

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.