moleculera biosciences
a precision medicine company

Determining if your insurance will consider the Autoimmune Brain Panel™ *(formerly known as the Cunningham Panel™)* a Covered Benefit

By utilizing the following step-by-step process to start a discussion with your insurance carrier, you can usually get some idea of the potential for coverage. However, it is not possible to guarantee that any insurance company will cover the Autoimmune Brain Panel™, regardless of which provider orders it, or whether the provider is, or is not, in the insurance company's provider network.

✓	ACTION	COMMENTS
	We strongly recommend that you start this process **before** you have the specimen collected. This way you will have a good idea of what your financial responsibility will be for the Autoimmune Brain Panel™ *(formerly known as the Cunningham Panel™).*	
	Call the ordering provider's office. Ask them to provide the ICD-10 diagnosis code(s) the ordering provider has used/will use for ordering the Autoimmune Brain Panel™.	**ICD-10 Codes:**
	Call the member services department at your insurance company. The telephone number will be on the back of your insurance card.	**Insurance phone #:**
	Ask to speak to a representative in the pre-authorization/pre-certification department.	**Representative's name:**
	Tell the representative that your provider has ordered the Autoimmune Brain Panel™and you would like their help to see if it is considered a *covered expense* under your plan.	
	You may be asked if Moleculera Biosciences is in the insurance plan's network of contracted providers. **Moleculera Biosciences does not accept insurance (is not contracted with any insurance plans/companies), therefore we will always be out-of-network.**	Our **Tax ID #: 45-3509017** National Provider ID **(NPI) #: 1013356211**.
	Ask the representative if your policy has **out-of-network benefits**	YES NO
	If YES, do I have an out-of-network deductible?	YES NO
	If YES, what is the amount of the out-of-network deductible?	$
	If YES, how much of the out-of-network deductible has been met so far this year?	Subtract the amount met so far from the total out-of-network deductible required. This should tell you how much is left to be satisfied before the insurance company will **pay** anything toward your claim.

✓	ACTION	COMMENTS
	If YES, ask **what percentage** of covered charges are allowed under my out-of-network benefits?	_____ %
	Ask the representative of the insurance company to treat the testing as in-network (sometimes called a "gap exception" or "network exception") since Moleculera Biosciences is **the ONLY** laboratory that provides this testing.	Offer to provide Moleculera's Sole Performing Laboratory statement to the insurance representative. You'll find that document under the Patient Resources section of our website.
	Provide the ICD-10 diagnosis codes you received from the ordering provider (see 2nd step above)	
	Provide the CPT (Current Procedural Terminology) codes associated with the Autoimmune Brain Panel™ (provided on the right) →→→ If the representative tells you "those are covered codes" **don't stop there!** **Ask the following essential questions:**	83520 x4 – Immunoassay for analyte ($45 x4 = $180) 88230 – Tissue culture for non-neoplastic disorders; lymphocyte ($375) 86352 – Cellular function assay involving stimulation and detection of biomarker ($440)
	A. Are these codes covered when provided by **any** lab, or only an in-network lab?	If you are told that these codes can be performed by an in-network laboratory, explain that the codes are "methodology codes." This means they describe **how** the test is done, not what is being tested **for**. Moleculera Biosciences is the **only** laboratory in the world that provides this panel of tests.
	B. Do any of these codes required medical necessity review in order to be considered a covered expense?	If yes, ask the representative to request records from the ordering provider.
	C. Are these CPT codes covered for **all** ICD-10 diagnosis codes?	If not, ask, "under which diagnosis codes **are** these CPT codes covered?"
	D. Are any of these codes considered experimental or investigational?	If yes, ask the representative what steps should be taken to obtain an exception for your case.
	E. Does my insurance plan require a referral and/or authorization from my PCP (primary care provider) for this test?	If yes, request that your primary care provider submit the appropriate request for coverage of your test.
	In order to determine whether (in their opinion) this test is medically necessary for the patient's symptoms and condition, the insurance company representative may ask you to obtain medical records from the ordering provider and submit those to them. If the representative asks you to do this, be sure to obtain a fax number or address to submit this information.	**Fax #**:
	Keep careful notes of the date(s) of your call(s)	**Call dates**:

✓	ACTION	COMMENTS
	Always ask the representative to provide a **call reference number or a case number** for your conversation/request.	**Call reference/Case #**:
	Ask the representative for a date or period of time (10 days, 2 weeks, a month, etc.) when you can expect a determination (approval/denial).	**Response period given:**
	Be prepared to follow up with your insurance company around the dates/time periods they gave you.	**Follow-up date:**

SOME IMPORTANT THINGS TO NOTE:

1. Please keep in mind that a "covered expense" does not necessarily mean that the insurance carrier will **pay** for the test. The test may be considered "covered" and still be applied to your in- or out-of-network deductible.

2. When an insurance company representative states that a procedure code is "covered at 100%", they mean it is covered at *100% of what the company "allows" (or prices) for that code*. It does not mean that they will pay 100% of our billed charge. Moleculera Biosciences, Inc. is not contracted with any insurance plan and does not recognize their allowable charges as full payment. Any balance due is the responsibility of the patient/patient family.

3. When contacting your insurance company, please be aware that any information provided by the representative is an **estimate only**. All claims are subject to review for medical necessity and benefit coverage at the time the claim is submitted.

4. If the patient is covered through an HMO (Health Maintenance Organization) plan, it is imperative to obtain a referral and/or authorization **from the patient's PCP (primary care provider)** for our test. It is important to talk to your insurance plan customer service representative about this and to know in advance what the requirements are. Ask the question: "Since the patient is covered by an HMO plan, does testing provided by an out-of-network lab require a referral and/or authorization from the PCP?"

5. Some insurance carriers offer a service called **predetermination** of benefits. These in-depth reviews are done prior to the service being rendered, involve review by a medical professional, and may offer a greater level of assurance that a service will be covered. Please note that predetermination can take anywhere from 30-45 working days to complete.

FINALLY, be persistent! You are the patient's greatest advocate.