

## **Understanding Your Insurance Coverage**

### **A Guide to Navigating the Insurance Pre-authorization Process**

Payment is a primary concern when choosing weight loss surgery. Most patients can't afford the procedure without the help of insurance. The good news is that many insurance companies do cover the procedure. The approval process may be extensive and detailed, but a good surgeon will have the team to make this process as easy as possible.

First, you need to know what kind of coverage you have. Then, you can follow the plan guidelines for referrals and approvals.

### **Does my plan cover weight loss surgery?**

To find out, check the “**certificate of coverage**” or “**summary plan definition**” for your health plan. Insurance companies are required by law to provide this information. If you don't have one, you can get this document from your employer or directly from the insurance company.

The certificate of coverage will list what types of services the plan does not cover. Insurance companies may approve some types of weight loss surgery and deny others. Make sure that your inquiries specify the procedure in which you are interested.

You can also call your insurance company to find out if your plan covers weight loss surgery and, if so, which types. Some insurance companies also publish their coverage policies on their web site.

### **What type of insurance plan do I have?**

Knowing your type of insurance coverage will help with the approval process. Health insurance typically falls into one of two types: **managed care** and **fee-for-service**. Managed care plans usually have agreements with specific doctors, hospitals and other providers to deliver services. These physicians and providers form the plan's network.

How much money patients have to pay and whether they can use out-of-network doctors depends on the type of managed care plan. The different kinds of managed care plans are described below.

In fee-for-service and out-of-network managed care plans, the patient and the insurer each pay part of the costs. Patients have to pay all costs up to a certain amount, called a deductible. After meeting the deductible, patients are responsible for a percentage of costs, known as coinsurance. The insurance company pays the rest. These types of plans have no network, so patients can use the doctor or hospital of their choice.

The patient's financial responsibility in Health Maintenance Organizations (HMOs) and other in-network plans is a relatively small set fee called a co-payment. The amount of the co-payment depends on the plan.

## What are the rules for my managed care plan?

There are three basic types of managed care plans:

1. **Health Maintenance Organization (HMO)**---Least expensive, but least flexible
2. **Point of Service (POS)**---Combines an HMO with out-of-network options for more flexibility
3. **Preferred Provider Organization (PPO)**---Similar to fee-for-service, but with a network

**HMOs** have direct contracts with your employers, a network of doctors, hospitals and other service providers. Patients must get care inside the network. You need a referral to see a specialist, who must also be in the network. This type of plan does not charge a deductible. Patients usually pay a co-payment for each doctor visit. This fee typically ranges from \$5 to \$25.

**POS plans** let patients use providers both inside and outside the network. Out-of-network services usually cost more, and fewer services are covered. Patients need a referral to a network specialist to receive in-network coverage. Depending on the plan, they can also go to an out-of-network specialist without a referral. Some services, however, may require prior approval, called pre-authorization, from the insurance company prior to any surgical procedure or specialized medical care.

If using an in-network provider, patients pay a co-payment, but no deductible or co-insurance. Using an out-of-network provider follows the same payment setup as the fee-for-service plan: an initial deductible, plus coinsurance.

Like POS plans, **PPOs** allow patients to use in-network and out-of-network providers. Going outside the network typically costs more. These types of plans usually do not require a referral to see a specialist. Similar to POS plans, pre-certification may be required. When using in-network services, patients pay part of the cost in the form of a co-payment. Seeing an out-of-network provider uses the same payment program as a fee-for-service plan.

Insurance companies are constantly developing new types of plans by mixing and matching components of the three basic plan structures (HMO, POS and PPO). One company may also offer a different type of plan to a specific employer or group. Don't assume that all plans of a specific insurer are the same.

## Obtaining Insurance Approval for Weight Loss Surgery

Many people find that the greatest obstacle to getting weight loss surgery is obtaining insurance approval. It's not easy, but it can be done. You simply need to work with your primary care physician and your weight loss surgeon to provide the necessary documentation.

You also need to understand your insurer's rules for covering the procedure. Many insurers publish their coverage policies on their web sites. Some insurers will advise you of the policy over the phone. It's important to understand the rules of your insurance provider as soon as you start thinking weight loss surgery may be an option for you.

## Guide to Insurance Coverage

Weight Loss Surgery Center at UMMC, Fairview

420 Delaware Street SE, MMC 290, Minneapolis, MN 55455

A good weight loss surgery program will usually have an insurance specialist to guide you through this process.

Before you begin, you should understand your health insurance coverage. This will help avoid frustration and anxiety as you go through the approval path.

Yesterday's article offered guidelines to determine whether your plan covers weight loss surgery. It also described the different types of health care plans. Knowing the structure of your plan will help you understand your choices in service providers and payment responsibilities.

### My plan covers the surgery: Now what?

After making sure that your plan covers weight loss surgery, you will need to go through the following steps:

- **Approval from your primary-care physician.** Some insurance plans require your primary-care physician to refer you to a weight loss surgeon; others don't. Either way, you should get the support of your primary-care physician. He or she will work closely with your surgeon throughout the approval process and for follow-up care.
- **Organization of medical records,** including any history of dieting or other weight-loss efforts. Your surgeon and primary-care physician will need this information to write a letter of medical necessity, which is required for insurance pre-authorization. Make sure that your primary care physician has documented your attempts to lose weight in his or her office records.
- **Consultation with a weight loss surgeon.** The surgeon will meet with you to explain and make sure you feel comfortable with the program and with him or her as your physician. The office will help gather the information needed for the letter of medical necessity, including:
  - Your height and weight history and your current body mass index (BMI). The National Institutes of Health (NIH) requires surgery candidates to have a BMI of at least 40. Individuals with a BMI of at least 35 with significant co-morbidities (medical conditions caused by obesity) may also be candidates for surgery.
  - A description of obesity-related health conditions, such as diabetes or sleep disorders. This history should include medical records from prior treatment, medications taken and documentation of how these conditions have affected your daily life.
  - A detailed description of how obesity limits your daily activities, such as walking, dressing yourself or maintaining personal hygiene.
  - A history of efforts to lose weight through dieting, including medically and non-medically supervised programs. This information may include participation in diet groups such as Weight Watchers and Jenny Craig.

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- A history of weight loss attempts through exercise, such as receipts for gym memberships or fitness classes.
- **Documentation of medically supervised weight loss.** If you have not already participated in a physician-supervised weight loss program, many insurance companies will require you to do so before they approve surgery. Most carriers require six months of physician documentation. As soon as possible, check with your carrier for its specific policy.
- **Other professional consultations and tests.** Some insurance providers require surgery candidates to consult with other specialists, including a nutritionist and a psychologist. Your surgeon's office can refer you for these consultations and order the tests required by the insurer. In fact, a good program will often have these specialists as part of its team.

### When will I find out if my request is approved?

Insurance providers usually respond to requests for surgery approval within 30 days of receiving the letter of medical necessity. This approval is called pre-certification. Call your insurance carrier if you have not received a response after one month.

### What if my request is denied?

Don't lose hope. Even if your insurance company denies the first request for pre-authorization, you still have options. Most health plans have an established appeals process. However, you need to act quickly and follow your plan's guidelines to improve your chances of reversing the decision.

If this occurs, you should talk with our surgery schedulers and nurse clinicians for assistance on how to proceed.