



PRIOR AUTHORIZATION SERVICES FOR ADMINISTRATIVE SERVICES (ASO) ONLY PLANS EFFECTIVE 01/01/2021

- **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 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[®] 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, cardiac rehab, pain management, 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:

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| <ol style="list-style-type: none"> 1. Advanced/High Tech Radiology Imaging 2. Behavioral Health Services <ol style="list-style-type: none"> a. Elective or Emergency Inpatient, Partial Hospitalization Treatment Program, and Residential Treatment Center (RTC) Admissions b. 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 9. Inpatient Facility Admissions Including Transfers <ol style="list-style-type: none"> a. (In-Network) b. Hospital c. Rehab d. Skilled Nursing e. Long Term Acute / Sub-acute Care 10. Molecular and Genomic Testing 11. Musculoskeletal Joint and Spine Surgery 12. Non-Emergent Air Ambulance | <ol style="list-style-type: none"> 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. Pain Management 25. Physical Therapy 26. Prosthetics and Orthotics 27. Radiation Oncology for all Outpatient and Office Services 28. Specialty Pharmacy 29. Specialty Pharmacy Infusion Site of Care 30. Speech Therapy 31. Transplant Evaluations 32. Wound Care |
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MEDICAL/SURGICAL SCREENING CRITERIA	BEHAVIORAL HEALTH SCREENING CRITERIA
<ul style="list-style-type: none"> • MCG Care Guidelines (MCG) • BCBSTX Medical Policies (MP) • American Society of Addiction Medicine (ASAM) Criteria • Texas Department of Insurance Standards for Reasonable Cost Control and Utilization Review for Chemical Dependency (CD) Treatment Centers for CD service provided in Texas • AIM Specialty Health (AIM) (vendor solution): AIM Evidence-based Guidelines 	<ul style="list-style-type: none"> • MCG Care Guidelines (MCG) • BCBSTX Medical Policies (MP) • American Society of Addiction Medicine (ASAM) Criteria • Texas Department of Insurance (DOI) Standards for Reasonable Cost Control and Utilization Review for Chemical Dependency Treatment Centers

SPECIALTY PHARMACY PROGRAMS

For the Provider Administered Drug Therapy Reviews, 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, Provider Administered Drug Therapy Reviews also leverages information contained within the package insert, NCCN, DrugDex, etc. in addition to the medical policies themselves.

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