New York State Medicaid General Billing Guidelines

DOULA SERVICES

Version 2024 – 01

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 the eMedNY fiscal agent. 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 Doula 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

Doula service providers may submit their claims to NYS Medicaid using electronic or paper formats.

2.1 Electronic Claims

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

2.2 Paper Claims

Doula Services providers who choose to submit their claims on paper forms must use the New York State Medicaid eMedNY-150003 claim form.

To order New York State Medicaid eMedNY - 150003 forms, please contact the eMedNY call center at 1-800-343-9000.

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

2.3 Doula Services Billing Instructions

This subsection of the Billing Guidelines covers the specific NYS Medicaid billing requirements for Doula 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 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, pended, or denied.

2.3.1 eMedNY - 150003 Claim Form Field Instructions

There are some exceptions or unique instructions for Doula services as included in these guidelines.

Patient's Name (Field 1)

837P Ref: Loop 2010BA NM1

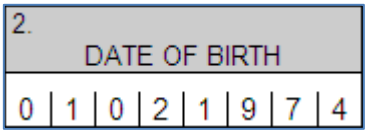
Enter the member's first name, followed by the last name. This information may be obtained from the member's Common Benefit ID Card (CBIC).

Date of Birth (Field 2)

837P Ref: Loop 2010BA DMG02

Enter the member's birth date. This information may be obtained from the CBIC. The birth date must be in the format MMDDYYYY as shown in Exhibit 2.4.2-1.

Exhibit 2.4.2-1



Patient's Sex (Field 5A)

837P Ref: Loop 2010BA DMG03

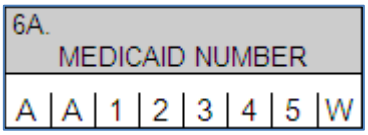
Place an 'X' in the appropriate box to indicate the member's sex. This information may be obtained from the CBIC.

Medicaid Number (Field 6A)

837P Ref: Loop 2010BA NM109

Enter the Member ID. This information may be obtained from the CBIC. Member IDs are assigned by NYS Medicaid and are composed of 8 characters in the format AANNNNNA, where A = alpha character and N = numeric character as shown in Exhibit 2.4.2-2.

Exhibit 2.4.2-2



Was Condition Related To (Field 10)

837P Ref: Loop 2300 CLM11

If applicable, place an 'X' in the appropriate box to indicate whether the service rendered to the member was work related or for a condition resulting from an accident or a crime. Select the boxes in accordance with the following:

- Member's Employment

  If the claim is covered by Worker's Compensation, place an X in the box.

- Crime Victim

  Use this box to indicate that the condition treated was the result of an assault or crime.

- Auto Accident

  Use this box to indicate Automobile No-Fault. Leave this box blank if condition is related to an auto accident other than no-fault or if no-fault benefits are exhausted.

- Other Liability

  Use this box to indicate that the condition was related to an accident-related injury of a different nature from those indicated above.

If the condition being treated is not related to any of these situations, leave these boxes blank.

Emergency Related (Field 16A)

837P Ref: Loop 2400 SV109

Enter an 'X' in the Yes box only when the condition being treated is related to an emergency; otherwise leave this field blank.

Name of Referring Physician or Other Source (Field 19)

837P Ref: Loop 2310A NM1

Leave this field blank.

Address [or Signature – SHF Only] (Field 19A)

Leave this field blank.

Prof CD [Professional Code – Ordering/Referring Provider] (Field 19B)

Leave this field blank.

Identification Number [Ordering/Referring Provider] (Field 19C)

837P Ref: Loop 2310A NM109

Leave this field blank.

DX Code (Field 19D)

837P Ref: Loop 2300 HI01-2

If applicable, enter the secondary diagnosis.

NDC [National Drug Code] (Field 20)

837P Ref: Loop 2410 LIN03

Leave this field blank.

Unit (Field 20A)

837P Ref: Loop 2400 SV103

Leave this field blank.

Quantity (Field 20B)

837P Ref: Loop 2400 SV104

Leave this field blank.

Cost (Field 20C)

837P Ref: Loop 2400 SV102

Leave this field blank

Name of Facility Where Services Rendered (Field 21)

837P Ref: Loop 2010AA NM1 or 2310C NM1

Leave this field blank

Address of Facility (Field 21A)

837P Ref: Loop 2010AA N3 and N4 OR 2310C N3 and N4

Leave this field blank

Service Provider Name (Field 22A)

837P Ref: Loop 2310B NM1

Leave this field blank.

Prof CD [Profession Code – Service Provider] (Field 22B)

Leave this field blank.

Identification Number [Service Provider] (Field 22C)

837P Ref: Loop 2310B NM1

Leave this field blank.

Sterilization/Abortion Code (Field 22D)

837P Ref: Loop 2300 HI01-2

Leave this field blank.

Status Code (Field 22E)

Leave this field blank.

Possible Disability (Field 22F)

837P Ref: Loop 2300 CLM12

Leave this field blank

EPSDT C/THP (Field 22G)

837P Ref: Loop 2400 SV111

Leave this field blank.

Family Planning (Field 22H)

837P Ref: Loop 2400 SV112

Place an 'X' in the NO box because the services being claimed is not a family planning service.

Prior Approval Number (Field 23A)

837P Ref: Loop 2300 REF02 when REF01 = G1

Leave this field blank.

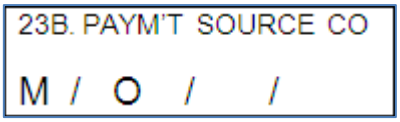
Payment Source Code [Box M and Box O] (Field 23B)

837P Ref: No Map

Note : Providers of doula services are not required to bill other insurance or Medicare before Medicaid. However, the claim to Medicaid must include Medicare non covered amounts, as described below, when a patient has Medicare and Medicaid.

This field has two components: Box M and Box O as shown in Exhibit 2.4.2-7 below:

Exhibit 2.4.2-7



Both boxes need to be filled as follows:

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 member is covered by Medicare and whether Medicare approved or denied payment. Enter the appropriate numeric indicator from the following list.

- No Medicare involvement – Source Code Indicator = 1

  This code indicates that the member does not have Medicare coverage.

- Member has Medicare Part B; Medicare approved the service – Source Code Indicator = 2

  This code indicates that the service is covered by Medicare and that Medicare approved the service and ***either made a payment or paid 0.00 due to a deductible.*** Medicaid is responsible for reimbursing the Medicare deductible and /or (full or partial) coinsurance.

- Member has Medicare Part B; Medicare denied payment – Source Code Indicator = 3

  This code indicates that Medicare denied payment or did not cover the service billed.

Box O

Box O is used to indicate whether the member has insurance coverage other than Medicare or Medicaid or whether the member 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. Enter the appropriate indicator from the following list.

- No Other Insurance involvement – Source Code Indicator = 1

  This code indicates that the member does not have other insurance coverage.

- Member has Other Insurance coverage – Source Code Indicator = 2

This code indicates that the member has other insurance regardless of the fact that the insurance carrier(s) paid or denied payment or that the service was covered or not by the other insurance. When the value ***2*** is entered in Box 'O', the two-character code that identifies the other insurance carrier must be entered in the space following Box O. If more than one insurance carrier is involved, enter the code of the insurance carrier who paid the largest amount.

- Member Participation – Source Code Indicator = 3

  This code indicates that the member has incurred a pre-determined amount of medical expenses, which qualify him/her to become eligible for Medicaid.

Exhibit 2.4.2-8 provides a full illustration of how to complete field 23B and the relationship between this field and fields 24J, 24K, and 24L.

Exhibit 2.4.2-8

	BOX M	BOX O
23B. PAYM'T SOURCE CO 11 M / C / /	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 12 M / C / * / *	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 13 M / C / * / *	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 21 M / C / /	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 22 M / C / * / *	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 23 M / C / * / *	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 31 M / C / /	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 32 M / C / * / *	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 33 M / C / * / *	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.

Procedure Section: Fields 24A to 24O

The claim form can accommodate up to seven procedures with a single member, plus a block of procedures in a hospital setting, if all the information in the Header Section of the claim (Fields 1–23B) applies to all the procedures.

Date of Service (Field 24A)

837P Ref: Loop 2400 DTP03 when DTP01 = 472

Enter the date on which the service was rendered in the format MM/DD/YY.

NOTE: A service date must be entered for each procedure code listed.

Place [of Service] (Field 24B)

837P Ref: Loop 2300 CLM05-1

This two-digit code indicates the type of location where the service was rendered ***(E.g. 12 - patient's home)***. Please note that place of service code is different from locator code. Other Place of Service Codes may be found in the NUBC UB-04 Manual.

Procedure Code (Field 24C)

837P Ref: Loop 2400 SV101-2

Enter the appropriate five-character procedure code.

NOTE: Procedure codes, definitions, prior approval requirements (if applicable), fees, etc. are available at www.emedny.org in the Doula Services provider policy manual.

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

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

If the Procedure Code requires the addition of modifiers, enter one or more (up to four) modifiers in these fields.

NOTE: Modifier values and their definitions can be found on the web page for this manual under Procedure Codes and Fee Schedule, which can be found at www.emedny.org in the Doula Services provider policy manual.

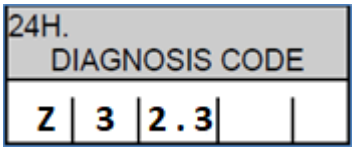
Diagnosis Code (Field 24H)

837P Ref: Loop 2400 SV107 (Diagnosis Pointers)

Enter an ICD-10-CM Diagnosis Code as shown in Exhibit 2.4.2-9.

NOTE: Include ICD-10-CM diagnosis code Z32.2 or Z32.3 as appropriate. ICD-10-CM values and their definitions can be found on the www.emedny.org webpage in the Doula Services provider policy manual.

Exhibit 2.4.2-9



Days or Units (Field 24I)

837P Ref: Loop 2400 SV104

Enter '1' as the number of units.

Charges (Field 24J)

837P Ref: Loop 2400 SV102

This field must contain the Amount Charged.

Amount Charged

When Box M in field 23B has an entry value of ***1*** or ***3***, enter the amount charged. The Amount Charged may not exceed the provider's customary charge for the procedure.

Medicare Approved Amount

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:

- If billing for the Medicare ***deductible***, the Medicare Approved amount should equal the Deductible amount claimed, which must not exceed the established amount for the year in which the service was rendered.
- 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.

NOTES:

- *The entries in field 23B, Payment Source Code, determine the entries in field's 24J, 24K, and 24L. Field 24J must never be left blank or contain zeroes.*
- *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.*

Unlabeled (Field 24K)

837P Ref: No Map

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*.

Box M=2

- When billing for the Medicare *deductible*, enter 0.00.
- When billing for the Medicare *coinsurance*, enter the Medicare Paid amount as the sum of the Medicare paid amount and the Medicare deductible, if any.

Box M=3

Enter 0.00 to indicate that Medicare denied payment or did not cover the

service. If none of the above situations are applicable, leave this field blank.

Unlabeled (Field 24L)

837P Ref: No Map

This field must be completed when Box O in field 23B has an entry value of *2* or *3*.

- When Box O has an entry value of *2*,
  - If there is only one insurance carrier, enter the other insurance payment.
  - If more than one insurance carrier contributes to payment of the claim, enter the total amount paid by all other insurance carriers.
- When Box O has an entry value of *3*,
  - Enter the amount the member paid.
  - If the member is covered by other insurance and the member made payment, enter the sum.

If the other insurance carrier denied payment, enter 0.00 in field 24L. Proof of denial of payment must be maintained in the member's billing record.

If none of the above situations are applicable, leave this field blank.

NOTES:

- *It is the responsibility of the provider to determine whether the member's Other Insurance carrier covers the service being billed for, as Medicaid is always the payer of last resort.*
- *Leave the last row of Fields 24H, 24J, 24K, and 24L blank.*

Consecutive Billing Section: Fields 24M to 24O

Leave this section blank.

Trailer Section: Fields 25 through 34

The information entered in the Trailer Section of the claim form (fields 25 through 34) must apply to all claim lines entered in the Procedure Section of the form.

Certification [Signature of Physician or Supplier] (Field 25)

837P Ref: Loop 2300 CLM06

The billing provider or authorized representative must sign the claim form. Rubber stamp signatures are not acceptable. Please note that the certification statement is on the back of the form.

Provider Identification Number (Field 25A)

837P Ref: Loop 2010AA NM109 OR Loop 2310B NM109

Enter the provider's 10-digit National Provider Identifier (NPI).

Medicaid Group Identification Number (Field 25B)

837P Ref: 837P Ref: Loop 2010AA NM109

Leave this field blank.

Locator Code (Field 25C)

837P Ref: No Map

Leave this field blank.

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

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

Leave this field blank.

County of Submittal (Unnumbered Field)

837P Ref: No Map

Enter the name of the county wherein the claim form is signed. The County may be left blank ***only*** when the provider's address is within the county wherein the claim form is signed.

Date Signed (Field 25E)

837P Ref: No Map

Enter the date on which the provider or an authorized representative signed the claim form. The date should be in the format MM/DD/YY.

NOTE: In accordance with New York State regulations, claims must be submitted within 90 days of the Date of Service unless acceptable circumstances for the delay can be documented. For more information about billing claims over 90 days or two years from the Date of Service, refer to Information for All Providers, General Billing section, which can be found at www.emedny.org by clicking on the link to the webpage as follows: General Billing.

Physician's or Supplier's Name, Address, Zip Code (Field 31)

837P Ref: Loop 2010AA NM1, N3, and N4

Enter the provider's name and correspondence address, using the 5-digit ZIP code or the ZIP plus four.

NOTE: It is the responsibility of the provider to notify Medicaid of any change of address or other pertinent information within 15 days of the change. For information on where to direct address change requests please refer to Information for All Providers, Inquiry section which can be found at www.emedny.org by clicking on the link to the webpage as follows: General Inquiry.

Patient's Account Number (Field 32)

837P Ref: Loop 2300 CLM01

This field can accommodate up to 20 alphanumeric characters and will be returned on the Remittance Advice.

Other Referring/Ordering Provider ID/License Number (Field 33)

837P Ref: Loop 2310A NM109

Leave this field blank.

Prof CD [Profession Code – Other Referring/Ordering Provider] (Field 34)

Leave this field blank.

3. Remittance Advice

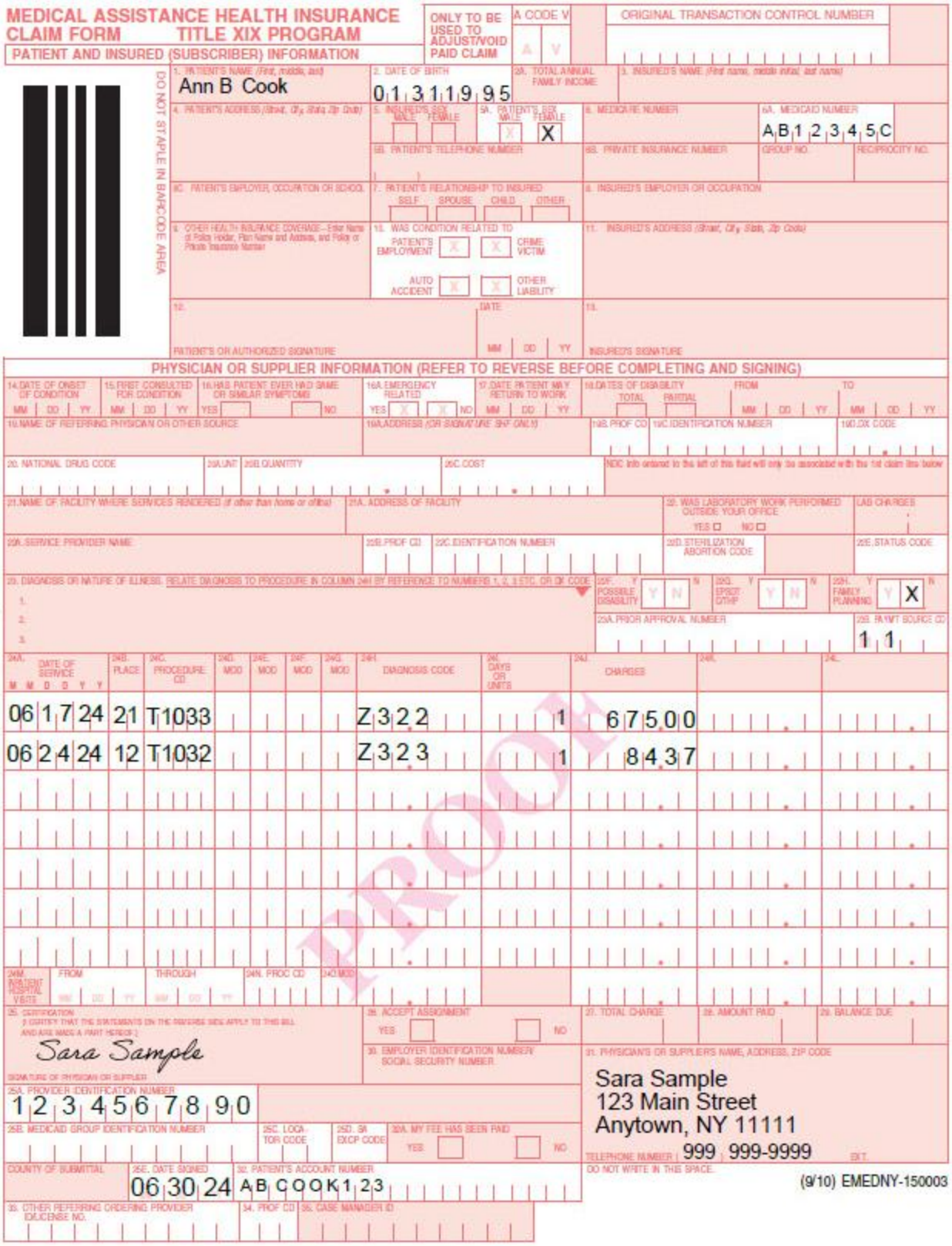
The Remittance Advice is an electronic, PDF or paper statement issued by eMedNY that contains the status of claim transactions processed by eMedNY during a specific reporting period. Statements contain the following information:

- 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 pended) after processing
- The eMedNY edits (errors) that resulted in a claim denied or pended
- Subtotals (by category, status and member ID) 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.

4. Appendix A Claim Sample

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

ONLY TO BE USED TO ADJUST/VOID PAID CLAIM

ORIGINAL TRANSACTION CONTROL NUMBER

DO NOT STAPLE IN BARCODE AREA

1. PATIENT'S NAME: Ann B Cook

2. DATE OF BIRTH: 01 31 19 95

6A. MEDICAID NUMBER: AB12345C

PHYSICIAN OR SUPPLIER INFORMATION (REFER TO REVERSE BEFORE COMPLETING AND SIGNING)

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

1.
2.
3.

25A. PRIOR APPROVAL NUMBER

25B. PAYMT SOURCE CD: 11

24A. DATE OF SERVICE MM DD YY	24B. PLACE	24C. PROCEDURE CD	24D. MOD	24E. MOD	24F. MOD	24G. MOD	24H. DIAGNOSIS CODE	24I. DAYS OR UNITS	24J. CHARGES	24K.	24L.
06 17 24	21	T1033					Z322	1	67500		
06 24 24	12	T1032					Z323	1	8437		

25. CERTIFICATION (I CERTIFY THAT THE STATEMENTS ON THE REVERSE SIDE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.)

Sara Sample

SIGNATURE OF PHYSICIAN OR SUPPLIER

26. ACCEPT ASSIGNMENT: YES NO

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

Sara Sample
123 Main Street
Anytown, NY 11111
999 999-9999

TELEPHONE NUMBER

DO NOT WRITE IN THIS SPACE.

25A. PROVIDER IDENTIFICATION NUMBER: 1234567890

26E. DATE SIGNED: 06 30 24

32. PATIENT'S ACCOUNT NUMBER: ABCOOK123

(9/10) EMEDNY-150003

PROOF