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PRIOR AUTHORIZATION REQUIREMENTS MATRIX BY PAYER

2026 Comprehensive Reference Guide for Medical Billing

Professionals

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Quick Reference Guide

Accesscritical payerportalsandcontactinformation instantly. Turnaround times listed reflect 2026 standards for standard (non-urgent) requests.

PRO TIP

Keep proof of portal submission. 2026 audit standards require timestamped screenshots if the payer portal does not generate an immediate reference ID.

Payer	Auth Portal	Phone	Turnaround	Retro-Auth?	Appeal Window
Medicare (Noridian)	Portal Link	855-XXX-XXXX	N/A	Emergency only	120 days
UnitedHe al thc are	UHC Provider Por tal	87 7-XXX-XXXX	2-5 days	Rarely	180 days
BCBS (varies)	Availity	Varies	2-14 days	Varies	60-180 days
Aetna	Aetna Provider Por tal	800-XXX-XXXX	2-5 days	Limited	60 days
Cigna	CHCP Portal	800-XXX-XXXX	2-7 days	Limited	180 days
Humana	Humana Portal	800-XXX-XXXX	3-5 days	Case-by-case	60 days

Documentation Checklist

- Patient Demographics & Insurance Card
- Current Clinical Notes (last 30 days)
- Conservative Treatment History
- Specific CPT & ICD-10 Codes
- Referring Provider NPI

Emergency Protocols

For emergent cases, always mark "URGENT/STAT" on the portal. Medicare allows retro-auth for life-threatening conditions if documented within 48 hours.

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Authorization Matrix: Imaging & Therapy

High-Tech Imaging

CPT	Description	Medicare	UHC	BCBS	Aetna	Cigna	Notes
70553	MRI brain w/ & w/o	No PA	PA Req	PA Req	PA Req	PA Req	Use eviCore for BCBS
72148	MRI lumbar spine	No PA	PA Req	PA Req	PA Req	PA Req	AIM for Aetna
74177	CT abd & pelvis	No PA	PA after 1st	PA Req	PA Req	PA Req	Emergency exempt
70498	CT angiography neck	No PA	PA Req	PA Req	PA Req	PA Req	Check diagnosis
78815	PET scan tumor	LCD Review	PA Req	PA Req	PA Req	PA Req	Oncology indication

Physical & Occupational Therapy

Note:Visitcountstypicallyresetpercalendaryear.Verifyplan specifics.

CPT	Description	Medicare	UHC	BCBS	Aetna	Humana	Notes
97110	Therapeutic exercises	No PA	PA > 12	PA > 8	PA > 12	PA > 12	Initial eval exempt
97140	Manual therapy	No PA	PA > 12	PA > 8	PA > 12	PA > 12	Track visit count
97530	Therapeutic activities	No PA	PA > 12	PA > 8	PA > 12	PA > 12	Combined limit
97112	Neuro re-education	No PA	PA > 12	PA > 8	PA > 12	PA > 12	Check plan specifics

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Authorization Matrix: Surgery & DME

Orthopedic Surgery

CPT	Description	Medicare	UHC	BCBS	Aetna	Cigna	Notes
27447	Total knee arthroplasty	No PA*	PA Req	PA Req	PA Req	PA Req	*WISeR states only
63030	Lumbar discectomy	No PA*	PA Req	PA Req	PA Req	PA Req	*WISeR states only
29881	Knee ar throscopy	No PA*	PA Req	PA Req	PA Req	PA Req	Check conservative tx
29827	Shoulder ar throscopy	No PA*	PA Req	PA Req	PA Req	PA Req	Document failed PT

Durable Medical Equipment (DME)

HCPCS	Description	Medicare	UHC	BCBS	Humana	Notes
E0601	CPAP device	PA Req	PA Req	PA Req	PA Req	UTN req Medicare
K0823	Power wheelchair	PA Req	PA Req	PA Req	PA Req	Face-to-face req
E1390	Oxygen concentrator	PA Req	PA rental	PA Req	PA Req	Check O2 levels
E0470	RAD resp device	PA Req	PA Req	PA Req	PA Req	New 4/2026 Medicare

MEDICARE ALERT

Effective Jan 2026, the WISeR model impacts surgical authorizations in 6 pilot states. If your practice is outside these states, traditional LCD coverage rules apply instead of PA.

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Authorization Matrix: Injections & Behavioral

Pain Management Injections

CPT	Description	Medicare	UHC	BCBS	Aetna	Humana
64483	Epidural inj lumbar	No PA	PA > 2	PA Req	PA > 1	PA > 2
20610	Major joint injection	No PA	PA > 3	PA > 3	PA > 3	No PA
64640	Peripheral nerve destr	LCD Rev	PA Req	PA Req	PA Req	PA Req
J0585	Botox injection	PA Req	PA Req	PA Req	PA Req	PA Req

Behavioral Health

CPT	Description	Medicare	UHC	BCBS	Aetna	Cigna
90837	Psychotherapy 60m	No PA	PA > 20	PA > 12	PA > 20	PA > 24
90847	Family psychotherapy	No PA	PA > 12	PA > 8	PA > 12	PA > 12
90853	Group psychotherapy	No PA	PA > 20	PA > 12	PA > 20	PA > 24
99214	Psych E/M complex	No PA	No PA	No PA	No PA	No PA

BEHAVIORAL HEALTH PARITY ACT

Recent enforcement ensures quantitative treatment limitations (visit counts) for BH cannot be more restrictive than medical/surgical benefits. If you see denials based on arbitrary limits, flag for immediate appeal under MHPAEA.

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2026 Updates Tracker

Date	Payer	Change	Action Required
Jan 1	CMS	PA decision times: 72hr expedited	Update workflows
Jan 1	Medicare	WISeR model begins	Check if in 6 states
Jan 13	Medicare	DMEPOS exemption process	Apply if qualified
Apr 13	Medicare	New DMEPOS codes added	Update auth tracking
TBD	UHC	Radiology PA expansion	Monitor bulletins

Common Denial Codes

Code	Description	Responsibility	Bill Patient?
CO-197	Prior authorization absent	Provider	No
PR-197	Prior authorization absent	Patient	Usually yes
CO-198	Authorization exceeded	Provider	No
CO-15	Auth number missing	Provider	No

Stop Chasing Authorizations. Start Treating Patients.

MedSole RCMreduces denialrates byanaverageof 35%withinthe first 90 days. Let our dedicated authorization team handle the p aper wor k.

Talk to our billing experts today

Contact Direct

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RESOURCE GUIDE #3

CO-197 DENIAL PREVENTION CHECKLIST

YourDailyGuidetoStoppingAuthorizationDenials Before They Happen

Every CO-197 Denial Costs You:

- $25-45 in staff rework time
- 14-21 days payment delay
- Potential write-off if not resolved
- Patient dissatisfaction

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Scheduling Stage

⚠ CRITICAL: This is where 68% of CO-197 denials originate. Never skip verification!

☐ Verify Insurance Eligibility

- ☐ Confirm active coverage
- ☐ Check effective dates
- ☐ Verify patient is eligible on DOS
- ☐ Note any plan changes

☐ Check Authorization Requirements

- ☐ Look up CPT/HCPCS on payer matrix
- ☐ Verify if procedure requires PA
- ☐ Check diagnosis-specific requirements
- ☐ Confirm place of service rules

☐ Patient Plan Specifics

- ☐ In-network vs out-of-network rules
- ☐ Referral requirements
- ☐ Visit limits (therapy/behavioral health)
- ☐ Medical vs vision/dental coverage

☐ Initiate Authorization (If Required)

- ☐ Submit request immediately
- ☐ Document submission date/time
- ☐ Get confirmation/reference number

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Pre-Service Verification (Day Before)

☐ Authorization Status Check

- ☐ Confirm authorization approved
- ☐ Verify auth still valid (not expired)
- ☐ Check approved units/visits remaining
- ☐ Confirm approved provider matches

☐ Validate Authorization Details

- ☐ Auth number documented correctly
- ☐ Service date within auth dates
- ☐ CPT codes match authorization
- ☐ Location matches if specified

☐ Patient Communication

- ☐ Remind patient of appointment
- ☐ Inform if auth still pending
- ☐ Discuss financial responsibility
- ☐ Document conversation

Day of Service

☐ Final Authorization Check

- ☐ Verify auth still active
- ☐ Confirm no last-minute changes
- ☐ Print auth for chart if needed

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Billing/Claim Submission

☐ Pre-Submission Validation

- ☐ Auth number on claim form
- ☐ Box 23 (paper) or Loop 2300 (electronic)
- ☐ Auth not expired on DOS
- ☐ Service matches authorization

☐ Claim Scrubbing

- ☐ Flag claims needing authorization
- ☐ Hold if auth missing/expired
- ☐ Verify auth # format correct
- ☐ Cross-check with auth tracking

☐ Special Payer Requirements

- ☐ Medicare: UTN for DME
- ☐ Some payers: Auth in different field
- ☐ Multiple auth numbers if needed
- ☐ Notification vs authorization

Tracking & Monitoring

☐ Authorization Tracking System

- ☐ Patient name and ID
- ☐ Authorization number
- ☐ Effective dates (start/end)

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Payer Policy Monitoring

☐ Monthly Tasks

- Review payer bulletins/updates
- Check for new auth requirements
- Update internal auth matrix
- Communicate changes to team

☐ Quarterly Tasks

- Audit authorization process
- Review denial trends
- Update quick reference guides
- Refresh staff training

☐ Annual Tasks

- Full payer requirement review
- Contract term verification
- Process optimization review
- Technology assessment

Emergency Protocols

☐ When Authorization is Missing

☐ Can service be rescheduled?

☐ Is retroactive auth possible?

☐ Is it truly emergent?

☐ Document decision thoroughly

☐ Urgent/Emergent Services

☐ Document emergency nature

☐ Note time sensitivity

☐ Request retro-auth immediately

☐ Follow up within 24 hours

Red Flags - STOP and Verify

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Quick Reference Numbers

Major Payer Auth Lines

Medicare MAC:	Check your region
UnitedHe al thc are:	877-XXX-XXXX
BCBS:	State-specific
Aetna:	800-XXX-XXXX
Cigna:	800-XXX-XXXX
Humana:	800-XXX-XXXX

Radiology Benefit Managers

eviCore:	800-XXX-XXXX
AIM Specialty:	800-XXX-XXXX
CareCore/Carelon:	866-XXX-XXXX

REMEMBER: PREVENTION IS PROFITABLE
Every denial prevented saves:
- Staff time for patient care
- Cash flow consistency
- Patient relationships
- Your sanity