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CMS-0057-F

Interoperability and Prior Authorization through the lens of every stakeholder

A multi-stakeholder perspective on prior authorization interoperability and compliance readiness.

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Problem Statement

Despite years of healthcare digital transformation, prior authorization (PA) workflows remain a fragmented and operationally burdensome process driven by disconnected payer portals, manual documentation, phone calls, and inconsistent submission workflows.

The challenge is further intensified by limited interoperability across payers, providers, delegated entities, intermediaries, and EHR platforms, making real-time coverage discovery and authorization workflows difficult at the point of care. As a result, providers continue to spend significant time managing manual documentation, denials, and fragmented authorization processes across multiple systems.

Overview of CMS-0057-F

The Centers for Medicare & Medicaid Services finalized CMS-0057-F, the Interoperability and Prior Authorization Final Rule, in January 2024, with implementation timelines stretching through 2026 and 2027. If you are a health plan, a provider organization, a delegated utilization management firm, or a technology vendor in this space, this rule is not something you can monitor from a distance. The clock is already running.

At its core, CMS-0057-F is a response to one of American healthcare's most persistent and costly dysfunctions: prior authorization. Study after study has quantified the toll - physicians and staff spending approximately **13 hours per week** on prior authorization administrative burden (2025 AMA Prior Authorization Physician Survey), care delays ranging from days to weeks, and an estimated **$35 billion** in waste annually from a process that, in many cases, adds friction without adding clinical value. CMS did not set out to eliminate prior authorization as a tool. What the agency is doing is mandating that the PA process be digitized, standardized, automated, and made measurably faster.

Entities Impacted

CMS-0057-F applies to Medicare Advantage organizations, state Medicaid and CHIP Fee-for-Service programs, Medicaid managed care plans, CHIP managed care entities, and QHP issuers in the Federally Facilitated Exchanges.

CMS-0057-F mandates four distinct FHIR API categories for impacted payers - a **Prior Authorization API**, an expanded **Patient Access API,** a new **Provider Access API,** and a **Payer-to-Payer exchange API.** Each addresses a different gap in healthcare data flow, and each carries its own compliance requirements and timelines. This article focuses specifically on the Prior Authorization API and the operational reforms it introduces across the prior authorization lifecycle. It examines how the rule directly impacts provider care approval workflows, payer response processes, and day-to-day clinical operations.

Within the prior authorization domain, the rule operates on three binding dimensions: a FHIR-based PA API built on the Da Vinci CRD (Coverage Requirements Discovery), DTR (Documentation Templates and Rules), and PAS (Prior Authorization Submission) implementation guides; binding decision turnaround times of **72 hours for urgent requests** and **7 calendar days for standard ones**; and a denial specificity mandate requiring every denied PA to cite specific clinical criteria rather than a generic blanket justification.

Compliance Timeline Summary For Payers

January 1, 2026: PA process requirements take effect - 72-hour urgent and 7-calendar-day standard decision timelines, denial specificity mandate, and annual PA metrics public reporting (first report due March 31, 2026).
January 1, 2027: All FHIR API requirements go live - Prior Authorization API (CRD/DTR/PAS), Patient Access API enhancements to include PA data, Provider Access API, and Payer-to-Payer API. The timelines for Patient Access, Provider Access, and Payer-to-Payer APIs are included here for full context; this article examines the Prior Authorization API components in depth.

CMS-0057-F: Prior Authorization - Stakeholder Impact at a Glance

Payers

Three Da Vinci FHIR APIs (CRD, DTR, PAS) to build & operate

Large National Plans

- Dedicated FHIR teams; building & testing CRD, DTR, PAS
- FHIR translation layers over legacy admin systems (e.g., FACETS, HealthEdge)

Regional & Mid-size Plans

- Vendor roadmap-dependent; routing through intermediary hubs

Small Plans

- Platform vendor-dependent; most still assessing

Common Challenges

- Questionnaire content (converting clinical criteria into FHIR format)
- Delegate accountability
- Public metrics exposure: approval/denial rates publicly reported
- 72-hr clock runs 24/7 — after-hours review or AI triage needed

Providers

Point-of-care PA check(CRD) → auto-populated docs(DTR) → electronic submission(PAS)

Large Health Systems

- Major EHRs actively implementing CRD/DTR integrations
- Pilots underway with payers & intermediaries

Mid-sized Groups

- Mixed readiness; EHR vendor roadmap-dependent
- Some testing; others waiting passively

Small & Independent

- EHR readiness varies; portals remain primary channel
- Many still assessing compliance requirements

Common Challenges

- EHR vendor dependency
- Data quality dependency
- Majority of the market still on portals/fax
- Inconsistent FHIR implementation across payers

Delegated Entities

PA decisions & data exchange executed by delegate — compliance accountability generally stays with the payer

- Health plan holds compliance accountability; delegate executes PA decisions
- Must meet 72-hour (urgent) / 7-calendar-day (standard) timelines & denial reasons
- Payer faces consequences if delegate misses timelines
- Mixed approaches – Payer owned FHIR frontend vs Delegate supported PAS APIs and a mix of both

Common Challenges

- Multi-payer integration burden: different FHIR models per health plan
- Contract renegotiation pressure
- The two-path dilemma: build own FHIR infrastructure vs. rely on payer/intermediaries front-end

Intermediaries

Single hub, many connections — routing PA transactions across existing provider and payer networks.

Administrative Clearinghouses

- Extending existing eligibility and claim networks to add FHIR PA routing
- Shifting to subscription pricing model

Health Information Exchanges

- Exploring PA data portability via existing record-sharing frameworks

Common Challenges

- Business model transition: per-transaction fees shifting to platform/subscription model
- Direct FHIR connections may reduce hub dependency long-term - most payers still prefer hubs today

The Provider Lens

Ask any physician practice administrator what their biggest non-clinical headache is, and prior authorization will almost always surface in the first breath. CMS-0057-F is, in many respects, a rule written with provider frustration in mind, even though the direct compliance obligations fall primarily on payers, the rule's success or failure will be measured almost entirely by what changes inside provider workflows.

What actually changes for Providers

The most immediate and tangible change for providers is access to real-time coverage requirement information at the point of care. Under the CRD framework, a clinician's EHR system - through a CDS Hooks integration can query the payer's Coverage Requirements Discovery service the moment a clinician is about to order a procedure or medication. Before the provider has even left the ordering screen, the system can return guidance: **PA (Prior Auth) required, PA (Prior Auth) not required,** or **documentation needed.** This is a fundamental shift from the current reality where most Prior Auth determinations require a portal submission, a fax or a phone call.

The DTR component then handles what happens when documentation is needed. Instead of provider staff manually gathering clinical notes and completing lengthy payer-specific questionnaires, DTR enables a SMART on FHIR app to launch directly within the EHR workflow. The application can automatically pre-populate the required form fields using available clinical data, with CMS recommending the use of Clinical Quality Language (CQL) for auto-population. In theory, and in well-implemented scenarios, this can substantially reduce documentation time, in environments with high-quality EHR data and well-configured rules logic.

The turnaround time mandate

The binding decision timelines deserve particular emphasis. Today's PA process has no federal floor for how long a payer can take to respond to a non-urgent PA request for Medicare Advantage. Seven calendar days sounds modest, but for a patient waiting for an MRI, a specialty drug, or a surgical procedure, that ceiling can be the difference between a three-day wait and a three-week one. For urgent requests, the 72-hour mandate is equally significant. These timelines are not aspirational; CMS has tied them to compliance obligations and plans.

Denial specificity

CMS-0057-F requires that denial notices include the specific reason tied to clinical criteria, the relevant clinical documentation reviewed, and information about the appeals process. For providers managing denial appeals which today represent a significant staff overhead, this change fundamentally alters the starting point of every appeal. The specificity requirement means that providers who understand how to read and respond to detailed denial rationales will have a measurable advantage in overturning inappropriate denials.

For a practice seeing 40 to 60 prior authorization requests per week, the difference between a rule-compliant payer experience and the current status quo could represent a significant portion of the 13 hours of weekly PA administrative time that physicians and staff currently carry (2025 AMA survey) - time that could be redirected to patient care

What Providers still have to do

For the first time, providers and their patients have a guaranteed ceiling on how long a payer can take to respond to a prior authorization request. For standard requests, that ceiling is 7 calendar days and for urgent ones, 72 hours. What does that mean in practice?

A patient waiting on an MRI can now expect a decision within a week rather than wondering whether it will take two or three. A patient whose condition is time-sensitive gets a response within three days, not whenever the payer gets around to it. These are not targets or best-effort commitments, they are binding requirements under the rule.

The Payer Lens

If providers are the intended beneficiaries of CMS-0057-F, payers are the entities with the heaviest lift. Within the prior authorization domain that this article covers, every major technical requirement - the FHIR-based PA API, the CDS Hooks server for CRD, the questionnaire infrastructure for DTR, and the PAS submission workflow, places the implementation burden squarely on health plans. And for Medicare Advantage organizations, Medicaid managed care plans, and QHP issuers operating under CMS jurisdiction, compliance is not optional.

The API build-out

On paper, the requirement reads simply: expose FHIR R4-compliant APIs for prior authorization. In practice, this requires payers to build or procure infrastructure capable of supporting real-time coverage requirement discovery, SMART on FHIR-based DTR workflows, and PAS-based prior authorization submissions. These services must also operate at scale with low-latency performance to support real-time clinical workflows effectively. For a large national MA plan processing tens of thousands of PA requests per day, this is a substantial infrastructure investment.

The content management challenge is equally significant. CRD requires that payers expose their coverage requirements including which services require PA, which don't, and what clinical documentation is needed in a structured, query-able format. Most payers have this information locked in policy documents, clinical criteria PDFs, and proprietary utilization management systems. Converting that institutional knowledge into FHIR-accessible structured data that can be consumed by a CDS Hooks service is often a complex and time-intensive data management effort for many organizations.

Decision timeline compliance

The 72-hour and 7-day decision timelines create pressure not just on the technology stack but on the clinical review processes behind it. Many payers have built their UM workflows around business-day staffing models. Meeting a 72-hour clock on urgent requests requires either round-the-clock clinical review staffing, AI-assisted decision support capable of routing and pre-adjudicating requests outside business hours, or a combination of both. Plans that rely heavily on delegated UM entities will also need to contractually and operationally ensure that their delegates can meet these timelines - a point that has created significant renegotiation of UM vendor contracts across the market.

The reporting requirements

One component of the rule that has received less attention than it deserves is the PA metrics reporting mandate. Beginning in 2026, payers covered by the rule must report publicly and share with CMS - data on prior authorization rates, approval rates, denial rates, appeal rates, and decision turnaround times, stratified by service type. This transparency is significant for two reasons: it creates competitive accountability, since a plan with denial rates dramatically higher than peer organizations will attract scrutiny; and it creates a data trail that regulators can use to identify patterns of inappropriate PA use.

The Delegated Entities Lens

One of the most underappreciated dimensions of CMS-0057-F is its implications for delegated utilization management organizations. Across the industry, particularly in Medicare Advantage and Medicaid managed care, health plans routinely delegate PA decision-making to specialty UM vendors. These delegated entities often make the majority of a plan's PA decisions, yet they sit in a peculiar regulatory position under this rule.

Where the delegation model creates risk

Under CMS-0057-F, the compliance obligation is widely understood to rest with the impacted payer — the rule applies directly to payers, and where utilization management has been delegated, the primary plan is generally held accountable for the delegate's performance. But in practice, the payer cannot meet its obligations without the delegate's full cooperation. If a delegated UM entity cannot receive PA requests via the FHIR-based API, process them within the mandated timelines, and return decisions in the required format, the payer faces compliance exposure regardless of where operationally the failure occurred.

The timeline pressure compounds the problem. A delegated UM entity that handles, say, musculoskeletal PA decisions for 15 different MA plans faces a staggering integration challenge. Each payer may have chosen a different FHIR platform, a different intermediary, or a slightly different workflow model. The delegate must interface with all of them. Unlike a payer that builds one API and connects to many providers, a delegated UM firm must potentially connect to many payers, each with their own implementation choices.

What makes this harder still is that the integration model itself varies by health plan. Some plans provide their own CRD and DTR services and expect the delegate to consume those endpoints directly. Others route transactions through a front-door intermediary such as a clearinghouse hub and require the delegate to connect through that layer. Some plans push the CRD responsibility entirely onto the delegate, expecting them to host and operate the coverage requirement discovery service on the plan's behalf. The result is not one integration pattern but a different one for each health plan relationship - a mix-and-match reality that multiplies both the engineering effort and the ongoing maintenance burden for any delegated UM organization operating at scale.

What compliant delegation looks like

In practical terms, delegated entities likely pursue one of the paths below or a hybrid approach.

Delegate-led API infrastructure	Payer/Intermediary-led front door	Delegate as decision engine
Delegated UM entity builds and manages its own FHIR-compliant PA APIs, processes authorization requests within its UM platform, and returns CMS-compliant decisions.	Payer or clearinghouse acts as the FHIR entry point, receives PA requests, and translates them into formats supported by the delegate's existing UM systems.	Payer or intermediary manages the provider-facing FHIR layer, while the delegated UM entity receives PAS submissions and serves as the back-end authorization decision service.

It is worth noting that the role of CRD and DTR in delegated UM arrangements remains genuinely unsettled. The compliance obligation ultimately rests with the payer. However, the Da Vinci CRD implementation guide assigns responsibility for generating valid coverage requirement responses to the entity operating the decision-making service, which in delegated models is typically the UM vendor. Whether a delegate hosts and operates its own CRD service, consumes a payer-provided CRD endpoint, or relies on an intermediary to surface those requirements is not prescribed by the rule, and the market has not yet converged on a standard approach. Based on implementation of discussions and industry forums, this is an area where payers and delegated entities are still actively working through the operating model together, and the answers are likely to vary by delegation arrangement and payer strategy.

The Intermediaries/3rd Parties Lens

No discussion of CMS-0057-F's implementation landscape is complete without addressing the role of healthcare intermediaries, the entities that sit between payers, providers, and delegated entities in the data exchange layer. This is a part of the story that rarely appears in the regulatory summaries but profoundly shapes how the rule actually gets implemented in practice.

Why Intermediaries matter in a FHIR world

In theory, FHIR APIs are standards-based, interoperable, and should enable direct point-to-point connectivity between provider EHR systems and payer API endpoints. In practice, the healthcare ecosystem is too fragmented for this ideal to hold. There are thousands of providers EHR instances, hundreds of payer organizations, and dozens of different FHIR implementation guide versions in varying states of adoption. Building direct connectivity between every provider system and every payer is both technically and economically untenable. Intermediaries solve this problem by acting as a many-to-many hub.

How clearinghouse hubs are positioning

The clearinghouse model is well-suited to the CMS-0057-F landscape. Companies already operating at the center of healthcare administrative transactions, eligibility checks, claim submissions, and remittance advice have a natural foundation for extending their networks to cover CRD, DTR, and PAS workflows. Several clearinghouses, such as Availity, are adopting a hub-and-spoke model for prior authorization workflows. Providers connect once to the hub, and the hub routes transactions to participating payers. This reduces the complexity of managing separate FHIR integrations for every payer relationship. For a mid-sized physician practice that lacks the IT resources to maintain dozens of payer-specific FHIR connections, this hub model is a compelling value proposition, and it is one of the more practical near-term paths for the large share of the market that will not have a FHIR-capable EHR by January 2027.

Intermediary dynamics

Several categories of established intermediary are actively positioning for this role. Clearinghouses already carry the majority of administrative healthcare transactions and are extending those rails to support FHIR-based PA; their existing payer and provider network footprints give them a structural head start.

What is particularly interesting about the intermediary dynamic is the business model tension it creates. Most of the intermediaries have historically made money on transaction volume, each eligibility check; each claim's submission carries a fee. In a FHIR-based world where the PA process is designed to be real-time and API-driven, the per-transaction economics are different. Intermediaries are adapting by moving toward platform and subscription pricing models, and by differentiating the depth and reliability of their payer connectivity networks. Networks with a given intermediary cover quickly new payers are added, will become a key evaluation criterion for provider organizations choosing which hub to connect through.

A Landscape of Solutions

The compliance deadline has created a genuine market for CMS-0057-F technology solutions, with vendors ranging from established healthcare IT leaders to startups built specifically around the Da Vinci implementation guides. Organizations are generally pursuing one of three approaches to achieve CMS-0057-F compliance. Some are building custom solutions based on the Da Vinci implementation guides, while others are adopting commercial off-the-shelf (COTS) platforms with pre-built Da Vinci support. A third group is leveraging portal-based FHIR solutions that provide a familiar user experience while managing the FHIR API complexity behind the scenes, with each approach offering different trade-offs in speed, cost, and long-term control.

Payer-side platforms

Several established EHR and care management vendors now offer FHIR-compliant API platforms to help health plans meet CMS-0057-F requirements. However, payers operating on legacy systems such as FACETS and QNXT face a more complex modernization journey. These organizations often require FHIR translation layers or middleware to bridge the gap between legacy architectures and modern interoperability standards.

Pure-play interoperability vendors have also emerged as critical players in this space. FHIR-native integration platforms such as Smile Digital Health help payers connect legacy core systems to the FHIR APIs required by CMS-0057-F. These platforms handle data translation between proprietary formats, such as EDI X12, and FHIR R4 standards, while also supporting CRD workflows through CDS Hooks. Many also provide additional interoperability capabilities, including Patient Access and Provider Directory APIs.

Provider-side and EHR vendor solutions

Most major EHR vendors now offer native support for CRD and DTR workflows, including CDS Hooks integration and SMART on FHIR capabilities. Readiness varies more significantly among specialty-focused and ambulatory EHR vendors serving independent practices. While many are actively advancing their CRD and DTR roadmaps, implementation timelines and maturity levels differ, making early engagement with EHR partners essential for providers.

Point solutions and specialized vendors

A category of point solutions has grown specific components of the compliance requirement. Several vendors have built PA-specific workflow tools that layer on top of existing EHR systems, while others have developed FHIR-native PA automation platforms specifically targeting CMS-0057-F use cases. In the UM space, a growing number of AI-assisted PA review platforms are emerging that aim to accelerate clinical decision timelines, a direct response to the 72-hour requirement.

It is worth noting that the market is still maturing. Organizations should conduct structured testing against the Da Vinci IG conformance requirements rather than relying solely on vendor self-certification, as capabilities and production readiness vary across the market.

The Small Practices

When asked about CMS-0057-F readiness, small and independent practices are largely still working through what compliance means for them, with many not yet ready.

The EHR dependency problem

Everything about CMS-0057-F's provider-side benefits the real-time coverage requirement lookup, the auto-populated documentation templates; the electronic PA submission runs through the EHR. A practice whose EHR vendor does not support CRD, DTR, and PAS will not see any of these benefits in their daily workflow. They will continue to use phone trees, payer portals, and fax machines. The rule requires payers to build compliant APIs, but it does not require EHR vendors to build compliant clients.

This is not a hypothetical problem. The 2024 CAQH Index, which tracks adoption of electronic administrative transactions across the industry, found that only 35% of prior authorization transactions were conducted fully electronically as of 2023. That figure captures the scale of the readiness gap: the majority of the market, including most smaller and specialty-specific EHR environments, is still operating on manual or semi-electronic workflows.

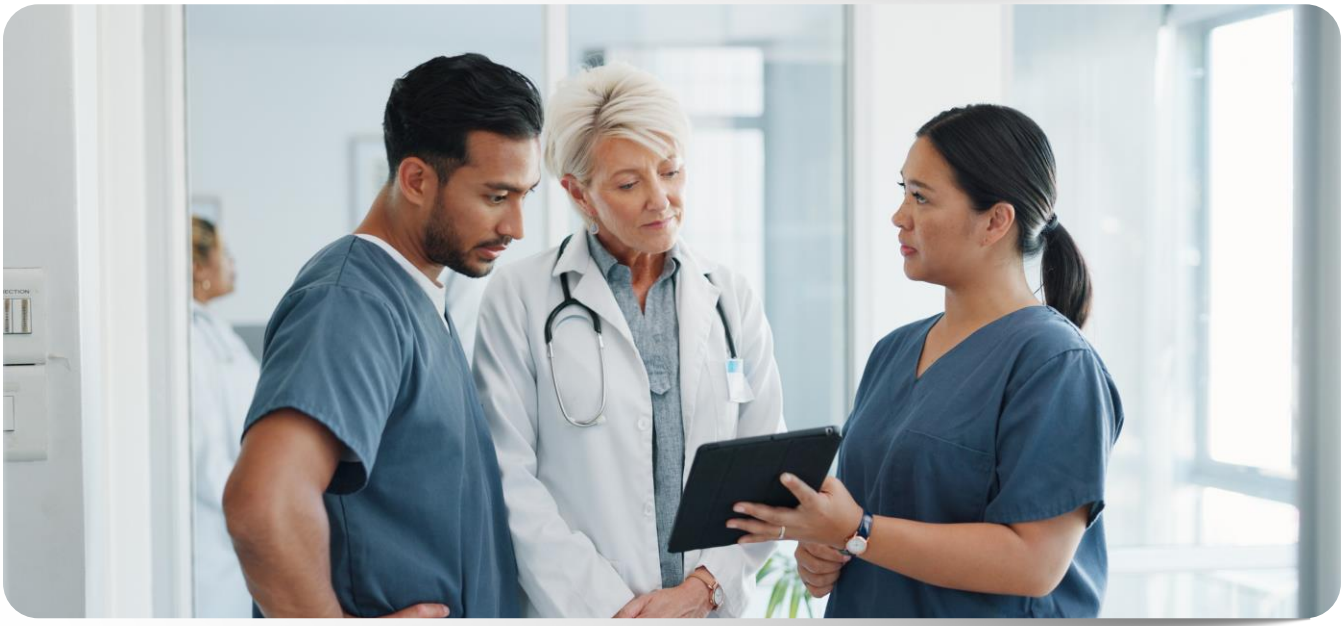
What small practices are actually doing

In the absence of native EHR support, small practices are taking a few pragmatic approaches.

Some are increasingly relying on payer portals which are generally expected to remain available alongside the new FHIR-based APIs, submitting PA requests through a web interface rather than via API. This approach does not capture the efficiency gains. The rule is designed to create but it remains a practical submission path from the payer's perspective.

A smaller but growing number of independent practices are turning to PA management service vendors who act as an outsourced prior authorization function. These services handle the PA submission process on the practice's behalf, using their own FHIR-connected infrastructure.

> The benefits of CMS-0057-F may reach different parts of the market at different speeds — and small and independent practices, who arguably carry the highest administrative burden per clinician, may face the steepest path to capturing them.



Portals in the new FHIR world

Ask how most physician practices submit prior authorization requests today and the answer will not be “FHIR API.” It will be “the payer portal”, “the Intermediary Portal”, “Fax”, and other channels. Portals, the web-based submission interfaces maintained by health plans, delegated UM entities, and intermediaries, have been the de facto electronic channel for PA for the better part of a decade. They replaced fax for a large share of submissions, but they are not APIs in any technical sense. They are human-operated web forms processed by staff on the payer side. Understanding how this dominant channel evolves post-January 2027 is essential context for any provider organization trying to work out what changes in their daily workflow.

Portals are not going away

It is widely understood that CMS-0057-F's primary mandate is for payers to build and expose FHIR-based APIs not to eliminate existing portal channels. Providers will still be able to submit prior authorization requests through existing portals. Likewise, organizations without FHIR-capable EHRs, which still represent much of the market today, will continue to have a valid submission pathway.

The timeline and denial specificity requirements apply regardless of how the request arrives. A provider submitting through the portal on January 2, 2027, is expected to receive a decision within 7 calendar days and a specific denial reason if the request is denied. Those are process obligations that fall on the payer regardless of the submission channel. Portals, in other words, remain a fully valid pathway. The rule just requires that a faster, more structured API channel now exists alongside them.

How health plan portals are adapting

Health plans that maintain their own provider-facing portals are taking one of two approaches. Some are building FHIR APIs as a separate technical layer while leaving the portal largely unchanged. The provider's experience stays the same, but the underlying data exchange is now standardized on the back end. Others are investing in portal modernization that wires the portal directly to the FHIR PA API, so a provider submitting through a web form is effectively submitting a FHIR-compliant request without needing to know anything about FHIR.

The second approach is more architecturally sound long-term, but it requires the health plan to have built a production-quality FHIR API first. This is precisely the challenge for payers still running legacy core administrative systems. For providers, the practical outcome of both approaches is the same: the familiar portal interface survives, but what happens behind it is changing.

Intermediary portals: The most viable near-term path for small Providers

The Intermediary's existing network - already the channel through which hundreds of thousands of providers check eligibility and submit claims, is being positioned explicitly as a CMS-0057-F compliant submission hub. The model works as follows: the provider uses a familiar web interface, but the Intermediary's infrastructure handles the FHIR API call to the payer on the back end. The provider does not need a FHIR-capable EHR. They do not need CDS Hooks integration. They submit through the portal they already use, and the compliance mechanics happen beneath the surface.

This model has a meaningful limitation worth naming directly. The real-time CRD benefit - the PA requirement check that fires at the exact moment a clinician enters an order inside the EHR - is not available through a portal. That workflow requires EHR-native CDS Hooks integration, which a standalone portal simply cannot replicate. What the intermediary portal model can deliver is the PAS submission layer (structured electronic PA request routed via FHIR), and increasingly some form of DTR-style questionnaire surfaced as a structured web form. Some intermediaries are exploring "standalone DTR" implementations where the documentation questionnaire is presented in a browser window the provider opens outside their EHR, then submitted via the FHIR API. The Da Vinci DTR implementation guide specifically supports a standalone launch mode for exactly this use case. Pre-population from clinical data will be limited without the EHR connection, but the questionnaire itself can still be completed and submitted compliantly.

What portal-dependent Providers can realistically expect post-2027

For a provider without a FHIR-capable EHR: they will benefit from the rule's process changes regardless of how they submit. Faster turnaround, specific denial reasons, and publicly reported payer metrics all apply irrespective of the submission channel. What they will not have access to - at least not automatically - is the proactive CRD check at the point of care or the fully auto-populated DTR questionnaire. Providers have several practical options for participating in the new ecosystem.

They can submit requests through intermediary portals that route transactions to payer FHIR APIs behind the scenes. They may also use standalone DTR web applications to complete documentation outside the EHR environment. Some organizations may choose outsourced PA management services that handle the entire submission process using their own FHIR infrastructure. Others can continue using payer portals that have been modernized to support FHIR-enabled prior authorization workflows through a browser interface.

How the market is filling the gap

Several market players have recognized that "EHR-less FHIR access" is a real and underserved need. Pure-play PA automation vendors are developing web-based interfaces that allow providers to initiate the CRD/DTR/PAS workflow through a browser without requiring any EHR integration. These tools embed the FHIR client inside a web application that connects directly to the payer's FHIR API. The provider experience looks like a structured, intelligent web form rather than a raw API interaction which is, frankly, how most small-practice staff will want to engage with this workflow regardless of what the technology underneath looks like.

The question that should drive every portal-dependent practice planning is not whether they need to adopt FHIR APIs directly by January 2027 - they do not. The question is whether they will be positioned to capture the efficiency gains that the new infrastructure makes possible. A practice still relying entirely on manual portal submission in 2027 will be doing more work per PA request than a peer who has connected through an intermediary hub or a FHIR-capable web tool.

SMART on FHIR and DTR scalability

The Documentation Templates and Rules framework and the SMART on FHIR apps that implement it, represent one of the more technically elegant components of CMS-0057-F. It also represents one of the more practically challenging ones to scale.

What DTR is supposed to do

The core DTR workflow is, on paper, straightforward. When a coverage requirement discovery response indicates that clinical documentation is needed for a PA request, the EHR launches a SMART on FHIR app - either the payer's proprietary DTR app or an EHR-native DTR client. The app queries the patient's FHIR record to pre-populate a questionnaire (defined in FHIR Questionnaire resource format with CQL logic), the clinician reviews and completes any remaining fields and the completed documentation is returned as a Questionnaire Response that can accompany the PA request. The clinical documentation that previously required manual assembly is now semi-automated.

Where scalability gets complicated

The scalability challenges emerge at several points in this workflow. First, CQL (Clinical Quality Language) logic or any other rules logic which DTR relies on to retrieve and pre-populate clinical data from the EHR is highly sensitive to data quality. In a well-structured environment with clean, coded clinical data, CQL/other rules logic works well. In an EHR with inconsistent clinical data modelling, partial FHIR implementation, or legacy data in non-FHIR formats, the auto-population rates drop sharply. A DTR implementation that theoretically saves 30 minutes of documentation time may save as little as 5 minutes if the underlying data quality is poor.

Second, the app distribution model creates maintenance challenges. Each payer must either maintain its own DTR SMART on FHIR app or use a standard app provided through the EHR vendor or an intermediary. In practice, this means that a provider organization working with multiple payers may need to manage a separate DTR app for each, with its own authentication, questionnaire logic, and update cadence - a maintenance overhead that grows with the number of payer relationships.

Third, the questionnaire content itself needs ongoing maintenance. Coverage requirements change. Clinical criteria get updated. New services come under PA requirements. Each change requires a corresponding update to the FHIR Questionnaire resource, the rules logic, and any payer-specific configuration. Payers who are accustomed to updating their clinical criteria in PDF form will need to establish formal processes for keeping their FHIR questionnaire artifacts synchronized with their underlying policy changes.

Is CRD required? What the rule actually says

Coverage Requirements Discovery is the component of the Da Vinci stack that has generated the most implementation debate, and the question of whether it is truly necessary or whether it can be deferred in favor of other approaches - surfaces frequently in implementation conversations. The answer is nuanced and depends on how one interprets both the regulatory text and the practical value proposition.

What the rule says

CMS-0057-F does not explicitly name CRD as a discrete mandatory component. What the rule mandates is an API that allows providers to identify prior authorization requirements before submitting a request - effectively, the capability that CRD provides. The rule references the Da Vinci IGs as the expected technical approach but gives payers some latitude in how they implement the underlying capability.

The case for CRD

From a clinical workflow perspective, CRD is arguably the most valuable component of the entire framework. The ability to determine at the point of order entry, before the provider has left the ordering screen whether a PA is required is transformative for workflow efficiency.

Today, in some cases, the discovery that a PA is needed happens hours or days after the order is placed, when the scheduling or billing team processes it. That downstream discovery adds delay, requires the clinician to re-engage, and often requires patient communication about changed timelines. CRD moves this decision to the point where it can be acted upon in real time.

The implementation reality

The challenge with CRD is that it places real-time performance requirements on payer infrastructure. A CDS Hooks response that takes 8 to 10 seconds is unusable in a clinical ordering workflow - providers will simply dismiss the hook or disable it. The Da Vinci CRD Implementation Guide sets a target of 5 seconds for hook responses, with compliance expected 90% of the time.

Well-optimized implementations in practice often aim for sub-2-second responses to deliver a smooth clinical experience. Achieving this requires fast access to coverage requirement data, quick provider authentication, and network infrastructure capable of handling peak-hour load without degradation.

Closing Thoughts

CMS-0057-F is, in the most literal sense, a beginning. It establishes a floor - a baseline set of technical standards and operational requirements that the market must meet. But the real transformation that this rule envisions will not be complete when the FHIR APIs are live. It will be complete when a physician in a rural primary care practice can enter an order, instantly know whether a PA is needed and what documentation to provide, submit the request in seconds, and receive a decision within hours - all without lifting the phone.

That future is technically achievable today. The standards exist. The implementation guides are mature. Early adopter payers and providers have demonstrated that it works.

What remains is the harder work of broad market adoption: EHR vendors building compliant client-side implementations, payers investing in the quality of their FHIR questionnaire content, delegated entities modernizing their technology stacks, and intermediaries building robust connectivity networks.

The prior authorization problem has been called intractable for 20 years. CMS-0057-F does not solve it by regulatory fiat, but it does, for the first time, create real, enforceable accountability for the infrastructure needed to solve it. That is not a small thing.

How Cybage can help?

CMS-0057-F sets a firm deadline, and the path to compliance requires more than technology. It demands deep FHIR expertise, a clear understanding of Da Vinci implementation guides, a thorough understanding of payer workflows, and the ability to move quickly without disrupting existing operations.

We bring both the domain knowledge and the technical depth to help you navigate this transition confidently.

Where we add value:

Compliance Readiness Assessment

Helping you assess where you stand today against CMS-0057-F requirements and defining a clear, pragmatic path forward.

FHIR Implementation Guidance

Drawing hands-on experience across multiple FHIR projects to accelerate your implementation and avoid common pitfalls.

Prior Authorization Workflow Design

Supporting your map, redesign, and optimize PA workflows to meet the new electronic exchange mandates.

Team Augmentation

Embedding compliance-aware FHIR engineers alongside your team to build capacity and deliver outcomes faster.

Whether you're assessing gaps or advancing implementation, Cybage provides the expertise to help you move forward with confidence.

Reach out to us at business@cybage.com to know more.