UnitedHealthcare RI Rite Smiles Medicaid Dental Plan

PRIOR AUTHORIZATION METRICS FOR MEDICAL ITEMS AND SERVICES (EXCLUDING DRUGS)

Medicaid Prior Authorization Metrics

To comply with the CMS Interoperability and Prior Authorization final rule, UnitedHealthcare RI RIte Smiles Medicaid Dental Plan is required to annually report aggregated prior authorization metrics on our website. Specifically, this includes a list of all medical items and services (excluding drugs) that require prior authorization, as well as data on prior authorization requests for those items and services (e.g., approvals, denials, etc.) over the previous calendar year. Publicly reporting these metrics promotes transparency and accountability, helps patients understand prior authorization processes, and enables providers to evaluate payer performance. In addition, metrics can be used to compare plans, programs, and payers.

Reporting Period: 2025

These are the medical items and services for which we require prior authorization (excluding drugs)

Dental Provider Manual - UnitedHealthcare Rhode Island RIte Smiles

Prior to January 1, 2026, impacted payers are required to send prior authorization decisions within the following timeframes:

- For MA plans and applicable integrated plans, 72 hours for **expedited requests** (urgent) and 14 calendar days for **standard requests** (non-urgent)
- For state CHIP FFS programs, 14 days for **standard requests** (non-urgent)
- For Medicaid managed care plans and CHIP managed care entities, 72 hours for **expedited requests** (urgent) and 14 calendar days for **standard requests** (non-urgent)
- For QHP issuers on the FFEs, 72 hours for **expedited requests** (urgent) and 15 days for **standard requests** (non-urgent)

There are no Medicaid FFS program required timeframes for either type of prior authorization request prior to January 1, 2026, and there are no CHIP FFS program required decision timeframes for expedited prior authorization requests prior to January 1, 2026.

Beginning January 1, 2026, the CMS Interoperability and Prior Authorization final rule requires Medicaid managed care plans to send prior authorization decisions within:

- 72 hours for **expedited requests** (urgent)
- 7 calendar days for **standard requests** (non-urgent)

Standard (non-urgent) Prior Authorization Requests

	How many times this happened	Out of total requests	Percentage
Request approved	6074	9052	67.1%
Request denied	2978	9052	32.9%
Request approved only after time for review was extended	7	7	0.1%
Request approved only after appeal	142	17	12%

Expedited (urgent) Prior Authorization Requests (Response Due to Provider Within 72 Hours)

	How many times this happened	Out of total requests	Percentage
Request approved	0	0	0
Request denied	0	0	0
Request approved only after time for review was extended	0	0	0
Request approved only after appeal	0	0	0

Time Between Receiving a Prior Authorization Request and Sending a Decision

	Mean (Average) Time	Median (Middle) Time
Standard (non-urgent) Prior Authorization Requests (response due to provider within 7 calendar days)	0.57942996	0
Expedited (urgent) Prior Authorization Requests (response due to provider within 72 hours)	0	0