BlueCross BlueShield of Illinois

Blue Cross Community Options℠ Benefit Preauthorization Requirements (Updated December 2017)

This information applies to the following Blue Cross Community Options, or Blue Cross and Blue Shield of Illinois (BCBSIL) Medicaid, members: Blue Cross Community MMAI (Medicare-Medicaid)℠, Blue Cross Community Integrated Care Plan (ICP)℠ and Blue Cross Family Health Plan℠ (FHP).

Limitations of Covered Benefits by Member Contract
The table below includes information on benefit preauthorization requirements for non-emergency services provided to BCBSIL Medicaid (MMAI, ICP and FHP) 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, ICP or FHP 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), Effective June 1, 2017	

• **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**
 	
Note: For specific codes that apply, visit eviCore's Web Portal at https://www.evicore.com/healthplan/bcbsil
	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.
	
	Including Network Exceptions including Out-of-Plan or Out-of-Network (due to Network Adequacy) for managed programs

Prior Authorization Rules - Medicaid Medical / Surgical (Non-Behavioral Health)	
BENEFIT PREAUTHORIZATION REQUIREMENTS through BCBSIL	
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®. Or, call toll-free (MMAI: 877-723-7702; ICP: 888-657-1211; FHP: 877-860-2837) between 8 a.m. and 8 p.m. (Local Time) Monday through Friday, except holidays.	
Covered Service	**Prior Authorization Required?**
Office visits to PCPs or specialists, including dieticians, nurse practitioners, and physician assistants	No
Allergy care, including tests and serum	May be required. Check member eligibility and benefits.
Diabetes self-management services	May be required. Check member eligibility and benefits.
Injections	May be required. Check member eligibility and benefits.
Podiatry (foot and ankle) services	Yes
Minor surgeries	May be required. Check member eligibility and benefits.
Routine physicals, children's preventive health programs, and Tot-to-Teen checkups	No
Medical supplies; durable medical equipment	May be required. Check member eligibility and benefits.
Hospital services (inpatient, outpatient, and skilled nursing)	Yes
Nursing facilities and swing bed hospital services	Yes
Dialysis services	Requires Notification - Effective Aug. 1, 2017
Surgery, including pre-and post-operative care: assistant surgeon, anesthesiologist, organ transplants	May be required. Check member eligibility and benefits. All transplants and pre-transplant evaluations require prior authorization.
Emergency dental care	Yes
Special rehabilitation services, such as: physical therapy, occupational therapy, speech therapy, cardiac rehabilitation, pulmonary rehabilitation	Yes
Laboratory, X-ray, EKGs, medical imaging services, and other diagnostic tests	May be required. Check member eligibility and benefits.
Home health care and intravenous services	Yes
Personal care services and private duty nursing (home- or school-based) for children under age 21, who qualify under the EPSDT program	Yes If your child is disabled, they may qualify for more services. Please call the customer service number on the member's BCBSIL ID card and ask to speak with a Care Coordinator/Case Manager for more information.
Hearing services	Yes
Second opinions (in-network)	No
Chemotherapy and radiation therapy	Yes
Nutritional counseling services	May be required. Check member eligibility and benefits.
Covered services provided in school-based health clinics	No
Pregnancy-related and maternity services	No
Ground and air ambulance	Ground - No Air - Yes
PET, MRA, MRI, and CT scans	May be required. Check member eligibility and benefits.

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Prior Authorization Rules - Medicaid Medical / Surgical (Non-Behavioral Health), *continued*	
Covered Service	**Prior Authorization Required?**
Hospice	Yes
Home birthing	Notification is required
Nutritional products and special medical foods	Yes
Breast Pumps and replacement supplies	No - Subject to benefit and DME dollar amount
Bariatric surgery	Yes
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.

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
Transcranial Magnetic Stimulation*	Yes **Only a covered benefit for MMAI members*

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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