

## Medical Coverage Policy | Prior Authorization via Web-Based Tool for Procedures



**EFFECTIVE DATE:** 03|01|2024

**POLICY LAST REVIEWED:** 01|03|2024

### OVERVIEW

This policy documents the prior authorization request process for certain medical procedures, using the Blue Cross & Blue Shield of Rhode Island (BCBSRI) online prior authorization tool. Services such as dental services rendered in the outpatient setting will not be authorized by this system. Please refer to the individual policies on the web.

### MEDICAL CRITERIA

Generally, InterQual criteria, is used to determine medical necessity and is found in the online authorization tool. Medical necessity criteria from Centers for Medicare and Medicaid Services (CMS) National and Local Coverage Determinations (NCD/LCD) is used when applicable for Medicare Advantage Members to determine medical necessity of services and is found in the online authorization tool. However, for those policies specifically listed in the Related Policies section of this policy, BCBSRI medical criteria is used.

### PRIOR AUTHORIZATION

Prior authorization is required for Medicare Advantage Plans and recommended for Commercial Products.

If a service that requires prior authorization is performed on an urgent basis, a retrospective authorization must be obtained through the online tool.

If the complexity of a procedure is unknown prior to the service, a retrospective authorization must still be obtained.

### POLICY STATEMENT

#### Medicare Advantage Plans and Commercial Products

Medical Procedures are considered medically necessary when the criteria in the BCBSRI online prior authorization tool has been met.

Requests for medical procedures should be obtained via the BCBSRI online prior authorization tool, which is available only to participating providers. All other providers should fax the request to Utilization Management at 401-272-8885 to complete the prior authorization process. Please see reference to the procedures requiring prior authorization through the online tool below.

<https://www.bcsri.com/BCBSRIWeb/Login.do?redirectTo=/providers/preauth/preauthProviderOverview.jsp>

### COVERAGE

Benefits may vary between groups/contracts. Please refer to the appropriate Benefit Booklet, Evidence of Coverage, or Subscriber Agreement for applicable coverage for benefits/coverage.

### BACKGROUND

Not applicable

### CODING

The following codes, in the attached grid listed in the link below, are covered when the applicable medical criteria are met:

## [2024 Prior Authorization of Procedures](#)

### **RELATED POLICIES**

Anastomosis of Extracranial-Intracranial Arteries  
Arthrotomy for Temporomandibular Joint (TMJ) Disorder  
Balloon Dilation of the Eustachian Tube  
Biofeedback  
Cryosurgical Ablation of Miscellaneous Solid Tumors other than Renal, Liver and Prostate  
Gender Affirming Care  
Glucose Monitoring – Continuous  
Implantation of Intrastromal Corneal Ring Segments  
Infertility Services  
Intensity Modulated Radiotherapy  
Laser Treatment for Proliferative Vascular Lesions  
Minimally Invasive Procedures for Back Pain  
Miscellaneous Vascular Embolization Procedures  
Orthognathic Surgery  
Percutaneous Tibial Nerve Stimulation (PTNS)  
Prior Authorization of Spinal Procedures  
Prostatic Artery Embolization (PAE) for Benign Prostatic Hyperplasia  
Prostatic Urethral Lift  
Radiofrequency Ablation of Miscellaneous Solid Tumors Excluding Liver Tumors  
Removal of Implantable Devices  
Spinal Cord Stimulation  
Stereotactic Body Radiation Therapy  
Surgical and Debulking Treatments for Lymphedema  
Transcatheter Mitral Valve Repair  
Transurethral Water Jet Ablation (Aquablation) for Benign Prostatic Hypertrophy  
Varicose Vein Treatment

### **PUBLISHED**

Provider Update, March 2024  
Provider Update, February 2023  
Provider Update, June/December 2022  
Provider Update, March, June 2021  
Provider Update, March 2020

### **REFERENCES:**

Not applicable

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