



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](#).

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												
DO NOT STAMP IN BARCODE AREA	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 MALE <input type="checkbox"/> FEMALE <input checked="" type="checkbox"/>		5A. PATIENT'S SEX MALE <input type="checkbox"/> FEMALE <input checked="" type="checkbox"/>		6. MEDICARE NUMBER		6A. MEDICAID NUMBER X X 1 2 3 4 5 X		
				5B. PATIENT'S TELEPHONE NUMBER		6B. PRIVATE INSURANCE NUMBER		GROUP NO.		RECIPROCALITY NO.		
	4C. 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						
	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 <input type="checkbox"/> AUTO ACCIDENT <input type="checkbox"/> OTHER LIABILITY <input type="checkbox"/>		11. INSURED'S ADDRESS (Street, City, State, Zip Code)						
				12. DATE		13.						
	PATIENT'S OR AUTHORIZED SIGNATURE			MM DD YY		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		18. DATES OF DISABILITY TOTAL <input type="checkbox"/> PARTIAL <input type="checkbox"/> FROM MM DD YY TO MM DD YY	
	19. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE			19A. ADDRESS (OR SIGNATURE SHF ONLY)			19B. PROF. CD		19C. IDENTIFICATION NUMBER 1 1 2 3 4 5 6 7 8 9		19D. DX CODE	
20. NATIONAL DRUG CODE		20A. UNITS		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		22E. STATUS CODE		
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						23F. POSSIBLE DISABILITY Y <input type="checkbox"/> N <input checked="" type="checkbox"/>		23G. EPISODIC/CHRONIC Y <input type="checkbox"/> N <input type="checkbox"/>		23H. FAMILY PLANNING Y <input type="checkbox"/> N <input type="checkbox"/>		
1.						23A. PRIOR APPROVAL NUMBER		23B. PRIOR SOURCE CD 1 1				
2.												
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. CHARGES 3 0 0 0		
0 9 1 6 1 0		1 1	9 2 0 1 2					3 6 2 0 1		8 0 0		
0 9 1 6 1 0		1 1	9 2 0 8 1					3 6 2 0 1		8 0 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		
Signature of Physician or Supplier <i>James Strong</i>						30. EMPLOYER IDENTIFICATION NUMBER/SOCIAL SECURITY NUMBER		31. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE James Strong, OD 312 Main Street Anytown, New York 11111				
25A. PROVIDER IDENTIFICATION NUMBER 1 1 2 3 4 5 6 7 8 9						25B. MEDICAID GROUP IDENTIFICATION NUMBER 0 0 3		25C. LOCAL CODE		25D. SA EXCP CODE		
25E. DATE SIGNED 09 20 10						32. PATIENT'S ACCOUNT NUMBER A B C 1 2 3 4 5		33A. MY FEE HAS BEEN PAID YES <input type="checkbox"/> NO <input type="checkbox"/>		33. PHYSICIAN'S OR SUPPLIER'S TELEPHONE NUMBER () EXT.		
COUNTY OF SUBMITTAL						32. DATE SIGNED		32. PATIENT'S ACCOUNT NUMBER		33. PHYSICIAN'S OR SUPPLIER'S TELEPHONE NUMBER () EXT.		
33. OTHER REFERRING ORDERING PROVIDER LICENSE NO.						34. PROF. CD		36. CASE MANAGER ID				