



CLINICAL GUIDELINES

Pediatric Abdomen Imaging Guidelines

Effective: September 1, 2026

VERSION 2.0.2026

EviCore
By ~~EVERNORTH~~

EviCore healthcare Clinical Decision Support Tool Diagnostic Strategies: This tool addresses common symptoms and symptom complexes. Imaging requests for individuals with atypical symptoms or clinical presentations that are not specifically addressed will require physician review. Consultation with the referring physician, specialist, and/or individual's Primary Care Physician (PCP) may provide additional insight.

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General Guidelines

(PEDAB-1)

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Procedure Codes Associated with Abdomen Imaging

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MRI	CPT®
MRI Abdomen without contrast	74181
MRI Abdomen with contrast (rarely used)	74182
MRI Abdomen without and with contrast	74183
Unlisted MRI procedure (for radiation planning or surgical software)	76498
MRA	CPT®
MRA Abdomen	74185
CT	CPT®
CT Abdomen without contrast	74150
CT Abdomen with contrast	74160
CT Abdomen without and with contrast	74170
CT Abdomen and Pelvis without contrast	74176
CT Abdomen and Pelvis with contrast	74177
CT Abdomen and Pelvis without and with contrast	74178
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	CPT®
CTA Abdomen	74175
CTA Abdomen and Pelvis	74174
Nuclear Medicine	CPT®
PET Imaging; limited area (this code not used in pediatrics)	78811
PET Imaging; skull base to mid-thigh (this code not used in pediatrics)	78812
PET Imaging; whole body (this code not used in pediatrics)	78813
PET with concurrently acquired CT; limited area (this code rarely used in pediatrics)	78814
PET with concurrently acquired CT; skull base to mid-thigh	78815
PET with concurrently acquired CT; whole body	78816
Adrenal Nuclear Imaging Cortex and/or Medulla	78075
Spleen Imaging Only with or without Vascular Flow	78185
Liver Imaging Static	78201
Liver Imaging with Vascular Flow	78202
Liver and Spleen Imaging Static	78215
Liver and Spleen Imaging with Vascular Flow	78216
Hepatobiliary System Imaging, Including Gallbladder When Present	78226
Hepatobiliary System Imaging, Including Gallbladder When Present; with Pharmacologic Intervention, Including Quantitative Measurement(s) When Performed	78227

Gastric Mucosa Imaging	78261
Gastroesophageal Reflux Study	78262
Gastric Emptying Study	78264
GI Bleeding Scintigraphy	78278
Gastrointestinal Protein Loss	78282
Intestinal Imaging	78290
Peritoneal-Venous Shunt Patency	78291
Kidney Imaging (Nuclear) Static	78700
Kidney Imaging (Nuclear) with Vascular Flow	78701
Kidney Flow and Function, Single Study without Pharmacologic Intervention	78707
Kidney Imaging with Vascular Flow and Function with Pharmacological Intervention, Single	78708
Kidney Imaging with Vascular Flow and Function with and without Pharmacological Intervention, Multiple	78709
Nuclear Non-imaging Renal Function	78725
Ureteral Reflux Study (Radiopharmaceutical Voiding Cystogram)	78740
Radiopharmaceutical Localization Imaging Limited area	78800
Radiopharmaceutical Localization Imaging Whole Body	78802
Radiopharmaceutical Localization Imaging SPECT	78803
Ultrasound	CPT®
Ultrasound, abdomen; complete	76700

Ultrasound, abdomen; limited	76705
Ultrasound, abdominal wall	76705
Ultrasound, retroperitoneal; complete	76770
Ultrasound, retroperitoneal; limited	76775
Ultrasound, transplanted kidney (with duplex Doppler)	76776
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

General Guidelines (PEDAB-1.0)

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- A pertinent clinical evaluation since the onset or change in symptoms including a detailed history, physical examination, appropriate laboratory studies and basic imaging such as plain radiography or ultrasound should be performed prior to considering advanced imaging (CT, MR, Nuclear Medicine), unless the individual is undergoing guideline-supported scheduled imaging evaluation. A meaningful technological contact (telehealth visit, telephone call, electronic mail or messaging) since the onset or change in symptoms can serve as a pertinent clinical evaluation.
- These guidelines are based upon using advanced imaging to answer specific clinical questions that will affect individual management. Imaging is not indicated if the results will not affect individual management decisions. Standard medical practice would dictate continuing conservative therapy prior to advanced imaging in individuals who are improving on current treatment programs.
- Unless otherwise stated in a specific guideline section, the use of advanced imaging to screen asymptomatic individuals for disorders involving the abdomen is not supported. Advanced imaging should only be approved in individuals who have documented active clinical signs or symptoms of disease.
- Unless otherwise stated in a specific guideline section, repeat imaging studies of the same body area 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 should be the initial imaging study of choice in most children with abdominal conditions and should be done prior to advanced imaging.
 - For those individuals who do require advanced imaging after ultrasound, 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.

Red Flags

- Children with abdominal pain AND ANY of the following red flag signs or symptoms require additional investigation. The initial ultrasound is not required. Additional labs may be helpful but are not required.
 - Pain that wakes the child from sleep
 - Unexplained fever (T >100.4°F)
 - History of malignancy with a likelihood or propensity to metastasize to abdomen

- Dysphagia
- GI bleeding
- Significant vomiting
- Elevated WBC per the testing laboratory's range
- Low WBC (absolute neutrophil count <1000)
- Guarding, rebound tenderness, or other peritoneal signs
- Severe chronic diarrhea or nocturnal diarrhea in a toilet-trained child
- Failure to thrive, involuntary weight loss, or delay in linear growth or pubertal development
- Family history of inflammatory bowel disease, familial polyposis syndrome, celiac disease, or peptic ulcer disease
- Abdominal mass, hepatomegaly, and/or splenomegaly on exam
- Jaundice
- Perianal disease
- Suspected or confirmed COVID-19 infection with concern for multisystem inflammatory syndrome in children (MIS-C)
- Failure to respond to 4 weeks of recent (within 60 days) provider directed conservative care
- See the condition-specific sections for when the above list of exclusionary criteria apply and lead directly to advanced imaging.
- The appropriate advanced imaging for the condition is listed in the condition-specific section.

Health Equity Considerations

Health equity is the highest level of health for all individuals; health inequity is the avoidable difference in health status or distribution of health resources due to the social conditions in which individuals are born, grow, live, work, and age. Social determinants of health are the conditions in the environment that affect a wide range of health, functioning, and quality of life outcomes and risks. Examples include the following: safe housing, transportation, and neighborhoods; racism, discrimination, and violence; education, job opportunities, and income; access to nutritious foods and physical activity opportunities; access to clean air and water; and language and literacy skills.

Pediatric Abdominal Imaging Age Considerations (PEDAB-1.1)

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- Many conditions affecting the abdomen in the pediatric population are different diagnoses than those occurring in the adult population. For those diseases that occur in both pediatric and adult populations, differences may exist in management due to individual age, comorbidities, and differences in disease natural history between children and adults.
- Individuals age 18 years old and younger should be imaged according to the Pediatric Abdomen Imaging Guidelines if discussed. Any conditions not specifically discussed in the Pediatric Abdomen Imaging Guidelines should be imaged according to the General Abdomen Imaging Guidelines. Individuals age >18 years old should be imaged according to the General Abdomen Imaging Guidelines, except where directed otherwise by a specific guideline section.

Pediatric Abdomen Imaging Appropriate Clinical Evaluation and Conservative Treatment (PEDAB-1.2)

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- See: General Guidelines (PEDAB-1.0)

Pediatric Abdomen Imaging Modality General Considerations (PEDAB-1.3)

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- Ultrasound
 - See: **General Guidelines (PEDAB-1.0)**
- MRI
 - MRI Abdomen is generally performed without and with contrast (CPT[®] 74183) 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 these guidelines for the clinical condition being evaluated, MRI of all necessary body areas should be obtained concurrently in the same 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 may be the procedure of choice in these cases.
- CT
 - CT Abdomen typically extends from the dome of the diaphragm to the upper margin of the sacroiliac joints, and CT Abdomen and Pelvis extends from the dome of the diaphragm through the ischial tuberosities.
 - In general, CT Abdomen is appropriate when evaluating solid abdominal organs.
 - In general, CT Abdomen and Pelvis is appropriate when evaluating inflammatory or infectious processes, hematuria, or conditions that 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 Abdomen or Abdomen and Pelvis may be medically necessary for further evaluation of abnormalities suggested on prior US or MRI studies.
 - CT may be medically necessary 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 the best examination may require coordination between the provider and the imaging service.
- Nuclear Medicine
 - Nuclear medicine studies are commonly used in evaluation of the pediatric kidney and gallbladder. Other less common indications exist as well:
 - Esophageal motility study (CPT[®] 78258) and/or Gastroesophageal reflux study (CPT[®] 78262) is medically necessary in the evaluation of gastroesophageal reflux.
 - Nuclear intestinal imaging (preferred code for Meckel's Scan, CPT[®] 78290) or Gastric mucosa imaging (alternate code for Meckel's scan, CPT[®] 78261) is medically necessary for the following:
 - Suspected Meckel's diverticulum
 - Gastric mucosa imaging (CPT[®] 78261) is also medically necessary for:
 - Barrett's esophagus
 - Thoracic masses suspected of containing gastric mucosa
 - Gastric emptying study (CPT[®] 78264) is medically necessary for evaluation of either suspected delayed or rapid gastric emptying.

- Gastric emptying study with small bowel transit (CPT[®] 78265) is medically necessary for evaluation of suspected abnormalities in both total and regional times for gastrointestinal transit of the small bowel.
- Gastric emptying study with small bowel and colon transit (CPT[®] 78266) is medically necessary for evaluation of suspected abnormalities in both total and regional times for gastrointestinal transit to the colon.
- Gastrointestinal bleeding scintigraphy (CPT[®] 78278) is medically necessary for evaluation of brisk active GI bleeding with indeterminate endoscopy.
- Gastrointestinal protein loss study (CPT[®] 78282) is medically necessary for decreased serum albumin or globulins and no evidence of GI bleeding.
- Peritoneal-venous shunt patency study (CPT[®] 78291) is medically necessary for evaluation of shunt patency and function in an individual with ascites.
- Nuclear renal imaging (CPT[®] 78701, CPT[®] 78707, CPT[®] 78708, or CPT[®] 78709) is medically necessary for evaluation of the following:
 - Renal transplant follow-up
 - Kidney salvage vs. nephrectomy surgical decisions
 - Acute renal failure with no evidence of obstruction on recent ultrasound
 - Chronic renal failure to estimate prognosis for recovery
- 3D Rendering
 - 3D Rendering indications in pediatric abdomen imaging are identical to those in the general imaging guidelines. See: **3D Rendering (Preface-4.1)** 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 (PEDAB-1)

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1. Bridges MD. ACR–SPR Practice parameter for the performance and interpretation of magnetic resonance imaging (MRI). Revised 2022 (Resolution 8).
2. Karmazyn BK, John SD, Siegel MJ, et al. ACR–ASER–SCBT–MR–SPR Practice parameter for the performance of pediatric computed tomography (CT). Last review date: 2019 (Resolution 6).
3. Reighard C, Junaid S, Jackson WM, et al. Anesthetic exposure during childhood and neurodevelopmental outcomes: a systematic review and meta-analysis. *JAMA Netw Open*. 2022;5(6):e2217427. doi:10.1001/jamanetworkopen.202217427.
4. Abell TL, Camilleri M, Donohoe K, et al. Consensus Recommendations for Gastric Emptying Scintigraphy: A Joint Report of the American Neurogastroenterology and Motility Society and the Society of Nuclear Medicine. *The American Journal of Gastroenterology*. 2008;103(3):753-763. doi: 10.1111/j.1572-0241.2007.01636.x.
5. 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
6. 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>.
7. Blumfield E, Swenson DW, Iyer RS, Stanescu AL. Gadolinium-based contrast agents — review of recent literature on magnetic resonance imaging signal intensity changes and tissue deposits, with emphasis on pediatric patients. *Pediatric Radiology*. 2019;49(4):448-457. doi: 10.1007/s00247-018-4304-8.
8. Implementation Guide: Medicaid State Plan Eligibility Groups Mandatory Coverage Infants and Children under Age 19 Guidance Portal. <https://www.hhs.gov/guidance/document/implementation-guide-medicaid-state-plan-eligibility-eligibility-groups-aeu-mandatory-2>.
9. Baluch A, Shewayish S. (2019). Neutropenic Fever. In: Velez, A., Lamarche, J., Greene, J. (eds) *Infections in Neutropenic Cancer Patients*. Springer, Cham. https://doi.org/10.1007/978-3-030-21859-1_8.

Generalized Abdominal Pain (PEDAB-2)

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Generalized Abdominal Pain (PEDAB-2)

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- Chronic abdominal pain is a common complaint among children and adolescents. Chronic is defined as abdominal pain lasting for over 2 months.
- Functional abdominal pain disorders, including functional abdominal pain and functional dyspepsia (including symptoms of epigastric pain, burning, postprandial fullness, early satiety), are conditions in which there is no structural or organic disease.
- Ultrasound Abdomen (CPT® 76700 or CPT® 76705) is medically necessary as the initial imaging for children with no red flag signs or symptoms, normal physical examination, and normal laboratory studies (preliminary labs may include CBC, electrolytes, lipase, amylase, urinalysis, ESR, CRP, LFTs, and/or stool for blood and stool culture if diarrhea)
 - Gastroenterology (GI) specialist evaluation or consultation is helpful in determining the need for advanced imaging in these cases.
 - CT Abdomen (CPT® 74160) with contrast or CT Abdomen and Pelvis (CPT® 74177) with contrast is medically necessary if there are any red flag signs or symptoms (as listed in **General Guidelines (PEDAB-1.0)**).
- Children with abdominal pain that can be localized to a particular area of the abdomen should be imaged according to the relevant guideline section:
 - **Right Lower Quadrant Pain (PEDAB-3)**
 - **Flank Pain, Renal Stone (PEDAB-4)**
 - **Right Upper Quadrant Pain (PEDAB-8)**
 - **Left Upper Quadrant Pain (PEDAB-25)**
 - **Left Lower Quadrant Pain (PEDAB-29)**

Health Equity Considerations

Abdominal pain is a common reason for Emergency Department (ED) assessment in the pediatric population. Children with abdominal pain are assessed for conditions that require urgent evaluation and treatment such as appendicitis, intussusception, volvulus, or adhesion.¹¹ Appendicitis is an important diagnostic differential to consider for acute abdominal pain for potential urgent or emergent abdominal surgery. Health outcomes are dependent on appropriate diagnosis and treatment.¹²

Health disparities influence children's healthcare as they may have long-term impacts on important outcomes such as health as an adult, educational attainment, and economic success.¹³ Health disparities facing minority children with abdominal pain include lack of advanced imaging such as ultrasound or computed tomography (CT) scan, and

having a higher appendiceal perforation rate.¹⁴ Studies also showed that racial and ethnic minorities are less likely to receive opioid analgesia even when symptoms are severe.¹⁵ Lastly, non-Hispanic Black and Hispanic individuals were more likely than non-Hispanic whites to have a prolonged length of stay.¹⁶ Solutions to health disparity issues include continued data and research, policy interventions, and individual and family engagement.

References (PEDAB-2)

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1. Maqbool A, Liacouras CA. Major symptoms and signs of digestive tract disorders. Nelson Textbook of Pediatrics, Chapter 352. eds Kliegman RM, St. Geme JW III, Blum NJ, Tasker RC, Wilson KM, Schuh AM, Mack CL. 22nd edition. 2024, pp 2224-2237.
2. Maqbool A, Liacouras CA, Brownell JN, Ufberg PJ. Disorders of Brain-Gut Interaction (Functional Gastrointestinal Disorders). Nelson Textbook of Pediatrics, Chapter 389. eds Kliegman RM, St. Geme JW III, Blum NJ, Tasker RC, Wilson KM, Schuh AM, Mack CL. 22nd edition 2024, pp 2385-2388.
3. Reust CE, Williams A. Acute abdominal pain in children. Am Fam Physician. 2016;93(10):830-6.
4. Sanchez TR, Corwin MT, Davoodian A, Stein-Wexler R. Sonography of Abdominal Pain in Children. *Journal of Ultrasound in Medicine*. 2016;35(3):627-635. doi:10.7863/ultra.15.04047.
5. Harwood R, Partridge R, Minford J, Almond S. Paediatric abdominal pain in the time of COVID-19: a new diagnostic dilemma. *J Surg Case Rep*. 2020;2020(9):rjaa337. doi:10.1093/jscr/rjaa337.
6. Noda S, Ma J, Romberg EK, Hernandez RE, Ferguson MR. Severe COVID-19 initially presenting as mesenteric adenopathy. *Pediatr Radiol*. 2021;51(1):140-143. doi:10.1007/s00247-020-04789-9.
7. Caro-Domínguez P, Navallas M, Riaza-Martin L, Ghadimi Mahani M, et. al. Imaging findings of multisystem inflammatory syndrome in children associated with COVID-19. *Pediatr Radiol*. 2021;51(1):13. doi:10.1007/s00247-021-05065-0.
8. Koppen IJ, Nurko S, Saps M, Di Lorenzo C, Benninga MA. The pediatric Rome IV criteria: what's new? *Expert Rev Gastroenterol Hepatol*. 2017;11(3):193-201. doi:10.1080/17474124.2017.1282820.
9. Sahn B, Eze OP, Edelman MC, Chougar CE, Thomas RM, Schleien CL, Weinstein T. Features of Intestinal Disease Associated With COVID-Related Multisystem Inflammatory Syndrome in Children. *J Pediatr Gastroenterol Nutr*. 2021;72(3):384-387.
10. Hyams JS, Di Lorenzo C, Saps M, Shulman RJ, Staiano A, van Tilburg M. Functional disorders: children and adolescents. *Gastroenterology*. 2016;S0016-5085(16)00181-5. doi:10.1053/j.gastro.2016.02.015.
11. Kim JS. Acute abdominal pain in children. *Pediatr Gastroenterol Hepatol Nutr*. 2013;16(4):219#224. doi:10.5223/pghn.2013.16.4.219.
12. Wang L, Haberland C, Thurm C, Bhattacharya J, Park KT. Health outcomes in US children with abdominal pain at major emergency departments associated with race and socioeconomic status. *PLoS One*. 2015;10(8):e0132758. doi:10.1371/journal.pone.0132758.
13. Montoya-Williams D, Peña MM, Fuentes-Afflick E. In pursuit of health equity in pediatrics. *J Pediatr X*. 2020;5:100045. doi:10.1016/j.jymptdx.2020.100045.
14. Goyal MK, Chamberlain JM, Webb M, et al; Pediatric Emergency Care Applied Research Network (PECARN). Racial and ethnic disparities in the delayed diagnosis of appendicitis among children. *Acad Emerg Med*. 2021;28(9):949#956. doi:10.1111/acem.14142.
15. Guedj R, Marini M, Kossowsky J, Berde CB, Kimia AA, Fleegler EW. Racial and ethnic disparities in pain management of children with limb fractures or suspected appendicitis: a retrospective cross-sectional study. *Front Pediatr*. 2021;9:652854. doi:10.3389/fped.2021.652854.
16. Johnson TJ, Weaver MD, Borrero S, Davis EM, Myaskovsky L, Zuckerbraun NS, Kraemer KL. Association of race and ethnicity with management of abdominal pain in the emergency department. *Pediatrics*. 2013;132(4):e851#e858. doi:10.1542/peds.2012-3127.

Right Lower Quadrant Pain (PEDAB-3)

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Right Lower Quadrant Pain (PEDAB-3)

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- The presence of any red flag findings per **General Guidelines (PEDAB-1.0)** precludes adjudication based on any other criteria.
- Ultrasound (CPT® 76700 or CPT® 76705) is medically necessary as the initial examination. If positive or negative for uncomplicated appendicitis, no further imaging is necessary.
 - If the appendix is not visualized on ultrasound and the white blood cell count is not elevated, no further imaging is necessary in nearly all cases, although the referring physician should make the final determination of the need for advanced imaging.
- CT Abdomen and Pelvis with contrast (CPT® 74177), MRI Abdomen and Pelvis without contrast (CPT® 74181 and CPT® 72195), or MRI Abdomen and Pelvis without and with contrast (CPT® 74183 and CPT® 72197) is medically necessary for any of the following:
 - Individuals who are overweight (BMI $\geq 85^{\text{th}}$ percentile for age)
 - Insufficient local ultrasound expertise exists
 - Ultrasound findings are inconclusive
 - Clinical suspicion of or initial imaging suggestive of complication (e.g., abscess, bowel obstruction)
- If the appendix is absent, follow guidelines in: **Generalized Abdominal Pain (PEDAB-2)**

References (PEDAB-3)

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1. Salazar JH, Aiken JJ. Acute Appendicitis. Nelson Textbook of Pediatrics, Chapter 391. eds Kliegman RM, St. Geme JW III, Blum NJ, Tasker RC, Wilson KM, Schuh AM, Mack CL. 22nd edition 2024. pp 2397-2403.
2. Cohen B, Bowling J, Midulla P, et al. The non-diagnostic ultrasound in appendicitis: is a non-visualized appendix the same as a negative study? *Journal of Pediatric Surgery*. 2015;50(6):923-927. doi:10.1016/j.jpedsurg.2015.03.012.
3. Bachur RG, Levy JA, Callahan MJ, Rangel SJ, Monuteaux MC. Effect of Reduction in the Use of Computed Tomography on Clinical Outcomes of Appendicitis. *JAMA Pediatrics*. 2015;169(8):755. doi:10.1001/jamapediatrics.2015.0479.
4. Dibble EH, Swenson DW, Cartagena C, Baird GL, Herliczek TW. Effectiveness of a Staged US and Unenhanced MR Imaging Algorithm in the Diagnosis of Pediatric Appendicitis. *Radiology*. 2018;286(3):1022-1029. doi:10.1148/radiol.2017162755.
5. Koberlein GC, Trout AT, Rigsby CK, et al. ACR Appropriateness Criteria® Suspected Appendicitis-Child. *Journal of the American College of Radiology*. 2019;16(5). doi:10.1016/j.jacr.2019.02.022.
6. Repplinger MD, Pickhardt PJ, Robbins JB, et al. Prospective Comparison of the Diagnostic Accuracy of MR Imaging versus CT for Acute Appendicitis. *Radiology*. 2018;288(2):467-475. doi:10.1148/radiol.2018171838.
7. Harwood R, Partridge R, Minford J, Almond S. Paediatric abdominal pain in the time of COVID-19: a new diagnostic dilemma. *J Surg Case Rep*. 2020;2020(9):rjaa337. doi:10.1093/jscr/rjaa337.
8. Imler D, Keller C, Sivasankar S, et. al. Magnetic resonance imaging versus ultrasound as the initial imaging modality for pediatric and young adult patients with suspected appendicitis. *Acad Emerg Med*. 2017;24(5):569-577. doi:10.1111/acem.13180.
9. Jennings R, Guo H, Goldin A, Wright DR. Cost-effectiveness of imaging protocols for suspected appendicitis. *Pediatrics*. 2020;145(2):e20191352. doi:10.1542/peds.2019-1352.
10. AlFraih Y, Robinson T, Stein N, Kam A, Flageole H. Quality assurance and performance improvement project for suspected appendicitis. *Pediatr Qual Saf*. 2020;5(3):e290. doi:10.1097/pq9.0000000000000290.
11. Wolfe C, Halsey-Nichols M, Ritter K, McCoin N. Abdominal pain in the emergency department: how to select the correct imaging for diagnosis. *Open Access Emerg Med*. 2022;14:335-345. doi:10.2147/OAEM.S342724.
12. Badlis, M., Amari, K., Alkheshi, M. et al. Ultrasound and computed tomography in differentiating between simple and complicated appendicitis in pediatric patients. *Pediatr Surg Int*. 2024;40(299). doi:10.1007/s00383-024-05880-0.
13. Desoky SM, George M, Epelman M, et al. Imaging of right lower quadrant pain in children and adolescents: AJR Expert Panel narrative review. *AJR Am J Roentgenol*. 2022;220(6):765-910. doi: 10.2214/AJR.22.28358.
14. Mangus CW, Janke AT, Mahajan P, Michelson KA. MRI adoption in pediatric appendicitis: trends and outcomes. *Hosp Pediatr*. 2025;15(5):416–422. doi:10.1542/hpeds.2024-008077.

Flank Pain, Renal Stone (PEDAB-4)

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Flank Pain, Renal Stone (PEDAB-4)

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- The presence of any red flag findings per **General Guidelines (PEDAB-1.0)** precludes adjudication based on any other criteria.
- Flank Pain imaging indications in pediatric individuals are very similar to those for adult individuals. See: **Flank Pain, Rule Out or Known Renal/Ureteral Stone (AB-4)** in the Abdomen Imaging Guidelines.
 - Ultrasound (CPT[®] 76770 or CPT[®] 76775) is the medically necessary initial study in children.
 - CT Abdomen and Pelvis without contrast (CPT[®] 74176) is medically necessary if ultrasound is inconclusive.
 - MRI Abdomen (CPT[®] 74183) and Pelvis (CPT[®] 72197) without and with contrast is medically necessary if CT is inconclusive or if significant concern for radiation exposure from frequent CT use for a particular individual.
 - If hematuria is present, see: **Hematuria (PEDAB-7)** for imaging guidelines.
- Nuclear kidney imaging (CPT[®] 78707, CPT[®] 78708, CPT[®] 78709, or CPT[®] 78803) is medically necessary for evaluation of recurrent flank pain when CT and ultrasound are non-diagnostic, or for suspected obstructive uropathy.

References (PEDAB-4)

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1. American College of Radiology ACR Appropriateness Criteria® Acute onset of flank pain-Suspicion of stone disease (Urolithiasis) Revised 2015. <https://acsearch.acr.org/docs/69362/Narrative/>. doi: 10.1097/ruq.0b013e3182625974.
2. Kim CK, Biyyam DR, Becker MD, et al. ACR–SPR Practice parameter for the performance of renal scintigraphy. Revised 2017 (Resolution 29).
3. Tekgül S, Dogan HS, Kočvara R, et al. European Association of Urology. *European Society for Paediatric Urology. Guidelines on Paediatric Urology* 2015 with limited text update March 2017.
4. Mendichovszky I, Solar BT, Smeulders N, Easty M, Biassoni L. Nuclear Medicine in Pediatric Nephro-Urology: An Overview. *Seminars in Nuclear Medicine*. 2017;47(3):204-228. doi: 10.1053/j.semnuclmed.2016.12.002.
5. Dillman JR, Rigsby CK, Iyer RS, Alazraki AL, Anupindi SA, Brown BP, Chan SS, Dorfman SR, Falcone RA, Garber MD, Nguyen JC. ACR Appropriateness Criteria® Hematuria-Child. *Journal of the American College of Radiology*. 2018 May 31;15(5):S91-103.
6. Bowen DK, Tasian GE. Pediatric Stone Disease. *Urologic Clinics of North America*. 2018;45(4):539-550. doi: 10.1016/j.ucl.2018.06.002.
7. Grivas N, Thomas K, Drake T, et al. Imaging modalities and treatment of paediatric upper tract urolithiasis: A systematic review and update on behalf of the EAU urolithiasis guidelines panel. *J Pediatr Urol*. 2020;16(5):612-624.

Urinary Tract Infection (UTI) (PEDAB-5)

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Upper Urinary Tract (PEDAB-5.1)

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- Ultrasound evaluation (CPT[®] 76770 or CPT[®] 76775) is the medically necessary initial imaging for all children with first-time upper urinary tract infection to diagnose hydronephrosis, pyelonephritis, or congenital renal anomaly.
 - If hydronephrosis is present, this should be further evaluated with voiding cystourethrography (VCUG), to evaluate for vesicoureteral reflux.
 - In boys, this is generally accomplished using fluoroscopic imaging and iodinated contrast to exclude urethral abnormalities.
 - In girls, Ureteral Reflux Study (Radiopharmaceutical Voiding Cystogram) (CPT[®] 78740) or fluoroscopic VCUG may be performed.
 - Contrast Enhanced Voiding Urosonography (CeVUS) may also be utilized at institutions with expertise in this modality.
- Diuretic renography using Tc-99m MAG 3 (CPT[®] 78707, CPT[®] 78708, or CPT[®] 78709) is medically necessary for:
 - differentiating a dilated non-obstructed urinary system from a true stenosis (e.g., UPJ obstruction; ureteral-vesical junction [UVJ] obstruction)
 - quantifying renal parenchymal function
 - ultrasound findings that are compatible with a multicystic dysplastic kidney to evaluate function of the affected kidney or a ureteral-pelvic junction (UPJ) obstruction of the contralateral kidney
 - diagnostic evaluation of upper tract dilatation when VCUG is negative
 - renal function evaluation in individuals with hydronephrosis
- CT is sensitive in diagnosing pyelonephritis and has a role in evaluation of renal abscess or unusual complications such as xanthogranulomatous pyelonephritis but has no role in the routine evaluation of UTI.
 - CT Abdomen and Pelvis with contrast (CPT[®] 74177) is medically necessary to evaluate the entire genitourinary tract for congenital abnormalities of distal tracts in complicated pyelonephritis.
- Magnetic resonance urography (MRU) (CPT[®] 74183 and CPT[®] 72197), is not a first-line test for the routine evaluation of a UTI but is medically necessary (where available) for investigation of a dilated upper urinary tract.
 - NOTE: MRU requires sedation in young children.
 - MRU can also quantitate renal function.
- Technetium-99m-dimercaptosuccinic acid (Tc-99m DMSA) scintigraphy (CPT[®] 78700, CPT[®] 78701, or CPT[®] 78803), is sensitive for evaluation of renal cortical damage.
 - DMSA scintigraphy is medically necessary for:
 - individuals with atypical or recurrent febrile acute urinary tract infections

- Atypical findings may include poor response to antibiotics, elevated creatinine, poor urine stream, or non E-coli organism.
- individuals with febrile urinary tract infections older than 5 years of age with known vesicoureteral reflux
- detection of post-pyelonephritic renal scarring at least 6 months after the documented upper tract UTI in high-risk individuals with recurrent UTIs
- Radiopharmaceutical nuclear medicine imaging (CPT® 78800, CPT® 78801, CPT® 78802, CPT® 78803, CPT® 78830, CPT® 78831, or CPT® 78832) is medically necessary for evaluation of suspected pyelonephritis or diffuse interstitial nephritis.
- Nuclear non-imaging renal function study (CPT® 78725) is a quantitative study that can be used to evaluate renal function.
- US Kidneys and bladder (CPT® 76770 or CPT® 76775) (preferred) and/or Voiding Cystourethrography (CPT® 78740) are medically necessary for children with atypical (poor response to antibiotics within 48 hours, sepsis, poor urine stream, raised creatinine, or non-E. coli UTI) or recurrent febrile UTI.

Lower Urinary Tract (PEDAB-5.2)

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- Ultrasound evaluation (CPT[®] 76770 or CPT[®] 76775) is medically necessary as the initial imaging for all children with first time UTI to diagnose hydronephrosis, pyelonephritis, or congenital renal anomaly.
 - Fluoroscopic Voiding cystourethrography (VCUG) is medically necessary for detection of possible vesico-ureteral reflux (VUR) in neonates or young children when hydronephrosis is seen on ultrasound.
- The American Academy of Pediatrics clinical practice guidelines no longer recommend routine VCUG for females, 2 to 24 months of age, after the first febrile UTI.
 - The current recommendation is to postpone the VCUG until the second febrile UTI UNLESS there are:
 - atypical or complex clinical circumstances
 - renal/bladder ultrasound findings that reveal hydronephrosis, scarring, or obstructive uropathy
- Vesicoureteral Reflux (VUR)
 - Fluoroscopic VCUG is typically performed for diagnosis and grading of VUR, and is the medically necessary first modality used for diagnosis.
 - Ureteral Reflux Study (Radiopharmaceutical Voiding Cystogram) (CPT[®] 78740), fluoroscopic VCUG, or CeVUS are medically necessary for follow up imaging of VUR.
- Male individuals with first UTI should be evaluated with fluoroscopic VCUG studies rather than radionuclide cystography, to visualize the male urethra for possible abnormalities such as posterior urethral valves, strictures, or diverticula.
- For female individuals, radionuclide cystography (CPT[®] 78740) or fluoroscopic VCUG are medically necessary as the initial study.
- MR urography is medically necessary for evaluation of ectopic distal ureteral insertion, or other complex lower urinary tract anatomy.
- Siblings of individuals with known vesicoureteral reflux can undergo Ureteral Reflux Study (Radiopharmaceutical Voiding Cystogram) (CPT[®] 78740) if they have renal scarring on ultrasound or history of UTI and no prior evaluation for VUR.

References (PEDAB-5)

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1. Urinary Tract Infection: Clinical Practice Guideline for the Diagnosis and Management of the Initial UTI in Febrile Infants and Children 2 to 24 Months. *Pediatrics*. 2011;128(3):595-610. doi:10.1542/peds.2011-1330.
2. Wang ME, Chang PW. Urinary tract infections. *Nelson Textbook of Pediatrics*, Chapter 575. eds Kliegman RM, St. Geme JW III, Blum NJ, Tasker RC, Wilson KM, Schuh AM, Mack CL. 22nd edition. 2024, pp 3263-3268.
3. Jackson EC. Urinary Tract Infections in Children: Knowledge Updates and a Salute to the Future. *Pediatrics in Review*. 2015;36(4):153-166. doi:10.1542/pir.36-4-153.
4. Peters CA, Skoog SJ, Arant BS, et al. Management and screening of primary vesicoureteral reflux in children. *American Urological Association*. Published 2010. Reviewed and Validity Confirmed 2017.
5. Fettich J, Colarinha P, Fischer S, et al. Guidelines for direct radionuclide cystography in children. *European Journal of Nuclear Medicine and Molecular Imaging*. 2003;30(5). doi:10.1007/s00259-003-1137-x.
6. Mendichovszky I, Solar BT, Smeulders N, Easty M, Biassoni L. Nuclear Medicine in Pediatric Nephro-Urology: An Overview. *Seminars in Nuclear Medicine*. 2017;47(3):204-228. doi:10.1053/j.semnuclmed.2016.12.002.
7. Riccabona M. Imaging in childhood urinary tract infection. *La radiologia medica*. 2015;121(5):391-401. doi:10.1007/s11547-015-0594-1.
8. ACR Appropriateness Criteria® Urinary Tract Infection-Child: 2023 Update. Expert Panel on Pediatric Imaging; Chandra T, Bajaj M, Iyer RS, et al. *J Am Coll Radiol*. 2024;21(6S):S326-S342. doi:10.1016/j.jacr.2024.02.025.
9. Buettcher M, Trueck J, Niederer-Loher A, et al. Swiss consensus recommendations on urinary tract infections in children. *European Journal of Pediatrics*. 2021;180(3):663-74.
10. Vali R, Armstrong IS, Bar-Sever Z, et al. SNMMI procedure standard/EANM practice guideline on pediatric [99mTc] Tc-DMSA renal cortical scintigraphy: an update. *Clinical and Translational Imaging*. 2022;4:1-2.
11. Ergun R, Sekerci CA, Tanidir Y, et al. Abnormal DMSA renal scan findings and associated factors in older children with vesicoureteral reflux. *International Urology and Nephrology*. 2021;53(10):1963-8.
12. ACR-SPR practice parameter for the performance of fluoroscopic and sonographic voiding cystourethrography in children. Revised 2019 (Resolution 10). Available at: <https://www.acr.org/-/media/ACR/Files/Practice-Parameters/voidingcysto.pdf?la=en>.
13. Smith, A, Nickoladis P, Kharu G., et al. Expert Panel on Urological Imaging. ACR Appropriateness Criteria® Acute Pyelonephritis. *Am Coll Radiol (ACR)*; Revised 2022. <https://acsearch.acr.org/docs/69489/Narrative/>.
14. Yang S, Gill PJ, Anwar MR, et al. Kidney ultrasonography after first febrile urinary tract infection in children. *JAMA Pediatr*. 2023;177(8):764-773. doi:10.1001/jamapediatrics.2023.1387.
15. Mattoo TK, Shaikh N, Nelson CP. Contemporary management of urinary tract infection in children. *Pediatrics*. 2021;147(2):e2020012138. doi:10.1542/peds.2020-012138.
16. Olson P, Dudley AG, Rowe CK. Contemporary management of urinary tract infections in children. *Curr Treat Options Peds*. 2022;8(3):192-210. doi:10.1007/s40746-022-00242-1.

Pediatric Acute Gastroenteritis (PEDAB-6)

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Pediatric Acute Gastroenteritis (PEDAB-6)

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- Advanced imaging is not medically necessary in pediatric acute gastroenteritis unless there is a concern for diagnosis other than acute gastroenteritis. See specific symptom/diagnosis sections listed below.
- CT Abdomen and Pelvis with contrast (CPT® 74177) is medically necessary if abdominal red flag symptoms are present as listed in **General Guidelines (PEDAB-1.0)**.
- Additional imaging studies will depend on the specific symptoms. See the following sections for additional imaging guidelines:
 - **Generalized Abdominal Pain (PEDAB-2)** in the Pediatric Abdomen Imaging Guidelines
 - **Right Lower Quadrant Pain (PEDAB-3)** in the Pediatric Abdomen Imaging Guidelines
 - **Right Upper Quadrant Pain (PEDAB-8)** in the Pediatric Abdomen Imaging Guidelines
 - **Inflammatory Bowel Disease, Crohn Disease, or Ulcerative Colitis (PEDAB-9)** in the Pediatric Abdomen Imaging Guidelines
 - **Constipation, Diarrhea, and Irritable Bowel Syndrome (PEDAB-12)** in the Pediatric Abdomen Imaging Guidelines
 - **Abdominal Mass (PEDAB-13)** in the Pediatric Abdomen Imaging Guidelines
 - **Left Upper Quadrant (PEDAB-25)** in the Pediatric Abdomen Imaging Guidelines
 - **Intussusception (PEDAB-27)** in the Pediatric Abdomen Imaging Guidelines
 - **Bowel Obstruction (PEDAB-28)** in the Pediatric Abdomen Imaging Guidelines
 - **Left Lower Quadrant Pain (PEDAB-29)** in the Pediatric Abdomen Imaging Guidelines

References (PEDAB-6)

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1. Hammershaimb EA, Kotloff KL. Acute gastroenteritis in children. Nelson Textbook of Pediatrics. Chapter 366. eds Kliegman RM, St. Geme JW III, Blum NJ, Tasker RC, Wilson KM, Schuh AM, Mack CL. 22nd edition. 2024. pp 2355-2375.

Hematuria (PEDAB-7)

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Hematuria (PEDAB-7)

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Hematuria is a relatively common complaint in pediatric individuals, and the imaging considerations are different from those occurring in adult individuals.

- Ultrasound kidneys (CPT[®] 76770 or CPT[®] 76775) and bladder (CPT[®] 76856 or CPT[®] 76857) are medically necessary for asymptomatic gross hematuria or microscopic hematuria with proteinuria present.
- Imaging is not considered medically necessary for asymptomatic microscopic hematuria without proteinuria.
- For painful hematuria and no recent trauma, ANY of the following studies are medically necessary:
 - CT Abdomen and Pelvis without contrast (CPT[®] 74176)
 - Ultrasound kidneys (CPT[®] 76770 or CPT[®] 76775)
 - Ultrasound bladder (CPT[®] 76856 or CPT[®] 76857)
- For hematuria and recent trauma, the following studies are medically necessary:
 - CT Abdomen and Pelvis with contrast (CPT[®] 74177)
- CT Cystography (CT Pelvis with bladder contrast – CPT[®] 72193) is medically necessary if gross hematuria is present and pelvic fracture or traumatic bladder injury is suspected.
- 3-D reconstruction (CPT[®] 76377 or CPT[®] 76376) is medically necessary, if requested, for surgical planning.

References (PEDAB-7)

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1. Dillman JR, Rigsby CK, Iyer RS, Alazraki AL, Anupindi SA, Brown BP, Chan SS, Dorfman SR, Falcone RA, Garber MD, Nguyen JC. ACR Appropriateness Criteria® Hematuria-Child. *Journal of the American College of Radiology*. 2018 May 31;15(5):S91-103.
2. Flores FX. Clinical evaluation of the child with hematuria. Nelson Textbook of Pediatrics. Chapter 558. eds Kliegman RM, St. Geme JW III, Blum NJ, Tasker RC, Wilson KM Schuh AM, Mack CL. 22nd edition 2024, pp 3184-3185.
3. ACR Appropriateness Criteria® Hematuria-Child. Revised 2018.
4. Viteri B, Calle-Toro JS, Furth S, Darge K, Hartung EA, Otero H. State-of-the-art renal imaging in children. *Pediatrics*. 2020;145(2):e20190829. doi:10.1542/peds.2019-0829.

Right Upper Quadrant Pain (PEDAB-8)

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Right Upper Quadrant Pain (PEDAB-8)

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- The presence of any red flag findings per **General Guidelines (PEDAB-1.0)** precludes adjudication based on any other criteria.
- Right upper quadrant pain imaging indications in pediatric individuals are very similar to those for adult individuals. See: **Abdominal Pain (AB-2)** in the Abdomen Imaging Guidelines.
 - US Abdomen (CPT[®] 76700) and/or Nuclear medicine imaging of the hepatobiliary system (HIDA scan, CPT[®] 78226 or CPT[®] 78227) is medically necessary for initial diagnosis of:
 - suspected acute cholecystitis or acalculous cholecystitis (symptoms may include RUQ pain with fever, elevated white blood cell count, positive Murphy sign).
 - suspected gallstones and bile duct obstruction (symptoms may include RUQ pain, no fever, normal white blood cell count).
 - Ultrasound results are not needed prior to nuclear medicine imaging of the hepatobiliary system (HIDA scan, CPT[®] 78226 or CPT[®] 78227).
 - MRI Abdomen with and without contrast (CPT[®] 74183) or CT Abdomen with contrast (CPT[®] 74160) is medically necessary when either US or NM is equivocal.
 - In individuals with complaints of RUQ pain with no fever and an ultrasound shows only gallstones, MRI Abdomen without contrast (CPT[®] 74181), MRI Abdomen without and with contrast (CPT[®] 74183), or Nuclear medicine imaging of the hepatobiliary system (HIDA scan, CPT[®] 78226 or CPT[®] 78227) is medically necessary to exclude other sources of pain.

References (PEDAB-8)

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1. Gerard PS, Biyyam DR, Brown RKJ, et al. ACR-SPR practice parameter for the performance of hepatobiliary scintigraphy. *ACR Practice Parameters*. Revised 2021 (Resolution 22).

Inflammatory Bowel Disease, Crohn Disease, or Ulcerative Colitis (PEDAB-9)

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Inflammatory Bowel Disease, Crohn Disease, or Ulcerative Colitis (PEDAB-9)

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- Enterography is the medically necessary advanced imaging study for individuals with inflammatory bowel disease (IBD).
 - MR Enterography (CPT[®] 74183 or CPT[®] 74181 and CPT[®] 72197 or CPT[®] 72195) is generally preferred over CT when possible to avoid radiation exposure for children.

Children with Suspected Crohn Disease

Clinical features including weight loss, loose stools, vomiting, and intermittent abdominal pain. Small bowel imaging can provide important information to guide treatment relating to presence, severity, and extent of Crohn's disease and its complications. Initial evaluation typically includes laboratory evaluation and upper and lower endoscopy.

- MR Enterography (CPT[®] 74183 or CPT[®] 74181 and CPT[®] 72197 or CPT[®] 72195), CT Enterography (CPT[®] 74177), or MRI Abdomen and Pelvis without and with contrast (CPT[®] 74183 and CPT[®] 72197) is medically necessary for ANY of the following:
 - To detect severity and distribution of inflammatory changes
 - To identify complications (such as fistulizing disease or abscess formation)
- MR Enterography (CPT[®] 74183 or CPT[®] 74181 and CPT[®] 72197 or CPT[®] 72195) or CT Enterography (CPT[®] 74177) is medically necessary for evaluation of chronic abdominal pain associated with diarrhea due to concern for inflammatory bowel disease if:
 - there is a positive family history of inflammatory bowel disease, **OR**
 - there are endoscopy or colonoscopy findings suggestive of inflammatory bowel disease, **OR**
 - elevated inflammatory markers (fecal lactoferrin $\geq 4.0\text{ug/g}$, CRP $>0.5\text{mg/dL}$, or fecal calprotectin $\geq 50\text{ug/g}$), **OR**
 - diagnosis is still in doubt after colonoscopy and evaluation of inflammatory markers, and Crohn's disease is suspected.
- MR Enterography (CPT[®] 74183 or CPT[®] 74181 and CPT[®] 72197 or CPT[®] 72195) or CT Enterography (CPT[®] 74177) is medically necessary prior to endoscopy if requested by or in consultation with the physician who will be performing the endoscopy.

- MRI Pelvis with contrast (CPT[®] 72196) or MRI Pelvis without and with contrast (CPT[®] 72197) is medically necessary for the following:
 - Concern for perianal fistula or abscess
- See: **IBD (Crohn's Disease or Ulcerative Colitis) (AB-23.1)** in the Abdomen Imaging Guidelines for additional information regarding serologic markers

Children with Established IBD

- MR Enterography (CPT[®] 74183 or CPT[®] 74181 and CPT[®] 72197 or CPT[®] 72195), CT Enterography (CPT[®] 74177), or MRI Abdomen and Pelvis without and with contrast (CPT[®] 74183 and CPT[®] 72197), is medically necessary for ANY of the following:
 - Monitoring response to disease-modifying treatment on an annual basis or when treatment change is being considered
 - Monitoring post-operative recurrence
 - Individuals with new or worsening symptoms or suspected complications including abscess, perforation, fistula, or obstruction
- CT Abdomen and Pelvis with contrast (CPT 74177) is medically necessary if requested (instead of CTE or MRE) for ANY of the following:
 - New or worsening symptoms
 - Suspected complications including abscess, perforation, fistula, or obstruction
- MRI Pelvis with contrast (CPT[®] 72196) or MRI Pelvis without and with contrast (CPT[®] 72197) is medically necessary for the following:
 - Concern for perianal fistula or abscess

References (PEDAB-9)

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1. Moore MM, Gee MS, Iyer RS, et. al. ACR Appropriateness Criteria[®] Crohn Disease-Child. *J Am Coll Radiol*. 2022;19(5S):S19-S36.
2. Duigenan S, Gee MS. Imaging of Pediatric Patients With Inflammatory Bowel Disease. *American Journal of Roentgenology*. 2012;199(4):907-915. doi: 10.2214/ajr.11.7966.
3. Stein RE, Anupindi SA, Baldassano RN. Inflammatory bowel disease. Nelson Textbook of Pediatrics, Chapter 336. eds Kliegman RM, St. Geme JW III, Blum NJ, Shah SS, Tasker RC, Wilson KM, Schuh AM, Mack CL. 22nd edition. 2024, pp 2316-2322.
4. Maltz R, Podberesky DJ, Saeed SA. Imaging modalities in pediatric inflammatory bowel disease. *Current Opinion in Pediatrics*. 2014;26(5):590-596. doi: 10.1097/mop.0000000000000131.
5. Schooler GR, Hull NC, Mavis A, Lee EY. MR Imaging Evaluation of Inflammatory Bowel Disease in Children: *Magnetic Resonance Imaging Clinics of North America*. 2019;27(2):291-300. doi: 10.1016/j.mric.2019.01.007.
6. Bruining DH, Zimmermann EM, Loftus EV Jr, Sandborn WJ, Sauer CG, Strong SA. Consensus recommendations for evaluation, interpretation, and utilization of computed tomography and magnetic resonance enterography in patients with small bowel Crohn's disease. *Radiology*. 2018;154(4):1172-1194. doi: 10.1148/radiol.2018171737.
7. Splawski JB, Pfefferkorn MD, Schaefer ME, et al. NASPGHAN clinical report on postoperative recurrence in pediatric crohn disease. *JPGN*. 2017;65:475-48.
8. Chavhan GB, Caro-Dominguez P. Diffusion-weighted imaging in pediatric body magnetic resonance imaging. *Pediatric Radiology*. 2016;46:847-857.
9. He L, Sun Y, Hu X, Yao Q. Diagnostic performance of magnetic resonance enterography and ultrasound in children with inflammatory bowel disease: a diagnostic test accuracy meta-analysis. *Eur Radiol*. 2022;32(2):1330-1341. doi:10.1007/s00330-021-08172-6.
10. Furman MS, Lee EY. Beyond Crohn disease: Current role of radiologists in diagnostic imaging assessment of inflammatory bowel disease transitioning from pediatric to adult patients. *Radiol Clin North Am*. 2020;58(3):517-527. doi:10.1016/j.rcl.2020.01.007.
11. Kim PH, Yoon HM, Jung AY, Lee JS, Cho YA. Diagnostic performance of diffusion-weighted imaging for evaluation of bowel inflammation in paediatric inflammatory bowel disease: a systematic review and meta-analysis. *Journal of Crohn's and Colitis*. 2022;16(1):68-78. doi:10.1093/ecco-jcc/jjab111.

Abdominal Sepsis (Suspected Abdominal Abscess) (PEDAB-10)

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Abdominal Sepsis (Suspected Abdominal Abscess) (PEDAB-10)

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- Abdominal sepsis imaging indications in pediatric individuals are identical to those for adult individuals.
 - See: **Abdominal Sepsis (Suspected Abdominal Abscess) (AB-3)** in the Abdomen Imaging Guidelines.

Postoperative Pain within 60 Days Following Abdominal Surgery (PEDAB-11)

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Postoperative Pain within 60 Days Following Abdominal Surgery (PEDAB-11)

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- Any of the following are medically necessary in individuals with suspected postoperative complications (e.g., bowel obstruction, abscess, anastomotic leak, etc.):
 - CT Abdomen and Pelvis with contrast (CPT® 74177)
 - Ultrasound Abdomen (CPT® 76700 or CPT® 76705)
 - MRI Abdomen and Pelvis without and with contrast (CPT® 74183 and CPT® 72197)
 - MRI Abdomen and Pelvis without contrast (CPT® 74181 and CPT® 72195)
 - Because MRI may not be practical for the timely evaluation of post-operative abscesses, MRI should only replace CT when the study can be completed in a similar time frame as CT.
- Radiopharmaceutical nuclear medicine imaging (CPT® 78800, CPT® 78801, CPT® 78802, CPT® 78803, CPT® 78830, CPT® 78831, or CPT® 78832) is medically necessary for evaluation of any of the following:
 - Peritonitis
 - Postoperative fever without localizing signs or symptoms
- Beyond 60 days post-operatively, see: **Generalized Abdominal Pain (PEDAB-2)**.

References (PEDAB-11)

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1. Chang KJ, Marin DM, Kim DH, et al. Suspected small bowel obstruction. *ACR Appropriateness Criteria*®. Date of origin: 1996. Last review date: 2019.
2. Yagmhai V, Rosen MP, Lalani T, et al. Acute (nonlocalized) abdominal pain and fever or suspected abdominal abscess. *ACR Appropriateness Criteria*®. Date of origin: 1996. Last review date: 2012.
3. Vries EFJD, Roca M, Jamar F, Israel O, Signore A. Guidelines for the labelling of leucocytes with 99mTc-HMPAO. *European Journal of Nuclear Medicine and Molecular Imaging*. 2010;37(4):842-848. doi: 10.1007/s00259-010-1394-4.
4. ACR–SABI–SAR–SPR PRACTICE PARAMETER FOR THE PERFORMANCE OF COMPUTED TOMOGRAPHY (CT) OF THE ABDOMEN AND COMPUTED TOMOGRAPHY (CT) OF THE PELVIS Revised 2021.
5. Lee MH, Eutsler EP, Sheybani EF, Khanna G. Rapid non-contrast magnetic resonance imaging for post appendectomy intra-abdominal abscess in children. *Pediatric Radiology*. 2017;47:935–941.

Constipation, Diarrhea, and Irritable Bowel Syndrome (PEDAB-12)

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Constipation, Diarrhea, and Irritable Bowel Syndrome (PEDAB-12)

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- Constipation and diarrhea are extremely common complaints in children. The overwhelming majority of individuals do not require advanced imaging for evaluation of constipation or diarrhea.
- Irritable bowel is rare in young children, but more common in adolescents. The overwhelming majority of individuals do not require advanced imaging for evaluation of irritable bowel syndrome.
 - In most cases, causes of constipation can be excluded based on a careful history and physical examination. Advanced Imaging should be performed if warning signs of other diseases are present.
- Constipation associated with additional signs or symptoms:
 - CT Abdomen (CPT® 74160) or Abdomen and Pelvis (CPT® 74177) with contrast is medically necessary if there are any red flag signs or symptoms (as listed in **General Guidelines (PEDAB-1.0)**)
 - Clinical suspicion of tethered cord (e.g., abnormal physical findings over the spine, abnormal neurological exam, or symptoms refractory to provider-directed treatment for at least 3 months), see: **Spinal Dysraphism and Tethered Cord (PEDSP-4)** in the Pediatric and Special Populations Spine Imaging Guidelines.
- Diarrhea associated with additional signs or symptoms:
 - CT Abdomen (CPT® 74160) with contrast or CT Abdomen and Pelvis (CPT® 74177) with contrast is medically necessary if there are any red flag signs or symptoms (as listed in **General Guidelines (PEDAB-1.0)**).
 - See: **Inflammatory Bowel Disease, Crohn Disease, or Ulcerative Colitis (PEDAB-9)** for concerns regarding suspected inflammatory bowel disease.
- Irritable bowel syndrome associated with additional signs or symptoms:
 - CT Abdomen (CPT® 74160) with contrast or CT Abdomen and Pelvis (CPT® 74177) with contrast is medically necessary if there are any red flag signs or symptoms (as listed in **General Guidelines (PEDAB-1.0)**).
- Hirschsprung disease:
 - MRI Pelvis without and with contrast (CPT® 72197) is medically necessary post-operatively in individuals who have signs of complications related to treatment to assess the position of the pulled-through bowel, the sphincter muscles, and the area of the posterior urethra.

References (PEDAB-12)

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1. Maqbool A, Liacouras CA. Major symptoms and signs of digestive tract disorders. Nelson Textbook of Pediatrics, Chapter 352. eds Kliegman RM, St. Geme JW III, Blum NJ, Tasker RC, Wilson KM, Schuh AM, Mack CL. 22nd edition 2024, pp 1902-1912.
2. Maqbool A, Liacouras CA, Brownell JN, Ufberg PJ. Disorders of Brain-Gut Interaction (Functional Gastrointestinal Disorders). Nelson Textbook of Pediatrics, Chapter 389. eds Kliegman RM, St. Geme JW III, Blum NJ, Tasker RC, Wilson KM, Schuh AM, Mack CL. 22nd edition 2024, pp 2385-2388.
3. Webster J, Fiorino FN, Liacouras CA. Encopresis and functional constipation. Nelson Textbook of Pediatrics, Chapter 335.3. eds Kliegman RM, St. Geme JW III, Blum NJ, Tasker RC, Wilson KM, Schuh AM, Mack CL. 22nd edition. 2024. pp 1958-1961.
4. Hammershaimb EA, Kotloff KL Acute Gastroenteritis in Children. Nelson Textbook of Pediatrics, Chapter 366. eds Kliegman RM, St. Geme JW III, Blum NJ, Tasker RC, Wilson KM, Schuh AM, Mack CL. 22nd edition. 2024, p 2355-2375.
5. Zella GC, Israel EJ. Chronic Diarrhea in Children. *Pediatrics in Review*. 2012;33(5):207-218. Doi :10.1542/pir.33-5-207.
6. Hasosah M. Chronic refractory constipation in children: Think beyond stools. *Glob Pediatr Health*. 2021;8. doi: 10.1177/2333794X211048739.
7. Rosen MJ, Dhawan A, Saeed SA. Inflammatory bowel disease in children and adolescents. *JAMA Pediatr*. 2015;169(11):1053-60.doi:10.1001/jamapediatrics.2015.1982.
8. Quitadamo P, Tambucci R, Mancini V, et al. Diagnostic and therapeutic approach to children with chronic refractory constipation: consensus report by the SIGENP motility working group. *Dig and Liv Dis*. 2024;56(3):406-420.
9. Tambucci R, Quitadamo P, Thapar N, et al. Diagnostic tests in pediatric constipation. *Journal of Pediatric Gastroenterology and Nutrition*. 2018. doi:10.1097/mpg.0000000000001874.

Abdominal Mass (PEDAB-13)

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Abdominal Wall Mass (PEDAB-13.1)

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- For initial imaging of a newly discovered abdominal wall mass, ANY of the following studies are medically necessary:
 - Ultrasound (CPT[®] 76700 or CPT[®] 76705)
 - MRI Abdomen without contrast (CPT[®] 74181) or without and with contrast (CPT[®] 74183)
 - MRI Pelvis without contrast (CPT[®] 72195) or without and with contrast (CPT[®] 72197) may be added to MRI Abdomen if below the umbilicus.
- If ultrasound and/or MRI are inconclusive or insufficient for preoperative planning, ANY of the following studies are medically necessary:
 - CT Abdomen with contrast (CPT[®] 74160) or without contrast (CPT[®] 74150)
 - CT Abdomen and Pelvis with contrast (CPT[®] 74177) or without contrast (CPT[®] 74176) if below the umbilicus

Intra-Abdominal Mass (PEDAB-13.2)

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- Ultrasound (CPT® 76700) is medically necessary as the initial imaging study for children with an intra-abdominal mass.
 - US with Doppler (CPT® 93975) is medically necessary to evaluate vascular supply.
- Additional imaging studies will be determined by the results of the ultrasound, and will depend on the location and organ involvement associated with the mass as well as history, physical exam, and laboratory findings. See the following sections for additional imaging guidelines:
 - **General Guidelines (PEDONC-1)** in the Pediatric and Special Populations Oncology Imaging Guidelines
 - **Pediatric Lymphomas (PEDONC-5)** in the Pediatric and Special Populations Oncology Imaging Guidelines
 - **Neuroblastoma (PEDONC-6)** in the Pediatric and Special Populations Oncology Imaging Guidelines
 - **Pediatric Renal Tumors (PEDONC-7)** in the Pediatric and Special Populations Oncology Imaging Guidelines
 - **Pediatric Germ Cell Tumors (PEDONC-10)** in the Pediatric and Special Populations Oncology Imaging Guidelines
 - **Pediatric Liver Tumors (PEDONC-11)** in the Pediatric and Special Populations Oncology Imaging Guidelines
 - **Pediatric Adrenocortical Carcinoma (PEDONC-14)** in the Pediatric and Special Populations Oncology Imaging Guidelines
 - **Liver Lesion Characterization (PEDAB-15)**
 - **Adrenal Lesions (PEDAB-17)**
 - **Indeterminate Renal Lesion (PEDAB-19)**
 - **Spleen (PEDAB-26)**

References (PEDAB-13)

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1. Allen-Rhoades W and Steuber CP. Clinical assessment and differential diagnosis of the child with suspected cancer. *Principles and Practice of Pediatric Oncology*. eds Pizzo PA and Poplack DG. 7th edition 2016. pp. 101-111.
2. Malkan AD, Loh A, Bahrami A, et al. An Approach to Renal Masses in Pediatrics. *Pediatrics*. 2014;135(1):142-158. doi: 10.1542/peds.2014-1011.
3. Crane GL, Hernanz-Schulman M. Current Imaging Assessment of Congenital Abdominal Masses in Pediatric Patients. *Seminars in Roentgenology*. 2012;47(1):32-44. doi: 10.1053/j.ro.2011.07.004.
4. Chung EM, Graeber AR, Conran RM. Renal tumors of childhood: radiologic-pathologic correlation part 1. The 1st Decade: From the Radiologic Pathology Archives. *RadioGraphics*. 2016;36(2):499-522. doi: 10.1148/rg.2016150230.
5. Chung EM, Lattin GE, Fagen KE, et al. Renal tumors of childhood: radiologic-pathologic correlation part 2. The 2nd Decade: From the Radiologic Pathology Archives. *RadioGraphics*. 2017;37(5):1538-1558. doi: 10.1148/rg.2017160189.
6. Kim HHR, Hull NC, Lee EY, Phillips GS. Pediatric abdominal masses: Imaging guidelines and recommendations. *Radiol Clin North Am*. 2022;60(1):113-129. doi:10.1016/j.rcl.2021.08.008.

Renovascular Hypertension and Other Secondary Causes of Hypertension (PEDAB-14)

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Renovascular Hypertension and Other Secondary Causes of Hypertension (PEDAB-14)

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- Clinical evaluation for suspected hypertension should include repeated blood pressure measurements (generally ≥ 3 measurements).
 - Trained health care professionals in the office setting should make a diagnosis of hypertension (HTN) if a child or adolescent has auscultatory-confirmed blood pressure (BP) readings ≥ 95 th percentile at 3 different visits.
 - Blood pressure can be obtained in-clinic, at home, or by using a wearable ambulatory blood pressure measurement (ABPM) device that records blood pressure at frequent intervals during normal activities and is downloaded later for computer analysis.

For Children Aged 1-<13 years	For Children Aged ≥ 13 years
Normal BP: $< 90^{\text{th}}$ Percentile	Normal BP: $< 120 / < 80$ mm Hg
Elevated BP: $\geq 90^{\text{th}}$ percentile to $< 95^{\text{th}}$ percentile or $120 / 80$ mm Hg to $< 95^{\text{th}}$ percentile (whichever is lower)	Elevated BP: $120 / < 80$ to $129 / < 80$ mm Hg
Stage 1 HTN: $\geq 95^{\text{th}}$ percentile to $< 95^{\text{th}}$ percentile + 12 mmHg, or $130 / 80$ to $139 / 89$ mm Hg (whichever is lower)	Stage 1 HTN: $130 / 80$ to $139 / 89$ mm Hg
Stage 2 HTN: $\geq 95^{\text{th}}$ percentile + 12 mm Hg, or $\geq 140 / 90$ mm Hg (whichever is lower)	Stage 2 HTN: $\geq 140 / 90$ mm Hg

- ANY of the following studies are medically necessary for initial evaluation of a pediatric individual with suspected secondary hypertension:
 - Doppler or Duplex Ultrasound (CPT[®] 93975 or CPT[®] 93976)
 - Complete retroperitoneal Ultrasound (CPT[®] 76770)

- Captopril renography (CPT[®] 78709) has largely been abandoned in clinical practice, replaced by CTA and MRA Abdomen, but may be supported for unusual circumstances.

Other considerations for imaging evaluation:

- CTA Abdomen (CPT[®] 74175) or MRA Abdomen (CPT[®] 74185) is medically necessary for pediatric individuals with hypertension to exclude fibromuscular dysplasia or other blood-flow restricting lesions of the renal arteries and suprarenal aorta.
- Children with high clinical suspicion for renin-mediated hypertension should undergo additional imaging whether Doppler US findings are positive or negative due to poor sensitivity for detecting distal intrarenal or accessory renal artery stenosis. CTA (CPT[®] 74175) has high sensitivity and specificity, and is medically necessary for these individuals.
- Echocardiography (CPT[®] 93306) is medically necessary at initial evaluation to screen for cardiac abnormalities, coarctation of the aorta, and end-organ damage such as left ventricular hypertrophy.
- Nuclear renal imaging (CPT[®] 78707, CPT[®] 78708, or CPT[®] 78709) is medically necessary for evaluation of the following:
 - Severe hypertension with progressive renal insufficiency or failure to respond to three-drug therapy
 - Malignant or accelerated hypertension
 - Acute worsening of previously stable hypertension
 - Diastolic BP >100 in an individual <35 years old
 - New onset severe hypertension
 - Hypertension in presence of asymmetric kidneys
 - Hypertension in presence of acute elevation in creatinine either unexplained or after treatment with ACE inhibitor
 - Abdominal bruit
 - Recurrent acute pulmonary edema and hypertension
 - Hypokalemia with normal or elevated plasma renin level in absence of diuretic therapy
 - Hypertension with known neurofibromatosis

References (PEDAB-14)

v2.0.2026

1. Castelli PK, Dillman JR, Smith EA, Vellody R, Cho K, Stanley JC. Imaging of Renin-Mediated Hypertension in Children. *American Journal of Roentgenology*. 2013;200(6). doi: 10.2214/ajr.12.9427.
2. Chhadia S, Cohn RA, Vural G, Donaldson JS. Renal Doppler evaluation in the child with hypertension: a reasonable screening discriminator? *Pediatric Radiology*. 2013;43(12):1549-1556. doi: 10.1007/s00247-013-2741-y.
3. Castelli PK, Dillman JR, Kershaw DB, Khalatbari S, Stanley JC, Smith EA. Renal sonography with Doppler for detecting suspected pediatric renin-mediated hypertension – is it adequate? *Pediatric Radiology*. 2013;44(1):42-49. doi: 10.1007/s00247-013-2785-z.
4. Harvin HJ, Verma N, Nikolaidis P, et al. Renovascular hypertension. ACR Appropriateness Criteria®. Revised 2017.
5. Trautmann A, Roebuck DJ, McLaren CA, Brennan E, Marks SD, Tullus K. Non-invasive imaging cannot replace formal angiography in the diagnosis of renovascular hypertension. *Pediatric Nephrology*. 2016;32(3):495-502. doi: 10.1007/s00467-016-3501-7.
6. Macumber IR, Flynn JT. Systemic hypertension. Nelson Textbook of Pediatrics, Chapter 494. eds Kliegman RM, St. Geme JW III, Blum NJ, Tasker RC, Wilson KM, Schuh AM, Mack CL. 22nd edition 2024, pp 2910-2919.
7. Brady TM. Hypertension. Pediatrics in Review. 2012;33(12):541-552. doi: 10.1542/pir.33-12-541.
8. Ilivitzki A, Glozman L, Alfonso RL, Ofer A, Razi NB, Shapira MR. Sonographic evaluation of renovascular hypertension in the pediatric population: State-of-the-art. *Journal of Clinical Ultrasound*. 2017;45(5):282-292. doi: 10.1002/jcu.22467.
9. Mendichovszky I, Solar BT, Smeulders N, Easty M, Biassoni L. Nuclear Medicine in Pediatric Nephro-Urology: An Overview. *Seminars in Nuclear Medicine*. 2017;47(3):204-228. doi: 10.1053/j.semnuclmed.2016.12.002.
10. Ingelfinger JR. The Child or Adolescent with Elevated Blood Pressure. *New England Journal of Medicine*. 2014;370(24):2316-2325. doi: 10.1056/nejmcp1001120.
11. Kim CK, Biyyam DR, Becker MD, et al. ACR–SPR Practice Guideline for the Performance of Renal Scintigraphy. Revised 2017 (Resolution 29).
12. Tekgül S, Dogan HS, Kočvara R, et al. European Association of Urology. European Society for Paediatric Urology. Guidelines on Paediatric Urology 2015 with limited text update March 2017.
13. Flynn JT, Kaelber DC, Baker-Smith CM, et al. Clinical practice guideline for screening and management of high blood pressure in children and adolescents. *Pediatrics*. 2017;140(3):e20171904. doi: 10.1542/peds.2017-3035.
14. Fleury AS, Durand RE, Cahill AM, et al. Validation of computed tomography angiography as a complementary test in the assessment of renal artery stenosis: a comparison with digital subtraction angiography. *Pediatr Radiol* 2021;51:2507–2520. doi:10.1007/s00247-021-05145-1.

Liver Lesion Characterization (PEDAB-15)

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Liver Lesion Characterization (PEDAB-15)

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- *High-risk individuals:
 - Prematurity
 - Low birth weight
 - Underlying chronic liver disease
 - Beckwith-Weidman syndrome
 - Familial adenomatous polyposis
 - Trisomy 18
 - Portosystemic shunts
 - Aicardi syndrome
 - Hereditary tyrosinemia
 - Bile salt export pump deficiency
- Pediatric-specific imaging considerations includes:
 - US Abdomen (CPT[®] 76700 or CPT[®] 76705) is medically necessary as the initial study in children. MRI is preferred over CT when possible to reduce radiation exposure.
- Liver lesion discovered on US:
 - Any high-risk individual*
 - MRI Abdomen without and with contrast (CPT[®] 74183) or CT Abdomen with contrast (CPT[®] 74160)
 - Indeterminate liver lesion <3cm
 - Contrast-Enhanced US (CEUS, CPT[®] 76978, CPT[®] 76979)
 - If after Contrast-Enhanced US the lesion remains indeterminate or not fully characterized, or if Contrast-Enhanced US is not available:
 - MRI Abdomen without and with contrast (CPT[®] 74183) or CT Abdomen with contrast (CPT[®] 74160)
 - Indeterminate liver lesion >3cm
 - MRI Abdomen without and with contrast (CPT[®] 74183) or CT Abdomen with contrast (CPT[®] 74160)
- Liver lesion discovered on CT (non-contrast or single-contrast) or non-contrast MRI
 - Indeterminate Liver Lesion <3cm
 - Contrast-Enhanced US (CEUS, CPT[®] 76978, CPT[®] 76979)
 - If, after Contrast-Enhanced US, the lesion remains indeterminate or not fully characterized, or if Contrast-Enhanced US is not available:

- MRI Abdomen without and with contrast (CPT[®] 74183) or CT Abdomen with contrast (CPT[®] 74160)
- Indeterminate Liver Lesion >3cm
 - MRI Abdomen without and with contrast (CPT[®] 74183) or CT Abdomen with contrast (CPT[®] 74160)
- For the imaging of specific focal liver lesions:
 - Suspected hepatic adenoma:
 - CT Abdomen (CPT[®] 74160 or CPT[®] 74170) or MRI Abdomen (CPT[®] 74183) every 6 months for 2 years, and then annually, to establish any growth patterns and assess for malignant transformation.
 - Hepatic Hemangioma
 - Limited US Abdomen in 6-12 months
 - If stable or decreasing in size: Surveillance 6-12 months until 2 years. After 2 years, no further follow-up is considered medically necessary unless it becomes symptomatic
 - If increasing in size: follow-up 3-6 months or biopsy
 - See below for pre-operative considerations
 - Focal Nodular Hyperplasia (FNH):
 - MRI Abdomen (CPT[®] 74183) or CT Abdomen (CPT[®] 74160 or CPT[®] 74170) to confirm a diagnosis of FNH. The use of Eovist contrast is often diagnostic in differentiating FNH from other lesions seen on MRI or CT.
 - Additional follow-up is limited abdominal US in 6-12 months
 - If stable or decreasing in size: Surveillance 6-12 months until 2 years. After 2 years, no further follow-up is considered medically necessary unless it becomes symptomatic.
 - In adolescent females diagnosed with FNH who are continuing to use oral contraceptives: Additional follow-up is annual US for 2 to 3 years. Follow-up with CT or MRI is medically necessary if the lesion is not adequately visualized on US.
 - If increasing in size: follow-up 3-6 months or biopsy
 - Hepatic cysts:
 - Asymptomatic, simple cysts
 - Limited US Abdomen in 6-12 months
 - If stable or decreasing in size: Surveillance 6-12 months until 2 years. After 2 years, no further follow-up is considered medically necessary unless it becomes symptomatic
 - If increasing in size: follow-up 3-6 months or biopsy
 - For complicated cysts (US shows internal septations, fenestrations, calcifications, irregular walls, as well as the presence of daughter cysts):

- MRI Abdomen (CPT[®] 74183) or CT Abdomen (CPT[®] 74160 or CPT[®] 74170) is medically necessary
- Additional scenarios and follow-up imaging for an indeterminate lesion:
 - Indeterminate lesion <1cm in high-risk individuals* on US, CT, or unenhanced MRI not specifically dealt with in the above guidelines:
 - If **biopsy cannot be performed**, follow-up MRI is medically necessary at 3-6 months. Additional imaging in this setting can be considered on an individual basis. This timeframe would also apply if the lesion is indeterminate and an MRI with Eovist is requested for further evaluation in this setting.
- Nuclear medicine liver imaging (ONE of CPT[®] codes: CPT[®] 78201, CPT[®] 78202, CPT[®] 78803, CPT[®] 78215, or CPT[®] 78216) is medically necessary for the following when ultrasound, CT, and MRI are unavailable or contraindicated:
 - Evaluation of liver mass, trauma, or suspected focal nodular hyperplasia (FNH)
 - Differentiation of hepatic hemangioma from FNH
 - Diffuse hepatic disease or elevated liver function tests
 - Suspected accessory spleen (CPT[®] 78215 or CPT[®] 78216 only)

Background and Supporting Information

- For liver lesions in children, it is important to differentiate between benign incidental versus malignant lesions.

Risk factors for malignant liver tumors in children

Hepatoblastoma	Hepatocellular carcinoma
◦ Prematurity	◦ Liver cirrhosis
◦ Low birth weight	◦ Chronic hepatitis B and C
◦ BWS and other overgrowth syndromes	◦ Hereditary tyrosinemia
◦ Familial adenomatous polyposis	◦ Portosystemic shunts
◦ Trisomy 18	◦ Bile salt export pump deficiency
◦ Portosystemic shunts	
◦ Aicardi syndrome	

References (PEDAB-15)

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1. Hegde SV, Dillman JR, Lopez MJ, Strouse PJ. Imaging of multifocal liver lesions in children and adolescents. *Cancer Imaging*. 2012;12(3):516-529. doi: 10.1102/1470-7330.2012.0045.
2. Fernandez-Pineda I. Differential diagnosis and management of liver tumors in infants. *World Journal of Hepatology*. 2014;6(7):486. doi: 10.4254/wjh.v6.i7.486.
3. Siegel MJ, Masand PM. Liver. In: Siegel MJ, editor. *Pediatric Sonography*. 5th ed, Philadelphia, Wolters Kluwer, 2019. p 211-272.
4. Squires JE, Balistreri WF. Evaluation of patients with possible liver dysfunction. Nelson Textbook of Pediatrics, Chapter 403.1. eds Kliegman RM, St. Geme JW III, Blum NJ, Tasker RC, Wilson KM, Schuh AM, Mack CL. 22nd edition. 2024, pp 2442-2444.
5. Chung EM, Cube R, Lewis RB, Conran RM. Pediatric Liver Masses: Radiologic-Pathologic Correlation Part 1. Benign Tumors. *RadioGraphics*. 2010;30(3):801-826. doi: 10.1148/rq.303095173.
6. Shamir SB, Kurian J, Kogan-Liberman D, Taragin BH. Hepatic Imaging in Neonates and Young Infants: State of the Art. *Radiology*. 2017;285(3):763-777. doi: 10.1148/radiol.2017170305.
7. Bernard O, Franchi-Abella S, Branchereau S, et al. Congenital portosystemic shunts in children: recognition, evaluation, and management. *Semin Liver Dis*. 2012;32:273–87.
8. Kalish JM, Doros L, Helman LJ, et al. Surveillance recommendations for children with overgrowth syndromes and predisposition to wilms tumors and hepatoblastoma. *Clin Cancer Res*. 2017;23:e115–22.
9. Karmazyn B, Rao GS, Johnstone L, et. al. Diagnosis and follow-up of incidental liver lesions in children. *Journal of Pediatric Gastroenterology and Nutrition*. 2022;74(3):320-327.
10. Moreira-Silva H, Amorim J, Santos-Silva E. Incidental liver lesions in children: A practical and evidence-based approach. *Clin Res Hepatol Gastroenterol*. 2022;46(5):101904.
11. Scheers I, Tambucci R, De Magnee C, et al. Paediatric hepatocellular adenomas: Lessons from a systematic review of relevant literature. *JHEP Rep*. 2024;6(6):101078. doi:10.1016/j.jhepr.2024.101078.

Liver Disease (PEDAB-16)

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Pediatric Liver Failure and Cirrhosis (PEDAB-16.1)

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- Elevated liver function testing imaging indications in pediatric individuals are very similar to those for adult individuals. See: **Abnormal Liver Chemistries (AB-30)** in the Abdomen Imaging Guidelines.
- Causes of liver failure or cirrhosis in pediatric individuals are different from adults, and are frequently idiopathic, but commonly due to ONE of the following:
 - Biliary dysfunction (biliary atresia, cystic fibrosis, etc.)
 - Metabolic disease
 - Post-infectious
- Liver ultrasound (CPT[®] 76700) with duplex Doppler (CPT[®] 93975) is medically necessary as an initial study for individuals prior to approving CT or MRI for pediatric individuals.
 - MRI Abdomen without and with contrast (CPT[®] 74183) is indicated for evaluation of ultrasound findings that are inconclusive or technically limited, and is preferred over CT when possible to reduce radiation exposure.
- Repeat liver ultrasound (CPT[®] 76705) with duplex Doppler (CPT[®] 93975 or CPT[®] 93976) is medically necessary in pediatric individuals in the following circumstances:
 - Annually, for known chronic liver dysfunction or cirrhosis of any cause
 - New or worsening findings on history, physical exam, or laboratory results that suggest progression of liver disease
 - Portal venous congestion or portal hypertension is suspected
- Nuclear medicine liver imaging (ONE of CPT[®] codes: CPT[®] 78201, CPT[®] 78202, CPT[®] 78803, CPT[®] 78215, or CPT[®] 78216) is rarely performed, but is medically necessary for the following when ultrasound, CT, and MRI are unavailable or contraindicated:
 - Diffuse hepatic disease or elevated liver function tests

References (PEDAB-16.1)

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1. Squires JE, Balistreri WF. Evaluation of patients with possible liver dysfunction. Nelson Textbook of Pediatrics, Chapter 403.1. eds Kliegman RM, St. Geme JW III, Blum NJ, Tasker RC, Wilson KM, Schuh AM, Mack CL. 22nd edition 2024, pp 2442-2444.
2. Fusillo S, Rudolph B. Nonalcoholic Fatty Liver Disease. Pediatrics in Review. 2015;36(5):198-206. doi:10.1542/pir.36-5-198.
3. Rijn RV, Nievelstein R. Paediatric ultrasonography of the liver, hepatobiliary tract and pancreas. European Journal of Radiology. 2014;83(9):1570-1581. doi:10.1016/j.ejrad.2014.03.025.
4. Paranjape SM, Mogayzel PJ. Cystic Fibrosis. Pediatrics in Review. 2014;35(5):194-205. doi:10.1542/pir.35-5-194.
5. Royal HD, Brown ML, Drum DE, et al. Society of Nuclear Medicine Procedure guideline for hepatic and splenic imaging 3.0, version 3.0, approved July 20, 2003.
6. Ranucci G, Corte DC, Alberti D, et al. Diagnostic approach to neonatal and infantile cholestasis: a position paper by the SIGENP liver disease working group. *Dig Liv Dis*. 2022;54(1):40-53.
7. Duarte-Rojo A, Taouli B, Leung DH, et al. Imaging-based noninvasive liver disease assessment for staging liver fibrosis in chronic liver disease: a systematic review supporting the AASLD practice guideline. *Hepatology*. 2025;81(2):725-748. doi:10.1097/HEP.0000000000000852.

Biliary Disease (PEDAB-16.2)

ABP.LD.0016.2.A

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- The definition of conjugated hyperbilirubinemia is serum conjugated bilirubin >1mg/dL if total bilirubin <5.0 or greater than 20 percent of total bilirubin if total bilirubin >5.0mg/dL. Obstructive causes of liver disease need to be evaluated. Additional labs may include total and fractionated bilirubin, AST, ALT, Alk Phos, GGT, and/or urinalysis.
- Ultrasound Abdomen (CPT® 76700 or CPT® 76705) is medically necessary as the initial imaging study.
 - Advanced imaging such as CT, MRI is rarely medically necessary unless otherwise indicated below.
- After initial ultrasound:
 - If biliary atresia is suspected:
 - Hepatobiliary system imaging (HIDA scan) is medically necessary if requested by surgeon before liver biopsy.
 - If choledochal cyst is suspected:
 - CT Abdomen with contrast (CPT® 74160) or MRI/MRCP (CPT® 74183 or CPT® 74181) is medically necessary.
 - For preoperative assessment: MRI/MRCP (CPT® 74183 or CPT® 74181) is medically necessary.
 - If primary biliary disease such as primary sclerosing cholangitis or primary biliary cholangitis is suspected:
 - CT Abdomen with contrast (CPT® 74160) or MRI/MRCP (CPT® 74183 or CPT® 74181) is medically necessary.
- Follow-up of resected choledochal cysts (types I and IV, and type V not treated by transplantation):
 - Immediately after resection:
 - Ultrasound Abdomen (CPT® 76700 or CPT® 76705) AND MRI Abdomen with cholangiography (CPT® 74183) is medically necessary.
 - Years 1-20 post-resection:
 - Ultrasound Abdomen (CPT® 76700 or CPT® 76705), biannually
 - MRI Abdomen with cholangiography (CPT® 74183) is medically necessary on every 3-year schedule (in lieu of ultrasound) for any of the following:
 - Ultrasound is not feasible due to body habitus
 - Ultrasound is unavailable
 - Years 21-40 post-resection:
 - Ultrasound Abdomen (CPT® 76700 or CPT® 76705), every 3 years

- MRI Abdomen with cholangiography (CPT® 74183) is medically necessary on every 4-year schedule (in lieu of ultrasound) for any of the following:
 - Ultrasound is not feasible due to body habitus
 - Ultrasound is unavailable
- Residual cystic tissue is present following resection:
 - Ultrasound Abdomen (CPT® 76700 or CPT® 76705), annually

References (PEDAB-16.2)

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1. Soares KC, Goldstein SD, Ghaseb MA, Kamel I, Hackam DJ, Pawlik TM. Pediatric choledochal cysts: diagnosis and current management. *Pediatr Surg Int*. 2017 Jun;33(6):637-650. doi: 10.1007/s00383-017-4083-6. Epub 2017 Mar 31. PMID: 28364277.
2. Abbey P, Kandasamy D, Naranje P. Neonatal Jaundice. *Indian J Pediatr*. 2019 Sep;86(9):830-841. doi: 10.1007/s12098-019-02856-0. Epub 2019 Feb 21. PMID: 30790186.
3. Ranucci G, Corte DC, Alberti D, et al. Diagnostic approach to neonatal and infantile cholestasis: a position paper by the SIGENP liver disease working group. *Dig Liv Dis*. 2022;54(1):40-53.
4. Napolitano M, Franchi-Abella S, Damasio MB, et al. Practical approach to imaging diagnosis of biliary atresia, part 1: prenatal ultrasound and magnetic resonance imaging, and postnatal ultrasound. *Pediatr Radiol*. 2021;51(2):314-331. doi:10.1007/s00247-020-04840-9.
5. Napolitano M, Franchi-Abella S, Damasio MB, et al. Practical approach to imaging diagnosis of biliary atresia, part 2: magnetic resonance cholecystopancreatography, hepatobiliary scintigraphy, percutaneous cholecysto-cholangiography, endoscopic retrograde cholangiopancreatography, percutaneous liver biopsy, risk scores and decisional flowchart. *Pediatr Radiol*. 2021;51(8):1545-1554. doi:10.1007/s00247-021-05034-7.
6. Koea J, O'Grady M, Agrawal J, Srinivasa S. Defining an optimal surveillance strategy for patients following choledochal cyst resection: results of a systematic review. *ANZ Journal of Surgery*. 2022;92(6):1356-1364. doi:10.1111/ans.17775.
7. Madadi-Sanjani O, Wirth TC, Kuebler JF, Petersen C, Ure BM. Choledochal cyst and malignancy: a plea for lifelong follow-up. *Eur J Pediatr Surg*. 2019;29(2):143-149. doi:10.1055/s-0037-1615275.

Liver Elastography (PEDAB-16.3)

ABP.LD.0016.3.A**v2.0.2026**

- The following is medically necessary for initial staging of liver fibrosis in suspected chronic liver disease:
 - Transient Elastography or Vibration-Controlled Transient Elastography (VCTE, e.g. Fibroscan) (CPT[®] 91200) is the initial imaging modality.
 - Magnetic Resonance Elastography (MRE, CPT[®] 76391) is medically necessary for ANY of the following:
 - Transient Elastography failure despite use of an XL-probe, OR BMI ≥ 30
 - Conflict between clinical picture and transient elastography results

References (PEDAB-16.3)

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1. Banc-Husu AM, Bass LM. Transient elastography in pediatric liver disease. *Journal of Pediatric Gastroenterology and Nutrition*. 2021;73(2):141-144.
2. Serai SD, Franchi-Abella S, Syed AB, Tkach JA, Toso S, Ferraioli G. MR and Ultrasound Elastography for fibrosis assessment in children: practical implementation and supporting evidence-AJR expert panel narrative review. *AJR Am J Roentgenol*. 2024. doi:10.2214/AJR.23.30506.
3. Fawaz R, Baumann U, Ekong U, et al. Guideline for the evaluation of cholestatic jaundice in infants. *J Pediatr Gastroenterol Nutr*. 2017;64(1):154-168. doi:10.1097/MPG.0000000000001334.
4. Demirtas D, Unal E, Idilman IS, et al. Magnetic resonance elastography in evaluation of liver fibrosis in children with chronic liver disease. *Insights into Imaging*. 2023;14(39). doi:10.1186/s13244-023-01390-0.
5. Nielsen J, Kjaer MS, Rasmussen A, et al. Transient elastography and magnetic resonance elastography in comparison to histopathology. *Diagnostics*. 2022;12(11):2785. doi:10.3390/diagnostics12112785.

Adrenal Lesions (PEDAB-17)

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Adrenal Lesions (PEDAB-17)

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- Adrenal masses in infants and young children usually present as palpable abdominal masses or are detected on in utero US. In the neonates, the common masses are adrenal hemorrhage and neuroblastoma. Abdominal US is the medically necessary initial imaging study.
 - If an adrenal mass is detected, it can often be adequately evaluated with short interval follow-up retroperitoneal ultrasound (CPT[®] 76770) in 7 to 10 days.
 - If repeat ultrasound is concerning for neuroblastoma or there is high clinical concern for neuroblastoma, MRI Abdomen without and with contrast (CPT[®] 74183) or CT Abdomen without and with contrast (CPT[®] 74170) are medically necessary to confirm the diagnosis. MRI is preferred over CT when possible to reduce radiation exposure. If these studies, confirm neuroblastoma ¹²³I-Metaiodobenzylguanidine (MIBG) scintigraphy is medically necessary for staging.
 - Neuroblastoma is the most common primary adrenal tumor in pediatric individuals between day 1 and 5 years of age. See: **Neuroblastoma (PEDONC-6)** in the Pediatric and Special Populations Oncology Imaging Guidelines.
- Additional adrenal imaging considerations include the following:
 - Adrenal Nuclear Imaging of the cortex and/or medulla (CPT[®] 78075) is medically necessary for the following:
 - Distinguishing adrenal adenoma from adrenal hyperplasia.
 - Evaluation of suspected pheochromocytoma or paraganglioma.
 - MIBG preferred (ONE of CPT[®] codes: CPT[®] 78800, CPT[®] 78801, CPT[®] 78802, CPT[®] 78803, or CPT[®] 78804).
 - For known pheochromocytoma or paraganglioma, see: **Neuroendocrine Cancers and Adrenal Tumors (ONC-15)** in the Oncology Imaging Guidelines.
 - Evaluation of suspected neuroblastoma, ganglioneuroblastoma, or ganglioneuroma.
 - MIBG preferred (ONE of CPT[®] codes: CPT[®] 78800, CPT[®] 78801, CPT[®] 78802, CPT[®] 78803, or CPT[®] 78804 or hybrid SPECT/CT CPT[®] 78830, CPT[®] 78831, or CPT[®] 78832), see: **Neuroblastoma (PEDONC-6)** in the Pediatric and Special Populations Oncology Imaging Guidelines.
 - History of multiple endocrine neoplasia syndromes: See **Multiple Endocrine Neoplasias (MEN) (PEDONC-2.8)** in the Pediatric and Special Populations Oncology Imaging Guidelines

- History of neurofibromatosis: See **Neurofibromatosis 1 and 2 (NF1 and NF2) (PEDONC-2.3)** in the Pediatric and Special Populations Oncology Imaging Guidelines
- History of von Hippel-Lindau disease: See **Von Hippel-Lindau Syndrome (VHL) (PEDONC-2.10)** in the Pediatric and Special Populations Oncology Imaging Guidelines

References (PEDAB-17)

v2.0.2026

1. Gawande, R, Castenaeda, R and Daldrup-Link, H. Adrenal hemorrhage in pearls and pitfalls. *Pediatric imaging: variants and other difficult diagnoses*. eds. Heike E, Daldrup-Link, and Newman B. Cambridge University Press, Apr 24, 2014.
2. Moreira SG, Pow-Sang JM. Evaluation and Management of Adrenal Masses. *Cancer Control*. 2002;9(4):326-334. doi: 10.1177/107327480200900407.
3. Sharp SE, Gelfand MJ, Shulkin BL. Pediatrics: Diagnosis of Neuroblastoma. *Seminars in Nuclear Medicine*. 2011;41(5):345-353. doi: 10.1053/j.semnuclmed.2011.05.001.
4. Bombardieri E, Giammarile F, Aktolun C, et al. 131I/123I-Metaiodobenzylguanidine (mIBG) scintigraphy: procedure guidelines for tumour imaging. *European Journal of Nuclear Medicine and Molecular Imaging*. 2010;37(12):2436-2446. doi:10.1007/s00259-010-1545-7.
5. Chrisoulidou A, Kaltsas G, Ilias I, Grossman AB. The diagnosis and management of malignant pheochromocytoma and paraganglioma. *Endocrine-Related Cancer*. 2007;14(3):569-585. doi: 10.1677/erc-07-0074.
6. Ganguly A. Primary Aldosteronism. *New England Journal of Medicine*. 1998;339(25):1828-1834. doi: 10.1056/nejm199812173392507.
7. Orth DN. Cushing's Syndrome. *New England Journal of Medicine*. 1995;332(12):791-803. doi: 10.1056/nejm199503233321207.
8. Siegel MJ, Chung EM. Adrenal gland, pancreas, and other retroperitoneal structures. In Siegel MJ, editor. *Pediatric sonography*. 5th ed. Philadelphia, Wolters Kluwer, 2019. p 467-512.
9. White PC, Yang M. Congenital adrenal hyperplasia and related disorders. *Nelson Textbook of Pediatrics*, Chapter 616. eds Kliegman RM, St. Geme JW III, Blum NJ, Shah SS, Tasker RC, Wilson KM, Schuh AM, Mack CL. 22nd edition. 2024, pp 3462-3471.
10. Sargar KM, Khanna G, Bowling RH. Imaging of Nonmalignant Adrenal Lesions in Children. *RadioGraphics*. 2017;37(6):1648-1664. doi: 10.1148/rg.2017170043.
11. Ozcan HN, Tan AA, Ardicli B, et al. Imaging findings of primary adrenal tumors in pediatric patients. *Diagn Interv Radiol*. 2021;27(6):811-815. doi:10.5152/dir.2021.20701.
12. Bittman ME, Lee EY, Restrepo R, Eisenberg RL. Focal adrenal lesions in pediatric patients. *AJR*. 2013;200:W542-W556. doi:10.2214/AJR.12.8677.
13. Zhang K, Zhang Y, Zhang Y, Chao M. A retrospective analysis of the clinical characteristics of 207 hospitalized children with adrenal masses. *Front Pediatr*. 2023;11:1215095. doi:10.3389/fped.2023.1215095.

Hemochromatosis (PEDAB-18)

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Hereditary (Primary) Hemochromatosis (PEDAB-18.1)

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- Hereditary hemochromatosis imaging indications in pediatric individuals are identical to those for adult individuals. See: **Hereditary (Primary) Hemochromatosis (HH) and Other Iron Storage Diseases (AB-11.2)** in the Abdomen Imaging Guidelines.

Transfusion-Associated (Secondary) Hemochromatosis (PEDAB-18.2)

ABP.HC.0018.2.A

v2.0.2026

- Transfusion-associated hemochromatosis is a common complication of exposure to repeated red blood cell transfusions. This can occur in any individual with exposure to >20 transfusion episodes, but is most common among sickle cell disease, thalassemia, bone marrow failure (aplastic anemia, Fanconi anemia, etc.), oncology patients, and hematopoietic stem cell transplant patients.
- T2* MRI has been well established in the determination of organ iron burden in transfusion-associated hemochromatosis. Contrast use is not necessary for evaluation of iron burden. The following studies are medically necessary for evaluation of transfusion-associated hemochromatosis:
 - MRI Abdomen without contrast (CPT[®] 74181) for liver iron evaluation.
 - MRI Cardiac without contrast (CPT[®] 75557) for cardiac iron evaluation.
 - MRI Chest without contrast (CPT[®] 71550) can be approved as a single study to evaluate both heart and liver iron burden.
 - CPT[®] 74181 and CPT[®] 75557 can be approved alone, or together.
 - If requested, CPT[®] 71550 will evaluate both heart and liver and should not be approved with any other codes.
- Screening MRI is medically necessary every 12 months for chronically transfused individuals at risk of hemochromatosis.
- Imaging is medically necessary every 3 months for treatment response in individuals receiving active treatment (chelation and/or phlebotomy).

References (PEDAB-18)

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1. Evidence-Based Management of Sickle Cell Disease: Expert Panel Report, 2014. *Pediatrics*. 2014;134(6). doi:10.1542/peds.2014-2986.
2. Chavhan GB, Babyn PS, Thomas B, Shroff MM, Haacke EM. Principles, Techniques, and Applications of T2*-based MR Imaging and Its Special Applications. *RadioGraphics*. 2009;29(5):1433-1449. doi:10.1148/rg.295095034.
3. Children's Oncology Group. Long-term follow-up guidelines for survivors of childhood, adolescent, and young adult cancers. Version 4.0 – October 2013, Monrovia, CA.
4. Reeder SB, Yokoo T, Franca M, et al. Quantification of liver iron overload with MRI: review and guidelines from the ESGAR and SAR. *Radiology*. 2023;307(1):e221856. doi:10.1148/radiol.221856.

Indeterminate Renal Lesion (PEDAB-19)

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Indeterminate Renal Lesion (PEDAB-19)

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- Indeterminate renal lesion characterization imaging indications in pediatric individuals are very similar to those for adult individuals. See: **Indeterminate Renal Lesion (AB-35)** in the Abdomen Imaging Guidelines.
- Indeterminate renal lesion imaging indications in pediatric individuals are uncommon and are usually cysts or congenital anomalies.
- Pediatric-specific imaging considerations include the following:
 - Pediatric renal cysts have a lower risk of malignant progression than do renal cysts in adults.
 - MRI Abdomen without and with contrast (CPT[®] 74183) or CT Abdomen with contrast (CPT[®] 74160) is medically necessary for individuals who have simple cysts but are symptomatic and surgical intervention is being considered.
 - MRI Abdomen without and with contrast (CPT[®] 74183) or CT Abdomen without and with contrast (CPT[®] 74170) is medically necessary for pediatric individuals with complex renal cyst identified on ultrasound.
 - For individuals with congenital anomalies, nuclear medicine studies with diuretic renography (CPT[®] 78708 or CPT[®] 78709) are medically necessary to determine function and cystography to determine presence of associated reflux.
 - Individuals with solid renal masses, see: **Pediatric Renal Tumors (PEDONC-7)** in the Pediatric and Special Populations Oncology Imaging Guidelines.
 - Individuals with renal tumor predisposition syndromes, see: **Other Renal Cell Cancer Predisposition Syndromes (PEDONC-2.17)** in the Pediatric and Special Populations Oncology Imaging Guidelines.

References (PEDAB-19)

v2.0.2026

1. Bar-Server Z, Shammash A, et al. Pediatric Nephro-Urology: Overview and updates in diuretic renal scans and renal cortical scintigraphy. *Semin Nucl Med.* 2022;52(4):419-431. doi:10.1053/j.semnuclmed.2021.12.002.
2. Kim CK, Biyyam DR, Becker MD, et al. ACR–SPR Practice parameter for the performance of renal scintigraphy. Revised 2017 (Resolution 29).
3. Maid M, Bar-Server Z, et al. the SNMMI and ENM procedural guidelines for diuresis renography in infants and children. *J Nucl Med.* 2018;59(10):1636-1640. doi:10.2967/jnumed.118.215921.
4. Thomas CC, Jana M, et al. Ultrasound imaging of renal cysts in children. *J Ultrasound Med.* 2021;40(3):621-635. doi:10.1002/jum.15435.
5. Gimpel C, Avni EF, Breysem L, et al. Imaging of kidney cysts and cystic kidney disease in children: an international working group consensus statement. *Radiology.* 2019;290(3):769-782. doi:10.1148/radiol.2018181243.
6. Peard L, Gargollo P, Grant C, et al. Validation of the modified Bosniak classification system to risk stratify pediatric cystic renal masses: An international, multi-site study from the pediatric urologic oncology working group of the societies for pediatric urology. *J Pediatr Urol.* 2022;18(2):180.e1-180.e7. doi:10.1016/j.jpuro/2021.12.001.
7. Dell KM, Hartung EA. Approach to simple kidney cysts in children. *Pediatric Nephrology.* 2024;39:3387-3395. doi:10.1007/s00467-024-06386-6.

Hydronephrosis (PEDAB-20)

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Hydronephrosis (PEDAB-20)

ABP.HN.0020.A

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Hydronephrosis is a relatively common finding in pediatric individuals, with the following imaging considerations:

- Evaluation of antenatal hydronephrosis (AHN) with retroperitoneal ultrasound (CPT[®] 76771)
 - Postnatal ultrasound within 24 hours of life is medically necessary for males with distended bladder or infants with moderate/severe antenatal hydronephrosis diagnosed prenatally.
 - Postnatal ultrasound after seven days of life is medically necessary for infants with mild prenatal hydronephrosis.
 - A second postnatal ultrasound, even if initial is normal, at 4-6 weeks of age is medically necessary for all infants with antenatal hydronephrosis.
 - After this, infants with known hydronephrosis may be followed by ultrasound every 3-12 months until resolution of hydronephrosis.
 - This imaging represents a guideline-supported, scheduled follow-up imaging evaluation, as described in **Clinical Information (Preface-3.1)** in the Preface Imaging Guidelines.
- Hydronephrosis associated with urinary tract infection or vesicoureteral reflux, see: **Urinary Tract Infection (UTI) (PEDAB-5)** for imaging guidelines.
- In individuals with obstructive uropathy (including ureteropelvic junction obstruction (UPJO), ureterovesical junction obstruction (UVJO), and bladder outlet obstruction), retroperitoneal ultrasound (CPT[®] 76770) and diuretic renography (CPT[®] 78707, CPT[®] 78708, or CPT[®] 78709) are medically necessary for preoperative planning and postoperatively at 3 to 12 months.
 - If hydronephrosis has resolved on postoperative imaging then no further routine imaging is indicated.
- Magnetic resonance urography (MRU) (CPT[®] 74183 and CPT[®] 72197) is medically necessary in individuals with inconclusive ultrasound and diuretic renography.
- CT Abdomen with contrast (CPT[®] 74160) is medically necessary in individuals with inconclusive ultrasound and a suspected vascular cause of UPJO.

References (PEDAB-20)

v2.0.2026

1. Darge K, Siegel MJ. Kidney. In: Seigel MJ, editor *Pediatric Sonography*, 5th ed, Philadelphia, Wolters Kluwer, 2019. p 396-466.
2. Sinha A, Bagga A, Krishna A, et al. Revised guidelines on management of antenatal hydronephrosis. *Indian Journal of Nephrology*. 2013;23(2):83. doi: 10.4103/0971-4065.109403.
3. Dervoort KV, Lasky S, Sethna C, et al. Hydronephrosis in Infants and Children: Natural History and Risk Factors for Persistence in Children Followed by a Medical Service. *Clinical medicine Pediatrics*. 2009;3. doi: 10.4137/cmped.s3584.
4. Hsi RS, Holt SK, Gore JL, Lendvay TS, Harper JD. National Trends in Followup Imaging after Pyeloplasty in Children in the United States. *Journal of Urology*. 2015;194(3):777-782. doi: 10.1016/j.juro.2015.03.123.
5. Di Carlo HN, Crigger CB. Obstruction of the urinary tract. *Nelson Textbook of Pediatrics*, Chapter 577. eds Kliegman RM, St. Geme JW III, Blum NJ, Shah SS, Tasker RC, Wilson KM Schuh AM, Mack CL. 22nd edition. 2024, pp 3275-3279.
6. Nguyen HT, Benson CB, Bromley B, et al. Multidisciplinary consensus on the classification of prenatal and postnatal urinary tract dilation (UTD classification system). *Journal of Pediatric Urology*. 2014;10(6):982-998. doi: 10.1016/j.jpuro.2014.10.002.
7. Chow JS, Koning JL, Back SJ, Nguyen HT, Phelps A, Darge K. Classification of pediatric urinary tract dilation: the new language. *Pediatric Radiology*. 2017;47(9):1109-1115. doi: 10.1007/s00247-017-3883-0.
8. Brown BP, Simoneaux SF, Dillman JR, Rigsby CK, Iyer RS, Alazraki AL, Bardo DM, Chan SS, Chandra T, Dorfman SR, Garber MD. ACR Appropriateness Criteria® Antenatal Hydronephrosis—Infant. *Journal of the American College of Radiology*. 2020 Nov 1;17(11):S367-79.
9. Yalçınkaya F, Özçakar ZB. Management of antenatal hydronephrosis. *Pediatr Nephrol*. 2020;35(12):2231-239. doi:10.1007/s00467-019-04420-6.
10. Chen Z, Huang H, Yang J, Cai H, Yu Y. The diagnostic value of magnetic resonance urography for detecting ureteric obstruction: as systematic review and meta-analysis. *Ann Med*. 2020;52(6):275-282. doi:10.1080/07853890.2020.1741672.

Polycystic Kidney Disease (PEDAB-21)

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Polycystic Kidney Disease (PEDAB-21)

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- Abdominal ultrasound (CPT[®] 76700) or retroperitoneal ultrasound (CPT[®] 76770) is medically necessary for clinical concern of polycystic kidney disease, or for screening individuals who are at risk for autosomal dominant polycystic kidney disease (ADPKD).
- There are no established MRI-based diagnostic criteria for ADPKD in children younger than 15 years of age.
- For older children and teens, imaging indications for MRI Abdomen without contrast (CPT[®] 74181) would be identical to those for adult individuals. See: **Polycystic Kidney Disease (AB-38.1)** in the Abdomen Imaging Guidelines.

References (PEDAB-21)

v2.0.2026

1. Devarajan P. Autosomal Recessive polycystic kidney disease. Nelson Textbook of Pediatrics, Chapter 563.2. eds Kliegman RM, St. Geme JW III, Blum NJ, Shah SS, Tasker RC, Wilson KM, Schuh AM, Mack CL. 22nd edition 2024, pp 3213.
2. Devarajan P. Autosomal dominant polycystic kidney disease. Nelson Textbook of Pediatrics, Chapter 563.3. eds Kliegman RM, St. Geme JW III, Blum NJ, Shah SS, Tasker RC, Wilson KM, Schuh AM, Mack CL. 22nd edition 2024, p 3214.
3. Gimpel C, Avni EF, Breysem L, et al. Imaging of Kidney Cysts and Cystic Kidney Diseases in Children: An International Working Group Consensus Statement. *Radiology*. 2019;290(3):769-782. doi:10.1148/radiol.2018181243.
4. Gimpel C, Bergmann C, Bockenhauer D, et al. International consensus statement on the diagnosis and management of autosomal dominant polycystic kidney disease in children and young people. *Nat Rev Nephrol*. 2019;15(11):713-726. doi: 10.1038/s41581-019-0155-2.
5. Torres VE, Ahn C, Barten TRM, et al. KDIGO 2025 clinical practice guideline for the evaluation, management, and treatment of autosomal dominant polycystic kidney disease (ADPKD): executive summary. *Kidney International*. 2025;107:234-254. doi:10.1016/j.kint.2024.07.010.

Blunt Abdominal Trauma (PEDAB-22)

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Blunt Abdominal Trauma (PEDAB-22)

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- Blunt abdominal trauma imaging indications in pediatric individuals are identical to those for adult individuals. See: **Blunt Abdominal Trauma (AB-10.1)** in the Abdomen Imaging Guidelines.

Hernias (PEDAB-23)

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Hernias (PEDAB-23)

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- Hernia imaging indications in pediatric individuals are identical to those for adult individuals. See: **Hernias (AB-12)** in the Abdomen Imaging Guidelines.

Abdominal Lymphadenopathy (PEDAB-24)

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Abdominal Lymphadenopathy (PEDAB-24)

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- Abdominal lymphadenopathy imaging indications in pediatric individuals are identical to those for adult individuals. See: **Abdominal Lymphadenopathy (AB-8)** in the Abdomen Imaging Guidelines.

Left Upper Quadrant Pain (PEDAB-25)

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Left Upper Quadrant Pain (PEDAB-25)

ABP.LT.0025.A

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- Left upper quadrant pain imaging indications in pediatric individuals are identical to those for adult individuals. See: **Abdominal Pain (AB-2)** in the Abdomen Imaging Guidelines.
- Nuclear medicine spleen imaging (CPT[®] 78185) is medically necessary for left upper quadrant pain when neither ultrasound nor CT is available.

References (PEDAB-25)

v2.0.2026

1. Royal HD, Brown ML, Drum DE, et al. Society of Nuclear Medicine Procedure guideline for hepatic and splenic imaging 3.0, version 3.0, approved July 20, 2003.

Spleen (PEDAB-26)

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Spleen (PEDAB-26)

ABP.SP.0026.A

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- Spleen imaging indications in pediatric individuals are very similar to those for adult individuals. See: **Spleen (AB-34)** in the Abdomen Imaging Guidelines.
- Nuclear medicine spleen imaging (CPT[®] 78185) is medically necessary for the following indications when CT is unavailable:
 - Splenic trauma
 - Evaluation of splenic function
 - Suspected splenic mass, cyst, abscess, infarct, or metastasis
 - Radiation treatment planning
 - Asplenia
 - Suspected functional accessory spleen:
 - CPT[®] 78215 or CPT[®] 78216 instead of CPT[®] 78185 is medically necessary, if requested
- Pediatric-specific imaging considerations include the following:
 - MRI is preferred over CT when possible to reduce radiation exposure.

References (PEDAB-26)

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1. Remiker AS, Brandow AM. Splenomegaly. Nelson Textbook of Pediatrics, Chapter 535. eds Kliegman RM, St. Geme JW III, Blum NJ, Shah SS, Tasker RC, Wilson KM, Schuh AM, Mack CL. 22nd edition. 2024, pp. 3061-3062.
2. Remiker AS, Brandow AM. Hyposplenism, splenic trauma, and splenectomy. Nelson Textbook of Pediatrics, Chapter 536. eds Kliegman RM, St. Geme JW III, Blum NJ, Shah SS, Tasker RC, Wilson KM, Schuh AM, Mack CL. 22nd edition. 2024, pp. 3063.
3. Navarro OM, Siegel MJ. Spleen and Peritoneal Cavity. In: Siegel MJ, editor. Pediatric Sonography, 5th ed. Philadelphia. Wolters Kluwer. 2019. p 304-345.
4. Di Serafino M, Verde F, Ferro F, et al. Ultrasonography of the pediatric spleen: a pictorial essay. *J Ultrasound*. 2019;22(4):503-512. doi:10.1007/s40477-018-0341-2.

Intussusception (PEDAB-27)

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Intussusception (PEDAB-27)

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- Intussusception, telescoping of one bowel loop into another, is a frequent cause of abdominal pain in young children. It may be associated with bloody stool.
 - Ultrasound (CPT[®] 76700 or CPT[®] 76705) is medically necessary as an initial study if there is a strong suspicion for intussusception.
 - CT Abdomen and/or Pelvis with contrast (CPT[®] 74160 or CPT[®] 74177) is medically necessary to help characterize or diagnose pathologic lead points identified on ultrasound.

References (PEDAB-27)

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1. Maqbool A, Liacouras CA. Intussusception. Nelson Textbook of Pediatrics, Chapter 379.3. eds Kliegman RM, St. Geme JW III, Blum NJ, Shah SS, Tasker RC, Wilson KM, Schuh AM, Mack CL. 22nd edition. 2024, pp 2300-2301.
2. Edwards EA, Pigg N, Courtier J, Zapala MA, Mackenzie JD, Phelps AS. Intussusception: past, present and future. *Pediatric Radiology*. 2017;47(9):1101-1108. doi: 10.1007/s00247-017-3878-x.
3. Coley BDBD. Caffey's Pediatric Diagnostic Imaging. Philadelphia, PA: Elsevier; 2019. Chapter 107, pp1040-1049.
4. Atweh LA, Naffaa L, Barakat A, Baassiri A. Imaging Acute Non-Traumatic Abdominal Pathologies in Pediatric Patients: A Pictorial Review. *Journal of Radiology Case Reports*. 2019;13(7). doi: 10.3941/jrcr.v13i7.3443.
5. Plut D, Phillips GS, Johnston PR, Lee EY. Practical imaging strategies for intussusception in children. *AJR Am J Roentgenol*. 2020;215(6):1449-1463. doi:10.2214/AJR.19.22445.
6. Hom J, Kaplan C, Folwer S, Messina C, Chandran L, Kunkov S. Evidence-based diagnostic test accuracy of history, physical examination, and imaging for intussusception: a systematic review and meta-analysis. *Pediatr Emerg Care*. 2022;38(1):e225-e230. doi:10.1097/PEC.0000000000002224
7. Rahmani E, Amani-Beni R, Hekmatnia Y, et al. Diagnostic accuracy of ultrasonography for detection of intussusception in children; a systematic review and meta-analysis. *Arch Acad Emerg Med*. 2023;11(1):e24. doi:10.22037/aaem.v11i1.1914.
8. Lin-Martore M, Firnberg MT, Kohn MA, Kornblith AE, Gottlieb M. Diagnostic accuracy of point-of-care ultrasonography for intussuception in children: a systematic review and meta-analysis. *Am J Emerg Med*. 2022;58:255-264. doi:10.1016/j.ajem.2022.06.025.
9. Li X-Z, Wang H, Song J, Liu Y, Lin Y-Q, Sun Z-X. Ultrasonographic diagnosis of intussusception in children: a systematic review and meta-analysis. *J Ultrasound Med*. 2021;40(6):1077-1084. doi:10.1002/jum.15504

Bowel Obstruction (PEDAB-28)

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Bowel Obstruction (PEDAB-28.1)

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- Suspected high-grade obstruction
 - MRI Abdomen and Pelvis without and with contrast (CPT[®] 74183 and CPT[®] 72197) is medically necessary (preferred to avoid unnecessary radiation exposure).
 - CT Abdomen and Pelvis with contrast (CPT[®] 74177) is medically necessary if MRI is not readily available.
- Suspected intermittent or low-grade small bowel obstruction.
 - MRI Abdomen and Pelvis without and with contrast (CPT[®] 74183 and CPT[®] 72197) is medically necessary (preferred to avoid unnecessary radiation exposure).
 - CT Abdomen and Pelvis with contrast (CPT[®] 74177) is medically necessary if MRI is not readily available.
 - If the etiology or level of suspected intermittent or low-grade small bowel obstruction remains undetermined and additional imaging is needed after CT Abdomen and Pelvis, the following are medically necessary:
 - CT Enteroclysis (CPT[®] 74176 or 74177), or
 - CT Enterography (CPT[®] 74177), or
 - MR Enteroclysis (CPT[®] 74183 and CPT[®] 72197), or
 - MR Enterography (CPT[®] 74183 and CPT[®] 72197)
- Small bowel obstruction suspected to be secondary to Crohn's Disease
 - See: **Inflammatory Bowel Disease, Crohn Disease, or Ulcerative Colitis (PEDAB-9)**

References (PEDAB-28)

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1. Expert Panel on Gastrointestinal Imaging. ACR Appropriateness Criteria[®] suspected small-bowel obstruction. American College of Radiology (ACR); 2019.
2. Bower KL, Lollar DI, Williams SL et al. Small bowel obstruction. *Surg Clin North Am*. 2018;98(5):945-971. doi:10.1016/j.suc.2018.05.007.
3. Hull NC, Kim HR, et al. Neonatal and pediatric bowel obstruction: Imaging guidelines and recommendations. *Radiologic Clinics of North America*. 2022;60(1):131-148. doi:10.1016/j.rcl.2021.08.006.

Left Lower Quadrant Pain (PEDAB-29)

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Left Lower Quadrant Pain (PEDAB-29)

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Diverticulitis is the most common cause of left lower quadrant pain in adults but is extremely rare in children.

- CT Abdomen and Pelvis (CPT[®] 74177) with contrast is medically necessary if there are any red flag signs or symptoms (as listed in **General Guidelines (PEDAB-1.0)**)
- In the absence of red flags, advanced imaging is rarely helpful in the initial evaluation of these individuals. Consultation with a gastroenterologist can be helpful in determining the appropriate diagnostic pathway.
 - Pelvic ultrasound (CPT[®] 76856) is the medically necessary initial imaging study of choice for children for detecting gynecologic abnormalities that may cause left lower quadrant pain.
 - For male individuals or if ultrasound is inconclusive, advanced imaging may be appropriate for management as directed by gastroenterological evaluation or consultation.

References (PEDAB-29)

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1. Maqbool A, Liacouras CA. Major symptoms and signs of digestive tract disorders. Nelson Textbook of Pediatrics, Chapter 352. eds eds Kliegman RM, St. Geme JW III, Blum NJ, Shah SS, Tasker RC, Wilson KM, Schuh AM, Mack CL. 22nd edition 2024, pp 2224-2237.
2. Maqbool A, Liacouras CA, Brownell JN, Ufberg PJ. Disorder of Brain-Gut Interaction (Functional Gastrointestinal Disorders). Nelson Textbook of Pediatrics, Chapter 389. eds Kliegman RM, St. Geme JW III, Blum NJ, Shah SS, Tasker RC, Wilson KM, Schuh AM, Mack CL. 22nd edition 2024, pp 2385-2390.
3. Han J, Son J, Oh C. Features of colonic diverticulitis in children and adolescents: a multicenter study. *Asian Journal of Surgery*. 2024;47:2195-2199. doi:10.1016/j.asjsur.2024.02.049.
4. Walter SS, Maurer M, Storz C, et al. Effects of radiation dose reduction on diagnostic accuracy of abdominal CT in young adults with suspected acute diverticulitis: a retrospective intraindividual analysis. *Academic Radiology*. 2019;26(6):782-790. doi:10.1016/j.acra.2019/08.007.

Celiac Disease (Sprue) (PEDAB-30)

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Celiac Disease (Sprue) (PEDAB-30)

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- Celiac disease imaging indications in pediatric individuals are identical to those for adult individuals. See: **Celiac Disease (Sprue) (AB-24)** in the Abdomen Imaging Guidelines.

Background and Supporting Information:

There is no need for radiological small bowel imaging in uncomplicated celiac disease.

References (PEDAB-30)

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1. Van Weyenberg SJB, Mulder CJJ, Van Waesberghe JHTM. Small bowel imaging in celiac disease. *Dig Dis*. 2015;33(2):252-259. doi:10.1159/000369516.

Transplant (PEDAB-31)

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Transplant (PEDAB-31)

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- Liver and kidney transplant imaging indications in pediatric individuals are identical to those for adult individuals. See: **Transplant (AB-42)** in the Abdomen Imaging Guidelines.
- For post-transplant lymphoproliferative disorder in pediatric individuals, see: **Pediatric Aggressive Mature B-Cell Non-Hodgkin Lymphomas (NHL) (PEDONC-5.3)** in the Pediatric and Special Populations Oncology Imaging Guidelines.

Gaucher Disease (PEDAB-32)

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Gaucher Disease (PEDAB-32)

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See: **Gaucher Disease (PEDPN-4)** in the Pediatric Peripheral Nerve and Neuromuscular Disorders Imaging Guidelines.

Vomiting Infant, Malrotation, and Hypertrophic Pyloric Stenosis (PEDAB-33)

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Vomiting Infant, Malrotation, and Hypertrophic Pyloric Stenosis (PEDAB-33)

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- Vomiting in infants is generally classified as either bilious (implying obstruction distal to the Sphincter of Oddi) or non-bilious.
- Bilious vomiting may be a true emergency, as some of the conditions causing this could result in compromise of blood supply to the intestines, a potentially life-threatening situation.
- Suspected malrotation is an indication for emergent imaging. If malrotation with mid-gut volvulus is suspected, Ultrasound abdomen, limited (CPT® 76705) is medically necessary.
- Hypertrophic Pyloric Stenosis is an idiopathic condition wherein the circular muscle controlling emptying of the stomach thickens causing a relative obstruction of the gastric outlet. The condition can occur at any age (including occasionally in adults), but the typical child is male, aged 2 to 6 weeks. Projectile non-bilious vomiting is the most common presenting complaint, but the description of projectile vomiting is subjective. The differential diagnosis for non-bilious vomiting includes common conditions such as viral gastroenteritis and gastro-esophageal reflux.
 - US Abdomen, limited (CPT® 76705) is medically necessary for infants with persistent projectile non-bilious vomiting. If initial studies are not diagnostic, repeat studies are medically necessary (as frequently as daily) until the vomiting resolves or the diagnosis is made.

References (PEDAB-33)

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1. Singh A, Liacouras CA. Hypertrophic pyloric stenosis. Nelson Textbook of Pediatrics. Chapter 375.1. eds Kliegman RM, St. Geme JW III, Blum NJ, Shah SS, Tasker RC, Wilson KM, Schuh AM, Mack CL. 22nd edition. 2024, pp 2278-2279.
2. Bales CB, Liacouras CA. Malrotation. Nelson Textbook of Pediatrics. Chapter 376.3. eds Kliegman RM, St. Geme JW III, Blum NJ, Shah SS, Tasker RC, Wilson KM, Schuh AM, Mack CL. 22nd edition. 2024, pp 2284-2285.
3. Hwang J-Y. Emergency ultrasonography of the gastrointestinal tract of children. *Ultrasonography*. 2017;36(3):204-221. doi:10.14366/usg.16052.
4. Atweh LA, Naffaa L, Barakat A, Baassiri A. Imaging Acute Non-Traumatic Abdominal Pathologies in Pediatric Patients: A Pictorial Review. *Journal of Radiology Case Reports*. 2019;13(7). doi: 10.3941/jrcr.v13i7.3443.
5. Coley BDBD. Caffey's Pediatric Diagnostic Imaging. Philadelphia, PA: Elsevier; 2019. Chapters 100 and 102.
6. American College of Radiology ACR Appropriateness Criteria® Vomiting in Infants. Revised 2020. <https://acsearch.acr.org/docs/69445/Narrative/>.
7. Rich BS, Dolgin SE. Hypertrophic pyloric stenosis. *Pediatr Rev*. 2021;42(10):539-545. doi:10.1542/pir.2020.003277.
8. van den Bunder FAIM, Derikx JPM, Kiblawi R, van Rijn RR, Dingemann J. Diagnostic accuracy of palpation and ultrasonography for diagnosing infantile hypertrophic pyloric stenosis: a systematic review and meta-analysis. *Br J Radiol*. 2022;95(1139):20211251. doi:10.1259/bjr.20211251.
9. Nguyen HN, Kulkarni M, Jose J, et al. Ultrasound for the diagnosis of malrotation and volvulus in children and adolescents: a systematic review and meta-analysis. *Arch Dis Child*. 2021;106(12):1171-1178. doi:10.1136/archdischild-2020-321082
10. El-Ali AM, Schiess DM, Tassel DV, et al. Ultrasound for midgut volvulus and malrotation: frequency and predictors of a non-diagnostic examination in a multi-institutional cohort. *Pediatr Radiol*. 2025;55(5):925-935. doi:10.1007/s00247-024-06141-x.
11. Nguyen HN, Navarro OM, Bloom DA, et al. Ultrasound for midgut malrotation and midgut volvulus: AJR expert panel narrative review. *AJR*. 2022;218(6):931-939. doi:10.2214/AJR.21.27242.
12. Binu V, Nicholson C, Cundy T, et al. Ultrasound imaging as the first line of investigation to diagnose intestinal malrotation in children: safety and efficacy. *Journal of Pediatric Surgery*. 2021;53(12):2224-2228.

Pancreatitis (PEDAB-34)

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Acute Pancreatitis (PEDAB-34.1)

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- The presence of any red flag findings per **General Guidelines (PEDAB-1.0)** precludes adjudication based on any other criteria.
 - If red flag is present (as per **General Guidelines (PEDAB-1.0)**), then CT Abdomen and Pelvis with contrast (CPT[®] 74177), CT Abdomen with contrast (CPT[®] 74160), or MRI/MRCP (CPT[®] 74183 or CPT[®] 74181) is medically necessary.
- Initial imaging
 - US Abdomen (CPT[®] 76700 or CPT[®] 76705) is medically necessary
 - If ultrasound performed and is nondiagnostic due to technical limitation (obesity, overlying gas, etc.), or if ultrasound is negative and there is continued clinical suspicion of acute pancreatitis, MRI/MRCP (CPT[®] 74183 or CPT[®] 74181) is medically necessary.
 - CT Abdomen and Pelvis with contrast (CPT[®] 74177) or CT Abdomen with contrast (CPT[®] 74160) is medically necessary if MRI/MRCP cannot be performed.
 - CT Abdomen and Pelvis with contrast (CPT[®] 74177) is medically necessary for management of acute pancreatitis in the following situations:
 - Evaluation of known or suspected complications of acute pancreatitis
 - To characterize degree of organization of collections before intervention
- Abdominal US (CPT[®] 76700 or CPT[®] 76705) is medically necessary to follow known fluid collections for resolution or progression.
- Acute Recurrent Pancreatitis (ARP)
 - MRI/MRCP (CPT[®] 74183 or CPT[®] 74181) is medically necessary for the following:
 - To identify structural or obstructive causes
 - To assess for progression to chronic pancreatitis
 - In a child who requires sedation for imaging, it is reasonable to alternate MRI/MRCP with Abdominal US (CPT[®] 76700 or CPT[®] 76705) or CT Abdomen with contrast (CPT[®] 74160) for serial monitoring of acute recurrent pancreatitis as recommended by or in consultation with a gastroenterologist or pancreatic specialist.

Background and Supporting Information

- The role of imaging is to identify findings at diagnosis, assess for local complications, identify potential etiologies, monitor evolution of local complications, plan and guide interventions.

Chronic Pancreatitis (PEDAB-34.2)

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- The role of imaging is to contribute to or establish initial diagnosis, stage/monitor disease, assess for superimposed acute pancreatitis, identify potential etiologies of chronic pancreatitis, characterize secretory function, and/or plan for surgical intervention.
- If chronic pancreatitis is suspected, the following are medically necessary:
 - MRI Abdomen without and with contrast (CPT[®] 74183)
 - CT Abdomen and Pelvis with contrast (CPT[®] 74177) or CT Abdomen with contrast (CPT[®] 74160) if MRI cannot be performed
- To evaluate suspected or known episode of acute pancreatitis in a child with chronic pancreatitis, the following is medically necessary:
 - Abdominal US (CPT[®] 76700 or CPT[®] 76705)
 - CT Abdomen and Pelvis with contrast (CPT[®] 74177) or CT Abdomen with contrast (CPT[®] 74160) or MRI/MRCP (CPT[®] 74183 or CPT[®] 74181) are medically necessary in the following situations:
 - If ultrasound is negative and imaging diagnosis of acute pancreatitis is needed
 - If planning endoscopic or surgical interventions

References (PEDAB-34)

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1. Trout AT, Anupindi SA, Freeman AJ, et. al. North American Society for Pediatric Gastroenterology, Hepatology and Nutrition and the Society for Pediatric Radiology joint position paper on noninvasive imaging of pediatric pancreatitis: literature summary and recommendations. *J Pediatr Gastroenterol Nutr.* 2021;72(1):151-167. doi:10.1097/MPG.0000000000002964.
2. Trout AT, Ayyala RS, Murati MA, et al. Current state of imaging of pediatric pancreatitis: AJR expert panel narrative review. *AJR Am J Roentgenol.* 2021;217(2):265-277. doi: 10.2214/AJR.21.25508.
3. Trout AT, Abu-El-Haija M, Anupindi SA, et al. Interobserver agreement for CT and MRI findings of chronic pancreatitis in children: a multicenter ancillary study under the INSPPIRE consortium. *AJR Am J Roentgenol.* 2022;219(2):303-313.