

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

To comply with the CMS Interoperability and Prior Authorization [final rule](#), Johns Hopkins Advantage MD (HMO and PPO) 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: Member Services at 877-293-5325 (PPO) or 877-293-4998 (HMO) (TTY: 711). Oct. 1 through Feb. 14 – Monday through Sunday 8 a.m. to 8 pm and Feb 15 through Sept. 30 – Monday through Friday, 8 a.m. to 8 p.m. On evenings and weekends, you may have to leave a message.

Reporting Period: 2025

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



Use [this search tool](#) to look up whether a medical item, procedure or service requires 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 to send prior authorization decisions within:

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

Johns Hopkins Advantage MD Medicare Advantage Contract ID: H1339 (VA HMO)

Standard (non-urgent) Prior Authorization Requests

	How many times this happened	Out of total requests	Percentage
Request approved	11	13	84.6%
Request denied	2	13	15.4%
Request approved only after time for review was extended	0	13	0.0%

Standard (non-urgent) Prior Authorization Requests Approved after Appeal

	How many times this happened	Out of total appeals	Percentage
Request approved only after appeal	1	1	100.0%

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	1	0.0%
Request denied	1	1	100.0%
Request approved only after time for review was extended	0	1	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)	2 days	1 day
Expedited (urgent) Prior Authorization Requests (response due to provider within 72 hours)	less than 1 day	less than 1 day

Johns Hopkins Advantage MD Medicare Advantage Contract ID: H1225 (HMO)

Standard (non-urgent) Prior Authorization Requests

	How many times this happened	Out of total requests	Percentage
Request approved	11,237	13,385	84.0%
Request denied	2,148	13,385	16.0%
Request approved only after time for review was extended	0	13,385	0.0%

Prior Authorization Requests Approved after Appeal

	How many times this happened	Out of total appeals	Percentage
Request approved only after appeal	185	242	76.4%

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

	How many times this happened	Out of total requests	Percentage
Request approved	381	872	43.7%
Request denied	491	872	56.3%
Request approved only after time for review was extended	0	872	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)	4 days	1 day
Expedited (urgent) Prior Authorization Requests (response due to provider within 72 hours)	less than 2 days	less than 2 days

Johns Hopkins Advantage MD Medicare Advantage Contract ID: H3890 (PPO)

Standard (non-urgent) Prior Authorization Requests

	How many times this happened	Out of total requests	Percentage
Request approved	10,370	12,154	85.3%
Request denied	1,784	12,154	14.7%
Request approved only after time for review was extended	0	12,154	0.0%

Prior Authorization Requests Approved after Appeal

	How many times this happened	Out of total appeals	Percentage
Request approved only after appeal	180	192	93.8%

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

	How many times this happened	Out of total requests	Percentage
Request approved	282	677	41.7%
Request denied	395	677	58.3%
Request approved only after time for review was extended	0	677	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 day
Expedited (urgent) Prior Authorization Requests (response due to provider within 72 hours)	less than 2 days	less than 2 days