BlueCross BlueShield of Texas

Consumer Directed HealthSelect℠ In Area (Texas)
PRIOR AUTHORIZATION & REFERRAL REQUIREMENTS LIST
Effective August 1, 2018

- **Consumer Directed HealthSelect** is an open access plan utilizing the Blue Essentials provider network. Participants do not have to designate a Primary Care Physician (PCP) and in-network referrals are not required.
- **Out-of-Network Services always require medical management review.** If no prior authorization is obtained for Out-of-Network Services requiring Prior Authorization (See #6 below), benefits may be reduced or denied. Emergency Services are an exception to this requirement.
- **Prior Authorization requires Medical Management Review.**
- **If Medicare is Primary, no referrals or prior authorizations are required.**

PRIOR AUTHORIZATION REQUIREMENTS through eviCore	
Outpatient Only 1. **Molecular and genomic testing** 2. **Radiation oncology for all outpatient and office services** 3. **Advanced Radiology Imaging** 4. **Sleep Studies and Sleep Durable Medical Equipment (DME)** **(No prior authorization required for the resupply of Sleep DME supplies effective 8/1/2018)**	**Requires contacting eviCore for Prior Authorization at evicore.com or 855-252-1117** **Note**: For specific codes that apply, please visit https://www.evicore.com/healthplan/bcbs on eviCore.com or call toll-free **855-252-1117**.

PRIOR AUTHORIZATION & REFERRAL REQUIREMENTS through iExchange / Medical Management	PRIOR AUTHORIZATION through iExchange / Medical Management	REFERRAL through iExchange / Medical Management
1. **Inpatient Facility Admissions Including Transfers *(In-Network)*** - Hospital - Rehab - Long Term Acute Care / Sub-acute - Inpatient admissions - Inpatient hospice and rehabilitation - Skilled nursing (facility-based) - Congenital Heart Disease Services - Reconstructive Procedures (including but not limited to breast reduction surgery) - Transplant Services - Orthognathic Surgery	Prior Authorization Requires Medical Management. Any network service where Prior Authorization is not obtained by the provider before the service is rendered, the service will be denied by BCBSTX and the participants will be held harmless in all instances.	No referral required for any service by network providers. For Out-of-Network referrals see #6.
2. **Obstetrical Care**	Maternity notification.	No referral required for any service by network providers. For Out-of-Network referrals see #6.

Updated 12-17-2018

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- **Out-of-Network Services always require medical management review.** If no prior authorization is obtained for Out-of-Network Services requiring Prior Authorization (See #6 below), benefits may be reduced or denied. Emergency Services are an exception to this requirement.
- **Prior authorization requires Medical Management Review.**
- **If Medicare is Primary, no referrals or prior authorizations are required.**

PRIOR AUTHORIZATION & REFERRAL REQUIREMENTS through iExchange / Medical Management	PRIOR AUTHORIZATION through iExchange / Medical Management	REFERRAL through iExchange / Medical Management
3. **Outpatient** - **Private duty nursing** - **Home infusion therapy** (Out-of-Network/Out-of-Plan not covered) - **Home health (Exception: Home Dialysis no prior authorization needed)** - **Select durable medical equipment (DME) greater than $1,000 (including but not limited to prosthetic devices)** - **Non Emergent Air and Ground Ambulance** - **Congenital Heart Disease Services** - **Reconstructive Procedures (including but not limited to breast reduction surgery)** - **Transplant Services** - **Outpatient Surgery - Facility setting (Including but not limited to: diagnostic catheterization, electrophysiology implant and sleep apnea).** - **Orthognathic Surgery** - **Specialty Drugs (See List for Qualifying Drugs)**	Prior Authorization Requires Medical Management Review. First visits for physical therapy, speech therapy, and occupational therapy do not require a Prior Authorization. All subsequent visits will require an approved Prior Authorization to include a treatment plan. Any network service where Prior Authorization is not obtained by the provider before the service is rendered, the service will be denied by BCBSTX and the participants will be held harmless in all instances.	No referral required for any service by network providers.
4. **Bariatric Surgery**	Not covered under the Consumer Directed HealthSelect benefit plan.	Not covered under the Consumer Directed HealthSelect benefit plan.
5. **In-Network**	Refer to specific service on this Prior Authorization list.	No referral required for any service by network providers.
6. **Out-of-Network**	Out-of-network services may require Medical Management review for certain services requiring Prior Authorization. Emergency services are an exception to this requirement.	Out-of-network services may require Medical Management review for certain services requiring Prior Authorization. Emergency services are an exception to this requirement.

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- **Out-of-Network Services always require medical management review.** If no prior authorization is obtained for Out-of-Network Services requiring Prior Authorization (See #6 below), benefits may be reduced or denied. Emergency Services are an exception to this requirement.
- **Prior authorization requires Medical Management Review.**
- **If Medicare is Primary, no referrals or prior authorizations are required.**

PRIOR AUTHORIZATION & REFERRAL REQUIREMENTS through iExchange / Medical Management	PRIOR AUTHORIZATION through iExchange / Medical Management	REFERRAL through iExchange / Medical Management
Delegated to Magellan – Behavioral Health (BH) Prior Authorization Services Inpatient, Residential, and Partial Day Stays. Call Magellan at 800-442-4093.		
1. Inpatient Facility Admissions Including Transfers (In-Network) - Neurobiological Disorders - Substance Abuse Disorders - Serious Mental Illness **2. Outpatient Behavioral Health Services** - (including Intensive Outpatient Program (IOP) for MH and SUD; Psychological and Neuropsychological Testing; Repetitive Transcranial Magnetic Stimulation (rTMS); Electro-Convulsive Therapy (ECT); and Applied Behavioral Analysis (ABA), for Autism Spectrum	Prior Authorization is required (Please call Magellan).	Out-of-network services always require Medical Management Review and referral when participant wants to use their in-network benefits.

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