



## Imaging Management Program Frequently Asked Questions

### 1. What is the logical sequence of radiological evaluation for shoulder pain?

Answer: The most appropriate imaging test is a shoulder MRI. However the following criteria must be met. The pain must be accompanied by one other sign or symptom (limited range of motion, crepitus, locking, joint line tenderness or clinical effusion). Also, the patient must fail a four week trial of conservative therapy including NSAIDS. If the pain worsens during therapy or the patient has a contraindication for NSAIDS, this is considered a failure of therapy and the MRI can be certified.

### 2. What is the logical sequence of radiological evaluation for uncomplicated low back pain?

Answer: The appropriate imaging procedure is a lumbar MRI without contrast (unless there is a history of prior surgery which would be an indication for an MRI without and with contrast administration). However, the following criteria must be met. The pain must last for greater than 6 weeks and the patient must fail a trial of conservative therapy including NSAIDS. If the pain worsens during therapy or the patient has a contraindication for NSAIDS, this is considered a failure of therapy and the MRI can be certified.

### 3. What is the appropriate imaging for closed head injury?

Answer: The most appropriate imaging study for acute head trauma is a CT scan of the head. However, the patient must have one of the following symptoms in order to meet criteria for the study: amnesia, altered level of consciousness, vomiting, neurological symptoms, headache, seizure, ataxia, aphasia, visual field loss, diplopia, memory loss, coagulopathy or decreased strength or decreased sensation in an extremity.

### 4. What is the most appropriate imaging for headache?

Answer: Simple uncomplicated headaches in patients from young adults to 50 years of age do not require imaging. If the headaches are complicated by their severity or other clinical findings or symptomatology (please refer to the criteria for CT or MRI of the brain for the rather long list of associated symptoms) CT or MRI could be certified. If there is a suspicion of an acute bleed (such as suspected ruptured aneurysm) CT is the more appropriate modality. Otherwise, MRI is the preferred modality.

5. When is contrast appropriate for CT or MRI?

Answer: This is too complex a question for a simple answer. Each indication for each modality carries its own need for contrast. Please refer to the criteria for specific requirements for each indication. However, CareCore does not certify contrast administration unless there is a specific indication. If the radiologist sees an abnormality on an unenhanced scan, he/she can add the contrast at the time and call to certify the contrast within 2 business days. An example is MRI of the brain for MS. If the diagnosis is proven, contrast will be certified. If the diagnosis is merely suspected, contrast will not be certified since, without plaques, contrast adds nothing to the study and the vast majority of these scans are normal.

6. Why are studies requested by PCPs non-certified?

Answer: CareCore does not differentiate between physicians for certification of studies. If a case is not certified, it does not meet criteria. The most common reason is that the person calling CareCore with the clinical information (usually not the physician) does not have all the appropriate information that is in the patient's chart. The more information available at the time of the initial call, the more likely there will be an immediate certification.

7. "Is there any documentation from the American College of Cardiology that supports the redirection of a nuclear stress test to a stress echo, when not contraindicated?"

Answer: The CareCore National (CCN) Criteria are not a reproduction of the American College of Cardiology (ACC) appropriateness criteria. They are enhanced clinical pathways that are consistent with the ACC guidelines and were developed by our advisory panel members, who are all actively practicing board certified cardiologists in both academic and private practice and Fellows of the American College of Cardiology. After thorough review of the ACC literature and in-depth discussion between the cardiology panel members, the CareCore medical necessity criteria were developed to allow for a "step-wise" approach to the assessment of the cardiac patient. The CareCore criteria address current symptoms, cardiac risk factors, prior imaging, and prior interventions in determining the need for cardiac imaging procedures. In addition to the CareCore Cardiology panel review of the criteria, the health plan's Medical Directors review and authorize the implementation of the criteria or suggest revisions

There are many recent such articles that equate the sensitivity and specificity of MPI (nuclear stress test) and ESE (stress echocardiography) and suggest that for the vast majority of indications, an ESE is equal to MPI. Given this equivalence, CareCore feels that in certain patient populations (i.e. pre-menopausal female) an ESE avoids patient radiation and is a third less expensive. In addition, peer-reviewed articles assess the negative predictive value of standard exercise stress testing (ETT) compared to ESE. The authors conclude that "ESE should be reserved for patients with abnormal baseline ECG or reduced functional capacity" and that ETT should be the first-line test barring these contraindications.

8. "What is the radiation exposure to a cardiologists performing multi slice CCTAs?"

Answer: There is no radiation exposure to anyone with CCTA; all the staff should be out of the CT scan room during the scanning. There is radiation exposure to any interventionalist performing every catheterization procedure. The amount of exposure will vary greatly depending on many factors: the type of fluoro equipment (pulsed fluoro or not), the length of the procedure, the care of the physician to stay out of the primary beam, etc. However, every laboratory performing these procedures is required to monitor the exposure to every person involved in the exams, including the physicians. Each of these people is supposed to have knowledge of and access to those exposure reports; everyone should know their monthly and cumulative doses.

9. "Facts and percentages were given on negative CT scan for pulmonary emboli, but no recommendation given on what to do instead. What is an alternative test?"

Answer: The report presented by Yale regarding the over-use of imaging in their Emergency Department at the 2008 American Roentgen Ray Society (ARRS) meeting stated that the greatest abuse seemed to be related to CTA for pulmonary emboli. They didn't recommend a substitute procedure. Their implication was that there was an over-utilization of such testing and that a better use of clinical screening should be made in order to reduce unnecessary tests, especially those involving patient radiation exposure.

10. "During the verbal discussion of the breast MRI slide, the Gail Risk calculation was mentioned to the group. Do you have a website or literature to explain this further?"

Answer: The Gail risk calculator is one of several similar tools used to calculate the lifetime risk of a patient developing breast cancer. This one is maintained by the NCI. The recent literature states that women with a greater than 20% lifetime risk should have an annual breast MRI. The calculator can be found at: <http://www.cancer.gov/bcrisktool>.

11. "Why can't CT of abdomen and pelvis be done together or interchangeably?"

Answer: CT scans of the abdomen and pelvis are not interchangeable because they have different CPT Codes. Since all the certifications are CPT Code specific, they cannot be substituted for each other.

12. "What are the contraindications for an MRI?"

Answer: The contraindications of MRI are generally related to the presence of ferrous metal within a patient that is susceptible to moving within the patient when placed into the magnetic field, related to electronics such as pacemakers that could malfunction in the magnetic field or to coiled wires that can heat when a current is created within the wire loops as they are moved through the magnetic field. Another relative contraindication is severe claustrophobia. Metal that is within the soft tissues (such as muscle, scar tissue or the like) is not a contraindication. Ferrous metal in the soft fatty tissue behind the globe of the eye can move and injure the optic nerve. Aneurysm clips for cerebral aneurysms are placed within the CSF spaces, not in tissue; as such, if they are made of ferrous metal, they can torque in the magnetic field and tear the vessel to which they are attached. Most such medical devices today are made to be MR compatible but older ones still exist in patients. The rendering sites are all experienced with this and they can usually do the appropriate screening to prevent all such patient injuries.

13. "Why wouldn't it be easier for providers to just send CCN the member's history and physical exam and then CCN can decide which is the most appropriate test for the member?"

Answer: CCN is not replacing the role of the physician. Certainly, the supply of appropriate history and laboratory findings, as suggested, would greatly speed the precertification process for the referring physicians' offices and lead to many fewer cases going to physician review, further speeding the process. The lack of this clinical information being given to CCN during the precertification process is the greatest cause for frustration to the referring physicians' offices.

14. "When should contrast be used in MRI for Multiple Sclerosis (MS)?"

Answer: MS plaques are always seen in a non-contrast MRI (FLAIR or T2) images. Contrast is used to help determine plaque enhancement, not the presence of plaque. When MS is the "rule out" diagnosis, contrast is not certified.

If the unenhanced MRI shows plaques, the radiologist should add the contrast and has up to two business days to call CareCore to get the certification. When MS is a known diagnosis by prior scans, a contrast study can be primarily certified.

MS diagnosis can't be made based on only results of MRI; other clinical info is needed to support the diagnosis.

15. "Why do asymptomatic MS patients get yearly MRI scans?"

Answer: The neurologist is looking for new plaque. The placement of plaque may indicate progression of disease. If member is in for annual exam and is asymptomatic, no contrast needed, although the criteria still allow it. (Many MS specialists are now following MS patients with non-contrast scans.)

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