



Complex Lab Tests: How to Get Them Covered



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Complex Lab Tests: How to Get Them Covered

This handout provides information about payment for complex lab tests. It also provides checklists to help patients and families get complex lab tests covered and to prepare an appeal if your claim or request is denied.

Health Plan Terms are listed and defined on pages 14 to 17.

Always talk with your health care providers about your health care issues, such as health plan coverage for lab tests.

About Health Insurance

Knowing more about how the health insurance system works in the U.S. can help you get a lab test covered or prepare to handle a claim or appeal for a denied lab test.

The purpose of insurance is to protect you from financial ruin. If you have insurance, you are called a “member” of a certain plan offered by the company. Most insured patients (including Medicare Advantage members) pay a monthly fee, called a premium, to their plan. In some cases, plans may have no premium.



Premiums are used by health plans to pay for your health care costs. If you are very ill with a complex, long term condition, it is likely that your premium will pay a large part of your costs. The amount paid by your health plan is reduced through your co-payments, co-insurance, and deductibles, though these payments can add up.

Medicare is the federal government health insurance program for people who are 65 or older, younger people with certain special needs, or people with end-stage renal disease (kidney failure). Medicare Part A covers hospital, nursing home, or hospice services. Most people do not pay a premium for Part A because they are eligible based on meeting prior work and tax rules. Part B covers medically needed services that diagnose or treat a medical condition, or services that prevent or detect an illness. Most people pay something for Part B. Many people who have Medicare also purchase a supplemental plan to help offset costs that are not covered by Medicare.

Medicaid is a federal and state funded program for those who meet low income guidelines. Each state decides what is covered. Some health care providers do not accept Medicaid patients. Most times, this is because they think the payment rate is too low and not enough to cover their costs. Some providers cannot meet the requirements to enroll or they do not want to go through the process.

Medicaid patients may have a harder time getting access to all the health care services that a commercially insured patient who has purchased a full-service plan can access.



In the U.S., health plans for those under age 65 are offered by more than 150 companies. The level of covered benefits varies with each plan and companies often offer more than one plan. In most cases, more costly plans offer more covered benefits.

When a health care provider decides that a patient will require a lab test, they should check the patient's health plan to see if they are eligible to have the test covered. Many errors with health plan billing can be avoided if the correct claim is submitted to the correct health plan.

Some lab tests that are not emergencies may require a pre-authorization or approval from the health plan before the test can be done. If a test is denied, a patient can follow an appeals process prior to having the test to try to get the service approved. See pages 6 through 10.

Claims are sent in by fax, computer or mail. The two forms are CMS-1500 and UB-04 (for hospital care). The health plan reviews all items on the form. If the test is something that requires review by a clinician (based on the CPT code), then it may be reviewed for medical necessity using the health plan's guidelines. This is done before they decide about coverage.

The form tells the health plan:

- If the provider is in-network
- Who will receive or received the test
- The billed amount
- Where the payment should be sent

After the claim is reviewed, the health plan decides about payment to the provider.

It is easy to have an error or something missing on the form that could cause a claim to be denied. There are 33 sections on the CMS-1500 form and 81 fields on the UB-04 form.

The two main reasons claims are denied are for issues with eligibility (about 25% or one out of four) and missing data or data that is not valid (about 10% or one out of ten). It will help to know why a test was denied before you pursue an appeal.

How to Access Medical Coverage Policies

Medical coverage policies provide guidance to health plans when they decide about a test. Each health plan creates unique policies for:

- Procedures
- Medicines
- Tests
- Equipment

Find out about your health plan's coverage policy details for the test in question.

Try to get this information before your provider orders a test.

How do I find out if a lab test is covered by my health plan?

Do your homework

- ❑ Ask your health care provider for the name of the lab test they plan to order, as well as the name of the test and the CPT codes.
- ❑ Ask for the diagnosis codes (ICD10) the provider is going to use on the claim form they will submit to the health plan.

Contact your health plan

- ❑ Call the member phone number on the back of your insurance card or go to their website to see if their policies are online. When you try to find details about a test, try search terms like "medical policy," "medical coverage," or "medical guidelines."

Other tips

- Contact the health plan a couple of times to confirm that the information you receive is the same each time.
- Try to obtain all information in writing. This written information may be helpful if you have to appeal a denied request for a test.
- Write down and keep the name of the person who gave you the information and the date and time you talked with them. Take screenshots of online conversations with health plan representatives.
- Ask whether the test is being done by a Par or Non-Par provider. Your test may be covered, but your provider may not be in-network. In this case, you will need to be prepared to find out if the test can be ordered by an in-network provider as well as the costs, if you decide to use a Non-Par provider.
- An "authorization" from the health plan means the request meets their criteria for payment but it does not mean they will pay 100% of the cost. Ask about the amount they cover for the CPT code(s), if the request applies to your deductible and if you have co-insurance or a co-payment.
- Health care policies are reviewed every year by the health plan, so check each time a test is ordered. If your health plan changes you will want to check your new health plan as they may not have the same guidelines.

Medicare's guidelines can be found at [cms.gov/medicare-coverage-database](https://www.cms.gov/medicare-coverage-database). All National Coverage Decisions (NCD) and Local Coverage Decisions (LCD) are posted.

NCD are for Medicare Administrative Contractors (MAC), the insurer that pays Medicare claims. LCD are issued by MAC when no NCD are available.

Medicare Advantage plans are supposed to follow these guidelines but sometimes they do not. You may need to be prepared for an appeal if you have a test that is covered by Medicare but not covered by a commercial health plan.

How to Appeal a Denied Request for a Test

Health plans will deny a request for a test that does not meet the policy or coverage criteria. They send you an Explanation of Benefit (EOB) notice or a letter. They must share the reasons they denied the test. Knowing why a lab test request was denied can help you prepare your case to try to have the decision reversed.

Why was a request for a lab test denied?

- Obtain and read the letter about why the lab test was denied
- Obtain and read the Explanation of Benefits about the lab test
- Choose the reason(s) why the lab test was denied. See details about terms on pages 7, 8 and 14 to 17. Check all that apply:
 - Clerical reasons
 - Coordination of benefits (COB)
 - Lack of information
 - Lack of pre-authorization
 - Out-of-network
 - Timely filing
 - Non-covered service
 - Not medically necessary
 - Experimental or Investigational

For denials that are “Not medically necessary” or “Experimental or Investigational”:

- Obtain the internal communications of the insurance company about the denied request (see **Sample Letter: Getting Records from a Health Plan** on page 12)
- Ask insurance company for a copy of the medical policy that was applied

Common Reasons a Request for a Lab Test is Denied

Clerical Reasons: A request that is denied for a clerical reason can often be resolved. The process and forms are complex, and it is easy to make a simple mistake that can cause a request to be denied. Ask for a claim to be processed again before you submit an appeal if the reason the request was denied was for missing information or if you need to correct an item on the form like the spelling of a name, the date of birth or details about the doctor who ordered the test.

Coordination of Benefits (COB): If the service is denied for this reason, contact your health care provider to confirm that your claim was sent to the correct insurance company.

Lack of Information: If your request is denied for lack of information, contact your provider to have them submit the missing information to the health plan. You can also ask for a copy of what was submitted in case you need to follow up with the health plan.

Lack of Prior Authorization (also called Pre-Authorization): Know your health care benefits *before* a test is done. For some tests, the health plan may require that the provider first ask permission to do the test. If a request is denied for this reason, there are fewer appeal options. Based on the health plan, there may be an option to submit a request for a retrospective review.

Out-of-Network: If a claim is denied for this reason, you can ask for an exception. In certain cases, a “one-time agreement” or “letter of agreement” can be settled upon by the health plan and the provider. Talk with your provider about reaching a rate that works for both parties.

Timely Filing: If a claim is denied for this reason, contact the provider of the test and ask NOT to be billed for the test. Since the patient does not submit claims, the provider is accountable for the timely filing of claims.

Non-Covered Benefit: Some health plans exclude coverage for specific tests, such as genetic tests. An appeal for this reason is not likely to be successful.

Not Medically Necessary: Often, when a request is denied for this reason, the health plan has a policy that outlines the criteria that are required to approve the request. If a request does not meet all criteria, it may be denied. Review the reasons listed in the denial letter so you can decide whether there is a reason to appeal the denied request. For example, if the provider did not clearly document a required element and if this can be shown to the payer, they may overturn the denied request or claim.



Experimental or Investigational: Technology evolves quickly, and there may not be enough evidence that a test can improve health outcomes. In this case, a payer will consider the test “experimental or investigational.” Since policies vary among payers, you may learn that payers do not view the same test the same way. It can be helpful for providers to review the coverage policy and if it is out-of-date, to provide up-to-date information to include with a request for appeal.

Know Your Appeal Rights

If your test request was denied for reasons that are more clinical in nature (experimental or investigational, medical necessity, or non-covered service), make sure you know your appeal rights.

Ask your health plan how many appeal levels you have, and whether there is an option for an outside review or a peer-to-peer review. Some health plans allow the provider to coordinate the appeal, while others require the member to submit the required documents. Most health plans offer one or two levels of internal appeal that must be done before an outside review (independent review) is offered. If it is not required to do this first you can think about going straight to an outside review, where the test is reviewed by an expert. See the section about independent reviews on pages 10 to 11.

If a peer-to-peer review is an option, obtain follow-up phone and fax contact numbers for the appeals department and contact your provider to ask them to complete this on your behalf. If a peer-to-peer review is not an option, submitting an appeal may be your best option.

When You Submit an Appeal

Be prepared: Before you submit an appeal review these tips and fill out the **Appeal Checklist** on page 9. This will help you avoid delays and increase the chance of a timely and successful appeal.

- Make sure you have the correct appeal phone number and fax number. If you submit an appeal to the wrong department it may lead to a delay in a response or no response at all.
- If you send your appeal by mail, send it certified. Health plans receive large amounts of mail, so sending it certified will help to reduce the risk of loss.
- Print on one side only. Do not include any pages that are printed on both sides – some scanners will skip over the back side of a page if you print on both sides of the paper. Do not staple documents.

Appeal Checklist

- Get instructions from your health plan about how to appeal, and find out the details on:

Due date: _____

Where and how to send the appeal (fax, email, address):

Forms, if any, that must be filled out:

- Review the reason(s) the request was denied in the denial letter and the Explanation of Benefits
- For denied requests that are due to lack of “medical necessity” or “investigational or experimental,” gain insight into the denied request by asking for internal communications of the health plan about the denial (see section on **Getting Medical Records from the Health Plan** on pages 12 to 13).
- In the right place on the forms *or* in a cover letter, state:
 - You believe this test is a covered benefit (insist; do not insult)
 - You have reviewed the reason for the denied request
 - You have addressed the reason for the denied request with new documentation that you did not submit before and that relates to the reason the request was denied
- Include the proper documents when you file an appeal. In most cases, this includes:
 - Denial letter from the health plan
 - Documentation to help overcome the denied request
- If the request was denied due to lack of “medical necessity” or “investigational or experimental,” include statement of medical necessity from the provider and clinical guidelines, if they exist.
- Send your appeal by email or fax and confirm with the health plan that it was received.
- If mailing is required, send by certified mail or use a delivery service like Federal Express or UPS that tracks the delivery and gives you the option to require a signature upon receipt.

Submit the appeal: After you finish the background work, make sure you include these documents when you submit your appeal:

- Letter from your health plan that said test was denied
- Health plan appeal form (if this applies)
- Completed authorization of representation form (required if provider submits the appeal on your behalf)
- Statement of medical necessity or clinic note from the provider who ordered the test. This statement needs to include:
 - Explanation of why the test was ordered
 - The outcome of the test if it was already done
 - If the results were used to make a clinical decision or impact the course of care
- Statement about why you feel the test should be covered. Be sure to include any other information that may help overturn a medical decision in your case.
- Clinical guidelines showing support of the test (if available) or documentation from the provider showing the test is “standard of care”
- If the test is covered by Medicare, attach proof of coverage (see details about Medicare on pages 3, 5, 6, 10 and 14)

Other Issues

If time is critical due to health or money reasons, you can request an expedited appeal. This process may be as simple as checking a box on an appeal form or filling out a separate form.

If your employer has an Administrative Services Only (ASO) plan, then the health plan only administers the plan – the money to pay for services comes from your employer. You may want to reach out to your Human Resources department for an exception to the benefit plan while you pursue an appeal with your health plan. Some employer plans have an insurance broker that can help you navigate the appeal process or can help you find out what is and is not covered under the terms of your plan.

If you have a Medicare Advantage or traditional Medicare plan, you may have up to 5 levels of appeal based on the cost of the test. Your appeal packet is close to what was described above. The third level of appeal is an Administrative Law Judge (ALJ) level. At that point, you may want to ask your health care provider to assist when talking with any judges.

Independent Review Organization (IRO)

If your test is denied by the health insurance company, you may have rights to an outside review by an independent review organization (IRO). The IRO has experts

that are not employed by your health plan. They will look at your case independently and in most cases without bias. It is an important second chance. With “newer” tests, this is often the best way of getting a test approved. Many times, when a denied claim is overturned through the IRO it causes a health plan to change their policy to something more favorable to patients.



The success rate with an IRO is often much higher than that of the grievance process within a health plan. In many states, the success rate exceeds 50%. Thus, it is worthwhile to submit an appeal to an IRO even if you lost the appeal within the health plan.

When you submit a case to an IRO, make sure that all IRO request forms are filled out. Some states require that a form be signed by the doctor who ordered the test. This is often the case if a claim is denied because a test is “investigational or experimental.” Other states require a patient signature. Also, some states require a fee to process an outside review. If any piece of required information is missing, the appeal may be delayed or not processed. Submit the same information listed in the section **When You Submit an Appeal** on pages 8 to 10 when you submit a claim or request for review to an IRO.

When you request an outside review, make sure to request that the denied test be reviewed by a doctor of “like-kind.” You do not want a skin doctor to review a request for a cancer test. List sub-specialties as well. Thus, if your request is for a test related to blood cancer, make sure to state that you want your request reviewed by a blood cancer doctor, not a general cancer doctor.

If your health care provider is aware of other patients who have gone through the outside review process for the same reason and have had success, ask your provider if you can include the other patients’ overturn letters in your appeal packet as long as the **personal health information is blocked out**. Showing other examples of approved requests may support the use of the test in your case. Outside review is most often the last level of review you can try so present the most thorough appeal you can.

The key to getting a test covered is to explain why the test was ordered, the results, and what the provider wants to do with the results. In addition, the IRO is often influenced by factors that your health plan likely did not consider when your appeal was denied. So, include those factors in a cover letter, which is part of your IRO appeals packet. It is OK to share your opinion about why you thought the test was useful and how it helped you or your family. It is also OK to add information to strengthen your case or make any part of the medical record more relevant to support your case.

It can also be helpful to include other objective information, in the form of medical records or opinions, in the IRO submission. Then, clearly state in your cover letter that you have provided medical information that was not available to the health plan when they reviewed your appeal.

Increase Success with an IRO Submission Checklist

- Obtain the IRO submission forms from your health plan
- Fill out the forms
- Include payment, if required
- Add cover letter stating:
 - You want the review to be by a doctor of “like-kind”
 - The effect of this denial on the patient or family
 - New information has been added and list what it is
 - This test is a covered benefit (insist; don’t insult)
- Include one or more pieces of new information about your appeal inside the health plan, such as:
 - Overturn letters from other patients if you have permission and can block out personal health information
 - A statement giving more details about the case along with details about your circumstances
 - New medical documentation or opinions that you did not submit as part of the grievance process

In your cover letter to the IRO, insist at the start and end of the letter that you believe that this test is a covered benefit and that you have supplied ample material to prove that. Be kind – insist but do not insult in your letter.

Getting Medical Records from the Health Plan

Under HIPAA (Health Insurance Portability and Accountability Act of 1996), it is your right to have access to your medical records. This includes both paper and electronic records.

Health plans are “covered entities,” so they must abide by these laws. Contact your health plan by phone to find out the process to request the documentation for the service requested. This includes internal communication within the health plan that led to the decision being made.

Be clear that your request includes more than the letters that the health plan sent to you. The health plan may require you to fill out and sign a form or pay a fee to complete the request.

You do not need to request medical records for the appeal from your health plan. You should have received information by mail about your claim, why it was denied, and how it was appealed. Clinic notes needed for the appeal should be done by your health care provider.

They may also be able to provide health care articles to support the test in question. Sometimes, the manufacturer of the test may also be of help. When you submit a case to outside review you should provide the best medical reasons to overturn the decision. These additional resources may provide that information.

Sample Letter to Get Health Plan Documents to Help with an Appeal

[Insert date here]

Dear Colleague:

I am a member of _____ health plan. As a member, it is my right to have correspondence and documents related to the following denials for laboratory testing:

[Insert description of denial here. Include test name and date of service.]

Therefore, I am requesting the following from the health plan:

- 1) All records of deliberations, emails and any other health plan correspondence related to the denial of the claims listed above and described in your denial letter of [insert date here]. It is not necessary to send medical records from my care providers as I already have these.
- 2) Please deliver these documents in a sturdy shipping container rather than an envelope.

Sincerely,

[Your signature goes here]

[Your name, typed or printed, goes here]

Other Sources for Help

Each state has a Department of Insurance. The extent of help you may receive varies based on state laws. If you have tried all options with the health plan, it may be worthwhile to contact your state's Department of Insurance. Some states also offer consumer assistance programs. These programs help patients with health insurance problems. To locate a state's assistance program, go to [cms.gov/CCIIO/Resources/Consumer-Assistance-Grants](https://www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants).

You may want to contact your congressman, congresswoman or senator. You may not get your issue resolved but it may help to inform your elected official about it. They all must uphold the rules in their state, and they all hold views about health care in our country and how it is paid for.

If you have additional resources, outside of the cost of the actual test, you may want to contact an expert in health care law. This would be someone in your local area who knows about health plan denials. Discuss fees with this expert because it may not be worth the time or expense to pursue this option. It will likely depend on the importance of the test that was denied.

If you are a Medicare member, you have access to the Medicare Beneficiary Ombudsman (MBO) [cms.gov/Center/Special-Topic/Ombudsman/Medicare-Beneficiary-Ombudsman-Home.html](https://www.cms.gov/Center/Special-Topic/Ombudsman/Medicare-Beneficiary-Ombudsman-Home.html). This service assists members with questions, complaints, appeals, and requests for information.

You may also access your State Health Insurance Assistance Programs (SHIP) for help with questions about Medicare benefits at [shiptacenter.org](https://www.shiptacenter.org).

Health Plan Terms

This section lists common health plan terms and defines them. Always check with your health plan for details.

Appeal: A request you submit to your health plan to review a denied claim.

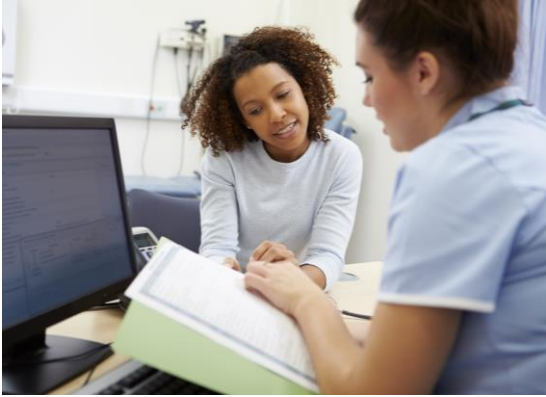
Authorization: See "Pre-Authorization," on page 17.

Certificate of Coverage: The contract between you and your health plan that outlines your benefits. It may also be called a Summary Plan Description (SPD).

Claim: A bill for health care services that your provider submits to the health plan for payment. In some cases, your lab test will be on its own claim and in other cases it will be on a claim with other health care services (such as a doctor's visit) that you had at the same time.

CMS 1500 Form: Used to submit claims to health plans.

Co-Insurance: Patient share of the cost of a health care service.

**Co-Payment (also called Co-Pay):**

Fixed amount paid for a health care service, most times at the time of service. For example, if your health plan has a 20% co-payment for a visit to the doctor, and the doctor's visit cost \$200. You would pay \$40 and your health plan would pay \$160, if you have met your deductible amount (see "Deductible" on this page). Likewise, a 20% co-pay for a \$100 lab test means that you pay \$20 and your health plan pays \$80.

Coordination of Benefits (COB): Applies to Medicare patients who have purchased supplementary plans to fill gaps in Medicare coverage. Plans that provide the primary health or prescription coverage for a Medicare patient can decide which health plan has the main payment responsibility and what supplementary plans will contribute.

Covered Benefit: A health care service that is paid by your health plan based on the payment rules of that health plan. If you receive a service that is NOT covered, then you pay for all of it. For example, take the case of a visit to a doctor that costs \$200 and is a covered benefit of your health plan. If the payment rules are that you pay 20% and the health plan pays 80% then you would pay \$40 and the health plan would pay \$160. If this service was NOT a covered benefit, you owe \$200. Also, your payment for an uncovered service does NOT count toward your deductible. So, when you have an uncovered test you pay for it *and* it does not count toward your deductible. Therefore, you need to know if the test you plan to receive is covered or not.

CPT Codes: Current Procedural Terminology codes are part of the billing system. They are used by care providers and health plans to identify medical procedures and services such as lab tests. In most cases, each lab test has its own code. The system is published by the American Medical Association (AMA) and is updated each year.

Deductible: Amount paid per year by a patient for health care services before the health plan will start paying. Thus, if yours was \$3,000, the health plan would not start paying your health care bills until you paid the first \$3,000 that year. It only applies to covered benefits. You have unlimited liability for uncovered benefits. This means the deductible does not apply and you must pay for the entire bill. Not the same as a co-pay, which is a fee you pay at the time of the service (see definition of "Co-Payment" on this page) for a covered health care service.

Denial: When the health plan does not intend to pay. Lab tests may be denied because:

- The health plan does not have enough information from the provider to figure out if the test is a covered benefit.
- The lab test is not considered a covered benefit for your condition. In some cases, a lab test is a covered benefit for some medical conditions, but not for others.

- The lab test is never a covered benefit because it is deemed “Investigational or Experimental,” or useless.



Explanation of Benefits (EOB): Written information from your health plan that explains details about your claim. May contain CPT codes (see definition on page 15) that describe the lab test you had, and ICD codes that explain the reason for the lab test. It may include denial codes that describe why the insurance company does not intend to pay for the lab test unless you provide more written details or submit an appeal that convinces them to pay. It is often hard to understand. It is NOT a bill.

External Review: When a claim is looked at by an outside agency, other than the health plan. In most cases, if you lose an appeal, your health plan has an option that allows you to appeal to an outside agency, which is often called an independent review organization (IRO). In many cases where medically necessary lab tests are denied, you are more likely to win your appeal at an IRO and it is your right to do this.

Health Care Provider: Doctors (also known as physicians), nurses, physician assistants, and genetic counselors are examples of health care providers. Doctors can order lab tests in all states. Nurses, physician assistants and genetic counselors can order lab tests in most states, but sometimes have limits on what lab tests they can order and the type of supervision they need when they order tests.

Health Plan: Health insurance companies like Aetna, UnitedHealthcare, Anthem, Cigna and Blue Cross/Blue Shield offer health plans that lay out the health care services that are covered for a person who is a member of the plan. Companies can offer more than one plan. Most times, more costly plans tend to provide more covered services.

ICD Codes: International Classification of Diseases used to describe clinical features or diagnoses. Most times, a medically needed lab test will be paid for if it has the right ICD code (or codes) assigned to it on the claim form.

In-Network: When a health care provider, a hospital or a clinical lab is part of a health plan network. Also known as Par (short for “participating”) providers. This type of clinical lab works with the health plan to create a fee sheet for lab tests. This is one way that your health plan can protect you from high lab test fees. Out-of-Network labs (see page 17) sometimes, but not always, charge the health plan high fees. Patients may receive high bills from a lab because the provider ordered the lab test from an Out-of-Network lab.

Maximum Out-of-Pocket: The amount of money a patient should pay for health services during a plan year. This only applies to covered benefits. It does not apply to lab tests that are not covered.

Medical Coverage Policy: Policies issued by health insurance plans that outline medical coverage criteria for a procedure or service, including lab tests.

Medical Director: A doctor who works for an insurance plan who makes medical decisions. If there is a dispute about coverage for a lab test, this is often the person who decides if your lab test claim is covered by the health plan.



Medicaid: Provides health coverage to eligible low-income adults, children, pregnant women, elderly adults and people with disabilities. Medicaid is administered by states, according to federal requirements. The program is funded jointly by states and the federal government.

Medicare: The federal government health insurance program for people who are 65 or older, certain younger people with special needs, or people with End-Stage Renal Disease (kidney failure).

Medicare Advantage: An alternative to original Medicare, offered by private companies approved by Medicare. Covers all Medicare services, and some of these plans also offer extra coverage, such as for vision, hearing and dental needs.

Member: A person covered under a health plan.

Non-Par Provider: See Out-of-Network below.

Out-of-Network: When a health care provider is not participating in the health plan network. Also known as Non-Par (for non-participating) providers.

Par Provider: See In-Network on page 16.

Peer-to-Peer Review: When the doctor who ordered a medical test meets with the medical director at the health plan to discuss why a test should be covered.

Pre-Authorization (also called Prior Authorization): A required process that allows a provider to determine coverage and secure an approval from a payor for a lab test. This does not guarantee payment. NOT doing this before a test could result in non-payment for the test.

Predetermination: Allows the health plan to review a lab test request for medical necessity. In this process, which is done as a courtesy, benefit coverage is figured out before the test is done so any limits imposed by the plan can be addressed. A pre-authorization is required by many health plans. If the payor suggests having a pre-authorization, go ahead and request that it be done.

Premium: Amount of money you pay monthly to have health insurance. Employers often cover some portion of this amount.

UB-04 Claim Form: Used to submit hospital claims to health plans.



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PLUGS (Patient-centered Laboratory Utilization Guidance Services) is a non-profit laboratory stewardship collaboration within Seattle Children's Hospital Department of Laboratories. Our mission is to improve laboratory test ordering, retrieval, interpretation and reimbursement.

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