



Clinical documentation attachments required for authorizations submitted via Availity Essentials

Effective Jan. 1, 2026, the Centers for Medicare & Medicaid Services (CMS) requires prior authorization (PA) decisions within seven calendar days for standard (non-urgent) requests for medical items and services (See CMS Interoperability and Prior Authorization Final Rule - CMS-0057-F).

Humana is committed to maintaining the new streamlined time frame for PA decisions in accordance with this rule. To comply, all supporting clinical documentation must be submitted at the time of the PA request. Beginning May 16, 2026, providers submitting outpatient Medicare authorization requests for PA services via the Availity Essentials™ portal will be required to upload supporting clinical documentation. Exceptions may apply.

The following FAQs address some common questions. If you have other questions, please call **800-457-4708 (TTY: 711)** Monday-Friday, 7 a.m. – 7 p.m., Eastern time.

Frequently Asked Questions

How has the PA time frame changed?

CMS now requires impacted payers to send PA decisions to providers within 72 hours for expedited (urgent) requests and seven calendar days for standard (non-urgent) requests.

Why is Humana implementing this change?

To streamline the PA process and comply with CMS Interoperability and Prior Authorization Final Rule - CMS-0057-F, supporting clinical documentation must be received with the authorization request. This ensures that Humana has the information necessary to promptly and accurately review requests.

Which services are affected by this update?

This requirement applies to Medicare outpatient authorization requests for PA services submitted directly through Availity Essentials. It does not apply to home health services, inpatient services or Medicaid membership. This change does not impact submissions outside of Availity Essentials.

What happens if clinical records are not available when submitting an outpatient PA request via Availity Essentials?

Availity Essentials will require clinical records to be attached before submission for outpatient PA services. If records are unavailable, your progress will be saved as a draft in the Authorization/Referral dashboard for up to 90 days. You may resume and submit once documentation is available. Please note, draft entries are not considered submissions; Humana will not receive your request until it is submitted with records attached.



What types of clinical documentation are required?

Required information may include, but is not limited to, the items below:

- **Patient details:** Full name, date of birth and Humana policy ID number
- **Referring and servicing provider details:** Name, National Provider Identifier (NPI), Tax Identification Number (TIN), specialty and contact information (including fax)
- **Diagnosis and procedure codes:** Accurate International Classification of Diseases (ICD) diagnosis codes (up to six) and procedure codes (up to 10, as applicable) specific to the request
- **Treatment details:** Specific service, procedure, item or medication being requested, including planned date of service, service location, inpatient or outpatient status, quantity, medication dosage, frequency and duration
- **Clinical rationale:** Detailed explanation of medical necessity with supporting evidence from medical records. See [Humana.com/CoveragePolicies](https://www.humana.com/CoveragePolicies) for more information on clinical guidelines.
- **Relevant medical history:** Past medical conditions, current medications, allergies and significant laboratory results
- **Supporting documentation:** Imaging studies, laboratory reports, prior treatments or therapies, progress notes or other relevant clinical data that supports the medical necessity of the request

Where can I learn more?

For additional details, please refer to the CMS Interoperability and Prior Authorization Final Rule - CMS-0057-F and Humana coverage policies at [Humana.com/CoveragePolicies](https://www.humana.com/CoveragePolicies).