EviCore By EVERNORTH

Post-Acute Care
Frequently Asked Questions

BlueCross BlueShield of Illinois

Q: Which members will EviCore manage for the Post-Acute Care program?

A: EviCore will manage prior authorizations for Blue Cross Blue Shield of Illinois members who are enrolled in the following programs:

Medicare

- Blue Cross Medicare Advantage (PPO) SM
- Blue Cross Community MMAI (Medicare-Medicaid Plan) SM **No longer delegated as of 1/1/2026**
- Blue Cross Medicare Advantage HMO
- Illinois Individual Medicare HMO
- Illinois Individual Medicare PPO
- Illinois Group Medicare PPO

Q: Which Post-Acute Care services require authorization?

A: Services requiring authorization are:

- Skilled nursing facility admissions
- Inpatient rehabilitation facility admissions
- Long-term acute care admissions

Q: How do I check the eligibility and benefits of a member?

A: Eligibility and benefits should be verified on https://www.availity.com/ before every scheduled PAC admission. Providers are encouraged to check online, if providers do not have online access, they may also call the Interactive Voice Response automated telephone system at 800-972-8088.

More information about checking eligibility and benefits can be found on the Eligibility and Benefits page in the Claims and Eligibility section of the Blue Cross Blue Shield of Illinois website at www.bcbsil.com.

Q: How do I initiate a prior authorization request or a length of stay extension?

A: A prior authorization can be initiated via:

- EviCore Post-Acute Care Web Portal: www.EviCore.com/pages/providerlogin.aspx
- Fax at 855-826-3725
- Phone: 855-252-1117

Q: How do I check the preauthorization status for a member?

A: Our web portal provides 24/7 access to check on the status of your authorization request. To access the portal, please visit www.EviCore.com/pages/providerlogin.aspx.

You may also call EviCore at 855-252-1117 to check on the prior authorization status and request a fax confirmation letter.

Q: What are the hours of operation?

A: Our hours of operation are:

- 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

After-hour and on-call coverage is available for urgent issues, including weekends and holidays.

Q: Who is responsible to submit the initial post-acute care authorization requests?

A: The hospital is responsible for submitting post-acute care admission requests, as the hospital will likely have ready access to the documentation needed to review the request. The requesting post-acute care facility may submit the request if they share the same NPI or Tax ID # (i.e. the hospital and inpatient rehabilitation facility share the same ID.

Q: What are the prior authorization requirements?

A: The information requirements are found on our 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

Please note: authorization forms are required for all Post-Acute Care authorization requests.

Q: Where can I find the post-acute care pre-authorization request form?

A: The authorization form can be found by visiting our resource site, under “Solution Resources”, at Blue Cross Blue Shield of Illinois - Medicaid/Medicare Plans Provider Resources | EviCore by Evernorth.

Q: What criteria does EviCore utilize to authorize Post-Acute Care Admissions?

A: EviCore may utilize a number of resources in reviewing pre-authorization requests, including, but not limited to, the applicable benefit plan document, McKesson IQ Guidelines and Medicare Benefit Policy Manuals & Clinical Findings.

Q. When will I receive the authorization number once the prior authorization request has been approved by EviCore?

A: Once approved, the authorization number will be communicated to the hospital or to the requesting post-acute care facility. The authorization number should then be communicated by the hospital to the accepting post-acute care facility.

Q: How will the authorization determinations be communicated to the providers?

A: EviCore authorization approvals may be communicated in the following ways:

- Web Portal: Providers may also visit www.EviCore.com/pages/providerlogin.aspx to view the authorization determination.
- Telephone: An outbound call will be placed by one of our clinical support specialists to providers.
- Fax: Once the determination is communicated to the provider, EviCore will fax the authorization and/or denial letter to the requesting provider.

Note: The authorization number will begin with the letter 'A' followed by an eight-digit number.

Q: How can the accepting provider confirm that the prior authorization number is valid?

A: Providers can confirm that the prior authorization is valid by logging into our web portal, which provides 24/7 access to view prior authorization numbers. To access the portal, please visit: www.EviCore.com/pages/providerlogin.aspx.

To request a fax letter with the prior authorization number, please call EviCore at 855.252.1117 to speak with a customer service specialist. Additionally, the prior authorization number that you are provided will serve as the same number used for length of stay re-certifications.

Q: How many days does EviCore authorize for each level of service requested?

A: EviCore will provide authorizations by facility type in the following ways:

Authorization	Initial	Concurrent
Skilled Nursing Facility	3 business days	7 calendar days
Inpatient Rehab	5 calendar days	5 calendar days
Long Term Acute Care	5 calendar days	7 calendar days

Q: When does the initial prior authorization approval expire?

A: The initial authorization expires 7 days from the date of issue. This means that the patient must be admitted to the post-acute care facility within 7 days of the initial authorization approval. If the patient is not discharged within this time frame, a new authorization is required.

Q: How will I be informed about the number of days being authorized?

A: The number of days being authorized will be communicated at the same time the authorization determination and number are communicated via:

- Web Portal: www.EviCore.com/pages/providerlogin.aspx
- Telephone: Outbound call may be placed by one of our clinical support specialists

Q: What is the process if an admission to a post-acute care facility or an extension of days does not meet clinical criteria?

A: If a post-acute care admission or length of day extension does not meet clinical criteria in accordance with the member's health benefit plan:

- EviCore will reach out telephonically to offer a Peer-to-Peer discussion prior to a denial.
- It is important to provide additional clinical information needed or to take advantage of the Peer-to-Peer discussion prior to a final determination being made.
- Once a decision to deny has been rendered, an appeal must be filed.

Q: What is a Peer to Peer (P2P) review and its advantages?

A: A Peer-to-Peer (P2P) Review is a conversation/meeting between your clinical team (MD, PA, or NP) over the phone to discuss a patient's case.

- The P2P process can clarify the patient's clinical needs, which the clinical record may not be conveyed clearly.
- P2P may negate the need to submit an appeal with the health plan or QIO.
- P2P request must be submitted within 48 hours of the denial determination.
- EviCore Medical Directors are available 24 hours a day, 7 days a week for P2P reviews.

EviCore Medical Directors may request a proactive P2P review before determination, *Unable to Extend*, because they want additional information or details from the primary care doctor

Q: How do I obtain the denial rationale for DENC (Detailed Explanation of Medical Non-coverage) notice?

A: Requests for the denial rationale for DENC will be sent to DENCRationaleRequests@EviCore.com. EviCore will email the rationale within 4 hours of receipt. If the request is received after 5pm CST Monday through Friday, the request will be returned by 9am CST the next day Tuesday through Saturday. If the request is received after 4pm CST Saturday, the request will be returned by 9am CST the next business day.

Q: How do I file an appeal if I disagree with the decision to deny?

A: Once a service has been denied, you must file an appeal to have the request re-reviewed.

- Medicaid appeal requests may be submitted via email to GPDA&G@bcbsil.com
- Medicare appeal requests may be submitted via email to: mapdanadg@bcbsnm.com

Q: What is the requirement for members admitted to a post-acute care facility after being discharged to home from an acute care facility?

A: In the event that the medical condition or diagnosis has changed since being discharged from the acute care facility, the member will need an evaluation from a physician for medical clearance. A re-evaluation by PT/OT/ST may also be required, depending on the situation.

Q: Who should request prior authorization for post-acute care admissions for patients needing placement after being discharged to home from the acute care setting?

A: The post-acute facility, home health agency or PCP can initiate a pre-authorization request in this situation. The member will require a physician's order along with medical clearance.

Q: Can a patient be admitted to a post-acute care facility directly from the emergency room or from an observation stay?

A: Yes, the hospital is responsible to submit the post-acute care admission requests.

Q: What if an authorization is issued to a facility and the patient or family wants to change the facility at the last minute?

A: The hospital should contact EviCore with any change to the accepting post-acute care facility. We will then update the authorization in our system. It is very important to update EviCore of any changes to the accepting post-acute care facility in order for claims to be correctly processed for the facility that receives the member.

Q: If a patient is in a post-acute care facility and is transferred to the hospital for observation, does the facility have to get a new authorization in order for the patient to return?

A: If the authorization has NOT expired and is being returned to the same post-acute care facility

for the same condition, a new authorization is not required. The hospital should call EviCore to confirm the authorization status.

Q: Do you approve cases retrospectively if no authorization was obtained before the admission?

A: Retrospective requests must be initiated by phone within one (1) year following the date of service for Medicare cases by Non-Participating Providers only; retro requests cannot be initiated for Medicaid cases. In many instances, the services must have been urgent and medically necessary. Please have all clinical information

relevant to your request available when you contact EviCore.

Q: If I am an out of network facility located in the state of Illinois, how do I obtain an authorization?

A: Out of network providers in the state of Illinois are required to go through EviCore for pre-certification on post-acute care requests.

Q: How do I determine if a provider is in network?

A: Participation status can be verified by visiting www.bcbsil.com/provider.

Providers may also contact EviCore at 855-252-1117 EviCore receives a provider file from Blue Cross Blue Shield of Illinois with all independently contracted participating and non-participating providers.

Q: Where do I submit my claims?

A: All claims will continue to be filed directly to Blue Cross Blue Shield of Illinois.

Q: How do I submit a program related question or concern?

A: For program related questions or concerns, please email: clientservices@EviCore.com.

Q: Where can I find additional information?

For more information and reference documents, please visit our implementation site: Blue Cross Blue Shield of Illinois - Medicaid/Medicare Plans Provider Resources | EviCore by Evernorth