Massachusetts Division of Insurance

Examination Report:

Massachusetts Health Insurance Prior Authorization Practices

January 14, 2026

Examination Years: 2023 and 2024

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I. EXECUTIVE SUMMARY

Approximately 1.3 million people are enrolled in Massachusetts-issued insured health plans subject to state managed care laws and regulations. The use of prior authorization (also called prospective review)[1] has been noted by Massachusetts health insurance carriers, providers, consumer advocates, health economists and others as an important consideration for further examination. Prior authorization processes have been cited as a source of clinical burden and continuing member-patient confusion. They also can vary widely across the market. Conversely, insurers have stated that prior authorization processes, responsibly managed, can be important tools to ensure that services are appropriate to treat a covered person's health condition.

When these processes are implemented responsibly, member-patients can access safe, clinically appropriate, evidence-based care, with appropriate limits on unsafe or low-value care inconsistent with clinical evidence. When these processes are not implemented responsibly, prior authorization can increase consumer confusion, delay needed care and/or add administrative burdens to an already overwhelmed health care delivery system. Citing the need for responsible management of prior authorization, some Massachusetts health insurance carriers have in fact announced in recent years that they have retired or eased prior authorization processes to address member-patients' access to care and reduce clinical burdens for specific services where the value is no longer supported.

Massachusetts has never examined in detail the use of prior authorization in the Commonwealth. In light of the importance of the topic, on January 23, 2025, Insurance Commissioner Michael Caljouw launched an examination of carrier practices concerning the use of prior authorization in the Commonwealth. See Examination Letter (redacted) attached as Appendix "A". The Division of Insurance (Division) subsequently provided detailed examination instructions for compliance, reviewed and analyzed the corresponding data submissions.

The following report examines prior authorization data submitted by the fourteen reporting carriers who offered fully insured health products in Massachusetts in 2023 and 2024. Consistent with the Division's authority, this report does not contain information about prior authorization processes used in plans offered under Medicare, Medicaid, self-insured plans, or those covered under fully insured health plans issued in another state.

A. Prior Authorization Requests

According to the data received from the reporting carriers, in 2023, carriers received a total of 1.39 million prior authorization requests and approved over 1.21 million (86.9%). In 2024, 1.58 million prior authorization requests were received and over 1.36 million (86.2%) were approved. Overall, the total number of prior authorization requests increased by 13.3% from 2023 to 2024.

1 The phrases "prior authorization" or "prospective review" are often used interchangeably. The instant report uses "prior authorization" since it is the most commonly used phrase.

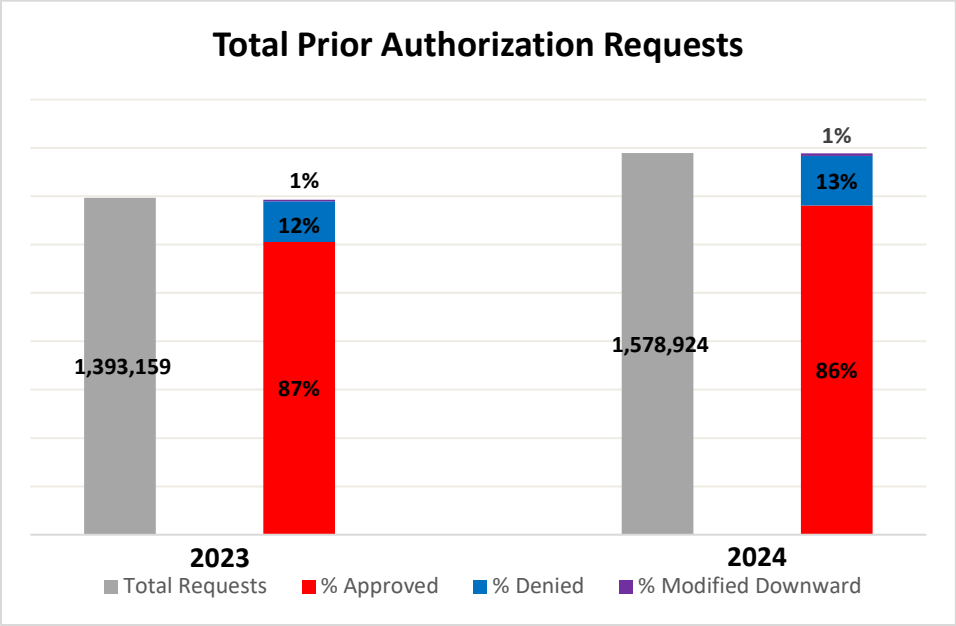

Exhibit 1

Prior Authorization requests also differed by health care categories during 2023 and 2024:

- The largest number of requests were for radiology and pathology/lab tests, with a combined 566,833 requests in 2023 (40.6% of the total) and 621,416 requests in 2024 (39.4% of the total).

- Requests for generic, brand-name, and specialty drugs increased the most between 2023 and 2024, with a combined 240,127 requests in 2023 and 376,423 requests in 2024, which is an increase of 136,296 requests or 56.8% between 2023 and 2024.

- Total requests for inpatient stays represented fewer than 2% of the total requests in both years, and outpatient med/surg and BH office visits represented a little more than 5% of total requests.

	2023 Prior Auth Requests	2024 Prior Auth Requests	Change from 2023-2024
Inpatient non-Behavioral Health	21,860	22,537	677
Inpatient Behavioral Health	5,972	106	(5,866)
Outpatient Med/Surg Off Visit	36,572	45,180	8,608
Outpatient Behavioral Health Off Visi	36,683	39,660	2,977
Outpatient Amb Surgery	45,649	61,965	16,316
Outpatient Radiology	469,284	509,467	40,183
Outpatient PT/OT/ST	39,279	35,582	(3,697)
Outpatient Home Health	17,095	10,926	(6,169)
Outpatient Path/Lab	97,549	111,949	14,400
Outpatient DME/Prosthetics	245,395	225,574	(19,821)
Outpatient Ancillary/Other	89,658	88,214	(1,444)
Drugs in the Medical Benefit	48,036	51,341	3,305
Generic Drugs	44,488	59,678	15,190
Brand Name Drugs	151,540	263,625	112,085
Specialty Drugs	44,099	53,120	9,021
	1,393,159	**1,578,924**	**185,765**

Exhibit 2

Prior authorization approval rates also differed by health care category during 2023 and 2024:

- The prior authorization approval rate was 89.0% and 89.6% in 2023 and 2024 respectively; the approval rate for pathology/labs was 71.2% and 64.6% in 2023 and 2024 respectively.
- The approval rates for inpatient services were between 94.7% and 98.6% in 2023 and between 93.7% and 98.1% in 2024.
- The approval rates for outpatient office visits were between 82.6% and 96.0% in 2023 and between 81.1% and 94.8% in 2024.
- The approval rates for PT/OT/ST, home health and DME were between 95.2% and 98.6% in 2023 and between 91.7% and 98.1% in 2024.
- The approval rates for generic, brand-name and specialty drugs were between 72.8% and 88.5% in 2023 and between 78.0% and 94.2% in 2024.

	2023 Prior Auth Requests	% Approved
2023 Inpatient non-Behavioral Health	21,860	94.7%
2023 Inpatient Behavioral Health	5,972	98.6%
2023 Outpatient Med/Surg Off Visit	36,572	82.6%
2023 Outpatient Behavioral Health Off Visit	36,683	96.0%
2023 Outpatient Amb Surgery	45,649	92.3%
2023 Outpatient Radiology	469,284	89.0%
2023 Outpatient PT/OT/ST	39,279	98.6%
2023 Outpatient Home Health	17,095	97.3%
2023 Outpatient Path/Lab	97,549	71.2%
2023 Outpatient DME/Prosthetics	245,395	95.2%
2023 Outpatient Ancillary/Other	89,658	85.5%
2023 Drugs in the Medical Benefit	48,036	95.8%
2023 Generic Drugs	44,488	78.6%
2023 Brand Name Drugs	151,540	72.8%
2023 Specialty Drugs	44,099	88.5%

Exhibit 3A

	2024 Prior Auth Requests	% Approved
2024 Inpatient non-Behavioral Health	22,537	93.7%
2024 Inpatient Behavioral Health	106	98.1%
2024 Outpatient Med/Surg Off Visit	45,180	81.1%
2024 Outpatient Behavioral Health Off Visit	39,660	94.8%
2024 Outpatient Amb Surgery	61,965	91.9%
2024 Outpatient Radiology	509,467	89.6%
2024 Outpatient PT/OT/ST	35,582	98.1%
2024 Outpatient Home Health	10,926	91.7%
2024 Outpatient Path/Lab	111,949	64.6%
2024 Outpatient DME/Prosthetics	225,574	95.7%
2024 Outpatient Ancillary/Other	88,214	85.4%
2024 Drugs in the Medical Benefit	51,341	94.2%
2024 Generic Drugs	59,678	78.0%
2024 Brand Name Drugs	263,625	80.0%
2024 Specialty Drugs	53,120	91.3%

Exhibit 3B

B. Service Codes and Prior Authorization Review

Across the market, carriers apply prior authorization requirements to specific service codes. As examples of the differing approaches adopted by Massachusetts carriers, in 2023, one carrier required prior authorization for 2,438 distinct service/supply codes. Conversely, another carrier applied prior authorization to 11,798 distinct service/supply codes. During 2024, across the market the total number of codes subject to prior authorization remained relatively stable to the total number of codes subject to prior authorization in 2023.

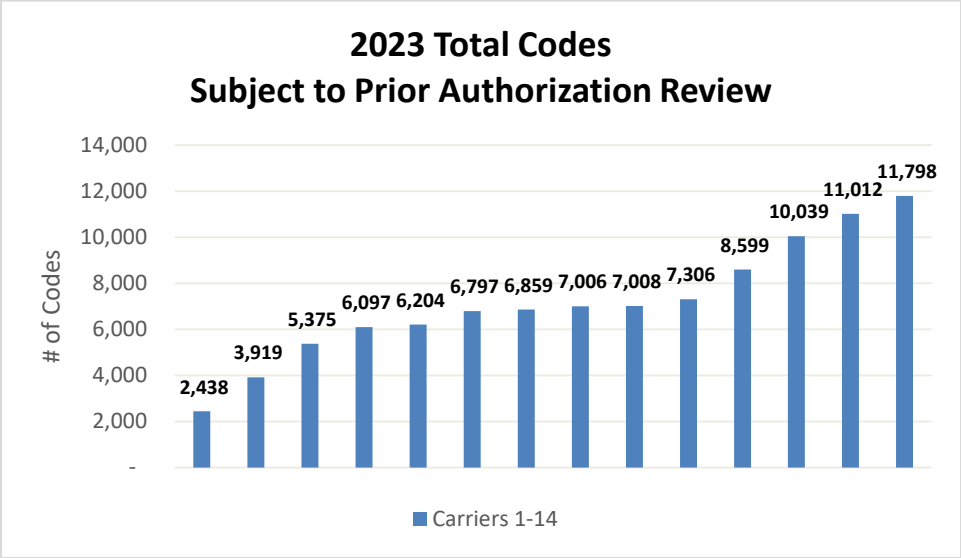

Exhibit 4A

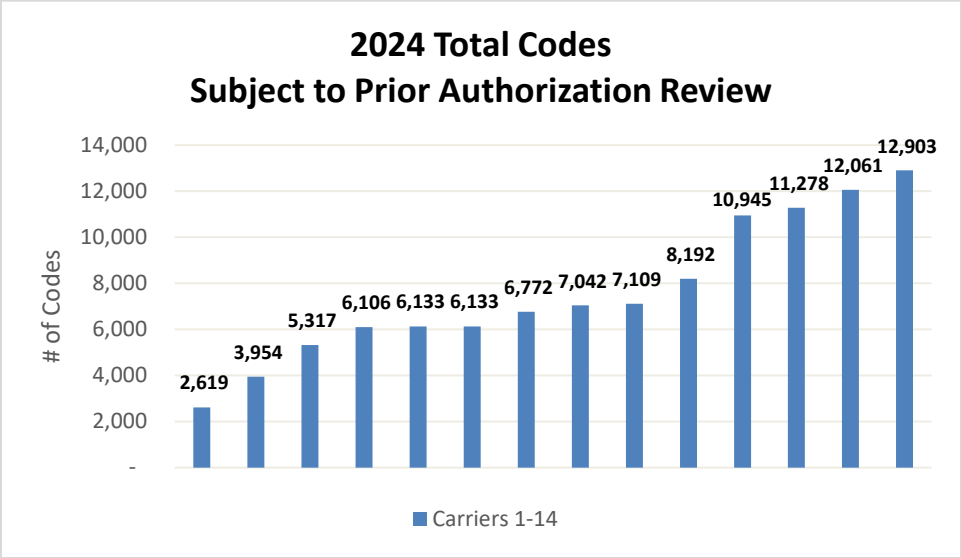

Exhibit 4B

C. Service Codes Retired from Prior Authorization

- Carriers periodically review service codes that are subject to prior authorization and retire those which are no longer needed pursuant to the judgment of the carrier.

- Carriers collectively retired 2,208 utilization codes in 2023 and 1,820 utilization codes in 2024 from being subject to prior authorization. In the carrier's data responses, they indicated an intent to eliminate 255 additional utilization codes in 2025.

UNIQUE CODES/SERVICES CURRENTLY SUBJECT TO PROSPECTIVE REVIEW THAT VOLUNTARILY RETIRED:

2023	2024	2025
2,208	1,820	266

Exhibit 5

D. Service Codes Without Utilization or With Approval Rates Over 90%

- There were instances in 2023 and 2024 where there was no utilization of services for specific codes subject to prior authorization.

- In some instances, carriers approved over 90% of requested services where prior authorization was applied for specific codes (either through an initial review or through internal appeal).

	Total Codes w/Requests	Total Codes w/o Utilization	Total Codes w/ >90% Approved	Prop Codes w/ >90% approved
2023 Inpatient non-Behavioral Health	650	428	161	24.8%
2023 Outpatient Behavioral Health Off Visit	27	7	18	66.7%
2023 Outpatient Radiology	176	8	64	36.4%
2023 Outpatient PT/OT/ST	4	0	4	100.0%
2023 Outpatient Home Health	7	0	7	100.0%
2023 Outpatient Pathology/Lab	442	4	52	11.8%
2023 Outpatient DME/Prosthetics	74	57	15	20.3%
2023 Outpatient Ancillary/Other	75	11	19	25.3%
2023 Drugs in the Medical Benefit	717	23	664	92.6%
2023 Generic Drugs	590	0	454	76.9%
2023 Brand Name Drugs	509	0	286	56.2%
2023 Specialty Drugs	627	0	459	73.2%

Exhibit 6A

- For one carrier as identified in Exhibit 6B, a significant number of codes were identified for 2023 as scheduled to be subject to prior authorization where there was no utilization of the specified service or where most of the requests were approved:
  - 538 of 3,898 (13.7%) utilization codes had no utilization requests during 2023.
  - 2,203 of 3,898 (56.5%) utilization codes were approved over 90% of the time in 2023.

	Total Codes w/Requests	Total Codes w/o Utilization	Total Codes w/ >90% Approved	Prop Codes w/ >90% approved
2024 Inpatient non-Behavioral Health	649	429	148	22.8%
2024 Outpatient Behavioral Health Off Visit	27	7	21	77.8%
2024 Outpatient Radiology	176	6	76	43.2%
2024 Outpatient PT/OT/ST	4	0	3	75.0%
2024 Outpatient Home Health	0	0	0	N/A
2024 Outpatient Pathology/Lab	442	4	37	8.4%
2024 Outpatient DME/Prosthetics	75	89	16	21.3%
2024 Outpatient Ancillary/Other	76	55	40	52.6%
2024 Drugs in the Medical Benefit	356	30	308	86.5%
2024 Generic Drugs	459	0	374	81.5%
2024 Brand Name Drugs	547	0	286	52.3%
2024 Specialty Drugs	768	0	555	72.3%

Exhibit 6B

- For one carrier as identified in Exhibit 6A, a significant number of codes were identified for 2023 as scheduled to be subject to prior authorization where there was no utilization of the specified service or where most of the requests were approved:
  - 630 of 3,579 (11.7%) utilization codes had no utilization requests during 2024.
  - 1,864 of 3,579 (52.1%) utilization codes were approved over 90% of the time in 2024.

The examination data demonstrates that there are substantial differences in how and when carriers require prior authorization across the market. There is ample opportunity for the streamlining and standardization of prior authorization. It is important that this be achieved in a balanced manner and the complete elimination of prior authorization would not be beneficial to health care patients. Patients and the health care ecosystem would benefit from greater efficiencies, and carriers should employ prior authorization only in instances where it promotes high-quality, cost-effective care while restricting potential fraud, waste, or abuse.

II. OVERVIEW

There were approximately 1.3 million Massachusetts persons covered under Massachusetts-issued health plans at the end of 2024.[2] Massachusetts residents may be covered under government programs (e.g., Medicare and Medicaid), plans issued in other states (e.g. covering persons whose work offers health insurance through another state even though they live in Massachusetts), and self-funded employment-based plans (preempted from state insurance regulation). Although similar prior authorization processes may exist those covered under these other plans, Massachusetts insurance law has limited application to them.

In Massachusetts, carriers offer insured health plans that arrange for the delivery of covered health care through a network of contracted providers or employ utilization review processes to determine the medical necessity of a requested service or treatment. As noted in M.G.L. c. 176O, section 1, utilization review is defined as "a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include, but are not limited to, ambulatory review, prospective review [prior authorization], second opinion, certification, concurrent review, case management, discharge planning or retrospective review." According to M.G.L. c. 176O, section 2, carriers employing utilization review are required to be accredited on a biennial basis by the Bureau of Managed Care (Bureau) within the Division. Carriers applying for managed care accreditation are required to submit materials that document how the carrier, or any carrier-subcontracted utilization review organization, satisfies certain standards established by the Bureau of Managed Care within 211 CMR 52.00 ("Managed Care Consumer Protections and Accreditation of Carriers"). These standards are designed to enable Carriers to arrange for the delivery of covered health care through a network of contracted providers and employ utilization review processes to determine the medical necessity of a requested service. As part of these processes, carriers have generally implemented prior authorization (also called "prospective review") processes – the focus of the present examination - to evaluate whether certain covered services are medically necessary and appropriate to treat a particular patient.

Carriers must comply with utilization standards identified in 211 CMR 52.07, including the following:

2 As of December 31,2024, there were 1,269,792 persons enrolled in non-government Massachusetts-issued insured health coverage. Among closed network HMO plans, there were 906,629 insured plan members (525,031 in employer group coverage and 381,598 in individual coverage). Among insured preferred provider plans (insurance carriers/HMOs), there were 363,163 members.

(2) Written Plan. Utilization Review conducted by a Carrier or a Utilization Review Organization shall be conducted pursuant to a written plan, under the supervision of a physician and staffed by appropriately trained and qualified personnel, and shall include a documented process to:

(a) review and evaluate its effectiveness;

(b) ensure the consistent application of Utilization Review criteria; and

(c) ensure the timeliness of Utilization Review determinations.

(3) Criteria. A Carrier or Utilization Review Organization shall adopt Utilization Review criteria and conduct all Utilization Review activities pursuant to said criteria.

(a) The criteria shall be, to the maximum extent feasible, scientifically derived and evidence-based, and developed with the input of Participating Providers, consistent with the development of Medical Necessity criteria consistent with 958 CMR 3.101: Carrier's Medical Necessity Guidelines.

(b) Utilization Review criteria shall be up to date and applied consistently by a Carrier or the Utilization Review Organization and made easily accessible to subscribers, Health Care Providers and the general public on a Carrier's website; or, in the alternative, on the Carrier's Utilization Review Organization's website so long as the Carrier provides a link on its website to the Utilization Review Organization's website; provided, however, that a Carrier shall not be required to disclose licensed, proprietary criteria purchased by a Carrier or Utilization Review Organization on its website, but must disclose such criteria to a Provider or subscriber upon request.

(c) Any new or amended preauthorization requirement or restriction shall not be implemented unless the Carrier's and/or Utilization Review Organization's respective website has been updated to clearly reflect the new or amended requirement or restriction.

(d) Adverse Determinations rendered by a program of Utilization Review, or other denials of requests for Health Services, shall be made by a person licensed in the appropriate Specialty related to such Health Services and, where applicable, by a Provider in the same licensure category as the ordering Provider.

In addition to the above, when a carrier makes an:

(4) Initial Determination Regarding a Proposed Admission, Procedure or Service.

(a) When requiring prospective review for a Health Care Service or Benefit, a Carrier shall use and accept, or a Carrier shall require and ensure that its Utilization Review Organization use and accept, only the prospective review forms designated by the Commissioner for the specific types of Health Care Services and Benefits identified in the designated forms.

(b) If the Carrier fails to use or accept the designated prospective review form, or fails to respond within two business days after receiving a completed prospective review request from a Provider, pursuant to the submission of the prospective review form under 211 CMR 52.07(4)(a), the prospective review request shall be deemed to have been granted. (c) In addition to any other requirements under applicable law, a Carrier shall make, or a Carrier shall require and ensure that its Utilization Review Organization makes, an initial determination regarding a proposed admission, procedure or service that requires such a determination within two working days of obtaining all necessary information. For purposes of 211 CMR 52.07, "necessary information" shall include the results of any face-to-face clinical evaluation or Second Opinion that may be required.

(d) In the case of a determination to approve an admission, procedure or service, the Carrier or Utilization Review Organization shall notify the Provider rendering the service by telephone within 24 hours, and shall send written or electronic confirmation of the telephone notification to the Insured and the Provider within two working days thereafter.
(e) In the case of an Adverse Determination, the Carrier or the Utilization Review Organization shall notify the Provider rendering the service by telephone within 24 hours, and shall send written or electronic confirmation of the telephone notification to the Insured and the Provider within one working day thereafter.
(f) Any new or amended Prospective Review requirement or restriction shall not be effective, unless and until the Carrier's or Utilization Review Organization's website has been updated to reflect the new or amended requirement or restriction.
(g) Subject to 211 CMR 52.07(4)(a) through (f), nothing in 211 CMR 52.07(4) shall: 1. require a treating Health Care Provider to obtain information regarding whether a proposed admission, procedure or service is Medically Necessary on behalf of an Insured; 2. restrict the ability of a Carrier or Utilization Review Organization to deny a claim for an admission, procedure or service if the admission, procedure or service was not Medically Necessary, based on information provided at the time of claim; or 3. shall restrict the ability of a Carrier or Utilization Review Organization to deny a claim for an admission, procedure or service if other terms and conditions of coverage are not met at the time of service or time of claim.

When considering a request for a service, carriers are expected to notify insured individuals about the carrier's decision promptly, in accordance with 211 CMR 52.07(6):

(6) Written Notice. The written notification of an Adverse Determination shall include a substantive clinical justification that is consistent with generally accepted principles of professional medical practice, and shall, at a minimum:
(a) include information about the claim including, if applicable, the date(s) of service, the Health Care Provider(s), the claim amount, and any diagnosis, treatment, and denial code(s) and their corresponding meaning(s);
(b) identify the specific information upon which the Adverse Determination was based shall explain the reason for any denial, including the specific Utilization Review criteria or Benefits provisions used in the determination, and;
(c) discuss the Insured's presenting symptoms or condition, diagnosis and treatment interventions;
(d) explain in a reasonable level of detail the specific reasons such medical evidence fails to meet the relevant medical review criteria;
(e) reference and include, or provide a website link(s) to the specifically applicable, clinical practice guidelines, medical review criteria, or other clinical basis for the Adverse Determination;
(f) a description of any additional material or information necessary for the Insured to perfect the claim and an explanation of why such material or information is necessary;
(g) if the Carrier specifies alternative treatment options which are Covered Benefits, include identification of Providers who are currently accepting new patients;
(h) prominently explain all appeal rights applicable to the denial, including a clear, concise and complete description of the Carrier's formal internal Grievance process and the procedures for obtaining external review pursuant to 958 CMR 3.000: Health Insurance

Consumer Protection, and a clear, prominent description of the process for seeking expedited internal review and concurrent expedited internal and external reviews, including applicable timelines, pursuant to 958 CMR 3.000; and a clear and prominent notice of a patient's right to file a Grievance with the with the Office of Patient Protection; and information on how to file a Grievance with the Office of Patient Protection.

(i) prominently notify the Insured of the availability of, and contact information for, the consumer assistance toll-free number maintained by the Office of Patient Protection, and if applicable, the Massachusetts consumer assistance program; and (j) include a statement, prominently displayed on all product/plan materials in at least the languages identified by the Centers for Medicare & Medicaid Services as the top non-English languages in Massachusetts, that clearly indicates how the Insured can request oral interpretation and written translation services from the Carrier consistent with 958 CMR 3.000: Health Insurance Consumer Protection.

In the event of a denial or adverse determination, an individual or that individual's health care provider may seek a reconsideration in accordance with 211 CMR 52.07(7), or an internal and external appeal as set forth within 958 CMR 3.000 and M.G.L. c. 176O, section 13.

III. Prior Authorization Processes and the Massachusetts Landscape

As noted within the definition of "utilization review" within M.G.L. c. 176O, section 1, carriers may employ prior authorization processes (commonly referred to as "prospective review") to examine the medical necessity of an inpatient stay, procedure, device, prescription drug, or course of treatment. In section 1 of M.G.L. c. 176O, "prospective review" is defined as "Utilization Review conducted prior to an admission or a course of treatment."

Carriers either employ Utilization Review Organizations or their own administrative processes to establish prior authorization/prospective review procedures that they apply to covered services. Carriers are expected to make their requirements clear to all insured individual members and the contracting providers in their networks. These members and providers should receive information explaining which procedures, treatments, or supplies require approval to be covered by the health plan. One of the reasons that a provider's claim may be denied is because the procedure, treatment, or supply did not have appropriate approval before being delivered to the patient.

Carriers commonly identify procedures, treatments, or supplies subject to prior review by reference to the CPT (Common Procedural Technology) code used to identify the service. Carriers examine all the codes relevant to their covered services and identify the codes subject to review. These decisions should be made in concert with each carrier's medical directors.

When service codes identified as being subject to review are processed, carriers must provide explanations to providers about how to submit the information necessary for their review that the service is medically necessary and appropriate. Once received, the carrier must make a decision according to statutory timelines, unless the record is incomplete and additional information is required from the provider.

Since M.G.L. c. 176O was initially enacted in 2001, the Massachusetts legislature has established additional standards for utilization review over the years:

Sections 5A-C:	Acceptance and recognition of information submitted pursuant to current coding standards and guidelines required; use of standardized claim formats
Sections 5D:	Establishment of base fee schedule for evaluation and management services for behavioral health providers
Sections 9A-B:	Alternate payment arrangements involving downside risk prohibited without risk certificate
Sections 12A-B:	Step therapy protocols
Section 18:	Responsibility of Carrier for behavioral health services compliance
Section 19:	Display of name and telephone number of health service manager on enrollment cards of Carrier
Section 20:	Information provided to insured adults by behavioral health manager
Section 21:	Submission by Carrier of annual comprehensive financial statement
Section 22:	Participation in medical assistance program as condition for participation in Carrier's provider network
Section 23:	Disclosure by Carrier upon request for network status of health care provider and estimated or maximum allowed amount or charge for a proposed admission, procedure or service and amount insured responsible to pay; establishment of toll-free telephone number and website
Section 24:	Internal appeals processes for risk-bearing provider organizations; patient's right to third-party advocate; external review process
Section 25:	Use and acceptance of specifically designated prospective review forms
Section 26:	Establishment of standardized processes and procedures for the determination of patient's health benefit plan eligibility at or prior to time of service
Section 27:	Development and use of common summary of payments form; implementation of education plan
Section 28:	Provider directories; contents; audits; print copies; customer service contact information; accommodations; accuracy; updates
Section 29:	Health care provider credentialing

Over the past decade, the Division issued the following Bulletins to standardize certain prior authorization forms across the market:

Bulletin 2024-03:	Prospective Review Forms for Medication, Hepatitis C and Chemotherapy
Bulletin 2024-01:	Prospective Review Form for Applied Behavioral Analysis Services
Bulletin 2022-07:	Prospective Review Forms for Chemotherapy and Oncology
Bulletin 2017-04:	Prospective Review Form for Hepatitis C Medication, non-OB Ultrasound and SYNAGIS
Bulletin 2016-08:	Prospective Review Forms for Medication and Imaging Services
Bulletin 2015-08:	Prospective Review Forms for Behavioral Health Services

Additionally, the Division issued regulatory guidance from time-to-time relaxing prior authorization processes to address heightened service needs, patient access concerns, and/or supply chain disruptions creating barriers to needed care. A partial list (only since 2022) of this approach includes:

Bulletin 2024-09:	Closures of Carney and Nashoba Valley Hospitals
Bulletin 2024-03:	Step Therapy Protocols
Bulletin 2023-11:	Community-Based Emergency Behavioral Health Care
Bulletin 2023-07:	Certain Behavioral Health Acute Treatment
Bulletin 2022-08:	Behavioral Health Patients Awaiting Psychiatric Inpatient Admissions
Bulletin 2022-06:	Relaxation of Prior Authorization for Certain Types of Imaging
Bulletin 2022-05:	Relaxation of Prior Authorization for Prescription Infant Formula
Bulletin 2022-03:	Extended Relaxation of Prior Authorization/Health Facility Constraints
Bulletin 2022-01:	Acute Care Hospital at Home/Staffing and Capacity Constraints

IV. Division of Insurance Special Examination of Prior Authorization Practices

On January 23, 2025, the Division called a special examination under M.G.L. c. 175, s.4, as well as M.G.L. c. 176A, §3; M.G.L. c. 176B, §2; and M.G.L. c. 176G, §10, for the purpose of collecting information about health plans' use of prior authorization processes in Massachusetts in 2023 and 2024.

The examination letter provided, in pertinent part, that:

> "[P]rior authorization processes are often cited as a source of clinical burden and of continuing member-patient confusion. They also vary widely across the market. While internal and external appeal rights exist, exercising these rights can be time-consuming and costly. The Massachusetts Division of Insurance reviews utilization review processes, including the use of prior authorization processes. This review occurs in a variety of ways, among them managed care accreditation reviews. Health insurance carriers currently may use prior authorization within their utilization processes so long as they adhere to legal and clinical standards. Health insurance carrier medical necessity guidelines can be employed only after receiving input from regional practicing providers, and reviewing peer-reviewed literature, clinical guidance, and studies from federal authorities like the Centers for Medicare & Medicaid Services and the Centers for Disease Control and Prevention.
>
> Local and national evidence demonstrates that prior authorization processes, responsibly managed, are important utilization management tools to ensure that services are medically necessary and appropriate to treat a covered person's health condition. Employers and individuals purchasing health coverage rely on health insurance carriers to conduct utilization management to avoid unnecessary medical care, care that carries a risk of patient harm, and/or avoidable costs. When prior authorization processes are implemented responsibly, member-patients access safe, clinically appropriate, evidence-based care, with appropriate limits on unsafe or low-value care inconsistent with existing clinical evidence. Some Massachusetts health insurance carriers have announced in recent years that they have retired or limited prior authorization processes to ease member-patients' access to care and reduce clinical burdens for specific services where the value is no longer supported.

Examination of the Reasonable Use of Prior Authorization

The Division of Insurance is interested in examining carrier utilization review in greater detail with the goal of promoting reduced administrative waste, unnecessary cost and confusion caused by some prior authorization processes. Therefore, I am notifying you that that I am calling an examination pursuant to M.G.L. c. 175, §4; M.G.L. c. 176A, §3; M.G.L. c. 176B, §2; and M.G.L. c. 176G, §10. After the Division of Insurance completes its review and analysis of all requested information, it intends to issue a report later this year with aggregated information on these matters. The Division of Insurance will consider whether further regulatory guidance can help eliminate or reduce unnecessary prior authorization processes and foster more consistency across the Massachusetts market." *See* Appendix "A" (footnote omitted herein).

Following the examination call letter, the Division issued corresponding data collection guidance so that respondents could provide detailed information on their processes, including the services to which prior authorization approvals were required, and the number of approvals, modifications and denials, as well as information on subsequent appeals and their results. Specifically, the Division requested each carrier to identify the service codes for which they required prior authorization and to identify the following categories for 2023 and 2024:

- Inpatient non-behavioral health admissions
- Inpatient behavioral health admissions
- Outpatient medical/surgical office visits
- Outpatient behavioral health office visits
- Outpatient ambulatory surgery
- Outpatient radiology
- Outpatient physical therapy/occupational therapy/speech therapy
- Outpatient home health care
- Outpatient pathology/laboratory tests
- Outpatient Durable Medical Equipment and prosthetics
- Outpatient other ancillary care
- Prescription Drugs in the Medical Benefit
- Generic Prescription Drugs
- Brand-Name Prescription Drugs
- Specialty Prescription Drugs

Consistent with the provisions of the Special Examination, the Division treats company-specific information collected under such an examination as confidential. The examination report presents aggregated information only.

V. Perspectives on Prior Authorization

According to a 2025 White Paper produced by the National Association of Insurance Commissioners (NAIC), prior authorization "is intended to ensure safety (e.g., prevent negative drug interactions), reduce utilization of medically unnecessary or ineffective treatments or services, and contain health care costs. [Prior authorization] is used for a broad range of services, treatments, and medications. By formalizing in advance, in writing, the insurer's commitment to covering a health care service, [prior authorization]

can achieve a favorable balance between costs and benefits for both [Carriers] and their members. It can also provide needed assurance for consumers and providers prior to the provision of services. While [prior authorization] can benefit [Carriers], providers, and consumers, the process has been criticized for burdening providers and delaying care for consumers."[3]

"Prior authorization seemingly imposes substantial administrative burdens, costs and inefficiencies on providers. According to a recent American Medical Association (AMA) online survey of 1000 physicians, physicians or their staff spend 13 hours per week requesting [prior authorizations]. According to the same AMA survey, 40% of participating physicians have staff who work exclusively on [prior authorizations]. Providers' [electronic health records] do not always integrate with [Carrier] systems, requiring staff to manually enter data into systems or use antiquated technology, such as fax machines, and phones to transmit sensitive information. Furthermore, incorrect or missing patient demographic and insurance information can delay [prior authorization] or result in unexpected denials.[4]

Among the concerns raised in the NAIC's White Paper:

- There is lack of consistency among Carriers' medical necessity criteria.
- There is lack of transparency about Carriers' medical necessity criteria.
- Carrier prior authorization systems are outdated and cumbersome.
- Medical necessity criteria are sometimes misaligned with standards of care.
- Consumers experience disruptions in care.
- There are higher costs in the long run due to added provider/payor administrative waste.
- There are adverse and inequitable outcomes.

Throughout the winter of 2024/2025, the Division held stakeholder listening sessions on the Massachusetts health insurance landscape. For many years, health care economists have pointed to wasteful administrative spending as one factor leading to excess health cost growth in the United States. In a 2020 publication, Harvard University Professor David Cutler defined health care administrative costs as "the nonclinical costs of running a medical system."[5] A 2020 *Health Affairs Forefront* article provided a summary of administrative spending estimates with estimates ranging between 15 and 30 percent of medical spending.[6] However, not all administrative spending is wasteful and during the Division's listening sessions, stakeholders focused specifically on the issue of prior authorization with varying views presented.

Health Care for All, the Massachusetts Medical Society and the Massachusetts Health & Hospital Association (MHA) created a coalition concerning prior authorization reform, collectively representing Massachusetts patients, physicians and healthcare providers, and hospital systems. The coalition asserted that "the burdens associated with the prior authorization process far exceed the stated benefits of cost and quality control, leading to avoidable patient harm, physician burnout, and waste in the system in a time of

3 *Prior Authorization White Paper*, NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS, (2025), page 2, available at https://content.naic.org/sites/default/files/inline-files/PA%20white%20paper%2012.4.2025%20final.pdf.

4 *Id.* at page 4.

5 David M. Cutler, *Reducing Administrative Costs in U.S. Health Care*, THE HAMILTON PROJECT, March 2020, available at https://www.hamiltonproject.org/assets/files/Cutler_PP_LO.pdf.

6 Laura Tollen, Elizabeth Keating, Alan Weil, *How Administrative Spending Contributes To Excess US Health Spending*, HEALTH AFFAIRS, Feb. 20, 2020, available at https://www.healthaffairs.org/content/forefront/administrative-spending-contributes-excess-us-health-spending.

unprecedented financial strain and uncertainty."[7] These coalition partners also cite to a recent national survey by the American Medical Association:

- 93% of physicians in the respondent class stated that prior authorization limits delayed access to necessary care;
- 94% of physician respondents said prior authorization requirements significantly negatively impacted patient clinical outcomes; and
- approximately one-in-four physicians reported that prior authorization requirements led to a serious adverse health event for their patients.

A 2023 Massachusetts Medical Society survey identified that the largest category of stressors contributing to burnout was administrative burden, with prior authorization noted by 58%.[8] The broad coalition also asserts that the staffing needed to process prior authorization requests contributes to increased expenses and overhead unrelated to patient care.

Conversely, the Massachusetts Association of Health Plans (MAHP) has highlighted the important role that prior authorization can play in constraining health costs. Their 2023 Milliman report analyzed the complete elimination of prior authorization and estimated that this drastically altered setting would result in commercial premium increases of between 9.1% to 23.3% annually.[9] The MAHP report did caution readers that the wide variance in prior authorization approaches across plans makes its cost impact ranges difficult to gauge: "overall effectiveness can vary from plan to plan, even when the scope of services is similar, due to varying clinical considerations such as medical policy and clinical judgement as well as the plan's resources and rigor applied to the [prior authorization] process internally."[10]

A 2023 Blue Cross Blue Shield Association Milliman study found that the complete elimination of prior authorization would negatively impact premiums, with increases in the commercial market nationally totaling between $43 billion and $63 billion, or $240-$360 annually per member in additional premiums.[11]

Blue Cross Blue Shield of Massachusetts (BCBSMA) stated in its pre-filed testimony to the 2025 Health Policy Commission's (HPC) Cost Trends Hearing that it has "removed prior authorization requirements for certain services such as habilitation services and home care" and "98% of claims do not require prior

7 Testimony in Support of an Act to Improve the Health Insurance Prior Authorization Process, Massachusetts Medical Society (July 15, 2025), https://www.massmed.org/Advocacy/State-Advocacy/State-Testimony/Testimony-in-Support-of-an-Act-to-Improve-the-Health-Insurance-Prior-Authorization-Process/.

8 SUPPORTING MMS PHYSICIANS' WELL-BEING REPORT: RECOMMENDATIONS TO ADDRESS THE ON-GOING CRISIS, (Massachusetts Medical Society, March 2023), available at https://www.massmed.org/Publications/Supporting-MMS-Physicians--Well-being-Report---Recommendations-to-Address-the-Ongoing-Crisis/.

9 FREDERICK (FRITZ) BUSCH & PETERE FIELEK, POTENTIAL IMPACTS ON COSTS AND PREMIUMS RELATED TO THE ELIMINATION OF PRIOR AUTHORIZATION REQUIREMENTS IN MASSACHUSETTS, MILLIMAN (Oct. 10, 2023), available at https://www.milliman.com/en/insight/potential-impacts-costs-premiums-elimination-prior-authorization-massachusetts.

10 *Id.*

11 FREDERICK (FRITZ) BUSCH & STACEY MULLER, POTENTIAL IMPACTS ON COMMERCIAL COSTS AND PREMIUMS RELATED TO THE ELIMINATION OF PRIOR AUTHORIZATION REQUIREMENTS, MILLIMAN (MARCH 30, 2023), available at https://www.milliman.com/en/insight/potential-impacts-elimination-of-prior-authorization-requests.

authorization."[12] In its announcement of the home care relaxation, BCBSMA noted that the removal of prior authorization helped to "reduce administrative burden on clinicians and help hospitals expedite discharges at a time when many are struggling with overcrowding. It will also reduce delays for members ready to transition their care from hospital to home."[13]

Consistent with the recognition that responsible prior authorization has value, the HPC examined the added costs of low-value care. In its 2018 Cost Trends Report, the HPC selected 19 measures of low-value care and found that more than 20% of patients received at least one instance of low-value care, with patients bearing nearly 15% of the unnecessary spending—close to $12 million—in the form of higher out-of-pocket costs. In total, there were nearly 800,000 low-value services identified over the study time period, accounting for nearly $80 million in health care spending.[14]

VI. Codes and Services Subject to Prior Authorization

A. Examination Data: Prior Authorization Requests

According to the fourteen reporting carriers, in 2023, there were 1.39 million requests and 1.21 million approvals (86.9%). In 2024, there were 1.58 million requests and with just over 1.36 million (86.2%) approved. Overall, the number of requests increased by 13.3% from 2023 to 2024.

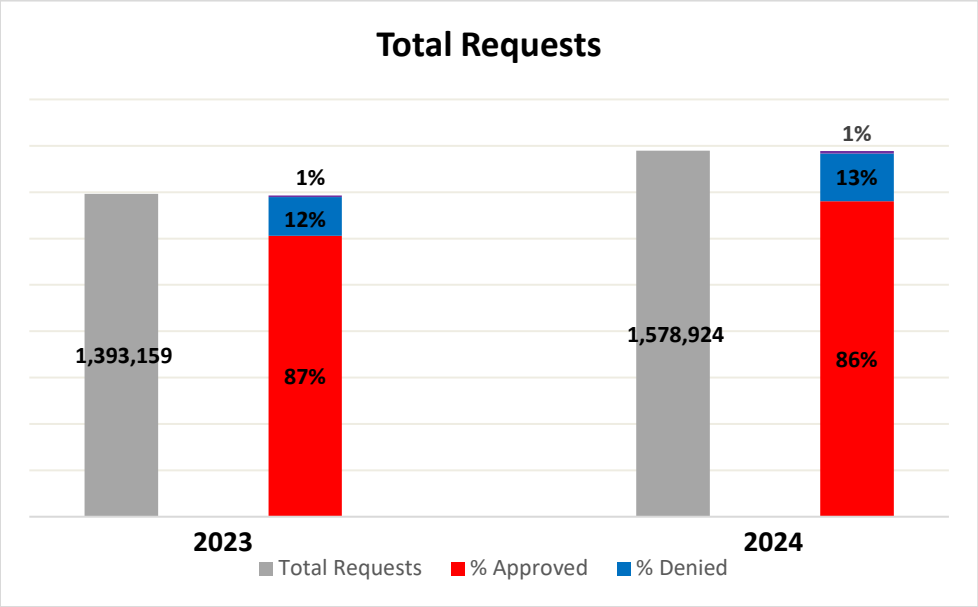

Exhibit 7

12 Working Together to Safeguard the Commonwealth's Commitment to Health Care Affordability, Access, and Equity, Massachusetts Health Policy Commission, (Nov. 12, 2025), https://masshpc.gov/meetings/annual-cost-trends-hearing/2025-cth.

13 Press Release, Blue Cross Blue Shield of Massachusetts, Blue Cross Blue Shield of Massachusetts Removes Prior Authorization for Home Care Services, (Nov. 6, 2023), available at https://newsroom.bluecrossma.com/2023-11-06-BLUE-CROSS-BLUE-SHIELD-OF-MASSACHUSETTS-REMOVES-PRIOR-AUTHORIZATION-REQUIREMENTS-FOR-HOME-CARE-SERVICES.

14 2018 ANNUAL HEALTH COST TRENDS REPORT, (Health Policy Commission, Feb. 2019), available at https://masshpc.gov/publications/annual-cost-trends-report/2018-annual-health-care-cost-trends-report.

	2023 Prior Auth Requests	2024 Prior Auth Requests	Change from 2023-2024
Inpatient non-Behavioral Health	21,860	22,537	677
Inpatient Behavioral Health	5,972	106	(5,866)
Outpatient Med/Surg Off Visit	36,572	45,180	8,608
Outpatient-Behavioral Health Off Visit	36,683	39,660	2,977
Outpatient Amb Surgery	45,649	61,965	16,316
Outpatient Radiology	469,284	509,467	40,183
Outpatient PT/OT/ST	39,279	35,582	(3,697)
Outpatient Home Health	17,095	10,926	(6,169)
Outpatient Path/Lab	97,549	111,949	14,400
Outpatient DME/Prosthetics	245,395	225,574	(19,821)
Outpatient Ancillary/Other	89,658	88,214	(1,444)
Drugs in the Medical Benefit	48,036	51,341	3,305
Generic Drugs	44,488	59,678	15,190
Brand Name Drugs	151,540	263,625	112,085
Specialty Drugs	44,099	53,120	9,021
	1,393,159	**1,578,924**	**185,765**

Exhibit 8

Requests differed by type of service:

- The largest number of requests were for radiology and pathology/lab tests with a combined 566,833 requests in 2023 (40.6% of the total) and 621,416 request in 2024 (39.4% of the total).

- Consistent with increased utilization of these services, prior authorization requests for generic, brand-name, and specialty drugs increased the most between 2023 and 2024, with a combined 240,127 requests in 2023 and 376,423 requests in 2024, a 57% increase (136,296 requests).

- Total requests for inpatient stays represented fewer than 2% of all total requests in both years, and outpatient medical/surgical and behavioral health office visits represented a little more than 5% of all total requests.

The rates of prior authorization approvals for 2023 and 2024 differed by type of services:

- the approval rates for non-behavioral health inpatient services were 94.7% in 2023 and 93.7% in 2024; the approval rates in behavioral health inpatient services were 98.6% in 2023 and 98.1% in 2024;

- the approval rates for non-behavioral health outpatient office visits were 82.6% in 2023 and 81.1% in 2024; the approval rates for behavioral health outpatient office visits were 96.0% in 2023 and 94.8% in 2024;

- the approval rate for radiology was 89.0% in 2023 and 89.6% for 2024;

- the approval rate for pathology/labs was 71.2% in 2023 and 64.6% for 2024;

- the approval rates for physical therapy/occupational therapy and speech therapy services, home health and durable medical equipment were between 95.2% and 98.6% in 2023 and 91.7% and 98.1% in 2024; and

- the approval rates for generic, brand-name and specialty drugs were between 72.8% and 88.5% in 2023 and 78.0% and 91.3% in 2024.

	2023 Prior Auth Requests	Proportion Approved
2023 Inpatient non-Behavioral Health	21,860	94.7%
2023 Inpatient Behavioral Health	5,972	98.6%
2023 Outpatient Med/Surg Off Visit	36,572	82.6%
2023 Outpatient Behavioral Health Off Visit	36,683	96.0%
2023 Outpatient Amb Surgery	45,649	92.3%
2023 Outpatient Radiology	469,284	89.0%
2023 Outpatient PT/OT/ST	39,279	98.6%
2023 Outpatient Home Health	17,095	97.3%
2023 Outpatient Path/Lab	97,549	71.2%
2023 Outpatient DME/Prosthetics	245,395	95.2%
2023 Outpatient Ancillary/Other	89,658	85.5%
2023 Drugs in the Medical Benefit	48,036	95.8%
2023 Generic Drugs	44,488	78.6%
2023 Brand Name Drugs	151,540	72.8%
2023 Specialty Drugs	44,099	88.5%

Exhibit 9A

	2024 Prior Auth Requests	% Approved
2024 Inpatient non-Behavioral Health	22,537	93.7%
2024 Inpatient Behavioral Health	106	98.1%
2024 Outpatient Med/Surg Off Visit	45,180	81.1%
2024 Outpatient Behavioral Health Off Visit	39,660	94.8%
2024 Outpatient Amb Surgery	61,965	91.9%
2024 Outpatient Radiology	509,467	89.6%
2024 Outpatient PT/OT/ST	35,582	98.1%
2024 Outpatient Home Health	10,926	91.7%
2024 Outpatient Path/Lab	111,949	64.6%
2024 Outpatient DME/Prosthetics	225,574	95.7%
2024 Outpatient Ancillary/Other	88,214	85.4%
2024 Drugs in the Medical Benefit	51,341	94.2%
2024 Generic Drugs	59,678	78.0%
2024 Brand Name Drugs	263,625	80.0%
2024 Specialty Drugs	53,120	91.3%

Exhibit 9B

Different services/codes were subject to company-specific prior authorization requirements across the market. This means that one service/code may be subject to prior authorization for one carrier but not

others in the market. Accordingly, providers must keep track of each carrier's requirements to determine whether a specific service is or is not subject to prior review.

As an example of this variance, in 2023 carriers reported between 2,438 and 11,798 codes subject to review across the market.

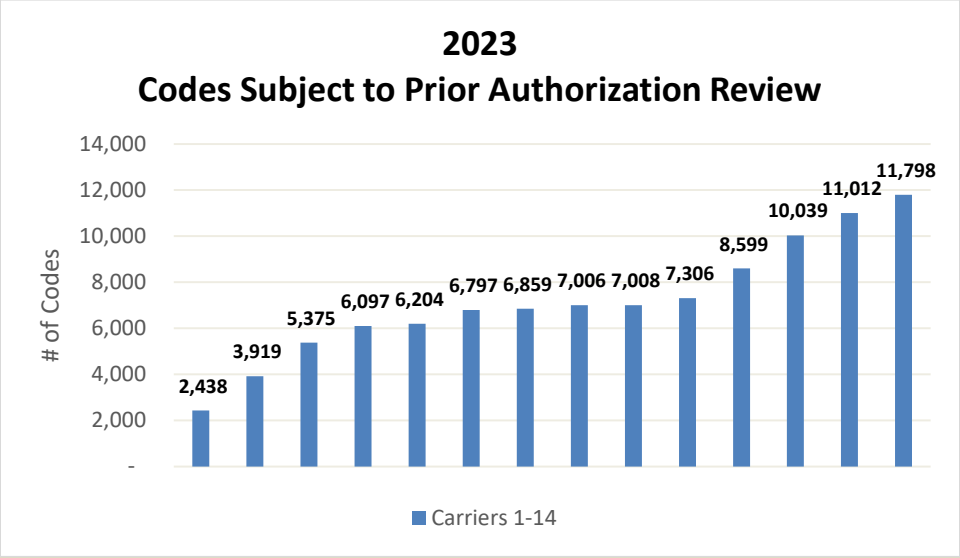

Exhibit 10

In 2024, carriers reported between 2,615 and 12,903 codes subject to review across the market.

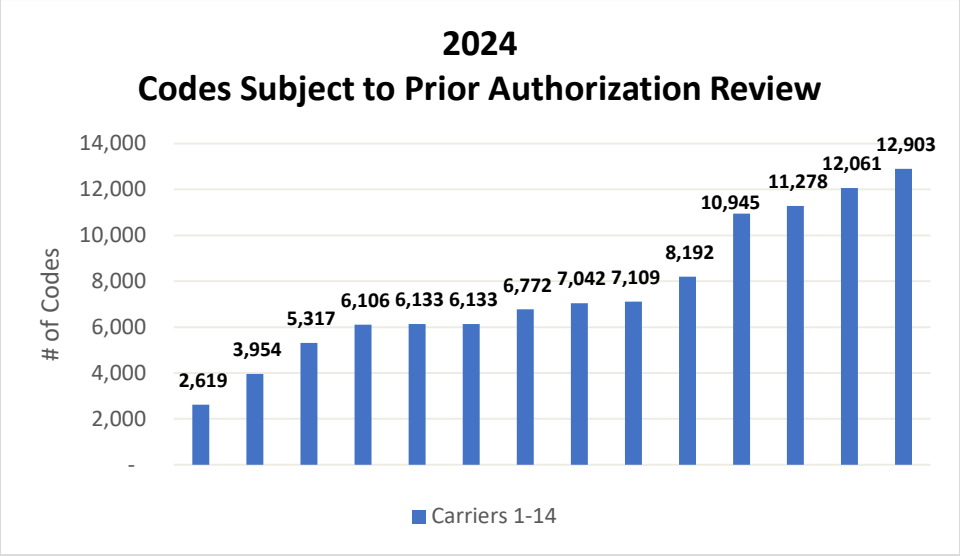

Exhibit 11

Although there were some carriers who increased or decreased the amount of services/codes subject to prior authorization, the number of services/codes subject to prior authorization stayed relatively flat during the periods of 2023 and 2024 for most carriers.

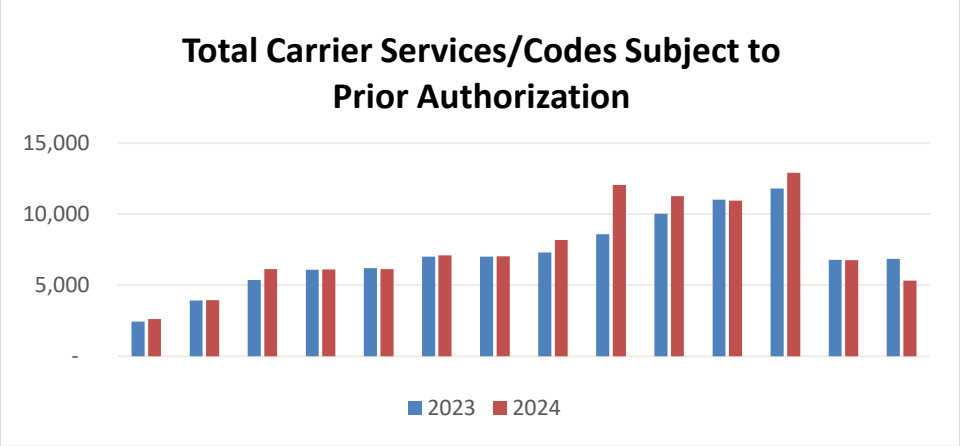

Exhibit 12

1. Inpatient Care

Certain carriers indicated that they do not perform any prior authorization for inpatient medical/surgical admissions. These carriers generally require that they be notified by a provider that a patient was admitted and the carriers may conduct a concurrent review of the inpatient stay after admission. Two carriers, however, appear to be material outliers on this issue with a significantly higher number of inpatient services/codes still subject to prior authorization.

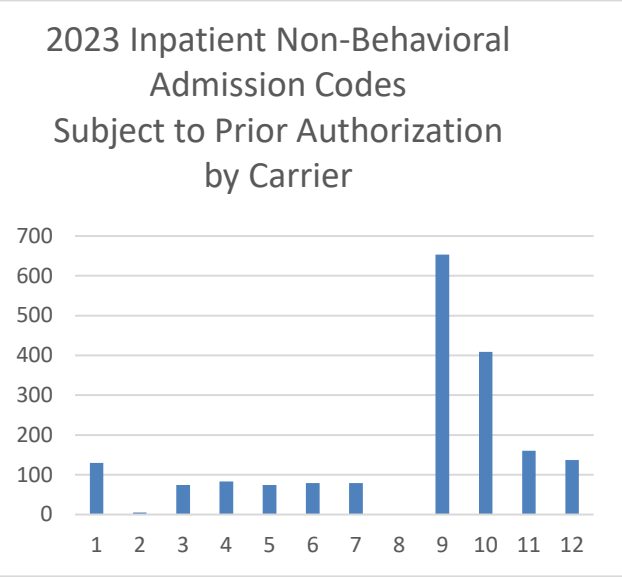

Exhibit 13

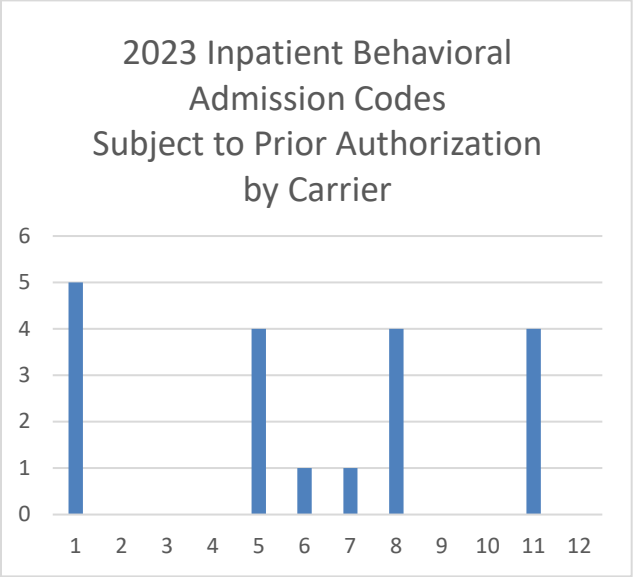

Exhibit 14

For inpatient behavioral admissions, half of the carriers indicated that they did not apply prior authorization requirements to these admissions. The other half of the market (seven carriers) reported that they apply prior authorization requirements to five or fewer services/codes.

2. Outpatient Care

Office Visits

For outpatient medical/surgical office visits, four carriers indicated that they did not apply prior authorization for these visits or applied prior authorization requirements to one or two services/codes. The remaining carriers reported that they require prior authorization for between 55 to 489 services/codes.

In the outpatient behavioral health landscape, all carriers applied prior authorization requirements to some degree, ranging from two to 30 codes across the market.

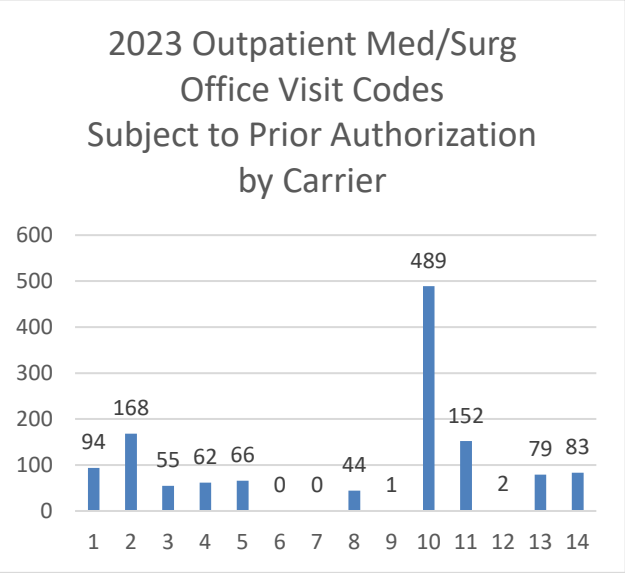

Exhibit 15

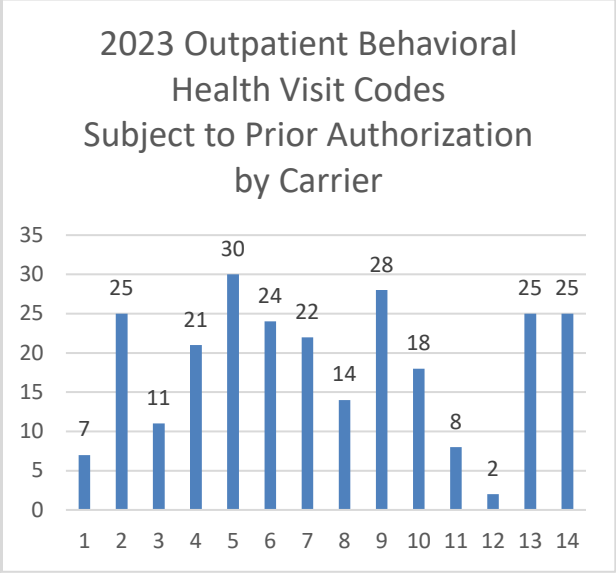

Exhibit 16

Ambulatory Surgery and Durable Medical Equipment

For outpatient ambulatory surgery, carriers reported widely disparate prior authorization approaches. While two carriers only applied prior authorization to fewer than 100 codes, the remaining carriers applied prior authorization to between 268 and 1,274 codes.

For durable medical equipment, some carriers applied prior authorization requirements to fewer than 100

codes. The remaining carriers designated that prior authorization was required for between 190 and 2,381 codes.

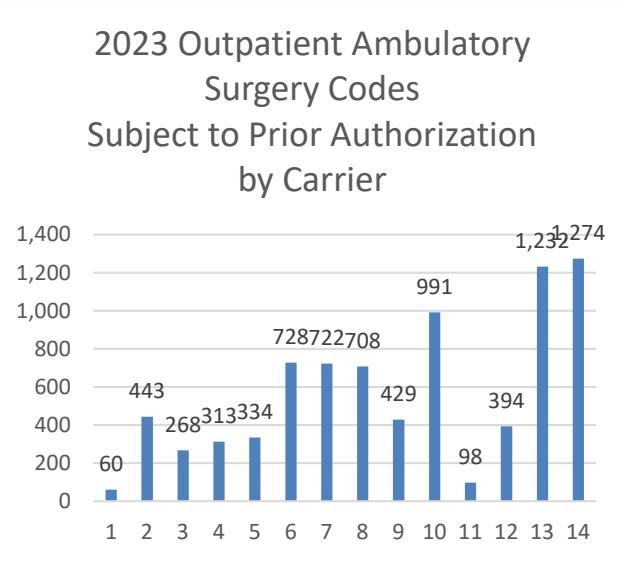

Exhibit 17

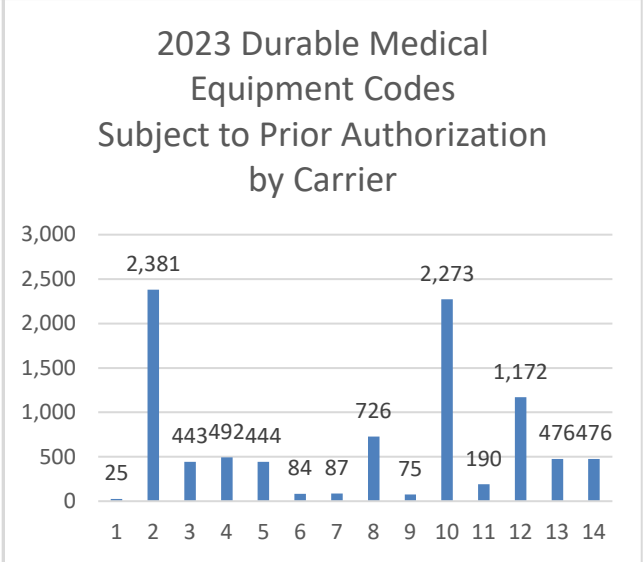

Exhibit 18

Radiology and Pathology/Laboratory Tests

For outpatient radiology, one carrier applied prior authorization to only 27 radiology codes. The remaining carriers applied requirements for between 77 and 218 codes.

For outpatient pathology/laboratory tests, six carriers applied prior authorization for 114 or fewer pathology codes. The remaining carriers applied the requirements to between 323 and 766 codes.

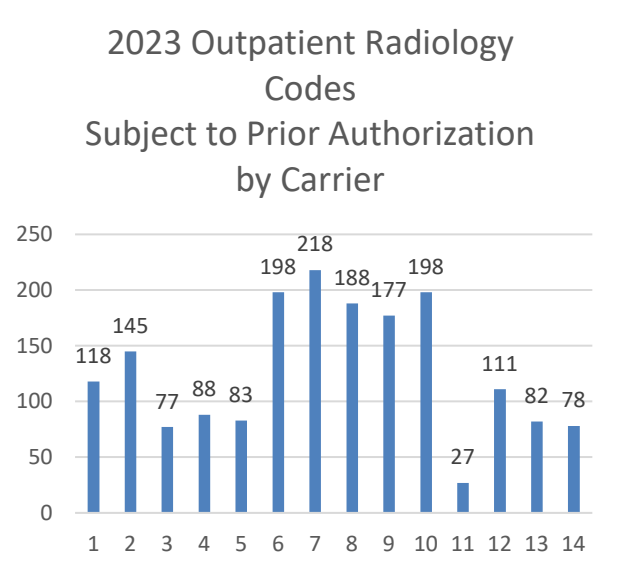

Exhibit 19

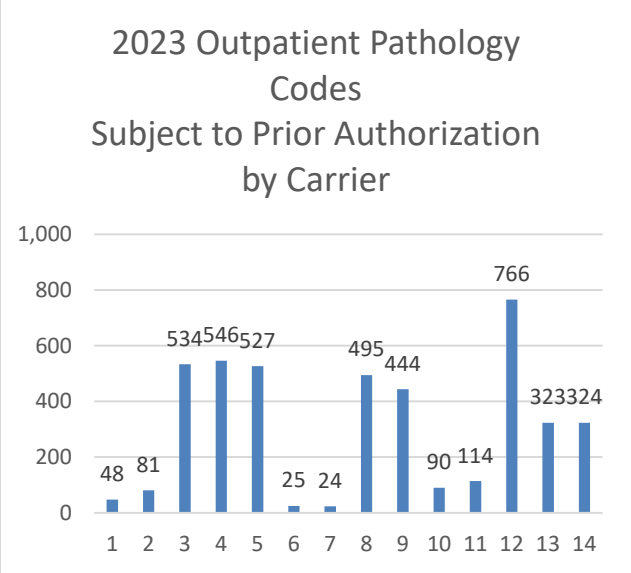

Exhibit 20

Outpatient PT/OT/ST and Home Health Visits

Two carriers reported not applying prior authorization to Physical Therapy/Occupational Therapy/Speech Therapy utilization codes, while six others apply prior authorization to fewer than ten codes. The remaining carriers reported applying prior authorization to between 24 and 85 utilization codes in this area.

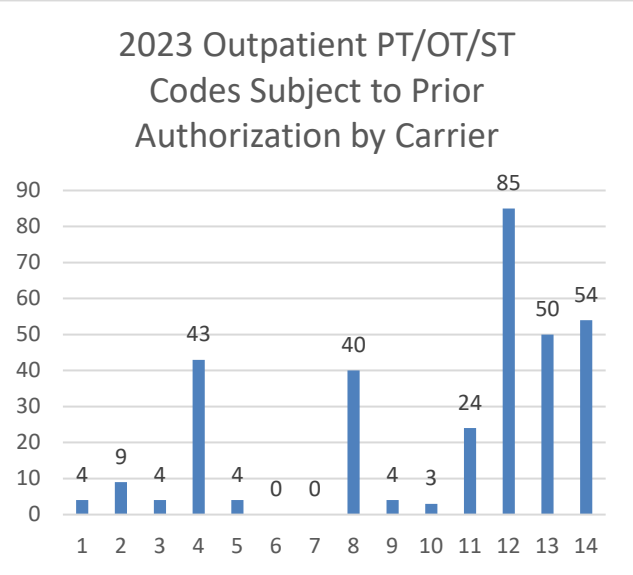

Exhibit 21

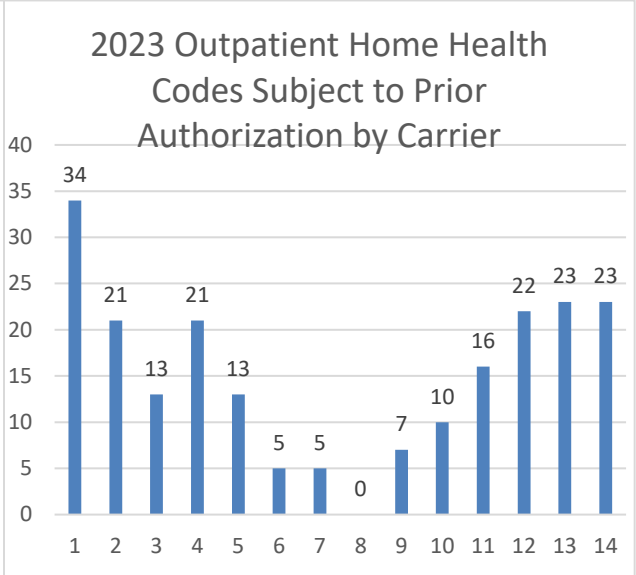

Exhibit 22

One carrier reported not applying prior authorization to home health care codes. The remaining carriers reported applying prior authorization for between five and 345 utilization codes.

Outpatient Ancillary Services

One carrier reported not applying prior authorization to outpatient ancillary service utilization codes and nine others reported applying prior authorization to fewer than 100 codes. The remaining carriers reported applying prior authorization to between 156 and 1,313 utilization codes.

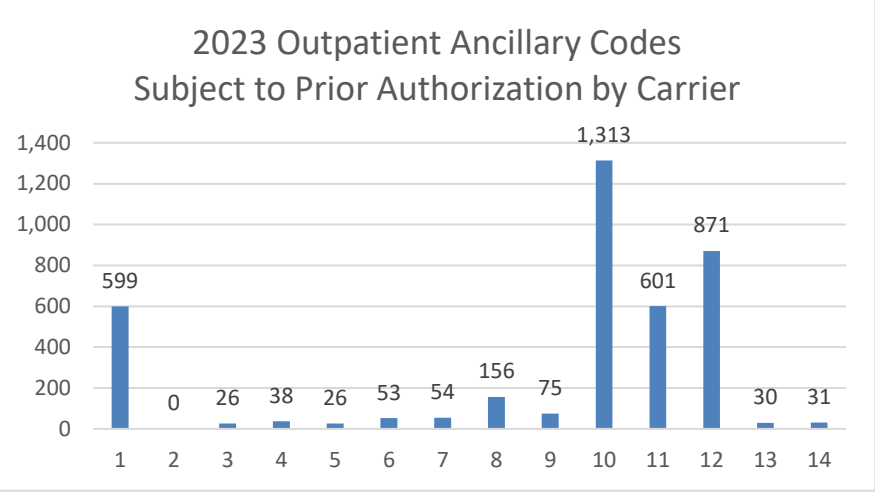

Exhibit 23

3. Prescription Drugs

Prescription Drugs in the Medical Benefit

One carrier reported only applying prior authorization to nine utilization codes for prescription drugs in the medical benefit while another carrier reported applying prior authorization to 720 codes. The remaining carriers reported applying prior authorization to between 59 and 402 utilization codes.

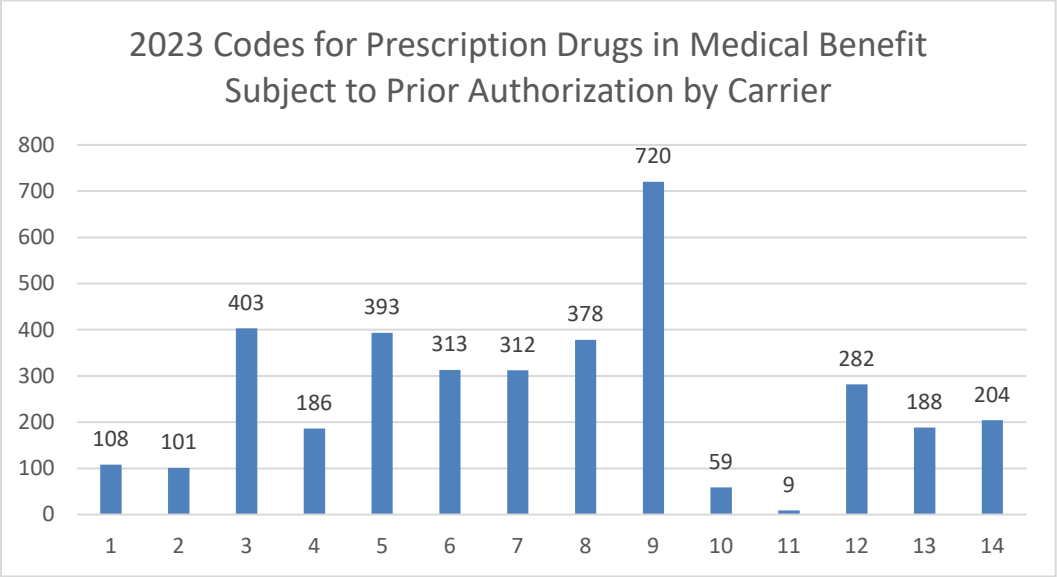

Exhibit 24

Generic Prescription Drugs

For generic prescription drugs, one carrier reported only applying prior authorization to 144 utilization codes. The remaining carriers reported applying prior authorization to between 421 and 4,851 utilization codes.

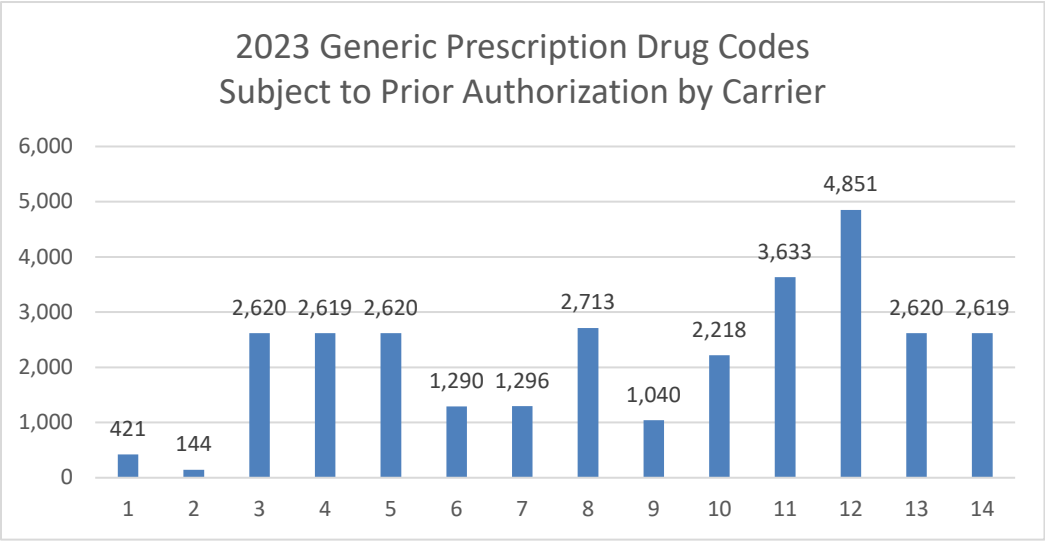

Exhibit 25

Brand Name Prescription Drugs

Regarding brand name prescription drugs, the data showed a wide variance of practices. Two carriers reported applying prior authorization to approximately 200 utilization codes while two carriers applied prior authorization to more than 3,500 codes. The remaining carriers reported applying prior authorization to between 500 and 1,500 utilization codes.

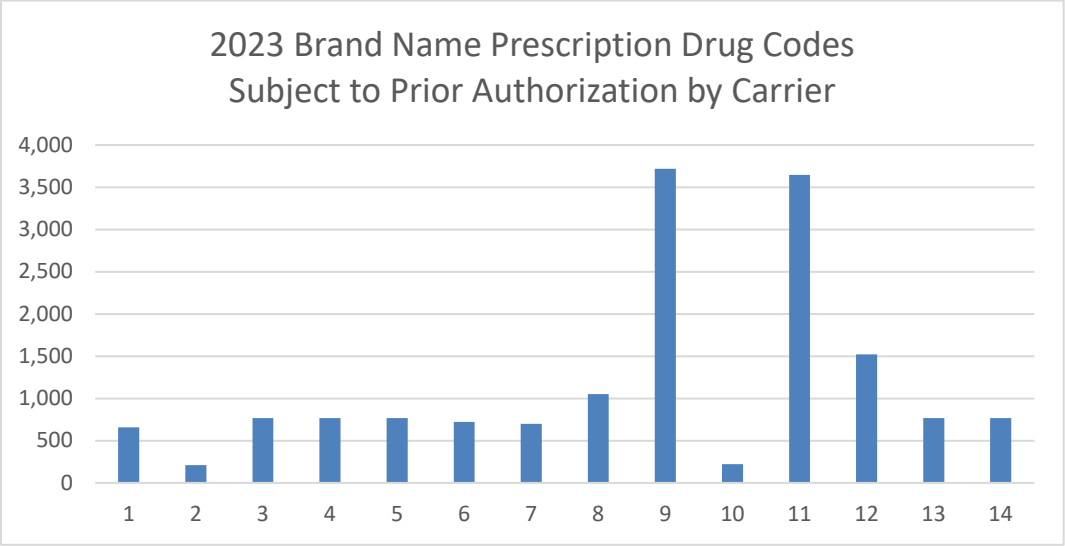

Exhibit 26

Specialty Prescription Drugs

Three carriers reported applying prior authorization to fewer than 200 utilization codes for specialty prescription drugs. The remaining carriers reported applying prior authorization to between 788 and 3,488 utilization codes.

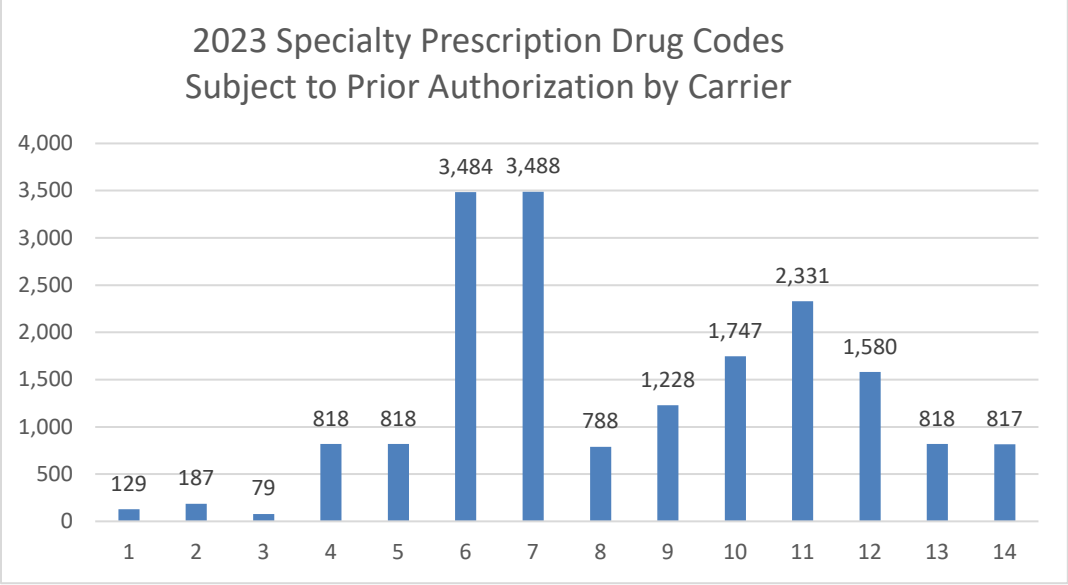

Exhibit 27

VII. Service Codes Retired

Carriers reported that they periodically review their requirements that certain procedures, services or supplies go through prior authorization. Carriers then decide to retire or no longer require that certain utilization codes be subject to prior authorization.

The reporting carriers stated that they collectively retired 2,208 codes from prior authorization in 2023, and collectively retired 1,820 codes from prior authorization in 2024.

According to their submitted data, carriers indicated that they intended to retire only 266 further codes subject to their review by the end of 2025.

UNIQUE CODES/SERVICES CURRENTLY SUBJECT TO VOLUNTARILY RETIRED FROM PRIOR AUTHORIZATION:

2023	2024	2025
2,208	1,820	266

Exhibit 28

During the period of the examination, in 2023, 60% of the retired codes and in 2024, 69% of the retired codes that were no longer reviewed under prior authorization requirements were in the prescription drug field. During those years, over 30% of the other retired codes related to outpatient non-behavioral health procedures.

Percent of Codes Retired from being subject to Prospective Review

Type of Code	2023	Retired Codes	2024	Retired Codes
Outpatient Non-BH	818	37%	550	30%
Inpatient Non-BH	5	0%	0	0%
Prescription Drugs	1326	60%	1248	69%
Inpatient and Outpatient BH	60	3%	13	1%

Exhibit 29

There were additional retired codes during the examination period within the inpatient non-behavioral health and inpatient/outpatient behavioral health categories, but they did not constitute a significant number of the total number of codes retired from prior authorization in either 2023 or 2024.

VIII. Use of Codes for Prior Authorization

As discussed earlier, carriers in the Massachusetts market maintain different systems and require different services/codes to undergo prior authorization. The examination data demonstrated that, across the market, many services/codes are subject to prior authorization even when carriers may not have experienced any utilization for that service/code in 2023 or 2024. For other services/codes, carriers may require prior authorization for a particular service/code but approve a substantial amount of those requests, either as part of an initial review or as part of internal appeal of an initial denial.

The following presents more observations on submitted data from two specific companies of the examined carriers (2023 de-identified data) as additional context for prior authorization practices in the Massachusetts market.

Company A: For this carrier, a significant number of codes were subject to prior authorization without requests for utilization or where requests were significantly approved for those codes:

- There were 3,898 codes in 2023 and 3,579 codes in 2024 subject to prospective review.
  - 538 of codes in 2023 and 630 codes in 2024 **did not have any requests for approval**.
- Requests for **physical therapy, occupational therapy or speech therapy services** and **home health** visits in 2023 were **approved more than 90%** of the time.

COMPANY A

Categories	2023 Codes subject to Prosp Review	Codes w/out Utilization Requests in 2023	Percent w/out Utililzation Requests in 2023	Codes where in 2023 Prosp Review Request is Approved Over 90% of Time	Percent of Codes Where Prosp Rev is Approved Over 90% of Time in 2023	Codes where in 2023 Prosp Review Request is Approved Less than 90% of Time in 2023	Percent of Codes Where Prosp Rev is Approved Less than 90% of Time in 2023
2023 Inpatient non-Behavioral Health	650	428	66%	161	24.8%	61	9%
2023 Inpatient Behavioral Health	-	-		-		-	
2023 OUTP Med/Surg Off Visit	N/A	N/A	N/A	N/A	N/A	N/A	N/A
2023 OUTP-Behavioral Health	27	7	26%	18	66.7%	2	7%
2023 OUTP Radiology	176	8	5%	64	36.4%	104	59%
2023 OUTP PT_OT_ST	4	-	0%	4	100.0%	-	0%
2023 OUTP Home Health	7	-	0%	7	100.0%	-	0%
2023 OUTP Path_Lab	442	4	1%	52	11.8%	386	87%
2023 OUTP DME_Pros_med	74	57	77%	15	20.3%	2	3%
2023 OUTP Ancillary_Other	75	11	15%	19	25.3%	45	60%
2023 Drgs in Med Benefit	717	23	3%	664	92.6%	30	4%
2023 Generic Drgs	590	-	0%	454	76.9%	136	23%
2023 Branded Drgs	509	-	0%	286	56.2%	223	44%
2023 Specialty Drgs	627	-	0%	459	73.2%	168	27%

COMPANY A

Categories	2024 Codes subject to Prosp Review	Codes w/out Utilization Requests in 2024	Percent w/out Utililzation Requests in 2024	Codes where in 2024 Prosp Review Request is Approved Over 90% of Time	Percent of Codes Where Prosp Rev is Approved Over 90% of Time in 2024	Codes where in 2024 Prosp Review Request is Approved Less than 90% of Time in 2024	Percent of Codes Where Prosp Rev is Approved Less than 90% of Time in 2024
2024 Inpatient non-Behavioral Health	649	429	66%	148	23%	72	11%
2024 Inpatient Behavioral Health	-	-		-		-	
2024 OUTP Med/Surg Off Visit	N/A	N/A	N/A	N/A	N/A	N/A	N/A
2024 OUTP-Behavioral Health	27	6	22%	21	78%	-	0%
2024 OUTP Radiology	176	6	3%	76	43%	94	53%
2024 OUTP PT_OT_ST	4	-	0%	3	75%	1	25%
2024 OUTP Home Health	-	-	0%	-	0%	-	0%
2024 OUTP Path_Lab	442	89	20%	37	8%	316	71%
2024 OUTP DME_Pros_med	75	55	73%	16	21%	4	5%
2024 OUTP Ancillary_Other	76	30	39%	40	53%	6	8%
2024 Drgs in Med Benefit	356	15	4%	308	87%	33	9%
2024 Generic Drgs	459	-	0%	374	81%	85	19%
2024 Branded Drgs	547	-	0%	286	52%	261	48%
2024 Specialty Drgs	768	-	0%	555	72%	213	28%

Company B: For another carrier, a significant number of codes were subject to prior authorization without experienced utilization or where requests were routinely approved for those codes:

- There were 5,718 codes in 2023 and 5,762 codes in 2024 subject to prospective review.
  - 3,809 codes in 2023 and 3,501 codes in 2024 **did not have any requests for approval**.

COMPANY B

Categories	2023 Codes subject to Prosp Review	Codes w/out Utilization Requests in 2023	Percent w/out Utililzation Requests in 2023	Codes where Prosp Review Request is Approved Over 90% of Time in 2023	Percent of Codes Where Prosp Rev is Approved Over 90% of Time in 2023	Codes where Prosp Review Request is Approved Less than 90% of Time in 2023	Percent of Codes Where Prosp Rev is Approved Less than 90% of Time in 2023
2023 Inpatient non-Behavioral Health	74	58	78%	9	12%	7	9%
2023 OUTP-Behavioral Health	29	4	14%	16	55%	9	31%
2023 OUTP Amb Surgery	333	151	45%	80	24%	102	31%
2023 OUTP Radiology	80	7	9%	18	23%	55	69%
2023 OUTP PT_OT_ST	4	2	50%	-	0%	2	50%
2023 OUTP Home Health	-	-	0%	-	0%	-	0%
2023 OUTP Path_Lab	195	4	2%	69	35%	122	63%
2023 OUTP DME_Pros_med	443	382	86%	28	6%	33	7%
2023 OUTP Ancillary_Other	26	8	31%	3	12%	15	58%
2023 Drgs in Med Benefit	328	89	27%	196	60%	43	13%
2023 Generic Drgs	2,620	1,989	76%	415	16%	216	8%
2023 Branded Drgs	768	489	64%	171	22%	108	14%
2023 Specialty Drgs	818	626	77%	151	18%	41	5%

COMPANY B

Categories	2024 Codes subject to Prosp Review	Codes w/out Utilization Requests in 2024	Percent w/out Utililzation Requests in 2024	Codes where in 2024 Prosp Review Request is Approved Over 90% of Time	Percent of Codes Where Prosp Rev is Approved Over 90% of Time in 2024	Codes where Prosp Review Request is Approved Less than 90% of Time in 2024	Percent of Codes Where Prosp Rev is Approved Less than 90% of Time in 2024
2024 Inpatient non-Behavioral Health	79	51	65%	9	11%	19	24%
2024 OUTP-Behavioral Health	27	5	19%	16	59%	6	22%
2024 OUTP Amb Surgery	326	105	32%	80	25%	141	43%
2024 OUTP Radiology	97	2	2%	18	19%	77	79%
2024 OUTP PT_OT_ST	4	2	50%	-	0%	2	50%
2024 OUTP Home Health	12	4	0%	-	0%	8	0%
2024 OUTP Path_Lab	255	9	4%	69	27%	177	69%
2024 OUTP DME_Pros_med	456	318	70%	28	6%	110	24%
2024 OUTP Ancillary_Other	27	9	33%	3	11%	15	56%
2024 Drgs in Med Benefit	296	16	5%	196	66%	84	28%
2024 Generic Drgs	2477	1,824	74%	415	17%	238	10%
2024 Branded Drgs	812	486	60%	171	21%	155	19%
2024 Specialty Drgs	894	670	0%	151	17%	73	8%

Exhibit 27

The review of the market-wide examination data clearly shows this same pattern. Each examined carrier maintains a system of prior authorization where there is a material number of codes subject to prior authorization where carriers did not experience any utilization[15] or for which carriers routinely approved a significant proportion of submitted requests.

15 The lack of experienced utilization for a specific service/code should not necessarily mean that prior authorization should be retired for that area. The Division of Insurance is mindful of the arguments raised by both proponents and opponents concerning the "sentinel effect". The "sentinel effect" is the asserted impact on medical and prescription drug expenses after prior authorization would be removed for a specific area. Its premise is grounded in the assertion that there will be requests for services (previously unsubmitted during the time of required prior authorization because providers did not expect an approval) that will be submitted once requirements are removed. There may also be, for example, services that are in the category of "rarely occurring but very expensive" where the lack of experienced utilization in a particular year holds less comparable value to the carrier in its decisions on services subject to prior authorization.

IX. INTERROGATORIES

Continuity of Approvals

Carriers were specifically asked to explain how each would handle prior authorizations for new members who had obtained approval for a service from their prior carrier, and whether that prior carrier approval would be accepted for at least 90 days from the date that the new carrier learns of the previous approval.

Our examination demonstrated that:

- All carriers are aware that there are required "continuity of care" provisions when a patient is in their second or third trimester or is terminally ill (with life expectancy of fewer than 6 months).
- Moreover, most carriers indicated that they would agree to provide new members with a 90-day transition period for approvals made by a patient's previous carrier, provided that the new carrier is notified of that approval; the service is covered; and the provider delivering the service is in the network for the new carrier.
  - A few carriers indicated that they may require their new member (or their provider) submit a copy of their previous approval or process a "continuation of care" form.
- For prescription drugs, carriers already must comply with Massachusetts PACT Act requirements for continuity of care for Chronic Condition Medications (Asthma, Diabetes, Heart Conditions), including a one-time transition fill for new members joining a plan from another plan.
- In addition, most carriers indicated that they would allow for a one-time fill or a 30- or 90-day supply of medication for a new member joining their plan when the member is stable on a medication that requires prior authorization to ensure that there is no delay in receiving necessary prescription drugs.

Chronic Care, Primary Care and Behavioral Health Services

Carriers were asked if they allow longer validity periods (at least 90 days) for authorizations for Chronic Care, Primary Care, and Behavioral Health services.

Generally, carriers did not have clear responses to this interrogatory and indicated that they needed to review such requests on a more specific, individualized basis.

Urgent Care Response Times

Carriers were asked to identify their current and planned protocols (with an effective date of January 1, 2026) to respond to providers' urgent care authorization requests, towards the goal of providing appropriate responses within 24 hours of receiving all necessary information needed from the requesting facility to process such requests.

Among the carriers, the vast majority of the carriers (eleven) indicated that they did not apply any prior authorization in the field of urgent care. Of the remaining carriers, two indicated that they applied prior authorization for urgent care requests within 24 hours of receiving all necessary information and one indicated that it would complete such requests according to statutory standards, requiring that decisions be made within 48 hours of receiving all necessary information.

X. CONCLUSION

Approximately 1.3 million persons are enrolled in Massachusetts-issued insured health plans that are regulated by state managed care laws, including those that regulate prior authorization systems. Current regulations governing prior authorization set forth the expectation that carriers follow specific timelines and notice requirements. Carrier decisions must be based on standard medical necessity criteria developed with appropriate input from the medical community and be available to providers and the public.

In summary, the examination of 2023 and 2024 prior authorization practices in the Massachusetts market demonstrated the following:

- There is a need for more demonstrated rigor and transparency around carrier processes used to set prior authorization requirements, including the implementation and ongoing review of specific carrier requirements.

- There are specific services/codes where the value of the continued use of prior authorization is outweighed by concomitant burdens.

- There are disparate requirements across the market for which services require prior authorization and greater standardization of the services for which prior authorization requirements apply would hold value.

- Prior authorization clearly has value when evidence exists that it is being used responsibly.

Regulatory guidelines should promote the streamlining and standardization of prior authorization requirements but be crafted in a manner beneficial to consumers, patients and the broader health care community. Such regulations should include promote high-quality of care while restricting low-value care, potential fraud, waste, or abuse.

Acknowledgments

On January 23, 2025, the Massachusetts Division of Insurance ("Division") launched an examination of certain health insurance carrier practices in greater detail pursuant to M.G.L. c. 175, §4; M.G.L. c. 176A, §3; M.G.L. c. 176B, §2; and M.G.L. c. 176G, §10. See Commissioner's Examination Letter (redacted) attached as Appendix "A". The present report provides aggregated information on these matters and is based on data for calendar years 2023 and 2024 submitted by Massachusetts health insurance carriers accredited and licensed by the Division. The Commissioner of Insurance acknowledges that the enclosed report was prepared by Division of Insurance and Health Care Access Bureau staff. The Commissioner notes his particular appreciation to Kevin Beagan, Shannon Lynch, Rebecca Butler, Mary Hosford, Cara Libman and Colby Dillon for their work. Staff have reviewed the reasonableness of the information provided by all carriers but did not independently verify that the submitted responses were factually accurate. Where certain carrier submissions were incomplete, staff applied estimates consistent with the information collected from all submitting carriers in extremely limited circumstances.

APPENDIX A: EXAMINATION LETTER

COMMONWEALTH OF MASSACHUSETTS
Office of Consumer Affairs and Business Regulation
DIVISION OF INSURANCE
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http://www.mass.gov/doi

MAURA T. HEALEY
GOVERNOR

KIM DRISCOLL
LIEUTENANT GOVERNOR

MICHAEL T. CALJOUW
COMMISSIONER OF INSURANCE

January 23, 2025

[redacted]

Re: Prior Authorization Practices

Dear [redacted]

Thank you for your company's continuing participation in the Division of Insurance's detailed health care listening sessions this fall and winter. As we examine the drivers of health care costs, an issue national in scope, the Division of Insurance continues to be concerned about the consequential impacts that costs have on Massachusetts businesses and individual purchasers of health coverage. We will report this spring on these cost drivers so that the Commonwealth can best support affordability efforts. Reforms across all health care stakeholders will help advance the critical goals of affordable, accessible and equitable care.

Health Insurance Carrier Use of Prior Authorization

During these sessions, the use of prior authorization[1] was noted by Massachusetts health insurance carriers and providers alike as an important consideration. Prior authorization processes are often cited as a source of clinical burden and of continuing member-patient confusion. They also vary widely across the market. While internal and external appeal rights exist, exercising these rights can be time-consuming and costly.

The Massachusetts Division of Insurance reviews utilization review processes, including the use of prior authorization processes. This review occurs in a variety of ways, among them managed care accreditation reviews. Health insurance carriers currently may use prior

[1] Prior authorization processes are one set of utilization management tools that commercial and government payers, including Medicare and Medicaid, use to ensure that member-patients receive care based on established evidence of clinical efficacy and safety. In addition to federal regulations including those governing Medicare Advantage plans, MassHealth employs prior authorization processes and requirements. Massachusetts legislative proposals would prohibit or limit prior authorization for the fully insured market to varying degrees.

authorization within their utilization processes so long as they adhere to legal and clinical standards. Health insurance carrier medical necessity guidelines can be employed only after receiving input from regional practicing providers, and reviewing peer-reviewed literature, clinical guidance, and studies from federal authorities like the Centers for Medicare & Medicaid Services and the Centers for Disease Control and Prevention.

Local and national evidence demonstrates that prior authorization processes, responsibly managed, are important utilization management tools to ensure that services are medically necessary and appropriate to treat a covered person's health condition. Employers and individuals purchasing health coverage rely on health insurance carriers to conduct utilization management to avoid unnecessary medical care, care that carries a risk of patient harm, and/or avoidable costs.[2]

When prior authorization processes are implemented responsibly, member-patients access safe, clinically appropriate, evidence-based care, with appropriate limits on unsafe or low-value care inconsistent with existing clinical evidence. Some Massachusetts health insurance carriers have announced in recent years that they have retired or limited prior authorization processes to ease member-patients' access to care and reduce clinical burdens for specific services where the value is no longer supported.

Examination of the Reasonable Use of Prior Authorization

The Division of Insurance is interested in examining carrier utilization review in greater detail with the goal of promoting reduced administrative waste, unnecessary cost and confusion caused by some prior authorization processes. Therefore, I am notifying you that that I am calling an examination pursuant to M.G.L. c. 175, §4; M.G.L. c. 176A, §3; M.G.L. c. 176B, §2; and M.G.L. c. 176G, §10. After the Division of Insurance completes its review and analysis of all requested information, it intends to issue a report later this year with aggregated information on these matters. The Division of Insurance will consider whether further regulatory guidance can help eliminate or reduce unnecessary prior authorization processes and foster more consistency across the Massachusetts market.

As part of this examination, by June 1, 2025, I expect that each Massachusetts licensed health insurance carrier will forward detailed information concerning their utilization processes, including but not limited to:

(1) A detailed inventory of the specific items and services (and CPT codes where applicable) for which the health insurance carrier is using prior authorization processes as of January 1, 2025.
(2) From this larger list, identification of those items and services for which the health insurance carrier will retire or limit the use of prior authorization processes by January 1, 2026, including at minimum the following:

---

[2] As one example, the United States Government Accountability Office has cited the value of using prior authorization for certain "items and services with high unnecessary utilization and high improper payment rates." See 2018 GAO report to Senate Committee on Finance.

a. Continuity of Previous Authorizations: the health insurance carrier is to explain how it will administer treatment authorizations that incoming member-patient authorizations previously received from another insurance carrier for at least 90 days from the date that the in-taking health insurance carrier learns of the previous authorization.
b. Chronic Care, Primary Care and Behavioral Health Services: the health insurance carrier is to include its plans to require longer validity periods (at least 90 days) for authorizations for those Chronic Care, Primary Care and Behavioral Health services identified in category (1); such efforts shall be consistent with the terms of MGL c. 26, section 8K.
c. Other Services: the health insurance carrier is to include a list of all other items and services currently subject to prior authorization processes that the health insurance carrier has voluntarily chosen to retire by January 1, 2026; these retired items and services may include, for example, generic medications, items or services with extremely low authorization denial rates, or those where prevailing clinical evidence no longer supports requiring authorization.
d. Urgent Care Response Times: the health insurance carrier is to identify its current and planned protocols (as of January 1, 2026) for responding to providers' urgent care authorization requests towards the goal of providing appropriate responses within 24 hours of receiving all necessary information needed from the requesting facility to process such requests.

The Division of Insurance will separately contact your company with further, detailed information concerning the data to be collected under this examination.

Further Comments on Prior Authorization Processes

Self-Funded Plans
When health insurance carriers are acting as administrators for employment-sponsored non-insured health plans, plan sponsors should be encouraged to take steps consistent with these practices.

Glide Path to Automation
Automating prior authorization processes may ultimately provide the greatest benefit to the health care system, reducing time, cost, and administrative burdens for member-patients, providers, and health insurance carriers[3]. An end-to-end authorization process that is (1) completed electronically and (2) through a defined set of data exchange standards and technologies may have real value for all participants in the health care system. This reform could materially decrease resource needs and ensure that the same data standards are used by the entire health care community. As health insurance carriers engage collaboratively with

[3] For example, the Council for Affordable Quality Healthcare's (CAQH) 2023 Index Report found that in addition to the $193 billion health insurance carriers and providers have saved annually due to previous automation efforts, nationally health care stakeholders could further save $18.3 billion by transitioning to fully electronic prior authorization transactions. There is abundant research on excess administrative costs nationally. See, e.g., David Cutler, Reducing Administrative Costs in in U.S. Health Care (The Hamilton Project, 2020); Health Affairs, "The Role of Administrative Waste in Excess US Health Spending" (October 2022).

providers and subject matter experts on this topic, the Division of Insurance would appreciate timely updates on the work needed ahead, including related legal, regulatory and infrastructure considerations.

Thank you for your attention to these matters.

Sincerely,

Michael T. Caljouw
Commissioner of Insurance

CC: [redacted]

APPENDIX B

LIST OF CARRIERS RESPONDING TO THE SURVEY AS PART OF SPECIAL EXAMINATION

4 Ever Life Insurance Company[1]
Aetna Health, Inc
Aetna Health Insurance Company
Aetna Life Insurance Company
Blue Cross and Blue Shield of Massachusetts[2]
Boston Medical Center Health Plan, Inc. (d/b/a WellSense Health Plan)
Cigna Health and Life Insurance Company
Fallon Community Health Plan, Inc.
Harvard Pilgrim Health Care, Inc. (a Point32Health company)
Health New England, Inc.
HPHC Insurance Company, Inc. (a Point32Health company)
Mass General Brigham Health Plan, Inc.
Tufts Associated Health Maintenance Organization, Inc. (a Point32Health company)
Tufts Health Public Plans, Inc. (a Point32Health company)
Tufts Insurance Company (a Point32Health company)
UnitedHealthcare Insurance Company
Wellfleet Insurance Company[1]

[1.] 4 Ever Life Insurance Company and Wellfleet Insurance Company responded to the survey, but responses were not presented in survey results because of limited membership in the Massachusetts market.

[2.] Blue Cross Blue Sheild of Massachusetts comprises responses of both Blue Cross and Blue Shield of Massachusetts, Inc. and Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc.

APPENDIX C

DATA SURVEY TO BE COMPLETED AS PART OF EXAMINATION

2023 INPATIENT NON-BEHAVIORAL HEALTH PRIOR AUTHORIZATIONS BY 2023 CODE IDENTIFIER

Instructions: Please provide the CPT Codes, Healthcare Common Procedure Coding System (HCPCS) codes, Diagnosis Related Groups (DRGs), J-Codes, and National Drug Codes (NDCs) or the best available code for all inpatient non-behavioral health services and items that were subject to Prior Authorization in 2023 by code. Include the below information for the calendar year 2023.

a)Please provide the CPT Codes, Healthcare Common Procedure Coding System (HCPCS) codes, Diagnosis Related Groups (DRGs), J-Codes, and National Drug Codes (NDCs) or the best available code for all services, items and prescriptions that were subject to Prior Authorization by code;
b)Name of service/Item;
c)Number of times patients/providers requested authorization for services;
d)For standard requests, average time to make a determination in calendar days;
e)For expedited requests, average time to make a determination by number of hours;
f)Number of requests authorized;
g)Number of requests modified downward. Please submit the total number of partial denials for each code. This category does not include pre-authorizations that were voided and replaced with a new authorization request.
h)Number of requests denied;
i)Number of reduced or denied requests appealed through the internal appeals process;
j)Number of internally appealed requests approved;
k)Number of internally appealed requests denied.
l) Please provide any additional comments within notes section.

Code including CPT and other Codes	Name of Service/Item	No. of Requests Made	Standard Time to Make Determination	Expedited Time to Make Determination	No. of Requests Authorized	No. of Requests Modified Downward	No. of Requests Denied	No. of Internal Appeals Filed	No. of Appeals Approved	No. of Appeals Denied	Notes

2023 INPATIENT BEHAVIORAL HEALTH PRIOR AUTHORIZATIONS BY 2023 CODE IDENTIFIER

Instructions: Please provide the CPT Codes, Healthcare Common Procedure Coding System (HCPCS) codes, Diagnosis Related Groups (DRGs), J-Codes, and National Drug Codes (NDCs) or the best available code for all inpatient behavioral health services and items that were subject to Prior Authorization in 2023 by code. Include the below information for the calendar year 2023.

a)Please provide the CPT Codes, Healthcare Common Procedure Coding System (HCPCS) codes, Diagnosis Related Groups (DRGs), J-Codes, and National Drug Codes (NDCs) or the best available code for all services, items and prescriptions that were subject to Prior Authorization by code;
b)Name of service/Item;
c)Number of times patients/providers requested authorization for services;
d)For standard requests, average time to make a determination in calendar days;
e)For expedited requests, average time to make a determination by number of hours;
f)Number of requests authorized;
g)Number of requests modified downward. Please submit the total number of partial denials for each code. This category does not include pre-authorizations that were voided and replaced with a new authorization request.
h)Number of requests denied;
i)Number of reduced or denied requests appealed through the internal appeals process;
j)Number of internally appealed requests approved;
k)Number of internally appealed requests denied.
l) Please provide any additional comments within notes section.

Code including CPT and other Codes	Name of Service/Item	No. of Requests Made	Standard Time to Make Determination	Expedited Time to Make Determination	No. of Requests Authorized	No. of Requests Modified Downward	No. of Requests Denied	No. of Internal Appeals Filed	No. of Appeals Approved	No. of Appeals Denied	Notes

2023 OUTPATIENT MEDICAL/SURGERY OFFICE VISIT PRIOR AUTHORIZATIONS BY 2023 CODE

Instructions: Please provide the CPT Codes, Healthcare Common Procedure Coding System (HCPCS) codes, Diagnosis Related Groups (DRGs), J-Codes, and National Drug Codes (NDCs) or the best available code for all outpatient medical/surgery office visits, services and items that were subject to Prior Authorization in 2023 by code. Include the below information for the calendar year 2023.

a)Please provide the CPT Codes, Healthcare Common Procedure Coding System (HCPCS) codes, Diagnosis Related Groups (DRGs), J-Codes, and National Drug Codes (NDCs) or the best available code for all services, items and prescriptions that were subject to Prior Authorization by code;
b)Name of service/Item;
c)Number of times patients/providers requested authorization for services;
d)For standard requests, average time to make a determination in calendar days;
e)For expedited requests, average time to make a determination by number of hours;
f)Number of requests authorized;
g)Number of requests modified downward. Please submit the total number of partial denials for each code. This category does not include pre-authorizations that were voided and replaced with a new authorization request.
h)Number of requests denied;
i)Number of reduced or denied requests appealed through the internal appeals process;
j)Number of internally appealed requests approved;
k)Number of internally appealed requests denied.
l) Please provide any additional comments within notes section.

Code including CPT and other Codes	Name of Service/Item	No. of Requests Made	Standard Time to Make Determination	Expedited Time to Make Determination	No. of Requests Authorized	No. of Requests Modified Downward	No. of Requests Denied	No. of Internal Appeals Filed	No. of Appeals Approved	No. of Appeals Denied	Notes

2023 OUTPATIENT BEHAVIORAL HEALTH PRIOR AUTHORIZATIONS BY 2023 CODE IDENTIFIER

Instructions: Please provide the CPT Codes, Healthcare Common Procedure Coding System (HCPCS) codes, Diagnosis Related Groups (DRGs), J-Codes, and National Drug Codes (NDCs) or the best available code for all outpatient behavioral health services and items that were subject to Prior Authorization in 2023 by code. Include the below information for the calendar year 2023.

a)Please provide the CPT Codes, Healthcare Common Procedure Coding System (HCPCS) codes, Diagnosis Related Groups (DRGs), J-Codes, and National Drug Codes (NDCs) or the best available code for all services, items and prescriptions that were subject to Prior Authorization by code;
b)Name of service/Item;
c)Number of times patients/providers requested authorization for services;
d)For standard requests, average time to make a determination in calendar days;
e)For expedited requests, average time to make a determination by number of hours;
f)Number of requests authorized;
g)Number of requests modified downward. Please submit the total number of partial denials for each code. This category does not include pre-authorizations that were voided and replaced with a new authorization request.
h)Number of requests denied;
i)Number of reduced or denied requests appealed through the internal appeals process;
j)Number of internally appealed requests approved;
k)Number of internally appealed requests denied.
l) Please provide any additional comments within notes section.

Code including CPT and other Codes	Name of Service/Item	No. of Requests Made	Standard Time to Make Determination	Expedited Time to Make Determination	No. of Requests Authorized	No. of Requests Modified Downward	No. of Requests Denied	No. of Internal Appeals Filed	No. of Appeals Approved	No. of Appeals Denied	Notes

2023 OUTPATIENT AMBULATORY SURGERY PRIOR AUTHORIZATIONS BY 2023 CODE IDENTIFIER

Instructions: Please provide the CPT Codes, Healthcare Common Procedure Coding System (HCPCS) codes, Diagnosis Related Groups (DRGs), J-Codes, and National Drug Codes (NDCs) or the best available code for all outpatient ambulatory surgery services and items that were subject to Prior Authorization in 2023 by code. Include the below information for the calendar year 2023.

a)Please provide the CPT Codes, Healthcare Common Procedure Coding System (HCPCS) codes, Diagnosis Related Groups (DRGs), J-Codes, and National Drug Codes (NDCs) or the best available code for all services, items and prescriptions that were subject to Prior Authorization by code;
b)Name of service/Item;
c)Number of times patients/providers requested authorization for services;
d)For standard requests, average time to make a determination in calendar days;
e)For expedited requests, average time to make a determination by number of hours;
f)Number of requests authorized;
g)Number of requests modified downward. Please submit the total number of partial denials for each code. This category does not include pre-authorizations that were voided and replaced with a new authorization request.
h)Number of requests denied;
i)Number of reduced or denied requests appealed through the internal appeals process;
j)Number of internally appealed requests approved;
k)Number of internally appealed requests denied.
l) Please provide any additional comments within notes section.

Code including CPT and other Codes	Name of Service/Item	No. of Requests Made	Standard Time to Make Determination	Expedited Time to Make Determination	No. of Requests Authorized	No. of Requests Modified Downward	No. of Requests Denied	No. of Internal Appeals Filed	No. of Appeals Approved	No. of Appeals Denied	Notes

2023 OUTPATIENT RADIOLOGY PRIOR AUTHORIZATIONS BY 2023 CODE IDENTIFIER

Instructions: Please provide the CPT Codes, Healthcare Common Procedure Coding System (HCPCS) codes, Diagnosis Related Groups (DRGs), J-Codes, and National Drug Codes (NDCs) or the best available code for all outpatient radiology services and items that were subject to Prior Authorization in 2023 by code. Include the below information for the calendar year 2023.

a)Please provide the CPT Codes, Healthcare Common Procedure Coding System (HCPCS) codes, Diagnosis Related Groups (DRGs), J-Codes, and National Drug Codes (NDCs) or the best available code for all services, items and prescriptions that were subject to Prior Authorization by code;
b)Name of service/Item;
c)Number of times patients/providers requested authorization for services;
d)For standard requests, average time to make a determination in calendar days;
e)For expedited requests, average time to make a determination by number of hours;
f)Number of requests authorized;
g)Number of requests modified downward. Please submit the total number of partial denials for each code. This category does not include pre-authorizations that were voided and replaced with a new authorization request.
h)Number of requests denied;
i)Number of reduced or denied requests appealed through the internal appeals process;
j)Number of internally appealed requests approved;
k)Number of internally appealed requests denied.
l) Please provide any additional comments within notes section.

Code including CPT and other Codes	Name of Service/Item	No. of Requests Made	Standard Time to Make Determination	Expedited Time to Make Determination	No. of Requests Authorized	No. of Requests Modified Downward	No. of Requests Denied	No. of Internal Appeals Filed	No. of Appeals Approved	No. of Appeals Denied	Notes

2023 OUTPATIENT PT/OT/ST PRIOR AUTHORIZATIONS BY 2023 CODE IDENTIFIER

Instructions: Please provide the CPT Codes, Healthcare Common Procedure Coding System (HCPCS) codes, Diagnosis Related Groups (DRGs), J-Codes, and National Drug Codes (NDCs) or the best available code for all Outpatient Physical Therapy / Occupational Therapy / Speech Therapy services and items that were subject to Prior Authorization in 2023 by code. Include the below information for the calendar year 2023.

a)Please provide the CPT Codes, Healthcare Common Procedure Coding System (HCPCS) codes, Diagnosis Related Groups (DRGs), J-Codes, and National Drug Codes (NDCs) or the best available code for all services, items and prescriptions that were subject to Prior Authorization by code;
b)Name of service/Item;
c)Number of times patients/providers requested authorization for services;
d)For standard requests, average time to make a determination in calendar days;
e)For expedited requests, average time to make a determination by number of hours;
f)Number of requests authorized;
g)Number of requests modified downward. Please submit the total number of partial denials for each code. This category does not include pre-authorizations that were voided and replaced with a new authorization request.
h)Number of requests denied;
i)Number of reduced or denied requests appealed through the internal appeals process;
j)Number of internally appealed requests approved;
k)Number of internally appealed requests denied.
l) Please provide any additional comments within notes section.

Code including CPT and other Codes	Name of Service/Item	No. of Requests Made	Standard Time to Make Determination	Expedited Time to Make Determination	No. of Requests Authorized	No. of Requests Modified Downward	No. of Requests Denied	No. of Internal Appeals Filed	No. of Appeals Approved	No. of Appeals Denied	Notes

2023 OUTPATIENT HOME HEALTH/ POST-ACUTE CARE PRIOR AUTHORIZATIONS BY 2023 CODE

Instructions: Please provide the CPT Codes, Healthcare Common Procedure Coding System (HCPCS) codes, Diagnosis Related Groups (DRGs), J-Codes, and National Drug Codes (NDCs) or the best available code for all Outpatient Home Health and Post-Acute Care services, and items that were subject to Prior Authorization in 2023 by code. Include the below information for the calendar year 2023.

a)Please provide the CPT Codes, Healthcare Common Procedure Coding System (HCPCS) codes, Diagnosis Related Groups (DRGs), J-Codes, and National Drug Codes (NDCs) or the best available code for all services, items and prescriptions that were subject to Prior Authorization by code;
b)Name of service/Item;
c)Number of times patients/providers requested authorization for services;
d)For standard requests, average time to make a determination in calendar days;
e)For expedited requests, average time to make a determination by number of hours;
f)Number of requests authorized;
g)Number of requests modified downward. Please submit the total number of partial denials for each code. This category does not include pre-authorizations that were voided and replaced with a new authorization request.
h)Number of requests denied;
i)Number of reduced or denied requests appealed through the internal appeals process;
j)Number of internally appealed requests approved;
k)Number of internally appealed requests denied.
l) Please provide any additional comments within notes section.

Code including CPT and other Codes	Name of Service/Item	No. of Requests Made	Standard Time to Make Determination	Expedited Time to Make Determination	No. of Requests Authorized	No. of Requests Modified Downward	No. of Requests Denied	No. of Internal Appeals Filed	No. of Appeals Approved	No. of Appeals Denied	Notes

2023 OUTPATIENT DME/PROSTETHICS/MEDICAL SUPPLIES PRIOR AUTHORIZATIONS BY 2023 CODE

Instructions: Please provide the CPT Codes, Healthcare Common Procedure Coding System (HCPCS) codes, Diagnosis Related Groups (DRGs), J-Codes, and National Drug Codes (NDCs) or the best available code for all Outpatient DME/Prosthetics/Medical Supplies that were subject to Prior Authorization in 2023 by code. Include the below information for the calendar year 2023.

a)Please provide the CPT Codes, Healthcare Common Procedure Coding System (HCPCS) codes, Diagnosis Related Groups (DRGs), J-Codes, and National Drug Codes (NDCs) or the best available code for all services, items and prescriptions that were subject to Prior Authorization by code;
b)Name of service/Item;
c)Number of times patients/providers requested authorization for services;
d)For standard requests, average time to make a determination in calendar days;
e)For expedited requests, average time to make a determination by number of hours;
f)Number of requests authorized;
g)Number of requests modified downward. Please submit the total number of partial denials for each code. This category does not include pre-authorizations that were voided and replaced with a new authorization request.
h)Number of requests denied;
i)Number of reduced or denied requests appealed through the internal appeals process;
j)Number of internally appealed requests approved;
k)Number of internally appealed requests denied.
l) Please provide any additional comments within notes section.

Code including CPT and other Codes	Name of Service/Item	No. of Requests Made	Standard Time to Make Determination	Expedited Time to Make Determination	No. of Requests Authorized	No. of Requests Modified Downward	No. of Requests Denied	No. of Internal Appeals Filed	No. of Appeals Approved	No. of Appeals Denied	Notes

2023 OUTPATIENT ANCILLARY/OTHER SERVICES PRIOR AUTHORIZATIONS BY 2023 CODE

Instructions: Please provide the CPT Codes, Healthcare Common Procedure Coding System (HCPCS) codes, Diagnosis Related Groups (DRGs), J-Codes, and National Drug Codes (NDCs) or the best available code for all Outpateint Ancillary/Other Services sand items that were subject to Prior Authorization in 2023 by code. Include the below information for the calendar year 2023.

a)Please provide the CPT Codes, Healthcare Common Procedure Coding System (HCPCS) codes, Diagnosis Related Groups (DRGs), J-Codes, and National Drug Codes (NDCs) or the best available code for all services, items and prescriptions that were subject to Prior Authorization by code;
b)Name of service/Item;
c)Number of times patients/providers requested authorization for services;
d)For standard requests, average time to make a determination in calendar days;
e)For expedited requests, average time to make a determination by number of hours;
f)Number of requests authorized;
g)Number of requests modified downward. Please submit the total number of partial denials for each code. This category does not include pre-authorizations that were voided and replaced with a new authorization request.
h)Number of requests denied;
i)Number of reduced or denied requests appealed through the internal appeals process;
j)Number of internally appealed requests approved;
k)Number of internally appealed requests denied.
l) Please provide any additional comments within notes section.

Code including CPT and other Codes	Name of Service/Item	No. of Requests Made	Standard Time to Make Determination	Expedited Time to Make Determination	No. of Requests Authorized	No. of Requests Modified Downward	No. of Requests Denied	No. of Internal Appeals Filed	No. of Appeals Approved	No. of Appeals Denied	Notes

2023 DRUGS IN THE MEDICAL BENEFIT PRIOR AUTHORIZATIONS BY 2023 CODE IDENTIFIER

Instructions: Please provide the CPT Codes, Healthcare Common Procedure Coding System (HCPCS) codes, Diagnosis Related Groups (DRGs), J-Codes, and National Drug Codes (NDCs) or the best available code for all Drugs in the Medical Benefit that were subject to Prior Authorization in 2023 by code. Include the below information for the calendar year 2023.

a)Please provide the CPT Codes, Healthcare Common Procedure Coding System (HCPCS) codes, Diagnosis Related Groups (DRGs), J-Codes, and National Drug Codes (NDCs) or the best available code for all services, items and prescriptions that were subject to Prior Authorization by code;
b)Name of service/Item;
c)Number of times patients/providers requested authorization for services;
d)For standard requests, average time to make a determination in calendar days;
e)For expedited requests, average time to make a determination by number of hours;
f)Number of requests authorized;
g)Number of requests modified downward. Please submit the total number of partial denials for each code. This category does not include pre-authorizations that were voided and replaced with a new authorization request.
h)Number of requests denied;
i)Number of reduced or denied requests appealed through the internal appeals process;
j)Number of internally appealed requests approved;
k)Number of internally appealed requests denied.
l) Please provide any additional comments within notes section.

Code including CPT and other Codes	Name of Service/Item	No. of Requests Made	Standard Time to Make Determination	Expedited Time to Make Determination	No. of Requests Authorized	No. of Requests Modified Downward	No. of Requests Denied	No. of Internal Appeals Filed	No. of Appeals Approved	No. of Appeals Denied	Notes

2023 GENERIC DRUGS PRIOR AUTHORIZATIONS BY 2023 CODE IDENTIFIER

Instructions: Please provide the CPT Codes, Healthcare Common Procedure Coding System (HCPCS) codes, Diagnosis Related Groups (DRGs), J-Codes, and National Drug Codes (NDCs) or the best available code for all generic drugs that were subject to Prior Authorization in 2023 by code. Include the below information for the calendar year 2023.

a)Please provide the CPT Codes, Healthcare Common Procedure Coding System (HCPCS) codes, Diagnosis Related Groups (DRGs), J-Codes, and National Drug Codes (NDCs) or the best available code for all services, items and prescriptions that were subject to Prior Authorization by code;
b)Name of service/Item;
c)Number of times patients/providers requested authorization for services;
d)For standard requests, average time to make a determination in calendar days;
e)For expedited requests, average time to make a determination by number of hours;
f)Number of requests authorized;
g)Number of requests modified downward. Please submit the total number of partial denials for each code. This category does not include pre-authorizations that were voided and replaced with a new authorization request.
h)Number of requests denied;
i)Number of reduced or denied requests appealed through the internal appeals process;
j)Number of internally appealed requests approved;
k)Number of internally appealed requests denied.
l) Please provide any additional comments within notes section.

Code including CPT and other Codes	Name of Service/Item	No. of Requests Made	Standard Time to Make Determination	Expedited Time to Make Determination	No. of Requests Authorized	No. of Requests Modified Downward	No. of Requests Denied	No. of Internal Appeals Filed	No. of Appeals Approved	No. of Appeals Denied	Notes

2023 BRAND NAME DRUGS PRIOR AUTHORIZATIONS BY 2023 CODE IDENTIFIER

Instructions: Please provide the CPT Codes, Healthcare Common Procedure Coding System (HCPCS) codes, Diagnosis Related Groups (DRGs), J-Codes, and National Drug Codes (NDCs) or the best available code for all brand name drugs that were subject to Prior Authorization in 2023 by code. Include the below information for the calendar year 2023.

a)Please provide the CPT Codes, Healthcare Common Procedure Coding System (HCPCS) codes, Diagnosis Related Groups (DRGs), J-Codes, and National Drug Codes (NDCs) or the best available code for all services, items and prescriptions that were subject to Prior Authorization by code;
b)Name of service/Item;
c)Number of times patients/providers requested authorization for services;
d)For standard requests, average time to make a determination in calendar days;
e)For expedited requests, average time to make a determination by number of hours;
f)Number of requests authorized;
g)Number of requests modified downward. Please submit the total number of partial denials for each code. This category does not include pre-authorizations that were voided and replaced with a new authorization request.
h)Number of requests denied;
i)Number of reduced or denied requests appealed through the internal appeals process;
j)Number of internally appealed requests approved;
k)Number of internally appealed requests denied.
l) Please provide any additional comments within notes section.

Code including CPT and other Codes	Name of Service/Item	No. of Requests Made	Standard Time to Make Determination	Expedited Time to Make Determination	No. of Requests Authorized	No. of Requests Modified Downward	No. of Requests Denied	No. of Internal Appeals Filed	No. of Appeals Approved	No. of Appeals Denied	Notes

2023 SPECIALTY DRUGS PRIOR AUTHORIZATIONS BY 2023 CODE IDENTIFIER

Instructions: Please provide the CPT Codes, Healthcare Common Procedure Coding System (HCPCS) codes, Diagnosis Related Groups (DRGs), J-Codes, and National Drug Codes (NDCs) or the best available code for all speciality drugs that were subject to Prior Authorization in 2023 by code. Include the below information for the calendar year 2023.

a)Please provide the CPT Codes, Healthcare Common Procedure Coding System (HCPCS) codes, Diagnosis Related Groups (DRGs), J-Codes, and National Drug Codes (NDCs) or the best available code for all services, items and prescriptions that were subject to Prior Authorization by code;
b)Name of service/Item;
c)Number of times patients/providers requested authorization for services;
d)For standard requests, average time to make a determination in calendar days;
e)For expedited requests, average time to make a determination by number of hours;
f)Number of requests authorized;
g)Number of requests modified downward. Please submit the total number of partial denials for each code. This category does not include pre-authorizations that were voided and replaced with a new authorization request.
h)Number of requests denied;
i)Number of reduced or denied requests appealed through the internal appeals process;
j)Number of internally appealed requests approved;
k)Number of internally appealed requests denied.
l) Please provide any additional comments within notes section.

Code including CPT and other Codes	Name of Service/Item	No. of Requests Made	Standard Time to Make Determination	Expedited Time to Make Determination	No. of Requests Authorized	No. of Requests Modified Downward	No. of Requests Denied	No. of Internal Appeals Filed	No. of Appeals Approved	No. of Appeals Denied	Notes

CODES CURRENTLY SUBJECT TO PRIOR AUTHORIZATION THAT WILL BE VOLUNTARILY RETIRED BY 1/1/2024

Code including CPT and other Codes	Name of Service/Item	Notes

2024 INPATIENT NON-BEHAVIORAL HEALTH PRIOR AUTHORIZATIONS BY 2024 CODE IDENTIFIER

Instructions: Please provide the CPT Codes, Healthcare Common Procedure Coding System (HCPCS) codes, Diagnosis Related Groups (DRGs), J-Codes, and National Drug Codes (NDCs) or the best available code for all inpatient non-behavioral health services and items that were subject to Prior Authorization in 2024 by code. Include the below information for the calendar year 2024.

a)Please provide the CPT Codes, Healthcare Common Procedure Coding System (HCPCS) codes, Diagnosis Related Groups (DRGs), J-Codes, and National Drug Codes (NDCs) or the best available code for all services, items and prescriptions that were subject to Prior Authorization by code;
b)Name of service/Item;
c)Number of times patients/providers requested authorization for services;
d)For standard requests, average time to make a determination in calendar days;
e)For expedited requests, average time to make a determination by number of hours;
f)Number of requests authorized;
g)Number of requests modified downward. Please submit the total number of partial denials for each code. This category does not include pre-authorizations that were voided and replaced with a new authorization request.
h)Number of requests denied;
i)Number of reduced or denied requests appealed through the internal appeals process;
j)Number of internally appealed requests approved;
k)Number of internally appealed requests denied.
l) Please provide any additional comments within notes section.

Code including CPT and other Codes	Name of Service/Item	No. of Requests Made	Standard Time to Make Determination	Expedited Time to Make Determination	No. of Requests Authorized	No. of Requests Modified Downward	No. of Requests Denied	No. of Internal Appeals Filed	No. of Appeals Approved	No. of Appeals Denied	Notes

2024 INPATIENT BEHAVIORAL HEALTH PRIOR AUTHORIZATIONS BY 2024 CODE IDENTIFIER

Instructions: Please provide the CPT Codes, Healthcare Common Procedure Coding System (HCPCS) codes, Diagnosis Related Groups (DRGs), J-Codes, and National Drug Codes (NDCs) or the best available code for all inpatient behavioral health services and items that were subject to Prior Authorization in 2024 by code. Include the below information for the calendar year 2024.

a)Please provide the CPT Codes, Healthcare Common Procedure Coding System (HCPCS) codes, Diagnosis Related Groups (DRGs), J-Codes, and National Drug Codes (NDCs) or the best available code for all services, items and prescriptions that were subject to Prior Authorization by code;
b)Name of service/Item;
c)Number of times patients/providers requested authorization for services;
d)For standard requests, average time to make a determination in calendar days;
e)For expedited requests, average time to make a determination by number of hours;
f)Number of requests authorized;
g)Number of requests modified downward. Please submit the total number of partial denials for each code. This category does not include pre-authorizations that were voided and replaced with a new authorization request.
h)Number of requests denied;
i)Number of reduced or denied requests appealed through the internal appeals process;
j)Number of internally appealed requests approved;
k)Number of internally appealed requests denied.
l) Please provide any additional comments within notes section.

Code including CPT and other Codes	Name of Service/Item	No. of Requests Made	Standard Time to Make Determination	Expedited Time to Make Determination	No. of Requests Authorized	No. of Requests Modified Downward	No. of Requests Denied	No. of Internal Appeals Filed	No. of Appeals Approved	No. of Appeals Denied	Notes

2024 OUTPATIENT MEDICAL/SURGICAL OFFICE VISIT PRIOR AUTHORIZATIONS BY 2024 CODE

Instructions: Please provide the CPT Codes, Healthcare Common Procedure Coding System (HCPCS) codes, Diagnosis Related Groups (DRGs), J-Codes, and National Drug Codes (NDCs) or the best available code for all outpatient medical/surgical office visit services and items that were subject to Prior Authorization in 2024 by code. Include the below information for the calendar year 2024.

a)Please provide the CPT Codes, Healthcare Common Procedure Coding System (HCPCS) codes, Diagnosis Related Groups (DRGs), J-Codes, and National Drug Codes (NDCs) or the best available code for all services, items and prescriptions that were subject to Prior Authorization by code;
b)Name of service/Item;
c)Number of times patients/providers requested authorization for services;
d)For standard requests, average time to make a determination in calendar days;
e)For expedited requests, average time to make a determination by number of hours;
f)Number of requests authorized;
g)Number of requests modified downward. Please submit the total number of partial denials for each code. This category does not include pre-authorizations that were voided and replaced with a new authorization request.
h)Number of requests denied;
i)Number of reduced or denied requests appealed through the internal appeals process;
j)Number of internally appealed requests approved;
k)Number of internally appealed requests denied.
l) Please provide any additional comments within notes section.

Code including CPT and other Codes	Name of Service/Item	No. of Requests Made	Standard Time to Make Determination	Expedited Time to Make Determination	No. of Requests Authorized	No. of Requests Modified Downward	No. of Requests Denied	No. of Internal Appeals Filed	No. of Appeals Approved	No. of Appeals Denied	Notes

2024 OUTPATIENT BEHAVIORAL HEALTH PRIOR AUTHORIZATIONS BY 2024 CODE IDENTIFIER

Instructions: Please provide the CPT Codes, Healthcare Common Procedure Coding System (HCPCS) codes, Diagnosis Related Groups (DRGs), J-Codes, and National Drug Codes (NDCs) or the best available code for all outpatient behavioral health services and items that were subject to Prior Authorization in 2024 by code. Include the below information for the calendar year 2024.

a)Please provide the CPT Codes, Healthcare Common Procedure Coding System (HCPCS) codes, Diagnosis Related Groups (DRGs), J-Codes, and National Drug Codes (NDCs) or the best available code for all services, items and prescriptions that were subject to Prior Authorization by code;
b)Name of service/Item;
c)Number of times patients/providers requested authorization for services;
d)For standard requests, average time to make a determination in calendar days;
e)For expedited requests, average time to make a determination by number of hours;
f)Number of requests authorized;
g)Number of requests modified downward. Please submit the total number of partial denials for each code. This category does not include pre-authorizations that were voided and replaced with a new authorization request.
h)Number of requests denied;
i)Number of reduced or denied requests appealed through the internal appeals process;
j)Number of internally appealed requests approved;
k)Number of internally appealed requests denied.
l) Please provide any additional comments within notes section.

Code including CPT and other Codes	Name of Service/Item	No. of Requests Made	Standard Time to Make Determination	Expedited Time to Make Determination	No. of Requests Authorized	No. of Requests Modified Downward	No. of Requests Denied	No. of Internal Appeals Filed	No. of Appeals Approved	No. of Appeals Denied	Notes

2024 OUTPATIENT AMBULATORY SURGERY PRIOR AUTHORIZATIONS BY 2024 CODE IDENTIFIER

Instructions: Please provide the CPT Codes, Healthcare Common Procedure Coding System (HCPCS) codes, Diagnosis Related Groups (DRGs), J-Codes, and National Drug Codes (NDCs) or the best available code for all outpatient ambulatory surgery services and items that were subject to Prior Authorization in 2024 by code. Include the below information for the calendar year 2024.

a)Please provide the CPT Codes, Healthcare Common Procedure Coding System (HCPCS) codes, Diagnosis Related Groups (DRGs), J-Codes, and National Drug Codes (NDCs) or the best available code for all services, items and prescriptions that were subject to Prior Authorization by code;
b)Name of service/Item;
c)Number of times patients/providers requested authorization for services;
d)For standard requests, average time to make a determination in calendar days;
e)For expedited requests, average time to make a determination by number of hours;
f)Number of requests authorized;
g)Number of requests modified downward. Please submit the total number of partial denials for each code. This category does not include pre-authorizations that were voided and replaced with a new authorization request.
h)Number of requests denied;
i)Number of reduced or denied requests appealed through the internal appeals process;
j)Number of internally appealed requests approved;
k)Number of internally appealed requests denied.
l) Please provide any additional comments within notes section.

Code including CPT and other Codes	Name of Service/Item	No. of Requests Made	Standard Time to Make Determination	Expedited Time to Make Determination	No. of Requests Authorized	No. of Requests Modified Downward	No. of Requests Denied	No. of Internal Appeals Filed	No. of Appeals Approved	No. of Appeals Denied	Notes

2024 OUTPATIENT RADIOLOGY PRIOR AUTHORIZATIONS BY 2024 CODE IDENTIFIER

Instructions: Please provide the CPT Codes, Healthcare Common Procedure Coding System (HCPCS) codes, Diagnosis Related Groups (DRGs), J-Codes, and National Drug Codes (NDCs) or the best available code for all outpatient radiology services and items that were subject to Prior Authorization in 2024 by code. Include the below information for the calendar year 2024.

a)Please provide the CPT Codes, Healthcare Common Procedure Coding System (HCPCS) codes, Diagnosis Related Groups (DRGs), J-Codes, and National Drug Codes (NDCs) or the best available code for all services, items and prescriptions that were subject to Prior Authorization by code;
b)Name of service/Item;
c)Number of times patients/providers requested authorization for services;
d)For standard requests, average time to make a determination in calendar days;
e)For expedited requests, average time to make a determination by number of hours;
f)Number of requests authorized;
g)Number of requests modified downward. Please submit the total number of partial denials for each code. This category does not include pre-authorizations that were voided and replaced with a new authorization request.
h)Number of requests denied;
i)Number of reduced or denied requests appealed through the internal appeals process;
j)Number of internally appealed requests approved;
k)Number of internally appealed requests denied.
l) Please provide any additional comments within notes section.

Code including CPT and other Codes	Name of Service/Item	No. of Requests Made	Standard Time to Make Determination	Expedited Time to Make Determination	No. of Requests Authorized	No. of Requests Modified Downward	No. of Requests Denied	No. of Internal Appeals Filed	No. of Appeals Approved	No. of Appeals Denied	Notes

2024 OUTPATIENT PT/OT/ST PRIOR AUTHORIZATIONS BY 2024 CODE IDENTIFIER

Instructions: Please provide the CPT Codes, Healthcare Common Procedure Coding System (HCPCS) codes, Diagnosis Related Groups (DRGs), J-Codes, and National Drug Codes (NDCs) or the best available code for all Outpatient Physical Therapy / Occupational Therapy / Speech Therapy services and items that were subject to Prior Authorization in 2024 by code. Include the below information for the calendar year 2024.

a)Please provide the CPT Codes, Healthcare Common Procedure Coding System (HCPCS) codes, Diagnosis Related Groups (DRGs), J-Codes, and National Drug Codes (NDCs) or the best available code for all services, items and prescriptions that were subject to Prior Authorization by code;
b)Name of service/Item;
c)Number of times patients/providers requested authorization for services;
d)For standard requests, average time to make a determination in calendar days;
e)For expedited requests, average time to make a determination by number of hours;
f)Number of requests authorized;
g)Number of requests modified downward. Please submit the total number of partial denials for each code. This category does not include pre-authorizations that were voided and replaced with a new authorization request.
h)Number of requests denied;
i)Number of reduced or denied requests appealed through the internal appeals process;
j)Number of internally appealed requests approved;
k)Number of internally appealed requests denied.
l) Please provide any additional comments within notes section.

Code including CPT and other Codes	Name of Service/Item	No. of Requests Made	Standard Time to Make Determination	Expedited Time to Make Determination	No. of Requests Authorized	No. of Requests Modified Downward	No. of Requests Denied	No. of Internal Appeals Filed	No. of Appeals Approved	No. of Appeals Denied	Notes

2024 OUTPATIENT HOME HEALTH/ POST-ACUTE CARE PRIOR AUTHORIZATIONS BY 2024 CODE

Instructions: Please provide the CPT Codes, Healthcare Common Procedure Coding System (HCPCS) codes, Diagnosis Related Groups (DRGs), J-Codes, and National Drug Codes (NDCs) or the best available code for all Outpatient Home Health and Post-Acute Care services, and items that were subject to Prior Authorization in 2024 by code. Include the below information for the calendar year 2024.

a)Please provide the CPT Codes, Healthcare Common Procedure Coding System (HCPCS) codes, Diagnosis Related Groups (DRGs), J-Codes, and National Drug Codes (NDCs) or the best available code for all services, items and prescriptions that were subject to Prior Authorization by code;
b)Name of service/Item;
c)Number of times patients/providers requested authorization for services;
d)For standard requests, average time to make a determination in calendar days;
e)For expedited requests, average time to make a determination by number of hours;
f)Number of requests authorized;
g)Number of requests modified downward. Please submit the total number of partial denials for each code. This category does not include pre-authorizations that were voided and replaced with a new authorization request.
h)Number of requests denied;
i)Number of reduced or denied requests appealed through the internal appeals process;
j)Number of internally appealed requests approved;
k)Number of internally appealed requests denied.
l) Please provide any additional comments within notes section.

Code including CPT and other Codes	Name of Service/Item	No. of Requests Made	Standard Time to Make Determination	Expedited Time to Make Determination	No. of Requests Authorized	No. of Requests Modified Downward	No. of Requests Denied	No. of Internal Appeals Filed	No. of Appeals Approved	No. of Appeals Denied	Notes

2024 OUTPATIENT PATHOLOGY/LAB PRIOR AUTHORIZATIONS BY 2024 CODE IDENTIFIER

Instructions: Please provide the CPT Codes, Healthcare Common Procedure Coding System (HCPCS) codes, Diagnosis Related Groups (DRGs), J-Codes, and National Drug Codes (NDCs) or the best available code for all Outpatient Pathology/Lab, including Genetic Testing services and items that were subject to Prior Authorization in 2024 by code. Include the below information for the calendar year 2024.

a)Please provide the CPT Codes, Healthcare Common Procedure Coding System (HCPCS) codes, Diagnosis Related Groups (DRGs), J-Codes, and National Drug Codes (NDCs) or the best available code for all services, items and prescriptions that were subject to Prior Authorization by code;
b)Name of service/Item;
c)Number of times patients/providers requested authorization for services;
d)For standard requests, average time to make a determination in calendar days;
e)For expedited requests, average time to make a determination by number of hours;
f)Number of requests authorized;
g)Number of requests modified downward. Please submit the total number of partial denials for each code. This category does not include pre-authorizations that were voided and replaced with a new authorization request.
h)Number of requests denied;
i)Number of reduced or denied requests appealed through the internal appeals process;
j)Number of internally appealed requests approved;
k)Number of internally appealed requests denied.
l) Please provide any additional comments within notes section.

Code including CPT and other Codes	Name of Service/Item	No. of Requests Made	Standard Time to Make Determination	Expedited Time to Make Determination	No. of Requests Authorized	No. of Requests Modified Downward	No. of Requests Denied	No. of Internal Appeals Filed	No. of Appeals Approved	No. of Appeals Denied	Notes

2024 OUTPATIENT DME/PROSTETHICS/MEDICAL SUPPLIES PRIOR AUTHORIZATIONS BY 2024 CODE

Instructions: Please provide the CPT Codes, Healthcare Common Procedure Coding System (HCPCS) codes, Diagnosis Related Groups (DRGs), J-Codes, and National Drug Codes (NDCs) or the best available code for all Outpatient DME/Prosthetics/Medical Supplies that were subject to Prior Authorization in 2024 by code. Include the below information for the calendar year 2024.

a)Please provide the CPT Codes, Healthcare Common Procedure Coding System (HCPCS) codes, Diagnosis Related Groups (DRGs), J-Codes, and National Drug Codes (NDCs) or the best available code for all services, items and prescriptions that were subject to Prior Authorization by code;
b)Name of service/Item;
c)Number of times patients/providers requested authorization for services;
d)For standard requests, average time to make a determination in calendar days;
e)For expedited requests, average time to make a determination by number of hours;
f)Number of requests authorized;
g)Number of requests modified downward. Please submit the total number of partial denials for each code. This category does not include pre-authorizations that were voided and replaced with a new authorization request.
h)Number of requests denied;
i)Number of reduced or denied requests appealed through the internal appeals process;
j)Number of internally appealed requests approved;
k)Number of internally appealed requests denied.
l) Please provide any additional comments within notes section.

Code including CPT and other Codes	Name of Service/Item	No. of Requests Made	Standard Time to Make Determination	Expedited Time to Make Determination	No. of Requests Authorized	No. of Requests Modified Downward	No. of Requests Denied	No. of Internal Appeals Filed	No. of Appeals Approved	No. of Appeals Denied	Notes

2024 OUTPATIENT ANCILLARY/OTHER SERVICES PRIOR AUTHORIZATIONS BY 2024 CODE

Instructions: Please provide the CPT Codes, Healthcare Common Procedure Coding System (HCPCS) codes, Diagnosis Related Groups (DRGs), J-Codes, and National Drug Codes (NDCs) or the best available code for all Outpatient Ancillary/Other Services and items that were subject to Prior Authorization in 2024 by code. Include the below information for the calendar year 2024.

a)Please provide the CPT Codes, Healthcare Common Procedure Coding System (HCPCS) codes, Diagnosis Related Groups (DRGs), J-Codes, and National Drug Codes (NDCs) or the best available code for all services, items and prescriptions that were subject to Prior Authorization by code;
b)Name of service/Item;
c)Number of times patients/providers requested authorization for services;
d)For standard requests, average time to make a determination in calendar days;
e)For expedited requests, average time to make a determination by number of hours;
f)Number of requests authorized;
g)Number of requests modified downward. Please submit the total number of partial denials for each code. This category does not include pre-authorizations that were voided and replaced with a new authorization request.
h)Number of requests denied;
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j)Number of internally appealed requests approved;
k)Number of internally appealed requests denied.
l) Please provide any additional comments within notes section.

Code including CPT and other Codes	Name of Service/Item	No. of Requests Made	Standard Time to Make Determination	Expedited Time to Make Determination	No. of Requests Authorized	No. of Requests Modified Downward	No. of Requests Denied	No. of Internal Appeals Filed	No. of Appeals Approved	No. of Appeals Denied	Notes

2024 DRUGS IN THE MEDICAL BENEFIT PRIOR AUTHORIZATIONS BY 2024 CODE IDENTIFIER

Instructions: Please provide the CPT Codes, Healthcare Common Procedure Coding System (HCPCS) codes, Diagnosis Related Groups (DRGs), J-Codes, and National Drug Codes (NDCs) or the best available code for all Drugs in the Medical Benefit that were subject to Prior Authorization in 2024 by code. Include the below information for the calendar year 2024.

a)Please provide the CPT Codes, Healthcare Common Procedure Coding System (HCPCS) codes, Diagnosis Related Groups (DRGs), J-Codes, and National Drug Codes (NDCs) or the best available code for all services, items and prescriptions that were subject to Prior Authorization by code;
b)Name of service/Item;
c)Number of times patients/providers requested authorization for services;
d)For standard requests, average time to make a determination in calendar days;
e)For expedited requests, average time to make a determination by number of hours;
f)Number of requests authorized;
g)Number of requests modified downward. Please submit the total number of partial denials for each code. This category does not include pre-authorizations that were voided and replaced with a new authorization request.
h)Number of requests denied;
i)Number of reduced or denied requests appealed through the internal appeals process;
j)Number of internally appealed requests approved;
k)Number of internally appealed requests denied.
l) Please provide any additional comments within notes section.

Code including CPT and other Codes	Name of Service/Item	No. of Requests Made	Standard Time to Make Determination	Expedited Time to Make Determination	No. of Requests Authorized	No. of Requests Modified Downward	No. of Requests Denied	No. of Internal Appeals Filed	No. of Appeals Approved	No. of Appeals Denied	Notes

2024 GENERIC DRUGS PRIOR AUTHORIZATIONS BY 2024 CODE IDENTIFIER

Instructions: Please provide the CPT Codes, Healthcare Common Procedure Coding System (HCPCS) codes, Diagnosis Related Groups (DRGs), J-Codes, and National Drug Codes (NDCs) or the best available code for all generic drugs that were subject to Prior Authorization in 2024 by code. Include the below information for the calendar year 2024.

a)Please provide the CPT Codes, Healthcare Common Procedure Coding System (HCPCS) codes, Diagnosis Related Groups (DRGs), J-Codes, and National Drug Codes (NDCs) or the best available code for all services, items and prescriptions that were subject to Prior Authorization by code;
b)Name of service/Item;
c)Number of times patients/providers requested authorization for services;
d)For standard requests, average time to make a determination in calendar days;
e)For expedited requests, average time to make a determination by number of hours;
f)Number of requests authorized;
g)Number of requests modified downward. Please submit the total number of partial denials for each code. This category does not include pre-authorizations that were voided and replaced with a new authorization request.
h)Number of requests denied;
i)Number of reduced or denied requests appealed through the internal appeals process;
j)Number of internally appealed requests approved;
k)Number of internally appealed requests denied.
l) Please provide any additional comments within notes section.

Code including CPT and other Codes	Name of Service/Item	No. of Requests Made	Standard Time to Make Determination	Expedited Time to Make Determination	No. of Requests Authorized	No. of Requests Modified Downward	No. of Requests Denied	No. of Internal Appeals Filed	No. of Appeals Approved	No. of Appeals Denied	Notes

2024 BRAND NAME DRUGS PRIOR AUTHORIZATIONS BY 2024 CODE IDENTIFIER

Instructions: Please provide the CPT Codes, Healthcare Common Procedure Coding System (HCPCS) codes, Diagnosis Related Groups (DRGs), J-Codes, and National Drug Codes (NDCs) or the best available code for all brand name drugs that were subject to Prior Authorization in 2024 by code. Include the below information for the calendar year 2024.

a)Please provide the CPT Codes, Healthcare Common Procedure Coding System (HCPCS) codes, Diagnosis Related Groups (DRGs), J-Codes, and National Drug Codes (NDCs) or the best available code for all services, items and prescriptions that were subject to Prior Authorization by code;
b)Name of service/Item;
c)Number of times patients/providers requested authorization for services;
d)For standard requests, average time to make a determination in calendar days;
e)For expedited requests, average time to make a determination by number of hours;
f)Number of requests authorized;
g)Number of requests modified downward. Please submit the total number of partial denials for each code. This category does not include pre-authorizations that were voided and replaced with a new authorization request.
h)Number of requests denied;
i)Number of reduced or denied requests appealed through the internal appeals process;
j)Number of internally appealed requests approved;
k)Number of internally appealed requests denied.
l) Please provide any additional comments within notes section.

Code including CPT and other Codes	Name of Service/Item	No. of Requests Made	Standard Time to Make Determination	Expedited Time to Make Determination	No. of Requests Authorized	No. of Requests Modified Downward	No. of Requests Denied	No. of Internal Appeals Filed	No. of Appeals Approved	No. of Appeals Denied	Notes

2024 SPECIALTY DRUGS PRIOR AUTHORIZATIONS BY 2024 CODE IDENTIFIER

Instructions: Please provide the CPT Codes, Healthcare Common Procedure Coding System (HCPCS) codes, Diagnosis Related Groups (DRGs), J-Codes, and National Drug Codes (NDCs) or the best available code for all speciality drugs that were subject to Prior Authorization in 2024 by code. Include the below information for the calendar year 2024.

a)Please provide the CPT Codes, Healthcare Common Procedure Coding System (HCPCS) codes, Diagnosis Related Groups (DRGs), J-Codes, and National Drug Codes (NDCs) or the best available code for all services, items and prescriptions that were subject to Prior Authorization by code;
b)Name of service/Item;
c)Number of times patients/providers requested authorization for services;
d)For standard requests, average time to make a determination in calendar days;
e)For expedited requests, average time to make a determination by number of hours;
f)Number of requests authorized;
g)Number of requests modified downward. Please submit the total number of partial denials for each code. This category does not include pre-authorizations that were voided and replaced with a new authorization request.
h)Number of requests denied;
i)Number of reduced or denied requests appealed through the internal appeals process;
j)Number of internally appealed requests approved;
k)Number of internally appealed requests denied.
l) Please provide any additional comments within notes section.

Code including CPT and other Codes	Name of Service/Item	No. of Requests Made	Standard Time to Make Determination	Expedited Time to Make Determination	No. of Requests Authorized	No. of Requests Modified Downward	No. of Requests Denied	No. of Internal Appeals Filed	No. of Appeals Approved	No. of Appeals Denied	Notes

CODES CURRENTLY SUBJECT TO PRIOR AUTHORIZATION THAT WILL BE VOLUNTARILY RETIRED BY 1/1/2025

Code including CPT and other Codes	Name of Service/Item	Notes

CODES CURRENTLY SUBJECT TO PRIOR AUTHORIZATION THAT WILL BE VOLUNTARILY RETIRED BY 1/1/2026

Code including CPT and other Codes	Name of Service/Item	Notes

Please provide responses to the following:

Continuity of Previous Authorizations: the health insurance carrier is to explain how it will administer treatment authorizations that incoming member-patient authorizations previously received from another insurance carrier for at least 90 days from the date that the in-taking health insurance carrier learns of the previous authorization.

Chronic Care, Primary Care and Behavioral Health Services: the health insurance carrier is to include its plans to require longer validity periods (at least 90 days) for authorizations for those Chronic Care, Primary Care and Behavioral Health services identified in category (1); such efforts shall be consistent with the terms of MGL c. 26, section 8K.

Urgent Care Response Times: the health insurance carrier is to identify its current and planned protocols (as of January 1, 2026) for responding to providers' urgent care authorization requests towards the goal of providing appropriate responses within 24 hours of receiving all necessary information needed from the requesting facility to process such requests. Urgent Care will be considered as all care delivered in an urgent care setting not including care provided in an Emergency Room (ER) setting.

APPENDIX D
PROSPECTIVE REVIEW EXPERIENCE BY CATEGORY

INPATIENT

Inpatient Non-Behavioral Health
PR Requests

	CY 2023	CY 2024
Total Requests	21,517	22,052
% Approved	94%	93%
% Modified Downward	2%	1%
% Denied	4%	6%

Inpatient Behavioral Health
PR Requests

	CY 2023	CY 2024
Total Requests	5,972	106
% Approved	99%	97%
% Modified Downward	0%	0%
% Denied	1%	3%

OUTPATIENT

Outpatient MedSurg Office Visits
PR Requests

	CY 2023	CY 2024
Total Requests	36,718	44,922
% Approved	82%	81%
% Modified Downward	1%	1%
% Denied	16%	18%

Outpatient Home Health
PR Requests

	CY 2023	CY 2024
Total Requests	17,016	10,820
% Approved	97%	92%
% Modified Downward	1%	1%
% Denied	1%	4%

Outpatient Behavioral Health
PR Requests

	CY 2023	CY 2024
Total Requests	35,756	43,987
% Approved	82%	81%
% Modified Downward	1%	1%
% Denied	16%	18%

Outpatient Pathology/Laboratory
PR Requests

	CY 2023	CY 2024
Total Requests	97,477	111,663
% Approved	71%	64%
% Modified Downward	1%	1%
% Denied	28%	33%

Outpatient Ambulatory Surgery
PR Requests

	CY 2023	CY 2024
Total Requests	45,615	63,540
% Approved	91%	91%
% Modified Downward	1%	0%
% Denied	7%	8%

Outpatient DME/PROS/MED SUPPLIES
PR Requests

	CY 2023	CY 2024
Total Requests	245,320	225,387
% Approved	96%	95%
% Modified Downward	0.3%	0.5%
% Denied	4%	3%

Outpatient Radiology
PR Requests

	CY 2023	CY 2024
Total Requests	459,254	503,052
% Approved	89%	89%
% Modified Downward	0.3%	0%
% Denied	10%	10%

Outpatient Ancillary/ Other
PR Requests

	CY 2023	CY 2024
Total Requests	89,503	87,822
% Approved	85%	75%
% Modified Downward	2%	12%
% Denied	12%	13%

Outpatient PT_OT_ST
PR Requests

	CY 2023	CY 2024
Total Requests	39,470	35,566
% Approved	99%	98%
% Modified Downward	0.4%	1%
% Denied	0.6%	1%

DRUGS IN MEDICAL BENEFIT & PRESCRIPTIONS

Drugs in Medical Benefit
PR Requests

	CY 2023	CY 2024
Total Requests	47,906	50,960
% Approved	96%	94%
% Modified Downward	0%	1%
% Denied	4%	6%

Branded Drugs
PR Requests

	CY 2023	CY 2024
Total Requests	122,850	213,215
% Approved	78%	80%
% Modified Downward	0.1%	0%
% Denied	22%	20%

Generic Drugs
PR Requests

	CY 2023	CY 2024
Total Requests	38,459	40,370
% Approved	78%	81%
% Modified Downward	0.4%	0%
% Denied	22%	19%

Specialty Drugs
PR Requests

	CY 2023	CY 2024
Total Requests	40,888	51,468
% Approved	89%	91%
% Modified Downward	1%	0%
% Denied	10%	10%