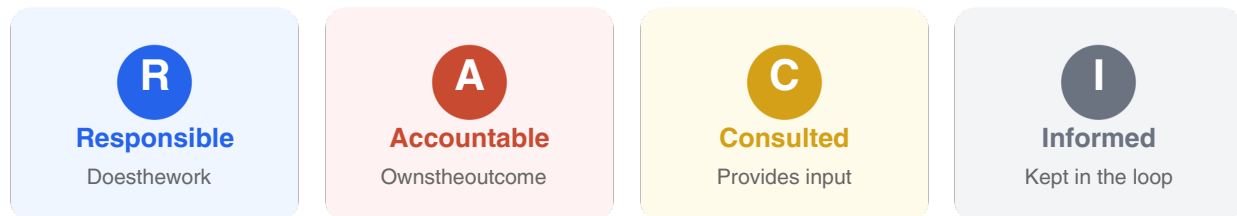


The Prior Authorization

RACI Matrix

Eliminate role confusion, reduce physician abrasion, and close the accountability gaps that turn prior authorizations into denials.



Why this matters. Denials often stem from role confusion between "Rendering" and "Ordering" providers. When no one clearly owns a step in the prior authorization process, documentation falls through the cracks, attestations go unsigned, and authorization status goes unmonitored. The RACI model establishes clear ownership at every stage, reducing administrative redundancy and the physician abrasion that comes from repeated callbacks and rework.

WHAT'S INSIDE

- 1 Prior Authorization Responsibility Assignment Matrix with five critical workflow tasks
- 2 The Rule of Singular Accountability and why it prevents the paper chase
- 3 Appeals hierarchy with regulatory deadlines across all three review levels
- 4 Executive mandate for long term revenue integrity

Prior Authorization RACI Matrix

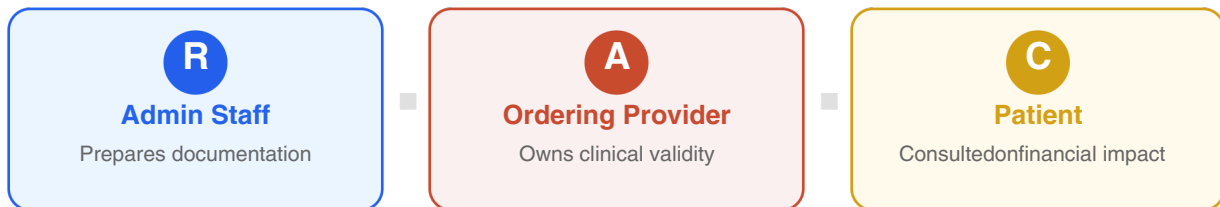
Five critical tasks with clear role ownership to prevent authorization related denials.

| Task | Responsible (R) | Accountable (A) | Consulted (C) | Informed (I) |
|---|--------------------------------|-------------------------------|-------------------------------|--------------------------------|
| Check Payer Rules | R Admin Staff | A Billing Manager | C Payer Relations | I Ordering Provider |
| Sign Medical Necessity Attestations | R Admin Staff (Prep) | A Ordering Provider | C Specialist | I Patient |
| Monitor Auth Status (EDI 277) | R RCM Specialist | A Billing Manager | C Admin Staff | I Rendering Provider |
| Check Patient Financial Responsibility | R Patient Access | A Billing Manager | C Patient | I Rendering Provider |
| File Internal Appeals | R Billing Specialist | A Billing Manager | C Ordering Provider | I Finance Dept |

The Rule of Singular Accountability

The core rule of the RACI model is **singular accountability**. Every task must have exactly one person who is Accountable. For medical necessity attestations, the Ordering Provider is the only party the payer will accept.

While admin staff may prepare the documentation, the clinician is Accountable (A) for the clinical validity. By clarifying these roles and consulting the patient on financial responsibility, organizations eliminate the "paper chase" that leads to burnout, missed deadlines, and preventable denials.



The payer will only accept attestation from the Ordering Provider. No amount of admin preparation substitutes for clinical sign off. Making the clinician Accountable (not merely Informed) is what prevents the authorization from stalling.

Navigating Denials and Appeals

Even a perfect prevention workflow will face unavoidable denials. Success in this stage requires distinguishing between "**Medical Necessity**" denials (clinical disputes) and "**Administrative**" denials (missing data).

The Appeals Hierarchy

Providers must adhere to strict regulatory timeframes to preserve their right to reimbursement.

Level 1 Internal Review

Demonstrate medical necessity or correct administrative errors.

Regulatory Deadlines:

- **Urgent appeals:** decided within 72 hours
- **Pre service:** decided within 30 days
- **Post service:** decided within 60 days

Level 2 Medical Director Review

A peer to peer clinical evaluation involving an insurer's medical director who was not involved in the initial adjudication.

Level 3 External / Third Party Review

An independent review mandated by law. Requests must be filed within 4 months of the final internal denial. If the reviewer finds the treatment necessary, the insurer must cover it.

Executive Mandate for Revenue Integrity

A "Pre Approval" is **not a guarantee of payment**. Risks such as "Retrospective Medical Necessity Review" and "Coding Discrepancies" (where the billed code differs from the authorized code) can lead to post service denials even after authorization is granted.

Long term revenue integrity requires absolute grounding in medical policy documentation and precise coding alignment from the initial request through final adjudication.

Retrospective Medical Necessity Review

Payer reviews clinical justification after service has been delivered

Coding Discrepancies

Billed code differs from the authorized procedure code

Authorization Expiration

Service rendered after the authorization window closes

C Suite leadership must treat prior authorization not as a back office task, but as a core component of the organization's financial defense strategy.

Operationalize this framework:

- 1 Map your current prior authorization workflow against the RACI matrix to identify accountability gaps
- 2 Review your appeals process against the regulatory deadlines to ensure you are preserving reimbursement rights at every level
- 3 Align your C Suite around prior authorization as a revenue integrity strategy, not a clerical function