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

Contact Name (if additional info is needed): _____

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

MRI Cervical Spine 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.

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. (**Mandatory**) Indicate the reason for imaging by selecting ONLY ONE of the following:

   ☐ Acute cervical pain (onset within the last 6 weeks) – **Answer Section A only**

   ☐ Subacute cervical pain (greater than 6 weeks) and NO prior MRI for this episode of pain – **Answer Section B only**

   ☐ Chronic or recurrent cervical pain (greater than 3 months) AND prior MRI for same episode of pain – **Answer Section C only** *(NOTE: select B if pain has been present greater than 3 months and there has NOT been an MRI)*

   ☐ Multiple Sclerosis – **Answer Section D only** *(NOTE: If brain and C-spine will be requested, attach chart notes to the request. Full clinical review WILL BE REQUIRED.)*

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.

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

MRI Cervical Spine Questionnaire - SECTION A

Acute Cervical Pain (onset within the last 6 weeks)

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: Uncomplicated acute cervical pain (less than 6 weeks) with or without suspected radiculopathy (no red flags) does not warrant the use of MRI. Radicular symptoms alone, in the absence of objective neurological signs, do not normally indicate a need for an MRI within an early time period.

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

☐ Acknowledge

1. (**Mandatory**) What are the current PHYSICAL EXAM findings related to cervical spine? (NOTE: Patient complaint or reporting of symptoms is not adequate.) ***Select One***
   - ☐ Normal Exam
   - ☐ New onset of sensory loss in a dermatomal distribution
   - ☐ New onset of motor weakness
   - ☐ New onset of reflex changes in arms
   - ☐ Progressive changes in previously documented neurological signs

2. Is there evidence of neurological signs or symptoms to suggest spinal cord involvement? ***Select One***
   - ☐ New onset of bilateral numbness or weakness in hands or arms
   - ☐ New onset of bilateral reflex changes in the arms
   - ☐ New onset of bilateral neurological symptoms AND signs on physical exam
   - ☐ None of the above

3. Is there objective evidence (e.g., exams, lab, etc.) OR significant suspicion for any of the following? ***Select One***
   - ☐ Malignancy (suspected or newly diagnosed)
   - ☐ Infection
   - ☐ Immunosuppression
   - ☐ Destruction of bone disc margin on plain radiographs (x-rays)
   - ☐ None of the above

4. Is there a history of any of the following types of *SIGNIFICANT* recent trauma? ***Select One***
   - ☐ Cranial trauma
   - ☐ Significant fall
   - ☐ Significant whiplash following high speed impact
   - ☐ Unable to evaluate patient for 48 hours and cervical trauma is suspected
   - ☐ No history of significant trauma

5. Has other imaging been done? ***Select One***
   - ☐ Yes
   - ☐ No

6. Did other imaging show evidence of spinal instability or spinal fracture ***Select One***
   - ☐ Yes
   - ☐ No

END SECTION A – Acute Cervical Pain (Onset within the last 6 weeks)

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

MRI Cervical Spine Questionnaire - SECTION B

Subacute Cervical Pain (greater than 6 weeks) and no prior MRI

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: This assessment is for patients with pain present for 6 weeks or longer with NO prior MRI for this episode of pain.

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

☐ Acknowledge

1. Has there been a prior MRI for this episode of cervical pain? ***Select One***

   ☐ Yes Full clinical review is REQUIRED. Please attach clinical information including the prior MRI Report and notes indicating the reason for MRI at this time.

   ☐ No Continue to next question

2. What are the current PHYSICAL EXAM findings? (NOTE: Patient complaint or reporting of symptoms is not adequate.) ***Select One***

   ☐ Sensory loss in a dermatomal distribution
   ☐ Motor weakness in arms
   ☐ Onset of reflex changes in arms
   ☐ Progressive worsening of previously documented neurological signs
   ☐ Normal exam OR other neurological signs or symptoms

3. Has there been prior neck surgery with SIGNIFICANT new neurological signs and symptoms documented in the records?

   ☐ Yes
   ☐ No

4. Has there been other imaging testing done which shows evidence of spinal instability or spinal fracture?

   ☐ Yes
   ☐ No

5. Does the patient have evidence of SUBSTANTIAL spinal canal stenosis on other imaging tests?

   ☐ Yes
   ☐ No

6. Does the patient have a complex congenital anomaly or deformity of the spine?

   ☐ Yes
   ☐ No

END SECTION B – Subacute Cervical Pain (Greater than 6 weeks and no prior MRI)

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

MRI Cervical Spine Questionnaire - SECTION C

Chronic Cervical Pain (greater than 3 months) AND prior MRI (if no prior MRI, use section B)

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: This assessment is for patients who have had cervical spine pain for at least 3 months AND who have had a prior MRI.

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

☐ Acknowledge

1. What are the current cervical spine PHYSICAL EXAM findings? (NOTE: Patient complaint or reporting of symptoms is not adequate.) ***Select One***
   - ☐ Normal exam OR other neurological signs or symptoms
   - ☐ Sensory loss in a dermatomal distribution
   - ☐ Motor weakness in arms
   - ☐ Onset of reflex changes in arms
   - ☐ Progressive worsening of previously documented neurological signs

2. Do the current exam findings indicate evidence of significant worsening of the neurological status of the patient?
   - ☐ Yes
   - ☐ No

3. Has the patient had electrodiagnostic testing (EMG/Nerve Conduction Study) which show evidence of ACUTE cervical radiculopathy?
   - ☐ Yes – **What is the Approximate date of most recent testing:** _____
   - ☐ No

4. Is the patient a candidate for cervical spine surgery OR has there been a prior cervical spine surgery? **Select one**
   - ☐ Prior cervical spine surgery
   - ☐ Candidate for cervical spine surgery
   - ☐ Unknown

5. Which of the following is present to indicate a need for imaging after a prior cervical surgery? ***Select One***
   - ☐ New objective neurological findings on physical exam
   - ☐ Worsening of neurological findings on physical exam
   - ☐ Plain radiographs (x-rays) or other imaging (e.g., CT, bone scan) are concerning for adverse effects (i.e., hardware issues)
   - ☐ Clinical findings are concerning for adverse effects of surgery
   - ☐ None of the above

6. Has the patient seen a spine surgeon and been determined to be a candidate for spine surgery? **Select One**
   - ☐ Yes
   - ☐ No

7. Have there been substantial changes in the neurological exam findings since the prior MRI was done? (NOTE: Chart notes must document neurological exam and show objective evidence of change/ worsening) **Select One**
   - ☐ Sensory changes in a dermatomal distribution
   - ☐ Weakness in a radicular distribution
   - ☐ Exam and presentation concerning for neurogenic claudication / myelopathy
   - ☐ Neurological exam is stable

8. Has it been more than one year since the last MRI? **Select One**
   - ☐ Yes
   - ☐ No

END SECTION C – Chronic Cervical Pain (Greater than 3 months AND prior MRI)

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

MRI Cervical Spine Questionnaire - SECTION D

Multiple Sclerosis

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. Is there a suspicion of multiple sclerosis (MS) with change in exam findings, specifically of neurological signs and symptoms?
   ☐ Yes
   ☐ No

2. Is the patient KNOWN to have MS with new onset of neurological deficits which are referable to the cervical spinal cord?
   ☐ Yes
   ☐ No

3. Is the MRI being requested for surveillance or to evaluate a response to medical treatment?

   ☐ Yes Full clinical review is required. Please submit clinical information with current treatment regimen, duration of treatment, and current exam findings for review.
   ☐ No

END SECTION D – Multiple Sclerosis