Molina Clinical Policy
Whole Body MRI: Policy No. 662

Last Approval: 2/9/2022
Next Review Due By: February 2023

DISCLAIMER

This Molina Clinical Policy (MCP) 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) can be contraindicated in any of the following circumstances; there is a metallic body in the eye, for magnetically activated implanted devices such as pacemakers and 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. A whole body MRI uses powerful magnets and radio waves to create pictures of the bodies bony and soft tissue structures. An MRI does not use ionizing radiation (x-rays).

COVERAGE POLICY

Whole Body MRI **may be considered medically necessary** when **ANY** of the following criteria are met:

1. **Bony Metastases.** Whole Body MRI is reported to have a higher accuracy for metastases than other whole-body imaging techniques, including bone scintigraphy and PET/CT as it is sensitive for both initial diagnosis and response to treatment.
2. **Multiple Myeloma.** The medical literature considers Whole Body MRI to be the gold standard.
3. **Lymphoma.** The medical literature supports Whole Body MRI, especially for patients with low FDG avidity.
4. **Leukemia.**
5. **Staging Solid Pediatric Malignancies** (e.g., neuroblastoma, Ewing sarcoma, and rhabdomyosarcoma).
6. **Identifying Complications of Cancer Therapy** (e.g., osteonecrosis [steroid induced]).
7. **Screening Surveillance in Cancer Predisposition Syndromes**
   a. Neurofibromatosis (both NF1 and NF2)
   b. Li-Fraumeni Syndrome
   c. Hereditary Paraganglioma Pheochromocytoma Syndrome
   d. Hereditary Retinoblastoma
8. **Rheumatologic Disease.** Global assessment of active and chronic disease of joints and tendons in both axial and appendicular skeleton. Detects pre-structural inflammatory change in joints, discs, synovium, bone marrow and soft tissues. Whole body MRI is indicated for the following:
   a. Rheumatoid Arthritis (RA)
   b. Psoriatic Arthritis
   c. Ankylosing Spondylitis
   d. Systemic Sclerosis (Scleroderma)
   e. Juvenile Spondyloarthropathies

9. **Multifocal Inflammatory Myopathies.** To assess total disease burden, target sites of active disease for biopsy of the following:
   a. Polymyositis
   b. Muscular Dystrophies

10. **Multifocal Osteonecrosis** including the following:
    a. Sickle Cell (to distinguish osteomyelitis from osteonecrosis)
    b. Alcohol Misuse
    c. Coagulopathies
    d. Systemic Lupus Erythematosus (SLE)
    e. Renal Failure

11. **Multifocal Bone Lesions and Marrow Replacement Processes**
    a. Multiple Exostoses (for detection of malignant transformation)
    b. Langerhans Cell Histiocytosis
    c. Gaucher Disease

12. **Vascular Malformation Syndromes** that may affect multiple organs, bones and soft tissues such as:
    a. Sturge-Weber Syndrome
    b. von Hippel-Lindau Syndrome
    c. Osler-Weber-Rendu (or Hereditary Hemorrhagic Telangiectasia)
    d. Angiomatosis
    e. Gorham's Disease
    f. Maffucci's Syndrome
    g. Klippel-Trénaunay-Weber Syndrome

13. **Workup of Fever of Unknown Origin (FUO)**

14. **Radiation Therapy Planning**

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 Code

CPT	Description
76498	Unlisted magnetic resonance procedure (whole body MRI)

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 not 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

2/9/2022 New policy.

REFERENCES

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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.*