NEW YORK STATE
MEDICAID PROGRAM

MANAGED CARE REFERENCE GUIDE:
ENROLLEE ROSTERS

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Section I – Purpose Statement

The purpose of this document is to assist participating managed care organizations in understanding and complying with the New York State Medicaid (NYS-Medicaid) requirements.

The guide addresses Enrollee Rosters.

This document is customized for managed care providers as an instructional as well as a reference tool.

Section II –Enrollee Rosters

Enrollee information is contained in rosters compiled by the State Department of Health (SDOH) for the Plans. The enrollee roster is the vehicle by which data such as Plan enrollment, guarantee date, and county of fiscal responsibility are distributed to the Plan.

Rosters are available on the HPN (Health Provider Network) for the Plan according to the SDOH Medicaid Monthly Schedule which is produced in November for the year ahead. All plans are required to utilize an Internet Service Provider (ISP) to access the HPN for purposes of accessing the Medicaid and Family Health Plus roster site.

The Internet site through which to access the HPN is:

This is a secure site with access granted by the Bureau of Managed Care Financing. **The HPN requires each user to possess a User ID and password** to enter the roster application. If you do not have a User ID and password, you should contact that Bureau at 518-474-5050. You will not be granted access to this site without proper authorization.

- ✓ Enter your **User ID and password**
- ✓ Click on the link for the **Health Provider Network** (HPN)
- ✓ Click on **Programs, Office of Managed Care Page and Rosters Home Page** Once you have clicked on the Rosters Home Page you will be able to select the files you have access to.

The specifications for the enrollee rosters are on the following pages.

A list of the County/District codes is provided in Appendix A and a list Insurance Coverage Codes can be found in Appendix B, at the end of this document. These lists of codes will help you in interpreting information included on your enrollee rosters.

Direct questions about the information contained in a Roster or the HPN, receipt date for Rosters, or the Medicaid Monthly Schedule may be directed to the State Department of Health's Managed Care Unit at (518) 474-5050.

Monthly Managed Care Roster File Layout and Field Descriptions

The Monthly Managed Care Recipient Roster lists every Medicaid recipient who is eligible for Medicaid as of the pulldown or processing date and enrolled in a managed care plan (MCO) for the upcoming month.

There are two roster reports generated each month. One (Primary) is produced around 10 days prior to the beginning of the effective month of the report, which is the weekend of the pulldown (for example, June 22nd for the July roster).

A second roster is produced the first full weekend after the beginning of the effective month (for example, July 6th for the July roster). The second report shows only additional enrollees who were not included on the first roster. These enrollees generally are added because their Medicaid eligibility recertification occurred later than the processing date (pulldown date) of the first roster, but was completed before the first day of the effective month. As a result, they were not reflected on the first roster, but added via the second roster production.

Data Elements

The following data is reported for each enrollee on the roster:

CIN – Enrollee's Medicaid Client Identification Number

Social Security Number – Enrollee's Social Security Number

Enrollee's Name

Enrollee's Sex

Enrollee's Date of Birth

Enrollee's Address

Case Number – Case number assigned by the local district

Local Office Code

Expiration Date – End of the month in which the roster expires

Medicaid Coverage
Code which defines the enrollee's type of Medicaid eligibility.

A	Full Medicaid Coverage
B	Full Medicaid Coverage except Long Term Care
L	Perinatal Family
T	HR/UT
P	Prepaid Capitation Plan (PCP) Coverage
G	PCP/Guarantee Coverage
Q	PCP/HR Coverage
R	PCP Guarantee/HR
U	Family Health Plus
W	Family Health Plus/Guarantee
Y	Aliessa Alien
1	Community Coverage w/Community Based Long Term Care
2	Community Coverage without Long Term Care
6	Community Coverage without Long Term Care (legal alien during 5 year ban)

Note: Generally local districts are expected to change recipients' fee for service coverage code from "A", "B", "L", "T" , "Y", "1", "2" or "6" to "P" or "G" when enrolled in a Medicaid managed care plan; however, failure to do so does not change the validity of plan enrollment.

Aid Category
Defines the type of medical assistance the enrollee is eligible for with the Medicaid program. This code is used to derive the rate code under which the capitation claim is paid (Aid to Dependent Children, HR, SSI, Family Health Plus).

Individual Disposition Status Code
Indicates whether recipient's case is active or closed. Valid code values are:

07	Active
08	Inactive
10	Inactive/Sanctioned
11	Denied
13	Deceased
15	Deleted
20	Case Closed"

Medicaid Exception Code
Code used to restrict type of medical services or to place processing constraints on enrollee. The only code displayed (if applicable) is "83 – Mandated Alcohol Substance and Abuse Treatment". All other exception code values are suppressed.

Medicare Code
Indicates the type of Medicare coverage for an enrollee.

2 Part A,
3 Part B,
1 Both Part A and B

Note: Any enrollee with Medicare coverage in a mainstream managed care plan or special needs plan must be disenrolled prospectively (based on the pulldown dates).

Health Insurance Claim Number (HIC) – Enrollee's Medicare Number

Benefit Package
Benefit package number assigned to the plan. The benefit package value is 70 for all Family Health Plus plans.

Capitation Code – Indicates enrollment in plan. "3" = enrolled

PCP Begin Date – Enrollee's most recent effective enrollment date

Rate Code
Four-digit code assigned during claims processing which represents enrollee's age, sex and aid categories. This corresponds to the capitation premium group. This field is suppressed for Special Needs Plans, as enrollees' HIV status is also factored in determining their rate.

Guarantee Date
The date through which capitation payments are guaranteed to the plan (calculated as 6 months subsequent to the initial enrollment date).

Authorization Through Date
The date through which the enrollee is eligible for Medicaid benefits

Recertification Date
The date of the onset of the recertification process for an enrollee. This date is available for New York City enrollees only.

Transaction Date
The date of the most recent capitation transaction for the enrollee on file

Insurance Code
Indicates any third party insurance for which the enrollee is eligible

Begin Date – The date third party insurance is applicable

End Date – The date third party insurance is terminated

Reason Code – Code indicates reason recipient is enrolled

Codes 00–04 indicate voluntary enrollment

05 and 06 indicate auto assignment

07 indicates automated newborn enrollment

New Indicator
Indicated for enrollees whose most recent enrollment effective date on file is equal to the roster effective date.

Monthly Roster File Layout and Field Descriptions				
Field Name	**Record Positions**		**Field Size**	**Explanation**
Trans-Dist	1	2	2	The two digit county/district code assigned by NYS to the county of fiscal responsibility for enrollee
Provider ID	3	10	8	The MMIS ID number of plan in which the recipient is enrolled
Recipient ID	11	18	8	The MMIS ID number of the enrollee
Filler	19	21	3	
Social Security Number	22	30	9	The SSN of enrollee
Last Name	31	46	16	The last name of enrollee
First Name	47	56	10	The first name of enrollee
Middle Initial	57	57	1	Middle initial of enrollee
Sex	58	58	1	Sex of enrollee (F=Female, M=Male, U=Unborn)
Date of Birth (MMDDCCYY)	59	66	8	Date of birth of enrollee
Care of Name	67	82	16	Name of person in care of enrollee
Street	83	110	28	Street address of person in care of enrollee (Mailing address)
City	111	125	15	City address of person in care of enrollee
State	126	127	2	State address of person in care of enrollee
Zip Code	128	132	5	Zip code of person in care of enrollee
Case Number	133	142	10	Case number assigned by County DSS
Loc Off	143	145	3	Code which indicates the local DSS office
Expiration Date (MMDDCCYY)	146	153	8	The date the roster expires
Medicaid Coverage	154	154	1	Code which defines whether the recipient is eligible for services through a MC plan
Aid Category	155	156	2	Defines the type of medical asst for which the enrollee is eligible within the MA program – this code is used to derive the rate code under which the capitation claim is paid
Aid Category	155	156	2	Defines the type of medical asst for which the enrollee is eligible within the MA program – this code is used to derive the rate code under which the capitation claim is paid
Individual Disposition Status Code	155	156	2	Code indicating if recipient's case is active or closed.
Medicaid Exception Code	157	158	2	Code used to restrict types of medical services or to place processing constraints which require claims review
Medicaid Exception Code	159	160	2	Same as above
Medicaid Exception Code	161	162	2	The two digit county/district code assigned by NYS to the county of fiscal responsibility for enrollee
Medicare Code	163	163	1	Indicates the type of Medicare coverage for enrollee (2=Part A, 3=Part B, 1=Both Part A & B)
Health Insurance Claim No.	164	175	12	Enrollee's Medicare Number

Monthly Roster File Layout and Field Descriptions				
Field Name	**Record Positions**		**Field Size**	**Explanation**
Benefit Package	176	177	2	Benefit package number assigned to plan
Capitation Code	178	178	1	Indicates recipient's enrollment in plan (3=Enrolled)
PCP Begin Date (CCYYMMDD)	179	186	8	Recipient's most recent effective enrollment date
Rate Code	187	190	4	Four digit code assigned during claims processing which represents the age, sex, and aid category of enrollee and corresponds to the capitation payment amount
Guarantee Date (CCYYMMDD)	191	198	8	The date through which capitation payments are guaranteed to the plan
Authorization Date (CCYYMMDD)	199	206	8	The date through which the enrollee is eligible for MA benefits.
Recertification Date	207	214	8	The date of the onset of the recertification process for an enrollee.
Transaction Date	215	222	8	The most recent transaction date for enrollee on file
Insurance Code	223	224	2	Indicates any insurance for which the enrollee is eligible
Begin Date (CCYYMMDD)	225	332	8	The date for which insurance was applicable
End Date (CCYYMMDD)	333	240	8	The date for which insurance was terminated
Insurance Code	241	242	2	Same as above
Begin Date	243	250	8	Same as above
End Date	251	258	8	Same as above
Reason Code	259	260	2	Code indicating method of recipient's enrollment
Fee Flag	261	262	2	For future use
Filler	263	267	5	
New Indicator	268	268	1	Indicates this is the first time recipient is appearing on roster

Monthly Managed Care Recipient Roster File Layout – PIC Format

```
01  HMO-ROSTER-RECORD.
        05  HMO-ROS-927-TRANS-DIST                                  PIC X(02).
05  HMO-ROS-048-PROV-ID-NUM                                          PIC X(08).
05  HMO-ROS-CIN                                                      PIC X(08).
05  FILLER                                                           PIC X(03).
05  HMO-ROS-031-SSN                                                  PIC X(09).
05  HMO-ROS-SSN-REDEF REDEFINES HMO-ROS-031-SSN.
10  HMO-ROS-RESP-WORKER                                              PIC X(05).
10  FILLER                                                           PIC X(04).
        05  HMO-ROS-NAME.
10  HMO-ROS-005A-LAST-NAME                                           PIC X(16).
10  HMO-ROS-005B-FIRST-NAME                                          PIC X(10).
10  HMO-ROS-005C-MI                                                  PIC X(01).
05  HMO-ROS-012-SEX                                                  PIC X(01).
05  HMO-ROS-010-DOB.
15  HMO-ROS-DOB-MM                                                   PIC X(02).
15  HMO-ROS-DOB-DD                                                   PIC X(02).
15  HMO-ROS-DOB-CC                                                   PIC X(02).
15  HMO-ROS-DOB-YY                                                   PIC X(02).
05  HMO-ROS-DOB-NUM  REDEFINES HMO-ROS-010-DOB                       PIC 9(08).
05  HMO-ROS-007-C-O-NAME                                             PIC X(16).
05  HMO-ROS-008-STREET                                               PIC X(28).
05  HMO-ROS-883-CITY                                                 PIC X(15).
05  HMO-ROS-884-STATE                                                PIC X(02).
05  HMO-ROS-009-ZIP                                                  PIC X(05).
05  HMO-ROS-928-CASE-NUM                                             PIC X(10).
05  HMO-ROS-014-LOC-OFF                                              PIC X(03).
05  HMO-ROS-EXPIR-DATE.
10  HMO-ROS-EXPIR-MM                                                 PIC X(02).
10  HMO-ROS-EXPIR-DD                                                 PIC X(02).
10  HMO-ROS-EXPIR-CC                                                 PIC X(02).
10  HMO-ROS-EXPIR-YY                                                 PIC X(02).
05  HMO-ROS-EXPIR-NUM  REDEFINES HMO-ROS-EXPIR-DATE                  PIC 9(08).
05  HMO-ROS-027-MAID-COV                                             PIC X(01).
05  HMO-ROS-015-AID-CAT                                              PIC X(02).
05  HMO-ROS-120-INDIV-STATUS                                         PIC X(02).
05  HMO-ROS-022-MAID-EXC-CD OCCURS 2 TIMES                           PIC X(02).
05  HMO-ROS-023-MARE-CD                                              PIC X(01).
05  HMO-ROS-004-HIC-NUM                                              PIC X(12).
05  HMO-ROS-BNFT-PKG                                                 PIC X(02).
05  HMO-ROS-CAP-CODE                                                 PIC X(01).
05  HMO-ROS-PCP-FROM-DT                                              PIC X(08).
05  HMO-ROS-RATE-CODE                                                PIC X(04).
05  HMO-ROS-GUAR-DATE                                                PIC X(08).
05  HMO-ROS-GUAR-NUM  REDEFINES HMO-ROS-GUAR-DATE                    PIC 9(08).
05  HMO-ROS-AUTH-DT                                                  PIC X(08).
05  HMO-ROS-AUTH-DT-NUM REDEFINES HMO-ROS-AUTH-DT                    PIC 9(08).
05  HMO-ROS-RECERT-DT                                                PIC X(08).
05  HMO-ROS-RECERT-DT-NUM REDEFINES HMO-ROS-RECERT-DT                PIC 9(08).
05  HMO-ROS-LAST-TRANS-DT                                            PIC X(08).
** TPHI INSURANCE INFORMATION ***
05  HMO-INSUR-INFO              OCCURS 2 TIMES.
10  HMO-ROS-018-INS-CD                                               PIC X(02).
10  HMO-ROS-INS-DATES.
15  HMO-ROS-019A-BGN-DATE                                            PIC X(08).
15  HMO-ROS-019B-END-DATE                                            PIC X(08).
05  HMO-ROS-REASON-CODE                                              PIC X(02).
05  HMO-ROS-FEE-FLAG                                                 PIC X(02).
05  FILLER                                                           PIC X(05).
05  HMO-ROS-NEW-IND                                                  PIC X(01).
```

Monthly Disenrollment Report

The Disenrollment Report provides managed care organizations (MCOs) with a list of those enrollees on the previous month's roster who were disenrolled from the MCO, transferred to another MCO, or whose enrollments were removed from the file. The Disenrollment Report does not include enrollees who were dropped from the roster due to loss of Medicaid coverage (unless the local district also ends the enrollment on file). Enrollees who have lost eligibility, but remain enrolled, are listed on the Error Report. They will not be reflected on the Disenrollment Report, even when they are removed from the Error Report (coverage lapsed greater than 90 days).

Data Elements:

CIN – Client Identification Number or Medicaid Identification Number of disenrolled individual.
Social Security Number
Name
Sex
Date of Birth (DOB)
Address
Case Number – Individual's case number, assigned by local district
Local Office Code
Disenrollment From Date – Effective date of disenrollment/transfer
Disenrollment Reason Code – see (1) below
Disenrollment Reason – see (2) below
Aid Category – Defines the type of medical assistance for which the disenrollee is eligible. Aid category codes of 68, 69, 70 and 72 indicate a Family Health Plus (FHP) recipient.

Those recipients whose Disenrollment Reason is indicated as "Disenrolled" are clarified by use of a Disenrollment Reason Code. These codes are:

59	Lost Family Health Plus eligibility
66	Recipient retroactively disenrolled (plan must void claims subsequent to the disenrollment date
85	Death
86	Enrollee request
93	Enrollee exempt/excluded from managed care enrollment
95	Lost MA eligibility
97	Moved out of plan's service area

Note: A general disenrollment reason is indicated for all enrollees on this report. Reasons indicated are:

Disenrolled (see reason codes under (1) above)
Enrolled in Another Plan – Enrollee transferred to another plan
Enrollment Deleted – Enrollment removed from file (i.e., Enrolled in error)
Undeterminable - Enrollment/disenrollment transactions need to be manually reviewed to determine reason.

This report is also useful in determining why a recipient who was enrolled for less than six months may not have received guaranteed coverage, as they continue to be Medicaid eligible.

Monthly Disenrollment Report, PIC Format

LABEL RECORDS ARE STANDARD
BLOCK CONTAINS 25 RECORDS
RECORD CONTAINS 180 CHARACTER
DATA RECORD IS PCP-DIS-RECORD.

```
01      PCP-DIS-RECORD.
   05  PCP-DIS-TRANS-DIST                  PIC X(02).
   05  PCP-DIS-PROV-ID-NUM                 PIC X(08).
   05  PCP-DIS-CIN                         PIC X(08).
   05  PCP-DIS-SSN                         PIC X(09).
   05  PCP-DIS-NAME.
      10  PCP-DIS-LAST-NAME                PIC X(16).
      10  PCP-DIS-FIRST-NAME               PIC X(10).
      10  PCP-DIS-MI                       PIC X(01).
   05  PCP-DIS-SEX                         PIC X(01).
   05  PCP-DIS-DOB.
      10  PCP-DIS-DOB-MM                   PIC X(02).
      10  PCP-DIS-DOB-DD                   PIC X(02).
      10  PCP-DIS-DOB-YR                   PIC X(04).
   05  PCP-DIS-C-O-NAME                    PIC X(16).
   05  PCP-DIS-STREET                      PIC X(28).
   05  PCP-DIS-CITY                        PIC X(15).
   05  PCP-DIS-STATE                       PIC X(02).
   05  PCP-DIS-ZIP                         PIC X(05).
   05  PCP-DIS-CASE-NUM                    PIC X(10).
   05  PCP-DIS-LOC-OFF                     PIC X(03).
   05  PCP-DIS-FROM-DT.
      10  PCP-DIS-FROM-YR                  PIC X(04).
      10  PCP-DIS-FROM-MM                  PIC X(02).
      10  PCP-DIS-FROM-DD                  PIC X(02).
   05  PCP-DIS-REASON-CD                   PIC X(02).
   05  PCP-DIS-REASON                      PIC X(25).
   05  PCP-DIS-AID-CAT                     PIC X(02).
   05  FILLER                              PIC X(01).
```

Monthly Error Report

The purpose of the error report is to track on an interim basis those enrollees who lost Medicaid eligibility because their case is closed, or because their Medicaid coverage "expired" (no action was taken by the local department of social services to either end or reauthorize the enrollee's eligibility), but who remain enrolled in the plan.

The enrollees are indicated on the Error Report with the following messages:

"No PCP Cov or Eligibility Expired" – Indicates recipients whose Medicaid eligibility has either lapsed or was terminated prior to the last day of the previous month.

"Eligibility Ended (last day of previous month)" – Indicates recipients whose Medicaid eligibility expired the last day of the month before the roster month. If the recipient remains on the Error Report (that is, no action taken to end or reauthorize eligibility), the message will change to (1) above, in subsequent months.

"Eligibility Ended (last day of previous month) (Closed)" – Indicates recipients whose Medicaid eligibility was terminated effective the last day of the month before the roster month. If the recipient remains on the Error Report for subsequent months, the message will change to (1) above.

Generally, recipients who have lost Medicaid eligibility will appear on the Error Report for the first time for reasons (2) and (3) indicated above. However, recipients who were on the previous month's roster and whose eligibility ends effective prior to the last day of the previous month, will appear on the Error Report for the first time with reason (1) indicated above. Also included in (1) will be the carryovers from (2) and (3). Thus, these reason codes alone cannot be used to identify all of the recipients who were on the previous month's roster and are now on the Error Report.

All of the above enrollees are removed from the monthly roster, but their Medicaid records continue to reflect managed care enrollment for 90 days, even though the recipient is not actively enrolled in Medicaid. The Error Report provides a means of tracking these recipients for a 90-day period. If the recipient is re-certified or re-opened as Medicaid eligible within that period, this allows the recipient to be automatically reinstated on the roster, without the need to actively re-enroll in the plan.

In New York City, the expired cases are automatically closed after 90 days, and their PCP enrollment terminated. These expired cases are dropped at this time from the Error Report (no Medicaid coverage or PCP enrollment). Prepaid Capitation Plan (PCP) enrollment for closed cases is terminated after 90 days as well.

Upstate, expired cases are not automatically closed. However, their PCP enrollment is automatically terminated after 90 days. PCP enrollment for closed cases is terminated after 90 days as well, and they, too, are dropped from the Error Report.

The Error Report also indicates recipients whose eligibility has changed from Medicaid to Family Health Plus (FHP) or vice versa, but a corresponding enrollment for the Medicaid managed care or the FHP plan has not been entered in the system. These cases need to be reviewed by the local district and the appropriate enrollment entered in the system.

Cases requiring this review are indicated on the Error Report with the following messages:

"MA Elig Enroll w/FHP Ben Pac"
Indicates recipients who have been determined Medicaid eligible but are still enrolled with a Family Health Plus plan.

"FHP Elig Enroll w/MA Ben Pac"
Indicates recipients who have been determined Family Health Plus eligible but are still enrolled with a Medicaid managed care plan.

Note: Another reason for inclusion on the Error Report is:

"County Codes Do Not Match"
Indicates recipients who are receiving Medicaid in one fiscal district, but enrollment is in another fiscal district (usually due to a change of address). These discrepancies must be reconciled between the two districts, and until that is done, the case is reflected on the Error Report.

Data Elements:
The following data is reported for each enrollee on the Error Report:

Recipient ID: Enrollee's Medicaid Identification Number

County: Enrollee's district of financial responsibility for Medicaid eligibility

Aid Category: Defines the type of medical assistance the enrollee is eligible for with the Medicaid program. Aid categories 68, 69, 70 or 72 designate a Family Health Plus enrollee.

Case Number: Enrollee's case number assigned by the local district

Error Message – see (1)– (6) above.

Monthly Error Report – PIC Format

```
01 PROV-ERR-RECORD.
   05 PROV-IREF-NAME          PIC X(25).
   05 PROV-IREF-CIN           PIC X(08).
   05 PROV-IREF-CNTY          PIC X(02).
   05 PROV-IREF-AID-CAT       PIC X(02).
   05 PROV-IREF-CASE          PIC X(10).
   05 PROV-PCP-CIN            PIC X(08).
   05 PROV-PCP-CNTY           PIC X(02).
   05 PROV-PCP-CASE           PIC X(10).
   05 PROV-PROV-ID            PIC X(08).
   05 PROV-ERR-MSG            PIC X(28).
   05 PROV-RESP-WRKR          PIC X(05).
```

Medicaid Eligibility Verification System (MEVS)

New York State has implemented the Medicaid Eligibility Verification System (MEVS) as a method for providers to verify recipient eligibility prior to provision of Medicaid services. Plans may use MEVS, if necessary, to verify information about Medicaid eligibility.

The Identification Card (Common Benefit or Connect) no longer constitutes full authorization for provision of medical services and supplies. A recipient must present an official Common Benefit Identification Card or Connect Card to the provider when requesting services. The verification process through MEVS can be completed to determine the recipient's eligibility for Medicaid services and supplies.

The verification process through MEVS can be completed using any one of the following methods:

(1) the MEVS Terminal (OMNI 3750)

(2) a telephone verification process

(3) direct CPU link or batch transmissions

Verifications can be completed within seconds with a touchtone telephone, a rotary telephone with a tone generator, or an MEVS terminal. Information available through MEVS will provide you with:

The eligibility status for a Medicaid recipient for a specific date;

The county having financial responsibility for the recipient (used to determine the contact office for prior approval and prior authorization); and

Any Medicare or third party insurance coverage that a recipient may have for the date of inquiry, including managed care coverage.

MEVS is convenient and easy to use – it is available 24 hours a day, seven days a week. MEVS provides current eligibility status information for all Medicaid recipients and is updated on a daily basis.

The MEVS manual is available at and can be downloaded from www.emedny.org. The manual contains different sections discussing the Common Benefit Identification Card, the verification equipment, procedures for verification, a description of eligibility responses, and test transactions.

Section III – Appendices

Appendix A – County / District Codes

An alphabetical listing of all the counties and their corresponding district codes is listed below. These codes are also available at www.emedny.org. Select Provider Manuals under "Information for All Providers."

01	Albany
02	Allegany
03	Broome
04	Cattaraugus
05	Cayuga
06	Chautauqua
07	Chemung
08	Chenango
09	Clinton
10	Columbia
11	Cortland
12	Delaware
13	Dutchess
14	Erie
15	Essex
16	Franklin
17	Fulton
18	Genesee
19	Greene
20	Hamilton
21	Herkimer
22	Jefferson
23	Lewis
24	Livingston
25	Madison
26	Monroe
27	Montgomery
28	Nassau
29	Niagara
30	Oneida
31	Onondaga
32	Ontario
33	Orange
34	Orleans
35	Oswego
36	Otsego
37	Putnam
38	Rensselaer
39	Rockland
40	St. Lawrence
41	Saratoga
42	Schenectady
43	Schoharie
44	Schuyler
45	Seneca
46	Steuben
47	Suffolk
48	Sullivan
49	Tioga
50	Tompkins
51	Ulster
52	Warren
53	Washington
54	Wayne
55	Westchester
56	Wyoming
57	Yates
66	New York City
97	OMH Administered
98	OMR/DD Administered
99	Breast and Cervical Cancer Treatment Program

Appendix B – Insurance Coverage Codes

Third Party Health Resources

Insurance codes are used to identify Third Party Resources (TPR) other than Medicaid and Medicare, under which a client has insurance coverage, including managed care. Such coverage must be utilized for payment of medical services prior to submitting claims to Medicaid. Insurance and coverage codes are also available at: www.emedny.org.

- ✓ Select **Provider Manuals** under "Information for All Providers."

- ✓ Under **MEVS**, information specific to managed care will be reported to you when you request an eligibility verification for a Medicaid recipient.

The MEVS response via the Verifone Omni 3750 terminal or alternate access will be INS and COV codes followed by a two-digit insurance code and up to 20 alphabetic coverage codes or the word ALL indicating what services are covered. The telephone response will be insurance and coverage codes and a two-digit insurance code, and up to 20 messages or ALL indicating what services are covered.

Please refer to the MEVS Provider Manual for more detailed information on eligibility verifications, which can be found on the eMedNY website at: http://www.emedny.org/ProviderManuals/AllProviders/MEVS/MEVS_Provider_Manual/1_0/mevs_manual.html.

The MEVS response will include information on a maximum of two third party insurance carriers. If a Medicaid recipient is covered by more than two carriers you will receive a response of ZZ as an insurance code which indicates additional insurance. To obtain coverage information when there are more than two carriers, call 1-800-343-9000.

Other insurance codes are available at www.emedny.org.

- ✓ Select **Provider Manuals**

- ✓ The codes are listed in the Information for All Providers section, under **Third Party Information**

Insurance Coverage Codes

MEVS will only return coverage codes for Medicaid Managed Care Plans. These codes identify which services are covered by the client's managed care plan.

Code	Description	Explanation
A	Inpatient Hospital	All inpatient services are covered, except psychiatric care.
B	Physician In-Office	Services provided in the physician's office are generally covered.
C	Emergency Room	Self-Explanatory
D	Clinic	Both hospital based and free-standing clinic services are covered.
E	Psychiatric Inpatient	Self-Explanatory
F	Psychiatric Outpatient	Self-Explanatory
G	Physician In-Hospital	Physician services provided in a hospital or nursing home are covered.
H	Drugs No Card	Drug coverage is available, but a drug card is not needed.
I	Lab/X-Ray	Laboratory and x-ray services are covered.
J	Dental	Self-Explanatory
K	Drugs Co-pay	Although the insurance carrier expects a co-payment, you may not request it from the recipient. If the insurance payment is less than the Medicaid fee, you can bill Medicaid for the balance, which may cover the co-payment.
L	Nursing Home	Some nursing home coverage is available. You must bill until benefits are exhausted.
M	Drugs Major Medical	Drug coverage is provided as part of a Major medical policy
N	All Physician Services	Physician services, without regard to where they were provided, are covered.
O	Drugs	Self-Explanatory
P	Home Health	Some home health benefits are provided. Continue to bill until benefits are exhausted.
Q	Psychiatric Services	All psychiatric services, inpatient and outpatient, are covered.
R	ER and Clinic	Self-Explanatory
S	Major Medical	The following services are covered: physician, clinic, emergency room, inpatient, laboratory, referred ambulatory, transportation and durable medical equipment.
T	Transportation	Medically necessary transportation is covered.
U	Coverage to Complement Medicare	All services paid by Medicare, which require a coinsurance or deductible payment, should be billed to the insurance carrier prior to billing Medicaid.
V	Substance Abuse Services	All substance abuse services, regardless of where they are provided, are covered.
W	Substance Abuse Outpatient	Self-Explanatory
X	Substance Abuse Inpatient	Self-Explanatory
Y	Durable Medical Equipment	Self-Explanatory
Z	Optical	Self-Explanatory
All	All of the above	All services are covered.