



Kaiser Foundation Health Plan of Washington

Clinical Review Criteria

Magnetic Resonance Guided Focused Ultrasound (MRgFUS) of the Brain

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Criteria

For Medicare Members

Source	Policy
CMS Coverage Manuals	None
National Coverage Determinations (NCD) Local Coverage Determinations (LCD)	None Magnetic-Resonance-Guided Focused Ultrasound Surgery (MRgFUS) for Essential Tremor and Tremor Dominant Parkinson's Disease (L37729)
Local Coverage Article (LCA)	Billing and Coding: Magnetic-Resonance-Guided Focused Ultrasound Surgery (MRgFUS) for Essential Tremor and Tremor Dominant Parkinson's Disease (A57512)

For Non-Medicare Members

Kaiser Permanente has elected to use the **MRI-Guided Focused Ultrasound Surgery, Brain (KP-0991 04012026)** MCG* Care Guideline for medical necessity determinations. For access to the MCG Clinical Guidelines criteria, please see the MCG Guideline Index through the provider portal under *Quick Access*.

***MCG manuals are proprietary and cannot be published and/or distributed.** However, on an individual member basis, Kaiser Permanente can share a copy of the specific criteria document used to make a utilization management decision. If one of your patients is being reviewed using these criteria, you may request a copy of the criteria by calling the Kaiser Permanente Clinical Review staff at 1-800-289-1363 or access the MCG Guideline Index using the link provided above.

If requesting this service (or these services), please send the following documentation to support medical necessity:

- Last 6 months of clinical notes from requesting provider &/or specialist

The following information was used in the development of this document and is provided as background only. It is provided for historical purposes and does not necessarily reflect the most current published literature. When significant new articles are published that impact treatment option, Kaiser Permanente will review as needed. This information is not to be used as coverage criteria. Please only refer to the criteria listed above for coverage determinations.

Background

MRI-guided focused ultrasound surgery is a noninvasive procedure to create brain lesions to treat neurologic conditions. The procedure combines MRI thermography and high-intensity focused ultrasound. Treatment involves focus alignment, target verification, and therapeutic ablation; thermal damage is prevented by circulating chilled water around the head during treatment. During the procedure, the patient is monitored for transient symptoms, and the target location is adjusted to patient response in order to avoid permanent deficits.

Applicable Codes

Considered Medically Necessary when criteria in the applicable policy statements listed above are met:

CPT® or HCPCS Codes	Description
61715	Magnetic resonance image guided high intensity focused ultrasound (MRgFUS), stereotactic ablation of target, intracranial, including stereotactic navigation and frame placement.

***Note:** Codes may not be all-inclusive. Deleted codes and codes not in effect at the time of service may not be covered.

**To verify authorization requirements for a specific code by plan type, please use the [Pre-authorization Code Check](#).

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Date Created	Date Reviewed	Date Last Revised
11/04/2025	11/04/2025 ^{MPC} ,	11/04/2025

^{MPC} Medical Policy Committee

Revision History	Description
11/04/2025	MPC approved to adopt hybrid MCG criteria for MRI-Guided Focused Ultrasound Surgery, Brain. Requires 60-day notice, effective date 04/01/2026.