***The following list contains Medicare Advantage Prior Authorizations which are required during the normal course of business. Please note that several Prior Authorizations have been waived due to COVID-19.**

General Information for MEDICARE ADVANTAGE only –

This list contains inpatient and outpatient prior authorization requirements for providers who participate in Arkansas Blue Cross and Blue Shield Blue Medicare and Health Advantage Medicare Advantage plans. The term "prior authorization" (preauthorization, precertification, preadmission) is defined as a process through which physicians or other healthcare providers obtain advance approval from the health plan(s) as to whether an item or service will be covered.

These changes affect services provided to members of the following Medicare Advantage plans:

- BlueMedicare Premier HMO
- Health Advantage Blue Premier HMO
- Health Advantage Blue Classic HMO
- BlueMedicare Saver Choice PPO
- BlueMedicare Value Choice PPO
- BlueMedicare Premier Choice PPO

*Disclaimer: The Prior Authorization list may not be all inclusive as it is a point in time document and any additions will be made with appropriate provider notification and in accordance with CMS regulation.

Prior authorization is not required for emergencies seen in emergency room and urgent care visits.

Requests for prior authorizations per services listed as required are classified in two ways specific to CMS regulation and are to be requested as follows:

- **EXPEDITED** prior authorization is to be requested when care is deemed to be of priority need and authorization response given within 72 hours.

- **STANDARD** prior authorization is to be requested when routine care is being provided or scheduled. Authorization response will be within 14 days for standard requests.

*In effort to allow Arkansas Blue Cross and Blue Shield rapid response to the most time sensitive requests for patients and providers, please be sure to identify your request appropriately as standard or expedited based upon patient care needs.

INPATIENT CARE AND SERVICES

ACUTE INPATIENT HOSPITAL - prior approval is required for all inpatient admissions and it is your responsibility to inquire prior to rendering service

Example procedures include:

- Acute hospital (includes inpatient hospice)
- Acute rehab facilities
- Bladder slings*
- Breast reconstruction
- Cardiac procedures/surgeries
    - Cardiac catheterizations*
- Cardiology
- Cardiovascular
- Chiari malformation decompression surgery*
- Chimeric antigen receptor T-cell therapy (CAR-T)
- Cosmetic and reconstructive procedures*
- Gastric pacing
- Gender reassignment surgery
- Hip surgery to repair impingement syndrome
- Hyperbaric oxygen therapy*
- Hysterectomy (abdominal and laparoscopic surgeries)
- Hysterectomy (vaginal)
- Inpatient confinements (except hospice)
    - Surgical and nonsurgical stays
- Long-term acute care
- Lung biopsy and resection
- Negative pressure wound therapy (NPWT)*
- Obesity surgeries
- Orthopedic surgeries*
    - Non-spine and joint surgeries
    - Hip, knee and shoulder arthroscopy
- Orthognathic surgery procedures, bone grafts, osteotomies and surgical management of the temporomandibular joint
- Prostate surgeries (prostatectomy)
- Reconstructive or other procedures that may be considered cosmetic, such as*:
    - Blepharoplasty/canthoplasty
    - Breast Reconstruction/breast enlargement
    - Breast reduction/mammoplasty
    - Excision of excessive skin due to weight loss
    - Gastroplasty/gastric bypass
    - Lipectomy or excess fat removal

* Can be performed in either an inpatient or outpatient setting. Criteria varies depending on nature.

    - Surgery for varicose veins, except stab phlebectomy
- Shoulder Arthroplasty including revision procedures
- Skin and tissue substitutes*
- Sleep apnea procedures and surgeries*
    - Applies to inpatient or outpatient procedures and surgeries, including, but not limited to: palatopharyngoplasty – oral pharyngeal reconstructive surgery that includes laser-assisted uvulopalatoplasty
    - Applies only for surgical sleep apnea procedures and not sleep studies
- Spinal procedures, such as*:
    - Artificial Intervertebral Disc Surgery (cervical spine)
    - Arthrodesis for spine deformity
    - Cervical laminoplasty
    - Cervical, lumbar and thoracic laminectomy and\or laminotomy procedures
    - Kyphectomy
    - Laminectomy with rhizotomy
    - Spinal fusion surgery
- Thyroid surgeries (thyroidectomy and lobectomy) *
- Transplant of tissue or organs
- Transplant surgeries
- Varicose vein: surgical treatment and sclerotherapy
- Whole exome sequencing*

BEHAVIORAL HEALTH SERVICES - Benefits and prior authorization requirements vary by policy; it is your responsibility to verify benefits and authorization requirements prior to rendering services

Example procedures include:

- Behavioral health services
    - Inpatient Psychiatric Services
    - Partial Hospital (PHP) Services
    - Intensive Outpatient (IOP) Services
    - Transcranial Magnetic Stimulation (TMS)

SKILLED NURSING FACILITY - prior approval is required for all inpatient admissions and it is your responsibility to inquire prior to rendering service

Example procedures include:

- Inpatient confinements (except hospice)
    - Surgical and nonsurgical stays
    - Stays in a skilled nursing facility or rehabilitation facility

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* Can be performed in either an inpatient or outpatient setting. Criteria varies depending on nature.

OUTPATIENT CARE AND SERVICES

DIAGNOSTIC SERVICES LABS/IMAGING - prior approval is required for all outpatient procedures and it is your responsibility to inquire into prior to rendering service

Example procedures include:

- Capsule endoscopy
- Diagnostic imaging†
    - Bone and/or join imaging
    - Bone marrow imaging
    - Computed tomography (CT) scan
    - Electrophysiology (EPS) or EPS with 3D mapping
    - Gastric studies
    - Magnetic resonance angiogram (MRA)
    - Magnetic resonance imaging (MRI)
    - Myocardial perfusion imaging single photon emission computed tomography (MPI SPECT)
    - Nuclear stress test
    - Outpatient transthoracic echocardiogram (TTE)
    - Positron emission tomography (PET) scan/National Oncology PET Registry (NOPR)
    - Single photon emission computerized tomography (SPECT) scan
    - Transesophageal echocardiogram (TEE)
- Video electroencephalograph (EEG)

OUTPATIENT HOSPITAL COVERAGE - prior approval is required for all outpatient procedures and it is your responsibility to inquire prior to rendering service

Example procedures include:

- Autologous chondrocyte implantation
- Bladder slings*
- Blepharoplasty
- Breast procedures
    - Breast cancer biopsy (excisional)
    - Breast lumpectomy
    - Other breast procedures (excludes breast reconstruction following medically necessary mastectomies for breast cancer)
    - Simple mastectomy and gynecomastia surgery (excludes radical and modified) †
- Cardiac procedures/surgeries
    - Cardiac catheterizations*
    - Outpatient coronary angioplasty/stent

* Can be performed in either an inpatient or outpatient setting. Criteria varies depending on nature.

    - Patent foramen ovale (PFO) and atrial septal defect (ASD) closure
    - Transcatheter valve surgeries (TMVR, TAVR/TAVI and MitraClip)
- Cardiology
- Chiari malformation decompression surgery*
- Cosmetic and reconstructive procedures
- Decompression of peripheral nerve (e.g., carpal tunnel surgery)
- Dorsal column (lumbar)
    - Neurostimulators: trial or implantation
- Endoscopic nasal balloon dilation procedures
- Epidural injections (outpatient only)
- Esophagogastroduodenoscopy (EGD)
- Facet injections
- Facility-based sleep studies (PSG)
- Foot surgeries: bunionectomy and hammertoe
- Functional endoscopic sinus surgery (FESS)
- Gender dysphoria treatment
- Hysterectomy (abdominal and laparoscopic surgeries)
- Hyperbaric oxygen therapy*
- Infertility services and pre-implantation genetic testing
- Inpatient admissions – post-acute services
- Lung biopsy and resection†
- Molecular diagnostic/genetic testing
- Negative pressure wound therapy (NPWT)*
- Oral, orthognathic, temporomandibular joint (TMJ) surgeries
- Orthognathic surgery
- Orthotics
- Orthopedic surgeries*
    - Non Spine and joint surgeries
- Osteochondral allograft/knee
- Penile implant
- Reconstructive or other procedures that may be considered cosmetic, such as*:
    - Blepharoplasty/canthoplasty
    - Breast Reconstruction/breast enlargement
    - Breast reduction/mammoplasty
    - Excision of excessive skin due to weight loss
    - Gastroplasty/gastric bypass
    - Lipectomy or excess fat removal
    - Surgery for varicose veins,except stab phlebectomy
- Rhinoplasty
- Routine maternity care
- Skin and tissue substitutes*
- Sleep apnea procedures and surgeries
    - Applies to inpatient or outpatient procedures and surgeries, including, but not limited to: palatopharyngoplasty – oral pharyngeal reconstructive surgery that includes laser-assisted uvulopalatoplasty
    - Applies only for surgical sleep apnea procedures and not sleep studies
- Spinal fusion, decompression, kyphoplasty and vertebroplasty

* Can be performed in either an inpatient or outpatient setting. Criteria varies depending on nature.

- Spinal procedures, such as*:
    - Artificial Intervertebral Disc Surgery (cervical spine)
    - Arthrodesis for spine deformity
    - Cervical laminoplasty
    - Cervical, lumbar and thoracic laminectomy and\or laminotomy procedures
    - Kyphectomy
    - Laminectomy with rhizotomy
- Surgery for obstructive sleep apnea
- Surgical nasal/sinus endoscopic procedures and balloon sinus ostial dilation
- Thyroid surgeries (thyroidectomy and lobectomy) *
- Uvulopalatopharyngoplasty
    - Laser-assisted procedures
- Vein procedures
- Whole exome sequencing*

OUTPATIENT DIAGNOSTIC THERAPEUTIC RADIOLOGY SERVICES - prior approval is required for all outpatient procedures and it is your responsibility to inquire prior to rendering service

Example procedures include

- Hypothermia
- Nuclear Medicine Radiological Services.
- Proton beam radiotherapy
    - Radiation Oncology
    - Radiology
- Remote afterloading high dose rate radionuclide interstitial or intracavitary brachytherapy
- Therapeutic Radiological Services

ADDITIONAL BENEFITS

MEDICAL EQUIPMENT - prior approval is required and it is your responsibility to inquire prior to rendering service

Example procedures include:

- Bone growth stimulators
- Cardiac devices
    - Cardiac implantable devices [e.g., pacemakers, leadless pacemaker, left atrial appendage closure (LAAC), defibrillators (implantable and subcutaneous) and cardiac resynchronization therapy]
    - Loop recorders

* Can be performed in either an inpatient or outpatient setting. Criteria varies depending on nature.

    - Wearable cardiac devices (e.g., LifeVest®)
- Chemotherapy agents, supportive drugs and symptom management drugs category
- Cochlear and auditory brainstem implants
- Cochlear device and/or implantation
- Dental implants
- Electric beds
- Electric or motorized wheelchairs and scooters
- High-frequency chest compression vests
- Lower limb prosthetics, such as microprocessor-controlled lower limb prosthetics
- Neuromuscular stimulators
- Neurostimulators
- Noninvasive home ventilators
- Other durable medical equipment (DME)
- Pain infusion pump
- Prosthetics
- Spinal cord stimulators
- Stimulators
- Ventricular assist devices (VADs)
- Wheelchairs/scooters

REHABILITATION - prior approval is required and it is your responsibility to inquire prior to rendering service

Example procedure include:

- Supervised Exercise Therapy

ACUPUNCTURE - prior approval is required and it is your responsibility to inquire prior to rendering service

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OTHER - prior approval may be required and it is your responsibility to inquire prior to rendering service

Example procedures include:

- Home infusion

Pharmacy Prescriptions

* Can be performed in either an inpatient or outpatient setting. Criteria varies depending on nature.

Please contact Prime Therapeutics at 1-800-693-6651 or fax at 1-800-693-6703 (Monday - Friday from 7 a.m. - 5:30 p.m. CST) to request approval for a prescription drug that requires a prior authorization.

* Can be performed in either an inpatient or outpatient setting. Criteria varies depending on nature.