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2025 Magnetic Resonance Imaging (MRI) Pelvis

Diagnostic Imaging

MRI-Pelvis-HH

Last Review Date: 05/21/2025
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Guideline Initiated: 06/30/2019

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Magnetic Resonance Imaging (MRI) Pelvis

MRI Pelvis 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 35391	Multiple Imaging in Oncology

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 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: [32] [15] [25]

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.

MRI Pelvis Guideline

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

[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.

(*__NOTE__: *Aneurysm for diagnosis and monitoring is completed with computed tomography [CT] angiography [CTA] or magnetic resonance angiography [MRA] See CTA or MRA Abdomen and Pelvis guidelines*)

References: [16] [20]

1. Cancer is known, limited to the pelvis and **EITHER** of the following:
    a. Initial diagnosis for staging and metastasis evaluation
    b. Surveillance (*Follow the NCCN surveillance. See **Surveillance** section below*)

    References: [21] [27] [19]
2. Infection or inflammatory disease, limited to the pelvis, is suspected or known, CT is **contraindicated or unavailable** and **ANY** of the following:
    a. Crohn's disease, pancreatitis, pyelonephritis or ulcerative colitis complication evaluation and symptoms are persistent (eg, cramping, diarrhea, pain).
    b. Inflammatory disease or peritonitis is suspected, for diagnosis.

    References: [22] [29] [35]
3. Lumbosacral plexus pathology is suspected or known for **ANY** of the following:
    a. MRI of the lumbar spine is non-diagnostic or indeterminate.
    b. Masses are suspected, symptoms are persistent **AND** unilateral changes are present **OR** electromyography (EMG) is non-diagnostic or indeterminate.
    c. Tumor is known and symptomatic (eg, pain, swelling).
    d. Trauma is known, for follow-up.

    References: [14]
4. Pain in the pelvis is known, with unknown diagnosis/etiology, and **ANY** of the following:
    a. CT is **contraindicated or unavailable** and **ANY** of the following:
        i. Age is over 65 years old **AND** pelvic pain is acute.
        ii. Initial workup is non-diagnostic or indeterminate. (***NOTE:** *initial workup must include: imaging [eg, ultrasound], laboratory testing [eg, CBC, chemistry, urinalysis])*
    b. Hip pain is acute, **AFTER** fall or minor trauma, X-rays are negative and fracture is suspected.
    c. Pediatric individual and initial workup is non-diagnostic or indeterminate. (***NOTE:** *initial workup must include: imaging [eg, ultrasound], laboratory testing [eg, CBC, chemistry, urinalysis])*

References: [40] [41] [52] [26] [39] [33]

5. Post-surgical assessments for evaluation of complications or disease recurrence.
6. Prior pelvic ultrasound is non-diagnostic or indeterminate.
7. Renal pathologies (hematuria, renal colic, complicated UTI) are suspected and ultrasound is non-diagnostic or indeterminate. (*__NOTE__: *use CT urography for hematuria evaluation and kidney stone complications.*)
   References: [24] [49]
8. Small bowel bleeding when endoscopy is non-diagnostic or indeterminate. (**NOTE**: *Use CT enterography [CTE]*)
   References: [28]
9. Trauma, blunt, to the pelvis is known, complications are suspected and CT is **contraindicated or unavailable.**
   References: [44]
10. Weight loss occurred and is unintentional and unexplained (more than 10% of body weight in 2 months or more than 5% of body weight in 6 months) and CT is **contraindicated or unavailable**.
    References: [36]

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*)

Blood/Bone Marrow Cancers Surveillance section

Acute Lymphoblastic Leukemia Surveillance

Acute lymphoblastic leukemia: No imaging surveillance suggested.
References: [2024 Acute Lymphoblastic Leukemia Version 3.2024]

Acute Myeloid Leukemia Surveillance reuse

Blastic plasmacytoid dendritic cell neoplasm surveillance includes a repeat PET/CT for individuals with prior evidence of extramedullary disease.
References: [37]

Chronic Lymphocytic Leukemia/Small Cell Lymphocytic Lymphoma Surveillance

Chronic lymphocytic leukemia/small cell lymphocytic lymphoma: No imaging surveillance suggested.
References: [53]

Chronic Myeloid Leukemia Surveillance

Chronic Myeloid Leukemia: No imaging surveillance suggested.
References: [43]

Hairy Cell Leukemia Surveillance

Hairy cell leukemia: No imaging surveillance suggested.
References: [2025 Hairy Cell Leukemia Version 1.2025]

Multiple Myeloma Surveillance

Multiple myeloma surveillance includes **ANY** of the following:

1. Multiple myeloma, surveillance imaging when recurrence is suspected with **ANY** of the following:
    a. CT scan, low dose
    b. FDG PET/CT
    c. MRI (- contrast material), whole-body
2. Smoldering myeloma, surveillance imaging annually (or more often when recurrence is suspected) with **ANY** of the following:
    a. CT scan, low dose
    b. FDG PET/CT
    c. MRI (- contrast material), whole-body

References: [2025 Multple Myeloma Version 2.2025]

Pelvis Surveillance Section

Anal Cancer Surveillance

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

1. Complete remission, when local or inguinal node recurrence is suspected and **EITHER** of the following: (**NOTE**: *FDG-PET/CT scan is **NOT** indicated*)

a. Chest, abdomen and pelvis CT (+ contrast) and abdomen and pelvis MRI (+ contrast), annually for 3 years

b. Chest CT (- contrast) and abdomen and pelvis MRI (+ contrast), annually for 3 years

2. Peri-anal cancer, with biopsy proven squamous cell carcinoma surveillance with **BOTH** of the following: (**NOTE**: *FDG-PET/CT scan is **NOT** indicated*)

a. Chest, abdomen and pelvis CT (+ contrast) and abdomen and pelvis MRI (+ contrast), annually for 3 years

b. Chest CT (- contrast) and abdomen and pelvis MRI (+ contrast), annually for 3 years

3. Persistent disease surveillance as follows:

a. Chest, abdomen and pelvis CT (+ contrast) and abdomen and chest MRI (+ contrast), annually for 3 years

b. Chest CT (- contrast), abdomen and pelvis MRI (+ contrast), annually for 3 years

4. Progressive disease is biopsy proven, locally recurrent for restaging and **EITHER** of the following:

a. Chest, abdomen and pelvis CT (+ contrast) and abdomen and chest MRI (+ contrast), annually for 3 years

b. Chest CT (- contrast) and abdomen and chest MRI (+ contrast), annually for 3 years

References: [2025 Anal Carcinoma Version 3.2025]

Bladder Cancer Surveillance

Bladder cancer imaging surveillance includes **ANY** of the following:

1. Metastatic disease surveillance includes **ANY** of the following:

a. Computed tomography urography (CTU) or magnetic resonance urography (MRU); follow-up every 3 to 6 months **AND** when symptoms are new or changing.

b. CT chest, abdomen and pelvis; follow-up every 3 to 6 months **AND** when symptoms are new or changing. (*__NOTE__: *FDG positron emission tomography/ computed tomography (PET/CT) for category 2B*)

2. Muscle invasive bladder cancer (MIBC) and upper tract (greater then or equal to T2 disease) surveillance includes **ANY** of the following:

a. Abdominal and pelvic imaging and **ANY** of the following:

i. Abdomen and pelvis CT/MRI/FDG-PET imaging every 3 to 6 months for 2 years, then annually for up to 5 years and then clinically as indicated

ii. FDG PET/CT for category 2B, if **NOT** previously completed

iii. FDG PET/CT when high risk and metastatic disease is suspected. (*__NOTE__: *Use for biopsy guidance and should **NOT** be used to delineate the anatomy of the upper urinary tract.*)

b. Chest imaging for follow-up, with or **WITHOUT** cystectomy **OR** cT4b disease and **ANY** of the following:

i. Chest CT (± contrast); Use as a single exam when abdomen and pelvis imaging is needed.

ii. FDG PET/CT for category 2B, if **NOT** previously completed

iii. FDG PET/CT when high risk and metastatic disease is suspected. (*__NOTE__: *Use help guide biopsy*)

c. Post-bladder sparing (eg, chemoradiation or partial cystectomy) or post-cystectomy follow-up and **ANY** of the following:

i. Years 1 and 2 and **ALL** of the following:

A. Chest CT; every 3 to 6 months

B. CTU or MRU; every 3 to 6 months

C. FDG PET/CT for category 2B **ONLY** when metastatic disease is suspected; every 3 to 6 months.

ii. Years 3 to 5 and **ALL** of the following:

A. Abdominal and pelvis CT or MRI, annually

B. Chest CT; annually

C. FDG PET/CT for category 2B **ONLY** when metastatic disease is suspected; annually.

3. Non-muscle invasive bladder cancer (NMIBC) and upper tract (less than or equal to T1 disease) surveillance includes **ANY** of the following:

a. Low-risk and intermediate risk NMIBC: CT/MRI imaging at baseline of abdomen/ pelvis and then as clinically indicated

b. High-risk NMIBC: Imaging of upper tract baseline, then every 1 to 2 years through year 10 then as clinically indicated thereafter

c. Post-cystectomy NIMBC; follow-up with CTU or MRU at 3 months and 12 months, then annually through year 5

4. Urothelial carcinoma of the prostate **OR** primary carcinoma of the urethra and **ANY** of the following:
    a. Low risk T1 or less than T1 disease: MRI or CT of pelvis (± contrast)
    b. High risk T1 or T2 or higher disease chest CT **AND** MRI or CT of the abdomen and pelvis: every 3 to 6 months for 2 years and then annually

References: [17]

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
    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: [13]

Cervical Cancer Surveillance

Cervical cancer surveillance includes **ANY** of the following: (*__NOTE__: *if first post-treatment imaging is non-diagnostic or indeterminate, consider repeating in 3 months*)

1. Stage I cervical cancer and **ANY** of the following:
    a. Fertility sparing, pelvic magnetic resonance imaging (MRI) (+ contrast); follow-up 6 months after surgery and then annually for 2 to 3 years
    b. Non-fertility sparing, stage IB3 or high risk factors requiring post-operative adjuvant radiation or chemotherapy follow-up with positron emission tomography/ computed tomography (PET/CT) (abdomen, chest, groin, neck, pelvis) 3 to 6 months after completion of treatment. Imaging is based on symptomatology and clinical concern for recurrent/metastatic disease.
2. Stage II to IV cervical cancer and **ANY** of the following:
    a. PET/CT of the abdomen, chest, groin, neck and pelvis **OR** CT of the abdomen, chest and pelvis; follow-up 3 to 6 months after completion of therapy.
    b. MRI (+ contrast) of the pelvis; follow-up 3 to 6 months after completion of therapy
    c. Other imaging should be based on symptomatology and clinical concern for recurrent/metastatic disease.
3. Stage IVB or recurrence; follow-up imaging as appropriate (CT, MRI, or FDG-PET/CT) to assess response or to determine further therapy. (**NOTE**: *If first post-treatment FDG-PET/CT is indeterminate, then consider repeating in 3 months.)*
4. Suspected recurrence or metastasis and **ANY** of the following:
    a. Neck, chest, abdomen, pelvis, groin FDG-PET/CT
    b. MRI (+ contrast) of the pelvis

References: [1]

Colon Cancer Surveillance

Colon cancer surveillance includes **ANY** of the following: (*__Note__: *Routine computed tomography [CT] scanning are **NOT** recommended beyond 5 years.*)

1. Stage II or III disease surveillance includes CT chest, abdomen and pelvis every 6 to 12 months from date of surgery, for a total of 5 years. (**NOTE**: *PET/CT is **NOT** indicated*.)
2. Stage IV disease surveillance includes CT chest, abdomen and pelvis every 3 to 6 months for 2 years, then every 6 to 12 months for a total of 5 years. (**NOTE**: *PET/CT is **NOT** indicated*.)

References: [2025 Colon Cancer Version 3.2025]

Gestational Trophoblastic Neoplasia Surveillance reuse

Gestational trophoblastic neoplasia surveillance for intermediate trophoblastic tumor (placental site trophoblastic tumor [PSTT] or epithelioid trophoblastic tumor [ETT]), after treatement includes FDG-PET/CT (whole body) at the completion of chemotherapy and then FDG-PET/CT or CT chest, abdomen and pelvis every 6 to 12 months for 2 to 3 years.
References: [2]

Mesothelioma: Peritoneal Surveillance

Mesothelioma: peritoneal surveillance includes CT chest **AND** CT or MRI abdomen and pelvis every 3 to 6 months for 5 years then annually.
References: [2025 Mesothelioma: Peritoneal Version 2.2025]

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]**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).

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.
    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

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

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.

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 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.

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

iv. More than 10 years, then as clinically indicated

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: [46]

Ovarian, Fallopian Tube or Primary Peritoneal Cancers Surveillance

Ovarian, fallopian tube or primary peritoneal cancer surveillance includes **ALL** of the following:

1. Malignant germ cell/sex cord-stromal tumor surveillance for **ANY** of the following:

a. Malignant germ cell tumors surveillance with chest/abdomen/pelvis CT every 3 months for years 1 and 2, every 6 to 12 months for year 3, then clinically as indicated.

b. Malignant sex cord-stromal tumors surveillance when symptomatic (eg, abdominal distention, pain, uterine bleeding), biomarkers are elevated or physical exam demonstrates suspicious findings.

2. Stage I through IV, primary treatment was received; follow-up imaging if symptoms are new or progressing.

References: [2025 Ovarian, Fallopian Tube or Primary Peritoneal Cancers Version 2.2025]

Penile Cancer Surveillance

Penile cancer surveillance when there is lymph node involvement, includes **ANY** of the following:

1. Classification pN0, N1 imaging with CT abdomen and pelvis every 6 months for the first 2 years, then every 12 months in years 3 and 4.
2. Classification pN2, N3 imaging with CT abdomen and pelvis **and** chest CT every 3 months in year 1, then every 6 months in years 2 to 4.
3. Inguinal region surveillance with CT (+ contrast) or MRI (+ contrast)

References: [18]

Prostate Cancer Surveillance

Prostate cancer active surveillance candidates repeat multiparametric MRI (mpMRI) pelvis every 12 months (or longer) when life expectancy is longer than 10 years
Active surveillance includes **ALL** of the following:

1. Prostate specific antigen (PSA) every 6 months or more
2. Digital rectal exam every 12 months or more
3. Repeat prostate biopsy every 2 to 5 years, but **NO** more often than 12 months or more
4. Repeat mpMRI pelvis every 12 months or more

Active surveillance candidates must have the following:

1. Life expectancy is 10 years or more.
2. Prostate cancer classification is very-low-risk, low risk or favorable intermediate-risk

References: [2025 Prostate Cancer Version 2.2025]

Rectal Cancer Surveillance

Rectal cancer surveillance includes **ANY** of the following: (*__NOTE__: *Routine CT scanning is **NOT** recommended beyond 5 years*.)

1. Non-operative management surveillance imaging includes **ALL** of the following:
    a. Computed tomography (CT) chest and abdomen every 6 to 12 months for a total of 5 years (*__NOTE__: *CT pelvis is included once MRI rectum has been exhausted*.)
    b. Magnetic resonance imaging (MRI) rectum every 6 months for up to 3 years
2. Operative management surveillance imaging includes **ANY** of the following:
    a. Endoscopic submucosal dissection (ESD) surveillance pelvis MRI (+ contrast) every 3 to 6 months for 2 years, then every 6 month up to year 5.
    b. Stage II and III surveillance imaging includes **ALL** of the following:
        i. Chest, abdomen and pelvis CT every 6 to 12 months for a total of 5 years.
        ii. Fluorodeoxyglucose-positron emission tomography (FDG-PET)/computed tomography (CT) is **NOT** recommended.
    c. Stage IV surveillance imaging includes **ALL** of the following:
        i. Chest, abdomen and pelvis CT every 3 to 6 months for 2 years, then every 6 to 12 months for a total of 5 years.
        ii. FDG-PET/CT scan is **NOT** recommended.
    d. Transanal local excision only, surveillance imaging includes pelvis MRI (+ contrast), every 3 to 6 months for the first 2 years, then every 6 months for a total of 5 years.

References: [2025 Rectal Cancer Version 2.2025]

Small Bowel Adenocarcinoma Surveillance

Small bowel adenocarcinoma surveillance (duodenum and jejunum/ilium) includes chest, abdominal and pelvic CT every 6 to 12 months for 2 years, then every 12 months for years 3 to 5. (*__NOTE__: *Fluorodeoxyglucose-positron emission tomography (FDG-PET)/computed tomography (CT) is **NOT** indicated.*)
References: [11]

Soft Tissue Sarcoma Surveillance

Soft tissue sarcoma surveillance includes **ANY** of the following: (*__NOTE__: *Use contrast imaging; for long term surveillance to minimize radiation exposure,MRI may be substituted.*)

1. Desmoid tumor (aggressive fibromatosis) imaging surveillance includes computed tomography (CT) or magnetic resonance imaging (MRI) every 3 to 6 months for 3 years, then every 6 to 12 months thereafter
2. Extremity, trunk or head and neck, for long-term follow-up with **ANY** of the following:
    a. Long-term follow-up with **ALL** of the following:
        i. Chest CT imaging (- contrast) to detect asymptomatic distant recurrence
        ii. MRI for imaging of primary site
    b. Stage I tumors and **ALL** of the following:
        i. Chest CT imaging (- contrast) every 6 to 12 months
        ii. Post-operative baseline and periodic imaging of primary site with MRI or CT if MRI is **contraindicated or unavailable**.
    c. Stage II and III tumors and **ANY** of the following:
        i. Baseline and periodic imaging of primary site
        ii. Chest and other known sites of metastatic disease imaging (CT [- contrast] or X-ray) every 2 to 6 months for 2 to 3 years, then every 6 months to complete a total of 5 years, then annually.
        iii. Post-operative reimaging to assess the primary tumor site and rule out metastatic disease (MRI or CT if MRI is **contraindicated or unavailable**.
3. Retroperitoneal/intra-abdominal, after management of primary disease imaging surveillance includes chest/abdomen/pelvis CT or MRI every 3 to 6 months for 3 years, then every 6 months for the next 2 years, then annually.

References: [51]

Testicular Cancer Surveillance

Testicular cancer surveillance includes **ANY** of the following: (*__NOTE__: *If a magnetic resonance imaging (MRI) is being considered instead of the abdomen/pelvis computed tomography [CT] [eg, CT **contraindicated**], MRI protocol should include **ALL** nodes needing assessment. The same imaging modality (CT or MRI) should be used throughout surveillance*.)

1. Nonseminoma stage I **WITHOUT** recurrence risk factors (eg, lymphovascular invasion, or an invasion spermatic cord or scrotum) for active surveillance with **ALL** of the following intervals:
    a. Abdomen ± pelvis CT (+ contrast) or MRI and the following intervals:
        i. 1st year every 4 to 6 months

ii. 2nd year every 6 months

iii. 3rd year annually

iv. 4th and 5th year as clinically indicated

b. Chest CT (+ contrast) (when thoracic symptoms are present) and the following intervals:

i. 1st year at 4 months and 12 months

ii. 2nd year, annually

iii. 3rd to 5th year, clinically as indicated

2. Nonseminoma stage I with recurrence risk factors (eg, lymphovascular invasion, or an invasion spermatic cord or scrotum) for active surveillance for **ALL** of the following:

a. Abdomen ± pelvis CT (+ contrast) or MRI and the following intervals:

i. 1st year every 4 months

ii. 2nd year every 4 to 6 months

iii. 3rd year every 6 months

iv. 4th year annually

v. 5th year clinically as indicated

b. Chest CT (+ contrast) (when thoracic symptoms are present) and the following intervals:

i. 1st year every 4 months

ii. 2nd year every 4 to 6 months

iii. 3rd year every 6 months

iv. 4th year annually

v. 5th year clinically as indicated

3. Nonseminoma stage IA/B after 1 cycle of adjuvant bleomycin, etopside, cisplatin (BEP) chemotherapy or primary retroperitoneal lymph node dissection (RPLND) surveillance and **ALL** of the following:

a. Abdomen ± pelvis CT (+ contrast) or MRI annually for the first 2 years, then clinically as indicated

b. Chest CT (+ contrast) (when thoracic symptoms are present) and the following intervals:

i. 1st year every 6 to 12 months

ii. 2nd year annually, then clinically as indicated

4. Nonseminoma stage II to III after complete response to chemotherapy ± post-chemotherapy RPLND surveillance for **ALL** of the following intervals:
   a. Abdomen ± pelvis CT (+ contrast) or MRI and the following intervals:
      i. 1st year every 4 to 6 months
      ii. 2nd year every 6 to 12 months
      iii. 3rd year annually
      iv. 4th and 5th year, clinically as indicated
   b. Chest CT (+ contrast) (when thoracic symptoms are present) and the following intervals:
      i. 1st year every 4 to 6 months
      ii. 2nd year every 6 to 12 months
      iii. 3rd to 5th years, clinically as indicated.
5. Nonseminoma pathologic stage IIA/B post primary RPLND and treated with adjuvant chemotherapy, surveillance with abdominal ± pelvic CT (+ contrast) or MRI 4 months after RPLND, then as clinically indicated, **AND** chest CT (+ contrast) (when thoracic symptoms are present) every 6 months for the 1st year then annually through year 5
6. Nonseminoma pathologic stage II A/B post-primary RPLND and **NOT** treated with adjuvant chemotherapy surveillance **ALL** of the following intervals:
   a. Abdomen ± pelvis CT (+ contrast) or MRI and the following intervals:
      i. 1st year, at 4 months
      ii. 2nd year annually with chest X-ray or chest CT (+ contrast) (when thoracic symptoms are present) every 3 to 6 months.
      iii. 3rd through 5th year clinically as indicated
   b. Chest CT (+ contrast) (when thoracic symptoms are present) and the following intervals:
      i. 1st year every 2 to 4 months
      ii. 2nd year every 3 to 6 months
      iii. 3rd through 5th year annually
7. Seminoma stage I surveillance after orchiectomy with chest CT (+ contrast) (for symptomatic patients), as clinically indicated **AND** abdomen ± pelvis CT (± contrast) or MRI (± contrast) for **ANY** of the following intervals:

a. 1st year, at 4 to 6 months and 12 months
b. 2nd year every 6 months
c. 3rd year, every 6 to 12 months
d. 4th and 5th year, every 12 to 24 months

8. Seminoma stage I seminoma surveillance after adjuvant treatment (chemotherapy or radiation) with chest CT (+ contrast) (in symptomatic patients) as clinically indicated **AND** abdomen ± pelvis CT (± contrast), annually for the first 3 years, then clinically as indicated for years 4 and 5

9. Seminoma stage IIA and non-bulky IIB seminoma surveillance after radiotherapy and/or post-chemotherapy with chest CT (+ contrast) (when thoracic symptoms are present) every 6 months for first 2 years, then clinically as indicated **AND** abdomen ± pelvis CT (+ contrast) or MRI and **ANY** of the following intervals:

a. 1st year, at 3 months and then 9 **OR** 12 months
b. 2nd and 3rdyear, annually
c. 4th and 5th year, clinically as indicated

10. Seminoma II, **NOT** treated with adjuvant chemotherapy and post-primary retroperitoneal lymph node dissection surveillance imaging with CT or MRI abdomen and pelvis and or chest CT (+ contrast) (when thoracic symptoms are present) and **ANY** of the following:

a. 1st year, every 4 months
b. 2nd year, every 6 months
c. 3rd year, annually
d. 4th and 5th year, clinically as indicated

11. Seminoma II, after adjuvant chemotherapy and post-primary retroperitoneal lymph node dissection surveillance imaging includes abdomen and pelvis CT or MRI and chest CT (+ contrast) (when thoracic symptoms are present) follow-up every 6 months for the 1st year, annually year 2, then clinically as indicated for years 3 to 5

12. Seminoma bulky stage IIB, IIC and III surveillance after chemotherapy, with for **ANY** of the following intervals: (***NOTE**: *Fluorodeoxyglucose (FDG) PET skull base to mid thigh as clinically indicated*)

a. CT or MRI of the abdomen and pelvis
    i. 1st year, every 4 months
    ii. 2nd year, every 6 months

iii. 3rd and 4th year, annually

iv. 5th year, clinically as indicated

b. Chest CT (+ contrast) (when thoracic symptoms are present) and the following intervals:

i. 1st year every 4 months

ii. 2nd year every 6 months

iii. 3rd to 5th year annually

13. Seminoma with residual mass larger than 3 cm, surveillance with a PET/CT scan from skull base to mid-thigh to delineate viable residual tumor (CT is **NOT** specific enough); if PET-negative following chemotherapy, surveillance with abdominal and pelvis CT (+ contrast) every 6 months for the 1st year, then annually thereafter.

References: [23]

Uterine Neoplasm Surveillance

Uterine neoplasm surveillance includes **ANY** of the following:

1. Endometrial carcinoma surveillance includes **ANY** of the following:
   a. Fertility-sparing treatment for **ANY** of the following:
      i. Pelvic ultrasound for individuals with ovarian preservation
      ii. Other imaging should be based on symptomatology and clinical concern for metastatic disease.
      iii. Repeat pelvic magnetic resonance imaging (MRI) for individuals with persistent endometrial carcinoma after 6 to 9 months of **FAILED** medical therapy (eg, chemotherapy, radiation), especially if considering further fertility-sparing approaches.
   b. Non–fertility-sparing treatment- Imaging should be guided by individual symptoms, risk assessment and clinical concern for recurrent or metastatic disease.
2. Uterine sarcoma surveillance imaging includes **ALL** of the following:
   a. Abdominal/pelvic MRI and chest CT (- contrast), every 3 to 6 months for the first 3 years, then every 6 to 12 months for the next 2 years. (*__NOTE__: *Depending on histology grade and initial stage, use annual to biannual imaging thereafter, for up to an additional 5 years*.)
   b. Chest/abdomen/pelvis computed tomography (CT) every 3 to 6 months for the first 3 years, then every 6 to 12 months for the next 2 years. (*__NOTE__: *Depending on*

histology grade and initial stage, use annual to biannual imaging thereafter, for up to an additional 5 years.)

c. Neck/chest/abdomen/pelvis/groin fluorodeoxyglucose (FDG)-positron emission tomography/CT (PET) if metastasis is suspected.

d. Additional imaging should be based on symptomatology and clinical concern for metastatic disease.

References: [3]

Vaginal Cancer Surveillance section

Vaginal cancer surveillance includes fluorodeoxyglucose-positron emission tomography/computed tomography (FDG-PET/CT) of the pelvis 3 to 4 months after completion of radiation therapy, repeat clinically as indicated (MRI is used if FDG-PET/CT is **contraindicated or unavailable** or non-diagnostic or indeterminate).

References: [4]

Vulvar Cancer Surveillance

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

1. Vulvar cancer surveillance includes **ANY** of the following:
    a. Computed tomography (CT) chest, abdomen and pelvis or fluorodeoxyglucose-positron emission tomography (FDG-PET)/CT neck, chest, abdomen, pelvis and groin if recurrence or metastasis is suspected.
    b. FDG-PET/CT or pelvis magnetic resonance imaging (MRI) at 3 to 6 months to assess treatment response after definitive primary treatment
2. Vulvovaginal melanoma surveillance includes **ANY** of the following:
    a. CT pelvis every 3 to 12 months
    b. FDG-PET/CT in cases of high-risk disease, every 3 to 12 months

References: [5]

MRI Pelvis Summary of Changes

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

Table 1. 2025 MRI Pelvis Summary of Changes

Date	Type of Change	Summary
05/21/2025	Annual	• Added the following to keep in line with current evidence: ▪ "Note: Aneurysm" per ACR ▪ "Prior pelvic ultrasound is non-diagnostic or indeterminate" as less advanced imaging is appropriate prior to MRI ▪ "Renal pathologies" per ACR ▪ "Small bowel bleeding" per ACR ▪ "Trauma, blunt" per ACR • Changed wording of Peri-procedural indication • Removed the following as current evidence no longer supports the evidence: ▪ "Aneurysm is suspected or known" as it is CTA/MRA is more appropriate. Note added for clarity, ▪ "Avascular necrosis (osteonecrosis) of the hip and/or pelvis is suspected or known" as it is covered by a later indication ▪ Combination studies as they are redundant ▪ "Congenital malformation of pelvis" as this falls under the "Prior pelvis ultrasound" indication ▪ Criteria under "Weight loss" as they are redundant ▪ "Defecatory outlet obstruction" as this falls under the "Prior pelvis ultrasound" indication ▪ "Diverticula of the urethra" as this falls under the "Prior pelvis ultrasound" indication ▪ "Edema of the lower extremities is diffuse," as this falls under the "Prior pelvis ultrasound" indication ▪ "Fever of unknown origin" as this falls under the "Prior pelvis ultrasound" indication ▪ "Fracture or injury is suspected" as this falls under the "Prior pelvis ultrasound" indication ▪ "Hernia is suspected or known" as this falls under the "Prior pelvis ultrasound" indication ▪ "Hip evaluation, bilateral" as less advanced imaging is more appropriate ▪ "May-Thurner syndrome" as this falls under the "Prior pelvis ultrasound" indication ▪ NCD 220.2 as it does not have clinical indications for MRI ▪ "Organ abnormality or enlargement" as this falls under the "Prior pelvis ultrasound" indication

Date	Type of Change	Summary

- "Pain with nerve pathology" as this falls under the "Prior pelvis ultrasound" indication
- "Pelvic congestion syndrome as this falls under the "Prior pelvis ultrasound" indication
- "Prior MRI pelvis imaging is non-diagnostic or indeterminate." as it is too broad
- "Reproductive pathology is suspected or known" as this falls under the "Prior pelvis ultrasound" indication
- "Retroperitoneal fibrosis" as this falls under the "Prior pelvis ultrasound" indication
- "Sacroiliac joint dysfunction" from under "Pain in the pelvic area" as this falls under the "Prior pelvis ultrasound" indication
- "Sacroiliitis (infection or inflammotry) is suspected" as this falls under the "Prior pelvis ultrasound" indication
- Under "Cancer"
  - "B symptoms" as it is too vague
  - "Paraneoplastic syndrome" due to lack of EBM
  - "Pelvic mass or tumor demonstrated by physical exam" as this falls under the "Prior pelvis ultrasound" indication
  - "Pelvic mass is suspected" as this falls under the "Prior pelvis ultrasound" indication
  - "Prostate cancer is suspected or known" as this falls under the "Prior pelvis ultrasound" indication
- Under "Infection or inflammatory disease is suspected"
  - "Diverticulitis" as this falls under the "Prior abdominal ultrasound" indication
  - "Pelvic infection is suspected with infection symptoms" as it is redundant
  - "Perianal fistula" as this falls under the "Prior abdominal ultrasound" indication
  - "Urethral stricture" as this falls under the "Prior abdominal ultrasound" indication
- "Urethral stricture abnormality" as this falls under the "Prior pelvis ultrasound" indication

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MRI Pelvis Procedure Codes

Table 1. MRI Pelvis Associated Procedure Codes

CODE	DESCRIPTION
72195	Magnetic resonance (eg, proton) imaging, pelvis; without contrast material(s)
72196	Magnetic resonance (eg, proton) imaging, pelvis; with contrast material(s)
72197	Magnetic resonance (eg, proton) imaging, pelvis; without contrast material(s), followed by contrast material(s) and further sequences
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 Pelvis Definitions

5-alpha reductase inhibitors (5-ARIs) are a class of medications that treat male pattern hair loss and enlarged prostates. They work by blocking dihydrotestosterone (DHT), which can cause the prostate to shrink and stop growing. This can help with urinary symptoms and manage the symptoms of an enlarged prostate.

Abscess is a swollen area within body tissue, containing an accumulation of pus.

Adenomyosis is a gynecologic condition that causes endometrial tissue in the lining of the uterus to grow into the muscular wall of the uterus. It enlarges the uterus and may lead to very heavy menstrual bleeding.

Adnexa is the area of the body that contains the ovaries, fallopian tubes and ligaments that hold the reproductive organs in place. The adnexa is located in the lower abdomen, near the pelvic bone.

Anorectal manometry is a noninvasive procedure that evaluates the function of the anal and rectal muscles.

Athletic pubaligia is a painful, soft tissue injury that occurs in the groin area that most often occurs during sports which require sudden changes of direction or intense twisting movements.

Avascular necrosis is localized death of bone tissue due to impaired or disrupted blood supply (as from traumatic injury or disease).

Axial spondylarthropathy is an inflammatory disease of the axial skeleton associated with significant pain and disability.

Balloon expulsion test (BET) is a diagnostic procedure used to evaluate defecatory disorders, particularly pelvic floor dyssynergia, by assessing the ability to expel a rectally inserted and inflated balloon within a specified time frame.

B symptoms refer to systemic symptoms of fever, night sweats and weight loss which can be associated with both Hodgkin lymphoma and some non-Hodgkin lymphomas. The presence of B symptoms is a prognostic factor for some lymphomas.

Biliary disease refers to conditions affecting the gallbladder, bile ducts and other structures involved in the production and flow of bile.
Congenital is a condition or trait present from birth.
Conservative management is an approach to treating pain utilizing non-surgical treatment options such as physical therapy, medication and injections, for a designated time, usually 4 to 6 weeks.
C-reactive protein (CRP) is a pentameric protein synthesized by the liver, whose level rises in response to inflammation.
Crohn's disease is chronic inflammation that typically involves the lower portion of the ileum, often spreads to the colon, and is characterized by diarrhea, cramping, loss of appetite and weight and the development of abscesses and scarring.
Dermatomyositis is a rare disease that causes muscle inflammation and skin rash. Symptoms include a red or purple rash on sun exposed skin and eyelids, calcium deposits under the skin, muscle weakness and trouble talking or swallowing.
Diverticula is an abnormal pouch or sac opening from a hollow organ.
Diverticulitis is inflammation of an abnormal pouch or sac opening from a hollow organ (such as the intestine or bladder).
Edema an abnormal infiltration and excess accumulation of serous fluid in connective tissue or in a serous cavity.
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.
Endoscopy is a procedure that uses an endoscope to examine the inside of the body. An endoscope is a thin, tube-like instrument with a light and a lens for viewing. It may also have a tool to remove tissue to be checked under a microscope for signs of disease.
Endometriosis is the presence and growth of functioning endometrial tissue in places other than the uterus that often results in severe pain and infertility.
Fibroids are growths made of smooth muscle cells and fibrous connective tissue. These growths develop in the uterus and appear alone or in groups. They range in size, from as small as a grain of rice to as big as a melon. In some cases, fibroids can grow into the uterine cavity or outward from the uterus on stalks.
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.
Gleason score is a score that is the sum of the two Gleason grades assigned to a prostate tumor that is based on a scale of 2 to 10 with the lowest numbers indicating a slow-growing tumor unlikely to spread and the highest numbers indicating an aggressive tumor.

Table 1. Prostate Cancer Grade Groups

Grade Group	Gleason Score	Cancer Grade
Grade Group 1	Gleason score of 6 or less	Low grade cancer
Grade Group 2	Gleason score 3+4=7	Medium grade cancer
Grade Group 3	Gleason score 4+3=7	Medium grade cancer with more abnormal cells
Grade Group 4	Gleason score of 8	High grade cancer
Grade Group 5	Gleason score of 9 to 10	High grade cancer

Hematoma is a mass of usually clotted blood that forms in a tissue, organ or body space as a result of a broken blood vessel.

Hematospermia is the presence of blood in the semen.

Hereditary paraganglioma syndrome is an autosomal dominant disorder characterized by the development of paragangliomas, which are tumors arising from paraganglia, often due to mutations in the succinate dehydrogenase (SDH) gene complex.

Hernia is a gap in the muscular wall that allows the contents inside the abdomen to protrude outward.

Iliac vein compression syndrome (May-Thurner syndrome) also known as May-Thurner syndrome, is a condition where the left common iliac vein is compressed by the overlying right common iliac artery and the underlying vertebral body, leading to venous congestion and stasis, which predisposes to venous thromboembolism (VTE).

Incarcerated (also referred to as irreducible) is used to describe herniae, in which their contents are unable to pass back through the hernial opening to their anatomical site of origin. Incarceration is a risk factor for bowel obstruction and strangulation, and therefore usually necessitates urgent surgery.

Incisional hernia is a hernia that develops along a prior surgical incision in the abdomen.

Indeterminate findings are inconclusive or insufficient for treatment planning.

Insufficiency fracture is a type of fracture that occurs in weakened bone due to normal stress or low-energy trauma, often associated with conditions like osteoporosis.

Ischemia is a deficient supply of blood to a body part (such as the heart or brain) due to obstruction of the inflow of arterial blood.

Lumbosacral plexopathy is a rare condition characterized by acute onset of pain followed by sensory and motor deficits, reflex changes, and muscle atrophy.

Magnetic resonance (MR) defecography is an imaging exam that uses an MRI machine to examine the pelvic floor, rectum and sphincter.

Magnetic resonance enterography (MRE) is a type of magnetic resonance imaging (MRI) that uses a contrast material to produce detailed images of the small intestine and bowel.

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.

Magnetic resonance venogram (MRV) is a diagnostic procedure that uses a combination of a large magnet, radiofrequencies, and a computer to produce detailed images of organs and structures within the body. An MRV uses magnetic resonance technology and intravenous (IV) contrast dye to visualize the veins. Contrast dye causes the blood vessels to appear opaque on the X-ray image, allowing the visualization the blood vessels being evaluated. MRV is useful in some cases because it can help detect causes of leg pain other than vein problems.

May-Thurner syndrome (iliac vein compression syndrome) is a condition where the left common iliac vein is compressed by the overlying right common iliac artery and the underlying vertebral body, leading to venous congestion and stasis, which predisposes to venous thromboembolism (VTE).

Meralgia paresthetica is a disorder characterized by tingling, numbness and burning pain in the outer side of the thigh. The disorder is caused by compression of the lateral femoral cutaneous nerve, a sensory nerve to the skin, as it exits the pelvis.

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.

Multiple endocrine neoplasia type 1 (MEN1) is a rare endocrine tumor syndrome with high penetrance. This syndrome is also known as Wermer syndrome. It primarily causes neoplasia of the parathyroid glands, the anterior pituitary gland and the neuroendocrine tissue of gastro-entero-pancreatic organ systems.

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

Multiple endocrine neoplasia type 1 (MEN1) is a rare endocrine tumor syndrome with high penetrance. This syndrome is also known as Wermer syndrome. It primarily causes neoplasia of the parathyroid glands, the anterior pituitary gland and the neuroendocrine tissue of gastro-entero-pancreatic organ systems.

Non-diagnostic is a result that does not lead to a confirmed diagnosis.

Occult hernia or hidden hernia, also commonly referred to as an occult inguinal hernia, is an undetectable mass of herniated tissue.

Osteomyelitis is an infectious, inflammatory disease of bone. It is often painful, bacterial in origin and may result in the death of bone tissue.

Osteonecrosis is localized death of bone tissue due to impaired or disrupted blood supply.

Paraneoplastic syndrome is a group of rare disorders that are triggered by an abnormal immune system response to a cancerous tumors.

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.

Pelvic congestion syndrome occurs when varicose veins develop around the ovaries, similar to varicose veins that occur in the legs. The valves in the veins no longer function normally, which causes blood to back up. The veins become engorged or "congested", which can be very painful.
Perianal refers to the area of skin surrounding the anus, the opening of the rectum to the outside of the body. It's a region that can be prone to various conditions due to its sensitivity and proximity to the digestive tract.
Peritonitis is inflammation of the smooth transparent serous membrane that lines the cavity of the abdomen of a mammal and is folded inward over the abdominal and pelvic viscera.
PI-RADS Assessment Categories for Prostate Cancer uses a combination of imaging findings (T2W, DWI, and dynamic contrast enhancement [DCE]) predicts the probability of a cancer that is clinically significant, which is defined as the presence of any of the following:

- Gleason score ≥7 (including 3+4 with prominent but not predominant Gleason 4 component)
- volume is greater than or equal to 0.5 mL
- Extraprostatic extension

Each lesion is assigned a score from 1 to 5 indicating the likelihood of clinically significant cancer:

Table 2. PI-RADS Assessment Categories for Prostate Cancer

PI-RADS Category	PI-RADS Category Description
PIRADS 1	Very low (clinically significant cancer is highly unlikely to be present)
PIRADS 2	Low (clinically significant cancer is unlikely to be present)
PIRADS 3	Intermediate (the presence of clinically significant cancer is equivocal)
PIRADS 4	High (clinically significant cancer is likely to be present)
PIRADS 5	Very high (clinically significant cancer is very likely to be present)

Piriformis syndrome is a condition in which the piriformis muscle, located in the buttock region, spasms and causes buttock pain because the piriformis muscle compresses the sciatic nerve.
Placenta accreta is a condition where the placenta abnormally adheres to the uterine wall, potentially leading to severe maternal morbidity and mortality due to life-threatening hemorrhage.
Placenta percreta is a severe form of placenta accreta spectrum (PAS) where the placental villi invade through the myometrium into the serosa and potentially into adjacent organs, leading to significant maternal morbidity and mortality due to life-threatening hemorrhage.
Positron emission tomography (PET) scan is a procedure in which a small amount of radioactive glucose (sugar) is injected into a vein, and a scanner is used to make detailed,

computerized pictures of areas inside the body where the glucose is taken up. It is a medical imaging test that shows the metabolic or biochemical function of organs and tissues.

Prostate specific antigen (PSA) is a protease (an enzyme that hydrolyzes proteins) secreted by epithelial cells of the prostate gland. PSA's concentration in blood serum tends to be proportional to the clinical stage of the disease, making it useful in detecting prostate cancer.

Prostate-specific membrane antigen (PSMA) is a type II membrane protein originally characterized by the murine monoclonal antibody (mAb) 7E11-C5.3 and is expressed in all forms of prostate tissue, including carcinoma.

Pudendal neuralgia is long-term pelvic pain that originates from damage or irritation of the pudendal nerve – a main nerve in the pelvis. The pudendal nerve supplies areas including the: lower buttocks. area between the buttocks and genitals (perineum) area around the anus and rectum.

Recurrence is a new occurrence of something that happened or appeared before.

Retroperitoneal fibrosis (RPF) occurs when extra fibrous tissue forms in the area behind the stomach and intestines. The tissue forms a mass (or masses) or tough fibrotic tissue. It can block the tubes that carry urine from the kidney to the bladder. The cause of this problem is mostly unknown.

Sacroiliac joint dysfunction is a condition in which pain is caused by the sacroiliac joint that connects the sacrum and the pelvis, believed to be caused by either too much movement (hypermobility) or too little movement (hypomobility) at the joint.

Sacroiliitis is an inflammation of one or both of the sacroiliac joints, which are situated where the lower spine and pelvis connect.

Spigelian hernia is a rare ventral hernia that is defined as herniation of abdominal contents or peritoneum through a defect, namely the Spigelian fascia which is comprised of the transversus abdominis and the internal oblique aponeuroses.

Spondylarthropathy is an inflammatory arthritis affecting the spine.

Staging in cancer is the process of determining how much cancer is within the body (tumor size) and if it has metastasized (spread).

Strangulated hernia occurs when the hernia contents are ischemic due to a compromised blood supply. This phenomenon occurs most commonly when there is a small opening in the musculature and a significant quantity of contents within the hernia itself.

Stress fracture is a tiny crack in a bone caused by repetitive force, often from overuse — such as repeatedly jumping up and down or running long distances.

Stricture is a narrowing or constriction of the lumen of a tube, duct or hollow organ such as the esophagus, ureter or urethra.

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.

Ulcerative colitis (UC) is a nonspecific inflammatory disease of the colon of unknown cause characterized by diarrhea with discharge of mucus and blood, cramping abdominal pain, inflammation and edema of the mucous membrane with patches of ulceration.
Ulcerated is a break in the skin or mucous membrane with loss of surface tissue, disintegration and necrosis of epithelial tissue and often pus.
Ultrasound is the diagnostic or therapeutic use of ultrasound and especially a noninvasive technique involving the formation of images used for the examination and measurement of internal body structures and the detection of bodily abnormalities.
Varicocele is abnormal dilation and enlargement of the scrotal venous pampiniform plexus which drains blood from each testicle.
Von Hippel-Lindau disease is a rare genetic disease that is characterized by hemangiomas of the retina and cerebellum, cysts or tumors of the central nervous system, pancreas, kidneys, adrenals and reproductive organs that is typically inherited as an autosomal dominant trait.

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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.

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.

For Internal Use Only:

11248 11249 11253 11282 11325 11328 11333 11349 11350 11351 11352 11354 11355 11356 11358 11359 11360 11361 11362 11365 11366 11367 11368 11369 11370 11374 11375 11394 11395 11396 11565