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Subject: Computed Tomography (CT) Abdomen and Pelvis

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DESCRIPTION:

Computed tomography (CT) is a radiologic modality that provides clinical information in the detection, differentiation and demarcation of disease. CT is a form of medical imaging that involves the exposure of members to ionizing radiation. CT should only be performed under the supervision of a physician with training in radiation protection to optimize examination safety. Radiation exposure should be taken into account when considering the use of this technology. This guideline addresses the use of CT of the abdomen and pelvis for evaluation, diagnosis and management of abdomen and pelvis related conditions in the outpatient setting.

POSITION STATEMENT:

Computed tomography (CT) of the abdomen, pelvis and abdomen and pelvis **meets the definition of medical necessity** for the diagnosis and evaluation of the following:

Abdomen CT

Indications for Abdomen CT

Evaluation of suspicious known mass/tumors (unconfirmed diagnosis of cancer) for further evaluation of indeterminate or questionable findings

- Initial evaluation of papable abdominal or abdominal wall mass/tumor found by physical exam or imaging study, such as ultrasound (US).

- Surveillance: One follow-up exam to ensure no suspicious change has occurred in a tumor in the abdomen. No further surveillance unless tumor(s) are specified as highly suspicious, or change was found on exam or last follow-up imaging.

Evaluation of known cancer for further evaluation of indeterminate or questionable findings, identified by physical examination or imaging exams such as ultrasound (US)

- Initial staging of known cancer
    - All cancers, excluding the following:
        - Basal cell carcinoma of the skin;
        - Melanoma without symptoms or signs of metastasis.
- Follow-up of known cancer:
    - Follow-up of known cancer of member undergoing active treatment within the past year.
    - Known cancer with suspected abdominal metastasis based on a sign, symptom or an abnormal lab value.
    - Active monitoring for recurrence as clinically indicated.

Evaluation of suspected infection or inflammatory disease based on exam or discovered on previous imaging

- Right upper quadrant pain for suspected biliary disease with negative or equivocal ultrasound or HIDA scan.
- Suspected cholecystitis or retained gallstones with recent equivocal ultrasound.
- Epigastric or left upper quadrant pain if labs or other imaging are inconclusive.

Evaluation of an organ or abnormality seen on previous imaging

Adrenal

- To locate a pheochromocytoma once there is clear biochemical evidence (may require abdomen and pelvis imaging).
- Suspected adrenal mass ≥ 1 cm incidentally discovered with no history of malignancy (one follow-up in 6-12 months to document stability).
- If adrenal mass ≥ 4 cm and no diagnosis of cancer, can approve for preoperative planning (surgery to rule out adrenal cortical carcinoma).
- Adrenal mass < 4 cm with history of malignancy (if ≥ 4 cm consider biopsy or PET/CT unless pheochromocytoma is suspected).

Liver

Indeterminate liver lesion > 1 cm seen on ultrasound (MRI study of choice but CT can be approved)

- Hepatitis/hepatoma screening after ultrasound is abnormal, equivocal, or non-diagnostic (may be limited in patients who are obese, those with underlying hepatic steatosis, as well as nodular livers).
- Jaundice or abnormal liver function tests after equivocal or abnormal ultrasound.
- Follow up of suspected adenoma every 6-12 months.

- To confirm diagnosis of focal nodular hyperplasia seen on other imaging.
- Follow-up of focal nodular hyperplasia (FNH) annually if US is inconclusive.
- Surveillance of HCC in members who have received liver-directed therapy, surgical resection, medical treatment or transplant (MRI or CT) at one month post treatment and then every 3 months for up to two years.

Pancreas

- Pancreatic cystic lesion found on initial imaging.
- Intraductal papillary mucinous neoplasm (IPMN) and mucinous cystic neoplasm (MCN) require surveillance imaging as follows (if MRI is contraindicated) if indeterminate on initial imaging and duct communication is present:
    - Cysts under 1.5cm separated by age: < 65 with follow up yearly and 65-79 with follow-up every 2 years.
- Cysts that are 1.5-1.9 cm followed yearly for 5 years, then every 2 years for 4 years.
- Lesions 20 mm to < 30 mm MRI/CT or EUS biannually for 1 year, then every year until stable.
- Lesions ≥ 30 mm MRI/CT or EUS every 6 months.
- Yearly surveillance for members determined to have greater than 5% lifetime risk of developing pancreatic cancer starting at age 50, or 10 years younger than the earliest age of cancer affected first degree relative (except with Peutz-Jeghers start at age 35).
- Suspected acute pancreatitis with pain and abnormal amylase and lipase and <48-72 hours if ultrasound is inconclusive.
- Presentation with atypical signs and symptoms including equivocal amylase and lipase.
- Known necrotizing pancreatitis requiring follow-up.
- Pancreatitis by history (including pancreatic pseudocyst) with abdominal pain suspicious for worsening, or reexacerbation.

Renal

- An indeterminate renal mass on other imaging.
- Active surveillance for members with tuberous sclerosis and known angiomyolipomas if MRI is contraindicated.
- Follow-up for solid renal masses under 1 cm at 6 and 12 months then annually.

Spleen

- Incidental findings of the spleen that are indeterminate on other imaging.

Other indications for an abdominal CT

- Occult hernia when physical exam or prior imaging (ultrasound and MRI) is non-diagnostic or equivocal and limited to the abdomen.

Evaluation of suspected infection or for follow-up known infection

- Persistent abdominal pain not explained by previous imaging/procedure.
- Any known infection that is clinically suspected to have created an abscess in the abdomen.

- Any history of fistula limited to the abdomen that requires re-evaluation, or is suspected to have recurred. Abnormal fluid collection limited to the abdomen seen on prior imaging that needs follow-up evaluation.
- Diagnosis of diverticulitis or appendicitis in an adult if abdominal pain and tenderness to palpation is present and AT LEAST one of the following:
    - Elevated WBC
    - Fever
    - Anorexia
    - Nausea and vomiting
- Suspected appendictitis in a child after ultrasound has been obtained.
- Suspected peritonitis (from any cause) if abdominal pain and tenderness to palpation is present, and **AT LEAST** one of the following:
    - Rebound, guarding or rigid abdomen; **OR**
    - Severe tenderness to palpation over the entire abdomen.
- Complications of diverticulitis with severe abdominal pain or severe tenderness or mass, not responding to antibiotic treatment, (prior imaging study is not required for diverticulitis diagnosis.

Evaluation of suspected inflammatory disease or follow-up

- Suspected of inflammatory bowel disease (Crohn's or ulcerative colitis) with abdominal pain, and persistent diarrhea, or bloody diarrhea.
- Known inflammatory bowel disease, (Crohn's or ulcerative colitis) with recurrence or worsening signs/symptoms requiring re-evaluation.

Pre-operative evaluation

- For abdominal surgery or procedure.

Post-operative/procedural evaluation

- Follow-up of known or suspected post-operative complication involving only the abdomen.
- A follow-up study to help evaluate a member's progress after treatment, procedure, intervention or surgery. Documentation requires a medical reason that clearly indicates why additional imaging is needed.

Indication for combination studies for the initial pre-therapy staging of cancer or active monitoring for recurrence as clinically indicated or evaluation of suspected metastases

- ≤5 concurrent studies to include CT or MRI of any of the following areas as appropriate depending on the cancer: neck, abdomen, pelvis, chest, brain, cervical spine, thoracic spine or lumbar spine.

Combination of studies with abdomen CT:

Abdomen CT/Pelvis CT/Chest CT/Neck MRI/Neck CT with MUGA

- Known tumor/cancer for initial staging or evaluation before starting chemotherapy or radiation treatment.

Pelvic CT

Indications for Pelvic CT

Initial staging of prostate cancer

Prostate cancer when PSA levels >10 ng/mLor clinically advanced disease (T2b, T2c, T3 or T4) and nomogram (e.g. Partin table (prostate cancer staging nomogram), cancer of prostate risk assessment CAPRA) indicating probability of lymph node involvement >10%).

Known prostate cancer for workup of recurrence and response to treatment when there is a contraindication for MRI

- Initial treatment by radical prostatectomy:
    - Failure of PSA to fall to undetectable levels or PSA detectable and rising on at least 2 subsequent determinations.
- Initial treatment radiation therapy:
    - Post radiation therapy rising PSA or positive digital exam and is candidate for local therapy.

Evaluation of suspicious known mass/tumors

- Initial evaluation of suspicious pelvic masses/tumors found only in the pelvis by physical exam and ultrasound has been performed or for further evaluation of abnormality seen on ultrasound (US) or when US would be inconclusive.
- Surveillance: One follow-up exam to ensure no suspicious change has occurred in a tumor in the pelvis. No further surveillance CT unless tumor(s) are specified as highly suspicious, or change was found on exam or last follow-up imaging.
- Initial staging of known cancer
    - All cancers, excluding the following:
        - Basal cell carcinoma of the skin
        - Melanoma without symptoms or signs of metastasis
- Follow-up of known cancer
    - Follow-up of known cancer of member undergoing active treatment within the past year.
    - Known cancer with suspected pelvis metastasis based on a sign, symptom or an abnormal lab value.
    - Active monitoring for recurrence as clinically indicated.

Evaluation of suspected infection or inflammatory disease

- Suspected acute appendicitis (or severe acute diverticulitis) in an adult if pelvic pain and tenderness to palpation is present, with **AT LEAST one** of the following:
    - Elevated WBC; **OR**
    - Fever; **OR**
    - Anorexia; **OR**
    - Nausea and vomiting.

- Suspected appendicitis in a child after ultrasound has been obtained.
- Suspected complications of diverticulitis (known to be limited to the pelvis by prior imaging) with pelvic pain or severe tenderness, not responding to antibiotic treatment.
- Suspected perianal fistula.
- Suspected infection in the pelvis (based on elevated WBC, fever, anorexia or nausea and vomiting).
- Suspected inflammatory bowel disease (Crohn's or ulcerative colitis) with abdominal pain and persistent diarrhea or bloody diarrhea.

Evaluation of known infection or inflammatory disease follow-up

- Complications of diverticulitis confined to the pelvis with severe pelvic pain or severe tenderness or mass, not responding to antibiotic treatment, (prior imaging study is not required for diverticulitis diagnosis).
- Known inflammatory bowel disease, (Crohn's or ulcerative colitis) with recurrence or worsening signs/symptoms requiring re-evaluation.
- Known infection that is clinically suspected to have created an abscess in the pelvis.
- History of fistula limited to the pelvis that requires re-evaluation or is suspected to have recurred.
- Abnormal fluid collection seen on prior imaging that needs follow-up evaluation.
- Known infection in the pelvis.

Evaluation of known or suspected vascular disease (e.g., aneurysms, hematomas)**

- Evidence of vascular abnormality identified on imaging studies.
- Evaluation of suspected or known aneurysms limited to the pelvis or in evaluating pelvic extent of aortic aneurysm
    - Suspected or known iliac artery aneurysm >2.5 cm **AND** equivocal or indeterminate ultrasound results; **OR**
    - Prior imaging (e.g. ultrasound) demonstrating iliac artery aneurysm >2.5cm in diameter; **OR**
    - Suspected complications of known aneurysm as evidenced by clinical findings such as new onset of pelvic pain; **OR**
    - Follow up of iliac artery aneurysm: Six (6) month if between 3.0-3.5 cm and if stable follow yearly. If >3.5cm, <six (6) month follow up (and consider intervention).
- Scheduled follow-up evaluation of aorto/iliac endograft or stent.
    - Routine, baseline study (post-op/intervention) is warranted within 1-3 months.
    - Asymptomatic at six (6) month intervals, for one (1) year, then annually.
    - Symptomatic/complications related to stent graft-more frequent imaging may be needed.
- Suspected retroperitoneal hematoma or hemorrhage.

Evaluation of trauma

- Evaluation of trauma with lab or physical findings of pelvic bleeding.
- Evaluation of physical or radiological evidence of complex or occult pelvis fracture or for pre-operative planning of compex fractures.

Pre-operative evaluation

- For diagnostic purposes prior to pelvic surgery or procedure.

Post-operative/procedural evaluation

- Follow-up of known or suspected post-operative complication involving the hips or the pelvis.
- A follow-up study to help evaluate a member's progress after treatment, procedure, intervention or surgery. Documentation requires a medical reason that clearly indicates why additional imaging is needed.

Other indications for pelvic CT

- Subacute or chronic pelvic pain not explained by previous imaging/procedure.
- To provide an alternative to initial or follow-up of an indeterminate or inconclusive finding on ultrasound and MRI cannot be done.
- Hernia with suspected complications (e.g. bowel obstruction or strangulation, or non-reducible) or prior to surgical repair or physicial exam or prior imaging (e.g., ultrasound) is non-diagnostic or equivocal.
- Ischemic bowel.
- Known or suspected aseptic/avascular necrosis of hip(s) and MRI is contraindicated after completion of initial x-ray.
- Sacroiliitis (infectious or inflammatory) after completion of initial x-ray and MRI is contraindicated.
- Sacroiliac joint dysfunction and MRI contraindicated when there is:
    - Persistent back and/or sacral pain unresponsive to four (4) weeks of conservative treatment, received within the past six (6) months, including physical therapy or physician supervised ***home exercise program (HEP).

Indication for combination studies for the initial pre-therapy staging of canceror active monitoring for recurrence as clinically indicated or evaluation of suspected metastases

- < 5 concurrent studies to include CT or MRI of any of the following areas as appropriate depending on the cancer: neck, abdomen, pelvis, chest, brain, cervical spine, thoracic spine or lumbar spine.

*****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 documentation provided regarding completion of HEP (after suitable 6 week period), or inability to complete HEP due to physical reason (i.e., increased pain, inability to physically perform exercises. (Member inconvenience or noncompliance without explanation does not constitute "inability to complete" HEP).

Abdomen/Pelvic CT

Indications for Abdomen/Pelvic CT

Evaluation of suspicious or known mass/tumors

- Initial evaluation of suspicious masses/tumors found by physical exam or imaging study such as ultrasound (US), and both the abdomen and pelvis are likely affected.
- Surveillance: One follow-up exam to ensure no suspicious change has occurred in a tumor in the abdomen and pelvis. No further surveillance CT unless tumor(s) are specified as highly suspicious or a change was found on the last follow-up CT, new/changing sign/symptoms or abnormal lab values. Initial staging of known cancer:
    - All cancers, excluding the following:
        - Basal cell carcinoma of the skin.
        - Melanoma without symptoms or signs of metastasis.
- Prostate cancer when PSA levels ≥10 ng/mL, biopsy GS ≥8, or clinically advanced disease (T2b, T2c, T3, or T4) AND nomogram (e.g., Partin, Cancer of Prostate Risk Assessment CAPRA) indicating probability of lymph node involvement >10%).
- Follow-up of known cancer:
    - Follow-up of known cancer of member undergoing active treatment within the past year.
    - Known cancer with suspected abdominal/pelvic metastasis based on a sign, symptom or an abnormal lab value
    - Active monitoring for recurrence as clinically indicated.

Evaluation of hematuria

- Hematuria (documented by greater than 3 red blood cells (RBC) per high-power field on urinalysis and not based on a dipstick test).
- Macroscopic or gross hematuria (non-infectious documented by urinalysis).

Evaluation of known or suspected kidney or ureteral stones

- Acute flank pain with hematuria (can be confirmed by dip stick).
- Flank pain without hematuria with indeterminate or positive findings on other imaging.
- Known calculi in members >50 years of age.
- Known renal calcli in members < 50 years of age after ultrasound has been obtained and in non-diagnostic, inconclusive, or shows an abnormality needing further evaluation.

Evaluation of recurrent urinary tract Infections in women (defined as at least 3 episodes of uncomplicated infection in the past twelve months)

- When there is suspicion of renal calculi or outflow obstruction.

Evaluation of suspected infection or inflammatory disease

- Suspected diverticulitis or acute appendicitis for initial imaging along with ONE of the following:
    - Elevated WBC; **OR**
    - Fever; **OR**
    - Anorexia; **OR**
    - Nausea and vomiting.
- Suspected appendicitis in child after ultrasound has been obtained.

- Consider ultrasound or MRI in pregnant women with suspected appendicitis.

Suspected acute pancreatitis

- For first time presentation with pain and abnormal amylase and lipase and < 48-72 hours.
- Presentation with high clinical suspicion of acute pancreatitis (amylase and lipase may be normal).
- Known necrotizing pancreatitis requiring follow-up.

Suspected inflammatory bowel disease (Crohn's or ulcerative colitis) with abdominal pain, and persistent diarrhea, or bloody diarrhea

- Suspected small bowel obstruction when there is a strong clinical suspicion
- Crampy pain, vomiting, distention, high pitched or absent bowel sounds, prior history of abdominal surgery or based on initial radiograph.

Suspected peritonitis (from any cause) if abdominal pain and tenderness to palpation is present, and **AT LEAST ONE** of the following:

- Rebound, guarding (not voluntary) or rigid abdomen; OR
- Severe tenderness to palpation present over entire abdomen.

Suspected colonic or mesenteric ischemia

Follow-up evaluation of known infection or inflammatory disease

- Complications of diverticulitis with severe abdominal/pelvic pain or severe tenderness or mass not responding to antibiotic treatment (prior imaging study is not required for diverticulitis diagnosis).
- Pancreatitis by history (including pancreatic pseudocyst) with continued abdominal pain, early satiety, nausea, vomiting or signs of infection greater than 4 weeks from initial presentation.
- Known inflammatory bowel disease, (Crohn's or ulcerative colitis) with recurrence or worsening signs/symptoms requiring re-evaluation.
- Known infection that is clinically suspected to have created an abscess in the abdomen or pelvis.
- History of fistula that requires re-evaluation, or is suspected to have recurred in the abdomen or pelvis.
- History of fistula that requires re-evaluation or is suspected to have recurred in the abdomen and pelvis.
- Abnormal fluid collection seen on prior imaging that needs follow-up evaluation.
- Follow-up for peritonitis (from any cause) if abdominal/pelvic pain and tenderness to palpation is present, and **AT LEAST One** of the following:
- Rebound, guarding or rigid abdomen; **OR**
- Severe tenderness to palpation present over entire abdomen.

Evaluation of known or suspected aortic aneurysm

- Known or suspected aneurysm > 2.5 cm and equivocal or indeterminate ultrasound results.
- Suspected complications of known aneurysm as evidenced by signs/symptoms such as new onset of abdominal or pelvic pain.

- Scheduled follow-up evaluation of aorto/iliac endograft or stent.
- Evaluation of endovascular/interventional abdominal vascular procedures for luminal patency versus restenosis due to conditions such as atherosclerosis, thromboembolism and intimal hyperplasia.
- Evaluation of post-operative complications (e.g. pseudoaneurysms, related to surgical bypass grafts, vascular stents and stent-grafts in the peritoneal cavity).
- Follow-up for post-endovascular repair (EVAR) or open repair of abdominal aortic aneurysm (AAA) or abdominal extent of iliac artery aneurysms. Routine, baseline study (post-op/intervention) is warranted within 1-3 months.
    - Asymptomatic at six (6) month intervals, for one (1) year, then annually.
    - Symptomatic/complications related to stent graft (more frequent imaging may be needed).
- Follow-up study may be needed to help evaluate a member's progress after treatment, procedure, intervention or surgery. Documentation requires a medical reason that clearly indicates why additional imaging is needed for the type and area(s) requested.

Evaluation of trauma

- Suspected retroperitoneal hematoma or hemorrhage based on lab or physical findings.
- Blunt injury with suspicion of multisystem trauma and hematuria.
- Penetrating abdominal injury with suspicion of multisystem trauma with or without hematuria

Pre-operative evaluation

- For abdominal/pelvic surgery or procedure.

Post-operative/procedural evaluation

- Follow-up of known or suspected post-operative complication.
- A follow-up study to help evaluate a member's progress after treatment, procedure, intervention or surgery. Documentation requires a medical reason that clearly indicates why additional imaging is needed.

Other indications for abdomen/pelvic CT Combo

- Persistent abdomen/pelvic pain not explained by previous imaging/procedure.
- For symptoms of fevers to more than 101 F, drenching night sweats, and unexplained weight loss of more than 10% of body weight over 6 months, if CXR, labs and an ultrasound of the abdomen and pelvis have been completed (can also approve chest CT).
- Unexplained weight loss of 10% of body weight in two months (member history); with a second MD visit documenting further decline in weight.
- Unexplained weight loss of 5% of body weight in six months confirmed by documentation to include the following:
    - Related history and abdominal exam
    - Chest x-ray
    - Abdominal ultrasound
    - Lab tests(must include TSH)
    - Colonoscopy if member is fifty plus (50+) years old.

- Unexplained abdominal pain in members seventy-five (75) years or older (USPSTF does not recommend screening colonoscopy over age 75 years).
- Suspected spigelian hernia (ventral hernia) or incisional hernia (evidenced by a surgical abdominal scar) when ordered as a pre-operative study **OR** when physical exam or prior imaging (e.g., ultrasound) is non-diagnostic or equivocal **OR** ultrasound is contraindicated due to obesity.
- Hernia with suspected complications (e.g., bowel obstruction, strangulation) or prior to surgical repair **OR** when physical exam or prior imaging (e.g., ultrasound) is non-dianostic or equivocal.

Indication for combination studies for the initial pre-therapy staging of canceror monitoring for recurrence as clinically indicated or evaluation of suspected metastases

- ≤5 concurrent studies to include CT or MRI of any of the following areas as appropriate depending on the cancer: neck, abdomen, pelvis, chest, brain, cervical spine, thoracic spine or lumbar spine.

BILLING/CODING INFORMATION:

CPT Coding:

72192	Computed tomography, pelvis; without contrast material
72193	Computed tomography, pelvis; with contrast material(s)
72194	Computed tomography, pelvis; without contrast material, followed by contrast material(s) and further sections
74150	Computed tomography, abdomen; without contrast material
74160	Computed tomography, abdomen; with contrast material(s)
74170	Computed tomography, abdomen; without contrast material, followed by contrast material(s) and further sections
74176	Computed tomography, abdomen and pelvis; without contrast material
74177	Computed tomography, abdomen and pelvis; with contrast material(s)
74178	Computed tomography, abdomen and pelvis; without contrast material in one or both body regions, followed by contrast material(s) and further sections in one or both body regions
76380	Computed tomography, limited or localized follow-up study

REIMBURSEMENT INFORMATION:

Reimbursement for computed tomography (72192 – 72194, 74150 – 74170, and 74176 – 74178, 76380) performed on the same anatomical area is limited to two (2) computed tomography (72192 – 72194, 74150 – 74170, and 74176 – 74178, 76380) within a 6-month period. Computed tomography (72192 – 72194, 74150 – 74170, and 74176 – 74178, 76380) in excess of two (2) computed tomography (72192 – 72194, 74150 – 74170, and 74176 – 74178, 76380) within a 6-month period are subject to medical review of documentation to support medical necessity. Documentation should include radiology reason for study, radiology comparison study-date and time, radiology comparison study observation, radiology impression, and radiology study recommendation.

Reimbursement for computed tomography (72192 – 72194, 74150 – 74170, and 74176 – 74178, 76380) for an oncologic condition undergoing active treatment or active treatment completed within the previous 12 months on the same anatomical area is limited to four (4) computed tomography (72192 – 72194, 74150 – 74170, and 74176 – 74178, 76380) within a 12-month period. Computed tomography (72192 – 72194, 74150 – 74170, and 74176 – 74178, 76380) for an oncologic condition in excess of four (4) computed tomography (72192 – 72194, 74150 – 74170, and 74176 – 74178, 76380) within a 12-month period are subject to medical review of documentation to support medical necessity. Documentation should include radiology reason for study, radiology comparison study-date and time, radiology comparison study observation, radiology impression, and radiology study recommendation.

Re-imaging or additional imaging of the abdomen, pelvis and abdomen and pelvis due to poor contrast enhanced exam or technically limited exam is the responsibility of the imaging provider.

LOINC Codes:

The following information may be required documentation to support medical necessity: physician history and physical, physician progress notes, plan of treatment and reason for computed tomography (CT) of the abdomen and pelvis.

Documentation Table	LOINC Codes	LOINC Time Frame Modifier Code	LOINC Time Frame Modifier Codes Narrative
Physician history and physical	28626-0	18805-2	Include all data of the selected type that represents observations made six months or fewer before starting date of service for the claim
Attending physician progress note	18741-9	18805-2	Include all data of the selected type that represents observations made six months or fewer before starting date of service for the claim
Plan of treatment	18776-5	18805-2	Include all data of the selected type that represents observations made six months or fewer before starting date of service for the claim
Radiology reason for study	18785-6	18805-2	Include all data of the selected type that represents observations made six months or fewer before starting date of service for the claim
Radiology comparison study-date and time	18779-9	18805-2	Include all data of the selected type that represents observations made six months or fewer before starting date of service for the claim
Radiology comparison study observation	18834-2	18805-2	Include all data of the selected type that represents observations made six months or fewer before starting date of service for the claim
Radiology-study observation	18782-3	18805-2	Include all data of the selected type that represents observations made six months or fewer before starting date of service for the claim
Radiology-impression	19005-8	18805-2	Include all data of the selected type that represents observations made six months or fewer before starting date of service for the claim
Radiology study-recommendation (narrative)	18783-1	18805-2	Include all data of the selected type that represents observations made six months or fewer before starting date of service for the claim

PROGRAM EXCEPTIONS:

Coverage for the radiology services referenced in this guideline performed and billed in an outpatient or office location will be handled through the Radiology Management program for select products. The National Imaging Associates (NIA) will determine coverage for these services for select products. Refer to member's contract benefits.

Federal Employee Plan (FEP): FEP is excluded from the National Imaging Associates (NIA) review; follow FEP guidelines.

Medicare Advantage products:

The following Local Coverage Determination (LCD) was reviewed on the last guideline reviewed date: Computed Tomography of the Abdomen and Pelvis, (L29119) located at fcso.com.

The following National Coverage Determination (NCD) was reviewed on the last guideline reviewed date: Computed Tomography, (220.1) located at cms.gov.

DEFINITIONS:

Diverticulitis: inflammation of a diverticulum, especially inflammation related to colonic diverticula, which may undergo perforation with abscess formation.

Hematoma: a localized collection of blood, usually clotted, in an organ, space, or tissue, usually due to a break in the wall of a blood vessel.

Hepatomegaly: enlargement of the liver.

Pancreatitis (acute): pancreatitis with sudden onset, fever, abdominal pain, nausea, vomiting, tachycardia, and often increased blood levels of pancreatic enzymes. It may be accompanied by complications such as hemorrhaging or necrosis.

Pancreatic pseudocyst: a cystic collection of fluid and necrotic debris whose walls are formed by the pancreas and nearby organs. It occurs as a complication of acute pancreatitis and may subside spontaneously or become secondarily infected and develops into an abscess.

Splenomegaly: enlargement of the spleen.

RELATED GUIDELINES:

Computed Tomography to Detect Coronary Artery Calcification, 04-70450-02

Computed Tomographic Angiography (CTA), 04-70450-03

Computerized Axial Tomography (CT), Head/Brain 04-70450-18

Computerized Axial Tomography (CT), Temporal Bone/Mastoid & Maxillofacial 04-70450-19

Computerized Axial Tomography (CT), of the Neck for Soft Tissue Evaluation 04-70450-20

Computerized Axial Tomography (CT), Thorax (Chest) 04-70450-21

Computerized Axial Tomography (CT), Spine (Cervical, Thoracic, Lumbar) 04-70450-23

Computerized Axial Tomography (CT), Extremity (Upper & Lower) 04-70450-24

Whole Body Computed Tomography (CT) Scanning, 04-70450-25

OTHER:

Other name used to report computed tomography (CT):

CAT scanning

Pediatric Examinations

The use of CT in pediatric examinations requires assessment of the risks, benefits and use of the studies. The lowest possible radiation dose consistent with acceptable diagnostic image quality should be used in pediatric examinations. Radiation doses should be determined periodically based on a reasonable sample of pediatric examinations. Technical factors should be appropriate for the size and the age of the child and should be determined with consideration of parameters (e.g., characteristics of the imaging system, organs in the radiation field, lead shielding).

REFERENCES:

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2. American College of Radiology (ACR) Appropriateness Criteria® Stress/Insufficiency Fracture, Including Sacrum, Excluding Other Vertebrae, Revised 2016.
3. American College of Radiology (ACR) and Society for Pediatric Radiology (SPR) Practice Guideline for the Performance of Computed Tomography (CT) of the Abdomen and Computed Tomography (CT) of the Pelvis, Revised 2016.
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15. National Imaging Associates, Inc. CT Abdomen, 2019.
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COMMITTEE APPROVAL:

This Medical Coverage Guideline (MCG) was approved by the Florida Blue Medical Policy & Coverage Committee on 03/26/20.

GUIDELINE UPDATE INFORMATION:

09/15/09	New Medical Coverage Guideline.
01/01/10	Revised BCBSF Radiology Management program exception section and updated the references.
01/01/11	Annual HCPCS coding update: added 74176, 74177 and 74178.
08/15/11	Scheduled review. Updated position statement. Added 76380. Revised limitation to two (2) within a 6-month period. Updated references.
10/01/11	Revision; formatting changes.
05/15/12	Revised and expanded position statement for: abdomen; appendicitis (added acute), diverticulitis, gastroparesis (added diabetic), infectious or inflammatory process, inflammatory bowel disease and added vascular abnormality. Revised and expanded position statement for: abdomen-other, added persistent abdominal pain, partial small bowel obstruction (complete or high-grade) and tumor evaluation. Revised and expanded position statement for: pelvis (appendicitis (added acute), and added organ enlargement and vascular abnormality. Revised and expanded position statement for: pelvic-other, added tumor evaluation. Revised and expanded position statement for abdomen and pelvis CT combination: adrenal mass, appendicitis (added acute), added organ enlargement and vascular abnormality. Revised and expanded position statement for: abdomen and pelvic CT combination-other, added tumor evaluation. Deleted but is not limited to. Updated references.
11/15/13	Scheduled review; MCG subject changed to “Computed Tomography Abdomen and Pelvis”. Added; aorta aneurysm, cholecystitis, diverticulitis, hepatitis C/hepatoma, inflammatory bowel disease (recurrence), pancreatitis, fistula, peritonitis, retroperitoneal hematoma or hemorrhage. Renal colic (add to abdomen, pelvis and abdomen/pelvis), renal mass (add to pelvis and abdomen/pelvis), prostate cancer (add to pelvis); add/revise indications: cancer, infection, and mass/tumor. Updated definitions, program exceptions and reference sections.
11/15/14	Scheduled review. No change to position statements.
12/15/14	Added diverticulitis (suspected or known) to abdomen and pelvis CT combination.
03/15/18	Revision; revised position statements (abdomen, pelvis, abdomen and pelvis). Updated definitions and references.
06/15/18	Added statement for Egrifta.
11/15/19	Revised position statements (abdomen, pelvis, abdomen and pelvis CT). Updated references.
04/15/20	Review/revision. Revised position statement and expand criteria for (abdomen, pelvis, abdomen and pelvis CT). Updated references.