

Application for Treatment

Blindness Education, Screening and Treatment (BEST)



The Health and Human Services Commission (HHSC) administers the BEST Program under the authority of Texas Human Resources Code, Chapter 91.027. This program is funded through voluntary donations. Therefore, you may encounter a waiting list in times of limited funding. For information, call 1-877-787-8999 HHSC Office of the Ombudsman.

Please Read Instructions Carefully Before Completing

Applicant Information <i>Please type or print legibly</i>		Social Security Number:
Last Name:	First Name:	Full Middle Name:
Physical Address (Not a P.O. Box):		
City:	State:	ZIP Code:
County:	Texas Resident? (must have a valid address / no PO) <input type="checkbox"/> Yes <input type="checkbox"/> No	Colonias Resident? <input type="checkbox"/> Yes <input type="checkbox"/> No
Daytime telephone number: ()	Date of Birth (mm/dd/yyyy):	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Eye Condition (Check one)		
What eye condition or disease poses an urgent medical necessity and risk of blindness to the applicant?		
<input type="checkbox"/> Diabetic Retinopathy (Page 3-4) <input type="checkbox"/> Glaucoma (Page 5) <input type="checkbox"/> Detached Retina (Page 6-7) <input type="checkbox"/> Other: _____ (Page 7)		
If the eye disease is other than diabetic retinopathy, glaucoma, or detached retina, justify the urgent nature of the recommended treatment with an accompanying physician's letter and note the requested procedural codes on page 7.		

Medical Insurance (Check one)

Record whether the applicant has medical insurance coverage at the time of application.

- | | |
|--|---|
| <input type="checkbox"/> Medicaid | <input type="checkbox"/> Medicare |
| <input type="checkbox"/> Worker's Compensation | <input type="checkbox"/> Private Insurance through employment |
| <input type="checkbox"/> Private Insurance through other means | <input type="checkbox"/> None |
| <input type="checkbox"/> Other: _____ | |

For Demographic Purposes Only

The **BEST** program does not use the following information to determine eligibility for treatment services. The information is solely used to provide outreach services for underserved areas in the state.

Ethnicity (select one)

- | | |
|---|---|
| <input type="checkbox"/> Hispanic or Latino | <input type="checkbox"/> Not Hispanic or Latino |
|---|---|

Race (select all that apply)

- | | |
|---|--|
| <input type="checkbox"/> American Indian or Alaska Native | <input type="checkbox"/> Native Hawaiian or other Pacific Islander |
| <input type="checkbox"/> Asian | <input type="checkbox"/> White |
| <input type="checkbox"/> Black or African American | <input type="checkbox"/> Other: _____ |

Primary Support (select one)

Indicate the applicant's largest single source of economic support at the time of application, even if it accounts for less than one-half of the applicant's total support.

- | | |
|--|--|
| <input type="checkbox"/> Personal income (earnings, interest, dividends, rent) | <input type="checkbox"/> Family and friends |
| <input type="checkbox"/> Public Support (SSI, SSDI, TANF, etc.) | <input type="checkbox"/> All other sources (private disability insurance, private charities, etc.) |

Affidavit

I understand that to be eligible for the BEST program I must:

- Be a resident of the state of Texas,
- Have no health insurance or other resources to pay for eye medical treatment described on this application,
- Agree that the eye medical treatment recommended is an urgent medical necessity for the prevention of blindness and
- Is a qualifying eye medical disease such as glaucoma, diabetic retinopathy and/or detached retina.

I hereby certify that I meet all the above eligibility requirements.

Applicant's signature: _____

Date: _____

Note: Cataracts are not covered under the BEST Program. Other eye medical treatments outside of the diseases mentioned may require further review by either the State Eye Medical Consultant and/or BEST Program Specialist.

Effective 9/7/16

Would you like to be contacted by the Texas Workforce Commission (TWC) for:

A. Vocational rehabilitation services to help you go to work or keep a job? Yes No

----- or -----

B. Older Blind independent living (OIB) services to help function more independently (age 55<)? Yes No

TREATMENT INFORMATION

Patient's **corrected** visual acuity

OD:

OS:

APPLICATION INSTRUCTIONS

Codes and Corresponding Maximum Affordable Payment Schedule (MAPS) Rates

NOTE: CPT codes and descriptions are copyrighted by the AMA and may not be distributed without license agreement.

- Enter a check in the corresponding fees that you are requesting (physician fee or facility fee).
- Provide a justification if you plan to perform an in-office procedure outside of a physician's office.
- For unlisted procedure, input the dollar amount you are requesting for the physician and facility fee.

Common procedures for DIABETIC RETINOPATHY

CPT Code	Description	Maximum Allowable Payment for Physician Fee	Physician Fee (✓)	Maximum Allowable Facility Fee	Facility Fee (✓)	✓	
						O D	O S
67036	Vitrectomy, mechanical, pars plana approach;	\$971.43 (90-day global period)		\$1,654.18			
67039	with focal endolaser photocoagulation	\$1,272.67 (90-day global period) No additional payment allowed for 67036		\$1,654.18			
67040	with endolaser panretinal photocoagulation	\$1,438.77 (90-day global period) No additional payment allowed for 67228		\$1,654.18			
67041	with removal of preretinal cellular membrane	\$1,343.80 (90-day global period)		\$1,654.18			
67042	w/removal internal limiting membrane of retina, includes, if performed, intraocular tamponade	\$1,536.12 (90-day global period)		\$1,654.18			

DIABETIC RETINOPATHY, In-Office Procedures

Please provide justification below if procedures cannot be completed in office.

CPT Code	Description	Maximum Allowable Physician Fee	Physician Fee (√)	Maximum Allowable Facility Fee	Facility Fee (√)	√	
						O D	O S
J3300	Injection, triamcinolone acetonide, preservative free, per 1 mg (use for Trivaris)	\$3.49		N/A	N/A		
J9035	Injection, bevacizumab (Avastin, Imuron), per each 10 mg	\$61.09		N/A	N/A		
67028	Intravitreal Injection, A Pharmacologic Agent (Sep Proc)	\$103.13		\$59.91			
67228	Treatment of extensive or progressive retinopathy, one or more sessions; photo-coagulation	\$1,022.49 (in office procedure; 90-day global period)		\$218.40			
92134	Scanned computerized ophthalmic Dx imaging, posterior segment	\$44.93		N/A	N/A		

DIABETIC RETINOPATHY, In-Office Procedures, continued

92225	Extended ophthalmoscopy with interpretation and report	\$26.89 per eye (for retinal evaluation)		N/A	N/A		
92235	Fluorescein angiography (includes multiframe imaging) with interpretation and report	\$140.23 per eye (add-on to 92225)		N/A	N/A		

Justification to perform in-office Diabetic Retinopathy procedures outside of physician's office:

Requests for unlisted procedures to treat DIABETIC RETINOPATHY

The maximum allowable payments for unlisted code requests will be inputted once a completed application is received. All procedures must be authorized by the BEST Program before treatment.

CPT Code	Description	Maximum Allowable Payment for Physician Fee	Requested Physician Fee	Maximum Allowable Payment for Facility Fee	Requested Facility Fee	√	
						O D	O S
			\$		\$		
			\$		\$		
			\$		\$		

Justification to perform unlisted Diabetic Retinopathy procedures:

Common procedures for GLAUCOMA

CPT Code	Description	Maximum Allowable Physician Fee	Physician Fee (√)	Maximum Allowable Facility Fee	Facility Fee (√)	√	
						OD	OS
66180	Aqueous Shunt To Extraocular Reservoir	\$1,177.02		\$1,680.01			
67255	Scleral reinforcement w/graft	\$868.64		\$809.22			

GLAUCOMA, In-Office Procedures

Please provide justification below if procedures cannot be completed in-office.

CPT Code	Description	Maximum Allowable Physician Fee	Physician Fee (√)	Maximum Allowable Facility Fee	Facility Fee (√)	√	
						OD	OS
66710	Ciliary body destruction; cyclo-photocoagulation, transscleral	\$455.42 (90-day global period)		\$633.77			
66761	Iridotomy / Iridectomy by laser surgery, one or more sessions	\$299.53 (in office procedure; 90-day global period; Argon or YAG)		\$191.29			
92020	Gonioscopy (separate procedure)	\$26.89 one or both eyes		N/A			
92083	Extended visual field exam, with interpretation and report	\$92.58 one or both eyes		N/A			
92133	Scanned computerized ophthalmic Dx imaging, post segment, with interp/report, unilateral or bilateral; optic nerve	\$44.93		N/A			

Justification to perform Glaucoma procedures outside of physician's office:

Requests for unlisted procedures to treat GLAUCOMA

The maximum allowable payments for unlisted code requests will be inputted once a completed application is received. All procedures must be authorized by the BEST Program before treatment.

CPT Code	Description	Maximum Allowable Physician Fee	Requested Physician Fee	Maximum Allowable Facility Fee	Requested Facility Fee	√	
						OD	OS
			\$		\$		
			\$		\$		
			\$		\$		

Justification to perform unlisted Glaucoma procedures:

Common procedures for RETINAL DETACHMENT

CPT Code	Description	Maximum Allowable Physician Fee	Physician Fee (√)	Maximum Allowable Facility Fee	Facility Fee (√)	√	
						OD	OS
67107	Repair of retinal detachment; scleral buckling, with or without implant, cryotherapy, photocoagulation, and drainage of subretinal fluid;	\$1,253.95 (90-day global period)		\$1,654.18			
67108	with vitrectomy, any method w/ or w/o air or gas tamponade, focal endolaser photocoagulation, cryotherapy, drainage, scleral buckling, lens removal	\$1,628.36 (90-day global period) No additional payment allowed for 67036-67043		\$1,654.18			
67113	Repair of complex retinal detachment, with vitrectomy and membrane peeling, with or without air, gas, or silicone oil tamponade, cryotherapy, endolaser, drainage, scleral buckling, and/or lens removal	\$1,770.64 (90-day global period) No additional payment allowed for 67036-67043		\$1,654.18			

RETINAL DETACHMENT In-Office Procedures

Please provide justification below if procedures cannot be completed in-office.

CPT Code	Description	Maximum Allowable Physician Fee	Physician Fee (√)	Maximum Allowable Facility Fee	Facility Fee (√)	√	
						OD	OS
67141	Prophylaxis of retinal detachment, one more sessions; cryotherapy, diathermy	\$537.11 (in office procedure; 90-day global period)		\$194.25	N/A		

Effective 9/7/16

67145	Prophylaxis of retinal detachment, one or more sessions; photocoagulation	\$532.69 (in office procedure; 90-day global period)		\$218.40	N/A		
-------	---	---	--	-----------------	------------	--	--

Justification to perform Retinal Detachment procedures outside of physician's office:

Requests for unlisted procedures to treat RETINAL DETACHMENT

Once the application is received, DBS staff will input maximum allowable payments for unlisted code requests.
All procedures must be authorized by the BEST program before treatment.

CPT Code	Description	Maximum Allowable Physician Fee	Requested Physician Fee	Maximum Allowable Facility Fee	Requested Facility Fee	√	
						OD	OS
			\$		\$		
			\$		\$		
			\$		\$		

Justification to perform unlisted Retinal Detachment procedures:

Other Eye Disease

Describe Eye Disease Posing an Urgent Medical Necessity:

- List each requested CPT or HCPCS code and the corresponding physician and facility fees being requested.
- Please attach a physician's letter justifying the urgent nature of the patient's diagnosis and recommended treatment.
- Once the application is received, BEST staff will input the maximum allowable payments for unlisted code requests.

CPT Code	Description	Maximum Allowable Physician Fee	Requested Physician Fee	Maximum Allowable Facility Fee	Requested Facility Fee	√	
						OD	OS
			\$		\$		
			\$		\$		

Effective 9/7/16

			\$		\$		
			\$		\$		
			\$		\$		
			\$		\$		
			\$		\$		
			\$		\$		
			\$		\$		
			\$		\$		
			\$		\$		

BILLING INFORMATION

Incorporated are many, but not all Medicare procedural rules for reimbursement of medical and related services. These rules include bilateral and multiple procedure payment adjustments. We also use the National Correct Coding Initiative to prevent improper coding and the use of code pairs that are mutually exclusive. Please calculate your fees accordingly. You may contact **BEST** Program about current procedures and rates. Rates are subject to change.

Treating Physician

The noted physician fee in the amount of \$ _____ constitutes payment in full for service(s) noted herein. I will notify the **BEST** Program Specialist if any noted service was not provided.

Signature of Treating Physician:

Date:

Contact Name:

Last Name:	First Name:	**State of Texas Payee ID#:
------------	-------------	-----------------------------

Business Name (if different from above):

Address:	City:	State:
	ZIP Code:	ZIP Code Suffix if known:
Phone Number:	Fax Number:	County:

Anesthesiologist

The fee for providing anesthesiology services for the preceding noted service(s) is \$ _____. This amount constitutes payment in full. Note: **BEST** pays up to one-half of the surgeon's fees for anesthesiology services.

Signature of Anesthesiologist:

Date:

Last Name:	First Name:	**State of Texas Payee ID#:
------------	-------------	-----------------------------

Business Name (if different from above):

Effective 9/7/16

Billing Address:	City:	State:
	ZIP Code:	ZIP Code Suffix if known:
Phone Number:	Fax Number:	County:
Contact Name:		Contact Phone:

Surgical Facility

The total of facility fees is calculated as 100% of the highest facility fee + 50% of each additional facility fee. The sum of this calculation for the noted facility fees in the amount of \$_____ constitutes payment in full for services noted herein. I will notify the BEST Program Specialist if any noted service was not provided.

Business Name: _____ **State of Texas Payee ID#: _____

Billing Address:	City:	State:
	ZIP Code:	ZIP Code Suffix if known:
Phone Number:	Fax Number:	County:
Contact Name:		Contact Phone:
Billing Rep Signature:		Date:

Physician-Prescribed Drug Treatment (12 months maximum)

▶ Please provide copy of prescription and quote from pharmacy.

Drug	Refills	Pharmacy	Cost

Total: \$

Pharmacy

Billing Name:		**State of Texas Payee ID#:
Address:	City:	State:
	ZIP Code:	County:
Phone Number:		Fax Number:
Billing Rep Signature:		Date:

For BEST Program Use Only

Requisition Number: _____		
<input type="checkbox"/> Approved <input type="checkbox"/> Not Approved	Referred for Medical Consultant Review? <input type="checkbox"/> Yes <input type="checkbox"/> No	Physician: _____
	Surgical Facility: _____	

Effective 9/7/16

Date Referral Sent:	Date Received:	Anesthesiologist:
Signed:		Pharmacy:

Please mail or fax this application to:

BEST Program
Attention: Laura D. Marin
4800 N. Lamar Blvd MC 1416
Austin, TX 78756

You can read more about the BEST program by visiting the following web site:

<https://hhs.texas.gov/services/disability/blind-and-visually-impaired/blindness-education-screening-and-treatment>.

With few exceptions, individuals are entitled, on request, to be informed about the information that HHSC collects about them. Individuals also are entitled to receive and review the information. (Sections 552.021, 552.023, and 559.004 of the Government Code).

** If you have questions about your State of Texas Payee ID Number, please contact the Texas Comptroller's Office at 1-800-252-5555.