Molina Clinical Policy
Abdomen MRI: Policy No. 639

Last Approval: 12/8/2021
Next Review Due By: December 2022

DISCLAIMER

This Molina Clinical Policy (MCP) is intended to facilitate the Utilization Management process. Policies are not a supplementation or recommendation for treatment; Providers are solely responsible for the diagnosis, treatment and clinical recommendations for the Member. It expresses Molina's determination as to whether certain services or supplies are medically necessary, experimental, investigational, or cosmetic for purposes of determining appropriateness of payment. The conclusion that a particular service or supply is medically necessary does not constitute a representation or warranty that this service or supply is covered (e.g., will be paid for by Molina) for a particular Member. The Member's benefit plan determines coverage – each benefit plan defines which services are covered, which are excluded, and which are subject to dollar caps or other limits. Members and their Providers will need to consult the Member's benefit plan to determine if there are any exclusion(s) or other benefit limitations applicable to this service or supply. If there is a discrepancy between this policy and a Member's plan of benefits, the benefits plan will govern. In addition, coverage may be mandated by applicable legal requirements of a State, the Federal government or CMS for Medicare and Medicaid Members. CMS's Coverage Database can be found on the CMS website. The coverage directive(s) and criteria from an existing National Coverage Determination (NCD) or Local Coverage Determination (LCD) will supersede the contents of this MCP and provide the directive for all Medicare members. References included were accurate at the time of policy approval and publication.

OVERVIEW

Magnetic Resonance Imaging (MRI) is the modality of choice used in the evaluation, diagnosis and management of most brain related conditions.

COVERAGE POLICY

Abdomen MRI **may be considered medically necessary** when the following criteria are met:

1. **Chronic Abdominal/Pelvic Pain**

   The initial evaluation of abdominal pain consists of a detailed history and physical examination, appropriate laboratory studies, and frequently non-advanced imaging such as x-ray or ultrasound. The presence of certain “red flags” may preclude the initial performance of non-advanced imaging. In some cases, endoscopy may be the preferred study. In children under the age of 14, ultrasound should be the initial study performed for evaluation of abdominal pain.

   For the majority of clinical conditions, imaging both the abdomen and pelvis is warranted. Imaging can be limited to part of the abdominal cavity for follow up of specific organs or when the pathology is localized to a particular region of the abdominal cavity.

Location	Recommendations (Male)
Generalized	Initial ultrasound
Right Upper Quadrant	Initial ultrasound
Left Upper Quadrant	Consider ultrasound and/or evaluate for possible gastric causes
Left Lower Quadrant	MRI/CT if concern for conditions listed below
Right Lower Quadrant	MRI/CT if concern for conditions listed below

Location	Recommendations (Female)
Generalized	Initial ultrasound
Right Upper Quadrant	Initial ultrasound
Left Upper Quadrant	Consider ultrasound and/or evaluate for possible gastric causes
Left Lower Quadrant	Initial pelvic ultrasound
Right Lower Quadrant	Initial pelvic ultrasound

OR

2. **Kidney Stones (Suspected)**
   a. Flank pain and +/- hematuria.

OR

3. **Kidney Stones (Known or Follow Up)**
   a. If initial x-ray (KUB) or ultrasound is indeterminate.

OR

4. **Asymptomatic Microscopic Hematuria (AMH)** is only diagnosed by microscopy; a dipstick reading suggestive of hematuria should not lead to imaging or further investigation without confirmation of three or greater red blood cells per high power field.)
   a. Abdomen / pelvic CT is recommended.

OR

5. **Known Tumor or Mass (limited to the upper abdominal cavity only [e.g., liver, kidney, adrenal])**
   a. Initial evaluation of a recently diagnosed cancer
   b. Follow up of a known tumor or mass after completion of treatment or with new signs/symptoms.
   c. Surveillance of a known tumor or mass according to accepted clinical standards.

OR

6. **Suspected Tumor or Mass Not Confirmed as Cancer (limited to the upper abdominal cavity only [e.g., liver, kidney, adrenal])**
   a. Evaluation of an abnormality seen on x-ray or other imaging.
   b. Evaluation of an abnormality on physical examination and initial evaluation with x-ray or ultrasound has been completed.

OR

7. **Infection Suspected**
   a. Appendicitis, acute abdominal pain with at least one of the following:
      - Nausea/vomiting; **OR**
      - Fever of at least 100.3 or higher; **OR**
      - Abdominal rigidity, guarding/rebound tenderness, or other peritoneal signs; **OR**
      - Elevated white blood cell count (WBC).
   b. Diverticulitis including complication with severe abdominal tenderness or mass, not responding to antibiotics.
   c. Abscess (limited to the upper abdominal cavity only [e.g., liver, kidney, adrenal])
   d. Any known infection that is clinically suspected to have created an abscess.
   e. Re-evaluation of an abscess after treatment.

OR

8. **Fistula**
   a. Evaluation of a known or suspected fistula.

OR

9. **Inflammation**
   a. Suspected pancreatitis (new or recurrent) with abnormal amylase or lipase or severe focal pain.
   b. Known pancreatitis and concern for pseudocyst formation.
   c. Suspected inflammatory bowel disease (new or recurrent) with abdominal pain, persistent diarrhea or bloody diarrhea (abdomen / pelvic CT is recommended).
   d. MR enterography for evaluation of known inflammatory bowel disease.
   e. Abdomen / pelvic imaging is recommended.

OR

10. Trauma
   a. Suspected abdominal or retroperitoneal hemorrhage (limited to the upper abdominal cavity only).

OR

11. Vascular Disease (aneurysm, etc.)
   a. CTA or MRA may be preferred; abdomen / pelvic imaging is recommended.
   b. Vascular abnormality seen and indeterminate on other imaging studies.
   c. Aortic aneurysm and ultrasound is indeterminate or this is for preoperative planning.
   d. Follow up after endograph repair and CTA is not also ordered.

OR

12. Weight Loss
   a. Abdomen / pelvic imaging is recommended.
   b. Loss of 5% of body weight persisting for 6 months with initial evaluation of a chest x-ray, ultrasound, laboratory testing (including TSH), and colon cancer screening (if over 50 years old) completed.
   c. Loss of 10% of body weight in less than 2 months with at least one MD visit documenting weight loss.

OR

13. Other
   a. Evaluation of an abnormality seen on other imaging and the diagnosis remains uncertain.
   b. For evaluation of a known or suspected ventral or incisional hernia.
   c. High Risk – any patient over 75 years of age or diabetic with persisting pain (not intermittent only).
   d. Abdomen / pelvic imaging is recommended.

Pre / Post-Procedural

- Pre-operative evaluation.
- Post-operative for routine recommended follow up or for potential post-operative complications.
- A repeat study may be needed to help evaluate a patient's progress after treatment procedure intervention or surgery. The reason for the repeat study and that it will affect care must be clear.

Indications for Magnetic Resonance Cholangiopancreatography (MRCP)

In most clinical indications, ultrasound is the imaging modality of choice for initial imaging. Additional indications include:

- For evaluation of known or suspected abnormality of the pancreaticobiliary tree (e.g. pancreatic divisum, retained gall stone, etc.).
- For evaluation of chronic pancreatitis without known etiology.
- For further evaluation of an indeterminate abnormality seen on prior imaging (ultrasound or CT).
- For patients who have had a failed ERCP and still require evaluation.

Contraindications

MRI can be contraindicated in any of the following circumstances: a metallic body in the eye, for magnetically activated implanted devices such as pacemakers and defibrillators, insulin pumps, neurostimulators, and for some types of metal, and aneurysm clipping. The imaging facility should always be consulted with any compatibility questions as the types of metal used and development of MRI compatible devices is continually changing.

Additional Critical Information

The above medical necessity recommendations are used to determine the best diagnostic study based on a Member's specific clinical circumstances. The recommendations were developed using evidence-based studies and current accepted clinical practices. Medical necessity will be determined using a combination of these recommendations as well as the Member's individual clinical or social circumstances.

- Tests that will not change treatment plans should not be recommended.
- Same or similar tests recently completed need a specific reason for repeat imaging.

DOCUMENTATION REQUIREMENTS. Molina Healthcare reserves the right to require that additional documentation be made available as part of its coverage determination; quality improvement; and fraud; waste and abuse prevention processes. Documentation required may include, but is not limited to, patient records, test results and credentials of the provider ordering or performing a drug or service. Molina Healthcare may deny reimbursement or take additional appropriate action if the documentation provided does not support the initial determination that the drugs or services were medically necessary, not investigational or experimental, and otherwise within the scope of benefits afforded to the member, and/or the documentation demonstrates a pattern of billing or other practice that is inappropriate or excessive.

CODING & BILLING INFORMATION

CPT Codes

CPT	Description
74181	Magnetic Resonance Imaging (MRI) abdomen without contrast
74182	Magnetic Resonance Imaging (MRI) abdomen with contrast
74183	Magnetic Resonance Imaging (MRI) abdomen without and with contrast

CODING DISCLAIMER. Codes listed in this policy are for reference purposes only and may not be all-inclusive. Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement. Listing of a service or device code in this policy does not guarantee coverage. Coverage is determined by the benefit document. Molina adheres to Current Procedural Terminology (CPT®), a registered trademark of the American Medical Association (AMA). All CPT codes and descriptions are copyrighted by the AMA; this information is included for informational purposes only. Providers and facilities are expected to utilize industry standard coding practices for all submissions. When improper billing and coding is not followed, Molina has the right to reject/deny the claim and recover claim payment(s). Due to changing industry practices, Molina reserves the right to revise this policy as needed.

APPROVAL HISTORY

12/8/2021	Policy reviewed; clarified clinical parameters for hematuria; updated references.
Review Dates	12/19/2018 ,12/10/2019, 12/9/2020
9/19/2017	New policy.

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APPENDIX

Reserved for State specific information. *Information includes, but is not limited to, State contract language, Medicaid criteria and other mandated criteria.*