



# **New York State 150003 Billing Guidelines**

**REHABILITATION 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 Rehabilitation 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

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](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, 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 pending) after processing
- The eMedNY edits (errors) that resulted in a claim denied or pending
- 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				ONLY TO BE USED TO ADJUST/VOID PAID CLAIM		A CODE V		ORIGINAL TRANSACTION CONTROL NUMBER															
PATIENT AND INSURED (SUBSCRIBER) INFORMATION																							
1. PATIENT'S NAME (First, middle, last) <b>SUSAN SAMPLE</b>			2. DATE OF BIRTH <b>0 5   2 0   1 9   9 0</b>			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 <input type="checkbox"/> FEMALE <input type="checkbox"/>		5A. PATIENT'S SEX MALE <input type="checkbox"/> FEMALE <input checked="" type="checkbox"/>		8. MEDICARE NUMBER		6A. MEDICAID NUMBER <b>X   X   1   2   3   4   5   X</b>													
6. PATIENT'S EMPLOYER, OCCUPATION OR SCHOOL				7. PATIENT'S RELATIONSHIP TO INSURED SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER <input type="checkbox"/>		8. INSURED'S EMPLOYER OR OCCUPATION		9B. PRIVATE INSURANCE NUMBER		GROUP NO. RECIPROCALITY NO.													
3. 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 <input type="checkbox"/> CRIME VICTIM <input type="checkbox"/> AUTO ACCIDENT <input type="checkbox"/> OTHER LIABILITY <input type="checkbox"/>		11. INSURED'S ADDRESS (Street, City, State, Zip Code)		12. PATIENT'S OR AUTHORIZED SIGNATURE		INSURED'S SIGNATURE													
PHYSICIAN OR SUPPLIER INFORMATION (REFER TO REVERSE BEFORE COMPLETING AND SIGNING)																							
14. DATE OF ONSET OF CONDITION MM DD YY		15. FIRST CONSULTED FOR CONDITION MM DD YY		16. HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS YES <input type="checkbox"/> NO <input type="checkbox"/>		16A. EMERGENCY RELATED YES <input type="checkbox"/> NO <input type="checkbox"/>		17. DATE PATIENT MAY RETURN TO WORK MM DD YY		16. DATES OF DISABILITY TOTAL PARTIAL FROM TO MM DD YY MM DD YY													
19. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE				19A. ADDRESS (OR SIGNATURE SHF ONLY)				19B. PROF. CD.		19C. IDENTIFICATION NUMBER <b>1   1   2   3   4   5   6   7   8   9</b>													
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 <input type="checkbox"/> NO <input type="checkbox"/>		LAB CHARGES													
22A. SERVICE PROVIDER NAME				22B. PROF. CD.		22C. IDENTIFICATION NUMBER		22D. SPECIALIZATION ABBREVIATION 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 IX CODE								22F. POSSIBLE DISABILITY <input checked="" type="checkbox"/> Y <input type="checkbox"/> N		22G. EPISOD DTHP <input type="checkbox"/> Y <input type="checkbox"/> N		22H. FAMILY PLANNING <input type="checkbox"/> Y <input checked="" type="checkbox"/> N											
23A. PRIOR APPROVAL NUMBER								23B. PRINT SOURCE CD <b>1   1</b>															
24A. DATE OF SERVICE M M D D Y Y		24B. PLACE		24C. PROCEDURE CD		24D. MOD		24E. MOD		24F. MOD		24G. MOD		24H. DIAGNOSIS CODE <b>3   4   4   1</b>		24I. DAYS OR LIMITS		24J. CHARGES <b>0   2</b>		24K.		24L.	
0 9   1 6   1 0		1 2		9 2   5 0   7										3   4   4   1		0 2		9, 4 0					
0 9   1 6   1 0		1 2		9 7   5 3   0										3   4   4   1		0 4		9, 4 0					
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.				26. ACCEPT ASSIGNMENT YES <input type="checkbox"/> NO <input type="checkbox"/>				27. TOTAL CHARGE		28. AMOUNT PAID		29. BALANCE DUE											
SIGNATURE OF PHYSICIAN OR SUPPLIER <b>James Strong</b>				30. EMPLOYER IDENTIFICATION NUMBER/SOCIAL SECURITY NUMBER				31. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE <b>James Strong 312 Main Street Anytown, New York 11111</b>				TELEPHONE NUMBER ( ) ( ) EXT. DO NOT WRITE IN THIS SPACE.											
25A. PROVIDER IDENTIFICATION NUMBER <b>1   1   2   3   4   5   6   7   8   9</b>				25B. MEDICAID GROUP IDENTIFICATION NUMBER				25C. LOCAL DR CODE <b>0 0 3</b>		25D. SA EXDP CODE		32A. MY FEE HAS BEEN PAID YES <input type="checkbox"/> NO <input type="checkbox"/>		COUNTY OF SUBMITAL									
25E. DATE SIGNED <b>09   17   10</b>		32. PATIENT'S ACCOUNT NUMBER <b>A   B   C   1   2   3   4   5</b>				33. OTHER REFERRING ORDERING PROVIDER LICENSE NO.		34. PROF. CD.		35. CASE MANAGER TO													

REHABILITATION SERVICES