Prior Approval for Private Duty Nursing

Paper Form

(eMedNY 361502)

NEW YORK STATE | Department of Health | Medicaid Program

AGENDA

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

Private Duty Nursing Resources

eMedNY Website – www.emedny.org

Private Duty Nursing Resources

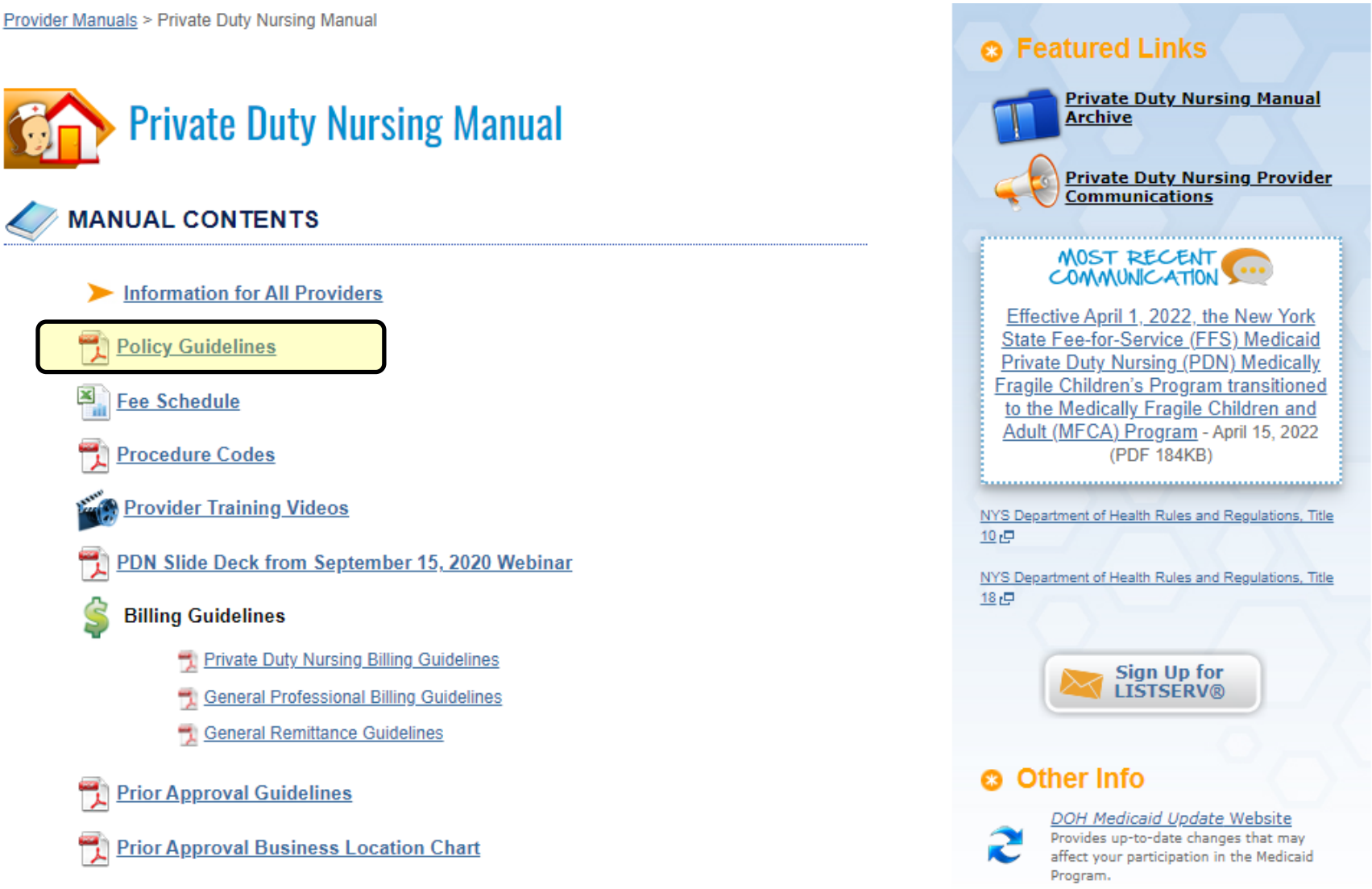
PDN Provider Manual

Private Duty Nursing Resources

PDN Provider Manual

Private Duty Nursing Resources

PDN Policy Guidelines



Provider Manuals > Private Duty Nursing Manual

Private Duty Nursing Manual

MANUAL CONTENTS

- Information for All Providers
- Policy Guidelines
- Fee Schedule
- Procedure Codes
- Provider Training Videos
- PDN Slide Deck from September 15, 2020 Webinar
- Billing Guidelines
  - Private Duty Nursing Billing Guidelines
  - General Professional Billing Guidelines
  - General Remittance Guidelines
- Prior Approval Guidelines
- Prior Approval Business Location Chart

Featured Links

Private Duty Nursing Manual Archive

Private Duty Nursing Provider Communications

MOST RECENT COMMUNICATION

Effective April 1, 2022, the New York State Fee-for-Service (FFS) Medicaid Private Duty Nursing (PDN) Medically Fragile Children's Program transitioned to the Medically Fragile Children and Adult (MFCA) Program - April 15, 2022 (PDF 184KB)

NYS Department of Health Rules and Regulations, Title 10

NYS Department of Health Rules and Regulations, Title 18

Sign Up for LISTSERV®

Other Info

DOH Medicaid Update Website
Provides up-to-date changes that may affect your participation in the Medicaid Program.

Private Duty Nursing Resources

PDN Prior Approval Requirements

PDN Manual

eMedNY > Private Duty Nursing Provider Policy

NEW YORK STATE OF OPPORTUNITY. Department of Health

Table of Contents

Private Duty Nursing Resources

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 6.8 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 5.1 for detailed requirements	✓	✓	✓

Private Duty Nursing Resources

PDN Fee Schedule

Private Duty Nursing Resources

PDN Procedure Codes

Private Duty Nursing Resources

PDN Billing Guidelines

Private Duty Nursing Manual

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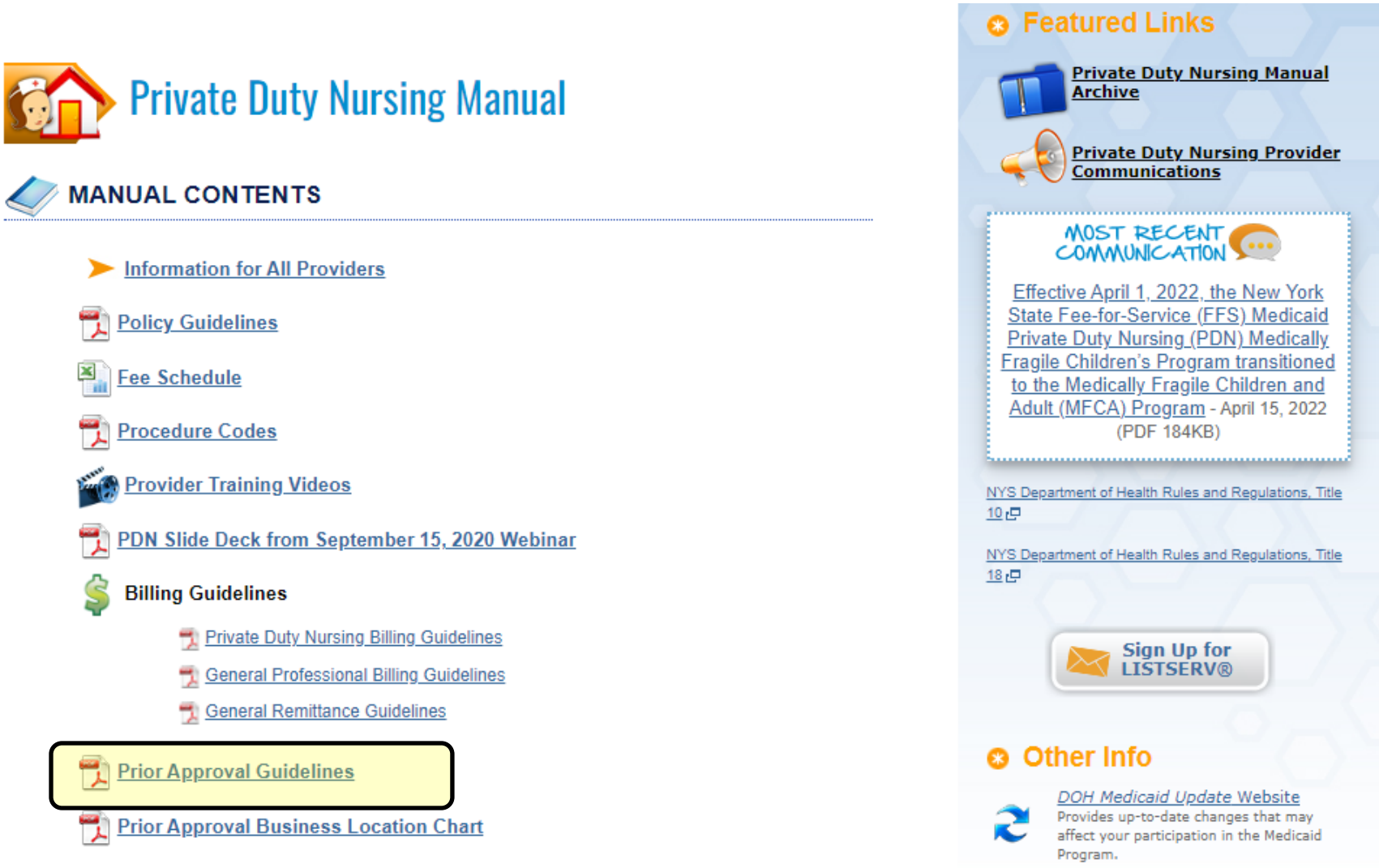
Private Duty Nursing Resources

PDN Prior Approval Guidelines



Most Recent Communication

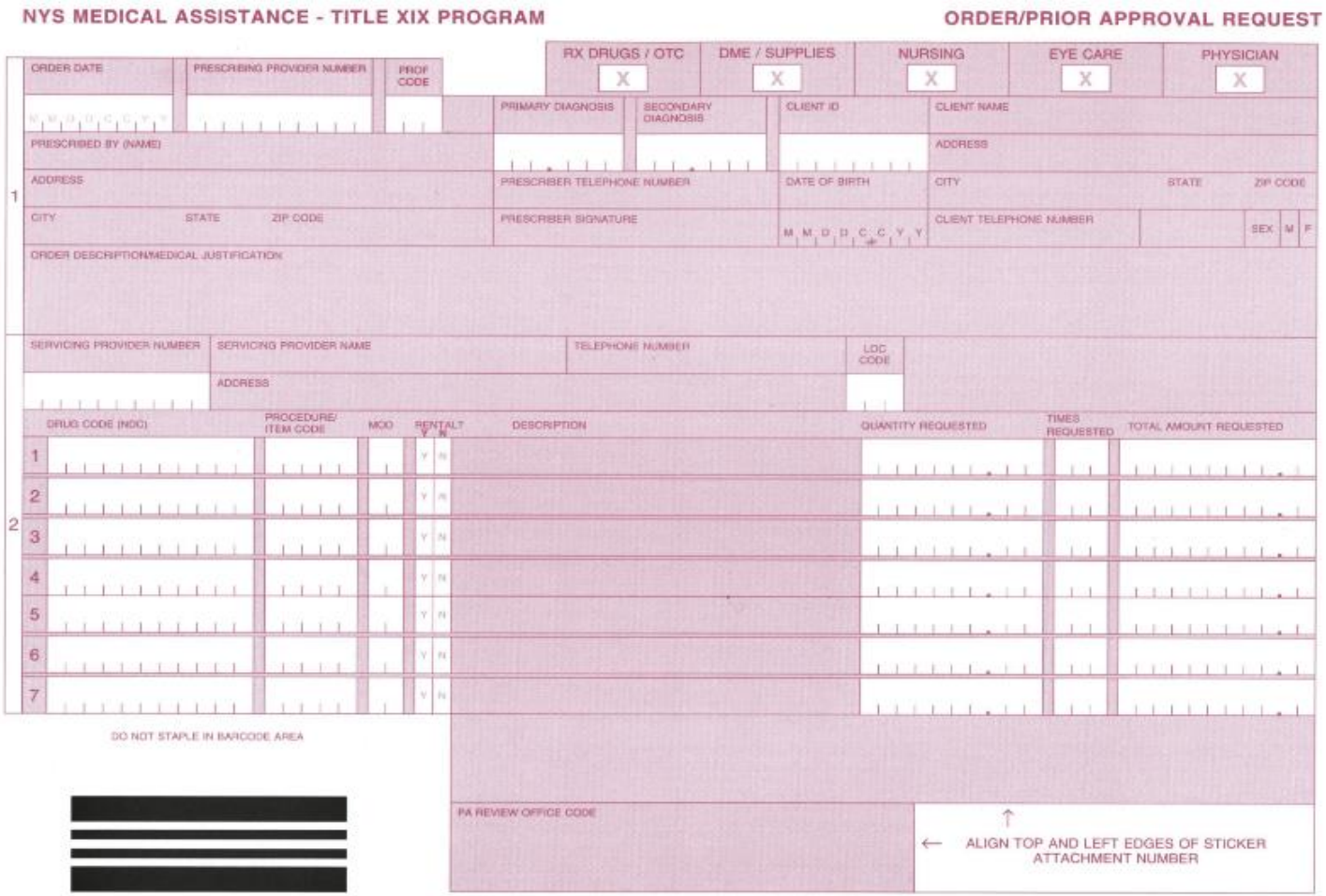
Medically Fragile Children and Adult Program

Prior Approval - General Information

- Prior Approval (PA) for all PDN services is required 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

RX DRUGS / OTC | DME / SUPPLIES | NURSING | EYE CARE | PHYSICIAN

ORDER DATE | PRESCRIBING PROVIDER NUMBER | PROF CODE

PRIMARY DIAGNOSIS | SECONDARY DIAGNOSIS | CLIENT ID | CLIENT NAME

PRESCRIBED BY (NAME) | ADDRESS

ADDRESS | PRESCRIBER TELEPHONE NUMBER | DATE OF BIRTH | CITY | STATE | ZIP CODE

CITY | STATE | ZIP CODE | PRESCRIBER SIGNATURE | CLIENT TELEPHONE NUMBER | SEX

ORDER DESCRIPTION/MEDICAL JUSTIFICATION

SERVICING PROVIDER NUMBER | SERVICING PROVIDER NAME | TELEPHONE NUMBER | LOC CODE

ADDRESS

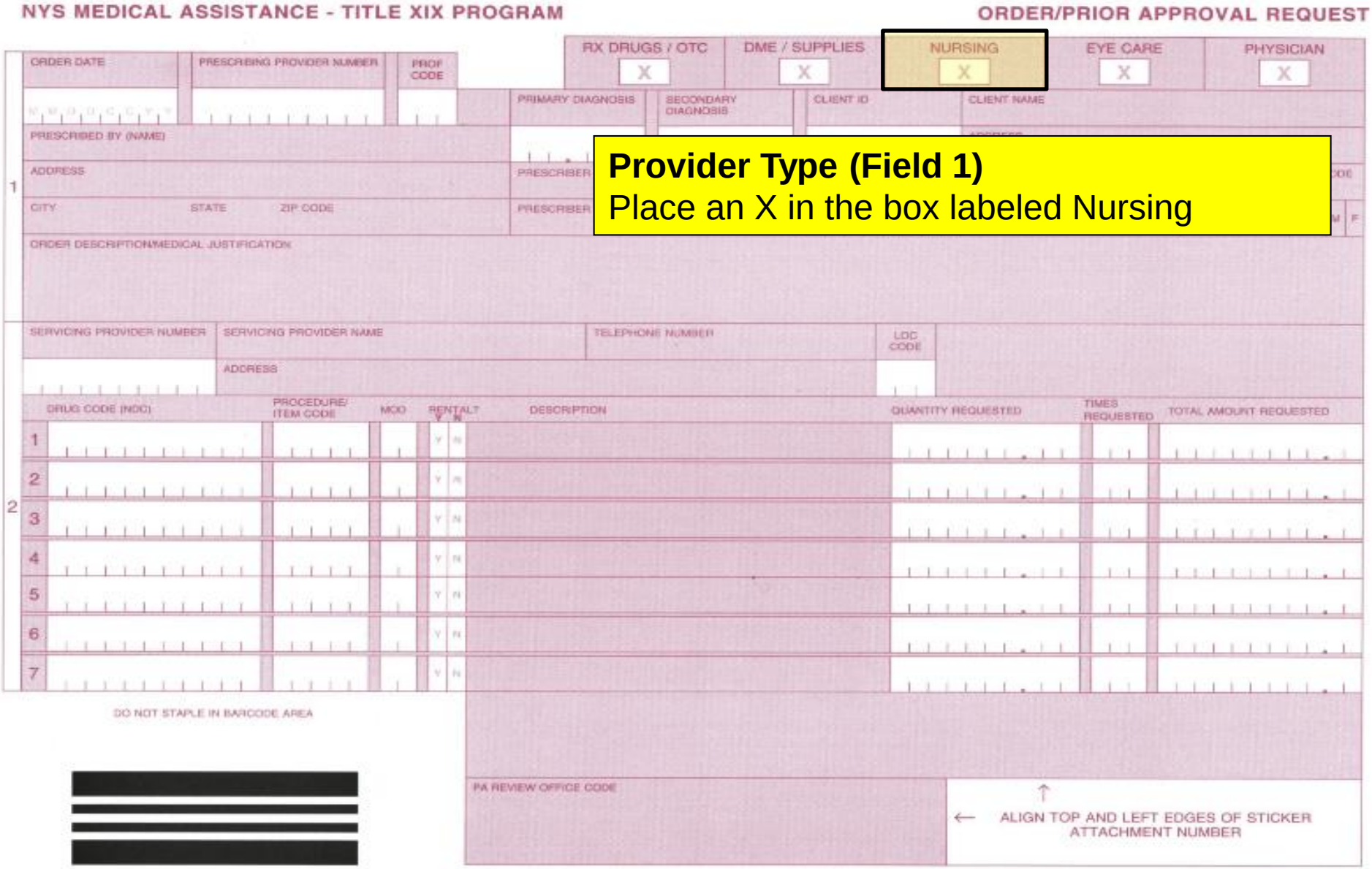
	DRUG CODE (NDC)	PROCEDURE/ ITEM CODE	MOD	RENTAL	DESCRIPTION	QUANTITY REQUESTED	TIMES REQUESTED	TOTAL AMOUNT REQUESTED
1				Y N				
2				Y N				
3				Y N				
4				Y N				
5				Y N				
6				Y N				
7				Y N				

DO NOT STAPLE IN BARCODE AREA

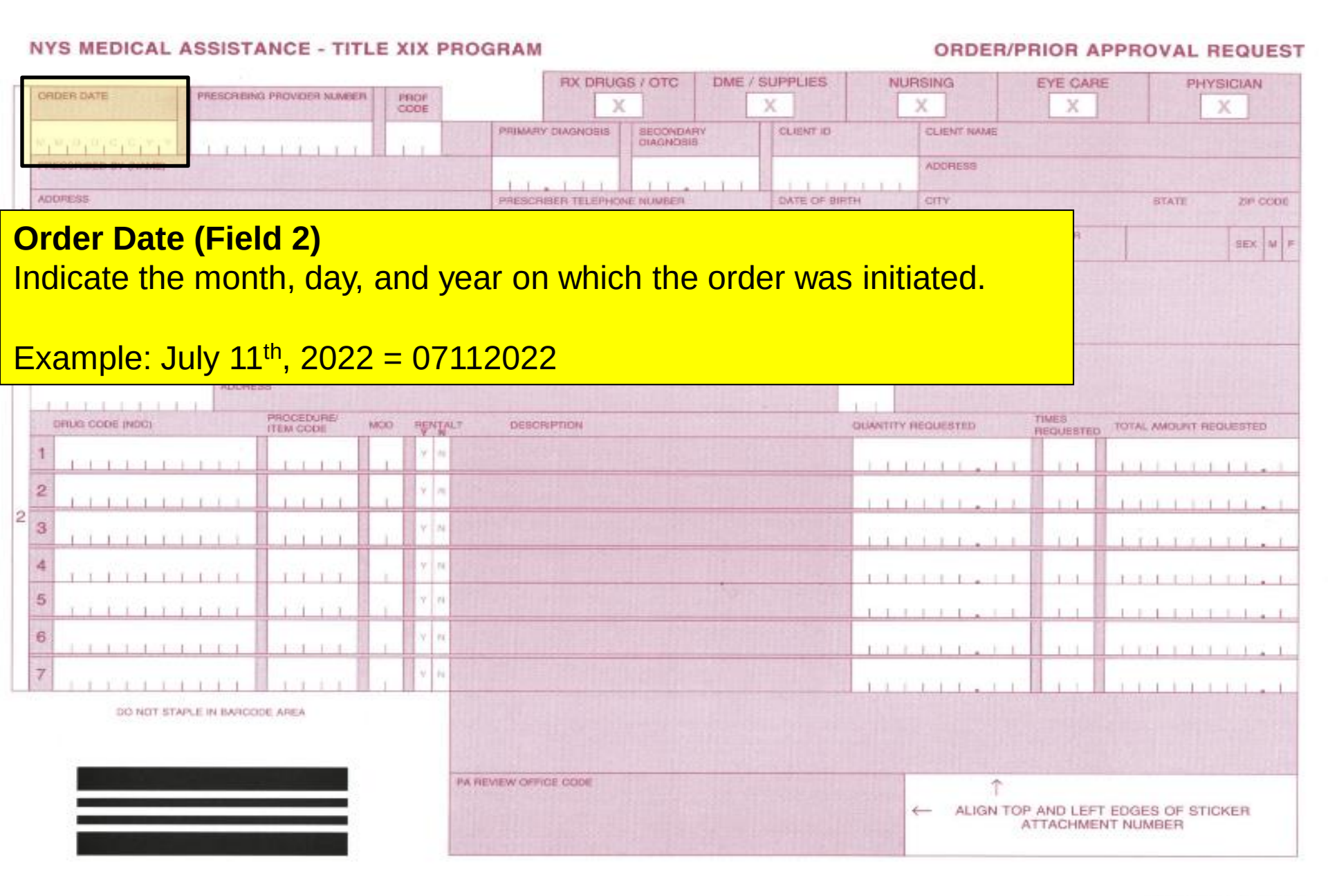
PA REVIEW OFFICE CODE

ALIGN TOP AND LEFT EDGES OF STICKER ATTACHMENT NUMBER

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

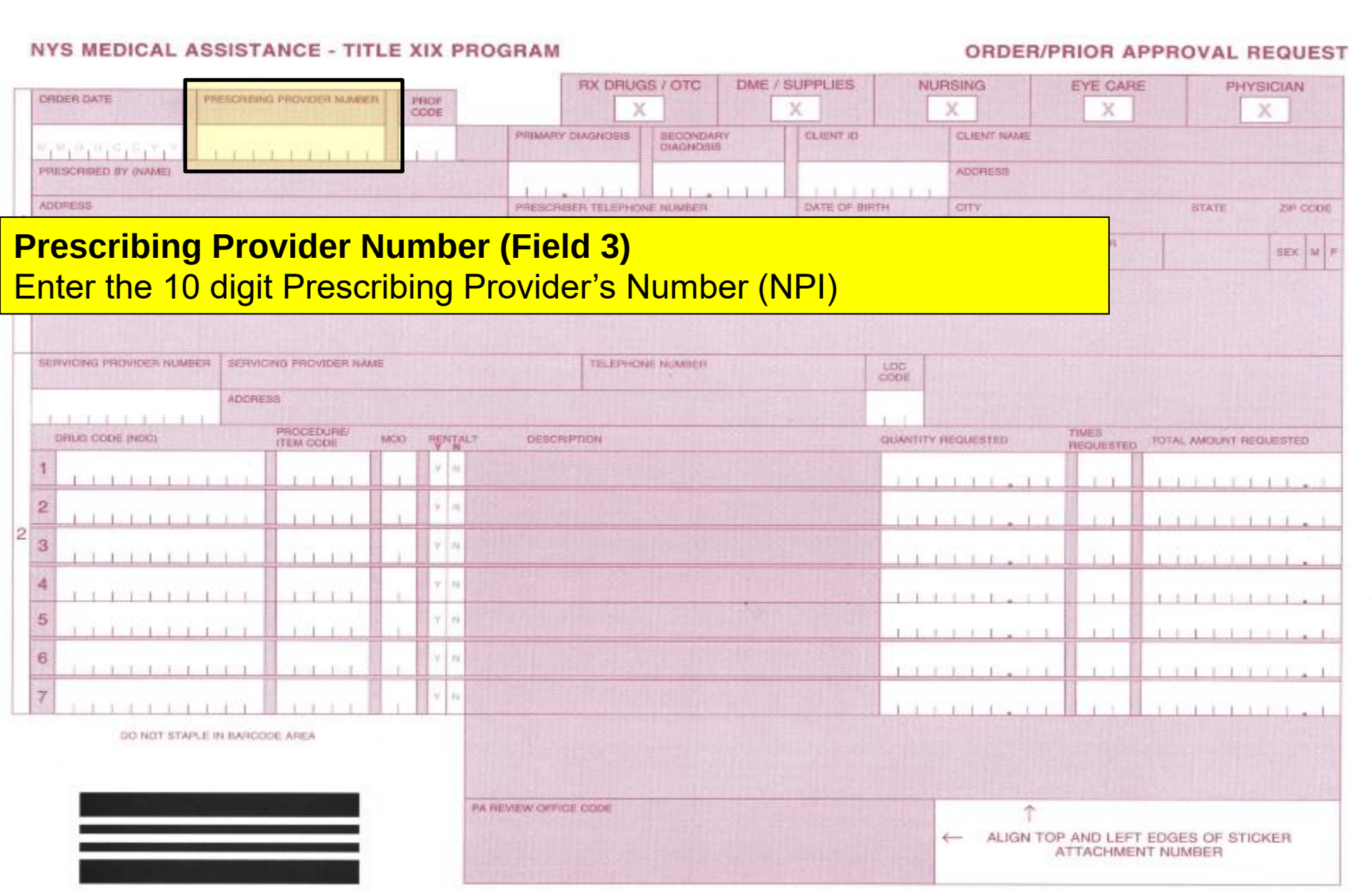


Provider Type (Field 1)
Place an X in the box labeled Nursing



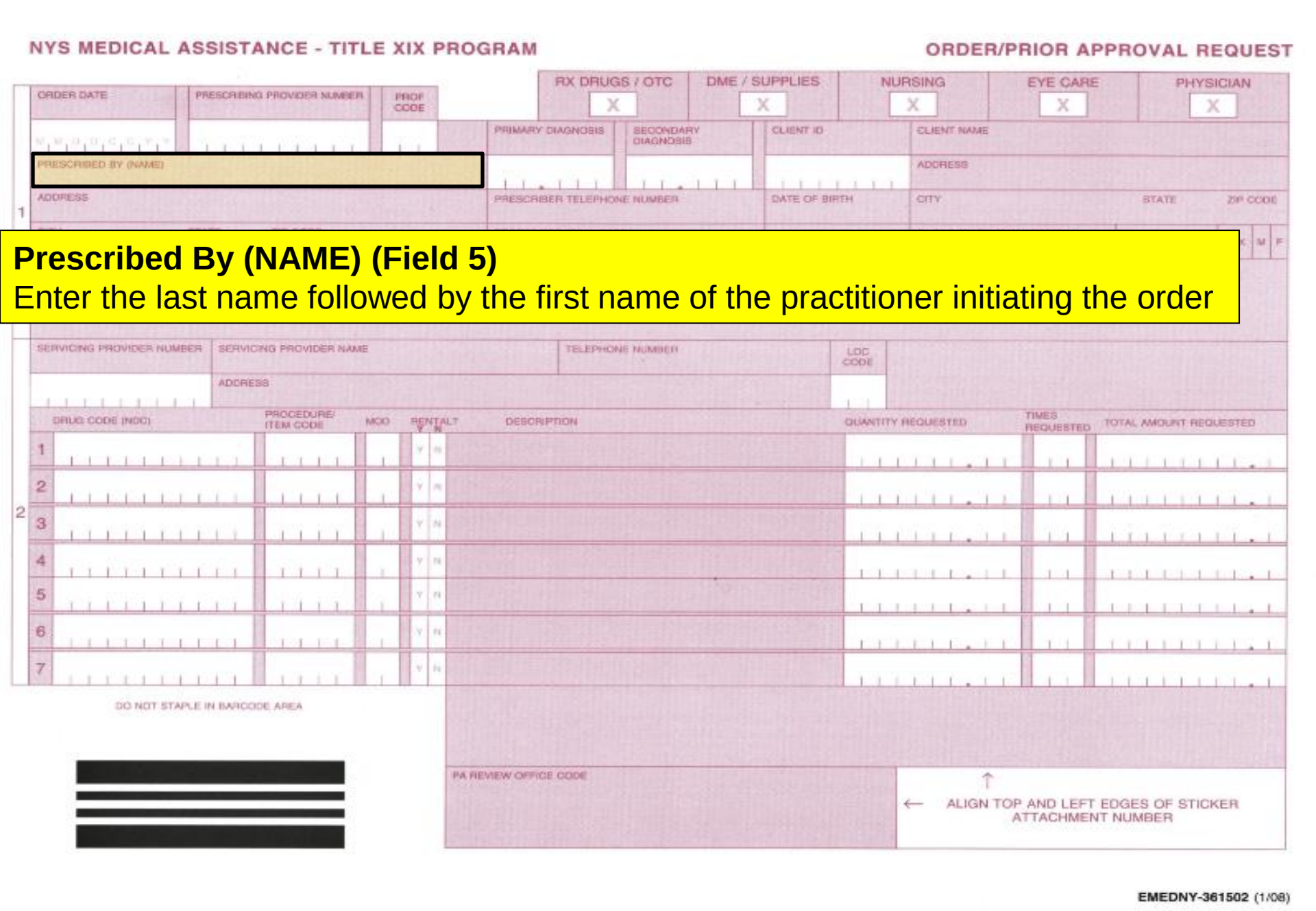
Order Date (Field 2)
Indicate the month, day, and year on which the order was initiated.

Example: July 11th, 2022 = 07112022



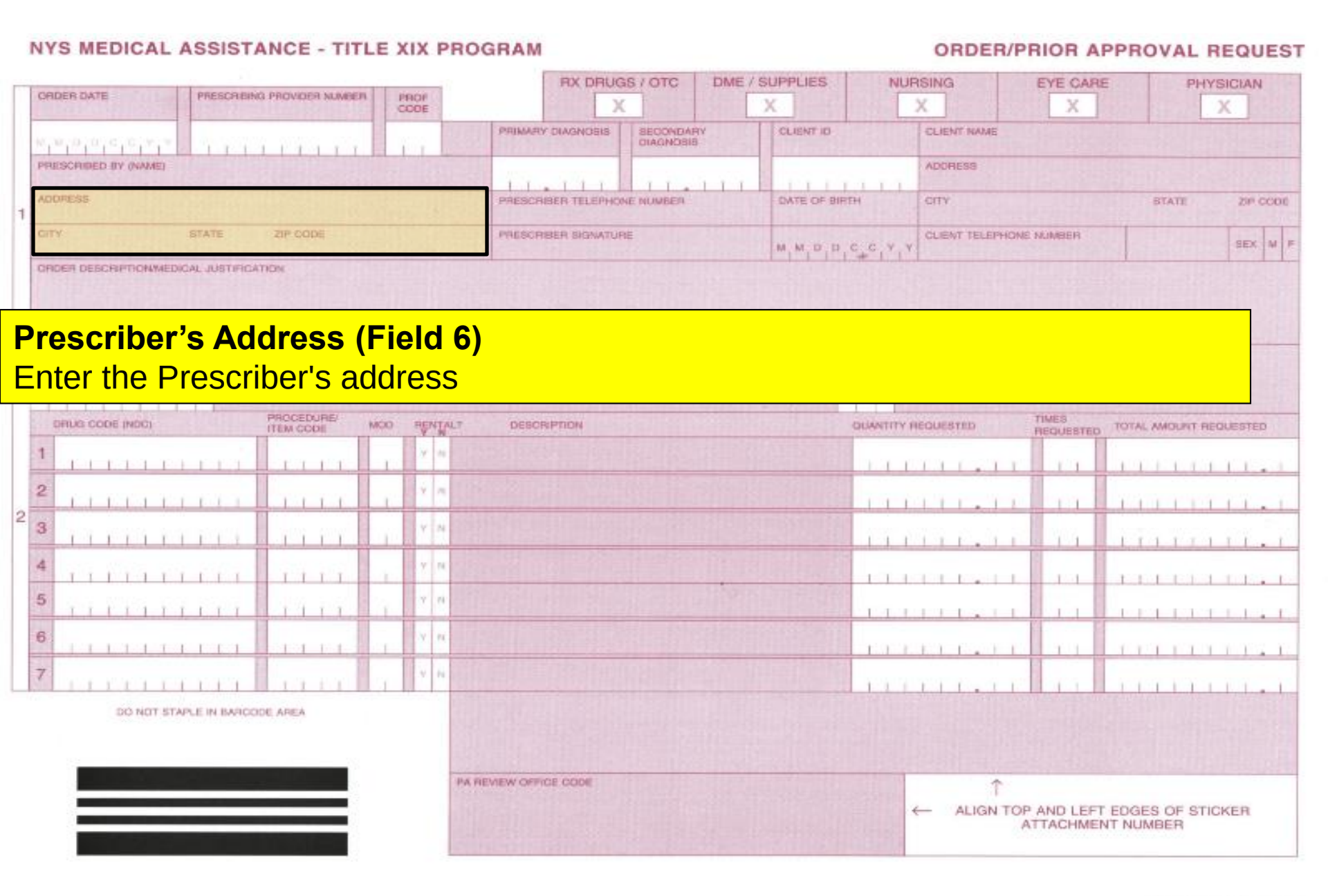
Prescribing Provider Number (Field 3)
Enter the 10 digit Prescribing Provider's Number (NPI)

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

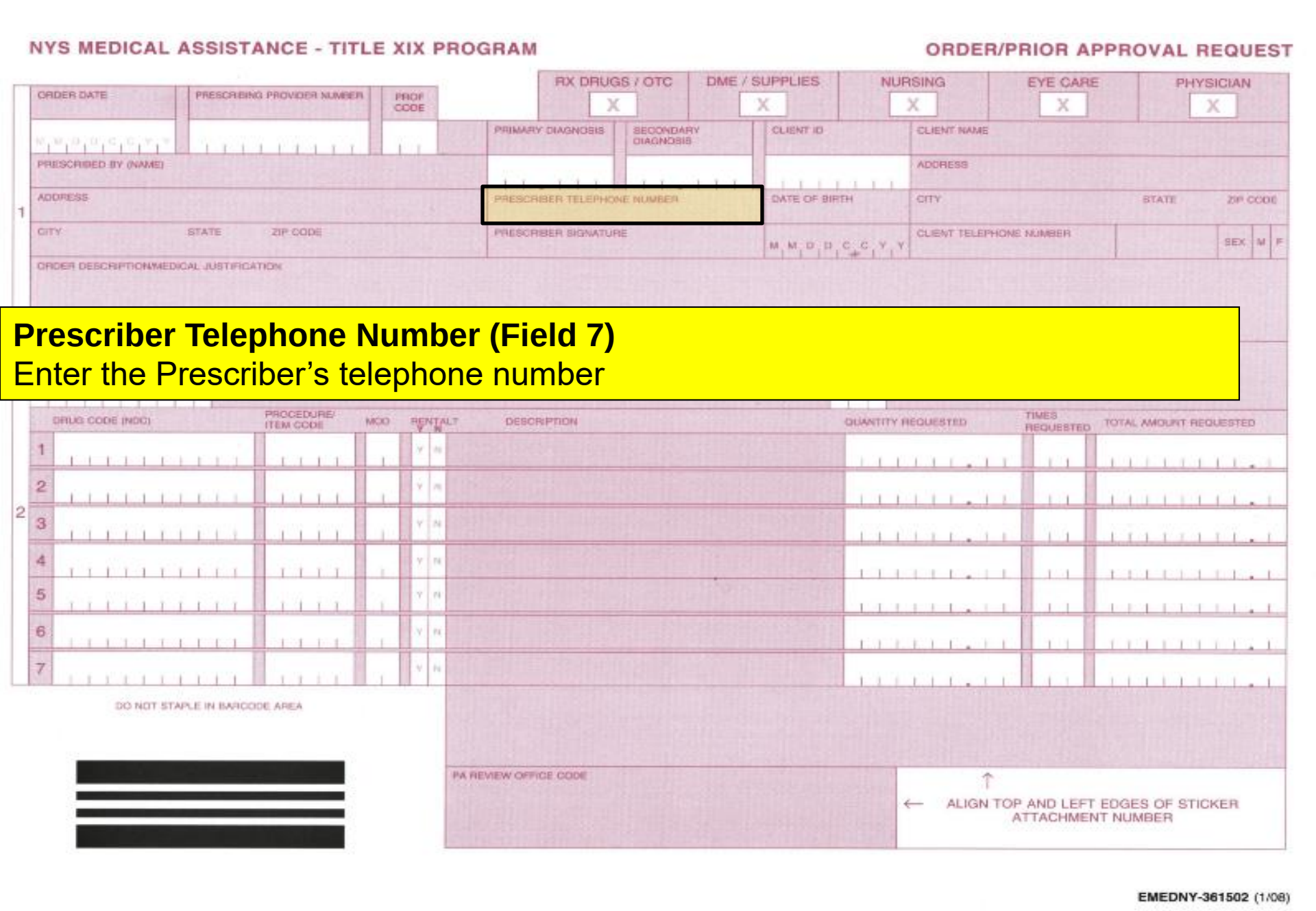


Prescribed By (NAME) (Field 5)

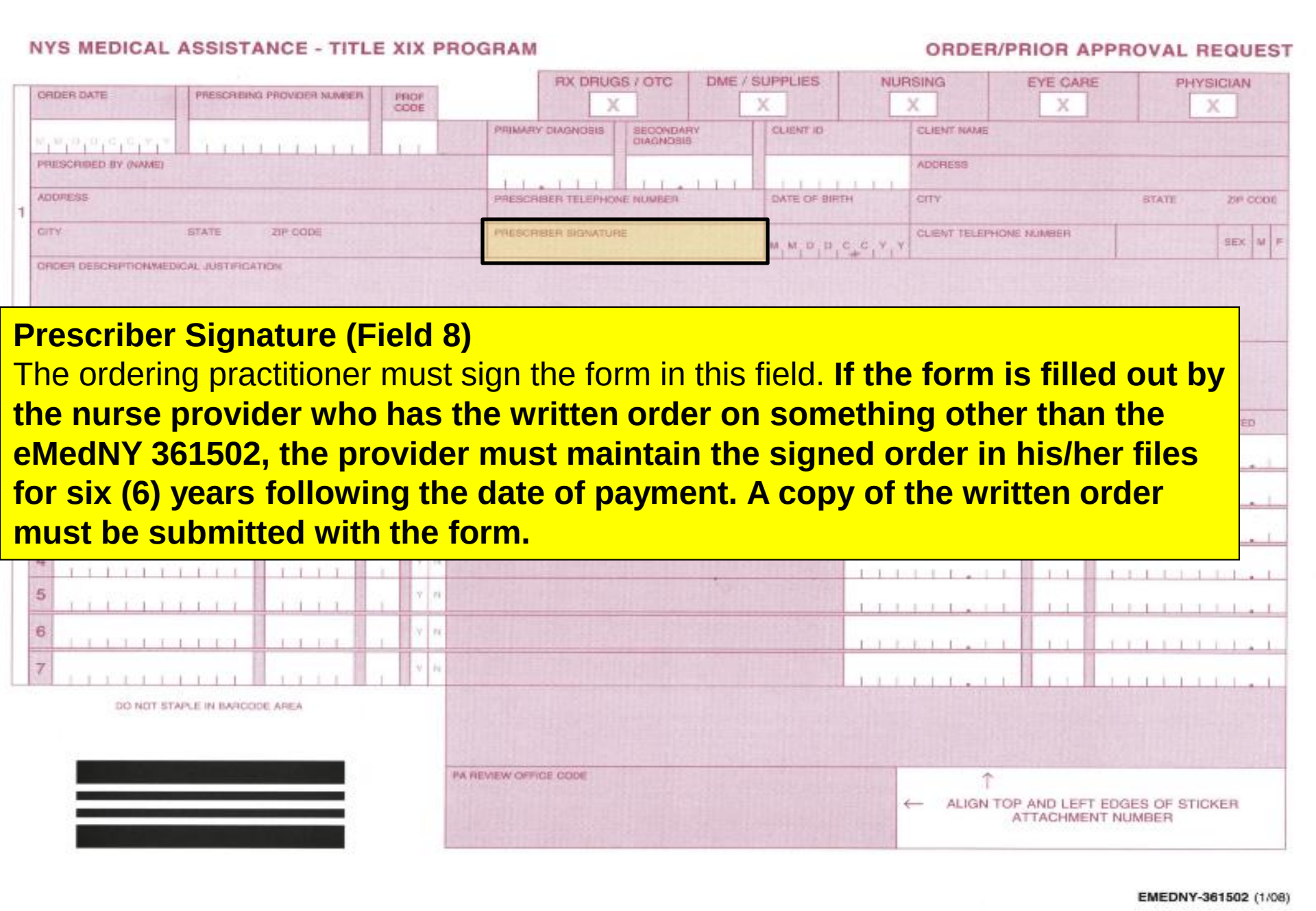
Enter the last name followed by the first name of the practitioner initiating the order



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

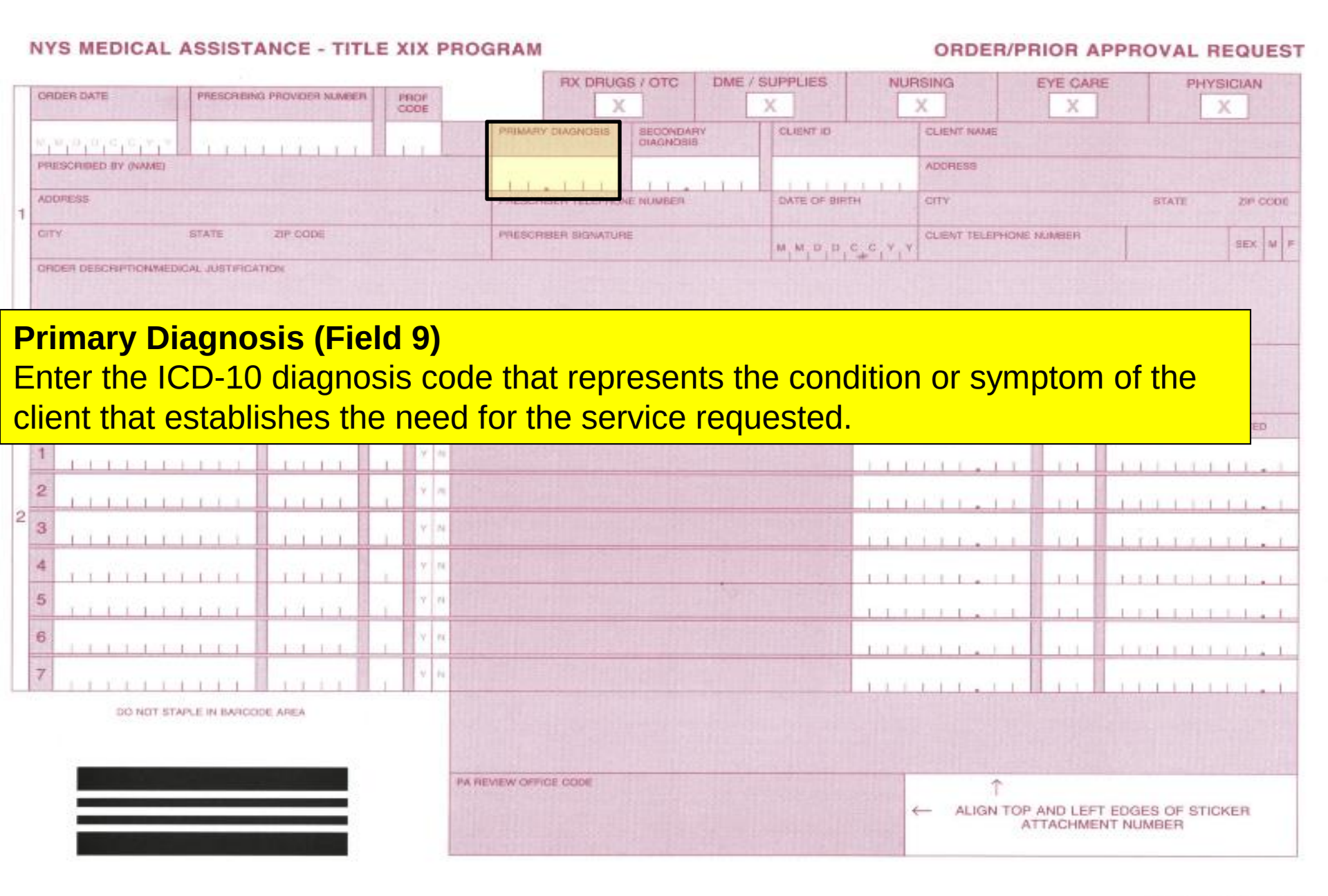


Prescriber Telephone Number (Field 7)
Enter the Prescriber's telephone number



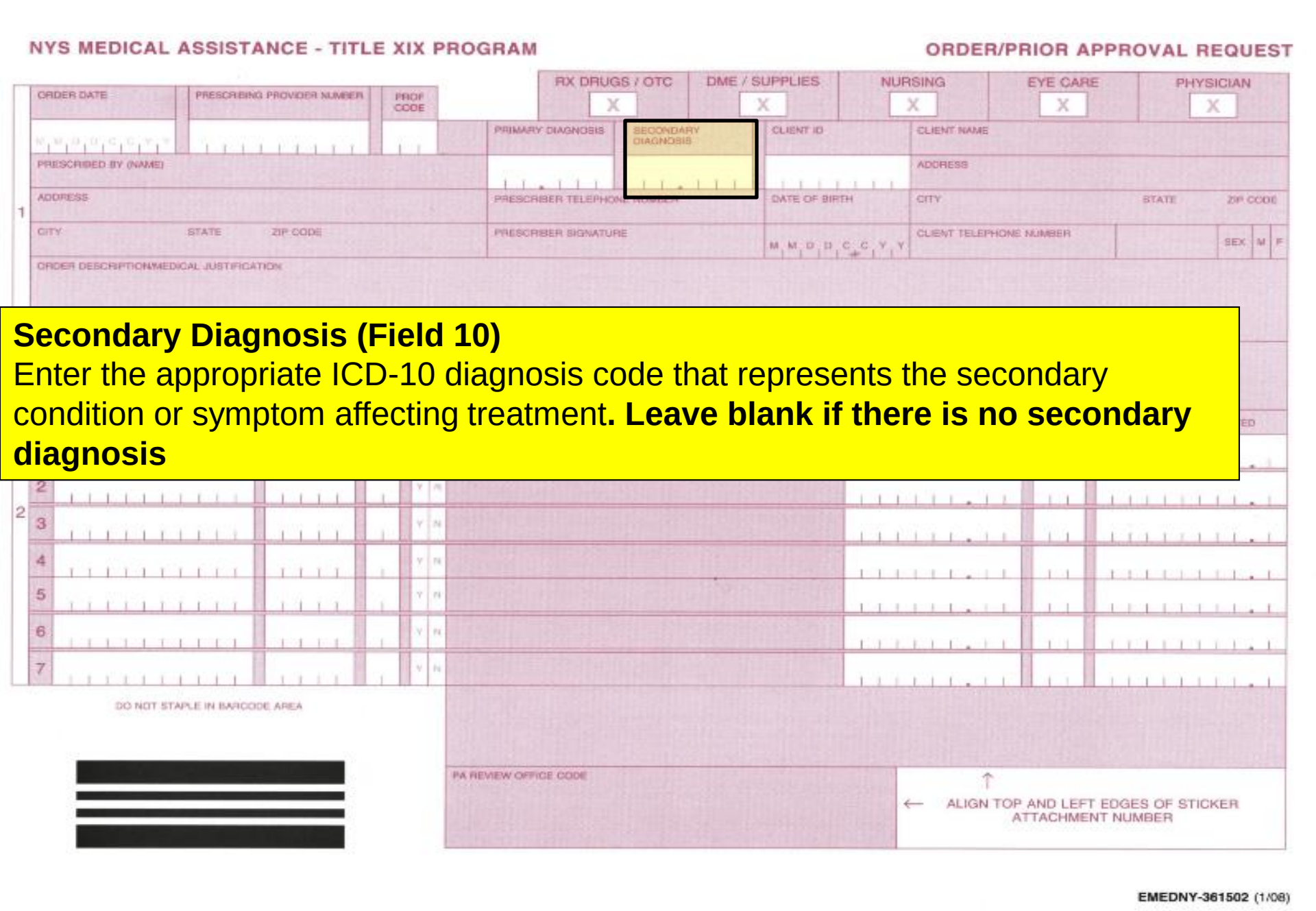
Prescriber Signature (Field 8)

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.**



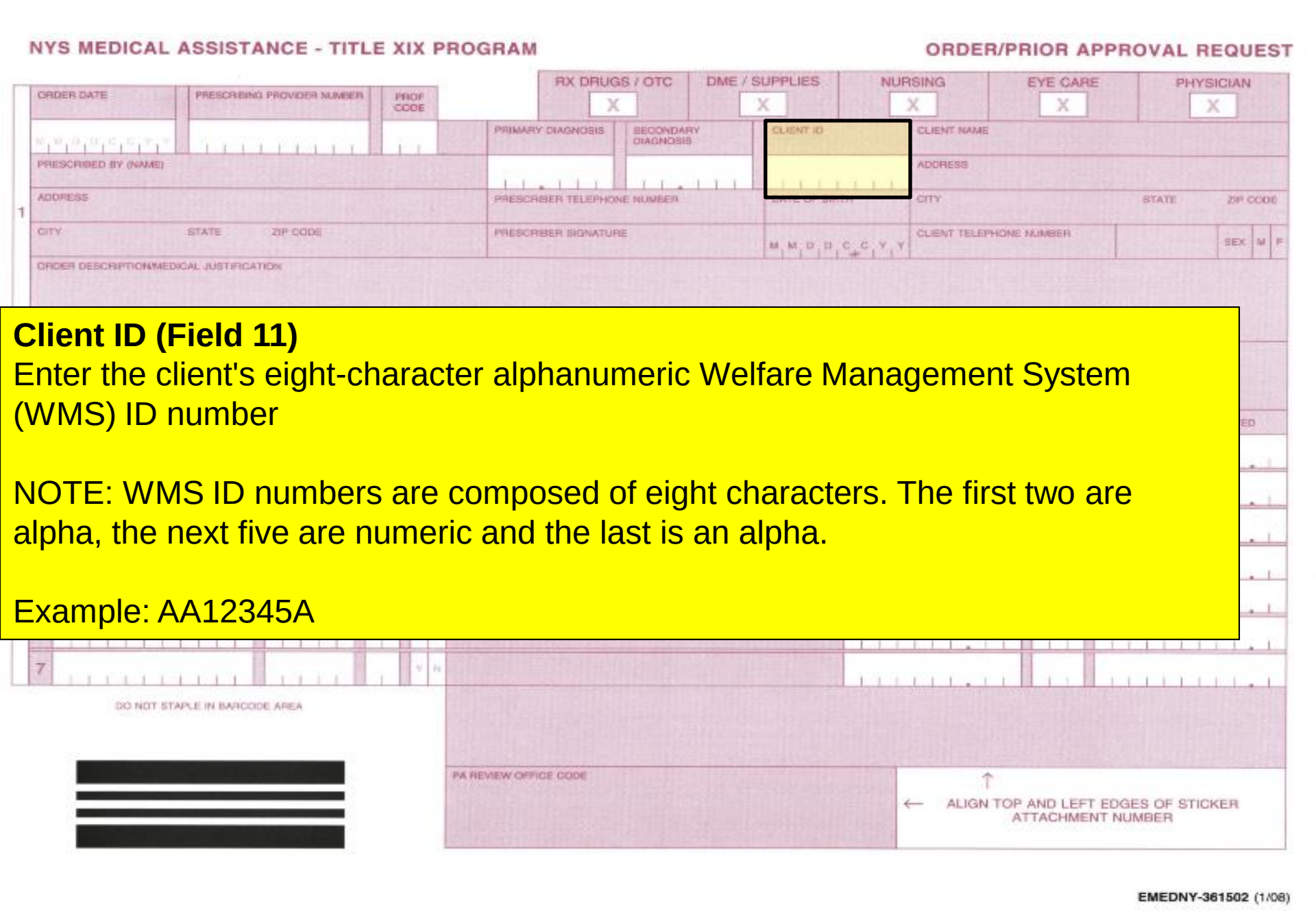
Primary Diagnosis (Field 9)

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



Secondary Diagnosis (Field 10)

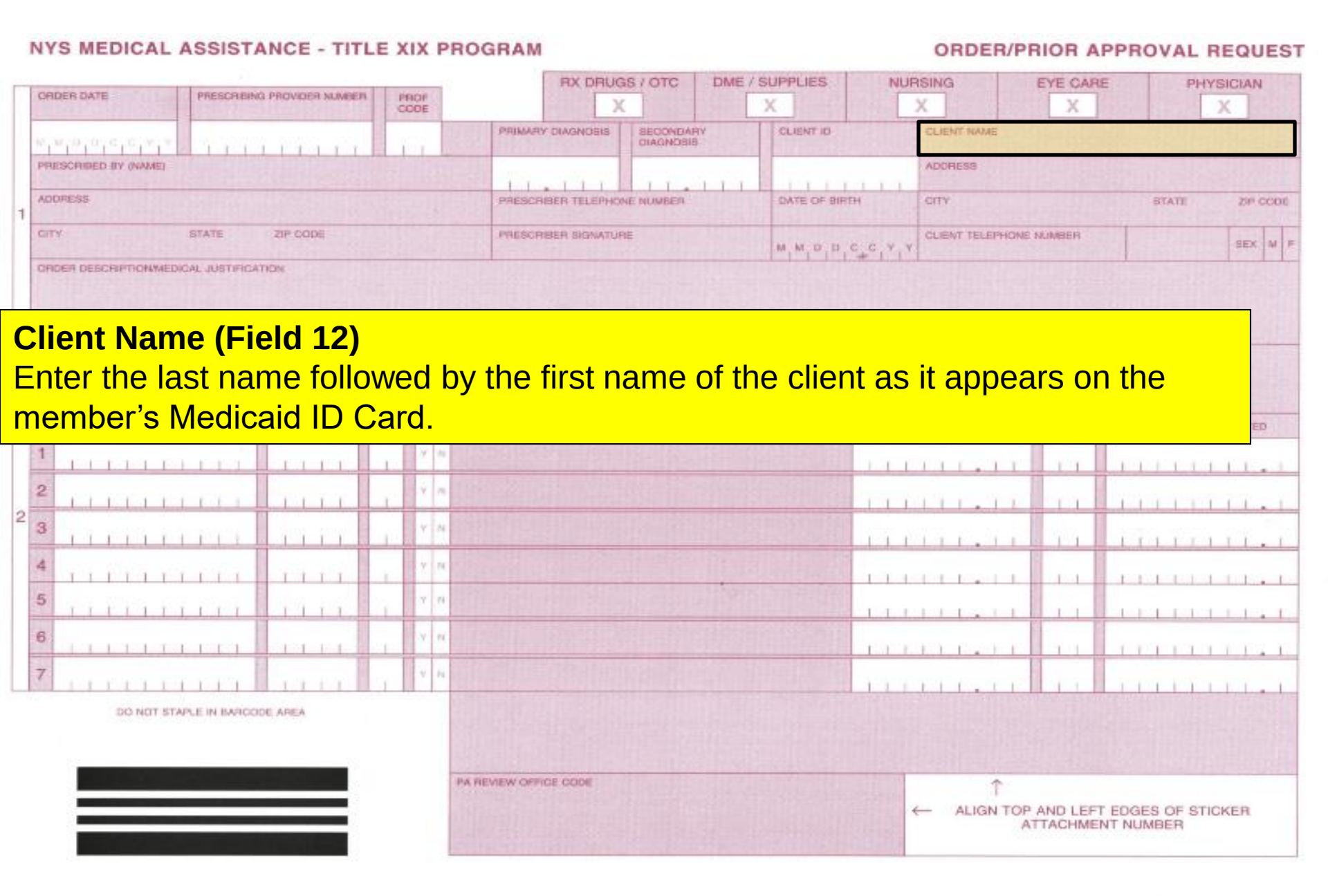
Enter the appropriate ICD-10 diagnosis code that represents the secondary condition or symptom affecting treatment**. Leave blank if there is no secondary diagnosis**



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



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.

NYS MEDICAL ASSISTANCE - TITLE XIX PROGRAM

ORDER/PRIOR APPROVAL REQUEST

RX DRUGS / OTC	DME / SUPPLIES	NURSING	EYE CARE	PHYSICIAN
X	X	X	X	X

1

ORDER DATE (M M D D C C Y Y) | PRESCRIBING PROVIDER NUMBER | PROF CODE | PRIMARY DIAGNOSIS | SECONDARY DIAGNOSIS | CLIENT ID | CLIENT NAME

PRESCRIBED BY (NAME) | ADDRESS

ADDRESS | PRESCRIBER TELEPHONE NUMBER | DATE OF BIRTH (M M D D C C Y Y) | CITY | STATE | ZIP CODE

CITY | STATE | ZIP CODE | PRESCRIBER SIGNATURE | CLIENT TELEPHONE NUMBER | SEX | M | F

ORDER DESCRIPTION/MEDICAL JUSTIFICATION

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

2

	DRUG CODE (NDC)	PROCEDURE/ ITEM CODE	MOD	RENTAL Y	RENTAL N	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

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PA REVIEW OFFICE CODE

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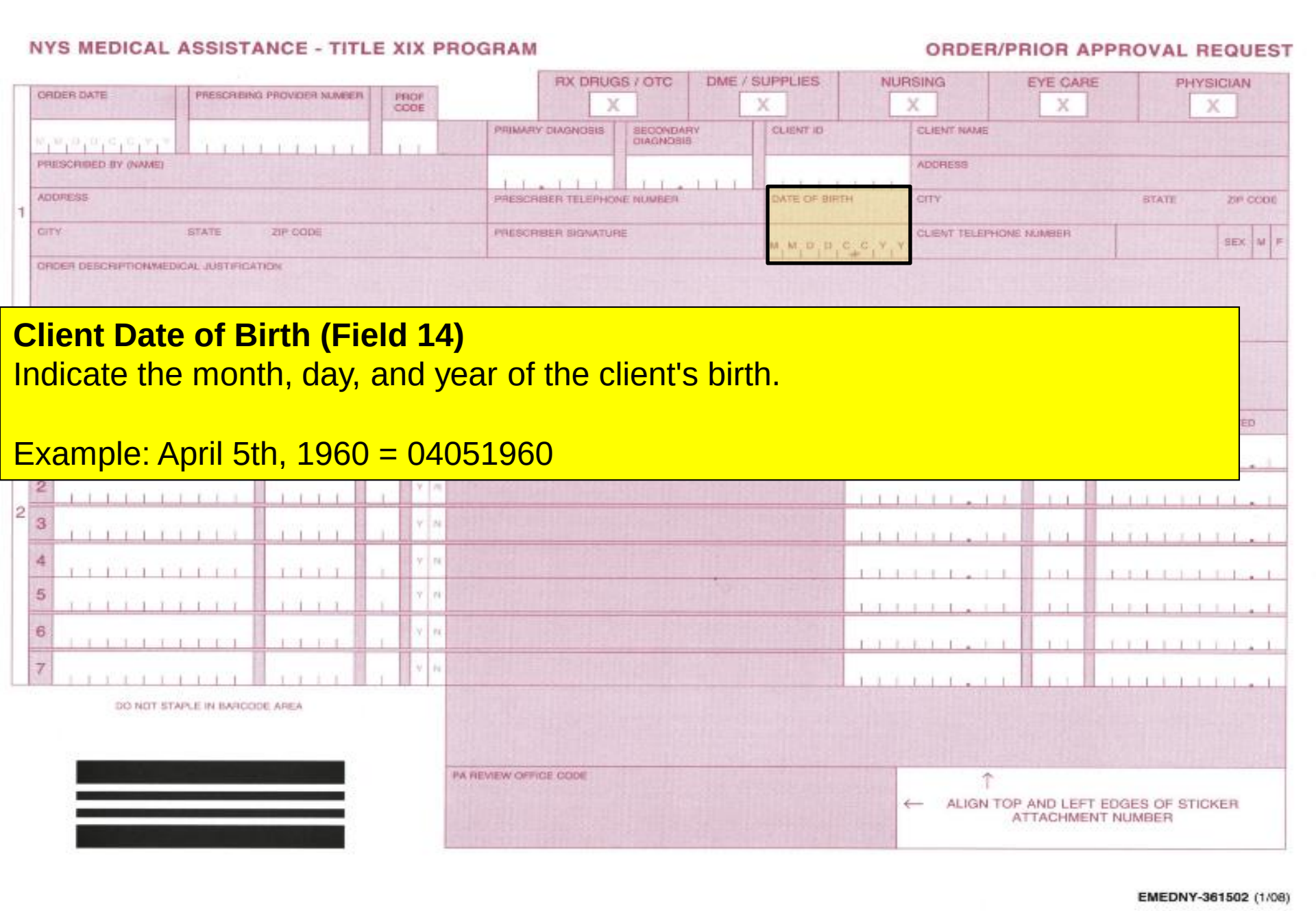
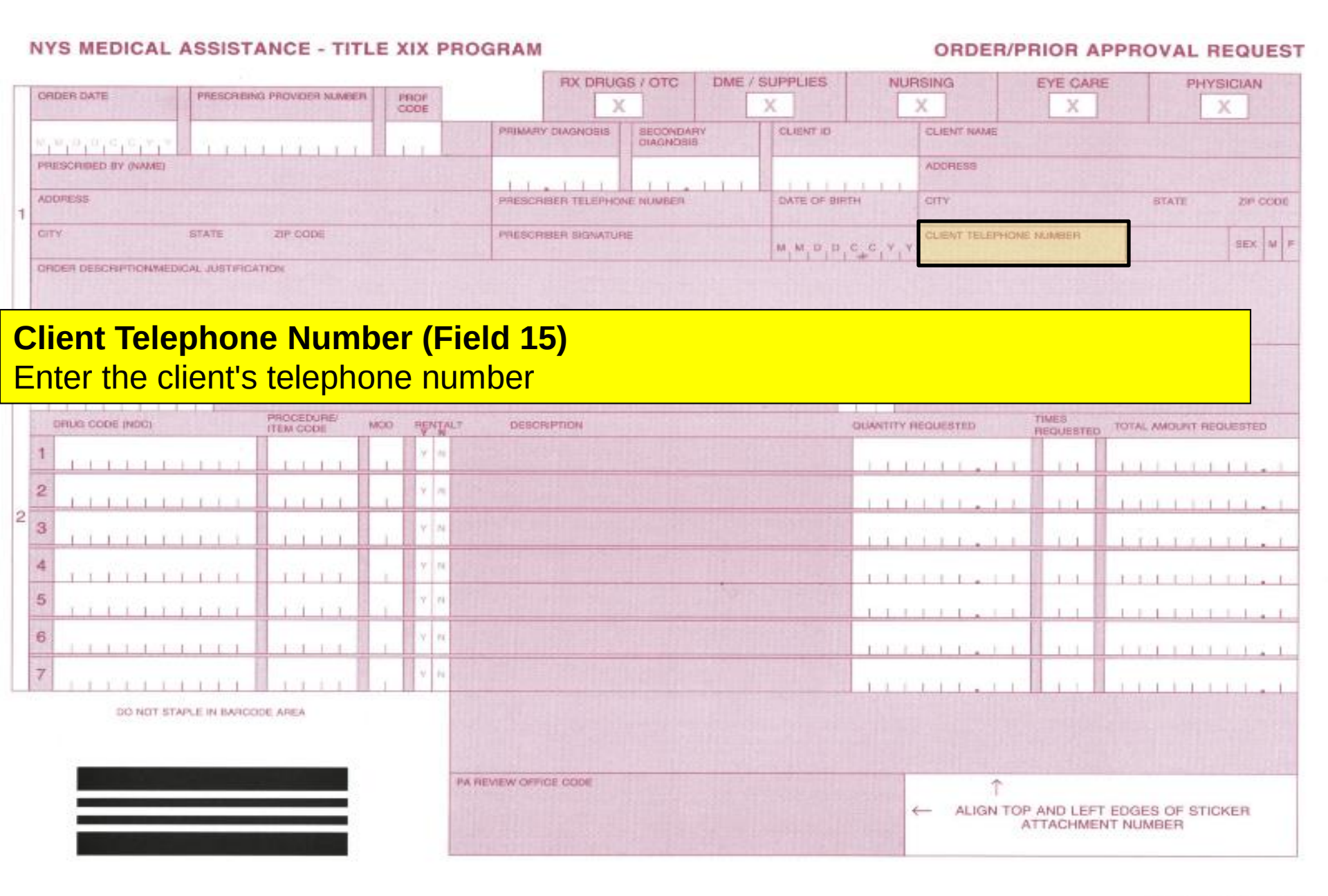
EMEDNY-361502 (1/08)



Client Date of Birth (Field 14)
Indicate the month, day, and year of the client's birth.

Example: April 5th, 1960 = 04051960



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

NYS MEDICAL ASSISTANCE - TITLE XIX PROGRAM

ORDER/PRIOR APPROVAL REQUEST

RX DRUGS / OTC	DME / SUPPLIES	NURSING	EYE CARE	PHYSICIAN
X	X	X	X	X

1

ORDER DATE (M M D D C C Y Y) | PRESCRIBING PROVIDER NUMBER | PROF CODE | PRIMARY DIAGNOSIS | SECONDARY DIAGNOSIS | CLIENT ID | CLIENT NAME

PRESCRIBED BY (NAME) | ADDRESS

ADDRESS | PRESCRIBER TELEPHONE NUMBER | DATE OF BIRTH (M M D D C C Y Y) | CITY | STATE | ZIP CODE

CITY | STATE | ZIP CODE | PRESCRIBER SIGNATURE | CLIENT TELEPHONE NUMBER | SEX M F

ORDER DESCRIPTION/MEDICAL JUSTIFICATION

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

2

	DRUG CODE (NDC)	PROCEDURE/ ITEM CODE	MOD	RENTAL Y	RENTAL N	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

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PA REVIEW OFFICE CODE

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← ALIGN TOP AND LEFT EDGES OF STICKER ATTACHMENT NUMBER

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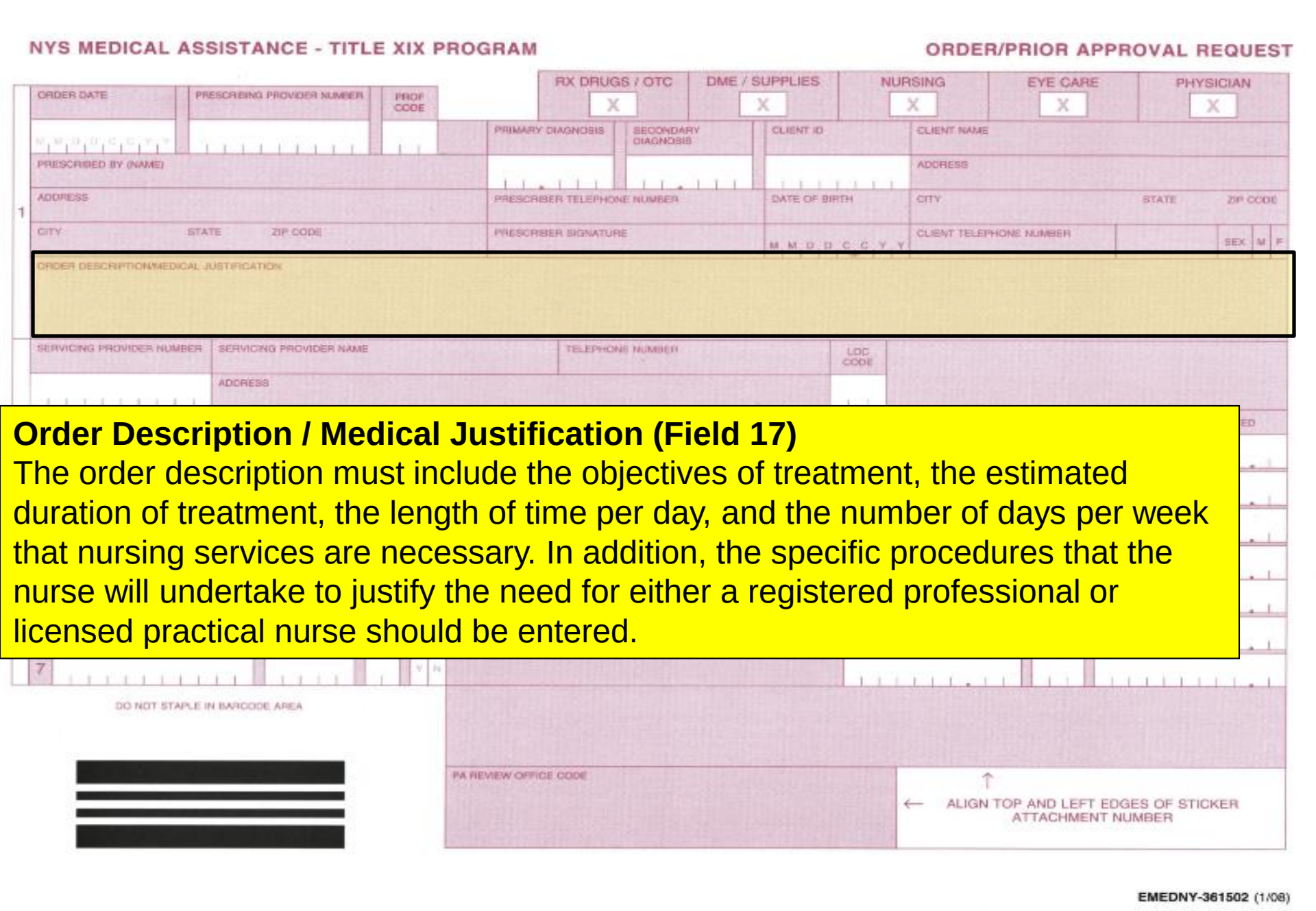
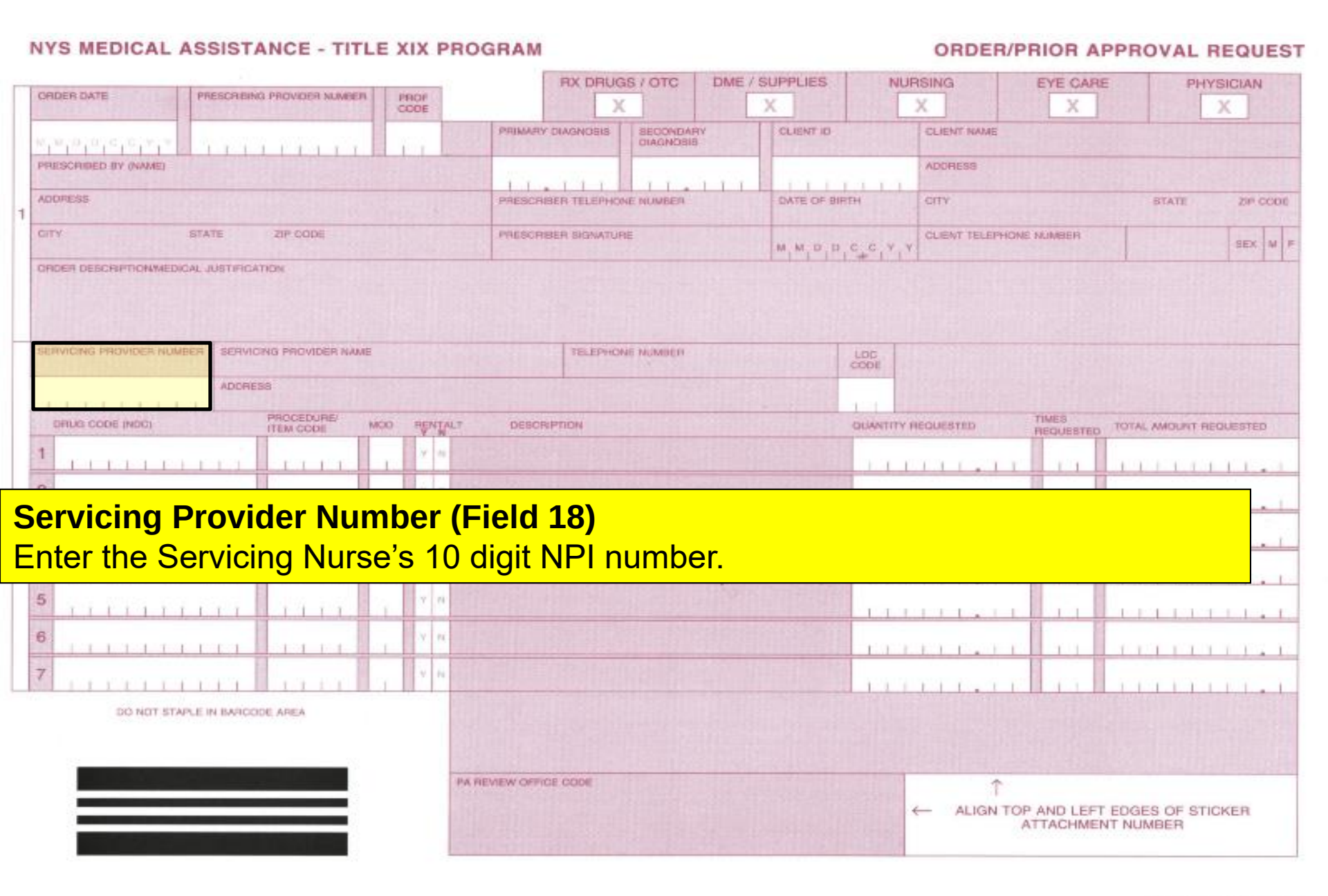
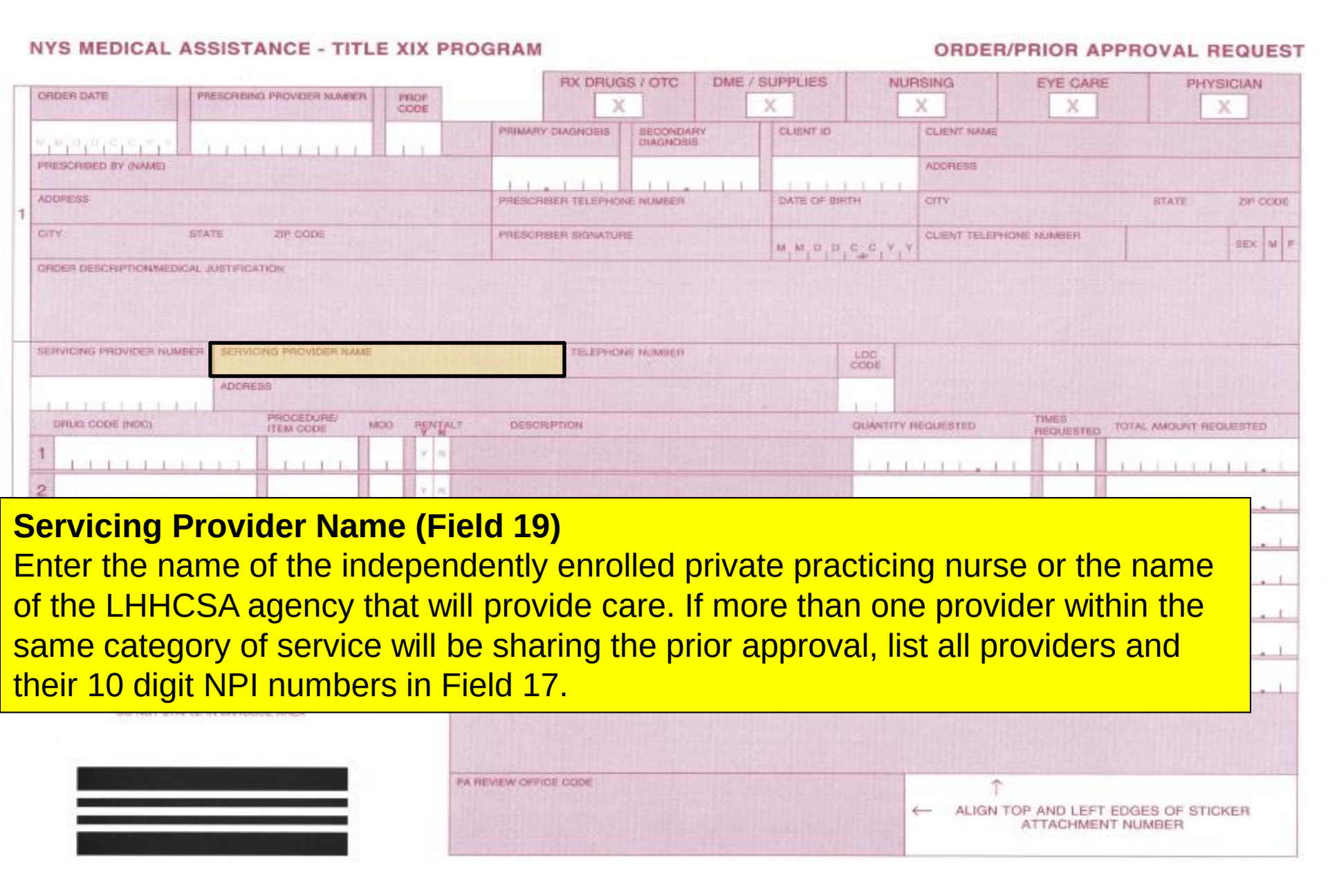


Order Description / Medical Justification (Field 17)

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.

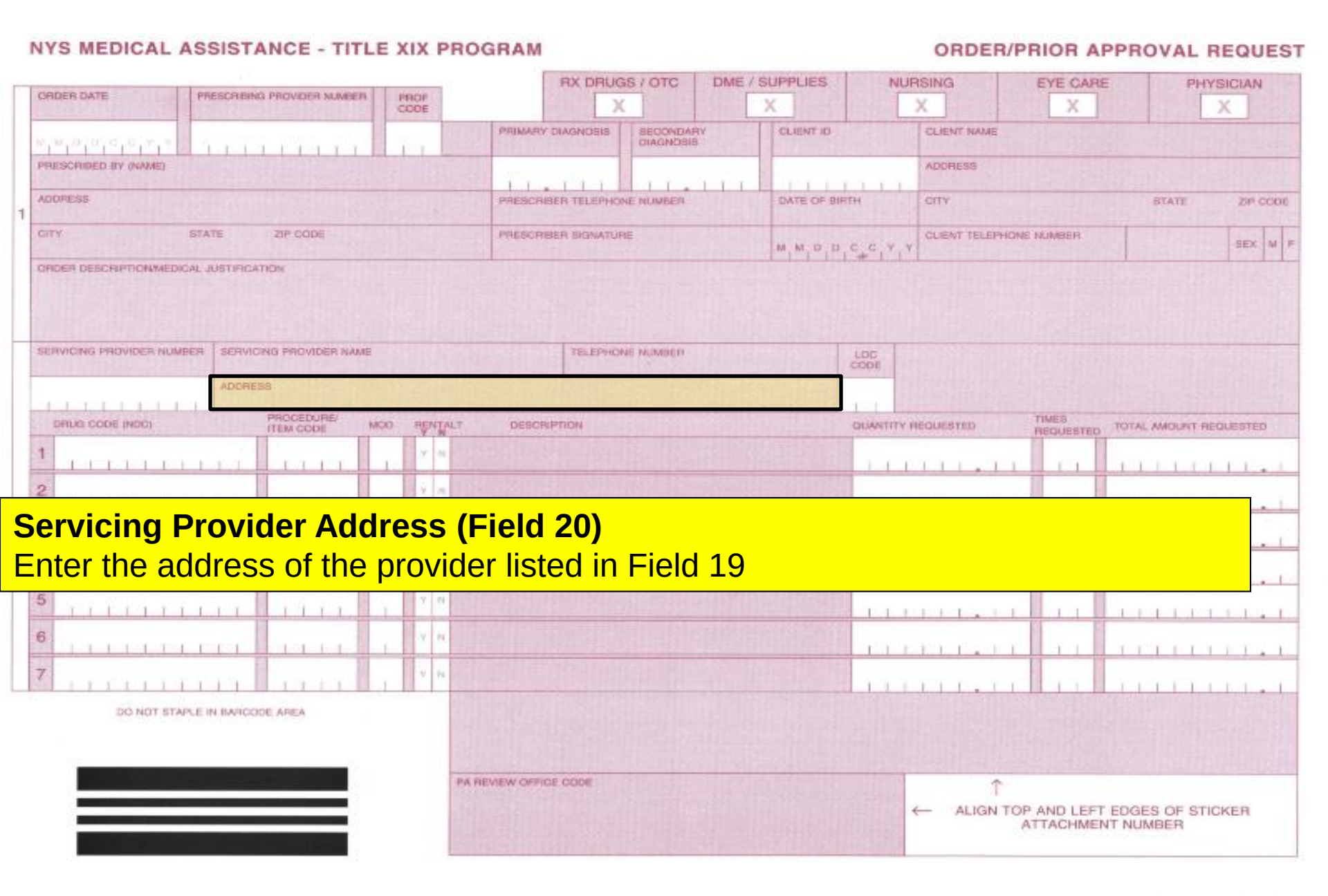


Servicing Provider Number (Field 18)
Enter the Servicing Nurse's 10 digit NPI number.



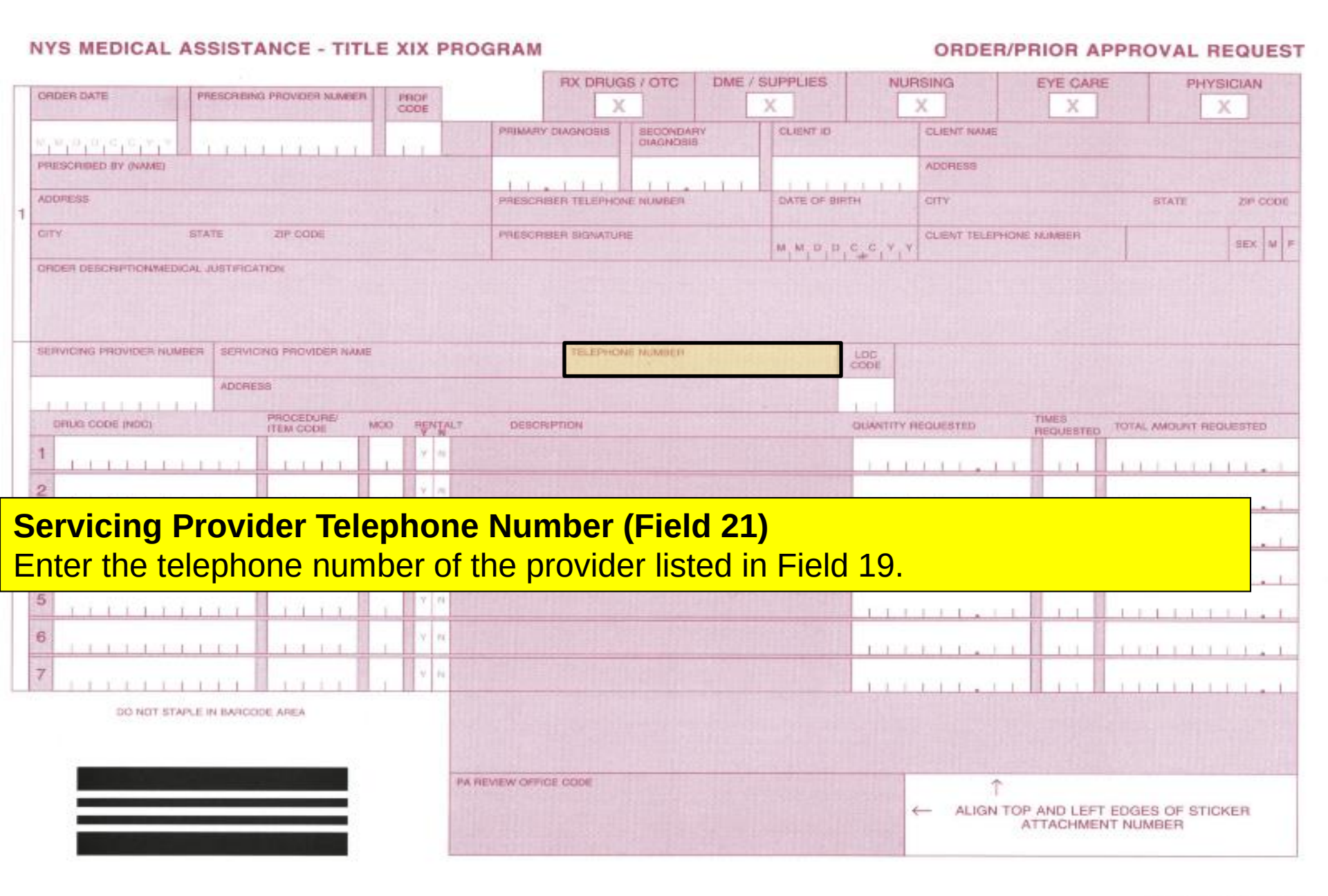
Servicing Provider Name (Field 19)

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.

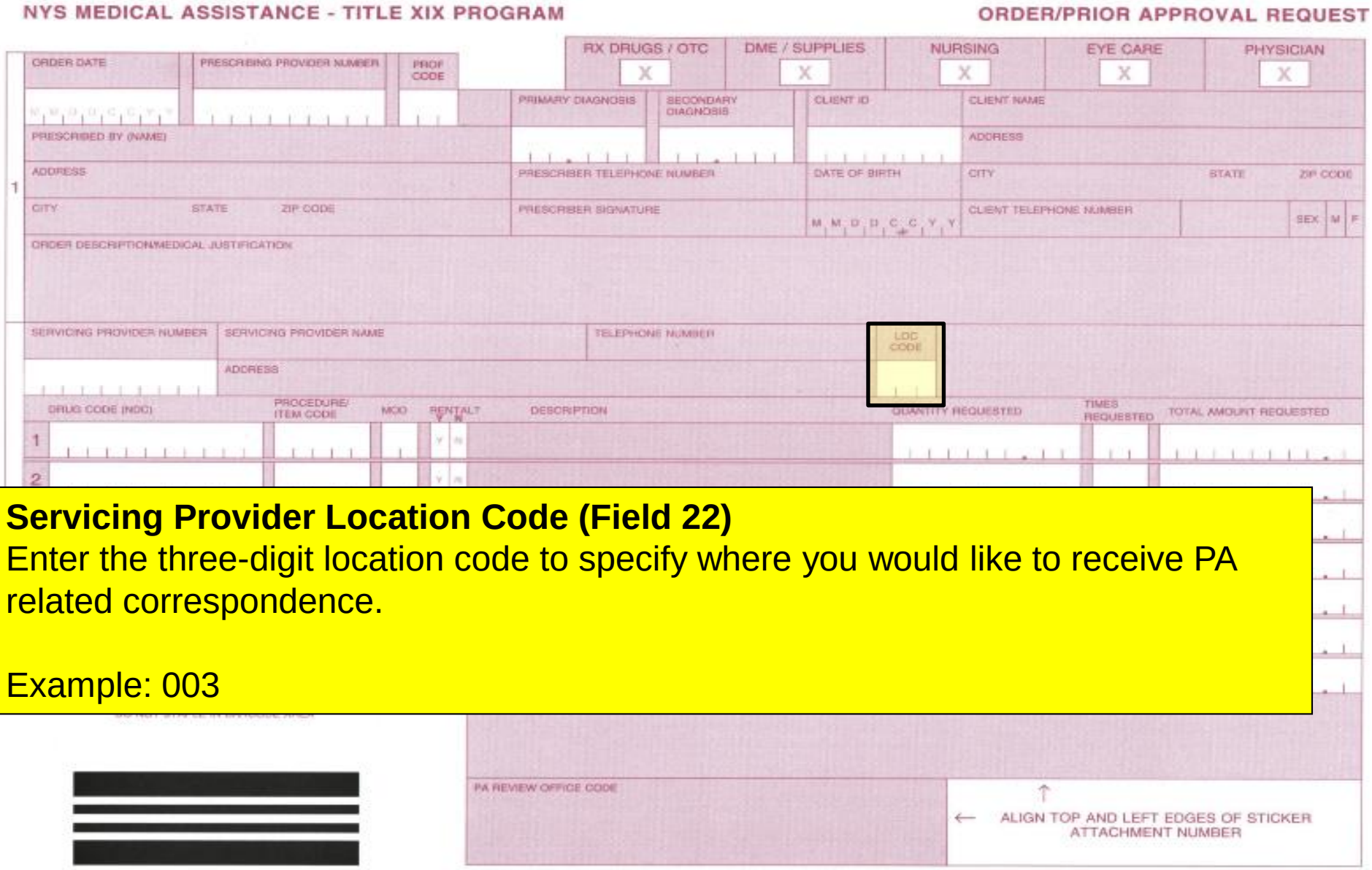


Servicing Provider Address (Field 20)

Enter the address of the provider listed in Field 19



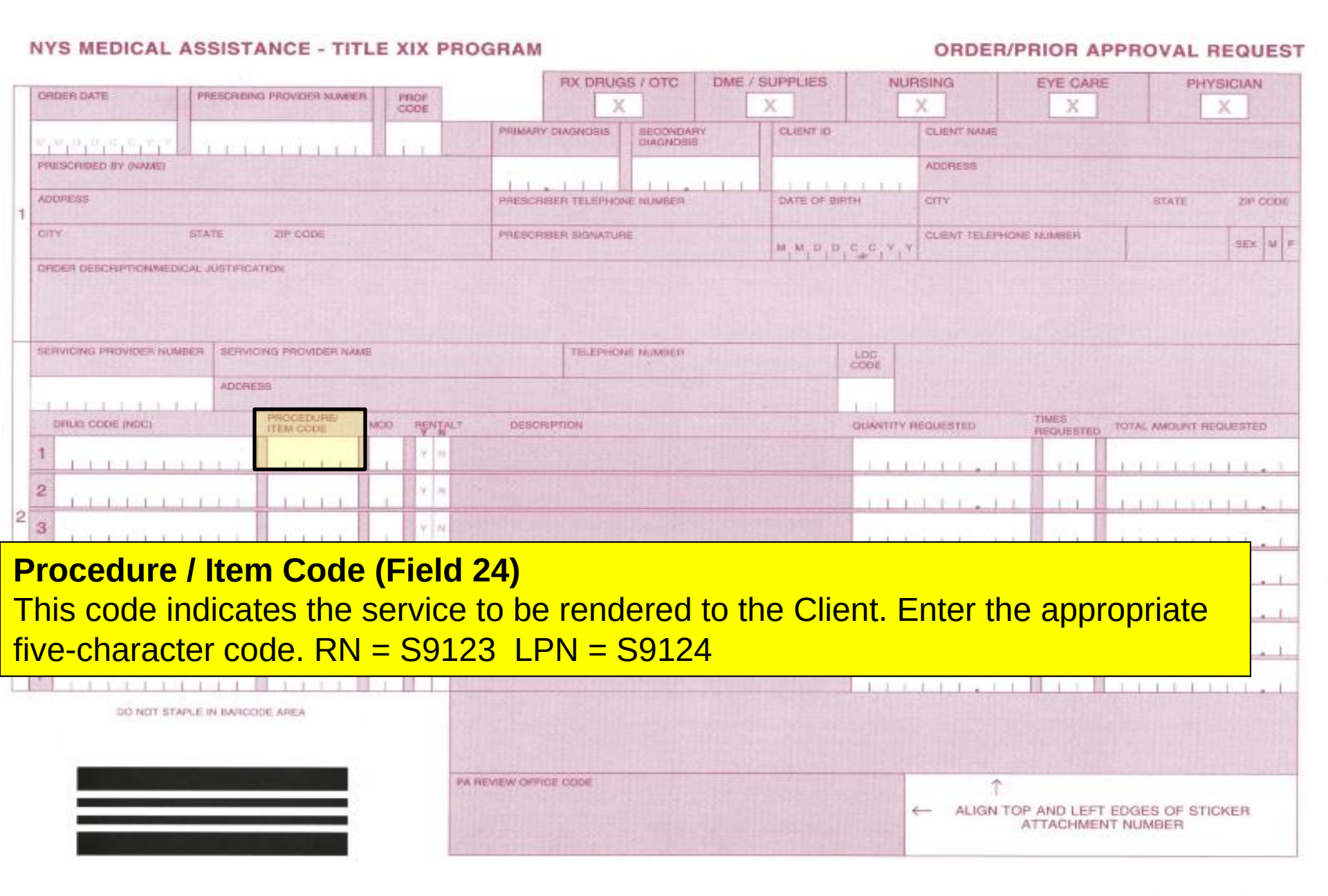
Servicing Provider Telephone Number (Field 21)
Enter the telephone number of the provider listed in Field 19.



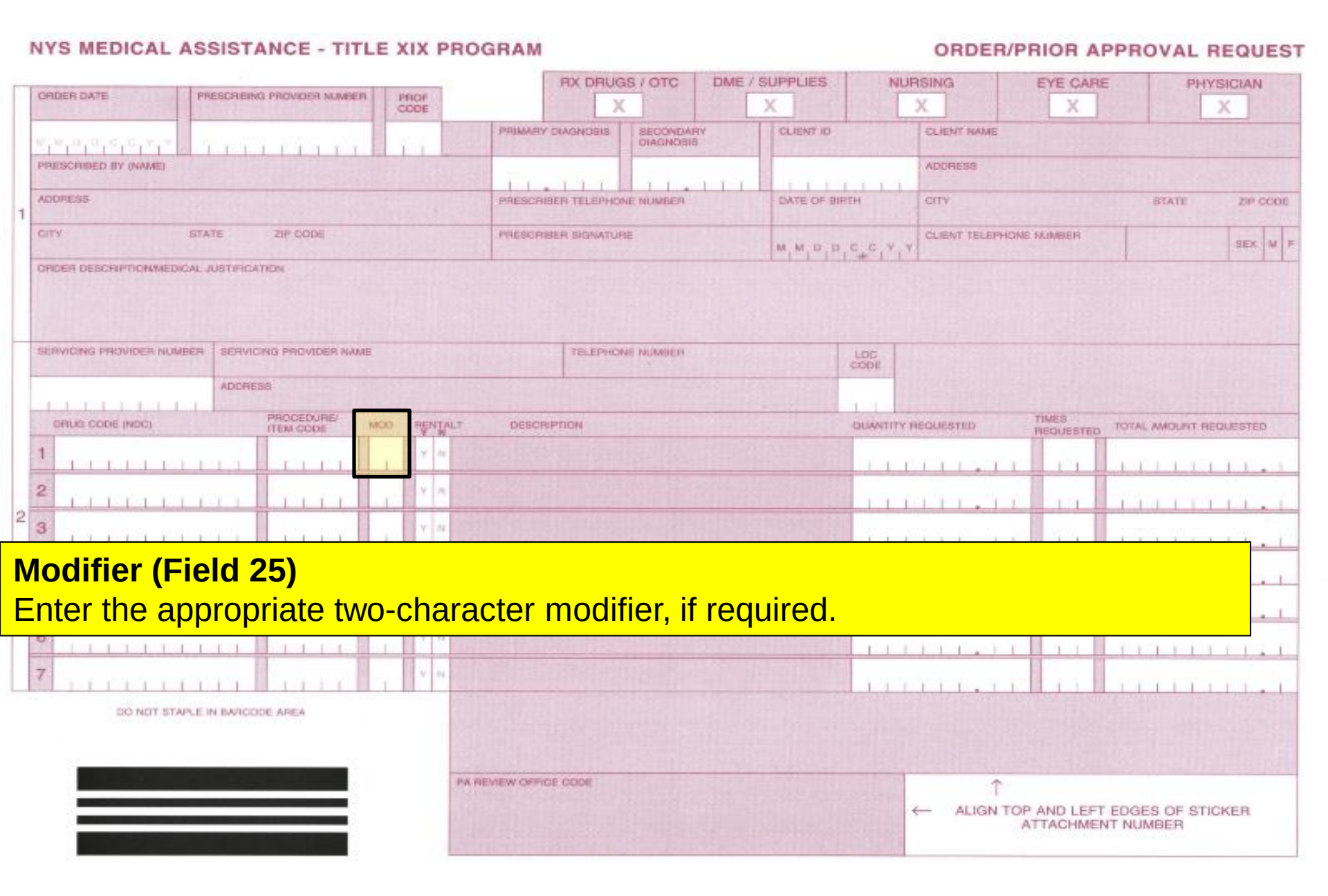
Servicing Provider Location Code (Field 22)

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

Example: 003

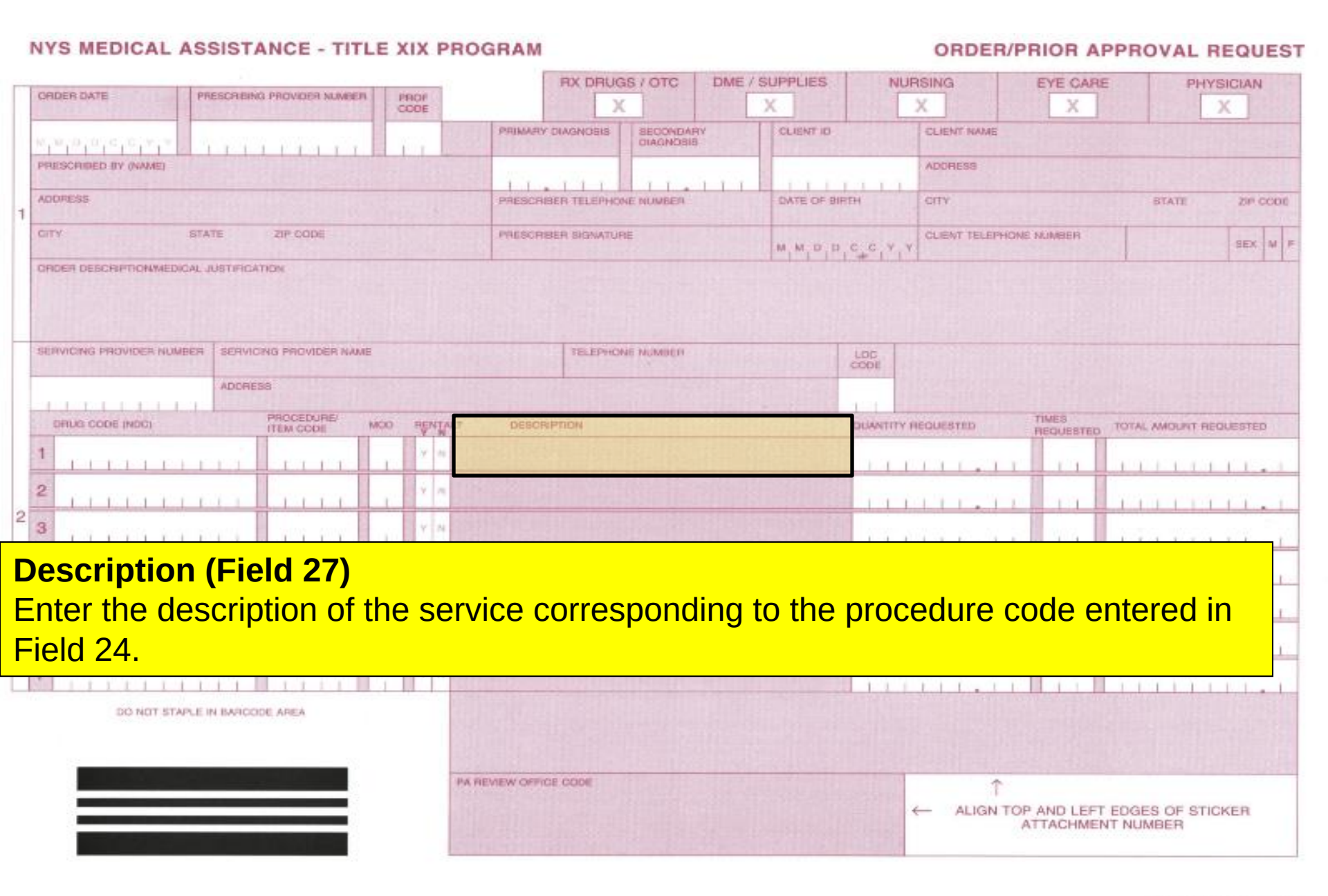


Procedure / Item Code (Field 24)
This code indicates the service to be rendered to the Client. Enter the appropriate five-character code. RN = S9123 LPN = S9124

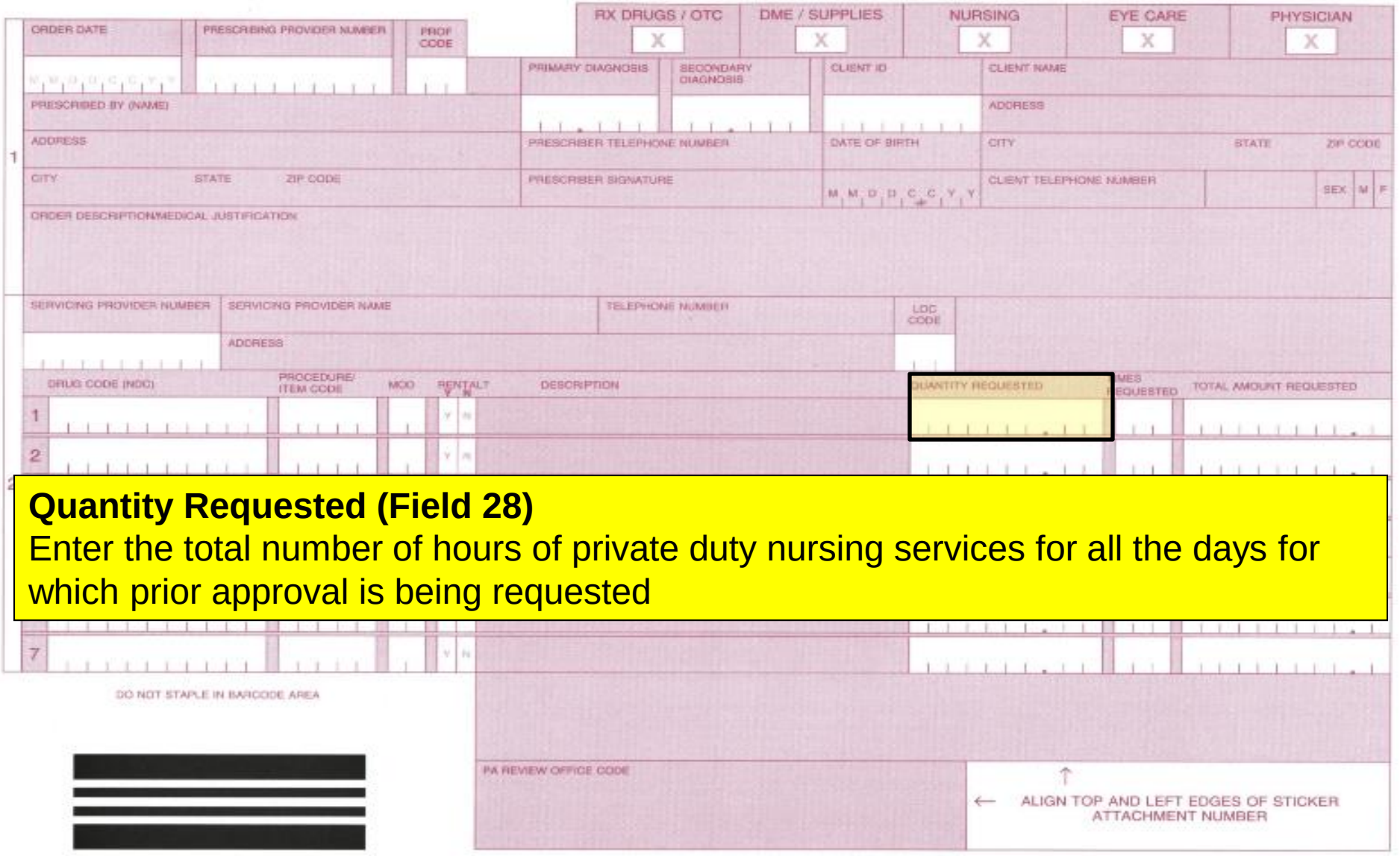


Modifier (Field 25)

Enter the appropriate two-character modifier, if required.

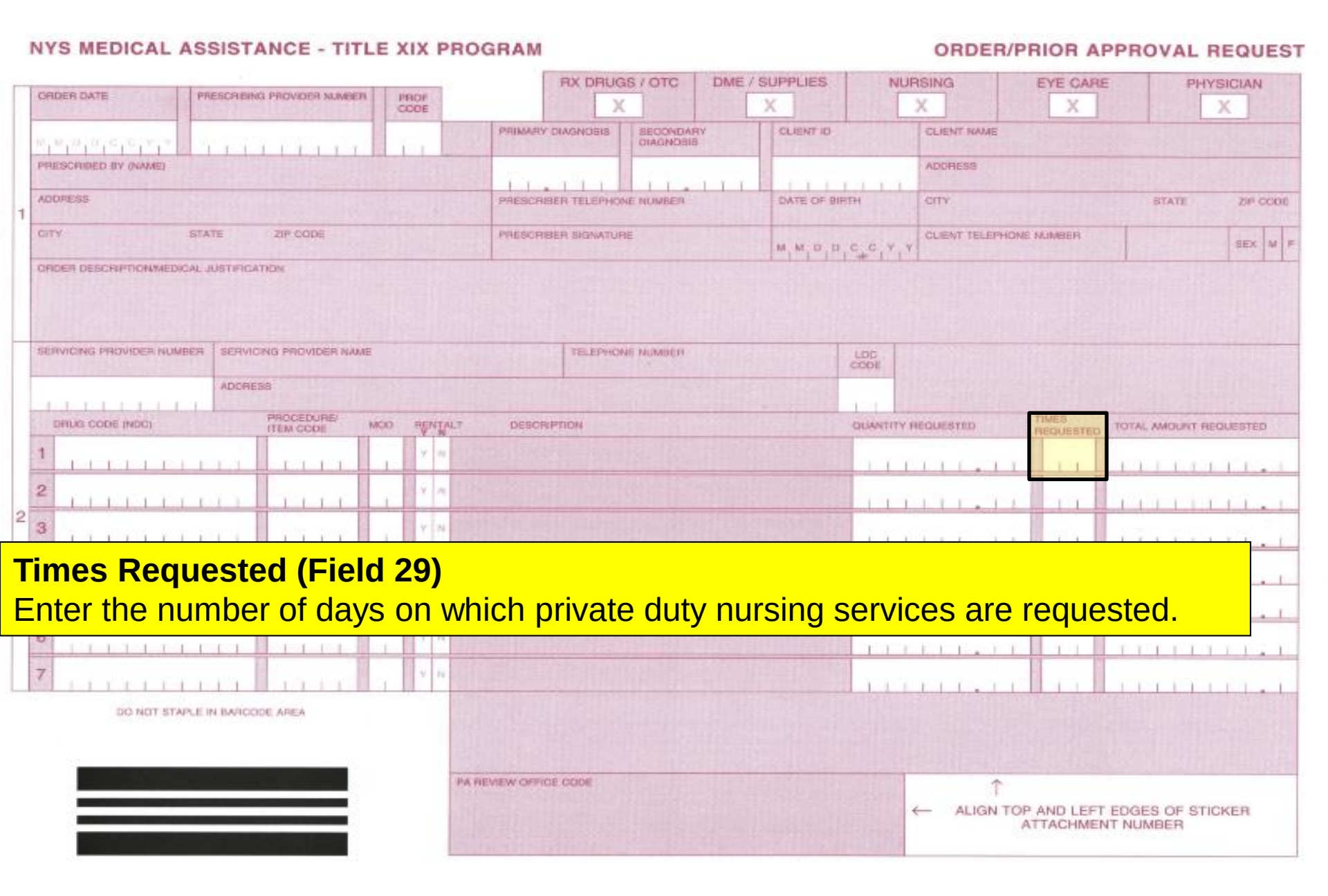


Description (Field 27)
Enter the description of the service corresponding to the procedure code entered in Field 24.



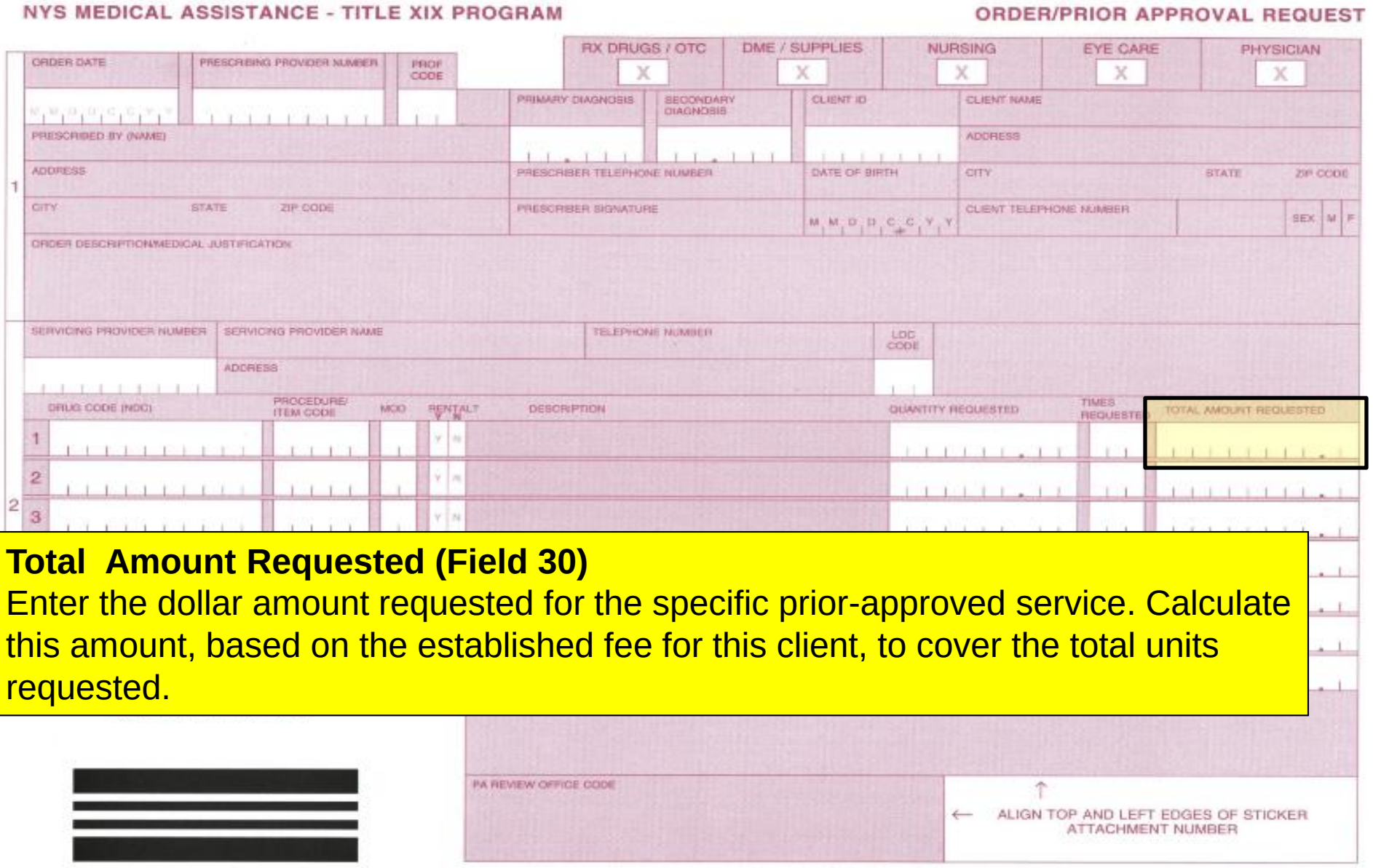
Quantity Requested (Field 28)

Enter the total number of hours of private duty nursing services for all the days for which prior approval is being requested



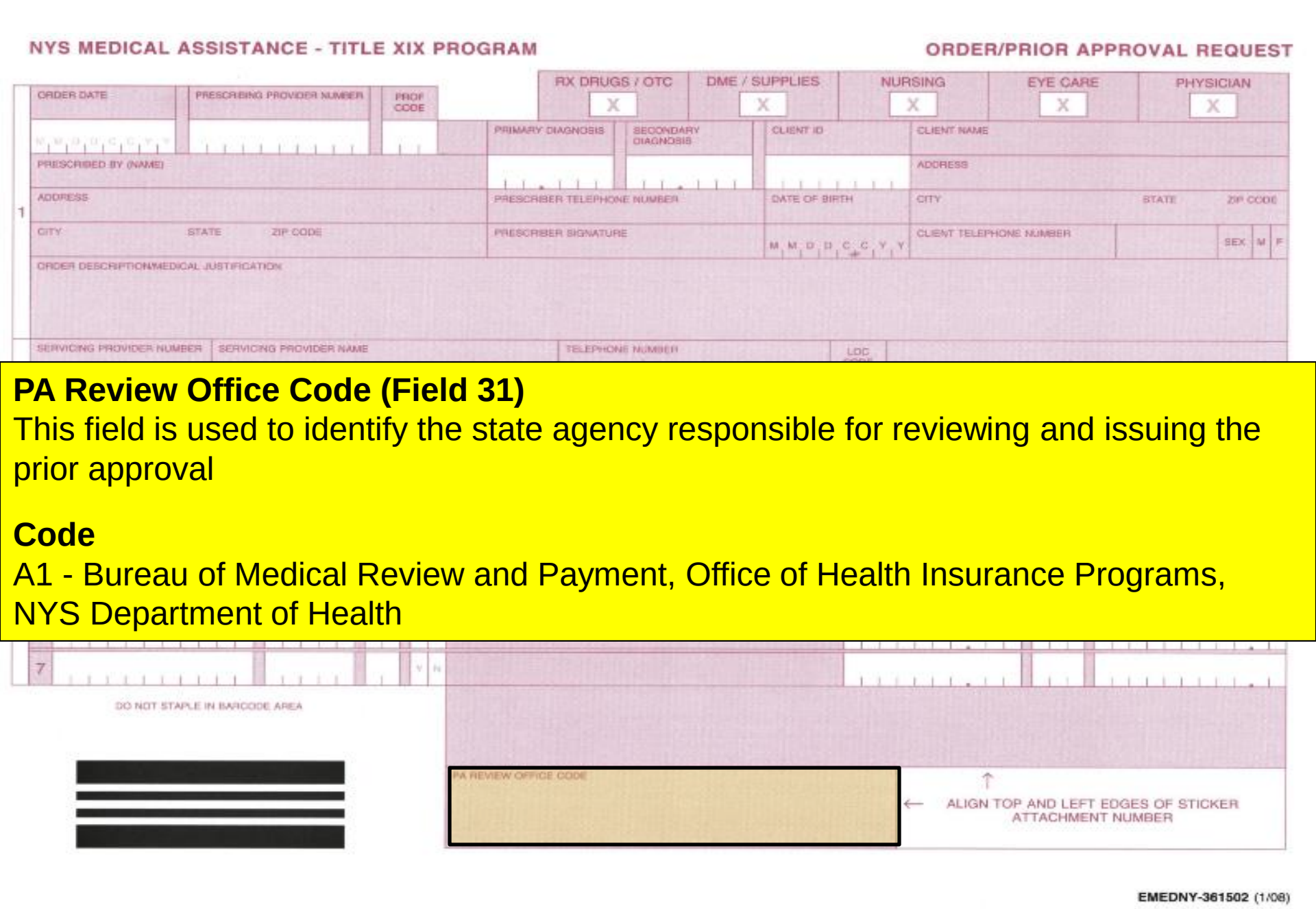
Times Requested (Field 29)

Enter the number of days on which private duty nursing services are requested.



Total Amount Requested (Field 30)

Enter the dollar amount requested for the specific prior-approved service. Calculate this amount, based on the established fee for this client, 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

Code

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

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 required 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

NEW YORK STATE | Department of Health | Medicaid Program