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Noninvasive Radiologic Techniques for the Evaluation and Monitoring of Patients with Chronic Liver Disease Corporate Medical Policy

File Name: Noninvasive Techniques for the Evaluation and Monitoring of Patients with Chronic Liver Disease
File Code: 2.04.VT41
Origination: 03/2018
Last Review: 01/2024
Next Review: 01/2025
Effective Date: 02/01/2024

Description/Summary

Noninvasive radiologic techniques to monitor liver fibrosis are being investigated as alternatives to liver biopsy in patients with chronic liver disease. These include ultrasound radiologic methods, transient elastography, acoustic radiation force impulse imaging, and real-time transient elastography. Magnetic Resonance Elastography is addressed in an AIM policy: Appropriate Use Criteria: Imaging of the Abdomen and Pelvis.

Policy

Coding Information

Click the links below for attachments, coding tables & instructions.

[Attachment I - CPT® Coding Table](#)

[Attachment II - ICD-10-CM Coding Table](#)

When a service may be considered medically necessary

Transient elastography (FibroScan) imaging may be considered **medically necessary** for the initial evaluation or monitoring of patients with chronic liver disease.

The use of transient elastography for the evaluation of a diagnosis of abnormal liver function tests is considered **medically necessary** when performed by a board-certified gastroenterologist or a board-certified pediatric gastroenterologist.

Magnetic resonance elastography use and medical necessity criteria are addressed in Carelon Medical Benefits Management clinical appropriateness guidelines and cancer treatment pathways - Imaging of the Abdomen and Pelvis.

Multiparametric MRI (LiverMultiScan) use and medical necessity criteria are addressed in Carelon Medical Benefits Management clinical appropriateness guidelines and cancer treatment pathways - Imaging of the Abdomen and Pelvis.

When a service is considered investigational

The use of other noninvasive imaging, including but not limited to, acoustic radiation force impulse imaging (eg, Acuson S2000) and real-time tissue elastography, is considered investigational for the evaluation or monitoring of patients with chronic liver disease. NOTE: Magnetic resonance elastography and Multiparametric MRI (LiverMultiScan) use is addressed in AIM policy: Appropriate Use Criteria: Imaging of the Abdomen and Pelvis.

Reference Resources

1. Blue Cross and Blue Shield Association. Noninvasive Techniques for the Evaluation and Monitoring of Patients With Chronic Liver Disease, MPRM #2.04.41. Last reviewed: December, 2023. Accessed January 2024.
2. Carelon Medical Benefits Management clinical appropriateness guidelines and cancer treatment pathways. Imaging of the Abdomen and Pelvis 2023-04-09. Accessed January 2024.

Document Precedence

Blue Cross and Blue Shield of Vermont (BCBSVT) Medical Policies are developed to provide clinical guidance and are based on research of current medical literature and review of common medical practices in the treatment and diagnosis of disease. The applicable group/individual contract and member certificate language, or employer's benefit plan if an ASO group, determines benefits that are in effect at the time of service. Since medical practices and knowledge are constantly evolving, BCBSVT reserves the right to review and revise its medical policies periodically. To the extent that there may be any conflict between medical policy and contract/employer benefit plan language, the member's contract/employer benefit plan language takes precedence.

Audit Information

BCBSVT reserves the right to conduct audits on any provider and/or facility to ensure compliance with the guidelines stated in the medical policy. If an audit identifies instances of non-compliance with this medical policy, BCBSVT reserves the right to recoup all non-compliant payments.

Administrative and Contractual Guidance

Benefit Determination Guidance

Prior approval may be required and benefits are subject to all terms, limitations and conditions of the subscriber contract.

Incomplete authorization requests may result in a delay of decision pending submission of missing information. To be considered complete, see policy guidelines above.

NEHP/ABNE members may have different benefits for services listed in this policy. To confirm benefits, please contact the customer service department at the member's health plan.

Federal Employee Program (FEP): Members may have different benefits that apply. For further information please contact FEP customer service or refer to the FEP Service Benefit Plan Brochure. It is important to verify the member's benefits prior to providing the service to determine if benefits are available or if there is a specific exclusion in the member's benefit.

Coverage varies according to the member's group or individual contract. Not all groups are required to follow the Vermont legislative mandates. Member Contract language takes precedence over medical policy when there is a conflict.

If the member receives benefits through an Administrative Services Only (ASO) group, benefits may vary or not apply. To verify benefit information, please refer to the member's employer benefit plan documents or contact the customer service department. Language in the employer benefit plan documents takes precedence over medical policy when there is a conflict.

Policy Implementation/Update information

03/2018	New Medical Policy. Input received from external providers. Policy statements to focus solely on radiologic techniques.
01/2019	2019 January Adaptive maintenance update effective 01/01/2019: Added Codes 76391, 76981, 76982 & 76983 effective 01/01/2019 the CAT III Code 0346T [Ultrasound, elastography (List separately in addition to code for primary procedure)] was deleted effective 01/01/2019.
10/2019	External feedback received. Clarifying language around transient elastography added. Added ICD-10-CM R94.5 code to coding table as medically necessary.
07/2020	Reviewed BCBSA MPRM 2.04.41, updated references, policy statement remains unchanged. Revised codes K83.01, K83.09.
10/2020	Adaptive Maintenance: Added codes K74.00, K74.01, K74.02 new codes effective 10/01/2020.
07/2021	Policy statement unchanged; Clarified that MR Elastography is addressed in separate AIM advanced Imaging Policy. Code 76391 will require prior approval.
02/2022	Updated investigational service to include multiparametric magnetic resonance imaging, updated references. Added codes to coding table 0648T, 0649T, 0697T, 0698T as investigational effective 01/01/2022.

03/2022	Reviewed Policy and added language for Multiparametric MRI (LiverMultiScan). Added code 76391 to coding table as requiring prior approval to align with current prior approval list. Removed codes 0648T & 0649T from investigational to requiring prior approval.
01/2023	Policy reviewed no changes to policy statement. References updated. Added code 0014M to coding table as investigational. The code was mirrored from corporate investigational medical policy.
12/2023	Adaptive Maintenance Effective 01/01/2024: Deleted code 0014M, added code 81517 as medically necessary.
01/2024	Policy reviewed. No change to policy statement References updated.

Eligible providers

Qualified healthcare professionals practicing within the scope of their license(s).

Approved by BCBSVT Medical Directors

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Vice President and Chief Medical Officer

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Senior Medical Director

Attachment I CPT® Coding Table

The following codes are considered medically necessary when applicable criteria have been met.			
Code Type	Number	Brief Description	Policy Instructions
CPT®	91200	Liver elastography, mechanically induced shear wave (eg, vibration), without imaging, with interpretation and report	Refer to (Attachment II) - ICD-10-CM coding table
CPT®	76391	Magnetic resonance (eg, vibration) elastography	Requires Prior Approval
CPT®	76981	Ultrasound, elastography; parenchyma (eg, organ)	Refer to (Attachment II) - ICD-10-CM coding table
CPT®	76982	Ultrasound, elastography; first target lesion	Refer to (Attachment II) - ICD-10-CM coding table

CPT®	+76983	Ultrasound, elastography; each additional target lesion (List separately in addition to code for primary procedure)	Refer to (Attachment II) - ICD-10-CM coding table
CPT®	81517	Liver disease, analysis of 3 biomarkers, reported as a risk score and risk of liver fibrosis and liver related clinical events within 5 years	Medically Necessary
CPT®	0648T	Quantitative magnetic resonance for analysis of tissue composition (eg, fat, iron, water content), including multiparametric data acquisition, data preparation and transmission, interpretation and report, obtained without diagnostic MRI examination of the same anatomy (eg, organ, gland, tissue, target structure) during the same session; single organ	Requires Prior Approval
CPT®	0649T	Quantitative magnetic resonance for analysis of tissue composition (eg, fat, iron, water content), including multiparametric data acquisition, data preparation and transmission, interpretation and report, obtained with diagnostic MRI examination of the same anatomy (eg, organ, gland, tissue, target structure); single organ (List separately in addition to code for primary procedure)	Requires Prior Approval
The following codes will be denied as Not Medically Necessary, Non-Covered, Contract Exclusions or Investigational.			
Code Type	Number	Brief Description	Policy Instructions

CPT®	0697T	Quantitative magnetic resonance for analysis of tissue composition (eg, fat, iron, water content), including multiparametric data acquisition, data preparation and transmission, interpretation and report, obtained without diagnostic MRI examination of the same anatomy (eg, organ, gland, tissue, target structure) during the same session; multiple organs	Investigational
CPT®	0698T	Quantitative magnetic resonance for analysis of tissue composition (eg, fat, iron, water content), including multiparametric data acquisition, data preparation and transmission, interpretation and report, obtained with diagnostic MRI examination of the same anatomy (eg, organ, gland, tissue, target structure); multiple organs (List separately in addition to code for primary procedure)	Investigational

Attachment II
ICD-10-CM Table

The following diagnoses codes are considered eligible when applicable criteria outlined in policy have been met.	
Code	Description
B16.0	Acute hepatitis B with delta-agent with hepatic coma
B16.1	Acute hepatitis B with delta-agent without hepatic coma
B16.2	Acute hepatitis B without delta-agent with hepatic coma
B16.9	Acute hepatitis B without delta-agent and without hepatic coma
B17.0	Acute delta-(super) infection of hepatitis B carrier
B17.10	Acute hepatitis C without hepatic coma
B17.11	Acute hepatitis C with hepatic coma
B17.2	Acute hepatitis E

B17.8	Other specified acute viral hepatitis
B17.9	Acute viral hepatitis, unspecified
B18.0	Chronic viral hepatitis B with delta-agent
B18.1	Chronic viral hepatitis B without delta-agent
B18.2	Chronic viral hepatitis C
B18.8	Other chronic viral hepatitis
B18.9	Chronic viral hepatitis, unspecified
B19.0	Unspecified viral hepatitis with hepatic coma
B19.10	Unspecified viral hepatitis B without hepatic coma
B19.11	Unspecified viral hepatitis B with hepatic coma
B19.20	Unspecified viral hepatitis C without hepatic coma
B19.21	Unspecified viral hepatitis C with hepatic coma
B19.9	Unspecified viral hepatitis without hepatic coma
K70.0	Alcoholic fatty liver
K70.10	Alcoholic hepatitis without ascites
K70.11	Alcoholic hepatitis with ascites
K70.2	Alcoholic fibrosis and sclerosis of liver
K70.30	Alcoholic cirrhosis of liver without ascites
K70.31	Alcoholic cirrhosis of liver with ascites
K70.40	Alcoholic hepatic failure without coma
K70.41	Alcoholic hepatic failure with coma
K70.9	Alcoholic liver disease, unspecified
K71.0	Toxic liver disease with cholestasis
K71.10	Toxic liver disease with hepatic necrosis, without coma
K71.11	Toxic liver disease with chronic lobular hepatitis
K71.2	Toxic liver disease with acute hepatitis
K71.3	Toxic liver disease with chronic persistent hepatitis
K71.4	Toxic liver disease with chronic lobular hepatitis
K71.50	Toxic liver disease with fibrosis and cirrhosis of liver
K71.51	Toxic liver disease with chronic active hepatitis without ascites
K71.6	Toxic liver disease with hepatitis, not elsewhere classified
K71.7	Toxic liver disease with fibrosis and cirrhosis of liver
K71.8	Acute and subacute hepatic failure without coma
K71.9	Toxic liver disease, unspecified
K72.00	Acute and subacute hepatic failure without coma

K72.01	Acute and subacute hepatic failure with coma
K72.10	Chronic hepatic failure without coma
K72.11	Chronic hepatic failure with coma
K72.90	Hepatic failure, unspecified without coma
K72.91	Hepatic failure, unspecified with coma
K73.0	Chronic persistent hepatitis, not elsewhere classified
K73.1	Chronic lobular hepatitis, not elsewhere classified
K73.2	Chronic active hepatitis, not elsewhere classified
K73.8	Other chronic hepatitis, not elsewhere classified
K73.9	Chronic hepatitis, unspecified
K74.0	Hepatic fibrosis
K74.00	Hepatic fibrosis, unspecified
K74.01	Hepatic fibrosis, early fibrosis
K74.02	Hepatic fibrosis, advanced fibrosis
K74.1	Hepatic sclerosis
K74.2	Hepatic fibrosis with hepatic sclerosis
K74.3	Primary biliary cirrhosis
K74.4	Secondary biliary cirrhosis
K74.5	Biliary cirrhosis, unspecified
K74.60	Unspecified cirrhosis of liver
K74.69	Other cirrhosis of liver
K75.0	Abscess of liver
K75.1	Phlebitis of portal vein
K75.2	Nonspecific reactive hepatitis
K75.3	Granulomatous hepatitis, not elsewhere classified
K75.4	Autoimmune hepatitis
K75.81	Nonalcoholic steatohepatitis (NASH)
K75.89	Other specified inflammatory liver diseases
K75.9	Inflammatory liver disease, unspecified
K76.0	Fatty (change of) liver, not elsewhere classified
K76.1	Chronic passive congestion of liver
K76.2	Central hemorrhagic necrosis of liver
K76.3	Infarction of liver
K76.4	Peliosis hepatis
K76.5	Hepatic veno-occlusive disease
K76.6	Portal hypertension

K76.7	Hepatorenal syndrome
K76.81	Hepatopulmonary syndrome
K76.89	Other specified diseases of liver
K76.9	Liver disease, unspecified
K77	Liver disorders in diseases classified elsewhere
K83.01	Primary sclerosing cholangitis
K83.09	Other cholangitis
R94.5	Abnormal results of liver function studies