SAN FRANCISCO HEALTH PLAN

CO-66: Prior Authorization

APPROVAL/REVIEW/REVISION HISTORY			
Signature	**Title**	**Date**	**Action**
DocuSigned by: Nina Maruyama 9D4617B1400D431...	CCO	12/23/2025	New Policy
Signed by: Steve O'Brien 60DFB20814944C4...	CMO	12/23/2025	

San Francisco Health Plan℠

SFHP POLICY AND PROCEDURE

Prior Authorization

Policy and Procedure Number:	CO-66
Department:	Clinical Operations
Accountable Lead:	Clinical Operations Policy Analyst
Lines of Business and Coverage Programs Affected:	☒Medi-Cal ☒SFHP Care Plus (HMO D-SNP) ☒Healthy Workers HMO ☐Healthy SF ☐City Option ☐All lines of business and coverage programs as listed above

POLICY STATEMENT

San Francisco Health Plan's (SFHP) Clinical Operations (CO) Department conducts utilization management (UM) by reviewing authorization requests and applying clinical criteria to make evidence-based decisions, in accordance with the benefits covered under SFHP contracts and other program agreements, thereby ensuring the medical necessity of services provided to members.

The purpose of this policy is to outline the process for review of prior authorizations.

CO considers both Medicare and Medi-Cal coverage criteria when making integrated organization decisions (hereafter referred to as UM decisions) for Care Plus members.

SFHP ensures prior authorization requests are reviewed and notification to members and providers are completed in a timely manner consistent with applicable regulatory requirements. Timeliness of determinations are made consistent with the turnaround times outlined in CO-22: Medical Authorization Requests and Decision Timeframes and utilizing the medical necessity criteria outlined in CO-57: UM Clinical Criteria.

All sections within this policy apply to SFHP's three (3) managed care lines of business unless otherwise specified.

PROCEDURE

I. Prior Authorization Requirements

A. Prior Authorization is never required for emergency, urgent care, and special arrangements (family planning, sexually transmitted infection services, HIV testing) regardless of where services are received.

B. Basic prenatal care, OB/GYNs and family medicine providers for routine and preventive care, preventive services, specialty provider office visits, and a number of other services do not require prior authorization when received within the member's medical group / network.

C. Many elective inpatient and outpatient services, provided within and/or outside of the member's medical group / network, require prior authorization from SFHP before reimbursement is made.

    a. Providers should consult SFHP's *Authorization Service Code Lookup Tool* for specific prior authorization requirements.

D. For services subject to prior authorization, all non-emergent requests should be submitted at least 5 business days prior to the anticipated service date.

E. Prior authorization requests must be for future services. Any request to authorize services after the date they took place must be submitted separately as a retrospective request. For retrospective authorization requests, reference policy CO-22: Medical Authorization Requests and Decision Timeframes.

F. All preadmission testing should be done outpatient prior to the admission. Surgical procedures should be done on the day of admission. Exceptions must meet medical necessity criteria. Elective admissions are not approved for weekends and/or holidays unless treatment or surgery is scheduled for that day.

G. Prior authorization requests to SFHP may be submitted via provider portal (preferred submission method), fax, email, telephone, or mail. Failure to obtain prior authorization in a timely manner may result in denial. Faxed requests must be submitted using SFHP's Prior Authorization request form with all required information typed in; handwritten forms will not be accepted.

H. SFHP requires that providers submit sufficient clinical information to make an authorization decision. Clinical information should include relevant recent notes on the member's health history and progress, physical exams, prescriptions, and the medical reasons for the requested service.

I. If the requested service will be rendered outside of the member's medical group / network, providers must state why the service cannot be performed within the member's group / network. SFHP provides coverage for such requests as long as the medically-necessary care is not available within the

member's network.

J. The approval period for all services is one year. The exception is elective surgeries, which are approved for a 3-month period.

   When medically necessary services are required beyond the one-year approval period, SFHP will re-authorize the service upon request.

K. CO staff provide authorization decisions to members and providers within the required timeframe. Members are notified of approval, denial, partial denial, and deferral decisions by mail. Providers are notified of all decision types by fax. Authorization status and decisions are also visible on the provider portal. CO staff may also notify members and providers of decisions by phone or other alternative formats as specified via member preferences.

L. UM Criteria. Resources are available to assist in determining review decisions. SFHP's clinical criteria hierarchy and criteria approval process are outlined in CO-57: UM Clinical Criteria.

II. Submission of Authorization Requests

A. Servicing providers are encouraged to submit requests using SFHP provider portal to access real time authorization rules and decisions (i.e., auto approval, pending nurse review, final determination).
B. Servicing provider may also fax requests using the standard SFHP Prior Authorization Request Form.
C. If the following information is not received, the authorization request is not able to be processed, and the requesting provider is notified by either fax or phone.
   a. Member's first and last name
   b. Member's date of birth
   c. Name of rendering provider/facility
   d. At least one valid diagnosis code
   e. At least one valid service code (CPT/HCPCS)
   f. Units/Quantities when appropriate (e.g., durable medical equipment and medical supplies.
   g. Current prescription signed by a physician within the past year, when appropriate (e.g., durable medical equipment and medical supplies.)

   The authorization request is processed when a new request is submitted with the required information.

III. Provider Requested Modifications

A. Requests by the provider to modify an existing, previously approved Authorization Request are accepted for review for the duration of the authorization prior to the

service(s) being rendered. Or within 30 days of the service happening. Providers must submit documentation for all change requests via fax and must reference the original Authorization Number and the code(s) and/or detail(s) to be modified. Modification requests restart the decision timeframe and follow the same timeframe as the initial request. The member is notified of any authorization changes resulting from approved provider-requested modifications.

B. Change requests are accepted only for approved Authorization Requests for the following modifications:

    a. Types of service – for example, only similar items or procedures may be modified (e.g., microspore tape versus paper tape, right wheels versus left wheels, etc.).

    b. Addition of units or relevant services (e.g., if the provider requests more units to be added to the original authorization).

    c. The dates of an authorization can only be modified if the member has not received the service or due to administrative error.

IV. Provider Responsibilities

A. Providers are required to submit documentation to substantiate medical necessity of the requested services with the prior authorization request.
B. Providers are responsible for verifying eligibility coverage and medical group / network assignment prior to service delivery. This helps providers avoid the possibility of getting denied reimbursement for services already rendered. Approval of an authorization does not guarantee payment of claims. SFHP recognizes that circumstances (e.g., emergency services, retroactive eligibility) may occur when submission of an authorization request is not possible.

MONITORING

A. Monthly, the utilization management (UM) workgroup monitors authorization and appeal metrics, clinical member grievance (including Independent Medical Reviews, State Fair Hearings, and Consumer Complaints) trends, as well as service utilization trends. The UM workgroup submits reports to the Utilization Management Committee (UMC) and Quality Improvement and Health Equity Committee (QIHEC) for oversight, input, and strategic direction. Collaboratively, the committees make recommendations for corrective action and/or identify where UM processes can be revised, if necessary, to improve member experience, address barriers, and ensure the UM criteria are consistent with current industry and evidence-based practices and state/federal regulations.

B. Quarterly, the Clinical Operations Nurse Trainer Auditor conducts an internal audit of authorization files including adverse and favorable determinations. The purpose of the internal audit is to ensure authorization files meet the statutory/regulatory requirements of CMS/DHCS/DMHC as well as accreditation guidelines of NCQA. The audit follows NCQA's 8/30 audit sample methodology.

C. Annually, inter-rater reliability audits are conducted for both physician and nurse reviewers to ensure decision making accuracy and consistency.

D. Annually, the Clinical Operations Director leads a cross-functional evaluation of the UM Program's effectiveness. The evaluation process includes reassessment of program structure, scope, processes and sources used to determine benefit coverage and medical necessity. It considers member and practitioner experience, regulatory compliance, data trends, and a status assessment of annual goals and activities. The UM Evaluation informs the UM Workplan. The UM Evaluation, UM Workplan, and UM Program Description are reviewed and approved by the UMC and QIHEC.

E. The SFHP Chief Medical Officer (CMO), Medical Director, or physician designee identifies potential quality issues (PQI), including provider preventable conditions (PPCs), and follows the PQI process defined in QI-18 and the PPC process defined in QI-19.

F. Annually, medical groups delegated to perform utilization management are audited as outlined in DO-02: Oversight of Delegates. In addition, to provide real-time oversight, SFHP's Delegation Oversight Nurse conducts quarterly authorization files review audits.

DEFINITIONS

Business Day: Every official working day of the week. The days between and including Monday to Friday, and do not include federal holidays (as defined by the U.S. Office of Personnel Management) or weekends.

Calendar Day: All the days in a week, month, or year, including weekends and holidays.

Concurrent Review: Any review for an extension of a previously approved ongoing course of treatment beyond the approved length of time or number of treatments.

Delegated Group: Contracted medical group or health plan acting on SFHP's behalf. Delegated Groups have the authority to carry out health plan functions that SFHP would otherwise perform in accordance with the terms and conditions specified in the

Delegation Agreement. This authority includes the right to decide what to do and how to do it, within the parameters agreed upon by SFHP and the Delegated Group**.**

Delegation of UM Decisions: Occurs when SFHP gives another entity the authority to carry out the UM function that it would otherwise perform. This authority includes the right to decide what to do and how to do it within agreed parameters. A mutual agreement defines the specific functions that are delegated in compliance with standards established by the National Committee on Quality Assurance (NCQA), the California Department of Health Care Services (DHCS), the California Department of Managed Health Care (DMHC), and others. SFHP is obligated to oversee delegated functions (i.e., to ensure that these functions are properly performed). Medical groups that are delegated by SFHP for UM include North East Medical Services (NEMS), Brown & Toland Physicians (BTP), Hill Physicians (HIL), Jade Health Care (JADE), and All American Medical Group (AAMG).

Medical Necessity: The Medi-Cal definition of Medical Necessity is reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness or injury. For members who are eligible for EPSDT services, services are determined to be medically necessary when needed to correct or ameliorate defects and physical and mental illnesses or conditions.

Network Providers: Any Provider that contracts with SFHP or a Delegated Group for the delivery of covered services.

Potential Quality Issues (PQI): These are potential issues with the quality of care or service delivered by a practitioner. SFHP provides a mechanism for peer review for PQIs in the form of a committee that meets to evaluate the need to alter the practitioner's participation in its health care delivery system based on evidence of serious quality deficiencies. The Plan also provides reports to the Medical Board of California and other reporting agencies as required.

Receipt Date: The date the authorization request was received **regardless** of SFHP's business hours.

Retrospective (Post-Service) Authorization Review: Request for authorization after the first **and** last date of service have occurred (post-service).

Routine Prior Authorization (Pre-service) Review: A service that SFHP must approve, in whole or in part, in advance of a member obtaining medical care or services not on an urgent basis.

Urgent/Expedited: When the member's condition is such that the member faces an imminent and serious threat to his or her health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or the normal routine timeframe for the decision making process would be detrimental to the member's life or health or

could jeopardize the member's ability to regain maximum function (California Health and Safety Code §1367.01 (h)(2)).

Urgent Prior Authorization (Pre-service) Review: A service that SFHP must approve in whole or in part, in advance of a member obtaining medical care or services. Urgency results when the application of the time periods for making non-urgent care determinations could result in adverse health consequences.

AFFECTED DEPARTMENTS/PARTIES

Compliance and Regulatory Affairs
Health Services – Clinical Operations
Operations – Claims
Operations – Member Services
Operations – Provider Network Management
Provider Network

RELATED POLICIES & PROCEDURES, DESKTOP PROCESS and PROCESS MAPS

1. CARE-12: California Children's Services (CCS)
2. CL-07: Provider Dispute Resolution Mechanism
3. CO-01: Utilization Management Notice of Action Letters
4. CO-02: Skilled Nursing and Custodial Long-Term Care (LTC) Admissions
5. CO-12: Emergency Medical and Psychiatric Services
6. CO-22: Medical Authorization Requests and Decision Timeframes
7. CO-32: Hospice Care
8. CO-57: UM Clinical Criteria
9. DO-02: Oversight of Delegates
10. MEM-01: Other Health Coverage/Coordination of Benefits
11. Pharm-02: Pharmacy Prior Authorization
12. Pharm-08: Annual Review of Formulary, Prior Auth Criteria, and Policies
13. GA-01: Clinical Member-Grievances
14. GA-03: Member Appeals
15. QI-18: Potential Quality Issues

REVISION HISTORY

Original Date of Issue: December 18, 2025
Revision Approval Date(s):

REFERENCES

1. 28 CCR §§1300.67, 1300.67.2.2, 1300.71.38, and 1300.71.4

2. DHCS/SFHP Contract, Exhibit A, Attachment III, Subsection 2.3 (Utilization Management Program)
3. H&S Code §§1367, 1367.01, 1367.62, 1363, 1371.4, 1371.5, 1374.72 and 1262.8
4. Medi-Cal Bulletin 438, March 2011
5. Medi-Cal Provider Manual: Administrative Days (http://files.Medi-Cal.ca.gov/pubsdoco/publications/masters-mtp/part2/admin_i00.doc)
6. MMCD APL 14-005
7. NCQA Standard MED 1 Medicaid Benefits and Services
8. NCQA Standard UM 2 Clinical Criteria for UM Decisions
9. NCQA Standard UM 3 Communication Services
10. NCQA Standard UM 4 Appropriate Professionals
11. NCQA Standard UM 5 Timeliness of UM Decisions
12. NCQA Standard UM 11 Procedures for Pharmaceutical Management B and D
13. NCQA Standard UM 12 UM Information Integrity
14. DHCS APL 20-017: Requirements for Reporting Managed Care Program Data
15. DHCS APL 21-011: Grievance and Appeal Requirements, Notice, and “Your Rights” Templates
16. DHCS APL 22-010: Cancer Biomarker Testing
17. DHCS APL 23-009: Authorizations for Post-Stabilization Care Services
18. DMHC APL 22-030: Requirement for Plans to “Arrange for” Covered Services
19. HSC § 1367.667(a) Biomarker Testing Coverage
20. 42 CFR § 438.210 Coverage and Authorization Services