COMMUNITY FIRST HEALTH PLANS

HMO & UFCP

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	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$^{\triangle}$
Includes all:		
Inpatient facility-to-facility transfers	X	X$^{\triangle}$
NICU/Special Care Nursery admissions	X	X$^{\triangle}$
Intraoperative Monitoring	X	X$^{\triangle}$
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$^{\triangle}$
Notification of DISCHARGE Required from all facilities	X	X

LEGEND

X$^{\triangle}$ 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 HMO/ UFCP 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. UFCP - Maximum per Calendar Year = 60 visits per year. Home Health and Outpatient services **cannot** be combined

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

X^{6} Any procedure that could be deemed as cosmetic requires authorization

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

REMINDER: BENEFIT COVERAGE MUST BE VERIFIED AT THE TIME OF THE REQUEST

CFHP AUTHORIZATION LIST	HMO	ASO
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[△]
Prior Authorization required for the medical procedures/services below (contracted/participating and non-contracted/non-participating providers):		
Abortion	X	X
Allergen Immunotherapy Services - when not provided by an Allergist or Immunologist	X	X[1]
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.	NA	NA
Bariatric Surgery	NA	X[3]
Bone Growth Stimulators	X	X
Chiropractic Treatment • CHIP requires authorization if greater than 12 visits	X	NA
Cosmetic Procedures or Surgeries	NA	NA
Dental - Oral maxillofacial surgery (including orthognathic surgery)	X	X[1]
Dental General Anesthesia - Benefit limitations outlined in Certificate of Coverage	X	X
External Defibrillators	X	X
Hearing Aids for adults 21 and over	X	X
Hysterectomy	X	X
Implantable devices (e.g., Interspinous Process Decompressors) - includes trials	X	X
Insulin Pumps/Continuous Glucose Monitoring Systems 95250, 95251	X	X
Mammoplasty (Male and Female)	X[6]	X[6]
Otoplasty (including Microtia Repair)	X[6]	X[6]
Rhinoplasty / Septoplasty	X[6]	X[6]

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Scar Revision	X[6]	X[6]
Vagus Nerve Stimulation	X	X[1]
Varicose Vein Treatment	X[6]	X[6]
Behavioral Health (BH) / Chemical Dependency (CD) / Substance Abuse		
Applied Behavioral Analysis (ABA) Therapy	X	X[1]
Residential Treatment (BH/CD)	X	X[△]
Inpatient Services (Includes Detox/ Rehab)	X	X[1]
Intensive Outpatient Services (Includes Outpatient Detox/ Rehab)	X	X[1]
ECT (Electro Convulsive Therapy) / TMS (Transcranial Magnetic Stimulation)	X	X[1]
Psychological / Neuropsychological Testing – if testing is greater than 8 hours/year	X	X[1]
Partial Hospitalization Services	X	X[1]
Cancer Chemotherapy Requires preauthorization for each medication greater than $500 per dose	X	X[1]
Durable Medical Equipment/Orthotics/Prosthetics (for each item greater than $500)		
All Custom DME (HCPCS Codes = Exxxx & Kxxxx)	X	X[1]
All Custom Orthotics/Prosthetics (HCPCS Codes = Lxxxx)	X	X[1]
Total Cost for Purchases must be included in the request for authorization • Based on billed charges	X	X[1]
All rentals, including:		
Bone or Spinal Cord Stimulators	X	X[1]
Insulin Pumps/Continuous Glucose Monitoring Systems	X	X[1]
Hospital Grade Breast Pumps – after the initial 60 day rental period	X	X
Experimental/Investigational Services	X	X[1]
Genetic Testing (to includes office-based testing)	X	X[1]

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Imaging Services/ Diagnostic Procedures		
MRI, MRA – if not ordered by a Neurologist, Neurosurgeon or Orthopedic MD	X	X[1]
SPECT, Three Dimensional (3D) Imaging/CTA - if not ordered by a cardiologist or cardiothoracic specialist	X	X[1]
Sleep Studies	X	X[1]
Video EEG Monitoring	X	X[1]
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[1]
Nursing Services (including initial evaluations)		
Private Duty Nursing (PDN)	X	NA
Skilled Nursing	X	X
Nutritional Supplements/Formulas (HCPCS Codes = Bxxxx) (Coverage based on diagnoses outlined in the Certificate of Coverage)	X	X
Obesity Treatment and Surgery	NA	X[3]
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[2]	X[2]

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Out-of-Network Specialists:		
Any non-urgent referral for Out-of-Network specialty office visits	NA	NA
2nd Opinions Out-of-Network	NA	NA
Pain Management		
Implantable pumps (Baclofen/fentanyl)	X	X
Spinal Cord and other Nerve Stimulators – includes trials	X	X
Pharmaceuticals Rx Medical Injectables Any injectable medication, including chemotherapy, greater than $500 per dose. Based on billed charges. NDC, HCPCS and billable units are required on the claim	X	X
Examples includes the following medications:		
Aflibercept (Eylea)	X	X
Eteplirsen (Exondys-51)	X	X
Histrelin implant (Supprelin LA)	X	X
Hyaluronate (Orthovisc or Gel-One)	X	X
IVIG (immune globulin)	X	X
Natalizumab (Tysabri)	X	X
Nusinersen (Spinraza)	X	X
Omalizumab (Xolair)	X	X
Onabotulinumtoxin A (Botox)	X	X
Pembrolizumab (Keytruda)	X	X
Romiplostim (NPlate)	X	X
Zoledronic Acid	X	X
Oncology drugs when utilized for off label use	X	X

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Supplies		
Medical supplies(HCPCS Codes = Axxxx)	X	X[1]
Telemonitoring	X	X[1]
Therapy/Rehabilitation		
Occupational and Physical Therapy - All visits, required in units and/or encounters along with procedure codes (Home and Outpatient) **NOTE:** OT and PT Evaluations and Re-Evaluations Do NOT require authorization	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[4]
Transplant		
ALL Services for Transplantation: Solid organ and Stem cell transplants (pre-transplant evaluation and transplant procedures)	X	X[1]
Transportation **NOTE:** Emergent transport subject to retrospective medical necessity review		
Wound Care		
Facility Based	X	X[1]
Hyperbaric Treatment	X	X[1]
All Wound Vac.(Negative-pressure wound therapy) to include related supplies	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.	X	X[1]

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