

Important Notice: Prior Authorization (PA) Update Effective 1.1.2027

Dear Provider Partners,

Please be advised of the following Utilization Management (UM) Prior Authorization (PA) process updates that will become effective **January 1, 2027**.

1. Prior Authorization Grid Updates

The Prior Authorization Grid has been updated to reflect current authorization requirements. Providers are encouraged to review the revised PA Grid and ensure requests are submitted in accordance with the updated guidelines beginning January 1, 2027. Starting 1/1/2027, the updated PA grid will be located here: <https://connect.chcnetwork.org/Provider-Announcements>

2. Specialty Referral Requirements

Effective January 1, 2027, referrals for specialty services must originate from the member's assigned Primary Care Provider (PCP).

Authorization requests for specialty services submitted directly by specialty providers, without an associated PCP referral when required, will not be processed. These requests will be cancelled and redirected to the member's PCP for appropriate referral submission and coordination of care.

3. Out-of-Network Consultation and Evaluation & Management (E&M) Services

Effective January 1, 2027, requests for the following out-of-network Evaluation and Management (E&M) codes will no longer be accepted as prospective prior authorization requests:

- **99205** – New Patient Office/Outpatient Visit
- **99215** – Established Patient Office/Outpatient Visit
- **99245** – Outpatient Consultation

Please note: These codes may not be submitted prospectively for authorization, either as standalone requests or when included with other services on the same authorization request. If CPT codes **99205**, **99215**, or **99245** are submitted on an authorization request, the request may be rejected. Any other services on the request that require prior authorization must be submitted separately for prospective review and determination.

Providers requesting reimbursement for these services must submit the request to the Utilization Management Department as a **retrospective review request** following the rendered service.



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Retrospective review submissions must include:

- Medical records supporting the level of service billed
- Clinical documentation demonstrating medical necessity
- Any additional records necessary to support review of the requested visit code

Requests submitted without sufficient clinical documentation may result in delays or denial of coverage determination.

Provider Action Required

Providers should review their current referral and authorization workflows to ensure compliance with these changes prior to the January 1, 2027 implementation date.

If you have questions regarding these updates, please contact Provider Services or the Utilization Management Department.

Thank you for your continued partnership in providing high-quality care to our members.

Sincerely,

Utilization Management Department

