

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

To comply with the CMS Interoperability and Prior Authorization [final rule](#), Health Alliance Plan of Michigan 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: Customer Service Team at (800) 801-1770 (TTY: 711). We're available during the following times: April 1 through Sept. 30: Monday - Friday, 8 a.m. to 8 p.m; Oct. 1 through March 31: seven days a week, 8 a.m. to 8 p.m.

Reporting Period: 2025

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



https://portal.hap.org/providers/docs/lists/Prior_Authorization_List_Summary.approval.11012025.pdf

https://portal.hap.org/providers/docs/lists/CBHM_Auth_List_05-01-25.pdf

https://portal.hap.org/providers/docs/lists/DME_services_that_require_prior_auth_03-01-2026.pdf

https://portal.hap.org/providers/docs/lists/Services_that_require_prior_auth_List_03-01-2026.pdf

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)

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	70,192	80,982	87%
Request denied	10,790	80,982	13%

	How many times this happened	Out of total requests	Percentage
Request approved within 7 days*	65,678	80,982	91%
Request denied within 7 days*	6,858	80,982	9%

CY2025 Data: CMS allowed MA plans 14 days to complete decisions on standard authorization requests

	How many times this happened	Out of total requests	Percentage
Request approved after time for review was extended*	0	80,982	0%
Request denied after time for review was extended	0	80,982	0%

	How many times this happened	Out of total appeals	Percentage
Request approved after appeal	1,895	2318	82%
Request denied after appeal	423	2318	18%

Expedited (urgent) Prior Authorization Requests

(Response Due to Provider Within 72 Hours)

	How many times this happened	Out of total requests	Percentage
Request approved	1,902	2,161	88%
Request denied	259	2,161	12%

	How many times this happened	Out of total requests	Percentage
Request approved within 72 hours	1,899	2,161	88%
Request denied within 72 hours	256	2,161	12%

	How many times this happened	Out of total requests	Percentage
Request approved after time for review was extended*	0	2,161	0%
Request denied after time for review was extended	0	2,161	0%

*As noted on the first page of this template, it is **optional** to report this metric separately for standard prior authorizations and expedited prior authorizations.

	How many times this happened	Out of total appeals	Percentage
Request approved after appeal	64	70	91%
Request denied after appeal	6	70	9%

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)	1.8 days	0 days
Expedited (urgent) Prior Authorization Requests (response due to provider within 72 hours)	0.2 day	0 days

Health Alliance Plan (HAP) has HMO, HMO C-SNP, HMO-POS, PPO plans with Medicare contracts. HAP Medicare Complete Duals (HMO D-SNP) and HAP Medicare Complete Assist (PPO D-SNP) are Medicare health plans with a Medicare contract and a contract with the Michigan Medicaid Program. Enrollment depends on contract renewals.

Y0076_ALL Prior Auth Med Item Serv HAP_C