BlueCross BlueShield of Illinois

Prior Authorization Program
Glossary of Terms

Administrative Days – When Blue Cross and Blue Shield of Illinois covers days in a hospital for members who are ready to be discharged to a lower level of care, but the there is a problem finding an open bed in the facility where the member will be transferred.

Adverse Benefit Determination – This is the denial, reduction, limited authorization, suspension, or termination of a newly requested benefit or benefit currently being provided to a member. These include determinations based on the type or level of service, medical necessity criteria or requirements, appropriateness of setting, or effectiveness of a service.

Appeal – An appeal is a request for review of a decision made by BCBSIL about a service. It is a way for members to ask for someone to review BCBSIL's actions. An appeal might occur if BCBSIL does not approve or pay for a service your provider asked for, allow you to get a service in a timely manner, or answer an appeal request in a timely manner.

ASAM – (American Society of Addiction Medicine) – ASAM is the most widely used set of standards for review of care for patients with addiction and co-occurring conditions.

Clinical Criteria – A set of signs, symptoms, laboratory tests, and other medical reasons to decide if a person has a disease or condition.

CPT Codes – (Current Procedural Terminology) – These are special numbers or codes doctors and hospitals use to show what medical service or treatment was done.

HCPCS Codes – (Healthcare Common Procedure Coding System) – These are special numbers or codes used to show medical supplies, equipment, and some medicines that were used.

Emergency Services – The evaluation of an emergency medical condition. These include treatment for severe pain, injury or illness, as well as treatment to keep a condition from getting worse.

EOB – (Explanation of Benefits) – A letter sent by BCBSIL to tell you what services were covered.

External Independent Review – A review of appeal decisions after a denial that is done by a provider outside of BCBSIL.

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Hospitalization – Care in a hospital that requires admission as an inpatient and usually requires an overnight stay.

MCG – (Milliman Care Guidelines) – A set of nationally recognized evidence-based criteria used to evaluate care guidelines for patient-centered care decisions.

Medical Necessity/Medically Necessary – A decision by BCBSIL that a health care service, treatment plan, prescription drug, or supplies are needed to prevent, diagnose, or treat an illness. These must meet accepted standards of medicine.

Medical Policy – A set of rules from BCBSIL about approving medical care.

Prior Authorization – When your health plan decides that a health care service, treatment plan, prescription drug or durable medical equipment is medically necessary. BCBSIL may require approval for certain services before you receive them, except in an emergency.

Prior Authorization Change Log – A list of the changes to prior authorization requirements that includes the date of the change and reason for the change.

Prior Authorization Grid – A list of the services requiring prior authorization used by your doctor.

Service Authorization Program – The program that covers all the reviews that BCBSIL does for health care services provided for members.

State Fair Hearing – An appeal of an adverse decision with an Impartial Hearing Officer authorized to conduct State Fair Hearings.

Utilization Management – BCBSIL program to ensure members get the right health care while also controlling costs.