7 PRIOR AUTHORIZATION BOTTLENECKS IN MEDICAL PRACTICES

01 Incomplete clinical documentation at submission

FIX: Build documentation review into the clinical encounter itself, verifying that functional impact and conservative care history are captured before a request goes out, not after it is denied.

02 No single owner tracking each request

FIX: Assign case ownership from submission through decision, with a status log checked daily.

03 Misreading "no authorization required"

FIX: Standardize the language: no authorization required via the payer portal, decision ID saved, benefits verified, medical necessity documentation still required before service.

04 Payer-specific criteria that shift without warning

FIX: Maintain a living reference of current criteria by specialty and service line, reviewed on a set schedule rather than after a denial reveals the change.

05 Peer-to-peer reviews with mismatched expertise

FIX: Request the reviewer's credentials before the call, and have the clinical summary and guideline citations ready so the conversation can move to substance immediately.

06 Manual, portal-by-portal submission

FIX: Centralize submission tracking in a single internal system, even when the payer-facing process varies by case.

07 Denials treated as dead ends instead of data

FIX: Run root cause analysis on denial and peer-to-peer volume by category. The pattern points directly at which part of the practice needs the next fix.

Call Us: 914-444-1909 datamatrixmedical.com

DataMatrix® Medical