CIGNA MEDICAL COVERAGE POLICIES - RADIOLOGY

Spine Imaging Guidelines

Effective Date: February 02, 2027

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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Spine Imaging Guidelines

General Guidelines (SP-1.0)

SP.GG.0001.0.A
v1.0.2027

Criteria

- These Spine Imaging Guidelines are intended for further investigation of spinal conditions or concerns. Imaging guidelines for non-spinal, musculoskeletal (MSK) conditions or concerns (e.g., shoulder, elbow, wrist, hand, arm, pelvis, hip, knee, ankle, leg, foot) are located in **Musculoskeletal Imaging Guidelines**.
- Before advanced diagnostic imaging can be considered, there must be an in-person clinical evaluation as well as a clinical re-evaluation after a trial of failed conservative therapy. Conservative therapy is not required in the presence of a Red Flag Indication or if otherwise stated in the Spine Imaging Guidelines.
- An in-person clinical evaluation performed after the current episode of symptoms started or changed is required and must include relevant:
  - history
  - physical examination
  - neurological examination documenting **AT LEAST ONE** of the following:
    - motor strength testing
    - sensory examination (e.g., documentation of the specific dermatomal distribution of altered sensation)
    - deep tendon reflex examination
    - nerve root tension signs, when applicable (e.g., straight leg raise test, slump test, femoral nerve tension test)
- For those spinal conditions/disorders for which the Spine Imaging Guidelines require a plain x-ray of the spine prior to consideration of an advanced imaging study, the plain x-ray must be performed after the current episode of symptoms started or changed and results need to be available to the requesting provider of the advanced imaging study (see: **Anatomic Guidelines [SP-2.1]**).
- Clinical re-evaluation is required prior to consideration of advanced diagnostic imaging to document failure of clinical improvement following a trial of provider-directed treatment after the current set of symptoms or physical exam findings started or changed as follows:
  - A documented trial of conservative care lasting at least six weeks in duration
  - A clinical re-evaluation or documentation of other meaningful contact (e.g., email, telephone, video consult) with the provider's office following the initial evaluation
  - Details will be in the specific criteria sections throughout this publication regarding when conservative treatment is required.

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- Any bowel/bladder abnormalities or emergent or urgent indications should be documented at the time of the initial clinical evaluation and clinical re-evaluation.
- Altered sensation to pressure, pain, and temperature should be documented by the specific anatomic distribution (e.g., dermatomal, stocking/glove or mixed distribution).
- Motor deficits (weakness) should be defined by the specific myotomal distribution (e.g., weakness of toe flexion/extension, knee flexion/extension, ankle dorsi/plantar flexion, wrist dorsi/palmar flexion) and gradation of muscle testing should be documented as follows:

Grading of Manual Muscle Testing	
0	No muscle activation
1	Trace muscle activation, such as a twitch, without achieving full range of motion
2	Muscle activation with gravity eliminated, achieving full range of motion
3	Muscle activation against gravity, full range of motion
4	Muscle activation against some resistance, full range of motion
5	Muscle activation against examiner's full resistance, full range of motion

- Pathological reflexes (e.g., Hoffmann's, Babinski, and Chaddock sign) should be reported as positive or negative.
- Asymmetric reflexes and reflex examination should be documented as follows:

Grading of Reflex Testing	
0	No response
1+	A slight but definitely present response
2+	A brisk response
3+	A very brisk response without clonus
4+	A tap elicits a repeating reflex (clonus)

- Advanced diagnostic imaging is often urgently indicated and may be necessary if serious underlying spinal and/or non-spinal disease is suggested by the presence

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of certain individual factors referred to as “Red Flags.” See: **Red Flag Indications (SP-1.2)**.

- Spinal specialist evaluation can be helpful in determining the need for advanced diagnostic imaging, especially for individuals following spinal surgery.
- The need for repeat advanced diagnostic imaging should be carefully considered and may not be medically necessary if prior advanced diagnostic imaging has been performed. In cases of chronic low back pain with no disease progression, repeat imaging is considered not medically necessary. Requests for simultaneous, similar studies such as spinal MRI and CT need to be documented as required for pre-operative surgical planning. These studies may be helpful in the evaluation of complex failed spinal fusion cases or needed for pre-operative surgical planning when the determination of both soft tissue and bony anatomy is required.
- Serial advanced imaging, whether CT or MRI, for surveillance of healing or recovery from spinal disease is not supported by the currently available scientific evidence-based medicine for the majority of spinal disorders.
  - Requests for repeat imaging may be considered on a case-by-case basis (e.g., concern for delayed union or non-union of spinal fracture, pseudoarthrosis of fusion, etc.).
- Advanced imaging is considered not medically necessary for resolved or improving spinal pain and/or radiculopathy.
- Advanced diagnostic imaging has not been shown to be of value in individuals with stable, longstanding spinal pain without neurological features or without clinically significant or relevant changes in symptoms or physical examination findings.
- Anatomic regions of the spine/pelvis that are included in the following MRI and CT advanced diagnostic imaging studies:
  - Cervical spine: from the skull base/foramen magnum through T1
  - Thoracic spine: from C7 through L1
  - Lumbar spine: from T12 through mid-sacrum
  - Pelvis: includes hips, sacroiliac joints, sacrum, coccyx
- CT or MRI of the cervical and thoracic spine will image the entire spinal cord since the end of the spinal cord or conus medullaris usually ends at L1 in adults. Therefore, lumbar spine imaging is not needed when the goal is to image only the spinal cord unless there is known or suspected low lying conus medullaris (e.g., tethered cord).

Health Equity Consideration

Health equity is the highest level of health for all individuals; health inequity is the avoidable difference in health status or distribution of health resources due to the social conditions in which individuals are born, grow, live, work, and age. Social determinants of health are the conditions in the environment that affect a wide range of health, functioning, and quality of life outcomes and risks. Examples include the following: safe housing, transportation, and neighborhoods; racism, discrimination, and violence;

education, job opportunities, and income; access to nutritious foods and physical activity opportunities; access to clean air and water; and language and literacy skills.

Spine Imaging Guidelines

General Considerations (SP-1.1)

SP.GG.0001.1.A
v1.0.2027

- See: **General Guidelines (SP-1.0)**

Background and Supporting Information

Straight leg raise test (also known as the Lasegue's test) – With the individual in the supine position, the hip medially rotated and adducted, and the knee extended, the examiner flexes the hip until the individual complains of pain or tightness in the back or back of the leg. If the pain is primarily back pain, it is less specific whereas if the pain is primarily in the leg, it is more likely nerve root irritation/radiculopathy. Disc herniation or pathology causing pressure between the two extremes are more likely to cause pain in both areas. The examiner then slowly and carefully drops the leg back (extends it) slightly until the individual feels no pain or tightness. The individual is then asked to flex the neck so the chin is on the chest, or the examiner may dorsiflex the individual's foot, or both actions may be done simultaneously. Both maneuvers are considered to be provocative tests for neurological tissue.

Slump test – The individual is seated on the edge of the examination table with the legs supported, the hips in neutral position, and the hands behind the back. The examination is performed in sequential steps. First, the individual is asked to "slump" the back into thoracic and lumbar flexion. The examiner maintains the individual's chin in neutral position to prevent neck and head flexion. The examiner then uses one arm to apply overpressure across the shoulders to maintain flexion of the thoracic and lumbar spines. While this position is held, the individual is asked to actively flex the cervical spine and head as far as possible (i.e., chin to chest). The examiner then applies overpressure to maintain flexion of all three parts of the spine (cervical, thoracic, and lumbar) using the hand of the same arm to maintain overpressure in the cervical spine. With the other hand, the examiner then holds the individual's foot in maximum dorsiflexion. While the examiner holds these positions, the individual is asked to actively straighten the knee as much as possible. The test is repeated with the other leg and then with both legs at the same time. If the individual is unable to fully extend the knee because of pain, the examiner releases the overpressure to the cervical spine and the individual actively extends the neck. If the knee extends further, the symptoms decrease with neck extension, or the positioning of the individual increases the individual's symptoms, then the test is considered positive.

Femoral nerve tension test (also known as the prone knee bending test) – The individual lies prone while the examiner passively flexes the knee as far as possible so that the individual's heel rests against the buttock. At the same time, the examiner should ensure that the individual's hip is not rotated. If the examiner is unable to flex the

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individual's knee past 90 degrees because of a pathological condition in the hip, the test may be performed by passive extension of the hip while the knee is flexed as much as possible. The flexed knee position should be maintained for 45 to 60 seconds. Unilateral neurological pain in the anterior thigh may indicate an L2-4 nerve root distribution. Pain in the anterior thigh indicates tight quadriceps muscles or stretching of the femoral nerve.

Hoffmann's sign – The examiner holds the individual's middle finger and briskly flicks the distal phalanx. A positive test is noted if the interphalangeal joint of the thumb of the same hand flexes.

Babinski's sign – The examiner runs a sharp instrument along the plantar surface of the foot from the calcaneus along the lateral border to the forefoot. A positive test occurs with extension of the great toe with flexion and splaying of the other toes. A negative test occurs with no movement of the toes at all or uniform bunching up of the toes.

Chaddock sign – The examiner strokes the lateral malleolus. A positive test occurs with extension of the great toe.

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Red Flag Indications (SP-1.2)

SP.GG.0001.2.A
v1.0.2027

Criteria

Red Flag Indications are intended to represent the potential for life or limb threatening conditions. Red Flag Indications are clinical situations in which localized spine pain and associated neurological features are likely to reflect serious underlying spinal and/or non-spinal disease and warrant exception to the requirement for documented failure of six weeks of provider-directed treatment. Advanced diagnostic imaging of the symptomatic level is considered medically necessary **and/or** work-up for a non-spinal source of spine pain for Red Flag Indications.

- Red Flag Indications include:
  - motor weakness
  - aortic aneurysm or dissection
  - cancer
  - cauda equina syndrome
  - fracture
  - infection
  - severe radicular pain

Motor Weakness

(See: Grading of Manual Muscle Testing and Reflex Testing in **General Guidelines [SP-1.0]**)

History, Symptoms or Physical Exam Findings (In-person clinical evaluation for the current episode of the condition required)	Advanced Diagnostic Imaging
Clinical presentation including one or more of the following: • new onset motor weakness of grade 3/5 or less of specified muscle(s) • new onset foot drop • new onset bilateral lower extremity weakness • progressive objective motor/sensory/deep tendon reflex deficits on clinical re-evaluation	MRI of the relevant spinal level* without contrast **OR** MRI of the relevant spinal level* without and with contrast **The SI joint and sacrum are relevant levels of the spine and are captured with pelvic imaging*.

Aortic Aneurysm or Dissection

History, Symptoms or Physical Exam Findings (In-person clinical evaluation for the current episode of the condition required)	Advanced Diagnostic Imaging
• new onset of back and/or abdominal pain in an individual with a known AAA; ***or*** • Acute dissection is suspected.	Spine imaging is considered not medically necessary. See: **Aortic Disorders, Renal Vascular Disorders and Visceral Artery Aneurysms (PVD-6)** in the Peripheral Vascular Disease Imaging Guidelines.

Cancer

History, Symptoms or Physical Exam Findings (In-person clinical evaluation for the current episode of the condition required)	Advanced Diagnostic Imaging
There is clinical suspicion of spinal malignancy **AND ONE** or more of the following: • night pain • uncontrolled or unintended weight loss • pain unrelieved by change in position • age >70 years • severe or worsening spinal pain	**ONE** of the following: • MRI of the relevant spinal level* without contrast **OR** • MRI of the relevant spinal level* without and with contrast **OR** • CT of the relevant spinal level* without contrast **OR** • CT Myelogram of the relevant spinal level* **The SI joint and sacrum are relevant levels of the spine and are captured with pelvic imaging*.
Individual with a known history of cancer with back pain raising suspicion of spinal malignancy	See: **Spinal/Vertebral Metastases (ONC-31.6)** in the Oncology Imaging Guidelines

Cauda Equina Syndrome

History, Symptoms or Physical Exam Findings (In-person clinical evaluation for the current episode of the condition required)	Advanced Diagnostic Imaging
Clinical presentation including one or more of the following: • acute onset of bilateral sciatica • perineal sensory loss (“saddle anesthesia”) • decreased anal sphincter tone • new onset bowel/bladder incontinence • otherwise unexplained acute urinary retention	MRI Lumbar Spine without contrast (CPT® 72148) **OR** MRI Lumbar Spine without and with contrast (CPT® 72158)

Fracture

History, Symptoms or Physical Exam Findings (In-person clinical evaluation for the current episode of the condition required)	Advanced Diagnostic Imaging
• Clinical suspicion of a pathological spinal fracture ◦ Advanced imaging is considered medically necessary after x-ray; no conservative treatment is needed.	See: **Spinal Compression Fractures (SP-11.1)** for appropriate imaging studies
• Clinical suspicion of a spinal fracture after trauma ◦ Advanced imaging is considered medically necessary after x-ray; no conservative treatment is needed.	See: **Neck (Cervical Spine) Trauma (SP-3.2)**, **Upper Back (Thoracic Spine) Trauma (SP-4.2)**, or **Low Back (Lumbar Spine) Trauma (SP-6.2)** for appropriate imaging studies
• Clinical suspicion of a spinal fracture related to ankylosing spondylitis or diffuse idiopathic skeletal hyperostosis (DISH) ◦ Advanced imaging is considered medically necessary ***without*** x-ray or conservative treatment.	See: **Neck (Cervical Spine) Trauma (SP-3.2)**, **Upper Back (Thoracic Spine) Trauma (SP-4.2)**, **Low Back (Lumbar Spine) Trauma (SP-6.2)**, or **Inflammatory Spondylitis (SP-10.2)** for appropriate imaging studies

Infection

History, Symptoms or Physical Exam Findings (In-person clinical evaluation for the current episode of the condition required)	Advanced Diagnostic Imaging
There is a clinical suspicion of spinal infection (e.g., disc space infection, epidural abscess, or spinal osteomyelitis) and one or more of the following: • fever • history of IV drug use • recent bacterial infection (UTIs, pyelonephritis, pneumonia) • recent spinal intervention (e.g., surgery, pain injection, or stimulator implantation) • immunocompromised states • long term use of systemic glucocorticoids • organ transplant recipient taking anti-rejection medication • diabetes mellitus • HIV/AIDS • chronic dialysis • immunosuppressant therapy • neoplastic involvement of the spine • laboratory values indicative of infection (e.g., elevated WBC, ESR, CRP, positive cultures) • decubitus ulcer or wound overlying spine • abnormal x-ray or CT suspicious for infection	**ONE** of the following: • MRI of the relevant spinal level* without and with contrast **OR** • MRI of the relevant spinal level* without contrast **OR** • CT of the relevant spinal level* without IV contrast **OR** • CT of the relevant spinal level* with IV contrast **OR** • FDG-PET/CT whole-body when x-ray or CT are abnormal **AND** when MRI cannot be performed or is inconclusive **OR** • 3-phase bone scan complete spine **OR** • Bone SPECT or Bone SPECT/CT **OR** • Gallium scan whole body or limited spine **OR** • Gallium SPECT or SPECT/CT **OR** • Gallium scan whole body or limited spine** with SPECT or SPECT/CT **The SI joint and sacrum are relevant levels of the spine and are captured with pelvic imaging.* ***Any bone scan can be combined with any Gallium scan*

History, Symptoms or Physical Exam Findings (In-person clinical evaluation for the current episode of the condition required)	Advanced Diagnostic Imaging
There is a clinical suspicion of spinal infection (e.g., disc space infection, epidural abscess, or spinal osteomyelitis) **and** one or more of the following: • new neurologic deficit on physical examination • cauda equina syndrome	**ONE** of the following: • MRI of the relevant spinal level* without and with contrast **OR** • MRI of the relevant spinal level* without contrast **OR** • CT of the relevant spine level* without IV contrast **OR** • CT of the relevant spinal level* with IV contrast **The SI joint and sacrum are relevant levels of the spine and are captured with pelvic imaging.*

Severe Radicular Pain

All the following must be present (In-person clinical evaluation for the current episode of the condition required)	Advanced Diagnostic Imaging
• Severe radicular pain in a specified spinal nerve root distribution (minimum 9/10 on the Visual Analog Scale (VAS); **and** • Documented significant functional loss at work or at home; **and** • Severity of pain unresponsive to a minimum of seven (7) days of provider-directed treatment; **and** • Treatment plan includes **one** of the following: ◦ transforaminal epidural steroid injection (TFESI) at any level(s); or ◦ interlaminar epidural steroid injection (ILESI) at the cervical or thoracic levels; or ◦ urgent/emergent spinal surgery; or ◦ urgent/emergent referral to/consultation from a spine specialist (Interventional Pain physician or Spine Surgeon)	MRI of the relevant spinal level* without contrast **OR** MRI of the relevant spinal level* without and with contrast **The SI joint and sacrum are relevant levels of the spine and are captured with pelvic imaging.*

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Definitions (SP-1.3)

SP.GG.0001.3.A
v1.0.2027

Criteria

- **Radiculopathy**, for the purpose of this policy, is defined as the presence of pain resulting in significant functional limitations (i.e., diminished quality of life and impaired, age-appropriate activities of daily living), dysaesthesia(s) or paraesthesia(s) reported by the individual in a specified dermatomal distribution of an involved named spinal root(s) and **ONE or MORE** of the following:
  - Loss of strength of specific named muscle(s) or myotomal distribution(s) or demonstrated on detailed neurologic examination (within the prior 3 months), concordant with nerve root compression of the involved named spinal nerve root(s)
  - Altered sensation to light touch, pressure, pin prick or temperature demonstrated on a detailed neurologic examination (within the prior 3 months) in the sensory distribution concordant with nerve root compression of the involved named spinal nerve root(s)
  - Diminished, absent, or asymmetric reflex(es) on a detailed neurologic examination (within the prior 3 months) concordant with nerve root compression of the involved named spinal nerve root(s)
  - **Either** of the following:
    - A concordant radiologist's interpretation of an advanced diagnostic imaging study (MRI or CT) of the spine demonstrating compression of the involved named spinal nerve root(s) or foraminal stenosis at the concordant level(s) (performed within the prior 12 months)
    - Electrodiagnostic studies (EMG/NCVs) diagnostic of nerve root compression of the involved named spinal nerve root(s) (performed within the prior 12 months)
- **Radicular pain** is pain which radiates to the upper or lower extremity along the course of a spinal nerve root, typically resulting from compression, inflammation and/or injury to the nerve root.
- **Radiculitis** is defined, for the purpose of this policy, as radicular pain without objective neurological findings.

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Evidence Discussion (SP-1)

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Prior to advanced imaging, it is critical to perform a detailed history and physical examination in the evaluation of an individual for spinal pathology (Childress & Stuek, 2020; Mathieu et al., 2023; Chou et al., 2009). Features of the clinical history and physical examination not only help in the formulation of a differential diagnosis but also influence decisions about diagnostic imaging (Deyo, Rainville, & Kent, 1992). Also, as the more common findings on imaging studies are often nonspecific and non-diagnostic, clinical history and exam findings play a crucial role (Ciesla et al., 2011). These incidental findings may lead to unnecessary further diagnostic workup and additional negative downstream outcomes.

Multiple studies have shown most individuals with acute neck or back pain will improve with 6 weeks of conservative care (Hutchins et al., 2021; Childress & Becker, 2016; Shubha, Deyo, & Berger, 2012); however, conservative care would not be necessary for individuals with Red Flag Indications (Verhagen et al., 2016).

Risks associated with imaging include, but are not limited to, radiation exposure and contrast complications (Webster & Cifuentes, 2010; Lee et al., 2019). Studies have also linked the increase rate of imaging with the increase rate of surgery and also found early magnetic resonance imaging (MRI) had an eight-fold increased risk of surgery (Webster & Cifuentes, 2010; Watson & Yu, 2023). It should also be of note that routine repeat advanced imaging for many spinal conditions has been shown to have limited value (Panagopoulos et al., 2017; Ries et al., 2018; Linna et al., 2024).

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Imaging Techniques (SP-2)

Guideline Page

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Anatomic Guidelines (SP-2.1)

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Criteria

- Anatomic regions of the spine/pelvis that are included in the following MRI and CT advanced diagnostic imaging studies:
  - Cervical spine: from the skull base/foramen magnum through T1
  - Thoracic spine: from C7 through L1
  - Lumbar spine: from T12 through mid-sacrum
  - Pelvis: includes hips, sacroiliac joints, sacrum, coccyx
- CT or MRI Cervical and Thoracic Spine will image the entire spinal cord since the end of the spinal cord or conus medullaris usually ends at L1 in adults. Therefore, lumbar spine imaging is considered not medically necessary when the goal is to image only the spinal cord unless there is known or suspected low-lying conus medullaris (e.g., tethered cord).
- The results of plain x-rays performed after the current episode of symptoms started or changed need to be available to the requesting provider of the advanced imaging study for the following conditions:
  - See: **Spinal Compression Fractures (SP-11)**
  - See: **Lumbar Spine Spondylolysis/Spondylolisthesis (SP-8)**
  - See: **Inflammatory Spondylitis (SP-10.2)**
  - See: **Upper Back (Thoracic Spine) Pain without and with Neurological Features (Including Stenosis) (SP-4.1)**
  - See: **Neck (Cervical Spine) Trauma (SP-3.2)**
  - See: **Coccydynia without Neurological Features (SP-5.2)**
  - See: **Spinal Deformities (e.g., Scoliosis/Kyphosis) (SP-14)** and **Spinal Dysraphism (PEDSP-4)** in the Pediatric and Special Populations Spine Imaging Guidelines
  - See: **Sacro-Iliac (SI) Joint Pain, Inflammatory Spondylitis/Sacroiliitis and Fibromyalgia (SP-10)**
  - See: **Post-Operative Spinal Disorders (SP-15)**

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MRI of the Spine (SP-2.2)

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Criteria

- See: **Procedure Codes Associated with Spine Imaging**
- For MR Spectroscopy, all spine uses are considered not medically necessary.
  - See: **Imaging of Intervertebral Discs (SP-2.5)**
- MRI Spine is performed either without contrast, with contrast, *or* without and with contrast. A "with contrast" study alone is considered medically necessary only to complete a study begun without contrast. Contrast is generally considered not medically necessary for most disc and nerve root disorders, fractures, and degenerative disease.
- MRI Spine indications include:
  - Evaluation of disc disease, spinal cord and nerve root disorders, and most other spinal conditions including evaluation of congenital anomalies of the spine and spinal cord
  - Suspicion for or surveillance of known spine/spinal canal/spinal cord neoplastic disease
  - Suspicion, diagnosis of, or surveillance of spinal infections, multiple sclerosis, or other causes of myelitis, syringomyelia, cauda equina syndrome, or other "red flag" indications. See: **Red Flag Indications (SP-1.2)**.
  - Pre-operative evaluation to define abnormal or variant spinal anatomy that could influence the outcome of a potential surgical procedure. See: **Prior to Spine Surgery (SP-16.1)**.
  - Spinal imaging for individuals having undergone recent spinal surgery (e.g., laminectomy, discectomy, spinal decompression) when history and physical examination is suspicious for hematoma, post-surgical infection, or cerebrospinal fluid (CSF) leak

Positional MRI

- Positional MRI is also referred to as dynamic, weight-bearing, or kinetic MRI. Currently, there is inadequate scientific evidence to support the medical necessity of this study. As such, it should be considered not medically necessary.

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CT of the Spine (SP-2.3)

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Criteria

- See: **Procedure Codes Associated with Spine Imaging**
- CT Spine indications include:
  - Contraindication to MRI
    - CT (contrast as requested) is considered medically necessary when **ANY** of the following MRI contraindications are documented **AND** indications for the MRI are met:
      - implanted ferromagnetic materials
      - electronically, magnetically, or mechanically activated implanted devices that are not determined by the manufacturer as MRI compatible/conditional
  - CT without contrast or CT without and with contrast (even if MRI has already been performed) for any spinal trauma/fractures, especially spinal trauma/fractures that could result in spinal instability and spinal cord/spinal nerve compression
  - CT without contrast or CT without and with contrast (even if MRI has already been performed) for spinal neoplastic disease – primary or metastatic
  - CT without contrast (even if MRI has already been performed) in conjunction with discography (see: **Imaging of Intervertebral Discs [SP-2.5]**)
  - CT without contrast, or CT without and with contrast (even if MRI has already been performed) for pre-operative evaluation to define abnormal or variant bony spinal anatomy that could influence the outcome of a potential surgical procedure (see: **Prior to Spine Surgery [SP-16.1]**)
  - CT without contrast or CT without and with contrast (even if MRI has already been performed) to assess spinal fusions when pseudoarthrosis is suspected (not to be used for routine post-operative assessment where x-rays are sufficient and/or there are no concordant clinical signs or symptoms)
  - CT without contrast or CT without and with contrast (even if MRI has already been performed) for congenital, developmental, or acquired spinal deformity (see: **Spinal Deformities [e.g., Scoliosis/Kyphosis] [SP-14]**)
  - CT Lumbar without contrast (CPT® 72131) or CT Lumbar without and with contrast (CPT® 72133) for spondylolysis when routine x-rays are negative and/or MRI is equivocal, indeterminate, or non-diagnostic (see: **Lumbar Spine Spondylolysis/ Spondylolisthesis [SP-8]**)
  - CT without contrast or CT without and with contrast to evaluate calcified lesions (e.g., osteophytes, ossification of the posterior longitudinal ligament [OPLL])

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CT/Myelography (SP-2.4)

SP.IM.0002.4.A
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Criteria

- See: **Procedure Codes Associated with Spine Imaging**
- CT/Myelography is generally considered not medically necessary as an initial study when a diagnostic quality MRI has been obtained.
- CT/Myelography indications include:
  - To clarify equivocal, indeterminate, or non-diagnostic MRI findings or to further evaluate the significance of multiple spinal abnormalities
  - When an MRI is contraindicated
  - Pre-operative planning for spine surgery (e.g., multilevel spinal stenosis or when a previous MRI is insufficient, equivocal, indeterminate, or non-diagnostic) (see: **Prior to Spine Surgery (SP-16.1)**)
  - Evaluation after previous spinal surgery when an MRI without and with contrast is contraindicated or MRI results are equivocal, indeterminate, or non-diagnostic
  - The guidelines allow for the approval of the post-myelogram CT (i.e., CPT® 72126, CPT® 72129, and CPT® 72132) only and not any other myelogram-related procedure codes (i.e., CPT® 72265 or CPT® 62284).

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Imaging of Intervertebral Discs (SP-2.5)

SP.IM.0002.5.A
v1.0.2027

Criteria

Post-lumbar Discography CT

- These guidelines allow for the post-lumbar discography CT procedure codes only and do not include any other discography-related procedure codes. A post-lumbar discography CT is considered medically necessary when **BOTH** of the following apply:
  - A CT Lumbar Spine without contrast (CPT® 72131) is considered medically necessary if verified to be performed as a post-discography CT.
  - A post-discography CT is requested and the discography has already been approved.

Magnetic Resonance Spectroscopy

- Magnetic Resonance Spectroscopy (MRS) involves the analysis of the levels of certain chemicals in pre-selected voxels (small regions) on an MRI scan done at the same time.
  - MRS (CPT® 76390, 0609T, 0610T, 0611T, and 0612T) is considered not medically necessary for all spine imaging uses at this time.

Background and Supporting Information

- Provocative Discography/CT and MR Spectroscopy lumbar spine are procedures purported to diagnose (or rule-out) a discogenic “pain generator” (i.e., the source of non-specific axial spinal pain). These diagnostic studies, when reported as positive, are often used as an indication for spinal fusion in individuals with non-specific axial back pain.
- The following uses of discography are considered controversial:
  - To identify a symptomatic pseudoarthrosis in a failed spinal fusion
  - To identify which of two herniated discs seen on MRI is symptomatic when not determined clinically or otherwise
  - To confirm the discogenic nature of pain in an individual with an abnormal disc seen on MRI and to rule out pain from an adjacent disc level
  - To confirm the presumptive diagnosis of “internal disc disruption”
  - Discography of the cervical and/or thoracic spine
- The following uses of MR Spectroscopy lumbar spine are considered controversial:

- To identify which of two herniated discs seen on MRI is symptomatic when not determined clinically or otherwise
- To confirm the discogenic nature of pain in an individual with an abnormal disc seen on MRI and to rule out pain from an adjacent disc level
- To confirm the presumptive diagnosis of “internal disc disruption”

Spine Imaging Guidelines

Ultrasound of the Spinal Canal (SP-2.6)

SP.IM.0002.6.A
v1.0.2027

Criteria

- Spinal canal ultrasound (CPT® 76800) describes the evaluation of the spinal cord (canal and contents) and is most often performed in newborns, infants, young children, and intraoperatively.
- CPT® 76800 describes evaluation of the entire spine and should not be reported multiple times for imaging of different areas of the spinal canal.
- CPT® 76998, rather than CPT® 76800, should be used to report intraoperative spinal canal ultrasound (ultrasonic guidance). Intraoperative use of spinal ultrasound (CPT® 76998) would not require prior authorization.

Indications for spinal canal ultrasound (CPT® 76800):

- This study is generally limited to infants, newborns, and young children because of incomplete ossification of the vertebral segments surrounding the spinal cord, including the assessment of CSF in the spinal canal and for image-guided lumbar puncture.
- When ossification of the vertebral segments is incomplete for evaluation of suspected or known tethered cord (see: **Tethered Cord [PEDSP-5]** in the Pediatric and Special Populations Spine Imaging Guidelines)
- Evaluation of suspected occult and non-occult spinal dysraphism (see: **Spinal Dysraphism [PEDSP-4]** in the Pediatric and Special Populations Spine Imaging Guidelines)
- Evaluation of spinal cord tumors, vascular malformations, and cases of birth-related trauma
- Contraindicated for use in the adult spine for the assessment of spinal pain, radiculopathy, facet inflammation, nerve root inflammation, disc herniation, and soft tissue conditions surrounding the adult spine other than for superficial masses

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Limitations of Spinal Imaging in Degenerative Disorders (SP-2.7)

SP.IM.0002.7.A
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Criteria

- Non-specific axial spinal pain is ubiquitous. Advanced diagnostic imaging infrequently identifies the source of the spinal pain (pain generator).
- Incidental findings on MRI and CT, including bulging, protruding, extruding or herniated discs, are often non-concordant, asymptomatic and increase in incidence as the spine ages.
- In individuals with poorly defined clinical presentations, “abnormal” spinal advanced diagnostic imaging results are infrequently clinically concordant, significant, material, or substantive and may even lead to inappropriate treatment.
- Performing advanced spinal imaging based only on the presence of spinal degenerative findings identified on x-rays is considered not medically necessary in individuals who are either asymptomatic or present with non-specific axial spinal pain.

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Miscellaneous Spinal Lesions (SP-2.8)

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Criteria

Vertebral body hemangiomas

- Vertebral body hemangiomas are common and are generally benign and incidental findings on plain x-rays and advanced diagnostic imaging studies.
- If the appearance of a vertebral body hemangioma is typical on plain x-ray, further spinal advanced diagnostic imaging is considered not medically necessary, unless there are associated neurologic symptoms or signs on physical examination.
- If the appearance of a vertebral body hemangioma is atypical on plain x-ray, with or without neurological signs or symptoms on physical exam, MRI without contrast or MRI without and with contrast is considered medically necessary.
- Occasionally, MRI may be equivocal, indeterminate, or non-diagnostic, and CT without contrast of the spinal area is considered medically necessary to help clarify the diagnosis.
- No follow-up imaging is considered medically necessary once the diagnosis of a vertebral body hemangioma is established without neurological features.

Tarlov cysts

- Tarlov cysts are most often cystic dilatations of nerve root sleeves in the lumbar spine and sacrum.
- Controversy exists as to whether Tarlov cysts can result in neurologic signs and symptoms, but they can result in erosion of the adjacent bone.
- Usually Tarlov cysts are benign, incidental findings on advanced diagnostic imaging studies. Further evaluation of a known or suspected Tarlov cyst can be performed with an MRI Lumbar Spine without and with contrast study (CPT® 72158) or CT/ Myelography Lumbar Spine (CPT® 72132).

Other spinal lesions

- MRI without and with contrast or a CT without contrast is considered medically necessary if:
  - Other spinal lesions are seen on routine x-rays or a non-contrast MRI; ***and***
  - These additional advanced imaging studies are recommended by a spine specialist or radiologist to further characterize or diagnose the lesion; ***or***
  - Required for surgical planning.

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MRA Spinal Canal (SP-2.9)

SP.IM.0002.9.A
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Criteria

- MR angiography (MRA) Spine (CPT® 72159) imaging is utilized infrequently.
- Cerebrospinal Fluid (CSF) flow studies using MRI are included in CPT® codes 70551, 70552, and 70553 and should not be coded or reported separately, (see **CSF Flow Imaging (HD-24.4)**)

Indications may include:

- Suspected spinal cord arteriovenous malformation (AVM) or arteriovenous fistula (AVF):
  - MRI Spine of the relevant spine region without and with contrast should be the initial imaging study.
  - If suspicion for a spinal AVM or AVF is high based upon the results of the MRI Spine, catheter angiography is recommended.
- Subarachnoid hemorrhage where no brain aneurysm has been previously identified
  - Catheter angiography should be performed and is the most definitive study to define possible spinal pathology resulting in a spinal canal subarachnoid hemorrhage.
  - See: **General Guidelines – CT and MR Angiography (CTV and MRV) (HD-1.5)** in the Head Imaging Guidelines
  - See: **Cerebral Aneurysms (HD-12.1)** in the Head Imaging Guidelines
- Pre-operative planning
  - MRA Spinal canal may be useful in identifying major intercostal feeder vessels to the spinal cord prior to surgical procedures that might interfere with this blood supply. However, catheter angiography is generally a more definitive study for this purpose.
- 3D Rendering (CPT® 76377 or CPT® 76376) is considered medically necessary with spinal angiography to define the presence, location, and anatomy of intraspinal vascular malformations.

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Spine PET/CT (SP-2.10)

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Criteria

- At the present time, there is controversy regarding spine PET/CT due to inadequate scientific evidence to support the medical necessity of PET/CT for the routine assessment of spinal disorders, other than for neoplastic disease.
- See: **Spinal/Vertebral Metastases (ONC-31.6)** in the Oncology Imaging Guidelines
- Spine PET/CT is considered not medically necessary.

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Cone-beam CT (SP-2.11)

SP.IM.0002.11.A
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Criteria

- Cone-beam CT for imaging of the cervical spine is considered not medically necessary.

3D Rendering (SP-2.12)

SP.IM.0002.12.A
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- See: **3D Rendering (MS-3)** in the Musculoskeletal Imaging Guidelines

Spine Imaging Guidelines

Evidence Discussion (SP-2)

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- X-rays are first line imaging for suspected inflammatory spine disease (Czuczman et al., 2021), following trauma (Hassankhani et al., 2024), concerns of spinal deformities (Boas, 2007), or post-operative spinal disorders (Corona-Cedillo et al., 2021). Although x-rays may not confirm a definitive diagnosis, they provide information that can better direct advanced imaging modalities.
- MRI utilizes a magnetic field and radio waves with computer processing to produce detailed images which have excellent soft tissue characterization and is the primary modality for evaluating the spinal cord, intervertebral disc disease, and other soft tissue pathology of the spine (American College of Radiology [ACR], 2022a; Eldaya et al., 2024; Agarwal et al., 2020). Positional MRI (Weishaupt et al., 2000) and MR Spectroscopy (Jakoniuk et al., 2022) lack sufficient scientific evidence to support their routine clinical use (Weishaupt et al., 2000).
- CT provides high spatial resolution for evaluation of osseous structures and can depict fractures, alignment abnormalities, and bony encroachment on the spinal canal with greater sensitivity than radiography in trauma settings (Hassankhani et al., 2024). CT also demonstrates bone destruction, calcification, and structural changes associated with neoplastic or degenerative processes, though it is less effective than MRI for characterization of marrow and spinal cord pathology (Agarwal et al., 2020). In the evaluation of spinal trauma, multidetector CT has been shown to have high sensitivity and specificity for detecting clinically significant fractures, approaching near-complete detection in many studies (Hassankhani et al., 2024). However, CT has important limitations in assessing soft tissue, ligamentous injury, and intrinsic spinal cord abnormalities, which may reduce its diagnostic yield for non-osseous etiologies (Hassankhani et al., 2024; Agarwal et al., 2020).
- CT/Myelography provides indirect visualization of the thecal sack in the spinal canal. MRI is the primary advanced imaging for these indications as the cord, thecal sac, and spinal canal can be directly visualized. CT/Myelography may provide additional anatomic detail in select scenarios, such as evaluation of canal stenosis or clarification of findings seen on other imaging modalities (Agarwal et al., 2020). However, compared with MRI, CT/Myelography is limited in its ability to evaluate intrinsic spinal cord abnormalities and soft tissue pathology, and it involves an invasive intrathecal contrast technique (Hassankhani et al., 2024; Agarwal et al., 2020).
- Ultrasound can be used to visualize the spinal canal in young children before the posterior elements ossify. Ultrasound will not penetrate ossified bone (Rees et al., 2021).
- Magnetic resonance angiography (MRA) has limited indications in spine imaging. While there is limited evidence supporting its use in initial evaluation of spinal cord

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pathology, it may provide additional information in cases of suspected vascular abnormalities, such as identifying abnormal vessels associated with spinal vascular malformations or ischemia (Agarwal et al., 2020).

- There is inadequate scientific evidence to support PET/CT for the routine assessment of spinal disorders, other than for neoplastic disease.
- There is inadequate scientific evidence to support cone beam CT for the routine assessment of spinal disorders outside of the operative setting, which is outside the coverage of these guidelines.

Spine Imaging Guidelines

References (SP-2)

v1.0.2027

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Neck (Cervical Spine) Pain Without/With Neurological Features (Including Stenosis) and Trauma (SP-3)

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Neck (Cervical Spine) Pain without and with Neurological Features (Including Stenosis) (SP-3.1)

SP.NP.0003.1.A
v1.0.2027

Criteria

***All* the following are required prior to advanced imaging:**
• An in-person clinical evaluation for the current episode of the condition is required to have been performed before advanced imaging is considered. This may have been either the initial clinical evaluation or a clinical re-evaluation (see also: **General Guidelines (SP-1.0)**). • A documented failure of a 6-week trial of provider-directed treatment after the current set of symptoms or physical exam findings started or changed (unless presence of a red flag as defined in **Red Flag Indications (SP-1.2)**) • Clinical re-evaluation after treatment period (may consist of an in-person evaluation or other meaningful contact) (see also: **General Guidelines (SP-1.0)**)

Advanced Diagnostic Imaging:	MRI Cervical Spine, without contrast (CPT® 72141)
Comments:	CT Cervical Spine without contrast (CPT® 72125) **OR** CT Myelography (CPT® 72126) is considered medically necessary when MRI is contraindicated.

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Neck (Cervical Spine) Trauma (SP-3.2)

SP.NP.0003.2.A
v1.0.2027

Criteria

***All* the following are required prior to advanced imaging:**
• An in-person clinical evaluation for the current episode of the condition is required to have been performed before advanced imaging is considered. This may have been either the initial clinical evaluation or a clinical re-evaluation (see also: **General Guidelines (SP-1.0)**). • A documented failure of a 6-week trial of provider-directed treatment after the current set of symptoms or physical exam findings started or changed (unless presence of a red flag as defined in **Red Flag Indications (SP-1.2)**) • Clinical re-evaluation after treatment period (may consist of an in-person evaluation or other meaningful contact) (see also: **General Guidelines (SP-1.0)**) • Results of plain x-rays of the cervical spine performed after the current episode of symptoms started or changed need to be available to the requesting provider (not required for high-risk mechanisms as below**)

Advanced Diagnostic Imaging:	**MRI Cervical Spine without contrast (CPT® 72141) OR CT Cervical Spine without contrast (CPT® 72125)** **For individuals with ankylosing spondylitis or diffuse idiopathic skeletal hyperostosis (DISH), both MRI of the entire spine (CPT® 72141, 72146, and/or 72148) AND CT of the entire spine (CPT® 72125, 72128, and/or 72131) are considered medically necessary.** **For individuals with ankylosing spondylitis or DISH, plain x-rays and a 6-week trial of provider-directed treatment and clinical re-evaluation are NOT required.**
Comments:	Plain x-rays **ARE** required for suspected fracture in **non-high** risk injuries. Plain x-rays and a 6-week trial of provider-directed treatment and clinical re-evaluation are **NOT** required for individuals with a high risk factor(s) for suspected cervical spine injury within the last 3 months (See below**).

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**High-risk factors of suspected cervical spine injury may include:

- long term use of systemic glucocorticoids
- history of prior low energy fractures
- history of low bone mineral density
- age ≥65 years
- head trauma and/or maxillofacial trauma
- pedestrian in a motor vehicle accident
- fall from elevation ≥3 feet/5 stairs
- diving accident
- head-on motor vehicle collision without/with airbag deployment
- rollover motor vehicle collision
- ejection from the vehicle in a motor vehicle collision
- high speed of the vehicle at the time of collision
- not wearing a seatbelt/shoulder harness in a motor vehicle collision
- minor direct/indirect trauma to the cervical spine/maxillofacial areas in individuals with ankylosing spondylitis or DISH

Background and Supporting Information

- Pain radiation patterns from the cervical spine area into the thoracic spine area do not necessarily justify the addition of thoracic spine advanced diagnostic imaging.
- Cervical radiculopathy is often confused with shoulder disorders, brachial plexopathy, peripheral nerve entrapment, and/or motor/sensory neuropathies. Electrodiagnostic testing (EMGs/NCVs) is generally used to confirm, not establish, a diagnosis of peripheral nerve entrapment and/or a motor/sensory neuropathy based upon history and physical examination findings. Electrodiagnostic testing is often considered when advanced imaging of the spine does not reveal neurocompressive pathology and/or after 6 weeks of unimproved symptoms of extremity pain, weakness, numbness, and/or tingling.
- Individuals with ankylosing spondylitis or DISH are at high risk of cervical spine fractures even with minor direct/indirect trauma to the cervical spine which can result in quadriparesis/quadriplegia.

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Evidence Discussion (SP-3)

v1.0.2027

X-rays provide critical information that cannot be obtained with advanced imaging modalities and remain central to providing optimal care for spine individuals (Eldaya et al., 2024; Matsumoto et al., 1998; Baker et al., 2020). Unnecessary CT scans increase individuals' radiation exposure (Baker et al., 2020); however, it is the initial imaging for individuals involved in trauma with a high-risk factor for cervical spine injury (Hassankhani et al., 2024). Additionally, for individuals with diffuse idiopathic skeletal hyperostosis (DISH) or ankylosing spondylitis with a history of low-energy trauma, whole spine MRI or CT imaging is mandatory due to the high prevalence of acute fractures and the low specificity for fracture detection on radiographs (Lantsman et al., 2020; Le et al., 2021). The American College of Radiology (ACR) Appropriateness Criteria for Cervical Neck Pain or Cervical Radiculopathy (revised 2018) indicates that in the absence of red flag symptoms, early advanced imaging may not be required as abnormal findings are not uncommon in asymptomatic individuals and correlate poorly with the presence of neck pain (Eldaya et al., 2024).

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Upper Back (Thoracic Spine) Pain Without/With Neurological Features (Including Stenosis) and Trauma (SP-4)

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Upper Back (Thoracic Spine) Pain without and with Neurological Features (Including Stenosis) (SP-4.1)

SP.TS.0004.1.A
v1.0.2027

Criteria

***All* the following are required prior to advanced imaging:**
• An in-person clinical evaluation for the current episode of the condition is required to have been performed before advanced imaging is considered. This may have been either the initial clinical evaluation or a clinical re-evaluation (see also: **General Guidelines (SP-1.0)**). • A documented failure of a 6-week trial of provider-directed treatment after the current set of symptoms or physical exam findings started or changed (unless presence of a red flag as defined in **Red Flag Indications (SP-1.2)**) • Clinical re-evaluation after treatment period (may consist of an in-person evaluation or other meaningful contact) (see also: **General Guidelines (SP-1.0)**) • Plain x-rays are required for thoracic back pain with or without neurological features (unless presence of a red flag as defined in **Red Flag Indications (SP-1.2)**)

Advanced Diagnostic Imaging:	**MRI Thoracic Spine without contrast (CPT® 72146)**
Comments:	A CT Thoracic spine without contrast (CPT® 72128) **OR** CT Myelography (CPT® 72129) is considered medically necessary when MRI is contraindicated.

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Upper Back (Thoracic Spine) Trauma (SP-4.2)

SP.TS.0004.2.A
v1.0.2027

Criteria

All the following are required prior to advanced imaging:
• An in-person clinical evaluation for the current episode of the condition is required to have been performed before advanced imaging is considered. This may have been either the initial clinical evaluation or a clinical re-evaluation (see also: **General Guidelines (SP-1.0)**). • A documented failure of a 6-week trial of provider-directed treatment after the current set of symptoms or physical exam findings started or changed (unless presence of a red flag as defined in **Red Flag Indications (SP-1.2)**). • Clinical re-evaluation after treatment period (may consist of an in-person evaluation or other meaningful contact) (see also: **General Guidelines (SP-1.0)**). • Conservative treatment and clinical re-evaluation are not required in high-risk individuals. ◦ High-risk individuals include those that have sustained an acute traumatic injury with midline thoracolumbar tenderness, high-energy injury mechanisms, or greater than 60 years of age. • **After above criteria are met:** MRI Thoracic Spine without contrast (CPT® 72146) OR CT Thoracic Spine without contrast (CPT® 72128)

Indication:	Advanced Imaging
Ankylosing Spondylitis (AS) or Diffuse Idiopathic Skeletal Hyperostosis (DISH)	• MRI of the entire spine (CPT® 72141, 72146, and/or 72148) **AND** • CT of the entire spine (CPT® 72125, 72128, and/or 72131) For individuals with AS or DISH, a 6-week trial of provider-directed treatment and clinical re-evaluation are **NOT** required.

Background and Supporting Information

- Thoracic radiculopathy presents with pain radiation from the thoracic spine around the trunk. At upper thoracic spine levels, the pain radiation is from the thoracic spine around the rib cage following the sensory distribution of an intercostal nerve.

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Evidence Discussion (SP-4)

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The precision in identifying thoracic spine diseases is dependent on a meticulous association with the individual's clinical examination and medical history because the usual observations from imaging studies are frequently ambiguous and non-conclusive (Linna et al., 2024).

Wood et al. (1995) demonstrated that asymptomatic individuals may exhibit positive findings on thoracic spine MRI at a rate as high as 70%. For individuals with atraumatic thoracic back pain, data from Linna et al. (2024) support initial conservative management followed by evaluation by a surgical specialist before ordering a thoracic spine MRI. Red flag indications, however, obviate the need for conservative care.

Regarding the value of x-rays, Goodwin et al. (2022) stated that plain films provide critical information that cannot be obtained with other imaging modalities, and they remain central to providing optimal care for spine individuals. When there is a history of blunt trauma and a high-risk factor for thoracic spine injury, however, CT imaging is appropriate for initial imaging (Inaba et al., 2015; Hassankhani et al., 2024).

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Low Back (Lumbar Spine) Pain/Coccydynia without Neurological Features (SP-5)

Guideline Page

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Low Back (Lumbar Spine) Pain without Neurological Features (SP-5.1)

SP.LB.0005.1.A
v1.0.2027

Criteria

***All* the following are required prior to advanced imaging:**
• An in-person clinical evaluation for the current episode of the condition is required to have been performed before advanced imaging is considered. This may have been either the initial clinical evaluation or a clinical re-evaluation (see also: **General Guidelines (SP-1.0)**). • A documented failure of a 6-week trial of provider-directed treatment after the current set of symptoms or physical exam findings started or changed (unless presence of a red flag as defined in **Red Flag Indications (SP-1.2)**). • Clinical re-evaluation after treatment period (may consist of an in-person evaluation or other meaningful contact) (see also: **General Guidelines (SP-1.0)**)

Advanced Diagnostic Imaging:	**MRI Lumbar Spine without contrast (CPT® 72148)**
Comments:	A CT Lumbar spine without contrast (CPT® 72131) **OR** CT Myelography (CPT® 72132) is considered medically necessary when MRI is contraindicated.

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Coccydynia without Neurological Features (SP-5.2)

SP.LB.0005.2.A
v1.0.2027

Criteria

All the following are required prior to advanced imaging:
• An in-person clinical evaluation for the current episode of the condition is required to have been performed before advanced imaging is considered. This may have been either the initial clinical evaluation or a clinical re-evaluation (see also: **General Guidelines (SP-1.0)**). • A documented failure of a 6-week trial of provider-directed treatment after the current set of symptoms or physical exam findings started or changed (unless presence of a red flag as defined in **Red Flag Indications (SP-1.2)**). • Clinical re-evaluation after treatment period (may consist of an in-person evaluation or other meaningful contact) (see also: **General Guidelines (SP-1.0)**) • Plain x-rays of the sacrum/coccyx are negative for fracture.

Advanced Diagnostic Imaging:	MRI Pelvis without contrast (CPT® 72195)
Comments:	A CT Pelvis without contrast (CPT® 72192) when MRI is contraindicated

Background and Supporting Information

Coccydynia is often reported by individuals as “tailbone” pain that is usually idiopathic or post-traumatic and generally follows a benign course.

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Evidence Discussion (SP-5)

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Acute low back pain is usually a self-limited condition and improves with conservative treatment in 6 weeks. The American College of Radiology (ACR) Appropriateness Criteria for low back pain (revised 2021) states that imaging may be considered in those individuals who have had up to 6 weeks of medical management and physical therapy that resulted in little or no improvement in their back pain (Hutchins et al., 2021).

A meta-analysis by Chou et al. (2009) found no clinically significant difference in individual outcomes between those who had immediate lumbar imaging versus usual care. It should also be noted that there are risks associated with imaging including but not limited to radiation exposure and contrast complications (Shubha, Deyo, & Berger, 2012). Studies have also linked the increase rate of imaging with the increase rate of surgery and also found early magnetic resonance imaging (MRI) had an eight-fold increased risk of surgery (Shubha, Deyo, & Berger, 2012; Webster & Cifuentes, 2010).

Health Equity Consideration - Low Back Pain

Low back pain (LBP) is defined by the World Health Organization as the pain between the lower edge of the ribs and the buttocks and is considered acute if it happens suddenly or chronic if it lasts more than 3 months (WHO). In the Global Burden of Diseases, Injuries, and Risk Factors study (2017), over the 28-year period studied, LBP was one of the three leading chronic non-communicable diseases (GBD 2017). There has been exploration of a biopsychosocial paradigm of pain for chronic LBP, which considers influences including psychological, social and environmental factors (Aroke et al. 2020).

Social factors were associated with higher rates of often avoidable/unnecessary utilization outcomes such as Emergency Department visits and hospitalizations, imaging, and associated with lower preventive utilization outcomes, such as PT visits (Pak et al. 2024). In a study (Pak, 2024) social risk factors such as food insecurity and housing instability have shown to have detrimental effects on health, health care outcomes and heath disparities. Income, geographic location, and educational level were identified as contributing to LBP treatment disparities, with increased risk of receiving non-guideline concordant care, including opioid and MRI prescriptions, before conservative treatments were prescribed (Mathieu et al. 2024). Better understanding is needed to address the needs and expectations of patients suffering from LBP and how their individual characteristics may affect their access and utilization of healthcare services.

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Lower Extremity Pain with Neurological Features (Radiculopathy, Radiculitis, or Plexopathy and Neuropathy) With or Without Low Back (Lumbar Spine) Pain (SP-6)

Guideline Page

Lower Extremity Pain with Neurological Features (Radiculopathy, Radiculitis, or Plexopathy and Neuropathy) with or without Low Back (Lumbar Spine) Pain (SP-6.1)....59
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Lower Extremity Pain with Neurological Features (Radiculopathy, Radiculitis, or Plexopathy and Neuropathy) with or without Low Back (Lumbar Spine) Pain (SP-6.1)

SP.LE.0006.1.A
v1.0.2027

Criteria

***All* the following are required prior to advanced imaging:**
• An in-person clinical evaluation for the current episode of the condition is required to have been performed before advanced imaging is considered. This may have been either the initial clinical evaluation or a clinical re-evaluation (see also: **General Guidelines (SP-1.0)**). • A documented failure of a 6 week trial of provider-directed treatment after the current set of symptoms or physical exam findings started or changed (unless presence of a red flag as defined in **Red Flag Indications (SP-1.2)**). • Clinical re-evaluation after treatment period (may consist of an in-person evaluation or other meaningful contact) (see also: **General Guidelines (SP-1.0)**).

Advanced Diagnostic Imaging:	**MRI Lumbar Spine without contrast (CPT® 72148)**
Comments:	A CT Lumbar spine without contrast (CPT® 72131) **OR** CT Myelography (CPT® 72132) is considered medically necessary when MRI is contraindicated. See also: **Lumbar Spinal Stenosis (SP-9.1)**

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Low Back (Lumbar Spine) Trauma (SP-6.2)

SP.LE.0006.2.A
v1.0.2027

Criteria

***All* the following are required prior to advanced imaging:**
• An in-person clinical evaluation for the current episode of the condition is required to have been performed before advanced imaging is considered. This may have been either the initial clinical evaluation or a clinical re-evaluation (see also: **General Guidelines (SP-1.0)**). • A documented failure of a 6-week trial of provider-directed treatment after the current set of symptoms or physical exam findings started or changed (unless presence of a red flag as defined in **Red Flag Indications (SP-1.2)**). • Clinical re-evaluation after treatment period (may consist of an in-person evaluation or other meaningful contact) (see also: **General Guidelines (SP-1.0)**). • Conservative treatment and clinical re-evaluation are not required in high-risk individuals. ◦ High-risk individuals include those that have sustained an acute traumatic injury with midline thoracolumbar tenderness, high-energy injury mechanisms, or greater than 60 years of age. • **After above criteria are met:** MRI Lumbar Spine without contrast (CPT® 72148) **OR** CT Lumbar Spine without contrast (CPT® 72131)

Indication:	Advanced Diagnostic Imaging
Ankylosing Spondylitis (AS) or Diffuse Idiopathic Skeletal Hyperostosis (DISH)	• MRI of the entire spine (CPT® 72141, 72146, and/or 72148) **AND** • CT of the entire spine (CPT® 72125, 72128, and/or 72131) For individuals with AS or DISH, a 6-week trial of provider-directed treatment and clinical re-evaluation are **NOT** required.

- For definitions of radiculopathy, radiculitis, and radicular pain, see **Definitions (SP-1.3)**.

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- For Sciatic Neuropathy, Femoral Neuropathy, Peroneal Neuropathy and Meralgia Paresthetica, see **Focal Neuropathy (PN-2)** in the Peripheral Nerve and Neuromuscular Disorders Imaging Guidelines.
- For Lumbar and/or Lumbosacral Plexopathy, see **Lumbar and Lumbosacral Plexus (PN-5)** in the Peripheral Nerve and Neuromuscular Disorders (PNND) Imaging Guidelines.
- Advanced imaging of the hip or pelvis is not generally required in the evaluation of apparent lumbar radiculopathy unless a separate recognized indication for such studies is documented. See: **Hip (MS-24)** in the Musculoskeletal Imaging Guidelines.

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Evidence Discussion (SP-6)

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Acute low back pain is usually a self-limited condition and improves with conservative treatment in 6 weeks. The American College of Radiology (ACR) Appropriateness Criteria® for low back pain (revised 2021) states that imaging may be considered in those individuals who have had up to 6 weeks of medical management and physical therapy that resulted in little or no improvement in their back pain (Hutchins et al., 2021).

A meta-analysis by Chou et al. found no clinically significant difference in individual outcomes between those who had immediate lumbar imaging versus usual care (Chou et al., 2009). It should also be noted that there are risks associated with imaging including but not limited to radiation exposure and contrast complications (Shubha, Deyo, & Berger, 2012). Studies have also linked the increase rate of imaging with the increase rate of surgery and also found early magnetic resonance imaging (MRI) had an eight-fold increased risk of surgery (Shubha, Deyo, & Berger, 2012; Webster & Cifuentes, 2010). In typical individuals with low back pain or radiculopathy, MR imaging does not appear to have measurable value in terms of planning conservative care. That knowledge of imaging findings does not alter outcome, and that individual knowledge of imaging findings is associated with a lesser sense of well-being (Modic et al., 2005).

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References (SP-6)

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Myelopathy (SP-7)

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Spine Imaging Guidelines

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Myelopathy (SP-7.1)

SP.MI.0007.1.A
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Criteria

- Myelopathy is the development of abnormal spinal cord function with long tract signs usually secondary to spinal cord compression, but also inflammation (transverse myelitis, MS, etc.), neoplastic disease, or spinal cord infarction.
  - For imaging of transverse myelitis, see **Transverse Myelitis (HD-16.4)** in the Head Imaging Guidelines.
- Examination findings may include loss of manual dexterity, spastic legs, ataxia, hyperreflexia, upgoing toes (positive Babinski), Hoffmann's sign, sustained clonus, Lhermitte's sign, crossed radial reflex, inverted radial reflex, and/or finger escape sign. Sensory level and urinary incontinence/retention may be seen.
  - Advanced imaging is considered medically necessary in the initial evaluation of documented or reasonably suspected myelopathy.
- X-rays are not required for advanced imaging in individuals with potential myelopathy regardless of any history of spine surgery, trauma, or other reasons which may otherwise require x-rays (e.g., **Neck (Cervical Spine) Trauma (SP-3.2)**, **Upper Back (Thoracic Spine) Trauma (SP-4.2)**, **Post-Operative Spinal Disorders (SP-15)**).
- Conservative treatment is not a requirement for advanced imaging in individuals with potential myelopathy.
- MRI Cervical and Thoracic Spine without contrast, or without and with contrast, are considered medically necessary for:
  - evaluation of reasonably suspected myelopathy
  - post-traumatic syrinx with increased spinal pain or worsening neurological symptoms
  - sustained, prominent, and unexplained Lhermitte's sign
  - unexplained Babinski's or Hoffmann's signs
  - unexplained hyperreflexia
  - unexplained bilateral motor weakness
- MRI Cervical, Thoracic, and Lumbar Spine without contrast, or without and with contrast, are considered medically necessary for:
  - suspected tethered cord and/or low-lying conus medullaris
- CT without contrast, or CT with contrast (myelography), can also be considered for either of the following:
  - an alternative to MRI, when MRI is contraindicated
  - in addition to MRI, for surgical planning

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Background and Supporting Information

Lhermitte's sign – With the individual in the long leg sitting position on the examination table, the examiner passively flexes the individual's head and one hip simultaneously with the leg kept straight. A positive test occurs if there is sharp pain down the spine and into the upper or lower extremities.

Babinski's sign – The examiner runs a sharp instrument along the plantar surface of the foot from the calcaneus along the lateral border to the forefoot. A positive test occurs with extension of the great toe with flexion and splaying of the other toes. A negative test occurs with no movement of the toes at all or uniform bunching up of the toes.

Hoffman's sign – The examiner holds the individual's middle finger and briskly flicks the distal phalanx. A positive test is noted if the interphalangeal joint of the thumb of the same hand flexes.

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Evidence Discussion (SP-7)

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- MRI is well established in the literature as the primary imaging modality for evaluation of myelopathy. It provides superior soft tissue definition to other options and allows direct visualization of intramedullary cord signal changes which can affect prognosis and management (Agarwal et al., 2021).
- CT myelography is a complementary technique that may be used in situations where MRI cannot be performed or when additional anatomic detail is needed for procedural planning. It may allow better visualization of bony neuroforaminal narrowing and may provide additional anatomic information when the MRI is ambiguous (Agarwal et al., 2021; Song et al., 2009).
- CT can be useful in demonstrating bony encroachment on the cord, but MRI is superior in demonstrating bone marrow changes and intramedullary cord signal. It is of limited value in evaluation of non-compressive causes of myelopathy (Agarwal et al., 2021).

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Lumbar Spine Spondylolysis/ Spondylolisthesis (SP-8)

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Spondylolysis (SP-8.1)

SP.SP.0008.1.A
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Criteria

Results of plain x-rays performed after the current episode of symptoms started or changed need to be available to the requesting provider, unless otherwise specified below.

Indication	Imaging Study
• Clinical suspicion of spondylolysis is high	• X-ray is not required. • Tomographic SPECT Planar (CPT® 78803 or 78831) • SPECT/CT Hybrid (CPT® 78830 or 78832)
• Negative SPECT bone scan	MRI Lumbar Spine without contrast (CPT® 72148) **OR** CT Lumbar Spine without contrast (CPT® 72131)
• Evaluation of a lesion seen on SPECT bone scan	CT Lumbar Spine without contrast (CPT® 72131)
• Documented need for preoperative planning	MRI Lumbar Spine without contrast (CPT® 72148) **AND/OR** CT Lumbar Spine without contrast (CPT®72131)
• Documented failure of 6 weeks of provider-directed conservative treatment (which may include immobilization with a spinal orthosis) after the current set of symptoms or physical exam findings started or changed with clinical re-evaluation	MRI Lumbar Spine without contrast (CPT® 72148) **OR** CT Lumbar Spine without contrast (CPT® 72131)
• Evaluation for stress reaction in bone, to visualize nerve roots	MRI Lumbar Spine without contrast (CPT® 72148)
• When an MRI is medically necessary, however, it is contraindicated	CT Lumbar Spine without contrast (CPT® 72131)

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Indication	Imaging Study
• Evaluation of bony anatomy	CT Lumbar Spine without contrast (CPT® 72131)
• Monitor healing of a pars interarticularis fracture that was determined to have healing potential on a prior CT (i.e., non-sclerotic lesion)	CT Lumbar Spine without contrast (CPT® 72131) of the symptomatic spinal level

- For pediatric spondylolysis, see **Spondylolysis (PEDSP-2.4)** in the Pediatric and Special Populations Spine Imaging Guidelines.
- Bony healing cannot be achieved non-surgically in an established well defined isthmic pars interarticularis defect whether it is developmental or the result of a pars interarticularis fracture non-union. Repeat advanced diagnostic imaging is considered not medically necessary in this setting.

Spondylolisthesis (SP-8.2)

SP.SP.0008.2.A
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Criteria

- CT Lumbar Spine without contrast (CPT® 72131) or MRI Lumbar Spine without contrast (CPT® 72148) can be considered after plain x-ray (results of plain x-rays performed after the current episode of symptoms started or changed must be available to the requesting provider) for the following:
  - A documented failure of 6-week trial of provider-directed treatment after the current set of symptoms or physical exam findings started or changed and clinical re-evaluation (see also: **General Guidelines [SP-1.0]**); ***or***
  - Preoperative evaluation; ***or***
  - See: **Red Flag Indications (SP-1.2)**

Background and Supporting Information

- Stress reactions and stress fractures of the pars interarticularis are most common in athletes and others whose activities involve repetitive flexion/extension loading of the lumbar spine and may be acute or chronic and unilateral or bilateral. Pars interarticularis defects can be an incidental finding on plain x-rays and is frequently asymptomatic.
- Spondylolisthesis is the forward (anterolisthesis) or backward (retrolisthesis, usually not clinically significant) displacement of one vertebra in relation to an adjacent vertebra, most commonly at L4-5 and L5-S1, although other levels of the spine may be involved. Spondylolisthesis is often an incidental finding on plain x-ray and is frequently asymptomatic.

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Evidence Discussion (SP-8)

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Spondylolysis is a very common incidental finding on radiographs in the general population but majority will be asymptomatic (Standaert & Herring, 2000). Spondylolysis is one of the potential causes of back pain in gymnasts (Kruse & Lemmen, 2009). Symptomatic pars lesions are particularly a clinical problem in adolescent athletes (Standaert & Herring, 2000; Leone et al., 2011). Spondylolysis and spondylolisthesis are a common cause of low back pain especially in young athletes but is a less common cause of neurologic compromise (Foreman et al., 2013). Plain radiographs with particular views display the majority of defects (Harvey et al., 1998). MRI has sensitivity of 78% for detecting L4-L5 lumbar degenerative spondylolisthesis compared with 98% for lateral standing films (Kuhns et al., 2015). MRI is less sensitive than CT for detecting pars defects but it is useful for evaluating bone marrow edema,nerve root compression, and stress reactions (Leone et al., 2011).

Lumbar spondylolysis can heal with conservative treatment depending on the spinal level affected and stage of the defects. The site of defects in the pars, condition of contralateral pars, presence of spondylolisthesis, the degree of lumbar lordosis are among other factors significantly affecting union (Fujii et al., 2004).

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Lumbar Spinal Stenosis (SP-9)

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Lumbar Spinal Stenosis (SP-9.1)

SP.ST.0009.1.A
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Criteria

- MRI Lumbar Spine without contrast (CPT® 72148) or CT Lumbar Spine without contrast (CPT® 72131) is considered medically necessary for those individuals with clinical suspicion of lumbar spinal stenosis if:
  - Documented failure of 6-week trial of provider-directed treatment after the current set of symptoms or physical exam findings started or changed and clinical re-evaluation (see also: **General Guidelines (SP-1.0)**); ***or***
  - Red Flag Indications (see: **Red Flag Indications (SP-1.2)**); ***or***
  - Severe symptoms of neurogenic claudication restricting normal activity or requiring the frequent use of narcotic analgesics
- A CT/Myelogram Lumbar Spine (CPT® 72132) may also be considered for individuals who have failed 6 weeks of provider-directed treatment if requested by the operating surgeon for surgical planning, especially for multi-level lumbar spinal stenosis.

Background and Supporting Information

Lumbar spinal stenosis refers to a decrease in the space available for the neural elements within the spinal canal that include spinal nerve roots and the cauda equina. It is usually a degenerative condition of the aging spine which can be asymptomatic or a common cause of buttock/low back and/or leg pain (neurogenic claudication) in this population. Neurogenic claudication is a common symptom of lumbar spinal stenosis that is aggravated by walking, especially down hills or stairs, with prolonged standing and is often relieved by sitting and bending forward. Neurogenic claudication should be differentiated from vascular claudication (leg/calf pain) that is often aggravated by walking and relieved fairly rapidly by stopping and rest. The differential diagnosis for lumbar spinal stenosis should include peripheral vascular disease, hip disorders, and peripheral neuropathy.

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Evidence Discussion (SP-9)

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A presumptive diagnosis of symptomatic lumbar stenosis can be made with the history and physical examination (Katz & Harris, 2008). Imaging can help differentiate neurogenic claudication from vascular claudication. MRI or CT may confirm the presence of spinal stenosis. The American College of Radiology (ACR) Appropriateness Criteria for low back pain (revised 2021) states MRI may be helpful when there is low back pain with radiculopathy or signs of spinal stenosis (Hutchins et al., 2021). Bony findings can be seen better on CT and soft-tissue lesions are more detectable on MRI (Hutchins et al., 2021). In individuals with subacute or chronic low back pain with or without radiculopathy that is a surgical or intervention candidate with persisting symptoms after six weeks of conservative treatment, CT lumbar spine without IV contrast can also be used to assess facets and neural foramina and is equal to MRI for predicting significant spinal stenosis (Hutchins et al., 2021). For those not responsive to conservative treatment, surgery should be considered. A prospective cohort study evaluating individual outcomes two years after spine surgery for spinal stenosis showed individuals had better outcomes than individuals who did not have surgery (Tosteson et al., 2008).

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Sacro-Iliac (SI) Joint Pain, Inflammatory Spondylitis/Sacroiliitis and Fibromyalgia (SP-10)

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Sacro-Iliac (SI) Joint Pain/Sacroiliitis (SP-10.1)

SP.SI.0010.1.A
v1.0.2027

Criteria

- CT Pelvis without contrast (CPT® 72192) or MRI Pelvis without contrast (CPT® 72195) is considered medically necessary if:
  - Initial plain x-rays are equivocal or not diagnostic; ***and***
  - There is documented failure of 6 weeks of provider-directed treatment after the current set of symptoms or physical exam findings started or changed and clinical re-evaluation (see also: **General Guidelines (SP-1.0)**); ***or***
  - Any ONE of the following:
    - Fractures of the sacrum or sacroiliac joint(s); ***or***
    - See: **Red Flag Indications (SP-1.2)**; ***or***
    - Pre-operative planning
- For suspected neoplastic or infectious disease, see **Red Flags (SP-1.2)**.
- See: **Rheumatoid Arthritis (RA) and Inflammatory Arthritis (MS-15.1)** in the Musculoskeletal Imaging Guidelines

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Inflammatory Spondylitis (SP-10.2)

SP.SI.0010.2.A
v1.0.2027

Criteria

- **Initial imaging (including ankylosing spondylitis in the absence of trauma)**
  - Plain x-rays are required initially, then:
    - MRI Sacroiliac Joints (MRI Pelvis) without and with contrast (CPT® 72197) AND MRI Spine area of interest without and with contrast) **OR**
    - MRI Sacroiliac Joints (MRI Pelvis) without contrast (CPT® 72195) AND MRI Spine area of interest without contrast **OR**
    - MRI Sacroiliac Joints (MRI Pelvis) without and with contrast (CPT® 72197) **OR**
    - MRI Sacroiliac Joints (MRI Pelvis) without contrast (CPT® 72195) **OR**
    - MRI Spine area of interest without and with contrast **OR**
    - MRI Spine area of interest without contrast **OR**
    - If MRI is contraindicated:
      - CT Sacroiliac Joints (CT Pelvis) without contrast (CPT® 72192) **OR**
      - CT Sacroiliac Joints (CT Pelvis) without contrast (CPT® 72192) AND CT Spine area of interest without contrast **OR**
      - CT Spine area of interest without contrast
  - When plain x-rays **AND** MRI of the sacroiliac joints are negative, then:
    - MRI Spine area of interest without and with contrast **OR**
    - MRI Spine area of interest without contrast **OR**
    - CT Spine area of interest without contrast
- **Follow-up imaging for treatment response or disease progression (including ankylosing spondylitis)**
  - Repeat plain x-rays show no progression of disease of the SI joints **OR** SI joints and spine area of interest then,
    - MRI Sacroiliac Joints (MRI Pelvis) without and with contrast (CPT® 72197) AND MRI Spine area of interest without and with contrast) **OR**
    - MRI Sacroiliac Joints (MRI Pelvis) without contrast (CPT® 72195) AND MRI Spine area of interest without contrast **OR**
    - MRI Sacroiliac Joints (MRI Pelvis) without and with contrast (CPT® 72197) **OR**
    - MRI Sacroiliac Joints (MRI Pelvis) without contrast (CPT® 72195)
- If there is documented ankylosing spondylitis or diffuse idiopathic skeletal hyperostosis (DISH) and spine pain following trauma, then:
  - See: **Neck Trauma (SP-3.2)**, **Upper Back Trauma (SP-4.2)**, **Low Back Trauma (SP-6.2)**

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Fibromyalgia (SP-10.3)

SP.DI.0010.3.A
v1.0.2027

Criteria

- Advanced diagnostic imaging is not supported by the scientific evidence for the evaluation and treatment of fibromyalgia.

Background and Supporting Information

- Sacroiliitis can present with pain localized to the SI joint or referred pain to the buttock and/or posterior thigh without neurologic signs or symptoms. Affected individuals can often point to the SI joint as the pain source. Provocative and/or therapeutic SI joint anesthetic/corticosteroid injections can have diagnostic value.

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Evidence Discussion (SP-10)

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For individuals with proven sacro-iliac joint disorders visible on routine plain x-rays, there is no evidence that advanced diagnostic imaging substantiates changes to individual management decisions.

X-rays are first line imaging for suspected inflammatory sacroiliitis but have a low sensitivity for detecting abnormalities in early disease, and x-ray findings may not be visible until several years after onset of symptoms (Bernard et al., 2017). SI Joint MRI is appropriate when x-ray is equivocal or non-diagnostic (Bernard et al., 2017). There is increase the diagnostic accuracy of MRI in sacroiliitis with use of contrast (Bernard et al., 2017). The benefits of contrast usage should be weighed against the need for IV access and increased cost (American College of Radiology [ACR], 2026). The risk of contrast reaction with MRI contrast agents is lower than with iodinated contrast agents with CT and the risk of nephrogenic systemic fibrosis in patients with renal failure has become negligible with the newer type 2 macrocyclic contrast agents (ACR, 2026). If an individual is unable to undergo MRI, a non-contrast CT may be helpful as it has improved sensitivity over conventional radiography for detection of subtle erosions, although it lacks sensitivity for inflammatory changes of inflammatory sacroiliitis (Bernard et al., 2017).

With suspected inflammatory spondylitis, x-rays are useful to assess for structural changes of syndesmophytes, erosions, vertebral body squaring, and ankylosis (Czuczman et al., 2021). MRI has shown inflammatory changes in the SI joints prior to visible x-ray changes in several studies. However, the ability of MRI to characterize inflammation in early ankylosing spondylitis, the ability of MRI to predict erosive changes, and the value of monitoring treatment effects using serial MRI studies remains controversial in adults (Czuczman et al., 2021).

Plain x-rays are not required prior to advanced imaging in individuals with documented ankylosing spondylitis or diffuse idiopathic skeletal hyperostosis (DISH) and spine pain following trauma, due to high risk of spinal fractures even with low-energy trauma and the low specificity for fracture detection on x-ray in these individuals (Lantsman et al., 2020).

Advanced diagnostic imaging is not supported by scientific evidence for the evaluation and treatment of fibromyalgia.

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Spinal Compression Fractures (SP-11)

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Spinal Compression Fractures (SP-11.1)

SP.FX.0011.1.A
v1.0.2027

Criteria

Individuals with no history of malignancy

- MRI without contrast, CT without contrast, or whole-body bone scan (CPT® 78306), SPECT (CPT® 78803), or SPECT/CT (CPT® 78830) of the affected spinal region is considered medically necessary after plain x-ray evaluation ***and*** the location of the individual's spinal pain is concordant with the spinal x-rays for any **ONE** of the following:
  - X-rays reveal a new spinal compression fracture; ***or***
  - X-rays are non-diagnostic and severe spinal pain persists for more than one week in an individual already predisposed to low energy/insufficiency fractures; ***or***
  - The age of the spinal compression fracture deformity on plain x-ray is indeterminate; ***or***
  - Surgical planning following known insufficiency spinal compression fractures in individuals who are candidates for kyphoplasty, vertebroplasty, or other spine surgical procedures

Individuals with a history of malignancy

- For individuals with new symptomatic or asymptomatic vertebral compression fractures on radiographs, please refer to the cancer-specific guidelines within the General Oncology Imaging Guidelines for appropriate imaging studies.
- See also: **Red Flag Indications (SP-1.2)**

Background and Supporting Information

Insufficiency/low energy spinal compression fractures of the spine occur due to the lack of structural integrity to withstand physiologic loads and minor spinal trauma. Low bone mineral density is the primary etiology for most of these fractures but could also occur in the setting of other bone disease and medical conditions, in addition to neoplastic disease and infection. Sudden localized back pain, with or without trauma, is a typical presentation of insufficiency/low energy spinal compression fractures and can often be an incidental finding on plain x-rays and can be asymptomatic.

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Evidence Discussion (SP-11)

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The diagnosis of a spinal compression fracture may be suspected based on history and physical examination. Plain anteroposterior and lateral radiographs are commonly used in the initial evaluation of a suspected compression fracture and can demonstrate characteristic findings such as vertebral height loss or wedge deformity (Old & Calvert, 2004; Alexandru & So, 2012).

Advanced imaging modalities may provide added diagnostic information, particularly when fractures are not well visualized on plain films or when further characterization of fracture morphology is needed (Old & Calvert, 2004; McCarthy & Davis, 2016).

It has been shown that bone marrow signal on MRI can help identify an acute fracture and distinguish ages of compression fractures (Yamato et al., 1998; Piazzolla et al., 2015). Additionally, the benefits of advanced imaging prior to vertebral augmentation have been reported (Benz et al., 2009; Ma et al., 2010; Spiegl et al., 2009).

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Spinal Pain Related to Cancer (SP-12)

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Spinal Pain Related to Cancer (SP-12)

SP.CA.0012.A
v1.0.2027

- For guidelines regarding advanced diagnostic imaging in this clinical setting, see **Spinal/Vertebral Metastases (ONC-31.6)**.

Spine Imaging Guidelines

Spinal Canal/Cord Disorders (e.g., Syringomyelia) (SP-13)

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Initial Imaging Pathway (SP-13.1)

SP.CD.0013.1.A
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Criteria

- MRI Cervical Spine without contrast or without and with contrast (CPT® 72141 or CPT® 72156) and MRI Thoracic Spine without contrast or without and with contrast (CPT® 72146 or CPT® 72157) is considered medically necessary when syringomyelia is suspected.
- Once a syrinx is identified by prior imaging, the following are considered medically necessary if not already performed:
  - MRI Brain without contrast (CPT® 70551) to evaluate for syringobulbia **AND**
  - MRI Cervical Spine without contrast or without and with contrast (CPT® 72141 or CPT® 72156) **AND**
  - MRI Thoracic Spine without contrast or without and with contrast (CPT® 72146 or CPT® 72157) **AND**
  - MRI Lumbar Spine without contrast or without and with contrast (CPT® 72148 or CPT® 72158) to define the lower most extent of the syrinx or to identify a skip lesion

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Follow-up Imaging (SP-13.2)

SP.CD.0013.2.A
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Criteria

- MRI Cervical Spine without contrast (CPT® 72141) and MRI Brain without contrast (CPT® 70551) and/or MRI Thoracic Spine without contrast (CPT® 72146) are considered medically necessary in any of the following scenarios:
  - If there is a concern for malignancy, imaging can be performed without and with contrast.
  - Annual imaging until non-progression of the syringomyelia is established
  - Following surgical treatment (including posterior fossa decompression)
  - Advanced diagnostic imaging every three years for life can be performed once non-progression of the syringomyelia is established.
  - Repeat advanced diagnostic imaging is considered medically necessary when there is evidence of neurologic deterioration.

Background and Supporting Information

Syringomyelia may begin to form in childhood but rarely becomes symptomatic before the adult years.

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Evidence Discussion (SP-13)

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- MRI of the cervical and thoracic spine is the preferred initial imaging for suspected syringomyelia because it is highly sensitive for detecting syrinx cavities and associated abnormalities such as Chiari malformations or CSF flow obstruction (Flint, 2021).
- Once a syrinx is identified, extending MRI to the brain and entire spinal axis can define the full extent of disease, identify skip lesions, and detect underlying causes such as tumors or hindbrain pathology, which is important given the variable presentation and poor correlation between symptoms and cavity size (Flint, 2021).
- MRI provides detailed, radiation-free evaluation that supports monitoring and surgical decision making, although repeated imaging may increase cost and incidental findings that do not correlate with symptoms, which should be balanced against the need to detect progression or complications (Flint, 2021).

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Spinal Deformities (e.g., Scoliosis/ Kyphosis) (SP-14)

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Spinal Deformities (e.g., Scoliosis/ Kyphosis) (SP-14.1)

SP.SC.0014.1.A
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Criteria

- MRI without contrast, MRI without and with contrast, or CT/Myelography if MRI is contraindicated of the affected spinal regions is considered medically necessary after plain x-rays (e.g., Cobb radiographs) of the affected spinal regions have been performed and results are available to the requesting provider:
  - for pre-operative evaluation; ***or***
  - for cases of congenital scoliosis and other atypical curves that may be associated with spinal canal/cord pathology such as tethered cord, syringomyelia, diastematomyelia, or tumors; ***or***
  - for cases of scoliosis and/or kyphosis when there are associated neurologic signs and symptoms on physical examination; ***or***
  - scoliosis with a convex left thoracic curve due to a high association of a convex left thoracic curve with underlying spinal canal/cord pathology
- CT of the affected spinal regions (contrast as requested) is considered medically necessary in cases with a complex osseous deformity for pre-operative evaluation.
- CT Angiography (CTA) or MR Angiography (MRA) is considered not medically necessary for pre-operative planning for initial anterior spinal surgery for surgical correction of spinal deformities.

Revision Anterior Spinal Deformity Surgery (SP-14.2)

SP.SC.0014.2.A
v1.0.2027

Criteria

- If requested by the operating surgeon, the following studies can be performed for pre-operative planning for revision of anterior thoracic or lumbar spinal surgery:
  - CTA Pelvis (CPT® 72191) **OR**
  - CTA Abdomen (CPT® 74175) **OR**
  - CTA Abdomen and Pelvis (CPT® 74174) **OR**
  - MRA Pelvis (CPT® 72198) and/or MRA Abdomen (CPT® 74185)

Background and Supporting Information

- Scoliosis is defined as a curvature of the spine in the coronal plane. Scoliosis can involve any or all levels of the spine but generally involves the thoracic and/or lumbar spine. Scoliosis initially occurs in the pediatric and adolescent population and persists throughout life. If scoliosis begins in adulthood, it is usually secondary to neurologic disorders (e.g., post-traumatic paralysis) or degenerative spondylosis. Sagittal plane spinal deformity (e.g., kyphosis, hyperlordosis) may be associated with scoliosis.

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Evidence Discussion (SP-14)

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Plain radiography continues to be the primary imaging modality for the initial diagnosis of spinal deformity and for follow-up of deformity progression (Calloni et al., 2017; Wright, 2000). Plain x-rays allow the easy measurement of Cobb angles which remains essential in the evaluation of scoliosis (Calloni et al., 2017).

Individuals with congenital scoliosis, atypical curves (e.g., left thoracic) or abnormal neurological findings will benefit from MRI to help identify spinal cord abnormalities (Calloni et al., 2017; Winter et al., 1992; Barnes et al., 1993; Belmont et al., 2004). CT is considered the gold standard for the evaluation of osseous structures and can be useful in the evaluation of complex bony deformity (Calloni et al., 2017). Additionally, MRI and CT can be valuable for pre-operative evaluation and can provide detailed characterization of neural axis abnormalities and deformity anatomy (Ozturk et al., 2010; Garg & Aryal, 2023; Negrini et al., 2018).

For revision anterior spinal deformity surgery, vascular imaging such as CT angiography or MR angiography may provide additional anatomic information for surgical planning, however, concerns associated with these modalities are radiation exposure with CT-based techniques, availability of the imaging modalities in close proximity to individuals, potential out of pocket costs to individuals, and sensitivity to individual movement with MRI (Gstöttner et al., 2011; Watson & Yu, 2023).

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Post-Operative Spinal Disorders (SP-15)

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Greater than Six Months Post-Operative (SP-15.1)

SP.OP.0015.1.C
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Criteria

- Following plain x-rays of the affected spinal regions post-surgical and performed after the current episode of symptoms started or changed with results available to the requesting provider, MRI without and with contrast, MRI without contrast, or CT without contrast of the affected spinal region(s) is considered medically necessary when:
  - Individual is more than 6 months post-operative **AND**
  - There is a documented failure of a 6-week trial of provider-directed treatment after the current set of symptoms started or changed with clinical re-evaluation
  - If a Red Flag Indiction is present, conservative care is not required. See: **Red Flag Indications (SP-1.2)**.

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Routine Post-Fusion Imaging (SP-15.2)

SP.OP.0015.2.A
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Criteria

- Following a clinically successful spinal fusion, advanced diagnostic imaging is generally considered not medically necessary.
- PET is not currently considered medically necessary for the routine assessment of spinal fusions or unsuccessful spine surgery (see also: **Spine PET (SP-2.10)**).

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Prolonged Intractable Pain Following Spinal Surgery Within Six Months (SP-15.3)

SP.OP.0015.3.A
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Criteria

- Following plain x-rays of the affected spinal regions post-surgical with results available to the requesting provider, MRI without and with contrast of the affected spinal region(s) is considered medically necessary if there are residual, new, recurrent, or worsening symptoms related to the spinal region(s) for which surgery was performed within the last 6 months.
  - CT without contrast, or CT with contrast (Myelography) of the affected spinal region(s) if MRI is contraindicated.

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Revision Anterior Fusion Surgery (SP-15.4)

SP.OP.0015.4.A
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Criteria

- If requested by the operating surgeon, the following studies for pre-operative planning prior to surgical revision of a thoracic or lumbar anterior spinal arthrodesis:
  - CTA Pelvis (CPT® 72191) **OR**
  - CTA Abdomen (CPT® 74175) **OR**
  - CTA Abdomen and Pelvis (CPT® 74174) **OR**
  - MRA Pelvis (CPT® 72198) and/or MRA Abdomen (CPT® 74185)

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Evidence Discussion (SP-15)

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Despite advances made in high-resolution spinal imaging, plain films remain integral in providing optimal care for spine individuals and continue to provide critical information that cannot be obtained with other imaging modalities (Goodwin, Buchowski, & Sciubba, 2022). X-ray imaging with anteroposterior, lateral, oblique, and flexion-extension views is considered the primary imaging modality for post-operative evaluation and can provide complementary information to advanced imaging (Hayashi et al., 2012; Hutchins et al., 2021). X-rays can provide information as to whether a concomitant instability is present which would further assist with pre-operative planning. Also, when prior surgery is a concern, x-ray provides additional clinical information as to the details of the hardware for which this detail can many times be obscured with advanced imaging techniques (MRI/CT). An x-ray often has a larger field-of-view than an MRI or CT and has the potential to identify more proximal or distal pathology in the spine that could ultimately assist in determining the individual's diagnosis (Goodwin, Buckowski, & Sciubba, 2022). X-rays can also determine whether an advanced diagnostic imaging study is actually needed, what specific advanced diagnostic imaging study is warranted, and if contrast is required.

There are minimal risks associated with advanced imaging including but not limited to radiation exposure, implanted device complications, metallic foreign body complications, and contrast complications (Watson & Yu, 2023) . Studies have also linked the increase rate of imaging with the increase rate of surgery and found early magnetic resonance imaging (MRI) had an eightfold increased risk of surgery (Srinivas, Deyo, & Berger, 2012; Eldaya et al., 2025).

Although most individuals with acute neck or back pain will improve with 6 weeks of conservative care (Hutchins et al., 2021; Chou et al., 2009; Childress & Becker, 2016), conservative care would not be necessary for individuals with prolonged intractable pain present within 6 months of surgery or if a red flag indication was present. In general, initial plain x-rays and an initial course of conservative care can provide a significant clinical benefit that would outweigh the clinical harm from perhaps briefly delaying advanced imaging if needed. A course of conservative care or plain x-ray findings many times may obviate the need for advanced imaging which possess their own set of significant risks.

For revision thoracic or lumbar anterior spinal arthrodesis, vascular imaging such as CT angiography or MR angiography can provide detailed evaluation of vascular anatomy relevant to surgical planning, however, risks are present with these modalities including radiation exposure with CT-based techniques, availability of the imaging modalities in close proximity to individuals, potential out-of-pocket costs to individuals, and sensitivity to individual movement with MRI (Gstöttner et al., 2011; Watson & Yu, 2023).

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Other Imaging Studies and Procedures Related to the Spine Imaging Guidelines (SP-16)

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Prior to Spine Surgery (SP-16.1)

SP.OI.0016.1.A
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Criteria

- Advanced imaging needed for surgical planning (e.g., MRI and/or CT) should be performed within the past 6 months for pre-operative planning prior to spine surgery when the criteria for advanced imaging studies of the spine are met as otherwise stated in the Spine Imaging Guidelines. (See: **MRI of the Spine [SP-2.2]**, **CT of the Spine [SP-2.3]**, **CT/Myelography [SP-2.4]**)
- MR Angiography (MRA) and CT Angiography (CTA) are generally considered not medically necessary for pre-operative planning of initial anterior spinal surgery unless abnormal vasculature is known or reasonably anticipated.

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Prior to Interventional Spinal Injections (SP-16.2)

SP.OI.0016.2.A
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Criteria

- Advanced diagnostic imaging studies of the spine are not required prior to facet joint injections, medial branch blocks, or radiofrequency ablations unless the criteria for advanced imaging studies of the spine are met as otherwise stated in the Spine Imaging Guidelines.
- Advanced diagnostic imaging studies of the cervical spine and/or thoracic spine are considered medically necessary within 24 months prior to interlaminar or transforaminal epidural steroid injections of the cervical and/or thoracic spine when the criteria for advanced imaging studies of the spine are met as otherwise stated in the Spine Imaging Guidelines.
- Advanced diagnostic imaging studies of the lumbar spine are considered medically necessary prior to transforaminal epidural steroid injections of the lumbar spine when the criteria for advanced imaging studies of the spine are met as otherwise stated in the Spine Imaging Guidelines.
- Advanced diagnostic imaging studies of the lumbar spine are not required prior to lumbar spine interlaminar or caudal epidural steroid injections unless the criteria for advanced imaging studies of the spine are met as otherwise stated in the Spine Imaging Guidelines.
- For an individual with evidence of symptomatic spinal stenosis, MRI or CT with or without myelography demonstrating severe spinal stenosis at the level to be treated within the past 24 months is required for an initial trial of a transforaminal, interlaminar, or caudal epidural steroid injection when **ALL** of the following criteria are met:
  - Diagnostic evaluation has ruled out other potential causes of pain
  - Significant functional limitations resulting in diminished quality of life and impaired age-appropriate activities of daily living (ADLs)
  - Failure of at least 4 weeks of conservative treatment (e.g., exercise, physical methods including physical therapy and/or chiropractic care, NSAIDs, and/or muscle relaxants)
- See: **Red Flag Indications (SP-1.2)** for severe radicular pain

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Prior to Spinal Cord Stimulator (SCS) Placement/Removal (SP-16.3)

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Criteria

- MRI Thoracic Spine without contrast (CPT® 72146) is generally the study of choice prior to SCS placement. CT Thoracic Spine without contrast (CPT® 72128) **OR** CT/ Myelography Thoracic Spine (CPT® 72129) are acceptable alternatives.
- Imaging of the lumbar spine is considered not medically necessary for placement nor removal of spinal cord stimulators because placement or removal is not affected by lumbar spine findings and does not require advance imaging.

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Following Vertebral Augmentation Procedures (SP-16.4)

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Criteria

- CT without contrast of the affected spinal region(s) within 24 hours post-procedure to evaluate neurologic sequelae resulting from cement extravasation

Background and Supporting Information

- Repeat advanced diagnostic imaging studies are not necessary with each spinal injection or series of spinal injections.

Spine Imaging Guidelines

Evidence Discussion (SP-16)

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- Advanced imaging prior to spine surgery has been shown to improve characterization of neural and osseous pathology and assist with procedural planning, particularly in identifying targets for intervention such as nerve root compression or spinal stenosis (Hutchins et al., 2021). However, imaging findings may not always correlate with symptoms and can contribute to increased interventions, including surgery, without clear improvement in clinical outcomes (Ghaly et al., 2015; Hutchins et al., 2021).
- Advanced imaging prior to interventional spinal injections may help identify underlying pathology and exclude serious conditions such as malignancy, infection, or hematoma when clinical concern is present (Ghaly et al., 2015). MRI has not been shown to change the outcome of interventional pain procedures in recent scientific evidence-based studies and without substantial change in the clinical picture or intervening surgery. Routine imaging in the absence of these factors may increase downstream utilization without improving clinical outcomes (Ghaly et al., 2015; Hutchins et al., 2021).
- Imaging prior to spinal cord stimulator placement can provide anatomic detail relevant to procedural planning, particularly in evaluating the spinal canal and epidural space at the level of lead placement (Hutchins et al., 2021). MRI is often preferred for evaluation of soft tissue structures, while CT or CT myelography may be used when MRI is contraindicated or limited by artifact. Imaging of regions outside the area of clinical concern may have limited diagnostic value in the absence of specific indications and may contribute to unnecessary resource utilization (Hutchins et al., 2021).
- Following vertebral augmentation procedures, CT imaging can provide detailed assessment of complications such as cement extravasation, which may result in neurologic deficits when involving the spinal canal or intradural space (Baek et al., 2021). Evidence suggests that most instances of cement leakage are asymptomatic and clinically insignificant, and therefore routine imaging is not required in the absence of symptoms. However, when neurologic deficits occur, prompt imaging evaluation is important to guide management and potential intervention (Baek et al., 2021).

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Spine Imaging Guidelines

Procedure Codes Associated with Spine Imaging

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MRI/MRA	CPT®
MRI Cervical without contrast	72141
MRI Cervical with contrast	72142
MRI Cervical without and with contrast	72156
MRI Thoracic without contrast	72146
MRI Thoracic with contrast	72147
MRI Thoracic without and with contrast	72157
MRI Lumbar without contrast	72148
MRI Lumbar with contrast	72149
MRI Lumbar without and with contrast	72158
MRA Spinal Canal	72159
MRI Pelvis without contrast	72195
MRI Pelvis with contrast	72196
MRI Pelvis without and with contrast	72197
MR Spectroscopy	76390
Magnetic resonance spectroscopy, determination and localization of discogenic pain (cervical, thoracic, or lumbar); acquisition of single voxel data, per disc, on biomarkers (ie, lactic acid, carbohydrate, alanine, laal, propionic acid, proteoglycan, and collagen) in at least 3 discs	0609T

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MRI/MRA	CPT®
Magnetic resonance spectroscopy, determination and localization of discogenic pain (cervical, thoracic, or lumbar); transmission of biomarker data for software analysis	0610T
Magnetic resonance spectroscopy, determination and localization of discogenic pain (cervical, thoracic, or lumbar); postprocessing for algorithmic analysis of biomarker data for determination of relative chemical differences between discs	0611T
Magnetic resonance spectroscopy, determination and localization of discogenic pain (cervical, thoracic, or lumbar); interpretation and report	0612T

CT	CPT®
CT Cervical without contrast	72125
CT Cervical with contrast (Post-Myelography CT)	72126
CT Cervical without and with contrast	72127
CT Thoracic without contrast	72128
CT Thoracic with contrast (Post-Myelography CT)	72129
CT Thoracic without and with contrast	72130
CT Lumbar without contrast	72131
CT Lumbar with contrast (Post-Myelography CT)	72132
CT Lumbar without and with contrast	72133
CT Pelvis without contrast	72192
CT Pelvis with contrast	72193
CT Pelvis without and with contrast	72194

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Ultrasound	CPT®
Spinal canal ultrasound	76800

Spine Imaging Guidelines