

HEALTH PLAN POLICY	
Policy Title: Step Process for Magnetic Resonance Imaging (MRI)	Policy Number: MUM49 Revision: B
Department: Medical Management	Sub-Department: Utilization Management
Applies to Product Lines: <input type="checkbox"/> Medicaid <input type="checkbox"/> Children’s Health Insurance Plan <input checked="" type="checkbox"/> Health Insurance Exchange <input checked="" type="checkbox"/> Medicare <input checked="" type="checkbox"/> USFHP <input checked="" type="checkbox"/> Commercial Insured <input checked="" type="checkbox"/> Non Insured Business	
Origination/Effective Date: 05/09/2018	
Reviewed Date(s):	Revision Date(s): 04/24/2019, 05/19/2020

SCOPE:

The purpose of the policy is to define the process utilized for medical necessity review for Magnetic Resonance Imaging diagnostic scans. The health plan’s review processes for these requests will help members have appropriate access to care based on benefit availability and interventions employed.

DEFINITIONS AND ACRONYMS:

- **Computed Tomography scan (CT)**
- **Magnetic Resonance Imaging (MRI)**
- **Medical Necessity** - Defined by the health plan as a determination that has been made by a licensed physician and/or qualified clinician for services requested that clinical documentation supports to be justified as reasonable, necessary, and appropriate, based on evidence based guidelines criteria and accepted clinical standards of practice for medical and behavioral health conditions.
- **Prior Authorization** - Prior Authorization is the assessment of a proposed service (such as an elective procedure, admission or therapy) to determine if the member has eligible coverage for the service and whether the request demonstrates medically necessity.

POLICY:

Magnetic Resonance Imaging (MRI) may be indicated for the following reasons:

1. Evaluation of musculoskeletal dysfunction after unsuccessful employment of more conservative therapies
2. Pre-operative evaluation of internal structures to determine what medical techniques would be most appropriate
3. Assessment of a bodily structure that has, new onset, decreased or progressive dysfunction
4. Assessment of bodily structures that have experienced trauma
5. Evaluation of unusual masses or lesions that exhibit suspected malignant or neoplastic behavior, or for suspected recurrence or metastasis
6. Evaluation of bony structures for the presence or progression of osteomyelitis, osteolysis or chronic inflammation
7. Evaluation of new onset neurologic disorders with an atypical presentation, or chronic, progressive neurologic disorders

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8. Evaluation of known or suspected congenital abnormalities
9. Assess function of devices implanted to stabilize or improve function
10. Evaluation of persistent pulmonary conditions or continued abnormal imaging, unresponsive to more conservative medical treatment and a chest x-ray has been performed
11. Assessment of new onset cardiopulmonary symptoms with an atypical or may constitute a medical emergency
12. Follow-up evaluation of progressive vascular disease
13. New onset gastrointestinal pain or abnormalities with an atypical presentation that may constitute a medical emergency
14. Allergy to radiographic material with would exclude a CT scan

During the medical necessity review, clinically licensed staff will review the provided clinical documentation to determine if appropriate steps were employed prior to request for the MRI. These are non-invasive evidenced-based interventions that will be employed prior to the request for the MRI and are part of the medical necessity review. The request will also be reviewed to determine if the MRI was requested by a board certified specialist, qualified to understand and interpret the findings of the MRI:

- A. The member has a positive bone scan
- B. The member has had a plain x-ray results nondiagnostic
- C. Requesting physician is an orthopedist, neurologist or other specialist. Requests submitted by Emergency Department physicians, Primary Care Providers or Hospitalists will not be considered medically necessary.
- D. Failure of conservative therapy for at least six (6) weeks within the last six (6) months, including but not limited to, unless contraindicated:
 - o Rest
 - o Ice
 - o Heat
 - o Activity modification
 - o Acupuncture and/or stimulators
 - o Medications
 - o Injections (i.e. epidural, facet, bursal and/or joint, not including trigger point)
 - o Diathermy
 - o Physical Therapy
 - o Chiropractic care
 - o Home exercises

Review of all care requests will be conducted utilizing nationally recognized evidenced-based medical necessity criteria. Utilization Review staff are licensed registered nurses and licensed vocational nurses. Additional review and oversight may also be done by other independently licensed physical, social and behavioral healthcare professionals.

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Requests that do not meet the appropriate evidenced-based criteria guidelines for medical necessity and/or do not clearly show failure of an appropriate response to non-invasive evidenced-based interventions will be sent to the medical director for a medical necessity determination.

In the event the medical director or their designee does not approve a request for the MRI, the requesting provider is instructed on the process to initiate an appeal.

REFERENCES:

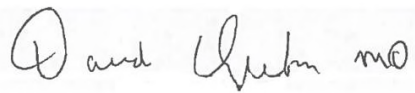
- MCG Ambulatory Care, 21st Edition

RELATED DOCUMENTS:

None.



Nancy Horstmann
Chief Executive Officer Health Plans



David Engleking, M.D.
Medical Director

REVISION HISTORY:

Revision	Date	Description of Change	Committee
New	05/09/2018	Initial release.	Executive Leadership
A	04/24/2019	Annual review. Product lines updated.	Executive Leadership
B	05/19/2020	Annual review. No change to policy content.	Executive Leadership