

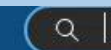


Training Video For NYS Medicaid Providers

ePACES

Key Objectives

Familiarize providers with the
ePACES Dispensing Validation System (DVS) Request
and Response for Durable Medical Equipment (DME)



 Microsoft Start

 Search the web



Add shortcut

[What's New](#)[Information](#)[Provider Enrollment](#)[Provider Manuals](#)[Provider Outreach and Training](#)[Contacts](#)[eMedNY HIPAA Support](#)[eMedNY Tools Center](#)[PTAR](#)**NEW! For Practitioners ONLY**

PROVIDER ENROLLMENT

PORTAL**ENROLL TODAY!**

Pharmacy Benefit Transition



Department of Health

Medicaid NYRx

LEARN MORE**Are you compliant with NYSDOH EFT Requirement?****Login ePACES**[ePACES Information](#)**Login eXchange**[eXchange Information](#)**Medicaid NYRx**[Member Resource Site](#)**Provider Enrollment Maintenance Portal****Web Portal**[Web Portal Information](#)**Enteral Web Portal****Login PTAR**

welcome to

eMedNY**NEW MEDICARE CARDS****MEDICAID MANAGED CARE NETWORK****PTAR**[click here for more information](#)**REVALIDATION**[click here for more information](#)**NOTE:** Access to ePACES requires enrollment

Please contact the eMedNY Call Center at 800-343-9000 to enroll in ePACES

• *welcome to*

ePACES


Username:

Password:

Please Note: Medicaid recipient level data is confidential and is protected by state and federal laws and regulations. It can be used only for the purposes directly connected to the administration of the Medicaid program. You are required to read, understand and comply with these regulations. There are significant state, civil and federal criminal penalties for violations.

[View Medicaid Confidentiality Regulations.](#)

☒ **I have read and I agree to the Medicaid Confidentiality Regulations**

 **Agree / Login**

Change Provider:



Go

Claims

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Please make sure your Provider Name is displayed at the top of the page before continuing. If your Provider Name is incorrect or not available in the "Change Provider" drop-down box at the top of the page, please contact the eMedNY HelpDesk at 800-343-9000.

For further information, please visit these sites:

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

•• PA/DVS Initial Request

▼ General Information

• Client Information

* Indicates required field(s)

* Enter a Client ID:

▶ Go

▶ Clear

General Information Prior Approval Items

* Indicates required field(s)

Client Information

* Enter a Client ID: AA00000A Go

Patient Account #:

Name:

Gender:

DOB:

Transaction Type: Dental - DVS

Provider Service Address:

Address Line 1:

Dental - DVS
Dental - Non DVS
Non Dental - DVS
Non Dental - Non DVS

Select - **Non Dental – DVS** to request a **DVS** for DME

- Procedure code description in DME Provider Manual is preceded by #
- Fee Schedule indicates a PA Code of 6

• **Provider Service Address**

Address Line 1:

Address Line 2:

City:

State: 

Zip:

• **Contact Information**

Name:

Telephone: Ext:

E-Mail:


Fax #:

Leave Provider Service Address and Contact Information blank for a DVS Request

• Referring Provider

• Use an Existing Provider


*Select a Name:



OR Search for a Medicaid Provider:

Last Name:


Provider Number:



OR

• Enter a New Non-Medicaid Provider


* NPI #:



• Ordering Provider

• Use an Existing Provider


*Select a Name:



OR Search for a Medicaid Provider:

Last Name:


Provider Number:



OR

• Enter a New Non-Medicaid Provider

* NPI #:




A Referring Provider is required when the client is a restricted recipient

• Referring Provider

• Use an Existing Provider


*Select a Name:



OR Search for a Medicaid Provider:

Last Name:


Provider Number:



OR

• Enter a New Non-Medicaid Provider


* NPI #:



• Ordering Provider

• Use an Existing Provider


*Select a Name:



OR Search for a Medicaid Provider:

Last Name:


Provider Number:



OR

• Enter a New Non-Medicaid Provider

* NPI #:



An Ordering Provider is required on all DME DVS requests

- Referring Provider

- Use an Existing Provider

*Select a Name:



OR Search for a Medicaid Provider:

Last Name:

Provider Number:



OR

- Enter a New Non-Medicaid Provider

* NPI #:



- Ordering Provider

- Use an Existing Provider

*Select a Name:



OR Search for a Medicaid Provider:

Last Name:

Provider Number:



OR

- Enter a New Non-Medicaid Provider

* NPI #:



Event Information

* Facility Type: ☒ Professional/Dental ☐ (UB) Institutional

* Service Type: Release Of Information:

Accident Date: Service Date: From:

Onset Date: To:

Admission Date: Discharge Date:

Related Causes Information

Related Causes: ☐ Employment ☐ Another Party Responsible ☐ Auto Accident

Accident Location: NY US

Diagnosis

Primary: Secondary:

Event Information

Facility Type: ☒ Professional/Dental ☐ (UB) Institutional

Service Type:

Accident Date:

Onset Date:

Admission Date:

Related Causes Information

Related Causes:

Accident Location:

Diagnosis

Primary:


Codes

Code	Description
<u>1</u>	Medical Care
<u>2</u>	Surgical
<u>3</u>	Consultation
<u>4</u>	Diagnostic X-Ray
<u>5</u>	Diagnostic Lab
<u>6</u>	Radiation Therapy
<u>7</u>	Anesthesia
<u>8</u>	Surgical Assistance
<u>11</u>	Used Durable Medical Equipment
<u>12</u>	Durable Medical Equipment Purchase
<u>14</u>	Renal Supplies in the Home
<u>15</u>	Alternate Method Dialysis
<u>16</u>	Chronic Renal Disease (CRD) Equipment
<u>17</u>	Pre-Admission Testing
<u>18</u>	Durable Medical Equipment Rental
<u>20</u>	Second Surgical Opinion
<u>21</u>	Third Surgical Opinion

Event Information

Facility Type: ☒ Professional/Dental ☐ (UB) Institutional 

Service Type:  Release Of Information: 

Accident Date: 

M - The Provider has Limited or Restricted Ability to Release Data
Y - Yes, Provider has a Signed Statement Permitting Release of Medical Information

Onset Date:  To: 

Admission Date:  Discharge Date: 

Related Causes Information

Related Causes: ☐ Employment
☐ Another Party Responsible
☐ Auto Accident

Accident Location:  

Diagnosis

Primary: Secondary:











A screenshot of a form with a light green background. It contains three sections, each with a light green header bar. The first section is labeled 'Pattern of Delivery' with a dropdown arrow. The second section is labeled 'Home Oxygen Therapy' with a dropdown arrow. The third section is labeled 'Home Health Care' with a dropdown arrow. Each section is preceded by a small orange circle with a white dot inside.

Section	Dropdown Arrow
Pattern of Delivery	▼
Home Oxygen Therapy	▼
Home Health Care	▼

Pattern of Delivery, Home Oxygen Therapy and Home Health Care sections:

Leave blank for a DME DVS Request

- **Attachments**

Type	Transmission Code	Control Number	Description
<input type="text"/> 	<input type="text"/> 	<input type="text"/>	<input type="text"/>
<input type="text"/> 	<input type="text"/> 	<input type="text"/>	<input type="text"/>
<input type="text"/> 	<input type="text"/> 	<input type="text"/>	<input type="text"/>
<input type="text"/> 	<input type="text"/> 	<input type="text"/>	<input type="text"/>
<input type="text"/> 	<input type="text"/> 	<input type="text"/>	<input type="text"/>

[Enter More Attachments...](#)



**Certification
Category**

Condition Codes

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

[Enter More Certification Information...](#)

- **Comments**





Next



▶ General Information

▼ Prior Approval Items

* Indicates required field(s)

Line	Service Dates	*NDC/Proc & Modifiers	Unit Count Basis Meas.	Line Amount	More Details	Remove
1	From: MM/DD/YYYY  To: 	<div></div> <div><div></div><div></div></div> <div><div></div><div></div></div>	<div></div> <div>UN-Unit ▼</div>	\$ <div></div>		

◀ Previous

▶ Submit

▶ Enter Another DVS For This Client





▶ Clear

REMINDER: A DVS request requires the current date and not a past or future date

▶ General Information

▼ Prior Approval Items

* Indicates required field(s)

Line	Service Dates	*NDC/Proc & Modifiers	Unit Count Basis Meas.	Line Amount	More Details	Remove				
1	From: <input type="text"/>  To: <input type="text"/> 	<input type="text"/> <table border="1"><tr><td></td><td></td></tr><tr><td></td><td></td></tr></table>					<input type="text"/> UN-Unit ▼	\$ <input type="text"/>		

Enter modifier(s) when applicable

◀ Previous

▶ Submit

▶ Enter Another DVS For This Client

▶ Clear

Request Submitted.



▼ General Information

* Indicates required field(s)

• **Client Information**

* Enter a Client ID:

▶ Go

▶ Clear

Change Provider:

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DVS – Response Action Codes

A1: Certified in total - All requested services/units authorized

A3: Not Certified - Requested services/units are not authorized

C: Cancelled - DVS has been cancelled

CT: Contact Payer - Contact the payer for additional information 1-800-343-9000

NA: No Action Required - Authorization unnecessary for service requested

DVS – Response Action Codes

Action Codes and Response Descriptive Text

When Action code 'A3' is received in a DVS response transaction, it is accompanied by a Health Care Services Decision Reason Code in the Response Descriptive Text Field

The codes most used by NYSDOH are listed below

01	Price Authorization Expired
04	Authorized Quantity Exceeded
0C	Authorization/Access Restrictions
0D	Requires PCP authorization
0H	Certification Not Required for this Service
0L	Exceeds Plan Maximums
0N	No Prior Approval
0Q	Duplicate Request
0X	Service Inconsistent with Provider Type

0Y	Service inconsistent with Patient's Age
0Z	Service inconsistent with Patient's Gender
10	Product/service/procedure delivery pattern (e. g. , units, days, visits, weeks, hours, months)
12	Patient is restricted to specific provider
14	Plan/contractual guidelines not followed
21	Transport Request Denied
25	Services were not considered due to other errors in the request.
26	Missing Provider Role

Search Criteria

Requested within the last days

Review Identification #:

Client Last Name:

Date Sent:
(mm/dd/yyyy)



Client ID:

Action:

Service Type:



Show ☐ all transactions for this provider ☒ just my transactions

Search

Clear

Client ID ▼	Name ▼	Date Sent ▼	Service Type ▼	Review ID Number ▼	Cert. Type	Action ▼	Response Descriptive Text	Image Upload
LL02399Q	SMITH, JOAN	6/01/2024 3:20:58 PM	12			A3	Not Certified, 25-Services were not considered due to other errors in the request.	
LL02399Q	SMITH, JOAN	6/01/2024 3:20:58 PM	18	12345678900		A1	Certified in total	

Search Criteria

Requested within the last days

Review
Identification #:

Client Last Name:

Date Sent:
(mm/dd/yyyy)



Client ID:

Action:

Service Type:



Show ☐ all transactions for this provider ☒ just my transactions

Search

Clear

Client ID ▼	Name ▼	Date Sent ▼	Service Type ▼	Review ID Number ▼	Cert. Type	Action ▼	Response Descriptive Text	Image Upload
LL02399Q	SMITH, JOAN	6/01/2024 3:20:58 PM	12			A3	Not Certified, 25-Services were not considered due to other errors in the request.	
LL02399Q	SMITH, JOAN	6/01/2024 3:20:58 PM	18	12345678900		A1	Certified in total	

Client Information

Client ID: LL02399Q

Patient Account #:

Name: SMITH JOAN

Gender: F

DOB:

Transaction Type:

Non Dental - DVS

Response

Action Code: A1-Certified in total

Issue Date: 6/01/2024

Effective Date: 6/01/2024

Review ID Number: 12345678900

Expiration Date: 6/05/2024

Prescribing Provider

No Provider Chosen

DVS number for claim



Reference and Contact Information

eMedNY Website

- www.emedny.org

Durable Medical Equipment Provider Manual

- www.emedny.org/ProviderManuals/DME/index.aspx

ePACES Reference Sheets

- https://www.emedny.org/HIPAA/QuickRefDocs/ePACES-DVS_Request.pdf
- https://www.emedny.org/HIPAA/QuickRefDocs/ePACES_DME_DVS_Request_Response_Cheat_Sheet.pdf

eMedNY Call Center

- 800-343-9000



Conclusion

ePACES DVS Request and
Response for DME



www.emedny.org