

**DETROIT MEDICAL CENTER  
REQUEST FOR NEW SMS INVISION-LINK CDM CODE  
PATIENT ACCOUNTING INFORMATION**

**DEPARTMENT COMPLETES:**

DMC HOSPITAL NAME: \_\_\_\_\_ DATE OF REQUEST: \_\_\_\_\_

DEPARTMENT NAME: \_\_\_\_\_

COST CENTER# \_\_\_\_\_

DEPARTMENT REQUESTING PERSON XXXX

TITLE: \_\_\_\_\_

PHONE #: \_\_\_\_\_ FAX #: \_\_\_\_\_ PAGER#: \_\_\_\_\_

DESCRIPTION OF HEALTH CARE SERVICES TO BE ADDED TO THE CHARGE DESCRIPTION MASTER:

SMS CDM CODE General Description (30 Characters or less): \_\_\_\_\_

SMS CDM CODE Technical Description (30 Characters or less) : \_\_\_\_\_

**CONTRIBUTING SYSTEM -**

CERNER	<input type="checkbox"/>
PHARMNET	<input type="checkbox"/>
PYXIS	<input type="checkbox"/>
SURGINET	<input type="checkbox"/>
IMPACT	<input type="checkbox"/>
SUNQUEST	<input type="checkbox"/>

**CHECK ONE:**

TIER CODE	<input type="checkbox"/>
BASE CODE	<input type="checkbox"/>

**CHECK ONE:**

ANCILLARY CHARGE	<input type="checkbox"/>
STATISTICAL CHARGE	<input type="checkbox"/>

**CHECK ONE:**

FACILITY CHARGE	<input type="checkbox"/>
PRO FEE CHARGE	<input type="checkbox"/>

**CHECK ONE:**

ADDITION	<input type="checkbox"/>
DELETION	<input type="checkbox"/>
MODIFICATION	<input type="checkbox"/>

ADD BASE CODE <input type="checkbox"/>	COPY EXISTING CDM NUMBER: _____
ADD TIER CODE <input type="checkbox"/>	COPY EXISTING CDM NUMBER: _____

**PHARMNET SYSTEM ONLY:**

IS THIS A SELF ADMINISTERED DRUG? : YES <input type="checkbox"/> NO <input type="checkbox"/>	
CDM NUMBER:	_____
DESCRIPTION:	_____

**LAB REQUEST ONLY:**

EXPLODE CODE	<input type="checkbox"/>
PANEL CODE	<input type="checkbox"/>
AUTOMATED LAB	<input type="checkbox"/>
<b>DESCRIPTION:</b>	
PARENT CODE:	_____
SIBLING CODE:	_____
SIBLING CODE:	_____
SIBLING CODE:	_____
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SIBLING CODE:	_____

**CHECK ONE FOR SUPPLIES ONLY**

STERILE SUPPLY	<input type="checkbox"/>
NON STERILE SUPPLY	<input type="checkbox"/>

**COMPLETE WHEN APPLICABLE**

PROSTHETIC ORTHOTIC DEVICE:	<input type="checkbox"/>
PACEMAKER:	<input type="checkbox"/>
SUPPLY INCIDENTAL / RADIOLOGY:	<input type="checkbox"/>
SUPPLY INCIDENTAL /DIAGNOSTIC SRVC	<input type="checkbox"/>
OTHER IMPLANTS:	<input type="checkbox"/>
OTHER SUPPLY/DEVICE:	<input type="checkbox"/>

**SUPPLY DETAIL INFORMATION:**

LAWSON/ITEM NUMBER:	_____
MANUFACTURER:	_____
VENDOR:	_____
CATALOGUE:	_____

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**CLINICAL TRIAL AND GRANT STUDY ONLY:**

DOES THIS CHARGE HAVE ANYTHING TO DO WITH A CLINICAL TRIAL OR GRANT STUDY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
IS THIS AN INVESTIGATIONAL DEVICE? YES <input type="checkbox"/> NO <input type="checkbox"/>	IDE NUMBER: _____
DMC RESEARCH REVIEW APPROVAL DATE: _____	
NAME OF PI: _____	
TITLE OF STUDY: _____	
SPONSORING COMPANY OR AGENCY: _____	
<b>*****PLEASE REMEMBER TO ATTACHED CMS APPROVAL LETTER*****</b>	

**PLEASE FILL IN AS MUCH INFORMATION AS POSSIBLE:**

GL KEY:		INS CODE:		MODIFIER:	
EXISTING CDM :		NEW CDM		PRICE (TOTAL CHARGE):	
PRICE EFFECTIVE DATE:		PRO FEE FLAT AMT:		PRO FEE PCT AMT:	
REV CODES:	MCARE:	BCBS:	MCAID		
CPT4 CODES:	MCARE:	BCBS:	MCAID		

**SHOULD DMC MARK UP CALCULATION BE APPLIED?**      YES       NO

**FINANCE PRICING REVIEW SIGNATURE:** \_\_\_\_\_      **DATE REVIEWED** \_\_\_\_\_

**NURSE AUDITOR REVIEW:**

**PLEASE PROVIDE EFFECTIVE DATE:**

<b>PATIENT CHARGEABLE:</b> YES <input type="checkbox"/> NO <input type="checkbox"/>	<b>REV CODE EFFECTIVE DATE:</b> _____ <b>PROC CODE EFFECTIVE DATE:</b> _____
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**RECOMMENDATIONS:**

REV CODES:	MCARE:	BCBS:	MCAID	MODIFIER
CPT4 CODES:	MCARE:	BCBS:	MCAID	MODIFIER

**CODING COMPLETED BY:**

DEPARTMENT: <input type="checkbox"/>	HEALTH INFORMATION MANAGEMENT (HIM): <input type="checkbox"/>
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**NURSE AUDITOR SIGNATURE:** \_\_\_\_\_      **DATE REVIEWED** \_\_\_\_\_

**COMMENTS:** \_\_\_\_\_

**PATIENT FINANCE USE:**

DATE RECEIVED: \_\_\_\_\_      MANAGER'S INITIALS: \_\_\_\_\_

PATIENT FINANCE – INFO SYS ANALYST ASSIGNED: \_\_\_\_\_

DATE COMPLETED: \_\_\_\_\_

DATE FAXED TO CONTRIBUTING SYSTEM REPRESENTATIVE: \_\_\_\_\_

**CONTRIBUTING SYTEM: (PLEASE CHECK ONE)**

CERNER       SURGINET       SUNQUEST       PYXIS       CLINIVISION       PHARMNET       RAMS

**PATIENT FINANCE – INFO SYS ANALYST SIGNATURE:** \_\_\_\_\_

**CERNER CIS REVIEW COMPLETED:**

**CIS REPRESENTATIVE SIGNATURE:** \_\_\_\_\_

DATE REVIEWED: \_\_\_\_\_      DATE FAXED TO PT. FINANCE: \_\_\_\_\_

**Detroit Medical Center**  
**Request for New Orders/CDM Form**  
**CIS Information**

Order Description - Long Name \_\_\_\_\_  
(200 characters or less) (Example: Electrocardiogram with interpretation and Report)

Order Description - Display Name \_\_\_\_\_  
(45 characters or less) (Example: EKG w/interp/Report)

Additional Synonyms (Optional) \_\_\_\_\_  
(45 characters or less) (Example: ECG, EKG)

Where would you like the order to display? (Which category/sub-category)-  
\_\_\_\_\_

Should the order display on a task list? Y / N

If yes, what should the associated task display? \_\_\_\_\_  
(45 characters or less) (Usually the same as the order description)

Is the task view only, or can it be charted as Done/Not Done?    View Only    Done/Not Done

Is the orderable    Order Only (no charge) / Order with a Charge / Charge Only (Departmental display only)

Please circle the features you would like assigned to this orderable (All are optional):

Duplicate Checking    Please indicate duplicate checking time parameters (most orders are 24 hours)  
\_\_\_\_\_

Nurse Review    This requires online review by nurse

Requisition Printing    If you would like a requisition to print, please indicate where.  
\_\_\_\_\_

Prep Screen    This is the preparatory information the caregivers will need to know about a test.  
(Example, the patients hair must be washed prior to an EEG.) Indicate the text  
and when you would like the prep screen to display - Pop-up when the order is  
placed or available upon request?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

ORC Text    This is text that will appear on the order details each time this orderable is  
placed. (Example: "Collect 1 Lavender top tube" for a CBC.) Indicate text  
\_\_\_\_\_  
\_\_\_\_\_

What current order uses the order entry format you would like assigned for this orderable? (Is you can't  
find one, please describe any special order details this orderable requires.  
\_\_\_\_\_  
\_\_\_\_\_

Please Email request to CIS CERNER at [CISCDMRequest@dmc.org](mailto:CISCDMRequest@dmc.org)  
or Fax request to CIS CERNER - CIS Fax# (313) 578-3955  
or Scan/email requests to [CISCDMRequest@dmc.org](mailto:CISCDMRequest@dmc.org)