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2025 Magnetic Resonance Imaging (MRI) Lumbar Spine

Diagnostic Imaging

MRI-LSpine-HH

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MRI Lumbar Spine Overview

Low back pain (LBP) is a common issue, affecting up to 84% of adults at some point in their lives. For example, a survey in 2002 found that 26% of people reported having back pain lasting at least one day in the last three months. It's important to know that serious medical conditions are rarely the cause of back pain.

Serious conditions that can cause back pain, such as cauda equina syndrome, cancer that has spread to the spine or spinal infections, are rare and affect less than 1% of people with LBP. If you have symptoms or risk factors for these serious conditions, further investigation including advanced imaging is warranted.

The initial evaluation of your back pain typically starts with a detailed history and physical examination. For most cases of acute pain lasting less than four weeks, imaging tests and blood work are not usually needed right away. If there are signs suggesting a serious underlying issue—like a history of cancer, significant weight loss, pain that persists beyond one month, or pain that worsens at night—further tests may be necessary.

Imaging tests like MRI or CT scans are generally not required for most people with acute LBP. A 2009 review showed that early imaging often does not improve outcomes and can lead to unnecessary procedures and higher costs. MRI results can sometimes show abnormalities even when there is no significant clinical problem. Therefore, imaging is typically reserved for cases with severe or progressive symptoms, or if there is a strong suspicion of a serious condition.

For most patients, imaging is only necessary if there's no improvement after four to six weeks of conservative treatment, or if there are specific symptoms that suggest more serious issues. If you have persistent symptoms, advanced imaging to explore further treatment options may be considered.

In summary, while back pain is very common, serious underlying conditions are rare. Most cases of acute back pain improve on their own with time and conservative treatment. Imaging is usually reserved for cases where there are concerning symptoms or when initial treatments have not been effective.

Magnetic Resonance Imaging (MRI) Lumbar Spine

MRI Lumbar Spine Related National Coverage Determination (NCD)/Local Coverage Determination (LCD)

Please refer to https://www.cms.gov/medicare-coverage-database/search.aspx if applicable to the individual's health plan membership.

Type/ID Number	Title
LCD 34220	Lumbar MRI
LCD 35391	Multiple Imaging in Oncology
LCD 37281	Lumbar MRI

Clinical Judgment

These medical policies are designed to provide clinical guidance and do not supplant a provider's independent professional judgment. Physicians retain full and independent authority to determine appropriate care based on each patient's individual clinical circumstances. Although services may

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be subject to documentation requirements, medical necessity review, or coverage limitations, nothing in this policy is intended to restrict or interfere with a physician's independent medical judgment.

MRI General Contraindications

MRI is contraindicated for **ANY** of the following:

- Safety, related to clinical status (body mass index exceeds MRI capability, intravascular stents within recent 6 weeks)
- Safety, related to implanted devices (aneurysm clips, cochlear implant, implantable cardio-defibrillators, insulin pump, permanent pace maker, spinal cord stimulator)[1]
  References: [22] [9] [15]

Preamble: Pediatric Diagnostic Imaging

HealthHelp's clinical guidelines for the Diagnostic Imaging program, are intended to apply to both adults and pediatrics (21 years of age or younger), unless otherwise specified within the criteria.

Low Back Pain Including Symptoms of Radiculopathy and Sciatica

Magnetic resonance imaging (MRI) of the lumbar spine is considered medically appropriate when there is pain in the back with active conservative management (chiropractic treatments, physical therapy) and the documentation demonstrates **EITHER** of the following:

1. Attempted within the last 6 months, for at least 6 weeks **AND** symptoms persist or worsen.
   References: [19] [16] [4]
2. Symptoms progress or worsen during current course of conservative management
   References: [19] [16] [4]

MRI Lumbar Spine Guideline

Magnetic resonance imaging (MRI) of the lumbar spine is considered medically appropriate when the documentation demonstrates **ANY** of the following:

1. Lumbar radiculopathy is demonstrated on nerve conduction study **OR** electromyography (EMG) (*__NOTE:__ *An EMG is **NOT** recommended to determine the cause of axial lumbar, cervical or thoracic spine pain*.)

[1]Some implanted devices that were once absolute contraindications to a MRI may now be accepted, including if the specific MRI is able to accommodate the device or the device itself is deemed safe for MRI.

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References: [4] [16]

2. Pain in the back and **ANY** of the following:
    a. Back pain, in a pediatric individual, and **EITHER** of the following:
        i. Chronic **AND** inflammation, infection or malignancy is suspected.
        ii. Isolated back pain, X-ray is completed and **ANY** of the following: (**NOTE**: *Conservative management is **NOT** required if any of these "red flags" exist*.)
            A. Age is 5 years or younger.
            B. Fever
            C. Malaise
            D. Pain at night that disrupts sleep.
            E. Pain is constant.
            F. Pain lasts more than 4 weeks.
            G. Postural changes (kyphosis or scoliosis)
            H. Radicular pain
            I. Stiffness or gelling in the early morning.
            J. Weight loss (more than 5% in 2 months or 10% in 6 months)
    b. Conservative management, active (chiropractic treatments, physical therapy), and **EITHER** of the following:
        i. Attempted within the last 6 months, for at least 6 weeks **AND** symptoms persist (10 days or more) or worsen.
        ii. Symptoms progress or worsen during current course of conservative management

    References: [19] [16] [4] [7]
3. Arnold-Chiari malformation is known, demonstrated on prior imaging.
    References: [28] [26] [25]
4. Cancer, tumor, recurrence or metastasis evaluation for **ANY** of the following:
    a. Prior imaging for bone metastasis is abnormal, non-diagnostic or indeterminate.
    b. Spinal tumor is known **AND** symptoms are new or progressing (eg, non-traumatic pain is new or increasing).
    c. Surveillance following the **National Comprehensive Cancer Network (NCCN) Guideline's** surveillance recommendations (*see **Surveillance** section*).

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References: [5] [20]

5. Cauda equina syndrome is suspected or known, symptomatic with back pain/sciatica **AND** neurological symptoms (eg, bowel/bladder dysfunction, leg and foot numbness, saddle anesthesia) are present.
References: [13] [8]

6. Cerebrospinal fluid (CSF) leak is suspected (eg, cerebrospinal-venous fistula, CSF rhinorrhea, orthostatic headache, otorrhea, post lumbar puncture headache, post spinal surgery headache, spontaneous idiopathic intracranial hypotension [SIH]).
References: [14]

7. Compression fracture(s) evaluation and **ANY** of the following:
    a. Compression fractures are known and treated **AND** back pain is new or worsening.
    b. New, demonstrated on X-ray, and **EITHER** of the following:
        i. **NO** known malignancy **AND** back pain is worsening
        ii. Cancer is known, with or **WITHOUT** worsening back pain, for differentiation of benign osteoporotic fractures from metastatic disease. (*__NOTE__: *a follow-up MRI, 6 to 8 weeks after initial MRI, when imaging is non-diagnostic or indeterminate, is appropriate*.)

    References: [20]

8. Infection (eg, abscess, discitis, osteomyelitis) is suspected or known and **ANY** of the following:
    a. Active treatment, to assess response
    b. Immune system suppression-related (eg, cancer, diabetes, dialysis, human immunodeficiency virus [HIV], intravenous drug use) spinal infection is suspected, from signs/symptoms (eg, abnormal white blood cell count, erythrocyte sedimentation rate [ESR], back pain).
    c. Prior imaging is abnormal, non-diagnostic or indeterminate.
    d. Signs/symptoms are present (eg, abnormal complete blood count [CBC], c-reactive protein [CRP] or ESR, chills, fever, pain)

    References: [24]

9. Inflammatory disease (non-infectious) is suspected or known, **AFTER** rheumatology evaluation (eg, CRP, ESR) is completed and **ANY** of the following:
    a. Neuroinflammatory conditions (eg, Behcet's syndrome, sarcoidosis) are suspected with abnormal neurologic physical exam (eg, abnormal gait or reflexes, bowel/

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bladder dysfunction, extremity weakness) **AND** rheumatology evaluation (eg, CRP, ESR) is completed.

b. Rheumatoid arthritis with abnormal neurologic physical exam (eg, abnormal gait or reflexes, bowel/bladder dysfunction, extremity weakness) **OR** X-ray (within the last 6 months) demonstrates subluxation. (*__NOTE__: *Initial imaging should be a lateral X-ray in flexion and neutral. MRI is indicated with negative X-rays when neurological deficit is present or symptoms suggest cervical instability.*)

c. Spondyloarthropathies are suspected or known, X-ray(s) (within the last 6 months) are non-diagnostic or indeterminate **AND** rheumatology evaluation (eg, CRP, ESR) is completed.

References: [4] [11]

10. Neurological deficits (eg, abnormal reflexes, foot drop, loss of sensation, numbness/ tingling) are new and demonstrated on physical exam (eg, ankle jerk, knee jerk)
11. Post-surgical assessments for evaluation of complications or disease recurrence (within 90 days)
12. Sacral dimple, in a pediatric individual, is suspicious (eg, deep, larger than 0.5 cm, located within the superior portion of the gluteal crease or above the gluteal crease, multiple dimples or associated with cutaneous markers) **OR** duplicated or deviated gluteal cleft is known (*__NOTE__: *In ages 3 months old or younger, ultrasound should be done*).
References: [1]
13. Scoliosis with **ANY** of the following:
    a. Age of onset is early (before age 10 years).
    b. Atypical curve (eg, Kyphosis more than 30 degrees, left thoracic curve, short segment)
    c. Neurological deficit is new or unexplained.
    d. Pre-operative planning
    e. Spinal deformity is progressive.
    f. Treatment planning depends on imaging

    References: [12] [17]
14. Spondylolysis (Pars defect) or spondylolisthesis, in adults, **AND** extension/flexion X-rays demonstrate instability. (*__NOTE__: *Initial imaging bone scan with single photon emission computed tomography [SPECT] is superior to MRI and CT in the detection of pars intrarticularis pathology, including spondylolysis*.)
References: [10] [21]

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15. Spondylolysis (Pars defect), in a pediatric individual, is suspected **AND** X-ray is negative.
16. Tethered cord or spinal dysraphism is suspected or known from preliminary imaging, neurological exam **OR** high risk cutaneous stigmata.
    References: [1]
17. Toe walking, in a pediatric individual, with signs/symptoms of upper motor neuron abnormalities (eg, hyperreflexia, orthopedic deformity with concern for spinal cord pathology, spasticity)
18. Trauma or acute injury evaluation, X-ray or CT is abnormal, non-diagnostic or indeterminate, neurological deficits are new or progressing and **ANY** of the following:
    a. Nerve root injury is suspected.
    b. Spinal abnormalities (eg, ankylosing spondylitis, diffuse idiopathic skeletal hyperostosis) are known. (*__NOTE__: *Both a MRI and CT are appropriate.*)
    c. Unexaminable condition (eg, distracting injury, Glasgow coma scale is less than 15)

    References: [2] [18]

Combination CT and MRI for Metastases Evaluation Guideline

Combination CT/MRI studies (5 or less concurrent studies, with a CT or MRI appropriate for cancer location: abdomen, brain, cervical spine, chest, lumbar spine, neck, pelvis and/or thoracic spine) for **ANY** of the following situations:

1. Staging evaluation, for baseline pre-therapy
2. Surveillance following the National Comprehensive Cancer Network (NCCN) Guidelines recommended schedule (*See **Surveillance** section*)

Combination CT Lumbar Spine and MRI Lumbar Spine Guideline

Computed tomography (CT) lumbar spine combined with magnetic resonance imaging (MRI) lumbar spine is considered medically appropriate when the documentation demonstrates **ANY** of the following:

1. Bony and soft tissue abnormality is known **AND** imaging may change the treatment plan.
2. Fractures are complex or pathologic.
3. Malignant process of spine evaluation with both bony and soft tissue involvement

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Spine Surveillance section

Bone Cancer Surveillance

Bone cancer surveillance includes **ANY** of the following:

1. Chondrosarcoma surveillance for **ANY** of the following:
    a. Atypical cartilaginous tumor surveillance with cross-sectional imaging (CT + contrast, MRI ± contrast) every 6 to 12 months for 2 years, then annually as clinically indicated
    b. Low-grade, extracompartmental appendicular tumor, grade I axial tumors or high-grade (grade II or III, clear cell or extracompartmental) tumors surveillance with **ALL** of the following:
        i. Chest CT at least every 6 months for 5 years, then annually for at least 10 years, then if symptoms are new or progressing.
        ii. MRI (± contrast) or CT (+ contrast) if symptoms are new or progressing.
2. Chordoma surveillance with **ALL** of the following:
    a. Chest CT imaging every 6 months, annually for 5 years, then annually thereafter, then if symptoms are new or worsening.
    b. Imaging of primary site, timing and modality (eg, MRI ± CT [both + contrast]) if symptoms are new or progressing, up to 10 years
3. Ewing Sarcoma after primary treatment completed surveillance with **ALL** of the following:
    a. Chest CT: every 3 months
    b. Primary site imaging with MRI ± CT (both + contrast), increase intervals after 24 months and after 5 years, annually, then if symptoms are new or progressing (indefinitely) (*__NOTE__: *PET/CT [head-to-toe] is appropriate*)
4. Giant cell tumor of the bone surveillance with **ALL** of the following:
    a. Chest CT or MRI imaging every 6 to 12 months for 4 years, then annually thereafter, then if symptoms are new or progressing
    b. Surgical site imaging if symptoms are new or progressing (eg, CT and/or MRI, both with contrast)
5. Osteosarcoma surveillance with primary site and chest imaging (using same imaging that was done for initial work-up) for **ANY** of the following: (*__NOTE__: *PET/CT [head-to-toe] is appropriate*.)
    a. Image every 3 months for years 1 and 2

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b. Image every 4 months for year 3

c. Image every 6 months for years 4 and 5

d. Image annually for year 6 and thereafter, then if symptoms are new or progressing

References: [2025 Bone Cancer Version 1.2026]

Central Nervous System (CNS) Cancer Surveillance

Central nervous system (CNS) cancer surveillance includes **ANY** of the following:

1. Brain metastasis, limited **OR** extensive, image with brain magnetic resonance imaging (MRI) every 2 to 3 months for 1 to 2 years, then every 4 to 6 months indefinitely
2. Glioblastoma, *IDH* wild-type, magnetic resonance imaging with (MRI) of the brain and **ANY** of the following:
    a. Pre-operative and post-operative; within 48 hours
    b. Pre-radiation planning; every 3 to 5 weeks, post-operatively
    c. Post-radiation; 3 to 6 weeks post-radiation, then every 2 to 3 months for 3 years, then every 2 to 4 months indefinitively
3. Glioma, imaging with MRI of the brain and **ANY** of the following:
    a. Astrocytoma, *IDH* mutated and **ANY** of the following:
        i. Grade 2 and **ANY** of the following:
            A. After radiation therapy (RT) **AND** chemotherapy: every 6 months until tumor progression
            B. After RT **OR** chemotherapy: every 3 to 4 months for the 1st 5 years, then every 3 to 4 months until tumor progression
            C. After surgery: every 3 to 4 months until tumor progression
        ii. Grade 3 and **ANY** of the following;
            A. After RT **AND** chemotherapy: every 6 months until tumor progression
            B. After RT **OR** chemotherapy: every 3 to 4 months for the 1st 5 years, then every 3 to 4 months until tumor progression
        iii. Grade 2 or 3, recurrent; image every 2 to 3 months
    b. Oligodendroglioma, *IDH* mutated, 1p/19q co-deleted and **ANY** of the following:
        i. Grade 2 and **ANY** of the following:

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A. After radiation therapy (RT) **AND** chemotherapy: every 6 to 9 months until tumor progression

B. After RT **OR** chemotherapy: every 3 to 4 months for the 1st 5 years, then every 3 to 4 months until tumor progression

C. After surgery: every 3 to 4 months until tumor progression (*__NOTE__: *For individuals who underwent gross total resection, every 6 to 9 months for 5 years post-surgery until tumor progression*)

ii. Grade 3 and **ANY** of the following:

A. After radiation therapy (RT) **AND** chemotherapy: every 6 to 9 months until tumor progression

B. After RT **OR** chemotherapy: every 3 to 4 months for the 1st 5 years, then every 3 to 4 months until tumor progression

iii. Grade 2 or 3, recurrent, image every 3 to 4 months

4. Leptomeningeal metastases imaging with MRI of the brain and/or total spine every 2 to 3 months for the 1st 2 years, every 6 months until year 5, then annually indefinitively
5. Medulloblastoma, imaging with MRI of the brain every 2 to 3 months for 2 years
6. Primary CNS lymphoma, image every 2 to 3 months for 2 years

References: [23]

Neuroendocrine and Adrenal Tumors Surveillance

Neuroendocrine and adrenal cancer surveillance includes **ANY** of the following:[2]

1. Adrenal gland tumors surveillance imaging includes **ANY** of the following:
   a. Localized disease: chest computed tomography (CT) (± contrast) and abdominal CT or magnetic resonance imaging (MRI) (+ contrast) every 3 to 12 months up to 5 years, then if symptoms are new or progressing.
   b. Locoregional unresectable or metastatic disease; chest CT (± contrast) and CT or MRI abdomen and pelvis (+ contrast) or FDG positron emission tomography (PET)/CT every 3 to 12 months up to 5 years, then if symptoms are new or progressing.
2. Carcinoid syndrome surveillance imaging includes **BOTH** of the following:
   a. Abdominal/pelvic multiphasic CT or MRI every 3 to 12 months and chest CT (± contrast) if symptoms are new or progressing.

[2]**NO** surveillance is indicated for appendiceal tumors 2 cm or smaller **WITHOUT** aggressive features (eg, high-grade cytologic atypia, infiltrative invasion lymphatic and hematogenous metastases).

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b. Echocardiogram (ECHO) every 1 to 3 years or as clinically indicated **WITHOUT** known carcinoid heart disease (CHD) and at least annually for individuals with established CHD.

3. Gastrointestinal tract (well-differentiated grade 1/2), lung and thymus imaging and **ANY** of the following:
   a. Lung nodules, multiple or tumorlets, image with chest CT (- contrast) every 12 to 24 months if symptoms are new or progressing.
   b. Rectal tumor is 1 cm to 2 cm or less: image with rectal MRI at 6 and 12 months if symptoms are new or progressing.
4. Gastrointestinal (GI) tract (jejunum/ileum/colon, duodenum, rectum), lung and/or thymus neuroendocrine tumor (NET) surveillance includes imaging post-resection with **ANY** of the following:
   a. Jejunum/ilium/colon, duodenum, rectum and thymus, surveillance imaging with abdominal ± pelvic multiphasic CT or MRI according to **ONE** of the following levels of frequency[3]:
      i. Within 3 months to 12 months post-operatively
      ii. After 12 months, image every 12 to 24 months for 10 years
      iii. After 10 years if symptoms are new or progressing.
   b. Lung/thymus tumors surveillance chest CT (± contrast) for primary tumors, (as clinically indicated for primary GI tumors) according to **ONE** of the following levels of frequency:
      i. Within 12 weeks to 12 months post-operatively
      ii. After 12 months, image every 12 to 24 months for 10 years
      iii. After 10 years if symptoms are new or progressing.
5. Grade 3, well-differentiated neuroendocrine surveillance includes chest CT (± contrast) as clinically indicated for **ANY** of the following:
   a. Locally advanced/metastatic disease with favorable biology (low Ki-67 [eg, less than 55%], positive somastatin receptor [SSTR] based PET imaging) includes abdominal/pelvic MRI (+ contrast) or abdominal/pelvic multiphasic CT for surveillance with **ANY** of the following:
      i. Resectable disease surveillance every 3 to 6 months for 2 years, then every 6 to 12 months for up to 10 years **AND** chest CT if symptoms are new or progressing.

[3]High-grade tumors are appropriate for more frequent monitoring.

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ii. Unresectable disease surveillance every 12 weeks to 24 weeks (depending on tumor biology) **AND** chest CT (± contrast), SSTR-PET/CT, SSTR-PET/MRI or FDG-PET/CT; if symptoms are new or progressing.

b. Locally advanced/metastatic disease with unfavorable biology (high Ki-67 [eg 55% or higher], rapid growth rate, FDG avid tumors, negative SSTR-based PET imaging), includes surveillance imaging, every 8 weeks to 12 weeks (depending on tumor biology) with **ALL** of the following:

i. Abdominal/pelvic MRI (+ contrast) or abdominal/pelvic multiphasic CT and FDG PET/CT as clinically indicated

ii. Chest CT (± contrast) if symptoms are new or progressing.

iii. FDG-PET/CT, if symptoms are new or progressing.

c. Locoregional disease (resectable) abdominal/pelvic MRI (+ contrast) or abdominal/pelvic multiphasic CT with frequency of **ONE** of the following:

i. Every 3 to 6 months for 2 years (depending on tumor biology, Ki-67) and chest CT as clinically indicated

ii. Every 6 months to 12 months for up to 10 years (depending on tumor biology, Ki-67) and chest CT as clinically indicated

d. Multiple endocrine neoplasia, type 1 (MEN1) screening surveillance for **ANY** of the following tumor types: (*__NOTE__: *For prolonged surveillance, use imaging studies without radiation.*)

i. Lung/thymic NETs: chest CT or MRI (+ contrast) every 1 to 3 years

ii. PanNET: abdominalpelvic CT or MRI (+ contrast) every 1 to 3 years

iii. Parathyroid: if calcium rises, re-image with single-photon emission computed tomography (SPECT) scan (SPECT-CT preferred) or 4D-CT

iv. Pituitary: pituitary or sella MRI (+ contrast) of the pituitary every 3 to 5 years

e. Poorly differentiated large or small cell carcinoma and/or mixed neuroendocrine/non-neuroendocrine neoplasm or unknown primary, imaging surveillance includes **ALL** of the following:

i. Locoregional unresectable or metastatic disease surveillance imaging includes **EITHER** chest CT (± contrast) with abdominal/pelvic MRI (+ contrast) **OR** chest/abdominal/pelvic multiphasic CT; every 6 weeks to 16 weeks

ii. Resectable surveillance imaging includes **EITHER** chest CT (± contrast) with abdominal/pelvic MRI (+ contrast) **OR** chest, abdomenl and pelvis

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multiphasic CT; every 12 weeks for the 1st year, and every 6 months thereafter

f. Post-operative from potentially curative surgery surveillance for at least 10 years (longer if high-risk)

6. Pancreatic neuroendocrine tumor surveillance imaging, post-resection, includes chest CT (± contrast) as clinically indicated and abdominal multiphasic CT or MRI with imaging frequency of **ONE** of the following[4]:

   a. Within 3 to 12 months post-operatively

   b. After 12 months, image every 6 to 12 months for 10 years

   c. After 10 years if symptoms are new or progressing.

7. Pheochromocytoma/paranganglioma surveillance imaging and **ANY** of the following:

   a. Locally unresectable disease or distant metastases, imaging every 12 weeks for 12 months, includes **ANY** of the following:

      i. Chest, abdomen and pelvis CT with contrast

      ii. Chest CT (± contrast) and abdominal/pelvic MRI (- contrast) (if risk for hypertensive episode)

      iii. FDG-PET/CT for bone dominant disease

      iv. SSTR-PET/CT or SSTR-PET/MRI (if previous SSTR-positive or concern for disease progression) prior to radionuclide therapy

   b. Resectable disease, post-resection includes chest CT (± contrast) and abdominal/ pelvic CT or MRI (+ contrast), if clinically indicated with imaging frequency of **ONE** of the following:

      i. 12 weeks to 12 months after resection

      ii. Every 6 to 12 months for the 1st 3 years

      iii. Annually from year 4 to 10.

      iv. More than 10 years, then as clinically indicated

[4]High-grade tumors are appropriate for more frequent monitoring.

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TIP

NCCN recommends following the surveillance protocols from designated guidelines for the following hereditary endocrine neoplasia syndromes :

- Thyroid cancer guideline, use for: Multiple endocrine neoplasia, type 2 (MEN2) with genetic evaluation of inherited syndromes
- Kidney cancer, use for:
  - Hereditary paraganglioma/pheochromocytoma syndrome
  - Tuberous sclerosis complex (TSC1 and TSC2)
  - von Hippel Lindau syndrome (VHL)
- Genetic/Familial High-Risk Assessment: Breast, Ovarian, and Pancreatic, use for:
  - Neurofibromatosis type 1 (NF1)
  - Li-Fraumeni syndrome (TP53)
  - Lynch syndrome (MLH1, EPCAM/MSH2, MSH6, PMS2)
- Genetic/Familial High-Risk Assessment: Colorectal, use for:
  - Lynch syndrome (MLH1, EPCAM/MSH2, MSH6, PMS2)
  - Familial adenomatous polyposis (APC)

References: [2025 Neuroendocrine and Adrenal Tumors Version 3.2025]

Occult Primary Cancer Surveillance

Occult primary cancer surveillance imaging for long-term surveillance includes diagnostic tests based on symptomatology.

References: [27]

MRI Lumbar Spine Summary of Changes

MRI lumbar spine guideline had the following version changes from 2024 to 2025:

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Table 1. 2025 MRI Lumbar Spine Summary of Changes

Date	Type of Change	Summary
05/16/2025	Annual	• Added the following to keep in line with current evidence: ▪ (*__NOTE__: *X-rays are only required at initial diagnosis*.) at "Cancer, tumor, recurrence or metastasis evaluation" to decrease radiation exposure ▪ "Rheumatoid arthritis" under "Inflammatory disease" per ACR ▪ "Scoliosis" per ACR • Removed the following as current evidence no longer supports the indication: ▪ Combination studies as they are redundant ▪ "Limp or refusal or walk" as it in regards to a child whose age is 5 years or less and this is redundant with earlier indication ▪ NCD 220.1 as there are no clinical indications for MRI ▪ "Pediatric demyelinating disease" from under "Isolated back pain" per ACR ▪ "Prior MRI Lumbar Spine is non-diagnostic or indeterminate" as it is too broad

MRI Lumbar Spine Procedure Codes

Table 1. MRI Lumbar Spine Associated Procedure Codes

CODE	DESCRIPTION
72148	Magnetic resonance (eg, proton) imaging, spinal canal and contents, lumbar; without contrast material
72149	Magnetic resonance (eg, proton) imaging, spinal canal and contents, lumbar; with contrast material(s)
72158	Magnetic resonance (eg, proton) imaging, spinal canal and contents, without contrast material, followed by contrast material(s) and further sequences; lumbar
0649T	Quantitative magnetic resonance for analysis of tissue composition (eg, fat, iron, water content), including multiparametric data acquisition, data preparation and transmission, interpretation and report, obtained with diagnostic MRI examination of the same anatomy (eg, organ, gland, tissue, target structure); single organ

MRI Lumbar Spine Definitions

Abscess is a swollen area within body tissue, containing an accumulation of pus.
Acute disseminated encephalomyelitis (ADEM) is an immune-mediated demyelinating disorder of the central nervous system characterized by acute onset of widespread inflammation, polyfocal neurologic deficits, and encephalopathy, often following an infection.
Ankylosing spondylosis (spondylitis) is a chronic inflammatory disease that affects the spine, sacroiliac joints and often other joints (such as the shoulder), and is marked by pain and stiffness.
Behcet's disease is a chronic, relapsing systemic vasculitis characterized by recurrent oral and genital ulcers, uveitis, and various other systemic manifestations.

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Bone scan is a nuclear imaging procedure that examines the bones in the skeleton. It can help diagnose and track bone diseases, and can also be used to monitor the progress of certain treatments.

Cauda equina syndrome is a neurologic emergency caused by compression of the nerve roots in the lumbar spine, leading to symptoms such as bowel and bladder dysfunction, saddle anesthesia, and varying degrees of motor and sensory loss in the lower extremities.

Cerebrospinal fluid (CSF) is a colorless liquid that is comparable to serum, is secreted from the blood into the lateral ventricles of the brain, and serves chiefly to maintain uniform pressure within the brain and spinal cord.

Cerebrospinal fluid (CSF) leak is a leak of cerebrospinal fluid that results from a hole or tear in the dura (the outermost layer of the meninges).

Cerebrospinal fluid (CSF) rhinorrhea is a condition where the fluid that surrounds the brain leaks into the nose and sinuses.

Chiari malformation (Arnold-Chiari syndrome) is a congenital abnormality in which the lower surface of the cerebellum and the lower brain stem protrude into the spinal canal through the foramen magnum.

Compression is reducing in size, quantity or volume, as if by squeezing.

Compression fracture is a break in the vertebrae and can cause the vertebrae to collapse, making them shorter.

Computed tomography (CT) is an imaging test that uses X-rays to computer analysis to generate cross sectional images of the internal structures of the body that can be displayed in multiple planes.

Conservative management is an approach to treating pain utilizing non-surgical treatments that are both passive **AND** active, for a designated time (usually 4 to 6 weeks). Passive conservative management includes acupuncture, braces, ice/heat, injections, medications (NSAIDS, Tylenol). Active conservative management includes physical therapy (PT) program, supervised by a licensed physical therapist and/or osteopathic manipulative medicine (OMT) or chiropractic care.

C-reactive protein (CRP) is a pentameric protein synthesized by the liver, whose level rises in response to inflammation.

Dermatome is a skin area that receives sensory innervation from a single spinal nerve dorsal root.

Diffuse idiopathic skeletal hyperostosis (DISH) is a condition that causes ligaments to become calcified and hard. It usually affects the ligament around the spine, but it can also affect other areas of the body where ligaments join to bone.

Discitis is an uncommon primary infection of the vertebral disc, specifically the nucleus pulposus, often involving the cartilaginous end plate and vertebral body, and is most commonly caused by Staphylococcus aureus.

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Drop metastases are intradural extramedullary spinal metastases that arises from intracranial lesions.

Electromyogram (EMG) is a diagnostic test that measures the electrical activity of muscles at rest and during contraction using a needle electrode inserted into the muscle.

Erythrocyte sedimentation rate (ESR) is a blood test that measures the rate at which red blood cells settle at the bottom of a test tube over one hour, indicating the presence of inflammation in the body.

Fistula is an abnormal connection between two epithelialized surfaces, often involving organs such as the gut, bladder, vagina, or skin, and can result from various causes including surgery, trauma, Crohn's disease, diverticular disease, or malignancy.

Glasgow Coma Scale (GCS) is a clinical tool used to assess a patient's level of consciousness, particularly after traumatic brain injury (TBI). The GCS evaluates three aspects of responsiveness: eye opening, verbal response, and motor response. Scores range from 3 to 15, with higher scores indicating better neurological function.

Gelling, also known as the "gelling phenomenon", occurs after shorter periods of inactivity, such as sitting or resting during the day. It's caused by synovial fluid thickening and becomes gel-like when joints aren't moving. This makes it harder for the joints to move, but the fluid returns to normal once movement is started again.

Human Immunodeficiency Virus (HIV) is a retrovirus that primarily infects CD4+ T lymphocytes, leading to progressive immunodeficiency and potentially resulting in AIDS.

Indeterminate findings are inconclusive or insufficient for treatment planning.

Kyphosis is the exaggerated outward curvature of the thoracic region of the spine resulting in a rounded upper back.

Leptomeningeal carcinomatosis is a severe complication of late-stage cancer characterized by the spread of malignant cells to the leptomeninges, including the pia mater, arachnoid, and subarachnoid space, leading to rapid mortality despite treatment.

Magnetic resonance imaging (MRI) is a non-invasive diagnostic technique that produces computerized images of internal body tissues and is based on nuclear magnetic resonance of atoms within the body induced by the application of radio waves.

Malaise is an indefinite feeling of debility or lack of health often indicative of or accompanying the onset of an illness.

Metastases is the spread of a disease-producing agency (such as cancer cells) from the initial or primary site of disease to another part of the body.

Myelogram is a radiographic visualization of the spinal cord after injection of a contrast medium into the spinal subarachnoid space.

Nerve conduction study (NCS) is a test that measures how fast an electrical impulse moves through the nerve and can identify nerve damage.

Neurocutaneous disorders are disorders that affect the brain, spinal cord, organs, skin and bones. The diseases are lifelong conditions that can cause tumors to grow in these areas.

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Neurological deficits are abnormalities or impairments in the function of the brain, spinal cord, or nerves, resulting in a loss or reduction of specific neurological functions.
Non-diagnostic is a result that does not lead to a confirmed diagnosis.
Orthostatic headache is a headache while upright, that is relieved by lying down.
Osteomyelitis is an infectious, inflammatory disease of bone. It is often painful, bacterial in origin and may result in the death of bone tissue.
Otorrhea is drainage of liquid from the ear.
Pars defect, also known as spondylolysis, is a stress fracture or defect in the pars interarticularis of the vertebra, commonly affecting the lower lumbar spine.
Pars interarticularis is a segment of bone located between the superior and inferior articular processes of the vertebrae, most commonly in the lumbar spine.
Pediatric approximate ages are defined by the US Department of Health (USDH), the Food and Drug Administration (FDA), and the American Academy of Pediatrics (AAP) as the following:

1. Infancy, between birth and 2 years of age
2. Childhood, from 2 to 12 years of age
3. Adolescence, from 12 to 21 years of age, further defined by the AAP into:
    a. Early (ages 11–14 years)
    b. Middle (ages 15–17 years),
    c. Late (ages 18–21 years)
    d. Older ages may be appropriate for children with special healthcare needs.

Pes cavus, also known as cavus foot, is an orthopedic condition that causes the foot's arch to be abnormally high and unable to flatten.
Proprioception is the perception or awareness of the position and movement of the body.
Radiculopathy is an irritation of or injury to a spinal nerve root (as from being compressed) that typically causes pain, numbness or muscle weakness in the part of the body which is supplied with nerves from that root.
Recurrence is a new occurrence of something that happened or appeared before.
Rheumatoid arthritis (RA) is an autoimmune disease (usually chronic) that is characterized by pain, stiffness, inflammation, swelling and sometimes destruction of the joints.
Sacral dimple is a small indentation or pit in the skin located on the lower back, typically above the crease between the buttocks. It is a congenital condition, meaning it's present at birth. Most sacral dimples are harmless and do not require treatment. However, in some cases, they can be associated with underlying spinal or spinal cord abnormalities, especially if they are large, accompanied by other skin abnormalities or have other unusual features.
Rhinorrhea is excessive mucous drainage from the nose.

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Sarcoidosis is a chronic disease of unknown cause, that is characterized by the formation of nodules, especially in the lymph nodes, lungs, bones and skin.
Sciatica is pain along the course of a sciatic nerve, especially in the back of the thigh, lower back, buttocks, hips or adjacent parts.
Scoliosis is a sideways curvature of the spine.
Short segment is a curve in the spinal column that is less than 6 segments.
Single-photon emission computed tomography (SPECT) is a nuclear imaging test that uses a radioactive substance and a special camera to create 3D images of the body's organs, tissue and bones. The images show how blood flows to tissues and organs.
Spinal dysraphism is a congenital abnormality that results in an abnormal structure in the spine, including the bony structure, the spinal cord and the nerve roots.
Spondylarthropathy is an inflammatory arthritis affecting the spine.
Spondylolisthesis is the forward displacement of a vertebra on the one below it and especially of the fifth lumbar vertebra on the sacrum producing pain by compression of nerve roots.
Spondylolysis is a stress fracture of the bones of the lower spine due to overuse.
Spontaneous intracranial hypotension (SIH) is a condition characterized by cerebrospinal fluid (CSF) hypovolemia due to a noniatrogenic spinal CSF leak, often presenting with orthostatic headache.
Staging in cancer is the process of determining how much cancer is within the body (tumor size) and if it has metastasized (spread).
Stigmata is a mental or physical mark that indicates a disease or defect. It can also refer to a specific diagnostic sign of a disease.
Surveillance in cancer is the ongoing, timely and systematic collection and analysis of information on new cancer cases, extent of disease, screening tests, treatment, survival and cancer deaths.
Tethered spinal cord syndrome (TSCS) is a disorder of the nervous system caused by tissue that attaches itself to the spinal cord and limits the movement of the spinal cord.

MRI Lumbar Spine References

[1] Balani, A., Sidpra, J., . . . Mankad, K. (2024). *International Consensus Statement on the Radiological Evaluation of Dysraphic Malformations of the Spine and Spinal Cord*. *American Journal of Neuroradiology*, 1-20.
[2] Beckmann, N.M., West, O.C., . . . Bykowski, J. (2019). ACR Appropriateness Criteria Suspected Spine Trauma. *Journal of the American College of Radiology, 16*(5S), S264-S285.

© Copyright 2024 WNS (Holdings) Ltd.

[3] Bergsland, E., Rose, J.B., . . . Zhen, D.B. (2025). Neuroendocrine and Adrenal Tumors Version 2.2025. *National Comprehensive Cancer Network*. Retrieved: June 2025. https://www.nccn.org/professionals/physician_gls/pdf/neuroendocrine.pdf

[4] Bernard, S.A., Kransdorf, M.J., . . . Weissman, B.N. (2017). ACR Appropriateness Criteria Chronic Back Pain Suspected Sacroiliitis-Spondyloarthropathy. *Journal of the American College of Radiology, 14*(5S), S62-S70.

[5] Bestic, J.M., Wessell, D.E., . . . Kransdorf, M.J. (2020). ACR Appropriateness Criteria Primary Bone Tumors. *Journal of the American College of Radiology, 17*(5S), S226-S238.

[6] Bierman, J.S., Hirbe, A., . . . Wustrack, R.L. (2025). Bone Cancer Version 2.2025. *National Comprehensive Cancer Network*. Retrieved: June 2025. https://www.nccn.org/professionals/physician_gls/pdf/bone.pdf

[7] Booth, T.N., Iyer, R.S., . . . Palasis, S. (2017). ACR Appropriateness Criteria Back Pain—Child. *Journal of the American College of Radiology, 14*(5), S13-S24.

[8] Bullock, L., Thompson, K. & Spector. L. (2022) Cauda Equina Syndrome. *The Orthopedic Clinics of North America, 53*(2), 247-254.

[9] Carpenter, J.P., Litt, H. & Gowda, M. (2023). Magnetic Resonance Imaging and Arteriography. A.N. Sidawy (Eds.). *Rutherford's Vascular Surgery and Endovascular Therapy* (30). (pp. 336-394.e4). Philadelphia, PA: Elsevier.

[10] Chung, C. & Shimer, A. (2021). Lumbosacral Spondylolysis and Spondylolisthesis. *Clinics in Sports Medicine, 40*(3), 123-145.

[11] Czuczman, G.J., Mandell, J.C., . . . Beaman, F.D. (2021). ACR Appropriateness Criteria Inflammatory Back Pain: Known or Suspected Axial Spondyloarthritis: 2021 Update. *Journal of the American College of Radiology, 18*(11S), S340-S360.

[12] Das, S., Stone, L, . . . Kellym, M. (2023) Spine Deformity Associated with Chiari I Malformation and Syringomyelia. *Neurosurgery Clinics of North America, 34*(1), 151-157.

[13] Diehn, F.E. & Krecke, K.N. (2021). Neuroimaging of Spinal Cord and Cauda Equina Disorders. *Continuum, 27*(1), 225-263.

[14] Dobrocky, T., Nicholson, P., . . . Piechowiak, E.I. (2022). Spontaneous intracranial hypotension: searching for the CSF leak. *The Lancet Neurology, 21*(4), 269-380.

[15] Gupta, S.K., Ya'qoub, L., . . . Saeed, I.M. (2020). Safety and Clinical Impact of MRI in Patients with Non–MRI-conditional Cardiac Devices. *Radiology: Cardiothoracic Imaging, 2*(5), e200086.

[16] Hutchins, T.A., Peckham, M., . . . Corey, A.S. (2021). ACR Appropriateness Criteria Low Back Pain: 2021 Update. *Journal of the American College of Radiology, 18*(11S), S361-S379.

[17] Jones, J.Y., Saigal, G., . . . Karmazyn, B. (2019). ACR Appropriateness Criteria Scoliosis-Child. *Journal of the American College of Radiology, 16*(5), S244-S251.

[18] Kadom, N., Palasis, S., . . . Karmazyn, B. (2019). ACR Appropriateness Criteria Suspected Spine Trauma-Child. *Journal of the American College of Radiology, 16*(5), S286-S299.

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[19] Kasch, R., Truthmann, J., . . . Schmidt, C.O. (2022). Association of Lumbar MRI findings with current and future Back pain in a population-based cohort study. *Spine, 47*(3), 201-211.
[20] Khan, M.A., Jennings, J.W., . . . Burns, J. (2023). ACR Appropriateness Criteria Management of Vertebral Compression Fractures: 2022 Update. *Journal of the American College of Radiology, 20*(5), S102-S124.
[21] Linton, A.A. & Hsu, W.K. (2022). A Review of Treatment for Acute and Chronic Pars Fractures in the Lumbar Spine. *Current Reviews in Musculoskeletal Medicine, 15*(4), 259-271.
[22] Maralani, P.J., Schieda, N., . . . Weinreb, J. (2020). MRI safety and devices: An update and expert consensus. *Journal of Magnetic Resonance Imaging, 51*(3), 657-674.
[23] Nabors, L.B., Portnow, J., . . . Willmarth, N.E. (2025). Central Nervous System Cancers Version 1.2025. *National Comprehensive Cancer Network*. Retrieved: June 2025. https://www.nccn.org/professionals/physician_gls/pdf/cns.pdf
[24] Ortiz, A.O., Levitt, A., . . . Corey, A.S. (2021). ACR Appropriateness Criteria Suspected Spine Infection. *Journal of the American College of Radiology, 18*(11S), S488-S501.
[25] Pindrik, J., McAllister, A.S. & Jones, J.Y. (2022). Imaging in Chiari I Malfomation. *Neurosurgery Clinics of North America, 34*(1), 67-79.
[26] Rosenblum, J.S., Pomeraniec, I.J. & Heiss, J.D. (2022). Chiari malformation (update on diagnosis and treatment). *Neurologic Clinics, 40*(2), 297-307.
[27] Stevenson, M.M., Bowles, D.W., . . . Wang, S. (2025). Occult Primary Version 2.2025. *National Comprehensive Cancer Network*. Retrieved: February 2025. https://www.nccn.org/professionals/physician_gls/pdf/occult.pdf
[28] Tam, S.K.P., Chia, J.M., . . . Foroughi, M. (2022). Assessment of patients with a Chiari malformation type I. *Brain and Spine*, *2*, 100850.
[29] Witte, D.H. (2021). Advanced Imaging in Orthopaedics. F.M. Azar & J.H. Beaty (Eds.). *Campbell's Operative Orthopaedics* (14), (pp. 141-176). Philadelphia, PA: Elsevier.

Disclaimer section

Purpose

The purpose of the HealthHelp's clinical guidelines is to assist healthcare professionals in selecting the medical service that may be appropriate and supported by evidence to safely improve outcomes. Medical information is constantly evolving, and HealthHelp reserves the right to review and update these clinical guidelines periodically. HealthHelp reserves the right to include in these guidelines the clinical indications as appropriate for the organization's program objectives. Therefore the guidelines are not a list of all the clinical indications for a stated procedure, and associated Procedure Code Tables may not represent all codes available for that state procedure or that are managed by a specific client-organization.

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Clinician Review

These clinical guidelines neither preempt clinical judgment of trained professionals nor advise anyone on how to practice medicine. Healthcare professionals using these clinical guidelines are responsible for all clinical decisions based on their assessment. All Clinical Reviewers are instructed to apply clinical indications based on individual patient assessment and documentation, within the scope of their clinical license.

Payment

The use of these clinical guidelines does not provide authorization, certification, explanation of benefits, or guarantee of payment; nor do the guidelines substitute for, or constitute, medical advice. Federal and State law, as well as member benefit contract language (including definitions and specific contract provisions/exclusions) take precedence over clinical guidelines and must be considered first when determining eligibility for coverage. All final determinations on coverage and payment are the responsibility of the health plan. Nothing contained within this document can be interpreted to mean otherwise.

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National and Local Coverage Determination (NCD and LCD)

NOTICE
To ensure appropriate review occurs to the most current NCD and/or LCD, always defer to https://www.cms.gov/medicare-coverage-database/search.aspx.

Background

National Coverage Determinations (NCD) and Local Coverage Determinations (LCD) are payment policy documents outlined by the Centers for Medicare and Medicaid Services (CMS) and the government's delegated Medicare Audit Contractors (MACs) that operate regionally in jurisdictions.

CMS introduced variation between different jurisdictions/Medicare Audit Contractors (MACs) and their associated covered code lists with the transition to ICD 10. The variation resulted in jurisdictions independently defining how codes are applied for exclusions, limitations, groupings, ranges, etc. for the medical necessity indications outlined in the NCD and LCD. Due to this variation, there is an inconsistent use/application of codes and coverage determinations across the United States between the different MACs.

In addition, **WITHOUT** notice, CMS can change the codes that indicate medical necessity and the format of the coverage determinations/associated documents (eg, Articles). This is an additional challenge for organizations to keep up with ongoing, unplanned changes in covered codes and medical necessity indications.

Medical Necessity Codes

Due to the variation in code application between jurisdictions/MACs and that updates can happen without notification, HealthHelp is not able to guarantee full accuracy of the codes listed for any Coverage Determination, and advises that prior to use, the associated Coverage Determination Articles are reviewed to ensure applicability to HealthHelp's programs and any associated NCDs and LCDs.

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