Medical Policy
MR Angiography (MRA) Spinal Canal

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Policy Number: 789
BCBSA Reference Number: N/A
NCD/LCD: Local Coverage Determination (LCD): Magnetic Resonance Angiography (MRA) (L33633)

Related Policies
MR Angiography (MRA) Chest, #786
CT/MR Angiography (CTA/MRA) Head: Cerebrovascular, #768
CT/MR Angiography (CTA/MRA) Neck, #769

Policy¹
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

Medicare HMO BlueSM and Medicare PPO BlueSM Members

MR Angiography (MRA) Spinal Canal is not covered. For Medicare Advantage members living in Massachusetts, see the link below.

Local Coverage Determination (LCD): Magnetic Resonance Angiography (MRA) (L33633)  

For Medicare Advantage members living outside of Massachusetts, please see the Centers for Medicare and Medicaid Services website for information regarding your specific jurisdiction at https://www.cms.gov.

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>Outpatient</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Commercial Managed Care (HMO and POS)</strong></td>
</tr>
<tr>
<td>The requirements of BCBSMA Radiology Management Program may require a precertification/prior authorization via AIM Specialty Health.</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 to learn how to use technologies to determine if pre-certification or prior authorization applies.</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>
</tr>
<tr>
<td><strong>Commercial PPO and Indemnity</strong></td>
</tr>
<tr>
<td>The requirements of BCBSMA Radiology Management Program may require a precertification/prior authorization via AIM Specialty Health.</td>
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<td><strong>Medicare HMO BlueSM</strong></td>
</tr>
<tr>
<td>This is not a covered service.</td>
</tr>
<tr>
<td><strong>Medicare PPO BlueSM</strong></td>
</tr>
<tr>
<td>This is not a covered service.</td>
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</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:

<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>
</tr>
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<tbody>
<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>
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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


31. Shekelle P. Diagnosis and treatment of low back pain: a joint clinical practice guideline from the American College of Physicians and the American Pain Society. What’s new? What’s different?


Endnotes