CLINICAL CRITERIA FOR UM DECISIONS
Precertification of Outpatient Lumbar Spine Magnetic Resonance Imaging (MRIs)
(CPT codes include: 72148, 72149 and 72158)

Capital Health Plan provides coverage for outpatient lumbar spine MRI for members 13 years of age or older who meet the medical necessity criteria below. Prior authorization is required for this service to be covered.

Capital Health Plan has adopted Medicare rules for our Commercial members with regards to ordering MRIs. Chiropractic treatment is limited to non-invasive conservative measures, only. If conservative measures have failed and/or have been deemed inappropriate, it is expected that the patient will be referred to the appropriate contracted M.D. or D.O. able to assume further care, including medications and/or other forms of more invasive treatment. Therefore, ALL requests for MRIs MUST be ordered by a contracted M.D. or D.O. assuming responsibility for management of the patient.

Low Back pain complicated by any one of the following:

1. Persistent low back pain and/or radicular pain beyond 6 weeks in duration that has failed to improve with a reduction in pain and improvement in functional activities of daily living (ADLs) after 6 weeks of documented evidenced-based conservative treatment* with ALL of the following having occurred within the past 6 months:
   - Participation in the Center for Orthopedic & Sports Physical Therapy (COSPT) Back and Neck Program, or in physical therapy at Tallahassee Memorial Hospital Outpatient Rehab, or in chiropractic directed care
   AND
   - Evaluation and/or directed care by PCP, rheumatologist, orthopedist, pain management, neurologist, or neurosurgery
   AND
   - Trial use of analgesics and/or other appropriate medications
   AND
   - Modification of activity that exacerbates or produces symptoms

   OR

2. Objective neurological deficits as indicated by ANY of the following:
   - Urinary urgency, frequency, retention, or overflow incontinence
   - Fecal incontinence
• Spasticity
• Sensory loss that is severe, persistent, or progressive
• Objective muscle weakness of ≤3
• Asymmetric hypo or hyperreflexia
• Clonus
• Positive Babinski sign
• Pathologic reflexes
• Gait abnormality (e.g., spastic or ataxic)
• Cauda equina syndrome
• Saddle anesthesia
• Bilateral leg weakness

OR

3. Suspected malignancy as indicated by localized lumbar pain and **ANY** of the following:
   • Personal history or concurrent diagnosis of cancer, especially breast, lung, prostate, lymphoma, sarcoma, or kidney
   • Unexplained weight loss
   • Positive bone scan or suspicious lesion found on other imaging

OR

4. Immunosuppression, or suspected inflammatory or demyelinating process (e.g., immunosuppression medications, Rheumatoid Arthritis, Lupus, Multiple Sclerosis [MS], Amyotrophic Lateral Sclerosis [ALS/Lou Gehrig’s disease], HIV/AIDS)

OR

5. Documentation of recent significant lumbar spine trauma **within** the last 3 months

OR

6. Suspected spinal infections, such as vertebral osteomyelitis, disc space infection or epidural abscess; **AND ONE** of the following:
   • Fever
   • Elevated Erythrocyte Sedimentation Rate (ESR)
   • Recent history of spinal surgery
   • Positive bone scan
   • Recent history of intravenous (IV) drug abuse, other source of infection, or recent invasive procedure

OR

7. Prior lumbar spine surgery **AND ONE** of the following:
   • Surgery within the past 6 months to 1 year with **significant** new symptoms
   • Concern for post operative complication that interferes with functional ADL’s (e.g., intolerance for walking, sitting, standing and/or ability to transfer from positions)
• Concern for and/or imaging showing hardware failure

OR

8. Radiologic evidence of spondylosis or spondylolisthesis (e.g., plain x-ray, bone scan, CT scan, or SPECT) and ONE of the following:
   • Urinary retention or incontinence
   • Significant pain
   • Symptoms of spinal claudication
   • Focal neurologic findings

OR

9. History of spinal stenosis with progressive or debilitating symptoms of neurogenic pseudoclaudication, including ONE of the following:
   • Back, leg, or buttock pain worse with prolonged standing and activities requiring lumbar extension
   • Leg weakness ≤3
   • Wide-based gait or abnormal Romberg test

*Evidenced-based conservative treatment* should include documentation of a minimum of 3 sessions of physical therapy or chiropractic care within the past 6 months which INCLUDES a discharge summary from the physical therapist or chiropractor.

Medical Necessity Approvals to be made by:
- Medical Director
- Physician Reviewer
- Medical Services Coordinator
- Nurse Reviewer
- Authorized CCD staff when UM criteria are met

These criteria apply to the following products when determined to be included in the member’s benefit package:
- Commercial

Source Documents:

Medicare rules regarding chiropractors ordering diagnostic testing for Medicare beneficiaries:  


Approved by G&A: 10/6/16, 11/30/17
Approved by UMWG: 8/30/18

*Capital Health Plan reserves the right to make changes to these criteria at any time to accommodate changes in medical necessity and industry standards.*