BlueCross BlueShield of Illinois

Medicaid Service Authorization Program Details and Notification Requirements – effective Jan. 1, 2026

This information applies to members of Blue Cross Community Health Plans℠.

Detailed requirements and our service program glossary are available on our website. See prior authorization support materials for more information, including our digital lookup tool.

Out-of-network and non-network providers: Non-participating providers must seek prior authorization for all services except for emergency services, services exempt from authorization requirements (see below), or as required by law.

All Medicaid providers must be registered through HFS' IMPACT system and have a HFS Medicaid Provider ID number.

Emergency Services: Do not require prior authorization.

Limitations of covered benefits by member contract: The content below includes information on prior authorization and preservice notification requirements for non-emergency services provided to our Medicaid members. Medical necessity, as defined in the member handbook, must be determined before an authorization number will be issued. Claims received by Blue Cross and Blue Shield of Illinois that do not have an authorization number may result in an adverse determination. Providers may not seek payment from the member when services are deemed not to meet medical necessity and the claim is denied.

Prior authorization and notification requirements: For scheduled services, prior authorization may be required prior to service. Notification of inpatient admission is required within one business day after a member is admitted. Notification of extension requests for ongoing care must be submitted within one business day from the last covered day of service. Failure to meet these requirements may result in an adverse determination.

Medical necessity: Medical necessity, as defined in the member's handbook, must be met for all services regardless of prior authorization requirements. All services are subject to retrospective review and recoupment in accordance with state and federal rules and regulations. Clinical information must accompany all requests for authorization to demonstrate medical necessity. Cases in which clinical information does not accompany the authorization request may result in an adverse determination.

Clinical criteria and medical policy information: Our service authorization program utilizes nationally recognized criteria in addition to our health plan specific medical polices to review for medical necessity and standard of care. For American Society of Addiction Medicine Criteria and MCG Care Guidelines, visit: Availity® Essentials. You may also review our medical policies.

Services exempt from prior authorization requirements:

- Emergency services
- Family planning and reproductive healthcare
- School-based health center services+
- Local health department services+
- Pediatric Palliative Care Program (PPCP)+
- Mobile Crisis Response Services
- Screening services provided under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit for children+
- Mental health services provided within 30 days of a crises

+ Non-contracted providers obtain prior authorization before rendering services.

Services exempt from preservice requirements:

- For inpatient behavioral health care, providers should notify BCBSIL within 48 hours of admission: if notification requirements **are met**, utilization review won't be initiated for the first 72 hours of the admission.
- For substance use residential treatment, providers should notify us within 24 hours of initiation of services. Utilization review may begin after the 24-hour notification period.
- For outpatient behavioral health care, including partial hospitalization and intensive outpatient treatment, providers should notify us within 24 hours of initiation of services. Utilization review may begin after the 24-hour notification period

Facility Admission Requirements

Planned inpatient: All planned (elective) inpatient hospital care (surgical, non-surgical, behavioral health and/or substance use) admissions must have prior authorization before the admission occurs.

Unplanned inpatient: All unplanned inpatient hospital care (surgical, non-surgical, behavioral health and/or substance use) notification must be made within one business day of admission to the facility.

Skilled nursing and long-term acute: Admission to a skilled nursing facility, a long-term acute care hospital or a rehabilitation facility requires a prior authorization.

Substance use residential programs: All residential program admissions for substance use treatment require notification within 24 hours of admission and are subject to medical necessity review.

Concurrent Review

Definition: A concurrent review is conducted during an inpatient stay or during any course of treatment.

Process: The process includes evaluating a patient's medical necessity and the appropriateness of care during an active episode of care, such as a hospital stay, to ensure ongoing efficiency, effectiveness and quality of care. A concurrent review may be conducted by phone, fax or Availity Essentials.

Goal: The goal is to ensure the patient receives the right level of care at the right time, manage costs, streamline care transitions, and coordinate ongoing services to meet the member's needs while in an acute or post-acute setting.

Retrospective Review

Definition: Retrospective (postservice) review is the process of making a determination (approval or denial) of coverage and/or medical necessity after services have been rendered.

Process: The process includes reviewing eligibility and benefits, clinical data and requesting additional supporting documentation.

Goal: The goal is to assess clinical appropriateness.

Quality Review

A quality review is a systematic postservice evaluation of a process or service to ensure it meets defined standards and expectations and is used to maintain and improve performance.

Peer to Peer Discussion

Definition: A peer to peer is a discussion between a patient's treating provider and the plan's medical director or appropriate designee to discuss a prior authorization adverse decision.

Goal: This allows for an exchange of additional clinical information that may not have been in the initial submission.

Medicaid Prior Authorization Requirements

For detailed prior authorization procedure code requirements, delegation information, clinical criteria and associated medical policies, refer to prior authorization support materials (government programs) and our digital lookup tool.

Note: Some authorization requests will be submitted to Carelon Medical Benefits Management.

Reminder: Eligibility and benefits as well as prior authorization verification and submission can be initiated online using the Authorizations & Referrals tool via Availity Essentials.

Medical and Surgical Services Authorization Requirements

Postacute inpatient stays, skilled nursing facility, rehabilitation and long-term acute care services require prior authorization and must be obtained through and confirmed by BCBSIL.

Covered Service Category	Prior authorization required?
Advanced imaging (PET, MRA, MRI and CT scans)	Specific codes may require prior authorization. Refer to PA requirements.
Allergy care, including tests and serum	Specific codes may require prior authorization. Refer to PA requirements.
Air Ambulance	Yes, fixed wing medical transportation
Ambulance	Ground – No
Bariatric surgery	Yes
Breast pumps and replacement supplies	No – Subject to benefit and DME dollar amount
Chemotherapy and radiation therapy	Specific codes may require prior authorization. Refer to PA requirements.
Chiropractic services	Yes
Covered services provided in school-based health clinics	No
Durable medical equipment – medical supplies, orthotics, and prosthetics	Refer to the procedure code list for prior authorization requirements. Prior authorization is required for any single DME, repair, prosthetic or orthopedic device greater than $1,500.
Emergency dental care	Yes
Emergency services	No
Diabetes self-management services	Specific codes may require prior authorization. Refer to PA requirements.
Dialysis services	Prior authorization required for hemodialysis performed >3x per week

Covered Service Category	Prior authorization required?
Doula services	Prior authorization is required if greater than quantity limit.
Family planning and reproductive healthcare	No
Genetic testing	Specific codes may require prior authorization. Refer to PA requirements.
Hearing services and devices	Yes
Home birthing	Notification is required.
Home health care and intravenous services	Specific codes may require prior authorization. Refer to PA requirements.
Hospice	Yes
Outpatient hospital services	Specific codes may require prior authorization. Refer to PA requirements.
Skilled nursing and therapy services	Specific codes may require prior authorization. Refer to PA requirements.
Sleep services	Specific codes may require prior authorization. Refer to PA requirements.
Injections	Specific codes may require prior authorization. Refer to PA requirements.
Lactation counseling	Required if greater than the quantity limit.
Long term support services	Require preassessment, 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.
Skilled nursing facilities	Yes
Custodial nursing facility	Yes, prior authorization is required until member is listed on patient credit file.
Nutritional counseling services	Specific codes may require prior authorization. Refer to PA requirements.
Medical oncology services	Specific codes may require prior authorization. Refer to PA requirements.
Minor surgeries	Specific codes may require prior authorization. Refer to PA requirements.
Musculoskeletal services (spine, joint, pain)	Refer to the procedure code list for prior authorization requirements.
Office visits to primary care providers or specialists, nurse practitioners and physician assistants	No, if in network provider, otherwise prior authorization is required.
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 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 for more information.

Covered Service Category	Prior authorization required?
Podiatry (foot and ankle) services	Specific codes may require prior authorization. Refer to PA requirements.
Pregnancy-related and maternity services	No
Radiation oncology services	Specific codes may require prior authorization. Refer to PA requirements.
Routine physicals, children's preventive health programs and tot-to-teen checkups	No
Second opinions (in-network)	No
Surgery, including pre- and postoperative care: assistant surgeon, anesthesiologist and organ transplants	Specific codes may require prior authorization. Refer to PA requirements. (Note: All transplants and pretransplant evaluations require prior authorization.)
Special rehabilitation services, such as physical therapy, occupational therapy, speech therapy, cardiac rehabilitation and pulmonary rehabilitation	Specific codes may require prior authorization. Refer to PA requirements.

Behavioral Health Authorization Requirements

Mobile Crisis Response Services, substance use disorder (SUD) treatment (notification required), and mental health crisis services are exempt from prior authorization requirements.

Covered Service Category	Prior Authorization Required?
Standard office visits to mental health specialists, which could include counselors, social workers, psychiatrists or psychologists	No
Inpatient mental health treatment	Yes
Inpatient substance use treatment	Yes
Mental health partial hospitalization	Yes
Substance use partial hospitalization	Yes
Medication assisted treatment for opioid dependence	No
Mental health intensive outpatient treatment	Yes
Substance use 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	No
Neuropsychological testing	No
Electroconvulsive therapy	No
Developmental testing	No
SUPR admission/discharge assessment	No
SUPR substance use group therapy	No
SUPR substance use individual therapy	No
SUPR substance use intensive individual/group therapy	Yes

Covered Service Category	Prior Authorization Required?
SUPR substance use residential	Yes
SUPR substance use detoxification	Yes

Change Log

Review date	Service authorization change	Rationale	Effective date
October 2025	Services exempt from preservice requirements	The HCAPA (Healthcare Access and Protection Act) - HB 5395,1/1/26 requirements	Jan 1, 2026
October 2025	Added information on program exemptions and added clarity to Prior Auth needed column. No requirement edits were made.	Additional clarity needed based on program, contractual and legislative requirements.	Nov 1, 2025
August 2025	n/a	n/a	Sept 1, 2025

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