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 #:** _____

Cardiac Imaging Questionnaire

INSTRUCTIONS FOR COMPLETING QUESTIONNAIRE:

- Answer all of the initial questions (Page 1) and then complete the Clinical Questions in the next section.
- Failure to answer ***mandatory*** questions in any part of the questionnaire may lead to technical denial regardless of other answers provided.
- Chart notes are not required for questionnaire based reviews
- 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: Cardiac imaging criteria are based on the Washington State Health Technology Clinical Committee Technology assessment which can be found at the following link: https://www.hca.wa.gov/about-hca/programs-and-initiatives/health-technology-assessment/health-technology-reviews

Initial Questions

(**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

(**Mandatory**) Chart notes must be attached or faxed with all cardiac imaging requests to prevent delays in processing if additional information is needed. DO NOT copy and paste into a notes field if you enter this request through the Comagine Health Provider Portal as your request will be voided and you will have to resubmit.

☐ Acknowledge

1. (**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
2. (**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
3. (**Mandatory**) Indicate the reason for cardiac imaging: ***Select One***
   - ☐ Coronary artery disease (known or suspected)
   - ☐ Pre op cardiac clearance
   - ☐ Neither of the above - Full clinical review is REQUIRED. Please submit clinical including history, physical exam, clinical rationale for requested imaging and diagnostic testing results.

END of INITIAL QUESTIONS – Please complete Clinical Questions on the next page

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

Cardiac Imaging – Clinical Questions

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.

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

☐ Acknowledge

1. Please indicate how you will be providing clinical information. ***Select one***
   - ☐ Submission by attaching documents to this form (preferred)
   - ☐ Faxing documents separately

2. Please indicate the current cardiac status for the patient. ***Select one***
   - ☐ High risk of coronary artery disease (CAD)
   - ☐ Known CAD
   - ☐ Low to intermediate risk of CAD
   - ☐ No known CAD or risk factors for CAD

3. Please select the most appropriate statement regarding an exercise treadmill test (ETT)? ***Select one***
   - ☐ Patient had a normal ETT but is having symptoms of cardiac ischemia/angina
   - ☐ Patient is not physically capable of performing ETT – ***answer question #4***
   - ☐ Electrocardiogram abnormalities prevent accurate interpretation of ETT
   - ☐ Patient has known CAD and is having changing cardiac symptoms
   - ☐ Patient is at high risk for CAD with no changes in cardiac symptoms at this time
   - ☐ Patient is being worked up for major surgery and cardiac clearance with nuclear testing is required – ***answer question #5***
   - ☐ None of the above

4. Why is the patient unable to complete an ETT? ***Select one***
   - ☐ Orthopedic or musculoskeletal conditions prevent prolonged walking
   - ☐ Respiratory conditions
   - ☐ Cardiac conditions such as congestive heart failure or angina
   - ☐ Inability to follow instructions/cooperate with testing
   - ☐ Other – Please explain: _____

5. Please indicate the type of surgery for which cardiac clearance is being sought.

   Surgery planned: _____

END CLINICAL QUESTIONS FOR CARDIAC IMAGING