~~cyst~~National Imaging Associates, Inc.	
Clinical guidelines **CHEST (THORAX) MRI**	**Original Date: September 1997**
CPT Codes: 71550, 71551, 71552	**Last Revised Date: April 2023~~March 2022~~**
Guideline Number: NIA_CG_021	**Implementation Date: January 2024~~23~~**

GENERAL INFORMATION

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

INDICATIONS FOR CHEST MRI

The combination of superior soft tissue contrast and lack of ionizing radiation may make Chest Magnetic Resonance Imaging (MRI) preferable for the pediatric population, during pregnancy and also when frequent serial imaging is needed. ~~or evaluation of the non-lung parenchyma.~~ This must be weighed against a longer acquisition time, ~~and~~ greater likelihood of ~~artifact from~~ patient motion~~.~~ artifact as well as the lack of experience in obtaining and interpreting non-vascular chest MR. Recent technological advancements have made non-vascular thoracic MRI increasingly utilized, however ~~C~~C**hest Computed Tomography (CT) is ~~generally better for lung parenchymal evaluation at this time~~**. Chest Magnetic Resonance Angiography (MRA) is ordered for evaluation of the intrathoracic blood vessels. Chest MRI and Chest MRA should not be approved at the same time.

Chest Mass (non-lung parenchymal)[1-7]

- Mass or lesion, including lymphadenopathy, after non-diagnostic x-ray or ultrasound (Chest CT indicated for pulmonary nodule)
- Thymoma screening in Myasthenia Gravis patients[8]

~~* National Imaging Associates, Inc. (NIA) is a subsidiary of Magellan Healthcare, Inc.~~

- Congenital thoracic malformation on other imaging (chest x-ray, echocardiogram, gastrointestinal study, or inconclusive CT)[9-12]

Chest Wall (MRI preferred over CT):

- Pain (after initial evaluation with chest x-ray and/or rib films)~~32~~
- History of known or suspected cancer involving the chest wall
- Signs and symptoms of infection with concern for chest wall involvement, such as: fever, elevated inflammatory markers, known infection at other sites
- Suspected chest wall injuries (including musculotendinous, costochondral cartilage, sternoclavicular joint, and manubriosternal joint injuries) when imaging will potentially alter management
- Malformations (such as pectus excavatum, pectus carinatum, scoliosis) in patients with cardiorespiratory symptoms for whom treatment is being considered
- Mass or lesion after inconclusive initial imaging (MRI preferred over chest CT for chest wall mass)
- ~~Chest Wall Pain (after initial evaluation with chest x-ray and/or rib series radiographs)~~

- ~~History of known or suspected cancer~~
- ~~Signs and symptoms of infection (non-lung parenchymal), such as:~~
  - ~~Accompanying fever~~
  - ~~Elevated inflammatory markers~~
  - ~~Known infection at other sites~~
- ~~Suspected muscle or tendon tear where imaging would change treatment~~

Brachial Plexopathy[13, 14]

- If mechanism of injury or Electromyography/Nerve Conduction Velocity (EMG/NCV) studies are suggestive
- Chest MRI is preferred study, but neck and/or shoulder (upper extremity) MRI can be ordered depending on the suspected location of injury

Cystic Fibrosis[15]

- Can be an alternative to Chest CT to evaluate perfusion abnormalities, bronchiectasis, and mucus plugging if needed for treatment planning

Vascular Diseases are better evaluated with Chest CTA or MRA[16]

- Superior vena cava (SVC) syndrome[17]
- Subclavian Steal Syndrome after positive or inconclusive ultrasound[18, 19]
- Thoracic Outlet Syndrome[16, 20, 21]

- Takayasu's arteritis[22]
- Acute or chronic aortic dissection[23, 24]
- Pulmonary hypertension - To evaluate for cause after echocardiogram or right heart catheterization[25, 26]

Congenital Malformations

- Congenital heart disease with pulmonary hypertension[27]
- Pulmonary sequestration[28]

Atrial fibrillation with ablation planned[29]

Preoperative/procedural evaluation

- Pre-operative evaluation for a planned surgery or procedure

Post-operative/procedural evaluation

- Post-surgical follow-up when records document medical reason requiring additional imaging

Other Indications

Further evaluation of indeterminate findings on prior imaging (unless follow up is otherwise specified within the guideline):

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

BACKGROUND

Magnetic Resonance Imaging (MRI) is a noninvasive imaging technique for detection and evaluation of various disease and conditions in the chest, e.g., congenital anomalies and aneurysms. MRI may be used instead of computed tomography (CT) in patients with allergies to radiographic contrast or with impaired renal function. Also, to decrease radiation exposure, Chest MRI may be used rather than CT when repeated imaging is expected (i.e., surveillance).

OVERVIEW

MRI for Non-Parenchymal Masses[30]

CT and MRI are similar in usefulness when imaging the chest wall and pleura. The main advantages of MRI are lack or radiation, superior contrast resolution for delineation of anatomy, evaluation of local invasion, greater ability to image in "unconventional planes" and real time imaging capabilities. CT is still the gold standard for evaluation parenchymal disease; however, MR is also now being considered in the assessment of endometriosis, lung nodules and lung cancer staging. The lack of standardized protocols and experience in interpretation still limits the usefulness of non-vascular chest MRI.

Due to the capability of MR to distinguish certain fat and fluid characteristics, MR can be superior to CT for evaluating mediastinal masses. The presence of microscopic fat allows MR to distinguish thymic hyperplasia from mass. Similarly, because of macroscopic fat, MR is useful in evaluating dermoid cysts teratomas, thymolipomas, lipomas and liposarcomas.
MRI can also differentiate simple from complex cystic lesions better than CT, and is thus useful for evaluating cystic mediastinal masses, such as thymic, foregut duplication or pericardial cysts and lymphatic malformations.

Finally, MRI can help differentiate types of neurogenic tumors (schwannomas, neurofibromas and ganglioneuromas) that may have similar CT features, to evaluate of intraspinal and neural extension of the tumor, as well as to assess adherence or invasion of a mediastinal mass to adjacent structures.

MRI and Myasthenia Gravis – Myasthenia Gravis is a chronic autoimmune disease characterized by weakness of the skeletal muscles causing fatigue and exhaustion that is aggravated by activity and relieved by rest. It most often affects the ocular and other cranial muscles and is thought to be caused by the presence of circulating antibodies. Symptoms include ptosis, diplopia, chewing difficulties, and dysphagia. Thymoma has a known association with myasthenia. Contrast-enhanced MRI may be used to identify the presence of a mediastinal mass suggestive of myasthenia gravis in patients with renal failure or allergy to contrast material.

MRI and Thoracic Outlet Syndrome – Thoracic outlet syndrome is a group of disorders involving compression at the superior thoracic outlet that affects the brachial plexus, the subclavian artery, and veins. It refers to neurovascular complaints due to compression of the brachial plexus or the subclavian vessels. Magnetic resonance multi-plane imaging shows bilateral images of the thorax and brachial plexus and can demonstrate the compression of the brachial plexus and venous obstruction.

MRI and Brachial Plexus - MRI is the only diagnostic tool that accurately provides high resolution imaging of the brachial plexus. The brachial plexus is formed by the cervical ventral rami of the lower cervical and upper thoracic nerves which arise from the cervical spinal cord, exit the bony confines of the cervical spine, and traverse along the soft tissues of the neck, upper chest, and course into the arms.

POLICY HISTORY

Date	Summary
2023	Updates on mass imaging and chest wall imaging
March 2022	• Updated references
April 2021	• Added details on brachial plexopathy imaging • Expanded introduction section • Added Cystic Fibrosis imaging (alternative to CT) • Clarified pre-operative evaluation for a planned surgery or procedure
May 2020	• Added Chest Wall Pain section: ○ *Chest Wall Pain (after initial evaluation with chest x-ray and/or rib series radiographs)* • *History of known or suspected cancer* • *Signs and symptoms of infection (non-lung parenchymal), such as:* ○ *Accompanying fever* ○ *Elevated inflammatory markers* ○ *Known infection at other sites* • *Suspected muscle or tendon tear where imaging would change treatment* • Thoracic Aortic Disease: removed section and added note: *Chest CTA or MRA is preferred for vascular pathology* • Thoracic Outlet Syndrome: removed section and added note: *Chest CTA or MRA is preferred for vascular pathology* • Brachial Plexopathy: added note: *Chest MRI is preferred study vs. neck or shoulder MRI*
May 2019	• Expanded indications including: vascular and congenital anomalies • Updated thoracic aortic section and reformatted to match other guidelines.

REFERENCES

1. Azizad S, Sannananja B, Restrepo CS. Solid Tumors of the Mediastinum in Adults. *Semin Ultrasound CT MR*. Jun 2016;37(3):196-211. doi:10.1053/j.sult.2016.03.002
2. Carter BW, Benveniste MF, Betancourt SL, et al. Imaging Evaluation of Malignant Chest Wall Neoplasms. *Radiographics*. Sep-Oct 2016;36(5):1285-306. doi:10.1148/rg.2016150208
3. Carter BW, Benveniste MF, Truong MT, Marom EM. State of the Art: MR Imaging of Thymoma. *Magn Reson Imaging Clin N Am*. May 2015;23(2):165-77. doi:10.1016/j.mric.2015.01.005
4. Carter BW, Gladish GW. MR Imaging of Chest Wall Tumors. *Magn Reson Imaging Clin N Am*. May 2015;23(2):197-215. doi:10.1016/j.mric.2015.01.007
5. Carter BW, Betancourt SL, Benveniste MF. MR Imaging of Mediastinal Masses. *Top Magn Reson Imaging*. Aug 2017;26(4):153-165. doi:10.1097/rmr.0000000000000134
6. Hochhegger B, Marchiori E, Sedlaczek O, et al. MRI in lung cancer: a pictorial essay. *Br J Radiol*. Jul 2011;84(1003):661-8. doi:10.1259/bjr/24661484
7. Mullan CP, Madan R, Trotman-Dickenson B, Qian X, Jacobson FL, Hunsaker A. Radiology of chest wall masses. *AJR Am J Roentgenol*. Sep 2011;197(3):W460-70. doi:10.2214/ajr.10.7259
8. Kumar R. Myasthenia gravis and thymic neoplasms: A brief review. *World J Clin Cases*. Dec 16 2015;3(12):980-3. doi:10.12998/wjcc.v3.i12.980
9. Ferreira Tda A, Chagas IS, Ramos RT, Souza EL. Congenital thoracic malformations in pediatric patients: two decades of experience. *J Bras Pneumol*. Mar-Apr 2015;41(2):196-9. doi:10.1590/s1806-37132015000004374
10. Hellinger JC, Daubert M, Lee EY, Epelman M. Congenital thoracic vascular anomalies: evaluation with state-of-the-art MR imaging and MDCT. *Radiol Clin North Am*. Sep 2011;49(5):969-96. doi:10.1016/j.rcl.2011.06.013
11. Karaosmanoglu AD, Khawaja RD, Onur MR, Kalra MK. CT and MRI of aortic coarctation: pre- and postsurgical findings. *AJR Am J Roentgenol*. Mar 2015;204(3):W224-33. doi:10.2214/ajr.14.12529
12. Poletto E, Mallon MG, Stevens RM, CM A. Imaging Review of Aortic Vascular Rings and Pulmonary Sling. *J Am Osteopath Coll Radiol*. 2017;6(2):5-14.
13. Mansukhani KA. Electrodiagnosis in traumatic brachial plexus injury. *Ann Indian Acad Neurol*. Jan 2013;16(1):19-25. doi:10.4103/0972-2327.107682
14. Vijayasarathi A, Chokshi FH. MRI of the brachial plexus: A practical review. *Appl Radiol*. 2016;45(4):9-18.
15. Woods JC, Wild JM, Wielpütz MO, et al. Current state of the art MRI for the longitudinal assessment of cystic fibrosis. *J Magn Reson Imaging*. Nov 2020;52(5):1306-1320. doi:10.1002/jmri.27030
16. Zurkiya O, Ganguli S, Kalva SP, et al. ACR Appropriateness Criteria® Thoracic Outlet Syndrome. *J Am Coll Radiol*. May 2020;17(5s):S323-s334. doi:10.1016/j.jacr.2020.01.029
17. Friedman T, Quencer KB, Kishore SA, Winokur RS, Madoff DC. Malignant Venous Obstruction: Superior Vena Cava Syndrome and Beyond. *Semin Intervent Radiol*. Dec 2017;34(4):398-408. doi:10.1055/s-0037-1608863

18. Osiro S, Zurada A, Gielecki J, Shoja MM, Tubbs RS, Loukas M. A review of subclavian steal syndrome with clinical correlation. *Med Sci Monit*. May 2012;18(5):Ra57-63. doi:10.12659/msm.882721
19. Potter BJ, Pinto DS. Subclavian steal syndrome. *Circulation*. Jun 3 2014;129(22):2320-3. doi:10.1161/circulationaha.113.006653
20. Chavhan GB, Batmanabane V, Muthusami P, Towbin AJ, Borschel GH. MRI of thoracic outlet syndrome in children. *Pediatr Radiol*. Sep 2017;47(10):1222-1234. doi:10.1007/s00247-017-3854-5
21. Povlsen S, Povlsen B. Diagnosing Thoracic Outlet Syndrome: Current Approaches and Future Directions. *Diagnostics (Basel)*. Mar 20 2018;8(1)doi:10.3390/diagnostics8010021
22. Keser G, Direskeneli H, Aksu K. Management of Takayasu arteritis: a systematic review. *Rheumatology (Oxford)*. May 2014;53(5):793-801. doi:10.1093/rheumatology/ket320
23. Barman M. Acute aortic dissection. *ESC e-J Cardio Pract*. 2014;12(25):02Jul2014. doi:https://www.escardio.org/Journals/E-Journal-of-Cardiology-Practice/Volume-12/Acute-aortic-dissection
24. American College of Radiology. ACR Appropriateness Criteria® Thoracic Aorta Interventional Planning and Follow-up. American College of Radiology. Updated 2017. Accessed November 20, 2022. https://acsearch.acr.org/docs/3099659/Narrative/
25. Ascha M, Renapurkar RD, Tonelli AR. A review of imaging modalities in pulmonary hypertension. *Ann Thorac Med*. Apr-Jun 2017;12(2):61-73. doi:10.4103/1817-1737.203742
26. Rose-Jones LJ, McLaughlin VV. Pulmonary hypertension: types and treatments. *Curr Cardiol Rev*. 2015;11(1):73-9. doi:10.2174/1573403x09666131117164122
27. Pascall E, Tulloh RM. Pulmonary hypertension in congenital heart disease. *Future Cardiol*. Jul 2018;14(4):343-353. doi:10.2217/fca-2017-0065
28. Sancak T, Cangir AK, Atasoy C, Ozdemir N. The role of contrast enhanced three-dimensional MR angiography in pulmonary sequestration. *Interact Cardiovasc Thorac Surg*. Dec 2003;2(4):480-2. doi:10.1016/s1569-9293(03)00118-x
29. Kolandaivelu A. Role of Cardiac Imaging (CT/MR) Before and After RF Catheter Ablation in Patients with Atrial Fibrillation. *J Atr Fibrillation*. Aug-Sep 2012;5(2):523. doi:10.4022/jafib.523
30. Nguyen ET, Bayanati H, Bilawich AM, et al. Canadian Society of Thoracic Radiology/Canadian Association of Radiologists Clinical Practice Guidance for Non-Vascular Thoracic MRI. *Can Assoc Radiol J*. Nov 2021;72(4):831-845. doi:10.1177/0846537121998961

~~ADDITIONAL RESOURCES~~

~~1. Aralasmak A, Cevikol C, Karaali K, et al. MRI findings in thoracic outlet syndrome. *Skeletal Radiol*. Nov 2012;41(11):1365-74. doi:10.1007/s00256-012-1485-3~~

~~2. Baez JC, Seethamraju RT, Mulkern R, Ciet P, Lee EY. Pediatric Chest MR Imaging: Sedation, Techniques, and Extracardiac Vessels. *Magn Reson Imaging Clin N Am*. May 2015;23(2):321-35. doi:10.1016/j.mric.2015.01.010~~

~~3. Bonci G, Steigner ML, Hanley M, et al. ACR Appropriateness Criteria(®) Thoracic Aorta Interventional Planning and Follow-Up. *J Am Coll Radiol*. Nov 2017;14(11s):S570-s583. doi:10.1016/j.jacr.2017.08.042~~

~~4. Cardinale L, Ardissone F, Novello S, et al. The pulmonary nodule: clinical and radiological characteristics affecting a diagnosis of malignancy. *Radiol Med*. Sep 2009;114(6):871-89. doi:10.1007/s11547-009-0399-1~~

~~5. Cline B, Hurwitz LM, Kim CY. MR Venography of the Central Veins of the Thorax. *Top Magn Reson Imaging*. Aug 2017;26(4):167-174. doi:10.1097/rmr.0000000000000139~~

~~6. Dillman JR, Yarram SG, D'Amico AR, Hernandez RJ. Interrupted aortic arch: spectrum of MRI findings. *AJR Am J Roentgenol*. Jun 2008;190(6):1467-74. doi:10.2214/ajr.07.3408~~

~~7. Doherty JU, Kort S, Mehran R, et al. ACC/AATS/AHA/ASE/ASNC/HRS/SCAI/SCCT/SCMR/STS 2019 Appropriate Use Criteria for Multimodality Imaging in the Assessment of Cardiac Structure and Function in Nonvalvular Heart Disease: A Report of the American College of Cardiology Appropriate Use Criteria Task Force, American Association for Thoracic Surgery, American Heart Association, American Society of Echocardiography, American Society of Nuclear Cardiology, Heart Rhythm Society, Society for Cardiovascular Angiography and Interventions, Society of Cardiovascular Computed Tomography, Society for Cardiovascular Magnetic Resonance, and the Society of Thoracic Surgeons. *J Am Coll Cardiol*. Feb 5 2019;73(4):488-516. doi:10.1016/j.jacc.2018.10.038~~

~~8. Dudzinski DM, Isselbacher EM. Diagnosis and Management of Thoracic Aortic Disease. *Curr Cardiol Rep*. Dec 2015;17(12):106. doi:10.1007/s11886-015-0655-z~~

~~9. Erbel R, Aboyans V, Boileau C, et al. 2014 ESC Guidelines on the diagnosis and treatment of aortic diseases: Document covering acute and chronic aortic diseases of the thoracic and abdominal aorta of the adult. The Task Force for the Diagnosis and Treatment of Aortic Diseases of the European Society of Cardiology (ESC). *Eur Heart J*. Nov 1 2014;35(41):2873-926. doi:10.1093/eurheartj/ehu281~~

~~10. Hannuksela M, Stattin EL, Johansson B, Carlberg B. Screening for Familial Thoracic Aortic Aneurysms with Aortic Imaging Does Not Detect All Potential Carriers of the Disease. *Aorta (Stamford)*. Feb 2015;3(1):1-8. doi:10.12945/j.aorta.2015.14-052~~

~~11. Hansen MS, Kellman P. Image reconstruction: an overview for clinicians. *J Magn Reson Imaging*. Mar 2015;41(3):573-85. doi:10.1002/jmri.24687~~

~~12. Hazenfield JM, Gaskill-Shipley MF. Neoplastic and Paraneoplastic Involvement of the Spinal Cord. *Semin Ultrasound CT MR*. Oct 2016;37(5):482-97. doi:10.1053/j.sult.2016.05.009~~

~~13. Hiratzka LF, Bakris GL, Beckman JA, et al. 2010 ACCF/AHA/AATS/ACR/ASA/SCA/SCAI/SIR/STS/SVM guidelines for the diagnosis and~~

management of patients with Thoracic Aortic Disease: a report of the American College of Cardiology Foundation/American Heart Association Task Force on Practice Guidelines, American Association for Thoracic Surgery, American College of Radiology, American Stroke Association, Society of Cardiovascular Anesthesiologists, Society for Cardiovascular Angiography and Interventions, Society of Interventional Radiology, Society of Thoracic Surgeons, and Society for Vascular Medicine. *Circulation*. Apr 6 2010;121(13):e266-369. doi:10.1161/CIR.0b013e3181d4739e
14. Kircher MF, Willmann JK. Molecular body imaging: MR imaging, CT, and US. Part II. Applications. *Radiology*. Aug 2012;264(2):349-68. doi:10.1148/radiol.12111703
15. Lau C, Feldman DN, Girardi LN, Kim LK. Imaging for surveillance and operative management for endovascular aortic aneurysm repairs. *J Thorac Dis*. Apr 2017;9(Suppl 4):S309-s316. doi:10.21037/jtd.2017.03.89
16. Mongeon FP, Marcotte F, Terrone DG. Multimodality Noninvasive Imaging of Thoracic Aortic Aneurysms: Time to Standardize? *Can J Cardiol*. Jan 2016;32(1):48-59. doi:10.1016/j.cjca.2015.09.025
17. Mueller GC, Lu JC, Mahani MG, Dorfman AL, Agarwal PP. MR Imaging of Thoracic Veins. *Magn Reson Imaging Clin N Am*. May 2015;23(2):293-307. doi:10.1016/j.mric.2015.01.001
18. Nörenberg D, Ebersberger HU, Diederichs G, Hamm B, Botnar RM, Makowski MR. Molecular magnetic resonance imaging of atherosclerotic vessel wall disease. *Eur Radiol*. Mar 2016;26(3):910-20. doi:10.1007/s00330-015-3881-2
19. Pynnonen MA, Gillespie MB, Roman B, et al. Clinical Practice Guideline: Evaluation of the Neck Mass in Adults. *Otolaryngol Head Neck Surg*. Sep 2017;157(2_suppl):S1-s30. doi:10.1177/0194599817722550
20. Rajiah P. CT and MRI in the Evaluation of Thoracic Aortic Diseases. *Int J Vasc Med*. 2013;2013:797189. doi:10.1155/2013/797189
21. Ruano CA, Marinho-da-Silva A, Donato P. Congenital Thoracic Venous Anomalies in Adults: Morphologic MR Imaging. *Curr Probl Diagn Radiol*. Jul-Aug 2015;44(4):337-45. doi:10.1067/j.cpradiol.2015.01.002
22. Rubin DI. Brachial and lumbosacral plexopathies: A review. *Clin Neurophysiol Pract*. 2020;5:173-193. doi:10.1016/j.cnp.2020.07.005
23. Smith BM, Lu JC, Dorfman AL, Mahani MG, Agarwal PP. Rings and slings revisited. *Magn Reson Imaging Clin N Am*. Feb 2015;23(1):127-35. doi:10.1016/j.mric.2014.09.011
24. Stojanovska J, Rodriguez K, Mueller GC, Agarwal PP. MR Imaging of the Thoracic Aorta. *Magn Reson Imaging Clin N Am*. May 2015;23(2):273-91. doi:10.1016/j.mric.2015.01.004
25. Zapala MA, Ho-Fung VM, Lee EY. Thoracic Neoplasms in Children: Contemporary Perspectives and Imaging Assessment. *Radiol Clin North Am*. Jul 2017;55(4):657-676. doi:10.1016/j.rcl.2017.02.008

Reviewed / Approved by NIA Clinical Guideline Committee

POLICY HISTORY

Date	Summary
April 2023	• Updates on mass imaging and chest wall imaging • General Information moved to beginning of guideline with added statement on clinical indications not addressed in this guideline • Added statement regarding further evaluation of indeterminate findings on prior imaging
March 2022	• Updated references

Reviewed / Approved by NIA Clinical Guideline Committee

Disclaimer: *National Imaging Associates, Inc. (NIA) authorization policies do not constitute medical advice and are not intended to govern or otherwise influence the practice of medicine. These policies are not meant to supplant your normal procedures, evaluation, diagnosis, treatment and/or care plans for your patients. Your professional judgement must be exercised and followed in all respects with regard to the treatment and care of your patients. These policies apply to all Evolent Health LLC subsidiaries including, but not limited to, National Imaging Associates ("NIA"). The policies constitute only the reimbursement and coverage guidelines of NIA. Coverage for services varies for individual members in accordance with the terms and conditions of applicable Certificates of Coverage, Summary Plan Descriptions, or contracts with governing regulatory agencies. NIA reserves the right to review and update the guidelines at its sole discretion. Notice of such changes, if necessary, shall be provided in accordance with the terms and conditions of provider agreements and any applicable laws or regulations.*

~~**GENERAL INFORMATION**~~

~~It is an expectation that all patients receive care/services from a licensed clinician. All appropriate supporting documentation, including recent pertinent office visit notes, laboratory data, and results of any special testing must be provided. If applicable: All prior relevant imaging results and the reason that alternative imaging cannot be performed must be included in the documentation submitted.~~

~~**Disclaimer:** Magellan Healthcare service authorization policies do not constitute medical advice and are not intended to govern or otherwise influence the practice of medicine. These policies are not meant to supplant your normal procedures, evaluation, diagnosis, treatment and/or care plans for your patients. Your professional judgement must be exercised and followed in all respects with regard to the treatment and care of your patients. These policies apply to all Magellan Healthcare subsidiaries including, but not limited to, National Imaging Associates ("Magellan"). The policies constitute only the reimbursement and coverage guidelines of Magellan. Coverage for services varies for individual members in accordance with the terms and conditions of applicable Certificates of Coverage, Summary Plan Descriptions, or contracts with governing regulatory agencies. Magellan reserves the right to review and update the guidelines at its sole discretion. Notice of such changes, if necessary, shall be provided in accordance with the terms and conditions of provider agreements and any applicable laws or regulations.~~