Frequently Asked Insurance Questions

- ***How long does it take to get insurance approval?***

  Once you have completed your appointments, and we have all the documentation that is needed, we will send in to your insurance an authorization request for surgery. Once it is sent in to your insurance, it can take anywhere from 4-6 weeks before an authorization is received, depending on your insurance. Some insurance companies require the documentation to be reviewed by their medical director. Because of this, they can get backed up on reviewing the documentation. Most insurance companies have specific requirements when it comes to bariatric surgery. They will, on occasion, request additional information from either you or your primary care physician. You should contact your insurance company to see what their requirements are and gather any additional documentation that might be needed such as documentation of weight loss attempts.

- ***How can they deny insurance payment for a life-threatening disease?***

  Payment may be denied because there may be a specific exclusion in your policy for obesity surgery or "treatment of obesity." If you feel this is not correct, you should contact the Human Resource Department at the employer that the insurance is thru. They will have to make the correction with your plan. If this exclusion is correct, you would need to work with your Human Resource Department to see if they will make an exception.

  Insurance payment may also be denied for lack of "medical necessity." A therapy is deemed to be medically necessary when it is needed to treat a series of life-threatening conditions. In the case of morbid obesity, alternative treatments – such as dieting, exercise, behavior modification, and some medications – are considered to be available. Medical necessity denials usually hinge on the insurance company's request for some form of documentation, such as 6 months or more of physician-supervised weight loss attempts illustrating that you have tried unsuccessfully to lose weight by other methods. They may also have a stipulation that you have been morbidly obese for a certain time frame such as 5 years.

- ***If my insurance company denies me for surgery after I have had my initial visits, what would my next step be?***

  Once we receive the denial letter from your insurance company, we will begin to work on the appeal process. We will contact you to let you know what additional information they have requested. You may need to contact your primary care physician to request the information and have it sent to us.

- ***What can I do to help the process?***

  Gather all the information (diet records, medical records, medical tests) your insurance company may require. This reduces the likelihood of a denial for failure to provide "necessary" information. Letters from your personal physician and consultants attesting to the "medical necessity" of treatment are particularly valuable. When several physicians report the same findings, it may confirm a medical necessity for surgery. All of this information should be sent to Grand Health Partners or brought to your first appointment.

- ***What constitutes a medical weight loss program?***

  Insurance companies have different guidelines for the medical weight loss program. Typically they will require a certain time frame such as 6 months, of a medically supervised weight loss program. This means that you must have 6 consecutive visits with a physician. The physician must document your weight, go over your diet, exercise and behavior. Some insurances do require that you actually meet with a Dietitian, Exercise Physiologist and Behaviorist. The insurance companies may also require that the weight loss attempts happened within the previous, 2, 3 or 4 years. You should check with your insurance company to see what their requirements are.

- ***Do I need an authorization for office visits?***

  Please check with your insurance company on your policy benefits to see if you will need an authorization for your office visits.

- ***Why are there out of pocket expenses when my insurance company tells me they pay for everything at 100%?***

  Insurance companies pay for the services that are billable to them. Before you have any appointments scheduled here, you will receive a Wellness Commitment Plan. This will show you what your out of pocket expenses are. Our physicians do not participate with all insurances. For the non-participating insurances we will bill your insurance for you. The claim may be processed as out of network and you could end up with a deductible on charges you typically would pay just a copay. There are other services that are just not covered by your insurance company at this office. We are unable to bill for your dietitian visits, behavioral visits, exercise visits and the food supplements that you are required to take prior to and after your surgery.

- ***Can I make payments on my out of pocket expenses?***

  We do not typically do payment arrangements of the Wellness Commitment Plan fees that are due prior to surgery. If you need to pay this amount in more than the three (3) initial payments we have, you can do so, however surgery will not be scheduled until this is paid in full. We do have outside financing available thru Med Loan Finance. You can contact them at (800) 504-4053 or visit their website at www.medloanfinance.com for details.

- ***Will my laboratory tests be covered by my insurance?***

  You may have your labs done at any Laboratory that participates with your particular insurance. We will put all of your diagnosis on the lab slip so that they can bill the services for medical necessity. Many times patients have coverage for labs only for preventative health. We are a specialty office and can not code the lab request for preventative health. If you have this stipulation on your insurance policy, you can talk with your Primary Care Physician and they may be able to order the labs that we need with your regular preventative health labs.