Local Coverage Determination (LCD): Magnetic Resonance Imaging of the Orbit, Face, and/or Neck (L34375)

Contractor Information

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<th>Contractor Name</th>
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LCD Information

Document Information

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<td>For services performed on or after 10/01/2015</td>
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CMS National Coverage Policy

Language quoted from CMS National Coverage Determinations (NCDs) and coverage provisions in interpretive manuals are italicized throughout the Local Coverage Determination (LCD). NCDs and coverage provisions in interpretive manuals are not subject to the LCD Review Process (42 CFR 405.860[b] and 42 CFR 426 [Subpart D]). In addition, an administrative law judge may not review an NCD. See § 1869(f)(1)(A)(i) of the Social Security Act.

Unless otherwise specified, italicized text represents quotation from one or more of the following CMS sources:

Change Request 7296, Transmittals 132 and 2171, dated March 4, 2011
Change Request 7441, Transmittals 134 and 2293, dated August 26, 2011
CMS Manual System, Pub. 100-02, Medicare Benefit Policy Manual, Chapter 15, Section 80.6 - 80.6.4
CMS Manual System, Pub. 100-03, Medicare National Coverage Determinations, Chapter 1, Part 4, Section 220.2
CMS Manual System, Pub. 100-04, Medicare Claims Processing Manual, Chapter 13, Section 40

Coverage Guidance

Coverage Indications, Limitations, and/or Medical Necessity

Magnetic Resonance Imaging (MRI) is a noninvasive diagnostic imaging modality used to diagnose a variety of central nervous system disorders. MRI provides superior tissue contrast when compared to CT, is able to image in multiple planes, is not affected by bone artifact, provides vascular imaging capability, and makes use of safer contrast media (gadolinium chelate agents). Its major disadvantage over CT is the longer scanning time required for study, making it less useful for emergency evaluations. Contraindications include patients with cardiac pacemakers, implanted neurostimulators, cochlear implants, metal in the eye and older ferromagnetic intracranial aneurysm clips. All of these may be potentially displaced when exposed to the powerful magnetic fields used in MRI.

MRI of the Orbit, Face, and/or Neck will be considered medically reasonable and necessary when used to diagnose and characterize pathology of the nasopharynx, oropharynx, and neck including tumors, infection, soft tissue pathologies, and congenital abnormalities.

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

- MRI is not covered for patients with cardiac pacemakers or with metallic clips on vascular aneurysms unless the Medicare beneficiary meets the provisions of the following exceptions:

Effective for claims with dates of service on or after July 7, 2011, the contraindications will not apply to pacemakers when used according to the FDA-approved labeling in an MRI environment, or effective for claims with dates of service on or after February 24, 2011, CMS believes that the evidence is promising although not yet convincing that MRI will improve patient health outcomes if certain safeguards are in place to ensure that the exposure of the device to an MRI environment adversely affects neither the interpretation of the MRI result nor the proper functioning of the implanted device itself. We believe that specific precautions (as listed below) could maximize benefits of MRI exposure for beneficiaries enrolled in clinical trials designed to assess the utility and safety of MRI exposure. Therefore, CMS determines that MRI will be covered by Medicare when provided in a clinical study under section 1862(a)(1)(E) (consistent with section 1142 of the Act) through the Coverage with Study Participation (CSP) form of Coverage with Evidence Development (CED) if the study meets the criteria in each of the three paragraphs in CMS Pub 100-03, CMS National Coverage Determination Manual, Chapter 1, Section 220.2.C.1

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• MRI during a viable pregnancy is also contraindicated at this time.

• 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.

• 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.

Nationally Non-Covered Indications:

CMS has determined that MRI of cortical bone and calcifications, and procedures involving spatial resolution of bone and calcifications, are not considered reasonable and necessary indications within the meaning of section 1862(a)(1)(A) of the Act, and are therefore non-covered.

When Magnetic Resonance Imaging is used for an investigational purpose, an acceptable advance notice of denial of payment must be given to the patient when the provider does not want to accept financial responsibility for the service.

In some instances, MRI of the brain, as well as MRI of the orbit, face, and/or neck may be medically necessary on the same day. The medical record should document the medical necessity for these two procedures being performed on the same day.

Initial imaging of the thyroid should be done with ultrasound or nuclear medicine, unless there is a known carcinoma present.

Coding Information

Bill Type Codes:

Contractors may specify Bill Types to help providers identify those Bill Types typically used to report this service. Absence of a Bill Type does not guarantee that the policy does not apply to that Bill Type. Complete absence of all Bill Types indicates that coverage is not influenced by Bill Type and the policy should be assumed to apply equally to all claims.

012x  Hospital Inpatient (Medicare Part B only)
013x  Hospital Outpatient
014x  Hospital - Laboratory Services Provided to Non-patients
021x  Skilled Nursing - Inpatient (Including Medicare Part A)
022x  Skilled Nursing - Inpatient (Medicare Part B only)
023x  Skilled Nursing - Outpatient
075x  Clinic - Comprehensive Outpatient Rehabilitation Facility (CORF)
085x  Critical Access Hospital

Revenue Codes:

Contractors may specify Revenue Codes to help providers identify those Revenue Codes typically used to report this service. In most instances Revenue Codes are purely advisory. Unless specified in the policy, services reported under other Revenue Codes are equally subject to this coverage determination. Complete absence of all Revenue Codes indicates that coverage is not influenced by Revenue Code and the policy should be assumed to apply equally to all Revenue Codes.

032X  Radiology - Diagnostic - General Classification
061X  Magnetic Resonance Technology (MRT) - General Classification

CPT/HCPCS Codes

Group 1 Paragraph:
N/A
ICD-10 Codes that Support Medical Necessity

Group 1 Paragraph:
N/A

ICD-10 Codes that DO NOT Support Medical Necessity

Additional ICD-10 Information
N/A

General Information

Associated Information
Documentation Requirements
The documentation of the study requires a formal written report, with clear identifying demographics, the name of the interpreting provider, reason for the test, and interpretive report and copies of all images obtained. The computerized data with image reconstruction should also be maintained.

The medical record must contain documentation, including a written or electronic request for the procedure which fully supports the medical necessity of the procedure performed. This documentation includes, but is not limited to relevant medical history, physical examination, diagnosis (if known), pertinent signs and symptoms and results of pertinent diagnostic tests and/or procedures. This entire documentation—not just the test report or the findings/diagnosis on the order, must be made available upon request.

When a CT scan and MRI are performed on the same day for the same anatomical area, the medical record must clearly reflect the medical necessity for performing both tests.

If the provider of the service is other than the ordering/referring physician, that provider must maintain hard copy documentation of test results and interpretation, along with copies of the ordering/referring physician’s order for the study. The physician must state the clinical indication/medical necessity for the study in his order for the test.

Rules for Testing Facility to Furnish Additional Tests:
If the testing facility cannot reach the treating physician/practitioner to change the order or obtain a new order and documents this in the medical record, then the testing facility may furnish the additional diagnostic test if all of the following criteria apply:

• The testing center performs the diagnostic test ordered by the treating physician/practitioner;
• The interpreting physician at the testing facility determines and documents that, because of the abnormal result of the diagnostic test performed, an additional diagnostic test is medically necessary;
• Delaying the performance of the additional diagnostic test would have an adverse effect on the care of the beneficiary;
• The result of the test is communicated to and is used by the treating physician/practitioner
in the treatment of the beneficiary; and
• The interpreting physician at the testing facility documents in his/her report why additional testing was done.

Rules for Testing Facility Interpreting Physician to Furnish Different or Additional Tests:
The following applies to an interpreting physician of a testing facility who furnishes a diagnostic test to a beneficiary who is not a hospital inpatient or outpatient. The interpreting physician must document accordingly in his/her report to the treating physician/practitioner.

Test Design:
Unless specified in the order, the interpreting physician may determine, without notifying the treating physician/practitioner, the parameters of the diagnostic test (e.g., number of radiographic views obtained, thickness or tomographic sections acquired, use or non-use of contrast media).

Utilization Guidelines
In general, it is not medically necessary to perform myelography, CT examinations, and MRI examinations for evaluation of the same condition on the same day. The medical record should document the necessity for evaluations in addition to a MRI.

It is expected that these services would be performed as indicated by current medical literature and/or standards of practice. When services are performed in excess of established parameters, they may be subject to review for medical necessity.

Sources of Information and Basis for Decision
FCSO reference LCD number(s) – L28927, L29221, L29363


Revision History Information

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<td>The language and/or ICD-10-CM diagnoses were updated to be consistent with the current ICD-9-CM LCD’s language and coding.</td>
<td>Provider Education/Guidance</td>
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Associated Documents

Attachments
Coding guidelines 2015

Related Local Coverage Documents
N/A

Related National Coverage Documents
N/A

Keywords
N/A