BlueCross BlueShield of Illinois

Medicaid Prior Authorization Requirements Summary, Effective Jan. 1, 2021

(Updated February 2021)

This information applies to Blue Cross Community MMAI (Medicare-Medicaid)SM and Blue Cross Community Health PlansSM (BCCHPSM) members.

Limitations of Covered Benefits by Member Contract
The table below includes information on prior authorization requirements for non-emergency services provided to BCBSIL's Medicaid (MMAI and BCCHP) members. Medical necessity, as defined in the Member Handbook, must be determined before a benefit preauthorization number will be issued. Claims received that do not have a prior authorization number may be denied. Independently contracted providers may not seek payment from the MMAI or BCCHP member when services are deemed not to meet the medical necessity definition in the Member Handbook and the claim is denied.
Network Participation
Out-of-network providers must seek prior authorization for all services.
Notification Requirements
In cases of an emergency, notification is required within one business day of admission.
Medical Necessity
Medical necessity, as defined in the Member's handbook, must be met for all services regardless if prior authorization is required. All services are subject to retrospective review and recoupment in accordance with State and Federal rules and regulations.
Inpatient Facility Admission Summary
All planned (elective) inpatient hospital care (surgical, non-surgical, behavioral health and/or substance abuse). Elective admissions must have prior authorization before the admission occurs.
All unplanned inpatient hospital care (surgical, non-surgical, behavioral health and/or substance abuse). Notification must be made within one business day of admission to the facility.
Admission to a skilled nursing facility, a long term acute care hospital (LTACH) or a rehabilitation facility.
All residential treatment program admissions.
Claim Filing Reminder: Include the Prior Authorization Number
Illinois Medicaid providers should include the assigned prior authorization number when submitting the claim for services rendered. Inclusion of this number will help ensure timely and accurate processing of the claim. **For electronic Professional and Institutional claims (837P and 837I transactions):** • If the prior authorization number is applicable for **all services rendered on the claim**, it should be included in the **2300 Loop**, REF02 element with the G1 qualifier in REF01. • If the prior authorization number is applicable to **a single service line on the claim**, it should be submitted in the **2400 Loop**, REF02 element with the G1 qualifier in REF01. **For paper claims:** The prior authorization number should be submitted in **Box 23 of the CMS-1500 Professional claim form** and in **Field 63 of the UB-04 Institutional claim form**.

Prior Authorization Rules - Medicaid Medical / Surgical (Non-Behavioral Health)	
PRIOR AUTHORIZATION REQUIREMENTS* THROUGH EVICORE HEALTHCARE (EVICORE) **Including Network Exceptions [out-of-plan or out-of-network (due to network adequacy) for managed programs]*	

• **Outpatient Molecular Genetics**
• **Outpatient Radiation Therapy**
• **Musculoskeletal Services**
  - **Chiropractic**
  - **Physical/Occupational/Speech Therapy**
  - **Spine, Joint, Pain**
• **Radiology Imaging Services**
• **Outpatient Medical Oncology**
• **Outpatient Sleep**
• **Post-Acute Care**
• **Outpatient Specialty Drug**
	The eviCore Healthcare Web Portal at https://www.evicore.com/healthplan/bcbsil is available 24x7. After a one-time registration, you may initiate a case, check status, review guidelines, view authorizations/eligibility and more. The Web Portal is the quickest, most efficient way to obtain information.
	
	You may also call eviCore toll-free at 855-252-1117 between 7 a.m. and 7 p.m. (Local Time) Monday through Friday, except holidays.
	
	For specific codes that apply, refer to eviCore's Web Portal.

Prior Authorization Rules - Medicaid Medical / Surgical (Non-Behavioral Health)	
PRIOR AUTHORIZATION REQUIREMENTS THROUGH BCBSIL	
Reminder: Eligibility and benefits as well as prior authorization verification and submissions can be initiated online through the Availity Provider Portal®.	
Covered Service	**Prior authorization required?**
Advanced Imaging (PET, MRA, MRI, and CT scans)	Refer to the procedure code list for prior authorization requirements.
Allergy care, including tests and serum	Refer to the procedure code list for prior authorization requirements.
Ambulance	Air – Yes, fixed wing medical transportation Ground – No
Bariatric surgery	Yes
Breast pumps and replacement supplies	No – Subject to benefit and DME dollar amount
Chemotherapy and radiation therapy	Yes – Refer to the procedure code list for prior authorization requirements.
Covered services provided in school-based health clinics	No
Durable Medical Equipment (DME) – Medical supplies, orthotics and prosthetics (any single DME, prosthetic and orthopedic device greater than $1500)	Refer to the procedure code list for prior authorization requirements.
Emergency dental care	Yes
Diabetes self-management services	Refer to the procedure code list for prior authorization requirements.
Dialysis services	Yes – Out-of-network, out-of-state, procedure code 90999, chronic dialysis procedures more than 3 times a week
Hearing services and devices	Yes
Home birthing	Notification is required.
Home health care and intravenous services	Yes – Refer to the procedure code list for prior authorization requirements.
Hospice	Yes
Hospital services (inpatient, outpatient, and skilled nursing)	Refer to the procedure code list for prior authorization requirements.
Injections	Refer to the procedure code list for prior authorization requirements.
Long Term Support Services	Long Term Support Services require pre-assessment, eligibility determination and service planning. This process is completed with the member's care/service coordinator and the treatment team. Once service planning is complete, the authorization process is completed according to State guidelines and requirements. Eligibility is limited to members qualified due to waiver status or eligibility established after evaluation.
Nursing facilities	Yes
Nutritional counseling services	Refer to the procedure code list for prior authorization requirements.
Minor surgeries	Refer to the procedure code list for prior authorization requirements.
Office visits to PCPs or specialists, including dieticians, nurse practitioners, and physician assistants	No
Personal care services and private duty nursing (home- or school-based) for children under age 21, who qualify under the Early, Periodic Screen, Diagnostic and Treatment (EPSDT) program	Yes. If the child is disabled, the child may qualify for more services. Call Customer Service and ask to speak with a Care Coordinator/Case Manager for more information.

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Prior Authorization Rules - Medicaid Medical / Surgical (Non-Behavioral Health), *continued*	
Covered Service	**Prior Authorization Required?**
Podiatry (foot and ankle) services	Refer to the procedure code list for prior authorization requirements.
Pregnancy-related and maternity services	No
Routine physicals, children's preventive health programs and Tot-to-Teen checkups	No
Second opinions (in-network)	No
Surgery, including pre-and post-operative care: assistant surgeon, anesthesiologist, organ transplants	Refer to the procedure code list for prior authorization requirements. (Note: All transplants and pre-transplant evaluations require prior authorization.)
Special rehabilitation services, such as: physical therapy, occupational therapy, speech therapy, cardiac rehabilitation, pulmonary rehabilitation	Refer to the procedure code list for prior authorization requirements.
Prior Authorization Rules - Medicaid Behavioral Health	
Standard office visits to mental health specialists, which could include counselors, social workers, psychiatrists, or psychologists	No
Inpatient Mental Health Treatment	Yes
Inpatient Substance Abuse Treatment	Yes
Mental Health Day Treatment	Yes
Substance Abuse Day Treatment	Yes
Medication Assisted Treatment for Opioid Dependence	No
Mental Health Intensive Outpatient Treatment	Yes
Substance Abuse Intensive Outpatient Treatment	Yes
Assessment and Treatment Planning Services	No
Mobile Crisis Response	No
Crisis Stabilization	No
Crisis Intervention	No
Assertive Community Treatment	Yes
Community Support Team	Yes
Psychosocial Rehabilitation	Yes
Psychological Testing	Yes, upon notification from BCBSIL
Neuropsychological Testing	Yes, upon notification from BCBSIL
Electroconvulsive Therapy	Yes
Developmental Testing	Refer to the procedure code list for prior authorization requirements
Applied Behavioral Analysis	Yes (For codes 97151 and 97152, prior authorization is only required beyond 8 hours. All other codes require prior authorization.)
SUPR Admission/Discharge Assessment	Yes, for services rendered above 8 units daily
SUPR Substance Abuse Group Therapy	Yes, for services rendered above 12 units daily
SUPR Substance Abuse Individual Therapy	Yes, for services rendered above 12 units daily
SUPR Substance Abuse Residential	Yes
SUPR Substance Abuse Detoxification	Yes

Note: Post-acute inpatient stays, Skilled Nursing Facility (SNF), rehabilitation and Long-term Acute Care (LTAC) services are reviewed by eviCore. Prior authorization for these services must be obtained through, and will be confirmed by, BCBSIL.

Checking eligibility and/or benefit information and/or the fact that a service has been prior authorized is not a guarantee of payment. Benefits will be determined once a claim is received and will be based upon, among other things, the member's eligibility and the terms of the member's certificate of coverage applicable on the date services were rendered. If you have questions, call the number on the member's ID card.

The above material is for informational purposes only and is not a substitute for the independent medical judgment of a physician or other health care provider. Physicians and other health care use their own medical judgment based upon all available information and the condition of the patient in determining the appropriate course of treatment. Regardless of benefits, the final decision about any service or treatment is between the member and their health care provider.

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