

Capsule Endoscopy Clinical Worksheet

Please utilize this worksheet to become familiar with the clinical information required during the clinical review for a Capsule Endoscopy.

	Patient Name:
Diagnosis	Diagnosis, if known or ruled out:
	ICD-10 Codes:
	CPT code for procedure that's planned to be performed:
	Date of last visit:

General Clinical Information	
	<p>What is a capsule endoscopy being requested?</p> <ul style="list-style-type: none"> <input type="radio"/> Member is unable to tolerate endoscopic procedure <input type="radio"/> GI Bleeding <input type="radio"/> Crohn's Disease (Suspected/Known) <input type="radio"/> Known Celiac Disease <input type="radio"/> Screening and Surveillance of members with a Genetic Syndrome (Polyposis, Peutz-Jehgers, etc) <input type="radio"/> Other reason not listed <input type="radio"/> Unknown <p>Has the member had a previous Capsule Endoscopy for this reason?</p> <ul style="list-style-type: none"> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown <p>If yes, please note the date the most recent Capsule Endoscopy was performed:</p> <p>Please note the date this Capsule Endoscopy will be performed:</p>
	<p>Please only answer the following question if the request is for "Crohn's Disease (Suspected/Known)":</p> <p>The request is for:</p> <ul style="list-style-type: none"> <input type="radio"/> Suspected Crohn's <input type="radio"/> Known Crohn's <p>If the request is for "Known Crohn's", is the Capsule Endoscopy request for Crohn's for any of the following reason?</p> <ul style="list-style-type: none"> <input type="radio"/> Assessment of small bowel mucosal healing beyond the reach of ileocolonoscopy <input type="radio"/> Suspected small bowel recurrence after colectomy <input type="radio"/> None of the above <input type="radio"/> Unknown <p>If the request is for "Suspected Crohn's" OR "Known Crohn's" with "None of the above" or "Unknown" as the reason, is the member experiencing any of the following? (Select all that apply)</p> <ul style="list-style-type: none"> <input type="radio"/> Chronic diarrhea (> 30 days) <input type="radio"/> Abdominal pain <input type="radio"/> Weight loss <input type="radio"/> GI bleeding, associated with fatigue <input type="radio"/> None of the above

Additional Clinical Information

Please only answer the following question if the request is for “Crohn’s Disease (Suspected/Known)”:

If the request is for “Suspected Crohn’s” AND the member is experiencing “Chronic diarrhea (>30 days) or “Abdominal pain”, are any of the following biomarkers positive?

- ESR
- CRP
- Fecal calprotectin
- None of the above
- Unknown

Has an ileocolonoscopy been performed?

- Yes
- No
- Unknown

If yes, please note the appropriate result:

- Negative/Normal
- Inconclusive
- Reveals cause of symptoms
- None of the above
- Unknown

Has a previous CT or MRI of the Abdomen and/or Pelvis been performed?

- Yes
- No
- Unknown

If yes, please select the appropriate result.

- Negative/Normal
- Inconclusive
- Reveals cause of symptoms
- None of the above
- Unknown

Please only answer the following question if the request is for “Known Celiac Disease”:

Is this Capsule Endoscopy for the evaluation of known Celiac Disease?

Has the member completed a 6-month trial of a gluten-free diet?

- Yes
- No
- Unknown

If yes, despite the 6 months of treatment, are any of the following symptoms present:

- Bloating
- Diarrhea
- Abdominal pain
- Weight loss
- Abdominal distention
- Evidence of malabsorption
- None of the above
- Unknown

If “unknown” or “none of the above” is selected, please note any current symptoms not listed above:

If “none of the above” is selected, please note your reason why the capsule endoscopy is needed:

Additional Clinical Information

Please only answer the following question if the request is for “GI Bleeding”:

If the member has had a previous Capsule Endoscopy, please select the appropriate result:

- Negative/Normal
- Revealing cause of GI bleed
- None of the above
- Unknown

How many previous CE has the member had for this reason?

Are any of the following signs or symptoms present?

- Observed blood per rectum
- Melena
- Black stool
- Obscure bleeding
- Iron deficiency anemia
- None of the above
- Unknown

If “none of the above” is selected, please note why you think the capsule endoscopy study is needed:

Has the member had an EGD?

- Yes
- No
- Unknown

If yes, please select the appropriate results:

- Negative/Normal
- Revealing cause of GI bleed
- None of the above
- Unknown

Has the member had a colonoscopy?

- Yes
- No
- Unknown

If yes, please select the appropriate result:

- Negative/Normal
- Revealing cause of GI bleed
- None of the above
- Unknown

If “none of the above” is selected, please note why you think the capsule endoscopy study is needed:

Please only answer the following question if the request is for “ Other reason not listed ”:

Are any of the following conditions present?

- Esophageal varices
- Non-reversible coagulopathy
- Recent MI (Myocardial Infarction)
- Other reason not listed
- Unknown

If “none of the above” is selected, please note why you think the capsule endoscopy study is needed:

Additional Clinical Information

Please only answer the following question if the request is for “Screening and Surveillance of members with a Genetic Syndrome ”:

Please note the date this Capsule Endoscopy will be performed:

Please select the appropriate Genetic Syndrome:

- Peutz-Jehgers Syndrome
- Juvenile Polyposis Syndrome
- BMMND (Biallelic Mismatch Repair Deficiency)
- Other

If “other” is selected please specify:

Has a previous capsule endoscopy been performed?

- Yes
- No
- Unknown

If “Yes”, please provide date and result