Medical Policy
MR Angiography (MRA) Spinal Canal

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Policy Number: 789
BCBSA Reference Number: N/A

Related Policies
- Medicare Advantage: High-Technology Radiology and Sleep Disorder Management Clinical and Utilization Guidance Redirect, #923
- MR Angiography (MRA) Chest, #786
- CT/MR Angiography (CTA/MRA) Head: Cerebrovascular, #768
- CT/MR Angiography (CTA/MRA) Neck, #769

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

ADULTS
MR Angiography (MRA) Spinal Canal is considered MEDICALLY NECESSARY for the following conditions:

Abnormalities detected on other imaging studies which require additional clarification to direct treatment

Post-operative or post-procedure evaluation

Preoperative or pre-procedure evaluation
Note: This indication is for preoperative evaluation of conditions not specifically referenced elsewhere in this policy.

PEDIATRICS
MR Angiography (MRA) Spinal Canal is considered MEDICALLY NECESSARY for the following conditions:
Abnormality detected on other imaging study which requires additional clarification to direct treatment

Post-operative or post-procedure evaluation

Pre-operative or pre-procedure evaluation

Prior Authorization Information
Pre-service approval is required for all inpatient services for all products.
See below for situations where prior authorization may be required or may not be required.
Yes indicates that prior authorization is required.
No indicates that prior authorization is not required.
N/A indicates that this service is primarily performed in an inpatient setting.

<table>
<thead>
<tr>
<th>Commercial Managed Care (HMO and POS)</th>
<th>Commercial PPO and Indemnity</th>
</tr>
</thead>
<tbody>
<tr>
<td>The requirements of BCBSMA Radiology Management Program may require a precertification/prior authorization via AIM Specialty Health.</td>
<td></td>
</tr>
<tr>
<td>These requirements are member-specific: please verify member eligibility and requirements through Online Services by logging onto Provider Central (<a href="http://www.bluecrossma.com/provider">www.bluecrossma.com/provider</a>). Refer to our Quick Tip <a href="https://provider.bluecrossma.com/ProviderHome/portal/home/office-resources/plans-and-products/bluecard-and-out-of-area-programs/">https://provider.bluecrossma.com/ProviderHome/portal/home/office-resources/plans-and-products/bluecard-and-out-of-area-programs/</a> for an overview of pre-certification and prior authorization requirements.</td>
<td></td>
</tr>
<tr>
<td>Ordering clinicians should request pre-certification from AIM Specialty Health at <a href="http://www.aimspecialtyhealth.com">www.aimspecialtyhealth.com</a> or call 1-866-745-1783 (when applicable).</td>
<td></td>
</tr>
</tbody>
</table>

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, and Indemnity:

CPT Codes

<table>
<thead>
<tr>
<th>CPT codes:</th>
<th>Code Description</th>
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<tbody>
<tr>
<td>72159</td>
<td>Magnetic resonance angiography, spinal canal and contents, with or without contrast material(s)</td>
</tr>
</tbody>
</table>

Policy History

<table>
<thead>
<tr>
<th>Date</th>
<th>Action</th>
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<tbody>
<tr>
<td>1/2018</td>
<td>Prior authorization information for Medicare HMO Blue and Medicare PPO Blue removed. 1/1/2018</td>
</tr>
<tr>
<td>8/2017</td>
<td>Local Coverage Determination (LCD): Magnetic Resonance Angiography (MRA) (L33633) added for Medicare Advantage members. 8/1/2017</td>
</tr>
<tr>
<td>5/2017</td>
<td>Prior Authorization Information clarified. 5/1/2017</td>
</tr>
<tr>
<td>Date</td>
<td>Event</td>
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<tr>
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<td>-----------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>2/2017</td>
<td>Clinical literature was reviewed.</td>
</tr>
<tr>
<td>9/2016</td>
<td>Policy clarified to include pediatric imaging indications. 9/1/2016 Adopted AIM Clinical Appropriateness</td>
</tr>
<tr>
<td>7/2016</td>
<td>New medical policy describing medically necessary indications. Effective 7/1/2016. Adopted AIM Clinical</td>
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<tr>
<td></td>
<td>Date: May 4, 2015.</td>
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</tbody>
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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

**Spine Bibliography**


Endnotes