

**NEW YORK STATE  
MEDICAID PROGRAM**

**PHYSICIAN**

**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 Physicians 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](#) section. 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](http://www.emedny.org).

Prior approval requests can also be requested via ePACES. ePACES is an internetbased 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](http://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.

### **Expedited / Priority Shipping:**

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. 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
- 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 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.

Physician Prior Approval Guidelines

[\(Prior Approval Form \(eMedNY 361502\)\)](#)

**NYS MEDICAL ASSISTANCE - TITLE XIX PROGRAM** **ORDER/PRIOR APPROVAL REQUEST**

|  |                             |                         |  |  |   |  |   |
|--|-----------------------------|-------------------------|--|--|---|--|---|
| ORDER DATE<br><small>M M D D C C Y Y</small> | PRESCRIBING PROVIDER NUMBER | PROP CODE               | <input checked="" type="checkbox"/> 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 |
| 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 | MOQ | RENTAL? | DESCRIPTION | QUANTITY REQUESTED | TIMES REQUESTED | TOTAL AMOUNT 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

### **PROVIDER TYPE (Field 1)**

Place an X in the box labeled Physician.

### **ORDER DATE (Field 2)**

Indicate the month, day, and year on which the request is submitted.

**Example:** October 1, 2005 = 10012005

|            |   |   |   |   |   |   |   |
|------------|---|---|---|---|---|---|---|
| ORDER DATE |   |   |   |   |   |   |   |
| 1          | 0 | 0 | 1 | 2 | 0 | 0 | 5 |

### **PRESCRIBING PROVIDER NUMBER (Field 3)**

Leave blank.

### **PROF CODE (Field 4)**

Leave blank.

### **PRESCRIBED BY (NAME) (Field 5)**

Leave blank.

### **ADDRESS (Field 6)**

Leave blank.

### **PROVIDER TELEPHONE NUMBER (Field 7)**

Leave blank.

### **PRESCRIBER SIGNATURE (Field 8)**

The physician must sign his/her name in this field.

**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 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 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 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)**

This field is provided to allow for supplementary information concerning the service/treatment plan.

**SERVICING PROVIDER NO (Field 18)**

Enter the 10-digit servicing provider number..

**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, under which you enrolled.

**ADDRESS (Field 20)**

Enter the address.

**TELEPHONE NUMBER (Field 21)**

Enter office telephone number.

**LOC CODE (Field 22)**

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

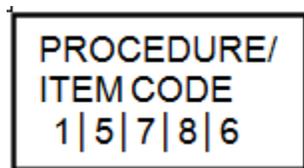
**DRUG CODE (NDC) (Field 23)**

Leave blank.

**PROCEDURE / ITEM CODE (Field 24)**

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

**Example:**



**MOD (Field 25)**

Enter a two-character modifier, if required.

**RENTAL? (Field 26)**

Leave blank.

**DESCRIPTION (Field 27)**

Enter the description corresponding to the Procedure/Item 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 32

Physician Prior Approval Guidelines

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|                    |  |  |  |   |   |   |  |  |  |
|--------------------|--|--|--|---|---|---|--|--|--|
| QUANTITY REQUESTED |  |  |  |   |   |   |  |  |  |
|                    |  |  |  | 3 | 2 | . |  |  |  |

**Example:** Quantity of 1

|                    |  |  |  |  |   |   |  |  |  |
|--------------------|--|--|--|--|---|---|--|--|--|
| QUANTITY REQUESTED |  |  |  |  |   |   |  |  |  |
|                    |  |  |  |  | 1 | . |  |  |  |

**TIMES REQUESTED (Field 29)**

Leave 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.

**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 Medicaid Management, NYS Department of Health