EviCore
By EVERNORTH

2026 CMS Turnaround Time Update

Effective January 1, 2026, the turnaround time for **routine prior authorization requests** for **Medicare and Medicaid members** will be **seven (7) calendar days**, reduced from the current **fourteen (14) days**. This change is part of the **CMS Advancing Interoperability and Prior Authorization Final Rule** and applies to **Medicare and Medicaid members**.

What are the key changes for an ordering provider?

- Routine (non-urgent) requests: A decision will be made within seven (7) calendar days from the date the request is received.
- Urgent requests: No change—decision will continue to be made within seventy-two (72) hours.

What members are impacted by this change?

- Medicare members
- Medicaid members—unless their state has more restrictive turnaround times

What if there is important clinical information missing from the initial request?

- If critical clinical details are missing, EviCore will contact the ordering provider by phone and/or fax.
- The outreach will specify the required clinical information needed for the medical necessity review.

How long will a prior authorization request stay in a hold status for missing information?

- Requests missing clinical information will remain in a hold status for three (3) calendar days from the initial case request date.
- This allows time for submission of missing details and completion of the medical necessity review.

How does an ordering provider submit additional clinical information for review?

- Providers can:
    - Upload documents via the provider portal
    - Fax additional information
- Providers may contact EviCore at any time during the review process.
- Peer-to-peer discussions are available at any time before an initial decision is made.

Does EviCore hold all cases for provider outreach before making an adverse determination?

- No, if sufficient clinical information is submitted, a decision should be made within the required seven (7)-day timeframe.
- To help avoid denials, please submit complete and accurate clinical documentation at the start of the case to meet medical necessity with your initial request.

What options are available if a prior authorization request is denied?

- A determination letter will be sent to the ordering provider with next steps.
- For Medicare cases, an educational peer-to-peer discussion is available; however, the decision cannot be changed based on the discussion.
- Medicaid cases have multiple post-decision options available.
- Please refer to the denial letter for available appeal options on both Medicare and Medicaid cases.