

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 Financing, Utilization Management 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: Elizabeth Lovell-Poynor (elizabeth.lovell-poynor@wyo.gov) and Sarah Hoffdahl (Sarah.Hoffdahl@wyo.gov).

Reporting Period: 2025

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

- Acute Behavioral Health
- Behavioral Health Outpatient
- Behavioral Health Residential
- Dental (including Severe Malocclusion)
- Durable Medical Equipment
- Extended Home Health Care
- Extended Psychiatric Care
- Extraordinary Heavy Care
- Gastric Bypass
- Genetic Testing
- Home Health
- Medical Procedures (Inpatient & Outpatient)
- Occupational Therapy
- Physical Therapy
- Skilled Nursing
- Speech Therapy
- Transplants
- Unlisted Procedures
- Vagus Nerve Stimulator
- Vision

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	9,294	10,708	87%
Request denied	1,106	10,708	10%

	How many times this happened	Out of total requests	Percentage
(optional) Request approved with 7 days	8,987	10,708	84%
(optional) Request denied within 7 days	257	10,708	2%

	How many times this happened	Out of total requests	Percentage
Request approved only after time for review was extended*	0	0	0
(optional) Request denied after time for review was extended	0	0	0

	How many times this happened	Out of total appeals	Percentage
Request approved only after appeal	5	20	25%
(optional) Request denied after appeal	12	20	60%

Expedited (urgent) Prior Authorization Requests

(Response Due to Provider Within 72 Hours)

	How many times this happened	Out of total requests	Percentage
Request approved	0	0	0
Request denied	0	0	0

	How many times this happened	Out of total requests	Percentage
(optional) Request approved with 72 hours	0	0	0
(optional) Request denied within 72 hours	0	0	0

	How many times this happened	Out of total requests	Percentage
Request approved only after time for review was extended*	0	0	0
(optional) Request denied after time for review was extended	0	0	0

*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	0	0	0
(optional) Request denied after appeal	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 (response due to provider within 7 calendar days)	3 days	1 days
Expedited (urgent) Prior Authorization Requests (response due to provider within 72 hours)	0 day	0 day

In 2025, we received a total of 10,708 standard (non-urgent) prior authorization requests for our covered patients.

87% of those requests were approved:

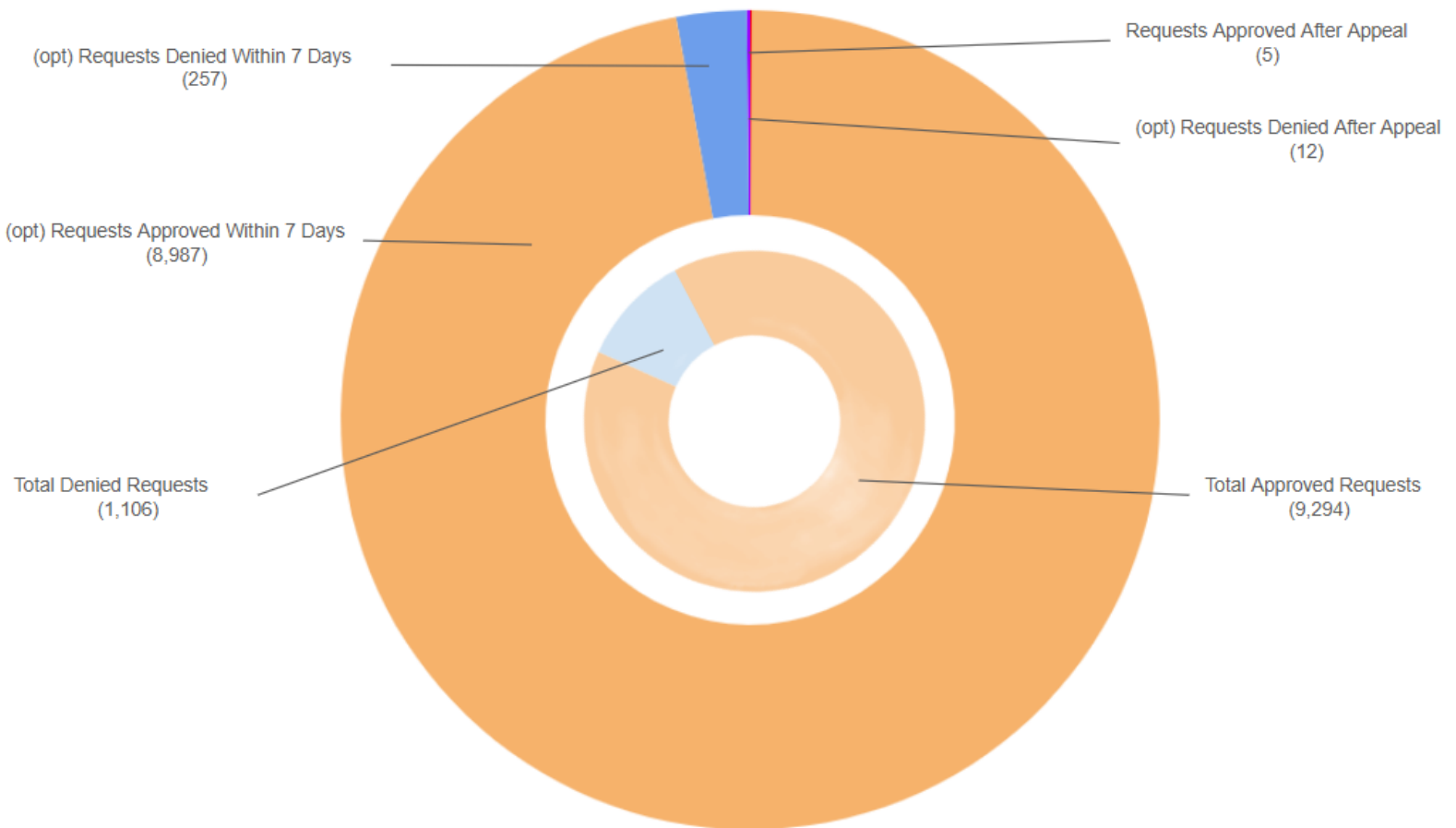
The mean (average) time that it took to make standard prior authorization decisions was

3 days

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

1 day

Standard (non-urgent) Prior Authorization Requests





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)