



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

To comply with the CMS Interoperability and Prior Authorization [final rule](#), [Wyoming Department of Health, Healthcare Finance, Home and Community Based Services] 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: [Dillion Johnson, 307-777-8760, dillion.johnson1@wyo.gov].

Reporting Period: [2025]

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



Community Choices Waiver

Adult Day Services - Health Model, Adult Day Services - Social Model, Assisted Living Facility Services -Standard, Assisted Living Facility Services - Memory Care Unit, Case Management - Service Plan Development/Annual Update, Case Management - Monitoring, Environmental Modification - New, Environmental Modification - Repair, Home Delivered Meals - Hot, Home Delivered Meals - Frozen, Home Health Aide, Homemaker, Non-Medical Transportation - Public Transit Multipass, Non-Medical Transportation - Service Route, Non-Medical Transportation - Wheelchair Accessible Vehicle, Non-Medical Transportation - Non-Wheelchair Accessible Vehicle, Personal Emergency Response System (PERS) - Landline Installation, PERS - Landline Monitoring, PERS - Cellular Installation, PERS - Cellular Monitoring, Personal Support Services - Agency Based, Respite - In Home, Respite - Assisted Living Facility, Respite - Skilled Nursing Facility, Transition Intensive Case Management, Transition Intensive Case Management - Training Certificate, Transition Setup Expenses

DD Waiver

Adult Day Services (Basic), Adult Day Services (Intermediate), Adult Day Services (High), Behavioral Support Services - BCBA, Behavioral Support Services - BCaBA, Behavioral Support Services – RBT, Case Management, Case Management - Targeted (TCM), Child Habilitation Services (Ages 0-12), Child Habilitation Services (Ages 13-17), Cognitive Retraining, Community Living Services (Basic Individual), Community Living Services (Basic - Group of 2), Community Living Services (Basic - Group of 3 or more), Community Living Services (Basic), Community Living Services - Self-Directed Levels 3 – 6 (Comprehensive Waiver Only), Community Living Services - Level 3 (Comprehensive Waiver Only), Community Living Services - Level 4 (Comprehensive Waiver Only), Community Living Services - Level 5 (Comprehensive Waiver Only), Community Living Services - Level 6 (Comprehensive Waiver Only), Community Living Services - Host Home (Comprehensive Waiver Only), Community Support Services (Basic), Community Support Services (Intermediate)

DD Waiver continued

Community Support Services (High), Companion Services (Individual), Companion Services (Group up to 3), Crisis Intervention Support , Dietician, Environmental Modification (New), Environmental Modification (Repair), Homemaker, Individual Habilitation Training, Occupational Therapy (Individual), Personal Care, Physical or Occupational Therapy (Group), Physical Therapy (Individual), Respite (Individual), Respite (Group of 2) , Respite Daily (Individual), Respite Daily (Group of 2), Specialized Equipment (New) , Specialized Equipment (Repair), Speech, Language and Hearing Services (Individual), Speech, Language and Hearing Services (Group), Supported Employment (Individual), Supported Employment (Group), Supported Employment Follow Along, Transportation - Per 5 Mile Trip, Transportation - Per 10 Mile Trip, Transportation - Multipass, Psychological Assessments, Neuropsychological Assessments

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 expedited prior authorization requests prior to January 1, 2026.

Beginning January 1, 2026, the CMS Interoperability and Prior Authorization [final rule](#) requires State Medicaid Agencies 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	32,044	32,044	100%
Request denied	0	32,044	0%

	How many times this happened	Out of total requests	Percentage
(optional) Request approved with 7 days	32,044	32,044	100%
(optional) Request denied within 7 days	0	32,044	0%

	How many times this happened	Out of total requests	Percentage
Request approved only after time for review was extended*	NA*	NA*	NA*
(optional) Request denied after time for review was extended	NA*	NA*	NA*

	How many times this happened	Out of total appeals	Percentage
Request approved only after appeal	NA*	NA*	NA*
(optional) Request denied after appeal	NA*	NA*	NA*

Expedited (urgent) Prior Authorization Requests

(Response Due to Provider Within 72 Hours)

	How many times this happened	Out of total requests	Percentage
Request approved	NA**	NA**	NA**
Request denied	NA**	NA**	NA**

	How many times this happened	Out of total requests	Percentage
(optional) Request approved with 72 hours	NA**	NA**	NA**
(optional) Request denied within 72 hours	NA**	NA**	NA**

	How many times this happened	Out of total requests	Percentage
Request approved only after time for review was extended*	NA**	NA**	NA**
(optional) Request denied after time for review was extended	NA**	NA**	NA**

*As noted on the first page of this template, it is **optional** to report this metric separately for standard prior authorizations and expedited prior authorizations.

	How many times this happened	Out of total appeals	Percentage
(optional) Request approved only after appeal	NA**	NA**	NA**
(optional) Request denied after appeal	NA**	NA**	NA**

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 7 calendar days)	<24 hours	<24 hours
Expedited (urgent) Prior Authorization Requests (response due to provider within 72 hours)	NA**	NA**

Notes

1. NA*, Wyoming HCBS approves all services in the budget. The system is designed to not allow services that would be denied. There is no timely review process or appeals.
2. NA**, Wyoming HCBS does not have an expedited process. All prior authorizations are created within 24 hours of the Benefit Management Software receiving the request.

In 2025, we received a total of 32,044 standard (non-urgent) prior authorization requests for our covered patients.
100% of those requests were approved:

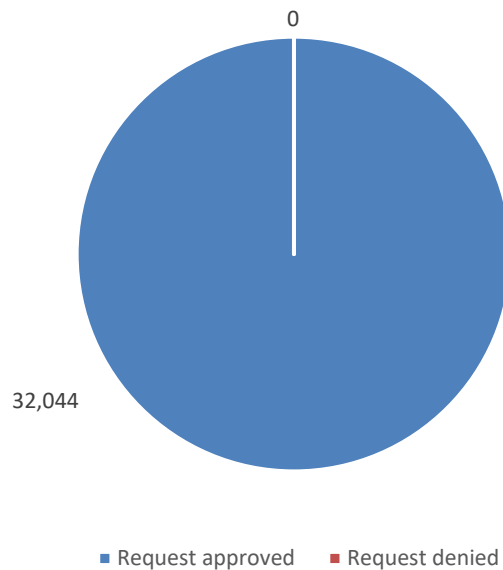
The mean (average) time that it took to make standard prior authorization decisions was

<24 hours

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

<24 Hours

Number of standard (non-urgent) prior authorization requests for our covered patients.





**In 2025, we received a total of 0 expedited (urgent) prior authorization requests for our covered patients.
-% of those requests were approved:**

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

-- day(s)

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

-- day(s)