


PRIOR AUTHORIZATION METRICS FOR MEDICAL ITEMS AND SERVICES (EXCLUDING DRUGS)

To comply with the CMS Interoperability and Prior Authorization [final rule](#), Priority Partners is required to annually report aggregated prior authorization metrics on our website. Specifically, this includes a list of all medical items and services (excluding drugs) that require prior authorization, as well as data on prior authorization requests for those items and services (e.g., approvals, denials, etc.) over the previous calendar year. Publicly reporting these metrics promotes transparency and accountability, helps patients understand prior authorization processes, and enables providers to evaluate payer performance. In addition, metrics can be used to compare plans, programs, and payers. For questions on the data below, contact: Customer Service at 800-654-9728 (TTY: 711), Monday through Friday, 8 a.m. to 5 p.m.

Reporting Period: 2025

These are the medical items and services for which we require prior authorization (excluding drugs) 

Use [this search tool](#) to look up whether a medical item, procedure or service requires prior authorization.

Prior to January 1, 2026, impacted payers are required to send prior authorization decisions within the following timeframes:

- For MA plans and applicable integrated plans, 72 hours for **expedited requests** (urgent) and 14 calendar days for **standard requests** (non-urgent)
- For state CHIP FFS programs, 14 days for **standard requests** (non-urgent)
- For Medicaid managed care plans and CHIP managed care entities, 72 hours for **expedited requests** (urgent) and 14 calendar days for **standard requests** (non-urgent)
- For QHP issuers on the FFEs, 72 hours for **expedited requests** (urgent) and 15 days for **standard requests** (non-urgent)

There are no Medicaid FFS program required timeframes for either type of prior authorization request prior to January 1, 2026, and there are no CHIP FFS program required decision timeframes for expedited prior authorization requests prior to January 1, 2026.

Beginning January 1, 2026, the CMS Interoperability and Prior Authorization [final rule](#) requires Medicaid managed care plans to send prior authorization decisions within:

- 72 hours for **expedited requests** (urgent)
- 7 calendar days for **standard requests** (non-urgent)

Priority Partners

Standard (non-urgent) Prior Authorization Requests

	How many times this happened	Out of total requests	Percentage
Request approved	139,125	159,978	87.0%
Request denied	19,608	159,978	12.3%
Request approved only after time for review was extended	1,167	159,978	0.7%

Standard (non-urgent) Prior Authorization Requests Approved after Appeal

	How many times this happened	Out of total appeals	Percentage
Request approved only after appeal	221	2,402	9.2%

Expedited (urgent) Prior Authorization Requests (Response Due to Provider Within 72 Hours)

	How many times this happened	Out of total requests	Percentage
Request approved	3,058	3,470	88.1%
Request denied	378	3,470	10.9%
Request approved only after time for review was extended	20	3,470	0.6%

Expedited (urgent) Prior Authorization Requests Approved after Appeal

	How many times this happened	Out of total appeals	Percentage
Request approved only after appeal	7	402	1.7%

Time Between Receiving a Prior Authorization Request and Sending a Decision

	Mean (Average) Time	Median (Middle) Time
Standard (non-urgent) Prior Authorization Requests (response due to provider within 7 calendar days)	2 days	2 days
Expedited (urgent) Prior Authorization Requests (response due to provider within 72 hours)	3 days	less than 1 day