

IR Pre-Authorization Readiness Checklist – 2025 Edition

This checklist is designed to help Interventional Radiology (IR) practices, outpatient labs, and imaging centers ensure that all prior-authorization requirements are met, documentation is complete, and payer communications are properly tracked. Use it as a quick daily reference for both administrative and clinical staff.

1. Verify Eligibility & Coverage

- Confirm patient's plan is active on the date of service.
- Identify payer and verify if authorization is required for the ordered procedure.
- Determine if the payer uses a TPA (eviCore, AIM, Carelon, NIA, etc.).
- Check for plan-specific exclusions (e.g., 'experimental' or 'investigational' procedures).
- Document representative name, date, and reference number for all benefit checks.

2. Gather Required Clinical Documentation

- Include the clinical indication and diagnosis supported by imaging or test results.
- Document all conservative therapies tried or contraindicated (compression, exercise, anticoagulation, wound care, prior interventions).
- Reference clinical evidence or guidelines (SIR, SVS, ACR, OEIS).
- If ABI or segmental pressures were not performed, document why (e.g., noncompressible vessels, urgency, external study).
- Attach comparison imaging, labs, and prior procedure notes.

3. Submit & Track the Authorization

- Use the correct TPA portal; verify payer assignment before submitting.
- Upload all documentation and save confirmation numbers.
- Record submission date and contact information in the tracking log.
- Follow up after 3 business days if no response; escalate as needed.
- Keep copies of all correspondence and screen captures.

4. Handle 'No Auth Required' or Urgent Requests Carefully

- Confirm and record representative's name, date, and reference number for 'no auth required' responses.
- Understand this does not guarantee coverage—document medical necessity anyway.
- For urgent cases, describe why delay could cause harm (bleeding, tissue loss, ischemia).
- Include imaging and clinical data to justify expedited review.
- If denied expedited review, escalate in writing to the payer's medical director.

5. Prepare for Peer-to-Peer Reviews

- Prepare concise case summaries explaining diagnosis, failed therapies, and need for intervention.
- Keep supporting literature or guideline references ready.
- Document all peer-to-peer calls with reviewer name, date, and outcome.

6. Post-Approval & Denial Management

- Save authorization numbers and approval letters in the medical record.
- Confirm CPT® codes match the authorized procedure(s).
- Review denial reasons and appeal promptly with supporting documentation.
- Track denial trends by payer or TPA to identify problem areas.

7. Reducing the Administrative Burden

- Assign dedicated staff or partner with an outsourced pre-authorization service.
- StreamlineMD clients can leverage full-service prior-authorization management including benefit verification, submission, and peer-to-peer coordination.
- Outsourced teams track payer policy changes, manage documentation uploads, and monitor turnaround times.
- Ensure communication between the pre-auth service and clinical staff for accuracy and efficiency.

Quick Tip: Even when a payer says 'no authorization required,' treat it as 'documentation required later.' If it's not in writing, it's not defensible.

Version: 2025 Edition | Intended for internal workflow optimization and staff/physician education.