BlueCross BlueShield of New Mexico

Prior Authorizations

Some situations require prior authorization (approval) from Blue Cross and Blue Shield of New Mexico (BCBSNM). These situations include the following:

- Going outside of the BCBSNM Centennial Care network of providers
- Being admitted to the hospital
- Receiving certain services, such as home health care

BCBSNM's Centennial Care network of providers will get approvals for you.

BCBSNM may not approve the request. If the request is denied by BCBSNM, you and your provider will be notified. The reason for the denial will be explained. Standard requests are reviewed as quickly as your health condition requires, but no later than 14 calendar days after BCBSNM receives the request from your provider. A 14-day extension may be granted, if requested by your provider. It may also be granted if there is a reason that the delay would be in your best interest. For information on expedited reviews, please see the BCBSNM member handbook. If you have other insurance besides Medicare, all BCBSNM Centennial Care prior authorization guidelines still apply.

Prior Authorizations for Native American Members

Native American members do not need prior authorizations to visit any Indian Health Service, tribal health provider, or urban Indian provider (all together referred to as "I/T/U"). This also applies to Tribal 638 facilities. Even if these facilities and providers are not contracted in the BCBSNM Centennial Care provider network, you can still see them. We understand the importance of your relationship with your I/T/U provider. Our Care Coordinators will help you coordinate your care with these providers. If you need a Care Coordinator, call **1-877-232-5518** and select option 3 (TTY: **711**).

You can receive services directly from any I/T/U provider, including facilities that are operated by Native American/Alaskan Indian tribes. You can also get prescriptions at I/T/U facilities that are not on the Drug List without obtaining prior authorization from BCBSNM.

Physical Health Benefits

In the chart below, it says that prior authorization depends on the exact service. These are just some of the services that may need prior authorization.

That means you will need to call Member Services at **1-866-689-1523** (TTY: **711**) to find out if the exact service you are checking on requires prior authorization.

Such services are funded in part with the State of New Mexico.

The following services are covered when medically necessary:

Covered Service	Prior Authorization Required?
Office visits to PCPs or specialists, including dieticians, nurse practitioners, and physician assistants	No
Allergy care, including tests and serum	Dependent on exact service
Diabetes self-management services	Dependent on exact service
Injections	Dependent on exact service
Podiatry (foot and ankle) services	Yes
Minor surgeries	Dependent on exact service
Therapies	Yes
Routine physicals, children's preventive health programs and Tot-to-Teen checkups	No
Medical supplies; durable medical equipment	All medical supplies costing $2,500 or more require prior authorization. Please call Member Services and ask to speak with a Care Coordinator/Case Manager for more information.
Hospital services (inpatient, outpatient, and skilled nursing)	Yes
Nursing facilities and swing bed hospital services	Yes
Dialysis services	No
Surgery, including pre-and post-operative care: Organ transplants	Dependent on surgery; all transplants and pre-transplant evaluation require prior authorization
Emergency dental care	Yes
Special rehabilitation services, such as: Physical therapy Occupational therapy Speech therapy Cardiac rehabilitation Pulmonary rehabilitation	Yes
Laboratory, X-ray, EKGs, medical imaging services, and other diagnostic tests	Dependent on exact service
Home health care and intravenous services	Yes
Personal care services and private duty nursing (home- or school-based) for children under age 21, who qualify under the EPSDT program	Yes If your child is disabled, he or she may qualify for more services. Please call Member Services and ask to speak with a Care Coordinator/Case Manager for more information.
Hearing services	Yes
Second opinions	No
Chemotherapy and radiation therapy	Yes
Nutritional counseling services	Dependent on exact service
Covered services provided in school-based health clinics	No
Pregnancy-related and maternity services	No

Such services are funded in part with the State of New Mexico.

Covered Service	Prior Authorization Required?
Ground and air ambulance	Ground - No Air – Yes
PET, MRA, MRI, and CT scans	Yes
Hospice	Yes
Home birthing	Yes
Nutritional products and special medical foods	Yes
Breast pumps and replacement supplies	Electric Breast Pumps - No Manual Breast Pumps – No
Bariatric surgery	Yes

Behavioral Health Benefits

Behavioral health services help to support people facing emotional problems, mental illness, and/or substance abuse. Sometimes, behavioral health conditions may occur in combination with each other, or in addition to a physical condition. Covered services are services paid for by BCBSNM Centennial Care. The type of service you may need depends on your situation. A Care Coordinator can help you find out what services are covered for you and whether the service will need to be preauthorized. If you need a Care Coordinator, call **1-877-232-5518** and select option 3 (TTY: **711**).

Some of the services available for the behavioral health benefit are included in the table below:

Covered Service	Age Applies To	Prior Authorization Required?
Psychiatric Inpatient Hospital Services	All ages	Yes
Inpatient Professional Services	All ages	No
Partial Hospitalization	All ages	Yes
Hospital Outpatient Services	All ages	No
Evaluation	All ages	No
Psychological Testing	All ages	Yes
Assessment	All ages	No
Counseling	All ages	No
Therapy (Services beyond core coverage may need prior authorization)	All ages	No
Comprehensive Community Support Service (Services beyond core coverage may need prior authorization)	All ages	No
Telehealth Services	All ages	No
Intensive Outpatient for Substance Abuse and Co-occurring Disorders	All ages	No
Behavior Support Consultation	All ages	No
Recovery Services	All ages	No
Pharmacy Services	All ages	May be required based upon the drug prescribed

Covered Service	Age Applies To	Prior Authorization Required?
Applied Behavior Analysis (Autism Spectrum Disorder)	12 months up to 21 years of age	Yes
Residential Treatment Center (RTC) (Services beyond core coverage may need prior authorization)	Under age 21	Yes
Group Home Services	Under age 21	Yes
Treatment Foster Care (Services beyond core coverage may need prior authorization)	Under age 21	Yes
Day Treatment Services	Under age 21	No
Multi-Systematic Therapy	Under age 21	No
Behavioral Management Skills Development Services	Under age 21	No
School-Based Counseling	Under age 21	No
Psychosocial Rehabilitation Program (PSR)	Age 21 and older	No
Assertive Community Treatment	Age 21 and older	No
Psychiatric Emergency Room Services	Age 21 and older	No

Long-Term Care and Community Benefits

Centennial Care covers long-term care services, if you qualify. Long-term care includes medical and non-medical care for people who have disabilities or long-lasting illnesses. Long-term care helps meet health and personal needs. Most long-term care is to help people with support services, such as activities of daily living like dressing, bathing, and using the bathroom. Long-term care can be provided in the home and in the community. If your care requires it, coverage is available for nursing facilities and swing bed hospital services. Prior authorization is required.

If you live in a nursing home and want to move out, we want to help you find a place that is right for you. Please call your Care Coordinator to learn more about Community Benefits. Community Benefits are services that give help to people who need long-term supports and services. This support helps people so they may stay in their own home. Community Benefits do not provide 24-hour care. They are meant to help a person's natural supports.

Everyone has the right to apply for the Community Benefit. The person applying must place their name on the Central Registry. Individuals may apply by calling the Aging and Disability Resources Center. The toll-free number for the Aging and Disability Resources Center is **1-800-432-2080**. Only residents of the State of New Mexico may be registered. Eligibility for Community Benefits is based on long-term care needs, medical criteria, and a person's financial situation.

Prescription Drug Benefits

Centennial Care covers drugs and other items listed in this section only when bought at a participating pharmacy (unless required in an emergency), or ordered through the Mail Order Service.

The BCBSNM Centennial Drug List is a list of drugs that are covered under Centennial Care. HSD reviews the Drug List for all Medicaid managed care plans and it is updated quarterly. BCBSNM will send you a copy of the Drug List if you request one. To request a copy, call Member Services at **1-866-689-1523** (TTY: **711**). You can also see the Drug List on our website, **bcbsnm.com/medicaid**.

To make sure you do not have any problems filling your prescriptions, always ask your provider to check the Drug List. If your provider prescribes a drug that is not on the list or that is not already approved to treat your condition, the provider must have prior authorization from BCBSNM before you can get that medicine. A prior authorization is sometimes called an "exception." Without prior authorization, the pharmacy will not be able to fill your prescription. We will look at your provider's request and give approval only if we find the drug is medically necessary.

Most of the time, we give approval for two reasons:

- A similar drug on the list does not improve your health as much as the drug you are asking for
- A similar drug on the list is harmful to your health

Specialty pharmacy drugs, such as most injectable and high-cost drugs, require prior authorization from BCBSNM. Some self-administered drugs, whether injectable or not, are specialty pharmacy drugs and you must order them through a participating specialty pharmacy provider in order to be covered. Intestinal nutritional products must be prescribed by a Centennial Care network provider and must have prior authorization from BCBSNM to be covered.

Vision Benefits

BCBSNM covers the following routine vision care, eyeglasses, and eye checkups through a program administered by Davis Vision.

Below are some of the services covered under your BCBSNM Centennial Care plan:

Covered Service	Time Limit	Age Applies To
Minor repairs to eyeglasses	Any time	All ages
Lens tinting if certain conditions are present	Any time	All ages
Lenses to prevent double vision	Any time	All ages
Eye exam for medical conditions (diabetes, cataracts, hypertension, and glaucoma) requiring follow-up and treatment	Every 12 months or as medically needed	All ages
One routine eye exam	Every 12 months	Under age 21
Frames	Every 12 months	Under age 21
Replacement lenses, if lost, broken, or have deteriorated	Any time	Under age 21
Corrective lenses	1 set every 12 months	Under age 21
One routine eye exam	Every 36 months	Age 21 and older
Frames	Every 36 months	Age 21 and older
Replacement frames and lenses for members with a developmental disability, if lost, broken, or have deteriorated	Any time	Age 21 and older
Corrective lenses	1 set every 36 months	Age 21 and older

Such services are funded in part with the State of New Mexico.

Please call Member Services at **1-866-689-1523** (TTY: **711**) for more information on prior authorizations and to verify what vision benefits will apply to you. You may receive more than the standard number of eye exams each year if you have diabetes or other diseases that could affect your eyesight.

Dental Benefits

Centennial Care covers services for eligible members through a program administered by DentaQuest®. Dental visits are necessary for good health. Regular dental checkups and cleanings are important for children as well as adults. Schedule a well-baby checkup with your dental provider by the time your baby is two years old.

If you need oral surgery or have an accident that injures your teeth, the services may be covered through Centennial Care as part of the medical/surgical program. Please call Member Services at **1-866-689-1523** (TTY: **711**) before receiving such services, so you know which providers will be approved for payment.

The following services are covered when medically necessary. These are just some of the services that may need prior authorization.

Covered Service	Time Limit	Age Applies To	Prior Authorization Required?
Tooth extractions (pulling of teeth)	N/A	All ages	No
Emergency services	No limit	All ages	No
One complete series of intraoral X-rays (with one added set of bitewing X-rays)	Every five years; Added set of bitewing X-rays once every 12 months	All ages	No
One complete oral exam	Every 12 months	All ages	No
Fillings, stainless steel crown, resin crown, and one recementation of a crown or inlay or fixed bridge	N/A	All ages	No
Periodontic scaling and root planning	N/A	All ages	Yes
Two denture adjustments	Every 12 months	All ages	No
Incision and drainage of an abscess	N/A	All ages	No
One cleaning and periodic exam	Every six months	Under age 21	No
One fluoride treatment	Every six months	Under age 21	No
One sealant for each permanent molar (Replacement of a sealant within the five year period requires prior authorization	Every five years	Under age 21	No
General anesthesia and IV sedation, including nitrous oxide	N/A	Under age 21	No
Therapeutic pulpotomy	N/A	Under age 21	No
Orthodontic services (braces)	N/A	Under age 21	Yes
Dental services in a hospital	N/A	Under age 21	No - Dentist Yes – Facility
Reimplantation of permanent tooth	N/A	Under age 21	No

Such services are funded in part with the State of New Mexico.

Covered Service	Time Limit	Age Applies To	Prior Authorization Required?
Fixed space maintainers (passive appliances)	N/A	Under age 21	Yes
General anesthesia and IV sedation, not including nitrous oxide	N/A	Age 21 and older	No
One cleaning	Every 12 months; Every six months for members with developmental disabilities	Age 21 and older	No
One fluoride treatment	Every 12 months	Age 21 and older	Yes

Note: Federally Qualified Health Center members will not need prior authorization on any dental service.

Transportation Benefits

If you do not have a car or anyone to give you a ride, you may be eligible for transportation to help you get to your non-emergency medical, long-term care, or behavioral health appointments. If you have an emergency and you need help getting to an emergency room, call 911.

LogistiCare coordinates all non-emergency transportation for members, including food and lodging expenses, when you have to travel a long distance to get covered medical care. You can use these benefits only for medical needs. Transportation for any non-medical reason is not covered.

Some of the covered transportation services are included in the table below:

Covered Service	Prior Authorization Required?	Prior Notice to LogistiCare
Ride to routine appointment	No	3 working days up to two weeks
Ride to behavioral health appointment	No	3 working days up to two weeks
Mass transit	No	4 working days
Mileage reimbursement	Yes	14 days prior up to the day of appointment
Meals	Yes	3 working days
Lodging	Yes	3 working days

If you must travel more than 65 miles one way or must travel outside New Mexico to receive health care, you must call LogistiCare for approval to request transportation. If you have to travel to another city or state for an approved appointment, it is important to make plans for these trips as soon as possible and no later than three working days before the appointment.

You will have to call BCBSNM Member Services first, if you need a ride to any out-of-network provider (even for family planning and even if you already have prior

authorization for the visit). The approval for a ride to an out-of-network provider is different from any prior authorization you might have received for the provider visit itself.

Alternative Benefit Plan (ABP)
Below are some of the covered and non-covered ABP services. Some of the limitations may not apply for members ages 19 and 20. All services may be subject to some limitations, including prior authorizations. Please call Member Services at **1-866-689-1523** (TTY: **711**) for more information.

ABP Plan Covered Services	Details
Autism Spectrum Disorder	Covered through age 22
Bariatric Surgery	Limited to one per lifetime
Behavioral Health Professional Services: Outpatient Behavioral Health and Substance Abuse Services	None
Cancer Clinical Trials	None
Cardiac Rehabilitation	Limited to 36 hours per cardiac event
Chemotherapy	None
Dental Services	See Member Handbook for limitations
Diabetes Treatment, including Diabetic Shoes	None
Dialysis	None
Disease Management	None
Durable Medical Equipment	Certain items have set limitations
Educational Materials and Counseling for a Healthy Lifestyle	None
Emergency Services (including emergency room visits and psychiatric ER)	None
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)	For individuals age 19 and 20
Eye Exams and Treatment Related to Treatment and Testing of Eye Diseases Only	Refraction is not covered
Family Planning, Sterilization, Pregnancy Termination, Contraceptives	None
Eyeglasses and Contact Lenses	Covered only for aphakia (following removal of the lens)
Hearing Testing or Screening as part of a Routine Health Exam	Hearing aids not covered; hearing testing by an audiologist or hearing aid dealer is not covered
Home Health Services	Limited to 100 visits per year; a visit cannot exceed four hours
Hospice Services	Limited to $10,000 lifetime benefit
Hospital Inpatient	Certain items have set limitations
Hospital Outpatient	Certain items have set limitations
Immunizations	None
Inhalation Therapy	None
IV Infusions	None
Laboratory Services, including Diagnostic Testing and Other Age-Appropriate Tests	None
Mammography, Colorectal Cancer Screenings, Pap Smears, PSA Tests and Other	None

Such services are funded in part with the State of New Mexico.

ABP Plan Covered Services	Details
Age-Appropriate Tests	
Medical Supplies: Diabetic Supplies Only	None
Medication-Assisted Treatment for Opioid Dependence	Some limitations apply
Nutritional Counseling	None
Obstetric/Gynecological Care, Prenatal Care, Deliveries, Midwives	None
Orthotics	Foot orthotics, including shoes and arch supports, are only covered when an integral part of a leg brace or diabetic shoes
Physician and Most Practitioner Services and Visits, including Maternity Services, Surgeries, and Anesthesia	None
Podiatry Services	None
Prescription Drug Items	Over-the-counter drug items are not covered, except for prenatal drug items, low-dose aspirin as preventive for cardiac conditions, contraceptive drugs and devices, and items for treating diabetes
Preventive Care	ABP preventive services include the A&B recommendations of the United States Preventive Services Task Force (USPSTF)
Prosthetics	None
Pulmonary Rehabilitation	Limited to 36 hours per year
Radiology, including Diagnostic Imaging and Radiation Therapy, Mammography, and other Age-Appropriate Imaging	None
Reconstructive Surgery	None
Rehabilitation and Habilitation: Physical Therapy, Occupational Therapy, and Speech and Language Pathology	Short-term therapy only (significant and demonstrable improvement within a two-month period from the initial date of treatment); extension of short-term therapy may be extended for one period of up to two months; long-term therapy not covered
Rehabilitation Inpatient Hospitalization: Step-Down Lower Level of Care from an Acute Care Hospital for not more than 14 Days	Extended care hospitals (also called long-term care hospitals) are not covered
Reproductive Health Services	None
Skilled Nursing	None
Sleep Studies	None
Telemedicine	None
Tobacco Cessation Counseling	None
Transplant Services	Limited to 2 per lifetime
Transportation Services (Emergency and Non-Emergency Medical), including Air and Ground Ambulance, Taxi, and Handivan	See Member Handbook for more information
Urgent Care Services	None

Such services are funded in part with the State of New Mexico.

Value-Added Services

In addition to covering the services required by state law, your Blue Cross Community Centennial health plan offers extra services to help keep you and your family healthy. These are called “value-added services.”

Some value-added services are not always available all year and may have additional limits and steps. Call Member Services at **1-866-689-1523** (TTY: **711**) for more details. Also, some services may change from year to year. These services include:

Value-Added Service	Applies To	Members on Standard Medicaid Plan	Members on Alternative Benefit Plan (ABP)	Members on ABP-Exempt Plan	Prior Authorization Required for Value-Added Service?
Adult Chemical Dependency Residential Treatment Center (RTC) Services	RTC services for members age 21 and older with severe medical disorders and patients with alcohol/substance abuse problems	✓	✓	✓	Yes
Adult Routine Physicals and Related Testing	Members age 21 and older	✓	Not a value-added service; standard ABP benefits apply	Not a value-added service; standard ABP benefits apply	No
One Box of Baby Diapers	Newborn members	✓	✓	✓	Yes
Dental Varnish in a PCP’s Office	Birth to age three	✓	Not eligible	Not eligible	No
Electroconvulsive Therapy (ECT) (Treatment for Psychiatric Conditions)	Members who meet standard ECT medical necessity criteria	✓	Not a value-added service; standard ABP benefits apply	Not a value-added service; standard ABP benefits apply	Yes
Extended Adult Vision Benefits (One Vision Exam, Set of Frames, and Lenses Every 12 Months)	Members age 21 and older	✓	Not eligible	Extended 12-month benefits do not apply (Coverage every 36 months for members age 21 and older)	Yes
Extended Lodging for Homeless Members (Post-Hospitalization Lodging)	Homeless members	✓	✓	✓	Yes
Full Medicaid Benefits for Pregnant Women Categories of Eligibility (COE) 301 and 035 (Full Benefits including Dental, Vision, Prescription Drugs, and Behavioral Health)	Certain pregnant members	✓	Not a value-added service; standard ABP benefits apply	Not a value-added service; standard ABP benefits apply	Only if a particular service should require one
Infant Car Seat	Pregnant members	✓	✓	✓	Yes
Infant Mental Health Program	Birth to age three	✓	Not eligible	Not eligible	Yes
Inpatient Detox at Non-Hospital-Based Facilities	Chemically dependent members	✓	✓	✓	Yes
Portable Infant Crib	Pregnant members	✓	✓	✓	Yes
Traditional Healing Benefit (Reimbursement for Traditional Healing Practices Used to Treat Medical Conditions)	Native American members	✓	✓	✓	Yes
Transitional Living for Chemically Dependent/Psychiatrically Impaired Adults and Children	Members enrolled in outpatient substance abuse center or in active treatment for psychiatric issues	✓	Not eligible	Not eligible	Yes

Such services are funded in part with the State of New Mexico.

Prior Authorizations for Out-of-Network Providers

Providers and facilities not listed in BCBSNM's provider directory or in BCBSNM's online Provider Finder are considered out-of-network providers. If you have Medicare, your Medicare PCP is not considered out of network. In order for services from an out-of-network provider to be covered by BCBSNM, you need to get a prior authorization from BCBSNM, except in the situations listed below:

- Emergency care (life-threatening) from a hospital and emergency ambulance
- Urgent care received at an urgent care center
- Family planning such as education and counseling about birth control and pregnancy, lab tests, follow-up care, birth control pills, and devices such as IUDs and condoms, tubal ligation, and vasectomies
- Native Americans visiting I/T/U providers or Tribal 638 facilities

If your out-of-network service is preauthorized and that provider recommends another out-of-network service, it is your responsibility to make sure you have prior authorization for the new service. If you do not get prior authorization before you receive out-of-network services, you may have to pay the provider. Call BCBSNM Member Services for help or for prior authorization at **1-866-689-1523** (TTY: **711**).

If BCBSNM provides prior authorization for you to see an out-of-network provider, you will not have to pay more than you would have had to if you had received services from an in-network provider.

Referrals

BCBSNM does not require a referral when you see any in-network medical, behavioral, or long-term care provider. A referral is not needed for emergency services, Early Periodic Screening, Diagnosis and Treatment (EPSDT) services, women's services, or any service, such as vision and dental.

When you need to go to a specialist, remember that your PCP knows you and your medical history. They may be able to suggest a treatment or a provider that is better for you. Please talk to your PCP if you can before making an appointment with a specialist. Some providers may not accept you as a patient, if you have not received a written referral by another provider. This is sometimes referred to as a physician-to-physician referral. BCBSNM does not need to be told when this happens.

Such services are funded in part with the State of New Mexico.