

How Small Hospitals Can Prevent Prior Authorization Breakdowns



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Why This Matters Now



Small hospitals face big challenges—every prior authorization step counts.



Lean Teams, Big Responsibility

Small and rural hospitals run lean, with fewer staff and no dedicated prior authorization team.



Missed Steps Create Delays

A missed requirement does not just cost time. It delays the care a patient is waiting on.



Today's Focus

Where prior authorization breaks down for smaller systems, and how to close the gap.



Better processes today lead to faster approvals, better care, and a stronger bottom line.

Prior Authorization by the Numbers



53M

Prior authorization determinations
made by Medicare Advantage plans
in 2024

99%

Of Medicare Advantage enrollees
must get prior authorization for some
services

#1

Prior authorization is the top
administrative burden reported by
medical practices

The Denial Problem, in Data



7.7%

Of Medicare Advantage prior authorization requests were denied or partially denied in 2024

80.7%

Of appealed denials were overturned in the patient's favor

11.5%

Of denials were ever appealed by patients

Source: KFF analysis of CMS Medicare Advantage data, 2026 (52.8M determinations; 4.1M denied)

The Toll on Patients and Rural Hospitals



1 in 5

Privately insured adults had doctor-recommended care denied in the past year

41%

Of patients hit by a prior authorization denial reported a delay in care

120%

Growth in Medicare Advantage enrollment since 2014, concentrating burden on rural hospitals



The Real Cost of a Missed Step

One small miss can create a big impact across every part of your organization.



Triggers a Chain Reaction

One missed requirement or documentation gap sets off a chain reaction.



Delays Care for the Patient

Care gets delayed while paperwork is corrected and approvals are resubmitted.



Rework for Staff

Extra time, extra follow-ups, and duplicate work for teams already stretched thin.



Revenue at Risk

Denials and delays put revenue your team worked hard to protect at risk.



One small miss is never small. It impacts patient care, staff capacity, and your bottom line—all at the same time.

Where Breakdowns Start



Breakdowns rarely happen at the end—they start much earlier in the process.



Ordering

Treatment gets ordered and scheduled before prior authorization staff have time to submit and work it.



Documentation

Clinical notes do not capture what the payer needs to approve.



Submission

No clear owner for who submits, tracks, and follows up.



Payer Review

Inconsistent interpretation across payers with no system to track it.



Addressing these early points prevents delays, denials, and unnecessary rework.



Align Clinical Expectations with Payer Criteria

Set the stage for smoother approvals by aligning early.



1. Orders Happen Fast

Providers often order treatment that needs prior authorization without leaving staff enough lead time to submit and work it.



2. Education Is the Fix

The fix starts with education, not blame.



3. Know What Payers Need—And When

Clinical staff need to understand what payers require, and when, before the order goes in.



4. Build Lead Time Into Workflows

Build a standard lead time into ordering workflows so prior authorization staff have room to work.



KEY TAKEAWAY

Education + awareness + lead time = fewer delays, fewer denials, and better patient outcomes.

The Cost of an Undertrained Workforce



Gaps in knowledge lead to costly mistakes across the entire revenue cycle.



Inconsistent Payer Interpretation

Inconsistent payer interpretation from one staff member to the next.

↓ **RESULT:** Unpredictable outcomes and avoidable delays or denials.



Incomplete or Incorrect Documentation

Documentation that does not match what a payer requires for approval.

↓ **RESULT:** Requests are denied, causing rework and delays.



Coding Lacks Specificity

Coding that lacks the specificity payers are looking for.

↓ **RESULT:** Claims are underpaid, denied, or appealed.



Learned by Trial and Error

Staff who learned the process by trial and error instead of training.

↓ **RESULT:** Lower confidence, increased errors, and higher turnover.



Investing in training today prevents denials tomorrow.

A knowledgeable team = consistent approvals, fewer delays, and stronger financial results.

How Denials Actually Happen



Denials are rarely random—they follow a pattern.

The Denial Lifecycle



1. Walk Through the Denial Lifecycle

Understand where it starts, who touches it, and where it stalls.



2. Identify Where Ownership Gets Lost

Gaps in communication and unclear roles between clinical and revenue cycle teams create risk.



3. Most Denials Trace Back to Three Key Points

- Incomplete documentation
- Missed deadlines
- Unclear ownership



Find the breakdown. Fix the process. Prevent the denial.

Clarity and accountability at every step protect patient care, staff time, and revenue.

Case Study

Small changes. Big impact.



SETTING:

A 60-bed rural hospital orders an outpatient MRI for a patient with worsening back pain late on a Friday afternoon.



THE BREAKDOWN:

The order reaches prior authorization staff with no lead time, the clinical notes omit the conservative-treatment history the payer requires, and no one clearly owns the submission.



THE RESULT:

The payer denies the request for insufficient documentation. Care is delayed nine days while staff spend hours on rework and an appeal.



THE FIX APPLIED:

Cross-functional ownership, a standard 72-hour lead time built into ordering, and a pre-submission documentation check.



THE OUTCOME:

On the next similar case, authorization is approved in two days, with no delay to the patient and no rework for staff.



THE IMPACT

Better process.
Faster approvals.
Better patient care.



TURNAROUND TIME

9 DAYS

Reduced to 2 days



OUTCOME

APPROVED

First time



STAFF IMPACT

NO REWORK

More time for
patient care

Building Clearer Workflows Across Teams

Stronger workflows today prevent denials tomorrow.



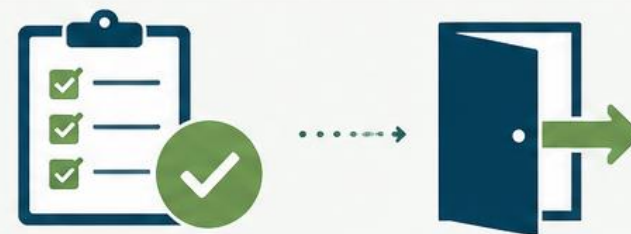
1. Assign Cross Functional Ownership

Assign cross functional ownership for each step, from order to submission to appeal.



2. Add Pre-Billing Checks

Add pre-billing checks before a claim goes out the door.



3. Build Denial Prevention Checkpoints

Build denial prevention checkpoints into the process instead of adding them after a denial happens.



Clear ownership. Built-in checks. Fewer denials. Better outcomes.

Standardized workflows protect patient care, staff time, and revenue.

Documentation That Gets Approved

Clear. Complete. Just what the payer needs.



1

Start from each payer's medical-necessity criteria and write the note to answer them.



WHY IT MATTERS:

Directly addressing criteria increases approval rates.



2

Capture the conservative treatments already tried, with dates and outcomes.



WHY IT MATTERS:

Payers want proof the standard of care was followed.



3

Use diagnosis codes specific enough to match what the payer requires.



WHY IT MATTERS:

Specific codes show medical necessity and support the request.



4

Keep a short, payer-specific checklist for your highest-volume procedures.



WHY IT MATTERS:

Saves time and helps ensure consistency every time.



5

Verify the documentation packet before submission, not after a denial.



WHY IT MATTERS:

Catches gaps early and prevents avoidable denials.



Right documentation. Right first time. Better outcomes.

Answer the payer. Tell the full story. Get approved.

Training the Whole Team

Strong teams. Consistent processes. Better outcomes.



- 1** **Replace trial-and-error learning**
with a standard onboarding path.



BENEFIT:
Builds confidence faster
and improves accuracy.



- 2** **Cross-train** so coverage never
depends on a single person.



BENEFIT:
Stronger coverage and
less risk of disruption.



- 3** **Maintain a living payer playbook:**
who requires what, and when.



BENEFIT:
Up-to-date requirements
at your fingertips.



- 4** **Review denied cases together**
as teaching moments, not blame.



BENEFIT:
Turns denials into lessons
and drives improvement.



- 5** **Refresh training** whenever major
payers change their rules.



BENEFIT:
Keeps the team current and
prevents avoidable denials.



Invest in your people. Strengthen your process. Reduce your denials.
Well-trained teams approve more, faster.



Automation That Removes Busywork



- ✓ Replace phone-and-fax submissions with electronic prior authorization
- ✓ Run eligibility and benefit checks automatically at scheduling
- ✓ Flag services that need authorization before the order is placed
- ✓ Track every request in one queue, with status and deadlines visible to all
- ✓ Full automation could save the industry \$20 billion a year (2024 CAQH Index)

What to Track

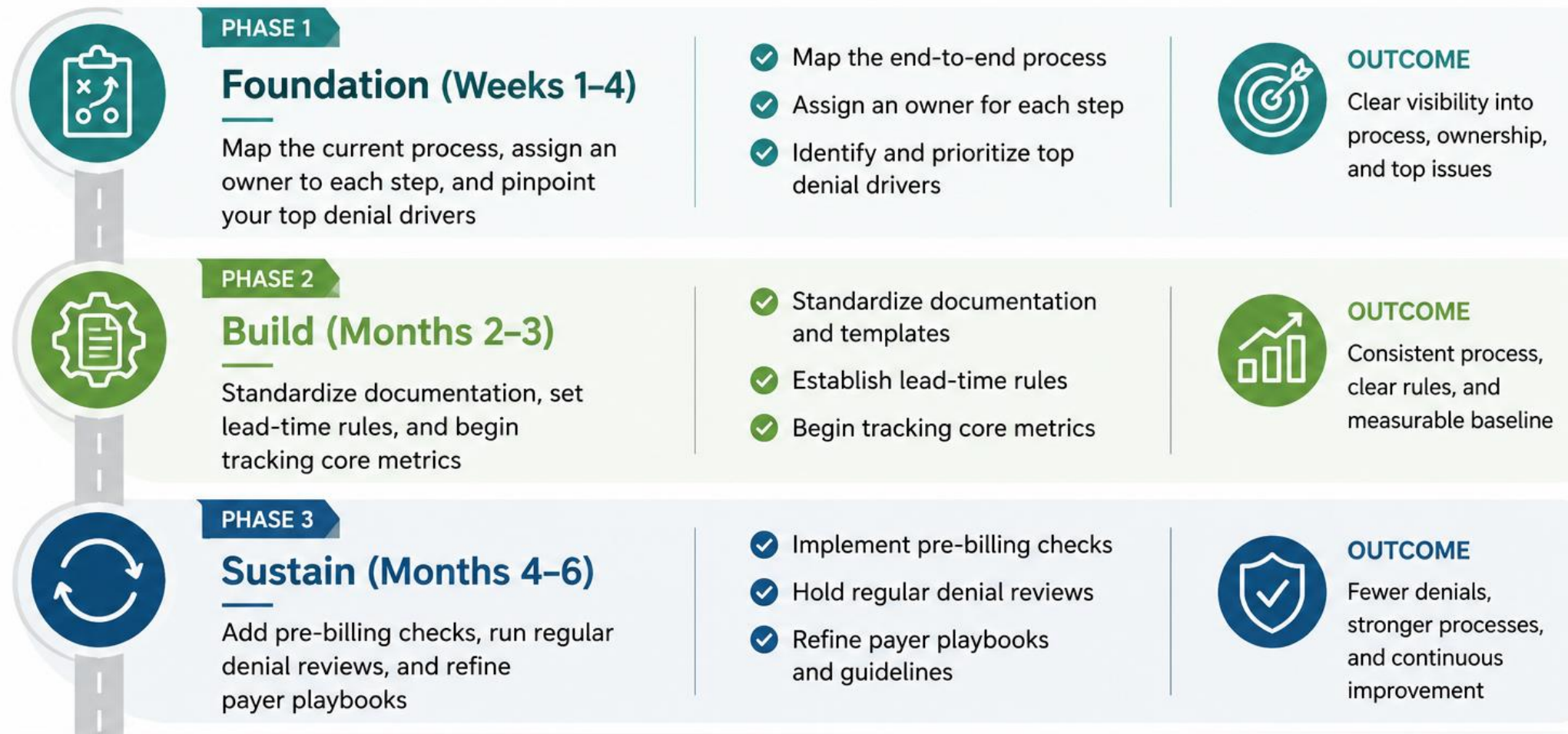


- Initial approval rate
- Authorization turnaround time
- Denials by payer
- Denials by service line
- Appeals success rate
- Top documentation deficiencies
- Expired authorizations
- Average days from order to approval

A Phased Implementation Roadmap



A clear plan. Measurable steps. Better outcomes.



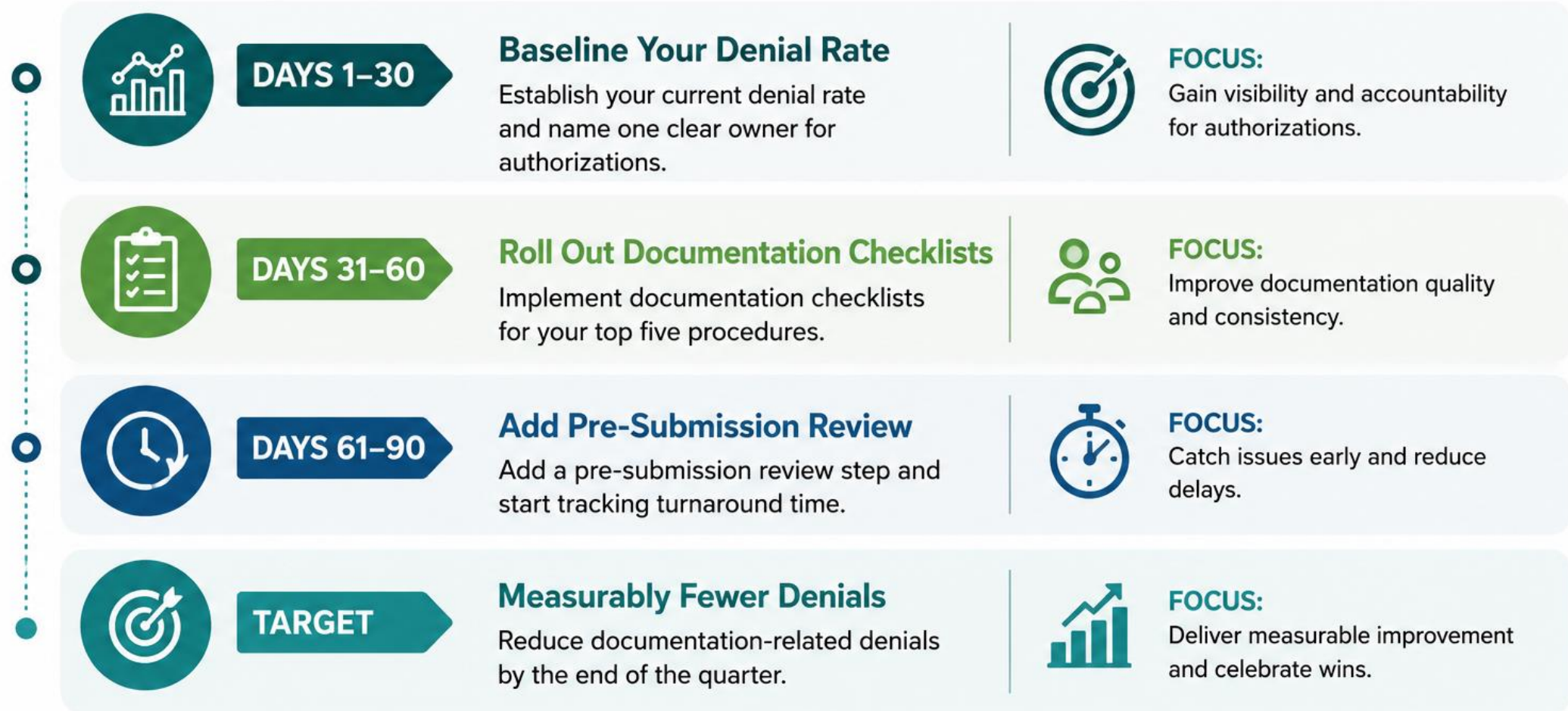
Small steps today lead to stronger denials performance tomorrow.

Focus on the foundation. Build consistency. Sustain results.



Your First 90 Days

Small steps. Clear focus. Measurable results.



90 days of focus can drive long-term results.

Plan the work. Work the plan. Track the impact.



Roles and Responsibilities

Denial prevention is a team effort. Everyone has a part to play.



Providers

- ✓ **Order early and flag services** that need authorization.



Clinical Staff

- ✓ **Document to payer criteria** the first time.



Revenue Cycle

- ✓ **Submit, track, and follow up** with clear ownership.



Leadership

- ✓ **Protect lead time, fund training,** and review the metrics.



Everyone

- ✓ **Treat a denial as a process signal,** not a personal failure.



Shared responsibility. Clear processes. Fewer denials. Better outcomes.



Key Takeaways



- Prior authorization delays are patient care delays, not just an administrative backlog
- Clinical and revenue cycle teams need shared expectations, not separate processes
- Training closes the gap that process alone cannot fix
- Standardized workflows turn one-time fixes into lasting protection

Q&A

