Cohere Medical Policy - Magnetic Resonance Imaging (MRI), Neck/Orbit/Face

Clinical Policy for Medical Necessity Review

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Important Notices

Notices & Disclaimers:

GUIDELINES ARE SOLELY FOR COHERE'S USE IN PERFORMING MEDICAL NECESSITY REVIEWS AND ARE NOT INTENDED TO INFORM OR ALTER CLINICAL DECISION-MAKING OF END USERS.

Cohere Health, Inc. ("**Cohere**") has published these clinical guidelines to determine the medical necessity of services (the "**Guidelines**") for informational purposes only, and solely for use by Cohere's authorized "**End Users**". These Guidelines (and any attachments or linked third-party content) are not intended to be a substitute for medical advice, diagnosis, or treatment directed by an appropriately licensed healthcare professional. These Guidelines are not in any way intended to support clinical decision-making of any kind; their sole purpose and intended use is to summarize certain criteria Cohere may use when reviewing the medical necessity of any service requests submitted to Cohere by End Users. Always seek the advice of a qualified healthcare professional regarding any medical questions, treatment decisions, or other clinical guidance. The Guidelines, including any attachments or linked content, are subject to change at any time without notice.

Other Notices:

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Policy Information:

Specialty Area: Diagnostic Imaging
Policy Name: Cohere Medical Policy - Magnetic Resonance Imaging (MRI), Neck/Orbit/Face
Type: [**X**] Adult (18+ yo) | [**X**] Pediatric (0-17 yo)

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Medical Necessity Criteria

Service: Magnetic Resonance Imaging (MRI), Neck/Orbit/Face

Cohere Health takes an evidence-based approach to reviewing imaging and procedure requests, meaning that sufficient clinical information must be provided at the time of submission to determine medical necessity. Documentation must include a recent and detailed history, physical examination related to the onset or change in symptoms, relevant lab results, prior imaging, and details of previous treatments. Advanced imaging or procedures should be requested after a clinical evaluation by the treating provider, which may include a referral to a specialist.

- When a specific clinical indication is not explicitly addressed in the Cohere Health medical policy, medical necessity will be determined based on established clinical best practices, as supported by evidence-based literature, peer-reviewed sources, professional society guidelines, and state or national recommendations, unless otherwise directed by the health plan.
- Requests submitted without clinical documentation, or those that do not align with the provided clinical information—such as mismatched laterality, body part, or CPT code—may be denied for lack of medical necessity due to insufficient or inconsistent clinical information.
- Repeat diagnostic testing due to technical issues—such as patient motion, incomplete exams, or incorrect imaging sequences—may not be considered medically necessary, as it is the responsibility of the imaging center to deliver appropriate, high-quality studies as originally authorized. Similarly, repeat imaging requested at a different facility based solely on provider preference may not be approved for medical necessity.
- When there are multiple diagnostic or therapeutic procedures requested simultaneously or within the past three months, each will be reviewed independently. Clinical documentation must clearly justify all of the following:
    - The medical necessity of each individual request

    - Why prior imaging or procedures were inconclusive or why additional/follow-up studies are needed
    - How the results will impact patient management or treatment decisions
- Requests involving adjacent or contiguous body parts may be considered not medically necessary if the documentation demonstrates that the patient's primary symptoms can be adequately assessed with a single study or procedure.
- Cohere Health evaluates imaging exams based on medical necessity, regardless of contrast use. If an initial non-contrast study is completed and the radiologist later determines that contrast is needed to clarify a finding, the original authorization number may be used—provided the contrast-enhanced exam is performed at the same imaging center and within the original request's validity period, unless otherwise directed by the health plan.

Description

Magnetic resonance imaging (MRI) is a noninvasive diagnostic tool that provides detailed images of the soft tissues and hard structures of the extracranial head. It allows for the evaluation of the morphology and pathology of extracranial structures, including the neck, orbit, and jaw. MRI can be performed with or without contrast and does not require the use of radiation.[1]

Medical Necessity Criteria

Indications

Magnetic resonance imaging (MRI), neck/orbit/face is considered appropriate if **ANY** of the following is **TRUE**:

- **ANY** of the following orbital indications:
  - Trauma-related conditions, including traumatic visual defect with suspected orbital injury[2]; **OR**
  - Trauma that is not related to the cervical spine; **OR**
  - **ANY** of the following conditions, known or suspected:
    - Congenital conditions (e.g., capillary hemangioma, optic nerve hypoplasia); **OR**
    - Neoplastic conditions, benign or malignant, detection, and follow-up (e.g., dermoid, lymphoma, metastases)[2,3]; **OR**
    - Orbital pseudotumor or orbital inflammatory disease; **OR**
    - Osseous lesions (e.g., fibrodysplasia, Paget's), when computed tomography (CT) is completed or contraindicated and further evaluation is needed; **OR**
    - Foreign body, suspected clinically or seen on prior imaging when CT is completed or contraindicated and further evaluation is needed; **OR**
    - Orbital infectious process, suspected or known, and **ANY** of the following:
      - Medical management has failed (e.g., orbital cellulitis not responding appropriately to antibiotics); **OR**
      - The patient is pediatric; **OR**
      - The patient is immunocompromised; **OR**
    - Optic nerve inflammation is suspected, including optic neuritis; **OR**
    - Scleritis confirmed clinically with failure of medical management or with complication suspected[4]; **OR**
    - Uveitis, confirmed clinically with complication suspected; **OR**
    - Thyroid eye disease when **ANY** of the following are **TRUE**:[5]
      - Needed to exclude other etiologies of symptoms; **OR**
      - In severe or atypical cases to identify apical crowding (narrowing of the space at the orbital apex), a risk factor for dysthyroid optic neuropathy (DON); **OR**
      - To prepare for orbital or strabismus surgery; **OR**
    - Venous conditions such as orbital varices; **OR**

- Additional evaluation is needed when etiology remains unclear following a complete eye examination that includes funduscopy, including **ANY** of the following:
  - Diplopia; **OR**
  - Enophthalmos; **OR**
  - Exophthalmos; **OR**
  - Eye pain, with history or other signs or symptoms indicating nonischemic pathology; **OR**
  - Orbital asymmetry; **OR**
  - Preseptal or postseptal orbital mass, otherwise unexplained; **OR**
  - Ophthalmoplegia; **OR**
  - Eye movement abnormality in a child (e.g., strabismus or nystagmus in a child 6 months or older); **OR**
  - Proptosis; **OR**
  - Unilateral papilledema; **OR**
  - Orbital hemorrhage, when the underlying lesion is suspected, and CT has been completed; **OR**
  - Vision loss or visual field deficit with history or other signs/symptoms indicating nonischemic intraorbital pathology; **OR**
- Preoperative, postoperative, or pretreatment evaluation for surgery, radiation, or chemotherapy; **OR**

- Temporal bone and inner ear indications, including **ANY** of the following:
  - MRI-preferred indications, including **ANY** of the following:
    - Cholesteatoma, initial, and 9- to 12-month postoperative follow-up; **OR**
    - Sensorineural hearing loss, acquired or congenital; **OR**
    - Bell's palsy or other facial nerve abnormalities requiring evaluation of the extracranial portion of the nerve; **OR**
    - Tinnitus, unexplained by history or physical examination, and is worsening or affects daily function; **OR**
  - CT is contraindicated or already performed, and further evaluation is needed, including **ANY** of the following:
    - **ANY** of the following conditions, known or suspected[6]:
      - Neoplastic conditions, detection, and follow-up (including tumors of the internal or external auditory canal, inner ear, and mastoid); **OR**

- Otitis media, recurrent with at least 3 episodes in the past 12 months, with complications suspected (e.g., hearing loss, intracranial extension, mastoiditis); **OR**
- Malignant otitis externa, unresponsive to antibiotics; **OR**
- Mastoiditis; **OR**
- Other infectious processes involving the middle or inner ear, where imaging is needed to direct appropriate management; **OR**

■ Symptoms/signs, evaluated by complete auditory examination, including **ANY** of the following[6]:
- Conductive, mixed-conductive, or congenital hearing loss; **OR**
- Total deafness, otherwise unexplained; **OR**
- Vertigo, unexplained by history or physical examination with **ANY** of the following:
  - Worsening symptoms; **OR**
  - Affected daily function; **OR**
  - Associated hearing loss or other neurological deficits; **OR**
  - History of prior infection such as otitis or meningitis; **OR**
  - History of prior trauma; **OR**

■ Trauma-related conditions related to the ear, further evaluation after CT completed[7-9]; **OR**

■ Vascular conditions, known or suspected, related to the ear or temporal bone including evaluation of pulsatile tinnitus[10]; **OR**

○ Preoperative, postoperative, or pretreatment evaluation for surgery, radiation, or chemotherapy (including evaluation for cochlear implant); **OR**

- Face/paranasal sinus indications, including **ANY** of the following:
  - **ANY** of the following MRI-preferred indications:
    - Bell's palsy or other facial nerve abnormalities requiring evaluation of the extracranial portion of the nerve; **OR**
    - Trigeminal neuralgia with **ANY** of the following[11]:
      - Atypical trigeminal neuralgia, defined by **ANY** of the following symptoms:
        - Bilateral hearing loss; **OR**
        - Dizziness/vertigo; **OR**
        - Visual changes; **OR**
        - Sensory loss or numbness; **OR**
        - Pain lasting longer than 2 minutes; **OR**
        - Pain outside trigeminal nerve distribution and progression; **OR**

        - Refractory trigeminal neuralgia when done for surgical planning; **OR**
    - Conditions (known or suspected), with CT either contraindicated or already performed, and further evaluation is needed for **ANY** of the following[6]:
        - Anatomic abnormalities (e.g., deviated septum), suspected as a cause of patient symptoms and surgical management is being considered; **OR**
        - Congenital conditions and craniofacial abnormalities[1]; **OR**
        - Sinusitis if infective and **ANY** of the following[1,12-14]:
            - A complication is suspected (e.g., abscess formation, involvement of adjacent structures such as orbits, cavernous sinus, or intracranial); **OR**
            - The patient is immunocompromised, and invasive fungal sinusitis is suspected; **OR**
            - Allergic fungal sinusitis (AFS) is suspected, with failed medical treatment or surgery is contemplated; **OR**
            - **ALL** of the following:
                - **ANY** of the following:
                    - Four or more acute episodes per year and surgery/biologic therapy are contemplated; **OR**
                    - Not resolving despite two courses of antibiotics; **OR**
                    - Chronic rhinosinusitis, symptomatic (e.g., discharge, congestion, anosmia, pain), severity staging or restaging when management change is contemplated; **AND**
                - CT maxillofacial is nondiagnostic or contraindicated; **OR**
        - Osteomyelitis; **OR**
        - Odontogenic infections with suspected complications (e.g., abscess formation, facial swelling, nerve, sinus involvement); **OR**
        - Unexplained facial swelling (e.g., over the mandible); **OR**
        - Foreign body (suspected), clinically or seen on prior imaging; **OR**
        - Neoplastic conditions for initial staging, treatment planning, response assessment, and surveillance; **OR**
        - Lymphadenopathy with failure of conservative management (e.g., rest, antibiotics, anti-inflammatory, analgesics) that is documented for a period of greater than two weeks for reactive adenopathy; **OR**
        - Sinonasal polyposis detected on nasal endoscopy with **ALL** of the following[12,15]:

        - The patient is symptomatic; **AND**
        - No relief with appropriate medical therapy such as systemic corticosteroids, antihistamines, and antibiotics; **AND**
        - Surgical intervention or biologic therapy is being contemplated; **OR**
    - Known sinonasal polyposis with complications suspected, such as involvement of the orbits; **OR**
    - Noninfectious inflammatory involvement of the sinus is suspected based on clinical history and symptoms, such as a history of granulomatosis with polyangiitis[1]; **OR**
    - Salivary gland disorder (e.g., chronic unexplained xerostoma, autoimmune involvement, palpable mass, or salivary duct evaluation via MR sialography); **OR**
    - Vascular malformations, such as arteriovenous malformations[1,10]; **OR**
  - For evaluation of **ANY** of the following symptoms when applicable:
    - Anosmia with **ANY** of the following[16]:
        - Persistent anosmia with nondiagnostic endoscopy; **OR**
        - Abnormal endoscopy with further evaluation needed; **OR**
        - Known or suspected neoplasm; **OR**
        - History of head or facial trauma; **OR**
    - Cerebrospinal fluid (CSF) leak (MR cisternography), confirmed on testing or strong clinical history such as prior trauma or CSF leak that increases after Valsalva maneuvers, further evaluation after CT is completed[12]; **OR**
    - Epistaxis with failure of conservative management (e.g., nasal packing/tampon, cautery) **OR**
    - Epistaxis with detection of mass, polyp, or other pathology on examination that requires further evaluation[1]; **OR**
- Neck indications, including **ANY** of the following:
  - Initial staging, treatment assessment, and surveillance of known malignant conditions in the neck not otherwise listed (e.g., nasopharynx, oropharynx, hypopharynx, larynx, salivary glands, jaw, oral cavity); **OR**
  - Thyroid masses or goiter when ultrasound is nondiagnostic or requires further work-up; **OR**
  - Lymphadenopathy or palpable mass, and **ANY** of the following[2,17]:
    - Ultrasound was suspicious for malignancy; **OR**
    - Has been present for at least 2 weeks; **OR**
    - Not felt to be due to infection; **OR**

        - Mass does not resolve after treatment with antibiotics for suspected infection; **OR**
        - Lymphadenopathy or mass is larger than 1.5 cm; **OR**
        - Ulceration of skin over the mass; **OR**
        - Mass or lesion detected on laryngoscopy; **OR**
    - Assessment of signs and symptoms, including **ANY** of the following:
        - Odynophagia; **OR**
        - Globus sensation or dysphagia when clinical examination, including endoscopy and fluoroscopy, are negative or require further evaluation; **OR**
        - Vocal cord paralysis; **OR**
        - Neck pain that is not related to cervical spine or dissection and has not resolved with conservative treatment (e.g., rest and analgesics) that is documented for a period of greater than 4 weeks; **OR**
        - Cranial neuropathy of cranial nerves (CN) 9-11; **OR**
        - Brachial plexus pathology, suspected due to anatomic (e.g., cervical rib) or clinical symptoms (e.g., positive electromyography results, symptoms related to scalene muscles, symptoms that worsen with arm overhead), including but not limited to trauma, neurogenic thoracic outlet syndrome, neuropathies affecting brachial plexus (e.g., chronic inflammatory demyelinating polyneuropathy [CIDP], or suspected or known mass); **OR**
        - Ear pain unexplained by otolaryngological evaluation and a trial of conservative therapy (e.g., topical and systemic antibiotics, ear drops); **OR**
    - Infectious conditions (e.g., tonsillitis, epiglottitis, cellulitis) and **ANY** of the following:
        - Suspected compromise of the airway; **OR**
        - Surgery is planned; **OR**
        - Lack of improvement with appropriate therapy; **OR**
        - Retropharyngeal abscess, suspected; **OR**
        - Ludwig's angina, suspected; **OR**
    - Localization of parathyroid adenoma when lab tests indicate primary hyperparathyroidism and neck ultrasound and Sestamibi scan (nuclear medicine scan) are normal or nondiagnostic[18]; **OR**
    - Presurgical evaluation, planning, or guidance, including radiation planning; **OR**

- Foreign body when initial radiographs and CT are nondiagnostic, unavailable, or contraindicated; **OR**
- Suspected extracapsular spread of a tumor into the surrounding neck structures; **OR**
- Suspected recurrent thyroid cancer or rising thyroglobulin, with negative ultrasound and physical exams to detect occult neck nodes[19]; **OR**

- Repeat imaging (defined as a repeat request following recent imaging of the same anatomic region with the same or similar modality) will be considered reasonable and necessary if **ALL** of the following are **TRUE**:
  - There are no established guidelines; **AND**
  - **ANY** of the following:
    - There are new or worsening symptoms not addressed in the guidelines, such that repeat imaging would influence treatment; **OR**
    - There is need for a one-time clarifying follow-up of a prior indeterminate finding; **OR**
    - In the absence of change in symptoms, there is an established need for monitoring which would influence management.

Non-Indications

Magnetic resonance imaging (MRI), neck/orbit/face may not be considered appropriate if **ANY** of the following is **TRUE**:

- The patient has undergone advanced imaging of the same body part within 3 months without undergoing treatment or developing new or worsening symptoms[20].

*NOTE: MRI in patients with claustrophobia should be requested at the discretion of the ordering provider.
**NOTE: MRI in pregnant patients should be requested at the discretion of the ordering provider and obstetric care provider.

Level of Care Criteria

Inpatient or Outpatient

Procedure Codes (CPT/HCPCS)

CPT/HCPCS Code	Code Description
70540	Magnetic resonance imaging (MRI) (e.g., proton); orbit, face and/or neck; without contrast material(s)
70542	Magnetic resonance imaging (MRI) (e.g., proton); orbit, face and/or neck; with contrast material(s)
70543	Magnetic resonance imaging (MRI) (e.g., proton); orbit, face and/or neck; without contrast material(s) and further sequences

Medical Evidence

Saltagi et al. (2021) reviewed spontaneous intracranial hypotension (SIH). The condition manifests as decreased cerebrospinal fluid (CSF) volume due to leakage through a dural defect, occurring without a discernible underlying cause. Magnetic resonance imaging (MRI) is a preferred initial, noninvasive diagnostic tool (with and without gadolinium contrast enhancement). Spinal MRI or CT myelography is useful for extradural fluid collection to identify a 'fast' leak; a dynamic CT myelogram or digital subtraction myelogram can locate the precise leak. Spine MRI may reveal secondary findings indicative of SIH, such as dural thickening, enhancement, or engorgement of the epidural venous plexus.[21]

Bond et al. (2020) present a review of the diagnostic evaluation of anosmia and hyposmia, including etiology (e.g., trauma, chronic sinusitis, neoplasms, respiratory viral infections). Smell tests primarily diagnose the conditions; however, MRI is often widely used. Functional MRI can diagnose suspected posttraumatic abnormalities.[22]

Nael et al. (2015) conducted a study to identify distinctive MR perfusion patterns for parathyroid adenomas (PTAs) to allow differentiation from neighboring thyroid tissue and cervical lymph nodes, which may exhibit similar imaging characteristics. Utilizing dynamic 4D contrast-enhanced MR imaging enables the exploitation of the hypervascular features of PTAs. Multiparametric MR perfusion analysis demonstrates a diagnostic accuracy of 96% in distinguishing PTAs from adjacent thyroid tissue or lymph nodes.[23]

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Policy Revision History/Information

Original Date: April 1, 2022		
Review History		
Version 2	08/29/2024	Annual review and policy restructure.
Version 3	10/30/2024	Edited repeat imaging criteria language.
Version 4	09/11/2025	Annual review Updated content layout to align with revised template, including repeat imaging criteria Added new criteria for thyroid eye disease, with new reference Burch (2022) Expanded infective sinusitis and neck mass/lymphadenopathy criteria