

Patient Name: \_\_\_\_\_ Insurance ID or Claim #: \_\_\_\_\_

## Brain Imaging (MRI or CT Scan) Questionnaire

### INSTRUCTIONS FOR COMPLETING QUESTIONNAIRE:

- Answer all of the initial questions (Page 1)
- Select the reason for imaging by answering question #3. Based on your answer to question #3, 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 #3.
- Failure to answer **mandatory** questions in any part of the questionnaire may lead to technical denial regardless of other answers provided.
- Chart notes are not required for questionnaire based reviews
- Follow directions exactly. If the question says “select one” answer, only one is needed. Selecting more than one can lead to technical denial.

**INSTRUCTIONAL NOTE FOR WASHINGTON MEDICAID REQUESTS ONLY:** You are responsible for verifying eligibility *prior to submitting* requests. Information on when to submit to Qualis Health can be found in the Washington Medicaid Apple Health Medical Provider Guides located on-line at:

<http://www.hca.wa.gov/billers-providers/claims-and-billing/professional-rates-and-billing-guides>

### 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)** Will you be submitting more than one request for complex imaging for this patient?  
 Yes **(STOP: Do not complete the questionnaire.** Full review is required for multiple requests. You must submit chart notes for review to avoid delays in final determinations)  
 No Continue to next question

3. Indicate the reason for imaging **Select One**

Headache – answer Section A only

All indications other than headache – 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

## Brain Imaging (MRI or CT Scan) Questionnaire - SECTION A

### Headache

*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)** Has the patient had prior brain imaging? **Select One**
  - Yes
  - No
  - Unknown
  
2. **(Mandatory)** Is imaging for either an acute, recurrent headache *OR* a chronic persistent headache?
  - Yes
  - No
  
3. **(Mandatory)** Please select the most appropriate reason for the current brain imaging request? **Select one**
  - Unexplained new or previously unknown abnormal finding on exam
  - Chronic headache **STOP. Do not complete questionnaire.** Full clinical review is required. Attach chart notes including prior MRI results and notes indicating why MRI is being requested at this time
  - Secondary headache caused by another condition
  - None of the above **STOP. Do not complete questionnaire.** Full clinical review is required. Attach chart notes including prior MRI results and notes indicating why MRI is being requested at this time
  
4. Please document if one of the following is present on examination or noted in the records? **Select one**
  - Cognitive disturbance (i.e. confusion)
  - Objective non-focal neurologic signs (i.e. ataxia)
  - Fever or meningismus
  - Headache precipitated by exertion or Valsalva maneuver
  - History or suspicion of cancer
  - History or suspicion of HIV infection or immunological compromise
  - Patient is over 50 years old
  - Suspicion of subarachnoid hemorrhage
  - Patient has risk factor for cerebral venous thrombosis (CVT) **answer #5**
  - None of the above
  
5. Please document if one of the following is present on examination or noted in the records? **Select one**
  - Pregnant or post partum patient
  - Severe dehydration
  - Neither of the above

**END SECTION A – Headache Imaging**

## Brain Imaging (MRI or CT Scan) Questionnaire - SECTION B

### All indications OTHER than headache

*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 brain imaging *for a headache*, **STOP**. Complete the WA Brain Headache Imaging assessment (Section A).

**INSTRUCTIONAL NOTE:** The scope of this advance imaging assessment is not intended to interfere with timely action in the setting of more urgent care or in situations that require more acute clinical decision – making such as with ACUTE head injury.

**(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. **(Mandatory)** Please select the clinical indication for imaging? **Select One**
  - Post trauma or injury – answer ONLY question #2 and #3 if indicated
  - Seizures – answer ONLY questions #4 thru #7 as indicated
  - Brain Tumor (primary or metastatic) OR evaluation with cancer elsewhere answer ONLY question #8 and #9 if indicated
  - None of the above **STOP. Do not complete questionnaire.** Full clinical review is required. Attach chart notes including recent history, physical exam and rationale for imaging
  
2. For head trauma or injury, has there been other imaging such as a CT or MRI?
  - Yes **STOP. Do not complete questionnaire.** Full clinical review is required for repeat imaging. Attach chart notes including prior imaging results, recent history, physical exam and rationale for REPEAT imaging
  - No Continue to next question
  
3. When was the trauma or injury which is prompting this request for imaging? **Select one**
  - Within the last 30 days
  - Greater than 1 month but less than 6 months ago
  - Greater than 6 months ago
  - Unknown
  
4. Select the appropriate indication for imaging in a patient with seizures? **Select one**
  - New onset seizures – answer ONLY question #5 and #6 if indicated)
  - Seizures refractory to treatment (answer ONLY question #7)
  
5. Has the patient had complex imaging since the onset of their seizures? **Select one**
  - Yes – answer question #6
  - No
  - Unknown

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6. When was the imaging done? **Select one**
- Within the last 90 days **STOP. Do not complete questionnaire.** Full clinical review is required for repeat imaging. Attach chart notes including prior imaging results, recent history, physical exam and rationale for REPEAT imaging
  - Greater than 90 days ago
  - Unknown
7. For seizures refractory to treatment, indicate the reason for imaging? **Select all that apply**
- Increased seizure activity with therapeutic blood level of anticonvulsant
  - Over 12 weeks since initiation of anticonvulsant medication
  - No concurrent seizure provoking medications
  - None of the above
8. For brain tumor, select indication for imaging? **Select one**
- New or worsening central nervous system symptoms or findings
  - Periodic assessment of tumor or metastatic lesion – answer #9
9. Was the most recent brain imaging done within the last 90 days? **Select one**
- Yes **STOP. Do not complete questionnaire.** Full clinical review is required for repeat imaging. Attach chart notes including prior imaging results, recent history, physical exam and rationale for REPEAT imaging
  - No

**END SECTION B – Brain Imaging for All Indications other than Headache**