

HOW PRIOR AUTHORIZATIONS WORK

What triggers denials and the language insurers respond to

Understand exactly how prior auth decisions are made — from the inside.

This guide is for informational purposes only and does not constitute legal, medical, or financial advice.

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What Prior Authorization Actually Is

Prior authorization is a requirement from your insurance company that certain services, medications, or procedures be approved before they are performed. Your provider submits the request — but the outcome depends heavily on the documentation submitted and whether it matches the plan's specific criteria.

A provider's recommendation does not automatically mean a service will be approved. Coverage decisions depend on documentation, plan benefits, and review processes that most patients never see.

The Reality of How Requests Are Reviewed

Many people assume that if a doctor recommends a treatment, insurance will approve it. In reality, approval decisions are based on whether the submitted information meets specific, predefined coverage criteria.

In many systems, a large portion of requests are screened electronically before a human reviewer ever looks at them. Requests that do not match expected patterns or that contain missing information are often denied automatically. This is why the initial denial rate can exceed 80% in some systems — not because care is inappropriate, but because the submission was incomplete.

What Reviewers Are Actually Looking For

Clinical Criteria	Documentation Criteria
Diagnosis and severity of the condition	Correct diagnosis codes (ICD codes)
How long symptoms have been present	Documented prior treatment history
Impact on daily functioning	Records from outside facilities (if relevant)
Treatments already tried and results	Pharmacy history for medication trials
Test results or imaging findings	Specialist notes and evaluations
Whether lower-cost options were attempted first	Functional impact statements

The Prior Authorization Workflow

Understanding the process from your perspective helps you know when to act, when to wait, and when something may have gone wrong.

Step 1 — Provider Determines Authorization Is Needed

Your doctor recommends a medication, test, or procedure that requires approval before it can proceed. Confirm your insurance information on file is current. Provide your complete medical history and list all medications and treatments already tried.

Step 2 — Provider Submits Authorization Request

The office sends clinical documentation to your insurance company, typically electronically. Respond quickly if the office requests additional information. Provide records from other providers if needed.

Step 3 — Insurance Reviews the Request

The insurer evaluates medical necessity based on plan rules and submitted documentation. Automated systems may screen the request before a human reviewer is involved. Do not assume approval is automatic.

Step 4 — Decision Is Issued

You will usually receive a notice directly from the insurer. Open all mail from your insurance company promptly. Check your patient portal for updates.

Step 5 — If Denied

Use the Denials and Appeals guides to determine next steps. A denial is not always final. Do not wait — appeal deadlines are often time-limited.

Why Your Doctor May Not Catch Everything

Physicians are not trained in medical school on insurance authorization processes. Their training focuses on diagnosing and treating — not on payer criteria. Authorization requests are typically handled by office staff who learn on the job. Missing a required detail is common and usually not due to negligence.

Your organized records and active participation can make the difference in whether a prior authorization is approved on the first submission.

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