

**PRIOR AUTHORIZATION REQUIREMENTS
LIST FOR INDIVIDUAL & FAMILY MARKETS,
FULLY INSURED GROUP MEMBERS AND
ADMINISTRATIVE SERVICES ONLY (ASO)
GROUPS**

**Effective 01/01/2023 - 09/17/2023
Updated 07/15/2023**

- BCBSNM has two types of preservice review to assess benefits and medical necessity: prior authorization and recommended clinical review. Similarities predominate over differences between these two types of preservice review. The primary difference is that prior authorization is required for certain services whereas recommended clinical review is elective for services that do not require prior authorization.
- **Prior Authorization** is required by BCBSNM for certain services to determine in advance the Medical Necessity or Experimental, Investigational and/or Unproven nature of certain care and services based on MCG Criteria, Medical Policy and Member benefits. The list below describes the services that require Prior Authorization.
- **Eligibility and Benefits Reminder:** Obtain eligibility and benefits first to confirm membership, verify coverage and determine whether or not 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.

2023 PRIOR AUTHORIZATION REQUIREMENTS

***Inpatient Medical/Surgical Facility Admissions Including Transfers*:**

- Acute Care / Hospital
- Long Term Acute Care / Sub-acute
- Hospice Care
- Rehabilitation Facility
- Skilled Nursing Facility

Note: Prior Authorization is required for all inpatient services.

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

- Dialysis obtained from an Out-of-Network-Provider*
- Home Health Services including but not limited to home private duty nursing (PDN) and home infusion therapy (HIT)*
- Home Hospice*
- Home Infusion Therapy (HIT)*
- Home Hemodialysis*
- Non-Emergent Air Ambulance*
- Transplant Evaluations and Transplants
- Out-of-Network/Out-of-Plan Services*
 - Outpatient elective surgery received in an out-of-network Hospital or ambulatory surgical center*

*Codes not available.

Outpatient Medical/Surgical Services for FI & ASO Members (through Carelon Medical Benefits Management [formerly known as AIM Specialty Health®] or BCBSNM as indicated below)**

- Advanced Imaging / Radiology (Carelon)
- Molecular Genetic Lab Testing (Carelon)
- Musculoskeletal - Joint, Spine Surgery (Carelon)
- Musculoskeletal - Pain (Carelon)
- Radiation Therapy / Radiation Oncology (Carelon)
- Sleep (ASO with Carelon)
- Select Outpatient Services including but not limited to: (BCBSNM)
 - Cardiology – Lipid Apheresis
 - Ear, Nose and Throat
 - Gastroenterology
 - Neurology
 - Outpatient Surgery (Breast, Deactivation of Headache Triggers, Jaw)
 - Pain Management
 - Sleep Studies (FI with BCBSNM)
 - Wound Care

*Codes not available.

****Note: [Click here to view or download a list of Medical Surgical procedure codes that requires Prior Authorization for Fully Insured & ASO Members.](#)**

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 Fully Insured \(FI\) and 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 Fully Insured \(FI\) & Administrative Services Only \(ASO\) Members.](#)

***Behavioral Health and Chemical Dependency Facility Admissions*:**

- Inpatient
- Residential Treatment Center (RTC)

Behavioral Health and Chemical Dependency Services Outpatient:

- Applied Behavioral Analysis (ABA)**
- Electroconvulsive Therapy**
- Intensive Outpatient Treatment*
- Partial Hospitalization*
- Psychological Testing/Neuropsychological Testing**
- Repetitive Transcranial Magnetic Stimulation**

*Codes not available.

[**Note: Click here to view or download a list of Mental Health procedure codes that requires Prior Authorization for Fully Insured & 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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