Year 2025 Prior Authorization Metrics

To comply with the CMS Interoperability and Prior Authorization final rule, New Mexico Health Care Authority 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. Public reporting of these metrics promotes transparency and accountability, helps patients understand prior authorization processes, and enables providers to evaluate payer performance. In addition, metrics can be used to compare plans, programs, and payers. For questions on the data below, contact: Christina G. Lucero, Staff Manager, TPA Unit, Exempt Services & Programs Bureau at Christina.Lucero@hca.nm.gov.

Prior Authorization Requests

Review Category	Review Result	Volume	Percentage of TOTAL VOLUME
Standard (Non-urgent)	Approved *Without* Time Extension	2,558	60%
	Approved *With* Time Extension*	1,270	30%
	Denied	406	10%
	TOTAL VOLUME	4,234	—
Expedited (Urgent) **	Approved	0	—
	Denied	0	—
	TOTAL VOLUME	0	—

** Under certain circumstances, the decision time frame for standard requests may be extended. Time Extension applies when the Request for Information (RFI) process is used to obtain additional or missing information needed to make a review decision from a provider or recipient, as appropriate, without adversely prolonging the recipient's receipt of medical care and/or Medicaid services.*

*** Urgent requests must include provider's statement to certify that applying the standard review timeline may seriously jeopardize the life or health of the enrollee, or ability to regain maximum functionality, or would cause serious pain.*

Time Between Receiving a Prior Authorization Request and Sending a Decision

Review Category	Mean (Average) Response Time (in calendar days)	Median (Middle) Response Time (in calendar days)
Standard (Non-urgent)	6 days	4 days
Expedited (Urgent)	—	—

Reconsideration Requests

Review Category	Review Result	Volume	Percentage of TOTAL VOLUME
Standard (Non-urgent)	Upheld after Reconsideration	2	67%
	Modified after Reconsideration	0	—
	Overturned after Reconsideration (with additional information provided)	1	33%
	Overturned after Reconsideration (without additional information provided)	0	—
	TOTAL VOLUME	3	—
Expedited (Urgent)	Upheld after Reconsideration	0	—
	Modified after Reconsideration	0	—
	Overturned after Reconsideration (with additional information provided)	0	—
	Overturned after Reconsideration (without additional information provided)	0	—
	TOTAL VOLUME	0	—

Definitions:

Reconsideration *is an internal, document-only administrative re-evaluation submitted directly to the Fee-for-Service (FFS) Third-Party Assessor (TPA) within 30 calendar days of an initial prior authorization denial. This process serves as a preliminary mechanism for providers to submit corrected, clarified, or missing clinical documentation to rectify a denial without escalating to a formal dispute.*

Per the Comagine Health TPA contract: "Reconsideration: A provider or recipient, as applicable to the program type, who is dissatisfied with a medical necessity or LOC decision made by the Contractor may request reconsideration. The Contractor shall perform a reconsideration review in accordance with 8.350.2 NMAC, Reconsideration of Utilization Review Decisions, including performing and furnishing the reconsideration decision within 7 business days." A provider/member still has an option to file an appeal via Fair Hearing following a reconsideration.

Overturned *= The original denial decision was reversed, and the appeal review resulted in an approval of all previously denied services;* ***Upheld*** *= The original denial decision was unchanged, and the appeal review resulted in all previously denied services remaining denied;* ***Modified*** *= The original denial decision was changed, and the appeal review resulted in a portion of the previously denied services being approved.*

View the list of the medical items and services for which we require prior authorization (excluding drugs).