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

EFFECTIVE DATE: 07|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.bcbsri.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 Treatments for Lymphedema and Lipedema
Transcatheter Mitral Valve Repair
Transurethral Water Jet Ablation (Aquablation) for Benign Prostatic Hypertrophy
Varicose Vein Treatment

PUBLISHED

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

REFERENCES:

Not applicable

CLICK THE ENVELOPE ICON BELOW TO SUBMIT COMMENTS

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