mercy care | ARIZONA DEPARTMENT OF CHILD SAFETY Comprehensive Health Plan

Prior authorization metrics for medical items and services (excluding drugs)

To comply with the CMS Interoperability and Prior Authorization Final Rule, Mercy Care is required to annually report aggregated prior authorization metrics on our website.
Specifically, this includes a list of all medical items and services (excluding drugs) that require prior authorization, as well as data on prior authorization requests for those items and services (e.g., approvals, denials, etc.) over the previous calendar year. Publicly reporting these metrics promotes transparency and accountability, helps patients understand prior authorization processes, and enables providers to evaluate payer performance. In addition, metrics can be used to compare plans, programs, and payers. For questions on the data below, contact: mercycarepriorauthorization@mercycareaz.org.

Reporting Period: 2025
Product: Department of Child Safety Comprehensive Health Plan (DCS CHP)

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

- PA tool for Mercy Care ACC-RBHA, Long Term Care, Developmental Disabilities, DCS CHP and Mercy Care Advantage

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

- For MA plans and applicable integrated plans, 72 hours for **expedited requests** (urgent) and 14 calendar days for **standard requests** (non-urgent)
- For state CHIP FFS programs, 14 days for **standard requests** (non-urgent)
- For Medicaid managed care plans and CHIP managed care entities, 72 hours for **expedited requests** (urgent) and 14 calendar days for **standard requests** (non-urgent)
- For QHP issuers on the FFEs, 72 hours for **expedited requests** (urgent) and 15 days for **standard requests** (non-urgent)

There are no Medicaid FFS program required timeframes for either type of prior authorization request prior to January 1, 2026, and there are no CHIP FFS program required decision timeframes for expedited prior authorization requests prior to January 1, 2026.

Beginning January 1, 2026, the CMS Interoperability and Prior Authorization Final Rule, requires Medicaid managed care plans to send prior authorization decisions within:

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

Standard (non-urgent) Prior Authorization requests

	Percentage
Request approved	82%
Request denied	18%

	Percentage
Request approved only after appeal	25%

Expedited (urgent) Prior Authorization requests (response due to provider Within 72 hours)

	Percentage
Request approved	72%
Request denied	28%

Standard (non-urgent) and Expedited (urgent) Prior Authorization requests

	Percentage
Request approved only after time for review was extended	62%

Time between receiving a Prior Authorization request and sending a decision

	Mean (Average) Time	Median (Middle) Time
Standard (non-urgent) Prior Authorization Requests (response due to provider within 7 calendar days)	6.53 days	0 day
Expedited (urgent) Prior Authorization Requests (response due to provider within 72 hours)	2.06 days	0 day