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

To follow new federal rules, Aetna must share certain information each year on our website.

We must post a list of all medical items and services (not including medicines) that need prior authorization. We also have to share numbers from the past year that show how many prior authorization requests we got, how many were approved, and how many were denied. Sharing this information helps everyone see how the process works. It also helps patients understand what to expect and lets doctors compare how different health plans perform.

If you have questions about the information below, please contact: 1-833-570-6671.

Reporting Period: 2025
Product: Medicare Advantage
Contract: H3219

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

2025 Participating provider precertification list for Aetna

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

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

Beginning January 1, 2026, the CMS Interoperability and Prior Authorization final rule requires Medicare Advantage plans and applicable integrated plans to send prior authorization decisions within:

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

Standard (non-urgent) Prior Authorization Requests

	Percentage
Request approved	88.53%
Request denied	11.47%
Request approved after appeal	80.43%

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

	Percentage
Request approved	86.86%
Request denied	13.14%

Prior Authorizations Extended and Approved

	Percentage
Request approved after time for review was extended	N/A

Time Between Receiving a Prior Authorization Request and Determination

	Mean (Average) Time	Median (Middle) Time
Standard (non-urgent) Prior Authorization Requests (response due to provider within 14 calendar days)	2.28 day(s)	1 day(s)
Expedited (urgent) Prior Authorization Requests (response due to provider within 72 hours)	0.65 day(s)	0 day(s)

See Evidence of Coverage for a complete description of plan benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by service area.

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