Navigating Pre-Authorizations: Procedures or Testing

Picture this: Your cardiologist recommended heart catheterization at your last appointment. The nurse tells you that they have requested pre-authorization and will schedule the testing when they hear back from your insurance company. You thank the nurse and leave the office.

So... what really just happened and what does your insurance have to do with it?

A pre-authorization is a restriction that requires your doctor to get the go-ahead from your benefit plan before a procedure or test will be covered. Sometimes these requests are called pre-approvals, prior approvals, or prior authorizations, but they all mean the same thing. This practice is common in all types of insurance, and even with government sponsored coverage like Medicare, Medicaid, or Tricare.

Your insurance company will review the request sent in by your doctor's office and decide, based on their policies, if you meet their criteria for the testing. Much like you would need to be pre-approved for an auto loan or a mortgage; this process is typical with insurance companies. But why do you have to go through it?

Sometimes, your doctor will prescribe a service or a procedure that uses a newer technique. If that occurs, your health plan may want to review your medical record or require that your doctor provide rationale as to why you need the prescribed service, as opposed to a standard procedure. Additionally, a test or procedure may require prior authorization if it has not yet been approved by the FDA, or if there is a lack of medical or scientific evidence to demonstrate effectiveness.

After the health plan has completed their review, you and your doctor should both receive the decision, typically in writing. This process can take up to 30 days. However, if your doctor feels that waiting that long might harm you, an urgent (called expedited) request can be submitted. At that point, you should receive a decision within 72 business hours.

A prior authorization is not a guarantee of payment, so just because you are approved for that heart catheterization doesn't necessarily mean that your insurance company will end up paying for it once you actually have it. However, an approval is a pretty good indication of your health plan's intentions to pay for the service.

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