

# Gastroenterology (GI) Pathology Approved Protocol Selections



Practice Name \_\_\_\_\_

Account Number \_\_\_\_\_

At my request, I hereby authorize Inform Diagnostics to perform the Approved Protocols, as individually selected below, that I believe to be medically necessary and appropriate\*\* for the diagnosis and/or treatment of my patients, on specimens that I forward to Inform Diagnostics for diagnostic workup.

It is Inform Diagnostics' responsibility to emphasize clinician choice, proper disclosure, client/clinician education, and to facilitate the ability of a client/clinician to order any testing that he/she believes to be medically necessary and appropriate\*\* for the diagnosis and/or treatment of his/her patients.

STAIN	SPECIMEN(S) TYPE AND MEDICAL RATIONALE – MEDICAL NECESSITY
<b>Alcian Blue/PAS</b> CPT Code: 88313*	<input type="checkbox"/> <b>Gastric specimens:</b> To enhance the detection of intestinal metaplasia <sup>1</sup> <input type="checkbox"/> <b>Duodenal specimens:</b> To enhance the detection of gastric metaplasia in inflammatory conditions such as peptic duodenitis <sup>1</sup> <input type="checkbox"/> <b>Esophageal specimens:</b> To enhance the detection of intestinal metaplasia in Barrett's esophagus <sup>1,2</sup>
<b>IHC for <i>H. pylori</i></b> CPT Code: 88342*	<input type="checkbox"/> <b>Gastric specimens:</b> To enhance the detection of <i>Helicobacter pylori</i> <sup>3</sup>
<b>CD3</b> CPT Code: 88342*	<input type="checkbox"/> <b>Duodenal specimens:</b> To enhance the detection of <i>Celiac/Sprue</i> <input type="checkbox"/> <b>Small Intestine specimens</b>

Your protocol selections will be implemented within 24–48 hours from receipt at Inform Diagnostics.

Please note that this Approved Protocol Form supersedes and replaces any existing Approved Protocol Form that you may have on file with Inform Diagnostics.

By signing below, I am aware of the test components, the CPT\* codes for the components, and the reimbursement rates for the tests ordered. I am also aware that the use of a protocol order may result in the ordering of tests that are not covered. I understand the potential implications of signing a protocol order. I also understand that I have the ability to “Opt Out” of the protocol order for each patient by writing “Opt Out” on the individual test requisition, or for all my patients by contacting Inform Diagnostics' Client Services at 866.588.3280.

I confirm that informed consent will be obtained, if required by state law. I certify that I will discuss with each patient their results and how their results inform treatment recommendations. I attest that the pathologist/clinician name listed below is authorized by law in the relevant jurisdiction to order the test(s) requested herein. I confirm that I maintain on file each patient's assignment of benefits authorizing insurance benefits to be paid to ancillary healthcare service providers.

Pathologist/Clinician Name \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

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## Additional Pathologists/Clinicians

Pathologist/Clinician Name \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Pathologist/Clinician Name \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Pathologist/Clinician Name \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

*This protocol will be effective on the date that the Medical Director at Inform Diagnostics reviews and approves.*

**Please return the signed form via email to Inform Diagnostics.**

tcpcproduct@informdx.com

**This protocol form has been reviewed and approved by the Medical Director of Inform Diagnostics.**

Signature \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

### REFERENCES

1. Odze R, Goldblum J; Surgical Pathology of the GI Tract, Liver, Biliary Tract and Pancreas, Second Edition 2009.
  2. K.Wang, R.Sampliner. Updated Guidelines 2008 for the Diagnosis, Surveillance and Therapy of Barrett's Esophagus. American Journal of Gastroenterology.
- \*The CPT codes provided are based on AMA guidelines and are for informational purposes only. CPT coding is the sole responsibility of the billing party. Please direct any questions regarding coding to the payer being billed.

### \*\*MEDICAL NECESSITY

The Centers for Medicare and Medicaid Services (CMS) is responsible for administering Medicare and other federally mandated healthcare programs throughout the United States. Medicare laws prohibit payment for services and items deemed by local Medicare Carriers as not medically reasonable and necessary for the diagnosis or treatment of an illness or injury. In such cases, documentation of "medical necessity" is required before a claim may be paid. Medicare, with a few exceptions, will not pay for routine checkups or screening tests, defined as "diagnostic procedures performed in the absence of signs or symptoms."