Aetna Better Health® of New Jersey

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

To comply with the CMS Interoperability and Prior Authorization final rule, Aetna Better Health® of New Jersey 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, please contact: 1-855-232-3596 (TTY: 711)

At Aetna Better Health® of New Jersey, our mission is to reduce administrative burdens for providers while delivering exceptional care to our members.

One way we achieve this is by continually reviewing prior authorization requirements. This effort helps ensure that care is delivered more efficiently and without unnecessary delays.

2025 Key Highlights

- **Total Prior Authorizations Processed:** 60,611
- **Hospital Stay Insights:** 89.30% of hospital stays were observation stays, which do **not** require prior authorization
- **99.36%** of authorization decisions were completed on time to support timely, seamless care

Reporting Period: January 1, 2025, to December 31, 2025

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

Aetna Better Health of New Jersey Prior Authorization Requirements Search Tool (ProPAT)

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

- 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)

Beginning January 1, 2026, the CMS Interoperability and Prior Authorization final rule require 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	40,306	55,635	72.45%
Request denied	15,329	55,635	27.55%

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

	How many times this happened	Out of total appeals	Percentage
Request approved only after appeal	380	2,527	15.03%

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

	How many times this happened	Out of total requests	Percentage
Request approved	9,780	11,289	86.63%
Request denied	1,509	11,289	13.37%

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

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Time Between Receiving a Prior Authorization Request and Sending a Decision

	Mean (Average) Time	Median (Middle) Time
Standard (non-urgent) Prior Authorization Requests	8.77 days	10.0 days
Expedited (urgent) Prior Authorization Requests	0.58 days	0.0 days