2025 CCO Prior Authorization Report

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Executive Summary

House Bill 2517

Oregon House Bill (HB) 2517, passed during the 2021 Legislative Session, requires the Oregon Health Authority (OHA) to compile and post information reported from coordinated care organizations (CCOs) regarding prior authorizations received during the calendar year. This report contains aggregate CCO data, including the number of requests for prior authorizations (PAs) received by the CCOs, the number of requests initially denied, the reasons for the denials, the total number of PA related appeals, and the number of PA related denials that were reversed on appeal.

Background

CCO Contract Exhibit I reporting requirements

CCO Grievance and Appeal System requirements, including PA reporting, are outlined in Exhibit I of the CCO Contract. OHA began collecting PA data from CCOs in Quarter 3 of 2022 via changes to the quarterly Exhibit I Grievance and Appeal System reports. OHA releases an updated CCO Prior Authorization report annually containing data related to the prior year. This report contains data from Quarters 1-4 of calendar year 2025.

Changes in reporting and impact in 2025

OHA continues to refine the data collection and cleaning process. Routine error checks that result in error logs being sent to the CCOs for correction were implemented to improve data quality. Additional logic error checks were added in 2025 to ensure denial reasons that only apply to prior authorization were used for PA denials. Continued refinement of the error check process should improvement the quality and accuracy of PA data in current and future reports.

Prior authorization, denial, and appeal process

Although many Oregon Health Plan (OHP) services require CCOs to provide direct access --no referral or prior approval – many other services require approval before the service is administered. This is known as prior authorization. Prior authorizations (PAs) are submitted by a provider to the member's CCO. Examples of common services that require PA include: planned surgical procedures, care in a skilled nursing facility, and some radiological services such as magnetic resonance imaging (MRI).

CCOs are required to review PA requests as quickly as the member's health condition requires, per 410-141-3835, and must meet the review timeframes listed on the next page.

Timeframes for prior authorizations

- Standard decisions must be made within 14 days. If more time is needed, CCOs can request an extension of 14 additional days.
- If a member or provider feel that following the standard timeframe puts the member's life, health or ability to function in danger, an expedited prior authorization decision can be requested.
- Expedited decisions are typically made within 72 hours. If a determination is made that an expedited decision is not required (based on the criteria described in the bullet above), the request will revert back to the standard timeframe.

Denials and appeals

If a PA is not approved, members receive notification of the denial, also called a Notice of Adverse Benefit Determination (NOABD). These notices provide information about the member's rights, including how to appeal to the CCO if the member disagrees with the denial and how to ask OHA to review the denial in a contested case hearing.

An appeal could lead to an overturned denial. Like PAs, CCOs are also required to review appeal requests as quickly as the member's health condition requires, per 410-141-3890, and must meet the review timeframes listed below

Timeframes for appeals

- Members must ask for an appeal within 60 days of a denial (the date of the Notice of Adverse Benefit Determination). Authorized representatives and providers, with written consent, can also ask for an appeal on the member's behalf.

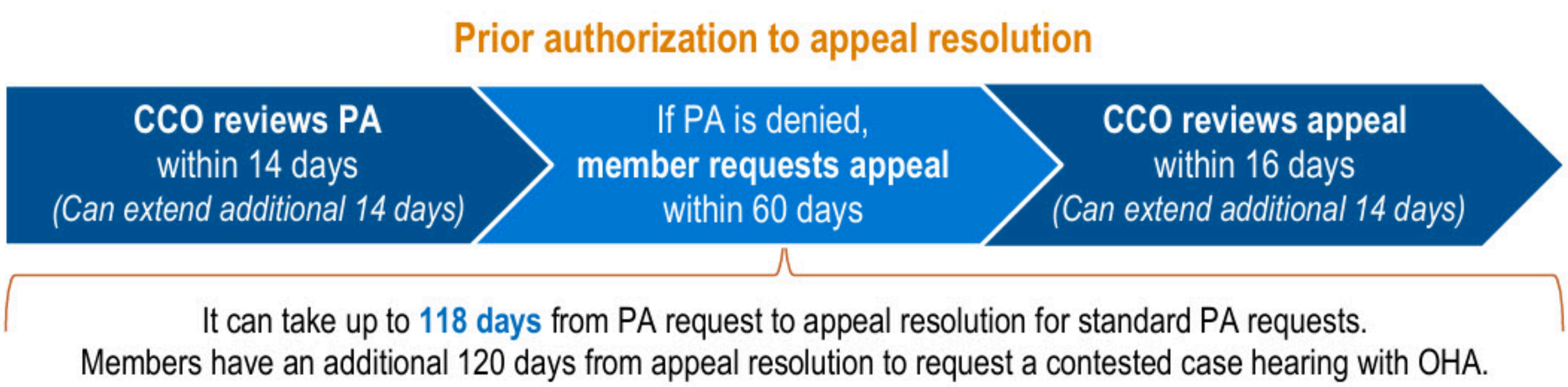
- For standard appeals, CCOs have 16 days to review the request and respond. If more time is needed, CCOs can request an extension of 14 additional days.

- If a member or provider feel that following the standard timeframe puts the member's life, health or ability to function in danger, an expedited appeal can be requested.

- CCOs are required to resolve expedited appeals within 72 hours. If a determination is made that an expedited decision is not required (based on the criteria described in the bullet above), the request will revert back to the standard timeframe.

Please see Figure 1 below to better understand prior authorization, denial, and appeal timeframes. These timeframes are important to consider when interpreting the data presented in the remaining Figures below. Approval or denial of a request for PA and/or resolution of an appeal or contested case hearing related to a request for PA may not necessarily occur within the same quarter as the date the PA was submitted to the CCO for consideration.

Figure 1. Timeframes for PA Review and Appeal



CCO Prior Authorization Reporting and Review

CCOs are required to submit the Grievance and Appeal Log to OHA quarterly (within 45 days after the end of each quarter). Respective due dates each year are: Feb. 14, May 15, Aug. 14, and Nov.14. On a quarterly basis, OHA cleans the data, performs an analysis and compiles data related specifically to Prior Authorizations (PAs). Results of the analysis for quarters 1-4 in 2025 are included on the next 4 pages.

Figure 2. Prior Authorizations and Denials by Quarter
This figure presents the 2025 Prior Authorization data, summarizing the total PA requests received and denied by quarter. There were 1,792,720 prior authorizations requests submitted and a total of 180,122 PA requests were denied, showing an overall denial rate of 10.05%. While the total PA requests increased in Q3 and Q4 when compared to Q1 and Q2, denial rates were lower in Q3 and Q4 by over 1% when compared to Q1 and Q2.

Figure 3. Prior Authorization Denials by Denial Type (Action Category)
This figure summarizes the number of PAs denied, breaking them down by different denial types/action categories and quarter. The majority of denials, over 96%, were for "Denial or limited authorization of a requested service." The next most common reason was "Member's request to obtain services outside the MCE provider's panel." All other categories such as denial of payment, reduction or suspension of approved services and technical failures had fewer denials in comparison.

Figure 4. Prior Authorization Denials by Denial Reason (Sub Category)
This figure displays the number of PAs denied, summarizing them by different denial reasons (Sub Categories) and quarter. The majority of denials were due to two reasons "The service is not medically/dentally appropriate" with 64,630 denials and "Treatment is not a covered service" with 37,993 denials.

Figure 5. Prior Authorization Denials Appealed by Quarter
This figure presents 2025 data on the outcomes of appeals made on denied PAs, segmented by quarter. In 2025, there were 12,085 denied PAs appealed and out of those, 4,429 appeal decisions were reversed, meaning initial denial decision was overturned. The highest decision reversal rate was in Q1 with almost 42% of PA denial decisions appealed being overturned. Q4 had the lowest rate of PA denial decisions overturned by appeal (almost 34%) as well as the lowest amount of total PA denials submitted for appeal (2,151).

Note: Reporting for Q3 and Q4 2024 was based on data received from 10 of the 16 CCOs because of data quality issues. This may explain increases in total PA requests, denials, and appeals when comparing 2024 to 2025 data. Additionally, OHA continues to make efforts to improve the quality of data reporting. Changes in PA denial rates and rate of PA denials overturned by appeal may reflect improved data accuracy and reporting and not necessarily increases in actual PA denials and PA denials overturned by appeal.

CCO Prior Authorization Reporting and Review Continued

To ensure accuracy and alignment with reporting requirements, all data reflects denial categories that were based on the use of a prior authorization (PA) process, avoiding possible misclassification and to prevent reporting numbers for claim denials. The report excludes specific denial reasons and denial types that are typically used for claim denials or services that do not require a PA.

2025 CCO Statewide Aggregate Prior Authorization Data by Quarter

Figure 2. Prior Authorizations and Denials by Quarter

2025 Percentage of Denied PAs by Quarter

Quarter	Percentage of Denied PAs
Q1 2025	10.69%
Q2 2025	10.89%
Q3 2025	9.31%
Q4 2025	9.46%
% of Denied PAs in 2025	**10.05%**

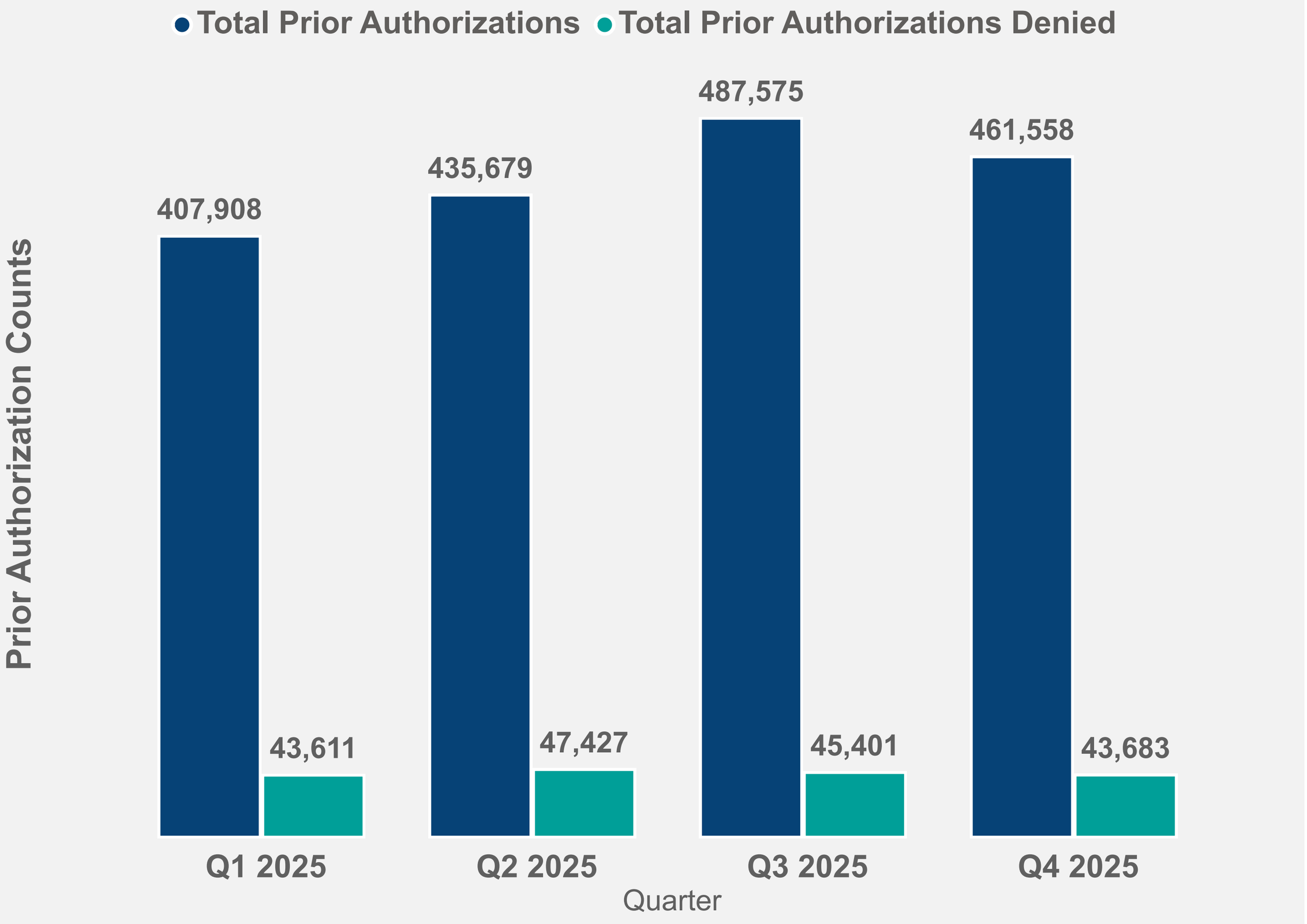
Total Prior Authorizations in 2025

1,792,720

Total Denied PAs in 2025

180,122

2025 Total Prior authorizations requested and denied by Quarter



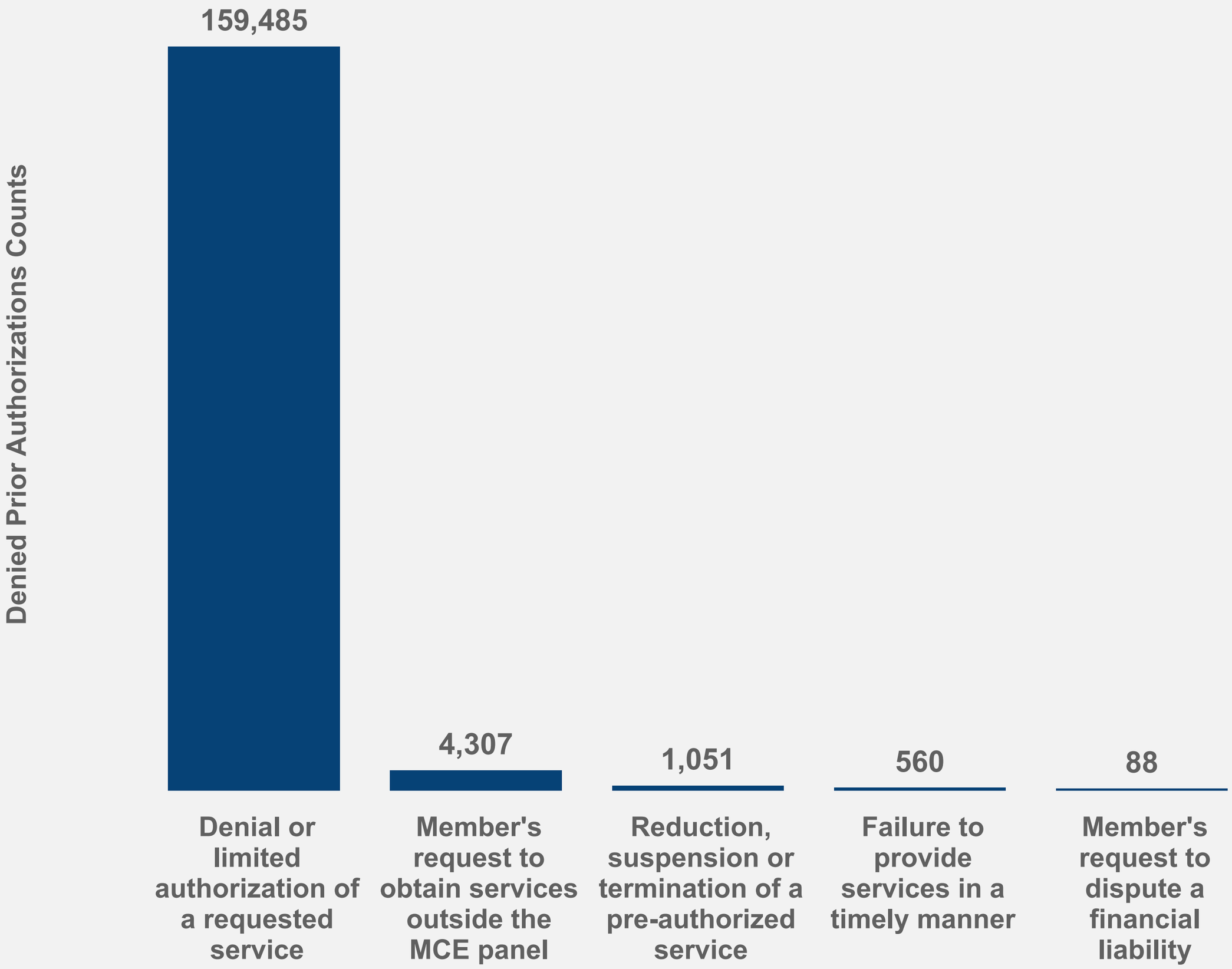
2025 CCO Statewide Aggregate Prior Authorization Denials Data by Quarter

Figure 3. Prior Authorization Denials by Denial Type (Action Category)

2025 Prior Authorization Denials by Denial Type (Action Category) and Quarter

Denial Type	Q1 2025	Q2 2025	Q3 2025	Q4 2025	Total
Denial or limited authorization of a requested service	35,927	40,781	41,948	40,829	**159,485**
Member's request to obtain services outside the MCE panel	986	1,362	921	1,038	**4,307**
Reduction, suspension or termination of a pre-authorized service	107	288	586	70	**1,051**
Failure to provide services in a timely manner	145	199	101	115	**560**
Member's request to dispute a financial liability	8	51	29		**88**
Total	**37,173**	**42,681**	**43,585**	**42,052**	**165,491**

2025 Prior Authorization Denials by Denial Type (Action Category)



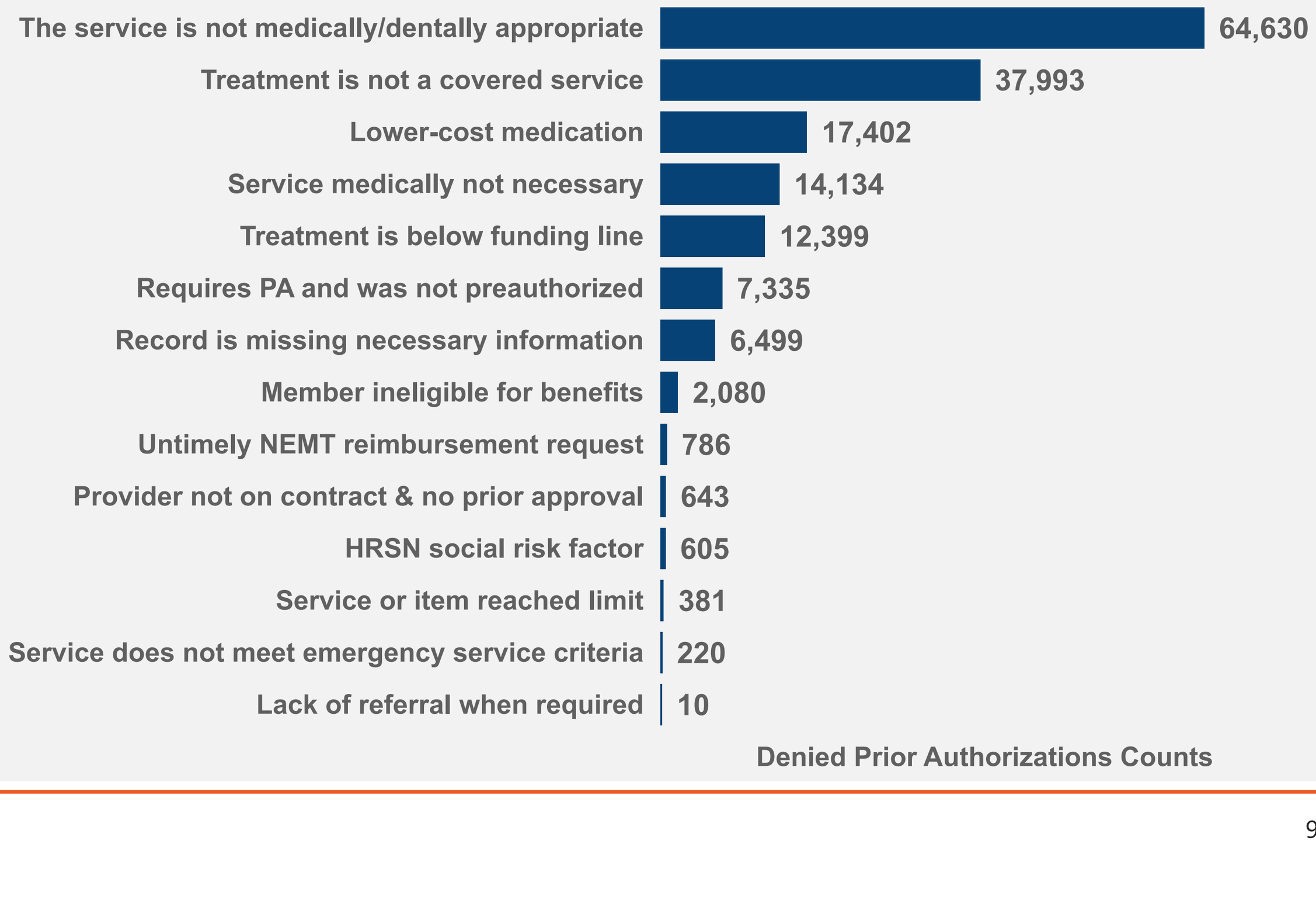
2025 CCO Statewide Aggregate Prior Authorization Denials Data by Quarter

Figure 4. Prior Authorization Denials by Denial Reason (Sub Category)

2025 Prior Authorization Denials by Denial Reason (Sub Category) and Quarter

Denial Reason	Q1 2025	Q2 2025	Q3 2025	Q4 2025	Total
The service is not medically/dentally appropriate	15,596	16,127	16,498	16,409	**64,630**
Treatment is not a covered service	9,966	9,565	9,280	9,182	**37,993**
Lower-cost medication	3,213	4,744	4,718	4,727	**17,402**
Service medically not necessary	2,908	3,323	4,055	3,848	**14,134**
Treatment is below funding line	2,796	3,220	3,234	3,149	**12,399**
Requires PA and was not preauthorized	2,185	1,987	2,301	862	**7,335**
Record is missing necessary information	1,007	1,792	1,881	1,819	**6,499**
Member ineligible for benefits	626	370	486	598	**2,080**
Untimely NEMT reimbursement request	189	182	328	87	**786**
Provider not on contract & no prior approval	173	140	191	139	**643**
HRSN social risk factor	151	151	132	171	**605**
Service or item reached limit	17	28	135	201	**381**
Service does not meet emergency service criteria	52	69	42	57	**220**
Total	**38,881**	**41,700**	**43,285**	**41,251**	**165,117**

2025 Prior Authorization Denials by Denial Reason (Sub Category)



2025 CCO Statewide Aggregate Denied Prior Authorizations Appealed Data by Quarter

Figure 5. Prior Authorization Denials Appealed by Quarter

2025 Percentage of PA Appeals reversed

Quarter	Percentage of PA Appeals Reversed 2025
Q1 2025	41.93%
Q2 2025	36.02%
Q3 2025	36.86%
Q4 2025	33.72%
% PA Appeals Reversed in 2025	**36.65%**

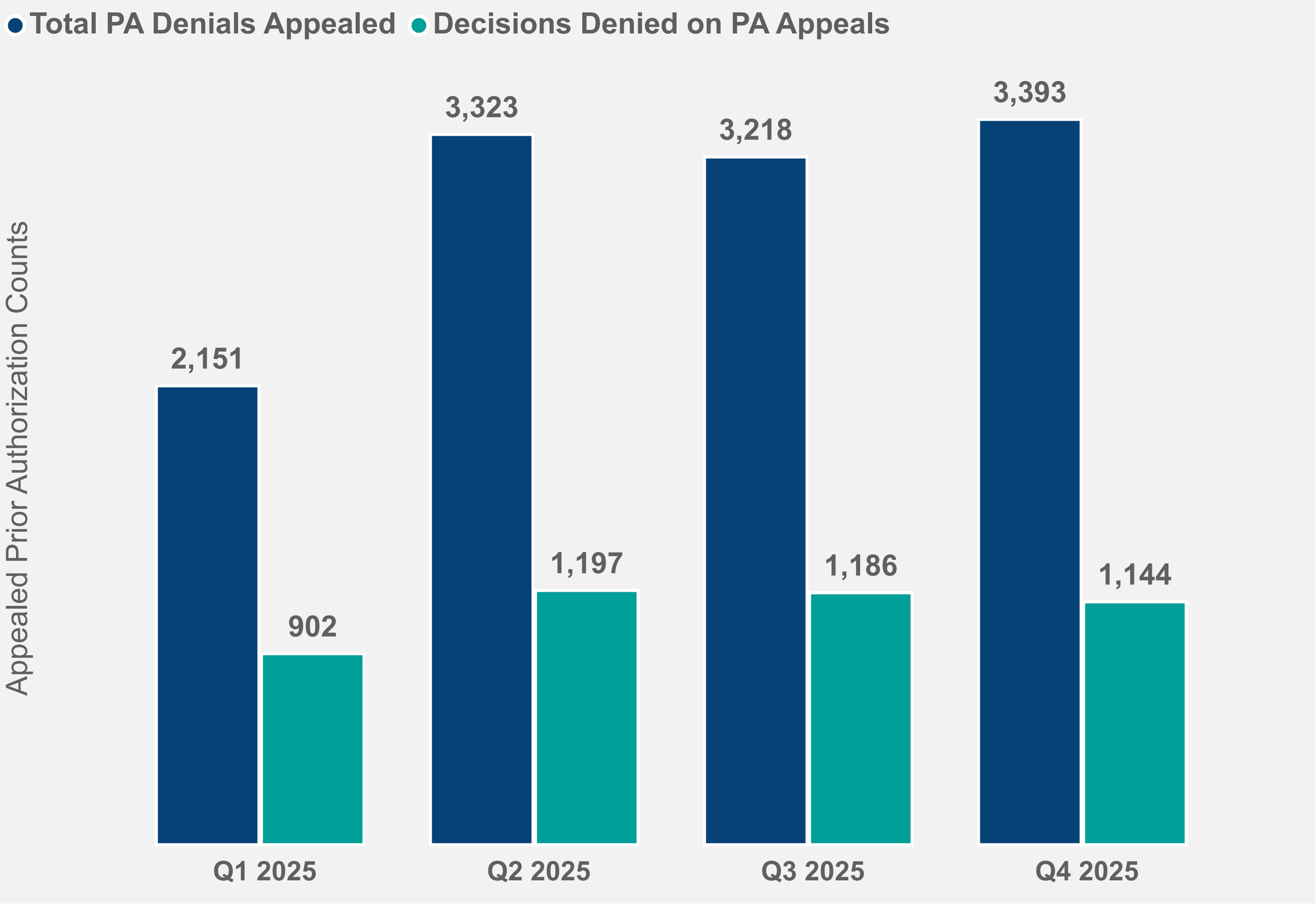
Total PAs Appealed in 2025

12,085

Total PA Appeals Reversed in 2025

4,429

2025 Prior Authorization Denials Reversed on Appeals



References and language access

References

- Oregon House Bill 2517
- CCO Contract Exhibit I Section 10, Paragraph b, Sub Para. 1.
    - Contract templates are posted on the Oregon Health Authority CCO Contract Forms webpage
- Oregon Administrative Rules 410-141-3835, 410-141-3890, 410-141-3915

Language access and accommodation

- You can get this document in other languages, large print, braille or a format you prefer free of charge. Contact HSD.QualityAssurance@odhsoha.oregon.gov or 503-945-5772. TTY 711. We accept all relay calls.