

Order Form: Physician Referral

Please email completed form to: BWHCTScheduling@partners.org or fax to 617/ 732-7963. If you have any questions please call Coordinator @ 617/ 732-7631

BWH CT Colonography (CTC) Request Form For screening and diagnostic CTC's that does not follow Conventional Colonoscopy

To be filled out by referring physician and/or GI physician

Patient Name: _____

Patient Unit Number: _____

Does the patient have Medicare as a primary insurance? **Yes or No** (please circle)

Referring Physician: _____

Physician pager number/ contact number: _____

Q. Does the patient have symptoms that would require a CT Colonography for diagnostic purposes, including, but not limited to: constipation, abdominal pain, gastrointestinal bleeding, abnormal weight loss, diverticulosis of colon, benign neoplasms, primary or secondary malignant neoplasms, symptoms involving digestive system

If yes, please comment on the patients symptoms: _____

*(*Scheduler, if the patient has symptoms listed above please schedule as a CTCDX. Please report diagnosis/description of symptoms in the IDX history field.)*

If no, this is a Screening CT Colonography: (**Scheduler, please schedule as a CTCSCR*)

For Screening CT Colonography, please note:

Screening CT Colonography will most likely **not** be covered by your insurance. CT Colonography has been shown in several studies to be effective in certain patient groups, however insufficient studies have been performed to document its accuracy in a screening population. CT Colonography is best suited for patients who are unable or unwilling to undergo conventional Colonoscopy. Although the experience with this test is promising, the precise role of CT Colonography has not been established, particularly for polyps and cancers less than 1cm. When clinically feasible, standard Colonoscopy is the optimal screening tool. As a result a waiver (or an ABN for Medicare patients) must be signed. **The cost of the exam is \$899.** The patient will receive 2 bills, one from the Brigham and Women's Physician's Organization (\$200) and one from the hospital (\$699).

Physician please note:

- **A Screening CT Colonography is performed under low dose radiation without IV contrast. You are ordering a Screening CT Colonography (CPT 0066T).**
- **A Diagnostic CT Colonography is performed at full radiation dose with IV contrast. You are ordering an Abdominal CT (74160), Pelvic CT (72193), and a 3D-reconstruction (76375).**

Preferred dates for exam: _____ , _____ , _____

Name/Number of person filling out this request: _____

****Exclusion criteria: active inflammation, history of Crohn's disease, lack of an intact ileocecal valve or anorectum, recent colectomy, or history of pelvic irradiation (relative contraindication). Please contact a Radiologist before scheduling.****

Order Form: Incomplete Colonoscopy

Please fax completed form to Coordinator at fax 617/ 732-7963 or call 617/ 732-7631 with any questions.

BWH Completion CT Colonography (CTC) Request Form For both screening and diagnostic completion CTC following Conventional Colonoscopy To be filled out by referring physician and/or GI physician.

Patient Name: _____

Patient Unit Number: _____

Does the patient have Medicare as a primary insurance? **Yes or No** (please circle)

Requesting Physician/Endoscopist: _____ Physician pager/contact #: _____

Quality of Bowel Prep (Excellent, Good, Fair, Poor): _____

Was the Colonoscopy a screening or diagnostic? _____

If the Colonoscopy was a **screening** an ABN or waiver is required in order for the completion CTC to be performed.
Please fax ABN to Coordinator @ fax # 617/ 732-7963

If the Colonoscopy was **diagnostic**, what was the original reason for Colonoscopy (i.e. any pertinent symptoms such as pain, bleeding, change in bowel habits, etc)? _____

If no indication, please comment: _____

Reason Unable to Complete Colonoscopy (i.e. obstructing mass, pain tortuosity, etc.): _____

Were there any Biopsies or other procedures performed? (If yes, please check with Radiologist prior to scheduling CTC.) _____

Any complications during Endoscopy? _____

Patient's BUN/ Cr. and Clinical Status: _____

Physician, please note:

▪ Although CT Colonography has been shown in several studies to have high sensitivity in certain patient groups, insufficient studies have been performed to document its accuracy in a screening population. CT Colonography is best suited for patients who are unable or unwilling to undergo conventional Colonoscopy. Although the experience with this test is promising, the precise role of CT Colonography has not been established, particularly for polyps and cancers less than 1cm. When clinically feasible, standard Colonoscopy is the optimal screening technique. Screening CT Colonography will most likely **not** be covered by insurance. As a result an ABN or waiver must be signed: **the cost of the exam is \$899.**

- **A Screening CT Colonography is performed under low dose radiation without IV contrast. You are ordering a Screening CT Colonography (CPT 0066T).**
- **A Diagnostic CT Colonography is performed at full radiation dose with IV contrast. You are ordering an Abdominal CT (74160), Pelvic CT (72193), and 3D-reconstruction (76375).**

Name/Number of person filling out this request: _____

****Exclusion criteria: active inflammation, history of Crohn's disease, lack of an intact ileocecal valve or anorectum, recent colectomy, or history of pelvic irradiation (relative contraindication). Please contact a Radiologist before scheduling****

Advance Beneficiary Notice (ABN)

BWH Department of Radiology

Location

Phone #

ADVANCE BENEFICIARY NOTICE (ABN)

NOTE: You need to make a choice about receiving these health care items or services.

We expect that Medicare will not pay for the item(s) or service(s) that are described below. Medicare does not pay for all of your health care costs. Medicare only pays for covered items and services when Medicare rules are met. The fact that Medicare may not pay for a particular item or service does not mean that you should not receive it. There may be a good reason your doctor recommended it. Right now, in your case, **Medicare probably will not pay for the following.**

Items or Services:

CT Colonography Screening (CT137) = CPT code 0066T

A non-invasive method to screen the colon for polyps and/or abnormalities.

Physician charge = \$200, Hospital charge = \$699 (*please note you will receive 2 different bills)

Because:

CT Colonography as a method of screening the colon is **not covered by Medicare at this time.**

The purpose of this form is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you might have to pay for them yourself. Before you make a decision about your options, you should **read this entire notice carefully.**

- Ask us to explain, if you do not understand why Medicare probably will not pay.
- Ask us how much these items or services will cost you, in case you have to pay for them yourself or through other insurance.

PLEASE CHOOSE **ONE** OPTION. CHECK **ONE** BOX. **SIGN & DATE** YOUR CHOICE.

Option 1. YES. I want to receive these items or services

I understand that Medicare will not decide whether to pay unless I receive these items or services. Please submit my claim to Medicare. I understand that you may bill me for items or services and that I may have to pay the bill while Medicare is making its decision. If Medicare does pay, you will refund to me any payments I made to you that are due to me. If Medicare denies payment, I agree to be personally and fully responsible for payment. That is, I will pay personally, either out of pocket or through any other insurance that I have. I understand I can appeal Medicare's decision.

Option 2. NO. I have decided not to receive these items or services.

I will not receive these items or services. I understand that you will not be able to submit a claim to Medicare and that I will not be able to appeal your opinion that Medicare won't pay.

Date

Signature of patient or person acting on patient's behalf

NOTE: Your health information will be kept confidential. Any information that we collect about you on this form will be kept confidential in our offices. If a claim is submitted to Medicare, your health information on this form may be shared with Medicare. Your health information which Medicare sees will be kept confidential by Medicare.

Waiver for Non-Medicare Patients

BWH Department of Radiology CT Colonography Screening Program Waiver

Insurance Coverage Advisory prior to rendering radiological services for CT Colonography

Welcome to Brigham and Women's Hospital Department of Radiology CT Colonography Screening program. You are scheduled to receive a CT Colonography Screening, which means you are experiencing no health problems related to the radiology services you will receive. If this is not accurate, please inform us of your symptoms at once. The level of radiation for this procedure is about 40% of a typical abdominal CT exam.

Although CT Colonography has been shown in several studies to be effective in certain patient groups, insufficient studies have been performed to document its accuracy in a screening population. CT Colonography is best suited for patients who are unable or unwilling to undergo conventional Colonoscopy. Although the experience with this test is promising, the precise role of CT Colonography has not been established, particularly for polyps and cancers less than 1cm. When clinically feasible, standard Colonoscopy is the optimal screening tool. As a result, this waiver (or an ABN for Medicare patients) must be signed. **The cost of the exam is \$899.** You will receive 2 bills, one from the Brigham and Women's Physician's Organization (\$299) and one from the hospital (\$600).

Insurance information: Your insurance has established rules for paying for health care services. The radiology service that you are receiving today will most likely **not** meet the coverage requirements of your insurance program and your insurer likely will not pay for these services. As a result, you will be held financially responsible for payment of your CT Colonography Screening.

Patient Release and Waiver: Your signature below denotes that you have read this notice and understand and accept this financial responsibility.

Signature of Patient or Person acting in their behalf

Date

Please print full name

Release of Information: Please provide the **name, address and phone number** of your primary care, or other physician responsible for coordinating your care, where you would like the results of today's test sent.

Name:

Address:

Phone: