PRIOR AUTHORIZATION

Prior authorization for eye wear will be considered only when the item is medically necessary. If the service requires prior authorization (PA), the provider should not fill the prescription or dispense the eye wear until an approval letter is obtained from Medicaid.

Completed requests with all required documentation should be mailed to the Prior Authorization Unit (PAU) (see Contact/Referral Information Appendix D).

Required Documentation for Prior Authorization

Request for prior authorization should include:

- Completed **PA-01 Form** (Appendix B),
- Copy of the prescription, and
- Letter which documents medical necessity for all PA requests.
    - The letter of medical necessity **must** be obtained from the prescribing provider and must be specific to each individual recipient.
- Copy of the invoice and a detailed description of the items(s) for all codes "manually priced" as noted in the eye wear fee schedule (Appendix A).

The PA-01 Form must include information regarding all eye wear items that will be delivered on the same date of service to the recipient, **including those items that do not require PA.**

The items which require PA must be listed on the first line(s) of the PA-01 Form under the "Description of Services" section and must include the following:

- Field #11 - Procedure Code
- Field #11A - Modifier-when applicable
- Field #11B - Description
- Field #11C - Requested Units
- Field #11D - Requested Amount

Items that do not require PA must be listed below those that require PA on the PA-01 form. Only the Description (Field #11B) should be completed for items that do not require prior PA.

NOTE: DO NOT ENTER A PROCEDURE CODE FOR ITEMS THAT DO NOT REQUIRE PRIOR AUTHORIZATION.

Prior authorization request related to eye wear will be granted for a three month authorization period. The provider should indicate the appropriate three-month span in the "Dates of Service" sections on the PA-01 Form. The "Begin Date of Service" (Field #7) must be the date of initial contact with the recipient. The "End Date of Service" must be three months from the begin date of service specified in Field #7.

Prior authorization for code V2102 is required ONLY for lenses over 12.00D sphere. The following modifiers must be used for PA and claims for payment ONLY in conjunction with procedure code V2102 when the lens is over 12.00D spheres:
1) RT-indicates right eye; and
2) LT-indicates left eye.

Providers who are enrolled as a group must indicate the individual provider's Medicaid provider number on the Form PA-01 (Field 6) when requesting PA. This provider number must match the attending provider number in item 24K of the CMS-1500 when services are billed.

Prior Authorization Requests for Contact Lenses

The provider must submit the following information with the PA request for contact lenses:

- Recipient's condition making them eligible for contact lenses;
- Indicate if the recipient is aphakic or not aphakic;
- Substantiation for special fittings (e.g.; Keratoconus);
- All appropriate procedure codes;
- The provider's total fee that includes professional fitting services (excluding initial examination), the contact lenses, the required care kits, and follow-up visits for 90-days; and
- A statement as to whether:
    - This is an original fitting (or refitting) or for replacement lenses;
    - This is for unilateral or bilateral lenses;
    - The lenses are spherical or toric;
    - The lenses are rigid (PMMA or gas permeable) or soft lenses; and
    - The lenses are daily wear or extended wear.

NOTE: Prior authorization requests that do not include all items as listed above will be returned to the provider for more information.

Prior Authorization Decisions and Delivery of Service

A PA request that contains all of the required documentation should not take longer than 25 days to process. Should the provider fail to receive a PA decision within a timely manner, the provider should contact the PAU (see Appendix D).

Once the review process has been completed, providers are notified via letter whether or not the service has been approved or denied. If the procedure is not approved, a denial reason is indicated in this letter. The letter also includes the 9-digit PA number assigned to the request which must be used when billing. This 9-digit number must be entered in item 23 of the CMS 1500 form or the electronic HIPAA compliant equivalent, 837P when billing.

Upon PA approval, the provider should deliver the services as soon as possible within the authorized period. In order for a claim to be paid, PA required services must have been approved and the dates of service must fall between the dates listed on the PA. The actual date that the service was delivered should be used as the date of service when filing a claim for payment.

After PA approval is received and the eye wear is delivered to the patient, the provider should bill for all of the services rendered. All eye wear services, regardless of whether PA required, may be billed on the same claim form (see Section 46.5 for more on claims related information).

Post Authorization

Post authorization may be obtained for a procedure that normally requires prior authorization if a recipient becomes retroactively eligible for Medicaid. However, such requests must be submitted within six months from the date of Medicaid certification of retroactive eligibility.