

NURSING SERVICES

The information contained in this document will assist Nursing Services providers enrolled in the New York State (NYS) Medicaid Program with understanding and complying with Medicaid requirements for billing and submitting claims.

Providers should use the information in this document along with the Nursing Services Manual posted at www.emedny.org

- ✓ Select **Provider Manuals** from the menu
- ✓ Click on **Nursing Services**
- ✓ Click on **Billing Guidelines**

Nursing Services providers who bill electronically should refer to the 837P Companion Guide (CG) and the 837 Professional Supplemental Guide posted at www.emedny.org.

- ✓ Select **NYHIPAADESK** from the menu
- ✓ Click on **eMedNY Companion Guides and Sample Files**
- ✓ Look for the box labeled “837 Professional Health Care Claim Transaction” and click on the link for the **837 Professional Companion Guide**

The NYS Medicaid Technical Supplementary Companion Guide provides technical information needed to successfully transmit and receive electronic data. The Technical Supplementary CG is available at www.emedny.org.

- ✓ Select **NYHIPAADESK** from the menu
- ✓ Click on **eMedNY Companion Guides and Sample Files**
- ✓ Look for the box labeled “Technical Guides” and click on the link **TECHNICAL SUPPLEMENTARY Companion Guide**

Questions about the information in this Training Matrix should be directed to the eMedNY Call Center at the following number:

1-800-343-9000

The following is an explanation of the information contained in the matrix and instructions for use.

Column 1 eMedNY-150001 Field Number	This refers to the Field Number on the eMedNY-150001 Form.
Column 2 eMedNY-150001 Field Name	This refers to the Field Name on the eMedNY-150001 Form.
Column 3 HIPAA 837P Loop	This refers to the 837P Loop in which this data is found for electronically submitted claims.
Column 4 HIPAA 837P Segment Information	This refers to the 837P Segment in which this data is found for electronically submitted claims.
Column 5 NYS Medicaid Instructions	This column puts forth instructions for data use and content.

Notes:

- Only fields with Medicaid application will be explained in this document.
- Electronic submitters are urged to review the Phase II Companion Guides at www.emedny.org for complete instructions on HIPAA data requirements.
- The source of the codes used for billing is the Medicaid Nursing Services Provider Manual.
- The information contained this document is subject to change.

New York State Training Matrix – Nursing Services

eMedNY 150001 Field Number	eMedNY- 150001 Field Name	HIPAA 837P Loop	HIPAA 837P Segment Information	NYS Medicaid Instructions
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The following two fields (unnumbered) should only be used to adjust or void a paid claim. Do not write in these fields when preparing an original claim form.

*	CODE (A/V)	2300	Claim Information CLM05-3	<p>Used to indicate an adjustment (replacement) or a void to a previously paid claim.</p> <p>eMedNY-150001 Instructions: Place a “7” over the A box to indicate an adjustment or an “8” over the V box to indicate a void or place an X on the appropriate box.</p> <p>HIPAA Instructions: Enter code “7” to indicate an adjustment or “8” to indicate a void.</p>
*	ORIGINAL CLAIM REFERENCE NUMBER	2300	Original Reference Number REF02	<p><i>Adjustment to Cancel One or More Claims Originally Submitted on the Same Document/Record (TCN):</i> An adjustment should be submitted to cancel or void one or more individual claims that were originally submitted on the same document/record and share the same Transaction Control Number (TCN).</p> <p>The following instructions must be followed:</p> <ul style="list-style-type: none"> • The adjustment must be submitted in a new claim form (copy of the original form is unacceptable). • The adjustment must contain all claims submitted in the original document (all claims with the same TCN) except for the claim(s) to be voided; these claims must be omitted in the adjustment. All applicable fields must be completed. <p>The adjustment will cause the cancellation of the omitted individual claims from the TCN history records as well as the cancellation of the original TCN payment and the repricing of the new TCN (Adjustment) based on the adjusted information.</p> <p>Void A void is submitted to nullify all individual claim lines originally submitted on the same document/record and sharing the same TCN.</p> <p>When submitting a void, please follow the instructions below:</p> <ul style="list-style-type: none"> • The void must be submitted on a new claim form (copy of the original form is unacceptable). • The void must contain all the claim lines to be cancelled and all applicable fields must be completed. <p>Voids cause the cancellation of the original TCN history records and payment.</p>

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eMedNY 150001 Field Number	eMedNY-150001 Field Name	HIPAA 837P Loop	HIPAA 837P Segment Information	NYS Medicaid Instructions
1	PATIENT'S NAME	2010BA	Subscriber Name NM103 NM104	Enter the recipient's name as it appears on the Common Benefit Identification Card.
2	DATE OF BIRTH	2010BA	Subscriber Demographic Information DMG02	Enter the recipient's birth date indicated on the Common Benefit ID Card. eMedNY-150001 Instructions: The format entered must be MMDDYYYY. HIPAA Instructions: The format of the date must be CCYYMMDD.
5A	PATIENT'S SEX	2010BA	Subscriber Demographic Information DMG03	eMedNY-150001 Instructions: Place an X in the appropriate box to indicate the recipient's sex. HIPAA Instructions: Enter an M or F.
6A	MEDICAID NUMBER	2010BA	Subscriber Name NM109	Enter the recipient's ID number (Client ID Number) as it appears on the Common Benefit Identification Card.
10	WAS CONDITION RELATED TO	2300	Claim Information CLM11-1	eMedNY-150001 Instructions: If applicable, place an X in the appropriate box to indicate whether the service rendered to the recipient was for a condition resulting from an accident or a crime. HIPAA Instructions: See Companion Guide.
16A	EMERGENCY RELATED	2400	Professional Services SV109	Enter an 'X' in the Yes box only when the condition being treated is related to an emergency (the patient requires immediate intervention as a result of severe, life threatening or potentially disabling condition); otherwise leave this field blank. HIPAA Instructions: If applicable, enter a "Y" to indicate an emergency service.
19	NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	2310A	Referring Provider Name NM103	Enter the ordering provider's name in this field.

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eMedNY 150001 Field Number	eMedNY-150001 Field Name	HIPAA 837P Loop	HIPAA 837P Segment Information	NYS Medicaid Instructions
19B	REFERRING PHYSICIAN PROFESSION CODE (PROF CD)	2310A	Referring Provider Secondary Information REF02	<p>The 3-digit Profession Code replaces the 2-digit License Type code.</p> <p>eMedNY-150001 Instructions: If applicable, when a license number is indicated in Field 19C, the Profession Code that identifies the Ordering/Referring Provider's profession must be entered in this field. Profession Codes are listed at www.eMedNY.org</p> <p>Under the NYHIPAADESK tab:</p> <ul style="list-style-type: none"> ✓ Select eMedNY Crosswalks from the menu ✓ Click on Using License Number ✓ Click on Provider License Type to Profession Code Mapping <p>HIPAA Instructions: The Profession Code is reported before the license number.</p>
19C	REFERRING PHYSICIAN IDENTIFICATION NUMBER	2310A	Referring Provider Secondary Information REF02	<p>Enter the Ordering Provider's Medicaid ID Number in this field. If he/she is not enrolled in Medicaid, enter his/her license number in this field.</p> <p>If a license number is used, it must be preceded by two zeroes (00) if it is a NY State license or by the standard Post Office abbreviation of the state of origin if it is an out-of-state license.</p> <p>Please refer to Appendix A – Codes for the Post Office state abbreviations in the Billing Section of the Nursing Manual, found at www.emedny.org.</p>
19D	DX CODE	2300 2400	Health Care Diagnosis Code HI02-2 Diagnosis Pointer SV107-1	Leave this field blank.
22A	SERVICE PROVIDER NAME	2310B	Rendering Provider Name NM103	<p>Agencies Only</p> <p>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.</p>

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eMedNY 150001 Field Number	eMedNY-150001 Field Name	HIPAA 837P Loop	HIPAA 837P Segment Information	NYS Medicaid Instructions
22B	SERVICE PROVIDER PROF CD	2310B	Rendering Provider Secondary Information REF02	<p>Agencies Only If a license number is indicated in Field 22C, enter Profession code 010 or 022 in this field to identify the service provider's profession.</p> <p>HIPAA Instructions: The Profession Code is reported before the license number.</p>
22C	SERVICE PROVIDER IDENTIFICATION NUMBER	2310B	Rendering Provider Secondary Information REF02	<p>Agencies Only Enter the license number of the nurse that provided the services in this field. The license number must be preceded by two zeroes (00) if it is a NY State license or by the standard Post Office abbreviation of the state of origin if it is an out-of-state license. Please refer to Appendix A – Codes for the Post Office state abbreviations in the billing section of the Nursing Manual, found at www.emedny.org.</p> <p>HIPAA Instructions: The Profession Code is reported before the license number.</p>
22D	STERILIZATION ABORTION CODE	2300	Claim Note NTE02	Leave this field blank.
22E	STATUS CODE	N/A	N/A	Leave this field blank.
22F	POSSIBLE DISABILITY	2300	Claim Information CLM12	Place an 'X' in the Y box for YES or an 'X' in the N box for NO to indicate whether the service was for treatment of a condition which appeared to be of a disabling nature (the inability to engage in any substantial or gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or has lasted or can be expected to last for a continuous period of not less than 12 months).
22G	EPSDT/CTHP	2300	EPSDT Referral CRC02	Leave this field blank.
22H	FAMILY PLANNING	2400	Professional Services SV112	Leave this field blank.
23A	PRIOR APPROVAL NUMBER	2300	Prior Authorization or Referral Number REF02	If applicable enter the Prior Approval number assigned by the New York State Department of Health for the service rendered in this field.

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eMedNY 150001 Field Number	eMedNY- 150001 Field Name	HIPAA 837P Loop	HIPAA 837P Segment Information	NYS Medicaid Instructions
23B	PAYMENT SOURCE CODE	N/A	N/A	<p>This field has two components: box M and box O. Both boxes need to be filled as follows:</p> <p>Box M The values entered in this box define the nature of the amounts entered in fields 24J and 24K. Box "M" is used to indicate whether the patient is covered by Medicare and whether Medicare approved or denied payment.</p> <p>Box O Box "O" is used to indicate whether the patient has insurance coverage other than Medicare or Medicaid or whether the patient is responsible for a pre-determined amount of his/her medical expenses. The values entered in this box define the nature of the amount entered in field 24L.</p> <p>See chart at the end of this document to see how to complete field 23B and the relationship between this field and fields 24J, 24K, and 24L.</p>
24A	DATE OF SERVICE	2400	Date-Service Date DTP03	<p>Enter the date on which the service was rendered in the format MM/DD/YY. If the nursing hours extend over a period of 2 days, enter each date with the appropriate number of hours on separate lines.</p> <p>Note: A service date must be entered for each procedure code listed.</p> <p>HIPAA Instructions: The format of the date must be CCYYMMDD.</p>
24B	PLACE	2300	Claim Information CLM05-1	<p>Enter the 2-digit place of service where the service was rendered. Select the appropriate codes from the Appendix A – Place of Service Codes, found at the end of the billing section of the Nursing Manual, found at www.emedny.org.</p>
24C	PROCEDURE CODE	2400	Professional Services SV101-2	<p>This code identifies the type of service that was rendered to the recipient.</p> <p>Enter the appropriate 5-character Procedure Code.</p> <p>Procedure codes, definitions, prior approval requirements (if applicable), fees, etc. can be found on this web page under Procedure Codes and Fee Schedule for this manual.</p>

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24D-G	MODIFIER	2400	Professional Services SV101-3, SV101-4 SV101-5, SV101-6	<p>If the Procedure Code requires the addition of modifiers, enter one or more (up to four) modifiers in these fields to further define the procedure.</p> <p>Enter modifier “U1” to indicate the Care at Home Waiver Program.</p> <p>Enter modifier “TT” to indicate individualized service provided to more than one patient in the same setting.</p>
24H	DIAGNOSIS CODE	2300 2400	Health Care Diagnosis Code HI01-2 Diagnosis Pointer SV107	Enter the appropriate Diagnosis Code from the <i>International Classification of Diseases, Ninth Revision, Clinical Modification</i> (ICD-9-CM), which describes the patient’s main condition or symptom for which the procedure was performed.
24I	DAYS OR UNITS	2400	Professional Services 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.
24J	CHARGES	2400	Professional Services SV102	<p>eMedNY-150001 Instructions: This field must contain either the Amount Charged or the Medicare Approved Amount based on the code entered in Field 23B Payment Source Code.</p> <p>Special Instructions When two patients are simultaneously under the care of a private duty nurse, the normal hourly fee should be multiplied by 1.5 and divided by 2. The resulting amount is the maximum that can be billed for each patient.</p> <p>Example: A RN services two Medicaid patients simultaneously (procedure code S9124 – TT). The associated \$20.00 fee should be adjusted as follows for each patient: \$20 x 1.5 divided by 2. = \$15</p> <p>Note: Field 24J must never be left blank or contain zero.</p> <p>HIPAA Instructions: Enter the amount charged. The Medicare Approved amount is calculated from the Medicare Paid amount in Loop 2320, AMT02, or Loop 2430, SVD02, and Medicare Deductible and Co-insurance amounts in Loops 2320/2430, CAS03, 6, 9, 12,15, 18.</p>

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24K	UNLABELED	2320 2430	COB Payer Paid Amount AMT02/ Line Adjudication Information SVD02	If applicable, enter the Medicare Paid amount. (See Payment Source Code chart for additional instructions).
24L	UNLABELED	2320 2430 2300	COB Payer Paid Amount AMT02 Line Adjudication Information SVD02 Patient Paid Amount AMT02 (Spend down)	If applicable, enter the amount paid by another third party insurance or spend down amount (patient participation). (See Payment Source Code chart for additional instructions). HIPAA Instructions: If applicable, enter the other insurance paid amount in Loop 2430, SVD02. Enter spend down (patient participation) amount in Loop 2300, AMT02.
25	CERTIFICATION	2300	Claim Information CLM06	The private duty nurse must sign the claim form (for Agencies, an authorized representative of the agency must sign the claim form). Rubber stamp signatures are not acceptable.
25A	PROVIDER IDENTIFICATION NUMBER	2010AA	Billing Provider Secondary Identification REF02	Enter the Provider ID Number assigned to providers at the time of enrollment in the Medicaid program. For paper claims this information is preprinted on the claim form.
25B	MEDICAID GROUP IDENTIFICATION NUMBER	2010AB	Pay to Provider Secondary Identification REF02	If payment is to be made to a group practice, enter the Medicaid Group ID assigned to the group here. If the provider or the service(s) rendered is not associated with a Group Practice or a Shared Health Facility, leave this field blank.
25C	LOCATOR CODE	2010AA	Billing Provider Secondary Identification REF02	Enter the three-digit Locator Code issued by New York State DOH. Providers need to enter an additional zero to the left of a previously issued two-digit Locator Code to comply with eMedNY billing requirements.

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eMedNY 150001 Field Number	eMedNY-150001 Field Name	HIPAA 837P Loop	HIPAA 837P Segment Information	NYS Medicaid Instructions
25D	SA EXCP CODE	2300	Service Authorization Exception Code REF02	Leave this field blank.
	COUNTY OF SUBMITTAL	N/A	N/A	Enter the name of the county wherein the claim form is signed. The County may be left blank only when the provider's address, as preprinted in the lower right corner of the claim form, is within the county wherein the claim form is signed.
25E	DATE SIGNED	N/A	N/A	Enter the date on which the provider signed the claim form.
31	PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS	2010AA	Billing Provider Name Billing Provider Address Billing Provider City, State and Zip Code	For paper claims, the provider's name and address will be preprinted in this field.
32	PATIENT'S ACCOUNT NUMBER	2300	Claim Information CLM01	eMedNY-150001 Instructions: For record-keeping purposes, the provider may choose to identify a patient by using an office account number. This field can accommodate up to 20 alphanumeric characters and is reported on the remittance statement. HIPAA Instructions: Required data and is reported on the HIPAA 835 electronic remittance.
33	OTHER REFERRING /ORDERING PROVIDER ID/LICENSE NUMBER	2310A	Referring Provider Secondary Information REF02	Leave this field blank.
34	PROF CD	2310A	Referring Provider Secondary Information REF02	Leave this field blank.

23B. PAYM'T SOURCE CO
M / O / /

BOX M

BOX O

23B. PAYM'T SOURCE CO 1 1 M / O / /	Code 1 – No Medicare involvement. Field 24J should contain the amount charged and field 24K must be left blank.	Code 1 – No Other Insurance involvement. Field 24L must be left blank.
23B. PAYM'T SOURCE CO 1 2 M / O / * / *	Code 1 – No Medicare involvement. Field 24J should contain the amount charged and field 24K must be left blank.	Code 2 – Other Insurance involved. Field 24L should contain the amount paid by the other insurance or \$0.00 if the other insurance did not cover the service or denied payment. ** You must indicate the two-digit insurance code.
23B. PAYM'T SOURCE CO 1 3 M / O / * / *	Code 1 – No Medicare involvement. Field 24J should contain the amount charged and field 24K must be left blank.	Code 3 – Indicates patient's participation. Field 24L should contain the patient's participation amount. If Other Insurance is also involved, enter the total payments in 24L and ** enter the two-digit insurance code.
23B. PAYM'T SOURCE CO 2 1 M / O / /	Code 2 – Medicare Approved Service. Field 24J should contain the Medicare Approved amount and field 24K should contain the Medicare payment amount.	Code 1 – No Other Insurance involvement. Field 24L must be left blank.
23B. PAYM'T SOURCE CO 2 2 M / O / * / *	Code 2 – Medicare Approved Service. Field 24J should contain the Medicare Approved amount and field 24K should contain the Medicare payment amount.	Code 2 – Other Insurance involved. Field 24L should contain the amount paid by the other insurance or \$0.00 if the other insurance did not cover the service or denied payment. ** You must indicate the two-digit insurance code.
23B. PAYM'T SOURCE CO 2 3 M / O / * / *	Code 2 – Medicare Approved Service. Field 24J should contain the Medicare Approved amount and field 24K should contain the Medicare payment amount.	Code 3 – Indicates patient's participation. Field 24L should contain the patient's participation amount. If Other Insurance is also involved, enter the total payments in 24L and ** enter the two-digit insurance code.
23B. PAYM'T SOURCE CO 3 1 M / O / /	Code 3 – Medicare denied payment or did not cover the service. Field 24J should contain the amount charged and field 24K should contain \$0.00.	Code 1 – No Other Insurance involvement. Field 24L must be left blank.
23B. PAYM'T SOURCE CO 3 2 M / O / * / *	Code 3 – Medicare denied payment or did not cover the service. Field 24J should contain the amount charged and field 24K should contain \$0.00.	Code 2 – Other Insurance involved. Field 24L should contain the amount paid by the other insurance or \$0.00 if the other insurance did not cover the service or denied payment. ** You must indicate the two-digit insurance code.
23B. PAYM'T SOURCE CO 3 3 M / O / * / *	Code 3 – Medicare denied payment or did not cover the service. Field 24J should contain the amount charged and field 24K should contain \$0.00.	Code 3 – Indicates patient's participation. Field 24L should contain the patient's participation amount. If Other Insurance is also involved, enter the total payments in 24L and ** enter the two-digit insurance code.

** - Other Insurance Code