Comagine Health

AK Imaging Assessment *updated December 2020*

I affirm that the recipient's Medicaid eligibility has been confirmed.

- ○ Yes
- ○ No (Per the Alaska Medicaid Provider Manual, page 17 & 19, providers are responsible for evaluating Medicaid eligibility and third party liability prior to submitting review requests to Comagine Health. For questions regarding eligibility or other insurance coverage, log on to the Conduent State Healthcare provider portal at www.medicaidalaska.com or call Conduent Provider Inquiry at (907) 644-6800 or (800) 770-5650 (toll-free in Alaska).

1. Is the imaging procedure being requested, for a work-related injury?
   - ○ Yes (STOP: We are unable to process this work related review. Please contact the patient's employer for assistance.)
   - ○ No

2. Is the imaging procedure for an injury?
   - ○ Yes Date: [ ]
   - ○ No

3. What imaging procedure is being requested? (select ONE)
   - ○ Angiogram
   - ○ MRI
   - ○ PET (select one)
     - ○ Staging
     - ○ Restaging
   - ○ Other:

4. Imaging procedure being requested to assess: (select ONE)
   - ○ 70551
   - ○ 70553
   - ○ 72141
   - ○ 72146
   - ○ 72148
   - ○ 72156
   - ○ 72158
   - ○ 73221
   - ○ 73222
   - ○ 73721
   - ○ 74183
   - ○ 78452
   - ○ 78815
   - ○ Other **(If selected, please fill out AKM Imaging Assessment B at the bottom of this form.)**

5. Part of body to be imaged: (select ONE)
   - ○ Abdominal
   - ○ Abdominal and Pelvis
   - ○ Brain
   - ☐ Breast (If selected, you must select one of the following: bilateral, left or right)
     - ○ Breast – Bilateral
     - ○ Breast – Left
     - ○ Breast – Right
   - ○ Cervical Spine
   - ○ Chest
   - ☐ Elbow (If selected, you must select one of the following: left or right)
     - ○ Elbow – Left
     - ○ Elbow – Right
   - ○ Face/Orbit/Ear/Throat
   - ☐ Foot (If selected, you must select one of the following: left or right)
     - ○ Foot – Left
     - ○ Foot – Right
   - ☐ Hand (If selected, you must select one of the following: left or right)
     - ○ Hand – Left
     - ○ Hand – Right
   - ○ Heart
   - ☐ Hip (If selected, you must select one of the following: left or right)
     - ○ Hip – Left
     - ○ Hip – Right
   - ☐ Knee (If selected, you must select one of the following: left or right)
     - ○ Knee – Left
     - ○ Knee – Right
   - ☐ Lower Extremity (If selected, you must select one of the following: left or right)
     - ○ Lower Extremity – Left (non-joint) Site Requested
     - ○ Lower Extremity – Right (non-joint) Site Requested
   - ○ Lumbar Spine
   - ☐ Shoulder (If selected, you must select one of the following: left or right)
     - ○ Shoulder – Left
     - ○ Shoulder – Right
   - ○ Thoracic Spine
   - ☐ Upper Extremity (If selected, you must select one of the following: left or right)
     - ○ Upper Extremity – Left (non-joint) Site Requested
     - ○ Upper Extremity – Right (non-joint) Site Requested
   - ○ Whole Body PET (base of skull to thigh)
   - ☐ Wrist (If selected, you must select one of the following: left or right)
     - ○ Wrist – Left
     - ○ Wrist – Right
   - ○ Other (Enter Text)

6. Reason for the requested imaging procedure: (include restaging, follow-up, pre/postop, accident, rule out dx, differential dx, etc.)

7. Previous Care completed: (select all that apply)

- ☐ HEP (Home Exercise Program) (If selected, answer all the following questions)
  - Date HEP was complete:
  - What body part?
  - Was HEP effective in reducing your symptoms? ◯ Yes ◯ No
- ☐ Imaging (If selected, answer all the following questions)
  - Date imaging was completed:
  - What type of imaging test? (select ONE)
    - ◯ MRI
    - ◯ CT
    - ◯ US
    - ◯ PET
    - ◯ X-Ray
    - ◯ Other: Enter Text
- ☐ Labs (If selected, answer all the following questions)
  - Date labs were complete:
  - Type of lab tests and results:
- ☐ Medications (If selected, answer all the following questions)
  - Type of medication: (select all that apply)
    - ☐ Narcotics (If selected, answer all the following questions)
      - Narcotics – date medication was completed:
      - Narcotics – duration and results:
    - ☐ NSAIDS (nonsteroidal anti-inflammatory drugs) or Acetaminophen (If selected, answer all the following questions)
      - NSAIDS or Acetaminophen – date medication was completed:
      - NSAIDS or Acetaminophen – duration and results:
    - ☐ Other: (If selected, answer all the following questions)
      - Other – date medication was completed:
      - Other – duration and results:
- ☐ Surgery/Biopsy (If selected, answer all the following questions)
  - Date surgery/biopsy was completed:
  - Surgery/biopsy results:
- ☐ Physical/Occupational Therapy (If selected, answer all the following questions)
  - Date therapy was completed:
  - What body part?
  - Was therapy effective in reducing your symptoms? Yes No
- ☐ Activity Modification or Other: (Enter Text) (If selected, answer all the following questions)
  - Activity modification or Other – date completed:
  - Activity modification or Other – duration and results:
- ☐ Not Applicable

8. Current treatment: (select all that apply)
   - ☐ Cancer Care: Chemo/Radiation
   - ☐ HEP (Home Exercise Program)
   - ☐ Narcotics Ordered
   - ☐ NSAIDS or Acetaminophen Ordered
   - ☐ Physical/Occupational Therapy
   - ☐ Steroid Modification (Oral or Injection)
   - ☐ Other: Enter Text
   - ☐ Not applicable

9. Brief description of the patient's plan of care and any other information to be considered for this imaging review (Example: symptoms and duration, surgery/procedure planning, ruling out a diagnosis)

10. Are you requesting additional imaging services in this episode?
    - ○ Yes (To request for additional imaging services, please complete a separate assessment.)
    - ○ No (Please complete the following AKM Imaging Assessment B if you selected Other in question 4.)

AKM Imaging Assessment B

This assessment is only required if you selected "other" in question 4 above in the AK Imaging Assessment.

1. Has the patient presented with new or changing symptoms or findings? (Required to be completed.)
   - ○ Yes
   - ○ No

2. Is the requested imaging for diagnosis? (Required to be completed.)
   - ○ Yes
   - ○ No

3. Is the requested imaging procedure required for treatment planning? (Required to be completed.)
   - ○ Yes
   - ○ No

AFFIRMATION

Affirm that the submitted clinical documentation supports the requested stay/service(s) and are medically necessary and consistent with the recipient's current level of impairment. (Required to be completed.)

☐ I affirm

Acknowledge the services are subject to post payment review of medical necessity and completeness of documentation according to Medicaid program rules and that the Department of Health & Social Services may recoup payment for any services that are not medically necessary, not properly documented, or not in compliance with Medicaid program rules. (Required to be completed.)

☐ I acknowledge

Acknowledge that approval of this authorization request does not guarantee payment. (Required to be completed.)

☐ I acknowledge

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