Instructions for use

The following coverage policy applies to health benefit plans administered by Cigna. Coverage policies are intended to provide guidance in interpreting certain standard Cigna benefit plans and are used by medical directors and other health care professionals in making medical necessity and other coverage determinations. Please note the terms of a customer’s particular benefit plan document may differ significantly from the standard benefit plans upon which these coverage policies are based. For example, a customer’s benefit plan document may contain a specific exclusion related to a topic addressed in a coverage policy.

In the event of a conflict, a customer’s benefit plan document always supersedes the information in the coverage policy. In the absence of federal or state coverage mandates, benefits are ultimately determined by the terms of the applicable benefit plan document. Coverage determinations in each specific instance require consideration of:

1. The terms of the applicable benefit plan document in effect on the date of service
2. Any applicable laws and regulations
3. Any relevant collateral source materials including coverage policies
4. The specific facts of the particular situation

Coverage policies relate exclusively to the administration of health benefit plans. Coverage policies are not recommendations for treatment and should never be used as treatment guidelines.

This evidence-based medical coverage policy has been developed by eviCore, Inc. Some information in this coverage policy may not apply to all benefit plans administered by Cigna.

These guidelines include procedures eviCore does not review for Cigna. Please refer to the Cigna CPT code list for the current list of high-tech imaging procedures that eviCore reviews for Cigna.

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<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tr>
<td>AIDS</td>
<td>Acquired Immunodeficiency Syndrome</td>
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<tr>
<td>ALS</td>
<td>Amyotrophic Lateral Sclerosis</td>
</tr>
<tr>
<td>CIDP</td>
<td>Chronic Inflammatory Demyelinating Polyneuropathy</td>
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<tr>
<td>CNS</td>
<td>Central Nervous System</td>
</tr>
<tr>
<td>CPK</td>
<td>Creatinine Phosphokinase</td>
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<tr>
<td>CT</td>
<td>Computed Tomography</td>
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<tr>
<td>EMG</td>
<td>Electromyogram</td>
</tr>
<tr>
<td>LEMS</td>
<td>Lambert-Eaton Myasthenic Syndrome</td>
</tr>
<tr>
<td>MG</td>
<td>Myasthenia Gravis</td>
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<tr>
<td>MRI</td>
<td>Magnetic Resonance Imaging</td>
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<tr>
<td>MRN</td>
<td>Magnetic Resonance Neurography</td>
</tr>
<tr>
<td>MRS</td>
<td>Magnetic Resonance Spectroscopy</td>
</tr>
<tr>
<td>NCV</td>
<td>Nerve Conduction Velocity</td>
</tr>
<tr>
<td>PET</td>
<td>Positron Emission Tomography</td>
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<tr>
<td>PNS</td>
<td>Peripheral Nervous System</td>
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<tr>
<td>PNST</td>
<td>Peripheral Nerve Sheath Tumor</td>
</tr>
<tr>
<td>POEMS</td>
<td>Polyneuropathy, Organomegaly, Endocrinopathy, M-protein, Skin Changes</td>
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<tr>
<td>TOS</td>
<td>Thoracic Outlet Syndrome</td>
</tr>
</tbody>
</table>
PN-1: General Guidelines

A current clinical evaluation (within 60 days) is required before advanced imaging can be considered. The clinical evaluation may include a relevant history and physical examination, including a neurological examination, appropriate laboratory studies, non-advanced imaging modalities, electromyography and nerve conduction (EMG/NCV) studies. Other meaningful contact (telephone call, electronic mail or messaging) by an established individual can substitute for a face-to-face clinical evaluation.

- MRI is, most often, preferable to CT.

References

# PN-2: Focal Neuropathy

<table>
<thead>
<tr>
<th>Focal Disorder</th>
<th>EMG/NCV Initially?</th>
<th>Advanced Imaging</th>
</tr>
</thead>
</table>
| Carpal Tunnel Syndrome         | YES                | ➤ No established role for advanced imaging.  
➤ Ultrasound of the wrist to estimate size of the carpal tunnel and diameter of the median nerve may be helpful in the evaluation and confirmation of carpal tunnel syndrome pre-operatively when EMG findings are equivocal and clinical findings are uncertain.  
➤ See **MS-21: Wrist** and **SP-3: Neck (Cervical Spine) Pain Without/With Neurological Features and Trauma**. |
| Ulnar Neuropathy               | YES                | ➤ Ultrasound for evaluation when clinical findings and EMG/NCV findings are uncertain.  
➤ MRI of the elbow without contrast (CPT® 73221) or MRI of the upper arm forearm without contrast (CPT® 73218) for ANY of the following:  
   ➤ Pre-operative  
   ➤ Complex cases when diagnosis remains uncertain after EMG and US |
| Radial Neuropathy              | YES                | ➤ MRI of the Upper Arm or Forearm without contrast (CPT® 73218) in severe cases when surgery is being considered.  
➤ MRI of the Upper Arm or Forearm without and with contrast (CPT® 73220) if there is a suspicion of a nerve tumor such as a neuroma. |

**Radial Neuropathy Notes:** Leads to wrist drop with common sites of entrapment the inferior aspect of the humerus (Saturday night palsy) or the forearm (Posterior Interosseus Syndrome).  
Trauma or fractures of the humerus, radius, or ulna can damage the radial nerve.

| Sciatic Neuropathy             | YES                | ➤ CT Pelvis with contrast (CPT® 72193) or MRI pelvis without contrast (CPT® 72195) should be performed in the evaluation of these entities.  
➤ CT Pelvis without contrast is not indicated due to lack of soft tissue contrast. It should only be performed in the rare circumstance of contrast allergy and contraindication to MRI such as pacemaking device. |

**Sciatic Neuropathy Notes:** Trauma to the gluteal area with hematoma, injection palsy, hip or pelvic fractures, or hip replacement (arthroplasty) and rarely Piriformis Syndrome involves entrapment of the sciatic nerve at the sciatic notch in the pelvis by a tight piriformis muscle band.
<table>
<thead>
<tr>
<th>Focal Disorder</th>
<th>EMG/NCV Initially?</th>
<th>Advanced Imaging</th>
</tr>
</thead>
<tbody>
<tr>
<td>Femoral Neuropathy</td>
<td>NO</td>
<td>CT Pelvis with contrast (CPT® 72193) or MRI Pelvis without contrast (CPT® 72195) should be performed in the evaluation of these entities.</td>
</tr>
</tbody>
</table>

**Femoral Neuropathy Notes:** as a complication of pelvic surgery in women or those on anticoagulants with retroperitoneal bleeding.

<table>
<thead>
<tr>
<th>Meralgia Paresthetica</th>
<th>NO</th>
<th>CT Pelvis with contrast (CPT® 72193) or MRI Pelvis without contrast (CPT® 72195) may be performed for ANY of the following:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>- Pre-operative</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Cases of diagnostic uncertainty</td>
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<tr>
<td></td>
<td></td>
<td>CT Pelvis without contrast is not indicated due to lack of soft tissue contrast. It should only be performed in the rare circumstance of contrast allergy and contraindication to MRI such as pacemaking device.</td>
</tr>
</tbody>
</table>

**Meralgia Paresthetica Notes:** Sensory loss in the lateral femoral cutaneous nerve as it exits the pelvis under the inguinal ligament (lateral thigh without extension into lower leg).

| Peroneal Neuropathy         | YES                | MRI Knee without contrast (CPT® 73721) or MRI Lower Extremity other than joint without contrast (CPT® 73718) in severe cases when surgery is considered. |

**Peroneal Neuropathy Notes:** Foot drop which usually resolves unless L5 radiculopathy. Imaging is applicable only after an L5 radiculopathy has been ruled out (this can be typically achieved on physical exam, or supplemented by neurophysiological testing) since L5 dysfunction is by far the most common cause of foot drop.

| Tarsal Tunnel Syndrome      | N/A                | See [MS-27: Foot (Tarsal Tunnel Syndrome)](https://www.eviCore.com)                                                                 |

| Other Peripheral Mononeuropathies | N/A | MRI without or without and with contrast if preoperative. |
References


<table>
<thead>
<tr>
<th>Poly-Disorder</th>
<th>EMG/NCV Initially?</th>
<th>Advanced Imaging</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>PNS/CNS Crossover Syndromes</td>
<td>YES</td>
<td>MRI without and with contrast of brain and/or spinal cord if clinical findings point to abnormalities in those areas.</td>
<td>Guillain-Barré syndrome</td>
</tr>
<tr>
<td>AIDS Related Cytomegaloviral Neuropathy/Radiculopathy</td>
<td>YES</td>
<td>MRI Lumbar Spine without and with contrast (CPT® 72158) if suspected.</td>
<td>Urinary retention and a clinically confusing picture in the legs.</td>
</tr>
<tr>
<td>Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)</td>
<td>YES</td>
<td>MRI Lumbar Spine without and with contrast (CPT® 72158) if uncertain following EMG.</td>
<td></td>
</tr>
<tr>
<td>Multifocal Motor Neuropathy</td>
<td>YES</td>
<td>MRI Brachial Plexus without and with contrast (CPT® 71552 or CPT® 73220) if uncertain following EMG.</td>
<td></td>
</tr>
<tr>
<td>POEMS (Polyneuropathy, Organomegaly, Endocrinopathy, M-protein, Skin changes)</td>
<td>YES</td>
<td>Advanced imaging is for the non-neurological entities of this rare osteoscleroticplasmacytoma syndrome.</td>
<td>See <a href="#">ONC-25: Multiple Myeloma and Plasmacytomas</a></td>
</tr>
<tr>
<td>Subacute Sensory Neuronopathy &amp; Other Paraneoplastic Demyelinating Neuropathies</td>
<td>YES</td>
<td>Advanced imaging should be guided by specific clinical concern (See relevant guideline). For evaluation of suspected paraneoplastic syndromes. See <a href="#">ONC 30.3: Paraneoplastic Syndromes</a></td>
<td></td>
</tr>
</tbody>
</table>
References


PN-4: Brachial Plexus

- Upper extremity other than joint MRI without or without and with contrast (CPT® 73218 or CPT® 73220), Chest MRI without or without and with contrast (CPT® 71550 or CPT® 71552) or Neck MRI without (CPT® 70540) or without and with contrast (CPT® 70543) (if upper trunk) after EMG/NCV examination for:
  - Malignant infiltration (EMG not required)
  - Radiation plexitis to r/o malignant infiltration
  - Brachial plexitis (Parsonage-Turner Syndrome or painful brachial amyotrophy).
    - Self-limited syndrome characterized by initial shoulder region pain followed by weakness of specific muscles in a pattern which does not conform to involvement of a single root or distal peripheral nerve
    - Consider MRI of the cervical spine if radiculopathy.
  - See SP-3: Neck (Cervical Spine) Pain Without/With Neurological Features and Trauma
    - Traumatic injury
    - Neurogenic Thoracic Outlet Syndrome (TOS) failed a 2 to 3 month trial of conservative management and are being considered for surgical treatment.
  - See CH-31: Thoracic Outlet Syndrome (TOS)
    - Preoperative study which requires evaluation of the brachial plexus

References
PN-5: Lumbar and Lumbosacral Plexus

MRI Pelvis without and with contrast with fat suppression imaging (CPT® 72197) OR MRI Abdomen and Pelvis without and with contrast with fat suppression imaging (CPT® 74183 and CPT® 72197) OR if MRI is not available, CT Pelvis with contrast (CPT® 72193) OR CT Abdomen and Pelvis with contrast (CPT® 74177) after EMG/NCV based on whether the upper lumbar plexus (abdominal retroperitoneal space) or the lumbosacral plexus (pelvis), respectively, is involved based on:

- Malignant infiltration (EMG not required)
- Radiation plexopathy to r/o malignant infiltration
- Traumatic injury
- Concern for retroperitoneal hematoma in patients on anticoagulation or who have other thrombotic disorders (EMG/NCV not necessary)

References


## PN-6: Muscle Disorders

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<td>PN-6.3: Gaucher Disease (Storage Disorders)</td>
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</table>
**PN-6.1: Neuromuscular Disease**

- Myasthenia Gravis (MG) is associated with thymic disease and can undergo:
  - Chest CT with contrast (CPT® 71260) after an established diagnosis of MG.
    - Can be repeated if initial CT previously negative and now symptoms of chest mass, rising anti-striated muscle antibody titers, or need for preoperative evaluation (clinical presentation, electro-diagnostic studies, and antibody titers).
  - Chest CT without contrast (CPT® 71250) may be used if there is concern regarding adverse effects of contrast in individuals with MG.
- Lambert–Eaton myasthenic syndrome (LEMS) is associated with small cell lung cancer and can undergo:
  - Chest CT with contrast (CPT® 71260) with a suspected diagnosis (CXR, symptoms of lung mass, clinical presentation, electro-diagnostic studies, and antibody titers).
  - Can be repeated if initial CT previously negative after 3 months with persistent suspicion.
- Stiff man syndrome is associated with small cell lung cancer and breast cancer
  - Chest CT with contrast (CPT® 71260) if Stiff Man Syndrome is suspected based on clinical findings.

**PN-6.2: Inflammatory Muscle Diseases**

- MRI Lower Extremity non-joint without contrast (CPT® 73718) or MRI Lower Extremity non-joint without and with contrast (CPT® 73720) and/or MRI Upper Extremity non-joint (CPT® 73218) or MRI Upper Extremity non-joint without and with contrast (CPT® 73220), usually the most affected muscle is imaged (when criteria is met imaging can be approved for bilateral studies) for:
  - Additional evaluation of myopathy or myositis (based on clinical exam and adjunct testing with EMG/NCV and labs)
  - To plan muscle biopsy
  - See PEDMS-10.3: Inflammatory Muscle Diseases
- All cases with dermatomyositis and polymyositis can undergo search for occult neoplasm (See ONC–30.3: Paraneoplastic Syndromes):
  - Chest CT with contrast (CPT® 71260) for lung cancer and pelvic ultrasound (in women) (CPT® 76856 or CPT® 76857 and/or CPT® 76830 [transvaginal]) for ovarian cancer should be done initially
  - Abdomen and Pelvis CT with contrast (CPT® 74177) if the above fail to make a diagnosis

Background and Supporting Information

MRI and ultrasound are increasingly being used in the evaluation of muscle disease. MRI may be helpful in demonstrating abnormalities in muscles that are difficult to examine or not clinically weak, and MRI can also help distinguish between different types of muscle disease. MRI is also useful in determining sites for muscle biopsy.
PN-6.3: Gaucher Disease (Storage Disorders)

- See AB-11: Gaucher Disease and Hemochromatosis in the Abdomen Imaging Guidelines.
- See PEDPN-4: Gaucher Disease in the pediatric PND Imaging Guidelines.

References


PN-7: Newer Imaging Techniques

PN-8: Amyotrophic Lateral Sclerosis (ALS)

- MRI Brain, Cervical, Thoracic, and Lumbar Spine most often without contrast, but may be without and with contrast with meningeal symptoms.
  - Can be considered when ALS is suspected (combination of upper and lower motor neuron findings) to establish a diagnosis.
  - Repeat imaging can be evaluated based on the appropriate [Spine Imaging Guidelines](#).

References


**PN-9: Peripheral Nerve Sheath Tumors (PNST)**

- Tumors (Schwannomas or Neurofibromas) that arise from Schwann cells or other connective tissue of the nerve are located anywhere in the body and can undergo advanced imaging when suspected, which may include:
  - MRI Brain without and with contrast (CPT® 70553) (Vestibular Schwannomas Refer to HD-33.1: Acoustic Neuroma and Other Cerebellopontine Angle Tumors).
  - Cervical, thoracic, and lumbar spine MRI without and with contrast (CPT® 72156, CPT® 72157, and CPT® 72158) if paraspinal neurofibroma is found any spine level or multiple simplex perineural neurofibromas.
  - Follow-up imaging is not needed unless:
    - New symptoms or neurological findings develop.
    - Post operatively, at the discretion of the surgeon and to reestablish baseline if the tumor was not completely removed
    - CT Chest and Abdomen with contrast (CPT® 71260 and CPT® 74160) if malignant transformation (5%) is known or suspected
  - See PEDONC-2.3: Neurofibromatosis 1 and 2 (NF1 and NF2)).

**References**

PN-10: This section intentionally left blank