Molina Clinical Review
Brain MRI: Policy No. MCR-611

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

Magnetic Resonance Imaging (MRI) is the modality of choice used in the evaluation, diagnosis and management of most brain related conditions.

COVERAGE POLICY

MRI of the Brain **may be considered medically necessary** when one of the following criteria are met:

1. **Neurological Issues.** Includes, but is not limited to, any of the following:
   a. Weakness; **OR**
   b. Numbness or tingling; **OR**
   c. Sensory loss; **OR**
   d. Lack of coordination; **OR**
   e. Problems with speech; **OR**
   f. Vision problems; **OR**
   g. Cranial nerve deficits; **OR**
   h. Changes in mental status when these complaints are suspected to arise from the brain; **OR**
   i. Suspected Stroke or TIA.

OR

2. **Demyelinating Disease (Multiple Sclerosis, Neuromyelitis Optica, Clinically Isolate Syndrome)**
   a. Suspected Demyelinating disease – for evaluation of Members with symptoms consistent with a possible diagnosis of demyelinating disease; **OR**
   b. Known Multiple Sclerosis as indicated by **ANY** of the following:
      - Worsening or new symptoms without imaging in the past three months; **OR**
      - Follow up of or surveillance of known disease and no imaging within the last year; **OR**
      - Follow up of disease progression after a change in medications and no imaging in the last three months.

OR

3. **Movement Disorders**
   a. New onset of movement disorders; **OR**
   b. Suspected Parkinson's disease; **OR**
   c. Known Parkinson's disease but with new symptoms.

OR

4. **Headache, with ANY of the following:**
   a. Papilledema; **OR**
   b. Awakens you from sleep; **OR**

c. Worst headache of your life; **OR**
d. Sudden change in headache pattern; **OR**
e. New onset of headache over the age of 50; **OR**
f. Recent head injury with headache; **OR**
g. Coital headaches; **OR**
h. Headaches which are clearly positional or worsen with coughing, sneezing; **OR**
i. History of cancer or HIV; **OR**
j. Headache during pregnancy; **OR**
k. Uncontrolled vomiting; **OR**
l. New headache with a first-degree family history (sibling, parent or child) of aneurysm; **OR**
m. Abnormal neurological exam findings.

OR

5. **Age Less Than 6**
   a. Headache present on awakening; **OR**
   b. Unresponsive to medical treatment.

OR

6. **Cognitive Dysfunction**
   a. Mini-Mental State Examination (MMSE) testing with a score less than 25; **OR**
   b. Montreal Cognitive Assessment (MoCA) testing with a score of less than 26; **AND**
   c. Have been screened for major depression (current recommendations do not specify modality thus CT can be utilized in certain clinical scenarios); **OR**
   d. Acute onset of mental status changes.

OR

7. **Brain Tumor**
   a. Follow up after completion of treatment or with new signs/symptoms; **OR**
   b. Surveillance according to accepted clinical standards; **OR**
   c. Suspected pituitary tumor with abnormal blood work or vision changes; **OR**
   d. Screening for metastatic disease with known widespread disease or for certain malignancies with a high association of metastatic brain disease.

OR

8. **Seizure**
   a. New onset; **OR**
   b. Chronic, with a change in character or unresponsive to therapy.

OR

9. **Congenital Conditions**
   a. Known or suspected neurocutaneous disease (e.g., neurofibromatosis, tuberous sclerosis); **OR**
   b. Evaluation of known or suspected congenital brain abnormalities; **OR**
   c. Macrocephaly in a child > 6 months of age (should have ultrasound as initial study if < 6 months of age); **OR**
   d. Microcephaly; **OR**
   e. Follow up of a ventricular shunt; **OR**
   f. Known or suspected Arnold Chiari malformation; **OR**
   g. Developmental delay. The diagnosis of Autism or Autism Spectrum Disorder (ASD) is made clinically based on a careful history, clinical examination, and observation of behavior. Routine imaging is not recommended unless this diagnosis remains in question or there is concern for underlying pathology based on other factors.

OR

10. **Head Trauma**
    a. Headaches; **OR**
    b. Vomiting; **OR**

c. Mental status changes; **OR**
d. Seizures; **OR**
e. Abnormal neurological exam findings.

OR

11. **Infection / Inflammatory Disease**
    a. Suspected meningitis or encephalitis; **OR**
    b. Underlying medical condition associated with inflammatory conditions of the brain and symptoms suggestive of brain involvement.

OR

12. **Pre / Post-Procedural**
    a. Pre-operative evaluation; **OR**
    b. Post-operative for routine recommended follow up or for potential post-operative complications; **OR**
    c. 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.

OR

13. **Other**
    a. Follow up of known hemorrhage or hematoma; **OR**
    b. For further evaluation of an abnormality seen on a Brain CT; **OR**
    c. Vertigo felt to be of central origin; **OR**
    d. Abnormal EEG.

OR

14. **Brain MRI with Internal Auditory Canal (IAC)**
    a. Suspected acoustic neuroma (sensorineural hearing loss, tinnitus, or ataxia); **OR**
    b. Tinnitus and other causes have been ruled out.

OR

15. **Brain / Cervical Spine MRI Combination**
    a. For evaluation of known Multiple Sclerosis; **OR**
    b. Diagnosis of follow-up of Arnold Chiari malformation, syrinx, or syringomyelia.

Contraindications

MRI imaging can be contraindicated in any of the following circumstances:

1. There is a metallic body in the eye; **OR**
2. For magnetically activated implanted devices (e.g., pacemakers, 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.

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

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
70551	MRI (Magnetic Resonance Imaging) brain without contrast
70552	MRI (Magnetic Resonance Imaging) brain with contrast
70553	MRI (Magnetic Resonance Imaging) brain 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	9/19/2017, 11/1/2018, 12/10/2019, 12/9/2020
7/26/2017	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.*