Bayer HealthCare Inc. offers this billing guide to hospital customers as part of its comprehensive educational program on the reimbursement process. We understand that medical practice today requires working with health insurers that finance the care of your patients. Bayer is committed to providing you with up-to-date reimbursement information for the entire Bayer suite of diagnostic imaging contrast agents for enhanced magnetic resonance imaging (MRI), magnetic resonance angiography (MRA), and computed tomography (CT) procedures.

This billing guide provides information about general coverage, coding, and payment information for Bayer imaging agents and associated diagnostic imaging procedures in the hospital inpatient and hospital outpatient settings. Because providers face a multitude of Current Procedural Terminology (CPT) coding options for imaging procedures, we also provide CPT codes for MRI, MRA, X-ray, and CT procedures beginning on page 12 in this brochure.

In the sections that follow, we present an overview of the major public and private insurers’ general coverage and reimbursement policies for diagnostic radiology services.

Bayer HealthCare also operates the Reimbursement Helpline to answer coverage, coding, and payment questions about its products and associated diagnostic imaging procedures.

The toll-free Bayer Helpline number is 1-800-423-7539 and e-mail is imaging@prgweb.com.

Helpline hours are Monday through Friday, 9:00 am to 5:00 pm, Eastern time.

Information provided in this resource is for informational purpose only and does not guarantee that codes will be appropriate or that coverage and reimbursement will result. Customers should consult with their payers for all relevant coverage, coding, and reimbursement requirements. It is the sole responsibility of the provider to select proper codes and ensure the accuracy of all claims used in seeking reimbursement. Neither this resource nor the Bayer Healthcare Reimbursement Helpline is intended as a legal advice or as a substitute for a provider’s independent professional judgment.

Introduction

Reimbursement Process
Coverage

Coverage refers to the decision by an insurer to provide program benefits for a specific product or medical service. Coverage policies, which vary by payer, typically specify whether a proposed course of treatment is medically necessary and, therefore, eligible for reimbursement under a patient’s healthcare plan.

When considering whether a product or service is covered, it is important to distinguish between coverage and payment. It is possible for a service or product to be bundled or packaged, which means that it is covered but not paid separately. An example would be a service that falls under an all-inclusive payment mechanism like diagnosis-related groups (DRGs) or per diems.

Medicare

Medicare typically covers diagnostic radiology procedures and imaging agents when they are considered reasonable and necessary for the diagnosis or treatment of an illness or injury. Medicare often bases its coverage decisions on information submitted on claim forms, including diagnosis codes and procedure codes. In some cases, Medicare may also look at accompanying documentation that is submitted with a claim. Medicare may also look at accompanying documentation that is submitted with a claim.

Medicare has developed the following specific coverage policies for MRI and CT procedures:

- In general, Medicare covers non-investigational uses of MR that are reasonable and necessary when performed on approved MR units
- Medicare generally covers reasonable and necessary CT scans when performed using approved CT equipment, provided that the medical and scientific literature and opinion support the effective use of a scan for the patient’s condition

Medicare’s national coverage determination for CT does not make reference to specific procedures. In the absence of a national policy, each local Medicare carrier has established a local coverage determination (LCD) for their jurisdiction that provides coverage guidelines for CT procedures. The LCDs provide specific guidelines and requirements, ranging from patient diagnosis to equipment technology. Because of variations in each carrier’s local policy, it is important to be familiar with the LCD for CT procedures in your state. LCDs are available for review on each carrier’s website, or contact the Reimbursement Helpline for more information.

Private Insurers

Like Medicare, most private insurers cover MRIs, CT scans, other diagnostic radiology procedures, and imaging agents when determined to be medically necessary and appropriate; however, benefits vary from payer to payer and also depend on the specific contract terms that a provider negotiates with a given plan. Some private insurers have medical criteria for coverage similar to those used by Medicare, while others have developed their own policies. As a condition of coverage, some managed care plans may also require that providers obtain prior authorization before providing diagnostic imaging services.

Check your patient’s policy or call the Reimbursement Helpline for help determining specific policy limits or requirements that might apply to Bayer products or related diagnostic imaging procedures.

Medicaid

Because decisions regarding Medicaid benefits are generally left to the states, Medicaid coverage policies will be determined on a state-by-state basis. While some state Medicaid programs may utilize coverage guidelines for contrast agents and associated diagnostic imaging procedures that mirror Medicare’s policies, other programs may provide more limited benefits for diagnostic services. Additionally, some states may have prior authorization requirements for such services.

For more specific information, check your state’s Medicaid coverage policies, or call the Reimbursement Helpline if you need help researching specific guidelines or restrictions.
Coding systems provide a uniform language for describing medical, surgical, and diagnostic services, as well as patient conditions and certain drugs and supplies. Correct coding of all components of a service is necessary to obtain appropriate reimbursement.

Hospitals bill for services and items using the CMS-1450 claim form, commonly known as the UB-04 claim form. Although specific coding requirements vary by insurer, Medicare and many other payers rely on four coding systems to process claims for hospital inpatient and hospital outpatient services:

- International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) codes
- CPT codes
- Healthcare Common Procedure Coding System (HCPCS) codes
- Revenue codes

We describe each type of code on the following pages.

All codes must be supported with adequate documentation in the medical record; such documentation may be requested in the event of an audit or a retrospective claims review.

ICD-10-CM Codes

Diagnosis Codes

All claim forms must include at least one ICD-10-CM diagnosis code to describe the patient's condition. Because there are many possible circumstances that may require diagnostic imaging services, such services can be billed with a variety of diagnosis codes. Some payers have coverage policies that list specific covered diagnosis codes for MRI, X-ray, and CT procedures; these codes will vary from payer to payer.

Providers should consult a complete listing of current ICD-10-CM diagnosis codes to determine which code(s) best reflect the condition of any specific patient for whom a claim is submitted. Additionally, providers should always select the appropriate ICD-10-CM diagnosis code(s) with the highest level of specificity.

Procedure Codes

Hospitals report inpatient services using ICD-10-CM procedure codes for Medicare and many other payers. There are dozens of ICD-10-CM procedure codes that describe several types of diagnostic radiology services.

ICD-10-CM procedure codes are not used on Medicare claims for hospital outpatient services; however, the coding requirements of other payers may vary.

Providers should consult a complete listing of current ICD-10-CM procedure codes to determine which code(s) appropriately describe the service(s) rendered to the patient.

CPT Codes

Medicare claims for hospital outpatient services must include appropriate CPT codes to describe the services performed. Many non-Medicare payers also require hospital outpatient departments to use CPT codes to report outpatient services. An entire section of the CPT book is dedicated to radiology; this section includes codes for MRIs, MRAs, and CT scans, as well as other diagnostic imaging services. Many of these CPT codes specify whether an imaging technique is performed without contrast material, with contrast material, or without contrast material followed by with contrast material.

In many instances, it may be appropriate to use modifiers in conjunction with CPT codes. Modifiers are two-digit numeric or alphanumeric codes that are appended to CPT codes to provide additional detail or to indicate that a service has been altered in some way.

CPT codes are not used on Medicare hospital inpatient claims; however, the coding requirements of other payers may vary. For a listing of CPT codes for MRI, MRA, and CT procedures, please see pages 11–23 in this brochure. However, providers should also consult a complete listing of current CPT codes to determine if an alternative code may be appropriate.

All codes must be supported with adequate documentation in the medical record; such documentation may be requested in the event of an audit or a retrospective claims review.
The American Medical Association (AMA)—the organization that updates and maintains CPT codes—instructs providers to select a CPT code with a descriptor “that accurately identifies the service performed,” rather than a code “that merely approximates the service provided.” In the absence of a specific code that accurately identifies a service, providers should “report the service using the appropriate unlisted procedure or service code.”

HCPCS Codes
Medicare, as well as many private payers and Medicaid plans, requires that hospital outpatient departments report many drugs, supplies, other items, and certain services using alphanumeric HCPCS codes, which are often highly specific in nature. Providers are not required to bill contrast material with HCPCS codes when reporting many contrast-enhanced diagnostic radiology services. However, there are some HCPCS codes for certain imaging agents that may be used in limited circumstances—for example, when reporting low-osmolar contrast material (LOCM) and MR contrast on Medicare claims in the hospital outpatient setting. Please see page 11 for appropriate HCPCS codes.

Please note that the availability of an HCPCS code for a particular product does not necessarily indicate that the product is separately reimbursable.

Depending on the insurer and the particular service and agent provided, reimbursement for contrast materials may be included within the payment for the associated imaging procedure. When using the LOCM and MR contrast HCPCS codes, providers should report correct units of service per the code descriptors.

HCPCS codes are not used on Medicare hospital inpatient claims*; however, the coding requirements of other payers may vary. In situations that warrant the use of HCPCS codes, providers should consult a complete listing of current HCPCS codes and select the appropriate HCPCS code(s) with the highest level of specificity to describe the product(s) or service(s) furnished.

Next, we briefly discuss some of the differences between Medicare’s HCPCS coding requirements and the requirements of other payers. Because billing policies for contrast materials are often complex and payer-specific, we encourage you to contact your payers to verify their particular coding requirements for the imaging agents used at your facility. The Reimbursement Helpline is available to research payer-specific billing information; please contact us if you would like our assistance in this area.

Medicare
Hospital outpatient departments, when billing, must use the HCPCS codes found on the table on page 11 of this brochure.

In the hospital outpatient setting, payment for most contrast agents is packaged into the payment of the associated independent diagnostic procedure. Hospitals should still report contrast on claim forms using the appropriate HCPCS code.

Private Insurers and Medicaid
The coding requirements of non-Medicare payers will likely vary. Some insurers may not require providers to bill imaging agents with HCPCS codes for many contrast-enhanced diagnostic radiology procedures.

Please see page 11 for appropriate HCPCS codes.

If you are unsure whether a particular payer accepts contrast agent HCPCS codes, we encourage you to contact the payer directly or call Bayer’s Reimbursement Helpline at 1-800-423-7539.

* An exception exists for hemophilia clotting factors.
Revenue Codes

All claim forms must include a revenue code for each line item. Revenue codes are four-digit codes that allow hospitals to attribute services and supplies to specific cost centers within the hospital. Each service or supply provided during the patient's hospital inpatient stay or hospital outpatient visit must be associated with a revenue code.

Several revenue codes are relevant to imaging services. The revenue code series in Table 1 are applicable to CT scans, MR procedures, and other diagnostic radiology procedures.

### Table 1

<table>
<thead>
<tr>
<th>Revenue Code</th>
<th>Descriptor</th>
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<tbody>
<tr>
<td>035X</td>
<td>Computed tomographic (CT) scans</td>
</tr>
<tr>
<td>061X</td>
<td>Magnetic resonance technology (MRT)</td>
</tr>
<tr>
<td>032X</td>
<td>Radiology-diagnostic</td>
</tr>
</tbody>
</table>

When LOCM or MR contrast is furnished and is not reported with an HCPCS code (for example, in the hospital inpatient setting for Medicare), hospitals may include the cost of the contrast agent in the charge for the associated imaging procedure using a revenue code from one of the series to the right. Alternatively, hospitals may report a separate charge for the contrast using one of the revenue codes in Table 2.

### Table 2

<table>
<thead>
<tr>
<th>Revenue Code</th>
<th>Descriptor</th>
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</thead>
<tbody>
<tr>
<td>0254</td>
<td>Drugs incident to other diagnostic services</td>
</tr>
<tr>
<td>0255</td>
<td>Drugs incident to radiology</td>
</tr>
</tbody>
</table>

In situations where it is appropriate to report LOCM or MR contrast using an HCPCS code (for example, under OPPS), the appropriate revenue code is 0636 (Drugs Requiring Detailed Coding).

Providers should consult a complete listing of current revenue codes and select the appropriate revenue codes for the services rendered to the patient. Hospital billing staff members should determine which revenue codes to use at their facility by selecting the most appropriate code from each series.

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Payment methodologies often vary depending on where a procedure is performed. This is especially true of the Medicare program. Below, we outline the payment systems that different payers use to reimburse services furnished in the hospital inpatient and hospital outpatient settings.

Hospital Inpatient Departments

Medicare

Medicare pays for hospital inpatient admissions using the hospital inpatient prospective payment system, commonly referred to as the DRG system. Under this system, each hospital inpatient case is assigned to a single DRG based on the patient’s diagnosis(es) and the procedure(s) performed (as reported with ICD-10-CM codes on the claim form). That DRG provides a fixed, hospital-specific payment that is intended to cover all facility costs during the inpatient stay.

The payment rate for each DRG is based on a relative weight (which measures the resource use associated with the DRG as compared to other DRGs) and is adjusted for each hospital to reflect geographic differences in hospital labor costs, indigent care, and teaching status. DRG payments do not cover the costs of physician services, as physician services are reimbursed separately under the Medicare physician fee schedule.

As with most other drugs and supplies, Medicare currently does not provide separate payment for contrast agents and associated diagnostic imaging procedures when furnished on an inpatient basis; rather, reimbursement for these items and services is packaged into the single payment rate for the DRG.

Additionally, most imaging procedures do not affect DRG assignment; instead, a case involving a diagnostic radiology service will generally be assigned to a DRG based on the other procedures or diagnoses on the claim form. For this reason, DRG assignments and payment rates for diagnostic imaging procedures can vary greatly depending on the specifics of a particular case.

For your reference, we provide a table that summarizes the pertinent Medicare hospital inpatient reimbursement information for imaging agents and MR, MRA, and CT procedures on page 10 in this brochure.

Private Insurers

Most private insurers negotiate contracts with facilities regarding hospital inpatient payment methods. These contracts are typically negotiated annually. Many private payers use DRG systems to reimburse hospital inpatient services. Other common payment arrangements used by private insurers are per diems, percentage of allowable charges, and negotiated rates for specific treatments. Private insurers are unlikely to provide separate payment for contrast material or other drugs and supplies when furnished in the inpatient setting.

Medicaid

Each state Medicaid program determines the method it uses to pay for hospital inpatient services. The majority of states base reimbursement for hospital inpatient services on prospective payment systems, which include DRGs and per diems, and provide a single payment to the hospital with no separate payment for imaging agents or other drugs and supplies. Some states, however, use other reimbursement methods, including cost-based payments.

Many Medicaid programs also adjust payments to reflect a hospital’s case mix, or the intensity of care required by patients treated at the facility.
Payment (continued)

Hospital Outpatient Departments

Medicare

Medicare reimburses most hospital outpatient services under the Hospital Outpatient Prospective Payment System (OPPS), which also is known as the ambulatory payment classification (APC) system. Under OPPS, separately payable items and services are assigned to APC groups based on the CPT and HCPCS codes included on the claim form. Each APC is associated with a fixed payment amount, which is intended to cover the facility’s costs for services described in that code and provided in the hospital outpatient setting.

OPPS allows for payment for multiple APCs during a single hospital outpatient visit. APC payments for procedures are adjusted for each geographic region to reflect local differences in labor costs. In addition to receiving Medicare’s portion of the APC payment, hospitals also receive a set co-payment from the patient. Physician services are reimbursed separately based on the Medicare physician fee schedule and are not included in APC payments to hospitals.

Diagnostic imaging procedures—Medicare hospital outpatient payments for diagnostic imaging procedures are based on the APCs to which the procedures are assigned. CPT codes for MR (Table 3) and CT (Table 4) procedures map to the APC groupings.

Table 3
<table>
<thead>
<tr>
<th>MR APC</th>
<th>Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>0284</td>
<td>MRI with contrast</td>
</tr>
<tr>
<td>0337</td>
<td>MRI without contrast followed by with contrast</td>
</tr>
</tbody>
</table>

Table 4
<table>
<thead>
<tr>
<th>CT APC</th>
<th>Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>0282</td>
<td>Miscellaneous CT</td>
</tr>
<tr>
<td>0283</td>
<td>CT with contrast</td>
</tr>
<tr>
<td>0333</td>
<td>CT without contrast followed by with contrast</td>
</tr>
</tbody>
</table>

Bayer imaging agents—Medicare provides packaged payment for contrast agents under the OPPS drug packaging methodology. This payment methodology packages the cost of drugs into the associated APC of the independent procedure. This payment policy for contrast agents applies to Bayer’s MR and CT contrast agents. Hospital providers have several ways to report contrast agents, including uncoded charges on revenue code line, including the charge for the contrast agent in the charge for the procedure (inpatient claims), or reporting the appropriate HCPCS code for the contrast agent when used (outpatient claims). Hospitals’ outpatient departments that provide contrast agents in association with independent procedures involving imaging must bill both services (imaging procedure and contrast agent) on the same claim so that the cost of the contrast agent can be appropriately packaged retrospectively into payment for the imaging procedure.

Please refer to the appropriate product pages in this brochure for billing instructions. It is important to note that the median costs for services in APC groups that include contrast are higher than median costs for services in APC groups that do not include contrast. Medicare publishes the payment rates of APC groups under the “Hospital Outpatient Regulations and Notices” tab on the HOPPS website. For access, visit [http://www.cms.hhs.gov/HospitalOutpatientPPS](http://www.cms.hhs.gov/HospitalOutpatientPPS), or call the Bayer Reimbursement Helpline at 1-800-423-7539 for assistance.
Private Payers
Private insurer payments for hospital outpatient services are often based on a percentage of billed or allowable charges, previously negotiated payment rates, or preset per-diem/per-visit rates. Whether a hospital outpatient department receives separate reimbursement for contrast material will depend on the plan in question, the particular agent and imaging service furnished, and the contract that the facility has negotiated with the plan. Facing increasing pressures to control costs, many private insurers are adopting bundled payment arrangements for services like contrast-enhanced diagnostic radiology studies.

Medicaid
Medicaid reimbursement for hospital outpatient services varies from state to state. Medicaid programs typically base hospital outpatient payments on state-specific fee schedules, preset per-diem/per-visit rates, or percentage of charges. There is significant variation in Medicaid payment amounts among states; however, Medicaid programs typically pay less than other insurers. State-specific policies will determine whether imaging agents are paid separately in hospital outpatient departments.

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Summary of Medicare: Inpatient

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<th>CT or MR Procedure</th>
<th>Imaging Agent</th>
</tr>
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<tbody>
<tr>
<td>ICD-10-CM Procedure Codes</td>
<td>Specific codes for CTs</td>
<td>Gadolinium-based MR Contrast, LOCM CT/X-ray Contrast</td>
</tr>
<tr>
<td></td>
<td>✷ See Coding section of Billing Guide for list of codes</td>
<td>Generally not used to report contrast</td>
</tr>
<tr>
<td></td>
<td>✷ Codes do not distinguish procedures with and without contrast</td>
<td></td>
</tr>
<tr>
<td>Revenue Codes</td>
<td>035X—CT scans 061X—MRT 032X—Radiology–diagnostic</td>
<td>Cost of the contrast agent may be included in the charge for the associated imaging procedure using 035X, 061X, or 032X revenue code</td>
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<td></td>
<td>Alternatively, hospitals may report a separate charge for the contrast using one of the following:</td>
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<tr>
<td></td>
<td></td>
<td>✷ 0254—Drugs incident to other diagnostic services</td>
</tr>
<tr>
<td></td>
<td></td>
<td>✷ 0255—Drugs incident to radiology</td>
</tr>
<tr>
<td>Payment</td>
<td>Reimbursement for imaging procedure bundled into DRG payment</td>
<td>Cost of the contrast agent may be included in the charge for the associated imaging procedure using 035X, 061X, or 032X revenue code</td>
</tr>
<tr>
<td></td>
<td>✷ MR and CT ICD-10-CM procedure codes do not influence DRG assignment</td>
<td>Alternatively, hospitals may report a separate charge for the contrast using one of the following:</td>
</tr>
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For information regarding the Bayer portfolio of diagnostic imaging agents, please call your Bayer HealthCare Sales Consultant at 1-888-842-2937, option 5. For customer service or purchasing information regarding any Bayer diagnostic imaging agent, please call 1-877-229-3750.
# Summary of Medicare: Outpatient

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<td><strong>CT or MR Procedure</strong></td>
<td><strong>LOCM CT/X-ray Contrast</strong></td>
</tr>
<tr>
<td>CPT Codes</td>
<td><strong>Specific codes for MR and CTs</strong></td>
<td>Generally not used to report contrast</td>
</tr>
<tr>
<td></td>
<td>✷ See codes listed earlier in this piece</td>
<td></td>
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<tr>
<td></td>
<td>✷ Many codes specify without contrast, with contrast, or without contrast followed by with contrast</td>
<td></td>
</tr>
<tr>
<td></td>
<td>✷ Special C-codes must be used instead of CPT codes for certain MR procedures</td>
<td></td>
</tr>
<tr>
<td>HCPCS Codes</td>
<td><strong>LOCM reported with Q9965–Q9967</strong></td>
<td>See the following CPT code pages for appropriate codes</td>
</tr>
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<td></td>
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<td></td>
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<td>061X—MRT</td>
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<td></td>
</tr>
<tr>
<td>Payment</td>
<td><strong>Payment based on APC grouping to which procedure is assigned</strong></td>
<td>Packages payment into associated independent diagnostic procedure</td>
</tr>
<tr>
<td></td>
<td>✷ Procedures with contrast generally paid higher than those without contrast</td>
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Gadavist®
(gadobutrol) injection
1 mmol/mL

CPT Codes

Gadavist-specific MRI Codes

**A9585** injection, gadobutrol, 0.1 mL

**MRI, Breast**
- 77058 MRI, breast, without and/or with contrast material(s); unilateral
- 77059 MRI, breast, without and/or with contrast material(s); bilateral

**MRI, Brain (Including Brain Stem)**
- 70552 with contrast material(s)
- 70553 without contrast material(s), followed by contrast material(s) and further sequences

**MRI, Spinal Canal and Contents, Thoracic**
- 72147 with contrast material(s)
- 72157 without contrast material(s), followed by contrast material(s) and further sequences

**MRI, Spinal Canal and Contents, Cervical**
- 72142 with contrast material(s)
- 72156 without contrast material(s), followed by contrast material(s) and further sequences

**MRI, Spinal Canal and Contents, Lumbar**
- 72149 with contrast material(s)
- 72158 without contrast material(s), followed by contrast material(s) and further sequences

Gadavist-specific MRA Codes

**A9585** injection, gadobutrol, 0.1 mL

**MRA, Abdomen**
- 74185 with or without contrast material(s)

**MRA, Neck**
- 70548 with contrast material(s)
- 70549 without contrast material(s) followed by with contrast material(s) and further sequences

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Indications and Usage

Gadavist® (gadobutrol) injection is a gadolinium-based contrast agent indicated for use with magnetic resonance imaging (MRI):
- To detect and visualize areas with disrupted blood brain barrier (BBB) and/or abnormal vascularity of the central nervous system in adult and pediatric patients (including term neonates)
- To assess the presence and extent of malignant breast disease

Gadavist® is indicated for use in magnetic resonance angiography (MRA):
- To evaluate known or suspected supra-aortic or renal artery disease in adult and pediatric patients (including term neonates)

Please see Important Safety Information on following page.

Please note that the MR C-codes apply only to Medicare hospital outpatient claims; providers should use the standard CPT codes when submitting claims for the above services to non-Medicare payers.
Important Safety Information

**WARNING: NEPHROGENIC SYSTEMIC FIBROSIS (NSF)**

Gadolinium-based contrast agents (GBCAs) increase the risk for NSF among patients with impaired elimination of the drugs. Avoid use of GBCAs in these patients unless the diagnostic information is essential and not available with non-contrasted MRI or other modalities. NSF may result in fatal or debilitating fibrosis affecting the skin, muscle and internal organs.

- The risk of NSF appears highest among patients with:
  - Chronic, severe kidney disease (GFR <30 mL/min/1.73m²), or
  - Acute kidney injury
- Screen patients for acute kidney injury and other conditions that may reduce renal function. For patients at risk for chronically reduced renal function (for example, age >60 years, hypertension or diabetes), estimate the glomerular filtration rate (GFR) through laboratory testing.
- For patients at highest risk for NSF, do not exceed the recommended GADAVIST dose and allow a sufficient period of time for elimination of the drug from the body prior to any re-administration.

**Contraindication and Important Information about Hypersensitivity Reactions:** Gadavist® is contraindicated in patients with history of severe hypersensitivity reactions to Gadavist®. Anaphylactic and other hypersensitivity reactions with cardiovascular, respiratory, or cutaneous manifestations, ranging from mild to severe, including death, have uncommonly occurred following Gadavist® administration. Before Gadavist® administration, assess all patients for any history of a reaction to contrast media, bronchial asthma and/or allergic disorders. These patients may have an increased risk for a hypersensitivity reaction to Gadavist®.

**Acute Kidney Injury:** In patients with chronic renal impairment, acute kidney injury sometimes requiring dialysis has been observed with the use of some GBCAs. Do not exceed the recommended dose; the risk of acute kidney injury may increase with higher than recommended doses.

**Extravasation and Injection Site Reactions:** Ensure catheter and venous patency before the injection of Gadavist®. Extravasation into tissues during Gadavist® administration may result in moderate irritation.

**Overestimation of Extent of Malignant Disease in MRI of the Breast:** Gadavist® MRI of the breast overestimated the histologically confirmed extent of malignancy in the diseased breast in up to 50% of the patients.

**Low Sensitivity for Significant Arterial Stenosis:** The performance of Gadavist® MRA for detecting arterial segments with significant stenosis (>50% renal, >70% supra-aortic) has not been shown to exceed 55%. Therefore, a negative MRA study alone should not be used to rule out significant stenosis.

**Adverse Reactions:** The most frequent (≥0.5%) adverse reactions associated with Gadavist® in clinical studies were headache (1.5%), nausea (1.1%) and dizziness (0.5%).

Please click here to see the Gadavist® Full Prescribing Information (Vials & Syringes).

Please click here to see the Gadavist® Full Prescribing Information (Pharmacy Bulk Package).

Learn more about Gadavist at gadavist.com

Please note that the MR C-codes apply only to Medicare hospital outpatient claims; providers should use the standard CPT codes when submitting claims for the above services to non-Medicare payers.
Indications and Usage

Central Nervous System: Magnevist® (gadopentetate dimeglumine) injection is indicated for the use with magnetic resonance imaging (MRI) in adults and pediatric patients (2 years of age and older) to visualize lesions with abnormal vascularity in the brain (intracranial lesions), spine and associated tissues. Magnevist® has been shown to facilitate visualization of intracranial lesions including but not limited to tumors.

Extracranial/Extraspinal Tissues: Magnevist® is indicated for use with MRI in adults and pediatric patients (2 years of age and older) to visualize lesions with abnormal vascularity in the head and neck.

Body: Magnevist® is indicated for use with MRI in adults and pediatric patients (2 years of age and older) to visualize lesions with abnormal vascularity in the body.

Please see Important Safety Information on following pages.
**Important Safety Information**

**WARNING: NEPHROGENIC SYSTEMIC FIBROSIS (NSF)**

Gadolinium-based contrast agents (GBCAs) increase the risk for NSF among patients with impaired elimination of the drugs. Avoid use of GBCAs in these patients unless the diagnostic information is essential and not available with non-contrast MRI or other modalities. NSF may result in fatal or debilitating fibrosis affecting the skin, muscle and internal organs.

- Do not administer MAGNEVIST to patients with:
  - Chronic, severe kidney disease (GFR <30 mL/min/1.73m²), or
  - Acute kidney injury

- Screen patients for acute kidney injury and other conditions that may reduce renal function. For patients at risk for chronically reduced renal function (for example, age >60 years, hypertension or diabetes), estimate the glomerular filtration rate (GFR) through laboratory testing.

Do not exceed the recommended MAGNEVIST dose and allow a sufficient period of time for elimination of the drug from the body prior to re-administration.

**Contraindications:**

Magnevist® is contraindicated in patients with:

- Chronic, severe kidney disease (glomerular filtration rate, GFR <30 mL/min/1.73m²), or
- Acute kidney injury, or
- History of severe hypersensitivity reactions to Magnevist®.

**Hypersensitivity Reactions:** Anaphylactoid and anaphylactic reactions with cardiovascular, respiratory and/or cutaneous manifestations rarely resulting in death have occurred. The risk of hypersensitivity reactions is higher in patients with a history of reaction to contrast media, bronchial asthma, or allergic disorders. Hypersensitivity reactions can occur with or without prior exposure to GBCAs.

**Renal Failure:** In patients with renal impairment, acute renal failure (acute kidney injury) requiring dialysis or worsening renal function has occurred, mostly within 48 hours of Magnevist® injection. The risk of acute renal failure is higher with increasing dose of contrast. Use the lowest possible dose, evaluate renal function in patients with renal impairment, and allow sufficient time for contrast elimination before re-administration. Elimination half-life in patients with mild or moderate renal impairment is 3 to 4 hours. Elimination half-life in patients with severe renal impairment is about 11 hours. Magnevist® is cleared by glomerular filtration and is dialyzable. After 3 dialysis sessions of 3 hours each, about 97% of the administered dose is eliminated from the body; each dialysis session removes about 70% of the circulating drug.

**Please see additional Important Safety Information on following page.**
**Magnevist®**
(gadopentetate dimeglumine) injection
0.5 mmol/mL

**Magnevist Important Safety Information (continued)**

**Injection Site Reaction:** Skin and soft tissue necrosis, thrombosis, fascitis, and compartment syndrome requiring surgical intervention (e.g., compartment release or amputation) have occurred very rarely at the site of the contrast injection or the dosed limb. Total volume and rate of Magnevist® Injection, extravasation of contrast agent, and patient susceptibility might contribute to these reactions. Phlebitis and thrombophlebitis may be observed generally within 24 hours after Magnevist® Injection and resolve with supportive treatment. Determine the patency and integrity of the intravenous line before administration of Magnevist® Injection. Assessment of the dosed limb for the development of injection site reactions is recommended.

**Interference with Visualization of Lesions with Non-Contrast MRI:** As with any paramagnetic contrast agent, Magnevist® Injection might impair the visualization of lesions seen on non-contrast MRI. Therefore, caution should be exercised when Magnevist® MRI scans are interpreted without a companion non-contrast MRI scan.

**Adverse Reactions:** In clinical trials, the most frequently reported adverse reactions (≥1%) included headache (4.8%), nausea (2.7%), injection site coldness/localized coldness (2.3%) and dizziness (1%).

Please see additional Important Safety Information on previous page.

Please click here to see the Magnevist® Full Prescribing Information (Vials & Syringes).

Please click here to see the Magnevist® Full Prescribing Information (Pharmacy Bulk Package).

Learn more about Magnevist at magnevist.com
Eovist®
(gadoxetate disodium) injection
0.25 mmol/mL

CPT Codes

Eovist-specific MRI Codes

A9581  injection, gadoxetate disodium, per 1.0 mL

MRI, Abdomen (for Liver MRI)
74182  with contrast material(s)
74183  without contrast material(s), followed by
contrast material(s) and further sequences

Information provided in this resource is for informational purpose only and does not guarantee that codes will be appropriate or that coverage and reimbursement will result. Customers should consult with their payers for all relevant coverage, coding, and reimbursement requirements. It is the sole responsibility of the provider to select proper codes and ensure the accuracy of all claims used in seeking reimbursement. Neither this resource nor the Bayer Healthcare Reimbursement Helpline is intended as a legal advice or as a substitute for a provider’s independent professional judgment.

Indication and Usage
Eovist® (gadoxetate disodium) injection is indicated for intravenous use in magnetic resonance imaging (MRI) of the liver to detect and characterize lesions in patients with known or suspected focal liver disease.

Important Safety Information

**WARNING: NEPHROGENIC SYSTEMIC FIBROSIS (NSF)**

Gadolinium-based contrast agents (GBCAs) increase the risk for NSF among patients with impaired elimination of the drugs. Avoid use of GBCAs in these patients unless the diagnostic information is essential and not available with non-contrasted MRI or other modalities. NSF may result in fatal or debilitating fibrosis affecting the skin, muscle and internal organs.

- The risk for NSF appears highest among patients with:
  - Chronic, severe kidney disease (GFR <30 mL/min/1.73m²), or
  - Acute kidney injury

- Screen patients for acute kidney injury and other conditions that may reduce renal function. For patients at risk for chronically reduced renal function (for example, age >60 years, hypertension or diabetes), estimate the glomerular filtration rate (GFR) through laboratory testing.

- For patients at highest risk for NSF, do not exceed the recommended EOVIST dose and allow a sufficient period of time for elimination of the drug from the body prior to any re-administration.

**Contraindication and Important Information about Hypersensitivity Reactions:** Eovist® is contraindicated in patients with history of severe hypersensitivity reactions to Eovist®. Anaphylactic and other hypersensitivity reactions with cardiovascular, respiratory and cutaneous manifestations, ranging from mild to severe, including shock have uncommonly occurred following Eovist® administration. Before Eovist® administration, assess all patients for any history of a reaction to contrast media, bronchial asthma and allergic disorders. These patients may have an increased risk for a hypersensitivity reaction to Eovist®.

Please see additional Important Safety Information on following page.
Eovist®
(gadoxetate disodium) injection
0.25 mmol/mL

Eovist Important Safety Information (continued)

Acute Kidney Injury: In patients with chronic renal impairment, acute kidney injury sometimes requiring dialysis has been observed with the use of some GBCAs. The risk of acute kidney injury might be lower with Eovist® due to its dual excretory pathways. Do not exceed the recommended dose; the risk of acute kidney injury may increase with higher than recommended doses.

Extravasation and Injection Site Reactions: Ensure catheter and venous patency before the injection of Eovist®. Extravasation into tissues during Eovist® administration may result in local tissue reactions. Strictly avoid intramuscular administration of Eovist® because it may cause myocyte necrosis and inflammation.

Interference with Laboratory Tests: Serum iron determination using complexometric methods (for example, ferrocene complexation method) may result in falsely high or low values for up to 24 hours after the examination with Eovist® because of the caloxetate trisodium excipients.

Interference with Visualization of Liver Lesions: Severe renal or hepatic failure may impair Eovist® imaging performance. In patients with end-stage renal failure, hepatic contrast was markedly reduced and was attributed to elevated serum ferritin levels. In patients with abnormally high (>3 mg/dL) serum bilirubin, reduced hepatic contrast was observed. If Eovist® is used in these patients, complete MRI no later than 60 minutes after Eovist® administration and use a paired non-contrast and contrast MRI set for diagnosis.

Adverse Reactions: The most frequent (≥0.5%) adverse reactions associated with Eovist® are nausea (1.1%), headache (1.1%), feeling hot (0.8%), dizziness (0.6%), and back pain (0.6%).

Please see additional Important Safety Information on previous page.

Please click here to see the Eovist® Full Prescribing Information.

Learn more about Eovist at eovist.com
Ultravist®
(iopromide) injection
240 | 300 | 370 mg I/mL

## CPT Codes

### Ultravist-specific CT Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q9966</td>
<td>low osmolar contrast media 200-299 mg/mL iodine, per 1.0 mL</td>
</tr>
<tr>
<td>Q9967</td>
<td>low osmolar contrast media 300-399 mg/mL iodine, per 1.0 mL</td>
</tr>
</tbody>
</table>

### Indications and Usage

Ultravist® (iopromide) injection is an iodinated contrast agent indicated for:

**Intra-arterial Procedures**: 300 mg iodine per mL for cerebral arteriography and peripheral arteriography; 370 mg iodine per mL for coronary arteriography and left ventriculography, visceral angiography, and aortography.

**Intravenous Procedures**: 240 mg iodine per mL for peripheral venography; 300 mg iodine per mL for excretory urography; 300 mg iodine per mL and 370 mg iodine per mL for contrast Computed Tomography (CT) of the head and body (intrathoracic, intraabdominal and retroperitoneal regions) for the evaluation of neoplastic and non-neoplastic lesions. The usefulness of contrast enhancement for the investigation of the retrobulbar space and of low grade or infiltrative glioma has not been demonstrated.

* For information on the concentrations and doses for the Pediatric Population [see Dosage and Administration (2.3) and Use in Specific Populations (8.4) in the Full Prescribing Information].

Please see Important Safety Information on following pages.
Ultravist®
(iopromide) injection
240 | 300 | 370 mg I/mL

Ultravist Important Safety Information

**WARNING: NOT FOR INTRATHECAL USE**

Inadvertent intrathecal administration may cause death, convulsions, cerebral hemorrhage, coma, paralysis, arachnoiditis, acute renal failure, cardiac arrest, seizures, rhabdomyolysis, hyperthermia, and brain edema.

**Contraindications:** Ultravist® injection is contraindicated for intrathecal use.

Preparatory dehydration (e.g. prolonged fasting and the administration of a laxative before Ultravist® injection) is contraindicated in pediatric patients because of risk of renal failure.

**Anaphylactoid Reactions:** Life-threatening or fatal anaphylactoid reactions may occur during or after Ultravist® administration, particularly in patients with allergic disorders. Increased risk is associated with a history of previous reaction to a contrast agent, a known sensitivity to iodine and known allergic disorders or other hypersensitivities. Exercise extreme caution when considering the use of iodinated contrast agents in patients with these histories or disorders. Emergency facilities and personnel trained in the treatment of anaphylactoid reactions should be available for at least 30 to 60 minutes after Ultravist® administration.

**Contrast Induced Acute Kidney Injury:** Acute kidney injury, including renal failure, may occur after intravascular administration of Ultravist®. Risk factors include: pre-existing renal insufficiency, dehydration, diabetes mellitus, congestive heart failure, advanced vascular disease, elderly age, concomitant use of nephrotoxic or diuretic medications, multiple myeloma/paraproteinemia, repetitive and/or large doses of Ultravist®. Use the lowest necessary dose of Ultravist® in patients with renal impairment. Adequately hydrate patients prior to and following Ultravist® administration.

**Cardiovascular Reactions:** Hemodynamic disturbances including shock and cardiac arrest may occur during or shortly after administration of Ultravist®. Observe patients with preexisting cardiovascular disease for several hours following Ultravist® administration.

**Thromboembolic Complications:** Angiography may be associated with local and distal organ damage, ischemia, thromboembolism and organ failure. In angiographic procedures, consider the possibility of dislodging plaques or damaging or perforating the vessel wall. The physicochemical properties of the contrast agent, the dose and the speed of injection can influence the reactions. Monitor electrocardiograms and vital signs throughout the procedure. Exercise care when performing venography in patients with suspected thrombosis, phlebitis, severe ischemic disease, local infection, venous thrombosis or a totally obstructed venous system. Clotting may occur when blood remains in contact with syringes containing iodinated contrast agents. Avoid angiography whenever possible in patients with homocystinuria because of the risk of inducing thrombosis and embolism.

**Reactions in Patients with Hyperthyroidism, Pheochromocytoma, or Sickle Cell Disease:** Thyroid storm has occurred after the intravascular use of iodinated contrast agents in patients with hyperthyroidism, or with autonomously functioning thyroid nodule. Evaluate the risk in such patients before use of any iodinated contrast agent. Administer iodinated contrast agents with extreme caution in patients with known or suspected pheochromocytoma. Inject the minimal amount of contrast necessary. Contrast agents may promote sickling in individuals who are homozygous for sickle cell disease when administered intravascularly.

**Extravasation:** Extravasation of Ultravist® may cause tissue necrosis and/or compartment syndrome, particularly in patients with severe arterial or venous disease.

Please see additional Important Safety Information on following page.
Increased Radiation Exposure: The decision to use contrast enhancement is associated with risk and increased radiation exposure.

Interference with Image Interpretation: The use of Ultravist® Injection may obscure some lesions which were seen on non-contrast CT scans. Calcified lesions are less likely to enhance. The enhancement of tumors after therapy may decrease. The opacification of the inferior vermis following contrast agent administration has resulted in false-positive diagnosis. Cerebral infarctions of recent onset may be better visualized with contrast enhancement. However, older infarctions may be obscured by the contrast agent. In patients with normal blood-brain barriers and renal failure, iodinated contrast agents have been associated with blood-brain barrier disruption and accumulation of contrast in the brain. Accumulation of contrast in the brain also occurs in patients where the blood-brain barrier is known or suspected to be disrupted.

Severe Cutaneous Adverse Reactions: Severe cutaneous adverse reactions (SCAR) may develop from 1 hour to several weeks after intravascular contrast agent administration. These reactions include Stevens-Johnson syndrome and toxic epidermal necrolysis (SJS/TEN), acute generalized exanthematous pustulosis (AGEP) and drug reaction with eosinophilia and systemic symptoms (DRESS). Reaction severity may increase and time to onset may decrease with repeat administration of contrast agent; prophylactic medications may not prevent or mitigate severe cutaneous adverse reactions. Avoid administering Ultravist® to patients with a history of a severe cutaneous adverse reaction to Ultravist®.

Most Common Adverse Reactions: Most common adverse reactions (>1%) are headache, nausea, injection site and infusion site reactions, vasodilatation, vomiting, back pain, urinary urgency, chest pain, pain, dysgeusia, and abnormal vision.

Please see additional Important Safety Information on previous page.

Please click here to see the Ultravist® Full Prescribing Information (Vials and Syringes).

Please click here to see the Ultravist® Full Prescribing Information (Pharmacy Bulk Package).

Learn more about Ultravist at ultravist.com
Bayer HealthCare Inc. also provides additional information on non-reimbursement topics.

For information regarding Bayer's portfolio of diagnostic imaging agents, please call your Bayer HealthCare Sales Consultant at 1-888-842-2937, option 5.

For customer service or purchasing information regarding any Bayer diagnostic imaging agent, please call 1-877-229-3750.

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