



Prior Authorization rules - Medicaid Medical / Surgical (Non-Behavioral Health)

PRIOR AUTHORIZATION REQUIREMENTS* through eviCore® - Effective 01/01/2019

| Covered Service | Prior Authorization |
|--|--|
| 1. Cardiology 2. Radiology 3. Medical Oncology 4. Molecular Genetics 5. Musculoskeletal - (PT/OT/ST;Spine/Joint Pain/Chiro) 6. Radiation Therapy 7. Sleep 8. Specialty Drug 9. Post Acute Care | Utilizing the eviCore healthcare web portal is the most efficient way to initiate a case, check status, review guidelines, view authorizations / eligibility and more eviCore healthcare web portal ^{PDF} OR Call eviCore toll-free at 1-855-252-1117 between 6 a.m. to 6 p.m. central standard time (CST) Monday through Friday and between 9 a.m. to noon 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 access eviCore healthcare web portal

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 Call toll free 1-877-311-1627 between 8 a.m. to 8 p.m. (Local Time) 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 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 Blue Cross Blue Shield Texas 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 Blue Cross and Blue Shield Texas 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 Utilization Management requirements

| Covered Service | Prior Authorization |
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| 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, eligibility 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 dietitians, nurse practitioners and physician assistants | No |



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| 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 Coordinator/Case Manager for more information. |
| 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 |
| <p>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. Press "CTRL" and "F" keys at the same time to bring up the search box.</p> | |
| <p>*Providers requesting Behavioral Health services for Texas Medicaid Plans must contact Magellan for authorization requirements</p> | |
| <p>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.</p> | |
| <p>eviCore® is a trademark of eviCore healthcare, LLC, formerly known as CareCore, an independent company that provides utilization review for select health care services on behalf of Blue Cross and Blue Shield of Texas</p> | |
| <p>By clicking this link, you will go to a new website/app ("site"). This new site may be offered by a vendor or an independent third party. The site may also contain non-Medicare related information. In addition, some sites may require you to agree to their terms of use and privacy policy.</p> | |