Evolent Clinical Guideline 2045 for Pelvis Magnetic Resonance Imaging (MRI)

Guideline Number: Evolent_CG_2045	**Applicable Codes**	
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Original Date: September 1997	**Last Revised Date:** July 2025	**Implementation Date:** January 2026

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STATEMENT

General Information

- *It is an expectation that all patients receive care/services from a licensed clinician. All appropriate supporting documentation, including recent pertinent office visit notes, laboratory data, and results of any special testing must be provided. If applicable: All prior relevant imaging results and the reason that alternative imaging cannot be performed must be included in the documentation submitted.*
- *Where a specific clinical indication is not directly addressed in this guideline, medical necessity determination will be made based on widely accepted standard of care criteria. These criteria are supported by evidence-based or peer-reviewed sources such as medical literature, societal guidelines and state/national recommendations.*
- *The guideline criteria in the following sections were developed utilizing evidence-based and peer-reviewed resources from medical publications and societal organization guidelines as well as from widely accepted standard of care, best practice recommendations.*

Purpose

Pelvis Magnetic Resonance Imaging (MRI) generates images of the organs and structures within the pelvis without the use of ionizing radiation.

Special Note

- There is not an Abdomen Pelvis MRI combo (comparable to a CT Abdomen/Pelvis). If imaging of both the abdomen and pelvis are indicated, two separate exams (and authorization) are required (i.e., MRI Abdomen and MRI Pelvis)
- For evaluating the placenta or imaging the maternal pelvis without need for fetal assessment, use the Pelvic MRI guideline. When assessment of the fetus is needed, see Evolet Clinical Guideline 2027 for Fetal MRI for indications.

INDICATIONS FOR PELVIC MRI

Inflammation and Infection

- For evaluation of Inflammatory Bowel Disease (IBD) such as Crohn's or Ulcerative Colitis (includes MR Enterography) [1,2]
    - For suspected inflammatory bowel disease after complete work up including physical exam, labs, and recent colonoscopy
    - Known inflammatory bowel disease with recurrence or worsening signs/symptoms requiring re-evaluation or for monitoring therapy
- Perianal disease [3–5]

- Suspected perianal fistula or occult anorectal abscess [6]
- For patients with recurrent fistula in anal or perianal Crohn's disease [7]
- Any history of fistula limited to the pelvis that requires re-evaluation or is suspected to have recurred

- Infection
  - Suspected infection in the pelvis (based on elevated WBC, fever, anorexia, or nausea and vomiting)
  - Complications of diverticulitis limited to the pelvis (prior imaging study is not required for diverticulitis diagnosis) with severe abdominal pain or severe tenderness or mass, not responding to antibiotic treatment
  - Any known infection to have created an abscess in the pelvis that requires re-evaluation
- Stricture
  - Suspected urethral stricture or periurethral pathology after initial evaluation with cystoscopy or urethroscopy and additional imaging is needed (such as for suspected malignancy, diverticula, fistula or extensive fibrosis **OR** for preoperative planning) [8]

For Inflammation and Infection When CT is Contraindicated or Cannot Be Performed

- Any known infection that is clinically suspected to have created an abscess in the pelvis
- Abnormal fluid collection limited to the abdomen seen on prior imaging that needs follow-up evaluation
- Suspected peritonitis when abdominal pain and tenderness to palpation are present, and at **LEAST** one of the following [5]:
  - Rebound, guarding or rigid abdomen, **OR**
  - Severe tenderness to palpation over the entire abdomen
- Complications of diverticulitis (diagnosed either clinically or by imaging) with severe abdominal pain, severe tenderness, or mass that is not responding to antibiotic treatment)

Hernia [9]

- Suspected athletic pubalgia (sports hernia) in a patient with persistent groin pain that occurs with exertion, who has not responded to active conservative treatment for four weeks, when prior imaging (ultrasound or CT) is inconclusive
- Suspected hernia and CT is inconclusive, contraindicated or cannot be performed and one of the following:
  - Deep pelvic hernia (obturator, sciatic or perineal)
  - Groin (e.g. inguinal or femoral), occult or incisional hernia **AND** exam and ultrasound are non-diagnostic or equivocal

- Known or suspected inguinal, obturator, sciatic perineal hernia with suspected complications based on one or more of the following:
    - Symptoms such as severe pain, vomiting, diarrhea or blood in stool
    - Exam findings such as inability to reduce hernia, severe tenderness, guarding, rebound
    - Complication is suggested on prior imaging
- Known pelvic or groin hernia, imaging is needed for surgical planning and clinical reason MRI is being requested rather than CT

Musculoskeletal Indications

- Initial evaluation of suspicious mass/tumor of the bones, muscles or soft tissues of the pelvis found on an imaging study, and needing clarification, or found by physical exam and after x-ray or ultrasound is completed
- Evaluation of suspected fracture and/or injury when initial imaging is completed or for confirmed stress (fatigue) fracture for 'return to play' evaluation [(10)]
- For evaluation of known or suspected aseptic/avascular necrosis of hip(s) after completion of initial x-ray [(11)]
- Known or suspected sacroiliitis (infectious or inflammatory) after completion of x-ray and rheumatologic workup [(12)]
- For evaluating the lumbosacral plexus [(13)] with any **ONE** of the following:
    - Confirm involvement in symptomatic patients with known tumor
    - Assess extent of injuries in the setting of pelvic trauma
    - Exclude the presence of masses in patients with unilateral changes, or inconclusive or abnormal findings on EMG when there are persistent symptoms
    - Evaluation when lumbar spine MRI is suspicious or indeterminate
- Suspicion of pudendal neuralgia in the setting of chronic pelvic pain with genital numbness and erectile dysfunction when other causes have been ruled out (see Background regarding diagnosis) [(14)]
- Suspicion of meralgia paresthetica when prior testing is inconclusive (diagnostic nerve block; electrodiagnostic testing; **AND** somatosensory evoked potentials) [(15)]
- Persistent musculoskeletal pelvic pain (including sacroiliac joint dysfunction and piriformis syndrome) with **ALL** of the following [(16,17)]:
    - Initial x-ray completed
    - Pain is unresponsive to four (4) weeks of active conservative treatment received within the past six (6) months (physical therapy, chiropractic care or physician supervised home exercise plan (HEP))
- Evaluation of both hips when the patient meets hip MRI guidelines (x-ray + persistent pain unresponsive to conservative treatment) for both the right and left hip, Pelvis MRI is

the preferred study.

- If labral tear is suspected due to a positive anterior impingement sign or posterior impingement sign, then bilateral hip MRIs are the preferred studies (not Pelvis MRI)
- If bilateral hip arthrograms are requested and otherwise meet guidelines, bilateral hip MRIs are the preferred studies (not Pelvis MRI)

- For further evaluation of congenital anomalies of the sacrum and pelvis and initial imaging has been performed

Other Indications

- Chronic pelvic pain syndrome once after initial workup including imaging (such as ultrasound and endoscopy) and laboratory evaluation does not reveal a clear cause
- Evaluation of undescended testes in adults and in children, including determination of location of testes, if ordered by a specialist [18]
- Evaluation and characterization of uterine and adnexal masses, (e.g., fibroids, ovaries, tubes, and uterine ligaments) or congenital uterine or renal abnormality where ultrasound has been done previously [19]
- Evaluation of abnormal uterine bleeding when ultrasound findings are indeterminate [20]
  - Age ≤ 50 – Vascular stalk or focal doppler signal on US
  - Age > 50 – Thickened endometrium, vascular stalk or focal doppler signal on US
- Evaluation of uterus prior to and after embolization [21]
- Evaluation of endometriosis when preliminary imaging has been completed or to follow up known endometriosis [22]
- Further evaluation of suspected adenomyosis when ultrasound is inconclusive, such as the following [23]:
  - Uterine abnormality on US
    - Anechoic spaces/cysts in myometrium
    - Heterogeneous echotexture
    - Obscured endometrial/myometrial border
    - Sub-endometrial echogenic linear striations
    - Thickening of the transition zone
    - Uterine enlargement
    - Uterine wall thickening
- Prior to uterine surgery if there is an abnormality suspected on prior ultrasound
- Suspected placenta accreta or percreta when ultrasound is indeterminate [24]
- Elevated CA-125 with abnormal or indeterminate ultrasound [25]
- Further assessment of a scrotal or penile mass when ultrasound is inconclusive [26]

- Investigation of a malfunctioning penile prosthesis
- Suspected urethral diverticulum and other imaging (ultrasound) is inconclusive **OR** for surgical planning **OR** with findings on exam or cystoscopy that are highly suggestive of urethral diverticulum (i.e., ostia on cystoscopy or tender cystic lesion on anterior vaginal wall overlying the urethra) [27,28]
- Suspected pelvic congestion syndrome (including May-Thurner and nutcracker syndromes) when ultrasound is indeterminate [29]
- Pelvic pain when a gynecologic cause is suspected after initial imaging (ultrasound and/or CT) and laboratory evaluation has been completed [19]
- Suspected patent urachus or other urachal abnormalities when ultrasound is non-diagnostic [30]
- MR defecography for suspected structural cause of defecatory outlet obstruction to confirm diagnosis if other testing is equivocal (anorectal manometry and balloon expulsion testing) [31]
- Transient or episodic hematospermia and age ≥ 40 with negative or inconclusive ultrasound [32,33]
- Persistent hematospermia (duration > 1 month, any age) with negative or inconclusive ultrasound [33]

When CT is Contraindicated or Cannot be Performed

- Persistent abdominal/pelvic pain after initial laboratory evaluation and either ultrasound and/or scope has been completed and does not reveal a cause
- Fever of unknown origin (temperature of ≥ 101 degrees for a minimum of 3 weeks) after **ALL** of the following have been completed and a source is not identified: complete blood count with differential, three sets of blood cultures, chest x-ray, complete metabolic panel, urinalysis, ESR, ANA, RA, serologic testing (EBV, EMV, HIV and hepatitis), tuberculin test
- Any B-symptoms of fevers more than 101° F, drenching night sweats, or unexplained weight loss of more than 10% of body weight over 6 months with documented concern for lymphoma/malignancy [34]
- Weight loss: **ONE** of the following:
    - Clinically significant unintentional weight loss i.e., ≥5% of body weight in less than 12 months (or ≥ 2% in one month), with signs or symptoms suggestive of an abdominal cause
- Ongoing unexplained clinically significant weight loss i.e., ≥5% of body weight in less than 12 months (or ≥ 2% in one month) [35] after initial workup (chest x-ray, age appropriate cancer screening (such as colonoscopy and mammography) and labs (including CBC, CMP, HbA1C, TSH, stool hemoccult, ESR/CRP, HIV, Hepatitis C)) has been completed, no cause identified, and second visit documenting further decline in weight. [36] Suspected or known retroperitoneal fibrosis after workup complete workup and ultrasound to determine extent of disease. [37,38]

- Suspected paraneoplastic syndrome (including dermatomyositis) with high suspicion of abdominal malignancy and appropriate workup has been done [39]
- Suspected Pheochromocytoma/Paraganglioma with elevated plasma or urine metanephrines and/or normetanephrines
- For acute unilateral (or asymmetric) lower extremity edema with negative or inconclusive doppler US
- For chronic (greater than 3 months) unilateral (or asymmetric) lower extremity edema and suspicion of malignant cause [40]
- Further evaluation of a new onset or non-reducible varicocele [41]
- Prior to Bone Marrow Transplant (BMT) [42,43]
- Follow-up of abnormal lymph nodes with no prior history of malignancy
  - Follow-up imaging at 3 months [44]

Suspected Malignancy

Suspected Prostate Cancer [45,46]

- Prior to prostate biopsy when notes indicate that biopsy is planned [47]
- In individuals with previous negative biopsy and ongoing concerns of increased risk of prostate cancer (i.e., rising or persistently elevated PSA **OR** suspicious digital rectal exam (DRE))
- For evaluation of elevated PSA (on two separate levels) when PI-RADS classification needed to make decision on whether or not to perform a biopsy when **ALL** of the following has been provided [46]:
  - Digital rectal examination (DRE) findings
  - PSA elevation not attributed to benign disease
  - Biopsy has been discussed with the patient (Typically, this request would be from the person performing the biopsy (i.e., urologist) and imaging done at the facility where the fusion biopsy would be performed should a higher risk lesion be identified.)
- For evaluation of a very suspicious prostate nodule on exam when biopsy is under consideration [46]
- Follow up MRI can be approved at the following intervals [48,49]:
  - PI-RADS 3-5 lesions: 12-month interval
  - PI-RADS 1-2 lesions: 24-month interval
    - Earlier for PI-RADS 1-2 if biopsy is clearly planned, progressive rise in PSA or other risk factors exist

Known Malignancy

NOTE: For malignancies in the pelvis, pelvis MRI is appropriate in addition to other systemic imaging (CT or PET) in the situations described below

Initial Staging or Recurrence

- Pelvis MRI is indicated (if not previously done) for the following malignancies:
  - Anal Carcinoma [50]
  - Cervical Cancer [51]
  - Colon or Rectal Cancer [52]
  - Gestational Trophoblastic Neoplasia [53]
  - Ovarian Cancer [54]
  - Pediatric Solid Tumors [55]
  - Penile Cancer [56]
  - Prostate Cancer [46]
  - Sarcoma in the pelvis (soft tissue or bone) [57]
  - Uterine Neoplasms [51]
  - Vulvar Cancer [58]
- For all other malignancies, Pelvis MRI is indicated for surgical or radiation planning or to clarify indeterminate findings on CT

Restaging

- Pelvis MRI is indicated for restaging during active treatment (every 2-3 cycles of chemo or immunotherapy, following radiation and/or after surgery) for the following malignancies:
  - Anal Carcinoma [50]
  - Colon or Rectal Cancer [52]
  - Ovarian Cancer [54]
  - Pediatric Solid Tumors [55]
  - Prostate Cancer [46]:
    - When recurrence is suspected
  - Sarcoma in the pelvis (soft tissue or bone) [57]
  - Uterine Cancer [51]
  - Vulvar Cancer [58]
- For all other malignancies, Pelvis MRI is indicated for surgical or radiation planning or to clarify indeterminate findings on CT

Surveillance

- Cervical cancer: as clinically indicated [51]
- Ovarian Cancer: every 3-6 months for 2 years then every 6-12 months for 3 years [54]
- Pediatric solid tumors: as clinically indicated (frequent imaging is appropriate) [55]
- Prostate Cancer: Annually if on active surveillance [46]
- Rectal Cancer: every 3-6 months for 2 years, every 6-12 months for 5 years [59]
- Sarcoma in the pelvis (soft tissue or bone): Every 3-6 months for 5 years, then annually for 5 years [57]
- For other cancers not listed above, Pelvis MRI is not typically used during surveillance, however, can be considered on a case to case basis

PREOPERATIVE OR POSTOPERATIVE ASSESSMENT

When not otherwise specified in the guideline:

Preoperative Evaluation:

- Imaging of the area requested is needed to develop a surgical plan

Postoperative Evaluation:

- Known or suspected complications
- A clinical reason is provided how imaging may change management

NOTE: This section applies only within the first few months following surgery

FURTHER EVALUATION OF INDETERMINATE FINDINGS

Unless follow up is otherwise specified within the guideline:

- For initial evaluation of an inconclusive finding on a prior imaging report that requires further clarification
- One follow-up exam of a prior indeterminate MR/CT finding to ensure no suspicious interval change has occurred. (No further surveillance unless specified as highly suspicious or change was found on last follow-up exam)

IMAGING IN KNOWN GENETIC CONDITIONS

- BHDS (Birt-Hogg-Dube): annually starting at age 20 (or earlier with family history of

renal tumors diagnosed before age 30) [60,61]

- FAP (Familial Adenomatous Polyposis): annual [62]
- Multiple Endocrine Neoplasia type 1 (MEN1): annually starting at age 8 [63,64]
- STK11 (Peutz-Jeghers Syndrome): at diagnosis, annually starting at age 8 [65]
- For other syndromes and rare diseases not otherwise addressed in the guideline, coverage is based on a case-by-case basis using societal guidance

Combination studies for known genetic conditions

NOTE: When medical necessity is met for an individual study **AND** conscious sedation is required (such as for young pediatric patients or patients with significant developmental delay), the entire combination is indicated)

Brain/Chest/Abdomen/Pelvis MRI [63,64]

- Multiple Endocrine Neoplasia Syndrome Type 1 (MEN-1)
  - Annually starting at age 8
  - Every 3 years include Brain MRI

OTHER COMBINATION STUDIES WITH PELVIS MRI

NOTE: When medical necessity is met for an individual study **AND** conscious sedation is required (such as for young pediatric patients or patients with significant developmental delay), the entire combination is indicated)

Abdomen/Pelvis MRI

- As a dedicated CPT code does not exists for Abdomen and Pelvis MRI (unlike CT), when a disease process is reasonably expected to involve both the abdomen and pelvis **AND** the guideline criteria have been met, two separate authorizations are required: Abdomen MRI (CPT 74181, 74182, 74183) and Pelvis MRI (CPT 72195, 72196, 72197).

Pelvis MRI and Pelvis MRA

- When needed for clarification of vascular involvement from tumor (including suspected renal vein thrombosis) [66]
- Prior to uterine artery embolization for fibroids [67]

Pelvis MRI and Fetal MRI

- When medical necessity has been met for Pelvis MRI (such as for suspected placenta accreta or percreta when ultrasound is indeterminate [24] **AND** medical necessity has been met for Fetal MRI (such as suspected fetal abnormality after ultrasound has been performed), two separate authorizations are required: Pelvis MRI (CPT 72195) and Fetal

MRI (CPT 74712).

Combination Studies for Malignancy for Initial Staging or Restaging

Unless otherwise specified in this guideline, indication for combination studies for malignancy for initial staging or restaging:

- Concurrent studies to include CT or MRI of any of the following areas as appropriate depending on the cancer: Abdomen, Brain, Chest, Neck, Pelvis, Cervical Spine, Thoracic Spine or Lumbar Spine.

CODING AND STANDARDS

Codes

72195, 72196, 72197, +0698T

Applicable Lines of Business

☒	CHIP (Children's Health Insurance Program)
☒	Commercial
☒	Exchange/Marketplace
☒	Medicaid
☒	Medicare Advantage

BACKGROUND

PI-RADS Assessment Categories for Prostate Cancer

The assignment of a PI-RADS category is based on MRI findings only and does not incorporate other factors, including PSA testing, DRE (digital rectal exam), or clinical history.

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

Conservative Therapy

Conservative therapy should include a multimodality approach consisting of a combination of active and inactive components. Completion of at least one active modality for 4 weeks in the past 6 months is required:

Active Modalities

- Physical therapy
- Physician-supervised home exercise program (HEP) (See Below)
- Chiropractic care

Inactive Modalities

- Medications (e.g., NSAIDs, steroids, analgesics)
- Injections
- Medical Devices (e.g., TENS unit, bracing)

Home Exercise Program (HEP)

The following two elements are required to meet guidelines for completion of conservative therapy:

- Information provided on exercise prescription/plan AND
- Follow-up with patient with documentation provided regarding completion of HEP over at least a 4-week period **OR** documented inability to complete HEP due to increased pain with inability to physically perform the prescribed exercises.

NOTE: Patient inconvenience or noncompliance without explanation does not meet the “inability to complete HEP” criterium

MRI and Lumbosacral Plexopathy

Complete lumbar (L1-L4) or sacral plexopathy (L5-S3) may present with weakness, sensory loss, and flaccid loss of tendon reflexes. Clinical diagnosis is confirmed by EMG. Acute and chronic plexopathies may be caused by nerve sheath tumors; infectious, autoimmune, hereditary, or idiopathic neuropathies; extrinsic compression; or trauma. There is no CPT® code specifically for imaging of the LS plexus.

Pudendal neuralgia may be considered in chronic pain patients who meet the Nantes criteria: pain in the area innervated by the pudendal nerve, pain more severe with sitting, pain that does not awaken the patient from sleep, pain with no objective sensory impairment, and pain relieved by pudendal block. All five criteria must be met for diagnosis.

Contraindications and Preferred Studies

- Contraindications and reasons why a CT/CTA cannot be performed may include: impaired renal function, significant allergy to IV contrast, pregnancy (depending on

trimester)

- Contraindications and reasons why an MRI/MRA cannot be performed may include: impaired renal function, claustrophobia, non-MRI compatible devices (such as non-compatible defibrillator or pacemaker), metallic fragments in a high-risk location, patient exceeds wight limit/dimensions of MRI machine

SUMMARY OF EVIDENCE

Diagnostic imaging of acute abdominal pain in adults [3]

- **Study Design**: This document is a review article that provides evidence-based guidelines for the diagnostic imaging of acute abdominal pain in adults.
- **Target Population**: The target population includes adults presenting with acute abdominal pain in both outpatient and emergency settings.
- **Key Factors**: The article outlines the appropriate imaging modalities based on the location of pain and clinical presentation. It highlights the use of ultrasonography for right upper quadrant pain, CT for right or left lower quadrant pain, and the limited diagnostic value of conventional radiography.

ACR Appropriateness Criteria® Hernia [9]

- **Study Design**: This document is a guideline by the ACR focusing on the initial imaging of suspected abdominopelvic hernias.
- **Target Population**: The target population includes adults with signs or symptoms prompting suspicion of abdominopelvic hernia.
- **Key Factors**: The guideline discusses the use of CT, ultrasound, and MRI as first-line imaging modalities for evaluating hernias. It also addresses the appropriateness of different imaging techniques based on the type of hernia suspected.

ACR Appropriateness Criteria® Acute Pelvic Pain in the Reproductive Age Group: 2023 Update [19]

- **Study Design**: This document is a guideline update by the American College of Radiology (ACR) focusing on the initial imaging in the reproductive age adult population with acute pelvic pain.
- **Target Population**: The target population includes patients with acute pelvic pain, both with positive and negative beta-human chorionic gonadotropin (b-hCG) levels, and suspected gynecological and non-gynecological etiologies.
- **Key Factors**: The guideline emphasizes the use of transabdominal and transvaginal pelvic ultrasound with Doppler as initial imaging. It also discusses the appropriateness of CT and MRI in different scenarios based on the suspected etiology.

ANALYSIS OF EVIDENCE

Analysis [3,9,19]:

In summary, while there is consensus on the utility of MRI in specific scenarios, the recommendations vary based on the clinical context and the specific condition being evaluated. MRI is generally considered a valuable imaging modality, particularly when other methods are inconclusive or not suitable.

Shared Conclusions

- **MRI as a Secondary Option**: All three articles agree that MRI is often a secondary option when other imaging modalities (like ultrasound or CT) are inconclusive or not feasible.
- **Use of Contrast**: The use of IV contrast in MRI is a common consideration across the articles, with specific recommendations varying based on the clinical scenario.
- **Pregnancy Considerations**: MRI is preferred for pregnant patients due to the lack of ionizing radiation.

POLICY HISTORY

Date	Summary
July 2025	• Added a Summary of Evidence and Analysis of Evidence
June 2025	• This guideline replaces Evolent Clinical Guideline 037 for Pelvis MRI • Added in general information statement regarding guideline criteria development by reputable sources, standard of care, and best practices • Fistula and inflammation section revised • Hernia and musculoskeletal pelvic pain section revised • Genetics imaging and malignancy sections updated • Applicable Line of Business adjusted – Medicare checked • Updated language in the preoperative/postoperative section • Segment added to combinations studies about if the required use of conscious sedation is needed the entire combination is indicated • Background section shortened and integrated into indications • References updated

Date	Summary
June 2024	• Revised the purpose • Clarified when to use Fetal MRI and Pelvis MRI • Made Inflammation and Infection section to re-organize information • Clarified gynecologic reasons of why MRI vs CT • Prostate Cancer condensed in the suspected section • Known Malignancy was adjusted to follow same organization as other guidelines • Genetics and Rate Diseases was adjusted/added • Combination studies were adjusted to align across Guidelines

LEGAL AND COMPLIANCE

Guideline Approval

Committee

Reviewed / Approved by Evolent Specialty Clinical Services Guideline Review Committee

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Evolent Clinical Guidelines are comprehensive and inclusive of various procedural applications for each service type. Our guidelines may be used to supplement Medicare criteria when such criteria is not fully established. When Medicare criteria is determined to not be fully established, we only reference the relevant portion of the corresponding Evolent Clinical Guideline that is applicable to the specific service or item requested in order to determine medical necessity.

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