



Questions about prior authorization? Here's what you need to know.

? What does prior authorization mean?

Some types of care require your provider to get an approval from us before you receive care. This is called prior authorization.

? Why is prior authorization needed?

Prior authorization helps ensure you get proper care. It helps us work with your doctor to evaluate services for medical necessity before you receive treatment or services.

? What is medical necessity?

Medical necessity means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice. We use medical records and recognized clinical guidelines to establish medical necessity.

Your NYC Medicare Advantage Plus Plan will generally cover care as long as it is medically necessary and the service is included in your *Evidence of Coverage* and benefits charts.

? How do I know if I need prior authorization before I receive care?

It is the provider's responsibility to ask for prior authorization from Empire BlueCross BlueShield (Empire). **You aren't responsible for asking for it when you see a provider that accepts NYC Medicare Advantage Plus.** We've provided a list on the pages that follow of some common services to help you know when to ask.

? **How does prior authorization work?**

Providers who accept NYC Medicare Advantage Plus are required to ask for prior authorization before providing certain types of care, and once approved by Empire, the provider will only bill you for your applicable copay or coinsurance. If your provider doesn't ask for prior authorization when required, the claim will be denied. The provider CANNOT bill you for the treatment if they did not get prior authorization.

Out-of-network providers aren't required to ask for prior authorization. We encourage you to ask your provider to request it for you before you get care. Here's why:

- If the provider doesn't ask for prior authorization, Anthem will review the claim after you've been treated.
- If the claim is determined to be medically necessary, we will process it according to the rules of your plan.

- If the claim is determined to not be medically necessary, we will deny the claim and let you know that you have the right to appeal the decision. The provider CAN bill you for the treatment.

Whether you see an in-network or out-of-network provider, if your provider does ask for prior authorization and it is denied:

- You will be notified. If you choose to continue with the treatment, you will be responsible for the cost.
- We will let you know that you have the right to appeal the decision.

The important thing to remember is that you are not responsible for asking for prior authorization when you see an in-network provider. If you see an out-of-network provider, you can ask them to request it for you.

Below is a general list of services to help you know when prior authorization is required or when to ask your provider to request it. Please note, this is not a complete list and is provided as a guide to help you get the most out of your plan. Detailed prior authorization information is available for your providers.



Inpatient admissions

- Elective inpatient admissions
- Rehabilitation facility admissions
- Skilled nursing facility admissions
- Long-term acute care (LTAC) care



Select outpatient services

- Orthotics (performed primarily on ankle, back, foot, and knee)
- Elective inpatient surgery
- All potentially cosmetic surgeries
- Arthroscopies/arthroplasties
- Bariatric/gastric obesity surgery
- Breast reconstruction
- Cervical fusions
- Continuous glucose monitoring (CGM)
- Coronary artery bypass graft (CABG)
- Defibrillator/pacemaker insertion or replacement
- Genetic testing
- Endoscopies
- Epidermal growth factor receptor testing
- Home health
- Hyperbaric oxygen therapy
- Intracardiac electrophysiological studies (EPS) catheter ablation
- Knee and hip replacements
- Knee orthoses
- Laminectomies/laminotomies
- Laparoscopies
- Nerve destructions
- Nonemergency ground, air, and water transportation
- Occupational therapy
- Oncology (Breast), mRNA, gene expression profiling
- Pain management
- Physical therapy
- Sleep studies and sleep-study-related equipment and supplies
- Spinal orthoses
- Spinal procedures
- Tonsillectomy/adenoidectomy
- UPPP surgery (Uvulopalatopharyngoplasty - removal of excessive soft tissue in the back of the throat to relieve obstruction)
- Vascular angioplasty and stents
- Vascular embolization and occlusion services
- Vascular ultrasound



Durable medical equipment (DME) and prosthetics

- Automated external defibrillators
- Bone stimulators
- Cochlear implants
- Cough assist (insufflator/exsufflator)
- High-frequency chest wall oscillator
- Insulin and infusion pumps
- Left ventricular assist device
- Nonstandard wheelchairs
- Nonstandard beds
- Oral appliances for obstructive sleep apnea
- Patient transfer systems
- Pneumatic compression devices
- Power wheelchair repairs
- Power wheelchairs, accessories, and power-operated vehicles (POVs)
- Prosthetics, orthotics
- Sleep-study-related equipment and supplies
- Speech-generating devices and accessories
- Spinal cord stimulators
- Tumor treatment field therapy
- Ventilators
- Wound pump



Radiology services

- CT scan (including CT angiography)
- Echocardiograms
- MRA scan
- MRI scan
- MRS scan
- Nuclear cardiac scan
- PET scan
- Radiation (oncology)
- Radiation therapy



Behavioral health services

- Day hospital/partial hospital admissions
- Inpatient admissions
- Intensive outpatient therapy
- Psychological and neuropsychological testing
- Rehabilitation facility admissions
- Transcranial magnetic stimulation (TMS) for depression



Transplants: human organ and bone marrow/stem cell transplants

Prior authorization is required for Medicare-covered transplant admissions.



Inpatient services:

- Heart transplant
- Islet cell transplant
- Kidney transplant
- Liver transplant
- Lung or double lung transplant
- Multivisceral transplant
- Pancreas transplant
- Simultaneous pancreas/kidney transplant
- Small bowel transplant
- Stem cell/bone marrow transplant (with or without myeloablative therapy)



Outpatient services:

- Donor leukocyte infusion
- Stem cell/bone marrow transplant (with or without myeloablative therapy)

Out-of-network/noncontracted providers are under no obligation to treat NYC Medicare Advantage Plus Plan members, except in emergency situations. Please call our Member Services number or see your *Evidence of Coverage* for more information, including the cost sharing that applies to out-of-network services.

The NYC Medicare Advantage Plus Plan is offered through an alliance between Empire BlueCross BlueShield Retiree Solutions and EmblemHealth. Empire and EmblemHealth have come together to create a new, customized, fully insured group Medicare Advantage program for the City of New York.

Empire BlueCross BlueShield Retiree Solutions is an LPPO plan with a Medicare contract. Enrollment in Empire BlueCross BlueShield Retiree Solutions depends on contract renewal. Empire BlueCross BlueShield Retiree Solutions is the trade name of Anthem Insurance Companies, Inc. Independent licensee of the Blue Cross Blue Shield Association.

EmblemHealth insurance plans are underwritten by EmblemHealth Plan, Inc., EmblemHealth Insurance Company, and Health Insurance Plan of Greater New York (HIP). EmblemHealth Services Company, LLC provides administrative services to EmblemHealth companies. The EmblemHealth companies are separate companies from Empire BlueCross BlueShield.