DIAGNOSTIC FACET INJECTION AND MEDIAL BRANCH BLOCK QUESTIONNAIRE

Patient Name ______________________________________ Medicaid ID # ______________________

CPT Codes: 64490, 64491, 64492, 64493, 64494, 64495, 0213T, 0214T, 0215T, 0216T, 0217T, 0218T

1. **NOTICE:** Medicaid's Fee for Service program does not require review via Qualis for patient with: Medicaid Managed Care (Healthy Options), Medicare, other primary carriers, Take Charge/FPO, Detox Only, unmet Spend-down OR injections in the inpatient or ED setting.

2. Have you confirmed the Medicaid client's eligibility for the planned date of service of this spinal injection procedure?
   ☐Yes = Go to #3
   ☐No = STOP. Need to confirm eligibility before submitting

3. Is the client's primary medical coverage Emergency Related Services Only (ERSO)?
   ☐Yes = **go to #4**
   ☐No = **go to #5**

4. If client has ERSO coverage, is this spinal injection to treat cancer?
   ☐Yes = Go to #5
   ☐No = Call Medical Assistance Customer Service Center (MACSC) at 1-800-562-3022

5. (**Mandatory**) **DISCLAIMER:** This guideline based review will result in a recommendation to Health Care Authority. HCA makes the final determination regarding authorization & payment. Services **ARE NOT** authorized until HCA has issued an authorization number.
   ☐Acknowledge

6. **INSTRUCTIONAL NOTE**: See http://www.lni.wa.gov/claimsins/providers/treatingpatients/treatguide/for procedure guideline that must be followed if future facet neurotomy planned.

7. **INSTRUCTIONAL NOTE:** Requests for a third or subsequent injection FOR ANY SPINAL NERVE requires submission of chart notes for clinical review. DO NOT COMPLETE QUESTIONNAIRE.

8. **INSTRUCTIONAL NOTE**: NO MORE THAN TWO (2) SPINAL NERVES BILATERALLY OR THREE (3) SPINAL NERVES UNILATERALLY ALLOWED PER DATE OF SERVICE.

9. (**Mandatory**) Side of Body: (Select ONE)
   ☐Bilateral
   ☐Left
   ☐Right

10. (**Mandatory**) Indicate spinal nerves/levels to be injected (up to THREE): INSTRUCTIONAL NOTE: THORACIC INJECTIONS NOT COVERED, REFER TO FACET NEUROTOMY MEDICAL TREATMENT GUIDELINE. (Enter up to THREE):

    1)__________________________ 2)________________________ 3)__________________________

11. (**Mandatory**) Indication for Facet injection(s) and/or Medial branch block(s): (Select ONE)
    ☐Diagnostic
    ☐Therapeutic

12. (**Mandatory**) Has patient had prior injection(s)? **NOTE: 2 or more prior injections require submission of medical records for review by Qualis Health. Do not complete questionnaire.** (Select ONE)
    - ☐ No prior injections
    - ☐ Only one prior injection
    - ☐ 2 or more prior injections (see NOTE above)

13. (**Mandatory**) Is the patient a potential candidate for facet neurotomy based on the level of this injection?
    - ☐ Yes
    - ☐ No
    - ☐ To be determined based on results of block

14. Has patient had conservative care?
    - ☐ Yes = go to #15
    - ☐ No = go to #17

15. How many months of conservative care has patient had? (Select ONE)
    - ☐ Less than 2 months
    - ☐ 2 – 5 months
    - ☐ 6 or more months

16. Please indicate conservative approaches used: (Select all that apply)
    - ☐ Chiropractic Care
    - ☐ Home exercise
    - ☐ Massage therapy
    - ☐ Narcotic therapy
    - ☐ NSAIDs
    - ☐ Steroids
    - ☐ Structured PT

17. Does patient have radicular pain?
    - ☐ Yes
    - ☐ No

18. Does patient have pain or tenderness at the level planned for injection?
    - ☐ Yes
    - ☐ No

19. **OBJECTIVE PHYSICAL EXAM** findings? **NOTE: Patient complaint/report of symptoms NOT adequate**. (Select all that apply)
    - ☐ Normal exam
    - ☐ Dermatomal sensory loss
    - ☐ Motor weakness
    - ☐ Reflex asymmetry or loss

20. What diagnostic testing has been done? (Select ONE)
    - ☐ CT
    - ☐ MRI
    - ☐ X-ray
    - ☐ None of the above

21. Did the diagnostic testing rule out a correctable structural lesion?
    - ☐ Yes
    - ☐ No