CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 1339	Date: SEPTEMBER 21, 2007
	Change Request 5677

SUBJECT: Magnetic Resonance Imaging (MRI) Procedures

I. SUMMARY OF CHANGES: Separate payment is made for contrast medium used in performing MRI services.

NEW / REVISED MATERIAL
EFFECTIVE DATE: January 1, 2007
IMPLEMENTATION DATE: October 22, 2007

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	13/40/Magnetic Resonance Imaging (MRI) Procedures

III. FUNDING:

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

Unless otherwise specified, the effective date is the date of service.

Attachment - Business Requirements

Pub. 100-04	Transmittal: 1339	Date: September 21, 2007	Change Request: 5677

SUBJECT: Magnetic Resonance Imaging (MRI) Procedures

EFFECTIVE DATE: January 1, 2007

IMPLEMENTATION DATE: October 22, 2007

I. GENERAL INFORMATION

A. Background: Prior to January 1, 2007, separate payment was not made for contrast media used in certain MRI procedures because the contrast media was included in the payment for the procedure.

B. Policy: Effective January 1, 2007, separate payment is made for the contrast media used in various imaging procedures. The cost of the contrast media is no longer included in the practice expense relative values units for the procedures. In addition to the CPT code representing the imaging procedure, the appropriate HCPCS "Q" code (Q9945-Q9954; Q9958-Q9964) can be separately billed and paid for the contrast medium utilized in performing the service.

II. BUSINESS REQUIREMENTS

Use "Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DMERC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
5677.1	FIs and carriers shall pay separately for the contrast medium identified with the appropriate HCPCS "Q" code (Q9945-Q9954; Q9958-Q9964) used in performing various MRI procedures.	X		X	X							
5677.2	FIs and carriers do not have to retroactively process for the period between January 1, 2007 and the implementation date. Carriers are to reprocess claims that are brought to their attention that have been denied with dates of service on or after January 1, 2007.	X		X	X							

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)							
		A/	DM	FI	CA	DM	RH	Shared-System Maintainers	OTHER

								FISS	MCS	VMS	CWF	
5677.3	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within 1 week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X		X	X							

IV. SUPPORTING INFORMATION

A. For any recommendations and supporting information associated with listed requirements, use the box below: N/A
"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

B. For all other recommendations and supporting information, use this space: N/A

V. CONTACTS

Pre-Implementation Contact(s): Roberta Epps
Post-Implementation Contact(s): Regional offices

VI. FUNDING

A. *For Fiscal Intermediaries, Carriers, and the Durable Medical Equipment Regional Carrier (DMERC)*:
No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

B. *For Medicare Administrative Contractors (MAC)*:
The contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the Statement of Work (SOW). The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the contracting officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the

contracting officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

40 - Magnetic Resonance Imaging (MRI) Procedures

(Rev. 1339, Issued: 09-21-07, Effective: 01-01-07, Implementation: 10-22-07)

Prior to January 1, 2007

Carriers do not make additional payments for three or more MRI sequences. The RVUs reflect payment levels for two sequences.

The TC RVUs for MRI procedures that specify "with contrast" include payment for paramagnetic contrast media. Carriers do not make separate payment under code A4647.

A diagnostic technique has been developed under which an MRI of the brain or spine is first performed without contrast material, then another MRI is performed with a standard (0.1mmol/kg) dose of contrast material and, based on the need to achieve a better image, a third MRI is performed with an additional double dosage (0.2mmol/kg) of contrast material. When the high-dose contrast technique is utilized, carriers:

- Do not pay separately for the contrast material used in the second MRI procedure;

- Pay for the contrast material given for the third MRI procedure through supply code *Q9952, the replacement code for* A4643, when billed with CPT codes 70553, 72156, 72157, and 72158;

- Do not pay for the third MRI procedure. For example, in the case of an MRI of the brain, if CPT code 70553 (without contrast material, followed by with contrast material(s) and further sequences) is billed, make no payment for CPT code 70551 (without contrast material(s)), the additional procedure given for the purpose of administering the double dosage, furnished during the same session. Medicare does not pay for the third procedure (as distinguished from the contrast material) because the CPT definition of code 70553 includes all further sequences; and

- Do not apply the payment criteria for low osmolar contrast media in §30.1.2 to billings for code *Q9952, the replacement code for* A4643.

Effective January 1, 2007

With the implementation for calendar year 2007 of a bottom-up methodology, which utilizes the direct inputs to determine the practice expense (PE) relative value units (RVUs), the cost of the contrast media is not included in the PE RVUs. Therefore, a separate payment for the contrast media used in various imaging procedures is paid. In addition to the CPT code representing the imaging procedure, separately bill the appropriate HCPCS "Q" code (Q9945 – Q9954; Q9958-Q9964) for the contrast medium utilized in performing the service.