BlueCross BlueShield of Texas

Revised 6/20/2020

PRIOR AUTHORIZATION SERVICES FOR FULLY INSURED MEMBERS EFFECTIVE 01/01/2020

- **Most Out-of-Network/Out-of-Plan Services require medical management review.** If no prior authorization or referral is obtained for Out-of-Network/Out-of-Plan Services, no benefits may be available and network claims will be denied. Emergency Services are an exception.
- Health care providers who are part of an HMO Limited Provider Network must refer care to health care providers in the same Limited Provider Network.
- **Not all requirements apply to each product (**Blue Choice PPO℠, Blue Essentials℠, Blue Premier℠, Blue Advantage HMO℠ or MyBlue Health℠**).**
- **It is imperative that providers check eligibility and benefits and verify prior authorization requirements through Availity® at www.availity.com.**

The following services may require prior authorization based on the member's benefit plan:

Inpatient Facility Admission (acute care, inpatient rehab, skilled nursing, hospice, long term acute care/sub-acute care, etc.)

- Prior authorization is required for all planned (elective) inpatient hospital care (surgical, non-surgical, behavioral health and/or substance abuse). Elective admissions must have prior authorization before the admission occurs.
- All unplanned inpatient hospital care (surgical, non-surgical, behavioral health and/or substance abuse). Notification must be made within 48 hours admission to the facility.

Other Services:

1. **Advanced/High Tech Radiology Imaging**
2. **Behavioral Health Services**
   - Elective or Emergency Inpatient, Partial Hospital, and Residential Treatment Center (RTC) Admissions
   - Applied Behavior Analysis (ABA), Intensive Outpatient Programs (IOP), Outpatient Electroconvulsive Therapy (ECT), Psychological/Neuropsychological Testing, and Repetitive Transcranial Magnetic Stimulation (rTMS)
3. **Dialysis including Home Hemodialysis**
4. **Durable Medical Equipment**
5. **Home Health Services including but not limited to home private duty nursing (PDN) and home infusion therapy (HIT)**
6. **Home Infusion Therapy**
7. **Hospice *(outpatient and/or home)***
8. **Hyperbaric Treatment**
13. **Obstetrical Care**
14. **Occupational Therapy**
15. **Oral and Dental Procedures and Surgery**
16. **Out-of-Network/Out-of-Plan Services**
17. **Outpatient Cardiology Services**
18. **Outpatient Ear Nose and Throat**
19. **Outpatient Gastroenterology Services**
20. **Outpatient Neurology Services**
21. **Outpatient Sleep Studies and Sleep Durable Medical Equipment**
22. **Outpatient Surgical Procedures**
23. **Outpatient Wound Care Services**
24. **Physical Therapy**
25. **Prosthetics and Orthotics**
26. **Radiation Oncology for all Outpatient and Office Services**

9. Inpatient Facility Admissions Including Transfers *(In-Network)* • Hospital • Rehab • Skilled Nursing • Long Term Acute / Sub-acute Care **10. Molecular and Genomic Testing** **11. Musculoskeletal Joint and Spine Surgery** **12. Non-Emergent Air Ambulance**	**27. Specialty Pharmacy** **28. Specialty Pharmacy Infusion Site of Care** **29. Speech Therapy** **30. Transplant Evaluations** **31. Wound Care**
MEDICAL/SURGICAL SCREENING CRITERIA	**BEHAVIORAL HEALTH SCREENING CRITERIA**
• MCG Care Guidelines (MCG) • BCBSTX Medical Policies (MP) eviCore Healthcare® (vendor solution): • eviCore Evidence-based Guidelines	• MCG Care Guidelines (MCG) • Texas Department of Insurance (DOI) Standards for Reasonable Cost Control and Utilization Review for Chemical Dependency Treatment Centers • BCBSTX Medical Policies (MP) • Blue Cross and Blue Shield Association Policy Reference Manual Magellan Health (vendor solution for certain plans): • Magellan Healthcare Guidelines • Texas Department of Insurance (DOI) Standards for Reasonable Cost Control and Utilization Review for Chemical Dependency Treatment Centers

SPECIALTY PHARMACY PROGRAMS

For the Specialty Review Unit (SRU), the screening criteria used are contained within BCBSTX Medical Policies which include the statement:

Medical policies are a set of written guidelines that support current standards of practice. They are based on current peer-reviewed scientific literature. A requested therapy must be proven effective for the relevant diagnosis or procedure. For drug therapy, the proposed dose, frequency and duration of therapy must be consistent with recommendations in at least one authoritative source. This medical policy is supported by FDA-approved labeling and nationally recognized authoritative references. These references include, but are not limited to: MCG care guidelines, DrugDex (IIb level of evidence or higher), NCCN Guidelines (IIb level of evidence or higher), NCCN Compendia (IIb level of evidence or higher), professional society guidelines and CMS coverage policy.

Due to the above, SRU also leverages information contained within the package insert, NCCN, DrugDex, etc. in addition to the medical policies themselves.