Checking Your Insurance Benefits for Genetic Testing

Cystic Fibrosis Testing

If you are interested in having Cystic Fibrosis screening test, we recommend you check with your insurance company to find out if this testing will be covered.

Many carriers do not cover this test for screening purposes and may require a prior authorization.

If your insurance company does not cover this test, you would be responsible for the full fee billed by the outside genetic lab. The test costs more than $560.

In order to make it easier for you to verify your benefit, we have provided the procedure and diagnosis codes below:

- **CPT (Procedure) Code:** 81220
- **Diagnosis Code:** Z13.228

Spinal Muscular Atrophy

If you are interested in having a Spinal Muscular Atrophy screening test, we recommend that you check with your insurance company to find out if this testing will be covered.

Many carriers do not cover this test for screening purposes and may require a prior authorization.

If your insurance company does not cover this test, you would be responsible for the full fee billed by the outside genetic lab. The test costs more than $475.

In order to make it easier for you to verify your benefit, we have provided the procedure and diagnosis codes below:

- **CPT (Procedure) Code:** 81329
- **Diagnosis Code:** Z13.828

Non-invasive Prenatal Testing (NIPT)

Please refer to this information provided by the outside testing lab for more information about insurance benefits and financial programs.

Sequential Screening

If you are interested in Sequential Screening, we recommend you check with your insurance company to find out how this testing will be covered.

Most carriers consider these as a covered service and pay the service according to your general x-ray/lab or diagnostic benefit. For most patients, this means the services are applied to your deductible, then covered at your particular coinsurance rate. Every policy is different; call the customer service number on the back of your insurance card to find out your specific coverage.

An important question to ask your insurance company: Is there a maximum number of screening ultrasounds allowed for pregnancy? If your policy does have a maximum number of ultrasounds covered, the coverage for this ultrasound may result in denial of future ultrasounds like the anatomy screening at 20 weeks.

In order to make it easier for you to verify your benefits, we have provided the procedure and diagnosis codes below:

<table>
<tr><th>Sequential Screening Step One
CPT (Procedure) Codes</th><th>Sequential Screening Step Two
CPT (Procedure) Codes</th></tr>
<tr><td>Ultrasound: 76813 ($558)
Blood Draw: 36415 ($30)
Labs: 81508 ($277.85) – These tests will be billed by an outside lab, not WHA.
Prices are estimates only and meant to be used as a guide. Prices are subject to change.</td><td>Blood Draw: 36415 ($30)
Labs: 81511 ($698.54) – These tests will be billed by an outside lab, not WHA.
Prices are estimates only and meant to be used as a guide. Prices are subject to change.</td></tr>
<tr><td colspan="2">Diagnosis Codes</td></tr>
<tr><td colspan="2">If you are younger than 35 when you are expected to deliver: Z36.0
If you are 35 years old or older when you are expected to deliver:
O09.511 (first pregnancy)
O09.521 (If you have had a previous pregnancy)</td></tr>
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