Comagine Health Washington State Department of Labor & Industries

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

Contact Name (if additional info is needed): _____

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

MRI Thoracic Spine Questionnaire

INSTRUCTIONS FOR COMPLETING QUESTIONNAIRE:

- DO NOT COMPLETE this questionnaire for Washington Apple Health (Medicaid) - Comagine Health does not review thoracic spine MRI for Medicaid.
- 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.

Initial Questions

1. (**Mandatory**) This guideline based review will result in a RECOMMENDATION ONLY to Washington State Department of Labor and Industries. If the recommendation is to approve, PLEASE NOTE that services ARE NOT authorized until final determination is made by the Department.

   ☐ 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: ***Select one***

   ☐ Acute thoracic back pain (onset within the last 6 weeks)
   Answer Section A only

   ☐ Subacute or chronic thoracic back pain (onset greater than 6 weeks)
   Answer Section B 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 #:** _____

MRI Thoracic Spine Questionnaire - SECTION A

Acute Thoracic 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 thoracic pain without the presence of red flags usually does not warrant the use of MRI.

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

☐ Acknowledge

Instructional Note: Answer question one below, and then based on the answer to that question, answer ONLY the questions you are directed to answer. Answering more than one set of questions may lead to a technical denial regardless of answers to other questions.

1. (**Mandatory**) Select the indication for thoracic spine MRI for this patient: ***Select One***
   - ☐ Bilateral neurogenic weakness in lower extremities by physical exam **Answer question #2**
   - ☐ Infection (current or suspected) **Answer question #3**
   - ☐ History or suspicion of cancer **Answer question #4**
   - ☐ Focal thoracic pain following a fall from height or direct trauma **Answer question #5-8**
   - ☐ Symptoms compatible with focal thoracic radiculopathy **Answer question #9**
   - ☐ None of the above **Please submit clinical information with recent history, physical exam, and reason for thoracic MRI for full review.**

2. 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

3. Please indicate why infection is suspected. ***Select One***
   - ☐ Elevated Sedimentation Rate
   - ☐ Fever greater than 100.4 degrees F (or 38.0C)
   - ☐ 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. For 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. Is there a recent history of low velocity trauma (e.g., fall from height or struck by object)?
   - ☐ Yes
   - ☐ No

6. Is there a history of osteoporosis OR is the patient over age 70?
   - ☐ Yes
   - ☐ No

7. Have plain radiographs (x-rays) or CT scan(s) been done on the thoracic spine?
   - ☐ Yes
   - ☐ No

8. What were the results of the plain radiographs (x-rays) or CT scan(s)? ***Select one***
   - ☐ No evidence of fracture
   - ☐ Vertebral compression fracture(s) present
   - ☐ Other fracture(s) present

9. Does the patient have acute bowel or bladder dysfunction (incontinence) after direct thoracic trauma?
   - ☐ Yes
   - ☐ No

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

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

MRI Thoracic Spine Questionnaire - SECTION B

Subacute or Chronic Thoracic Pain (greater than 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 is for patients with pain present for 6 weeks or longer with NO prior MRI. Uncomplicated thoracic pain without the presence of red flags usually does not warrant the use of MRI.

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

☐ Acknowledge

1. Please indicate the primary reason for the thoracic spine MRI. ***Select One***
   - ☐ Thoracic back pain without radiation
   - ☐ Thoracic back pain with radiation
   - ☐ None of the above

2. What are the current PHYSICAL and NEUROLOGICAL EXAM findings? (NOTE: Patient complaint or reporting of symptoms is not adequate.)
   - ☐ Normal Exam
   - ☐ Motor, sensory, or reflex changes in a thoracic radicular pattern

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

END SECTION B – Subacute or Chronic Thoracic Pain (Greater than 6 weeks)