



**First Health
Services Corporation®**

A Coventry Health Care Company



December 2006

Alaska Medical Assistance Newsletter

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First Health Services Corp.
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First Health Services, in conjunction with the Department of Health & Social Services, publishes this monthly newsletter to offer providers useful information, monthly reminders, and tips on how to make billing easier.

Claim Forms Revised

December 2006

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The National Uniform Claim Committee (NUCC) has approved revisions to the CMS-1500 Claim Form to accommodate the reporting of the National Provider Identifier (NPI) number. Its use is required as of April 1, 2007 with a transition period commencing prior to that date. The Alaska Medicaid Management Information System (MMIS) is being modified to accommodate the changes found in the new CMS-1500 but is not yet equipped to accept and process this revised form. As the changes to the system are implemented, additional instructions will be provided. In the meantime, please familiarize yourself with the changes. For a list of the changes from the current (12/90) version to the revised (08/05) version, view the change log document posted on the NUCC Website, <http://www.nucc.org>. For providers who use the 837P to submit claims, the NUCC is updating the crosswalk from the 837P to the revised CMS-1500 claim form. Once it is completed, it will also be available on the NUCC Website.

FHSC and the State of Alaska offices will be closed on December 25, 2006 in observance of Christmas Day.

The National Uniform Billing Committee (NUBC) approved the UB-04 as the replacement for the UB-92 at its February 2005 meeting. Submitters (health care providers such as hospitals, skilled nursing facilities, hospices, and other institutional claim filers) can use the UB-04 beginning March 1, 2007; however, there will be a transitional period between March 1, 2007 and May 22, 2007 where the UB-04 or the UB-92 can be used. Starting May 23, 2007 all institutional paper claims must use the UB-04; the UB-92 will no longer be acceptable after this date.

For more information visit the NUBC Website at: <http://www.nubc.org/>

Useful Fax numbers:

- PA: 644-6831
- PI/Enrollment: 644-8127
- EPS: 644-8122
- Finance: 644-8120

Medicare Crossover Claims

When billing Alaska Medical Assistance, please wait 45 days from the date on your Medicare EOMB to allow cross-over processing time. Submitting your cross-over claim before the 45 day processing time may cause a duplicate payment. *Providers are reminded that Medical Assistance recipients should not have a credit balance.* As stated in 7 AAC 43.081, an overpayment occurs when the division reimburses a provider in excess of the amount due because of billing practices of the provider. Such practices could result in recoupment of the overpayment.

National Provider ID (NPI)

The deadline for providers submitting electronic transactions to begin using NPI exclusively is May 23, 2007. If you do not yet have an NPI, you can [apply online](#).

The estimated time to complete the NPI application is 20 minutes. If you prefer a paper application, please call (800) 465-3203.

Getting an NPI is free – not having one can be costly.

NPI Tip:

When applying for your NPI, CMS urges you to include your legacy identifiers, not only for Medicare but for all payors. If reporting a Medicaid number, include the associated State name. This information is critical for payors in the development of crosswalks to aid in the transition to the NPI.

NPI: Get it. Share it. Use it.

National Provider Identifier

Only six months remaining until the National Provider Identifier (NPI) compliance Date of May 23, 2007. Over 1,300,000 NPIs have been issued so far—do you have your NPI yet?

Act Now!

Don't procrastinate; getting your NPI is only the first step in preparing for the compliance date. You should allow time to share your NPI with payers and other trading partners, update your referral lists, as well as to modify and test computer systems.

Resources for Commonly Asked Questions

CMS has compiled a [list of resources](#) that will help to answer many questions on NPI. Visit to view this resource. In addition, CMS continues to build its database of [Frequently Asked Questions \(FAQs\)](#) for NPI. Recently, an FAQ on Electronic File Transfer (EFT) of payments from health plans to health care providers was added. For more information visit the [CMS Website](#).

Do you have your NPI yet?

All HIPAA healthcare providers, whether they are individuals or organizations, must obtain an NPI for use to identify themselves in HIPAA standard transactions. Once enumerated, a provider's NPI will not change. The NPI remains with the provider regardless of job or location changes.

HIPAA-covered entities such as providers completing electronic transactions, healthcare clearinghouses, and large health plans, must use only the NPI to identify covered healthcare providers in standard transactions by May 23, 2007.

Additional information and resources can be found in the following links:

9/26 NPI Roundtable Transcript Available Now

The transcript for the 9/26 NPI Roundtable can be found at:

<http://www.cms.hhs.gov/EducationMaterials/Downloads/NationalProviderIdentifierRoundtable.pdf> on the CMS website.

NPI Training Package: Module 5 Available Now

Module 5, Medicare Implementation, provides the NPI requirements specific to Medicare providers. This module will be updated as new requirements are announced or changes are made. Module 5 is now posted at:

http://www.cms.hhs.gov/NationalProviderStand/Downloads/NPI_TrainingPackage.pdf on the CMS NPI Page.

As always, more information and education on the NPI can be found at the CMS NPI page <http://www.cms.hhs.gov/NationalProviderStand> on the CMS website.

Providers can apply for an NPI online at: <https://nppes.cms.hhs.gov> or can call the NPI enumerator to request a paper application at (800) 465-3203.

Reminder...

When requesting TPL avoidance, remember to continue to bill your claim(s) with an EOB that has a valid denial for that benefit year until you are notified by FHSC that your TPL avoidance has been approved by the state. Do not hold claims.

You do not have to bill each claim to the TPL as long as you have a denial for that benefit year.

Electronic Billers:

Loop 2300 (Claim Text Loop) is used only for explaining details regarding your claim; entries in this field will cause your claim to stop for review by claims resolution staff. Using Loop 2300 to enter the servicing provider or the UPIN will also cause a delay in reimbursement.

Behavioral Health Updates

Therapeutic Transition Days (TTD)

If Therapeutic Transition Days (TTD) have been approved, they must be billed separately from any regular rate claim which has already paid. An adjustment to the paid regular rate claim will NOT result in payment for the TTD.

Therapeutic transition day means a calendar day related to a hospitalization in a residential psychiatric treatment center that is authorized by the division for payment of services for a recipient under the age of 21 who has been stabilized and therefore is ready for transition or discharge. TTDs are designed to allow RPTC health providers to continue delivering care and receiving certification for services while facilitating difficult discharge plans that include movement to a less intense level of care. Refer to the *Policy and Procedure for TTD* flyer that is dated June 6, 2006 for further clarification. The Revenue code for TTDs is 19X and the reimbursement rate is \$211. If you have already billed these days using the regular revenue code you will need to void the claim and resubmit your claim using the TTD revenue code when the void processes.

Individual Service Agreement (ISA) Funds

The State has made additional funds available to meet the needs of youth returning from residential treatment or who are at risk for out-of-home placement. The ISA resources are available for youths for which there are no other payment sources through the youth's community behavioral health center.

Service Agreements are only available through Community Behavioral Health Centers. Providers can recommend the individual service agreement to the Community Behavioral Health Center in the discharge planning process.

For provider agreement details and eligibility go to the state web site <http://www.hss.state.ak.us/dbh/> and click on **Grants**.

Alaska Provider Information Form

The newly revised Alaska Provider Information form is now available on FHSC's website at <http://alaska.fhsc.com>. Choose **Providers**, then choose **Behavioral Health**, then choose **Information**; the form is listed on the bottom of the page.

For your convenience, the form may be filled out online. Once completed, you may print the form and fax, mail, or email it to FHSC. The fax number is (907) 644-5998. The email address is myntashea@fhsc.com. The mailing address is: First Health Services Corporation, Attention: Lyn Tashea, PO Box 240808, Anchorage, AK 99524-0808.

For more information contact Lyn Tashea at (907) 644-6800 or (800) 770-5650 (in state, toll-free).

Medicare DME, Orthotics and Supply Suppliers

The Centers for Medicare and Medicaid Services (CMS) will be linking Medicare provider numbers with NPI numbers.

As mentioned in the paper *Medicare Expectations on Determination of Subparts by Medicare Organization Health Care Providers Who Are Covered Entities Under HIPAA*, **Medicare DME suppliers are required to obtain an NPI for every location.**

April - December 2006 Training Schedule:

The April to December 2006 training schedule is available on FHSC's Website at <http://alaska.fhsc.com>. Choose **Training**, and then choose **Schedule**.

Paper Billers:

Be sure to use the correct provider identification number on your claim form(s). Claims with incorrect provider identification numbers will be returned for resubmission with the correct information necessary for processing.

COBA Reminder:

To ensure successful COBA crossover claims remember to update your Medicare number with our Provider Enrollment unit and to enter your Medicaid Provider ID number in the appropriate fields on your Medicare claims. You can update your provider file by sending us your "Welcome to Medicare" letter or by sending in an RA with your Medicare EOB/MRN from within the past three months with a note for us to update your Medicare number in our provider files. Be sure to also indicate your Medicaid Provider identification number so we can update the correct provider file.

Medicare DME, Orthotics and Supply Suppliers (con't)

The only exception to this requirement is the situation in which a Medicare DME supplier is a sole proprietor. A sole proprietor is eligible for only one NPI (the individual's NPI) regardless of the number of locations the supplier may have.

The requirement for Medicare DME suppliers to obtain NPI numbers for every practice location applies also to those Medicare DME suppliers who do not send electronic claims to Medicare. Federal regulations require the unique enumeration of every location of a Medicare DME supplier regardless of how claims are submitted. Remember, sole proprietors are eligible for only one NPI. Failure to comply with this requirement may result in delayed processing or the rejection of Medicare claims.

For more information on Medicare Subpart Expectations, please visit the Medicare Subpart Guidance Paper at:

<http://www.cms.hhs.gov/NationalProvidentStand/Downloads/Medsubparts01252006.pdf>

Provider Training

Providers and billing staff are encouraged to attend training. There is no charge to attend, as training is sponsored under contract with the State of Alaska, Department of Health and Social Services, Division of Health Care Services. All participants should bring their provider billing manuals.

Because of limited space, you are encouraged to register early; registration for each class will close one day prior to the date of the class. Only registered attendees with a confirmed registration are guaranteed a seat. Those without a confirmed registration may be turned away. If registration requests exceed the available seats, additional sessions may be offered.

Register for classes in one of the following ways:

- Complete the online registration form on the First Health Services Website at <http://alaska.fhsc.com>.
- Complete the registration form in the Alaska Medical Assistance Training Schedule and fax to First Health Services at (907) 644-9845 or Mail to P.O. Box 240808, Anchorage, Alaska 99524-0808.

After First Health Services receives and processes your registration, you will receive a confirmation for the classes in which you are enrolled.

Training Email and Fax Numbers

The Alaska Medical Assistance training email address (anctraining@fhsc.com) is provided for your convenience to send in your questions and comments regarding training offered by FHSC, and to submit completed training registration forms. For Indian Health Services (IHS) training information, the training email address is ihs@fhsc.com.

Training also provides a fax number ((907) 644-9845) for your convenience in sending in registration forms or correspondence to FHSC's training department. Remember, our professional staff is ready to assist you, whatever your training needs may be.

Please do not send sensitive or confidential information via email, as this is not a secure method of sending confidential information.

Friendly Reminders...

- When transmitting electronic claims that have attachments, make sure the Attachment Fax Cover Sheet accompanies the attachments. The fax sheet must be dated the same date as the electronic transmission in order for us to match the attachments with the transmission.
- Write your Prior Authorization number on your claims for reimbursement if the service(s) required prior authorization and you did obtain the authorization. Services that require prior authorization are indicated in your billing manual and fee schedule.

December Training Schedule

CANCELLED: The **Dental Services** teleconference scheduled for December 14, 2006 has been cancelled.

Teleconference

December 7, 2006 Edit Resolution..... 1:00 p.m. – 3:00 p.m.

Anchorage

December 12, 2006 Intro. to AK Medical Assistance 8:30 a.m. – 12:00 p.m.

Eligibility 2:00 p.m. – 3:15 p.m.

Prior Authorization 3:30 p.m. – 5:00 p.m.

December 13, 2006 Remittance Advice..... 8:30 a.m. – 10:30 a.m.

Resubmission Turnaround Documents..... 10:45 a.m. – 12:00 p.m.

Appeals 2:00 p.m. – 3:30 p.m.

December 14, 2006 Adjustments and Voids 8:30 a.m. – 10:00 a.m.

Transportation and Accommodations 10:15 a.m. – 12:15 p.m.

Forms Issues

Hysterectomy Form Issues:

The Hysterectomy form has 3 parts: **Part I** is required for all providers and requires the physician’s signature. If a consent form was not obtained: Fill out the reason in 1 or 2 of Part I.

Part II is filled out by the physician, nurse, whomever and signed. This is the surgical consent part. If consent was not obtained (see 1 or 2 of Part I) this will not be filled out at all.

Part III is the consent filled out and signed by the patient. Again, if a consent form was not obtained (see 1 and 2 of Part I) this will not be filled out at all.

What Providers Need to Know:

Part I is always filled out – it is required. If a consent form was not obtained there needs to be a reason in 1 or 2 of Part I. If a consent form was not obtained—only Part I is filled out.

Parts II and III are only filled out if the consent form was obtained.

Waiting on an Adjustment?

Be sure to write the correct CCN number on your claim form. Incorrect CCN numbers will hold up any adjustments you are expecting.

Resubmission Turnaround Document (RTD)

Claims that are in Resubmission Turnaround Document (RTD) status on the in-process page of your Remittance Advice (RA) require some response from you as the provider.

Use the worksheet from the back of the RA when the claim went into RTD status to correct incomplete information or to attach additional information by the deadline on the worksheet. Sign and date the worksheet as it is an amendment of your original claim. *Send in only the RTD worksheet with any attachments*, as applicable. Your claim will not process until you respond and may hold up the rest of your claim lines.

You are given 90 days to send your corrected RTD worksheet to First Health. If no response is received from you after 60 days, a 2nd notice letter is generated. You have 30 days from the receipt of the letter to respond. Remember, the deadline does not change. If no response is received by the deadline, the claim will deny for Edit 076 – "RTD filing limit exceeded." If you receive the 076 denial, it is now too late to send in the corrected RTD worksheet. You must resubmit a corrected claim.

You may need to backtrack 90 days to find the RA in which the claim went into RTD status to determine the reason for the RTD so that the appropriate corrections can be made.

Do not attempt to make an adjustment to a claim or to add a claim line to the RTD. RTDs are an opportunity for you to correct a claim so that it can continue to process.

Electronic Billing

Providers have the option to bill electronically. You must have successfully tested for HIPAA compliant electronic transactions, have practice management software that supports the transactions, and have an information submission agreement on file with FHSC. You may contact FHSC's EMC/HIPAA coordinator or visit FHSC's website at <http://alaska.fhsc.com> for more information.

Be aware that any information entered in the **comments**, **narrative**, or **supporting documentation** fields on your electronic claim form will cause the claim to pend for review. Some providers, for example, DME providers must enter information in this field for the claim to process. However, if you are entering extraneous information in this field, your claim will stop to review. An example of extraneous information in this field would be a procedure code description when the description is not needed.

Unique Identification Numbers

Reminder to providers that submit claims electronically: Fax claim attachments the same day that you submit your claims. Enter a unique identification number of your choosing on each page of the attachment. Enter the unique identification number in the appropriate field on your claim form and write the unique identification number on the fax cover sheet. FHSC uses this unique identification number to match claim attachments to your electronic claims. Fax attachments to (907) 644-8122 or (907) 644-8123 on the same day that you submit your electronic claim. The fax attachment cover sheet is available in the Forms Appendix of your billing manual. You can also locate it in the Provider Manuals listed on the First Health website in the **Providers** menu. For more information, go to FHSC's website:

<http://alaska.fhsc.com>, choose the **HIPAA** menu, and then choose **Companion Guide**.

Request for Records:

At the request of a Department of Health and Social Services representative, an authorized federal representative, or another authorized representative, including an employee of the Department of Law, **a provider shall provide records free of charge**, including financial, clinical, and other records, which relate to the provision of goods or services on behalf of a recipient. A provider who maintains records in an electronic format shall ensure that the data is readily accessible.

Adjustments and Voids

Only *paid* claims may be adjusted or voided; denied claims may be corrected and resubmitted. Allow up to three weeks for an adjustment or void to process before submitting a corrected claim.

There are two ways to refund an overpayment to Medical Assistance:

1. Send a completed adjustment/void form(s) *without* a refund check. The funds will be collected from future payments and will appear on future remittance advice statements.
2. Send a completed adjustment/void form(s) *with* a refund check attached for the refund to be applied to the corresponding claim(s) only.
3. First Health accepts electronic adjustments and voids via the 837 transaction. Indicate 7 in the appropriate field for an adjustment transaction. Indicate 8 in the appropriate field for a void transaction. Refunds to the State of Alaska for electronic adjustments and voids will be taken from future remittance payments. If you wish to send a refund check, you must fill out the adjustment/void form and attach your check to the form. We cannot process refund checks for electronic transactions.

Important Reminder: Send adjustment/void form(s) and refund check together.

If Medical Assistance receives the adjustment/void form(s) and refund check separately, the funds will be collected from future payments *and* the refund check will be deposited and reported as a refund only *without* being applied to the corresponding claims, therefore processing the refund amount twice.

Vaccine Update

The Alaska Division of Public Health's Vaccines for Children (VFC) Program provides most vaccine products, free of charge, to Alaska's healthcare providers for administration to Alaska residents. This program does not, however, currently offer the two newly licensed vaccines that have recently become available:

- Human Papillomavirus (PPV) vaccine
- Rotavirus vaccine

Family Planning Clinics, Advanced Nurse Practitioners, Physicians

Medicaid/DKC will reimburse family planning clinics, advanced nurse practitioners and physicians for these two vaccines when they are given to Medicaid/DKC-eligible recipients until such time that they are made available through Public Health's Vaccines for Children (VFC) Program.

Medicaid will reimburse up to \$142.50 per dose plus an administration fee for Gardasil[®], the Merck HPV vaccine. Reimbursement coverage is limited to eligible female recipients 9 through 20 years of age. The CPT code is 90649.

Medicaid also will reimburse up to \$79.69 plus an administration fee for RotaTeq[®], Merck's oral rotavirus vaccine. RotaTeq[®] is licensed only for infants 6-32 weeks of age. The CPT code is 90680.

Rural Health Clinics (RHC), Federally Qualified Health Centers (FQHC)

In the case of RHC/FQHC providers, the department realizes that providing these new vaccines will result in increased cost, however, additional reimbursement for these new program costs can be considered only if a request for rate adjustment is made by the provider in accordance with 7 AAC 43.860 (j). The department's Office of Rate Review will consider requests that meet these regulatory requirements which state, in part, that the adjustment request must be made in writing and must include an analysis

Listen to This



Vaccine Update (con't)

demonstrating that providing these vaccines will result in increased per visit cost of more than two and one-half percent.

Providers are encouraged to thoroughly review 7 AAC 43.860 (j) prior to requesting an adjustment.

Hearing Services Providers

When billing for hearing devices using HCPC codes for binaural hearing aids, submit on the claim using one line indicating "1" in the unit field. Binaural relates to both ears. Claims billed for binaural HCPC codes using one line indicating "2" in the unit field are incorrect. Claims billed for binaural HCPC codes using two lines indicating a RT modifier for the right ear and a LT modifier for the left ear with a "1" in the unit field per line are incorrect.

When billing for postage cost reimbursement, use HCPC code V5299 which requires prior authorization. See regulation 7 AAC 43.927(i) for delivery and dispensing expenses reimbursement requirements. The claim must be submitted with the approved prior authorization number and postage invoice that corresponds with the billed charge.

When billing for labor and repair cost reimbursement, use HCPC code V5014 for the repair cost attaching the manufacturer's invoice corresponding with the charge amount and HCPC code L7520 for the labor cost (including the time spent in 15 minute increments). See regulation 7 AAC 43.927 (j) for labor and repair reimbursement requirements. Please remember to itemize billed charges when necessary and attach supporting documentation when required.

If you have questions, call the Provider Inquiry Unit at (907) 644-6800 locally or (800) 770-5650 selecting option **1** for **Providers** and option **1** again for **Inquiry**.

Provider Records Requirements and Retention

A provider shall maintain records necessary to support the care and services for which payment is requested, and must retain those records for **at least seven years** from the date services were provided.

Some professional standards require record retention for longer periods of time. Records must be accurate, and shall include:

- Patient information for each service provided, including the recipient receiving treatment; specific services provided, extent of service, date of each service, and individual who provided each service,
- Financial information for each service provided, including date of each service and charge, each payment source pursued, date and amount of all debit and credit billing actions, and amounts billed and paid,
- Clinical information pertinent to each service provided (according to applicable professional standards, applicable state and federal laws, applicable Alaska Medical Assistance provider billing manuals, and any pertinent contracts) to a patient for which services have been billed to Medical Assistance, identify the recipient's diagnosis, the medical need, each service, prescription, supply, or plan of care prescribed by the provider—including therapeutic services, and annotated case notes, dated and be signed or initialed by the individual who provided each service.

PATIENT INFORMATION



FINANCIAL INFORMATION



CLINICAL INFORMATION



AT LEAST SEVEN YEARS

See 7 AAC 43.005-7 and AAC 43.1990 for the regulations regarding records and record retention.

Durable Medical Equipment and Orthotic and Prosthetic Provider (Provider Type 76 and 71)



**DME & ORTHOTIC &
PROSTHETIC PROVIDERS**
Proof of Medicare Enrollment
Deadline: 12/31/2006

Durable Medical Equipment (DME) Providers and Prosthetic and Orthotic Providers are required to show proof of Medicare enrollment by December 31, 2006 to continue being enrolled with the Alaska Medical Assistance Program (Medicaid).

For Prosthetic and Orthotic providers, please send in a copy of your business license, your certification as indicated above, and a copy of your "Welcome to Medicare Enrollment Letter." For DME providers, please provide a copy of your "Welcome to Medicare Enrollment Letter." If proof of being enrolled with Medicare is not provided to the State of Alaska's Fiscal Agent, First Health Service Corporation (FHSC) by December 31, 2006, you will be disenrolled from the Alaska Medical Assistance Program as a DME provider or a Prosthetic and Orthotic provider and will no longer be able to bill under your current DME or Prosthetic and Orthotic provider number. This requirement is based on the following regulation:

7 AAC 43.1900 Enrolling; general provisions; covered items & services

(a) The department may enroll under this section a provider that provides the department with evidence that the provider holds a valid business license issued under AS 43.70 and 12 AAC 12. The department will reenroll a provider under this section as either a

- (1) durable medical equipment provider, if the provider provides
 - (A) durable medical equipment;
 - (B) medical supplies;
 - (C) respiratory therapy services;
 - (D) home infusion therapy services; or
 - (E) noncustomized-fabricated Orthotics; or
- (2) prosthetics and orthotics provider, regardless of whether the provider provides other items or services in (1) of this subsection, if the provider
 - (A) provides prosthetics and orthotics; and
 - (B) is certified by the American Board of Certification in Prosthetics and Orthotics, the Board for Orthotist/Prosthetist Certification, the National Examining Board of Ocularists, Inc., or other similar certifying agencies approved by the department . . .

(n) In addition to the requirement of (a) of this section, on or after January 1, 2007, a provider enrolled with the department under this section shall provide to the department evidence that the provider is enrolled as a Medicare provider for durable medical equipment, prosthetics, orthotics, and supplies.

Vision Exams and Services for Over/Under Age 21



Vision care services are covered if an eligible recipient has significant difficulties or complaints relating to vision or if an attending ophthalmologist or optometrist finds health reasons for a vision examination. All Alaska Medical Assistance vision service providers are required to use Rochester Optical when prescribing frames, lenses, or contact lenses for Alaska Medical Assistance recipients. Their address is:

Rochester Optical
 1260 Lyell Avenue
 Rochester, NY 14606
 Phone: (585) 254-0029
 Fax: (585) 254-0132
 Provider Number OP161NY

Children and adults have slightly different coverages and requirements. Please take a look at the comparison below.

Under Age 21	Age 21 and Over
<p><u>Exams.</u> One exam in a calendar year.</p> <p><u>Additional Exam(s).</u> Prior authorization is not required for a second vision exam; however, medical justification must be submitted with the claim. If a third or subsequent vision exam is needed in a calendar year, prior authorization is required. Medical justification must be submitted with the prior authorization form.</p>	<p><u>Exams.</u> One exam in a calendar year.</p> <p><u>Additional Exam(s).</u> Prior authorization is not required; however, medical justification must be submitted with the claim.</p>
<p><u>Eyeglass Limitation.</u> One pair of eyeglasses in a calendar year.</p> <p><u>Additional Pair(s).</u> Prior authorization is not necessary for a second pair of eyeglasses; however, the provider's medical record must clearly document the medical need for a second pair. For more than the second pair of eyeglasses, prior authorization is required. Medical justification must be submitted with the prior authorization form.</p>	<p><u>Eyeglass Limitation.</u> One pair of eyeglasses in a calendar year.</p> <p><u>Additional Pair(s).</u> Prior authorization is required. Medical justification must be submitted with the prior authorization form indicating a prescription change or other medical reason. Lost or broken glasses will not be replaced.</p>
<p><u>Contact Lenses:</u> Contacts require prior authorization and may be authorized only when required as a result of cataract surgery, aphakia, keratoconus, corneal degeneration, rejection of an implant, or when other medical reasons exist.</p>	

Vision Exams and Services for Over/Under Age 21 (con't)

Dispensing and Fitting: Dispensing and fitting eyeglasses do not require prior authorization. Prior authorization is required for the fitting of contact lenses. For services that require prior authorization, the ophthalmologist or optometrist who performed the vision exam must request authorization before submitting the order to Rochester Optical. When completing the prior authorization form for frames, lenses, or contacts, enter Rochester Optical's provider number in Field No.2, OP161NY. Enter the ophthalmologist or optometrist's name and address in Field No.4. A copy of the approved prior authorization form must be submitted with the order to Rochester Optical.

When completing the prior authorization form for an additional vision exam or contact lens fitting, enter the provider number of the ophthalmologist or optometrist who performed the vision exam in Field No. 2.

Note: Prior authorization requests for a vision exam and eyeglasses may not be submitted on the same form. Prior authorization requests for contact lenses and contact lens fitting may not be submitted on the same form.