LOURDES HOSPITAL
169 Riverside Drive
Binghamton, New York 13905
LAB MANUAL

SUBJECT: Patient Registration, Accessioning, and General Information **ORIGIN DATE: 1997**

REVIEWED: 06/02/2016 **REVISED:3/99,6/02,10/04,1/2009,2010,4/7/2014**

REGULATORY REFERENCES: **CROSS REFERENCES:**

POLICY To ensure the integrity of the specimen drawn, the quality of results reported and to provide demographic and insurance information concerning the patient.

PROCEDURE:

1. Each Patient must be registered for the actual date of service. Verify all patient demographics, date of service, patient's full name, and date of birth, location and ordering provider to assure that all information is accurate and up to date. If any of these are incorrect, a new registration must be issued with the correct information.

2. The laboratory order form must include the patients full name, date of birth, name of ordering provider, diagnosis code (ICD) and must be signed and dated by the provider. The collection date and time are to be filled in when the specimen is drawn. For those sites with Computer access, follow the order entry procedure to generate specimen labels.

3. Perform venipuncture on the patient per protocol and label specimens. See procedure on Performance of the Venipuncture. If no computer labels are available, hand write patient information on tubes, including full name, date of birth, date and time of collection and initials of person drawing sample. All specimens are to be labeled in the presence of the patient. When the specimens are received in the laboratory a computer label will be generated. These computer labels contain all the above listed information plus an accession number (which is a unique identifier of the patient) and the tests to be performed.

4. All specimens being transported to the Laboratory will be recorded on a Transfer Log. If computer access is not available, a manual transfer log will be utilized at each site. This log is to contain the following information: Site location, Date/Time specimen was drawn, Patients' full name, Patient DOB, tests requested, practitioner ordering tests, date/time sent to the laboratory, Date and time received by the laboratory and date the report is received back from the laboratory(if provider is from the facility). This log will include all specimens being transported and will be signed by the courier at the time it is picked up for transport. Those sites that have Computer access will print a computer generated Transfer list which includes all of the above information.

5. Samples drawn in a serum separator tube are allowed to sit upright for a minimum of 30 minutes. They are then centrifuged for a minimum of 10 minutes. The samples are then stored in Ziploc biohazard bags at the proper temperature for each test until transported to the lab.

6. All physician order forms and a copy of the Transfer log are placed in the outside pocket on the biohazard bag containing the specimens being transported and forwarded to the Hospital Laboratory.

7. The hospital courier will pick up the specimens, sign off date, time and initials on the transfer log and transport them to the hospital specimen processing area following the transport policy.

PROCESSING and RETENTION OF SPECIMENS BY THE LABORATORY

The Lourdes Laboratory Test Directory now has a link on the main page of the Lourdes Intranet. This is found at the bottom of the right side of the page, click on the Laboratory Test Directory. In the gray box labeled Laboratory Test Directory, you may search for a test by typing the name in the Search box or by clicking on a letter in the alphabet to search for the desired test. This list contains tests for which the Clinical Laboratory has established test codes.

For sites that do not have access to the Lourdes intranet, this directory is available at Medstaff.lourdes.com

If either site is not available or you do not find the desired test in the directory, call the laboratory at 798-5806 for specimen requirements and processing. Testing can often be added to specimens already in the laboratory depending on specimen and test stability. Call the laboratory at 798-5216 for assistance in adding on testing.

TEST CANCELLATION

Requests to cancel a procedure will be granted if the procedure has not been set-up. No charge will be made in this case. If a procedure has been set up, a report and charge will be issued. No charge will be made for a procedure canceled by the laboratory due to an unacceptable or improper specimen.

MEDICAL NECESSITY

Effective June 1, 1989, the Health Care Financing Administration (HCFA) required that physicians submit an appropriate diagnosis code using the medical necessity code (ICD) for each procedure, service, or supply billed under Medicare Part B. Most insurance companies and Medicaid also use medical necessity (ICD) codes as a means of determining if diagnosis and treatment, as indicated by the CPT codes submitted, fit the illness or symptoms indicated by the medical necessity (ICD) code. Most medical necessity-based denials of payment are based on what the insurer believes is inappropriate use of a procedure or test for the reported diagnosis.
As cost containment pressures increase, accurate coding of both procedure codes (CPT) and diagnosis codes (ICD) is becoming essential for payment of most Medicare, Medicaid, and insurance claims.

Definitive medical necessity (ICD) codes should only be assigned and recorded in the medical record after a diagnosis is clearly determined. Terms such as Arule out≅, Aprobable≅, and Asuspected≅ should NOT be used since they cannot be coded as such and may be interpreted as a firm diagnosis by a third-party payer.