Benefit Prior Authorization

In addition to checking eligibility and benefits, there may be other steps you need to take to help our members maximize their benefits before treatment begins. At Blue Cross and Blue Shield of Illinois (BCBSIL), we use benefit preauthorization requirements to help make sure that the service or drug being requested is medically necessary, as defined in the member’s certificate of coverage. With a focus on improving health care delivery, benefit preauthorization allows us to influence health outcomes.

An overview of benefit preauthorization, predetermination of benefits guidelines and related information is included below as a reminder of definitions and important details. Special processes for out-of-area Blue Plan, Federal Employee Program (FEP) and Government Programs [Blue Cross Medicare AdvantageSM and Blue Cross Community Health PlansSM (BCCHPSM)] members are referenced later in this section. For more information, refer to the Claims and Eligibility/Prior Authorization section of our website at bcbsil.com/provider. Also watch our Blue Review, as well as the News and Updates section of our Provider website, for important announcements.

Benefit preauthorization (also called benefit pre-certification or pre-notification) is the process of determining whether the proposed treatment or service meets the definition of “medically necessary” as set forth in the member’s benefit plan, by contacting BCBSIL or the appropriate benefit preauthorization vendor for prior approval of services.

Verification of benefits and/or approval of services after preauthorization are not a guarantee of payment of benefits. Payment of benefits is subject to several factors, including, but not limited to, eligibility at the time of service, payment of premiums/contributions, amounts allowable for services, supporting medical documentation and other terms, conditions, limitations and exclusions set forth in the member’s policy certificate and/or benefits booklet and/or summary plan description as well as any pre-existing conditions waiting period, if any, at the time services are rendered.

Benefit Preauthorization for Inpatient and Ancillary Medical Services

Most BCBSIL PPO member contracts require that benefit preauthorization is requested from BCBSIL or the benefit preauthorization vendor, if applicable, for the following services:

- Inpatient hospital admission and rehabilitation
- Inpatient Skilled Nursing Facility admission
- Long-term acute care
- Coordinated home health care
- Inpatient hospice (some employer groups)
- Residential Treatment Center (RTC) admission
- Partial Hospitalization Program (PHP) admission

Many employer groups also require benefit preauthorization for Private Duty Nursing, certain IV medication and certain outpatient services. When eligibility and benefits are verified, providers will be able to determine if a group requires benefit preauthorization for outpatient services.

Benefit Preauthorization for Outpatient Medical/Surgical Services

Although most groups do not require benefit preauthorization for outpatient services, there are some who do require benefit preauthorization for certain outpatient services. When you verify eligibility and benefits, you will be able to determine if a group requires benefit preauthorization for outpatient services.

Time Frames

Benefit preauthorization for elective or non-emergency admissions is required prior to admission or within two business days of an emergency admission. Specific time frames for benefit preauthorization vary according to employer requirements. To help ensure clinical review and determination in time for the member’s elective or non-emergency service, requesting benefit preauthorization is recommended two weeks prior to the scheduled service or as early as possible.
Responsibility for Benefit Preauthorization

In accordance with the PPO member’s benefit plan document with BCBSIL, the member is responsible for requesting preauthorization of services. Professional providers may request benefit preauthorization on behalf of a member.

For inpatient admission and certain outpatient services, in accordance with the PPO provider’s hospital contract with BCBSIL, the PPO facility provider has agreed to a Utilization Review Program that includes notification by the PPO facility for inpatient admission and certain outpatient procedures.

It is best practice for providers to support the member by providing the benefit preauthorization. Please be aware that the member is required to be held harmless if the PPO facility provider fails to obtain benefit preauthorization for inpatient admission and certain outpatient services; penalties are specified in the PPO hospital contract.

The member is responsible for benefit preauthorization if they use out-of-network or out-of-state providers.

How to Obtain Benefit Preauthorization

Electronic Requests – Submit online pre-certification and authorization requests and inquiries (HIPAA 278 transactions) through Availity® or your preferred Web vendor portal.

Online Benefit Preauthorization Tool – Sign up to use iExchange®, our online tool that supports direct submission and provides online determination of benefits for inpatient admissions and select outpatient services, both benefit preauthorization and concurrent review. For additional information, including the iExchange online enrollment form, visit the Education and Reference Center/Provider Tools section of the BCBSIL website.

Telephone Inquiries – Call the pre-certification number on the member’s BCBS ID card. If the member’s ID card is not available, providers may call the Customer Care Call Center (CCCC) at 800-572-3089 or the BCBSIL Provider Telecommunications Center (PTC) at 800-972-8088; upon verification of eligibility and benefits, you will be advised on how to proceed.

Benefit Preauthorization Exceptions

HMO Members

BCBSIL has delegated medical management and pre-certification for the HMO products (HMO Illinois®, Blue Advantage HMO®, Blue Precision HMO®, BlueCare Direct HMO® and Blue Focus Care HMO®) to the medical groups (MGs) and Independent Practice Associations (IPAs). Services provided to HMO members must have prior MG/IPA approval to be eligible for benefits.

Behavioral Health (Mental Health and Substance Abuse)

BCBSIL manages benefits for behavioral health care services for most PPO and Blue Choice PPO members; however, some employer groups are managed by other behavioral health vendors. For details, including benefit preauthorization guidelines, refer to the Behavioral Health Program section.

Government Programs

For information on benefit preauthorization requirements for non-emergency services provided to Government Programs – Blue Cross Medicare Advantage and Blue Cross Community Health Plans – members, refer to the corresponding Provider Manual in the Standards and Requirements/BCBSIL Provider Manual section of the BCBSIL website. You may also call the appropriate number on the member’s BCBSIL ID card. Government programs products include Blue Cross Medicare Advantage PPO (MA PPO), Blue Cross Medicare Advantage HMO (MA HMO), Blue Cross Community MMAI (Medicare-Medicaid Plan) and Blue Cross Community Health Plans 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 MA PPO, MA HMO, BCCHP and MMAI member when services are deemed not to meet the medical necessity definition in the Member Handbook and the claim is denied.
BlueCard® Out-of-area Members
An online “router” tool is available to help you locate Plan-specific benefit preauthorization/pre-certification and medical policy information for out-of-area Blue Plan members. Look for the Pre-cert Router (out-of-area) link under the Claims and Eligibility tab on our website at bcbsil.com/provider. When you enter the alpha prefix from the member’s ID card, you will be redirected to the appropriate Blue Plan’s website for more information. Predetermination of benefits requests for members with Blue Plan benefits in another state should be sent to the Plan indicated on the member’s ID card. For additional information, refer to the BlueCard Program Manual located in the Standards and Requirements/BlueCard Program section of the BCBSIL website.

Federal Employee Program (FEP) Members
For FEP members, you must call the local Blue Plan where services are being rendered for benefit preauthorization, regardless of the state in which the member is insured. A predetermination of benefits review is required for the following services: outpatient/inpatient surgery for morbid obesity; outpatient/inpatient surgical correction of congenital anomalies; and outpatient/inpatient oral/maxillofacial surgical procedures needed to correct accidental injuries to jaws, cheeks, lips, tongue, roof and floor of mouth.

Predetermination of Benefits
A predetermination of benefits is a written request for verification of benefits prior to services being rendered. A predetermination is recommended when the service could be considered experimental, investigational or cosmetic.

Predetermination approvals and denials are based on provisions in our medical policies. Medical policies may also be used as a guideline to determine what documentation may be required with the request. The Medical Policies of BCBSIL are accessible online and located in the Standards and Requirements/Medical Policies section of our Provider website. Note: this process does not apply to HMO members. Refer to the HMO Scope of Benefits for coverage.

Note: A predetermination approval does not guarantee payment for services. Providers should also verify eligibility and benefits, since benefits are also subject to eligibility and coverage limitations at the time services are rendered.

Predetermination of benefits may be requested through our online tool, iExchange, or by using the Predetermination Request Fax Form located in the Education and Reference Center/Forms section of our Provider website. Completed forms should be faxed to 800-852-1360. Providers will be notified of approvals through a letter. In the case of an adverse determination, the providers will be notified by both a phone call and a letter.

Predetermination of Benefits Exceptions
The information in this section does not apply to HMO Illinois, Blue Advantage HMO, Blue Precision HMO, BlueCare Direct HMO, Blue Focus Care HMO, MA PPO, MA HMO, BCCHP and MMAI members.
Prior Authorization for High-tech Imaging Services
BCBSIL has partnered with AIM Specialty Health® (AIM) to implement a statewide utilization management and quality improvement program for the management of outpatient diagnostic imaging services. Most BCBSIL PPO members are included in the Radiology Quality Initiative (RQI) program for elective outpatient high-tech imaging services.*

*Exceptions:
- Obtaining RQI numbers for Blue Choice OptionsSM and Blue Choice Select PPOSM members is not required.
- Obtaining an RQI number for HMO and government programs members is not required.

As a reminder, checking eligibility and benefits is always an important first step. The RQI does not replace or override any benefit preauthorization/pre-certification requirements specified by the member's benefit plan.

Compliance with the RQI program is required for the outpatient diagnostic non-emergency imaging services listed below when performed in a physician’s office, the outpatient department of a hospital or a freestanding imaging center:
- CT scans
- CTA scans
- MRI, MRS, MRA scans
- Nuclear cardiology studies
- PET scans and Breast MRI (must meet medical policy criteria)

The RQI number is not required when the place of service is a hospital (inpatient), emergency room, urgent care, immediate care center or during a 23-hour observation period. The ordering physician must prospectively obtain the RQI number. The performing imaging provider cannot obtain an RQI number but should verify that an RQI number was issued prior to performing the service. Hospitals have access to the AIM website to verify the RQI by entering the member's name and identification number. Facilities may not obtain an RQI on behalf of ordering physicians.

To obtain an RQI number, the physician may access the AIM website at aimspecialtyhealth.com or contact the AIM Call Center at 800-455-8415. The RQI is valid for 30 days. There is no grace period if the service is not performed.

In addition to BCBSIL, other BCBS plans may also have radiology management programs that are tied to member benefits. Therefore, it is important to check benefits for out-of-area BCBS members prior to rendering services. For additional information, refer to the BlueCard Program Manual.

Please note that the fact that a guideline is available for any given treatment, or that a service has been pre-certified or an RQI number has been issued 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, including, but not limited to, exclusions and limitations applicable on the date services were rendered.
Benefit Preauthorization through eviCore
BCBSIL has contracted with eviCore healthcare, LLC (eviCore) to provide certain utilization management services for select outpatient molecular and genomic testing, outpatient radiation therapy, advanced imaging, musculoskeletal and cardiology procedures. eviCore is an independent company that provides specialty medical benefits management for BCBSIL.

Benefit Preauthorization Requirements
BCBSIL requires benefit preauthorization (for medical necessity)* through eviCore for some BCBSIL members with the commercial PPO products/networks listed below:

- PPO (PPO)
- Blue Choice Preferred PPOSM (BCE)
- Blue Choice PPOSM (BCS)**
- Blue OptionsSM/BlueChoice OptionsSM (BCO)**

NOT included for HMO members in Illinois where benefit preauthorization (for medical necessity under the applicable benefit plan) is performed by the member’s medical group.

Refer to the eviCore implementation site and select the BCBSIL health plan for the applicable Current Procedural Terminology (CPT®) and Healthcare Common Procedure Coding System (HCPCS) code list and radiation therapy physician worksheets.

Contact Information
Benefit preauthorization through eviCore for outpatient molecular and genomic testing and outpatient radiation therapy can be obtained using one of the following methods:

- **Online** – The eviCore Healthcare Web Portal is available 24 hours a day, seven days a week. After a one-time registration, you are able to initiate a case, check status, review guidelines, view authorizations/eligibility and more. The Web Portal is the quickest, most efficient way to obtain information.
- **Telephone** – Providers can call toll-free at 855-252-1117 between 7 a.m. to 7 p.m. (local time) Monday through Friday.

More specific program-related information can be found on the eviCore implementation site. Also watch our Blue Review, as well as the News and Updates section of our website at bcbsil.com/provider, for important announcements.

*Preauthorization determines whether the proposed service or treatment meets the definition of medical necessity under the applicable benefit plan. Preauthorization of a service is not a guarantee of payment of benefits. Payment of benefits is subject to several factors, including, but not limited to, eligibility at the time of service, payment of premiums/contributions, amounts allowable for services, supporting medical documentation, and other terms, conditions, limitations, and exclusions set forth in the member’s policy certificate and/or benefits booklet and or summary plan description. Regardless of any preauthorization or benefit determination, the final decision regarding any treatment or service is between the patient and the health care provider.

**These products are not currently offered in Central and Southern Illinois.

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Please note that verification of eligibility and benefits, and the fact that a service or treatment has been preauthorized or predetermined for benefits, 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. Regardless of any benefit determination, the final decision regarding any treatment or service is between the patient and the health care provider. Certain employer groups may require preauthorization/pre-certification through other vendors. If you have any questions, please call the number on the member’s ID card.

Availity is a trademark of Availity, LLC, a separate company that operates a health information network to provide electronic information exchange services to medical professionals. Availity provides administrative services to BCBSIL. AIM Specialty Health (AIM) is an independent company that provides medical necessity review for select health care services on behalf of BCBSIL. AIM is a wholly owned subsidiary of Anthem, Inc. and an independent third party vendor that is solely responsible for its products and services. eviCore is a trademark of eviCore healthcare, LLC, formerly known as CareCore, an independent company that provides utilization review for select health care services on behalf of BCBSIL. BCBSIL makes no endorsement, representations or warranties regarding any products or services offered by third party vendors such as Availity, AIM and eviCore. If you have any questions about the products or services offered by such vendors, you should contact the vendor(s) directly.