



- 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 PPOSM, Blue EssentialsSM, Blue PremierSM, Blue Advantage HMOSM or MyBlue HealthSM or Blue High Performance NetworkSM).
- It is imperative that providers check eligibility and benefits and verify prior authorization requirements through Availity[®] Essentials to determine if a service required prior authorization. Refer to the Utilization Management page on the provider website for more information.
- For elective inpatient services that do not require a prior authorization, refer to [Recommended Clinical Review Services List for Fully Insured & Certain Administrative Services Only Groups](#).
- Providers should seek Clinical Review within 48 hours of admission to the facility for all unplanned inpatient hospital care (surgical, non-surgical, mental health and/or substance use disorder) to prevent post-service medical necessity reviews that may result in an adverse determination.

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

Outpatient Medical/Surgical Services (through Carelon Medical Benefits Management or BCBSTX as indicated below) ²

- Advanced Imaging / Radiology, Cardiology (Carelon)
- Molecular Genetic Lab Testing (Carelon)
- Musculoskeletal - Joint, Spine Surgery, Musculoskeletal - Pain (Carelon)
- Radiation Therapy / Radiation Oncology (Carelon)
- Sleep (Carelon) ³
- **Select Outpatient Services including but not limited to: (BCBSTX)**
 - Cardiology – Lipid Apheresis
 - Ear, Nose and Throat
 - Gastroenterology
 - Neurology
 - Outpatient Surgery (Breast, Deactivation of Headache Triggers, Jaw)
 - Pain Management
 - Sleep Studies
 - Wound Care

Other services that require Prior Authorization includes but not limited to:

Mental Health and Substance Use Disorder Services
Outpatient:

- Applied Behavioral Analysis (ABA) ²
- Electroconvulsive Therapy₂
- Intensive Outpatient Treatment₁
- Partial Hospitalization₁
- Psychological Testing/Neuropsychological Testing₂
- Repetitive Transcranial Magnetic Stimulation₂

¹Codes not available.

² [Note: Click here to view or download a list of Mental Health procedure codes that requires Prior Authorization for Fully Insured and Certain ASO Groups.](#)



<ul style="list-style-type: none"> • Home Health Services including but not limited to home private duty nursing (PDN), home infusion therapy (HIT) and PT/OT/ST₁ • Home Hemodialysis₁ • Home Hospice₁ • Home Infusion Therapy (HIT)₁ • Medical Transportation (<i>through Alacura Medical Transportation Management</i>)₂ <ul style="list-style-type: none"> - Non-emergency Fixed-Wing Air Ambulance₄ • Transplant Services, Transplant Evaluations and Transplants • Out-of-Network/Out-of-Plan Services₁ <ul style="list-style-type: none"> - Outpatient elective surgery received in an out-of-network Hospital or ambulatory surgical center - Dialysis obtained from an Out-of-Network-Provider₁ <p>¹Codes not available.</p> <p>² Note: Click here to download a list of Outpatient procedure codes that requires Prior Authorization for Fully Insured and certain ASO Groups.</p> <p>³ Applicable for certain ASO Groups.</p> <p>⁴ Medical Transportation managed by BCBSTX for account groups (TRS Fully Insured Account: 212824) until 5/23/25.</p>	
<p>Specialty Pharmacy Medications that are covered by Medical Benefits₂</p> <ul style="list-style-type: none"> • Infusion Site of Care - medical necessity review required for therapy and for place of infusion. • Medical Oncology & Supportive Care (through Carelon) – medical necessity review required for oncology drugs that are supported by an oncology diagnosis. • Provider Administered Drug Therapies - medical necessity review required for therapy only. 	<p>Pharmacy Benefits (Prime):₃</p> <p>Prior Authorization is required on some medications before drug will be covered. Check the drug list guide if Prior Authorization is required for a specific drug.</p> <p>³Note: Click here to view Prior Authorization/Step Therapy Program information to determine if the drug requires Prior Authorization under Pharmacy Benefits.</p> <p>For a comprehensive list of services that might require Prior Authorization and an overview of the Prior Authorization process and requirements, visit https://www.bcbstx.com/provider/claims/um.html</p>
<p>MEDICAL/SURGICAL SCREENING CRITERIA</p>	<p>MENTAL HEALTH SCREENING CRITERIA</p>
<ul style="list-style-type: none"> • MCG Care Guidelines • BCBSTX Medical Policies • American Society of Addiction Medicine Criteria • Texas Department of Insurance Standards for Reasonable Cost Control and Utilization Review for Substance Use Disorder 	<ul style="list-style-type: none"> • MCG Care Guidelines • BCBSTX Medical Policies • Texas Department of Insurance Standards for Reasonable Cost Control and Utilization Review for Substance Use Disorder Treatment Centers • American Society of Addiction Medicine Criteria



<p>Treatment Centers for CD service provided in Texas.</p> <ul style="list-style-type: none">• Carelon Medical Benefits Management (vendor solution): Carelon Evidence-based Guidelines	<p><u>Magellan Health (vendor solution for certain plans):</u></p> <ul style="list-style-type: none">• Magellan Healthcare Guidelines• American Society of Addiction Medicine (ASAM) Criteria
PHARMACY SCREENING CRITERIA	
<p>For the Provider Administered Drug Therapy Reviews, the screening criteria used are contained within BCBSTX Medical Policies which include the statement:</p> <p>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.</p> <p>Due to the above, Provider Administered Drug Therapy Reviews also leverages information contained within the package insert, NCCN, DrugDex, etc. in addition to the medical policies themselves.</p> <p>Click here to review clinical criteria applied for drugs covered by Pharmacy Benefits.</p>	

³ Applicable Administrative Services Only Accounts

- BCS - TEGNA, INC - SUPPLEMENTAL PLANS
- SPEAKING ROCK ENTERTAINMENT CENTER

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