Effective 11/1/2023
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Contra Costa Health Plan Authorization Matrix

Disclaimer:

- All services provided by Non-Contracted/Out of Network Providers require Prior Authorization, except for Emergency Services for all CCHP members, and Sensitive Services for Medi-Cal members
- For Commercial A / IHSS members, in network is CCRMC only, except for: optometry, dialysis, DME, and mental health for which the CPN network is considered in-plan. Other services are reviewed on a case-by-case basis
- For Medi-Cal members, only Medi-Cal covered codes would be processed according to the Authorization Matrix. All Medi-Cal billing guidelines and billing limits must be followed

Service Type	Services	Medi-Cal Members	Commercial Plan A Members		Commercial Plan B Members
			Plan A	IHSS A2 + A2	
Inpatient Admission	Elective/scheduled inpatient admissions including obstetrics and hospice	PA Required	PA Required	PA Required	PA Required
	Hospice	None	PA Required	PA Required	PA Required
	Inpatient Admissions (discussed further below) including, but not limited to, Medical/Surgical, Telemetry, Intermediate Care/Step-Down, Intensive Care, Maternity/OB, Long Term Acute Care, Acute Rehab, SNF, Mental Health and Substance Use Treatment	PA Required	PA Required	PA Required	PA Required
Behavioral/Mental Health Services	Outpatient Behavioral Health - Psychotherapy - Psychiatry Substance Use Treatment	No PA Required	No PA Required	No PA Required	No PA Required
	Comprehensive Diagnostic Evaluation (CDE)	PA Required	PA Required	PA Required	PA Required
	Functional Behavioral Assessment (FBA)/Applied Behavior Analysis (ABA)	PA Required	PA Required	PA Required	PA Required

Service Type	Services	Medi-Cal Members	Commercial Plan A Members		Commercial Plan B Members
			Plan A	IHSS A2 + A2	
	Neuropsychology/Neuropsych Testing (NPT)	PA Required	PA Required	PA Required	PA Required
Dental	Dental	Not Covered	Not Covered	IHSS Plan A2 – None Plan A2 - Not Covered	Not Covered
	Dental Anesthesia	PA Required	PA Required	PA Required	PA Required
Dialysis Treatment	Dialysis / Hemodialysis	None	None	None	None
Diagnostic Procedures	Bronchoscopy	None	None	None	None
	Colonoscopy	None	None	None	None
	Colposcopy	None	None	None	None
	Cystoscopy	None	None	None	None
	Endoscopy	None	None	None	None
	ERCP	None	None	None	None
	Mediastinoscopy	None	None	None	None
	Sigmoidoscopy	None	None	None	None
DME and Supplies	DME (non rentals)	No PA Required if Billed Charge is <$500	No PA Required if Billed Charge is <$500	No PA Required if Billed Charge is <$500	No PA Required if Billed Charge is <$500
	DME Rentals	No PA Required if Billed Charge is <$500	No PA Required if Billed Charge is <$500	No PA Required if Billed Charge is <$500	No PA Required if Billed Charge is <$500
	Enteral Products/Enteral Nutrition	PA Required	PA Required	PA Required	PA Required
	Hearing Aids	PA Required	PA Required	Not Covered	PA Required

Service Type	Services	Medi-Cal Members	Commercial Plan A Members		Commercial Plan B Members
			Plan A	IHSS A2 + A2	
	Non-reusable medical supplies, wound care, incontinence supplies, bathroom items	None (up to Medi-Cal limit)	Not Covered	Not Covered	Not Covered
	Prosthetics, Orthotics, Appliances, and Braces	No PA Required if Billed Charge is <$500	PA Required	PA Required	PA Required
Experimental / Investigational Services	Experimental/Investigational Services	PA Required	PA Required	PA Required	PA Required
Imaging and Diagnostic Services	CT Scans (except total body)	None	None	None	None
	Dexa Scan - > 65 years old with no previous DEXA in the last 2 years Referral form	None	None	None	None
	ECHO	None	None	None	None
	EEG	None	None	None	None
	EKG	None	None	None	None
	Electromyography (EMG), Nerve Conduction Study (NCS), Electronystagmography (ENG)	PA Required	PA Required	PA Required	PA Required
	Mammograms 1/year	None	None	None	None
	Magnetic Resonance Imaging (MRI) & Magnetic Resonance Angiography (MRA)	None	None	None	None
	OB ultrasound (limited to 2 OB ultrasounds; unlimited if requested by perinatologist)	None	None	None	None
	PET Scans/other ultrasounds	PA Required	PA Required	PA Required	PA Required
	Total Body Scan Physician administered medications	PA Required	PA Required	PA Required	PA Required
	Pulmonary function tests	None	None	None	None

Service Type	Services	Medi-Cal Members	Commercial Plan A Members		Commercial Plan B Members
			Plan A	IHSS A2 + A2	
	Thyroid Scan	None	None	None	None
	X-Rays (non-Mammograms)	None	None	None	None
Home-based Services	Home Health Services including home infusion therapy	None	None	None	None
	In Home Hospice Services	None	None	None	None
Lab and Testing Services	Labs (no genetic testing)	None	None	None	None
	Labs for genetic testing (except for cancer biomarker for stage iii/iv for FDA approved)	PA Required	PA Required	PA Required	PA Required
	Labs genetic testing for cancer biomarker for stage iii/iv for FDA approved	Retro Auth Required	Retro Auth Required	Retro Auth Required	Retro Auth Required
	RAST or MAST Testing	PA Required	PA Required	PA Required	PA Required
Medi-Cal CalAIM Services	Community Health Worker (CHW)	No PA Required (up to 2hrs/day, total of 6hrs/year)	Not Covered	Not Covered	Not Covered
	Community Supports (CS)/In Lieu of Services (ILOS) - CalAIM	PA Required	Not Covered	Not Covered	Not Covered
	Enhanced Care Management (ECM) for CalAIM	PA Required	Not Covered	Not Covered	Not Covered
Minor Surgery	Breast Biopsy	None	None	None	None
	Dilation and Curettage procedure (non-family planning / state supported services)	None	None	None	None
	FNA	None	None	None	None
	Foreign Body Removal	None	None	None	None
	Hardware Removal	None	None	None	None
	Hemorrhoid Sclerosing	None	None	None	None

Service Type	Services	Medi-Cal Members	Commercial Plan A Members		Commercial Plan B Members
			Plan A	IHSS A2 + A2	
	Malignment Treatment (1 time)	None	None	None	None
	Nail Removal	None	None	None	None
	ORIF of finger	None	None	None	None
	Porta Cath Placement	None	None	None	None
	Punch Biopsy	None	None	None	None
	Vitrectomy	None	None	None	None
OB Care including pregnancy, childbirth, and postpartum	Global Outpatient Obstetrics (OB) Care	No PA Required for up to 13 OB visits/11 months	No PA Required for up to 13 OB visits/11 months	No PA Required for up to 13 OB visits/11 months	No PA Required for up to 13 OB visits/11 months
	Doula Services - Combination of prenatal and postpartum	No PA Required (up to Medi-Cal limit)	Not Covered	Not Covered	Not Covered
Office Visits	Acupuncture	No PA Required for up to 10 visits/year	No PA for up to 10 visits/year	Not Covered	No PA for up to 10 visits/year
	Chiropractic Care	No PA Required for up to 10 visits/year	No PA Required for up to 10 visits/year	Not Covered	No PA Required for up to 20 visits/year
	PCP Referral to Self for Specialty Care	PA Required	PA Required	PA Required	PA Required
	PCP Services	No PA Required for Assigned PCP / PCP Group only	No PA Required for Assigned PCP / PCP Group only	No PA Required for Assigned PCP / PCP Group only	No PA Required for Assigned PCP / PCP Group only

Service Type	Services	Medi-Cal Members	Commercial Plan A Members		Commercial Plan B Members
			Plan A	IHSS A2 + A2	
	Preventative Services including influenza vaccination & GYN Services (routine women's health)	None	None	None	None
	Specialist at Tertiary Care Center (i.e., UCSF, Stanford, Lucille Packard, or other noncontracted facilities)	PA Required	PA Required	PA Required	PA Required
	Specialist Provider Office Visits (except for those listed in **Special Programs**)	None	None	None	None
Outpatient Services	Skilled Nursing Facility Based Physical Therapy, Speech Therapy, and Occupational Therapy (starting January 1, 2023)	PA Required	PA Required	PA Required	PA Required
Outpatient Surgeries & Procedures	Outpatient Surgeries and Procedures	PA Required	PA Required	PA Required	PA Required
Special Programs	Bariatric Surgery	PA Required	PA Required	PA Required	PA Required
	Neurosurgery consult, evaluation and services	PA Required	PA Required	PA Required	PA Required
	Organ transplant evaluation	PA Required	PA Required	PA Required	PA Required
	Pain Management procedures	PA Required	PA Required	PA Required	PA Required
	Sleep lab/Sleep studies	PA Required	PA Required	PA Required	PA Required
	Transgender consults and referrals	PA Required	PA Required	PA Required	PA Required
Therapy & Rehabilitation Services	Cardiac and pulmonary rehabilitation	PA Required	PA Required	PA Required	PA Required
	Outpatient Physical, Occupational, Speech therapy	None	None	None	None
Transplant	Major Organ Transplant evaluation and services (see DHCS APL 21-015 for further information)	PA Required	PA Required	PA Required	PA Required

Service Type	Services	Medi-Cal Members	Commercial Plan A Members		Commercial Plan B Members
			Plan A	IHSS A2 + A2	
Transportation	Non-Emergency Transportation (Unaccompanied Minors require a signed Minor Consent form)	PA Required	Not Covered	Not Covered	Not Covered
	Non-Medical Transportation	Contact Member Services / Transportation Line	Not Covered	Not Covered	Not Covered
Treatments	Chemo and Radiation Therapy (for cancer related diagnosis) except for intensity-modulated radiation (IMRT)	None	None	None	None
	Chemo/Radiation Therapy (not related to cancer)	PA Required	PA Required	PA Required	PA Required
	Tuberculosis Treatment	No PA Required if coordinated by Local Health Department	No PA Required if coordinated by Local Health Department	No PA Required if coordinated by Local Health Department	No PA Required if coordinated by Local Health Department
Vision Care	Optometry/Vision Care - Diagnostics, ancillary, supplemental procedures (1 in 24 months, annually for individuals with diabetes)	None	None	None	None
	2nd eye exam with refraction medically necessary (within 24 months), or otherwise more frequently if medically necessary	PA Required	PA Required	PA Required	PA Required
	Contact Lens	PA Required	No PA Required for 1 annually	Not Covered except for keratoconus	No PA Required for 1 annually

Service Type	Services	Medi-Cal Members	Commercial Plan A Members		Commercial Plan B Members
			Plan A	IHSS A2 + A2	
	Glasses	No PA Required for 1 per 24 months	No PA Required for 1 annually	Not Covered except for keratoconus	No PA Required for 1 annually
	Orthoptics and Pleoptics	Not Covered	Not Covered	Not Covered	Not Covered