

- Prior authorizations, or prior approvals, are a required pre-service medical necessity review. A prior authorization is the process where we review the requested service or drug to see if it is medically necessary and covered under the member's health plan. Not all services and drugs require prior authorization.
- **NOTE:** Not all requirements apply to self-funded/ASO health plans, and they may have additional prior authorization requirements. It is imperative that providers check eligibility and benefits and verify prior authorization requirements through [Availity®](#).

2025 PRIOR AUTHORIZATION REQUIREMENTS	
<p><b>Inpatient Medical/Surgical Facility Admissions Including Transfers*:</b></p> <ul style="list-style-type: none"> <li>• Acute Care / Hospital</li> <li>• Hospice Care</li> <li>• Long Term Acute Care / Sub-acute</li> <li>• Rehabilitation Facility</li> <li>• Skilled Nursing Facility</li> </ul> <p><i>*Codes not available.</i> <i>Note: For Maternity Care, Prior Authorization should be obtained for stays that exceed more than 48 hours for a vaginal delivery and 96 hours for a caesarean-section delivery.</i></p> <hr/> <p><b>Mental Health and Substance Use Disorder Facility Admissions: *</b></p> <ul style="list-style-type: none"> <li>• Inpatient</li> <li>• Residential Treatment Center (RTC)</li> </ul> <p><b>Mental Health and Substance Use Disorder Services Outpatient:</b></p> <ul style="list-style-type: none"> <li>• Applied Behavioral Analysis (ABA)**</li> <li>• Electroconvulsive Therapy**</li> <li>• Intensive Outpatient Treatment*</li> <li>• Partial Hospitalization*</li> <li>• Psychological Testing/Neuropsychological Testing**</li> <li>• Repetitive Transcranial Magnetic Stimulation**</li> </ul> <p><i>*Codes not available.</i> <i>**Note: <a href="#">Click here to view or download a list of Mental Health procedure codes that requires Prior Authorization.</a></i></p>	<p><b>Outpatient Medical/Surgical Services (through Carelon Medical Benefits Management) **</b></p> <ul style="list-style-type: none"> <li>• Advanced Imaging / Radiology (Carelon)</li> <li>• Molecular Genetic Lab Testing (Carelon)</li> <li>• Musculoskeletal – Spine Surgery (Carelon)***</li> <li>• Radiation Therapy / Radiation Oncology (Carelon)</li> </ul> <p><b>Select Outpatient Services including but not limited to: (BCBSMT)**</b></p> <ul style="list-style-type: none"> <li>• Orthopedic Musculoskeletal****</li> <li>• Pain Management</li> <li>• Sleep Studies</li> </ul> <p><b>Other services that require Prior Authorization includes but not limited to:</b></p> <ul style="list-style-type: none"> <li>• Dialysis obtained from an Out-of-Network-Provider*</li> <li>• Home Health Services including private duty nursing (PDN) when a covered benefit*</li> <li>• Home Hemodialysis**</li> <li>• Home Hospice**</li> <li>• Home Infusion Therapy (HIT)**</li> <li>• Non-Emergent Air Ambulance**</li> <li>• Out-of-Network/Out-of-Plan Services* <ul style="list-style-type: none"> <li>○ Outpatient elective surgery received in an out-of-network Hospital or ambulatory surgical center.</li> </ul> </li> <li>• Transplant Evaluations and Transplants**</li> </ul> <p><i>*Codes not available.</i> <i>**Note: <a href="#">Click here to view or download a list of Outpatient procedure codes that requires Prior Authorization.</a></i> <i>***Effective for Fully Insured 4/22/24 and ASO (upon renewal) on or after 4/22/24.</i> <i>****ASO only effective 4/22/24 for accounts not transitioned to Carelon.</i></p>
<p><b>Specialty Pharmacy Medications that are covered by Medical Benefits**</b></p> <ul style="list-style-type: none"> <li>• Infusion Site of Care (BCBS)- medical necessity review required for therapy and for place of infusion.</li> </ul>	<p><b>Pharmacy Benefits (Prime): **</b></p> <p>Prior Authorization is required on some medications before drug will be covered. Check the drug list guide if</p>

**2025 COMMERCIAL**  
**PRIOR AUTHORIZATION REQUIREMENTS SUMMARY**  
**EFFECTIVE 01/01/2025**

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<ul style="list-style-type: none"><li>• Provider Administered Drug Therapies (BCBS)- medical necessity review required for therapy only.</li><li>• Medical Oncology &amp; Supportive Care (Carelon) – medical necessity review required for oncology drugs that are supported by an oncology diagnosis.</li></ul> <p><a href="#">**Note: Click here to view or download a list of Specialty Drugs procedure codes that requires Prior Authorization.</a></p>	<p>Prior Authorization is required for a specific drug.</p> <p><a href="#">***Note: Click here to view Prior Authorization/Step Therapy Program information to determine if the drug requires Prior Authorization under Pharmacy Benefits.</a></p>
<p>Please note that verification of eligibility and benefits, and/or the fact that a service or treatment has been preauthorized or predetermined for benefits is not a guarantee of payment. Benefits will be decided once a claim is received. They will be based on, among other things, the member’s eligibility, and the terms of the member’s certificate of coverage effective on the date of service.</p>	

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