MRI Upper Extremity Questionnaire

INSTRUCTIONS FOR COMPLETING QUESTIONNAIRE:
• Answer all of the initial questions (Page 1)
• Complete ONLY the section for the part of the body for which you are requesting imaging. Answering questions in multiple sections will lead to a technical denial.
• 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) Select the side of the body for this imaging request
☐ Right
☐ Left
☐ Bilateral

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

4. (Mandatory) For Labor and Industries ONLY: Are you requesting imaging on the upper arm or forearm (e.g., humerus, ulna, radius)?
☐ Yes (STOP: Please use the LNI Non-Joint Extremity MRI assessment which contains the appropriate clinical questions. For Wa Medicaid CPT codes for nonjoint imaging do not require review)
☐ No Continue to next question

5. (Mandatory) Indicate the body part for the requested imaging. Select one
☐ Shoulder – answer Section A only
☐ Elbow – answer Section B only
☐ Wrist/Hand – answer Section C only

Proceed to the appropriate section based on the body part being imaged and answer ONLY that section.

END of INITIAL QUESTIONS – proceed to complete ONLY one other section
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. (Mandatory) Have x-rays been done and interpreted?
   - Yes
   - No
   - Interpretation is pending
   - Unknown

2. Please select the primary clinical indication for the requested imaging? Select one
   - Acute pain (answer ONLY question 3 and if directed to do so, questions 4 or 5)
   - Subacute or chronic pain (answer ONLY question 6 and if directed to do so, question 7)

3. Select the clinical indication for imaging with acute shoulder pain? Select one
   - Significant trauma with shoulder pain, weakness and suspected RTC tear requiring immediate imaging and treatment
   - Continued pain after shoulder trauma which has not been responsive to at least 4 weeks of conservative treatment (answer #4)
   - Clinical signs and symptoms suspicious for rotator cuff tear or impingement in patient age 35 or greater
   - Suspected instability or labral tear, patient age less than 35 years (answer #5)
   - None of the above

4. Indicate which of the following symptoms or physical exam findings are present to indicate the need for MRI after 4 weeks of treatment? Select up to two:
   - External rotational pain or weakness
   - Anterior or posterior shoulder instability
   - Impingement signs
   - Loss of abduction
   - Persistent pain with activity
   - Normal exam
   - None of the above

5. Select the clinical indication for imaging in patient age 34 or less with suspected instability or labral tear? Select one:
   - Recurrent dislocation
   - Suspected intra-articular loose bodies
   - Suspected avascular necrosis
   - None of the above
6. Select the clinical indication for imaging in patient with subacute or chronic pain. Select one

☐ Pain with clinical suspicion for instability, rotator cuff tear or labral tear
☐ Prior surgery with substantial increase in objective signs of impingement, instability or labral tear
☐ Surgery planned and no MRI has been done within the last 6 months
☐ Imaging to evaluate abnormality or red flag answer #7
☐ None of the above

7. Select the abnormality or red flag for which MRI evaluation is requested. Select one

☐ Palpable mass on exam
☐ Suspected fracture
☐ Suspected infection
☐ Abnormalities on plain x-rays
☐ Suspected neoplasm
☐ Hemarthrosis
☐ None of the above

END SECTION A – SHOULDER MRI
MRI Elbow - 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.

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

☐ Acknowledge

1. (Mandatory) Have elbow x-rays been done and interpreted?
   ☐ Yes
   ☐ No
   ☐ Interpretation is pending
   ☐ Unknown

2. Based on the findings, including physical exam, clinical suspicion of which of the following is necessitating MRI at this time? Select one
   ☐ Suspected fracture and/or ligament tear after severe, acute trauma
     Date of trauma must be documented here: ______________________
   ☐ Biceps tendon rupture
   ☐ Mass (palpable or by x-ray)
   ☐ Avascular necrosis
   ☐ Intra-articular loose bodies or heterotropic calcifications
   ☐ Cartilaginous defect
   ☐ Epicondylitis answer #3
   ☐ None of the above

3. If imaging is for medial or lateral epicondylitis, select all that apply:
   ☐ Pain at or just distal to the epicondyle
   ☐ Pain worse with resisted wrist extension
   ☐ Steroid injection done or contraindicated
   ☐ Wrist splinting or forearm band attempted
   ☐ PT/OT or activity modification for 12 weeks
   ☐ NSAID’s or other medications for 3 weeks or more
   ☐ None of the above

END SECTION B – ELBOW MRI
MRI Hand or Wrist - 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. (Mandatory) Have wrist and/or hand x-rays been done and interpreted?
   - Yes
   - No
   - Interpretation is pending
   - Unknown

2. Is this imaging for RECENT acute trauma? Select one
   - Yes (answer question #3)
   - No STOP: Do not complete the questionnaire. Full clinical review is required for chronic wrist/hand pain. Attach clinical documentation including x-ray results, history, physical exam and reason for MRI

3. Is there clinical suspicion for one of the following, necessitating an MRI for this patient? Select one
   - Suspected fracture (i.e. evaluation of scaphoid fracture)
   - Suspected ligament or cartilage tear (i.e. triangular cartilage tear)
   - Kienbock’s disease
   - Ganglion cyst
   - Soft tissue mass
   - Carpal tunnel syndrome
   - None of the above

END SECTION C – HAND/WRIST MRI