Blue Cross Medicare Advantage℠

Prior Authorization rules - Medicare Advantage Medical / Surgical/Behavioral Health

PRIOR AUTHORIZATION REQUIREMENTS* through eviCore® - Effective 09/01/2019 through 12/31/2019	
1. Radiology **2. Medical Oncology** **3. Molecular Genetics** **4. Musculoskeletal - (Spine/Joint/Pain)** **5. Radiation Therapy** **6. Sleep** **7. Specialty Drug**	**Utilizing the eviCore Healthcare Web Portal is the most efficient way to initiate a case, check status, review guidelines, view authorizations / eligibility and more url: https://www.evicore.com/healthplan/bcbs OR** **Call eviCore toll-free at 1-855-252-1117 between 7 a.m. to 7 p.m. local time Monday through Friday except holidays.** **TX ONLY between 6 a.m. to 6 p.m. central time Monday through Friday and between 9 a.m. to noon central time (CT) on Saturdays, Sundays, and legal holidays.**

***Including Network Exceptions [out-of-plan or out-of-network (due to network adequacy) for managed programs]**

Note: For specific codes that apply, please access url: https://www.evicore.com/healthplan/bcbs
For a full list of services, visit the Blue Cross and Blue Shield of Texas (BCBSTX) eviCore webpage at BCBSTX.com/provider under Clinical Resources.

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through Blue Cross and Blue Shield of Texas
call toll free 1-877-774-8592 between 8 a.m. to 8 p.m. (CT) Monday through Friday except holidays.

Network Participation
Out of network providers must seek prior authorization for all services. The exceptions are for emergency services, emergency ambulance services, stabilization and services provided by I.H.S.
Notification Requirements
In cases of an emergency, notification is required within one business day of admission.
Medical Necessity
Medical necessity must be met for all services regardless if prior authorization is required. All services are subject to retrospective review and recoupment in accordance with State and Federal rules and regulations.
Inpatient Facility Admission Summary
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 one business day of admission to the facility.
All admissions to a skilled nursing facility, a long term acute care hospital (LTACH) or a rehabilitation facility.
All residential treatment program admissions.
Limitations Of Covered Benefits by Member Contract
This list is not exhaustive. The presence of codes on this list does not necessarily indicate coverage under the member benefits contract. Member benefits differ in their plans. Consult the member benefit booklet or contact a customer service representative to determine coverage for a specific medical service or supply.

Covered Service	**Prior Authorization**
Allergy care, including tests and serum	Please refer to the preauthorization grid for authorization requirements
Bariatric surgery	Yes
Blepharoplasty	Yes
Botox Injections	Yes
Covered Service	**Prior Authorization**
Chemotherapy and Radiation Therapy	Yes
Dental Care	Yes
DME - Medical supplies, Orthotics and Prosthesis	Refer to the procedure code list for benefit preauthorization requirements
Ground and fixed wing air ambulance	Ground - No
	Air - Yes, fixed wing medical transportation

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Home health care and intravenous services	Refer to the procedure code list for benefit preauthorization requirements
Hospital services (inpatient, outpatient)	Please refer to the procedure code list for Authorization Requirements. Inpatient stays with services that are managed by eviCore will be reviewed through eviCore.
Hyperbaric Oxygen	Yes
Injections	Refer to the procedure code list for benefit preauthorization requirements
Implantable Devices	Yes
Laboratory, X-ray, EKGs, medical imaging services and other diagnostic tests	Refer to the procedure code list for benefit preauthorization requirements
Long Term Acute Care (LTAC)	Yes
Minor surgeries	Refer to the procedure code list for benefit preauthorization requirements
Network Exceptions including Out of Plan or Out of Network (due to Network Adequacy)	Refer to the procedure code list for benefit preauthorization requirements
Nutritional counseling services	Refer to the procedure code list for benefit preauthorization requirements
Nutritional products and special medical foods	Yes
Office visits to PCPs or specialists, including dieticians, nurse practitioners and physician assistants	No
Podiatry (foot and ankle) services	Refer to the procedure code list for benefit preauthorization requirements
PET, MRA, MRI and CT scans	Refer to the procedure code list for benefit preauthorization requirements
Routine physicals	No
Second opinions (in network)	No
Skilled Nursing Facilities	Yes
Special rehabilitation services, such as: physical therapy, occupational therapy, speech therapy, cardiac rehabilitation, pulmonary rehabilitation	Yes, Refer to the procedure code list for benefit preauthorization requirements
Surgery, including pre-and post-operative care: assistant surgeon, anesthesiologist, organ transplants	Refer to the procedure code list for benefit preauthorization requirements; all transplants and pre-transplant evaluation require prior authorization
Intersex Reassignment Surgery 55970, 55980	Yes

Summary of Services and Behavioral Health UM requirements
***Providers requesting services for Texas Medicare Advantage HMO Plans should contact Magellan for authorization requirements**

Covered Service	Prior Authorization
All Inpatient Stays Facilities/Hospitals	Yes
Partial Hospitalization	Yes
Psychological/Neuropsychological Testing	Yes, upon notification by BCBSTX
Electroconvulsive Therapy	Yes
Transcranial Magnetic Stimulation	Yes
Outpatient Services	Refer to the procedure code list for benefit preauthorization requirements

Please view the comprehensive preauthorization grid for a list of procedure codes that require review. The document allows for bookmarking and searching for the code.
Press "CTRL" and "F" keys at the same time to bring up the search box.

Please note that the fact that a service has been preauthorized/pre-certified is not a guarantee of payment. Benefits will be determined once a claim is received and will be based upon, among other things, the member's eligibility and the terms of the member's certificate of coverage applicable on the date services were rendered.

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