BlueCross BlueShield Arizona

An Independent Licensee of the Blue Cross Blue Shield Association

Prior Authorization Metrics

Calendar Year 2025

Medicare Advantage

We're Working to Make Prior Authorizations Easier

24/7 Access to AZ Blue

Our clinical teams are standing by 24/7 to respond to urgent authorizations within 8 hours of submission.

Protecting Members from Catastrophic Medical Expenses

Health insurance's fundamental purpose is to shield you from the financial shock of extreme medical costs. AZ Blue is here to protect members, often **taking care of more than 99% of hospital charges** that we see ranging from hundreds of thousands of dollars to well over a million dollars.

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 (AZ Blue) Medicare Advantage (MA) plans served more than 32,000 members in the central and southern geographic areas of Arizona, in Maricopa, Pinal, and Pima counties in 2025. AZ Blue offered the MA Blue Best Life Plus HMO and MA Blue Best Life Classic HMO plans in 2025.

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 Medicare Advantage Prior Authorization Code List

If you are one of our members, please utilize the prior authorization lookup tool.

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

In calendar year 2025, there were a total of 41,758 standard and expedited prior authorization determinations for AZ Blue MA members.

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Standard Prior Authorizations for MA 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	35,217	37,315	94.38%
Request denied	2,098	37,315	5.62%

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Most prior authorization requests are approved—more than **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 **Clinical 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 30 days**. This is required by regulation, even if the service may be appropriate once all information is received.

Standard Prior Authorizations After an Extension for MA 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	18	37,135	0.05%

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 MA Enrollees

Table 3 displays the overall number and percentage of approvals for all prior authorizations in which there was an appeal.

Table 3	How many times this happened	Out of total appeals	Percentage
Request approved only after appeal	434	477	90.99%

This happens because:

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

Appeals help ensure decisions reflect the most complete and up-to-date information about your care.

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Expedited Prior Authorizations for AZ Blue MA Members (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	4,174	4,443	93.95%
Request denied	269	4,443	6.05%

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 MA 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	1	4,443	0.02%

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 MA 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 within 14 calendar days)	2.11 days	<1 day
Expedited (urgent) Prior Authorization Requests (response due to provider within 72 hours)	11.83 hours	2.52 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 Medicare Advantage Plans to send prior authorization decisions within:

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