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Prior Authorizations

Some situations require prior authorization (approval) from Blue Cross and Blue Shield of New Mexico (BCBSNM). These situations include, but are not limited to:

- Going outside of the BCBSNM network of providers (except for emergency care, urgent care at an urgent care center, certain family planning services, and Native Americans going to Indian Health Services)
- Being admitted to the hospital
- Receiving certain services from any provider, whether in-network or out-of-network

To find out if a certain service requires approval from BCBSNM, look at the three lists below. There is a list for physical health services, a list for behavioral health services, and a list for community benefit services.

If you seek services from providers in the BCBSNM network, those providers will know which services need approval from BCBSNM. They will also ask BCBSNM for approvals on your behalf. If you get approval to go to an out-of-network provider for a service and that provider recommends another out-of-network service, you are responsible to get approval from BCBSNM.

Standard requests for approvals are reviewed by BCBSNM as quickly as your health condition requires, but no later than 7 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*.

BCBSNM may not give approval. If the request for approval is denied by BCBSNM, you and your provider will be notified. The reason for the denial will be explained along with your appeal and fair hearing rights.

If you have other insurance besides Medicare, all BCBSNM prior authorization (approval) requirements still apply.

Prior Authorizations for Native American Members

Native American members do not need prior authorizations (approvals) 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 provider network, you can still see them without approval from BCBSNM. 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** (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 Preferred Drug List without obtaining approval from BCBSNM.

Physical Health Services

Physical health services are those that support a person's body. They may include preventive care services, well-child visits, early and periodic screening, diagnostic and treatment (EPSDT), family planning services, and urgent or emergency care. Covered services available for the Standard Medicaid Plan and Alternative Benefit Plan (ABP) are listed in the table below. Covered services are services paid for by BCBSNM. The "✓" in the column will tell you if the service(s) are covered for the Standard Medicaid Plan and/or the ABP.

Sometimes it says in the table that prior authorization is "dependent on exact service." That means your BCBSNM network provider may need to call Member Services at **1-866-689-1523** (TTY: **711**) to find out if the exact service they are checking on requires prior authorization. You are also welcome to call Member Services about prior authorizations or any other questions you may have about your health plan.

The physical health services listed below are covered when medically necessary. Other terms, conditions, and/or limitations may apply.

PHYSICAL HEALTH SERVICES			
Service	**Standard Medicaid Plan Covered Service**	**ABP Covered Service**	**Prior Authorization?**
Allergy care, including tests and serum	✓	✓	Dependent on exact service
Anesthesia services	✓	✓	No
Bariatric surgery	✓	Lifetime limit	Dependent on exact service
Breast pumps and replacement supplies	✓	✓	No - subject to benefit and Durable Medical Equipment (DME) dollar amount
Cancer clinical trials	✓	✓	Yes
Chemotherapy and radiation therapy	✓	✓	Dependent on exact service
Community interveners for deaf and blind	✓	✓	Yes
Covered services provided in school-based health clinics	✓	✓	No
Dialysis services	✓	✓	Notification is required

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PHYSICAL HEALTH SERVICES			
Service	**Standard Medicaid Plan Covered Service**	**ABP Covered Service**	**Prior Authorization?**
DME and supplies	✓	✓ Limits apply	Dependent on exact service
Early and Periodic Screening, Diagnosis and Treatment (EPSDT)	✓	✓ Age limited	No
Emergency dental care	✓	✓	No
Emergency services	✓	✓	No
EPSDT personal care services	✓	✓ Age limited	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
EPSDT private duty nursing	✓	✓ Age limited	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
EPSDT rehabilitation services	✓	✓ Age limited	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
Family planning	✓	✓	No
Ground and air ambulance	✓	✓	Ground - No Air - Yes, fixed wing air ambulance
Hearing services and devices	✓	✓ Age limited	Yes
Home birthing	✓	✓	Dependent on exact service
Home health care and intravenous services	✓	✓ Limits apply	Yes
Hospice services	✓	✓	Yes
Hospital services (inpatient, outpatient, and skilled nursing)	✓	✓	Dependent on exact service

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PHYSICAL HEALTH SERVICES			
Service	**Standard Medicaid Plan Covered Service**	**ABP Covered Service**	**Prior Authorization?**
Inhalation therapy services	✓	✓	No
Injections	✓	✓	Dependent on exact service
Inpatient rehabilitative facilities	✓	✓ Skilled nursing or acute rehab facility only	Yes
IV outpatient services	✓	✓	Yes
Laboratory, X-ray, EKGs, medical imaging services, and other diagnostic tests	✓	✓	Dependent on exact service
Long-term services and supports	✓	✓	Yes - please call Member Services and ask to speak with a Care Coordinator for more information
Molecular genetics	✓	✓	Dependent on exact service
Nursing facility services	✓	✓	Yes
Nutritional counseling services	✓	✓	Dependent on exact service
Nutritional services	✓		Dependent on exact service
Office visits to PCPs or specialists, including dieticians, nurse practitioners, and physician assistants	✓	✓	No
Organ and tissue transplant services	✓	✓ Lifetime limit	All transplant and pre-transplant evaluations require prior authorization
Orthotics and prostheses	✓	✓ Limits apply	Dependent on exact service
Outpatient professional services	✓	✓	No
Outpatient surgery	✓	✓	Dependent on exact service
PET, MRA, MRI, and CT scans	✓	✓	Dependent on exact service
Pharmaceutical gender reassignment services	✓	✓	Yes
Physical therapy	✓	✓ Limits apply	Dependent on exact service
Podiatry (foot and ankle) services	✓	✓ Limits apply	Dependent on exact service
Pregnancy-related and maternity services, including pregnancy termination procedures	✓	✓	No

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PHYSICAL HEALTH SERVICES			
Service	**Standard Medicaid Plan Covered Service**	**ABP Covered Service**	**Prior Authorization?**
Primary gender reassignment (male-to-female or female-to-male) chest and/or genital surgeries	✓	✓	Yes
Routine physicals, children's preventive health programs and Tot-to-Teen checkups	✓	✓	No
Smoking cessation services	✓	✓	No
Special rehabilitation services, such as physical therapy, occupational therapy, speech therapy, cardiac rehabilitation, pulmonary rehabilitation	✓	✓ Limits apply	Dependent on exact service
Telemedicine services	✓	✓	No
Treatment of diabetes	✓	✓	Dependent on exact service
Urgent care services	✓	✓	No

Behavioral Health Services

Behavioral health services are covered for the treatment of mental, emotional or substance use disorder. Sometimes, behavioral health conditions may occur in combination with each other, or in addition to a physical condition. Covered services available for the behavioral health benefit on the Standard Medicaid Plan and Alternative Benefit Plan (ABP) are listed in the table below. Covered services are services paid for by BCBSNM. The "✓" in the column will tell you if the service(s) are covered for the Standard Medicaid Plan and/or the ABP.

Sometimes it says in the table that prior authorization is "dependent on exact service." That means your BCBSNM network provider or Care Coordinator may need to call Member Services at **1-866-689-1523** (TTY: **711**) to find out if the exact service they are checking on requires prior authorization or if it is a covered service. If you need a Care Coordinator, call **1-877-232-5518** (TTY: **711**). You are also welcome to call Member Services about prior authorizations or any other questions you may have about your health plan.

The behavioral health services listed below are covered by BCBSNM:

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BEHAVIORAL HEALTH SERVICES				
Service	**Standard Medicaid Plan Covered Service**	**ABP Covered Service**	**BH Age**	**Prior Authorization?**
Accredited Residential Treatment Center Services for Adults with Substance Use Disorders	✓	✓	18 years and older	Yes
Accredited Residential Treatment Center Services for Youth	✓	✓	Under age 21	Yes
Applied Behavior Analysis (ABA) Stage 1 and 2	✓	✓	12 months and older	Yes, dependent upon exact service
Applied Behavior Analysis (ABA) Stage 3	✓	✓	12 months and older	Yes, dependent upon exact service
Assertive Community Treatment	✓	✓	18 years and older	No
Behavior Management Services	✓	✓	Under age 21	No
Cognitive Enhancement Therapy	✓	✓	18 years and older	No
Comprehensive Assessments	✓	✓	All ages	No
Comprehensive Community Support Services (CCSS)	✓	✓	All ages	No
Crisis Intervention	✓	✓	All ages	No
Crisis Triage Centers	✓	✓	All ages	No
Day Treatment	✓	✓	Under age 21	No
Electroconvulsive Therapy		✓	All ages	No
Emergency Services	✓	✓	All ages	No
Family Peer Support Services	✓	✓	All ages	No
Family Support (Behavioral Health)	✓	✓	All ages	No
Group Home	✓	✓	Under age 21	Yes
Inpatient Psychiatric Service	✓	✓	All ages	Yes
Inpatient Substance Abuse Services	✓	✓	All ages	Yes
Medication Assisted Treatment: Buprenorphine for Opioid Use Disorder	✓	✓	All ages	No
Multi-Systemic Therapy	✓	✓	Ages 10 to 18	No
Non-Accredited Residential Treatment Center Services for Youth	✓	✓	Under age 21	Yes
Opioid Treatment Program	✓	✓	All ages	No
Outpatient Crisis Stabilization Center	✓	✓	14 years and older	No
Outpatient Professional Services	✓	✓	All ages	No

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BEHAVIORAL HEALTH SERVICES				
Service	**Standard Medicaid Plan Covered Service**	**ABP Covered Service**	**BH Age**	**Prior Authorization?**
Partial Hospitalization	✓	✓	5 years and older	Yes, requires prior authorization beyond 45 days
Peer Support Services	✓	✓	All ages	No
Psychological/Neuropsychological Testing	✓	✓	All ages	No
Psychosocial Rehabilitation (PSR) Program	✓	✓	18 years and older	No
Recovery Services	✓	✓	All ages	No
Respite Care	✓	✓	Under age 21	Yes, for services beyond 30 days or 720 hours in a calendar year
School Based Counseling	✓	✓	All ages	No
Screening, Brief Intervention, Referral to Treatment (SBIRT) Services	✓	✓	Age 11 and older	No
Smoking Cessation	✓	✓	Under age 21 OR for pregnant members	No
Standard Office Visits to Mental Health Specialists (which could include counselors, social workers, psychiatrists, or psychologists)	✓	✓	All ages	No
Sub Acute Residential Treatment Center for Youth	✓	✓	Under age 21	Yes
Supportive Housing	✓	✓	All ages	No
Telemedicine Services	✓	✓	All ages	No
Treat First	✓	✓	All ages	No
Treatment Foster Care	✓	✓	Under age 21	Yes

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Long-Term Care and Community Benefit Services

Turquoise 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, in the community, in assisted living, or in the nursing home. 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. Natural supports are sources of support that come directly from people and communities, such as family, school, and work.

Everyone has the right to apply for the Community Benefit. Individuals may apply by calling the New Mexico Aging and Disability Resources Center. The toll-free number for the Aging and Disability Resources Center is **1-800-432-2080** (TTY: **505-476-4939**). 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.

Covered services available for the Community Benefit are listed in the table below. Please remember that some of these services are only covered for Agency-Based Community Benefits (ABCB) and some for Self-Directed Community Benefits (SDCB). Covered services are services paid for by BCBSNM. The "✓" in the column will tell you if the service(s) are covered for ABCB, SDCB, or both.

The Community Benefit Services listed below are covered by BCBSNM:

COMMUNITY BENEFIT SERVICES				
Service	**ABCB**	**SDCB**	**Prior Authorization?**	**Details**
Adult Day Health	✓		Yes	
Assisted Living	✓		Yes	These services will not be covered for individuals in Assisted Living Facilities, Personal Care, Respite Environmental Modifications, Emergency Response, or Adult Day Health. The Assisted Living Program is responsible for all of these services at the Assisted Living Facility.
Behavioral Support Consultation	✓	✓	Yes	

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COMMUNITY BENEFIT SERVICES				
Service	**ABCB**	**SDCB**	**Prior Authorization?**	**Details**
Community Transition (community reintegration members only)	✓		Yes	**Limit:** Coverage for these services is limited to $3,500 per person every five years. Deposits for Assisted Living Facilities are limited to a maximum of $500. In order to be eligible for this service, the person must have a nursing facility stay at least 90 days prior to transition into the community.
Customized Community Supports		✓	Yes	
Emergency Response	✓	✓	Yes	
Employment Supports	✓	✓	Yes	
Environmental Modification	✓	✓	Yes	**Limit**: Coverage for these services is limited to $6,000 every 5 years.
Home Health Aide	✓	✓	Yes	
Nutritional Counseling	✓	✓	Yes	
Personal Care Services (consumer-directed and consumer-delegated)	✓		Yes	
Private Duty Nursing Services for Adults (RN or LPN)	✓	✓	Yes	
Related Goods (phone, internet, printer, etc.)		✓	Yes	**Limit:** Coverage is limited to $2,000 every year (this is separate from the one-time funding for start-up goods). Experimental or prohibited treatments and goods are not covered.
Respite	✓	✓	Yes	**Limit:** Coverage is limited annually to 300 maximum hours per care plan year.
Respite RN	✓	✓	Yes	**Limit:** Coverage is limited annually to 300 maximum hours per care plan year. Additional hours may be requested if an eligible member's health and safety needs exceed the specified amount. Nursing respite services must not be provided by a member of the member's household or by any relative approved as the employed caregiver.
Sefl-Directed Personal Care (Homemaker)	✓	✓	Yes	
Skilled Maintenance Therapy Services (occupational, physical, and speech therapy)	✓	✓	Yes	A signed therapy referral for treatment notice must be provided from the member's Primary Care Provider.

COMMUNITY BENEFIT SERVICES				
Service	**ABCB**	**SDCB**	**Prior Authorization?**	**Details**
Specialized Therapies (acupuncture, biofeedback, chiropractic, cognitive rehabilitation therapy, hippotherapy, massage therapy, naprapathy, Native American healers)		✓	Yes	**Limit:** Coverage is limited to $2,000 every year (annually) for all combined therapy services (Value-Added Services have separate limits).
Start-up Goods		✓	Yes	**Limit:** One-time coverage up to $2,000
Transportation – Non-Medical		✓	Yes	**Limit:** Only vehicle mileage and bus/taxi passes are covered. Coverage is limited to $1,000 every year for vehicle mileage and bus/taxi passes. Not a covered service for minors. Limited to a 75-mile radius of the member's home.

NOTE: There is an annual cost limit for community benefits. It is set by HCA. Your Comprehensive Needs Assessment will decide your cost of care for community benefits. If the cost from your Comprehensive Needs Assessment is greater than the annual cost limit from HCA, BCBSNM is not required to pay more than the limit from HCA.

Prescription Drugs

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

The BCBSNM Drug List is a list of drugs that are covered under Turquoise Care. HCA 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, your provider must request a 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. BCBSNM 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 an in-network specialty pharmacy provider in order to be covered. Non-

prescription enteral nutritional products taken by mouth or delivered by a temporary naso-enteric tube (e.g., nasogastric, nasoduodenal, or nasojejunal tube) are not covered, unless you have a genetic inborn error of metabolism and the product is prior authorized by BCBSNM.

Vision Services

Turquoise Care covers routine vision care, eyeglasses, and eye checkups through a program administered by Davis Vision.

The following vision services are covered under the Turquoise Care plan:

VISION SERVICES		
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)	Every 12 months	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 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 over

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 Services

Turquoise 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 Turquoise 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.

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The following dental services are covered under the Turquoise Care plan. See the table below for services that need prior authorization.

DENTAL SERVICES			
Covered Service	**Time Limit**	**Age Applies To**	**Prior Authorization?**
Dental services in a hospital	N/A	Under age 21; unless over the age of 21 with a developmental disability	No – Dentist Yes – Facility
Emergency services	No limit	All ages	No
Fillings; prefabricated stainless steel crown per permanent or deciduous tooth; one prefabricated resin crown per permanent or deciduous tooth; and one recementation of a crown or inlay; and one recementation fixed bridge	N/A	All ages	No
Fixed space maintainers (passive appliances)	N/A	Under age 21	Yes
General anesthesia and IV sedation, including nitrous oxide	N/A	Under age 21	Yes
General anesthesia and IV sedation, not including nitrous oxide	N/A	Age 21 and older	Yes
Incision and drainage of an abscess	N/A	All ages	No
One cleaning	Every 6 months	Under age 21	No
One cleaning	Every 12 months; every 6 months for members with developmental disabilities	Age 21 and older	No
One complete oral exam	Every 6 months	Under age 21	No
One complete oral exam	Every 12 months	Age 21 and older	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 fluoride treatment	Every 6 months	Under age 21	No
One fluoride treatment	Every 12 months	Age 21 and older	No
One sealant for each permanent molar (replacement of a sealant within the five- year period requires prior authorization)	Every 5 years	Under age 21	No
Orthodontic services (braces)	N/A	Under age 21	Yes

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DENTAL SERVICES			
Covered Service	**Time Limit**	**Age Applies To**	**Prior Authorization?**
Periodontic scaling and root planing	N/A	All ages	Yes
Reimplantation of permanent tooth	N/A	Under age 21	No
Therapeutic pulpotomy	N/A	Under age 21	No
Tooth extractions (pulling of teeth)	N/A	All ages	No
Two denture adjustments	Every 12 months	All ages	No

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

Transportation Services

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**.

ModivCare 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, long-term care, or behavioral services. You can use these benefits only for medical, long-term care, and/or behavioral needs. Transportation for any non-medical reason is not covered.

The transportation services covered under the Turquoise Care plan are in the table below:

TRANSPORTATION SERVICES		
Covered Service	**Prior Authorization?**	**Prior Notice to ModivCare**
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

Sometimes you must travel a distance for medical or behavioral health care. If you must travel more than 65 miles (one way) from your home for this care, you must get a written note of approval. This note needs to be from the provider who referred you for care. You must also get a written note from the service provider you traveled to see. This note should explain that medical or behavioral health care you need is not available in your home community.

Sometimes you must travel outside New Mexico to receive health care. This is called out-of-state transportation. Out-of-state transportation and related expenses require prior authorization.

Sometimes you must travel to another city or state for an approved appointment. You need to plan your transportation for these trips. You should make your plans at least two weeks (10 working days) ahead of time. If that is not possible, make your plans no later than three working days before the appointment.

Turquoise Care covers one other person to ride with you to your appointments (including that one other person's meals and lodging, if applicable) in the following situations:

- You are under the age of 18 and the other person to ride with you is your parent or legal guardian; or
- It is medically necessary for the other person to ride with you. Your doctor/provider must provide proof of medical necessity in writing. The other person to ride with you must be at least 18 years of age.

Turquoise Care does not cover other persons to ride with you to your appointments, such as your minor child(ren).

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), you will have to call BCBSNM Member Services first. 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.

You might be able to be repaid for mileage if you have to drive your own vehicle to a covered appointment. This must be authorized by ModivCare. Do not expect to be paid for mileage if you do not call ModivCare's Reservation Line first at **1-866-913-4342** (TTY: **1-866-288-3133**). There are certain criteria that ModivCare can explain such as filling out a form, having your provider sign the form, and submitting the form within 30 days after the appointment.

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.

ALTERNATIVE BENEFIT PLAN	
Covered Service	**Service Limitation(s)**
Allergy testing and injection	
Annual physical exam and consultation	Includes a health appraisal exam, laboratory and radiological tests, and early detection procedures.
Applied Behavioral Analysis (ABA)	

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ALTERNATIVE BENEFIT PLAN	
Covered Service	**Service Limitation(s)**
Bariatric surgery	Limited to one per lifetime. Criteria may be applied that considers previous attempts by the member to lose weight, BMI, and health status.
Behavioral health professional and substance abuse services, evaluations, testing, assessments, therapies and medication management	
Cancer clinical trials	
Cardiovascular rehabilitation	Limited to short-term therapy (two consecutive months) per cardiac event.
Chemotherapy	
Chronic care management services	
Dental services	The ABP covers dental services for adults in accordance with 8.310.2 NMAC. Recipients age 19-20 may receive dental services according to the increased periodicity schedule under EPSDT.
Diabetes treatment, including diabetic shoes, medical supplies, equipment and education	
Dialysis	
Diagnostic imaging	
Disease management	
Drug/alcohol dependency treatment services, including outpatient detoxification, therapy, partial hospitalization and intensive outpatient program (IOP) services	
Durable medical equipment, medical supplies, orthotic appliances and prosthetic devices, including repair or replacement	Requires a provider's prescription. DME is limited to a periodicity schedule and must be medically necessary. Disposable medical supplies are limited to diabetic and contraceptive supplies. Foot orthotics, including shoes and arch supports, are covered only when an integral part of a leg brace, or are diabetic shoes.
Electroconvulsive therapy	
Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services, including routine oral and vision care, for individuals age 19-20	
Emergency services, including emergency room visits, emergency transportation, psychiatric emergencies and emergency dental care	

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ALTERNATIVE BENEFIT PLAN	
Covered Service	**Service Limitation(s)**
Family planning and reproductive health services and devices, sterilization, pregnancy termination, contraceptives, and insertion and/or removal of contraceptive devices	Sterilization reversal is not covered. Infertility treatment is not covered.
Federally Qualified Health Center (FQHC) and Rural Health Center (RHC) services	
Genetic evaluation and testing	Limited to Triple Serum Test and genetic testing for the diagnosis or treatment of a current illness. Does not include random genetic screening.
Habilitative and rehabilitative services, including physical, speech and occupational therapy	Limited to short-term therapy (two consecutive months) per condition.
Hearing screening as part of a routine health exam	Hearing aids and hearing aid testing by an audiologist or hearing aid dealer are not covered, except for recipients age 19-20. The ABP does not cover audiology services.
Holter monitors and cardiac event monitors	
Home health care, skilled nursing and intravenous services	Home health care is limited to 100 visits per year. A visit cannot exceed four hours.
Hospice care services	
Immunizations	Includes ACIP-recommended vaccines.
Inpatient physical and behavioral health hospital/medical services and surgical care	Includes services in a psychiatric unit of a general hospital and inpatient substance abuse detoxification. Surgeries for cosmetic purposes are not covered.
Inpatient rehabilitative services/facilities	Includes services in a nursing or long-term acute rehabilitation facility/hospital. Coverage is limited to temporary stays as a step-down level of care from an acute care hospital when medically necessary and the discharge plan for the recipient is the eventual return home.
Internal prosthetics	
IV infusions	
Lab tests, x-ray services and pathology	
Maternity care, including delivery and inpatient maternity services, non-hospital births, and pre- and post-natal care	
Medication assisted therapy for opioid addiction	
Non-emergency transportation when necessary to access covered medical services	

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ALTERNATIVE BENEFIT PLAN	
Covered Service	**Service Limitation(s)**
Nutritional evaluations and counseling – dietary evaluation and counseling as medical management of a documented disease, including obesity	
Organ and tissue transplants	Transplants are limited to two per lifetime.
Osteoporosis diagnosis, treatment and management	
Outpatient surgery	
Over-the-counter medicines – prenatal drug items and low-dose aspirin as preventive for cardiac conditions	Other over-the-counter items may be considered for coverage only when the item(s) is considered more medically or economically appropriate than a prescription drug, contraceptive drug or device, or for treating diabetes.
Periodic age-appropriate testing and examinations – glaucoma, colorectal, mammography, pap tests, stool, blood, cholesterol and other preventive/diagnostic care and screenings	Includes US Preventive Services Task Force "A" and "B" recommendations; preventive care and screening recommendations of the HRSA Bright Futures program; and additional preventive services for women recommended by the Institute of Medicine.
Physician visits	
Podiatry and routine foot care	Covered when medically necessary due to malformations, injury, acute trauma or diabetes.
Prescription medicines	
Primary care to treat illness/injury and chronic disease management	
Pulmonary therapy	Limited to short-term therapy (two consecutive months) per condition.
Radiation therapy	
Reconstructive surgery for the correction of disorders that result from accidental injury, congenital defects or disease	
Skilled nursing	Subject to the 100-visit home health limit when provided through a home health agency.
Sleep studies	Limited to diagnostic sleep studies performed by certified providers/facilities.
Specialist visits	
Specialized Behavioral Health services for adults: Intensive Outpatient Programs (IOP), Assertive Community Treatment (ACT) and Psychosocial Rehabilitation (PSR)	The ABP does not cover behavioral health supportive services: Family Support, Recovery Services and Respite Services.

ALTERNATIVE BENEFIT PLAN	
Covered Service	**Service Limitation(s)**
Telemedicine services	
Tobacco cessation treatment and services (may include counseling, prescription medications, and products)	
Transitional Care Management services	
Urgent care services/facilities	
Vision care for eye injury or disease	Refraction for visual acuity and routine vision care are not covered, except for recipients age 19-20.
Vision hardware (eyeglasses or contact lenses)	Covered only following the removal of the lens from one or both eyes (aphakia). Coverage of materials is limited to one set of contact lenses or eyeglasses per surgery, within 90 days following surgery. Vision hardware is covered for recipients age 19-20 following a periodicity schedule.

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Value-Added Services

In addition to covering the services required by state law, the BCBSNM 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	Description	Prior Authorization Required for Value Added Service?
INFANT CAR SEATS	Pregnant Members who complete prenatal visit requirements and are engaged in care coordination.	Prior authorization (PA) required - annual VAS program maximum one car seat per member.
LEARN TO LIVE	VAS targets members 13 years and older and caregivers. Learn to Live is a Cognitive Behavioral Therapy digital solution for multiple conditions, including unlimited one-to-one coaching sessions for Members 13 years and older and their caregivers. Confidential, 24/7/365, user-paced solution that increases access for depression, stress and worry, resilience, anxiety, insomnia, and more, with a consistent focus on resilience and mindfulness; health equity approach; multimedia and interactivity; crisis protocol.	Prior authorization (PA) not required.
PORTABLE INFANT CRIBS	VAS targets pregnant members who complete prenatal requirements and engage in Care Coordination. Members will receive a portable crib and SIDs related educational materials for parents, caregivers, and health care providers.	Prior authorization (PA) required- annual VAS program maximum one per lifetime.
PRENATAL EDUCATION	VAS targets pregnant members engaged in care coordination. Prenatal community classes in-person at partner hospitals within Albuquerque and Roswell. Classes include childbirth, labor and prep, newborn education and breastfeeding.	Prior authorization (PA) required- annual VAS program maximum one per lifetime.
ASSISTANCE WITH SDoH	VAS targets members with socioeconomic needs in their care plan that cannot be resolved by other means, such a new pair of shoes, mattress, clothing for an interview after release/discharge from a facility, bus passes to work, sporting gear, other tangible goods.	Prior authorization (PA) required; one occurrence per year or until funds are exhausted.

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ELECTROCONVULSIVE THERAPY (ECT)	VAS targets members 18 years and older with appropriate diagnosis. ECT is offered when it is the safest and most effective treatment per guidelines for certain psychiatric conditions such as resistant major depressive disorder, depression with certain comorbid medical conditions, treatment-resistant mania secondary to bipolar disorder or schizoaffective disorder.	Prior authorization (PA) not required.
EPIC + HEALTH PARTNERSHIP PROGRAM	VAS targets members in Bernalillo County that area experiencing chronic homelessness with severe mental illness, typically co-occurring with substance abuse disorder and physical ailments, and combination of frequent ED, hospital, and justice admissions. This program includes individualized program assistance, intensive case management, housing referrals, move-in support, navigation assistance for employment, financial literacy, and medical and non-medical transportation.	Prior authorization (PA) required - Limited to 10 Members for one year of housing plus extensive case management and wraparound services.
HOME MEAL DELIVERY	VAS targets members who are transitioning from an inpatient or long-term facility to the community, receiving community benefits and unable to prepare their meals or purchase groceries, or who are pregnant with diabetes. Gestational pregnant members will be offered three (3) meals per day for a total of four (4) weeks. Additional weeks or meals may be provided as authorized by the case manager.	Prior authorization (PA) required - members who have been discharged from a facility will be offered the option of ordering twenty-one (21) meals. The meal benefit consists of three (3) meals per day for seven (7) days.
REMOTE MONITORING PROGRAM	VAS targets high risk members with chronic conditions with a need for frequent monitoring. Tablet and related medical devices such as blood pressure cuff, pulse oximeter, and scale are provided for members to receive care from their home. Paramedicine professionals monitor the member's medical condition and vital signs such as blood pressure and oxygen levels in real time and may coordinate with the Member's provider(s) as necessary.	Prior authorization (PA) required.
RESPITE BED	VAS targets members who are medically vulnerable and chronically homeless who are being discharged from an ER or hospital in need of a temporary respite bed.	Prior authorization (PA) required- Annual VAS program maximum one 30 day stay per year.
FRIENDS AND FAMILY CIRCLE	VAS targets parents/caretakers that are caring for family members with complex needs that struggle to do basic routine things like going to a movie, restaurant, or shopping. The VAS will pay a friend or family member to provide respite care for the member.	Prior authorization (PA) required- gift card will be issued by the SDOH vendor. $45 per day with a limit of 10 days per year.

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TRANSITIONAL LIVING FOR CHEMICALLY DEPENDENT / PSYCHIATRICALLY IMPAIRED ADULTS	This VAS is for members 18 years or older enrolled in an outpatient substance abuse center or in active treatment for psychiatric issues. Transitional living step down from a higher level of care to an identified community placement to stabilize members with an identified plan to return to independent living.	Prior authorization (PA) required- annual VAS program maximum 180 days stay per year.
WELLNESS CENTERS	This VAS is for adults, children, adolescents, families with behavioral health needs. Wellness/Drop-in centers and Family support centers provide peer driven/family driven BH recovery services, education on resources, and support in accessing resources such as housing, food, substance use disorder treatment, and other needed assistance.	Prior authorization (PA) not required- VAS program maximum 4 hours per week per Member.
TRADITIONAL HEALING	Will only be offered if traditional healing is not approved as a covered benefit for Turquoise Care. This VAS is available to Native American Members for Traditional Healing practices.	Prior authorization (PA) not required.
AFTER SCHOOL YOUTH ACTIVITIES	VAS targets members under 18 years old to pay for after school or sports activities. The VAS would cover registration fees, equipment purchases uniform fees, etc.	Prior authorization (PA) required- limited to $50 per member per year.
CARE GIVER THANK YOU PACKAGES	Caregivers will be offered an option of multiple thank you gift packages. Items may include a fleece blanket, heating pad, essential package with Clorox wipes, toiletries and fan or games and an art set. The package will also include important phone numbers and caregiver educational material.	Prior authorization (PA) not required- VAS limited to caregivers who specialize in Long Term Services and Supports (LTSS), Home and Community Based Services (HCBS)
SHOWER CHAIRS	VAS targets elderly or members with disabilities who need a convenience shower chair.	Prior authorization (PA) not required- limited to one shower chair per member per year.
VIRTUAL HEALTH PARTNERS	VAS targets members in need of a nutrition, fitness, and a lifestyle modification program. The program provides on demand individualized care with 24/7 access to Dieticians and Health coaches, live group events, unlimited messaging with experts, monitoring tools, and on-demand access to a variety of media supports (meal plans, recipes, fitness videos, cooking demos, and lifestyle modification module) and two to four one-on-one appointments with a dietician to support and encourage a healthy lifestyle.	Prior authorization (PA) required- Members will be identified for the program based on diagnosis such as pregnancy status and/or specific diagnoses such as prediabetes, diabetes, hypertension, obesity, and/or kidney disease.

RESOURCE TOOL KIT (Justice/Homeless)	VAS targets justice involved members and members experiencing homelessness. A "Tool Kit" notebook will contain both pre-identified statewide and national resource listings, and space to add personalized notes and resources. The tool kit will include preprinted resource information on the first several pages, such as the NMCAL, Utility help and support, food banks, housing, etc. The member and team can add additional information to the remainder of the notebook.	No Prior authorization (PA) required.
INFANT DIAPERS	Available for pregnant members and new moms. Infant diapers are available for the 1st month from birth.	Prior Authorization: To qualify for infant DIAPERS, the member must complete prenatal requirements and must be engaged in care coordination. Once this is complete, an authorization is issued for the infant diapers.

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. Services from an out-of-network provider are not covered without first getting 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 if you had received services from an in-network provider.

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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.