Subject: Fetal MRI (74712, 74713)		Original Effective Date: 12/13/17
Policy Number: MCR: 643	**Revision Date(s):**	
Review Date: 12/13/17, 12/19/18		

DISCLAIMER

This Molina Clinical Review (MCR) is intended to facilitate the Utilization Management process. It expresses Molina's determination as to whether certain services or supplies are medically necessary, experimental, investigational, or cosmetic for purposes of determining appropriateness of payment. The conclusion that a particular service or supply is medically necessary does not constitute a representation or warranty that this service or supply is covered (i.e., will be paid for by Molina) for a particular member. The member's benefit plan determines coverage. Each benefit plan defines which services are covered, which are excluded, and which are subject to dollar caps or other limits. Members and their providers will need to consult the member's benefit plan to determine if there are any exclusion(s) or other benefit limitations applicable to this service or supply. If there is a discrepancy between this policy and a member's plan of benefits, the benefits plan will govern. In addition, coverage may be mandated by applicable legal requirements of a State, the Federal government or CMS for Medicare and Medicaid members. CMS's Coverage Database can be found on the CMS website. The coverage directive(s) and criteria from an existing National Coverage Determination (NCD) or Local Coverage Determination (LCD) will supersede the contents of this Molina Clinical Review (MCR) document and provide the directive for all Medicare members.

DESCRIPTION OF PROCEDURE/SERVICE/PHARMACEUTICAL

MRI (Magnetic Resonance Imaging) is a non-X-ray (no ionizing radiation) imaging scan that uses a strong magnetic field and radiofrequency waves to produce detailed cross sectional views of soft tissues, bones and vascular structures. These cross sectional images can be reconstructed, rotated and displayed in many different planes. A MR scan can be performed either without (non-enhanced) or with (contrast enhanced) injection of gadolinium containing contrast material into a vein.

APPROVAL SUPPORT

Sonography is the imaging modality of choice for fetal evaluation and should be performed prior to MRI in the majority of clinical situations.

- For evaluation of known or suspected fetal abnormalities
- For evaluation of placenta previa or placenta accreta in second and third trimester with history of prior C-section.

If this cpt code is a non-covered benefit, a Pelvic MRI may be substituted.

ADDITIONAL CRITICAL INFORMATION

The above medical necessity recommendations are used to determine the best diagnostic study based on a patient's specific clinical circumstances. The recommendations were developed using evidence based studies and current accepted clinical practices. Medical necessity will be determined using a combination of these recommendations as well as the patient's individual clinical or social circumstances.

- Tests that will not change treatment plans should not be recommended.
- Same or similar tests recently completed need a specific reason for repeat imaging.

REFERENCES USED FOR DETERMINATIONS

1. Pugash D et al (2008) Prenatal ultrasound and fetal MRI: The comparative value of each modality in prenatal diagnosis. Eur J Radiol 68(2):214-226.
2. Frates MC, Kumar AJ, Benson CB, Ward VL, Tempany CM. Fetal anomalies: comparison of MR imaging and US for diagnosis. *Radiology.* 2004; 232(2):398-404.
3. Glenn OA, Goldstein RB, Li KC, et al. Fetal magnetic resonance imaging in the evaluation of fetuses referred for sonographically suspected abnormalities of the corpus callosum. *J Ultrasound Med.* 2005; 24(6):791-804.
4. Levine D, Barnes PD, Madsen JR, Abbott J, Mehta T, Edelman RR. Central nervous system abnormalities assessed with prenatal magnetic resonance imaging. *Obstet Gynecol.* 1999; 94(6):1011-1019.
5. Getahun D, Oyelese Y, Salihu HM, Ananth CV. Previous cesarean delivery and risks of placenta previa and placental abruption. *Obstet Gynecol.* 2006; 107(4):771-778.
6. Baughman WC, Corteville JE, Shah RR. Placenta accreta: spectrum of US and MR imaging findings. *Radiographics.* 2008; 28(7):1905-1916.
7. Derman AY, Nikac V, Haberman S, Zelenko N, Opsha O, Flyer M. MRI of placenta accreta: a new imaging perspective. *AJR Am J Roentgenol.* 2011; 197(6):1514-1521.

CODING INFORMATION: THE CODES LISTED IN THIS POLICY ARE FOR REFERENCE PURPOSES ONLY. LISTING OF A SERVICE OR DEVICE CODE IN THIS POLICY DOES NOT IMPLY THAT THE SERVICE DESCRIBED BY THIS CODE IS COVERED OR NON-COVERED. COVERAGE IS DETERMINED BY THE BENEFIT DOCUMENT. THIS LIST OF CODES MAY NOT BE ALL INCLUSIVE.

	Description
74712	Fetal MRI (single gestation)
74713	Fetal MRI (multiple gestation)