PRIOR AUTHORIZATION

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

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

Required Documentation for Prior Authorization

Request for PA shall include the following:

1. Completed Form PA-01. (See Appendix B);

2. Copy of the prescription;

3. Letter that documents medical necessity for all PA requests; and

NOTE: The letter of medical necessity **must** be obtained from the prescribing provider and must be specific to each individual beneficiary.

4. Copy of the invoice and a detailed description of the items(s) for all codes "manually priced" as noted in the eyewear fee schedule. (See Appendix A).

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

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

1. Field 11 - Procedure Code;

2. Field 11A - Modifier-when applicable;

3. Field 11B – Description;

4. Field 11C - Requested Units; and

5. Field 11D - Requested Amount.

Items that do not require PA must be listed below those that require PA on the Form PA-01. Only the "Description" (Field 11B) shall be completed for items that do not require PA.

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

PA requests related to eyewear will be granted for a 3-month authorization period. The provider shall indicate the appropriate 3-month span in the "Dates of Service" sections on the Form PA-01. The "Begin Date of Service" (Field 7) must be the date of initial contact with the beneficiary. The "End Date of Service" must be 3 months from the begin date of service specified in Field 7.

Providers 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:

1. The medical condition that makes the beneficiary eligible for contact lenses;
2. Whether the beneficiary is aphakic or not aphakic;
3. Substantiation for special fittings (e.g.; Keratoconus);
4. All appropriate procedure codes;
5. The provider's total fee, including professional fitting services (excluding initial examination), the contact lenses, the required care kits, and follow-up visits for 90 days; and
6. A statement indicating if the contact lenses are:
    a. An original fitting (or refitting) or for replacement lenses;
    b. For unilateral or bilateral lenses;
    c. Spherical or toric;
    d. Rigid (PMMA or gas permeable) or soft lenses; and
    e. Daily wear or extended wear.

NOTE: PA 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 shall not take longer than ~~25~~ seven calendar days to process. Should the provider fail to receive a PA decision within a timely manner, the provider shall contact the PAU. (See Appendix D for Contact Referral Information).

Once the review process has been completed, providers are notified, via letter, of the decision to approve or deny the service. If the service is not approved, a denial reason is indicated in this letter. If approved, the letter also includes the nine~~9~~-digit PA number assigned to the request, which must be used when billing. This nine~~9~~-digit number must be entered in item 23 of the CMS~~--~~1500 form or the electronic Health Insurance Portability and Accountability Act (HIPAA) compliant equivalent, 837P when billing.

Upon PA approval, the provider shall 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 shall be used as the date of service when filing a claim for payment.

After PA approval is received and the eyewear is delivered to the beneficiary, the provider shall bill for all of the services rendered. All eyewear services, regardless of whether PA is required, may be billed on the same claim form. (See Section 46.5 - Reimbursement for more information on claims related information).

Post Authorization

Post authorization may be obtained for a procedure that normally requires PA if a beneficiary becomes retroactively eligible for Medicaid; however, such requests must be submitted within six~~6~~ months from the date of Medicaid certification of retroactive eligibility.