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Winning the Prior Authorization Battle: Improving Patient Access, Reducing Delays & Protecting Revenue



November 10, 2026

01

The Problem

Prior authorization delays patient care, increases administrative burden and puts revenue at risk.

The downstream stakes are high

The burden is visible across patient access, staff capacity, and the time required across all specialties

95%

of physicians say PA delays access to necessary care

AMA, 2026

79%

report patients **abandon treatment** because of authorization challenges

AMA, 2026

13 hrs

of physician and staff time per week consumed by PA

AMA, 2026

24 vs 16

minutes per PA request: manual vs. health-plan portal

CAQH Index, 2024

Sources: AMA 2026 Prior Authorization Physician Survey; CAQH 2024 Index

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The National and Hawai’i impact of prior authorizations

Revenue cycle friction is measurable, and the access burden is especially visible in Hawai’i

HFMA / GUIDEHOUSE RCM SURVEY

54.6%

of surveyed organizations reported Medicare Advantage PA denial rates above 6%

HAWAI'I PHYSICIAN SURVEY

98%

reported PA-related care delays

19.8

staff hours/week spent on PA

8 days

average initial PA decision wait

Why it matters: Delayed decisions, rework and preventable denials put both patient access and revenue at risk.

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Sources: HFMA/Guidehouse, 2024 RCM Survey; Rooks, Chinen & Withy, “Impact of Prior Authorizations on Healthcare in Hawai‘i” (n=88). Hawai‘i results are physician-reported.

How prior authorizations become revenue leakage

Connect front-end errors to downstream financial consequences

01

INCOMPLETE INTAKE

Missing order details, incorrect coverage

→

02

AUTH DELAY

Rework, payer follow-up, late clinicals

→

03

ACCESS IMPACT

Rescheduled care, unused capacity

→

04

REVENUE RISK

Avoidable denials, rework and delayed cash

Control Points: Clean-case standards • Real-time status visibility • Payer playbooks • Denial analytics

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On paper, the front-end is simple

The ideal workflow: four clean handoffs, each one feeding the next, until one handoff lacks clean data

01 **Order/Referral Received** → 02 **Verify Eligibility and Benefits** → 03 **Prior Authorization Obtained** → 04 **Appointment Scheduled** → 05 **Patient Seen**

The catch: every step depends on clean data from the step prior

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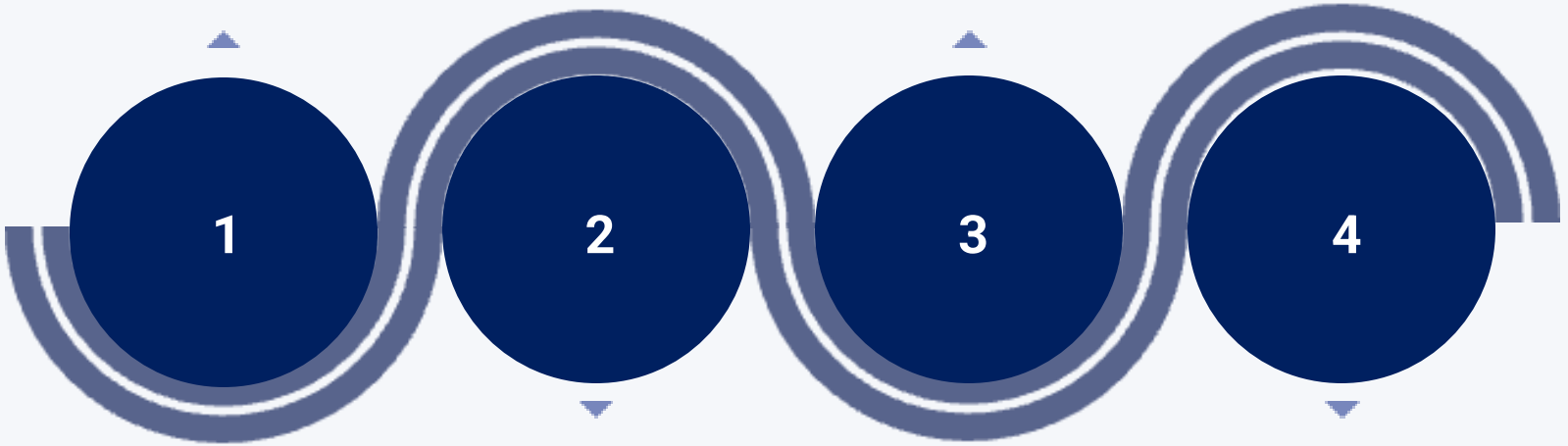
A scheduling error starts a domino effect

Scheduling Error

Wrong/incomplete insurance, CPT/Dx code, provider, DOS, or demographic information enters the workflow.

Delayed Authorization Initiation

Rework starts the authorization clock later, leaving less time before the scheduled service.



Rework

Staff correct data, confirm benefits, obtain missing information, or contact the patient again.

Impact

Reschedules, cancellations, patient/provider frustration, lost capacity, and potential revenue leakage.

Accurate intake is a prior authorization control point. Validate coverage, service codes, clinical requirements and demographics are needed before an authorization can be initiated.

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What does your payer list in your EMR look like?

51

Humana entries in a single payer list

Duplicate and inconsistent payer names make it easy to pick the wrong plan at scheduling. That's where the failed E&B checks and late authorizations begin.

Select insurance plan: "Humana"

HUMANA MEDICARE ADVANTAGE PPO	Humana Gold Plus (HMO)
HUMANA MEDICARE ADVANTAGE (PPO)	HUMANA GOLD PLUS HMO
HUMANA MDCR ADV PPO	HUMANA GOLD PLUS MDCR ADV HMO
Humana Medicare Advantage	HUMANA MCR
HUMANA MEDICARE ADV	HUMANA MEDICARE
HUMANA MEDICARE ADVANTAGE - 14601	Humana Managed Medicare
HUMANA MEDICARE ADVANTAGE 14678	HUMANA MCR REPLACEMENT
HUMANA MEDICARE ADVANTAGE HMO	HUMANA MEDICARE REPLACEMENT

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Five reasons prior authorizations delay care

Manual channels	Portals, calls and faxes create extra touches and inconsistent follow-up
Missing documentation	Missing clinicals are discovered too late in the scheduling cycle
Complex payer rules	Requirements vary by payer, plan, service, clinical criteria and submission channel
No status visibility	Schedulers chase updates instead of confidently managing the schedule
First-in, first-out queues	The highest-risk cases surface days, or hours, before care

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Measure where your front-end is leaking

Patient Access / Scheduling

- How many E&B ineligible cases trace back to incorrect patient demographics?
- How many patients are scheduled with or without the auth or referral in hand?
- How many are scheduled without a referral or diagnosis code on file?

Prior Authorizations

- How many appointments are rescheduled because the auth wasn't available?
- What do your back-end PA and E&B denials look like?
- How long are payers taking to approve auths, on average?

Document each process in a specific SOP, so every scheduler and PA specialist works the same way.

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02

The Solution

A proactive operating model built around patient care.

Revenue Is Not Earned at One Desk. It’s Across the Whole Cycle

From scheduling to final payment, every step works together to turn care into revenue.

01

Scheduling

Efficient schedules, reminders, and authorization approvals

›

02

Registration

Accurate patient information and verified eligibility & benefits

›

03

Charge Capture

Bill for every reimbursable service provided, every time

›

04

Billing

Clean, coded claims submitted accurately and on time

›

05

Denial Management

Identify the cause, correct errors, and resubmit

›

06

A/R Follow-Up

Resolve unpaid claims and outstanding balances

The cycle closes only when insurance payments, adjustments, write-offs, and patient balances are fully reconciled.

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Move from reactive to proactive

Design the process around the patient's date of service, not the order the cases arrive

01

Intake

Complete patient, insurance, provider, procedure, diagnosis, facility prior to DOS

02

Requirements

Identify payer rules, auth need, clinical criteria and submission channel

03

Initiate

Send the request with required clinical documentation as early as appropriate

04

Manage

Track pending cases, payer requests, missing information and peer-to-peer needs

05

Return status

Give scheduling a clear Approved / NAR / denial status

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Prioritize the work that protects patient access

A work queue should answer one question: **what needs attention next?**

HIGHEST URGENCY

STAT / Same-Day / Walk-Ins

- Immediate review and escalation
- Confirm required documentation at intake
- Use a defined rapid-response path

APPROACHING DOS

Near-Term DOS

- Prioritize cases nearing the scheduling threshold
- Account for payer-specific turnaround times
- Escalate missing clinicals before they become a cancellation

PLAN AHEAD

Routine / Future DOS

- Work early enough to absorb payer follow-up
- Standardize routine follow-up intervals
- Keep cases moving without crowding out urgent work
- Build a waitlist to fill openings when cases move

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Measure what improves access and protects revenue

Six metrics linking authorization, patient access and revenue

Turnaround Time

How long from clean intake to final auth status?

Readiness

What % of cases are complete before the DOS?

Reschedules

How many visits are delayed or cancelled due to authorization?

Exceptions

What % of cases need missing information or manual work?

Denials

Which payer, procedure and documentation issues drive them?

Productivity

How many touches and staff minutes per case?

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Create clear ownership at every handoff

Prior authorization is a connected patient access and revenue cycle responsibility

Patient Access / Scheduling

Accurate case creation, date of service, patient communication

Clinical Documentation

Complete documentation, timely responses, medical necessity support

Authorization

Requirements, submission, follow-up, escalation, status

Revenue Cycle Leadership

Denial trends, staffing, metrics, process improvement

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Put technology to work at every step

Referral

Tech + People

- Automate referral and order intake, document capture and routing

Scheduling

AI-assisted

- Consider a centralized call center team
- Voice AI
- Self-scheduling platforms

E&B Verifications

Tech + People

- Automate eligibility and benefits verifications
- Use an insurance discovery solution

Prior Authorizations

Tech + People

- Automate initiation and follow-up for high-volume payers
- People handle the exceptions

Charge Capture

Tech + People

- Perform 100% audits using technology
- Charge audit experts review medical records for flagged claims

Connect ownership across the entire front-end process using a streamlined, consistent process.

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Automate the predictable. Use human expertise for the complex.

Technology removes repetitive work; people keep judgment where it matters

Good candidates for automation

- Payer connectivity and portal transactions
- Standardized intake and case routing
- Routine status checks and work-queue updates
- Repetitive, follow-up tasks
- Data movement between EMR, auth and scheduling workflows.

Keep human expertise in the loop

- Missing or conflicting clinical information
- Payer-specific exceptions and portal restrictions
- Peer-to-peer and medical necessity workflows
- Procedure or code changes
- Complex cases requiring provider or payer outreach

The goal isn't zero human work; it's human effort on the cases that truly need it.

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Design the workflow to scale

Growth shouldn't cost turnaround time, accuracy or patient experience

- Standardize intake fields and required documentation **before** adding volume
- Roll out in phases by provider, facility, procedure or payer
- Validate automation and payer workflows before the next phase
- Build capacity for seasonal spikes and unexpected growth
- Cross-train staff for priority queues and exception handling
- Revisit payer mix, procedure mix, staffing and automation as you grow

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03

The Path Forward

Practical steps healthcare leaders can take to improve access and protect revenue.

A six-step improvement framework

Evaluate your current state and build a more predictable process

1 Map

Document the order-to-authorization workflow

2 Find

Identify bottlenecks, rework and failure points

3 Prioritize

Organize work by DOS, urgency and payer requirements

4 Standardize

Define required data, ownership and escalation paths

5 Automate

Remove repetitive work while preserving exception handling

6 Measure

Track turnaround, reschedules, denials, exceptions and productivity

EXCEPTION PATH · WHO OWNS IT?

Missing referral or clinical documents	**Payer Request**	**Peer-to-peer**	**Denial / Appeals**	**DOS at Risk**
PA/Front-Office Team	PA/Front-Office Team	Provider	PA Team + Provider	Escalation Queue

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12 changes you can take back to your organization

Connect patient access, clinical, scheduling, authorization and RCM workflows

Scheduling

- Set lead-time rules by procedure and payer
- Prioritize by DOS + urgency, not first-in, first-out
- Run a daily 3/5/7-day schedule-at-risk worklist

Intake + Clinicals

- Define a clean-case intake standard
- Move procedure-specific documentation needs upstream
- Give every missing-info exception an owner and due date

Prior Authorizations

- Create routine vs. exception work queues
- Build payer/procedure playbooks for high-volume services
- Set escalation clocks for pending, P2P, denial and DOS risk

Tech + Analytics

- Automate repetitive submission and status work
- Make PA status visible to scheduling without chasing
- Track TAT, readiness, reschedules, denials, exceptions, touches

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Thank you.
Questions?

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