2026 Prior Authorization Compliance Checklist

Medicare Advantage Plans — CMS Final Rule

Effective Date: Plan year 2026 (January 1, 2026)

Source: CMS-4201-F

- 1. Update Authorization Turnaround Times

Urgent requests:	72 hours maximum (was 14 days)
Standard requests:	7 calendar days maximum (was 14 days)

- 2. Verify Electronic Prior Auth Capability

API integration required:	FHIR-based if available
Portal fallback:	Must support real-time status checks

- 3. Train Staff on Denial Reason Transparency

All denials must include:	Specific reason (not just code)
	Clinical rationale if medical necessity

- 4. Implement Continuity of Care Protocols

Ongoing treatment:	Auto-approve during transition period
New members:	120-day continuation required

- 5. Update Appeals Process Documentation

Internal appeals:	30 days for standard, 72 hrs for urgent
External review rights:	Must be disclosed in all denials

- 6. Audit Prior Auth Logs for Compliance Gaps

Review Q4 2025 data:	Identify requests exceeding new limits
Estimate impact:	Calculate potential penalty exposure

- 7. Communicate Changes to Providers

Send bulletin by Feb 15:	New timelines and expectations
Update contracts:	Reflect CMS requirements

Penalties for Non-Compliance:

CMS may impose intermediate sanctions including suspension of new enrollments and civil monetary penalties up to $25,000 per determination for systematic violations.

Resources:

- Full policy text → axlow.com
- RevCycleAI weekly intelligence → revcycleai.com/newsletter