

Quick Reference:

Current vs. Finalized Prior Authorization Timeframes

The CMS 0057-F Final Rule significantly impacts prior authorization timelines by standardizing and expediting the process. Under the current framework, some organizations allow *up to* 14 days for prior authorization decisions, while expedited requests are handled *within* 72 hours (three days).

With the new rule, the directive is for standard prior authorizations to be completed within a maximum of seven days, and expedited requests must be resolved in no more than 72 hours. This change ensures a more uniform and swift response, improving efficiency and patient care across.

Line of Business	Current Standard		Finalized Standard	
	Expedited	Standard	Expedited	Standard
Medicare Advantage and Applicable Integrated Plans	No later than 72 hours	No later than 14 calendar days	No later than 72 hours	No later than 7 calendar days
Medicaid Managed Care				
CHIP Managed Care				
Medicaid FFS	Not specified in federal regulation	Not specified in federal regulation	No later than 72 hours	No later than 7 calendar days
CHIP FFS		No later than 14 calendar days		
QHP Issuers on the FFEs	No later than 72 hours	No later than 15 calendar days	No change	No change

Caveats for all timeframes

As expeditiously as the beneficiary's health condition requires and within state-established time frames.

** After receiving request, unless a shorter minimum time frame is established under state law.*

Get the full picture.

Learn the necessary insights to be confident and successful in your implementation. Watch the recorded webinar, How to Successfully Implement the CMS Final Rule, for more details on this quick reference.



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