

# Magnetic Resonance Spectroscopy (MRS)

**Guideline Number:** MMG077.Q

**Effective Date:** March 1, 2024

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## Related Policies

None

## Coverage Rationale

**Magnetic resonance spectroscopy (MRS) is proven and medically necessary in certain circumstances.** For medical necessity clinical coverage criteria, refer to the InterQual® CP: Imaging, Imaging, Brain.

Click [here](#) to view the InterQual® criteria.

## Applicable Codes

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this guideline does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

CPT Code	Description
76390	Magnetic resonance spectroscopy

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## Description of Services

Magnetic resonance spectroscopy (MRS), also known as nuclear or proton magnetic resonance spectroscopy, is a refinement of MRI. Specialized hardware and software attached to standard MRI equipment produce a spectroscopic graph of biochemical metabolites at various points in tissue, rather than an anatomic or structural image. Limitations of MR spectroscopy technology include signal quality related to the size of tissue area under study, and signal sensitivity to tissue movement, blood flow, and fat or gas adjacent to the tissue study area. Combining MR spectroscopy data with MRI data, especially in areas that may be difficult to biopsy, has the potential to yield significant clinical information about the biochemical and pathophysiologic composition of specific lesions.

# Guideline History/Revision Information

Date	Summary of Changes
03/01/2024	<ul style="list-style-type: none"><li>• Routine review; no content changes</li><li>• Archived previous policy version MMG077.P</li></ul>

## Instructions for Use

This Medical Management Guideline provides assistance in interpreting UnitedHealthcare standard benefit plans. When deciding coverage, the member specific benefit plan document must be referenced as the terms of the member specific benefit plan may differ from the standard plan. In the event of a conflict, the member specific benefit plan document governs. Before using this guideline, please check the member specific benefit plan document and any applicable federal or state mandates. UnitedHealthcare reserves the right to modify its Policies and Guidelines as necessary. This Medical Management Guideline is provided for informational purposes. It does not constitute medical advice.

UnitedHealthcare may also use tools developed by third parties, such as the InterQual® criteria, to assist us in administering health benefits. UnitedHealthcare West Medical Management Guidelines are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.

Member benefit coverage and limitations may vary based on the member’s benefit plan Health Plan coverage provided by or through UnitedHealthcare of California, UnitedHealthcare Benefits Plan of California, UnitedHealthcare of Oklahoma, Inc., UnitedHealthcare of Oregon, Inc., UnitedHealthcare Benefits of Texas, Inc., or UnitedHealthcare of Washington, Inc.