CMS Prior Authorization Change Summary: Effective 01/01/2026

On January 1, 2026, the Centers for Medicare & Medicaid Services (CMS) will implement new prior authorization (PA) response time requirements for all providers.

- **Standard prior authorization requests** will be completed within 7 calendar days, with a possible extension up to 14 calendar days under certain circumstances.
- **Expedited/Urgent prior authorization requests** will be completed within the lesser of 72 hours -OR- the current BD turnaround time.

With shorter response times for supporting clinical information requests, all necessary clinical information should be submitted at the time of the authorization request.

Additional Information

- Complete clinicals include Diagnosis, History and Current Condition, Treatment Plan and Interventions, and Relevant Diagnostic Tests.
- Response times can be lessened if all information is submitted with the authorization request.
- Missing clinical information may lead to a denial due to inadequate supporting records.
- Submitting prior authorization requests via the secure Availity portal allows for faster review.

Centene clinical policies and criteria can be found at Availity. If you have any questions, please contact your provider relations representative.