HENRY FORD HEALTH

PATHOLOGY AND LABORATORY MEDICINE

INSURANCE PRIOR AUTHORIZATION/PRE-CERTIFICATION

What exactly is a prior authorization or pre-certification requirement? A prior authorization requirement, also known as a pre-authorization or pre-certification, is a clause in the health insurance policy that says the patient *must* get permission from their health insurance company before they receive certain health care services which includes specialized laboratory testing. Failure to get the testing authorized first can result in the claim being denied payment and the sending institution or patient being responsible for the cost of the test.

Which services have a prior authorization or pre-certification requirement? Many genomic tests and esoteric tests require prior authorization or pre-certification for outpatient services. Check with patient's insurance carrier to determine if authorization or pre-certification is required. Access insurance website or contact health care plan directly via phone to see if the test requires prior authorization/pre-certification.

Who is responsible for obtaining prior authorization or pre-certification? Organization/laboratory sending the sample to the performing lab or ordering provider is responsible for obtaining prior authorization or pre-certification for specialized laboratory tests. Failure to obtain or initiate prior authorization/ pre-certification prior to collection will result in a bill to the sending laboratory or patient. Bills for this type of testing can range from just under one hundred dollars to thousands of dollars based on the test ordered.

How to get prior authorization/pre-certification and information needed to complete the process. Call or contact the health insurance company and complete the prior authorization/pre-certification process. This could include submitting information via insurance provider's website, completing and faxing insurance provider's specific form or calling the insurance carrier and providing the information over the phone.

Be prepared to provide the following information at the time of request.

- Patient demographic information and health plan number.
- The prescribing physician's name and business information – possibly ordering provider's NPI number
- Patient's diagnosis, including the ICD-10 code
- The CPT code for the test requested. Locate CPT codes on Commonly ordered CPT and Test Codes Chart | Henry Ford Health - Detroit, MI or in HFHS Laboratory User's Guide for genomic testing performed. https://lug.hfhs.org
- Name and NPI of the laboratory that is billing the test. (Please note that the name of the laboratory may not be the laboratory that performed the testing) Laboratory NPI for Prior Authorization | Henry Ford Health - Detroit, MI
- Reason testing is necessary. For example, *"The result of the test will directly impact the treatment being delivered to the member" It* is best to use the same generic verbiage that each insurance provider uses, as a reason the test is necessary.
- In some cases, insurance provider may need to know family medical history, types of treatments tried for this problem in the recent past, physical exam findings, imaging findings, or lab results to support the request.

How long does it take for the decision from the insurance carrier? Sometimes a decision comes back in a few hours. Other times, it may take several days or weeks before the decision is rendered.