

Instructions for Obtaining Pre-Authorization for Ophthalmology Services

The following services require pre-authorization by TVHP:

- The following codes, regardless of where the service is performed: 15822, 15823, 66821, 66984, 66982, 67900, 67904 and 67908
- New technologies or new applications of existing technologies
- Any procedure code that is considered an “unlisted” procedure code as defined by the AMA Current Procedural Terminology (CPT) manual (CPT codes xxx99)
- 66982 is generally approved as 66984 and then considered for upgrade post-operatively upon request and with a copy of the operative report.

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

- Ensure that the TVHP Medical Pre-Authorization Request Form is **completely** filled out so your request can be processed in a timely manner. Including office and facility addresses.
- Physician signature is required on every request.
- Pre-authorization requests must include the codes for any additional procedures that will be performed during the surgical session.
- **Providers must use participating Evercare facilities and receive authorization for the facility and anesthesia from Evercare.** The Evercare Authorization Request Form should be completed and faxed to Evercare at 1-866-785-1649. **If an out-of-network facility is to be used, a facility authorization must be obtained directly from the health plan. Complete a facility notification form and fax to Evercare at 1-866-785-1649, or contact a Star Plus representative at 1-888-887-9003 and follow prompts. TVHP will not approve requests for services at out-of-network facilities until a facility authorization number is received.**
- Fax the completed form and any supporting clinical information to TVHP at 1-252-451-2133.
- After TVHP has received the request it will be entered into the medical management system and a Clinical Reviewer Specialist will review the information. If necessary, you may be contacted for additional information.
- You will be notified within **two 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 TVHP Medical Director.
- Written documentation for all decisions, whether approved or denied, will be issued within two business days.

Pre-authorization requests using the Eye Health Manager:

Participating providers may utilize the OptiCare/TVHP web site to obtain pre-authorizations for cataract surgery (CPT 66984) at www.opticare-ehn.com. For automatic approval of a pre-authorization request, the procedure must be performed at a participating Evercare facility and the clinical information supporting the request must meet OptiCare/TVHP guidelines for medical necessity (i.e., best-corrected visual acuity of 20/50 or worse). If a request for pre-authorization meets medical necessity guidelines, an approval number will be issued and the provider may print an authorization letter immediately. If a request for authorization does not meet the medical necessity guidelines, the request will “pend” for further review. The provider should fax all supporting clinical information to TVHP at 1-252-451-2133.



OptiCare Managed Vision , Inc.
 AECC Total Vision Health Plan of Texas, Inc.
 112 Zebulon Court
 Rocky Mount, NC 27804
 Medical Pre-Authorization Request
 Phone Toll Free (800) 465-6972
 Please fax your request to: (252) 451-2133

_____ EMERGENT
 _____ URGENT
 _____ ROUTINE

Date _____ Office Contact _____ Phone _____ Fax _____
 Attending Physician _____ NPI# _____
 Patient Name (Last) _____ (First) _____ (Middle) _____ DOB _____
 ID # _____ HMO (Plan) _____ Group # _____
 Other Insurer (if any) _____
 Date of Admit _____ Date of Surgery _____ IP/OP (Circle One) Anticipated LOS _____
 Facility Name & Address _____

Diagnosis: (must be provided)		Procedure: (must be provided)		Circle: (appropriate eye(s))	
ICD 9 _____	Description _____	CPT _____	DESCRIPTION _____	RT	LT 50
ICD 9 _____	Description _____	CPT _____	DESCRIPTION _____	RT	LT 50
ICD-9 _____	Description _____	CPT _____	DESCRIPTION _____	RT	LT 50

Medical Reason for Request _____
 Attach additional pages if necessary

Patient's Subjective Complaint: _____
 Patient's BCVA: OD _____ OS _____
 Target Refraction: OD _____ OS _____

A comprehensive ophthalmic evaluation, including manifest refraction documenting the medical necessity for cataract surgery must be done no longer than three months prior to surgery.

Signature of Attending Physician: _____ Date: _____
 Office Location: _____

PRE CERTIFICATION/AUTHORIZATION IS NOT A GUARANTEE OF PAYMENT. COVERED SERVICES ARE BASED ON MEMBER ELIGIBILITY AND BENEFIT LIMITATIONS AT THE TIME SERVICE (S) ARE RENDERED.

DO NOT WRITE BELOW THIS LINE - FOR OFFICE USE ONLY

Reviewing Physician _____ Approve _____ Approved LOS _____
 Denied: _____ Rationale for Denial: _____
 Recommendation for alternative treatment(s) _____

Reviewing Physician Signature _____ Date _____
 Authorization # _____ or Denial Reference # _____ Date _____
 Medical Claims Administrator Signature _____

If Denied: Please refer to your Provider Manual or call 1-800-465-6972 to be informed of your appeal rights.

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