Prior Authorization Request FAQs

1. Where do I find the Prior Authorization forms?

The Prior Authorization forms are located on the Provider Portal under the Dashboard under 'Forms'.

2. How do I submit a Prior Authorization form?

A new form must be submitted for each member and date of service:

Davis Vision
Fax: 1 (800) 584-2329
*Email at UMPauth@versanthealth.com

Superior Vision
Fax: 1 (855) 313-3106
Email at ECS@superiorvision.com

*Note: New email for Davis Vision Prior Authorization request submissions.

After the prior authorization request is received, a fax or email acknowledgement is sent to the provider. This also includes information on how to contact the Utilization Management Department.

3. Which form do I use for Superior Vision?

Superior Vision uses two (2) prior authorization forms:

- Superior Vision Medical / Surgical Prior Authorization Request Form– for all medical / surgical procedure requests
- Superior Vision Routine and Medically Necessary Services Prior Authorization Request Form– for routine vision and medically necessary contact lenses (may include specialty lenses, contact lenses, replacement glasses, low vision aids, additional eye exam, vision therapy)

Note: Superior Vison Commercial patients do not have a prior authorization requirement for routine vision services (including medically necessary contact lenses).

4. Which form do I use for Davis Vision?

- Davis Vision Routine and Medically Necessary Services Prior Authorization Request Form– for routine vision and medically necessary contact lenses (may include specialty lenses, contact lenses, replacement glasses, low vision aids, additional eye exam, vision therapy)

Note: BCBS FEP authorization requests have a separate form:
FEP Routine and Medically Necessary Services Prior Authorization Request Form (use only for FEP members).

5. What are the best practices to follow when submitting a prior authorization request?

- Complete all areas on the prior authorization form. Most importantly, the areas labeled in red.
- Include all the necessary clinical information to support the request (failure to submit the required documentation may result in a denial).
- Use a new form for each patient, each date of service, and submit separately.

6. How long does it take to receive a response after submitting a standard authorization request?

- Timeframes for a response to an authorization request follow all CMS and state requirements
- Medicaid requests follow individual state requirements, which are typically 2 or 3 days
- Medicare requests follow the CMS requirement of 14 days
- Commercial requests follow state commercial requirements, which are typically 2 or 3 days
- These timeframes may be extended if there is a request for the provider to submit additional information

7. What are the criteria to submit an urgent / expedited request?

- For an urgent request, use the same prior authorization form and check the box on the form certifying the request is urgent and a delay in treatment could jeopardize the patient's life, health, or ability to regain maximum function **and** provide the medical indication for the expedited request.
- Routine Benefits: Urgent requests should not apply to routine services. However, if an expedited request is necessary, proceed with the process described above.
- This request requires immediate action to prevent a serious deterioration of a member's health that results in an unforeseen illness or an injury, or
- Failure to expedite the request could jeopardize the ability of the individual to regain maximum function based upon a prudent layperson's judgment, or
- In the opinion of the treating physician, failure to expedite the request would subject the individual to severe pain that cannot be adequately managed without the treatment being requested.
- An urgent condition is a situation that has the potential to become an emergency in the absence of treatment.

Urgent timeframe turnaround times: Timeframes for a response to an urgent authorization request follow all CMS and state requirements. An urgent request response timeframe is typically 72 hours. If the request is for an urgent Medicare Part B, the response timeframe is 24 hours.

8. Who conducts the clinical reviews and makes the determination for approval or denial of the requested service?

- Staff who have a doctorate in optometry or who are board certified ophthalmologists complete all clinical reviews

9. What is the peer-to-peer process?

- A peer-to-peer conversation provides the provider/practitioner the opportunity to discuss a prior authorization request with a physician of the same/similar licensure. A peer-to-peer conversation can occur prior to a decision being rendered and can be requested by either the Company's Medical Director or the requesting or performing practitioner/provider

10. How do a schedule a Peer-to-peer

- The peer-to-peer discussion must be scheduled. The requesting provider/practitioner must state the specific issue to be discussed with Medical Director to clarify that Peer to Peer is the appropriate forum for this conversation and that other personnel might not better resolve this matter
- The prior authorization staff will ask for the best date and time the provider is available for the peer-to-peer discussion. Based on the requested timeframe, a peer-to-peer conversation is scheduled. After the completion of the peer-to-peer, the Medical Director enters documentation in the utilization management system

11. If I request a peer-to-peer, what is the timeframe to receive a response?

- The timeframe to receive a response of a peer-to-peer request is:
  - **Standard Requests –** All requests will be addressed within one (1) business day
  - **Urgent Requests –** same business day if request is received prior to 4pm ET. If request is received after 4pm ET, every attempt will be made to conduct the peer-to-peer same business day, but no later than 10am ET the next business day

12. If I have a question about the prior authorization process or to schedule a Peer-to-Peer, who do I contact?

Note: You will need to include the provider's office name, patient's name, patient ID number, date of birth, date of request, and three available times

Davis Vision
Phone: 1 (800) 773-2847
*Email: **UMfax@versanthealth.com**

Superior Vision
Phone: 1 (888) 273-2121
Email: **ECS@superiorvision.com**

*This email address is for follow up and general inquiries, please see 'How do I submit a Prior Authorization form?' above for submitting an initial prior authorization request.