



**HFS**

Illinois Department of  
Healthcare and Family Services

We improve lives.

## **Prior authorization metrics for medical items and services (excluding drugs) – Calendar Year 2025**

### **CMS Final Rule**

To comply with the CMS Interoperability and Prior Authorization [Final Rule](#), the Illinois Department of Healthcare and Family Services (HFS) 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. In accordance with the Final Rule, this report is limited to fee-for-service (FFS) data. The Final Rule also requires each Medicaid MCO to post a prior authorization report with their health plan specific metrics.

It is important to note that the prior authorization data reported under the Final Rule include services that may not have been approved for various reasons, including administrative reasons such as missing medical documentation; coverage reasons such as requests for services not covered under the health plan; or clinical reasons such as requests for services that do not align with clinical policy or existing medical evidence (for example, experimental treatments). For questions on prior authorizations or the data below, contact the Medicaid Provider helpdesk at 1-877-782-5565.

The following pages provide the required data.

**Reporting Period:** Calendar Year 2025 (January 1, 2025 – December 31, 2025)

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

HFS requires prior authorization from the following services:

- Adaptive Behavior Support Services
- Bariatric Surgery<sup>1</sup>
- Dental<sup>2</sup>
- Durable Medical Equipment (DME) and Supplies
- Home Health
- Inpatient Coronary Artery Bypass Grafting (CABG) and Back Surgeries
- Non-emergency Transportation<sup>3</sup>
- Optometric Supplies
- Podiatry

Therapies (Occupational, Physical, Speech)

The [Fee Schedules](#) available online provide more detailed information on the above services which require prior authorization.

Dental, non-emergency transportation, and inpatient CABG and Back Surgeries prior approvals are administered by outside vendors: [DentaQuest](#), [Transdev](#), and [Acentra Health](#). Please visit their websites for additional information.

Beginning January 1, 2026, the CMS Interoperability and Prior Authorization [Final Rule](#) requires state Medicaid agencies to send prior authorization decisions within:

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

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<sup>1</sup> Prior approval is required for surgeon(s). Prior approval is not required for an assistant surgeon.

<sup>2</sup> The dental fee schedule identifies procedure codes that require prepayment review, but it does not distinguish between prior approval and prepayment review. Prior approval is required for four procedure codes: D4277, D4278, D8080, D8670.

<sup>3</sup> Non-emergency transportation prior authorizations include requests for managed care members enrolled in a [HealthChoice Illinois](#) (HCI) plan who require non-emergency ground ambulance services. Although these members are in managed care, the associated claims are billed directly to HFS FFS and providers must obtain prior approval through the transportation vendor. Additional information is available in the [December 14, 2021 Provider Notice](#).

There are no Medicaid FFS program required timeframes for either type of prior authorization request prior to January 1, 2026, and there are no Children's Health Insurance Program (CHIP) fee for service (FFS) program required decision timeframes for expedited prior authorization requests prior to January 1, 2026.

The data tables that follow display information on 1) standard requests, 2) expedited requests, and 3) the amount of time between receiving a prior authorization request and sending a decision. In addition to HFS-administered services<sup>4</sup> this report also includes detailed information from three HFS FFS vendors (dental, institution inpatient CABG and back surgery, and non-emergency transportation vendors).

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<sup>4</sup> HFS-administered prior approval requests are received by HFS's Prior Approval Team and include adaptive behavior support services, bariatric surgery, DME and supplies, gender affirmation services, home health, optometric supplies, pathways services, podiatry, occupation therapy, physical therapy, and speech therapy.

## 1. Standard (non-urgent) Prior Authorization Requests

	How many times this happened	Out of total standard requests	Percentage
<b>Request Approved</b>			
<b>All services</b>	<b>65,978</b>	<b>122,544</b>	<b>53.8%</b>
HFS-administered	37,251	67,506	55.2%
Dental	4,392	21,014	20.9%
Institutional inpatient CABG and back surgery	259	261	99.2%
Non-emergency transportation	24,076	33,763	71.3%
<b>Request Denied</b>			
<b>All services</b>	<b>56,556</b>	<b>122,544</b>	<b>46.2%</b>
HFS-administered	30,245	67,506	55.2%
Dental <sup>a</sup>	16,622	21,026	79.1%
Institutional inpatient CABG and back surgery	2	261	0.8%
Non-emergency transportation <sup>b</sup>	9,687	33,763	28.7%

### Notes:

<sup>a</sup> Dental prior authorizations include coverage for orthodontia, including D8080 (Comprehensive Orthodontic Treatment) and D8670 (Periodic Orthodontic Treatment Visits). Because providers often submit D8080 together with all anticipated D8670 visits, a single denial for not meeting medical necessity criteria can result in multiple denied line items. As a result, denial counts can appear higher than the number of underlying clinical denials.

<sup>b</sup> The non-emergency transportation vendor is required to adjudicate trip requests within five days. If a prior authorization request does not contain enough information to validate the trip within that timeframe, the request must be denied. When the missing information is provided after the five-day window, a new prior authorization must be submitted and processed. This process can artificially increase the number of recorded denials.

	How many times this happened	Out of total requests <sup>a</sup>	Percentage
Request approved only after time for review was extended	0	0	0%
Request approved only after appeal	60	21,014	0.3%

### Note:

<sup>a</sup> Total requests are the total number of standard dental requests. HFS-administered services, and services from institutional inpatient CABG and back surgery and non-emergency transportation vendors did not receive requests for approval after appeal.

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

	<b>How many times this happened</b>	<b>Out of total expedited requests</b>	<b>Percentage</b>
<b>Request Approved</b>			
<b>All services</b>	<b>120,294</b>	<b>138,075</b>	<b>87.1%</b>
HFS-administered	17	25	68.0%
Dental	0	12	0%
Institutional inpatient CABG and back surgery	0	0	0%
Non-emergency transportation	120,277	138,038	87.1%
<b>Request Denied</b>			
<b>All services</b>	<b>17,781</b>	<b>138,075</b>	<b>12.9%</b>
HFS-administered	8	25	32.0%
Dental	12	12	100%
Institutional inpatient CABG and back surgery	0	0	0%
Non-emergency transportation	17,761	138,038	12.9%

	<b>How many times this happened</b>	<b>Out of total expedited requests</b>	<b>Percentage</b>
Request approved only after time for review was extended	0	0	0

### 3. Time Between Receiving a Prior Authorization Request and Sending a Decision

	Mean (Average Time)	Median (Middle) Time
<b>Standard (non-urgent) Prior Authorization Requests (response due to provider within 7 calendar days)</b>		
<b>All services</b>	<b>13.9 days</b>	<b>N/A<sup>a</sup></b>
HFS-administered	18.7 days <sup>b</sup>	7 days
Dental	13.6 days	1.0 days
Institutional inpatient CABG and back surgery	1 day	0 days
Non-emergency transportation	4.8 days	5 days
<b>Expedited (urgent) Prior Authorization Requests (response due to provider within 72 hours)</b>		
<b>All services</b>	<b>1.5 days</b>	<b>N/A</b>
HFS-administered	1 day	0 days
Dental	1.3 days	1.3 days
Institutional inpatient CABG and back surgery	--	--
Non-emergency transportation	1.5 days	1 day

**Notes:**

<sup>a</sup> Medians are reported separately for HFS-administered services and by vendor.

<sup>b</sup> Response times for HFS-administered (non-vendor) services are based on the Received Date and Disposition Date. These dates are updated when certain actions are taken on the request such as when a provider requests an additional copy of the decision. This can artificially extend the recorded response times and HFS is actively working to address this issue.

**Data Methodology Limitations:**

HFS has identified several limitations when collecting data related to standard (non-urgent) and expedited (urgent) prior authorizations requests and is actively working on solutions for future reporting. These limitations include the following:

- HFS reports prior authorizations for non-vendor services based on each individual service requested and reviewed. In contrast, some vendors report prior authorizations by counting the number of requests submitted, and a single

request can include multiple services. HFS is working with its vendors to ensure that reporting is consistent across all vendors.

- As noted above, reported prior authorization counts can include services that were not approved for various reasons, including administrative issues (such as missing medical documentation), coverage limitations (such as requests for noncovered services), or clinical determinations (such as services that do not meet medical policy or evidence based standards, including experimental treatments).
- Dental prior authorization metrics in Illinois require careful interpretation because medical necessity is strictly defined by the presence of one or more automatic qualifying conditions or through achieving a qualifying score on the Handicapping Labio-Lingual Deviation (HLD) index. Requests that do not meet these criteria are denied as not medically necessary under Medicaid policy. Many families seek orthodontic care for cosmetic reasons, and providers can submit prior authorization requests even when they know the case is unlikely to qualify. These submissions increase the denominator of requests and lead to higher denial rates.
- As noted above, dental prior authorizations include two procedure codes: (1) orthodontic adjustments (D8670) and (2) the initial placement of orthodontic appliances (D8080). Illinois uses a global payment model in which comprehensive treatment (D8080) and up to 11 related adjustment visits (D8670) are submitted together. When a request does not meet medical necessity criteria, a single denial for the comprehensive service results in multiple denied adjustment lines, which increases the observed denial rate for D8670.