BLUE ADVANTAGE HMO™ and BLUE ADVANTAGE PLUS™ HMO
PREAUTHORIZATION / REFERRAL REQUIREMENTS
Effective JANUARY 1, 2017

- Blue Advantage HMO is an HMO plan. Out-of-Network/Out-of-Plan Services (see below) always require medical management review. If no preauthorization or referral is obtained for Out-of-Network/Out-of-Plan Services, no benefits are available and claims will be denied. Emergency Services are an exception to this requirement.
- Blue Advantage Plus HMO is an HMO plan with added point-of-service benefits, offering some out-of-network benefits at a higher cost share for members. For the out-of-network benefits, members may also be responsible for the difference between the provider’s charge and allowable amount, which may be significant.
- Blue Advantage HMO and Blue Advantage Plus HMO PCP referral to a specialist and referrals requested by a specialist must be coordinated by the PCP for in-network benefits to apply when services are rendered by in-network or out-of-network providers.

Please Note: There is a new requirement for a preauthorization for designated list of surgical CPT codes if provided in an outpatient hospital setting (see below).

PREAUTHORIZATION REQUIREMENTS through eviCore - Effective 10/3/2016

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<th>PREAUTHORIZATION/REFERRAL REQUIREMENTS through iExchange / Medical Management</th>
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| **1. List of Surgical CPT Codes requiring preauthorization if provided in an outpatient hospital setting:**
  - Arthroscopy - 29826, 29827, 29881, 29888
  - Tonsillectomy, Adenoidectomy & Tympanostomy - 30140, 31255, 36561, 42820, 42821, 42825, 42826, 69436
  - Liver Biopsy - 47000
  - Laparoscopy & Hysteroscopy - 47562, 47563, 47564, 49650-49655, 58585
  - Hernia Repair - 49505, 49585, 49587
  - Abdominal Paracentesis - 49083
  - Lithotripsy - 50590
  - Urological Procedures - 52000, 52005, 52204, 52224, 52234, 52235, 52260, 52281, 52310, 52332, 52351-52353, 52356, 57288
  - Carpal Tunnel - 64721
  - Cataract Surgery - 66821, 66982, 66984
| Preauthorization required through Medical Management Review if performed in an outpatient hospital setting. | Referral required from primary care physician (PCP) for all elective services. (Need for referral is waived if member was emergently admitted inpatient and when is moving to a lower level of care facility). For Out-of-Network referrals see # 6 or # 7 |

| **2. Inpatient Facility Admissions Including Transfers**
  - Hospital
  - Hospice
  - Long Term Acute Care / Sub-acute
  - Rehab
  - Skilled Nursing
| Certain Facility Admissions Require Medical Management Review. | Referral required from primary care physician (PCP) for all elective services. (Need for referral is waived if member was emergently admitted inpatient and when is moving to a lower level of care facility). For Out-of-Network referrals see # 6 or # 7 |

| **3. Obstetrical Care**
| Maternity notification through iExchange | For Out-of-Network referrals see # 6 or # 7 |

| **4. Hospice (outpatient and/or home)**
| Preauthorization requires Medical Management Review | For Out-of-Network referrals see # 6 or # 7 |

| **5. Transplant Evaluations**
| Preauthorization requires Medical Management Review | For Out-of-Network referrals see # 6 or # 7 |

| **6. In-Network / In-Plan Services**
| Refer to specific service on this preauthorization list. | iExchange Referral for ALL Primary Care Physician (PCP) referrals to Specialists (outside of PCP’s Call Group / Back Ups) |

| - Out-of-network/out-of-plan services always require Medical Management Review. If no preauthorization is obtained for the out-of-network/out-of-plan services, no benefits are available and claims will be denied. Emergency services are an exception to this requirement.
  - If no in-network provider is available, or for continuity of care, out-of-network/out-of-plan services require Medical Management Review and preauthorization for in-network level of benefits. Emergency services are an exception to this requirement. | - Out-of-network/out-of-plan services always require Medical Management Review. If no referral is obtained for the out-of-network/out-of-plan services, no benefits are available and claims will be denied. Emergency Services are an exception to this requirement.
  - If no in-network provider is available, or for continuity of care, out-of-network/out-of-plan services require Medical Management Review and referral for in-network level of benefits. Emergency services are an exception to this requirement. |

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**BLUE ADVANTAGE HMO SM and BLUE ADVANTAGE PLUS SM HMO PREAUTHORIZATION / REFERRAL REQUIREMENTS Effective JANUARY 1, 2017**

- Blue Advantage HMO is an HMO plan. Out-of-Network/Out-of-Plan Services (see below) always require medical management review. If no preauthorization or referral is obtained for Out-of-Network/Out-of-Plan Services, no benefits are available and claims will be denied. Emergency Services are an exception to this requirement.
- Blue Advantage Plus HMO is an HMO plan with added point-of-service benefits, offering some out-of-network benefits at a higher cost share for members. For the out-of-network benefits, members may also be responsible for the difference between the provider’s charge and allowable amount, which may be significant.
- Blue Advantage HMO and Blue Advantage Plus HMO PCP referral to a specialist and referrals requested by a specialist must be coordinated by the PCP for in-network benefits to apply when services are rendered by in-network or out-of-network providers.

Please Note: There is a new requirement for a preauthorization for designated list of surgical CPT codes if performed in an outpatient hospital setting (see above).

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- Blue Advantage Plus members may use their out-of-network/out-of-plan benefits, which will result in higher out-of-pocket expenses.  
- If no in-network provider is available, or for continuity of care, out-of-network/out-of-plan services require Medical Management Review and preauthorization for in-network level of benefits. Emergency services are an exception to this requirement.  
**Note:** When an in-network provider is available, prior to referring a Blue Advantage Plus HMO member to an out-of-network provider for non-emergency services, the referring provider must complete the Out-Of-Network Enrollee Notification Form. | - Out-of-network/out-of-plan services always require Medical Management Review and referral when a Blue Advantage Plus member wants to use their in-network benefits. Emergency services are an exception to this requirement.  
- Blue Advantage Plus members may use their out-of-network/out-of-plan benefits, which will result in higher out-of-pocket expenses.  
- If no in-network provider is available, or for continuity of care, out-of-network/out-of-plan services require Medical Management Review and referral for in-network level of benefits. Emergency services are an exception to this requirement.  
**Note:** When an in-network provider is available, prior to referring a Blue Advantage Plus HMO member to an out-of-network provider for non-emergency services, the referring provider must complete the Out-Of-Network Enrollee Notification Form. |
| **9. Durable Medical Equipment** | DME greater than $2500 requires preauthorization. | For Out-of-Network referrals see #6 or #7 |
| **10. Home Health Services including but not limited to home private duty nursing (PDN) and home infusion therapy (HIT)** | Preauthorization Requires Medical Management Review | iExchange Referral required from PCP For Out-of-Network referrals see #6 or #7 |
| **11. Hyperbaric Treatment** | Preauthorization Requires Medical Management Review | For Out-of-Network referrals see #6 or #7 |
| **12. Drug/Alcohol Treatment** | Call Magellan for Preauthorization - 800-729-2422 | For Out-of-Network referrals see #6 or #7 |
| **13. Mental Health Services** | Call Magellan for Preauthorization - 800-729-2422 | For Out-of-Network referrals see #6 or #7 |
| **14. Home Infusion Therapy (HIT)** | Preauthorization Requires Medical Management Review | For Out-of-Network referrals see #6 or #7 |
| **15. Physical Therapy** | iExchange Referral required from PCP to Specialist For Out-of-Network referrals see #6 or #7 | For Out-of-Network referrals see #6 or #7 |
| **16. Occupational Therapy** | iExchange Referral required from PCP to Specialist For Out-of-Network referrals see #6 or #7 | For Out-of-Network referrals see #6 or #7 |
| **17. Speech Therapy** | iExchange Referral required from PCP to Specialist For Out-of-Network referrals see #6 or #7 | For Out-of-Network referrals see #6 or #7 |
| **18. Sleep Studies** | Out-of-Network/Out-of-Plan Services always require Medical Management Review. If no preauthorization is obtained for the Out-of-Network/Out-of-Plan Services, no benefits are available and network claims will be denied. Emergency Services are an exception to this requirement. | For Out-of-Network referrals see #6 or #7 |

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