C8911

MAGNETIC RESONANCE ANGIOGRAPHY WITHOUT CONTRAST FOLLOWED BY WITH CONTRAST, CHEST (EXCLUDING MYOCARDIUM)

Healthcare Common Procedure Coding System

The Healthcare Common Procedure Coding System (HCPCS) is a collection of codes that represent procedures, supplies,products and services which may be provided to Medicare beneficiaries and to individuals enrolled in private health insurance programs. HCPCS codes primarily correspond to services, procedures, and equipment not covered by CPT® codes.

C8911 Magnetic resonance angiography without contrast followed by with contrast, chest (excluding myocardium)

HCPCS Code	C8911	The Healthcare Common Prodecure Coding System (HCPCS) is a collection of codes that represent procedures, supplies, products and services which may be provided to Medicare beneficiaries and to individuals enrolled in private health insurance programs.The codes are divided into two levels, or groups, as described Below: Level I Codes and descriptors copyrighted by the American Medical Association's current procedural terminology, fourth edition (CPT-4). These are 5 position numeric codes representing physician and nonphysician services. **** NOTE: **** CPT-4 codes including both long and short descriptions shall be used in accordance with the CMS/AMA agreement. Any other use violates the AMA copyright. Level II Includes codes and descriptors copyrighted by the American Dental Association's current dental terminology, seventh edition (CDT-2011/12). These are 5 position alpha-numeric codes comprising the d series. All other level II codes and descriptors are approved and maintained jointly by the alpha-numeric editorial panel (consisting of CMS, the Health Insurance Association of America, and the Blue Cross and Blue Shield Association). These are 5 position alpha- numeric codes representing primarily items and nonphysician services that are not represented in the level I codes.
Code Description	Magnetic resonance angiography without contrast followed by with contrast, chest (excluding myocardium)	Contains all text of procedure or modifier long descriptions. As of 2013, this field contains the consumer friendly descriptions for the AMA CPT codes. The AMA owns the copyright on the CPT codes and descriptions; CPT codes and descriptions are not public property and must always be used in compliance with copyright law.
Short Description	Mra w/o fol w/cont, chest	Short descriptive text of procedure or modifier code (28 characters or less). The AMA owns the copyright on the CPT codes and descriptions; CPT codes and descriptions are not public property and must always be used in compliance with copyright law.
Pricing Indicator Code #1	53	Code used to identify the appropriate methodology for developing unique pricing amounts under part B. A procedure may have one to four pricing codes.

Pricing Indicator Code #1 Description	Statute	Description of Pricing Indicator Code #1
Multiple Pricing Indicator Code	A	Code used to identify instances where a procedure could be priced under multiple methodologies.
Multiple Pricing Indicator Code Description	Not applicable as HCPCS priced under one methodology	HCPCS Multiple Pricing Indicator Code Description
Statute Number	1833(t)(2)	Number identifying statute reference for coverage or noncoverage of procedure or service.
Coverage Code	D	A code denoting Medicare coverage status.
Coverage Code Description	Special coverage instructions apply	HCPCS Coverage Code Description
ASC Payment Group Code	YY	The 'YY' indicator represents that this procedure is approved to be performed in an ambulatory surgical center. You must access the ASC tables on the mainframe or CMS website to get the dollar amounts.
ASC Payment Group Effective Date	20080101	The date the procedure is assigned to the ASC payment group.
Berenson-Eggers Type Of Service Code	I2D	This field is valid beginning with 2003 data. The Berenson-Eggers Type of Service (BETOS) for the procedure code based on generally agreed upon clinically meaningful groupings of procedures and services.
Berenson-Eggers Type Of Service Code Description	Advanced imaging - MRI/MRA: other	HCPCS Berenson-Eggers Type Of Service Code Description
Type Of Service Code #1	4	The carrier assigned CMS type of service which describes the particular kind(s) of service represented by the procedure code.
Type Of Service Code #1 Description	Diagnostic radiology	Description of HCPCS Type Of Service Code #1
Anesthesia Base Unit Quantity	0	The base unit represents the level of intensity for anesthesia procedure services that reflects all activities except time. These activities include usual preoperative and post-operative visits, the administration of fluids and/or blood incident to anesthesia care, and monitering procedures. **** NOTE: **** The payment amount for anesthesia services is based on a calculation using base unit, time units, and the conversion factor.
Code Added Date	20011001	The year the HCPCS code was added to the Healthcare common procedure coding system.
Action Effective Date	20011001	Effective date of action to a procedure or modifier code

Action Code	N	A code denoting the change made to a procedure or modifier code within the HCPCS system.
Action Code Description	No maintenance for this code	HCPCS Action Code Description
Status	Actual	
Last Update Date	2026	

Contact Information for HCPCS
HCPCS Email Address: hcpcs@cms.hhs.gov
The PDAC has a toll free helpline
(877) 735-1326
HCPCS-related questions must be submitted online
via the www.codingclinicadvisor.com website

For all questions regarding this bundle please contact Support@DataLabs.Health. Also feel free to let us know about any suggestions or concerns. All additional information as well as customer support is available at https://www.datalabs.health/.