

Cigna Medical Coverage Policies – Radiology Pediatric Pelvis Imaging Guidelines

Effective February 1, 2021



Instructions for use

The following coverage policy applies to health benefit plans administered by Cigna. Coverage policies are intended to provide guidance in interpreting certain standard Cigna benefit plans and are used by medical directors and other health care professionals in making medical necessity and other coverage determinations. Please note the terms of a customer's particular benefit 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 supersedes the information in the coverage policy. In the absence of federal or state coverage mandates, 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 and regulations
3. Any relevant collateral source materials including coverage policies
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.

This evidence-based medical coverage policy has been developed by eviCore, Inc. Some information in this coverage policy may not apply to all benefit plans administered by Cigna.

These guidelines include procedures eviCore does not review for Cigna. Please refer to the [Cigna CPT code list](#) for the current list of high-tech imaging procedures that eviCore reviews for Cigna.

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Procedure Codes Associated with Pelvis Imaging	
MRI	
MRI Pelvis without contrast	CPT® 72195
MRI Pelvis with contrast (rarely used)	72196
MRI Pelvis without and with contrast	72197
Unlisted MRI procedure (for radiation planning or surgical software)	76498
MRA	
MRA Pelvis	CPT® 72198
CT	
CT Abdomen and Pelvis without contrast	CPT® 74176
CT Abdomen and Pelvis with contrast	74177
CT Abdomen and Pelvis without and with contrast	74178
CT Pelvis without contrast	72192
CT Pelvis with contrast	72193
CT Pelvis without and with contrast	72194
CT Guidance for Needle Placement (Biopsy, Aspiration, Injection, etc.)	77012
CT Guidance for and monitoring of Visceral Tissue Ablation	77013
CT Guidance for Placement of Radiation Therapy Fields	77014
Unlisted CT procedure (for radiation planning or surgical software)	76497
CTA	
CTA Abdomen and Pelvis	CPT® 74174
CTA Pelvis	72191
Ultrasound	
Ultrasound, pelvic (nonobstetric), complete	CPT® 76856
Ultrasound, pelvic transvaginal	76830
Ultrasound, pelvic (nonobstetric), limited or follow-up	76857
Ultrasound, scrotum and contents	76870
Duplex scan of arterial inflow and venous outflow of abdominal, pelvic, scrotal contents and/or retroperitoneal organs; complete study	93975
Duplex scan of arterial inflow and venous outflow of abdominal, pelvic, scrotal contents and/or retroperitoneal organs; limited study	93976
Duplex scan of aorta, inferior vena cava, iliac vasculature, or bypass grafts; complete	93978
Duplex scan of aorta, inferior vena cava, iliac vasculature, or bypass grafts; limited	93979
Duplex scan of arterial inflow and venous outflow of penile vessels; complete	93980
Duplex scan of arterial inflow and venous outflow of penile vessels; limited study	93981

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PEDPV-1.0: General Guidelines

- A recent (within 60 days) face to face evaluation including a detailed history, physical examination, and appropriate laboratory studies should be performed prior to considering the use of an advanced imaging (CT, MRI, Nuclear Medicine) procedure. An exception can be made if the individual is undergoing guideline-supported scheduled follow up imaging evaluation.
- Unless otherwise stated in a specific guideline section, the use of advanced imaging to screen asymptomatic individuals for disorders involving the pelvis is not supported. Advanced imaging of the pelvis should only be approved in individuals who have documented active clinical signs or symptoms of disease involving the pelvis.
- Unless otherwise stated in a specific guideline section, repeat imaging studies of the pelvis are not necessary unless there is evidence for progression of disease, new onset of disease, and/or documentation of how repeat imaging will affect individual management or treatment decisions.
- Ultrasound
 - ◆ Ultrasound should be the initial imaging in most pelvic conditions to rule out those situations that do not require advanced imaging.
 - ◆ For those individuals who do require advanced imaging, ultrasound can be very beneficial in selecting the proper modality, body area, image sequences, and contrast level that will provide the most definitive information for the individual.
 - ◆ CPT® codes vary by body area and presence or absence of Doppler imaging and are included in the table at the beginning of this guideline.
 - ◆ Transabdominal ultrasound is appropriate in all pediatric individuals.
 - ◆ Transvaginal (TV) ultrasound is appropriate in pediatric individuals who are sexually active or use a tampon and consent to the study. Ultrasound (complete CPT® 76856, or limited CPT® 76857) should substitute for TV in pediatric individuals or non-sexually active adult females.

PEDPV-1.1: Pediatric Pelvis Imaging Age Considerations

Many conditions affecting the pelvis in the pediatric population are different diagnoses than those occurring in the adult population. For those diseases which occur in both pediatric and adult populations, minor differences may exist in management due to individual age, comorbidities, and differences in disease natural history between children and adults.

- Individuals who are <18 years old should be imaged according to the Pediatric Pelvis Imaging Guidelines if discussed. Any conditions not specifically discussed in the Pediatric Pelvis Imaging Guidelines should be imaged according to the **General Pelvis Imaging Guidelines**. Individuals who are ≥18 years should be imaged according to the **General Pelvis Imaging Guidelines**, except where directed otherwise by a specific guideline section.

PEDPV-1.2: Pediatric Pelvis Imaging Appropriate Clinical Evaluation

- See **PEDPV-1.0: General Guidelines**

PEDPV-1.3: Pediatric Pelvis Imaging Modality General Considerations

- Ultrasound
 - ◆ See **PEDPV-1.0: General Guidelines**
- MRI
 - ◆ MRI Pelvis is generally performed without and with contrast (CPT® 72197) unless the individual has a documented contraindication to gadolinium or otherwise stated in a specific guideline section.
 - ◆ Due to the length of time required for MRI acquisition and the need to minimize individual movement, anesthesia is usually required for almost all infants (except neonates) and young children (age <7 years) as well as older children with delays in development or maturity. This anesthesia may be administered via oral or intravenous routes. In this individual population, MRI sessions should be planned with a goal of minimizing anesthesia exposure by adhering to the following considerations:
 - MRI procedures can be performed without and/or with contrast use as supported by these condition-based guidelines. If intravenous access will already be present for anesthesia administration and there is no contraindication for using contrast, imaging without and with contrast may be appropriate if requested. By doing so, the requesting provider may avoid repetitive anesthesia administration to perform an MRI with contrast if the initial study without contrast is inconclusive.
 - Recent evidence based literature demonstrates the potential for gadolinium deposition in various organs including the brain, after the use of MRI contrast.
 - The U.S. Food and Drug Administration (FDA) has noted that there is currently no evidence to suggest that gadolinium retention in the brain is harmful and restricting gadolinium-based contrast agents (GBCAs) use is not warranted at this time. It has been recommended that GBCA use should be limited to circumstances in which additional information provided by the contrast agent is necessary and the necessity of repetitive MRIs with GBCAs should be assessed.
 - If multiple body areas are supported by eviCore guidelines for the clinical condition being evaluated, MRI of all necessary body areas should be obtained concurrently in the same anesthesia session.
 - ◆ The presence of surgical hardware or implanted devices may preclude MRI.
 - ◆ The selection of best examination may require coordination between the provider and the imaging service.
- CT
 - ◆ CT Pelvis typically extends from the iliac crest to the ischial tuberosities, and CT Abdomen and Pelvis extends from the dome of the diaphragm through the ischial tuberosities.
 - In general, CT Pelvis is appropriate when evaluating solid pelvic organs.

- In general, CT Abdomen and Pelvis is appropriate when evaluating inflammatory or infections processes, hematuria, or conditions which appear to involve both the abdomen and the pelvis.
 - In some cases, especially in follow-up of a known finding, it may be appropriate to limit the exam to the region of concern to reduce radiation exposure.
 - ◆ The contrast level in pediatric CT imaging is specific to the clinical indication, as listed in the specific guideline sections.
 - ◆ CT Pelvis or Abdomen and Pelvis may be indicated for further evaluation of abnormalities suggested on prior US or MRI Procedures.
 - ◆ CT may be appropriate without prior MRI or US, as indicated in specific sections of these guidelines.
 - ◆ CT should not be used to replace MRI in an attempt to avoid sedation unless listed as a recommended study in a specific guideline section.
 - ◆ The selection of best examination may require coordination between the provider and the imaging service.
- 3D Rendering
- ◆ 3D Rendering indications in pediatric pelvis imaging are identical to those in the general imaging guidelines. See **Preface-4.1: 3D Rendering** in the Preface Imaging Guidelines

The guidelines listed in this section for certain specific indications are not intended to be all-inclusive; clinical judgment remains paramount and variance from these guidelines may be appropriate and warranted for specific clinical situations.

References

1. Berland LL, Cernigliaro JG, Ho VB, et al. ACR Practice parameter for performing and interpreting magnetic resonance imaging (MRI). American College of Radiology. Revised 2017.
2. Faerber EN, Abramson SJ, Benator RM, et al. ACR-ASER-SCBT-MR-SPR Practice parameter for the performance of pediatric computed tomography (CT). American College of Radiology. Revised 2014.
3. Ing C, Dimaggio C, Whitehouse A, et al. Long-term Differences in Language and Cognitive Function After Childhood Exposure to Anesthesia. *Pediatrics*. 2012;130(3). doi:10.1542/peds.2011-3822.
4. Monteleone M, Khandji A, Cappell J, Lai WW, Biagas K, Schleien C. Anesthesia in Children. *Journal of Neurosurgical Anesthesiology*. 2014;26(4):396-398. doi:10.1097/ana.0000000000000124.
5. Dimaggio C, Sun LS, Li G. Early Childhood Exposure to Anesthesia and Risk of Developmental and Behavioral Disorders in a Sibling Birth Cohort. *Anesthesia & Analgesia*. 2011;113(5):1143-1151. doi:10.1213/ane.0b013e3182147f42.
6. Macdonald A, Burrell S. Infrequently Performed Studies in Nuclear Medicine: Part 2. *Journal of Nuclear Medicine Technology*. 2009;37(1):1-13. doi:10.2967/jnmt.108.057851.
7. FDA Drug Safety Communication: FDA identifies no harmful effects to date with brain retention of gadolinium-based contrast agents for MRIs; review to continue. FDA Drug Safety Communication. May 22, 2017.
8. Siegel MJ. *Pediatric Sonography*. 5th ed. Philadelphia: Wolters Kluwer. p 513-556.
9. Fraum TJ, Ludwig DR, Bashir MR, Fowler KJ. Gadolinium-based contrast agents: A comprehensive risk assessment. *Journal of Magnetic Resonance Imaging*. 2017;46(2):338-353. doi:10.1002/jmri.25625.
10. Update on FDA approach to safety issue of gadolinium retention after administration of gadolinium-based contrast agents available at <https://www.fda.gov/media/116492/download>.

PEDPV-2: Abnormal Uterine Bleeding

- Abnormal uterine bleeding imaging indications in pediatric individuals are very similar to those for adult individuals. See **PV-2: Abnormal Uterine Bleeding** in the Pelvis Imaging Guidelines.
- Pediatric-specific imaging considerations include the following:
 - ◆ Transvaginal ultrasound is generally not appropriate in individuals who have never been sexually active.
 - ◆ MRI Pelvis without contrast or without and with contrast (CPT® 72195 or CPT® 72197) is indicated if ultrasound is inconclusive.

Background and Supporting Information

- The causes of vaginal bleeding in children differ from those in adolescents. Vaginal bleeding after the first week or so of life but before menarche is always abnormal and warrants evaluation. Common conditions before normal menarche include vaginal foreign bodies, infections, precocious puberty, and estrogen exposure. After menarche, pregnancy and excessive menstrual bleeding (dysfunction) must be considered.

References

1. Mansfield MJ. Precocious puberty. *Pediatric and adolescent gynecology*. eds. Emans SJ and Laufer MR. Philadelphia, PA. Lippincott Williams & Wilkins, 6th ed. 2012;114-124.
2. Upadhyia KK, Sucato GS. Abnormal Uterine Bleeding. *Nelson Textbook of Pediatrics*, chapter 142.2. eds. Kliegman RM, St. Geme JW III, Blum NJ, Shah SS, Tasker RC, Wilson KM. 21st edition 2020; 1060-1062.

PEDPV-3: Pelvic Inflammatory Disease (PID)

- Pelvic inflammatory disease imaging indications in pediatric individuals are very similar to those for adult individuals. See **PV-7: Pelvic Inflammatory Disease (PID)** in the Pelvis Imaging Guidelines.
- Pediatric-specific imaging considerations include the following:
 - ◆ Transvaginal ultrasound is generally not appropriate in individuals who are pre-pubescent or victims of abuse.
 - ◆ MRI Pelvis without contrast (CPT® 72195) or without and with contrast (CPT® 72197) is indicated if ultrasound is inconclusive.
 - ◆ CT Pelvis with contrast (CPT® 72193) is indicated if MRI is not readily available.

References

1. Burstein GR. Sexually transmitted infections. *Nelson Textbook of Pediatrics*, chapter 146. eds Kliegman RM, St. Geme JW III, Blum NJ, Shah SS, Tasker RC, Wilson KM. 21st edition 2020; 1081-1091.
2. Cohen HL, Raju AD. Abnormalities of the female genital tract Chapter 126 Caffey's Pediatric Diagnostic Imaging. eds. Coley B, Saunders E, Philadelphia PA, 2013. pp 1201-1211.
3. Caprio MG, Serafino MD, Feo AD, et al. Ultrasonographic and multimodal imaging of pediatric genital female diseases. *Journal of Ultrasound*. 2019;22(3):273-289. doi:10.1007/s40477-019-00358-5.

PEDPV-4: Amenorrhea

- Girls with primary amenorrhea and any of the following should be evaluated initially with pelvic ultrasound (CPT® 76856 or CPT® 76857):
 - ◆ Normal pubertal development and negative pregnancy test.
 - Transvaginal ultrasound (CPT® 76830) can also be approved if requested for better view of genitourinary anomalies in sexually active females.
 - ◆ Delayed puberty with follicle-stimulating hormone (FSH) or luteinizing hormone (LH) that is elevated for the individual's age and Tanner stage.
- MRI Pelvis without contrast or without and with contrast (CPT® 72195 or CPT® 72197) and/or MRI Abdomen without contrast or without and with contrast (CPT® 74181 or CPT® 74183) are indicated for the following:
 - ◆ Evaluation of congenital anomalies of the uterus and/or urinary system identified on Abdominal and Pelvic ultrasound (CPT® 76700 and CPT® 76856) in order to better define complex anatomy.
 - ◆ Preoperative planning in girls with distention of the vagina by fluid (hydrocolpos) or blood (hematocolpos) due to congenital vaginal obstruction.

References

1. Langer JE, Oliver ER, Lev-Toaff AS, Coleman BG. Imaging of the Female Pelvis through the Life Cycle. *RadioGraphics*. 2012;32(6):1575-1597. doi:10.1148/rg.326125513.
2. Upadhyaya KK, Suscato GS. Amenorrhea. *Nelson Textbook of Pediatrics*, chapter 142.1. eds Kliegman RM, St. Geme JW III, Blum NJ, Shah SS, Tasker RC, Wilson KM. 21st edition. 2020; 1059-1060.
3. Cohen HL and Raju AD. Amenorrhea and abnormalities of puberty. *Caffey's Pediatric Diagnostic Imaging*, chapter 128. eds Brian Coley, Elsevier Saunders, Philadelphia PA, 12th edition. 2013; 12.
4. Behr SC, Courtier JL, Qayyum A. Imaging of Müllerian Duct Anomalies. *RadioGraphics*. 2012;32(6). doi:10.1148/rg.326125515.
5. Caprio MG, Serafino MD, Feo AD, et al. Ultrasonographic and multimodal imaging of pediatric genital female diseases. *Journal of Ultrasound*. 2019;22(3):273-289. doi:10.1007/s40477-019-00358-5.

PEDPV-5: Endometriosis

- Endometriosis imaging indications in pediatric individuals are very similar to those for adult individuals. See **PV-6: Endometriosis** in the Pelvis Imaging Guidelines.
- Pediatric-specific imaging considerations include:
 - ◆ Transvaginal ultrasound is generally not appropriate in individuals who are pre-pubescent or have never been sexually active.

Reference

1. Upadhyia KK, Suscato GS. Dysmenorrhea. Nelson Textbook of Pediatrics, chapter 142.3. eds Kliegman RM, St. Geme JW III, Blum NJ, Shah SS, Tasker RC, Wilson KM. 21st edition 2020; 1062-1063.

PEDPV-6: Suspected Adnexal Mass

- Suspected adnexal mass imaging indications in pediatric individuals are very similar to those for adult individuals. See **PV-5: Adnexal Mass/Ovarian Cysts** in the Pelvis Imaging Guidelines. Ultrasound is the first study indicated for evaluation of a suspected adnexal mass.
- Pediatric-specific imaging considerations include the following:
 - ◆ Transvaginal ultrasound is generally not appropriate in individuals who are pre-pubescent or have never been sexually active.
 - ◆ Adnexal masses with a solid component in individuals, age ≥ 15 years, should be imaged according to **PEDONC-10: Pediatric Germ Cell Tumors** in the Pediatric Oncology Imaging Guidelines.

References

1. Allen-Rhoades WA and Steuber CP. Clinical assessment and differential diagnosis of the child with suspected cancer. *Principles and Practice of Pediatric Oncology*, chapter 6. eds. Pizzo PA and Poplack DG. 2016;7:101-111.
2. Kelleher CM, Goldstein AM. Adnexal Masses in Children and Adolescents. *Clinical Obstetrics and Gynecology*. 2015;58(1):76-92. doi:10.1097/grf.0000000000000084.
3. Caprio MG, Serafino MD, Feo AD, et al. Ultrasonographic and multimodal imaging of pediatric genital female diseases. *Journal of Ultrasound*. 2019;22(3):273-289. doi:10.1007/s40477-019-00358-5.

PEDPV-7: Pelvic Pain/Dyspareunia, and Ovarian Torsion

- Pelvic Pain/Dyspareunia imaging indications in pediatric individuals are identical to those for adult individuals. See **PV-11: Pelvic Pain/Dyspareunia, Female** in the Pelvis Imaging Guidelines.
- Ovarian torsion in children is typically associated with a normal ovary. Spontaneous torsion of a normal ovary is more common than torsion caused by a lead mass, such as a cyst or tumor. Torsion involves both the ovary and fallopian tube and typically presents with acute onset of lower abdominal pain, often associated with nausea or vomiting.
 - ◆ Transabdominal ultrasound (CPT® 76856) with Doppler (CPT® 93975) is appropriate in all pediatric individuals.
 - ◆ Transvaginal (TV) ultrasound (CPT® 76856) with Doppler (CPT® 93975) is appropriate in pediatric individuals who are sexually active or use a tampon and consent to the study. Transvaginal ultrasound is generally not appropriate in individuals who are pre-pubescent or have never been sexually active

References

1. Naffaa L, Deshmukh T, Tumu S, Johnson C, Boyd KP, Meyers AB. Imaging of Acute Pelvic Pain in Girls: Ovarian Torsion and Beyond. *Current Problems in Diagnostic Radiology*. 2017;46(4):317-329. doi:10.1067/j.cpradiol.2016.12.010.
2. Siegel MJ. *Pediatric Sonography*. 5th ed. Philadelphia: Wolters Kluwer. p 513-556.
3. Sintim-Damoa A, Majmudar AS, Cohen HL, Parvey LS. Pediatric Ovarian Torsion: Spectrum of Imaging Findings. *RadioGraphics*. 2017;37(6):1892-1908. doi:10.1148/rg.2017170026.
4. Cohen HL, Raju AD. Abnormalities of the female genital tract Chapter 126 *Caffey's Pediatric Diagnostic Imaging*. eds. Coley B, Saunders E, Philadelphia PA, 2013. pp 1201-1211.
5. Caprio MG, Serafino MD, Feo AD, et al. Ultrasonographic and multimodal imaging of pediatric genital female diseases. *Journal of Ultrasound*. 2019;22(3):273-289. doi:10.1007/s40477-019-00358-5.
6. Ssi-Yan-Kai G, Rivain A-L, Trichot C, et al. What every radiologist should know about adnexal torsion. *Emergency Radiology*. 2017;25(1):51-59. doi:10.1007/s10140-017-1549-8.

PEDPV-8: Polycystic Ovary Syndrome

- Polycystic ovary syndrome imaging indications in pediatric individuals are identical to those for adult individuals. See **PV-8: Polycystic Ovary Syndrome** in the Pelvis Imaging Guidelines.

References

1. Fondin M, Rachas A, Huynh V, et al. Polycystic Ovary Syndrome in Adolescents: Which MR Imaging–based Diagnostic Criteria? *Radiology*. 2017;285(3):961-970. doi:10.1148/radiol.2017161513.
2. Cohen HL, Raju AD. Abnormalities of the female genital tract Chapter 126 Caffey's Pediatric Diagnostic Imaging. eds. Coley B, Saunders E, Philadelphia PA, 2013. pp 1201-1211.
3. Huddleston HG, Quinn M, Gibson M. Polycystic Ovary Syndrome and Hirsutism Nelson Textbook of Pediatrics, Chapter 567 eds Kliegman RM, St. Geme JW III, Blum NJ, Shah SS, Tasker RC, Wilson KM. 21st edition 2020. pp 2857-2861.

PEDPV-9: Periurethral Cysts and Urethral Diverticula

- Periurethral cysts and urethral diverticula imaging indications in pediatric individuals are identical to those for adult individuals. See **PV-13: Periurethral Cysts and Urethral Diverticula** in the Pelvis Imaging Guidelines.

PEDPV-10: Section Intentionally Left Blank

PEDPV-11: Undescended Testis

- Pediatric-specific imaging considerations include the following:
 - ◆ Suspected undescended testis is an indication for referral to a surgical subspecialist who should make the decision or be consulted on necessary imaging studies.
- The following imaging is indicated for boys with suspected undescended testis based on a recent detailed physical exam.
 - ◆ Scrotal ultrasound (CPT® 76870) if testis not palpable in the scrotal sac and there is concern for retractile or inguinal testis,
 - If ultrasound is inconclusive, EITHER of the following:
 - MRI Abdomen (CPT® 74183) and Pelvis (CPT® 72197) without and with contrast, however MRI has a high false negative rate.
 - CT Abdomen and Pelvis with contrast (CPT® 74177).
 - Urology evaluation is recommended and is frequently helpful in determining the most appropriate imaging pathway

Background and Supporting Information

- Boys with a history of cryptorchidism (undescended testis) have a several-fold risk increase of testicular cancer. It is important to diagnose and treat this condition either by bringing the undescended testis into the scrotum, or resecting the testis.

References

1. Kolon TF, Herndon CDA, Baker LA, et al. Evaluation and treatment of cryptorchidism: AUA Guideline, Copyright© 2014 *American Urological Association Education and Research, Inc.*®.
2. Inappropriate Use of Ultrasound in Management of Pediatric Cryptorchidism. *Pediatrics*. 2015;136(3). doi:10.1542/peds.2015-0222d.
3. Elder JS. Disorders and anomalies of the scrotal contents. Nelson Textbook of Pediatrics, chapter 560. eds Kliegman RM, St. Geme JW III, Blum NJ, Shah SS, Tasker RC, Wilson KM. 21st edition 2020; 2827-2833.
4. Poppas DP and Medina C. Undescended testicle or cryptorchidism. *Cornell University Institute for Pediatric Urology*.
5. Krishnaswami S, Fannesbeck C, Penson D, Mcpheeters ML. Magnetic Resonance Imaging for Locating Nonpalpable Undescended Testicles: A Meta-analysis. *Pediatrics*. 2013;131(6). doi:10.1542/peds.2013-0073.
6. Aggarwal H, Rehfuss A, Hollowell J. Management of undescended testis may be improved with educational updates for referring providers. *Journal of Pediatric Urology*. 2014;10(4):707-711. doi:10.1016/j.jpuro.2013.10.025.
7. Cohen HL, Miller SF Abnormalities of the male genital tract Chapter 125 Caffey's Pediatric Diagnostic Imaging. eds. Coley B, Saunders E, Philadelphia PA, 2013. pp 1193-1200.

PEDPV-12: Scrotal Pathology

- Scrotal pathology imaging indications in pediatric individuals are very similar to those for adult individuals. See **PV-20: Scrotal Pathology** in the Pelvis Imaging Guidelines.
- Pediatric-specific imaging considerations include the following:
 - ◆ Scrotal US (CPT® 76870) with Doppler (CPT® 93975 or CPT® 93976) is indicated for concerns of testicular torsion.
 - ◆ MRI Pelvis without contrast (CPT® 72195) or without and with contrast (CPT® 72197) is indicated if torsion is unlikely on ultrasound and no surgical exploration is planned. MRI is not typically used for the acute scrotum due to the limited availability of equipment and the long examination time involved.

References

1. ACR Appropriateness Criteria®. *American College of Radiology*. 2018.
2. Elder JS. Disorders and anomalies of the scrotal contents. *Nelson Textbook of Pediatrics, chapter 545*. eds Kliegman RM, Stanton BF, St. Geme JW III, et al. 20th edition 2016;2592-2598.
3. MacDonald A, Burrell S. Infrequently Performed Studies in Nuclear Medicine: Part 2. *Journal of Nuclear Medicine Technology*. 2009;37(1):1-13. doi:10.2967/jnmt.108.057851.
4. Tekgül S, Riedmiller H, Gerharz E, et al. Guidelines on paediatric urology. *European Association of Urology*. Revised March 2013.
5. Alkhorri NA, Barth RA. Pediatric scrotal ultrasound: review and update. *Pediatric Radiology*. 2017;47(9):1125-1133. doi:10.1007/s00247-017-3923-9.
6. Cohen HL, Miller SF Abnormalities of the male genital tract Chapter 125 Caffey's Pediatric Diagnostic Imaging. eds. Coley B, Saunders E, Philadelphia PA, 2013. pp 1193-1200.

PEDPV-13: Penis-Soft Tissue Mass

- Penile soft tissue masses are very rare in pediatric individuals, and imaging indications are identical to those for adult individuals. See **PV-18: Penis – Soft Tissue Mass** in the Pelvis Imaging Guidelines.

PEDPV-14: Incontinence

- Incontinence imaging indications in pediatric individuals are very similar to those for adult individuals. See **PV-22: Urinary Incontinence/Pelvic Prolapse/Fecal Incontinence** in the Pelvis Imaging Guidelines.
- Pediatric-specific imaging considerations include the following:
 - ◆ MRI Pelvis without and with contrast (CPT® 72197) is indicated if ultrasound is inconclusive or spinal abnormality is suspected.
 - ◆ CT Pelvis with contrast (CPT® 72193) is approvable if MRI is not readily available.

Background and Supporting Information

- Most often incontinence in children is not due to a medical condition. Several uncommon disorders that can lead to urinary incontinence include a spinal cord defect such as spina bifida, ureteral duplication with ectopic insertion, and overactive bladder or dysfunctional voiding.

References

1. Elder JS. Enuresis and voiding dysfunction. *Nelson Textbook of Pediatrics*. Chapter 558. eds Kliegman RM, St. Geme JW III, Blum NJ, Shah SS, Tasker RC, Wilson KM. 21st edition 2020;2816-2821.
2. Mandell GA, Eggli DF, Gilday DL, et al. Procedure guideline for radionuclide cystography in children. *Society of Nuclear Medicine*. Version 3.0 approved January 2003.
3. Peters CA, Skoog SJ, Arant BS, et al. Management and screening of primary vesicoureteral reflux in children: AUA guideline 2010. *American Urological Association*.
4. Fettich J, Colarinha P, Fischer S, et al. Guidelines for direct radionuclide cystography in children. *Paediatric Committee of the European Association of Nuclear Medicine*. Dec 2002.

PEDPV-15: Patent Urachus

- Ultrasound Pelvis (CPT® 76856) is indicated as the initial evaluation for patent urachus.
 - ◆ ANY of the following are indicated if the ultrasound is inconclusive or insufficient for preoperative planning:
 - MRI Pelvis without contrast (CPT® 72195)
 - MRI Pelvis without and with contrast (CPT® 72197)
 - CT Pelvis with contrast (CPT® 72193)
- Repeat imaging of asymptomatic individuals is not generally necessary, but is indicated for the following:
 - ◆ New or worsening symptoms
 - ◆ Preoperative planning

Background and Supporting Information

The urachus is a “tube” connecting the fetal bladder to the umbilical cord. It is usually obliterated during fetal growth, but if it remains patent, there can be a complete or partial connection between the bladder and the umbilicus.

References

1. Villavicencio CP, Adam SZ, Nikolaidis P, Yaghmai V, Miller FH. Imaging of the Urachus: Anomalies, Complications, and Mimics. *RadioGraphics*. 2016;36(7):2049-2063. doi:10.1148/rg.2016160062.
2. Berrocal T, López-Pereira P, Arjonilla A, Gutiérrez J. Anomalies of the Distal Ureter, Bladder, and Urethra in Children: Embryologic, Radiologic, and Pathologic Features. *RadioGraphics*. 2002;22(5):1139-1164. doi:10.1148/radiographics.22.5.g02se101139.
3. Little DC, Shah SR, Peter SDS, et al. Urachal anomalies in children: the vanishing relevance of the preoperative voiding cystourethrogram. *Journal of Pediatric Surgery*. 2005;40(12):1874-1876. doi:10.1016/j.jpedsurg.2005.08.029.
4. Yiee JH, Garcia N, Baker LA, Barber R, Snodgrass WT, Wilcox DT. A diagnostic algorithm for urachal anomalies. *Journal of Pediatric Urology*. 2007;3(6):500-504. doi:10.1016/j.jpuro.2007.07.010.
5. Naiditch JA, Radhakrishnan J, Chin AC. Current diagnosis and management of urachal remnants. *Journal of Pediatric Surgery*. 2013;48(10):2148-2152. doi:10.1016/j.jpedsurg.2013.02.069.
6. West HC, Anton CG Bladder and Urethra; Chapter 120 Caffey's Pediatric Diagnostic Imaging. eds. Coley B, Saunders E, Philadelphia PA, 2013. pp 1157-1166.
7. Elder JS. Anomilies of the Bladder Nelson Textbook of Pediatrics, Chapter 556 eds Kliegman RM, St. Geme JW III, Blum NJ, Shah SS, Tasker RC, Wilson KM. 21st edition 2020. pp 2810-2813.