Texas Children's	Maternal Magnetic Resonance Imaging (MRI)	
Guideline # 11220	***Categories*** Clinical →Care Management CM, TCHP Guidelines	***This Guideline Applies To:*** Texas Children's Health Plan ***Document Owner*** Bhavana Babber

GUIDELINE STATEMENT:

Magnetic Resonance Imaging (MRI) of the fetus, placenta, and maternal pelvic imaging is a covered benefit with prior authorization of Texas Children's Health Plan (TCHP) effective January 1, 2020.

DEFINITIONS:

FDA- Food and Drug Administration

ACR- American College of Radiology

GUIDELINE

1. All requests for prior authorization for Fetal MRI are received via fax, phone or mail by the Utilization Management Department and processed during normal business hours.
2. The Utilization Management professional receiving the request evaluates the submitted information to determine if the documentation supports the requested medication as an eligible service.
3. To request prior authorization documentation supporting the medical necessity of the requested treatment must be provided.
4. Current treating physician visit note dated within 30 days stating the need for Fetal MRI must accompany the prior authorization.
5. Magnetic resonance imaging (MRI) of the fetus, placenta, and maternal pelvic imaging (procedure code 74712) is a benefit for pregnant TCHP members.
6. Reimbursement
    - 6.1 Procedure code 74712 may be reimbursed as follows:
        - 6.1.1 The *total component* may be reimbursed:
            - 6.1.1.1To the physician, radiation treatment center, portable X-ray supplier, radiological lab, and physiological lab providers for services rendered in the office setting.
            - 6.1.1.2 To the hospital, radiation treatment center, portable X-ray supplier, radiological lab, and physiological lab providers for services rendered in the outpatient hospital setting.
        - 6.1.2 The *professional component* may be reimbursed:

6.1.2.1To the physician, portable X-ray supplier, radiological lab, and physiological lab providers for services rendered in the office and outpatient hospital setting.

6.1.2.2 To physician providers for services rendered in the inpatient hospital setting.

6.1.3 The *technical component* may be reimbursed:

6.1.3.1To the physician, radiation treatment center, portable X-ray supplier, radiological lab, and physiological lab providers for services rendered in the office setting.

6.1.3.2 To the radiation treatment center, portable X-ray supplier, radiological lab, and physiological lab providers for services rendered in the outpatient hospital setting.

7. Fetal MR is indicated when:
   - 7.1 An abnormality on ultrasound is not clearly defined and more information is sought in order to make a decision about therapy, delivery, or to advise a family about prognosis (ie: potential anomaly in the setting of maternal obesity, oligohydramnios, or advanced gestational age)
   - 7.2 An abnormality is identified on ultrasonography and the treating physician desires MR-specific information in order to make decisions about care.
   - 7.3 A fetus is significantly at risk for abnormality that will affect prognosis even if no finding is discovered with ultrasound (ie: neurologic ischemia after laser ablation of placental anastomoses in Twin-Twin Transfusion Syndrome).

8. Requirements for Fetal MRI
   - 8.1 Screening for ferromagnetic devices or implants is negative in the mother.
   - 8.2 Gestational age: Currently there are no specific guidelines from the FDA. However, imaging in the first trimester is not recommended as this is the time of organogenesis. ACR suggests imaging after 18 weeks due to the unknown effects of higher magnetic field strength and potentially prolonged imaging times. However, no current evidence exists to show that fetal MRI is harmful to either the mother or fetus
   - 8.3 Appropriate indication for the Fetal MRI
   - 8.4 The use of gadolinium has not been adequately studied in pregnant human subjects and is not used during pregnancy unless absolutely clinically necessary, especially during organogenesis.

9. Requests that do not meet the criteria established by this guideline will be referred to a TCHP Medical Director/Physician reviewer for review and the Denial Policy will be followed.
10. Preauthorization is based on medical necessity and not a guarantee of benefits or eligibility. Even if preauthorization is approved for treatment or a particular service, that authorization applies only to the medical necessity of treatment or service. All services are subject to benefit limitations and exclusions. Providers are subject to State and Federal Regulatory

compliance and failure to comply may result in retrospective audit and potential financial recoupment.

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Status	Date	Action
Approved	09/16/2021	Clinical & Administrative Advisory Committee Reviewed and Approved for Implementation

RELATED DOCUMENTS:

REFERENCES:

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