



CMS/APPROPRIATE USE CRITERIA (FOR MEDICARE PART B PATIENTS ONLY)

NPI# _____ Name of CDSM Consulted (software used) _____
 Determination Result (**check one**): 1) Adheres to 2) Does Not Adhere to 3) Not Applicable

REPORTING INSTRUCTIONS

Deliver CD with report by: Patient Courier STAT Follow Up Date & Time: _____
 Send additional copies of report to: _____

Today's Date: _____ Exam Date/Time: _____
 Patient Last Name: _____ First: _____ M: _____
 Phone: _____ DOB: _____ Pregnant: Y N
 Ordering Provider: _____ Provider Signature: _____
 Signs/Symptoms **Must Be Listed**: _____ ICD 10 *optional*: _____

MRI - Magnetic Resonance Imaging

Contrast

If no option is selected, the referring physician defers to the radiologist as to whether contrast is medically necessary.

Without Contrast With & Without Contrast

Study

Abdomen Pelvis
 Brain
 IAC*
 Chest
 C-Spine T-Spine L-Spine
 Neck
 Orbit/Face/Neck
 TMJ

Musculoskeletal

	Left	Right	Arthrogram
<input type="checkbox"/> Shoulder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Elbow	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Wrist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Hand	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Thumb	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Hip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Femur	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Knee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Tib/Fib	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Ankle	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Foot	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Pelvic Bone	<input type="checkbox"/>	<input type="checkbox"/>	

Vascular

MRA/MRI, Specify: _____
 Intracranial/Circle of Willis
 Carotids*
 Renal MRA*
 Abdominal Aortogram w/Runoff*

Ultrasound General

Abdomen Limited organ: _____
 Extremity, Non Vascular, Specify: _____

 OB EDC: _____ LMP: _____
 Pelvic w/Transvaginal
 Renal/Bladder
 Scrotum
 Thyroid Thyroid FNA
 Other: _____

Ultrasound Vascular

ABI - include Segmentals/Arterial Doppler PRN
 Aorta Doppler
 Carotid Doppler
 Renal Arterial Doppler
 Venous Doppler Upper Extremity (DVT)
 Bilat Left Right
 Venous Doppler Lower Extremity (DVT)
 Bilat Left Right

CT - Computed Tomography

Contrast

If no option is selected, the referring physician defers to the radiologist as to whether contrast is medically necessary.

Without Contrast

Study

Head/Brain CT Angiography
 Orbits
 Facial Bones
 Sinus
 Carotid CT Angiography
 Soft Tissue Neck
 Chest CT Angiography
 Cardiac Scoring
 Pulmonary Embolism Study w/ contrast
 Colonography (Virtual Colonoscopy)
 Abdomen and/or Pelvis CT Angiography
 Lower Extremity Vascular Runoff (3D)
 Renal Stone
 C-Spine T-Spine L-Spine Myelogram
 CT IVP
 CT Upper Extremity: _____
 3D Reconstruction Pre-Surgical Planning
 CT Lower Extremity: _____
 3D Reconstruction Pre-Surgical Planning

X-ray

Skull
 Paranasal Sinuses
 Soft Tissue Neck
 Clavicle
 Chest PA PA/LAT
 Ribs w/PA Chest
 Bilat Left Right
 Abdomen (KUB)
 Hip
 Bilat Left Right
 Pelvis
 Sacrum & Coccyx
 Osseous Survey

Spine

Cervical Thoracic Lumbar
 With Flexion/Extension
 Scoliosis Series

Extremity (Specify):

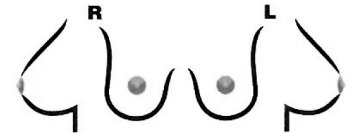
_____ Left Right
 _____ Left Right
 _____ Left Right
 _____ Left Right

Special Studies

Barium Swallow
 Upper GI Series w/Small Bowel
 Barium Enema w/Air Contrast
 Cystogram Voiding
 Specify: _____

Breast Imaging

Screening Digital Mammogram (3D Tomosynthesis)
 Patient has **NO** Symptoms
 Diagnostic Digital Mammogram (3D Tomosynthesis) w/Breast Ultrasound PRN
 Bilat Unilat LT RT
 Breast Ultrasound
 Bilat Unilat LT RT



Nuclear Medicine

Bone Scan SPECT
 Whole Body Limited: _____
 Bone Scan/3 Phase
 Thyroid Uptake w/Scan
 Thyroid Therapy, Dose: _____ mCi
 Whole Body I131 Imaging (Thyroid Met)
 Parathyroid Imaging
 White Blood Cell Scan
 Whole Body Limited: _____
 Gastric Emptying
 Hepatobiliary (HIDA)
 w/GB Ejection Fraction (CCK)
 Kidney/Renal Scan
 w/Lasix DMSA
 Liver/Spleen Imaging
 MUGA, Gated Heart Imaging
 Specify: _____

Steroid Injections

Level Desired

Interlaminar Epidural: _____
 Transforaminal Epidural (Nerve Root Block): _____
 Facet Joint: _____
 Sacroiliac Joint L R
 Joint (Specify): L R

GENERAL

Please check in 30 minutes prior for MRI and 15 minutes for all other appointments unless stated otherwise. You will need to bring a picture ID, a copy of your insurance card and any completed, related studies such as X-rays or CT scans. Tell your doctor and the technologist if you are pregnant or think you may be pregnant. We require 24-hour notice for changes to any appointment or for cancellations.

****Diabetic patients and patients age 60 or older will require a creatinine test prior to the administration of IV contrast. Test results need to be within 30 days of exam date. If needed, a test can be performed onsite free of charge the day of the exam. Please call the center for more information.****

MRI

Patients cannot be examined if they have any of the following: a pacemaker, aneurysm clips in the brain, ear implants, implanted spinal cord stimulation or metallic fragments in one or both eyes.

Patients will be asked to remove all metal from their person (i.e., earrings, watches, hairpins, barrettes) and credit cards. Lockers are provided. It is helpful if patient's clothing is comfortable and doesn't include metal buttons, snaps or zippers.

For MRCPs, MRAs of abdomen and renals, or MRIs of the liver, pelvis and abdomen: The patient should not have anything to eat or drink (including water) 4 hours prior to exam.

CT

Please notify the center of any history of allergies prior to taking prep.

CT of Abdomen & Pelvis

Plan on arriving 1 hour before exam for the administration of oral contrast. Do not eat or drink anything 6 hours prior to exam.

CT Colonography

Patients MUST pick up Tagitol V from our office at least 2 days prior to scheduled CT appointment.

CT of Multi-Phase Liver/Renal

Do not eat or drink anything 6 hours prior to exam.

Abdomen: Pancreatic or Gastric Tumor/Renal

No oral contrast.

Do not eat or drink anything 6 hours prior to exam.

ULTRASOUND

For abdomen, aorta, liver transplant, mesenteric duplex, portal-hepatic duplex or renal arterial duplex: Do not eat or drink (including water) after midnight the evening before the exam.

For pelvis, renal and OB ultrasounds, you will need a full bladder. Drink 32 ounces of water 1 hour before the exam and do not urinate until after test.

NO PATIENT PREP is necessary for the following ultrasound procedures: thyroid, breast, carotid duplex, testicular, venous duplex, ABI and arterial lower extremity.

BREAST IMAGING

Do not wear deodorant, powder or lotion.

NUCLEAR MEDICINE

Special prep may be required before the scan is performed. Please call our center 24 hours prior to exam for exam instructions.

DIAGNOSTIC RADIOLOGY

Barium Swallow UGI & SBFT

Nothing to eat or drink after midnight the night before the exam.

Call us with questions:

ANCHORAGE

4100 Lake Otis Pkwy, Suite 102, Anchorage, AK 99508

Scheduling: **729.5800** | Fax: **729.5889**