BlueCross BlueShield of Illinois

Medicaid Benefit Preauthorization Requirements (Effective Jan. 1, 2018)

This information applies to Blue Cross Community MMAI (Medicare-Medicaid)[SM] and Blue Cross Community Health Plans[SM] (BCCHP) members.

Limitations of Covered Benefits by Member Contract
The table below includes information on benefit preauthorization 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 benefit preauthorization 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

Prior Authorization Rules - Medicaid Medical / Surgical (Non-Behavioral Health)	
BENEFIT PREAUTHORIZATION REQUIREMENTS* THROUGH EVICORE HEALTHCARE (EVICORE)	

• **Outpatient Molecular Genetics**
• **Outpatient Radiation Therapy**
• **Musculoskeletal Services**
  - **Chiropractic**
  - **Physical/Occupational/Speech Therapy**
  - **Spine, Joint, Pain**
• **Outpatient Cardiology and Radiology Imaging Services**
• **Outpatient Medical Oncology**
• **Outpatient Sleep**
• **Post-Acute Care**
• **Outpatient Specialty Drug**
 	
**Including Network Exceptions [out-of-plan or out-of-network (due to network adequacy) for managed programs]*
	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)	
BENEFIT PREAUTHORIZATION REQUIREMENTS THROUGH BCBSIL	
Reminder: Always check eligibility and benefits first, through Availity™ or your preferred vendor portal. If benefit preauthorization is required, you may initiate a request online through iExchange®.	
Covered Service	**Prior authorization required?**
Advanced Imaging (PET, MRA, MRI, and CT scans)	Refer to the procedure code list for benefit preauthorization requirements.
Allergy care, including tests and serum+A24:B57	Refer to the procedure code list for benefit preauthorization requirements.
Ambulance	Air – Yes 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 benefit preauthorization 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 benefit preauthorization requirements.
Emergency dental care	Yes
Diabetes self-management services	Refer to the procedure code list for benefit preauthorization requirements.
Dialysis services	Notification is required.
Hearing services and devices	Yes
Home birthing	Notification is required.
Home health care and intravenous services	Yes – Refer to the procedure code list for benefit preauthorization requirements.
Hospice	Yes
Hospital services (inpatient, outpatient, and skilled nursing)	Refer to the procedure code list for benefit preauthorization requirements.
Injections	Refer to the procedure code list for benefit preauthorization 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 benefit preauthorization requirements.
Minor surgeries	Refer to the procedure code list for benefit preauthorization 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 your child is disabled, the child may qualify for more services. Please 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*	
Podiatry (foot and ankle) services	Yes
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 benefit preauthorization 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 benefit preauthorization requirements.

Prior Authorization Rules - Medicaid Behavioral Health	
Covered Service	**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 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
Assertive Community Treatment	Yes
Community Support Residential	Yes
Community Support Team	Yes
Psychosocial Rehabilitation	Yes
Psychological Testing	Yes
Neuropsychological Testing	Yes
Electroconvulsive Therapy	Yes
Developmental Testing	Yes
DASA Admission/Discharge Assessment	Yes, for services rendered above 8 units daily
DASA Substance Abuse Group Therapy	Yes, for services rendered above 12 units daily
DASA Substance Abuse Individual Therapy	Yes, for services rendered above 12 units daily
DASA Substance Abuse Residential	Yes
DASA Substance Abuse Detoxification	Yes

Note: Post-acute inpatient stays, SNF, rehabilitation and LTAC services are reviewed by eviCore. Benefit preauthorization 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 preauthorized 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, contact the appropriate number on the member's ID card.

eviCore healthcare (eviCore) is an independent specialty medical benefits management company that provides utilization management services for BCBSIL.

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