COMMUNITY FIRST HEALTH PLANS

# University Family Care Plan 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 University Family Care Plan (UFCP) product line. ***NOTE: ALL services for UFCP Members provided by University Health (UH), University Medical Associates (UMA), and UT Health San Antonio (UT) do not require prior authorization.***

| PRIOR AUTHORIZATION REQUESTS |
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| • 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/OUT-OF-SERVICE AREA PROVIDER SERVICES, SUPPLIES, EQUIPMENT |
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| • 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 |
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| **ADMISSIONS (Inpatient/Facilities/Programs)**<br>**Timely notification (within 24 hours) required for admission to all facilities/services listed below to include concurrent review.**<br>**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*<br>(Time limits allowed vary by plan) | X |
| Behavioral Health/Substance Use – Day Programs, including Intensive Outpatient (IOP)<br>• Does not include office visits with contracted/participating Providers. | X |
| Behavioral Health/Substance Use – Partial Hospitalization Program (PHP) | X |
| Behavioral Health/Substance Use – Residential Treatment Center (RTC) | X |
| Elective Inpatient Admissions<br>• All emergent inpatient/post-stabilization admissions require notification within 24 hours of admission or the next business day. | X |
| Inpatient Facility-to-Facility Transfers*<br>**NOTE**: The accepting facility is responsible for obtaining authorization prior to the transfer of a Member. | X |
| Intraoperative Monitoring | X |
| NICU/Special Care Nursery | X |
| Notification of Discharge (required from all facilities) | X |
| **Ambulatory (Medical Procedures & Services)** | |
| Abortion* | X |
| Ambulance Services<br>• Non-emergency<br>• Ground<br>• Air<br>**NOTE**: The referring physician or facility must originate authorization request. | X |
| Bariatric Surgery | X |
| Cochlear & other Auditory Implants* | X |
| Cosmetic or Reconstructive Procedures/Surgeries** | X |

| | PA REQUIRED |
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| **Ambulatory (Medical Procedures & Services), continued** | |
| Dental Oral Maxillofacial Surgery, including Orthognathic Surgery* | X |
| External Defibrillators | X |
| Hysterectomy | X |
| Implantable Devices, including trials<br>(e.g., Bone Growth, Spine and Nerve Stimulators, Interspinous Process Decompressors) | X |
| Insulin Pumps/Continuous Glucose Monitoring Systems | X |
| Mammoplasty, Male and Female** | X |
| Otoplasty** | X |
| Rhinoplasty/Septoplasty** | X |
| Scar Revision** | X |
| Vagus Nerve Stimulation | X |
| Venous Procedures** | X |
| Ventricular Assist Devices (VAD) | X |
| **Behavioral Health (BH)/Chemical Dependency (CD)/Substance Use** | |
| Electro Convulsive Therapy (ECT)/Transcranial Magnetic Stimulation (TMS) | X |
| Intensive Outpatient Services (IOP) including Outpatient DetoX/Rehab | X |
| Inpatient Services, including Detox/Rehab | X |
| Residential Treatment Centers (RTC – BH/CD) | X |
| Partial Hospitalization Program (PHP) | X |
| Psychological/Neuropsychological Testing, if testing is greater than 8 hours in duration | X |
| **Clinician Administered Drugs (CAD**<br>**Refer to the separate CAD Prior Authorization List for specific codes requiring prior authorization** | |
| **Durable Medical Equipment/Orthotics/Prosthetics/Supplies***<br>**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.**<br>**ALL DME rentals require prior authorization.**<br>**Power mobility devices and accessories, lymphedema pumps and pneumatic compressors require prior authorization regardless of the cost.** | |
| DME (HCPCS codes = Exxxx & Kxxxx)<br>All DME rentals require prior authorization<br>Total cost of purchases must be included in authorization request. | X |
| Orthotics/Prosthetics (HCPCS codes = Lxxxx)<br>Total cost of purchases must be included in authorization request. | X |
| Insulin Pumps – all rentals/purchases | X |
| Hospital Grade Breast Pumps – all rentals/purchases (after initial 60-day rental period) | X |
| **Experimental/Investigational Services** | |
| Experimental/Investigational Services* | X |
| **Imaging Services/Diagnostic Procedures** | |
| Electrophysiology Implants (Outpatient and Office-based) | X |

| | PA REQUIRED |
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| **Imaging Services/Diagnostic Procedures, continued** | |
| MRI, MRA (if not ordered by a Cardiologist, Neurosurgeon, Neurologist, or Orthopedic MD) | X |
| Sleep Apnea Studies & Procedures | X |
| Facility and Home Video EEG Monitoring | X |
| **Molecular Diagnostic/Genetic Testing**<br>NOTE: PA is not required for codes 81220, 81420, and 81329 | |
| Molecular Diagnostic/Genetic Testing, including Office-based Testing | X |
| **Nursing Services***<br>(including initial evaluations) | |
| Private Duty Nursing (PDN) | N/A |
| Skilled Nursing | X |
| **Nutritional Supplements/Formulas** | |
| Nutritional supplements/formulas* (HCPCS codes = Bxxxx) | X |
| **Pain Management** | |
| Implantable Pumps (Baclofen/Fentanyl) | X |
| **Radiation Therapy** | |
| Intensity Modulated Radiation Therapy (IMRT) | X |
| Stereotactic Radiosurgery (SRS) | X |
| Stereotactic Body Radiation Therapy (SBRT) | X |
| **Supplies** | |
| Medical Supplies* | X |
| **Telemonitoring** | |
| Telemonitoring | X |
| **Therapy/Rehabilitation***<br>NOTE: Authorization is not required for ECI services. Visit limitations apply for therapies to include chiropractic services. | |
| Cardiac & Pulmonary Rehabilitation Services | X |
| Occupational and Physical Therapy<br>All visits required in units and/or encounters along with procedure codes.<br>**NOTE**: OT and PT evaluations and re-evaluations DO NOT require authorization. | X |
| Speech Therapy, required ongoing treatments<br>A re-evaluation will be issued if ongoing treatments are authorized (home or outpatient).<br>**NOTE**: ST evaluations DO NOT require prior authorization. | X |
| **Transplant** | |
| All Transplant Services – Solid Organ, CAR-T Cell, and Stem Cell Transplants (Pre-Transplant Evaluation and Transplant Procedures) | X |
| **Wound Care** | |
| Facility-based | X |
| Hyperbaric Treatment | X |

| | PA REQUIRED |
|---|---|
| **Wound Care, continued** | |
| All Wound Vac (negative-pressure wound therapy) to include related supplies | X |
| **Unlisted and Miscellaneous Codes** | |
| Community First requires standard codes when requesting authorization.<br>Should an unlisted or miscellaneous code be used, medical necessity documentation and rationale must be prior authorized. | 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/Community First Authorization Form and MUST include referral from the Member's Primary Care Provider (PCP) or Specialist.
- Authorization is not required for out-of-network Emergency Room or observation for ALL product lines.

**APPLICABLE**

**If a benefit is labeled N/A, it is not covered by Community First Health Plans 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.**