



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

To comply with the CMS Interoperability and Prior Authorization final rule, Troy Medicare 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:

Troy Medicare Customer Service toll-free at 888-494-TROY (8769) TTY: 711
Representatives are available 8am to 8pm Eastern Time
October 1 to March 31, 7 days a week
April 1 to September 30, Monday to Friday

Reporting Period: 2025

These are the medical items and services for which we require prior authorization (excluding drugs): www.troymedicare.com/for-providers/prior-authorization-code-search

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	775	918	84%
Request denied	140	918	15%
Approved after appeal	6	12	50%
Percentage of prior authorization requests for which the timeframe for review was extended	0	918	0%

*Includes requests withdrawn and/or dismissed

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

	How many times this happened	Out of total requests*	Percentage
Request approved	180	218	83%
Request denied	38	218	17%
Approved after appeal	10	25	40%
Percentage of prior authorization requests for which the timeframe for review was extended	0	218	0%

*Includes requests withdrawn and/or dismissed

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)	2.4 days	1.7 days
Expedited (urgent) Prior Authorization Requests (response due to provider within 72 hours)	1.6 days	<1 day