TEXAS MEDICAID & HEALTHCARE PARTNERSHIP (TMHP)

PRIOR AUTHORIZATION REPORT

MEDICAL ITEMS AND SERVICES

TMHP
Texas Medicaid & Healthcare Partnership
A STATE MEDICAID CONTRACTOR

Prior authorization metrics for medical items and services (excluding drugs)

To comply with the CMS Interoperability and Prior Authorization final rule, the Texas Health & Human Services Commission 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:

The TMHP Contact Center via email on the TMHP website at **tmhp.com** or call **800-925-9126**.

Reporting period: calendar year 2025

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

Please refer to the *Texas Medicaid Provider Procedures Manual* available on the TMHP website at **tmhp.com** for the procedures that require prior authorization.

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 [MA plans, state Medicaid agencies, Medicaid managed care plans, state CHIP agencies, CHIP managed care entities] to send prior authorization decisions within:

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

72 Hour Expedited Requests

Placeholder. *Expedited PA request volume currently unavailable.*

Standard (non-urgent) FFS acute care PA requests

Standard PA requests	How many times this happened	Out of total requests	Percentage	Average time to process
Request approved	**34,346**	**42,711**	**80.4%**	**3.5 days**
Request denied	**8,365**	**42,711**	**19.6%**	**3.5 days**

Note: *Average time to process includes all complete and deficient/pended PA requests.*

Ambulance FFS PA requests

Ambulance PA requests	How many times this happened	Out of total requests	Percentage	Average time to process
Request approved	**7,621**	**8,459**	**90%**	**2 days**
Request denied	**838**	**8,459**	**10%**	**2 days**

Prior authorizations at a glance

In 2025, we received a total of **42,711** standard (non-urgent) prior authorization requests for our covered patients. **80%** of those requests were approved: