



# PRIOR AUTHORIZATION REPORT 2025

**Medical Items and Services (Excluding Drugs)**



**HSCSN**

**Health Services for Children with Special Needs**

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## EXECUTIVE SUMMARY

This report presents aggregated prior authorization (PA) metrics for Health Services for Children with Special Needs (HSCSN) for Calendar Year 2025. The report summarizes prior authorization activity, including total requests received, approval and denial outcomes, appeals outcomes, and decision timelines for both standard (non-urgent) and expedited (urgent) prior authorization requests.



During the reporting period, the MCP processed 30,093 prior authorization requests, of which 29,959 were standard requests and 134 were expedited requests.

The approval rate for standard requests was 96%, while 99% of expedited requests were approved. The average decision time for standard requests was 7 days, with a median time of 3 days. Expedited requests were processed more rapidly, with an average determination time of 26 hours and a median time of 22 hours.

These results demonstrate HSCSN's commitment to timely and clinically appropriate prior authorization review processes.

### OVERALL APPROVAL RATE



# PRIOR AUTHORIZATION PROGRAM OVERVIEW

HSCSN utilizes a prior authorization program to evaluate medical services that require clinical review before services are rendered. The process supports:

- Appropriate utilization of healthcare services
- Verification of medical necessity
- Compliance with clinical guidelines
- Coordination of care for members with special healthcare needs

Prior authorization determinations are made by qualified clinical staff and medical directors using established medical necessity criteria.

Two types of prior authorization requests are reviewed:

### **Standard Requests (Non-Urgent)**

Requests that do not require immediate clinical intervention.

### **Expedited Requests (Urgent)**

Requests that involve urgent clinical circumstances where delays could seriously jeopardize the health of the member.

## **Prior Authorization Request Volume**

During the reporting period, HSCSN received the following number of prior authorization requests.

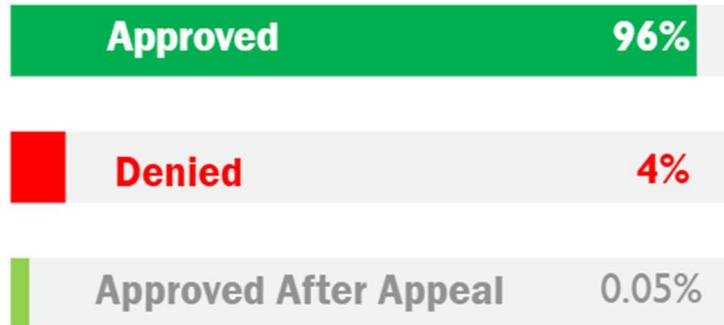
<b>Request Type</b>	<b>Number of Requests</b>
<b>Standard Prior Authorization Requests</b>	<b>29,959</b>
<b>Expedited Prior Authorization Requests</b>	<b>134</b>
<b>Total Prior Authorization Requests</b>	<b>30,093</b>

Standard requests represented the majority of prior authorization activity during the reporting period.

## PRIOR AUTHORIZATION OUTCOMES

### Standard

The table below summarizes the outcomes of standard prior authorization requests.

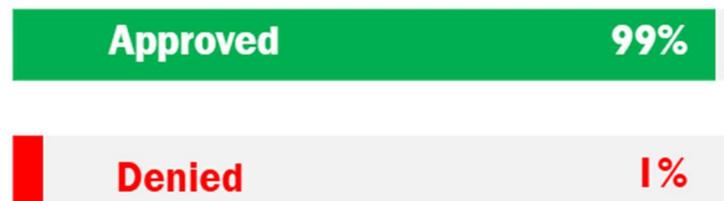


Outcome	Count	Percentage
Approved	28,713	96%
Denied	1,246	4%

The low rate of approvals after appeal suggests that initial clinical determinations are generally accurate and aligned with established medical necessity guidelines.

### Expedited

The following table summarizes outcomes for expedited prior authorization requests.

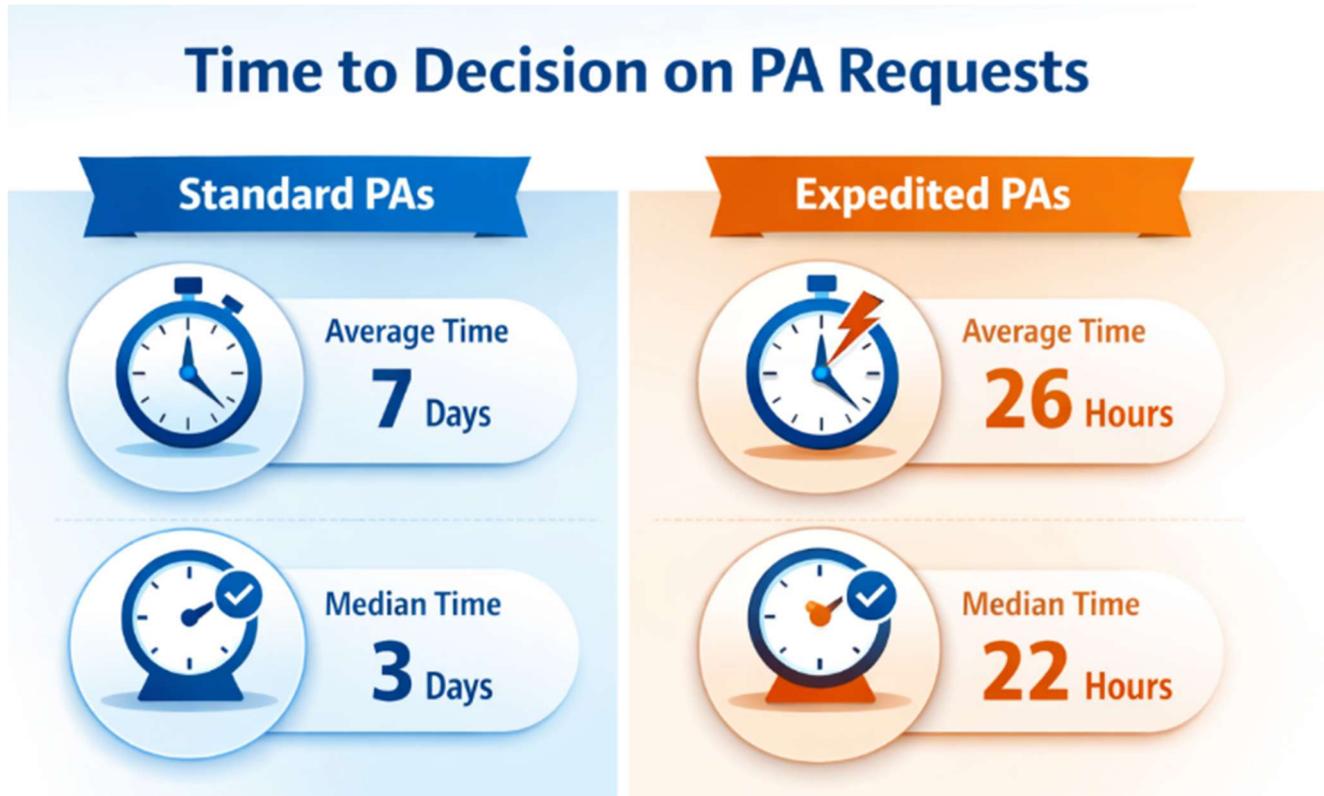


Outcome	Count	Percentage
Approved	133	99%
Denied	1	1%

Expedited requests typically involve urgent clinical circumstances and require prompt review and decision-making.

## PRIOR AUTHORIZATION DECISION TIMELINESS

Decision timeliness measures the elapsed time between the receipt of a prior authorization request and the issuance of a determination.



### Standard Prior Authorization Requests (Non-urgent)

Metric	Time
Average Time to Decision	7 days
Median Time to Decision	3 days

### Expedited Prior Authorization Requests (Urgent)

Metric	Time
Average Time to Decision	26 hours
Median Time to Decision	22 hours

These decision times demonstrate HSCSN's commitment to meeting regulatory response timelines and providing timely determinations.

## EXTENDED TIMEFRAME REVIEWS

In certain circumstances, regulations permit extending the review timeframe when additional information is required.



During the reporting period, **no prior authorization requests required an extended review timeframe.**

### Regulatory Reference

This report is published in accordance with the **Centers for Medicare & Medicaid Services (CMS) Interoperability and Prior Authorization Final Rule**, which requires Medicaid Managed Care Plans to publicly report prior authorization metrics annually. The reporting requirements are established under **42 CFR §438.210**.

## Contact Information

For questions regarding this report or prior authorization processes, please contact:

Utilization Management Department

Health Services for Children with Special Needs (HSCSN)

[www.hscsnhealthplan.org](http://www.hscsnhealthplan.org)



# HSCSN

Health Services for Children with Special Needs, Inc.