



# **New York State 150003 Billing Guidelines**

**NURSING SERVICES**



**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](http://www.emedny.org).**

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

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# 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 Private Duty Nursing services.

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

## 2. Claims Submission

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

### 2.1 Electronic Claims

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

### 2.2 Paper Claims

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

### 2.3 Nursing Services Billing Instructions

This subsection of the Billing Guidelines covers the specific NYS Medicaid billing requirements for Nursing 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](http://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

##### Service Provider Name (Field 22A)

**837P Ref: Loop 2310B NM1**

##### Agencies Only

Enter the name of the private duty nurse who provided the service. If more than one nurse rendered services to the patient on the same day, a separate claim must be submitted for each nurse.

## Identification Number [Service Provider] (Field 22C)

**837P Ref: Loop 2310B NM1**

### Agencies Only

Enter the NPI of the nurse that provided the services in this field.

## MOD [Modifier] (Fields 24D, 24E, 24F, and 24G)

**837P Ref: Loop 2400 SV101-3, 4, 5, 6, and 7**

Under certain circumstances, the procedure code must be expanded by a two-digit modifier to further explain or define the nature of the procedure. If the Procedure Code requires the addition of modifiers, enter one or more (up to four) modifiers in these fields.

Enter modifier **"TT"** to indicate individualized service provided to more than one patient in the same setting.

Only enter modifier **"U1"** to indicate the Care at Home Waiver Program when resubmitting or adjusting claims for a date of service when no prior approval was required. When a Prior Approval Number is entered in Field 23A, Modifier **"U1"** should not be entered on the claim

### Special Instructions for Claiming Medicare Deductible

When billing for the Medicare *deductible*, modifier **"U2"** must be used in conjunction with the Procedure Code for which the deductible is applicable. **Do not** enter the **"U2"** modifier if billing for Medicare coinsurance.

**NOTE: Modifier values and their definitions are available under Procedure Codes and Fee Schedule at [www.emedny.org](http://www.emedny.org) by clicking on the link to the webpage as follows: [Private Duty Nursing Manual](#).**

## Days or Units (Field 24I)

**837P Ref: Loop 2400 SV104**

One hour of nursing service equals one unit. Partial hours (30 minutes or more) should be rounded up to one hour.

The total number of hours of service provided to the patient **during the same day by the same nurse** should be entered in one line only even if the service was provided in separate shifts.

## SA EXCP Code [Service Authorization Exception Code] (Field 25D)

### 837P Ref: Loop 2300 REF03 when REF01 = 4N

Private Duty Nursing (PDN) providers who enroll in the Training and Experience component of the Medically Fragile Children and Adult (MFCA) Program will receive an enhanced fee of thirty percent (30%) added to the approved hourly fee at the time of claims processing. In order to be eligible to receive this add-on payment, the PDN provider must certify that they have the training and experience to care for medically fragile children and adults in the community setting. To accomplish this, fill out the appropriate enrollment form. The enrollment forms can be found on [emedny.org](https://www.emedny.org) and at the following links:

- [Independent RN/LPN MFCA Enrollment Form](#)
- [Nurse Registry \(Agency\) MFCA Enrollment Form](#)

Upon receipt of your satisfactorily completed enrollment form, a new Specialty Code 579 will be added to your enrollment file to enable you to receive the Medically Fragile Children and Adult training and Experience fee enhancement at the time of claims processing.

### Billing Instructions for the 30% add-on payment

In order to be reimbursed the 30% add-on amount, *enter a Service Authorization (SA) Exception Code of "7" in this field*; otherwise leave this field blank.

PDN Providers may also choose to enroll in the MFCA PDN Provider Directory. Providers who successfully enroll in the MFCA Directory will receive an enhanced fee of forty-five percent (45%) added at the time of claims processing. **No Service Authorization (SA) Exception Code is required for the Directory enhancement.**

### 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](http://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 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

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

17. DATE PATIENT MAY RETURN TO WORK

18. DATES OF DISABILITY

19. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

20. NATIONAL DRUG CODE

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

22. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE

23. DIAGNOSIS OR NATURE OF ILLNESS. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN 24H BY REFERENCE TO NUMBERS 1, 2, 3, ETC. OR 01 CODE

24. PROCEDURE CODES

25. CERTIFICATION

26. ACCEPT ASSIGNMENT

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

32. PATIENT'S ACCOUNT NUMBER

33. OTHER REFERRING ORDERING PROVIDER (LICENSE NO.)

34. PROF. CO.

35. CASE MANAGER ID

Signature: **James Strong**

Address: **James Strong, R.N., 312 Main Street, Anytown, NY 11111**

Phone: **(9/10) EMEDNY-150003**

NURSING SERVICES