

Insurance Considerations for Lab Testing Coverage

* Read this when you are ready to focus on the specifics regarding lab testing insurance issues *

Remember, **\$\$\$ MESH wants to save you money \$\$\$**, so you should know what your insurance plan will pay for BEFORE you need the testing done; you might not need us - being prepared helps **YOU** be in control of **YOUR** health.

Insurance coverage for lab testing varies WIDELY. It depends on the type of insurance plan you have, the plan design, the deductible amount, coinsurance, out-of-pocket expectations, and whether the tests are preventive or medically necessary. When your provider is ordering labs for you, make sure to ask if they consider the test(s) preventive. If they do, **make sure they use the correct preventive code (most often Modifier 33) to avoid you being billed for a service that should have been free.** MESH does not bill insurance for services, we simply provide deep discounts for you if you need us.

In a majority of insurance plans, lab tests are subject to deductibles and coinsurance amounts like other medical services unless they fall into a preventive category. Only lab testing defined as preventive (certain screening tests) is required to be covered 100% by insurances. Most insurance plans will pay 100% of your lab expenses for the remainder of the year once you have met your deductible and/or out-of-pocket maximum. Even diagnostic or medically necessary lab tests are typically subject to the deductible / coinsurance requirements of your plan. **Payments for services to MESH Labs DO COUNT toward your deductible and out-of-pocket amounts.**

If you have had past labs obtained while on insurance, you should have received an Explanation of Benefits (EOB). At the bottom of these pages is an *EXTENSIVE* outline of the information contained on an EOB. **When you compare an EOB to our MESH lab pricing**, you will be amazed at how overpriced labs are for the usual patient. To find the exact coverage terms expected for labs under your plan, review the "Summary of Benefits and Coverage (SBC)" provided by your insurance plan or contact your HR/benefits manager.

The most common preventive screenings are below - verify thru your insurance if they cover these for you

Cancer Screenings

Colorectal Cancer Screening: For adults aged 45 to 75. This includes stool-based tests (FIT or fecal occult blood test) and, in many cases, blood-based biomarker tests.

Cervical Cancer Screening (Pap Smear/HPV Test): For women, generally starting at age 21, and specifically HPV testing for women 30–65.

Breast Cancer Screening (Mammogram): Routine, age-appropriate screening for women.

Prostate Cancer Screening (PSA): Screenings for men, usually according to age-based guidelines.

Lung Cancer Screening: Low-dose computed tomography (CT) for high-risk adults (age 50–80 with a significant smoking history).

Infectious Disease Screenings

HIV Screening: For all adolescents and adults at increased risk, and generally recommended at least once.

Hepatitis C (HCV) Screening: A one-time screen for all adults 18-79.

Hepatitis B (HBV) Screening: For adults at high risk, including pregnant women.

Sexually Transmitted Infection (STI) Screenings: Specifically for syphilis, chlamydia, and gonorrhea for high-risk individuals.

Women's Health & Prenatal

BRCA Genetic Testing/Counseling: For women at high risk of breast/ovarian cancer.

Rh Incompatibility Screening: For pregnant women.

Gestational Diabetes Screening: For pregnant individuals.

Anemia Screening: For pregnant individuals.

Children & Adolescent Screenings

Lead Screening: For children at risk for exposure.

Dyslipidemia Screening: For children at higher risk of lipid disorders.

Hemoglobin/Anemia Screening: For children.

Autism Screening: For children at 18 and 24 months.

Developmental Screening: For children under age 3.

Cardiovascular & Metabolic Screening

Lipid Panel (Cholesterol Screening): Typically to detect high cholesterol in at-risk patients

Blood Pressure Screening: For all adults with high blood pressure history or findings

Diabetes (Type 2) Screening: For adults aged 35 to 70 with overweight or obesity, or as recommended based on risk factors.

An Explanation of Benefits (EOB) for lab testing is a statement from your health insurance company that explains how a laboratory claim was processed. It's not a bill, but it shows what was charged, what the insurer paid, and what you may still owe.

Here's what is usually included on a lab testing EOB:

1. Patient & Claim Information

Patient name

Member ID / policy number

Claim number

Date(s) of service

Provider name (lab such as LabCorp, Quest, hospital lab)

Provider ID or NPI

2. Test Details (Line-Item Level)

For each lab test billed it should show you:

Procedure code (CPT/HCPCS)

Diagnosis code (ICD-10)

Brief description of the test

3. Financial Breakdown (Per Test)

This is the core of the EOB:

Amount billed (what the lab charged the insurance company)

Allowed amount / contracted rate (rate the insurance company 'allows' to be charged)

The negotiated amount the insurer allows

Plan discount / adjustment - if there are any discounts this is where they will be applied

The amount written off (based on contracts, etc.)

Amount paid by insurance

Patient responsibility, broken down into:

Deductible

Coinsurance

Copay and non-covered amount (if any)

4. Coverage Determinations (see #7 below if any of these cost you money / coverage)

Covered vs. not covered indicators (should explain why something isn't covered if it isn't)

Preventive vs. diagnostic classification (important because they only pay 100% of preventive)

In-network or out-of-network status

Reason codes or remark codes explaining:

Medical necessity issues

Coding mismatches

Frequency limits

Missing diagnosis codes

Experimental or excluded tests (occasionally these may be negotiated or resolved with your efforts)

5. Totals Summary

Total amount billed

Total allowed amount

Total paid by insurance

Total patient responsibility

6. Deductible & Out-of-Pocket Tracking

Deductible applied from this particular claim

Remaining deductible to be met

Out-of-pocket maximum status - how much of your out-of-pocket has been met

7. Appeal & Rights Information (**make sure** you pursue these remedies if you think errors exist)

Instructions on how to appeal

Deadline for appeal

Contact information for:

Insurance carrier

Member services

Explanation of patient rights

8. Notes Specific to Lab Testing (Very Common)

Lab EOBs often include: (**again, see #7 above if any of these cost you money / coverage**)

Partial coverage (some tests covered, others denied)

Preventive test denials due to diagnostic coding errors

Reflex testing that wasn't pre-authorized (some test results automatically trigger another confirming test)

Multiple labs submitting separate claims

Bundled vs. unbundled test adjustments (sometimes labs are cheaper if bundled together)

Common Red Flags to Watch For

Preventive labs processed as diagnostic - a letter from your provider regarding the difference may fix this

Out-of-network lab used unknowingly - make sure you know what labs are in-network from insurance policy

Tests denied due to diagnosis code mismatch - a letter from your provider with correct codes may fix this

Lab billed under hospital outpatient instead of independent lab - hospital always more \$\$

Duplicate testing on same date - if you have the same tests done on the same day they only pay for one

It is **WORTH YOUR TIME** to really understand what is and what is not covered by your insurance plan from a type of testing coverage (preventive or diagnostic) and monetary (deductible / co-insurance amounts). You can save a lot of money and headaches if you are aware BEFORE you need your next labs.

\$\$ MESH Network Services Labs \$\$ can save you money when your insurance doesn't cover the tests!!