BlueCross BlueShield of Texas

Prior Authorization rules - Medicaid Medical / Surgical (Non-Behavioral Health)	
Prior authorization REQUIREMENTS* through eviCore® - Effective 01/01/2024	
1. Radiology **2. Molecular Genetics** **3. Musculoskeletal - (PT/OT/ST;Spine/Joint/Pain/Chiro)** **4. Sleep** **5. 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 at: eviCore healthcare webportal OR call eviCore toll-free at 1-855-252-1117 between 6 a.m. to 6 p.m. (CST) Monday through Friday and between 9 a.m to 12 p.m. (CST) on Saturdays, Sundays, and legal holidays.**
***including Network Exceptions including Out of Plan or Out of Network (due to Network Adequacy)**	
Note: For specific codes that apply, please visit eviCore healthcare web portal **For a full list of services, visit the Blue Cross and Blue Shield of Texas (BCBSTX) Medicare webpage**	
Prior Authorization rules - Medicaid Medical / Surgical (Non-Behavioral Health) through BCBSTX. Call toll free 1-877-560-8055 for STAR/CHIP benefits or 1-877-784-6802 for STAR kids benefits between 8 a.m. to 8 p.m. (CST) Monday through Friday except holidays. **Prior to May 1, 2024, Providers requesting Behavioral Health services must contact Magellan Healthcare® at 1-800-327-9251 for prior authorization. All request after May 1, 2024 should reference the below list for prior authorization requirements and call BCBSTX for authorization requests.**	
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 Indian Health Services.	
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 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	
The table below includes information on benefit prior authorization requirements for non-emergency services provided to BCBSTX Medicaid members. Medical necessity, as defined in the Member Handbook, must be determined before a benefit prior authorization number will be issued. Claims received that do not have a benefit prior authorization number may be denied. Independently contracted providers may not seek payment from the BCBSTX Medicaid member when services are deemed not to meet the medical necessity definition in the Member Handbook and the claim is denied.	
Summary of Services and UM requirements	
Covered Service	**Prior Authorization**
Allergy care, including tests and serum	Please refer to the prior authorization grid for authorization requirements
Bariatric surgery	Yes
Breast Pumps and replacement supplies	No - Subject to benefit and DME dollar amount

Chemotherapy and radiation therapy	Yes, Please refer to the prior authorization grid for authorization requirements
Covered services provided in school-based health clinics	No
DME - Medical supplies, Orthotics and Prosthesis	Please refer to the procedure code list for Authorization Requirements
Emergency dental care	Yes
Diabetes self-management services	Please refer to the prior authorization grid for authorization requirements
Dialysis services	Yes, Out of Network, Out of State, CPT code 90999, Chronic Dialysis procedures over 3 times a week
Ground and air ambulance	Ground - No
	Air - Yes, fixed wing air ambulance.
Hearing services and devices	Yes
Home birthing	Notification is required
Home health care and intravenous services	Yes, Please refer to the prior authorization grid for authorization requirements.
Hospice	Yes
Hospital services (inpatient, outpatient, and skilled nursing)	Please refer to the prior authorization grid for authorization requirements
Injections	Please refer to the prior authorization grid for authorization requirements
Laboratory, X-ray, EKGs, medical imaging services, and other diagnostic tests	Please refer to the prior authorization grid for authorization requirements
Long Term Services and Supports	Long Term Services and Supports require pre-assessment, eligibilty determination and service planning. This process is completed with the member's care/service coordinator and the treatment team. Once service planning is complete, the authorization process is completed according to State guidelines and requirements. Eligibility is limited to members qualified due to waiver status or eligibility established after evaluation.
Nursing facilities	Yes
Nutritional counseling services	Please refer to the prior authorization grid for authorization requirements
Minor surgeries	Please refer to the prior authorization grid for authorization requirements
Office visits to PCPs or specialists, including dieticians, nurse practitioners, and physician assistants	No
Personal care services and private duty nursing (home- or school-based) for children under age 21, who qualify under the EPSDT program	Yes
	If your child is disabled, he or she may qualify for more services. Please call Customer Service and ask to speak with a Care
PET, MRA, MRI, and CT scans	Please refer to the prior authorization grid for authorization requirements
Podiatry (foot and ankle) services	Yes
Pregnancy-related and maternity services	No
Pregnancy-related ultrasound (TX only)	Members are permitted to have three ultrasounds without prior authorization
Routine physicals, children’s preventive health programs, and Tot-to-Teen checkups	No
Second opinions (in network)	No
Surgery, including pre-and post-operative care: assistant surgeon, anesthesiologist, organ transplants	Please refer to the prior authorization grid for authorization requirements; all transplants and pre-transplant evaluation require prior authorization

Special rehabilitation services, such as: physical therapy, occupational therapy, speech therapy, cardiac rehabilitation, pulmonary rehabilitation	Please refer to the prior authorization grid for authorization requirements
Behavioral Health Covered Service	**Prior Authorization**
Inpatient Mental Health Services	Yes
Inpatient Substance Abuse Services (Detox)	Yes
Substance Abuse Residential Services	Yes
Substance Abuse Residential Withdrawal Management Services	Yes
Mental Health Services in a Residential Setting (Only Covered Benefit for CHIP/STAR KIDS)	No
Partial Hospitilization	Yes
Intensive Outpatient Program for Mental Health	Yes
Intensive Outpatient Program for Substance Abuse	Yes
Coordinated Speciality Care	Yes
Mental Health Targeted Case Management	No
Mental Health Rehabilitative Services	No
Outpatient Mental Health Services	No
Outpatient Substance Abuse Services	No
Medication Assisted Treatment	No
Outpatient Withdrawal Management Services	No
Applied Behavioral Health (Allowable only for members 20 years of age or younger)	Yes
Psychological and Neuropsychological Testing	No
Electroconvulsive Therapy	No
Peer Specialist Services	No

Please view the comprehensive prior authorization grid for a list of procedure codes that require review. The document allows for bookmarking and searching for the code.

Please note that the fact that a service has been prior authorized/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.