New York State
150003 Billing Guidelines

PODIATRY

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. CSC is the eMedNY contractor and is responsible for its operation.

The information contained within this document was created in concert by eMedNY DOH and eMedNY CSC. 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 Podiatry 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

Podiatrists can submit their claims to NYS Medicaid in electronic or paper formats.

2.1 Electronic Claims

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

2.2 Paper Claims

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

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

2.3 Podiatry Services Billing Instructions

This subsection of the Billing Guidelines covers the specific NYS Medicaid billing requirements for Podiatrists. 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, pended, or denied.

2.3.1 eMedNY - 150003 Claim Form Field Instructions

Days or Units (Field 24I)

837P Ref: Loop 2400 SV104

If a procedure was performed and approved by Medicare more than one time on the same date of service, enter the number of times in this field. If the procedure was performed only one time, this field may be left blank.

Note: Medicaid only pays for podiatry services for members with active coverage that are over the age of 21.

3. Remittance Advice

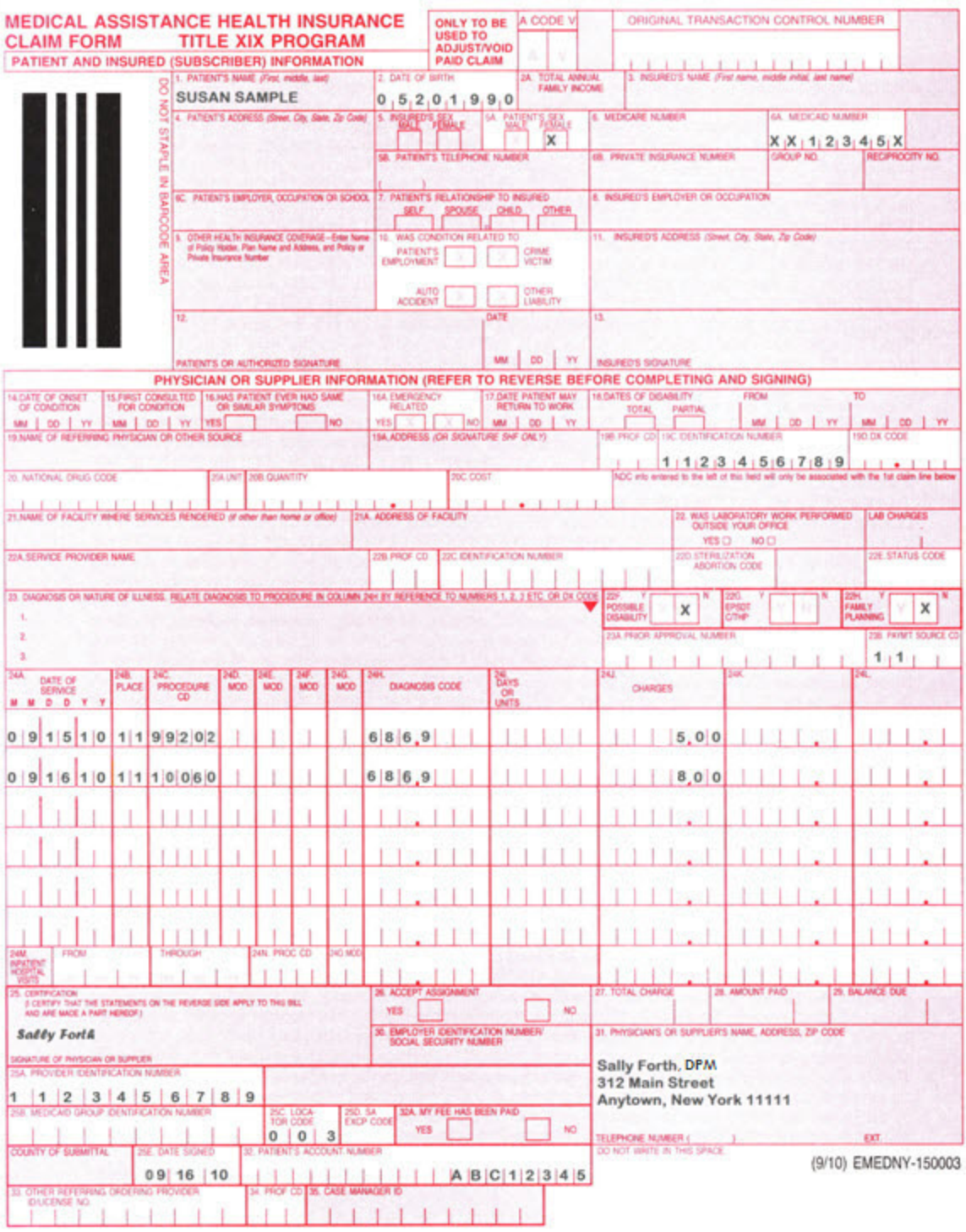
The Remittance Advice is an electronic, PDF or paper statement issued by eMedNY that contains the status of claim transactions processed by eMedNY during a specific reporting period. Statements contain the following information:

- 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

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

ONLY TO BE USED TO ADJUST/VOID PAID CLAIM

A CODE V

ORIGINAL TRANSACTION CONTROL NUMBER

DO NOT STAPLE IN BARCODE AREA

1. PATIENT'S NAME (First, middle, last): SUSAN SAMPLE

2. DATE OF BIRTH: 0 5 2 0 1 9 9 0

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: X X 1 2 3 4 5 X

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 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. 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 CTHP Y N

22H. FAMILY PLANNING Y N: X

23A. PRIOR APPROVAL NUMBER

23B. PAYMT SOURCE CD: 1 1

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.
0 9 1 5 1 0	1 1	9 9 2 0 2					6 8 6 . 9		5 0 0		
0 9 1 6 1 0	1 1	1 0 0 6 0					6 8 6 . 9		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.)

Sally Forth

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

Sally Forth, DPM
312 Main Street
Anytown, New York 11111

TELEPHONE NUMBER ( ) EXT.

25A. PROVIDER IDENTIFICATION NUMBER: 1 1 2 3 4 5 6 7 8 9

25B. MEDICAID GROUP IDENTIFICATION NUMBER

25C. LOCATOR CODE: 0 0 3

25D. SA EXCP CODE

32A. MY FEE HAS BEEN PAID YES NO

DO NOT WRITE IN THIS SPACE

COUNTY OF SUBMITTAL

25E. DATE SIGNED: 0 9 16 10

32. PATIENT'S ACCOUNT NUMBER: A B C 1 2 3 4 5

33. OTHER REFERRING ORDERING PROVIDER ID/LICENSE NO.

34. PROF CD

35. CASE MANAGER ID

(9/10) EMEDNY-150003

PODIATRY