



American Academy of Ophthalmic Executives®

Prior Authorization Checklist and Guidelines

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- Always have patient provide insurance card(s). Scan and/or copy both sides and notate the date of the copy.
- Verify eligibility prior to patient presenting to practice. This can determine, prior to being seen, if coverage is active or if the patient will be responsible.
- When scheduling surgery, prior authorization should be obtained in the same month. This confirms coverage is still active. While a prior authorization does not guarantee payment, you are guaranteed not to get paid without one.
- When prior authorizing or pre-certifying coverage, always provide the payer representative with:
 - 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 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 patients' coverage
 - Confirmation that physician is in or out-of- network
 - Complete the “Good Faith Estimate for Health Care Items and Services” form as appropriate. (Visit aao.org/surprise-billing to download this form.)
 - Patient deductible, copayment and/or maximum out-of-pocket
 - If approved, the prior authorization number and approved date range.
- Educate patient on estimated out-of-pocket expense. Remember 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, it is proactive to 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 the complex CPT code on the preauthorization.
- Preauthorization does not look at CCI bundles. Always verify any payer specific bundles. Many payers have a look-up option on their website.
- When determining coverage for Category III codes, ask for the allowable. If there is no allowable, there is no coverage.
- Verify coverage if performing an office-based surgery when payers typically only cover in a facility (no site of service differential).