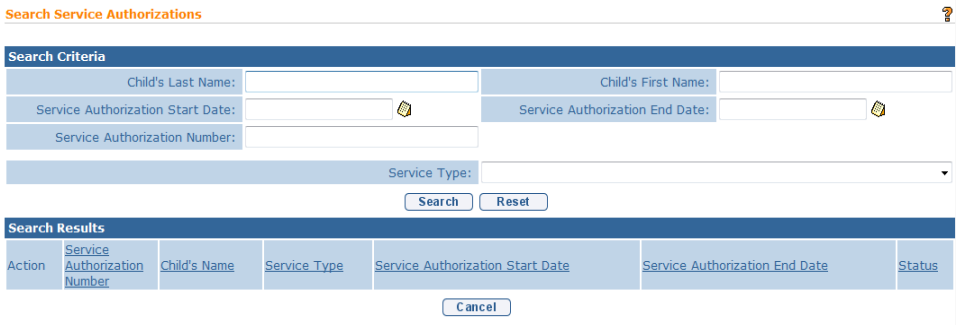


6. Type unique **Invoice Number.** Invoice numbers are alpha-numeric and case sensitive; duplicate vendor invoice numbers are not allowed. ***Invoice Number** must be entered. Be sure to write down Invoice Number to search for at a later time.* **Municipality** defaults to Municipality of the User.

> **Important Information**
> If the **Invoice Number** is unknown, the Vendor name and the date the Invoice was created can be searched using the **Invoice Search** page. 🕮 *See* **Searching/Viewing Invoices** for further information.
>
> **Invoice numbers are case sensitive**. Be sure to note the upper and lowercase letters when documenting an invoice number.

7. Type **Invoice Date**. ***Invoice Date*** *must be entered. Date fields must be formatted as* ***mm/dd/yyyy*** *format.*

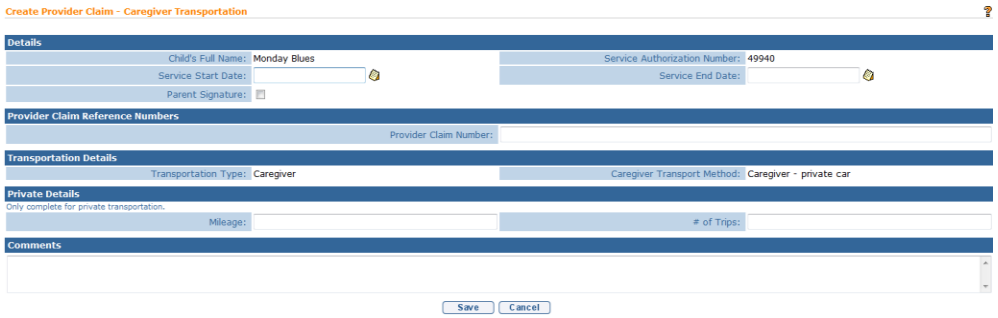
8. Click **Save** button. **Search Service Authorizations** page displays with the following sections: **Search Criteria** and **Search Results**.



9. Type all known information in **Search Criteria** section. Select **Transportation** from **Service Type** field. Click **Search** button. Records matching criteria display in **Search Results** section. To search again, click **Reset** button.

   To view a Service Authorization, click **View** link under **Action** column for Service Authorization. Review the Service Authorization. After reviewing, click **Close** button.

   To select a specific Service Authorization, click **Select** link under **Action** column for Service Authorization. **Create Provider Claim – Caregiver Transportation** page displays with the following sections: **Details**, **Provider Claim Reference Numbers**, **Transportation Details**, **Public Details *or* Private Details** and **Comments**.



10. Navigate from field-to-field in **Create Provider Claim – Caregiver Transportation** page using **Tab** key; enter information. *Date fields must be formatted as* ***mm/dd/yyyy*** *format.*

    Service Start Date and **Service End Date** are *required* fields.

Details section:

- **Service Start/Service End Date** are dates the service is delivered and are validated against the **Service Authorization Start/End Date**.

- **Parent Signature** checkbox indicates that a Parent Signature is on file with the Provider. The delivery of some EI services does not require a parent signature (for example Service Coordination). If the service delivered does not require the provider to maintain a parent signature, this box does not need to be checked.

Provider Claim Reference Numbers section:

- **Provider Claim Number** is the unique internal tracking number assigned to a Claim by the Provider of Record. If this number is not assigned by the Provider of Record, NYEIS will automatically generate a claim number.

Transportation Details section:

➲ This section is read-only. Fields are pre-populated based on data from the Service Authorization.

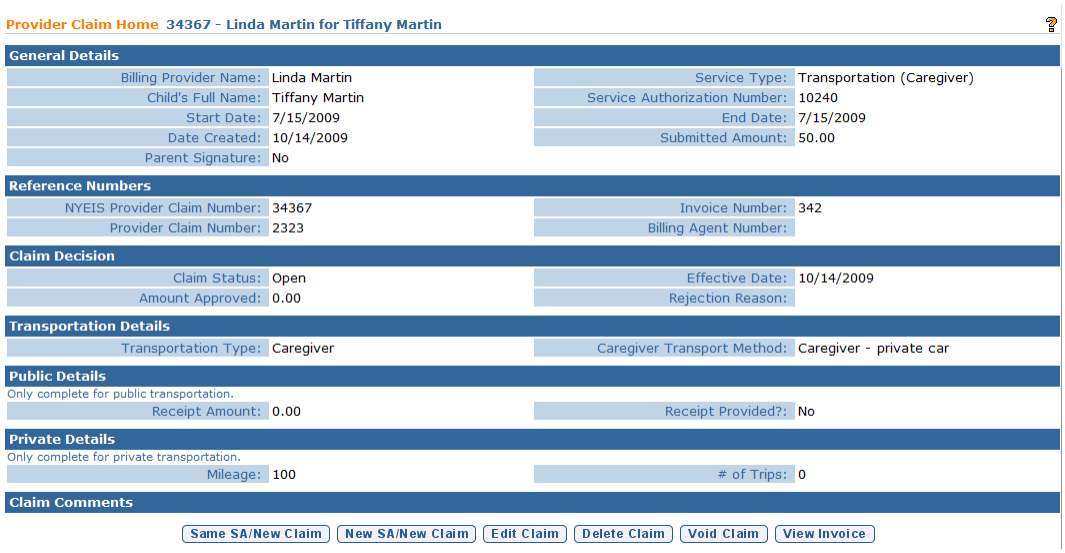
Public Details section:

➲ If **Public Transportation** is used, complete the **Public Details** section. The **Receipt Amount** is the amount paid if the Provider Claim is approved.

Private Details section:

➲ If **Private Transportation** is used, complete the **Private Details** section. These fields are used along with the associated Service Authorization fields (i.e., **Fixed Roundtrip Rate**, **Cost Per Mile**) to calculate the amount paid if the Provider Claim is approved.

11. Click **Save** button. **Provider Claim Home** page displays. The following additional functions for Provider Claims are available from the **Provider Claim Home** page: **Same SA/New Claim**, **New SA/New Claim**, **Edit Claim**, **Delete Claim**, **Void Claim** and **View Invoice**. 🕮 *See* **Claims** for further information.



Provider Claim Home 34367 - Linda Martin for Tiffany Martin

General Details

Billing Provider Name:	Linda Martin	Service Type:	Transportation (Caregiver)
Child's Full Name:	Tiffany Martin	Service Authorization Number:	10240
Start Date:	7/15/2009	End Date:	7/15/2009
Date Created:	10/14/2009	Submitted Amount:	50.00
Parent Signature:	No		

Reference Numbers

NYEIS Provider Claim Number:	34367	Invoice Number:	342
Provider Claim Number:	2323	Billing Agent Number:	

Claim Decision

Claim Status:	Open	Effective Date:	10/14/2009
Amount Approved:	0.00	Rejection Reason:	

Transportation Details

Transportation Type:	Caregiver	Caregiver Transport Method:	Caregiver - private car

Public Details

Only complete for public transportation.

Receipt Amount:	0.00	Receipt Provided?:	No

Private Details

Only complete for private transportation.

Mileage:	100	# of Trips:	0

Claim Comments

Same SA/New Claim | New SA/New Claim | Edit Claim | Delete Claim | Void Claim | View Invoice

Notes:

- The **Claim Status** field is in **Open** status until the Invoice has been submitted and processed in the nightly batch. The system will determine if the claim passes the billing rules during the nightly batch. The **Claim Status** field is then updated.

- The **Claim Status** is set to **System Approved** if a claim is submitted and passes the billing rules. The status will then become **Approved** overnight. The municipality will then be able to release claim for vendor payment**.**

- The **Claim Status** is set to **Denied** if a Claim will not be paid due to a billing rule violation.

Invoice - TRANSPORTATION - VENDOR

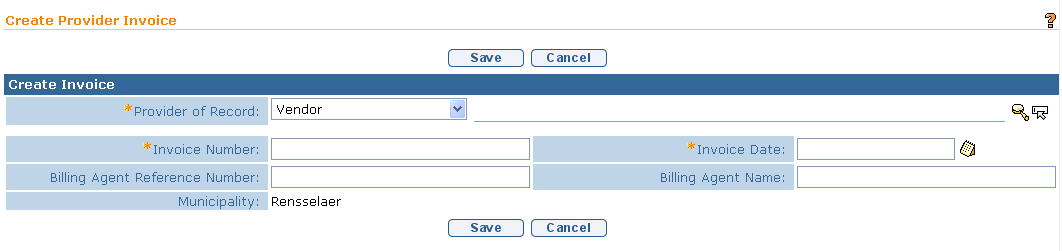
A specific process is followed when creating an Invoice(s) for ***Transportation – Vendor*** Claims.

Invoice data can *only* be edited if the **Status** is **Draft**. Draft is defined as an Invoice that has not been submitted for approval into NYEIS. If a change is needed after an Invoice is submitted, then the Invoice *must* be voided and a new one created.

A Vendor, rather than a Provider, is entered for **Transportation – Vendor** type Invoices.

1. Log in to NYEIS. User Home Page displays.

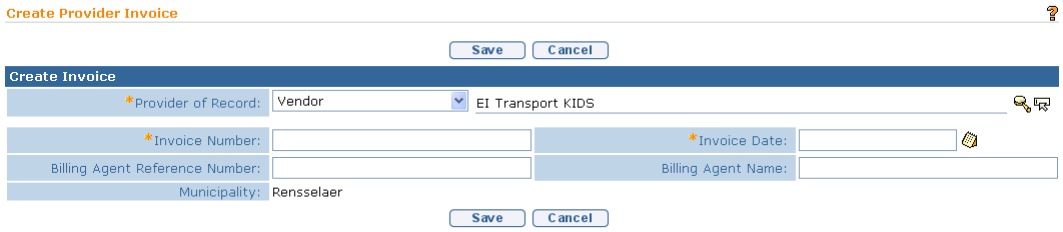
2. Click **Create Invoice** link under **My Shortcuts** section. **Create Provider Invoice** page displays.



3. Select **Vendor** from the **Provider of Record** drop down.

4. Click **Search** icon for **Provider** *(Vendor)* **of Record** to identify Vendor. **Vendor Search** page displays.

5. Type all known information in **Search Criteria** section. Click **Search** button. Records matching criteria display in **Search Results** section. *To search again, click **Reset** button.* Click **Select** link under **Action** column for Vendor of choice. **Create Provider Invoice** page displays.



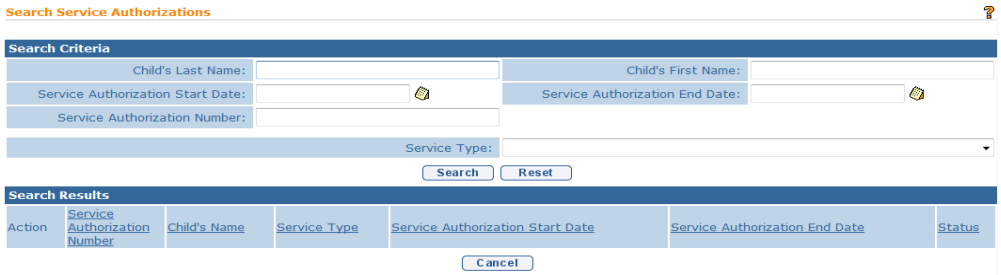
6. Type unique **Invoice Number.** Invoice numbers are alpha-numeric and case sensitive; duplicate vendor invoice numbers are not allowed. ***Invoice Number** must be entered. Be sure to write down Invoice Number to search for at a later time.* **Municipality** defaults to Municipality of the User.

Important Information
If the **Invoice Number** is unknown, the Vendor name and the date the Invoice was created can be searched using the **Invoice Search** page. 🕮 *See* **Searching/Viewing Invoices** for further information.

Invoice numbers are case sensitive. Be sure to note the upper and lowercase letters when documenting an invoice number.

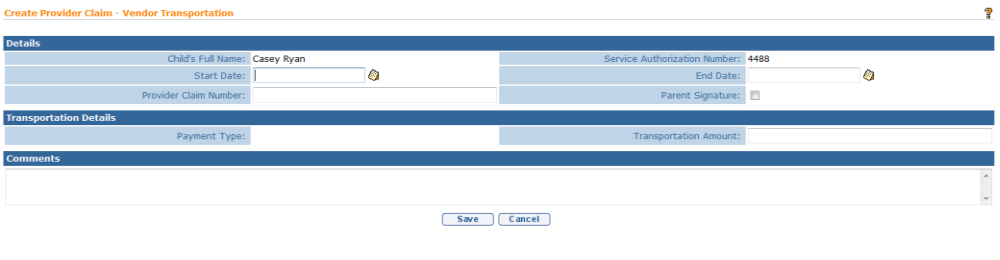
7. Type **Invoice Date**. ***Invoice Date*** *must be entered. Date fields must be formatted as* ***mm/dd/yyyy*** *format.*

8. Click **Save** button. **Search Service Authorizations** page displays with the following sections: **Search Criteria** and **Search Results**.



Type all known information in **Search Criteria** section. Select **Transportation** from **Service Type** field. Click **Search** button. Records matching criteria display in **Search Results** section. To search again, click **Reset** button.

To select a specific Service Authorization, click **Select** link under **Action** column for Service Authorization. **Create Provider Claim – Vendor Transportation** page displays with the following sections: **Details**, **Transportation Details** and **Comments**.



9. Navigate from field-to-field in **Create Provider Claim – Vendor Transportation** page using **Tab** key; enter information. *Date fields must be formatted as* ***mm/dd/yyyy*** *format.*

   Start Date, End Date and **# of Trips** are *required* fields.

   Details section:

   - **Start/End Date** are dates the service is delivered and are validated against the **Service Authorization Start/End Date**.

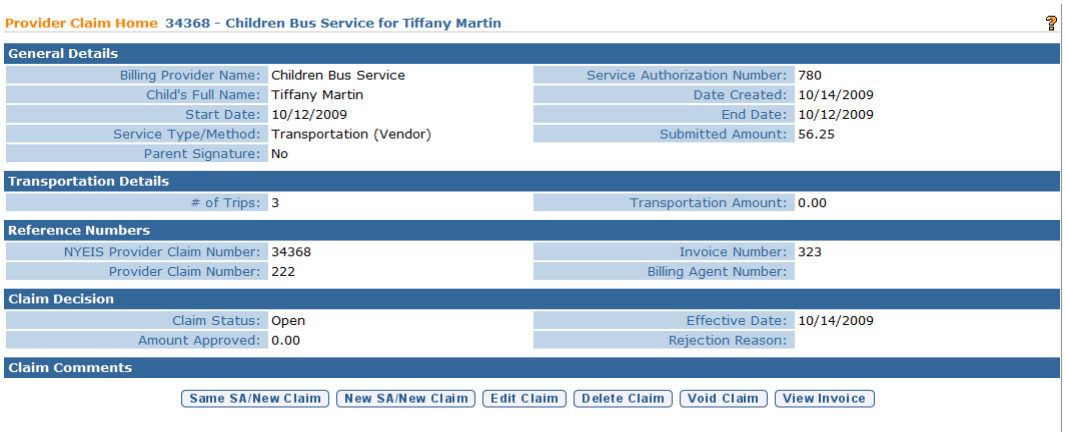
   - **Parent Signature** checkbox indicates that a Parent Signature is on file with the Provider. Transportation does not require the provider to maintain a parent signature; this box does not need to be checked

- **Provider Claim Number** is the unique internal tracking number assigned to a Claim by the Provider of Record. If this number is not assigned by the Provider of Record, NYEIS will automatically generate a claim number.

Transportation Details section:

➲ **Payment Type** displays the information from the Service Authorization. User will enter the **# of Trips** for billing.

10. Click **Save** button. **Provider Claim Home** page displays. The following additional functions for Provider Claims are available from the **Provider Claim Home** page: **Same SA/New Claim**, **New SA/New Claim**, **Edit Claim**, **Delete Claim**, **Void Claim** and **View Invoice**. 🕮 *See* **Claims** for further information.



Notes:

- The **Claim Status** field is in **Open** status until the Invoice has been submitted and processed in the nightly batch. The system will determine if the claim passes the billing rules during the nightly batch. The **Claim Status** field is then updated.

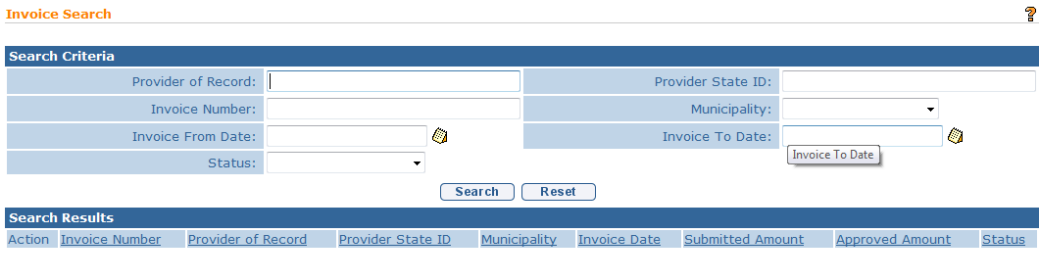
- The **Claim Status** is set to **System Approved** if a claim is submitted and passes the billing rules. The status will then become **Approved** overnight. The municipality will then be able to release claim for vendor payment**.**

- The **Claim Status** is set to **Denied** if a Claim will not be paid due to a billing rule violation.

Searching/Viewing Invoices

1. Log in to NYEIS. User Home Page displays.

2. Click **Invoices** link under **Search** section. **Invoice Search** page displays.



3. Type all known information in **Search Criteria** section.

   The Invoice Number (written down prior) can now be used to search using the **Invoice Number** field.

> **Important Information**
> Invoice numbers are alpha-numeric and case sensitive.

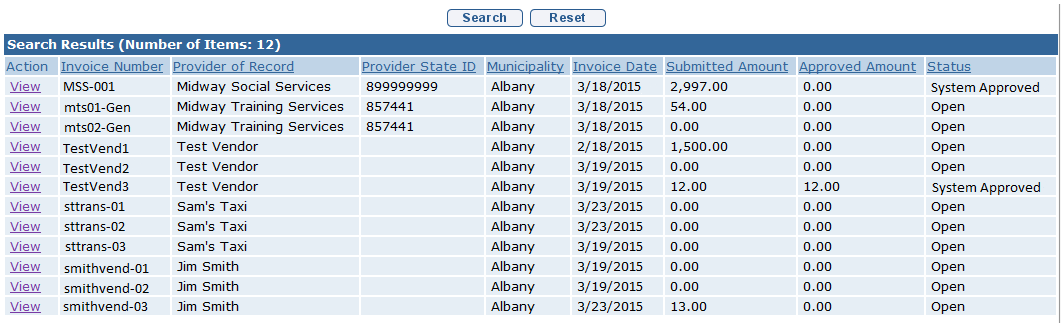
   Every Invoice has an assigned status. Where an Invoice is in the process will determine the **Status**. Prior to being submitted, an Invoice is considered **Draft**, after submission it is considered **Submitted** and continues through the process.

   After the Invoice is submitted and processed overnight, the user can view the status for the Invoice which will display **System Approved.** Any claims in **Pending** status seen on the **System Approved** invoice are awaiting a waiver decision. 🕮 *See* **Waivers** section later in this unit for further information.

> **Important Information**
> Invoices submitted **prior to 4/1/2013** include the following invoice statuses:
>
> - **Fully Adjudicated –** This invoice status reflects an invoice where all claims on the invoice have been adjudicated, meaning a claim decision (approved/denied) is in place for all claims on the invoice
>
> - **Partially Adjudicated –** This invoice status indicates that one or more claims on the invoice are in **Pending** status, pending a waiver approval for the given claim(s). 🕮 *See* **Waivers** section later in this unit for further information

   Invoices that are voided are given a status of 'Void".

4. Click **Search** button. Records matching criteria display in **Search Results** section.

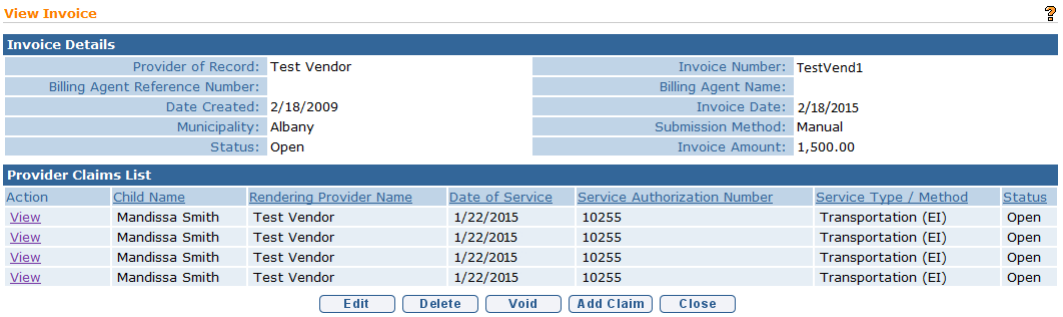


Search Reset

Search Results (Number of Items: 12)

Action	Invoice Number	Provider of Record	Provider State ID	Municipality	Invoice Date	Submitted Amount	Approved Amount	Status
View	MSS-001	Midway Social Services	899999999	Albany	3/18/2015	2,997.00	0.00	System Approved
View	mts01-Gen	Midway Training Services	857441	Albany	3/18/2015	54.00	0.00	Open
View	mts02-Gen	Midway Training Services	857441	Albany	3/18/2015	0.00	0.00	Open
View	TestVend1	Test Vendor		Albany	2/18/2015	1,500.00	0.00	Open
View	TestVend2	Test Vendor		Albany	3/19/2015	0.00	0.00	Open
View	TestVend3	Test Vendor		Albany	3/19/2015	12.00	12.00	System Approved
View	sttrans-01	Sam's Taxi		Albany	3/23/2015	0.00	0.00	Open
View	sttrans-02	Sam's Taxi		Albany	3/23/2015	0.00	0.00	Open
View	sttrans-03	Sam's Taxi		Albany	3/19/2015	0.00	0.00	Open
View	smithvend-01	Jim Smith		Albany	3/19/2015	0.00	0.00	Open
View	smithvend-02	Jim Smith		Albany	3/19/2015	0.00	0.00	Open
View	smithvend-03	Jim Smith		Albany	3/23/2015	13.00	0.00	Open

*To search again, click **Reset** button.* Click **View** link under **Action** column for Invoice of choice. **View Invoice** page displays. *Click column heading to sort data in ascending or descending order.*



View Invoice

Invoice Details

Provider of Record:	Test Vendor	Invoice Number:	TestVend1
Billing Agent Reference Number:		Billing Agent Name:	
Date Created:	2/18/2009	Invoice Date:	2/18/2015
Municipality:	Albany	Submission Method:	Manual
Status:	Open	Invoice Amount:	1,500.00

Provider Claims List

Action	Child Name	Rendering Provider Name	Date of Service	Service Authorization Number	Service Type / Method	Status
View	Mandissa Smith	Test Vendor	1/22/2015	10255	Transportation (EI)	Open
View	Mandissa Smith	Test Vendor	1/22/2015	10255	Transportation (EI)	Open
View	Mandissa Smith	Test Vendor	1/22/2015	10255	Transportation (EI)	Open
View	Mandissa Smith	Test Vendor	1/22/2015	10255	Transportation (EI)	Open

Edit Delete Void Add Claim Close

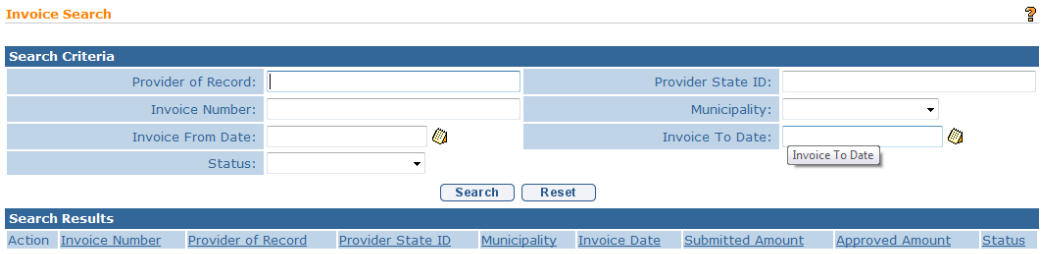
5. The following additional functions are available when viewing an Invoice before it has been submitted **Edit**, **Delete**, **Void**, **Add Claim** and **Close** buttons. Once an Invoice is submitted, the **Edit**, **Delete**, and **Add Claim** functions are no longer available.

Editing Invoices

An **Invoice** can *only* be edited if the **Status** is **Draft**. Draft is defined as an Invoice that has not been submitted for approval into NYEIS. If an Invoice needs to be edited or deleted after an Invoice is submitted, then the Invoice *must* be voided and a new one created.

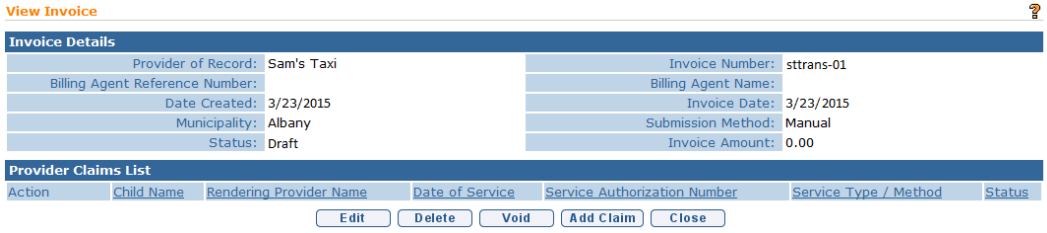
1. Log in to NYEIS. User Home Page displays.

2. Click **Invoices** link under **Search** section. **Invoice Search** page displays.

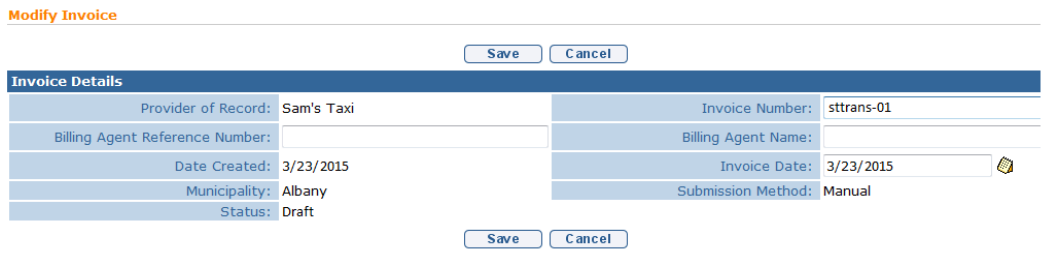


3. Type all known information in **Search Criteria** section. Click **Search** button. Records matching criteria display in **Search Results** section. *To search again, click **Reset** button.* Click **View** link under **Action** column for Invoice of choice. **View Invoice** page displays.

Important Information
Invoice numbers are alpha-numeric and are case sensitive.



4. Click **Edit** button. **Modify Invoice** page displays.



5. Apply edits to the following fields: **Invoice Number**, **Billing Agent Reference Number**, **Billing Agent Name** or **Invoice Date**.

Important Information
The **Provider of Record** and **Municipality** *cannot* be edited. If either of the fields changes, the Invoice should be deleted.

6. Click **Save** button. **View Invoice** page displays.

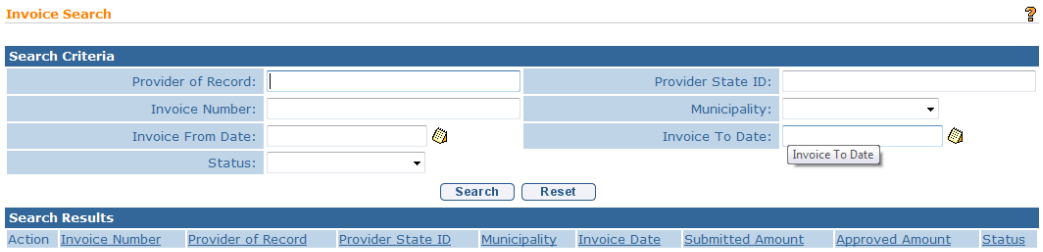
Deleting Invoices

Invoices can *only* be deleted if the **Status** is **Draft**. Draft is defined as an Invoice that has not been submitted for approval into NYEIS. If a deletion is needed after an Invoice is submitted, then the Invoice *must* be voided and a new one created.

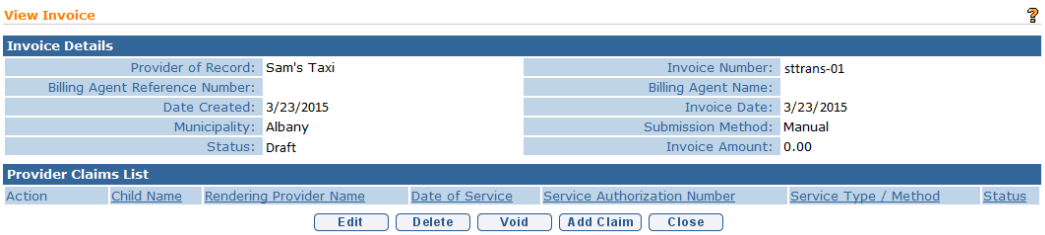
Be aware selecting **Delete Invoice** will delete the Invoice, including all Claims and Service Lines attached.

1. Log in to NYEIS. User Home Page displays.

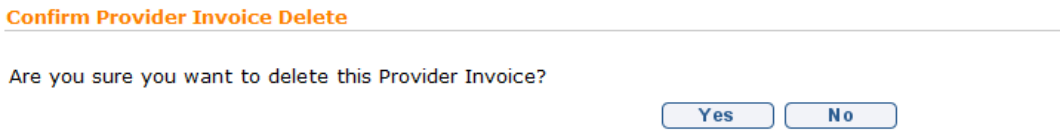
2. Click **Invoices** link under **Search** section. **Invoice Search** page displays.



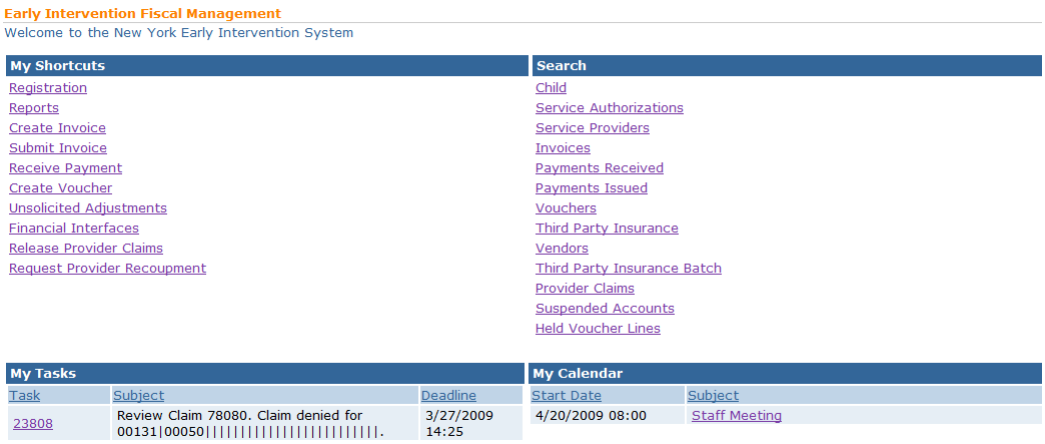
3. Type all known information in **Search Criteria** section. Click **Search** button. Records matching criteria display in **Search Results** section. *To search again, click **Reset** button.* Click **View** link under **Action** column for Invoice of choice. **View Invoice** page displays.



4. Click **Delete** button. **Confirm Provider Invoice Delete** page displays with the message ***Are you sure you want to delete this Provider Invoice?***



5. Click **Yes** button to delete entire Invoice. User Home page displays.



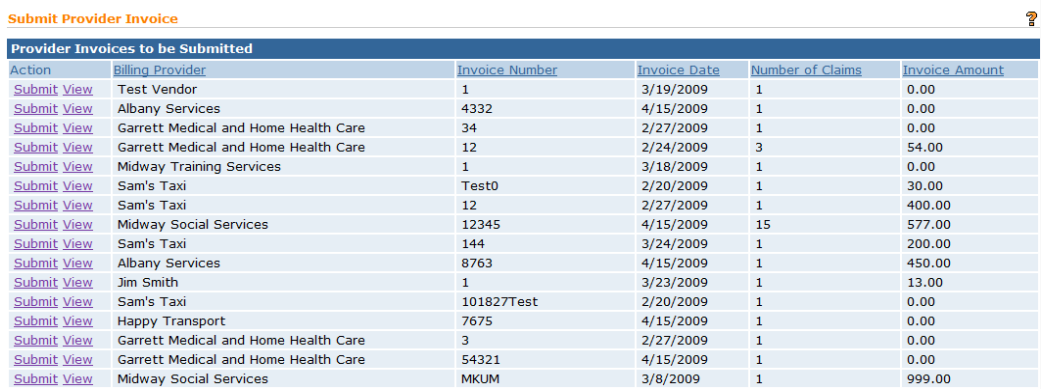
Adding Claims to Invoices

📖 *See* **Claims**, ***Adding Provider Claims*** section for complete details.

Submitting Invoices

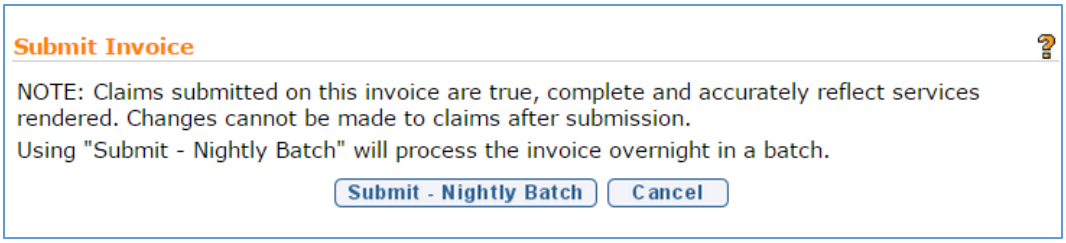
1. Log in to NYEIS. User Home Page displays.

2. Click **Submit Invoice** under **My Shortcuts** section. **Submit Provider Invoice** page displays.



Action	Billing Provider	Invoice Number	Invoice Date	Number of Claims	Invoice Amount
Submit View	Test Vendor	1	3/19/2009	1	0.00
Submit View	Albany Services	4332	4/15/2009	1	0.00
Submit View	Garrett Medical and Home Health Care	34	2/27/2009	1	0.00
Submit View	Garrett Medical and Home Health Care	12	2/24/2009	3	54.00
Submit View	Midway Training Services	1	3/18/2009	1	0.00
Submit View	Sam's Taxi	Test0	2/20/2009	1	30.00
Submit View	Sam's Taxi	12	2/27/2009	1	400.00
Submit View	Midway Social Services	12345	4/15/2009	15	577.00
Submit View	Sam's Taxi	144	3/24/2009	1	200.00
Submit View	Albany Services	8763	4/15/2009	1	450.00
Submit View	Jim Smith	1	3/23/2009	1	13.00
Submit View	Sam's Taxi	101827Test	2/20/2009	1	0.00
Submit View	Happy Transport	7675	4/15/2009	1	0.00
Submit View	Garrett Medical and Home Health Care	3	2/27/2009	1	0.00
Submit View	Garrett Medical and Home Health Care	54321	4/15/2009	1	0.00
Submit View	Midway Social Services	MKUM	3/8/2009	1	999.00

3. Identify Invoice for submission. Click **Submit** link under **Action** column. **Submit Invoice** page displays with the message:



Click **Submit – Nightly Batch** button. **Submit Provider Invoice** list page displays.

Using Submit- Nightly Batch will process the invoice overnight. All claims in the invoice will run through the NYEIS Invoice business rules to determine for each claim whether it passes the rules and is approved, fails the rules and is denied, or is pending indicating the claim violates a billing rule for which an upfront waiver has been denied and requires the submission of a justification from the provider.

Following overnight processing, the user can view the status for the Invoice which will display **System Approved.** Individual Claims on the invoice will either be **Approved** (vendor claims only), **System Approved**, **Denied**, or **Pending** (i.e., violates a billing rule for which an upfront waiver has been denied and requires the submission of a justification from the provider). 🕮 *See* **Waivers** section later in this unit for further information

Important Information
As part of a nightly batch process, if any approved **Claim** is determined to be the first service delivered on a service authorization and the date of service is greater than 30 days from the **Effective Start of the Authorizing IFSP**, a task is generated to the providers Service Authorization Work Queue to supply a late reason. 🕮 *See* **Appendix D** for a listing of late reasons.

As part of NYEIS's system batch processes the system checks if the date that the first service is delivered is later than 30 days after the date of the authorizing IFSP. When this occurs the **Provider** is assigned a **Task** in their **Service Authorization Work Queue** to provide a Late Reason. This information is then viewable on the **Service Authorization** Homepage.

Voiding Invoices

Invoices that are submitted and/or subsequently processed can be voided. As opposed to deleting an invoice, a voided invoice and its associated claims can continue to be viewed in the system. An Invoice cannot be voided if **Status** is **Draft**. Draft is defined as an Invoice that has not been submitted for approval into NYEIS.

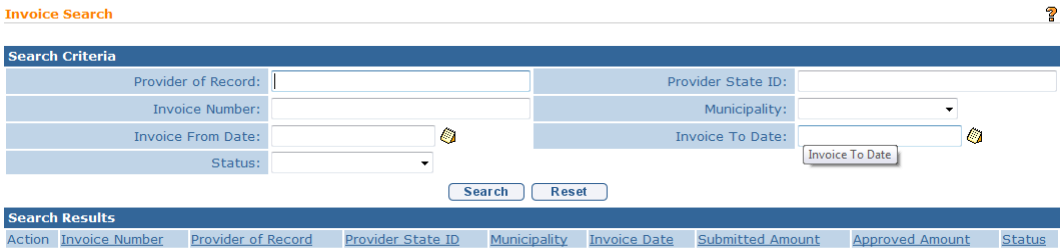
Be aware selecting **Void Invoice** will void the Invoice, including all Claims and Service Lines attached.

> **Important Information**
> When an invoice is voided, each Claim within the Invoice is voided. The next payment batch to the Provider will be reduced by the amount of the Void. Payment reductions can be seen on the **Payment Summary Detail List** page with the amount in the **Credit** column.

For each Claim submitted prior to 4/1/2013 in an Invoice that is voided, the System checks if any 3rd Party Reimbursement has started. If a Void occurs on a Claim that has been submitted for reimbursement to Commercial Insurance or Medicaid, a credit is sent to the 3rd Party, if the 3rd Party pays the Claim. If the voided Claim is part of a State Voucher, a credit is created and goes into the next State Voucher. *See* **Voiding Claims** for further information on voiding individual Claims. Claims submitted and subsequently voided after 4/1/2013 are processed by the SFA.

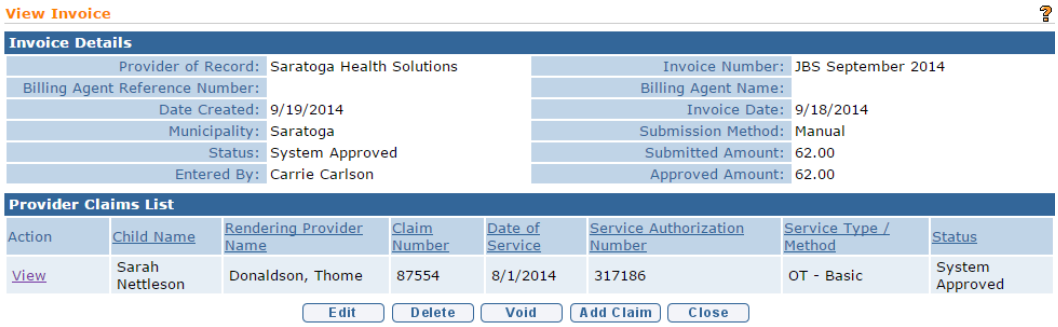
1. Log in to NYEIS. User Home Page displays.

2. Click **Invoices** link under **Search** section. **Invoice Search** page displays.



3. Type all known information in **Search Criteria** section. Click **Search** button. Records matching criteria display in **Search Results** section. *To search again, click **Reset** button.* Click **View** link under **Action** column for Invoice of choice. **View Invoice** page displays.

Important Information
Invoice numbers are alpha-numeric and case sensitive


View Invoice

Invoice Details

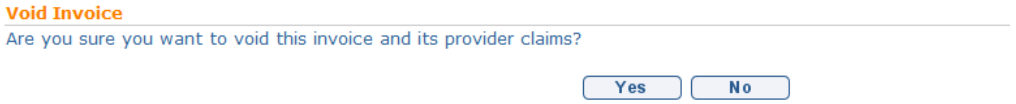
Provider of Record:	Saratoga Health Solutions	Invoice Number:	JBS September 2014
Billing Agent Reference Number:		Billing Agent Name:	
Date Created:	9/19/2014	Invoice Date:	9/18/2014
Municipality:	Saratoga	Submission Method:	Manual
Status:	System Approved	Submitted Amount:	62.00
Entered By:	Carrie Carlson	Approved Amount:	62.00

Provider Claims List

Action	Child Name	Rendering Provider Name	Claim Number	Date of Service	Service Authorization Number	Service Type / Method	Status
View	Sarah Nettleson	Donaldson, Thome	87554	8/1/2014	317186	OT - Basic	System Approved

Edit Delete Void Add Claim Close

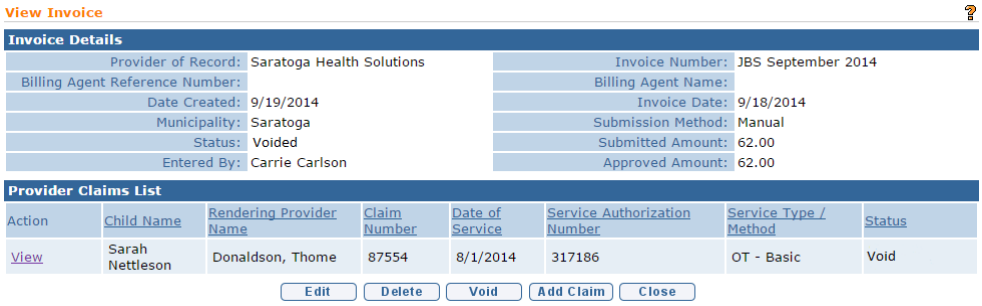
4. Click **Void** button. **Void Invoice** page displays with the message ***Are you sure you want to void this invoice and its provider claims?***


Void Invoice

Are you sure you want to void this invoice and its provider claims?

Yes No

5. Click **Yes** button to void entire Invoice. **View Invoice** page displays.


View Invoice

Invoice Details

Provider of Record:	Saratoga Health Solutions	Invoice Number:	JBS September 2014
Billing Agent Reference Number:		Billing Agent Name:	
Date Created:	9/19/2014	Invoice Date:	9/18/2014
Municipality:	Saratoga	Submission Method:	Manual
Status:	Voided	Submitted Amount:	62.00
Entered By:	Carrie Carlson	Approved Amount:	62.00

Provider Claims List

Action	Child Name	Rendering Provider Name	Claim Number	Date of Service	Service Authorization Number	Service Type / Method	Status
View	Sarah Nettleson	Donaldson, Thome	87554	8/1/2014	317186	OT - Basic	Void

Edit Delete Void Add Claim Close

CLAIMS

Adding Provider Claims

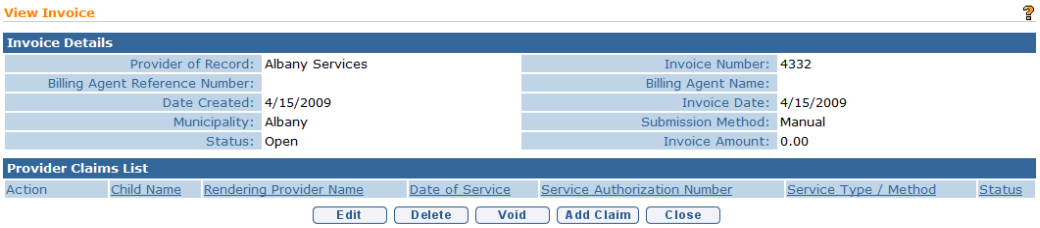
Claims can only be added to Invoices with a Status of Draft.

1. Log in to NYEIS. User Home Page displays.

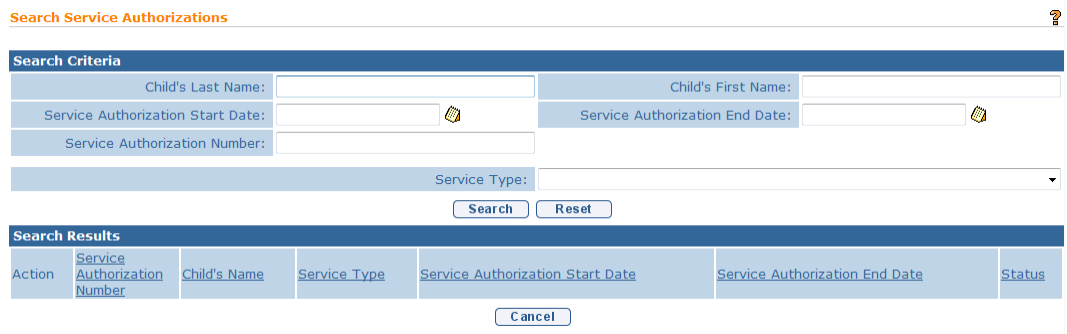
2. Click **Invoices** link under **Search** section. **Invoice Search** page displays.

3. Type all known information in **Search Criteria** section. Click **Search** button. Records matching criteria display in **Search Results** section. *To search again, click **Reset** button.* Click **View** link under **Action** column for Invoice of choice. **View Invoice** page displays.

Important Information
Invoice numbers are alpha-numeric and case sensitive.



4. Click **Add Claim** button. **Search Service Authorizations** page displays with the following sections: **Search Criteria** and **Search Results**.



5. Type all known information in **Search Criteria** section. Select **Service Type** field. Click **Search** button. Records matching criteria display in **Search Results** section. To search again, click **Reset** button.

   To view a Service Authorization, click **View** link under **Action** column for Service Authorization. The Service Authorization can be reviewed to verify remaining visits, effective dates and availability of co-visits and/or make up visits, etc. After reviewing, click **Close** button.

   To select a specific Service Authorization, click **Select** link under **Action** column for Service Authorization. **Create Provider Claim** page displays.

6. Navigate from field-to-field in **Create Provider Claim** page using **Tab** key; enter information. *Date fields must be formatted as **mm/dd/yyyy** format.* Below are possible sections that will display.

Details section:

- **Service Start/End Date** are dates the service is delivered and are validated against the **Service Authorization Start/End Date**.

- **Service Start/End Time** are in 24 hour time format.

- **Visit Type** *must* be provided by the Provider to indicate type of service being billed. Options are: **Regular** (for any regularly scheduled visit), **CoVisit** (if agreed to authorized on the IFSP) or **Makeup Visit** (if agreed to and authorized on the IFSP). Number of visits are authorized on Service Authorization. NYEIS will automatically reduce the total visits each time a visit is billed.

- **Parent Signature** checkbox indicates that a Parent Signature is on file with the Provider. The delivery of some EI services does not require a parent signature (for example Service Coordination). If the service delivered does not require the provider to maintain a parent signature, this box does not need to be checked.

Referring Provider section:

- **The Referring Provider NPI** is required for all General Service, Evaluation, and Service Coordination billing. A claim will not save with a missing or invalid referring provider NPI.

Rendering Provider section:

- ➲ **The Rendering Provider** is auto populated with the Rendering Provider assigned on the Service Authorization. If the Rendering Provider that delivered the service is different than the Rendering Provider assigned on the Service Authorization, the appropriate Rendering Provider should be selected on the claim.

Provider Claim Reference Numbers section:

- **Provider Claim Number** is a unique tracking number assigned to a Claim by the Provider of Record. If the Provider does not enter a Claim number, the system will automatically assign it when the Claim is created.

- **Medical Record Number** can be used for the Provider's internal use. It is not required.

ICD Codes section:

- **ICD Codes** allows the Provider to enter three ICD Codes (which have previously been entered on the child's record) and one additional ICD Code (which may or may not have been previously entered on the child's record).

- To add data for the **Diagnosis (ICD) Code 1** field, select the **Search** icon. Type all known information in **Search Criteria** section. (ICD Codes, if available, will be one or more previously documented ICD Codes in the child's case.) Click **Search** button. Records matching the search criteria display in **Search Results** section. If applicable, select the most appropriate code for *the service delivered.*

  *Click **Select** link under **Action** column to* identify **ICD Code**. **Create Provider Claim** page displays.

- To add data for the **Diagnosis (ICD) Codes 2 and 3** fields, repeat the above step.

- To add data for the **Diagnosis (ICD) Code 4** field, select the **Search** icon. Type all known information in **Search Criteria** section. (**Diagnosis (ICD) Code 4** can be selected from the list of all available ICD Codes.) Click **Search** button. Records matching the search criteria display in **Search Results** section. If applicable, select the most appropriate code *for the service delivered*. *To search again, click **Reset** button.*

  *Click **Select** link under **Action** column to identify* **ICD Code**. **Create Provider Claim** page displays.

Important Information
If the EIP provider determines that there is no appropriate ICD code applicable to the service(s) being delivered in the child's record (e.g., child's health assessment or child's multidisciplinary evaluation, prescriptions, written orders, written recommendations, or referrals), the EIP provider is responsible for securing and providing accurate and appropriate diagnosis codes for Early Intervention services provided to children and families in the EIP, consistent with the scope of practice of his or her professional license, certification, or registration. Users with access rights can add these ICD codes to the child's record in NYEIS via the **Health Assessments** link found on the child's integrated case homepage.

7. Click **Search** icon to identify **Rendering Provider** and **Diagnosis (ICD) Codes** for defined sections. Click **Select** link under **Action** column for record of choice. **Create Provider Claim** page displays. *Be sure that the **Rendering Provider** and **Diagnosis (ICD) Codes** are selected.*

8. Click **Save** button. **Create Provider Service Line** page displays.

9. Select the **Procedure Code** (HCPCS, **CPT, etc.)** from the drop down and **Units** for Service Line.

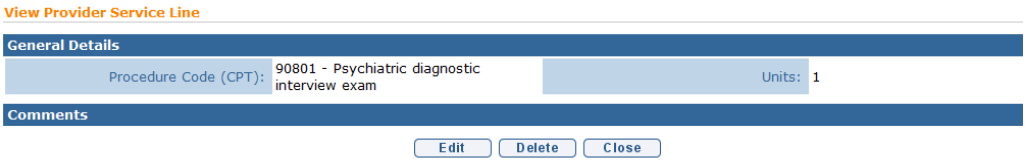
   Some Procedure Codes have a number of minutes associated with them. Based on the code reported by the Provider, the number of units billed for that Procedure Code *must* be indicated. For example, if a Provider uses a code with a 15 minute association, and the Provider worked with the Child for 30 minutes, the units on the Claim would be two. NYEIS does not validate whether the number of units entered for a Procedure Code is appropriate based on the length of the visit. It is the provider's responsibility to enter the correct number of units for a claim.

   Important Information
   Claims that require a Procedure code will be denied if they are submitted without a Procedure Code selected. 🕮 *See* **Claims** for more information on **Provider Claim Home** page.

10. Click **Save** button. **Provider Claim Home** page displays. *Click **Save & New** button from the **Create Provider Service Line** page to add additional Procedure Codes.*

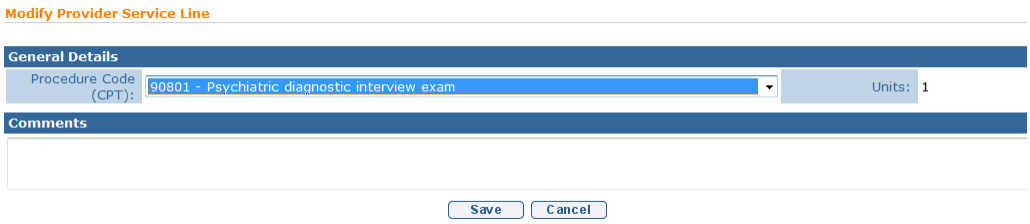
    The following options are available for **Service Lines** section:

    ➲ Click **View** link under **Action** column. **View Provider Service Line** page displays. This page also gives the capability to **Edit** or **Delete** a Provider Service Line.



Or

➲ Click **Edit** link under **Action** column. **Modify Provider Service Line** page displays.

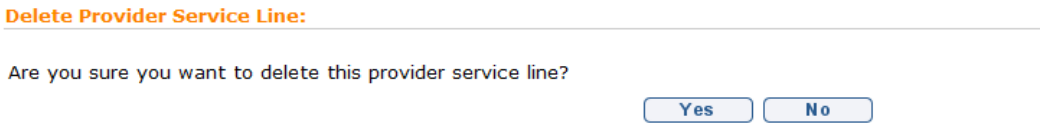


Edit **Procedure Code (HCPCS, CPT, etc.)**. Edit **Comments** as needed. Click **Save** button. **Provider Claim Home** page displays.

Or

➲ Click **Delete** link under **Action** column. **Delete Provider Service Line** page displays the message ***Are you sure you want to delete this provider service line?*** Click **Yes** button. **Provider Claim Home** page displays.

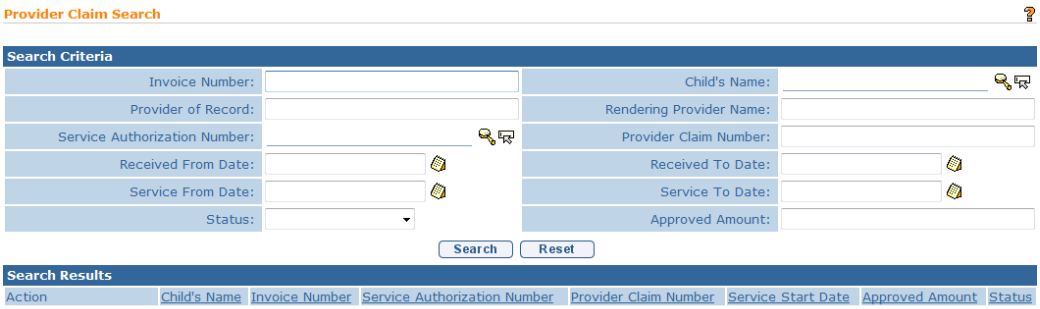
➲



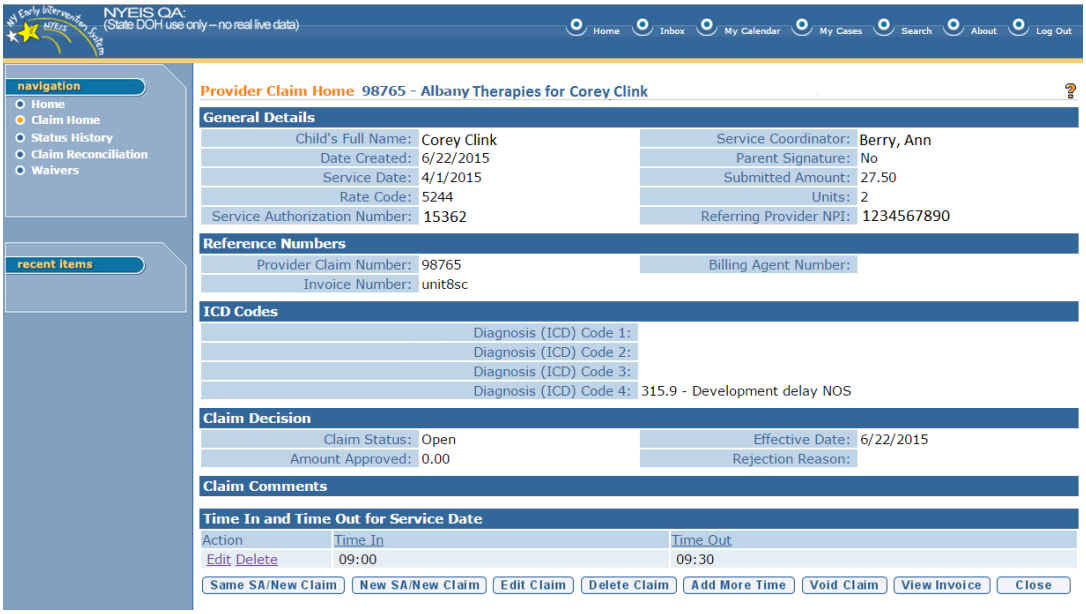
Searching/Viewing Claims

1. Log in to NYEIS. User Home Page displays.

2. Click **Provider Claims** link under **Search** section. **Provider Claim Search** page displays.



3. Type all known information in **Search Criteria** section. Click **Search** button. Records matching criteria display in **Search Results** section. *To search again, click **Reset** button.* Click **View** link under **Action** column for Claim of choice. **Provider Claim Home** page displays. The following additional functions for Provider Claims are available from the **Provider Claim Home** page: **Same SA/New Claim**, **New SA/ New Claim**, **Edit Claim**, **Delete Claim**, **Add Service Line**, **Void Claim** and **View Invoice**. 🕮 *See* sections below for further information.



Important Information

Provider Claims go through the following Status lifecycle. Users can search for Claims by **Status** on the **Provider Claim Search** page.

Open: Claim has not been submitted for approval and can be edited.

Submitted: Claim has been submitted for approval.

System Approved: Claim has been adjudicated by NYEIS and will move on for further processing

Approved: Specific status for Vendor claims only (Transportation, Respite ATD) - Claim has passed the Invoice Rules.

Denied: Claim has failed one or more Invoice Rules or was rejected by the Municipality. A Denial Reason is added to the Claim and displays on the **Provider Claim Home** page.

Pending: Claim has violated a billing rule for which an upfront waiver has been denied and is awaiting the submission of a justification from the provider and Approval.

HIPAA Reject: Claims in 'Pending' status for greater than 28 days are automatically set to this status.

County Provided Service: Municipality was the Provider of Record for an approved Claim. A payment is not created for the Municipality. This Claim will

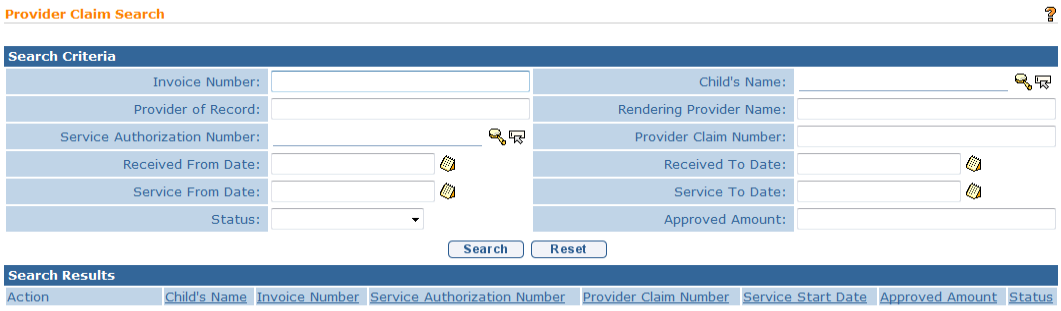
not be included in the County Payment File (applicable to pre 4/1/2013 submitted claims only).
Municipal Audit: Claim has been recouped due to Municipal audit.
Municipal Audit Processing: Claim has been recouped due to Municipal audit and included on a payment file reducing a payment.
Municipal Audit Recovered: Claim has been recouped due to Municipal audit and the net of the provider payment is less than zero. This happens when the total of the provider claim released is less than the recouped claims.
Municipal Rejected: Claim was reviewed by a Muncipal Finance user and manually rejected (applicable to pre 4/1/2013 submitted claims only)
SDOH Audit: Claim has been recouped due to an SDOH audit.
SDOH Audit Processing: Claim has been recouped due to SDOH audit and included on a payment file reducing a payment.
SDOH Audit recovered: Claim has been recouped due to SDOH audit and the net of the provider payment is less than zero. This happens when the total of the provider claim released is less than the recouped claims.
SDOH Unqualified Personnel: Claim has been recouped; SDOH determined unqualified personnel on the claim.
SDOH Unqualified Personnel Processing: Claim has been recouped; SDOH determined Unqualifed Personnel on a claim -- included on the payment file reducing the payment.
SDOH Unqualified Personnel Recovered: Claim has been recouped; SDOH determined Unqualified Personnel on a claim and the net of the provider payment is less than zero. This happens when the total of the provider claim released is less than the recouped claims.
Released: Municipality has released the approved Claim for Payment.
Processing: Claim has been included in the Municipal Payment File to Municipal Finance.
Paid: Claim has been paid to the Provider.
Void: Claim has been voided.
Void Processing: Claim has been voided and included on a Provider payment.
Void Recovered: Claim has been voided and the Payment containing the credit has been reconciled. Note: General Service Claims submitted after 4/1/2013 and subsequently voided will receive the status of Void Recovered in NYEIS; however, the processing and payment recovery of the voided claim is completed by the SFA.
Retro/Retro Processing/Retro Paid: Claim has been part of a retroactive rate reimbursement.

Editing Claims

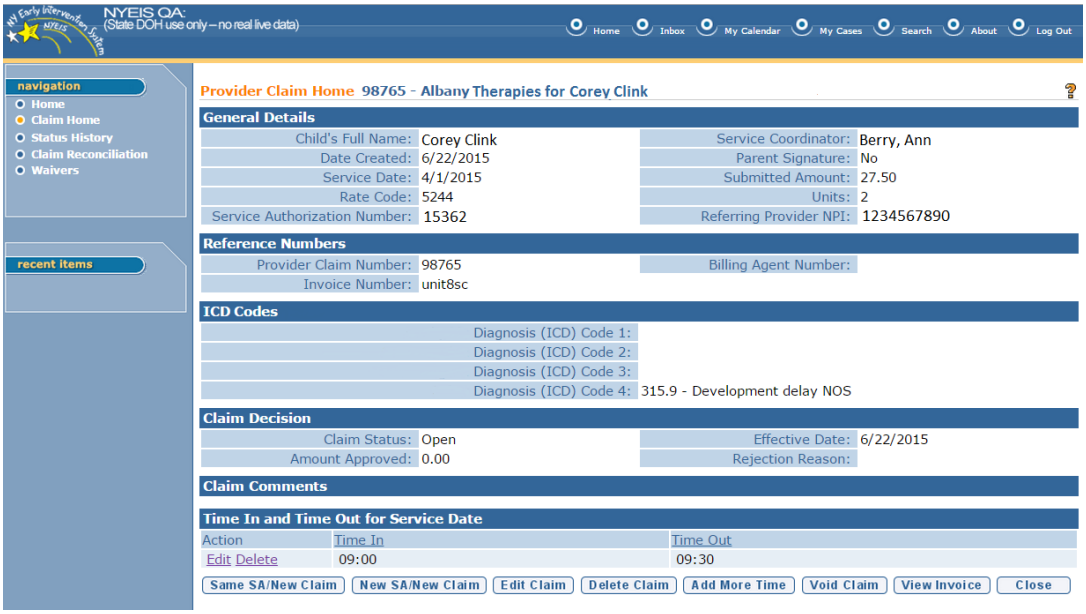
Claim data attached to an **Invoice** can *only* be edited if the **Status** is **Draft**. If a deletion is needed after a Claim is submitted, then the Claim *must* be voided and if desired, the claim can be rebilled as a new claim on a new invoice.

1. Log in to NYEIS. User Home Page displays.

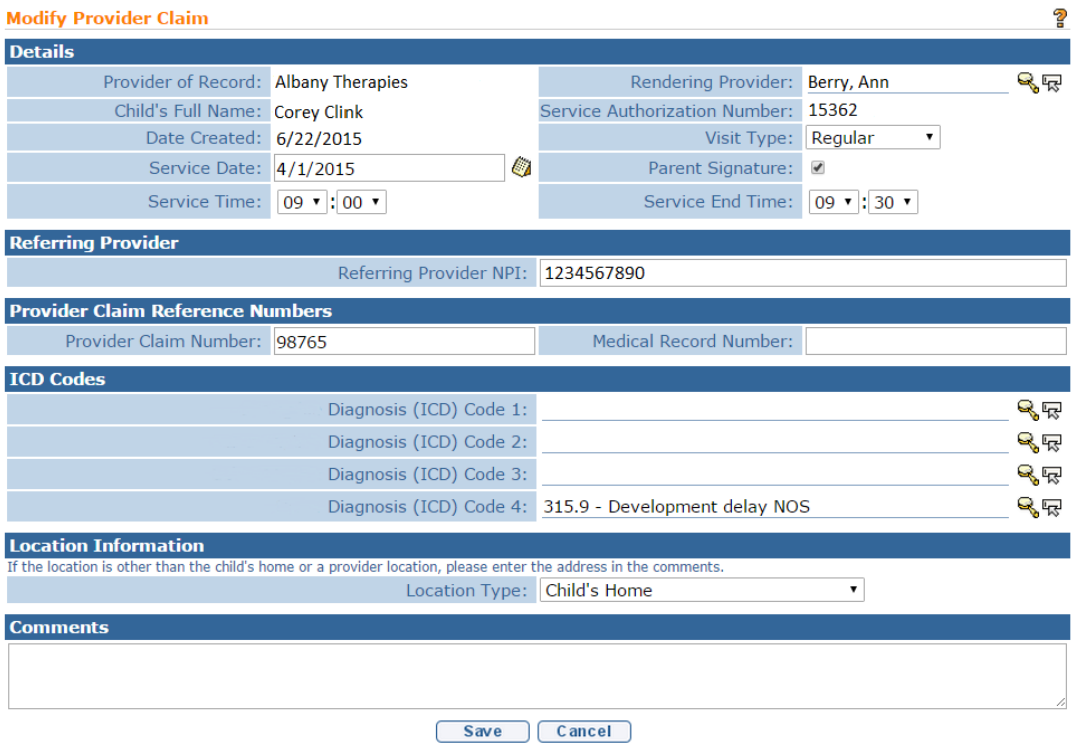
2. Click **Provider Claims** link under **Search** section. **Provider Claim Search** page displays.



3. Type all known information in **Search Criteria** section. Click **Search** button. Records matching criteria display in **Search Results** section. *To search again, click **Reset** button.* Click **View** link under **Action** column for Claim of choice. **Provider Claim Home** page displays.



4. Click **Edit Claim** button. **Modify Provider Claim** page displays



5. Apply changes.

6. Click **Save** button. **Provider Claim Home** page displays.

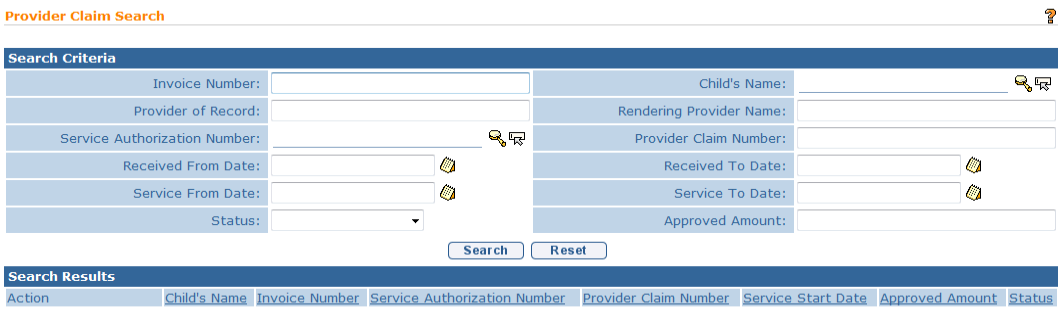
Deleting Claims

Claim data attached to an **Invoice** can *only* be deleted if the **Status** is **Draft**. If a deletion is needed after a Claim is submitted, then the Claim *must* be voided and if desired, the claim can be rebilled as a new claim on a new invoice.

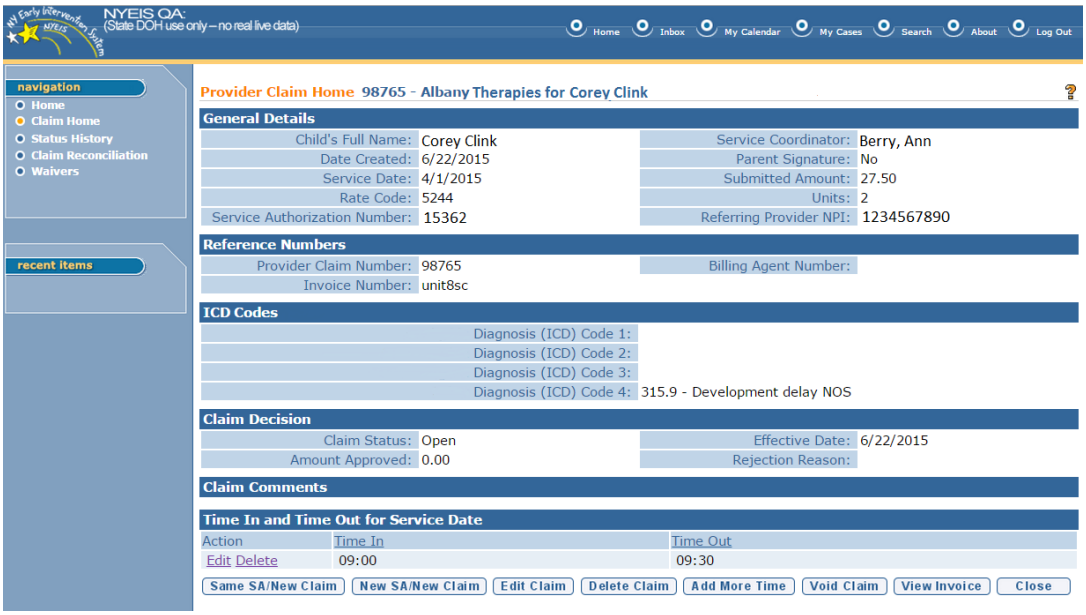
Be aware selecting **Delete Claim** will delete the Claim and all attached Service Lines.

1. Log in to NYEIS. User Home Page displays.

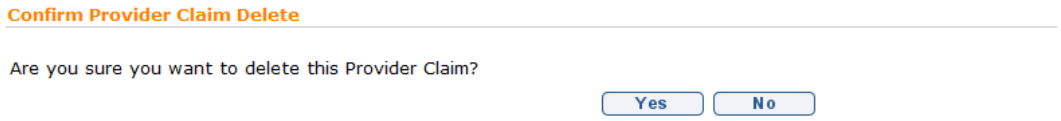
2. Click **Provider Claims** link under **Search** section. **Provider Claim Search** page displays.



3. Type all known information in **Search Criteria** section. Click **Search** button. Records matching criteria display in **Search Results** section. *To search again, click **Reset** button.* Click **View** link under **Action** column for Claim of choice. **Provider Claim Home** page displays.



4. Click **Delete Claim** button. **Confirm Provider Claim Delete** page displays with the message ***Are you sure you want to delete this Provider Claim?***



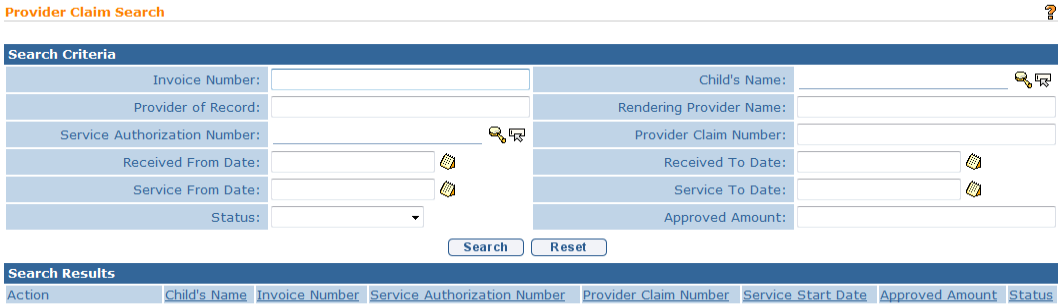
5. Click **Yes** button to delete entire Claim. **View Invoice** page displays.

6. Click **Close** button. User Home Page displays.

Adding Additional Service Lines to a Claim

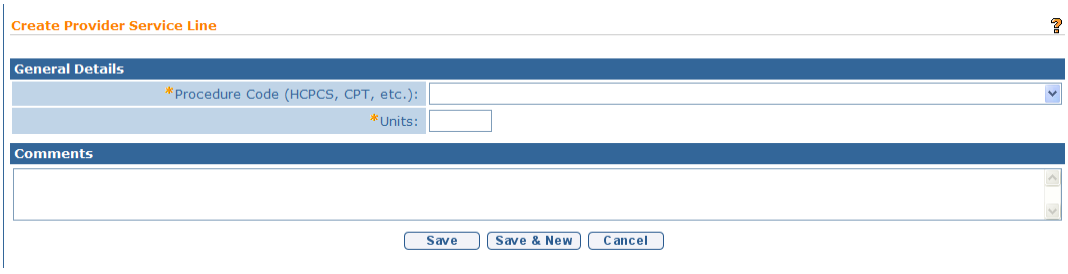
1. Log in to NYEIS. User Home Page displays.

2. Click **Provider Claims** link under **Search** section. **Provider Claim Search** page displays.



3. Type all known information in **Search Criteria** section. Click **Search** button. Records matching criteria display in **Search Results** section. *To search again, click **Reset** button.* Click **View** link under **Action** column for Claim of choice. **Provider Claim Home** page displays.

4. Click **Add Service Line** button. **Create Provider Service Line** page displays.



Service Coordination, Special Instruction and Evaluations do not have Service Lines.

5. Select from the **Procedure Code (HCPCS, CPT, etc.)** drop down. Type **Units**. Type **Comments** *(Optional).*

   Some Procedure Codes have a number of minutes associated with them. Based on the code reported by the Provider, the number of units billed for that Procedure Code *must* be indicated. For example, if a Provider uses a code with a 15 minute association, and the Provider worked with the Child for 30 minutes, the units on the Claim would be two. NYEIS does not validate whether the number of units entered for a Procedure Code is appropriate based on the length of the visit. It is the provider's responsibility to enter the correct number of units for a claim.

   Important Information
   Claims that require a Procedure code will be denied if they are submitted without a Procedure code selected. 🕮 *See* **Claims** for more information on **Provider Claim Home** page.

6. Click **Save** button to save Service Line. **Provider Claim Home** page displays with Service Line(s).

   Or

   Click **Save & New** to save Service Line and create an additional Service Line.

7. Click **Home** from the Navigation Bar. User Home Page displays.

Voiding Claims

A Claim cannot be voided if **Status** is **Draft**. Claims that are in a **Submitted** or later statuses such as **Pending**, **System Approved**, and **Approved** can instead be voided.

Be aware selecting **Void Claim** will void the Claim and all Service Lines attached.

Important Information
Applicable to all pre 4/1/2013 submitted claims and all vendor claims:

- After a Claim is voided, the next payment batch to a Provider will be reduced by the amount of the Void. Payment reductions can be seen on the **Payment Summary Detail List** page with the amount in the **Credit** column.

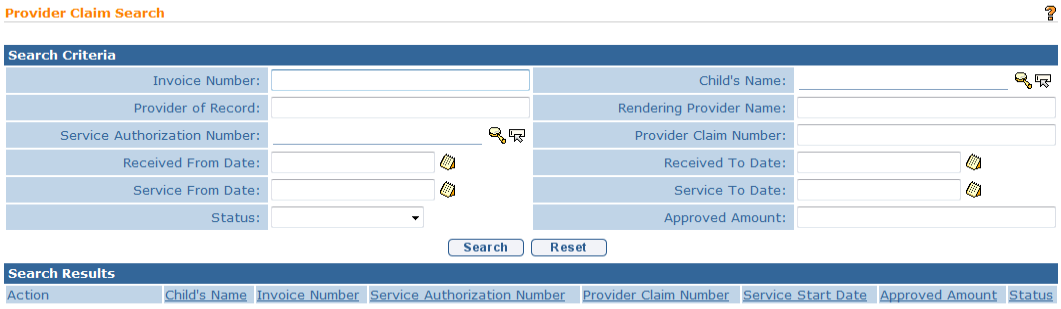
- If a Void occurs on a Claim that has been submitted for reimbursement to Commercial Insurance or Medicaid, a credit gets sent to the 3rd Party if the 3rd Party pays the Claim. If the voided Claim is part of a State Voucher, a credit is created and goes into the next State Voucher.

- If a Claim is voided prior to being released for payment, the Claim will not be included in the list of Claims that can be released. The voided Claim will not be part of the County Payment File.

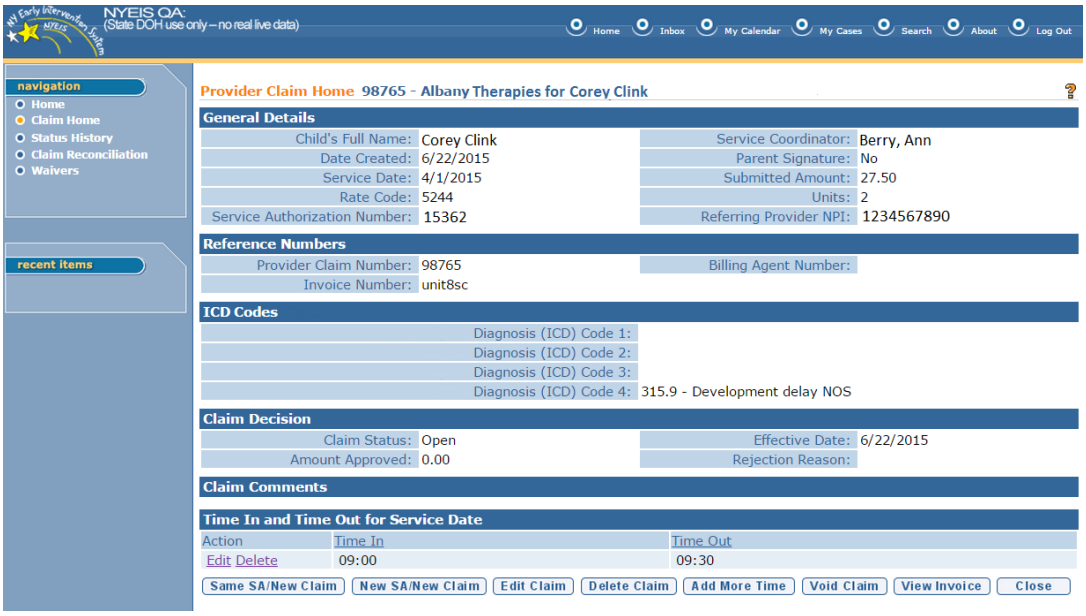
Claims submitted after 4/1/2013 that are subsequently voided will display a status of '**Void Recovered'**, however the processing and payment recovery of the voided claim is completed by the **State Fiscal Agent**

1. Log in to NYEIS. User Home Page displays.

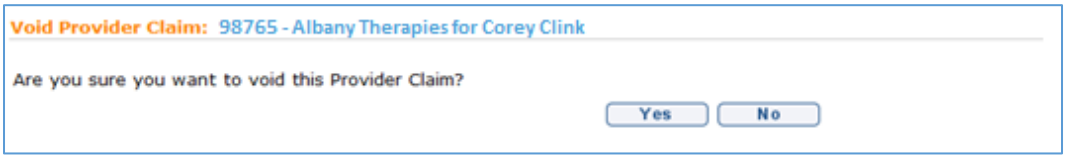
2. Click **Provider Claims** link under **Search** section. **Provider Claim Search** page displays.



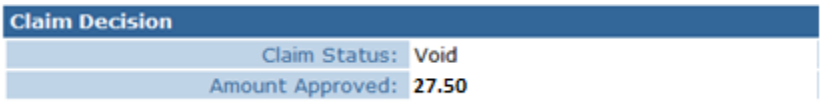
3. Type all known information in **Search Criteria** section. Click **Search** button. Records matching criteria display in **Search Results** section. *To search again, click **Reset** button.* Click **View** link under **Action** column for Claim of choice. **Provider Claim Home** page displays.



4. Click **Void Claim** button. **Void Provider Claim** page displays with the message ***Are you sure you want to void this Provider Claim?***



5. Click **Yes** button to void entire Claim. **Provider Claim Home** page displays. **Claim Status** displays **Void**.

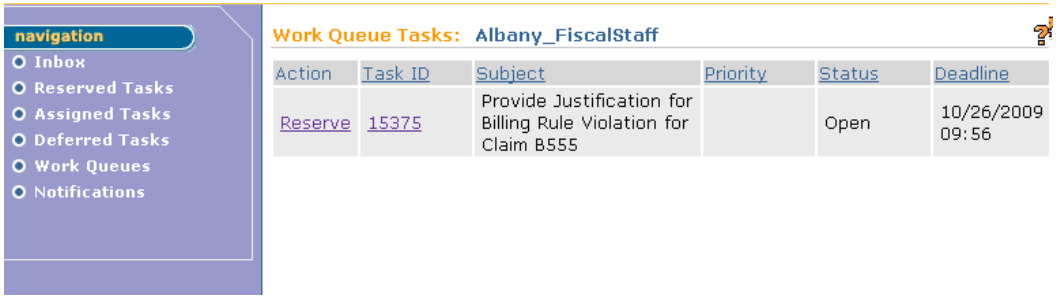


Important Information
If the State changes a provider's approval status to Disqualified or Disapproved, the system will automatically void any claims with a status of Submitted, Processing, and Paid when the recorded claim service date falls on or after the effective date of the Provider's status change.

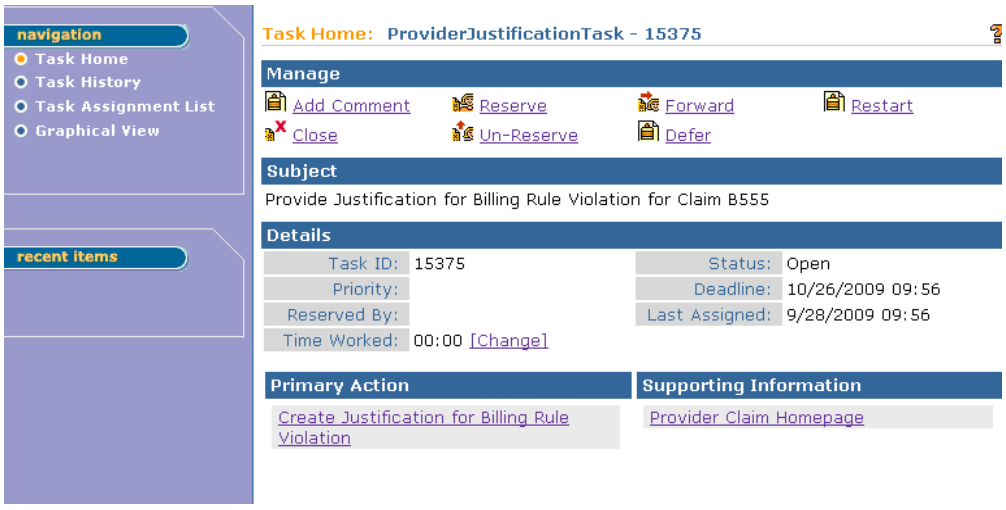
WAIVERS

A Waiver is needed if a Claim is submitted and it violates a billing rule for which an upfront waiver has been denied and requires the submission of a justification from the provider. A Claim can violate one or more billing rules for which an upfront waiver has been denied and the **Status** of the Claim appears as **Pending**. For each Claim in Pending Status, a task is created for the Provider in the **Financials Work Queue** to provide a justification for each of the billing violations for which an upfront waiver has been denied on the Claim. If the provider is not online, the task goes to the Municipality's **Fiscal Staff Work Queue** to obtain the justification from the provider.

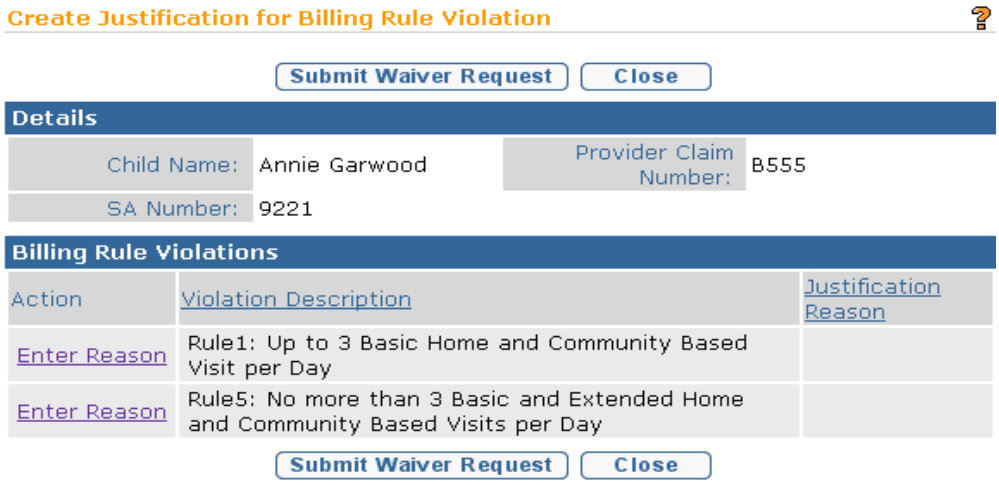
1. From the provider **Financial** work queue, or the Municipality's **Fiscal Staff** work queue if the provider is not on NYEIS, select **Task** Provide Justification for Billing Rule Violation.



2. Click on the Reserve link under the Action column. Click **Reserve & View** to display Task Home Page.



3. Select Create Justification for Billing Rule Violation under the Primary Action. Create Justification for Billing Rule Violation page displays with list of billing rule violations for the Claim.

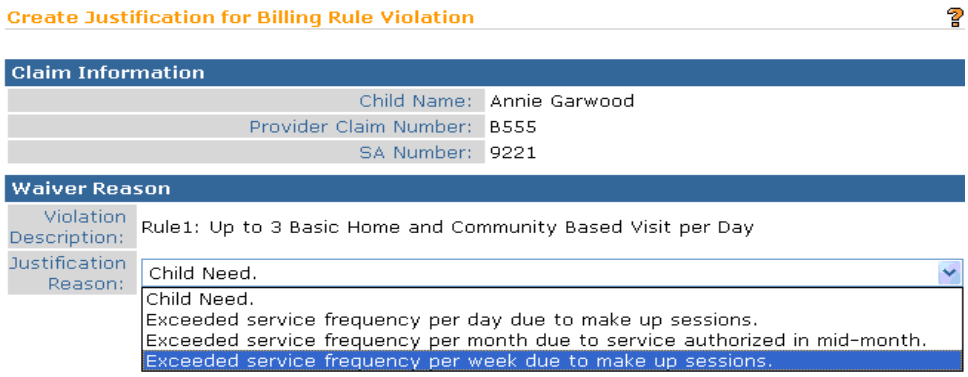


4. Select **Enter Reason** under the Action Column to select justification reason for each violation. Click **Save**. After the Provider provides justification, the Early Intervention Official Designee (EIO/D) receives a task to review the Request for Waiver. The EIO/D can then approve or reject the request for Waiver.

   If the Request for Waiver is approved, the claim becomes **Approved**. If the Request for Waiver is rejected, the Claim is denied.

Important Information:
The Approval status assigned and nature of further claim processing upon EIO/D approval of a waiver request will vary depending on the *original provider claim submission date:*

- If claim associated with the approved waiver request was submitted prior to 4/1/2013: The approval status is **'Approved'**
- If claim associated with the approved waiver request was submitted on or after 4/1/2013: The approval status is '**System Approved**'

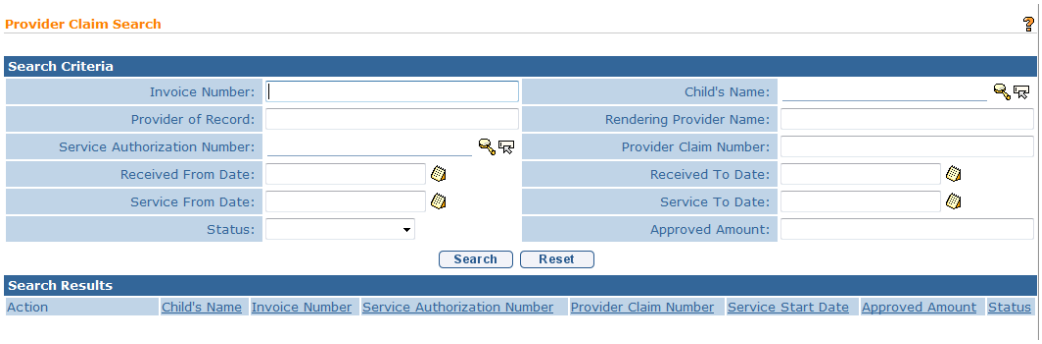


The Provider can view the status of claims, either [Approved/System Approved] or Denied, by viewing the **Claim Homepage.** Providers with appropriate access to a child's **IFSP Homepage** may also click the **Waivers** link off the navigation bar to view the status of any waivers for that IFSP.

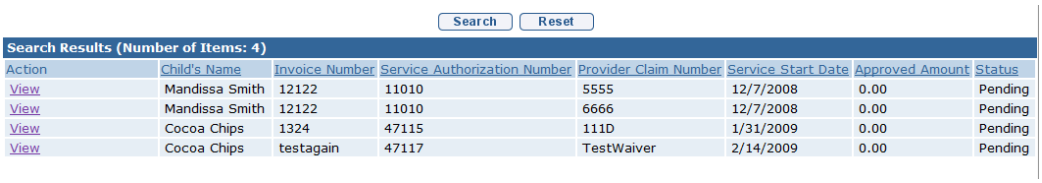
Important Information
Waivers *must* be approved/rejected by an EIO/D. 🕮 *See* **EIO/D waiver approval/rejection steps** for more information.

1. Log in to NYEIS. User Home Page displays.

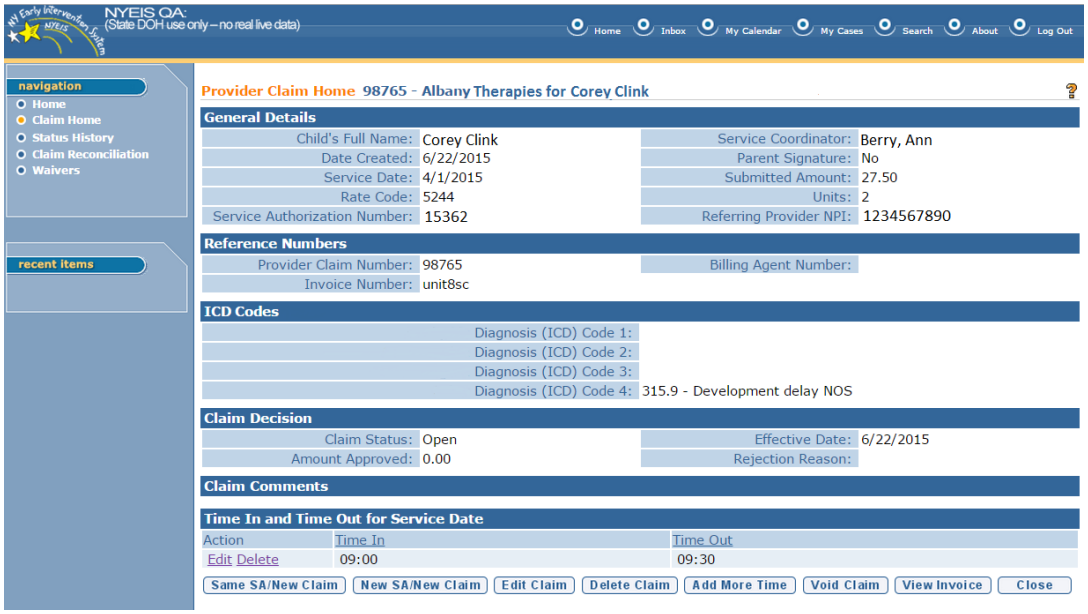
2. Click **Provider Claims** link under **Search** section. **Provider Claim Search** page displays.



3. Type all known information in **Search Criteria** section. Click **Search** button. Records matching criteria display in **Search Results** section. *To search again, click **Reset** button.* Click **View** link under **Action** column for Claim of choice.

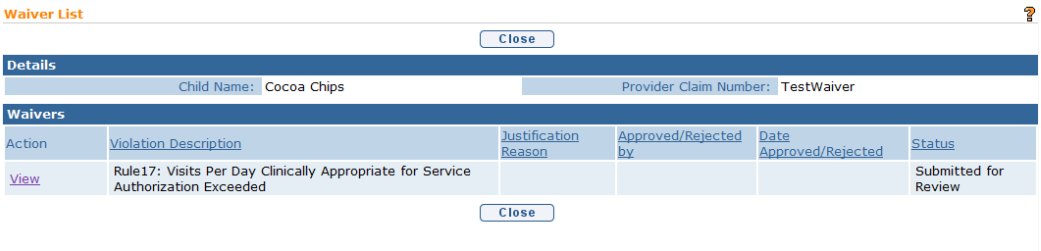


4. **Provider Claim Home** page displays. Click **Waivers** from the Navigation Bar.

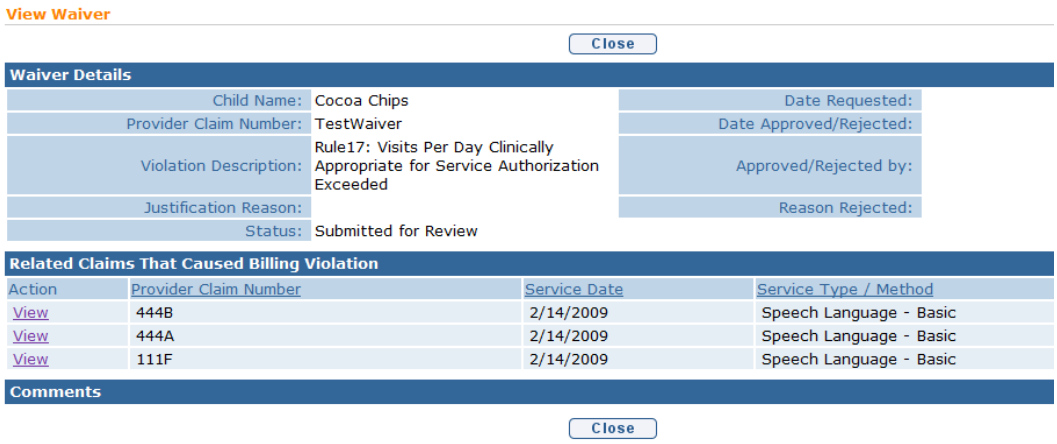


5. **Waiver List** page displays. This page contains the list of billing violations that make up this waiver.

> **Important Information**
> This Waivers list does not include any Upfront waivers.



6. Click **View** link under **Action** column to display a specific billing violation. **View Waiver** page displays with the section listing the r**elated claims that contributed to the Billing Rule Violation**. The EIO/D has the opportunity to view the combination of claims to aide with their decision to approve or reject the waiver request.



7. Click **Close** button. **Waiver List** page displays.

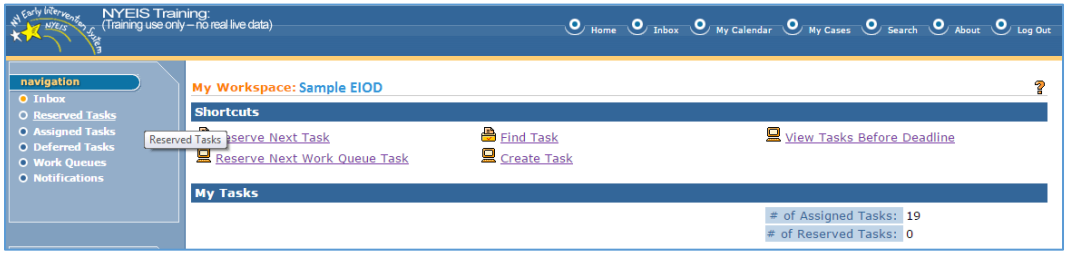
8. Click **Close** button. **Provider Claim Home** page displays.

EIO/D waiver approval/rejection steps:

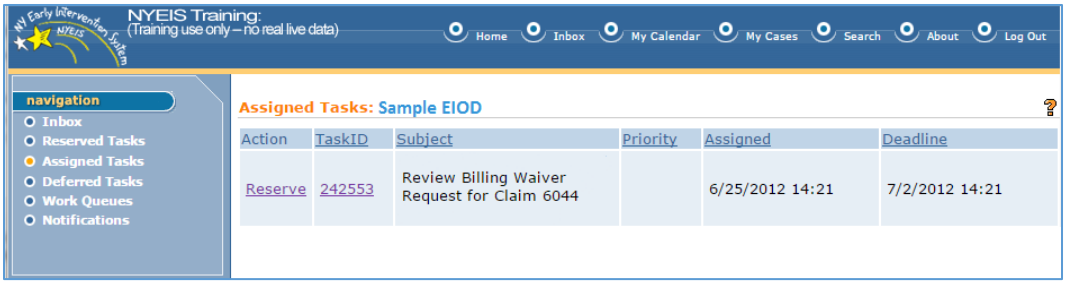
After the provider submits a waiver request for an individual claim, the child's assigned EIO/D receives a task to approve or reject the waiver request. Approved waiver requests result in the claim becoming **System Approved** while rejected waiver requests result in the claim being **Denied**.

Important Information
Approval of a submitted waiver request is a *Municipal* function.
If a waiver request is denied in error, the claim can only be resubmitted on a new invoice. No further action can be taken with a **Denied** claim.

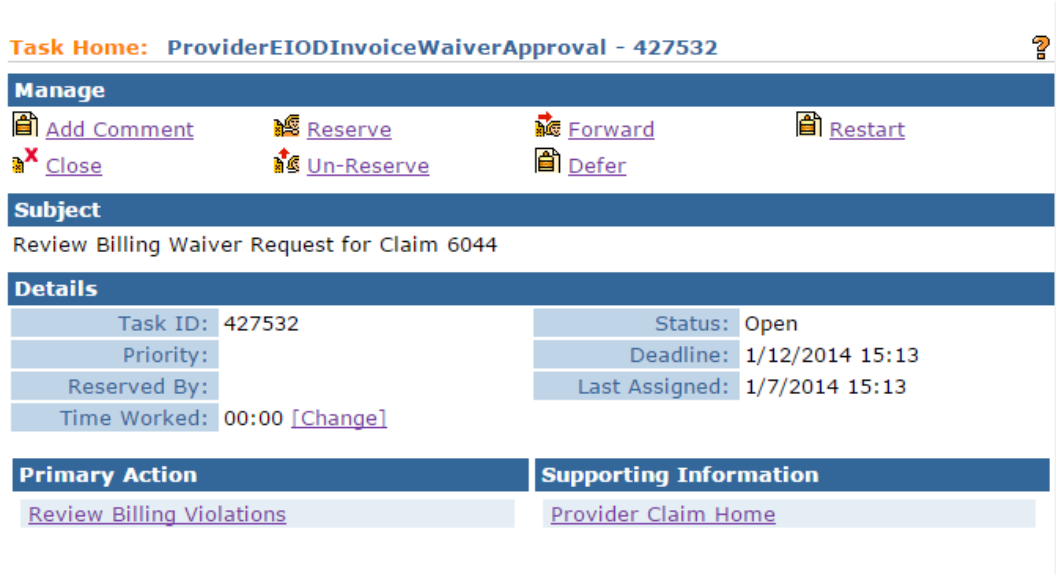
1. Click Inbox on upper menu bar. **My Workspace** Page displays:



2. Click on **Assigned Tasks** in the left-hand Navigation Bar. **Assigned Tasks** page displays:



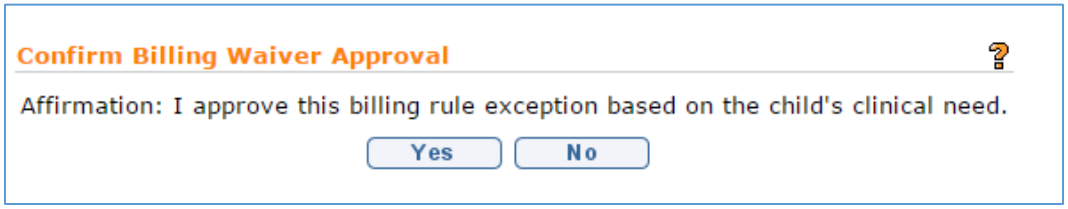
3. Look for a task with subject "Review Billing Waiver Request for Claim (Claim number)". The claim number referenced in the subject will correspond to the claim in **Pending** status. Click on the Task ID number. **Task Home** page displays for selected task:



4. Follow Task's **Primary Action**: *Review Billing Violations*. Alternatively, clicking on the link to the *Provider Claim Home* under the **Supporting Information** cluster will load the Provider Claim. Hit the **Back** button when review of claim is complete. After following the Tasks Primary Action, the **Waiver Requested For Following Violations** page displays:

5. **<u>If Approving ALL associated Billing Violations with a given Claim</u>**

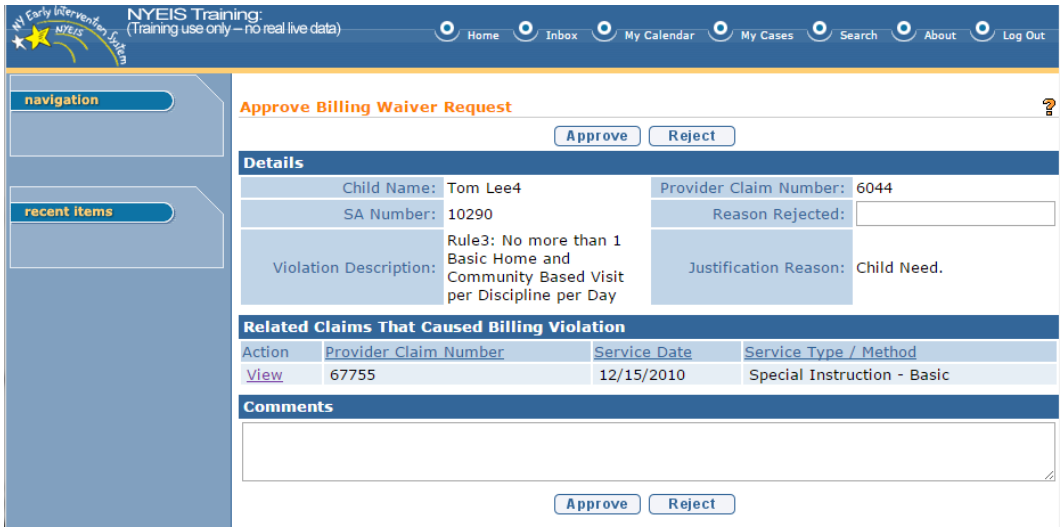
In cases where multiple billing violations exist for a claim, click the **Approve All** button to approve all related billing waivers at once. The **Confirm Billing Waiver Approval** page displays:



Click the **Yes** button to approve all associated waivers for the given claim. **Waiver Requested For Following Violations** page displays with an 'Approved' status assigned to all violations. Clicking **No** returns to the **Waiver Requested For Following Violations**, without any decisions recorded:

<u>If rejecting a submitted waiver request or to render a decision on an individual billing violation with a given claim:</u>

Click the **Manage** link to review corresponding to any individual violations cited. **Approve Billing Waiver Request** page displays:



If desired click the **View** link in the **Related Claims That Caused Billing Violation** cluster to view the claim. Click the **Back** button when review is complete:

a. To **reject** the request, record a rejection reason in the **Reason Rejected** field (optional), record any comments in **Comments** section (optional), then click the **Reject** button. **Confirm Billing Waiver Rejection** page displays. Click **Yes** to proceed with rejection or click **No** to return to previous page

b. To approve the request, enter comments in the **Comments** section (optional), then click **Approve. Confirm Billing Waiver Approval** page displays. Click **Yes to proceed with approval or click No to return to previous page.**

6. Following the decision by the EIOD on the given claim, the **Waiver Requested For Following Violations** page displays. The Status column will reflect the most recent decision on the claim ('Approved' or 'Rejected'):

Clicking **Finished** applies the decision to the claim. If Approved, the claim will status will reflect **System Approved.** If Rejected, the claim status will reflect **Denied**

PROVIDER ELECTRONIC (837) CLAIMING

This section contains information to guide Users through the process of electronically submitting claims – to NYEIS. Only electronic claims adhering to the HIPAA 5010 transaction format can be accepted into NYEIS.

The following sections provide information about the pre-approval process for submitting electronic claims, and the subsequent general flow of events that occur when a provider submits (uploads) an electronic 837P claim file into NYEIS. Users are provided with feedback on each submissions status by way of '999' and 'F-File' response files. Details on how to interpret this information is provided in this topic.

Getting Approved and Configured for Electronic Claiming

Before a provider is permitted to upload 837P transactions into NYEIS, they must complete the following steps:

1. Review the "Procedures to Submit Electronic Claims" file located on the Health Commerce System in the NYEIS Electronic Claiming folder.
2. Download the "Request to Submit Electronic" and the "837 HealthCare Claim Professional Companion Guide".
3. On the "Request to Submit Electronic Claims" request an ETIN for each municipality that is in your agency's Catchment Area and that you want to submit electronic claims for.
4. Send completed form to NYEIS@health.ny.gov. ETINs will be generated and registered in the NYEIS Test System and Testing Instructions will be supplied to the provider.
5. Complete the testing process.

During the testing phase providers are supplied the documentation needed to successfully complete the process. Download the "837 HealthCare Claim Professional Companion Guide" and the "Procedures to Submit Electronic Claims" from the Health Commerce System (HCS) in the NYEIS Folder.

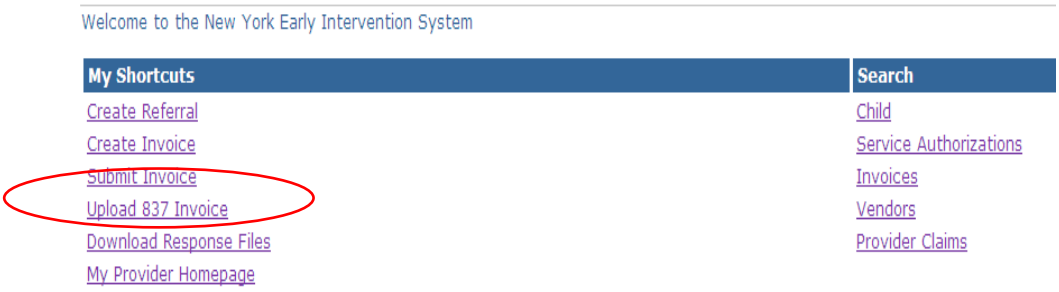
Important Information
The provider's account will be configured in NYEIS after successfully completing the testing process. This will enable the provider to successfully upload the 837P Claim file.

Uploading the 837P Claim File to NYEIS

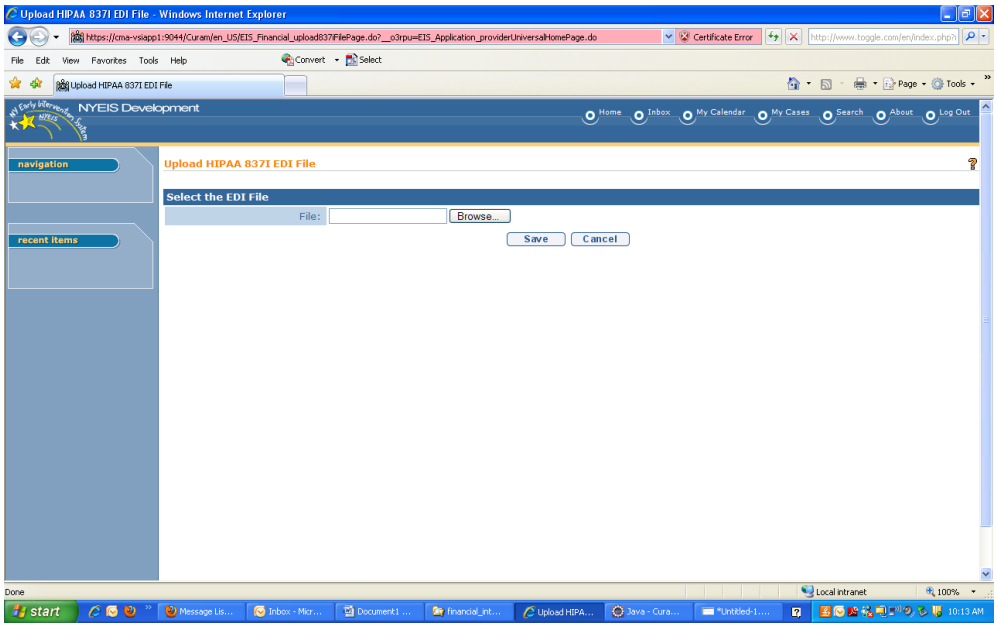
All 837P electronic claim files must adhere to the HIPAA 5010A EDI transaction format in order to be successfully uploaded to NYEIS and processed. The file will be rejected if it does not adhere to the HIPAA 5010A standard.

Important Information
Once the 837P Invoice file has been uploaded to NYEIS it will take at a minimum 24 hours for the file to be fully processed. Processing involves three phases, or review steps.

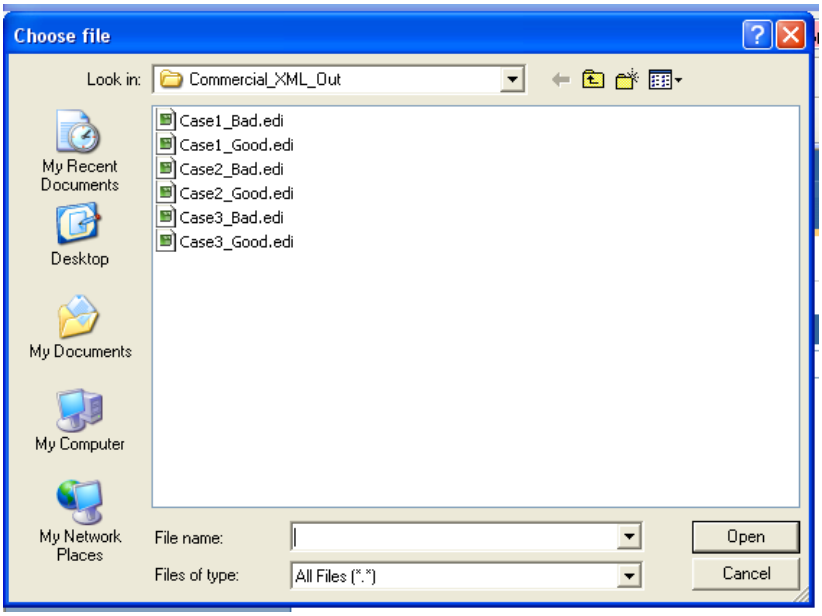
1. To submit an 837P claim file to NYEIS, select the "Upload 837 Invoice" menu option.



2. A screen will display allowing you to browse your computer to find the 837P HIPAA claim file.

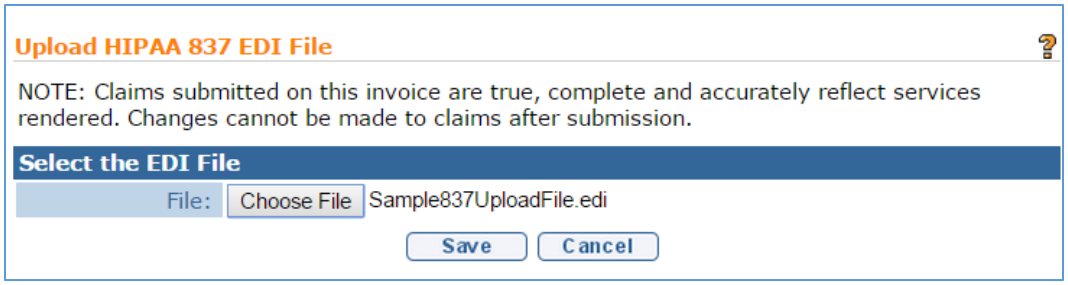


3. To upload claims select the Browse button.



4. Choose the file that is to be uploaded into NYEIS by either double clicking on the file name or clicking once on the file name, then clicking the Open button.

5. The file name will be placed in the file field on the Upload screen. Click Save to transmit the claim file into NYEIS:



6. A confirmation message stating that you have successfully uploaded your file 837P file will be displayed.

Checking the 837P Claim File Status

NYEIS processes the submitted 837P electronic claim file in three phases, or review steps.

837P Processing Overview

The 837P claim file is first reviewed to ensure it conforms to the HIPAA 5010 file format standard (Step 1). If the system detects any non-conformities in the file, the system provides feedback in the form a 999 Response file. The provider must review the 999 File, correct all errors listed in the 999, and resubmit the 837P. If no errors are detected, the 999 Response File provides notice that the submitted 837P file passed the HIPAA 5010 standards review.

Important Information
If the 837P file that is uploaded to NYEIS is not in a recognized format (e.g., a Word document is uploaded), the system will not generate a 999 Response File for files in the HIPAA 5010 file format standard. Rather, the uploaded file is placed into an "Invalid" file folder that is monitored daily by the Operations team.

Once the 837P file passes the 5010 file format standards, the system next analyzes the file for proprietary "pre-invoice" errors (Step 2). All claims that pass the "pre-invoice" review are then analyzed to confirm that they pass all Early Intervention claiming rules (Step 3). Errors with the invoice or claims may be identified at each Step.

Important Information
An F-File Response will be created after Step 2 if the system identifies "pre-invoice" errors in 837P claim file. Step 2 is completed within one hour after the 837P passes the Step 1 review.

In addition, the claims that pass the Step 2 "pre-invoice" review are then processed in Step 3, the Early Intervention claiming rules review. If any of these claims are found to have claiming rule violations, the claim is visible within NYEIS as a denied claim. Step 3 is completed during a nightly batch process.

An F-File Response will only be generated and made available once all of the pre-invoice and claiming rules reviews have been completed and there are errors detected. If none of the claims in a submitted 837P file pass the "pre-invoice" review, then the F-File is immediately made available to the provider. Otherwise, providers should wait 24 hours to check for an F-File response in order to ensure that all of the claiming rules have been run against the file.

The 999 Response File

Step 1 of the process always results in the creation of the 999 Response file. The purpose of the 999 Response File is to acknowledge receipt of the 837P file and provide a status pertaining to each segment in the 837P EDI transaction. The file informs the user if the 837P file conforms to the mandatory HIPAA 5010 file format standard.

Important Information
Any errors detected in the 837P file during this Step are listed in the 999 Response File and must be corrected by the provider. The 837P file must then be resubmitted.

Tips for reading the results contained in the 999 file are provided. 📖 *See **Tips for Reading the 999 Response File*** below. Users can optionally purchase a guide to the 999 called 'EDI 999 Transaction Functional Acknowledgement'. Use your preferred search engine to find vendors who sell the guide.

The F-File Response

If the submitted 837P file passes the HIPAA 5010 file format standard test, review Steps 2 and 3 are initiated. These Steps generally occur within 24 hours after the system generates an error-free 999 Response File.

During these Steps, the 837P data is reviewed for "pre-invoice" errors (Step 2) and Early Intervention claiming rule violations (Step 3). For example, in Step 2 the ETIN recorded in the 837P submitted file is checked for validity, and in Step 3 claiming rule violations are run against each claim. If errors are found, the system generates the F-File response to notify the provider of any errors that the system identified.

Important Information
An F-File will be created after Step 2 if the system identifies "pre-invoice" errors with 837P claim file. Step 2 is completed within one hour after the 837P passes the Step 1 review.

In addition, the claims that pass the Step 2 "pre-invoice" review are then processed in Step 3, the Early Intervention claiming rules review. If any of these claims are found to have claiming rule violations, the claim is visible within NYEIS as a denied claim. Step 3 is completed during a nightly batch process.

An F-File Response will only be generated and made available once all of the pre-invoice and claiming rules reviews have been completed…and there are errors detected. If none of the claims in a submitted 837P file pass the "pre-invoice" review, then the F-File is immediately made available to the provider. Otherwise, providers should wait 24 hours to check for an F-File response in order to ensure that all of the claiming rules have been run against the file.

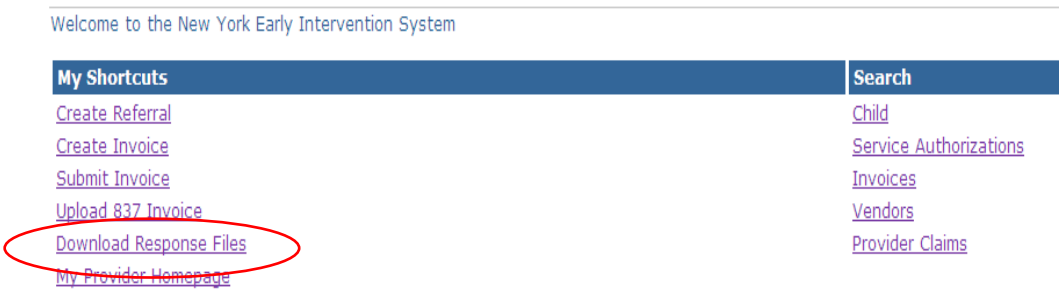
The F-File is structured as a comma-delimited file that can be opened in any text editor or Microsoft Excel for review. Textual error messages are listed in the file (e.g. "Submitter ETIN Invalid") along with additional information to describe the errors. Tips for reading the F-File are provided. 🕮 *See **Tips for Reading the F-File Response*** below. Tips for reading the F-file can also be found in the "837 HealthCare Claim Professional Companion Guide" document on the Health Commerce System (HCS) in the NYEIS Folder.

Important Information
- An F-File will not be generated if no errors are detected during Step 2 "pre-invoice" review.
- If errors are detected, the provider will need to correct the error in their 837P file and resubmit it.
- If the detected error is at the claim level, such as an invalid Service Authorization number, then only the claims affected need to be submitted on a new 837P.
- If the detected error is at the header level, such as invalid ETIN, then the entire file typically needs to be resubmitted.

The last section of this document includes a table that explains each of the **837P pre-invoice review** errors displayed in the F-File and notes what actions are taken if the error is encountered. 🕮 *See **F-File "Pre-Invoice" Error Guidance.***

Accessing the Response Files

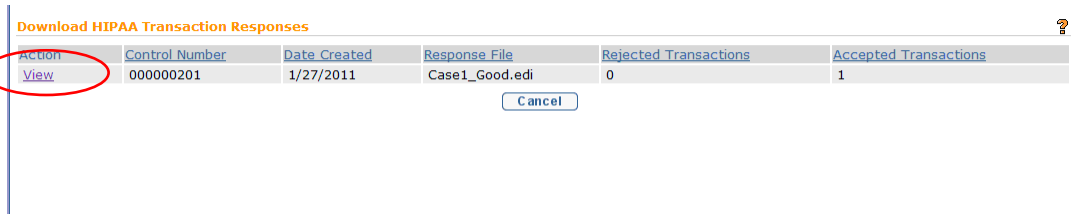
1. To access and review the response files generated by NYEIS to check on the status of a submitted claim file, click on the **Download Response Files** link from your homepage or click on the **My Provider Homepage** link and then click on the **Response Files** link in the Navigation bar.



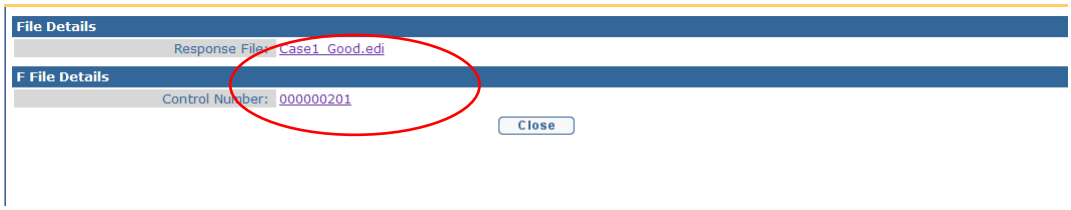
2. The **Download HIPAA Transaction Responses** list page is displayed. This page lists the 999 Response file identifier (**Control Number** column), **Date Created**, file name (**Response File** column) and how many transactions in the 837P file were accepted or rejected based on the standard HIPAA 5010 file formatting rules.

   Note that the **Rejected Transactions** and **Accepted Transactions** columns are not intended to provide statistics concerning how many claims in your file have been accepted or rejected. They only indicate whether the transaction sets in your file adhere to standard HIPAA 5010 formatting guidelines.

3. Review the 999 Response File to obtain information related to any rejected claims. The **Control Number** column on this page represents segment ISA13 from the submitted 837P file. The **Response File** column label is the same as the name of the 837P file that was submitted.



4. To view the responses of a transmission, click on the **View** action link. A page displays with two sections: **File Details** and **F-File Details**. The **File Details** section displays the system generated 999 Response File. An F-File may also be displayed in the **F- File Details** section, but only if errors were detected during Step 2 and/or Step 3 of the process described previously. If there were no errors during this Step, the F-File will not be available for you to select from the screen.



Click the link in **Response File** field for the 999 Response File, or the **Control Number** field for the F-File (if displayed), to open or save the file to your hard drive. 🕮 *See **Tips for Reading the 997 Response File** or **Tips for Reading the F-File Response*** when reviewing either file. Tips for reading the F-file can also be found in the "F-Filer Error Guidance" document on the Health Commerce System (HCS) in the NYEIS Folder.

Important Information
The leading 0 for values is not being displayed on the f-file because of the way Microsoft Excel is formatting the column when the f-file is opened. Try these steps to get around the auto-formatting:

- After clicking on the f-file in NYEIS, click on the Save option instead. Save the file with a ".txt" extension (choose All Files as the "Save As Type" and then type in .txt at the end of the filename.)
- Open Excel.
- With Excel open, click on the File > Open menu option.
- Browse your computer for the .txt file you just saved and open it. A Text Import Wizard should come up.
- Choose "Delimited" and then click Next.
- Make sure only the "Comma" delimiter option is selected and then click Next.
- Individually select each column that you want to be formatted as text and then select the "Text" column data while the column is highlighted. This text option will maintain any leading 0's in the numbers.
- Click Finish.

Adjudicating the Claim

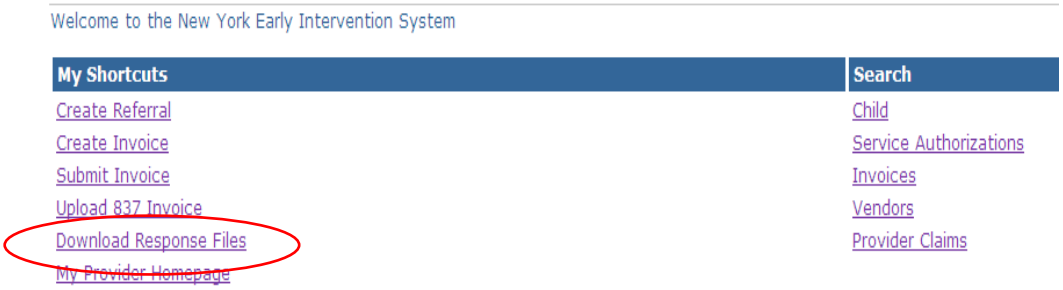
Once an 837P passes the HIPAA 5010 "pre-invoice" and Early Intervention claiming rule reviews, the claims are approved, denied, or pended similar to online NYEIS Invoicing. The status of the invoice and its claims can subsequently be viewed by searching for the invoice. 🕮 *See* ***Searching/Viewing Invoices*** for further information.

Every Invoice has an assigned status. The status of the Invoice depends on where it is in the Invoice process. Prior to being submitted, an Invoice is considered **Draft**, after submission it is considered **Submitted** and continues through the process. Once the System approves and/or denies all Claims, the Invoice is considered **System Approved**. Invoices that are voided are given a **Void** status.

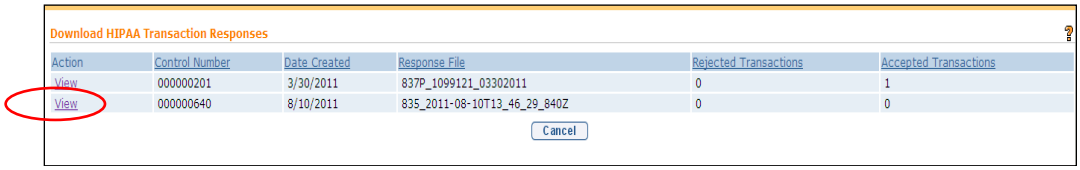
Accessing the 835 Remittance File

The status of any claim submitted via the 837P electronic claim can be viewed in the HIPAA 835 Claim Payment/Advice file that NYEIS generates on a daily basis. These 835 files are accessed via the **Download Response Files** menu option on the User Home page.

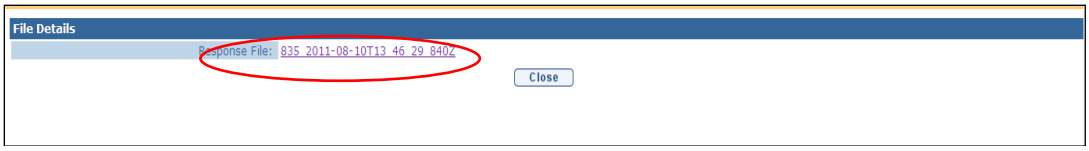
1. To access and review the 835, click on the **Download Response Files** link from your homepage or click the **My Provider Homepage** link and then click on the **Response Files** link in the Navigation bar. The **Download HIPAA Transaction Responses** list page displays.



2. The 835 Remittance File will have the '835' prefix in the **Response File** name. Click on the **View** link in the **Action** column action to access the 835 file. A page with a File Details section displays.



3. Click the **Response File** field link to open or save the file to your hard drive.



4. The following information provides a general guideline for when providers should expect to receive an 835 Remittance File as a result of the claim adjudication process:

   - Denied claim – If a claim is denied during the adjudication process, an 835 Remittance file will be generated and made available to the provider.
   - Approved claim – The 835 will be created for an approved claim after the claim has been generated for payment and included on a check or EFT by County Finance Office. Each municipality is responsible for processing their own payments, so the response time for receiving these 835 Remittance files will vary.
   - Pended claims – The 835 Remittance File does not support pended claims. Providers will receive a Task in their **Financial** Work Queue which requires they provide a billing justification reason for the pended claim. 🕮 *See* **Appendix H - Workflows** for further information about the task.

Tips for Reading the 999 Response File

An understanding of how to read the standard HIPAA 999 Implementation Acknowledgement file is required in order to comprehend the status of a submitted claim batch and to correct any errors noted at this step in the process. Here are some tips for reading the 999 file:

- Review the AK9 segment in the 999.

- If you see an **A** in the AK9 segment, your file was received and accepted for further processing by NYEIS. Remember: **A** = Accepted. Below is an example of an accepted 999.

ISA*00* *00* *ZZ*NYEIS *ZZ*ALBAnnnn
*101210*1032*U*00401*000000201*0*T*:~
GS*FA*NYEIS*ALBAnnnn*20101210*1032*201*X*005010X231A1~
ST*999*0001*005010X231A1~
AK1*HC*201*005010X222A1~
AK9***A***1*1*1~
SE*6*0001~
GE*1*201~
IEA*1*000000201~

- If you see an **R** in the IK5 or AK9 segments, your file was rejected. Remember: **R** = Rejected. Below is an example of a rejected 999. To help interpret this example, the superscript numbers provided cross reference the Number column in the 999 legend that is provided below.

  ISA*00* *00* *ZZ*NYEIS *ZZ*ALBAnnnn
  *101210*1032*U*00401*000000201*0*T*:~
  GS*FA*NYEIS*ALBAnnnn*20101210*1032*201*X*005010X231A1~
  ST*999*0001*005010X231A1~
  AK1*HC*201*005010X222A1~
  AK2*837*0001*005010X222A1~
  IK3^{1}*NM1^{2}*103^{3}*2330B^{4}*8^{5}~
  IK4^{6}*09^{7}*67^{10}*2^{11}~
  IK5***R***~
  AK9***R***1*1*0~
  SE*6*0001~
  GE*1*201~
  IEA*1*000000201~

- Any time there are IK3 and IK4 segments in a 999, there is a rejected 837P. These segments will appear between the AK2 and IK5 segments (see the previous bullet for an example). The IK3 segment is used to report errors in a data segment in the submitted 837P and identify the location of the data segment in the file. The IK4 segment is used to report errors in a data element or composite data structure in the submitted 837P and identify the location of the data element in the file. See below for the 999 legend that describes each element in the IK3 and IK4 segments.

Legend for the 999 File 'IK3' and 'IK4' Segments

Number	Element	Name	Instructions
1	IK3	*Error Identification: This segment is used to report errors in a data segment and identify the location of the data segment.*	
2	IK301	Segment ID Code	This contains the identification of the data segment in error (e.g., "NM1" or "SV1").
3	IK302	Segment Position In Transaction Set	This is the numerical count of this data segment from the start of the transaction set (i.e. from the start of the ST loop in the 837P file that was submitted to NYEIS).
4	IK303	Loop Identifier Code	This identifies the loop within which the error occurred on the file submitted to NYEIS.
5	IK304	Implementation Segment Syntax Error Code	This element contains the error noted for the segment. The codes and descriptions are: 1. Unrecognized segment ID 2. Unexpected segment 3. Required segment missing 4. Loop occurs over maximum times 5. Segment exceeds maximum use 6. Segment not in defined transaction set 7. Segment not in proper sequence 8. Segment has data element errors I4. Implementation "Not Used" segment present I6. Implementation dependent segment missing I7. Implementation loop occurs under minimum times I8. Implementation segment below minimum use I9. Implementation dependent "Not Used" segment present

	CTX	*Segment Context and Business Unit Identifier: This segment is used to report when the error identified in this IK3 loop was triggered by a situational requirement of the Implementation Guide and the error occurs at the segment level.*	
	CTX01-1	Context Name	Always contains the value **"SITUATIONAL TRIGGER"**.
	CTX01-02	Context Reference	Context Reference
	CTX02	Segment ID Code	Code defining the segment ID of the data segment in error.
	CTX03	Segment Position in Transaction Set	This is the numerical count of this data segment from the start of the transaction set (i.e. from the start of the ST loop in the 837P file that was submitted to NYEIS). The transaction set header (i.e. the ST segment) is count position 1.
	CTX04	Loop Identifier Code	This identifies the loop within which the error occurred on the file submitted to NYEIS.
	CTX05-01	Element Position in Segment	This is used to indicate the relative position of a simple data element, or the relative position of a composite data structure with the relative position of the component within the composite data structure, in error.
	CTX05-02	Component Data Element Position in Composite	Required when the situational requirement relates to a component data element within a composite data structure.
	CTX05-03	Repeating Data Element in Position	Required when the situational requirement relates to a repeating data element.
	CTX06	Reference in Segment	Required when CTX05 is used and the data element reference number of the data element identified in CTX05-1 is known by the submitter of the 999, and it is not a composite data element.
	CTX06-1	Data Element Reference Number	Reference number used to locate the data element in the Data Element Dictionary.

	CTX06-02	Data Element Reference Number	Required when CTX05-2 is used and the data element reference number of the data element identified in CTX05-2 is known.
6	IK4	*Implementation Data Element Note: This segment is used to report errors in a data element or composite data structure and identify the location of the data element.*	
7	IK401-1	Element Position in Segment	This is used to indicate the relative position of the data element or composite data structure in error. If CLM03 was in error, the value would be "3."
8	IK401-2	Component Data Element Position in Composite	This identifies the component data element position within the composite data structure. This element is only included when an error occurs in a composite data element and the composite data element position can be determined.
9	IK401-3	Repeating Data Element Position	This identifies the specific repetition of a data element that is in error. This is a situational element that is not always provided.
10	IK402	Data Element Reference Number	This identifies the "Data Element Number" reference number from the Implementation Guide.

11	IK403	Implementation Data Element Syntax Error Code	This element contains the code indicating the type of error found. The values and descriptions are: 1. Required data element missing 2. Conditionally required data element missing 3. Too many data elements 4. Data element too short 5. Data element too long 6. Invalid character in data element 7. Invalid code value 8. Invalid date 9. Invalid time 10. Exclusion condition violated 12. Too many repetitions 13. Too many components I6. Code value not used in implementation I9. Implementation dependent data element missing I10. Implementation "Not Used" data element present I11. Implementation too few repetitions I12. Implementation pattern match failure I13. Implementation dependent "Not Used" data element present
12	IK404	Copy of Bad Data Element	This element contains a copy of the data in error. This is a situational element that is not always provided.
	CTX	*Element Context: This segment is used to report when the error identified in this IK4 loop was triggered by a situational requirement of the Implementation Guide and the error occurs at the element level.*	
	CTX01-1	Context Name	Always contains the value **"SITUATIONAL TRIGGER"**.
	CTX01-02	Context Reference	Context Reference
	CTX02	Segment ID Code	Code defining the segment ID of the data segment in error.

	CTX03	Segment Position in Transaction Set	This is the numerical count of this data segment from the start of the transaction set (i.e. from the start of the ST loop in the 837P file that was submitted to NYEIS). The transaction set header (i.e. the ST segment) is count position 1.
	CTX04	Loop Identifier Code	This identifies the loop within which the error occurred on the file submitted to NYEIS.
	CTX05-01	Element Position in Segment	This is used to indicate the relative position of a simple data element, or the relative position of a composite data structure with the relative position of the component within the composite data structure, in error.
	CTX05-02	Component Data Element Position in Composite	Required when the situational requirement relates to a component data element within a composite data structure.
	CTX05-03	Repeating Data Element in Position	Required when the situational requirement relates to a repeating data element.
	CTX06	Reference in Segment	Required when CTX05 is used and the data element reference number of the data element identified in CTX05-1 is known by the submitter of the 999, and it is not a composite data element.
	CTX06-1	Data Element Reference Number	Reference number used to locate the data element in the Data Element Dictionary.
	CTX06-02	Data Element Reference Number	Required when CTX05-2 is used and the data element reference number of the data element identified in CTX05-2 is known.

Tips for Reading the F-File Response

Each error in an F-File is presented as a row of data. The position and description of the F-File columns that relate to each row of data is as follows:

Column #	Column Name	Column Description
1	Error Message	A textual message describing the error.
2	Error Data	The data that caused the error.
3	GS Reference	The Group Control Number from the submitted file (segment GS06).
4	ISA Reference	The ISA Number from the submitted file (segment ISA13).
5	Created Date	The date the error message was generated in NYEIS. This date is not meant to represent the date the file was submitted to NYEIS.
6	File Name	The original name of the file that was submitted to NYEIS and in which the error was detected.
7	Claim Number	The Claim Reference Number (CLM01) associated with the error. This column will only be populated if the error is detected within the 2300 claim loop, which includes errors detected at the 2400 service line level.
8	SA Number	The claim Service Authorization Number (2300REF02) associated with the error. This column will only be populated if its value is available at, or above, the file level where the error was detected.
9	Child Reference Number	The Child Reference Number (2010BANM109) associated with the error. This column will only be populated if its value is available at, or above, the file level where the error was detected.
10	Service Date	The claim service line Service Date (2400DTP03) associated with the error. This column will only be populated if its value is available at, or above, the file level where the error was detected.

F-File "Pre-Invoice" Error Guidance

Once there are no errors generated on the 999 file, the submitted 837P is reviewed by step two of the file receipt process. Generally this step occurs within 24 hours after generating an error-free 999 response file. During this step, various pre-adjudication edit checks are performed against the data in the submitted 837P file and an F-File is generated to notify providers of any errors. For example, the ID of each rendering provider listed in the submitted file is checked for validity. The F-File is structured as a comma-delimited file that can be opened in any text editor or spreadsheet software such as Microsoft Excel for review. Textual error messages are listed in the file (e.g. "The NPI reported in data element 2310BNM109 for the rendering provider is not valid"), along with additional information to describe the errors. Tips for reading the F-File are provided at the end of this document.
Important - If no errors are generated during Step 2, then no F-File response will be generated. If errors are generated, then the user will need to correct the error in their file and resubmit. If the error is at the claim level, such as an invalid Service Authorization number, then only the claims affected need to be submitted on a new 837. If the error is at the header level, such as invalid ETIN, then the entire file typically needs to be resubmitted.

The table below explains each of the 837P edits that may result in errors being displayed on the F-File and notes what actions are taken if an edit is exception is encountered.

Please review the bolded text in the **"Action Taken by NYEIS if Exception Encountered"** column for guidance on what to do if a particular edit has been encountered and is displayed on the F-file response file.

Check for Pre-Invoice Errors

Sample Error Text Description of Edit	Relevant 837P Data Item(s) Used in Edit	Action Taken by NYEIS if Exception Encountered	Notes	Relative Level of Edit (Header or Claim)
"Test transaction not accepted in NYEIS" Check for test file	ISA15 (Usage Indicator)	If the value is "T", then the file is a test file and it will not be processed any further by NYEIS. The **F-File** response file produced by NYEIS will include a record indicating that this is a test file. **NYEIS will STOP processing the 837P file. The 837P file must be corrected and resubmitted.**		Header
"Unable to identify receiving municipality county code (_1000B/NM1/_09_Identification_Code_)" Validate Municipality Code	1000BNM109 (Muni Code)	If the Municipality Code cannot be found in NYEIS, then the file will not be processed any further by NYEIS. The **F-File** response file produced by NYEIS will include a record indicating that the county could not be found. **NYEIS will STOP processing the 837P file. The 837P file must be corrected and resubmitted.**		Header

Sample Error Text Description of Edit	Relevant 837P Data Item(s) Used in Edit	Action Taken by NYEIS if Exception Encountered	Notes	Relative Level of Edit (Header or Claim)
"The Submitter ETIN reported in data element GS02 is not valid for the municipality code reported in data element 1000BNM109." Validate Submitter	GS02 (submitter ETIN) 1000BNM109 (Muni Code)	If the Submitter cannot be found in NYEIS (or the Submitter has not yet been configured by NYEIS to send electronic 837P transactions), then the file will not be processed any further by NYEIS. The **F-File** response file produced by NYEIS will include a record indicating that the submitter could not be found. **NYEIS will STOP processing the 837P file. The 837P file must be corrected and resubmitted.**		Header

Sample Error Text Description of Edit	Relevant 837P Data Item(s) Used in Edit	Action Taken by NYEIS if Exception Encountered	Notes	Relative Level of Edit (Header or Claim)
"The provider has not yet been configured to submit HIPAA 4010 production files to NYEIS for the ETIN (ISA06) and Muni Code (1000BNM109) submitted in the file. Your file will not be processed any further." Validate Submitter is Configured to Submit Production Files	ISA12 (HIPAA Version Indicator) ISA06 (Submitter ETIN) 1000BNM109 (Muni Code)	If the submitter has not yet been configure to submit production files for the HIPAA version indicated in the file, then the file will not be processed any further by NYEIS. The **F-File** response file produced by NYEIS will include a record indicating that the submitter has not yet been configured to submit this version of the 837P transaction. **NYEIS will STOP processing the 837P file. The 837P file must be corrected and resubmitted.**		

Sample Error Text Description of Edit	Relevant 837P Data Item(s) Used in Edit	Action Taken by NYEIS if Exception Encountered	Notes	Relative Level of Edit (Header or Claim)
"Unable to identify billing provider (2000A/_2010AA/NM1/_09_Identification_Code_)" Validate Billing Provider	1000BNM109 (Muni Code) GS04 (Date) 2010AANM109 (Billing Provider NPI)	If the Billing Provider cannot be found in NYEIS, or is not active in NYEIS as of the date in GS04, then no claims for this Billing Provider will be processed by NYEIS. The **F-File** response file produced by NYEIS will include a record indicating that the Billing Provider could not be found. **NYEIS will STOP processing the 837P file if there are no other Billing Providers in the file. The 837P file must be corrected and resubmitted. Otherwise, NYEIS will continue processing the 837P file and attempt to validate the next Billing Provider.**	If the Billing Provider is not found, then NYEIS checks for the Billing Provider via use of the **2010AAREF02** segment. Dashes are supported in the identifier value for both 2010AANM109 and 2010AAREF02. The 2000A (Billing Provider) loop is allowed to repeat according to HIPAA standards. NYEIS accommodates this requirement by skipping to the end of the iteration (in case there is another Billing Provider in the file), rather than terminating the process immediately.	Header

Sample Error Text Description of Edit	Relevant 837P Data Item(s) Used in Edit	Action Taken by NYEIS if Exception Encountered	Notes	Relative Level of Edit (Header or Claim)
"Submitter ETIN in ISA_06 Does not match Provider Clearing House ETIN" Validate Clearinghouse ETIN	ISA06 (Sender ETIN)	If the Clearinghouse ETIN cannot be validated against what is in NYEIS for this provider, then no claims for this Billing Provider will be processed by NYEIS. The **F-File** response file produced by NYEIS will include a record indicating that the Submitter ETIN is invalid. **NYEIS will STOP processing the 837P file if there are no other Billing Providers in the file. The 837P file must be corrected and resubmitted. Otherwise, NYEIS will continue processing the 837P file and attempt to validate the next Billing Provider.**	This validation only occurs if a provider is submitting claims through a clearinghouse. The 2000A (Billing Provider) loop is allowed to repeat according to HIPAA standards. NYEIS accommodates this requirement by skipping to the end of the iteration (in case there is another Billing Provider in the file), rather than terminating the process immediately.	Header

Sample Error Text Description of Edit	Relevant 837P Data Item(s) Used in Edit	Action Taken by NYEIS if Exception Encountered	Notes	Relative Level of Edit (Header or Claim)
"Unable to identify Child (_2000A/_2000B/_2010BA/NM1/_09_Identification_Code_)" Validate Child	2010BANM109 (Child Reference Number)	If the child is not found in NYEIS, then no claims for this child will be processed by NYEIS. The **F-File** response file produced by NYEIS will include a record indicating that the child could not be identified. **NYEIS will STOP processing the 837P file if there are no other children in the file. Otherwise, NYEIS will continue processing the 837P file and attempt to validate the next Child. Any claims related to children who could not be validated by NYEIS must be corrected and resubmitted on another 837P file.**		Header

Sample Error Text Description of Edit	Relevant 837P Data Item(s) Used in Edit	Action Taken by NYEIS if Exception Encountered	Notes	Relative Level of Edit (Header or Claim)
"NYEIS is not currently supporting electronic adjustments or replacements to previously submitted claims" Validate Claim Frequency Type Code	2300CLM0503 (Claim Frequency Type Code)	If Claim Frequency Code is not equal to **"1"** or **"8"** for a particular claim, then **NYEIS will log an error for that claim**. The **F-File** response file produced by NYEIS will include a record indicating that NYEIS does not currently support electronic adjustments or replacements to previously submitted claims. **NYEIS will continue processing the 837P file.**	Only Claim Frequency Codes "1" (original) or "8" (void) are supported by NYEIS.	Claim

Sample Error Text Description of Edit	Relevant 837P Data Item(s) Used in Edit	Action Taken by NYEIS if Exception Encountered	Notes	Relative Level of Edit (Header or Claim)
"Unable to match Service Authorization number to the Child and Billing Provider" Validate Service Authorization	2300REF02 (Service Authorization number…where 2300REF01 = "G1") 2010BANM109 (Child Reference Number) 2010AANM109 or 2010AAREF02 (Billing Provider ID)	If the Service Authorization is <u>not</u> found in NYEIS using the relevant data, then **NYEIS will log an error for that claim**. The **F-File** response file produced by NYEIS will include a record indicating that the Service Authorization could not be matched. **NYEIS will continue processing the 837P file.**		Claim

Sample Error Text Description of Edit	Relevant 837P Data Item(s) Used in Edit	Action Taken by NYEIS if Exception Encountered	Notes	Relative Level of Edit (Header or Claim)
"Invalid ICD Code" Validate Diagnosis Codes	2300HI0102, 2300HI0202, 2300HI0302, 2300HI0402 (Health Care Diagnosis Code)	If the Claim Diagnosis Code does not exist as an active ICD code in NYEIS, then **NYEIS will log an error for that claim**. The **F-File** response file produced by NYEIS will include a record indicating that it is an invalid Diagnosis Code. **NYEIS will continue processing the 837P file.**	NYEIS supports up to 4 Diagnosis Codes. Any additional codes are ignored during processing.	Claim

Sample Error Text Description of Edit	Relevant 837P Data Item(s) Used in Edit	Action Taken by NYEIS if Exception Encountered	Notes	Relative Level of Edit (Header or Claim)
"Referring Provider 2310A loop is missing." Confirm Referring Provider NPI exists for non-vendor based claims.	2310ANM109 (Identification Code)	If the referring provider NPI is not submitted with a non-vendor based claim, then NYEIS will log an error for that claim. The F-File response file produced by NYEIS will include a record indicating that the NPI associated with the referring provider must be submitted with the claim. **NYEIS will continue processing the 837P file**		Claim

Sample Error Test Description of Edit	Relevant 837P Data Item(s) Used in Edit	Action Taken by NYEIS if Exception Encountered	Notes	Relative Level of Edit (Header or Claim)
"The NPI reported in data element 2310ANM109 for the referring provider is not valid." Validate Referring Provider NPI	2310ANM109 (Identification Code)	If the Referring Provider NPI is not formatted properly, then NYEIS will log an error for that claim. The F-File response file produced by NYEIS will include a record indicating that the NPI associated with the Referring Provider is not valid. The following criteria are used to determine if the format of the Referring Provider NPI is valid: • The length of the NPI must be ten. • The NPI must be numeric. • The NPI must pass a checksum validation that is based on an established formula for NPIs. **NYEIS will continue processing the 837P file**		Claim

Sample Error Test Description of Edit	Relevant 837P Data Item(s) Used in Edit	Action Taken by NYEIS if Exception Encountered	Notes	Relative Level of Edit (Header or Claim)
"The NPI reported in data element 2310BNM109 for the rendering provider is not valid." "The SSN/FEIN reported in data element 2310BNM109 for the rendering provider is not valid." "The Reference Number reported in data element 2310BREF02 for the rendering provider is not valid." Validate Rendering Provider ID	2310BNM108 (Identification Code Qualifier) 2310BNM109 (Identification Code) OR 2310BREF02 (Reference_Identification_Qualifier) 2310BREF02 (Rendering Provider Secondary Identifier)	If the ID associated with the Rendering Provider is not found in NYEIS, then NYEIS will log an error for that claim. The F-File response file produced by NYEIS will include a record indicating that the ID associated with the Rendering Provider could not be identified. **NYEIS will continue processing the 837P file**	2310BREF01 and 2310BREF02 are only available on HIPAA 5010 transactions. 2310BREF01 must be 'G2".	Claim

Sample Error Text Description of Edit	Relevant 837P Data Item(s) Used in Edit	Action Taken by NYEIS if Exception Encountered	Notes	Relative Level of Edit (Header or Claim)
"Referring Provider 2310A loop is missing." Confirm Referring Provider NPI exists for non-vendor based claims.	2310ANM109 (Identification Code)	If the referring provider NPI is not submitted with a non-vendor based claim, then NYEIS will log an error for that claim. The F-File response file produced by NYEIS will include a record indicating that the NPI associated with the referring provider must be submitted with the claim. **NYEIS will continue processing the 837P file**		Claim

Sample Error Text Description of Edit	Relevant 837P Data Item(s) Used in Edit	Action Taken by NYEIS if Exception Encountered	Notes	Relative Level of Edit (Header or Claim)
"The NPI reported in data element 2310ANM109 for the referring provider is not valid." Validate Referring Provider NPI	2310ANM109 (Identification Code)	If the Referring Provider NPI is not formatted properly, then NYEIS will log an error for that claim. The F-File response file produced by NYEIS will include a record indicating that the NPI associated with the Referring Provider is not valid. The following criteria are used to determine if the format of the Referring Provider NPI is valid: • The length of the NPI must be ten. • The NPI must be numeric. • The NPI must pass a checksum validation that is based on an established formula for NPIs. **NYEIS will continue processing the 837P file**		Claim

Sample Error Text Description of Edit	Relevant 837P Data Item(s) Used in Edit	Action Taken by NYEIS if Exception Encountered	Notes	Relative Level of Edit (Header or Claim)
"The rendering provider is not a current employee/contractor of the billing provider." Confirm Rendering Provider is an Employee/Contractor of the Billing Provider	2310BNM108 (Identification Code Qualifier) 2310BNM109 (Identification Code) 2010AANM109 or 2010AAREF02 (Billing Provider ID) OR 2310BREF02 (Reference_Identification_Qualifier) 2310BREF02 (Rendering Provider Secondary Identifier) 2010AANM109 or 2010AAREF02 (Billing Provider ID)	If the Rendering Provider is not found to be an active employee/contractor of the billing provider, then NYEIS will log an error for that claim. The F-File response file produced by NYEIS will include a record indicating that the Rendering Provider is not a current employee/contractor of the billing provider. **NYEIS will continue processing the 837P file.**	2310BREF01 and 2310BREF02 are only available on HIPAA 5010 transactions. 2310BREF01 must be 'G2".	Claim

"The rendering provider NPI reported in data element 2310BNM109 is associated with more than one active employee/contractor of the billing provider." "The rendering provider SSN/FEIN reported in data element 2310BNM109 is associated with more than one active employee/contractor of the billing provider." "The rendering provider Reference Number reported in data element 2310BREF02 is associated with more than one active employee/contractor of the billing provider." Determine if the Reported Rendering Provider ID is Used by More Than One Active Employee/Contractor of the Billing Provider	2310BNM108 (Identification Code Qualifier) 2310BNM109 (Identification Code) 2010AANM109 or 2010AAREF02 (Billing Provider ID) **OR** 2310BREF02 (Reference_Identification_Qualifier) 2310BREF02 (Rendering Provider Secondary Identifier) 2010AANM109 or 2010AAREF02 (Billing Provider ID)	If more than one active employee/contractor of the billing provider is found to use the same ID reported for the rendering provider, then **NYEIS will log an error for that claim**. The **F-File** response file produced by NYEIS will include a record indicating that the ID reported for the rendering provider is associated with more than one active employee/contractor of the billing provider. **NYEIS will continue processing the 837P file.**	2310BREF01 and 2310BREF02 are only available on HIPAA 5010 transactions. 2310BREF01 must be 'G2".	Claim

"The Procedure Code is too long or it is missing. One and only one code should be entered here. (_2400/_SV101-02)" Check Length of Procedure Code	2400SV101-02 (Procedure Code)	One procedure code should be reported in this segment. If the length of the procedure code is too long to be validated by NYEIS, or if the procedure code does not exist in the file, then **NYEIS will log an error for that claim**. The **F-File** response file produced by NYEIS will include a record indicating that the procedure code is too long. **NYEIS will continue processing the 837P file.**		Claim

Check for Early Intervention Claiming Errors

Sample Error Text Description of Edit	Relevant 837P Data Item(s) Used in Edit	Action Taken by NYEIS if Exception Encountered	Notes	Relative Level of Edit (Header or Claim)
"Claim: <Claim Number> has an invalid rendering Provider with Reference Number: <Primary Alternate ID>. The rendering provider was not an active employee/contractor of the billing agency on the service date." On the service date recorded in the claim, the rendering provider was not an active employee / contractor of the billing provider.	HIPAA Data Element (Rendering Provider Identifier)	**Claim is not uploaded to NYEIS.** **Submit a new 837P file (new Invoice Number) if the employees status of the rendering was an error and is corrected.**		Claim
"Claim: <Claim Number> has an invalid rendering Provider with Reference Number: <Primary Alternate ID>. The rendering provider is not recognized by NYEIS as an ABA Aide. Contact the Bureau of Early Intervention Provider Approval Unit for assistance." The rendering provider recorded in the claim is not recorded in NYEIS as an ABA Aide.	HIPAA Data Element (Rendering Provider Identifier)	**Claim is not uploaded to NYEIS.** **Submit a new 837P file (new Invoice Number) if the restriction on the rendering was an error and is corrected.**		Claim
"Claim: <Claim Number> has an invalid rendering Provider with Reference Number: <Primary Alternate ID>. The rendering provider is not a service coordinator." The rendering provider recorded in the claim is not recorded in NYEIS as a service coordinator.	HIPAA Data Element (Rendering Provider Identifier)	**Claim is not uploaded to NYEIS.** **Submit a new 837P file (new Invoice Number) after the issue is been corrected.**		Claim
"Claim: <Claim Number> has an invalid rendering Provider with Reference Number: <Primary Alternate ID>. The rendering provider is not approved for the	HIPAA Data Element (Rendering	**Claim is not uploaded to NYEIS.**		Claim

Sample Error Text Description of Edit	Relevant 837P Data Item(s) Used in Edit	Action Taken by NYEIS if Exception Encountered	Notes	Relative Level of Edit (Header or Claim)
Qualified Profession authorized to provide the service. Contact the Bureau of Early Intervention Provider Approval Unit for assistance." The rendering provider recorded in the claim is not approved for a Qualified Profession that is eligible to perform the service designated in the claim.	Provider Identifier)	**Submit a new 837P file (new Invoice Number) if the Qualified Profession issue was an error and is corrected.**		
"Claim: <Claim Number> has an invalid rendering Provider with Reference Number: <Primary Alternate ID>. There was an active restriction placed on the rendering provider on the claim service date. Contact the Bureau of Early Intervention Provider Approval Unit for assistance." The rendering provider had an active restriction in place on the date of service specified in the claim.	HIPAA Data Element (Rendering Provider Identifier)	**Claim is not uploaded to NYEIS.** **Submit a new 837P file (new Invoice Number) if the restriction was an error and has been corrected.**		Claim

Sample Error Text Description of Edit	Relevant 837P Data Item(s) Used in Edit	**Action Taken by NYEIS if Exception Encountered**	Notes	Relative Level of Edit (Header or Claim)
"The Provider Invoice Number is a duplicate for the Provider of Record." The invoice number is already in NYEIS on a non-voided invoice.	HIPAA Data Element (Provider Invoice Number)	**837 is not uploaded to NYEIS.** **Submit a new 837P file (new Invoice Number) after the error is corrected.**		Header
"You must enter an invoice number." There is no invoice number entered.	HIPAA Data Element (Provider Invoice Number)	**837 is not uploaded to NYEIS.** **Submit a new 837P file (new Invoice Number) after the error is corrected.**		Header
"You must enter a provider for the invoice." There is no provider entered on the invoice.	HIPAA Data Element (Billing Provider Identification Code)	**837 is not uploaded to NYEIS.** **Submit a new 837P file (new Invoice Number) after the error is corrected.**		Header

Sample Error Text Description of Edit	Relevant 837P Data Item(s) Used in Edit	**Action Taken by NYEIS if Exception Encountered**	Notes	Relative Level of Edit (Header or Claim)
"You must enter a municipality for the invoice." There is no municipality entered on the invoice	HIPAA Data Element (Muni Code)	**837 is not uploaded to NYEIS.** **Submit a new 837P file (new Invoice Number) after the error is corrected.**		Header
"You must enter a date for the invoice." There is no invoice date entered on the invoice.	HIPAA Data Element (Invoice Date)	**837 is not uploaded to NYEIS.** **Submit a new 837P file (new Invoice Number) after the error is corrected.**		Header
"A borough cannot be billed on an invoice, invoices must be billed at the NYC - Citywide level." The municipality entered on the invoice corresponds to a NYC borough instead of NYC-Citywide.	HIPAA Data Element (Muni Code)	**837 is not uploaded to NYEIS.** **Submit a new 837P file (new Invoice Number) after the error is corrected.**		Header

Sample Error Text Description of Edit	Relevant 837P Data Item(s) Used in Edit	Action Taken by NYEIS if Exception Encountered	Notes	Relative Level of Edit (Header or Claim)
“Claim <Claim number> has invalid times : <times that caused the error>” The service times in the 2300 segment are not formatted in the manner that NYEIS needs them. The service times need to be in this format: CV?-hhmm-hhmm.	HIPAA Data Element (Claim Note Description)	**Claim is not uploaded to NYEIS.** **Submit a new 837P file (new Invoice Number) after the error is corrected.**	CV? references the service type. Service times are represented by ‘hhmm’. Colons (:) cannot be used to separate hours and minutes.	Claim
"A Line on Claim: <Claim number> has an invalid procedural code: <CPT Code>” The procedural code(CPT) entered on the claim line is not recognized as a valid code by NYEIS	HIPAA Data Element (Procedure Code)	**Claim is not uploaded to NYEIS.** **Submit a new 837P file (new Invoice Number) after the error is corrected.**		Claim

Sample Error Text Description of Edit	Relevant 837P Data Item(s) Used in Edit	Action Taken by NYEIS if Exception Encountered	Notes	Relative Level of Edit (Header or Claim)
"The Provider is not approved as of the Service Date recorded in the claim. Please contact the Bureau of Early Intervention Provider Approval Unit for assistance regarding the provider's status." The billing provider is not approved to provide the service on the service date recorded in the claim.	HIPAA Data Element (Rendering Provider Identifier) HIPAA Data Element (where 2300REF01 = "G1")	**Claim is not uploaded to NYEIS.** **Submit a new 837P file (new Invoice Number) if the Approval status was an error and has been corrected.**	Contact the Bureau of Early Intervention, Provider Approval Unit to determine why the billing provider was not in Approved status on the claim service date.	Claim
"There are not enough units remaining on the service authorization to cover the invoiced visit." The number of units remaining on the Service Authorization is less than the units required for the claim.		**Claim is not uploaded to NYEIS.** **Submit a new 837P file (new Invoice Number) after the error is corrected.**	Contact the EIO/D or Service Coordinator to amend the SA and add more units.	Claim

Sample Error Text Description of Edit	Relevant 837P Data Item(s) Used in Edit	Action Taken by NYEIS if Exception Encountered	Notes	Relative Level of Edit (Header or Claim)
"Service Date is outside the date range of the Service Authorization." The claim service date does not fall within the Service Authorization Start Date and End Date.	HIPAA Data Element (Service Date)	**Claim is not uploaded to NYEIS. Submit a new 837P file (new Invoice Number) after the error is corrected.**		Claim
"The Service Authorization was suspended on the date of service." The status of the service authorization specified was suspended on the date of service specified	HIPAA Data Element (Service Date)	**Claim is not uploaded to NYEIS. Submit a new 837P file (new Invoice Number) if the SA status of suspended was an error and has been corrected.**	Contact the EIO/D or Service Coordinator to determine why the Service Authorization or associated IFSP is has a status of 'Suspended'.	Claim

Sample Error Text Description of Edit	Relevant 837P Data Item(s) Used in Edit	Action Taken by NYEIS if Exception Encountered	Notes	Relative Level of Edit (Header or Claim)
"You must enter a service start date." No service start date is entered in the claim.	HIPAA Data Element (Service Date)	**Claim is not uploaded to NYEIS. Submit a new 837P file (new Invoice Number) after the error is corrected.**		Claim
"The service start date cannot be in the future." The service date recorded in the claim is in the future.	HIPAA Data Element (Service Date)	**Claim is not uploaded to NYEIS. Submit a new 837P file (new Invoice Number) after the error is corrected.**		Claim
"You must enter a claim start time." "You must enter a claim end time." General services claims need a start and end time.	HIPAA Data Element (Claim Note Description)	**Claim is not uploaded to NYEIS. Submit a new 837P file (new Invoice Number) after the error is corrected.**		Claim

Sample Error Text Description of Edit	Relevant 837P Data Item(s) Used in Edit	Action Taken by NYEIS if Exception Encountered	Notes	Relative Level of Edit (Header or Claim)
"The claim start time must proceed the end time." The service start time recorded in the claim occurs after the service end time.	HIPAA Data Element (Claim Note Description)	**Claim is not uploaded to NYEIS. Submit a new 837P file (new Invoice Number) after the error is corrected.**		Claim
"You must enter a visit type." The service type in the 2300 segment is not recorded or not recognized by NYEIS. The service type needs to be in this format: CV?-hhmm-hhmm	HIPAA Data Element (Claim Note Description)	**Claim is not uploaded to NYEIS. Submit a new 837P file (new Invoice Number) after the error is corrected.**	CV? References the service type. CV1 = regular CV2 = makeup CV3 = co visit	Claim
"You must enter a Location Type.**"** The claim does not indicate the service location.	HIPAA Data Element (Place of Service Code)	**Claim is not uploaded to NYEIS. Submit a new 837P file (new Invoice Number) after the error is corrected.**		Claim

Sample Error Text Description of Edit	Relevant 837P Data Item(s) Used in Edit	Action Taken by NYEIS if Exception Encountered	Notes	Relative Level of Edit (Header or Claim)
"You must enter an ICD Diagnosis Code.	HIPAA Data Element (Diagnosis Code)	**Claim is not uploaded to NYEIS.** **Submit a new 837P file (new Invoice Number) after the error is corrected.**		Claim
"Provider has no active contract for the invoiced municipality." The billing provider on the invoice 1) does not have a contract with the county designated in the invoice, or 2) has a contract but it does not include the service type/method associated with the Service Authorization service.	HIPAA Data Element (Billing Provider Identification Code) HIPAA Data Element (Muni Code)	**Claim is not uploaded to NYEIS.** **Submit a new 837P file (new Invoice Number) if the contract issue was an error and has been corrected.**	Review the NYEIS contract record associated with the county designated in the invoice. Confirm that the contract is Active and includes the service type / method designated in the Service Authorization. Contact the Municipality to resolve errors with the contract.	Claim

Sample Error Text Description of Edit	Relevant 837P Data Item(s) Used in Edit	Action Taken by NYEIS if Exception Encountered	Notes	Relative Level of Edit (Header or Claim)
"Service date not valid. Service Coordination claim already exists on this service date." An approved claim already exists in NYEIS for service coordination for the child on this date	HIPAA Data Element (Service Date)	**Claim is not uploaded to NYEIS.** **Submit a new 837P file (new Invoice Number) after the error is corrected.**		Claim
"Rendering Provider must be selected for the claim." A rendering provider is not specified.	HIPAA Data Element (Rendering Provider Identifier)	**Claim is not uploaded to NYEIS.** **Submit a new 837P file (new Invoice Number) after the error is corrected.**		Claim
"There are not enough dollars remaining on the service authorization to cover the invoiced amount." Pertains to respite and transportation claims. The amount entered exceeds the service authorization amount.		**Claim is not uploaded to NYEIS.** **Submit a new 837P file (new Invoice Number) after the error is corrected.**		Claim

Sample Error Text Description of Edit	Relevant 837P Data Item(s) Used in Edit	**Action Taken by NYEIS if Exception Encountered**	Notes	Relative Level of Edit (Header or Claim)
"The Provider Agency was restricted for this service type on the date of service." The agency or rendering provider is restricted for the product on the date of service specified.	HIPAA Data Element (Billing Provider Identification Code)	**Claim is not uploaded to NYEIS.** **Submit a new 837P file (new Invoice Number) if the restriction was an error and is corrected.**	Contact the Bureau of Early Intervention, Provider Approval Unit to determine why the billing provider or rendering provider was restricted on the service date.	Claim