NEW YORK STATE
MEDICAID PROGRAM

NURSING SERVICES

PRIOR APPROVAL GUIDELINES

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Section I - Purpose Statement

The purpose of this document is to assist the provider community to understand and comply with the New York State Medicaid (NYS-Medicaid) requirements and expectations for:

- Obtaining Prior Approval
- Field by Field Instructions for Prior Approval Form (eMedNY 361501)

This document is customized for Nursing Services providers and it should be used by the provider's billing staff as an instructional as well as a reference tool.

Section II - Instructions for Obtaining Prior Approval

Electronic prior approval requests and responses can be submitted on the HIPAA 278 transaction. The Companion Guide for the HIPAA 278 is available on the www.nyhipaadesk.com website. Click on eMedNY Companion Guides and Sample Files. Access to the final determinations will be available though eMedNY eXchange messages or by mail. To sign up for eXchange, visit www.emedny.org.

Prior approval requests can also be requested via ePACES. ePACES is an internet-based program available to enrolled Medicaid providers. For information about enrolling in ePACES, contact CSC at (800) 343-9000. A reference number will be returned to your ePACES screen, which can be later used to check the approval status on ePACES. Visit www.emedny.org for more information.

Paper prior approval request forms, with appropriate attachments, should be sent to Computer Sciences Corporation, PO Box 4600, Rensselaer, NY 12144-4600. A supply of the new Prior Approval forms is available by contacting CSC at the number above.

This section of the manual describes the preparation and submission of the New York State Medical Assistance (Title XIX) Program Order/Prior Approval Request Form (eMedNY 361501). It is imperative that these procedures are used when completing the forms. Request forms that do not conform to these requirements will not be processed by eMedNY.

Services that require prior approval are underlined in the Procedure Code Section of this Manual.

Receipt of prior approval does NOT guarantee payment. Payment is subject to client's eligibility and other guidelines.

Requests for prior approval should be submitted before the date of service or dispensing date. However, sometimes unforeseen circumstances arise that delay the submission of the prior approval request until after the service is provided. If this occurs, the prior approval request must be received by the department within 90 days of the date of service, accompanied by an explanation of why the item was dispensed/service was provided before the prior approval request was approved.

Prior approvals must be obtained before services commence; except in cases of emergency. In that instance, no more than two (2) days [forty-eight (48) consecutive hours] will be approved retrospectively. In cases where services are provided on an emergency basis, the Medicaid Director or his/her designee must be notified on the next business day. In limited circumstances, prior approval may be granted retrospectively at the discretion of the Medicaid Director, or his/her designee, providing the prior approval request is received by the Medicaid Director or his/her designee within ninety (90) days of the date of service was provided.

The request must give a detailed explanation for the delay. Requests submitted without an explanation will be returned, without action, to the provider.

To reduce processing errors (and subsequent processing delays), please do not run-over writing or typing from one field (box) into another. The displayed Prior Approval Request Form is numbered in each field to correspond with the instructions for completing the request.

Prior Approval Form (eMedNY 361501)

RX DRUGS / OTC	DME / SUPPLIES	NURSING	EYE CARE	PHYSICIAN
X	X	X	X	X

2 ORDER DATE	3 ID / LICENSE NUMBER	4 PROF CODE	9 PRIMARY DIAGNOSIS	10 SECONDARY DIAGNOSIS	11 CLIENT ID	12 CLIENT NAME
M M D D C C Y Y						
5 PRESCRIBED BY (NAME)						13 ADDRESS
6 ADDRESS			7 PROVIDER TELEPHONE NUMBER		14 DATE OF BIRTH	CITY STATE ZIP CODE
CITY STATE ZIP CODE			8 PRESCRIBER SIGNATURE		M M D D C C Y Y	15 CLIENT TELEPHONE NUMBER / 16 SEX M F

17 ORDER DESCRIPTION / MEDICAL JUSTIFICATION:

18 SERVICING PROVIDER ID	19 SERVICING PROVIDER NAME	21 TELEPHONE NUMBER	22 LOC CODE
	20 ADDRESS		

	23 DRUG CODE (NDC)	24 PROCEDURE/ ITEM CODE	25 MOD	26 RENTAL?	27 DESCRIPTION	28 QUANTITY REQUESTED	29 TIMES REQUESTED	30 TOTAL AMOUNT REQUESTED
1				Y N				
2				Y N				
3				Y N				
4				Y N				
5				Y N				
6				Y N				
7				Y N				

DO NOT STAPLE IN BARCODE AREA

[redacted]

31 PA REVIEW OFFICE CODE

↑

← ALIGN TOP AND LEFT EDGES OF STICKER ATTACHMENT NUMBER

Section III - Field by Field (eMedNY 361501) Instructions

PROVIDER TYPE (Field 1)

Place an X in the box labeled Nursing.

ORDER DATE (Field 2)

Indicate the month, day, and year on which the order was initiated.

Example: September 9, 2005

ORDER DATE							
0	9	0	9	2	0	0	5

ID / LICENSE NUMBER (Field 3)

Enter the Ordering Provider's MMIS ID Number as in the example below. Right justify the information in this field.

Example:

ID / LICENSE NUMBER								
		0	1	2	3	4	5	6	7

If the Ordering Provider is not enrolled with MMIS, enter his/her license number. If entering a NYS license number, the license number must be preceded by two zeros as in the example below.

Example:

ID / LICENSE NUMBER								
		0	0	2	3	4	5	6	7

If entering an out-of-state license number, the two-digit United States Post Office state abbreviation should be entered in place of the two zeros as in the example below.

Example:

ID/ LICENSE NUMBER								
		N	J	2	3	4	5	6	7

PROF CODE (Field 4)

If the Ordering Provider's license number has been used in Field 3, enter the Profession Code from the list below:

TYPE	PROFESSION CODE
Physician or Surgeon	060
Nurse Practitioner	030-045

PRESCRIBED BY (NAME) (Field 5)

Enter the last name followed by the first name of the practitioner initiating the order.

PRESCRIBER (Field 6)

Enter the ordering practitioner's address.

PROVIDER TELEPHONE NUMBER (Field 7)

Enter the telephone number of the ordering practitioner.

PRESCRIBER SIGNATURE (Field 8)

The ordering practitioner must sign the form in this field. If the form is filled out by the nurse provider who has the written order on something other than the eMedNY 361501, the provider must maintain the signed order in his/her files for six (6) years following the date of payment. A copy of the written order must be submitted with the form.

PRIMARY DIAGNOSIS (Field 9)

Enter the ICD-9-CM diagnosis code that represents the condition or symptom of the Client that establishes the need for the service requested. ICD-9-CM is the *International Classification of Diseases - 9th Revision - Clinical Modification Coding System*.

Example:

PRIMARY DIAGNOSIS						
8	9	7	•	0		

SECONDARY DIAGNOSIS (Field 10)

Enter the appropriate ICD-9-CM diagnosis code that represents the secondary condition or symptom affecting treatment. Leave blank if there is no secondary diagnosis.

CLIENT ID (Field 11)

Enter the client's eight-character alphanumeric Welfare Management System (WMS) ID number.

Example:

CLIENT ID NUMBER							
A	A	1	2	3	4	5	X

NOTE: (WMS) ID numbers are composed of eight characters. The first two are alpha, the next five are numeric, and the last one is alpha.

CLIENT NAME (Field 12)

Enter the last name followed by the first name of the client as it appears on the Medicaid ID Card.

ADDRESS (Field 13)

Enter the client's address.

DATE OF BIRTH (Field 14)

Indicate the month, day, and year of the client's birth.

Example: April 5, 1940 = 04051940

DATE OF BIRTH							
0	4	0	5	1	9	4	0

CLIENT TELEPHONE NUMBER (Field 15)

Enter the client's phone number.

SEX (Field 16)

Place an X on M for Male or F for Female to indicate the client's gender.

ORDER DESCRIPTION / MEDICAL JUSTIFICATION (Field 17)

The order description must include the objectives of treatment, the estimated duration of treatment, the length of time per day, and the number of days per week that nursing services are necessary. In addition, the specific procedures that the nurse will

undertake to justify the need for either a registered professional or licensed practical nurse should be entered.

SERVICING PROVIDER ID (Field 18)

Enter the nurse provider's MMIS ID number assigned to you by the New York State Department of Health at the time of your enrollment. Right justify the information in this field.

Example: 01234567

SERVICING PROVIDER ID								
		0	1	2	3	4	5	6	7

SERVICING PROVIDER NAME (Field 19)

Enter the name of the independently enrolled private practicing nurse or the name of the LHCSA agency that will provide care. If more than one provider within the same category of service will be sharing the prior approval, list all providers and their ID numbers in Field 17.

ADDRESS (Field 20)

Enter the address of the provider listed in Field 19.

TELEPHONE NUMBER (Field 21)

Enter the telephone number of the provider listed in Field 19.

LOC CODE (Field 22)

Enter the three-digit location code to specify where you would like to receive PA related correspondence (Example 003).

DRUG CODE (NDC) (Field 23)

Leave blank.

PROCEDURE ITEM CODE (Field 24)

This code indicates the service to be rendered to the recipient. Refer to the New York State Procedure Code Section of this Manual. Enter the appropriate five-character code.

MOD (Field 25)

Enter the appropriate two-character modifier, if applicable. Refer to the New York State Procedure Code Section of this Manual.

RENTAL? (Field 26)

Leave this field blank.

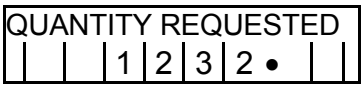
DESCRIPTION (Field 27)

Enter the description of the service corresponding to the procedure code entered in Field 24.

QUANTITY REQUESTED (Field 28)

Enter the total number of hours of private nursing services for all the days for which prior approval is being requested.

Example: Quantity of 1,232



TIMES REQUESTED (Field 29)

Enter the number of days on which private nursing services are requested.

TOTAL AMOUNT REQUESTED (Field 30)

Enter the dollar amount requested for the specific prior-approved service. Calculate this amount, based on the established fee for this client, to cover the total units requested.

PA REVIEW OFFICE CODE (Field 31)

This field is used to identify the state agency responsible for reviewing and issuing the prior approval. See Information for All Provider, Inquiry Section for the appropriate reviewing agency and enter the corresponding code as listed below.

CODE	
A1	Bureau of Medical Review and Payment, Office of Medicaid Management, NYS Department of Health (for clients from all other counties not listed below)
03	Broome County Department of Social Services

07	Chemung County Human Resources Center
14	Erie County Department of Social Services
30	Oneida County Department of Social Services
42	Schenectady County Department of Social Services
50	Tompkins County Department of Social Services
55	Westchester County Department of Social Services