Prior Approval for Private Duty Nursing

Paper Form (eMedNY 361502)



Prepared by GDIT

eMedNY

1/27/2023 11:28 AM

AGENDA

- eMedNY Website Private Duty Nursing Resources
- Prior Approval General Information
- Prior Approval Form (eMedNY 361502)
- Important Reminders
- Reference and Contact Information

eMedNY Website - www.emedny.org



PDN Provider Manual



PDN Provider Manual

Provider Manuals

Welcome! Your Provider Manual to the New York Medicaid Program offers you a wealth of information about Medicaid, as well as specific instructions on how to submit a claim for rendered services.

Information for All Providers gives you pertinent policy and resource information!

Click on your provider manual below, and read about specific rules governing the provision of your care and service to Medicaid recipients. This section also contains billing instructions, as well as pertinent procedure codes and fee schedules.

Click on the link to the <u>Department of Health's Medicaid Update website</u>. This monthly publication is mailed to active providers, and informs providers of up-to-date changes in the Medicaid Program. This website has an index that makes finding relevant articles an easy task!

Your provider manual, along with recent Medicaid Update articles, will act as an effective guide to your participation in Medicaid.

SELECT A PROVIDER MANUAL





Radiology Prior Approval

Residential Health



Medicaid Eligibility Verification System (MEVS) Reference Material

The following information is a list of MEVS resources, including quick reference guides and the full manual.

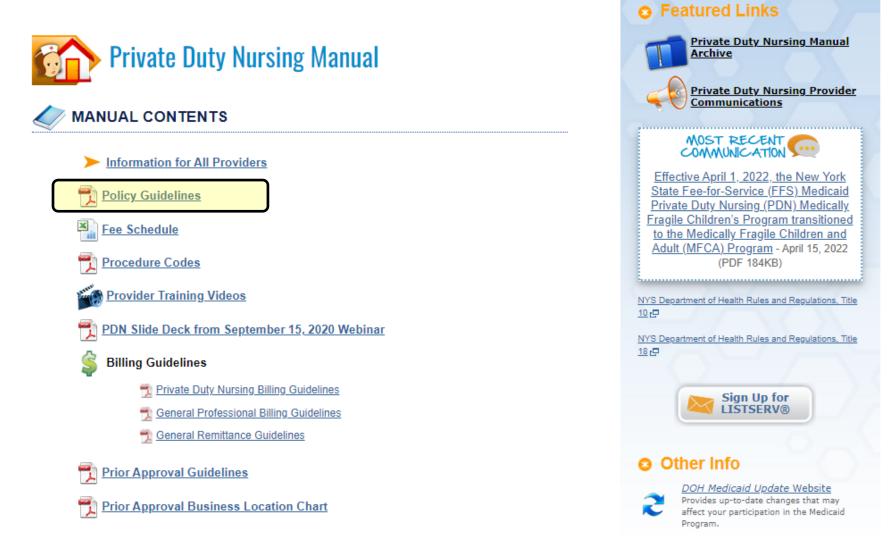
- MEVS/DVS Provider Manual
- MEVS Quick Reference Guides
- Choosing which MEVS method is right for you

Supplemental Documentation

The following information is not part of your provider

PDN Policy Guidelines

Provider Manuals > Private Duty Nursing Manual



PDN Prior Approval Requirements

NEW YORK STATE OF OPPORTUNITY.

Department of Health

PDN Manual

eMedNY > Private Duty Nursing Provider Policy

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PDN Prior Approval Requirements

6.0 Prior Approval Requirements

6.1 Documentation Chart

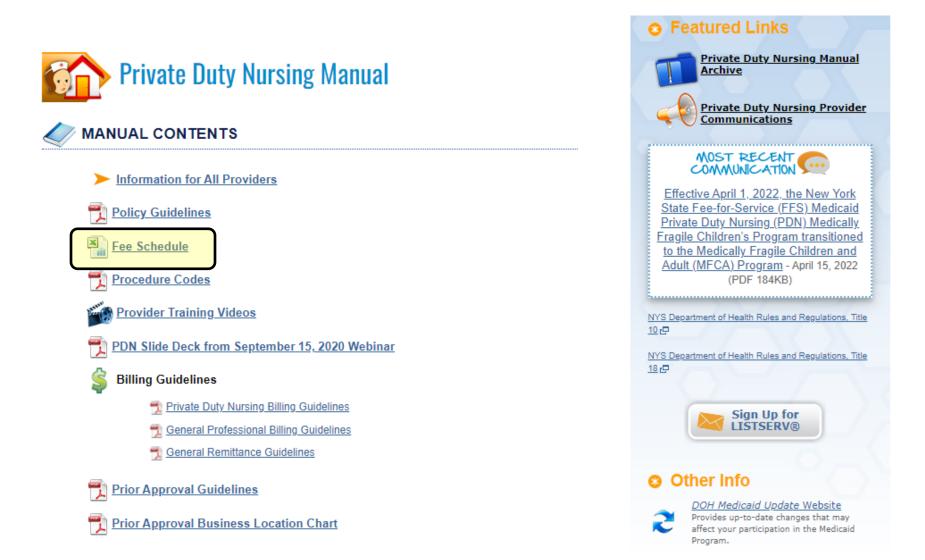
Prior approval for all PDN services is required before the start of providing services and the request must be submitted by a Medicaid enrolled PDN provider. There are two categories of prior approvals: New Case and Renewal/Reevaluation prior approvals. Prior approval requests are reviewed in the order in which they are received by the Department. It is the provider's responsibility to obtain all necessary paperwork and submit those requests prior to the start of providing services.

The following chart summarizes the documentation requirements for each approval interval. Requirements needing additional explanation will be discussed in more detail in other sections of the manual.

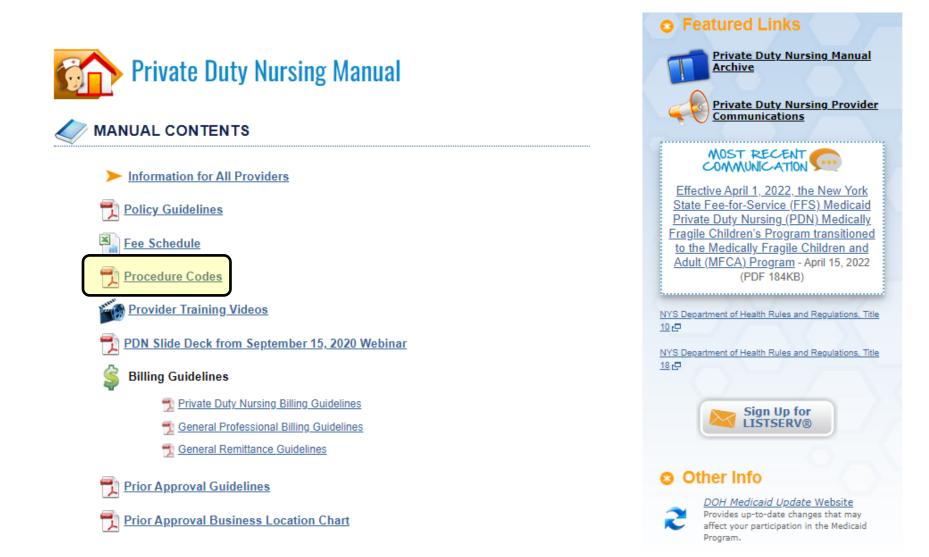
All required documentation must be dated within 6 months of the PA start date.

| Information Required | New Cases | Every 6 Months | Every 12 Months |
|---|--------------|-------------------|--------------------|
| Physician's Order for Nursing Services, including: RN or LPN level of care Statement justifying RN level of care (annually, if applicable) Number of PDN hours requested (per day or per week) and distribution of hours (daytime, nighttime, flexible use hours) See section <u>6.8</u> for more information | ~ | ~ | ~ |
| Physician Plan of Care/Skilled Nursing Tasks: Documentation of the skilled nursing needs and physician plan of care for the member. See Section <u>5.1</u> for detailed requirements | ~ | ~ | ~ |

PDN Fee Schedule



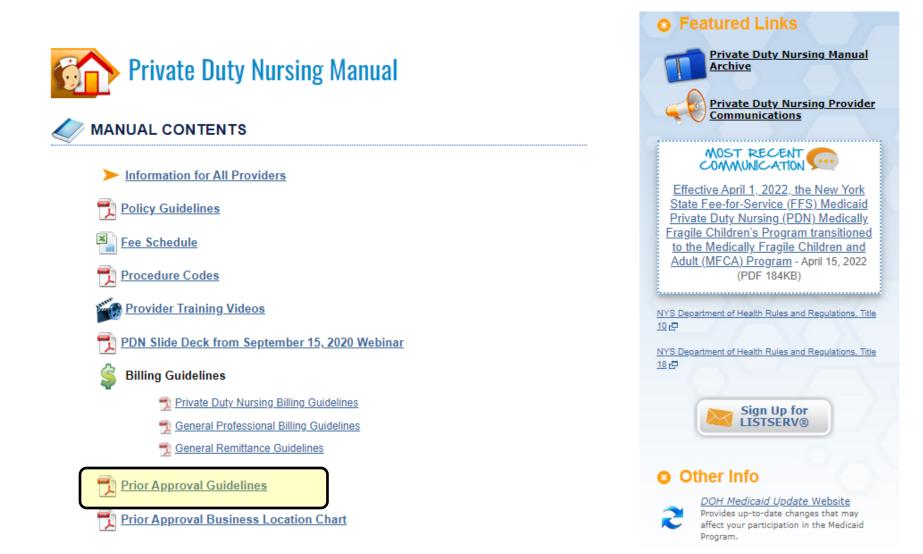
PDN Procedure Codes



PDN Billing Guidelines



PDN Prior Approval Guidelines



Most Recent Communication

Medically Fragile Children and Adult Program



Prior Approval - General Information

- Prior Approval (PA) for all PDN services is <u>required</u> before the start of providing services
- A PA request must be submitted by a Medicaid enrolled PDN or PDN Agency and ordered by a Medicaid enrolled Physician or Nurse Practitioner
- It is the provider's responsibility to obtain and submit all necessary paperwork
- Approval of PDN services will be for a period of up to six months
- Full disclosure of primary insurance must be made to Medicaid. Providers must submit for approval to the primary insurance before requesting PDN hours from Medicaid
- Receipt of prior approval does NOT guarantee payment. Payment is subject to client's eligibility and other guidelines

Private Duty Nursing Prior Approval Request

PRIOR APPROVAL FORM (eMedNY 361502)

NYS MEDICAL ASSISTANCE - TITLE XIX PROGRAM

ORDER/PRIOR APPROVAL REQUEST

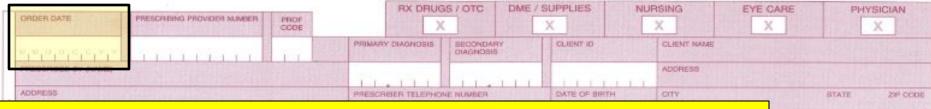
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NOTE: Prior Approval can also be requested electronically and on ePACES

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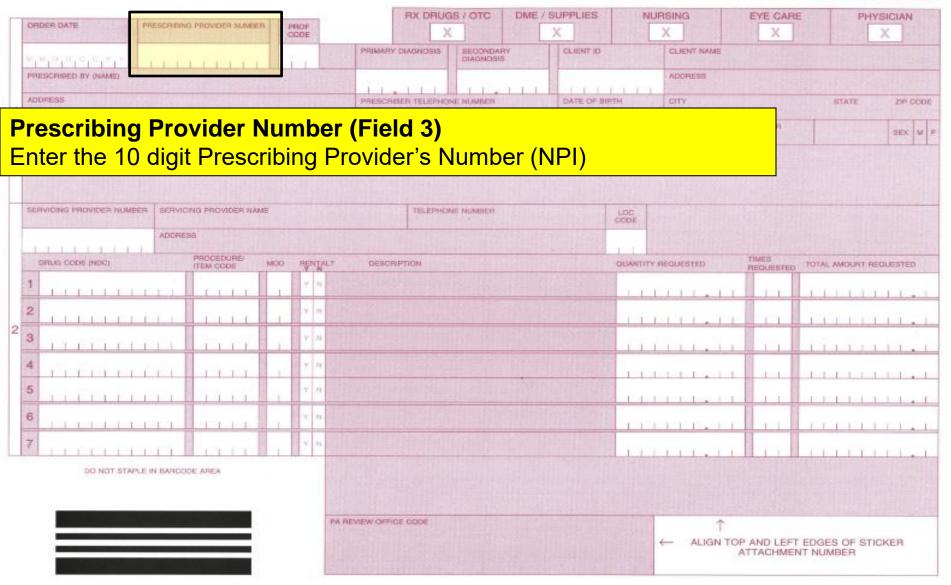
Indicate the month, day, and year on which the order was initiated.

Example: July 11th, 2022 = 07112022

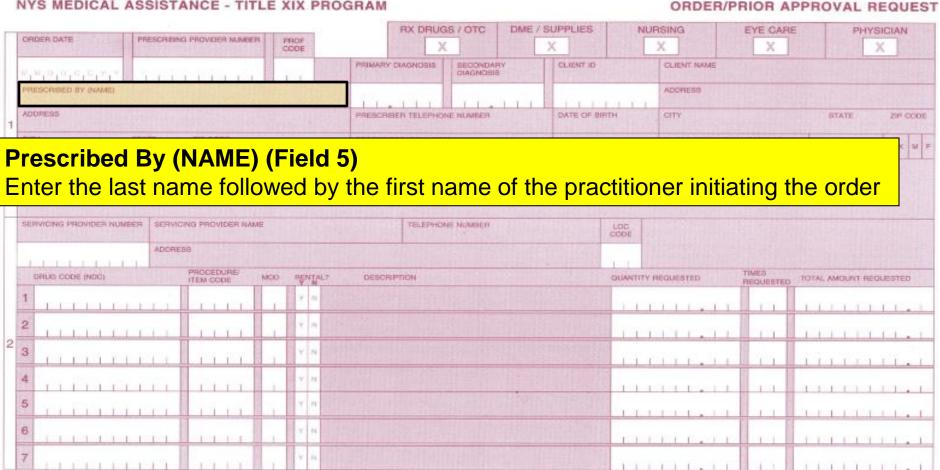
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NOTE: Prescribing Provider is also referred to as the Ordering or Referring Provider



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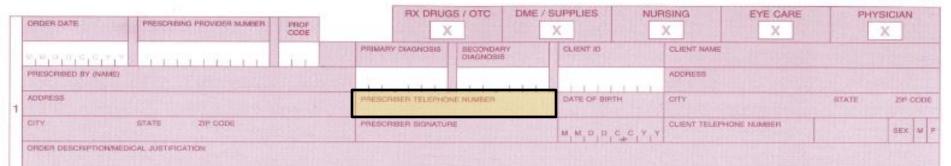
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Prescriber's Address (Field 6) Enter the Prescriber's address

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ORDER/PRIOR APPROVAL REQUEST



Prescriber Telephone Number (Field 7) Enter the Prescriber's telephone number

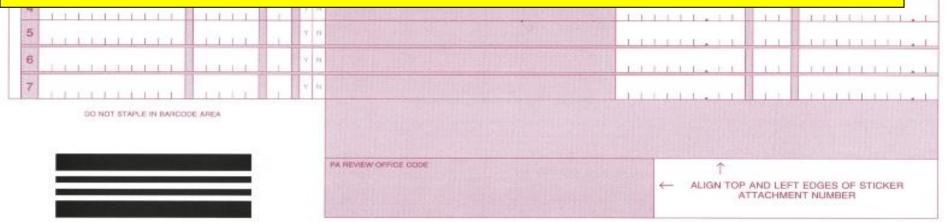
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ORDER/PRIOR APPROVAL REQUEST

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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.



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ORDER/PRIOR APPROVAL REQUEST

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Primary Diagnosis (Field 9)

Enter the ICD-10 diagnosis code that represents the condition or symptom of the client that establishes the need for the service requested.

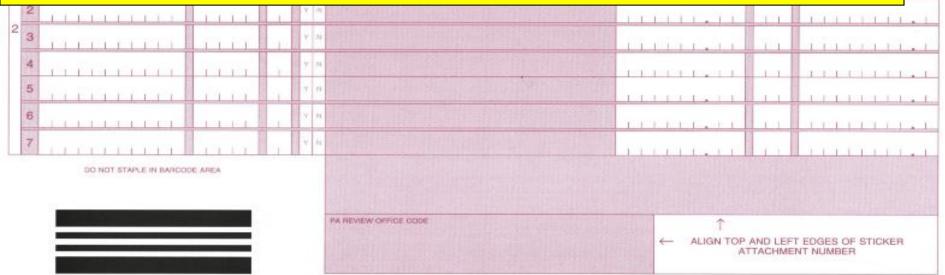
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ORDER/PRIOR APPROVAL REQUEST

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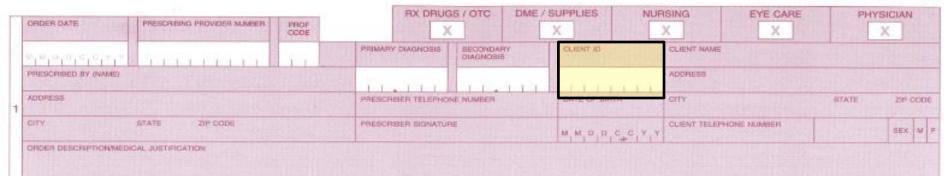
Secondary Diagnosis (Field 10)

Enter the appropriate ICD-10 diagnosis code that represents the secondary condition or symptom affecting treatment. Leave blank if there is no secondary diagnosis



ED.

ORDER/PRIOR APPROVAL REQUEST



Client ID (Field 11)

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

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

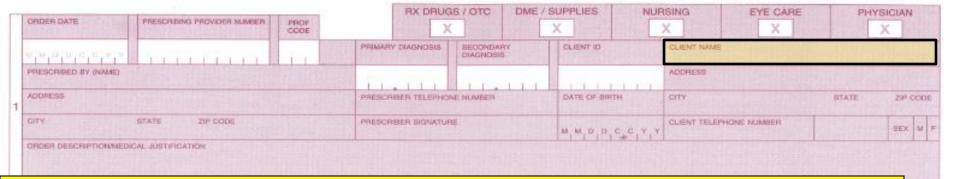
Example: AA12345A



EMEDNY-361502 (1/08)

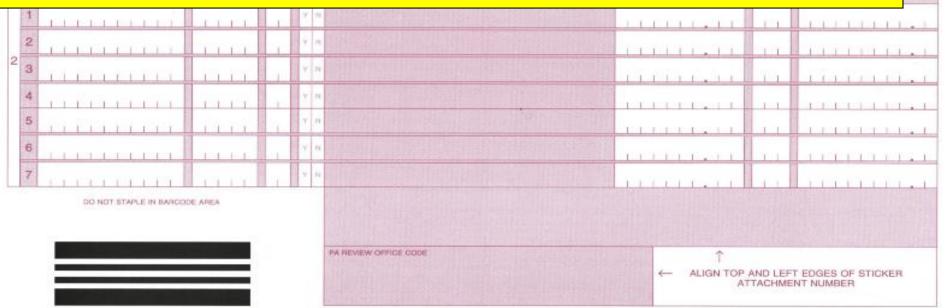
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ORDER/PRIOR APPROVAL REQUEST



Client Name (Field 12)

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



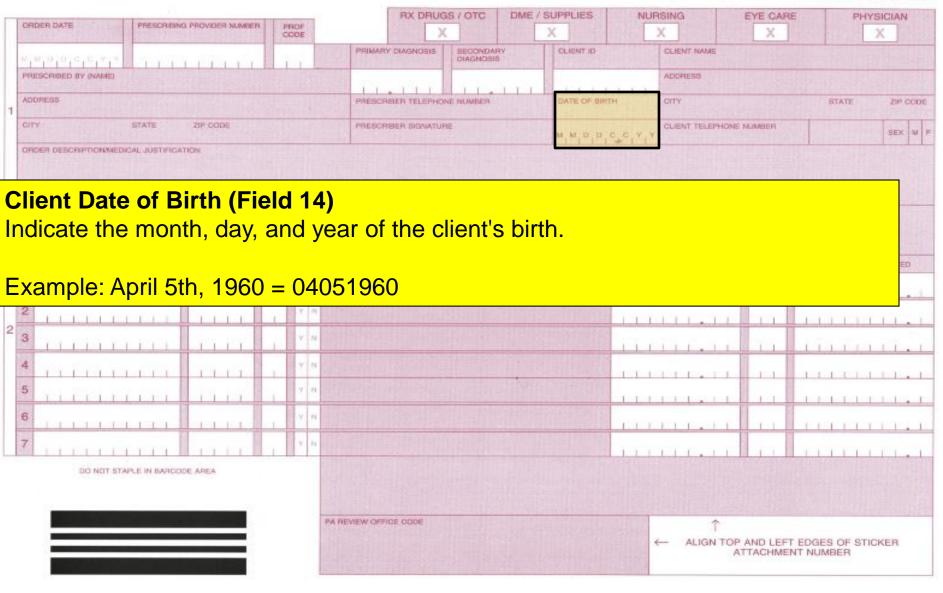
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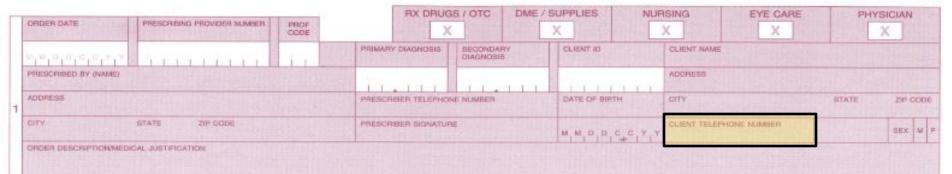
Client Address (Field 13) Enter the client's address

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ORDER/PRIOR APPROVAL REQUEST



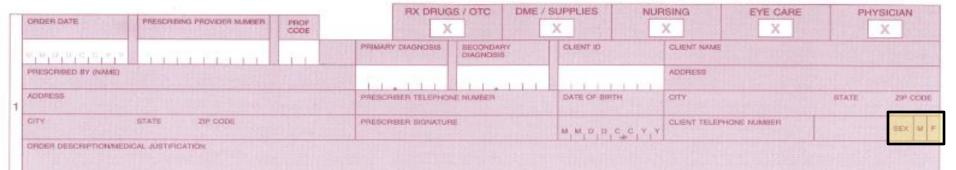
ORDER/PRIOR APPROVAL REQUEST



Client Telephone Number (Field 15) Enter the client's telephone number

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ORDER/PRIOR APPROVAL REQUEST



Client Sex (Field 16) Place an X on M for Male or F for Female to indicate the client's gender

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ORDER/PRIOR APPROVAL REQUEST

| - | | HX DRUG | IS/OTC DME/S | UPPLIES | NUF | ISING | EYE CARE | PHYSICIAN |
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| | ORDER DATE PRESCRIBING PROVIDER NUMBER PROF | X | | x | | x | X | x |
| | N_N_D_D_C_C_Y_V | PRIMARY DIAGNOSIS | DIAGNOBIS | CLIENT ID | | CLIENT NAME | | |
| | PRESCRIDED BY (NAME) | 1.1.1.1.1 | 11.111 | | | ADORESS | | |
| 1 | ADDRESS | PRESCRIBER TELEPHON | NE NUMBER | DATE OF BIR | TH | CITY | | STATE ZP CODE |
| | CITY STATE ZIP CODE | PRESCRIBER SIGNATUR | ιE. | M.M.D.D | C. C. Y. Y | | HOME NUMBER | SEX M F |
| | ORDER DESCRIPTIONYAEDICAL JUSTIFICATION | | | | | | | |
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| | ADORESS | | | | 1.1 | Net Here | | |
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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.



ORDER/PRIOR APPROVAL REQUEST

| - | | | | 1 | RX DRUG | S / OTC | DME / SUPPLI | ES | NURSING | EYE CARE | 100 | PHYSIC | IAN |
|---|-------------------------|-----------------------------|--|--------------|--------------|------------|--------------|----------|-------------------|---------------------------|--------------|-----------|----------|
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ORDER/PRIOR APPROVAL REQUEST

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| | ORDER DATE PRESCREING PROVIDER NUMBER PROF | > | | x | X | X | X |
| | N_N_D_0_C_C_Y_= | PRIMARY DIAGNOSIS | SECONDARY DIAGNOSIS | CLIENT ID | CLIENT NAME | | |
| | PRESCRIDED BY (NAME) | 1.1 | 11.11 | LI LI LI | ADDRESS | | |
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| | ORDER DESCRIPTION/MEDICAL JUSTIFICATION | | | | | | |
| | SERVICING PROVIDER NUMBER SERVICING PROVIDER NAME | TELEPHO | NE NUMBER | LDI | 5 DE | | |
| | ADDRESS | | | 1 | | | |
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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 NPI numbers in Field 17.

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ORDER/PRIOR APPROVAL REQUEST

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ORDER/PRIOR APPROVAL REQUEST

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ORDER/PRIOR APPROVAL REQUEST

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related correspondence.

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ORDER/PRIOR APPROVAL REQUEST

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ORDER/PRIOR APPROVAL REQUEST

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| | ORDER DESCRIPTION/MEDICAL JUSTIFICATION | 12210 | | 1112503 | | | Int high | | | | 1 1 1 |
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| | SERVICING PROVIDER NUMBER SERVICING PROVIDER NAME | | TELEPHON | E NUMBER | 121 - 121 | | LDC | | | | |
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ORDER/PRIOR APPROVAL REQUEST

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ORDER/PRIOR APPROVAL REQUEST

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| | which prior approval is being | | | Ŭ | | - |
| | which phot approval is being | equested | | | | |
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ORDER/PRIOR APPROVAL REQUEST

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ORDER/PRIOR APPROVAL REQUEST

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| | his amount, based on the estab | | | | | | | |
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ORDER/PRIOR APPROVAL REQUEST

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PA Review Office Code (Field 31)

This field is used to identify the state agency responsible for reviewing and issuing the prior approval

Code

A1 - Bureau of Medical Review and Payment, Office of Health Insurance Programs, NYS Department of Health

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Prior Approval Form - Mailing Addresses

Paper prior approval request forms with appropriate attachments should be sent to:

Regular Mail/Shipping:

eMedNY PO Box 4600 Rensselaer, NY 12144-4600

Expedited/Priority Shipping:

eMedNY 327 Columbia Turnpike ATTN: Box 4600 Rensselaer, NY 12144

Important Reminders

Prior Approval (PA) for all PDN services is <u>required</u> before the start of providing services

A PA request must be submitted by a Medicaid enrolled PDN or PDN Agency and ordered by a Medicaid enrolled Physician or Nurse Practitioner

It is the provider's responsibility to obtain and submit all necessary paperwork

> Approval of PDN services will be for a period of up to six months

Important Reminders

Full disclosure of primary insurance must be made to Medicaid. Providers must submit for approval to the primary insurance before requesting PDN hours from Medicaid

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

Prior Approval for PDN services can be requested on paper, electronically and on ePACES

Contact the eMedNY call center at 800-343-9000 to order paper Prior Approval request forms

Reference and Contact Information

- eMedNY Website
 - www.emedny.org
- Private Duty Nursing Manual
 - www.emedny.org/ProviderManuals/NursingServices/index.aspx
- eMedNY Call Center
 - 800-343-9000

THANK YOU





Prepared by GDIT

1/27/2023 11:28 AM