Cohere Medicare Advantage Policy - Magnetic Resonance Imaging (MRI), Pelvis

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.

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Other Notices:

Policy Information:

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

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Medical Necessity Criteria

Service: Magnetic Resonance Imaging (MRI), Pelvis

Related CMS Documents

Please refer to CMS Medicare Coverage Database for the most current applicable CMS National Coverage.[1-3]

- National Coverage Determination (NCD). Magnetic resonance imaging (MRI)(220.2)
- Local Coverage Determination (LCD). Multiple imaging in oncology (L35391)
    - Billing and Coding: Multiple imaging in oncology (A56848)

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.[4,5]

Medical Necessity Criteria

Indications

Magnetic resonance imaging (MRI), pelvis is considered appropriate if **ANY** of the following is **TRUE**[4,5]:

- For the evaluation of the prostate with **ANY** of the following:
  - Prostatitis with **ALL** of the following[5]:
    - Transrectal ultrasound is nondiagnostic or 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[6-8]; **OR**
  - For the 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[9]; **OR**
        - Prostate-specific antigen (PSA) greater than 10 mg/mL; **OR**
        - Gleason score greater than or equal to seven on prior biopsy; **OR**
        - Indeterminate, intermediate-risk lesion(s) (PIRADS-3) characterized on prior MRI with prostate cancer, surveillance (up to annual)[10]; **OR**
    - Indeterminate, low-risk lesion(s) (PIRADS-1 or PIRADS-2); **OR**
    - Known low-risk prostate cancer annual active surveillance as defined by **ANY** of the following:
      - PSA less than 10 mg/mL; **OR**
      - Low clinical tumor grade (cT1-cT2a); **OR**
      - Grade Group 1 (Gleason score less than or equal to six)[10]; **OR**
    - Prostate cancer, post-treatment follow-up for **ANY** of the following indications:
      - Detectable and rising PSA; **OR**
      - Prior radical prostatectomy (surgical removal of the whole of the prostate) with detectable PSA; **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[11]; **OR**
            - Placental attachment disorders (e.g., placenta accreta, placenta increta)[12]; **OR**
        - Follow-up to initial imaging study for further evaluation to characterize a uterine abnormality or lesion if pelvic ultrasound results are inconclusive[4,13]; **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[7,14]:
    - **ANY** of the following:
        - 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[15,16]; **OR**
        - Endometriosis with involvement beyond the ovary[13]; **OR**
        - Pelvic organ prolapse[17]; **OR**
        - Uterine leiomyoma (fibroid) when an intervention is planned[18]; **OR**
        - Urethral stricture or mass; **OR**
        - Pelvic neoplasms; **OR**
        - Uterine or cervical abnormalities; **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 or ankylosing spondylitis)[18]; **OR**
    - Lumbosacral plexopathy[19]; **OR**

- Potential bony infection (osteomyelitis)[20]; **OR**
- Septic arthritis[21]; **OR**
- Characterization, staging, or follow-up of a bony lesion for suspected or known malignancy or metastatic disease[22]; **OR**
- Ulcer or wound with clinical concern for soft tissue infection or osteomyelitis[21]; **OR**
- Persistent athletic pubalgia (sports hernia) or osteitis pubis after 3 months of conservative treatment[22]; **OR**
- Trauma-related conditions, including suspected traumatic or stress fracture with indeterminate computed tomography (CT)[23-25]; **OR**
- Avascular necrosis (AVN) or osteonecrosis; **OR**

- Other evaluation of the pelvis when ultrasound is not appropriate or non-diagnostic, CT is contraindicated or inconclusive, for **ANY** of the following:
  - Extension of an indicated abdominal MRI for complete evaluation of organs and structures such as ureters or bowel (e.g., MR enterography, MR urography) or for neoplastic staging; **OR**
  - Pouchitis[5]; **OR**
  - Fistula; **OR**
  - Lymphadenopathy when **ANY** of the following is **TRUE**:
    - 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**
      - Three or more lymph nodes in a single region or cluster; **OR**
      - Two or more lymph nodes in two or more regions; **OR**
  - Acute appendicitis in a pediatric (less than or equal to 17 years of age) patient with **ANY** of the following:
    - Ultrasound is inconclusive; **OR**
    - Appendix is not seen; **OR**
  - Acute appendicitis in a pregnant patient with **ALL** of the following:
    - 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; **OR**
- Neoplastic conditions for **ANY** of the following:
    - Initial staging; **OR**
    - Treatment planning; **OR**
    - Response assessment; **OR**
    - Surveillance, for **ANY** of the following[2,3,26-28]:
        - The patient is assumed to have either no known disease or disease that is stable or clinically insignificant (every 6-12 months for an overall duration [e.g., 5 years]); **OR**
        - Suspected recurrence/progression; **OR**
        - Evaluation of response to treatment when a change in therapy is contemplated (no more often than after two cycles of chemotherapy or 6-8 weeks since the prior imaging evaluation); **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 surveillance every other year[26]; **OR**
    - Peutz-Jeghers syndrome surveillance 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 or 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** 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 is not considered appropriate if **ANY** of the following is **TRUE**:[29]

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

*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

Disclaimer: S Codes are non-covered per CMS guidelines due to their experimental or investigational nature.

Evaluation of Clinical Harms and Benefits

Clinical determinations for Medicare Advantage beneficiaries are made in accordance with 42 CFR 422.101 guidance outlining CMS's required approach to decision hierarchy in the setting of NCDs/LCDs identified as being "not fully established". When clinical coverage criteria are "not fully established" Medicare Advantage organizations are instructed to create publicly accessible clinical coverage criteria based on widely-accepted clinical guidelines and/or scientific studies backed by a robust clinical evidence base. Clinical coverage criteria provided by Cohere Health in this manner include coverage rationale and risk/benefit analysis.

The potential clinical harms of using these criteria may include:

- There is a risk of malfunction of implanted medical devices (e.g., implanted pacemakers, cochlear implants).
- A potential exists for allergic reactions to contrast material, if used in the study. The MRI department staff will monitor the patient for an allergic reaction and treat as recommended by a physician.[4-6]
- Use of gadolinium-based contrast is not recommended during pregnancy or in patients with acute or chronic kidney injury or disease.[4-6]
- If sedation is used for the study (for anxiety or claustrophobia), there is a risk of over-sedation. The patient will be monitored during the procedure to reduce this risk.
- There is uncertain risk for magnetic resonance imaging (MRI) in pregnant patients. The decision to image in a pregnant patient should be made on an individual basis in consultation with the patient's obstetric provider.[7]
- There is a risk of increased healthcare costs and complications from the inappropriate use of additional interventions.[8]

The clinical benefits of using these criteria include:

- MRI demonstrates superior sensitivity and diagnostic accuracy in identifying acute pelvic fractures when compared to computed tomography (CT). MRI is also effective in detecting occult pelvic fractures and soft tissue anomalies.[9]
- MRI demonstrates high sensitivity and specificity in 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.[10]
- Quantitative diffusion MRI of the abdomen and pelvis 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.[11]
- Enhanced overall patient satisfaction and healthcare experience.

This policy includes provisions for expedited reviews and flexibility in urgent cases to mitigate risks of delayed access. Evidence-based criteria are employed to prevent inappropriate denials, ensuring that patients receive medically necessary care. The criteria aim to balance the need for effective treatment with the minimization of potential harms, providing numerous clinical benefits in helping avoid unnecessary complications from inappropriate care.

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 the remaining 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 initial 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.[30]

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.[31]

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.[32]

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Policy Revision History/Information

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Review History		
Version 2	10/16/2025	Annual review. Expanded prostatitis and lymphadenopathy criteria in the Indications section. Rearranged bullets for improved usability and organization. Removed metallic clip, incompatible implantable devices, and metallic foreign body in orbits language from non-indications. Updated Harms and Benefits language. Added reference #29.