Danbury Hospital
Department of Pathology & Laboratory Medicine
Technically Speaking

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Annual Physician Notices

The Office of Inspector General (OIG) recommends that all clinical laboratories distribute an Annual Physician notice to health care providers who order laboratory testing. This notice serves to educate, update & inform on issues related to compliance, billing, and coding practices of the clinical laboratory.

- **Federal law requires that ordering physicians provide diagnostic information with every test requisition.** Laboratory coding updates & the Medicare laboratory fee schedule may be found on the following websites: LMRP at www.empiremedicare.com and NCD at www.cms.hhs.gov. . Please be aware that organ & disease oriented panels will only be billed and paid, when all the component tests of the panel are medically necessary. Also be aware that Medicaid reimbursement will be equal to, or less than Medicare reimbursement.
- The Danbury Hospital Department of Pathology and Laboratory Medicine has specific policies regarding REFLEX TESTING & CRITICIAL ALERT VALUES. These are presented to the Executive Committee of the Medical Staff for review & approval on an annual basis. If desired, copies can be obtained by calling our Laboratory's Client Service Representative, Sandra Smith at 797-7800.
- Below are listed the laboratory clinical consultants & their telephone number:

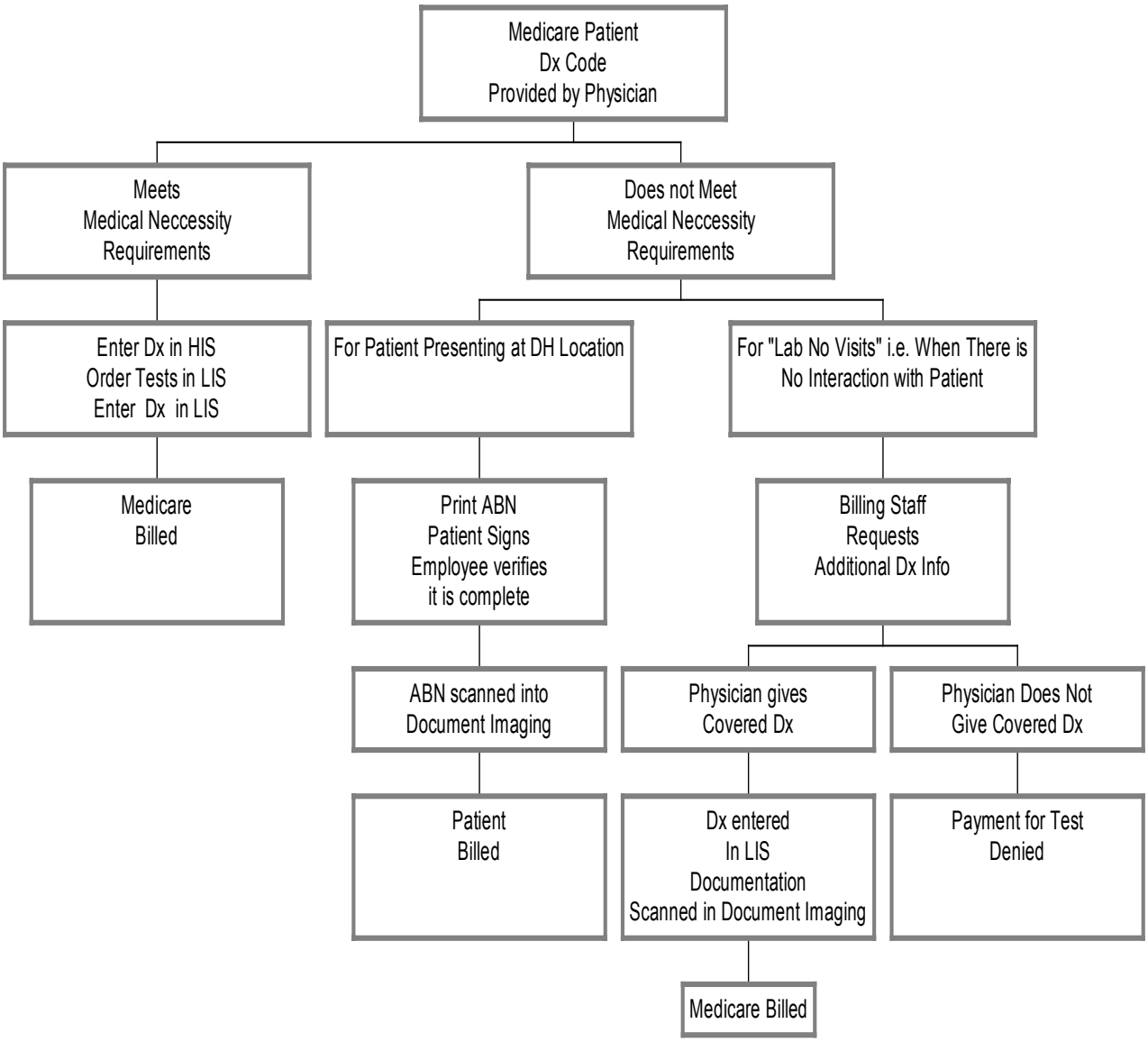
  Ramon Kranwinkel, MD – 797-7338
  Frank Braza, MD – 797-7397
  Beatriz Cuello, MD – 797-7034
  Leonel Edwards, MD – 797-7527
  Hani El-Fanek, MD – 731-8647
  Shiv M. Gupta, MD – 797-7222
  William Johns, MD – 797-7222
  Steven Sieber, MD – 731-8002
  Jeffrey West, MD – 731-8651
  John (Jack) Wolk, MD – 797-7551

- The Centers for Medicare & Medicaid Services (CMS) requires Medicare carriers implement policies to ensure that services paid by Medicare are medically necessary. Local carriers have established limited coverage policies under which reimbursement for certain tests will only be approved if the tests are ordered for

certain documented diagnoses and will not pay for tests ordered for "screening" purposes. If a limited coverage test is ordered for a

diagnosis that is not on the Medicare's carrier's list of acceptable codes, Medicare will not pay. The patients are liable providing that an Advance Beneficiary Notice (ABN) has been given by the providers of these services and/or the ordering physicians prior to service. Without the ABN, services denied by Medicare as routine screening or not "medically necessary" cannot be billed to the beneficiary. See flowsheet below.

Medical Necessity Process for Medicare Patients



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