DRAFT Medical Coverage Policy | Prior Authorization of Services, Treatments or Procedures

EFFECTIVE DATE: 02|01|2026
POLICY LAST REVIEWED: 11|05|2025

OVERVIEW

This policy documents the prior authorization request process for certain medical procedures, using the Blue Cross & Blue Shield of Rhode Island (BCBSRI) online prior authorization tool. Services such as dental services rendered in the outpatient setting will not be authorized by this system. Please refer to the individual policies on the web.

MEDICAL CRITERIA

Generally, InterQual criteria, is used to determine medical necessity and is found in the online authorization tool. Medical necessity criteria from Centers for Medicare and Medicaid Services (CMS) National and Local Coverage Determinations (NCD/LCD) is used when applicable for Medicare Advantage Members to determine medical necessity of services and is found in the online authorization tool. However, for those policies specifically listed in the Related Policies section of this policy, BCBSRI medical criteria is used.

PRIOR AUTHORIZATION

Prior authorization is required for Medicare Advantage Plans and recommended for Commercial Products.

Effective 10/1/2025, for Fully-Funded Commercial Products only, prior authorization requests may not be needed when the requesting physician is a BCBSRI Contracted Primary Care Provider. See below for a list of specialties. Prior authorization continues to be needed for all other Commercial Products, including Self-Funded and Medicare Advantage Plans.

The following specialties, that are credentialed as a primary care provider, are included in this exemption:

- Internal Medicine
- Pediatric Medicine
- Family Practice
- Obstetrics and Gynecology
- Doctor of Osteopathic Medicine
- NP (Nurse Practitioner)/PCP (Primary Care Physician or Provider)
- PA (Physician Assistant)

Effective 5/15/2025, prior authorization requests for certain services may not be needed when the requesting physician is a Blue Cross and Blue Shield of Rhode Island (BCBSRI) Contracted Primary Care Provider. Please see the attached code grid for applicable services.
The following specialties are included in this exemption:

- Internal Medicine
- Pediatric Medicine
- Family Practice
- NP (Nurse Practitioner)/PCP (Primary Care Physician or Provider)
- PA (Physician Assistant)

If a service that requires prior authorization is performed on an urgent basis, a retrospective authorization must be obtained through the online tool.

If the complexity of a procedure is unknown prior to the service, a retrospective authorization must still be obtained.

POLICY STATEMENT

Medicare Advantage Plans and Commercial Products

Medical Procedures are considered medically necessary when the criteria in the BCBSRI online prior authorization tool has been met.

Requests for medical procedures should be obtained via the BCBSRI online prior authorization tool, which is available only to participating providers. All other providers should fax the request to Utilization Management at 401-272-8885 to complete the prior authorization process. Please see reference to the procedures requiring prior authorization through the online tool below.

https://www.bcbsri.com/BCBSRIWeb/Login.do?redirectTo=/providers/preauth/preauthProviderOverview.jsp

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- Internal Medicine
- Pediatric Medicine
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COVERAGE

Benefits may vary between groups/contracts. Please refer to the appropriate Benefit Booklet, Evidence of Coverage, or Subscriber Agreement for applicable coverage for benefits/coverage.

BACKGROUND

Not applicable

CODING

The following codes, in the attached grid listed in the link below, are covered when the applicable medical criteria are met:

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RELATED POLICIES

Anastomosis of Extracranial-Intracranial Arteries
Balloon Dilation of the Eustachian Tube
Biofeedback
Catheter Ablation as Treatment for Atrial Fibrillation
Corneal Collagen Cross-Linking
Cryosurgical Ablation of Miscellaneous Solid Tumors other than Renal, Liver and Prostate
Diagnosis and Treatment of Sacroiliac Joint Pain
Epidural Injections for Pain Management
Expanded Fertility Services
Gender Affirming Care
Glucose Monitoring – Continuous
Implantation of Intrastromal Corneal Ring Segments
Infertility Services

Intensity Modulated Radiotherapy
Laparoscopic, Percutaneous, and Transcervical Techniques for the Myolysis of Uterine Fibroids and Hysterectomies
Laser Treatment for Proliferative Vascular Lesions
Medical Necessity
Microwave Tumor Ablation
Minimally Invasive Procedures for Back Pain
Miscellaneous Vascular Embolization Procedures
Orthognathic Surgery
Ovarian and Internal Iliac Vein Embolization as a Treatment of Pelvic Congestion Syndrome
Percutaneous Left Atrial Appendage Closure Devices for Stroke Prevention in Atrial Fibrillation
Percutaneous and Subcutaneous Tibial Nerve Stimulation
Prior Authorization of Spinal Procedures
Radiofrequency Ablation of Miscellaneous Solid Tumors Excluding Liver Tumors
Removal of Implantable Devices
Stereotactic Body Radiation Therapy
Surgical Treatment of Snoring and Obstructive Sleep Apnea
Surgical Treatments for Lymphedema and Lipedema
Total Joint Arthroplasty – Hip and Knee
Transcatheter Mitral Valve Repair
Transurethral Water Jet Ablation (Aquablation) for Benign Prostatic Hypertrophy
Varicose Vein Treatment

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Provider Update, January/March/May/June/September/October/November/December 2025
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REFERENCES

Not applicable