Cohere Medical Policy -
Magnetic Resonance Imaging (MRI), Pelvis

Clinical Policy for Medical Necessity Review

Version: 3
Cohere Health UMC Approval Date: August 21, 2025
Last Annual Review: August 21, 2025
Revision: Not Applicable
Next Annual Review: August 21, 2026

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:

Fee schedules, relative value units, conversion factors and/or related components are not assigned by the AMA, are not part of CPT, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for data contained or not contained herein.

Policy Information:

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

Table of Contents

Medical Necessity Criteria

Service: Magnetic Resonance Imaging (MRI), Pelvis

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 versatile imaging technique that operates on the interaction between radiofrequency electromagnetic fields and specific nuclei in the body, typically hydrogen nuclei, following exposure to a powerful magnetic field. This method allows for the discrimination between normal and abnormal tissues, offering a highly sensitive diagnostic tool for detecting diseases. The effectiveness of MRI stems from the notable contrast inherent in various tissues, both healthy and diseased, owing to differences in their magnetic relaxation properties. The use of contrast and the type of magnetic resonance (MR) contrast (e.g., extracellular or hepatobiliary-specific) should be at the request of the ordering provider with guidance from the radiologist. The MR field of view should be limited to the area of interest and, in some cases, may not be the preferred imaging study.[1,2]

Medical Necessity Criteria

Indications

Magnetic resonance imaging (MRI), pelvis is considered appropriate if **ANY** of the following is **TRUE**[1]:

- For evaluation of the prostate with **ANY** of the following[3,4]:
  - Prostatitis with **ALL** of the following[5]:
    - Transrectal ultrasound is nondiagnostic/equivocal; **AND**
    - **ANY** of the following:
      - The patient remains febrile for more than 36 hours; **OR**
      - The patient's symptoms do not improve on antibiotics; **OR**
  - For detection and surveillance of prostate cancer and **ANY** of the following:
    - Initial imaging, including **ANY** of the following:
      - Biopsy is planned and digital rectal examination (DRE) has been performed; **OR**
      - Suspicious nodule on DRE, with or without prior biopsy; **OR**
      - The patient meets intermediate or high-risk criteria, including **ANY** of the following:
        - Clinical stage T2b or higher–T2c; **OR**
        - Prostate-specific antigen (PSA) greater than 10 ng/mL; **OR**
        - Gleason score greater than or equal to 7 on prior biopsy; **OR**
        - Indeterminate, intermediate-risk lesion(s) (Prostate Imaging Reporting and Data System-3 [PIRADS-3]) characterized on prior MRI with prostate cancer, surveillance (up to annual)[6]; **OR**
    - Patients with low-risk findings on prior MRI (PIRADS-1 or PIRADS-2) who resume clinical follow-up and demonstrate concerning change in PSA or other concerning clinical change[7]; **OR**
    - Known prostate cancer, low-risk, annual active surveillance as defined by **ANY** of the following:
      - PSA less than 10 ng/dLl **OR**
      - Low clinical tumor grade (cT1-cT2a); **OR**
      - Grade Group 1 (Gleason score less than or equal to 6)[8]; **OR**
    - Initial staging for unfavorable intermediate-, high- and very high-risk prostate cancer; **OR**
    - Restaging, post-treatment follow-up for **ANY** of the following indications[8]:

        - Following radiation therapy and the patient is a candidate for salvage therapy with **ANY** of the following:
            - Increasing PSA; **OR**
            - Positive DRE; **OR**
        - Following radical prostatectomy with **ANY** of the following:
            - Positive DRE; **OR**
            - Undetectable PSA becomes detectable and increases greater than or equal to 2 ng/mL; **OR**
            - PSA does not become undetectable; **OR**
    - Prostate cancer, metastatic with concern for progression; **OR**
- For the evaluation of the uterus, ovaries, or cervix, including **ALL** of the following:
    - Ultrasound has been performed; **AND**
    - **ANY** of the following:
        - Intrauterine pregnancy with the presence of **ANY** of the following on pelvic ultrasound:
            - Fetal anomalies[9]; **OR**
            - Placental attachment disorders (e.g., placenta accreta, placenta increta)[10]; **OR**
        - Follow-up to initial imaging study for further evaluation to characterize a uterine abnormality or lesion if pelvic ultrasound results are inconclusive[1,11]; **OR**
        - Further evaluation of dysfunctional uterine bleeding when ultrasound was indeterminate; **OR**
        - Known or suspected malignancies, including **ANY** of the following:
            - Uterine, ovarian, or cervical cancer, including borderline tumors such as Brenner tumor and moles (gestational trophoblastic tumors); **OR**
            - Endometrial cancer, biopsy-proven, staging, and follow-up; **OR**
- Pelvic abnormalities as indicated by **ALL** of the following[11]:
    - **ANY** of the following is **TRUE**:
        - Ultrasound has been performed and is indeterminate; **OR**
        - Ultrasound has been performed, and the patient requires further evaluation or surgical planning; **AND**
    - **ANY** of the following:
        - Abscess of the pelvis[12,13]; **OR**
        - Endometriosis with involvement beyond the ovary[11]; **OR**
        - Pelvic organ prolapse[14]; **OR**

        - Uterine leiomyoma (fibroid) when an intervention is planned[15]; **OR**
        - Urethral mass; **OR**
        - Pelvic neoplasms; **OR**
        - Evaluation of other reproductive organs, including the uterus/ovaries/testicles/fallopian tubes/cervix; **OR**
- Musculoskeletal imaging of the pelvis when plain radiograph is inconclusive, including **ANY** of the following:
    - Inflammatory arthropathies of the sacroiliac joint (e.g., psoriatic arthritis, ankylosing spondylitis)[16]; **OR**
    - Lumbosacral plexopathy[17]; **OR**
    - Potential bony infection (osteomyelitis)[18]; **OR**
    - Septic arthritis[18]; **OR**
    - Characterization, staging, or follow-up of a bony lesion for suspected or known malignancy or metastatic disease[19]; **OR**
    - Ulcer or wound with clinical concern for soft tissue infection or osteomyelitis[18]; **OR**
    - Persistent athletic pubalgia or osteitis pubis after up to 8 weeks of rest and/or physical therapy; **OR**
    - Trauma-related conditions including suspected traumatic or stress fracture)[20-21]; **OR**
    - Avascular necrosis (AVN); **OR**
- Other evaluation of the pelvis when ultrasound is not appropriate or nondiagnostic, and **ANY** of the following is **TRUE**:
    - Extension of an indicated abdominal MRI for **ANY** of the following:
        - Complete evaluation of organs and structures, such as ureters or bowel (e.g., MR enterography, MR urography); **OR**
        - Neoplastic staging; **OR**
    - Pouchitis or proctitis[2]; **OR**
    - Fistula[2]; **OR**
    - Perianal disease (abscess or fistula)[2]; **OR**
    - Rectal fistula (rectovesicular or rectovaginal)[2]; **OR**
    - Suspected complication of postproctectomy, coloproctectomy, or colectomy with pouch or other anastomosis[2]; **OR**
    - Lymphadenopathy when **ANY** of the following is **TRUE**[22]:
        - When lymphoproliferative disorder is suspected based on prior imaging; **OR**
        - When enlarged lymph nodes are palpable with **ANY** of the following:

        - The patient has suspicious symptoms (e.g., night sweats, fever, weight loss); **OR**
        - Nodes are in an unusual location (e.g., popliteal, iliac); **OR**
    - Follow-up of known pelvic lymphadenopathy at least 3 months after diagnosis with **ANY** of the following suspicious findings:
        - 1 cm or larger in short axis; **OR**
        - Round indistinct hilum; **OR**
        - 3 or more lymph nodes in a single region or cluster; **OR**
        - 2 or more lymph nodes in 2 or more regions; **OR**
- Acute appendicitis in a pediatric (age 17 or less) patient with **ANY** of the following[23]:
    - Ultrasound is inconclusive; **OR**
    - Appendix is not seen; **OR**
- Acute appendicitis in a pregnant patient with **ALL** of the following[13]:
    - Symptoms of acute appendicitis (e.g., fever, leukocytosis, right lower quadrant pain); **AND**
    - Ultrasound is inconclusive, or appendix is not seen; **OR**
- Pyelonephritis in a pregnant patient (abdominal MRI may be needed)[24]; **OR**
- Neoplastic conditions (including masses or mass-like conditions) not otherwise mentioned, including **ANY** of the following:
    - Staging of known rectal cancer; **OR**
    - Single follow-up to initial indeterminate imaging study for further evaluation to characterize a mass; **OR**
    - Concern for bladder neoplasm based on prior imaging or clinical abnormalities (e.g., persistent hematuria) or laboratory findings[4,10]; **OR**
- Screening of a patient with an increased risk of cancer due to **ANY** of the following:
    - Tuberous sclerosis surveillance every 1-3 years when the patient has known angiomyolipoma or renal cystic disease[25]; **OR**
    - Von Hippel Lindau disease every other year[26]; **OR**
    - Peutz-Jeghers syndrome starting at 18 years of age[27]; **OR**
    - Lynch syndrome at **ANY** of the following intervals[28]:
        - MRI starting at 50 years of age; **OR**
        - Starting at 10 years earlier than youngest family member with syndromic cancer; **OR**

        - Familial atypical multiple mole melanoma syndrome (FAMMM) with **ANY** of the following[28]:
            - MRI starting at 40 years of age; **OR**
            - Starting at 10 years earlier than youngest family member with syndromic cancer; **OR**
    - Follow-up to initial imaging study for further evaluation to characterize an abnormality/lesion related to an infection; **OR**
    - For evaluation of **ANY** of the following miscellaneous pathologies when prior testing has failed:
        - Ulcer or wound with clinical concern for infection[18]; **OR**
        - Suspected soft tissue infection with **ANY** of the following[18]:
            - Puncture wound with possible retained foreign body with normal radiograph; **OR**
            - Radiograph with soft tissue gas (without puncture wound); **OR**
            - High suspicion of necrotizing fasciitis; **OR**
        - Posttreatment follow-up/surveillance, including restaging; **OR**
        - Pretreatment for treatment planning, including staging (e.g., interventional radiology procedures, before biopsy, radiation, surgery); **OR**
        - Following open aortic aneurysm surgical repair (OSR) in the pelvis, cross-sectional imaging surveillance should be performed once every 5 years[29]; **OR**
    - Follow-up to initial imaging study for further evaluation to characterize an abnormality/lesion related to congenital anomalies; **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), pelvis 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.[30]

*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
72195	Magnetic resonance imaging (MRI) (e.g., proton), pelvis; without contrast material(s)
72196	Magnetic resonance imaging (MRI) (e.g., proton), pelvis; with contrast material(s)
72197	Magnetic resonance imaging (MRI) (e.g., proton), pelvis; without contrast material(s) followed by contrast material(s) and further sections
74712	Magnetic resonance (eg, proton) imaging, fetal, including placental and maternal pelvic imaging when performed; single or first gestation
74713	MRI fetal, including placental and maternal pelvic imaging when performed, each additional gestation (List separately in addition to code for primary procedure).

Medical Evidence

Almansouri et al. (2024) performed a systematic review to analyze the role of magnetic resonance imaging (MRI) and computed tomography (CT) for pelvic fractures. Twelve studies were analyzed involving 1,798 patients (52% female). Two of the studies were prospective and ten were retrospective. Diagnosing and managing pelvic fractures necessitates a personalized approach considering patient characteristics, injury mechanisms, and hemodynamic status. The authors note that MRI demonstrates superior sensitivity and diagnostic accuracy in identifying acute pelvic fractures, mainly concealed sacral fractures. MRI is also effective in detecting occult pelvic fractures and soft tissue anomalies. However, despite its diagnostic benefits, MRI is unlikely to replace CT as the gold standard due to factors such as shorter emergency department time and contraindications for MRI, especially in elderly patients. CT scanning remains preferred for initial diagnosis, aiding in the determination of emergent angiographic embolization needs and facilitating surgical planning in cases of pelvic fractures.[31]

Manti et al. (2022) conducted a prospective study that included 72 patients with symptoms indicative of endometriosis who underwent evaluation to plan surgical treatment. The mean age of the patients was 35.5 years (range: 20-46 years). Pelvic endometriosis was pathologically confirmed in 56 (77.7%) of the 72 patients. Among them, 22 patients (39.3%) underwent video laparoscopy (VLS), and 16 (72.2%) of those underwent surgery. MRI demonstrated high sensitivity and specificity for detecting various types of pelvic endometriosis. MRI allows the localization of lesions with highly fibrotic components that may not be recognizable with other imaging methods or visible during video laparoscopy.[32]

Hernando et al. (2022) reviewed quantitative diffusion MRI of the abdomen and pelvis, which involves employing multiple diffusion encodings and mapping diffusion parameters. Diffusion MRI allows the ability to gauge tissue microstructure sensitivity. In contrast to qualitative diffusion-weighted MRI, the quantitative approach enhances the standardization of tissue characterization, which is crucial for disease detection, staging, and treatment monitoring. Challenges include acquisition artifacts, limitations in

signal modeling, and biological variability. Technical performance concerns include addressing physiologic motion (respiratory, peristaltic, and pulsatile), handling image distortions, and managing a low signal-to-noise ratio. Currently, multi-center studies focus on validation through systematic assessments to assess reproducibility.[33]

References

1. American College of Radiology (ACR). ACR–SAR–SPR practice parameter for the performance of magnetic resonance imaging (MRI) of the soft-tissue components of the pelvis (resolution 19). http://www.acr.org
2. Levy AD, Liu PS, Kim DH, et al. Anorectal disease. ACR appropriateness criteria [Internet] American College of Radiology (ACR). Updated 2021. http://www.acr.org
3. Akin O, Woo S, Oto A, et al. Pre-treatment detection, surveillance, and staging of prostate cancer. ACR appropriateness criteria [Internet] American College of Radiology (ACR). Updated 2022. http://www.acr.org
4. National Comprehensive Cancer Network (NCCN). NCCN clinical practice guidelines in oncology. Prostate cancer early detection (Version 2.2025). Updated June 24, 2025. https://www.nccn.org/professionals/physician_gls/pdf/prostate_detection.pdf
5. Lam JC, Stokes W. Acute and chronic prostatitis. *Am Fam Physician*. 2024;110(1):45-51
6. Kang Z, Margolis DJ, Wang S, et al. Management strategy for prostate imaging reporting and data system category 3 lesions. *Curr Urol Rep*. 2023 Dec;24(12):561-570. doi:10.1007/s11934-023-01187-0
7. Tan N, Pollock JR, Margolis DJA, et al. Management of patients with a negative multiparametric prostate MRI examination: AJR Expert Panel Narrative Review. *AJR Am J Roentgenol*. 2024;223(2):e2329969. doi:10.2214/AJR.23.29969
8. National Comprehensive Cancer Network (NCCN). NCCN clinical practice guidelines in oncology. Prostate cancer (Version 2.2025). Updated April 16, 2025. https://www.nccn.org/professionals/physician_gls/pdf/prostate_detection.pdf
9. Sussman BL, Chopra P, Poder L, et al. Second and third trimester screening for fetal anomaly. ACR appropriateness criteria [Internet]

American College of Radiology (ACR). Updated 2020. http://www.acr.org

10. Poder L, Weinstein S, Maturen KE, et al. Placenta accreta spectrum disorder. ACR appropriateness criteria [Internet] American College of Radiology (ACR). Updated 2019. http://www.acr.org
11. Wall DJ, Reinhold C, Akin EA, et al. Female infertility. ACR appropriateness criteria [Internet] American College of Radiology (ACR). Updated 2019. http://www.acr.org
12. Scheirey CD, Fowler KJ, Therrien JA, et al. Acute nonlocalized abdominal pain. ACR appropriateness criteria [Internet] American College of Radiology (ACR). Updated 2018. http://www.acr.org
13. Kambadakone AR, Santillan CS, Kim DH, et al. Right lower quadrant pain. ACR appropriateness criteria [Internet] American College of Radiology (ACR). Updated 2022. http://www.acr.org
14. Khatri G, Bhosale PR, Robbins JB, et al. Pelvic floor dysfunction in females. ACR appropriateness criteria [Internet] American College of Radiology (ACR). Updated 2022. http://www.acr.org
15. Ascher SM, Wasnik AP, Robbins JB, et al. Fibroids. ACR appropriateness criteria [Internet] American College of Radiology (ACR). New 2022. http://www.acr.org
16. Czuczman GJ, Mandell JC, Wessell DE, et al. Inflammatory back pain, known or suspected axial spondyloarthritis. ACR appropriateness criteria [Internet] American College of Radiology (ACR). Updated 2021. http://www.acr.org
17. Boulter DJ, Job J, Shah LM, et al. Plexopathy. ACR appropriateness criteria [Internet] American College of Radiology (ACR). Updated 2021. http://www.acr.org
18. Pierce JL, Perry MT, Wessell DE, et al. Suspected osteomyelitis, septic arthritis, or soft tissue infection (excluding spine and diabetic foot). ACR appropriateness criteria [Internet] American College of Radiology (ACR). Updated 2022. http://www.acr.org
19. Stanborough R, Demertzis JL, Wessell DE, et al. Malignant or aggressive primary musculoskeletal tumor-staging and surveillance. ACR appropriateness criteria [Internet] American College of Radiology (ACR). Updated 2022. http://www.acr.org

20. Bartolotta RJ, Ha AS, Bateni CP, et al. Acute hip pain. ACR appropriateness criteria [Internet] American College of Radiology (ACR). http://www.acr.org
21. Morrison WB, Deely D, Fox MG, et al. Stress (fatigue/insufficiency) fracture, including sacrum, excluding other vertebrae. ACR appropriateness criteria [Internet] American College of Radiology (ACR). http://www.acr.org
22. Gaddey HL, Riegel AM. Unexplained lymphadenopathy: evaluation and differential diagnosis. *Am Fam Physician*. 2016;94(11):896-903
23. Koberlein GC, Trout AT, et al. Suspected appendicitis, child [Internet] American College of Radiology. Updated 2018. http://www.acr.org
24. Smith AD, Nikolaidis P, Khatri G, et al. Acute pyelonephritis [Internet] American College of Radiology. Updated 2022. http://www.acr.org
25. Krueger DA, Northrup H; International Tuberous Sclerosis Complex Consensus Group. Tuberous sclerosis complex surveillance and management: Recommendations of the 2012 International Tuberous Sclerosis Complex Consensus Conference. *Pediatr Neurol*. 2013;49(4):255-265. doi:10.1016/j.pediatrneurol.2013.08.002
26. Binderup LM, Smerdel M, Borgwadt L, et al. von Hippel-Lindau disease: Updated guideline for diagnosis and surveillance. *Eur J Med Genet*. 2022;65(8):104538. doi:10.1016/j.ejmg.2022.104538
27. National Comprehensive Cancer Network (NCCN). NCCN clinical practice guidelines in oncology. Genetic/familial high-risk assessment: Colorectal, endometrial, and gastric. (Version 1.2025). Updated June 13, 2025. https://www.nccn.org/professionals/physician_gls/pdf/genetics_ceg.pdf
28. Sawhney MS, Calderwood AH, Thosani NC, et al. ASGE guideline on screening for pancreatic cancer in individuals with genetic susceptibility: Summary and recommendations. *Gastrointest Endosc*. 2022;95(5):817-826. doi:10.1016/j.gie.2021.12.001
29. Isselbacher EM, Preventza O, Hamilton Black J 3rd, et al. 2022 ACC/AHA Guideline for the Diagnosis and Management of Aortic Disease: A Report of the American Heart Association/American College of Cardiology

Joint Committee on Clinical Practice Guidelines. *Circulation*. 2022;146(24):e334-e482. doi:10.1161/CIR.0000000000001106

30. Wasser EJ, Prevedello LM, Sodickson A, Mar W, Khorasani R. Impact of a real-time computerized duplicate alert system on the utilization of computed tomography. *JAMA Intern Med*. 2013;173(11):1024-1026. doi:10.1001/jamainternmed.2013.543
31. Almansouri 2nd DH, Elsherbini AI, Alharthi M, et al. The role of MRI and CT scan in classification and management of pelvic fractures: A systematic review. *Cureus*. 2024 Jan 13;16(1):e52215. doi:10.7759/cureus.52215
32. Manti F, Battaglia C, Bruno I, et al. The role of magnetic resonance imaging in the planning of surgical treatment of deep pelvic endometriosis. *Front Surg*. 2022 Jun 28:9:944399. doi:10.3389/fsurg.2022.944399
33. Hernando D, Zhang Y, Pirasteh A. Quantitative diffusion MRI of the abdomen and pelvis. *Med Phys*. 2022 Apr;49(4):2774-2793. doi:10.1002/mp.15246

Policy Revision History/Information

Original Date: August 2, 2024		
Review History		
Version 2	10/30/2024	Edited repeat imaging criteria language.
Version 3	08/21/2025	Annual review. Minor adjustments were made to the indications to better align with ACR and NCCN guidelines. Literature review - Description section updated. References were updated in alignment with the most recent guidelines from ACR and NCCN. Removed ACR guidelines for low back pain and abdomen from the references list. Removed relative contraindications (contrast allergy, metallic clips, incompatible implantable devices, metallic foreign body).