

Life Laboratories Annual Notice to Physicians

September 2026

Dear Colleague:

Life Laboratories is committed to complying with all guidelines set forth by the Federal Office of the Inspector General (OIG), The Center for Medicare and Medicaid Services (CMS), and the Department of Health and Human Services (DHHS). The laboratory participates in a Compliance Program to ensure that current federal regulatory policies are appropriately implemented and enforced. This Program also supports the fundamental mission of Life Laboratories to provide the highest level of patient care.

Under the *OIG Compliance Program Guidance for Clinical Laboratories*, all laboratories are required to send annual written notification to physicians and providers outlining policies and procedures for the ordering and billing of tests for Medicare beneficiaries.

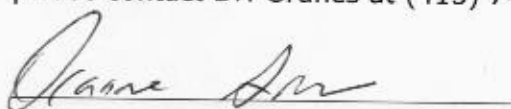
This letter serves as our 2026 annual notice with the focus on:

1. Medicare's Medical Necessity Requirements, including a sample ABN; and Non-Covered Service Waiver Forms.
2. Components of the approved profiles, including the Medicare fee rate.
3. Life Laboratories Reflex tests.
4. Ordering and Reporting Guidelines; and
5. Preauthorization of laboratory orders

A number of third party payers, including Blue Cross, Tufts, Cigna, and United Healthcare have implemented policies similar to the Medicare National Coverage Determination Guidelines and are now requiring a medically necessary diagnosis and/or prior authorization (for molecular and genetic testing). Life Laboratories will not be able to perform these tests without either a medically necessary diagnosis or documented prior authorization from the insurer, or the patient's written acceptance that they will be responsible for the cost. The prior authorizations must be completed by the ordering provider and accompany the requisition.

Please review the guidelines online. [Life Laboratories Provider Information | Trinity Health System \(Trinityhealthofne.org\)](https://www.trinityhealthofne.org/life-laboratories-provider-information) We encourage you to share this link with your staff.

If you have any questions regarding this letter or the attachments found on the link above, please contact Dr. Grunes at (413) 748-9576.



Dianne Grunes, MD
Medical Director



Linda Fountain
Laboratory Manager



Life Laboratories

ORDERING AND REPORTING GUIDELINES

This section includes information and guidelines to accurately process lab orders.

1. Standard Requisition and Required information

Recent revisions to the Health Insurance Portability and Accountability Act (HIPAA) mandate that labs receive specific information in order to submit claims. The following information should be included in the requisition:

- Name of physician or qualified healthcare professional ordering the test
- Address of the physician/qualified healthcare professional
- Phone number of the physician/qualified healthcare professional
- Patient's name
- Patient's address
- Patient's date of birth, sex, and (optional social security number)
- Patient's billing information (copy of insurance card, both sides)
- Name of subscriber
- Subscriber information (if the patient is not the subscriber)
- Tests ordered
- Diagnosis, signs, or symptoms
- Physician signature and date of the orders

Standard requisition forms are available from the lab. If an electronic requisition (eReq) is used, the same information must be included. Please also note that if a specimen is collected in the office, the item should be clearly labeled with two pieces of identification: the patient's full name and the patient's date of birth.

2. Standing Orders

Standing orders direct the laboratory to perform a particular test(s) at specific intervals for a defined period of time without having to submit a new requisition for each time. **Standing orders must be renewed in writing every twelve months, must state a start and stop date as well as the frequency of the order and must have a diagnosis stated for each standing order test.**

3. Critical Values and Call Back/Read Back Policies

The laboratory staff will call urgent and critical laboratory values to the physician's office or directly to the physician and will have the patient's name and lab value read back to verify the accuracy of the information.

4. Add on Orders

We recognize that additional tests may need to be ordered utilizing specimens that have already been collected. If the physician/physician extender needs to add on a test, the lab will need an order for the test with a corresponding diagnosis. The order for the add on test should be faxed to the lab. If no order is received, the lab will send a written request for the physician/physician extender to sign.

Life Laboratories

REFLEX TESTING

For some laboratory tests, when certain criteria are met, additional testing will be generated to provide more conclusive laboratory information for diagnosis and treatment. The CPT code will accurately reflex the testing that is performed.

INITIAL TEST	CPT CODE	REFLEX CRITERIA	CONFIRMATORY TEST
ANA Screen	86038	Positive	ANA titer
Anticardiolipin screen	86147	Positive or equivocal	Cardiolipin IgG and IgM
CBC with Diff	85025	Questionable Cell Counts/Cell Abnormalities	Manual differential
CDiff Panel (Toxin EIA & GDH antigen)	87324 87449	Indeterminate (Ag+, toxin EIA, negative)	CDiff toxin by PCR
Hepatitis A Antibody	86708	Positive	HAVAB IgM
Hepatitis B Core Antibody	86704	Neg Ag and AB, Pos Core total	HBcAB IgM
Thyroid Cascade	84443	TSH High TSH low T ₄ Free Normal T ₄ Free Low	T ₄ Free (end) T ₄ Free High (end) T ₃ Free (end) T ₃ Free (end)
Microbiology Culture	87070	Growth	Organism ID antibiotic sensitivity
Microbiology Blood Culture	87040	Growth	Rapid Blood Culture Identification PCR assay if first positive bottle within 72 hours, or if gram stain is different from previous positive
Rapid Strep A Screen	87430	Negative or Indeterminate	Culture
Treponemal AB	86780	Positive or equivocal	RPR and titer if RPR is positive
UA with sediment if needed	81003	Sediment reviewed if protein, blood, wbc, leukocyte esterase, nitrites is positive	Sediment review
UA with sediment and culture if needed.	81003	Sediment reviewed if protein, blood, nitrites, leukocytes is positive. Culture set up if positive for leukocyte esterase, nitrites, >6wbc, mod or large bacteria	Urine sediment urine culture Urine sensitivity
Vaginal wet mount	87210	Indeterminate for Trichomonas	Trichomonas Ag

In addition to above reflex testing, a confirmatory test procedure will be performed to validate the accuracy of the initial test result for the following test. This is per CDC recommendations.

INITIAL TEST	CPT CODE	REFLEX CRITERIA	CONFIRMATORY TEST
HbsAg	87340	Positive	HbsAg confirmation
HIV	86703	Positive	HIV Differentiation
Lyme Total Ab	86618	Positive or equivocal	Lyme IgG & Lyme IgM

Life Laboratories also utilizes outside reference laboratories to perform esoteric testing. These laboratories utilize reflex testing (i.e.: B. Pertussis AB, IgG/IgA, IgM CPT Codes: 86615 x 3).

Ordering Providers:

If you determine that reflex testing is not medically necessary, you must indicate this on the requisition by listing the specific test **AND** by writing "No Reflex" on the requisition next to the test. Any questions regarding reflex testing should be addressed to Dr. Dianne Grunes at (413) 748-9576.



Mercy Medical Center
Trinity Health

Life Laboratories

Medicare/Medicaid Organ or Disease Orientated Panels Disclosure Notice 2024

Panel Name	Individual Components	Panel CPT Code	Patient Bill Price	2024 Medicare Allowable
Basic Metabolic Panel	BUN/84520 Calcium, Total/82310 Carbon Dioxide/82374 Chloride/82435 Creatinine/82565 Glucose/82497 Potassium/84132 Sodium/84295	80048	30.00	8.46
Comprehensive Metabolic Panel	Albumin/82040 Alkaline Phosphatase/84075 BUN/84520 Bilirubin, Total/82247 Calcium, Total/82310 Carbon Dioxide/82374 Chloride/82435 Creatinine/82565 Glucose/82947 Potassium/84132 Protein, Total/84157 Sodium/84295 SGOT (AST)/84450 SGPT (ALT) 84460	80053	34.00	10.56
Electrolyte Panel	Carbon Dioxide/82374 Chloride/82435 Potassium/84132 Sodium/84295	80051	21.00	7.01
Hepatic Function Panel	Albumin/82040 Alkaline Phosphatase/84075 Bilirubin, Direct/82248 Bilirubin, Total/82247 Protein, Total/84157 SGOT (AST)/84450 SGPT (ALT)/84460	80076	26.00	8.17
Lipid Panel	Cholesterol/82465 HDL/83718 LDL, Calculated Triglycerides/84478	80061	52.00	13.39
Renal Function Panel	Albumin/82040 BUN/84520 Calcium, Total/82310 Carbon Dioxide/82374 Chloride/82435 Creatinine/82565 Glucose/82947 Phosphorus/84100 Potassium/84132 Sodium/84295	80069	25.00	8.68

Note: General Health panel is not an approved Medicare Panel.

How Medicare/Medicaid is billed for each profile: Life Laboratories is reimbursed the lower of the price it bills or the local prevailing fee schedule reimbursement. Your local carrier/agency fee schedule reimbursement rate may be slightly lower than the national Medicare fee schedule reimbursement rate. Federal laws require that Medicaid reimbursement be the same as or lower than Medicare reimbursement



Mercy Medical Center

Trinity Health

299 Carew Street • Springfield, MA • 01104 • TrinityHealthOfNE.org

Life Laboratories

413-748-9500

ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN)

Patient: _____ DOB: _____ Account #: _____

Note: If Medicare doesn't pay for the **D** test (s) checked below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **(D)** test(s) checked below.

(D) Test	Reason	Cost Approx	(D) Test	Reason	Cost Approx
☐ PT	☐ Diag and/ or Freq	\$18.00	☐ Thyroid Profile	☐ Diag and/ or Freq	\$55.00
☐ PTT	☐ Diag	\$18.00	☐ Iron / IBC	☐ Diag and/ or Freq	\$26.00
☐ CBC	☐ Diag	\$26.00	☐ Ferritin	☐ Diag and/ or Freq	\$43.00
☐ CBCD	☐ Diag	\$31.00	☐ CEA	☐ Diag and/ or Freq	\$55.00
☐ Hematocrit	☐ Diag	\$9.00	☐ CA 125	☐ Diag	\$74.00
☐ Hemoglobin	☐ Diag	\$8.00	☐ CA 19.9	☐ Diag	\$80.00
☐ Hgb A1C	☐ Diag	\$28.00	☐ CA 27.29	☐ Diag	\$80.00
☐ Retic	☐ Diag	\$13.00	☐ HCG	☐ Diag	\$46.00
☐ PSA Screen	☐ Diag and/ or Freq	\$57.00	☐ AFPTM	☐ Diag	\$52.00
☐ PSA Diagnostic	☐ Diag and/ or Freq	\$57.00	☐ Collagen Cross	☐ Diag	\$75.00
☐ Cholesterol	☐ Diag	\$16.00	☐ GGT	☐ Diag	\$23.00
☐ Lipid Profile	☐ Diag and/ or Freq	\$52.00	☐ Urine Culture	☐ Diag	\$50.00est
☐ HDL or LDL	☐ Diag and/ or Freq	\$30.00	☐ Fecal Occult Blood	☐ Diag	\$45.00
☐ Digoxin	☐ Diag	\$37.00	☐ Hepatitis Panel	☐ Diag	\$200.00est
☐ Glucose	☐ Diag and/ or Freq	\$14.00	☐ Natriuretic Peptide (BNP)	☐ Diag	\$98.00
☐ Lyme	☐ Diag	\$70.00	☐ HIV (DX & /or Monitor	☐ Diag	\$35-200
☐ TSH	☐ Diag and/ or Freq	\$55.00	☐ Vitamin D	☐ Diag	\$86.00
☐ Drug Screen Qual	☐ Diag	\$150.00	☐ Drug Confirmation	☐ Diag	\$85.00

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **(D) test / tests** listed above. **Note:** if you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare does not require us to do this.

(G) OPTIONS:

Check only one box. We cannot choose a box for you.

- ☐ **OPTION 1.** I want the **(D) test / tests** listed above. I want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.
- ☐ **OPTION 2.** I want the **(D) test / tests** listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**
- ☐ **OPTION 3.** * I don't want the **(D) tests / tests** listed above. I understand with this choice I am not responsible for payment, and **I cannot appeal to see if Medicare would pay.**

(H)* If Option 3 is checked please notify the ordering physician that you chose not to have the test(s) done.

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227 / TTY: 1-877-486-2048).

Signing below means that you have received and understand this notice. You also receive a copy

Signature of patient or person acting on patient's behalf:	Date:	Issued by:
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CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

Non-Covered Service Waiver Form

Please retain this document in your patient's medical record

For the Member

As a Blue Cross Blue Shield of Massachusetts member, I understand that I am responsible for all costs associated with the procedure/item listed below. My provider has informed me that Blue Cross Blue Shield of Massachusetts does not pay for this procedure/item because:

- ☒ The procedure or item is not considered medically necessary
- ☒ It is not a covered benefit under my benefit plan
- ☐ He/she is not contracted to perform this procedure or provide this item
- ☐ Other _____

(To be completed by provider, if applicable)

Member Name: _____

Member ID (include alpha prefix): _____

Member Signature: _____ Date: _____

For the Provider

As a participating Blue Cross Blue Shield of Massachusetts provider, I certify that I have informed my patient, _____, that Blue Cross Blue Shield of Massachusetts does not allow payment for the procedure/item listed below because:

- ☒ The procedure or item is not considered medically necessary
- ☒ It is not a covered benefit under the member's benefit plan
- ☐ I am not contracted to perform this procedure or provide this item
- ☐ Other _____

Procedure/Item:	Procedure Code:	Cost:
Cyclic Citrullinated Peptide (anti-CCP)	86200	\$73.00
hsCRP	86141	\$38.00
BNP	83880	\$98.00
Fecal Pancreatic Elastase (EL-1)	82656	\$34.00

Provider Name: Life Laboratories NPI: 1942226006

Provider Signature: _____ Date: _____

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As a Blue Cross Blue Shield of Massachusetts member, I understand that I am responsible for all costs associated with the procedure/item listed below. My provider has informed me that Blue Cross Blue Shield of Massachusetts does not pay for this procedure/item because:

- ☒ The procedure or item is not considered medically necessary
☒ It is not a covered benefit under my benefit plan
☐ He/she is not contracted to perform this procedure or provide this item
☐ Other _____

(To be completed by provider, if applicable)

Member Name: _____

Member ID (include alpha prefix): _____

Member Signature: _____ Date: _____

For the Provider

As a participating Blue Cross Blue Shield of Massachusetts provider, I certify that I have informed my patient, _____, that Blue Cross Blue Shield of Massachusetts does not allow payment for the procedure/item listed below because:

- ☒ The procedure or item is not considered medically necessary
☒ It is not a covered benefit under the member's benefit plan
☐ I am not contracted to perform this procedure or provide this item
☐ Other _____

Procedure/Item:	Procedure Code:	Cost:
Factor II (PT Gene Analysis)	81240	\$200.00
Factor V (Leiden)	81241	\$200.00
MTHFR	81291	\$200.00
Homocysteine	83090	\$34.00
NTX Urine (Collagen Cross-link; NTX-N-Telopeptide)	82523/82570	\$71.00

Provider Name: Life Laboratories NPI: 1942226006

Provider Signature: _____ Date: _____

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As a Blue Cross Blue Shield of Massachusetts member, I understand that I am responsible for all costs associated with the procedure/item listed below. My provider has informed me that Blue Cross Blue Shield of Massachusetts does not pay for this procedure/item because:

- ☒ The procedure or item is not considered medically necessary
☒ It is not a covered benefit under my benefit plan
☐ He/she is not contracted to perform this procedure or provide this item
☐ Other _____

(To be completed by provider, if applicable)

Member Name: _____

Member ID (include alpha prefix): _____

Member Signature: _____ Date: _____

For the Provider

As a participating Blue Cross Blue Shield of Massachusetts provider, I certify that I have informed my patient, _____, that Blue Cross Blue Shield of Massachusetts does not allow payment for the procedure/item listed below because:

- ☒ The procedure or item is not considered medically necessary
☒ It is not a covered benefit under the member's benefit plan
☐ I am not contracted to perform this procedure or provide this item
☐ Other _____

Procedure/Item:	Procedure Code:	Cost:
VAP Cholesterol	83701	\$114.00
Lipoprotein (a)	83695	\$50.00
LpPLA 2	83698	\$129.00
Fecal Calprotectin	83993	\$100.00

Provider Name: Life Laboratories NPI: 1942226006

Provider Signature: _____ Date: _____

Non-Covered Service Waiver Form

Please retain this document in your patient's medical record

For the Member

As a Cigna Insurance member, I understand that I am responsible for all costs associated with the procedure/item listed below. My provider has informed me that Cigna does not pay for this procedure/item because:

- ☐ Medical Technology Assessment Guidelines used by Cigna have not been met
- ☐ The diagnosis for which this procedure/item has been prescribed does not meet Medical Policy Guidelines
- ☐ The procedure or item is not considered medically necessary but experimental or investigational.

Member Name: _____

Member ID (include alpha prefix): _____

Member Signature: _____ Date: _____

For the Provider

As a participating Cigna provider, I certify that I have informed my patient, _____, that Cigna does not allow payment for the procedure/item listed below because:

- ☐ Medical Technology Assessment Guidelines used by Cigna have not been met, or
- ☐ The diagnosis for which this procedure/item has been prescribed does not meet Medical Policy Guidelines, or
- ☐ The procedure or item is not considered medically necessary but experimental or investigational.
- ☐ Other _____

Procedure/Item:	Procedure Code:	Cost:
Factor II (PT Gene Analysis)	81240	\$200.00
Factor V (Leiden)	81241	\$200.00

Provider Name: Life Laboratories NPI: 1942226006

Provider Signature: _____ Date: _____

Non-Covered Service Waiver Form

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For the Member

As a Blue Cross Blue Shield of Massachusetts member, I understand that I am responsible for all costs associated with the procedure/item listed below. My provider has informed me that Blue Cross Blue Shield of Massachusetts does not pay for this procedure/item because:

- ☒ The procedure or item is not considered medically necessary
- ☒ It is not a covered benefit under my benefit plan
- ☐ He/she is not contracted to perform this procedure or provide this item
- ☐ Other _____

(To be completed by provider, if applicable)

Member Name: _____

Member ID (include alpha prefix): _____

Member Signature: _____ Date: _____

For the Provider

As a participating Blue Cross Blue Shield of Massachusetts provider, I certify that I have informed my patient, _____, that Blue Cross Blue Shield of Massachusetts does not allow payment for the procedure/item listed below because:

- ☒ The procedure or item is not considered medically necessary
- ☒ It is not a covered benefit under the member's benefit plan
- ☐ I am not contracted to perform this procedure or provide this item
- ☐ Other _____

Procedure/Item:	Procedure Code:	Cost:
Chromogranin A	86316	\$64.00
CEA	82378	\$55.00
CA19-9	86301	\$80.00
CA125	86304	\$74.00
Hemochromatosis Gene	81256	\$250.0

Provider Name: Life Laboratories NPI: 1942226006

Provider Signature: _____ Date: _____