PROVIDER NEWSLETTER

Health Choice Utah
Provider Publication
Q1 2025

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HEALTH | CHOICE
UTAH

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"STAY UP TO DATE" COMMUNITY VACCINATION COLLABORATION

Health Choice Utah®, University of Utah Health Plans, Molina Healthcare®, and Select Health® are collaborating to promote vaccinations for children's safety. With Utah's pediatric vaccination rates falling below the national average, the risk of preventable diseases—like measles and polio—increases. The campaign encourages community involvement in raising awareness about the importance of vaccines. For more information, visit Stay up to Date, connect with us on social media, and find us in your local communities to help protect Utah's children and communities.

BEST-PRACTICES: BILLING HOME HEALTH

Home Health services ensure our members receive the care they need when confined to home or when ongoing care does not require hospital or skilled nursing facility level of care. The goal of home health care is to help the patient recover from an illness or injury, become more self-sufficient, be able to perform Activities of Daily Living, or slow the patient's decline. Home Health services must always be prior authorized.

When home health is needed, the following items are required for prior authorization:

- Services must be medically necessary to treat the covered person's illness, injury, or medical condition.
- Services must be clinically appropriate, meaning the right treatment, frequency, extent, and place of service.
- Services must not be for the convenience of the covered person, their family, or healthcare providers.
- Billed services must be on the member's Plan of Care that is signed by the healthcare Provider and have an approved authorization on file.

SUBMITTING A PRIOR AUTHORIZATION REQUEST

There are two ways to submit a prior authorization request:

- Online embedded form – visit our Prior Authorization web page.
  - » Scroll down to and click on "Submit a Prior Authorization Request."
  - » Complete all requested information, attach documentation, and click "Submit.
- Online Provider Portal – Log in or register.
  - » In the "Authorizations" section on the home page, view "Prior Authorization Guidelines" and "Codes Requiring Prior Authorization."
  - » The "Prior Authorization Form" is also available in the "Authorizations" section, or under the "Office Management" tab at the top of the page.
  - » Complete all information, attach documentation, and click "Submit."

COMMON CLAIM ERRORS

Referring Providers – No referring provider listed, or referring provider is not registered with **Medicaid. Prior Authorizations** – No prior authorization on file, or not enough units requested in prior authorization.

Timely Filing –

Health Choice Utah	Commercial or Individual/Family
(Medicaid primary) 365 days from DOS	(Primary) 365 days from DOS
(Medicare primary) within the later of 365 days from DOS or 180 days from Medicare EOB date	(Secondary) 180 days from primary's EOB adjudication date
(Corrections) 365 days from DOS	(Corrections) 365 days from DOS

Medicaid Note

Medicaid requires that every member be reassessed every 60 days to recertify the need for continuing home health care.

QUESTIONS?

Health Choice Utah 877-358-8797

GENETIC TESTING COVERAGE AND REQUIREMENTS

Health Choice Utah has identified growing utilization of genetic testing services and, subsequently, denials for these services are increasing year over year due to utilization of out-of-network labs, failure to confirm plan benefits, and follow plan process. Noncovered genetic testing services can result in high-dollar surprise bills to the member. To protect the patient, providers can explain the potential for noncoverage to the member so they can make an informed decision on whether to continue with the prescribed testing. If the member wants to proceed, the provider can request prior authorization, as required.

Health Choice Utah covers some genetic testing when the prior authorization requirements are followed, the plan policy criteria are met, and an in-network lab is used.

COVERAGE

Medicaid Plans – Refer to the Utah Medicaid Physician Services Manual Section 8-12, Laboratory Services, which outlines Medicaid coverage criteria for genetic testing services.

Laboratory services include:

- 8-12.9 Genetic Testing
- 8-12.10 Genetic Testing for EPSDT
- 8-12.10.4 Next Generation Sequencing (NGS)
- 8-12.10.5 Noncovered Testing

PRIOR AUTHORIZATION

Typically, genetic testing requires prior authorization. Search Codes Requiring Prior Authorization for specific code requirements.

IN-NETWORK LABS

To confirm a genetic testing laboratory's participating network status, visit the Health Choice Utah

Provider Directory.

1. Leave the location information blank.
2. Select "**Other Providers**" and then click **"Search Providers**."
3. On the resulting screen, narrow your search by selecting "Laboratory/Pathology" in the "Specialty" drop-down menu, then click "Search" to refresh the results.

WHEN AND HOW TO REQUEST A PEER-TO-PEER REVIEW

The primary role and purpose of a Peer-to-Peer (P2P) review is to provide additional information to discuss a denied decision. A P2P is an opportunity for conversation and to provide clinical context that may not have been provided with the initial prior authorization request. Granting a P2P does not indicate that a decision will be overturned or reversed.

Visit our Prior Authorization web page and scroll down to "Peer-to-Peer Information and Form" for an overview of the P2P process and Frequently Asked Questions.

Please bear in mind the following guidelines:

- **Submission of a Request Does Not Guarantee a Peer-to-Peer**
  A completed Peer-to-Peer Request Form is required, but approval for a P2P is not assured. If the case does not meet the outlined criteria, it may be directed to the appeal process.
- **Timeliness of Request**
  Requests must be submitted within 7 calendar days of the denial letter's date. Requests submitted outside this timeframe will be referred to the appeals process.
- **Scheduling Requirements**
  Providers must offer at least two different time slots for the P2P, with at least two hours separating the requested times.

  The proposed times should be at least two business days from the date of submission, to allow for documentation review and scheduling.

  While Health Choice Utah strives to accommodate provider availability, advanced planning is essential given the fast-paced nature of the health plan's operations.

Call Availability
During the scheduled 30-minute window, Health Choice Utah will attempt to contact the provider twice.

If unsuccessful, one additional opportunity will be granted to reschedule before referring the matter to the appeals process.

The P2P process is not specialty matched and does not replace the appeal process.

Providers are encouraged to ensure complete and accurate submissions to facilitate effective scheduling and discussions.

Again, a Peer-to-Peer review provides an opportunity to discuss additional information and/or clinical context to aid in reviewing a denied decision that may not have been available during initial prior authorization review. A P2P does not replace an initial prior authorization review, nor does it guarantee that a decision will be overturned or reversed.

We appreciate the care and services you provide our members.

BEHAVIORAL HEALTH PROVIDERS MUST REPORT CRITICAL INCIDENTS

As part of the requirements of the Medicaid 1115 waiver that allows us to pay for mental health and substance use residential treatment, the state of Utah is required to report any critical incidents involving any behavioral health provider to the Centers for Medicare and Medicaid (CMS).

Critical incidents should be reported for all Medicaid members with Serious Mental Illness (SMI).

If you become aware of any critical incident involving your facility, practice or patient you must report these to our Compliance department within 30 days of the incident.

We appreciate your help with this requirement to ensure Utah Medicaid can continue to cover residential treatment for Medicaid members.

TYPES OF CRITICAL INCIDENTS THAT MUST BE REPORTED:

- A serious injury of a member that occurred on the Behavioral Health facility premises and required an overnight admission to a hospital medical unit
- A serious physical assault of a member that occurred on the Behavioral Health facility premises and required medical intervention at a medical facility/medical unit/ER
- A serious physical assault by a member that occurred on the Behavioral Health facility premises and required medical intervention at a medical facility/medical unit/ER for the assailant and/or the victim
- An unexpected death of a member that occurred on Behavioral Health facility premises
- A sexual assault of or by a member that occurred on Behavioral Health facility premises
- An abduction of a member that occurred on Behavioral Health facility premises
- An instance of care ordered or provided to a member by someone impersonating a healthcare professional, that occurred on the Behavioral Health facility premises
- Behavioral Health provider medication errors resulting in an impact on the member's well-being, medical status or functioning
- A serious suicide attempt by a member that required an overnight admission to a hospital medical unit
- A completed suicide by a member
- A homicide that is attributed to a member

REPORTING REQUIREMENTS AND TIMEFRAMES

- Email Health Choice Utah at providers@healthchoiceutah.com with all of the following information:
  - Member's name and Medicaid ID
  - Provider/Facility Name
  - Date of the incident
  - Type of incident
- Only report critical incidents that involve Medicaid members with Serious Mental Illness (SMI) or

Serious Emotional Disturbance (SED).

» Report critical incidents within 30 days of the incident, even if the member has not been formally discharged from behavioral health services (not just for those actively in treatment).

DEFINITIONS

Critical incident means an event or occurrence that causes harm to a Medicaid Member or serves as an indicator of risk to a Medicaid Member's health or welfare, or the Medicaid Member causes harm to another individual.

Serious mental illness (SMI) means a mental, behavioral or emotional disorder resulting in serious functional impairment, which substantially interferes with or limits one or more major life activities. SMI applies to individuals who are 18 years of age or older.

Serious emotional disturbance is a diagnosable mental health condition in a child or adolescent, 0 to18 years of age, that significantly impacts their ability to function in family, school, or community settings.

Behavioral health facility premises includes all levels of care (inpatient, outpatient, residential and day treatment). It also includes the occurrence of a critical incident while a service was being provided via telehealth or in home.

REMINDER – CHECK MEMBER ELIGIBILITY AND BENEFITS

As has always been best practice regarding medicaid enrollees, remember to verify eligibility prior to every visit. Since medicaid eligibility can change from month to month—or during the month—verify eligibility in the month of the visit, and no more than 10 days prior to the visit. There are now three methods by which eligibility can be verified:

» PRISM portal (preferred)

» Medicaid Eligibility Lookup Tool

» Phone:

- Salt Lake City area – **801-538-6155**
- Utah, Idaho, Wyoming, Arizona, Colorado, Nevada, and New Mexico – **800-662-9651**
- From other states – **801-538-6155**

SEE A DISCREPANCY BETWEEN PRISM AND PROVIDER PORTAL OR EPIC?

Send us a heads-up at Providers@healthchoiceutah.com to help us keep our files aligned with PRISM.

PHARMACY

Our medication and pharmacy information is updated as changes occur. Please visit our Pharmacy webpage at least quarterly to view the most recent information.

ANNUAL NOTICE OF PHARMACY RESOURCES FOR PRESCRIBERS

For the 2025 year, a list of medical pharmacy medications that require authorization or are excluded, and the Preferred Drug List (PDL)/Formulary for retail/specialty pharmacy medications are available online. "Bookmark" the sites in following section to your internet favorites for convenient reference.

MEDICAL PHARMACY MEDICATIONS

View the current list of medical pharmacy services and products requiring prior authorization or that are excluded by visiting Search Codes Requiring Authorization.

For injections, infusions, and other medications administered in a clinical setting, complete the appropriate Prior Authorization Form:

» Fax Form

Remember to attach supporting documentation as indicated. Failure to submit clinical documentation to support this request will result in a dismissal of the request.

RETAIL PHARMACY MEDICATIONS

For retail and specialty pharmacy medications, view the Preferred Drug List (PDL)/Formulary for covered medications, drug tiers, prescribing limits, generic substitution, therapeutic interchange, step therapy, or prior authorization requirements. Pick the formulary that matches your member's benefit plan.

Retail Pharmacy Prior Authorization (PA) Process

Retail pharmacy PA requests may be submitted online or by fax. For online PA requests, visit our Pharmacy Benefit Manager (PBM), RealRx Home Dashboard. Go to "Request Prior Authorization" and click "Get Started".

If you prefer to print and fax the request, complete the appropriate Pharmacy Prior Authorization Form for the specific medication or category for your request and the form specific to the member's benefit plan. If there is not a specific form for the requested medication, use the General Pharmacy Prior Authorization Form for the member's benefit plan. Fax the completed form, along with all supporting documentation, to **385-425-4052**.

If you are requesting a drug that is not on the health plan formulary, complete the Pharmacy Formulary Exception Request Form. Include supporting clinical documentation showing a medical reason that a formulary alternative would not be effective for the member.

For upcoming changes to the formulary coverage and edits, notices are placed on the website for review. View the most current "Formulary Change Notices" on the Pharmacy Formularies webpage, just below the Searchable Directories.

RECENT AND UPCOMING FORMULARY CHANGES:

Health Choice Utah may add or remove drugs from the formulary during the year. If a drug that you are currently prescribing is scheduled to be removed from the formulary, we will notify you and the affected member at least 60 days before the change becomes effective. In cases where the

U.S. Food and Drug Administration (FDA) deems a drug unsafe, or the drug's manufacturer removes the drug from the market, we will immediately remove the drug from the formulary and notify you and the member afterward.

View Current Drug Lists (formularies) for each benefit plan, as well as the most current Formulary Change Notice.

REDUCING THE PHARMACY PRIOR AUTHORIZATION BURDEN

Did you know? Our Pharmacy team proactively reviews medication prior authorizations (PA) that are due to expire in the following month or two. If there is sufficient information to renew the PA (e.g., member adherence, efficacy of treatment for the member, whether the member has seen their provider in the plan year), we are extending the PA for you! This eases your PA burden and also prevents access to care issues for your patients. We will notify you any time an authorization has been extended.

Note: Certain medications always require provider submission of the PA request, so always check the formulary.

We are studying more ways to make the PA process easier for you. We'll post updates in future editions of Provider Newsletter.

QUESTIONS ABOUT PHARMACY BENEFITS?

Medical Pharmacy Medications – 877-358-8797

Retail Pharmacy Medications – 855-865-1404

PHARMACY RESOURCES

» View our Pharmacy Formularies for notices regarding upcoming changes to the formulary.

» View our Preferred Drug List (PDL)/Formulary for updates regarding retail and specialty pharmacy medications. This list also includes prescribing limits such as quantity limits, step therapy, and/or prior authorization requirements. Multiple formularies are available, depending on the member's benefit plan.

» Pharmacy Prior Authorization forms are available online with specific requirements for use and limitations listed in the form. Visit our Coverage Policies site to ensure you are submitting the correct form for the requested medication. Bookmark these links in your internet favorites for quick access to submit pharmacy prior authorization requests.

» The Retail Pharmacy Online Prior Authorization (PA) Submission tool has been updated to allow prior authorization as well as formulary exceptions to be submitted through the same web page. If submitting a formulary exception, it is important to indicate this on your request. To submit a request online, visit the RealRx Home Dashboard and click on the "Get Started" button under "Request Prior Authorization or Formulary Exception."

DID YOU KNOW?

MEDICAID WILL COVER A HOME BLOOD PRESSURE MONITOR

» Order Type: DME miscellaneous, Home BP cuff HCPC A4663

» Patient can take order to any in network Durable Medical Equipment vendor (Alpine Home Medical, Red Rock Medical)

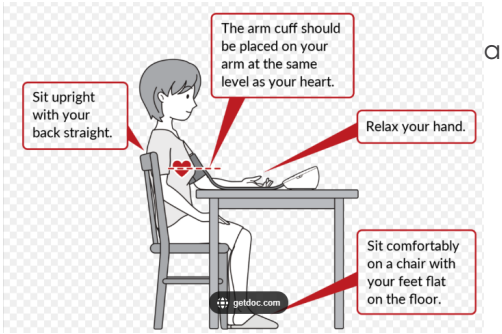
» Some Local libraries offer Blood Pressure Monitors to be "checked out" with a library card.

» For Information Phone: 801-943-4636 Or online Library of Things

THE IMPORTANCE OF PROPER SCREENING

Accurate screening is the first step in identifying patients at risk of hypertension. The patient should be seated comfortably for at least five minutes, with their back supported, feet flat on the floor, and their arm at heart level. Avoiding caffeine, smoking, or exercise 30 minutes prior to measurement is also essential to obtain an accurate reading.

It is essential to measure blood pressure at multiple visits, as single elevated reading does not necessarily confirm hypertension. The American College of Cardiology (ACC) recommends measuring blood pressure at least twice on separate occasions for an accurate diagnosis.



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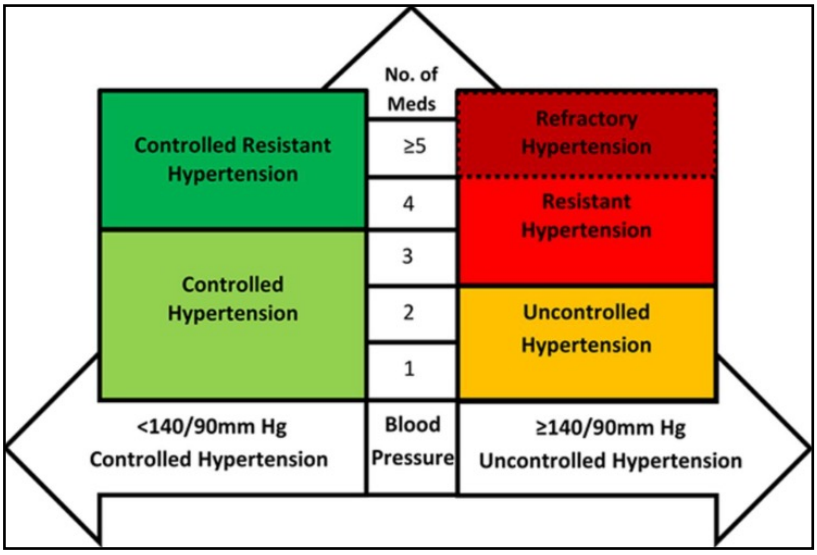
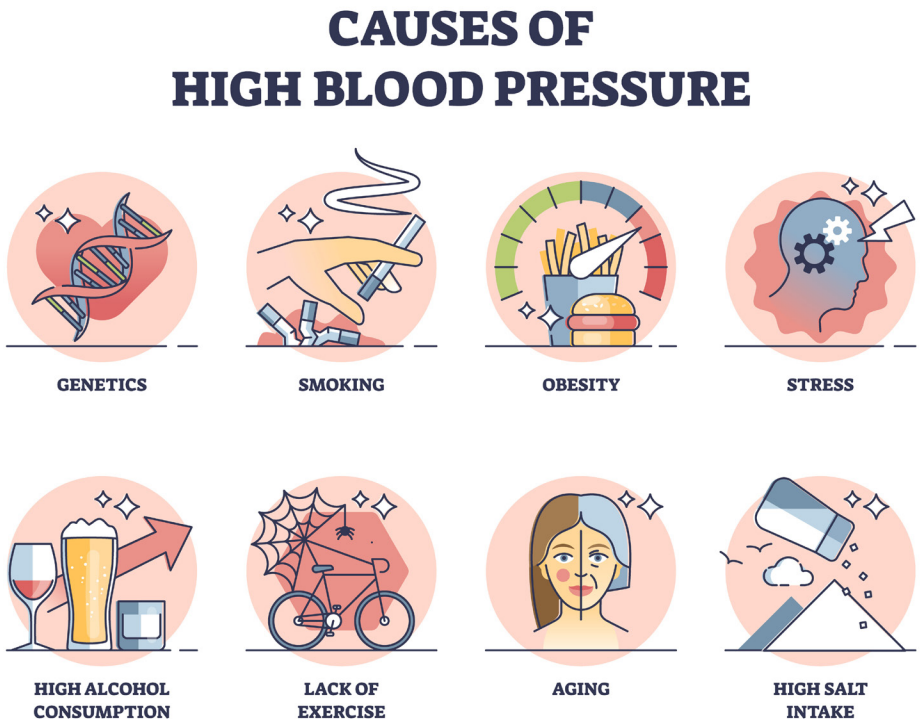
CODING FOR HYPERTENSION: CONTROLLED VS. UNCONTROLLED

Correct coding is vital for accurate clinical documentation and appropriate reimbursement. The ICD-10 codes for hypertension fall under the following categories:

- I10 – Essential (Primary) Hypertension (Controlled): This code is used for patients whose blood pressure is well-managed, typically with the help of medications or lifestyle modifications. If a patient's blood pressure is consistently below 130/80 mm Hg with treatment, they are considered to have controlled hypertension.
- I15 – Secondary Hypertension (Uncontrolled): This code is used when hypertension is poorly controlled, or when blood pressure readings consistently exceed 130/80 mm Hg despite treatment. It is essential to document the underlying cause of uncontrolled hypertension, such as kidney disease, endocrine disorders, or other secondary causes, as this will help direct further management.



Properly coding the type of hypertension a patient has—whether controlled or uncontrolled—helps providers track treatment progress and allows for more accurate management planning. It is also important to monitor and adjust treatment protocols for patients with uncontrolled hypertension, as prolonged high blood pressure can lead to serious complications.



NEW YEAR, NEW OPPORTUNITIES:

365 CHANCES FOR ANNUAL WELL VISITS

As we step into a new year, we are presented with 365 fresh opportunities to make a positive impact on our patients' health. One of the most effective ways to ensure their well-being throughout the year is by encouraging them to schedule their annual Well Visit.

The yearly Well Visit is a vital part of preventive healthcare, allowing providers time to assess a patient's overall health, screen for potential issues, and provide personalized health advice. It's a chance to build stronger relationships with patients, educate them about healthy lifestyle choices, and catch any health concerns before they become serious problems.

As we begin 2025, encourage your patients to take advantage of their Well Visit. Whether it's the start of the year or anytime throughout the next 12 months, there's no wrong time to prioritize their health.

Let's make this year the healthiest yet by reminding our patients about the importance of regular check-ups. With 365 days ahead, there's no shortage of opportunities to get them in for their annual visit!

MANAGING A1C AND KIDNEY HEALTH IN 2025

As we welcome the new year, it's the perfect time to refocus on managing patients' health, especially for those with diabetes or at risk. The start of 2025 brings a fresh opportunity to monitor and optimize patient care, with a specific emphasis on checking A1C levels, and screening kidney function through eGFR and uACR.

Quarterly A1C checks are crucial for tracking blood sugar control in diabetic patients, helping to adjust treatment plans and reduce the risk of long-term complications. Keeping A1C levels in target range is key to preventing issues like heart disease, nerve damage, and vision problems.

In addition, kidney health should be closely monitored. Screening for kidney disease by checking the estimated Glomerular Filtration Rate (eGFR) and urinary albumin-to-creatinine ratio (uACR) at least annually—or quarterly if the patient is at higher risk—can detect early signs of kidney damage. Early detection allows for timely interventions that can slow or prevent kidney disease progression.

This year, encourage your patients to stay on top of these critical health markers. By checking A1C quarterly and screening kidneys regularly, we can make 2025 a year of improved health and prevention. It's the perfect time to ensure your patients are staying proactive about their well-being!

WORK ON LIFESTYLE CHANGES

As we welcome the new year consider referring your patients to free self-management workshops to work on lifestyle changes for lasting habits and change.

RESOURCE AVAILABLE FOR YOUR PATIENTS

FREE EVIDENCED BASED CHRONIC DISEASE MANAGEMENT WORKSHOPS

- Originally developed at Stanford University. 30 years research, evaluated to show effectiveness
- Offered statewide: Virtual and In- Person workshops available
- Group meets once a week, 6 weeks in a row. Resource Book provided
- Refer Diabetics, Chronic Pain patients and any Chronic Health Conditions
- Participants learn tools in a group setting to self-manage their health condition/symptoms
- Caregivers welcome to attend

https://livingwell.utah.gov/ws_find.php#/

ANTIPSYCHOTIC MEDICATIONS AND INCREASED RISK OF DEVELOPING TYPE 2 DIABETES

Individuals taking an atypical antipsychotic drug, particularly younger patients under 40 years of age represent an under recognized group at high risk of developing Type 2 Diabetes. It is recommended members with schizophrenia, schizoaffective or bipolar disorder be screened annually for metabolic syndrome and cardiovascular disease. The prevalence of diabetes is 2–3-fold higher in people with severe mental illness than the general population. Managing diabetes in this population can be further complicated by the potential lack of insight with diet and activity, difficulty with medication adherence, and attending regular appointments. These factors contribute to a higher risk of cardiovascular complications and warrants additional screening measures.

Annual Screenings Recommended: A1C and LDL-C

HEDIS Measure Connection:

SMD: Diabetes monitoring for people with diabetes and schizophrenia

Measure evaluates the percentage of members 18-64 years of age with schizophrenia or schizoaffective disorder and diabetes who had both an LDL-C test and an HbA1c test.

SSD: Diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medications

Measure evaluates percentage of members 18-64 years of age with schizophrenia, schizoaffective disorder or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test.

(PPC) PRENATAL AND POSTPARTUM CARE

Measure evaluates percentage of deliveries of live births on or between October 8 of the year prior to the measurement year and October 7 of the measurement year. For these women, the measure assesses the following facets of prenatal and postpartum care.

Timeliness of Prenatal Care: percentage of deliveries that received a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment in the organization

Postpartum Care: percentage of deliveries that had a postpartum visit on or between 7 and 84 days after delivery

Having a healthy pregnancy is one of the best ways to promote a healthy birth. Getting early and regular prenatal care improves the chances of a healthy pregnancy. This care can begin even before pregnancy with a pre-pregnancy care visit to a health care provider.

Women and newborns require support and careful monitoring after birth. Most maternal and infant deaths occur in the first six weeks after delivery, yet this remains the most neglected phase in the provision of quality maternal and newborn care.

Basic care for all newborns should include promoting and supporting early and exclusive breastfeeding if possible, keeping the baby warm, increasing hand washing and providing hygienic umbilical cord and skin care.

Identifying conditions requiring additional care, and counselling on when to take a newborn to a health facility is critical. Families should be counselled on identification of danger signs, understanding the care that both the woman and newborn need, and where to reach services when needed.

DESCRIPTION	CODES
Prenatal Visits	**CPT**: 99201-99205, 99211-99215, 99241-99245, 99483 **CPT-CAT-II:** G0463, T1015
Stand Alone Prenatal Visits	**CPT:** 99500 **CPT-CAT-II:** 0500F, 0501F, 0502F **HCPCS:** H1000, H1001, H1002, H1003, H1004
Postpartum Visits	**CPT:** 57170, 58300, 59430, 99501 **CPT-CAT-II:** 0503F **HCPCS:** G0101 **ICD-10:** Z01.411, Z01.419, Z01.42, Z30.430, Z39.1, Z39.2

(EED) EYE EXAMS FOR PATIENTS WITH DIABETES

Best Practice and Measure Tips

» Provide member education on risks of Diabetic Eye Disease, and encourage scheduling annual exam.

» Obtain eye exam reports. Notate eye care provider name and demographics in chart if report not available.

» The dilated or retinal exam: it is best practice to have a bilateral retinal exam unless there is history of a unilateral eye enucleation.

- In some instances a unilateral retinal / dilated exam may be used if it meets guidelines for acceptable documentation.

» Documentation can be in the form of a note or letter prepared by an ophthalmologist, optometrist, PCP or other health care professional. Include: date of service, the test (indicate a dilated or retinal exam) or result, and the care provider's credentials.

- Documentation example: "Last diabetic retinal eye exam with John Smith, OD, was June 20XX with no retinopathy."

» Must indicate performed by Optometrist or Ophthalmologist.

» A slit-lamp examination must have documentation of dilation or evidence that the retina was examined to be considered compliant.

» Examination of macula, vessels and periphery without eye dilation meets criteria for a "retinal exam."

» A chart or photograph with date of fundus photography or retinal imaging (Example: Computerized Ophthalmic Imaging such as Optical Coherence Tomography - OCT) and one of the following is acceptable:

- Results read by a qualified reading center or by a system that provides an artificial intelligence (AI) interpretation.
- Results reviewed by an eye care professional.
- Results read by a qualified reading center operating under the direction of a medical director who is a retinal specialist.

» Prior year exam results must indicate retinopathy was not present.

» AI Reports:

- Acceptable: "Negative for more than mild diabetic retinopathy": This is only considered a negative result when it is a result of an exam read by AI (IDx-DR imaging system).
- Documentation of Provider type for AI Reports:
  - If it is noted that an Optometrist or Ophthalmologist reviewed the AI results, then choose the appropriate provider type in the dropdown.
  - Some of the reports state they were read by AI and do not list a provider. If so, choose the provider dropdown option, "Results read by a system that provides an artificial intelligence (AI) interpretation.

Not Acceptable:

» Routine fundoscopic exam without examination of macula, vessels and periphery.
» Documentation of "diabetes without complications."
» Exams performed by PCP or non-eye care professionals (optician)
» Refractive only exams
» Exams in which only the anterior (A) chamber of the eye is examined
» Glaucoma pressure checks
» Unilateral post-op eye exams which do not meet guidelines for acceptable documentation

CPT II codes:

Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed: With evidence of retinopathy **2022F**

Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed: W/O evidence of retinopathy **2023F**

CODING CORNER

CODES REQUIRING PRIOR AUTHORIZATION

Our list of Codes Requiring Prior Authorization is updated as changes occur. Please search this list prior to scheduling procedures or prescribing durable medical equipment to determine if prior authorization is required. Also take a moment to view Upcoming Changes to Codes Requiring Prior Authorization to ensure your authorizations for future procedures are also compliant.