Molina Clinical Review
Shoulder MRI: Policy No. 663

Last Approval: 4/13/2022
Next Review Due By: April 2023

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. References included were accurate at the time of policy approval and publication.

OVERVIEW

Magnetic Resonance Imaging (MRI) is a non-X-ray (non-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. Imaging can be performed either without (non-enhanced) or with (contrast enhanced) injection of gadolinium containing contrast material into a vein.

Ultrasound has been shown to have similar diagnostic accuracy when compared to MRI and can be considered in lieu of MRI 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.

COVERAGE POLICY

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

1. **Known Tumor or Mass**
   a. Initial evaluation of a recently diagnosed cancer
   b. Follow up of a known tumor or mass after completion of treatment or with new signs/symptoms.
   c. Surveillance of a known tumor or mass according to accepted clinical standards.

OR

2. **Suspected Tumor or Mass Not Confirmed as Cancer**
   a. Evaluation of an abnormality seen on x-ray or other imaging.
   b. Evaluation of an abnormality on physical examination and initial evaluation with x-ray or ultrasound has been completed.

OR

3. **Evaluation of Known or Suspected Infection**
   a. Suspected osteomyelitis and initial x-ray has been completed.

OR

4. **Evaluation of Known or Suspected Fractures**
   a. Suspected fracture and x-ray is non-diagnostic.
   b. Evaluation of fracture involving the joint space.

OR

5. Shoulder Pain

a. Initial x-ray has been performed and there has been at least 4 weeks of conservative therapy.*

* 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.

OR

6. Wrist Pain

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

* 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.

OR

7. Other

a. Evaluation of suspected avascular necrosis (AVN) when initial x-ray is non-diagnostic.
b. 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.
c. Evaluation of osteochondral defects or osteochondritis dessicans.
d. Evaluation of an abnormality seen on other imaging and the diagnosis remains uncertain.
e. For evaluation of the brachial plexus.

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.

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
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)

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

4/13/2022 New policy.

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Government Agency

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Peer Reviewed Publications

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National and Specialty Organizations

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APPENDIX

Reserved for State specific information. *Information includes, but is not limited to, State contract language, Medicaid criteria and other mandated criteria.*