

Imaging Management Program Frequently Asked Questions - FAQs

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

Answer: The first imaging study that should be performed for shoulder pain is a plain x-ray. If this does not explain the source of pain, the member should be re-evaluated following a trial of conservative management consisting of NSAIDs and physical therapy for at least 4 weeks. At this point if the member has not improved then MRI may be considered if the member has shoulder pain and a physical finding such as a positive Neer sign, positive Apley scratch test, positive apprehension test, or shoulder weakness.

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

Answer: Uncomplicated low back pain should not be imaged unless the pain has been documented to have been present for at least 6 weeks and that member has failed to get better with at least 6 weeks of conservative management with NSAIDs.

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

Answer: Closed head trauma does not always require imaging. CT is the imaging procedure of choice if the member has Glasgow coma scale is 13 or more with minor or mild closed head trauma with no neurologic deficit a focal neurological finding the member is under age 2

4. What is the most appropriate imaging for headache?

Answer: Imaging for a complaint of headache is not always appropriate unless there is an associated neurologic finding that is new. In this situation imaging should be performed with MRI. CT scan should be performed for a thunderclap headache or there is a complaint of the "worst headache of the person's life". MRI is also needed if the person is awakened from sleep with a headache or the headache gets worse with coughing straining or Valsalva maneuver. A complaint of headache in someone under age 5 or over age 50 which is new should be evaluated with MRI. MRI is also appropriate if there is a new headache and a personal history of cancer.

5. When is contrast appropriate for CT or MRI?

Answer: For CT studies the radiologist should determine whether contrast is needed. For MRI the providers should refer to the criteria document which can be viewed at the HealthPlus of Michigan website. If the radiologist sees an unexpected finding on a non contrast MRI study and feels that contrast is needed to clarify the finding it should be given when the member is in the office. The radiologist should then call CareCore National and request a change of code to the without and with code. A medical necessity review will be conducted and the radiologist must explain what was seen on the initial on contrast scan that required contrast to complete the evaluation.

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

Answer: A study is non-certified if the information provided is not consistent with the evidenced based criteria. The most common reason is that the caller does not have all of the appropriate information at the time of the call.

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. premenopausal 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. "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. 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.

12. "Why wouldn't it be easier for providers to just send CCN the member's history and physical exam and then CCN can decide what 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' office.

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

Answer: An annual MRI for members with MS is at the discretion of the member's neurologist. It is not require.

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