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.

CPT® (Current Procedural Terminology) is a registered trademark of the American Medical Association (AMA). CPT® five digit codes, nomenclature and other data are copyright 2016 American Medical Association. All Rights Reserved. No fee schedules, basic units, relative values or related listings are included in the CPT® book. AMA does not directly or indirectly practice medicine or dispense medical services. AMA assumes no liability for the data contained herein or not contained herein.
## Abbreviations for Pelvis Imaging Guidelines

<table>
<thead>
<tr>
<th>PV-1</th>
<th>General Guidelines</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td>PV-2</td>
<td>Abnormal Uterine Bleeding</td>
<td>4</td>
</tr>
<tr>
<td>PV-3</td>
<td>Amenorrhea</td>
<td>6</td>
</tr>
<tr>
<td>PV-4</td>
<td>Adenomyosis</td>
<td>7</td>
</tr>
<tr>
<td>PV-5</td>
<td>Adnexal Mass/Ovarian Cysts</td>
<td>9</td>
</tr>
<tr>
<td>PV-6</td>
<td>Endometriosis</td>
<td>10</td>
</tr>
<tr>
<td>PV-7</td>
<td>Pelvic Inflammatory Disease (PID)</td>
<td>16</td>
</tr>
<tr>
<td>PV-8</td>
<td>Polycystic Ovary Syndrome</td>
<td>17</td>
</tr>
<tr>
<td>PV-9</td>
<td>Infertility Evaluation, Female</td>
<td>18</td>
</tr>
<tr>
<td>PV-10</td>
<td>Intrauterine Device (IUD)</td>
<td>19</td>
</tr>
<tr>
<td>PV-11</td>
<td>Pelvic Pain/Dyspareunia, Female</td>
<td>20</td>
</tr>
<tr>
<td>PV-12</td>
<td>Leiomyomata/Uterine Fibroids</td>
<td>21</td>
</tr>
<tr>
<td>PV-13</td>
<td>Periurethral Cysts and Urethral Diverticula</td>
<td>22</td>
</tr>
<tr>
<td>PV-14</td>
<td>Uterine Anomalies</td>
<td>23</td>
</tr>
<tr>
<td>PV-15</td>
<td>Molar Pregnancy and Gestational Trophoblastic Neoplasia (GTN)</td>
<td>24</td>
</tr>
<tr>
<td>PV-16</td>
<td>Impotence/Erectile Dysfunction</td>
<td>25</td>
</tr>
<tr>
<td>PV-17</td>
<td>Penis–Soft Tissue Mass</td>
<td>26</td>
</tr>
<tr>
<td>PV-18</td>
<td>Pelvic Pain and Other Disorders, Male</td>
<td>27</td>
</tr>
<tr>
<td>PV-19</td>
<td>Scrotal Pathology</td>
<td>28</td>
</tr>
<tr>
<td>PV-20</td>
<td>Fistula In Ano</td>
<td>29</td>
</tr>
<tr>
<td>PV-21</td>
<td>Incontinence/Female Pelvic Organ Prolapse</td>
<td>30</td>
</tr>
<tr>
<td>PV-22</td>
<td>Patent Urachus</td>
<td>31</td>
</tr>
<tr>
<td>Abbreviation</td>
<td>Description</td>
<td></td>
</tr>
<tr>
<td>--------------</td>
<td>-------------</td>
<td></td>
</tr>
<tr>
<td>CA-125</td>
<td>cancer antigen 125 test</td>
<td></td>
</tr>
<tr>
<td>CT</td>
<td>computed tomography</td>
<td></td>
</tr>
<tr>
<td>FSH</td>
<td>follicle-stimulating hormone</td>
<td></td>
</tr>
<tr>
<td>GTN</td>
<td>gestational trophoblastic neoplasia</td>
<td></td>
</tr>
<tr>
<td>HCG</td>
<td>human chorionic gonadotropin</td>
<td></td>
</tr>
<tr>
<td>IC/BPS</td>
<td>interstitial cystitis/bladder pain syndrome</td>
<td></td>
</tr>
<tr>
<td>IUD</td>
<td>intrauterine device</td>
<td></td>
</tr>
<tr>
<td>KUB</td>
<td>kidneys, ureters, bladder (frontal supine abdomen radiograph)</td>
<td></td>
</tr>
<tr>
<td>LH</td>
<td>luteinizing hormone</td>
<td></td>
</tr>
<tr>
<td>MRA</td>
<td>magnetic resonance angiography</td>
<td></td>
</tr>
<tr>
<td>MRI</td>
<td>magnetic resonance imaging</td>
<td></td>
</tr>
<tr>
<td>MSv</td>
<td>millisievert</td>
<td></td>
</tr>
<tr>
<td>PA</td>
<td>posteroanterior projection</td>
<td></td>
</tr>
<tr>
<td>PID</td>
<td>pelvic inflammatory disease</td>
<td></td>
</tr>
<tr>
<td>TA</td>
<td>transabdominal</td>
<td></td>
</tr>
<tr>
<td>TSH</td>
<td>thyroid-stimulating hormone</td>
<td></td>
</tr>
<tr>
<td>TV</td>
<td>transvaginal</td>
<td></td>
</tr>
<tr>
<td>UCPPS</td>
<td>Urologic Chronic Pelvic Pain Syndrome</td>
<td></td>
</tr>
<tr>
<td>WBC</td>
<td>white blood cell count</td>
<td></td>
</tr>
</tbody>
</table>
PV-1~General Guidelines

PV-1.1 General Guidelines - Overview

✓ 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, appropriate laboratory studies, and non-advanced imaging modalities such as plain x-ray or pelvic (CPT®76856 or CPT®76857) and/or transvaginal ultrasound (CPT®76830).
  o The clinical evaluation may also include a gynecological and/or urological exam with appropriate laboratory studies such as blood count, tumor markers and endocrine evaluations.
  o Other meaningful contact (telephone call, electronic mail or messaging) by an established patient can substitute for a face-to-face clinical evaluation.

✓ Abdominal imaging begins at the diaphragm and extends to the umbilicus or iliac crest. Pelvic imaging begins at the umbilicus and extends to the pubis.

✓ Pregnant women can be evaluated with ultrasound or MRI without contrast to avoid radiation exposure.

Ultrasound

✓ Transvaginal ultrasound (TV) (CPT®76830) is the optimal study to evaluate female pelvic pathology.

✓ Pelvic ultrasound (complete CPT®76856 or, limited CPT®76857) can be performed if it is a complementary study to the TV ultrasound. It may substitute for TV in pediatric individuals or non-sexually active females.

✓ CPT®76942 is used to report ultrasound imaging guidance for needle placement during biopsy, aspiration, and other percutaneous procedures.

Soft Tissue Ultrasound

✓ Pelvic wall, buttocks, penis and perineum—CPT®76857

✓ Groin—CPT®76882

✓ Other soft tissue areas—CPT®76999

Scrotal Ultrasound

See also:

✓ PV-17~Impotence/Erectile Dysfunction

✓ PV-18~Penis-Soft Tissue Mass

✓ CPT®76870 Ultrasound of scrotum and contents
OTHER ULTRASOUND

✓ CPT®93975 Duplex scan (complete) scan of arterial inflow and venous outflow of abdominal, pelvic, scrotal contents and/or retroperitoneal organs; complete study

✓ CPT®93976 Duplex scan (limited) of arterial inflow and venous outflow of abdominal, pelvic, scrotal contents and/or retroperitoneal organs; limited study

✓ CPT®93975 and CPT®93976 should not be reported together during the same session

✓ 3D Rendering (CPT®76376 and CPT®76377) See Preface-4.1

CT

✓ CT pelvis with contrast is a possible modality unless there is a contrast allergy or CT without contrast to look for a calculus in the distal ureter or bladder.
  ○ CT is not generally warranted for evaluating pelvic anatomy because it is limited due to soft tissue contrast resolution

MRI

✓ Can be used as a more targeted study or for individuals allergic to iodinated contrast

✓ Pelvis MRI without contrast (CPT®72195) is the usual modality

✓ Pelvic MRI without and with contrast (CPT®72197) to evaluate the ovary or retroperitoneum

✓ Pelvis MRI with contrast only (CPT®72196) is rarely performed.
PV-2.1 Abnormal Uterine Bleeding (AUB)

- Initial evaluation includes any of the following:
  - Pelvic ultrasound (CPT®76856 and/or CPT®76857) and/or transvaginal ultrasound (CPT®76830), saline infusion sonohysterography (CPT®76831), hysteroscopy, D&C, and/or endometrial biopsy
  - If US is indeterminate for intracavitary lesion, 3-D Rendering (CPT®76376 or CPT®76377) may be approved as an add-on.

- For leiomyomas, MRI pelvis without contrast (CPT®72195) or MRI pelvis without and with contrast (CPT®72197) is appropriate for the following:
  - Guide the treatment of myomas in an enlarged uterus with multiple myomas and/or precise myoma mapping is of clinical importance (for surgical planning), or
  - When myomectomy is planned, before uterine artery embolization

- Generally, CT is not warranted for evaluating AUB since uterine anatomy is limited due to soft tissue contrast resolution.
  - An abnormal endometrium found incidentally on CT should be referred for TVUS for further evaluation.

References
PV-3.1 Amenorrhea

To identify etiology of genital and urinary tract abnormalities, the first step is the following:

- Ultrasound pelvis (CPT®76856 or CPT®76857) and/or TV (CPT®76830), hysterosalpingogram and/or hysteroscopy

The results of test(s) above determine the next steps, which may include:

- If ultrasound is indeterminate or equivocal for Asherman’s Syndrome, Polycystic Ovary Syndrome, or Androgen Secreting Ovarian Tumor, then MRI pelvis without contrast (CPT®72195) or without and with contrast (CPT®72197).

- Hormonally active adrenal tumor suspicion should be evaluated by criteria in AB-16~Adrenal Cortical Lesions in the Abdomen Imaging Guidelines.

- Individuals with absent uterus or a foreshortened vagina should have karyotype evaluation. Advanced imaging is generally not indicated.

- MRI head (pituitary protocol) without and with contrast (CPT®70553) if:
  - normal or low FSH and LH levels and evidence of increased intracranial pressure (e.g. headache, vomiting, vision changes)
  - prolactin (PRL) level is elevated above normal range in the absence of untreated hypothyroidism and/or drug-induced causes of elevated prolactin

- See also: HD-19~Pituitary in the Head Imaging Guidelines.

PV-3.2 Amenorrhea - Delayed Puberty

Delayed puberty can be further evaluated with thyroid function tests, LH, FSH and prolactin.

- Ultrasound, Pelvis (CPT®76856 or CPT®76857) and/or TV (CPT®76830), hysterosalpingogram and/or hysteroscopy

- MRI head (pituitary protocol) without and with contrast (CPT®70553) if:
  - normal or low FSH and LH levels and evidence of increased intracranial pressure (e.g. headache, vomiting, vision changes)
  - prolactin (PRL) level is elevated above normal range in the absence of untreated hypothyroidism and/or drug-induced causes of elevated prolactin

- See also: HD-19~Pituitary in the Head Imaging Guidelines.
References
PV-4.1 Adenomyosis

✓ Pelvic (CPT®76856 or CPT®76857) and/or TV Ultrasound (CPT®76830) along with color Doppler ultrasound (CPT® 93975 or CPT®93976) is the diagnostic procedure of choice for the initial evaluation of suspected adenomyosis.

✓ MRI Pelvis without contrast (CPT®72195) or MRI pelvis without and with (CPT®72197) is considered a second-line when:
  o Inconclusive US and the individual has failed several months (3 months) of hormone suppression; or
  o Enlarged uterus or with coexisting fibroids and further delineation would affect individual management

**Adenomyosis – Practice Notes**

Adenomyosis is when endometrial tissue, which normally lines the uterus, moves into the outer muscular walls of the uterus. Adenomyosis is a histologic diagnosis and is suspected by history and physical examination. Ultrasound findings of adenomyosis include heterogeneous myometrium, myometrial cysts, asymmetric myometrial thickness, and subendometrial echogenic linear striations.

**Reference**

# PV-5~Adnexal Mass/Ovarian Cysts

| PV-5.1 Suspected Adnexal Mass – Initial Evaluation in All Women | 11 |
| PV-5.2 Complex Adnexal Masses – Pre-Menopausal | 11 |
| PV-5.3 Complex Adnexal Masses – Post-Menopausal | 13 |
| PV-5.4 Screening for Ovarian Cancer | 13 |
| PV-5.5 Simple Cysts | 13 |
PELVIS IMAGING GUIDELINES

PV-5.1 Suspected Adnexal Mass – Initial Evaluation in All Women
✓ Transvaginal (TV) ultrasound imaging (CPT®76830) is the initial study of choice.1,2
  o Pelvic ultrasound (CPT®76856 or CPT®76857) can be performed if requested as a complimentary study to the TV ultrasound.
  o Duplex (Doppler) scan (CPT®93975 complete; CPT®93976 limited) may be approved as an add-on to TV US (CPT®76830)

✓ If ultrasound does not identify the origin of the pelvic mass (adnexal, uterine, or other in etiology)1, MRI pelvis without contrast (CPT®72195), OR without and with contrast (CPT® 72197; CPT®72195 if pregnant)
  o If the mass is unrelated to female pelvic anatomy, CT with contrast is indicated

If a Complex Adnexal Mass is identified in a pre-menopausal woman, see:
PV-5.2 Complex Adnexal Masses – Pre-Menopausal

If a Complex Adnexal Mass is identified in a post-menopausal woman, see:
PV-5.3 Complex Adnexal Masses – Post-Menopausal; PV-5.5 Simple Cysts

PV-5.2 Complex Adnexal Masses – Pre-Menopausal
For women of reproductive age (pre-menopausal), evaluation includes a pregnancy test (a quantitative hCG may be necessary if an ectopic pregnancy is suspected), CBC, serial hematocrit measurements, and appropriate cultures.

Symptomatic individuals often require immediate interventions (antibiotics, surgery, and/or expectant management)

Ultrasound characteristics usually suggest the diagnosis (ectopic pregnancy, functional cysts, tuboovarian abscess, hydrosalpinx, dermoid, endometrioma, hemorrhagic cyst and pedunculated fibroids) and direct the treatment.
✓ Hemorrhagic cyst:
  o If initial imaging confirms hemorrhagic cyst, follow up with pelvic ultrasound (CPT®76856 or CPT®76857 and/or [transvaginal] CPT®76830) in six weeks or following a menstrual cycle to evaluate for resolution. Duplex (Doppler) scan (CPT®93975 complete; CPT®93976 limited) may be approved as an add-on to TV US (CPT®76830)
  o If follow-up imaging confirms a hemorrhagic cyst that has not completely resolved, a repeat ultrasound (CPT®76856 or CPT®76857 and/or CPT®76830 [transvaginal]) can be performed in 6 months (sooner if signs or symptoms persist or if new symptoms occur).
PELVIS IMAGING GUIDELINES

✓ Endometriomas
  o If initial imaging confirms an endometrioma, follow-up ultrasound (CPT®76856 or CPT®76857 and/or CPT®76830 [transvaginal]) can be performed at 6 to 12 weeks then every 6 months if not surgically resected; duplex (Doppler) scan (CPT®93975 complete; CPT®93976 limited) may be approved as an add-on to TV US (CPT®76830)

✓ Dermoids (pre- and post-menopausal)
  o If initial imaging confirms a Dermoid, follow-up ultrasound (CPT®76856 or CPT®76857 and/or CPT®76830 [transvaginal]) can be performed at 6 to 12 months; duplex (Doppler) scan (CPT®93975 complete; CPT®93976 limited) may be approved as an add-on to TV US (CPT®76830)
    ▪ If surgical resection is not performed, then follow-up pelvic ultrasound (CPT®76856 or CPT®76857 and/or CPT®76830 [transvaginal]) for both pre-and post-menopausal women can be obtained every 6 to 12 months.
  o If initial ultrasound imaging (CPT®76857 or CPT®76856 and/or transvaginal CPT®76830) is indeterminate for Dermoids, the diagnosis can be confirmed by CT pelvis (contrast as requested) or MRI pelvis without contrast (CPT®72195) or MRI pelvis without and with contrast (CPT®72197)
    ▪ If surgical resection is not performed, then follow-up pelvic ultrasound (CPT®76856 or CPT®76857 and/or CPT®76830 [transvaginal]) for both pre-and postmenopausal women can be obtained every 6 to 12 months.

✓ Hydrosalpinxes or peritoneal cysts (pre- and post-menopausal)
  o If initial imaging confirms hydrosalpinxes or peritoneal cysts, advanced imaging is rarely indicated in these clinical scenarios. Send for physician review.
  o If initial ultrasound imaging (CPT®76857 or CPT®76856 and/or transvaginal CPT®76830) is indeterminate, one repeat US is indicated in 6 weeks or following a menstrual cycle to evaluate for resolution. Duplex (Doppler) scan (CPT®93975 complete; CPT®93976 limited) may be approved as an add-on to TV US (CPT®76830). 3-D Rendering (CPT®76376 or CPT®76377) may be approved as an add-on.

✓ Advanced imaging may be considered for elevated tumor makers if an ultrasound is indeterminate and/or ovarian malignancy is suspected.
  o CT abdomen and pelvis with contrast (CPT®74177) as a pre-operative study to evaluate for metastatic disease when cancer is known or suspected
  o CT abdomen and pelvis (CPT®74177) can detect omental metastases, peritoneal implants, pelvic and periaortic lymph node enlargement
  o CT abdomen and pelvis without and with contrast (CPT®74178) can be considered for suspected hepatic metastases and obstructive uropathy

✓ Advanced imaging may be indicated for an ovarian mass suspicious for metastatic disease (e.g. from breast, uterine, colorectal or gastric cancer) and should be evaluated based on the appropriate Oncology Imaging guideline.
**Practice Notes**

- Germ cell tumors are more common in young women which can be confirmed by beta hCG, AFP, and LDH
- CA-125 tumor marker can confirm for other malignancy suspicion

**PV-5.3 Complex Adnexal Masses – Post-Menopausal**

For post-menopausal women, most pelvic complex cysts or solid masses should be evaluated for surgical intervention and have tumor markers (CA-125) measured.

- An ovarian mass suspicious for metastatic disease (e.g. from breast, uterine, colorectal or gastric cancer) should be evaluated based on the appropriate Oncology Imaging guideline.

- If ultrasound is indeterminate, advanced imaging may be appropriate for high risk treatment planning. Send for Medical Director review.

- Some women for whom the usual management of a pelvic mass would include surgery may be at increased risk for perioperative morbidity and mortality. In such cases, repeat imaging may be a safer alternative than immediate surgery, although the frequency of follow-up imaging has not been determined.

**PV-5.4 Screening for Ovarian Cancer**

- See **ONC-21~Ovarian Cancer** in the Oncology Imaging Guidelines

**PV-5.5 Simple Cysts**

- For simple or thin walled cystic mass, follicular cyst (ovarian), tubular cystic mass (fallopian tube) on initial TV ultrasound (CPT®76830):
  - Repeat TV ultrasound (CPT®76830) and/or Pelvic ultrasound (CPT®76857 or CPT®76856)
    - According to the below schedule if <= 10 cm
    - CA-125 in all postmenopausal individuals
    - Cysts > 10 cm have not been studied and the current recommendation is to consider surgical intervention.
    - Advanced imaging may be appropriate for preoperative planning if requested by the operating surgeon or elevated tumor marker(s). Requests will be sent to Medical Director for review.
PELVIS IMAGING GUIDELINES

Simple Cyst Follow-Up

<table>
<thead>
<tr>
<th>Size</th>
<th>Pre-Menopausal</th>
<th>Post-Menopausal</th>
</tr>
</thead>
<tbody>
<tr>
<td>&gt; 1 cm to 5 cm</td>
<td>N/A</td>
<td>TV ultrasound (CPT®76830) and/or pelvic ultrasound (CPT®76857 or CPT®76856) at 6 months</td>
</tr>
<tr>
<td>&gt; 5 cm to 7 cm</td>
<td>TV ultrasound (CPT®76830) and/or pelvic ultrasound (CPT®76857 or CPT®76856) annually</td>
<td>TV ultrasound (CPT®76830) and/or pelvic ultrasound (CPT®76857 or CPT®76856) or MRI pelvis without and with contrast (CPT®72197) for follow-up as clinically indicated; follow-up intervals may be adjusted on basis of degree of cyst change</td>
</tr>
<tr>
<td>&gt; 7 cm to 10 cm</td>
<td>TV ultrasound (CPT®76830) and/or pelvic ultrasound (CPT®76857 or CPT®76856) every 6 months</td>
<td>MRI pelvis without and with contrast (CPT®72197) one time</td>
</tr>
</tbody>
</table>

Practice Notes

Suspected Adnexal Mass – Tumor Markers

The adnexa include the ovaries, Fallopian tubes, and ligaments that hold the uterus in place.

CA-125 is a tumor marker that is useful for the evaluation of adnexal mass:

- Elevation occurs with both malignant (epithelial cancer) and benign entities (leiomyoma, endometriosis, PID, inflammatory disease such as lupus, and inflammatory bowel disease).

- Increase in the markers over time occurs with malignancy only

- Obtain CA-125 in all post-menopausal individuals with simple cyst.

- Consider tumor markers individuals with an abnormal US that is not a simple cyst

- Other markers include Beta hCG, LDH, and AFP (germ cell tumors) and Inhibin A and B (granulosa cell tumor)

Simple and Complex Adnexal Cysts

Simple cysts are smooth walled and clear without debris. Simple cysts up to 10 cm in diameter as measured by ultrasound are almost universally benign and may safely be followed with ultrasound, without intervention, even in postmenopausal women and pediatric individuals with normal tumor markers.

Complex cysts can have solid areas or excrescences, and/or debris in them, greater than 3 mm irregular septations, mural nodules with Doppler-detected blood flow, and/or free abdominal/pelvic fluid.
References
PV-6.1 Endometriosis

✓ Pelvic (CPT®76856 or CPT®76857) and/or TV (CPT®76830) US is then the first line diagnostic exam for pain or abnormality on exam
  o In most individuals, US followed by medical treatment or laparoscopy should be considered prior to advanced imaging
  o Laparoscopy remains the definitive test for diagnosis and evaluation of endometriosis in most individuals.

✓ MRI pelvis without contrast (CPT®72195) or without and with (CPT®72197) is helpful:
  o When there is rectal involvement, rectovaginal endometriosis, deeply infiltrative bladder endometriosis, and cul-de-sac obliteration
    ▪ MRI has been shown to detect accurately rectovaginal endometriosis and cul-de-sac obliteration in the more than 90% of cases when sonographic gel was inserted in the vagina and rectum
  o To characterize complex adnexal masses as endometrioma if ultrasound is indeterminate
  o To enable complete lesion mapping prior to surgical excision of known endometriosis that was diagnosed during a previous surgery.

References

PV-7~Pelvic Inflammatory Disease (PID)

PV-7.1 Pelvic Inflammatory Disease

✓ Pelvic (CPT® 76856 or CPT® 76857) and/or TV (CPT® 76830) US is the initial study for imaging of pelvic inflammatory disease (PID)

✓ CT abdomen and pelvis with contrast (CPT® 74177) or CT pelvis with contrast (CPT® 72193) when:
  o US is indeterminate, or
  o Extensive abscess formation as determined by ultrasound

References
PV-8~Polycystic Ovary Syndrome

PV-8.1 Polycystic Ovary Syndrome
✓ Pelvic (CPT®76856 or CPT®76857) and/or TV US (CPT®76830) may be performed based on history, exam, and laboratory findings suspicious for this disease
✓ Abdomen CT with (bolus arterial phase) contrast (CPT®74160) only if elevated serum levels of androgens is found and an adrenal etiology is suspected.
  o See AB-16~Adrenal Cortical Lesions
  o Serum levels of androgens. Free testosterone level is thought to be the best measure.

Polycystic Ovary Syndrome – Practice Notes
Polycystic ovary syndrome is the most common hormonal disorder among women of reproductive age, and is one of the leading causes of infertility.

Ovaries are often enlarged and contain numerous small cysts located along the outer edge of each ovary. Signs and symptoms may include:
✓ Anovulation resulting in infrequent or prolonged menstrual periods
✓ Excessive amounts or effects of androgenic (masculinizing) hormones (e.g. excess hair growth)
✓ Acne
✓ Obesity

Reference
PV-9~Infertility Evaluation, Female

PV-9.1 Infertility Evaluation, Female

✓ Initial work-up of infertility in female:
  o Pelvic (CPT® 76856 or CPT® 76857) and transvaginal ultrasound (CPT® 76830). If indicated, color Doppler (CPT® 93975/93976) and/or 3D imaging (CPT® 76377).
  o Hysterosalpingography (HSG) (CPT® 74740)
    ▪ Injection of contrast through a catheter (CPT® 58340) is not currently prior authorized by eviCore healthcare
  o Sonohysterosalpingography (CPT® 76831)
    ▪ Injection of contrast through a catheter (CPT® 58340) is not currently prior authorized by eviCore healthcare

Practice Notes

These guidelines are not intended for fertility follow-up and management.

If infertility is a covered service, the specialist may, over the course of several menstrual cycles, request multiple ultrasounds to follow follicular maturation and monitor endometrial thickness.

References

PV-10.1 Intrauterine Device

✓ Pelvic (CPT®76856 or CPT®76857) and/or TV (CPT®76830) US if:
  o Abnormal pelvic exam prior to IUD insertion, such as pelvic mass, irregularly shaped uterus, or enlarged uterus.
  o Suspected complication at the time or immediately following IUD insertion:
    ▪ Abnormal IUD position
    ▪ Uterine perforation
    ▪ Severe pain
    ▪ Excessive bleeding
  o Failure to improve with conservative treatment (7 days) such as antibiotics for cramping, light bleeding, and/or low grade fever following IUD placement
  o NOT as routine imaging to evaluate position prior to, immediately after and, for example, 6 weeks after insertion

✓ If TV US is negative or non-diagnostic:
  o Pelvic US (CPT® 76856 or CPT® 76857)
  o If pelvic US is negative or non-diagnostic, plain x-ray should be performed if pregnancy test is negative.
  o Thereafter, CT pelvis without contrast (CPT®72192) or CT abdomen/pelvis without contrast (CPT®74176) or MRI pelvis without contrast (CPT®72195) can be considered when both ultrasound and plain x-ray are equivocal or non-diagnostic.

✓ If pregnancy test is positive:
  o Ultrasound can be performed to locate an intrauterine device (IUD)
    (CPT®76801 if a complete ultrasound has not yet been performed, CPT®76815 or CPT®76816 if a complete ultrasound was done previously, and/or CPT®76817 for a transvaginal ultrasound)

References

For unexplained pelvic pain and/or dyspareunia, the initial imaging test should be pelvic ultrasound (CPT®76856 or CPT®76857) and/or TV ultrasound (CPT®76830):
- If ovarian torsion is suspected, add Duplex (Doppler) scan (CPT®93975 or CPT®93976) to TV US (CPT®76830)
- For chronic pain, add Duplex Doppler (CPT®93975 or CPT®93976)

If initial ultrasound is normal, consider urological work-up, gastroenterology work-up or laparoscopic evaluation(s) in evaluation of pelvic pain.

If the initial ultrasound is equivocal for unexplained chronic pelvic pain then the following can be considered:
- CT pelvis with contrast (CPT®72193) and/or CT abdomen and pelvis with contrast (CPT®74177) for unexplained chronic pelvic pain

If the initial ultrasound is equivocal for unexplained chronic pelvic pain and if pelvic congestion is suspected:
- MRI pelvis (CPT®72195) and/or pelvis MRV (CPT®72198), and/or CTV pelvis (CPT®72191) for pelvic congestion

If pelvic AVM is suspected, and if one of the following is present, then CTA pelvis (CPT®72191) can be considered
- Pulsatile pelvic mass
- Incidental finding on prior imaging including ultrasound

Pelvic Pain/Hip Pain—Rule Out Piriformis Syndrome
- See PN-2~Focal Neuropathy in the PND Imaging Guidelines and
- MS-24 - Hip in the Musculoskeletal Imaging Guidelines.

Work-up of interstitial cystitis/bladder pain syndrome (IC/BPS) should include history, physical exam, laboratory exam (urinalysis and urine culture), and measurement of post void residual urine by bladder catheterization or by ultrasound (CPT®76856 or CPT®76857 or CPT®76830 [female]).
- CT pelvis with contrast (CPT®72193) and/or CT abdomen and pelvis with contrast (CPT®74177) may be indicated if ultrasound is equivocal for complicated interstitial cystitis/bladder pain syndrome (when ordered by Specialist) or uncomplicated when ultrasound is equivocal or abnormal.
Interstitial Cystitis/Bladder Pain Syndrome (IC/BPS) has an unpleasant sensation (pain, pressure, discomfort), perceived to be related to the urinary bladder. It is associated with lower urinary tract symptoms of more than six weeks duration, in the absence of infection or other identifiable causes.

References
PV-12~Leiomyomata/Uterine Fibroids

PV-12.1 Leiomyomata

Leiomyomata are also known as “fibroids.”

- Pelvic (CPT®76856 or CPT®76857) and/or TV US (CPT®76830) can be performed for the following:
  - Suspected leiomyomata
  - Pre-operative prior to myomectomy
  - Persistent or recurrent symptoms such as abnormal bleeding, pain, or pelvic pressure
  - If ultrasound is indeterminate and intracavitary lesion is suspected 3-D Rendering (CPT®76376/76377) may be added

- MRI pelvis without and with contrast (CPT®72197) or without contrast (CPT®72195) can be used in the evaluation of leiomyomas for the following:
  - Guide the treatment of myomas in an enlarged uterus with multiple myomas and/or precise myoma mapping is of clinical importance (for complex surgical planning)
  - Equivocal sonohysterography or panoramic hysteroscopy with suspected submucous leiomyoma and imaging is needed for surgical planning
  - Indeterminate US prior to myomectomy
  - Leiomyoma necrosis is suspected
  - Arterial embolization is being considered
    - If MRI is indeterminate, MRA pelvis (CPT®72198) or CTA pelvis (CPT®72191) can be considered if requested by the interventional radiologist planning the arterial embolization

- There is no evidence to support interval MRI after embolization unless persistent or recurrent symptoms

References
PV-13~Periurethral Cysts and Urethral Diverticula

PV-13.1 Periurethral cysts and urethral diverticula

Can be evaluated with any of the following, at providers’ request:

✔ Ultrasound (CPT®76856 or CPT®76857 and/or transvaginal CPT®76830

✔ Urethrography, or CT Urethrography can be performed to evaluate any urethral abnormalities

✔ If ultrasound is indeterminate, MRI pelvis without and with contrast (CPT®72197)

✔ Also see AB-40~Urinary Tract Infection

Periurethral cysts and urethral diverticula – Practice Note

Symptomatic infection of congenital periurethral glands can result in urethral diverticula. Symptoms include pain, urinary urgency, frequency of urination, recurrent urinary tract infection, dribbling after urination, or incontinence.

Reference


PV-14.1 Uterine Anomalies

- Pelvic ultrasound (CPT®76856 or CPT®76857) and/or TV ultrasound (CPT®76830) 3-D Rendering (CPT® 76376/76377) may be approved as an add-on
- Retroperitoneal ultrasound (CPT®76770 or CPT®76775) is indicated to evaluate for coexisting renal anomalies
- Pelvis MRI without and with contrast (CPT®72197):
  - Ultrasound defines a complex anomaly or is not definitive, or
  - Requested for surgical planning

References
PV-15.1 Molar Pregnancy and GTN

✓ Individuals should undergo brain imaging, preferably MRI brain without and with contrast (CPT®70553), CT abdomen and pelvis with contrast (CPT®74177), and chest x-ray as a metastatic work up.
  o Treatment is usually methotrexate
  o Weekly HCG tests are performed until they fall to zero.

Molar Pregnancy and GTN – Practice Note

A recurrent molar pregnancy is called gestational trophoblastic neoplasia (GTN). These cells are malignant and can metastasize to other organs such as lungs, brain, bone, and vagina.

References
PV-16.1 Impotence/Erectile Dysfunction

- Imaging depends on the suspected disease:
  - If erectile dysfunction suspected, penile Doppler ultrasound (CPT®93980) can be performed\(^2\)
  - If Peyronie disease suspected, Duplex ultrasound (CPT®93980) can be used to assess penile vasculature in Peyronie’s disease\(^1\)
  - If male hypogonadism is suspected, see HD-19~Pituitary in the Head Imaging Guidelines

Functional MRI or PET studies are considered investigational for this indication.

References
PV-17.1 Penis–Soft Tissue Mass

✔ Soft-tissue lesions of the penis should be evaluated initially penile ultrasound (CPT®76857).

✔ MRI of the pelvis with and without contrast (CPT®72197) or CT of the pelvis with contrast (CPT®72197) can be performed:
  o Penile ultrasound (CPT®76857) is equivocal (not clearly benign, simple cyst or Peyronie’s disease), or
  o Primary penile cancer is suspected

References
PV-18.1 Pelvic Pain and Other Disorders, Male

✓ Prostate Disorders
  o Suspected Benign Prostatic Hypertrophy with obstructive voiding symptoms can undergo:
    ▪ Transrectal ultrasound (CPT®76872) or US pelvis transabdominal (bladder and prostate)¹¹
  o Prostatitis with urinary retention or suspected abscess can undergo any of the following imaging studies¹²
    ▪ Transrectal ultrasound (CPT®76872) or US pelvis transabdominal (bladder and prostate)
    ▪ Pelvis CT with contrast (CPT®72193)
    ▪ Pelvis MRI without contrast (CPT®72195)
  o Pelvis CT with contrast (CPT®72193) may be used to differentiate between abscess and tumor if ultrasound is equivocal

✓ Hematospermia, transrectal ultrasound (TRUS) (CPT®76872) can be the initial imaging study in all cases⁶
  o Pelvis MRI without contrast (CPT®72195) can be considered to evaluate:
    ▪ Suspected hemorrhage within the seminal vesicles
    ▪ Radiation injury, neoplasia
    ▪ Failure of conservative treatment, or (2 weeks)
    ▪ Abnormal findings on transrectal ultrasound.

✓ Scrotal pain or mass initial evaluation by scrotal ultrasound (CPT®76870) and/or Duplex (Doppler) scan ultrasound (CPT®93975 or CPT®93976) of the scrotum.
  o MRI of the pelvis without and with contrast (CPT®72197) or Tc-99m scrotal scintigraphy (CPT®78761) if ultrasound is inconclusive¹,²

See AB-12.4 Indeterminate Groin Pain
See PN-5 Lumbar and Lumbosacral Plexus
See “Work-up of interstitial cystitis/bladder pain syndrome (IC/BPS)” PV-11.1

Pelvic Pain/Dyspareunia, Female
References

**PV-19.1 Scrotal Pathology**

- See **ONC-20**—Testicular and Non-epithelial Ovarian (Germ Cell) Cancer
- See **AB-12** (Inguinal) Hernia
- See **PACPV-13** Undescended Testes

Scrotal pain or mass initial evaluation by scrotal ultrasound (CPT®76870) and/or Duplex (Doppler) scan ultrasound (CPT®93975 or CPT®93976) of the scrotum.

  - MRI of the pelvis without and with contrast (CPT®72197) or Tc-99m scrotal scintigraphy (CPT® 78761) if ultrasound is inconclusive.

- See **AB-12.4** “Indeterminate Groin Pain”

- Cryptorchidism/undescended testis in the adult can undergo scrotal ultrasound (CPT®76870), MRI of the pelvis without and with contrast (CPT®72197) or Pelvis CT with contrast (CPT®72193)

- Varicocele suspected (for example, in inguinal hernia evaluation) can undergo Duplex (Doppler) scan ultrasound (CPT®76870 and/or CPT®93975 or CPT®93976) of the scrotum with color flow mapping in supine and upright positions to assess venous reflux into plexus pampiniformis.

**Scrotal Pathology – Practice Notes**

The causes of pain include torsion, epididymitis, strangulated hernia, segmental testicular infarction, trauma, testicular tumor, and idiopathic scrotal edema.¹

**Reference**

PV-20.1 Fistula In Ano

✓ MRI pelvis without and with contrast (CPT®72197) is indicated for the assessment of complex or recurrent fistulas.
  o Preoperative MRI frequently alters the surgical approach and MRI guided surgery can significantly decrease postoperative recurrence in complex cases by 75%.

References
PV-21~Incontinence/Female Pelvic Organ Prolapse

PV-21.1 Urinary Incontinence – Initial Imaging

✓ Initial Imaging, associated with other evaluations, are:
  o Non-Neurogenic Incontinence
    ▪ Measurements of post void residual urine by bladder ultrasound (CPT®76856 or CPT®76857 or CPT®76830 [female]). Bladder catheterization and/or urodynamic studies may be authorized if requested.
  o Neurogenic Incontinence
    ▪ Ultrasound of the urinary tract (CPT®76770 or CPT®76775) and/or urodynamic studies

PV-21.2 Urinary Incontinence – Further Imaging

✓ CT abdomen and/or pelvis, contrast as requested, can be performed for the following:
  o Non-diagnostic ultrasound or abnormality on ultrasound that requires further evaluation
  o Complicated incontinence
  o Suspected fistulae
  o Detecting ectopic ureters if ultrasound is non-diagnostic
  o Pre-operative planning when ordered by the operating physician

✓ MRI may be indicated for evaluation of the brain, spine, or other regions of the nervous system in neurogenic urinary incontinence

PV-21.3 Female Pelvic Organ Prolapse

✓ MRI abdomen (CPT®74181 or CPT®74183) and/or MRI Pelvis (CPT®72195 or CPT®72197) may be indicated for the following:
  o Pelvic floor anatomy and pelvic organ prolapse evaluations if exam and ultrasound are indeterminate, or
  o Equivocal results on CT, or
  o Pre-operative planning when ordered by the operating physician

✓ Dynamic MRI of abdomen (CPT®74181 or CPT®74183) and/or pelvis (CPT®72195 or CPT®72197) may be indicated for the following:
  o Pre-operative planning when ordered by the operating physician, or
  o Persistent incontinence following surgery
Urinary Incontinence – Practice Notes
Urinary incontinence can be “stress,” “urgency,” or mixed; neurogenic or non-neurogenic; and complicated or uncomplicated. Neurogenic incontinence can occur from cerebral, spinal or peripheral neurological diseases.

Complicated urinary incontinence includes:

✓ Failed conservative treatment
✓ Pain or dysuria
✓ Hematuria
✓ Recurrent infection
✓ Previous radical pelvic surgery
✓ Suspected fistula
✓ Suspected mass
✓ Previous pelvic or prostate irradiation

PV-21.4 Fecal Incontinence
This evaluation is similarly divided into those with suspected neurogenic (CNS or spinal cord) and non-neurogenic incontinence. Neurological Specialist evaluation will guide the specific imaging with neurogenic etiology.

✓ Non-Neurogenic imaging, associated with other evaluations, are:
  o Transanal, endoanal or transrectal ultrasound (CPT® 76872)
  o Anal manometry
  o Balloon Expulsion Test (BET)
  o Pudendal nerve terminal motor latency
  o EMG
  o Barium defecography (There are currently insufficient evidence-based data to generate appropriateness criteria for MR defecography)

✓ If the results of a recent ano-rectal manometry demonstrate: 1) weak pressures; and/or 2) an abnormal balloon expulsion test; and 3) a failure of a recent trial of conservative treatment in anticipation of surgical management, MRI pelvis without and with contrast (CPT® 72197) can be considered when requested by the operating surgeon.

See AB-21 Diarrhea, Constipation and Irritable Bowel
Practice Notes

Diagnostic assessment of fecal incontinence:

✔ Determine the severity of the incontinence by using the Bristol Stool Scale, which includes frequency, leakage, and pressure of urgency

✔ Step 1 - History and Physical, which should include digital rectal examination and perianal pinprick to help screen for neurogenic causes

✔ Step 2 - Diagnostic testing; Ano-rectal manometry and BET (balloon expulsion test, where a balloon is insufflated to 50ml, and time to expel is measured, as well as an inability to hold it in)

✔ Step 3 - Trial of conservative therapy (anti-diarrheal, etc.)

✔ Step 4 - Pelvic floor and anal canal imaging as well as EMG should be considered for individuals with decreased anal pressures who have failed conservative treatment, particularly if surgery is being considered. Imaging can be with endoanal ultrasound or MRI (MRI superior for seeing the external anal area for scarring and to identify anal sphincter atrophy).

References

PV-22~Patent Urachus

PV-22.1 Patent Urachus

✓ Drainage from the umbilicus, redness around umbilicus, abdominal pain, or urinary tract infection from persistent fetal connection between the bladder and the umbilicus can be evaluated by:
  o Ultrasound (CPT®76856 or CPT®76857 and/or CPT®76700 or CPT®76705)
  o CT pelvis with contrast (CPT®72193) if ultrasound is equivocal or if needed for surgical planning.

References