IEHP
Inland Empire Health Plan

Alert!

To: Direct Provider Network

From: Provider Relations

Date: November 25, 2026

Subject: **January 1: Upcoming Change to Authorization Process for Referrals**

Effective January 1, 2027, IEHP is embarking on a Prior Authorization Modernization Program to reduce prior authorization requirements for Medi-Cal and D-SNP members. IEHP Covered (CCA) referrals are excluded.

This initiative will result in a significant reduction in services requiring prior authorization, helping to streamline administrative processes and improve timely access to care. The program's primary objectives are to reduce administrative burden for providers and members while enhancing the member experience through more efficient access to medically necessary services.

Consult codes will still require PA.

The updated Prior Authorization List will be published in December 2026, and follow-up communications will provide further details. Your contracted IPAs will adhere to the same prior authorization requirements and share updates directly with your practice.

How Will the Referral Process Change?

1. **Submission Process:** Providers can submit authorization requests through the Provider Portal or, for a more streamlined experience, directly from their EMR, if they choose to do so, using the Prior Auth FHIR API, subject to applicable prerequisites. Providers are not required to use the Prior Auth FHIR API.

    - **Prerequisites**: Providers must have a verified Provider Portal account. In addition, the EMR vendor must be registered as an IEHP SMART Backend Client through the **IEHP Developer Portal** (https://www.iehp.org/devportal/index.html), have an approved application, API access, and credentials. As authorization submission workflows vary by EMR, providers should contact their EMR vendor for implementation, guidance and training.

2. **Receipt/PA Decision Process:** The **L number** will serve as the submission receipt. Additionally, authorization requests containing codes requiring prior approval will be split, with the determination attached to the corresponding **H record**.

3. Upon submission, status can be viewed or printed to identify services that do not require authorization and those that are pending review.

The prior authorization process **remains the same** for:

- Non-contracted provider requests
- Non-standard Benefit Codes
- Long Term Services and Supports (LTSS)
- Any elective service/procedure performed in an inpatient setting
- Elective admissions to an acute hospital/skilled nursing facility (SNF), rehabilitation facility or long-term acute care hospital (except for obstetric deliveries), Intermediate Care Facilities (ICF), Long Term Care (LTC)

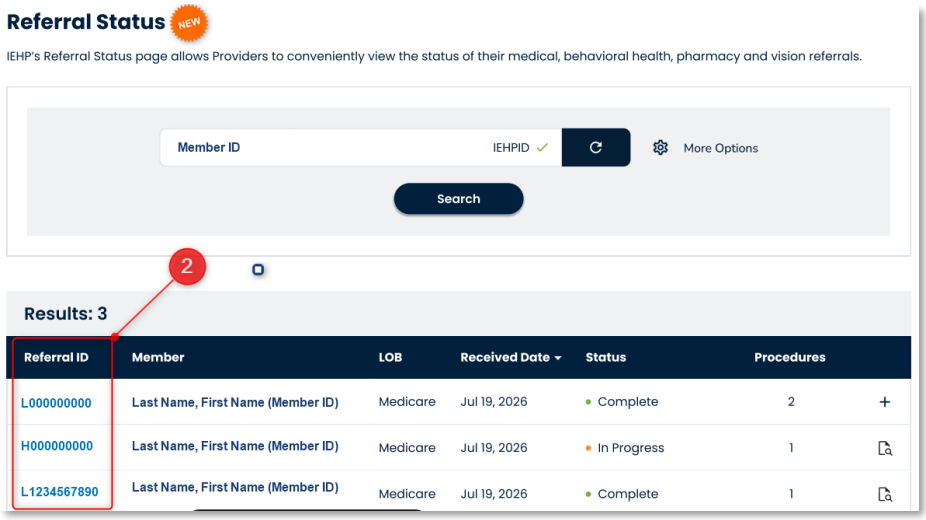
- Generic, miscellaneous, or not otherwise specified (NOS) codes
- Community Support Services (excluding Sobering Centers available in Riverside County only)
- Optometry Services
- Non-Emergent Medical Transportation (NEMT)

Referral Status Changes

1. **A new column will be added to the Referral Status tab > Procedures**



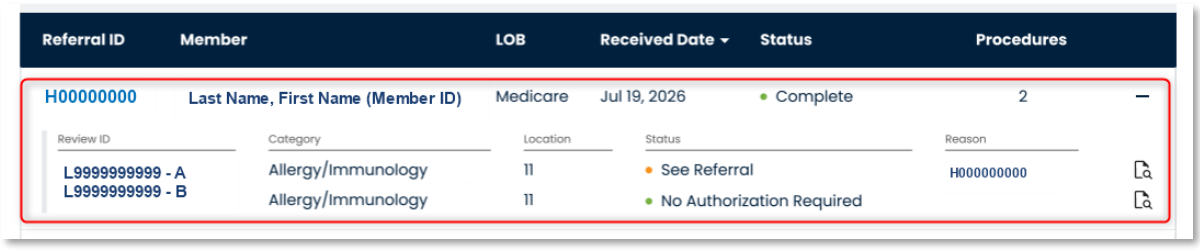
2. When viewing referral status, L/H Referral ID indicators will continue to appear and function as they do today:



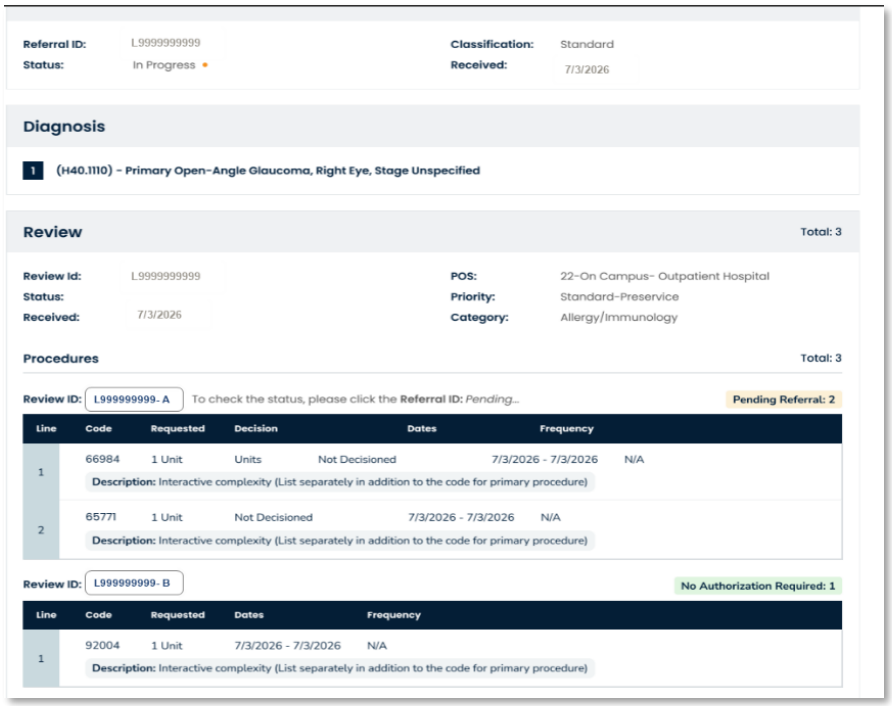
3. **Understanding L and H-Referral ID:**

L# is the confirmation number issued by IEHP when a referral is submitted and can be used to retrieve both the referral and the authorization status. If authorization is required for any submitted code(s), IEHP will issue a separate **H#**, which contains the authorization decision status (e.g. **Approved**, **Denied**, **In Progress**, or **Canceled**). If none of the submitted codes require authorization, the referral will remain under the L# with a status of "**No Authorization Required**."

Open the referral [+] to see the details:



4. Click the magnifying glass to view the entire referral request. This step remains unchanged:



How This Helps Your Practice

- Immediate visibility into PA requirements, confirming which services do and don't require PA, prompting quicker follow-up to provide care.

- If a member requires additional services during their consult or follow-up appointments, your practice can confirm whether the code requires a PA; if not, the services not requiring PA can be rendered immediately.

Please do not attempt to circumvent the process by faxing authorizations for services that do not require PA. These requests will be canceled, as a referral status notification available through the portal indicating that no authorization is required should be sufficient. Services may be rendered and billed accordingly.

Claims Reminder

Please remember that for services that require a PA, claims should reflect ONLY the authorized codes and quantities. Services that do not require a PA should be billed with the understanding that no authorization number is needed.

Resources for More Information

Additional guidance regarding this change, including Frequently Asked Questions (FAQs) and the PA list, will be shared soon.

If you have any questions, please contact the IEHP Provider Call Center at (909) 890-2054, (866) 223-4347 or email ProviderServices@iehp.org

All IEHP communications can be found at: www.providerservices.iehp.org > News and Updates > Notices