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## D-DIMER, QUANTITATIVE

### Specimen Required:

- Quantity:** 1.0 mL  
**Type:** Light Blue (3.2% Sodium Citrate) Platelet Poor Plasma  
**Temperature:** Frozen (<-20C); Refrigerate LIMITED TIME ONLY - See Notes

**Test Frequency:** Daily

**Methodology:** Immunoturbidimetric  
**Performed by:** Avera LabNet

### Collection Notes:

Blue top tubes must be filled to capacity to assure appropriate anticoagulant ratio.

Refer to "Special Collection Instructions for Coagulation Consultation" for Platelet Poor Plasma preparation instructions.

Avoid hemolysis.

TEMPERATURE: Freeze specimen if transport/storage will exceed 4 hours.  
Always use plastic transport vial for specimen preparation..

Frozen specimens for coagulation testing should be submitted as an individual specimen. DO NOT submit multiple test specimens in one tube.

Avoid tissue fluid contamination by drawing the Sodium Citrate tube after a primary tube has been collected.

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## GLUCOSE TOLERANCE, 2-HOUR -NON-PREGNANT ADULT

### Specimen Required:

- Quantity:** 0.5 mL  
**Type:** Green (Lithium Heparin) Plasma or Serum (red, gold or equivalent)  
**Temperature:** Refrigerate (2 - 8 C)

**Test Frequency:** Mon-Fri

**Methodology:** Spectrophotometric  
**Performed by:** Avera LabNet

### Collection Notes:

Gray (Sodium Fluoride) Plasma acceptable.

#### Patient Preparation:

1. Discontinue, when possible, medications known to affect glucose tolerance.
2. Patient should fast for at least 8 hours prior to test, should remain inactive, & receive nothing by mouth (including tobacco) during test period. A small sip of water or ice is permissible. Reasons for invalid results include emesis & conditions which delay stomach emptying.

#### Performance Summary:

1. Draw fasting glucose specimen
2. Give patient 75 g. glucose drink; begin timing to determine post-ingestion specimen collection times; glucose drink should be consumed within 5 minutes.
3. Draw glucose 2-hour post-ingestion.

- Centrifuge & separate serum from plasma asap after specimen is drawn.
- Each glucose specimen requires 0.5 ML plasma to be submitted for testing.
- Label each specimen transport tube specifically to identify what specimen it contains [fasting, 2 hour].
- Submit all test specimens with 1 requisition.

Three ways to diagnose diabetes are possible & each, in the absence of unequivocal hyperglycemia, must be confirmed on subsequent day by any 1 of the 3 methods listed below. Use of the hemoglobin A1c (A1C) for the diagnosis of diabetes is not recommended at this time.

#### Criteria for Diagnosis of Diabetes Mellitus

1. Symptoms of diabetes plus casual plasma glucose concentration  $\geq 200$  mg/dl (11.1 mmol/l). Casual is defined as any time of day since last meal. Classic symptoms include polyuria, polydipsia, & unexplained weight loss.
2. FPG  $\geq 126$  mg/dl (7.0 mmol/l). Fasting is no caloric intake for at least 8 hours.
3. 2-h postload glucose  $\geq 200$  mg/dl (11.1 mmol/l) during an OGTT. Test should be performed as described by WHO, using a glucose load containing the equivalent of 75 g anhydrous glucose dissolved in water.

In absence of unequivocal hyperglycemia, these criteria by repeat testing on a different day. The third measure (OGTT) is not recommended for routine clinical use.

Reference - American Diabetes Association.

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**PSA (PROSTATIC SPECIFIC ANTIGEN)**

**MEDICARE COVERAGE NOTICE:**

Test covered under Medical Review Policy -Medical necessity documentation/evaluation and appropriate waiver [ABN] use required.

**Specimen Required:**

- Quantity:** 1.0 mL
- Type:** Serum (red, gold, or equivalent)
- Temperature:** Refrigerate (2 - 8 C)

**Test Frequency:** Daily

**Methodology:** Microparticle Enzyme Immunoassay

**Performed by:** Avera LabNet

**Collection Notes:**

TEMPERATURE: Freeze specimen if transport/storage will exceed 5 days.

Separate specimens must be submitted when multiple tests are ordered.

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**PSA, SCREEN (PROSTATIC SPECIFIC ANTIGEN SCREEN)**

**MEDICARE COVERAGE NOTICE:**

Test covered under Medical Review Policy -Medical necessity documentation/evaluation and appropriate waiver [ABN] use required.

*Medical Necessity Comment:*

*Medicare will cover [on or after 1/1/00] prostate cancer screening tests for early detection of prostate cancer under the Balanced Budget Act of 1997.*

*Refer to Collection Note Section for payment requirements under this program.*

**Specimen Required:**

- Quantity:** 1.0 mL
- Type:** Serum (red, gold, or equivalent)
- Temperature:** Refrigerate (2 - 8 C)

**Test Frequency:** Daily

**Methodology:** Microparticle Enzyme Immunoassay

**Performed by:** Avera LabNet

**Collection Notes:**

TEMPERATURE: Freeze specimen if storage/transport will exceed 5 days.

PSA, Screen should be the test of choice when testing is desired for Medicare beneficiary as outlined by the Prostate Cancer Screening Program under the Balanced Budget Act of 1997.

Screening test programs are services ordered to detect an undiagnosed disease where early detection may prevent harm, where the patient has no signs, symptoms, or history of the disease.

Prostate Cancer Screening Tests and Procedures will be covered under the Medicare program if the following requirements are met:

- Performed on a male Medicare beneficiary age 50 or older;
- Ordered by the beneficiary's attending physician or qualified physician assistant, nurse practitioner, clinical nurse specialist, or certified nurse midwife
- Performed at a frequency no greater than once every 12 months [at least 11 months must have passed following the month in which the last Medicare-covered PSA was performed].
- Documentation of the time elapsed since the last Medicare-covered PSA must also be documented in the medical record.