

**Improving Medication Prior Authorizations Process in an Outpatient Mental Health Clinic:  
A Quality Improvement Project**

Naomi G. Suhler, MSN, PMHNP

NURS 703B: DNP Project

Kristienne McFarland, PhD, MSN, MA, CNM

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### **Abstract**

This quality improvement (QI) project sought to improve the quality of care of patients receiving mental health services in an outpatient clinic in the Pacific Northwest. The intention of this quality improvement project was to improve the medication prior authorization (PA) process, with the objective of reducing the overall time it takes to process the PA and submit to the insurance company. The strategy was to start with provider education about the PA process. This included an email with a high-level overview of the PA process with an attachment of a tip sheet for the provider to refer to when submitting the PA. Metrics were compared before and after the educational intervention. The data was analyzed using Microsoft Excel software. Implementation of the intervention reduced the average number of days to process PA from 5 days to 3 days. Prior to the intervention, an average of 57% of PAs required follow up questions to process the PA; this was reduced by approximately half, to 28% after the intervention. Average number of provider outreaches from billing staff went down from 2.06 per PA before to 1.75 after, a 0.31 (15%) reduction. While there was a decrease in the processing time of PAs, the number of PAs requiring follow-up questions, and a decrease in the number of outreaches to providers, it cannot be determined that the education intervention was the sole reason for this shift, since the act of observing and reviewing the PA process likely had an impact on the PA processing time as well.

### **Problem Description**

Prior Authorization (PA) is a utilization management tool that payors, including commercial insurance companies, Medicare, and Medicaid, use to help manage costs (Bhat et al., 2019). Often these payors stipulate requirements to be fulfilled before a medication will be covered and filled (Jones et al., 2021). The PA process and criteria for determination is frequently nontransparent and varied among health plans (Jones, et al., 2021). Use of PAs has expanded over the years, often creating a barrier for patients to receive medications in a timely manner (Kyle, 2023). The amount of time that clinicians, pharmacists and patients spend on PAs can be onerous and may lead to treatment delays, increased administrative costs and workflow burden (Jones, 2021). PA processing can be time consuming due to requirement variability by health plans, as there are various avenues used by insurance companies to initiate the PA process, including electronic facsimile, phone fax, and online portals, which can add time to processing PAs (Bhat et al., 2019). A consequence of the PA process is delayed treatment, which can lead to poor outcomes due to patients not receiving treatment in a timely manner or at all; the PA process has been estimated to cause 37-78% prescription abandonment (Salzbrenner, et al., 2022).

Given the concerns that PAs and other cost containment strategies negatively impact care and contribute to delays in care, several professional organizations are seeking legislative remedies (Barnett and Bodkin, 2020). In the meantime, clinicians and healthcare systems often need to create systems to coordinate workflow and communication among team members so that patients can receive safe, appropriate, cost-effective, and evidence-based care in a timely manner (Jones, 2021).

### **Available Knowledge**

PAs have become a standard established by commercial and governmental payors to determine coverage of care (Bhat et al., 2019). Use of PA have increased over the past years and are a common source of frustration for clinicians and patients as they frequently create a barrier to accessing prescription medications (Kyle, 2023). The PA process requires providers or administrative team

members to submit information about the patient's clinical status, often including notes and treatment history, which is then reviewed by payors to determine if the medication will be covered or denied (Bhat et al.,2019). In addition to PAs, cost containment strategies utilized by payors include step therapy protocols and limited formularies (Barnett et al., 2020).

While PAs may reduce the use of expensive medications, critics have argued that they create an undue and possibly harmful burden on providers and health care organizations (Barnett et al., 2020). Payors have different and unique requirements for evidence to be completed and differential decision-making processes before a medication is approved, and the process is often obscure and time consuming for providers and patients (Jones et al.,2021). Additional barriers in the PA process include lack of standardized workflow and forms (Jones et al., 2021). Clinicians or administrative staff must complete disparate requirements and submit required documentation to the health plan and then receive an approval or denial letter after a variable waiting period (Jones, 2021).

Many healthcare organizations have operationalized workflows to process PAs, with some systems having dedicated staff that solely work on PAs (Jones, 2021). One of the many problems is that PA requirements differ among health plans (Jones, 2021). Healthcare systems need more efficient systems to handle workflow and communication among team members so that patients can receive care in a timely manner (Jones, et al., 2021). Jones et al., (2021) reviewed outcomes of two initiatives to improve the medication PA process and found that the most success was found when organizations streamlined the PA processing using a standardized approach. Often gaps in the standardized workflow were discovered, leading members of the PA team or providers to create their own workarounds (Jones et al., 2021). Pain points in the medication PA process were classified by information transfer gaps, format disparities, outdated technology, unintended workarounds, and unintended care consequences caused by delayed care (Bhattacharjee, et al.,2019). Information gaps include different requirements by plans for accurate formulary information and PA requirements (Bhattacharjee, et al.,2019). While

electronic PA technology embedded into electronic prescribing software has allowed for on-line immediate processing in some cases, many plans still use CoverMyMeds or require facsimile communication, which adds further delay due to increased steps for processing PAs (Bhattacharjee, et al.,2019).

To deal with the complexities involved in PA processes among healthcare payors, it is recommended that an organization create a team or a specific team member to manage and streamline PA processes and to provide continual education and training to providers and PA administration team members (Bhattacharjee, et al.,2019). Brooks et al. (2023) completed a multifaceted initiative to improve PA processing, including re-structuring the approach to managing workflow and tracking PA responses. They found that educating the team in insurance authorizations, PA submissions, appeal letters, document formatting and submission, peer to peer scripts, and evidenced-based appeal letters helped to improve PA processing time and approval of treatment (Brooks et al., 2023). Bhat et al. (2019) provided tips and resources for successful PA management, which include familiarization with each plan's PA policies and formularies prior to submitting PAs. There was an emphasis on providers being educated on the PA process to help reduce errors and improve PA outcomes (Bhat, et al., 2023).

The PA process continues to be a burdensome administrative task to providers, an increased cost to the healthcare system as a whole and impacts the quality and timeliness of care patients receive. Improving PA workflows, streamlining the PA process, and educating providers can help reduce some of the burden on providers and staff and therefore may lead to more timely procurement of needed care (Jones et al., 2021).

### **Rationale**

A quality improvement (QI) project on PA processing time took place at an outpatient mental health private practice group of Psychiatric Mental Health Nurse Practitioners in the Pacific Northwest

that partners with the practice management group (PMG), which is a hybrid in-person and telepsychiatry company on the West Coast.

This project was guided by the Institute for Healthcare Improvement (IHI) methodology framework to provide structure to the initiative, and to develop the aim, measures, and changes (Institute for Health Improvement 2018). We utilized the Plan-Do-Study-Act (PDSA) methodology, in which small changes are tested in an incremental and systematic manner to evaluate whether changes made lead to actual improvements (Institute for Health Improvement 2018).

Our root cause analysis and creation of a cause-and-effect diagram identified that the current PA form is frequently submitted incompletely or missing information, which caused delays in PA authorization completion and processing time. The form was created by PMG and instituted for staff to request/delegate the NP Liaison staff, which is comprised of administrative personnel, to help manage the PA process, with a goal of reducing provider administrative burden and to improve care to patients. When forms are found to be incomplete and/or missing information, the PA staff reach out to the NP to obtain needed information to complete the PA, which may lead to delays. Based on feedback from the PA staff, providers seem to struggle with knowing what documentation is required by the payor to process the PA. After a review of several reports on PA quality improvement projects, it was determined that education of providers is a critical step to improving the processing of PAs in timely manner, reducing overall PA processing time and provider administrative burden, which improves patient care (Bhat et al., 2019). Additionally, the American Medical Association (AMA) recommends specific PA tips for providers to improve efficiency and effectively manage the PA process (American Medical Association, 2023).

### **Specific Aims**

The goal of this QI project is to improve overall processing time, which is the time from when the PA form was completed by the PA team to the time that it was submitted to the health plan. A

secondary aim is to reduce the number of callbacks from the PA team to the NPs which helps improve patient outcomes, thereby moving the PA along and hopefully reducing provider burden.

## **Methods**

### **Context**

PMG is a diverse group of over 850 independent mental health practitioners serving the Pacific Northwest. The mission is to create access to high quality mental health care for the served communities, with both in-person and telehealth care provided. Each licensed mental health professional is a separate, independent business unit. Providers receive support with administrative tasks, insurance billing, client placement and PAs. Offices are located throughout the Pacific Northwest. Each office has an office manager and two in-person office assistants. The provider support teams include scheduling, billing, and staff, who assist with obtaining medical records and prior authorizations. PMG provides an electronic medical record (EMR) system and practice management software. The software is utilized for scheduling, billing, reporting and analytics, customizable templates, smart electronic health record (EHR) dashboard, electronic prescribing, patient portal, appointment reminders, and telemedicine via the Zoom platform. The project team included a PMHNP Liaison from PMG an office manager, and a PMHNP. The team conducted a cause and affect analysis, utilizing an Ishikawa diagram to examine the reason the internal PA form is not utilized routinely, and is often incomplete. (Oliver & Ogrinc, 2022). The Ishikawa diagram provides context for how and why the specific process outcome occurs (Oliver & Ogrinc, 2022).

### **Intervention**

We utilized the PDSA method of implementing process improvement, which is used widely for QI most health care systems (Knudsen, et al 2019). The essence of the PDSA cycle is to structure the process of improvement in accordance with the scientific method of experimental learning (Knudsen, et al 2019). In this project, the PDSA cycle was focused on identifying and implementing the simplest

methods of providing information and education to PA teams about how to improve PA processing (Institute for Health Improvement 2018). We chose email communication as the study intervention as an efficient way to share information in a minimally burdensome time frame to already busy practitioners. The PDSA Cycle intervention, therefore, was an email to providers (Attachment 5), with a high-level overview about the PA process, how the NP Liaison Team can assist them in processing PAs, and an attachment with tips for PA completion (Attachment 6). The email and tips were based off the American Medical Association's documented guidelines on prior authorizations (American Medical Association, 2023).

### **Study of the Intervention**

The completed education tool was created to provide a review of the PA process and tips and tricks to help the PA go through in a timely manner. The NP Liaison team utilized a Microsoft Excel worksheet to track the number of PAs, the number of days it took for PA completion, and the number of times for each PA that the NP Liaison staff reached out to the providers regarding questions and further information needed to move the PA forward.

### **Measures**

The primary outcome measure for this project is the average amount of days required to process the PA. The process measure is the number of contacts from the NP Liaison to the NP. The balancing measures are the number of times the NP Liaison team reached out to the NP to complete the PA process.

### **Data Analysis**

Implementation of this quality improvement project was conducted over two weeks in June 2024. The data collected was analyzed before and after implementation. Data includes PA processing time before and after the intervention and the number of contacts by the NP Liaison team to the NP to



complete the prior authorization form and submit to the payor. The data was analyzed using Microsoft Excel software.

**Ethical Considerations**

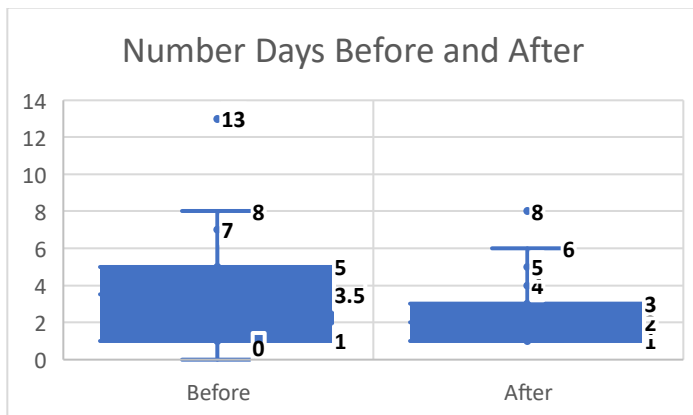
NP liaisons were notified of the opportunity to participate in the project via email and participation in the project was voluntary. There was no collection of identifying information of patients, NP liaisons, or NPs in the reporting. Data was stored in a protected Excel file at PMG within the operations department. The participating clinical site gave consent to the project by signing a letter of support. The project was submitted to OHSU Investigational Review Board (STUDY00027125) and deemed not to be research and therefore not needing further review. There are no conflicts of interest disclosed by the author, nor has the author received compensation for this project. The author is a NP with a working relationship with PMG, but the above work was not compensated by MHG company.

**Results**

Data was collected 4 weeks before the intervention and 3 weeks after the intervention. A total of 52 PAs were collected in the “before” time group and 29 were collected in the “after” time group. Quantitative data analysis was performed using Microsoft Excel software.

**Table 1:**

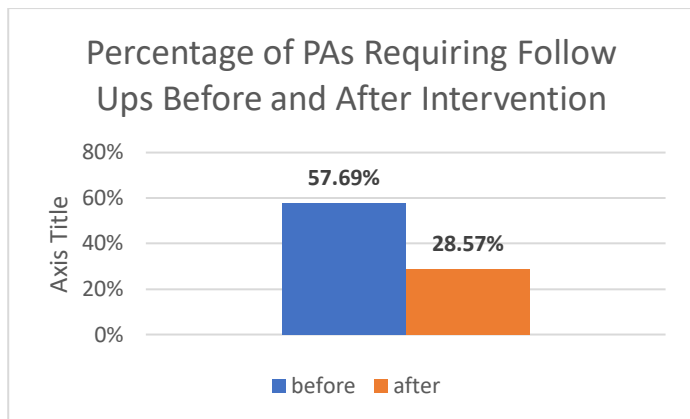
*Average numbers of days PA processing time*



Note: there was an outlier of 26 days (in the before group) that is not consistent with the rest of the data and caused by extraneous provider-related issues, therefore it was excluded from the data analysis.

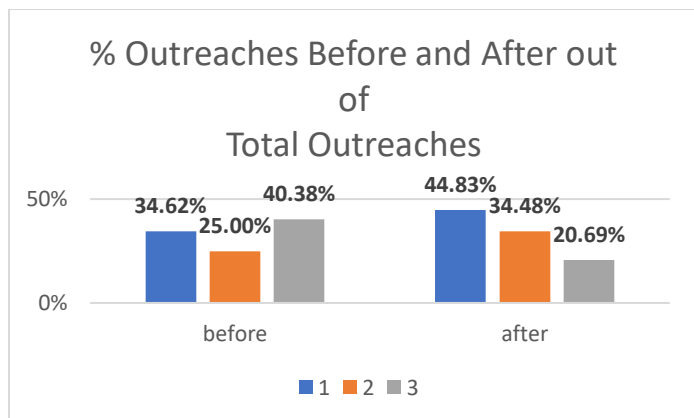
**Table 2:**

*The percentage of times the NP liaison had to follow up with the provider to obtain more information to process the PA.*



**Table 3:**

*Number of times the NP Liaison reached out to the NP to obtain clarification and more information.*



Average number of outreaches per PA went down to 2.06 before and 1.75 after, corresponding with a reduction of 0.31 (15%).

### Findings

Table 1 shows that the average number of days to process PA dropped from an average of 5 days to 3 days. There was a single extreme outlier of 26 days prior to the intervention related to a particular provider having personal issues and not responding to requests for information, therefore this data point was excluded from the before intervention data. Table 2 shows the percentage of times that the NP Liaison had to reach out to the NP to obtain clarification about the PA. Prior to the intervention, approximately 57% of PAs required follow up questions to process the PA which reduced to approximately 28% after the intervention. Table 3 shows the number of times the NP Liaison had to reach out to the NP for clarification to process the PA. Prior to the intervention, the NP Liaison reached out once approximately 34%, a second reach out 25% of the time and a third reach out approximately 40% of the time with the average number of outreaches down from to 2.06 before and 1.75 after, corresponding to an reduction of 0.31 (15%).

### Interpretation

The data showed there was a decrease in the number of days that it took to process the PAs from an average of 5 days to 3 days. It is unclear if this is improvement is a result of the intervention or due to the act of observing the NP liaison team focusing on the PA process issues overall. However, the data suggest an improvement, and show a decrease in the amount of follow up needed by the NP Liaison team to the NPs to process the prior authorizations. There was a shift in the type of questions the NP Liaisons had to address before and after the intervention, with percentage of insurance related questions decreased, clinical questions about the same, and an increase in the proportion of provider errors. This result is likely due to an increased awareness by the PA team of insurance related issues and fixing them prior to submitting the PA for processing.

The overarching goal was to reduce the PA processing time, which indeed occurred. While there are positive findings, conclusions about a cause-and-effect relationship cannot be made definitively, due to

possible methodological limitations which may cause bias. The observed improvement in PA processing time may be due to the educational email but may also be due to the PA team paying more attention and catching and addressing issues sooner because they knew this was under observation.

The outcome of this PDSA project contributed valuable learning to PMG and the QI project team due to focusing on the challenges faced in processing PAs and the act of collecting data. While not an intended outcome, the observation and recording of each PA proved useful for gathering data on phenomena without direct intervention. The comments by the PA specialists about challenges they faced provided insight into the varied problems that occurred while trying to process a PA. Three main themes were identified:

1. Insurance: Missing, incomplete or wrong insurance information
2. Clinical: Progress notes incomplete, missing documentation of step therapy, missing current diagnosis and missing indication for medication.
3. Provider: Errors in PA request; provided the wrong information, wrong dose or wrong formulation of the medication.

### **Limitations**

There were several challenges this project faced that created limitations. This QI project was focused on the process within one institution; therefore, there are limits to generalizability of the intervention and data outside the studied organization. Imprecision in the design, methods, measurement and analysis may lead to confounding and/or bias.

Additionally, given that this QI project utilized the PDSA structure and that this was the first/only iteration of the PDSA cycle, there was limited structure to the reporting tool utilized. While this made it difficult to quantify all the variables, the narrative comments provided insight into the complexity of the PA process and led to a greater understanding of the issues causing delays in processing the PA; subsequent iterations might have led to an improved tool leading to more precise data collection. For a

QI project, it might have been better to start with observation, allowing development of a streamlined data collection form to develop a deeper understanding of the problem before initiating the PDSA cycle.

Challenges were presented in PMG's rigidity and resistance to change, as well as resistance to having someone outside the organization delving into their PA process. It was difficult to find the correct stakeholders to obtain buy-in to this project, which manifested in stonewalling and slow rolling the project overall. An approach to consider for PDSA cycle 2 would be to collaborate with a stakeholder that has influence over other organizational stakeholders to help surmount some of the previously described obstacles. In this case, I eventually spoke with the operations director over several meetings, which facilitated buy-in to the project. Once that connection was made, the director of the PA team and I had biweekly meetings about the project, allowing it to go forward.

Another challenge was a lack of change implementation structure within the organization. There was a significant knowledge gap in QI methodology, leading to much of my time early on being spent on explaining QI methodology and the PDSA process. The reporting tool was not well designed by the operations team; moving forward it is recommended that a reporting tool be created with specific, quantifiable categories which may improve the analysis of results. Healthcare is a complex and dynamic system with numerous stakeholders, with entrenched behaviors manifesting as resistance to change (Braithwaite, 2024). Braithwaite (2024) recommends an appreciation of the complexity of the organizational environment, knowing the departmental hierarchical structures, conducting a stakeholder analysis early and identifying critical stakeholders for the project, and to choose projects that align with the organization's long-term agenda.

### **Conclusion**

Work to improve the current PA process at PMG requires ongoing effort and collaboration by the NP Liaison team and clinicians. PA processing time directly impacts patient care and outcomes. This initial PDSA cycle showed a shift in a positive direction including a decrease in PA processing time and

decrease in the total number of reach outs by the NP Liaison team to NP providers. The narrative component of the reporting tool showed three themes impacting PA processing time that would benefit from further exploration. There are areas of improvement that could be explored, specifically clinical and provider issues. Given that PMG is a practice management group, there are limitations over how much influence they have over providers and changing their behavior. Should a second PDSA cycle be implemented, the focus should be on developing a better reporting tool to capture more details about causes of delay in PA processing and to offer in person training for both the prescribers with the PA team provide education and a question and answers session.

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Figure 1.

### Cause and Effect Diagram

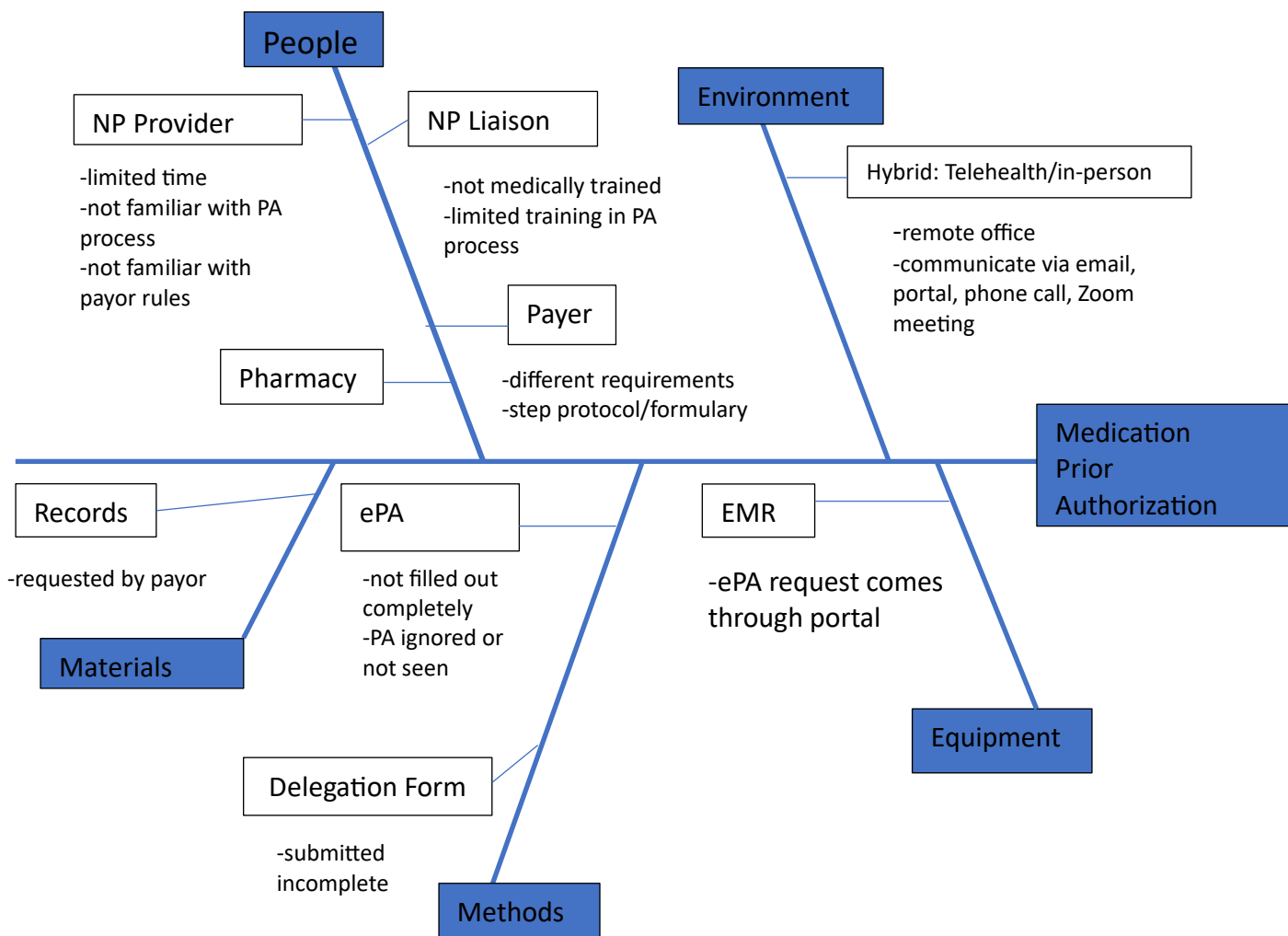


Figure 2.

### Prior Authorization Process Map

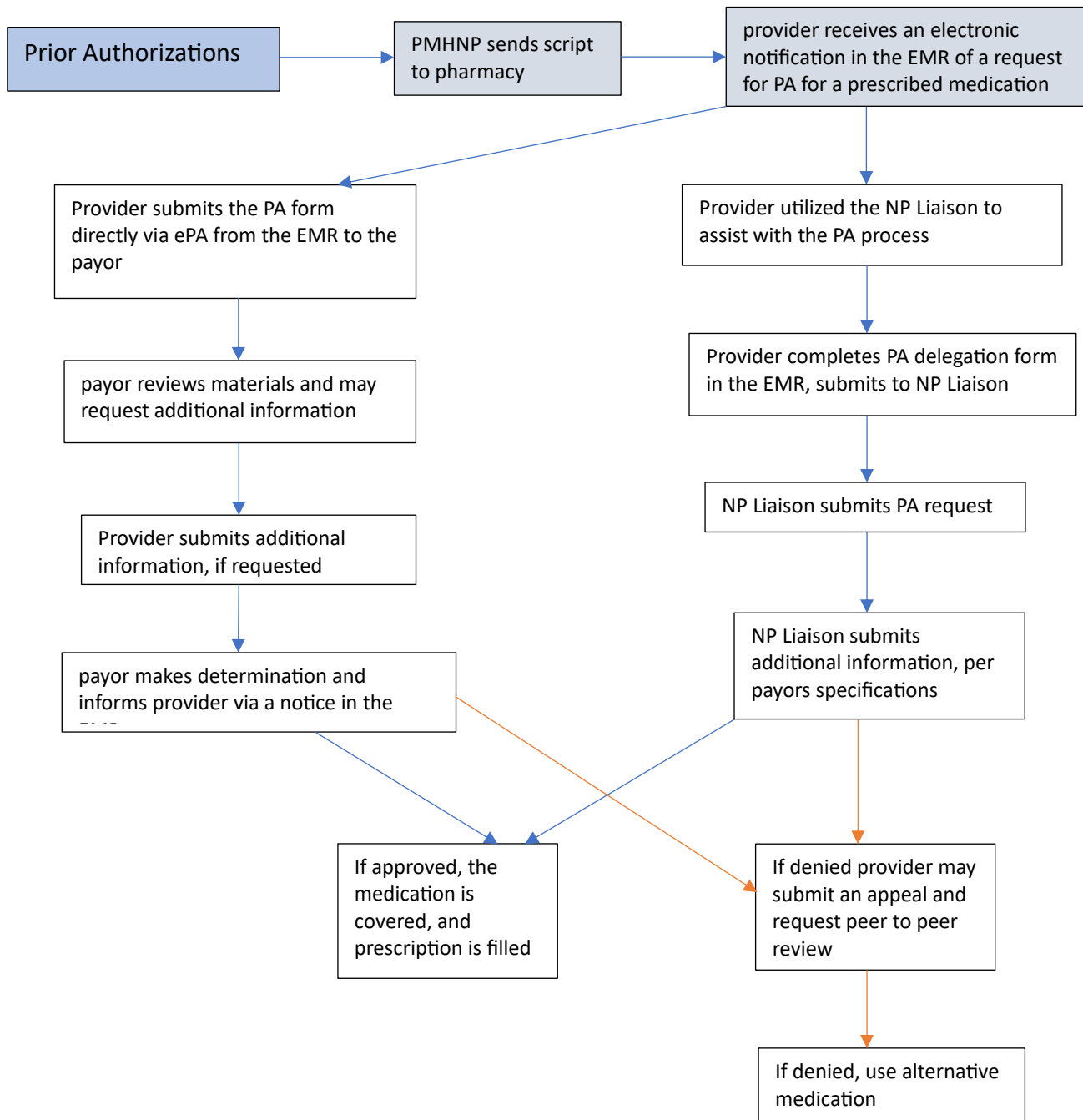


Figure 3.

### Prior Authorization (PA) Delegation Internal Form Process Flow

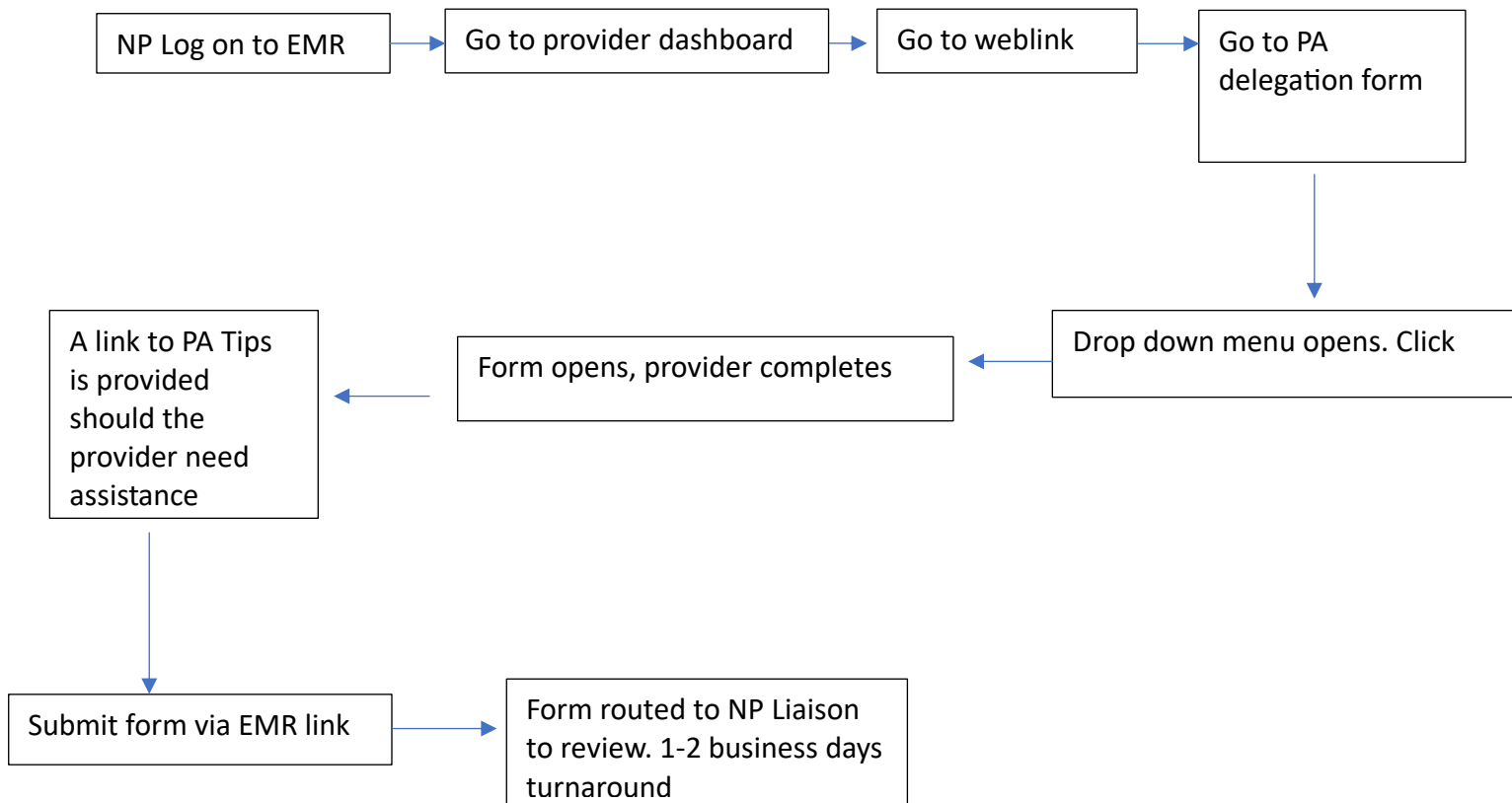


Figure 4.

## Project Timeline

Project Timeline: 4/2023-9/2024

	April	May	June	July	August	September
Finalize project design and approach (703A)	X					
Complete IRB determination or approval (703A)	X					
PDSA Cycle 1 (703B)			X			
Final data analysis (703B)			X			
Write sections 13-17 of final paper (703B)				X	X	
Prepare for project dissemination (703B)					X	

Figure 5.

**Email to providers**

Hello Prescribers,

**One of the services that the Nurse Practitioner Liaison team here at Mindful Therapy Group assist with is the management of prior authorizations.** Prior authorization, sometimes called preauthorization or precertification, is a health plan cost-control process in which health care providers must obtain advanced approval from a health plan. Frequently this process is costly, inefficient, responsible for patient care delays and adds to provider's administrative burden.

Whether you are new to private practice, or have been in private practice for years, this process can be confusing or even overwhelming. The goal of NP Liaison Prior Auth support is to improve care to our patients and reduce provider burden.

**You can submit a prior authorization request to the NP Liaison team using this link** that is hosted on the provider portal: [Prior Authorization Delegation Form](#)

**Attached to this email is a two page "Tips Sheet" to assist you in submitting and managing prior authorizations,** as well as more information about how the NP Liaison team support with prior authorizations.

Sincerely Yours,

Figure 6.

### Prior Authorization Tips

#### **TIP NO.1**

##### Utilize Your NP Liaison

##### Benefits:

NP Liaisons' have an extensive knowledge of medications that require Prior Authorization (PA) as they work through many PAs each day. The NP Liaison team can:

- Submit Prior Authorization Requests through Cover My Meds
- Fax PA and records to insurance plan
- Make phone calls about the PA and wait on hold
- Share knowledge with you on what is required for PAs and how to submit them
- Outreach to clients to get insurance card information, or any other non -clinical information to complete the PA request
- Check Cover My Meds for determination information
- Follow up on your behalf with insurance when a denial is made
- Answer questions you have around common medications that require a prior authorization or reach out to insurance companies on your behalf to check whether a medication needs an authorization
- The NP Liaison team can do a lot follow up legwork for you. Through insurance calls or Cover My Meds, the NP Liaisons can often get a determination within 1-2 days. They will take care of contacting your client for any missing information and wait on hold with insurance to ensure that we complete the prior authorization submission. If there is not an immediate determination, the determination will come via fax which will be uploaded to the client chart, and you will be tagged.

You can partner and support the NP Liaisons in setting expectations with your client about how long a PA takes to fully process, and by checking your AMD dashboard and fax recap emails for information about determination.

#### **TIP NO.2**

Check PA requirements before you send prescriptions to the pharmacy. You can do this by looking at the insurance formulary to check if there are specific requirements needed before a PA will be considered. Make sure you have tried all steps before submitting a PA request.

##### Benefits:

Ensure that the pharmacy will not be delayed in filling a prescription due to unmet PA prescription requirements as well as prevent medication nonadherence that may occur due to delays.

- Proactively checking PA requirements for prescriptions helps eliminate pharmacy phone calls about prescriptions requiring PA before they can be filled.
- Check benefits, proactive checking of PA requirements will save you and the NP Liaison team time in the long run.

### **TIP NO.3**

Establish a protocol to consistently document data required for PA in the medical record, specifically document in past medication and PA sections in AMD.

- Prescription PA criteria often involve “step therapy” in which other medications must first be tried with suboptimal outcomes before a health plan will approve payment for a particular drug. Having documentation to support the patient’s care plan can speed up the approval process and reduce the amount of provider involvement needed in the PA process.

Benefits:

Avoid delays in patient treatment, prevent potential follow-ups with patients for additional information and minimize provider time needed in the PA process.

### **TIP NO. 4**

When a PA is inappropriately denied, submit an organized, concise, and well-articulated appeal with supporting clinical information.

Benefits:

Increase chances of appeal success and reduce treatment delays for your patient.

- Under the Affordable Care Act, all health plans are required to have an appeal process for denied PAs. If the insurance plan upholds it’s original decision, an external appeal by an independent third-party reviewer may be requested. Providers can request an urgent or expedited review of PA appeals.

NP Liaison assistance: Appeals are case by case. The NP Liaisons can call the insurance to get information about why a PA was denied and what the insurance company needs. If there is extra information is needed that MTG has access to, they will submit it for you.

In some instances, the prescriber is required to submit the appeal and NP Liaisons are unable to support– typically when a lot of clinical information is needed. Know that while the NP Liaisons support to the furthest extent that they can, there will be times you will have to step in.

\*\*\*This document was Adapted from The American Medical Association, Prior Authorization Facts and Questions Document. For more information on Prior Authorizations go to [www.AMA.org](http://www.AMA.org)