



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

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 (DME) <i>*Benefit and frequency limits apply. Refer to CMS, Noridian, and/or Medi-Cal Provider Manual</i>	Cal MediConnect	Medi-Cal
	<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • CPAP and BIPAP • Enteral formula and supplies • Hospital bed and mattress • Power wheelchairs, scooters, manual wheelchairs except standard adult and pediatric, and motorized wheelchairs and accessories • Respiratory: Oxygen, BIPAP, CPAP, ventilators • Prosthetics & customized orthotics except off-the-shelf covered items • Hearing aids and repairs • Other specialty devices • Requests over the benefit limit
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	<ul style="list-style-type: none"> • All elective medical and surgical inpatient admissions to: <ul style="list-style-type: none"> • Acute hospital • Long Term Acute Care (LTAC) • All admissions for: <ul style="list-style-type: none"> • Acute inpatient psychiatric • Partial hospital psychiatric treatment • Substance use disorder including detoxification • Rehabilitation and therapy services: <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 (LTC) 	

Category of Service	Services Requiring Prior Authorization
Medications	<ul style="list-style-type: none"> 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	<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 Podiatric surgeries Radiation therapy: <ul style="list-style-type: none"> Proton beam therapy Stereotactic Radiation Treatment (SBRT) Sleep studies Spinal procedures except epidural injections Surgery for Obstructive Sleep Apnea (OSA) Temporomandibular Disorder (TMJ) treatment



Category of Service	Services Requiring Prior Authorization
	<ul style="list-style-type: none">• 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.