ATTACHMENT J - 17.9

OFFICE OF UTILIZATION MANAGEMENT PRIOR AUTHORIZATION EYEWEAR AND CONTACT LENSES

DEPARTMENT OF HEALTH
MEDICAL ASSISTANCE ADMINISTRATION

OFFICE of QUALITY MANAGEMENT	POLICY AND PROCEDURES

SUBJECT: Prior Authorization Process for Eyeglasses and Contact Lenses for the DC Medicaid Fee for Service (FFS) program

Effective Date:

Last Date Revised
June 13, 2008

The District of Columbia Medical Assistance Administration's (MAA) Medicaid program covers lenses with frames and contact lenses that are required to aid or improve vision when they are prescribed by a physician skilled in diseases of the eye or by an optometrist at the discretion of the patient, and when they meet the requirements below:

1. Eyeglasses are limited to one complete pair in a twenty-four (24) month period. Exceptions to this policy are:
    a. Recipients under twenty-one (21) years of age;
    b. Whenever there is a change in the prescription of more than plus or minus .5 (one half) diopter; and
    c. Broken or lost eyeglasses.
2. Special glasses such as sunglasses and tints must be justified in writing by the ophthalmologist or optometrist. Special tints and sunglasses are not allowed in addition to un-tinted eyewear.
3. Contact lenses must be prior authorized by the State Agency.

MAA also contracts with a quality improvement organization (QIO) to verify the medical necessity for eye glasses and contact lenses, and that the restrictions described above are followed. This document describes the policies and procedures that MAA and MAA's QIO will follow in authorizing Medicaid payments for eye glasses and contact lenses.

Purpose:
To help ensure that beneficiaries receive eyeglasses or contact lenses that best correct their vision problems and to make efficient use of recipient and MAA resources.

Policy:
MAA's QIO will execute the prior authorization process in advance of an optical provider providing eyeglasses or contact lenses for a Medicaid recipient in accordance with the DC Medicaid State Plan, Supplement to Attachment 31.B, Page 19C.

Procedures:

I. Provider Procedure:

1. Every requesting optical provider is to complete fields 1-11, 13,15A and 15B of the 719A Form by indentifying the appropriate ICD-9 and Current Procedural Terminology (CPT) codes for the services, the estimated charges and billing information.
2. The requesting provider faxes the 719A Form and supporting documentation to the QIO Prior Authorization Unit. The supporting documentation shall include:
    a. Results of the last eye examination, including the name of the optical provider and the date.
    b. A letter of justification for the replacement eyeglasses.
3. The requesting provider shall call the QIO Prior Authorization Unit for all inquiries.

II. QIO Prior Authorization Unit Procedure:

Timelines

a. Within five (5) business days of the 719A Form receipt date, the QIO Prior Authorization Unit will conduct a review of each complete 719A Form, and fax to the requesting provider all determinations, including information on appeal rights for denials, if the requested optical service or product is included within MAA's list of covered services.

b. If the requested optical service or product is not included within MAA's list of covered services, the requesting provider will be notified that their request has been forwarded to MAA for review. The QIO Prior Authorization Unit will then fax the complete 719A Form and supporting documentation to MAA. Within two (2) business days, MAA will review and manually price the requested service or product, and fax a decision to the QIO Prior Authorization Unit. Within seven (7) business days of the date the 719A Form was originally submitted by the requesting provider, the QIO Prior Authorization Unit will fax a decision to the requesting provider.

c. *All incomplete 719A forms will be returned to the requesting provider via fax immediately.* The requestor will have two (2) business days to complete the form and fax it back to the Prior Authorization Unit. The QIO will use medical criteria approved by MAA.

d. Authorization of an optical service or product is valid for a period of sixty (60) days.

Tracking

The QIO will maintain a tracking log of all prior authorization requests and transactions, which includes the recipient and requesting physician names and identification numbers, time log, billing provider name and identification number, the origin of the request, date of service, the type of service requested, and the prior authorization number issued. The

tracking log will be updated monthly on the QIO's web portal, under 'Out Patient'.

Prior Authorization Process

1. **Recipient and provider verification.** The QIO Prior Authorization Unit will implement the prior authorization process by verifying the:
    a. Patient's eligibility for Medicaid (located in the MMIS Recipient Subsystem screen), including the patient's active coverage period, as follows:
        - Date of services requested shall not exceed recipient's eligibility end dates;
        - If the recipient's eligibility end date is 999999, they are eligible for services indefinitely.
        - If specific eligibility codes are present, the request for prior authorization will be denied.
    b. Provider's status as an enrolled Medicaid provider (located in the MMIS Provider Subsystem screen);
        - Active Status (01)→Eligible to provide services; or
        - Inactive Status→ Not eligible to provide services.
    c. Presence of appropriate diagnosis and procedure codes;
    d. Written justification and supporting documentation; and
    e. Requesting provider signature and date.

2. **Data submission to MMIS.** If the eye glasses or contact lenses are approved, the QIO Prior Authorization Unit remotely and electronically enters the approved data into the MMIS Prior Authorization Subsystem. Upon the entry of all necessary data, a prior authorization number is generated. The data entry process includes populating the following fields:
    A. approval status-→A (indicating approval);
    B. provider Letter Status-→Y (mail letter to provider);
    C. recipient Number;
    D. billing Provider Number;
    E. approver ID Number;
    F. dates of Service Range;
    G. diagnosis Code;
    H. procedure Code (see list);
    I. unit Number (for each procedure code requested); and
    J. Estimated Charge.

3. **Transmittal of approval to provider.** The QIO's Prior Authorization Unit faxes to the requesting provider the 719A Form that includes a prior authorization number, approved dates of service range, approved HCPCS or CPT codes, and approved units.

III. Facility Submits Claim to ACS

The requesting provider must document the prior authorization number provided by the QIO (which is obtained and generated from the MMIS system) in Box 23 of the CMS 1500 as part of their claim submission. The payment will be denied if an authorization number is not present on the CMS 1500.

IV. Appeals Process:

a) The requesting provider may fax a request for reconsideration to the QIO Prior Authorization Unit.
b) The Prior Authorization Unit will:
    1. Arrange for a reviewer, other than the reviewer who performed the initial review, to perform the reconsideration review; and
    2. Issue the reconsideration decision within fourteen (14) business days of the reconsideration request.
        - If approved, the Prior Authorization Unit electronically remotely enters the approval data into the Prior Authorization Subsystem of the MMIS and QIO Web Portal.
        - If not approved, provide written notification of denied services including information on appeal rights.

V. Customer Service

a) The QIO Prior Authorization Unit will respond to provider and recipient inquiries regarding prior authorization requests.
b) If the QIO Prior Authorization Unit is unable to adequately answer provider and recipient inquiries, the QIO Director of DC Medicaid Programs will respond.
c) If neither the QIO Prior Authorization Unit, nor the QIO Director of DC Medicaid Programs, is able to adequately answer provider or recipient inquiries, the MAA Contracting Officer's Technical Representative will respond.

Exceptions:
See list of Ineligible Recipient Program Codes

Revision History

Enclosed Materials:

1. Sample of Completed 719A Form (Attachment A)
2. Instructions for How to Complete a 719A Form (Attachment B)
3. Ineligible Recipient Program Codes (Attachment C)
4. List of Current DC Medicaid Covered Optical Services (Attachment D)
5. Sample Letter for Requested Optical Codes Not Currently Covered by MAA (Attachment E)
6. Medical Assistance Administration Action Transmittal _____ (Attachment F)

Official Approval:	Date:
Senior Deputy Director Approval:	Date:

J.13.10.1	Eyewear – Contact Lenses Sample of Notification of Denial

(QIO LETTER HEAD)

TO:

FROM: QIO
Prior Authorization Unit

DATE:

SUBJECT: **Submitted Request for Eyeglasses and/or Contact Lenses Requires Additional Review**

Your submitted request for the prior authorization of Eye Glasses and/or Contact Lenses for District of Columbia (DC) Fee-for-Service (FFS) Medicaid recipient **Recipient's Name** requires further review.

The service code(s) provided on the 719A Form submitted for the above recipient is not currently in the Department of Health Care Finance (DHCF) List of Current District of Columbia Covered Optical Services. The request has been forwarded to a DHCF representative for evaluation. Delmarva Foundation will fax a final determination within seven (7) business days from the date the request was initially received by the QIO's Prior Authorization Unit.

Should you have a question, need or concern regarding prior authorization requests, please first contact the Delmarva Prior Authorization Unit at 202-496-6541. If your needs or concerns are not adequately addressed by the Prior Authorization Unit, contact (Insert Contact), the QIO Director, at (Insert Phone Number). After exhausting the first two steps, if your issue is still not resolved, contact the DHCF Contracting Officer's Technical Representative, Jennifer Campbell at 202 .