AMERICAN ACADEMY OF OPHTHALMOLOGY®

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# Prior Authorization Checklist and Guidelines

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- ☐ Always have patients provide insurance card(s). Scan and/or copy both sides and notate the date of the copy.
- ☐ Verify eligibility before the patient presents to the practice. This can reveal if coverage is active or if the patient will be responsible for payment before they are seen.
- ☐ When a surgical procedure is scheduled, prior authorization should be obtained in the same month. This confirms that coverage is still active. Although prior authorization does not guarantee payment, you are guaranteed not to get paid without one.
- ☐ When seeking prior authorizing or pre-certifying coverage, always provide the payer representative with the following data:
    - Anticipated date of service
    - CPT code(s)
    - ICD-10 code(s) for each service rendered
    - Place of service
    - Physician, practice NPI and tax ID.
- ☐ Always have the following information on record:
    - Name of payer representative if requested by phone: when submitted on the portal keep a copy of the submission
    - Date and time of call or submission
    - Effective date of the patient's coverage
    - Confirmation that the physician is in or out-of-network
        - Completed "Good Faith Estimate for Health Care Items and Services" form as appropriate (visit https://www.aao.org/surprise-billing to download this form)
    - Patient deductible, co-payment and/or maximum out-of-pocket expenses
    - If approved, the prior authorization number and approved date range
- ☐ Educate patients on estimated out-of-pocket expenses. Remember that out-of-pocket expenses for surgery may include facility fees and anesthesia. Patients should be aware of all costs before surgery.
- ☐ Submit the family of codes for approval (eg, 66982-66984). If there is a family of CPT codes, be proactive and preauthorize multiple codes, as the surgeon may have to change the procedure intraoperatively. Many payers will not allow for a CPT code they did not authorize. For example, if CPT code 66984 Cataract surgery was authorized and the procedure changed to a complex case (66982) intraoperatively, then payers often will deny the claim (initially and on appeal) because they were not provided with the complex CPT code at preauthorization.
- ☐ Preauthorization does not look at CCI bundles. Always verify any payer-specific bundles. Many payers have a look-up option on their website for this.
- ☐ When determining coverage for Category III codes, ask for the allowable. If there is no allowable, there is no coverage.
- ☐ Verify coverage when the surgical procedure will be performed in the office but payers typically cover it only when performed in a facility (ie, no site of service differential).