

# GHC-SCW Prior Authorization Metrics For Medical Items And Services

Group Health Cooperative of South Central Wisconsin (GHC-SCW) is committed to transparency and timely access to care. In accordance with the CMS Interoperability and Prior Authorization Final Rule (CMS-0057), we publish information about prior authorization requirements and related metrics each year.

This information helps members understand:

- Which medical items and services require prior authorization
- How often prior authorization requests are approved or denied
- How quickly prior authorization decisions are made

## What Is Prior Authorization?

Prior authorization is a process used by health plans to determine whether a specific medical item or service is medically necessary before it is provided. This process helps ensure care is appropriate, evidence-based and covered under your health plan. *Prescription drugs are not included in this reporting.*

## What services require Prior Authorization?

Some medical items and services require approval before they are covered, this report excludes prescription drugs. The list can be found below and was last updated on **January 26, 2026**.

[Click Here to View the Prior Authorization Services List](#)

*Under the CMS-0057 Interoperability and Prior Authorization Final Rule, prior authorization obligations may change as CMS issues new or updated guidance and as new CPT/HCPCS codes are released during the year.*

Visit [ghcscw.com/prior-authorization](https://ghcscw.com/prior-authorization) for more information.

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MK26-9-0(2.26)FL

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## Prior Authorization Metrics

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**Reporting Period:** January 1, 2025 – December 31, 2025  
(Authorizations received by GHC-SCW during calendar year 2025)

To meet federal transparency requirements, GHC-SCW reports aggregated data showing how prior authorization requests were handled during the reporting year.

### These metrics include:

- The total number of prior authorization requests received
- The number of requests approved
- The number of requests denied
- Requests approved after additional review or appeal
- Requests that were withdrawn or not completed

This data is reported in aggregate and does not include personally identifiable member information.

## Prior Authorization Decision Timeframes

Before January 1, 2026, health plans are required to issue prior authorization decisions within the timeframes below. These timeframes reflect federal requirements and are designed to support timely access to care.

### Medicaid Managed Care Plans

- Expedited (urgent) requests: within 72 hours
- Standard (non-urgent) requests: within 14 calendar days

### Qualified Health Plans (QHPs) on the Federally-Facilitated Exchange (FFE)

- Expedited (urgent) requests: within 72 hours
- Standard (non-urgent) requests: within 15 calendar days

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# Understanding GHC-SCW Prior Authorization Metrics

The charts in this report show how prior authorization requests were handled by GHC-SCW during the reporting period. These metrics are reported in accordance with federal transparency requirements and are shown in aggregate, meaning they reflect overall trends and **do not include any personal or identifying member information**.

## Approval and Denial Percentages

The approval and denial percentages show the percentage of prior authorization requests that resulted in each type of decision during the reporting year.

- **Approved** – The request was approved as submitted
- **Denied** – The request did not meet coverage or medical necessity criteria
- **Approved after appeal** – The request was approved after additional clinical review
- **Denied after appeal** – The request remained denied after appeal
- **Time for review extended** – The review timeframe was extended when allowed under federal rules

Most prior authorization requests are approved, particularly for urgent requests where timely care is critical.

## Urgent vs. Non-Urgent Requests

The charts are grouped by **urgent** and **non-urgent** requests:

- **Urgent requests** are used when a delay could seriously affect a member's health
- **Non-urgent requests** are used for services that can safely follow standard review timelines

Both types of requests are reviewed by clinical professionals using evidence-based guidelines

## Differences by Line of Business

Some charts separate results by coverage type, such as **BadgerCare Plus (WI-Medicaid)** and **Qualified Health Plans**. These distinctions reflect **different federal and state program rules**, not differences in how individual members are treated.

## Understanding Review Timeframes: Mean and Median

Some charts may show the time between receiving a prior authorization request and sending a decision. Decision times shown in the data below reflect completed requests only during the reporting period.

- **Mean** (average) time reflects the overall average decision time.
- **Median** (middle) time shows the midpoint, which helps reduce the effect of unusual or complex cases.

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## Non-Urgent Prior Authorization Requests

Line of Business	Decision Type	Percentage
Badgercare Plus (WI-Medicaid)	Request approved	98%
Badgercare Plus (WI-Medicaid)	Request denied	2%
Badgercare Plus (WI-Medicaid)	Request approved after appeal	0%
Badgercare Plus (WI-Medicaid)	Request denied after appeal	0%
Badgercare Plus (WI-Medicaid)	Request approved only after time for review was extended	0%
Badgercare Plus (WI-Medicaid)	Request denied after time for review was extended	0%
Qualified Health Plan	Request approved	97%
Qualified Health Plan	Request denied	3%
Qualified Health Plan	Request approved after appeal*	25%
Qualified Health Plan	Request denied after appeal*	75%
Qualified Health Plan	Request approved only after time for review was extended	0%
Qualified Health Plan	Request denied after time for review was extended	0%

## Urgent Prior Authorization Requests

Line of Business	Decision Type	Percentage
Badgercare Plus (WI-Medicaid)	Request approved	99%
Badgercare Plus (WI-Medicaid)	Request denied	1%
Badgercare Plus (WI-Medicaid)	Request approved after appeal	0%
Badgercare Plus (WI-Medicaid)	Request denied after appeal	0%
Badgercare Plus (WI-Medicaid)	Request approved only after time for review was extended	0%
Badgercare Plus (WI-Medicaid)	Request denied after time for review was extended	0%
Qualified Health Plan	Request approved	97%
Qualified Health Plan	Request denied	3%
Qualified Health Plan	Request approved after appeal	0%
Qualified Health Plan	Request denied after appeal	0%
Qualified Health Plan	Request approved only after time for review was extended	0%
Qualified Health Plan	Request denied after time for review was extended	0%

These charts show aggregated prior authorization activity for the reporting year and do not include individual member information.

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

Authorization Type	Line of Business	Mean (Average) Time	Median (Middle) Time
Non-Urgent Prior Authorization Requests	Badgercare Plus (WI-Medicaid)	1.2 days	0 days
Urgent Prior Authorization Requests	Badgercare Plus (WI-Medicaid)	0.4 days	0 days
Non-Urgent Prior Authorization Requests	Qualified Health Plan	1 days	0 days
Urgent Prior Authorization Requests	Qualified Health Plan	0.2 days	0 days

### Important Context for These Metrics

- Prior authorization requests are usually submitted by a provider's office, not the member.
- Approval rates can vary by service type and clinical complexity.
- Some denials occur because required documentation was missing or incomplete and may later be approved after review.
- These metrics are designed to promote transparency and do not reflect individual care outcomes.

### Questions About Prior Authorization?

If you have questions about whether a service requires prior authorization or need help understanding this information, please contact GHC-SCW Member Services at (608) 828-4853 or (800) 605-4327.

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\*Only had 4 appeals in these categories.

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