BlueCross BlueShield of New Mexico

PRIOR AUTHORIZATION REQUIREMENTS LIST FOR INDIVIDUAL & FAMILY MARKETS AND FULLY INSURED GROUP MEMBERS

Effective 01/01/2024

- 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 prior authorization is required.
- If you have any questions, please contact the BCBSNM Health Services Department at 800-325-8334.

- **Inpatient Facility Admission**+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.

2024 PRIOR AUTHORIZATION REQUIREMENTS EFFECTIVE 01/01/2024

Inpatient Medical/Surgical Facility Admissions Including Transfers:

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

Mental Health Admissions:

- Inpatient
- Residential Treatment Center (RTC)

Note: Prior Authorization is required for all elective inpatient facility care before the admission occurs.
Other services that require Prior Authorization include out of network exceptions for non-participating providers.

Substance Use Disorder Facility Admissions:

Inpatient Rehab

Prior authorization is required for all planned elective substance use disorder inpatient hospital care, except for the initial 4 days for in-network inpatient substance use disorder about treatment.

Pharmacy Benefits (Prime):*

Prior Authorization is required on some medications before the 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).

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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