

# EPIC Downtime Lab Orders



## EPIC Downtime Procedure for Lab Orders

In the event that the EPIC application is failing to respond, follow this procedure for ordering labs on downtime requisitions. This will ensure orders are able to be entered without issues and results will still be available in a timely manner.

Procedure includes:

- General Lab Downtime Requisition Instructions
- Anatomic Pathology Downtime Requisition Instructions

Locate your Green Gen Lab downtime requisitions. If unable to locate these requisitions, print the Green Gen Lab requisition from the Lab website (Laboratory Service Forms page). See below.

**CUMC-Bergan Mercy Laboratory**  
7500 Mercy Rd  
Omaha, NE 68124  
Phone: (402) 717-5227  
Fax: (402) 717-5252

Client Code: \_\_\_\_\_  
Account Name: \_\_\_\_\_  
Account Address: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Fax: \_\_\_\_\_

Stat  Call  Fax  
(Both name and number required)

Name: \_\_\_\_\_  
Number: \_\_\_\_\_  
CSN: \_\_\_\_\_  
MRN: \_\_\_\_\_

**PATIENT INFORMATION REQUIRED FOR TESTING**

(Legal Name) Last	First	MI	DOB	SSN	<input type="checkbox"/> Male <input type="checkbox"/> Female	Patient Phone Number
Patient ID	Physician #1 First & Last Name	Physician #2 First & Last Name	Date Collected	Time Collected	By	

**REQUIRED:** Indicate Appropriate ICD10 Numeric Code(s) in Box(es) Below

ICD10 1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_ 4. \_\_\_\_\_

**CHECK ONE:** (Must complete ALL information below or attach demographic AND insurance sheet.)

Bill to Office Account  
 Skilled Care - Bill to Office Account  
 Bill to Patient / Insurance

When tests printed in red are ordered on Medicare patients they are likely to be denied by Medicare unless medical necessity is established. Consult guide for complete list of NCD/LCD tests and have patient sign ABN waiver, if appropriate.

ABN waiver signed and attached?  Yes  No

Responsible Party:	Relationship to Policy Holder <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other: _____	Primary Insurance Name		Secondary Insurance Name	
		Address: _____	Address: _____	Address: _____	Address: _____
Name: _____		City, State, Zip: _____		City, State, Zip: _____	
Address: _____		Policy Number: _____		Policy Number: _____	
City, State, Zip: _____		Group Number: _____		Group Number: _____	
Phone Number of Guarantor: _____		Group Name: _____		Group Name: _____	

Test Code	Approved Name	Test Code	Chemistry	Test Code	Hematology	Test Code	OB/GYN
8004	BASIC METABOLIC PANEL	P 82721	DIRECT LDL	S 82027	CBC NO DIFF	L 80082	OBSTETRIC PANEL IP 19 SL
8005	COMP MET PANEL	P 82720	RETRIDOL	S 82028	CBC W/ DIFF	L 80081	OBSTETRIC PANEL W/ HIV IP 19 SL
8006	ELECTROLYTE PANEL	P 82726	PERITRN	S 82040	PT W/ INR (GSD)	S 80084	SBO GROUP AND RH L
8007	HEPATIC FUNCTION PANEL	P 82728	COLIC LID (POLITE)	S 82030	DIFF WBC	S 80085	UNITED SCREEN L
8008	RENAL FUNCTION PANEL	P 82701	PSA	S 82042	RETICULOCYTE	L 80086	RUBCOLL IGA S
8009	LIPID PANEL W/ D LDL REFLEX	P 82847	GLUCOSE RANDOM OR Fasting	S 820	SED RATE (SAR)	L 02	CYTIC PEROXID (read info sheet) L
8012	LIPID PANEL W/ D LDL REFLEX	P 82848	SPY GLUCOSE CHALLENGE 1 HR (9 AM 1HR POST)	S 82019	HEMOGLOBIN	L 011D	QUID SCREEN (read info sheet) S
8024	SCHEMATIC PANEL	P 82715	SPY GLUCOSE TOLERANCE 2 HR (75GM) (FAST, 1HR, 2HR)	S 82020	HEMATOCRIT	S 80087	MICROBIOLOGY
8043	TSH w/ DERIVATION	S 82715	SPY GLUCOSE TOLERANCE 2 HR (100GM) (FAST, 1HR, 2HR, 2HR POST)	S 82029	PROTEIN C (FUNCTIONAL)	S 8202	URE CULT SITE
8048	PSA TS	S 8251U	SPY GLUCOSE TOLERANCE 3 HR (100GM) (FAST, 1HR, 2HR, 3HR POST)	S 82030	PROTEIN C (FUNCTIONAL)	S 8202	BLOOD CULTURE
8049	TS (TSH) THYROID	S 8251U	SPY GLUCOSE TOLERANCE 3 HR (100GM) (FAST, 1HR, 2HR, 3HR POST)	S 82030	ANTI THROMBIN II (FUNCTIONAL)	S 8202	BODY FLUID CULT SITE
8050	TS (TSH) THYROID	S 8251U	SPY GLUCOSE TOLERANCE 3 HR (100GM) (FAST, 1HR, 2HR, 3HR POST)	S 82030	IMMUNOLOGY TESTS	S 8202	SWING CULT SITE
8051	TS TS	S 8251U	SPY GLUCOSE TOLERANCE 3 HR (100GM) (FAST, 1HR, 2HR, 3HR POST)	S 82030	INR (INR SCREEN NO REFLEX)	S 8202	FLUID DERIV CULT (HEP, HEM, SKIN)
8052	TOTAL TS	S 8251U	SPY GLUCOSE TOLERANCE 3 HR (100GM) (FAST, 1HR, 2HR, 3HR POST)	S 82030	HIS	S 8202	GENITAL CULT
8053	TPD ANTIBODY	S 82877	SPY	S 82030	HEP ATTS 2 & ANTIBODY (IGM)	S 8202	MRAI SCREEN SITE
8054	THYROGLOBULIN ANTIBODY	S 82716	HDL	S 82030	HEP & SURF IG (MULTI)	S 8202	RAPID STREP & SOX THROUT
8055	Chemistry	S 82029	HEMOGLOBIN A1C	L 8202	HEP ATTS 2 & CORE IGA IGM	S 8202	STREP & CULT
8056	ALBUMIN	P 82000	HEMOGLOBIN A1C	S 82027	HEP ATTS 2 & CORE IGA IGM	S 8202	STREP & CULT
8057	ALK PHOSPHATASE	P 82540	IRON	S 82027	HEP ATTS 2 & CORE IGA IGM	S 8202	ROUTINE CULT (WOUND) SITE
8058	ALT (SGPT)	P 82540	IRON, SER & IRON SAT	S 82027	HEP ATTS 2 & CORE IGA IGM	S 8202	UROLOGIC CULT
8059	AMYLASE	P 82540	LEAD (WHOLE BLOOD)	S 82027	HEP ATTS 2 & CORE IGA IGM	S 8202	TRACHEA CULT SITE
8060	AST (SGOT)	P 82540	LEAD (WHOLE BLOOD)	S 82027	HEP ATTS 2 & CORE IGA IGM	S 8202	URINE CULT
8061	B12 VITAMIN	P 82002	LH	S 82027	HEP ATTS 2 & CORE IGA IGM	S 8202	VAG, GRP & STREP CULT
8062	BETA LING (HIV) (DOB) (DOB)	S 82001	LH	S 82027	HEP ATTS 2 & CORE IGA IGM	S 8202	VAG, GRP & STREP CULT

1. Ensure that your Clinic Name and Location and Clinic Code are correct in the header.

2-03-25

- a. **A Clinic Code is present on the preprinted Green Gen Lab downtime requisitions.** Each clinic code is tied to information about the clinic. The clinic code drives billing, who is contacted if there are specimen problems, who is contacted if there are critical results.
- b. If you print the green Gen Lab Requisition from the website, you **MUST** write your clinic name and clinic code on the header of the requisition. If you do not know your clinic code, contact Lab at 402-717-5227.
2. **Call/Fax:** If lab results are to be called or faxed, mark the appropriate box at the top right corner, name of fax recipient, and secure fax number.
3. The top half of the General Reference lab requisition must be filled out completely.
  - a. **Patient's Legal Name: Required.** Print patient's last name, first name and middle initial.
  - b. **Patient's Social Security Number:** Necessary, if available, for correct identification.
  - c. **Patient's Date of Birth: Required.** Acceptable format is Month, Day, Year.
  - d. **Patient's Sex: Required.** Male or Female; checkmark appropriate box
  - e. **Patient's Phone #:** Phone number will appear on the patient's lab report to aid the physician contacting the patient.
  - f. **Patient ID:** This field is for MRN.
  - g. **Physician #1: Required.** Print ordering physician's First and Last name
  - h. **Physician #2:** For copy to another provider, print provider's First and Last name.
  - i. **Date Collected: Required.** Acceptable format is Month, Day, Year
  - j. **Time Collected: Required.** Use Military time (ie 0900, 1400) or conventional time (ie 9:00am/2 pm)
  - k. **Collected By: Required.** Print first initial and full last name (ie J. Doe)
  - l. **ICD10 CODE Diagnosis: Required.** Acceptable format is alphanumeric coded diagnosis. Narrative or descriptive codes will not be accepted.
  - m. **Bill to: Required.** Bill Type must be identified. Mark the appropriate box: Bill to Office Account or Bill to Patient/Insurance. If Bill to Patient/Insurance, insurance information **MUST** be filled out on form or a demographic sheet attached.
    - i. A copy of the front and back of the insurance card is **required**.
  - n. **Insurance Information Required**
    - i. Guarantor/Responsible Party (if other than patient): (Insured party's information)  
*SSN# of Guarantor: (Insured party's SSN)*  
Address, City, State, Zip
    - ii. PRIMARY Insurance: Name of Insurance Company  
Policy #:  
Group #:  
Address of Payer

- iii. SECONDARY Insurance: Name of Insurance Company  
Policy #:  
Group #:  
Address of Payer
- 4. The bottom half of the General Reference Lab Requisition:
  - a. **Medicare Limited Coverage Tests are printed in RED.** Refer to NCD/LCD Covered Codes available online on Lab website for diagnosis codes that meet compliance. If none of the codes are acceptable, an ABN (Advanced Beneficiary Notice) waiver must accompany the requisition. The ABN must be signed by the patient PRIOR to the service being performed. Please acknowledge whether a waiver has been signed and attached to the requisition.
    - i. Keep a copy of the ABN at the clinic to scan into EPIC.
  - b. **Tests:** Listed are the most common tests with the CPT codes for CHI Health Lab. The AMA (American Medical Association) approved panels are listed first on the left hand side of the requisition. All other tests are listed under the subtopics of THYROID TESTING, CHEMISTRY, DRUG LEVELS, HEMATOLOGY, IMMUNOLOGY TESTS, URINE TESTING, OB/GYN, AND MICROBIOLOGY TESTING.
  - c. **Marking Tests:** Mark the box to the left of the test name and keep within the boundary of the box. Testing could be delayed if clarification is needed for testing ordered.
  - d. **Tube Code:** On the right hand side of the test box, across from the test name the tube type is indicated with a letter. See Key explaining abbreviations at the bottom of the requisition.
  - e. **Additional Information:** When appropriate, complete any additional prompts for information. Examples are drug level dosage, total urine volumes, patient height and weight with appropriate units, and antibiotic information.
  - f. **Unlisted Tests:** Use the blank space at the bottom right under Additional Tests to write in any testing requested that is not listed. Provide a complete description of the requested test. No Abbreviations. Utilize online Lab test directory for correct name.
- 5. **Online Lab User's Guide:** Refer to the web page [www.CHIhealth.com/services/laboratory](http://www.CHIhealth.com/services/laboratory) for instructions on proper handling of specimens including tube types, specimen processing, "order of draw" and transport temperature.
- 6. **Specimen Labeling:** All Specimens are **required** to be labeled with: Patient's Last Name, Patient's First Name, Date of Birth, Collection Date and Time, and initials of collector.
  - a. Always label specimens in the presence of the patient.

- b. Bar-coded labels will not print if EPIC is unable to send orders to Cerner (lab IT system).
  - c. If submitting any molecular or microbiology specimens, include the source of the specimen.
7. Make a copy of the lab requisition form.
- a. Send the original sheet with the specimen in the biohazard bag.
  - b. **Keep the copy for your records and to follow-up on results.**
    - i. If EPIC is down, results may not go back into the patient's chart.
    - ii. Track the results by using the orders on your copy sheets.
    - iii. Call the Lab if there are outstanding results.

# EPIC Downtime Lab Orders



Locate your pink anatomic pathology downtime requisitions or print off the Anatomical Pathology Requisition (APR) from the lab website (Laboratory Service Forms page) for submitting any biopsies, tissues, pap smears, or non-gyn cytology during downtime.

<p>CUMC-Bergan Mercy Laboratory 7500 Mercy Rd Omaha, NE 68124 Phone: (402) 717-5227 Fax: (402) 717-5252</p>		Client Code: _____ Clinic: _____ Address: _____ Address Line2: _____ PHONE: _____ FAX: _____	<b>LAB USE ONLY</b> Date Received: _____ Number of Slides: _____ Accession Number: _____ Accession Number: _____ Account Number: _____ SMS Admit Number: _____		
PATIENT DEMOGRAPHIC AND INSURANCE INFORMATION REQUIRED FOR ALL TESTING					
(Legal Name) Last	First	MI	DOB	SSN	<input type="checkbox"/> Male <input type="checkbox"/> Female
_____	_____	_____	_____	_____	Phone Number _____
Patient ID	Physician #1 First & Last Name		Physician #2 First & Last Name		Date Collected _____
_____	_____		_____		Time Collected _____
REQUIRED: Indicate Appropriate ICD10 Numeric Code(s) in Box(es) Below					
ICD10	1. _____	2. _____	3. _____		
<b>CHECK ONE:</b> <input type="checkbox"/> Bill to Office Account <input type="checkbox"/> Bill to Patient / Insurance (MUST complete information below or attach registration sheet for ALL patients.)  MEDIPA \$\$ AUTHORIZATION NUMBER _____					
Numeric code must be given for all PAP testing to be billed to the patient or patient's insurance. If information is not complete, the form and specimen will be returned for completion prior to testing.					
<input type="checkbox"/> SCREENING PAP TEST No signs or symptoms of disease. Strictly preventive in nature. Medicare Patients: See waiver section below and sign as appropriate.					
<input type="checkbox"/> DIAGNOSTIC PAP TEST There are (or have been) signs or symptoms of disease. Appropriate ICD10 numeric code is written above.					
Guarantor / Responsible Party		Primary Insurance		Secondary Insurance Name	
_____		_____		_____	
Phone Number of Guarantor		Policy Number		Policy Number	
_____		_____		_____	
Address		Group Number		Group Number	
_____		_____		_____	
City, State, Zip		Address of Payer		Address of Payer	
_____		_____		_____	
GYN (PAP) CYTOLOGY			NON-GYN CYTOLOGY / FLUID		
SOURCE OF SPECIMEN		SPECIMEN SUBMITTED		SOURCE OF SPECIMEN	
<input type="checkbox"/> Cervical / Endocervical <input type="checkbox"/> Vaginal		<input type="checkbox"/> Smear Slide (Label slide with patient name and DOB in pencil.) <input type="checkbox"/> Liquid-Based PAP Test (Label container with patient name and DOB.)		<input type="checkbox"/> Sputum <input type="checkbox"/> Gastric <input type="checkbox"/> Esophageal <input type="checkbox"/> Bronch-Wash _____ <input type="checkbox"/> Breast Fluid R or L <input type="checkbox"/> Bronch-Brush _____ <input type="checkbox"/> CSF <input type="checkbox"/> Bal _____ <input type="checkbox"/> Fine Needle Aspiration <input type="checkbox"/> Urine	
Clinical Data: LMP: Date: _____ <input type="checkbox"/> Biopsy also sent <input type="checkbox"/> Menopause <input type="checkbox"/> Colpo <input type="checkbox"/> Chemo					

1. Ensure that your **Clinic Name and Location and Clinic Code** are correct in the header.
  - a. **A Clinic Code is present on the preprinted Pink Anatomic Pathology Lab downtime requisitions.** Each clinic code is tied to information about the clinic. The clinic code drives billing, who is contacted if there are specimen problems, who is contacted if there are critical results.
  - b. If you print the pink Anatomical Pathology Lab Requisition from the website, you **MUST** write your clinic name and clinic code on the header of the requisition. If you do not know your clinic code, contact Lab at 402-717-5227.

2. The top half of the Anatomic Path lab requisition must be filled out completely.
  - a. **Patient's Legal Name:** **Required.** Print patient's last name, first name and middle initial.
  - b. **Patient's Social Security Number:** Necessary, if available, for correct identification.
  - c. **Patient's Date of Birth:** **Required.** Acceptable format is Month, Date, Year.
  - d. **Patient's Sex:** **Required.** Male or Female; checkmark appropriate box
  - e. **Patient's Phone #:** Phone number will appear on the patient's lab report to aid the physician contacting the patient.
  - f. **Patient ID:** This field is for MRN.
  - g. **Physician #1:** **Required.** Print ordering physician's First and Last name
  - h. **Physician #2:** For copy to another provider, print provider's First and Last name.
  - i. **Date Collected:** **Required.** Acceptable format is Month, Day, Year
  - j. **Time Collected:** **Required.** Use Military time (ie 0900, 1400) or conventional time (ie 9:00am/2 pm)
  - k. **Collected By:** **Required.** Print first initial and full last name (ie J Doe)
  - l. **ICD10 CODE Diagnosis:** **Required.** Acceptable format is alphanumeric coded diagnosis. Narrative or descriptive codes will not be accepted. Professional fees associated with anatomic pathology specimens require diagnosis codes.
  - m. **Bill to:** **Required.** Bill Type must be identified. Mark the appropriate box: Bill to Office Account or Bill to Patient/Insurance.
    - i. A copy of the front and back of the insurance card is **required.**
  - n. **Pathology Bill:** Insurance information **MUST** be filled out on all forms or a demographic sheet attached even if marked Bill to Office. CHI Pathology will bill professional fees to patient's insurance for part of the histology testing. Lab will bill technical fees to bill type marked.
  - o. **Insurance Information Required**

Guarantor/Responsible Party (of other than patient): (Insured party's information)  
SSN# of Guarantor: (Insured party's SSN)  
Address, City, State, Zip

PRIMARY Insurance: Name of Insurance Company  
Policy #:  
Group #:  
Address of Payer

SECONDARY Insurance: Name of Insurance Company  
Policy #:  
Group #:  
Address of Payer

3. **Pap:** Mark one box; select “Screening PAP test” for those PAPs that have no diagnostic reason except screening. Follow Medicare/Medicaid rules for an ABN if pap is performed before Medicare frequency guidelines. Select “Diagnostic PAP Test” for all PAPs that have signs or symptoms of disease.
4. **The bottom half of the Anatomic Pathology Lab requisition is separated into three sections:** Gynecological Tests, Non-Gyn Cytology Fluids, and Histology/Tissue Specimens
5. **Gynecological tests: Fill out for Pap GYN Cytology**
  - a. **Required.** Indicate the source of the specimen. (Cervical/Endocervical or Vaginal)
  - b. **Required.** Check whether the specimen is a smeared slide or a ThinPrep fluid.
  - c. **Required.** Provide the date of the patient’s last menstrual period.
  - d. Provide as much clinical information as possible.
  - e. Record the date and diagnosis of the patient’s last Pap smear.
  - f. Include any other pertinent clinical information in the comments area.
  - g. Gonorrhea and Chlamydia boxes are available for Molecular testing on ThinPrep sample.
  - h. HPV testing can be ordered regardless if pap is normal. ASCUS will automatically reflex to have HPV testing done.
6. **Non-Gyn Cytology Fluids**
  - a. **Required.** Select the appropriate specimen source.
  - b. If Fine Needle is selected, specimen site must be included.
  - c. Designate whether the patient is on radiation therapy.
  - d. Include any pertinent clinical history.
7. **Histology/Tissue Specimens**
  - a. **Required.** Designate the source of the specimen and anatomic site/laterality. If more than one tissue is submitted, use the lines provided to indicate source and site in each numbered container on each corresponding line.
  - b. Record the pre-op diagnosis.
  - c. Record the patient’s clinical history.
  - d. Record the post-op diagnosis if applicable.
  - c. **Medicare Limited Coverage Test:** Mark whether ABN waiver is accompanying specimen and requisition. Refer to your NCD/LCD Covered Codes available online on Lab website for diagnosis codes that meet compliance. If none of the codes are acceptable, an ABN (Advanced Beneficiary Notice) waiver must accompany the requisition. The ABN must be signed by the patient PRIOR to the collection of the specimen. Please acknowledge whether a waiver has been signed and attached to the requisition.



- i. Keep a copy of the ABN at the clinic to scan into EPIC.
- 8. **Online Lab User's Guide:** Refer to the web page [www.CHIhealth.com/services/laboratory](http://www.CHIhealth.com/services/laboratory) for instructions on proper handling of specimens including transport temperature, ratios of formalin to tissue, and other information.
- 9. **Specimen Labeling:** All Specimens are **required** to be labeled with: Patient's Last Name, Patient's First Name, Date of Birth, Collection Date and Time, and initials of collector, AND site and source of specimen.
  - a. Always label specimens in the presence of the patient.
  - b. Bar-coded labels will not print if EPIC is unable to send orders to Cerner (lab IT system).
  - c. The primary container needs to be labeled not the lids.
- 10. Make a copy of the lab requisition form.
  - a. Send the original sheet with the specimen in the biohazard bag.
  - b. **Keep the copy for your records and to follow-up on results.**
    - i. If EPIC is down, results may not go back into the patient's chart.
    - ii. Track the results by using the orders on your copy sheets.
    - iii. Call the Lab if there are outstanding results.