COMMUNITY FIRST HEALTH PLANS

Authorization List
Effective 01/01/2020

IMPORTANT – Prior Authorization is not a guarantee of benefits or payment at the time of service. Remember, benefits will vary between plans, so always verify benefits.

See important Endnotes.

	STAR	STAR Kids	CHIP	HMO	ASO
Timely (within 24 hours) notification required for ADMISSION to all facilities/services to include Concurrent Review (Observation Stays do not require authorization):					
Admission to any level of acute or sub-acute care (LTAC), skilled nursing facilities, rehabilitation Excludes global OB 2 day vaginal and 4 day C-Section deliveries and Observation Stays	x	x	x	x	x$^{\Delta}$
Includes all:					
• Inpatient facility-to-facility transfers	x	x	x	x	x$^{\Delta}$
• NICU/Special Care Nursery admissions	x	x	x	x	x$^{\Delta}$
• Intraoperative Monitoring	x	x	x	x	x$^{\Delta}$
• Elective inpatient admissions ****No additional reimbursement will be provided for robotic assisted surgeries** *****All emergent inpatient admissions require notification by the close of the next business day**	x	x	x	x	x$^{\Delta}$
Notification required for DISCHARGE from all facilities	x	x	x	x	x$^{\Delta}$
Prior Authorization required for admission to facilities/programs listed below :					
Admissions to behavioral health/substance abuse residential, partial hospitalization, and day programs including IOP (does not include not office visits with contracted providers)	x	x	x	x	x$^{\Delta}$
Prior Authorization required for the medical procedures/services below (contracted and non-contracted providers):					
Abortion	x	x	x	x	x^{1}
Allergen Immunotherapy Services - unless provided by an Allergist or Immunologist	x	x	x	x	x^{1}
Ambulance Transfers: Non-emergency, Ground and Air	x	x	x	x	NA
Bariatric Surgery	x	x	NA	NA	x^{1}
Bone Growth Stimulators	x	x	x	x	x^{1}
Chiropractic Treatment • CHIP requires authorization if greater than 12 visits	x	x	x	x	NA
Cosmetic Procedures or Surgeries	x	x	NA	NA	NA
Dental - Oral maxillofacial surgery (including orthognathic surgery)	x	x	x	x	x^{1}
Dental General Anesthesia - refer to HHSC guidelines Medicaid	x	x	x	x	x^{1}
External Defibrillators	x	x	x	x	x^{1}
Hearing Aids for adults 21 and over	x	NA	NA	x	NA
Hysterectomy	x	x	x	x	x^{1}
Implantable devices (e.g., Interspinous Process Decompressors) - includes trials	x	x	x	x	x^{1}
Insulin Pumps/Continuous Glucose Monitoring Systems 95250, 95251	x	x	x	x	x^{1}
Mammoplasty (Male and Female)	x	x	x	x	x^{1}
Otoplasty (including Microtia Repair)	x	x	x	x	x^{1}
Rhinoplasty / Septoplasty	x	x	x	x	x^{1}
Scar Revision	x	x	x	x	x^{1}
Vagus Nerve Stimulation	x	x	x	x	x^{1}
Varicose Vein Treatment	x	x	x	x	x^{1}
Behavioral Health (BH) / Chemical Dependency (CD) / Substance Abuse					
Applied Behavioral Analysis (ABA) Therapy - Pending HHSC Benefit Coverage	x	x	x	x	x^{5}
Residential Treatment (BH/CD)	x	x	x	x	x^{1}
Inpatient Services (Includes Detox/ Rehab)	x	x	x	x	x^{1}
Intensive Outpatient Services (Includes Outpatient Detox/ Rehab)	x	x	x	x	x^{1}
ECT (Electro Convulsive Therapy) / TMS (Transcranial Magnetic Stimulation)	x	x	x	x	x^{1}
Psychological / Neuropsychological Testing – if testing is greater than 8 hours/year	x	x	x	x	x^{1}
Partial Hospitalization Services	x	x	x	x	x^{1}
Cancer Chemotherapy: requires preauthorization for allowable charges >$500 per dose	x	x	x	x	x^{1}
Durable Medical Equipment/Orthotics/Prosthetics					
All Custom DME (HCPCS Codes = Exxxx & Kxxxx)	x	x	x	x	x^{1}
All Custom Orthotics/Prosthetics (HCPCS Codes = Lxxxx)	x	x	x	x	x^{1}

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All purchases involving Medicaid allowable charges (for each item > $500) **Total Cost for Purchases must be** included in the request for authorization • CHIP/HMO based on billed charges	x	x	x	x	x[1]
All rentals, including:	x	x	x	x	x[1]
• Bone or Spinal Cord Stimulators	x	x	x	x	x[1]
• Insulin Pumps/Continuous Glucose Monitoring Systems	x	x	x	x	x[1]
• Hospital Grade Breast Pumps – after the initial 60 day rental period	x	x	x	x	x[1]
Experimental/Investigational Services	x	x	x	x	x[1]
Genetic Testing (to includes office-based testing)	x	x	x	x	x[1]
Imaging Services/ Diagnostic Procedures					
MRI, MRA – if not ordered by a Neurosurgeon or Orthopedic MD	x	x	x	x	x[1]
SPECT, Three Dimensional (3D) Imaging/CTA - if not ordered by a cardiologist or cardiothoracic specialist	x	x	x	x	x[1]
Sleep Studies	x	x	x	x	x[1]
Video EEG Monitoring	x	x	x	x	x[1]
OB ultrasounds	x	x	x	x	x[1]
• Limited to 3 ultrasounds for a pregnancy that is not high risk without being approved.	x	x	x	x	x[1]
• No authorization required for high risk pregnancy ultrasounds when appropriate High Risk Pregnancy ICD-10 codes are submitted on the claim. ** Please submit clinical information to support the medical necessity request for additional ultrasounds, prior to performing or within 24 hours of performing an urgent ultrasound	x	x	x	x	x[1]
Long Term Support Services (LTSS) – per State benefit					
Personal Care Services (PCS)	NA*	x	NA	NA	NA
Private Duty Nursing (PDN)	x	x	NA	NA	NA
Day Activity Health Services	NA	x	NA	NA	NA
MDCP:					
Employment Assistance	NA	x	NA	NA	NA
Supported Employment	NA	x	NA	NA	NA
Flexible Family Support Services	NA	x	NA	NA	NA
Respite Care (in home or out of home)	NA	x	NA	NA	NA
Financial Management Services	NA	x	NA	NA	NA
Transition Assistance Services	NA	x	NA	NA	NA
Adaptive Aids	NA	x	NA	NA	NA
Minor Home Modifications	NA	x	NA	NA	NA
Vehicle Modifications	NA	x	NA	NA	NA
Community First Choice:					
Personal Assistance Services	NA	x	NA	NA	NA
Habilitation	NA	x	NA	NA	NA
Emergency Response Services	NA	x	NA	NA	NA
Support Management	NA	x	NA	NA	NA
Prescribed Pediatric Extended Care Centers (PPECC)	NA	x	NA	NA	NA
Nursing Services (including initial evaluations)					
Private Duty Nursing (PDN)	x	x	x	x	NA
Skilled Nursing	x	x	x	x	x
Nutritional Supplements/Formulas (HCPCS Codes = Bxxxx)	x	x	x	x	x
Obesity Treatment and Surgery	x	x	NA	NA	x[Δ]
Out-of -Network					
ALL Non-Emergent Out of Network Services - inpatient or outpatient – Note: Letter of Agreement (LOA) may be required **NOTE: Authorization is required for post-stabilization emergency room inpatient admissions**	x[2]	x[2]	x[2]	x[2]	x[2]

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Out-of-Network Specialists:					
• Any non-urgent referral for Out-of-Network specialty office visits	x	x	x	x	x[1]
• 2nd Opinions Out-of-Network	x	x	x	x	x[1]
Pain Management	x	x	x	x	x[1]
Implantable pumps (Baclofen/fentanyl)	x	x	x	x	x[1]
Spinal Cord and other Nerve Stimulators – includes trials	x	x	x	x	x[1]
Pharmaceuticals Rx Medical Injectables: **Rx Medical Injectables: Any injectable medication, including chemotherapy, for Medicaid allowable charges> $500 per dose given in the outpatient setting. For CHIP/HMO/UFCP - based on billed charges > $500 per dose** **NDC, HCPCS and billable units are required on the claim**	x	x	x	x	x
Examples includes the following medications:					
• Aflibercept (Eylea)	x	x	x	x	x
• Eteplirsen (Exondys-51)	x	x	x	x	x
• Histrelin implant (Supprelin LA)	x	x	x	x	x
• Hyaluronate (Orthovisc or Gel-One)	x	x	x	x	x
• IVIG (immune globulin)	x	x	x	x	x
• Natalizumab (Tysabri)	x	x	x	x	x
• Nusinersen (Spinraza)	x	x	x	x	x
• Omalizumab (Xolair)	x	x	x	x	x
• Onabotulinumtoxin A (Botox)	x	x	x	x	x
• Pembrolizumab (Keytruda)	x	x	x	x	x
• Romiplostim (NPlate)	x	x	x	x	x
• Zoledronic Acid	x	x	x	x	x
Oncology drugs when utilized for off label use	x	x	x	x	x
Supplies:					
Medical supplies, based on Medicaid allowable limits - (HCPCS Codes = Axxxx)	x	x	NA	NA	x[1]
Telemonitoring	x	x	x	x	x[1]
Therapy/Rehabilitation					
Occupational and Physical Therapy - All visits, required in units and/or encounters along with procedure codes as per the HHSC guidelines (Home and Outpatient) NOTE: OT and PT Evaluations and Re-Evaluations Do NOT require authorization	x	x	x	x	x[4]
Speech Therapy –required for both Initial Evaluation and Ongoing Treatments – a re-evaluation will be issued if ongoing treatments are authorized (Home or Outpatient)	x	x	x	x	x[4]

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	STAR	STAR Kids	CHIP	HMO	ASO
Transplant					
ALL Services for Transplantation: solid organ and stem cell transplants (pre-transplant evaluation and transplant procedures)	x	x	x	x	x[1]
Transportation **NOTE: Emergent transport subject to retrospective medical necessity review**					
Wound Care					
Facility Based	x	x	x	x	x[1]
Hyperbaric Treatment	x	x	x	x	x[1]
All Wound Vac.(Negative-pressure wound therapy) to include related supplies	x	x	x	x	x[1]
Unlisted and Miscellaneous Codes					
CFHP requires standard codes when requesting authorization. **Should an unlisted or miscellaneous code be used**, medical necessity documentation and rationale must be prior authorized. For Medicaid - B9998 with Modifieres U1-U5 and T1999 are excluded from requiring authorization if within the allowable limits	x	x	x	x	x[1]

Endnotes:

x^{Δ} = Authorization for inpatient services is required from CFHP when services are obtained outside of University Hospital

x^{1} = **UFCP Requests require** a TEXAS REFERRAL/AUTHORIZATION FORMS THAT MUST BE SIGNED BY THE PRIMARY CARE PROVIDER (PCP) OR ORDERING PHYSICAN THAT HAS A VALID REFERRAL FROM THE PCP
Authorization for services is required from CFHP when the member **does not utilize a UFCP Network provider**

x^{2} = Authorization not required for OON Emergency Room or Observation for ALL product lines

x^{3} = ALL obesity treatment and surgery must be performed at University Hospital

x^{4} = Requires authorization for Home Therapy. Maximum per Calendar Year = 60 visits per year

x^{5} = Does not require authorization. Coverage based on diagnoses outlined in the Certificate of Coverage

NA=Not Applicable = Benefits not covered as per the date of this authorization list. Should services be covered after the date of this list, authorization will be required

NA*=Not a benefit managed by Community First at this time ; however, these services are available through the Texas Department of State Health Services for the STAR line of business

Medicaid = STAR and STAR Kids

BENEFIT COVERAGE MUST BE VERIFIED AT THE TIME OF THE REQUEST