Breast MRI Questionnaire
(77058, 77059)

Patient Name: _____

Medicaid ID #: _____

Contact Name (if additional info is needed): _____

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

INSTRUCTIONS FOR COMPLETING QUESTIONNAIRE:

- DO NOT COMPLETE this questionnaire for Washington Labor and Industries.
- 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.

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 Washington Medicaid. If the recommendation is to be approved, PLEASE NOTE that services ARE NOT authorized until a final determination is made by the agency.

   ☐ Acknowledge

2. (**Mandatory**) Has the patient had a breast MRI done within the last year (12 months)?

   ☐ Yes What was the date of the most recent breast MRI? **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. Indicate the reason for breast imaging: ***Select One***

   ☐ Staging or restaging with known breast cancer **– answer Section A only.** USE ONLY IF patient has current or history of breast cancer. Answer Section B for screening.

   ☐ Screening in high risk patient – **answer Section B only**. For diagnosed cancer or history of cancer, answer Section A.

   ☐ Suspected breast tumor – **answer Section B only**. For diagnosed cancer or history of cancer, answer Section A.

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 #:** _____

Breast MRI Questionnaire - SECTION A

Staging or Restaging with Known Breast Cancer

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: In general, patients with chronic headaches, or with acute exacerbations of their usual headache pattern, whether migraine or tension headache, do NOT require advanced imaging. Neuroimaging is not indicated in patients with a clear history of migraine, w/o red flag features for potential secondary headache and a normal neurological exam.

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

☐ Acknowledge

1. (Mandatory) Indicate the primary reason for the breast MRI being requested.
   - ☐ Staging of a newly diagnosed breast cancer BEFORE treatment (**answer question #2**)
   - ☐ Restaging of breast cancer AFTER treatment has been initiated or completed (**skip to questions #3 and 4**)

2. Has the patient had a previous breast MRI for staging? If yes, enter the date of the most recent MRI done for staging.
   - ☐ Yes **Date:** _____
   - ☐ No

3. For restaging MRI, which of the following represents the primary reason for imaging at this time? ***Select one***
   - ☐ Pre-surgical planning with locally advanced breast cancer before or after neoadjuvant chemotherapy to allow tumor localization or characterization
   - ☐ Suspected chest wall involvement with posteriorly located tumor
   - ☐ Tumor mapping to evaluate for multicentric disease with localized breast cancer and a candidate for breast conservation therapy
   - ☐ Determine response during or after neoadjuvant treatment with locally advanced breast cancer
   - ☐ Evaluation of residual tumor with positive margins after lumpectomy
   - ☐ Detect and stage invasive lobular cancer to tailor therapy when breast conservation is being considered
   - ☐ None of the above

4. Has the patient had a previous MRI for restaging? If yes, enter the date of the previous MRI.
   - ☐ Yes **Date:** _____
   - ☐ No

INSTRUCTIONAL NOTE: If there has been a prior restaging MRI done within the past 3 months, attaching chart notes including recent history, physical and MRI report is recommended to avoid delays if a full review is necessary.

END SECTION A – Staging or Restaging with Known Breast Cancer

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

Breast MRI Questionnaire - SECTION B

Breast MRI for High Risk Screening/Suspected Tumor

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: If you are requesting a breast MRI *for staging or restaging with known breast cancer*, **STOP** and complete Section A instead.

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

☐ Acknowledge

NOTE: After answering question #1, you will be directed to other questions within this section. Please answer only the questions referred to based on your response to question #1.

1. Indicate the primary reason for the MRI screening. ***Select one***
   - ☐ Screening in a high risk patient – **answer question #2**
   - ☐ Suspected breast tumor – **skip to question #5**

2. Does the patient have one of the following personal or family risk factors? ***Select one***
   (Note: *First degree relatives: Parent, sibling, child; Second degree relatives: Aunt, uncle, niece, nephew, grandparents, grandchildren, and half-siblings*)
   - ☐ Patient with a personal history of breast cancer
   - ☐ Two or more first or second degree relatives with breast or ovarian cancer
   - ☐ One first or second degree relative with breast cancer diagnosed before age forty-five (45)
   - ☐ Three (3) or more first or second degree relatives with breast cancer
   - ☐ Twenty percent (20%) or more estimated risk
   - ☐ GAIL model lifetime cancer risk of twenty percent (20%) or more
   - ☐ Chest radiation treatment between the ages of ten (10) and thirty (30)
   - ☐ Patient where sensitivity of mammography is considered limited
   - ☐ Patient or first degree relative with a history of a genetic syndrome - **Answer question #3**
   - ☐ Patient or a first or second degree relative test positive for BRCA1, BRCA2, TP53 or PTEN genes - **Skip to question #4**
   - ☐ None of the above

3. Please indicate which genetic syndrome is present in the patient or their first degree relative. ***Select one***
   - ☐ Li-Fraumeni Syndrome
   - ☐ Cowden Syndrome
   - ☐ Bannayan-Riley-Rulvacaba Syndrome
   - ☐ None of the above

4. Please indicate who has tested positive for BRCA1, BRCA2, TP53 or PTEN genes. ***Select one***
   - ☐ Patient
   - ☐ First degree relative
   - ☐ Second degree relative
   - ☐ None of the above

5. Is there a suspicion of an occult breast primary tumor with axillary nodal adenocarcinoma negative mammography or physical exam?
   - ☐ Yes
   - ☐ No

6. Has there been a prior MRI for evaluation of the suspected occult primary breast tumor? If yes, enter the date of the prior MRI for suspected occult primary breast tumor. ***Select one***
   - ☐ Yes **Date:** _____
   - ☐ No
   - ☐ Unknown

END SECTION B – Breast MRI for High Risk Screening/Suspected Tumor