



New York State 150003 Billing Guidelines

LABORATORY



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 Laboratory 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

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

2.1 Electronic Claims

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

If desired, these may be submitted using the 837 Institutional (837I). However, the 837I references are not provided in this manual.

2.2 Paper Claims

Laboratory 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 Laboratory Services Billing Instructions

This subsection of the Billing Guidelines covers the specific NYS Medicaid billing requirements for Laboratory 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.

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

If the service is ordered by a Physician Assistant or a Nurse Midwife, the supervising licensed practitioner's NPI must be entered in this field.

Independent Laboratories (COS 1000) Only

When providing services to a patient who is restricted to a primary provider (physician, clinic, podiatrist or dentist) who orders laboratory services, enter the NPI of the primary provider in this field. *Do not enter the license number of the primary provider.*

If the restricted patient was referred by his/her primary provider to another provider who orders laboratory services, the laboratory must enter the ordering provider's NPI in this field. *If the provider ordering the laboratory services is not the patient's primary provider*, then the primary's NPI must be entered in field 33.

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.*

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 PATIENT AND INSURED (SUBSCRIBER) INFORMATION										ONLY TO BE USED TO ADJUST/VOID PAID CLAIM		A CODE V		ORIGINAL TRANSACTION CONTROL NUMBER													
DO NOT STAPLE IN BARCODE AREA												1. PATIENT'S NAME (First, middle, last) JANE SMITH				2. DATE OF BIRTH 05/20/1990				3A. 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 M ☐ F ☒				5A. PATIENT'S SEX M ☐ F ☒				6. MEDICARE NUMBER			
												6C. PATIENT'S EMPLOYER, OCCUPATION OR SCHOOL				7. PATIENT'S RELATIONSHIP TO INSURED SELF ☐ SPOUSE ☐ CHILD ☐ OTHER ☐				8. INSURED'S EMPLOYER OR OCCUPATION				6A. MEDICAID NUMBER X X 1 2 3 4 5 X			
																								6B. PRIVATE INSURANCE NUMBER GROUP NO. REDUCTION NO.			
8. OTHER HEALTH INSURANCE COVERAGE - Enter Name of Policy Holder, Plan Name and Address, and Policy or Private Insurance Number												9. WAS CONDITION RELATED TO PATIENT'S EMPLOYMENT AUTO ACCIDENT ☐ CRIME VICTIM ☐ OTHER DISABILITY ☐				11. INSURED'S ADDRESS (Street, City, State, Zip Code)											
12. DATE MM DD YY												13. INSURED'S SIGNATURE				14. PATIENT'S OR AUTHORIZED SIGNATURE MM DD YY											
15. PHYSICIAN OR SUPPLIER INFORMATION (REFER TO REVERSE BEFORE COMPLETING AND SIGNING)												16. DATES OF DISABILITY FROM TO TOTAL PARTIAL MM DD YY MM DD YY															
17. DATE OF ONSET OF CONDITION MM DD YY				18. FIRST CONSULTED FOR CONDITION MM DD YY				19. HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS YES ☐ NO ☐				20. EMERGENCY RELATED YES ☐ NO ☐				21. DATE PATIENT MAY RETURN TO WORK MM DD YY											
22. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE												23. ADDRESS (OR SIGNATURE SHP ONLY)				24. PROP. CD 25. IDENTIFICATION NUMBER 1 1 2 3 4 5 6 7 8 9				26. DX CODE							
27. NATIONAL DRUG CODE				28. UNIT 29. QUANTITY				30. COST				31. NDC info entered to the left of this line will only be associated with the 1st claim line below															
32. NAME OF FACILITY WHERE SERVICES RENDERED (if other than home or office)												33. ADDRESS OF FACILITY				34. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE YES ☐ NO ☐				35. LAB CHARGES							
36. SERVICE PROVIDER NAME												37. PROP. CD 38. IDENTIFICATION NUMBER				39. STERILIZATION ABORTION CODE				40. STATUS CODE							
41. DIAGNOSIS OR NATURE OF ILLNESS. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN 34H BY REFERENCE TO NUMBERS 1, 2, 3 ETC. OR DX CODE												42. POSSIBLE DISABILITY Y ☐ N ☐				43. EPISOT GTHP Y ☐ N ☐				44. FAMILY PLANNING Y ☒ N ☐							
45. PRIOR APPROVAL NUMBER												46. PAYMT SOURCE CD 1 1 1				47. CHARGES JRK											
48. DATE OF SERVICE MM DD YY				49. PLACE				50. PROCEDURE CD				51. MOD. MOD. MOD. MOD.															
52. MOD. MOD. MOD. MOD.				53. DIAGNOSIS CODE				54. DAYS OR UNITS				55. CHARGES															
56. FROM				57. THROUGH				58. PROC. CD				59. MOD.															
60. CERTIFICATION I CERTIFY THAT THE STATEMENTS ON THE REVERSE SIDE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.												61. ACCEPT ASSIGNMENT YES ☐ NO ☐				62. TOTAL CHARGE				63. AMOUNT PAID							
64. EMPLOYER IDENTIFICATION NUMBER / SOCIAL SECURITY NUMBER												65. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE				66. BALANCE DUE											
67. SIGNATURE OF PHYSICIAN OR SUPPLIER James Strong												68. ABC Laboratory 312 Main Street Anytown, NY 11111				69. TELEPHONE NUMBER () EXT.											
70. PROVIDER IDENTIFICATION NUMBER 1 1 2 3 4 5 6 7 8 9																											
71. MEDICARE GROUP IDENTIFICATION NUMBER												72. LOCATOR CODE 0 0 3				73. SA EXCP CODE				74. MY FEE HAS BEEN PAID YES ☐ NO ☐							
75. COUNTY OF SUBMITTAL				76. DATE SIGNED 09 29 10				77. PATIENT'S ACCOUNT NUMBER				78. CASE MANAGER ID X X 1 2 3 4 5 X															
79. OTHER REFERRING ORDERING PROVIDER (LICENSE NO.)												80. PROP. CD				81. CASE MANAGER ID											