Comagine Health | Washington State Department of Labor & Industries | Washington State Health Care Authority

**Patient Name:** _____ **Insurance ID or Claim #:** _____

**Contact Name (if additional info is needed):** _____

**Contact Phone #:** _____ **Contact Fax #:** _____

# Brain Imaging (MRI or CT Scan) Questionnaire

INSTRUCTIONS FOR COMPLETING QUESTIONNAIRE:

- Answer all of the initial questions (Page 1).
- Select the reason for imaging by answering question #4. Based on your answer to question #4, you will be directed to complete ***one*** other section of the questionnaire. Answer ONLY the initial questions and the **ONE** other section as directed based on your answer to question #4.
- Failure to answer ***mandatory*** questions in any part of the questionnaire may lead to technical denial regardless of other answers provided.
- Follow directions exactly. If the question says "select one" answer, only one is needed. Selecting more than one can lead to technical denial.

**WARNING FOR WASHINGTON APPLE HEALTH (MEDICAID) REQUESTS:** Avoid delays in care by ensuring eligibility *prior to submitting* a request FOR MEDICAID MEMBERS. Before processing the request and sending it to Medicaid, Comagine Health staff will check eligibility in the ProviderOne system. You will be notified if Comagine Health is unable to review due to eligibility.

**INSTRUCTIONAL NOTE:** If multiple imaging tests are being requested, submit a separate request for EACH test. To avoid delays (should a full clinical review be necessary), include chart notes with your request. Records should include history, physical exam, recent imaging reports, and rationale for the imaging being requested.

## Initial Questions

1. (**Mandatory**) This guideline based review will result in a RECOMMENDATION ONLY to either Washington State Department of Labor and Industries or Washington Medicaid. If the recommendation is to approve, PLEASE NOTE that services ARE NOT authorized until final determination is made by the appropriate agency.

   ☐ Acknowledge

2. (**Mandatory**) Has the patient had the same or similar imaging done within the last three (3) months?

   ☐ Yes What was the date of the most recent imaging? **Date:** _____

   ☐ No Continue to next question

3. (**Mandatory**) Will you be submitting more than one request for complex imaging for this patient?

   ☐ Yes Full review *may* be required for multiple requests. To avoid delays, include chart notes with your request. Records should include history, physical exam, recent imaging reports, and rationale for the imaging being requested.

   ☐ No Continue to next question

4. Indicate the reason for imaging ***Select One***

   ☐ Headache – answer Section A only

   ☐ All indications other than headache – answer Section B only

Proceed to the appropriate section (based on your answer above) and answer the questions in ONLY that section

**END of INITIAL QUESTIONS –** proceed to complete ONLY one other section

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# Brain Imaging (MRI or CT Scan) Questionnaire - SECTION A

## Headache

*NOTE: Read the questions and responses carefully. If the answer says "Select One", selecting more than one answer can lead to technical denial regardless of how other questions are answered.*

**INSTRUCTIONAL NOTE**: In general, patients with chronic headaches, or with acute exacerbations of their usual headache pattern, whether migraine or tension headache, do NOT require advanced imaging. Neuroimaging is not indicated in patients with a clear history of migraine, w/o red flag features for potential secondary headache and a normal neurological exam.

(**Mandatory**) **DISCLAIMER**: I understand that the answers marked on this questionnaire must be supported by the medical records.

☐ Acknowledge

1. (**Mandatory**) Has the patient had previous brain imaging? ***Select One***
   - ☐ Yes - **answer questions #1a and 1b**
   - ☐ No - **skip to question #2**
   - ☐ Unknown

1a. What type of imaging has been done?

- ☐ CT Scan
- ☐ MRI
- ☐ Other/unknown

1b. What was the approximate date? **Date:** _____

2. (**Mandatory**) Is imaging for either an acute, recurrent headache *OR* a chronic, persistent headache?
   - ☐ Yes
   - ☐ No

3. (**Mandatory**) Please select the most appropriate reason for the current brain imaging request? ***Select one***
   - ☐ Unexplained new or previously unknown abnormal finding on exam
   - ☐ Chronic headache — Full clinical review MAY be required. Please attach chart notes including prior MRI results and notes indicating why the MRI is being requested at this time
   - ☐ Secondary headache caused by another condition
   - ☐ None of the above — Full clinical review is required. Please attach chart notes including prior MRI results and notes indicating why the MRI is being requested at this time

4. Please document if one of the following is present on examination or noted in the records. ***Select one***
   - ☐ Cognitive disturbance (i.e., confusion)
   - ☐ Objective non-focal neurologic signs (i.e., ataxia)
   - ☐ Fever or meningismus
   - ☐ Headache precipitated by exertion or Valsalva maneuver
   - ☐ History or suspicion of cancer
   - ☐ History or suspicion of HIV infection or immunological compromise
   - ☐ Patient is over 50 years old
   - ☐ Suspicion of subarachnoid hemorrhage
   - ☐ Patient has risk factor for cerebral venous thrombosis (CVT) ***answer question #5***
   - ☐ None of the above

5. Select the risk factor for the patient who is at risk for cerebral venous thrombosis (CVT). ***Select one***
   - ☐ Pregnant or postpartum patient
   - ☐ Severe dehydration
   - ☐ Neither of the above

**END SECTION A – Headache Imaging**

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# Brain Imaging (MRI or CT Scan) Questionnaire - SECTION B

## All indications OTHER than headache

*NOTE: Read the questions and responses carefully. If the answer says "Select One", selecting more than one answer can lead to technical denial regardless of how other questions are answered.*

**INSTRUCTIONAL NOTE**: If you are requesting brain imaging *for a headache*, **STOP** and complete Section A instead.

**INSTRUCTIONAL NOTE**: The scope of this advanced imaging assessment is not intended to interfere with timely action in the setting of more urgent care or in situations that require more acute clinical decision – making such as with ACUTE head injury.

(**Mandatory**) **DISCLAIMER**: I understand that the answers marked on this questionnaire must be supported by the medical records.

☐ Acknowledge

NOTE: After answering question #1, you will be directed to other questions within this section. Please answer only the questions referred to based on your response to question #1.

1. (**Mandatory**) Please select the clinical indication for non-headache imaging. ***Select One***
   - ☐ Post trauma or injury – **answer ONLY questions #2 & 3**
   - ☐ Seizures – **answer ONLY questions #4 & 5**
   - ☐ Brain Tumor (primary or metastatic) OR evaluation with known cancer elsewhere – **answer ONLY questions #6 & 7**
   - ☐ None of the above – Full clinical review REQUIRED. Submit clinical information for full review with recent history, physical exam, and rationale for imaging

2. Has there been other imaging such as a CT or MRI for head trauma or injury?
   - ☐ Yes Full clinical review MAY be required. Submit clinical information for full review with recent history, physical exam, prior imaging reports, and rationale for imaging.
   - ☐ No Continue to next question

2a. What was the date of the most recent brain imaging? Enter approximate date if the exact date is unknown.

**Date:** _____

2b. What type of imaging was done?

- ☐ CT Scan
- ☐ MRI
- ☐ Other or unknown

3. When was the trauma or injury which prompted this request for imaging? ***Select one***
   - ☐ Within the last 30 days
   - ☐ Greater than 1 month but less than 6 months ago
   - ☐ Greater than 6 months ago
   - ☐ Unknown

4. Which indication is most appropriate for patient with seizures? ***Select one***
   - ☐ New onset seizures – **answer ONLY questions #4a & 4b**
   - ☐ Seizures refractory to treatment – **answer ONLY question #5**

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4a. Has the patient had complex imaging since the onset of their seizures? ***Select one***

- ☐ Yes – **answer question #4b**
- ☐ No
- ☐ Unknown

4b. When was the imaging done? ***Select one***

- ☐ Within the last 90 days — Full clinical review MAY be required. Submit clinical information for full review with recent history, physical exam, prior imaging reports, and rationale for imaging.
- ☐ Greater than 90 days ago
- ☐ Unknown

5. Indicate the reason for imaging for seizures refractory to treatment. ***Select all that apply***
   - ☐ Increased seizure activity with therapeutic blood level of anticonvulsant
   - ☐ Over 12 weeks since initiation of anticonvulsant medication
   - ☐ No concurrent seizure provoking medications
   - ☐ None of the above

6. Select the indication for brain tumor imaging. ***Select one***
   - ☐ New or worsening central nervous system symptoms or findings
   - ☐ Periodic assessment of tumor or metastatic lesion – **answer question #7**

7. Was the most recent brain imaging done within the last 90 days? ***Select one***
   - ☐ Yes — Full clinical review MAY be required. Submit clinical information for full review with recent history, physical exam, prior imaging reports, and rationale for imaging. What was the date of the most recent brain imaging? Enter approximate date if exact date is unknown.

     **Date:** _____
   - ☐ No

**END SECTION B – Brain Imaging for All Indications other than Headache**