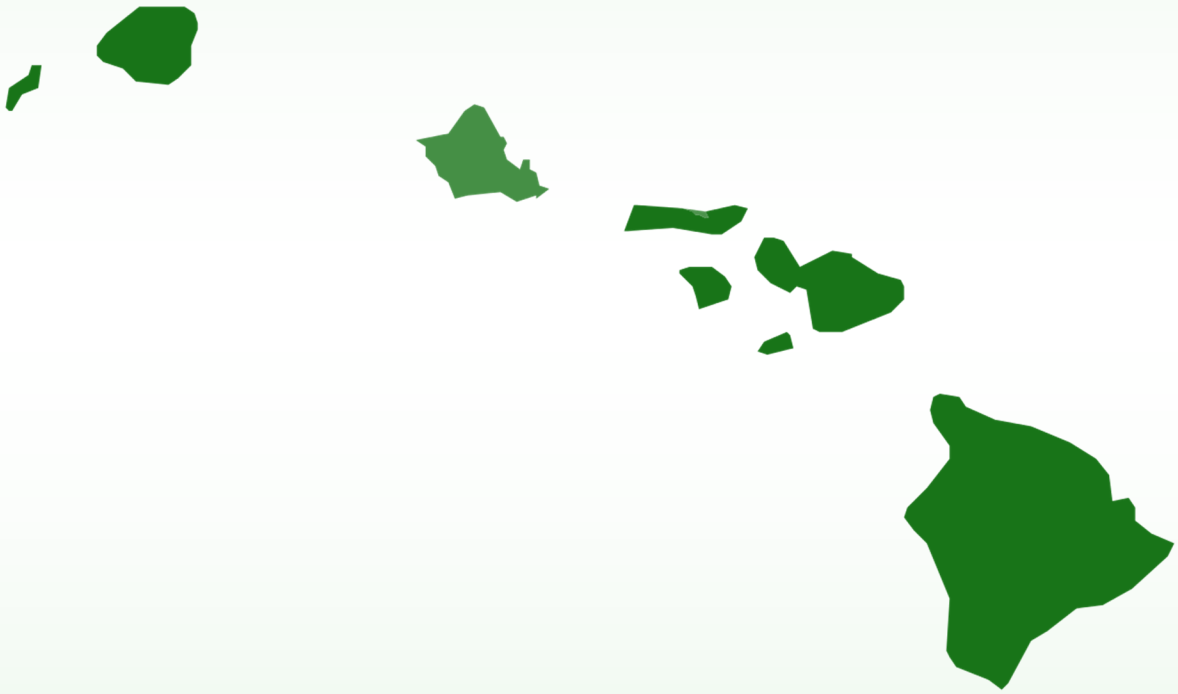
Healthcare Prior Authorization Report Hawaii 2024

(Preliminary Report Subject to Change)



State Health Planning and Development Agency

(SHPDA)

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Administrator's Message

March 2026

Prior Authorization (PA) of health insurance claims has been a very controversial and contentious issue nationwide. A national insurance executive, CEO Brian Thompson of UnitedHealthCare, was tragically murdered in 2024 highlighting these tensions. In Hawai`i, the physician community, along with other healthcare providers and consumer groups including SHPDA's Subarea Advisory Councils, have condemned to process as hampering healthcare operations, raising costs, and reducing access to care. Hawaii's healthcare insurers, with widely varying practices with respect to PA requirements and practices, maintain it is necessary to contain escalating costs. But they did not oppose HB250 (2025), and have contributed to this initial report of SHPDA on Prior Authorization practice in Hawai`i.

SHPDA proposed HB250 in 2925 to address the PA crisis. It was passed with no nay votes by the Legislature; and it was signed into law by Governor Josh Green MD as Public Law 151 (2025). The law required reporting by insurers to SHPDA of all their previous year insurance claims denials, denial challenges, and final adjudications by business line (Medicaid and commercial coverage, including Medicare Advantage) by January 31, 2026. Noting that PA reporting to the Med-QUEST agency was already required and occurring, SHPDA was directed to report the findings of this broader process to include commercial coverage to the Legislature by March 1, 2026.

SHPDA was further assigned the task of overseeing a Working Group of insurers, providers, and consumers, with DOH, DHS, and DCCA as ex-officio members to attempt to achieve consensus on the reporting parameters and format, and to further seek means of reducing tensions and streamlining the PA process across the health sector. Ultimately the goal, if PA remains a process used in the future, is to automate it.

The Working Group has engaged constructively in 2025 with four official meetings and several meetings of its related Permitted Interaction Group. Legislative House Health Chair Gregg Takayama, House Chair Lisa Martin, and Senate Health Chair Joy San Buenaventura each attended a Working Group meeting and expressed their view of the urgency of the issue and importance of our deliberations. The Working Group took the issue seriously and collegially, but the first-year process was, as expected, complicated.

Getting to consensus on the reporting template was the most difficult obstacle we faced. The difficult factors included that there are many categories of PA reporting – inpatient care, outpatient care, behavioral health, durable medical equipment, prescriptions and drugs, radiologic imaging, invasive procedures, transportation, and others. Med-QUEST requires all these categories and various others. However, the new Medicare reporting requirements (which is really Medicare Advantage commercial reporting) are more general, consisting mainly of total denials, including standard denials, expedited denials, and respective response times, but not in the categories Med-QUEST and Medicaid require. Insurers favored the simpler

Medicare reporting template, which was new and untested. Physicians and providers favored the more detailed categorical reporting. The Working Group was very divided on this.

The first reporting deadline of January 31 for 2025 data reporting was difficult for the plans to accomplish. One plan needed to report previous-year 2024 data to submit a complete year because their 2025 data was not yet fully available. Others had difficulty getting their data contractors or IT staff to adjust to the format chosen.

By the January 31 deadline, few providers of health insurance could submit completed set(s) of data collection forms by line of business and by selected health care services as recommended by the Prior Authorization Work Group using the template by the Centers for Medicare and Medicaid Services (CMS) for reporting prior authorization metrics. The accuracy of the data is also in question. For instance, numbers reported categorically did not add up to the total or were uninterpretable. Providers of commercial health insurance might have specific timeframes for their standard prior authorizations and expedited prior authorizations that are different from the timeframes of those required by the CMS. As a result, providers of commercial insurance might have difficulty extracting their prior authorization data to complete SHPDA's data collection forms that were based on the CMS reporting template.

SHPDA was expected to compile the prior authorization data by provider of health insurance, health care setting, and line of business, and to post a report of findings on the SHPDA website, including recommendations by March 1, 2026. As of this writing, SHPDA is still in the process of collecting and/or verifying information from some providers of health insurance. Therefore, the information in SHPDA's report on its website is preliminary and subject to change.

I take personal responsibility for finally agreeing that for the first round that the simpler Medicare process was acceptable. However, the result is that the submissions were not aligned for easy comparison, differ from plan-to-plan on what is reported, and were difficult to fairly interpret. The Working Group will clearly need to get much more specific on the reporting template for 2027 and thereafter to effectively monitor the PA reporting in the future with the ability to fairly compare plan behaviors. SHPDA also learned that the previously required reporting to the Med-QUEST agency also contains inaccuracies and omissions. We must do better.

Based on all of these (perhaps understandable) first-year issues, this report is being submitted four weeks late. And the plan comparison determinations offered are disappointing in lack of sufficient detail and insight to fairly compare plans and/or assess the issue comprehensively. *Realistically, the reporting date needs to be moved later than January 31 by one month to February 28 to allow companies to collect and report their data through the preceding year through December 31. That would move the SHPDA reporting data to file our*

Administrator's Message

summary report on the website and the submission to the Legislature by March 31 of each year, rather than by March 1.

For 2027 and beyond, SHPDA will ask the Working Group to include these following consistencies to allow better comparison and understanding of the results:

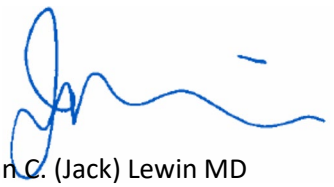
1) We will create a separate set of data collection forms that would allow commercial insurers to report prior authorization data based on their specific timeframes for standard prior authorizations and expediated prior authorizations.
2) We will add an additional data collection form to the current set of data collection forms to capture the *overall* prior authorization information for each line of business.
3) We will add additional rows in each data collection form to capture any prior authorization decisions that do not fall into any specific decision timeframes.

Despite the issues on the completeness and the accuracy of the prior authorization data in this report, SHPDA presents this report to the Legislature, Governor, and the public on our website in fulfillment of Act 151 (2025). It does have value. This preliminary report will at least inform the public what prior authorization data we collect. It will also serve as a reference guide for providers of health insurance in preparation of prior authorization data submission in the future. However, in no way is the status quo acceptable. The PA process needs to be streamlined, simplified, consistently and accurately reported, and automated.

In addition, the Working Group will continue its efforts toward streamlining and improving the entire PA process here. Our largest insurer voluntarily submitted a list of medical claims for which PA will no longer be required. SHPDA believes more of this kind of simplification should be voluntarily occurring across insurers as we examine how often some frequently invoked PA denials result routinely in reversal of the denial. This seems an apparent waste of time and resources for both providers and insurers. It is also a serious "hassle factor" for providers.

Finally, we thank the Legislature and the Governor for passage of PL 151, as well as the members of the Working Group for their contributions thus far. This is the beginning of a necessary process of streamlining and simplifying the current PA processes for the benefit of all.

Respectfully submitted,



John C. (Jack) Lewin MD
Administrator

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Section I. Commercial Plan Prior Authorization (PA), 2024

Table 1-1. Diagnostic Testing: Approved Rates

Insurer PA Request Type	Total Requests	Approved	Denied	Withdrawn	Out of Total Requests by PA Type Approved %	 Denied %
Hawaii Management Alliance Association (HMAA)						
Standard PA						
Expedited PA						
Hawaii Medical Service Association (HMSA)						
Standard PA						
Expedited PA						
Kaiser Permanente – Hawaii						
Standard PA						
Expedited PA						
UHA (University Health Alliance) Health Insurance						
Standard PA						
Expedited PA						
UnitedHealthCare						
Standard PA	8	2	6	0	**25.0**	**75.0**
Expedited PA	0	0	0	0		
State Total	**8**	**2**	**6**	**0**	**25.0**	**75.0**

Note:
(1) A blank cell ( ) indicates data not available.

Section I. Commercial Plan Prior Authorization (PA), 2024

Table 1-2. Diagnostic Testing: Denial Reasons

Insurer PA Request Type	Total PA Denied	Denial Reasons (see note)								
		R1	R2	R3	R4	R5	R6	R7	R8	R9
Hawaii Management Alliance Association (HMAA)										
Standard PA										
Expedited PA										
Hawaii Medical Service Association (HMSA)										
Standard PA										
Expedited PA										
Kaiser Permanente – Hawaii										
Standard PA										
Expedited PA										
UHA (University Health Alliance) Health Insurance										
Standard PA										
Expedited PA										
UnitedHealthCare										
Standard PA	**6**		2			4				
Expedited PA	**0**									
State Total	**6**		**2**			**4**				

Note:
(1) A blank cell ( ) indicates data not available.
(2) Prior Authorization denial reasons:
R1-Incomplete or Incorrect Information
(This might include any of the following: missing or incorrect patient information; errors in ICD-10 or CPT/HCPCS codes; missing medical records, inadequate physician notes, lack of relevant lab results, or failure to include previous treatment histories; etc.)
R2-Medical necessity criteria not met
R3-Non-covered services or exceeding limits
R4-Prior authorization timelines not met
(This might also include expired authorization or duplicate requests.)

Section I. Commercial Plan Prior Authorization (PA), 2024

Table 1-2. Diagnostic Testing: Denial Reasons

Insurer PA Request Type	Total PA Denied	Denial Reasons (see note)								
		R1	R2	R3	R4	R5	R6	R7	R8	R9

R5-Out-of-network providers
R6-Lack of step therapy/testing attempts
R7-Therapy requires multiple PA requests
R8-Non-formulary medications
R9-Other

(This might include but is not limited to any of the following: Invalid preauthorization request form submitted; Pre-existing Condition Exclusion; Lack of Peer-to-Peer Review; Treatment is not consistent with published clinical evidence; etc.)

Section I. Commercial Plan Prior Authorization (PA), 2024

Table 2-1. Durable Medical Supplies/Medical Equipment: Approved Rates

Insurer PA Request Type	Total Requests	Approved	Denied	Withdrawn	Out of Total Requests by PA Type Approved %	 Denied %
Hawaii Management Alliance Association (HMAA)						
Standard PA						
Expedited PA						
Hawaii Medical Service Association (HMSA)						
Standard PA						
Expedited PA						
Kaiser Permanente – Hawaii						
Standard PA						
Expedited PA						
UHA (University Health Alliance) Health Insurance						
Standard PA						
Expedited PA						
UnitedHealthCare						
Standard PA						
Expedited PA						
State Total						

Note:
(1) A blank cell ( ) indicates data not available.

Section I. Commercial Plan Prior Authorization (PA), 2024

Table 2-2. Durable Medical Supplies/Medical Equipment: Denial Reasons

Insurer PA Request Type	Total PA Denied	Denial Reasons (see note)								
		R1	R2	R3	R4	R5	R6	R7	R8	R9
Hawaii Management Alliance Association (HMAA)										
Standard PA										
Expedited PA										
Hawaii Medical Service Association (HMSA)										
Standard PA										
Expedited PA										
Kaiser Permanente – Hawaii										
Standard PA										
Expedited PA										
UHA (University Health Alliance) Health Insurance										
Standard PA										
Expedited PA										
UnitedHealthCare										
Standard PA										
Expedited PA										
State Total										

Note:
(1) A blank cell ( ) indicates data not available.
(2) Prior Authorization denial reasons:
R1-Incomplete or Incorrect Information
(This might include any of the following: missing or incorrect patient information; errors in ICD-10 or CPT/HCPCS codes; missing medical records, inadequate physician notes, lack of relevant lab results, or failure to include previous treatment histories; etc.)
R2-Medical necessity criteria not met
R3-Non-covered services or exceeding limits
R4-Prior authorization timelines not met
(This might also include expired authorization or duplicate requests.)

Section I. Commercial Plan Prior Authorization (PA), 2024

Table 2-2. Durable Medical Supplies/Medical Equipment: Denial Reasons

Insurer PA Request Type	Total PA Denied	Denial Reasons (see note)								
		R1	R2	R3	R4	R5	R6	R7	R8	R9

R5-Out-of-network providers
R6-Lack of step therapy/testing attempts
R7-Therapy requires multiple PA requests
R8-Non-formulary medications
R9-Other

(This might include but is not limited to any of the following: Invalid preauthorization request form submitted; Pre-existing Condition Exclusion; Lack of Peer-to-Peer Review; Treatment is not consistent with published clinical evidence; etc.)

Section I. Commercial Plan Prior Authorization (PA), 2024

Table 3-1. Inpatient Hospital Services: Approved Rates

Insurer PA Request Type	Total Requests	Approved	Denied	Withdrawn	Out of Total Requests by PA Type Approved %	 Denied %
Hawaii Management Alliance Association (HMAA)						
Standard PA						
Expedited PA						
Hawaii Medical Service Association (HMSA)						
Standard PA						
Expedited PA						
Kaiser Permanente – Hawaii						
Standard PA						
Expedited PA						
UHA (University Health Alliance) Health Insurance						
Standard PA						
Expedited PA						
UnitedHealthCare						
Standard PA						
Expedited PA						
State Total						

Note:
(1) A blank cell ( ) indicates data not available.

Section I. Commercial Plan Prior Authorization (PA), 2024

Table 3-2. Inpatient Hospital Services: Denial Reasons

Insurer PA Request Type	Total PA Denied	Denial Reasons (see note)								
		R1	R2	R3	R4	R5	R6	R7	R8	R9
Hawaii Management Alliance Association (HMAA)										
Standard PA										
Expedited PA										
Hawaii Medical Service Association (HMSA)										
Standard PA										
Expedited PA										
Kaiser Permanente – Hawaii										
Standard PA										
Expedited PA										
UHA (University Health Alliance) Health Insurance										
Standard PA										
Expedited PA										
UnitedHealthCare										
Standard PA										
Expedited PA										
State Total										

Note:
(1) A blank cell ( ) indicates data not available.
(2) Prior Authorization denial reasons:
R1-Incomplete or Incorrect Information
(This might include any of the following: missing or incorrect patient information; errors in ICD-10 or CPT/HCPCS codes; missing medical records, inadequate physician notes, lack of relevant lab results, or failure to include previous treatment histories; etc.)
R2-Medical necessity criteria not met
R3-Non-covered services or exceeding limits
R4-Prior authorization timelines not met
(This might also include expired authorization or duplicate requests.)

Section I. Commercial Plan Prior Authorization (PA), 2024

Table 3-2. Inpatient Hospital Services: Denial Reasons

Insurer PA Request Type	Total PA Denied	Denial Reasons (see note)								
		R1	R2	R3	R4	R5	R6	R7	R8	R9

R5-Out-of-network providers
R6-Lack of step therapy/testing attempts
R7-Therapy requires multiple PA requests
R8-Non-formulary medications
R9-Other

(This might include but is not limited to any of the following: Invalid preauthorization request form submitted; Pre-existing Condition Exclusion; Lack of Peer-to-Peer Review; Treatment is not consistent with published clinical evidence; etc.)

Section I. Commercial Plan Prior Authorization (PA), 2024

Table 4-1. Outpatient Hospital Services: Approved Rates

Insurer PA Request Type	Total Requests	Approved	Denied	Withdrawn	Out of Total Requests by PA Type Approved %	 Denied %
Cigna Health and Life Insurance Company						
Standard PA	2	0	2	0	**0.0**	**100.0**
Expedited PA	0	0	0	0		
Hawaii Management Alliance Association (HMAA)						
Standard PA						
Expedited PA						
Hawaii Medical Service Association (HMSA)						
Standard PA						
Expedited PA						
Kaiser Permanente – Hawaii						
Standard PA						
Expedited PA						
UHA (University Health Alliance) Health Insurance						
Standard PA						
Expedited PA						
UnitedHealthCare						
Standard PA						
Expedited PA						
State Total	**2**	**0**	**2**	**0**	**0.0**	**100.0**

Note:
(1) A blank cell ( ) indicates data not available.

Section I. Commercial Plan Prior Authorization (PA), 2024

Table 4-2. Outpatient Hospital Services: Denial Reasons

Insurer PA Request Type	Total PA Denied	Denial Reasons (see note)								
		R1	R2	R3	R4	R5	R6	R7	R8	R9
Cigna Health and Life Insurance Company										
Standard PA	**2**		2							
Expedited PA	**0**									
Hawaii Management Alliance Association (HMAA)										
Standard PA										
Expedited PA										
Hawaii Medical Service Association (HMSA)										
Standard PA										
Expedited PA										
Kaiser Permanente – Hawaii										
Standard PA										
Expedited PA										
UHA (University Health Alliance) Health Insurance										
Standard PA										
Expedited PA										
UnitedHealthCare										
Standard PA										
Expedited PA										
State Total	**2**		**2**							

Note:
(1) A blank cell ( ) indicates data not available.
(2) Prior Authorization denial reasons:
R1-Incomplete or Incorrect Information

Table 4-2. Outpatient Hospital Services: Denial Reasons

Insurer PA Request Type	Total PA Denied	Denial Reasons (see note)								
		R1	R2	R3	R4	R5	R6	R7	R8	R9

(This might include any of the following: missing or incorrect patient information; errors in ICD-10 or CPT/HCPCS codes; missing medical records, inadequate physician notes, lack of relevant lab results, or failure to include previous treatment histories; etc.)

R2-Medical necessity criteria not met

R3-Non-covered services or exceeding limits

R4-Prior authorization timelines not met

(This might also include expired authorization or duplicate requests.)

R5-Out-of-network providers

R6-Lack of step therapy/testing attempts

R7-Therapy requires multiple PA requests

R8-Non-formulary medications

R9-Other

(This might include but is not limited to any of the following: Invalid preauthorization request form submitted; Pre-existing Condition Exclusion; Lack of Peer-to-Peer Review; Treatment is not consistent with published clinical evidence; etc.)

Section I. Commercial Plan Prior Authorization (PA), 2024

Table 5-1. Physician Services: Approved Rates

Insurer PA Request Type	Total Requests	Approved	Denied	Withdrawn	Out of Total Requests by PA Type Approved %	 Denied %
Hawaii Management Alliance Association (HMAA)						
Standard PA						
Expedited PA						
Hawaii Medical Service Association (HMSA)						
Standard PA						
Expedited PA						
Kaiser Permanente – Hawaii						
Standard PA						
Expedited PA						
UHA (University Health Alliance) Health Insurance						
Standard PA						
Expedited PA						
UnitedHealthCare						
Standard PA						
Expedited PA						
State Total						

Note:
(1) A blank cell ( ) indicates data not available.

Section I. Commercial Plan Prior Authorization (PA), 2024

Table 5-2. Physician Services: Denial Reasons

Insurer PA Request Type	Total PA Denied	Denial Reasons (see note)								
		R1	R2	R3	R4	R5	R6	R7	R8	R9
Hawaii Management Alliance Association (HMAA)										
Standard PA										
Expedited PA										
Hawaii Medical Service Association (HMSA)										
Standard PA										
Expedited PA										
Kaiser Permanente – Hawaii										
Standard PA										
Expedited PA										
UHA (University Health Alliance) Health Insurance										
Standard PA										
Expedited PA										
UnitedHealthCare										
Standard PA										
Expedited PA										
State Total										

Note:
(1) A blank cell ( ) indicates data not available.
(2) Prior Authorization denial reasons:
R1-Incomplete or Incorrect Information
(This might include any of the following: missing or incorrect patient information; errors in ICD-10 or CPT/HCPCS codes; missing medical records, inadequate physician notes, lack of relevant lab results, or failure to include previous treatment histories; etc.)
R2-Medical necessity criteria not met
R3-Non-covered services or exceeding limits
R4-Prior authorization timelines not met
(This might also include expired authorization or duplicate requests.)

Section I. Commercial Plan Prior Authorization (PA), 2024

Table 5-2. Physician Services: Denial Reasons

Insurer PA Request Type	Total PA Denied	Denial Reasons (see note)								
		R1	R2	R3	R4	R5	R6	R7	R8	R9

R5-Out-of-network providers
R6-Lack of step therapy/testing attempts
R7-Therapy requires multiple PA requests
R8-Non-formulary medications
R9-Other

(This might include but is not limited to any of the following: Invalid preauthorization request form submitted; Pre-existing Condition Exclusion; Lack of Peer-to-Peer Review; Treatment is not consistent with published clinical evidence; etc.)

Section I. Commercial Plan Prior Authorization (PA), 2024

Table 6-1. Behavioral Health Services: Approved Rates

Insurer PA Request Type	Total Requests	Approved	Denied	Withdrawn	Out of Total Requests by PA Type Approved %	 Denied %
Hawaii Management Alliance Association (HMAA)						
Standard PA						
Expedited PA						
Hawaii Medical Service Association (HMSA)						
Standard PA						
Expedited PA						
Kaiser Permanente – Hawaii						
Standard PA						
Expedited PA						
UHA (University Health Alliance) Health Insurance						
Standard PA						
Expedited PA						
UnitedHealthCare						
Standard PA						
Expedited PA						
State Total						

Note:
(1) A blank cell ( ) indicates data not available.

Section I. Commercial Plan Prior Authorization (PA), 2024

Table 6-2. Behavioral Health Services: Denial Reasons

Insurer PA Request Type	Total PA Denied	Denial Reasons (see note)								
		R1	R2	R3	R4	R5	R6	R7	R8	R9
Hawaii Management Alliance Association (HMAA)										
Standard PA										
Expedited PA										
Hawaii Medical Service Association (HMSA)										
Standard PA										
Expedited PA										
Kaiser Permanente – Hawaii										
Standard PA										
Expedited PA										
UHA (University Health Alliance) Health Insurance										
Standard PA										
Expedited PA										
UnitedHealthCare										
Standard PA										
Expedited PA										
State Total										

Note:
(1) A blank cell ( ) indicates data not available.
(2) Prior Authorization denial reasons:
R1-Incomplete or Incorrect Information
(This might include any of the following: missing or incorrect patient information; errors in ICD-10 or CPT/HCPCS codes; missing medical records, inadequate physician notes, lack of relevant lab results, or failure to include previous treatment histories; etc.)
R2-Medical necessity criteria not met
R3-Non-covered services or exceeding limits
R4-Prior authorization timelines not met
(This might also include expired authorization or duplicate requests.)

Section I. Commercial Plan Prior Authorization (PA), 2024

Table 6-2. Behavioral Health Services: Denial Reasons

Insurer PA Request Type	Total PA Denied	Denial Reasons (see note)								
		R1	R2	R3	R4	R5	R6	R7	R8	R9

R5-Out-of-network providers
R6-Lack of step therapy/testing attempts
R7-Therapy requires multiple PA requests
R8-Non-formulary medications
R9-Other

(This might include but is not limited to any of the following: Invalid preauthorization request form submitted; Pre-existing Condition Exclusion; Lack of Peer-to-Peer Review; Treatment is not consistent with published clinical evidence; etc.)

Section I. Commercial Plan Prior Authorization (PA), 2024

Table 7-1. Drugs: Approved Rates

Insurer PA Request Type	Total Requests	Approved	Denied	Withdrawn	Out of Total Requests by PA Type Approved %	 Denied %
Cigna Health and Life Insurance Company						
Standard PA	14	10	4	0	**71.4**	**28.6**
Expedited PA	1	0	1	0	**0.0**	**100.0**
Hawaii Management Alliance Association (HMAA)						
Standard PA						
Expedited PA						
Hawaii Medical Service Association (HMSA)						
Standard PA						
Expedited PA						
Kaiser Permanente – Hawaii						
Standard PA						
Expedited PA						
UHA (University Health Alliance) Health Insurance						
Standard PA						
Expedited PA						
UnitedHealthCare						
Standard PA						
Expedited PA						
State Total	**15**	**10**	**5**	**0**	**66.7**	**33.3**

Note:
(1) A blank cell ( ) indicates data not available.

Section I. Commercial Plan Prior Authorization (PA), 2024

Table 7-2. Drugs: Denial Reasons

Insurer PA Request Type	Total PA Denied	Denial Reasons (see note)								
		R1	R2	R3	R4	R5	R6	R7	R8	R9
Cigna Health and Life Insurance Company										
Standard PA	**4**		4							
Expedited PA	**1**		1							
Hawaii Management Alliance Association (HMAA)										
Standard PA										
Expedited PA										
Hawaii Medical Service Association (HMSA)										
Standard PA										
Expedited PA										
Kaiser Permanente – Hawaii										
Standard PA										
Expedited PA										
UHA (University Health Alliance) Health Insurance										
Standard PA										
Expedited PA										
UnitedHealthCare										
Standard PA										
Expedited PA										
State Total	**5**		**5**							

Note:
(1) A blank cell ( ) indicates data not available.
(2) Prior Authorization denial reasons:
R1-Incomplete or Incorrect Information

Section I. Commercial Plan Prior Authorization (PA), 2024

Table 7-2. Drugs: Denial Reasons

Insurer PA Request Type	Total PA Denied	Denial Reasons (see note)								
		R1	R2	R3	R4	R5	R6	R7	R8	R9

(This might include any of the following: missing or incorrect patient information; errors in ICD-10 or CPT/HCPCS codes; missing medical records, inadequate physician notes, lack of relevant lab results, or failure to include previous treatment histories; etc.)

R2-Medical necessity criteria not met

R3-Non-covered services or exceeding limits

R4-Prior authorization timelines not met

(This might also include expired authorization or duplicate requests.)

R5-Out-of-network providers

R6-Lack of step therapy/testing attempts

R7-Therapy requires multiple PA requests

R8-Non-formulary medications

R9-Other

(This might include but is not limited to any of the following: Invalid preauthorization request form submitted; Pre-existing Condition Exclusion; Lack of Peer-to-Peer Review; Treatment is not consistent with published clinical evidence; etc.)

Section I. Commercial Plan Prior Authorization (PA), 2024

Table 8-1. Other: Approved Rates

Insurer PA Request Type	Total Requests	Approved	Denied	Withdrawn	Out of Total Requests by PA Type Approved %	 Denied %
Hawaii Medical Service Association (HMSA) – Commercial Plan Total						
Standard PA	130,870	108,360	22,510		**82.8**	**17.2**
Expedited PA	8,112	7,288	824		**89.8**	**10.2**
Hawaii Medical Service Association (HMSA) – EUTF						
Standard PA	29,271	24,469	4,802		**83.6**	**16.4**
Expedited PA	1,540	1,503	37		**97.6**	**2.4**
State Total	**169,793**	**141,620**	**28,173**		**83.4**	**16.6**

Note:
(1) A blank cell ( ) indicates data not available.

Section I. Commercial Plan Prior Authorization (PA), 2024

Table 8-2. Other: Denial Reasons

Insurer PA Request Type	Total PA Denied	Denial Reasons (see note)								
		R1	R2	R3	R4	R5	R6	R7	R8	R9
Hawaii Medical Service Association (HMSA) – Commercial Plan Total										
Standard PA	**22,510**									
Expedited PA	**824**									
Hawaii Medical Service Association (HMSA) – EUTF										
Standard PA	**4,802**									
Expedited PA	**37**									
State Total	**28,173**									

Note:

(1) A blank cell ( ) indicates data not available.

(2) Prior Authorization denial reasons:

R1-Incomplete or Incorrect Information

(This might include any of the following: missing or incorrect patient information; errors in ICD-10 or CPT/HCPCS codes; missing medical records, inadequate physician notes, lack of relevant lab results, or failure to include previous treatment histories; etc.)

R2-Medical necessity criteria not met

R3-Non-covered services or exceeding limits

R4-Prior authorization timelines not met

(This might also include expired authorization or duplicate requests.)

R5-Out-of-network providers

R6-Lack of step therapy/testing attempts

R7-Therapy requires multiple PA requests

R8-Non-formulary medications

R9-Other

(This might include but is not limited to any of the following: Invalid preauthorization request form submitted; Pre-existing Condition Exclusion; Lack of Peer-to-Peer Review; Treatment is not consistent with published clinical evidence; etc.)

Section II. Medicare Plan Prior Authorization (PA), 2024

Table 1-1. Diagnostic Testing: Approved Rates

Insurer PA Request Type	Total Requests	Approved	Denied	Withdrawn	Out of Total Requests by PA Type Approved %	 Denied %
AlohaCare						
Standard PA	163	155	8	0	**95.1**	**4.9**
Expedited PA	70	70	0	0	**100.0**	**0.0**
Hawaii Medical Service Association (HMSA)						
Standard PA						
Expedited PA						
Kaiser Permanente – Hawaii						
Standard PA						
Expedited PA						
UnitedHealthCare						
Standard PA	4,069	3,969	100	0	**97.5**	**2.5**
Expedited PA	459	439	20	0	**95.6**	**4.4**
State Total	**4,761**	**4,633**	**128**	**0**	**97.3**	**2.7**

Note:
(1) A blank cell ( ) indicates data not available.

Section II. Medicare Plan Prior Authorization (PA), 2024

Table 1-2. Diagnostic Testing: Denial Reasons

Insurer PA Request Type	Total PA Denied	Denial Reasons (see note)								
		R1	R2	R3	R4	R5	R6	R7	R8	R9
AlohaCare										
Standard PA	**8**		7			1				
Expedited PA	**0**									
Hawaii Medical Service Association (HMSA)										
Standard PA										
Expedited PA										
Kaiser Permanente – Hawaii										
Standard PA										
Expedited PA										
UnitedHealthCare										
Standard PA	**100**		63	36						1
Expedited PA	**20**		17	3						
State Total	**128**		**87**	**39**		**1**				**1**

Note:
(1) A blank cell ( ) indicates data not available.
(2) Prior Authorization denial reasons:
R1-Incomplete or Incorrect Information
(This might include any of the following: missing or incorrect patient information; errors in ICD-10 or CPT/HCPCS codes; missing medical records, inadequate physician notes, lack of relevant lab results, or failure to include previous treatment histories; etc.)
R2-Medical necessity criteria not met
R3-Non-covered services or exceeding limits
R4-Prior authorization timelines not met
(This might also include expired authorization or duplicate requests.)
R5-Out-of-network providers
R6-Lack of step therapy/testing attempts
R7-Therapy requires multiple PA requests
R8-Non-formulary medications
R9-Other

Section II. Medicare Plan Prior Authorization (PA), 2024

Table 1-2. Diagnostic Testing: Denial Reasons

Insurer PA Request Type	Total PA Denied	Denial Reasons (see note)								
		R1	R2	R3	R4	R5	R6	R7	R8	R9

(This might include but is not limited to any of the following: Invalid preauthorization request form submitted; Pre-existing Condition Exclusion; Lack of Peer-to-Peer Review; Treatment is not consistent with published clinical evidence; etc.)

Section II. Medicare Plan Prior Authorization (PA), 2024

Table 2-1. Durable Medical Supplies/Medical Equipment: Approved Rates

Insurer PA Request Type	Total Requests	Approved	Denied	Withdrawn	Out of Total Requests by PA Type Approved %	 Denied %
AlohaCare						
Standard PA	257	243	14	0	**94.6**	**5.4**
Expedited PA	86	85	1	0	**98.8**	**1.2**
Hawaii Medical Service Association (HMSA)						
Standard PA						
Expedited PA						
Kaiser Permanente – Hawaii						
Standard PA						
Expedited PA						
UnitedHealthCare						
Standard PA	12,930	9,634	3,296	0	**74.5**	**25.5**
Expedited PA	344	184	160	0	**53.5**	**46.5**
State Total	**13,617**	**10,146**	**3,471**	**0**	**74.5**	**25.5**

Note:
(1) A blank cell ( ) indicates data not available.

Section II. Medicare Plan Prior Authorization (PA), 2024

Table 2-2. Durable Medical Supplies/Medical Equipment: Denial Reasons

Insurer PA Request Type	Total PA Denied	Denial Reasons (see note)								
		R1	R2	R3	R4	R5	R6	R7	R8	R9
AlohaCare										
Standard PA	**14**		11	3						
Expedited PA	**1**			1						
Hawaii Medical Service Association (HMSA)										
Standard PA										
Expedited PA										
Kaiser Permanente – Hawaii										
Standard PA										
Expedited PA										
UnitedHealthCare										
Standard PA	**3,296**			3,296						
Expedited PA	**160**			160						
State Total	**3,471**		**11**	**3,460**						

Note:
(1) A blank cell ( ) indicates data not available.
(2) Prior Authorization denial reasons:
R1-Incomplete or Incorrect Information
(This might include any of the following: missing or incorrect patient information; errors in ICD-10 or CPT/HCPCS codes; missing medical records, inadequate physician notes, lack of relevant lab results, or failure to include previous treatment histories; etc.)
R2-Medical necessity criteria not met
R3-Non-covered services or exceeding limits
R4-Prior authorization timelines not met
(This might also include expired authorization or duplicate requests.)
R5-Out-of-network providers
R6-Lack of step therapy/testing attempts
R7-Therapy requires multiple PA requests
R8-Non-formulary medications
R9-Other

Section II. Medicare Plan Prior Authorization (PA), 2024

Table 2-2. Durable Medical Supplies/Medical Equipment: Denial Reasons

Insurer PA Request Type	Total PA Denied	Denial Reasons (see note)								
		R1	R2	R3	R4	R5	R6	R7	R8	R9

(This might include but is not limited to any of the following: Invalid preauthorization request form submitted; Pre-existing Condition Exclusion; Lack of Peer-to-Peer Review; Treatment is not consistent with published clinical evidence; etc.)

Section II. Medicare Plan Prior Authorization (PA), 2024

Table 3-1. Inpatient Hospital Services: Approved Rates

Insurer PA Request Type	Total Requests	Approved	Denied	Withdrawn	Out of Total Requests by PA Type Approved %	 Denied %
AlohaCare						
Standard PA	19	19	0	0	**100.0**	**0.0**
Expedited PA	11	11	0	0	**100.0**	**0.0**
Hawaii Medical Service Association (HMSA)						
Standard PA						
Expedited PA						
Kaiser Permanente – Hawaii						
Standard PA						
Expedited PA						
UnitedHealthCare						
Standard PA	5,540	4,757	704	79	**85.9**	**12.7**
Expedited PA	706	683	23	0	**96.7**	**3.3**
State Total	**6,276**	**5,470**	**727**	**79**	**87.2**	**11.6**

Note:
(1) A blank cell ( ) indicates data not available.

Section II. Medicare Plan Prior Authorization (PA), 2024

Table 3-2. Inpatient Hospital Services: Denial Reasons

Insurer PA Request Type	Total PA Denied	Denial Reasons (see note)								
		R1	R2	R3	R4	R5	R6	R7	R8	R9
AlohaCare										
Standard PA	**0**									
Expedited PA	**0**									
Hawaii Medical Service Association (HMSA)										
Standard PA										
Expedited PA										
Kaiser Permanente – Hawaii										
Standard PA										
Expedited PA										
UnitedHealthCare										
Standard PA	**704**		612	92						
Expedited PA	**23**		11	12						
State Total	**727**		**623**	**104**						

Note:
(1) A blank cell ( ) indicates data not available.
(2) Prior Authorization denial reasons:
R1-Incomplete or Incorrect Information
(This might include any of the following: missing or incorrect patient information; errors in ICD-10 or CPT/HCPCS codes; missing medical records, inadequate physician notes, lack of relevant lab results, or failure to include previous treatment histories; etc.)
R2-Medical necessity criteria not met
R3-Non-covered services or exceeding limits
R4-Prior authorization timelines not met
(This might also include expired authorization or duplicate requests.)
R5-Out-of-network providers
R6-Lack of step therapy/testing attempts
R7-Therapy requires multiple PA requests
R8-Non-formulary medications
R9-Other

Section II. Medicare Plan Prior Authorization (PA), 2024

Table 3-2. Inpatient Hospital Services: Denial Reasons

Insurer PA Request Type	Total PA Denied	Denial Reasons (see note)								
		R1	R2	R3	R4	R5	R6	R7	R8	R9

(This might include but is not limited to any of the following: Invalid preauthorization request form submitted; Pre-existing Condition Exclusion; Lack of Peer-to-Peer Review; Treatment is not consistent with published clinical evidence; etc.)

Section II. Medicare Plan Prior Authorization (PA), 2024

Table 4-1. Outpatient Hospital Services: Approved Rates

Insurer PA Request Type	Total Requests	Approved	Denied	Withdrawn	Out of Total Requests by PA Type Approved %	 Denied %
AlohaCare						
Standard PA	66	66	0	0	**100.0**	**0.0**
Expedited PA	43	43	0	0	**100.0**	**0.0**
Hawaii Medical Service Association (HMSA)						
Standard PA						
Expedited PA						
Kaiser Permanente – Hawaii						
Standard PA						
Expedited PA						
UnitedHealthCare						
Standard PA	52,440	50,567	973	0	**96.4**	**1.9**
Expedited PA	8,543	8,403	140	0	**98.4**	**1.6**
State Total	**61,092**	**59,079**	**1,113**	**0**	**96.7**	**1.8**

Note:
(1) A blank cell ( ) indicates data not available.

Section II. Medicare Plan Prior Authorization (PA), 2024

Table 4-2. Outpatient Hospital Services: Denial Reasons

Insurer PA Request Type	Total PA Denied	Denial Reasons (see note)								
		R1	R2	R3	R4	R5	R6	R7	R8	R9
AlohaCare										
Standard PA	**0**									
Expedited PA	**0**									
Hawaii Medical Service Association (HMSA)										
Standard PA										
Expedited PA										
Kaiser Permanente – Hawaii										
Standard PA										
Expedited PA										
UnitedHealthCare										
Standard PA	**973**	65	885	23						
Expedited PA	**140**	15	119	5		1				
State Total	**1,113**	**80**	**1,004**	**28**		**1**				

Note:
(1) A blank cell ( ) indicates data not available.
(2) Prior Authorization denial reasons:
R1-Incomplete or Incorrect Information
(This might include any of the following: missing or incorrect patient information; errors in ICD-10 or CPT/HCPCS codes; missing medical records, inadequate physician notes, lack of relevant lab results, or failure to include previous treatment histories; etc.)
R2-Medical necessity criteria not met
R3-Non-covered services or exceeding limits
R4-Prior authorization timelines not met
(This might also include expired authorization or duplicate requests.)
R5-Out-of-network providers
R6-Lack of step therapy/testing attempts
R7-Therapy requires multiple PA requests
R8-Non-formulary medications
R9-Other

Section II. Medicare Plan Prior Authorization (PA), 2024

Table 4-2. Outpatient Hospital Services: Denial Reasons

Insurer PA Request Type	Total PA Denied	Denial Reasons (see note)								
		R1	R2	R3	R4	R5	R6	R7	R8	R9

(This might include but is not limited to any of the following: Invalid preauthorization request form submitted; Pre-existing Condition Exclusion; Lack of Peer-to-Peer Review; Treatment is not consistent with published clinical evidence; etc.)

Section II. Medicare Plan Prior Authorization (PA), 2024

Table 5-1. Physician Services: Approved Rates

Insurer PA Request Type	Total Requests	Approved	Denied	Withdrawn	Out of Total Requests by PA Type Approved %	 Denied %
AlohaCare						
Standard PA	103	99	4	0	**96.1**	**3.9**
Expedited PA	37	37	0	0	**100.0**	**0.0**
Hawaii Medical Service Association (HMSA)						
Standard PA						
Expedited PA						
Kaiser Permanente – Hawaii						
Standard PA						
Expedited PA						
UnitedHealthCare						
Standard PA	6,699	6,402	297	0	**95.6**	**4.4**
Expedited PA	1,007	963	44	0	**95.6**	**4.4**
State Total	**7,846**	**7,501**	**345**	**0**	**95.6**	**4.4**

Note:
(1) A blank cell ( ) indicates data not available.

Section II. Medicare Plan Prior Authorization (PA), 2024

Table 5-2. Physician Services: Denial Reasons

Insurer PA Request Type	Total PA Denied	Denial Reasons (see note)								
		R1	R2	R3	R4	R5	R6	R7	R8	R9
AlohaCare										
Standard PA	**4**		4							
Expedited PA	**0**									
Hawaii Medical Service Association (HMSA)										
Standard PA										
Expedited PA										
Kaiser Permanente – Hawaii										
Standard PA										
Expedited PA										
UnitedHealthCare										
Standard PA	**297**	19	214	64						
Expedited PA	**44**	3	36	5						
State Total	**345**	**22**	**254**	**69**						

Note:

(1) A blank cell ( ) indicates data not available.

(2) Prior Authorization denial reasons:

R1-Incomplete or Incorrect Information
(This might include any of the following: missing or incorrect patient information; errors in ICD-10 or CPT/HCPCS codes; missing medical records, inadequate physician notes, lack of relevant lab results, or failure to include previous treatment histories; etc.)

R2-Medical necessity criteria not met

R3-Non-covered services or exceeding limits

R4-Prior authorization timelines not met
(This might also include expired authorization or duplicate requests.)

R5-Out-of-network providers

R6-Lack of step therapy/testing attempts

R7-Therapy requires multiple PA requests

R8-Non-formulary medications

R9-Other

Section II. Medicare Plan Prior Authorization (PA), 2024

Table 5-2. Physician Services: Denial Reasons

Insurer PA Request Type	Total PA Denied	Denial Reasons (see note)								
		R1	R2	R3	R4	R5	R6	R7	R8	R9

(This might include but is not limited to any of the following: Invalid preauthorization request form submitted; Pre-existing Condition Exclusion; Lack of Peer-to-Peer Review; Treatment is not consistent with published clinical evidence; etc.)

Section II. Medicare Plan Prior Authorization (PA), 2024

Table 6-1. Behavioral Health Services: Approved Rates

Insurer PA Request Type	Total Requests	Approved	Denied	Withdrawn	Out of Total Requests by PA Type Approved %	 Denied %
AlohaCare						
Standard PA	17	17	0	0	**100.0**	**0.0**
Expedited PA	1	1	0	0	**100.0**	**0.0**
Hawaii Medical Service Association (HMSA)						
Standard PA						
Expedited PA						
Kaiser Permanente – Hawaii						
Standard PA						
Expedited PA						
UnitedHealthCare						
Standard PA	267	184	83	0	**68.9**	**31.1**
Expedited PA	117	117	0	0	**100.0**	**0.0**
State Total	**402**	**319**	**83**	**0**	**79.4**	**20.6**

Note:
(1) A blank cell ( ) indicates data not available.

Section II. Medicare Plan Prior Authorization (PA), 2024

Table 6-2. Behavioral Health Services: Denial Reasons

Insurer PA Request Type	Total PA Denied	Denial Reasons (see note)								
		R1	R2	R3	R4	R5	R6	R7	R8	R9
AlohaCare										
Standard PA	**0**									
Expedited PA	**0**									
Hawaii Medical Service Association (HMSA)										
Standard PA										
Expedited PA										
Kaiser Permanente – Hawaii										
Standard PA										
Expedited PA										
UnitedHealthCare										
Standard PA	**83**	40	40	1						2
Expedited PA	**0**									
State Total	**83**	**40**	**40**	**1**						**2**

Note:
(1) A blank cell ( ) indicates data not available.
(2) Prior Authorization denial reasons:
R1-Incomplete or Incorrect Information
(This might include any of the following: missing or incorrect patient information; errors in ICD-10 or CPT/HCPCS codes; missing medical records, inadequate physician notes, lack of relevant lab results, or failure to include previous treatment histories; etc.)
R2-Medical necessity criteria not met
R3-Non-covered services or exceeding limits
R4-Prior authorization timelines not met
(This might also include expired authorization or duplicate requests.)
R5-Out-of-network providers
R6-Lack of step therapy/testing attempts
R7-Therapy requires multiple PA requests
R8-Non-formulary medications
R9-Other

Section II. Medicare Plan Prior Authorization (PA), 2024

Table 6-2. Behavioral Health Services: Denial Reasons

Insurer PA Request Type	Total PA Denied	Denial Reasons (see note)								
		R1	R2	R3	R4	R5	R6	R7	R8	R9

(This might include but is not limited to any of the following: Invalid preauthorization request form submitted; Pre-existing Condition Exclusion; Lack of Peer-to-Peer Review; Treatment is not consistent with published clinical evidence; etc.)

Section II. Medicare Plan Prior Authorization (PA), 2024

Table 7-1. Drugs: Approved Rates

Insurer PA Request Type	Total Requests	Approved	Denied	Withdrawn	Out of Total Requests by PA Type Approved %	 Denied %
AlohaCare						
Standard PA	435	356	79	0	**81.8**	**18.2**
Expedited PA	114	100	14	0	**87.7**	**12.3**
Hawaii Medical Service Association (HMSA)						
Standard PA						
Expedited PA						
Kaiser Permanente – Hawaii						
Standard PA						
Expedited PA						
UnitedHealthCare						
Standard PA	1,555	1,528	27	0	**98.3**	**1.7**
Expedited PA	230	229	1	0	**99.6**	**0.4**
State Total	**2,334**	**2,213**	**121**	**0**	**94.8**	**5.2**

Note:
(1) A blank cell ( ) indicates data not available.

Section II. Medicare Plan Prior Authorization (PA), 2024

Table 7-2. Drugs: Denial Reasons

Insurer PA Request Type	Total PA Denied	Denial Reasons (see note)								
		R1	R2	R3	R4	R5	R6	R7	R8	R9
AlohaCare										
Standard PA	**79**		79							
Expedited PA	**14**	1	13							
Hawaii Medical Service Association (HMSA)										
Standard PA										
Expedited PA										
Kaiser Permanente – Hawaii										
Standard PA										
Expedited PA										
UnitedHealthCare										
Standard PA	**27**		19	8						
Expedited PA	**1**		1							
State Total	**121**	**1**	**112**	**8**						

Note:
(1) A blank cell ( ) indicates data not available.
(2) Prior Authorization denial reasons:
R1-Incomplete or Incorrect Information
(This might include any of the following: missing or incorrect patient information; errors in ICD-10 or CPT/HCPCS codes; missing medical records, inadequate physician notes, lack of relevant lab results, or failure to include previous treatment histories; etc.)
R2-Medical necessity criteria not met
R3-Non-covered services or exceeding limits
R4-Prior authorization timelines not met
(This might also include expired authorization or duplicate requests.)
R5-Out-of-network providers
R6-Lack of step therapy/testing attempts
R7-Therapy requires multiple PA requests
R8-Non-formulary medications
R9-Other

Section II. Medicare Plan Prior Authorization (PA), 2024

Table 7-2. Drugs: Denial Reasons

Insurer PA Request Type	Total PA Denied	Denial Reasons (see note)								
		R1	R2	R3	R4	R5	R6	R7	R8	R9

(This might include but is not limited to any of the following: Invalid preauthorization request form submitted; Pre-existing Condition Exclusion; Lack of Peer-to-Peer Review; Treatment is not consistent with published clinical evidence; etc.)

Section III. Medicaid Plan Prior Authorization (PA), 2024

Table 1-1. Diagnostic Testing: Approved Rates

Insurer PA Request Type	Total Requests	Approved	Denied	Withdrawn	Out of Total Requests by PA Type Approved %	 Denied %
AlohaCare						
Standard PA	1,414	1,147	267	0	**81.1**	**18.9**
Expedited PA	582	573	9	0	**98.5**	**1.5**
Hawaii Medical Service Association (HMSA)						
Standard PA						
Expedited PA						
Kaiser Permanente – Hawaii						
Standard PA						
Expedited PA						
UnitedHealthCare						
Standard PA	500	476	24		**95.2**	**4.8**
Expedited PA	42	40	2		**95.2**	**4.8**
State Total	**2,538**	**2,236**	**302**	**0**	**88.1**	**11.9**

Note:
(1) A blank cell ( ) indicates data not available.

Section III. Medicaid Plan Prior Authorization (PA), 2024

Table 1-2. Diagnostic Testing: Denial Reasons

Insurer PA Request Type	Total PA Denied	Denial Reasons (see note)								
		R1	R2	R3	R4	R5	R6	R7	R8	R9
AlohaCare										
Standard PA	**267**	84	177	3		1				2
Expedited PA	**9**	2	7							
Hawaii Medical Service Association (HMSA)										
Standard PA										
Expedited PA										
Kaiser Permanente – Hawaii										
Standard PA										
Expedited PA										
UnitedHealthCare										
Standard PA	**24**	2	20							2
Expedited PA	**2**		2							
State Total	**302**	**88**	**206**	**3**		**1**				**4**

Note:
(1) A blank cell ( ) indicates data not available.
(2) Prior Authorization denial reasons:
R1-Incomplete or Incorrect Information
(This might include any of the following: missing or incorrect patient information; errors in ICD-10 or CPT/HCPCS codes; missing medical records, inadequate physician notes, lack of relevant lab results, or failure to include previous treatment histories; etc.)
R2-Medical necessity criteria not met
R3-Non-covered services or exceeding limits
R4-Prior authorization timelines not met
(This might also include expired authorization or duplicate requests.)
R5-Out-of-network providers
R6-Lack of step therapy/testing attempts
R7-Therapy requires multiple PA requests
R8-Non-formulary medications
R9-Other

Section III. Medicaid Plan Prior Authorization (PA), 2024

Table 1-2. Diagnostic Testing: Denial Reasons

Insurer PA Request Type	Total PA Denied	Denial Reasons (see note)								
		R1	R2	R3	R4	R5	R6	R7	R8	R9

(This might include but is not limited to any of the following: Invalid preauthorization request form submitted; Pre-existing Condition Exclusion; Lack of Peer-to-Peer Review; Treatment is not consistent with published clinical evidence; etc.)

Section III. Medicaid Plan Prior Authorization (PA), 2024

Table 2-1. Durable Medical Supplies/Medical Equipment: Approved Rates

Insurer PA Request Type	Total Requests	Approved	Denied	Withdrawn	Out of Total Requests by PA Type Approved %	 Denied %
AlohaCare						
Standard PA	1,794	1,688	106	0	**94.1**	**5.9**
Expedited PA	490	476	14	0	**97.1**	**2.9**
Hawaii Medical Service Association (HMSA)						
Standard PA						
Expedited PA						
Kaiser Permanente – Hawaii						
Standard PA						
Expedited PA						
UnitedHealthCare						
Standard PA	4,120	2,603	1,517		**63.2**	**36.8**
Expedited PA	406	266	140		**65.5**	**34.5**
State Total	**6,810**	**5,033**	**1,777**	**0**	**73.9**	**26.1**

Note:
(1) A blank cell ( ) indicates data not available.

Section III. Medicaid Plan Prior Authorization (PA), 2024

Table 2-2. Durable Medical Supplies/Medical Equipment: Denial Reasons

Insurer PA Request Type	Total PA Denied	Denial Reasons (see note)								
		R1	R2	R3	R4	R5	R6	R7	R8	R9
AlohaCare										
Standard PA	**106**	1	77	26		1				1
Expedited PA	**14**		8	5		1				
Hawaii Medical Service Association (HMSA)										
Standard PA										
Expedited PA										
Kaiser Permanente – Hawaii										
Standard PA										
Expedited PA										
UnitedHealthCare										
Standard PA	**1,517**	33	645	819		16				4
Expedited PA	**140**		26	114						
State Total	**1,777**	**34**	**756**	**964**		**18**				**5**

Note:

(1) A blank cell ( ) indicates data not available.

(2) Prior Authorization denial reasons:

R1-Incomplete or Incorrect Information
(This might include any of the following: missing or incorrect patient information; errors in ICD-10 or CPT/HCPCS codes; missing medical records, inadequate physician notes, lack of relevant lab results, or failure to include previous treatment histories; etc.)

R2-Medical necessity criteria not met

R3-Non-covered services or exceeding limits

R4-Prior authorization timelines not met
(This might also include expired authorization or duplicate requests.)

R5-Out-of-network providers

R6-Lack of step therapy/testing attempts

R7-Therapy requires multiple PA requests

R8-Non-formulary medications

R9-Other

Section III. Medicaid Plan Prior Authorization (PA), 2024

Table 2-2. Durable Medical Supplies/Medical Equipment: Denial Reasons

Insurer PA Request Type	Total PA Denied	Denial Reasons (see note)								
		R1	R2	R3	R4	R5	R6	R7	R8	R9

(This might include but is not limited to any of the following: Invalid preauthorization request form submitted; Pre-existing Condition Exclusion; Lack of Peer-to-Peer Review; Treatment is not consistent with published clinical evidence; etc.)

Section III. Medicaid Plan Prior Authorization (PA), 2024

Table 3-1. Inpatient Hospital Services: Approved Rates

Insurer PA Request Type	Total Requests	Approved	Denied	Withdrawn	Out of Total Requests by PA Type Approved %	 Denied %
AlohaCare						
Standard PA	447	115	332	0	**25.7**	**74.3**
Expedited PA	86	85	1	0	**98.8**	**1.2**
Hawaii Medical Service Association (HMSA)						
Standard PA						
Expedited PA						
Kaiser Permanente – Hawaii						
Standard PA						
Expedited PA						
UnitedHealthCare						
Standard PA	1,810	1,616	194		**89.3**	**10.7**
Expedited PA	295	287	8		**97.3**	**2.7**
State Total	**2,638**	**2,103**	**535**	**0**	**79.7**	**20.3**

Note:
(1) A blank cell ( ) indicates data not available.

Section III. Medicaid Plan Prior Authorization (PA), 2024

Table 3-2. Inpatient Hospital Services: Denial Reasons

Insurer PA Request Type	Total PA Denied	Denial Reasons (see note)								
		R1	R2	R3	R4	R5	R6	R7	R8	R9
AlohaCare										
Standard PA	**332**	9				2				321
Expedited PA	**1**					1				
Hawaii Medical Service Association (HMSA)										
Standard PA										
Expedited PA										
Kaiser Permanente – Hawaii										
Standard PA										
Expedited PA										
UnitedHealthCare										
Standard PA	**194**		2	7	7					178
Expedited PA	**8**		1							7
State Total	**535**	**9**	**3**	**7**	**7**	**3**				**506**

Note:
(1) A blank cell ( ) indicates data not available.
(2) Prior Authorization denial reasons:
R1-Incomplete or Incorrect Information
(This might include any of the following: missing or incorrect patient information; errors in ICD-10 or CPT/HCPCS codes; missing medical records, inadequate physician notes, lack of relevant lab results, or failure to include previous treatment histories; etc.)
R2-Medical necessity criteria not met
R3-Non-covered services or exceeding limits
R4-Prior authorization timelines not met
(This might also include expired authorization or duplicate requests.)
R5-Out-of-network providers
R6-Lack of step therapy/testing attempts
R7-Therapy requires multiple PA requests
R8-Non-formulary medications
R9-Other

Section III. Medicaid Plan Prior Authorization (PA), 2024

Table 3-2. Inpatient Hospital Services: Denial Reasons

Insurer PA Request Type	Total PA Denied	Denial Reasons (see note)								
		R1	R2	R3	R4	R5	R6	R7	R8	R9

(This might include but is not limited to any of the following: Invalid preauthorization request form submitted; Pre-existing Condition Exclusion; Lack of Peer-to-Peer Review; Treatment is not consistent with published clinical evidence; etc.)

Section III. Medicaid Plan Prior Authorization (PA), 2024

Table 4-1. Outpatient Hospital Services: Approved Rates

Insurer PA Request Type	Total Requests	Approved	Denied	Withdrawn	Out of Total Requests by PA Type Approved %	 Denied %
AlohaCare						
Standard PA	487	477	10	0	**97.9**	**2.1**
Expedited PA	362	358	4	0	**98.9**	**1.1**
Hawaii Medical Service Association (HMSA)						
Standard PA						
Expedited PA						
Kaiser Permanente – Hawaii						
Standard PA						
Expedited PA						
UnitedHealthCare						
Standard PA	3,983	3,731	252		**93.7**	**6.3**
Expedited PA	776	761	15		**98.1**	**1.9**
State Total	**5,608**	**5,327**	**281**	**0**	**95.0**	**5.0**

Note:
(1) A blank cell ( ) indicates data not available.

Section III. Medicaid Plan Prior Authorization (PA), 2024

Table 4-2. Outpatient Hospital Services: Denial Reasons

Insurer PA Request Type	Total PA Denied	Denial Reasons (see note)								
		R1	R2	R3	R4	R5	R6	R7	R8	R9
AlohaCare										
Standard PA	**0**									
Expedited PA	**0**									
Hawaii Medical Service Association (HMSA)										
Standard PA										
Expedited PA										
Kaiser Permanente – Hawaii										
Standard PA										
Expedited PA										
UnitedHealthCare										
Standard PA	**973**	65	885	23						
Expedited PA	**140**	15	119	5		1				
State Total	**1,113**	**80**	**1,004**	**28**		**1**				

Note:
(1) A blank cell ( ) indicates data not available.
(2) Prior Authorization denial reasons:
R1-Incomplete or Incorrect Information
(This might include any of the following: missing or incorrect patient information; errors in ICD-10 or CPT/HCPCS codes; missing medical records, inadequate physician notes, lack of relevant lab results, or failure to include previous treatment histories; etc.)
R2-Medical necessity criteria not met
R3-Non-covered services or exceeding limits
R4-Prior authorization timelines not met
(This might also include expired authorization or duplicate requests.)
R5-Out-of-network providers
R6-Lack of step therapy/testing attempts
R7-Therapy requires multiple PA requests
R8-Non-formulary medications
R9-Other

Section III. Medicaid Plan Prior Authorization (PA), 2024

Table 4-2. Outpatient Hospital Services: Denial Reasons

Insurer PA Request Type	Total PA Denied	Denial Reasons (see note)								
		R1	R2	R3	R4	R5	R6	R7	R8	R9

(This might include but is not limited to any of the following: Invalid preauthorization request form submitted; Pre-existing Condition Exclusion; Lack of Peer-to-Peer Review; Treatment is not consistent with published clinical evidence; etc.)

Section III. Medicaid Plan Prior Authorization (PA), 2024

Table 5-1. Physician Services: Approved Rates

Insurer PA Request Type	Total Requests	Approved	Denied	Withdrawn	Out of Total Requests by PA Type Approved %	 Denied %
AlohaCare						
Standard PA	287	280	7	0	**97.6**	**2.4**
Expedited PA	88	87	1	0	**98.9**	**1.1**
Hawaii Medical Service Association (HMSA)						
Standard PA						
Expedited PA						
Kaiser Permanente – Hawaii						
Standard PA						
Expedited PA						
UnitedHealthCare						
Standard PA	15,916	14,116	1,800		**88.7**	**11.3**
Expedited PA	1,472	1,410	62		**95.8**	**4.2**
State Total	**17,763**	**15,893**	**1,870**	**0**	**89.5**	**10.5**

Note:
(1) A blank cell ( ) indicates data not available.

Section III. Medicaid Plan Prior Authorization (PA), 2024

Table 5-2. Physician Services: Denial Reasons

Insurer PA Request Type	Total PA Denied	Denial Reasons (see note)								
		R1	R2	R3	R4	R5	R6	R7	R8	R9
AlohaCare										
Standard PA	**7**		7							
Expedited PA	**1**									1
Hawaii Medical Service Association (HMSA)										
Standard PA										
Expedited PA										
Kaiser Permanente – Hawaii										
Standard PA										
Expedited PA										
UnitedHealthCare										
Standard PA	**1,800**	221	242	938	295	7				97
Expedited PA	**62**	4	37	18		1				2
State Total	**1,870**	**225**	**286**	**956**	**295**	**8**				**100**

Note:
(1) A blank cell ( ) indicates data not available.
(2) Prior Authorization denial reasons:
R1-Incomplete or Incorrect Information
(This might include any of the following: missing or incorrect patient information; errors in ICD-10 or CPT/HCPCS codes; missing medical records, inadequate physician notes, lack of relevant lab results, or failure to include previous treatment histories; etc.)
R2-Medical necessity criteria not met
R3-Non-covered services or exceeding limits
R4-Prior authorization timelines not met
(This might also include expired authorization or duplicate requests.)
R5-Out-of-network providers
R6-Lack of step therapy/testing attempts
R7-Therapy requires multiple PA requests
R8-Non-formulary medications
R9-Other

Section III. Medicaid Plan Prior Authorization (PA), 2024

Table 5-2. Physician Services: Denial Reasons

Insurer PA Request Type	Total PA Denied	Denial Reasons (see note)								
		R1	R2	R3	R4	R5	R6	R7	R8	R9

(This might include but is not limited to any of the following: Invalid preauthorization request form submitted; Pre-existing Condition Exclusion; Lack of Peer-to-Peer Review; Treatment is not consistent with published clinical evidence; etc.)

Section III. Medicaid Plan Prior Authorization (PA), 2024

Table 6-1. Behavioral Health Services: Approved Rates

Insurer PA Request Type	Total Requests	Approved	Denied	Withdrawn	Out of Total Requests by PA Type Approved %	 Denied %
AlohaCare						
Standard PA	85	82	3	0	**96.5**	**3.5**
Expedited PA	13	13	0	0	**100.0**	**0.0**
Hawaii Medical Service Association (HMSA)						
Standard PA						
Expedited PA						
Kaiser Permanente – Hawaii						
Standard PA						
Expedited PA						
UnitedHealthCare						
Standard PA						
Expedited PA						
State Total	**98**	**95**	**3**	**0**	**96.9**	**3.1**

Note:
(1) A blank cell ( ) indicates data not available.

Section III. Medicaid Plan Prior Authorization (PA), 2024

Table 6-2. Behavioral Health Services: Denial Reasons

Insurer PA Request Type	Total PA Denied	Denial Reasons (see note)								
		R1	R2	R3	R4	R5	R6	R7	R8	R9
AlohaCare										
Standard PA	**3**	1	2							
Expedited PA	**0**									
Hawaii Medical Service Association (HMSA)										
Standard PA										
Expedited PA										
Kaiser Permanente – Hawaii										
Standard PA										
Expedited PA										
UnitedHealthCare										
Standard PA										
Expedited PA										
State Total	**3**	**1**	**2**							

Note:
(1) A blank cell ( ) indicates data not available.
(2) Prior Authorization denial reasons:
R1-Incomplete or Incorrect Information
(This might include any of the following: missing or incorrect patient information; errors in ICD-10 or CPT/HCPCS codes; missing medical records, inadequate physician notes, lack of relevant lab results, or failure to include previous treatment histories; etc.)
R2-Medical necessity criteria not met
R3-Non-covered services or exceeding limits
R4-Prior authorization timelines not met
(This might also include expired authorization or duplicate requests.)
R5-Out-of-network providers
R6-Lack of step therapy/testing attempts
R7-Therapy requires multiple PA requests
R8-Non-formulary medications
R9-Other

Section III. Medicaid Plan Prior Authorization (PA), 2024

Table 6-2. Behavioral Health Services: Denial Reasons

Insurer PA Request Type	Total PA Denied	Denial Reasons (see note)								
		R1	R2	R3	R4	R5	R6	R7	R8	R9

(This might include but is not limited to any of the following: Invalid preauthorization request form submitted; Pre-existing Condition Exclusion; Lack of Peer-to-Peer Review; Treatment is not consistent with published clinical evidence; etc.)

Section III. Medicaid Plan Prior Authorization (PA), 2024

Table 7-1. Drugs: Approved Rates

Insurer PA Request Type	Total Requests	Approved	Denied	Withdrawn	Out of Total Requests by PA Type Approved %	 Denied %
AlohaCare						
Standard PA	5,821	4,827	708	286	**82.9**	**12.2**
Expedited PA	110	100	6	4	**90.9**	**5.5**
Hawaii Medical Service Association (HMSA)						
Standard PA						
Expedited PA						
Kaiser Permanente – Hawaii						
Standard PA						
Expedited PA						
UnitedHealthCare						
Standard PA						
Expedited PA						
State Total	**5,931**	**4,927**	**714**	**290**	**83.1**	**12.0**

Note:
(1) A blank cell ( ) indicates data not available.

Section III. Medicaid Plan Prior Authorization (PA), 2024

Table 7-2. Drugs: Denial Reasons

Insurer PA Request Type	Total PA Denied	Denial Reasons (see note)								
		R1	R2	R3	R4	R5	R6	R7	R8	R9
AlohaCare										
Standard PA	**708**	73	578	57						
Expedited PA	**6**		6							
Hawaii Medical Service Association (HMSA)										
Standard PA										
Expedited PA										
Kaiser Permanente – Hawaii										
Standard PA										
Expedited PA										
UnitedHealthCare										
Standard PA										
Expedited PA										
State Total	**714**	**73**	**584**	**57**						

Note:
(1) A blank cell ( ) indicates data not available.
(2) Prior Authorization denial reasons:
R1-Incomplete or Incorrect Information
(This might include any of the following: missing or incorrect patient information; errors in ICD-10 or CPT/HCPCS codes; missing medical records, inadequate physician notes, lack of relevant lab results, or failure to include previous treatment histories; etc.)
R2-Medical necessity criteria not met
R3-Non-covered services or exceeding limits
R4-Prior authorization timelines not met
(This might also include expired authorization or duplicate requests.)
R5-Out-of-network providers
R6-Lack of step therapy/testing attempts
R7-Therapy requires multiple PA requests
R8-Non-formulary medications
R9-Other

Section III. Medicaid Plan Prior Authorization (PA), 2024

Table 7-2. Drugs: Denial Reasons

Insurer PA Request Type	Total PA Denied	Denial Reasons (see note)								
		R1	R2	R3	R4	R5	R6	R7	R8	R9

(This might include but is not limited to any of the following: Invalid preauthorization request form submitted; Pre-existing Condition Exclusion; Lack of Peer-to-Peer Review; Treatment is not consistent with published clinical evidence; etc.)