2026 Prior authorization

You need prior Plan approval for certain services.

BlueCross BlueShield Federal Employee Program

The pre-service claim approval processes for inpatient hospital admissions (called precertification) and for Other services (called prior approval) are detailed in Section 3 of the Service Benefit Brochure. A pre-service claim is any claim, in whole or in part, that requires approval from us before you receive medical care or services.

In other words, a pre-service claim for benefits may require precertification and prior approval. If you do not obtain precertification or prior approval as required, there may be a reduction or denial of benefits. Be sure to read all of the following precertification and prior approval information. Our FEP medical policies may be found by visiting **www.fepblue.org/policies**.

Inpatient hospital admission, inpatient residential treatment center admission, or skilled nursing facility admission

Precertification is the process by which – prior to your inpatient admission – we evaluate the medical necessity of your proposed stay, the procedure(s)/service(s) to be performed, the number of days required to treat your condition, and any applicable benefit criteria. Unless we are misled by the information given to us, we will not change our decision on medical necessity. In most cases, your physician or facility will take care of requesting precertification. Because you are still responsible for ensuring that your care is precertified, you should always ask your physician, hospital, inpatient residential treatment center, or skilled nursing facility whether or not they have contacted us and provided all necessary information. You may contact us at the phone number on the back of your ID card to ask if we have received the request for precertification. Keep reading this section for information about precertification of an emergency inpatient admission.

Warning:

We will reduce our benefits for the inpatient hospital stay by $500, even if you have obtained prior approval for the service or procedure being performed during the stay, if no one contacts us for precertification. If the stay is not medically necessary, we will not provide benefits for inpatient hospital room and board or inpatient physician care; we will only pay for covered medical services and supplies that are otherwise payable on an outpatient basis.

Exceptions

FEP Blue Standard® and FEP Blue Basic®

You do not need precertification in these cases:

- You are admitted to a hospital outside the United States; with the exception of admissions to residential treatment centers, and skilled nursing facilities.
- You have another group health insurance policy that is the primary payor for the hospital stay.
- Medicare Part A is the primary payor for the hospital or skilled nursing facility stay.

Note: Precertification for covered organ/tissue transplants performed at Blue Distinction Centers for Transplants is required even if you have another primary group health insurance policy or have primary Medicare Part A coverage.

Note: If you exhaust your Medicare hospital benefits and do not want to use your Medicare lifetime reserve days, then you do need precertification.

Note: Severe obesity surgery performed during an inpatient stay (even when Medicare Part A is your primary payor) must meet the surgical requirements listed in our medical policy in order for benefits to be provided for the admission and surgical procedure.

FEP Blue Focus®

You do not need precertification in these cases:

- You are admitted to a hospital outside the United States; with the exception of admissions to residential treatment centers.

Note: Special rules apply when Medicare or another payer is primary, as explained later in this document.

FEP Blue Standard® and FEP Blue Basic®

You must obtain prior approval for these services under both Standard and Basic Option in all outpatient and inpatient settings unless otherwise noted. Precertification is also required if the service or procedure requires an inpatient hospital admission. Contact us using the customer service phone number listed on the back of your ID card before receiving these types of services, and we will request the medical evidence needed to make a coverage determination:

Other Services

- **Gene therapy and cellular immunotherapy, for example, CAR-T and T-Cell receptor therapy**
- **Medical benefit drugs** – We require prior approval for certain drugs that will be submitted on medical claim for reimbursement. Contact the customer service number on the back of your ID card or visit us at **www.fepblue.org/medicalbenefitdrugs** for a list of these drugs.
- **Air Ambulance Transport (non-emergent)** – Air ambulance transport related to immediate care of a medical emergency or accidental injury does not require prior approval.
- **Outpatient facility-based sleep studies** – Prior approval is required for sleep studies performed in a provider's office, sleep center, clinic, any type of outpatient center, or any location other than your home.
- **Applied behavior analysis (ABA)** – Prior approval is required for ABA and all related services, including assessments, evaluations, and treatments.
- **Genetic testing** – Prior approval for genetic testing is required when the test is being performed to assess the risk of passing a genetic condition to a child, or when the member has no active disease or signs or symptoms of the disease that is being screened. Prior approval is not required when a member has an active disease, signs and symptoms of a genetic condition that could be passed to a child, or when the test is needed to determine a course of treatment for a disease. If you are unsure whether your genetic test requires prior authorization, call the customer service number on the back of your ID card before scheduling.
- **Hearing aids – prior approval is required to receive coverage for hearing aids**
- **Surgical services** – The surgical services on the following list require prior approval for care performed by Preferred, Participating/Member, and Non-participating/Non-member professional and facility providers:
  - Surgery for elective non-urgent orthopedic procedures: hip, knee, and spine.
  - Surgery for severe obesity;
  Note: Benefits for the surgical treatment of severe obesity – performed on an inpatient or outpatient basis – are subject to the pre-surgical requirements listed in our medical policy at **www.fepblue.org/legal/policies-guidelines**.
  - Surgery needed to correct accidental injuries to jaws, cheeks, lips, tongue, roof and floor of mouth except when care is provided within 72 hours of the accidental injury.
- **Proton beam therapy** – Prior approval is required for all proton beam therapy services except for members aged 21 and younger, or when related to the treatment of neoplasms of the nervous system including the brain and spinal cord; malignant neoplasms of the thymus; Hodgkin and non-Hodgkin lymphomas.

- **Stereotactic radiosurgery** – Prior approval is required for all stereotactic radiosurgery except when related to the treatment of malignant neoplasms of the brain, and of the eye specific to the choroid and ciliary body; benign neoplasms of the cranial nerves, pituitary gland, aortic body, or paraganglia; neoplasms of the craniopharyngeal duct and glomus jugular tumors; trigeminal neuralgias, temporal sclerosis, certain epilepsy conditions, or arteriovenous malformations.
- **Stereotactic body radiation therapy**
- **Reproductive Services** – Prior approval is required for intracervical insemination (ICI), intrauterine insemination (IUI), intravaginal insemination (IVI), and assisted reproductive technologies (ART).
- **Sperm/egg storage** – Prior approval is required for the storage of sperm and eggs for individuals facing iatrogenic infertility.
- **Organ/tissue transplants** – Prior approval is required for both the procedure and the facility. Contact us at the customer service phone number listed on the back of your ID card before obtaining services. We will request the medical evidence we need to make our coverage determination. We will consider whether the facility is approved for the procedure and whether you meet the facility's criteria.
  Some **organ transplant procedures** **listed in Section 5(b)** must be performed in a facility with a Medicare-Approved Transplant Program for the type of transplant anticipated. Transplants involving more than one organ must be performed in a facility that offers a Medicare-Approved Transplant Program for each organ transplanted. Contact your local Plan for Medicare's approved transplant programs.
  If Medicare does not offer an approved program for a certain type of organ transplant procedure, this requirement does not apply and you may use any covered facility that performs the procedure. If Medicare offers an approved program for an anticipated organ transplant, but your facility is not approved by Medicare for the procedure, please contact your Local Plan at the customer service phone number listed on the back of your ID card.
  Some blood or marrow stem cell transplants **listed in Section 5(b)** **must be performed in a** facility with a transplant program accredited by the Foundation for the Accreditation of Cellular Therapy (FACT), or in a facility designated as a Blue Distinction Center for Transplants or as a Cancer Research Facility. Other transplant procedures **listed in Section 5(b)** must be performed at a FACT-accredited facility. We described these types of facilities earlier in this section.
  Not every transplant program provides transplant services for every type of transplant procedure or condition listed, or is designated or accredited for every covered transplant. Benefits are not provided for a covered transplant procedure unless the facility is specifically designated or accredited to perform that procedure. Before scheduling a transplant, call your Local Plan at the customer service phone number listed on the back of your ID card for assistance in locating an eligible facility and requesting prior approval for transplant services.

- **Clinical trials for certain blood or marrow stem cell transplants** – In Section 5(b) we provide the list of conditions covered only in clinical trials. Contact us at the customer service phone number on the back of your ID card for information or to request prior approval before obtaining services. We will request the medical evidence we need to make our coverage determination. Even though we may state benefits are available for a specific type of clinical trial, you may not be eligible for inclusion in these trials or there may not be any trials available in a Blue Distinction Center for Transplants to treat your condition. If your physician has recommended you receive a transplant or that you participate in a transplant clinical trial, we encourage you to contact the Case Management Department at your Local Plan.
  Note: For the purposes of the blood or marrow stem cell clinical trial transplants covered under this Plan, a clinical trial is a research study whose protocol has been reviewed and approved by the Institutional Review Board (IRB) of the FACT-accredited facility, Blue Distinction Center for Transplants, or Cancer Research Facility where the procedure is to be performed.
- **Transplant travel** – We reimburse costs for transportation (air, rail, bus, and/or taxi) and lodging if you live 50 miles or more from the facility, up to a maximum of $5,000 per transplant for the member and companions. If the transplant recipient is age 21 or younger, we pay up to $10,000 for eligible travel costs for the member and companions. Reimbursement is subject to IRS regulations.
- **Prescription drugs and supplies – Certain prescription drugs and supplies require prior approval.** Contact CVS Caremark, our Pharmacy Program administrator, at 800-624-5060, TTY: 711, to request prior approval, or to obtain a list of drugs and supplies that require prior approval. We will request the information we need to make our coverage determination. You must periodically renew prior approval for certain drugs. See **Section 5(f)** for more information about our prescription drug prior approval program, which is part of our Patient Safety and Quality Monitoring (PSQM) program. Please note that updates to the list of drugs and supplies requiring prior approval are made periodically during the year. New drugs and supplies may be added to the list and prior approval criteria may change. Changes to the prior approval list or to prior approval criteria are not considered benefit changes.
  Note: Until we approve them, you must pay for these drugs in full when you purchase them – even if you purchase them at a Preferred retail pharmacy or through our Specialty Drug Pharmacy Program – and submit the expense(s) to us on a claim form. Preferred pharmacies will not file these claims for you.
  Standard Option members may use our Mail Service Prescription Drug Program to fill their prescriptions. **Basic Option** members with primary Medicare Part B coverage also may use this program once prior approval is obtained.
  Note: Neither the Mail Service Prescription Drug Program, nor the Specialty Drug Pharmacy Program, will fill your prescription for a drug requiring prior approval until you have obtained prior approval. CVS Caremark, the program administrator, will hold your prescription for you up to 30 days. If prior approval is not obtained within 30 days, your prescription will be unable to be filled and a letter will be mailed to you explaining the prior approval procedures.
- **Medical foods covered under the pharmacy benefit require prior approval.** See **Section 5(f)** for more information.

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You must obtain prior approval for these services in all outpatient and inpatient settings unless otherwise noted. Failure to obtain prior approval will result in a $100 penalty. Precertification is also required if the service or procedure requires an inpatient hospital admission. However, special rules apply when Medicare or another payer is primary, as explained later in this section. If an inpatient admission is necessary, precertification is also required. Contact us using the customer service phone number listed on the back of your ID card before receiving these types of services, and we will request the medical evidence needed to make a coverage determination:

- **Gene Therapy and Cellular Immunotherapy,** including Car-T and T-cell receptor therapy
- **Medical benefit drugs** – We require prior approval for certain drugs that will be submitted on medical claim for reimbursement. Contact the customer service number on the back of your ID card or visit us at **www.fepblue.org/medicalbenefitdrugs** for a list of these drugs.
- **Air Ambulance Transport (non-emergent)** – Air ambulance transport related to immediate care of a medical emergency or accidental injury does not require prior approval.
- **Applied behavior analysis (ABA)** – Prior approval is required for ABA and all related services, including assessments, evaluations, and treatments.
- **Genetic testing** – Prior approval for genetic testing will be required when the test is being performed to assess the risk of passing a genetic condition to a child, or when the member has no active disease or signs or symptoms of the disease that is being screened. Prior approval is not required when a member has an active disease, signs and symptoms of a genetic condition that could be passed to a child, or when the test is needed to determine a course of treatment for a disease. If you are unsure whether your genetic test requires prior authorization, call the customer service number on the back of your ID card before scheduling.
- **Surgical services** – The surgical services on the following list require prior approval and when care is provided in an inpatient setting, precertification is required for the hospital stay.
  - Procedures to treat severe obesity.
  Note: Benefits for the surgical treatment of severe obesity – performed on an inpatient or outpatient basis – are subject to the pre-surgical requirements listed in our medical policy which can be found at www.fepblue.org/legal/policies-guidelines. Benefits are only available for the surgical treatment of severe obesity when provided at a Blue Distinction Specialty Care Center for Bariatric (weight loss) Surgery.
  - Breast reduction or augmentation not related to treatment of cancer.
  - Oral maxillofacial surgeries/surgery on the jaw, cheeks, lips, tongue, roof and floor of the mouth, and related procedures.
  - Orthognathic surgery procedures, bone grafts, osteotomies and surgical management of the temporomandibular joint (TMJ).
  - Orthopedic procedures: hip, knee, ankle, spine, shoulder and all orthopedic procedures using computer-assisted musculoskeletal surgical navigation.
  - Reconstructive surgery for conditions other than breast cancer.
  - Rhinoplasty, Septoplasty and Varicose vein treatment.

- **Proton beam therapy** – Prior approval is required for all proton beam therapy services except for members aged 21 and younger, or when related to the treatment of neoplasms of the nervous system including the brain and spinal cord; malignant neoplasms of the thymus; Hodgkin and non-Hodgkin lymphomas.
- **Stereotactic radiosurgery** – Prior approval is required for all stereotactic radiosurgery except when related to the treatment of malignant neoplasms of the brain and of the eye specific to the choroid and ciliary body; benign neoplasms of the cranial nerves, pituitary gland, aortic body, or paraganglia; neoplasms of the craniopharyngeal duct and glomus jugular tumors; trigeminal neuralgias, temporal sclerosis, certain epilepsy conditions, or arteriovenous malformations.
- **Stereotactic body radiation therapy**
- **Reproductive services** – Prior approval is required for intracervical insemination (ICI), intrauterine insemination (IUI), and intravaginal insemination (IVI).
- **Sperm/egg storage** – Prior approval is required for the storage of sperm and eggs for individuals facing iatrogenic infertility.
- **Cardiac rehabilitation**
- **Cochlear implants**
- **Residential treatment center care for any condition**
- **Prosthetic devices (external),** including: microprocessor controlled limb prosthesis; electronic and externally powered prosthesis.
- **Pulmonary rehabilitation**
- **Radiology, high technology** including:
  - Magnetic resonance imaging (MRI)
  - Computed tomography (CT) scan
  - Positron emission tomography (PET) scan

  Note: High technology radiology related to immediate care of a medical emergency or accidental injury does not require prior approval.
- **Specialty durable medical equipment (DME),** rental or purchase, to include:
  - Specialty hospital beds
  - Deluxe wheelchairs, power wheelchairs and mobility devices and related supplies
- **Transplants:** Prior Approval is required for all transplants. **Prior approval is required for both** the procedure and if benefits require, the transplant program; precertification is required for inpatient care.
- **Blood or marrow stem cell transplants listed in Section 5(b)** must be performed in a transplant program designated as a Blue Distinction Center for Transplants. Read earlier in this section for more information about these types of programs.

  Not every transplant program provides transplant services for every type of transplant procedure or condition listed, or is designated or accredited for every covered transplant. Benefits are not provided for a covered transplant procedure unless the transplant program is specifically designated as a Blue Distinction Center for Transplants for that procedure. Before scheduling a transplant, call your Local Plan at the customer service phone number appearing on the back of your ID card for assistance in locating an eligible facility and requesting prior approval for transplant services.

- **Clinical trials for certain** blood or marrow stem cell **transplants** – in **Section 5(b)** we provide a **list of conditions covered only in clinical trials.**
  - Contact us at the customer service phone number on the back of your ID card for information or to request prior approval before obtaining services. We will request the medical evidence we need to make our coverage determination.
  Even though we may state benefits are available for a specific type of clinical trial, you may not be eligible for inclusion in these trials or there may not be any trials available in a Blue Distinction Center for Transplants to treat your condition. If your physician has recommended you receive a transplant or that you participate in a transplant clinical trial, we encourage you to contact the Case Management Department at your Local Plan.
  Note: For the purposes of the blood or marrow stem cell clinical trial transplants covered under this Plan, a clinical trial is a research study whose protocol has been reviewed and approved by the Institutional Review Board (IRB) of the Blue Distinction Center for Transplants where the procedure is to be performed.
- **Organ/tissue transplants**
  Benefits for certain transplants are limited to designated transplant centers or programs.
  Some transplants **listed in Section 5(b)** must be performed in a transplant program designated as a Blue Distinction Center for Transplants. Some organ transplants are not available in a Blue Distinction Center for Transplants and must be performed at a Preferred facility with a Medicare-Approved Transplant Program, if one is available.
  Transplants involving more than one organ must be performed in a facility that offers a Medicare-Approved Transplant Program for each organ transplanted. Contact your local Plan for Medicare's approved transplant programs.
  If Medicare does not offer an approved program for a certain type of organ transplant procedure, this requirement does not apply and you may use any covered Preferred facility and Preferred provider that performs the procedure.
  Contact us at the customer service phone number listed on the back of your ID card before obtaining services. We will request the medical evidence we need to make our coverage determination. Our review will include whether you meet the facility and transplant program criteria for the particular transplant.
  All members (including those who have Medicare Part A or another group health insurance policy as their primary payor) must contact us at the customer service phone number listed on the back of their ID card before obtaining services.
- **Transplant travel** – If you travel to a Blue Distinction Center for Transplants, we reimburse up to $5,000 per transplant for costs of transportation (air, rail, bus, and/or taxi) and lodging (for you and your traveling companions) if you live 50 miles or more from the facility.
- **Prescription drugs and supplies** – Certain prescription drugs and supplies, including medical foods administered orally, require prior approval. Contact CVS Caremark, our Pharmacy Program administrator, at 800-624-5060, TTY: 711, to request prior approval, or to obtain a list of drugs and supplies that require prior approval. We will request the information we need to make our coverage determination. You must periodically renew prior approval for certain drugs. See **Section 5(f)** for more information about our prescription drug prior approval program, which is part of our Patient Safety and Quality Monitoring (PSQM) program.

Notes:
- Updates are made periodically throughout the year to the list of drugs and supplies requiring prior approval. New drugs and supplies may be added to the list and prior approval criteria may change. Changes to the prior approval list or to prior approval criteria are not considered benefit changes.
- Until we approve them, you must pay for these drugs in full when you purchase them – even if you purchase them at a Preferred retail pharmacy or through our specialty drug pharmacy – and submit the expense(s) to us on a claim form. Preferred pharmacies will not file these claims for you.
-The Specialty Drug Pharmacy Program will not fill your prescription until you have obtained prior approval. CVS Caremark, the program administrator, will hold your prescription for you up to 30 days. If prior approval is not obtained within 30 days, your prescription will be returned to you along with a letter explaining the prior approval procedures.

Warning:

We will reduce our benefits by $100 for medically necessary services that require prior approval, if no one contacts us for prior approval. If the service is not medically necessary, we will not provide benefits. This benefit reduction does not apply to prescription drugs that require prior approval.

Special prior authorization situations related to coordination of benefits (COB)

The examples below provide the special situations regarding prior approval and precertification when Medicare is the primary payor.

Service Type: Inpatient hospital admission
Primary Payor: Medicare Part A
Precertification: No
Prior Approval: Not applicable

Service Type: Medicare hospital benefits exhausted and you do not want to use your Medicare lifetime reserve days
Primary Payor: Medicare Part A benefits not provided
Precertification: Yes
Prior Approval: Not applicable

Service Type: Severe obesity surgery when performed during an inpatient admission
Primary Payor: Medicare Part A
Precertification: No
Prior Approval: Yes

Service Type: Severe obesity surgery in an outpatient hospital or ambulatory surgical center (ASC)
Primary Payor: Medicare Part B
Precertification: Not applicable
Prior Approval: Yes

Service Type: Residential treatment center admission – inpatient
Primary Payor: Medicare Part A
Precertification: Yes
Prior Approval: Not applicable

Service Type: Residential treatment center – outpatient care
Primary Payor: Medicare Part B
Precertification: Not applicable
Prior Approval: Yes.

The examples below provide the special situations regarding prior approval and precertification when another healthcare insurance is the primary payor.

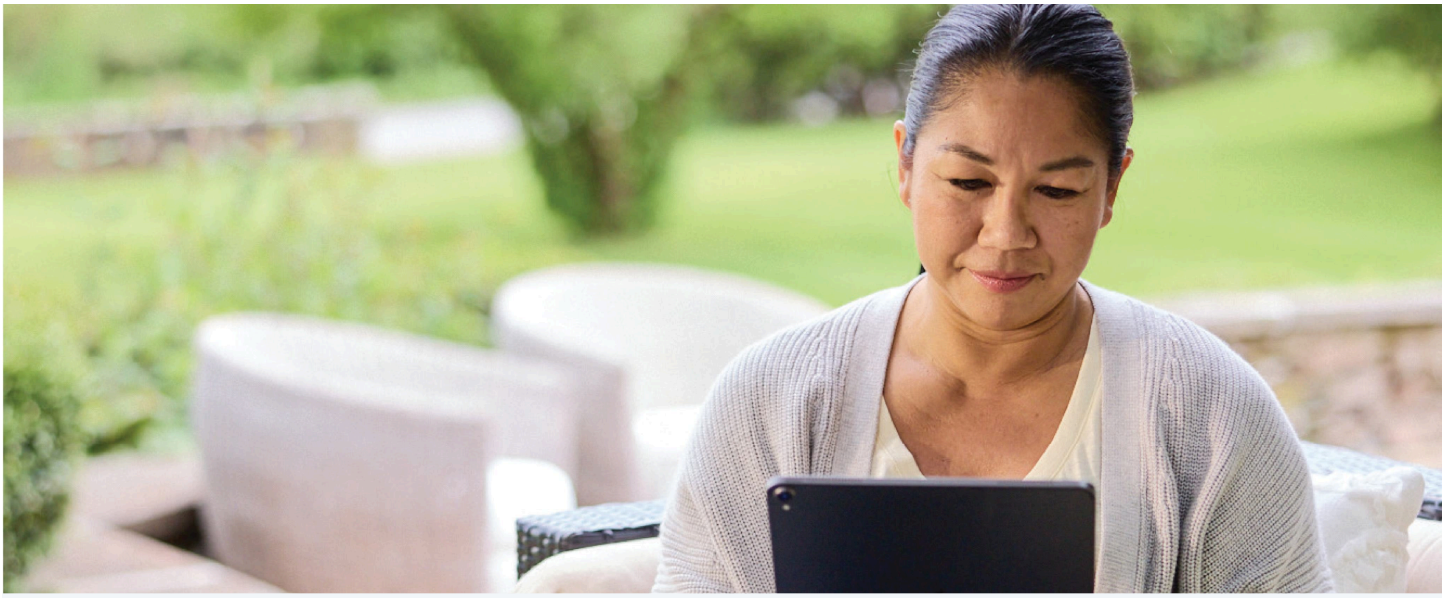
Service Type: Inpatient hospital admission
Primary Payor: Other healthcare insurance
Precertification: No
Prior Approval: Not applicable

Service Type: Severe obesity surgery when performed during an inpatient admission
Primary Payor: Other healthcare insurance
Precertification: No
Prior Approval: Yes

Service Type: Severe obesity surgery in an outpatient hospital or ambulatory surgical center (ASC)
Primary Payor: Other healthcare insurance
Precertification: Not applicable
Prior Approval: Yes

Service Type: Residential treatment center admission – inpatient
Primary Payor: Other healthcare insurance
Precertification: Yes
Prior Approval: Not applicable

Service Type: Residential treatment center – outpatient care
Primary Payor: Other healthcare insurance
Precertification: Not applicable
Prior Approval: Yes



Visit **fepblue.org/brochures** to view or download the Blue Cross and Blue Shield Service Benefit Plan brochures for full details.