Form Approved
OMB No. 0938-0581

CLINICAL LABORATORY IMPROVEMENT AMENDMENTS (CLIA) APPLICATION FOR CERTIFICATION

I. GENERAL INFORMATION

☐ Initial Application ☐ Survey
☐ Change in Certification Type
☐ Other Changes *(Specify)*
_____

CLIA IDENTIFICATION NUMBER
_____D_____
(If an initial application leave blank, a number will be assigned)

FACILITY NAME		FEDERAL TAX IDENTIFICATION NUMBER	
EMAIL ADDRESS		TELEPHONE NO. *(Include area code)*	FAX NO. *(Include area code)*
FACILITY ADDRESS — ***Physical Location of Laboratory (Building, Floor, Suite if applicable.)*** *Fee Coupon/Certificate will be mailed to this Address unless mailing address is specified*		MAILING/BILLING ADDRESS *(If different from street address)*	
NUMBER, STREET *(No P.O. Boxes)*		NUMBER, STREET	
CITY	STATE	CITY	STATE
ZIP CODE		ZIP CODE	
NAME OF DIRECTOR *(Last, First, Middle Initial)*		**FOR OFFICE USE ONLY** Date Received _____	

II. TYPE OF CERTIFICATE REQUESTED *(Check only one)*

☐ Certificate of Waiver *(Complete Sections I – VI and IX – X)*

☐ Certificate for Provider Performed Microscopy Procedures (PPM) *(Complete Sections I – X)*

☐ Certificate of Compliance *(Complete Sections I – X)*

☐ Certificate of Accreditation (Complete Sections I – X) and indicate which of the following organization(s) your laboratory is accredited by for CLIA purposes, or for which you have applied for accreditation for CLIA purposes

☐ The Joint Commission ☐ AOA ☐ AABB
☐ CAP ☐ COLA ☐ ASHI

If you are applying for a Certificate of Accreditation, you must provide evidence of accreditation for your laboratory by an approved accreditation organization as listed above for CLIA purposes or evidence of application for such accreditation within 11 months after receipt of your Certificate of Registration.

NOTE: Laboratory directors performing non-waived testing (including PPM) must meet specific education, training and experience under subpart M of the CLIA requirements. Proof of these requirements for the laboratory director must be submitted with the application.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0581. The time required to complete this information collection is estimated to average 30 minutes to 2 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.

III. TYPE OF LABORATORY *(Check the one most descriptive of facility type)*

- ☐ 01 Ambulance
- ☐ 02 Ambulatory Surgery Center
- ☐ 03 Ancillary Testing Site in Health Care Facility
- ☐ 04 Assisted Living Facility
- ☐ 05 Blood Bank
- ☐ 06 Community Clinic
- ☐ 07 Comp. Outpatient Rehab Facility
- ☐ 08 End Stage Renal Disease Dialysis Facility
- ☐ 09 Federally Qualified Health Center
- ☐ 10 Health Fair
- ☐ 11 Health Main. Organization
- ☐ 12 Home Health Agency
- ☐ 13 Hospice
- ☐ 14 Hospital
- ☐ 15 Independent
- ☐ 16 Industrial
- ☐ 17 Insurance
- ☐ 18 Intermediate Care Facility for Mentally Retarded
- ☐ 19 Mobile Laboratory
- ☐ 20 Pharmacy
- ☐ 21 Physician Office
  Is this a shared lab? ☐ Yes ☐ No
- ☐ 22 Practitioner Other *(Specify)* _____
- ☐ 23 Prison
- ☐ 24 Public Health Laboratories
- ☐ 25 Rural Health Clinic
- ☐ 26 School/Student Health Service
- ☐ 27 Skilled Nursing Facility/ Nursing Facility
- ☐ 28 Tissue Bank/Repositories
- ☐ 29 Other *(Specify)* _____

IV. HOURS OF LABORATORY TESTING *(List times during which **laboratory testing** is performed in HH:MM format)*

	SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
FROM:							
TO:							

(For multiple sites, attach the additional information using the same format.)

V. MULTIPLE SITES *(must meet one of the regulatory exceptions to apply for this provision)*

Are you applying for the multiple site exception?

☐ No. If no, go to section VI. ☐ Yes. If yes, complete remainder of this section.

Indicate which of the following regulatory exceptions applies to your facility's operation.

1. Is this a laboratory that has temporary testing sites?
   ☐ Yes ☐ No
2. Is this a not-for-profit or Federal, State or local government laboratory engaged in limited (not more than a combination of 15 moderate complexity or waived tests per certificate) public health testing and filing for a single certificate for multiple sites?
   ☐ Yes ☐ No
   If yes, provide the number of sites under the certificate_____ and list name, address and test performed for each site below.
3. Is this a hospital with several laboratories located at contiguous buildings on the same campus within the same physical location or street address and under common direction that is filing for a single certificate for these locations?
   ☐ Yes ☐ No
   If yes, provide the number of sites under this certificate_____ and list name or department, location within hospital and specialty/subspecialty areas performed at each site below.

If additional space is needed, check here ☐ and attach the additional information using the same format.

NAME AND ADDRESS/LOCATION		TESTS PERFORMED/SPECIALTY/SUBSPECIALTY
NAME OF LABORATORY OR HOSPITAL DEPARTMENT		
ADDRESS/LOCATION *(Number, Street, Location if applicable)*		
CITY, STATE, ZIP CODE	TELEPHONE NO. *(Include area code)*	
NAME OF LABORATORY OR HOSPITAL DEPARTMENT		
ADDRESS/LOCATION *(Number, Street, Location if applicable)*		
CITY, STATE, ZIP CODE	TELEPHONE NO. *(Include area code)*	

COLORADO Annual Test Volume Report

Facility Name: _____ **CLIA Number:** _____

This report provides detailed information for page 3 of the CMS-116 and must be completed fully for all new facilities or facilities making updates. Complete the information and transfer the total test volumes to Sections VI, VII, and VIII on the CMS-116 as directed. Incomplete information on this report will delay the processing of your request.

For each test currently performed at your facility, enter the required information. **DO NOT** include blood draws or specimens sent to another site for testing. **DO NOT** include drug testing for hiring or on current employees, unless treatment is provided.

Only common tests are listed. Write-in any test(s) performed that are not listed.

WAIVED TESTING

Annual # of tests		Manufacturer of Kit	Complete Name of Test
200	**Strep [**EXAMPLE ONLY**]**	Quidel	QuickVue In-Line Strep A
	Glucose		
	Chemistry, waived		
	Drugs of abuse, urine, waived		
	Fecal Occult Blood		
	Cholesterol		
	Pregnancy, urine		
	Hematocrit, spun		
	Hemoglobin		
	HIV		
	Influenza, A/B		
	Mononucleosis		
	PT/INR, waived		
	Rapid Strep*		
	Sedimentation Rate (ESR)		
	RSV		
	Urine dip, waived		

cultures should be listed under **NON-WAIVED TESTING on the back.*

0 **TOTAL WAIVED TESTING** *(Transfer this total to section **VI. WAIVED TESTING** page 3 of the CMS-116.)*

PPM TESTING (Provider-Performed Microscopy)

Annual Number of tests		SPECIALTY	Which provider(s) are performing this test: MD, DO, DDS, NP, PA, NMW, Other
	Wet Mounts (bacteria, Trichomonas, yeast)	Bacteriology & Parasitology	
	KOH (fungus/yeast) preps	Mycology	
	Pinworm exam	Parasitology	
	Fern test	Hematology	
	Post-coital (vaginal/cervical mucous)	Hematology	
	Urinalysis, microscopic	Urinalysis	
	Urinalysis; two or three glass test	Urinalysis	
	Fecal Leukocyte exam	Hematology	
	Post Vas / Semen (only *sperm presence* or *motility*)*	Hematology	
	Nasal Smears (eosinophils)	Hematology	

sperm count & morphology should be listed under Hematology in **NON-WAIVED TESTING on the back.*

0 **TOTAL PPM TESTING** *(Transfer this total to section **VII. PPM TESTING** on page 3 of the CMS-116.)*

NON-WAIVED TESTING (Moderate & High Complexity Testing)

For any other test(s) currently performed at your facility and not previously listed on this form, enter the annual test volume. **DO NOT** include blood draws or specimens sent to another site for testing. Tests are grouped by Specialty. Only common tests are listed. Write-in any test(s) performed that are not listed. Transfer any specialty total(s) to section **VIII. NON-WAIVED TESTING** on page 3 of the CMS-116.

HISTOCOMPATIBILITY

_____ Transplant
_____ Nontransplant
0 **TOTAL**

MICROBIOLOGY

Bacteriology
_____ Affirm
_____ Antibiotic Sensitivity
_____ Cultures
_____ Gram Stains
_____ Rapid Strep Tests
_____ Wet Preps

Mycobacteriology
_____ Mycobacteriology: _____

Mycology
_____ Dermatophyte Cultures (DTM)
_____ KOH Skin Scrapings

Parasitology
_____ Ova & Parasites
_____ Preps, direct (pinworm, fecal leukocytes, scabies)

Virology
_____ Influenza A/B
_____ RSV
_____ HIV
0 **TOTAL**

DIAGNOSTIC IMMUNOLOGY

Syphilis
_____ FTA, MHA-TP
_____ RPR

General Immunology
_____ Immunoglobulins (A, G, M, etc.)
_____ Mononucleosis
_____ Rheumatoid Factor
0 **TOTAL**

CHEMISTRY

Routine
_____ Albumin
_____ Alkaline Phosphatase
_____ ALT (SGPT)
_____ AST (SGOT)
_____ B-Type Natriuretic Peptide (BNP)
_____ Bilirubin, Direct
_____ Bilirubin, Total
_____ BUN
_____ Calcium
_____ Chloride
_____ Cholesterol, HDL
_____ Cholesterol, Total
_____ CO2, Total
_____ CPK
_____ CPK isoenzymes (CKMB)
_____ Creatinine
_____ Glucose
_____ Glycosylated Hemoglobin (A1C)
_____ LDH
_____ LDH isoenzymes
_____ Magnesium
_____ Myoglobin
_____ pH (blood gas)
_____ pCO2
_____ pO2
_____ Potassium
_____ Protein, Total
_____ Sodium
_____ Triglycerides
_____ Troponin

Urinalysis
_____ Urine dip, nonwaived
_____ Urine sediment exam

Endocrinology
_____ Pregnancy, serum
_____ PSA
_____ TSH

Toxicology
_____ Acetaminophen
_____ Carbamazepine/Tegretol
_____ Digoxin
_____ Drug screen, blood
_____ Drug screen, urine
_____ Gentamycin
_____ Phenobarbital
_____ Phenytoin/Dilantin
_____ Salicylate
_____ Theophylline
_____ Valproic Acid/Depakote
_____ Vancomycin
0 **TOTAL**

HEMATOLOGY

_____ D-Dimer
_____ Differential, automated
_____ Differential, manual
_____ Fern Test
_____ Hemoglobin
_____ Hematocrit
_____ Nasal smears (eosinophils)
_____ PTT
_____ Platelet, automated
_____ Platelet, estimate manual
_____ Post-coital (vaginal/cervical)
_____ Prothrombin Time (PT/INR)
_____ RBC, automated
_____ RBC, manual
_____ Reticulocyte Count
_____ Sperm, count & morphology
_____ Sperm, post-vas (presence/motility)
_____ WBC, automated
_____ WBC, manual
0 **TOTAL**

IMMUNOHEMATOLOGY

_____ ABO Group & Rh Group
_____ Antibody Detection (transfusion)
_____ Ab Detection (nontransfusion)
_____ Antibody Identification
_____ Compatibility Testing
0 **TOTAL**

PATHOLOGY

_____ Histopathology
_____ MOH's*
_____ Oral Pathology
_____ Cytology
0 **TOTAL**

RADIOBIOASSAY

_____ Radiobioassay
0 **TOTAL**

CLINICAL CYTOGENETICS

_____ Clinical Cytogenetics
0 **TOTAL**

ADDITIONAL TEST(S)

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

**To count MOH's testing, count each stage/block as 1 test when H & E stain is used; Count 1 test for each slide made when special stains are used.*

In the next three sections, indicate testing performed and annual test volume.

VI. WAIVED TESTING

Identify the waived testing performed. Be as specific as possible. This includes each analyte test system or device used in the laboratory.

e.g. (Rapid Strep, Acme Home Glucose Meter)

Indicate the estimated **TOTAL ANNUAL TEST** volume for all waived tests performed _____

☐ Check if no waived tests are performed

VII. PPM TESTING

Identify the PPM testing performed. Be as specific as possible.

e.g. (Potassium Hydroxide (KOH) Preps, Urine Sediment Examinations)

Indicate the estimated TOTAL ANNUAL TEST volume for all PPM tests performed _____

For laboratories applying for certificate of compliance or certificate of accreditation, also include PPM test volume in the "total estimated test volume" in section VIII.

☐ Check if no PPM tests are performed

If additional space is needed, check here ☐ and attach additional information using the same format.

VIII. NON-WAIVED TESTING *(Including PPM testing)*

If you perform testing other than or in addition to waived tests, complete the information below. If applying for one certificate for multiple sites, the total volume should include testing for ALL sites.

Place a check (✓) in the box preceding each specialty/subspecialty in which the laboratory performs testing. Enter the estimated annual test volume for each specialty. Do not include testing not subject to CLIA, waived tests, or tests run for quality control, calculations, quality assurance or proficiency testing when calculating test volume. (For additional guidance on counting test volume, see the information included with the application package.)

If applying for a Certificate of Accreditation, indicate the name of the Accreditation Organization beside the applicable specialty/subspecialty for which you are accredited for CLIA compliance. (The Joint Commission, AOA, AABB, CAP, COLA or ASHI)

SPECIALTY / SUBSPECIALTY	ACCREDITING ORGANIZATION	ANNUAL TEST VOLUME	SPECIALTY / SUBSPECIALTY	ACCREDITING ORGANIZATION	ANNUAL TEST VOLUME
HISTOCOMPATIBILITY			**HEMATOLOGY**		
☐ Transplant			☐ Hematology		
☐ Nontransplant			**IMMUNOHEMATOLOGY**		
MICROBIOLOGY			☐ ABO Group & Rh Group		
☐ Bacteriology			☐ Antibody Detection (transfusion)		
☐ Mycobacteriology			☐ Antibody Detection (nontransfusion)		
☐ Mycology			☐ Antibody Identification		
☐ Parasitology			☐ Compatibility Testing		
☐ Virology			**PATHOLOGY**		
DIAGNOSTIC IMMUNOLOGY			☐ Histopathology		
☐ Syphilis Serology			☐ Oral Pathology		
☐ General Immunology			☐ Cytology		
CHEMISTRY			**RADIOBIOASSAY**		
☐ Routine			☐ Radiobioassay		
☐ Urinalysis			**CLINICAL CYTOGENETICS**		
☐ Endocrinology			☐ Clinical Cytogenetics		
☐ Toxicology			**TOTAL ESTIMATED ANNUAL TEST VOLUME:**		

IX. TYPE OF CONTROL

VOLUNTARY NONPROFIT	FOR PROFIT	GOVERNMENT
☐ 01 Religious Affiliation	☐ 04 Proprietary	☐ 05 City
☐ 02 Private Nonprofit		☐ 06 County
☐ 03 Other Nonprofit		☐ 07 State
		☐ 08 Federal
_____ *(Specify)*		☐ 09 Other Government
		_____ *(Specify)*

X. DIRECTOR AFFILIATION WITH OTHER LABORATORIES

If the director of this laboratory serves as director for additional laboratories that are separately certified, please complete the following:

CLIA NUMBER	NAME OF LABORATORY

ATTENTION: READ THE FOLLOWING CAREFULLY BEFORE SIGNING APPLICATION

Any person who intentionally violates any requirement of section 353 of the Public Health Service Act as amended or any regulation promulgated thereunder shall be imprisoned for not more than 1 year or fined under title 18, United States Code or both, except that if the conviction is for a second or subsequent violation of such a requirement such person shall be imprisoned for not more than 3 years or fined in accordance with title 18, United States Code or both.

Consent: The applicant hereby agrees that such laboratory identified herein will be operated in accordance with applicable standards found necessary by the Secretary of Health and Human Services to carry out the purposes of section 353 of the Public Health Service Act as amended. The applicant further agrees to permit the Secretary, or any Federal officer or employee duly designated by the Secretary, to inspect the laboratory and its operations and its pertinent records at any reasonable time and to furnish any requested information or materials necessary to determine the laboratory's eligibility or continued eligibility for its certificate or continued compliance with CLIA requirements.

SIGNATURE OF OWNER/DIRECTOR OF LABORATORY *(Sign in ink)*	DATE

THE CLINICAL LABORATORY IMPROVEMENT AMENDMENTS (CLIA) APPLICATION (FORM CMS-116)

INSTRUCTIONS FOR COMPLETION

CLIA requires every facility that tests human specimens for the purpose of providing information for the diagnosis, prevention or treatment of any disease or impairment of, or the assessment of the health of, a human being to meet certain Federal requirements. If your facility performs tests for these purposes, it is considered, under the law, to be a laboratory. CLIA applies even if only one or a few basic tests are performed, and even if you are not charging for testing. In addition the CLIA legislation requires financing of all regulatory costs through fees assessed to affected facilities.

The CLIA application (Form CMS-116) collects information about your laboratory's operation which is necessary to determine the fees to be assessed, to establish baseline data and to fulfill the statutory requirements for CLIA. This information will also provide an overview of your facility's laboratory operation. All information submitted should be based on your facility's laboratory operation as of the date of form completion.

NOTE: WAIVED TESTS ARE NOT EXEMPT FROM CLIA. FACILITIES PERFORMING ONLY THOSE TESTS CATEGORIZED AS WAIVED MUST APPLY FOR A CLIA CERTIFICATE OF WAIVER.

NOTE: Laboratory directors performing non-waived testing (including PPM) must meet specific education, training and experience under subpart M of the CLIA requirements. Proof of these requirements for the laboratory director must be submitted with the application. Information to be submitted with the application include:

- **Verification of State Licensure, as applicable**
- **Documentation of qualifications:**
  - **Education (copy of Diploma, transcript from accredited institution, CMEs),**
  - **Credentials, and**
  - **Laboratory experience.**

Individuals who attended foreign schools must have an evaluation of their credentials determining equivalency of their education to education obtained in the United States. Failure to submit this information will delay the processing of your application.

ALL APPLICABLE SECTIONS MUST BE COMPLETED. INCOMPLETE APPLICATIONS CANNOT BE PROCESSED AND WILL BE RETURNED TO THE FACILITY. PRINT LEGIBLY OR TYPE INFORMATION.

I. GENERAL INFORMATION

For an initial applicant, check "initial application". For an initial survey or for a recertification, check "survey". For a request to change the type of certificate, check "Change in certificate type". For all other changes, including change in location, director, etc., check "other changes".

For an initial applicant, the CLIA number should be left blank. The number will be assigned when the application is processed. Be specific when indicating the name of your facility, particularly when it is a component of a larger entity; e.g., respiratory therapy department in XYZ Hospital. For a physician's office, this may be the name of the physician. **NOTE: The information provided is what will appear on your certificate.**

Facility street address must be the actual physical location where testing is performed, including floor, suite and/or room, if applicable. **DO NOT USE A POST OFFICE BOX NUMBER OR A MAIL DROP ADDRESS FOR THE NUMBER AND STREET OF THE ADDRESS.** If the laboratory has a separate mailing address, please complete that section of the application.

NOTE: For Office Use Only—Date received is the date the form is received by the state agency or CMS regional office for processing.

II. TYPE OF CERTIFICATE REQUESTED

When completing this section, please remember that a facility holding a:

- **Certificate of Waiver** can only perform tests categorized as waived;*
- **Certificate for Provider Performed Microscopy Procedures** (PPM) can only perform tests categorized as PPM, or tests categorized as PPM and waived tests;*
- **Certificate of Compliance** can perform tests categorized as waived, PPM and moderate and/or high complexity tests provided the applicable CLIA quality standards are met; and
- **Certificate of Accreditation** can perform tests categorized as waived, PPM and moderate and/or high complexity non-waived tests provided the laboratory is currently accredited by an approved accreditation organization.

*A current list of waived and PPMP tests may be obtained from your State agency. Specific test system categorizations can also be found on the Internet at: *http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfCLIA/clia.cfm*.

III. TYPE OF LABORATORY

Select your certificate type based on the highest level of test complexity performed by your laboratory. Laboratories performing non-waived tests can choose COA or COC based on the agency you wish to survey your laboratory.

A shared laboratory is when two or more sole practicing physicians collectively pool resources to fund a laboratory's operations. The definition of a shared laboratory may also include two or more physician group practices that share the expenses for the laboratory's operation.

IV. HOURS OF ROUTINE OPERATION

Provide only the times when actual laboratory testing is performed in your facility. Please use the HH:MM format.

V. MULTIPLE SITES

You can only qualify for the multiple site provision (more than one site under one certificate) if you meet one of the CLIA requirements described in 42 CFR 493. Hospice and HHA could qualify for an exception i.e. 493.35(b)(1-3), 493.43(b)(1-3) and 493.55(b)(1-3).

VI. WAIVED TESTING

Indicate the estimated total annual test volume for all waived tests performed. List can be found at: http:www.cms.gov/CLIA/downloads/waivetbl.pdf

VII. PPM TESTING

Indicate the estimated annual test volume for all PPM tests performed. List can be found at: http://www.cms.gov/clia/downloads/ppmp.list.pdf

VIII. NON-WAIVED TESTING *(INCLUDING PPM)*

The total volume in this section includes all non-waived testing, including PPM tests previously counted in section VII. Follow the specific instructions on page 3 of the Form CMS-116 when completing this section. (Note: The Accrediting Organization column should reflect accreditation information for CLIA purposes only; e.g., CAP, etc.).

IX. TYPE OF CONTROL

Select the type of control which most appropriately describes your facility.

X. DIRECTOR OF ADDITIONAL LABORATORIES

List all other facilities for which the director is responsible and that are under different certificate.

Note that for a Certificate of PPM, Certificate of Compliance or Certificate of Accreditation, an individual can only serve as the director for no more than five certificates.

Once the completed Form CMS-116 has been returned to the applicable State agency and it is processed, a fee remittance coupon will be issued. The fee remittance coupon will indicate your CLIA identification number and the amount due for the certificate, and if applicable the compliance (survey) or validation fee. If you are applying for a Certificate of Compliance or Certificate of Accreditation, you will initially pay for and receive a Registration Certificate. A Registration Certificate permits a facility requesting a Certificate of Compliance to perform testing until an onsite inspection is conducted to determine program compliance; or for a facility applying for a Certificate of Accreditation, until verification of accreditation by an approved accreditation organization is received by CMS.

If you need additional information concerning CLIA, or if you have questions about completion of this form, please contact your State agency.

TESTS COMMONLY PERFORMED AND THEIR CORRESPONDING LABORATORY SPECIALTIES/SUBSPECIALITIES

HISTOCOMPATIBILITY
HLA Typing (disease associated antigens)

MICROBIOLOGY

Bacteriology
Gram Stain
Culture
Susceptibility
Strep screen
Antigen assays (H.pylori, Chlamydia, etc.)

Mycobacteriology
Acid Fast Smear
Mycobacterial culture
Mycobacterial susceptibility

Mycology
Fungal Culture
DTM
KOH Preps

Parasitology
Direct Preps
Ova and Parasite Preps
Wet Preps

Virology
RSV (Not including waived kits)
HPV assay
Cell culture

DIAGNOSTIC IMMUNOLOGY

Syphilis Serology
RPR
FTA, MHATP

General Immunology
Allergen testing
ANA
Antistreptolysin O
Antigen/Antibody (hepatitis, herpes, rubella, etc.)
Complement (C3, C4)
Immunoglobulin
HIV
Mononucleosis assay
Rheumatoid factor
Tumor marker (AFP, CA 19-9, CA 15-3, CA 125)*

*Tumor markers can alternatively be listed under Routine Chemistry instead of General Immunology.

HEMATOLOGY
Complete Blood Count (CBC)
WBC count
RBC count
Hemoglobin
Hematocrit (Not including spun micro)
Platelet count
Differential
Activated Clotting Time
Prothrombin time (Not including waived instruments)
Partial thromboplastin time
Fibrinogen
Reticulocyte count
Manual WBC by hemocytometer
Manual platelet by hemocytometer
Manual RBC by hemocytometer
Sperm count

IMMUNOHEMATOLOGY
ABO group
Rh(D) type
Antibody screening
Antibody identification
Compatibility testing

PATHOLOGY
Dermatopathology
Oral Pathology
PAP smear interpretations
Other Cytology tests
Histopathology

RADIOBIOASSAY
Red cell volume
Schilling test

CLINICAL CYTOGENETICS
Fragile X
Buccal smear
Prader-Willi syndrome
FISH studies for: neoplastic disorders, congenital disorders or solid tumors.

CHEMISTRY

Routine Chemistry

Albumin
Ammonia
Alk Phos
ALT/SGPT
AST/SGOT
Amylase
Bilirubin
Blood gas (pH, pO2, pCO2)
BUN
Calcium
Chloride
Cholesterol
Cholesterol, HDL
CK/CK isoenzymes
CO2
Creatinine
Ferritin
Folate
GGT
Glucose (Not fingerstick)
Iron
LDH/LDH isoenzymes
Magnesium
Potassium
Protein, electrophoresis
Protein, total
PSA
Sodium
Triglycerides
Troponin
Uric acid
Vitamin B12

Endocrinology

Cortisol
HCG (serum pregnancy test)
T3
T3 Uptake
T4
T4, free
TSH

Toxicology

Acetaminophen
Blood alcohol
Blood lead (Not waived)
Carbamazepine
Digoxin
Ethosuximide
Gentamicin
Lithium
Phenobarbital
Phenytoin
Primidone
Procainamide
NAPA
Quinidine
Salicylates
Theophylline
Tobramycin
Therapeutic Drug Monitoring

Urinalysis**

Automated Urinalysis (Not including waived instruments)
Microscopic Urinalysis
Urine specific gravity by refractometer
Urine specific gravity by urinometer
Urine protein by sulfosalicylic acid

** Dipstick urinalysis is counted in Section VI. WAIVED TESTING

NOTE: This is not a complete list of tests covered by CLIA. Other non-waived tests and their specialties/subspecialties can be found at **http://www.cms.gov/CLIA/downloads/subject.to.CLIA.pdf** and **http://www.cms.gov/CLIA/downloads/IcCodes.pdf**. You may also call your State agency for further information. State agency contact information can be found at: **http://www.cms.gov/CLIA/downloads/CLIA.SA.pdf.**

GUIDELINES FOR COUNTING TESTS FOR CLIA

- For **histocompatibility**, each HLA typing (including disease associated antigens), HLA antibody screen, or HLA crossmatch is counted as one test.
- For **microbiology**, susceptibility testing is counted as one test per group of antibiotics used to determine sensitivity for one organism. Cultures are counted as one per specimen regardless of the extent of identification, number of organisms isolated and number of tests/procedures required for identification.
- For **general immunology**, testing for allergens should be counted as one test per individual allergen.
- For **hematology**, each **measured** individual analyte of a **complete blood count** or **flow cytometry** test that is ordered **and reported** is counted separately. The **WBC differential** is counted as one test.
- For **immunohematology**, each ABO, Rh, antibody screen, crossmatch or antibody identification is counted as one test.
- For **histopathology**, each block (not slide) is counted as one test. Autopsy services are not included. For those laboratories that perform special stains on histology slides, the test volume is determined by adding the number of special stains performed on slides to the total number of specimen blocks prepared by the laboratory.
- For **cytology**, each slide (not case) is counted as one test for both Pap smears and nongynecologic cytology.
- For **clinical cytogenetics**, the number of tests is determined by the number of specimen types processed on each patient; e.g., a bone marrow and a venous blood specimen received on one patient is counted as two tests.
- For **chemistry**, each analyte in a profile counts as one test.
- For **urinalysis**, microscopic and macroscopia examinations, each count as one test. Macroscopics (dipsticks) are counted as one test regardless of the number of reagent pads on the strip.
- For **all specialties/subspecialities**, do not count calculations (e.g., A/G ratior, MCH, T7, etc.), quality control, quality assurance, or proficiency testing assays.

If you need additional information concerning counting tests for CLIA, please contact your State agency.