



New York State 150003 Billing Guidelines

**DURABLE MEDICAL EQUIPMENT, MEDICAL
SUPPLIES, ORTHOPEDIC FOOTWEAR,
ORTHOTIC AND PROSTHETIC APPLIANCE**



eMedNY is the name of the New York State Medicaid system. The eMedNY system allows New York Medicaid providers to submit claims and receive payments for Medicaid-covered services provided to eligible members.

eMedNY offers several innovative technical and architectural features, facilitating the adjudication and payment of claims and providing extensive support and convenience for its users.

The information contained within this document was created in concert by DOH and eMedNY. More information about eMedNY can be found at www.emedny.org.

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APPLIANCES

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***For eMedNY Billing Guideline questions, please contact
the eMedNY Call Center 1-800-343-9000.***

1. Purpose Statement

The purpose of this document is to augment the General Billing Guidelines for professional claims with the NYS Medicaid specific requirements and expectations for Durable Medical Equipment (DME), Medical Supplies, Orthopedic Footwear, and Orthotic and Prosthetic Appliance services.

For providers new to NYS Medicaid, it is required to read the General Professional Billing Guidelines available at www.emedny.org by clicking: [General Professional Billing Guidelines](#).

2. Claims Submission

DME providers can submit their claims to NYS Medicaid in electronic or paper formats.

2.1 Electronic Claims

DME providers who choose to submit their Medicaid claims electronically are required to use the HIPAA 837 Professional (837P) transaction.

2.2 Paper Claims

DME providers who choose to submit their claims on paper forms must use the New York State eMedNY-150003 claim form.

To view a sample DME eMedNY - 150003 claim form, see Appendix A below. The displayed claim form is a sample and is for illustration purposes only.

2.3 DME Services Billing Instructions

This subsection of the Billing Guidelines covers the specific NYS Medicaid billing requirements for DME providers. Although the instructions that follow are based on the eMedNY-150003 paper claim form, they are also intended as a guideline for electronic billers to find out what information they need to provide in their claims. For further electronic claim submission information, refer to the eMedNY 5010 Companion Guide which is available at www.emedny.org by clicking: [eMedNY Transaction Information Standard Companion Guide CAQH - CORE CG X12](#).

It is important that providers adhere to the instructions outlined below. Claims that do not conform to the eMedNY requirements as described throughout this document may be rejected, pending, or denied.

2.3.1 eMedNY - 150003 Claim Form Field Instructions

Name of Referring Physician or Other Source (Field 19)

837P Ref: Loop 2310A NM1

Enter the ordering provider's name in this field.

Address [or Signature – SHF Only] (Field 19A)

If the ordering provider and the DME, supplies and appliances dispenser are part of the same Shared Health Care Facility, the ordering provider must obtain the ordering provider's signature in this field.

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Identification Number [Ordering/Referring Provider] (Field 19C)**837P Ref: Loop 2310A NM109****For Ordering Provider**

Enter the ordering provider's National Provider Identifier (NPI) in this field.

Date of Service (Field 24A)**837P Ref: Loop 2400 DTP03 when DTP01 = 472**

Enter the date on which the service was rendered in the format MM/DD/YY.

NOTES:

- *A service date must be entered for each Procedure Code listed.*
- *For Materials and Appliances, enter the date they are dispensed or delivered.*
- *When billing for a custom-made item of equipment, prosthetic or orthotic appliance subsequent to a patient's loss of eligibility under the circumstances outlined in the Policy Guidelines of this manual, the Date of Service should be the date the physician's order was received and the patient's Medicaid eligibility was verified.*

Other Referring/Ordering Provider ID/License Number (Field 33)**837P Ref: Loop 2310A NM109****Restricted Recipients**

When providing services to a patient who is restricted to an entity other than the provider entered in field 19C, the NPI of the restriction provider must be entered in this field.

If a patient is restricted to a facility, the NPI of the practitioner at the facility the patient is restricted to, must be entered in this field, *the ID of the facility cannot be used*.

If supplies or equipment are dispensed to a restricted patient who was referred by his/her primary provider to another provider who orders services, enter the primary provider's NPI in this field. The ordering provider information must be entered in fields 19B and 19C.

3. Remittance Advice

The Remittance Advice is an electronic, PDF or paper statement issued by eMedNY that contains the status of claim transactions processed by eMedNY during a specific reporting period. Statements contain the following information:

- A listing of all claims (identified by several items of information submitted on the claim) that have entered the computerized processing system during the corresponding cycle
- The status of each claim (denied, paid or pending) after processing
- The eMedNY edits (errors) that resulted in a claim denied or pending
- Subtotals and grand totals of claims and dollar amounts
- Other pertinent financial information such as recoupment, negative balances, etc.

The General Remittance Advice Guidelines contains information on selecting a remittance advice format, remittance sort options, and descriptions of the paper Remittance Advice layout. This document is available at www.emedny.org by clicking: [General Remittance Billing Guidelines](#).

APPENDIX A CLAIM SAMPLES

The eMedNY Billing Guideline Appendix A: Claim Samples contains an image of a claim with sample data.

MEDICAL ASSISTANCE HEALTH INSURANCE CLAIM FORM TITLE XIX PROGRAM

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

1. PATIENT'S NAME (First, middle, last) **JANE SMITH**

2. DATE OF BIRTH **05/20/1990**

3. INSURED'S NAME (First name, middle initial, last name)

4. PATIENT'S ADDRESS (Street, City, State, Zip Code)

5. INSURED'S SEX MALE FEMALE

6. MEDICARE NUMBER

7. PATIENT'S TELEPHONE NUMBER

8. INSURED'S EMPLOYER OR OCCUPATION

9. OTHER HEALTH INSURANCE COVERAGE - Enter Name of Policy Holder, Plan Name and Address, and Policy or Private Insurance Number

10. WAS CONDITION RELATED TO: PATIENT'S EMPLOYMENT CRIME VICTIM AUTO ACCIDENT OTHER LIABILITY

11. INSURED'S ADDRESS (Street, City, State, Zip Code)

12. DATE

PATIENT'S OR AUTHORIZED SIGNATURE _____ MM DD YY

INSURED'S SIGNATURE _____

PHYSICIAN OR SUPPLIER INFORMATION (REFER TO REVERSE BEFORE COMPLETING AND SIGNING)

14. DATE OF ONSET OF CONDITION

15. FIRST CONSULTED FOR CONDITION

16. HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS

17. DATE PATIENT MAY RETURN TO WORK

18. DATES OF DISABILITY

19. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

20. ADDRESS (OF SIGNATURE SHIP ONLY)

21. NATIONAL DRUG CODE

22. NAME OF FACILITY WHERE SERVICES RENDERED (if other than home or office)

23. ADDRESS OF FACILITY

24. SERVICE PROVIDER NAME

25. DIAGNOSIS OR NATURE OF ILLNESS. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN 244 BY REFERENCE TO NUMBERS 1, 2, 3 ETC. OR IX CODE

26. POSSIBLE DISABILITY

27. TOTAL CHARGE

28. AMOUNT PAID

29. BALANCE DUE

244	245	246	247	248	249	250	251	252	253	254	255	256	257	258	259	260
DATE OF SERVICE	PLACE	PROCEDURE CD	MOD	MOD	MOD	MOD	DIAGNOSIS CODE	SAYS OR UNITS	CHARGES	AMOUNT PAID	BALANCE DUE	FROM	THROUGH	PROC CD	MOD	DATE
M	D	D	Y	Y												
09	14	10	11	K10	001	R	R	8970	7200							
09	14	10	11	E02	75			7862	378							

30. EMPLOYER IDENTIFICATION NUMBER SOCIAL SECURITY NUMBER

31. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE

32. MEDICARE GROUP IDENTIFICATION NUMBER

33. COUNTY OF SUBMITTAL

34. DATE SIGNED

35. PATIENT'S ACCOUNT NUMBER

36. OTHER REFERRING ORDERING PROVIDER (LICENSE NO.)

37. PROF. CO.

38. CASE MANAGER ID

39. MY PEE HAS BEEN PAID

40. MY WRITE IN THIS SPACE

(9/10) EMEDNY-150003

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