FOUNDATION**ACCESS™**

Program FAQs for Providers

PATIENT OUTREACH

PRIOR AUTHORIZATIONS

APPEALS SUPPORT

The Foundation Medicine FoundationAccess™ program supports providers and their patients through the coverage and billing process. For each test ordered, we complete a benefits investigation and reach out to patients whom we expect may have out of pocket costs. Additionally, we support providers and patients by helping obtain prior authorizations when required, billing the patient's health plan for the test, and appealing denials with the patient's consent.

FOUNDATION MEDICINE®

Frequently Asked Questions

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2. What does this mean for my practice?
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6. What if insurance denies coverage of the test?
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Frequently Asked Questions

1. How does the FoundationAccess Program work?

STEP 1

Upon receipt of a Foundation Medicine Comprehensive Genomic Profiling (CGP) test specimen, Foundation Medicine will reach out to the patient's insurance company to obtain detailed benefit information (e.g. confirm insurance information, un-met deductible amounts, and lab benefit levels) if available.

STEP 2

Foundation Medicine will determine if the order requires a prior authorization (PA) and attempt to submit a PA request on behalf of the patient if Foundation Medicine knows a PA is required and the health plan will allow Foundation Medicine to seek a PA.

In situations where the treating physician must submit the PA request, Foundation Medicine will contact your office and provide the information to use when submitting a PA request.

STEP 3

Foundation Medicine will proactively reach out to all patients with expected out-of-pocket costs to discuss high level information about the testing their provider ordered, what they can expect to happen with their specimen, and how the FoundationAccess program works to support them through the coverage and reimbursement process.

When we expect that a patient will not have any out-of-pocket expenses for the ordered CGP test(s), they will not receive outreach via phone but will receive mailed materials informing them that we expect them to have no out-of-pocket costs for their Foundation Medicine CGP testing.

Frequently Asked Questions

2. What does this mean for my practice?

We will process the test as we normally do, with no impact to the ordering process.

Effective January 4, 2021, Foundation Medicine will begin proactive outreach to patients for which you have ordered Foundation Medicine CGP testing and discuss the following:

- What test was ordered
- What to expect from the FoundationAccess program
- How FoundationAccess works with the patient's health insurance plan
- Answer any additional patient questions or concerns regarding the out of pocket cost of testing

Telling your patients that Foundation Medicine will reach out regarding coverage for the test(s) you've ordered helps us take this conversation off your plate.

Hand out the FoundationAccess Patient Information Card so patients know to expect our call or letter in the mail.

3. How often will Foundation Medicine be contacting patients?

For patients with expected out of pocket costs for their CGP testing, Foundation Medicine will make two contact attempts by phone. If we are unable to reach the patient after the second attempt, we will not pursue them further.

For patients with no expected out of pocket costs for their CGP testing, Foundation Medicine will mail a letter.

When it is deemed appropriate, Foundation Medicine may have additional contact with the patient regarding insurance status, Advanced Beneficiary Notice status, etc.

Frequently Asked Questions

4. Will this impact test turnaround time?

No. We have structured the program to not impact test turnaround time. We will continue procuring specimens and initiating lab operations on the sample as we do today.

This includes our policy for prior authorization determination. Foundation Medicine's prior authorization support services are triggered by receipt of a patient's specimen. Tests are not placed on hold for prior authorization determinations when we receive your patient's specimen. While this allows us to process your patient's test without delay, we understand patients and physicians may want to know the results of a prior authorization determination prior to test processing. If you prefer to obtain a prior authorization decision prior to testing, please submit your patient's prior authorization request prior to sending their specimen to Foundation Medicine.

5. What if the patient wants to cancel their test?

We will continue to manage cancellations as we do today. Only providers can cancel the test, however patients can request the test be cancelled at any point prior to the test report being delivered. While we will not directly ask the patient if they wish to cancel a test during our conversations with them, if a patient expresses a strong desire to cancel the test, we will note that in our system and reach out to your office to inform you of the cancellation request. Patients will not be billed in the event of a test cancellation prior to test report delivery.

Frequently Asked Questions

6. What if insurance denies coverage of the test?

We will exhaust every available option for insurance coverage for Foundation Medicine testing, including prior authorization (when the laboratory is allowed to submit it) and appealing denied claims, prior to sending a bill to the patient. Foundation Medicine may reach out to your office to request support for the appeals process and upon request will provide sample letters of medical necessity to streamline the appeals process. If the patient's health insurance plan requires patient consent for the appeal, Foundation Medicine will also reach out to the patient to obtain their consent.

Foundation Medicine offers a needs-based financial assistance program for qualifying patients. Regardless of insurance coverage, patients may apply for financial assistance at any point in the testing process. Payment plans may also be available.

7. Can Foundation Medicine perform the prior authorization when it is required to be submitted by the treating physician?

In some cases, the health plan requires that the treating physician submit a prior authorization request, rather than the services provider. In situations where the treating physician must submit the PA request, Foundation Medicine will contact you or your office to provide information specific to Foundation Medicine and it's testing services, including the applicable CPT codes to use when submitting a PA request. Should you wish to change how Foundation Medicine contacts you, please reach out to your Foundation Medicine Account Executive, who can facilitate that change.

Commonly Asked Questions

8. What happens if a prior authorization is denied?

Prior authorization approvals and denials are at the sole discretion of the health plan. Foundation Medicine is not permitted to appeal prior authorization denials, however, the treating physician and patients are able to do so at their discretion. Regardless of the outcome of a prior authorization request, Foundation Medicine will bill the health plan for the test and appeal claim denials with the patient's consent. Where a claim is denied following any appeal authorized by the patient, the patient may be responsible for some or all of the testing cost.

9. What is Foundation Medicine's process for submitting a claim appeal?

The claim appeal process and timeline will vary among health plans and even plan types within a health plan. Claim appeal requirements also vary by health plan and can include obtaining written patient consent.

Once a health plan has received a claim appeal request, Foundation Medicine typically receives an initial decision from a health plan in approximately 30-45 days. If the decision is unfavorable and additional levels of appeal are available, Foundation Medicine will continue to appeal until all levels of appeal have been exhausted, so long as we have appropriate consent from the patient to do so.

If you have further questions, please reach out to our **Billing Department**:

Call: **877.246.9204**
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Fax: **440.528.6010**