

REFLEX TESTING ACKNOWLEDGEMENT

PURPOSE:

The purpose of this Reflex Testing acknowledgement is to ensure that providers understand when reflex tests will be performed and how they will be billed to Medicare.

POLICY:

The laboratory will automatically perform reflex tests according to the attached chart when all three of the following conditions are met:

1. An initial test has been performed as ordered;
2. The initial test result meets the criteria for the reflex test; and
3. The hospital's Medical Executive Committee has approved those tests and criteria.

The provider will always have the option to order any initial test without the reflex test.

BILLING OF REFLEX TESTS:

The hospital bills for medically necessary reflex tests according to the CPT code listed on the chart(s).

ACKNOWLEDGEMENT AND APPROVAL:

By signing this acknowledgement, you acknowledge that you have reviewed the chart(s) for each facility where you are applying for or currently maintain privileges and agree that, whenever the initial test ordered meets the reflex criteria, the corresponding reflex test will be performed, reported and billed. If this acknowledgement is not returned to us, reflex testing will not be billed OR performed without an additional order from you.

APPROVAL AND TERMINATION OF ACKNOWLEDGEMENT:

This acknowledgement will remain in effect for two years. The acknowledgement will be incorporated into the recredentialing process. This acknowledgement may be terminated at any time with written notice to the Medical Staff Office.

CHART(s): Please keep the attached chart(s) for your reference.

Signature: _____ Date: _____

Printed Name: _____



Northside Hospital

Dear Medical Staff Member/Applicant:

This letter is being provided to assist you in understanding the reflex tests performed by the laboratory at Northside Hospital and how they will be billed to Medicare.

Northside Hospital Laboratory will automatically perform Required Reflex Tests according to the criteria in the chart below when all three of the following conditions are met:

1. An initial test has been performed as ordered;
2. The initial test result meets the criteria for the reflex test; and
3. The hospital's Medical Executive Committee has approved those tests and criteria.

The physician will always have the option to order any initial test without the reflex test. The hospital bills for medically necessary reflex tests according to the CPT code listed on the chart below. By signing this acknowledgment, you confirm that you have reviewed the chart and understand that whenever the initial test ordered meets the reflex criteria, the corresponding reflex test will be performed, reported and billed.

After the acknowledgment is signed, please keep a copy and return the original with your application. The acknowledgment will remain in effect until your next re-appointment. The acknowledgment may be terminated at any time with written notice to the contact below.

INITIAL TEST	REFLEX CRITERIA	REFLEX TEST	CPT CODE
CBC w / Auto Diff	Instrument Parameters	Manual Differential	85007
Urinalysis	Dipstick Indicators	Microscopic Analysis	81001
TSH	0 – 0.0 uIU/ml	Free T4	84439
TSH	0.10 – 0.38 uIU/ml	Free T3 & Free T4	84481
TSH	4.4 – 90.0 uIU/ml	Free T4	84439
HBsAG	Positive	Neutralization Test	86382
HIV 1 & 2	Positive	Western Blot	86689
HTLV 1 & 2	Positive	Western Blot	86689
Strep Screen (Throat)	Negative	Culture	87070
Rheumatoid Factor	Positive	Titer	86431

Please contact Kristen Correia, Laboratory Director with any question at (727) 521-5067.

Physician

Signature _____ Date: _____