



**HealthSelect of Texas® & Consumer Directed HealthSelect<sup>SM</sup> Out-of-State Plan Participants  
PRIOR AUTHORIZATION & REFERRAL REQUIREMENTS LIST  
Effective September 1, 2020**

- **Participants utilize Blue Card PPO 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](http://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 Availity® Authorization & Referrals/Medical Management**

**PRIOR AUTHORIZATION through Availity Authorization & Referrals/Medical Management**

**REFERRAL through Availity Authorization & Referrals/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

**Inpatient Facility Admissions Including Transfers (In-Network) For Mental Health(MH) Prior Authorization Services**  
Inpatient, Residential, and Partial Day Stays

  - **Neurobiological Disorders**
  - **Substance Abuse Disorders**
  - **Serious Mental Illness**

Prior Authorization Requires Medical Management Review.

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.



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Effective September 1, 2020**

- Participants utilize Blue Card PPO network. Participants do not have to designate a 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 & REFERRAL REQUIREMENTS through Availity® Authorization & Referrals/Medical Management	PRIOR AUTHORIZATION through Availity Authorization & Referrals/Medical Management	REFERRAL through Availity Authorization & Referrals/Medical Management
<p><b>3. Outpatient</b></p> <ul style="list-style-type: none"> <li>- Private duty nursing</li> <li>- Home infusion therapy (Not covered – Non-Network)</li> <li>- Home health (Exception-Home Dialysis no prior authorization required)</li> <li>- Select durable medical equipment (DME) greater than \$1,000 (including but not limited to prosthetic devices)</li> <li>- Non Emergent Air and Ground Ambulance</li> <li>- Congenital Heart Disease Services</li> <li>- Reconstructive Procedures (including but not limited to breast reduction surgery)</li> <li>- Transplant Services</li> <li>- Outpatient Surgery - Facility setting (Including but not limited to: diagnostic catheterization, electrophysiology implant and sleep apnea.)</li> <li>- Orthognathic Surgery</li> <li>- Specialty Drugs (See List for Qualifying Drugs) Prior Authorization</li> <li>- Outpatient Mental Health (MH) Services Prior Authorization Services: (including Intensive Outpatient Program (IOP) for MH and SUD; Repetitive Transcranial Magnetic Stimulation (rTMS); Electro-Convulsive Therapy (ECT); and Applied Behavioral Analysis (ABA), for Autism Spectrum</li> </ul>	<p>Prior Authorization Requires Medical Management Review.</p> <p>First visits physical therapy, speech therapy, and occupational therapy do not require a Prior Authorization.</p> <p>All subsequent visits will require an approved Prior Authorization to include a treatment plan.</p>	<p>No referral required for any service by network providers.</p>
<p><b>4. Bariatric Surgery</b></p>	<p>Not covered under the HealthSelect Out-of-State Plan.</p>	<p>Not covered under the HealthSelect Out-of-State Plan.</p>
<p><b>5. In-Network</b></p>	<p>Refer to specific service on this Prior Authorization list.</p>	<p>No referral required for any service by network providers.</p>
<p><b>6. Out-of-Network</b></p>	<p>Out-of-network services require Medical Management Review for certain services requiring Prior Authorization.</p> <p>Emergency services are an exception to this requirement.</p>	<p>Out-of-network services require Medical Management Review for certain services requiring Prior Authorization.</p> <p>Emergency services are an exception to this requirement.</p>