



The Clinical and Financial Value of Preauthorization

How a Forward-Thinking Preauthorization Approach
Can Control Costs and Drive Better Outcomes
While Reducing Barriers to Care



Innovative Care
Management

In today's evolving health care landscape, preauthorization—commonly referred to as prior authorization or precertification—is under increased scrutiny. Critics argue it creates barriers to care, while national associations like the AMA call for its reform or even outright elimination. It's easy to draw the conclusion that preauthorization is the problem, yet the truth is more nuanced. When applied thoughtfully, preauthorization is not a barrier, but a safeguard, protecting members, partnering with providers, and preserving limited plan resources to ensure long-term sustainability of benefits.

Why Preauthorization Matters

Faced with frustrations, and in some instances, outright abuses, many critics overlook the value of preauthorization, but this practice exists for good reason. Done right, preauthorization can help plan sponsors and providers achieve shared goals.

1. Protecting Members from Financial Harm

While some advocate removing preauthorization requirements, eliminating preauthorization altogether overlooks the reality of health care delivery: Plans cannot cover every service due to limited resources, and without prospective review, members are left vulnerable.

Without preauthorization, care is delivered under the assumption of coverage, but if medical necessity cannot be established when claims are submitted, providers may pursue payment directly from members when they are notified that care is not covered under the plan. That leaves members with uncovered bills, medical debt and lasting financial harm.

With preauthorization, medical necessity is confirmed in advance, protecting members from this risk and ensuring they can proceed with confidence.

► Cost Is a Barrier to Care

45% of U.S. adults say they are worried about their ability to pay medical bills, and 28% have delayed or skipped care due to cost.

Source: [Peterson-KFF Health System Tracker](#)

2. Reducing Clinical Risks and Avoidable Care

At its core, preauthorization isn't about red tape—it's about making sure members get the right care at the right time. Reviews often bring to light when key diagnostic steps were missed or when conservative options should have been considered before moving to surgery. Sometimes the work was done but not documented, and other times it was truly overlooked. Either way, the process helps providers make sound, safe clinical decisions—and ensures the reasoning is clearly reflected in the record. These reviews aren't bureaucratic hurdles; they're safeguards.

In many cases, appropriate conservative treatments (such as physical therapy) can resolve issues entirely, avoiding unnecessary surgery or making procedures safer and less invasive. By promoting thoughtful, evidence-based decisions and ensuring care occurs at the right time, preauthorization helps protect members from preventable complications and supports better outcomes—clinically, financially, and personally.

3. Supporting Cost Containment and Value-Based Care

Preauthorization helps guide members to high-quality, lower-cost providers and contracted facilities.

With today's fragmented and increasingly complex networks, it's unrealistic to expect medical offices to track cost and coverage for each member's plan. Additionally, while price transparency is supposed to help plan members shop around for the best prices, few Americans know where to start. Preauthorization bridges the gap, protecting members from unexpected costs while preserving plan resources.

4. Facilitating Early Care Management

Historically, preauthorization served as the earliest clinically identifiable trigger for identifying complex cases. While today's analytics and faster claims systems have created new pathways, preauthorization still plays an important role in enabling timely intervention, member education and ongoing support. It also provides critical early insight into upcoming high-cost services—such as transplant evaluations—allowing stop-loss partners to be notified in advance and helping plans prepare funding reserves when needed.

▶ Not All Surgeries Are Necessary

Over a three-year period, U.S. hospitals performed more than 200,000 unnecessary back surgeries on Medicare enrollees, putting members at risk of complications resulting in costs of more than \$2 billion.

Source: [Lown Institute Hospitals Index](#)

▶ Comparison Shopping Is Hard When You Don't Know What's Covered

Only 17% of U.S. adults says they are aware of healthcare costs before receiving care.

Source: [Bentley-Gallup Business in Society Report](#)

▶ Preauthorization developed in the 1950s to 1970s from early utilization reviews.

Source: [Medical Economics](#)

Our Distinct Approach

At Innovative Care Management (ICM), our work is defined by a compassionate and responsive approach, renowned clinical excellence, and our steadfast independence from conflicts of interest. Unlike carriers and many medical management organizations owned by large parent companies or private equity, we do not sell insurance, pay claims, or hold financial incentives tied to approvals or denials. Medical management is all we do—and that clarity of purpose keeps us true to our mission. We serve both the people who depend on care and the plans that make that care possible, knowing that what benefits one ultimately benefits the other. We are an independent steward, and as such, we have a unique perspective that allows us to balance quality control with cost control.

Our approach to preauthorization is:

- **Evidence-Based:** We use MCG, a nationally recognized, evidence-based set of clinical care guidelines, continually updated for rigor and reliability.
- **Knowledgeable:** Our doctor reviewers bring higher-level clinical training and broad case-review experience to support sound decisions when cases fall outside typical guidelines.
- **Transparent:** We share clear rationales, maintain industry-leading turnaround times and publish performance metrics.
- **Trusted:** ICM has maintained URAC accreditation in Health Utilization Management (HUM) since 2001, underscoring our enduring reputation for reliability and quality.

From Denials-Driven to Approvals-Based

An AMA survey found that 94% of practicing physicians said preauthorization delayed access to necessary care. In some cases, these delays were associated with serious adverse events leading to hospitalization, disability or death. Statistics like this have prompted the AMA to call for critical changes to preauthorization practices.

As the industry debates the future of preauthorization, it's critical not to throw the baby out with the bathwater. Preauthorization itself isn't the problem. The real issue is when it has been applied as a denials-based system that puts up unreasonable barriers to clinically sound care.

ICM takes an approvals-based philosophy. We don't look for reasons to say no. We look for sound clinical reasons to say yes, always consistent with the plan's terms. We have the capacity and willingness to support proactive notification to avoid potential issues.

This approach removes barriers, protects members, and ensures care is appropriate, safe and accessible. Not all medical management vendors take this path, but we believe it's the only way preauthorization adds real value.

Looking Back, Moving Forward

If preauthorization isn't working for a plan, the answer isn't elimination. It's evolution. Requirements should be changed and customized so they work for the plan and its members.

ICM has been providing preauthorization services for more than 35 years. But longevity does not mean stagnation. Just as medicine has advanced, so too have the processes, timelines and methods of preauthorization. What worked a generation ago is no longer sufficient today.

Preauthorization has evolved from a blunt instrument into a tailored, efficient, evidence-based safeguard. Today, ICM leverages technology, specialty expertise and transparent communication to ensure preauthorization is not a barrier, but a partner in care.

Customized Approaches for Self-Funded Plans

Every plan has unique goals and priorities. That's why ICM begins with a set of thoughtfully developed preauthorization design models, each emphasizing different areas of focus, depending on what matters most to the plan. From there, we fine-tune the approach to align with each plan's specific needs and values. Plans can choose from:

- **Broader preauthorization:** For plans prioritizing navigation to high-quality providers with proven outcomes, ensuring thoughtful, judicious care.
- **Narrower preauthorization:** For plans focusing only on high-cost or high-risk procedures, minimizing member disruption while accepting some services may slip through.

The decision should always rest with the plan, not large corporations imposing one-size-fits-all mandates. ICM partners with plans to design preauthorization requirements that reflect their objectives and best serve their members.

▶ **Employer health plan costs are expected to rise by an average of nearly 9% in 2026 if nothing is done.***

The industry needs new strategies to control costs, and properly applied preauthorization processes can be part of that.

*[Mercer](#)

Preauthorization — Yesterday, Today and Tomorrow

Approach	What It Looks Like	Impact on Members	Impact on Providers	Impact on Plans
Old-Style Blanket Preauthorization	<ul style="list-style-type: none"> • Broad requirements applied to nearly every service • Slow processes • Little transparency 	<ul style="list-style-type: none"> • Frustration delays in care • Uncertainty 	<ul style="list-style-type: none"> • High paperwork burden • Unclear rationale for decisions 	<ul style="list-style-type: none"> • Administrative savings offset by inefficiency and provider abrasion
No Preauthorization	<ul style="list-style-type: none"> • Services delivered without prospective review • Medical necessity determined only after the fact 	<ul style="list-style-type: none"> • Surprise denials • Unexpected bills • Potential for medical debt or collections 	<ul style="list-style-type: none"> • Risk of uncompensated care when claims are denied 	<ul style="list-style-type: none"> • Wasteful spending • Duplication of services • Higher long-term costs
Evolved, Customized Preauthorization (ICM)	<ul style="list-style-type: none"> • Streamlined processes • Faster turnaround • Evidence-based reviews • Tailored requirements aligned with each plan's priorities (e.g., navigation to high-value care or focus on high-cost services) 	<ul style="list-style-type: none"> • Protection from surprise bills • Guidance to high-quality, lower-cost providers • Earlier engagement in care management 	<ul style="list-style-type: none"> • Clear expectations up front • Reduced burden through transparency and efficiency 	<ul style="list-style-type: none"> • Smarter resource stewardship • Sustained affordability • Alignment with plan-specific goals

Leveraging the Power of Preauthorization

Preauthorization is more than an administrative process. It is a safeguard that protects members, preserves benefits, and ensures responsible stewardship of plan resources while supporting quality care. At ICM, preauthorization has evolved. It is faster, more transparent and more flexible than ever before. And as always, it is customizable, enabling alignment with each plan's unique goals and priorities. Self-funded plans should never have to accept mandated, one-size-fits-all requirements. Instead, they deserve a trusted partner who will listen, consult and design an approach that reflects their best interests.

That is the role ICM has played for 35 years, and the role we will continue to play in the future: ensuring safe, appropriate, affordable care, guided by evidence and delivered with heart.