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: _____

Please return this completed form to the Credentialing Processing Center

REFLEX TESTING ACKNOWLEDGEMENT

PURPOSE: The purpose of this Reflex Testing acknowledgement is to ensure that our physicians understand when reflex tests will be performed and will be billed to Medicare.

POLICY: Oak Hill Hospital's Laboratory will automatically perform reflex tests according to the criteria in the attached list when all three of the following conditions are met, unless your order specifically states that you do not want the reflex test performed:

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

BILLING OF REFLEX TESTS: The hospital bills for medically necessary reflex tests according to the CPT code and Medicare fee schedule.

ACKNOWLEDGEMENT AND APPROVAL: By signing this acknowledgement, you acknowledge that you have reviewed the attachment and agree that, whenever the initial test ordered meets the reflex criteria, the corresponding reflex test will be performed, reported and billed.

If in the case of an individual patient, you consider the reflex test unnecessary, you must order the initial test without the reflex. With the exception to those tests required by law, you may order any test without the reflex option.

This acknowledgement may be terminated at any time with written notice to the Medical Staff Office.

Notification of any additions or modifications to reflex tests will be communicated via the Notification of Additions or Modifications for Relfex Testing form as they are approved by the Medical Executive Committee.

Physician Signature: _____ Date: _____

Physician's Name (please type or print): _____

Oak Hill Hospital

Policy/Procedure # TX037.736

RE: REFLEX TESTING		Department Approval:	Date:
		Administrative Approval:	Date:
Department: Nursing Administration		Medical Staff Approval:	Date:
Effective Date: January 7, 1994	Review Dates and Initials: May 4, 2001/July, 2003/ June,2005/ September,2006	Additional Approval:	Date:

Policies describing procedures/treatment are general guidelines to aid the professional in exercising judgement in rendering patient care.

Purpose

To provide follow-up testing (qualitative or quantitative) or crediting when certain screening tests are positive or elevated.

Reflex testing will be approved by the Medical staff on an annual basis before any reflex testing policy becomes effective.

Procedure

The following tests will be performed when the screening test is elevated or positive:

CHEMISTRY

- Thyroid screen -FT_4 reflexed if TSH <0.5 or >4.7. FT_3 reflexed if TSH <0.1 and FT_4 is normal.
- Total CPK > 60 u/L on females or > 90 u/L on males; the CKMB will automatically be performed and charged.

HEMATOLOGY

- If a differential is requested and the WBC is < 2.0 x 10^3 mg/dL; a buffy coat peripheral smear will be prepared, read and charged.
- If a differential is ordered, a manual differential will be performed in lieu of an automated differential; 1) if flagging reflexes a scan, and 2) if upon scanning approximately 200 cells microscopically any of the following are observed:
  1. NRBC's
  2. left shift (> 5% bands)

3. immature granulocytes
4. blasts
5. plasma cells
6. > 7% atypical lymphs
7. estimates of normal cells do not correlate with instrument data

COAGULATION

- A D-Dimer will be reflexed any time an FSP is greater than 12.
- A PFA-ADP will be reflexed with an abnormal PFA-EPI greater than 190 seconds.
- HIT AB Positive – Elisa confirmation.

URINALYSIS

- The urinalysis microscopic will be performed and charged if any of the following occur:
  1. the appearance is anything other than CLEAR
  2. the protein, nitrite, blood or leukocyte esterase are positive

MICROBIOLOGY

- A urine culture will be reflexed if the routine urinalysis results are WBC 's greater than 3.
- **Urine culture will be reflexed on all pediatric patients less than 12 years of age.**

- If any of the following are positive the tests indicated below will be performed and charged:
  1. RPR – MHA – TP
  2. HIV - Western Blot
  3. ANA EIA – ANA Pattern
  4. (+) Culture – Sensitivity
  5. HBSAG – confirmatory test
  6. Lyme Ab – Lyme Western Blot

BLOOD BANK

- If a direct antiglobulin is positive an elution shall be performed and charged.
- If the antibody screen is positive an antibody ID will be performed and charged.
- All units crossmatched on a patient shall have antigen typing performed and charged if the patient has demonstrated a clinically significant antibody either currently or in the past.
- A 2 unit crossmatch shall be performed and charged for any scheduled surgery patient who currently or in the past has demonstrated a clinically significant antibody.
- If platelet concentrates are requested the patient will be given the number of units based on his/her weight unless a specific number of units is requested as medically necessary.

HISTOLOGY/CYTOLOGY

- All special procedures will be performed upon the Pathologist's request upon initial review of the specimen.
- These tests have been approved by the Medical Staff to be performed without a written order when the screening test is positive or elevated.