

Instructions for Obtaining Pre-Authorization for Ophthalmology Services for AvMed Health Plans Members

The following services require pre-authorization by OptiCare:

- The CPT codes listed on the following page require pre-authorization regardless of where the service is performed.
- Any procedure code that is considered an “unlisted” procedure code as defined by the AMA Current Procedural Terminology (CPT) manual (CPT codes 6xx99)
- Any service that takes place in a facility
- Experimental and investigational services
- 66982 is generally approved as 66984 and then considered for upgrade post-operatively upon request and with a copy of the operative report.

Pre-authorization requests using the Eye Health Manager (preferred method):

Participating providers may utilize the OptiCare website to obtain pre-authorizations and verify status of pre-authorization requests at www.opticare.com. For automatic approval of a pre-authorization request, the procedure must be performed at a participating facility and the clinical information supporting the request must meet OptiCare guidelines for medical necessity. If a request for pre-authorization meets medical necessity guidelines, an approval number will be issued and the provider may print an authorization letter immediately. If a request for authorization does not meet the medical necessity guidelines, the request will pend for further review. The provider should fax all supporting clinical information to the OptiCare Utilization Management Department at (252) 451-2133. Submitting pre-authorization requests via the Eye Health Manager will significantly reduce waiting time for authorization determinations.

Please follow the instructions listed below when requesting a pre-authorization review via fax:

- Ensure that the *OptiCare Managed Vision Pre-Authorization Request Form for AvMed Members* is filled out completely so your request can be processed in a timely manner. Include office and facility addresses.
- Physician signature is required on every request.
- Pre-authorization requests must include the codes for all procedures that will be performed during the surgical session.
- Fax the completed form and any supporting clinical information to OptiCare at (252) 451-2133.
- After OptiCare has received the request it will be entered into the medical management system and a Clinical Reviewer will review the information. If necessary, you may be contacted for additional information.
- You will be notified within 14 business days upon completion of the review.
 - If the requested service is approved, an authorization letter will be faxed to your office.
 - If the requested service results in a denial, the requesting physician will be offered a peer to peer conference with an AvMed Medical Director.
- **Providers must use participating AvMed facilities and receive authorization for the facility and anesthesia directly from AvMed.** Upon receiving authorization from OptiCare for the services to be provided, a copy of the authorization should be faxed to AvMed's Clinical Coordination Department at (800) 552-8633 to obtain authorization for the facility.
- **Upon receiving an authorization from OptiCare, for a procedure with a drug component, a CuraScript Referral Form must be completed and faxed to (888) 773-7386. The following drugs must be obtained from CuraScript: Botox, Lucentis, Macugen, Myobloc and Visudyne.** Providers may purchase all other injectable drugs including Avastin, Dexamethasone, Fortaz, Kenalog, Ozurdex and Vancomycin from a supplier of choice and bill AvMed directly. Reimbursement is based on the current *Payment Allowance Limits for Medicare Part B Drugs* schedule. **Avastin is the only ocular drug that requires pre-authorization from AvMed.** Upon receiving authorization from OptiCare for the injection, a copy of the authorization should be faxed to AvMed's Clinical Coordination Department at (800) 552-8633 to obtain authorization for Avastin.

Emergency Procedures

Emergent procedures do not require prior authorization. Services provided on an emergent basis should be submitted to OptiCare for retrospective review and authorization by the next business day after services have been rendered. Retroactive review of services may be requested by submitting the CMS 1500 and medical records to OptiCare via fax to (252) 451-2133. **Upon approval by OptiCare, the facility authorization must be obtained from AvMed Health Plan's Clinical Coordination Department for any emergent procedures via fax to (800) 552-8633.**

Emergency care is defined as any health care service provided in a hospital emergency facility (or comparable facility) in order to evaluate and stabilize medical conditions of recent onset and severity (including severe pain), if such condition would lead a prudent layperson (possessing an average knowledge of medicine and health and acting prudently) to believe that failure to get immediate medical care might result in:

- placing the person's health in serious jeopardy
- serious impairment to bodily functions
- serious dysfunction of any bodily organ or part
- serious disfigurement
- in the case of a pregnant woman, serious jeopardy to the health of the fetus.

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OptiCare Managed Vision
 CPT Codes for Prior Authorization
 Effective July 1, 2010

Cataract Extraction and Related Procedures	Strabismus Surgery	Lid Procedures ** original photos required	Miscellaneous	
66825	67311	11440 -11446	17380	Electrolysis Epilation
66830	67312	14040	64612	Chemodenervation
66840	67314	14041	67027 - 67028	Intravitreal Injection
66850	67316	14060	67221 - 67225	Ocular Photodynamic Therapy
66852	67318	15004 - 15005	68761	Closure of Lacrimal Punctum
66920	67320	15120	76512	B-Scan
66930	67331	15260	92071 - 92072	Contact Lens Fitting-Disease
66940	67332	15261	92270	Electro-oculography
66982	67334	15630	92275	Electroretinography
66983	67335	15576	92283	Color Vision Examination
66984	67340	15822**	92284	Dark Adaptation
66985	67343	15823**	92286	Anterior Segment Photography
66986	67345	15841	95930	Visual Evoked Potential
66999	67399	15845	99241 - 99245	Outpatient Consultation
		15850	99251 - 99255	Inpatient Consultation
Corneal Transplant and Related Procedures	YAG Capsulotomy	15851	99261 - 99265	Follow-Up Inpatient Consult
	66820	21282		
	65710	67840		
	65730	67880 - 67882		
	65750	67900 – 67904**		
	65755 - 65756	67906 – 67911**		
	65765	67914 - 67924		
	65767	67961 - 67966		
	65770	67971 - 67975		
	65772	67999		
	65775			
	65780 - 65782	Lesion Removal		
	0289T	17110 - 17111		
	0290T	17280 - 17286		

All services performed in a facility require pre-authorization.

**Original photographs required for pre-authorization of lid procedures as designated above should be mailed to:

OptiCare Managed Vision
 ATTN: Medical Management Department
 P.O. Box 7548
 Rocky Mount, NC 27804

EMERGENCY PROCEDURES:

OptiCare Managed Vision considers procedures related to repair of a retinal detachment (67101 – 67145) to be urgent. Other procedures are considered on a case-by-case basis. Emergent procedures do not require prior authorization. Retroactive review of services may be requested by submitting the CMS 1500 and medical records to OptiCare via fax to (252) 451-2133. **Upon approval by OptiCare, the facility authorization must be obtained from AvMed Health Plan’s Clinical Coordination Department for any emergent procedures via fax to (800) 552-8633.**

Fax request to: (252) 451-2133

Phone: (800) 465-6972

PATIENT INFORMATION					
Patient Name				Plan	
Member ID				DOB	
CPT Code(s)				Modifier(s)	RT/OD LT/OS 50/OU
Diagnosis Code(s)				(Circle all that apply)	51 52 54 55 56 62 78 80 _____
REQUESTING PROVIDER INFORMATION					
Physician Name				Phone	
Address				Fax	
NPI				Contact	
Facility Name				DOS	
Facility Address					
CO-MANAGING PROVIDER INFORMATION (if applicable)					
Provider Name				Phone	
Address				Fax	
NPI					
All supporting findings must be documented in the medical records.					
CATARACT SURGERY (66982-66986)			YAG CAPSULOTOMY (66820-66821)		
<input type="checkbox"/> Manifest Refraction with BCVA _____ <input type="checkbox"/> Brightness Acuity (BAT) _____ <input type="checkbox"/> Patient Complaint(s) _____ <input type="checkbox"/> Location/Grade of Cataract _____ A comprehensive evaluation including manifest refraction, slit lamp examination and dilated fundus examination must be completed no more than 3 months prior to surgery.			<input type="checkbox"/> Manifest Refraction with BCVA _____ <input type="checkbox"/> Patient Complaint(s) _____ An ophthalmic evaluation including manifest refraction, slit lamp examination and dilated fundus examination must be completed no more than 3 months prior to surgery.		
CORNEAL TRANSPLANT (65710-65755, 65765-65770, 0289T – 0290T)			STRABISMUS (67311-67355)		
Medical records should include: <input type="checkbox"/> Manifest Refraction with BCVA <input type="checkbox"/> Patient Complaint(s) <input type="checkbox"/> Slit Lamp Exam Findings <input type="checkbox"/> Posterior Exam Findings			Medical records should include: <input type="checkbox"/> Cycloplegic Refraction with BCVA <input type="checkbox"/> Patient Complaint(s) <input type="checkbox"/> Deviation, Angle, Type <input type="checkbox"/> Distance and Near Vision		
INJECTIBLES, PDT, BOTOX (64612, 67028, 67221)			LID PROCEDURES (Refer to PA instructions for codes)		
Medical records should include: <input type="checkbox"/> Anticipated DOS <input type="checkbox"/> Date of Last Treatment <input type="checkbox"/> Name of Drug: (Avastin, Botox, Lucentis, Macugen, Visudyne)			Medical records should include: <input type="checkbox"/> Visual fields and photos with subjective complaints		
CONSULTS (99241-99265)			OTHER		
Medical records of referring physician must include: <input type="checkbox"/> Anticipated DOS <input type="checkbox"/> Name of requested consulting physician Dr. _____			Medical records should contain documentation to support medical necessity of procedure requested including slit lamp exam findings, dilated fundus exam findings, tear film volume, etc. as applicable.		
Signature of Requesting Physician (Required)			FOR OFFICE USE ONLY		
_____			Approval _____ Denial _____ Date _____		
_____			Auth # _____ MD _____		

Pre-authorization is not a guarantee of payment. Covered services are based on member eligibility and benefit limitations at the time service(s) are rendered. Payment is not authorized for services beyond those requested above. If further treatment is indicated, additional prior authorization must be obtained. Please verify member's eligibility prior to performing services.

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