

PHYSICIAN BILLING

The information contained in this document will assist Physician providers enrolled in the New York State (NYS) Medicaid Program with understanding and complying with Medicaid requirements for billing and submitting claims in either electronic or paper format.

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

- ✓ Select **Povider Manuals** from the menu
- ✓ Click on **Physician**
- ✓ Click on **Billing Guidelines**

Physician 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** or the **837 Professional Supplemental 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 electronic 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.
- The source of the codes used for billing is the Medicaid Physician Provider Manual.
- The information contained this document is subject to change.

New York State Training Matrix – Physician Billing

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> <ul style="list-style-type: none"> If submitting an adjustment (replacement) to a previously paid claim, enter 'X' or the value 7 in the 'A' box. If submitting a void to a previously paid claim, enter 'X' or the value 8 in the 'V' box. <p>HIPAA Instructions: Enter code "7" to indicate an adjustment or "8" to indicate a void.</p>
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New York State Training Matrix – Physician Billing

eMedNY 150001 Field Number	eMedNY 150001 Field Name	HIPAA 837P Loop	HIPAA 837P Segment Information	NYS Medicaid Instructions
	ORIGINAL CLAIM REFERENCE NUMBER	2300	Original Reference Number REF02	<p>If submitting an adjustment or a void, enter the appropriate Transaction Control Number (TCN) in this field. A TCN is a 16-digit identifier which is assigned to each claim document or electronic record regardless of the number of individual claims (service date/procedure combinations) submitted in the document/record. For example, a document or record containing a single service date/procedure combination will be assigned a unique, single TCN; a document or record containing five service date/procedure combinations will be assigned a unique, single TCN, which will be shared by all the individual claims submitted under that document/record.</p> <p>Adjustment An adjustment may be submitted to accomplish any of the following purposes:</p> <ul style="list-style-type: none"> • To change information contained in one or more claims submitted on a previously paid TCN • To cancel one or more claims submitted on a previously paid TCN (except if the TCN contained one single claim or if all the claims contained in the TCN are to be voided) <p>Adjustment to Change Information:</p> <p>If an adjustment is submitted to correct information on one or more claims sharing the same TCN, follow the instructions below:</p> <ul style="list-style-type: none"> • The Provider ID number, the Group ID number and the Patient's Medicaid ID number, must not be adjusted. • The adjustment must be submitted in a new claim form (copy of the original form is unacceptable). <p>The adjustment must contain all claims originally submitted in the same document/record (all claims with the same TCN) and all applicable fields must be completed with the necessary changes.</p> <p>The adjustment will cause the correction of the adjusted information in the TCN history records as well as the cancellation of the original TCN payment and the re-pricing of the TCN based on the adjusted information.</p>

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*	ORIGINAL CLAIM REFERENCE NUMBER	2300	Original Reference Number REF02	<p>Adjustment to Cancel One or More Claims Originally Submitted on the Same Document/Record (TCN):</p> <p>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 TCN. The following instructions must be followed:</p> <p>The adjustment must be submitted in a new claim form (copy of the original form is unacceptable).</p> <p>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> <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</p> <p>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>
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	<p>Enter the recipient's birth date indicated on the Common Benefit ID Card.</p> <p>eMedNY-150001 Instructions: The format entered must be MMDDYYYY.</p> <p>HIPAA Instructions: The format of the date must be CCYYMMDD.</p>

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5A	PATIENT'S SEX	2010BA	Subscriber Demographic Information DMG03	<p>eMedNY-150001 Instructions: Place an X in the appropriate box to indicate the recipient's sex.</p> <p>HIPAA Instructions: Enter an M or F.</p>
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	<p>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. If this does not apply, leave this field blank.</p> <p>HIPAA Instructions: See Companion Guide.</p>
16A	EMERGENCY RELATED	2400	Professional Services SV109	<p>Used to indicate that an emergency service was performed.</p> <p>eMedNY-150001 Instructions: If applicable, place an X in the "YES" box to indicate an emergency service. If not applicable, leave this field blank.</p> <p>HIPAA Instructions: If applicable, enter a "Y" to indicate an emergency service.</p>

New York State Training Matrix – Physician Billing

eMedNY 150001 Field Number	eMedNY 150001 Field Name	HIPAA 837P Loop	HIPAA 837P Segment Information	NYS Medicaid Instructions
19	NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	2310A	Referring Provider Name NM103	<p>This field should be completed only when claiming the following:</p> <ul style="list-style-type: none"> • Ordered Procedure • Referred Service • Surgical Assistance <p>Ordered Procedures</p> <p>If claiming any of the procedures listed below the name of the ordering provider must be entered in this field. If the procedures were performed by the billing physician, the billing physician's name should be entered in this field.</p> <ul style="list-style-type: none"> • All Radiology Procedures • Cardiac Fluoroscopy • Echocardiography • Non-invasive Vascular Diagnostic Studies • Consultations <p>Note: Consultation codes must not be claimed for a physician's own patient.</p> <p>Referred Service</p> <p>If the patient was referred by another provider enter the name of the referring provider in this field.</p> <p>Surgical Assistance</p> <p>If the claim is for surgical assistance services, the primary surgeon's name must be entered in this field.</p> <p>If no order or referral is involved or the claim is not for surgical assistance, leave this field blank.</p>

New York State Training Matrix – Physician Billing

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>eMedNY-150001 Instructions: If 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 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>

New York State Training Matrix – Physician Billing

eMedNY 150001 Field Number	eMedNY 150001 Field Name	HIPAA 837P Loop	HIPAA 837P Segment Information	NYS Medicaid Instructions
19C	REFERRING PHYSICIAN IDENTIFICATION NUMBER	2310A	Referring Provider Secondary Information REF02	<p>This field must be completed when the claim involves any of the following:</p> <ul style="list-style-type: none"> • Ordered Procedure • Referred Service • Surgical Assistance <p>Ordered Procedures</p> <p>If the service was ordered by another provider (see field 19 for the list of ordered procedures) enter the ordering provider’s Medicaid ID number in this field. If the ordering provider is not enrolled in Medicaid, enter his/her license number (please see instructions for entering license numbers below).</p> <p>Referred Service</p> <p>If the patient was referred for treatment by another physician, enter the referring provider’s Medicaid ID number in this field. If the referring provider is not enrolled in Medicaid, enter his/her license number (please see instructions for entering license numbers below). If the patient is restricted to another physician or outpatient facility, enter the Medicaid ID number of the patient’s primary physician or clinic in this field. The primary physician’s license number is not acceptable in this case.</p> <p>Surgical Assistance</p> <p>If the claim is for surgical assistance services, the Medicaid ID number of the primary operating physician must be entered in this field. If the primary surgeon is not enrolled in Medicaid, enter his/her license number (please see instructions for entering license numbers below). If no order or referral is involved or the claim is not from an assistant surgeon, leave this field blank.</p> <p>Instructions for Entering a License Number</p> <p>If a license number (or State Certification 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>

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eMedNY 150001 Field Number	eMedNY 150001 Field Name	HIPAA 837P Loop	HIPAA 837P Segment Information	NYS Medicaid Instructions
19D	DX CODE	2300 2400	Health Care Diagnosis Code HI02-2 Diagnosis Pointer SV107-2	Leave this field blank.
21	NAME OF FACILITY WHERE SERVICES RENDERED			This field should be completed only when the Place of Service Code entered in Field 24B is 99 – Other Unlisted Facility.
21A	ADDRESS OF FACILITY			This field should be completed only when the Place of Service Code entered in Field 24B is 99 – Other Unlisted Facility. Note: The address listed in this field does not have to be the facility address. It should be the address where the service was rendered.
22A	SERVICE PROVIDER NAME	2310B	Rendering Provider Name NM103	If the service was provided by a physician's assistant or a social worker enter his/her name in this field. Otherwise, leave this field blank.
22B	SERVICE PROVIDER PROF CD	2310B	Rendering Provider Secondary Information REF02	eMedNY-150001 Instructions: If a license number is indicated in Field 22C, the Profession Code that identifies the service provider's profession must be entered in this field. Profession Codes are listed at www.eMedNY.org . Under the NYHIPAADESK tab: <ul style="list-style-type: none"> ✓ Select Crosswalks from the menu ✓ Click on Using License Number ✓ Click on Provider License Type to Profession Code Mapping HIPAA Instructions: The Profession Code is reported before the license number.

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22C	SERVICE PROVIDER IDENTIFICATION NUMBER	2310B	Rendering Provider Secondary Information REF02	<p>If the service was provided by a physician's assistant or by a social worker, enter the service provider's Medicaid ID number in this field. For social workers not enrolled in Medicaid, the license number must be used. Otherwise, leave this field blank.</p> <p>Instructions for Entering a License Number</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>HIPAA Instructions: The Profession Code is reported before the license number.</p>
22D	STERILIZATION ABORTION CODE	2300	Claim Note NTE02	<p>If applicable, enter the appropriate code to indicate whether the service being claimed was related to an induced abortion or sterilization. The abortion/sterilization codes can be found in Appendix A – Codes of the Physician Manual.</p> <p>If the procedure is unrelated to abortion/sterilization, leave this field blank.</p> <p>If a code is entered in this field, it must be applicable to all procedures listed on the claim. Procedures that are not related to abortion or sterilization must be submitted on separate claim form(s).</p> <p>When billing for procedures performed for the purpose of sterilization (Code F), a completed Sterilization Consent Form, DSS-3134, is required and must be attached to the paper claim form.</p> <p>Notes:</p> <p>The following medical procedures are not induced abortions; therefore when billing for these procedures, leave this field blank.</p> <ul style="list-style-type: none"> • Spontaneous abortion (miscarriage); • Termination of ectopic pregnancy; • Drugs or devices to prevent implantation of the fertilized ovum; • Menstrual extraction. <p>Medicaid does not reimburse providers for hysterectomies performed for the purpose of sterilization. Please refer to the Policy Guidelines under Physician Manual.</p> <p>HIPAA Instructions: refer to 837P Companion Guide.</p>
22E	STATUS CODE	N/A	N/A	This field is left blank for physician billing.

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22F	POSSIBLE DISABILITY	2300	Claim Information CLM12	This field indicates whether the service was for treatment of a condition, which appears to be of a disabling nature. "X" the appropriate box to indicate <i>yes</i> or <i>no</i> .
22G	EPSDT/CTHP	2300	EPSDT Referral CRC02	This field must be completed if the physician bills for a periodic health supervision (well care) examination for a patient under 21 years of age, whether billing a Preventive Medicine Procedure Code or a Visit Code with a well care diagnosis. If applicable, place an 'X' in the Y box for YES.
22H	FAMILY PLANNING	2400	Professional Services SV112	<p>Medical family planning services include diagnosis, treatment, drugs, supplies and related counseling which are furnished or prescribed by, or are under the supervision of a physician or nurse practitioner. The services include, but are not limited to:</p> <ul style="list-style-type: none"> • Physician, clinic or hospital visits during which birth control pills, contraceptive devices or other contraceptive methods are either provided during the visit or prescribed. • Periodic examinations associated with a contraceptive method. • Visits during which sterilization or other methods of birth control are discussed. • Sterilization procedures. <p>This field must always be completed. Place an 'X' in the YES box if all services being claimed are family planning services. Place an 'X' in the NO box if at least one of the services being claimed is not a family planning service. If some of the services being claimed, but not all, are related to Family Planning, place the modifier FP in the two digit space following the procedure code in Field 24D to designate those specific procedures which are family planning services.</p>
23A	PRIOR APPROVAL NUMBER	2300	Prior Authorization or Referral Number REF02	If the provider is billing for a service that requires Prior Approval/Prior Authorization, enter in this field the eleven-digit prior approval number assigned for this service by the appropriate agency of the New York State Department of Health. If several service dates and/or procedures need to be claimed and they are covered by different prior approvals, a separate claim form has to be submitted for each prior approval.
23B	PAYMENT SOURCE CODE	N/A	N/A	The Payment Source Code must remain the same for all claim lines on the claim form. See chart at the end of this document.

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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.</p> <p>Example: July 1, 2003 = 07/01/03</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 Code where the service was rendered. If entering code 99 (Other Listed Facility) for any line on the claim, enter the exact address where the procedure was performed in Fields 21 and 21A.</p> <p>Place of service codes can be found in the Physician Manual, Appendix A – Place of Service Codes.</p>
24C	PROCEDURE CODE	2400	Professional Services SV101-2	<p>This code identifies the Type of Service that was rendered to the recipient. Enter the appropriate 5-character procedure code. Procedure codes, definitions, prior approval requirements (if applicable), fees, etc. can be found in the Procedure Codes and Fee Schedule of the Physician Manual.</p>
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>Modifier values and their definitions can be found in the Procedure Codes and Fee Schedule of the Physician Manual.</p> <p>Special Instructions for Claiming Medicare Deductible:</p> <p>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</p>
24H	DIAGNOSIS CODE	2300 2400	Health Care Diagnosis Code HI01-2 SV107-1	<p>Enter the appropriate Diagnosis Code from the <i>International Classification of Diseases, Ninth Revision, Clinical Modification Code</i> (ICD-9-CM), which describes the patient’s main condition or symptom for which the procedure was performed.</p> <p>Always enter subcategories, if they exist for the diagnosis reported. A diagnosis code with no entry following the decimal will only be accepted when no subcategory exists.</p>

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24I	DAYS OR UNITS	2400	Professional Services SV104	<p>Enter the number of times the procedure was performed on the date of service. If the procedure was performed only one time, this field may be left blank.</p> <p>When billing for anesthesia, each interval of 15 minutes of anesthesia time equals one unit. Compute the total number of anesthesia units as follows:</p> <ul style="list-style-type: none"> • Determine the number of 15-minute intervals in the total time that anesthesia was being administered. • Add to that result the anesthesia basic value for the procedure.

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24J	CHARGES	2400	Professional Services SV102	<p>This field must contain either the Amount Charged or the Medicare Approved Amount based on the code entered in Field 23B Payment Source Code. If the claim is subject to the Medicare reduction, use instruction in the Provider Manual to calculate the Medicare Approved Amount.</p> <p>Amount Charged:</p> <p>When Box 'M' in field 23B has an entry value of 1 or 3, enter the amount charged in this field. The Amount Charged may not exceed the provider's customary charge for the procedure.</p> <p>Medicare Approved Amount:</p> <p>When Box 'M' in field 23B has an entry value of 2, enter the Medicare Approved Amount in field 24J. The Medicare Approved amount is determined as follows:</p> <p>If billing for the Medicare deductible, the Medicare Approved amount should equal the Deductible amount claimed, which must not exceed the patient's yearly Medicare Deductible.</p> <p>If billing for the Medicare coinsurance, the Medicare Approved amount should equal the sum of: the amount paid by Medicare plus the Medicare co-insurance amount plus the Medicare deductible amount, if any.</p> <p>Notes:</p> <ul style="list-style-type: none"> • Field 24J must never be left blank or contain \$0.00 • It is the responsibility of the provider to determine whether Medicare covers the service being billed for. If the service is covered or if the provider does not know if the service is covered, the provider must first submit a claim to Medicare, as Medicaid is always the payer of last resort. <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 Loop 2320/2430, CAS03, 6, 9, 12,15, and 18.</p>

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24K		2320 2430	COB Payer Paid Amount AMT02/ Line Adjudication Information SVD02	<p>This field is used to indicate the Medicare Paid Amount and must be completed if Box 'M' in field 23B has an entry value of 2 or 3.</p> <p>The value in Box 'M' is 2 When billing for the Medicare deductible, enter \$0.00 in this field. When billing for the Medicare coinsurance, enter the Medicare Paid amount as the sum of the actual Medicare paid amount and the Medicare deductible, if any.</p> <p>The value in Box 'M' is 3 When Box 'M' in field 23B contains the value 3, enter \$0.00 in this field to indicate that Medicare denied payment or did not cover the service.</p> <p>If none of the above situations are applicable, leave this field blank.</p>

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eMedNY 150001 Field Number	eMedNY 150001 Field Name	HIPAA 837P Loop	HIPAA 837P Segment Information	NYS Medicaid Instructions
24L		2320 2430 2300	<p style="text-align: center;">COB Payer Paid Amount AMT02</p> <p style="text-align: center;">Line Adjudication Information SVD02</p> <p style="text-align: center;">Patient Paid Amount AMT02 (Spend down)</p>	<p>eMedNY-150001 Instructions: 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).</p> <p>This field must be completed when Box ‘O’ in field 23B has an entry value of 2 or 3.</p> <p>When the value in Box ‘O’ is 2, enter the Other Insurance payment in this field. If more than one insurance carrier contributes to payment of the claim, add the payment amounts and enter the total amount paid.</p> <p>When the value in Box ‘O’ is 3, enter the Patient Participation amount. If the patient is covered by other insurance and the insurance carrier(s) paid for the service, add the Other Insurance payment to the Patient Participation amount and enter the sum in this field.</p> <p>If none of the above situations are applicable, leave this field blank.</p> <p>Note: It is the responsibility of the provider to determine whether the recipient’s Other Insurance carrier covers the service being billed for, as Medicaid is always the payer of last resort.</p> <p>If the other insurance carrier denied payment enter \$0.00 in field 24L. Proof of denial of payment must be maintained in the patient’s billing record. Zeroes must also be entered in this field if any of the following situations apply:</p> <ul style="list-style-type: none"> ● Prior to billing the insurance company, the provider knows that the service will not be covered because: <ul style="list-style-type: none"> ○ The provider has had a previous denial for payment for the service from the service should be billed if the insurance policy changes. Proof of denials must be maintained in the patient’s billing record. Prior claims denied due to deductibles not being met are not to be counted as denials for subsequent billings. ○ In very limited situations the Local Department of Social Services (LDSS) has advised the provider to zero-fill other insurance payment for same type of service. This communication should be documented in the patient’s billing record. ● The provider bills the insurance company and receives a rejection because: <ul style="list-style-type: none"> ○ The service is not covered; or ○ The deductible has not been met.

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				<p>The provider cannot directly bill the insurance carrier and the policyholder is either unavailable to, or uncooperative in submitting claims to the insurance company. In these cases the LDSS must be notified prior to zero-filling.</p> <p>Since June 1, 1992 LDSS has subrogation rights enabling them to complete claim forms on behalf of uncooperative policyholders who do not pay the provider for the services. The LDSS office can direct the insurance company to pay the provider directly for the service whether or not the provider participates with the insurance plan.</p> <p>The provider should contact the third party worker in the local social services office whenever he/she encounters policyholders who are uncooperative in paying for covered services received by their dependents who are on Medicaid.</p> <p>In other cases the provider will be instructed to zero-fill the Other Insurance Payment in the Medicaid claim and the LDSS will retroactively pursue the third party resource.</p> <ul style="list-style-type: none"> • The recipient or an absent parent collects the insurance benefits and fails to submit payment to the provider. The LDSS must be notified so that sanctions and/or legal action can be brought against the recipient or absent parent. • The provider is instructed to zero-fill by the LDSS for circumstances not listed above. <p>HIPAA Instructions: If applicable, enter the other insurance paid amount in Loop 2430, SVD02. Enter spend down (patient participation) amount in Loop 2300, AMT02.</p>
<p><i>Fields 24M through 24O (INPATIENT HOSPITAL VISITS) may be used for block billing CONSECUTIVE visits within the SAME MONTH/YEAR made to a recipient in a hospital inpatient status.</i></p>				
24M	INPATIENT HOSPITAL VISITS FROM – THROUGH DATES	N/A	N/A	In the FROM box, enter the date of the first hospital visit in the format MM/DD/YY. In the THROUGH box, enter the date of the last hospital visit in the format MM/DD/YY.

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24N	PROCEDURE CODE	N/A	N/A	<p>If dates were entered in 24M, enter the appropriate five-character procedure code for the visit. Block billing may be used with the following procedure codes:</p> <ul style="list-style-type: none"> • 90238 • 90240 through 90282 • 94997 • 99231 through 99233 • 99296 through 99297 • 99433
24O	MODIFIER	N/A	N/A	<p>If the Procedure Code entered in 24N requires the addition of a modifier to further define the procedure, enter it in this field.</p>
25	CERTIFICATION	2300	Claim Information CLM06	<p>The billing physician must sign the claim form. Rubber stamp signatures are not acceptable.</p> <p>Please be careful that the signature is wholly contained within Box 25. Signatures that spill into other boxes may cause processing problems.</p> <p>Please note that the certification statement is on the back of the form.</p> <p>If billing electronically, the provider must have a Certification Statement on file.</p>
25A	PROVIDER IDENTIFICATION NUMBER	2010AA	Billing Provider Secondary Identification REF02	<p>The Medicaid Provider ID number is the eight-digit identification number assigned to providers at the time of enrollment in the Medicaid program.</p> <p>The Provider ID number is pre-printed by CSC on this field for all providers except for practitioner groups.</p>
25B	MEDICAID GROUP IDENTIFICATION NUMBER	2010AB	Pay to Provider Secondary Identification REF02	<p>If payment is to be made to a group practice ID, enter the Medicaid Group ID assigned to the provider here.</p>

New York State Training Matrix – Physician Billing

eMedNY 150001 Field Number	eMedNY 150001 Field Name	HIPAA 837P Loop	HIPAA 837P Segment Information	NYS Medicaid Instructions
25C	LOCATOR CODE	2010AA	Billing Provider Secondary Identification REF02	<p>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.</p> <p>For example, locator code 03 must be entered as 003, etc.</p> <p>Locator codes 001 and 002 are for administrative use only and are not to be entered in this field. If the provider renders services at one location only, enter locator code 003. If the provider renders service to Medicaid recipients at more than one location, the entry may be 003 or a higher locator code. Enter the locator code that corresponds to the address where the service was performed.</p> <p>Note: The provider is reminded of the obligation to notify Medicaid of all service locations as well as changes to any of them. For information on where to direct Locator Code updates, please refer to www.eMedNY.org</p> <p>Under the Provider Manuals tab:</p> <ul style="list-style-type: none"> ✓ Information for All Provider ✓ Inquiry Section
25D	SA EXCP CODE	2300	Service Authorization Exception Code REF02	<p>If it was necessary to provide a service covered under the Utilization Threshold Program and service authorization could not be obtained, enter the numeric SA exception code that best describes the reason for the exception.</p> <p>If the services being claimed require a specialty that is exempt from the Utilization Threshold Program, enter “7” in this field. Leave this field blank if it is not applicable.</p> <p>Additional information on the Utilization Threshold Program can be found at: www.eMedNY.org</p> <p>Under the Provider Manuals tab:</p> <ul style="list-style-type: none"> ✓ Information for All Providers ✓ Select General Policy, subsection “Utilization Threshold Program.” <p>If not applicable leave this field blank.</p>
Not Numbered	COUNTY OF SUBMITTAL	N/A	N/A	<p>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.</p>

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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	N/A	N/A	For paper claims, the provider's name and address will be preprinted in this field.
32	PATIENT'S ACCOUNT NUMBER	2300	Claim Information CLM01	<p>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.</p> <p>HIPAA Instructions: Required data and is reported on HIPAA 835 electronic remittance.</p>
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

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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.