CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 1998	Date: July 9, 2010
	Change Request 7040

SUBJECT: Magnetic Resonance Angiography (MRA)

I. SUMMARY OF CHANGES: MRA is a specific application of MRI. CMS believes that the continued existence of separate NCDs is unnecessary, and that the provisions of the MRA NCD at Pub. 100-03, NCD Manual, section 220.3, should be merged under the NCD for MRI at Pub. 100-03, NCD Manual, section 220.2. Thus, section 220.3, MRA of the NCD Manual, will no longer appear as a separate NCD.

The effect of this change will maintain existing national coverage for both MRI and MRA, and will eliminate the non-coverage language that currently exists for MRA at Pub. 100-03, NCD Manual, section 220.3, thereby permitting local Medicare contractors to cover (or not cover) all indications of MRA (and MRI) that are not specifically nationally covered or nationally non-covered.

EFFECTIVE DATE: JUNE 3, 2010
IMPLEMENTATION DATE: August 9, 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
R	13/40.1.1/Magnetic Resonance Angiography Coverage Summary

III. FUNDING:

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.

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: 1998	Date: July 9, 2010	Change Request: 7040

SUBJECT: **Magnetic Resonance Angiography (MRA)**

EFFECTIVE DATE: JUNE 3, 2010
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I. GENERAL INFORMATION

A. Background: The Centers for Medicare & Medicaid Services (CMS) in October, 1995, set forth the original conditions under which Magnetic Resonance Angiography (MRA) would be covered. Revisions to the national coverage determination (NCD) policy took place in 1997, 1999, and 2003, to expand coverage for additional indications. Currently covered indications include using MRA for specific conditions to evaluate flow in internal carotid vessels of the head and neck, peripheral arteries of lower extremities, abdomen and pelvis, and the chest. All other uses of MRA are nationally non-covered unless coverage is specifically indicated.

In addition, CMS recently reconsidered the NCD for magnetic resonance imaging (MRI) at Pub. 100-03, NCD Manual, section 220.2, and removed national non-coverage for MRI for blood flow determination, thereby permitting local Medicare contractors to make determinations within their respective jurisdictions. While reviewing published scientific evidence for the MRI reconsideration, CMS became aware of evidence that may speak to currently non-covered indications for MRA. As a result, CMS initiated this reconsideration to evaluate the current evidence for the non-covered indications for the MRA NCD at Pub. 100-03, NCD Manual, section 220.3..

B. Policy: MRA is a specific application of MRI. CMS believes that the continued existence of separate NCDs is unnecessary, and that the provisions of the MRA NCD at Pub. 100-03, NCD Manual, section 220.3 should be merged under the NCD for MRI at Pub. 100-03, NCD Manual, section 220.2. Thus, section 220.3, MRA, of the NCD Manual, will no longer appear as a separate NCD.

The effect of this change will maintain existing national coverage for both MRI and MRA, and will eliminate the non-coverage language that currently exists for MRA at Pub. 100-03, NCD Manual, section 220.3, thereby permitting local Medicare contractors to cover (or not cover) all indications of MRA (and MRI) that are not specifically nationally covered or nationally non-covered.

See Pub. 100-03, NCD Manual, section 220.2, for the MRA (and MRI) coverage policy, and Pub. 100-04, Claims Processing Manual, chapter 13, section 40.1, for claim processing instructions.

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	

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	
7040.1	Effective for claims with dates of services on or after June 3, 2010, contractors shall have the discretion to cover or not cover all indications of MRA (and MRI) that are not specifically nationally covered or nationally non-covered as stated in Pub. 100-03, NCD Manual, section 220.2.	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	
7040.2	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 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

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:
None	

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

V. CONTACTS

Pre-Implementation Contact(s): Kimberly Long, coverage, 410-786-5702, Patricia Brocato-Simons, coverage, 410-786-0261, Wanda Belle, coverage, 410-786-1851.

Post-Implementation Contact(s): Appropriate regional office

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs),* and/or *Carriers,* use only one of the following statements:

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)*, include the following statement:

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 .1998, Issued: 07- 09- 10, Effective: 06- 03-2010, Implementation: 08-09-2010)

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 *MRA (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.

40.1.1 – Magnetic Resonance Angiography Coverage Summary

(Rev. 1998, Issued: 07- 09- 10, Effective: 06- 03-2010, Implementation: 08-09-2010))

Section 1861(s)(2)(C) of the Act provides for coverage of diagnostic testing. Coverage of magnetic resonance angiography (MRA) of the head and neck, and MRA of the peripheral vessels of the lower extremities is limited as described in the Medicare National Coverage Determinations Manual. This instruction has been revised as of July 1, 2003, based on a determination that coverage is reasonable and necessary in additional circumstances. Under that instruction, MRA is generally covered only to the extent that it is used as a substitute for contrast angiography, except to the extent that there are documented circumstances consistent with that instruction that demonstrate the medical necessity of both tests. *Prior to June 3, 2010, there was* no coverage of MRA outside of the indications and circumstances described in that instruction.

Effective for claims with dates of services on or after June 3, 2010, contractors have the discretion to cover or not cover all indications of MRA (and MRI) that are not specifically nationally covered or nationally non-covered as stated in section 220.2 of the NCD Manual.

Because the status codes for HCPCS codes 71555, 71555-TC, 71555-26, 74185, 74185-TC, and 74185-26 were changed in the MPFSDB from N to R on April 1, 1998, any MRA claims with those HCPCS codes with dates of service between April 1, 1998, and June 30, 1999, are to be processed according to the contractor's discretionary authority to determine payment in the absence of national policy.