

Improving Prior Authorization Success Rates

Practical strategies to reduce delays, denials, rework, and lost revenue



Presented by MedCycle Solutions

Prior Authorization Webinar

Disclaimer



The information presented in this webinar is provided for educational and informational purposes only and is not intended to constitute legal, regulatory, coding, billing, or payer-specific advice.

Prior authorization, coverage, medical necessity, documentation, coding, and reimbursement requirements vary by payer, plan, provider, service, location, and individual patient circumstances and are subject to change.

Practices and providers are responsible for verifying current requirements directly with the applicable payer and for ensuring compliance with all applicable laws, regulations, contracts, and payer policies.

Prior authorization is not a guarantee of coverage or payment.

MedCycle Solutions recommends reviewing current payer policies and requirements before providing or billing for services.

Meet Your Presenter



Amy Fajardo, CS, RCM

Director of Client Operations | Director of MedInsights



Amy brings more than 25 years of experience in medical billing, credentialing, revenue cycle management, provider contracting, and medical administration. She has worked with physicians throughout the lifecycle of their practices—from startup and growth through transition and sale.

Her work focuses on building practical workflows, educating staff, supporting billing compliance and provider education, and improving operational efficiency. Amy also leads MedCycle's monthly MedInsights webinar series.

Today's Objectives

What your team should be able to do after this session



Understand the full process

From benefit verification through approval, documentation, and claim readiness.

Identify breakdowns

Recognize errors that create delays, denials, rescheduling, and lost revenue.

Submit stronger requests

Build complete, accurate requests supported by payer criteria and clinical documentation.

Manage what happens next

Create workflows for tracking, follow-up, appeals, and peer-to-peer reviews.

Goal

A repeatable process that protects patient care and reimbursement.

Why Prior Authorization Matters

The impact extends far beyond the authorization team



Patient Care

- Delayed treatment
- Rescheduled procedures
- Frustrated patients
- Interrupted care plans

Operations

- Repeated calls
- Staff rework
- Provider interruptions
- Scheduling disruption

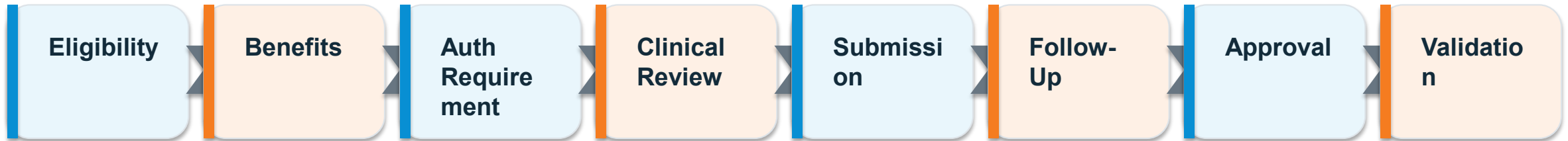
Revenue

- Authorization denials
- Delayed claims
- Appeal expense
- Potential lost reimbursement

Prior authorization is both a patient-access workflow and a revenue-cycle workflow.

Prior Authorization Is Not a Single Task

An approval number alone does not equal a successful authorization



The goal is alignment

Patient + payer + plan + provider + facility + service + diagnosis + dates + units/visits must all match.

Step 1: Verify Eligibility & Benefits

Start with the correct insurance before you check authorization



- Confirm active coverage, effective dates, member ID, group number, and primary/secondary order.
- Identify the patient's specific product — not just the insurance company.
- Verify provider and facility network status when applicable.
- Review benefits, referral requirements, and authorization requirements for the planned service.
- Reverify when coverage may have changed.

Remember

Same payer ≠ same authorization rules. Commercial, Medicare Advantage, Medicaid managed care, HMO, and PPO products can differ.

Know the Plan — Not Just the Payer

Authorization rules can vary within the same insurance company



Commercial

Employer and individual products

Medicare Advantage

Plan-specific authorization rules

Medicaid Managed Care

State + plan requirements

HMO / POS

Referral and network controls

PPO

Different benefit and authorization structure

Employer-Specific

Custom benefits may apply

Best practice

Document the exact plan/product used to determine authorization requirements.

Step 2: Determine Whether Authorization Is Required

Use current payer resources and document how you verified



- Check the payer portal, authorization tool, current policy, or payer representative.
- Verify the exact CPT/HCPCS code and place of service.
- Document date, method, representative/reference number, and staff member.
- If the payer states “no authorization required,” preserve the verification details.

Weak Documentation

“No auth required.”

No date

No method

No reference

No plan detail

Better

Date + plan + CPT + method +
reference #

Step 3: Know Exactly What Is Being Requested

Authorization staff should never have to guess



Required Details

- CPT/HCPCS code(s)
- Diagnosis code(s)
- Rendering provider
- Ordering/referring provider
- Facility / place of service
- Requested date/date range
- Visits or units

Clinical Support

- Office note
- Imaging
- Therapy history
- Medication trials
- Prior treatment
- Test results
- Relevant medical history

Avoid Vague Requests

- "Schedule injection"
- "Get auth for surgery"
- "Needs imaging"

Clarify the exact service before submission.

Clinical Documentation Drives Authorization

The record must demonstrate why the patient meets the payer's criteria

- Diagnosis, symptoms, severity, duration, and functional impact
- Previous treatment and response
- Conservative treatment requirements
- Medication history and failed therapies
- Imaging, labs, therapy, or other required testing
- Why the requested service is medically necessary now



Key Principle

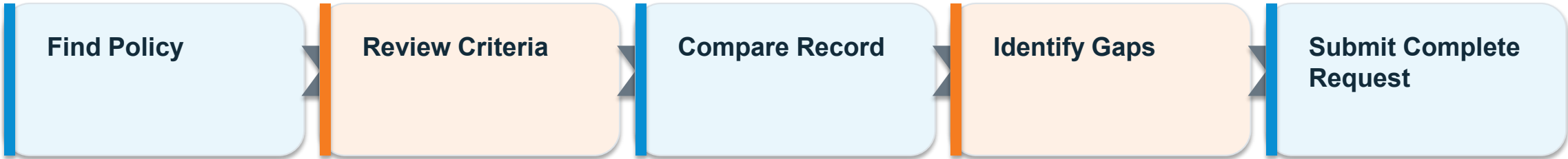
The provider may know the patient meets the criteria.

The payer can only evaluate what is documented and submitted.

Use the Payer's Medical Policy Before Submission



For high-risk services, build the request against the criteria



Example: Conservative Care

If the policy requires 6 weeks of conservative treatment, identify where the dates, treatment, and outcome are documented.

Example: Imaging

If specific imaging findings are required, confirm the report supports the payer's criteria before submitting.

Prevention beats appeal

Fix documentation gaps before submission whenever clinically appropriate.

Common Prior Authorization Breakdowns

Most failures fall into a few repeatable categories

Wrong insurance / plan

Eligibility was not updated

Wrong CPT code

Approved service $\neq$ performed service

Missing documentation

Criteria not demonstrated

Wrong provider

Authorization tied to another clinician

Wrong facility

Approved location differs

Expired authorization

DOS outside approved range

Units exceeded

Visits/units used up

Insurance changed

New coverage not rechecked

Build a Standard Authorization Checklist

Every request should answer the same core questions

☐ Patient & active coverage

☐ Correct plan/product

☐ Rendering provider

☐ Facility / place of service

☐ CPT/HCPCS confirmed

☐ Diagnosis confirmed

☐ Authorization required?

☐ Clinical criteria met?

☐ Complete submission?

☐ Tracking/reference #

☐ Approved dates & units

☐ Final pre-service validation

Track Every Authorization

A pending request needs an owner, a status, and a next action



Track the Request

Patient
Payer / plan
Provider / facility
CPT/HCPCS
Date submitted
Submission method
Reference number

Track the Work

Current status
Last follow-up
Next follow-up
Additional info needed
Assigned staff member
Escalation needed

Track the Outcome

Approval / denial
Authorization number
Approved dates
Approved visits / units
Expiration date
Appeal / P2P status

Use Clear Status Categories



Standard statuses make bottlenecks visible



Management insight

If 30 cases are stuck in “Documentation Needed,” the root cause may be upstream — not the authorization team.

Follow-Up Is Part of the Authorization



Submitting the request is not the finish line



Adjust timing to your service line

The process should never depend on someone remembering to check.

Peer-to-Peer Reviews

Make provider involvement efficient and time-sensitive

- Provide the patient, requested service, and denial/pending reason.
- Include the payer policy and the specific criteria in dispute.
- Summarize relevant clinical history, imaging, testing, and prior treatment.
- Provide the deadline, payer phone number, case/reference number, and instructions.
- Document the outcome immediately after the discussion.



Do Not Send

“Call insurance about authorization.”

Give the provider a complete case packet so clinical time is used for the clinical discussion.

Appeals: Respond to the Actual Denial Reason

Do not automatically resend the same documentation

Medical Necessity

Address the criteria

Missing Documentation

Supply the missing evidence

Incorrect CPT

Correct/clarify the requested service

Network / Site of Service

Review plan requirements

Benefit Exclusion

Confirm coverage and appeal rights

Administrative Error

Document verification and payer error

Appeal strategy

Match the response to the payer's stated reason and deadline.

Authorization Does Not Guarantee Payment

Approval is one piece of claim adjudication

Authorization Confirms

The payer reviewed a request under the information available at that time.

It does not override every other claim requirement.

Claims May Still Be Subject To

Eligibility • Benefits • Medical necessity
Coding requirements • Network status
Coordination of benefits • Timely filing
Provider enrollment • Coverage limitations
Patient responsibility • Claim edits

Operational takeaway

Authorization information must flow to billing — not stop with scheduling.

Validate the Authorization Before the Date of Service



Compare the approval to what is actually scheduled

✓ Same patient

✓ Same insurance

✓ Same CPT/HCPCS

✓ Same provider

✓ Same facility

✓ Correct date range

✓ Enough visits/units

✓ Authorization active

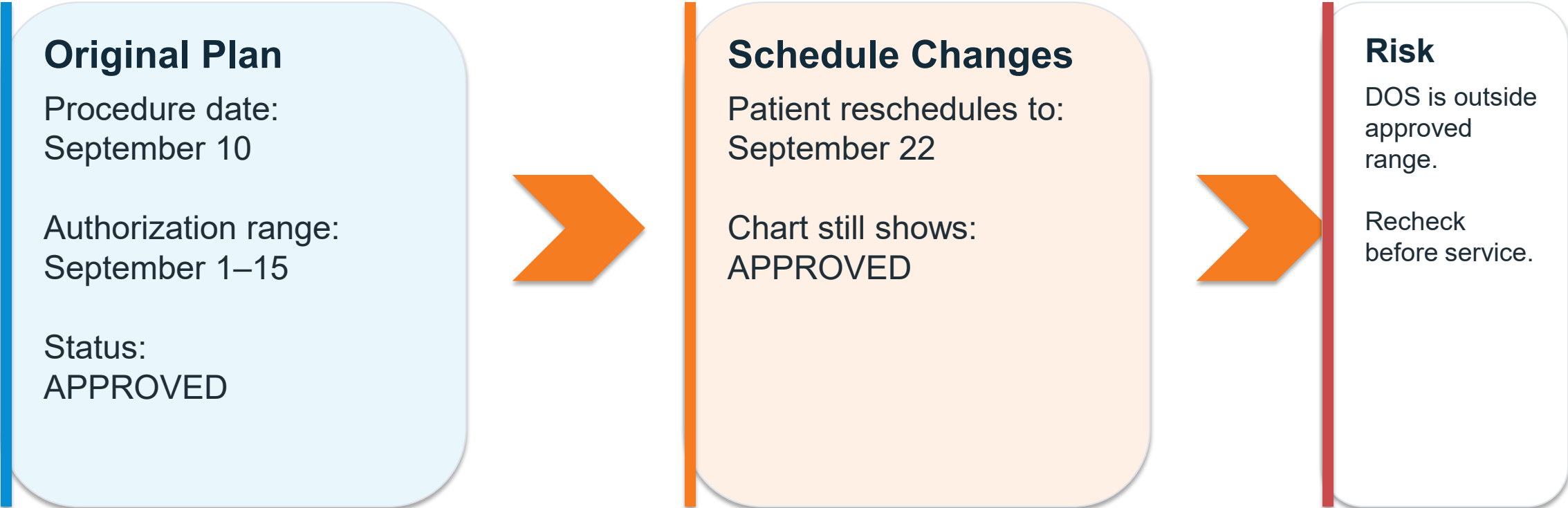
Final check

An authorization can still show "Approved" in the chart even when the scheduled service no longer matches the approval.

Example: The Procedure Was Rescheduled



Small scheduling changes can create expensive denials



Rule

A scheduling change should trigger an authorization review.

If Something Changes, Recheck the Authorization



Build this trigger into your workflow

Insurance

REVERIFY

Procedure

REVERIFY

CPT code

REVERIFY

Provider

REVERIFY

Facility

REVERIFY

Date

REVERIFY

Visits / units

REVERIFY

**Diagnosis when
relevant**

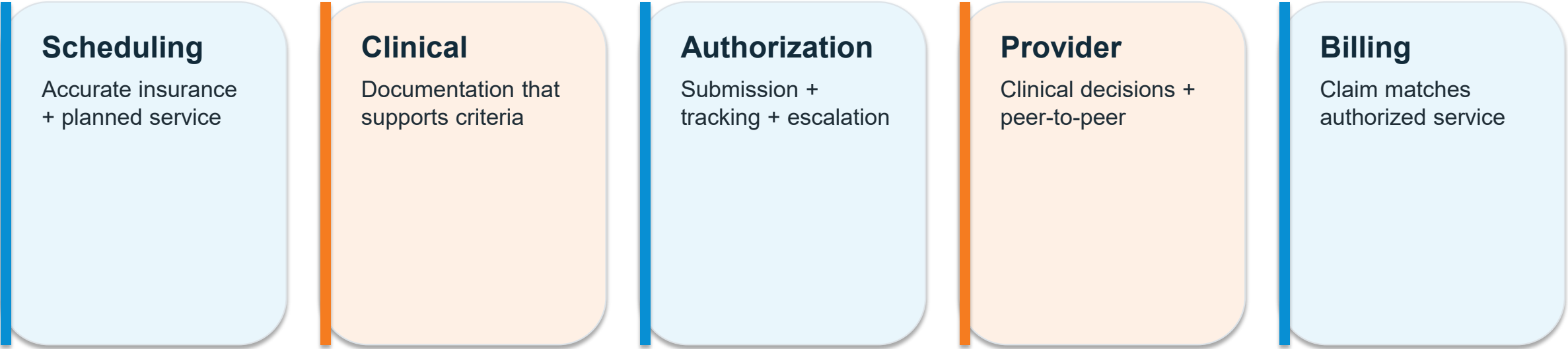
REVERIFY

Simple policy

Do not assume an existing authorization automatically carries over to a changed service.

Prior Authorization Cannot Operate in a Silo

Success depends on clear handoffs across the practice



Define ownership

Who verifies? Who submits? Who follows up? Who escalates? Who validates? Who updates billing?

Measure Prior Authorization Performance



You cannot improve what you cannot see

Initial Approval Rate

Approved on first submission

Authorization Denial Rate

Requests denied

Top Denial Reasons

Why requests fail

Turnaround Time

Submission → decision

P2P Volume

Provider review burden

Appeal Success Rate

Denied → overturned

Auth-Related Claim Denials

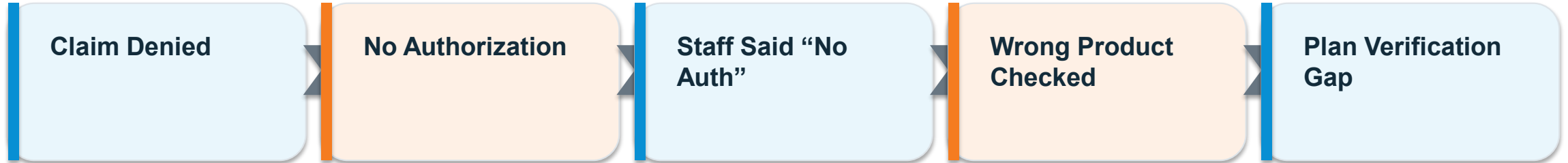
Downstream revenue impact

Rescheduled Procedures

Patient access impact

Use Root-Cause Analysis

Correct the workflow — not just the individual denial



The real problem

The denial was not simply “no authorization.” The workflow failed to require confirmation of the patient’s specific insurance product before checking authorization rules.

Fix the system

Add the plan/product verification step so the same error is less likely to repeat.

Build Payer-Specific Knowledge

Create internal resources — but do not let them become stale

Useful Internal Reference

- Portal / vendor
- Submission method
- Phone / escalation contacts
- Commonly authorized services
- Medical policy location
- Typical turnaround
- P2P / appeal process
- Known payer issues

Important Guardrail

Internal guides support the workflow.

They do not replace current verification.

Payer requirements, vendors, portals, and policies change.

Protect the Patient Experience

Authorization delays affect real people and real schedules

Patients May Have Arranged

- Transportation
- Time off work
- Childcare
- Medication holds
- Pre-op testing
- Family assistance

Communicate Clearly

- Explain pending status
- Set expectations
- Avoid promises
- Update when status changes
- Explain next steps

Avoid Saying

“Insurance approved it, so you’re covered.”

Authorization is not a guarantee of payment.

A Strong Prior Authorization Workflow

A repeatable 12-step process

1 Verify eligibility & benefits

2 Confirm planned service

3 Determine auth requirements

4 Review payer criteria

5 Review clinical documentation

6 Submit complete request

7 Track the request

8 Respond to payer requests

9 Escalate when needed

10 Validate approval

11 Reverify before service

12 Communicate to billing

Five Questions to Take Back to Your Practice

Use these to identify your biggest opportunities

1. Do we verify the patient's specific insurance plan before checking authorization requirements?

2. Do we compare clinical documentation to payer criteria before high-risk submissions?

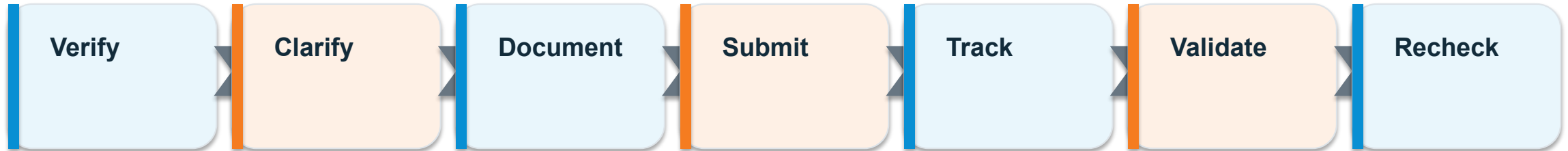
3. Does every pending authorization have an owner and a next follow-up date?

4. Do we validate the authorization against the actual scheduled service before DOS?

5. Do we track why authorizations and authorization-related claims are being denied?

Key Takeaway

Successful prior authorization begins before the request is submitted



Build consistency across the entire workflow

Accurate information + payer criteria + complete documentation + reliable follow-up + final validation = fewer preventable authorization problems.

Protect patient care. Reduce rework. Protect reimbursement.



Questions & Discussion

Thank you for joining us.

Contact Information



Amy Fajardo, CS, RCM

Director of Client Operations | Director of MedInsights

EMAIL

Amy@MedCycleSolutions.com

OFFICE PHONE

320-200-5548

Thank you for joining us!

MedCycle Solutions