Community Health Center Network *Setting the standard for Community Health Care*	**Community Health Center Network (CHCN) PRIOR AUTHORIZATION GRID** **Before services are provided PLEASE CHECK Provider Portal for:** ***Member Eligibility *Benefit Coverage *Contracted Provider** **Questions --Call CHCN at 510-297-0220** **02/09/2016**		**Click Here for CHCN's Provider Portal**	
Type of Service	**Benefit Criteria**	**Non-Covered Benefit**	**Authorization Required**	**No Authorization Required**
All Services from non-contracted providers	Excluding sensitive services		√	
All Out-of-Area Services	Outpatient and office		√	
Bariatric psychiatric evaluations			√	
Biofeedback	Refer to plan Evidence Of Coverage (EOC) for exceptions	√		
Cataract spectacles and lenses			√	
Cardiac Rehab			√	
Children's Developmental Evaluations				√
Chiropractic services	Refer to plan			
Clinical Trials			√	
Cosmetic Services	Exlcuding reconstructive or certain transgender surgeries. Refer to plan EOC	√		
Custodial Care Services		√		
Coumadin Clinic Services				√
Dental Care	**Medi-Cal:** IV Sedation and general anesthesia		√	
	Refer to plan EOC for coverage criteria and exceptions			
	Group Care: Covered through Public Authority	√		
Dermatology	Dr. Min-Wei (Christine) Lee PA required		√	
Diagnostic and Laboratory Services	Lab tests performed by Quest Diagnostics			√
	Lab tests performed by providers other than Quest Diagnostics		√	
	All genetic testing performed by Quest Diagnostics		√	
Dialysis	**AAH**: Refer to plan. Services provided by DaVita			√
	ABC: Extended authorizations for 6 months		√	
Durable Medical Equipment/Repair	**AAH:** Submit CHME DME Prior Authorization (PA) form to CHME: Phone: 1-800-906-0626; fax: 650-357-8551; email: aaquestions@chme.org; aaquestions@chme.org		√	
	ABC: Submit CHCN Prior Authorization form to CHCN, ONLY for the following DME: *Air Fluidized Beds, *Bone Growth Stimulators, *Cervical Collars, *Cold Therapy Units, *Compression Hosiery & Support Stockings, *Continuous Glucose Pump, *CPM device, *Cranial Helmets, *Diabetic Shoes, *Dynamic Splint, *Electric Patient Lifts, *Electric Seat Lift Chairs, *Home Infusion Therapy, *Insulin Pump, *Mastectomy Related Accessories, *Ocular Prosthetics, *Respiratory Therapy Medication, *Lymphedema Pumps, *Speech Generating Devices, *Tractions, *Vest Airway Clearance System		√	

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Enteral and nutrition formulas	**AAH:** refer to plan.			
	ABC: submit PA to CHCN		√	
Emergency Care/Treatment				√
Early and Periodic Screening, Diagnostic and Treatment (EPSDT) supplemental services				√
Experimental/Investigational treatments		√		
Facility admissions	Inpatient, SNF, LTAC, Hospice, Acute Rehab, Respite, Burn Centers		√	
Gender Identity/Transgender Services	Surgical Treatments		√	
Hearing Aids	**AAH:** refer to plan.			
	ABC: Submit PA to CHCN		√	
Home Health:	Evaluation			√
Skilled Nursing, OT,PT, ST	Visits beyond evaluation		√	
Hospice Services	Home or Inpatient		√	
Incontinence creams and washes		√		
Infertility treatment		√		
Injectable, Chemotherapy, Infusion, Transfusions--Outpatient	Refer to plan website for Drug Formulary		√	
Mental Health Services	**Mild to Moderate:** Refer to plan			
	AAH: Submit PA to BEACON for **Pre-Bariatric** surgery Psych Eval			
	ABC: Submit PA to CHCN for **Pre-Bariatric** surgery Psych Eval		√	
Nutrition and dietician assess/counseling	Pre-Bariatric surgery		√	
OB/GYN Services	Including ultrasounds			√
Ophthalmology	Annual services and care related to DM, glaucoma, ocular degeneration			√
Orthodontics, orthognathic and appliance therapy for TMJ		√		
Orthotics and Prosthetics (e.g. breast prostheses,	**AAH:** Refer to plan			
footwear to treat/prevent diabetes complications,	**ABC:** submit PA to CHCN		√	
Outpatient surgery and specialty procedures			√	
Outpatient Therapy (OT, PT, ST)	OT, PT, ST Initial Evaluations			√
	OT, PT, ST follow-up visits		√	
Podiatry	**Medi-Cal:** 1) ≥21 years if provided <u>OUTSIDE of FQHC</u> care setting or at a Rural Health Clinic (RHC) when Only certain chronic conditions are covered: e.g. Diabetes or equivalent 2) ≥21 years old if provided at FQHC or RHC greater than 2 visits/month		√	
	Medi-Cal: 1) < 21 years with no limitations on care settings 2) >21 years old if <u>provided at FQHC or RHC</u> up to 2 visits/month			√
	Group Care: All ages, clinic settings, and continuous		√	

Type of Service	Benefit Criteria	Non-Covered Benefit	Authorization Required	No Authorization Required
Preventive Care				√
Pulmonary Rehab			√	
Interventional Radiology				√
Radiology	**Advanced Radiology provided within the Hospital:** CT with or without contrast, MRI, MRA, Nuclear Med, PET Scans, DEXA Scans.		√	
	Advanced Radiology provided within Non-Hospital/Freestanding facilities: CT with contrast, MRI, MRA, PET Scans, and DEXA Scans for members 64 years of age and younger.		√	
	Advanced Radiology provided within Non-Hospital/Freestanding facilities: CT without contrast, Nuclear Med, and DEXA Scans for members 65 years of age and older.			√
	Routine: X-ray, Ultrasound including OB, Mammography, VCUG, IVP, BE, Upper GI			√
Second Opinions			√	
Sensitive Services (including therapeutic abortion & HIV testing & counseling	**Medi-Cal:** (contracted and non-contracted providers)			√
	Group Care: (contracted providers only)			√
	Group Care: (non-contracted providers)		√	
Sleep Studies				√
Specialist and Hospitalist Referrals (In-network)	Dr. Scott Taylor: PA required			√
Standard diagnostic procedures	EKG, PFT, EGD, KUB, Nuchal Translucency Scan, Transthoracic Echocardiograms			√
Specialty diagnostic procedures	Stress/Pharmacologic or Trans-esophageal Echocardiograms, Colonoscopy/Sigmoidoscopy		√	
Surgery Services - Outpatient	Includes Outpatient Laser Surgery of the Eye		√	
Transplant Services	All pre-transplant service evaluations, Kidney and Corneal		√	
	Medi-Cal: Refer to plans for major organ transplants (heart, lung, liver, bone marrow, etc.)	√		
	Group Care: All major organ and bone marrow transplants		√	
Vaccines				√
Wound Care services			√	