



## Authorization Requirements for STAR/CHIP/HMO

**Effective Date: January 1, 2012**

CFHP Health Services Management  
RightFax: (210) 358-6381/(800) 887-7974

Authorization Phone Numbers:  
(210) 358 – 6050 or (800) 434 - 2347

**ALL TEXAS REFERRAL/AUTHORIZATION FORMS MUST BE SIGNED BY THE PRIMARY CARE PROVIDER (PCP) OR ORDERING PHYSICIAN THAT HAS A VALID REFERRAL FROM THE PCP.**

<p><b>Ambulatory / Surgical Procedures</b></p> <ul style="list-style-type: none"> <li>▪ Abortion (According to HHSC guidelines)</li> <li>▪ Bariatric Surgery</li> <li>▪ Blepharoplasty</li> <li>▪ Circumcision &gt; 21 years old</li> <li>▪ Cosmetic Procedures</li> <li>▪ Dental             <ul style="list-style-type: none"> <li>○ Oral maxillofacial surgery (including orthognathic surgery)</li> <li>○ Dental extractions/rehabilitation in members &gt;8 years old (general anesthesia and facility)</li> </ul> </li> <li>▪ Hysterectomy</li> <li>▪ Implantable devices (eg. Interspinous Process Decompressors)</li> <li>▪ Mammoplasty</li> <li>▪ Otoplasty (including Microtia repair)</li> <li>▪ Rhinoplasty/Septoplasty</li> <li>▪ Scar Revision</li> <li>▪ Vagus Nerve Stimulation</li> <li>▪ Varicose Vein Treatment</li> </ul>	<p><b>Out of Network</b></p> <p><b>All services inpatient or outpatient – Letter of Agreement (LOA) required.</b>  <b>NOTE: Authorization is required post stabilization for emergency room admissions.</b>  <b>Specialists:</b></p> <ul style="list-style-type: none"> <li>▪ Any non-urgent referral for Out-of-Network specialty office visits</li> <li>▪ 2nd Opinions Out-of-Network</li> </ul>
<p><b>Behavioral Health / Chemical Dependency/Substance Abuse</b></p> <ul style="list-style-type: none"> <li>▪ All Residential Treatment (BH/CD)</li> <li>▪ Inpatient Services (Includes Detox/ Rehab)</li> <li>▪ Intensive Outpatient Services (Includes Outpatient Detox/ Rehab)</li> <li>▪ ECT (Electro Convulsive Therapy)</li> <li>▪ Psychological / Neuropsych Testing</li> <li>▪ Partial Hospitalization Services</li> <li>▪ Outpatient Therapy Visits &gt; 20 for all members. Treatment plan must be submitted prior to the 20th outpatient visit.</li> </ul>	<p><b>Pain Management</b></p> <ul style="list-style-type: none"> <li>▪ Implantable pumps (Baclofen/fentanyl)</li> <li>▪ Spinal Cord and other Nerve Stimulators</li> </ul>
<p><b>Hospital Services/Inpatient Admissions</b></p> <p>Admission to any level of acute or sub-acute care, hospice, skilled nursing facilities, rehabilitation, admission and all other inpatient facility type admission. Excludes global OB 2 day vaginal and 4 day C-Section deliveries. <b>All emergent inpatient admissions require notification by the close of the next business day.</b></p> <p><b>Includes all :</b></p> <ul style="list-style-type: none"> <li>▪ Inpatient facility to facility transfers</li> <li>▪ NICU/Special Care Nursery admissions (revenue codes 172,173,and 174) and all global admissions</li> <li>▪ Elective admissions</li> <li>▪ Intraoperative Monitoring</li> <li>▪ Non-Standard Intraoperative Techniques</li> <li>▪ Robotic Assisted Procedures (Please note that no additional reimbursement will be provided for robotic assistance.)</li> </ul>	<p><b>Pharmaceuticals</b></p> <p><b>Rx Medical Injectables:</b></p> <ul style="list-style-type: none"> <li>▪ <b>Any injectable, billed charges &gt; \$500 (except chemotherapy for cancer treatment)</b>              Examples include the following medications:             <ul style="list-style-type: none"> <li>▪ Antiemetics for chemotherapy treatment</li> <li>▪ Aranesp</li> <li>▪ Growth Hormone</li> <li>▪ IVIG</li> <li>▪ Neulasta</li> <li>▪ Synagis</li> <li>▪ Xolair</li> <li>▪ Alpha Hydroxyprogesterone Caproate (17P)</li> <li>▪ Infusion Therapy– Outpatient (Exception–Chemotherapy)</li> </ul> </li> <li>▪ <b>Oncology drugs when utilized for off label use.</b></li> </ul>
<p><b>Imaging Services/ Diagnostic Procedures</b></p> <ul style="list-style-type: none"> <li>▪ CTA – Abdomen</li> <li>▪ MRI/ MRA</li> <li>▪ PCP Office Based Nerve Conduction Studies (NCS/EMG)</li> <li>▪ OB ultrasounds             <ul style="list-style-type: none"> <li>○ Maternal Fetal Medicine Specialists (MFM’s): Follow the ACOG Guidelines.</li> <li>○ Non MFM (OB-GYN Providers): No authorization is required for any two (2) of these CPT codes per single pregnancy: 76801, 76805, 76813, 76817.                 <ul style="list-style-type: none"> <li>▪ No authorization is required for the following CPT Codes for up to three (3) additional gestations in conjunction with related single codes: 76802, 76810, 76814</li> </ul> </li> </ul> </li> </ul> <p><b>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.</b></p>	<p><b>Physician Office-Based Surgical/Diagnostic/Lab procedures, billed charges &gt; \$500</b></p> <p><b>Therapy/Rehabilitation</b></p> <ul style="list-style-type: none"> <li>▪ Occupational, Physical &amp; Speech Therapy (Home or Outpatient Setting)</li> <li>▪ ECI- only Commercial members require authorization</li> </ul> <p><b>NOTE: No authorization required for the initial evaluation</b></p>
<p><b>Nursing Services</b></p> <ul style="list-style-type: none"> <li>▪ Private duty</li> <li>▪ Home Health</li> </ul>	<p><b>Transplant</b></p> <p>Services for Transplant Evaluation and/or Transplant Procedure and one (1) year post transplant.</p> <p><b>Transportation</b></p> <ul style="list-style-type: none"> <li>▪ Non-emergent Air Transport</li> <li>▪ Non-emergent Ambulance</li> </ul> <p><b>NOTE: Emergent transport subject to medical necessity review</b></p> <p><b>Wound Care</b></p> <ul style="list-style-type: none"> <li>▪ Facility Based</li> <li>▪ Hyperbaric Treatment</li> <li>▪ Wound Vac and related supplies</li> </ul> <p><b>NOTE: No authorization required for the initial evaluation.</b></p> <p><b>Other Services, Supplies, and Tests</b></p> <ul style="list-style-type: none"> <li>▪ All DME Rentals</li> <li>▪ Bone Growth Stimulators</li> <li>▪ Chiropractor covered for STAR &amp; CHIP members only (Note: CHIP first 12 visits no authorization required)</li> <li>▪ DME ( &gt; \$500 purchase price)</li> <li>▪ Genetic Testing</li> <li>▪ Orthotics ( &gt; \$500 purchase price)</li> <li>▪ Prosthetics ( &gt; \$500 purchase price) (including cochlear implants)</li> <li>▪ Hearing aids for Medicaid adults 21 and over</li> <li>▪ Nutritional supplements/Formulas</li> <li>▪ Supplies over the Medicaid benefit limit</li> <li>▪ External bone anchored hearing aids</li> <li>▪ Continuous Glucose Monitoring Systems (Type II DM) A9276, A9277, A9278</li> <li>▪ External defibrillators</li> </ul>

**NOTE: Authorization Requirements do not confirm covered benefits for all products. Services considered experimental or investigational may not be covered.**