

BULLETIN

Michigan Medicaid Policy (MMP) | Health Services

Bulletin Number: MMP 26-02

Distribution: All Providers

Issued: January 23, 2026

Subject: Update to the Fee-for-Service Prior Authorization Process

Effective: As Indicated

Programs Affected: Medicaid, Healthy Michigan Plan, MI Coordinated Health, Maternity Outpatient Medical Services (MOMS), MICHild

This bulletin updates Medicaid program requirements for prior authorization (PA) processes for covered items and services, excluding drugs, as outlined within the [Centers for Medicare & Medicaid Services \(CMS\) Interoperability and Prior Authorization Final Rule \(CMS-0057-F\)](#).

Effective for PA requests submitted on and after March 22, 2026, the Michigan Department of Health and Human Services (MDHHS) will operationalize fee-for-service (FFS) PA requests as follows:

Requests for Standard Prior Authorization Review

- Determinations will be made for standard PA requests as quickly as a beneficiary's health condition requires, but in no case later than seven calendar days after MDHHS receives a request for services.
- The timeframe for standard PA decisions can be extended by up to 14 calendar days if the beneficiary or provider requests an extension, or if MDHHS determines that additional information from the provider is necessary to make a determination.
- When PA requests are returned to the provider requesting additional information, a 14-calendar day extension from the date of the return determination will be granted.
- Providers are to follow the PA request submission requirements as outlined in the MDHHS Medicaid Provider Manual and/or Medicaid policy bulletins, current on the date of submission. The MDHHS Medicaid Provider Manual and Medicaid policy bulletins can be accessed on the MDHHS [Policy, Letters & Forms](#) website.

Requests for Expedited Prior Authorization Review

- Determinations will be made for expedited PA requests as quickly as a beneficiary's health condition requires, but in no case later than 72 hours after MDHHS receives the request.

- Requests for expedited PA review will be considered if:
 - The service(s) will be rendered within 10 calendar days following the date of submission of the PA request.
 - Failure to render the service(s) within 10 calendar days may pose a serious risk to the beneficiary's life, health, or ability to attain, maintain, or regain maximum functional capacity.
 - Provision of the service(s) within 10 calendar days is medically necessary to correct a medical condition or prevent further deterioration or irreversible loss of function.
 - The service(s) are required for the beneficiary to be discharged from an inpatient hospital or nursing facility setting on the PA submission date.

Forms and Systems

- All PA request forms will be updated by March 22, 2026. Providers must use the most current PA form available on the [Medicaid Provider Forms and Other Resources](#) website.
- Community Health Automated Medicaid Processing System (CHAMPS) fields will be updated on March 22, 2026. Providers are encouraged to submit PA requests via direct data entry (DDE) in CHAMPS.

Additional information pertaining to MI Medicaid PA processes is located on the MDHHS [Prior Authorization](#) website and within the MDHHS Medicaid Provider Manual. Questions regarding the PA process should be directed to MDHHS - Health Services, Program Review Division via telephone at 800-622-0276. General provider inquiries should be directed to the Provider Support Helpline at 800-292-2550 or providersupport@michigan.gov.

MDHHS PA metrics will be published annually on the MDHHS [Prior Authorization](#) website starting March 31, 2026.

Additional program updates will be communicated in a forthcoming policy bulletin. Providers are encouraged to review the MDHHS Medicaid Provider Manual and Medicaid policy bulletins for quarterly technical updates throughout 2026.

Managed Care Organizations and Dental Health Plans

Managed Care Organizations (MCO) and Dental Health Plans (DHP) must provide, at a minimum, the full range of covered services described in this policy. MCOs and DHPs may choose to provide additional services over and above those specified. MCOs and DHPs are allowed to develop PA, documentation, and operational requirements that differ from FFS Medicaid requirements in accordance with their contract, applicable state law, and federal regulations. For beneficiaries enrolled in an MCO or DHP, the provider must check with the health plan for coverage and operational requirements.

Public Comment

The public comment portion of the policy promulgation process is being conducted concurrently with the implementation of the change noted in this bulletin. Any interested party wishing to comment on the change may do so by submitting comments to Samantha Rushman at RushmanS@michigan.gov.

Please include "Update to the FFS Prior Authorization Process" in the subject line.

Comments received will be considered for revisions to the change implemented by this bulletin.

Manual Maintenance

Retain this bulletin until the information is incorporated into the MDHHS Medicaid Provider Manual.

Questions

Any questions regarding this bulletin should be directed to Provider Inquiry, Department of Health and Human Services, P.O. Box 30731, Lansing, Michigan 48909-8231, or e-mailed to ProviderSupport@michigan.gov. When you submit an e-mail, be sure to include your name, affiliation, NPI number, and phone number so you may be contacted if necessary. Typical Providers may phone toll-free 800-292-2550. Atypical Providers may phone toll-free 800-979-4662.

An electronic copy of this document is available at www.michigan.gov/medicaidproviders >> Policy, Letters & Forms.

Approved



Meghan E. Groen, Chief Deputy Director
Health Services