Prior Authorization Metrics for Medical Items and Services (Excluding Drugs)

West Virginia CHIP

2025

To comply with CMS Interoperability and Prior Authorization Final Rule, The 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. Public reporting of 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: The Health Plan's Clinical Services Department at 800.624.6961, extension 6980.

Reporting Year: 2025

These are the medical items and services for which we require prior authorization (excluding drugs): https://www.healthplan.org/for-you-and-family/forms-prior-auth-list-notices

Prior to January 1, 2026, impacted payers were required to send prior authorization decisions within the following timeframes:

- For Medicare Advantage plans, 72 hours for **expedited requests** (urgent) and 14 calendar days for **standard requests** (non-urgent).

Beginning on January 1, 2026, the CMS Interoperability and Prior Authorization Final Rule require Medicare Advantage plans, state Medicaid agencies, Medicaid managed care plans, state CHIP agencies, CHIP managed care entities) to send prior authorization decisions within:

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

For Medicaid and CHIP plans, The Health Plan follows Prior Authorization decision timeframes as outlined in the contract with the West Virginia Bureau of Medical Services. These requirements are more stringent than the federal regulations. The Health Plan follows the following timeframes:

- For Medicaid and CHIP plans, 48 hours or 2 business days for **expedited requests** (urgent) and 5 business 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**
Requests approved	1332	1550	86%
Requests approved after the time for review was extended	2	4	50%
Requests approved after appeal	1	1	100%
Requests denied	218	1550	14%
Requests denied after the time for review was extended	2	4	50%
Requests denied after appeal	0	1	0%

Expedited (urgent) Prior Authorization Requests			
Type of decision	**How many times this happened**	**Out of total requests**	**Percentage**
Requests approved	10	10	100%
Requests approved after the time for review was extended	0	0	-
Requests approved after appeal	0	0	-
Requests denied	0	10	0%
Requests denied after the time for review was extended	0	0	-
Requests denied after appeal	0	0	-

Time Between Receiving a Prior Authorization Request and Sending a Decision		
Medicaid - Time Between Receiving a Prior Authorization Request and Sending a Decision		
	Mean (Average) Time	Median (Middle) Time
Standard (non-urgent) prior authorization requests (decision within 5 business days)	1 day	0 days
Expedited (urgent) prior authorization requests (2 business days)	1 day	0 day