The Quadrant Company

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Medicare Uses AI to Deny Prior Authorizations. Use AI to Answer.

Two vendors denied more than 20,000 Medicare requests in three months under the federal WISeR pilot. Here is what that pilot does, and the software your own team can run on the other side of it.

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Prior authorization is a health plan rule requiring doctors to get insurance approval before delivering a surgery, procedure, or drug. Without advance permission, the insurer refuses to pay the claim, leaving the patient or hospital with the bill.

Originally, this was entirely manual. A clinic staffer faxed paper forms to the insurer. An insurance nurse or medical director read chart notes and checked coverage manuals before approving care. Payers used this barrier on a simple theory: making doctors justify orders in advance stops unnecessary procedures, curbs overutilization, and protects insurer cash reserves.

However, manual review had a physical limit. Human reviewers could only read so many charts a day, capping disputes. Artificial intelligence eliminated that limit. Medicare now pays private technology vendors to run algorithms over prior authorization requests in traditional fee for service Medicare. Software scans electronic records in milliseconds, searching for missing words or checklist gaps.

Payers and their contractors use AI to expedite and issue immediate denials at unprecedented velocity. Because software costs almost nothing to run, vendors reject claims instantly. In Medicare, the federal WISeR pilot proves this reality: two private vendors denied more than 20,000 requests in their first three months (Electronic Frontier Foundation, September 2026). While denials arrive in seconds, approvals stall: one patient waited 83 days against a federal target of 72 hours (Electronic Frontier Foundation, September 2026). Meanwhile, doctors spend 13 hours each week on authorization paperwork (American Medical Association, May 2026). Operating rooms stand dark while clinical teams burn out fighting automated rejections. We ran the issue through Contextualism, our framework for training AI to grasp the full picture of a complex issue by stress testing it across four quadrants simultaneously.

The four filters

PROTAGONIST: FOR AI SCREENING OF PRIOR AUTHORIZATION. The protagonist argues firmly in favor of artificial intelligence screening: the Medicare trust fund faces depletion, and the government must stop paying erroneous, wasteful, and fraudulent claims. Without pre payment screening, billions vanish into overpriced skin substitutes and unneeded spinal implants. Post payment audits recover pennies on the dollar after money leaves public accounts. CMS launched the WISeR model on January 1st, 2026 across Arizona, New Jersey, Ohio, Oklahoma, Texas, and Washington to halt questionable spending early. Algorithms evaluate 100% of claims against National Coverage Determinations instantly, flagging documentation gaps so

clinicians can protect public solvency.

ANTAGONIST: AGAINST AI SCREENING OF PRIOR AUTHORIZATION. The antagonist argues firmly against algorithmic prior authorization: using artificial intelligence to deny necessary medical care to sick seniors is fundamentally wrong. Medicare has handed coverage decisions to private contractors whose profits rise with denial volume. An algorithm does not know the patient, cannot observe pain, and has zero clinical judgment. It acts like a blunt search engine, auto denying life saving operations because a clinical note lacked vendor specific phrasing. Surgeons plead with call centers while operating suites stand dark and patients suffer in limbo. Over 20,000 seniors were denied care in 90 days. This is automated care rationing masquerading as fiscal discipline.

WITNESS: THE PATIENT AND CLINICAL REALITY. The witness presents the factual reality of everyday patients: prior authorization is an invisible wall that appears after a doctor prescribes treatment. You visit an orthopedic surgeon for severe joint pain. Your doctor schedules surgery, but the clinic calls later saying your operation is postponed because an outside company has not approved it. Pharmacies report the same delay for critical medications. You call customer service, wait on hold, and speak with representatives who cannot explain why your doctor judgment was rejected. Patients watch nurses complete repetitive paperwork while surgical dates slip months into the future and pain continues.

UTILITARIAN: THE MACROECONOMIC AND SYSTEMIC VIEW. The utilitarian evaluates the net outcome for society: the current system is an absurd, wasteful arms race that consumes shared resources without improving patient health. Payers deploy software to auto deny claims and delay payouts, while hospitals hire armies of billing clerks to write appeals. Neither side solves the underlying problem. Society is funding two opposing computational armies fighting over messy records while care stalls in queues. The rational solution is an open, bidirectional data standard where Medicare coverage rules live inside electronic order entry, verifying clinical indications instantly and rendering retrospective prior authorization obsolete.

Where the truth lives

Both sides agree on the basics: Medicare is running out of money, and sending faxes back and forth to get approvals is broken. The real fight is about how software is used. Rejecting claims with algorithms does not eliminate waste if the tool ignores clinical reality. It simply dumps extra paperwork and delays on doctors, nurses, and sick people. Evidence from the WISeR pilot proves that automated review speeds up denials without improving accuracy. When an approval takes 83 days instead of the legal 72 hours, the system is not protecting taxpayers. It is simply wearing down patients and providers until they surrender.

How AI helps with this

Hospitals cannot fight automated insurance denials with manual clerical labor. When insurance companies reject claims in seconds, having staff type out forms by hand guarantees failure. Hospitals have to use software on their own side of the wall.

When a surgeon orders a procedure, clinical software like Notable reads the patient chart, pulls relevant doctor notes and test results, and builds a complete authorization packet before submission. That prevents simple paperwork mistakes. If an insurer issues an automated denial, internal software reads the rejection letter, finds the matching clinical evidence in the patient record, and drafts an appeal in minutes.

Most importantly, software tracks the big picture. Instead of fighting denials one by one, analytics tools group rejections by doctor, procedure, and insurance reviewer. Hospital executives take that data directly to payer leaders during contract negotiations to prove systemic delays. Through it all, a licensed doctor or nurse reviews the synthesized evidence and signs the final appeal.

The solution

Hospital leaders need an organized software defense that matches insurance automation while keeping human clinical judgment in charge.

- Tracking the clock: Software logs the exact minute every prior authorization request is sent, monitors insurance response times, and records every violation of the federal 72 hour deadline.
- Assembling the chart: Software gathers clinical notes and diagnostic tests before submission, catching documentation gaps early so claims are complete on day one.
- Spotting denial patterns: Software groups rejections by procedure code and insurance vendor, giving hospital executives hard data to challenge bad faith delays.
- The Name Standard: An absolute operational rule that no automated appeal ever leaves the facility without a named, licensed doctor or nurse reviewing and signing it.

Operational moves for health system leaders

1. Put an electronic timer on every prior authorization request. Configure revenue cycle software to record the submission minute for all surgical requests. Track insurer response times against the federal 72 hour deadline to build an auditable record of payer delays.

2. Use clinical software to draft appeal letters immediately. Deploy tools that scan patient charts and produce evidence backed appeal drafts within 60 minutes of receiving a denial, allowing staff to review and submit appeals rapidly.

3. Track which insurance vendors cause the most delays. Consolidate denial and overturn rates across private review companies. Present documented proof of automated delays to regional Medicare officials and commercial health plans.

4. Require a licensed clinician to sign every appeal. Establish strict protocols requiring a designated clinical supervisor to review and sign every appeal letter. Never let software submit appeals automatically without licensed human oversight.

The decision for leadership

Hospital leaders have two choices:

1. Absorb automated denials through clerical hiring. Organizations can continue hiring billing clerks to process mounting denial queues manually, accepting permanent margin erosion, delayed operating room schedules, and chronic clinical burnout.

2. Deploy software to protect hospital operations. Leadership can implement tools to track review clocks, generate clinical appeals in minutes, and expose systemic vendor delays. This choice protects surgical margin and gives clinical teams the operational leverage they need.

The executive takeaway

Private review vendors automated their denial process to cut costs, but health systems do not have to absorb the delay. By pairing smart clinical software with strict physician governance, leadership can turn administrative friction into decisive operational leverage.

Sources

- Electronic Frontier Foundation, "New Records Reveal Problems with Medicare's AI Prior Authorization Experiment," September 2026.
- Centers for Medicare and Medicaid Services, "WISeR (Wasteful and Inappropriate Service Reduction) Model," January 2026.
- American Medical Association, "AMA Survey: Prior Authorization Reform Pledge Falls Short with Physicians," May 2026.

Do this at your organization

You can email us to learn how you can build a prior authorization denial tracker at your organization using AI. Write to info@thequadco.ai.