EviCore
By EVERNORTH

Post Acute Care Quick Reference Guide

BlueCross BlueShield of Illinois

Prior Authorization Program

EviCore manages all Inpatient Post-Acute Care (PAC) Prior Authorization requests for Blue Cross and Blue Shield of Illinois (BCBSIL) members enrolled in the following programs:

- Blue Cross Medicare Advantage (PPO)SM
- Blue Cross Community MMAI (Medicare-Medicaid Plan)SM
- Blue Cross Medicare Advantage HMO
- Illinois Individual Medicare HMO
- Illinois Group Medicare PPO
- Blue Cross Community Health Plans (BCCHP)SM **(No longer delegated starting 8/1/2025).**

Prior Authorization is required for member admissions to the following provider types:

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

Providers should verify member eligibility and benefits on: https://www.availity.com

Prior Authorization & Concurrent Review Requirements

To ensure the Prior Authorization (PA) process is as quick and efficient as possible, we highly recommend submitting pertinent clinical information to substantiate medical necessity for the type of service being requested. The information requirements are outlined on our Prior Authorization requests forms. A link to the PA forms is available under the tab "Solution Resources" at: https://www.EviCore.com/resources/healthplan/blue-cross-blue-shield/illinois/medicaid-medicare

EviCore offers three convenient methods to request Prior Authorization reviews:

1. EviCore Web Portal www.EviCore.com
2. Fax PA requests to: **855-826-3725**
3. Telephone: Call **855-252-1117**

Hours of Operation

- Monday through Friday 7 a.m. – 6 p.m. CST
- Saturday 9 a.m. – 4 p.m. CST
- Sunday 9 a.m. – 1 p.m. CST
- Holidays 9 a.m. – 3 p.m. CST

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

Urgent Precertification Requests:

EviCore uses the NCQA/URAC definition of urgent: when a delay in decision-making may seriously jeopardize the life or health of the customer. Urgent requests can be initiated by phone (recommended) or fax and will be reviewed within 72 hours. (Medicaid is 48 hours)

Prior Authorization Outcomes

Once all information is submitted to EviCore, verbal outreach will be made to providers with a determination within 1 to 2 business days for routine requests.

Prior Authorization Approval

Written notification in the form of a letter will be faxed to both the referring provider and mailed to the member. Authorization information can be viewed and printed on demand from the EviCore web portal: www.EviCore.com

Clinical Consultations (Peer-to-Peer)

If a request requires further clinical discussion for approval, EviCore offers timely clinical consultations to reduce the occurrence of appeals. To schedule, please call our authorization call center at 855-252-1117.

Authorization Denials

Once a service has been denied, members and providers must file an appeal to have the request re-reviewed.

The denial rationale and appeal process are communicated verbally and via fax to the requesting provider and mailed to the member.

Appeals Process

Members requesting to appeal a denial for initial PAC services should contact BCBSIL. Instructions are outlined on the denial letter.

Medicare Members requesting to appeal the decision to end skilled care in a SNF facility should follow the Quality Improvement Organization (QIO) process as outlined on the NOMNC.

Electronic Medical Record (EMR) Access

EviCore can connect directly to eligible facilities' EMR systems to help manage PAC authorization requests. This integration allows EviCore clinical staff to automatically retrieve necessary documentation for medical necessity reviews, reducing the administration burden on facility staff and minimizing the risk of denials due to missing clinical information. To learn more about EMR integration and how to get started, contact the PAC Provider Engagement Manager in your region.

Authorization from EviCore 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.*