

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

To comply with the CMS Interoperability and Prior Authorization [final rule](#), MedStar Family Choice District of Columbia 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: [855-798-4244](tel:855-798-4244) or [202-363-4348](tel:202-363-4348) on business days from 8 a.m. to 5:30 p.m.

### Reporting Period: CY 2025

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



[https://www.medstarfamilychoicedc.com/-/media/project/mho/mfcdc/preauth\\_um/dc--prior-authorization-grid-mfc-dental-vision-final-22626-1.pdf](https://www.medstarfamilychoicedc.com/-/media/project/mho/mfcdc/preauth_um/dc--prior-authorization-grid-mfc-dental-vision-final-22626-1.pdf)

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

- For MA plans and applicable integrated plans, 72 hours for **expedited requests** (urgent) and 14 calendar days for **standard requests** (non-urgent)
- 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 either type of 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

	How many times this happened	Out of total requests	Percentage
Request approved	16,806	30,557	55%
Request denied	13,751	30,557	45%

	How many times this happened	Out of total requests	Percentage
Request approved within 7 days	15,448	30,557	51%
Request denied within 7 days	11,530	30,557	38%

	How many times this happened	Out of total requests	Percentage
Request approved only after time for review was extended	261	30,557	1%
Request denied after time for review was extended	1,755	30,557	6%

	How many times this happened	Out of total appeals	Percentage
Request approved only after appeal	5	35	14%
Request denied after appeal	30	35	86%

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

	How many times this happened	Out of total requests	Percentage
Request approved	508	595	85%
Request denied	87	595	15%

	How many times this happened	Out of total requests	Percentage
Request approved within 72 hours	499	595	84%
Request denied within 72 hours	80	595	13%

	How many times this happened	Out of total requests	Percentage
Request approved only after time for review was extended	17	595	28%
Request denied after time for review was extended	4	595	0%

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



**Time Between Receiving a Prior Authorization Request and Sending a Decision**

	<b>Mean (Average) Time</b>	<b>Median (Middle) Time</b>
Standard (non-urgent) Prior Authorization Requests (response due to provider within 7 calendar days)	2 days	1 day
Expedited (urgent) Prior Authorization Requests (response due to provider within 72 hours)	1 day	1 day

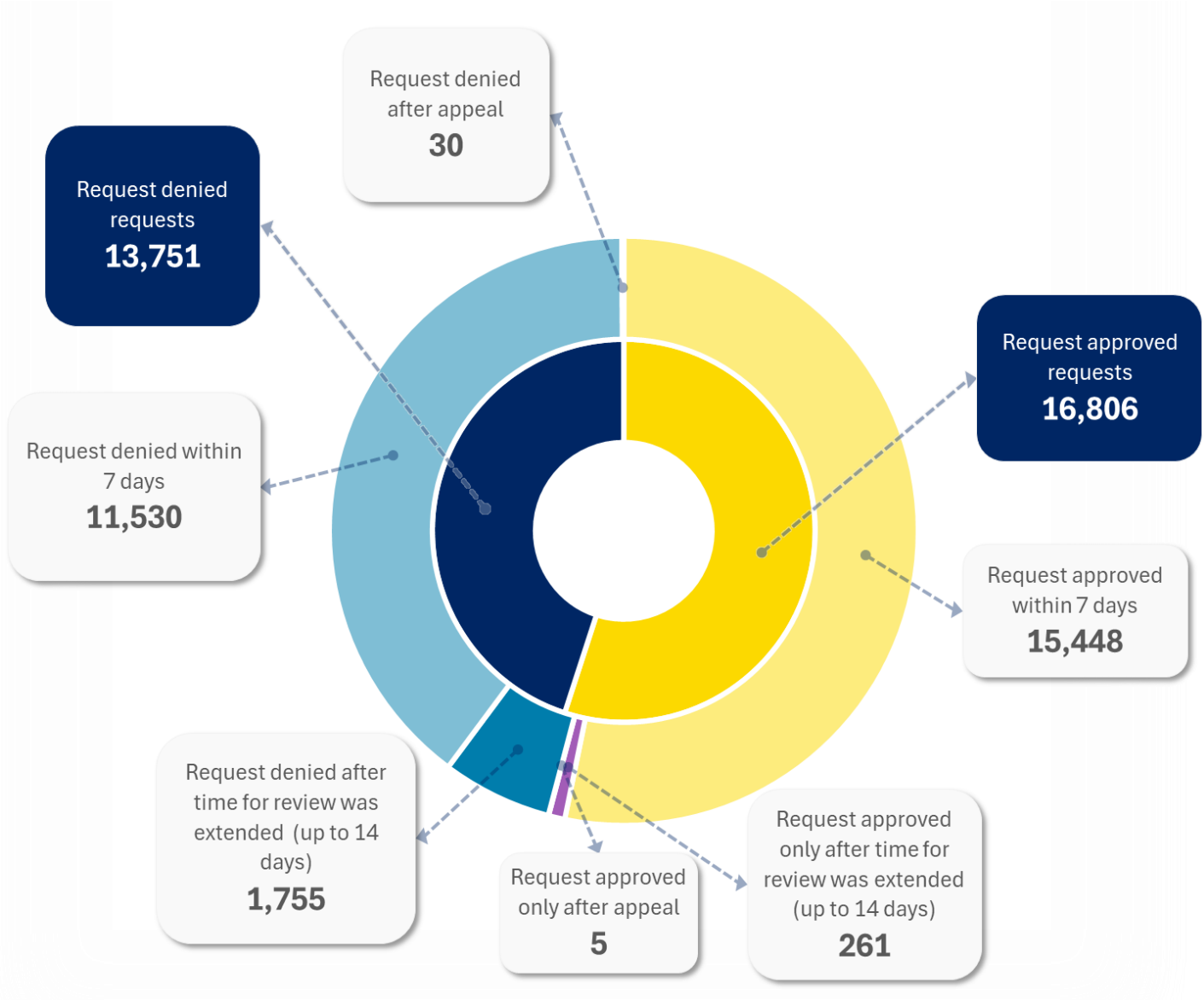
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# MedStar Family Choice

DISTRICT OF COLUMBIA

In 2025, we received a total of 30,557 standard (non-urgent) prior authorization requests for our covered patients.  
55% of those requests were approved:



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

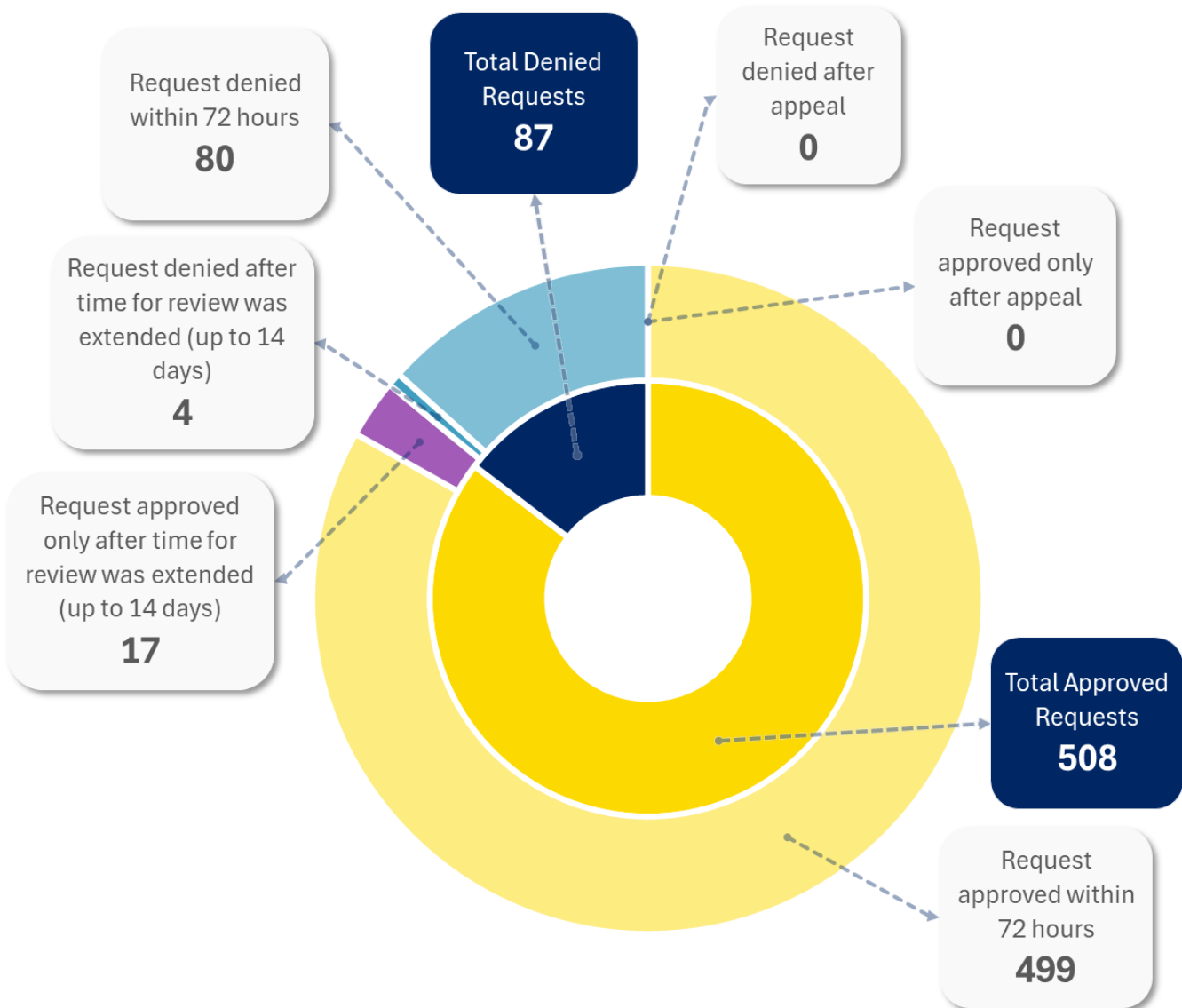
**2 days**

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

**1 day**



In 2025, we received a total of 595 expedited (urgent) prior authorization requests for our covered patients.  
84% of those requests were approved:



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

**1 day**

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

**1 day**