New York State
150003 Billing Guidelines

VISION CARE

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 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, pended, 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

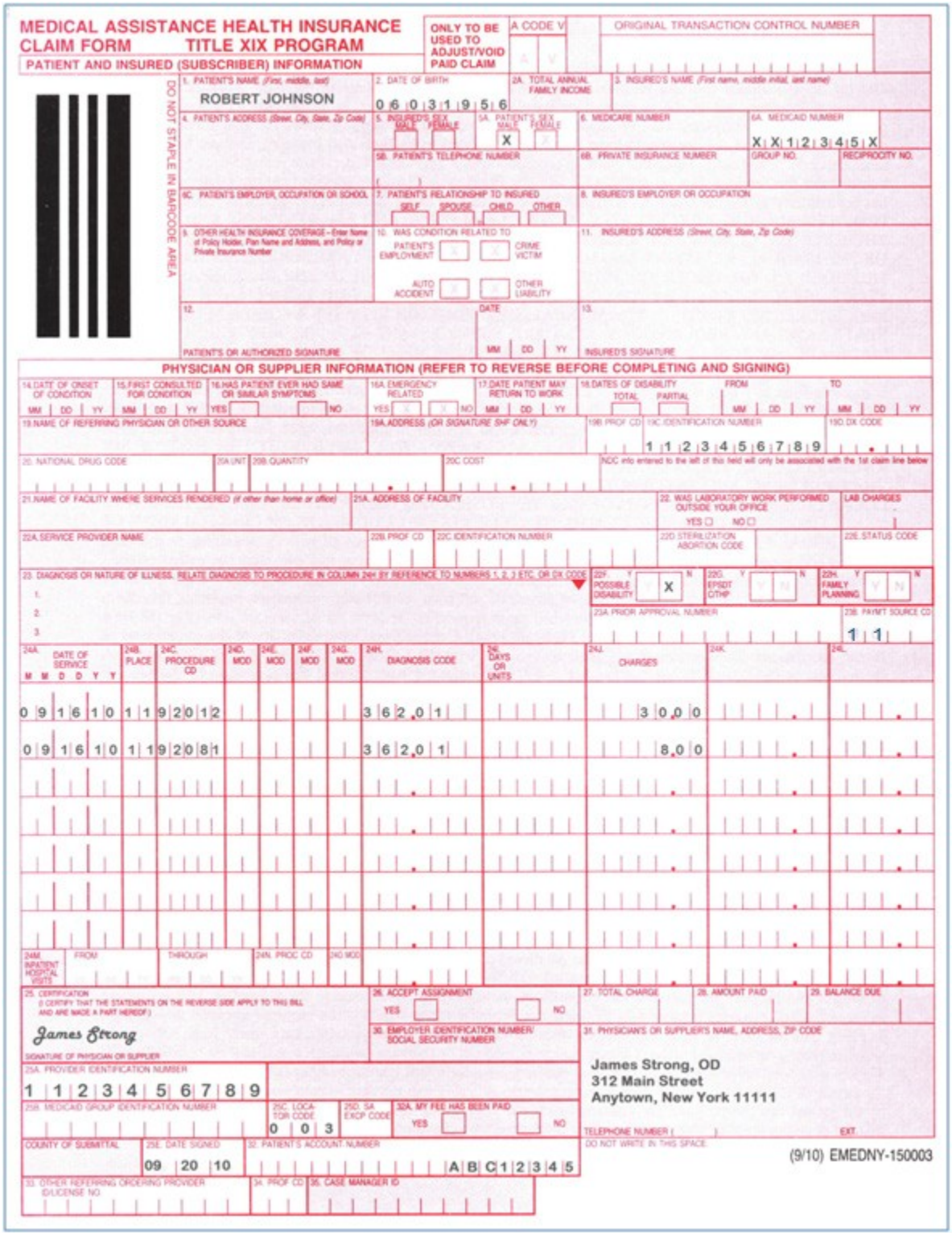
The Remittance Advice is an electronic, PDF or paper statement issued by eMedNY that contains the status of claim transactions processed by eMedNY during a specific reporting period. Statements contain the following information:

- 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 STAPLE IN BARCODE AREA

1. PATIENT'S NAME (First, middle, last): ROBERT JOHNSON

2. DATE OF BIRTH: 06 03 1956

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 X FEMALE

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 X 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: 112345678 9

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 X N

22G. EPSDT CTHP Y N

22H. FAMILY PLANNING Y N

23A. PRIOR APPROVAL NUMBER

23B. 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.
09 16 10	11	92012					362.01		300		
09 16 10	11	92081					362.01		80		

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, OD
312 Main Street
Anytown, New York 11111

25A. PROVIDER IDENTIFICATION NUMBER: 112345678 9

25B. MEDICAID GROUP IDENTIFICATION NUMBER

25C. LOCATOR CODE: 003

25D. SA EXCP CODE

32A. MY FEE HAS BEEN PAID YES NO

TELEPHONE NUMBER ( ) EXT

COUNTY OF SUBMITTAL

25E. DATE SIGNED: 09 20 10

32. PATIENT'S ACCOUNT NUMBER: ABC12345

DO NOT WRITE IN THIS SPACE

33. OTHER REFERRING ORDERING PROVIDER ID/LICENSE NO.

34. PROF CD

35. CASE MANAGER ID

(9/10) EMEDNY-150003