

Health plan prior authorization data

2025 annual report to the Legislature

Jan. 1, 2026

Patty Kuderer, *Insurance Commissioner*

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Background

In 2020, the Washington state Legislature enacted Engrossed Substitute Senate Bill (ESSB) 6404 (Chapter 316, Laws of 2020, codified at [RCW 48.43.0161](#)). This law requires health carriers with at least one percent of the market share for fully insured individual and group health plans in Washington state to annually report certain aggregated and deidentified data related to prior authorization to the Office of the Insurance Commissioner (OIC). Prior authorization is a utilization review tool used by carriers to review the medical necessity of requested health care services for specific health plan enrollees. Carriers choose the services subject to prior authorization review. Their prior authorization processes must comply with state law requirements related to medical necessity clinical standards, timeliness of prior authorization decisions and communicating prior authorization information and decisions to providers and patients (See [WAC 284-43-2000](#) et seq.)

The data reported by carriers includes prior authorization information for the following categories of health services:

- Inpatient medical/surgical
- Outpatient medical/surgical
- Inpatient mental health and substance use disorder
- Outpatient mental health and substance use disorder
- Diabetes supplies and equipment
- Durable medical equipment (DME)

The carriers must report the following information for the prior plan year (PY) for their commercial individual and group health plans for each category of services:

- The 10 codes with the highest number of prior authorization **requests** and the percent of approved requests.
- The 10 codes with the highest percentage of **approved** prior authorization requests and the total number of requests.
- The 10 codes with the highest percentage of prior authorization requests that were initially denied and then approved on **appeal** and the total number of such requests.

Carriers must also include the average response time in hours for prior authorization requests and the number of requests for each covered service in the lists above for:

- Expedited decisions
- Standard decisions
- Extenuating-circumstances decisions

[Engrossed Second Substitute House Bill 1357](#) added prescription drug prior authorization reporting requirements for health carriers beginning in reporting year 2024. Carriers submitted prescription drug prior authorization data in the same format as prescribed for medical services.

The reports from carriers were due Sept. 15, 2025, for PY 2024. The deidentified carrier submissions are available on the [Washington state open data portal](#).

RCW 48.43.0161(3) directs the Insurance Commissioner to submit an annual report to the Legislature by Jan. 1 of each year.

OIC implementation of ESSB 6404

The OIC developed its first set of prior authorization data templates in 2020 for PY 2019 reporting. Since then, OIC has standardized and refined the report to yield more informative results.

No changes were made to the 2024 reporting template for 2025. Reporting is based on the date a service was provided to a patient.

Carriers required to file a report in 2025 for PY 2024 based on market share as directed in RCW 48.43.0160(1) are:

- Aetna Life Insurance Company
- Asuris Northwest Health
- Cigna Health & Life Insurance Company
- Community Health Plan of WA
- Coordinated Care Corp.
- Kaiser Foundation Health Plan of the Northwest
- Kaiser Foundation Health Plan of Washington Options
- Kaiser Foundation Health Plan of Washington
- LifeWise Health Plan of WA
- Molina HealthCare of WA
- Premera Blue Cross
- Regence BlueCross BlueShield (BCBS) of Oregon
- Regence BlueShield
- UnitedHealthCare Insurance Co.
- UnitedHealthCare of Washington Inc.

The OIC sent carriers the final ESSB 6404 Instruction Sheet ([Appendix A](#)) and ESSB 6404 Response Template ([Appendix B](#)) on July 15, 2025. The deidentified carrier submissions are available on the [Washington state open data portal](#).

Carrier reporting

In 2015, OIC adopted rules that established minimum program and process standards for carriers' prior authorization activities. The rules, codified in WAC 284-43-2000 through 284-43-2060, include but are not limited to:

- Prior authorization program accreditation, e.g. accreditation by the National Committee for Quality Assurance (NCQA), Utilization Review Accreditation Commission (URAC), Joint Commission, or Accreditation Association for Ambulatory Health Care (AAAHC).
- Use of evidence-based clinical review criteria.
- Establishment of an online prior authorization submission process to provide more transparency and clearer guidance for providers and enrollees.
- Establishment of a secure online process for providers to submit prior authorization requests.
- Setting time limits for making prior authorization decisions.
- Required content of prior authorization approvals and denials.

In 2023, the legislature enacted E2SHB 1357, which modified several components of prior authorization review. New timelines were set for carrier responses to prior authorization requests and new standards were set related to access to and substance of carriers' prior authorization criteria. These changes impact health plans issued or renewed on or after Jan, 1, 2024. The OIC updated its [rules](#) to align with the statutory requirements of E2SHB 1357.

The legislature has limited carriers' ability to require prior authorization for certain services (e.g., initial substance use disorder inpatient stays,¹ medication for treatment of opioid use disorder,² chiropractic, physical therapy, and East Asian treatments,³ and effective January 1, 2027, outpatient mental health and substance use disorder office visits.⁴

Data reporting under RCW 48.43.0161 addresses the clinical services that are subject to prior authorization, rather than the processes used by carriers to conduct prior authorizations.

¹ [RCW 48.43.761](#).

² [RCW 48.43.760](#).

³ [RCW 48.43.016](#).

⁴ Id.

Findings

The OIC received PY 2024 data from 15 carriers.

Some variation was observed in submissions across carriers:

- There was variation in how carriers reported “tied” codes, with multiple codes having the same number of requests. Some carriers indicated that there were multiple codes with the same number of requests, and when those tied codes exceeded their top 10 reporting list, they did not include codes that exceeded their top 10 list despite the ties. Other carriers submitted more than their top 10 requests to account for the tied codes.
- Across the carriers, there was substantial variability in both the particular services or codes reported, and the number of claims reported for each such service.
- There were variations in the drug name submitted for each carrier.

As of Jan. 1, 2024, there were over 11,000 Common Procedure Terminology (CPT) codes and almost 8,000 Healthcare Common Procedural Coding System (HCPCS) codes in use.⁵

Key findings from the PY 2024 submitted data:

- Procedures with the most prior authorization requests tended to be for physical therapy services, MRI and CT scans, echocardiography and continuous airway pressure devices (CPAP devices).
- Among the top 10 procedures across all carriers with the most prior authorization requests, the approval rate ranged from 68% (physical therapy) to 97.5% (Therapeutic exercise).
- Among the top 10 most requested procedures across all carriers with the highest approval rates, 4 were for orthotic or prosthetic procedures.
- There is not a substantial difference in approval rates between medical/surgical prior authorization requests and mental health/substance use disorder prior authorization requests, although there was a slight decrease in mental health/substance use disorder approvals since last year.
- Prior authorization requests for DME procedure codes had the longest standard response time (100.3 hours) for the submitted procedure codes, followed by requests for inpatient mental health/substance use disorder procedures (45.1 hours). Requests for outpatient medical/surgical procedures had the shortest standard response time among the submitted codes (8.3 hours).
- Response time was longer for mental health/substance use disorder prior authorization requests (17.3 hours) compared to medical/surgical prior authorization requests (8.5 hours).

⁵ CPT codes are developed by the American Medical Association, <https://www.ama-assn.org/amaone/cpt-current-procedural-terminology>; HCPCS codes are developed by the HHS/Center for Medicare and Medicaid Services, <https://www.cms.gov/Medicare/Coding/MedHCPCSGenInfo>.

- Semaglutide (brand name Ozempic, Rybelus, Wegovy) was the prescription drug with the most prior authorization requests (18,505 requests, 47% approval rate). Fourteen carriers submitted this drug as one of their top 10 for prior authorization requests.

Prior authorization requests across carriers and code types

The carriers’ submissions were aggregated to observe and compare trends across carriers, service categories and service code types. All carrier submissions are included in this report. The first portion of the report addresses prior authorization for the six broad service categories in RCW 48.43.0161. The analysis of prescription drug submissions begins on page 23 of the report.

Carriers submitted the top 10 procedure codes with the highest number of prior authorization requests for six broad service categories in RCW 48.43.0161.

The health service code with the highest number of prior authorization requests for each broad health service category are found in Figure 1. This table and all analysis presented in this report excludes prior authorizations for Office Evaluation and Management (E&M) codes, as some health plans in Washington state require prior authorizations for referrals to in-network specialist office visits. This resulted in a high number of office visit E&M requests. The total number of requests for the previous reporting year (PY 2023) are shown in parentheses.

Figure 1 Highest number of prior authorization requests by service category

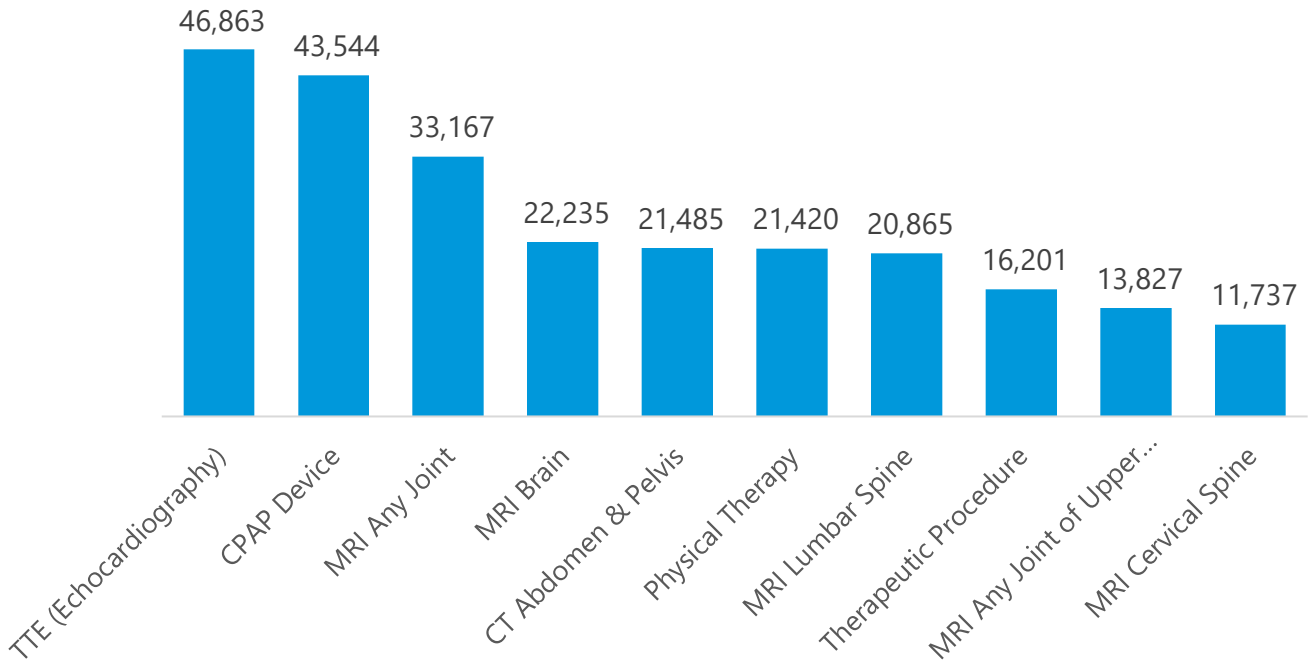
Service category	Code	Description	Total requests
Outpatient Med-Surg	93306	TTE (Echocardiogram) with Spectral & Color Flow Doppler	46,863 (44,108)
Outpatient MH-SUD	90837	Psychotherapy, 60 Minutes with Patient	9,372 (11,074)
DME	E0601	Cont. Airway Pressure Device (CPAP)	9,010 (9,995)
Diabetes Supplies and Equip	E2103	Nonadjunctive Nonimplanted Continuous Glucose Monitor/Receiver	1,983 (916)
Inpatient Med-Surg	121	Room & Board Semiprivate (Two Beds) – Medical/Surgical/Gyn	427 (178)
Inpatient MH-SUD	124	Room & Board Semiprivate (Two Beds) - Psychiatric	270 (189)

For the reported codes with the highest number of prior authorization requests, the code 93306 (complete transthoracic echocardiogram with doppler) within the service category Outpatient Med-Surg had the highest number of requests.

Figure 1 above excludes the prior authorization request data submitted for prescription drugs, and office E&M codes.

Figure 2 below details the total number of prior authorization requests for the 10 service codes with the highest number of requests for PY 2024, excluding prescription drugs and office E&M codes.

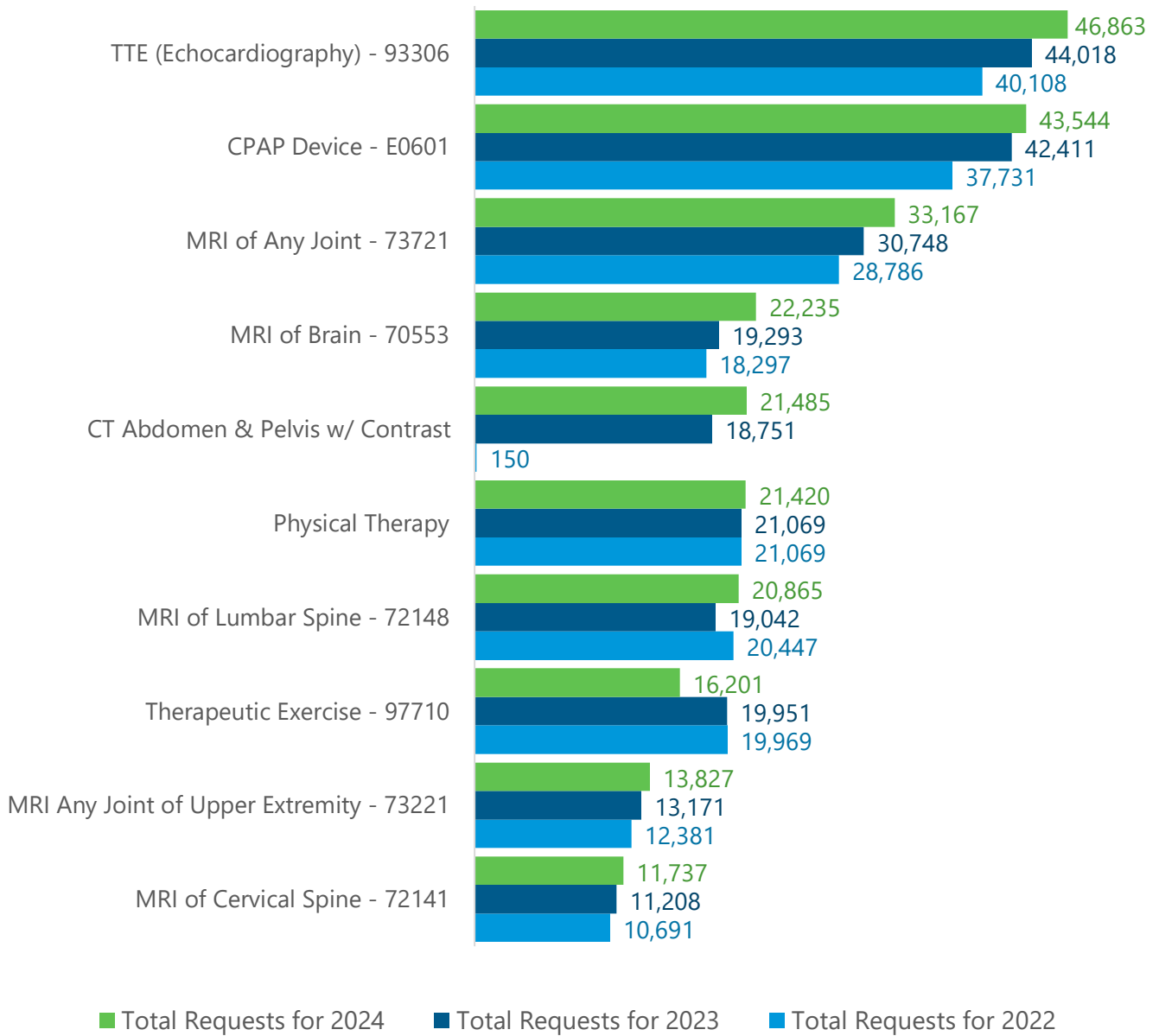
Figure 2 Highest number of requests by code totals 2024



Common procedures requiring prior authorization tended to be for MRI and CT scans, echocardiography, physical therapy, and continuous airway pressure (CPAP) devices.

Figure 3 below shows the total number of prior authorization requests for the 10 services codes with the highest number of requests for PY 2024, compared to the number of requests for those same service codes in PY 2023 and PY 2022.

Figure 3 Highest number of requests by code for 2024, 2023 and 2022 sorted by codes submitted for 2024.



Carriers submitted information about the approval rates for each code. Using the approval rates and the total number of requests, we determined the number of approved requests for each code. Excluding prescription drugs and office E&M prior authorization requests, for the service codes with the highest number of requests:

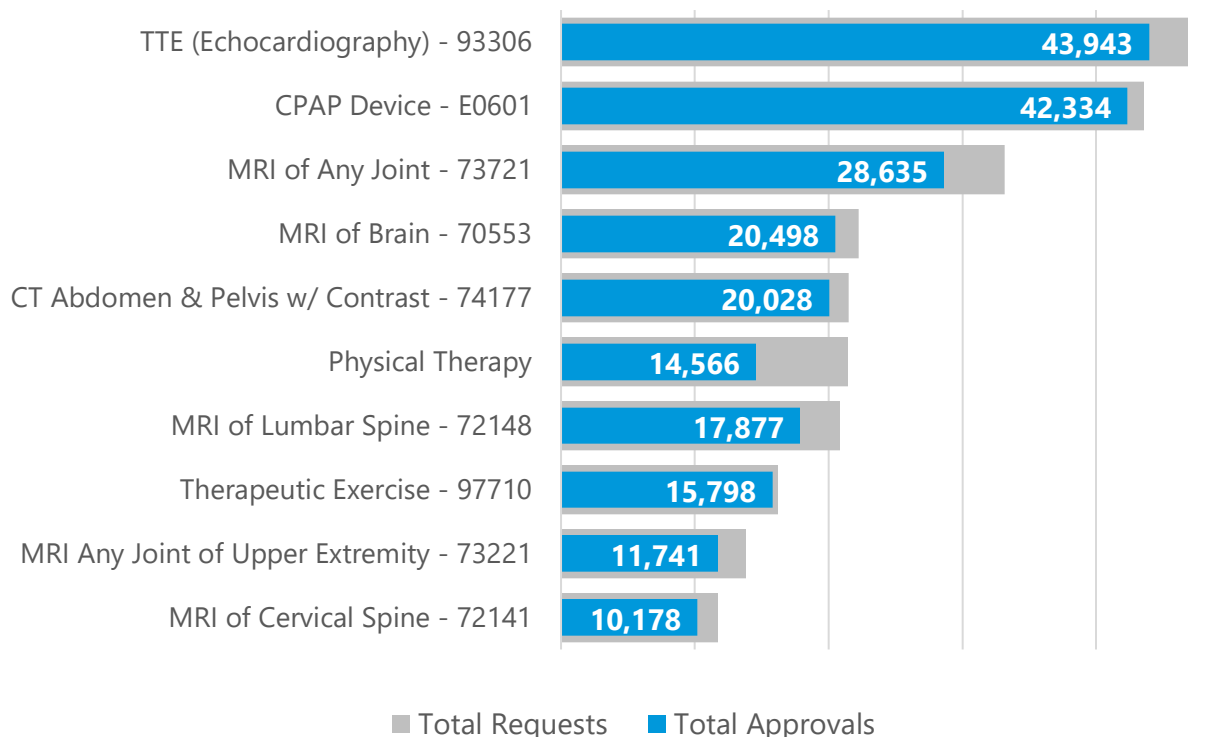
- The approval rate for all services was 90.5% (89.2% in PY 2023).
- Forty-four codes had 0% approval rates, with the number of requests ranging from 1 to 47.
- The lowest approval rate was 3.6%, for a wheelchair accessory code (HCPCS E1028), with 28 total requests. This excludes all codes that were approved 0% of the time.

- One hundred eighteen codes had approval rates of 100%. Among these codes, the number of requests ranged from 1 to 796 (98 of these codes had 15 or fewer total requests). The code with 796 prior authorization requests was HCPCS L4361 – Pneumatic walking boot.

Figure 4 shows the number of approved requests for each of the 10 most-requested codes.

Figure 4 Approved number of requests by code out of total requests

Number of approved requests out of the total number of requests for the codes with the highest number of prior authorization requests.



The data presented in Figures 2 - 4 are aggregated in the table in Figure 5 below. This table includes:

- The total number of requests
- The approval rates
- The number of carriers that reported each code

Figure 5 is sorted by total prior authorization requests in descending order.

Figure 5 Highest number of requests by code table

Code description	Total prior authorization requests	Number of approved requests	Approval percentage	Number of carriers that reported code
TTE (echocardiography) - 93306	46,863	43,943	93.8%	7
CPAP Device - E0601	43,544	42,334	97.2%	9
MRI Any Joint - 73721	33,167	28,635	86.3%	8
MRI Brain - 70553	22,235	20,498	92.2%	7
CT Abdomen & Pelvis - 74177	21,485	20,028	93.2%	5
Physical Therapy	21,420	14,566	68.0%	1
MRI Lumbar Spine - 72148	20,865	17,877	85.7%	6
Therapeutic Exercise - 97110	16,201	15,798	97.5%	6
MRI Any Joint of Upper Extremity - 73221	13,827	11,741	84.9%	2
MRI Cervical Spine - 72141	11,737	10,178	86.7%	2

Physical therapy was reported as the sixth most common code for prior authorization requests and had the lowest approval rate by a large margin. However, compared to other codes in the top 10, physical therapy was only reported by a single carrier for both 2024 and 2023, and in both years the approval rate was approximately 70%.

The OIC collected data from carriers showing the 10 codes with the highest prior authorization approval rate for each category of services. Several service codes appear in the top 10 services for both prior authorization requests and rate of prior authorization approvals.

The aggregated data in the tables below shows prior authorization data for the codes submitted by carriers with the highest approval rates. Figure 6 and Figure 7 below show the top 10 codes with the highest total number of requests. The first table (Figure 6) shows the 10 codes from this year’s reporting (PY 2024). The second table (Figure 7) shows last year’s reporting (PY 2023). Comparing the two, the total number of requests among procedures is generally similar. In both reporting years, CPAP devices had significantly more requests than other codes with high approval rates. As seen in Figure 5, CPAP device procedure codes have some of the highest number of total prior authorization requests.

- For this year’s reporting, the lowest approval percentage among the top 10 was 96% for a continuous positive airway pressure (CPAP) device. Three carriers reported a total of 4,864 requests for this service.
- All nine other codes among the codes with the highest approval rates had approval rates of 100%, as seen in Figure 6.
- Four of the 10 top codes with the highest approval rates were for orthotic or prosthetic procedures.
- Carriers reported 1,278 requests for genetics counseling, a marked increase from last year (390 requests). This service had a 100% approval rate.

- Beyond the reported top 10 codes in this category, carriers report that most codes had approval rates of 100%. Carriers reported 516 distinct codes; of these, 450, or 87% of them, were approved 100% of the time. This is similar to PY 2023, where 85% of codes were approved 100% of the time.

Figure 6 Highest prior authorization approval rate by code, PY 2024

Code description	Total requests	Total approvals	Approval rate	Number of carriers that reported code
CPAP Device - E0601	4,864	4,672	96%	3
Genetics Counseling - 96040	1,278	1,278	100%	2
Pneumatic Walking Boot - L4361	796	796	100%	2
TTE (echocardiography) - 93306	762	762	100%	1
Sleep Study - 95806	554	554	100%	2
Wrist Thumb Spica - L3809	415	415	100%	2
Psychotherapy - 90836	381	381	100%	1
Shoulder Orthosis - L3670	375	375	100%	2
Should Orthosis - L3660	345	345	100%	2
Cardiovascular Stress Test - 93015	344	344	100%	1

Figure 7 Highest prior authorization approval rate by code, PY 2023

Code description	Total requests	Total approvals	Approval rate	Number of carriers that reported code
CPAP Device - E0601	4,820	4,553	94%	3
Wrist Splint W/Wo Cock-Up - L3908	577	577	100%	2
Shoulder Orthosis - L3660	501	501	100%	2
Cystourethroscopy - 52000	498	498	100%	4
Mask Used W/ CPAP Device - A7027	470	470	100%	1
Wrist Thumb Spica - L3809	439	439	100%	2
Destruct Premalig Lesion - 17000	422	422	100%	2
Genetics Counseling - 96040	390	390	100%	1
Repair Orthotic Device - L4205	375	375	100%	2
Shoulder Orthosis - L3670	317	317	100%	2

Prior authorization requests by code type

The OIC further examined data within each of the requested health services categories:

- Inpatient medical/surgical
- Outpatient medical/surgical
- Inpatient mental health and substance use disorder
- Outpatient mental health and substance use disorder
- Diabetes supplies and equipment
- Durable medical equipment (DME)

Excluding office E&M codes, outpatient medical/surgical services had the highest number of total prior authorization requests, with 300,799 requests. Inpatient mental health and substance use disorder services had the fewest total requests, with 836. The total number of requests reported for the outpatient medical/surgical category saw a slight increase from the previous year (292,792 in PY 2023). There was some slight variation among the other service categories.

Figure 8 below shows the number of requests for each health service category. The figure uses the codes submitted for the top 10 codes with the highest number of prior authorization requests.

Figure 8 Total prior authorization requests by service category for 2024, 2023 and 2022.

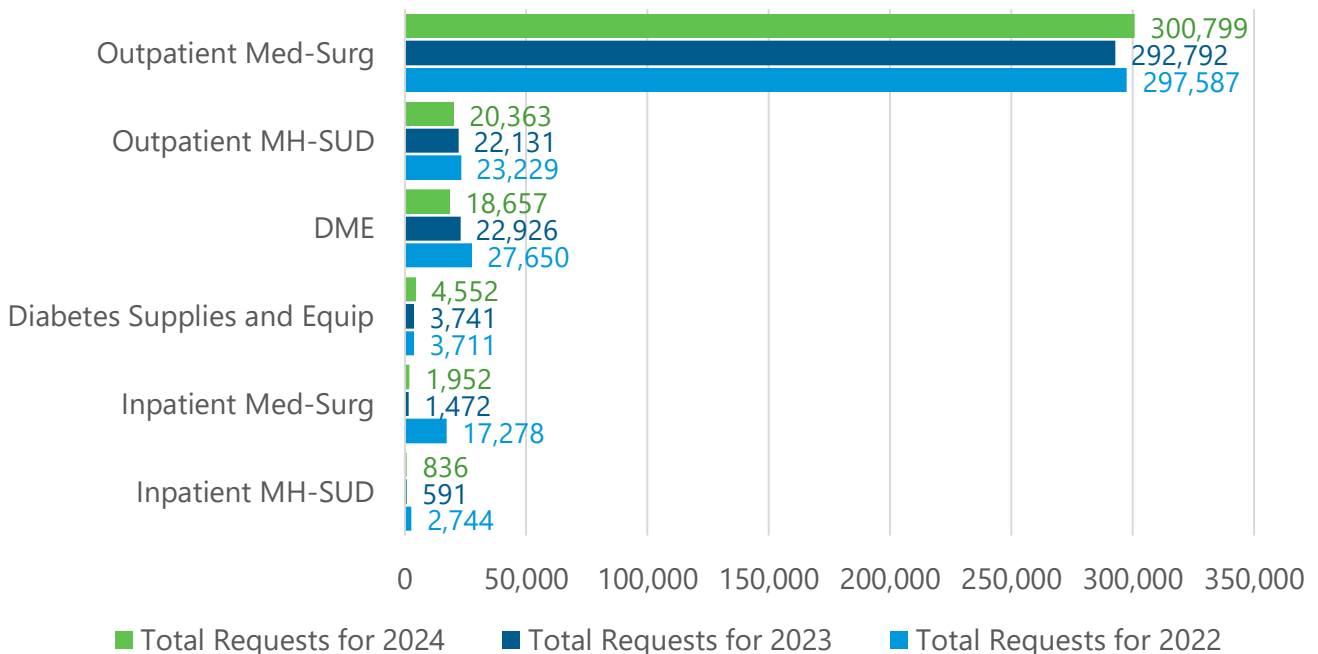


Figure 9 Top 5 highest number of code group requests PY 2024

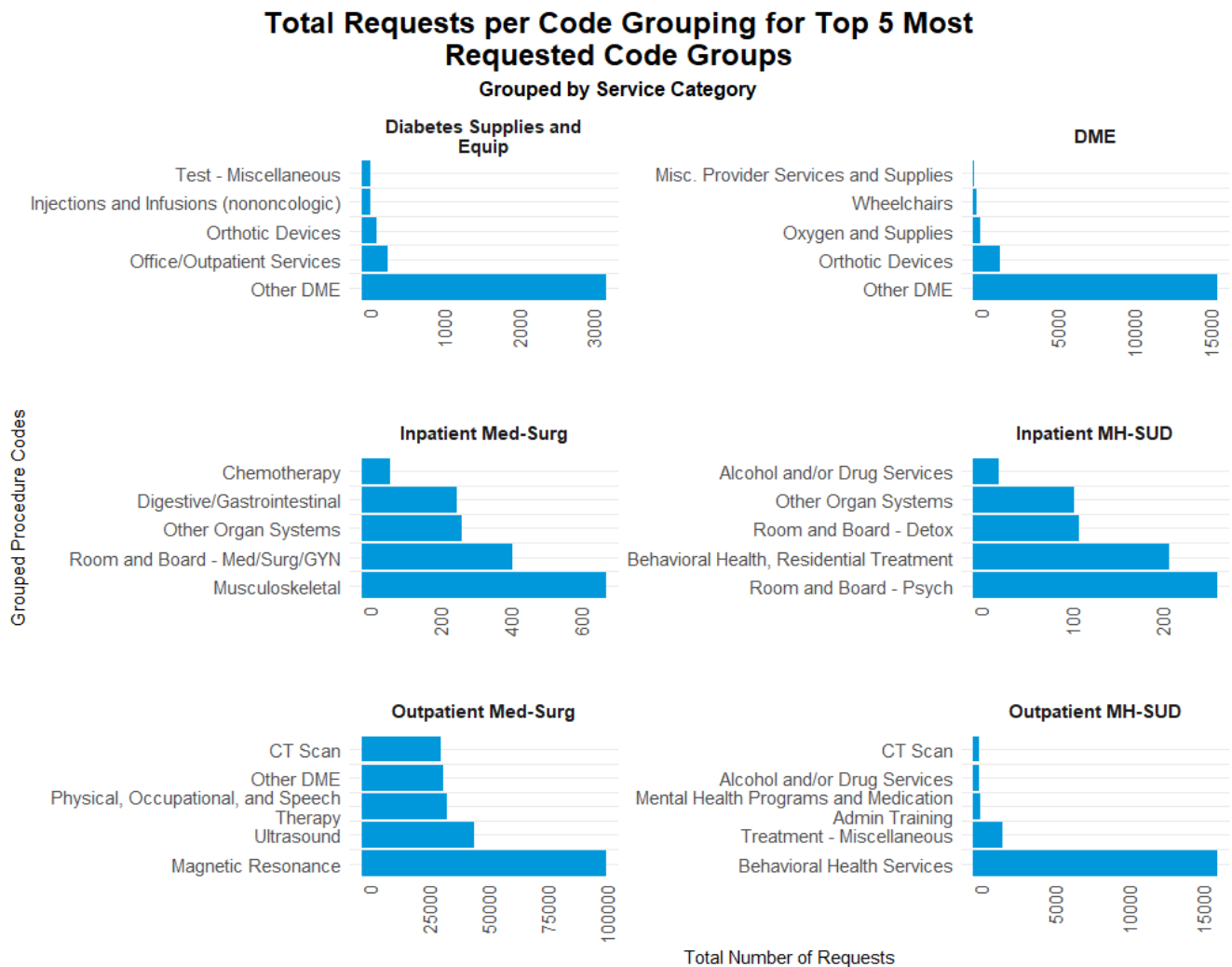


Figure 9 details total requests by code groupings aligned with the broad health services categories in RCW 48.43.0161. Code groupings are assigned using the CMS Restructured BETOS Classification System (RBCS), which allows researchers to group health care service codes into meaningful categories. We used the RBCS subcategories to determine code groupings. The data show that most health services categories had a single service code group with substantially more requests than other service code groups in the same category, as seen in Figure 9 above. Each group had a few additional codes with a significant number of requests. For example, among the 10 code groups with the most requests for outpatient mental health/substance use disorder codes:

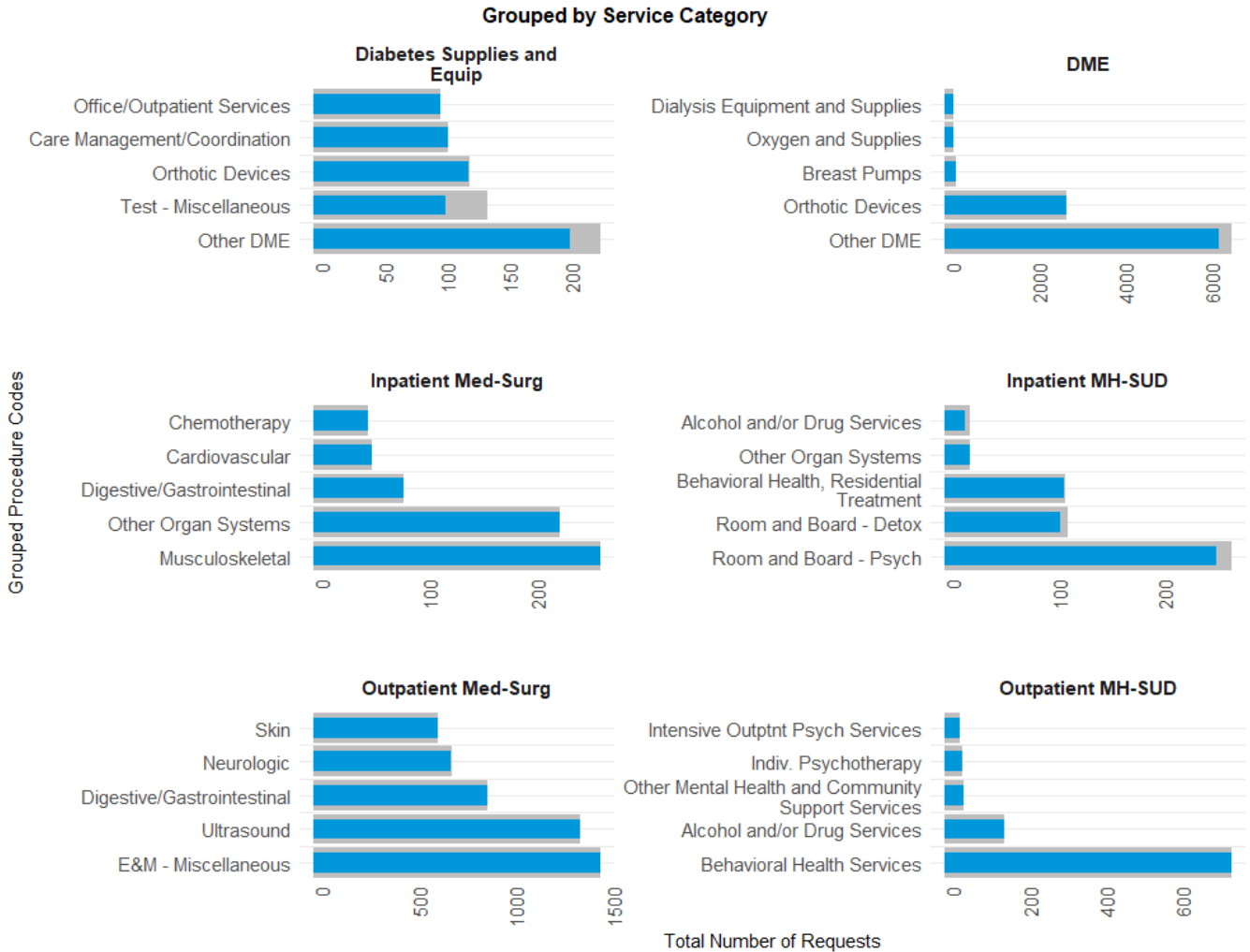
- The most requests were for the group Behavioral Health Services with 16,505 requests.
- The second-highest number was for the Treatment - Miscellaneous group with only 1,949 requests.

Figure 10 shows the breakdown of approved requests compared to the total number of requests for codes for each of the six health services categories. This figure details the number of approved requests

(in blue) out of the total number of requests (in gray) from the codes with the highest approval rates. Similar to Figure 9, like service codes are grouped.

Figure 10 Highest prior authorization approvals

Approved Requests per Code Grouping for Top 5 Most Approved Code Groups



Both inpatient and outpatient medical/surgical codes tend to have the highest percentage of approved prior authorization requests.

Looking at the top 10 codes is useful to examine the most prevalent codes submitted by the carriers. However, to get a fuller picture, we examined trends across all reported codes within each health services category.

Figure 11 details the changes in approval rates by service category. Outpatient Med-Surg, Inpatient Med-Surg, and Outpatient Mental Health/Substance Use Disorder were the service categories with the highest approval rates for PY 2024 among submitted codes. The DME service category saw the largest

increase in approval rate from 2023 to 2024. Diabetes Supplies and Equipment and Inpatient Mental Health/Substance Use Disorder codes saw decreases in approval rates from 2023 to 2024.

Figure 11 Approval rates for codes with the highest number of approvals

Service category	Approval rates				
	2020	2021	2022	2023	2024
Inpatient Med-Surg	97.4%	96.7%	100.0%	100.0%	100.0%
Inpatient MH-SUD	94.4%	97.1%	97.0%	95.7%	93.2%
Outpatient Med-Surg	98.3%	97.1%	99.6%	99.8%	99.9%
Outpatient MH-SUD	91.8%	89.8%	99.1%	99.9%	99.8%
DME	96.1%	95.9%	95.9%	96.5%	97.1%
Diabetes Supplies and Equip	84.1%	84.8%	85.7%	89.2%	82.4%

Figure 12 All reported codes for codes with the highest approval rates table, 2024

Service category	Approval rate	Number of distinct codes	Total number of requests	Count of distinct carriers
Inpatient Med-Surg	100.00%	176	856	15
Outpatient Med-Surg	99.89%	151	9,965	15
Outpatient MH-SUD	99.81%	114	1,228	13
DME	97.06%	146	10,404	15
Inpatient MH-SUD	93.15%	83	632	12
Diabetes Supplies and Equip	82.44%	70	1,219	13

Prior authorization request response times

For each submitted procedure code, the OIC collected the average standard, expedited and extenuating circumstances response time in hours. This report examines the response times for codes with the highest total number of prior authorization requests during the previous plan year and the response times for codes with the highest percentage of approved prior authorization requests during the previous plan year.

In the table below (Figure 13), the weighted average standard response times, expedited response times and extenuating circumstances response times are reported for each health services category. The weighted average response times are weighted; using the total number of requests for each type of response (standard, expedited, extenuating circumstances), as each submitted code had a variable number of associated requests. These results are averaged across all carrier submissions. For weighted

average standard response times, DME, inpatient mental health/substance abuse disorder and inpatient medical/surgical codes had the longest response times.

The average extenuating circumstances response time is substantially longer than other types of requests and longer than previous years' reporting. The number of extenuating circumstances requests was very low when compared to both standard and expedited requests. The number of extenuating circumstances requests in PY 2024 ranged from 0 (Diabetes Supplies and Equip) to 342 (Outpatient Med-Surg), excluding office E&M visits.

Figure 13 Weighted average response times for PY 2024 (PY 2023).

Service category	Weighted average standard response time in hours	Weighted average expedited response time in hours	Weighted average extenuating circumstances response time in hours
Outpatient Med-Surg	8.3 (12.1)	5.5 (15.6)	399.4 (43.1)
DME	100.3 (20.7)	2.3 (12.0)	474.6 (42.0)
Diabetes Supplies and Equip	34.6 (46.3)	5.5 (13.2)	NA (42.6)
Outpatient MH-SUD	16.2 (25.1)	5.8 (9.14)	296.9 (106.6)
Inpatient Med-Surg	39.6 (52.6)	22.2 (14.9)	405.1 (93.3)
Inpatient MH-SUD	45.1 (28.8)	23.2 (18.6)	116.1 (38.5)

Mental health/substance use disorder codes generally have longer standard response times than medical/surgical codes. All code groups in these two categories were analyzed.

Standard response time for mental health/substance use disorder code groups:

- Weighted average response time: 17.3 hours (down from 25.2 hours in PY 2023)

Standard response time for medical/surgical code groups:

- Weighted average response time: 8.5 hours (down from 12.3 hours in PY 2023)

For medical/surgical codes, the standard response time is driven largely by outpatient prior authorization requests, which had a total of 275,710 standard requests compared to inpatient medical/surgical codes, which had 1,686 standard requests in PY 2024.

Mental Health/Substance Use Disorder (MH/SUD) vs. medical/surgical prior authorization request findings

This section examines the difference in prior authorization requests between MH/SUD codes and medical/surgical codes for PY 2023 and PY 2024. To make this comparison, inpatient and outpatient MH/SUD codes were grouped together, and inpatient and outpatient medical/surgical codes were similarly grouped. Codes in both durable medical equipment and diabetes supplies and equipment categories were excluded from this analysis. The goal of this section is to determine whether any differences in prior authorization processes or outcomes exist between these two categories of health services.

The following chart (Figure 14) highlights the difference between the top 10 code groups for mental health/substance use disorder services and the top 10 code groups for medical/surgical services prior authorization requests for PY 2024 and 2023.

Figure 14 Medical-Surgical vs Mental Health/Substance Use Disorder

Total Requests per Code Grouping for Top 10 Most Requested Code Groups

Grouped by Service Category

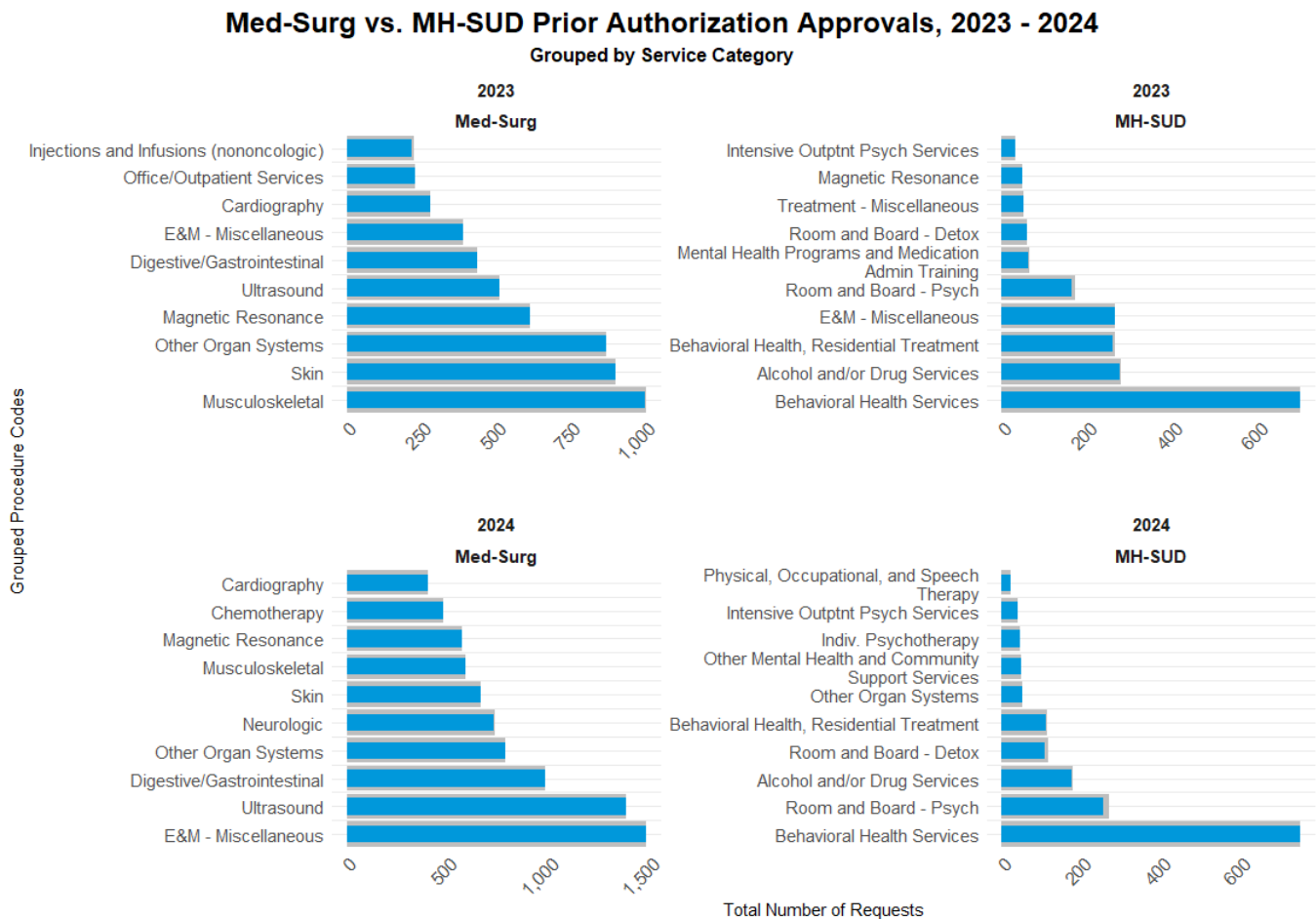


The findings display the 10 service code groups with the highest total number of prior authorization requests.

- For the medical/surgical category, Magnetic Resonance had the most requests for PY 2024 with a total of 102,808. Among these requests, 87% were approved.
- For the mental health/substance use disorder category, Behavioral Health Services (largely made up of psychotherapy procedures) had substantially more requests than any other code group, with a total of 16,506. Of these, 97.7% were approved.
- Excluding office E&M codes, for medical/surgical procedures there were 302,751 total requests reported in 2024 and 294,264 total requests reported in 2023. For mental health/substance use disorder codes, the total number of requests was 21,199 (down from 22,722 PY 2023).

The following figure (Figure 15) also compares medical/surgical and mental health/substance use disorder codes. Highlighted are the 10 code groupings with the highest number of prior authorization requests from the service code groups with the highest approval rates. The blue bars indicate the number of approvals, with gray bars representing the total requests.

Figure 15 Top 10 most approved Medical-Surgical vs Mental Health/Substance Use Disorder code groups



Among the top 10 service code groups with the highest approval rates:

- Medical/surgical procedures had an approval rate of 100%, except for musculoskeletal and neurologic services, which each had an approve rate of 99.7% and 99.3% respectively.
- The top 10 code groups in the mental health/substance use disorder group had approve rates ranging from 91.7% to 100% (5 code groups, behavioral health services, other organ systems, other mental health and community support services, individual psychotherapy, and intensive outpatient psych. services had approval rates of 100%).
- For this year’s reporting, medical/surgical code groups had an approval rate of 99.9% (up from 99.7% last year), and mental health/substance use disorder codes had an approval rate of 97.5% (down from 98.8% last year). These are the aggregate approval rates for the top 10 most approved codes submitted by each carrier. These overall approval rates are not representative of all prior authorization requests.

The table below (Figure 16) details the prior authorization approval rates for all codes in these two groups.

Figure 16 Medical-Surgical vs Mental Health/Substance Use Disorder prior authorization approval rates

Year	MH or Med-Surg	Total requests	Number of approvals	Percent approved
2020	Med-Surg	7,863	7,717	98.1%
2020	MH-SUD	4,564	4,262	93.4%
2021	Med-Surg	5,488	5,324	97.0%
2021	MH-SUD	5,134	4,856	94.6%
2022	Med-Surg	6,442	6,418	99.6%
2022	MH-SUD	3,704	3,613	97.5%
2023	Med-Surg	6,668	6,653	99.8%
2023	MH-SUD	2,108	2,083	98.8%
2024	Med-Surg	10,821	10,810	99.9%
2024	MH-SUD	1,860	1,814	97.5%

Prescription drug prior authorization reporting

[Engrossed Second Substitute House Bill 1357](#) directed the OIC to collect prescription drug prior authorization data from health carriers beginning in 2024 for PY 2023. This 2025 report marks the second year of collecting prescription drug prior authorization information.

Similar to the non-prescription drug data, the OIC requested the following information about codes with the highest percentage of:

- Prescription drug prior authorization requests during the previous plan year
- Approved prior authorization requests during the previous plan year
- Prior authorization requests that were initially denied and then subsequently approved on appeal

To compare prescription drug prior authorization reporting data across carriers, OIC requested that carriers submit prior authorization data at the Generic Product Identifier (GPI) 10 level. The GPI is a drug classification system created by Wolters Kluwer's Medi-Span.⁶ Specifically, the 10-character GPI was requested to capture a reasonable level of detail. Several carriers indicated that they did not have the GPI-10 codes available. In these cases, the 9-digit National Drug Code (NDC) was requested. Of the 15 carriers that submitted prescription drug data in some capacity, 11 provided GPI-10 codes. The remaining four submitted NDC-9 codes.

In addition to GPI/NDC, the reporting template also included a field for drug name. The name had to correlate with the GPI-10 or NDC-9 code reported. The OIC requested both the ingredient name and the brand names associated with the codes reported.

Prescription drugs with the most prior authorization requests

For the requested top 10 prescription drug codes with the highest number of prior authorization requests, semaglutide (brand names include Ozempic, Rybelsus and Wegovy) was the prescription drug with the most requests. Semaglutide (Ozempic, Rybelsus) is used to control blood sugar levels and reduce the risk of a stroke, heart attack or death in adults with type two diabetes. Semaglutide (Wegovy) is also increasingly used to help with weight loss. Fourteen carriers reported semaglutide within their respective top 10 codes with the highest number of prior authorization requests. Across all carriers, there were 18,505 requests for semaglutide in PY 2024, with 8,683 approvals (47% approval rate). Below is a table of the top 10 prescription drugs with the highest number of prior authorization requests across all carriers.

⁶ <https://www.wolterskluwer.com/en/solutions/medi-span/about/gpi>

Figure 17 Prescription drugs with the highest number of prior authorization requests (PY 2024)

Drug name	Brand names	Total requests	Total approvals	Percent approved	Count carriers
SEMAGLUTIDE	OZEMPIC, RYBELSUS, WEGOVY	18,505	8,683	46.92%	14
TIRZEPATIDE	MOUNJARO, ZEPBOUND	8,119	2,855	35.16%	13
LISDEXAMFETAMINE	VYVANSE, LISDEXAMFETA	3,266	1,502	45.99%	5
ADALIMUMAB	HUMIRA, AMJEVITA	2,370	2,050	86.48%	10
CYCLOSPORINE (OPHTH)	CEQUA, KLARITY, RESTASIS, VEVYE, VERKAZIA	1,973	1,427	72.33%	5
DUPILUMAB	DUPIXENT	1,886	1,500	79.52%	8
HYDROCODONE-ACETAMINOPHEN	HYDROCODONE-ACETAMINOPHEN	1,816	1,408	77.53%	4
LIRAGLUTIDE	VICTOZA	1,634	868	53.12%	5
EMPAGLIFLOZIN	JARDIANCE	1,451	1,232	84.93%	6
RIMEGEPANT	NURTEC	1,397	1,017	72.83%	6

The top 10 prescription drug codes reported above account for 76% of all drug codes reported in response to the request for the codes with the most prior authorization requests. Notably, among the prescription drugs with the highest number of prior authorization requests, the approval rates were markedly lower than among medical services. Across all reported prescription drugs with the highest number of prior authorization requests, the approval rate in 2024 was 56.9%.

Prescription drugs with the highest prior authorization approval rates

The OIC also collected information on the prescription drugs with the highest approval rates. Figure 18 details the top 10 drug codes with the highest approval rates ordered by total number of requests.

Figure 18 Prescription drugs with the highest prior authorization approval rates, ordered by total requests (PY 2024)

Drug Name	Brand Names	Total Requests	Total Approvals	Percent Approved	Count Carriers
DEXTROAMPHETAMINE	DEXTROAMPHETAMINE	131	131	100.0%	2
DEXTROMETHORPHAN	AUVELITY	117	117	100.0%	1
ADALIMUMAB	AMJEVITA, HUMIRA	95	95	100.0%	3
ETANERCEPT	ENBREL	85	85	100.0%	1
SECUKINUMAB	COSENTYX	73	73	100.0%	1
METHYLPHENIDATE	METHYLPHENIDATE, JORNAY	56	56	100.0%	2
ABEMACICLIB	VERZENIO	49	49	100.0%	3
RISANKIZUMAB	SKYRIZI	40	40	100.0%	4
REVLIMID	REVLIMID	39	39	100.0%	1
UPADACITINIB	XELJANZ XR, RINVOQ	39	39	100.0%	1

The drug prior authorization requests in the table above account for 36% of all submissions across carriers for this requested category.

All prescription drug prior authorization requests in this category had approval rates of 100% across all submitting carriers. This is a change from last year, when only 86% of all submitted prescription drug prior authorization requests had 100% approval rates.

Prescription drugs prior authorization response times

The average standard response time for prescription drug prior authorization requests ranged from 0.4 hours (flash glucose sensor, with 62 standard requests) to 60 hours (Dexcom receiver/sensor/transmitter, with 696 standard requests). Figure 19 shows the standard response times for the most commonly requested prescription drugs.

Figure 19 Standard response time for the most commonly requested prescription drugs, hours (PY2024)

Drug name	Brand names	Avg standard response time (hrs)	Total standard requests	Count carriers
SEMAGLUTIDE	OZEMPIC, RYBELSUS, WEGOVY	35.2	16,610	14
TIRZEPATIDE	MOUNJARO, ZEPBOUND	22.6	7,261	13
LISDEXAMFETAMINE	VYVANSE	45.5	2,890	5
CYCLOSPORINE	CEQUA, KLARITY, RESTASIS, VEVYE, VERKAZIA	27.7	1,907	5
ADALIMUMAB	HUMIRA, AMJEVITA	20.8	1,844	10
DUPILUMAB	DUPIXENT	22.7	1,504	8
LIRAGLUTIDE	VICTOZA	56.3	1,501	5
HYDROCODONE-ACETAMINOPHEN	HYDROCODONE-ACETAMINOPHEN	20.8	1,186	4
EMPAGLIFLOZIN	JARDIANCE	10.0	1,179	6
RIMEGEPANT	NURTEC	19.8	1,138	6

Prescription drug prior authorization data was grouped by therapeutic class to assess trends at a higher level. [Appendix C](#) provides details on primary uses for each therapeutic class. The antihyperglycemic therapeutic class had the prescription drugs with the most total prior authorization requests. This particular class consists of medications that lower blood glucose levels and are used to treat diabetes. Figure 20 below shows the top 10 therapeutic classes by total prior authorization requests and total approvals.

Figure 20 Top therapeutic classes with the most prior authorization requests (PY2024)

The total prescription drug prior authorization requests and approvals by drug therapeutic class for drugs with the most prior authorization requests

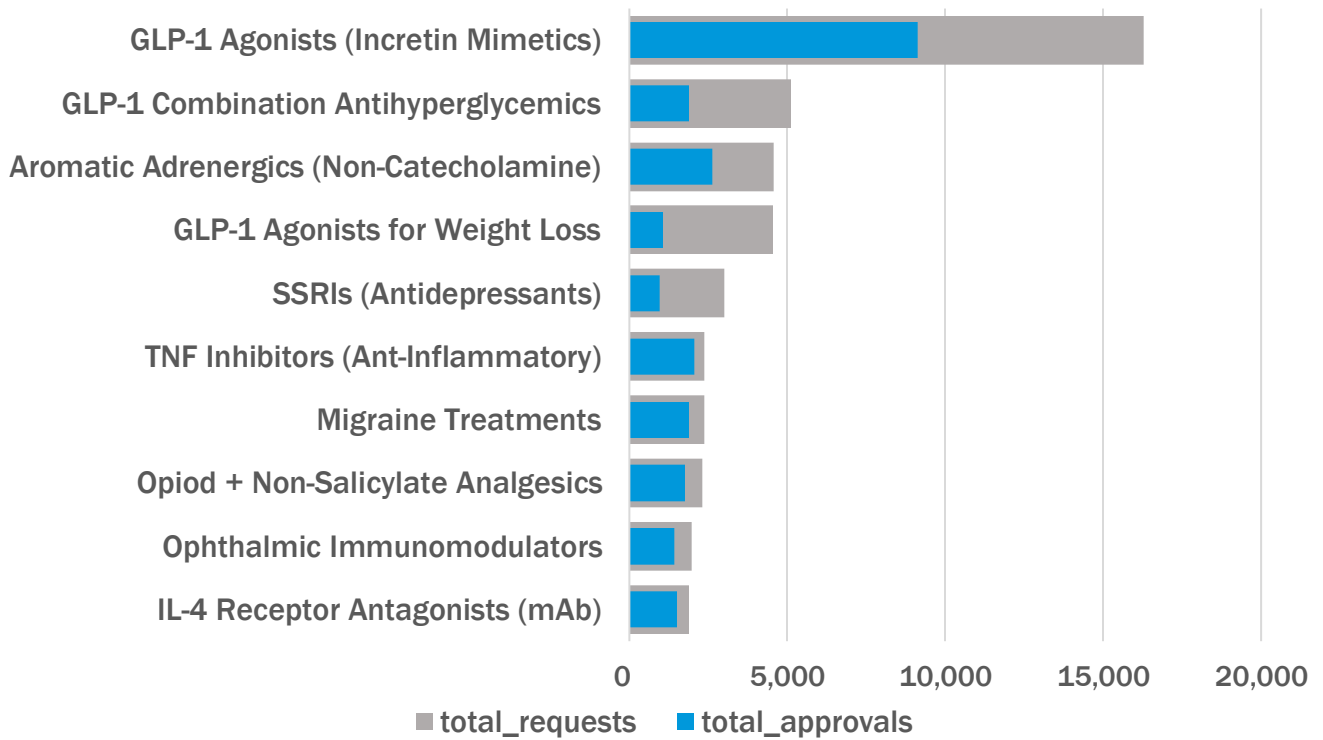


Figure 21 below provides further detail about all therapeutic classes and the drug within each class that had the most prior authorization requests. Semaglutide appears under both antihyperglycemic and anti-obesity classes, as it is used to treat both type two diabetes and obesity. For this particular drug, a majority of the prior authorization requests are for the diabetes medication.

Figure 21 All therapeutic classes and the drug in each class with the most prior authorization requests (PY 2024)

Therapeutic class	Drug name	Brand names	Total requests	Total approvals
ANTIHYPERGLY,INCRETIN MIMETIC(GLP-1 RECEP.AGONIST)	SEMAGLUTIDE	OZEMPIC, RYBELSUS	12,588	6,830
ADRENERGICS, AROMATIC, NON-CATECHOLAMINE	LISDEXAMPHETAMINE	LISDEXAMFETA, VYVANSE	3,266	1,502
ANTI-OBESITY GLUCAGON-LIKE PEPTIDE-1 RECEP AGONIST	SEMAGLUTIDE	WEGOVY	2,748	206
SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIS)	TIRZEPATIDE	MOUNJARO	2,386	684
ANTI-INFLAMMATORY TUMOR NECROSIS FACTOR INHIBITOR	ADALIMUMAB	HUMIRA, AMJEVITA	2,294	1,984
ANTIHYPERGLYCEMIC - INCRETIN MIMETICS COMBINATION	TIRZEPATIDE	ZEPBOUND, MOUNJARO	2,201	1,335
OPHTHALMIC ANTI-INFLAMMATORY IMMUNOMODULATOR-TYPE	CYCLOSPORINE	CEQUA, CYCLOSPORINE, RESTASIS, VERKAZIA, VEVYE, KLARITY	1,973	1,427
OPIOID ANALGESIC AND NON-SALICYLATE ANALGESICS	HYDROCODONE/ ACETAMINOPHEN	HYDROCODONE-ACETAMINOPHEN	1,816	1,408
INTERLEUKIN-4(IL-4) RECEPTOR ALPHA ANTAGONIST, MAB	DUPILUMAB	DUPIXENT	1,623	1,289
ANTIHYPERGLYCEMIC-SOD/GLUC COTRANSPORT2(SGLT2) INH	EMPAGLIFLOZIN	JARDIANCE	1,262	1,063
OPIOID ANALGESICS	OXYCODONE	OXYCODONE, OXYCONTIN, ROXICODONE	1,233	950
BETA-ADRENERGIC AND GLUCOCORTICOID COMBO, INHALED	BUDESONIDE-FORMOTEROL	SYMBICORT, BREYNA	1,191	655
DIRECT FACTOR XA INHIBITORS	APIXABAN	ELIQUIS	1,104	637
ANTIMIGRAINE PREPARATIONS	RIMEGEPANT	NURTEC	1,072	810
DIABETIC SUPPLIES	DEXCOM RECEIVER	DEXCOM	868	446

TOPICAL ANTI-INFLAMMATORY STEROIDAL	CLOBETASOL PROPIONATE	CLOBETASOL	818	247
TOPICAL ACNE AGENT,RETINOIC ACID RECEPTOR AGONIST	TRETINOIN	TRETINOIN, RETIN-A	662	315
ANTICONVULSANTS	PREGABALIN	PREGABALIN	488	158
TX FOR ATTENTION DEFICIT-HYPERACT(ADHD)/NARCOLEPSY	METHYLPHENIDATE	RITALIN	468	386
ANTIHYPERLIPIDEMIC - PCSK9 INHIBITORS	EVOLOCUMAB	REPATHA	415	355
ANDROGENIC AGENTS	TESTOSTERONE CYPIONATE	TESTOSTERONE	336	252
PROTON-PUMP INHIBITORS	OMEPRAZOLE	OMEPRAZOLE	236	210
TOPICAL IMMUNOSUPPRESSIVE AGENTS	TACROLIMUS	TACROLIMUS	219	164
ANTIPSORIATIC AGENTS,SYSTEMIC	RISANKIZUMAB-RZAA	SKYRIZI PEN	76	55
TOPICAL JANUS KINASE (JAK) INHIBITORS	RUXOLITINIB PHOSPHATE	OPZELURA	69	52
ANTICOAGULANTS	RIVAROXABAN	NA	52	49
IBS-C/CIC AGENTS, GUANYLATE CYCLASE-C AGONIST	LINACLOTIDE	LINZESS	36	16 N

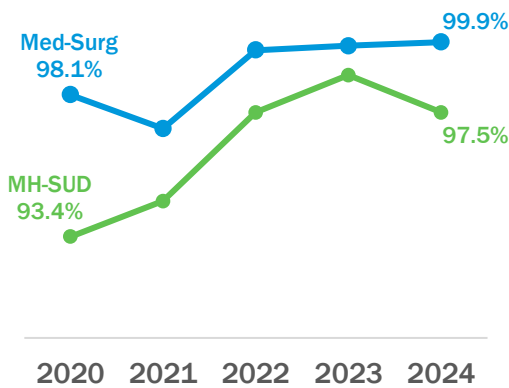
Conclusion

The review of the carrier submissions indicates several trends and notable comparisons. Outpatient medical/surgical codes had the most prior authorization requests. Inpatient medical/surgical codes had the highest approval rate, with codes in this category having an approval rate of 100%, the same as in 2022 and 2023. Codes in the category Diabetes Supplies and Equipment have the lowest approval rate (among codes with the highest approval rate), with 82.4% (89.2% in 2023), followed by DME with Inpatient mental health/substance use disorder with 93.2% (95.7% in 2023). Diabetes supplies and equipment codes saw the lowest approval rate since the inception of the reporting in 2020.

Among the reported codes/prescription drugs, the prior authorization approval rate was much lower for prescription drugs when compared to medical and MH/SUD codes. In 2024, the approval rate among the reported prescription drug prior authorizations was 56.9%, compared to 90.4% for medical and MH/SUD services.

Figure 22 Approval percent change

Change in approval rates for codes with the highest number of approvals.



Standard response times varied substantially across health services categories. Inpatient medical/surgical codes had an average standard response time of 39.6 hours (down from 52.6 hours in 2023), whereas outpatient medical/surgical codes had an average standard response time of 8.3 hours (down from 12.1 hours in 2023). The average inpatient MH-SUD standard response time increased to 45.1 hours (from 28.8 hours in 2023). As would be expected, expedited response times tended to be faster than both standard and extenuating circumstances response times. Codes with extenuating circumstances had the longest response times as compared to standard response times by a significant margin. The response times for extenuating circumstances saw a change from previous years, with some significant increases. It should be noted that this category of response

time had low total number of requests; most prior authorization requests are either standard or expedited.

There was also variation between mental health/substance use disorder codes and medical/surgical codes. Medical/surgical codes tended to have a shorter standard response time. The average standard response time for medical/surgical codes was 8.5 hours, as compared to 17.3 hours for mental health/substance use disorder codes. Among codes with the highest approval rates, the average approval rate for mental health/substance use disorder codes was 97%, as compared to 99.9% for medical/surgical codes. This gap has closed somewhat since PY 2020, and both categories have seen increases in approval rates since 2021, however this is a slight dip in approval rates for MH-SUD codes in 2024 (See Figure 22). There were substantially fewer mental health/substance use disorder codes reported.

Appendix A

RCW 48.43.0161 data reporting instruction sheet (Instructions sent to carriers)

For 2024 data submission (based on PY 2023 data)

Responses should be submitted to OIC at: market.conduct@oic.wa.gov

RCW 48.43.0161 requires health carriers to report prior authorization data based upon a threshold percentage of premiums written in Washington state. In interpreting this statute, the OIC took into consideration the consistency with existing National Association of Insurance Commissioner (NAIC) carrier financial reporting requirements. The OIC calculated the 1% threshold based upon premiums written in the individual, student health plan, small group and large group markets during 2024 as reported to the NAIC in the Supplemental Health Care Exhibit. The following carriers meet the 1% threshold for CY 2024:

- Aetna Life Insurance Company
- Asuris Northwest Health
- Cigna Health & Life Insurance Company
- Community Health Plan of WA
- Coordinated Care Corp.
- Kaiser Foundation Health Plan of the Northwest
- Kaiser Foundation Health Plan of Washington Options
- Kaiser Foundation Health Plan of Washington
- LifeWise Health Plan of WA
- Molina HealthCare of WA
- Premera Blue Cross
- Regence BlueCross BlueShield (BCBS) of Oregon
- Regence BlueShield
- UnitedHealthCare Insurance Co.
- UnitedHealthCare of Washington Inc.

By Sept. 15, 2025, the carriers listed above must report the de-identified and aggregated data listed below to the OIC for calendar year 2025, for Washington state residents enrolled in commercial health plans. The data is to be submitted using the Excel workbook accompanying these instructions. Failure to submit the data as specified is a violation that can result in fines and other appropriate penalties.

The data to be reported is as follows:

- The 10 inpatient medical or surgical codes, ten outpatient medical or surgical codes, 10 inpatient mental health and substance use disorder codes, 10 outpatient mental health and substance use disorder codes, 10 diabetes supplies and equipment codes, and 10 durable medical equipment codes with:
 - The highest total number of prior authorization requests during the previous plan year, including the total number of requests and percent of approved requests for each code.
 - The highest percentage of approved prior authorization requests during the previous plan year, including the total number of requests and percent of approved requests for each code. If more than 10 codes have an approval rate of 100%, the carrier should default to those codes with the greatest number of prior authorization requests.
 - The highest percentage of prior authorization requests that were initially denied, appealed by an enrollee and then subsequently approved on appeal, counting internal and external appeals, including the total number of requests and the percent of requests initially denied and then subsequently approved for each code.
- The average determination response time in hours for prior authorization requests to the plan and the number of requests with respect to each covered service included in the lists above for each of the following categories:
 - Expedited decisions;
 - Standard decisions;
 - Extenuating circumstances decisions. The OIC assumes that per WAC 284-43-2060, prior authorization will not have occurred for these claims. Under WAC 284-43-2060(6): *"claims and appeals related to an extenuating circumstance may still be reviewed for appropriateness, level of care, effectiveness, benefit coverage and medical necessity under the criteria for the applicable plan, based on the information available to the provider or facility at the time of treatment,"*. For claims processed via extenuating circumstances, the carrier should report the average response time in which authorization occurred following notification to the carrier by the provider or claim submission. In its reporting, a carrier may distinguish between claims for which a provider has notified the carrier of an extenuating circumstance prior to claims submission, and those claims that are administratively denied because a provider did not report the extenuating circumstances prior to claim submission and are then disputed by the provider.

[RCW 48.43.0161](#) requires reporting of response time in hours. A carrier whose data system does not track time in hours, but rather days, may use eight hours if the approval occurs within one day, but should report one day as 24 hours if there are multiple days involved.

[Engrossed Second Substitute House Bill 1357](#) has added prescription drug prior authorization reporting requirements for health carriers. Carriers should report the 10 prescription drugs:

- With the highest total number of prior authorization requests during the previous plan year, including the total number of prior authorization requests for each prescription drug.
- With the highest percentage of approved prior authorization requests during the previous plan year, including the total number of prior authorization requests for each prescription drug and the percent of approved requests for each prescription drug.
- With the highest percentage of prior authorization requests that were initially denied and then subsequently approved on appeal, including the total number of prior authorization requests for each prescription drug and the percent of requests that were initially denied and then subsequently approved for each prescription drug.

Attached is an Excel workbook for the carrier to enter its data. Each service category has a tab (including one for prescription drugs) with a labeled worksheet that contains three tables. The tables correspond with the requirements above. The top 10 codes entered into each **table are to be unique to each question asked**. CPT, HCPC and revenue codes are listed in separate columns.

For each code or codes (if the same service can be billed using more than one type of code) reported, provide a description of the service to which the code applies. Ten codes must be submitted in each table and each code must be accompanied by a description that correlates with the CPT, HCPC, or revenue code. The description should use full words, rather than abbreviations, so that non-coding personnel can interpret the information accurately. Providing only a description of the service does not meet the requirements for submission.

For prescription drug reporting, GPI 10 codes or nine-digit NDC codes are used to identify prescription drugs and are listed in separate columns in the Excel workbook. **We are requesting that carriers submit GPI 10 codes if available. Nine-digit NDC codes should be used if GPI 10 codes are not available.** When reporting using the nine-digit NDC codes, include only the five-digit labeler code and the four-digit product code, excluding the two-digit packaging code. **The GPI 10 codes reported must be 10 digits long and any NDC code reported must be nine digits long. Both fields must maintain leading zeros.** This is intended to clarify reporting and increase the OIC's ability to compare results across carriers.

The generic drug name must correlate with the GPI 10 or NDC code provided. For the generic drug name, only include the ingredient name. For example: the drug, "Palbociclib" should not include any packaging information. The GPI should be, "2153106000," or the nine-digit NDC code would be, "000690189." Please do not include the brand name. For example, "Ozempic" should be included as, "Semaglutide."

Please input all brand names associated with the GPI 10 that had applicable prior authorization requests. For each prescription drug at the GPI 10 level, please report the generic drug name (including only the ingredient name), as well as all brand names **for which there was a prior authorization request**. This should be a comma-separated list of prescription drug brand names. **The number of prior authorization requests should be aggregated at the GPI-10 (or NDC-9 if GPI not available) level.** See an example row for dextroamphetamine/amphetamine below:

Prescription Drug Generic Name	Prescription Drug Brand Name(s)	GPI 10	NDC-9 Code	Total number of prior authorization requests
Dextroamphetamine/ Amphetamine	Adderall, Adderall XR, Mydayis	6110990210		315

Prior authorization requests that include multiple services, some of which are approved and some of which are denied (i.e. "partial") prior authorizations, should be treated as denied and not counted more than once in a carrier's calculations.

When calculating the percentage of approved prior authorization requests, please include approved cases, denied cases, voided, withdrawn and pending cases in the denominator. Duplicate requests should not be included in the denominator.

Please report data for calendar year 2024, based upon the date of service.

Definitions:

- Codes - For medical, mental health and substance use disorder services, (Excel spreadsheet tabs 1-6) codes include CPT, HCPC and revenue codes. Only these codes can be utilized to represent a service or prior authorization. Non-industry standard codes cannot be used. If the same service can be paid using more than one type of code (e.g. both a HCPC and a revenue code), then prior authorization requests using either code should be combined in calculating the number of prior authorization requests and use one code. However, if a CPT or HCPC code applies to both medical/surgical and mental health/substance use disorder diagnoses, the volume of prior authorization requests for the service should be calculated separately for medical/surgical diagnoses and for mental health/substance use disorder diagnoses to determine whether that code constitutes one of the top 10 codes for either medical/surgical or mental health/substance use disorder services. "Unlisted codes," which are used when there is no CPT or HCPC code that accurately identifies the surgery or procedure being performed, should not be considered "codes" for purposes of reporting. For prescription drugs (Excel spreadsheet tab 7), codes include the GPI 10 or the nine-digit NDC codes. For NDC codes, please only include the five-digit labeler code and the four-digit product code, excluding the two-digit packaging code.
- Diabetes Supplies & Equipment – Materials and equipment used to assist in the monitoring of diabetes, including but not limited to blood sugar (glucose) test strips, blood glucose monitors,

lancet devices, lancets, and glucose control solutions for checking the accuracy of test strips and monitors.

- Durable Medical Equipment - Durable medical equipment is equipment that can withstand repeated use, is primarily and customarily used to serve a medical purpose, generally is not useful to a person in the absence of an illness or injury, and is appropriate for use in the home. As defined in [RCW 48.43.290](#), the [HealthCare.gov glossary](#) and for [Medicare coverage](#), durable medical equipment does not include implantable devices, prosthetics or orthotics.
- Expedited Request Decisions - Any request by a provider or facility for approval of a service where the passage of time could seriously jeopardize the life or health of the enrollee, seriously jeopardize the enrollee's ability to regain maximum function, in the opinion of a provider or facility with knowledge of the enrollee's medical condition, would subject the enrollee to severe pain that cannot be adequately managed without the service that is the subject of the request, or the enrollee is undergoing a current course of treatment using a nonformulary drug (See RCW 48.43. 830).
- Extenuating Circumstance - An unforeseen event or set of circumstances, which adversely affects the ability of a participating provider or facility to request prior authorization prior to service delivery (See WAC 284-43-2060).
- Prior Authorization – A mandatory process that a carrier or its designated or contracted representative requires a provider or facility to follow before a service is delivered, to determine if a service is a benefit and meets the requirements for medical necessity, clinical appropriateness, level of care, or effectiveness in relation to the applicable plan. This includes any term used by a carrier or its designated or contracted representative to describe this process. Per the definitions of “prior authorization” and “authorization” in WAC 284-43-0160, prior authorization occurs before a service is delivered and does not include concurrent reviews or continued stay reviews. For the purposes of this reporting, include only “clinical prior authorizations.” “Administrative prior authorizations” and prior authorizations for specialist out-of-network referrals should be excluded.
- Standard Request Decisions – A request by a provider or facility for approval of a service where the request is made in advance of the enrollee obtaining a service that is not required to be expedited (See WAC 284-43-0160 and 284-43-2050).

For questions, please contact Karen Brooks at 360-725-7028 or submit an email to CompanySupervisionMCO@oic.wa.gov.

Appendix B

ESSB 6404 response template

Each carrier was directed to complete the Excel spreadsheet below for each of the following categories of health care service codes:

- Inpatient medical/surgical codes
- Outpatient medical/surgical codes
- Inpatient mental health and substance use disorder codes
- Outpatient mental health and substance use disorder codes
- Diabetes supplies and equipment codes
- Durable medical equipment codes
- Prescription drug codes

Codes with the highest total number of prior authorization requests during the previous plan year

Column1	Description of Service	CPT Code	HCPC Code	Revenue Code	Total number of prior authorization requests for each code	Percentage of approved requests for each code	Average determination response time in hours for prior authorization requests - Expedited Decisions	Average determination response time in hours for prior authorization requests - Standard Decisions	Average determination response time in hours for prior authorization requests - Extenuating Circumstances Decisions	Number of Requests - Expedited Decisions	Number of Requests - Standard Decisions	Number of Requests - Extenuating Circumstances Decisions
Code 1												
Code 2												
Code 3												
Code 4												
Code 5												
Code 6												
Code 7												
Code 8												
Code 9												
Code 10												

Codes with the highest percentage of approved prior authorization requests during the previous plan year

Column1	Description of Service	CPT Code	HCPC Code	Revenue Code	Total number of prior authorization requests for each code	Percentage of approved requests for each code	Average determination response time in hours for prior authorization requests - Expedited Decisions	Average determination response time in hours for prior authorization requests - Standard Decisions	Average determination response time in hours for prior authorization requests - Extenuating Circumstances Decisions	Number of Requests - Expedited Decisions	Number of Requests - Standard Decisions	Number of Requests - Extenuating Circumstances Decisions
Code 1												
Code 2												
Code 3												
Code 4												
Code 5												
Code 6												
Code 7												
Code 8												
Code 9												
Code 10												

Codes with the highest percentage of prior authorization requests that were initially denied and then subsequently approved

Column1	Description of Service	CPT Code	HCPC Code	Revenue Code	Total number of prior authorization requests for each code	Percentage of requests initially denied and then subsequently approved for each code	Average determination response time in hours for prior authorization requests - Expedited Decisions	Average determination response time in hours for prior authorization requests - Standard Decisions	Average determination response time in hours for prior authorization requests - Extenuating Circumstances Decisions	Number of Requests - Expedited Decisions	Number of Requests - Standard Decisions	Number of Requests - Extenuating Circumstances Decisions
Code 1												
Code 2												
Code 3												
Code 4												
Code 5												
Code 6												
Code 7												
Code 8												
Code 9												
Code 10												

Codes with the highest total number of prior authorization requests during the previous plan

Column1	Prescription Drug Generic Name	Prescription Drug Brand Name(s)	GPI 10	NDC-9 Code	Total number of prior authorization requests for each code	Percentage of approved requests for each code	Average determination response time in hours for prior authorization requests - Expedited Decisions	Average determination response time in hours for prior authorization requests - Standard Decisions	Average determination response time in hours for prior authorization requests - Extenuating Circumstances Decisions	Number of Requests - Expedited Decisions	Number of Requests - Standard Decisions	Number of Requests - Extenuating Circumstances Decisions
Code 1												
Code 2												
Code 3												
Code 4												
Code 5												
Code 6												
Code 7												
Code 8												
Code 9												
Code 10												

Codes with the highest percentage of approved prior authorization requests during the

Column1	Prescription Drug Generic Name	Prescription Drug Brand Name(s)	GPI 10	NDC-9 Code	Total number of prior authorization requests for each code	Percentage of approved requests for each code	Average determination response time in hours for prior authorization requests - Expedited Decisions	Average determination response time in hours for prior authorization requests - Standard Decisions	Average determination response time in hours for prior authorization requests - Extenuating Circumstances Decisions	Number of Requests - Expedited Decisions	Number of Requests - Standard Decisions	Number of Requests - Extenuating Circumstances Decisions
Code 1												
Code 2												
Code 3												
Code 4												
Code 5												
Code 6												
Code 7												
Code 8												
Code 9												
Code 10												

Codes with the highest percentage of prior authorization requests that were initially denied

Column1	Prescription Drug Generic Name	Prescription Drug Brand Name(s)	GPI 10	NDC-9 Code	Total number of prior authorization requests for each code	Percentage of requests initially denied and then subsequently approved for each code	Average determination response time in hours for prior authorization requests - Expedited Decisions	Average determination response time in hours for prior authorization requests - Standard Decisions	Average determination response time in hours for prior authorization requests - Extenuating Circumstances Decisions	Number of Requests - Expedited Decisions	Number of Requests - Standard Decisions	Number of Requests - Extenuating Circumstances Decisions
Code 1												
Code 2												
Code 3												
Code 4												
Code 5												
Code 6												
Code 7												
Code 8												
Code 9												
Code 10												

Appendix C

This table provides details on primary uses for each therapeutic class. The short class names are used in Figure 20. The uses column describes what the class of drugs is used to treat.

Therapeutic class	Short class name	Uses
ANTIHYPERGLY,INCRETIN MIMETIC(GLP-1 RECEPTOR AGONIST)	GLP-1 Agonists (Incretin Mimetics)	Used to treat type 2 diabetes. Increase insulin secretion and suppress glucagon release.
ADRENERGICS, AROMATIC, NON-CATECHOLAMINE	Aromatic Adrenergics	Used to treat asthma, nasal congestion, and hypotension.
ANTI-OBESITY GLUCAGON-LIKE PEPTIDE-1 RECEPTOR AGONIST	GLP-1 Agonists for Weight Loss	Used to treat obesity.
SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIS)	SSRIs (Antidepressants)	Used to treat depression, anxiety, and related mood disorders.
ANTI-INFLAMMATORY TUMOR NECROSIS FACTOR INHIBITOR	TNF Inhibitors	Used to treat inflammation such as rheumatoid arthritis.
ANTIHYPERGLYCEMIC - INCRETIN MIMETICS COMBINATION	GLP-1 Combination Antihyperglycemics	Used to treat type 2 diabetes by mimicking incretin hormones.
OPHTHALMIC ANTI-INFLAMMATORY IMMUNOMODULATOR-TYPE	Ophthalmic Immunomodulators	Used to reduce pain or treat inflammation in the eyes.
OPIOID ANALGESIC AND NON-SALICYLATE ANALGESICS	Opioid + Non-Salicylate Analgesics	Narcotics such as morphine or oxycodone, plus non-salicylate analgesics like acetaminophen.
INTERLEUKIN-4(IL-4) RECEPTOR ALPHA ANTAGONIST, MAB	IL-4 Receptor Antagonists (mAb)	Used to treat inflammatory and allergic diseases by blocking IL-4 signaling.
ANTIHYPERGLYCEMIC-SODIUM/GLUCOCOTRANSPORT2(SGLT2) INH	SGLT2 Inhibitors	Used to treat type 2 diabetes.
OPIOID ANALGESICS	Opioid Analgesics	Narcotics such as morphine or oxycodone.
BETA-ADRENERGIC AND GLUCOCORTICOID COMBO, INHALED	Inhaled Beta-Agonist + Steroid Combo	Used to treat asthma and COPD.
DIRECT FACTOR XA INHIBITORS	Factor Xa Inhibitors	Prevent blood clots.
ANTIMIGRAINE PREPARATIONS	Migraine Treatments	Used to treat migraines.
DIABETIC SUPPLIES	Diabetic Supplies	Used for diabetes supplies.

TOPICAL ANTI-INFLAMMATORY STEROIDAL	Topical Steroids	Used topically to reduce inflammation and irritation.
TOPICAL ACNE AGENT,RETINOIC ACID RECEPTOR AGONIST	Topical Retinoids (Acne)	Used to treat acne by regulating epithelial cell growth through retinoic acid receptors.
ANTICONVULSANTS	Anticonvulsants	Used to treat seizures.
TX FOR ATTENTION DEFICIT-HYPERACT(ADHD)/NARCOLEPSY	ADHD/Narcolepsy Treatments	Used to treat ADHD and narcolepsy.
ANTIHYPERLIPIDEMIC - PCSK9 INHIBITORS	PCSK9 Inhibitors	Used to lower cholesterol levels.
ANDROGENIC AGENTS	Androgens	Used to increase androgen levels such as testosterone.
PROTON-PUMP INHIBITORS	PPIs (Proton Pump Inhibitors)	Used to treat stomach acid-related conditions.
ANTIBIOTICS	Antibiotics	Used to treat bacterial infections.
TOPICAL IMMUNOSUPPRESSIVE AGENTS	Topical Immunosuppressants	Used to treat inflammatory skin diseases.
ANTIPSORIATIC AGENTS,SYSTEMIC	Systemic Psoriasis Agents	Used to treat psoriasis.
TOPICAL JANUS KINASE (JAK) INHIBITORS	Topical JAK Inhibitors	Used to treat atopic dermatitis, psoriasis, alopecia, and vitiligo.
ANTICOAGULANTS	Anticoagulants	Used to prevent and treat blood clots.
IBS-C/CIC AGENTS, GUANYLATE CYCLASE-C AGONIST	GC-C Agonists (IBS-C/CIC Agents)	Used to treat chronic constipation and IBS-C by increasing intestinal fluid secretion.