Medical Covered Services
Prior Authorization Grid

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), available online at www.scfhp.com, for a complete list of covered services.

Santa Clara Family Health Plan (SCFHP) Utilization Management Department:

Telephone: 1-408-874-1821
Prior Authorization Request Submission Fax Lines: 1-408-874-1957 or 1-408-376-3548

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: 1-800-260-2055
Cal MediConnect: 1-877-723-4795

For Non-Emergency Medical Transportation (NEMT) & Non-Medical Transportation (NMT) contact SCFHP Customer Service

Benefits Authorized by Vendors:

Dental Services
Denti-Cal: 1-800-322-6384
Vision Services
Vision Service Plan (VSP): 1-844-613-4779

Medical Covered Services Prior Authorization Grid

<table>
<tr><th>Category of Service</th><th colspan="2">Services Requiring Prior Authorization</th></tr>
<tr><td>Behavioral Health Treatment</td><td colspan="2">All Behavioral Health Treatment Services for members age 21 years and under with behavioral conditions that may or may not include autism spectrum</td></tr>
<tr><td rowspan="2">Durable Medical Equipment (DME)

*Benefit and frequency limits apply. Refer to CMS, Noridian, and/or Medi-Cal Provider Manual</td><td>Cal MediConnect</td><td>Medi-Cal</td></tr>
<tr><td>• Custom made items
• Any other DME or medical supply exceeding $1000
• Prosthetics & customized orthotics exceeding $1000
• Hearing aids and repairs
• Other specialty devices
• Requests over the benefit limit</td><td>• CPAP and BIPAP
• Enteral formula and supplies
• Hospital bed and mattress
• Power wheelchairs, scooters, manual wheelchairs <u>except</u> standard adult and pediatric, and motorized wheelchairs and accessories
• Respiratory: Oxygen, BIPAP, CPAP, ventilators
• Prosthetics & customized orthotics <u>except</u> off-the-shelf covered items
• Hearing aids and repairs
• Other specialty devices
• Requests over the benefit limit</td></tr>
<tr><td>Experimental Procedure</td><td colspan="2">• Experimental procedures
• Investigational procedures
• New technologies</td></tr>
<tr><td>Home Health</td><td colspan="2">• All home health services
• Home IV infusion services</td></tr>
<tr><td>Inpatient Admissions</td><td colspan="2">• All elective medical and surgical inpatient admissions to:
    ◦ Acute hospital
    ◦ Long Term Acute Care (LTAC)
• All admissions for:
    ◦ Acute inpatient psychiatric
    ◦ Partial hospital psychiatric treatment
    ◦ Substance use disorder including detoxification
• Rehabilitation and therapy services:
    ◦ Acute rehabilitation facilities
    ◦ Skilled Nursing Facilities (SNF)</td></tr>
<tr><td>Long-Term Services and Supports (LTSS)</td><td colspan="2">• Community-Based Adult Services (CBAS)
• Long-Term Care (LTC)</td></tr>
</table>

Category of Service	Services Requiring Prior Authorization
Medications	• Refer to the 2020 Medical Benefit Drug Prior Authorization Grid • Physician administered drugs in the doctor's office or in an outpatient setting
Non-Contracted Providers	All non-urgent/non-emergent services provided by non-contracted providers
Organ Transplant	All organ transplants

Outpatient Services and Procedures	• Abdominoplasty/Panniculectomy
	• Bariatric surgery
	• Breast reduction and augmentation surgery
	• Cataract surgery
	• Cochlear auditory implant
	• Dental surgery, jaw surgery and orthognathic procedures
	• Dermatology:
	    • Laser treatment
	    • Skin injections
	    • Implants
	• All types of endoscopy **<u>except</u> colonoscopy**
	• Gender reassignment surgery
	• Genetic testing and counseling
	• Hyperbaric oxygen therapy
	• Intensive Outpatient Palliative Care (IOPC)
	• Neuro and spinal cord stimulators
	• Outpatient diagnostic imaging:
	    • 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
	    • Occupational Therapy (OT)
	    • Physical Therapy (PT)
	    • Speech Therapy (ST)
	• All plastic surgery and reconstructive procedures
	• Podiatry
	    • All podiatric surgeries
	    • All podiatric services provided in a nursing or skilled nursing facility
	• Radiation therapy:
	    • Proton beam therapy
	    • Stereotactic Radiation Treatment (SBRT)
	• Sleep studies
	• Spinal procedures **<u>except</u> epidural injections**

Category of Service	Services Requiring Prior Authorization
	• Surgery for Obstructive Sleep Apnea (OSA) • Temporomandibular Disorder (TMJ) treatment • Transplant-related services prior to surgery **except cornea transplant** • Unclassified procedures • Varicose vein treatment
Transportation	Non-Emergency Medical Transportation (NEMT) for ground and air **except ground transportation from facility to facility and hospital to home**.