

10 Preauthorization

Excluding plans which allow out-of-network coverage, all inpatient admissions, except for emergency admissions, (HMO and EPO members) should be directed to a BCBSNM contracted facility. For preauthorization, also referred to as prior authorization, prior approval or certification, call the Health Services department at **1-800-325-8334** with the following information:

- Member's name, identification number, and date of birth
- ICD-9 Diagnosis Code, scheduled procedure(CPT and/or HCPC codes), and dates of admission, estimated date of delivery or date of service
- Name of admitting facility
- PCP's name and admitting physician's name, NPI and phone number
- Related medical documentation

The Health Services department will then:

- Evaluate the appropriateness of the admission and level of care using Milliman criteria.
- If approved, Health Services personnel will respond within 5-15 business and/or calendar days with the following:
 - Certify a projected length of stay.
 - Verify member eligibility.
 - If approved, assign an authorization number.
- If not approved, Health Services will call and then follow up with a written explanation of the decision within 72 hours.

Note: "prior approval" refers to medical necessity only. Benefits limitations and eligibility at the time of admission may preclude coverage.

HMO and EPO BCBSNM members must select a hospital within the network of contracted BCBSNM facilities unless they have preauthorization from the Medical Director or his/her designee. BCBSNM PPO members using network hospitals will receive a higher benefit level than they would if services were rendered in an out-of-network hospital.

If the attending physician has privileges at more than one BCBSNM contracted facility, Customer Service can provide information regarding the most cost-effective facility so the member's out-of-pocket expenses are minimized.

If an extension of the initial length of stay is necessary, call the Health Services department at **1-800-325-8334** for extension of length of stay *before* the initial approved length of stay expires. Failure to obtain approval for length of stay beyond that which has been approved may result in reduced payment to the member and/or provider.

For behavioral health services, preauthorization must be obtained from Mesa Mental Health (MMH) *except* for members belonging to the following plans: Federal Employee Program (FEP), New Mexico Medical Insurance Pool (NMMIP), Alliance Indemnity, Giant Industries, Intrepid Mining, Ardent Health Services, or BlueEdge PPO/CDHP. For benefit and eligibility information, call MMH at 1-800-583-6372, or the BCBSNM Provider Service Unit at 1-888-349-3706. See Section 12, Behavioral Health and Chemical Dependency Services, for further information.

Most BCBSNM plans exclude reimbursement for services or do not allow for reimbursement where prior approval is required and has not been obtained. To ensure reimbursement, providers and members must comply with the member's benefit plan requirements for prior approval.

10.1 Services Requiring Preauthorization

The attending physician must obtain preauthorization through the BCBSNM Health Services Department for the services listed below (if covered by the member's plan), except in an emergency.

- Nonemergency or nonurgent care from a nonparticipating provider for HMO and EPO members
- Nonemergency or elective hospital or other facility admission, including rehabilitation, subacute, and skilled nursing care
- High-dose chemotherapy
- Home health care services
- Home IV services
- Infusion center services
- Home dialysis
- Hospice care
- Dental-related procedures
 - Oral/maxillofacial and temporomandibular joint (TMJ) surgery procedures, which may be subject to benefit limitations
- Infertility-related services
- All inpatient surgery and selected outpatient surgeries (also see below) including but not limited to the following:
 - Cochlear implants
 - Hysterectomy
 - Breast reduction
 - Bariatric surgery
 - Cosmetic procedures and all procedures that may be cosmetic, including but not limited to abdominoplasty and other skin reduction procedures
- All transplants and pretransplant evaluations

Note: Benefits for covered services will be approved when the transplant is performed at a facility that contracts with BCBS or through our national transplant network. A case manager can assist with information on the exclusive network of contracted facilities and required approvals. Call the Health Services

department for information on the transplant programs. Benefits will **not** be approved for transplants received at noncontracted facilities. Transplant benefits are limited by the member's specific plan, if covered, and exclude "search" services.

- Certain outpatient procedures, including:
 - Blepharoplasty
 - Rhinoplasty
 - Sclerotherapy
 - Uvulopalatopharyngoplasty (UPPP)
 - Varicose vein treatment by any means, including but not limited to ligation, stripping, sclerotherapy, or laser therapy
 - Vertebroplasty, kyphoplasty and IDET (Intradiscal Electrothermal Annuloplasty)
 - Potentially cosmetic surgery (e.g., keloids, scar revision, orthognathic surgery)
 - Cosmetic procedures and all procedures that may be cosmetic, including but not limited to abdominoplasty and other skin reduction procedures

Note: The above list is not all-inclusive as new surgical procedures may need to be reviewed. Contact the Health Services department regarding any outpatient procedures not listed above.

- Health education and counseling programs received from a provider who is not the member's PCP
 - Outpatient rehabilitative services including physical, occupational, and speech therapy, which may be subject to benefit limitations
 - Cardiac and pulmonary rehabilitation
 - Treatment of dental injuries—excluding initial emergency treatment (Most BCBSNM benefit plans limit coverage to the treatment of accidental injuries to sound, natural teeth)
 - Treatment of TMJ disorders or injuries
 - Durable medical equipment and medical supplies with a purchase price over \$500, or items or equipment requiring long-term rental. Benefits for rental will not exceed the purchase price of a new unit.
 - Orthotics, orthopedic appliances, and devices (including custom-fitted knee braces), and prosthetic devices regardless of total cost (call to verify plan-specific information)
 - Surgically implanted prosthetics, regardless of the total cost
 - Air ambulance services (unless during a medical emergency)
 - CTA scans, MRI of Breast, PET scans
 - Genetic testing or counseling
 - Certain medications require preauthorization and/or have dispensing limits
- Note: For a complete list of drugs requiring Preauthorization please visit bcbsnm.com (select *Providers*, and then *Drug List Limitations, Exclusions, and Preauthorization Criteria* under the *Pharmacy* heading).

- Inpatient, residential, and outpatient behavioral/mental health, substance abuse, and alcoholism services (see Section 12 for further information)

Note: Even if preauthorization is granted for treatment of a particular service, that authorization normally applies only to the medical necessity of treatment. **All services are subject to benefit limitations and exclusions, including consideration of pre-existing conditions.**

We continually evaluate our preauthorization list. Updates are provided in our [Blue Review](#) provider newsletter, and the current list is also available on our website at bcbsnm.com.

10.2 Referrals to Out-of-Network Providers for HMO Members

Although referrals are not required by BCBSNM for any covered service, requests for out-of-network provider services for HMO members require preauthorization. If not obtained, the out-of-network service will not be covered. If you believe the member needs the services of an out-of-network provider, the Health Services department or the Medical Director must review and approve all such requests before services are scheduled or rendered so the HMO member can receive benefits.

Authorizations for out-of-network services for HMO members are rarely considered for nonurgent, nonemergent services, and such preauthorizations will only be considered in the following exceptional circumstances:

- An emergency situation makes the use of an out-of-network provider necessary.
- No participating provider within the BCBSNM network can provide the service needed.

Note: Authorizations for out-of-network providers based on “nonavailability of services” may require that an in-network specialist who treats the condition in question document that such service is not available within the contracted network.

10.3 Emergency Care

Emergency services to screen and stabilize the patient are a benefit without prior approval. Since prudent layperson conditions are in effect, the patient may use 911 or emergency room services if they believe a medical emergency exists.

10.4 Urgent Care

When medically necessary care is provided to the patient in an urgent care facility for an illness or accidental injury, no preauthorization is required.

10.5 Radiology Quality Initiative Program

BCBSNM has partnered with American Imaging Management (AIM) to implement a Radiology Quality Initiative (RQI) program designed to meet the challenges of monitoring rapidly increasing utilization and managing rising high-tech imaging costs. The RQI program includes a preauthorization process promoting the utilization of relevant and cost-effective services by giving providers access to evidence-based guidelines that support ordering the most appropriate services for BCBSNM members.

Compliance with the RQI program is required. **Ordering** physicians (PCP or specialist) for BCBSNM members must contact AIM to obtain an RQI number *prior to scheduling* an imaging exam for the outpatient, diagnostic, nonemergency imaging services listed below when these services are performed in a physicians' office, the outpatient department of a hospital, or a freestanding imaging center:

- CT and CTA scans
- MRI and MRA scans
- PET scans
- Nuclear cardiology studies

Note: *Outpatient diagnostic imaging procedures performed in an emergency room, urgent care facility, ambulatory surgery center, or during an inpatient or observation stay are not impacted by this process and do not require an RQI number.*

Internet Requests

Visit AIM's website at americanimaging.net. AIM's online RQI function is fully interactive, processing RQI requests in real time using proprietary clinical criteria. RQI numbers are provided immediately for approved requests over the Internet. Ordering physicians and imaging physicians must register at americanimaging.net to begin using AIM's interactive website. Once a physician is registered, he or she can request an RQI number and verify that an RQI number was issued or is correct. The content of AIM Web applications is secured through Verisign at 128-bit encryption.

Telephone Requests

Call AIM's RQI Department toll-free at **1-866-745-1789**, Monday through Friday, 8 a.m. to 5 p.m. (Mountain Time), to request an RQI number or to verify that an RQI number has been issued.

Fax Requests

Complete an AIM provider fax form including all required information and fax to **1-800-610-0050**. You may download this fax form from americanimaging.net.

Required Information

AIM will require the information below for every request. Please have the member's chart or office notes available.

- Insurance information
- Member's name, BCBSNM ID number, and date of birth
- Ordering physician's name and address
- Name of imaging facility where the exam will be performed
- Type of service requiring RQI number from AIM (CPT code *optional*)
- Reason (indication) for the imaging procedure and/or ICD-9 CM diagnosis code
- Results of pertinent previous studies (labs, X-rays, etc.) and treatments, including their duration
- Member's symptoms

Based on clinical criteria, AIM will either issue an RQI number or forward the case to a nurse or physician for review. The physician reviewer may contact the ordering physician to discuss the case in greater detail within two business days of receipt of the request. Ordering physicians may also contact AIM's physician reviewer at any time during the RQI process. AIM will provide the ordering physician with an RQI number, which will be valid for 30 days from the date issued. Issuance of an RQI number is not a guarantee of payment. When submitted, the claim will be processed in accordance with the terms of a subscriber's health benefit plan.

Performing providers should confirm that an RQI number was issued. Issuance of an RQI number is not a guarantee of payment. When submitted, the claim will be processed in accordance with the terms of a subscriber's health benefit plan. *Hospitals and freestanding imaging centers that perform the imaging services listed cannot obtain an RQI number.*

Note: Some high-tech imaging services – primarily PET scans and cardiac imaging – may be determined to be as experimental or investigational and thereby denied, consistent with HCSC medical policy. In such situations, the requesting provider will be advised that the member should follow standard appeal processes.

Note: RQI numbers are valid for 30 days from the date issued. Retrospective requests will not be considered.

If you have any questions regarding the RQI program, contact the Network Management Department at **505-837-8800**, or **1-800-567-8540**. You may also visit [American Imaging Management](#) for further information about AIM.