envolve
Benefit Options

Driscoll Health Plan

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

The following services requires pre-authorization by Envolve Vision

- The following CPT codes regardless of where the service is performed: 15822, 15823, 66821, 66982, 67900, 67904, 67908 and anti-VegF injectables **excluding** Avastin (J9035)
- **Any service provided by a non-participating provider or at a non-participating facility**
- Any procedure code considered an unlisted procedure as defined by the AMA Current Procedural Terminology (CPT) manual (CPT codes 6xx99)
- Experimental and investigational services

For non-emergent procedures, the provider should submit a request to Envolve Vision at least 14 calendar days prior to the planned service date. Post-service requests for non-emergent procedures will not be processed. Providers will be required to submit a claim and/or claim appeal for consideration.

Please follow the instructions listed below when requesting a pre-authorization review:

- Ensure the attached Pre-Authorization Request Form is **completely** filed out, including both office and facility address and TIN – please use the "Section VI" area of the Texas Standard Prior Authorization Request Form for this information
- Requests for Anti-VEGF Injectables must also include the Pre-Authorization Request for Anti-VEGF Injectables form at https://www.envolvevision.com/providers/provider-forms.html
- Pre-authorization requests must include coding for **all** procedures planned
- The completed form and supporting clinical documentation (including original color photos for blepharoplasty/ptosis procedures) should be sent via secure email to umauthorization@EnvolveHealth.com. If you do not have access to a secure email program, contact the Utilization Management Department at 800-465-6972 and a reviewer will send you a secure email for reply with all required documentation attached. If you do not have the ability to email, you may fax your request at 877-865-1077.
- Providers should use participating Driscoll Health Plan facilities. **All requests for non-participating facilities will require review by Driscoll Health Plan**—Envolve Vision will forward your request to Driscoll Health Plan for non-par facility review
- **Please Note:** If your planned service does not require authorization by Envolve Vision **and** you are using a participating Driscoll Health Plan facility, you do not need to request a facility authorization separately from Driscoll Health Plan

Following receipt of your request:

- After Envolve Vision has received the request, it will be entered into our system for review. 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 the Envolve Vision Medical Director who made the denial.
- Participating providers may utilize the Envolve Vision website to verify status of pre-authorization requests at https://visionbenefits.envolvehealth.com/logon.aspx

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 by the next business day after services have been rendered.

Emergency care is defined by State of Texas Code as health care services provided in a hospital emergency facility, freestanding emergency medical care facility, or comparable emergency facility to evaluate and stabilize medical conditions of a recent onset and severity, including severe pain, that would lead a prudent layperson possessing an average knowledge of medicine and health to believe that the individual's condition, sickness, or injury is of such a nature that failure to get immediate medical care could:

- place the individual's health in serious jeopardy;
- result in serious impairment to bodily functions;
- result in serious dysfunction of a bodily organ or part;
- result in serious disfigurement; or
- for a pregnant woman, result in 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 STANDARD PRIOR AUTHORIZATION REQUEST FORM FOR HEALTH CARE SERVICES

Clear Form | Print

SECTION I — SUBMISSION

Issuer Name:	Phone:	Fax:	Date:

SECTION II — GENERAL INFORMATION

Review Type: ☐ Non-Urgent ☐ Urgent		Clinical Reason for Urgency:	
Request Type: ☐ Initial Request ☐ Extension/Renewal/Amendment		Prev. Auth. #:	

SECTION III — PATIENT INFORMATION

Name:	Phone:	DOB:	☐ Male ☐ Female ☐ Other ☐ 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

☐ Inpatient ☐ Outpatient ☐ Provider Office ☐ Observation ☐ Home ☐ Day Surgery ☐ Other: _____

☐ Physical Therapy ☐ Occupational Therapy ☐ Speech Therapy ☐ Cardiac Rehab ☐ Mental Health/Substance Abuse

Number of Sessions:_____ Duration:_____ Frequency: _____ Other: _____

☐ Home Health (MD Signed Order Attached? ☐ Yes ☐ No) (Nursing Assessment Attached? ☐ Yes ☐ No)

Number of Visits: _____ Duration:_____ Frequency: _____ Other: _____

☐ DME (MD Signed Order Attached? ☐ Yes ☐ No) (Medicaid Only: Title 19 Certification Attached? ☐ Yes ☐ 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: _____