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 #:** _____

Extremity (Lower or Upper Body) Imaging Questionnaire

INSTRUCTIONS FOR COMPLETING QUESTIONNAIRE:

- Answer all of the initial questions (Pages 1 & 2).
- Select the reason for imaging by answering question #5. Based on your answer to question #5, 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 #5.
- 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 (INCLUDING BILATERAL imaging) for this patient?
   - ☐ Yes Full review *may* be required for multiple requests including bilateral imaging. 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. Select the side of body for this imaging request: ***Select One***
   - ☐ Right
   - ☐ Left
   - ☐ Bilateral
5. Indicate the area of the body containing the body part to be imaged: ***Select One***
   - ☐ Lower – answer question #6 only
   - ☐ Upper – answer question #7 only

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6. Select the body part for this lower extremity imaging request: ***Select one***
   - ☐ Knee or Tibia – answer **Section A** only
   - ☐ Ankle or Foot – answer **Section B** only
   - ☐ Hip or Femur – answer **Section C** only

7. Select the body part for this upper extremity imaging request: ***Select one***
   - ☐ Shoulder or Humerus – answer **Section D** only
   - ☐ Wrist or Hand – answer **Section E** only
   - ☐ Elbow or Forearm – answer **Section F** only

Proceed to the appropriate section (based on your answer to question #6 or 7 above) and answer the questions in ONLY that section.

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

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Lower Extremity Imaging – Knee/Tibia Questionnaire – SECTION A

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

☐ Acknowledge

1. (**Mandatory**) Have weight bearing x-rays been done? ***Select One***
   - ☐ Yes
   - ☐ No/Unknown

1a. If the previous answer was **yes**, what were the findings on the weight bearing x-rays? ***Select one***

- ☐ Normal/no evidence of arthritis or degenerative disease
- ☐ Evidence of mild/early arthritis or degenerative disease
- ☐ Evidence of arthritis or degenerative disease
- ☐ Significant osteoarthritis, bone-on-bone or near total joint collapse
- ☐ Unknown

2. (**Mandatory**) Select the body part to be imaged. ***Select one***
   - ☐ Knee – **answer question #2a**
   - ☐ Tibia (non-joint) – **answer question #2c**

2a. Please select the primary clinical indication for the requested knee imaging. ***Select one***

- ☐ Internal derangement (e.g., meniscal, or cruciate ligament injury)
- ☐ Occult fracture
- ☐ Dislocation
- ☐ Collateral ligament injury
- ☐ Patellar subluxation or dislocation
- ☐ Cartilage injury
- ☐ Extensor mechanism injury
- ☐ Osteonecrosis
- ☐ Hemarthrosis
- ☐ Stress or insufficiency fracture
- ☐ Inflammatory arthritis
- ☐ Tendinopathy (including iliotibial band) – **answer question #2b**
- ☐ Bursitis (including the pes anserinum)
- ☐ None of the above

2b. Has the tendinopathy been unresponsive to conventional treatment? ***Select one***

- ☐ Yes
- ☐ No
- ☐ Treatment not yet initiated

2c. Select the primary reason for the requested tibia imaging. ***Select one***

- ☐ Osteomyelitis (known or suspected)
- ☐ Palpable mass of the shin/lower extremity
- ☐ Suspected fracture or fracture nonunion
- ☐ Abnormality on plain x-rays
- ☐ None of the above

Full clinical review MAY BE REQUIRED for all of the above. Please attach clinical including any prior imaging report and notes indicating why MRI is being requested at this time.

END SECTION A – Lower Extremity Imaging – Knee/Tibia Questionnaire

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

Lower Extremity Imaging – Foot/Ankle Questionnaire – SECTION B

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

☐ Acknowledge

1. (**Mandatory**) Have x-rays been done and interpreted? ***Select One***
   - ☐ Yes
   - ☐ No
   - ☐ Interpretation is pending
   - ☐ Unknown

2. (**Mandatory**) Is this imaging for RECENT acute trauma injury?
   - ☐ Yes - Full clinical review MAY BE REQUIRED for acute pain. Submit clinical documentation including x-ray results, history, physical exam, and reason for MRI.
   - ☐ No

3. (**Mandatory**) Select the body part to be imaged. ***Select one***
   - ☐ Ankle – **answer question #3a**
   - ☐ Foot – **answer question #3b**
   - ☐ Foot and ankle - Full clinical review is required if BOTH foot and ankle are being requested. Submit clinical documentation including x-ray results, history, physical exam, and reason for multiple MRIs.

3a. Indicate the primary clinical indication for the requested ankle imaging. ***Select one***
   - ☐ Achilles tendon injury
   - ☐ Ankle impingement syndrome is suspected based on clinical exam
   - ☐ Ankle instability is suspected based on clinical exam
   - ☐ Known or suspected infection
   - ☐ Known or suspected neoplasm
   - ☐ Multiple sites of degenerative joint disease by ankle x-rays
   - ☐ Osteochondral injury is suspected clinically
   - ☐ Suspected fracture
   - ☐ Tendon abnormality is suspected clinically
   - ☐ None of the above

3b. Please indicate the primary clinical indication for the requested foot imaging. ***Select one***
   - ☐ Avascular necrosis
   - ☐ Inflammatory arthropathy
   - ☐ Known or suspected fracture
   - ☐ Known or suspected neoplasm
   - ☐ Known or suspected osteomyelitis
   - ☐ Mortons neuroma
   - ☐ Plantar fasciitis
   - ☐ Tarsal tunnel syndrome
   - ☐ Tendinopathy
   - ☐ None of the above

END SECTION B – Lower Extremity Imaging – Foot/Ankle Questionnaire

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

Lower Extremity Imaging – Hip/Femur Questionnaire – SECTION C

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

☐ Acknowledge

1. (**Mandatory**) Have x-rays been done? ***Select One***
   - ☐ Yes – **answer question #1a.**
   - ☐ No or unknown

1a. If yes, did the x-rays show any of the following? ***Select one***
   - ☐ Normal x-rays
   - ☐ Equivocal for osteonecrosis of the femoral head
   - ☐ Monoarticular or atypical arthritis
   - ☐ Mild arthritis but the hip is the suspected source of referred pain
   - ☐ Suggestive of Pigmented Villonodular Synovitis or osteochondromatosis
   - ☐ Unknown results

2. (**Mandatory**) Which body part will be imaged? ***Select one***
   - ☐ Hip – **answer question #4**
   - ☐ Femur (non-joint) – **answer question #5**

3. Indicate the primary clinical indication for the hip imaging being requested. ***Select one***
   - ☐ Avascular necrosis of the femoral head is suspected with negative or equivocal plain x-rays
   - ☐ Osseous or surrounding soft tissue abnormality suspected but plain x-rays are negative
   - ☐ Radiographically occult condition
   - ☐ Septic arthritis or osteomyelitis
   - ☐ Severe muscle or tendon injury (including adductor aponeurosis)
   - ☐ Stress or insufficiency fracture
   - ☐ Surgical planning may be adversely affected if MRI information is not available
   - ☐ None of the above

4. Indicate the primary clinical indication for the femur imaging being requested. ***Select one***
   - ☐ Osteomyelitis (known or suspected)
   - ☐ Palpable mass of the femur
   - ☐ Suspected fracture or fracture nonunion
   - ☐ Abnormality on plain x-rays
   - ☐ None of the above

Full clinical review MAY BE REQUIRED. Please attach clinical information, including any prior imaging report and notes indicating why MRI is being requested at this time.

END SECTION C – Lower Extremity Imaging – Hip/Femur Questionnaire

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

Upper Extremity Imaging – Shoulder/Humerus Questionnaire – SECTION D

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

☐ Acknowledge

1. (**Mandatory**) Have x-rays been done and interpreted? ***Select One***
   - ☐ Yes
   - ☐ No
   - ☐ Interpretation is pending
   - ☐ Unknown

2. (**Mandatory**) Select the primary indication for the requested imaging. ***Select one***
   - ☐ Acute shoulder pain – **answer question #3**
   - ☐ Subacute or chronic shoulder pain – **answer question #4**
   - ☐ Upper arm/Humerus (non-joint) – **answer question #5**

3. Select the clinical indication for imaging with acute shoulder pain. ***Select one***
   - ☐ Significant trauma with shoulder pain, weakness and suspected rotator cuff tear requiring immediate imaging and treatment
   - ☐ Continued pain after shoulder trauma which has not been responsive to at least 4 weeks of conservative treatment – **answer question #3a**
   - ☐ Clinical signs and symptoms suspicious for rotator cuff tear or impingement in patient age 35 or greater
   - ☐ Suspected instability/labral tear, age less than 35 years – **answer question #3b**
   - ☐ None of the above

3a. Which symptoms or physical exam findings are present to indicate the need for MRI after 4 weeks of treatment? ***Select up to 2***
   - ☐ Normal exam
   - ☐ Anterior or posterior shoulder instability
   - ☐ External rotational pain or weakness
   - ☐ Impingement signs
   - ☐ Loss of abduction
   - ☐ Persistent pain with activity
   - ☐ None of the above

3b. Select clinical indication for imaging in patient age 35 or less with suspected instability/labral tear. ***Select one***
   - ☐ Recurrent dislocation
   - ☐ Suspected intra-articular loose bodies
   - ☐ Suspected avascular necrosis
   - ☐ None of the above

4. Select the clinical indication for imaging in patient with subacute or chronic pain. ***Select one***
   - ☐ Pain with clinical suspicion for instability, rotator cuff tear or labral tear
   - ☐ Prior surgery with substantial increase in objective signs of impingement, instability, or labral tear
   - ☐ Surgery planned and no MRI has been done within the last 6 months
   - ☐ Imaging to evaluate abnormality or red flag – **answer question #4a**
   - ☐ None of the above

4a. Select the abnormality or red flags for which MRI evaluation is requested. ***Select one***

- ☐ Palpable mass on exam
- ☐ Suspected fracture
- ☐ Suspected infection
- ☐ Abnormality on plain x-rays
- ☐ Suspected neoplasm
- ☐ Hemarthrosis
- ☐ None of the above

5. Select the primary reason for this imaging. ***Select one***

- ☐ Osteomyelitis (known or suspected)
- ☐ Palpable mass of the humerus
- ☐ Suspected fracture or fracture nonunion
- ☐ Abnormality on plain x-rays
- ☐ None of the above

Full clinical review MAY BE REQUIRED. Please submit clinical information including any prior imaging report and notes indicating why MRI is being requested at this time.

END SECTION D – Upper Extremity Imaging – Shoulder/Humerus Questionnaire

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

Upper Extremity Imaging – Wrist/Hand Questionnaire – SECTION E

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

- ☐ Acknowledge

1. (**Mandatory**) Have wrist and/or hand x-rays been done and interpreted? ***Select One***
   - ☐ Yes
   - ☐ No
   - ☐ Interpretation is pending
   - ☐ Unknown

2. (**Mandatory**) Is this imaging for RECENT acute trauma? ***Select one***
   - ☐ Yes
   - ☐ No - Full clinical review is REQUIRED for chronic wrist/hand pain. Submit clinical documentation including x-ray results, history, physical exam, and reason for MRI.

3. Select the clinical indication for imaging with acute shoulder pain. ***Select one***
   - ☐ Wrist
   - ☐ Hand
   - ☐ Wrist and hand - Full clinical review is required if BOTH wrist and hand are being requested. Submit clinical documentation including x-ray results, history, physical exam, and reason for multiple MRIs.

4. Is there clinical suspicion for one of the following, necessitating an MRI for this patient? ***Select one***
   - ☐ Abnormality on plain x-rays - Full clinical review is REQUIRED. Please submit clinical including any prior imaging report and notes indicating why MRI is being requested at this time.
   - ☐ Carpal tunnel syndrome
   - ☐ Ganglion cyst
   - ☐ Kienbocks disease
   - ☐ Osteomyelitis (known or suspected) - Full clinical review MAY BE REQUIRED. Please submit clinical including any prior imaging report and notes indicating why MRI is being requested at this time.
   - ☐ Palpable mass of wrist or hand
   - ☐ Suspected fracture (i.e., evaluation of scaphoid fracture)
   - ☐ Suspected ligament or cartilage tear (i.e., triangular cartilage tear)
   - ☐ None of the above - Full clinical review is REQUIRED. Please submit clinical information including any prior imaging report and notes indicating why MRI is being requested at this time.

END SECTION E – Upper Extremity Imaging – Wrist/Hand Questionnaire

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

Upper Extremity Imaging – Elbow/Forearm Questionnaire – SECTION F

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

☐ Acknowledge

1. (**Mandatory**) Have x-rays been done and interpreted? ***Select One***
   - ☐ Yes
   - ☐ No
   - ☐ Interpretation is pending
   - ☐ Unknown

2. (**Mandatory**) Indicate specific upper extremity body part to be imaged. ***Select one***
   - ☐ Elbow (joint)
   - ☐ Forearm (non-joint)

3. Based on the findings, including physical exam, clinical suspicion of which of the following is necessitating MRI at this time? ***Select one***
   - ☐ Avascular necrosis
   - ☐ Biceps tendon rupture at the elbow
   - ☐ Cartilaginous defect
   - ☐ Chronic elbow pain
   - ☐ Epicondylitis – **answer question #3a**
   - ☐ Intra-articular loose bodies or heterotopic calcifications
   - ☐ Mass (palpable or by x-ray) – **answer question #3b**
   - ☐ Osteomyelitis (known or suspected) – **answer questions #3c - 3j**
   - ☐ Suspected fracture and/or ligament tear after severe, acute trauma

     Date of trauma to the elbow: _____
   - ☐ None of the above

3a. For medial or lateral epicondylitis, ***select all that apply***.
   - ☐ Pain at or just distal to the epicondyle
   - ☐ Pain worse with resisted wrist extension
   - ☐ Steroid injection done or contraindicated
   - ☐ Wrist splinting or forearm band attempted
   - ☐ PT/OT or activity modification for 12 weeks
   - ☐ NSAIDs or other medications for 3 weeks or more
   - ☐ None of the above

3b. Does the patient have any of the following? ***Select all that apply***
   - ☐ Normal exam
   - ☐ Palpable mass in the area for which imaging is being requested
   - ☐ Recent trauma by history
   - ☐ Evidence of infection by physical exam

3c. Select the clinical indication for the requested imaging. ***Select one***
   - ☐ Suspected osteomyelitis
   - ☐ Osteomyelitis diagnosed by x-ray, further imaging needed for treatment or preoperative planning
   - ☐ Continued symptoms or findings after treatment

3d. Does the patient have any of the following findings? ***Select all that apply***

- ☐ Sedimentation rate greater than 30mm/hr.
- ☐ Temperature greater than 100.4 F (or 38.0 C)
- ☐ WBC greater than normal
- ☐ Positive blood cultures
- ☐ C-reactive protein greater than normal
- ☐ None of the above

3e. Are there recent x-rays which indicate osteomyelitis? ***Select one***

- ☐ Yes – **Date of x-rays:** _____
- ☐ No
- ☐ X-ray interpretation pending – **Date of x-rays:** _____
- ☐ Unknown or x-rays not done

3f. What type of fracture is suspected? ***Select one***

- ☐ Long bone fracture (e.g., femur, tibia, fibula, humerus)
- ☐ Stress fracture
- ☐ Unknown type of fracture
- ☐ Other – **Describe fracture:** _____

3g. Is non-union of a fracture suspected? ***Select One***

- ☐ Yes
- ☐ No
- ☐ Unknown

3h. How long has it been since the initial injury? ***Select One***

- ☐ Less than 12 weeks
- ☐ Between 12 weeks and 6 months
- ☐ Greater than 6 months
- ☐ Unknown

3i. When was the most recent imaging for this injury done? ***Select One***

- ☐ Only at the time of initial injury
- ☐ Within the past 2 weeks
- ☐ Greater than 2 weeks but less than 6 weeks ago
- ☐ Greater than 6 weeks ago
- ☐ Unknown

3j. What kind of imaging was done most recently? ***Select One***

- ☐ Plain film x-rays
- ☐ Bone scan
- ☐ CT scan
- ☐ MRI
- ☐ Unknown

END SECTION F – Upper Extremity Imaging – Elbow/Forearm Questionnaire