STATE MEDICAID PROGRAM

Medical Necessity Guidelines for Magnetic Resonance Imaging (MRI) - Knee

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I. POLICY STATEMENT

State Medicaid covers Magnetic Resonance Imaging (MRI) of the knee when the procedure is medically necessary for diagnosis or treatment planning of a covered condition. Prior authorization is required for all knee MRI procedures (CPT codes 73721, 73722, 73723).

II. DEFINITIONS

Conservative Therapy: A minimum trial period of non-invasive treatment including:

- Prescription-strength NSAIDs or other appropriate analgesics for at least 3 weeks, AND
- Physical therapy (supervised or home-based) for at least 6 weeks, AND
- Activity modification for at least 6 weeks

Acute Trauma: A specific injury occurring within the past 6 weeks with a documented mechanism of injury.

Mechanical Symptoms: Reproducible locking, catching, or giving way of the knee joint documented on physical examination.

III. COVERAGE CRITERIA

A. General Requirements

MRI of the knee will be authorized when ALL of the following are met:

1. **Plain film radiography (X-ray) has been performed** within the past 90 days with results documented in the medical record
2. **Ordering physician** is a Medicaid-enrolled provider
3. **Imaging facility** accepts Medicaid assignment

4. The MRI results will **directly influence treatment decisions** (must be documented in the clinical notes)

B. Specific Clinical Indications

MRI of the knee meets medical necessity criteria when ONE or more of the following conditions are documented:

1. Suspected Internal Derangement

Required Documentation:

- History of acute trauma OR chronic symptoms with specific mechanical complaints
- Physical examination findings including ONE or more:
  - Positive McMurray's test
  - Positive Apley's compression test
  - Joint line tenderness with effusion
  - Limited range of motion (>20° extension deficit or >30° flexion deficit)
- **AND** at least ONE of:
  - Knee locking episodes (documented, not patient report alone)
  - Persistent effusion after 4 weeks of conservative therapy
  - Mechanical catching or giving way confirmed on examination

Conservative Therapy Requirement:

- Must document trial of conservative therapy (as defined above) UNLESS:
  - Acute traumatic injury within 6 weeks with suspected ligament rupture, OR
  - True locking with inability to fully extend knee, OR
  - Progressive neurological symptoms

2. Suspected Ligamentous Injury

Required Documentation:

- Documented mechanism of injury (acute trauma)
- Physical examination showing ONE or more:
  - Positive Lachman's test (Grade 1B or higher)
  - Positive anterior drawer test
  - Positive posterior drawer test
  - Positive pivot shift test

- Valgus/varus stress instability (>5mm difference compared to contralateral knee)

Conservative Therapy Requirement:

- NOT required for acute injuries (<6 weeks) with Grade 2 or higher instability
- REQUIRED for chronic injuries (>6 weeks) unless surgical intervention is being considered

3. Pre-Surgical Planning

Required Documentation:

- Clinical diagnosis requiring surgical intervention
- Prior conservative therapy trial documented (minimum 6 weeks) showing failure to improve
- Surgical procedure scheduled or planned within 90 days
- MRI results will determine surgical approach or technique

Covered Pre-Surgical Scenarios:

- ACL/PCL reconstruction evaluation
- Meniscal repair vs. meniscectomy determination
- Multi-ligament injury assessment
- Osteochondral lesion characterization

4. Post-Surgical Complications

Required Documentation:

- Prior knee surgery documented with operative report
- New symptoms or complications including:
    - Suspected graft failure or rupture
    - Suspected hardware complication
    - Infection not confirmed by other imaging or aspiration
    - Unexplained persistent pain >3 months post-operation
    - Loss of range of motion >30° compared to immediate post-op baseline

5. Suspected Osteochondral Defect or Osteonecrosis

Required Documentation:

- Plain films showing:
    - Subchondral lucency or sclerosis, OR

- Joint space narrowing in patient <50 years old, OR
- Unexplained bone abnormality

- Clinical symptoms for >6 weeks including:
  - Pain at rest or with minimal activity
  - Night pain
  - Inability to bear weight

6. Suspected Neoplasm or Infection

Required Documentation:

- For suspected tumor:
  - Palpable mass, OR
  - Unexplained bone pain, OR
  - Abnormal plain films, OR
  - Constitutional symptoms (fever, weight loss, night sweats)
- For suspected infection:
  - Elevated inflammatory markers (ESR >30 mm/hr, CRP >10 mg/L, WBC >11,000), OR
  - Joint aspiration showing WBC >25,000 with >75% PMNs, OR
  - Clinical signs of septic arthritis (fever, warmth, inability to bear weight)

Conservative Therapy Requirement: NOT REQUIRED

7. Recurrent Hemarthrosis

Required Documentation:

- At least 2 documented episodes of acute knee swelling with aspiration showing blood
- Bleeding disorder workup completed
- Plain films to rule out fracture

IV. CRITERIA THAT DO NOT MEET MEDICAL NECESSITY

MRI of the knee will NOT be authorized for the following:

1. **Osteoarthritis as sole diagnosis** when:
   - Plain films show Kellgren-Lawrence Grade III or IV changes, AND

- No mechanical symptoms present, AND
- Conservative therapy has not been attempted

2. **Isolated degenerative meniscal tear** in patients >45 years old with:
    - Kellgren-Lawrence Grade IV osteoarthritis on X-ray, AND
    - No history of acute trauma, AND
    - No true mechanical locking
3. **Non-specific knee pain** without:
    - Abnormal physical examination findings, OR
    - Failed conservative therapy trial, OR
    - Concerning findings on plain films
4. **Routine screening** without symptoms or clinical findings
5. **Patient request** alone without clinical justification
6. **MRI ordered same day as plain films** when X-ray results are not yet available
7. **Chronic condition with no change in symptoms** when:
    - Prior MRI performed <12 months ago, AND
    - No new trauma or change in clinical presentation, AND
    - Not being used for pre-surgical planning
8. **Second opinion** when first MRI was adequate and recent (<6 months)

V. DOCUMENTATION REQUIREMENTS

Prior authorization requests must include ALL of the following:

1. **Completed prior authorization form** with:
    - Patient demographics and Medicaid ID
    - CPT code(s) requested (73721, 73722, or 73723)
    - ICD-10 diagnosis code(s)
2. **Clinical documentation** including:
    - History of present illness with timeline
    - Mechanism of injury (if applicable)
    - Physical examination findings (specific tests performed and results)
    - Conservative treatment attempts with dates and response
    - How MRI will change treatment plan

3. **Plain film radiology report** (dated within 90 days)
4. **Relevant laboratory results** (if applicable - for suspected infection or inflammatory conditions)

VI. FREQUENCY LIMITATIONS

- **Initial MRI**: Authorized when criteria met
- **Follow-up MRI**:
  - Within 12 months: Requires documentation of new trauma, significant change in clinical presentation, or pre-surgical planning
  - After surgical intervention: No time limitation if post-op complications suspected
  - Routine surveillance: NOT COVERED unless high-grade tumor or specific conditions requiring serial imaging

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VII. CPT CODES

Covered when medically necessary:

- 73721 - MRI lower extremity other than joint, without contrast
- 73722 - MRI lower extremity other than joint, with contrast
- 73723 - MRI lower extremity other than joint, without contrast followed by with contrast

Note: MR arthrography requires separate authorization with additional clinical justification.

VIII. ICD-10 CODES (Examples - Not All-Inclusive)

Commonly Approved Diagnoses:

- S83.5XXA - Sprain of cruciate ligament of knee
- S83.2XXA - Tear of meniscus, current injury
- M23.3XX - Other meniscus derangements
- M24.56X - Contracture, knee
- M25.56X - Pain in knee
- M87.05X - Idiopathic aseptic necrosis of femur
- C40.2XX - Malignant neoplasm of long bones of lower limb

- M86.16X - Other acute osteomyelitis, lower leg

IX. AUTHORIZATION DETERMINATION

- **Standard review**: Decision within 3 business days
- **Expedited review**: Decision within 24 hours (requires documented urgent medical need)
- **Retrospective review**: May be performed for claims submitted without prior authorization

Valid authorization period: 60 days from approval date

X. APPEAL PROCESS

Denials may be appealed within 60 days of notification. Appeal must include:

- Additional clinical documentation supporting medical necessity
- Peer-to-peer review request (optional)
- Member statement if desired

XI. REFERENCES

1. American College of Radiology (ACR) Appropriateness Criteria® - Acute Trauma to the Knee
2. American Academy of Orthopaedic Surgeons (AAOS) Clinical Practice Guidelines
3. InterQual® Clinical Criteria for Imaging
4. Centers for Medicare & Medicaid Services (CMS) National Coverage Determinations
5. Evidence-based medicine reviews and peer-reviewed literature

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Questions: Contact Provider Services at 1-800-XXX-XXXX or submit inquiries through the provider portal

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This guideline is subject to change based on new medical evidence, technology, or regulatory requirements. Providers should verify current policy before submitting authorization requests.