New York State
150003 Billing Guidelines

REHABILITATION SERVICES

Version 2011 - 01

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eMedNY is the name of the electronic 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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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 Rehabilitation 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

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

2.1 Electronic Claims

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

2.2 Paper Claims

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

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

2.3 Rehabilitation Services Billing Instructions

This subsection of the Billing Guidelines covers the specific NYS Medicaid billing requirements for Rehabilitation Services 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, pended, or denied.

2.3.1 eMedNY - 150003 Claim Form Field Instructions

Days or Units (Field 24I)

837P Ref: Loop 2400 SV104

Speech Pathology

For speech pathology treatment, each ½ hour equals 1 unit. For sessions in excess of ½ hour, indicate the number of ½ hour units provided. For example, for a 1½ hour session, enter 3 units.

Physical or Occupational Therapy

For physical/occupational therapy services, each 15 minutes equals 1 unit. For services in excess of 15 minutes (up to a maximum of 2 hours), indicate the number of 15-minute units provided. For example, a 1 hour physical/occupational therapy session, enter 4 units.

If only one unit of service was rendered, this field may be left blank.

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 pended) after processing
- The eMedNY edits (errors) that resulted in a claim denied or pended
- 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

ONLY TO BE USED TO ADJUST/VOID PAID CLAIM | A CODE V | ORIGINAL TRANSACTION CONTROL NUMBER

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

DO NOT STAPLE IN BARCODE AREA

1. PATIENT'S NAME (First, middle, last): SUSAN SAMPLE
2. DATE OF BIRTH: 0 5 2 0 1 9 9 0
2A. TOTAL ANNUAL FAMILY INCOME
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
5A. PATIENT'S SEX: MALE / FEMALE: X
5B. PATIENT'S TELEPHONE NUMBER
5C. PATIENT'S EMPLOYER, OCCUPATION OR SCHOOL
6. MEDICARE NUMBER
6A. MEDICAID NUMBER: X X 1 2 3 4 5 X
6B. PRIVATE INSURANCE NUMBER | GROUP NO. | RECIPROCITY NO.
7. PATIENT'S RELATIONSHIP TO INSURED: SELF / SPOUSE / CHILD / OTHER
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. PATIENT'S OR AUTHORIZED SIGNATURE | DATE MM DD YY
13. 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: YES / NO
16A. EMERGENCY RELATED: YES / NO
17. DATE PATIENT MAY RETURN TO WORK
18. DATES OF DISABILITY: TOTAL / PARTIAL; FROM / TO
19. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE
19A. ADDRESS (OR SIGNATURE SHF ONLY)
19B. PROF CD
19C. IDENTIFICATION NUMBER: 1 1 2 3 4 5 6 7 8 9
19D. DX CODE
20. NATIONAL DRUG CODE | 20A UNIT | 20B QUANTITY | 20C COST
NDC info entered to the left of this field will only be associated with the 1st claim line below
21. NAME OF FACILITY WHERE SERVICES RENDERED (if other than home or office)
21A. ADDRESS OF FACILITY
22. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE: YES / NO
LAB CHARGES
22A. SERVICE PROVIDER NAME
22B. PROF CD
22C. IDENTIFICATION NUMBER
22D. STERILIZATION ABORTION CODE
22E. STATUS CODE
23. DIAGNOSIS OR NATURE OF ILLNESS. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN 24H BY REFERENCE TO NUMBERS 1, 2, 3 ETC. OR DX CODE
1.
2.
3.
22F. POSSIBLE DISABILITY: N X
22G. EPSDT C/THP
22H. FAMILY PLANNING: N X
23A. PRIOR APPROVAL NUMBER
23B. PAYMT SOURCE CD: 1 1

24A. DATE OF SERVICE (MM DD YY)	24B. PLACE	24C. PROCEDURE CD	24D. MOD	24E. MOD	24F. MOD	24G. MOD	24H. DIAGNOSIS CODE	24I. DAYS OR UNITS	24J. CHARGES	24K.	24L.
09 16 10	12	92507					344.1	02	9.40		
09 16 10	12	97530					344.1	04	9.40		

24M. INPATIENT HOSPITAL VISITS | FROM | THROUGH | 24N. PROC CD | 24O. MOD

25. CERTIFICATION (I CERTIFY THAT THE STATEMENTS ON THE REVERSE SIDE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.)

James Strong

SIGNATURE OF PHYSICIAN OR SUPPLIER

25A. PROVIDER IDENTIFICATION NUMBER: 1 1 2 3 4 5 6 7 8 9
25B. MEDICAID GROUP IDENTIFICATION NUMBER
25C. LOCATOR CODE: 0 0 3
25D. SA EXCP CODE
26. ACCEPT ASSIGNMENT: YES / NO
27. TOTAL CHARGE
28. AMOUNT PAID
29. BALANCE DUE
30. EMPLOYER IDENTIFICATION NUMBER SOCIAL SECURITY NUMBER
31. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE:
James Strong
312 Main Street
Anytown, New York 11111
32A. MY FEE HAS BEEN PAID: YES / NO
TELEPHONE NUMBER ( ) EXT.
DO NOT WRITE IN THIS SPACE.
COUNTY OF SUBMITTAL
25E. DATE SIGNED: 09 17 10
32. PATIENT'S ACCOUNT NUMBER: A B C 1 2 3 4 5
33. OTHER REFERRING ORDERING PROVIDER ID/LICENSE NO.
34. PROF CD
35. CASE MANAGER ID

(9/10) EMEDNY-150003