BlueCross BlueShield Arizona

An Independent Licensee of the Blue Cross Blue Shield Association

Prior Authorization Metrics

Calendar Year 2025

Blue Cross Blue Shield of Arizona Health Choice

We're working to make Prior Authorizations easier

We've Made it Easier to Get Important Care

Nearly 400 services and procedures, like hysterectomies, no longer need prior authorization.

24/7 Access to AZ Blue

Our clinical teams are standing by 24/7 to respond to urgent authorizations within 72 hours of submission.

Getting Members the Care They Need

We find solutions so members stay on track with care. If a service can't be approved—like when it isn't FDA-approved or is considered experimental—our clinical team reaches out to the providers and members to find alternatives. That way, doctors are guiding the care, and members get the most from their coverage.

Fast Help When It Matters Most

When members are facing a health scare or life-altering diagnosis, they can count on AZ Blue. Our Clinical Rapid Response Team helps members navigate complexities, expedite prior authorizations for testing, and accelerate access to specialty care. Reach out at rapidresponse@azblue.com. It's like having an expert clinical friend on the inside.

Offering Personal Support

Sometimes, busy healthcare providers need some extra support too, and our Clinical Excellence Team reaches out to help. Our physicians, specialists, highly trained nurses, and other medical professionals make a difference for thousands of members.

The Clinical Excellence Team helps members and supports the healthcare system by providing personalized support to:

- Fill in care gaps in a busy and complex health system
- Help members manage health conditions
- Guide members to clinically proven options
- Help members navigate complex medical needs
- Check in on members after a hospitalization
- Respond rapidly to help members through a health scare
- Recommend lower-cost, high-value options

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Blue Cross Blue Shield of Arizona Health Choice serves 191,000 Arizona Medicaid members in the northern and central geographic service areas of Arizona, in Apache, Coconino, Gila, Maricopa, Mohave, Navajo, Pinal, and Yavapai counties.

As required by federal rules, we share general information about:

- Which medical services require prior authorization (not including prescription drugs)
- How often prior authorization requests were approved or denied during the previous year

This information is shared at an overall level and is **not tied to individual members**.

These are the medical items and services that require prior authorization (excluding drugs)

AZ Blue Health Choice Prior Authorization Grid

To comply with the CMS Interoperability and Prior Authorization final rule, AZ Blue is reporting 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.

Reporting Period: 2025

Prior Authorization Metrics

There were a total of 82,146 standard and expedited prior authorization determinations for Blue Cross Blue Shield of Arizona Health Choice members.

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Standard Prior Authorizations for Medicaid Enrollees

Table 1 shows the overall number and percentage of approvals and denials for all standard prior authorizations in 2025.

Table 1	How many times this happened	Out of total requests	Percentage
Request approved	63,222	71,937	87.89%
Request denied	8,715	71,937	12.11%

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Most prior authorization requests are approved—nearly **9 out of every 10**.

When a request isn't approved, it's usually for one of these reasons:

- **More information is needed** from the provider to complete the review
- The request **doesn't meet national clinical guidelines**
- The treatment is considered **experimental or investigational**

If a request is denied, our **Utilization Management team reaches out** to help. They work with providers to explain the decision and, when possible, discuss **covered alternatives**.

In some cases, we must deny a request if we **don't receive the needed information from the provider within 21 days**. This is required by regulation, even if the service may be appropriate once all information is received.

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Standard Prior Authorizations After an Extension for Medicaid Enrollees

Table 2 displays the overall number and percentage of approvals for prior authorizations in which the time for review was extended in 2025.

Table 2	How many times this happened	Out of total requests	Percentage
Request approved only after time for review was extended	49	71,937	0.07%

Sometimes we need a little more time to review a prior authorization request. This usually happens when we're **waiting for additional medical information** from your provider.

The extra time allows us to:

- Review all the details carefully
- Make sure the request meets clinical guidelines
- Avoid delays or confusion later

We continue working with your provider during an extension and a decision is made as soon as we have what we need.

Standard Prior Authorizations After Appeal for Medicaid Enrollees

Table 3 displays the overall number and percentage of approvals for all prior authorizations in which there was an appeal. Appeals help ensure decisions reflect the most complete and up-to-date information about your care.

Table 3	How many times this happened	Out of total appeals	Percentage
Request approved only after appeal	111	296	37.50%

About 3 out of 10 prior authorization requests are approved after an appeal.

This happens because:

- **New or additional medical information** is shared
- A provider is able to **clarify details** about the treatment or diagnosis

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Expedited Prior Authorizations for Medicaid Enrollees (excluding drugs)

Table 4 displays the overall number and percentage of approvals and denials for all expedited prior authorizations.

Table 4	How many times this happened	Out of total requests	Percentage
Request approved	9,416	10,209	92.23%
Request denied	793	10,209	7.77%

More than **9 out of every 10 urgent prior authorization requests are approved**, helping members get timely access to care when it matters most.

Expedited Prior Authorizations After an Extension for Medicaid Enrollees

Table 5 displays the overall number and percentage of approvals for expedited prior authorizations in which the time for review was extended.

Table 5	How many times this happened	Out of total requests	Percentage
Request approved only after time for review was extended	4	10,209	0.04%

We understand that urgent prior authorization requests are time-sensitive. In rare cases, we may need a little more time to review the request to review additional information from the provider.

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Turnaround Times for Prior Authorization Requests for Medicaid Enrollees

Table 6 displays the average and median times elapsed between the submission of a request and a determination for standard and expedited prior authorizations.

Table 6	Mean (Average) Time	Median (Middle) Time
Standard (non-urgent) Prior Authorization Requests (response due to provider and members within 14 calendar days)	3.96 days	1.09 days
Expedited (urgent) Prior Authorization Requests (response due to provider and members within 72 hours)	16.10 hours	2.78 hours

We review prior authorization requests quickly—**often much faster than the timeframes required.**

- **Standard requests** are typically reviewed in just a few days, and many are completed in less than one day.
- **Urgent (expedited) requests** are usually reviewed within hours, with many decisions made the same day.

Our goal is to balance speed with care—making sure every request is reviewed thoroughly, fairly, and based on the right medical information. When additional details are needed from your provider, we continue working with them right away, helping members get timely access to care when it matters most.

Beginning January 1, 2026, the CMS Interoperability and Prior Authorization Final Rule (CMS-0057-F) requires Medicaid Plans to send prior authorization decisions within:

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