Medical Necessity and Preauthorization

Insurance companies have a responsibility to ensure that healthcare dollars are used conscientiously. The process to review insurance plan's rules for service is known as preauthorization. Many surgeries, x-rays, MRIs require a review by the insurance carrier to determine if they feel the service requested is medically necessary. Our office staff will contact the insurance company and provide specific information regarding why the service is needed. The information usually requires diagnosis, symptoms and what has already been tried to alleviate the problem. The insurance plan will approve the service, request a peer review or deny the service. If the service is approved, the insurance will provide a preauthorization. Even with this preauthorization, the insurance plan states that this is not a guarantee of payment. Payment is based on the patient's individual benefits.

If a peer review is requested your physician is then required to speak directly to one of the medical directors at the insurance company to review why you need this service. This process can take several weeks to complete. If the service is denied as not being medically necessary, the insurance company may request that other testing or treatments be tried prior to allowing the requested service. They may also state that they will never approve the service for your symptoms. If this occurs you have the option of appealing the decision with your company, proceeding with the treatment and paying for it yourself, or trying another type of treatment.

Insurance companies that require referrals will require a referral for any service that does not need a preauthorization. Please make sure you contact your primary care physician and ask for a referral if our surgical schedulers request one.