



MASSACHUSETTS

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Medical Policy Fetal MRI

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Policy Number: 770

BCBSA Reference Number: N/A

Related Policies

- **Medicare Advantage: High-Technology Radiology and Sleep Disorder Management Clinical and Utilization Guidance Redirect, #923**
- Functional Magnetic Resonance Imaging (fMRI) Brain, #771
- Magnetic Resonance Imaging (MRI) Abdomen/ Cholangiopancreatography (MRCP), #773
- Magnetic Resonance Imaging (MRI) Bone Marrow Blood Supply, #798
- Magnetic Resonance Imaging (MRI) Breast (Also referred to as MR Mammography (MRM)), #774
- Magnetic Resonance Imaging (MRI) Cardiac, #835
- Magnetic Resonance Imaging (MRI) Cervical Spine, #775
- Magnetic Resonance Imaging (MRI) Chest, #776
- Magnetic Resonance Imaging (MRI) Head/Brain, #777
- Magnetic Resonance Imaging (MRI) Lower Extremity (Joint & Non-Joint), #779
- Magnetic Resonance Imaging (MRI) Lumbar Spine, #778
- Magnetic Resonance Imaging (MRI) Orbit, Face & Neck (Soft Tissues), #780
- Magnetic Resonance Imaging (MRI) Pelvis, #781
- Magnetic Resonance Imaging (MRI) Temporomandibular Joint (TMJ), #782
- Magnetic Resonance Imaging (MRI) Thoracic Spine, #783
- Magnetic Resonance Imaging (MRI) Upper Extremity (Any Joint), #784
- Magnetic Resonance Imaging (MRI) Upper Extremity (Non-Joint), #785
- Magnetic Resonance Spectroscopy (MRS), #488

Policy¹

Commercial Members: Managed Care (HMO and POS), PPO, and Indemnity

Fetal MRI is considered [MEDICALLY NECESSARY](#) for the following conditions:

Assessment prior to fetal intervention

- Following non-diagnostic ultrasound

Complication of monochorionic twins

- Following non-diagnostic ultrasound (**any one♦ of the following**)
 - Anatomy of conjoined twins
 - Demise of a monochorionic cotwin

Congenital anomaly of the abdomen and pelvis

- Following non-diagnostic ultrasound (**any one♦ of the following**)
 - Abdominal mass
 - Bowel obstruction
 - Genitourinary anomaly except rectourethral fistula

Congenital anomaly of the chest

- Following non-diagnostic ultrasound (**any one♦ of the following**)
 - Congenital diaphragmatic hernia
 - Congenital pulmonary airway malformation
 - Pleural effusion

Congenital anomaly of the head and neck

- Following non-diagnostic ultrasound (**any one♦ of the following**)
 - Agenesis of the corpus callosum
 - Cleft palate
 - Cortical malformation
 - Dandy-Walker syndrome
 - Encephalocele
 - Holoprosencephaly
 - Infarct, hemorrhagic or non-hemorrhagic
 - Intracranial mass
 - Meningocele/encephalocele
 - Neck mass
 - Posterior fossa anomaly
 - Vascular malformation, including vein of Galen
 - Ventriculomegaly
 - Vermian hypoplasia

Congenital anomaly of the spine

- Following non-diagnostic ultrasound (**any one♦ of the following**)
 - Caudal regression
 - Congenital anomaly of the vertebrae
 - Neural tube defect
 - Sacrococcygeal teratoma

Placental complication

- Following non-diagnostic ultrasound (**any one♦ of the following**)
 - Abruption
 - Accreta
 - Gestational trophoblastic disease
 - Previa

♦ List may not be exclusive

Prior Authorization Information

Inpatient

- For services described in this policy, precertification/preauthorization **IS REQUIRED** for all products if the procedure is performed **inpatient**.

Outpatient

- For services described in this policy, see below for products where prior authorization **might be required** if the procedure is performed **outpatient**.

	Outpatient
Commercial Managed Care (HMO and POS)	The requirements of BCBSMA Radiology Management Program may require a precertification/prior authorization via AIM Specialty Health. These requirements are member-specific:
Commercial PPO and Indemnity	<p>Please verify member eligibility and requirements through Online Services by logging onto Provider Central. Refer to our Quick Tip for an overview of pre-certification and prior authorization requirements.</p> <p>Ordering clinicians should request pre-certification from AIM Specialty Health or call 1-866-745-1783 (when applicable).</p> <p>Prior authorization information for Medicare HMO Blue and Medicare PPO Blue is addressed in medical policy #923, High Technology Radiology and Sleep Disorder Management for Medicare Advantage Products.</p>

CPT Codes / HCPCS Codes / ICD Codes

Inclusion or exclusion of a code does not constitute or imply member coverage or provider reimbursement. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage as it applies to an individual member.

Providers should report all services using the most up-to-date industry-standard procedure, revenue, and diagnosis codes, including modifiers where applicable.

The following codes are included below for informational purposes only; this is not an all-inclusive list.

The above medical necessity criteria MUST be met for the following codes to be covered for Commercial Members: Managed Care (HMO and POS), PPO, Indemnity, Medicare HMO Blue and Medicare PPO Blue:

CPT Codes

CPT codes:	Code Description
74712	Magnetic resonance (eg, proton) imaging, fetal, including placental and maternal pelvic imaging when performed; single or first gestation
74713	Magnetic resonance (eg, proton) imaging, fetal, including placental and maternal pelvic imaging when performed; each additional gestation (List separately in addition to code for primary procedure)

Policy History

Date	Action
1/2018	Prior authorization information for Medicare HMO Blue and Medicare PPO Blue removed. Prior authorization information for Medicare HMO Blue and Medicare PPO Blue is addressed in medical policy #923, High Technology Radiology and Sleep Disorder Management for Medicare Advantage Products . 1/1/2018
11/2017	Clinical literature was reviewed.
5/2017	Prior Authorization Information clarified. 5/1/2017
7/2016	New medical policy describing medically necessary indications. Effective 7/1/2016.

Adopted AIM Clinical Appropriateness Guidelines: Advanced Imaging Appropriate Use Criteria: Imaging of the Abdomen and Pelvis. Effective Date: May 4, 2015
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Information Pertaining to All Blue Cross Blue Shield Medical Policies

Click on any of the following terms to access the relevant information:

[Medical Policy Terms of Use](#)

[Managed Care Guidelines](#)

[Indemnity/PPO Guidelines](#)

[Clinical Exception Process](#)

[Medical Technology Assessment Guidelines](#)

References

1. American College of Radiology. *ACR-SPR Practice Parameter for the Safe and Optimal Performance of Fetal Magnetic Resonance Imaging (MRI)*. Reson, VA: ACR; 2014. <http://www.acr.org> Accessed September 10, 2014.
2. Australia and New Zealand Horizon Scanning Network. *Horizon Scanning Technology Horizon Scanning Report: MRI for the detection of foetal abnormalities*. Canberra: Commonwealth of Australia; October 2007. <http://www.horizonscanning.gov.au/>. Accessed September 10, 2014.
3. Levine D. Obstetric MRI. *J Magn Reson Imaging*. 2006;24(1):1-15.

Endnotes

¹ Based on AIM Specialty Health Clinical Appropriateness Guidelines: Advanced Imaging Appropriate Use Criteria: Imaging of the Abdomen and Pelvis.