

**NEW YORK STATE
MEDICAID PROGRAM**

VISION CARE

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 Vision Care 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 through 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) 522-5518 or (518) 447-9860. 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 have been modified to comply with eMedNY requirements. A supply of the new forms is available by contacting CSC at the number above. Paper prior approval forms, with appropriate attachments, should be sent to Computer Sciences Corporation, PO Box 4600, Rensselaer, NY 12144-4600.

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. 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.

A prior approval request will not be processed after 90 days from the date of service unless the provider's request is delayed due to circumstances outside of the control of the provider. Such circumstances include the following:

- Litigation
- Medicare/third-party insurer processing delays


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- Delay in the Client's Medicaid eligibility determination
- Administrative delay by the department or other State agency

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 keypunch 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 \(eMedNY 361502\)](#)

NYS MEDICAL ASSISTANCE - TITLE XIX PROGRAM				ORDER/PRIOR APPROVAL REQUEST			
ORDER DATE <small>M M D D C C Y Y</small>	PRESCRIBING PROVIDER NUMBER	PROF CODE	RX DRUGS / OTC <input checked="" type="checkbox"/>	DME / SUPPLIES <input checked="" type="checkbox"/>	NURSING <input checked="" type="checkbox"/>	EYE CARE <input checked="" type="checkbox"/>	PHYSICIAN <input checked="" type="checkbox"/>
PRESCRIBED BY (NAME)			PRIMARY DIAGNOSIS	SECONDARY DIAGNOSIS	CLIENT ID	CLIENT NAME	
ADDRESS			PRESCRIBER TELEPHONE NUMBER		DATE OF BIRTH	CITY	STATE ZIP CODE
CITY STATE ZIP CODE			PRESCRIBER SIGNATURE		<small>M M D D C C Y Y</small>	CLIENT TELEPHONE NUMBER	SEX M F
ORDER DESCRIPTION/MEDICAL JUSTIFICATION							
SERVICING PROVIDER NUMBER		SERVICING PROVIDER NAME		TELEPHONE NUMBER		LOC CODE	
ADDRESS							
1	DRUG CODE (NDC)	PROCEDURE/ITEM CODE	MOD	RENTAL?	DESCRIPTION	QUANTITY REQUESTED	TIMES REQUESTED
2				Y N			
3				Y N			
4				Y N			
5				Y N			
6				Y N			
7				Y N			
DO NOT STAPLE IN BARCODE AREA				PA REVIEW OFFICE CODE ↑ ← ALIGN TOP AND LEFT EDGES OF STICKER ATTACHMENT NUMBER			
							

EMEDNY-361502 (1/08)

Section III - Field by Field (eMedNY 361502) Instructions

PRIOR APPROVAL REQUEST TYPE (Field 1)

Place an X in the box labeled eye care.

ORDER DATE (Field 2)

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

Example: October 7, 2005 = 10072005

ORDER DATE									
1	0	0	7	2	0	0	5		

Prescribing Provider Number (Field 3)

If the Prior Approval is for dispensing only, enter the 10 digit Prescribing Provider's ID Number as in the example below.

Example:

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

PROF CODE (Field 4)

Leave this field blank.:

PRESCRIBED BY (NAME) (Field 5)

If the Prior Approval is for dispensing only, print the last name followed by the first name of the Practitioner initiating the order.

ADDRESS (Field 6)

If the Prior Approval is for dispensing only, enter the Prescriber's address.

PROVIDER TELEPHONE NUMBER (Field 7)

If the Prior Approval is for dispensing only, enter the Prescriber's telephone number.

PRESCRIBER SIGNATURE (Field 8)

Leave this field blank.

PRIMARY DIAGNOSIS (Field 9)

Leave this field blank.

SECONDARY DIAGNOSIS (Field 10)

Leave this field blank.

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 is an alpha.

CLIENT NAME (Field 12)

Enter the last name followed by the first name of the Client as it appears on the Common Benefit 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 telephone number.

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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)

Briefly describe the nature of the ocular condition or vision problem, treatment goals, and prognosis. Include the estimated treatment plan, the time necessary to complete each portion of treatment, and visual acuity with and without correction as appropriate. Attach additional pages of documentation as necessary.

SERVICING PROVIDER NO. (Field 18)

Enter the 10 digit Servicing 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 exact name, last name first.

ADDRESS (Field 20)

Enter the address.

TELEPHONE NUMBER (Field 21)

Enter office telephone number.

LOC CODE (Field 22)

Enter the 3-digit location code to specify where you would like to receive PA related correspondence.

DRUG CODE (NDC) (Field 23)

Leave this field blank.

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ITEM CODE (Field 24)

This code indicates the service to be rendered to the client. Refer to the procedure code section of this Manual. Enter the appropriate five-character code.

Example:

PROCEDURE/ ITEM CODE				
V	2	1	9	9

MOD (Field 25)

Enter a two-character modifier, if required.

RENTAL? (Field 26)

Leave this field blank.

DESCRIPTION (Field 27)

Enter the description corresponding to the Procedure Code entered in Field 24 above.

QUANTITY REQUESTED (Field 28)

Enter the number of units required in the far right column(s). Unused spaces to the left should be zero filled.

Example: Quantity of 2

QUANTITY REQUESTED						
0	0	0	0	0	2	•

TIMES REQUESTED (Field 29)

Leave this field blank.

TOTAL AMOUNT REQUESTED (Field 30)

Enter the dollar amount requested for the procedure. The dollar amount should be sufficient to cover the total units requested (e.g., reimbursement for a pair of lenses).

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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. Enter code **A1**.

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