

Services That Require Preauthorization



| Service | In-Network <small>(Personal Choice® network provider or BlueCard® PPO provider)</small> | Out-of-Network |
|---|--|----------------|
| ALL NON-EMERGENCY INPATIENT ADMISSIONS (Except maternity admissions) | Required | Required |
| OUTPATIENT SURGICAL PROCEDURES | | |
| Bunionectomy | Required | Required |
| Cataract Surgery | Not Required | Required |
| Laparoscopic Cholecystectomy | Required | Required |
| Hemorrhoidectomy | Required | Required |
| Hernia Repair | Not Required | Required |
| Arthroscopic Knee Surgery / Diagnostic Arthroscopy | Required | Required |
| Ligation and Stripping of Varicose Veins | Required | Required |
| Obesity Surgery | Required | Required |
| Orthognathic Surgery Procedures | Required | Required |
| Prostate Surgery | Not Required | Required |
| Spinal/Vertebral Surgery | Not Required | Required |
| Submucous Resection (nasal surgery) | Required | Required |
| Tonsillectomy and/or Adenoidectomy | Required | Required |
| TRANSPLANTS | Required | Required |
| OPERATIVE AND DIAGNOSTIC ENDOSCOPIES | Not Required | Required |
| MRI/MRA | Required | Required |
| CT/CTA SCAN | Required | Required |
| PET SCAN | Required | Required |
| NUCLEAR CARDIAC STUDIES | Required | Required |
| OUTPATIENT THERAPIES | Required | Required |
| Speech, Cardiac, Pulmonary, Respiratory | | |
| OUTPATIENT PRIVATE DUTY NURSING | Required | Required |
| OTHER FACILITY SERVICES | Required | Required |
| Skilled Nursing, Inpatient Hospice, Home Health, Birth Center | | |
| MENTAL HEALTH, SUBSTANCE ABUSE AND SERIOUS MENTAL ILLNESS TREATMENT | Required | Required |
| Inpatient | | |
| Partial hospitalization programs/Intensive outpatient programs | Required | Not Required |
| DAY REHABILITATION PROGRAMS | Required | Required |
| DENTAL SERVICES AS A RESULT OF ACCIDENTAL INJURY | Required | Required |
| NON-EMERGENCY AMBULANCE | Required | Required |
| DURABLE MEDICAL EQUIPMENT | Required | Required |
| Purchase items (including repairs and replacements) over \$500, and all rentals (except oxygen, diabetic supplies and unit dose medication for nebulizer) | | |
| PROSTHETICS AND ORTHOTICS | Required | Required |
| Purchase items (including repairs and replacements) over \$500 (except ostomy supplies) | | |
| NFUSION THERAPY IN A HOME SETTING | Required | Required |
| INFUSION THERAPY DRUGS | Required | Required |
| Administered in an Outpatient Facility or in a Professional Provider's Office (see list) | | |

For more information regarding preauthorization requirements please call 1-800-ASK-BLUE or visit www.ibx.com/providers/preapproval/index.html