NEW YORK STATE
MEDICAID PROGRAM

PRIVATE DUTY NURSING MANUAL

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 361502)

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 eMedNY HIPAA Support website. Click on eMedNY Companion Guides and Sample Files. Access to the final determinations will be available thru 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 eMedNY 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:

eMedNY, PO Box 4600, Rensselaer, NY 12144-4600.

A supply of the new Prior Approval forms is available by contacting eMedNY at the number above.

<u>Expedited / Priority Shipping:</u>
eMedNY, 327 Columbia Turnpike, ATTN: Box 4600, Rensselaer, NY 12144

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 361502). 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.

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. 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 361502)

Documentation Requirements

Private Duty Nursing prior approvals must be submitted with required documentation outlined in the Private Duty Nursing Policy Guidelines Manual, Section 6 and in accordance with all policies listed within the Private Duty Nursing Policy Guidelines Manual:

https://www.emedny.org/ProviderManuals/NursingServices/PDFS/Private_Duty_Nursing_Policy.pdf

Section III - Field by Field (eMedNY 361502) 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

Prescriber's Provider Number (Field 3)

Enter the 10 digit Prescriber's Provider Number as in the example below. .

Example:

Prescriber Prov. No.									
0	1	2	3	4	5	6	7	8	9

PROF CODE (Field 4)

Leave blank.

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.

PRESCRIBER 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 361502, 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 diagnosis code that represents the condition or symptom of the Client that establishes the need for the service requested. The ICD diagnosis code is the *International Classification of Diseases Clinical Modification Coding System*.

> **Example**:

PRIMARY DIAGNOSIS						
8	9	7	•	0		

SECONDARY DIAGNOSIS (Field 10)

Enter the appropriate ICD 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 NO (Field 18)

Enter the Servicing Nurse 10 digit provider number assigned to you.

Example
```
SERVICING PROVIDER NO
0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9
```

SERVICING PROVIDER NAME (Field 19)

Enter the name of the independently enrolled private practicing nurse or the name of the LHHCSA 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 10 digit provider 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

QUANTITY REQUESTED							
			1	2	3	2 •		

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 Health Insurance Programs, NYS Department of Health