COMMUNITY FIRST HEALTH PLANS

STAR, STAR Kids, & CHIP

Prior Authorization List

PY2021

IMPORTANT – ALL requests from a Non-Participating, Out of Network facility, provider or vendor requires prior authorization, with the exception of an emergent admission, and MUST be submitted by an In-Network PCP or Specialty Provider. 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.

CFHP AUTHORIZATION LIST	STAR	STAR KIDS	CHIP
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
Includes all:			
Inpatient facility-to-facility transfers NOTE: The accepting facility is responsible for obtaining authorization prior to the transfer of a member	X	X	X
NICU/Special Care Nursery admissions	X	X	X
Intraoperative Monitoring	X	X	X
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
Notification of DISCHARGE - Required from all facilities	X	X	X
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 office visits with contracted/participating, providers)	X	X	X

LEGEND

Medicaid = STAR and STAR Kids

X[1] Authorization not required for OON Emergency Room or Observation for ALL product lines

X[2] Any procedure that could be deemed as cosmetic requires authorization

NA **(Not Applicable)** Not a benefit 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

BENEFIT COVERAGE MUST BE VERIFIED AT THE TIME OF THE REQUEST

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Prior Authorization required for the medical procedures/services below (contracted/participating, and non-contracted/non-participating, providers):			
Abortion	X	X	X
Allergen Immunotherapy Services - unless provided by an Allergist or Immunologist	X	X	X
Ambulance Transfers: Non-emergency, Ground and Air **NOTE:** The referring physician or facility must originate the request for prior authorization Ambulance providers may not request pior authorization for this service.	X	X	X
Bariatric Surgery	X	X	NA
Bone Growth Stimulators	X	X	X
Chiropractic Treatment • CHIP requires authorization if greater than 12 visits	X	X	X
Cosmetic Procedures or Surgeries	X[2]	X[2]	NA
Dental - Oral maxillofacial surgery (including orthognathic surgery)	X	X	X
Dental General Anesthesia	X	X	X
External Defibrillators	X	X	X
Hearing Aids for adults 21 and over	X	NA	NA
Hysterectomy	X	X	X
Implantable devices (e.g., Interspinous Process Decompressors) - includes trials	X	X	X
Insulin Pumps/Continuous Glucose Monitoring Systems 95250, 95251	X	X	X
Mammoplasty (Male and Female)	X	X	X
Otoplasty (including Microtia Repair)	X	X	X
Rhinoplasty / Septoplasty	X	X	X
Scar Revision	X	X	X
Vagus Nerve Stimulation	X	X	X
Varicose Vein Treatment	X	X	X

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CFHP AUTHORIZATION LIST	STAR	STAR KIDS	CHIP
Behavioral Health (BH) / Chemical Dependency (CD) / Substance Abuse			
Applied Behavioral Analysis (ABA) Therapy	X	X	X
Residential Treatment (BH/CD)	X	X	X
Inpatient Services (Includes Detox/ Rehab)	X	X	X
Intensive Outpatient Services (Includes Outpatient Detox/ Rehab)	X	X	X
ECT (Electro Convulsive Therapy) / TMS (Transcranial Magnetic Stimulation)	X	X	X
Psychological / Neuropsychological Testing – if testing is greater than 8 hours/year	X	X	X
Partial Hospitalization Services	X	X	X
Cancer Chemotherapy Requires preauthorization for allowable charges >$500 per dose	X	X	X
Durable Medical Equipment/Orthotics/Prosthetics (for each line item greater than $500)			
All Custom DME (HCPCS Codes = Exxxx & Kxxxx)	X	X	X
All Custom Orthotics/Prosthetics (HCPCS Codes = Lxxxx)	X	X	X
All purchases for Medicaid - based on the Texas Medicaid fee schedule - allowable charges in which the line item total > $500) **Total Cost for Purchases must be** included in the request for authorization	X	X	X
All rentals, including: • Bone or Spinal Cord Stimulators • Insulin Pumps/Continuous Glucose Monitoring Systems • Hospital Grade Breast Pumps – after the initial 60 day rental period	X	X	X
Experimental/Investigational Services	X	X	X
Genetic Testing (to includes office-based testing)	X	X	X
Imaging Services/ Diagnostic Procedures			
MRI, MRA – if not ordered by a Neurosurgeon, Neurologist or Orthopedic MD	X	X	X

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SPECT, Three Dimensional (3D) Imaging/CTA - if not ordered by a cardiologist or cardiothoracic specialist	X	X	X
Sleep Studies	X	X	X
Video EEG Monitoring	X	X	X
OB ultrasounds • Limited to 3 ultrasounds for a pregnancy that is not high risk without being approved. • 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
Long Term Support Services (LTSS) – per State benefit			
Personal Care Services (PCS)	NA*	X	NA
Private Duty Nursing (PDN)	X	X	NA
Day Activity Health Services	NA	X	NA
MDCP:			
Employment Assistance	NA	X	NA
Supported Employment	NA	X	NA
Flexible Family Support Services	NA	X	NA
Respite Care (in home or out of home)	NA	X	NA
Financial Management Services	NA	X	NA
Transition Assistance Services	NA	X	NA
Adaptive Aids	NA	X	NA
Minor Home Modifications	NA	X	NA
Vehicle Modifications	NA	X	NA
Community First Choice:			
Personal Assistance Services	NA	X	NA

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Habilitation	NA	X	NA
Emergency Response Services	NA	X	NA
Support Management	NA	X	NA
Prescribed Pediatric Extended Care Centers (PPECC)	NA	X	NA
Nursing Services (including initial evaluations)			
Private Duty Nursing (PDN)	X	X	X
Skilled Nursing	X	X	X
Nutritional Supplements/Formulas (HCPCS Codes = Bxxxx) B4100 – thickener does not require authorization for Medicaid (STAR & STAR Kids) **Note:** Supplies that fall under formula (B codes) but may also be considered DME – such as feeding pumps, nasogastric tubing – require authorization	X	X	X
Obesity Treatment and Surgery	X	X	NA
Out-of-Network			
ALL requests from a Non-Participating, Out of Network facility, provider or vendor requires prior authorization, with the exception of an emergent admission, and MUST be submitted by an In-Network PCP or Specialty Provider. Note: Letter of Agreement (LOA) may be required.	X[1]	X[1]	X[1]
Out-of-Network Specialists:			
Any non-urgent referral for Out-of-Network specialty office visits	X	X	X
2nd Opinions Out-of-Network	X	X	X
Pain Management	X	X	X
Implantable pumps (Baclofen/fentanyl)	X	X	X
Spinal Cord and other Nerve Stimulators – includes trials	X	X	X

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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 - based on billed charges > $500 per dose NDC, HCPCS and billable units are required on the claim	X	X	X
Examples includes the following medications:			
Aflibercept (Eylea)	X	X	X
Eteplirsen (Exondys-51)	X	X	X
Histrelin implant (Supprelin LA)	X	X	X
Hyaluronate (Orthovisc or Gel-One)	X	X	X
IVIG (immune globulin)	X	X	X
Natalizumab (Tysabri)	X	X	X
Nusinersen (Spinraza)	X	X	X
Omalizumab (Xolair)	X	X	X
Onabotulinumtoxin A (Botox)	X	X	X
Pembrolizumab (Keytruda)	X	X	X
Romiplostim (NPlate)	X	X	X
Zoledronic Acid	X	X	X
Oncology drugs when utilized for off label use	X	X	X
Supplies:			
Medical supplies, authorization required for supplies over the limit for Medicaid (HCPCS Codes = Axxxx) Incontinence supplies require authorization for members under the age of 4. All supplies that require a modifier will need authorization	X	X	NA
Telemonitoring	X	X	X

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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
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
Transplant			
ALL Services for Transplantation: solid organ and stem cell transplants (pre-transplant evaluation and transplant procedures)	X	X	X
Transportation **NOTE:** Emergent transport subject to retrospective medical necessity review			
Wound Care			
Facility Based	X	X	X
Hyperbaric Treatment	X	X	X
All Wound Vac.(Negative-pressure wound therapy) to include related supplies	X	X	X
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 Modifiers U1-U5 and T1999 (for Enteral Nutritional Supplies) are excluded from requiring authorization if within the allowable limits T1999 for cotton tip applicators does not require authorization T1999 for needleless syringes the allowed amount is 8 syringes per month	X	X	X

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