

CMS pivots on MRA coverage decision

Mass Device

The Centers for Medicare and Medicaid Services said it no longer believes a separate coverage indication is necessary for magnetic resonance angiography, opening the procedure to the same reimbursement consideration as a traditional MRI.

The decision reverses an earlier stand by the national insurer on a procedure that tests for stenosis in arteries as different from traditional MRIs.

"CMS recently reconsidered the NCD for Magnetic Resonance Imaging (MRI) at section 220.2 and removed national non-coverage for MRI for blood flow determination, thereby permitting local Medicare contractors to make determinations within their respective jurisdictions," the agency [wrote](#) [1].

CMS first made the coverage decision on MRAs in 1995, but gradually expanded indications for coverage over the ensuing years and took up this decision starting in October 2009.

Kathryn Barry, a reimbursement consultant for Wallingford, Conn.-based [Medical Educational Technology Associates LLC](#) [2] told **MassDevice** that CMS is scrutinizing advanced diagnostics, especially MRI and CT scans, because "while they find a pathology, they cannot treat it, so the patient still has to come back for an interventional procedure."

MRAs analyze the amount of energy released from tissues exposed to a strong magnetic field, providing images of normal and diseased blood vessels in the head, neck, aorta and the abdomen.

CMS currently covers using MRA only for specific conditions to "evaluate flow in internal carotid vessels of the head and neck, peripheral arteries of lower extremities, abdomen and pelvis and the chest. All other uses of MRA are nationally non-covered unless coverage is specifically indicated."

[SOURCE](#) [3]

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[1] <http://www.cms.gov/mcd/viewdecisionmemo.asp?from2=viewdecisionmemo.asp&id=236>

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