

This Prior Authorization Grid contains services that require prior authorization only and is not intended to be a comprehensive list of covered services. Providers should refer to the appropriate Evidence of Coverage (EOC) for a complete list of covered services.

SCFHP Utilization Management Department:

Telephone: 408-874-1821

Prior Authorization Request Submission Fax Lines: 408-874-1957 or
408-376-3548

When faxing a request to SCFHP, please:

1. Use the SCFHP Prior Authorization Request – Medical Services Form found at www.scfhp.com
2. Attach pertinent medical records, treatment plans, test results and evidence of conservative treatment to support medical necessity.

Other Contact Information:

SCFHP Automated Eligibility: 1-800-720-3455

SCFHP Customer Service:

Medi-Cal & Healthy Kids: 1-800-260-2055

Cal MediConnect: 1-877-723-4795

For Non-Emergency Medical Transportation & Non-Emergency Transportation contact SCFHP Customer Service

Benefits Authorized by Vendors:

Dental Services:

Medi-Cal & Cal MediConnect: Contact Denti-Cal at 1-800-322-6384

Healthy Kids: Contact Liberty Dental at 1-888-902-0403

Vision Services: Contact Vision Service Plan (VSP) at 1-844-613-4779

Category of Service	Services Requiring Prior Authorization	
Behavioral Health Treatment	All Behavioral Health Treatment Services for members age 21 years and under with behavioral conditions that may or may not include autism spectrum	
Durable Medical Equipment <i>*Benefit and frequency limits apply. Refer to CMS, Noridian, and/or Medi-Cal Provider Manual</i>	Cal MediConnect	Medi-Cal & Healthy Kids HMO
	<ul style="list-style-type: none"> • Custom Made Items • Any other DME or Medical Supply Item Exceeding \$1000 • Prosthetics & Customized Orthotics Exceeding \$1000 • Hearing Aids • Other Specialty Devices 	<ul style="list-style-type: none"> • CPAP and BIPAP • Enteral Formula and Supplies • Hospital Bed and Mattress • Oxygen • Requests Over the Benefit Limit • Power Wheelchairs, Scooters, Manual Wheelchairs (except standard adult and pediatric), and Motorized Wheelchairs and Accessories • Respiratory: Oxygen, BIPAP, CPAP, Ventilators • Prosthetics & Customized Orthotics, not including off-the-shelf covered items • Hearing Aids • Other Specialty Devices
Experimental Procedure	<ul style="list-style-type: none"> • Experimental Procedures • Investigational Procedures • New Technologies 	
Home Health	<ul style="list-style-type: none"> • All Home Health Services • Home IV Infusion Services 	
Inpatient Admissions	<p>All elective medical and surgical inpatient admissions to:</p> <ul style="list-style-type: none"> • Acute Hospital • Long Term Acute Care (LTAC) <p>All admissions for:</p> <ul style="list-style-type: none"> • Acute Inpatient Psychiatric • Partial Hospital Psychiatric Treatment • Substance Use Disorder including Detoxification <p>Rehabilitation and Therapy Services</p> <ul style="list-style-type: none"> • Acute Rehabilitation Facilities • Skilled Nursing Facilities (SNF) 	
Long-Term Services and Supports (LTSS)	<ul style="list-style-type: none"> • Community-Based Adult Services (CBAS) • Long-Term Care 	
Medications	<ul style="list-style-type: none"> • Refer to the 2019 Medical Benefit Drug Prior Authorization Grid • Drugs administered in the doctor's office or in an outpatient setting 	

Category of Service	Services Requiring Prior Authorization
Non-Contracted Providers	All non-urgent/emergent services provided by non-contracted providers
Organ Transplant	All Organ Transplants
Outpatient Services and Procedures	<ul style="list-style-type: none"> • Abdominoplasty/Panniculectomy • Bariatric Surgery • Breast Reduction and Augmentation Surgery • Cataract Surgery • Cochlear Auditory Implant • Dental Surgery, Jaw Surgery and Orthognathic Procedures • Dermatology: <ul style="list-style-type: none"> • Laser Treatment • Skin Injections • Implants • All types of Endoscopy, except Colonoscopy • Gender Reassignment Surgery • Genetic Testing and Counseling • Hyperbaric Oxygen Therapy • Intensive Outpatient Palliative Care (IOPC) • Neuro and Spinal Cord Stimulators • Outpatient Diagnostic Imaging: <ul style="list-style-type: none"> • Magnetic Resonance Imaging (MRI) • Magnetic Resonance Angiography (MRA) • Nuclear Cardiology Procedures • Single-Photon Emission Computerized Tomography (SPECT) • Positron-Emission Tomography (PET/PET-CT) • Outpatient Therapies <ul style="list-style-type: none"> • Occupational Therapy (OT) • Physical Therapy (PT) • Speech Therapy (ST) • All Plastic Surgery and Reconstructive Procedures • Podiatry <ul style="list-style-type: none"> • All podiatric surgeries • All podiatric services provided in a nursing or skilled nursing facility • Radiation Therapy: <ul style="list-style-type: none"> • Intensity Modulated Radiation Therapy (IMRT) • Proton Beam Therapy • Stereotactic Radiation Treatment (SBRT) • Sleep studies • Spinal Procedures, except Epidural Injections • Surgery for Obstructive Sleep Apnea • Temporomandibular Disorder (TMJ) Treatment

Category of Service	Services Requiring Prior Authorization
	<ul style="list-style-type: none"> • Transplant-related services (EXCEPT Cornea transplant): Prior to surgery • Unclassified Procedures • Varicose Vein Treatment
Transportation	Non-Emergency Medical Transportation for ground and air <u>except</u> ground transportation from facility to facility and hospital to home.