

Benefit Criteria for Radiology Magnetic Resonance Imaging (MRI) to Change for the CSHCN Services Program

Effective for dates of service on or after November 1, 2008, benefit criteria for radiology magnetic resonance imaging (MRI) will change for the Children with Special Health Care Needs (CSHCN) Services Program.

The following procedure codes are benefits of the CSHCN Services Program and may be reimbursed to the following providers:

Procedure Codes	Place of Service	Providers
4-71550, 4-71552, 4-74181, 4-74182, and 4-74183	Office and outpatient hospital	Advanced practice nurses (APNs), physicians, physician groups, radiation treatment centers, hospitals, portable X-ray suppliers, radiological labs, and physiological labs
I-71550, I-71552, I-74181, I-74182, and I-74183	Office, inpatient hospital, and outpatient hospital	APNs, physicians, physician groups, portable X-ray suppliers, radiological labs, and physiological labs
T-71550, T-71552, T-74181, T-74182, and T-74183	Office	APNs, physicians, physician groups, radiation treatment centers, portable X-ray suppliers, radiological labs, and physiological labs
T-71550, T-71552, T-74181, T-74182, and T-74183	Home and independent lab	Portable X-ray suppliers, radiological labs, and physiological labs.

The following procedure codes are benefits of the CSHCN Services Program and may be used to submit claims for MRI services:

Procedure Codes					
4/I/T-70336	4/I/T-70540	4/I/T-70542	4/I/T-70543	4/I/T-70551	4/I/T-70552
4/I/T-70553	T-70554	I-70555	I-70557	I-70558	I-70559
4/I/T-71550	4/I/T-71551	4/I/T-71552	4/I/T-72141	4/I/T-72142	4/I/T-72146
4/I/T-72147	4/I/T-72148	4/I/T-72149	4/I/T-72156	4/I/T-72157	4/I/T-72158
4/I/T-72195	4/I/T-72196	4/I/T-72197	4/I/T-73218	4/I/T-73219	4/I/T-73220
4/I/T-73221	4/I/T-73222	4/I/T-73223	4/I/T-73718	4/I/T-73719	4/I/T-73720
4/I/T-73721	4/I/T-73722	4/I/T-73723	4/I/T-74181	4/I/T-74182	4/I/T-74183
4/I/T-75557	4/I/T-75558	4/I/T-75559	4/I/T-75560	4/I/T-75561	4/I/T-75562
4/I/T-75563	4/I/T-75564	4/I/T-76376	4/I/T-76377	4/I/T-77058	4/I/T-77059
4/I/T-77084					
Note: These procedure codes are not diagnosis-restricted.					

Four MRI services per rolling year are allowed without prior authorization.

The CSHCN Services Program considers functional MRI (fMRI) medically necessary when the following criteria are met:

- The fMRI procedure is used as a part of a preoperative evaluation for a planned craniotomy.
- The fMRI procedure is required for localization of eloquent areas of the brain (such as those responsible for speech, language, motor function, and senses) that might be put at risk during the proposed surgery.

Indications for intracranial neurosurgical procedures utilizing intraoperative MRI (iMRI) include, but are not limited to, the following:

- Oncologic neurosurgical procedures
- Epilepsy
- Chiari surgery
- Deep brain stimulators

Authorization Requirements

Authorization is not required for up to four MRI procedures per year.

Prior authorization will be considered for any additional MRI procedures with documentation of a severe or life-threatening medical condition that requires close monitoring with MRI to determine appropriate treatment. The condition requiring close monitoring with MRI must be such that, without such monitoring and treatment, the condition could progress to death or severe disability.

Reimbursement

A freestanding MRI facility may bill the technical portion only. The radiologist or neurologist who subsequently reads the MRI may bill the interpretation only. When the client is in the inpatient or outpatient setting, the radiologist or neurologist may bill the interpretation.

MRI procedures that specify “with contrast” include payment for paramagnetic contrast; therefore, low osmolar contrast material is not reimbursed separately.

Both professional and radiological services may be reimbursed at the lower of the billed amount or the amount allowed by Texas Medicaid.

Limitations

- Procedure codes 4/I/T-75559, 4/I/T-75560, 4/I/T-75563, and 4/I/T-75564 must be billed in conjunction with procedure codes 5-93015, 1-93016, T-93017, or I-93018.
- Procedure codes 7-01922, 4/I/T-76350, and 4/I/T-77021 will be denied if billed with the same date of service by the same provider as procedure code I-70557.
- Procedure codes 7-01922, 2-36000, 2-36005, 2-36406, 2-36410, I-70557, 4-76000, 4/I/T-76350, 4/I/T-76942, 4/I/T-77002, 4/I/T-77021, 1-90760, 1-90765, 1-90772, 1-90774, and 1-90775 will be denied if billed with the same date of service by the same provider as procedure code I-70558.

- Procedure codes 7-01922, 2-36000, 2-36005, 2-36406, 2-36410, I-70557, I-70558, 4-76000, 4/I/T-76350, 4/I/T-76942, 4/I/T-77002, 4/I/T-77021, 1-90760, 1-90765, 1-90772, 1-90774, and 1-90775 will be denied if billed with the same date of service by the same provider as procedure code I-70559.
- Procedure codes 7-01922 and 4/I/T-76350 will be denied if billed with the same date of service by the same provider as procedure code 4/I/T-71550.
- Procedure codes 7-01922, 2-36000, 2-36005, 2-36011, 2-36406, 2-36410, 4/I/T-71550, 4/I/T-71551, 4-76000, 4/I/T-76350, 4/I/T-76942, 4/I/T-77002, 1-90760, 1-90765, 1-90772, 1-90774, and 1-90775 will be denied if billed with the same date of service by the same provider as procedure code 4/I/T-71552.
- Procedure codes 7-01922 and 4/I/T-76350 will be denied if billed with the same date of service by the same provider as procedure code 4/I/T-74181.
- Procedure codes 7-01922, 2-36000, 2-36005, 2-36011, 2-36406, 2-36410, 4/I/T-74181, 4-76000, 4/I/T-76350, 4/I/T-76942, 4/I/T-77002, 1-90760, 1-90765, 1-90772, 1-90774, and 1-90775 will be denied if billed with the same date of service by the same provider as procedure code 4/I/T-74182.
- Procedure codes 7-01922, 2-36000, 2-36005, 2-36011, 2-36406, 2-36410, 4/I/T-74181, 4/I/T-74182, 4-76000, 4/I/T-76350, 4/I/T-76942, 4/I/T-77002, 1-90760, 1-90765, 1-90772, 1-90774, and 1-90775 will be denied if billed with the same date of service by the same provider as procedure code 4/I/T-74183.

For more information, call the TMHP-CSHCN Contact Center at 1-800-568-2413.