



New York State 150003 Billing Guidelines

VISION CARE



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.

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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 Vision Care 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

Vision Care providers can submit their claims to NYS Medicaid in electronic or paper formats.

2.1 Electronic Claims

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

2.2 Paper Claims

Vision Care 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 Vision Care Services Billing Instructions

This subsection of the Billing Guidelines covers the specific NYS Medicaid billing requirements for Vision Care 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, pending, or denied.

2.3.1 eMedNY - 150003 Claim Form Field Instructions

Service Provider Name (Field 22A)

837P Ref: Loop 2400 DTP03 when DTP01 = 472

If applicable, enter the name of the Licensed Ophthalmic Dispenser (Optician) or Optometrist who rendered the services being claimed and whose NPI appears in field 22C.

Otherwise, leave this field blank.

NOTES:

- *Field 22A MUST be completed ONLY by Optical Establishment providers enrolled with Category of Service 0401, 0402, or 0423 that employ:*
 - *Licensed Ophthalmic Dispensers (opticians) AND/OR*
 - *Licensed Optometrists*
- *For ophthalmic providers with Category of Service 0423, completion of fields 22A and 22C applies even when the billing provider and the service provider are one and the same.*
- *Fields 22A SHOULD NOT be completed by:*
 - *Self-employed Ophthalmic Dispensers (opticians) enrolled with Category of Service 0404*
 - *Eye Prostheses Fitters with category of Service 0405*
 - *Self-employed Optometrists enrolled with Category of Service 0422.*

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

Leave this field blank.

Identification Number [Service Provider] (Field 22C)

837P Ref: Loop 2310B NM1

This field **must** be completed when the billing provider (field 31) with category of service 0401, 0402, or 0423 employs a licensed Ophthalmic Dispenser (Optician) and/or Optometrist who is the actual service provider.

Enter the NPI of the provider who rendered the services if different from the billing provider (field 31).

If the service provider is the same as the billing provider, leave this field blank, except as noted below.

NOTES:

- *For ophthalmic providers with Category of Service 0423, completion of fields 22A and 22C applies even when the billing provider and the service provider are one and the same.*

- *Fields 22C SHOULD NOT be completed by:*
 - *Self-employed Ophthalmic Dispensers (opticians) enrolled with Category of Service 0404*
 - *Eye Prostheses Fitters with category of Service 0405*
 - *Self-employed Optometrists enrolled with Category of Service 0422.*

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									
1. PATIENT'S NAME (First, middle, last) ROBERT JOHNSON			2. DATE OF BIRTH 06 03 19 56		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 M <input type="checkbox"/> F <input checked="" type="checkbox"/>		5A. PATIENT'S SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>		6. MEDICARE NUMBER		6A. MEDICAID NUMBER X X 1 2 3 4 5 X
7. PATIENT'S TELEPHONE NUMBER			8. PRIVATE INSURANCE NUMBER		GROUP NO.		RECIPROcity NO.		
9. PATIENT'S EMPLOYER, OCCUPATION OR SCHOOL			10. 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				
10. OTHER HEALTH INSURANCE COVERAGE - Enter Name of Policy Holder, Plan Name and Address, and Policy or Private Insurance Number			11. WAS CONDITION RELATED TO PATIENT'S EMPLOYMENT 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			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 <input type="checkbox"/> NO <input type="checkbox"/>		17. DATE PATIENT MAY RETURN TO WORK MM DD YY		18. 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 SNF ONLY)		19B. PROF. CD		19C. IDENTIFICATION NUMBER 1 1 2 3 4 5 6 7 8 9	
20. NATIONAL DRUG CODE		20A. UNIT		20B. QUANTITY		20C. COST		NCC 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. STERILIZATION ABORTION 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						22F. POSSIBLE DISABILITY Y <input checked="" type="checkbox"/> N <input type="checkbox"/>		22G. EPSPD QTHP Y <input type="checkbox"/> N <input type="checkbox"/>	
1.						22H. FAMILY PLANNING Y <input type="checkbox"/> N <input type="checkbox"/>		23A. PRIOR APPROVAL NUMBER	
2.						23B. PRINT SOURCE CD 1 1			
3.									
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 3 6 2 0 1		24I. DAYS OR UNITS		24J. CHARGES 3 0 0 0	
24K. MOD		24L. MOD		24M. MOD		24N. MOD		24O. MOD	
24P. MOD		24Q. MOD		24R. MOD		24S. MOD		24T. MOD	
24U. MOD		24V. MOD		24W. MOD		24X. MOD		24Y. MOD	
24Z. MOD		24AA. MOD		24AB. MOD		24AC. MOD		24AD. MOD	
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24BD. MOD		24BE. MOD		24BF. MOD		24BG. MOD		24BH. MOD	
24BI. MOD		24BJ. MOD		24BK. MOD		24BL. MOD		24BM. MOD	
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24BX. MOD		24BY. MOD		24BZ. MOD		24CA. MOD		24CB. MOD	
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24CM. MOD		24CN. MOD		24CO. MOD		24CP. MOD		24CQ. MOD	
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24DN. MOD		24DO. MOD		24DP. MOD		24DQ. MOD		24DR. MOD	
24DS. MOD		24DT. MOD		24DU. MOD		24DV. MOD		24DW. MOD	
24DX. MOD		24DY. MOD		24DZ. MOD		24EA. MOD		24EB. MOD	
24EC. MOD		24ED. MOD		24EE. MOD		24EF. MOD		24EG. MOD	
24EH. MOD		24EI. MOD		24EJ. MOD		24EK. MOD		24EL. MOD	
24EM. MOD		24EN. MOD		24EO. MOD		24EP. MOD		24EQ. MOD	
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24FP. MOD		24FQ. MOD		24FR. MOD		24FS. MOD		24FT. MOD	
24FU. MOD		24FV. MOD		24FW. MOD		24FX. MOD		24FY. MOD	
24FZ. MOD		24GA. MOD		24GB. MOD		24GC. MOD		24GD. MOD	
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24GJ. MOD		24GK. MOD		24GL. MOD		24GM. MOD		24GN. MOD	
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24ZB. MOD		24ZC. MOD		24ZD. MOD		24ZE. MOD		24ZF. MOD	
24ZG. MOD		24ZH. MOD		24ZI. MOD		24ZJ. MOD		24ZK. MOD	
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24ZR. MOD		24ZS. MOD		24ZT. MOD		24ZU. MOD		24ZV. MOD	
24ZW. MOD		24ZX. MOD		24ZY. MOD		24ZZ. MOD			