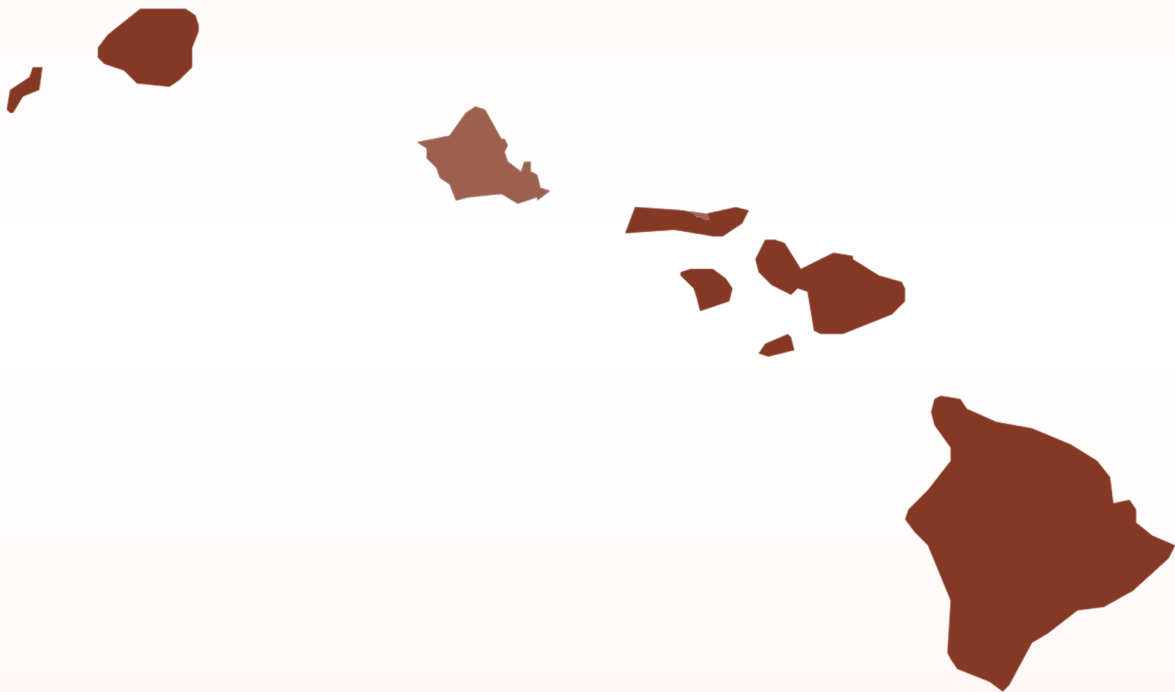


Healthcare Prior Authorization Report Hawaii 2025

(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 the 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 2025 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. There are many possible 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/Medicaid already requires health plans to report some of these categories as well as various others to the state. Starting in 2026, the Centers for Medicare and Medicaid Services (CMS) mandates health plans of Medicare Advantage, state Medicaid and some other plans to publicly report certain PA metrics from the previous calendar year on their websites. However, the new CMS reporting requirements are more general, consisting mainly of total approved and denied rates of standard PAs, expedited PAs, appeals and their respective response times, but not in the service categories that Med-QUEST and Medicaid require. Insurers favored the simpler CMS reporting template, which was new and untested. Physicians and

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healthcare providers favored the more detailed reporting of service categories. The Working Group was very divided on this.

The first reporting deadline of January 31 for 2025 data reporting was difficult for the health 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 insurers could submit completed set(s) of data collection forms by line of business and by selected health care service categories as recommended by the PA Working Group using the CMS template for reporting PA 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. Insurers of commercial health plans might have specific timeframes for their standard PAs and expedited PAs that are different from the timeframes of those required by the CMS. As a result, insurers of commercial health plans might have difficulty extracting their PA data to complete SHPDA's data collection forms that were based on the CMS reporting template.

SHPDA was expected to compile the PA data by insurer, healthcare 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 insurers. 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 CMS process was acceptable. However, the result is that the submissions were not aligned for easy comparison, differ from plan-to-plan on what was 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 can all do better, and we will.

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 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:

Administrator's Message

- 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 expedited 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 PA 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 PA data we collect. It will also serve as a reference guide for providers of health insurance in preparation of PA 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), 2025

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	1,993	1,954	39		98.0	2.0
Expedited PA	522	520	2		99.6	0.4
UHA (University Health Alliance) Health Insurance						
Standard PA						
Expedited PA						
UnitedHealthCare						
Standard PA	2	2	0	0	100.0	0.0
Expedited PA						
State Total	2,517	2,476	41	0	98.4	1.6

Note:

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

Section I. Commercial Plan Prior Authorization (PA), 2025

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	39		2	37						
Expedited PA	2			2						
UHA (University Health Alliance) Health Insurance										
Standard PA										
Expedited PA										
UnitedHealthCare										
Standard PA	0									
Expedited PA										
State Total	41		2	39						

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), 2025

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	7,884	7,288	596		92.4	7.6
Expedited PA	1,423	1,393	30		97.9	2.1
UHA (University Health Alliance) Health Insurance						
Standard PA						
Expedited PA						
UnitedHealthCare						
Standard PA						
Expedited PA						
State Total	9,307	8,681	626		93.3	6.7

Note:

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

Section I. Commercial Plan Prior Authorization (PA), 2025

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	596		94	502						
Expedited PA	30		3	27						
UHA (University Health Alliance) Health Insurance										
Standard PA										
Expedited PA										
UnitedHealthCare										
Standard PA										
Expedited PA										
State Total	626		97	529						

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), 2025

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
<i>R5-Out-of-network providers</i> <i>R6-Lack of step therapy/testing attempts</i> <i>R7-Therapy requires multiple PA requests</i> <i>R8-Non-formulary medications</i> <i>R9-Other</i> (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), 2025

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	455	451	4		99.1	0.9
Expedited PA	3	3	0		100.0	0.0
UHA (University Health Alliance) Health Insurance						
Standard PA						
Expedited PA						
UnitedHealthCare						
Standard PA						
Expedited PA						
State Total	458	454	4		99.1	0.9

Note:

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

Section I. Commercial Plan Prior Authorization (PA), 2025

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	4			4						
Expedited PA	0									
UHA (University Health Alliance) Health Insurance										
Standard PA										
Expedited PA										
UnitedHealthCare										
Standard PA										
Expedited PA										
State Total	4			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), 2025

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
<i>R5-Out-of-network providers</i> <i>R6-Lack of step therapy/testing attempts</i> <i>R7-Therapy requires multiple PA requests</i> <i>R8-Non-formulary medications</i> <i>R9-Other</i> (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), 2025

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	4	2	2	0	50.0	50.0
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	1,767	1,689	78		95.6	4.4
Expedited PA	289	289			100.0	
UHA (University Health Alliance) Health Insurance						
Standard PA						
Expedited PA						
UnitedHealthCare						
Standard PA						
Expedited PA						
State Total	2,060	1,980	80	0	96.1	3.9

Note:

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

Section I. Commercial Plan Prior Authorization (PA), 2025

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	78			78						
Expedited PA										
UHA (University Health Alliance) Health Insurance										
Standard PA										
Expedited PA										
UnitedHealthCare										
Standard PA										
Expedited PA										
State Total	80		2	78						

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), 2025

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
<i>(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.)</i>										
R2-Medical necessity criteria not met										
R3-Non-covered services or exceeding limits										
R4-Prior authorization timelines not met										
<i>(This might also include expired authorization or duplicate requests.)</i>										
R5-Out-of-network providers										
R6-Lack of step therapy/testing attempts										
R7-Therapy requires multiple PA requests										
R8-Non-formulary medications										
R9-Other										
<i>(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.)</i>										

Section I. Commercial Plan Prior Authorization (PA), 2025

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	3,303	3,057	246		92.6	7.4
Expedited PA	124	123	1		99.2	0.8
UHA (University Health Alliance) Health Insurance						
Standard PA						
Expedited PA						
UnitedHealthCare						
Standard PA						
Expedited PA						
State Total	3,427	3,180	247		92.8	7.2

Note:

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

Section I. Commercial Plan Prior Authorization (PA), 2025

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	246		5	241						
Expedited PA	1			1						
UHA (University Health Alliance) Health Insurance										
Standard PA										
Expedited PA										
UnitedHealthCare										
Standard PA										
Expedited PA										
State Total	247		5	242						

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), 2025

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
<i>R5-Out-of-network providers</i> <i>R6-Lack of step therapy/testing attempts</i> <i>R7-Therapy requires multiple PA requests</i> <i>R8-Non-formulary medications</i> <i>R9-Other</i> (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), 2025

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	11,876	11,838	38		99.7	0.3
Expedited PA	5	5	0		100.0	0.0
UHA (University Health Alliance) Health Insurance						
Standard PA						
Expedited PA						
UnitedHealthCare						
Standard PA						
Expedited PA						
State Total	11,881	11,843	38		99.7	0.3

Note:

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

Section I. Commercial Plan Prior Authorization (PA), 2025

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	38		1	37						
Expedited PA	0									
UHA (University Health Alliance) Health Insurance										
Standard PA										
Expedited PA										
UnitedHealthCare										
Standard PA										
Expedited PA										
State Total	38		1	37						

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), 2025

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	12	8	4	0	66.7	33.3
Expedited PA	1	1	0	0	100.0	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	10,988	8,968	2,020		81.6	18.4
Expedited PA	0	0	0			
UnitedHealthCare						
Standard PA						
Expedited PA						
State Total	11,001	8,977	2,024	0	81.6	18.4

Note:

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

Section I. Commercial Plan Prior Authorization (PA), 2025

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	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	2,020									
Expedited PA	0									
UnitedHealthCare										
Standard PA										
Expedited PA										
State Total	2,024		4							

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), 2025

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
<p><i>(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.)</i></p> <p><i>R2-Medical necessity criteria not met</i></p> <p><i>R3-Non-covered services or exceeding limits</i></p> <p><i>R4-Prior authorization timelines not met</i> <i>(This might also include expired authorization or duplicate requests.)</i></p> <p><i>R5-Out-of-network providers</i></p> <p><i>R6-Lack of step therapy/testing attempts</i></p> <p><i>R7-Therapy requires multiple PA requests</i></p> <p><i>R8-Non-formulary medications</i></p> <p><i>R9-Other</i></p> <p><i>(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.)</i></p>										

Section I. Commercial Plan Prior Authorization (PA), 2025

Table 8-1. Other: Approved Rates

Insurer PA Request Type	Total Requests	Approved	Denied	Withdrawn	Out of Total Requests by PA Type	
					Approved %	Denied %
UHA (University Health Alliance) Health Insurance – Medical Services						
Standard PA	7,564	5,787	1,777		76.5	23.5
Expedited PA	0	0	0			
State Total	7,564	5,787	1,777		76.5	23.5

Note:

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

Section I. Commercial Plan Prior Authorization (PA), 2025

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
UHA (University Health Alliance) Health Insurance – Medical Services										
Standard PA	1,777									
Expedited PA	0									
State Total	1,777									

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), 2025

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	186	181	5	0	97.3	2.7
Expedited PA	91	89	2	0	97.8	2.2
Hawaii Medical Service Association (HMSA)						
Standard PA						
Expedited PA						
Kaiser Permanente – Hawaii						
Standard PA	1,381	1,370	11		99.2	0.8
Expedited PA	356	356	0		100.0	0.0
UnitedHealthCare						
Standard PA	3,726	34,020	280	44	913.0	7.5
Expedited PA	491	471	18	2	95.9	3.7
State Total	6,231	36,487	316	46	585.6	5.1

Note:

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

Section II. Medicare Plan Prior Authorization (PA), 2025

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	5		5							
Expedited PA	2		2							
Hawaii Medical Service Association (HMSA)										
Standard PA										
Expedited PA										
Kaiser Permanente – Hawaii										
Standard PA	11		2	9						
Expedited PA	0									
UnitedHealthCare										
Standard PA	280	2	261	2						
Expedited PA	18		18							
State Total	316	2	288	11						

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), 2025

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), 2025

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	306	291	15	0	95.1	4.9
Expedited PA	71	69	2	0	14.5	0.4
Hawaii Medical Service Association (HMSA)						
Standard PA						
Expedited PA						
Kaiser Permanente – Hawaii						
Standard PA	8,505	7,570	935		89.0	11.0
Expedited PA	1,103	1,072	31		97.2	2.8
UnitedHealthCare						
Standard PA	698	589	109	0	84.4	15.6
Expedited PA	9	7	2	0	77.8	22.2
State Total	10,692	9,598	1,094	0	89.8	10.2

Note:

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

Section II. Medicare Plan Prior Authorization (PA), 2025

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	15	1	13	1						
Expedited PA	2		2							
Hawaii Medical Service Association (HMSA)										
Standard PA										
Expedited PA										
Kaiser Permanente – Hawaii										
Standard PA	935		118	817						
Expedited PA	31		6	25						
UnitedHealthCare										
Standard PA	109	2	9,611	90						
Expedited PA	2		1	1						
State Total	1,094	3	9,751	934						

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), 2025

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), 2025

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	24	23	1	0	95.8	4.2
Expedited PA	16	16	0	0	100.0	0.0
Hawaii Medical Service Association (HMSA)						
Standard PA						
Expedited PA						
Kaiser Permanente – Hawaii						
Standard PA	58	58	0		100.0	0.0
Expedited PA	3	3	0		100.0	0.0
UnitedHealthCare						
Standard PA	3,137	2,567	525	45	81.8	16.7
Expedited PA	334	322	12	0	96.4	3.6
State Total	3,572	2,989	538	45	83.7	15.1

Note:

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

Section II. Medicare Plan Prior Authorization (PA), 2025

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	1		1							
Expedited PA	0									
Hawaii Medical Service Association (HMSA)										
Standard PA										
Expedited PA										
Kaiser Permanente – Hawaii										
Standard PA	0									
Expedited PA	0									
UnitedHealthCare										
Standard PA	525		510	15						
Expedited PA	12		12							
State Total	538		523	15						

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), 2025

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), 2025

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	61	61	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	799	782	17		97.9	2.1
Expedited PA	149	149			100.0	
UnitedHealthCare						
Standard PA	2,039	1,980	57	2	97.1	2.8
Expedited PA	582	569	13	0	97.8	2.2
State Total	3,673	3,584	87	2	97.6	2.4

Note:

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

Section II. Medicare Plan Prior Authorization (PA), 2025

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	17		1	16						
Expedited PA										
UnitedHealthCare										
Standard PA	57	2	52	3						
Expedited PA	13		13							
State Total	87	2	66	19						

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), 2025

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), 2025

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	117	110	7	0	94.0	6.0
Expedited PA	37	37	0	0	100.0	0.0
Hawaii Medical Service Association (HMSA)						
Standard PA						
Expedited PA						
Kaiser Permanente – Hawaii						
Standard PA	1,486	1,418	68		95.4	4.6
Expedited PA	61	60	1		98.4	1.6
UnitedHealthCare						
Standard PA	2,010	1,522	488	0	75.7	24.3
Expedited PA	188	181	7	0	96.3	3.7
State Total	3,899	3,328	571	0	85.4	14.6

Note:

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

Section II. Medicare Plan Prior Authorization (PA), 2025

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	0									
Hawaii Medical Service Association (HMSA)										
Standard PA										
Expedited PA										
Kaiser Permanente – Hawaii										
Standard PA	68		1	67						
Expedited PA	1			1						
UnitedHealthCare										
Standard PA	488		37	451						
Expedited PA	7		7							
State Total	571		52	519						

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), 2025

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), 2025

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	8	8	0	0	100.0	0.0
Expedited PA	0	0	0	0		
Hawaii Medical Service Association (HMSA)						
Standard PA						
Expedited PA						
Kaiser Permanente – Hawaii						
Standard PA	1,089	1,085	4		99.6	0.4
Expedited PA	1	1	0		100.0	0.0
UnitedHealthCare						
Standard PA	794	311	482	0	39.2	60.7
Expedited PA	110	110	0	0	100.0	0.0
State Total	2,002	1,515	486	0	75.7	24.3

Note:

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

Section II. Medicare Plan Prior Authorization (PA), 2025

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	4		1	3						
Expedited PA	0									
UnitedHealthCare										
Standard PA	482	83	397	2						
Expedited PA	0									
State Total	486	83	398	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 II. Medicare Plan Prior Authorization (PA), 2025

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), 2025

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	664	501	163	0	75.5	24.5
Expedited PA	141	109	32	0	77.3	22.7
Hawaii Medical Service Association (HMSA)						
Standard PA						
Expedited PA						
Kaiser Permanente – Hawaii						
Standard PA						
Expedited PA						
UnitedHealthCare						
Standard PA	1,839	1,795	44	0	97.6	2.4
Expedited PA	254	250	4	0	98.4	1.6
State Total	2,898	2,655	243	0	91.6	8.4

Note:

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

Section II. Medicare Plan Prior Authorization (PA), 2025

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	163	13	64	65						21
Expedited PA	32	3	9	15						5
Hawaii Medical Service Association (HMSA)										
Standard PA										
Expedited PA										
Kaiser Permanente – Hawaii										
Standard PA										
Expedited PA										
UnitedHealthCare										
Standard PA	44		43	1						
Expedited PA	4		4							
State Total	243	16	120	81						26

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), 2025

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), 2025

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	1,856	1,539	317	0	82.9	17.1
Expedited PA	620	610	10	0	98.4	1.6
Hawaii Medical Service Association (HMSA)						
Standard PA						
Expedited PA						
Kaiser Permanente – Hawaii						
Standard PA						
Expedited PA						
UnitedHealthCare						
Standard PA	400	334	66		83.5	16.5
Expedited PA	13	13	0		100.0	0.0
State Total	2,889	2,496	393	0	86.4	13.6

Note:

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

Section III. Medicaid Plan Prior Authorization (PA), 2025

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	317	130	175	6		2				4
Expedited PA	10		10							
Hawaii Medical Service Association (HMSA)										
Standard PA										
Expedited PA										
Kaiser Permanente – Hawaii										
Standard PA										
Expedited PA										
UnitedHealthCare										
Standard PA	66	3	62			1				
Expedited PA	0									
State Total	393	133	247	6		3				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), 2025

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), 2025

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	2,127	2,018	109	0	94.9	5.1
Expedited PA	475	469	6	0	98.7	1.3
Hawaii Medical Service Association (HMSA)						
Standard PA						
Expedited PA						
Kaiser Permanente – Hawaii						
Standard PA						
Expedited PA						
UnitedHealthCare						
Standard PA	3,816	2,767	1,049		72.5	27.5
Expedited PA	136	116	20		85.3	14.7
State Total	6,554	5,370	1,184	0	81.9	18.1

Note:

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

Section III. Medicaid Plan Prior Authorization (PA), 2025

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	109	6	88	13		2				
Expedited PA	6	1	4	1						
Hawaii Medical Service Association (HMSA)										
Standard PA										
Expedited PA										
Kaiser Permanente – Hawaii										
Standard PA										
Expedited PA										
UnitedHealthCare										
Standard PA	1,049	21	699	305		15				9
Expedited PA	20		10	9		1				
State Total	1,184	28	801	328		18				9

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), 2025

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), 2025

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	459	112	347	0	24.4	75.6
Expedited PA	81	81	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	1,579	1,492	87		94.5	5.5
Expedited PA	245	241	4		98.4	1.6
State Total	2,364	1,926	438	0	81.5	18.5

Note:

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

Section III. Medicaid Plan Prior Authorization (PA), 2025

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	347	11	4			2				330
Expedited PA	0									
Hawaii Medical Service Association (HMSA)										
Standard PA										
Expedited PA										
Kaiser Permanente – Hawaii										
Standard PA										
Expedited PA										
UnitedHealthCare										
Standard PA	87	2	3	8	1					73
Expedited PA	4	1	1							2
State Total	438	14	8	8	1	2				405

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), 2025

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), 2025

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	493	480	13	0	97.4	2.6
Expedited PA	302	300	2	0	99.3	0.7
Hawaii Medical Service Association (HMSA)						
Standard PA						
Expedited PA						
Kaiser Permanente – Hawaii						
Standard PA						
Expedited PA						
UnitedHealthCare						
Standard PA	4,274	3,967	307		92.8	7.2
Expedited PA	761	740	21		97.2	2.8
State Total	5,830	5,487	343	0	94.1	5.9

Note:

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

Section III. Medicaid Plan Prior Authorization (PA), 2025

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	13	2	5			5				1
Expedited PA	2		2							
Hawaii Medical Service Association (HMSA)										
Standard PA										
Expedited PA										
Kaiser Permanente – Hawaii										
Standard PA										
Expedited PA										
UnitedHealthCare										
Standard PA	307	7	104	4		1				191
Expedited PA	21	1	16			1				3
State Total	343	10	127	4		7				195

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), 2025

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), 2025

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	474	459	15	0	96.8	3.2
Expedited PA	118	118	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	16,141	14,959	1,182		92.7	7.3
Expedited PA	1,577	1,499	78		95.1	4.9
State Total	18,310	17,035	1,275	0	93.0	7.0

Note:

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

Section III. Medicaid Plan Prior Authorization (PA), 2025

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	15		14	1						
Expedited PA	0									
Hawaii Medical Service Association (HMSA)										
Standard PA										
Expedited PA										
Kaiser Permanente – Hawaii										
Standard PA										
Expedited PA										
UnitedHealthCare										
Standard PA	1,182	103	300	372	306	10				91
Expedited PA	78	5	48	18		5				2
State Total	1,275	108	362	391	306	15				93

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), 2025

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), 2025

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	105	105	0	0	100.0	0.0
Expedited PA	3	3	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	108	108	0	0	100.0	0.0

Note:

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

Section III. Medicaid Plan Prior Authorization (PA), 2025

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										
Expedited PA										
State Total	0									

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), 2025

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), 2025

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	7,823	5,255	2,500	68	67.2	32.0
Expedited PA	1,458	1,115	322	21	76.5	22.1
Hawaii Medical Service Association (HMSA)						
Standard PA						
Expedited PA						
Kaiser Permanente – Hawaii						
Standard PA						
Expedited PA						
UnitedHealthCare						
Standard PA						
Expedited PA						
State Total	9,281	6,370	2,822	89	68.6	30.4

Note:

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

Section III. Medicaid Plan Prior Authorization (PA), 2025

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	2,500	67	2,402	9					22	
Expedited PA	322	23	296						3	
Hawaii Medical Service Association (HMSA)										
Standard PA										
Expedited PA										
Kaiser Permanente – Hawaii										
Standard PA										
Expedited PA										
UnitedHealthCare										
Standard PA										
Expedited PA										
State Total	2,822	90	2,698	9					25	

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), 2025

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.)