Utilization Management Program for Post-Acute Care

Quick Reference Guide

Blue Cross and Blue Shield of Illinois has contracted with eviCore healthcare, an independent specialty medical benefits management company, to provide preauthorization reviews for select services for its Medicare and Medicaid members.

Authorization Required

Preauthorization is required for member admissions to the following provider types:

- Skilled Nursing Facilities
- Inpatient Rehabilitation Facilities
- Long Term Acute Care Facilities

We offer four convenient methods to request preauthorization reviews:

- eviCore Post-Acute Care Web Portal
- Allscripts: eviCore can accept authorization requests and respond to providers who use Allscripts
- Facsimile: Clinical documentation can be faxed to 855-826-3725
- Telephone: Clinical information can be called to eviCore healthcare at 855-252-1117

Pre-Authorization Forms:

The forms are available on our implementation site: https://www.evicore.com/healthplan/BCBSIL

Hours of Operation that eviCore staff is available:

7 a.m. to 6 p.m. CST Monday through Friday (normal business hours)

Afterhours and on call coverage is available for urgent issues, including weekends and holidays

Pre-Authorization Requirements

The information requirements are found on our pre-authorization requests fax forms. The following supporting documents are also required:

- H & P (History and Physical)
- Consult Notes
- PT/OT/ST progress notes- include prior and current level of function
- Medications
- If available, please include: Discharge Summary
- & Social Work/Psychosocial Consult

Pre-Authorization Notifications are communicated via:

- **Allscripts**: eviCore healthcare can accept and respond to providers that use Allscripts
- **Web Portal**: Please visit https://www.evicore.com/pages/providerlogin.aspx
- **Telephone**: Outbound call may be placed by one of our clinical support specialists
- **Fax:** An authorization fax letter will be faxed to the requesting provider.
- Servicing providers may obtain initial authorizations (if not the requesting provider) via the eviCore web portal or by calling eviCore at: 855-252-1117

Intent to Deny | Denials

Initial Pre-Authorization Request:

- Providers will be offered a Peer to Peer (P2P) Review for any case that does not meet medical necessity on initial UM review.
- Additional clinical information that supports medical necessity must be received or P2P must occur within 1 business day or a denial letter issued.

Concurrent Authorization Request:

- eviCore allows 2 business days for Peer to Peer review to be scheduled for concurrent review requests, before issuing the denial letter. If decision is upheld the NOMNC (Notice of Medicare Non-Coverage) will be issued.

Authorization Denial

- If the Peer-to-Peer process does not result in a reversal of the recommendation of denial, the physician reviewer may suggest an alternate level of care and/or the appeals process.

Appeals Process

- Once a service has been denied, you must file an appeal to have the request re-reviewed. Appeals may be sent via email:

Medicaid Members: GPDA&G@bcbsil.com
Medicare Members: mapdanadg@bcbsnm.com

Authorization from eviCore healthcare does not guarantee claim payment. Services must be covered by the health plan and the member must be eligible at the time services are rendered. ***Claims submitted for services may be subject to benefit denial.*** *Please verify the member's benefits and eligibility with the health plan. Regardless of the benefit determination, the final decision regarding any health care services or treatment is between the member and their health care provider.*

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