

**NEW YORK STATE
MEDICAID PROGRAM**

DURABLE MEDICAL EQUIPMENT (DME)

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 Durable Medical Equipment (DME) 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 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 forms, with all 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.

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

DME Prior Approval Guidelines


- 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.

Items requiring DVS validation (enteral formulae, diapers, orthopedic footwear, DME and orthotic and prosthetic appliances) must be electronically approved on the date of service.

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		RX DRUGS / OTC <input checked="" type="checkbox"/>		DME / SUPPLIES <input checked="" type="checkbox"/>	
PRESCRIBED BY (NAME)		PRIMARY DIAGNOSIS		SECONDARY DIAGNOSIS		CLIENT ID	
ADDRESS		PRESCRIBER TELEPHONE NUMBER		DATE OF BIRTH		CLIENT NAME	
CITY		STATE		ZIP CODE		CLIENT TELEPHONE NUMBER	
CITY		STATE		ZIP CODE		SEX M F	
ORDER DESCRIPTION/MEDICAL JUSTIFICATION							
SERVICING PROVIDER NUMBER		SERVICING PROVIDER NAME		TELEPHONE NUMBER		LOC CODE	
ADDRESS							
1	2	3	4	5	6	7	8
DRUG CODE (NDC)	PROCEDURE/ITEM CODE	MOB	RENTAL?	DESCRIPTION	QUANTITY REQUESTED	TIMES REQUESTED	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							
				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 appropriate box for the type of service/supply for which Prior Approval is being requested.

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)

Enter the 10 digit Prescribing Provider's 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 blank

PRESCRIBED BY (NAME) (Field 5)

Print the last name followed by the first name of the Practitioner initiating the order.

ADDRESS (Field 6)

Enter the Prescriber's address.

PROVIDER TELEPHONE NUMBER (Field 7)

Enter the Prescriber's telephone number.

PRESCRIBER SIGNATURE (Field 8)

The Prescribing Provider must sign the form in this field except in the following circumstance: If the Prescribing Provider has written a fiscal order on other than the eMedNY 361502, the Dispensing Provider must write "Appears on Order" in this field. The Dispensing Provider must maintain the signed order in his/her files for six years following the date of payment.

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. ICD is the *International Classification of Diseases - Clinical Modification Coding System*.

Example:

PRIMARY DIAGNOSIS					
E	7	0	3	1	9

SECONDARY DIAGNOSIS (Field 10)

Enter the appropriate ICD diagnosis code which 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 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.

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)

Enter a detailed description of the supply/equipment/appliance prescribed, and indicate the reason for medical necessity (abbreviations may be used). Medical justification should include the patient's weight, height, a description of functional status and caretaking arrangements (if any) the presence of existing equipment or appliances, and the appropriateness of requested equipment within the patient's environment. Also, indicate the probable length of time the Client will require the item and if the Client has used this item previously.

If a medical/surgical supply has been ordered, the number of refills requested must be indicated.

SERVICING PROVIDER NO (Field 18)

Enter the 10-digit servicing provider number. This should be number of the provider who will supply the item and bill MMIS. .

Example:

SERVICING PROV NO									
0	1	2	3	4	5	6	7	8	9

SERVICING PROVIDER NAME (Field 19)

Enter the exact name, last name first, under which you enrolled in MMIS.

ADDRESS (Field 20)

Enter the address.

TELEPHONE NUMBER (Field 21)

Enter the office telephone number.

LOC CODE (Field 22)

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

DRUG CODE (NDC) (Field 23)

Leave blank.

PROCEDURE / ITEM CODE (Field 24)

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

MOD (Field 25)

Enter a two character modifier, if required.

RENTAL? (Field 26)

Enter an X in the appropriate space to indicate whether or not the rental of a DME item is being requested.

DESCRIPTION (Field 27)

Enter the description corresponding to the code entered in Field 24 above.

QUANTITY REQUESTED (Field 28)

Enter the number of units of the specific item being ordered to the left of the decimal point.

Example: Quantity of 32

QUANTITY REQUESTED									
					3	2	•		

Example: Quantity of 1

QUANTITY REQUESTED									
						1	•		

If the prior approval request is for a medical/surgical supply, enter the total number of units to be dispensed in the initial filling plus any refills which have been ordered (i.e., Quantity requested = quantity in initial filling + quantity in first refill, if applicable, + quantity in second refill, if applicable, etc.).

Note: The number of refills requested by the Dispensing Provider may not exceed the lower of:

- The number of refills requested by the Prescribing Provider; or**
- The number of refills indicated in the REFILLS column of the procedure code section of the Manual.**

TIMES REQUESTED (Field 29)

If the item is being purchased, leave this field blank. However, if the item is a rental, enter the number of months for which the item is requested.

Example: Four (4) months Requested = 4 (Written as 004).

TOTAL AMOUNT REQUESTED (Field 30)

Enter the total dollar amount for the item(s) requested. For rentals, enter the total dollar amount for the number of months the item(s) is requested.

Example: A patient lift of which the Maximum Reimbursable Amount (MRA) to the provider is \$1,035.36 has been requested for three months use. If the monthly rate is one-tenth of the MRA, then the amount is determined as follows:

$$\frac{1}{10} \times \$1,035.36 \times 3 \text{ months} = \$310.60$$

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' for all DME prior approval requests.