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 #:** _____

MRI Lumbar 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.
- 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.

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 a 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 low back pain (onset within the last 6 weeks)
   Answer Section A only
   ☐ Subacute back pain (greater than 6 weeks but less than 3 months)
   Answer Section B only
   ☐ Chronic back pain (greater than 3 months, NO PRIOR MRI for this episode of pain)
   Answer Section C only
   ☐ Chronic back pain (greater than 3 months, PRIOR MRI done)
   Answer Section D 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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MRI Lumbar Spine Questionnaire - SECTION A

Acute Low Back 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: This assessment should ONLY be used if the patient has had symptoms for 6 weeks or less. For greater than 6 weeks but less than 3 months, complete the Subacute Low Back Pain assessment; greater than 3 months, complete the Chronic Low Back Pain assessment.

(Mandatory) **DISCLAIMER**: I understand that the answers marked on this questionnaire must be supported by the medical records. Uncomplicated back pain without the presence of red flags does not warrant the use of MRI.

☐ Acknowledge

1. (Mandatory) What are the current PHYSICAL EXAM findings? (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 in a dermatomal distribution

2. Is Acute Cauda Equina Syndrome suspected? ***Select One***
   - ☐ Cauda Equina is not suspected – **answer question #3**
   - ☐ New onset of acute bladder or bowel dysfunction (i.e., incontinence)
   - ☐ New onset of bilateral neurological symptoms AND signs on physical examination

3. Is Infection suspected? ***Select One***
   - ☐ Yes – **answer question #3a**
   - ☐ No – **skip to question #4**

3a. If infection is suspected, please indicate why infection is suspected? ***Select One***
   - ☐ Elevated Sedimentation Rate
   - ☐ Fever greater than 100.4 degrees (or 38C)
   - ☐ Immunosuppression (i.e., chronic long term steroid use)
   - ☐ IV drug use (recent)
   - ☐ Current bacteremia
   - ☐ Suspicion of systemic or spinal infection
   - ☐ None of the above

4. Is there a history or suspicion of cancer with a new onset of low back pain? ***Select One***
   - ☐ Yes – **answer question #4a**
   - ☐ No – **skip to question #5**

4a. If there is a history or suspicion of cancer, are any of the following present? ***Select up to two***
   - ☐ Unexplained weight loss
   - ☐ Back pain with failure to improve after one month
   - ☐ Patient age over 50
   - ☐ None of the above

5. Has there been RECENT low velocity trauma (e.g., fall from height or struck by object)? ***Select One***
   - ☐ Yes
   - ☐ No (no further answers needed)

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

5a. If there is RECENT history of low velocity trauma, is there a history of osteoporosis OR is the patient over age 70? ***Select One***

- ☐ Yes
- ☐ No (no further answers needed)

5b. Have plain radiographs (x-rays) or CT Scan(s) been done on the spine? ***Select One***

- ☐ Yes
- ☐ No (no further answers needed)

5c. What were the results of the plain radiographs or CT scan(s)? ***Select One***

- ☐ No evidence of fractures
- ☐ Vertebral compression fracture(s) present
- ☐ Other fracture(s) present

END SECTION A – Acute Low Back Pain (onset within the last 6 weeks)

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

MRI Lumbar Spine Questionnaire – SECTION B

Subacute Low Back Pain (onset greater than 6 weeks but less than 3 months)

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 should ONLY be used for back pain present for greater than 6 weeks but less than 3 months.

(**Mandatory**) **DISCLAIMER**: I understand that the answers marked on this questionnaire must be supported by the medical records. Uncomplicated back pain without the presence of red flags does not warrant the use of MRI.

☐ Acknowledge

1. (**Mandatory**) Please indicate which of the following is the primary reason for MRI. ***Select One***
   - ☐ Low back pain without radiation
   - ☐ Low back pain with radiation/bilateral leg pain
   - ☐ Low back pain with radiation and one sided leg pain
   - ☐ None of the above

2. (**Mandatory**) How much conservative care has the patient had? ***Select One***
   - ☐ None
   - ☐ 2 to 5 weeks
   - ☐ 6 weeks or more

3. (**Mandatory**) Does the patient have a normal neurological exam (includes sensory and/or motor testing)? ***Select One***
   - ☐ Yes
   - ☐ No

4. (**Mandatory**) 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
   - ☐ Progressive (worsening) motor weakness on serial exams in a specific distribution
   - ☐ Exam did not include sensory testing
   - ☐ Exam did not include motor testing
   - ☐ None of the above

5. (**Mandatory**) Is there a suspicion of radiculopathy based on any of the following? ***Select all that apply***
   - ☐ (a) Radiculopathy is not suspected
   - ☐ (b) Pain documented in a specific nerve root distribution
   - ☐ (c) Leg pain is documented to be worse than back pain
   - ☐ (d) Exam findings or other testing suspicious for or consistent with radiculopathy

6. (**Mandatory**) Please specify what other testing has been done and has documented findings consistent with radiculopathy? ***Select one***
   - ☐ (a) EMG or Nerve Conduction Study
   - ☐ (b) Straight leg raising test documented at 45 degrees with a positive result
   - ☐ (c) Positive crossed leg straight leg raising test
   - ☐ (d) Motor weakness in a radicular distribution
   - ☐ (e) Sensory loss in a radicular distribution
   - ☐ (f) No other testing done **OR** none of the above (***if selected continue to answer remaining questions)***

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7. Is Cauda Equina Syndrome suspected? ***Select One***
   - ☐ Yes
   - ☐ No – ***skip to question #9***

8. Are any of the following documented causing Cauda Equina to be suspected? ***Select One***
   - ☐ Cauda Equina is not suspected
   - ☐ New onset of acute bladder or bowel dysfunction (i.e., incontinence)
   - ☐ New onset of bilateral neurological symptoms AND signs on physical examination
   - ☐ None of the above

9. Is Infection suspected? ***Select One***
   - ☐ Yes
   - ☐ No – ***skip to question #11***

10. If infection is suspected, please indicate why infection is suspected? ***Select One***
    - ☐ Elevated Sedimentation Rate
    - ☐ Fever greater than 100.4 degrees (or 38C)
    - ☐ Immunosuppression (i.e., chronic long term steroid use)
    - ☐ IV drug use (recent)
    - ☐ Current bacteremia
    - ☐ Suspicion of systemic or spinal infection
    - ☐ None of the above

11. Is there a history or suspicion of cancer with a new onset of low back pain? ***Select One***
    - ☐ Yes
    - ☐ No – ***skip to question #13***

12. If there is a history or suspicion of cancer, are any of the following present? ***Select up to two***
    - ☐ Unexplained weight loss
    - ☐ Back pain with failure to improve after one month
    - ☐ Patient age over 50
    - ☐ None of the above

13. Is there a RECENT history of low velocity trauma (e.g., fall from height or struck by object)? ***Select One***
    - ☐ Yes
    - ☐ No (no further answers needed)

14. If there is a RECENT history of low velocity trauma, is there a history of osteoporosis OR is the patient over age 70? ***Select One***
    - ☐ Yes
    - ☐ No

15. Have plain radiographs (x-rays) or CT Scan(s) been done on the spine? ***Select One***
    - ☐ Yes
    - ☐ No (no further answers needed)

16. What were the results of the plain radiographs or CT scan(s)? ***Select One***
    - ☐ No evidence of fractures
    - ☐ Vertebral compression fracture(s) present
    - ☐ Other fracture(s) present

END SECTION B – Subacute Low Back Pain (onset greater than 6 weeks but less than 3 months)

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

MRI Lumbar Spine Questionnaire – SECTION C

Chronic Low Back Pain (greater than 3 months) without 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.

(**Mandatory**) **DISCLAIMER**: I understand that the answers marked on this questionnaire must be supported by the medical records. Uncomplicated back pain without the presence of red flags does not warrant the use of MRI.

☐ Acknowledge

1. (**Mandatory**) Please indicate which of the following is the primary reason for MRI. ***Select One***
   - ☐ Low back pain without radiation
   - ☐ Low back pain with radiation/bilateral leg pain
   - ☐ Low back pain with radiation and one sided leg pain
   - ☐ None of the above

2. (**Mandatory**) How much conservative care has the patient had? ***Select One***
   - ☐ None
   - ☐ 2 to 5 weeks
   - ☐ 6 weeks or more

3. (**Mandatory**) Does the patient have a normal neurological exam (includes sensory and/or motor testing)? ***Select One***
   - ☐ Yes
   - ☐ No

4. (**Mandatory**) Has the patient had RECENT x-rays which show new evidence of SUBSTANTIAL spinal stenosis? ***Select One***
   - ☐ Unknown if x-rays were done ***OR*** results not known
   - ☐ X-rays did not show stenosis
   - ☐ X-rays have not been done
   - ☐ Recent x-rays show evidence of SUBSTANTIAL spinal stenosis

5. (**Mandatory**) 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
   - ☐ Progressive (worsening) motor weakness on serial exams in a specific distribution
   - ☐ Exam did not include sensory testing
   - ☐ Exam did not include motor testing
   - ☐ None of the above

6. (**Mandatory**) Is there a suspicion of radiculopathy based on any of the following? ***Select all that apply***
   - ☐ (a) Radiculopathy is not suspected
   - ☐ (b) Pain documented in a specific nerve root distribution
   - ☐ (c) Leg pain is documented to be worse than back pain
   - ☐ (d) Exam findings or other testing suspicious for or consistent with radiculopathy

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7. (**Mandatory**) Please specify what other testing has been done and has documented findings consistent with radiculopathy? ***Select one***
   - ☐ (a) EMG or Nerve Conduction Study
   - ☐ (b) Straight leg raising test documented at 45 degrees with a positive result
   - ☐ (c) Positive crossed leg straight leg raising test
   - ☐ (d) Motor weakness in a radicular distribution
   - ☐ (e) Sensory loss in a radicular distribution
   - ☐ (f) No other testing done **OR** none of the above (***if selected continue to answer remaining questions)***

8. Is Cauda Equina Suspected? ***Select One***
   - ☐ Yes
   - ☐ No

9. Are any of the following documented causing Cauda Equina to be suspected? ***Select One***
   - ☐ Cauda Equina is not suspected
   - ☐ New onset of acute bladder or bowel dysfunction (i.e., incontinence)
   - ☐ New onset of bilateral neurological symptoms AND signs on physical examination
   - ☐ None of the above

10. Is Infection suspected? ***Select One***
    - ☐ Yes
    - ☐ No – ***skip to question #12***

11. If infection is suspected, please indicate why infection is suspected? ***Select One***
    - ☐ Elevated Sedimentation Rate
    - ☐ Fever greater than 100.4 degrees (or 38C)
    - ☐ Immunosuppression (i.e., chronic long term steroid use)
    - ☐ IV drug use (recent)
    - ☐ Current bacteremia
    - ☐ Suspicion of systemic or spinal infection
    - ☐ None of the above

12. Is there a history or suspicion of cancer with a new onset of low back pain? ***Select One***
    - ☐ Yes
    - ☐ No – ***skip to question #14***

13. If there is a history or suspicion of cancer, are any of the following present? ***Select up to two***
    - ☐ Unexplained weight loss
    - ☐ Back pain with failure to improve after one month
    - ☐ Patient age over 50
    - ☐ None of the above

14. Is there a RECENT history of low velocity trauma (e.g., fall from height or struck by object)? ***Select One***
    - ☐ Yes
    - ☐ No (no further answers needed)

15. If there is a RECENT history of low velocity trauma, is there a history of osteoporosis OR is the patient over age 70? ***Select One***
    - ☐ Yes
    - ☐ No

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16. Have plain radiographs (x-rays) or CT Scan(s) been done on the spine? ***Select One***
- ☐ Yes
- ☐ No (no further answers needed)

17. What were the results of the plain radiographs or CT scan(s)? ***Select One***
- ☐ No evidence of fractures
- ☐ Vertebral compression fracture(s) present
- ☐ Other fracture(s) present

END SECTION C – Chronic Low Back Pain (greater than 3 months) WITHOUT prior MRI

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MRI Lumbar Spine Questionnaire – SECTION D

Chronic Low Back Pain (greater than 3 months) WITH 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. Based on your response to question #2, you will be directed to answer additional questions. DO NOT answer more than the questions to which you are directed.

INSTRUCTIONAL NOTE: This assessment should ONLY be used if the patient has had a prior lumbar spine MRI for their current injury/episode of back pain.

(Mandatory) **DISCLAIMER**: I understand that the answers marked on this questionnaire must be supported by the medical records. Uncomplicated back pain without the presence of red flags does not warrant the use of MRI.

☐ Acknowledge

1. (Mandatory) How long ago was the prior MRI done? ***Select One***

   ☐ Within the past 90 days — Full clinical review is REQUIRED. Please submit clinical information including prior MRI results and notes indicating rationale for repeat imaging.
   ☐ More than three (3) months but less than one (1) year ago
   ☐ Over one (1) year ago
   ☐ Date of prior MRI not known

2. (Mandatory) What is the reason for the MRI being requested now? ***Select One and then answer ONLY the questions you are directed to based on your response.***

   ☐ Objective worsening of neurologic status by physical exam – ***answer ONLY question #3***
   ☐ New electrodiagnostic testing (EMG) shows worsening of neurologic status – **answer ONLY question #4**
   ☐ Prior lumbar surgery has been done – **answer ONLY questions #5 and 6**
   ☐ Patient is considered a candidate for spine surgery – **answer ONLY question #7**
   ☐ None of the above — **Full clinical review is REQUIRED. Please submit clinical information including prior MRI and notes indicating why MRI is being requested at this time.**

3. 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
   ☐ Progressive (worsening) motor weakness on serial exams in a specific distribution
   ☐ Exam did not include motor testing
   ☐ Exam did not include sensory testing
   ☐ Other findings on exam
   ☐ None of the above

4. What are the new findings on electrodiagnostic (EMG) testing? ***Select One***

   ☐ Evidence of chronic radiculopathy
   ☐ Evidence of new or acute lumbar radiculopathy
   ☐ Evidence of acute on chronic radiculopathy
   ☐ Results of EMG are not available

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5. Are there substantial changes in the neurological exam findings? (NOTE: Chart notes must document neurological exam and show evidence of objective change.) ***Select One***

   ☐ Sensory loss in a dermatomal distribution
   ☐ Weakness in a radicular distribution
   ☐ Exam and presentation concerning for neurogenic claudication
   ☐ No substantial changes
   ☐ Other findings **Full clinical review MAY BE REQUIRED. Please attach clinical including prior MRI and notes indicating why MRI is being requested at this time.**

6. Which of the following is present to indicate a need for imaging after a prior lumbar surgery? ***Select One***

   ☐ New objective neurological findings on physical exam
   ☐ Worsening of neurological findings on physical exam
   ☐ Plain radiographs (x-rays) are concerning for adverse effects (i.e., hardware issues)
   ☐ Clinical findings are concerning for adverse effects of surgery
   ☐ None of the above

7. Has the patient seen a spine surgeon and been determined to be a candidate for spine surgery? ***Select One***

   ☐ Yes
   ☐ No

8. What are the substantial changes in the neurological exam findings? (NOTE: Chart notes must document neurological exam and show evidence of objective change.) ***Select One***

   ☐ Sensory loss in a dermatomal distribution
   ☐ Weakness in a radicular distribution
   ☐ Exam and presentation concerning for neurogenic claudication
   ☐ Other findings

END SECTION D – Chronic Low Back Pain (greater than 3 months) WITH prior MRI