CLINICAL CRITERIA FOR UM DECISIONS
Precertification of Outpatient Cervical Spine Magnetic Resonance Imaging (MRIs)
(CPT codes include: 72141, 72142 and 72156)

Capital Health Plan provides coverage for outpatient cervical 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.

Neck pain complicated by any one of the following:

1. Persistent neck 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. Evidence of cord compression, instability, or myelopathy 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)
• Hoffmann sign
• Disturbance with coordination
• Confirmed Rheumatoid Arthritis in the cervical spine
• Atlantoaxial subluxation or impaction on plain radiographs

OR

3. Suspected malignancy as indicated by localized cervical 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 cervical 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 cervical 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

8. Diagnosis of Chiari Malformation

*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:


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.*