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CMS Finalizes Prior Authorization Rule

February 06, 2024

CMS finalized the CMS Interoperability and Prior Authorization Final Rule (CMS-0057-F) Jan. 17, 2024. The rule takes steps to shorten and improve the prior authorization process for medical items and services (excluding drugs), reducing the burden on patients, providers, and payers. A streamlined process will shorten wait times, reduce delays in patient care, and save money across the board.

The rule sets requirements for several government administered health plans:

⇒ Medicare Advantage

⇒ Medicaid and the Children's Health Insurance Program (CHIP) fee-for-service programs

⇒ Medicaid managed care plans

⇒ CHIP managed care entities

⇒ Issuers of Qualified Health Plans (QHPs) offered on federally facilitated exchanges (FFEs)

Encouraging Timely Care

While prior authorization is necessary to ensure that a health plan will cover a procedure, it's not always a timely process. Patients who need care quickly are often left waiting for their needed care while providers struggle to meet often complex payer requirements.

Beginning in 2026, the impacted payers listed above (not including QHP issuers on the FFEs) will be required to adhere to the following rules for prior authorization requests:

⇒ Send decisions within 72 hours for urgent requests

⇒ Send decisions within seven calendar days for standard (i.e., non-urgent) requests

⇒ Include a specific reason for denying a request

⇒ Publicly report prior authorization metrics

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These requirements will cut response timeframes in half in many cases and help facilitate resubmission of the request or an appeal when needed; however, the American Medical Association (AMA) is advocating for even faster turnaround times: 24 hours for urgent requests and 48 hours for standard requests to protect patient safety.

Technical and Operational Requirements

The final rule also requires impacted payers to implement a Health Level 7 Fast Healthcare Interoperability Resources Prior Authorization application programming interface (API), which can be used to facilitate health data exchange and a more efficient electronic prior authorization process between providers and payers by automating the end-to-end prior authorization process. In addition to giving patients access to more of their data, this will help patients understand their payer's prior authorization process and its impact on their care.

CMS is delaying the dates for compliance with the API policies from Jan. 1, 2026, to Jan. 1, 2027, based on public comments received from patients, providers, and payers, allowing for time for staff training and updating or building an API. Starting January 2027, impacted payers will also be required to expand their current patient access API to include information about prior authorizations, which providers can use to retrieve patient claims, encounter, clinical, and prior authorization data. Additionally, impacted payers will be required to exchange (with a patient's permission) most of those same data using a Payer-to-Payer FHIR API when a patient moves between payers or has multiple concurrent payers.

The final rule also adds a new electronic measure for eligible clinicians under the Merit-based Incentive Payment System (MIPS), as well as for eligible hospitals and critical access hospitals, to report their use of payers' prior authorization APIs to submit an electronic request.

References:

CMS Final Rule to Expand Access to Health Information and Improve the Prior Authorization Process

CMS Interoperability and Prior Authorization Final Rule CMS-0057-F

AMA Prior Authorization