MRI may be considered medically necessary for a number of uses. The following descriptions should be used as general guidelines or examples of what may be considered medically necessary rather than as a restrictive list of specific covered indications:

- Coverage is limited to MRI units that have FDA premarket approval, and such units must be operated within the parameters specified by the approval.
- The services must be reasonable and necessary for the diagnosis or treatment of the specific patient involved.

Head, Central Nervous System and Spine

The following conditions may be considered medically necessary to obtain an MRI.

The MRI is useful in examining the:

- Head; or
- Central nervous system; or
- Spine.

Multiple sclerosis can be diagnosed with MRI and the contents of the posterior fossa are visible.
The inherent tissue contrast resolution of MRI makes it an appropriate standard diagnostic modality for general neuroradiology.

The MRI can assist in the differential diagnosis of mediastinal and retroperitoneal masses, including abnormalities of the large vessels such as aneurysms and dissection.

**Disc Disease Diagnosis**

The MRI may also be used to diagnose disc disease without regard to whether radiological imaging has been tried first to diagnose the problem.

**Procedure Codes**

70540, 70542, 70543, 70551, 70552, 70553, 70554, 70555, 70557, 70558, 70559, 72141, 72142, 72146, 72147, 72148, 72149, 72156, 72157, 72158, 76498

---

**Parenchyma of Solid Organs**

An MRI of the parenchyma of solid organs may be considered medically necessary in the following to detect anatomic disruption or neoplasia:

- Liver; or
- Urogenital system; or
- Adrenals; or
- Pelvic organs without the use of radiological contrast materials.

**Procedure Codes**

77021, 77022

---

**Pelvic and Retroperitoneal Neoplasms, Bone Neoplasm, and Aseptic Necrosis**

An MRI may be considered medically necessary when used in the following situations:

- To detect and stage pelvic and retroperitoneal neoplasms; or
- To evaluate disorders of cancellous bone and soft tissues; or
- Detection of pericardial thickening; or
- Primary and secondary bone neoplasm; or
- Aseptic necrosis can be detected at an early stage and monitored; or
- Infection of the bone due to metallic prostheses which are attached to the bone.

**Procedure Codes**

70336, 71550, 71551, 71552, 72195, 72196, 72197, 73218, 73219, 73220, 73221, 73222, 73223, 73718, 73719, 73720, 73721, 73722, 73723, 74181, 74182, 74183, 77084, C8903, C8904, C8905, C8908
Gating Devices and Surface Coils

Gating devices that eliminate distorted images caused by cardiac and respiratory movement cycles are now considered state-of-the-art techniques and may be considered medically necessary.

Surface and other specialty coils may be considered medically necessary, as they are used routinely for high resolution imaging where small limited regions of the body are studied.

Procedure Codes
76376, 76377, 0159T

Implanted Pacemakers (PM)

MRI for patients with implanted PMs may be considered medically necessary when the PMs are used according to the FDA-approved labeling for use in an MRI environment.

ALL of the following codes shall be reported on MRI claims for patients with implanted PMs that have FDA-approved labeling for use in an MRI environment:

- Appropriate MRI code; **and**
- Diagnosis code Z95.0 (cardiac pacemaker); **and**
- KX modifier.

If all of the above coding is not met the claim will deny.

Procedure Codes
75557, 75559, 75561, 75563

Contrast Material

When an MRI is considered medically necessary, payment can also be made for the contrast materials used to perform the study as follows:

- One MRI of the brain is performed without contrast material.
- Second MRI performed using contrast material(s) and further sequences, code 70553 should be reported.
- Should a third MRI be needed to achieve a better image, no additional payment can be made for the third MRI procedure because procedure code 70553 includes all further sequences.

Procedure Codes
70533, A9576, A9577, A9578, A9579, A9581, Q9953, Q9954
Coverage is limited to MRI units that have FDA premarket approval, and such units must be operated within the parameters specified by the approval.

The services must be considered medically necessary for the diagnosis or treatment of the specific patient involved.

An MRI is not covered when the following patient-specific contraindications are present:

- The danger inherent in bringing ferromagnetic materials within range of MRI units generally constrains the use of MRI on acutely ill patients requiring life support systems and monitoring devices that employ ferromagnetic materials; or
- In addition, the long imaging time and the enclosed position of the patient may result in claustrophobia, making patients who have a history of claustrophobia unsuitable candidates for MRI procedures; or
- During a viable pregnancy.

**Procedure Codes**

74712, 74713

**Other Uses**

All other uses of MRI for which there has not been specifically indicated coverage or non-coverage may be considered eligible for coverage through individual consideration.

**Nationally Non-covered Indications**

The following MRI imaging is considered not medically necessary and therefore non-covered:

- Cortical bone and calcifications; and
- Procedures involving spatial resolution of bone and calcifications.

Services that do not meet medical necessity criteria are denied as not medically necessary.

Documentation in the patient’s clinical records must document the medical necessity for performing the MRI and be available upon request.

**The policy position applies to all Medicare Advantage lines of business**
**Denial Statements**

Services denied as not reasonable and medically necessary, under section 1862(a)(1) of the Social Security Act, are subject to the Limitation of Liability provision. A contracted provider must inform the enrollee to request an organization determination from the plan or the provider can request the organization determination on the enrollee’s behalf. Failure to provide a compliant denial to the enrollee means that the enrollee is not liable for services provided by a contracted provider or upon referral from a contracted provider.

Reviewed/Approved by: _______________________________  Michael Pentecost, MD, Chief Medical Officer