New York State
150003 Billing Guidelines

HEARING AID/AUDIOLOGY 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 Hearing Aid/Audiology 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

Hearing Aid/Audiology Services providers can submit their claims to NYS Medicaid in electronic or paper formats.

2.1 Electronic Claims

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

2.2 Paper Claims

Hearing Aid/Audiology 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 Hearing Aid/Audiology Services eMedNY - 150003 claim form, see Appendix A below.

2.3 Hearing Aid/Audiology Services Billing Instructions

This subsection of the Billing Guidelines covers the specific NYS Medicaid billing requirements for Hearing Aid/Audiology 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

Name of Referring Physician or Other Source (Field 19)

837P Ref: Loop 2310A NM1

Enter the ordering provider's name in this field.

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.

NOTES:

- ***A service date must be entered for each procedure code listed.***
- ***In accordance with New York State policy, hearing aids must be dispensed within six months of the Ordering date. A claim form must be submitted within 90 days from the Date of Service entered on the claim form.***
- ***When billing for an ear mold subsequent to a patient's loss of eligibility, the Date of Service should be the date on which the ear mold impression was taken. The circumstances for this billing situation are outlined in the Policy Guidelines available at www.emedny.org by clicking on the link to the webpage as follows:*** Hearing Aid Manual.

3. Remittance Advice

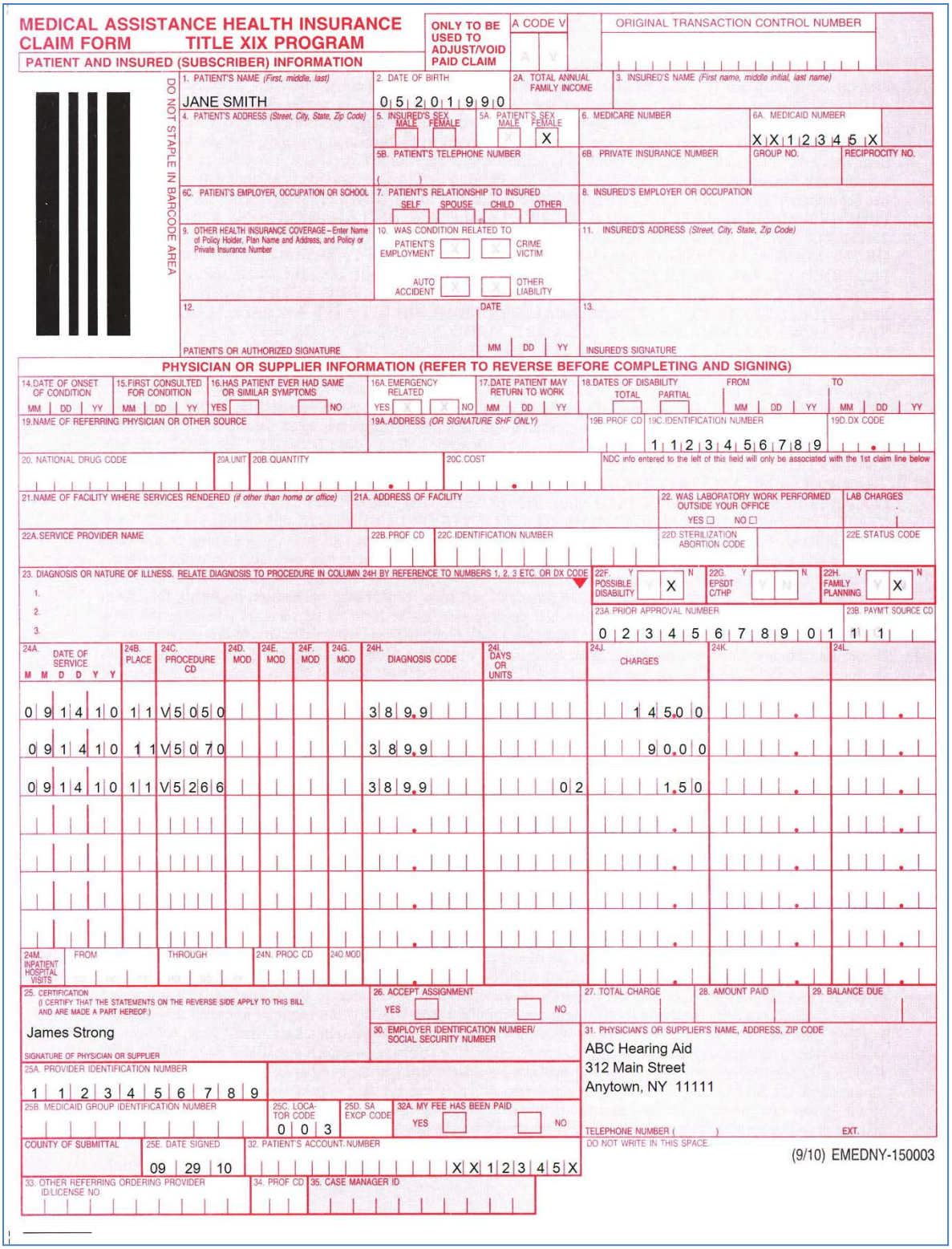
The Remittance Advice is an electronic, PDF or paper statement issued by eMedNY that contains the status of claim transactions processed by eMedNY during a specific reporting period. Statements contain the following information:

- 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 X / NO X
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 SHF ONLY)
19B. PROF CD
19C. IDENTIFICATION NUMBER: 1123456789
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: N X
22G. EPSDT C/THP: N
22H. FAMILY PLANNING: N X
23A. PRIOR APPROVAL NUMBER: 02345678901 11
23B. PAYMT SOURCE CD

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 14 10	11	V5050					389.9		140.00		
09 14 10	11	V5070					389.9		90.00		
09 14 10	11	V2656					389.9	02	1.50		

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
ABC Hearing Aid
312 Main Street
Anytown, NY 11111
25A. PROVIDER IDENTIFICATION NUMBER: 123456789
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 29 10
32. PATIENT'S ACCOUNT NUMBER: XX12345X
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