

Subject: Upper Extremity Joint MRI (73221, 73222, 73223)		Original Effective Date:
Upper Extremity Non-Joint MRI (73218, 73219, 73220)		12/13/17
Policy Number: MCR: 629	Revision Date(s): 12/11/18	
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

Ultrasound has been shown to have similar diagnostic accuracy when compared to MRI and can be considered in lieu of MRI imaging for evaluation of rotator cuff tears, labral injuries, and bicep tendon tears. It is recommended that the ultrasound be completed at a facility competent in performing and interpreting musculoskeletal ultrasound studies. Ultrasound has the benefit of being portable, does not expose the patient to ionizing radiation, and has dynamic imaging capabilities.

In children and adolescents, joint imaging is not necessarily subject to a failed course of conservative therapy. Early intervention may be appropriate.

Known tumor or mass

- Initial evaluation of a recently diagnosed cancer
- Follow up of a known tumor or mass after completion of treatment or with new signs/symptoms
- Surveillance of a known tumor or mass according to accepted clinical standards.

Suspected tumor or mass not confirmed as cancer

- Evaluation of an abnormality seen on x-ray or other imaging
- Evaluation of an abnormality on physical examination and initial evaluation with x-ray or ultrasound has been completed.

Evaluation of known or suspected infection

- Suspected osteomyelitis and initial x-ray has been completed

Evaluation of known or suspected fractures

- Suspected fracture and x-ray is non-diagnostic
- Evaluation of fracture involving the joint space

Pre/Post Procedural

- Pre-operative evaluation
- Post-operative for routine recommended follow up or for potential post-operative complications.
- A repeat study may be needed to help evaluate a patient's progress after treatment procedure intervention or surgery. The reason for the repeat study and that it will affect care must be clear.
- Preoperative planning for robotic surgery.

Other

- Evaluation of suspected avascular necrosis (AVN) when initial x-ray is non-diagnostic
- Evaluation of known or suspected autoimmune disease and x-rays are non-diagnostic and there is consideration to change the treatment regimen. Imaging should be limited to the most symptomatic joint.
- Evaluation of osteochondral defects or osteochondritis dessicans
- Evaluation of an abnormality seen on other imaging and the diagnosis remains uncertain
- For evaluation of the brachial plexus

Wrist Pain

**Conservative therapy consists of a combination of passive modalities such as rest, ice, activity modification, splinting or bracing, and active modalities such as physical therapy, a supervised home exercise program, and/or failed injections.*

- Initial x-ray has been performed and there has been at least 4 weeks of conservative therapy *
- Hemarthrosis – blood in the joint
- Suspected ligament tear with instability on examination or with joint space widening on stress view x-rays
- Locked wrist
- For suspected TFCC (triangular fibrocartilage complex) tear
- MRI arthrogram

Shoulder Pain

**Conservative therapy consists of a combination of passive modalities such as rest, ice, activity modification, splinting or use of sling, and active modalities such as physical therapy, a supervised home exercise program, and/or failed injections.*

- Initial x-ray has been performed and there has been at least 4 weeks of conservative therapy *
- Hemarthrosis – blood in the joint
- Exam findings suggestive of a rotator cuff tear (Neer, Hawkins, Apley Scratch test, drop arm test, empty can sign)
- MRI Arthrogram for evaluation of a labral injury (SLAP, Bankart lesion)
- First episode of dislocation in any patient under the age of 30.

Elbow Pain

****Conservative therapy consists of a combination of passive modalities such as rest, ice, activity modification, splinting or bracing, and active modalities such as physical therapy, a supervised home exercise program, and/or failed injections.***

- Initial x-ray has been performed and there has been at least 4 weeks of conservative therapy *
- Hemarthrosis – blood in the joint
- Exam findings of instability to varus or valgus stress
- Locked elbow
- Evaluation of distal biceps tendon tear
- MRI arthrogram

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

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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.

CPT	Description
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73221	MRI (Magnetic Resonance Imaging) Upper Extremity (arm) Joint without contrast)
73222	MRI (Magnetic Resonance Imaging) Upper Extremity (arm) Joint with contrast)
73223	MRI (Magnetic Resonance Imaging) Upper Extremity (arm) Joint without and with contrast)
73218	MRI (Magnetic Resonance Imaging) Upper Extremity (arm) without contrast)
73219	MRI (Magnetic Resonance Imaging) Upper Extremity (arm) with contrast)
73220	MRI (Magnetic Resonance Imaging) Upper Extremity (arm) without and with contrast)