

Local Coverage Determination (LCD): Lumbar MRI (L34220)

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Contractor Information

CONTRACTOR NAME	CONTRACT TYPE	CONTRACT NUMBER	JURISDICTION	STATE(S)
Noridian Healthcare Solutions, LLC	A and B MAC	01111 - MAC A	J - E	California - Entire State
Noridian Healthcare Solutions, LLC	A and B MAC	01112 - MAC B	J - E	California - Northern
Noridian Healthcare Solutions, LLC	A and B MAC	01182 - MAC B	J - E	California - Southern
Noridian Healthcare Solutions, LLC	A and B MAC	01211 - MAC A	J - E	American Samoa Guam Hawaii Northern Mariana Islands
Noridian Healthcare Solutions, LLC	A and B MAC	01212 - MAC B	J - E	American Samoa Guam Hawaii Northern Mariana Islands
Noridian Healthcare Solutions, LLC	A and B MAC	01311 - MAC A	J - E	Nevada
Noridian Healthcare Solutions, LLC	A and B MAC	01312 - MAC B	J - E	Nevada
Noridian Healthcare Solutions, LLC	A and B MAC	01911 - MAC A	J - E	American Samoa California - Entire State Guam Hawaii Nevada Northern Mariana Islands

LCD Information

Document Information

LCD ID

Original Effective Date

L34220

For services performed on or after 10/01/2015

LCD Title

Lumbar MRI

Revision Effective Date

For services performed on or after 10/01/2019

Proposed LCD in Comment Period

N/A

Revision Ending Date

N/A

Source Proposed LCD

DL34220

Retirement Date

N/A

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Notice Period Start Date

07/12/2018

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CMS National Coverage Policy

Title XVIII of the Social Security Act (SSA), §1862(a)(1)(A) states that no Medicare payment shall be made for items

or services that "are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member."

Title XVIII of the Social Security Act, §1862(a)(7) and 42 Code of Federal Regulations (CFR), §411.15 particular services excluded from coverage.

Title XVIII of the Social Security Act, §1833(e) prohibits Medicare payment for any claim lacking the necessary documentation to process the claim.

Title XVIII of the Social Security Act, §1842(p)(1) states that each claim submitted by a physician or practitioner shall include the appropriate diagnosis code (or codes)...". §1842(b)(18)(C) defines a practitioner. For services from physicians and (§1842(b)(18)(C)) practitioner submitted with an ICD-10 code that is missing, invalid, or truncated, contractors must return the billed service to the provider as unprocessable in accordance with CR 1910, Transmittal 1728, dated November 1, 2001 (MCM Part 3, Claim Process §3005.4(p)).

42 CFR §411.15(k) excludes specific services that are not reasonable and necessary.

CMS Manual System, Pub. 100-08, *Medicare Program Integrity Manual*, Chapter 3, §3.4.1.3, Diagnosis Code Requirement

42 CFR 410.32 and 410.33 indicates that diagnostic tests are payable only when ordered by the physician who is treating the beneficiary for a specific medical problem and who uses the results in such treatment.

CMS Manual System, Pub. 100-02, *Medicare Benefit Policy Manual*, Chapter 15, §§60, 60.1, 60.2, 60.3, 60.4, 60.4.1 and 80 indicate that the technical component of diagnostic tests is not covered as "incident to" physician healthcare services, but under a distinct coverage category and subject to supervision levels found in the Physician Fee Schedule database.

CMS Manual System, Pub. 100-08, *Medicare Program Integrity Manual*, Chapter 10, §§5-5.7.2 indicates that non-physician owned facilities performing primarily diagnostic tests should be enrolled as IDTFs rather than billing under physician PINs. See also 42 CFR 410.33.

CMS Manual System, Pub. 100-02, *Medicare Benefit Policy Manual*, Chapter 15, §80.4.1 and §250 govern payment for X-ray services supplied for patients in a Part A stay in a skilled nursing facility, or other facility, including payments under arrangement.

CFR 486.100 stipulates that portable X-rays must comply with Federal, State, and local laws and regulations.

CMS Manual System, Pub. 100-04, *Medicare Claims Processing Manual*, Chapter 13, §§40, 40.1.4 Magnetic Resonance Imaging (MRI) Procedures and Payment Requirements. Effective January 1, 2017 separate payment for the contrast media and the need to use the appropriate HCPCS "Q" code (Q9945 – Q9954; Q9958-Q9964) for the contrast medium utilized in performing the service. §40 allows beneficiaries with implanted PMs or cardioverter defibrillators (ICDs) for use in an MRI environment in a Medicare approved clinical study. §40.1.4, 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, effective July 7, 2011.

CMS Manual System, Pub. 100-04, *Medicare Claims Processing Manual*, Chapter 13, §100.1 describes how physicians should handle billing when two providers read a diagnostic radiologic procedure.

CMS Manual System, Pub. 100-03, *Medicare National Coverage Determinations Manual*, Chapter 1, Part 4, §220.2; Magnetic Resonance Imaging (MRI), the contraindications section 220.2.C.1 of the NCD was revised to read that the

contraindications will not apply to pacemakers when used according to the FDA-approved labeling in an MRI environment or in clinical trials.

CMS publication 100-3, *Medicare National Coverage Determinations*, Sections 220.1 "Computerized Tomography", and 220.2-220.2.B.2d and Section 220.2.c-220.D "Magnetic Resonance Imaging".

Denies Coverage of MRI for:

1. Imaging of cortical bone and calcification
2. Procedures involving spatial resolution of bone or calcification
3. MRI is not covered for patients with metallic clips on vascular aneurysms.

CMS publication 100-04 Medicare Claims Processing Manual Chapter 13 Section 40 denies coverage of MRI for: Measurement of blood flow and spectroscopy

Coverage Guidance

Coverage Indications, Limitations, and/or Medical Necessity

Magnetic Resonance Imaging (MRI) is a noninvasive method of imaging body structures based on the distribution of fixed water and other hydrogen-rich molecules in the human body. MRI uses a powerful magnet to align hydrogen atoms within the patient's soft tissues. As the nuclei return from excitation to equilibrium, the MRI receiver coil receives radio frequency wave signals that are transformed by the computer into diagnostic images. MRI produces cross sectional and 3-D images of soft tissues. Because bone contains little water (hydrogen nuclei), bone is relatively invisible to MRI. Blood is also relatively invisible because the hydrogen nuclei are moving in the blood stream.

MRI contrast agents can improve the sensitivity and/or specificity of an image, by altering inherent tissue response to magnetic fields. The contrast agent most commonly used is gadolinium.

MRI has proven useful in diagnosing cerebral infarctions, tumors, abscesses, edema, hemorrhage, nerve fiber demyelination (as in multiple sclerosis), and other disorders that increase fluid content of the affected tissues.

MRI of the spinal canal has the advantage of noninvasive visualization of the spinal cord.

MRI can:

- Differentiate solid from cystic tumors,
- Diagnose and localize spinal cord compression;
- Diagnose syringomyelia (progressive, chronic sensory disturbance, atrophy and spasticity of the spinal cord), disc disease, and any altered relationship between vertebral bodies, discs, spinal cord and nerve roots;
- Detect congenital spinal dysraphism (failure of fusion of parts along the dorsal midline of the spinal cord);

- Provide early detection of osteomyelitis, and
- Detect spinal cord abnormalities associated with osteomyelitis.

Coverage is limited to MRI units that have received FDA pre-market approval. Such units must be operated within the parameters specified by the approval.

Contrast is indicated for studying the central nervous system for metastatic disease, inflammatory disease, recurrent tumor versus scar, differentiation of microvascular from macrovascular infarction, and selected cases of complex vascular disease. Within the study of the spine, contrast also is indicated to differentiate recurrent disc versus scar or granulation tissue, spinal cord neoplasm, any case of myelopathy, and inflammatory cord disease.

History and clinical findings are critical factors to determine when a lumbar MRI is needed in order to efficiently manage low back pain and related disorders.

Lumbar MRI may be indicated for a patient with a "red-flag" condition, such as a suspected tumor, infection, herniated intervertebral disc with nerve compression, or a major neurological problem. The MRI test result may be needed to evaluate these conditions to determine the need for surgery or other aggressive therapy, such as a work-up for metastatic cancer.

"Red flags" are identified through an appropriate history plus a physical examination that typically includes evaluating muscle strength, limb circumference, reflexes, sensation, straight leg raise, and sitting knee extension tests.

"Red flags" include:

- Major trauma
- Minor trauma in a potentially osteoporotic patient
- History of cancer
- Fever
- Chills
- Unexplained weight loss
- Recent bacterial infection
- IV drug abuse
- Immune suppression
- Pain that worsens when supine or at night
- Saddle anesthesia
- Recent onset of bladder dysfunction
- Clinically significant or progressive neurologic deficit in the lower extremity
- Unexpected laxity of the anal sphincter
- Perianal or perineal sensory loss,
- Clinically significant motor weakness, or
- Other nerve root compromise

Eighty (80) to ninety (90) percent of patients with low back pain improve one month after symptom onset even without treatment. Therefore, spinal imaging tests are not generally necessary during the first month of symptoms except when a "red flag" (suggesting a medically emergent condition) is noted on the medical history and physical examination. For a "non-red flag" condition, the MRI may be appropriate after 1 month of symptoms.

For example, for a patient with low back pain syndrome where there is no known injury, history of cancer, or septic disorder and there are no symptoms or signs suggesting nerve root disorder or spinal cord dysfunction (i.e. no "red

flags"), MRI will be covered only if the patient has not responded to a reasonable trial of conservative management lasting at least **four weeks**.

If a patient's limitations due to low back symptoms do not improve within **four weeks**, findings on reassessment may reveal an indication for a MRI. However, since MRI changes are common in asymptomatic patients, MRI abnormalities alone do not retrospectively validate the need for the test without other supporting clinical rationale.

A lumbar MRI used to evaluate uncomplicated degenerative disc disease or herniated nucleus pulposus is not considered medically necessary when a surgical intervention or other aggressive treatment (e.g. intervertebral joint injection) is not under consideration.

When a lumbar MRI is ordered, Medicare expects that the information gained from the test will be used for medical decision-making. When the findings will not affect the treatment choices, the test is not reasonable or necessary.

Certain uses of lumbar MRI are considered investigational and are therefore not covered by Medicare. These include the measurement of blood flow, spectroscopy, imaging of cortical bone and calcifications, and for procedures involving spatial resolution of bone or calcifications.

A lumbar MRI that is a duplication of other imaging studies (such as a spinal CT scan) may be unreasonable or unnecessary. A lumbar MRI, however, could be complementary to a lumbar CT if there are inconclusive findings on a CT scan. Conversely, a lumbar CT may be warranted following an MRI study if the MRI study is found to be inconclusive. Documentation should support the medical necessity for the need for both studies.

The payment for a single lumbar MRI procedure includes two (2) and three (3) sequences.

Contraindications and limitations of lumbar MRI testing include:

- Patients with an allergy to contrast media,
- The effects upon a fetus are unknown at this time; therefore, pregnancy is to be handled at the discretion of the primary doctor,
- When the technical component is performed without the professional component.

Payment for more than one professional component (PC) of a single lumbar MRI:

Medicare will not pay twice for service that is required only once to diagnose or treat an illness or injury. Typically, this A/B MAC will pay for only one PC. This A/B MAC may pay for a second PC when the additional physician's expertise is necessary and reasonable to diagnose or treat the patient, such as to clarify a questionable finding. The physician performing the initial PC must have a valid reason to require another physician's expertise, such as to interpret a confusing MRI. The second physician's knowledge and expertise must be significantly greater than that of the first reader, and it must contribute substantially to the interpretation.

Multiple PCs of a single MRI in institutional settings:

In hospital settings, the physicians involved with MRI interpretations should reach an agreement among themselves as to who should bill Medicare for MRI interpretations and reports. If the physicians involved cannot resolve these issues among themselves, this A/B MAC will pay for the interpretation and report that directly contributes to the diagnosis and treatment of the individual patient. Typically, this will be the MRI interpretation and report that is performed simultaneously with the evaluation and management of the patient.

Each payable interpretation must include a complete, written report similar to one that is prepared by a specialist in the field. The content of the written report must address the relevant clinical issues, available comparative data, and

test findings. The format of the report must be separately identifiable. It may be included under a separate heading within the clinical record.

Multi-position MRI (reclining, standing)

Medicare does not provide additional payment for multiple MRI's such as in the reclining and upright positions. Bill for one unit of the MRI service.

Summary of Evidence

N/A

Analysis of Evidence (Rationale for Determination)

N/A

General Information

Associated Information

Documentation Requirements

Supportive documentation evidencing the condition and treatment is expected to be documented in the medical record and be available upon request.

The patient's medical record must be legible and clearly indicate the necessity and reasonableness of the service.

The documentation must clearly support the ICD-10-CM code(s) reported on the claim.

An attending/treating physician's order is required for each test. The order must be properly signed and dated.

Lumbar MRI abnormalities alone do not validate the need for the test without other supporting clinical rationale. Radiologists and/or ordering physicians should include sufficient clinical information in the report to justify its necessity.

The clinical findings and relevant prior treatment that support the need for the MRI must be documented in the MRI report or clinical record and made available to the contractor upon request.

The medical record of the referring physician must support a contemplated diagnosis or treatment change derived from the MRI findings. The contractor may request medical records from the referring physician if the radiologist's documentation does not validate that the service is reasonable and necessary.

According to national regulations, clinics which are (a) not physician owned and which are (b) billing Medicare

primarily for diagnostic tests may be required to enroll as IDTFs. For example, a nonphysician owner who establishes a Magnetic Resonance Imaging clinic by leasing office space, equipment, and hiring technicians, and hires a retired ophthalmologist to provide off-site (general) supervision of diagnostic testing without treatment would be more appropriately enrolled as an IDTF rather than merely billing all services through the physician's PIN.

Utilization Guidelines

Normally only one lumbar MRI is sufficient to diagnose the patient's condition. However, a second lumbar MRI, for the same patient, may be allowed providing the documentation indicates that comparative test results were needed to make a more definitive treatment decision.

Payment will be allowed for multiple scans of different areas of the body performed on the same day for the same patient when reasonable and necessary.

Sources of Information

N/A - See Bibliography

Bibliography

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NOTE: Some of the websites used to create this policy may no longer be available.

Revision History Information

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION	REASON(S) FOR CHANGE
10/01/2019	R8	10/01/2019: At this time 21st Century Cures Act will apply to new and revised LCDs that restrict coverage which requires comment and notice. This revision is not a restriction to the coverage. LCD was converted to the "no-codes" format.	<ul style="list-style-type: none"> • Revisions Due To Code Removal

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION	REASON(S) FOR CHANGE
10/01/2018	R7	<p>01/10/2019: At this time 21st Century Cures Act will apply to new and revised LCDs that restrict coverage which requires comment and notice. This revision is not a restriction to the coverage determination; and, therefore not all the fields included on the LCD are applicable as noted in this policy.</p> <p>Effective 10/1/2018, LCD is revised per the annual ICD-10-CM code update to add ICD-10-CM codes: M47.815</p>	<ul style="list-style-type: none"> • Revisions Due To ICD-10-CM Code Changes
10/01/2018	R6	<p>11/01/2018: At this time 21st Century Cures Act will apply to new and revised LCDs that restrict coverage which requires comment and notice. This revision is not a restriction to the coverage determination; and, therefore not all the fields included on the LCD are applicable as noted in this policy.</p> <p>Updated the CMS National Coverage Policy section to reflect requirement of CR 10877.</p>	<ul style="list-style-type: none"> • Other (Updated per CMS Guidelines)
10/01/2018	R5	<p>08/30/2018: At this time 21st Century Cures Act will apply to new and revised LCDs that restrict coverage which requires comment and notice. This revision is not a restriction to the coverage determination; and, therefore not all the fields included on the LCD are applicable as noted in this policy.</p> <p>Effective 10/1/2018, LCD is revised per the annual ICD-10-CM code update to:</p> <p>Add ICD-10-CM codes: T81.42XA; T81.42XD; T81.42XS; C4A.111; C4A.112; C4A.121; C4A.122</p>	<ul style="list-style-type: none"> • Revisions Due To ICD-10-CM Code Changes
08/27/2018	R4	<p>05/30/2018: This LCD version was created as a result of DL34220 being released to a Final LCD.</p> <p>At this time 21st Century Cures Act will apply to new and revised LCDs that restrict coverage which requires comment and notice. This revision is not a restriction to the coverage determination; and, therefore not all the fields included on the LCD are applicable as noted in this policy.</p> <p>Code changes from DL34220: Removal of M42.0; addition of C96.21 and C96.22; addition of M48.061 and M48.062 due to need of specificity of previously entered codes.</p>	<ul style="list-style-type: none"> • Creation of Uniform LCDs Within a MAC Jurisdiction

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION	REASON(S) FOR CHANGE
10/01/2017	R3	<p>DATE (08/30/2017): At this time 21st Century Cures Act will apply to new and revised LCDs that restrict coverage which requires comment and notice. This revision is not a restriction to the coverage determination; and, therefore not all the fields included on the LCD are applicable as noted in this policy.</p> <p>Effective 10/1/2017, LCD is revised per the annual ICD-10-CM code update to:</p> <p>Add ICD-10-CM codes: A18.03; A18.89; G12.25; G37.5; C96.22; C96.29; M48.061; M48.062</p> <p>Deleted ICD-10-CM codes: M48.06; C96.2</p>	<ul style="list-style-type: none"> Revisions Due To ICD-10-CM Code Changes
10/01/2016	R2	<p>Per ICD-10 Coding Update for 2016-2017: The ICD-10 Codes added are: T83.69XA*</p> <p>T83.69XD*, T85.625A*,T85.625D*,T85.625S*,T85.635A*, T85.635D*,T85.635S*,T85.890A*,T85.890D*,T85.890S* T85.695A*,T85.695D*,T85.695S*</p>	<ul style="list-style-type: none"> Revisions Due To ICD-10-CM Code Changes
10/01/2015	R1	<p>Codes changes/updates per FU updated reviewed and approved.</p>	<ul style="list-style-type: none"> Revisions Due To ICD-10-CM Code Changes

Associated Documents

Attachments

N/A

Related Local Coverage Documents

Article(s)

A57206 - Billing and Coding: Lumbar MRI

A56017 - Response to Comments: Lumbar MRI

LCD(s)

DL34220

- (MCD Archive Site)

Related National Coverage Documents

N/A

Public Version(s)

Updated on 09/20/2019 with effective dates 10/01/2019 - N/A

Updated on 01/10/2019 with effective dates 10/01/2018 - 09/30/2019

Updated on 11/02/2018 with effective dates 10/01/2018 - N/A

Updated on 08/30/2018 with effective dates 10/01/2018 - N/A

Updated on 07/02/2018 with effective dates 08/27/2018 - 09/30/2018

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Keywords

- Magnetic Resonance Imaging
- MRI
- Lumbar