**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/September 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.**