

May 22, 2026

The Honorable Mehmet C. Oz, MD, MBA
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
P.O. Box 8016
Baltimore, MD 21244-8016

Re: Implementation of the CMS Interoperability and Prior Authorization Implementation of the CMS Interoperability and Prior Authorization Final Rule (CMS-0057-F): AMA Findings on Public Reporting Practices and Recommendations to Improve Usability, Comparability, and Oversight

Dear Administrator Oz:

On behalf of the physician and medical student members of the American Medical Association (AMA), I want to commend the Centers for Medicare & Medicaid Services (CMS) for its leadership in adopting the 2024 Interoperability and Prior Authorization Final Rule ([CMS-0057-F](#)). This rule represents an important federal action by bringing transparency, accountability, and public oversight to prior authorization (PA) practices that have historically operated with limited visibility, despite their [profound impact](#) on patient access, physician burden, healthcare costs, and efficiency across the healthcare system.

The AMA strongly supports the goals CMS advanced through CMS-0057-F. By requiring payers to publicly disclose PA requirements, outcomes, and decision timelines, CMS created the foundation for beneficiaries to make more informed enrollment decisions, physicians to identify PA requirements before care is delayed, and the agency to strengthen oversight of payer PA practices. The rule reflects a clear recognition by CMS that PA transparency is not merely an administrative reporting exercise; it is an essential protection for patients, a tool for holding payers accountable, and a prerequisite for evaluating whether PA is being used appropriately.

As with any major federal transparency initiative, however, the first year of implementation has revealed areas where additional standards would help ensure the rule achieves CMS' full intent. Following the March 31, 2026, reporting deadline, the AMA reviewed PA disclosures for 15 Medicare Advantage (MA) contracts and identified significant deficiencies in the accessibility, completeness, format, and underlying methodology of the disclosures. These findings do not diminish the importance of CMS-0057-F. Rather, they underscore the need for targeted implementation refinements so that the rule can fully deliver on the transparency, consistency, and oversight goals CMS established.

This letter summarizes key findings from the AMA's review and offers recommendations to strengthen implementation of CMS-0057-F. With additional guidance, standardization, and enforcement, CMS can ensure that this historic rule becomes a true turning point in the federal effort to reduce patient harm, physician burden, and systemwide inefficiency caused by excessive and poorly monitored PA practices.

Methodology

The AMA evaluated 15 MA contracts offered in Miami-Dade County, Florida (ZIP code 33125) on April 1, 2026 immediately following the March 31, 2026 deadline for the CMS-0057-F reporting requirements. We used Medicare Plan Finder (MPF) as the starting point for plan selection to mirror how beneficiaries compare and evaluate MA coverage options during enrollment, and we reviewed plans in the same sequence they appeared under the default MPF display settings during plan comparison.

The evaluation spanned three domains: (1) compliance with CMS-0057-F public posting requirements and reporting deadlines; (2) the accuracy, completeness, and methodological consistency of reported data; and (3) the accessibility and interpretability of public disclosures. Accessibility was judged by the discoverability of PA metrics and service lists, how many navigational steps disclosures required from the homepage, whether plans clearly linked CMS contract identifiers, commonly known as H-numbers, to the plan names beneficiaries see in MPF and enrollment materials, whether disclosures were publicly available without navigating through provider or member pages, and whether plans presented information in searchable, structured formats that allowed beneficiaries and physicians to efficiently identify and compare PA requirements across plans.

Summary of Findings

1. Required PA data is posted in locations that beneficiaries and providers cannot reasonably find

While CMS-0057-F requires PA information to be “publicly accessible,” plans retain broad discretion over where they publish the required data, which made it nearly impossible to locate the information. Nearly all 15 plans reviewed published their disclosures within [provider-](#) or [member-facing](#) websites, [legal-compliance subsections](#), hyperlinks embedded within [PDF documents](#), or on pages requiring [five or more navigational steps](#) from the plan homepage. At least 10 plans posted lists of services requiring PA exclusively within provider-facing resources, with no beneficiary-facing equivalent. Others [failed](#) to clearly associate disclosed metrics and service lists with corresponding contract H-numbers and plan names, even though H-numbers are technical CMS contract identifiers that do not cleanly correspond to the consumer-facing plan names beneficiaries recognize, such as “AARP Medicare Advantage.” Few beneficiaries would know their plan’s H-number or know how to find it, limiting their ability to determine which PA disclosures apply to the MA product they were considering or enrolled in.

One [plan’s](#) disclosures could not be reached through website navigation at all and could only be found through search engine queries using the contract H-number, state, and plan name. Several [plans](#) directed beneficiaries to contact the insurer after enrollment to determine whether a service required PA rather than linking directly to PA requirements, and multiple plans informed beneficiaries that standard PA determinations would be issued within [14](#) or [15](#) days, directly contradicting the seven-day maximum timeframe established under CMS-0057-F

2. Reported metrics contain errors, omissions of required data, and inaccuracies

AMA’s review found widespread deficiencies in the quality, consistency, and interpretability of reported PA metrics. Several plans reported turnaround times [without](#) including units of time, while others used units that obscured actual response times. For example, some plans rounded sub-day determinations to “[0 days](#)” rather than reporting them in hours, making it difficult to distinguish between decisions issued within minutes, several hours, or nearly a full day. Multiple plans omitted entire reporting categories, including [one](#) that failed to report expedited approval and denial rates as well as mean and median expedited turnaround times.

There were also several internal inconsistencies and errors within plan filings. One plan [reported](#) two different totals for standard PA requests within the same document and reported expedited median turnaround times as both “zero days” and “one day” on different pages. The plan also reported an expedited mean turnaround time of 2.88 hours alongside a median of one day—a mathematical impossibility, as a median of 24 hours would require at least half of all determinations to take 24 hours or longer.

Most concerning, several plans explicitly acknowledged the unreliability of their own data. One [filing](#) included an internal editing note stating that data was “not accurate.” Another plan [stated](#) that its metrics “should not be relied upon as a complete or definitive representation of all PA activity” due to system limitations. That same plan reported both the highest denial rate and the highest appeal-overturn rate among the 15 MA contracts evaluated.

3. Service lists varied widely in format, organization, and granularity, making PA requirements difficult to interpret and compare across plans

Patients or clinicians trying to determine whether a specific item or service requires PA are generally attempting to answer one of three questions: whether the service being considered requires PA; whether a clinically appropriate alternative would be exempt from PA; and how that plan’s restrictions differ from those imposed by other plans. Few of the lists that plans posted would be able to be used to answer those questions.

Many consisted of long, [poorly organized](#) compilations of [billing codes](#) paired with highly technical descriptions that are difficult to interpret without coding manuals or insurer policy documents. In one example, a plan posted an [832-page file](#) listing thousands of procedure codes in a single undifferentiated sequence, with oncology testing, infused drugs, procedures, and durable medical equipment codes grouped together without organization by service type, clinical area, or care setting. Another posted a [104-page list](#) of billing codes with abbreviated procedure descriptions but no searchable categories or plain-language explanations. Plans also varied widely in the level of detail used to describe services subject to PA. Some [listed](#) broad categories such as “advanced imaging,” while others [used](#) highly specific, clinically complex order descriptions. The most problematic [example](#) involved a plan that grouped hundreds of Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes into large catch-all “Other” buckets with no description of what the codes represented.

Several payers introduced additional complexity by requiring users to navigate multiple layers of [plan-specific rules](#), [product types](#), and [geographic carve-outs](#), only to qualify the disclosures with disclaimers [stating](#) that requirements “may vary at our discretion,” or do not apply to all plans. Some plans also included directly contradictory statements, [asserting](#) that the published PA lists “reflect all covered services,” while also cautioning that PA may be subject to further coverage limitations, exclusions, and rules located elsewhere in plan documents.

4. Plans reported aggregated organization-wide PA metrics using methodologies that did not align with CMS-0057-F

Although CMS requires PA metrics to be reported at the contract level, multiple plans prominently displayed aggregated organization-wide statistics while relegating the required contract-level data behind secondary links or on less visible pages. This presentation obscured substantial variation in contract-level approval rates, denial rates, appeal outcomes, and decision timeframes—information beneficiaries need to evaluate the specific contract associated with the plan they are considering.

UnitedHealthcare's (UHC) disclosures illustrate how organization-wide statistics can distort the contract-specific picture. On its homepage, the group prominently [highlights](#) that "95.4 percent of PAs are approved," while relegating the underlying [contract-level disclosures](#) to a small link at the bottom of the page. Those statistics reveal contracts with approval rates as low as 72.2 percent—a figure most beneficiaries viewing UHC's website would likely never find.

More concerning, these organization-wide metrics were often calculated using methodologies that excluded entire categories of PA activity covered by CMS-0057. UHC, for example, states in a footnote beneath its 95.4 percent approval statistic that the calculation excludes behavioral health services, post-acute care, delegated arrangements, and other categories of PA activity. That methodology conflicts with CMS-0057-F, which excludes only drugs from PA reporting and does not permit plans to omit covered medical services or delegated PA activity from the required metrics.

Recommendations to Strengthen Implementation of CMS-0057-F

The review identified several opportunities to strengthen implementation of CMS-0057-F. By clarifying expectations and establishing clear reporting standards, CMS can ensure the rule achieves its intended purpose: empowering beneficiaries to make informed plan choices, enabling physicians to identify PA requirements more easily, and improving oversight of MA PA practices.

1. Link to PA metrics and requirements from each plan's page in Medicare Plan Finder

Despite the profound impact PA has on access to care and out-of-pocket costs, beneficiaries remain unable to evaluate plans' PA practices and outcomes at the point of enrollment. CMS-0057-F was intended to provide that visibility, but the information is posted in locations that most beneficiaries are unlikely to find while comparing coverage options. If these disclosures are intended to inform plan selection, they should appear within the tools beneficiaries already use to compare plans.

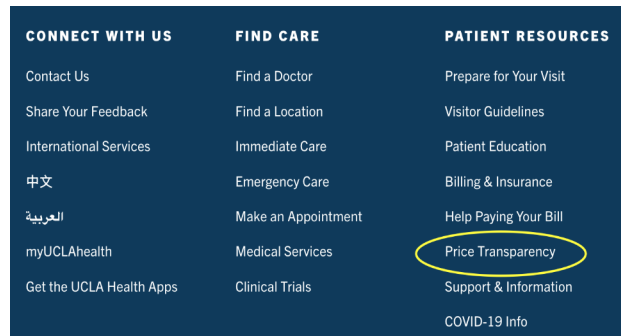
- CMS should add links to each plan's PA metrics and service lists directly on its MPF page, alongside the benefits, cost-sharing, formulary, and network information beneficiaries already use to make enrollment decisions. This would allow beneficiaries to evaluate not only what a plan covers, but how its PA practices may affect access to covered care. Because plans already publish this information online and CMS controls the MPF interface, CMS could implement this change through a minor update to the existing page layout, as shown in Appendix A, without imposing new reporting requirements or administrative burden on Medicare Advantage Organizations (MAOs).

2. Establish standards governing the location and discoverability of PA disclosures

CMS should also establish uniform requirements governing where and how MAOs publish PA information on their public websites. Our review found that while most plans technically complied with the letter of the rule, they posted disclosures in places that undermined the spirit of the rule, which was intended to promote transparency regarding PA practices.

CMS should require plans to make PA disclosures readily accessible and easily discoverable through a standardized location on their public websites. The agency did this when implementing the Hospital Price Transparency rule after hospitals posted pricing data in locations and formats that limited public accessibility and practical use. To improve discoverability, CMS required hospitals to include a direct link to pricing information in the footer of their public homepage, as shown below, and to maintain standardized plain-text locator files within the root directory of their websites. CMS should adopt analogous requirements for PA disclosures so the required information is not merely posted but placed where the public and oversight entities can reliably find it.

- At minimum, CMS should require MAOs to:
 - Display a clearly labeled hyperlink to PA disclosures (e.g., “*PA Metrics and Service Lists*”) in the footer of the organization’s homepage, as shown below.
 - Maintain direct, standardized public URLs for PA metrics and service lists (e.g., *payername.com/priorauthorizationmetrics*).
 - Maintain a standardized plain-text locator file (e.g., */cms-pa.txt*) in the root directory of the public website that identifies:
 - The direct URLs for PA metrics and service lists;
 - The reporting entity and associated contract identifiers; and
 - The designated compliance contact for reporting inaccuracies or accessibility concerns



UCLA Health Hospital Price Transparency footer link

- CMS should also clarify that PA disclosures do not satisfy the “publicly accessible” requirement if they are available only through provider or member portals, provider or member resource sections, legal or compliance pages, or other locations that cannot be reached through ordinary navigation from the plan’s public-facing website.

3. Establish standards for the quality, consistency, and scope of reported data

CMS issued an optional reporting [template](#) with the final rule, and the organizations that used it generally disclosed PA information more clearly and consistently. However, because the template was optional, plans published disclosures using widely variable and incomparable formats. Plans also used inconsistent methodologies to calculate PA metrics and reported them at different levels of aggregation, undermining the accuracy and reliability of the data. CMS should provide additional guidance to ensure that PA metrics are calculated, reported, and displayed consistently across MAOs. At minimum, CMS should:

- Require all MAOs to report PA metrics using the standardized reporting template.
- Require plans to include units for all turnaround time metrics, with turnaround times of less than one calendar day reported in hours.
- Pending any future transition to plan-level reporting, require MAOs to report metrics at the contract level, as CMS-0057-F currently requires, and prohibit organization-wide aggregate reporting that obscures contract-level performance variation.
- Clarify that drugs are the only category currently excluded from reported PA metrics and require plans to include all PA activity associated with medical items and services, including activity conducted through delegated arrangements.

- Define PA for reporting purposes as any pre-service review process through which a plan determines whether to approve or deny coverage of an item or service, regardless of the internal label applied to that process. This definition should include predetermination, precertification, advance notification, preauthorization, medical necessity review, site-of-service review, and any functionally equivalent utilization-management process.

4. Standardize the format and content of PA service lists

The AMA's findings demonstrate the need to standardize how plans report the items and services subject to PA. CMS recognized the value of standardized reporting when it issued the optional template for PA metrics and should extend that approach to PA service lists.

- Establish and require use of a standardized template for reporting services and medical items subject to PA. The template should organize services into uniform categories and include plain-language descriptions, CPT/HCPCS codes, site-of-service restrictions, prerequisite therapy requirements, and provider-type restrictions. A uniform structure would allow CMS and beneficiaries to compare PA requirements across plans and help physicians and care teams identify applicable PA requirements more easily at the point of care. Suggested categories are provided in Appendix B, and a proposed template is provided in Appendix C.

5. Create a PA comparison tool within Medicare Plan Finder

Even with a standardized reporting template, beneficiaries comparing MA plans during enrollment would still need to navigate multiple insurer websites, search through separate PA documents, and manually compare requirements across plans. CMS should build a PA comparison tool directly into MPF so beneficiaries can review PA requirements in the same place they already compare provider networks, formularies, benefits, and cost-sharing structures, as shown in Appendix D.

To support this functionality, CMS should require MAOs to submit PA service-list data in a standardized, machine-readable format, such as JavaScript Object Notation (JSON), using a CMS-defined schema with standardized field names, required data elements, allowed values, and formatting conventions. The machine-readable schema should align with the standardized PA service-list template so that the same categories and data elements appear across plan websites, CMS submissions, and MPF displays. This alignment would allow CMS to validate submissions, compare PA requirements across plans, audit inconsistent disclosures, and generate beneficiary-facing displays within MPF. Appendix E provides a proposed JSON schema for standardized PA service-list reporting, and Appendix F provides an example JSON entry for an MRI service.

- Require MAOs to submit PA service-list data through a CMS-defined machine-readable schema that aligns with the standardized PA service-list template described above.
- Configure MPF to display plan-level PA requirements using the same service categories and data elements submitted to CMS, including service or item name, applicable billing codes, site-of-service restrictions, prerequisite therapy requirements, and provider-type restrictions.
- Require the PA information posted on plan websites and displayed on MPF to come from the same underlying dataset submitted to CMS.
- Require MAOs to archive prior versions of submitted PA service lists and require CMS to maintain public historical access to prior-year datasets.

6. Establish oversight and enforcement procedures for PA reporting compliance

The AMA's findings demonstrate that passive oversight will not ensure that payers meet CMS-0057-F's reporting requirements. The agency's [FAQ](#) states that oversight will occur through existing program

authorities—which vary substantially across payer types—and that beneficiaries and providers may submit complaints to the appropriate authority. However, the FAQ does not explain how CMS will receive, review, or resolve those complaints, nor does it identify a proactive process for assessing whether PA disclosures are accessible, complete, accurate, consistently calculated, and reported in the required format.

CMS should establish clear oversight and enforcement procedures that draw on enforcement approaches used for Hospital Price Transparency and Health Insurance Portability and Accountability Act Administrative Simplification and should include clear mechanisms for auditing disclosures, correcting deficiencies, receiving complaints, and addressing sustained or repeated violations.

- Conduct periodic audits to ensure compliance with CMS-0057-F reporting requirements.
- Establish a centralized CMS mechanism for patients and physicians to report potential violations of CMS-0057-F.
- Require MAOs with reporting deficiencies to remediate violations within a specified timeframe and submit corrective action plans.
- Publicly post enforcement actions related to PA reporting noncompliance and impose escalating remedies for repeated or unresolved violations, including civil monetary penalties and other actions available under existing CMS authority.

Recommendations to Strengthen and Expand the CMS-0057-F Reporting Framework

1. Require plan-level reporting of PA metrics and service lists

CMS-0057-F requires MAOs to report PA metrics and service lists at the contract level, which is the level CMS uses for many MA oversight, compliance, and enforcement activities. The AMA understands the administrative rationale for this approach: contract-level reporting provides a standardized reporting unit and is simpler for plans and CMS to implement than plan-level reporting. However, contract-level reporting substantially limits the usefulness of PA disclosures for beneficiaries, physicians, and CMS oversight.

First, beneficiaries recognize and compare plans by the names displayed in MPF and enrollment materials, such as “UnitedHealthcare Medicare Advantage Choice Plan,” not by contract numbers such as “H-1234.” A beneficiary comparing plans would have no practical way to know that PA data for a marketed plan is reported under a contract number rather than the plan name they see during enrollment. As a result, beneficiaries are unlikely to find or use the relevant PA data when selecting coverage.

Second, a single MA contract may contain multiple plan benefit packages (PBPs) with different PA criteria, approval rates, denial rates, appeal outcomes, and decision timeframes. Contract-level aggregation masks variation across individual PBPs and can produce metrics that do not accurately reflect PA practices under any specific plan. By combining data across multiple PBPs, contract-level reporting obscures the plan-specific PA requirements and performance metrics that beneficiaries and CMS need to evaluate PA practices at the individual plan level.

The same problem applies to PA service lists. As demonstrated in the AMA’s review, contract-level disclosures can mask the PA requirements that apply to any individual plan and can become sprawling documents containing plan-specific carve-outs, geographic qualifiers, and exceptions. These disclosures make it difficult for physicians and practice staff to determine whether a patient’s specific plan requires PA for a particular service.

- Require plan-level, rather than contract-level, reporting of PA metrics and service lists. MAOs already maintain plan-specific PA criteria internally, so this change would not require plans to build new reporting infrastructure. CMS also already collects and displays plan-level information in MPF, including benefit designs, formularies, provider networks, and Star Ratings, demonstrating that CMS has the operational capacity to collect and present plan-level PA information using existing data systems.
- Prohibit MAOs from reporting PA metrics or service lists at the contract- or organization-wide level.

2. Require service-level reporting of PA metrics

CMS currently requires payers to report PA metrics in the aggregate across all services. In the final rule, however, CMS stated that it may consider requiring more granular reporting, including service-level reporting, in the future. The AMA urges CMS to move forward with that approach due to three significant limitations of aggregate reporting.

First, aggregate reporting masks where delays and denials are concentrated. High-volume, low-cost services with near-universal approval rates can inflate overall approval statistics while obscuring disproportionately higher denial rates for costly, clinically consequential services such as inpatient rehabilitation and post-acute care.

Second, aggregate reporting limits beneficiaries' ability to select plans based on the PA practices most relevant to their anticipated care needs. Many patients require predictable services, such as ongoing physical therapy or home healthcare. However, under the current reporting framework, they lack information on whether a plan has unusually restrictive PA policies, higher rates of denials, or longer decision timeframes for those services compared to other plans. That lack of visibility can lead to plan choices that do not reflect expected care needs, increasing the risk of unexpected out-of-pocket costs, delayed or forgone care, and coverage disruptions—outcomes that harm patients and increase downstream costs across the broader health system.

Third, without service-level reporting, CMS cannot readily identify inappropriate denials concentrated within particular services. Restrictive PA practices may therefore remain hidden until they surface through years of appeals, complaints, audits, investigative reporting, or litigation. The 2022 Office of the Inspector General (OIG) investigation into inappropriate post-acute care denials illustrates this problem. OIG [identified](#) those patterns only after a labor-intensive retrospective review of 250 randomly sampled PA determinations issued in June 2019. More targeted scrutiny of MA post-acute care denials did not begin until [years](#) later, after [investigative reporting](#) and class-action [litigation](#) brought the issue into sustained public view. With service-level reporting, CMS could identify emerging denial patterns and timeline violations directly from plan-reported data, before large numbers of beneficiaries experience care delays, denials, and disruptions.

Service-category-level reporting is also necessary to enforce [42 CFR 422.137\(d\)\(3\)](#), which requires plans to remove PA requirements for services that no longer warrant them. Without service-level data, CMS cannot identify which services may meet that threshold or verify plan compliance, leaving enforcement dependent on plan self-attestation.

- Require plans to report PA metrics disaggregated by standardized service categories, as outlined in Appendix B. This requirement should impose minimal burden on plans because they already process PA requests using billing codes that can be mapped to standardized CMS service categories.

3. Require plans to publicly report the most common reasons for denials

CMS-0057-F requires plans to communicate a specific reason to providers when an individual PA request is denied but does not require plans to publicly report the most common reasons for denials. Aggregate denial-reason reporting is critical because repeated denials based on medical necessity, administrative or procedural barriers, or benefit, coverage, or network limitations may indicate distinct plan-side failures that warrant different regulatory responses.

For example, elevated rates of medical necessity denials may indicate that a plan is applying coverage criteria that are more restrictive than Medicare standards or inconsistent with the clinical evidence base. High rates of administrative or procedural denials may reflect excessive documentation requirements, eligibility verification problems, noncompliance with electronic PA, or other operational barriers. Elevated rates of benefit, coverage, or network denials may indicate narrow provider networks, site-of-care restrictions, benefit limitations, or other restrictive coverage policies. Without disaggregated reporting of denial reasons, CMS cannot identify the primary drivers of inappropriate denials, target audits effectively, or address the plan practices producing those outcomes.

- Require payers to publicly report PA denials by denial rationale, using at minimum the following standardized categories:
 - **Medical necessity denials:** denials based on the plan's determination that the requested item or service does not meet applicable coverage criteria.
 - **Administrative or procedural denials:** denials based on incomplete documentation, eligibility verification issues, transmission failures, or other operational barriers.
 - **Benefit, coverage, or network denials:** denials based on network restrictions, site-of-care restrictions, benefit limitations, or other plan-design rules.
- Require payers to report appeal overturn rates stratified by denial category.

Conclusion

The AMA appreciates CMS' ongoing commitment to improving timely access to care and reducing the administrative burden that PA imposes on clinicians. CMS-0057-F represents an important step toward greater transparency, but the AMA's review shows that transparency requirements only achieve their purpose when the required information is accessible, comparable, accurate, and usable in real-world decision-making. Strengthening implementation of the rule would better equip beneficiaries to evaluate coverage options, help physicians identify PA requirements before care is delayed, and give CMS more reliable information to oversee MA organizations and identify problematic PA practices.

The AMA looks forward to working with CMS to make PA practices more transparent and helping patients receive timely access to medically necessary care. Please reach out to me directly at 312-464-5288 or John.Whyte@ama-assn.org if you have questions or need further information.

Sincerely,



John Whyte, MD, MPH

Cc: Chris Klomp
Joe Albanese

Appendix A. Mockup of Prior Authorization Links Within Medicare Plan Finder

Leon MediExtra (HMO)

Leon Health, Inc. | Plan ID: H4286-001-0

Star rating: ★ This plan got Medicare's **highest rating** (5 stars)

MONTHLY PREMIUM

\$0.00

Includes: Health & drug coverage

Doesn't include: the standard Part B premium

[What's the standard Part B premium?](#) ⓘ

TOTAL DRUG & PREMIUM COST (for the rest of 2026)

\$0.00

COPAYS/COINSURANCE

Primary doctor: \$0 copay

Specialist: \$0 copay

PLAN BENEFITS

- ✓ Vision
- ✓ Dental
- ✓ Hearing
- ✓ Transportation
- ✓ Fitness benefits

[See more benefits](#) ▼

DRUGS

[Add your prescription drugs](#)

Enter drugs you take regularly (if any) to see your estimated drug + premium cost

PROVIDERS

[Add your providers](#)

Find out if your providers are in a plan's network before you join.

PRIOR AUTHORIZATION

[Access this plan's prior authorization metrics](#) and the [list of services](#) requiring prior authorization.

Appendix B. Suggested Service Categories for Reporting Medical Items and Services Subject to PA

Sample Service Categories	Sample Subcategories
Imaging and Radiology Services	Magnetic resonance imaging; computed tomography; positron emission tomography; nuclear medicine imaging; diagnostic ultrasound; vascular imaging; echocardiography and cardiac imaging
Laboratory and Diagnostic Testing	Molecular and genetic testing; pathology and tissue-based diagnostics; oncology diagnostics and tumor profiling; infectious disease panels; reproductive, prenatal, and carrier screening; allergy, immunology, and autoimmune testing; toxicology and drug testing
Procedures and Surgeries	Cardiovascular procedures; orthopedic and joint procedures; spinal procedures; general surgical procedures; bariatric procedures; urological procedures; gynecological procedures; ophthalmological procedures; otolaryngology procedures; dermatological procedures; interventional pain management
Behavioral Health and Substance Use Disorder Services	Inpatient psychiatric admissions; residential SUD treatment; intensive outpatient and partial hospitalization programs; outpatient behavioral therapies; applied behavior analysis; medication-assisted treatment
Rehabilitation and Therapy Services	Physical therapy; occupational therapy; speech-language pathology; cardiac rehabilitation; pulmonary rehabilitation; specialized inpatient rehabilitation
Durable Medical Equipment, Prosthetics, Orthotics, and Supplies	Mobility equipment; respiratory equipment; prosthetic devices; orthotic devices; diabetes equipment and supplies
Inpatient and Facility-Based Services	Acute inpatient medical admissions; acute inpatient surgical admissions; inpatient rehabilitation facility admissions; skilled nursing facility admissions; long-term care hospital admissions

Sample Service Categories	Sample Subcategories
Home Health and Hospice Services	Home health periods of care; home infusion therapy; home dialysis training and support; hospice care
Part B Drugs and Infusion Therapies	Oncology infusions; biologic and immunomodulatory infusions; hematology infusions; specialty injectables; therapeutic apheresis

Appendix C. Proposed Template for Reporting Prior Authorization Requirements

To comply with the CMS Interoperability and Prior Authorization final rule, [Enter Organization Name] is required to publish a list of all medical items and services (excluding drugs) that require prior authorization. The list must be published using the template below, which promotes comparability across payers, helps beneficiaries understand prior authorization requirements when selecting coverage, and enables providers to identify applicable requirements at the point of care.

Imaging and Radiology Services

Service or medical item	Billing codes	Site-of-service restrictions	Prerequisite therapy requirements	Provider type restrictions
Magnetic resonance imaging (MRI)				
Computed tomography (CT)				
Positron emission tomography (PET / PET-CT)				
Nuclear medicine imaging				
Diagnostic Ultrasound				
Vascular Imaging				
Echocardiography and Cardiac Imaging				

Service or medical item	Billing codes	Site-of-service restrictions	Prerequisite therapy requirements	Provider type restrictions
Molecular and genetic testing				
Pathology and tissue-based diagnostics				
Oncology diagnostics and tumor profiling				
Infectious disease panels				
Reproductive, prenatal, and carrier screening				
Allergy, immunology, and autoimmune testing				
Toxicology and drug testing				

Appendix D. Mockup of PA Comparison Tool in Medicare Plan Finder

Prior authorization lookup and comparison

Find out whether a service requires advance approval from your Medicare Advantage plan. Select up to three plans to compare.

Your plan: Aetna Medicare Advantra (PPO) ▾
Compare with: Humana Gold Plus (HMO) ▾
Compare with: UnitedHealthcare AARP (PPO) ▾

Q Search for a service (e.g., MRI, knee replacement, physical therapy)

● Always required ● May apply — click to see conditions ● Not required

SERVICE	AETNA	HUMANA	UHC
▾ Imaging ▾ Magnetic resonance imaging (MRI)			
MRI of the brain <small>CPT 70551, 70552, 70553</small>	⚠ May apply ▾	✓ Always	✗ Not req'd
<div style="border: 1px solid #ccc; padding: 5px; font-size: 0.8em;"> <p>Aetna ● Conditions for MRI of the brain PA may apply to this service. Whether you need PA depends on the conditions below.</p> <div style="margin: 5px 0;"> 📍 Site-of-service restrictions ✓ PA required Hospital outpatient department (POS 22) ✗ No PA Doctor's office (POS 11), Freestanding imaging center (POS 24) </div> <div style="margin: 5px 0;"> 🔗 Prerequisite therapy requirements PA required unless documentation shows a trial of first-line therapy for the indication (e.g., headache prophylaxis for at least 4 weeks) or a prior head CT within the past 90 days. Exceptions apply for acute neurologic deficit, suspected stroke, or significant head trauma. </div> <div style="margin: 5px 0;"> 👤 Provider type restrictions PA not required when ordered by neurology, neurosurgery, or emergency medicine. PA required when ordered by primary care or other specialties. </div> <p style="font-size: 0.7em; margin-top: 5px;"> 🕒 Last reviewed by Aetna: Jan 15, 2026 🕒 Last changed: Sep 1, 2025 🔗 View Aetna's full clinical criteria ⬇️ Download this record (JSON) </p> </div>			
MRI of the spine <small>CPT 72141-72158</small>	⚠ May apply ▾	✓ Always	✗ Not req'd
MRI of joints (knee, shoulder, hip) <small>CPT 73218-73223, 73718-73723</small>	⚠ May apply ▾	✓ Always	⚠ May apply ▾
MRI of abdomen and pelvis <small>CPT 74181-74183</small>	✓ Always	✓ Always	⚠ May apply ▾
> Computed tomography (CT)			
> PET and PET/CT			

Appendix E. Proposed Machine-Readable Schema and Data Elements for Prior Authorization Service Lists

Data Element	Vocabulary Source	Plain-Language Display Example
Service category and sub-category	CMS-defined service category and sub-category	Imaging and Radiology Services
Billing codes	Current Procedural Technology (CPT) and Healthcare Common Procedure Coding System (HCPCS)	Procedure and item codes identifying the specific service subject to PA.
Site-of-service restrictions	CMS Place of Service codes	PA required in hospital outpatient settings, but not in physician offices.
Prerequisite therapy requirements	CPT, HCPCS, and CMS-defined criteria	PA required only after conservative treatment, prior testing, or specific documentation is provided.
Provider type restrictions	National Uniform Claim Committee Health Care Provider Taxonomy	PA requirements vary by provider specialty or facility type.

Appendix F. Annotated PA service list schema example: MRI

The following example illustrates the proposed record structure for an MRI and how each component supports structured validation, cross-plan comparison, and integration into Medicare Plan Finder.

Submission-level identifiers

Each record carries the submitting MAO's contract identifier, plan identifier, and plan benefit package identifier, together with the contract year, submission date, and schema version.

```
"submission_metadata": {  
  "contract_id": "H1234",  
  "plan_id": "H1234-001",  
  "plan_benefit_package_id": "001",  
  "contract_year": 2026,  
  "submission_date": "2026-01-15",  
  "schema_version": "1.0"  
},
```

Service-category identifiers

Each service entry carries a `service_category` and `service_subcategory` drawn from the CMS-defined service taxonomy, together with a `pa_status` field that takes one of three permitted values: `always`, `conditional`, or `never`.

```
"service_category": "Imaging",  
"service_subcategory": "Magnetic resonance imaging (MRI)",  
"pa_status": "conditional",
```

Site-of-service condition

The `site_of_service` condition type identifies, by CMS Place of Service code, the settings in which PA is required and the settings in which PA is not required. This replaces the ambiguity created by free-text site-of-service caveats.

```
"conditions": [  
  {  
    "id": "C001",  
    "condition_type": "site_of_service_restrictions",  
    "site_codes_requiring_pa": ["22"],  
    "site_codes_not_requiring_pa": ["11", "24"],  
    "description": "PA required at hospital outpatient department (POS 22). PA not required at office (POS 11) or freestanding imaging center (POS 24)."  
  }  
],
```

Prerequisite therapy condition

The `prerequisite_therapy_requirements` condition type defines required prior interventions, the minimum duration or lookback period for each, and standardized exception reasons drawn from a defined enumeration. This replaces narrative descriptions that obscure whether prior treatment is required and under what circumstances exceptions are permitted.

```
"id": "C002",  
"condition_type": "prerequisite_therapy_requirements",  
"prerequisite_steps": [  
  { "step": "plain_radiograph", "lookback_days": 90 },  
  { "step": "conservative_management", "minimum_duration_days": 42 }  
],  
"exception_permitted": true,  
"exception_reasons": ["ACUTE_TRAUMA", "NEUROVASCULAR_COMPROMISE"],  
"description": "PA required unless prior radiograph within 90 days and 6 weeks of conservative management documented."
```

Provider type restrictions

The provider_type condition type identifies the NUCC provider taxonomy codes for which PA is required and the codes for which PA is not required.

```
"id": "C003",  
"condition_type": "provider_type_restrictions",  
"provider_types_requiring_pa": ["207R00000X", "208000000X"],  
"provider_types_exempt": ["207X00000X", "207XS0114X"],  
"description": "PA required when ordered by primary care or pediatrics. PA not required when ordered by orthopedic surgery or sports medicine."
```

Explicit criteria logic

Logical relationships among the listed conditions are expressed using Boolean operators that reference the condition identifiers, permitting the conditions to be combined and evaluated programmatically rather than inferred from narrative structure. In the present example, PA applies when any of the four conditions evaluates to true.

```
"criteria_logic": "(C001 OR C002 OR C003)",
```

Structured metadata fields

Each record carries discrete last_reviewed_date, last_changed_date, and criteria_url fields, together with a prior_versions array referencing archived versions of the record. These fields support the historical archive and consistency requirements set forth in the Recommendation below.

```
"last_reviewed_date": "2026-01-15",  
"last_changed_date": "2025-09-01",  
"criteria_url": "https://[plan-domain]/criteria/mri-ankle",  
"prior_versions": [  
  { "version": "2025.1", "effective_through": "2025-08-31" },  
  { "version": "2024.2", "effective_through": "2025-02-28" }  
]
```