Aetna Better Health® of Oklahoma

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 Oklahoma 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: 1-844-365-4385 (TTY: 711)

At Aetna Better Health® of Oklahoma, 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:** 65,649
- **Hospital Stay Insights:** 54.6% 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 Oklahoma 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)

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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	57,340	64,295	89.18%
Request denied	6,955	64,295	10.82%

	How many times this happened	Out of total requests	Percentage
Request approved only after time for review was extended	2,026	3,035	66.75%

	How many times this happened	Out of total appeals	Percentage
Request approved only after appeal	288	1,594	18.06%

Expedited (urgent) Prior Authorization Requests

	How many times this happened	Out of total requests	Percentage
Request approved	1,055	1,354	77.92%
Request denied	299	1,354	22.08%

	How many times this happened	Out of total requests	Percentage
Request approved only after time for review was extended	15	35	42.86%

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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 (response due to provider within 14 calendar days)	1.91 days	2.0 days
Expedited (urgent) Prior Authorization Requests (response due to provider within 72 hours)	0.90 days	1.0 days