Before scheduling any diagnostic or therapeutic procedure, patients should always determine the following information well in advance of the appointment date:

- Is this procedure covered by my insurance?
- How much will I personally have to pay?
- Am I required to have pre-certification or pre-authorization for this procedure?
- If my insurance initially denies coverage, will I still be able to have the procedure?

First, patients should contact their insurance providers to inquire about coverage for the MEG Scan. The insurance company will probably request a procedure code for a Magnetoencephalography scan, part of the Magnetic Source Imaging (MSI) process. The code for MEG is usually 95965 for epilepsy patients and 95966 for brain mapping patients. These are the numeric codes (also called a CPT codes) you should mention when you call your insurance company in order to determine your coverage benefits.

In order to ensure that your insurance provider will cover this procedure, you need to specifically inquire about the above codes: 95965 (epilepsy) or 95966 (brain mapping). Frequently, the insurance representative will state that “Outpatient diagnostic procedures do not require pre-certification or authorization.” However, MEG/MSI procedures commonly do require prior approval, and the insurance company’s statement regarding typical outpatient diagnostic procedures is not adequate to ensure coverage by your insurance provider.

The insurance company may otherwise inform you that they consider this technology to be “investigational” or that MEG/MSI procedures are “not a covered benefit”. In the event that this occurs, patients are entitled to a review of their cases to be considered for coverage, which is often successful, but the referring physician is normally required to submit this request.

In either situation, the insurance company will most likely state that they require certain documentation in order to review your request for MEG. This documentation usually includes:

- A Letter of Necessity from the physician who referred you to our facility
- A Request for Pre-Determination of Benefits or Request and/or Pre-Authorization
- Clinical notes from the referring physician or from our lab about your medical condition

We will be happy to provide you with whatever information and assistance we can, but the process for determining your specific insurance benefits and appealing any insurance denials of coverage are ultimately the patient’s final responsibility. There may be more than one initial denial of coverage by the insurance provider if a denial occurs, but determination frequently pays off. However, any amount not covered by insurance will be the patient’s responsibility as the beneficiary of our healthcare services. In order to prevent any miscommunication, additional stress, or unwelcome surprises for our patients and their families, we must require all patients to obtain this insurance information before having their MEG Scan. We look forward to helping you with your medical needs; please call us if you have any difficulties during this process.