

TEST OBSOLETE NOTIFICATION

NOTIFICATION DATE: October 2, 2009

EFFECTIVE DATE: November 4, 2009

**MITOCHONDRIAL RESPIRATORY CHAIN COMPLEXES (RCC)
PROFILE, FIBROBLAST CULTURES
#81053**

EXPLANATION: Due to assay issues, Mayo Medical Laboratories will obsolete this test.

NOTE: A referral option is available to Baylor

ALTERNATE TEST: #91844, Electron Transport Chain Enzymes, Fibroblast (Baylor test code 3210)

NOTE: Because of the complex nature of test results for #91844, an interpretive report will be faxed under separate cover. The electronic report will include the following comment:

"Testing is complete. The final copy has been faxed to the referring laboratory."

SPECIMEN REQUIREMENTS: 2 - T25 flasks from skin biopsy, filled to neck with culture media. Maintain sterility and forward promptly at ambient temperature.

Prior to referral to Baylor, fibroblast cultures will be evaluated at Mayo Medical Laboratories, and the following tests may be ordered at an additional charge:

\$371.10 for #8482 "Fibroblast Culture"

\$194.30 for #88832 "Cryopreservation for Biochemical Studies"

CPT CODES: 84311 x6
82657 x6
88233
83912
83890
88240

FEE: \$ 955.00

ANALYTIC TIME: 6 weeks, depending on cell growth

QUESTIONS: Contact your Mayo Medical Laboratories' Regional Manager
Sara Siewert, Mayo Medical Laboratories' Technologist Support
Telephone: 800-533-1710



TEST DEFINITION

10/2/2009

Code Name

91844 Electron Transport Chain Enzymes

**** End of Name to order code Report ****

MML MML Test setup information

ORDER CODE	EFF DATE	TC	TITLE	Checking Normals	Print normals (# coded)	Perform Site *
91844	10/1/2009		Electron Transport Chain Enzymes			
			UNIT CODE ALWAYS MESSAGE - [ZBHMITO]			
			Test Performed by: Baylor Mitochondrial Diagnostic Laboratory			
			Attn: Mitochondrial Laboratory			
			One Baylor Plaza			
			NAB 2015			
			Houston, TX 77021-2024			
			Transport temp : Ambient\Frozen NO\Refrig NO			
			91844 Electron Transport Chain Enzymes			

*Performing Site Legend

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*** End of Report ***

MML Messages used as normals

CODE TEXT

Total of 0 normals codes

*** End of Report ***

1-800-533-1710

PATIENT NAME TESTING, 91844		PATIENT NUMBER		AGE 45	SEX F	ACCESSION # W2791157
ORDERING PHYSICIAN		CLIENT ORDER #				ACCOUNT # LIAISONS
COLLECTION 10/01/09 01:56 P DATE TIME	RECEIVED 10/01/09 01:56 P DATE TIME	REPORT PRINTED 10/02/09 09:48 A DATE TIME		SPECIMEN INFORMATION DATE OF BIRTH:		
Test Client Attn: Mayo Liaisons 200 First Street SW Rochester, MN 55905 507-284-8202						

TEST REQUESTED	HI	LO	REF RANGE	PERFORM SITE *
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Electron Transport Chain Enzymes
**Electron Transport
Chain Enzymes**

REF

Testing is complete. Final copy has been faxed to the referring laboratory.

Test Performed by: Baylor Mitochondrial Diagnostic Laboratory
 Attn: Mitochondrial Laboratory
 One Baylor Plaza
 NAB 2015
 Houston, TX 77021-2024

* PERFORMING SITE

PATIENT NAME TESTING, 91844	ORDER STATUS Final	COLLECTION DATE AND TIME 10/01/09 01:56 P
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BCM-MEDICAL GENETICS LABORATORIES

PATIENT NAME:

LAST NAME

FIRST NAME

MI

MITOCHONDRIAL DNA (mtDNA) DIAGNOSTICS CHECK LIST

Please indicate whether each feature is: PRESENT (Y); ABSENT (N); NOT KNOWN/TESTED (?); or IF THERE IS A FAMILY HISTORY (FHx).

If more detailed clinical information is required, please provide the name, e-mail address, and phone number of the contact person below.

CENTRAL NERVOUS SYSTEM

101	dd	Developmental Delay/MR	Y	N	?	FHx
102	ht	Hypotonia/Floppy Baby	Y	N	?	FHx
103	au	Autistic Features	Y	N	?	FHx
104	enc	Dementia/Encephalopathy	Y	N	?	FHx
105	ha	Headaches/Migraines	Y	N	?	FHx
106	stk	Stroke, Ischemic Episodes	Y	N	?	FHx
107	atx	Ataxia	Y	N	?	FHx
108	cm	Episodic Coma	Y	N	?	FHx
109	sz	Seizures	Y	N	?	FHx
110	mc	Myoclonus or Myoclonic Seizures	Y	N	?	FHx
111	pi	Perinatal Insult	Y	N	?	FHx
112	ps	Pyramidal Signs	Y	N	?	FHx
113	hp	Hemiparesis	Y	N	?	FHx
114	isz	Intractable Seizure, Refractory	Y	N	?	FHx
115	spas	Spasticity	Y	N	?	FHx
116	dyst	Dystonia	Y	N	?	FHx
117	cho	Chorea	Y	N	?	FHx

NEUROMUSCULAR

201	pn	Peripheral Neuropathy	Y	N	?	FHx
202	exi	Exercise Intolerance	Y	N	?	FHx
203	mw	Muscle Weakness/DMD-like	Y	N	?	FHx
204	cr	Muscle Cramps after Exercise	Y	N	?	FHx
205	fat	Easy Fatigability	Y	N	?	FHx
206	cmyo	Cardiomyopathy	Y	N	?	FHx
207	hb	Heart Block	Y	N	?	FHx
208	ar	Arrhythmia	Y	N	?	FHx
209	op	Ophthalmoparesis, CPEO	Y	N	?	FHx
210	emg	Abnormal EMG/NCV	Y	N	?	FHx
211	pto	Ptosis	Y	N	?	FHx

VISCERAL

301	gir	Gastrointestinal Reflux	Y	N	?	FHx
302	dge	Delayed Gastric Emptying	Y	N	?	FHx
303	pan	Pancreatitis	Y	N	?	FHx
304	dia	Diarrhea	Y	N	?	FHx
305	cst	Constipation	Y	N	?	FHx
306	cv	Cyclic Vomiting	Y	N	?	FHx
307	pob	Pseudoobstruction	Y	N	?	FHx
308	hpf	Hepatic Failure	Y	N	?	FHx
309	eta	Elevated Transaminases	Y	N	?	FHx
310	rtd	Renal Tubular Disease	Y	N	?	FHx
311	ap	Apnea/Hypoventilation	Y	N	?	FHx
312	rsf	Respiratory Deficiency/Failure	Y	N	?	FHx

METABOLITES/METOBOLIC

401	kto	Ketosis	Y	N	?	FHx
402	dca	Dicarboxylic Aciduria	Y	N	?	FHx
403	la	Lactic Acidosis	Y	N	?	FHx
404	csfl	High CSF Lactate	Y	N	?	FHx
405	oatgg	Organic Aciduria, Tiglyglycine	Y	N	?	FHx
406	lpc	Low Plasma Carnitine	Y	N	?	FHx
407	cpk	CPK Abnormalities	Y	N	?	FHx
408	pyr	Elevated Pyruvate	Y	N	?	FHx
409	csfp	Hi CSF Protein	Y	N	?	FHx
410	ala	Elevated Alanine	Y	N	?	FHx
412	3mg	3-Methylglutaconic	Y	N	?	FHx

SENSORY

501	rp	Retinitis Pigmentosa	Y	N	?	FHx
502	opa	Optic Atrophy	Y	N	?	FHx
503	cat	Cataract	Y	N	?	FHx
504	hl	Sensorineural Hearing Loss	Y	N	?	FHx
505	trv	Tortuous Retinal Vessels	Y	N	?	FHx

ENDOCRINE

601	db	Diabetes	Y	N	?	FHx
602	pd	Exocrine/Pancreatic Deficiency	Y	N	?	FHx
603	gf	Gonadal Failure	Y	N	?	FHx
604	hth	Hypothyroidism	Y	N	?	FHx
605	hpt	Hypoparathyroidism	Y	N	?	FHx
606	adr	Hypo/Hyper-adrenal Function	Y	N	?	FHx
607	ss	Short Statue	Y	N	?	FHx

OTHER CLINICAL

701	ftt	Failure to Thrive	Y	N	?	FHx
702	mce	Microcephaly	Y	N	?	FHx
703	sids	SIDS/Unexplained Death	Y	N	?	FHx
704	ca	Congenital Anomalies	Y	N	?	FHx
705	dys	Dysmorphic Features	Y	N	?	FHx
706	id	Immunodeficiency	Y	N	?	FHx
707	ma	Macrocytic Anemia	Y	N	?	FHx
708	pcbm	Pancytopenia/Bone Marrow Failure	Y	N	?	FHx
710	np	Neutropenia	Y	N	?	FHx

HAIR/SKIN FINDINGS

711	rash	Rashes w/Hypopigmentation	Y	N	?	FHx
712	htii	Hypertrichosis	Y	N	?	FHx
713	alp	Alopecia	Y	N	?	FHx
714	ac	Acrocyanosis	Y	N	?	FHx
001	mut	Mutation	Y	N	?	FHx
003	mi	Evidence of Maternal Inheritance	Y	N	?	FHx

ELECTROPHYSIOLOGY

801	baers	Abnormal BAERS	Y	N	?	FHx
802	vers	Abnormal VERS	Y	N	?	FHx
803	eeg	Abnormal EEG	Y	N	?	FHx

IMAGING/OTHER STUDIES

804	bg	Increased Signal Basal Ganglia	Y	N	?	FHx
805	dmy	Delay Myelination	Y	N	?	FHx
806	cea	Cerebellar Atrophy	Y	N	?	FHx
807	pstk	Posterior Stroke	Y	N	?	FHx
808	leuk	Leukodystrophy	Y	N	?	FHx
809	mrsf	MRS/Lactate Peak	Y	N	?	FHx
810	mri	Abnormal MRI	Y	N	?	FHx

MUSCLE BIOPSY

901	his	Abnormal Histology	Y	N	?	FHx
902	em	Abnormal Ultrastructure (EM)	Y	N	?	FHx
903	enz	Abnormal Respiratory Enzymes	Y	N	?	FHx
904	prol	Large Mitochondrial/Proliferation	Y	N	?	FHx
905	cox	COX Deficiency	Y	N	?	FHx
906	rrf	Ragged Red Fibers	Y	N	?	FHx

BCM-MEDICAL GENETICS LABORATORIES

PHONE: 800-411-GENE | FAX: 713-798-2787 | www.bcmgeneticlabs.org

SHIP TO: Medical Genetics Laboratories
Baylor College of Medicine
2450 Holcombe, Grand Blvd. -Receiving Dock
Houston, TX 77021-2024
Phone: 713-798-6555

MITOCHONDRIAL DNA (mtDNA) TEST REQUISITION

BILLING INFORMATION

IMPORTANT NOTICE: ONE OF THE THREE FOLLOWING BILLING OPTIONS MUST BE INDICATED BELOW.
PLEASE FORWARD ALL BILLING QUESTIONS TO: MEDGENBILLING@BCM.EDU

PATIENT INFORMATION

PATIENT NAME (LAST, FIRST, MI): _____ PATIENT DATE OF BIRTH (MM/DD/YY): _____
ADDRESS: _____ CITY, STATE, ZIP: _____
PHONE: _____ EMAIL: _____

PAYMENT OPTIONS

1. INSTITUTION CODE: _____ INSTITUTION NAME: _____
CONTACT NAME: _____ EMAIL (REQUIRED): _____
BILLING ADDRESS: _____ CITY, STATE, ZIP: _____
PHONE: _____ FAX: _____

2. SELF-PAY (PAYMENT MUST ACCOMPANY SAMPLE.): CREDIT CARD CHECK MONEY ORDER
 CREDIT CARD (PLEASE SELECT ONE): AMEX DISCOVER MC VISA
VALID CARD #: _____ EXPIRATION DATE (MM/YY): _____ CVC CODE: _____
BILLING ADDRESS: _____ CITY, STATE, ZIP: _____
CARDHOLDER PRINTED NAME: _____ CARDHOLDER SIGNATURE: _____
 CHECK/MONEY ORDER: CHECK/MONEY ORDER # _____ AMOUNT INCLOSED: _____

3. INSURANCE: (PLEASE PROVIDE A PHOTOCOPY OF THE FRONT AND BACK OF THE INSURANCE CARD OR HMO/MEDICAID HMO AUTHORIZATION/REFERRAL)

Please refer to the Financial Policy at www.bcmgeneticlabs.org for complete insurance filing information and the managed care contract list. Insurance is filed to our contracted carriers as a courtesy. Patients are responsible for non-covered services, deductibles, co-insurance, contract exclusions, non-authorized services, and remaining balances after insurance reimbursement. HMO policies must have required approved authorizations. CMA requires a prepayment amount. BCM-Medical Genetic Laboratories cannot bill out-of-state welfare programs. We can only accept authorized Texas Medicaid HMO covered charges for genetic testing. Please contact our billing office prior to submitting a Texas Medicaid sample. Contact medgenbilling@bcm.edu with questions.

ICD9 Diagnosis Code(s) must be provided or insurance cannot be filed: ICD9 CODE(S): _____

PPO, Commercial Insurance-provide complete billing information on page 2 of requisition and front/back photocopy of insurance card.

HMO-provide approved authorization, front/back photocopy of insurance card.

Texas Medicaid HMO-provide approved authorization, front/back photocopy of medicaid card, and contact billing at (713) 798-5849.

INSURED POLICYHOLDER'S INFORMATION

INSURED NAME (Last, First, MI) _____ INSURED SS OR ID#: _____ GENDER: FEMALE MALE
INSURED DATE OF BIRTH (MM/DD/YY): _____ RELATIONSHIP TO PATIENT: _____
INSURANCE CO. NAME: _____ INSURANCE CO. ADDRESS: _____
CITY, STATE, ZIP: _____ PHONE: _____
EMPLOYER: _____ GROUP#: _____

I AUTHORIZE BCM-MEDICAL GENETICS LABORATORIES TO FURNISH ANY MEDICAL INFORMATION REQUESTED ON MYSELF, OR MY COVERED DEPENDENTS. IN CONSIDERATION OF SERVICES RENDERED, I TRANSFER AND ASSIGN ANY BENEFITS OF INSURANCE TO BCM-MEDICAL GENETICS LABORATORIES. I UNDERSTAND I AM RESPONSIBLE FOR ANY CO-PAY, DEDUCTIBLES, OR NON-AUTHORIZED SERVICES AND REMAINING BALANCES AFTER INSURANCE REIMBURSEMENT. I UNDERSTAND I AM FULLY RESPONSIBLE FOR PAYMENT OF MY ACCOUNT IF THE BCM-MEDICAL GENETICS LABORATORIES IS NOT A PARTICIPANT WITH MY HEALTH PLAN, AND MY HEALTH PLAN DOES NOT FULLY REIMBURSE MY MEDICAL SERVICES DUE TO LACK OF AUTHORIZATION OR MEDICAL NECESSITY.

PRINTED NAME: _____ SIGNATURE: _____ DATE (MM/YY): _____