BlueCare Plus Tennessee

Prior Authorization Report for BlueCare Plus (HMO D-SNP)SM

MEDICAL ITEMS AND SERVICES (EXCLUDING DRUGS)

This report includes data on prior authorization requests for medical items and services in 2025. A list of medical items and services requiring prior authorization is available here.

2025 PRIOR AUTHORIZATION STATISTICS

Standard Prior Authorizations

In 2025, we were required to review and decide on standard (non-urgent) prior authorization requests within 14 days.

The information below shows how often we approved these requests. It also shows how quickly we responded.

Request Outcomes

	Frequency	Total requests	Percentage
Approved	98,583	109,960	89.65%
Denied	11,377	109,960	10.35%
Approved after appeal	497	633	78.52%

Response Time

Average response in days	2.29 days
Median* response in days	1 day

* The median is the middle value in the list of the shortest times to the longest times.

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2025 PRIOR AUTHORIZATION STATISTICS

Expedited Prior Authorizations

In 2025, payers were required to review and decide on expedited prior authorization requests within 72 hours.

These requests are used when care is needed soon and waiting for a standard decision may be harmful to a member's life, health or ability to recover. Emergencies (like a heart attack) don't require this type of review.

The information below shows how often we approved expedited prior authorization requests in 2025 and how quickly we responded.

Request Outcomes

	Frequency	Total requests	Percentage
Approved	239	280	85.36%
Denied	41	280	14.64%

Response Time

Average response in hours	18.37 hours
Median* response in hours	4 hours

Approved After Time For Review Was Extended**

	Frequency	Total requests	Percentage
Approved	47	110,240	0.0426%

* The median is the middle value in the list of the shortest times to the longest times.

** Standard and expedited requests may be extended up to 14 days in some circumstances. Examples include a member asking for an extension, or if we need more information to make a decision.

This information complies with the Centers for Medicare & Medicaid Services (CMS) Interoperability and Prior Authorization final rule.