Medical Policy

**Magnetic Resonance Imaging (MRI) Bone Marrow Blood Supply**

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**Policy Number:** 798  
BCBSA Reference Number: N/A

**Related Policies**
- Medicare Advantage: High-Technology Radiology and Sleep Disorder Management Clinical and Utilization Guidance Redirect, #923
- Fetal MRI, #770
- Functional Magnetic Resonance Imaging (fMRI) Brain, #771
- Magnetic Resonance Imaging (MRI) Abdomen/Cholangiopancreatography (MRCP) Abdomen, #773
- 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
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- Magnetic Resonance Imaging (MRI) Orbit, Face & Neck (Soft Tissues), #780
- Magnetic Resonance Imaging (MRI) Pelvis, #781
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- 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**

Magnetic Resonance Imaging (MRI) Bone Marrow Supply is considered **MEDICALLY NECESSARY** for the following conditions:

**Myeloma** ², ³
- Diagnosis when all of the following are met:
No lytic bone lesions seen on whole body radiography
  - Note: for further characterization of an equivocal bone lesion seen on whole body radiography. A dedicated MRI of the region (i.e. cervical, thoracic, lumbar spine, pelvis or extremity) should be obtained
To establish the diagnosis of myeloma at least one of the following is required:
  - Biopsy proven plasmacytoma
  - Clonal bone marrow plasma cells greater than 10%
  - M-protein greater than or equal to 3 g/dL and/or 10 to 60 percent bone marrow plasma cells

Note: The evidence for use of MRI in myeloma is insufficient for the evaluation of the following: Response to therapy, prognosis, and monoclonal gammopathy of uncertain significance (MGUS). For myeloma with back pain, see tumor evaluation (cervical, thoracic, lumbar spine).

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.

<table>
<thead>
<tr>
<th>Commercial Managed Care (HMO and POS)</th>
<th>Commercial PPO and Indemnity</th>
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<tbody>
<tr>
<td>The requirements of BCBSMA Radiology Management Program may require a precertification/prior authorization via AIM Specialty Health. These requirements are member-specific:</td>
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<tr>
<td>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.</td>
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<tr>
<td>Ordering clinicians should request pre-certification from AIM Specialty Health or call 1-866-745-1783 (when applicable).</td>
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<tr>
<td>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.</td>
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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>77084</td>
<td>Magnetic resonance (eg, proton) imaging, bone marrow blood supply</td>
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The following ICD Diagnosis Codes are considered medically necessary when submitted with the CPT codes above if medical necessity criteria are met:

ICD-10 diagnosis coding

<table>
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<tr>
<th>ICD-10-CM-diagnosis codes:</th>
<th>Code Description</th>
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<tr>
<td>C90.00</td>
<td>Multiple myeloma not having achieved remission</td>
</tr>
<tr>
<td>C90.20</td>
<td>Extramedullary plasmacytoma not having achieved remission</td>
</tr>
<tr>
<td>C90.30</td>
<td>Solitary plasmacytoma not having achieved remission</td>
</tr>
<tr>
<td>D47.2</td>
<td>Monoclonal gammapathy</td>
</tr>
<tr>
<td>E88.09</td>
<td>Other disorders of plasma-protein metabolism, not elsewhere classified</td>
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Policy History

<table>
<thead>
<tr>
<th>Date</th>
<th>Action</th>
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<tr>
<td>1/2018</td>
<td>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</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

References


Endnotes

1 Based on AIM Clinical Appropriateness Guidelines: Advanced Imaging Appropriate Use Criteria: Imaging of Bone Marrow Blood Supply.