Capital Health PLAN℠

An Independent Licensee of the Blue Cross and Blue Shield Association

MEDICAL COVERAGE GUIDELINES (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 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 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; **AND**
- In the last 6 months, symptoms have failed to improve despite 6 weeks of documented evidenced-based conservative treatment* that has included **ALL** of the following:

  a) Active participation in a physical therapy program (Center for Orthopedic & Sports Physical Therapy [COSPT] Back and Neck Program or at Tallahassee Memorial Hospital Outpatient Rehab) **OR** active participation in Chiropractic directed care, either of which must include at least 3 visits and/or a discharge summary;

  AND

  b) Evaluation by PCP, rheumatologist, orthopedist, pain management, neurologist, or neurosurgeon;

  AND

  c) Trial use of, and documentation of the response to, analgesics and/or other appropriate medications;

  AND

  d) Interference with functional activities of daily living (ADLs) and/or 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
- Pathologic reflexes (e.g., Babinski, Chaddock, Oppenheim, grasp)
- Gait abnormality (e.g., ataxic)
- Cauda equina syndrome
- Saddle anesthesia

OR

3. Documentation of a concern for/suspected malignancy with 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, suspected inflammatory process (e.g., Ankylosing spondylitis), 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 spondylolysis or spondylolisthesis (e.g., plain x-ray, bone scan, CT scan, or SPECT) and **ONE** of the following:
- Significant pain (pain scale of at least 5 on the 0 to 10 pain scale)
- Symptoms of neurogenic claudication or pseudoclaudication

OR

9. Radiologic evidence of spinal stenosis with progressive or debilitating symptoms of neurogenic claudication or pseudoclaudication, including **ONE** of the following:
- Back, leg, or buttock pain worse with prolonged standing and activities requiring lumbar extension
- Wide-based gait or abnormal Romberg test

OR

10. Evaluation for, or concern for, one of the following:
- Spinal cyst or mass that may not be related to malignancy (e.g., syrinx)
- Further evaluation or follow up imaging of a Schmorl's node following x-ray detection • Paget's disease

***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:
https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf

Approved by G&A: 10/6/16, 11/30/17
Approved by UMWG: 8/30/18, 11/7/19, 12/10/20, 12/9/21, 12/8/22, 12/14/23, 12/12/24

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