CHAPTER O-200

Optometric Services

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O-211 PRIOR APPROVAL PROCESS

Prior to the provision of certain services, approval must be obtained from the Department. If charges are submitted for services that require prior approval and approval was not obtained, payment will not be made for services as billed. See Chapter 100, Topic 111, for a general discussion of prior approval provisions.

The Department will not give prior approval for an item or service if a less expensive item or service is considered appropriate to meet the patient's need.

Prior approval to provide services does not include any determination of the patient's eligibility. When prior approval is given, it is the provider's responsibility to verify the patient's eligibility on the date of service.

Medicare Exception: An exception to the prior approval requirements exists in situations in which services or materials requiring prior approval are provided to a patient eligible for Medicare Part B benefits and the service or material is covered in the Medicare program. Prior approval requirements are waived in instances in which Medicare payment is approved.

If Medicare denies a **service** as non-covered, the provider must submit an HFS 2360 claim form with a note for special handling to the attention of the optometric program billing consultants at the address below.

If Medicare denies a **supply or material** as non-covered, the provider may request post approval from the Department. When post approval is received for a supply or material denied by Medicare, the provider is to submit an HFS 1443 claim form with a note for special handling to the attention of the optometric program billing consultants at the following address:

Illinois Department of Healthcare and Family Services
P.O. Box 19115
Springfield, Illinois 62794-9115
Attn: Optometric Billing Consultant

=O-211.1 PRIOR APPROVAL REQUESTS

Effective July 1, 2012

Prior approval requests must contain enough information for Department staff to make a well-informed decision on medical necessity, appropriateness and anticipated patient benefits of the service.

The single most common reason for denial of prior approval requests is lack of adequate information upon which to make an informed decision.

If the provider does not submit sufficient information for a determination, the Department sends a letter to the provider requesting additional information. If, after 30 days, the provider has not responded, the Department will generate a denial letter to the provider and patient.

The following services and materials may be provided only with prior approval of the Department:

- Contact lens/lenses and related service
- Custom-made artificial eye
- Low vision devices
- Polycarbonate eyeglass lenses for adults, age 21 and over (see Appendix O-2a for specific information).
- Eyeglasses fabricated by suppliers other than DOC
- Service/materials not otherwise identified on the schedule of procedures for optical services and supplies.

Refer to the Optometric Fee Schedule on the Department's Web site for the billing codes of the vision care services that require prior approval. If the code is hand-priced, the Department requires an invoice from the supplier verifying the cost.

Procedure: Prior approval to dispense or provide the above described service or material is to be requested by the provider using Form HFS 1409, Prior Approval Request. See Appendix O-2 for instructions for completing Form HFS 1409. Requests may be mailed to the Department in the Form HFS 2300, Prior Approval Request Envelope. Requests may also be faxed to the optometric prior approval unit at 217-524-7120.

The Department generates a letter, to both the provider and the patient, of the Department approval or disapproval of the prior approval request. The approval letter does include the amount approved for the item.

When billing for a service or material that has been approved for a patient, the claim is to be submitted to the Department as a routine claim on the HFS 1443.

O-212.5 FABRICATION OF GLASSES BY SUPPLIERS OTHER THAN DOC

Fabrication of glasses by a supplier other than the Department of Corrections is covered only with prior approval. Requests for prior approval must include sufficient detail on the type of lens or frame, to determine that DOC cannot manufacture them. The request must also include information explaining why a standard pair of glasses is not medically appropriate to meet the patient's need.

O-212.6 ITEMS NOT OTHERWISE IDENTIFIED

Services or materials that are not identified on the Optometric or Physician Fee Schedules require prior approval. Information must be submitted describing in detail the material or service to be provided. A history of past treatment provided is required. Additionally, the request for approval must show why the material or service is better than any other commonly used to deal with similar diagnoses or conditions. All items or services requested must be medically necessary.

O-212.7 FREQUENCY OF SERVICES

=O-212.71 Adult Services

Effective July 1, 2012

Eyeglasses for adults are covered if medically necessary. Adult participants who are 21 years of age and older are limited to one pair of eyeglasses in a two-year period. As of July 1, 2012, the Department will begin a two-year (730 days) count from the date of the last pair of eyeglasses ordered to determine eligibility for a new pair.

Example: A patient last ordered eyewear with a date of service May 1, 2012. The Department will count forward from that service date to determine eligibility for another pair of eyeglasses.

The Department will deny any prior approval requests submitted for additional adult eyewear beyond the stated limit.

This policy does not limit medically necessary eye examinations, or claims for repair/refitting of eyeglasses.

O-212.72 Children's Services

For children through age 20, eyeglasses are replaced as needed through the DOC laboratory, with no prior approval required.