

## AmeriHealth Caritas Louisiana

National Imaging Associates, Inc.*	
Clinical guidelines UPPER EXTREMITY MRI (Hand, Wrist, Arm, Elbow, Long bone, or Shoulder MRI)	Original Date: September 1997
CPT Codes: 73218, 73219, 73220, 73221, 73222, 73223, +0698T	Last Revised Date: May 2021
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**INDICATIONS FOR UPPER EXTREMITY MRI (HAND, WRIST, ARM, ELBOW or SHOULDER) (Plain radiographs must precede MRI evaluation)**

Some indications are for MRI, CT, or MR or CT Arthrogram. More than one should not be approved at the same time.

If an MR Arthrogram fits approvable criteria below, approve as MRI.

**Joint specific provocative orthopedic examination ([see Table 1](#))**

**Note:** With a positive orthopedic sign, an initial x-ray is always preferred. However, it is not required to approve advanced imaging.

- **Shoulder** (Bencardino, 2013; Jain, 2017; Loh, 2016, Somerville, 2017)
  - Any positive test listed
    - Rotator cuff weakness (van Kampen, 2014)
    - Bear hug test
    - Belly press test
    - Drop arm test
    - Full can test
    - Hornblower's sign
    - Internal rotation lag sign
    - Supraspinatus test (e.g., Jobe's or Empty can) in the setting of suspected rotator cuff tear
- **Elbow** (Kane, 2014; Karbach, 2017)

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- Any positive test listed
  - Valgus stress
  - Varus stress
  - Posterolateral rotatory drawer test
  - Milking maneuver
  - Push-up test
- **Wrist** (Pandey, 2014; Ruston, 2013)
  - Any positive test listed
    - Watson test (scaphoid shift test)
    - Scapholunate ballottement test
    - Reagan test (lunotriquetral ballottement test)

**Joint or muscle pain without positive findings on an orthopedic exam as listed above, after x-ray completed**

(Park, 2010; Pieters, 2020)

- Persistent joint or musculotendinous pain unresponsive to conservative treatment\*, within the last 6 months which includes active medical therapy (physical therapy, chiropractic treatments, and/or physician-supervised exercise\*\*) of at least four (4) weeks, OR
- With progression or worsening of symptoms during the course of conservative treatment.

**Other Specific Shoulder Conditions which are approvable after active conservative therapy (above) and x-ray:**

- Shoulder Impingement—Hawkin’s, Neer’s, Painful arc, Load and shift, and Yocum tests
- Non-Traumatic Shoulder Instability—Sulcus, Surprise, Anterior or Posterior draw, Apprehension, Anterior slide, Clunk, Crank, Empty can, HERI (hyperextension-internal rotation) tests
- Glenoid labral tear (i.e., SLAP lesion)—Apprehension, Relocation, Surprise, O’Brien’s, Superior labral, Anterior slide, Jerk, Compression rotation, Crank tests

**Shoulder Dislocations**

(Galvin, 2017; Kilocyne, 2017)

- Recurrent
- First time in any of the situations below that increase the risk or repeated dislocation
  - Glenoid or humeral bone loss on x-ray
  - 14-35 year-old competitive contact sport athlete

**Extremity Mass**

- Mass or lesion after non-diagnostic x-ray or ultrasound (Murphey, 2018)
  - If superficial, then ultrasound is the initial study
  - If deep, then x-ray is the initial study

### **Known Cancer of the Extremity**

(Bestic, 2019; Fitzgerald, 2015; Holzapfel, 2015; Kircher, 2012; [NCCN, 2019](#))

- Cancer staging
- Cancer restaging
- Signs or symptoms of recurrence

### **Infection of Bone or Joint**

(Beaman, 2017; Dodwell, 2013; Gludemans, 2019)

- Abnormal x-ray or ultrasound
- Negative x-ray but with a clinical suspicion of infection
  - Signs and symptoms of joint or bone infection include:
    - Pain and swelling
    - Decrease range of motion
    - Fever
  - Laboratory findings of infection include:
    - Elevated ESR or CRP
    - Elevated white blood cell count
    - Positive joint aspiration
- **Ulcer (diabetic, pressure, ischemic, traumatic) with signs of** infection (redness, warm, swelling, pain, discharge which may range from white to serosanguineous) that is not improving despite treatment and bone or deep infection is suspected
  - Increased suspicion if size or temperature increases, bone is exposed/positive probe-to-bone test, new areas of breakdown, new smell (Bowers, 2020)

### **Osteonecrosis (e.g., Avascular necrosis (AVN))**

(Felten, 2019; Murphey, 2014; 2016)

- Abnormal x-ray
- Normal x-rays but symptomatic and high-risk (e.g., glucocorticosteroid use, renal transplant recipient, glycogen storage disease, alcohol abuse (Fukushima, 2010), sickle cell anemia (Wali, 2011))

### **For evaluation of known or suspected autoimmune disease (e.g., rheumatoid arthritis)**

(Colebatch, 2013; Narvaez, 2010)

- Further evaluation of an abnormality or non-diagnostic findings on prior imaging
- Initial imaging of a single joint for diagnosis or response to therapy after plain films and appropriate lab tests (e.g., RF, ANA, CRP, ESR)
- Follow-up to determine treatment efficacy in the following:
  - Early rheumatoid arthritis
  - Advanced rheumatoid arthritis if x-ray and ultrasound are equivocal or noncontributory

### **Bone Fracture or Ligament Injury**

- Suspected stress or insufficiency fracture with a negative initial x-ray (Bencardino, 2017; Sadineni, 2015; Yin, 2010)
  - Repeat x-rays in 10-14 days if negative or non-diagnostic
- Pathologic fracture on x-ray (Fayad, 2005)
- Intraarticular fractures that may require surgery
- Suspected scaphoid fracture with negative x-rays
- Nonunion or delayed union as demonstrated by no healing between two sets of x-rays. If a fracture has not healed by 4-6 months, there is delayed union. Incomplete healing by 6-8 months is nonunion (Morshed, 2014).
- Clinical suspicion based on mechanism of injury and physical findings and x-ray completed
  - TFCC (triangular fibrocartilage complex) injury (Barlow, 2016; Ng, 2017)

### **Occult wrist ganglion, after indeterminate ultrasound**

(Meena, 2014)

- Clinical suspicion and failed 4 weeks conservative treatment including all of the below:
  - Activity modification
  - Rest, ice, or heat
  - Splinting or orthotics
  - Medication

**Osteochondral Lesions** (defects, fractures, osteochondritis dissecans) and x-ray completed (Smith, 2012; Taljanovic, 2019; Van Dijk, 2010; Van Bergen, 2016)

- Clinical suspicion based on mechanism of injury and physical findings
- Loose bodies or synovial chondromatosis seen on x-ray or ultrasound
  - In the setting of joint pain (Rajani, 2016)

### **Foreign Body**

(Laya, 2017)

- Indeterminate x-ray and ultrasound

### **Tendon or Muscle Rupture after x-ray**

(Garras, 2012; Peck, 2017; Wilkins, 2012)

- Clinical suspicion based on mechanism of injury and physical findings (i.e., Popeye, Hook, Yergasons sign)

### **Peripheral Nerve Entrapment (e.g., carpal tunnel)**

(Domkundwar, 2017; Dong, 2012, Donovan, 2010; Meyer, 2018; Tos, 2015)

- Abnormal electromyogram or nerve conduction study
- Abnormal x-ray or ultrasound
- Clinical suspicion and failed 4 weeks conservative treatment including at least two of the following (active treatment with physical therapy is not required):

- Activity modification
- Rest, ice, or heat
- Splinting or orthotics
- Medication

### **Brachial Plexopathy**

(Mansukhani, 2013; Vijayasarithi, 2016)

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

### **Pre-operative/procedural evaluation**

- Pre-operative evaluation for a planned surgery or procedure

### **Post-operative/procedural evaluation**

- When imaging, physical or laboratory findings indicate joint infection, delayed or non-healing or other surgical/procedural complications
- Joint prosthesis loosening or dysfunction, x-rays non-diagnostic (Fritz, 2014; 2015)

## **Table 1: Positive Orthopedic Joint Tests, Upper Extremity**

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### **ELBOW**

Moving valgus stress test  
 Hook test  
 Passive forearm pronation  
 Biceps squeeze test  
 Biceps Aponeurosis (BA) flex test  
 Table top relocation test

### **SHOULDER**

Drop Arm Test  
 External rotation lag sign 0 and 90 degrees  
 Full can test  
 Hook test  
 HornsbLOWER test  
 Internal rotation lag sign  
 Lift off test  
 Popeye sign

### **WRIST**

Snuff box pain (after initial x-ray)  
 Derby relocation test

Ulnar foveal sign/test  
Press test  
Ulnocarpal stress test (if concern for TFCC tear)

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## **BACKGROUND**

Magnetic resonance imaging shows the soft tissues and bones. With its multiplanar capabilities, high contrast, and high spatial resolution, it is an accurate diagnostic tool for conditions affecting the joint and adjacent structures. MRI can positively influence clinicians' diagnoses and management plans for patients with conditions such as primary bone cancer, fractures, abnormalities in ligaments/tendons/cartilage, septic arthritis, and infection/inflammation.

## **OVERVIEW**

**\*Conservative Therapy:** (musculoskeletal) should include a multimodality approach consisting of a combination of active and inactive components. Inactive components such as rest, ice, heat, modified activities, medical devices, (including crutches, immobilizer, metal braces, orthotics, rigid stabilizer, or splints, etc. and not to include neoprene sleeves), medications, injections (bursal, and/or joint, not including trigger point), and diathermy, can be utilized. Active modalities may consist of physical therapy, a physician-supervised home exercise program\*\*, and/or chiropractic care.

**\*\*Home Exercise Program - (HEP)** – the following two elements are required to meet guidelines for completion of conservative therapy:

- Information provided on exercise prescription/plan AND
- Follow up with member with information provided regarding completion of HEP (after suitable 4-week period), or inability to complete HEP due to physical reason- **i.e.**, increased pain, inability to physically perform exercises. (Patient inconvenience or noncompliance without explanation does not constitute "inability to complete" HEP).

**Rotator Cuff Tears** – 3.0 Tesla MRI has been found valuable for the detection of partial thickness rotator cuff tendon tears and small rotator cuff tendon tears. It is especially useful in detecting the partial tears due to increased spatial resolution. Increased spatial resolution results in precise measurements of rotator cuff tendon tears in all 3 planes, and it also reduces acquisition time which reduces motion artifacts. 3.0 Tesla makes it possible to adequately evaluate tendon edges and avoid underestimation of tears. MRI is less invasive than MR arthrography, and it is faster and less expensive. MRI may be useful in the selection of patients that may benefit from arthroscopy.

**MRI and Occult Fractures** – Magnetic resonance imaging may help to detect occult fractures of the elbow when posttraumatic elbow effusions are shown on radiographs without any findings of fracture. Effusions may be visualized on radiographs as fat pads, which can be elevated by the presence of fluid in the joint caused by an acute fracture. MRI may be useful when

effusions are shown on radiographs without a visualized fracture, but there is a clinical suspicion of a lateral condylar or radial head fracture.

**MRI and Avascular Necrosis** – Sports, such as racquetball and gymnastics, may cause repeated microtrauma due to the compressive forces between the radial head and capitellum. Focal avascular necrosis and osteochondritis dissecans of the capitellum may result. MRI can be used to evaluate the extent of subchondral necrosis and chondral abnormalities. The images may also help detect intraarticular loose bodies.

**MRI and Acute Osseous Trauma** – Many elbow injuries result from repetitive microtrauma rather than acute trauma, and the injuries are sometimes hard to diagnose. Non-displaced fractures are not always evident on plain radiographs. When fracture is suspected, MRI may improve diagnostic specificity and accuracy. T1-weighted images can delineate morphologic features of the fracture.

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

**Adhesive Capsulitis a.k.a. Frozen Shoulder** (Ramirez, 2019; Redler, 2019; Small, 2018) - MRI is the preferred modality for imaging after a failure of improvement with active conservative therapy. Affected patients have impaired range of shoulder motion with forward flexion, abduction, and external and internal rotation which may be associated with pain. Clinically, it can be distinguished from rotator cuff pathology, where passive range of motion is preserved, or neoplasm which may also have associated fever or weight loss. Treatment is with a combination of intracapsular steroid injection and active conservative care. Anti-inflammatory medications are also given to facilitate active treatment. When nonsurgical management, including anti-inflammatory medication, active care (physical therapy, a supervised home exercise program or manipulations), and injections, have failed to provide relief of symptoms by 9 to 12 months, surgical intervention is indicated, but this represents the minority of patients.

**The American Academy of Pediatrics “Choosing Wisely” Guidelines** advise against ordering advanced imaging studies (MRI or CT) for most musculoskeletal conditions in a child until all appropriate clinical, laboratory and plain radiographic examinations have been completed. “History, physical examination, and appropriate radiographs remain the primary diagnostic modalities in pediatric orthopedics, as they are both diagnostic and prognostic for the great majority of pediatric musculoskeletal conditions. Examples of such conditions would include, but not be limited to, the work up of injury or pain (spine, knees, and ankles), possible infection, and deformity. MRI examinations and other advanced imaging studies frequently require sedation in the young child (5 years old or less) and may not result in appropriate

interpretation if clinical correlations cannot be made. Many conditions require specific MRI sequences or protocols best ordered by the specialist who will be treating the patient. If you believe findings warrant additional advanced imaging, discuss with the consulting orthopedic surgeon to make sure the optimal studies are ordered (AAP, 2018).”

**POLICY HISTORY**

Date	Summary
May 2021	<ul style="list-style-type: none"> <li>• <b>Additional signs for rotator cuff tear that are considered useful</b></li> <li>• <b>Removed signs for impingement, shoulder instability and glenoid labral tear since active conservative therapy should be done first</b></li> <li>• <b>Added section about impingement, nontraumatic shoulder instability and glenoid labral tear requiring active conservative therapy</b></li> <li>• <b>Added information for the following: shoulder dislocation; suspected bone infection in the setting of ulcers and neuropathy; brachial plexopathy; treatment for rheumatoid arthritis</b></li> </ul>
May 2020	<ul style="list-style-type: none"> <li>• <b>Expanded the list of orthopedic signs and Added note: With a positive orthopedic sign, an initial x-ray is always preferred. However, it is not required to approve advanced imaging.</b></li> <li>• <b>Added information about adhesive capsulitis</b></li> <li>• <b>Clarified that if an MR Arthrogram fits approvable criteria, approve as MRI.</b></li> <li>• <b>Revised the information about an evaluation of an extremity mass.</b></li> </ul>
May 2019	<ul style="list-style-type: none"> <li>• <b>Added initial statement about approvals: ‘Some indications are for MRI, CT, or MR or CT Arthrogram. More than one should not be approved at the same time’.</b></li> <li>• <b>Expanded Extremity mass indications including peripheral lymphadenopathy; and mass with increased risk for malignancy</b></li> <li>• <b>Added indications for foreign body and peripheral nerve entrapment</b></li> <li>• <b>Modified Known Cancer indication to be more broad – ‘cancer staging, cancer restaging, signs or symptoms of recurrence’</b></li> <li>• <b>Expanded sections for bone fracture and infection of bone or joint to include list of signs or symptoms and laboratory findings (elevated ESR or CRP, elevated white blood cell count, positive joint aspiration)</b></li> </ul>





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**Reviewed / Approved by NIA Clinical Guideline Committee**



## GENERAL INFORMATION

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

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