Patient Name: _____________________________    Claim ID #: _______________________

LNI Spinal Injections – Diagnostic Facet Injection & Medial Branch Block Questionnaire
CPT Codes: 64490, 64491, 64492, 64493, 64494, 64495, 0213T, 0214T, 0215T, 0216T, 0217T, 0218T

1. INSTRUCTIONAL NOTE: Spinal Injections UR program applies ONLY to STATE FUND WORKERS’ compensation claims. For authorization of services pertaining to Self-Insured claims, please contact the injured worker’s employer or the third party administrator.

2. (Mandatory) DISCLAIMER: This is a guideline-based review that will result in a RECOMMENDATION ONLY. L&I must make the final determination of payment based on legal claim validity. Approval should occur within 24-48 hours.
   □ Acknowledge

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

4. INSTRUCTIONAL NOTE: NO MORE THAN TWO (2) JOINT LEVELS BILATERALLY OR THREE (3) JOINT LEVELS UNILATERALLY ALLOWED PER DATE OF SERVICE.

5. (Mandatory) Side of Body: (Select ONE)
   □ Bilateral
   □ Left
   □ Right

6. (Mandatory) Diagnostic Facet Injection(s) and/or Medial Branch Block(s) to be done on the following level(s): INSTRUCTIONAL NOTE: THORACIC INJECTIONS NOT COVERED, REFER TO FACET NEUROTOMY MEDICAL TREATMENT GUIDELINE. (Select up to THREE):
   □ C2
   □ L1
   □ T1 - T12 (See NOTE)
   □ C3
   □ L2
   □ C4
   □ L3
   □ C5
   □ L4
   □ C6
   □ L5
   □ C7

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

8. (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)
9. **(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

10. Has patient had conservative care?
    - [ ] Yes
    - [ ] No

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

12. Please indicate therapies used: (Select all that apply)
    - [ ] Chiro/Massage
    - [ ] Home exercise
    - [ ] Narcotic therapy
    - [ ] NSAIDs
    - [ ] Steroids
    - [ ] Structured PT

13. Does patient have radicular pain?
    - [ ] Yes
    - [ ] No

14. Does patient have pain or tenderness at the level planned for injection?
    - [ ] Yes
    - [ ] No

15. Does the PHYSICAL EXAM show any of the following? (Select all that apply)
    - [ ] Normal exam
    - [ ] Dermatomal sensory loss
    - [ ] Motor weakness
    - [ ] Reflex asymmetry or loss

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

17. Did the diagnostic testing rule out a correctable structural lesion?
    - [ ] Yes
    - [ ] No