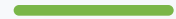




***Winning the Prior Authorization Battle:
Reducing Scheduling Delays and
Improving Practice Performance for
Orthopedic Practices***



October 2, 2026



From a broken schedule to a predictable one

01

The Problem

Why do fully booked orthopedic schedules keep falling apart?

02

The Insights

Where do delays really start, and what do they cost?

03

The Solution

What does a proactive, date-of-service-driven model look like?

04

Path Forward

What can your practice change starting Monday?

01

The Problem

Prior authorization is quietly draining capacity, revenue and patient trust from orthopedic schedules.

The Orthopedic Industry Impact

Orthopedic-specific research shows prior authorizations affect both practice operations and time to treatment

95%

of surveyed surgeons said total joint PA requests **increased** over five years

15 hrs

of surgeon and staff time **every week** spent on total joint prior authorization

71%

of practices have at least one staff member **dedicated only** to prior authorization

2026 AAOS SPINE STUDY

81.3%

of initially denied patients **ultimately had the recommended surgery.**

Most denials don't stop care. They delay it, and the practice absorbs the cost.

~7%

of patients studied were initially denied

30%

of denials cited missing documentation of six weeks of physical therapy

30.9%

of initial denials required a peer-to-peer appeal

7 days

average added delay for patients who went on to surgery

The downstream stakes are high

Across specialties, prior authorization delays reach the patient

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

On paper, the front-end is simple

The ideal workflow: four clean handoffs, each one feeding the next.



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

A scheduling error starts a domino effect



Clean scheduling is a PA control point. Validate insurance, CPT/Dx code, and demographics before a case enters the authorization queue.

What does your payer list in your EMR look like?

51

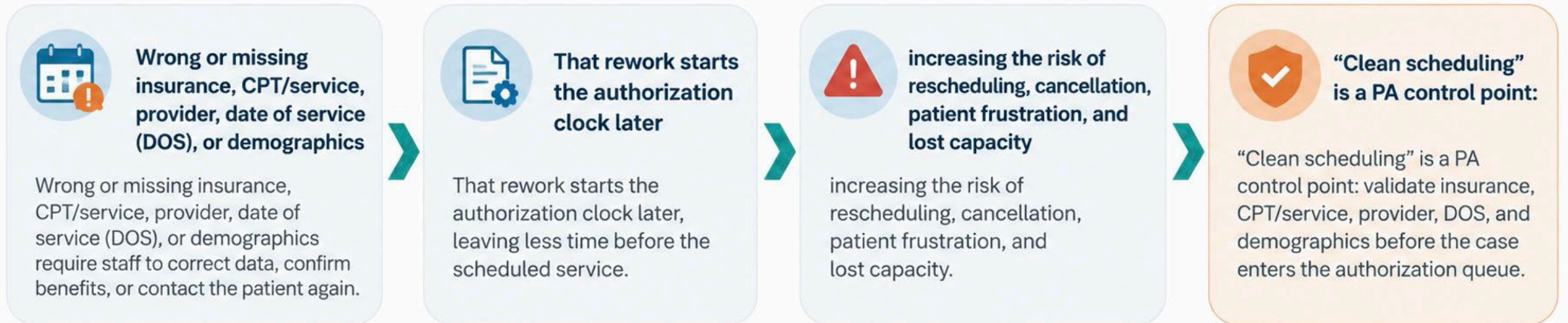
Humana entries in a single payer list

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

Every handoff can create downstream revenue leakage

Incomplete or inaccurate scheduling inputs can delay prior auths – adding additional friction and significant care delays.



One wrong keystroke at scheduling can unravel the entire front end, and the patient feels it first.

Five reasons prior auths break the schedule



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



Variable payer rules

Requirements differ by plan, procedure and service: imaging, injections, surgery



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

Measure where your front-end is leaking

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 authorization

- 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.**

03

The Solution

A proactive operating model built around the patient's date of service.

Move from reactive to proactive

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

1

Intake

Complete patient, insurance, provider, procedure, diagnosis, facility and DOS data

2

Requirements

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

3

Initiate

Send the request with required clinical documentation as early as appropriate

4

Manage

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

5

Return status

Give scheduling a clear Approved / NAR / denial status

Measure what actually moves the schedule

Six metrics that connect authorization performance

Turnaround time

How long from clean intake to final auth status?

Readiness

What % of cases are complete before the DOS?

Reschedules

How many delays or cancellations tie back 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?

Prioritize the work that protects the schedule

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

Create clear ownership at every handoff

Prior authorization is a coordinated practice workflow, not an isolated back-office task



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



Leadership / RCM

Denial trends, staffing, metrics, process improvement

Put technology to work at every step

The same four-step front end, using a tech-enabled approach

Referral

Automation + people

- Automate order entry for faxed referrals

Scheduling

AI-assisted

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

E&B Verifications

Automation

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

Prior auth

Automation + people

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

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

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

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

04

The Path Forward

Practical steps orthopedic leaders can take, starting today.

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

PA/Front-Office Team

Payer Request

PA/Front-Office Team

Peer-to-peer

Provider

Denial / Appeals

PA Team + Provider

DOS at Risk

Escalation Queue

12 changes you can take back to your practice

Connect scheduling, authorizations and technology into one operating model

Scheduling

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

Intake + clinicals

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

Authorization

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

Tech + analytics

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



**Thank you.
Questions?**

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