Oscar Adopted Clinical Guidelines - Medical
2026 Q1 CAS Summary of Changes

Michigan: Change from Oscar Clinical Guidelines to MCG Care Guidelines Editions for the Following Codes					
Oscar Clinical Guideline	**MCG Care Guideline(s) Edition**	**Section**	**Revision**	**Substantive Change?**	**Effective Date**
CG003_Noninvasive Positive Pressure Ventilation	MCG 29th Edition Continuous Positive Airway Pressure (CPAP) Device (A-0431) MCG 29th Edition Bilevel Positive Airway Pressure (BPAP) Device (A-0994) MCG 29th Edition Auto-Titrating Continuous Positive Airway Pressure (APAP) Device (A-1060)	Clinical Indications	The transition to MCG care guidelines updates the clinical criteria for positive airway pressure (PAP) device accessories. While both frameworks support the medical necessity of these supplies when utilized with an approved PAP device, specific updates have been made to eligibility and frequency parameters. Oscar Clinical Guidelines establish frequency limits of one per three months and specify eligibility for a single tubing type; MCG care guidelines for these codes do not include these specific frequency or quantity restrictions. Applicable procedure codes impacted: A4604 - Tubing with integrated heating element for use with positive airway pressure device A7037 - Tubing used with positive airway pressure device	**Yes**	**6/15/26**
	MCG 29th Edition	Clinical Indications	The transition to MCG care guidelines updates the clinical criteria for PAP interface	**Yes**	**6/15/26**

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Oscar Clinical Guideline	**MCG Care Guideline(s) Edition**	**Section**	**Revision**	**Substantive Change?**	**Effective Date**
	Continuous Positive Airway Pressure (CPAP) Device (A-0431) MCG 29th Edition Bilevel Positive Airway Pressure (BPAP) Device (A-0994) MCG 29th Edition Auto-Titrating Continuous Positive Airway Pressure (APAP) Device (A-1060)		equipment, including various mask and interface types. While both frameworks support the medical necessity of these devices for use with approved PAP therapy, specific updates have been made to eligibility and documentation requirements. Oscar Clinical Guidelines specify that a member is eligible for only one of these four mask types at a time and requires documentation of device compliance and current mask intolerance to switch types; MCG care guidelines do not include these specific eligibility restrictions or the prerequisite documentation for transitioning between interface types. Applicable procedure codes impacted: A7027 - Combination oral/nasal mask, used with continuous positive airway pressure device, each A7030 - Full face mask used with positive airway pressure device, each A7034 - Nasal interface (mask or cannula type) used with positive airway pressure device, with or without head strap A7044 - Oral interface used with positive airway pressure device, each		

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Oscar Clinical Guideline	**MCG Care Guideline(s) Edition**	**Section**	**Revision**	**Substantive Change?**	**Effective Date**
	MCG 29th Edition Continuous Positive Airway Pressure (CPAP) Device (A-0431) MCG 29th Edition Bilevel Positive Airway Pressure (BPAP) Device (A-0994) MCG 29th Edition Auto-Titrating Continuous Positive Airway Pressure (APAP) Device (A-1060)	Clinical Indications	The transition to MCG care guidelines updates the clinical criteria for the replacement of PAP cushions and interfaces. Both frameworks establish medical necessity for these supplies when used with an approved primary PAP device, with specific updates to the parameters for quantity and frequency. Oscar Clinical Guidelines establish a frequency limit of two replacements per month for these items; MCG care guidelines list these as necessary replacement supplies without explicitly defining monthly quantity thresholds. Applicable procedure codes impacted: A7028 - Oral cushion for combination oral/nasal mask, replacement only, each A7029 - Nasal pillows for combination oral/nasal mask, replacement only, pair A7031 - Face mask interface, replacement for full face mask, each	**Yes**	**6/15/26**
	MCG 29th Edition Continuous Positive Airway Pressure (CPAP) Device (A-0431)	Clinical Indications	The transition to MCG care guidelines updates the clinical criteria for nasal mask cushions and cannula pillows. Both frameworks establish medical necessity for these replacement components when standard supply requirements for PAP	**Yes**	**6/15/26**

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Oscar Clinical Guideline	**MCG Care Guideline(s) Edition**	**Section**	**Revision**	**Substantive Change?**	**Effective Date**
	MCG 29th Edition Bilevel Positive Airway Pressure (BPAP) Device (A-0994) MCG 29th Edition Auto-Titrating Continuous Positive Airway Pressure (APAP) Device (A-1060)		therapy are met and used in conjunction with an approved primary nasal interface (A7034). Oscar Clinical Guidelines establish a frequency cap of two replacements per month for these items; MCG care guidelines include these in the list of supported replacement supplies for CPAP and BPAP devices without explicitly defining this monthly quantity cap. Applicable procedure codes impacted: A7032 - Cushion for use on nasal mask interface, replacement only, each A7033 - Pillow for use on nasal cannula type interface, replacement only, pair A7034 - Nasal interface (mask or cannula type) used with positive airway pressure device, with or without head strap		
	MCG 29th Edition MCG 29th Edition CPAP Titration, Home (APAP) (A-0337)	Clinical Indications	The transition to MCG care guidelines updates the clinical criteria for PAP supporting equipment, including headgear and chinstraps. Both frameworks establish medical necessity for these items when utilized to support approved PAP therapy and standard supply requirements are met. Oscar Clinical Guidelines enforce a frequency limit of one replacement per six months for	**Yes**	**6/15/26**

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Oscar Clinical Guideline	**MCG Care Guideline(s) Edition**	**Section**	**Revision**	**Substantive Change?**	**Effective Date**
	MCG 29th Edition Continuous Positive Airway Pressure (CPAP) Device (A-0431) MCG 29th Edition Bilevel Positive Airway Pressure (BPAP) Device (A-0994) MCG 29th Edition Auto-Titrating Continuous Positive Airway Pressure (APAP) Device (A-1060)		each of these items; MCG care guidelines list these as standard equipment codes for supporting PAP therapy without explicitly defining this six-month frequency restriction. Applicable procedure codes impacted: A7035 - Headgear used with positive airway pressure device A7036 - Chinstrap used with positive airway pressure device		
	MCG 29th Edition CPAP Titration, Home (APAP) (A-0337)	Clinical Indications	The transition to MCG care guidelines updates the clinical criteria for disposable and non-disposable PAP filters. Both frameworks establish medical necessity for these components when paired with an approved PAP device and ordered via a valid prescription. Oscar Clinical Guidelines	**Yes**	**6/15/26**

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	MCG 29th Edition Continuous Positive Airway Pressure (CPAP) Device (A-0431) MCG 29th Edition Bilevel Positive Airway Pressure (BPAP) Device (A-0994) MCG 29th Edition Auto-Titrating Continuous Positive Airway Pressure (APAP) Device (A-1060)		establish frequency limits of two per month for disposable filters and one per six months for non-disposable filters, and specify eligibility for only one filter type; MCG care guidelines for these codes do not include these specific frequency limits or the single-type eligibility restriction. Applicable procedure codes impacted: A7038 - Filter, disposable, used with positive airway pressure device A7039 - Filter, non-disposable, used with positive airway pressure device		
	MCG 29th Edition Continuous Positive Airway Pressure (CPAP) Device (A-0431)	Clinical Indications	The transition to MCG care guidelines updates the clinical criteria for exhalation ports and humidifier water chambers. Both frameworks establish medical necessity for these components as replacement items for members with an approved primary PAP or humidifier device. Oscar Clinical Guidelines	**Yes**	**6/15/26**

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Oscar Clinical Guideline	**MCG Care Guideline(s) Edition**	**Section**	**Revision**	**Substantive Change?**	**Effective Date**
	MCG 29th Edition Bilevel Positive Airway Pressure (BPAP) Device (A-0994) MCG 29th Edition Auto-Titrating Continuous Positive Airway Pressure (APAP) Device (A-1060)		establish a frequency limit of one replacement per six months and note that these items are typically included with the initial equipment setup; MCG care guidelines identify these as applicable supply codes for replacement without explicitly defining this six-month frequency restriction or separate authorization requirement. Applicable procedure codes impacted: A7045 - Exhalation port with or without swivel used with accessories for positive airway devices, replacement only A7046 - Water chamber for humidifier, used with positive airway pressure device, replacement, each		
	MCG 29th Edition Bilevel Positive Airway Pressure (BPAP) Device (A-0994)	Clinical Indications	The transition to the MCG care guidelines updates the clinical criteria for E0471. Both frameworks establish medical necessity for these devices in the treatment of central sleep apnea, complex sleep apnea, and respiratory insufficiency related to neuromuscular or chest wall disease. Oscar Clinical Guidelines establish specific cardiac safety thresholds for complex sleep apnea, including a left ventricular ejection fraction (LVEF) requirement and the absence of	**Yes**	**6/15/26**

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Oscar Clinical Guideline	**MCG Care Guideline(s) Edition**	**Section**	**Revision**	**Substantive Change?**	**Effective Date**
			certain heart failure classifications; the MCG care guideline does not include these specific cardiac exclusions or the detailed polysomnography (PSG) ratio requirements for authorization. Applicable procedure codes impacted: E0471 - Respiratory assist device, bi-level pressure capability, with back-up rate feature, used with noninvasive interface, e.g., nasal or facial mask (intermittent assist device with continuous positive airway pressure device)		
	MCG 29th Edition CPAP Titration, Home (APAP) (A-0337) MCG 29th Edition Continuous Positive Airway Pressure (CPAP) Device (A-0431)	Clinical Indications	The transition to MCG care guidelines updates the clinical criteria for heated and non-heated humidifiers used with PAP therapy. Both frameworks establish medical necessity for these devices as standard accessories to improve therapy tolerance when used with an approved primary PAP device. Oscar Clinical Guidelines establish specific clinical indications for replacement - requiring documentation that the device is unrepairable, out of warranty, or malfunctioning - and limit initial approvals to once per plan year. MCG care guidelines identify these codes as standard medically	**Yes**	**6/15/26**

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Oscar Clinical Guideline	**MCG Care Guideline(s) Edition**	**Section**	**Revision**	**Substantive Change?**	**Effective Date**
	MCG 29th Edition Bilevel Positive Airway Pressure (BPAP) Device (A-0994) MCG 29th Edition Auto-Titrating Continuous Positive Airway Pressure (APAP) Device (A-1060)		necessary accessories without explicitly defining these specific replacement hurdles or the once-per-plan-year initial approval restriction. <u>Applicable procedure codes impacted</u>: E0561 - Humidifier, non-heated, used with positive airway pressure device E0562 - Humidifier, heated, used with positive airway pressure device		
	MCG 29th Edition Bilevel Positive Airway Pressure (BPAP) Device (A-0994)	Clinical Indications	The transition to the MCG care guideline updates the clinical criteria for E0470. Both frameworks establish medical necessity for these devices across various respiratory and sleep-disordered breathing conditions when used with a noninvasive interface. Oscar Clinical Guidelines specify distinct compliance thresholds, requiring documented usage on 70% of nights for 4 hours per period and a follow-up assessment within the first 90 days to authorize long-term use. The MCG care guideline advocates for annual assessments of adherence and effectiveness without	**Yes**	**6/15/26**

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Oscar Clinical Guideline	**MCG Care Guideline(s) Edition**	**Section**	**Revision**	**Substantive Change?**	**Effective Date**
			defining these specific quantitative compliance or documentation thresholds. Applicable procedure codes impacted: E0470 - Respiratory assist device, bi-level pressure capability, without back-up rate feature, used with noninvasive interface, e.g., nasal or facial mask		
	MCG 29th Edition CPAP Titration, Home (APAP) (A-0337) MCG 29th Edition CPAP Titration, Sleep Center (A-0338) MCG 29th Edition Continuous Positive Airway Pressure (CPAP) Device (A-0431)	Clinical Indications	The transition to MCG care guidelines updates the clinical criteria for Continuous Positive Airway Pressure (CPAP) devices (E0601). Both frameworks establish medical necessity for CPAP as a first-line therapy for obstructive sleep apnea (OSA) in pediatric and adult populations, as well as for central sleep apnea and obesity hypoventilation syndrome. Oscar Clinical Guidelines specify distinct administrative requirements for authorization beyond the initial 90-day period, including a documented compliance threshold of usage on at least 70% of nights for an average of 4 hours and a required clinical follow-up within the first 90 days. MCG care guidelines advocate for annual assessments of adherence and effectiveness without defining these specific quantitative compliance or documentation thresholds.	**Yes**	**6/15/26**

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			Applicable procedure codes impacted: E0601 - Continuous positive airway pressure (CPAP) device		
	MCG 29th Edition Oral Appliances (Mandibular Advancement Devices) (A-0341) MCG 30th Edition Oral Appliances (Mandibular Advancement Devices) (A-0341)	Applicable Billing Codes (HCPCS/CPT Codes)	The transition to MCG care guidelines updates the clinical criteria for custom-fabricated oral appliances used to reduce upper airway collapsibility. Both frameworks establish medical necessity for these devices in members with confirmed sleep-related breathing disorders who are unable to tolerate standard CPAP therapy. Oscar Clinical Guidelines establish medical necessity based on general diagnostic criteria for sleep-disordered breathing; MCG care guidelines include specific physiological prerequisites for approval, such as documentation of sufficient stable dentition, the absence of active dental disease, and healthy temporomandibular joint (TMJ) function. Applicable procedure codes impacted: K1027 - Oral device/appliance used to reduce upper airway collapsibility, without fixed mechanical hinge, custom fabricated, includes fitting and adjustment	**Yes**	**8/17/26**

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Oscar Clinical Guideline	**MCG Care Guideline(s) Edition**	**Section**	**Revision**	**Substantive Change?**	**Effective Date**
CG012_Experimental or Investigational Services	MCG 29th Diskography (Discography) (A-0135)	Clinical Indications	Oscar considers this code, 62292 (Injection procedure for chemonucleolysis, including discography, intervertebral disc, single or multiple levels, lumbar) experimental / investigational / unproven in CG012. The MCG care guideline considers this procedure medically necessary.	**Yes**	**6/15/26**
CG016_Diagnosis and Treatment of Infertility	MCG 30th Orbit and Ear CT Scan (A-0023)	Basic Infertility Services	For both genders, Oscar Clinical Guideline criteria includes CT imaging of sella turcica if prolactin is elevated. MCG Orbit and Ear CT Scan (A-0023) does not have criteria related to infertility workup. However, if there is cancer, ear, eye or mastoid disease, etc., then the member may meet medical necessity criteria. <u>Applicable procedure codes impacted</u>: 70480 - Computed tomography, orbit, sella, or posterior fossa or outer, middle, or inner ear; without contrast material 70481 - Computed tomography, orbit, sella, or posterior fossa or outer, middle, or inner ear; with contrast material(s) 70482 - Computed tomography, orbit, sella, or posterior fossa or outer, middle, or inner ear; without contrast material, followed by contrast material(s) and further sections	**Yes**	**8/17/26**

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Oscar Clinical Guideline	**MCG Care Guideline(s) Edition**	**Section**	**Revision**	**Substantive Change?**	**Effective Date**
	MCG 30th Brain MRI (A-0047)	Basic Infertility Services	For both genders, Oscar Clinical Guideline criteria includes MRI imaging of sella turcica if prolactin is elevated. Brain MRI (A-0047) has medical necessity criteria for Pituitary tumor signs or symptoms, such as Hyperprolactinemia. Applicable procedure codes impacted: 70551 - Magnetic resonance (eg, proton) imaging, brain (including brain stem); without contrast material 70552 - Magnetic resonance (eg, proton) imaging, brain (including brain stem); with contrast material(s) 70553- Magnetic resonance (eg, proton) imaging, brain (including brain stem); without contrast material, followed by contrast material(s) and further sequences.	**Yes**	**8/17/26**
CG024_Colorectal Cancer Screening	MCG 29th Colonography, CT (Virtual Colonoscopy) (A-0030)	General Medical Necessity Criteria Stool-Based and Imaging-Based Screening Tests	For 74263 (Computed tomographic (CT) colonography, screening, including image postprocessing), the criteria are similar between the Oscar Clinical Guideline and MCG care guideline for average or high risk screening for CT colonography.	**No**	**6/15/26**

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Oscar Clinical Guideline	**MCG Care Guideline(s) Edition**	**Section**	**Revision**	**Substantive Change?**	**Effective Date**
CG027_Breast Imaging	MCG 30th Breast MRI (A-0048)	Breast MRI	Oscar Clinical Guideline includes criteria for breast MRI surveillance for additional indications that MCG care guideline does not such as the member having breast conserving therapy or extremely dense breast tissue on mammography (Category D). MCG care guideline has less specific criteria about surveillance under postsurgery follow-up after breast cancer diagnosis, "Surveillance in contralateral breast in patient suspected to be at higher risk (eg, BRCA1-positive or BRCA2-positive)" Applicable procedure codes impacted: 77046 - Magnetic resonance imaging, breast, without contrast material; unilateral 77047 - Magnetic resonance imaging, breast, without contrast material; bilateral 77048 - Magnetic resonance imaging, breast, without and with contrast material(s), including computer-aided detection (CAD real-time lesion detection, characterization and pharmacokinetic analysis), when performed; unilateral 77049 - Magnetic resonance imaging, breast, without and with contrast material(s), including computer-aided detection (CAD	**Yes**	**8/17/26**

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Oscar Clinical Guideline	**MCG Care Guideline(s) Edition**	**Section**	**Revision**	**Substantive Change?**	**Effective Date**
			real-time lesion detection, characterization and pharmacokinetic analysis), when performed; bilateral		
	MCG 30th Tumor Imaging Positron Emission Tomography (PET) and PET-CT (A-0098)	Breast Positron Emission Tomography (PET) Scan	Oscar Clinical Guideline and the MCG care guideline have a similar stance that PET or PET-CT scans are considered NOT medically necessary for screening purposes, but considered medically necessary for diagnostic purposes for breast cancer. Applicable procedure codes impacted: 78811 - Positron emission tomography (PET) imaging; limited area (eg, chest, head/neck) 78812 - Positron emission tomography (PET) imaging; skull base to mid-thigh 78813 - Positron emission tomography (PET) imaging; whole body 78814- Positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization imaging; limited area (eg, chest, head/neck) 78815- Positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization imaging; skull base to mid-thigh	**No**	**8/17/26**

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Oscar Clinical Guideline	**MCG Care Guideline(s) Edition**	**Section**	**Revision**	**Substantive Change?**	**Effective Date**
CG047_Pain Management_ Facet Joint Injections_Medial Branch Blocks and Radiofrequency Facet Denervation	MCG 30th Facet Neurotomy (A-0218)	Initial Non-Pulsed Radiofrequency Facet Denervation	Radiofrequency Facet Denervation MCG care guideline does not have the same requirements as CG047, which requires non-radicular lower back and neck pain, limitation in activities of daily living (ADL) for at least 3 months, 6-week duration of conservative therapy, checking there has been no vertebral fusion at the levels or significant narrowing of the vertebral canal requiring surgery, and limits no more than 3 levels of facet joint denervation in a single session. Applicable procedure codes impacted: 64633- Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, single facet joint 64635- Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, single facet joint	**Yes**	**8/17/26**

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Oscar Clinical Guideline	**MCG Care Guideline(s) Edition**	**Section**	**Revision**	**Substantive Change?**	**Effective Date**
		Subsequent Non-Pulsed Radiofrequency Facet Denervation	MCG care guideline does not have the same requirements as CG047, which have time limitations and durations between subsequent radiofrequency facet denervation and within a 12-month period. Applicable procedure codes impacted: 64633- Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, single facet joint 64635- Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, single facet joint	**Yes**	**8/17/26**
	MCG 30th Facet Joint Injection (A-0695)	Initial Diagnostic Facet Joint Injections/Medial Branch Blocks	Diagnostic Facet Joint Injections/Medial Branch Blocks MCG care guideline does not have the same requirements as CG047, which requires non-radicular lower back and neck pain, limitation in ADLs, 6-week duration of conservative therapy, checking there has been no vertebral fusion at the levels or	**Yes**	**8/17/26**

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Oscar Clinical Guideline	**MCG Care Guideline(s) Edition**	**Section**	**Revision**	**Substantive Change?**	**Effective Date**
			other medical conditions, and limits no more than 3 per side per session. MCG care guideline requires 3 months' duration of chronic spinal pain. CG047 does not have specific pain duration for facet joint injection, but has a duration for at least 6 weeks of conservative therapy. Applicable procedure codes impacted: 64490- Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; single level 64493- Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; single level		
		Subsequent Diagnostic Facet Joint Injections/Medi	MCG care guideline and Oscar Clinical Guideline have similar criteria for second confirmatory diagnostic block 80% or greater	**Yes**	**8/17/26**

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		al Branch Blocks	relief, but for the rest of the section MCG care guideline has less requirements. Applicable procedure codes impacted: 64490- Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; single level 64493- Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; single level		
CG048_Pain Management_ Epidural Steroid Injections, Selective Nerve Root Block (SNRB), and Intradiscal Steroid Injections	MCG 29th Epidural Corticosteroid Injection (A-0225)	Initial Epidural Injections (Caudal, Interlaminal, or Transforaminal)	Cervical MCG care guideline criteria for cervical epidural injections does not have the same requirements as CG048, which requires interference with ADLs, duration for at least 6 weeks of conservative therapy, frequency of 2-week intervals, maximum injections per session of anatomic region and nerve root. Applicable procedure codes impacted: 62320 - Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other	**Yes**	**6/15/26**

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Oscar Clinical Guideline	**MCG Care Guideline(s) Edition**	**Section**	**Revision**	**Substantive Change?**	**Effective Date**
			solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, cervical or thoracic; without imaging guidance 62321- Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, cervical or thoracic; with imaging guidance (ie, fluoroscopy or CT) 64479 - Injection(s), anesthetic agent(s) and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); cervical or thoracic, single level Lumbar MCG care guideline criteria for lumbar epidural injections does not have the same requirements as CG048 as it does not require interference with ADL, duration for at least 6 weeks of conservative therapy, frequency of 2-week intervals, maximum injections per session of anatomic region and nerve root.		

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Oscar Clinical Guideline	**MCG Care Guideline(s) Edition**	**Section**	**Revision**	**Substantive Change?**	**Effective Date**
			<u>Applicable procedure codes impacted</u>: 62322 - Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); without imaging guidance 62323 - Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); with imaging guidance (ie, fluoroscopy or CT) 64483 - Injection(s), anesthetic agent(s) and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); lumbar or sacral, single level		
		Subsequent Epidural Injections (Caudal,	MCG care guideline criteria does not specify subsequent epidural injections for cervical or lumbar region. CG048 requires additional criteria with maximum root levels or anatomic region per session with at least	**Yes**	**6/15/26**

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		Interlaminal, or Transforaminal)	2-week intervals. Applicable procedure codes impacted: 62320 - Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, cervical or thoracic; without imaging guidance 62321- Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, cervical or thoracic; with imaging guidance (ie, fluoroscopy or CT) 64479 - Injection(s), anesthetic agent(s) and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); cervical or thoracic, single level 62322 - Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter		

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			placement, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); without imaging guidance 62323 - Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); with imaging guidance (ie, fluoroscopy or CT) 64483 - Injection(s), anesthetic agent(s) and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); lumbar or sacral, single level		
CG056_Pain Management_ Sacroiliac Intra-Articular Joint Injections	MCG 29th Sacroiliac Joint Injection (A-1048)	Initial Sacroiliac Intra-Articular Joint Injections	MCG care guideline for sacroiliac joint injection does not have the same requirements as CG056, which requires 3 months duration of pain, 6 weeks of conservative therapy, and that the injection is performed with image-guidance using fluoroscopy or CT. Applicable procedure codes impacted: 27096 - Injection procedure for sacroiliac joint, anesthetic/steroid, with image guidance (fluoroscopy or CT) including	**Yes**	**6/15/26**

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			arthrography when performed		
		Subsequent Sacroiliac Intra-Articular Joint Injections	MCG care guideline does not specify subsequent sacroiliac injections, but CG056 requires additional criteria such as 50% pain relief after previous injection, minimum interval of weeks between injections, maximum number of injections per side within 12 months. Applicable procedure codes impacted: 27096 - Injection procedure for sacroiliac joint, anesthetic/steroid, with image guidance (fluoroscopy or CT) including arthrography when performed	**Yes**	**6/15/26**

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Oscar Clinical Guideline	**MCG Care Guideline(s) Edition**	**Section**	**Revision**	**Substantive Change?**	**Effective Date**
CG069_Total Knee Arthroplasty	MCG 30th Knee Arthroplasty, Total (S-700)	General Medical Necessity Criteria	MCG care guideline does not require Kellgren Lawrence Grade IV or Modified Outerbridge Classification IV radiographic findings for degenerative joint disease. Also, MCG care	**Yes**	**8/17/26**

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Michigan: Change from Oscar Clinical Guidelines to MCG Care Guidelines Editions for the Following Codes					
Oscar Clinical Guideline	**MCG Care Guideline(s) Edition**	**Section**	**Revision**	**Substantive Change?**	**Effective Date**
			guideline does not require 3 months of persistent pain and 3-month trial of conservative management. MCG care guideline allows for additional indications to meet medical necessity such as congenital deformity, distal femur fracture or tibial plateau fracture in patient with osteoporosis, Hemophilic arthropathy, pigmented villonodular synovitis with joint destruction, osteonecrosis unamenable to medical therapy or joint-preserving surgery. Applicable procedure codes impacted: 27447- Arthroplasty, knee, condyle and plateau; medial AND lateral compartments with or without patella resurfacing (total knee arthroplasty) 27445- Arthroplasty, knee, hinge prosthesis (eg, Walldius type)		
		Simultaneous Bilateral Total Knee Arthroplasty	MCG care guideline does not specify medical necessity criteria related to simultaneous bilateral knee replacement, but lists bilateral arthroplasty as an indication for extended stay criteria. Oscar clinical guideline require each knee meets the General Medical Necessity Criteria	**Yes**	**8/17/26**

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Michigan: Change from Oscar Clinical Guidelines to MCG Care Guidelines Editions for the Following Codes					
Oscar Clinical Guideline	**MCG Care Guideline(s) Edition**	**Section**	**Revision**	**Substantive Change?**	**Effective Date**
			and meets inpatient hospital level of care criteria. Applicable procedure codes impacted: 27447- Arthroplasty, knee, condyle and plateau; medial AND lateral compartments with or without patella resurfacing (total knee arthroplasty) 27445- Arthroplasty, knee, hinge prosthesis (eg, Walldius type)		
		Removal or Revision of Total Knee Arthroplasty	MCG care guideline and Oscar Clinical Guideline have similar indications for revision except for the following: • MCG care guideline does not have criteria for Prosthesis/hardware failure, damage or fracture, loosening of prosthesis, implant or components that is confirmed by imaging. • MCG care guideline includes criteria for previous unicompartmental (unicondylar or patellofemoral) arthroplasty with destructive joint disease progression in unoperated compartment that the Oscar Clinical Guideline does not. • The Oscar Clinical Guideline requires additional documentation for	**Yes**	**8/17/26**

Michigan: Change from Oscar Clinical Guidelines to MCG Care Guidelines Editions for the Following Codes					
Oscar Clinical Guideline	**MCG Care Guideline(s) Edition**	**Section**	**Revision**	**Substantive Change?**	**Effective Date**
			infection and infection management or persistent pain for more than 6 months. Applicable procedure codes impacted: 27486 - Revision of total knee arthroplasty, with or without allograft; 1 component 27487 - Revision of total knee arthroplasty, with or without allograft; femoral and entire tibial component		
	MCG 30th Knee Arthroplasty, Total RRG (S-700-RRG)	Inpatient Hospital Unilateral or Bilateral Total Knee Arthroplasty	OCG allows for additional indications for inpatient surgery whereas MCG care guideline has same medical necessity criteria for outpatient and inpatient level of care: ● Non-elective surgery for unilateral or bilateral ● Co-morbidity such as BMI >40 Applicable procedure codes impacted: 27447- Arthroplasty, knee, condyle and plateau; medial AND lateral compartments with or without patella resurfacing (total knee arthroplasty) 27445- Arthroplasty, knee, hinge prosthesis (eg, Walldius type)	**Yes**	**8/17/26**
		Simultaneous	MCG care guideline does not specify medical	**Yes**	**8/17/26**

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Michigan: Change from Oscar Clinical Guidelines to MCG Care Guidelines Editions for the Following Codes					
Oscar Clinical Guideline	**MCG Care Guideline(s) Edition**	**Section**	**Revision**	**Substantive Change?**	**Effective Date**
		Bilateral Total Knee Arthroplasty	necessity criteria related to simultaneous bilateral knee replacement, but lists bilateral arthroplasty as an indication for extended stay criteria. Oscar clinical guideline require each knee meets the General Medical Necessity Criteria and meets inpatient hospital level of care criteria. Applicable procedure codes impacted: 27447- Arthroplasty, knee, condyle and plateau; medial AND lateral compartments with or without patella resurfacing (total knee arthroplasty) 27445- Arthroplasty, knee, hinge prosthesis (eg, Walldius type)		
		Removal or Revision of Total Knee Arthroplasty	MCG care guideline and Oscar Clinical Guideline have similar indications for revision except for the following: • MCG care guideline does not have criteria for Prosthesis/hardware failure, damage or fracture, loosening of prosthesis, implant or components that is confirmed by imaging. • MCG care guideline includes criteria for previous unicompartmental (unicondylar or patellofemoral) arthroplasty with destructive joint	**Yes**	**8/17/26**

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Michigan: Change from Oscar Clinical Guidelines to MCG Care Guidelines Editions for the Following Codes					
Oscar Clinical Guideline	**MCG Care Guideline(s) Edition**	**Section**	**Revision**	**Substantive Change?**	**Effective Date**
			disease progression in unoperated compartment that the Oscar Clinical Guideline does not. • The Oscar Clinical Guideline requires additional documentation for infection management or persistent pain for more than 6 months. Applicable procedure codes impacted: 27486 - Revision of total knee arthroplasty, with or without allograft; 1 component 27487 - Revision of total knee arthroplasty, with or without allograft; femoral and entire tibial component		
CG070_Total Hip Arthroplasty	MCG 30th Hip Arthroplasty (S-560)	General Medical Necessity Criteria	MCG care guideline and Oscar Clinical Guideline (OCG) have similar requirements of advanced joint disease with moderate to severe radiologic findings for the hip; however, OCG does specify the classification system used such as Kellgren-Lawrence System or Tönnis Classification System. MCG care guideline does not require 3 months of persistent pain and 3-month trial of conservative management. MCG care guideline allows for additional indications such as osteonecrosis of the femoral head.	**Yes**	**8/17/26**

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Michigan: Change from Oscar Clinical Guidelines to MCG Care Guidelines Editions for the Following Codes					
Oscar Clinical Guideline	**MCG Care Guideline(s) Edition**	**Section**	**Revision**	**Substantive Change?**	**Effective Date**
			Applicable procedure codes impacted: 27130- Arthroplasty, acetabular and proximal femoral prosthetic replacement (total hip arthroplasty), with or without autograft or allograft 27132 - Conversion of previous hip surgery to total hip arthroplasty, with or without autograft or allograft		
		Simultaneous Bilateral Total Hip Arthroplasty	MCG care guideline does not specify medical necessity criteria related to simultaneous bilateral hip replacement, but lists bilateral arthroplasty as an indication for extended stay criteria. OCG requires each hip meets the General Medical Necessity Criteria and meets inpatient hospital level of care criteria. Applicable procedure codes impacted: 27130- Arthroplasty, acetabular and proximal femoral prosthetic replacement (total hip arthroplasty), with or without autograft or allograft 27132 - Conversion of previous hip surgery to total hip arthroplasty, with or without autograft or allograft	**Yes**	**8/17/26**
		Removal or	MCG care guideline and Oscar Clinical	**Yes**	**8/17/26**

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Michigan: Change from Oscar Clinical Guidelines to MCG Care Guidelines Editions for the Following Codes					
Oscar Clinical Guideline	**MCG Care Guideline(s) Edition**	**Section**	**Revision**	**Substantive Change?**	**Effective Date**
		Revision of Total Hip Arthroplasty (THA)	Guideline have similar indications for revision except for the following: • OCG allows additional indications for functional disability AND persistent pain for more than 6 months • OCG requires additional documentation for infection management <u>Applicable procedure codes impacted</u>: 27134- Revision of total hip arthroplasty; both components, with or without autograft or allograft 27137- Revision of total hip arthroplasty; acetabular component only, with or without autograft or allograft 27138- Revision of total hip arthroplasty; femoral component only, with or without allograft		
	MCG 30th Hip Arthroplasty RRG (S-560-RRG)	Inpatient Hospital Unilateral or Bilateral Total Hip Arthroplasty	OCG allows for additional indications for inpatient surgery whereas MCG care guideline has same medical necessity criteria for outpatient and inpatient level of care: • Non-elective surgery for unilateral or bilateral • Co-morbidity such as BMI >40	**Yes**	**8/17/26**

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Michigan: Change from Oscar Clinical Guidelines to MCG Care Guidelines Editions for the Following Codes					
Oscar Clinical Guideline	**MCG Care Guideline(s) Edition**	**Section**	**Revision**	**Substantive Change?**	**Effective Date**
			Applicable procedure codes impacted: 27130- Arthroplasty, acetabular and proximal femoral prosthetic replacement (total hip arthroplasty), with or without autograft or allograft 27132 - Conversion of previous hip surgery to total hip arthroplasty, with or without autograft or allograft		
		Simultaneous Bilateral Total Hip Arthroplasty	MCG care guideline does not specify medical necessity criteria related to simultaneous bilateral hip replacement, but lists bilateral arthroplasty as an indication for extended stay criteria. OCG requires each hip meets the General Medical Necessity Criteria and meets inpatient hospital level of care criteria. Applicable procedure codes impacted: 27130- Arthroplasty, acetabular and proximal femoral prosthetic replacement (total hip arthroplasty), with or without autograft or allograft 27132 - Conversion of previous hip surgery to total hip arthroplasty, with or without autograft or allograft	**Yes**	**8/17/26**

Michigan: Change from Oscar Clinical Guidelines to MCG Care Guidelines Editions for the Following Codes					
Oscar Clinical Guideline	**MCG Care Guideline(s) Edition**	**Section**	**Revision**	**Substantive Change?**	**Effective Date**
		Removal or Revision of Total Hip Arthroplasty (THA)	MCG care guideline and Oscar Clinical Guideline have similar indications for revision except for the following: • OCG allows additional indications for functional disability AND persistent pain for more than 6 months • OCG requires additional documentation for infection management Applicable procedure codes impacted: 27134- Revision of total hip arthroplasty; both components, with or without autograft or allograft 27137- Revision of total hip arthroplasty; acetabular component only, with or without autograft or allograft 27138- Revision of total hip arthroplasty; femoral component only, with or without allograft	**Yes**	**8/17/26**

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Michigan: Change from Oscar Clinical Guidelines to MCG Care Guidelines Editions for the Following Codes					
Oscar Clinical Guideline	**MCG Care Guideline(s) Edition**	**Section**	**Revision**	**Substantive Change?**	**Effective Date**
CG076_Total Shoulder Arthroplasty and Reverse Shoulder Arthroplasty	MCG 30th Shoulder Arthroplasty (S-634)	General Medical Necessity Criteria	For shoulder arthroplasty for advanced joint disease, OCG requires specific Glenoid classification, signs, and symptoms for radiologic findings compared to MCG care guideline. OCG has additional requirements such as 3 months of persistent pain and 3-month trial of conservative management. MCG care guideline allows for additional indications such as osteonecrosis of the humeral head, massive rotator cuff tear, and rotator cuff-deficient arthropathy. Applicable procedure codes impacted: 23472 - Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral replacement (eg, total shoulder)	**Yes**	**8/17/26**
		Reverse Total Shoulder Arthroplasty	MCG care guideline utilizes the same criteria for reverse total shoulder arthroplasty as total shoulder arthroplasty. OCG requires deltoid muscle is intact AND there is 90 degrees of passive shoulder motion standalone medical necessity criteria or radiologic joint destruction criteria. Applicable procedure codes impacted:	**Yes**	**8/17/26**

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Michigan: Change from Oscar Clinical Guidelines to MCG Care Guidelines Editions for the Following Codes					
Oscar Clinical Guideline	**MCG Care Guideline(s) Edition**	**Section**	**Revision**	**Substantive Change?**	**Effective Date**
			23472 - Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral replacement (eg, total shoulder)		
		Simultaneous Bilateral Total Shoulder Arthroplasty	MCG care guideline does not have criteria for simultaneous or bilateral total shoulder arthroplasty. OCG has criteria that each shoulder meets the General Medical Necessity Criteria and inpatient hospital Level of Care criteria. Applicable procedure codes impacted: 23472 - Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral replacement (eg, total shoulder)	**Yes**	**8/17/26**
		Removal or Revision of Total Shoulder Arthroplasty (TSA)	MCG care guideline allows for additional indications such as rotator cuff failure. OCG requires additional documentation for infection management and pain for more than 6 months. Applicable procedure codes impacted: 23473 - Revision of total shoulder arthroplasty, including allograft when performed; humeral or glenoid component 23474 - Revision of total shoulder	**Yes**	**8/17/26**

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Michigan: Change from Oscar Clinical Guidelines to MCG Care Guidelines Editions for the Following Codes					
Oscar Clinical Guideline	**MCG Care Guideline(s) Edition**	**Section**	**Revision**	**Substantive Change?**	**Effective Date**
			arthroplasty, including allograft when performed; humeral and glenoid component		
	MCG 30th Shoulder Arthroplasty RRG (S-634-RRG)	Inpatient Hospital Simultaneous Bilateral Total Shoulder Arthroplasty	OCG allows for additional indications for inpatient surgery whereas MCG care guideline has same medical necessity criteria for outpatient and inpatient level of care: ● Non-elective surgery for unilateral or bilateral ● BMI > 40 ● Age > 70 and an additional comorbidity as listed in this section Applicable procedure codes impacted: 23472 - Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral replacement (eg, total shoulder)	**Yes**	**8/17/26**
		Reverse Total Shoulder Arthroplasty	MCG care guideline utilizes the same criteria for reverse total shoulder arthroplasty as total shoulder arthroplasty. OCG requires deltoid muscle is intact AND there is 90 degrees of passive shoulder motion standalone medical necessity criteria or radiologic joint destruction criteria. Applicable procedure codes impacted:	**Yes**	**8/17/26**

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Michigan: Change from Oscar Clinical Guidelines to MCG Care Guidelines Editions for the Following Codes					
Oscar Clinical Guideline	**MCG Care Guideline(s) Edition**	**Section**	**Revision**	**Substantive Change?**	**Effective Date**
			23472 - Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral replacement (eg, total shoulder)		
		Simultaneous Bilateral Total Shoulder Arthroplasty	MCG care guideline does not have criteria for simultaneous or bilateral total shoulder arthroplasty. OCG has criteria that each shoulder meets the General Medical Necessity Criteria and inpatient hospital Level of Care criteria. Applicable procedure codes impacted: 23472 - Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral replacement (eg, total shoulder)	**Yes**	**8/17/26**
		Removal or Revision of Total Shoulder Arthroplasty (TSA)	MCG care guideline allows for additional indications such as rotator cuff failure. OCG requires additional documentation for infection management. Applicable procedure codes impacted: 23473 - Revision of total shoulder arthroplasty, including allograft when performed; humeral or glenoid component 23474 - Revision of total shoulder arthroplasty, including allograft when	**Yes**	**8/17/26**

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Michigan: Change from Oscar Clinical Guidelines to MCG Care Guidelines Editions for the Following Codes					
Oscar Clinical Guideline	**MCG Care Guideline(s) Edition**	**Section**	**Revision**	**Substantive Change?**	**Effective Date**
			performed; humeral and glenoid component		

Florida: Policy Change from EviCore Radiology Guidelines to MCG Care Guidelines 30th Edition Radiology Guidelines				
EviCore Clinical Guideline	**MCG Care Guideline(s)**	**Revision**	**Substantive Change?**	**Effective Date**
Abdomen Imaging Guidelines	Abdominal/Pelvic CT Scan (A-0013) Abdominal/Pelvic CT Angiography (CTA) (A-0475) Abdominal/Pelvic MR Angiography (MRA) (A-0032) Abdominal MRI (A-0044) Cholangiopancreatography, MR (MRCP) (A-0064)	The transition to MCG care guidelines updates clinical pathways across the abdominal imaging suite. While the transition to MCG care guidelines does establish more direct pathways to CT and MRI for several abdominal imaging services, specific updates have been made to diagnostic hierarchies and surveillance intervals for specialized conditions. Computed Tomography (CT) CT authorization criteria include requirements for a primary study, such as Ultrasound (US), X-ray, or Endoscopy, based on the specific clinical indication. Defined pathways for suspected intermittent obstructions or specific low-level imaging findings have been updated.	**Yes**	**8/17/26**

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Florida: Policy Change from EviCore Radiology Guidelines to MCG Care Guidelines 30th Edition Radiology Guidelines				
EviCore Clinical Guideline	**MCG Care Guideline(s)**	**Revision**	**Substantive Change?**	**Effective Date**
	Colonography, CT (Virtual Colonoscopy) (A-0030) Hepatic Elastography, MR (A-1012) Hepatic Multiparametric MRI (A-1092) Magnetic Resonance Spectroscopy (A-0482) Tumor Imaging Positron Emission Tomography (PET) and PET-CT (A-0098)	Computed Tomography (CT) Colonography The frequency limit for certain follow-up screenings is established at a 5-year interval. Criteria for CT Colonography now include specific gastrointestinal signs and symptoms as exclusions. Magnetic Resonance Angiography (MRA) MRA clinical indications for acute vascular assessments and chronic ischemia have been updated. For chronic ischemia, criteria now involve a documented contraindication to CT Angiography (CTA) as part of the diagnostic process. Magnetic Resonance Cholangiopancreatography (MRCP) MRCP is positioned as a secondary diagnostic study. Clinical indications generally involve a prior CT scan that has been performed or is clinically unavailable. Magnetic Resonance Elastography (MRE) Clinical indications for hepatic elastography have been adjusted. Specific guidelines for Fontan-associated liver disease are not explicitly detailed in the new criteria set. MagneticResonance Imaging (MRI) Clinical applications for MRI, such as evaluations of pancreatic lesions and volume monitoring in Polycystic Kidney Disease, have been updated. MRI is primarily utilized for the clarification of indeterminate ultrasound findings in several clinical contexts. Surveillance frameworks for transplant-related imaging have been revised to a general pre-transplant screening pathway for		

Florida: Policy Change from EviCore Radiology Guidelines to MCG Care Guidelines 30th Edition Radiology Guidelines				
EviCore Clinical Guideline	**MCG Care Guideline(s)**	**Revision**	**Substantive Change?**	**Effective Date**
		asymptomatic patients. For Celiac Disease, documentation of adherence to a gluten-free diet is required for 12 months. Positron Emission Tomography (PET) PET/CT applications are focused on established malignancy staging and surveillance. Diagnostic criteria emphasize the establishment of a diagnosis through other modalities prior to PET/CT authorization. Experimental, Investigational, Unproven (EIU) Codes 0648T and 0649T are listed as not supported. Codes 0697T and 0698T are not currently addressed within the MCG care guidelines. Applicable procedure codes impacted: 0648T, 0649T, 0697T, 0698T, 74150, 74160, 74170, 74174, 74175, 74176, 74177, 74178, 74181, 74182, 74183, 74261, 74262, 74263, 76376, 76377, 76390, 74815, 76391, 78815, C8900, C8901, C8902, S8037		
Breast Imaging Guideline	Abdominal/Pelvic CT Angiography (CTA) (A-0475) Abdominal/Pelvic MR Angiography (MRA) (A-0032) Breast MRI (A-0048)	The transition to MCG care guidelines for breast imaging updates the clinical criteria for advanced diagnostic modalities. These guidelines establish specific clinical indicators for MRI and PET-based imaging, while adjusting diagnostic hierarchies and procedural requirements for specialized breast assessments. Computed Tomography Angiography (CTA) Clinical indications for Chest CTA have been updated. Breast	**Yes**	**8/17/26**

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EviCore Clinical Guideline	**MCG Care Guideline(s)**	**Revision**	**Substantive Change?**	**Effective Date**
	Chest CT Angiography (CTA) (A-0471) Chest MR Angiography (MRA) (A-0035) Tumor Imaging Positron Emission Tomography (PET) and PET-CT (A-0098)	reconstruction indications, specifically regarding the TDAP flap, are not currently listed under the updated Chest CTA criteria. Magnetic Resonance Angiography (MRA) The clinical pathway for Chest MRA has been adjusted. Breast reconstruction is not a listed indication within the updated Chest MRA framework. Magnetic Resonance Imaging (MRI) Updates to the breast MRI criteria include a revised diagnostic hierarchy. Clinical indicators generally involve a lesion being both nonpalpable and sonographically occult (not visible on ultrasound) prior to meeting MRI criteria. Updated guidelines also focus on technical factors regarding biopsy performance and the assessment of established clinical findings. Explicit pathways for saline implant rupture evaluation and imaging-pathology discordance are not specified in the current criteria set. Experimental, Investigational, Unproven (EIU) Clinical indications for approval have been established for PET Mammography (78811) and G0252 for initial diagnosis or surgical planning of breast cancer. Codes 0633T, 0634T, 0635T, 0636T, 0637T, 0638T, and S8080 are not currently addressed within the updated criteria set. Applicable procedure codes impacted:		

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EviCore Clinical Guideline	**MCG Care Guideline(s)**	**Revision**	**Substantive Change?**	**Effective Date**
		71555, 71275, 72191, 74174, 74175, 72198, 74185, 76376, 76377, 77021, 77047, 77048, 77049, 78811, C8903, C8905, C8906, C8908, G0252, S8080		
Cardiac Imaging Guideline	Abdominal/Pelvic CT Angiography (CTA) (A-0475) Abdominal/Pelvic CT Scan (A-0013) Abdominal/Pelvic MR Angiography (MRA) (A-0032) Abdominal MRI (A-0044) Brain, Single Photon Emission Computed Tomography (SPECT) (A-0090) Cardiac Radionuclide Angiography (Radionuclide Ventriculography) (A-0077) Chest CT Angiography (CTA) (A-0471) Chest CT Scan (A-0028)	The transition to MCG care guidelines for cardiac imaging criteria establishes a framework for modality selection in standard cardiovascular workups. These updates include revised requirements for transplant-related evaluations, pulmonary hypertension diagnostics, and the sequencing of advanced imaging studies. Computed Tomography (CT) Clinical indications for CT chest imaging in the cardiac transplant population have been updated. The criteria utilize a diagnosis-specific framework that includes clinical triggers such as infection or structural malformation. Magnetic Resonance Angiography (MRA) The diagnostic workup for pulmonary hypertension now follows a specific modality hierarchy. MRA is utilized as a secondary modality for specified subsets of the disease. Magnetic Resonance Imaging (MRI) The clinical scope for transplant-related MRIs has been updated. Under the revised guidelines, cardiac complication evaluations focus on specific preoperative planning contexts, such as liver transplant preparation.	**Yes**	**8/17/26**

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Florida: Policy Change from EviCore Radiology Guidelines to MCG Care Guidelines 30th Edition Radiology Guidelines				
EviCore Clinical Guideline	**MCG Care Guideline(s)**	**Revision**	**Substantive Change?**	**Effective Date**
	Chest MR Angiography (MRA) (A-0035) Chest MRI (A-0446) Gallium Scan (A-0066) Head CT Angiography (CTA) (A-0484) Labeled Leukocyte Scan (A-0070) Myocardial Perfusion Imaging, Pharmacologic Stress (A-0079) Myocardial Perfusion Imaging, Exercise Stress (A-0078) Myocardial Positron Emission Tomography (PET) and PET-CT (A-0097) Neck CT Angiography (CTA) (A-0470)	Nuclear Medicine (NM) Clinical pathways for Nuclear Medicine have been updated, particularly regarding pulmonary hypertension and transplant evaluations. Requirements for pulmonary hypertension imaging now include considerations regarding the availability of Cardiac MRI. Testing protocols for transplant evaluations are focused on preoperative risk assessment. Single-Photon Emission Computed Tomography (SPECT) The diagnostic application of SPECT has been revised. Under the updated framework, SPECT indications are primarily focused on neurologic (brain) or pulmonary (PE/Nodule) assessments. Applicable procedure codes impacted: 0742T, 70496, 70498, 71250, 71260, 71270, 71275, 71550, 71551, 71552, 71555, 72191, 72193, 72197, 72198, 73206, 74150, 74160, 74174, 74175, 74177, 74181, 74183, 74185, 76376, 76377, 78414, 78428, 78429, 78430, 78431, 78432, 78433, 78466, 78468, 78469, 78472, 78473, 78481, 78483, 78494, 78496, 78499, 78803, 78815, 78830		

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Florida: Policy Change from EviCore Radiology Guidelines to MCG Care Guidelines 30th Edition Radiology Guidelines				
EviCore Clinical Guideline	**MCG Care Guideline(s)**	**Revision**	**Substantive Change?**	**Effective Date**
	Pelvic MRI (A-0055) Somatostatin Receptor Scintigraphy (A-0087) Tumor Imaging Positron Emission Tomography (PET) and PET-CT (A-0098) Upper Extremity CT Angiography (CTA) (A-0473)			
Chest Imaging Guideline	Chest CT Angiography (CTA) (A-0471) Chest CT Scan (A-0028) Chest MR Angiography (MRA) (A-0035) Chest MRI (A-0446)	The transition to MCG care guidelines for chest imaging updates the clinical criteria for standard pulmonary and thoracic workups. These updates include revised requirements for post-transplant monitoring and the inclusion of specific advanced imaging technologies. Computed Tomography (CT) Clinical indications for post-transplant thoracic imaging have been updated. For patients in the post-hematopoietic stem cell transplant period, advanced imaging authorization now involves the review of specific hematologic data. Experimental, Investigational, Unproven (EIU)	**Yes**	**8/17/26**

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EviCore Clinical Guideline	**MCG Care Guideline(s)**	**Revision**	**Substantive Change?**	**Effective Date**
		The clinical criteria for Chest MRI have been expanded to include specific advanced modalities. HCPCS code C9791 (Magnetic resonance imaging with inhaled hyperpolarized xenon-129 contrast agent) is now recognized as an applicable code within the chest imaging framework. Applicable procedure codes impacted: 71260, 71270, 71271, 71275, 71550, 71551, 71552, 71555, 76376, 76377, 76497, C8909, C8910, C8911, C9791		
Head Imaging Guideline	Brain CT Scan (A-0016) Cervical Spine CT Scan (A-0025) Face and Sinuses CT Scan (A-0018) Lumbar Spine CT Scan (A-0027) Neck CT Scan (A-0022) Orbit and Ear CT Scan (A-0023) Thoracic Spine CT Scan (A-0026)	The transition to MCG care guidelines for adult head imaging updates clinical pathways for neurological workups, including standardizing the approach for common indications. These updates establish revised diagnostic hierarchies for cognitive decline, preventative screening thresholds for vascular conditions, and criteria for specialized neuro-functional evaluations. Computed Tomography (CT) Clinical indications for the evaluation of cognitive decline have been updated. The revised diagnostic hierarchy prioritizes MRI for the exclusion of treatable causes of dementia, utilizing CT as a secondary alternative. Computed Tomographic Angiography (CTA) Authorization criteria for CTA have been adjusted for several clinical scenarios. Screening thresholds for aneurysm now require a documented history of two or more first-degree family members.	**Yes**	**8/17/26**

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EviCore Clinical Guideline	**MCG Care Guideline(s)**	**Revision**	**Substantive Change?**	**Effective Date**
		Updated guidelines also focus on interventional planning for specific clinical findings, such as masses identified via nasal endoscopy. Magnetic Resonance Angiography (MRA) Preventative screening thresholds for vascular conditions, including those with genetic components, have been revised to require a documented family history of two or more first-degree relatives. Additionally, MRA criteria for balance-related assessments now involve the presence of specific vertebral artery symptoms. Functional Magnetic Resonance Imaging (fMRI) Authorization criteria for fMRI in preoperative planning for epilepsy now include documented failure of two or more anticonvulsant medications at maximal doses. The current framework focuses on preoperative functional assessment. Magnetic Resonance Imaging (MRI) Clinical pathways for sensory-related symptoms, such as anosmia or dysgeusia, now require documented prerequisites like trauma or prior endoscopy. Guidelines for specialized volumetric brain analysis (CPT 0865T) are not currently addressed in the updated criteria set. Magnetic Resonance Spectroscopy (MRS) MRS clinical applications are established for oncology and rare metabolic disorders. The updated framework focuses on these specific high-volume clinical scenarios. Single-Photon Emission Computed Tomography (SPECT)		

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Florida: Policy Change from EviCore Radiology Guidelines to MCG Care Guidelines 30th Edition Radiology Guidelines				
EviCore Clinical Guideline	**MCG Care Guideline(s)**	**Revision**	**Substantive Change?**	**Effective Date**
		The diagnostic utility of cerebrovascular SPECT has been updated, focusing primarily on brain death determination. Updated indications for SPECT do not currently include shunt malfunction evaluations or specific vascular challenge protocols. Applicable Procedure Codes Impacted: 0865T, 0866T, 70450, 70460, 70470, 70471, 70472, 70473, 70480, 70481, 70482, 70486, 70487, 70488, 70490, 70491, 70492, 71275, 72126, 72127, 72128, 72129, 72130, 72131, 72132, 72133, 76376, 76377, 76380, 76497, 77011, 70496, 70498, 70554, 70555, 70544, 70545, 70546, 70547, 70548, 70549, 70336, 70540, 70542, 70543, 70551, 70552, 70553, 72141, 72146, 72148, 72156, 72157, 72158, 76390, 78608, 78609, 78803, 78811, 78814, 78830, 78832		
Musculoskeletal Imaging Guideline	Abdominal/Pelvic CT Scan (A-0013) Ankle CT Scan (A-0014) Ankle MRI (A-0045) Arm CT Scan (A-0015) Arm MRI (A-0046) Arthrography, MR (A-0436) Brain CT Scan (A-0016)	The transition to MCG care guidelines for musculoskeletal imaging updates the clinical requirements for joint, tendon, and soft tissue evaluations. These updates include a revised coding structure for various orthopedic conditions and specialized trauma scenarios. Computed Tomography (CT) Authorization criteria for CT studies have been updated. Clinical indications for musculoskeletal CT are focused on primary diagnostic qualifiers and established injury patterns. Magnetic Resonance Imaging (MRI) Clinical pathways for upper extremity muscle pathology and chest wall soft tissue injuries have been consolidated under generalized guidelines, such as Arm MRI (A-0046). Diagnostic requirements for	**Yes**	**8/17/26**

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Florida: Policy Change from EviCore Radiology Guidelines to MCG Care Guidelines 30th Edition Radiology Guidelines				
EviCore Clinical Guideline	**MCG Care Guideline(s)**	**Revision**	**Substantive Change?**	**Effective Date**
	Brain MRI (A-0047) Brain Positron Emission Tomography (PET) and PET-CT (A-0096) Brain, Single Photon Emission Computed Tomography (SPECT) (A-0090) Cervical Spine CT Scan (A-0025) Cervical Spine MRI (A-0057) Chest CT Scan (A-0028) Chest MRI (A-0446) Elbow CT Scan (A-0017) Elbow MRI (A-0049) Face and Sinuses CT Scan (A-0018)	joint dislocations and surgical instability planning have been aligned with the current MCG care guidelines for musculoskeletal framework. Single Photon Emission Computed Tomography (SPECT) The clinical application of SPECT for musculoskeletal imaging has been updated. The updated criteria focus on standard imaging modalities for resolving diagnostic ambiguity in bone and soft tissue infections and for patients with hardware or metal implants. Applicable procedure codes impacted: 70336, 70450, 70551, 70553, 71250, 71260, 71550, 71552, 72125, 72128, 72131, 72192, 72193, 72194, 73200, 73201, 73202, 73206, 73700, 73701, 73702, 73706, 73225, 73725, 74160, 74177, 72141, 72146, 72148, 72156, 72157, 72158, 72195, 72196, 72197, 72198, 73219, 73220, 73221, 73222, 73223, 73718, 73719, 73720, 73721, 73722, 73723, 76376, 76377, 77078, 78803, 78830, 78811, 78812, 78813, 78814, 78815, 78816, C8912, C8913, C8914, C8934, C8935, C8936		

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EviCore Clinical Guideline	**MCG Care Guideline(s)**	**Revision**	**Substantive Change?**	**Effective Date**
	Foot and Foot Joints CT Scan (A-0019) Foot and Foot Joints MRI (A-0050) Gallium Scan (A-0066) Hand MRI (A-0447) Hip CT Scan (A-0641) Hip MRI (A-0642) Knee MRI (A-0052) Labeled Leukocyte Scan (A-0070) Lower Extremity CT Angiography (CTA) (A-0474) Lower Extremity CT Scan (A-0021) Lower Extremity MR Angiography (MRA) (A-0037)			

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EviCore Clinical Guideline	**MCG Care Guideline(s)**	**Revision**	**Substantive Change?**	**Effective Date**
	Lower Extremity MRI (A-0053) Lumbar Spine CT Scan (A-0027) Lumbar Spine MRI (A-0059) Lung, Single Photon Emission Computed Tomography (SPECT) (A-0091) Myocardial Positron Emission Tomography (PET) and PET-CT (A-0097) Pelvic MRI (A-0055) Shoulder MRI (A-0056) Somatostatin Receptor Scintigraphy (A-0087) Temporomandibular Joint MRI (A-0062) Thoracic Spine CT Scan (A-0026)			

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EviCore Clinical Guideline	**MCG Care Guideline(s)**	**Revision**	**Substantive Change?**	**Effective Date**
	Thoracic Spine MRI (A-0058) Tumor Imaging Positron Emission Tomography (PET) and PET-CT (A-0098) Upper Extremity CT Angiography (CTA) (A-0473) Upper Extremity MR Angiography (MRA) (A-0485) Wrist CT Scan (A-0029) Wrist MRI (A-0061)			
Neck Imaging Guideline	Abdominal/Pelvic CT Scan (A-0013) Brain MRI (A-0047) Cervical Spine CT Scan (A-0025) Cervical Spine MRI (A-0057)	The transition to MCG care guidelines for neck imaging criteria updates the framework for vascular and structural evaluations. These updates include standardized pathways for common clinical presentations and established documentation requirements for advanced imaging. Magnetic Resonance Imaging (MRI) Authorization criteria for MRI studies have been revised for several clinical scenarios. For chronic neck pain, clinical indications now include the documented failure of six weeks of conservative care, such as physical therapy or NSAIDs. Evaluation of salivary gland	**Yes**	**8/17/26**

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EviCore Clinical Guideline	**MCG Care Guideline(s)**	**Revision**	**Substantive Change?**	**Effective Date**
	Chest CT Angiography (CTA) (A-0471) Chest CT Scan (A-0028) Chest MR Angiography (MRA) (A-0035) Chest MRI (A-0446) Face and Sinuses CT Scan (A-0018) Neck CT Angiography (CTA) (A-0470) Neck CT Scan (A-0022) Neck MR Angiography (MRA) (A-0034) Neck, Orbit, and Face MRI (A-0054) Tumor Imaging Positron Emission Tomography (PET) and PET-CT (A-0098)	masses now involves the presence of specific secondary clinical indicators, such as facial nerve weakness or documented growth, to justify medical necessity. Applicable procedure codes impacted: 70486, 70487, 70488, 70490, 70491, 70492, 70498, 70540, 70542, 70543, 70547, 70548, 70549, 70551, 70553, 71250, 71260, 71275, 71550, 71552, 71555, 72125, 72141, 74160, 76376, 76377, 78815, 78816		

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EviCore Clinical Guideline	**MCG Care Guideline(s)**	**Revision**	**Substantive Change?**	**Effective Date**
Oncology Imaging Guideline	Abdominal MRI (A-0044) Abdominal/Pelvic CT Scan (A-0013) Abdominal/Pelvic MR Angiography (MRA) (A-0032) Bone Marrow MRI (A-0537) Brain CT Scan (A-0016) Brain MRI (A-0047) Brain Positron Emission Tomography (PET) and PET-CT (A-0096) Brain, Single Photon Emission Computed Tomography (SPECT) (A-0090) Breast MRI (A-0048) Cardiac Radionuclide Angiography (Radionuclide Ventriculography) (A-0077)	The transition to MCG care guidelines for oncology imaging criteria updates clinical protocols across high-volume diagnostic modalities. These updates establish revised diagnostic hierarchies for tumor characterization and clinical criteria for specialized nuclear medicine and whole-body imaging. Computed Tomography (CT) Clinical indications for the characterization and follow-up of brain tumors have been updated. The revised criteria prioritize MRI as the primary diagnostic tool, with CT utilized for specific clinical scenarios or in cases where there are patient contraindications. Positron Emission Tomography (PET) PET clinical pathways for the initial diagnosis and restaging of Multiple Myeloma and Non-Hodgkin Lymphoma have been updated. The revised framework aligns with standard oncology staging and response assessment protocols, such as Deauville scoring. Single-Photon Emission Computed Tomography (SPECT) The diagnostic application of SPECT and SPECT/CT hybrid imaging has been revised. Updated indications focus on standard oncological assessments and primary diagnostic pathways. Experimental, Investigational, Unproven (EIU) The clinical status of CPT 76498 (Unlisted magnetic resonance procedure) has been updated. Current guidelines focus on	**Yes**	**8/17/26**

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EviCore Clinical Guideline	**MCG Care Guideline(s)**	**Revision**	**Substantive Change?**	**Effective Date**
	Cervical Spine MRI (A-0057) Chest CT Angiography (CTA) (A-0471) Chest CT Scan (A-0028) Chest MRI (A-0446) Face and Sinuses CT Scan (A-0018) Functional MRI (fMRI) (70555) Head CT Angiography (CTA) (A-0484) Head MR Angiography (MRA) (A-0033) Lumbar Spine MRI (A-0059) Lung, Single Photon Emission Computed Tomography (SPECT) (A-0091) Magnetic Resonance Spectroscopy (A-0482)	established clinical indications for oncology-related evaluations, staging, and surveillance. Applicable procedure codes impacted: 70450, 70460, 70470, 70486, 70487, 70491, 70496, 70543, 70544, 70553, 70555, 71250, 71260, 71275, 71552, 72142, 72156, 72157, 72158, 72197, 74160, 74170, 74177, 74178, 74183, 74185, 76376, 76377, 76390, 76498, 77049, 77084, 78472, 78608, 78813, 78815, 78816, 78830		

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EviCore Clinical Guideline	**MCG Care Guideline(s)**	**Revision**	**Substantive Change?**	**Effective Date**
	Neck CT Scan (A-0022) Neck, Orbit, and Face MRI (A-0054) Pelvic MRI (A-0055) Thoracic Spine MRI (A-0058) Tumor Imaging Positron Emission Tomography (PET) and PET-CT (A-0098)			
Pelvis Imaging Guideline	Abdominal/Pelvic CT Angiography (CTA) (A-0475) Abdominal/Pelvic CT Scan (A-0013) Abdominal/Pelvic MRA (A-0032) Pelvic MRI (A-0055)	The transition to MCG care guidelines for adult pelvis imaging updates clinical criteria for high-volume diagnostic modalities including CT, MRI, and MRA. These guidelines establish a streamlined framework for evaluating pelvic masses, inflammatory conditions, and general vascular health. Computed Tomography (CT) Authorization criteria for CT studies have been updated for specific clinical scenarios. For suspected pelvic conditions such as varicocele or certain post-surgical assessments, clinical indications focus on general complications such as abscess or hematoma. Computed Tomographic Angiography (CTA) Clinical indications for pelvic CTA focus on specific vascular mapping of the liver, pancreas, stomach, kidney, spleen, and	**Yes**	**8/17/26**

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EviCore Clinical Guideline	**MCG Care Guideline(s)**	**Revision**	**Substantive Change?**	**Effective Date**
		retroperitoneum. Revised pathways have been established for preoperative vascular mapping and embolization procedures. Magnetic Resonance Angiography (MRA) MRA clinical indications for pelvic vascular mapping have been updated. Current guidelines focus on standard diagnostic pathways for vascular assessments. Magnetic Resonance Imaging (MRI) Clinical pathways for MRI in the assessment of endometriosis and chronic pelvic pain have been updated to include specific documentation of prior imaging, such as Ultrasound or CT scans. Criteria for hematospermia include age-based indications and the use of primary diagnostic studies. For suspected pelvic infections, the current framework includes a diagnostic sequence involving preliminary CT evaluation. Experimental, Investigational, Unproven (EIU) The use of Whole Body MRI (WBMRI) for specialized maternal screening is noted as having limited large-scale clinical evidence. Current criteria focus on established clinical applications of pelvic MRI and MRA. Applicable procedure codes impacted: 72191, 72192, 72193, 72194, 72195, 72196, 72197, 72198, 74176, 74177, 74178, 74712, 74713, 76376, 76377, 76498, C8918, C8919, C8920		

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EviCore Clinical Guideline	**MCG Care Guideline(s)**	**Revision**	**Substantive Change?**	**Effective Date**
Peripheral Nerve and Neuromuscular Disorders (PNND) Imaging Guideline	Abdominal/Pelvic CT Scan (A-0013) Ankle MRI (A-0045) Arm CT Scan (A-0015) Arm MRI (A-0046) Cervical Spine MRI (A-0057) Chest CT Scan (A-0028) Elbow CT Scan (A-0017) Elbow MRI (A-0049) Foot and Foot Joints MRI (A-0050) Hand MRI (A-0447) Hip CT Scan (A-0641) Hip MRI (A-0642) Knee MRI (A-0052) Lower Extremity MRI (A-0053)	The transition to MCG care guidelines for PNND imaging updates the clinical criteria for routine neurological evaluations, including assessments for nerve entrapment and trauma-related weakness. While many of these guidelines provide a symptoms-based framework comparable to prior standards, specific updates have been established for clinical scenarios where diagnostic pathways or surveillance requirements have changed . Magnetic Resonance Imaging (MRI) Authorization criteria for MRI studies have been updated for specific neuromuscular conditions. For suspected Motor Neuron Disease or ALS, the general framework for imaging now includes the evaluation of other common causes through clinical logic or physical therapy when concurrent symptoms are present. Clinical indicators for inflammatory myopathy focus on unexplained symmetric proximal weakness in conjunction with an explicit intent to perform a biopsy. Longitudinal surveillance for Gaucher Disease now follows generalized clinical pathways rather than a specific annual skeletal roadmap . Experimental, Investigational, Unproven (EIU) The clinical status of CPT 76498 (MR Neurography) has been updated. Current guidelines indicate that the role of this specific technology remains under review based on existing clinical evidence. Applicable procedure codes impacted:	**Yes**	**8/17/26**

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EviCore Clinical Guideline	**MCG Care Guideline(s)**	**Revision**	**Substantive Change?**	**Effective Date**
	Lumbar Spine MRI (A-0059) Neck CT Scan (A-0022) Neck, Orbit, and Face MRI (A-0054) Neurography, MR (A-1093) Shoulder MRI (A-0056) Thoracic Spine MRI (A-0058) Tumor Imaging Positron Emission Tomography (PET) and PET-CT (A-0098) Wrist CT Scan (A-0029) Wrist MRI (A-0061)	70490, 70491, 70492, 70540, 70543, 70551, 70553, 71250, 71260, 71270, 71550, 71552, 72141, 72146, 72148, 72156, 72157, 72158, 72192, 72193, 72194, 72195, 72197, 73200, 73201, 73202, 73218, 73220, 73221, 73223, 73718, 73720, 73721, 74160, 74177, 74178, 74181, 76391, 76498, 78815		
Peripheral Vascular Disease (PVD) Imaging Guideline	Abdominal MRI (A-0044) Abdominal/Pelvic CT Angiography (CTA) (A-0475) Abdominal/Pelvic CT Scan (A-0013)	The transition to MCG care guidelines for PVD imaging updates the framework for standard arterial and venous assessments across CT, CTA, MRI, and MRA modalities. While many clinical guidelines are comparable to prior standards, specific updates have been established for specialized vascular populations, nuclear medicine (PET and SPECT), and monitoring protocols. Computed Tomography (CT)	**Yes**	**8/17/26**

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EviCore Clinical Guideline	**MCG Care Guideline(s)**	**Revision**	**Substantive Change?**	**Effective Date**
	Abdominal/Pelvic MR Angiography (MRA) (A-0032) Brain MRI (A-0047) Cardiac MRI (A-0051) Chest CT Angiography (CTA) (A-0471) Chest CT Scan (A-0028) Chest MR Angiography (MRA) (A-0035) Chest MRI (A-0446) Face and Sinuses CT Scan (A-0018) Foot and Foot Joints MRI (A-0050) Head CT Angiography (CTA) (A-0484) Head MR Angiography (MRA) (A-0033)	Authorization criteria for CT studies have been updated for post-procedure surveillance and specific vascular conditions. Clinical indications for suprainguinal post-procedure monitoring and hemodialysis access now follow general surveillance and post-surgical complication guidelines. Criteria for small vessel vasculitis and IVC filter monitoring have been adjusted to focus on established clinical indicators for specific conditions. Computed Tomographic Angiography (CTA) Clinical indications for CTA have been revised for specific vascular assessments. Authorization for studies related to IVC filter evaluation or removal is based on clinical triggers established within the current diagnostic framework. Magnetic Resonance Angiography (MRA) MRA clinical indications for genetic arterial diseases and hypertension-related assessments have been updated. Guidelines now focus on localized indications for initial diagnoses and established surveillance intervals for found aneurysms. Authorization for MRA in the context of resistant hypertension now includes a diagnostic sequence involving primary studies such as Duplex Ultrasound . Magnetic Resonance Imaging (MRI) Clinical pathways for MRI in the evaluation of arteriovenous malformations (AVMs) have been aligned with standard deep tissue imaging protocols.		

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EviCore Clinical Guideline	**MCG Care Guideline(s)**	**Revision**	**Substantive Change?**	**Effective Date**
	Lower Extremity CT Angiography (CTA) (A-0474) Lower Extremity MR Angiography (MRA) (A-0037) Lumbar Spine MRI (A-0059) Neck CT Angiography (CTA) (A-0470) Neck MR Angiography (MRA) (A-0034) Neck, Orbit, and Face MRI (A-0054) Pelvic MRI (A-0055) Upper Extremity CT Angiography (CTA) (A-0473) Upper Extremity MR Angiography (MRA) (A-0485)	Nuclear Medicine (PET and SPECT) The diagnostic application of PET and SPECT for vascular inflammation and graft infections has been updated. PET criteria are primarily utilized for malignancy-related evaluations, and SPECT indications are established for standard vascular assessments . Experimental, Investigational, Unproven (EIU) Clinical indications have been established within the updated criteria set for CPT codes 0710T, 0711T, 0712T, and 0713T (Quantification of Plaque Morphology). Applicable procedure codes impacted: 0710T, 0711T, 0712T, 0713T, 70471, 70472, 70473, 70486, 70496, 70498, 70540, 70543, 70544, 70545, 70546, 70547, 70548, 70549, 70551, 70553, 71250, 71260, 71275, 71550, 71552, 71555, 72148, 72158, 72191, 72193, 72194, 72195, 72197, 72198, 73206, 73225, 73706, 73718, 73720, 73721, 73723, 73725, 74160, 74174, 74175, 74176, 74177, 74178, 74181, 74183, 74185, 75557, 75561, 75635, 78803, 78815, 78816		
Spine Imaging Guideline	Abdominal/Pelvic CT Angiography (CTA) (A-0475)	The transition to MCG care guidelines for spine imaging updates clinical criteria for CT, MRI, MRA, and PET modalities. While the guidelines for most diagnostic workups are comparable to prior	**Yes**	**8/17/26**

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EviCore Clinical Guideline	**MCG Care Guideline(s)**	**Revision**	**Substantive Change?**	**Effective Date**
	Abdominal/Pelvic CT Scan (A-0013) Abdominal/Pelvic MR Angiography (MRA) (A-0032) Brain CT Scan (A-0016) Brain MRI (A-0047) Brain Positron Emission Tomography (PET) and PET-CT (A-0096) Brain, Single Photon Emission Computed Tomography (SPECT) (A-0090) Cervical Spine CT Scan (A-0025) Cervical Spine MRI (A-0057) Chest CT Scan (A-0028) Chest MR Angiography (MRA) (A-0035)	standards or allow for broader physician discretion in routine diagnostics, specific updates have been established for specialized surgical planning and nuclear medicine pathways. Computed Tomography Angiography (CTA) Clinical indications for spinal CTA have been updated. Authorization criteria focus on generalized vascular clinical indications as established within the current diagnostic framework. Magnetic Resonance Angiography (MRA) MRA clinical indications for spinal canal and contents have been adjusted. Current guidelines prioritize the use of MRA for standard vascular surgical follow-up assessments. Single-Photon Emission Computed Tomography (SPECT) Authorization criteria for SPECT and SPECT/CT have been established for standard spine imaging protocols. Clinical pathways for suspected spondylolysis, determining the age of compression fractures, and the evaluation of painful pseudoarthrosis or hardware focus on established diagnostic triggers. Experimental, Investigational, Unproven (EIU) The clinical status of MR Spectroscopy (CPT 76390 and 0600T-series codes) has been updated. Current criteria for 76390 focus exclusively on brain neoplasms, particularly for differentiating tumors from other non-cancerous lesions. <u>Applicable procedure codes impacted</u>:		

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EviCore Clinical Guideline	**MCG Care Guideline(s)**	**Revision**	**Substantive Change?**	**Effective Date**
	Hip CT Scan (A-0641) Lumbar Spine CT Scan (A-0027) Lumbar Spine MRI (A-0059) Myocardial Positron Emission Tomography (PET) and PET-CT (A-0097) Pelvic MRI (A-0055) Thoracic Spine CT Scan (A-0026) Thoracic Spine MRI (A-0058) Tumor Imaging Positron Emission Tomography (PET) and PET-CT (A-0098)	0609T, 0610T, 0611T, 0612T, 70450, 70544, 70551, 70552, 70553, 71250, 71260, 72125, 72126, 72128, 72129, 72130, 72131, 72132, 72133, 72141, 72142, 72146, 72147, 72148, 72149, 72156, 72157, 72158, 72159, 72191, 72192, 72195, 72196, 72197, 72198, 74174, 74175, 74185, 76390, 78811, 78812, 78813, 78814, 78815, 78816, 78830, C8931, C8932, C8933		
Pediatric Abdomen Imaging Guideline	Abdominal/Pelvic CT Angiography (CTA) (A-0475) Abdominal/Pelvic CT Scan (A-0013)	The transition to MCG care guidelines updates clinical pathways across the pediatric abdominal imaging suite. While the transition to MCG care guidelines establishes a streamlined authorization process for the majority of standard pediatric presentations, specific	**Yes**	**8/17/26**

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EviCore Clinical Guideline	**MCG Care Guideline(s)**	**Revision**	**Substantive Change?**	**Effective Date**
	Abdominal/Pelvic MR Angiography (MRA) (A-0032) Abdominal MRI (A-0044) Cholangiopancreatography, MR (MRCP) (A-0064) Hepatic Elastography, MR (A-1012) Tumor Imaging Positron Emission Tomography (PET) and PET-CT (A-0098)	updates have been established for diagnostic sequences and primary imaging requirements. Computed Tomography (CT) Authorization criteria for pediatric abdominal CT, particularly for suspected appendicitis, focus on the results of primary diagnostic evaluations. The clinical framework aligns with standard diagnostic protocols and established clinical indicators for pediatric patients . Computed Tomographic Angiography (CTA) Clinical indications for pediatric CTA now include a diagnostic sequence that involves an indeterminate ultrasound prior to authorization. This requirement ensures that definitive vascular imaging is utilized following initial primary assessment . Magnetic Resonance Imaging (MRI) Clinical pathways for pediatric abdominal MRI, including evaluations for postoperative pain and suspected appendicitis, utilize an initial diagnostic approach focused on primary modalities such as ultrasound. Current guidelines establish specific clinical triggers and sequences to ensure diagnostic accuracy across various patient populations . Applicable procedure codes impacted: 74150, 74160, 74170, 74174, 74175, 74177, 74178, 74181, 74182, 74183, 74185, 76376, 76377, 76391, 78815		

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EviCore Clinical Guideline	**MCG Care Guideline(s)**	**Revision**	**Substantive Change?**	**Effective Date**
Pediatric and Special Populations Oncology Imaging Guideline	Abdominal MRI (A-0044) Abdominal/Pelvic CT Scan (A-0013) Abdominal/Pelvic MR Angiography (MRA) (A-0032) Bone Marrow MRI (A-0537) Brain CT Scan (A-0016) Brain MRI (A-0047) Brain Positron Emission Tomography (PET) and PET-CT (A-0096) Brain, Single Photon Emission Computed Tomography (SPECT) (A-0090) Breast MRI (A-0048) Cardiac Radionuclide Angiography (Radionuclide Ventriculography) (A-0077)	The transition to MCG care guidelines updates clinical pathways across the pediatric oncology imaging suite. While the transition establishes a streamlined framework for standard staging and surveillance that aligns with evidence-based pediatric protocols, specific updates have been made to clinical triggers for specialized assessments and rare genetic syndromes. Magnetic Resonance Imaging (MRI) Authorization criteria for pediatric MRI have been updated to utilize generalized high-risk clinical indicators. Guidelines for specialized brain analysis (CPT 0865T/0866T) and longitudinal monitoring for therapy-induced effects focus on established clinical indications within the pediatric framework. Magnetic Resonance Angiography (MRA) MRA clinical indications for pediatric bone tumors have been updated. The current framework positions MRA as a diagnostic tool based on established clinical indicators for preoperative planning. Positron Emission Tomography (PET) PET clinical pathways for the evaluation of pediatric-onset conditions, such as plexiform neurofibromas and multifocal bone disease, have been updated. Authorization focuses on established medical necessity triggers for staging and longitudinal monitoring. Single-Photon Emission Computed Tomography (SPECT) The diagnostic application of SPECT and SPECT/CT hybrid imaging for pediatric conditions, including neuroblastoma and thyroid	**Yes**	**8/17/26**

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EviCore Clinical Guideline	**MCG Care Guideline(s)**	**Revision**	**Substantive Change?**	**Effective Date**
	Cervical Spine MRI (A-0057) Chest CT Angiography (CTA) (A-0471) Chest CT Scan (A-0028) Chest MRI (A-0446) Face and Sinuses CT Scan (A-0018) Functional MRI (fMRI) (70555) Head CT Angiography (CTA) (A-0484) Head MR Angiography (MRA) (A-0033) Lumbar Spine MRI (A-0059) Lung, Single Photon Emission Computed Tomography (SPECT) (A-0091)	cancer management, has been revised. Updated indications focus on standard pediatric staging and diagnostic pathways. Experimental, Investigational, Unproven (EIU) The clinical status of CPT 76498 (Unlisted magnetic resonance procedure) has been updated. Current guidelines focus on established clinical applications where ionizing radiation exposure is a clinical priority for high-risk pediatric populations. Applicable procedure codes impacted: 0865T, 0866T, 70450, 70460, 70470, 70486, 70487, 70491, 70496, 70543, 70544, 70553, 70555, 71250, 71260, 71275, 71552, 72142, 72156, 72157, 72158, 72197, 74160, 74170, 74177, 74178, 74183, 74185, 76390, 76376, 76377, 76498, 77049, 77084, 78472, 78608, 78813, 78815, 78816, 78830		

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EviCore Clinical Guideline	**MCG Care Guideline(s)**	**Revision**	**Substantive Change?**	**Effective Date**
	Magnetic Resonance Spectroscopy (A-0482) Neck CT Scan (A-0022) Neck, Orbit, and Face MRI (A-0054) Pelvic MRI (A-0055) Thoracic Spine MRI (A-0058) Tumor Imaging Positron Emission Tomography (PET) and PET-CT (A-0098)			
Pediatric and Special Populations Spine Imaging Guideline	Abdominal/Pelvic CT Angiography (CTA) (A-0475) Abdominal/Pelvic CT Scan (A-0013) Abdominal/Pelvic MR Angiography (MRA) (A-0032) Brain CT Scan (A-0016)	The transition to MCG care guidelines updates clinical pathways for pediatric spine imaging across several diagnostic modalities. While many clinical guidelines remain comparable to prior standards, specific updates have been established for clinical scenarios where diagnostic wait periods or specialized nuclear medicine requirements have changed. Magnetic Resonance Imaging (MRI) Authorization criteria for pediatric spine MRI now include established observation periods for specific clinical presentations. For patients under 18 with back pain, the updated framework	**Yes**	**8/17/26**

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EviCore Clinical Guideline	**MCG Care Guideline(s)**	**Revision**	**Substantive Change?**	**Effective Date**
	Brain MRI (A-0047) Brain Positron Emission Tomography (PET) and PET-CT (A-0096) Brain, Single Photon Emission Computed Tomography (SPECT) (A-0090) Cervical Spine CT Scan (A-0025) Cervical Spine MRI (A-0057) Chest CT Scan (A-0028) Chest MR Angiography (MRA) (A-0035) Hip CT Scan (A-0641) Lumbar Spine CT Scan (A-0027) Lumbar Spine MRI (A-0059)	involves a 4-week pain duration requirement unless the clinical presentation includes systemic signs or a neurological deficit . Single-Photon Emission Computed Tomography (SPECT) The clinical application of SPECT and SPECT/CT for pediatric spinal conditions has been updated. Current authorization criteria focus on standard diagnostic pathways for evaluations of spondylolysis, suspected osteomyelitis, and painful scoliosis, utilizing established clinical triggers within the pediatric framework . Experimental, Investigational, Unproven (EIU) The clinical status of MR Spectroscopy (CPT 76390 and 0600T-series codes) has been updated. Consistent with the adult framework, criteria for 76390 focus exclusively on brain neoplasms, particularly for differentiating tumors from radiation necrosis or other non-cancerous lesions . Applicable procedure codes impacted: 0609T, 0610T, 0611T, 0612T, 70450, 70544, 70551, 70552, 70553, 71250, 71260, 72125, 72126, 72128, 72129, 72130, 72131, 72132, 72133, 72141, 72142, 72146, 72147, 72148, 72149, 72156, 72157, 72158, 72159, 72191, 72192, 72195, 72196, 72197, 72198, 74174, 74175, 74185, 76390, 78811, 78812, 78813, 78814, 78815, 78816, 78830		

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EviCore Clinical Guideline	**MCG Care Guideline(s)**	**Revision**	**Substantive Change?**	**Effective Date**
	Myocardial Positron Emission Tomography (PET) and PET-CT (A-0097) Pelvic MRI (A-0055) Thoracic Spine CT Scan (A-0026) Thoracic Spine MRI (A-0058) Tumor Imaging Positron Emission Tomography (PET) and PET-CT (A-0098)			
Pediatric Cardiac Imaging Guideline	Abdominal/Pelvic CT Angiography (CTA) (A-0475) Abdominal/Pelvic CT Scan (A-0013) Abdominal/Pelvic MR Angiography (MRA) (A-0032) Abdominal MRI (A-0044) Brain, Single Photon Emission Computed	The transition to MCG care guidelines updates clinical pathways across the pediatric cardiac imaging suite. While the transition establishes a streamlined and inclusive framework for congenital and structural heart disease, specific updates have been made to diagnostic hierarchies for certain vascular conditions . Magnetic Resonance Angiography (MRA) Authorization criteria for pediatric MRA have been updated within the diagnostic framework for suspected pulmonary hypertension. The current framework positions MRA as a secondary study to be utilized after primary modalities have been exhausted or ruled out . Applicable procedure codes impacted:	**Yes**	**8/17/26**

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EviCore Clinical Guideline	**MCG Care Guideline(s)**	**Revision**	**Substantive Change?**	**Effective Date**
	Tomography (SPECT) (A-0090) Cardiac Radionuclide Angiography (Radionuclide Ventriculography) (A-0077) Chest CT Angiography (CTA) (A-0471) Chest CT Scan (A-0028) Chest MR Angiography (MRA) (A-0035) Chest MRI (A-0446) Gallium Scan (A-0066) Head CT Angiography (CTA) (A-0484) Labeled Leukocyte Scan (A-0070) Myocardial Perfusion Imaging, Pharmacologic Stress (A-0079)	70496, 70498, 71250, 71260, 71270, 71275, 71550, 71551, 71552, 71555, 72191, 72193, 72197, 72198, 73206, 74150, 74160, 74174, 74175, 74177, 74181, 74183, 74185, 76376, 76377, 78414, 78428, 78430, 78431, 78432, 78433, 78466, 78468, 78469, 78472, 78473, 78481, 78483, 78494, 78496, 78803, 78830, 78815, 0742T		

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EviCore Clinical Guideline	**MCG Care Guideline(s)**	**Revision**	**Substantive Change?**	**Effective Date**
	Myocardial Perfusion Imaging, Exercise Stress (A-0078) Myocardial Positron Emission Tomography (PET) and PET-CT (A-0097) Neck CT Angiography (CTA) (A-0470) Pelvic MRI (A-0055) Somatostatin Receptor Scintigraphy (A-0087) Tumor Imaging Positron Emission Tomography (PET) and PET-CT (A-0098) Upper Extremity CT Angiography (CTA) (A-0473)			
Pediatric Chest Imaging Guideline	Chest CT Angiography (CTA) (A-0471) Chest CT Scan (A-0028)	The transition to MCG care guidelines updates clinical pathways across the pediatric chest imaging suite. While many guidelines are comparable to prior standards, specific updates have been made to clinical triggers for common respiratory conditions and established	**Yes**	**8/17/26**

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EviCore Clinical Guideline	**MCG Care Guideline(s)**	**Revision**	**Substantive Change?**	**Effective Date**
	Chest MR Angiography (MRA) (A-0035) Chest MRI (A-0446)	observation periods for persistent infections . Computed Tomography (CT) Authorization criteria for pediatric chest CT have been updated for various respiratory presentations. For conditions such as asthma and bronchiolitis, the updated framework utilizes evidence-based clinical indicators for advanced imaging. For persistent infections or pneumonia, clinical indications include a documented observation window of 4 to 9 weeks prior to the authorization of advanced imaging . Magnetic Resonance Imaging (MRI) Clinical pathways for pediatric chest MRI have been updated to focus on established diagnostic indications. Authorization for advanced imaging in the management of specific infectious diseases, such as tuberculosis, is based on the clinical triggers established within the updated criteria set . Applicable procedure codes impacted: 71260, 71270, 71271, 71275, 71550, 71551, 71552, 71555, 76376, 76377, 76497		
Pediatric Head Imaging Guideline	Brain CT Scan (A-0016) Cervical Spine CT Scan (A-0025)	The transition to MCG care guidelines updates clinical pathways across the pediatric head imaging suite. While the updated criteria establish a streamlined approach to standard neurological workups for many pediatric patients, specific updates have been made to diagnostic thresholds for chronic conditions and specialized neuro-functional evaluations.	**Yes**	**8/17/26**

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EviCore Clinical Guideline	**MCG Care Guideline(s)**	**Revision**	**Substantive Change?**	**Effective Date**
	Face and Sinuses CT Scan (A-0018) Lumbar Spine CT Scan (A-0027) Neck CT Scan (A-0022) Orbit and Ear CT Scan (A-0023) Thoracic Spine CT Scan (A-0026)	Computed Tomography (CT) Authorization criteria for pediatric head and sinus CT have been updated. For chronic rhinosinusitis, medical necessity is established based on a history of at least four acute episodes per year or symptoms persisting for 12 weeks or longer. Computed Tomographic Angiography (CTA) Clinical indications for CTA focus on standard pediatric vascular assessments. Authorization for specialized vascular extensions of sinus infections is based on clinical triggers established within the updated diagnostic framework. Magnetic Resonance Spectroscopy (MRS) The diagnostic application of MRS has been updated to focus on established high-volume pediatric indications. Authorization for MRS in the context of specific metabolic disorders, neonatal assessments, or surgical guidance is based on clinical indications established within the current criteria set. Functional Magnetic Resonance Imaging (fMRI) Authorization criteria for fMRI focus on established clinical indications for preoperative assessment. Magnetic Resonance Imaging (MRI) Clinical pathways for pediatric MRI have been updated, including revised age thresholds for pediatric headache profiles. Repeat spinal imaging for demyelinating disease is established based on specific		

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EviCore Clinical Guideline	**MCG Care Guideline(s)**	**Revision**	**Substantive Change?**	**Effective Date**
		clinical triggers, such as a change in clinical status or a change in therapy. Single-Photon Emission Computed Tomography (SPECT) The diagnostic utility of SPECT has been updated to focus on standard pediatric neurological assessments. Applicable procedure codes impacted: 70450, 70460, 70470, 70471, 70472, 70473, 70480, 70481, 70482, 70486, 70487, 70488, 70490, 70491, 70492, 72125, 72126, 72127, 72128, 72129, 72130, 72131, 72132, 72133, 76376, 76377, 76380, 76497, 77011, 70496, 70498, 70554, 70555, 70544, 70546, 70547, 70548, 70549, 70336, 70540, 70542, 70543, 70551, 70552, 70553, 72141, 72146, 72148, 72156, 72157, 72158, 0865T, 0866T, 76390, 78608, 78609, 78811, 78814, 78803, 78830, 78832		
Pediatric Musculoskeletal Imaging Guideline	Abdominal/Pelvic CT Scan (A-0013) Ankle CT Scan (A-0014) Ankle MRI (A-0045) Arm CT Scan (A-0015) Arm MRI (A-0046) Arthrography, MR (A-0436)	The transition to MCG care guidelines updates clinical pathways across the pediatric musculoskeletal imaging suite. While the transition establishes a streamlined authorization process for the majority of routine pediatric fractures and joint injuries, specific updates have been made to clinical triggers for specialized growth monitoring and systemic inflammatory conditions. Computed Tomography (CT) Authorization criteria for pediatric musculoskeletal CT have been updated to focus on primary diagnostic indicators for bone and joint injuries. Clinical indications for limb growth monitoring, such as discrepancy measurements for surgical timing, follow established	**Yes**	**8/17/26**

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EviCore Clinical Guideline	**MCG Care Guideline(s)**	**Revision**	**Substantive Change?**	**Effective Date**
	Brain CT Scan (A-0016) Brain MRI (A-0047) Brain Positron Emission Tomography (PET) and PET-CT (A-0096) Brain, Single Photon Emission Computed Tomography (SPECT) (A-0090) Cervical Spine CT Scan (A-0025) Cervical Spine MRI (A-0057) Chest CT Scan (A-0028) Chest MRI (A-0446) Elbow CT Scan (A-0017) Elbow MRI (A-0049)	clinical protocols within the current diagnostic framework. Magnetic Resonance Imaging (MRI) Clinical pathways for pediatric MRI have been updated for the management of systemic inflammatory and autoinflammatory conditions. The updated framework utilizes established clinical indicators and diagnostic sequences to evaluate for skeletal lesions and monitor disease progression. Single-Photon Emission Computed Tomography (SPECT) The clinical application of SPECT and SPECT/CT for pediatric orthopedic conditions has been updated. Current authorization criteria focus on standard diagnostic pathways for the evaluation of new pain, treatment response, and inflammatory joint profiles, utilizing established clinical triggers within the pediatric framework. Experimental, Investigational, Unproven (EIU) The clinical status of CPT 76498 (Unlisted magnetic resonance procedure/Whole-Body MRI) has been updated. Current guidelines focus on established clinical applications where this technology is utilized for monitoring high-risk autoinflammatory conditions and evaluating radiographically active lesions. Applicable procedure codes impacted: 70450, 71250, 71260, 72125, 72128, 72131, 72192, 72193, 72194, 73200, 73201, 73202, 73700, 73701, 73702, 74160, 74177, 77078, 73206, 73706, 73225, 73725, 70336, 70551, 70553, 71550, 71552, 72141, 72146, 72148, 72156, 72157, 72158, 72195, 72196, 72197,		

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EviCore Clinical Guideline	**MCG Care Guideline(s)**	**Revision**	**Substantive Change?**	**Effective Date**
	Face and Sinuses CT Scan (A-0018) Foot and Foot Joints CT Scan (A-0019) Foot and Foot Joints MRI (A-0050) Gallium Scan (A-0066) Hand MRI (A-0447) Hip CT Scan (A-0641) Hip MRI (A-0642) Knee MRI (A-0052) Labeled Leukocyte Scan (A-0070) Lower Extremity CT Angiography (CTA) (A-0474) Lower Extremity CT Scan (A-0021)	73218, 73219, 73220, 73221, 73222, 73223, 73718, 73719, 73720, 73721, 73722, 73723, 76498, 78803, 78830, 78811, 78812, 78813, 78814, 78815, 78816		

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EviCore Clinical Guideline	**MCG Care Guideline(s)**	**Revision**	**Substantive Change?**	**Effective Date**
	Lower Extremity MR Angiography (MRA) (A-0037) Lower Extremity MRI (A-0053) Lumbar Spine CT Scan (A-0027) Lumbar Spine MRI (A-0059) Lung, Single Photon Emission Computed Tomography (SPECT) (A-0091) Myocardial Positron Emission Tomography (PET) and PET-CT (A-0097) Pelvic MRI (A-0055) Shoulder MRI (A-0056) Somatostatin Receptor Scintigraphy (A-0087)			

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EviCore Clinical Guideline	**MCG Care Guideline(s)**	**Revision**	**Substantive Change?**	**Effective Date**
	Temporomandibular Joint MRI (A-0062) Thoracic Spine CT Scan (A-0026) Thoracic Spine MRI (A-0058) Tumor Imaging Positron Emission Tomography (PET) and PET-CT (A-0098) Upper Extremity CT Angiography (CTA) (A-0473) Upper Extremity MR Angiography (MRA) (A-0485) Wrist CT Scan (A-0029) Wrist MRI (A-0061)			
Pediatric Neck Imaging Guideline	Abdominal/Pelvic CT Scan (A-0013) Brain MRI (A-0047)	The transition to MCG care guidelines updates clinical pathways across the pediatric neck imaging suite. While the updated criteria establish a streamlined approach to standard diagnostic workups for many pediatric patients, specific updates have been made to specialized neurovascular assessment pathways.	**Yes**	**8/17/26**

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EviCore Clinical Guideline	**MCG Care Guideline(s)**	**Revision**	**Substantive Change?**	**Effective Date**
	Cervical Spine CT Scan (A-0025) Cervical Spine MRI (A-0057) Chest CT Angiography (CTA) (A-0471) Chest CT Scan (A-0028) Chest MR Angiography (MRA) (A-0035) Chest MRI (A-0446) Face and Sinuses CT Scan (A-0018) Neck CT Angiography (CTA) (A-0470) Neck CT Scan (A-0022) Neck MR Angiography (MRA) (A-0034) Neck, Orbit, and Face MRI (A-0054)	Magnetic Resonance Angiography (MRA) Authorization criteria for pediatric neck MRA have been updated to focus on established clinical indicators within the diagnostic framework. Evaluation for conditions such as pediatric "wry neck" (torticollis) now utilizes standard neurovascular imaging triggers established within the updated criteria set . Applicable procedure codes impacted: 70486, 70487, 70488, 70490, 70491, 70492, 70498, 70540, 70542, 70543, 70547, 70548, 70549, 70551, 70553, 71250, 71260, 71275, 71550, 71552, 71555, 72125, 72141, 74160, 76376, 76377, 78815, 78816		

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EviCore Clinical Guideline	**MCG Care Guideline(s)**	**Revision**	**Substantive Change?**	**Effective Date**
	Tumor Imaging Positron Emission Tomography (PET) and PET-CT (A-0098)			
Pediatric Pelvis Imaging Guideline	Abdominal/Pelvic CT Angiography (CTA) (A-0475) Abdominal/Pelvic CT Scan (A-0013) Abdominal/Pelvic MRA (A-0032) Pelvic MRI (A-0055)	The transition to MCG care guidelines for pediatric pelvis imaging updates all clinical criteria across diagnostic modalities. While the updated criteria establish a streamlined approach to acute trauma and standard vascular defects, specific updates have been established for specialized clinical scenarios and congenital anomalies . Computed Tomographic Angiography (CTA) Authorization criteria for pelvic CTA have been updated for post-reconstructive surgical assessments. Clinical indications for suspected complications following gender affirmation surgery focus on the diagnostic framework established for general vascular evaluations . Magnetic Resonance Imaging (MRI) Clinical pathways for pediatric MRI have been updated for specific developmental and functional conditions. Authorization for MRI in the assessment of cryptorchidism (undescended testes), voiding dysfunction, and patent urachus is based on the medical necessity indicators established within the current pediatric criteria set . Applicable procedure codes impacted: 72191, 72192, 72193, 72194, 72195, 72196, 72197, 72198, 74176, 74177, 74178, 74712, 74713	**Yes**	**8/17/26**

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EviCore Clinical Guideline	**MCG Care Guideline(s)**	**Revision**	**Substantive Change?**	**Effective Date**
Pediatric Peripheral Nerve and Neuromuscular Disorders (PNND) Imaging Guideline	Abdominal/Pelvic CT Scan (A-0013) Ankle MRI (A-0045) Arm CT Scan (A-0015) Arm MRI (A-0046) Cervical Spine MRI (A-0057) Chest CT Scan (A-0028) Elbow CT Scan (A-0017) Elbow MRI (A-0049) Foot and Foot Joints MRI (A-0050) Hand MRI (A-0447) Hip CT Scan (A-0641) Hip MRI (A-0642) Knee MRI (A-0052) Lower Extremity MRI (A-0053)	The transition to MCG care guidelines for Pediatric PNND imaging updates clinical criteria across diagnostic modalities. While the updated guidelines establish an efficient framework for high-acuity traumatic nerve injuries and metabolic neuromuscular assessments, specific updates have been made to clinical pathways for developmental and metabolic conditions. Magnetic Resonance Imaging (MRI) Authorization criteria for pediatric MRI have been updated to focus on established clinical indicators for neuromuscular conditions. For assessments such as brachial plexus birth injury (BPBI) and longitudinal monitoring for storage disorders like Gaucher Disease, the updated framework utilizes clinical indicators and diagnostic sequences established within the current pediatric criteria set. Applicable procedure codes impacted: 70490, 70491, 70492, 70540, 70543, 70551, 70553, 71250, 71260, 71270, 71550, 71552, 72141, 72146, 72148, 72156, 72157, 72158, 72192, 72193, 72194, 72195, 72197, 73200, 73201, 73202, 73218, 73220, 73221, 73223, 73718, 73720, 73721, 74177, 74178, 74181, 76391, 78815	**Yes**	**8/17/26**

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EviCore Clinical Guideline	**MCG Care Guideline(s)**	**Revision**	**Substantive Change?**	**Effective Date**
	Lumbar Spine MRI (A-0059) Neck CT Scan (A-0022) Neck, Orbit, and Face MRI (A-0054) Neurography, MR (A-1093) Shoulder MRI (A-0056) Thoracic Spine MRI (A-0058) Tumor Imaging Positron Emission Tomography (PET) and PET-CT (A-0098) Wrist CT Scan (A-0029) Wrist MRI (A-0061)			
Pediatric Peripheral Vascular Disease (PVD) Imaging Guideline	Abdominal MRI (A-0044) Abdominal/Pelvic CT Angiography (CTA) (A-0475) Abdominal/Pelvic CT Scan (A-0013)	The transition to MCG care guidelines updates clinical pathways across the pediatric PVD imaging suite. The updated criteria establish a streamlined approach to this imaging, encompassing CT, CTA, MRI, and MRA modalities. This updated framework aligns with clinical protocols for pediatric vascular assessments. Applicable Procedure Codes Impacted:	**Yes**	**8/17/26**

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EviCore Clinical Guideline	**MCG Care Guideline(s)**	**Revision**	**Substantive Change?**	**Effective Date**
	Abdominal/Pelvic MR Angiography (MRA) (A-0032) Brain MRI (A-0047) Cardiac MRI (A-0051) Chest CT Angiography (CTA) (A-0471) Chest CT Scan (A-0028) Chest MR Angiography (MRA) (A-0035) Chest MRI (A-0446) Face and Sinuses CT Scan (A-0018) Foot and Foot Joints MRI (A-0050) Head CT Angiography (CTA) (A-0484) Head MR Angiography (MRA) (A-0033)	70486, 70496, 70498, 70540, 70543, 70544, 70545, 70546, 70547, 70548, 70549, 70551, 70553, 71250, 71260, 71275, 71550, 71552, 71555, 72148, 72158, 72191, 72193, 72194, 72195, 72197, 72198, 73206, 73225, 73706, 73718, 73720, 73721, 73723, 73725, 74160, 74174, 74175, 74176, 74177, 74178, 74181, 74183, 74185, 75557, 75561, 75635, 78803, 78815, 78816		

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EviCore Clinical Guideline	**MCG Care Guideline(s)**	**Revision**	**Substantive Change?**	**Effective Date**
	Lower Extremity CT Angiography (CTA) (A-0474) Lower Extremity MR Angiography (MRA) (A-0037) Lumbar Spine MRI (A-0059) Neck CT Angiography (CTA) (A-0470) Neck MR Angiography (MRA) (A-0034) Neck, Orbit, and Face MRI (A-0054) Pelvic MRI (A-0055) Upper Extremity CT Angiography (CTA) (A-0473) Upper Extremity MR Angiography (MRA) (A-0485)			