SACROILIAC JOINT INJECTION QUESTIONNAIRE

Patient Name _____ Medicaid ID # _____

CPT Code: 27096

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**: Only first two injections per side can be done by questionnaire. 3rd injection or more **DO NOT COMPLETE QUESTIONNAIRE** – submit chart notes for review.

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

8. (**Mandatory**) Please indicate which imaging guidance will be used. (Select ONE)
   ☐CT guidance
   ☐Fluoroscopic guidance
   ☐None of the above

9. (**Mandatory**) Has patient had prior Sacroiliac joint injection(s) in the same side as this request? **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 (answer 7-12 **ONLY**)
   ☐Only one prior injection (answer **ALL**)
   ☐2 or more prior injections (see NOTE above)

10. Has patient had conservative care?
    ☐Yes = go to #11
    ☐No = go to #13

11. How many weeks of conservative care has the patient had?
    - ☐ Less than 2 weeks
    - ☐ 2 – 5 weeks
    - ☐ 6 or more weeks

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

13. **NOTE:** If this request is for a patient who has had a previous injection in the same area, complete questions 14 and 15.

14. How much improvement in function & pain was realized after the injection? (Select ONE)
    - ☐ None
    - ☐ Less than 30%
    - ☐ Greater than 30%

15. How was the percentage of improvement determined? (Select all that apply)
    - ☐ Documented decrease in use of pain medications
    - ☐ Documented improvement in ***objective*** findings on PE
    - ☐ Documented increased activity
    - ☐ Patient generated pain diary
    - ☐ Verbal report from patient