New York State
150003 Billing Guidelines

NURSING SERVICES

Version 2011 - 01

6/1/2011

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.

TABLE OF CONTENTS

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 Private Duty Nursing services.

For providers new to NYS Medicaid, it is required to read the General Professional Billing Guidelines available at www.emedny.org by clicking: General Professional Billing Guidelines.

2. Claims Submission

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

2.1 Electronic Claims

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

2.2 Paper Claims

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

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

2.3 Nursing Services Billing Instructions

This subsection of the Billing Guidelines covers the specific NYS Medicaid billing requirements for Nursing Services providers. Although the instructions that follow are based on the eMedNY-150003 paper claim form, they are also intended as a guideline for electronic billers to find out what information they need to provide in their claims. For further electronic claim submission information, refer to the eMedNY 5010 Companion Guide which is available at www.emedny.org 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

Service Provider Name (Field 22A)

837P Ref: Loop 2310B NM1

Agencies Only

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

Identification Number [Service Provider] (Field 22C)

837P Ref: Loop 2310B NM1

Agencies Only

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

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

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

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

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

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

Special Instructions for Claiming Medicare Deductible

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

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

Days or Units (Field 24I)

837P Ref: Loop 2400 SV104

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

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

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

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

Chapter 57 of the Laws of 2006 requires an increase in the amount of Medicaid payment for continuous nursing services provided to Medically Fragile Children outside of the institutional environment. Such increases are applicable to Private Duty Nursing Services provided to any Medicaid client, including those in the Care at Home Waiver programs, up to age 21. This will result in a 30% add-on to the amounts otherwise payable on Medicaid claims for such services.

In order to be eligible to receive this add-on payment, you must first attest that you possess the training and experience necessary to provide the specific care and satisfactorily address the nursing needs of the Medically Fragile Children to whom you are providing nursing service. To accomplish this, fill out either the "Individually Enrolled Provider" or "Licensed Home Health Care Services Agency" attestation. These attestations can be found at under Private Duty Nursing Provider Communications at www.emedny.org by clicking on the link to the webpage as follows: Private Duty Nursing Manual.

Upon receipt of your satisfactorily completed attestation, a new Specialty Code 579 will be added to your enrollment file to enable you to receive the Medically Fragile Children's service payment add-on.

Billing Instructions for the 30% add-on payment

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

3. Remittance Advice

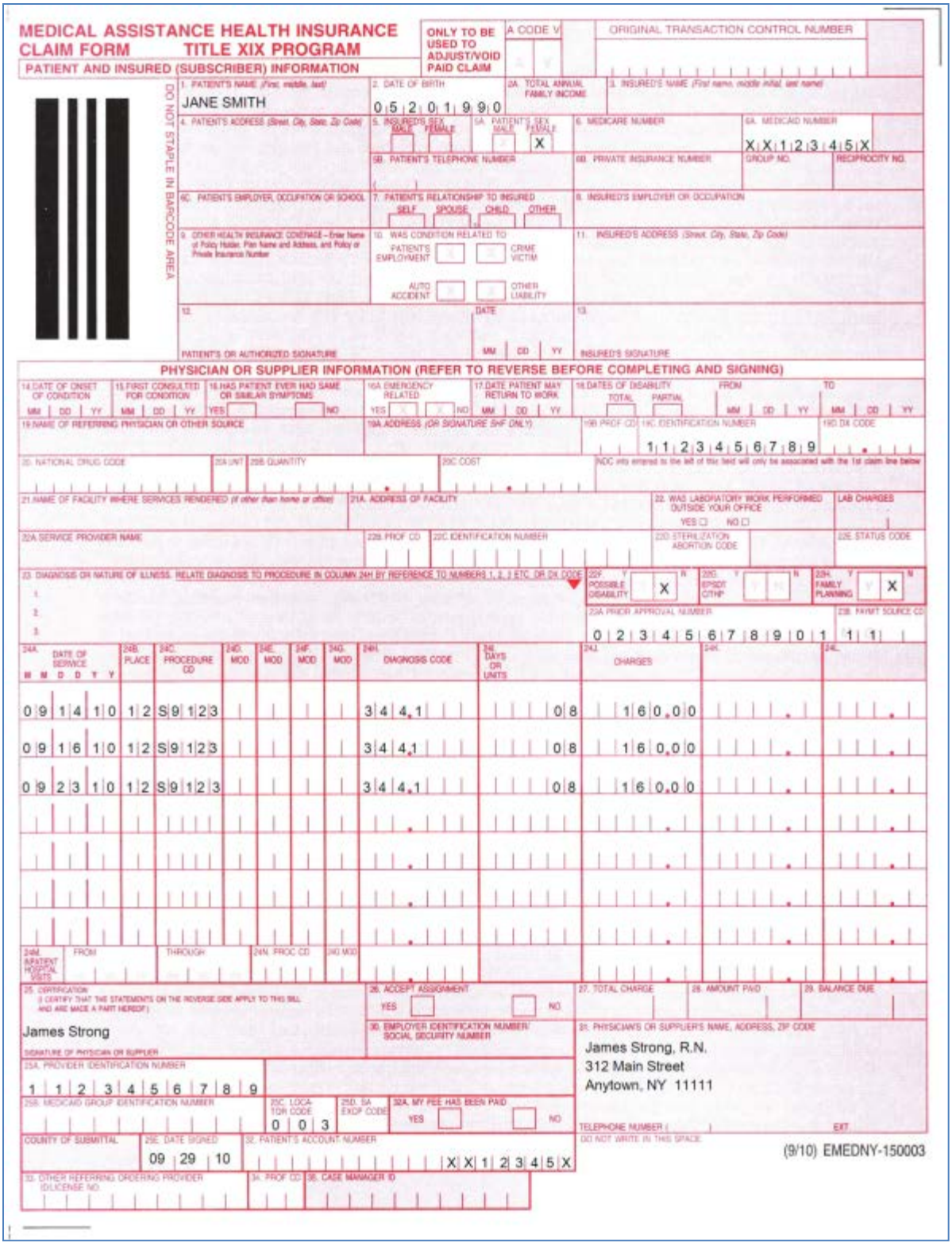
The Remittance Advice is an electronic, PDF or paper statement issued by eMedNY that contains the status of claim transactions processed by eMedNY during a specific reporting period. Statements contain the following information:

- A listing of all claims (identified by several items of information submitted on the claim) that have entered the computerized processing system during the corresponding cycle
- The status of each claim (denied, paid or pended) after processing
- The eMedNY edits (errors) that resulted in a claim denied or pended
- Subtotals and grand totals of claims and dollar amounts
- Other pertinent financial information such as recoupment, negative balances, etc.

The General Remittance Advice Guidelines contains information on selecting a remittance advice format, remittance sort options, and descriptions of the paper Remittance Advice layout. This document is available at www.emedny.org 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

DO NOT STAPLE IN BARCODE AREA

1. PATIENT'S NAME (First, middle, last): JANE SMITH

2. DATE OF BIRTH: 05 20 1990

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 FEMALE

5A. PATIENT'S SEX MALE FEMALE: X

6. MEDICARE NUMBER

6A. MEDICAID NUMBER: XX12345X

5B. PATIENT'S TELEPHONE NUMBER

6B. PRIVATE INSURANCE NUMBER

GROUP NO.

RECIPROCITY NO.

6C. PATIENT'S EMPLOYER, OCCUPATION OR SCHOOL

7. PATIENT'S RELATIONSHIP TO INSURED: SELF SPOUSE CHILD OTHER

8. INSURED'S EMPLOYER OR OCCUPATION

9. OTHER HEALTH INSURANCE COVERAGE – Enter Name of Policy Holder, Plan Name and Address, and Policy or Private Insurance Number

10. WAS CONDITION RELATED TO: PATIENT'S EMPLOYMENT CRIME VICTIM; AUTO ACCIDENT OTHER LIABILITY

11. INSURED'S ADDRESS (Street, City, State, Zip Code)

12. PATIENT'S OR AUTHORIZED SIGNATURE — DATE MM DD YY

13. 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 NO

16A. EMERGENCY RELATED YES NO

17. DATE PATIENT MAY RETURN TO WORK MM DD YY

18. DATES OF DISABILITY TOTAL PARTIAL FROM MM DD YY TO MM DD YY

19. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

19A. ADDRESS (OR SIGNATURE SHE ONLY)

19B. PROF CD

19C. IDENTIFICATION NUMBER: 123456789

19D. DX CODE

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 NO

LAB CHARGES

22A. SERVICE PROVIDER NAME

22B. PROF CD

22C. IDENTIFICATION NUMBER

22D. STERILIZATION ABORTION 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 DX CODE

1.
2.
3.

22F. POSSIBLE DISABILITY Y N: X

22G. EPSDT CTHP Y N

22H. FAMILY PLANNING Y N: X

23A. PRIOR APPROVAL NUMBER: 02345678901

23B. PAYMT SOURCE CD: 11

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	24I. DAYS OR UNITS	24J. CHARGES	24K.	24L.
09 14 10	12	S9123					3441	08	1600		
09 16 10	12	S9123					3441	08	1600		
09 23 10	12	S9123					3441	08	1600		

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.)

James Strong

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

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

32. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE

32A. PROVIDER IDENTIFICATION NUMBER: 1123456789

32B. MEDICAID GROUP IDENTIFICATION NUMBER

32C. LOCATION CODE: 003

32D. SA EXCP CODE

32A. MY FEE HAS BEEN PAID YES NO

TELEPHONE NUMBER ( ) EXT

COUNTY OF SUBMITTAL

32E. DATE SIGNED: 09 29 10

32. PATIENT'S ACCOUNT NUMBER: XX12345X

DO NOT WRITE IN THIS SPACE

(9/10) EMEDNY-150003

33. OTHER REFERRING ORDERING PROVIDER ID/LICENSE NO.

34. PROF CD

36. CASE MANAGER ID