CMS Manual System	Department of Health & Human Services
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services
Transmittal 1831	Date: October 16, 2009
	Change Request 6672

SUBJECT: Magnetic Resonance Imaging (MRI)

I. SUMMARY OF CHANGES: Effective September 28, 2009, CMS finds that the blanket non-coverage of MRI for blood flow determination at section 220.2 of the NCD Manual is no longer supported by the available evidence. Therefore, CMS is removing the phrase blood flow measurement, from the NCD, giving local Medicare contractors discretion to cover (or not cover) this use.

NEW / REVISED MATERIAL
EFFECTIVE DATE: SEPTEMBER 28, 2009
IMPLEMENTATION DATE: JANUARY 4, 2010

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:

SECTION A: For Fiscal Intermediaries and Carriers:
No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

SECTION B: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. 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.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

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

Attachment - Business Requirements

Pub. 100-04	Transmittal: 1831	Date: October 16, 2009	Change Request: 6672

SUBJECT: Magnetic Resonance Imaging (MRI)

Effective Date: September 28, 2009
Implementation Date: January 4, 2010

I. GENERAL INFORMATION

A. Background: The Centers for Medicare & Medicaid Services (CMS) received a request to delete the national non-coverage of blood flow measurement from the Magnetic Resonance Imaging (MRI) National Coverage Determination (NCD) at section 220.2 of the NCD Manual. The requestor points to an apparent contradiction between this non-coverage provision and the national coverage of MRI under the Magnetic Resonance Angiography NCD at section 220.3 of the NCD Manual.

The CMS also received a separate request to revise the reference to cardiac pacemakers to permit coverage for MRI when a beneficiary has an implanted device that has been designed, tested and Food and Drug Administration (FDA)-labeled for use in the MRI environment. Currently, the MRI is not covered for patients with cardiac pacemakers or with metallic clips on vascular aneurysms.

B. Policy: Effective September 28, 2009, CMS finds that the blanket non-coverage of MRI for blood flow determination at section 220.2 of the NCD Manual is no longer supported by the available evidence. Therefore, CMS is removing the phrase "blood flow measurement," from the NCD, giving local Medicare contractors discretion to cover (or not cover) this use.

In addition, CMS has not found evidence that MRI improves health outcomes in beneficiaries who have an implanted cardioverter-defibrillator or cardiac pacemaker approved by FDA for use in an MRI environment. CMS also notes that there are currently no such devices. Therefore, CMS proposes no change in this provision of the NCD Manual, and will retain the current contraindications.

NOTE: Effective September 28, 2009, be advised that the following 4 CPT codes will be changed from non-covered to covered, and will appear in the January 2010 Integrated Outpatient Code Editor (IOCE) Quarterly Updates:

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.

NOTE: All other uses of MRI noted in Pub. 100-03, NCD Manual, section 220.2, remain unchanged, including non-coverage of imaging of cortical bone and calcifications, procedures involving spatial resolution of bone and calcifications, for patients with FDA-approved (for an MRI environment) implanted cardioverter-defibrillators or cardiac pacemakers, or for patients with metallic clips on vascular aneurysms. Consult Pub. 100-03, NCD Manual, at section 220.2, for specific coverage and non-coverage indications associated with MRI and section 220.3, Magnetic Resonance Angiography, and Pub. 100-04, Claims Processing Manual, Chapter 13, Sections 40 and 40.1, MRI and MRA.

II. BUSINESS REQUIREMENTS TABLE

Use"Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6672.1	Effective for claims with dates of service on and after September 28, 2009, local Medicare contractors have discretion to pay for MRI for blood flow measurement (CPT codes 75558, 75560, 75562, and 75564, see above) according to criteria contained in section 220.2 of the NCD Manual.	X		X	X						
6672. 1.2	Contractors shall manually update their systems to contractor price CPT codes 75558, 75560, 75562 and 75564 effective for dates of service on or after September 28, 2009.	X		X	X						
6672.2	FISS shall update its system to reflect that codes 75558, 75560, 75562 and 75564 are covered on or after September 28, 2009.	X		X			X				
6672. 2.1	Effective for claims with dates of services on and after September 28, 2009, the January IOCE shall assign payable status indicators to CPT codes 75558, 75560, 75562 and 75564 for providers paid under OPPS.										IOCE
6672.3	Contractors shall not search for claims with dates of service September 28, 2009, through December 31, 2009, but shall adjust any claims brought to their attention.	X		X	X						

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6672. 4	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 one week of the availability of the provider education article. In addition, the provider	X		X	X						

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	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.										

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below:
Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
N/A	

Section B: For all other recommendations and supporting information, use this space:

V. CONTACTS

Pre-Implementation Contact(s): Kimberly Long, Coverage, 410-786-5702. kimberly.long@cms.hhs.gov, Patricia Brocato-Simons, Coverage, 410-786- 0261, patricia.brocatosimons@cms.hhs.gov., Michelle Atkinson, Coverage, 410-786-2881, michelle.atkinson@cms.hhs.gov, Brijet Burton, Coverage, 410-786-7364, brijet.burton@cms.hhs.gov, William Ruiz, Institutional Claims Processing, 410-786-9283, william.ruiz@cms.hhs.gov, April Billingsley, Practitioner Claims Processing, 410-786-0140, april.billingsley@cms.hhs.gov

Post-Implementation Contact(s): N/A

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs),* and/or *Carriers*:

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

Section B: *For Medicare Administrative Contractors (MACs)*:

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. 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. 1831; Issued: 10-16-09; Effective Date: 09-28-09; Implementation Date: 01-04-10)

Effective September 28, 2009

The CMS finds that the non-coverage of MRI for blood flow determination is no longer supported by the available evidence. CMS is removing the phrase "blood flow measurement" and local Medicare contractors will have the discretion to cover (or not cover).

Consult Pub. 100-03, NCD Manual, chapter 1, section 220.2, for specific coverage and non-coverage indications associated with MRI, and section 220.3, for Magnetic Resonance Angiography.

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.