NEW YORK STATE
MEDICAID PROGRAM

NEW YORK CITY
TRANSPORTATION

PRIOR AUTHORIZATION GUIDELINES

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Preface

Requests for the transportation of Medicaid eligible clients whose county of fiscal responsibility is outside the five boroughs comprising New York City must be referred to the department of social services in the county who retains fiscal responsibility for the client.

Section I - Purpose Statement

The purpose of this document is to assist the New York City provider community to understand and comply with the New York State Medicaid (NYS-Medicaid) requirements and expectations for:

- Obtaining prior authorization
- Field by Field Instructions for Prior Approval Form (eMedNY 389701)
- Field by Field Instructions for Prior Approval Form (eMedNY 410601)

This document is customized for Transportation Services 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 Authorization for the Transportation of New York City Medicaid Clients

Electronic prior approval requests can be submitted on the HIPAA 278 transaction. The Companion Guide for the HIPAA 278 is available online at:

www.emedny.org

- Click on **NYHIPAADESK**, then
- Click on **eMedNY Companion Guides and Sample Files**, then
- Click on **278 Request Prior Approval CG**

Access to the final determinations will be available through eMedNY eXchange messages or by mail. To sign up for eXchange, please go to:

http://www.emedny.org/selfhelp/index.html.

For orderers, a supply of the paper prior approval forms is available by contacting the eMedNY Call Center at:

(800) 343-9000 option 1, sub-option 4

Original paper prior approval request forms should be mailed 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 389701) and the New York State Medical Assistance (Title XIX) Group Transportation Prior Approval Form (eMedNY 410601).

> 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.

Prior authorization is required for all non-emergency transportation (including transportation by providers to Day Treatment sites) and must be obtained by the client's physician, physician assistant, dentist, podiatrist, optometrist, nurse practitioner, or designated medical professional. If authorization is granted, the transportation provider and the ordering provider each will receive a copy of the Transportation Prior Approval Roster and under no circumstances should a transportation provider request prior

authorization.

To obtain prior authorization for non-emergency transportation of New York City clients, the ordering provider must either:

- contact the eMedNY Call Center at (800) 343-9000 option 3, sub-option 2 or
- complete the eMedNY 389701 form and submit it to the eMedNY Contractor, Computer Sciences Corporation (CSC).

Prior authorization for Group Transportation (day treatment) may be requested by the Day Treatment Center using the eMedNY 410601 Group Transportation Prior Approval Form. Forms may be obtained from CSC. These prior authorizations will appear on the transportation provider's prior authorization roster. These prior authorizations may encompass from one to 12 months.

Requests for prior authorizations should be submitted before the date of service. However, sometimes unforeseen circumstances arise that delay the submission of the prior authorizations request until after the service is provided.

To reduce processing errors (and subsequent processing delays) do not run-over writing or typing from one field (box) into another.

The displayed Prior Approval Request Forms are numbered in each field to correspond with the instructions for completing the request.

Section III - Field by Field (eMedNY 389701) Instructions

The eMedNY 389701 Prior Approval Form should only be used when non-emergency transportation is being requested for New York City clients.

> This form is exclusive for New York City clients and should never be used otherwise.

ORDERING PROVIDER NUMBER (Field 1)

The Provider Identification Number of the provider that is ordering the trip(s) is entered in this field. This number will always be a Medicaid Provider Identification Number, not a license number. Right justify the information as shown in the example below.

Example:

ORDERING PROVIDER NUMBER								
	0	0	6	7	2	4	6	8

NAME AND ADDRESS (ORDERING PROVIDER) (Field 2)

The name and address of the ordering provider.

PROC CODE (Field 3)

The appropriate procedure code is to be entered in the field.

TRANSPORTATION PROVIDER NUMBER (Field 4)

The Provider Identification Number of the transportation provider is entered in this field.

NAME AND ADDRESS (TRANSPORTATION COMPANY) (Field 5)

The transportation company's name and address.

CLIENT ID (Field 6)

The client's Medicaid ID number is entered in this field. If the number is invalid, a reject will be caused and will appear on your weekly roster.

BEGINNING DATE OF SERVICE (Field 7)

The first date of service for this prior authorization is entered in this field.

NO. OF UNITS (Field 8)

The total number of one-way trips is entered in this field. A round trip is indicated by 002.

CAL DAYS (Calendar Days) (Field 9)

The total number of calendar days to cover the entire period of the prior authorization.

APPT TIME (Appointment Time) (Field 10)

This field indicates the time of appointment for the Medicaid client. This field may be left blank by the ordering provider.

DESTINATION (Field 11)

This field may be left blank by the ordering provider.

CLIENT NAME (Field 12)

The client's name, last name followed by first name, is entered in this field.

ADDRESS (Field 13)

This field may be left blank by the ordering provider.

FOR OFFICIAL USE ONLY (Field 14)

Leave this field blank.

SIGNATURE (Field 15)

An authorized agent for the ordering provider **must** sign the form in this field.

DATE (Field 16)

Enter the date the form was signed.

NYS MEDICAL ASSISTANCE – TITLE XIX PROGRAM **TRANSPORTATION PRIOR APPROVAL**

1. ORDERING PROVIDER NUMBER	2. NAME / ADDRESS	3. PROC CODE	4. TRANSPORTATION PROVIDER NUMBER	5. NAME / ADDRESS

6. CLIENT ID	7. BEGINNING DATE OF SERVICE	8. NO. OF UNITS	9. CAL. DAYS	10. APPT TIME	11. DESTINATION	12. CLIENT NAME	13. ADDRESS
	M|M|D|D|C|C|Y|Y						
	M|M|D|D|C|C|Y|Y						
	M|M|D|D|C|C|Y|Y						
	M|M|D|D|C|C|Y|Y						
	M|M|D|D|C|C|Y|Y						
	M|M|D|D|C|C|Y|Y						
	M|M|D|D|C|C|Y|Y						
	M|M|D|D|C|C|Y|Y						
	M|M|D|D|C|C|Y|Y						
	M|M|D|D|C|C|Y|Y						

14. FOR OFFICIAL USE ONLY

DO NOT STAPLE IN BARCODE AREA

I certify that the above orders are for trips that are medically necessary at the level of transportation ordered. And that statements on the reverse side apply to this order and are made a part hereof.

15. SIGNATURE	16. DATE
	M|M|D|D|C|C|Y|Y

EMEDNY–389701 (04/04)

Section IV - Field by Field (eMedNY 410601) Instructions

The eMedNY 410601 Prior Approval Form should only be used when non-emergency transportation is being requested for New York City clients.

> This form is exclusive for New York City clients and should never be used otherwise.

TREATMENT CENTER PROVIDER ID (Field 1)

The Provider Identification Number of the treatment center provider is entered in this field. This number will always be a Medicaid Provider Identification Number, not a license number. Right justify the information as shown in the example below.

Example:

TREATMENT CENTER PROVIDER ID									
		0	0	6	7	2	4	6	8

NAME, ADDRESS AND TELEPHONE (TREATMENT CENTER PROVIDER) (Field 2)

The name, address and telephone number of the treatment center provider.

BEGINNING DATE (Field 4)

The first date of service for this prior authorization is entered in this field.

TRANSPORTATION PROVIDER NUMBER (Field 5)

The Provider Identification Number of the transportation provider is entered in this field.

NAME, ADDRESS AND GARAGE (TRANSPORTATION COMPANY) (Field 6)

The transportation company's name, address and garage.

DESTINATION (Field 7)

This field may be left blank.

CLIENT ID (Field 8)

The client's Medicaid ID number is entered in this field. If the number is invalid, a reject will be caused and will appear on your weekly roster.

PROC CODE (Field 9)

The appropriate procedure code is to be entered in the field.

NO. OF UNITS (Field 10)

The total number of one-way trips is entered in this field. A round trip is indicated by 002.

CAL DAYS (Calendar Days) (Field 11)

The total number of calendar days to cover the entire period of the prior authorization.

CLIENT NAME (Field 12)

The client's name, last name followed by first name, is entered in this field.

ADDRESS (Field 13)

This field may be left blank by the treatment center provider.

WHEEL CHAIR (Field 14)

This a Yes/No field where the provider puts a Y or N in this field to indicate if the client uses a wheel chair or not.

DATE OF BIRTH (Field 15)

The client's date of birth.

SEX (Field 16)

The client's sex.

TREATMENT CENTER AUTHORIZED SIGNATURE (Field 17)

An authorized agent for the treatment center provider **must** sign the form in this field.

DATE (Field 18)

Enter the date the form was signed.

GROUP TRANSPORTATION AUTHORIZED SIGNATURE (Field 19)

An authorized agent for the group transportation provider **must** sign the form in this field.

DATE (Field 20)

Enter the date the form was signed.

FOR OFFICIAL USE ONLY (Field 22)

Leave this field blank.

NYS MEDICAL ASSISTANCE – TITLE XIX PROGRAM

GROUP TRANSPORTATION PRIOR APPROVAL

1. TREATMENT CENTER PROVIDER ID	2. NAME ADDRESS TELEPHONE	4. BEGINNING DATE M|M|D|D|C|C|Y|Y	5. TRANSPORTATION PROVIDER NUMBER	6. NAME ADDRESS GARAGE

7. DESTINATION

	8. CLIENT ID	9. PROCEDURE CODE	10. NO. OF UNITS	11. CAL. DAYS	12. CLIENT NAME	13. ADDRESS	14. WHEEL CHAIR	15. DATE OF BIRTH	16. SEX
1									
2									
3									
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5									
6									
7									
8									
9									
10									
11									
12									
13									
14									

[redacted]

DO NOT STAPLE IN BARCODE AREA

22. FOR OFFICIAL USE ONLY

I certify that the above orders are for trips that are medically necessary at the level of transportation ordered. And that statements on the reverse side apply to this order and are made a part hereof.

17. TREATMENT CENTER AUTHORIZED SIGNATURE	18. DATE M|M|D|D|C|C|Y|Y
19. GROUP TRANSPORTATION AUTHORIZED SIGNATURE	20. DATE M|M|D|D|C|C|Y|Y

EMEDNY-410601 (04/04)