BlueCross BlueShield of Illinois

Medicaid Prior Authorization and Notification Requirements
(Updated August 2025)

This information applies to Blue Cross Community Health Plans℠ members.

Limitations of Covered Benefits by Member Contract
The table below includes information on prior authorization and pre-notification (notification) requirements for non-emergency services provided to our Medicaid members with BCCHP℠. Medical necessity, as defined in the Member Handbook, must be determined before a prior authorization number will be issued. Claims received by Blue Cross and Blue Shield of Illinois that do not have a prior authorization number may result in an adverse determination. Providers may not seek payment from the 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.
Prior Authorization and Notification Requirements
For scheduled services, prior authorization is required prior to service. Notification of inpatient admission is required within one business day after a member is admitted. Notification of extension requests for ongoing care must be submitted within one business day from the last covered day of service. Failure to meet these requirements may result in an adverse determination.
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. Clinical information must accompany all requests for prior authorization to demonstrate medical necessity. Cases in which clinical information does not accompany the prior authorization request may result in adverse determinations.
Inpatient Facility Admission Summary
All planned (elective) inpatient hospital care (surgical, non-surgical, behavioral health and/or substance use) admissions must have prior authorization before the admission occurs.
All unplanned inpatient hospital care (surgical, non-surgical, behavioral health and/or substance use) 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 requires a prior authorization.
All substance use residential program admissions for substance misuse treatment require notification within 24 hours of admission and are subject to medical necessity review.

Prior Authorization Rules - Medicaid Medical /Surgical /Behavioral Health	
MEDICAID PRIOR AUTHORIZATION REQUIREMENTS* THROUGH CARELON MEDICAL BENEFITS MANAGEMENT (CARELON)	

• Genetic Testing
• Medical Oncology
• Radiation Oncology
• Musculoskeletal Services
  - Spine, Joint, Pain
• Rehabilitation
  - Physical/Occupational/Speech Therapy
• Radiology Imaging Services
 	
**Including Network Exceptions [out-of-plan or out-of-network (due to network adequacy) for managed programs]*
	The Carelon Provider Portal at providerportal.com 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 request and authorization and obtain information.
	
	You may also call Carelon toll-free at 866-455-8415 between 7 a.m. and 7 p.m. (Central Time) Monday through Friday, except holidays.

Prior Authorization Rules - Medical and Surgical Services	
MEDICAID PRIOR AUTHORIZATION REQUIREMENTS THROUGH BCBSIL	
Reminder: Eligibility and benefits as well as prior authorization verification and submission can be initiated online using the Authorizations & Referrals tool via the Availity® Essentials Provider Portal.	
Covered Service	**Prior authorization required?**
Advanced Imaging (PET, MRA, MRI, and CT scans)	Refer to the procedure code list for prior authorization requirements.
Allergy care, including tests and serum	Refer to the procedure code list for prior authorization requirements.
Ambulance	Air – Yes, fixed wing medical transportation 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 prior authorization requirements.
Chiropractic Services	Yes
Covered services provided in school-based health clinics	No
Durable Medical Equipment (DME) – Medical supplies, orthotics, and prosthetics	Refer to the procedure code list for prior authorization requirements. Additionally, prior authorization is required for any single DME, repair, prosthetic or orthopedic device greater than $1500.
Emergency dental care	Yes
Diabetes self-management services	Refer to the procedure code list for prior authorization requirements.
Dialysis services	PA required for Hemodialysis performed >3x per week
Doula Services	Required if greater than quantity limit.
Hearing services and devices	Yes
Home birthing	Notification is required.
Home health care and intravenous services	Yes – Refer to the procedure code list for prior authorization requirements.
Hospice	Yes
Outpatient Hospital Services	Yes – Refer to the procedure code list for prior authorization requirements.
Skilled Nursing and Therapy Services	Yes – Refer to the procedure code list for prior authorization requirements.
Injections	Refer to the procedure code list for prior authorization requirements.
Lactation Counseling	Required if greater than the quantity limit.
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.
Skilled Nursing facilities	Yes
Custodial Nursing Facility	Yes, until member is listed on patient credit file.
Nutritional counseling services	Refer to the procedure code list for prior authorization requirements.
Minor surgeries	Refer to the procedure code list for prior authorization requirements.
Office visits to PCPs or specialists, nurse practitioners, and physician assistants	No, if In Network provider, otherwise PA required.

Prior Authorization Rules - Medical and Surgical Services	
Covered Service	**Prior authorization required?**
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 the child is disabled, the child may qualify for more services. Call Customer Service and ask to speak with a Care Coordinator/Case Manager for more information.
Podiatry (foot and ankle) services	Refer to the procedure code list for prior authorization requirements.
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 prior authorization 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 prior authorization requirements.

Prior Authorization Rules - 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 Use Treatment	Yes
Mental Health Partial Hospitalization	Yes
Substance use Partial Hospitalization	Yes
Medication Assisted Treatment for Opioid Dependence	No
Mental Health Intensive Outpatient Treatment	Yes
Substance Use Intensive Outpatient Treatment	Yes
Assessment and Treatment Planning Services	No
Mobile Crisis Response	No
Crisis Stabilization	No
Crisis Intervention	No
Assertive Community Treatment	Yes
Community Support Team	Yes
Psychosocial Rehabilitation	Yes
Psychological Testing	No
Neuropsychological Testing	No
Electroconvulsive Therapy	No
Developmental Testing	Refer to the procedure code list for prior authorization requirements
SUPR Admission/Discharge Assessment	No
SUPR Substance Use Group Therapy	No
SUPR Substance Use Individual Therapy	No
SUPR Substance Use Intensive Individual/Group Therapy	Yes
SUPR Substance Use Residential	Yes
SUPR Substance Use Detoxification	Yes

Note: Post-acute inpatient stays, Skilled Nursing Facility (SNF), rehabilitation and Long-term Acute Care (LTAC) services require prior authorization and must be obtained through and confirmed by BCBSIL.

Checking eligibility and/or benefit information and/or obtaining prior authorization or pre-notification for a service 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.

Carelon Medical Benefits Management (formerly AIM Specialty Health) is an independent company that has contracted with BCBSIL to provide utilization management services for members with coverage through BCBSIL. 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. BCBSIL makes no endorsement, representations or warranties regarding third party vendors and the products or services they offer.