

**EFFECTIVE DATE:** 10|01|2026

**POLICY LAST REVIEWED:** 05|06|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>

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)

## **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:

### **Prior Authorization of Services, Treatments or Procedures**

## **RELATED POLICIES**

Balloon Dilation of the Eustachian Tube

Bariatric Surgery

Bioimpedance Devices for Detection and Management of Lymphedema

Bronchial Valves

Catheter Ablation as Treatment for Atrial Fibrillation

Closure Devices for Patent Foramen Ovale and Atrial Septal Defects

Corneal Collagen Cross-Linking

Cryosurgical Ablation of Miscellaneous Solid Tumors other than Renal, Liver and Prostate

Epidural Injections for Pain Management

Expanded Fertility Services

Gender Affirming Care

Implantation of Intrastromal Corneal Ring Segments

Infertility Services

Irreversible Electroporation (IRE) of Tumors Other Than Liver  
Laparoscopic, Percutaneous, and Transcervical Techniques for the Myolysis of Uterine Fibroids and Hysterectomies  
Laser Treatment for Proliferative Vascular Lesions  
Local or Whole Body Hyperthermia  
Medical Necessity  
Microvolt T-Wave Alternans Testing  
Minimally Invasive Procedures for Back Pain  
Miscellaneous Vascular Embolization Procedures  
New Technology and Miscellaneous Services  
Open and Thoracoscopic Approaches to Treat Atrial Fibrillation and Atrial Flutter (Maze and Related Procedures)  
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 Electrical Nerve Field Stimulator System for Functional Abdominal Pain Disorders (IB-Stim)  
Percutaneous and Subcutaneous Tibial Nerve Stimulation  
Percutaneous Revascularization Procedures for Lower Extremity Peripheral Arterial Disease  
Prior Authorization of Spinal Procedures  
Radiofrequency Ablation of Miscellaneous Solid Tumors Excluding Liver Tumors  
Removal of Implantable Devices  
Renal Denervation for Uncontrolled Hypertension  
Surgical Treatment of Snoring and Obstructive Sleep Apnea Syndrome  
Surgical Treatments for Lymphedema and Lipedema  
Total Joint Arthroplasty – Hip and Knee  
Transcatheter Mitral Valve Repair or Replacement  
Transurethral Water Jet Ablation (Aquablation) for Benign Prostatic Hypertrophy

#### **PUBLISHED**

Provider Update, January/February/March/April/July/August 2026  
Provider Update, January/March/May/June/September/October/November/December 2025  
Provider Update, March/June/July/August/September/November/December 2024  
Provider Update, February 2023  
Provider Update, June/December 2022

#### **REFERENCES**

Not applicable

**CLICK THE ENVELOPE ICON BELOW TO SUBMIT COMMENTS**

This medical policy is made available to you for informational purposes only. It is not a guarantee of payment or a substitute for your medical judgment in the treatment of your patients. Benefits and eligibility are determined by the member's subscriber agreement or member certificate and/or the employer agreement, and those documents will supersede the provisions of this medical policy. For information on member-specific benefits, call the provider call center. If you provide services to a member which are determined to not be medically necessary (or in some cases medically necessary services which are non-covered benefits), you may not charge the member for the services unless you have informed the member and they have agreed in writing in advance to continue with the treatment at their own expense. Please refer to your participation agreement(s) for the applicable provisions. This policy is current at the time of publication; however, medical practices, technology, and knowledge are constantly changing. BCBSRI reserves the right to review and revise this policy for any reason and at any time, with or without notice. Blue Cross & Blue Shield of Rhode Island is an independent licensee of the Blue Cross and Blue Shield Association.

