



Insurance Coverage

Everything You Need to Know to Become a Smarter Healthcare Consumer



Obtain Insurance Pre-Authorization

In an ideal world of health coverage, insurance plans would cover all procedures deemed necessary by your physician. Health insurance, however, is far from ideal. Depending on your health insurance plan, pre-authorization may be required to receive coverage on non-emergent care outside of standard care provided by your primary physician, or for certain procedures or specialists. By definition, pre-authorization is receiving prior approval from your insurer before a procedure is performed. It is your job as the insurance policy holder to know when pre-authorization may be necessary. Different providers are better than others at knowing when procedures need pre-authorization. Although your provider can initiate the pre-authorization process on your behalf, they may not and that could leave you with the bulk of the expenses.

While pre-authorization will guarantee that your health insurance has approved the procedure, it does not imply that they will cover the entire cost. Remember, your deductible and co-pays still apply. This, however, is preferable to being responsible for all of the expenses associated with a treatment not covered by your insurer. If your healthcare provider requires that you receive an expensive treatment or procedure, and there are any questions about your coverage, it is always better to get pre-authorization before proceeding with care.

Why do I need pre-authorization?

Most procedures that require pre-authorization fall out of the range of routine care provided by your primary care physician. If you receive a referral to see a specialist or surgeon or undergo an expensive treatment or service, pre-authorization may be required. Understanding your health coverage is important in terms of knowing when you may need to seek pre-authorization for healthcare services. Depending whether your policy is an HMO or a PPO can affect whether or not certain procedures or treatments are covered without prior authorization. So, if you are unsure what services are and are not covered by your health insurance plan, be sure to read up on your policy to avoid being left with extra medical expenses.

Who will make the request?

Often times your healthcare provider, requiring the uncovered treatment or procedure, will initiate the pre-authorization process with your insurer for you. Nevertheless, often does not mean always. There is nothing wrong with calling the insurance company and verifying that the authorization has been completed and approved. Sometimes these processes fall between the cracks and when they do, the healthcare consumer and not the provider is responsible for the associated expenses.

What you will need to make the request for authorization:

Pre-authorization requests generally require substantial background information such as:

- Other less costly and/or less invasive treatments that have already been tried and their duration
- Past history of the health issue (including the conditions surrounding its original manifestation)
- Physical documentation such as test results, images (x-rays, MRIs, ultrasounds, photos), etc.
- Other supporting information that solidifies the medical necessity for this visit, service, or procedure

Always check with your specific insurance plan to see what information they require. Remember, they want to validate medical necessity.

My pre-authorization was denied, now what?

Although pre-authorization denials are common, the insurance company usually provides a reason for the denial. Luckily, we're prepared to help you handle a denied claim too! Check out our "How to: Handle a Denied Medical Claim" Field Guide. It will walk you through the steps of challenging a denied medical claim. Before you start appealing the denial, make sure you documented medical necessity with written proof from your provider.

Managing Changes in Treatment

Something you may not know is that your insurance company can revoke the pre-authorization they previously granted if there is a change from what was initially authorized. Therefore, changes in treatment can become an issue. For example, a patient's treatment regimen for cancer that involves multiple drugs could be disallowed even if one of the drugs is changed and/or considered experimental. In order to avoid this, be sure to get authorization in writing from your insurer for any changes.

Prior Authorization vs. Pre-Authorization: How are they different?

Maybe you have come across a healthcare term similar to pre-authorization—prior authorization. Trying to identify the differences between these two terms is quite confusing because information provided by insurance companies about prior authorization is very vague. For examples, BCBS of Tennessee requires prior authorization for hospitalization (even just a 23-hour observation stay), home health services, and certain outpatient services like MRIs and CT scans. Other insurers, like Aetna, require prior authorization for prescription drugs not included in their formulary. Like pre-authorization, insurers require proof of medical necessity in order to consider approval. Even if your request for prior authorization is approved, it does not guarantee that the medical service or procedure will be covered. Contact your insurer if you are unsure about their policy in terms of prior and/or pre-authorization.

FAQs

If I get pre-authorization, does that mean that the service will be covered?

It should, however, pre-authorization does not guarantee that the service will be covered. It merely states that the insurer intends to cover the service, but on final review of the claim, your insurer may determine the service to have been unnecessary.

Will my claim be denied if I do not get pre-authorization?

Not necessarily. If the service is covered and necessary, your provider may authorize and cover the service. Depending on your policy, failure to get pre-authorization for some services may cause it to not be covered.

What services require pre-authorization?

Many non-emergency medical procedures and services require pre-authorization. If you are unsure, ask your provider. They are generally very familiar with which services typically require pre-authorization.



What do I need to do in order to get pre-authorization?

Your provider requests pre-authorization, so you need do nothing other than visit the provider and ask them if pre-authorization may be required. Your provider may have to present evidence of the necessity of the procedure by supplying your insurer with a report, lab and/or test results, scans, x-rays, photographs or other supporting materials that indicate that the procedure is necessary.

Will my healthcare provider always initiate the pre-authorization process on my behalf?

Although your provider can initiate the pre-authorization process on your behalf, they may not always do so and that may leave you with the bulk of the expense. It is the insured patient’s responsibility to know when pre-authorization is necessary. If you have any questions regarding whether pre-authorization is needed, contact your insurance company.

TERMS TO KNOW

Coverage: is the defined scope of services provided under a specific healthcare policy.

Denial: is a refusal of an insurer to accept responsibility as the guaranteed payor for services, treatments or products considered to be outside the scope of a defined healthcare plan.

Health plan: refers to the type of insurance chosen for healthcare coverage to meet the medical needs of the insured individual; types of plans include HMOs, PPOs, HDHPs, and so on.

Medically necessary: is defined by US legal doctrine as services or supplies that are needed for the diagnosis or treatment of a medical condition, that meet the criteria of standard medical practice in the local area, and are not mainly for the convenience of the patient or the provider.

Non-emergent care: refers to medical services that are not required for an illness or injury immediately. Unlike urgent or emergency care, professional attention is not necessary immediately to prevent further injury, disability, or death.

Original manifestation: is the point at which an illness or disability occurred or developed.

Pre-authorization: is the confirmation of coverage for a service or product by the insurer prior to the rendering of the service or disbursement of the product by the provider.

Reason for a denied medical claim: A medical claim can be denied for a number of reasons including: you hit your maximum lifetime benefit; you have a non-covered or experimental treatment; you have a pre-existing condition that is still outside of the coverage; or you experience a lapse in coverage and a health event manifests during that period of time when you did not have coverage. If the reason your medical claim was denied was not included in the denial itself, contact your insurance company to investigate.

Standard healthcare: includes routine medical care and services usually provided by a primary care physician; routine care could refer to services such as an annual physical, basic laboratory testing, and preventive care.

Notes:
