Molina Clinical Review
Lumbar Spine MRI: Policy No. MCR-621

Last Approval: 12/8/2021
Next Review Due By: December 2022

DISCLAIMER

This Molina Clinical Review (MCR) is intended to facilitate the Utilization Management process. Policies are not a supplementation or recommendation for treatment; Providers are solely responsible for the diagnosis, treatment and clinical recommendations for the Member. 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 (e.g., 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 MCP and provide the directive for all Medicare members.[1] References included were accurate at the time of policy approval and publication.

OVERVIEW

A Lumbosacral Spine MRI uses powerful magnets and radio waves to create pictures of the structures that make up the spine, the spinal cord, and the spaces between the vertebrae, through which the nerves travel. An MRI does not use radiation (x-rays).

COVERAGE POLICY

MRI Imaging can be contraindicated in any of the following circumstances; there is a metallic body in the eye, for magnetically activated implanted devices such as pacemakers and defibrillators, insulin pumps, neurostimulators, and for some types of metal, and aneurysm clipping. The imaging facility should always be consulted with any compatibility questions as the types of metal used and development of MRI compatible devices is continually changing. In children and adolescents, spinal imaging is not necessarily subject to a failed course of conservative therapy. Early intervention may be appropriate.

Lumbar Spine MRI **may be considered medically necessary** when the following criteria are met:

1. **Chronic Pain**
   a. Evaluation of chronic pain with recent documented trial of conservative therapy for 6 weeks (ending within the last 6 months). Conservative care consists of inactive treatments such as anti- inflammatory medications, activity modification, bracing, icing, etc. in addition to active treatments such as at least **ONE** of the following:
      - Physical Therapy; **OR**
      - Chiropractic Therapy; **OR**
      - Provider supervised home exercise program.

   OR

   b. Worsening pain or symptom progression during the course of conservative treatments.

OR

2. **Abnormal Neurologic Findings**
   a. Weakness, abnormal reflexes, or dermatomal sensory change documented on physical exam; **OR**
   b. Bowel or bladder dysfunction (decreased anal sphincter tone, or urinary issues [not due to stress incontinence or other female related urinary issues]); **OR**
   c. Saddle anesthesia; **OR**
   d. Abnormal electromyography (EMG) and nerve conduction study (NCS) findings indicating a cervical spine abnormality; **OR**
   e. Atrophy of related muscles; **OR**
   f. Neurogenic claudication (pseudoclaudication) only if x-ray shows significant lumbar spinal stenosis AND intervention is considered; **OR**

g. Scoliosis, when ordered by orthopedist or neurosurgeon and age of patient and severity of scoliosis on x-ray indicate bracing or surgery may be provided.

OR

3. **Known or Suspected Tumor or Mass**
   a. Initial evaluation of a recently diagnosed cancer; **OR**
   b. Follow up of a known tumor or mass after completion of treatment or with new signs/symptoms; **OR**
   c. Surveillance of a known tumor or mass according to accepted clinical standards; **OR**
   d. Severe bone pain with history of cancer; **OR**
   e. Positive bone scan and/or x-rays suggestive for bone cancer (primary or metastatic).

OR

4. **Trauma (includes blunt trauma to the spine with any abnormal neurological findings described above)**
   a. Failure to respond to a 6-week trial of conservative care. Conservative care consists of inactive treatments such as anti- inflammatory medications, activity modification, bracing, icing, etc. in addition to active treatments such as at least **ONE** of the following:
      - Physical Therapy; **OR**
      - Chiropractic Therapy; **OR**
      - Provider supervised home exercise program.

   OR
   b. Worsening pain or symptom progression during the course of *conservative treatments; **OR**
   c. For evaluation of spinal fractures.

OR

5. **Spine Issues Related to Immune System Suppression**
   a. Evaluation of spine abnormalities related to immune system suppression (e.g. HIV, chemotherapy, leukemia, or lymphoma).

OR

6. **Spine Issues Related to Infection or Other Inflammatory Process**
   a. Suspected infection, abscess, or inflammatory disease with abnormal signs, symptoms, lab tests or other imaging findings.

OR

7. **Congenital Conditions**
   a. Sacral dimples suspicious for dysraphism because of skin lesions such as hairy patches, sacral lipomas, hemangioma, dimple larger than 0.5 cm, or distance greater than 2.5 cm from anal verge; **OR**
   b. Known spinal dysraphism or spina bifida which needs follow-up; **OR**
   c. Possible tethered cord.

OR

8. **Other**
   a. Suspected Ankylosing Spondylitis-with sacral iliac pain, high ESR or C-reactive protein,+ HLA-B27, or indeterminate x-ray result; **OR**
   b. Known or suspected spinal vascular lesion/malformation

Pre / Post-Procedural

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

Additional Critical Information

The above medical necessity recommendations are used to determine the best diagnostic study based on a Member'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 Member'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.

DOCUMENTATION REQUIREMENTS. Molina Healthcare reserves the right to require that additional documentation be made available as part of its coverage determination; quality improvement; and fraud; waste and abuse prevention processes. Documentation required may include, but is not limited to, patient records, test results and credentials of the provider ordering or performing a drug or service. Molina Healthcare may deny reimbursement or take additional appropriate action if the documentation provided does not support the initial determination that the drugs or services were medically necessary, not investigational or experimental, and otherwise within the scope of benefits afforded to the member, and/or the documentation demonstrates a pattern of billing or other practice that is inappropriate or excessive.

CODING & BILLING INFORMATION

CPT Codes

CPT	Description
72148	MRI lumbar spine without contrast
72149	MRI lumbar spine with contrast
72158	MRI lumbar spine without and with contrast

CODING DISCLAIMER. Codes listed in this policy are for reference purposes only and may not be all-inclusive. Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement. Listing of a service or device code in this policy does guarantee coverage. Coverage is determined by the benefit document. Molina adheres to Current Procedural Terminology (CPT®), a registered trademark of the American Medical Association (AMA). All CPT codes and descriptions are copyrighted by the AMA; this information is included for informational purposes only. Providers and facilities are expected to utilize industry standard coding practices for all submissions. When improper billing and coding is not followed, Molina has the right to reject/deny the claim and recover claim payment(s). Due to changing industry practices, Molina reserves the right to revise this policy as needed.

APPROVAL HISTORY

12/8/2021	Policy reviewed, no changes to criteria, updated references.
Review Dates	12/13/2018, 12/10/2019, 12/9/2020
9/19/2017	New policy.

REFERENCES

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APPENDIX

Reserved for State specific information *(to be provided by the individual States, not Corporate). Information includes, but is not limited to, State contract language, Medicaid criteria and other mandated criteria.*