



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

To comply with the Centers for Medicare & Medicaid (CMS) Interoperability and Prior Authorization [final rule](#), Texas Independence 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: Texas Independence Health Plan at 833-471-8447 (TTY 833-414-8447)

Reporting Period: 2025

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

- Inpatient Hospital Stay
- Inpatient Psychiatric Hospital
- Inpatient Rehabilitation
- Long-Term Acute Care (LTAC)
- In office procedures and testing
- MRI
- PET Scan
- SPECT
- Labs >\$500
- DME, Prosthetics, Orthotics, or Diabetic Supplies >\$500
- Opioid Treatment Services
- Outpatient Substance Abuse Treatment (Individual and Group)
- Home Health
- Non-Emergent Ambulance Transport
- Outpatient surgeries and procedures
- Wound Care



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)

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

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



Standard (non-urgent) Prior Authorization Requests

	How many times this happened	Out of total requests	Percentage
Request approved	6,589	6,746	98%
Request denied	157	6,746	2%

	How many times this happened	Out of total requests	Percentage
Request approved only after time for review was extended	N/A	N/A	N/A
Request denied after time for review was extended	N/A	N/A	N/A

	How many times this happened	Out of total appeals	Percentage
Request approved only after appeal	0	2	0%
Request denied after appeal	2	2	100%

Expedited (urgent) Prior Authorization Requests

(Response Due to Provider Within 72 Hours)

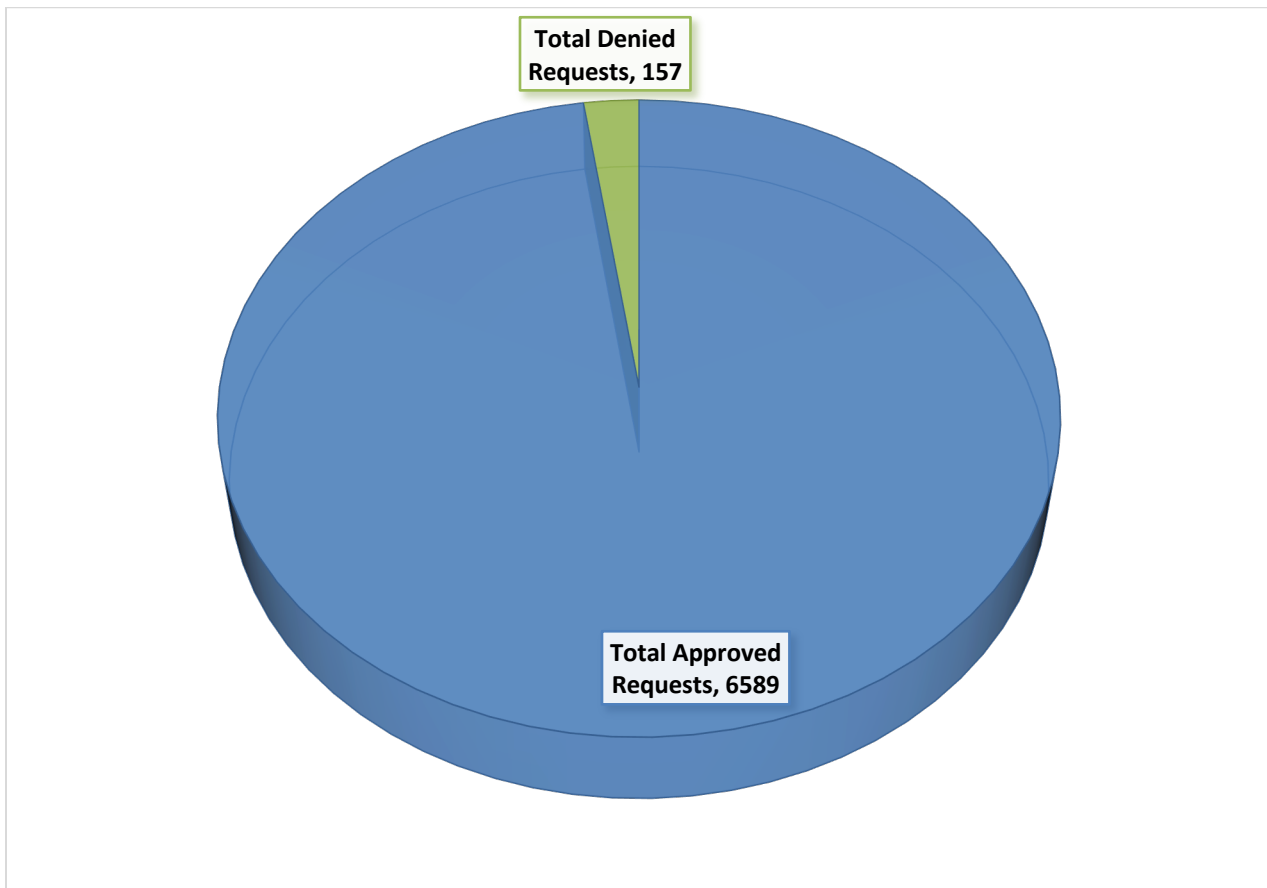
	How many times this happened	Out of total requests	Percentage
Request approved	211	214	99%
Request denied	3	214	1%

	How many times this happened	Out of total requests	Percentage
Request approved only after time for review was extended	N/A	N/A	N/A
Request denied after time for review was extended	N/A	N/A	N/A

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)	0.9 days	0.8 hours
Expedited (urgent) Prior Authorization Requests (response due to provider within 72 hours)	12 hours	1.78 hours

In 2025, we received a total of 6,746 standard (non-urgent) prior authorization requests for our covered patients.
98% of those requests were approved:



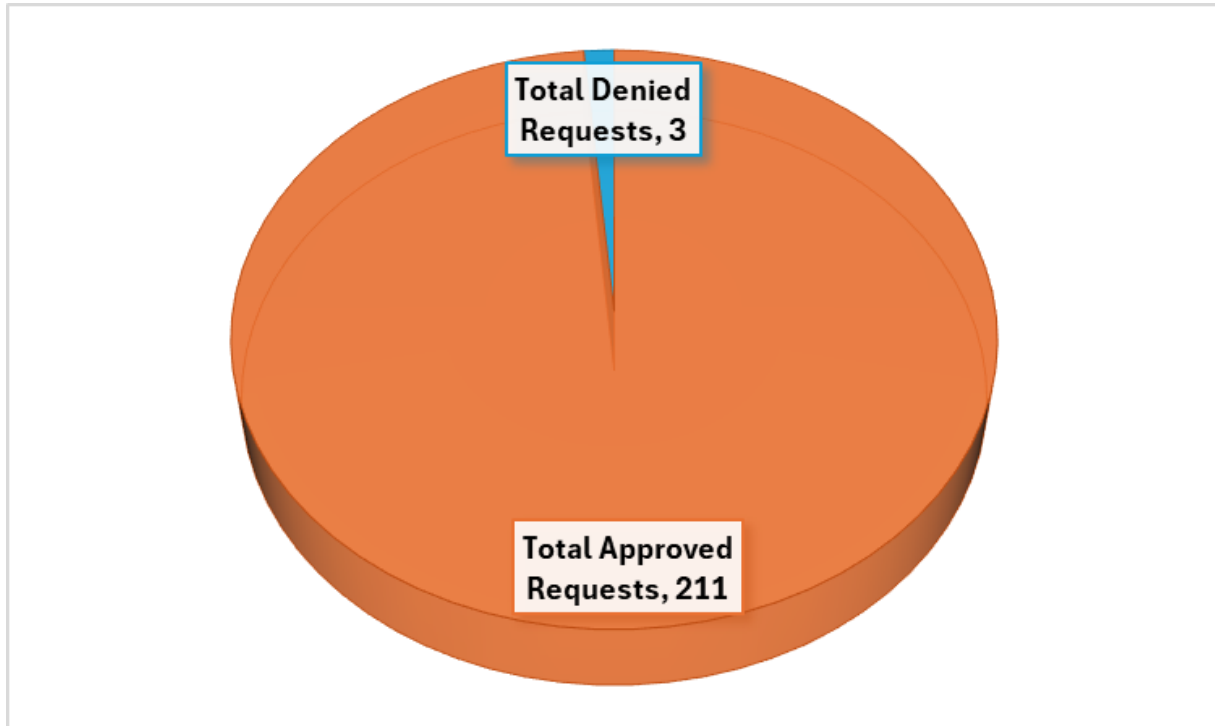
The mean (average) time that it took to make standard prior authorization decisions was

0.9 days

The median (middle) time that it took to make standard prior authorization decisions was

0.8 hours

In 2025, we received a total of 214 expedited (urgent) prior authorization requests for our covered patients. 99% of those requests were approved:



The mean (average) time that it took to make expedited prior authorization decisions was

12 hours

The median (middle) time that it took to make expedited prior authorization decisions was

1.78 hours