BlueCross BlueShield of New Mexico

PRIOR AUTHORIZATION SERVICES
PRIOR AUTHORIZATION REQUIREMENTS
LIST FOR FULLY INSURED and OTHER ADMINISTRATIVE SERVICES ONLY MEMBERS
EFFECTIVE 01/01/2027

- This document provides an overview of services/care categories for which prior authorization may be required for some commercial, non-HMO Blue Cross and Blue Shield of New Mexico members. Always check eligibility and benefits first via Availity® Essentials before rendering services to determine prior authorization requirements and utilization management vendor information, if applicable
- Prior authorization may be required for certain services when rendered out-of-network or out-of-state, depending on the member's benefits. Please check eligibility and benefits before rendering services out-of-network or out-of-state.
- Eligibility and Benefits Reminder: Obtain eligibility and benefits first to confirm membership, verify coverage, and determine if prior authorization is required.
- If you have any questions, please contact the BCBSNM Health Services Department at 800-325-8334.

- **Inpatient Facility Admission** (acute care, inpatient rehab, cardiac rehab, pain management, skilled nursing, hospice, long term acute care/sub- acute care, etc.)

  - Prior authorization is required for all planned (elective) inpatient hospital care, including surgical, non-surgical, behavioral health and/or substance abuse. Elective admissions must have prior authorization before the admission occurs.

  - In-network unplanned or emergency inpatient hospital care (surgical, non-surgical, behavioral health and/or substance abuse) requires notification of admission to the facility. Pre-stabilization and stabilization care or services are exceptions and don't require notification.

  - Notification is not required for out-of-network unplanned or emergency inpatient hospital care (surgical, non-surgical, behavioral health and/or substance abuse), including emergency admissions and post-stabilization care or services. However, notification of admission to the facility is encouraged.

Inpatient Medical/Surgical Facility Admissions Including Transfers *(Request prior authorization through BCBSNM) **	**Outpatient Medical/Surgical Services** *(through Carelon Medical Benefits Management when applicable or BCBSNM as indicated below) ***
• Acute Care/Hospital • Hospice Care • Long Term Acute/Sub-acute Care • Rehabilitation Facility • Skilled Nursing Facility **Code list not available.* • Notification is not required for unplanned or emergency inpatient hospital care (surgical, non-surgical), including emergency admissions. However, notification of admission to the facility is encouraged. **Outpatient Utilization Management after 2027 renewal ****	• Advanced Imaging/Radiology (Carelon) • Molecular Genetic Lab Testing (Carelon) • Musculoskeletal - Joint, Spine Surgery (Carelon) • Musculoskeletal - Pain (Carelon) • Radiation Therapy / Radiation Oncology (Carelon) • Sleep (ASO – Carelon) **Select Outpatient Services in the following categories until 2027 renewal- (see code list below for specific services that require PA) **:** ○ Ear, Nose and Throat ○ Gastroenterology

Other services that require Prior Authorization includes but not limited to:

- Home Health Services (for ASO only)
- Private Duty Nursing
- Home Hemodialysis* (for ASO only)
- Home Hospice* (for ASO only)
- Home Infusion Therapy (HIT)*
- Medical Transportation *(through Alacura Medical Transportation Management)* **
- Transplant Evaluations and Transplants**

*Codes not available.
***Refer to the Commercial Outpatient Medical Surgical Prior Authorization Code List for codes that may require prior authorization.*

Pharmacy Benefits (Prime): **
Prior Authorization is required on some medications before drug will be covered. Check the drug list guide if Prior Authorization is required for a specific drug.

***Note: Click here to view Prior Authorization/Step Therapy Program information to determine if the drug requires Prior Authorization under Pharmacy Benefits for certain ASO Groups.

Specialty Pharmacy Medications that are covered by Medical Benefits**

- Infusion Site of Care - *medical necessity review required for therapy and for place of infusion.*
- Provider Administered Drug Therapies - *medical necessity review required for therapy only.*
- Medical Oncology & Supportive Care (*through Carelon*) – *medical necessity review required for oncology drugs that are supported by an oncology diagnosis*

***Note: Click here to download a list of Specialty Pharmacy procedure codes that requires Prior Authorization for Administrative Services Only (ASO) Members.*

- Neurology
- Outpatient Surgery (Breast, Deactivation of Headache Triggers, Jaw)
- Pain Management
- Sleep Studies (Fully Insured)
- Wound Care
- Non-Emergent Fixed-Wing Air Ambulance** (for ASO Accounts)

*Codes not available.
***Note: Click here to view or download a list of Medical Surgical procedure codes that requires Prior Authorization for ASO Members.*

Mental Health and Substance Use Disorder Facility Admissions *(Request prior authorization through BCBSNM)**

- Residential Treatment Center (RTC)
- Inpatient Facility Admission
  - Notification is not required for unplanned or emergency inpatient hospital care (mental health and/or substance use disorder), including emergency admissions. However, notification of admission to the facility is encouraged.

Mental Health and Substance Use Disorder Services Outpatient *(through BCBSNM)*

- Applied Behavioral Analysis (ABA)**
- Intensive Outpatient Treatment*
- Partial Hospitalization*
- Repetitive Transcranial Magnetic Stimulation**

*Codes not available.
***Note: Click here to view or download a list of Mental Health procedure codes that require Prior Authorization for ASO Members*

For a comprehensive list of services that might require Prior Authorization and an overview of the Prior Authorization process and requirements at Blue Cross and Blue Shield of New Mexico (BCBSNM), refer to Section 10 of the Blues Provider Reference Manual.

Please note that verification of eligibility and benefits, and/or the fact that a service or treatment has been preauthorized or predetermined for benefits is not a guarantee of payment. Benefits will be decided once a claim is received. They will be based on, among other things, the member's eligibility, and the terms of the member's certificate of coverage effective on the date of service.

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