Billing and Coding Guidelines

Title
Billing and Coding Guidelines for Magnetic Resonance Imaging (RAD-024)

Effective Date
03/25/2009

Revision Effective date
07/16/2012

National Coverage
Title XVIII of the Social Security Act section 1862(a) (1) (A). This section allows coverage and payment of those services that are considered medically reasonable and necessary.

Title XVIII of the Social Security Act section 1862(a) (7). This section excludes routine physical examinations and services.

Title XVIII of the Social Security Act section 1833(e). This section prohibits Medicare payment for any claim which lacks the necessary information to process the claim.

42CRF410.32 Diagnostic tests may only be ordered by the treating physician (or other treating practitioners acting within the scope of their licenses and Medicare requirements) and diagnostic tests payable under the Physicians Fee Schedule must be furnished under the appropriate level of supervision by the physician.

CMS Pub.100-3, Ch. 1, Part 4, §220.2
CMS Pub.100-4 Ch.13 §40
CMS Pub.100-4 Rev.502
CMS Pub.100-04; Chapter 17; Section 70
Federal Register, Vol. 71, No. 236, 12/08/2006
CR 7296, effective 02/24/2011
CR 7441, effective 07/07/2011

Coding Information

1. V67.00, V67.09 V67.1, V67.2, and V71.1 are non-specific ICD-9 codes that require an additional ICD-9-CM code to specify the disease entity treated. When a metastasis of the primary neoplasm is suspected report V71.1 with a secondary neoplasm ICD-9 code (196.0-198.89) or personal history of neoplasm ICD-9 code (V10.00-V10.9).
2. List the appropriate CPT/HCPCS procedure code that most clearly describes the service(s) performed; include any necessary modifiers (e.g. 26, TC).
3. Effective for services performed on or after 04/01/2005 HCPCS code Q9952 replaces HCPCS code A4643.
4. Effective for dates of service 01/01/2008, HCPCS code A9579 replaces HCPCS code Q9952.
5. MRI procedure codes (70549, 70553, 70559, 71552, 72197, 73220, 73223, 73720, 73723, and 74183), should be reported only once per day. Per national Medicare regulations, these CPT codes are subject to the Correct Coding Initiative (CCI) edits.

6 List the appropriate ICD-9 code that most clearly describes the condition/diagnosis of the patient that is the reason for performance of the MRI. ICD-9 code(s) must be present on all Physicians' Service claims and must be coded to the highest level of accuracy and digit level completeness.

7. Consult the CCI for services that may be considered bundled into the MRI.

8. When billing for a screening test, requested by the beneficiary for denial, report a screening ICD-9 code and the GY modifier. (Item or service statutorily excluded or does not meet the definition of any Medicare benefit.)
9. When billing services, requested by the beneficiary for denial, for individuals that do not meet the medical necessity criteria listed in section "Indications and Limitations of Coverage or Medical Necessity," section of the MRI LCD, report an ICD-9 code that best described the patient's condition and the GA modifier if an ABN signed by the beneficiary is on file or the GZ modifier (item or service expected to be denied as not medically necessary) when there is no ABN for the service on file.

Magnetic Resonance Imaging (MRI) in Medicare Beneficiaries with FDA-Approved Implanted Permanent Pacemakers (PMs) for use in an MRI Environment
CR 7441
Effective for claims with dates of service on or after July 7, 2011, CMS believes that the evidence is adequate to conclude that magnetic resonance imaging (MRI) improves health outcomes for Medicare beneficiaries with implanted permanent pacemakers (PMs) when the PMs are used according to the FDA-approved labeling for use in an MRI environment. Other contraindications that may be present in any given beneficiary would continue to apply in patients with PMs. These other contraindications are listed in section 220.2.C.1 of the National Coverage Determinations (NCD) manual and referenced in CR 7296.

Effective February 24, 2011
Medicare will allow for coverage of MRI for beneficiaries with implanted PMs or cardioverter defibrillators (ICDs) for use in an MRI environment in a Medicare-approved clinical study as described in section 220.C.1 of the NCD manual.

Effective July 7, 2011
Medicare will allow for coverage of MRI for beneficiaries with implanted pacemakers (PMs) when the PMs are used according to the Food and Drug Administration (FDA)-approved labeling for use in an MRI environment as described in section 220.2.C.1 of the NCD Manual

Payment Requirements
For claims with dates of service on and after February 24, 2011, the following diagnosis code and modifier shall be reported on MRI claims for beneficiaries with implanted PMs, that are outside FDA-approved labeling for use in an MRI environment (in a Medicare-approved clinical study):

Appropriate MRI code

Q0 modifier

ICD-9 code V70.7- Examination of participant in clinical trial (for institutional claims)

Condition code 30 (for institutional claims)

ICD-9 code V45.02 (automatic implantable cardiac defibrillator) or ICD-9 code V45.01 (cardiac pacemaker),

NOTE: *Effective for claims with dates of service on and after October 1, 2013, providers report the following ICD-10 codes instead of the ICD-9 codes referenced above:*
Z006 – Encounter for examination for normal comparison and control in clinical research program

Z95810 – Presence of automatic (implantable) cardiac defibrillator

Z950 – Presence of cardiac pacemaker

For claims with dates of services on and after July 7, 2011, the following codes shall be reported on MRI claims for beneficiaries with implanted PMs that have FDA-approved labeling for use in an MRI environment:
Appropriate MRI code

ICD-9 code V45.01 (cardiac pacemaker)

KX modifier

NOTE: *Effective for claims with dates of service on and after October 1, 2013, providers report ICD-10 code Z950 instead of the ICD-9 code referenced above for patients with a cardiac pacemaker.*

A9579 Instructions and Information

A. <u>Prior to 01/01/2007;</u>

On April 1, 2005 CMS **replaced** HCPCS code A4643 (*supply of* ***additional high dose*** *contrast material(s) during magnetic resonance imaging, e.g., gadoteridol injection)* **with** Q9952 (injection *gadolinium-based magnetic resonance contrast agent, per ml)*. Previous to 4/1/2005 WPS paid A4643 per invoice rather than based on a fee schedule per dose. Q9952, on the other hand, is paid per fee schedule at ASP + 6 %, **per ml**.

A4643, and therefore Q9952, is only payable by Medicare when billed with one of four specific CPT codes (70553, 72156, 72157, & 72158), which are all central nervous system (brain & spinal canal) MRI studies.

B. Effective January 1, 2007:

Effective January 1, 2007, there are two changes in the billing of contrast material.
B1. As of 01/01/2007, a separate payment is made for contrast medium used in performing all MRI or MRA services.

B2 With the implementation for calendar year 2007 of a bottom-up methodology, which utilizes the direct inputs to determine practice expenses (PE) relative value units (RVUs), the cost of the contrast media is not included in the PE RVUs. Therefore, separate payment for the contrast media used in various imaging procedures is paid

C. Effective January 1, 2008:

Q9952 is deleted and replaced with A9579.

D. For Claims submitted to the FI/ OPPS for A9579 or *A9585:

In addition to requirements applicable to all claims the following apply to drug claims.
On claims to FIs the drug is identified by the appropriate HCPCS code for the drug administered and billed under revenue code 0636

*For imaging services performed requiring the use of a gadolinium-based magnetic resonance contrast agent, bill HCPCS code A9579 or A9585 with revenue code 636.

When a claim is received with a 636 revenue code, a HCPCS code and units must be billed. If either a HCPCS code or number of units is not included the claim will be subject to an edit.

Revenue code 636 is to be used to report drugs that are paid at a rate other than cost.

E. Contrast Media Summary

Information under section A above is included in this coding and billing article solely for the purpose to provide guidance for dates of service prior to 01/01/2007. Information under section B above is included in this coding and billing article solely for the purpose to provide rationale for understanding the billing changes beginning with the dates of service after 01/01/2007. To summarize, based on new CMS instructions in section B above, there were two changes made effecting billing MRI contrast.

The second (B2) states that as of 01/01/2007 Medicare will pay separately for the contrast medium used in performing any MRI services that require the use of contrast. If the service is CPT codes 70553, 72156, 72157, or 72158, the A9579 should be billed for the standard amount of material AND ALSO the additional amount for the increased dose.

MRI procedure codes (70549, 70553, 70559, 71552, 72197, 73220, 73223, 73720, 73723, and 74183) include a MRI sequence performed **without** contrast media, followed by a MRI sequence performed **with** contrast media, and followed by MRI **further sequences**. The contrast medium used may be billed separately. No addition payment is made by Medicare for the MRI procedure performed in the **further sequences** phase. The above listed procedures should be reported only once per day.

F. MRA and Contrast Material:

Contrast-enhanced MRA (CE-MRA) involves blood flow imaging after the patient receives an intravenous injection of a contrast agent. Gadolinium, a non-ionic element, is the foundation of all contrast agents currently in use. Gadolinium affects the way in which tissues respond to magnetization, resulting in better visualization of structures when compared to un-enhanced studies. Unlike ionic (iodine-based) contrast agents used in conventional angiography (CA) allergic reactions to gadolinium are extremely rare

Magnetic resonance angiography (MRA) is an application of magnetic resonance imaging (MRI). It is not the purpose of LCD Magnetic Resonance Imaging (MRI) and this companion document, to provide a comprehensive list of coding guidelines for magnetic resonance angiography (MRA).

CMS has a National Coverage Decision (NCD) for magnetic resonance angiography. This document can be viewed on-line in the CMS Manuals database by selecting publication 100-03, Chapter 1, Part 4, Section 220.3.

WPS NCD RAD-023 contains information taken directly from the CMS NCD mentioned above. The separate coding and billing guideline associated with RAD-023 is intended for use in combination with the NCD for MRA procedures. For payment instructions when contrast agents are used for MRA procedures refer to the coding and billing document associated with RAD-023

NCDs are binding on all carriers, fiscal intermediaries, quality improvement organizations, health maintenance organizations, competitive medical plans, and health care prepayment plans.

Under 42 CFR 422.256(b), an NCD that expands coverage is also binding on Medicare Advantage Organizations. In addition, an administrative law judge may not review an NCD. (See §1869(f)(1)(A)(i) of the Social Security Act.)

Denial Summary

Possible Contraindications: MRI may not be covered when the following patient-specific contraindications are present unless acceptable clinical judgment and current literature dictates otherwise:

1. For patients whom have metallic clips placed on vascular aneurysm, vena cava filters and other metallic implants.
2. For acutely ill patients requiring life support systems and monitoring devices which employ ferromagnetic materials.
3. For patients who have ferrous ocular foreign bodies imbedded shrapnel fragments, or Cochlear implants.
4. For patients who have claustrophobia or who can't lie still, unless these can be controlled by use of conscious sedation or appropriate imaging equipment is available.
5. During a viable pregnancy. However, the decision to perform a MRI during a viable pregnancy is left to the treating physician.

Reasons for Denial

1. Services that do not meet the medical necessity criteria will be denied as not medically necessary.
2. Services performed in other than approved setting will be denied as non-covered.
3. Services performed on other than FDA approved equipment will be denied as non-covered.
4. Services performed for screening purposes will be denied as non-covered.
5. Physicians' Services submitted without an ICD-9 code to support medical necessity or not coded to the greatest level of accuracy and digit completeness will be denied as unprocessable
6. This LCD does not specifically address MRI for blood flow testing. Effective September 28, 2009, the following 4 CPT codes changed from non-covered to covered.
   75558, Cardiac MRI for morphology/function w/o contrast materials; w/flow/velocity quantification
   75560, Cardiac MRI for morphology/function w/o contrast materials; w/flow/velocity quantification & stress
   75562, Cardiac MRI for morphology/function w/o contrast materials; followed by contrast materials/further sequences, w/flow/velocity quantification
   75564, Cardiac MRI for morphology/function w/o contrast materials; followed by contrast materials/further sequences, w/flow/velocity quantification & stress.
   Effective January 1, 2010, CPT codes 75558, 75560, 75562 and 75564 were discontinued according to the annual HCPCS update.
7. *Effective for claims with dates of service on and after February 24, 2011, contractors shall deny line items that do not include all of the following line items:*
   An appropriate MRI code
   ICD-9 code V45.02 (automatic implantable cardiac defibrillator) or ICD-9 code V45.01 (cardiac pacemaker)
   Modifier Q0
   ICD-9 code V70.7 - Examination of participant in clinical trial (for institutional claims only), and
   Condition code 30 - (for institutional claims only
8. *Effective for claims with dates of service on and after July 7, 2011, contractors shall deny MRI line items on professional claims when billed with ICD-9 diagnosis code V45.01 if*

modifier KX is not also present on the line or the conditions of requirement 7441-04.2.1 are not met.

Notes
* - *An* Asterisk indicates a revision to that section of the policy or companion document.

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Article Published Dates
12/01/2009

Revision History/Explanation
06/01/2012 - This guideline is effective for J-8 providers in Michigan MAC B 07/16/12, Michigan MAC A 07/23/12, Indiana MAC A 07/23/12 and Indiana MAC B 08/20/12.

*02/01/2012: Added to Section D, second statement new for 2012 HCPCS code A9585. Effective for dates of service 01/01/2012 and thereafter (seven).

10/01/2011: Removed from Denial Summary section, statement number 1 (one), which said
For patients with cardiac pacemakers;
Addition of section entitled Magnetic Resonance Imaging (MRI) in Medicare Beneficiaries with FDA-Approved Implanted Permanent Pacemakers (PMs) for use in an MRI Environment. Added reasons number 7 and 8 to section entitled Reasons for Denial. CR 7296 effective for DOS 02/24/2011. CR 7441 effective for DOS 07/07/2011 (six).

03/01/2011: Section A9579 Instructions and Information: Addition of information entitled For Claims submitted to the FI/ OPPS for A9579 (five).

10/01/2010, Reformatted (four)

01/01/2010, revised sentence number 6 to state that CPT codes 7558, 755602, 75562 and 75564 have been discontinued (three).

12/01/2009, As directed by CR 6672, sentence number 6 revised to state that MRI for blood flow testing is changed from non-covered to covered, effective 09/28/2009 (two);

10/01/2009, Paragraph 5 under Coding Information restated for clarity (one).

Last Reviewed On
01/04/2012