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

Contact Name (if additional info is needed): _____

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

Spinal Injection Questionnaire

INSTRUCTIONS FOR COMPLETING QUESTIONNAIRE:

- Answer all of the initial questions (Page 1)
- Select the clinical indicator for the spinal injection by answering question #3. Based on your answer to question #3, you will be directed to complete ***one*** other section of the questionnaire. This section will have additional instructions and may have a sub section of questions to answer. Answer ONLY the initial questions, the **ONE** other section as directed based on your answer to question #3, and any sub section indicated. Failure to answer all sets of questions may result in a TECHNICAL DENIAL.
- 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.

DISCLAIMER: This guideline based review will result in a RECOMMENDATION ONLY to either Washington State Department of Labor & Industries or Washington Apple Health (Medicaid). If the recommendation is to approve, PLEASE NOTE THAT Services ARE NOT authorized until final determination is made by the appropriate agency.

☐ Acknowledge

DISCLAIMER: Imaging guidance is required. I understand that payment may be denied if injections are performed without appropriate imaging guidance.

☐ Acknowledge

Initial Questions

1. (**Mandatory**) Indicate what type of imaging guidance will be used to perform this injection. ***Select one***
   - ☐ CT
   - ☐ Fluoroscopic
   - ☐ Type of imaging guidance at radiologist's discretion
   - ☐ None of the above

2. (**Mandatory**) Select type of spinal injection for this request: ***Select one***
   - ☐ Epidural Injection including selective nerve root block – **Answer Section A only**
   - ☐ Medial Branch Block – **Answer Section B only**
   - ☐ Sacroiliac Joint Injection – **Answer Section C 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.

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

Epidural and Selective Nerve Root Injections Questionnaire - SECTION A

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.

INSTRUCTIONS: Select the reason for injection by answering question #4 below. Based on your answer to question #4, you will be directed to complete a set of sub section questions. Failure to answer all sets of questions may result in a TECHNICAL DENIAL.

DISCLAIMER: A Selective Nerve Root Block (SNRB) is defined by LNI and Apple Health (Medicaid) as a SINGLE level, STEROID FREE, low volume injection done to determine if pain is coming from a specific nerve. PRE PROCEDURE PAIN LEVEL AND RESPONSE TO INJECTION MUST BE DOCUMENTED BY THE PROVIDER DOING THE INJECTION. If steroids are used, the injection will be considered a therapeutic steroid injection and the results will not be able to be used to support the need for spinal surgery. ***Select one***

- ☐ This request is for an injection containing steroids
- ☐ This request is for an injection that will not contain steroids
- ☐ Steroids to be given at the injectionist discretion
- ☐ Use of steroids for injection unknown

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

- ☐ Acknowledge

1. (**Mandatory**) How many prior injections have been done in the last 12 months for the spinal section (e.g., cervical, thoracic, lumbar) being requested? ***Select One***
   - ☐ None
   - ☐ Two (2) or fewer
   - ☐ Three (3) or more – Full clinical review MAY BE REQUIRED. Submit chart notes for review which include current exam and plan for injections, the prior injection procedure reports, documentation showing patient response to injections, amount of improvement in pain and function.
   - ☐ Unknown

2. **(Mandatory)** Indicate the reason for injection. ***Select One***
   - ☐ Therapeutic (pain relief) Epidural Steroid Injection – **Answer Sub Section A.1 only**
   - ☐ Diagnostic (steroids NOT being used) Selective Nerve Root Block – **Answer Sub Section A.2**

Epidural Steroid Injection Questionnaire - Sub Section A.1

3. Select the side of the spine OR approach for epidural steroid injection. **NOTE: BILATERAL INJECTIONS ARE NOT ALLOWED**. ***Select One***
   - ☐ Right
   - ☐ Left
   - ☐ Interlaminar
   - ☐ Caudal

4. Indicate the first spinal section for the proposed injection(s). ***Select One***
   - ☐ Cervical Spine – answer question #4a
   - ☐ Lumbar Spine – answer question #4b
   - ☐ Thoracic Spine – answer question #4c

4a. Select the cervical spinal nerve to be blocked, then skip to question #6. ***Select One***

- ☐ C2
- ☐ C3
- ☐ C4
- ☐ C5
- ☐ C6
- ☐ C7
- ☐ C8

4b. Select the lumbar spinal nerve to be blocked, then skip to question #6. ***Select One***

- ☐ L1
- ☐ L2
- ☐ L3
- ☐ L4
- ☐ L5
- ☐ S1 (one)

4c. Enter the thoracic spinal nerve to be blocked: _____

5. Will a second spinal nerve be blocked? ***Select One***

- ☐ Yes – Answer question #5a
- ☐ No – Skip to question #6

5a. Indicate the second spinal section for the proposed injection(s). ***Select One***

- ☐ Cervical Spine – answer question #5b
- ☐ Lumbar Spine – answer question #5c
- ☐ Thoracic Spine – answer question #5d

5b. Select the cervical spinal nerve to be blocked, then skip to question #11. ***Select One***

- ☐ C2
- ☐ C3
- ☐ C4
- ☐ C5
- ☐ C6
- ☐ C7
- ☐ C8

5c. Select the lumbar spinal nerve to be blocked, then skip to question #11. ***Select One***

- ☐ L1
- ☐ L2
- ☐ L3
- ☐ L4
- ☐ L5
- ☐ S1 (one)

5d. Enter the thoracic spinal nerve to be blocked: _____

6. How much conservative care has the patient had? ***Select One***

- ☐ None
- ☐ At least two (2) weeks
- ☐ Greater than two (2) weeks but less than six (6) weeks
- ☐ Six (6) weeks or more

Please consider ALL conservative care since the patient has had pain INCLUDING care from other providers.

7. Please indicate the types of conservative care the patient has had. ***Select all that apply***
   - ☐ Chiropractic care
   - ☐ Massage therapy
   - ☐ Structured physical therapy
   - ☐ Home exercise program
   - ☐ NSAIDs
   - ☐ Oral steroids
   - ☐ Narcotic medications
   - ☐ Non-narcotic medications
   - ☐ None of the above
   - ☐ Unknown

8. What are the current PHYSICAL EXAM findings? (NOTE: Exam findings only. Not patient complaint or reporting of symptoms.) ***Select all that apply***
   - ☐ Normal exam
   - ☐ Dermatomal sensory loss
   - ☐ Motor weakness
   - ☐ Asymmetric, decreased, or absent reflexes
   - ☐ Unknown

9. Has the patient had steroid injection(s) in the same spinal section (e.g., cervical, lumbar, etc.) as the requested injection? ***Select One***
   - ☐ Yes – INSTRUCTIONAL NOTE: If the patient has had prior injections in the same spinal section, you MUST answer the remaining questions to ensure timely processing of the request. This information is required for repeat injections.
   - ☐ No – Complete. No further questions need to be answered.

10. Was treatment with spinal steroid injections in the same spinal section started more than 1 year ago? ***Select One***
    - ☐ Yes – Full clinical review MAY BE REQUIRED. Submit chart notes showing history of injections given and response to injections.
    - ☐ No

11. Document the date(s) of the 3 most recent injection(s):
    - ☐ Injection 1 – **Date:** _____
    - ☐ Injection 2 – **Date:** _____
    - ☐ Injection 3 – **Date:** _____

12. How many steroid injection(s) have been given in the requested spinal segment (e.g., cervical, lumbar, etc.) in the past 2 years? ***Select One***
    - ☐ One (1) or two (2)
    - ☐ Three (3) or more
    - ☐ Unknown - Review of chart notes MAY BE REQUIRED. Please attach notes including the most recent injection report, provider notes documenting plan for injections and pain diaries if available.

13. How much improvement in pain AND function is documented on a validated instrument from the most recent injection? ***Select One***
    - ☐ None
    - ☐ Less than 30%
    - ☐ Greater than 30%
    - ☐ Unknown

14. How was the amount of improvement in pain and function determined? ***Select all that apply***
    - ☐ Documented decrease in the use of pain medications
    - ☐ Documented improvement in findings on physical examination
    - ☐ Documented increase in activity, return to work
    - ☐ Patient generated pain diary
    - ☐ Verbal report from patient (i.e., pain scale)

COMMENTS/NOTES: Please use this field to provide any specific information you want Comagine Health to have as this request is considered: _____

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END SUB SECTION A.1 – Epidural Steroid Injection Questionnaire

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Selective Nerve Root Block Injection Questionnaire - Sub Section A.2

3. Select the side of the spine for selective nerve root block. ***Select One***
    - ☐ Right
    - ☐ Left

4. Indicate the specific spinal nerve that is the target of the selective nerve root block. ***Select One***
    - ☐ Cervical Spine – answer question #4a
    - ☐ Lumbar Spine – answer question #4b
    - ☐ Thoracic Spine – answer question #4c

4a. Select the cervical spinal nerve to be blocked for SNRB, then skip to question #6. ***Select One***
    - ☐ C2
    - ☐ C3
    - ☐ C4
    - ☐ C5
    - ☐ C6
    - ☐ C7
    - ☐ C8

4b. Select the lumbar spinal nerve to be blocked for SNRB, then skip to question #6. ***Select One***
    - ☐ L1
    - ☐ L2
    - ☐ L3
    - ☐ L4
    - ☐ L5
    - ☐ S1 (one)

4c. Enter the thoracic spinal nerve to be blocked SNRB: _____

5. Has the patient been seen and evaluated by a spine surgeon? ***Select One***
   - ☐ Yes
   - ☐ No
   - ☐ Unknown

6. Has the patient had prior selective nerve root blocks OR steroid injections in the same spinal section (e.g., cervical, thoracic or lumbar) as the requested injection? ***Select One***
   - ☐ Yes
   - ☐ No – skip to question #9
   - ☐ Unknown – skip to question #9

6a. Document the date(s) of 3 most recent injections.

- ☐ Injection 1 – **Date:** _____
- ☐ Injection 2 – **Date:** _____
- ☐ Injection 3 – **Date:** _____

7. Chart notes should be attached or faxed with all selective nerve root block requests to prevent delays in processing if additional information is needed. Submit documents showing plan for the injection, history, physical exam, surgeons consult (if available), MRI, and other diagnostics, if available. How you will be providing clinical information? ***Select One***
   - ☐ Attaching documents (preferred)
   - ☐ Faxing documents separately
   - ☐ Faxing and attaching documents

COMMENTS/NOTES: Please use this field to provide any specific information you want Comagine Health to have as this request is considered: _____

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END SUB SECTION A.2 – Selective Nerve Root Block Injection Questionnaire

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

Medial Branch Blocks (MBB) Questionnaire - 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: Do NOT submit for thoracic or sacral spine. ONLY cervical and lumbar spine medial branch blocks are allowed.

INSTRUCTIONAL NOTE: Clinical documents are REQUIRED for processing this request. Please provide history, physical examination, reports for diagnostics such as imaging/NCS, and (if applicable) reports for prior MBBs and RFAs.

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

☐ Acknowledge

1. Select the spinal section for the injection. ***Select One***
   ☐ Cervical – Answer question #1a
   ☐ Lumbar – Skip to questions #1b & c

1a. Indicate the target facet joint level for the cervical block. NOTE: Only ONE facet joint is allowed in the cervical spine, then skip to question #2. ***Select One***

☐ Right C3-C4
☐ Right C4-C5
☐ Right C5-C6
☐ Right C6-C7
☐ Left C3-C4
☐ Left C4-C5
☐ Left C5-C6
☐ Left C6-C7

1b. Indicate the target facet joint(s) for the lumbar block. ***Select up to two joints***

☐ L1-L2
☐ L2-L3
☐ L3-L4
☐ L4-L5
☐ L5-S1

1c. Indicate the side of the lumbar spine for the medial branch block(s). ***Select one***

☐ Right
☐ Left
☐ Bilateral (lumbar only)

2. Is a discussion with the patient about a plan for a facet neurotomy/radiofrequency ablation based on the results of the requested injections documented in the medical records? ***Select one***

☐ Yes
☐ No
☐ No further procedures planned
☐ Unknown

3. Has the patient had a radiofrequency ablation/facet neurotomy in the spinal section of the requested block(s)? ***Select one***
   - ☐ Yes – **Date:** _____
   - ☐ No

4. Is the patient a candidate for radiofrequency ablation/facet neurotomy at the requested level? ***Select one***
   - ☐ Yes
   - ☐ No
   - ☐ Unknown
   - ☐ To be determined based on the results of the requested block(s)

5. Has the patient had conservative care? ***Select one***
   - ☐ Yes
   - ☐ No

6. How much conservative care has the patient had for the medial branch block injection?
   - ☐ None
   - ☐ Less than two (2) months
   - ☐ Two (2) to five (5) months
   - ☐ Six (6) months or more
   - ☐ Unknown

   Please consider ALL conservative care since the patient has had pain INCLUDING care from other providers.

7. Please indicate the types of conservative care the patient has had. ***Select all that apply***
   - ☐ Chiropractic care
   - ☐ Massage therapy
   - ☐ Structured physical therapy
   - ☐ Home exercise program
   - ☐ NSAIDs
   - ☐ Oral steroids
   - ☐ Narcotic medications
   - ☐ Non-narcotic medications
   - ☐ None of the above
   - ☐ Unknown

8. Does the patient complain of radicular pain? ***Select one***
   - ☐ Yes
   - ☐ No
   - ☐ Unknown

9. Does the patient have pain or tenderness on exam at the spinal level of the requested block(s)? ***Select one***
   - ☐ Yes
   - ☐ No
   - ☐ Unknown

10. What are the current PHYSICAL EXAM findings? (NOTE: Patient complaint or reporting of symptoms is not adequate.) ***Select all that apply***
    - ☐ Normal exam
    - ☐ Dermatomal sensory loss
    - ☐ Motor weakness
    - ☐ Asymmetric, decreased, or absent reflexes

11. Have any of the following diagnostic tests been done? ***Select all that apply***

- ☐ CT Scan
- ☐ MRI
- ☐ X-rays
- ☐ Electrodiagnostics (EMG/NCS)
- ☐ None
- ☐ Unknown

12. Has a surgically correctable structural lesion been ruled out either by testing or surgical consultation? ***Select one***

- ☐ Yes
- ☐ No
- ☐ Unknown

13. NOTE: Clinical documents are REQUIRED for processing this request. Please provide history, physical examination, reports for diagnostics such as imaging/NCS and (if applicable) reports for prior MBBs and RFAs. Indicate how you will be providing the required documents. ***Select one***

- ☐ Attaching documents (preferred)
- ☐ Faxing documents
- ☐ Faxing and attaching documents

COMMENTS/NOTES: Please use this field to provide any specific information you want Comagine Health to have as this request is considered: _____

_____

_____

_____

_____

END SECTION B – Medial Branch Blocks (MBB) Questionnaire

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

Sacroiliac Joint (SIJ) Injections Questionnaire - SECTION C

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. Select the side of the body for the injection. ***Select One***
   - ☐ Right
   - ☐ Left
   - ☐ Bilateral

2. Has the patient had any prior sacroiliac joint injection(s) for the same joint as this request? ***Select one***
   - ☐ No prior injections – Skip to question #2b
   - ☐ One prior injection – *Full clinical review MAY BE REQUIRED. To avoid delay and processing, submit clinical information, including prior injection reports, pain diaries and recent history and physical examination.*
   - ☐ Two (2) or more prior injections – Skip to question #3. *Full clinical review MAY BE REQUIRED. To avoid delay and processing, submit clinical information, including prior injection reports, pain diaries and recent history and physical examination.*

2a. How much improvement in pain and function did the patient get from the prior injection? ***Select one***
   - ☐ No improvement
   - ☐ Less than 30%
   - ☐ Greater than 30%
   - ☐ Unknown

2b. How is the amount of improvement documented? ***Select one***
   - ☐ Decreased in the use of pain medication
   - ☐ Improvement in objective findings on physical exam
   - ☐ Increase in activity
   - ☐ Patient documented on pain diary
   - ☐ Verbal report from patient (i.e., pain scale)

3. Is the injection being requested now being done on the same side as a prior injection? ***Select one***
   - ☐ Yes
   - ☐ No

4. How much conservative care has the patient had for their sacroiliac pain? ***Select One***
   - ☐ None
   - ☐ Less than two (2) weeks
   - ☐ Two (2) to five (5) weeks
   - ☐ Six (6) weeks or more
   - ☐ Unknown

Please consider ALL conservative care since the patient has had pain INCLUDING care from other providers.

5. Please indicate the types of conservative care the patient has had. ***Select all that apply***
   - ☐ Chiropractic treatment
   - ☐ Massage therapy
   - ☐ Home exercise program
   - ☐ Narcotic therapy
   - ☐ NSAIDs
   - ☐ Steroids
   - ☐ Structured physical therapy
   - ☐ Non-narcotic medications
   - ☐ None of the above
   - ☐ Unknown

COMMENTS/NOTES: Please use this field to provide any specific information you want Comagine Health to have as this request is considered: _____

_____

_____

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_____

END SECTION C – Sacroiliac Joint (SIJ) Injections Questionnaire