Medical Covered Services Prior Authorization Grid

Medi-Cal and DualConnect

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.

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

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

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
DualConnect:	1-877-723-4795

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

Benefits Authorized by Vendors:

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

Santa Clara Family Health Plan™

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<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</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>Medi-Cal</td><td>DualConnect</td></tr>
<tr><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 Medi-Cal benefit limit</td><td>• All items listed in the Medi-Cal column requiring prior authorization
• Custom made items
• DME or medical supply exceeding $1,000
• Requests over the Medicare benefit limit</td></tr>
<tr><td>Experimental Procedure</td><td colspan="2">• Experimental or 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
  • Intermediate Care 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)
• Community Supports</td></tr>
<tr><td>Medications</td><td colspan="2">• Refer to the Medical Benefit Drug Prior Authorization Grid</td></tr>
</table>

Category of Service	Services Requiring Prior Authorization
Non-Contracted Providers	All non-emergency 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 **except colonoscopy**
	• Gender reassignment surgery
	• Genetic testing and counseling
	  • **except biomarker testing that is associated with a federal Food and Drug Administration (FDA)-approved therapy cancer**
	  • **and except prenatal diagnostic genetic testing**
	• 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
	• Podiatric surgeries
	• Radiation therapy:
	  • 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
	• Transplant-related services prior to surgery **except cornea transplant** • Unclassified procedures • Varicose vein treatment
Transportation	Non-Emergency Medical Transportation (NEMT) **except ground transportation from facility to facility and hospital to home**.