PRESBYTERIAN
Health Plan, Inc.

P.O. Box 27489, Albuquerque, NM 87125-7489
www.phs.org

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

To comply with the Centers for Medicare & Medicaid Services (CMS) Interoperability and Prior Authorization Final Rule, Presbyterian Health Plan, Inc. (Presbyterian) 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 payor performance. In addition, metrics can be used to compare plans, programs and payors. For questions on the data below, contact (505) 923-6031.

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

Prior to Jan. 1, 2026, impacted payors are required to send prior authorization decisions within the following timeframes:

- Medicare Advantage plans and applicable integrated plans: 72 hours for **expedited requests** (urgent) and 14 calendar days for **standard requests** (non-urgent)
- State Children's Health Insurance Program (CHIP) fee-for-service (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 Qualified Health Plan (QHP) issuers on the Federally-Facilitated Exchanges (FFE): 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 Jan. 1, 2026, and there are no CHIP FFS program-required decision timeframes for expedited prior authorization requests prior to Jan. 1, 2026.

Beginning Jan. 1, 2026, the CMS Interoperability and Prior Authorization Final Rule requires Medicare Advantage plans and Medicaid managed care plans to send prior authorization decisions within:

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

Presbyterian exists to ensure all of the patients, members and communities we serve can achieve their best health.
www.phs.org

Medicare Standard (Non-Urgent) Prior Authorization Requests

Request Status	How many times this happened	Out of Total Requests	Percentage
Request approved	31,863	32,886	97%
Request denied	1,023	32,886	3%
Request approved only after time for review was extended*	0	32,886	0%
Request approved only after appeal	73	32,886	0.22%

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

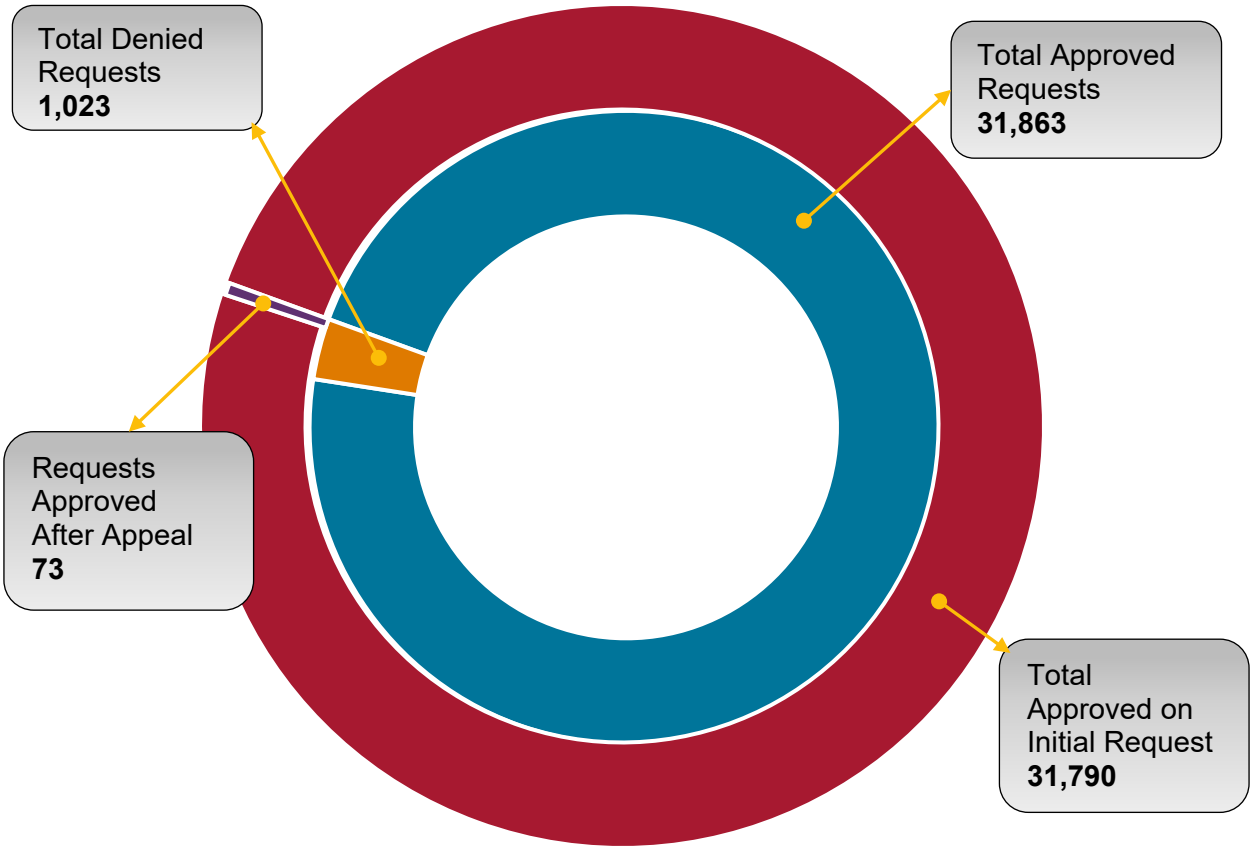
Request Status	How many times this happened	Out of Total Requests	Percentage
Request approved	3,224	3,405	95%
Request denied	181	3,405	5%
Request approved only after time for review was extended*	0	3,405	0%
Request approved only after appeal	73	32,886	0.22%

Time Between Receiving a Prior Authorization Request and Sending a Decision

Request Type	Mean (Average Time)	Median (Middle) Time
Standard (Non-Urgent) Prior Authorization Requests *(response due to provider within 7 calendar days)*	2.15 days	0.17 days
Expedited (Urgent) Prior Authorization Requests *(response due to provider within 72 hours)*	0.58 days	0.10 days

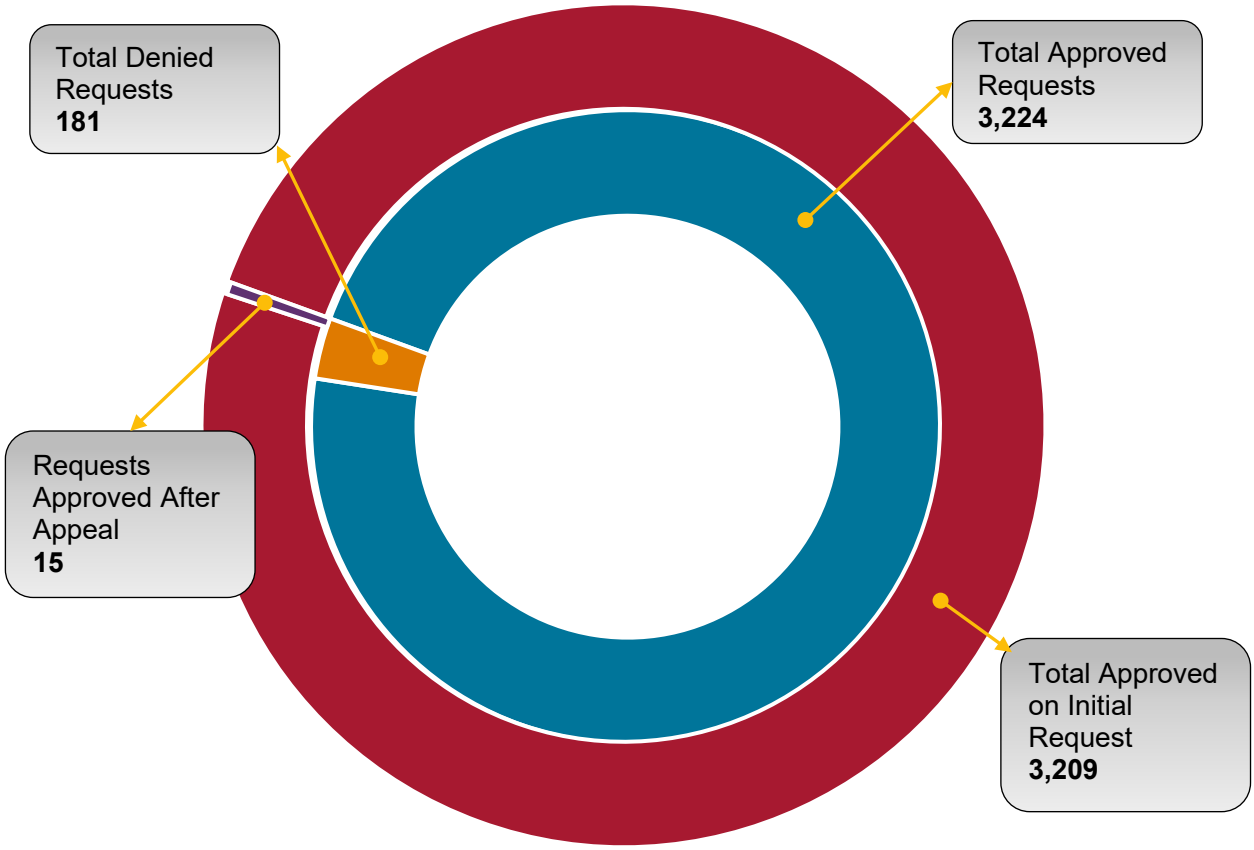
*There were no requests approved only after time for review was extended.

In 2025, we received a total of 32,886 standard (non-urgent) prior authorization requests for our covered patients.
95% of those requests were approved:



The mean (average) time that it took to make standard prior authorization decisions was:	**2.15 days**
The median (middle) time that it took to make standard prior authorization decisions was:	**0.17 days**

In 2025, we received a total of 3,405 expedited (urgent) prior authorization requests for our covered patients.
95% of those requests were approved:



The mean (average) time that it took to make expedited prior authorization decisions was:	**0.58 days**
The median (middle) time that it took to make expedited prior authorization decisions was:	**0.10 days**