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Magnetic Resonance Imaging (MRI)

MLN Matters Number: MM10877
Related Change Request (CR) Number: 10877
Related CR Release Date: October 19, 2018
Effective Date: April 10, 2018
Related CR Transmittal Number: R4147CP and R208NCD
Implementation Date: December 10, 2018

PROVIDER TYPES AFFECTED

This MLN Matters® Article is intended for physicians, providers, and suppliers billing Medicare Administrative Contractors (MACs) for MRI services provided to Medicare beneficiaries.

PROVIDER ACTION NEEDED

CR10877 informs MACs and providers that effective for claims with dates of service on and after April 10, 2018, Medicare will allow for MRI coverage for beneficiaries with an Implanted Pacemaker (PM), Implantable Cardioverter Defibrillator (ICD), Cardiac Resynchronization Therapy Pacemaker (CRT-P), or Cardiac Resynchronization Therapy Defibrillator (CRT-D). Please make sure your billing staffs are aware of these changes.

BACKGROUND

The Centers for Medicare & Medicaid Services (CMS) opened a National Coverage Analysis (NCA) to reconsider coverage indications for MRI, specifically, in the Medicare National Coverage Determinations (NCD) Manual, Section 220.2(C)(1) Contraindications. This NCA focused on the contraindications for a PM, ICD, CRT-P, or CRT-D in patients undergoing MRIs both on and off Food and Drug Administration (FDA) label.

CMS determined the evidence is sufficient to conclude that MRI for Medicare beneficiaries with an Implanted Pacemaker (PM), Implantable Cardioverter Defibrillator (ICD), Cardiac Resynchronization Therapy Pacemaker (CRT-P), or Cardiac Resynchronization Therapy Defibrillator (CRT-D) is reasonable and necessary under Section 1862(a)(1)(A) of the Social Security Act (the Act) under certain circumstances. CMS is modifying the NCD to eliminate the collection of additional information under the Coverage with Evidence Development (CED) paradigm under Section 1862(a) (1)(E) of the Act.

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CMS is revising the language in the NCD Manual to:

1. Remove the contraindication for Medicare coverage of MRI in a beneficiary who has an implanted PM or ICD (Section 220(C)(1))
2. Expand coverage to include CRT-P, or CRT-D devices (Section 220.2(B)(3))
3. Expand coverage for beneficiaries who have an implanted Food & Drug Administration (FDA)-approved, ICD, CRT-P, or CRT-D correspondingly under 220.2(B)(3) of the NCD Manual as a nationally covered MRI indication
4. Expand coverage for beneficiaries with an implanted PM, ICD, CRT-P, or CRT-D device that does not have FDA labeling specific for an MRI under certain conditions under Section 220.2(B)(3)
5. Remove the CED requirement

Effective for claims with dates of service on or after April 10, 2018, MACs will allow MRI line items for beneficiaries with implanted PMs, implanted ICDs, CRT-Ps, and CRT-Ds that include an appropriate MRI code, AND, ICD-10 diagnosis (dx) code Z95.0 - presence of cardiac pacemaker, (Z95.0 also includes presence of CRT-P), OR, ICD-10 dx Z95.810 presence of automatic ICD (Z95.810 also includes presence of automatic ICD with CRT-P, and, presence of CRT-D). MRI line items for beneficiaries with implanted PMs, implanted ICDs, CRT-Ps, and CRT-Ds that do not meet these requirements will be denied with the following messages:

1. Claim Adjustment Reason Code (CARC) 146 – Diagnosis was invalid for the date(s) of service reported
2. Group Code - CO

Your MAC will pay claims as follows for these Types of Bills (TOB) (deductible and coinsurance apply):

1. Professional claims (practitioners and suppliers) - based on the Medicare Physician Fee Schedule (MPFS)
2. TOB 11X - Prospective payment system (PPS), based on the diagnosis-related group
3. TOB 13X – Outpatient Prospective Payment System (OPPS), based on the ambulatory payment classification
4. Rural Health Clinics/Federally Qualified Health Centers (71x/77x). The professional component bills for the MRI with a qualified visit only, there is no payment for this service on an RHC/FQHC claim. The technical component is outside the scope of the RHC/FQHC benefit. Therefore, the provider of the technical service bills their MAC on the ANSI X12N 837P or hardcopy Form CMS-1500 and payment is made under the MPFS
5. TOB 85X (Critical Access Hospitals (CAHs) - For CAHs that elected the optional method of payment for outpatient services, the payment for technical services would be the same as the CAHs that did not elect the optional method - Reasonable cost. The professional component will be paid at 115 percent of the MPFS.

Effective April 10, 2018, the -Q0 and -KX modifiers on claims for MRIs for beneficiaries with an implanted pacemaker are no longer required and can be end-dated.

Any MRI for patients with an implanted pacemaker, ICD, CRT-P, or CRT-D that does not have FDA labeling specific to use in an MRI environment is only covered under the following conditions:

- MRI field strength is 1.5 Tesla using Normal Operating Mode;
- The PM, ICD, CRT-P, or CRT-D system has no fractured, epicardial, or abandoned leads;
- The facility has implemented a checklist which includes the following:
  - Patient assessment is performed to identify the presence of a PM, ICD, CRT-P, or CRT-D;
  - Before the scan, the facility communicates the benefits and harms of the MRI scan to the patient or the patient's delegated decision-maker;
  - Prior to the MRI scan, the PM, ICD, CRT-P, or CRT-D is interrogated and programmed into the appropriate MRI scanning mode;
  - A qualified physician, nurse practitioner, or physician assistant with expertise with PMs, ICDs, CRT-Ps, or CRT-Ds must directly supervise the MRI scan as defined in 42 CFR § §410.28 and 410.32;
  - Patients are observed throughout the MRI scan via visual and voice contact and monitored with equipment to assess vital signs and cardiac rhythm;
  - An advanced cardiac life support provider must be present for the duration of the MRI scan;
  - A discharge plan that includes before being discharged from the hospital/facility, the patient is evaluated, and the PM, ICD, CRT-P, or CRT-D is re-interrogated immediately after the MRI scan to detect and correct any abnormalities that might have developed.

Be Aware: For claims with dates of service on or after April 10, 2018, but processed prior to implementation of CR10877, MACs will not search their files. However, your MAC will adjust claims brought to their attention.

ADDITIONAL INFORMATION

The official instruction, CR10877, issued to your MAC regarding this change is available in two transmittals. The first updates the Medicare Claims Processing Manual and it is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R4147CP.pdf. The second updates the NCD Manual and it is at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R208NCD.pdf.

If you have questions, your MACs may have more information. Find their website at http://go.cms.gov/MAC-website-list.

DOCUMENT HISTORY

Date of Change	Description
October 22, 2018	Initial article released.