



# Preauthorization & AI

**Dustin Eubanks**

SVP of Partnerships @ Plenful

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Welcome

## What we'll cover today:

- 01 The lifecycle map
- 02 Why the burden is structural
- 03 Three costs (two, that you can't see)
- 04 Where AI holds up and where it does not
- 05 What good looks like
- 06 Live Q&A



Today we're going to  
focus on the money  
you *can* control

# The PA lifecycle map

## Steps 1–5 — everyone's process

**01** Determination – Is a PA needed?

**02** Clinical Coordination – What data do I need?

**03** Submission – Who do I send it to?

**04** Statusing – What is the status?

**05** Post-authorization monitoring – What was the outcome?

## Steps 6–7 — only in drug and infusion

**06**

**Benefit determination**  
– What is best for us and patient?

**07**

**Financials**  
– What is the financial details?

## The cost of not knowing what's required

13

hours per week

Physician and staff time spent  
on prior authorization

~40

PAs per physician, per week

The volume behind that time

29%

say EHR auth data is wrong

Rarely or never accurate on  
whether auth is required

Source: 2025 AMA prior authorization physician survey, released May 2026.

## Why the burden is structural, not cyclical

| Process Type                                             | Your Cost                               | Payer Cost                             |
|----------------------------------------------------------|-----------------------------------------|----------------------------------------|
| <b>Manual PA</b><br>Traditional paper/fax workflow       | <b>~\$10.97</b><br>Per transaction cost | <b>~\$3.52</b><br>Per transaction cost |
| <b>Fully electronic PA</b><br>Automated digital workflow | <b>~\$5.79</b><br>~47% cost reduction   | <b>~\$0.05</b><br>~99% cost reduction  |

Source: 2023 CAQH Index

# Three costs. You are managing one of them.

But you can manage and control more

## 1 VISIBLE

### Rework and denials

Already on your dashboard.  
Which is exactly why it  
absorbs all the attention.

## 2 INVISIBLE

### Leakage

A slow authorization doesn't  
produce a denial. It produces  
a referral that goes  
elsewhere.

## 3 INVISIBLE

### Benefit misrouting

You got the authorization.  
You got paid. You got paid  
the wrong amount.

# Rework and denials

Getting paid can be expensive

**11.81%**

initial denial rate, 2024

Continuing a multi-year rise

**\$25.7B**

a year on claims adjudication

Up 23% year over year

**~\$18B**

of that potentially unnecessary

About 70% of denials are ultimately overturned

Source: Kodiak Solutions (denial rate). Premier, February 2025 survey of 280 hospitals (adjudication spend).

# Leakage

Referring providers route on speed not on financial decisions.

# 79%

of physicians report patients  
at least sometimes abandon  
treatment because of prior  
authorization

## The competitive fact that should bother this room

- PE-backed independent specialty and infusion pharmacies win referrals on white-glove intake.
- They are not clinically better than a health system. They are faster at paperwork.
- You are losing high-margin scripts to competitors whose primary advantage is operational speed on a task you classify as overhead.
- There is no report anywhere in your organization for a script you never received.

# Benefit misrouting

You got paid but could you have received more.

## Sets four things at once

Reimbursement rate, patient cost share, site of care, and 340B eligibility. This is step 6.

## Made dozens of times a day

Usually by whoever picks up the referral — optimizing for whatever gets approved fastest.

## Cannot appear in your reporting

There is no denial code for “approved through the wrong benefit.”

## Show of hands

**Who can state their all-in cost per authorization, including clinical time and rework?**

Almost no hands. That’s the point.

THE NUMBER YOU CAN ACTUALLY DEFEND

# What one authorization really costs

Not considering if it was the right PA

Manual

**\$10 | \$49**

per drug prior authorization (Pharmacy | Medical)

Altarum / NIHCR review

**25 | 64**

minutes per authorization (Pharmacy | Medical)

Altarum / NIHCR review

With AI

**\$4 | \$9**

per drug prior authorization (Pharmacy | Medical)

Typical Result

**5 | 12**

minutes per authorization (Pharmacy | Medical)

Typical Result

# Where AI holds up — and where it does not

Automating a broken process is velocity without command. You get to the wrong answer faster, and at scale.

## TIER 1

### Document and data assembly

#### Proven

Referral fax and PDF ingestion, structured extraction, clinical documentation retrieval, form pre-population, clinical bundle assembly.

## TIER 2

### Decision support and routing

#### Real, needs guardrails

Benefit investigation, medical vs. pharmacy determination, payer policy matching, predicted-denial routing before submission.

## TIER 3

### Autonomous submission and appeals

#### Keep a human in the loop

End-to-end submission and drafted appeals, with review and an audit trail.

## Where AI holds up — what to be skeptical of

### **Vendors selling on approval rate**

Approval rate is mostly case mix, not tooling. Ask for touch time, time-to-decision, and first-pass rate.

### **Point solutions that automate submission but not intake**

The bottleneck is almost never the submission.

### **Black-box tools with no audit trail**

CMS-0057-F forces payers to state denial reasons.  
You should be able to show your work too.

### **Anything sold purely on FTE reduction**

The realistic outcome isn't fewer people. It's the same team absorbing two to three times the volume.

### **Anything that automates PA Submission and leaves Benefit Options and Financials to whoever picks up the referral**

Those are the margin steps.

## What good looks like

### RUNG 1

#### Decentralized and manual

Site-level auth, tribal knowledge, no shared requirements source.

Don't buy AI yet. Standardize, centralize the payer knowledge base, instrument it.

### RUNG 2

#### Automated but still painful

Some RPA or portal automation, but staff still work portals and rework denials.

Find your administrative touches. Usually the automation isn't the problem — the input data is.

### RUNG 3

#### Orchestrated and Navigated

Exception-based review, deliberate benefit determination, capacity that scales with volume.

This is what the market is selling. Very few are standing here.

## Four questions to take home

01

What is our all-in cost per authorization, including clinical time and rework and does anyone own that number?

02

What is our time-to-therapy, and how does it compare to the independent specialty pharmacy competing for the same referral?

03

Who decides medical vs. pharmacy benefit, and what are they optimizing for?

04

Can we absorb 2x authorization volume without 2x staff? If not, our growth plan and our staffing plan contradict each other.

### Core Takeaway

*Understanding and improving on these areas are exactly how you improve your margins and metrics to grow!*



# Q&A



Scan the QR code to  
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for intake authorization &  
connect with our team

