Preauthorization: The Basics

Preauthorization vs. Predetermination

Preauthorization is a mandatory process that allows an ordering provider to determine coverage and secure an approval from a payer for a proposed treatment or procedure, such as genetic testing. The exact process depends on the requirements set forth by the patient's health plan, but usually involves providing clinical information and the rationale for the procedure so that medical necessity can be established.

Predetermination is like preauthorization in that it involves a review of a proposed treatment or procedure for medical necessity. However, this process takes place *before* services are rendered. This allows any limitations under the patient's health plan to be addressed before services are provided. While preauthorization is required, predetermination is offered as a courtesy.

Covered vs. Approved

You call and speak with a representative of your patient's health plan to ask if a genetic test is covered. They tell you it is a covered benefit under the plan. Then your patient comes to you weeks later after receiving a letter from their plan stating that the test was not approved because it is not considered medically necessary. What went wrong?

It is important to be aware that just because a procedure is considered a covered benefit, does not mean it is automatically approved or reimbursed. When a test is listed as a covered benefit under a health plan, this simply means that it is eligible for reimbursement *if the request is found to meet medical necessity requirements* following preauthorization or predetermination review. Therefore, "covered" and "approved" are not one and the same.

When speaking with a representative of a patient's health plan prior to requesting genetic testing, it is important to ask not only whether the test is a *covered* benefit, but also whether *preauthorization* is required.