

Documenting Colon Cancer Screening
Fecal Occult Blood or FIT POC

1. Select Colon Cancer Screening Recommendation. Click on Orders. Select the appropriate Fecal Occult or FIT POC order.
2. Click on Orders for Signature “shopping cart.”
3. On Ordering Physician pop-up: select Order and Communication type of Cosign Required. Click OK.
4. Associate a diagnosis to the order (use Z12.11 Colon cancer screening) and click Sign.

When patient returns Fecal Occult Blood Test or FIT test:

1. Locate the patient on the Nurse Visit Schedule in Ambulatory Organizer and open patient’s chart.
2. Open patient’s orders. Click on the POC order to highlight it. Right click on the order and select Activate.
3. Go to the patient’s Task List and click on Stool Studies POC Task to open the POC Stool Studies PowerForm.
4. Document the test results on the PowerForm and sign.
5. Send the provider a message with Subject: Results Notification. Include the stool study results in the body of the message.

If results are received by other means and the patient is not returning the card:

1. Select Colon Cancer Screening Recommendation. Click on Actions and select PowerForm: Occult Blood Stool Done Elsewhere.
2. The Quality Measures PowerForm will open for charting. Click on the Health Maintenance section. Select Yes for Occult Blood Stool Done Elsewhere. Change the Performed on date and time to the date and time the test was performed. Sign the form.
3. Click on AdHoc on the top toolbar. Select Stool Studies POC. Click Chart. Change the Performed on date and time to the date and time the test was performed. Fill out the PowerForm and sign the form.

Documenting Colon Cancer Screening
Cologuard Order

1. Navigate to Colon Cancer Screening Recommendation on the Ambulatory Workflow page.
2. Click on Orders and select Order: Cologuard.
3. On Ordering Physician pop-up: select Order and Communication type of Cosign Required. Click OK.
4. Click on Orders for Signature “shopping cart.”
5. Associate the appropriate diagnosis, use either Z12.11 Colon cancer screening or Z12.12 Screening for rectal cancer and click Sign.
6. Fax Cologuard Order using Medical Record Request.
7. Select the Template: AMB CP Scheduling Comprehensive. Select the Sections: CST – Insurance information masked SSN, DIAG – Diagnosis, ORD – AMB Ambulatory Procedures
8. Enter Destination: Exact Sciences. Select the Device: !AmbClinicAdHoc or !FX(clinicname). Enter fax number: 9-1-844-870-8875. Send.

Completing Cologuard Transcribed Result

9. When Cologuard Results are received: Select Colon Cancer Screening Recommendation. Click on Actions. Click on Cologuard Result Reviewed.
10. This will open a PowerForm: POC Cologuard Transcribed Result. Change the Performed on date and time to when the test was performed. Document the Cologuard Result. Sign the PowerForm.

Documenting Colon Cancer Screening
Colonoscopy Documentation

1. When Colonoscopy Results are received from referred facility: Select Colon Cancer Screening Recommendation.
 - a. If the frequency of Colon Cancer Screening Recommendation needs to be changed from 10 years: Click Modify and update the due date and/or the timeframe variable. Select the Reason: Patient Risk Factors. Click Save. (If there is a question regarding the frequency, contact the provider to determine the frequency).
2. Click on Actions. Select Procedure: Colonoscopy. Update the Satisfy Date to the date the test was performed. Select the Reason: Expectation Satisfied Elsewhere. Click Save.

Documenting Colon Cancer Screening**Exclusions to Colon Cancer Screening**

1. When Colectomy Results are received, add the exclusion to the Problem List.
2. Navigate to the Problem List on the Ambulatory Workflow Page.
3. Review the Problem List to determine if one of the following exclusions is listed as a Problem. If so, select This Visit.
4. If the Problem is not on the Problem List, search for and select the appropriate problem: History of malignant neoplasm of large intestine (Z85.038) or History of malignant neoplasm of rectum, rectosigmoid junction and anus (Z85.048). Select Add as This Visit and Chronic.
 - a. Clinical staff may add the diagnosis code initially if known. Providers are responsible to add the diagnosis code to subsequent annual visits.
 - b. If clinical staff is uncertain of the correct diagnosis to add, check with the provider.
5. Update Procedure Histories from Recommendations.
6. Select Colon Cancer Screening from Recommendations. Click on Actions and select Procedure: Colectomy.
7. Enter the complete date of the procedure (month, day, year). Remove your own name from the Physician field. Update the Physician to the performing provider (if known). Click Save.