MRI Lumbar Spine

Medicare Advantage Medical Policy #MA-018
Original Effective Date: 05/28/2024
Current Effective Date: 05/01/2025

Applies to all products administered or underwritten by the Health Plan, unless otherwise provided in the applicable contract. Medical technology is constantly evolving, and we reserve the right to review and update Medical Policy periodically.

When Services May Be Eligible for Coverage

Coverage for eligible medical treatments or procedures, drugs, devices or biological products may be provided only if:

- *Benefits are available in the member's contract/certificate, and*
- *Medical necessity criteria and guidelines are met.*

Based on review of available data, the Health Plan may consider MRI of the lumbar spine to be **eligible for coverage**** for a patient with a "red flag" condition (see Policy Guidelines section) such as a suspected tumor, infection, herniated intervertebral disc with nerve compression, or a major neurological problem.

Based on review of available data, the Health Plan may consider MRI of the lumbar spine to be **eligible for coverage**** for evaluation of non-specific low back pain (no "red flag" conditions are present) when **ALL** following criteria are met:

- Patient has not responded to a reasonable trial of conservative management lasting at least 4 weeks (see Policy Guidelines); **AND**
- A patient is a potential candidate for spine surgical or interventional pain management procedure (e.g. epidural injection, paravertebral facet injection or neurolysis); **AND**
- Information gained from the test will be used for medical decision-making; **AND**
- Appropriate supporting clinical rationale is provided.

Based on review of available data, the Health Plan may consider MRI of the lumbar spine to be **eligible for coverage**** when there are inconclusive findings on other imaging studies (such as lumbar CT). Documentation should support the medical necessity for the need for both studies.

When Services Are Considered Not Medically Necessary

Based on review of available data, the Health Plan considers MRI of the lumbar spine used to evaluate uncomplicated degenerative disc disease or herniated nucleus to be **not medically necessary**** when a patient is not a potential candidate for spine surgical or interventional pain management procedure (e.g. epidural injection, paravertebral facet injection or neurolysis).

Based on review of available data, the Health Plan considers MRI of the lumbar spine that is a duplication of other imaging studies (such as CT spinal scan) to be **not medically necessary.****

Based on review of available data, the Health Plan considers MRI of the lumbar spine in all other situations to be **not medically necessary.****

When Services Are Considered Investigational

Coverage is not available for investigational medical treatments or procedures, drugs, devices or biological products.

Based on review of available data, the Health Plan considers MRI of the lumbar spine to be **investigational*** when performed for the following uses:

- The measurement of blood flow
- Spectroscopy
- Imaging of cortical bone and calcifications
- For procedures involving spatial resolution of bone or calcifications

When Services Are Not Covered

Based on review of available data, the Health Plan considers MRI of the lumbar spine performed on MRI units that have not received FDA pre-market approval to be **not covered.****

Based on review of available data, the Health Plan considers MRI of the lumbar spine for patients with metallic clips on vascular aneurysms to be **not covered.****

Policy Guidelines

"Red flags" are identified through an appropriate history plus a physical examination that typically includes evaluating muscle strength, limb circumference, reflexes, sensation, straight leg raise and sitting knee extension tests.

"Red flags" include:

- Major trauma
- Minor trauma in a potentially osteoporotic patient
- History of cancer
- Fever
- Chills
- Unexplained weight loss
- Recent bacterial infection
- IV drug abuse
- Immune suppression
- Pain that worsens when supine or at night
- Saddle anesthesia
- Recent onset of bladder dysfunction
- Clinically significant or progressive neurological deficit in the lower extremity
- Unexpected laxity of the anal sphincter
- Perianal or perineal sensory loss or sexual dysfunction
- Severe bilateral sciatica

- Clinically significant motor weakness
- Other nerve root compromise
- Spinal cord dysfunction

Documentation supporting medical necessity should be submitted at the time of the request and must include the following components:

Conservative management should include a combination of strategies to reduce inflammation, alleviate pain, and correct underlying dysfunction, including physical therapy **AND** at least **ONE** complementary conservative treatment strategy.

Physical therapy requirement includes **ANY** of the following:

- Physical therapy rendered by a qualified provider of physical therapy services;
- Supervised home treatment program that includes **ALL** of the following:
    - o Participation in a patient specific or tailored program
    - o Initial active instruction by MD/DO/PT with redemonstration of patient ability to perform exercises
    - o Compliance (documented or by clinician attestation on follow-up evaluation)
- Exception to the physical therapy requirement in unusual circumstances (for instance, intractable pain so severe that physical therapy is not possible) when clearly documented in the medical record.

Complementary conservative treatment requirement includes **ANY** of the following:

- Anti-inflammatory medications and analgesics (in the absence of contraindications);
- Adjunctive medications such as nerve membrane stabilizers or muscle relaxants (in the absence of contraindications);
- Alternative therapies such as acupuncture, chiropractic manipulation, massage therapy, activity modification, and/or a trial period of rest (e.g., from the aggravating/contributing factors) where applicable.

Clinical reevaluation

In most cases, reevaluation should include a physical examination. Direct contact by other methods, such as telephone communication or electronic messaging, may substitute for in-person evaluation when circumstances preclude an office visit.

Failure of conservative management requires **ALL** of the following:

- Patient has completed a full course of conservative management (as defined above) for the current episode of care
- Worsening of or no significant improvement in signs and/or symptoms upon clinical reevaluation
- More invasive forms of therapy are being considered

Documentation of compliance with a plan of therapy that includes elements from these areas is required where conservative management is appropriate.

Magnetic Resonance Imaging (MRI) is a noninvasive method of imaging body structures based on the distribution of fixed water and other hydrogen-rich molecules in the human body. MRI uses a powerful magnet to align hydrogen atoms within the patient's soft tissues. As the nuclei return from excitation to equilibrium, the MRI receiver coil receives radio frequency wave signals that are transformed by the computer into diagnostic images. MRI produces cross sectional and 3-D images of soft tissues. Because bone contains little water (hydrogen nuclei), bone is relatively invisible to MRI. Blood is also relatively invisible because the hydrogen nuclei are moving in the blood stream.

MRI contrast agents can improve the sensitivity and/or specificity of an image, by altering inherent tissue response to magnetic fields. The contrast agent most commonly used is gadolinium.

MRI has proven useful in diagnosing cerebral infarctions, tumors, abscesses, edema, hemorrhage, nerve fiber demyelination (as in multiple sclerosis), and other disorders that increase fluid content of the affected tissues.

MRI of the spinal canal has the advantage of noninvasive visualization of the spinal cord.

MRI can:

- Differentiate solid from cystic tumors,
- Diagnose and localize spinal cord compression;
- Diagnose syringomyelia (progressive, chronic sensory disturbance, atrophy and spasticity of the spinal cord), disc disease, and any altered relationship between vertebral bodies, discs, spinal cord and nerve roots;
- Detect congenital spinal dysraphism (failure of fusion of parts along the dorsal midline of the spinal cord);
- Provide early detection of osteomyelitis, and
- Detect spinal cord abnormalities associated with osteomyelitis.

Contrast is indicated for studying the central nervous system for metastatic disease, inflammatory disease, recurrent tumor versus scar, differentiation of microvascular from macrovascular infarction, and selected cases of complex vascular disease. Within the study of the spine, contrast also is indicated to differentiate recurrent disc versus scar or granulation tissue, spinal cord neoplasm, any case of myelopathy, and inflammatory cord disease.

History and clinical findings are critical factors to determine when a lumbar MRI is needed in order to efficiently manage low back pain and related disorders.

Eighty (80) to ninety (90) percent of patients with low back pain improve one month after symptom onset even without treatment. Therefore, spinal imaging tests are not generally necessary during the first month of symptoms except when a "red flag" (suggesting a medically emergent condition) is noted on the medical history and physical examination. For a "non-red flag" condition, the MRI may be appropriate after 1 month of symptoms.

For example, for a patient with low back pain syndrome where there is no known injury, history of cancer, or septic disorder and there are no symptoms or signs suggesting nerve root disorder or spinal cord dysfunction (i.e. no "red flags"), MRI will be covered only if the patient has not responded to a reasonable trial of conservative management lasting at least **four weeks**.

If a patient's limitations due to low back symptoms do not improve within **four weeks**, findings on reassessment may reveal an indication for a MRI. However, since MRI changes are common in asymptomatic patients, MRI abnormalities alone do not retrospectively validate the need for the test without other supporting clinical rationale.

Contraindications and limitations of lumbar MRI testing include:

- Patients with an allergy to contrast media,
- The effects upon a fetus are unknown at this time; therefore, pregnancy is to be handled at the discretion of the primary doctor,
- When the technical component is performed without the professional component.

Payment for more than one professional component (PC) of a single lumbar MRI:
Medicare will not pay twice for service that is required only once to diagnose or treat an illness or injury. Typically, this Health Plan will pay for only one PC. This Health Plan may pay for a second PC when the additional physician's expertise is necessary and reasonable to diagnose or treat the patient, such as to clarify a questionable finding. The physician performing the initial PC must have a valid reason to require another physician's expertise, such as to interpret a confusing MRI. The second physician's knowledge and expertise must be significantly greater than that of the first reader, and it must contribute substantially to the interpretation.

Multi-position MRI (reclining, standing)
Medicare does not provide additional payment for multiple MRI’s such as in the reclining and upright positions. Bill for one unit of the MRI service.

Rationale/Source

This medical policy was developed through consideration of peer-reviewed medical literature generally recognized by the relevant medical community, U.S. Food and Drug Administration approval status, nationally accepted standards of medical practice and accepted standards of medical practice in this community, technology evaluation centers, reference to federal regulations, other plan medical policies, and accredited national guidelines.

Supplemental Information

CMS National Coverage Policy

Title XVIII of the Social Security Act (SSA), §1862(a)(1)(A) states that no Medicare payment shall be made for items or services that "are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member."

Title XVIII of the Social Security Act, §1862(a)(7) and 42 Code of Federal Regulations (CFR), §411.15 particular services excluded from coverage.

Title XVIII of the Social Security Act, §1833(e) prohibits Medicare payment for any claim lacking the necessary documentation to process the claim.

Title XVIII of the Social Security Act, §1842(p)(1)states that each claim submitted by a physician or practitioner shall include the appropriate diagnosis code (or codes)...". §1842(b)(18)(C) defines a practitioner. For services from physicians and (§1842(b)(18)(C)) practitioner submitted with an ICD-10 code that is missing, invalid, or truncated, contractors must return the billed service to the provider as unprocessable in accordance with CR 1910, Transmittal 1728, dated November 1, 2001 (MCM Part 3, Claim Process §3005.4(p)).

42 CFR §411.15(k) excludes specific services that are not reasonable and necessary.

CMS Manual System, Pub. 100-08, Medicare Program Integrity Manual, Chapter 3, §3.4.1.3, Diagnosis Code Requirement

42 CFR 410.32 and 410.33 indicates that diagnostic tests are payable only when ordered by the physician who is treating the beneficiary for a specific medical problem and who uses the results in such treatment.

CMS Manual System, Pub. 100-02, Medicare Benefit Policy Manual, Chapter 15, §§60, 60.1, 60.2, 60.3, 60.4, 60.4.1 and 80 indicate that the technical component of diagnostic tests is not covered as "incident to" physician healthcare services, but under a distinct coverage category and subject to supervision levels found in the Physician Fee Schedule database.

CMS Manual System, Pub. 100-08, Medicare Program Integrity Manual, Chapter 10, §§5-5.7.2 indicates that non-physician owned facilities performing primarily diagnostic tests should be enrolled as IDTFs rather than billing under physician PINs. See also 42 CFR 410.33.

CMS Manual System, Pub. 100-02, Medicare Benefit Policy Manual, Chapter 15, §80.4.1 and §250 govern payment for X-ray services supplied for patients in a Part A stay in a skilled nursing facility, or other facility, including payments under arrangement.

CFR 486.100 stipulates that portable X-rays must comply with Federal, State, and local laws and regulations.

CMS Manual System, Pub. 100-04, Medicare Claims Processing Manual, Chapter 13, §§40, 40.1.4 Magnetic Resonance Imaging (MRI) Procedures and Payment Requirements. Effective January 1, 2017 separate payment for the contrast media and the need to use the appropriate HCPCS "Q" code (Q9945 – Q9954; Q9958-Q9964) for the contrast medium utilized in performing the service. §40 allows beneficiaries with implanted PMs or cardioverter defibrillators (ICDs) for use in an MRI environment in a Medicare approved clinical study. §40.1.4, Medicare will allow for coverage of MRI for beneficiaries with implanted pacemakers (PMs) when the PMs are used according to the Food and Drug Administration (FDA)-approved labeling for use in an MRI environment as described in section 220.2.C.1 of the NCD manual, effective July 7, 2011.

CMS Manual System, Pub. 100-04, Medicare Claims Processing Manual, Chapter 13, §100.1 describes how physicians should handle billing when two providers read a diagnostic radiologic procedure.

CMS Manual System, Pub. 100-03, Medicare National Coverage Determinations Manual, Chapter 1, Part 4, §220.2; Magnetic Resonance Imaging (MRI), the contraindications section 220.2.C.1 of the NCD was revised to read that the contraindications will not apply to pacemakers when used according to the FDA-approved labeling in an MRI environment or in clinical trials.

CMS publication 100-3, Medicare National Coverage Determinations, Sections 220.1 "Computerized Tomography", and 220.2-220.2.B.2d and Section 220.2.c-220.D "Magnetic Resonance Imaging".

References

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Policy History

Original Effective Date: 05/28/2024
Current Effective Date: 05/01/2025
05/28/2024 Utilization Management Committee review/approval. New policy.
04/15/2025 Utilization Management Committee review/approval. Coverage eligibility unchanged. Policy guidelines section updated to include conservative management definition.
Next Scheduled Review Date: 04/2026

Coding

The five character codes included in the Health Plan Medical Policy Coverage Guidelines are obtained from Current Procedural Terminology (CPT®)‡, copyright 2025 by the American Medical Association (AMA). CPT is developed by the AMA as a listing of descriptive terms and five character identifying codes and modifiers for reporting medical services and procedures performed by physician.

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Codes used to identify services associated with this policy may include (but may not be limited to) the following:

Code Type	Code
CPT	72148, 72149, 72158

HCPCS	No codes
ICD-10 Diagnosis	All related diagnoses

*Investigational – A medical treatment, procedure, drug, device, or biological product is Investigational if the effectiveness has not been clearly tested and it has not been incorporated into standard medical practice. Any determination we make that a medical treatment, procedure, drug, device, or biological product is Investigational will be based on a consideration of the following:

A. Whether the medical treatment, procedure, drug, device, or biological product can be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA) and whether such approval has been granted at the time the medical treatment, procedure, drug, device, or biological product is sought to be furnished; or
B. Whether the medical treatment, procedure, drug, device, or biological product requires further studies or clinical trials to determine its maximum tolerated dose, toxicity, safety, effectiveness, or effectiveness as compared with the standard means of treatment or diagnosis, must improve health outcomes, according to the consensus of opinion among experts as shown by reliable evidence, including:
    1. Consultation with technology evaluation center(s);
    2. Credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community; or
    3. Reference to federal regulations.

**Medically Necessary (or "Medical Necessity") - Health care services, treatment, procedures, equipment, drugs, devices, items or supplies that a Provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

A. In accordance with nationally accepted standards of medical practice;
B. Clinically appropriate, in terms of type, frequency, extent, level of care, site and duration, and considered effective for the patient's illness, injury or disease; and
C. Not primarily for the personal comfort or convenience of the patient, physician or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

For these purposes, "nationally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations and the views of Physicians practicing in relevant clinical areas and any other relevant factors.

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NOTICE: If the Patient's health insurance contract contains language that differs from the Health Plan's Medical Policy definition noted above, the definition in the health insurance contract will be relied upon for specific coverage determinations.

NOTICE: Medical Policies are scientific based opinions, provided solely for coverage and informational purposes. Medical Policies should not be construed to suggest that the Health Plan recommends, advocates, requires, encourages, or discourages any particular treatment, procedure, or service, or any particular course of treatment, procedure, or service.

NOTICE: Federal and State law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage.

Medicare Advantage Members
Established coverage criteria for Medicare Advantage members can be found in Medicare coverage guidelines in statutes, regulations, National Coverage Determinations (NCD)s, and Local Coverage Determinations (LCD)s. To determine if a National or Local Coverage Determination addresses coverage for a specific service, refer to the Medicare Coverage Database at the following link: https://www.cms.gov/medicare-coverage-database/search.aspx. You may wish to review the Guide to the MCD Search here: https://www.cms.gov/medicare-coverage-database/help/mcd-benehelp.aspx.

When coverage criteria are not fully established in applicable Medicare statutes, regulations, NCDs or LCDs, internal coverage criteria may be developed. This policy is to serve as the summary of evidence, a list of resources and an explanation of the rationale that supports the adoption of this internal coverage criteria.

InterQual®
Interqual® is utilized as a source of medical evidence to support medical necessity and level of care decisions. InterQual® criteria are intended to be used in connection with the independent professional medical judgment of a qualified health care provider. InterQual® criteria are clinically based on best practice, clinical data, and medical literature. The criteria are updated continually and released annually. InterQual® criteria are a first-level screening tool to assist in determining if the proposed services are clinically indicated and provided in the appropriate level or whether further evaluation is required. The utilization review staff does the first-level screening. If the criteria are met, the case is approved; if the criteria are not met, the case is referred to the medical director.