

Community First Health Plans, Inc. (Community First) requires prior authorization (PA) as a condition of payment for many services. This list contains information regarding such authorization requirements and is applicable to STAR, STAR Kids, and CHIP product lines.

IMPORTANT: All requests from non-participating, out-of-network facilities, providers, or vendors AND contracted out-of-service area providers require prior authorization, with the exception of an emergent admission, and **MUST** be submitted by a Community First network PCP or specialty provider.

	PA REQUIRED		
	STAR	STAR KIDS	CHIP
Admissions (Inpatient / Facilities / Programs)			
Timely notification (within 24 hours) required for admission to all facilities/services listed below to include concurrent review.			
NOTE: Observation stays and global OB 2-day vaginal and 4-day C-section deliveries do not require authorization.			
Admission to any level of acute or sub-acute care (LTAC), rehabilitation, skilled nursing facility* (time limits allowed vary by plan)	X	X	X
Behavioral Health/Substance use - Day Programs, including Intensive Outpatient <ul style="list-style-type: none"> Does not include office visits with contracted/participating providers 	X	X	X
Behavioral Health/Substance use, Partial Hospitalization	X	X	X
Behavioral Health/Substance use, Residential	X	X	X
Elective Inpatient Admissions <ul style="list-style-type: none"> No additional reimbursement will be provided for robotic assisted surgeries All emergent inpatient/post-stabilization admissions require notification within 24 hours of admission or the next business day 	X	X	X
Inpatient facility-to-facility transfers* NOTE: The accepting facility is responsible for obtaining authorization prior to the transfer of a Member	X	X	X
Intraoperative Monitoring	X	X	X
NICU/Special Care Nursery	X	X	X
Notification of Discharge (required from all facilities)	X	X	X
Admissions (Medical Procedures & Services)			
Prior authorization requirements apply to contracted/participating AND non-contracted/non-participating providers			
Abortion*	X	X	X
Ambulance Transfers <ul style="list-style-type: none"> Non-emergency Ground Air NOTE: The referring physician or facility must originate authorization request	X	X	X
Bariatric Surgery	X	X	N/A
Bone Growth Stimulators	X	X	X
Cochlear & Other Auditory Implants*	X	X	X
Cosmetic or Reconstructive procedures/surgeries**	X	X	X
Dental General Anesthesia (0 to less than 7 years of age only)	X	X	X
Dental Oral Maxillofacial Surgery, including orthognathic surgery*	X	X	X

	PA REQUIRED		
	STAR	STAR KIDS	CHIP
Admissions (Medical Procedures & Services), continued			
Electrophysiology Implants (outpatient and office-based)	X	X	X
External Defibrillators	X	X	X
Hearing Aids (for adults 21 and over)	X	X	N/A
Hysterectomy	X	X	X
Implantable devices, including trials (e.g., Interspinous Process Decompressors)	X	X	X
Insulin pumps/continuous glucose monitoring systems (95250, 95251)	X	X	X
Mammoplasty, male and female**	X	X	X
Mohs micrographic surgery	X	X	X
Otoplasty**	X	X	X
Rhinoplasty/Septoplasty**	X	X	X
Scar Revision**	X	X	X
Vagus Nerve stimulation	X	X	X
Venous procedures**	X	X	X
Behavioral Health (BH) / Chemical Dependency (CD) / Substance Use			
Applied Behavioral Analysis (ABA) therapy	X	X	N/A
Electro Convulsive Therapy (ECT) / Transcranial Magnetic Stimulation (TMS)	X	X	X
Intensive Outpatient services, including Outpatient Detox/Rehab	X	X	X
Inpatient services, including Detox/Rehab	X	X	X
Residential Treatment (BH/CD)	X	X	X
Partial Hospitalization services	X	X	X
Psychological/Neuropsychological testing, if testing is greater than 8 hours in duration	X	X	X
Chemotherapy			
Chemotherapy - allowable charges > \$500/dose	X	X	X
Durable Medical Equipment / Orthotics / Prosthetics*			
Retail total purchase of each, individual item requested > \$500			
All purchases for Medicaid are based on the Texas Medicaid fee schedule. Allowable charges in which line item total > \$500. CHIP benefit limitations outlined in Certificate of Coverage. Total cost of purchases must be included in the request for authorization. All DME rental requires prior authorization.			
DME (HCPCS codes = Exxxx & Kxxxx); Total cost of purchases must be included in authorization request	X	X	X
Orthotics/Prosthetics (HCPCS codes = Lxxxx); Total cost of purchases must be included in authorization request	X	X	X
Bone or Spinal Cord Stimulators, All rentals/purchases	X	X	X
Insulin Pumps; All rentals/purchases	X	X	X
Hospital Grade Breast Pumps; All rentals/purchases (after initial 60-day rental period)	X	X	X
Experimental/Investigational Services			
Experimental/Investigational services*	X	X	X

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Genetic Testing			
Genetic testing, including office-based testing	X	X	X
Imaging Services / Diagnostic Procedures			
Electrophysiology Implants, outpatient and office-based	X	X	X
MRI, MRA (if not ordered by a neurosurgeon, neurologist, or orthopedic MD)	X	X	X
Sleep Apnea studies & procedures	X	X	X
Facility and Home Video EEG monitoring	X	X	X
Long Term Support Services (LTSS), per State Benefit			
Prior authorization for LTSS is obtained by the Member's Community First Service Coordinator during the person-centered care planning process, which includes an assessment and determination of needs.			
Prescribed Pediatric Extended Care Centers (PPECC)	N/A	X	N/A
Nursing Services* (including initial evaluations)			
Private Duty Nursing (PDN)	X	X	X
Skilled Nursing	X	X	X
Nutritional Supplements / Formulas			
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.			
Nutritional supplements/formulas* (HCPCS codes = Bxxxx)	X	X	X
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			
Out-of-network specialists			
<ul style="list-style-type: none"> Any non-urgent referral for out-of-network specialty office visits Second opinions, out-of-network 	X	X	X
Pain Management			
Implantable pumps (Baclofen/Fentanyl)	X	X	X
Spinal cord and other nerve stimulators, including trials	X	X	X
Clinically Administered Drugs			
Any injectable medication, including chemotherapy, that has an allowable charge > \$500 per dose given in outpatient setting requires prior authorization. All new to market drugs that have not been assigned a permanent HCPCS code and are > \$500 per dose require prior authorization. Please refer to the complete prior authorization list for a full list of codes that require prior authorization.			
Oncology Drugs, when utilized for off-label use	X	X	X
Radiation Therapy			
Intensity Modulated Radiation Therapy (IMRT)	X	X	X
Stereotactic Radiosurgery (SRS)	X	X	X
Stereotactic Body Radiation Therapy (SBRT)	X	X	X

	PA REQUIRED		
	STAR	STAR KIDS	CHIP
Supplies			
Authorization required for supplies over the limit for Medicaid (HCPCS) and CHIP \$20k annually, and incontinence supplies for Members under the age of 4. All supplies that require a modifier will need authorization.			
Medical supplies*	x	x	x
Telemonitoring			
Telemonitoring	x	x	x
Therapy/Rehabilitation*			
NOTE: NO authorization is required for ECI services Each LOB has visit limitations for therapies			
Cardiac & Pulmonary rehabilitation services	x	x	x
Occupational and Physical Therapy, all visits required in units and/or encounters along with procedure codes as per HHSC guidelines (home and outpatient) NOTE: OT and PT evaluations and re-evaluations DO NOT require authorization	x	x	x
Speech therapy, required ongoing treatments A re-evaluation will be issued if ongoing treatments are authorized (home or outpatient) NOTE: ST evaluations DO NOT require prior authorization	x	x	x
Transplant			
All transplant services; solid organ and stem cell transplants (pre-transplant evaluation and transplant procedures)	x	x	x
Transportation			
Transportation	x	x	N/A
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			
Community First requires standard codes when requesting authorization Should an unlisted or miscellaneous code be used, medical necessity documentation and rationale must be prior authorized	x	x	x

*Benefit limitations apply. Please review Certificate of Coverage.

**Any procedure that could be deemed cosmetic requires prior authorization

ENDNOTES

- Prior authorization is not a guarantee of benefits or payment at the time of service.
- Benefits vary between plans; benefit coverage must be verified at the time of request.
- ALL requests require a Texas Referral/Authorization Form that MUST be signed by the primary care provider (PCP) or ordering physician who has a valid referral from the PCP.
- Authorization is not required for out-of-network Emergency Room or observation.

TERMS

N/A = NOT APPLICABLE

If a benefit is labeled N/A, it is not covered per the date of this authorization list. Should benefits labeled N/A be covered after the date of this list, prior authorization will be required.