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

To comply with the CMS Interoperability and Prior Authorization final rule, AultCare's PrimeTime Health Plan 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: Utilization Management 330-363-7407, 1-800-577-7407 (Toll Free), 711 TTY.

Reporting Period: 2025

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

https://www.primetimehealthplan.com/assets/PDFs/List-of-Services-That-Require-Prior-Authorization-.pdf

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 CHIP FFS, 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 requirements regarding prior authorization decision timeframes for either type of request prior to January 1, 2026, and there are no CHIP FFS requirements regarding prior authorization decision timeframes for expedited requests prior to January 1, 2026.

Beginning January 1, 2026, the CMS Interoperability and Prior Authorization final rule requires Medicare Advantage plans to send prior authorization decisions within:

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

Standard (Non-Urgent) Prior Authorization Requests

Type of decision	How many times this happened	Out of total requests	Percentage
Request approved	812	971	84%
Request approved only after time for review was extended	0	0	NA
Request approved only after appeal	3	4	75%
Request denied	159	971	16%
Request denied after time for review was extended	0	0	NA
Request denied after appeal	1	4	25%

Expedited (Urgent) Prior Authorization Requests

(Response due to provider within 72 hours)

Type of decision	How many times this happened	Out of total requests	Percentage
Request approved	132	167	79%
Request approved only after time for review was extended	0	0	NA
Request denied	35	167	21%
Request denied after time for review was extended	0	0	NA

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 14 calendar days)	3.8 days	3.9 days
Expedited (Urgent) Prior Authorization requests (response due to provider within 72 hours)	0.6 days	0.6 days