

**DRISCOLL HEALTH PLAN
INSTRUCTIONS FOR OBTAINING PRE-AUTHORIZATION FOR OPHTHALMOLOGY SERVICES**

The following services require pre-authorization by Envolve Vision

- The following CPT codes, regardless of where the service is performed: 15822, 15823, 66821, 66982, 66984, 67900, 67904, 67908 and J2778 (Lucentis), J0178 (Eylea), J2503 (Macugen) and J3396 (Visudyne).
- Any procedure code that is considered an unlisted procedure code as defined by the AMA Current Procedural Terminology (CPT) manual (CPT codes 6xx99)
- Any service provided by a non-participating provider or at a non-participating facility
- Experimental and investigational services

For non-emergent procedures, the provider must notify Envolve Vision with 14 calendar days prior to the service date. Post-service requests for non-emergent procedures will not be processed. The provider must submit a claim and/or claim appeal for consideration.

Please follow the instructions listed below when requesting a pre-authorization review for blepharoplasty/ptosis procedures:

- Ensure that the Pre-Authorization Request Form is completely filled out, including office and facility addresses, so your request can be processed in a timely manner.
- Pre-authorization requests for J2778 (Lucentis), J0178 (Eylea), J2503 (Macugen) and J3396 (Visudyne) must be sent using the Pre-Authorization Request for Anti-VEGF Injectables form at <https://visionbenefits.envolvehealth.com/forms.aspx>.
- Pre-authorization requests must include the codes for all procedures that will be performed during the surgical session.
- The completed form and supporting clinical information including original photos should be sent via secure e-mail to visionumauthorization@envolvehealth.com. If you do not have access to a secure e-mail program, contact the Utilization Management Department at 800-465-6972 and a Care Manager will send you a secure e-mail. Open the secure e-mail attachment, select "Reply to All", and attach the pre-authorization documents for submission to Envolve Vision. If you do not have the ability to transmit records electronically, please mail your request to:
Envolve Vision, Inc.
ATTN: Utilization Management Department
P.O. Box 7548
Rocky Mount, NC 27804
- After Envolve Vision has received the request it will be entered into the utilization management system and a Care Manager will review the information. If necessary, you may be contacted for additional information within 1 business day of receipt.
- You will be notified within 3 business days upon completion of the review.
 - If the requested service is approved, an authorization letter will be faxed to your office.
 - If the requested service results in a denial, the requesting physician will be offered a peer to peer conference with a Envolve Vision Medical Director.
- Providers must use participating Driscoll Health Plan facilities. Use of non-participating facilities requires authorization from Driscoll Health Plan. To facilitate this process, Envolve Vision will submit a copy of the authorization to Driscoll Health Plan to initiate a non-par facility authorization.
- Participating providers may utilize the Envolve Vision website to verify status of pre-authorization requests at <https://visionbenefits.envolvehealth.com/logon.aspx>.

Please follow the instructions listed below when requesting a pre-authorization review for services rendered in a non-participating facility or by a non-participating physician:

- Ensure that the Pre-Authorization Request Form is completely filled out, including office and facility addresses, so your request can be processed in a timely manner.
- Pre-authorization requests must include the codes for all procedures that will be performed during the surgical session.
- Fax the completed form and any supporting clinical information to Envolve Vision at (877) 865-1077. Pre-authorization requests for eyelid procedures (15822, 15823, 66821, 66982, 66984, 67900, 67904, 67908) must include original photos (if applicable) and e-mailed securely or mailed as noted above.
- After Envolve Vision has received the request it will be entered into the utilization management system and a Care Manager will review the information. If necessary, you may be contacted for additional information.
- You will be notified within 3 business days upon completion of the review.
 - If the requested service is approved, an authorization letter will be faxed to your office.

Emergency Procedures

Emergent procedures do not require prior authorization. Services provided on an emergent basis in a non-participating facility should be submitted to Envolve Vision for retrospective review and authorization by the next business day after services have been rendered.

Emergency care is defined as any health care service provided in a hospital emergency facility (or comparable facility) in order to evaluate and stabilize medical conditions of recent onset and severity (including severe pain), if such condition would lead a prudent layperson (possessing an average knowledge of medicine and health and acting prudently) to believe that failure to get immediate medical care might result in:

- placing the person's health in serious jeopardy
- serious impairment to bodily functions
- serious dysfunction of any bodily organ or part
- serious disfigurement
- in the case of a pregnant woman, serious jeopardy to the health of the fetus



Texas Standard Prior Authorization Request Form for Health Care Services

NOFR001 | 0415

Texas Department of Insurance

Please read all instructions below before completing this form.

*Please send this request to the issuer from whom you are seeking authorization. **Do not send this form** to the Texas Department of Insurance, the Texas Health and Human Services Commission, or the patient's or subscriber's employer.*

Beginning September 1, 2015, health benefit plan issuers must accept the Texas Standard Prior Authorization Request Form for Health Care Services if the plan requires prior authorization of a health care service.

In addition to commercial issuers, the following public issuers must accept the form: Medicaid, the Medicaid managed care program, the Children's Health Insurance Program (CHIP), and plans covering employees of the state of Texas, most school districts, and The University of Texas and Texas A&M Systems.

Intended Use: Use this form to request authorization **by fax or mail** when an issuer requires prior authorization of a health care service. An Issuer may also provide an **electronic version of this form** on its website that you can complete and submit electronically, through the issuer's portal, to request prior authorization of a health care service.

Do not use this form to: 1) request an appeal; 2) confirm eligibility; 3) verify coverage; 4) request a guarantee of payment; 5) ask whether a service requires prior authorization; 6) request prior authorization of a prescription drug; or 7) request a referral to an out of network physician, facility or other health care provider.

Additional Information and Instructions:

Section I – Submission:

An issuer may have already entered this information on the copy of this form posted on its website.

Section II – General Information:

Urgent reviews: Request an urgent review for a patient with a life-threatening condition, **or** for a patient who is currently hospitalized, **or** to authorize treatment following stabilization of an emergency condition. You may also request an urgent review to authorize treatment of an acute injury or illness, if the provider determines that the condition is severe or painful enough to warrant an expedited or urgent review to prevent a serious deterioration of the patient's condition or health.

Section IV – Provider Information:

- If the Requesting Provider or Facility will also be the Service Provider or Facility, enter "Same."
- If the requesting provider's signature is required, you may not use a signature stamp.
- If the issuer's plan requires the patient to have a primary care provider (PCP), enter the PCP's name and phone number. If the requesting provider is the patient's PCP, enter "Same."

Section VI – Clinical Documentation:

- Give a brief narrative of medical necessity in this space, or in an attached statement.
- Attach supporting clinical documentation (medical records, progress notes, lab reports, etc.), if needed.

Note: Some issuers may require more information or additional forms to process your request. If you think more information or an additional form may be needed, please check the issuer's website before faxing or mailing your request.

Note: If the requesting provider wants to be called directly about missing information needed to process this request, you may include the provider's direct phone number in the space given at the bottom of the request form. Such a phone call cannot be considered a peer-to-peer discussion required by 28 TAC §19.1710. A peer-to-peer discussion must include, at a minimum, the clinical basis for the URA's decision and a description of documentation or evidence, if any, that can be submitted by the provider of record that, on appeal, might lead to a different utilization review decision.

Texas Department of Insurance | 333 Guadalupe | Austin, Texas 78701 | (800) 578-4677 | www.tdi.texas.gov | @TexasTDI

Envolv Vision of Texas, Inc. is a subsidiary of Envolv Benefit Options

TEXAS STANDARD PRIOR AUTHORIZATION REQUEST FORM FOR HEALTH CARE SERVICES

SECTION I — SUBMISSION

Issuer Name:	Phone:	Fax:	Date:
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SECTION II — GENERAL INFORMATION

Review Type: <input type="checkbox"/> Non-Urgent <input type="checkbox"/> Urgent	Clinical Reason for Urgency:
Request Type: <input type="checkbox"/> Initial Request <input type="checkbox"/> Extension/Renewal/Amendment	Prev. Auth. #:

SECTION III — PATIENT INFORMATION

Name:	Phone:	DOB:	<input type="checkbox"/> Male	<input type="checkbox"/> Female
			<input type="checkbox"/> Other	<input type="checkbox"/> Unknown
Subscriber Name (if different):	Member or Medicaid ID #:	Group #:		

SECTION IV — PROVIDER INFORMATION

Requesting Provider or Facility		Service Provider or Facility	
Name:		Name:	
NPI #:	Specialty:	NPI #:	Specialty:
Phone:	Fax:	Phone:	Fax:
Contact Name:	Phone:	Primary Care Provider Name (see instructions):	
Requesting Provider's Signature and Date (if required):		Phone:	Fax:

SECTION V — SERVICES REQUESTED (WITH CPT, CDT, OR HCPCS CODE) AND SUPPORTING DIAGNOSES (WITH ICD CODE)

Planned Service or Procedure	Code	Start Date	End Date	Diagnosis Description (ICD version__)	Code

<input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> Provider Office <input type="checkbox"/> Observation <input type="checkbox"/> Home <input type="checkbox"/> Day Surgery <input type="checkbox"/> Other: _____
<input type="checkbox"/> Physical Therapy <input type="checkbox"/> Occupational Therapy <input type="checkbox"/> Speech Therapy <input type="checkbox"/> Cardiac Rehab <input type="checkbox"/> Mental Health/Substance Abuse Number of Sessions: _____ Duration: _____ Frequency: _____ Other: _____
<input type="checkbox"/> Home Health (MD Signed Order Attached? <input type="checkbox"/> Yes <input type="checkbox"/> No) (Nursing Assessment Attached? <input type="checkbox"/> Yes <input type="checkbox"/> No) Number of Visits: _____ Duration: _____ Frequency: _____ Other: _____
<input type="checkbox"/> DME (MD Signed Order Attached? <input type="checkbox"/> Yes <input type="checkbox"/> No) (Medicaid Only: Title 19 Certification Attached? <input type="checkbox"/> Yes <input type="checkbox"/> No) Equipment/Supplies (include any HCPCS Codes): _____ Duration: _____

SECTION VI — CLINICAL DOCUMENTATION (SEE INSTRUCTIONS PAGE, SECTION VI)

An issuer needing more information may call the requesting provider directly at: _____