



# CIGNA MEDICAL COVERAGE POLICY

The following Coverage Policy applies to all health benefit plans administered by CIGNA Companies including plans formerly administered by Great-West Healthcare, which is now a part of CIGNA.

**Subject Magnetic Resonance  
Cholangiopancreatography  
(MRCP)**

**Effective Date ..... 2/15/2011  
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Coverage Policy Number ..... 0306**

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## Hyperlink to Related Coverage Policies

### INSTRUCTIONS FOR USE

Coverage Policies are intended to provide guidance in interpreting certain **standard** CIGNA HealthCare benefit plans. Please note, the terms of a customer's particular benefit plan document [Group Service Agreement (GSA), Evidence of Coverage, Certificate of Coverage, Summary Plan Description (SPD) or similar plan document] may differ significantly from the standard benefit plans upon which these Coverage Policies are based. For example, a customer's benefit plan document may contain a specific exclusion related to a topic addressed in a Coverage Policy. In the event of a conflict, a customer's benefit plan document **always supercedes** the information in the Coverage Policies. In the absence of a controlling federal or state coverage mandate, benefits are ultimately determined by the terms of the applicable benefit plan document. Coverage determinations in each specific instance require consideration of 1) the terms of the applicable benefit plan document in effect on the date of service; 2) any applicable laws/regulations; 3) any relevant collateral source materials including Coverage Policies and; 4) the specific facts of the particular situation. Coverage Policies relate exclusively to the administration of health benefit plans. Coverage Policies are not recommendations for treatment and should never be used as treatment guidelines. Proprietary information of CIGNA. Copyright ©2011 CIGNA

## Coverage Policy

**CIGNA covers magnetic resonance cholangiopancreatography (MRCP) as medically necessary for ANY of the following indications:**

- evaluation of suspected or known biliopancreatic pathology when there is a low or moderate probability that endoscopic retrograde cholangiopancreatography (ERCP) will be needed (e.g., individual with a low to moderate probability of having choledocholithiasis, individual with pancreatitis of unknown etiology)
- ERCP is indicated but is not available, is contraindicated or is expected to be difficult (e.g., suspected or known anatomical or structural impediment such as congenital anomaly or post-surgical changes, severe cardiopulmonary disease, coagulopathy, pregnant individual, allergy to iodinated contrast material, uncooperative individual which may include the very young or very old)
- ERCP was recently attempted but could not be successfully completed

## General Background

Magnetic resonance cholangiopancreatography (MRCP) is a type of magnetic resonance imaging (MRI) exam that produces detailed images of the hepatobiliary and pancreatic systems, including the liver, gallbladder, bile ducts, pancreas and pancreatic duct. Usually following a suspicious abdominal ultrasound, MRCP is an established, noninvasive tool for the evaluation of biliary and pancreatic pathology.

Endoscopic retrograde cholangiopancreatography (ERCP) is an invasive procedure, involving passage of a thin, flexible scope through the mouth and into the duodenum, where it is used to evaluate the common bile duct or pancreatic duct. The overall complication rate for ERCP alone is approximately 3%; when endoscopy is also performed, the complication rate increases to approximately 8%, with a corresponding mortality rate of about 0.4%. An advantage of ERCP is that therapeutic maneuvers (e.g., gallstone extraction, stenting, balloon dilation, nasobiliary or nasopancreatic drainage, or tissue ablation or resection) can be performed at the time of the diagnostic procedure. ERCP continues to be the preferred diagnostic approach when there is a high suspicion of disease requiring intervention.

The diagnostic performance of MRCP is comparable with ERCP and MRCP does not expose the patient to the risks associated with invasive procedures such as ERCP or endoscopic ultrasound. Computed tomographic intravenous cholangiography (CT-IVC) is non-invasive but does require the use of contrast agents and radiation. There is no radiation exposure with MRCP and no contrast medium has to be administered for MRCP, but contrast may be used. Contrast enhanced-MRCP, as with CT-IVC, depends on near-normal hepatocyte function. Where available, MRCP has become the investigation of choice for many conditions when evaluating biliopancreatic disease, replacing diagnostic-only ERCP. Common MRCP indications include:

- the diagnosis of congenital and developmental biliary and pancreatic anomalies
- choledocholithiasis, particularly in patients with a low to intermediate probability of having choledocholithiasis, to exclude stones and prevent these patients from being subjected to an unnecessary ERCP procedure and its associated complications
- neoplasms
- post-surgical conditions, because ERCP is either difficult or impossible to perform in patients who have undergone certain surgical procedures because of unfavorable anatomy. Duodenal and gastric obstruction and anatomic variants such as juxta-ampullary diverticula and choledochal cysts also may contraindicate ERCP. In these cases, MRCP can provide useful information. MRCP also can be used to evaluate for late biliary complications after liver transplantation
- intrahepatic biliary disease – (e.g., primary sclerosing cholangitis)
- acute and chronic pancreatitis – acute (congenital abnormalities associated with pancreatitis, such as pancreas divisum and anomalous pancreatobiliary junction) chronic (ductal changes) (Sahni, et al., 2008).

### **U.S. Food and Drug Administration (FDA)**

MRI systems are regulated by the U.S. Food and Drug Administration (FDA) as Class II devices, and a large number of these systems have been approved via the FDA 510(k) process.

### **Literature Review**

Evidence in the peer-reviewed scientific literature demonstrates the safety, accuracy and clinical utility of MRCP. Compared with ERCP, MRCP is safer, without the risks associated with an invasive ERCP. The diagnostic accuracy of MRCP is considered to be equivalent to that of ERCP for a wide range of pancreatic and biliary ductal diseases. MRCP and ERCP both demonstrate high accuracy rates compared with surgical/pathology findings. Additionally, MRCP aids in treatment planning, as it can reliably be used as a first-line tool to identify the most appropriate therapeutic approach—ERCP, surgery, or continued medical management. If no therapeutic intervention is found to be necessary, MRCP avoids the potential morbidity and mortality associated with ERCP. Therefore, MRCP is an appropriate noninvasive tool with suspected biliopancreatic pathology when lower versus higher likelihood of therapeutic intervention is anticipated. MRCP is particularly useful where ERCP is hazardous or impossible (e.g., patient with anatomical or structural impediments, such as a previous gastroenteric anastomosis or gastrojejunostomy or congenital anomaly). It is also an important option for patients who failed ERCP. Previous surgery (e.g., Billroth II, Roux-en-Y or biliary-enteric anatomy), duodenal stenosis, or duodenal diverticulum make cannulation of the ducts difficult or even impossible and increase the risk of complications. ERCP and MRCP have different contraindications, allowing them to be used as complementary techniques (Repiso Ortega, et al., 2010; Maurea, et al., 2009; De Waele, et al., 2007; Kaltenthaler, et al., 2006; Verma, et al., 2006; Shanmugam, et al., 2005; Domagk, et al., 2004; Kaltenthaler, et al., 2004; Griffin, et al., 2003; Romagnuolo, et al., 2003; Rosch, et al., 2002; Taylor, et al., 2001; Farrell, et al., 2001).

### **Professional Societies/Organizations**

**American College of Gastroenterology (ACG):** In their practice guideline on acute pancreatitis, the ACG suggested indications for endoscopic ultrasound (EUS) or MRCP to determine the need for ERCP include:

- clinical course not improving sufficiently to allow timely laparoscopic cholecystectomy and intraoperative cholangiogram
- pregnant patient
- high-risk or difficult ERCP (e.g., coagulopathy, altered surgical anatomy)
- uncertainty regarding biliary etiology of pancreatitis (Banks, et al., 2006)

In the ACG practice guidelines for the diagnosis and management of neoplastic pancreatic cysts (Khalid and Brugge, 2007), the usefulness of MRCP is discussed (e.g., branch-duct intraductal papillary mucinous neoplasms, mucinous cystic neoplasms).

**American Gastroenterological Association (AGA):** In their Medical Position Statement on Acute Pancreatitis (2007), the AGA states the internal consistency of these necrotic collections is best determined by EUS or MRI. Regarding prevention of post-ERCP pancreatitis, the AGA notes that “ERCP should be avoided if alternative diagnostic tests (in particular, CT, MRCP, or EUS) can provide similar diagnostic information.”

**American College of Radiology (ACR):** ACR Appropriateness Criteria for Jaundice (revised 2008) notes that MRI can demonstrate both the site and cause of biliary obstruction. MR cholangiography has been shown to be useful in depicting the three-dimensional anatomy of the biliary and pancreatic ducts. MRCP is the most sensitive of the noninvasive techniques for detection of ductal calculi and may decrease the number of ERCP studies obtained prior to elective cholecystectomy. The ACR cites Shanmugam et al. (2005); noting studies recommended MRCP as the preferred test in patients with a high likelihood of choledocholithiasis. The ACR also notes that MRCP is valuable in both the clinical situation of failed ERCP and in patients with hilar biliary obstruction due to ductal tumor or periductal compression.

The ACR Appropriateness Criteria for Acute Pancreatitis (updated 2006) states MRCP has a high accuracy rate in detecting bile duct stones. Regarding pancreatic necrosis and evaluating peripancreatic inflammation and fluid collections, the integrity of the pancreatic duct can be assessed by means of MRCP in an MRI study. The ACR states “this is important, since in previous studies pancreatic duct rupture was reported in about 30% of patients with acute pancreatitis.”

ACR Practice Guideline for the performance of Magnetic Resonance Imaging (MRI) of the Abdomen (excluding the liver) (amended 2010) states that the addition of a heavily T2-weighted MRCP sequence may be beneficial for evaluation of the biliary and pancreatic ducts.

**American Society for Gastrointestinal Endoscopy (ASGE):** The Role of Endoscopy in the Evaluation of Suspected Choledocholithiasis Guideline (2010) states that patients at intermediate probability of choledocholithiasis (10%-50%) after initial evaluation benefit from additional biliary imaging to further triage the need for ductal stone clearance. Failure to identify common bile duct stones can result in recurrent symptoms, cholangitis, and acute biliary pancreatitis. MRCP is one of several options for evaluation.

The Role of Endoscopy in the Bariatric Surgery Patient Guideline (2008) notes that an ERCP is difficult in patients who had an Roux-en-Y gastrojejunal bypass (RYGB), and an MRCP should be performed in cases where other noninvasive imaging studies are inconclusive (e.g., for choledocholithiasis).

The Role of Endoscopy in Patients with Chronic Pancreatitis Guideline (Adler, 2006), states that ERCP should be reserved for patients in whom the diagnosis is still unclear after noninvasive pancreatic function testing or other noninvasive (CT/MRI) or less invasive (EUS) imaging studies have been performed.

The Role of ERCP in Diseases of the Biliary Tract and the Pancreas Guideline (Adler, et al., 2005) notes that regarding recurrent acute pancreatitis, “ideally, ERCP should be reserved for treatment of abnormalities found by less invasive imaging techniques. EUS and MRCP allow pancreatic and biliary anatomy to be defined noninvasively, without risk of pancreatitis and radiation exposure, and may detect microlithiasis, choledocholithiasis, unsuspected chronic pancreatitis, and, in some cases, pancreas divisum and annular pancreas. ERCP may still be required to obtain definitive imaging of the ductal anatomy. One should anticipate

the need to perform manometry, minor papilla cannulation, pancreatic sphincterotomy, or pancreatic-duct stent placement.”

The Role of Endoscopy in the Evaluation and Treatment of Patients with Pancreaticobiliary Malignancy states the following recommendation: “If the CT suggests cholangiocarcinoma, particularly of the bifurcation, an MRCP should be obtained to assess for resectability. If unresectable, endoscopic palliation of jaundice should be performed using the MRCP as a guide to unilateral drainage to minimize cholangitis” (based upon prospective controlled trials [Baron, et al., 2003]).

**National Institutes of Health (NIH):** The NIH published a state-of-the-science statement on ERCP for diagnosis and therapy in 2002. The NIH noted that both MRCP and EUS have been evaluated for the detection of common bile duct stones using ERCP as the reference standard. The sensitivity and specificity of these techniques exceed 90 percent when compared with ERCP. Some statements regarding MRCP included:

- For patients with suspected biliary pain who have had prior cholecystectomy and have low probabilities of common bile duct stones, diagnostic modalities less invasive than ERCP (i.e., MRCP or EUS) are preferred.
- The detection and staging of pancreatic and biliary tract cancers are best accomplished with contrast-enhanced CT scanning, MRCP, or EUS, but not ERCP. These modalities are relatively new and are based on technology that will continue to evolve, but it is clear that state-of-the-art, less invasive imaging is preferable to ERCP for diagnosis and staging in the overwhelming majority of cases.
- In patients who present with the typical findings of acute pancreatitis (elevated pancreatic enzymes, abdominal pain), ERCP has no role except when the diagnosis of acute biliary pancreatitis with concomitant cholangitis is suspected. Noninvasive imaging studies are the preferred diagnostic modalities, because these tests can define the pancreatic anatomy and the extent of the disease, can diagnose and quantify necrosis, and can determine whether pseudocysts are present.
- When the etiology of recurrent pancreatitis has not been defined by history (e.g., drugs, alcohol, family history), laboratory tests (e.g., calcium, triglycerides), and adequate pancreaticobiliary imaging (e.g., abdominal ultrasonography, CT), further evaluation may be considered. Potential causes include biliary stones, microlithiasis, pancreas divisum, small neoplasms, or sphincter of Oddi dysfunction. Various anatomic abnormalities can also cause recurrent pancreatitis. MRCP or EUS should be undertaken. If the imaging study is negative, then ERCP with sphincter of Oddi manometry can be considered.
- For the patient who presents with chronic abdominal pain or the possibility of pancreatic insufficiency (e.g., diabetes, malabsorption), the diagnosis of chronic pancreatitis should be considered. ERCP, MRI/MRCP, EUS, and CT have high degrees of accuracy for diagnosing structural abnormalities. There may be little correlation between the severity of symptoms and the abnormalities seen on the study.

## Summary

Studies in the published, peer-reviewed scientific literature support the safety, accuracy and clinical utility of MRCP for numerous biliopancreatic pathologies. MRCP aids in treatment planning and can help avoid unnecessary invasive procedures. MRCP is an appropriate noninvasive tool for suspected biliopancreatic pathology when there is little likelihood that therapeutic intervention will be required. If no therapeutic intervention is anticipated, MRCP avoids the potential morbidity and mortality associated with ERCP. Also, MRCP would, therefore, be appropriate if ERCP is anticipated to be difficult (e.g., patient with anatomical or structural impediment, such as a previous gastroenteric anastomosis, or gastrojejunostomy).

## Coding/Billing Information

**Note:** This list of codes may not be all-inclusive.

**Covered when medically necessary:**

CPT <sup>®</sup> * Codes	Description
74181†	Magnetic resonance (eg, proton) imaging, abdomen; without contrast material(s)
76498†	Unlisted magnetic resonance procedure (eg, diagnostic, interventional)

†Note: Covered when medically necessary and used to report magnetic resonance cholangiopancreatography (MRCP).

HCCPS Codes	Description
S8037	Magnetic resonance cholangiopancreatography (MRCP)

ICD-9-CM Diagnosis Codes	Description
156.0 – 156.9	Malignant neoplasm of gallbladder and extrahepatic bile ducts
157.0 – 157.9	Malignant neoplasm of pancreas
230.8	Carcinoma in situ of liver and biliary system
571.6	Biliary cirrhosis
574.00-574.91	Cholelithiasis
575.0- 575.9	Other disorders of gallbladder
576.0- 576.9	Other disorders of biliary tract
577.0- 577.9	Diseases of pancreas
751.60 – 751.69	Congenital anomalies of gallbladder, bile ducts, and liver
751.7	Congenital anomalies of pancreas
V12.3	Diseases of blood and blood-forming organs
V12.50	Personal history of certain other diseases; Unspecified circulatory disease
V15.08	Personal history of allergy to radiographic dye
V22.2	Pregnant state, incidental

\*Current Procedural Terminology (CPT®) ©2010 American Medical Association: Chicago, IL.

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## Policy History

<b>Pre-Merger Organizations</b>	<b>Last Review Date</b>	<b>Policy Number</b>	<b>Title</b>
CIGNA HealthCare	2/15/2008	0306	Magnetic Resonance Cholangiopancreatography (MRCP)

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