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

To comply with the CMS Interoperability and Prior Authorization final rule, MyTruAdvantage 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: Member Services: 1-844-425-4280 (TTY: 711) Hours are 8:00 a.m. - 8:00 p.m., local time, 7 days a week. On Thanksgiving and Christmas Day, and weekends and holidays from April 1 through September 30 alternate technologies (for example, voicemail) will be used and we will return your call within one (1) business day.

Reporting Period: 1/1/2025 through 12/31/2025

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

https://www.mytruadvantage.com/Prior-Authorization-List-2026

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 Medicare Advantage to send prior authorization decisions within:

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

In 2025, we received a total of 2,282 of standard (non-urgent) prior authorization requests for MyTruAdvantage H9042 (PPO) covered patients. 94.44% of those requests were approved:

Standard (non-urgent) Prior Authorization Requests

	How many times this happened	Out of total requests	Percentage
Request approved	2,282	2,660	94.44%
Request denied	109	128	4.56%

	How many times this happened	Out of total requests	Percentage
Request approved with 7 days	1,278	1,645	53.45%
Request denied within 7 days	55	74	2.30%

	How many times this happened	Out of total requests	Percentage
Request approved only after time for review was extended*	1,004	1,050	88.96%
Request denied after time for review was extended	54	54	2.26%

	How many times this happened	Out of total appeals	Percentage
Request approved only after appeal	145	153	88.96%
Request denied after appeal	18	18	11.04%

In 2025, we received a total of 378 expedited (urgent) prior authorization requests for MyTruAdvantage H9042 (PPO) covered patients. 95.21% of those requests were approved:

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

	How many times this happened	Out of total requests	Percentage
Request approved	378	2,660	95.21%
Request denied	19	128	4.79%

	How many times this happened	Out of total requests	Percentage
Request approved with 72 hours	367	1,645	92.44%
Request denied within 72 hours	19	74	4.79%

	How many times this happened	Out of total requests	Percentage
Request approved only after time for review was extended*	11	1,015	2.77%
Request denied after time for review was extended	0	54	0%

	How many times this happened	Out of total appeals	Percentage
Request approved only after appeal	8	153	100%
Request denied after appeal	0	18	0%

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)	7.22 days	7.07 days
Expedited (urgent) Prior Authorization Requests (response due to provider within 72 hours)	6.35 days	5.96 days

In 2025, we received a total of 865 standard (non-urgent) prior authorization requests for MyTruAdvantage H6529 (HMO) covered patients. 93.11% of those requests were approved:

Standard (non-urgent) Prior Authorization Requests

	How many times this happened	Out of total requests	Percentage
Request approved	865	1,026	93.11%
Request denied	67	71	7.21%

	How many times this happened	Out of total requests	Percentage
Request approved with 7 days	499	658	53.71%
Request denied within 7 days	27	31	2.91%

	How many times this happened	Out of total requests	Percentage
Request approved only after time for review was extended*	366	368	39.40%
Request denied after time for review was extended	40	40	4.31%

	How many times this happened	Out of total appeals	Percentage
Request approved only after appeal	66	68	82.50%
Request denied after appeal	14	15	17.50%

In 2025, we received a total of 161 expedited (urgent) prior authorization requests for MyTruAdvantage H6529 (HMO) covered patients. 97.58% of those requests were approved:

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

	How many times this happened	Out of total requests	Percentage
Request approved	161	1,026	97.58%
Request denied	4	71	2.42%

	How many times this happened	Out of total requests	Percentage
Request approved with 72 hours	159	658	96.36%
Request denied within 72 hours	4	31	2.42%

	How many times this happened	Out of total requests	Percentage
Request approved only after time for review was extended*	2	368	1.21%
Request denied after time for review was extended	0	40	0.00%

	How many times this happened	Out of total appeals	Percentage
Request approved only after appeal	2	68	66.67%
Request denied after appeal	1	15	33.33%

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)	7.14 days	6.96 days
Expedited (urgent) Prior Authorization Requests (response due to provider within 72 hours)	0.935 days	0.3 days

MyTruAdvantage has HMO and PPO plans with a Medicare contract. Enrollment in MyTruAdvantage depends on contract renewal. MyTruAdvantage complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1.844.425.4280 (TTY: 711). 注意：如果您使用繁體中文，您可以免費獲得語 言援助服務。請致電 1.844.425.4280 (TTY: 711) Y0150_PARPT_MM0093_C