HOME STATE HEALTH PLAN - INSTRUCTIONS FOR OBTAINING PRE-AUTHORIZATION FOR OPHTHALMOLOGY SERVICES

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 an non-participating facility or by a non-participating physician
- 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.
- **Provider 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 of receipt of all necessary information 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 Home State Health Plan facilities and receive authorization for the facility from Home State. To facilitate this process, OptiCare will submit a copy of the authorization to Home State 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 or by a non-participating physician:

- 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. . Pre-authorization requests for eyelid procedures (15822, 15823, 67900, 67904, 67908) must include original photos and be mailed to the address noted above.
- 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 of receipt of all necessary information 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

home state health™

_____ **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)** **Circle: (appropriate eye(s))**

ICD _____ Description_____CPT_____Description _____ RT LT 50

ICD _____ Description_____ CPT_____ Description _____ RT LT 50

ICD _____ 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 INTERNAL 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 _____

Reviewer Signature _____

PLEASE FAX YOUR REQUEST TO: (252) 451-2133 OR MAIL TO:
OptiCare Managed Vision, ATTN: Medical Management, P.O. Box 7548, Rocky Mount, NC 27804

If denied, please refer to your Provider Manual or call (800) 465-6972 to be informed of your appeal rights

The information contained in this transmission is intended only for the use of the individual or entity to whom it is addressed and may contain information that is confidential and exempt from disclosure under applicable law. **If the reader of this message is not the intended recipient or the employee or agent responsible for delivering this message to the intended recipient, you are hereby notified that any dissemination distribution, or copying of this communication is strictly prohibited. If you have received this communication in error, please notify us immediately by telephone and return the original message to us at the above address via the United States Postal Service. We apologize for any inconvenience this may have caused you. Thank you.**