

PRIOR AUTHORIZATION FAST-TRACK GUIDE

Strategies for Speeding Up Prior Authorization Approvals

UNDERSTANDING PRIOR AUTHORIZATIONS (PA)

Prior authorization is a requirement by health plans for providers to obtain approval before delivering a specific medical service, medication, or procedure. Delays can disrupt patient care and waste valuable administrative time. This guide outlines how to fast-track authorizations effectively.

THREE CORE ACCELERATION WORKFLOWS

- **Adopt Electronic Portals (ePA):** Avoid old-fashioned manual fax workflows. Use dedicated electronic authorization portals (like Availity or payer-specific sites) to receive immediate verification rules and speed up processing.
- **Build Pre-Compiled Clinical Packets:** For high-volume procedures (such as MRIs or specialty injections), create standard checksheets containing the last three clinical notes, failed conservative treatments (e.g., physical therapy logs), and objective diagnostic scan results.
- **Align with Policy Language:** Look up the payer's explicit Local Coverage Determinations (LCD) online before submitting. Use the exact medical keywords in your notes that the payer requires for coverage.

PAYER ESCALATION RULES

1. **Request an Urgent Peer-to-Peer (P2P) Review:** If an authorization is denied administratively, schedule a direct call between the ordering physician and the insurance company's medical director within the standard 48-hour window.
2. **Submit an Expedited Appeal:** When a patient's life or safety is compromised by waiting, explicitly mark the written appeal as "EXPEDITED / URGENT" to force a decision within 72 hours under state laws.