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

To follow new federal rules, Aetna Medicare FIDE (HMO D-SNP) must share certain information each year on our website.

We must post a list of all medical items and services (not including medicines) that need prior authorization. We also have to share numbers from the past year that show how many prior authorization requests we got, how many were approved, and how many were denied. Sharing this information helps everyone see how the process works. It also helps patients understand what to expect and lets doctors compare how different health plans perform.

If you have questions about the information below, please contact: 1-855-463-0933 (TYY 711).

**Reporting Period:** 2025
**Product:** Medicare FIDE
**Contract:** H1610 Aetna Medicare FIDE (HMO D-SNP)

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

**To access the prior auth grid, please click on this link. Then click on "Prior Authorization List"**

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

- For applicable integrated plans, 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 requires applicable integrated plans to send prior authorization decisions within:

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

**Standard (non-urgent) Prior Authorization Requests**

| | Percentage |
|---|---|
| Request approved | 92.68% |
| Request denied | 7.32% |
| Request approved after appeal | 31.0% |

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

| | Percentage |
|---|---|
| Request approved | 94.51% |
| Request denied | 5.49% |

**Prior Authorizations extended and approved**

| | Percentage |
|---|---|
| Request approved after time for review was extended | none |

**Time Between Receiving a Prior Authorization Request and Determination**

| | Mean (Average) Time | Median (Middle) Time |
|---|---|---|
| Standard (non-urgent) Prior Authorization Requests (response due to provider within 14 calendar days) | 3.98 days | 2.0 days |
| Expedited (urgent) Prior Authorization Requests (response due to provider within 72 hours) | 1.19 days | 1.0 days |

See Evidence of Coverage for a complete description of plan benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by service area.

Y0001_NR_7526550_2026_C