COMMUNITY FIRST HEALTH PLANS

Government (Medicaid, CHIP) 2025 Prior Authorization List

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

PRIOR AUTHORIZATION REQUESTS

- All services included in this list require prior authorization prior to providing the service(s) or item(s).
- Initial prior authorization requests should be submitted no less than five (5) business days before the start of the service.
- Prior authorization is *not* a guarantee of payment. Reimbursement of authorized service(s) is dependent upon Member eligibility, benefit limitations, and exclusions.

NOTE: Prior authorization requests missing essential/critical information will be returned to the requesting Provider to supply missing information.

NON-CONTRACTED OR OUT-OF-SERVICE AREA PROVIDER SERVICES, SUPPLIES, EQUIPMENT

- Prior authorization requirements are not limited to services and items on this list for non-contracted or out-of-service-area Providers.
- With the exception of emergency or post-stabilization care and facility-based professional services, receipt of ALL services and items from a non-contracted or out-of-service-area Provider in all non-emergency room places of service, require approval through Community First prior to providing services/items.

	PA REQUIRED			
	CHIP	STAR	STAR KIDS	STAR+PLUS
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	X
Behavioral Health/Substance Use — Day Programs, including Intensive Outpatient (IOP) • Does not include office visits with contracted/participating Providers.	X	X	X	X
Behavioral Health/Substance Use — Partial Hospitalization Program (PHP)	X	X	X	X
Behavioral Health/Substance Use — Residential Treatment Center (RTC)	X	X	X	X
Elective Inpatient Admissions • All emergent inpatient/post-stabilization admissions require notification within 24 hours of admission or the next business day.	X	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	X
Intraoperative Monitoring	X	X	X	X
NICU/Special Care Nursery	X	X	X	X
Notification of Discharge (required from all facilities)	X	X	X	X
Ambulatory (Medical Procedures & Services)				
Abortion*	X	X	X	X
Bariatric Surgery	N/A	X	X	X
Cochlear & Other Auditory Implants*	X	X	X	X
Cosmetic or Reconstructive Procedures/Surgeries**	X	X	X	X
Dental General Anesthesia (0 to less than 7 years of age only)	X	X	X	X
Dental Oral Maxillofacial Surgery, including Orthognathic Surgery*	X	X	X	X

	PA REQUIRED			
	CHIP	STAR	STAR KIDS	STAR+PLUS
Ambulatory (Medical Procedures & Services), continued				
External Defibrillators	X	X	X	X
Hearing Aids **NOTE:** PA required for STAR, STAR Kids, and STAR+PLUS Members 21 years and older only. PA not required for CHIP Members.		X	X	X
Hysterectomy	X	X	X	X
Implantable Devices, including trials (e.g., Bone Growth, Spine and Nerve Stimulators, Interspinous Process Decompressors)	X	X	X	X
Insulin Pumps/Continuous Glucose Monitoring Systems	X	X	X	X
Mammoplasty, Male and Female**	X	X	X	X
Otoplasty**	X	X	X	X
Rhinoplasty/Septoplasty**	X	X	X	X
Scar Revision**	X	X	X	X
Vagus Nerve Stimulation	X	X	X	X
Venous Procedures**	X	X	X	X
Ventricular Assist Devices (VAD)	X	X	X	X
Behavioral Health (BH)/Chemical Dependency (CD)/Substance Use				
Applied Behavioral Analysis (ABA) Therapy	N/A	X	X	X
Electro Convulsive Therapy (ECT)/Transcranial Magnetic Stimulation (TMS)	X	X	X	X
Intensive Outpatient Treatment (IOP), including Outpatient Detox/Rehab	X	X	X	X
Inpatient Admissions, including Detox/Rehab	X	X	X	X
Residential Treatment Center (RTC – BH/CD)	X	X	X	X
Partial Hospitalization Program (PHP)	X	X	X	X
Psychological/Neuropsychological testing, if testing is longer than 8 hours in duration	X	X	X	X
Clinician Administered Drugs (CAD) Refer to the separate CAD Prior Authorization List for specific codes requiring prior authorization				
Durable Medical Equipment/Orthotics/Prosthetics* **NOTE:** PA is only required for the codes listed with a **retail purchase cost of more than $1,000**. The total cost of each item requested must be included on the authorization request. ALL DME rentals require prior authorization. Power mobility devices and accessories, lymphedema pumps, and pneumatic compressors require prior authorization regardless of the cost. *Refer to the Medicaid PA code list or TMHP Provider Procedures Manual for limitations and supplies that require prior authorization.				
DME (HCPCS codes = Exxxx & Kxxxx) Total cost of purchases must be included in authorization request.	X	X	X	X
Orthotics/Prosthetics (HCPCS codes = Lxxxx) Total cost of purchases must be included in authorization request.	X	X	X	X
Insulin Pumps – all rentals/purchases	X	X	X	X
Hospital Grade Breast Pumps – all rentals/purchases (after intitial 60-day rental period)	X	X	X	X
Experimental/Investigational Services				
Experimental/Investigational Services*	X	X	X	X

	PA REQUIRED			
	CHIP	STAR	STAR KIDS	STAR+PLUS
Imaging Services/Diagnostic Procedures				
Electrophysiology Procedures (Outpatient and Office-based)	X	X	X	X
MRI, MRA (if not ordered by a Cardiologist, Neurosurgeon, Neurologist, or Orthopedic MD)	X	X	X	X
Sleep Apnea Studies & Procedures	X	X	X	X
Facility and Home Video EEG Monitoring	X	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.				
Molecular Diagnostic/Genetic Testing **NOTE:** PA is not required for codes 81220, 81420, and 81329.				
Molecular Diagnostic/Genetic Testing, including office-based testing	X	X	X	X
Nursing Services* (including initial evaluations)				
Private Duty Nursing (PDN)/Prescribed Pediatric Extended Care Centers (PPECC)	X	X	X	N/A
Skilled Nursing	X	X	X	X
Nutritional Supplements/Formulas B4100 thickener does not require authorization for Medicaid (STAR, STAR Kids, STAR+PLUS). **NOTE:** Supplies that fall under formula (B codes), but may also be considered DME, such as feeding pumps or nasogastric tubing, require authorization.				
Nutritional Supplements/Formulas* (HCPCS codes = Bxxxx)	X	X	X	X
Pain Management				
Implantable Pumps (Baclofen/Fentanyl)	X	X	X	X
Radiation Therapy				
Intensity Modulated Radiation Therapy (IMRT)	X	X	X	X
Stereotactic Radiosurgery (SRS)	X	X	X	X
Stereotactic Body Radiation Therapy (SBRT)	X	X	X	X
Supplies Authorization required for supplies exceeding $20k annually (the limit for Medicaid (HCPCS) and CHIP). Authorization required for incontinence supplies for Members under the age of 4. **All supplies that require a modifier need authorization.**				
Medical Supplies*	X	X	X	X
Telemonitoring				
Telemonitoring	X	X	X	X
Therapy/Rehabilitation* **NOTE:** NO authorization is required for ECI services.				
Cardiac & Pulmonary Rehabilitation Services	X	X	X	X

	PA REQUIRED			
	CHIP	STAR	STAR KIDS	STAR+PLUS
Therapy/Rehabilitation, continued*				
Occupational (OT) and Physical Therapy (PT) 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	X
Speech therapy (ST), 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	X
Transplant				
All Transplant Services — Solid Organ, CAR-T Cell, and Stem Cell Transplants (Pre-transplant evaluation and transplant procedures)	X	X	X	X
Transportation				
Ambulance Services • Non-emergency • Ground • Air **NOTE:** The referring physician or facility must originate authorization request.	X	X	X	X
Non-Emergency Medical Transportation (NEMT) **NOTE:** PA only required for trips over 120 miles.	X	X	X	X
Wound Care				
Facility-based	X	X	X	X
Hyperbaric Treatment	X	X	X	X
All Wound Vac (negative-pressure wound therapy) to include related supplies	X	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	X

**Benefit limitations apply. Please review Certificate of Coverage.*

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

ENDNOTES

- 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 with 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 by Community First Medicaid or CHIP 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.