Aetna Better Health®
of West Virginia

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 West Virginia 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: 1-888-348-2922 (TTY: 711)

At Aetna Better Health® of West Virginia, 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:** 84,304
- **Hospital Stay Insights:** 89.4% of hospital stays were observation stays
- **99.84%** of authorization decisions were completed on time to support timely, seamless care

Reporting Period: 2025

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

Aetna Better Health of West Virginia 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)

Aetna Better Health® of West Virginia already follows shorter timeframes:

- 2 calendar days for **expedited requests** (urgent)
- 5 business days for **standard request** (non-urgent)

Standard (non-urgent) Prior Authorization Requests

	How many times this happened	Out of total requests	Percentage
Request approved	66,770	82,698	80.74%
Request denied	15,928	82,698	19.26%

	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	185	718	25.76%

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Expedited (urgent) Prior Authorization Requests

	How many times this happened	Out of total requests	Percentage
Request approved	1,314	1,606	81.82%
Request denied	292	1,606	18.18%

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

Time Between Receiving a Prior Authorization Request and Sending a Decision

	Mean (Average) Time	Median (Middle) Time
Standard (non-urgent) Prior Authorization Requests	2.21 days	2.0 days
Expedited (urgent) Prior Authorization Requests	0.77 days	1.0 days