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

To comply with the CMS Interoperability and Prior Authorization final rule, Northern Michigan Regional Entity is required to annually report aggregated prior authorization metrics on our website.

Specifically, this includes a list of all medical items and services (excluding drugs) that require prior authorization, as well as data on prior authorization requests for those items and services (e.g., approvals, denials, etc.) over the previous calendar year. Public reporting of these metrics promotes transparency and accountability, helps patients understand prior authorization processes, and enables providers to evaluate payer performance. In addition, metrics can be used to compare plans, programs, and payers. For questions on the data below, contact: *Support@nmre.org*

REPORTING PERIOD: CALENDAR YEAR 2025

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

Program/Service	CPT/Procedure Code	Service Description
Substance Use Disorder Residential Services	H0018	Short-Term Residential Treatment Services
Substance Use Disorder Residential Services	H0019	Long-Term Residential Treatment Services
Opioid Treatment Program for Methadone	99202	New Patient, Office/Outpatient Medication Evaluation and Management Visit (15-29 Minutes)
Opioid Treatment Program for Methadone	99203	New Patient, Office/Outpatient Medication Evaluation and Management Visit (30-44 Minutes)
Opioid Treatment Program for Methadone	99204	New Patient, Office/Outpatient Medication Evaluation and Management Visit (45-59 Minutes)
Opioid Treatment Program for Methadone	99205	New Patient, Office/Outpatient Medication Evaluation and Management Visit (60-74 Minutes)
Opioid Treatment Program for Methadone	99212	Established Patient, Office/Outpatient Medication Evaluation and Management Visit (10-19 Minutes)
Opioid Treatment Program for Methadone	99213	Established Patient, Office/Outpatient Medication Evaluation and Management Visit (20-29 Minutes)
Opioid Treatment Program for Methadone	99214	Established Patient, Office/Outpatient Medication Evaluation and Management Visit (30-39 Minutes)
Opioid Treatment Program for Methadone	99215	Established Patient, Office/Outpatient Medication Evaluation and Management Visit (40-54 Minutes)

Opioid Treatment Program for Methadone	H0003	Laboratory Analysis of Specimens to Detect Presence of Alcohol or Drug
Opioid Treatment Program for Methadone	H0020	Alcohol and/or Drug Services, Methadone Administration and/or Service

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 [MA plans, state Medicaid agencies, Medicaid managed care plans, state CHIP agencies, CHIP managed care entities] to send prior authorization decisions within:

• 72 hours for expedited requests (urgent)

• 7 calendar days for standard requests (non-urgent)

CY 2025

Expedited (urgent) Prior Authorization Requests

(Response Due to Provider Within 72 Hours)

Status	How many times this happened	Out of total requests	Percentage
Request approved	13	13	100%
Request denied	0	13	0%

Status	How many times this happened	Out of total requests	Percentage
Request approved only after time for review was extended*	5	13	38.46%

*Note: Requests exceeding 72 hours did **not** meet expedited criteria and were approved within 14 days.

Standard (non-urgent) Prior Authorization Requests

(Response Due to Provider Within 14 calendar days)

Status	How many times this happened	Out of total requests	Percentage
Request approved	13467	13706	98.26%
Request denied	239	13706	1.74%

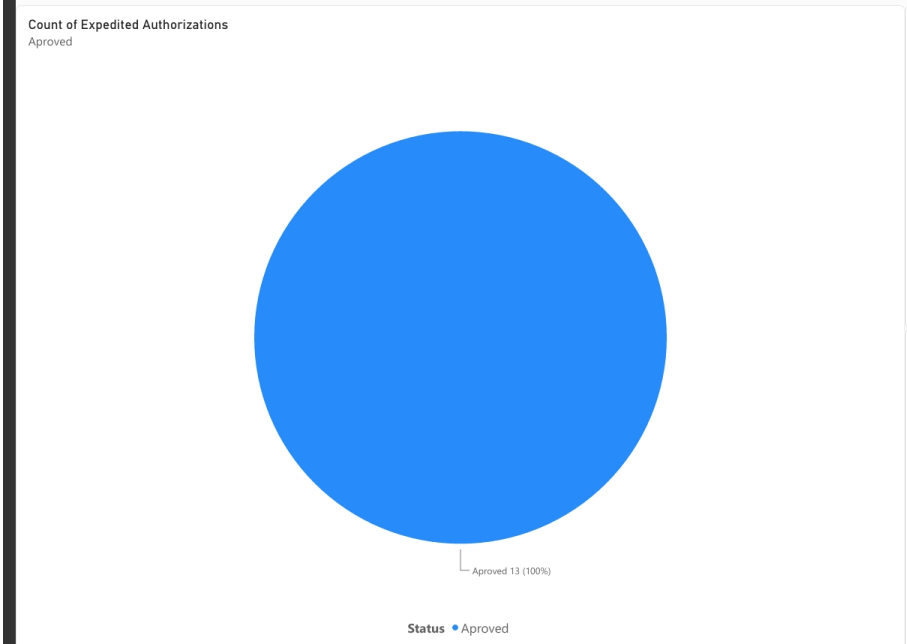
Status	How many times this happened	Out of total requests	Percentage
Request approved only after time for review was extended*	0	13706	0%

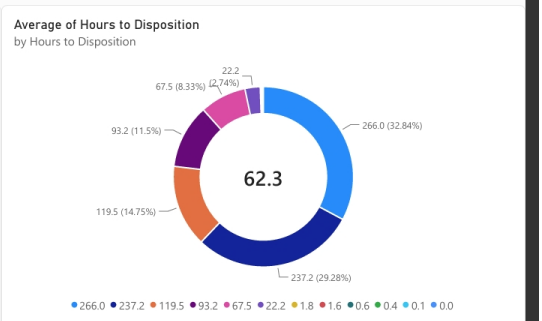
Status	How many times this happened	Out of total requests	Percentage
Request approved only after appeal	0	0	0%

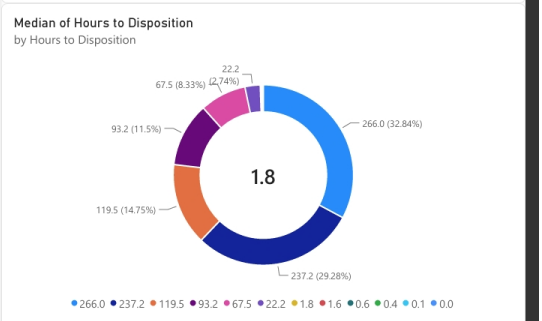
Time Between Receiving a Prior Authorization Request and Sending a Decision

Type	Mean (Average) Time	Median (Middle) Time
Standard (non-urgent) Prior Authorization Requests (response due to provider within 7 calendar days)	1.37 days	0 days
Expedited (urgent) Prior Authorization Requests (response due to provider within 72 hours)	62.32 hours	1.80 hours

In 2025, we received a total of 13 expedited (urgent) prior authorization requests for our covered beneficiaries. 100% of those requests were approved:



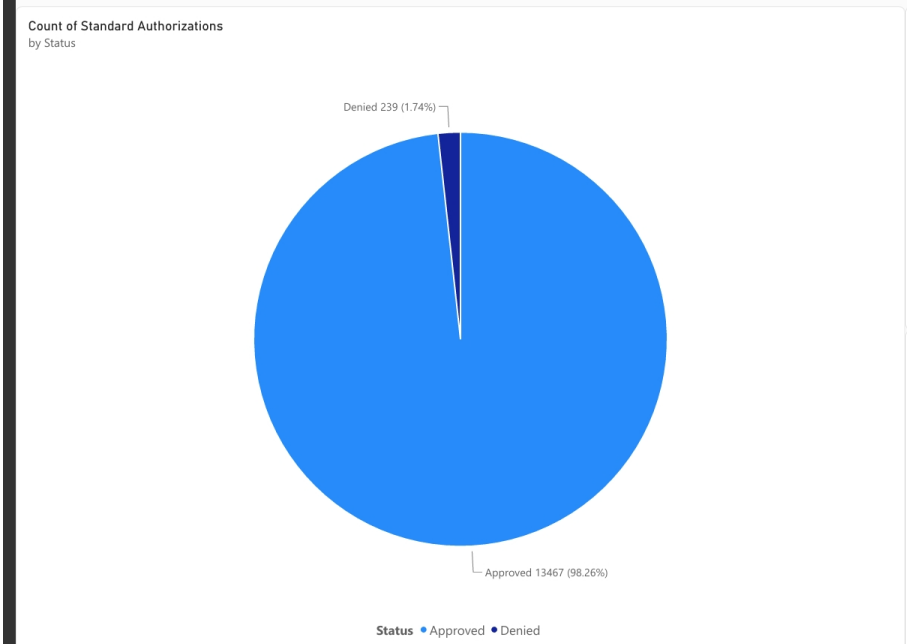


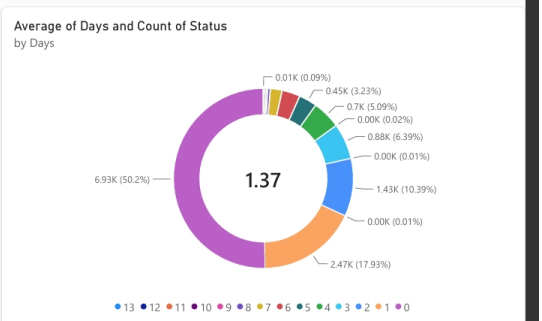


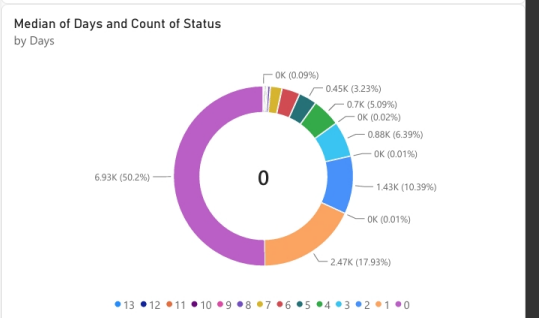
The mean (average) time that it took to make expedited prior authorization decisions was **62.3** hours.

The median (middle) time that it took to make expedited prior authorization decisions was **1.8** hours.

In 2025, we received a total of 13706 standard (non-urgent) prior authorization requests for our covered beneficiaries. 98.26% of those requests were approved:







The mean (average) time that it took to make standard prior authorization decisions was **1.37** days.

The median (middle) time that it took to make standard prior authorization decisions was **0** days.