

Instructions for Obtaining Pre-Authorization for Ophthalmology Services for Louisiana Healthcare Connections Members

The following services require pre-authorization by OptiCare:

- CPT codes 15822, 15823, 67900, 67904 and 67908 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 non-participating facility
- Experimental and investigational services

Please follow the instructions listed below when requesting a pre-authorization review for blepharoplasty procedures:

- Ensure that the *OptiCare Managed Vision Pre-Authorization Request Form* 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.
- The completed form and supporting clinical information including original photos should be mailed to:
OptiCare Managed Vision
ATTN: Medical Management Department
P.O. Box 7548
Rocky Mount, NC 27804
- 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 within 2 business days of receipt.
- You will be notified within 2 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 OptiCare Medical Director.
- Providers must use participating Louisiana Healthcare Connections facilities and receive authorization for the facility from Louisiana Healthcare Connections. To facilitate this process, OptiCare will submit a copy of the authorization to Louisiana Healthcare Connections to initiate the facility authorization.
- Participating providers may utilize the OptiCare website to verify status of pre-authorization requests at www.opticare.com.

Please follow the instructions listed below when requesting a pre-authorization review for services rendered in a non-participating facility:

- Ensure that the *OptiCare Managed Vision Pre-Authorization Request Form* 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 2 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 OptiCare Medical Director.

Emergency Procedures

Emergent procedures do not require prior authorization. Services provided on an emergent basis in a non-participating facility 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.

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.

OptiCare Managed Vision
112 Zebulon Court
Rocky Mount, NC 27804
Medical Pre-certification Request
Phone Toll Free (800) 465-6972

_____ **EMERGENT**
 _____ **URGENT**
 _____ **ROUTINE**

Date _____ Office Contact _____ Phone _____ Fax _____

Referring Physician _____ Referred to Physician _____ NPI# _____

Co-Management: Please specify Co-managing Provider _____

Patient Name (Last) _____ (First) _____ (Middle) _____ DOB _____

ID # _____ HMO (Plan) _____ Group # _____

Other Insurer (if any) _____

Date of Admit _____ Date of Surgery _____ IP/OP (Circle One) Anticipated LOS _____

Facility Name & Address _____

Diagnosis: (must be provided)

Procedure :(must be provided)

ICD 9 _____ Description _____ CPT _____ Description _____ **RT LT 50**

ICD 9 _____ Description _____ CPT _____ Description _____ **RT LT 50**

ICD-9 _____ Description _____ CPT _____ Description _____ **RT LT 50**

PCP Referral Number: _____ Effective date _____ Expiration date _____

Medical Reason for Request _____

Attach additional pages if necessary

Patient's Subjective Complaint: _____

Patient's BCVA: OD _____ OS _____

Signature of Attending Physician: _____ Date _____

Office Location: _____

PRE CERTIFICATION/AUTHORIZATION IS NOT A GUARANTEE OF PAYMENT. COVERED SERVICES ARE BASED ON MEMBER ELIGIBILITY AND BENEFIT LIMITATIONS AT THE TIME SERVICE(S) ARE RENDERED.

DO NOT WRITE BELOW THIS LINE - FOR OFFICE USE ONLY

Reviewing Physician _____ Approve _____ Approved LOS _____

Denied: _____ Rationale for Denial: _____

Recommendation for alternative treatment(s) _____

Reviewing Physician Signature _____ Date _____

Authorization # _____ or Denial Reference # _____ Date _____

Medical Claims Administrator Signature _____

If Denied: Please refer to your Provider Manual or call 1-800-465-6972 to be informed of your appeal rights

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