CIGNA MEDICAL COVERAGE POLICIES- RADIOLOGY

Abdomen Imaging Guidelines

Effective Date: February 02, 2027

Instructions for use

The following coverage policy applies to health benefit plans administered by Cigna. Coverage policies are intended to provide guidance in interpreting certain standard Cigna benefit plans and are used by medical directors and other health care professionals in making medical necessity and other coverage determinations. Please note the terms of a customer's particular benefit plan document may differ significantly from the standard benefit plans upon which these coverage policies are based. For example, a customer's benefit plan document may contain a specific exclusion related to a topic addressed in a coverage policy.

In the event of a conflict, a customer's benefit plan document always supersedes the information in the coverage policy. In the absence of federal or state coverage mandates, benefits are ultimately determined by the terms of the applicable benefit plan document. Coverage determinations in each specific instance require consideration of:

1. The terms of the applicable benefit plan document in effect on the date of service
2. Any applicable laws and regulations
3. Any relevant collateral source materials including coverage policies
4. The specific facts of the particular situation

Coverage policies relate exclusively to the administration of health benefit plans. Coverage policies are not recommendations for treatment and should never be used as treatment guidelines.

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

These guidelines include procedures EviCore does not review for Cigna. Please refer to the **Cigna CPT code list** for the current list of high-tech imaging procedures that EviCore reviews for Cigna.

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General Guidelines (AB-1)

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Abbreviations for Abdomen Imaging Guidelines

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Abbreviations for Abdomen Imaging Guidelines	
AAA	abdominal aortic aneurysm
AASLD	American Association for the Study of Liver Diseases
ACE	angiotensin-converting enzyme
ACG	American College of Gastroenterology
ACR	American College of Radiology
ACTH	adrenocorticotropic hormone
AFP	alpha-fetoprotein
AGA	American Gastroenterological Association
ALKP	alkaline phosphatase
ALT	alanine aminotransferase
ASGE	American Society for Gastrointestinal Endoscopy
AST	aspartate aminotransferase
AUA	American Urological Association
BEIR	Biological Effects of Ionizing Radiation
BMP	basic metabolic panel
BUN	blood urea nitrogen

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Abbreviations for Abdomen Imaging Guidelines	
CAG	Canadian Association of Gastroenterology
CBC	complete blood count
CMP	comprehensive metabolic panel
CNS	central nervous system
CT	computed tomography
CTA	computed tomography angiography
CTC	computed tomography colonography (aka: virtual colonoscopy)
DVT	deep vein thrombosis
ERCP	endoscopic retrograde cholangiopancreatography
ESR	erythrocyte sedimentation rate
EUS	endoscopic ultrasound
FNH	focal nodular hyperplasia
GFR	glomerular filtration rate
GGT	gamma glutamyl transferase
GI	gastrointestinal
HCC	hepatocellular carcinoma
HCPCS	Healthcare Common Procedural Coding System (commonly pronounced: “hix pix”)
HU	Hounsfield units
IAA	iliac artery aneurysm
IV	intravenous

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Abbreviations for Abdomen Imaging Guidelines	
KUB	kidneys, ureters, bladder (plain frontal supine abdominal radiograph)
LFT	liver function tests
MASLD	metabolic dysfunction associated steatotic liver disease (formerly known as NAFLD)
MRCP	magnetic resonance cholangiopancreatography
MRA	magnetic resonance angiography
MRE	magnetic resonance elastography
MRI	magnetic resonance imaging
mSv	millisievert
NAFLD	nonalcoholic fatty liver disease (now known as MASLD)
PA	posteroanterior projection
PET	positron emission tomography
RAS	renal artery stenosis
RBC	red blood cell
SBFT	small bowel follow through
SPECT	single photon emission computed tomography
VC	virtual colonoscopy (CT colonography)
PFT	pulmonary function tests
WBC	white blood cell
ZES	Zollinger-Ellison Syndrome

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General Guidelines (AB-1.0)

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Criteria

- A pertinent clinical evaluation since the new onset or change in symptoms is required prior to advanced imaging:
  - A pertinent clinical evaluation should include the following:
    - A detailed history and physical examination relevant to the current complaint, including a thorough abdominal examination with assessment for the presence, location, and characteristics of any abdominal mass, wall defect, or hernia
    - Appropriate laboratory studies
    - Non-advanced imaging modalities such as plain x-ray or ultrasound of the area of concern
  - For an established individual, a meaningful technological contact (telehealth visit, telephone call, electronic mail, or messaging) since the onset of change in symptoms can serve as a pertinent clinical evaluation.
- Abdominal imaging begins at the diaphragm and extends to the umbilicus or iliac crest.
- Pelvic imaging begins at the iliac crest and extends to the pubis.
  - The uterus, fallopian tubes and ovaries arise out of the pelvis and are considered pelvic organs. If the uterus or adnexa rise out of the pelvic cavity, above the level of the iliac crest or umbilicus on physical exam or previous imaging, abdominal imaging may be added for the completion of imaging.
- Imaging for clinical concerns at the dividing line can be providers' choice (abdomen and pelvis; abdomen or pelvis).

Red Flag Findings

- The presence of any red flag finding in an individual with abdominal pain indicates possible serious underlying pathology. In these cases, prerequisite testing (e.g., ultrasound and/or laboratory studies) is not required. Requests for appropriate advanced imaging (e.g., CT or MRI) may be approved without prior testing, consistent with the applicable condition-specific guideline.
- Red flag findings include ANY of the following:
  - History of malignancy with documented risk of abdominal or intra-abdominal metastasis
  - Immunocompromised individual (e.g., on immunosuppressive therapy, history of human immunodeficiency virus [HIV])

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- Fever (101 degrees Fahrenheit [38.5 degrees Celsius] or higher)
- Elevated white blood cell count (WBC) greater than 10,000 cells/mm³, or above the upper limit of normal for the particular lab reporting the result
- Low WBC (absolute neutrophil count less than 1,000 cells/mm³)
- Palpable abdominal mass of clinical concern
- Gastrointestinal (GI) bleeding, overt or occult, not obviously hemorrhoidal
- Abdominal tenderness documented as moderate or severe
- Peritoneal signs, such as guarding or rebound tenderness
- Suspected complication of bariatric surgery
- Notation by the ordering provider that the individual has a "surgical abdomen"
- Age 60 years or older with unintentional weight loss of 10 pounds or more, or 5% or more of body weight, over 6 months or less, without an identifiable reason

Pregnancy Considerations for Imaging

- In pregnant individuals evaluation with ultrasound or MRI without contrast to avoid radiation exposure is considered medically necessary.
- If these modalities are nondiagnostic or insufficient, CT or other imaging involving ionizing radiation may be performed when necessary to establish the diagnosis and guide management.

Imaging Recommended Per Drug Manufacturer

- When follow-up imaging for the purposes of monitoring or screening is recommended in the package insert for a particular drug therapy or medication, that imaging may be considered medically necessary.

Complications Related to COVID-19

- Please refer to the appropriate condition-specific guideline relevant to the presenting signs or symptoms in individuals with potential sequelae of COVID-19.

Pre-operative Radiologic Imaging

- If imaging is requested by the operating surgeon to support planned surgery, the imaging is considered medically necessary.
- Please refer to the appropriate condition-specific guideline relevant to the clinical condition for pre-operative imaging indications.

3D Rendering

- CPT® 76377 (3D rendering requiring image post-processing on an independent workstation) or CPT® 76376 (3D rendering not requiring image post-processing on an independent workstation) is considered medically necessary in the following clinical scenarios:

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  - Pre-operative planning for complex surgical cases
  - CT Urogram (See: **Hematuria and Hydronephrosis (AB-39)**)
  - MRCP (See: **MR Cholangiopancreatography (MRCP) (AB-27)**)
- CPT® codes for 3D rendering should not be billed in conjunction with computer-aided detection (CAD), MRA, CTA, nuclear medicine SPECT studies, PET, PET/CT, or CT Colonography (virtual colonoscopy).

Background and Supporting Information

The American College of Obstetricians and Gynecologists (ACOG) provides guidance on imaging during pregnancy and lactation. Ultrasonography and magnetic resonance imaging (MRI), which do not involve ionizing radiation, are the preferred imaging modalities in pregnant individuals. These modalities should be used when the results are expected to address a clinically relevant question or provide medical benefit (ACOG, 2017; Faerber et al., 2020).

When ultrasound or MRI cannot adequately answer the clinical question, imaging studies that involve ionizing radiation, such as radiography, computed tomography (CT), and nuclear medicine procedures, should not be withheld if they are necessary for timely diagnosis and management. In most cases, fetal radiation exposure from these modalities is well below thresholds associated with fetal harm, and the potential benefits of accurate diagnosis generally outweigh the theoretical risks of radiation exposure (ACR, 2023).

The use of gadolinium-based contrast with MRI should be limited and reserved for situations in which it significantly improves diagnostic performance and is expected to improve maternal or fetal outcomes. Similarly, iodinated intravenous contrast should only be used when necessary to obtain diagnostic information that will impact clinical management (ACR, 2024; Pedrosa et al., 2025).

Evidence Discussion

Evidence supported a tiered approach to abdominal imaging in which ultrasound is frequently used as the initial modality in appropriately selected clinical scenarios. Literature and guideline-based data demonstrated that ultrasound provided adequate diagnostic performance for hepatobiliary and superficial pathology while avoiding ionizing radiation (American College of Radiology [ACR], 2023; Dietrich et al., 2020). In addition to its safety profile, ultrasound allows real-time assessment and serves as an effective triage tool to determine whether further imaging is required and to guide modality selection, including the use of computed tomography (CT) or magnetic resonance imaging (MRI) without or with contrast (ACR, 2023, 2024). However, its diagnostic performance is reduced for deep structures, bowel pathology, and lesions obscured by overlying gas (ACR, 2023; Dietrich et al., 2020).

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Gastroenterology consultation may also be valuable in guiding imaging selection when the differential diagnosis includes mesenteric or colonic ischemia, chronic diarrhea or constipation, irritable bowel syndrome (IBS), obscure gastrointestinal bleeding, or pancreaticobiliary disease requiring consideration of magnetic resonance cholangiopancreatography (MRCP). Specialist evaluation can help refine pretest probability, determine the need for endoscopic or laboratory evaluation, and identify scenarios in which advanced imaging is clinically indicated (ACR, 2023, 2024).

Certain populations and clinical presentations warrant modification of a routine ultrasound-first strategy. In pediatric individuals and pregnant individuals, ultrasonography remains the preferred initial imaging modality because it avoids ionizing radiation while providing diagnostic information for a broad range of abdominal conditions. However, MRI may be required when ultrasound findings are nondiagnostic or when evaluation of deeper abdominal structures is necessary. This consideration is particularly relevant during the third trimester of pregnancy, when physiologic and anatomic changes may further limit ultrasound visualization (ACOG, 2017; ACR, 2023, 2024). Additionally, the absence of severe pain does not exclude significant intra-abdominal pathology. Individuals presenting with a painless acute abdomen or atypical symptoms, particularly older adults and immunocompromised populations, may still require prompt cross-sectional imaging when clinical suspicion for serious pathology remains high (ACR, 2023).

Deviation from this stepwise approach is warranted in the presence of clinical features that elevate pretest probability for serious or time-sensitive pathology. In these contexts, immediate cross-sectional imaging improves diagnostic yield and reduces delays in care (ACR, 2023).

- **Risk of metastases**: Advanced imaging is considered medically necessary when clinical suspicion for disseminated malignancy is high. CT and MRI provide superior detection of metastatic disease in the liver, lungs, and lymphatic structures, which are common sites of spread across multiple primary tumors. Ultrasound has reduced sensitivity for intraluminal and hollow viscus involvement due to acoustic limitations in gas-filled structures. Cross-sectional imaging allows comprehensive staging, which directly informs treatment pathways and prognostic assessment (ACR, 2023; National Institute for Health and Care Excellence [NICE], 2023). This is particularly relevant when systemic symptoms or known primary malignancy increase pretest probability of metastatic disease.
- **Fever**: Fever in combination with abdominal pain, gastrointestinal bleeding, vomiting, or unexplained weight loss signals possible intra-abdominal infection, ischemia, or inflammatory disease. CT is well suited for detecting complications such as perforation, abscess formation, and bowel ischemia due to its spatial resolution and ability to assess both bowel wall and mesenteric structures (ACR, 2023; ACR et al., 2021). MRI offers comparable soft tissue characterization without radiation, particularly in individuals requiring repeat imaging (ACR, 2023). Early cross-sectional

imaging reduces diagnostic uncertainty in conditions where progression to sepsis or perforation is possible (Sandherr et al., 2025).

- **Abnormal white blood cell count**: Leukocytosis or neutropenia modifies both risk stratification and urgency of imaging. In neutropenic individuals, clinical examination is often unreliable, and conditions such as neutropenic enterocolitis may progress rapidly with subtle initial findings. CT imaging allows early detection of bowel wall thickening, pneumatosis, or complications that would not be reliably visualized on ultrasound. Timely identification is critical given the high morbidity associated with delayed treatment in immunocompromised populations (Nematolahi et al., 2025; Sandherr et al., 2025). In leukocytosis, cross-sectional imaging similarly refines diagnosis across a spectrum of infectious and inflammatory conditions.
- **Concerning palpable mass**: Evaluation of a palpable mass requires modality selection based on suspected anatomic origin. Ultrasound is appropriate for initial characterization of superficial or cystic lesions, but CT or MRI is considered medically necessary when malignancy is suspected, when lesions are deep, or when local invasion must be assessed. Cross-sectional imaging provides superior delineation of tissue planes, vascular involvement, and regional spread, all of which are necessary for staging and management planning (ACR, 2023; NICE, 2023). When pain accompanies a mass, the likelihood of complications such as necrosis or obstruction increases, further supporting advanced imaging.
- **GI bleeding**: When endoscopic evaluation is nondiagnostic or contraindicated, CT angiography offers high diagnostic performance and facilitates localization of active bleeding. Its sensitivity and specificity, reported near 86% and 95% respectively, support its role in acute settings where rapid identification guides embolization or surgical intervention (Sengupta et al., 2023). Imaging selection should also account for hemodynamic stability and institutional expertise, as unstable individuals may require immediate intervention rather than staged diagnostics.
- **Significant abdominal tenderness, with or without peritoneal signs**: Severe or rapidly progressive abdominal pain raises concern for surgical pathology such as perforation, ischemia, or obstruction. CT is the preferred modality due to its ability to evaluate bowel integrity, detect free air, and assess mesenteric perfusion. Ultrasound lacks sufficient sensitivity in these contexts, particularly in individuals with guarding, obesity, or extensive bowel gas. This limitation is more pronounced in populations with atypical presentations, including older adults and immunocompromised individuals, where delayed diagnosis carries significant risk (ACR, 2023).
- **Post-bariatric surgery complications**: Individuals with altered anatomy after procedures such as Roux-en-Y gastric bypass are at elevated risk for internal hernia, obstruction, or marginal ulceration. These conditions often present with nonspecific symptoms and require early CT imaging for diagnosis. Cross-sectional imaging allows visualization of mesenteric swirl, bowel obstruction patterns, and ischemic changes, which are not reliably detected by ultrasound. Prompt identification reduces risk of bowel necrosis and associated morbidity (Fry & Finks, 2023).

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- **Unintentional weight loss**: Clinically significant weight loss, classically defined as at least 5% of body weight within one month or 10% over six months, is associated with increased mortality and warrants systematic evaluation. Imaging plays an important role when the initial history, physical examination, and laboratory assessment do not identify an etiology. Cross-sectional imaging is often preferred because it can detect occult malignancy, chronic infection, and structural gastrointestinal disease that may not be apparent through routine evaluation. Diagnostic imaging should be guided by clinical findings, risk factors, and the results of the initial assessment, particularly in older adults and individuals with additional features concerning for serious underlying disease (Rao et al., 2026; NICE, 2023).

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.

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CT Imaging (AB-1.2)

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Criteria

- CT imaging is a more generalized modality. CT Abdomen is usually performed with contrast (CPT® 74160):
  - Oral contrast has no relation to the IV contrast administered. Coding for contrast only refers to IV contrast. There is no coding for oral contrast.
  - Exceptions are noted in these guidelines and include:
    - CT Abdomen with contrast (CPT® 74160) or CT Abdomen without and with contrast (CPT® 74170) with suspicion of a solid organ lesion (liver, kidney, pancreas, spleen)
      - Please refer to the specific guideline for the lesion in question for specific guidance.
    - CT Abdomen without contrast (CPT® 74150) or CT Abdomen and Pelvis without contrast (CPT® 74176) if there is renal insufficiency/failure, or a documented allergy to contrast. It can also be considered medically necessary for diabetics or the very elderly.
    - CT Abdomen and Pelvis without and with contrast (CPT® 74178 – CT Urogram) for certain urologic conditions (e.g., hematuria).
  - Shellfish allergy:
    - It is commonly assumed that an allergy to shellfish infers iodine allergy, and that this implies an allergy to CT iodinated contrast media. However, this is NOT true. Shellfish allergy is due to tropomysins. Iodine plays no role in these allergic reactions. Allergies to shellfish do not increase the risk of reaction to IV contrast any more than that of other allergens.
  - CT Abdomen and Pelvis, usually with contrast (CPT® 74177), is considered medically necessary when signs or symptoms are generalized, or involve a lower quadrant of the abdomen.
  - CT Enterography (CPT® 74177) combines CT imaging with large volumes of ingested neutral bowel contrast material to allow visualization of the small bowel.
  - CT Enteroclysis
    - A tube is placed through the nose or mouth and advanced into the duodenum or jejunum. Bowel contrast material is infused through the tube and CT imaging is performed either with or without intravenous contrast.
    - CT Enteroclysis is used to allow visualization of the small bowel wall and lumen. CT Enteroclysis may allow better or more consistent distention of the small bowel than CT Enterography.

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    - Report by assigning: CPT® 74176 or CPT® 74177
  - Triple-phase CT
    - 3 phases of a triple-phase CT are:
      - 1) Hepatic arterial phase,
      - 2) Portal venous phase, and
      - 3) Washout or delayed acquisitions phase.
    - It should be noted that, in general, a pre-contrast or non-contrast CT is usually not needed in a standard triple-phase CT, except in those individuals previously treated with locoregional embolic or ablative therapies. Other specific instances in which a prior non-contrast CT is medically necessary for the evaluation of liver lesions are noted in **Liver Lesion Characterization (AB-29.1)**.
- CT Colonography (CTC)
  - There are 3 CPT® codes for CTC:
    - CPT® 74263: Screening CTC (only used for screening procedures)
    - CPT® 74261: CTC without contrast
    - CPT® 74262: CTC with contrast
  - See: **CT Colonography (CTC) (AB-25)** for further indications for these procedures

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MR Imaging (AB-1.3)

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Criteria

- MRI may be preferred as a more targeted study in cases of renal failure, in individuals allergic to intravenous CT contrast, and as noted in these guidelines.
  - MRI Abdomen with contrast only is essentially never performed. If contrast is indicated, MRI Abdomen without and with contrast (CPT® 74183) should be considered medically necessary.
  - For pregnant individuals ultrasound or MRI without contrast should be used to avoid radiation exposure. The use of gadolinium contrast agents is limited during pregnancy, as gadolinium contrast agents cross the placenta and enter the amniotic fluid with unknown long-term effects on the fetus.
    - See: **General Guidelines (AB-1.0): Pregnancy Considerations for Imaging** for additional discussion of this issue
- MR Elastography (CPT® 76391) replaces MRI Abdomen (CPT® 74183 or CPT® 74181) for requests for MR Elastography liver (See: **Liver Elastography (AB-45)**)

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MR Enterography and Enteroclysis Coding Notes (AB-1.4)

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Criteria

- MR Enterography or Enteroclysis is reported in one of two ways:
  - MRI Abdomen without and with contrast (CPT® 74183), or
  - MRI Abdomen without and with contrast (CPT® 74183) and MRI Pelvis without and with contrast (CPT® 72197)

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Ultrasound (AB-1.5)

AB.GG.0001.5.A
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Criteria

- Ultrasound, also called sonography, uses high frequency sounds waves to image body structures.
  - The routine use of 3D and 4D rendering (post-processing) in conjunction with ultrasound is considered not medically necessary.
  - All ultrasound studies require permanently recorded images either stored on film or in a Picture Archiving and Communication System (PACS).
  - The use of a hand-held or any Doppler device that does not create a hard-copy output is considered part of the physical examination and is not separately billable. This exclusion includes devices that produce a record that does not permit analysis of bi-directional vascular flow.
- Duplex scan describes an ultrasonic scanning procedure for characterizing the pattern and direction of blood flow in arteries and veins with the production of real-time images integrating B-mode 2D vascular structures, Doppler spectral analysis, and color flow Doppler imaging.
  - The minimal use of color Doppler alone, when performed for anatomical structure identification during a standard ultrasound procedure, is not separately reimbursable.

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Abdominal Ultrasound (AB-1.6)

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Criteria

- Complete abdominal ultrasound (CPT® 76700) includes all of the following required elements:
  - Liver, gallbladder, common bile duct, pancreas, spleen, kidneys, upper abdominal aorta, and inferior vena cava
  - If a particular structure or organ cannot be visualized, the report should document the reason.
- Limited abdominal ultrasound (CPT® 76705) is without all of these required elements and can refer to a specific study of a single organ, a limited area of the abdomen, or a follow-up study.
  - Further, CPT® 76705 should:
    - Be assigned to report follow-up studies once a complete abdominal ultrasound (CPT® 76700) has been performed; and
    - Be assigned to report ultrasonic evaluation of diaphragmatic motion; and
    - Be reported only once per individual imaging session; and
      - Not be reported with CPT® 76700 for the same individual for the same imaging session

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Retroperitoneal Ultrasound (AB-1.7)

AB.GG.0001.7.A
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Criteria

- Complete retroperitoneal ultrasound (CPT® 76770) includes all of the following required elements:
  - Kidneys, lymph nodes, abdominal aorta, common iliac artery origins, inferior vena cava
  - For urinary tract indications, a complete study can consist of kidneys and bladder
- Limited retroperitoneal ultrasound (CPT® 76775) studies are without all of these required elements and can refer to a specific study of a single organ, a limited area of the abdomen, or a follow-up study.
  - Further, CPT® 76775 should:
    - Be assigned to report follow-up studies once a complete retroperitoneal ultrasound (CPT® 76770) has been performed; and
    - Be reported only once per individual imaging session; and
      - Not be reported with CPT® 76770 for the same individual for the same imaging session

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Contrast-Enhanced Ultrasound (AB-1.9)

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Criteria

Ultrasound with contrast (CEUS, CPT® 76978, CPT® 76979) is an emerging technology that may be as good, if not better, than CT or MRI in certain circumstances. Abdominal Imaging Guidelines address its use as appropriate. CPT® 76978 refers to the initial imaging of the first lesion, and CPT® 76979 refers to additional lesions that are imaged subsequently.

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Quantitative MRI (AB-1.10)

AB.GG.0001.10.A
v1.0.2027

Criteria

- Quantitative MRI analysis of tissue composition (CPT® 0648T, 0649T, 0697T and 0698T)
  - These CPT codes are experimental and investigational.
  - See: **Quantitative MR Analysis of Tissue Composition (Preface-4.8)** and **Fatty Liver (Metabolic Associated Steatotic Liver Disease (MASLD), Formerly Known as NAFLD) (AB-29.2)** for further discussion of these modalities.

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RADCAT Grading System (AB-1.11)

AB.GG.0001.11.A

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- The RADCAT (Radiology Report Categorization) Grading System was developed in order to communicate to ordering physicians (most commonly in the ER setting) the relative urgency of a radiologic finding. It is not related to the LI-RADs reporting system, nor does it necessarily imply the need for follow-up imaging, as opposed to clinical follow-up. The rating system is as follows:
  - RADCAT 1: Normal Result
  - RADCAT 2: Routine Result
  - RADCAT 3: Result with recommendation for non-urgent routine follow-up
  - RADCAT 4: Priority Result
  - RADCAT 5: Critical Result

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Abdominal Pain (AB-2)

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Abdominal Pain (AB-2.2)

AB.AP.0002.2.A
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Criteria

- The presence of any red flag findings per **General Guidelines (AB-1.0)** precludes adjudication based on any other criteria.
- For pregnant individuals, see **General Guidelines (AB-1.0): Pregnancy Considerations for Imaging**
  - Abdominal and/or Pelvic and/or Transvaginal ultrasound (CPT® 76700 and/or CPT® 76856 and/or CPT® 76830) is considered medically necessary initially to avoid ionizing radiation.
  - MRI Abdomen and/or MRI Pelvis without contrast (CPT® 74181 and/or CPT® 72195) is considered medically necessary if the initial US is considered non-diagnostic.
- For the evaluation of left lower abdominal pain (including suspected diverticulitis), right lower abdominal pain (including suspected appendicitis), left upper abdominal pain, mid-abdominal pain, or non-specific abdominal pain of any duration:
  - CT Abdomen with contrast (CPT® 74160) or CT Abdomen and Pelvis with contrast (CPT® 74177) is considered medically necessary if ANY of the following are present:
    - Individuals aged 65 years or older
    - Prior Abdominal and/or Pelvic US appropriate to the anatomic area of concern have been performed and either demonstrated a need for additional imaging OR did not explain the source of pain
    - Recent laboratory studies relevant to the current episode have been performed and are non-diagnostic OR do not point to a specific etiology
      - Laboratory evaluation may include: complete blood count (CBC) with differential, comprehensive metabolic panel (CMP) or basic metabolic panel (BMP), chemistry profile including electrolytes, glucose, creatinine, blood urea nitrogen (BUN) with liver chemistries, erythrocyte sedimentation rate (ESR), amylase and lipase, C-reactive protein (CRP), inflammatory markers, pregnancy testing for reproductive age individuals, and urinalysis (dipstick and/or microscopy depending on the clinical context).
        - Not all listed studies are required; rather, a clinically appropriate subset should be obtained to guide differential diagnosis and determine whether advanced imaging is warranted.
- For follow-up imaging of diverticulitis:

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- CT Abdomen and Pelvis with contrast (CPT® 74177) is considered medically necessary for ANY of the following:
  - acute diverticulitis if symptoms or elevated WBC (greater than 10,000 cells/mm³, or above the upper limit of normal for the particular lab reporting the result) persist despite treatment
  - diverticulitis treated with radiologic intervention (e.g., drainage procedure)
  - complicated diverticulitis, including confirmed abscess, fistulae, free fluid, or perforation. (See: **Abdominal Sepsis/Suspected Abdominal Sepsis) (AB-3)**

- For the evaluation of non-operative treatment of acute appendicitis:
  - One-time CT Abdomen and Pelvis with contrast (CPT® 74177) is considered medically necessary for EITHER of the following:
    - symptoms suspicious for recurrent appendicitis OR
    - post non-operative treatment follow-up
- For the evaluation of splenic etiologies including suspected splenic infarct or abscess in the presence of concerning clinical features (e.g., severe abdominal pain and tenderness, fever, or history of atrial fibrillation):
  - CT Abdomen without and with contrast (CPT® 74170) or
  - CT Abdomen with contrast (CPT® 74160)
- For the evaluation of suspected small or large bowel etiologies (e.g., ischemia, obstruction, volvulus, or perforation):
  - CT Abdomen with contrast (CPT® 74160) or
  - CT Abdomen and Pelvis with contrast (CPT® 74177)
- For the evaluation of suspected gastroenteritis and/or enterocolitis in the presence of any red flag findings or clinical concern for complication (e.g., abscess, perforation, obstruction, toxic megacolon, or ischemia):
  - CT Abdomen and Pelvis with contrast (CPT® 74177)
    - If no red flag findings are present, initial evaluation should include history and physical exam, as well as relevant laboratory testing and/or abdominal x-ray.
      - CT Abdomen and Pelvis with contrast (CPT® 74177) is considered medically necessary following initial evaluation when:
        - Prior abdominal radiography demonstrates a need for additional imaging or does not explain symptoms; **or**
        - Laboratory studies related to the current episode are non-diagnostic or do not identify a specific etiology
    - For suspected ischemic enterocolitis, see: **Mesenteric Ischemia (AB-6.1)** or **Colonic Ischemia (Including Ischemic Colitis) (AB-6.2)**
    - For known or suspected IBD, see: **IBD (Crohn's Disease or Ulcerative Colitis) (AB-23.1)**

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- For pain described as pelvic, see: **Pelvic Pain/Dyspareunia, Female (PV-11.1)**, **Male Pelvic Disorders (PV-19.1)** or other appropriate sections based on likely etiology.

Evidence Discussion

Abdominal pain encompasses a wide differential, ranging from benign to life-threatening conditions. Initial evaluation relies on history, physical examination, and targeted laboratory testing to establish pretest probability and guide imaging selection (Yew et al., 2023; BMJ Best Practice, 2025). This approach supports appropriate modality use while limiting unnecessary radiation and resource utilization.

In low-risk presentations, ultrasound is an appropriate first-line modality. It is widely available, cost-effective, and avoids ionizing radiation and contrast exposure. It performs well in hepatobiliary and gynecologic conditions and is recommended for right upper quadrant and pelvic pain (Russo et al., 2023; Brook et al., 2024). Its limitations include reduced sensitivity for bowel, retroperitoneal, and gas-obscured pathology (Scheirey et al., 2018; Chang et al., 2020).

In pregnant individuals and other radiation-sensitive populations, ultrasound remains the preferred initial imaging modality because it avoids ionizing radiation while providing diagnostic information for many causes of abdominal pain. When ultrasound is nondiagnostic or evaluation of deeper abdominal structures is required, MRI serves as the preferred second-line modality because it offers excellent soft tissue characterization without fetal radiation exposure. This ultrasound-to-MRI pathway is supported by current recommendations and may be particularly important later in pregnancy, when physiologic and anatomic changes can limit ultrasound visualization (ACOG, 2017; ACR Expert Panel on Gastrointestinal Imaging et al., 2023).

CT of the abdomen and pelvis is preferred when ultrasound is nondiagnostic or when clinical features suggest serious pathology. It offers high diagnostic accuracy, rapid acquisition, and comprehensive evaluation of inflammatory, obstructive, and ischemic conditions, including appendicitis, diverticulitis, and bowel obstruction (Scheirey et al., 2018; Chang et al., 2020; American College of Radiology et al., 2021). CT also identifies alternative diagnoses in individuals with nonlocalized or atypical presentations.

In diverticulitis, CT confirms diagnosis and identifies complications such as abscess, perforation, fistula, or obstruction. Follow-up colonoscopy after resolution may be indicated in selected individuals, particularly those with complicated diverticulitis, atypical imaging findings, or features concerning for an underlying malignancy, such as mass-like wall thickening or regional lymphadenopathy (Hall et al., 2020; Schultz et al., 2020). This reflects the limitation of imaging alone in distinguishing inflammation from neoplasm.

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Appendicitis evaluation integrates clinical scoring systems with imaging. Tools such as the Appendicitis Inflammatory Response score (AIR) improve risk stratification but do not replace imaging in adult populations (Andersson & Stark, 2025). Ultrasound is often used initially, but indeterminate results are common. CT provides definitive diagnosis and reduces missed cases and negative appendectomy rates (Doubova et al., 2025; Moris et al., 2021). In non-operative management, CT also assesses treatment response and detects complications or recurrence (Podda et al., 2026; Talan & Di Saverio, 2021).

CT is also the preferred modality for suspected small bowel obstruction due to its ability to localize obstruction and detect complications such as ischemia (Chang et al., 2020). MRI serves as an alternative when radiation avoidance is required, though its use is limited by longer acquisition times, motion sensitivity, and reduced detection of free air and calculi (ACR Expert Panel on Gastrointestinal Imaging et al., 2023).

Overall, imaging in abdominal pain follows a tiered strategy. Ultrasound serves as an initial modality in lower-risk scenarios, while CT provides definitive evaluation in acute, complex, or indeterminate cases. This approach aligns with current appropriateness criteria and supports efficient, evidence-based care (Yew et al., 2023;Russo et al., 2023; Scheirey et al., 2018).

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Right Upper Quadrant and Epigastric Pain (AB-2.3)

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Criteria

- The presence of any red flag findings per **AB-1.0: General Guidelines** precludes adjudication based on any other criteria.
- For pregnant individuals, see: **General Guidelines (AB-1.0): Pregnancy Considerations for Imaging**
- For the evaluation of right upper quadrant pain in the absence of red flag findings:
  - Abdominal ultrasound (complete or limited) (CPT® 76700 or CPT® 76705) is the initial diagnostic test
  - CT Abdomen with contrast (CPT® 74160) or MRCP/MRI (MRI Abdomen without or without and with contrast) (CPT® 74181 or CPT® 74183) if ultrasound is equivocal or nondiagnostic
- For the evaluation of epigastric pain or dyspepsia in the absence of red flag findings:
  - Ultrasound Abdomen (CPT® 76700 or CPT® 76705) to assess for biliary/ pancreatic disease is the initial study
  - CT Abdomen with contrast (CPT® 74160) or MRI Abdomen without and with contrast (CPT® 74183), or MRCP (CPT® 74181 or CPT® 74183), is considered medically necessary to further evaluate non-diagnostic findings on ultrasound
    - The use of these advanced imaging procedures to evaluate abnormalities identified on the initial ultrasound may be addressed in the relevant condition-specific guideline. Refer to the applicable dedicated guideline for additional clinical indications and imaging recommendations.
  - CT Abdomen with contrast (CPT® 74160) or MRI Abdomen without and with contrast (CPT® 74183) is considered medically necessary for persistent symptoms after a negative or inconclusive ultrasound as well as ONE of the following:
    - Test and treat for Helicobacter pylori (H. pylori) and a trial of acid suppression with a proton pump inhibitor (PPI) for 4-8 weeks if eradication is successful, but symptoms do not resolve OR
    - An empiric trial of acid suppression with a PPI for 4-8 weeks

Special Considerations for Suspicion of Pancreatic Cancer

CT Abdomen with contrast (CPT® 74160), CT Abdomen and Pelvis with contrast (CPT® 74177), or MRI Abdomen without and with contrast (CPT® 74183) is appropriate for

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suspicion of pancreatic cancer in individuals aged 60 years or older with unintentional weight loss and any ONE of the following:

- diarrhea
- back pain
- abdominal pain
- nausea
- vomiting
- constipation
- new onset diabetes
- abnormal lab results raising the possibility of pancreatic cancer (e.g., elevated CA 19-9, Gamma-Glutamyl Transpeptidase (GGTP), alkaline phosphate, or bilirubin)
- non-diagnostic or negative prior US

If none of the above signs or symptoms applies, follow criteria for epigastric pain and dyspepsia.

See also: **Pancreatic Cancer-Suspected Diagnosis (ONC-13.2)** in the Oncology Imaging Guidelines.

Evidence Discussion

Right upper quadrant and epigastric pain have a broad differential that includes peptic, biliary, pancreatic, and malignant causes. In presentations consistent with dyspepsia, initial management is typically non-imaging based, using empiric acid suppression, Helicobacter pylori testing, and selective endoscopy (Moayyedi et al., 2017).

When non-peptic pathology is suspected, ultrasound is the preferred initial imaging modality. It is widely available, avoids ionizing radiation, and provides effective evaluation of hepatobiliary disease, including cholelithiasis, biliary dilation, and mass lesions (Russo et al., 2023; Vij et al., 2021). Its limitations include reduced sensitivity for bowel, retroperitoneal, and gas-obscured pathology (Vij et al., 2021; Scheirey et al., 2018).

If ultrasound is nondiagnostic or discordant with clinical findings, cross-sectional imaging is indicated. CT is preferred for suspected pancreatitis and acute inflammatory conditions due to its diagnostic accuracy and rapid acquisition (Vij et al., 2021; American College of Radiology et al., 2021). MRI and MRCP are appropriate for further characterization of biliary or pancreatic abnormalities, particularly when radiation avoidance is desired (Vij et al., 2021; ACOG Committee on Obstetric Practice, 2017). MRI offers superior soft tissue contrast but is more time-intensive and less sensitive for extraluminal air and calculi (Vij et al., 2021).

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Abdominal Sepsis (Suspected Abdominal Abscess) (AB-3)

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Abdominal Sepsis/Abscess (AB-3.1)

AB.AS.0003.1.A
v1.0.2027

Criteria

- The presence of any red flag findings per **General Guidelines (AB-1.0)** precludes adjudication based on any other criteria.
- For abdominal symptoms associated with fever (101 degrees Fahrenheit [38.5 degrees Celsius] or higher) and/or elevated white blood cell count (greater than 10,000 cells/mm³, or above the upper limit of normal for the particular lab reporting the result) ANY of the following are considered medically necessary:
  - CT Abdomen with contrast (CPT® 74160)
  - CT Pelvis with contrast (CPT® 72193)
  - CT Abdomen and Pelvis with contrast (CPT® 74177)
- For intraperitoneal abscess:
  - CT Abdomen and Pelvis with contrast (CPT® 74177)
    - Follow-up imaging when clinically indicated to assess treatment response, disease progression, or abscess resolution or complications.
- For follow-up imaging of known abnormal fluid collections after medical management or catheter drainage, ANY of the following are considered medically necessary:
  - Serial Ultrasound (CPT® 76705)
  - CT Abdomen with contrast (CPT® 74160)
  - CT Pelvis with contrast (CPT® 72193)
  - CT Abdomen and Pelvis with contrast (CPT® 74177)
    - The interval between studies should be guided by the individual's clinical course, including change in symptoms, laboratory findings, or need for procedural or surgical decision-making.

Evidence Discussion

Suspected intra-abdominal sepsis or abscess represents a time-sensitive clinical scenario that warrants immediate escalation to advanced imaging. Individuals presenting with abdominal symptoms accompanied by fever, leukocytosis, neutropenia, or other red-flag/high-risk features should undergo prompt CT of the abdomen and pelvis with intravenous contrast. CT provides rapid, comprehensive evaluation and is highly effective in identifying abscesses, source control targets, and complications of intra-abdominal infection (Bonomo et al., 2024; Brixey et al., 2024; Scheirey et al., 2018).This approach is particularly important in immunocompromised individuals, in whom serious intra-abdominal infection may present with subtle or atypical clinical findings.

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Following diagnosis and intervention, interval imaging may be required to monitor resolution or guide further management. This is particularly relevant after percutaneous drainage of fluid collections. Both CT and ultrasound are appropriate for serial assessment, with modality selection guided by the need for anatomic detail, radiation considerations, and procedural planning. The timing of follow-up imaging is not fixed and should be individualized based on clinical response and disease severity (Weiss et al., 2020).

Abdomen Imaging Guidelines

Reference (AB-3)

v1.0.2027

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Flank Pain, Rule Out or Known Renal/ Ureteral Stone (AB-4)

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Ultrasound (AB-4.0)

AB.US.0004.0.A
v1.0.2027

Criteria

- For the evaluation of flank pain and/or suspected renal or ureteral calculi, retroperitoneal ultrasound (CPT® 76770 or CPT® 76775) is considered medically necessary in place of CT Abdomen and Pelvis for any initial or follow-up indications, when requested by provider.

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Suspected Renal/Ureteral Stone(s) (AB-4.1)

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Criteria

- CT Abdomen and Pelvis without contrast (CPT® 74176) is considered medically necessary for ANY of the following:
  - Suspected renal/ureteral stone with symptoms in non-pregnant adults (e.g., flank pain or renal colic) OR
  - Suspected staghorn calculi
- CT Abdomen and Pelvis without contrast (CPT® 74176) or CT Urogram (CPT® 74178) is considered medically necessary for the following:
  - Suspected renal/ureteral stones (e.g., flank pain or renal colic) with hematuria
- Ultrasound (CPT® 76770 or CPT® 76775) or MRI Abdomen and Pelvis without contrast (CPT® 74181 and CPT® 72195) is considered medically necessary for the following:
  - Suspected renal/ureteral stone in pregnant individuals (e.g., flank pain or renal colic)
    - The use of gadolinium contrast agents is contraindicated during pregnancy unless the specific clinical need for that procedure outweighs risk to the fetus.
- For suspected renal or ureteral stone in pediatric individuals (e.g., flank pain or renal colic)
  - See: **Flank Pain, Renal Stone (PEDAB-4)** in the Pediatric Abdomen Imaging Guidelines

Evidence Discussion

Non-contrast CT (NCCT) is the preferred initial imaging modality for adults presenting with acute flank pain and suspected urolithiasis. It provides high sensitivity and specificity for detecting ureteral calculi, accurately characterizes stone size, location, overall stone burden, and identifies complications such as obstruction or infection. CT is particularly valuable in suspected staghorn calculi because it accurately delineates stone burden and collecting-system anatomy for treatment planning. NCCT also allows evaluation of alternative causes of abdominal or flank pain, which is essential in undifferentiated presentations (Expert Panel on Urological Imaging et al., 2023; Shastri et al., 2023). In individuals presenting with suspected stone disease and associated hematuria, CT-based evaluation may also assist in excluding alternative urinary tract pathology when clinically indicated (Expert Panel on Urological Imaging et al., 2023).

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In pregnancy, ultrasound is recommended as the first-line modality due to avoidance of ionizing radiation. If ultrasound is nondiagnostic and clinical suspicion persists, non-contrast MRI may be used for further evaluation (Juliebø-Jones et al., 2022; American College of Obstetricians and Gynecologists' Committee on Obstetric Practice, 2017).

When NCCT is inconclusive or when complications or alternative diagnoses are suspected, contrast-enhanced imaging, including CT urography or MRI, may be warranted to clarify findings and guide management (Expert Panel on Urological Imaging et al., 2023; Shastri et al., 2023).

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Observation of Known Renal/Ureteral Stone(s) (AB-4.2)

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Criteria

- Radiopaque Stones
  - Initial follow-up imaging:
    - Retroperitoneal ultrasound (CPT® 76770 or CPT® 76775) and kidneys, ureters, and bladder (KUB) x-ray
  - Subsequent follow-up imaging:
    - If initial follow-up ultrasound and KUB are negative, and there is no hematuria and individual is asymptomatic:
      - See: **Annual Surveillance (AB-4.4)**
    - If initial follow-up ultrasound and KUB demonstrates hydronephrosis, retained stone, or if the individual has persistent hematuria, or is symptomatic:
      - CT Abdomen and Pelvis without contrast (CPT® 74176)
- Non-radiopaque Stones (i.e., radiolucent)
  - Initial follow-up imaging:
    - CT Abdomen and Pelvis without contrast (CPT® 74176)
  - Subsequent follow-up imaging:
    - If CT is negative:
      - See: **Annual Surveillance (AB-4.4)**
    - If CT demonstrates a retained stone, hydronephrosis, or if the individual is being evaluated for surgery:
      - Further imaging can be considered on an individual basis
- ANY of the following are considered medically necessary for surgical/procedural evaluation of staghorn calculi:
  - CT Abdomen and Pelvis (contrast as requested)
  - 3-D reconstruction (CPT® 76377 or CPT® 76376)
  - Nuclear kidney imaging (CPT® 78707, CPT® 78708, or CPT® 78709) when there is concern for a poorly functioning kidney

Background and Supporting Information

- Radiopaque versus radiolucent stones on plain radiograph:
  - Radiopaque
    - Calcium-based stones (70-80%)

        - Struvite stones (triple phosphate) (usually opaque but variable – 15-20%)
    - Radiolucent
        - Uric acid (5-10%)
        - Cystine (1-3%)
        - Medication stones (e.g. indinavir) (1%)

Evidence Discussion

Follow-up imaging for known renal and ureteral calculi should balance diagnostic sensitivity with cumulative radiation exposure. For many stable individuals with known radiopaque stones, ultrasound and plain radiography (KUB) provide adequate surveillance while reducing radiation burden. Ultrasound offers a radiation-free option for longitudinal monitoring and can detect hydronephrosis and larger calculi, whereas KUB may be useful for tracking interval growth of known radiopaque stones (NICE, 2019; Pearle et al., 2026; Shastri et al., 2023).

Non-contrast CT (NCCT) remains the most sensitive modality for assessing stone size, location, and interval change. Its reproducibility supports precise assessment of disease progression and treatment response, making it particularly useful when accurate measurement is needed or when ultrasound or KUB findings are inconclusive. However, repeated CT examinations may increase cumulative radiation exposure (Pearle et al., 2026; Shastri et al., 2023).

Evidence comparing ultrasound and CT suggests similar overall diagnostic outcomes in selected clinical contexts, supporting ultrasound as an acceptable surveillance strategy when the risk of progression is low and clinical stability is maintained (Shastri et al., 2023; Pearle et al., 2026).

Plain radiography (KUB) has a limited but specific role in follow-up of radiopaque calculi. It is most useful for assessing interval growth or migration of known visible stones but lacks sensitivity for initial detection and for radiolucent calculi (Pearle et al., 2026; Shastri et al., 2023).

MRI is not routinely used for stone surveillance. Although it avoids radiation exposure, calculi are poorly visualized on MRI, limiting its diagnostic utility despite advantages in soft tissue imaging (Shastri et al., 2023).

Overall, imaging selection should be individualized according to stone characteristics, clinical status, and the need to minimize radiation exposure. While CT provides the highest diagnostic accuracy, ultrasound and KUB are appropriate surveillance options for many individuals with stable, known stone disease (Pearle et al., 2026; NICE, 2019; Shastri et al., 2023).

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Follow-Up of Treated Renal/Ureteral Stone (AB-4.3)

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Criteria

- Post-shock wave lithotripsy (SWL):
  - Retroperitoneal ultrasound (CPT® 76770 or CPT® 76775) is the appropriate initial follow-up imaging.
  - Retroperitoneal ultrasound (CPT® 76770 or CPT® 76775) and/or CT Abdomen and Pelvis (contrast as requested) is considered medically necessary for ANY of the following:
    - Individuals who are symptomatic
    - Individuals with hydronephrosis
    - Individuals who have residual fragments
  - Individuals treated by SWL who have passed fragments, are asymptomatic, and without hydronephrosis can be followed according to **Annual Surveillance (AB-4.4)**.
- Post-medical expulsive therapy (MET):
  - Retroperitoneal ultrasound is considered medically necessary for individuals treated by MET who have passed a stone and are symptomatic.
  - CT Abdomen and Pelvis (contrast as requested) is considered medically necessary if hydronephrosis is demonstrated with ultrasound.
  - Individuals treated by MET who have passed a stone and are asymptomatic can be followed according to **Annual Surveillance (AB-4.4)**.
- Post-ureteroscopic extraction with an intact stone:
  - Retroperitoneal ultrasound is considered medically necessary for individuals without symptoms.
  - CT Abdomen and Pelvis with contrast (CPT® 74177) is considered medically necessary for individuals with symptoms or hydronephrosis demonstrated on ultrasound.
  - Individuals without symptoms or without hydronephrosis demonstrated on ultrasound can be followed according to **Annual Surveillance (AB-4.4)**.
- Post-ureteroscopic extraction requiring fragmentation of the stone(s):
  - Retroperitoneal ultrasound is considered medically necessary for individuals without symptoms.

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  - CT Abdomen and Pelvis without contrast (CPT® 74176) is considered medically necessary for individuals without symptoms, but hydronephrosis demonstrated on ultrasound.
  - Individuals without symptoms or without hydronephrosis demonstrated on ultrasound can be followed according to **Annual Surveillance (AB-4.4)**.
  - Retroperitoneal ultrasound and KUB for individuals with symptoms and a radiopaque stone
  - CT Abdomen and Pelvis without contrast (CPT® 74176) is considered medically necessary for individuals with symptoms and a non-radiopaque stone.
- Post-surgical/procedural treatment of staghorn calculi:
  - CT Abdomen and Pelvis without contrast (CPT® 74176)
  - Retroperitoneal ultrasound and/or CT Abdomen and Pelvis (contrast as requested) is considered medically necessary for individuals with persistent symptoms and/or hydronephrosis.

Evidence Discussion

Following treatment of renal calculi, ultrasound is the preferred initial modality for follow-up. It allows assessment for residual stones and detection of hydronephrosis without exposing individuals to ionizing radiation (Pearle et al., 2019; Shastri et al., 2023). In asymptomatic individuals, periodic surveillance with ultrasound is appropriate to monitor for recurrence or progression (NICE, 2019; Pearle et al., 2019).

CT imaging is reserved for individuals with recurrent symptoms or when ultrasound identifies concerning findings such as hydronephrosis or equivocal results. In these cases, non-contrast CT provides definitive evaluation of residual or recurrent stone burden and guides further management (Pearle et al., 2019; Shastri et al., 2023).

This approach balances diagnostic accuracy with minimization of cumulative radiation exposure in individuals requiring longitudinal monitoring (NICE, 2019; Pearle et al., 2019; Shastri et al., 2023).

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Annual Surveillance (AB-4.4)

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Criteria

- Annual surveillance is considered medically necessary for stable individuals with a history of stones to assess for stone growth or formation of new stones:
  - Plain x-ray (KUB) is considered medically necessary for individuals with radiopaque stones.
  - Retroperitoneal ultrasound (CPT® 76770 or CPT® 76775) is the preferred modality for individuals with non-radiopaque stones.

Evidence Discussion

For surveillance of known urolithiasis, imaging selection is guided by stone composition and the need to limit radiation exposure. Plain radiography (KUB) is a cost-effective and accessible option for monitoring radiopaque stones, allowing assessment of interval growth or stability (Pearle et al., 2019; Shastri et al., 2023).

Ultrasound is preferred for individuals with radiolucent stones and for those requiring repeated imaging, as it avoids ionizing radiation while providing adequate assessment for stone burden and associated hydronephrosis (NICE, 2019; Pearle et al., 2019; Shastri et al., 2023).

In clinically stable individuals, annual imaging is reasonable for surveillance. The interval may be shortened or extended based on stone activity, recurrence risk, or changes in symptoms. This risk-adapted approach aligns follow-up intensity with disease behavior while minimizing unnecessary imaging (Pearle et al., 2019; NICE, 2019).

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Mesenteric/Colonic Ischemia (AB-6)

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Abdomen Imaging Guidelines

Mesenteric Ischemia (AB-6.1)

AB.MI.0006.1.A
v1.0.2027

Criteria

Acute Mesenteric Ischemia

- For suspicion of acute mesenteric ischemia, ONE of the following imaging studies is considered medically necessary:
  - CTA Abdomen and/or Pelvis (Mesenteric protocol) (CPT® 74175, or CPT® 74174, or CPT® 72191) (preferred initial imaging modality), OR
  - MRA Abdomen and/or Pelvis (CPT® 72198 and/or CPT® 74185), OR
  - CT Abdomen and Pelvis with contrast (CPT® 74177)

Chronic Mesenteric Ischemia

- For suspicion of chronic mesenteric ischemia:
  - Mesenteric Artery Duplex Ultrasound (CPT® 93975 or CPT® 93976) and/or ONE of the following:
    - CTA Abdomen and Pelvis (CPT® 74174) OR
    - MRA Abdomen and Pelvis (CPT® 74185 and CPT® 72198)
- For clinical concern of median arcuate ligament syndrome, see: **Median Arcuate Ligament Syndrome, Nutcracker Syndrome and other Abdominal Vascular Compression Syndromes (PVD-18)** in the Peripheral Vascular Disease (PVD) Imaging Guidelines
- For suspicion of superior mesenteric artery syndrome, see: **Superior Mesenteric Artery (SMA) Syndrome (AB-20.4)**

Pre- and Post-Treatment for Mesenteric Ischemia

- Pre-operative evaluation, if not already performed (including prior to endovascular intervention):
  - CTA Abdomen and Pelvis (CPT® 74174)
- Post-procedure surveillance imaging following invasive treatment for mesenteric ischemia (celiac, superior mesenteric, and inferior mesenteric angioplasty with or without stenting, or mesenteric artery bypass grafting):
  - Baseline Duplex Ultrasound (CPT® 93975 or CPT® 93976) within 1 month of the procedure
  - Duplex Ultrasound (CPT® 93975 or CPT® 93976) at 6 months, 12 months, 18 months, and 24 months, then annually thereafter

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- CT Abdomen with contrast (CPT® 74160) or CT Abdomen and Pelvis with contrast (CPT® 74177) or CTA Abdomen (CPT® 74175) or CTA Abdomen and Pelvis (CPT® 74174) or MRA Abdomen (CPT® 74185) and if requested, MRA Pelvis (CPT® 72198):
  - For symptoms suggesting recurrent ischemia OR
  - In the absence of symptoms, following a Duplex Ultrasound if, on the Duplex study:
    - Celiac axis:
      - Peak systolic velocity (PSV) greater than 370 cm/s or a substantial increase from the post-treatment baseline PSV (substantial increase has not been defined), or demonstration of restenosis of 70% or greater
    - Superior mesenteric artery:
      - PSV greater than 420 cm/s, or a substantial increase from the post-treatment baseline PSV (substantial increase has not been defined), or demonstration of restenosis of 70% or greater
    - Inferior mesenteric artery:
      - Substantial increase from the post-treatment baseline PSV (substantial increase has not been defined)

Surveillance of Asymptomatic Mesenteric Artery Occlusive Disease

- Annual Mesenteric Artery Duplex Ultrasound (CPT® 93975 or CPT® 93976)

Evidence Discussion

Mesenteric ischemia reflects impaired intestinal perfusion due to arterial occlusion, venous thrombosis, or systemic hypoperfusion. Acute mesenteric ischemia most commonly arises from embolic or thrombotic arterial disease, with mesenteric venous thrombosis representing a smaller subset. Clinical presentation is characterized by severe abdominal pain that exceeds examination findings, particularly in individuals with cardiovascular disease, atrial fibrillation, or hypercoagulable states (Ahmed, 2021; Bala et al., 2022). Given the high mortality associated with delayed diagnosis, rapid and accurate imaging is essential (Ahmed, 2021; Bala et al., 2022).

Current guidelines consistently identify computed tomography angiography (CTA) as the first-line imaging modality in suspected acute mesenteric ischemia. CTA enables simultaneous evaluation of mesenteric vessels and bowel viability, allowing detection of occlusion, ischemic injury, and complications such as pneumatosis (Bala et al., 2022; Koelemay et al., 2025). This supports its central role in criteria addressing acute diagnostic imaging.

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Chronic mesenteric ischemia is typically caused by progressive atherosclerotic disease affecting the mesenteric arteries. Symptoms such as postprandial pain, weight loss, and food avoidance reflect limited perfusion during increased metabolic demand. While multivessel disease is most common, clinically significant ischemia may occur with single-vessel involvement when collateral circulation is insufficient (Huber et al., 2021; Koelemay et al., 2025). Revascularization is recommended once symptomatic disease is confirmed (Huber et al., 2021; Koelemay et al., 2025).

For chronic disease and asymptomatic mesenteric artery occlusive disease, duplex ultrasound is supported as an appropriate first-line and surveillance modality. It provides a noninvasive assessment of flow velocities with high negative predictive value for excluding significant stenosis under optimal conditions (Zierler et al., 2018). Its role is particularly relevant for longitudinal follow-up after revascularization and in monitoring individuals without symptoms (Zierler et al., 2018; Koelemay et al., 2025).

Cross-sectional imaging with CTA, and in selected cases magnetic resonance angiography (MRA), is recommended for confirmatory diagnosis and pre-intervention planning. CTA offers detailed anatomic characterization of stenosis and collateral circulation, which is essential for procedural decision-making. MRA demonstrates high diagnostic accuracy but is limited by availability and reduced ability to assess calcification (Lam et al., 2022; Koelemay et al., 2025).

Across clinical contexts, imaging selection reflects a consistent framework. Acute presentations require immediate, high-resolution vascular imaging, favoring CTA. Chronic and asymptomatic disease allow for an initial duplex-based approach, followed by CTA or MRA when intervention is considered. Post-treatment and surveillance strategies prioritize duplex ultrasound due to its safety profile and suitability for repeated assessment. These recommendations align with contemporary vascular and radiologic guidelines and provide a clear evidence base for criteria addressing diagnosis, treatment planning, and longitudinal surveillance (Bala et al., 2022; Koelemay et al., 2025; Zierler et al., 2018).

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Colonic Ischemia (Including Ischemic Colitis) (AB-6.2)

AB.MI.0006.2.A
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Criteria

- If colonic ischemia is suspected in the setting of significant abdominal pain, CT Abdomen and Pelvis with contrast (CPT® 74177) is considered medically necessary as the initial imaging modality if ANY of the following:
  - rectal bleeding OR
  - moderate or severe abdominal tenderness OR
  - fever (101 degrees Fahrenheit [38.5 degrees Celsius] or higher) OR
  - guarding, rebound tenderness, or other peritoneal signs OR
  - elevated WBC (defined as greater than 10,000 cells/mm³, or above the upper limit of normal for the particular lab reporting the result)
- Repeat imaging for asymptomatic or improving individuals, including routine post-operative imaging, is generally considered not medically necessary.
- CTA Abdomen (CPT® 74175) or CTA Abdomen and Pelvis (CPT® 74174) or MRA Abdomen (CPT® 74185) AND if requested, MRA Pelvis (CPT® 72198) is considered medically necessary for suspected right sided or pancolonic ischemia based on findings from the initial CT Abdomen and Pelvis.

Background and Supporting Information

- Clinical features concerning for colonic ischemia include sudden-onset cramping abdominal pain accompanied by urgency to defecate and passage of bright red blood, maroon blood, or bloody diarrhea, particularly in individuals with cardiovascular disease, diabetes mellitus, kidney disease, previous abdominal surgery, use of constipating medications, chronic obstructive pulmonary disease (COPD), or atrial fibrillation (Ahmed, 2021; Brandt et al., 2015). In the appropriate clinical setting, advanced imaging may be warranted to evaluate for ischemic injury and associated complications.

Evidence Discussion

Colonic ischemia is usually caused by transient hypoperfusion rather than persistent arterial occlusion. By the time of presentation, mesenteric blood flow has often normalized, so imaging findings reflect mucosal injury rather than ongoing ischemia. This distinction explains why routine vascular imaging is not appropriate in most cases and why CT, rather than CTA, is emphasized (Brandt et al., 2015).

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Contrast-enhanced CT is the preferred initial modality in individuals with clinically significant symptoms, including abdominal pain with objective findings such as tenderness, fever, leukocytosis, or rectal bleeding. CT provides sufficient information to confirm suspected ischemia, exclude alternative diagnoses, and assess severity, which supports restricting imaging to individuals with higher pre-test probability rather than nonspecific symptoms (Brandt et al., 2015; Ginsburg et al., 2018).

Repeat imaging is not routinely indicated because radiographic findings may persist after clinical improvement and do not reliably guide ongoing management. Limiting repeat studies reduces unnecessary radiation exposure without compromising clinical care. Imaging is therefore reserved for individuals with worsening symptoms or concern for complications (Brandt et al., 2015; Ginsburg et al., 2018).

CTA or MRA is selectively appropriate when initial CT demonstrates right-sided or pancolonic involvement. This distribution is associated with proximal mesenteric arterial disease and worse outcomes, representing a higher-risk subgroup in which vascular imaging may alter management (Brandt et al., 2015).

This evidence supports criteria that restrict initial imaging to symptomatic individuals with objective findings, discourage routine repeat imaging, and reserve vascular imaging for anatomically high-risk presentations (Brandt et al., 2015; Ginsburg et al., 2018).

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Post-Operative Pain Within 60 Days Following Abdominal Surgery – Abdominal Procedure (AB-7)

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Post-Op Pain and/or Complication Within 60 Days (AB-7.1)

AB.OP.0007.1.A
v1.0.2027

Criteria

- CT Abdomen and/or Pelvis with contrast (CPT® 74177, or CPT® 74160, or CPT® 72193) is considered medically necessary for suspected post-operative/post-procedure complications (e.g., bowel obstruction, abscess, anastomotic leak, or post-endoscopic complication).
- Beyond 60 days post-operatively, see: **Abdominal Pain (AB-2)**.
- For liver post-transplant indications and imaging, see: **Liver Transplant, Post-Transplant Imaging (AB-42.3)**
- For kidney post-transplant indications and imaging, see: **Kidney Transplant, Post Transplant (AB-42.6)**
- For suspected ureter or bladder injury indications and imaging, see **Ureteral and/or Bladder Trauma of Injury (PV-25.1)**

Evidence Discussion

Post-operative and post-procedural abdominal complications most commonly occur within the first 60 days and require prompt evaluation when suspected. Early imaging is necessary to identify conditions such as bowel obstruction, abscess, and anastomotic leak, all of which carry significant morbidity if diagnosis is delayed (O'Malley & Revels, 2020; Scheirey et al., 2018).

Contrast-enhanced CT is the primary imaging modality in this setting due to its speed, availability, and high diagnostic accuracy across a broad range of complications (Caraiani et al., 2020; Pietryga et al., 2025). CT effectively identifies intra-abdominal fluid collections, differentiates seroma from hematoma or abscess, and detects complications such as leak or obstruction. The use of intravenous contrast improves detection of inflammatory changes and enhances delineation of post-operative anatomy (Caraiani et al., 2020; Pietryga et al., 2025). Detection of suspected anastomotic leak is a particularly important indication for contrast-enhanced cross-sectional imaging, as delayed diagnosis is associated with increased morbidity and mortality (Barbaro et al., 2021).

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Abdominal Lymphadenopathy (AB-8)

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Abdominal Lymphadenopathy (AB-8.1)

AB.AL.0008.1.A
v1.0.2027

Criteria

- History of malignancy
  - Refer to oncology guidelines specific for known malignancy
  - Biopsy may be considered
- For suspected lymphoproliferative disorder:
  - Imaging modality for biopsy is at the discretion of the interventional radiologist
    - Imaging studies performed as part of a CT-, MR-, or Ultrasound-guided procedure should be reported using appropriate CPT® codes
  - PET/CT (CPT® 78815) is considered medically necessary prior to biopsy in order to determine a more favorable site for biopsy, when a prior biopsy was nondiagnostic, or a relatively inaccessible site is contemplated which would require invasive surgical intervention for biopsy attempt.
- If clinical evaluation, laboratory findings, biopsy, or PET imaging suggest benign etiology, and no history of malignancy:
  - First follow-up imaging at 3 months
    - CT Abdomen and Pelvis with contrast (CPT® 74177) is considered medically necessary
  - Additional follow-up imaging at 6 and 12 months, if no improvement at 3 months
    - CT Abdomen and Pelvis with contrast (CPT® 74177) is considered medically necessary
  - Further imaging is considered NOT medically necessary if clinically significant changes are not seen within one year of follow-up imaging.
- If a follow-up CT demonstrates a concerning change, biopsy should be performed.
  - If biopsy is inconclusive, PET/CT (CPT® 78815) is considered medically necessary

Evidence Discussion

Abdominal lymphadenopathy has a broad differential that includes infectious, inflammatory, and malignant causes. Imaging alone is not sufficient for definitive diagnosis, and tissue sampling remains the standard when lymphoproliferative disease is suspected (Fowler et al., 2019; Kwon & Lee, 2025).

CT is the primary imaging modality for evaluation of intra-abdominal lymph nodes. It allows detection, characterization, and anatomic localization, and it is routinely used to guide percutaneous biopsy and to monitor interval change (Fowler et al., 2019; Heller et al., 2013). Serial imaging may be appropriate when clinical, laboratory, or prior biopsy

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findings suggest a benign or self-limited process, with consideration of cumulative radiation exposure (Heller et al., 2013; Fowler et al., 2019).

PET/CT provides functional assessment of metabolic activity but lacks specificity, as uptake may be seen in both malignant and benign conditions. Its role is therefore adjunctive (Zeman et al., 2021; Kwon & Lee, 2025). PET/CT is most useful when prior biopsy is inconclusive or when identifying the most appropriate site for tissue sampling in cases with multiple or inaccessible lymph nodes (Zeman et al., 2021; Fowler et al., 2019).

Abdomen Imaging Guidelines

Inguinal Lymphadenopathy (AB-8.2)

AB.AL.0008.2.A
v1.0.2027

Criteria

There is no evidence-based support for advanced imaging of clinically evidenced isolated inguinal lymphadenopathy without biopsy. Advanced imaging should be directed by results of biopsy. If biopsy results are negative or benign, then advanced imaging is considered not medically necessary.

- High suspicion of lymphoma: See **Non-Hodgkin Lymphomas (ONC-27)** and **Hodgkin Lymphoma (ONC-28)** in the Oncology Imaging Guidelines
- Prior history of malignancy: See **Metastatic Cancer, Carcinoma of Unknown Primary Site, and Other Types of Cancer (ONC-31)** in the Oncology Imaging Guidelines
- If biopsy is positive for malignancy, advanced imaging is guided by sections specific to the histological diagnosis.

Background and Supporting Information

- Localized inguinal lymphadenopathy should prompt:
  - search for adjacent extremity injury or infection (Falk et al., 2025; Walker et al., 2025)
  - 3 to 4 weeks of observation if clinical picture is benign (Falk et al., 2025; Walker et al., 2025)
  - excisional or image-guided core needle biopsy under ultrasound or CT guidance of most abnormal lymph node if condition persists or malignancy suspected (Falk et al., 2025; Walker et al., 2025)
- Generalized inguinal lymphadenopathy should prompt:
  - diagnostic work-up, including serological tests, for systemic diseases (Falk et al., 2025; Walker et al., 2025) and
  - excisional or image-guided core needle biopsy under ultrasound or CT guidance of most abnormal lymph node if condition persists or malignancy suspected (Falk et al., 2025; Kwon & Lee, 2025)

Evidence Discussion

Inguinal lymphadenopathy is frequently benign, often reactive to localized infection or inflammation, and commonly resolves without intervention. Clinical history and physical examination are often sufficient to establish the diagnosis, which supports a conservative initial approach (Falk et al., 2025; Walker et al., 2025).

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There is limited evidence supporting the use of advanced cross-sectional imaging in the initial evaluation of isolated inguinal lymphadenopathy. Given the high prevalence of benign causes and low pre-test probability of malignancy, routine imaging would result in low diagnostic yield and potential overutilization (Falk et al., 2025; Walker et al., 2025).

Imaging becomes appropriate only when biopsy results or clinical findings indicate a need for further staging or characterization. If evaluation confirms a benign etiology, no imaging follow-up is warranted (Falk et al., 2025; Kwon & Lee, 2025).

This framework supports criteria that restrict imaging in low-risk presentations, prioritize tissue diagnosis, and limit advanced imaging to cases where results will change management (Falk et al., 2025; Kwon & Lee, 2025).

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Sclerosing Mesenteritis and Mesenteric Panniculitis (AB-8.3)

AB.AL.0008.3.A
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Criteria

- For new or worsening clinical symptoms in an individual with a diagnosis of sclerosing mesenteritis or mesenteric panniculitis:
  - CT Abdomen and Pelvis without and with contrast (CPT® 74178) is considered medically necessary
- Requests for follow-up imaging in asymptomatic individuals or for sequential imaging to monitor for the development of malignancy is based upon size of lymph nodes:
  - For asymptomatic individuals with lymph nodes measuring less than 10mm, annual surveillance imaging is considered medically necessary for up to 2 consecutive years to confirm benign stability with either of the following:
    - CT Abdomen and/or Pelvis without and with contrast (CPT® 74170, 74178, 72194) OR
    - MRI Abdomen and/or Pelvis without and with contrast (CPT® 74183, 72197)
  - If lymph nodes are greater than or equal to 10mm, PET/CT (CPT® 78815) or biopsy is considered medically necessary.

Background and Supporting Information

Sclerosing mesenteritis is a rare idiopathic inflammatory disorder of the small-bowel mesentery characterized by varying degrees of chronic inflammation, fat necrosis, and fibrosis. Mesenteric panniculitis, mesenteric lipodystrophy, and retractile mesenteritis are generally considered manifestations along the same disease spectrum rather than distinct entities (Saha et al., 2024; Worthington et al., 2025).

The mesentery contains blood vessels, lymphatics, nerves, and adipose tissue that support the small intestine. Disease involvement may result in mass effect on adjacent bowel loops, mesenteric vessels, and other intra-abdominal structures. Progressive fibrosis may lead to complications such as bowel obstruction and vascular compromise (Saha et al., 2024; Sulbaran et al., 2023).

Characteristic imaging features are described by Coulier's criteria, and the diagnosis is generally supported when at least three of the following findings are present (Worthington et al., 2025):

- A mesenteric fatty mass that displaces adjacent structures without direct invasion
- Increased attenuation of mesenteric fat

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- Soft-tissue nodules or mesenteric lymph nodes within the affected mesentery
- A hypoattenuating fatty halo surrounding mesenteric vessels or lymph nodes
- A hyperattenuating pseudocapsule surrounding the mesenteric lesion

The etiology of sclerosing mesenteritis remains uncertain. Proposed mechanisms include prior abdominal surgery or trauma, autoimmune-mediated inflammation, ischemia, infection, and paraneoplastic processes (Saha et al., 2024; Sulbaran et al., 2023).

Evidence Discussion

Published data regarding the association between sclerosing mesenteritis and malignancy are inconsistent. Some studies and meta-analyses have demonstrated no significant increase in malignancy risk compared to the general population, whereas others suggest a modestly elevated long-term risk, particularly for lymphoma, with most cases identified within the first year following diagnosis (Saha et al., 2024; Worthington et al., 2025). This variability contributes to a lack of consensus regarding optimal surveillance strategies.

The role of imaging in disease monitoring is similarly uncertain. Although cross-sectional imaging may demonstrate changes in mesenteric inflammation, available evidence indicates limited correlation between radiologic findings and clinical symptoms or disease progression (Worthington et al., 2025). As a result, routine serial imaging in asymptomatic individuals has not been consistently supported by the literature (Saha et al., 2024; Worthington et al., 2025).

Evidence suggests that the likelihood of clinically significant progression is low in individuals with stable imaging findings over time. Studies have indicated that individuals without radiologic progression over an initial period (e.g., approximately two years) are unlikely to demonstrate subsequent clinically meaningful change, supporting a more conservative imaging approach in stable cases (Saha et al., 2024; Worthington et al., 2025).

Conversely, the presence of new or evolving imaging findings such as increasing mesenteric mass size, development of lymphadenopathy, or other concerning features may indicate an alternative or superimposed process, including malignancy, and warrants further diagnostic evaluation (Saha et al., 2024; Worthington et al., 2025). Taken together, the available evidence supports a risk-adapted approach to imaging, in which follow-up is guided by initial clinical and radiologic features, symptom progression, and the presence of concerning changes rather than routine long-term surveillance in all individuals (Saha et al., 2024; Worthington et al., 2025).

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Bariatric Surgery and Percutaneous Gastrostomy (AB-9)

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Bariatric Post-Operative Complications (AB-9.1)

AB.BS.0009.1.A
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Criteria

- For the evaluation of post-operative complications:
  - CT Abdomen and Pelvis with contrast (CPT® 74177), CT Abdomen with contrast (CPT® 74160), or CTA Abdomen and Pelvis (CPT® 74174) is considered medically necessary for individuals who have had weight loss surgery and present with suspected complications evidenced by:
    - nausea or vomiting OR
    - abdominal pain or tenderness OR
    - fever (101 degrees Fahrenheit [38.5 degrees Celsius] or higher) OR
    - abdominal distension OR
    - suspected hernia
- Internal hernias in individuals who have had Roux-en-Y gastric bypasses may have intermittent and relatively mild abdominal symptoms which require immediate evaluation with CT imaging.
- See: **Post-Operative Pain Within 60 Days Following Abdominal Surgery – Abdominal Procedure (AB-7)**

Evidence Discussion

The American College of Radiology (ACR) classifies routine preoperative advanced imaging in bariatric candidates as usually not appropriate, given the low probability that such imaging alters surgical planning in the absence of specific clinical indications (Pietryga et al., 2025). This position aligns with cohort evidence showing that extensive preoperative testing rarely changes operative strategy at a meaningful rate, particularly when history, physical examination, and standard workup are unremarkable (Schneider et al., 2018; Ghaderi et al., 2020).

In contrast, post-operative evaluation requires a low threshold for advanced imaging. Bariatric procedures, particularly Roux-en-Y gastric bypass, introduce risks for complications that often present with nonspecific symptoms. These include internal hernia, anastomotic leak, marginal ulceration, stenosis, perforation, and intussusception (Shin & Kim, 2020; Pietryga et al., 2025). Splenic complications, most commonly infarction or abscess, have also been documented (Mousavimaleki et al., 2022). Clinical indicators such as abdominal pain or tenderness, nausea or vomiting, fever, abdominal

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distension, leukocytosis, or failure of expected weight loss should prompt immediate evaluation for post-operative complications (Edwards et al., 2025; Pietryga et al., 2025).

CT of the abdomen and pelvis with contrast is the primary diagnostic modality in this setting due to its high sensitivity across a broad range of complications. It enables assessment of bowel configuration, mesenteric anatomy, and extraluminal findings, and contrast enhancement improves detection of anastomotic leaks and inflammatory changes (Musella et al., 2018; Pietryga et al., 2025). Current post-operative pathways and imaging guidance consistently support CT as first-line imaging in symptomatic individuals (Edwards et al., 2025; Pietryga et al., 2025).

Internal hernia represents a time-sensitive complication after Roux-en-Y gastric bypass and often presents with intermittent or mild abdominal symptoms. This variability can delay diagnosis (Nawas et al., 2022; Kagoma & Gayer, 2018). CT is the preferred initial study and should be obtained promptly when hernia is suspected (Pietryga et al., 2025; Nawas et al., 2022). However, CT sensitivity is imperfect, and persistent clinical concern should prompt surgical evaluation, as diagnostic laparoscopy remains more definitive in this context (Altinoz et al., 2020; Nawas et al., 2022).

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Percutaneous Gastrostomy (AB-9.2)

AB.BS.0009.2.A
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Criteria

- Percutaneous Endoscopic Gastrostomy (PEG)
  - CT Abdomen without (CPT® 74150) or CT Abdomen with contrast (CPT® 74160) is considered medically necessary:
    - For pre-operative assessment in the presence of:
      - abdominal wall defects (e.g., open abdomen) OR
      - the presence of “ostomy” sites or drain tubes OR
      - abdominal surgical scars or history of prior major abdominal surgery (e.g., laparotomy, laparoscopy) OR
      - known situs inversus OR
      - known paraesophageal hernia OR
      - previous endoscopic attempt did not achieve adequate transillumination through the abdominal wall or compression and a suitable site for PEG placement could not be determined
  - Percutaneous Gastrostomy via Interventional Radiologist using CT guidance
    - A pre-operative CT Abdomen without (CPT® 74150) or CT Abdomen with contrast (CPT® 74160) is considered medically necessary for complicated cases in which a safe window cannot be determined via fluoroscopy.
    - See above indications for CT prior to endoscopic or surgical gastrostomy tube placement for pre-operative indications.
  - Suspected complication of a gastrostomy or jejunostomy tube placed endoscopically or by interventional radiology (IR):
    - CT Abdomen without (CPT® 74150) or CT Abdomen with contrast (CPT® 74160) or CT Abdomen and Pelvis without (CPT® 74176) or CT Abdomen and Pelvis with contrast (CPT® 74177)

Evidence Discussion

Routine pre-procedure CT imaging does not reduce complication rates in percutaneous endoscopic gastrostomy (PEG) placement. Retrospective data show no difference in bleeding, need for operative intervention, or tube-related complications between individuals who underwent CT prior to placement and those who did not. Complications related to interposed viscera are more directly linked to failure of proper endoscopic technique, particularly inadequate transillumination and external indentation, rather than absence of pre-procedural imaging (Gutjahr et al., 2020). Notably, the single case of transcolonic PEG placement reported in the non-CT cohort occurred in the setting

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of failed transillumination, further supporting the importance of proper endoscopic technique rather than routine pre-procedural imaging (Gutjahr et al., 2020). Consistent with these findings, major society guidelines emphasize technique-driven site selection and do not recommend routine cross-sectional imaging in standard PEG placement (Arvanitakis et al., 2021a; Arvanitakis et al., 2021b; Kohli et al., 2025).

Pre-procedural CT should therefore be reserved for selected cases with suspected complex anatomy, prior abdominal surgery, or failed transillumination, where safe access cannot be confirmed endoscopically (Arvanitakis et al., 2021a; Arvanitakis et al., 2021b; Kohli et al., 2025; Gutjahr et al., 2020).

Post-procedurally, CT has a defined role in evaluating suspected complications. It provides rapid assessment of tube position and can identify complications such as malposition, internal bumper migration, perforation, or injury to adjacent viscera (Yasin et al., 2020; Arvanitakis et al., 2021b). Cross-sectional imaging is particularly useful when clinical findings are unclear or when complications are not detectable by endoscopic evaluation alone (Yasin et al., 2020; Arvanitakis et al., 2021b).

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Blunt Abdominal Trauma (AB-10)

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Blunt Abdominal Trauma (AB-10.1)

AB.BA.0010.1.A
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Criteria

- Abdominal and/or Pelvic ultrasound (CPT® 76700 and/or CPT® 76856) is considered medically necessary for the evaluation of blunt abdominal trauma when requested.
- CT Abdomen and/or Pelvis with contrast (CPT® 74160, or CPT® 72193, or CPT® 74177) is considered medically necessary for:
  - High probability of intra-abdominal injury after blunt abdominal trauma, with new onset of ANY of the following conditions:
    - Abdominal pain or tenderness
    - Pelvic or femur fracture
    - Lower rib fracture
    - Costal margin tenderness or evidence of thoracic wall trauma
    - Diminished breath sounds
    - Vomiting
    - Pneumothorax
    - Hematocrit less than 30%
    - Hematuria
    - Elevated AST
    - Non-examinable individual (e.g., intoxicated, less than fully conscious, Glasgow Coma Scale Score less than 13, or other condition that precludes a reliable clinical examination)
  - Evidence of abdominal wall trauma or presence of a seat-belt sign
  - If an ultrasound demonstrates definitive abnormalities or yields inconclusive findings

Evidence Discussion

In blunt abdominal trauma, ultrasound is an appropriate initial modality when rapid assessment is needed. It can detect free fluid but lacks sensitivity for solid organ, bowel, and retroperitoneal injuries. A negative or indeterminate study does not exclude clinically significant injury (Gerardo et al., 2024; Smyth et al., 2022).

In hemodynamically stable individuals with high-risk features, contrast-enhanced CT is the preferred modality. CT accurately identifies solid organ injury, hemorrhage, mesenteric disruption, and bowel injury, and is recommended when clinical findings raise concern, including abdominal pain or tenderness, associated fractures, thoracic

injury, vomiting, abnormal laboratory values, hematuria, or inability to examine the individual (Gerardo et al., 2024; Lee et al., 2026; Costa et al., 2026).

Abdominal wall trauma, particularly a seat belt sign, is strongly associated with intra-abdominal injury and warrants a low threshold for CT imaging. Ultrasound findings that are positive or inconclusive also require CT for definitive evaluation (Pourmand et al., 2024; Smyth et al., 2022; Gerado et al., 2024).

Imaging decisions in blunt abdominal trauma are driven by clinical risk and examination findings rather than the timing of injury. Current guidelines do not support routine CT for all individuals with recent trauma, as a selective approach based on high-risk features maintains diagnostic accuracy while reducing unnecessary radiation and low-yield imaging (Gerardo et al., 2024; Lee et al., 2026). This approach also accounts for variability in presentation, including delayed or evolving intra-abdominal injuries that declare themselves through changes in symptoms rather than a fixed timeframe (De Simone et al., 2024; Smyth et al., 2022).

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Gaucher Disease and Hemochromatosis (AB-11)

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Gaucher Disease (AB-11.1)

AB.GD.0011.1.A

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- For evaluation of neurologic involvement in Gaucher Disease, see: **Gaucher Disease (Storage Disorders) (PN-8.6)** in the Peripheral Nerve Disorders (PND) Imaging Guidelines.

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Hereditary (Primary) Hemochromatosis (HH) and Other Iron Storage Diseases (AB-11.2)

AB.GD.0011.2.A
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Criteria

- MRI Abdomen without contrast (CPT® 74181) for iron quantification
  - If transferrin iron saturation (TS) is 45% or greater OR elevated serum ferritin (males [assigned at birth] greater than 300 ng/ml, females [assigned at birth] greater than 200 ng/ml) **AND**
  - Genetic studies for hemochromatosis have been performed and results are ANY of the following:
    - Negative for hemochromatosis
    - C282Y/H63D compound heterozygote
    - C282Y heterozygote
    - Non-C282Y homozygote
- For the evaluation of suspected hepatic iron overload in chronic transfusional states (e.g., sickle cell disease, thalassemia, oncology individuals, bone marrow failure, and stem cell transplant individuals):
  - MRI Abdomen without contrast (CPT® 74181) for iron quantification can be performed annually.
- See: **Transfusion-Associated (Secondary) Hemochromatosis (PEDAB-18.2)** in the Pediatric Abdomen Imaging Guidelines regarding transfusion-associated hepatic iron deposition.
- If clinical, biopsy, or radiological findings suggest advanced fibrosis or cirrhosis and HCC surveillance is requested, then follow HCC Screening Guidelines – See: **Chronic Liver Disease, Cirrhosis and Screening for HCC (AB-26.1)**.
- Role of MR Elastography (CPT® 76391):
  - The role of MR Elastography to assess the degree of fibrosis in the setting of hemochromatosis is not yet clearly defined and thus not currently considered medically necessary.

Background and Supporting Information

Hereditary hemochromatosis is a disorder characterized by excessive iron deposition, which may lead to hepatic injury and fibrosis (European Association for the Study of

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the Liver [EASL], 2022; Girelli et al., 2022). Treatment consists of phlebotomy, with response monitored by serum ferritin levels (EASL, 2022; Kowdley et al., 2019).

In individuals with HFE C282Y/C282Y homozygosity, hepatic iron quantification is generally not required for routine evaluation. Individuals with serum ferritin levels greater than 1,000 µg/L and/or elevated liver enzymes should undergo liver biopsy for fibrosis staging and evaluation of concomitant liver disease. In contrast, individuals with serum ferritin levels less than 1,000 µg/L and normal liver enzymes are generally managed with therapeutic phlebotomy (Kowdley et al., 2019).

Magnetic resonance imaging (MRI) is a noninvasive modality used to estimate hepatic iron concentration (Reeder et al., 2023; Hernando et al., 2023). According to the American College of Gastroenterology (ACG) Clinical Guideline (2019), MRI is appropriate for this purpose in the evaluation of hemochromatosis (Kowdley et al., 2019). Studies suggest that MRI-derived measurements of hepatic iron concentration may be more useful for excluding clinically significant iron overload than for definitively establishing the diagnosis (Kowdley et al., 2019; Reeder et al., 2023). In addition, MRI can help differentiate primary from secondary iron overload by demonstrating characteristic patterns of iron deposition, including involvement of the reticuloendothelial system in secondary forms of iron overload (Kowdley et al., 2019; Reeder et al., 2023). However, when there is a concomitant need to stage hepatic fibrosis, liver biopsy remains the preferred method (Kowdley et al., 2019).

The ACG diagnostic algorithm for the evaluation of hemochromatosis does not include MR elastography at any stage, including assessment of fibrosis severity (Kowdley et al., 2019).

MR elastography may be limited in the setting of significant hepatic iron deposition, as iron-related artifact can degrade signal intensity and reduce diagnostic reliability (Ghoz et al., 2019; Zerunian et al., 2024; Sgier et al., 2024).

Evidence Discussion

Magnetic resonance imaging (MRI) is a validated, noninvasive modality for quantifying hepatic iron concentration, with strong accuracy and reproducibility across imaging platforms (Hernando et al., 2023; Reeder et al., 2023). MRI techniques such as T2 allow for reliable estimation of liver iron burden and can differentiate patterns of iron deposition, supporting distinction between primary and secondary iron overload (Reeder et al., 2023; Elhaie et al., 2025: Kowdley et al., 2019).

Elevated serum ferritin levels are associated with increased risk of advanced fibrosis and cirrhosis in hereditary hemochromatosis. Ferritin levels greater than 1,000 mcg/L are linked to a significantly higher likelihood of cirrhosis, whereas lower levels are associated with minimal risk, supporting their role in risk stratification (EASL, 2022; Girelli et al., 2022); Kowdley et al., 2019.

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Although MRI is effective for iron quantification, its role in serial monitoring during treatment is less clearly defined, and clinical management primarily relies on serum ferritin to guide phlebotomy and assess response (EASL, 2022; Kowdley et al., 2019).

Magnetic resonance elastography (MRE) has reduced reliability in the presence of hepatic iron overload due to signal degradation, which can result in non-diagnostic examinations. Iron overload has been shown to predict elastography failure, and even newer techniques demonstrate decreased feasibility in moderate to severe iron deposition (Ghoz et al., 2019; Sgier et al., 2024; Zerunian et al., 2024).

Computed tomography (CT) is less sensitive for hepatic iron quantification and requires dual-energy techniques while exposing patients to ionizing radiation; therefore, its use is generally limited to cases where MRI is unavailable (Reeder et al., 2023).

In treated hereditary hemochromatosis, total body iron stores may also be estimated through iron removed via serial phlebotomy, which correlates with hepatic iron burden and supports laboratory-based monitoring strategies over repeated imaging (EASL, 2022; Kowdley et al., 2019).

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Hernias (AB-12)

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Inguinal or Femoral Hernia, or Indeterminate Groin Pain (AB-12.1)

AB.IH.0012.1.A
v1.0.2027

Criteria

- Clinical examination alone is usually sufficient to confirm the diagnosis of an evident groin hernia.
- If musculoskeletal etiologies such as osteitis pubis or athletic pubalgia are in the differential, see: **Joint Instability and Dysfunction (MS-30.1)** or **Muscle and Tendon Injury (MS-11.1)** in the Musculoskeletal Imaging Guidelines.
- Ultrasound pelvic limited (CPT® 76857) or Ultrasound pelvic complete (CPT® 76856) is the initial imaging study if:
  - vague groin swelling with diagnostic uncertainty OR
  - poor localization of swelling (as might be seen with a small hernia and prominent overlying fat) OR
  - intermittent swelling not present on examination OR
  - other/indeterminate groin complaints without swelling
- If ultrasound is indeterminate or non-diagnostic, ONE of the following is considered medically necessary:
  - CT Pelvis with contrast (CPT® 72193) or CT Pelvis without contrast (CPT® 72192)
  - MRI Pelvis without contrast (CPT® 72195) or MRI Pelvis without and with contrast (CPT® 72197)
- For suspected incarceration or strangulation (**initial ultrasound is not required**):
  - CT Pelvis with contrast (CPT® 72193) or CT Pelvis without contrast (CPT® 72192)
- For chronic post-surgical groin pain (after hernia repair):
  - Pelvic ultrasound (CPT® 76856 or CPT® 76857) or US-guided nerve block
  - CT Pelvis with contrast (CPT® 72193) or CT Pelvis without contrast (CPT® 72192) or MRI Pelvis without contrast (CPT® 72195) or MRI Pelvis without and with contrast (CPT® 72197) can be approved if either ultrasound or ultrasound-guided nerve block is indeterminate or non-diagnostic, to assess for other, non-neuropathic causes.

Evidence Discussion

Diagnosis of inguinal and femoral hernias is primarily clinical, based on history and physical examination. When findings are equivocal or symptoms are nonspecific, ultrasound is the preferred initial imaging modality. It is widely available, lacks ionizing radiation, and allows dynamic assessment with maneuvers such as Valsalva, which

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improve detection of small or intermittently reducible hernias (Shakil et al., 2020; Plumb et al., 2022; Garcia et al., 2022). These dynamic features are not reproducible with CT, which provides a static evaluation (Plumb et al., 2022).

When ultrasound is inconclusive or when there is concern for a complicated hernia, including incarceration or strangulation, cross-sectional imaging is appropriate. CT of the pelvis or MRI can further characterize anatomy, assess for complications, and evaluate alternative diagnoses. Established imaging guidelines support escalation to CT or MRI in these settings but do not support routine abdominal CT for uncomplicated suspected groin hernia (Garcia et al., 2022; Stabilini et al., 2023).

Post-operative groin pain requires a structured approach before advanced imaging. Common causes include neuropathic pain, recurrence, and mesh-related complications (Plumb et al., 2022; Stabilini et al., 2023). Initial evaluation with ultrasound, along with targeted interventions such as nerve block when clinically indicated, can clarify the etiology. Advanced imaging is reserved for cases in which these initial assessments are nondiagnostic or when complications are suspected (Plumb et al., 2022; Stabilini et al., 2023).

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Spigelian, Ventral, Umbilical, or Incisional Hernia (AB-12.2)

AB.IH.0012.2.A
v1.0.2027

Criteria

- For known or suspected primary or recurrent Spigelian hernia (anterior abdominal wall hernia through the semilunar line), ventral hernia, umbilical, or incisional hernia:
  - CT Abdomen without or with contrast (if hernia is at or above the umbilicus) (CPT® 74150 or CPT® 74160) OR
  - CT Pelvis without or with contrast (if hernia is below the umbilicus) (CPT® 72192 or CPT® 72193) OR
  - CT Abdomen and Pelvis without or with contrast (if hernia is above and below the umbilicus, or indeterminate) (CPT® 74176 or CPT® 74177)

Evidence Discussion

Abdominal wall hernias, including Spigelian, ventral, umbilical, and incisional types, may be difficult to fully characterize on physical examination, particularly in individuals with obesity, prior surgery, or multiple defects. Clinical exam often underestimates defect size, fails to identify occult or secondary hernias, and cannot reliably define the relationship of the hernia to surrounding structures (Garcia et al., 2022; Plumb et al., 2022).

CT provides comprehensive anatomic detail, including precise localization, measurement of defect size, identification of multiple or occult hernias, and characterization of hernia contents. These findings directly inform operative planning, including surgical approach and mesh selection (Garcia et al., 2022). CT imaging should be targeted to the region of concern (Garcia et al., 2022). Imaging of the abdomen or pelvis alone is appropriate when the suspected hernia is anatomically localized above or below the umbilicus, while combined abdomen and pelvis imaging is considered medically necessary when the extent spans regions or is uncertain. This focused approach aligns imaging extent with expected anatomy and avoids unnecessary imaging beyond the clinically relevant area (Garcia et al., 2022).

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Hiatal Hernia (AB-12.3)

AB.IH.0012.3.A
v1.0.2027

Criteria

- CT Chest with contrast (CPT® 71260) and/or CT Abdomen with contrast (CPT® 74160) is considered medically necessary to evaluate ANY of the following:
  - For pre-operative treatment planning
  - Suspected complication of primary disease or surgery

Background and Supporting Information

- Hiatal hernias occur when a portion of the stomach herniates through the diaphragmatic hiatus into the thoracic cavity. Potential complications include gastric volvulus, obstruction, reflux, and symptoms such as vomiting, chest pain, or dysphagia (Sfara & Dumitrascu, 2019; Daly et al., 2024).

Evidence Discussion

Hiatal hernias are frequently asymptomatic but may present with a range of symptoms depending on size and type, including gastroesophageal reflux, dysphagia, chest pain, or respiratory complaints (Sfara & Dumitrascu, 2019). Clinical evaluation is typically guided by the presenting symptom complex, with targeted diagnostic testing recommended based on suspected complications (Sfara & Dumitrascu, 2019; Daly et al., 2024).

Current surgical society guidelines emphasize that advanced imaging should not be used routinely in the evaluation of uncomplicated hiatal hernia. Rather, imaging is generally reserved for individuals with suspected complications (e.g., volvulus, obstruction) or for preoperative planning in individuals being considered for surgical intervention (Daly et al., 2024; Markar et al., 2023). This approach reflects an effort to minimize unnecessary testing and reduce radiation exposure, particularly when imaging findings are unlikely to alter management.

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Abdominal Mass (AB-13)

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Abdominal Wall Mass (AB-13.1)

AB.AM.0013.1.A
v1.0.2027

Criteria

- Abdominal ultrasound and/or Pelvic ultrasound (CPT® 76700 or CPT® 76705 and/or CPT® 76856) is considered medically necessary as the initial imaging study to assess an abdominal wall or subcutaneous mass.
- MRI Abdomen without and with contrast (CPT® 74183) or CT Abdomen with contrast (CPT® 74160) is considered medically necessary to further characterize a suspected malignant or indeterminate mass detected on ultrasound.
  - Pelvic imaging may be considered medically necessary depending on the anatomic location and extent of the mass.

For individuals with an abdominal wall mass and clinical suspicion for endometriosis, also refer to **Suspected Endometriosis (PV-6.1)**.

Evidence Discussion

Most abdominal wall and subcutaneous masses are benign and often diagnosed clinically. When imaging is required, ultrasound is the preferred initial modality due to its ability to distinguish cystic from solid lesions and assess vascularity with high specificity (Fowler et al., 2019).

Indeterminate or suspicious findings on ultrasound warrant further evaluation with contrast-enhanced CT or MRI. CT provides rapid assessment of lesion size and extent, while MRI offers superior soft tissue characterization when malignancy is suspected. Additional noncontrast CT imaging adds little diagnostic value (Fowler et al., 2019).

Imaging should be limited to the involved anatomic region, with pelvic imaging included when the mass extends beyond the abdominal wall. This stepwise approach supports ultrasound first, followed by targeted advanced imaging when clinically indicated (Fowler et al., 2019).

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Indeterminate Intra-Abdominal Mass (AB-13.2)

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Criteria

- For a palpable abdominal mass on physical examination:
  - Abdominal ultrasound (CPT® 76700) and/or Pelvic ultrasound (CPT® 76856) is considered medically necessary in lieu of CT, if requested
  - CT Abdomen with contrast (CPT® 74160) if above the umbilicus
  - CT Abdomen and Pelvis with contrast (CPT® 74177) if extending below the umbilicus
  - CT Pelvis with contrast (CPT® 72193) if involving the pelvis
- Indeterminate findings on a prior CT or ultrasound:
  - MRI Abdomen without and with contrast (CPT® 74183)
    - MRI Pelvis without and with contrast (CPT® 72197) is considered medically necessary to evaluate if the mass extends below the umbilicus or involves the pelvis
- For a pulsatile abdominal mass, suspected aortic aneurysm: See: **Abdominal Aortic Aneurysm (AAA) (PVD-6.3)** in the Peripheral Vascular Disease (PVD) Imaging Guidelines.
- For females (assigned at birth) with a suspected adnexal mass or fibroid: See: **Adnexal Mass/Ovarian Cysts (PV-5)** or **Leiomyomata/Uterine Fibroids and Other Uterine Masses (PV-12)** in the Pelvis Imaging Guidelines.
- Pregnant individual:
  - Abdominal and/or Pelvic and/or Transvaginal ultrasound (CPT® 76700 and/or CPT® 76856 and/or CPT® 76830) is appropriate for initial imaging.

Evidence Discussion

The origin and characteristics of a palpable intra-abdominal mass are often not reliably defined on physical examination. Ultrasound and contrast-enhanced CT both demonstrate diagnostic utility in this setting. Ultrasound is a reasonable initial modality due to its lack of ionizing radiation, accessibility, and ability to guide selection of subsequent imaging, although its performance may be limited by body habitus and bowel gas (Fowler et al., 2019).

Contrast-enhanced CT provides comprehensive evaluation and has high diagnostic accuracy for confirming or excluding a mass and determining its organ of origin.

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Reported performance includes positive predictive value of 99% and negative predictive value of 97%, with correct identification of organ origin in most cases (Fowler et al., 2019).

MRI is reserved for further characterization of indeterminate findings on ultrasound or CT, offering superior soft tissue differentiation and improved assessment of lesion composition and extent. This stepwise approach supports ultrasound for initial assessment, CT for definitive evaluation, and MRI for problem-solving when needed (Fowler et al., 2019).

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Abnormal Findings on Endoscopy/ Colonoscopy (AB-13.3)

AB.AM.0013.3.A
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Criteria

The following criteria applies to findings on endoscopy or colonoscopy that have NOT been diagnosed or biopsy-proven as malignant. For biopsy-proven malignancy, refer to the appropriate Oncology Imaging Guideline.

- For suspicious (not clearly benign) submucosal lesion(s) noted in the stomach or small bowel (including the duodenum), or for gastric extrinsic compression identified on endoscopy, ONE of the following is considered medically necessary:
  - CT Abdomen with contrast (CPT® 74160) OR
  - CT Abdomen and Pelvis with contrast (CPT® 74177)
- For suspicious (not clearly benign) lesion(s) noted above the rectum (in the colon or small bowel), unexplained colonic extrinsic compression on colonoscopy, or pre-operative planning for complete surgical removal of a polypoid lesion the following are considered medically necessary:
  - CT Abdomen and Pelvis with contrast (CPT® 74177)
  - MRI Pelvis without and with contrast (CPT® 72197) or MRI Pelvis without contrast (CPT® 72195) is considered medically necessary in addition to CT when there is an additional suspicious lesion(s) in the distal sigmoid or rectum
- For submucosal rectal lesions or unexplained extrinsic compression in the rectum:
  - MRI Pelvis without and with contrast (CPT® 72197), or if requested, MRI Pelvis without contrast (CPT® 72195)
- For endoscopic findings suspicious for malignancy (e.g., friable, necrotic, or partially obstructing mass, or an endoscopic appearance described as consistent with malignancy), the following cross-sectional imaging for staging and assessment is considered medically necessary prior to histologic confirmation:
  - CT Chest with contrast (CPT® 71260)
  - CT Abdomen and Pelvis with contrast (CPT® 74177)
- For criteria specific to biopsy-proven colorectal cancer, See **Colorectal Cancer – Initial Work-up/Staging (ONC-16.2)** in the Oncology Imaging Guidelines.
- For criteria specific to biopsy-proven Gastrointestinal Stromal Tumor (GIST): See **Gastrointestinal Stromal Tumor (GIST) (ONC-12.5)** in the Oncology Imaging Guidelines.
- For criteria specific to biopsy-proven gastric cancer: See **Gastric Cancer - Initial Work-up/Staging (ONC-14.9)** in the Oncology Imaging Guidelines.

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Evidence Discussion

Endoscopic ultrasound (EUS), with or without fine-needle aspiration, is the preferred initial modality for characterization of submucosal lesions of the stomach and rectum identified on endoscopy. EUS provides high-resolution assessment of bowel wall layers, allowing determination of lesion origin, depth, and features suggestive of malignancy, which cannot be reliably established with cross-sectional imaging alone (Jacobson & Shami, 2024; Sharzehi et al., 2022).

When lesions are indeterminate, suspicious, or associated with extrinsic compression, cross-sectional imaging is indicated to evaluate extent and identify extraintestinal disease. Contrast-enhanced CT of the abdomen and pelvis provides rapid and accurate assessment of the gastrointestinal tract and surrounding structures, including detection of lymphadenopathy, metastatic disease, and involvement beyond the bowel wall. CT is therefore appropriate for lesions in the stomach, small bowel, or colon when further characterization or preoperative planning is required (Fowler et al., 2019; Benson et al., 2025a, 2025b).

For rectal or distal sigmoid lesions, MRI of the pelvis with or without contrast is preferred for local staging due to its superior soft tissue resolution and ability to define involvement of the rectal wall, mesorectal fascia, and adjacent structures. This added detail is necessary for surgical planning and risk stratification in distal lesions (Benson et al., 2025b; Maccioni et al., 2023).

When endoscopic findings are highly suggestive of malignancy, cross-sectional imaging for staging is appropriate prior to histologic confirmation. CT of the chest, abdomen, and pelvis with contrast is recommended to evaluate for distant metastatic disease and guide management (Benson et al., 2025a, 2025b; National Comprehensive Cancer Network, 2026).

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Lower Extremity Edema (AB-14)

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Lower Extremity Edema (AB-14)

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In the setting of inferior vena cava (IVC) thrombus secondary to the filter or concern for proximal deep vein thrombosis (DVT) (iliofemoral), see: **Acute Limb Swelling (PVD-12)** and for evaluation of chronic limb swelling/May-Thurner Syndrome, see: **Chronic Limb Swelling Due to Venous Insufficiency/Venous Stasis Changes/Varicose Veins (PVD-13)** in the Peripheral Vascular Disease Imaging Guidelines.

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Zollinger-Ellison Syndrome (ZES-Gastrinoma) (AB-15)

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Zollinger-Ellison Syndrome (ZES-Gastrinoma) (AB-15.1)

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- For suspected gastrinoma, see: **Neuroendocrine Cancers and Adrenal Tumors (ONC-15)** in the Oncology Imaging Guidelines.

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Adrenal Cortical Lesions (AB-16)

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Adrenal Cortical Lesions (AB-16)

AB.AC.0016.A
v1.0.2027

Code	Description
74150	CT Abdomen without contrast
74160	CT Abdomen with contrast
74170	CT Abdomen without and with contrast
74181	MRI Abdomen without contrast
74183	MRI Abdomen without and with contrast
78812	PET, Skull Base to Mid-Thigh
78815	PET/CT, Skull Base to Mid-Thigh

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Asymptomatic Adrenal Cortical Lesions (AB-16.1)

AB.AC.0016.1.A
v1.0.2027

Criteria

- The following recommendations are for asymptomatic individuals:
  - For symptomatic individuals, see: **Symptomatic Adrenal Cortical Lesions (AB-16.2)**.
  - US is not a prerequisite study for advanced imaging in the evaluation of any adrenal abnormality.
- Abdominal pain may be present in large or rapidly expanding adrenal tumors due to mass effect or hemorrhage.
  - If the source of abdominal pain is suspected to be an incidental adrenal mass and initial imaging was indeterminate, immediate reimaging with a dedicated adrenal protocol study (see 3 imaging modalities below) is reasonable irrespective of the size of the mass.
  - See: **Abdominal Pain (AB-2)** in the Abdomen Imaging Guidelines for imaging recommendations if abdominal pain is unrelated to the adrenal mass.
- The three imaging modalities that can be used for definitive benign characterization of an adrenal mass are:
  - CT Abdomen without contrast (CPT® 74150)
  - CT Abdomen without and with contrast (CPT® 74170)
  - CS-MRI (chemical shift MRI, CPT® 74181)
- The following list represents definitively benign characteristics of the adrenal gland. This list applies wherever "benign characteristics" are mentioned in the table below:
  - 10 Hounsfield units (HFU) or less on computed tomography (CT)
  - Absolute washout of 60% or greater or relative washout of 40% or greater on CT abdomen without and with contrast using calculated washout (adrenal protocol CT, CPT® 74170)
    - An important exception to the washout rule: Non-adenomatous adrenal masses that may show elevated washout on adrenal protocol CT but are not benign include:
      - adrenal metastasis from hypervascular tumors (e.g. RCC and HCC)
      - pheochromocytoma
      - adrenocortical carcinoma

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        - clinical suspicion should be used in these cases to guide further investigation
    - Decreased signal on Chemical Shift MRI (CS-MRI, CPT® 74181)
    - Cyst, if imaging was completed without and with contrast and demonstrated no enhancement, defined as a change of less than 10 HFU between the unenhanced and contrast-enhanced CT images.
    - Adrenal myelolipoma (macroscopic fat)
- If a definitive benign diagnosis cannot be made during follow-up imaging using a dedicated CT adrenal protocol (If less than 60% absolute washout or less than 40% relative washout) or lack of signal drop out on MRI chemical shift:
    - Additional imaging is considered medically necessary at 6-12 months from initial follow up, OR
    - Consider resection for possible primary adrenocortical carcinoma after biochemical evaluation and exclusion of pheochromocytoma.
        - For individuals who are poor surgical candidates, if ordered by or in consultation with an endocrinologist, endocrine surgeon, or urologist:
            - Imaging as requested
- CT Abdomen without and with contrast (CPT® 74170) may be considered medically necessary in place of any below recommended CT Abdomen without contrast for the following:
    - Facility protocol is to cease imaging if adrenal mass is found to have an attenuation value of less than 10 HFU on initial non-contrasted images
- MRI Abdomen without contrast (CPT® 74181) is considered medically necessary in place of CT for the following:
    - Clips that cause artifacts when using CT
    - Allergy to CT contrast
    - Individuals in whom radiation exposure should be limited (children, pregnant individuals, individuals with known germline mutations, and individuals with recent excessive radiation exposure)
- CS MRI may not detect the intracellular lipid in an adrenal mass if HFU is 30 HU or more on CT without contrast. CS MRI is less effective than CT without and with contrast with calculated washout for adenomas with unenhanced attenuation of more than 20 HU
- Below imaging can be applied to bilateral adrenal masses, with each lesion addressed separately.

Mass Characteristics and Appropriate Imaging

Mass Details	Imaging Study
• Asymptomatic AND • Incidentally found on US, CT, or MRI of area OTHER than the abdomen or if seen only on US of the abdomen AND • Any size AND • No history of cancer	• CT Abdomen without contrast (CPT® 74150)
• Asymptomatic AND • Incidentally found on CT Chest without contrast, entirely imaged, and fully characterized as indeterminate by HFU score AND • greater than 2 cm AND • No history of cancer	• CT Abdomen without and with contrast (CPT® 74170) in lieu of above recommended CT Abdomen without contrast (CPT® 74150)
• Asymptomatic AND • Incidentally found on CT or MRI of the Abdomen or Abdomen and Pelvis AND • less than 1 cm in short axis AND • No history of cancer	• No further imaging is considered medically necessary ◦ It is uncertain as to whether subcentimeter nodularity or adrenal thickening qualifies as an adrenal mass on radiology reports
• Asymptomatic AND • Incidentally found on CT or MRI of the Abdomen or Abdomen and Pelvis AND • No prior imaging for comparison AND • Diagnostic with benign imaging characteristics AND • 1 cm or greater AND • No history of cancer	• No further imaging is considered medically necessary, regardless of size ◦ The risk of malignancy in a mass with diagnostically benign findings on imaging is extremely low

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Mass Details	Imaging Study
• Asymptomatic AND • 1 cm to 2 cm AND • Incidentally detected and indeterminate on any CT or MRI Abdomen or Abdomen and Pelvis AND • No prior imaging for comparison AND • No history of cancer	• Reimaging is considered medically necessary at 12 months from the initial indeterminate study, as follows*: ◦ CT Abdomen without and with contrast (CPT® 74170 - adrenal protocol), CT Abdomen without contrast (CPT® 74150), or CS-MRI (chemical shift MRI, CPT® 74181) ▪ No further imaging is considered medically necessary after initial 12 month study if ANY of the following: - Definitively benign characteristics - Stable in size (change of less than 8mm) over a period greater than 1 year (likely benign adenoma) *NOTE: These instructions are regarding indeterminate lesions without prior studies to compare, in asymptomatic individuals. If prior imaging exists for comparison and radiology report shows stability over 1 year or if the imaging study already shows definitively benign characteristics, no further imaging is medically necessary

Mass Details	Imaging Study
• Asymptomatic AND • Greater than 2 cm to less than 4 cm AND • Incidentally detected and indeterminate on any CT or MRI Abdomen or Abdomen and Pelvis AND • No prior imaging for comparison AND • No history of cancer	• Reimaging is considered medically necessary immediately after initial indeterminate study, as follows*: ◦ CT Abdomen without and with contrast (CPT® 74170 - adrenal protocol), or CS-MRI (chemical shift MRI, CPT® 74181) ▪ Further follow-up imaging is considered medically necessary at 6 and 12 months ▪ No further imaging is considered medically necessary if the initial study or follow up study has definitively benign characteristics or if follow up study shows stability in size (change of less than 8mm) over a period greater than 1 year (as likely benign adenoma) *NOTE: These instructions are regarding indeterminate lesions without prior studies to compare, in asymptomatic individuals. If prior imaging exists for comparison and radiology report shows stability over 1 year or if the imaging study already shows definitively benign characteristics no further imaging is medically necessary.
• Asymptomatic AND • 4 cm or greater AND • Incidentally detected and indeterminate on any CT or MRI Abdomen or Abdomen and Pelvis AND • No prior imaging for comparison AND • No history of cancer	• Reimaging is considered medically necessary immediately after initial indeterminate study, as follows: ◦ CT Abdomen without and with contrast (CPT® 74170) or chemical shift MRI (CPT® 74181) • Consider resection for possible primary adrenocortical carcinoma ◦ See: **Adrenocortical Carcinoma (ONC-15.13)** in the Oncology Imaging Guidelines

Mass Details	Imaging Study
• History of cancer with a likelihood or propensity to metastasize to the adrenal gland or abdomen • Incidentally detected and indeterminate on any CT or MRI Abdomen or Abdomen and Pelvis	• See: **Adrenal Gland Metastases (ONC-31.4)** in the Oncology Imaging Guidelines
• Known adrenal mass with benign characteristics, but newly symptomatic or new hormonal excess	• Repeat imaging per **Adrenal Hormone Excess/Symptomatic Adrenal Lesions (AB-16.2)**

Background and Supporting Information

Adrenal incidentalomas are adrenal masses discovered during imaging performed for reasons unrelated to suspected adrenal disease. Current endocrine society guidelines recommend biochemical evaluation of most adrenal incidentalomas to assess for hormone excess, with the exception of lesions demonstrating imaging characteristics diagnostic of myelolipoma or simple cysts. However, laboratory evaluation is not required solely to obtain imaging in an asymptomatic individual with an incidentally detected adrenal lesion (Fassnacht et al., 2023).

Approximately 75% of adrenal incidentalomas are benign adenomas. Lipid-rich adenomas typically demonstrate attenuation values of 10 Hounsfield units (HU) or less on unenhanced CT and can often be characterized as benign without additional imaging. Lesions that do not meet these criteria may require further characterization using dedicated adrenal CT washout protocols or chemical-shift magnetic resonance imaging (MRI) (Mody et al., 2021; Fassnacht et al., 2023; Kebebew, 2021).

Adrenal masses are frequently identified on contrast-enhanced CT examinations performed for unrelated abdominal indications. When an adrenal lesion is identified on a contrast-enhanced study alone, characterization may be limited because unenhanced attenuation values and contrast washout characteristics are unavailable. Dedicated adrenal imaging protocols can provide additional characterization of indeterminate lesions (Mody et al., 2021; Fassnacht et al., 2023).

An adrenal protocol CT includes assessment of lesion attenuation on unenhanced imaging and evaluation of contrast washout on delayed imaging. Chemical-shift MRI can also be used to assess for intracellular lipid content and may be considered when CT is contraindicated or when iodinated contrast administration is not appropriate (Mody et al., 2021; Fassnacht et al., 2023).

Imaging features associated with benign adrenal lesions include smooth margins, homogeneous appearance, absence of calcification, hemorrhage, or necrosis, lack of fluorodeoxyglucose (FDG) avidity on positron emission tomography (PET), and lesion stability over time. Imaging features associated with malignancy include irregular margins, heterogeneous appearance, calcification, hemorrhage, necrosis, FDG avidity, interval growth, and larger lesion size (Fassnacht et al., 2023; Kebebew, 2021; Kiseljak-Vassiliades et al., 2020).

The adrenal glands are a common site of metastatic disease. Primary malignancies most frequently associated with adrenal metastases include lung cancer, melanoma, renal cell carcinoma, and gastrointestinal malignancies (Kebebew, 2021; Kiseljak-Vassiliades et al., 2020).

Benign Adenoma Imaging Characteristics		
Imaging Study:	Findings consistent with Adenoma:	Indeterminate for Adenoma:
CT Abdomen without contrast	10 Hounsfield Units or less	Greater than 10 Hounsfield Units
CT Abdomen without and with contrast, including calculated washout	Absolute washout of 60% or greater or relative washout of 40% or greater	Absolute washout of less than 60% and relative washout of less than 40%
Chemical Shift MRI	Signal drop out	Lack of signal drop out

Evidence Discussion

CT abdomen is the preferred initial imaging modality for evaluation of adrenal masses because it provides accurate lesion characterization, is widely available, and permits assessment of attenuation characteristics and contrast washout patterns. Most adrenal incidentalomas are benign adenomas, many of which are lipid-rich and demonstrate attenuation values of 10 HU or less on unenhanced CT. Using this threshold, unenhanced CT demonstrates high specificity for adenoma characterization (Corwin & Remer, 2021; Mody et al., 2021; Fassnacht et al., 2023).

For lesions that do not meet diagnostic benign imaging criteria, adrenal protocol CT allows calculation of absolute and relative contrast washout, improving differentiation between adenomas and non-adenomas. Studies support adrenal washout CT as an effective method for characterizing indeterminate adrenal lesions, with reported sensitivity approaching 98% and specificity approximately 92% (Mody et al., 2021; Grajewski & Caoili, 2021).

Chemical-shift MRI is an accepted alternative when CT or iodinated contrast is contraindicated. MRI can identify intracellular lipid and assist in characterization of

lipid-poor adenomas; however, its diagnostic performance decreases in lesions with higher attenuation values, where CT washout analysis may provide greater diagnostic confidence (Mody et al., 2021; Grajewski & Caoili, 2021).

Current endocrine and radiology guidelines support additional imaging evaluation for indeterminate adrenal lesions because the differential diagnosis includes pheochromocytoma, adrenocortical carcinoma, metastatic disease, and other clinically significant pathologies. Conversely, lesions demonstrating established benign imaging features generally do not require further characterization (Fassnacht et al., 2023; Mody et al., 2021; Kebebew, 2021).

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Abdomen Imaging Guidelines

Adrenal Hormone Excess/Symptomatic Adrenal Lesions (AB-16.2)

AB.AC.0016.2.A
v1.0.2027

Criteria

- Prior to advanced imaging, adrenal hormone excess must be clinically suspected and then biochemically confirmed via testing listed in the table below.
- The following imaging recommendations can also be followed in asymptomatic individuals with an adrenal incidentaloma who are found to have abnormalities at initial hormonal evaluation.
- For severe hormone elevation or rapidly progressing symptoms for which adrenocortical carcinoma is suspected, see: **Adrenocortical Carcinoma (ONC-15.13)** in the Oncology Imaging Guidelines.

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Condition	Signs/Symptoms (not required to be documented for imaging)	Laboratory requirements PRIOR to initial adrenal imaging	Indicated Imaging
• Suspected cortisol excess (adrenal Cushing's Syndrome)	• Weight gain • Hyperglycemia/ diabetes • Low bone mineral density/fractures • Hyperpigmented Striae • Lipodystrophy ("buffalo hump")	• adrenocorticotropic hormone (ACTH) low/suppressed AND • Cortisol elevation documented by any of the following: ◦ Elevated morning cortisol following overnight 1mg dexamethasone suppression (cortisol greater than 1.8 mcg/dL) ◦ Elevated late night salivary cortisol ◦ Elevated urine free cortisol	• CT Abdomen without contrast (CPT® 74150) ◦ If CT Abdomen without contrast shows an indeterminate adrenal mass, the following is considered medically necessary immediately: ▪ CT Abdomen without and with contrast adrenal protocol (CPT® 74170) OR ▪ MRI Abdomen without contrast chemical shift (CPT® 74181)

Condition	Signs/Symptoms (not required to be documented for imaging)	Laboratory requirements PRIOR to initial adrenal imaging	Indicated Imaging
• Suspected adrenal hyper-androgenism/ virilizing adrenal tumor	• Hirsutism • Virilization (voice deepening, clitoromegaly)	• Elevated serum dehydroepi-androsterone sulfate (DHEAS) AND/OR • Elevated testosterone	• CT Abdomen without contrast (CPT® 74150) ◦ If CT Abdomen without contrast shows an indeterminate mass, the following is considered medically necessary immediately: ▪ CT Abdomen without and with contrast adrenal protocol (CPT® 74170) OR ▪ MRI Abdomen without contrast chemical shift (CPT® 74181) • In individuals with an elevated testosterone level and an ovarian etiology is suspected, see: **Polyendocrine Metabolic Ovarian Syndrome (PMOS) (PV-8.1)** in the Pelvis Imaging Guidelines and **Ovarian Cancer-**

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Condition	Signs/Symptoms (not required to be documented for imaging)	Laboratory requirements PRIOR to initial adrenal imaging	Indicated Imaging
			Suspected/ Diagnosis (ONC-21.2) in the Oncology Imaging Guidelines.
• Suspected feminizing adrenal tumor	• Gynecomastia • Testicular atrophy	• Elevated serum estradiol AND • Non-elevated serum luteinizing hormone (LH) AND • No testicular mass seen on dedicated imaging	• CT Abdomen without contrast (CPT® 74150) ◦ If CT Abdomen without contrast shows an indeterminate adrenal mass, the following is considered medically necessary immediately: ▪ CT Abdomen without and with contrast adrenal protocol (CPT® 74170) OR ▪ MRI Abdomen without contrast chemical shift (CPT® 74181)

Abdomen Imaging Guidelines

Condition	Signs/Symptoms (not required to be documented for imaging)	Laboratory requirements PRIOR to initial adrenal imaging	Indicated Imaging
• Suspected primary aldosteronism (Conn's Syndrome)	• HTN • Hypokalemia	• Serum aldosterone level of 10 ng/dL or greater in the setting of suppressed renin and spontaneous hypokalemia (Serum potassium level less than 3.5mEq/L) OR • Confirmatory testing showing lack of aldosterone suppression.	• CT Abdomen without contrast (CPT® 74150) ◦ If CT Abdomen without contrast shows an indeterminate adrenal mass, the following is considered medically necessary immediately: ▪ CT Abdomen without and with contrast adrenal protocol (CPT® 74170) OR ▪ MRI Abdomen without contrast chemical shift (CPT® 74181)

Condition	Signs/Symptoms (not required to be documented for imaging)	Laboratory requirements PRIOR to initial adrenal imaging	Indicated Imaging
• Suspected pheo-chromocytoma/ paraganglioma	• HTN • Palpitations • Tremor • Pallor • Flushing • Hyperadrenergic spells	• Elevated plasma free metanephrines OR • Elevated urinary fractionated metanephrines	• CT Abdomen and Pelvis without and with contrast (CPT® 74178), CT Abdomen and Pelvis with contrast (CPT® 74177), or MRI Abdomen (CPT® 74183) and Pelvis (CPT® 72197) without and with contrast • See also: **Adrenal Nuclear Imaging (AB-16.4)** and **Adrenal Tumors (ONC-15.10)** in the Oncology Imaging Guidelines and **Hereditary Paraganglioma-Pheochromocytoma Syndromes (PEDONC-2.13)** in the Pediatric and Special Populations Oncology Imaging Guidelines
• Suspected adrenocortical carcinoma	• Rapidly progressive symptoms • Elevation of multiple adrenal hormones	• N/A	• See: **Adrenocortical Carcinoma (ONC-15.13)** in the Oncology Imaging Guidelines

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Condition	Signs/Symptoms (not required to be documented for imaging)	Laboratory requirements PRIOR to initial adrenal imaging	Indicated Imaging
• Confirmed adrenal hormone excess AND • Requested for surgical planning AND • Requested by or in consultation with an endocrinologist, endocrine surgeon, or urologist	N/A	N/A	• Repeat imaging as requested

Background and Supporting Information

- Functional adrenal tumors may present with excess production of cortisol, aldosterone, adrenal androgens, estrogens, or catecholamines. Surgical resection is generally the preferred treatment for virilizing adrenal tumors, feminizing adrenal tumors, pheochromocytoma/paraganglioma (PPGL), and suspected adrenocortical carcinoma because of the potential for malignancy and associated morbidity. Adrenal tumors causing autonomous cortisol secretion or primary aldosteronism may also be managed surgically when unilateral disease is identified (Adler et al., 2025; Fassnacht et al., 2023; Shah et al., 2021).

Suspected cortisol excess (Adrenal Cushing's syndrome)

- Adrenal Cushing's syndrome results from autonomous cortisol production by an adrenal adenoma or carcinoma. Suppressed or low adrenocorticotropic hormone (ACTH) levels are consistent with an adrenal source of cortisol excess. Clinical manifestations may develop gradually and diagnosis is frequently delayed because

signs and symptoms often evolve over several years (Fleseriu et al., 2021; Fassnacht et al., 2023)

Suspected adrenal hyperandrogenism/virilizing adrenal tumor

- Testosterone is produced by both the ovary (primary source) and adrenal gland while DHEA and DHEAS are produced almost exclusively by the adrenal gland (Kanakis et al., 2019; Shah et al., 2021).
- The magnitude of androgen elevation has limited predictive value for identifying tumors; however, markedly elevated testosterone levels within the adult male reference range or a dehydroepiandrosterone sulfate (DHEAS) level greater than 700 mcg/dL may be suggestive of a tumor (Kanakis et al., 2019; Shah et al., 2021).

Suspected feminizing adrenal tumor

- Adrenal tumors, mainly carcinomas (extremely rare, 0.5–2.0 per million), can secrete both estrogens and high amounts of adrenal androgens, which aromatize to estrogens. In this case, gynecomastia is usually of recent onset, progresses rapidly and testicular atrophy can also be seen. (Kanakis et al., 2019; Kiseljak-Vassiliades et al., 2020)
- Common causes of excessive endogenous estrogens should be excluded prior to adrenal imaging. These include increased secretion from testis (Leydig cell or Sertoli cell tumors, stimulation of normal Leydig cells by LH or hCG) and increased aromatization of androgens to estrogens (aging, obesity, alcoholic cirrhosis, hyperthyroidism, drugs, hCG-secreting tumors, aromatase excess syndrome). (Kanakis et al., 2019; Kiseljak-Vassiliades et al., 2020)

Suspected primary aldosteronism (Conn's syndrome)

- A positive screen for primary aldosteronism is an aldosterone level of 10 ng/dL or greater in the setting of suppressed renin and spontaneous hypokalemia. Suppressed renin is defined as a plasma renin activity of 1 ng/mL/hour or less or a plasma renin concentration less than 5 to 8.2 mU/L. Spontaneous hypokalemia is defined as a serum potassium level less than 3.5 mEq/L (Adler et al., 2025; Hundemer & Vaidya, 2019).
- The most common dynamic confirmatory tests include the oral sodium suppression test, the seated intravenous saline suppression test, the fludrocortisone suppression test, and the captopril challenge test, and results that indicate a "positive" result are unique to the each test. For example, if oral sodium loading is used, a 24-hour urine aldosterone excretion of more than 12 mcg in the setting of 24-hour urine sodium excretion of more than 200 mEq is diagnostic of primary aldosteronism (and values of more than 10 mcg/24 hours are strongly suggestive) (Adler et al., 2025; Hundemer & Vaidya, 2019).
- Primary hyperaldosteronism may be managed medically with mineralocorticoid receptor antagonists (spironolactone and eplerenone) in cases of bilateral adrenal

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disease or poor surgical candidacy. If there has been no recent adrenal imaging, reimaging can be considered in cases of diagnostic uncertainty or poor response to medical therapy (Adler et al., 2025; Hundemer & Vaidya, 2019).

Suspected pheochromocytoma/paraganglioma

- A pheochromocytoma (85% of chromaffin tumors) arises from the chromaffin cells in the adrenal medulla and commonly produces one or more of the following catecholamines: epinephrine, norepinephrine and dopamine(Taïeb et al., 2019; NCCN, 2025).
- A paraganglioma (15-20% of chromaffin tumors) arises from the extra-adrenal chromaffin cells of the sympathetic paravertebral ganglia of the thorax, abdomen, and pelvis (catecholamine producing) or the parasympathetic ganglia along the glossopharyngeal and vagal nerves in the neck and base of skull (not catecholamine producing)(Taïeb et al., 2019; NCCN, 2025).
- Cases of pheochromocytoma/paraganglioma can be sporadic but one-third are hereditary and due to germ-line mutations that may increase malignant potential (Taïeb et al., 2019; NCCN, 2025)

Suspected adrenocortical carcinoma

- Adrenocortical carcinoma may be suspected radiographically or clinically. Approximately 60% of individuals present with evidence of adrenal steroid hormone excess, with or without virilization. Hormonally inactive ACCs typically produce symptoms related to tumor burden, including abdominal pain, back pain, early satiety, and weight loss (Fassnacht et al., 2023; Shah et al., 2021).

Evidence Discussion

Current endocrine and oncology guidelines recommend cross-sectional imaging after biochemical evidence demonstrates adrenal hormone excess to localize the adrenal source, characterize adrenal lesions, and guide treatment planning (Adler et al., 2025; Fassnacht et al., 2023; Vaidya et al., 2019).

CT abdomen is generally the preferred initial imaging modality because it provides high spatial resolution and allows characterization of adrenal lesions based on size, attenuation, enhancement, and washout characteristics. These imaging features help distinguish benign adenomas from lesions requiring further evaluation, including pheochromocytoma, adrenocortical carcinoma, and metastatic disease (Fassnacht et al., 2023; Vaidya et al., 2019).

MRI with chemical-shift imaging serves as an important alternative when iodinated contrast administration is contraindicated or when additional lesion characterization is required. MRI can identify intracellular lipid and assist in differentiating benign adenomas from non-adenomatous lesions (Vaidya et al., 2019; Fassnacht et al., 2023).

For suspected pheochromocytoma or paraganglioma, imaging of both the abdomen and pelvis may be necessary because paragangliomas arise from extra-adrenal paraganglionic tissue and may occur throughout the sympathetic chain, including the abdomen and pelvis. Comprehensive imaging also contributes to staging and treatment planning (Taïeb et al., 2019; NCCN, 2025).

When adrenocortical carcinoma is suspected, cross-sectional imaging is essential for characterization of the primary lesion, assessment of local invasion, and evaluation for metastatic disease. Imaging findings directly influence surgical planning and staging (Shah et al., 2021; Fassnacht et al., 2023; Kiseljak-Vassiliades et al., 2020).

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Adrenal Insufficiency (AB-16.3)

AB.AC.0016.3.A
v1.0.2027

Criteria

- Biochemical confirmation of primary adrenal insufficiency is required prior to imaging and may be established by either:
  - Low morning cortisol with elevated ACTH, or
  - An abnormal/suboptimal corticotropin stimulation test.
- CT Abdomen (contrast as requested) is considered medically necessary if the cause of primary adrenal insufficiency is unclear.
  - MRI Abdomen (contrast as requested) is considered medically necessary if CT is contraindicated.
- Imaging is considered NOT medically necessary if clinical presentation and labs are consistent with ANY of the following:
  - Primary autoimmune destruction of the adrenal cortex (Addison's disease)
  - Congenital adrenal hyperplasia
  - Adrenoleukodystrophy

Evidence Discussion

Primary adrenal insufficiency should be established by biochemical testing before imaging is performed. Current endocrine guidelines recommend diagnosis based on laboratory evidence of adrenal failure, including a low morning cortisol level with elevated adrenocorticotropic hormone (ACTH) and/or an abnormal corticotropin stimulation test. Imaging is not intended to establish the diagnosis of primary adrenal insufficiency but rather to evaluate its underlying cause when the etiology remains uncertain (Bornstein et al., 2016; Charoensri & Auchus, 2024).

Computed tomography (CT) of the abdomen is the preferred initial imaging modality when evaluation of a structural cause of primary adrenal insufficiency is indicated. CT provides detailed assessment of adrenal gland morphology and can identify adrenal enlargement, calcification, hemorrhage, infiltrative processes, infection, primary adrenal tumors, and metastatic disease that may contribute to adrenal dysfunction (Bornstein et al., 2016; Hahner et al., 2021).

Imaging is most useful when the etiology of primary adrenal insufficiency remains unclear after clinical and laboratory evaluation. Potential causes identifiable on imaging include adrenal hemorrhage, tuberculosis and other infections, infiltrative disorders, primary adrenal malignancies, and metastatic disease. CT can detect characteristic morphologic findings that may help establish these diagnoses and guide further

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management (Abreu-Gomez et al., 2025; Badawy et al., 2021; Elhassan et al., 2023; Hahner et al., 2021).

Conversely, imaging is generally not indicated when clinical and laboratory findings establish a known autoimmune or genetic cause of primary adrenal insufficiency, such as autoimmune adrenalitis (Addison disease), congenital adrenal hyperplasia, or adrenoleukodystrophy, because imaging findings are unlikely to alter diagnosis or management in these conditions (Bornstein et al., 2016; Hahner et al., 2021).

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Abdominal Aortic Aneurysm (AAA), Iliac Artery Aneurysm (IAA), and Visceral Artery Aneurysms Follow-Up of Known Aneurysms and Pre-Op Evaluation (AB-17)

Guideline Page

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Abdominal Aortic Aneurysm (AAA) (AB-17.1)

AB.17.1.A
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- For the evaluation of an abdominal aortic aneurysm or pulsatile abdominal mass, see: **Abdominal Aortic Aneurysm (AAA) (PVD-6.3)** in the Peripheral Vascular Disease Imaging Guidelines.

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Iliac Artery Aneurysm (IAA) (AB-17.2)

AB.17.2.A
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- For the evaluation of iliac artery aneurysm (IAA) see: **Iliac Artery Aneurysm (IAA) (PVD-6.4)** in the Peripheral Vascular Disease Imaging Guidelines.

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Visceral Artery Aneurysm (AB-17.3)

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- For the evaluation of known or suspected visceral artery aneurysm, see: **Visceral Artery Aneurysm (PVD-6.5)** in the Peripheral Vascular Disease Imaging Guidelines.

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Abdominal Aortic Aneurysm (AAA) and Iliac Artery Aneurysm (IAA)-Post Endovascular or Open Aortic Repair (AB-18)

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AAA, IAA, Post Endovascular or Open Aortic Repair (AB-18.1)

AB.18.1.A

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- For open aortic abdominal aneurysm repair and additional imaging indications, see: **Post Aortic Endovascular/Open Surgery Surveillance Studies (PVD-6.8)** in the Peripheral Vascular Disease Imaging Guidelines.

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Aortic Dissection and Imaging for Other Aortic Conditions (AB-19)

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Aortic Dissection and Other Aortic Conditions (AB-19.1)

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- For the evaluation of aortic dissection and other aortic conditions, see: **Aortic Imaging** in the Peripheral Vascular Disease Imaging Guidelines.

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Imaging for Other Aortic Conditions (AB-19.2)

AB.19.2.A
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- For imaging indications for other aortic conditions, see: **Aortic Imaging** in the Peripheral Vascular Disease Imaging Guidelines.

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Bowel Obstruction, Gastroparesis, and Bloating (AB-20)

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Bowel Obstruction (AB-20.1)

AB.BO.0020.1.A
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Criteria

- Suspected bowel obstruction:
  - CT Abdomen and Pelvis with contrast (CPT® 74177) is considered medically necessary
  - Pediatric individuals:
    - MRI Abdomen and Pelvis without and with contrast (CPT® 74183 and CPT® 72197) is considered medically necessary in lieu of CT, if requested.
  - Pregnant individuals:
    - MRI Abdomen and Pelvis without contrast (CPT® 74181 and CPT® 72195) is considered medically necessary
  - 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 ONE of the following is considered medically necessary:
    - CT Enteroclysis (CPT® 74176 or CPT® 74177) OR
    - CT Enterography (CPT® 74177) OR
    - MR Enteroclysis (CPT® 74183 and CPT® 72197) OR
    - MR Enterography (CPT® 74183 and CPT® 72197)
- CT Enterography (CPT® 74177) is considered medically necessary if there is a suspected small bowel tumor as a cause of the small bowel obstruction (including a history of no prior abdominal or pelvic surgery, no known hernia and/or concomitant obscure GI bleeding)
- When Crohn's Disease is the suspected cause of small bowel obstruction:
  - See: Suspected **IBD (Crohn's Disease or Ulcerative Colitis) (AB-23.1)** and **Known IBD (AB-23.2)**
- For small bowel obstruction in individuals with a history of bariatric surgery, see: **Bariatric Surgery Post-Operative Complications (AB-9.1)**

Background and Supporting Information

- Complete or high-grade obstruction can be defined as no fluid or gas passing beyond the site of obstruction. In incomplete or partial obstruction (low-grade), some fluid or gas passes beyond the point of obstruction. A plain film is not required prior to advanced imaging for suspicion of either high- or low- grade obstruction (Chang et al., 2020).

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Evidence Discussion

Evidence synthesized in the ACR Appropriateness Criteria demonstrates that contrast-enhanced CT has high diagnostic accuracy for bowel obstruction, with strong performance in identifying transition points, determining severity, and detecting complications such as ischemia and perforation. Observational studies consistently show that CT findings guide management decisions, particularly in distinguishing partial from complete obstruction and identifying surgically urgent cases (Chang et al., 2020).

Advanced techniques such as CT enterography and enteroclysis improve detection of low-grade or intermittent obstruction by enhancing small bowel distention and mucosal detail. Clinical series report increased diagnostic yield in cases where standard CT is inconclusive and in the evaluation of suspected small bowel tumors, especially in individuals without prior surgery or with obscure gastrointestinal bleeding (Chang et al., 2020).

MRI is supported by safety and diagnostic data in radiation-sensitive populations. ACOG guidance indicates that MRI provides adequate evaluation of abdominal pathology without ionizing radiation and is appropriate in pregnancy when contrast is avoided. Pediatric literature also supports MRI as a radiation-sparing alternative, though limitations in motion sensitivity and availability remain (Committee Opinion No. 723, 2017; Chang et al., 2020).

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Nausea and Vomiting as the Primary Symptom (AB-20.3)

AB.BO.0020.3.A
v1.0.2027

Criteria

- The presence of any red flag findings per **General Guidelines (AB-1.0)** precludes adjudication based on any other criteria.
- Nausea and vomiting as the primary symptom
  - Prior to advanced imaging, an initial clinical assessment, including a thorough history and physical examination, should be performed. In the absence of findings suggestive of a serious underlying condition and when the etiology remains unclear, laboratory evaluation should be obtained and should include a complete blood count (CBC), chemistry profile, and pregnancy testing in individuals of reproductive age. Subsequent imaging should be guided by the findings of the initial evaluation, as follows:
    - CT Abdomen and Pelvis with contrast (CPT® 74177) is considered medically necessary for ANY of the following:
      - If the initial assessment does not suggest a specific cause
      - If the evaluation proves unproductive
    - Symptoms suggesting mucosal disease (e.g., gastroesophageal reflux disease (GERD), suspicion of ulcer disease):
      - EGD prior to advanced imaging
    - If nausea and vomiting remains unexplained despite workup and CT Abdomen and Pelvis is negative:
      - Gastric emptying study (CPT® 78264)
    - Symptoms suggesting an intracranial etiology (vertigo/nystagmus, associated headache, or neurogenic vomiting suggested by a positional nature and/or associated with other neurologic signs and symptoms):
      - See: **Headache (HD-11)** , **Dizziness, Vertigo and Syncope (HD-23)**, or other Head Imaging Guidelines depending on the predominant neurologic presentation
      - See: **General Guidelines – Other Imaging Situations (HD-1.7)** in the Head Imaging Guidelines for persistent, unexplained nausea and vomiting, when GI evaluation is negative.
    - Nausea and vomiting associated with RUQ pain, dyspeptic symptoms or epigastric pain, see: **Right Upper Quadrant and Epigastric Pain (AB-2.3)**

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Evidence Discussion

Nausea and vomiting should first be evaluated through a structured clinical assessment. Evidence supports the use of detailed history, physical examination, laboratory testing, and pregnancy assessment to identify common etiologies without immediate imaging (Scorza et al., 2007). This approach distinguishes among mucosal, obstructive, endocrine, neurologic, and medication-related causes and directs appropriate next steps.

Targeted testing is guided by clinical suspicion. Upper endoscopy is considered medically necessary when symptoms suggest mucosal disease such as reflux or peptic ulcer disease, and should precede advanced imaging. Similarly, imaging selection should reflect likely etiology rather than routine use. Appropriateness criteria emphasize reserving CT for cases in which the initial evaluation is non-diagnostic or when intra-abdominal pathology, such as obstruction or inflammation, is suspected (Chang et al., 2020; Scheirey et al., 2018).

CT of the abdomen and pelvis with contrast is supported when the initial assessment does not identify a cause or when evaluation remains unproductive. In this setting, CT provides high diagnostic yield for structural and inflammatory conditions that may explain persistent symptoms (Chang et al., 2020; Scheirey et al., 2018).

If nausea and vomiting remain unexplained despite appropriate evaluation and negative CT findings, gastric emptying scintigraphy is supported to assess for delayed gastric emptying. Evidence demonstrates its utility in identifying gastroparesis in individuals with persistent symptoms after exclusion of structural disease (Camilleri et al., 2022; Staller et al., 2025).

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Superior Mesenteric Artery (SMA) Syndrome (AB-20.4)

AB.BO.0020.4.A
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Criteria

- CTA Abdomen (CPT® 74175) or MRA Abdomen (CPT® 74185) are considered medically necessary for clinical suspicion of SMA syndrome and ANY of the following:
  - Recent significant weight loss which leads to a loss of retroperitoneal fat
  - Presence of a severe debilitating illness such as malignancy, malabsorption syndromes, acquired immunodeficiency syndrome (AIDS), high-level trauma, and extensive burns
  - History of corrective spine surgery for scoliosis
  - Anorexia Nervosa
  - Abdominal surgery
  - Congenital short ligament of Treitz
  - Radiologic findings or clinical history suggestive of duodenal obstruction
  - Failure to diagnose persistent nausea and/or vomiting despite the workup outlined in **Nausea and Vomiting as the Primary Symptom (AB-20.3)**

Background and Supporting Information

- Superior mesenteric artery (SMA) syndrome is a rare cause of duodenal obstruction in which there is a decrease in the aortomesenteric angle with resulting compression of the duodenum by the SMA (Haider et al., 2020; Oka et al., 2023).
- The typical clinical scenario includes an episode of weight loss followed by chronic food intolerance with nausea and vomiting, further weight loss, and epigastric pain, and can be relieved by lying prone or in the left lateral decubitus position (Oka et al., 2023; Hakimian & Torkelson, 2023; Sinagra et al., 2018).
- The diagnosis can be suspected with barium studies demonstrating delayed passage of contrast beyond the duodenum, dilatation of the first and second portions of the duodenum, anti-peristaltic flow of barium proximal to the obstruction, and relief of obstruction when placed in the prone, knee-chest, or left lateral position, or with an upper endoscopy revealing pulsatile extrinsic compression of the duodenum, or plain films suggesting duodenal obstruction (Oka et al., 2023; Hakimian & Torkelson, 2023; Sinagra et al., 2018).

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Evidence Discussion

CTA or MRA of the abdomen is the diagnostic standard for suspected superior mesenteric artery (SMA) syndrome, supported by case series and clinical reviews demonstrating accurate visualization of the aortomesenteric angle and distance. These measurements are essential for confirming vascular compression of the third portion of the duodenum and correlate with the clinical features of obstruction (Oka et al., 2023; Sinagra et al., 2018).

The literature identifies predisposing factors such as rapid weight loss, severe catabolic illness, prior spine surgery, and anatomic variants that reduce the aortomesenteric angle and increase the risk of duodenal compression. These clinical contexts support targeted use of CTA or MRA when suspicion is high (Oka et al., 2023; Hakimian & Torkelson, 2023).

Other diagnostic modalities, including upper gastrointestinal studies or endoscopy, may demonstrate duodenal dilation or suggest obstruction but lack specificity and cannot confirm the vascular etiology. As a result, they are considered adjunctive rather than definitive (Haider et al., 2020; Oka et al., 2023).

CTA or MRA is therefore supported when clinical suspicion persists, particularly in individuals with risk factors or unexplained, persistent nausea and vomiting despite prior evaluation. These modalities provide both diagnostic confirmation and exclusion of alternative causes of obstruction, aligning with their use in cases where initial workup is non-diagnostic (Oka et al., 2023; Sinagra et al., 2018; Hakimian & Torkelson, 2023).

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Bloating, Gas, and Distention (AB-20.5)

AB.BO.0020.5.A
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Criteria

- The presence of any red flag findings per **General Guidelines (AB-1.0)** precludes adjudication based on any other criteria.
- For bloating as the primary symptom, present for at least 3 months, see: **Irritable Bowel Syndrome (AB-21.4)**
- For documented suspicion of bowel obstruction (e.g., individuals with prior abdominal surgery, previous history of SBO, known adhesions, history of Crohn's Disease, etc.) see: **Bowel Obstruction (AB-20.1)**.
- If associated with constipation, see: **Constipation (AB-21.3)**
- If associated with dyspeptic symptoms, see: **Right Upper Quadrant and Epigastric Pain (AB-2.3)**
- CT Abdomen and Pelvis with contrast (CPT® 74177) is considered medically necessary if ANY of the following clinical features are present:
  - History of malignancy with documented risk of abdominal or intra-abdominal metastasis
  - Fever (101 degrees Fahrenheit [38.5 degrees Celsius] or higher)
  - Elevated WBC greater than 10,000 cells/mm³, or above the upper limit of normal for the particular lab reporting the result
  - Low WBC (absolute neutrophil count less than 1,000 cells/mm³)
  - Palpable abdominal mass of clinical concern
  - GI bleeding, overt or occult, not obviously hemorrhoidal
  - Abdominal tenderness documented as moderate or severe
  - Peritoneal signs, such as guarding or rebound tenderness
  - Suspected complication of bariatric surgery
  - Documentation by the ordering provider that the individual has a "surgical abdomen"
  - Age 60 years or older with unintentional weight loss of 10 pounds or more, or 5% or more of body weight over 6 months or less, without an identifiable reason

Background and Supporting Information

Bloating and abdominal distension are common gastrointestinal complaints, affecting a substantial proportion of individuals with irritable bowel syndrome and an estimated 20–30% of the general population (Lacy et al., 2021; Sperber et al., 2021). Bloating refers to the subjective sensation of increased abdominal pressure, whereas distension

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represents an objective increase in abdominal girth (Lacy et al., 2021; Moshiree et al., 2023).

The American Gastroenterological Association (AGA) has published best practice advice for the evaluation and management of belching, bloating, and distension. These recommendations emphasize the importance of a thorough clinical history and physical examination, targeted evaluation for dietary and functional causes, and selective use of diagnostic testing (Moshiree et al., 2023). The AGA advises that additional diagnostic studies, including serologic testing, endoscopy, imaging, and motility studies, should be guided by clinical presentation and reserved for individuals with concerning features or refractory symptoms (Moshiree et al., 2023).

Evidence Discussion

Determining when symptoms of bloating, gas, and abdominal distension warrant imaging is guided by clinical risk stratification, including individual age, symptom severity, and the presence of alarm features such as weight loss, anemia, gastrointestinal bleeding, or persistent or worsening symptoms (Moshiree et al., 2023; Lacy et al., 2021). In the absence of these features, routine imaging is generally not indicated (Moshiree et al., 2023).

Computed tomography (CT) of the abdomen provides high-resolution, cross-sectional evaluation of the gastrointestinal tract and surrounding structures, particularly when performed with intravenous (IV) and/or oral contrast (American College of Radiology [ACR], 2019). CT imaging allows for comprehensive assessment of intra-abdominal pathology and is highly sensitive for detecting conditions such as bowel obstruction, intra-abdominal malignancy, ischemia, and infectious or inflammatory processes (Chang et al., 2020; Scheirey et al., 2018).

In individuals with concerning clinical features or suspected complications, CT plays an important role in identifying or excluding serious underlying pathology that may not be apparent through clinical evaluation alone. However, its use should be selective, as most individuals with functional gastrointestinal disorders do not have structural abnormalities detectable on imaging (Lacy et al., 2021; Moshiree et al., 2023).

CT imaging involves exposure to ionizing radiation and, when contrast is used, carries additional risks including allergic reaction and contrast-induced nephropathy in susceptible individuals (ACR Committee on Drugs and Contrast Media, 2023). Despite these risks, the rapid image acquisition and high diagnostic accuracy of CT make it an appropriate modality when clinically indicated, particularly in higher-risk individuals where timely diagnosis is critical (Chang et al., 2020; Scheirey et al., 2018).

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Diarrhea, Constipation, and Irritable Bowel (AB-21)

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Acute and Persistent Diarrhea (Up to 30 Days) (AB-21.1)

AB.DC.0021.1.A
v1.0.2027

Criteria

- The presence of any red flag findings per **General Guidelines (AB-1.0)** precludes adjudication based on any other criteria.
- Routine advanced imaging is considered not medically necessary for uncomplicated diarrhea (up to 30 days in duration).
- Prior to advanced imaging, individuals with travel and/or dysenteric (including bloody) diarrhea should undergo biological assessment and/or antimicrobial treatment.
- CT Abdomen and Pelvis with contrast (CPT® 74177) is considered medically necessary if:
  - Suspected ischemia (See: **Mesenteric Ischemia (AB-6.1)** and **Colonic Ischemia (AB-6.2)**) OR
  - Individuals older than 50 years of age with significant abdominal pain OR
  - Previous gastric bypass OR
  - Immunocompromised OR
  - Obstruction, toxic megacolon, or perforation suspected

Evidence Discussion

Acute diarrhea is most often due to self-limited infectious causes, with resolution typically occurring within one to four weeks. In this setting, routine advanced imaging has low diagnostic yield and is considered not medically necessary. Evaluation is guided by clinical assessment, with stool-based testing and, when indicated, empiric antimicrobial therapy in individuals with travel-associated or dysenteric diarrhea (Shane et al., 2017; Hamilton & Cifu, 2019; Smalley et al., 2019).

CT of the abdomen and pelvis with intravenous contrast is appropriate when clinical features raise concern for complications or alternative diagnoses associated with increased morbidity. These include suspected bowel ischemia, obstruction, perforation, or toxic megacolon, as well as presentations in higher-risk populations such as older adults with significant abdominal pain, individuals with prior gastric bypass, and those who are immunocompromised. In these settings, CT provides accurate detection of structural and vascular pathology, including obstruction, perforation, severe colitis, and impaired bowel perfusion. Intravenous contrast improves evaluation of bowel wall enhancement and mesenteric vasculature, which is essential for identifying ischemic

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or inflammatory processes (Hamilton & Cifu, 2019; McDonald et al., 2018; Ihara et al., 2024).

Abdomen Imaging Guidelines

Chronic Diarrhea (More than 30 Days) (AB-21.2)

AB.DC.0021.2.A
v1.0.2027

Criteria

- Prior to advanced imaging, basic lab work should include routine CBC, chemistries, as well as stool tests for pathogens.
- CT Abdomen with contrast (CPT® 74160), CT Abdomen and Pelvis with contrast (CPT® 74177), CT Enterography (CPT® 74177), or MR Enterography (CPT® 74183 or CPT® 74183 and CPT® 72197), is considered medically necessary if ALL of the following have been performed:
  - Colonoscopy has been performed and is nondiagnostic or suggestive of inflammatory bowel disease
  - Fecal calprotectin or fecal lactoferrin testing has been performed
  - Testing for giardia antigen or polymerase chain reaction (PCR) for giardia have been performed
  - Testing for celiac disease with serum immunoglobulin A (IgA) tissue transglutaminase (tTG) has been performed.
- See: **Suspected IBD (Crohn's Disease or Ulcerative Colitis) (AB-23.1)** for concerns regarding inflammatory bowel disease.

Evidence Discussion

Chronic diarrhea is defined as symptoms persisting or recurring for four weeks or longer, reflecting a shift from primarily infectious causes to functional, inflammatory, malabsorptive, or structural conditions (Ihara et al., 2024; Arasaradnam et al., 2018). Initial evaluation is non-imaging based and includes laboratory testing, stool studies, and endoscopic assessment. Recommended testing includes complete blood count, serum chemistries, stool studies for infectious pathogens, fecal inflammatory markers such as calprotectin or lactoferrin, and targeted testing for conditions including celiac disease and giardiasis (Smalley et al., 2019; Burgers et al., 2020; Arasaradnam et al., 2018).

Cross-sectional imaging is appropriate only after this evaluation has been completed and remains nondiagnostic, including colonoscopy findings that are either unrevealing or suggestive of inflammatory bowel disease. In this context, CT of the abdomen or abdomen and pelvis with contrast is indicated for suspected obstruction, malignancy, or extra-luminal disease. CT enterography or MR enterography is appropriate when small bowel pathology is suspected, particularly Crohn's disease, as these techniques improve evaluation of mucosal and transmural inflammation (Arasaradnam et al., 2018;

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Ihara et al., 2024). MRI may be preferred when radiation avoidance is desired, while CT remains widely used due to availability and diagnostic accuracy (Arasaradnam et al., 2018; Ihara et al., 2024).

Abdomen Imaging Guidelines

Constipation (AB-21.3)

AB.DC.0021.3.A
v1.0.2027

Criteria

- The presence of any red flag findings per **General Guidelines (AB-1.0)** precludes adjudication based on any other criteria.
- CT Abdomen and Pelvis with contrast (CPT® 74177) is considered medically necessary if:
  - Concern for obstruction
- MRI Defecography (MRI Pelvis without contrast CPT® 72195) is considered medically necessary if the following conditions are met:
  - Individual has undergone ano-rectal manometry **and** a balloon-expulsion test, **and** the results confirm a defecatory disorder, **and** the individual has failed a trial of biofeedback or other conservative therapy.

  OR

  - There are conflicting results between ano-rectal manometry **and** balloon expulsion test **or** one of these studies is not able to be performed **or** there is a need to identify structural abnormalities (i.e., retroceles, rectal intussusception, prolapse)

  OR

  - To guide planned surgical therapy for rectoceles, cystoceles, or uterine prolapse.

Background and Supporting Information

Defecography is an imaging modality used in the evaluation of constipation to assess structural causes of outlet dysfunction, including rectal prolapse, rectocele, and enterocele (Wald et al., 2021; Rao et al., 2026). Defecography can be performed using fluoroscopic barium techniques (conventional defecography) or magnetic resonance imaging (dynamic MRI) (van Iersel et al., 2017; Rao et al., 2026).

Gastroenterology and colorectal surgery society guidelines recommend colonoscopy as part of the initial evaluation in individuals with chronic constipation who present with alarm features such as hematochezia, anemia, or unintentional weight loss to exclude malignancy or other serious pathology (Alavi et al., 2024; Wald et al., 2021).

Evidence Discussion

Clinical presentation and results of minimally invasive testing guide the appropriate use of imaging in constipation. Evidence-based guidelines and systematic reviews consistently demonstrate that imaging is not routinely indicated in uncomplicated

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constipation and should be reserved for individuals with alarm features, suspected secondary causes, or refractory symptoms after initial evaluation (Luo et al., 2025; Wald et al., 2021; Alavi et al., 2024).

Cross-sectional imaging with computed tomography (CT) plays a central role in individuals presenting with constipation accompanied by red flag symptoms such as weight loss, anemia, gastrointestinal bleeding, or suspected infection or malignancy. Evidence demonstrates that CT has a high diagnostic yield for identifying secondary causes of constipation, including obstructive lesions, inflammatory processes, and malignancy, due to its ability to evaluate both the bowel and extraintestinal structures (Alavi et al., 2024; Rao et al., 2026). The rapid acquisition time further supports its use in acute or clinically complex presentations. While CT involves ionizing radiation and potential risks related to intravenous contrast, these risks are outweighed in clinical scenarios where serious underlying pathology is suspected and timely diagnosis is necessary (Rao et al., 2026).

In contrast, dynamic pelvic floor imaging is indicated in individuals with chronic, refractory constipation when a defecatory disorder is suspected. Evidence supports the use of defecography following nondiagnostic or confirmatory physiologic testing, such as anorectal manometry and balloon expulsion testing, to further characterize structural and functional abnormalities (Blackett et al., 2022; Rao et al., 2026; Wald et al., 2021). Comparative studies demonstrate that magnetic resonance (MR) defecography provides superior soft tissue contrast and improved detection of certain abnormalities, such as intussusception, compared with conventional fluoroscopic defecography, although fluoroscopic techniques may remain more sensitive for detecting rectocele and enterocele (van Iersel et al., 2017).

MR defecography is particularly valuable for comprehensive evaluation of pelvic floor dysfunction and preoperative planning, as it allows simultaneous visualization of multiple pelvic compartments without radiation exposure. Its use is supported in individuals with persistent symptoms despite conservative management or when noninvasive testing is inconclusive (Alavi et al., 2024; Wald et al., 2021; Rao et al., 2026). The absence of ionizing radiation makes MR defecography preferable in select populations; however, longer acquisition times and susceptibility to motion artifact may limit diagnostic accuracy in some cases (Rao et al., 2026; van Iersel et al., 2017).

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Irritable Bowel Syndrome (AB-21.4)

AB.DC.0021.4.A
v1.0.2027

Criteria

- The presence of any red flag findings per **General Guidelines (AB-1.0)** precludes adjudication based on any other criteria.
- Advanced imaging in the absence of alarm symptoms has a low diagnostic yield, however imaging can be considered medically necessary in the following circumstances:
  - CT Abdomen with contrast (CPT® 74160) or CT Abdomen and Pelvis with contrast (CPT® 74177) is considered medically necessary in the following circumstances:
    - Presence of ANY of the following alarm symptoms:
      - Unintentional weight loss of 10 pounds or more or 5% or more of body weight over 6 months or less, without an identifiable cause.
      - Frequent nocturnal awakenings due to gastrointestinal symptoms
      - Fever (101 degrees Fahrenheit [38.5 degrees Celsius] or higher)
      - Blood in the stool or iron deficiency anemia (See: **GI Bleeding (AB-22)** for appropriateness of imaging in this circumstance)
      - New onset and progressive symptoms
      - Onset of symptoms after age 50
      - Family history of colon cancer or inflammatory bowel disease
      - Findings of an abdominal mass
      - Presence of lymphadenopathy
    - After ALL of the following studies have been performed:
      - Fecal calprotectin of 50ug/g or greater, fecal lactoferrin of 4.0ug/g or greater, or CRP greater than 0.5 in individuals with diarrhea-predominance
      - Testing for giardia antigen or PCR for giardia
      - Celiac testing should also be performed in individuals with diarrhea-predominance IBS, and if positive see: **Celiac Disease (AB-24.1)** for imaging guidance.

Background and Supporting Information

Irritable bowel syndrome (IBS) is a disorder of gut–brain interaction characterized by recurrent abdominal pain associated with altered bowel habits, abdominal distention, and bloating (Drossman et al., 2026; Lacy et al., 2021; Vasant et al., 2021). IBS is a positive clinical diagnosis rather than a diagnosis of exclusion, and current guidelines

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recommend a symptom-based diagnostic approach (Lacy et al., 2021; Drossman et al., 2026).

IBS is classified into subtypes based on predominant stool pattern, including constipation-predominant (IBS-C), diarrhea-predominant (IBS-D), mixed (IBS-M), and unclassified IBS (Lacy et al., 2021; Savarino et al., 2022).

The Rome V framework continues to define IBS using symptom-based diagnostic criteria centered on recurrent abdominal discomfort or pain associated with defecation and changes in stool frequency or form at least three days per month, while further emphasizing its classification as a disorder of gut–brain interaction (Drossman et al., 2026; Lacy et al., 2021).

Evidence Discussion

Risk stratification based on demographic and clinical factors,such as age, family history, symptom onset, associated alarm features, and physical examination findings, determines when imaging is medically necessary in individuals with suspected irritable bowel syndrome (IBS). Evidence-based guidelines consistently emphasize that routine imaging is not indicated in individuals with typical IBS symptoms who meet symptom-based diagnostic criteria in the absence of alarm features (Lacy et al., 2021; Vasant et al., 2021; Drossman et al., 2026).

Imaging is reserved for a subset of individuals in whom clinical features raise concern for alternative or serious underlying pathology. Alarm features, including gastrointestinal bleeding, anemia, unintentional weight loss, nocturnal symptoms, or a family history of colorectal cancer or inflammatory bowel disease, warrant further diagnostic evaluation to exclude inflammatory or malignant conditions (Lacy et al., 2021; Vasant et al., 2021).

Cross-sectional imaging, particularly computed tomography (CT), is supported in these higher-risk populations due to its ability to detect structural, inflammatory, and neoplastic processes affecting the gastrointestinal tract and surrounding structures (Savarino et al., 2022; Vasant et al., 2021). CT demonstrates high diagnostic utility in identifying conditions such as bowel obstruction, inflammatory bowel disease, and malignancy, particularly in individuals with atypical presentations or concerning clinical features (Savarino et al., 2022).

The use of CT must be balanced against its risks, including exposure to ionizing radiation and potential adverse effects from intravenous contrast. However, in appropriately selected high-risk individuals, the diagnostic benefit of CT imaging outweighs these risks by enabling timely identification of clinically significant pathology that would not be expected in uncomplicated IBS (Lacy et al., 2021; Drossman et al., 2026; Vasant et al., 2021).

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Fecal Incontinence (AB-21.5)

AB.FI.0021.5.A
v1.0.2027

Criteria

The evaluation of fecal incontinence generally proceeds as follows:

- Determine the severity of the incontinence (Bristol Stool Scale, Fecal Incontinence Severity Index, etc.)
- History and physical to include digital rectal examination and perianal pinprick (to assess for neurogenic causes)
- Trial of conservative management
- Diagnostic testing if symptoms persist to include:
  - Ano-rectal Manometry (manometry, sensation, volume tolerance, and compliance)
  - Balloon Expulsion Test
  - Endoanal ultrasound (CPT® 76872) to confirm sphincter defects in individuals with suspected sphincter injury (e.g. history of vaginal delivery or anorectal surgery)
  - MRI Pelvis without and with contrast (CPT® 72197) or MRI Defecography (CPT® 72195) is considered medically necessary if:
    - Ano-rectal manometry suggests weak sphincter pressures **AND/OR** there is an abnormal balloon expulsion test **AND**
    - There has been failure of a trial of conservative management since the onset of or change in symptoms **AND**
    - Results of imaging would modify planned management

Background and Supporting Information

Fecal incontinence (FI) is the recurrent involuntary passage of stool and may result from impairment of the anal sphincter complex, pelvic floor dysfunction, altered rectal sensation or compliance, or neurologic dysfunction (Wald et al., 2021).

The American Society of Colon and Rectal Surgeons (ASCRS) recommends endoanal ultrasound (EAUS) as a useful diagnostic tool in the evaluation of individuals with fecal incontinence, particularly in individuals with a history of vaginal delivery or anorectal surgery. EAUS can identify internal and external anal sphincter defects that may contribute to sphincter dysfunction (Bordeianou et al., 2023).

The American College of Gastroenterology (ACG) and ASCRS recommend physiologic testing, including anorectal manometry and balloon expulsion testing, in individuals whose symptoms persist despite conservative management to further characterize

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anorectal function and guide treatment decisions (Wald et al., 2021; Bordeianou et al., 2023).

Evidence Discussion

The evaluation of fecal incontinence begins with a comprehensive history and physical examination, including anorectal examination, to identify potential structural, neurologic, and functional causes of symptoms. Professional society guidelines from the American College of Gastroenterology (ACG), American Society of Colon and Rectal Surgeons (ASCRS), and American College of Obstetricians and Gynecologists (ACOG) support this approach as the foundation of diagnostic evaluation (ACOG, 2019; Bordeianou et al., 2023; Wald et al., 2021).

For individuals who fail conservative management, anorectal manometry and balloon expulsion testing provide objective assessment of anorectal sensation, sphincter function, rectal compliance, and defecatory dysfunction. These tests help guide subsequent diagnostic evaluation and therapeutic decision-making (Sbeit et al., 2021; Wald et al., 2021).

Evidence supports EAUS as the preferred imaging modality for suspected anal sphincter injury. EAUS is widely available, well tolerated, and demonstrates high diagnostic accuracy for identifying internal and external anal sphincter defects. In addition, studies have shown good interobserver agreement for the detection and characterization of sphincter abnormalities, supporting its role as the first-line imaging examination in individuals with suspected obstetric or surgery-related sphincter injury (Bordeianou et al., 2023; Sbeit et al., 2021).

MRI provides complementary anatomic information in the evaluation of fecal incontinence. The ACG notes that EAUS more clearly visualizes the internal anal sphincter, whereas MRI is superior for distinguishing external anal sphincter tears from scar tissue and for identifying external sphincter atrophy (Wald et al., 2021). MRI defecography may also provide functional assessment of pelvic floor disorders and impaired evacuation. Accordingly, MRI is most appropriately utilized when physiologic testing demonstrates abnormalities and surgical intervention is being considered, or when additional characterization of sphincter pathology is needed beyond that provided by EAUS (Sbeit et al., 2021; Wald et al., 2021).

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GI Bleeding (AB-22)

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GI Bleeding (AB-22.1)

AB.GI.0022.1.A
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Criteria

- CTA Abdomen (CPT® 74175), CTA Abdomen and Pelvis (CPT® 74174), or CT Abdomen and Pelvis with contrast (CPT® 74177) are considered medically necessary for the initial evaluation of ANY of the following:
  - If therapeutic angiography is being considered
  - If colonoscopy cannot be performed in an individual with active lower GI bleeding
  - If endoscopy cannot be performed in an individual with active upper GI bleeding
  - If surgery is being considered for treatment of GI bleeding
  - GI bleeding with moderate to severe abdominal pain and/or tenderness
  - GI bleeding and hemodynamic instability
  - If there is concern for an aorto-enteric fistula, including known or suspected aortic aneurysm, or history of any type of aortic aneurysm repair
- If there is brisk active GI bleeding AND endoscopy does not reveal a source
  - Gastrointestinal Bleeding Scintigraphy (CPT® 78278) is considered medically necessary
- Iron Deficiency Anemia:
  - If the bleeding is of suspected gastrointestinal origin:
    - Upper endoscopy and colonoscopy should be performed, unless contraindicated
    - Small bowel video capsule endoscopy is medically necessary, if upper and lower endoscopies are negative
    - If small bowel video capsule endoscopy is negative OR for further evaluation of abnormal video capsule findings ONE of the following is considered medically necessary:
      - CT Abdomen and Pelvis with contrast (CPT® 74177)
      - CT Enterography (CPT® 74177)
      - MR Entergraphy (CPT® 74183 or CPT® 74183 and CPT® 72197) is medically necessary if there is a contraindication to CT Enterography.
- If the bleeding is determined to be non-gastrointestinal, refer to the appropriate condition-based guideline.

Evidence Discussion

Cross-sectional imaging is used selectively in gastrointestinal bleeding based on severity, hemodynamic status, and whether endoscopy can be performed. When endoscopy is not feasible, incomplete, or nondiagnostic in the setting of ongoing or

brisk bleeding, CT angiography (CTA) is the preferred next step (Sengupta et al., 2024; Nagpal et al., 2024).

CTA enables rapid detection and precise localization of active hemorrhage, typically at bleeding rates of 0.3 to 0.5 mL/min, while also identifying underlying causes. This capability is critical when therapeutic angiography or surgery is being considered, as localization improves procedural success and reduces unnecessary intervention (Wortman et al., 2017; Sengupta et al., 2024). It is also well suited for individuals with hemodynamic instability or abdominal pain, where evaluation of vascular, mesenteric, and extraluminal pathology is required (Nagpal et al., 2024; Sengupta et al., 2024).

Gastrointestinal bleeding scintigraphy detects slower or intermittent bleeding at lower rates but lacks anatomic precision. Its role is therefore limited to cases where bleeding is not brisk or CTA is nondiagnostic (Sengupta et al., 2024).

In iron deficiency anemia, bidirectional endoscopy is the initial evaluation. When negative, capsule endoscopy is recommended for small bowel assessment. Cross-sectional imaging is reserved for cases with negative or inconclusive capsule findings or when further anatomical characterization is required (DeLoughery et al., 2024; Pennazio et al., 2023; Thakral et al., 2024; Auerbach et al., 2025).

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Small Bowel Bleeding Suspected (AB-22.2)

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Criteria

- If the small bowel is the suspected source of bleeding, and if endoscopic studies (upper endoscopy, colonoscopy and if available video capsule endoscopy) are unrevealing:
  - CT Enterography (CPT® 74177) is considered medically necessary
  - MR Enterography (CPT® 74183 or CPT® 74183 and CPT® 72197) is considered medically necessary, if there is a contraindication to CT Enterography
- Meckel's scan (CPT® 78290) is considered medically necessary if bleeding is suspected from a Meckel's diverticulum.

Evidence Discussion

Small bowel bleeding is an uncommon but important cause of persistent bleeding after negative upper and lower endoscopy. Evaluation prioritizes mucosal visualization followed by selective use of cross-sectional imaging (Pennazio et al., 2023; Thakral et al., 2024).

Video capsule endoscopy (VCE) is the first-line test in stable individuals, as it allows noninvasive visualization of the small bowel with a high diagnostic yield and strong predictive value for clinically significant lesions (Pennazio et al., 2023; Wild & Ko, 2025). Findings from VCE frequently guide therapeutic endoscopy, surgery, or medical management (Pennazio et al., 2023; Thakral et al., 2024).

Routine imaging prior to VCE is not indicated. CT or MR enterography should be obtained before capsule placement only in individuals at risk for retention, including those with obstructive symptoms, Crohn's disease, prior radiation, or suspected tumors (Pennazio et al., 2023).

Following a negative or inconclusive VCE, CT enterography is generally preferred due to its availability and high spatial resolution. It allows detection and characterization of masses, vascular lesions, and inflammatory disease not fully defined on capsule imaging (Thakral et al., 2024; Wild & Ko, 2025; Pennazio et al., 2023). MR enterography is a reasonable alternative when radiation exposure is a concern but is used less frequently due to practical limitations (Pennazio et al., 2023; Thakral et al., 2024).

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Inflammatory Bowel Disease (AB-23)

Guideline Page

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Suspected IBD (Crohn's Disease or Ulcerative Colitis) (AB-23.1)

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v1.0.2027

Criteria

- Suspected Crohn's Disease or Ulcerative Colitis:
  - CT Abdomen and Pelvis with contrast (CPT® 74177) OR CT Enterography (CPT® 74177) OR MR Enterography (CPT® 74183 or CPT® 74183 and CPT® 72197) is considered medically necessary for ANY of the following:
    - History of malignancy with documented risk of abdominal or intra-abdominal metastasis
    - Fever (101 degrees Fahrenheit [38.5 degrees Celsius] or higher)
    - Elevated WBC greater than 10,000 cells/mm³, or above the upper limit of normal for the particular lab reporting the result
    - Palpable abdominal mass of clinical concern
    - GI bleeding, overt or occult, not obviously hemorrhoidal
    - Abdominal tenderness documented as moderate or severe
    - Peritoneal signs, such as guarding or rebound tenderness
    - Suspected complication of bariatric surgery
    - Documentation by the ordering provider that the individual has a "surgical abdomen"
    - Age 60 years or older with unintentional weight loss of 10 pounds or more, or 5% or more of body weight over 6 months or less, without an identifiable reason
  - Chronic diarrhea without the above signs or symptoms, see: **Diarrhea, Constipation, and Irritable Bowel (AB-21)**
  - CT Enterography (CPT® 74177) OR MR Enterography (CPT® 74183 or CPT® 74183 and CPT® 72197) is considered medically necessary for the evaluation of chronic abdominal pain with diarrhea in the absence of red flag criteria (as noted in **General Guidelines AB-1.0**) when there is documented concern for inflammatory bowel disease and if ANY of the following:
    - 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 of 4.0 ug/g or greater, CRP greater than 0.5 mg/dL, or fecal calprotectin 50 ug/g or greater), **OR**
    - Diagnosis is still in doubt after colonoscopy and evaluation of inflammatory markers, and Crohn's disease is suspected

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- CT Abdomen and Pelvis with or without contrast (CPT® 74177 or CPT® 74176) can be performed prior to endoscopy if requested by or in consultation with the provider who will be performing the endoscopy.

Background and Supporting Information

Serologic and genetic markers have been investigated for their potential role in the diagnosis of inflammatory bowel disease (IBD). These markers may be considered in select clinical scenarios where conventional diagnostic evaluations are inconclusive; however, current clinical guidelines do not recommend their routine use for screening or diagnosis in individuals presenting with gastrointestinal symptoms (Lichtenstein et al., 2025; Rubin et al., 2025; Smalley et al., 2019).

In particular, the presence of an isolated positive serologic or genetic marker, without corroborating clinical findings such as elevated inflammatory biomarkers or abnormal endoscopic evaluation, is not sufficient to establish a diagnosis of IBD (Lichtenstein et al., 2025; Rubin et al., 2025). As a result, such findings alone should not be used to guide decisions regarding advanced imaging.

Commonly evaluated serologic markers include anti-glycan antibodies (e.g., anti-Saccharomyces cerevisiae antibodies [ASCA], anti-chitobioside carbohydrate antibodies [ACCA], anti-laminaribioside carbohydrate antibodies [ALCA], anti-mannobioside carbohydrate antibodies [AMCA]), as well as anti–outer membrane porin C (anti-OmpC), anti-CBir1, perinuclear anti-neutrophil cytoplasmic antibodies (pANCA), pancreatic antibodies (PAB), and goblet cell antibodies (GAB). These markers may provide adjunctive information but lack sufficient sensitivity and specificity to independently confirm or exclude disease (Lichtenstein et al., 2025; Rubin et al., 2025).

Evidence Discussion

The use of noninvasive biomarkers and imaging modalities in suspected inflammatory bowel disease (IBD) has been extensively evaluated to determine their diagnostic utility and appropriate role in clinical decision-making. Current evidence supports the use of inflammatory biomarkers, such as fecal calprotectin and C-reactive protein (CRP), as effective tools for risk stratification and exclusion of disease in low-risk individuals.

A meta-analysis demonstrated that low levels of fecal calprotectin (less than 40 mcg/g) or CRP (0.5 mg/dL or less) are associated with a high negative predictive value for IBD, supporting their role in distinguishing functional gastrointestinal disorders, such as irritable bowel syndrome, from inflammatory conditions. These findings indicate that, in the absence of objective inflammatory markers, the likelihood of underlying IBD is low and further invasive or advanced diagnostic testing may not be warranted (Smalley et al., 2019; Lichtenstein et al., 2025).

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Similarly, Katsinelos et al. evaluated the diagnostic yield of capsule endoscopy in individuals presenting with abdominal pain and diarrhea. The study demonstrated a diagnostic yield of 90.1% in individuals with elevated inflammatory markers, compared to 0% in those without evidence of inflammation. These findings highlight the limited utility of advanced imaging modalities, such as capsule endoscopy, in individuals without biochemical or clinical evidence of inflammatory disease (Katsinelos et al., 2011).

Consistent with these data, the Canadian Association of Gastroenterology (CAG) recommends against the routine use of capsule endoscopy in individuals presenting with chronic abdominal pain or diarrhea in the absence of abnormal inflammatory biomarkers or prior abnormal endoscopic or imaging findings (Enns et al., 2017). This recommendation reflects the low diagnostic yield and limited clinical value of advanced imaging in low-risk populations.

Additional guidance from professional societies, including the American College of Gastroenterology (ACG) and the American College of Radiology (ACR), emphasizes that imaging and advanced diagnostic evaluation should be reserved for individuals with objective evidence of inflammation or other findings suggestive of IBD (Kim et al., 2020; Lichtenstein et al., 2025; Rubin et al., 2019). These recommendations support a stepwise diagnostic approach in which noninvasive biomarkers are used to guide the need for further testing.

Further imaging-based studies have demonstrated the utility of modalities such as MR enterography in assessing disease activity when IBD is clinically suspected and supported by objective findings, reinforcing that imaging is most effective when applied in appropriately selected individual populations (Kim et al., 2017; Soydan et al., 2019).

Collectively, the available evidence demonstrates that in individuals without objective evidence of inflammation, such as normal fecal calprotectin, normal CRP, and unremarkable endoscopic findings, the diagnostic yield of advanced imaging is low. Accordingly, the routine use of advanced imaging in this population is unlikely to provide clinically meaningful benefit and is not supported by current evidence-based guidelines (Enns et al., 2017; Kim et al., 2020; Lichtenstein et al., 2025; Rubin et al., 2019).

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Known IBD (AB-23.2)

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Criteria

- CT Abdomen and Pelvis with contrast (CPT® 74177), CT Enterography (CPT® 74177), or MR Enterography (CPT® 74183 or CPT® 74181 and CPT® 72197 or CPT® 72195) is considered medically necessary for individuals with known Crohn's Disease or Ulcerative Colitis and ANY of the following:
  - To determine change in treatment
  - Monitoring response to therapy
  - Suspected complications including abscess, perforation, fistula, or obstruction

Evidence Discussion

Cross-sectional imaging is indicated in established inflammatory bowel disease (IBD) when objective assessment of inflammation or complications will alter management. Both CT enterography and MR enterography (MRE) demonstrate high accuracy for detecting active disease and complications, including abscess, fistula, perforation, and obstruction (Lichtenstein et al., 2025). These findings directly inform treatment modification, as imaging-defined inflammation and penetrating disease correlate with the need for escalation or change in therapy (Lichtenstein et al., 2025; Rubin et al., 2025).

MRE is preferred for serial evaluation due to the absence of ionizing radiation, while maintaining diagnostic performance comparable to CT (Lichtenstein et al., 2025). Diffusion-weighted imaging further improves sensitivity to active inflammation and correlates with endoscopic severity, supporting its role in monitoring treatment response (Kim et al., 2017; Soydan et al., 2019). CT remains appropriate when rapid evaluation is required, particularly in suspected acute complications.

The literature consistently supports the use of CT or MRE in individuals with known IBD for three indications: guiding treatment changes, assessing response to therapy, and evaluating suspected complications, where imaging findings provide clinically actionable information (Kim et al., 2020; Lichtenstein et al., 2025; Rubin et al., 2025).

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Perirectal/Perianal Crohn's Disease (AB-23.3)

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Criteria

- Perirectal/Perianal Fistula:
  - MRI Pelvis without and with contrast (CPT® 72197)
  - Endoscopic ultrasound is preferential to CT in this setting.
  - CT Pelvis with contrast (CPT® 72193) is an inferior study in this setting, and should be reserved for situations in which MRI or Endoscopic ultrasound cannot be performed.
- Perirectal/Perianal Abscess:
  - MRI Pelvis without and with contrast (CPT® 72197)
  - CT Pelvis with contrast (CPT® 72193) is inferior but can be considered medically necessary as an alternative if desired.

This section is applicable to individuals with Crohn's Disease. See: **Fistula in Ano (PV-21.1)** and **Perirectal Abscess (PV-21.2)** in the Pelvis Imaging Guidelines for non-Crohn's related perirectal and/or perianal fistulae.

Evidence Discussion

Accurate imaging of perianal and perirectal Crohn's disease requires clear delineation of fistula tracts and detection of associated abscess. MRI pelvis provides superior soft tissue resolution, allowing precise characterization of fistulas and their relationship to sphincter structures, which supports its role as the preferred modality (Kim et al., 2020; Lichtenstein et al., 2025).

Endoscopic ultrasound offers comparable accuracy for fistula detection in selected cases and is preferred over CT when MRI is not feasible. CT pelvis with contrast reliably detects abscess but has limited sensitivity for defining fistulous tracts due to lower spatial resolution (Kim et al., 2020).

Accordingly, MRI is preferred for both fistula and abscess evaluation, endoscopic ultrasound is an appropriate alternative for fistula assessment, and CT should be reserved for cases where MRI or ultrasound cannot be performed, or when rapid assessment of suspected abscess is needed (Kim et al., 2020; Lichtenstein et al., 2025).

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Primary Sclerosing Cholangitis (PSC) (AB-23.4)

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Criteria

- Primary Sclerosing Cholangitis (PSC):
  - MRCP is considered medically necessary to assess for PSC in those:
    - with IBD and any elevated liver function study (including alkaline phosphatase, gamma-glutamyl transpeptidase (GGTP), bilirubin, AST, or ALT)
    - without IBD, but with persistent cholestatic liver tests. (See: **Abnormal Liver Chemistries (AB-30)**)
  - Ultrasound (CPT® 76700 or 76705) or MRI/MRCP is considered medically necessary as surveillance for cholangiocarcinoma in individuals with PSC every 6 months.

Background and Supporting Information

Primary sclerosing cholangitis (PSC) is a chronic, progressive disease of the liver and biliary tract characterized by inflammation, fibrosis, and multifocal stricturing of the intrahepatic and extrahepatic bile ducts (European Association for the Study of the Liver [EASL], 2022). The disease can lead to progressive cholestasis, biliary cirrhosis, and ultimately end-stage liver disease.

PSC is strongly associated with inflammatory bowel disease (IBD), particularly ulcerative colitis, and may occur in individuals with or without known IBD (EASL, 2022; Assis & Bowlus, 2023). Biliary obstruction can occur at various levels within the biliary tree and may result in complications such as recurrent cholangitis.

Individuals with PSC are at increased risk for hepatobiliary malignancies, particularly cholangiocarcinoma, which should be considered in the presence of dominant strictures. There is also an increased risk of gallbladder polyps and other malignancies (Assis & Bowlus, 2023; EASL, 2022).

Given the progressive nature of the disease and the associated risk of malignancy, imaging plays an important role in the diagnosis, risk stratification, and longitudinal surveillance of individuals with PSC (EASL, 2022; Venkatesh et al., 2022).

Evidence Discussion

Magnetic resonance cholangiopancreatography (MRCP) is the preferred noninvasive modality for diagnosing primary sclerosing cholangitis (PSC), as it provides high-

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resolution visualization of multifocal biliary strictures without the risks associated with invasive procedures (EASL, 2022; Assis & Bowlus, 2023; Venkatesh et al., 2022). This supports its use in individuals with suspected PSC, including those with inflammatory bowel disease or persistent cholestatic liver enzyme abnormalities.

MRI-based imaging is also central to surveillance due to the elevated risk of cholangiocarcinoma. Observational data demonstrate an association between routine MRI surveillance and improved survival, likely driven by earlier detection of malignancy and disease progression (Tan et al., 2024). Comparative studies further show that MRI outperforms ultrasound in detecting early-stage cholangiocarcinoma, identifying lesions with more favorable prognostic features (Eaton et al., 2021; Tan et al., 2024).

Guidelines support ongoing surveillance with cross-sectional imaging, although optimal intervals are not standardized and should be guided by individual risk factors. Overall, the evidence supports MRCP for diagnosis and MRI-based imaging for surveillance in PSC, given their diagnostic performance and clinical impact (EASL, 2022; Assis & Bowlus, 2023; Venkatesh et al., 2022).

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Celiac Disease (Sprue) (AB-24)

Guideline Page

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Abdomen Imaging Guidelines

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Celiac Disease (AB-24.1)

AB.CD.0024.1.A
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Criteria

- CT Abdomen and Pelvis with contrast (CPT® 74177), CT Enteroclysis (CPT® 74176 or CPT® 74177), or CT Enterography (CPT® 74177), or MR Enterography (CPT® 74183, or CPT® 74183 and CPT® 72197) is considered medically necessary for:
  - one-time study after initial, confirmed diagnosis of celiac disease OR
  - confirmed celiac disease and new or continued symptoms (e.g., bloating, diarrhea, abdominal pain, unintentional weight loss, abdominal distention, evidence of malabsorption, or anemia) despite adherence to 6 months of a gluten free diet

Background and Supporting Information

Celiac disease is an autoimmune disorder characterized by immune-mediated damage to the small intestinal villi following ingestion of gluten (wheat, barley, and rye) (Austin et al., 2024; Rubio-Tapia et al., 2023).

Potential complications include ulcerative jejunitis, lymphoma, and small intestinal adenocarcinoma (Rubio-Tapia et al., 2023).

Diagnosis is typically initiated with serologic antibody testing and confirmed with small bowel biopsy obtained via endoscopy (Austin et al., 2024; Rubio-Tapia et al., 2023).

Capsule endoscopy may be considered in individuals with positive serology and negative biopsy results or when endoscopy is contraindicated (Rubio-Tapia et al., 2023; Austin et al., 2024).

Evidence Discussion

Serologic testing and upper endoscopy with small bowel biopsy remain the standard methods for confirming the diagnosis of celiac disease (Austin et al., 2024; Rubio-Tapia et al., 2023).

Cross-sectional imaging modalities, including CT enterography and MR enterography, provide noninvasive evaluation of the small bowel and are increasingly utilized to assess disease extent and detect complications such as ulcerative jejunoileitis, lymphoma, and small bowel malignancy (Penizzotto et al., 2024; Wang et al., 2024). These techniques enable detailed visualization of bowel wall abnormalities as well as extraintestinal findings, including mesenteric lymphadenopathy, which may indicate more advanced or complicated disease (Penizzotto et al., 2024; Rossi et al., 2023).

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Magnetic resonance enterography has demonstrated correlation with endoscopic, histologic, and serologic findings in individuals with nonresponsive celiac disease, supporting its role in evaluating persistent or refractory symptoms (Radmard et al., 2017). Imaging is particularly valuable in individuals with suspected complications or those who fail to respond to standard therapy, where further diagnostic clarification is necessary to guide management (Green et al., 2022; Rubio-Tapia et al., 2023).

Overall, cross-sectional imaging serves as an important adjunct in select clinical scenarios, facilitating early identification of complications and supporting timely intervention to reduce morbidity (Wang et al., 2024; Penizzotto et al., 2024; Green et al., 2022).

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CT Colonography (CTC) (AB-25)

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Abdomen Imaging Guidelines

CTC (AB-25.1)

AB.CT.0025.1.A
v1.0.2027

Note:

A screening CTC (CPT® 74263) can ONLY be used for an individual who is a candidate for average risk screening as defined below. It cannot be used for any other indication. If the request for a CTC is for any other reason than average risk screening, please refer to diagnostic CTC indications. A diagnostic CTC would be the appropriate code, if approvable, for any other reason than average risk screening. This would include surveillance for a history of colon polyps, the evaluation of a change in bowel habits, abdominal pain, bleeding, etc. Please refer to the definition below of an average-risk individual, as well as the circumstances for which a diagnostic CTC is appropriate.

Criteria

- Screening CTC (CPT® 74263) for colorectal cancer is considered NOT medically necessary if:
  - FIT-DNA (multi-targeted stool DNA test) within the last 3 years, OR
  - colonoscopy within the last 10 years
- Screening CTC (CPT® 74263) is considered medically necessary every 5 years for colorectal cancer for:
  - Average-risk individuals ages 45 to 75
    - Average risk is defined as:
      - no previously diagnosed colorectal cancer, or colonic adenomas, or inflammatory bowel disease involving the colon
  - Individuals between 76 to 85 if there is no history of a previously negative colonoscopy or CTC, or, if in the opinion of the provider, the benefits of screening outweigh the risks.
  - Individuals with a SINGLE first-degree relative diagnosed after 60 years of age with colorectal cancer or an advanced adenoma can be screened with CTC beginning at age 40.
    - If there are 2 or more first degree relatives at any age with CRC or an advanced adenoma, or a first degree relative diagnosed before 60 years of age, the individual should be screened via colonoscopy, not CTC.
- Diagnostic CTC without contrast (CPT® 74261) is considered medically necessary for:
  - Failed conventional colonoscopy due to a known colonic lesion, structural abnormality, or technical difficulty, and/or

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  - Conventional colonoscopy is considered medically contraindicated. Contraindications may include:
    - Coagulopathy
    - Intolerance to sedation
    - Elderly individuals 80 years of age or older
    - Recent (within the last 60 days) myocardial infarction (MI)
- Diagnostic CTC with contrast (CPT® 74262) is considered medically necessary if:
  - there is a known obstructing colorectal malignancy, when imaging is required for pre-operative staging, if desired.
  - there is a clearly stated indication for IV contrast to evaluate extra-colonic organs. When performed in this setting, a CTC with contrast will substitute for a CT Abdomen and Pelvis such that an additional CT Abdomen and Pelvis would generally not be considered medically necessary.
- MRI Colonography:
  - Currently, no published society-endorsed guideline with respect to colorectal cancer screening lists MRI Colonography as an alternative screening study. As such, requests for MRI Colonography would be considered investigational at this time. There is no specific CPT assigned for this procedure. It is sometimes requested as an MRI Abdomen and MRI Pelvis.

Background and Supporting Information

CT Colonography is a minimally invasive imaging modality used to evaluate the colon for polyps and colorectal cancer. The procedure is typically performed without intravenous contrast, as bowel preparation, colonic insufflation, and thin-section CT imaging provide adequate visualization of the colonic mucosa (Thomas et al., 2025; Wolf et al., 2018).

Evidence Discussion

Guideline recommendations vary slightly in preferred colorectal cancer (CRC) screening strategies for asymptomatic, average-risk individuals; however, multiple organizations recognize CT colonography (CTC) as an acceptable screening option. The US Preventive Services Task Force and the American Cancer Society include CTC among recommended screening modalities for average-risk adults (Davidson et al., 2021; Wolf et al., 2018).

CT colonography is generally not recommended for individuals at increased risk for colorectal cancer, including those with a personal history of adenomas or colorectal cancer, inflammatory bowel disease, or known hereditary cancer syndromes (Shaukat et al., 2021; Qaseem et al., 2023; Thomas et al., 2025).

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CTC has demonstrated comparable sensitivity and specificity to colonoscopy for the detection of clinically significant polyps, while offering a minimally invasive alternative that does not require sedation (Thomas et al., 2025; Davidson et al., 2021). However, bowel preparation requirements are similar to those of conventional colonoscopy, and CTC is associated with ionizing radiation exposure. Additionally, because CTC is a diagnostic rather than therapeutic procedure, any detected lesions require follow-up colonoscopy for removal or biopsy (Shaukat et al., 2021; Thomas et al., 2025).

Overall, CTC provides an effective, noninvasive screening option for appropriately selected average-risk individuals, particularly those who are unable or unwilling to undergo colonoscopy (Wolf et al., 2018; Davidson et al., 2021; Thomas et al., 2025).

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Cirrhosis and Liver Screening for Hepatocellular Carcinoma (HCC); Ascites and Portal Hypertension (AB-26)

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Chronic Liver Disease, Cirrhosis and Screening for HCC (AB-26.1)

AB.CL.0026.1.A
v1.0.2027

Criteria

HCC Screening and Surveillance

- Ultrasound (CPT® 76700 or CPT® 76705) every 6 months for HCC screening is considered medically necessary in ANY of the following circumstances:
  - All individuals, regardless of etiology, with cirrhosis or advanced fibrosis (e.g., Fibrosis Score F3 or greater on an elastography study, or results of a lab study such as FIB-4 or a biopsy indicative of severe activity or advanced fibrosis).
  - All individuals with Hepatitis B, regardless of the presence of cirrhosis or advanced fibrosis.
- See: **Hepatic Arteries and Veins (AB-43.1)** for individuals with Chronic Budd-Chiari Syndrome (BCS) and HCC surveillance in Budd-Chiari Syndrome/Hepatic Vein Thrombosis.
- See: **Monitoring After Fontan Procedure (AB-26.4)** for individuals who have undergone the FONTAN procedure.
- See: **General Guidelines (AB-1.0)** for use of medications or treatments which increase risk of HCC.

Evaluation of Liver Nodules

- If liver nodule is identified in the setting of chronic liver disease:
  - Less than 1cm
    - Repeat US in 3 months, then every 3 to 6 months
    - If stable for 2 years, return to US every 6 months
  - Greater than or equal to 1cm
    - Multiphase CT Liver (either CPT® 74160 or CPT® 74170) or MRI Abdomen without and with contrast (CPT® 74183) should be performed.
      - If negative: Return to routine surveillance US in 6 months.
      - If Li-RADS NC (non-categorizable): Repeat the same study or an alternative diagnostic imaging in 3 months or less.
      - If Li-RADS 1 (definitely benign): Return to routine surveillance US in 6 months.

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  - If Li-RADS 2 (probably benign): CT or MRI in 6 months can be approved (US requests are approvable if desired). If unchanged, return to routine surveillance US.
  - If Li-RADS 3 (intermediate): CT or MRI in 3-6 months, and can be repeated every 6 months 2 more times, for a total of 18 months from the initial finding. If no change by 18 months, return to US surveillance every 6 months.
  - If Li-RADS 4 (probable HCC): Repeat the same study or alternative imaging in 3 months or less. If HCC confirmed: See: **Upper GI Cancers (ONC-14)** in the Oncology Imaging Guidelines.
  - If Li-RADS 5 (HCC confirmed): See: **Upper GI Cancers (ONC-14)** in the Oncology Imaging Guidelines.
  - If Li-RADS M (Malignant, not definitely HCC): Repeat the same study or alternative imaging in 3 months or less, and follow appropriate Oncology guidelines upon diagnosis.
- Exceptions to the above algorithms:
  - Advanced imaging (Multiphase CT Liver (either CPT® 74160 or CPT® 74170) or MRI Abdomen without and with contrast (CPT® 74183) for surveillance may be substituted for US in the following circumstances:
    - Obesity (BMI greater than 35 kg/m²)
    - Marked parenchymal heterogeneity (suggestive of advanced liver fibrosis) noted on US
    - Visualization limitations noted on US which could be technical (such as obscuration by intestinal gas, chest wall deformity, etc.), or those related to structural or parenchymal changes in the liver
  - For individuals on the Liver Transplant list: See: **Liver Transplant, Pre-Transplant (AB-42.1)**
  - For Magnetic Resonance Elastography (MRE) indications, see: **Liver Elastography (AB-45)**
- For an Alpha-fetoprotein level of 20 ng/mL or greater:
  - Multiphasic CT or MRI Abdomen is considered medically necessary
  - Further imaging should follow the above Li-RADS algorithm, depending on the findings of the CT or MRI.
  - If the initial CT or MRI does not reveal a lesion, but the AFP increases on subsequent testing, repeat CT or MRI may be considered medically necessary.
- Contrast-Enhanced Ultrasound (CEUS)
  - Further studies are needed to assess the value of CEUS in this setting, and it is considered not medically necessary at this time.

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Background and Supporting Information

The American Association for the Study of Liver Diseases (AASLD) recommends HCC surveillance in at-risk individuals using ultrasound with or without alpha-fetoprotein (AFP) (Singal et al., 2023).

The Liver Imaging Reporting and Data System (LI-RADS) is the standardized imaging classification system endorsed by the AASLD for reporting liver observations in individuals at risk for HCC (American College of Radiology, 2023; Singal et al., 2023).

LI-RADS categories include (American College of Radiology, 2023):

- LI-RADS NC: Non-categorizable observation due to technical limitations or inadequate imaging quality.
- LI-RADS 1: Definitely benign.
- LI-RADS 2: Probably benign.
- LI-RADS 3: Intermediate probability of malignancy.
- LI-RADS 4: Probably HCC.
- LI-RADS 5: Definitely HCC.
- LI-RADS M: Malignant but not specific for HCC.

Primary sclerosing cholangitis (PSC) is a chronic cholestatic liver disease characterized by inflammation and fibrosis of the intrahepatic and extrahepatic bile ducts, resulting in multifocal strictures and segmental dilatation that may produce a beaded appearance on cholangiographic imaging (Bowlus et al., 2023).

Primary biliary cholangitis (PBC) is an autoimmune cholestatic liver disease characterized by progressive destruction of the small intrahepatic bile ducts and is commonly associated with antimitochondrial antibodies (Lindor et al., 2022).

Evidence Discussion

Ultrasound is the standard modality for hepatocellular carcinoma (HCC) surveillance in individuals with cirrhosis or advanced fibrosis due to its safety, accessibility, and ability to support longitudinal monitoring. It avoids ionizing radiation and can be repeated at six-month intervals, which aligns with the tumor doubling time of HCC and improves the likelihood of detecting early-stage disease (Singal et al., 2023). For this reason, AASLD recommends semiannual ultrasound, with or without alpha-fetoprotein (AFP), in all at-risk individuals, independent of underlying etiology.

The National Comprehensive Cancer Network (NCCN) recommends hepatocellular carcinoma (HCC) surveillance for individuals with chronic hepatitis B infection even in the absence of cirrhosis, regardless of fibrosis stage. The NCCN HCC screening algorithm specifically identifies individuals with chronic hepatitis B without cirrhosis as a risk group that should be enrolled in an HCC surveillance program (NCCN, 2025).

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Recommended surveillance consists of liver ultrasound and alpha-fetoprotein (AFP) testing every 6 months (NCCN, 2026).

Additional factors that may further support HCC surveillance among non-cirrhotic individuals with hepatitis B include a PAGE-B score of ≥10, a family history of HCC, men from hepatitis B endemic regions who are older than 40 years, women from endemic regions who are older than 50 years, and individuals from Africa, who may warrant surveillance at an earlier age (NCCN, 2026).

The NCCN Principles of Imaging note that HCC screening and surveillance are considered cost-effective in individuals with chronic hepatitis B, even in the absence of cirrhosis. Furthermore, individuals with viral hepatitis who have achieved a complete or sustained viral response should continue to undergo HCC surveillance because their risk is not completely eliminated (NCCN, 2026).

The diagnostic pathway following nodule detection is driven primarily by lesion size and growth dynamics. Sub-centimeter lesions have a low probability of representing clinically significant HCC and are not reliably characterized with cross-sectional imaging. Multiphase CT and contrast-enhanced MRI lack sufficient sensitivity and specificity in lesions less than 1 cm, largely due to limited visualization of arterial phase enhancement and washout in very small nodules. As a result, short-interval follow-up with ultrasound and AFP at 3 to 6 months is recommended to detect interval growth or evolution of imaging features (Singal et al., 2023).

In contrast, lesions measuring 1 cm or greater warrant diagnostic evaluation with multiphase CT or contrast-enhanced MRI. At this threshold, imaging can reliably assess hallmark vascular features of HCC, including arterial phase hyperenhancement and delayed washout. These features allow for noninvasive diagnosis using standardized criteria, most commonly operationalized through the LI-RADS framework (Singal et al., 2023; American College of Radiology, 2023). LI-RADS categories stratify malignancy probability and guide management, including short-interval follow-up for indeterminate lesions (LR-3), expedited imaging for probable HCC (LR-4), and treatment referral for definite HCC (LR-5). This structured approach supports the tiered management outlined in your criteria.

While CT and MRI demonstrate higher sensitivity for early HCC detection in some studies, particularly in Asian hepatitis B cohorts, these findings have limited applicability to broader Western populations. Concerns regarding cumulative radiation exposure with CT and the cost, access, and contrast-related constraints of MRI limit their routine use for surveillance. AASLD therefore supports reserving cross-sectional imaging for diagnostic clarification rather than primary screening (Kim et al., 2019; Singal et al., 2023).

Ultrasound performance may be reduced in individuals with obesity, parenchymal heterogeneity, or limited acoustic windows. In such cases, substitution with CT or MRI

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for surveillance is reasonable, as visualization limitations directly impair detection sensitivity. This exception is consistent with guideline-based acknowledgment that surveillance effectiveness depends on adequate image quality (Singal et al., 2023).

AFP serves as a complementary biomarker in this framework. Marked elevation, particularly values ≥20 ng/mL or rising trends, increases pretest probability of HCC and justifies diagnostic imaging even in the absence of a discrete ultrasound finding. When cross-sectional imaging remains negative, continued AFP elevation may prompt repeat CT or MRI, reflecting the limitations of single time-point imaging in detecting early or infiltrative disease (Singal et al., 2023).

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Ascites (AB-26.2)

AB.CL.0026.2.A
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Criteria

- Abdominal ultrasound (CPT® 76700 or CPT® 76705) and/or Doppler (CPT® 93975) with diagnostic paracentesis is required for all initial evaluations of ascites to determine the need for further or advanced imaging.
  - Further advanced imaging is determined by the nature of etiology of the ascites (e.g., portal hypertension secondary to cirrhosis, malignancy such as ovarian or pancreatic, heart failure, etc.).
- Peritoneal-venous shunt patency study (CPT® 78291) is considered medically necessary for evaluation of shunt patency and function in an individual with ascites.

Background and Supporting Information

Guidance from the American Association for the Study of Liver Diseases (AASLD) recommends that the initial evaluation of individuals with ascites include a comprehensive medical history, physical examination, laboratory studies (including complete blood count, liver function tests, and serum and urine electrolytes), abdominal ultrasound with Doppler, and diagnostic paracentesis with ascitic fluid analysis (Biggins et al., 2021; Runyon, 2021). The AASLD specifically recommends that diagnostic paracentesis be performed in all individuals with new-onset ascites that is accessible for sampling (Biggins et al., 2021; Runyon, 2021).

Similarly, European Association for the Study of the Liver (EASL) guidelines emphasize abdominal ultrasound as part of the first-line evaluation to confirm the presence of ascites and assess for underlying liver disease and portal hypertension (European Association for the Study of the Liver [EASL], 2018). These guidelines also support routine diagnostic paracentesis in new-onset ascites to determine etiology and guide subsequent management (Aithal et al., 2020; EASL, 2018).

Evidence Discussion

Ultrasound is highly sensitive for detecting ascitic fluid and is capable of identifying small volumes, making it the most effective initial imaging modality for suspected ascites (EASL, 2018; Moore & Wong, 2019).

Doppler ultrasound further improves diagnostic evaluation by assessing portal and hepatic venous flow, which is critical in identifying portal hypertension as an underlying cause of ascites (EASL, 2018; Garcia-Tsao et al., 2017; Kaplan et al., 2024). Diagnostic paracentesis with ascitic fluid analysis remains essential for distinguishing etiologies

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such as portal hypertension, malignancy, and infection, which subsequently directs further imaging and management (Biggins et al., 2021; Runyon, 2021).

Additional imaging is guided by findings from the initial evaluation. Computed tomography (CT) is useful for identifying malignancy, peritoneal disease, or complications of cirrhosis when clinically indicated (Aithal et al., 2020; EASL, 2018). Echocardiography is appropriate when cardiac etiologies, such as heart failure, are suspected contributors to ascites (Moore & Wong, 2019).

For individuals with refractory ascites who have undergone peritoneovenous shunt placement (e.g., LaVeen shunt), nuclear medicine peritoneovenous shunt studies provide a reliable method for evaluating shunt patency and function (Runyon, 2021).

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Portal Hypertension (AB-26.3)

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Criteria

- In evaluating the cause of portal hypertension:
  - Abdominal US (CPT® 76700 or CPT® 76705) and/or Duplex Doppler US [CPT® 93975] of the liver and upper abdomen is considered medically necessary to distinguish ANY of the following:
    - pre-hepatic causes (including portal vein thrombosis, extrinsic compression from a tumor)
    - intrahepatic causes (including cirrhosis)
    - post-hepatic (including hepatic vein thrombosis)
- CT Abdomen with contrast (CPT® 74160) or MRI Abdomen without and with contrast (CPT® 74183) is considered medically necessary for ANY of the following indications:
  - Ultrasound is technically limited in assessing hepatic and/or portal vessels
  - Suspicion of portal vein thrombosis, cavernous transformation, or extrinsic impression, but ultrasound was indeterminate
  - Portal hypertension along with secondary signs are present (including splenomegaly or porto-systemic collaterals)
  - Recurrent (2 or more episodes in the preceding 6 months) or persistent hepatic encephalopathy despite appropriate medical treatment, in individuals with cirrhosis or portal hypertension
- For TIPS (transjugular intrahepatic portosystemic shunt)
  - See: **Hepatic Arteries and Veins (AB-43.1)**

Background and Supporting Information

Portal hypertension is categorized based on the anatomical location of increased resistance to portal blood flow: pre-hepatic (e.g., portal vein thrombosis, extrinsic compression), intrahepatic (most commonly cirrhosis), and post-hepatic (e.g., hepatic vein thrombosis) (de Franchis et al., 2022; Kaplan et al., 2024). Cirrhosis accounts for the majority of portal hypertension cases.

Cirrhosis is a histologic diagnosis; however, the term compensated advanced chronic liver disease (cACLD) is used to describe a spectrum of advanced fibrosis and cirrhosis that may be difficult to distinguish clinically due to limited or absent symptoms (de Franchis et al., 2022). Progression to decompensated advanced chronic liver disease (dACLD) is defined by the development of complications such as ascites, hepatic

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encephalopathy, or gastroesophageal varices (de Franchis et al., 2022; Kaplan et al., 2024).

The development of gastroesophageal varices and associated hemorrhage represents one of the most clinically significant complications of portal hypertension (Garcia-Tsao et al., 2017; Kaplan et al., 2024).

The gold standard for assessing portal hypertension is measurement of the hepatic venous pressure gradient (HVPG), defined as the pressure gradient between the portal vein and inferior vena cava; however, this requires invasive testing (de Franchis et al., 2022; Kaplan et al., 2024). Clinically significant portal hypertension (CSPH) is defined as HVPG greater than 10 mm Hg (de Franchis et al., 2022).

Non-invasive approaches are recommended for risk stratification in individuals with suspected cACLD. Current consensus guidance supports combining liver stiffness measurement (LSM), typically obtained via transient elastography, with platelet count to stratify the risk of CSPH and guide further evaluation (de Franchis et al., 2022; Kaplan et al., 2024).

Evidence Discussion

Initial evaluation of suspected portal hypertension includes clinical assessment supported by imaging to evaluate hepatic structure and vascular flow. Ultrasound with Doppler provides critical information regarding liver morphology, portal vein patency, and alterations in hepatic and portal venous flow, and is widely used as the first-line imaging modality due to its accessibility and lack of ionizing radiation (Berzigotti et al., 2021; de Franchis et al., 2022; Kaplan et al., 2024).

Cross-sectional imaging with computed tomography (CT) or magnetic resonance imaging (MRI) provides additional diagnostic value when ultrasound findings are inconclusive or when evaluation for complications such as malignancy, thrombosis, or advanced cirrhosis is required (Augustine et al., 2023; Garcia-Tsao et al, 2017; Kaplan et al., 2024). Selection of imaging modality should consider individual factors including pregnancy, contrast exposure risks, cost, and individual tolerance.

Surrogate markers of clinically significant portal hypertension (CSPH) include the presence of gastroesophageal varices or portosystemic collaterals on imaging (de Franchis et al., 2022; Kaplan et al., 2024). In the absence of these findings, invasive testing such as HVPG measurement or liver biopsy may be required for definitive diagnosis; however, these approaches are increasingly reserved for cases of diagnostic uncertainty (de Franchis et al., 2022).

Non-invasive modalities have demonstrated strong correlation with portal hypertension severity. Transient elastography (TE) provides quantitative liver stiffness measurement (LSM), which correlates with the degree of fibrosis and risk of CSPH (Berzigotti et al., 2021). More refined risk stratification models integrating LSM with platelet count have

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been developed and validated to predict CSPH and the presence of high-risk varices (de Franchis et al., 2022; Kaplan et al., 2024).

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Abdomen Imaging Guidelines

Monitoring After Fontan Procedure (AB-26.4)

AB.CL.0026.4.A
v1.0.2027

Criteria

- Abdominal ultrasound (CPT® 76700 or CPT® 76705) and Doppler (CPT® 93975) are considered medically necessary every 6 months or per institution protocol.
- MR Elastography (CPT® 76391) is considered medically necessary every 6 months
- If any sized lesions are detected on ultrasound:
  - MRI Abdomen without contrast (CPT® 74181) or MRI Abdomen without and with contrast (CPT® 74183) with follow-up timeframes as requested.
- If advanced fibrosis or cirrhosis is detected on any imaging modality:
  - HCC monitoring every 6 months after advanced fibrosis or cirrhosis is detected with MRI Abdomen without contrast (CPT® 74181) or MRI Abdomen without and with contrast (CPT® 74183) is considered medically necessary.
- CT Abdomen and Pelvis with contrast (CPT® 74177), CT Abdomen with contrast (CPT® 74160), or other elastography techniques (i.e., Fibroscan) can be used to assess and monitor individuals with contraindications to MRI (e.g., pacemaker devices, etc.).

Evidence Discussion

Fontan physiology produces chronic venous hypertension and reduced hepatic perfusion, leading to progressive fibrosis, cirrhosis, and an increased risk of hepatocellular carcinoma (HCC) (Emamaullee et al., 2020; Hilscher & Kamath, 2023). Disease progression is often clinically silent, which supports structured, longitudinal surveillance.

Ultrasound with Doppler remains an accessible first-line modality for routine monitoring of hepatic morphology and hemodynamics. However, its sensitivity is limited in Fontan-associated liver disease (FALD) due to heterogeneous parenchymal changes and congestion. As fibrosis advances, cross-sectional imaging becomes necessary for improved lesion detection and characterization. MR-based techniques, including MR elastography, provide noninvasive quantification of liver stiffness and are useful for tracking fibrosis progression over time (Jarasvaraparn et al., 2026).

Lesion detection in FALD requires a low threshold for MRI. The altered hepatic vascular environment disrupts typical enhancement patterns used to diagnose HCC, particularly the expected delayed washout. As a result, imaging findings may be indeterminate, and

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LI-RADS criteria are less reliable in this population (Chavhan et al., 2021; Hilscher & Kamath, 2023). MRI, with or without contrast, is therefore appropriate when ultrasound identifies any lesion, regardless of size, to allow multiphasic evaluation.

Once advanced fibrosis or cirrhosis is identified, semiannual HCC surveillance is warranted, consistent with general HCC screening principles, though applied with recognition of reduced imaging specificity in FALD (Benson et al., 2024; Emamaullee et al., 2020; Téllez et al., 2023). MRI is preferred for surveillance due to its higher sensitivity in detecting small or atypical lesions. When MRI is contraindicated, CT or alternative elastography methods provide reasonable substitutes, though with known limitations in lesion characterization and fibrosis assessment.

Given the absence of standardized society guidelines specific to FALD, current practice reflects expert consensus and institutional protocols. These approaches emphasize early detection, multimodality imaging, and escalation to advanced imaging or biopsy when findings are indeterminate (Jarasvaraparn et al., 2026; Emamaullee et al., 2020; Téllez et al., 2023). The proposed criteria are consistent with this framework and appropriately integrate surveillance intervals, modality selection, and contingency pathways based on imaging findings and patient-specific constraints.

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MR Cholangiopancreatography (MRCP) (AB-27)

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MRCP (AB-27.1)

AB.MR.0027.1.A
v1.0.2027

Criteria

- MRCP (Magnetic Resonance Cholangiopancreatography) is a non-invasive imaging procedure, which is used to visualize the biliary and pancreatic ductal system. It is used most often in the following circumstances:
  - Suspected gallstone pancreatitis (See: **Pancreatitis (AB-33)**)
  - Suspected biliary pain (See: **Right Upper Quadrant and Epigastric Pain (AB-2.3)**
  - Pancreatic cyst and pseudocyst evaluation (See: **Pancreatic Lesion (AB-31)**, and **Pancreatitis (AB-33)**)
  - Choledochal cyst surveillance (See: **Biliary Disease PEDAB-16.2**)
  - Evaluation of abnormal liver chemistries (See: **Abnormal Liver Chemistries (AB-30.1)**)
  - Evaluation of the pancreas secondary to abdominal trauma with suspected duct injury or pseudocyst
  - Recurrent pancreatitis of unknown etiology (See: **Pancreatitis (AB-33)**)
  - Evaluation and follow-up of Primary Sclerosing Cholangitis (See: **Primary Sclerosing Cholangitis (PSC) (AB-23.4)**)
  - Evaluation of jaundice (See: **Abnormal Liver Chemistries (AB-30.1)**)
  - Evaluation of congenital anomalies of the cystic and hepatic ducts
  - Post-surgical biliary anatomy and complications (See: **Liver Transplant, Post-Transplant Imaging (AB-42.3)**)
  - For further evaluation of ultrasound or CT findings of abnormally dilated biliary duct, dilated pancreatic duct, or enlargement or fullness of the pancreas.
- Code assignment for MRCP
  - In general, there is no specific CPT code to describe MRCP. To report an MRCP, one of the MRI Abdomen codes should be selected, depending on contrast needs (CPT® 74181, CPT® 74182, or CPT® 74183). There is also a level II HCPCS code for MCRP, S8037; however simultaneous billing of any of these codes is redundant and unnecessary.
  - Reporting or billing a *second* MRI code to represent the “MRCP portion” of the study is not supported. When this occurs, it is usually seen as two simultaneous MRI requests, an MRI Abdomen without and with contrast (CPT® 74183) AND an additional MRI Abdomen without contrast (CPT® 74181). This second MRI code, as noted, is not supported. Both the primary MRI Abdomen AND the MRCP portion of the study are covered by the single MRI Abdomen code (CPT® 74183).

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- Requests for 3D rendering (either CPT® 76376 or CPT® 76377) are approvable, if requested, in addition to the primary MRI Abdomen code (CPT® 74181, CPT® 74182, or CPT® 74183).

Evidence Discussion

Magnetic resonance cholangiopancreatography (MRCP) is a noninvasive MRI technique used to visualize the biliary and pancreatic ductal systems. It employs heavily T2-weighted sequences to highlight static fluid, allowing clear delineation of ductal anatomy without ionizing radiation or endoscopic instrumentation (American College of Radiology [ACR], 2023; Manfredi et al., 2020).

MRCP is appropriate when ductal pathology is suspected or when prior imaging is inconclusive. Common indications include suspected gallstone pancreatitis, biliary-type pain, pancreatic cysts and pseudocysts, and choledochal cyst surveillance. It is also used in the evaluation of abnormal liver chemistries, jaundice, recurrent pancreatitis of unclear etiology, and suspected ductal injury following abdominal trauma. Additional applications include assessment of primary sclerosing cholangitis, congenital biliary anomalies, post-surgical biliary anatomy, and further characterization of ductal dilation or pancreatic abnormalities identified on ultrasound or CT (Dumonceau et al., 2019; Manfredi et al., 2020; Tenner et al., 2024).

Evidence supports MRCP as a first-line diagnostic modality for many pancreaticobiliary conditions due to its accuracy in detecting ductal obstruction and choledocholithiasis. Current practice places MRCP prior to endoscopic retrograde cholangiopancreatography (ERCP), reserving ERCP for therapeutic intervention. MRCP and endoscopic ultrasound (EUS) are complementary, with MRCP providing ductal mapping and EUS offering higher sensitivity for small stones (American Society for Gastrointestinal Endoscopy, 2019; Dumonceau et al., 2019).

Limitations include longer acquisition times, motion sensitivity, and variable availability (ACR, 2023; Granata et al., 2021). Safety concerns relate to gadolinium-based contrast when used. Gadolinium retention has been observed, though no confirmed clinical harm has been established in individuals with normal renal function. Risk remains relevant in severe renal impairment (ACR, 2023; ESUR Contrast Media Safety Committee, 2025; McDonald et al., 2018).

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Gallbladder (AB-28)

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Abdomen Imaging Guidelines

Gallbladder (AB-28.1)

AB.GP.0028.1.A
v1.0.2027

Criteria

- Findings on ultrasound or endoscopic ultrasound (EUS) suspicious for malignancy:
  - CT Abdomen with contrast (CPT® 74160) or CT Abdomen without and with contrast (CPT® 74170)
- Findings on ultrasound inconclusive for adenomyomatosis:
  - Contrast-Enhanced US (CEUS, CPT® 76978, CPT® 76979)
    - If US and CEUS are inconclusive for adenomyomatosis:
      - MRI Abdomen without and with contrast (CPT® 74183)
- For confirmed gallbladder malignancy:
  - See **Gallbladder and Biliary Tumors - Initial Work-up/Staging (ONC-14.6)** in the Oncology Imaging Guidelines

Gallbladder Polyps

- Individuals at increased risk for gallbladder malignancy (if surgery not chosen):
  - Age greater than 50 years old
  - Primary Sclerosing Cholangitis (PSC)
  - Indian ethnicity
  - Sessile polyp or gallbladder wall thickening greater than 4mm
- Increased risk for gallbladder malignancy:
  - Polyp less than 6 mm
    - Ultrasound at 6 months, then yearly for 5 years
  - Polyp 6-9 mm (If cholecystectomy is not chosen)
    - Ultrasound at 6 months, then yearly for 5 years
- No increased risk for gallbladder malignancy:
  - Polyp less than 6 mm
    - Ultrasound at 1, 3, and 5 years
  - Polyp 6-9 mm
    - Ultrasound at 6 months, and then yearly for 5 years
- Gallbladder polyp greater than or equal to 10 mm:
  - Surgery recommended.
  - If surgery is not performed, follow guidelines for individuals at increased risk for gallbladder malignancy as noted above.

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Background and Supporting Information

Transabdominal ultrasound is the preferred first-line imaging modality for the detection, characterization, and surveillance of gallbladder polyps. Endoscopic ultrasound (EUS) may provide additional lesion characterization in selected individuals when further evaluation is needed. Current evidence and guideline recommendations do not support routine use of CT or MRI before conventional ultrasound in the initial investigation of gallbladder polyps. Cross-sectional imaging is generally reserved for indeterminate findings or suspicion of malignancy (Foley et al., 2022; Wiles et al., 2017).

Evidence Discussion

Transabdominal ultrasound is the primary modality for detection and surveillance of gallbladder polyps due to its diagnostic adequacy for size measurement and morphologic assessment, which are the key determinants of malignancy risk (Foley et al., 2022; Wiles et al., 2017). Longitudinal stability, particularly over a five-year interval, is used as a surrogate for benign behavior, which underpins surveillance-based management strategies.

Guideline recommendations support risk-stratified follow-up based on polyp size and individual factors. Increased malignancy risk is associated with age above 50, primary sclerosing cholangitis, and sessile morphology. Growth, particularly increases exceeding 2 mm, is also considered clinically meaningful, reflecting either true progression or measurement variability beyond expected limits (European Society of Gastrointestinal Endoscopy et al., 2022; Foley et al., 2022).

Advanced imaging modalities are not recommended for routine surveillance because they do not improve detection or risk stratification of small polyps. Their role is reserved for problem-solving. CT is appropriate when malignancy is suspected, as it enables evaluation of local invasion, lymphadenopathy, and biliary obstruction, all of which inform staging and management decisions (Foley et al., 2022; McCain et al., 2018).

For adenomyomatosis, ultrasound remains the preferred modality due to its ability to demonstrate characteristic features such as intramural cystic spaces and comet-tail artifacts. High-frequency probe selection and focal depth optimization allow reliable identification in most cases. MRI is reserved for indeterminate cases where ultrasound and CEUS do not adequately distinguish benign hyperplastic changes from neoplastic processes (Bonatti et al., 2017; Golse et al., 2017).

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Liver Lesion Characterization (AB-29)

Guideline Page

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Liver Lesion Characterization (AB-29.1)

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Indeterminate Liver Lesions Criteria

- **Indeterminate liver lesion discovered on US:**
  - Indeterminate liver lesion measuring 1cm or greater on initial imaging
    - No suspicion or evidence of extrahepatic malignancy or underlying liver disease:
      - MRI Abdomen without and with contrast (CPT® 74183) or CT Abdomen with contrast (CPT® 74160) or Contrast-Enhanced US (CEUS, CPT® 76978, CPT® 76979)
    - Known history of extrahepatic malignancy:
      - MRI Abdomen without and with contrast (CPT® 74183) or CT Abdomen with contrast or without and with contrast (CPT® 74160 or CPT® 74170)
    - Known history of chronic liver disease:
      - See: **Chronic Liver Disease, Cirrhosis, and Screening for HCC (AB-26.1)**
  - Indeterminate liver lesion measuring less than 1cm on initial imaging
    - Known underlying chronic liver disease:
      - See: **Chronic Liver Disease, Cirrhosis, and Screening for HCC (AB-26.1)**
    - Known history of an extrahepatic malignancy:
      - MRI Abdomen without and with contrast (CPT® 74183) is the preferred study.
      - Contrast-Enhanced US (CPT® 76978, CPT® 76979) is appropriate.
- **Indeterminate liver lesion discovered on non-contrast CT or non-contrast MRI**
  - Liver lesion on initial imaging:
    - No suspicion or evidence of extrahepatic malignancy or underlying liver disease:
      - Multiphase CT Abdomen with contrast (CPT® 74160), MRI Abdomen without and with contrast (CPT® 74183), or CEUS (CPT® 76978 and/or CPT® 76979)
    - Known history of extrahepatic malignancy:
      - MRI Abdomen without and with contrast (CPT® 74183), CT Abdomen with contrast or without and with contrast (CPT® 74160 or CPT® 74170), or CEUS (CPT® 76978 or CPT® 76979)
    - Known chronic liver disease:
      - See: **Chronic Liver Disease, Cirrhosis, and Screening for HCC (AB-26.1)**
- Additional scenarios and follow-up imaging for an indeterminate lesion in an individual based on risk factors:
  - Low risk individuals defined as:
    - No known primary malignancy

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        - No hepatic dysfunction (abnormal liver tests)
        - No underlying chronic liver disease
        - No history of alcoholism, sclerosing cholangitis, choledochal cysts, hemochromatosis, or anabolic steroid use
    - High risk individuals would have ONE or MORE of the above conditions
    - Indeterminate lesion measuring less than 1cm on US, CT, or MRI, **low-risk** individual and no suspicious imaging features noted on the study
        - No further imaging
    - Indeterminate lesion measuring less than 1cm in **high-risk individuals** on US, CT, or unenhanced MRI not specifically dealt with in the above guidelines:
        - MRI Abdomen without and with contrast (CPT® 74183)
        - If, after MRI, the lesion remains indeterminate or not fully characterized
            - See: **Liver Metastases (ONC-31.2)** or malignancy-specific guidelines in the Oncology Imaging Guidelines.
            - If biopsy cannot be performed, follow-up MRI can be obtained in 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.
    - Most lesions measuring 1cm or greater can be categorized by MRI or histology. For lesions which have been categorized, regardless of size, see below.

- **Focal Liver Lesions Criteria**
- For the imaging of specific focal liver lesions:
    - **Suspected hepatic adenoma:**
        - MRI is considered the best technique for characterization.
        - Follow-up imaging can be CT Abdomen with contrast or without and with contrast (CPT® 74160 or CPT® 74170) or MRI Abdomen without and with contrast (CPT® 74183) every 6 months for 2 years, and then annually, to establish any growth patterns and assess for malignant transformation.
    - **Hepatic Hemangioma (if not completely characterized on initial CT without a liver protocol):**
        - Multiphase CT Abdomen with contrast or without and with contrast (CPT® 74160 or CPT® 74170) or MRI Abdomen without and with contrast (CPT® 74183)
        - Follow-up imaging is considered medically necessary as follows:
            - In individuals with cirrhosis or chronic hepatitis B, continued imaging with multiphase CT Abdomen with contrast or without and with contrast (CPT® 74160 or CPT® 74170) or MRI Abdomen without and with contrast (CPT® 74183) every 3-6 months for one year.
                - For continued HCC surveillance after one year, see also: **Chronic Liver Disease, Cirrhosis and Screening for HCC (AB-26.1)**

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  - Giant hemangiomas (greater than 4cm) can be followed by limited abdominal US in 6-12 months. If no change in size, no further follow-up is indicated, unless it becomes symptomatic.
  - See below for pre-operative considerations
- **Focal Nodular Hyperplasia (FNH):**
  - MRI Abdomen without and with contrast (CPT® 74183) or CT Abdomen with contrast or without and with contrast (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 annual US for 2 to 3 years in women diagnosed with FNH who are continuing to use oral contraceptives. Follow-up with CT Abdomen with contrast or without and with contrast (CPT® 74160 or CPT® 74170) or MRI Abdomen without and with contrast (CPT® 74183) can be done if the lesion is not adequately visualized on US.
- **Hepatic cysts:**
  - Asymptomatic, simple cysts do not require additional follow-up.
  - For complicated cysts (US shows internal septations, fenestrations, calcifications, irregular walls, as well as the presence of daughter cysts):
    - CT Abdomen with contrast or without and with contrast (CPT® 74160 or CPT® 74170) or MRI Abdomen without and with contrast (CPT® 74183) can be performed

- **Additional indications for advanced imaging (MRI Abdomen or CT Abdomen)**:
  - If documented that a percutaneous liver biopsy is to be considered if imaging is atypical or inconclusive.
  - Fatty liver (hepatic steatosis) on US with a focal liver lesion.
  - **If there is a technical limitation to US (e.g., marked heterogeneity, or other specifically noted technical limitations of US such as obscuration by intestinal gas, chest wall deformity, etc.)
  - For suspected liver metastases, see: **Liver Metastases (ONC-31.2)** in the Oncology Imaging Guidelines

- Preoperative studies for individuals with large hemangiomas or adenomas considered for resection:
  - MRA Abdomen (CPT® 74185) or CTA Abdomen (CPT® 74175) can be considered

- For indeterminate lesions measuring 1cm or greater in categories for which defined guidelines do not exist (i.e., underlying chronic liver disease, **Chronic Liver Disease, Cirrhosis, and Screening for HCC (AB-26.1)**, underlying malignancy, **Liver Metastases (ONC-31.2)** or the specific malignancy in the Oncology Imaging Guidelines, hepatic adenoma, etc.) a biopsy should be considered when the findings from advanced imaging are inconclusive. In clinical situations when a biopsy cannot

be performed (such as a medical contraindication or a liver transplant candidate due to the risk of needle-tract seeding), or is inconclusive, a short-term surveillance MRI can be performed in 3-4 months to monitor lesion stability.

- This can be repeated every 6 months, as necessary in this scenario. This timeframe would also apply if an MRI with Eovist is requested for short-term follow-up of an indeterminate lesion imaged on MRI Abdomen without and with contrast performed with other contrast, such as gadolinium. An exception would be if the differential is between FNH vs. hepatic adenoma or other benign lesions. FNH follow-up is yearly, and hepatic adenoma would require a 6 month follow-up study; if the differential of the lesion is between FNH and hepatic adenoma, then the follow-up study should be 6 months.

Background and Supporting Information

An indeterminate liver lesion is a focal hepatic abnormality that cannot be definitively classified as benign or malignant on initial imaging evaluation. Lesions measuring 1 cm or greater are generally considered clinically significant because they may require additional diagnostic evaluation to establish etiology and guide management (Chernyak et al., 2020).

Advanced imaging approvals in this section refer to MRI Abdomen without and with contrast (CPT® 74183), CT Abdomen with contrast (CPT® 74160), CT Abdomen without and with contrast (CPT® 74170), and Contrast-Enhanced Ultrasound (CEUS) (CPT® 76978 for the initial lesion and CPT® 76979 for additional lesions).

When only CT Abdomen with contrast (CPT® 74160) is identified as the appropriate study, this reflects American College of Radiology appropriateness recommendations indicating that a preceding non-contrast CT examination does not provide additional diagnostic benefit for characterization of most indeterminate liver lesions. Additionally, a standard multiphasic (triple-phase) CT examination of the liver does not routinely require a pre-contrast acquisition (Chernyak et al., 2020).

Evidence Discussion

CT, MRI, and contrast-enhanced ultrasound (CEUS) are established imaging modalities for the characterization of focal liver lesions. Selection among these modalities depends on lesion size, imaging appearance, patient-specific factors, and the diagnostic question being addressed (Frenette et al., 2024).

CT provides high spatial resolution and can accurately characterize many benign and malignant liver lesions. However, lesion characterization may be limited for lesions smaller than 1 cm because the resolution of CT often does not allow definitive characterization of very small lesions (Chernyak et al., 2020; Gore et al., 2017). ACR Appropriateness Criteria further note that, for many clinical scenarios involving indeterminate liver lesions, multiphasic contrast-enhanced CT is appropriate whereas

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the addition of a non-contrast CT acquisition is generally not associated with improved diagnostic characterization (Chernyak et al., 2020).

MRI provides superior soft tissue contrast and multiparametric tissue evaluation, resulting in greater diagnostic accuracy for characterization of indeterminate liver lesions, particularly small lesions and lesions identified in individuals with a known extrahepatic malignancy. Evidence supports the use of MRI when additional characterization is needed or when distinguishing benign from malignant lesions may impact management (Chernyak et al., 2020; EASL, 2016; Frenette et al., 2024).

CEUS has also emerged as a valuable problem-solving modality for characterization of indeterminate focal liver lesions. The use of intravascular contrast agents allows real-time evaluation of lesion vascularity and enhancement patterns without ionizing radiation, providing diagnostic performance that may be comparable to CT and MRI in selected clinical scenarios (Dietrich et al., 2020; Frenette et al., 2024).

Current guidelines support selection of CT or MRI based on lesion characteristics, clinical context, and prior imaging findings, with MRI generally preferred when characterization of small or indeterminate lesions is required (American College of Radiology, 2024; EASL, 2016; Frenette et al., 2024).

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Fatty Liver (Metabolic Associated Steatotic Liver Disease (MASLD), Formerly Known as NAFLD) (AB-29.2)

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Criteria

- Fatty liver (hepatic steatosis) incidentally discovered on imaging (US/CT/MRI) or suspected:
  - Magnetic Resonance Elastography (MRE) (CPT® 76391) may be considered medically necessary if criteria are met, see: **Liver Elastography (AB-45)**
  - The following procedures are considered experimental and investigational for the evaluation of fatty liver disease:
    - Magnetic Resonance-Protein Density Fat Fraction (MRI-PDFF, usually requested as CPT® 74181 or 74183),
    - MR Spectroscopy (MR-S, CPT® 76390), and
    - Multiparametric MRI referred to as Liver Multiscan (LMS, Category III CPT® code 0648T or 0649T)
  - HCC Screening for Fatty Liver with cirrhosis or advanced fibrosis:
    - See: **Chronic Liver Disease, Cirrhosis, and Screening for HCC (AB-26.1)**
  - MRI or CT for the further evaluation of incidentally discovered fatty liver on US, in the absence of a specific finding needing further characterization such as a nodule, is generally considered not medically necessary. See: **Liver Lesion Characterization and Additional Indications for Advanced Imaging (AB-29.1)**. In addition, the finding of fatty liver alone on CT with contrast does not require MRI for confirmation.
  - Requests for imaging studies to screen individuals at high-risk for MASLD (formerly known as NAFLD) (e.g., diabetes or obesity) or for screening family members of individuals with MASLD is not approvable at this time.

Evidence Discussion

Metabolic dysfunction-associated steatotic liver disease (MASLD), previously known as nonalcoholic fatty liver disease (NAFLD), is the most common cause of hepatic steatosis. While steatosis may be identified incidentally on ultrasound, CT, or MRI, disease severity is driven by the presence of fibrosis, which is the strongest predictor of liver-related outcomes and mortality. Therefore, accurate noninvasive assessment of fibrosis is important for risk stratification and management (Castera et al., 2023;

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European Association for the Study of the Liver [EASL], European Association for the Study of Diabetes [EASD], & European Association for the Study of Obesity [EASO], 2024; Rinella et al., 2023).

Magnetic resonance elastography (MRE) provides a quantitative assessment of liver stiffness and has demonstrated high diagnostic accuracy for detecting and staging hepatic fibrosis. Current American Association for the Study of Liver Diseases (AASLD) guidance recognizes MRE as a valuable noninvasive tool for evaluating fibrosis in individuals with suspected NAFLD/MASLD, particularly when additional characterization of liver disease severity is clinically warranted (Castera et al., 2023; Rinella et al., 2023).

Other MRI-based technologies, including magnetic resonance proton density fat fraction (MR-PDFF), magnetic resonance spectroscopy (MRS), and multiparametric MRI techniques such as LiverMultiScan, have been developed to evaluate hepatic fat content and other tissue characteristics. Although these technologies show promise, current evidence remains insufficient to establish their routine clinical use. Professional society guidance notes limitations including a lack of validated diagnostic thresholds, limited evidence demonstrating improved clinical outcomes or changes in individual management, uncertainty regarding comparative performance, and the need for further large-scale validation studies. As a result, these techniques remain primarily utilized in research settings and clinical trials (Caussy et al., 2018; EASL et al., 2024; National Institute for Health and Care Excellence [NICE], 2019; Rinella et al., 2023).

Current AASLD guidance does not recommend routine imaging-based screening for MASLD in asymptomatic individuals at increased risk, including those with obesity, type 2 diabetes mellitus, or a family history of liver disease. This recommendation reflects insufficient evidence that imaging-based screening improves clinical outcomes, together with concerns regarding cost-effectiveness and downstream resource utilization. Instead, current guidance emphasizes targeted risk assessment using clinical and noninvasive fibrosis evaluation strategies (Chalasani et al., 2018; Rinella et al., 2023).

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Polycystic Liver Disease (AB-29.3)

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Criteria

- MRI Abdomen without and with contrast (CPT® 74183) or CT Abdomen with contrast or without and with contrast (CPT® 74160, CPT® 74170) is considered medically necessary for assessment of liver volume and disease burden in individuals with known or suspected polycystic liver disease when prognostic assessment will impact clinical management.
- MRI Abdomen without and with contrast (CPT® 74183) or CT Abdomen with contrast or without and with contrast (CPT® 74160, CPT® 74170) is considered medically necessary when complications of polycystic liver disease are suspected, including but not limited to:
  - Cyst rupture
  - Cyst hemorrhage
  - Acute upper abdominal pain concerning for cyst-related complication
- Surveillance imaging of asymptomatic individuals is considered not medically necessary.

Background and Supporting Information

Polycystic liver disease (PLD) is generally defined as the presence of greater than 20 hepatic cysts or cysts occupying approximately one-half of the hepatic parenchymal volume (European Association for the Study of the Liver [EASL], 2022; van Aerts et al., 2018).

PLD most commonly occurs as an extrarenal manifestation of autosomal dominant polycystic kidney disease (ADPKD). It may also occur as isolated autosomal dominant polycystic liver disease (ADPLD), a genetically distinct disorder in which cystic liver disease develops in the absence of significant renal involvement. Although both conditions share overlapping clinical and radiologic features, ADPKD represents the most common cause of PLD in clinical practice (EASL, 2022; van Aerts et al., 2018; Wong et al., 2017).

Evidence Discussion

Ultrasound is the preferred initial imaging modality for diagnosing polycystic liver disease because it is highly sensitive for detecting hepatic cysts and assessing cyst burden. In individuals with ADPKD, hepatic cysts represent the most common extrarenal

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manifestation of disease, supporting the use of ultrasound for initial evaluation (Mavilia et al., 2018; Wong et al., 2017; van Aerts et al., 2018).

Current evidence does not support routine surveillance imaging in asymptomatic individuals with PLD. Follow-up imaging is generally reserved for those who develop symptoms, suspected complications, or require treatment planning (EASL, 2022; van Aerts et al., 2018).

MRI and CT provide complementary assessment of liver volume, cyst distribution, and cyst-related complications. Cross-sectional imaging is particularly valuable when complications such as cyst hemorrhage, infection, rupture, or mass effect are suspected. MRI offers superior soft tissue contrast and enhanced characterization of cyst contents, allowing improved detection of hemorrhagic or proteinaceous cysts and more detailed evaluation of complex cystic lesions. These capabilities make MRI particularly useful when ultrasound findings are inconclusive or when detailed preprocedural assessment is required (EASL, 2022; Mavilia et al., 2018).

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Isolated or Incidental Hepatomegaly (AB-29.4)

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Criteria

- Initial imaging of hepatomegaly discovered or suspected on physical examination:
  - US Abdomen (CPT® 76700 or CPT® 76705) and Duplex (CPT® 93975 or CPT® 93976)
- Further evaluation of abnormalities identified on the initial ultrasound:
  - Refer to specific guidelines for the abnormality detected on US
    - Fatty liver (liver steatosis), see: **Fatty Liver (Metabolic Associated Steatotic Liver Disease (MASLD), formerly known as NAFLD) (AB-29.2)**
    - Hepatic lesion, see: **Liver Lesion Characterization (AB-29.1)**
- Hepatomegaly discovered on ultrasound and no indeterminate abnormalities:
  - Medical workup, including lab studies (e.g., liver function tests), history and physical examination should be performed to assess for suspected underlying disease (e.g., infiltrative disorders such as amyloidosis or lymphoma)
    - Lab abnormalities and/or symptoms of a specific disease process should follow imaging studies outlined in the guideline for that disease process.
    - Advanced imaging in the absence of symptoms or lab abnormalities indicative of an underlying disorder is considered not medically necessary.

Background and Supporting Information

Hepatomegaly is defined as enlargement of the liver and may be detected on physical examination or imaging studies. It is a nonspecific clinical finding that may be associated with a wide range of hepatic and systemic disorders and does not necessarily indicate primary liver disease (Arif-Tiwari et al., 2023).

Potential causes of hepatomegaly include the following (Arif-Tiwari et al., 2023; Mavilia et al., 2018):

- Primary liver disease (e.g., viral hepatitis, alcohol-associated liver disease, metabolic dysfunction-associated steatotic liver disease [MASLD])
- Primary hepatic malignancy or metastatic liver disease
- Infiltrative disorders (e.g., amyloidosis, lymphoma)
- Impaired hepatic venous outflow or systemic venous congestion (e.g., congestive heart failure, Budd-Chiari syndrome)

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- Storage disorders (e.g., Gaucher disease, alpha-1 antitrypsin deficiency)
- Polycystic liver disease

Evidence Discussion

Ultrasound is generally the preferred initial imaging modality for evaluation of hepatomegaly because it can confirm liver enlargement and identify focal or diffuse hepatic abnormalities. When ultrasound findings are indeterminate or suggest a specific underlying process, subsequent CT or MRI may provide additional characterization and guide management (Arif-Tiwari et al., 2023).

Although MRI-based techniques can accurately quantify hepatic fat content, imaging findings alone do not reliably predict the severity of underlying hepatic histopathology. Current evidence and expert guidance indicate that routine quantification of hepatic steatosis has limited value in everyday clinical management (Castera et al., 2023; Rinella et al., 2023).

Advanced imaging is therefore most appropriately guided by specific clinical findings, laboratory abnormalities, or imaging features that suggest an underlying hepatic disorder. The decision to pursue CT, MRI, or other advanced imaging modalities should be based on the suspected etiology of hepatomegaly and the need for additional diagnostic characterization rather than the presence of hepatomegaly alone (Arif-Tiwari et al., 2023; Rinella et al., 2023).

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Abnormal Liver Chemistries (AB-30)

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Abnormal Liver Chemistries (AB-30.1)

AB.LC.0030.1.A
v1.0.2027

Criteria

Elevated AST and/or ALT (greater than 33 IU/l for males [assigned at birth], greater than 25 IU/l for females [assigned at birth]) and other liver function tests (LFTs) are normal or Hepatocellular pattern of elevation (AST and ALT disproportionately elevated to ALKP):

- Less than two times the upper limit of normal (ULN):
  - Repeat lab after 3 weeks and discontinuation of medications associated with elevated LFTs (such as statins, niacin, sulfa, rifampin, tetracycline, estrogen) if applicable.
  - If LFTs remain elevated: Abdominal US (CPT® 76700 or CPT® 76705)
    - Above studies do not explain the cause of the elevated transaminases AND HAV IgG, HBsAg, HBcAb, HBsAb, HCV Ab, iron panel (may include ferritin, serum iron, iron-binding capacity, or transferrin saturation) have been performed and are inconclusive:
      - CT Abdomen with contrast (CPT® 74160)
- Two to fifteen times the upper limit of normal:
  - Abdominal US (CPT® 76700 or CPT® 76705)
    - Above studies do not explain the cause of the elevated transaminases AND HAV IgG, HBsAg, HBcAb, HBsAb, HCV Ab, iron panel (may include ferritin, serum iron, iron-binding capacity, or transferrin saturation) have been performed and are inconclusive:
      - CT Abdomen with contrast (CPT® 74160)
- Greater than fifteen times the upper limit of normal:
  - Abdominal US with Doppler (CPT® 76700 or CPT® 76705 and CPT® 93975) OR
  - CT Abdomen with contrast (CPT® 74160) OR
  - CT Abdomen and Pelvis with contrast (CPT® 74177)
    - Above studies do not explain the cause of the elevated transaminases AND HAV IgG, HBsAg, HBcAb, HBsAb, HCV Ab, iron panel (may include ferritin, serum iron, iron-binding capacity, or transferrin saturation) have been performed and are inconclusive:

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        - MRI Abdomen without and with contrast (CPT® 74183) and/or MRCP (CPT® 74181)
- If the findings suggest chronic liver disease, see: **Chronic Liver Disease, Cirrhosis and Screening for HCC (AB-26.1)**
- If the findings suggest hemochromatosis, see: **Hereditary (Primary) Hemochromatosis (HH) and Other Iron Storage Disease (AB-11.2)**

Elevated alkaline phosphatase level (or GGT), and other LFTs are normal or cholestatic pattern of elevation (ALKP elevated disproportionately to AST and ALT):

- If isolated alkaline phosphatase (ALKP) elevation, GGT should be obtained for confirmation of hepatic etiology, prior to imaging.
- If ALKP is elevated with other LFTs, no confirmatory test is necessary.
    - Confirmed hepatic etiology of elevated ALKP:
        - Abdominal or RUQ ultrasound (CPT® 76700 or CPT® 76705)
            - Dilated biliary ducts on US:
                - MRCP
        - No dilated biliary ducts on US:
            - Anti-mitochondrial antibody (AMA) should be checked prior to advanced imaging.
                - If AMA testing is negative and ALKP is greater than two times the upper limit of normal:
                    - MRCP
                - If AMA testing is negative and the ALKP level is between one and two times the upper limit of normal:
                    - observe for 6 months
                    - if ALKP remains elevated after 6 months: MRCP
- CT Abdomen with contrast (CPT® 74160) if the above studies are unrevealing or individual cannot undergo MRCP.

Isolated elevated bilirubin (no other LFTs elevated):

- Elevation is unconjugated (elevated indirect bilirubin), and no other LFT elevations:
    - No advanced imaging
- Elevation is conjugated (elevated direct bilirubin)
    - RUQ ultrasound
        - Dilated biliary ducts on ultrasound:

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    - MRCP
  - No dilated biliary ducts on US:
    - Anti-mitochondrial antibody (AMA) should be checked prior to advanced imaging
      - AMA negative and elevation persists or is unexplained:
        - MRCP or liver biopsy
- CT Abdomen with contrast (CPT® 74160) if the above studies are unremarkable or the individual cannot undergo MRCP.

Clinical jaundice, no known predisposing condition:

- Abdominal ultrasound (CPT® 76700 or CPT® 76705)
  - For further imaging, follow guideline for elevated bilirubin
- Clinical jaundice, suspected mechanical obstruction based on clinical condition or laboratory values (e.g., known choledocholithiasis, acute and chronic pancreatitis, suspected stricture from a recent invasive procedure, previous biliary surgery, suspected tumor):
  - CT Abdomen with contrast (CPT® 74160) or MRI and/or MRCP (CPT® 74183 or CPT® 74181)
- US findings suggesting mechanical biliary obstruction, non-diagnostic or technically limited US (e.g., large amounts of intestinal gas, obesity with BMI greater than 35 kg/m²):
  - CT Abdomen with contrast (CPT® 74160) or MRI and/or MRCP (CPT® 74183 or CPT® 74181)

Additional considerations:

- For individuals with elevated LFTs and suspicion of sclerosing cholangitis, such as those with IBD, see: **Primary Sclerosing Cholangitis (PSC) (AB-23.4)**.
- For individuals with elevated LFTs and history of underlying malignancy, please refer to the specific oncology guidelines, when appropriate.
- Requests for additional advanced imaging (CT, MRI, etc.) are based on the prior imaging results, as appropriate to the finding (for example, if a lesion is identified that needs further characterization, refer to liver lesion imaging as per **Liver Lesion Characterization (AB-29.1)**)
- For MRE indications, see: **Liver Elastography (AB-45)**

Background and Supporting Information

- The standard laboratory tests commonly referred to as liver chemistries or liver function tests (LFTs) include bilirubin, alkaline phosphatase (ALKP), aspartate

aminotransferase (AST), alanine aminotransferase (ALT), and gamma-glutamyl transferase (GGT) (Kwo et al., 2026; Kalas et al., 2021).

- Patterns of liver chemistry abnormalities can help identify the underlying disease process and guide further evaluation (Kwo et al., 2026; Metra et al., 2022):
  - Hepatocellular pattern: AST and ALT are disproportionately elevated compared to ALKP.
  - Cholestatic pattern: ALKP is disproportionately elevated compared with AST and ALT.
  - Mixed pattern: ALKP, AST, and ALT are all elevated without a predominant hepatocellular or cholestatic pattern.
  - Isolated hyperbilirubinemia: Elevated bilirubin with normal AST, ALT, and ALKP.
- "R" Ratio
  - The "R" ratio is used to classify liver chemistry abnormalities as predominantly hepatocellular, cholestatic, or mixed (Kwo et al., 2026; Kalas et al., 2021).
  - R=(ALT/Upper limit of normal (ULN))/(ALKP/ULN ALKP)
    - If the "R" ratio:
      - greater than 5 = hepatocellular
      - less than 2 = cholestatic
      - 2-5 = mixed pattern
  - For hepatocellular, use AST or ALT elevation guidelines
  - For cholestatic, use ALKP elevation guidelines
  - Use ULN for ALT as noted above, and ULN for alkaline phosphatase based on the individual lab report

Evidence Discussion

Abnormal liver chemistries are an important component of the evaluation of suspected liver disease and may reflect hepatocellular injury, cholestasis, impaired hepatic function, or biliary obstruction. Interpretation of abnormal liver chemistries requires consideration of the specific laboratory pattern, degree of abnormality, and clinical context because similar abnormalities may arise from a broad range of hepatic and extrahepatic conditions (Kalas et al., 2021; Kwo et al., 2026).

The pattern and degree of liver chemistry abnormalities help guide further diagnostic evaluation and imaging selection. Clinical practice guidelines recommend that imaging selection be tailored to the specific laboratory abnormality, associated symptoms, and clinical context. Ultrasound is often the preferred initial imaging modality because it can assess hepatic parenchyma, biliary dilation, and other structural abnormalities. CT or MRI may be indicated when ultrasound findings are indeterminate, when a focal hepatic abnormality requires further characterization, or when more comprehensive assessment of the liver and biliary system is needed (Arif-Tiwari et al., 2023; Hindman et al., 2019).

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Current evidence supports integrating liver chemistries with clinical findings, laboratory evaluation, and imaging studies rather than relying on any single diagnostic test. Imaging is most useful when directed by the pattern of abnormal liver chemistries and the suspected underlying etiology. This approach improves diagnostic yield and helps ensure that advanced imaging is used when it is most likely to affect diagnosis, management, or treatment planning (Arif-Tiwari et al., 2023; Kwo et al., 2026; Metra et al., 2022).

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Pancreatic Lesion (AB-31)

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Pancreatic Cystic Lesions (AB-31.1)

AB.PC.0031.1.A
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Criteria

- **Pancreatic Cyst seen on Imaging-Initial Management**:
  - MRI Abdomen without and with contrast (CPT® 74183) and/or MRCP are the tests of choice for initial evaluation.
    - Both MRI Abdomen and MRCP may be considered medically necessary, but only one CPT® code 74183 should be reported, not two.
  - CT Pancreatic protocol (CPT® 74160) or EUS are alternatives in individuals who are unable to undergo MRI.
  - Indeterminate pancreatic cysts may benefit from a second imaging modality or EUS prior to proceeding with surveillance. MRI/MRCP can be approved to better characterize the lesion, without reference to the timeframe for follow-up imaging, if a previous US or CT Abdomen has been performed.
  - Radiographic diagnosis of a non-neoplastic cyst or classic features of a serous cystadenoma
    - No further imaging
  - If ANY of the following concerning features are present the individual should proceed to EUS with fine-needle aspiration (FNA) and depending on findings, surgical consultation:
    - Main pancreatic duct greater than 5mm
    - Cyst 3cm or greater
    - Change in main duct caliber with upstream atrophy
      - If EUS does not reveal findings of main duct involvement, patulous ampulla, cytology with high-grade dysplasia or pancreatic malignancy, or a mural nodule, then follow up MRI should performed in 6 months.
- **Pancreatic Cyst Follow-up Imaging**:
  - If high risk features (See below High Risk Considerations and Features) are not present, then the next follow-up imaging proceeds as follows:
    - Cyst less than 1cm: MRI in 2 years
    - Cyst 1cm or greater but less than 2cm: MRI in 1 year
    - Cyst 2 to 3cm: if cyst is not clearly an Intraductal papillary mucinous neoplasms (IPMN) or Mucinous cystic neoplasm (MCN) then proceed with EUS. If it is an IPMN or MCN, then MRI at 6-12 months.
    - If the cyst is determined to be a serous cystadenoma, then no further imaging is considered medically necessary unless the individual becomes symptomatic.

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- **Additional Surveillance for a presumed Intraductal papillary mucinous neoplasms (IPMN) or Mucinous cystic neoplasms (MCN) (imaging from time of presentation):**
  - Cyst less than 1cm
    - MRI every 2 years for 4 years
    - If stable after 4 years consider lengthening of interval imaging
    - If increase in cyst size, then MRI or EUS is considered medically necessary in 6 months
    - If stable, repeat imaging in 1 year and if stability persists return to MRI every 2 years
  - Cyst 1cm or greater but less than 2cm
    - MRI yearly for 3 years
    - If stable for 3 years, then change to MRI every 2 years for 4 years
    - If stable after the additional 4 years, consider lengthening of interval for surveillance
    - If increase in cyst size, repeat MRI in 6 months. If stable, repeat MRI in 1 year and if stability persists, resume original surveillance schedule.
  - Cyst 2cm or greater but less than 3cm
    - MRI every 6 to 12 months for 3 years
    - If stable after 3 years, change to MRI every year for 4 years
    - If stability persists, consider lengthening of surveillance interval
  - Cyst measuring 3cm or greater
    - MRI alternating with EUS every 6 months for 3 years
    - If stable for 3 years, increase interval to MRI alternating with EUS yearly for 4 years
    - If stability persists, consider lengthening of surveillance interval
    - If increase in cyst size, EUS with FNA is considered medically necessary
  - Additional considerations
    - Individuals with asymptomatic cysts that are diagnosed as pseudocysts on initial imaging and clinical history, or are determined to be serous cystadenomas, do not require further evaluation.
    - Individuals who are not medically fit for surgery should not undergo further surveillance of incidentally found pancreatic cysts, irrespective of size.
    - Surveillance should be discontinued if an individual is no longer a surgical candidate. However, follow-up imaging can be performed if requested for a symptomatic cyst (such as the development of jaundice secondary to cyst), in which palliative treatment might be available.
    - High-Risk Considerations and Features
      - Individuals with IPMNs or MCNs with new onset or worsening diabetes

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- Rapid increase in cyst size (greater than 3mm/year) during surveillance may have an increased risk of malignancy and should undergo a short-interval MRI or EUS.
- Additional high-risk features which may prompt early evaluation are:
  - jaundice secondary to the cyst
  - acute pancreatitis secondary to the cyst
  - significantly elevated CA 19-9
  - presence of a mural nodule or solid component either within the cyst or in the pancreatic parenchyma
  - dilation of the main pancreatic duct greater than 5mm
  - focal dilation of the pancreatic duct concerning for main duct IPMN or an obstructing lesion
  - IPMNs or MCNs measuring 3cm or greater in diameter
  - presence of high-grade dysplasia or pancreatic cancer on cytology. In this circumstance, imaging should be at the discretion of the provider.

- **Post-op surveillance:**
  - Surgically resected serous cystadenomas, pseudocyst, or other benign cyst:
    - No additional imaging after resection
  - Surgically resected mucinous cystic neoplasms (MCNs) without an associated pancreatic malignancy (can have low, intermediate, or high-grade dysplasia):
    - No additional post-op surveillance
  - Surgically resected MCNs with invasive cancer:
    - Standard surveillance-based pancreatic cancer guidelines (See: **Pancreatic Cancer-Surveillance/Follow-up (ONC-13.5)** in the Oncology Imaging Guidelines) for 5 years. No surveillance required after 5 years.
  - Surgically resected IPMNs
    - IPMN with cancer
      - Pancreatic cancer surveillance guidelines (See: **Pancreatic Cancer-Surveillance/Follow-up (ONC-13.5)** in the Oncology Imaging Guidelines)
    - IPMN with high-grade dysplasia
      - MRI Abdomen without and with contrast (CPT® 74183) or EUS every 6 months
    - IPMN with low- or intermediate-grade dysplasia
      - MRI Abdomen without and with contrast (CPT® 74183) every 2 years
  - Surgically resected solid-pseudopapillary neoplasm with negative margins:
    - MRI Abdomen without and with contrast (CPT® 74183) yearly for 5 years
- See: **MR Cholangiopancreatography (MRCP) (AB-27)** for coding guidelines for MRCP.

Background and Supporting Information:

Pancreatic cystic lesions include a spectrum of entities ranging from benign lesions, such as pseudocysts and serous cystadenomas, to premalignant neoplasms, including intraductal papillary mucinous neoplasms (IPMNs) and mucinous cystic neoplasms (MCNs) (Elta et al., 2018; Gardner et al., 2024)

IPMNs are mucin-producing epithelial neoplasms that arise from the pancreatic ductal system and are classified as main duct, branch duct, or mixed-type lesions. MCNs are mucin-producing cystic neoplasms that typically occur in the pancreatic body or tail and possess malignant potential. In contrast, serous cystadenomas are generally considered benign lesions and typically do not require surveillance once confidently diagnosed (Elta et al., 2018; European Study Group on Cystic Tumours of the Pancreas, 2018; Gardner et al., 2024).

MRI and MRCP are the preferred imaging modalities for characterization and surveillance of pancreatic cystic lesions because they provide detailed assessment of cyst morphology, pancreatic duct communication, and associated pancreatic abnormalities without ionizing radiation exposure (Fábrega-Foster et al., 2020; Gardner et al., 2024; Vege et al., 2015).

The American Gastroenterological Association and other professional societies recommend MRI as the preferred surveillance examination because it provides superior assessment of the relationship between a cystic lesion and the pancreatic ductal system. CT remains an appropriate alternative when MRI is contraindicated, unavailable, or when additional evaluation of calcifications or other lesion characteristics is needed (European Study Group on Cystic Tumours of the Pancreas, 2018; Fábrega-Foster et al., 2020; Vege et al., 2015).

Endoscopic ultrasound (EUS) provides high-resolution assessment of cyst morphology and permits tissue acquisition through fine-needle aspiration when additional diagnostic information is required. EUS is most commonly used when imaging demonstrates concerning features, when the diagnosis remains uncertain, or when further risk stratification is needed to guide management decisions. The ability to obtain cyst fluid and tissue samples can improve assessment of malignancy risk and inform therapeutic planning (Elta et al., 2018; Facciorusso et al., 2020; Gardner et al., 2024).

Evidence Discussion

Surveillance strategies for pancreatic cystic lesions are based on evidence demonstrating that the risk of malignancy varies according to cyst size, growth rate, morphologic characteristics, and associated clinical findings. Current professional society guidelines support risk-stratified surveillance approaches, with more intensive surveillance recommended for larger cysts and for lesions exhibiting high-risk or worrisome features. The goal of surveillance is to identify progression to high-grade

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dysplasia or invasive carcinoma while minimizing unnecessary procedures and imaging (Elta et al., 2018; European Study Group on Cystic Tumours of the Pancreas, 2018; Gardner et al., 2024).

MRI is the preferred modality for surveillance because it provides high-quality characterization of pancreatic cysts and pancreatic duct anatomy without exposure to ionizing radiation. Professional society guidelines support MRI-based surveillance, while CT serves as an alternative for individuals who cannot undergo MRI (Gardner et al., 2024; Fábrega-Foster et al., 2020; Vege et al., 2015).

Evidence demonstrates that rapid cyst growth, mural nodules, main pancreatic duct dilation, elevated CA 19-9, obstructive jaundice, pancreatitis attributable to the cyst, and new-onset diabetes are associated with increased malignant potential and warrant earlier evaluation with MRI, EUS, or EUS-FNA (Elta et al., 2018; European Study Group on Cystic Tumours of the Pancreas, 2018; Gardner et al., 2024).

EUS plays an important role in the evaluation of cysts with concerning features because it provides detailed lesion characterization and allows tissue acquisition. Evidence supports the use of EUS-guided sampling to improve diagnostic assessment of selected pancreatic cystic lesions (Facciorusso et al., 2020; Gardner et al., 2024).

Postoperative surveillance recommendations vary based on pathology. Benign cystic lesions and noninvasive MCNs have a low risk of recurrence and generally do not require ongoing surveillance following complete resection. In contrast, IPMNs may recur or progress elsewhere within the pancreatic ductal system, supporting continued surveillance after resection, particularly when high-grade dysplasia or invasive carcinoma is present (Elta et al., 2018; Gardner et al., 2024).

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Incidental Pancreatic Mass or Suspected Metastatic Disease to Pancreas (AB-31.2)

AB.PC.0031.2.A
v1.0.2027

Criteria

- For the evaluation of incidental pancreatic mass or suspected metastatic disease to the pancreas, CT Abdomen with contrast with dual phase imaging (CPT® 74160), or MRI Abdomen without and with contrast (CPT® 74183) is considered medically necessary.

Evidence Discussion

Multiphasic pancreatic protocol CT and MRI are established imaging modalities for the evaluation of pancreatic masses. Dual-phase CT improves lesion detection and assessment of local extension, while MRI provides additional soft tissue characterization and may be useful when further evaluation is needed. Both modalities are considered appropriate for the assessment of incidental pancreatic masses and suspected pancreatic involvement by metastatic disease (Bolan et al., 2023, McKinney et al., 2021; Megibow, 2023).

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Pancreatic Pseudocysts (AB-32)

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Pancreatic Pseudocysts (AB-32.1)

AB.32.1.A
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See: **Acute Pancreatitis (AB-33.1)** or **Chronic Pancreatitis (AB-33.2)**

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Pancreatitis (AB-33)

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Acute Pancreatitis (AB-33.1)

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Criteria

- The presence of any red flag findings per **General Guidelines (AB-1.0)** precludes adjudication based on any other criteria.
- Imaging:
  - **Initial imaging for suspicion of pancreatitis (typical symptoms, less than 48 to 72 hours, first-time presentation):**
    - Abdominal ultrasound (CPT® 76700 or CPT® 76705)
      - Purpose is to establish for the presence/absence of gallstones and biliary ductal dilation.
      - Doppler ultrasound (CPT® 93975) can be approved to assess vasculature, if requested.
    - If ultrasound or CT is performed and is nondiagnostic due to technical limitations (e.g., obesity, overlying gas, etc.):
      - MRI/MRCP (CPT® 74183 or CPT® 74181)
      - CT Abdomen and Pelvis with contrast (CPT® 74177) or CT Abdomen with contrast (CPT® 74160) if ultrasound is nondiagnostic and MRI/MRCP cannot be performed.
    - In suspected acute biliary pancreatitis and/or cholangitis (dilated ducts or choledocholithiasis on ultrasound, elevated liver chemistries with a negative ultrasound, suspicion of cholangitis (classic triad is RUQ pain, fever, and jaundice))
      - MRI/MRCP (CPT® 74183 or CPT® 74181)
  - **Initial imaging in individuals with atypical signs and symptoms when diagnoses other than pancreatitis are being considered (e.g., bowel perforation, bowel ischemia):**
    - CT Abdomen and Pelvis with contrast (CPT® 74177) or CT Abdomen with contrast (CPT® 74160)
    - MRI/MRCP (CPT® 74181 or CPT® 74183) can be considered medically necessary for pregnant individuals (non-contrast), or those with renal insufficiency (without or without and with depending on request).
  - **Follow-up imaging (late phase and thereafter):**
    - Continued or worsening symptoms:
      - CT Abdomen and Pelvis with contrast (CPT® 74177), CT Abdomen with contrast (CPT® 74160) or MRI and/or MRCP (CPT® 74183 or CPT® 74181)

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- Follow-up of known pancreatic or peri-pancreatic fluid collections (including pseudocysts), to follow-up symptomatic collections, or for interventional planning:
  - MRI/MRCP (CPT® 74183 or CPT® 74181) or CT Abdomen and Pelvis with contrast (CPT® 74177)
    - If requested, CT Abdomen with contrast (CPT® 74160) or Abdominal ultrasound (CPT® 76705 or CPT® 76700) can be approved.

    Note:

    Frequency or intervals for additional follow-up is not defined and depends on clinical circumstances, response to therapy, etc.
- If, despite initial imaging, the etiology of the pancreatitis is still in doubt:
  - MRI/MRCP (CPT® 74183 or CPT® 74181) or CT Abdomen and Pelvis with contrast (CPT® 74177)
    - If requested, CT Abdomen with contrast (CPT® 74160) can be approved.

◦ **Acute recurrent pancreatitis:**
- Abdominal ultrasound (CPT® 76705 or CPT® 76700)
- MRI/MRCP (CPT® 74183 or CPT® 74181)
- CT Abdomen and Pelvis with contrast (CPT® 74177)
- See: **Chronic Pancreatitis (AB-33.2)**

Background and Supporting Information

- Knowledge base:
  - A diagnosis of acute pancreatitis is established when at least 2 of the following three criteria are present:
    - Characteristic abdominal pain (typically epigastric or left upper quadrant pain with radiation to the back, chest, or flank)
    - Amylase or lipase greater than 3 times the upper limit of normal
    - Imaging findings consistent with acute pancreatitis on cross-sectional imaging studies (e.g., CT or MRI) (Foster et al., 2019; Tenner et al., 2024).
  - The early phase of acute pancreatitis generally occurs during the first week after symptom onset and is characterized predominantly by a systemic inflammatory response (Tenner et al., 2024). During the first week, imaging findings correlate poorly with clinical severity. Advanced imaging is generally most informative when obtained approximately 5–7 days after admission, when local complications have evolved and pancreatic necrosis can be more accurately identified and characterized (Foster et al., 2019; Tenner et al., 2024).
    - Goals of imaging during the early phase:
      - Establish the correct diagnosis of acute pancreatitis or provide an alternative diagnosis

- Establish the underlying etiology
- Stage the morphologic severity
- Assess for complications in individuals who deteriorate or fail to improve (Expert Panel on Gastrointestinal Imaging et al., 2019; Tenner et al., 2024).

◦ The late phase may extend for weeks to months after the initial episode and is primarily characterized by local complications and the maturation of pancreatic fluid collections (Tenner et al., 2024). Acute peripancreatic fluid collections occur during the first 4 weeks of interstitial edematous pancreatitis. These collections lack a mature wall and are confined by normal fascial planes (Foster et al., 2019). If the acute peripancreatic fluid collection persists beyond four weeks, it may be organized and evolve into a pancreatic pseudocyst or a walled-off necrosis (Foster et al., 2019)

▪ Goals of imaging during late phase:

- Monitor established pancreatic and peripancreatic collections
- Delineate the presence of symptomatic and asymptomatic complications
- Guide interventional and surgical procedures (Expert Panel on Gastrointestinal Imaging et al., 2019; Tenner et al., 2024).

◦ Etiologies of pancreatitis (Tenner et al., 2024):

▪ Gallstones and alcohol account for 75-80% of all cases

▪ Hypercalcemia, hypertriglyceridemia, medications, a benign or malignant obstruction, pancreatic mass, genetic causes (hereditary pancreatitis), autoimmune pancreatitis (IgG4), infectious etiologies, ischemia secondary to vascular disease, anatomic abnormalities (e.g., pancreas divisum), physiologic abnormalities (Sphincter of Oddi dysfunction), idiopathic causes (Tenner et al., 2024).

Evidence Discussion

Abdominal ultrasound is recommended as the initial imaging study in individuals with acute pancreatitis to evaluate for biliary etiologies, particularly cholelithiasis and biliary obstruction, which account for a substantial proportion of acute pancreatitis cases. Ultrasound is effective for detecting gallstones and assessing the biliary tree and therefore plays an important role in identifying the underlying etiology of disease (Porter et al., 2019; Tenner et al., 2024).

Advanced imaging with CT or MRI is generally reserved for individuals in whom the diagnosis remains uncertain or who fail to improve clinically. Contrast-enhanced CT has high diagnostic accuracy for acute pancreatitis and is valuable for evaluating pancreatic necrosis and other complications. MRI/MRCP provides comparable diagnostic capability while offering superior evaluation of the pancreatic and biliary ducts and may be preferred in individuals with contrast allergy, renal insufficiency, suspected

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choledocholithiasis, or pancreatic duct abnormalities (Porter et al., 2019; Tenner et al., 2024).

In individuals with persistent symptoms or clinical deterioration after 48 to 72 hours, CT or MRI is supported for assessment of local complications, including necrotizing pancreatitis and pancreatic or peripancreatic fluid collections (Foster et al., 2019; Greenberg et al., 2016; Tenner et al., 2024).

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Chronic Pancreatitis (AB-33.2)

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Criteria

- The presence of any red flag findings per **General Guidelines (AB-1.0)** precludes adjudication based on any other criteria.
- If chronic pancreatitis is suspected:
  - Initial imaging:
    - CT Abdomen with contrast (CPT® 74160) **OR** CT Abdomen without and with contrast (CPT® 74170) **OR** CT Abdomen and Pelvis with contrast (CPT® 74177) **OR** CT Abdomen and Pelvis without and with contrast (CPT® 74178) **OR** MRI Abdomen without and with contrast (CPT® 74183)
      - If diagnostic imaging demonstrates chronic pancreatitis (e.g., pancreatic calcification in combination with pancreatic atrophy and/or dilated pancreatic duct):
        - Additional imaging is considered not medically necessary in the absence of new or worsening symptoms
    - If initial CT or MRI is inconclusive or nondiagnostic of chronic pancreatitis, either of the following are considered medically necessary:
      - MRI/MRCP with secretin enhancement (CPT® 74183 or CPT® 74181), OR
      - Endoscopic ultrasound (EUS)
    - If EUS is inconclusive, pancreatic function testing and/or ERCP is considered medically necessary
    - If abdominal ultrasound is requested at any stage for evaluation of chronic pancreatitis, this is considered medically necessary and may be approved in lieu of advanced imaging
  - If initial imaging fails to confirm chronic pancreatitis, but the clinical suspicion remains, repeat CT, MRI/MRCP, secretin-enhanced MRI/MRCP, or EUS may be performed after 6 months.
- Known chronic pancreatitis with new or worsening symptoms suggestive of disease progression or complications, any of the following are considered medically necessary:
  - CT Abdomen with contrast (CPT® 74160) **OR** CT Abdomen without and with contrast (CPT® 74170) **OR** CT Abdomen and Pelvis with contrast (CPT® 74177) **OR** CT Abdomen and Pelvis without and with contrast (CPT® 74178) **OR** MRI/MRCP (CPT® 74183 OR CPT® 74181) **OR** Abdominal ultrasound (CPT® 76700 or CPT® 76705)
  - Possible etiologies of worsening pain include:

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    - peptic ulcer disease
    - GI cancers
    - pseudocysts
    - duodenal or common bile duct obstruction
    - pancreatic duct stone or strictures
    - inflammatory masses at the head of the pancreas:
- For pre-surgical planning or post-surgical evaluation for treatment of complications of chronic pancreatitis:
    - CT Abdomen with contrast or without and with contrast (CPT® 74160 or CPT® 74170), **OR** MRI/MRCP (CPT® 74183 or CPT® 74181) **OR** Abdominal ultrasound (CPT® 76700 or CPT® 76705)
- Routine screening for pancreatic cancer in chronic pancreatitis:
    - Routine surveillance to monitor for the occurrence of pancreatic cancer in individuals with chronic pancreatitis is not supported at this time.
    - For pancreatic cancer screening guidelines in inherited syndromes, including hereditary pancreatitis, see: **Screening Studies for Pancreatic Cancer (ONC-13.1)** in the Oncology Imaging Guidelines.

Background and Supporting Information

- Chronic pancreatitis (CP) is a progressive inflammatory disorder characterized by irreversible structural pancreatic changes that may result in chronic pain, exocrine pancreatic insufficiency, and endocrine dysfunction (Gardner et al., 2020; Singh et al., 2019; Thierens et al., 2024).
- Secretin-enhanced MRCP provides functional assessment of the pancreatic ductal system by stimulating pancreatic bicarbonate secretion, allowing improved visualization of the main pancreatic duct and side branches when conventional imaging is inconclusive (Gardner et al., 2020; Gonoi et al., 2019).

Evidence Discussion

CT and MRI/MRCP are recommended first-line imaging modalities for the evaluation of chronic pancreatitis because they are widely available and reliably identify characteristic pancreatic structural abnormalities. EUS may be considered when cross-sectional imaging is nondiagnostic but is not generally recommended as an initial diagnostic test because of its invasive nature and interobserver variability (Gardner et al., 2020; Singh et al., 2019).

When conventional imaging remains inconclusive, secretin-enhanced MRCP may improve detection of early chronic pancreatitis through enhanced visualization of pancreatic ductal anatomy and exocrine pancreatic function (Gardner et al., 2020).

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Current evidence does not support routine imaging surveillance for pancreatic malignancy in individuals with chronic pancreatitis. Although pancreatic cancer risk is increased in this population, the American College of Gastroenterology notes a lack of randomized trials or high-quality evidence demonstrating a benefit from routine screening and therefore does not recommend surveillance solely on the basis of chronic pancreatitis (Gardner et al., 2020).

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Exocrine Pancreatic Insufficiency (AB-33.3)

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v1.0.2027

Criteria

- The presence of any red flag findings per **General Guidelines (AB-1.0)** precludes adjudication based on any other criteria.
- Pancreatic Insufficiency:
  - The initial evaluation for pancreatic insufficiency should include ONE of the following laboratory results:
    - Elevation in fecal fat
    - Fecal elastase less than 200 mcg/g
    - Serum trypsinogen less than 20ng/mL
  - When ANY of the above laboratory abnormalities are present, the following are considered medically necessary for the evaluation of suspected pancreatic insufficiency
    - CT Abdomen with contrast (CPT® 74160) OR
    - CT Abdomen without and with contrast (CPT® 74170) OR
    - MRI/MRCP (CPT® 74183 or 74181)
  - For suspected pancreatic insufficiency due to known chronic pancreatitis, see: **Chronic Pancreatitis (AB-33.2)**
  - For suspected pancreatic insufficiency due to known cystic fibrosis, see: **(PEDAB-16)** and **(PEDCH-5.1)**
  - For suspected pancreatic cancer, see: **Pancreatic Cancer – Suspected/ Diagnosis (ONC-13.2)**

Background and Supporting Information

Exocrine pancreatic insufficiency (EPI) is characterized by insufficient pancreatic enzyme activity resulting in maldigestion and malabsorption. When intraduodenal pancreatic enzyme levels become significantly reduced, individuals may develop symptoms including steatorrhea, abdominal discomfort, bloating, flatulence, weight loss, and nutritional deficiencies (Forsmark, 2018; Whitcomb et al., 2023).

Common pancreatic disorders associated with EPI include chronic pancreatitis, pancreatic ductal adenocarcinoma, recurrent acute pancreatitis, cystic fibrosis, and prior pancreatic resection (Capurso et al., 2019; Forsmark, 2018; Whitcomb et al., 2023).

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Evidence Discussion

Fecal elastase is a widely accepted first-line test for the evaluation of exocrine pancreatic insufficiency (EPI) because it is noninvasive, readily available, and has good diagnostic performance. Fecal elastase values below 100 mcg/g of stool provide strong evidence of EPI, whereas values between 100 and 200 mcg/g are considered indeterminate and should be interpreted in conjunction with clinical findings and other diagnostic data (Whitcomb et al., 2023).

Additional laboratory markers that may support a diagnosis of EPI include elevated fecal fat and low serum trypsinogen levels. Elevated fecal fat reflects impaired fat digestion resulting from pancreatic enzyme deficiency, while low serum trypsinogen is associated with reduced pancreatic exocrine function and may be particularly useful in advanced disease (Forsmark, 2018; Whitcomb et al., 2023).

Cross-sectional imaging with CT or MRI/MRCP is not diagnostic of EPI itself but is valuable for identifying underlying pancreatic disorders and structural abnormalities that may cause pancreatic exocrine dysfunction. Imaging therefore serves an important role in evaluating the etiology of EPI and supporting management decisions (Forsmark, 2018; Whitcomb et al., 2023).

EPI commonly occurs in individuals with chronic pancreatitis, pancreatic ductal adenocarcinoma, recurrent acute pancreatitis, cystic fibrosis, and prior pancreatic surgery. Consequently, evidence supports evaluation for underlying pancreatic pathology when laboratory findings and clinical symptoms suggest pancreatic exocrine dysfunction (Capurso et al., 2019; Whitcomb et al., 2023).

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Asymptomatic Elevation of Pancreatic Enzymes (AB-33.4)

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v1.0.2027

Criteria

- If there is the incidental elevation of amylase or lipase:
  - If isolated amylase elevation, prior to imaging, the source of the elevation should be confirmed as pancreatic by the performance of amylase isoenzymes demonstrating that the source is not salivary, or the absence of macroamylase should be ascertained by blood test.
  - If the lipase is elevated alone or in combination with an elevated amylase, or if the amylase is confirmed as pancreatic in origin:
    - Abdominal Ultrasound is medically necessary initially.
    - If US is inconclusive, nondiagnostic, or the elevated pancreatic enzymes persist:
      - MRI/MRCP is medically necessary (CPT® 74183).
        - It is best performed as a secretin-stimulation test in this setting.
      - CT Abdomen (pancreatic protocol, CPT® 74160) is considered medically necessary if there is a contraindication to MRI.
  - If the pancreatic enzyme elevation persists at one year, either MRI Abdomen with MRCP (CPT® 74183) or CT Abdomen with pancreatic protocol (CPT® 74160, when MRI is contraindicated) can be repeated.

Evidence Discussion

Persistent elevation of pancreatic enzymes may be associated with a variety of pancreatic and pancreaticobiliary disorders, including acute pancreatitis, chronic pancreatitis, pancreatic duct abnormalities, and biliary obstruction. However, elevated amylase or lipase levels are not specific for a particular diagnosis and should be interpreted in the context of clinical findings and additional diagnostic testing. Abdominal imaging plays an important role in evaluating the etiology of unexplained pancreatic enzyme elevation and identifying clinically significant pancreatic or pancreaticobiliary pathology (Gonoi et al., 2019; Tenner et al., 2024).

Ultrasound is an appropriate initial imaging modality because it can readily identify biliary duct dilation and cholelithiasis. When ultrasound is nondiagnostic or pancreatic enzyme elevations persist without an identified cause, CT or MRI/MRCP may provide additional evaluation of the pancreas and pancreatic ductal system. MRCP is particularly

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useful for detecting pancreatic duct abnormalities that may contribute to chronic asymptomatic pancreatic hyperenzymemia (Gonoi et al., 2019; Tenner et al., 2024).

Abdomen Imaging Guidelines

References (AB-33)

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Abdomen Imaging Guidelines

Spleen (AB-34)

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Spleen (AB-34.1)

AB.SP.0034.1.C
v1.0.2027

Criteria

- Incidental splenic findings on US:
  - CT Abdomen without and with contrast (CPT® 74170) or MRI Abdomen without and with contrast (CPT® 74183) is considered medically necessary
- Incidental splenic findings on CT or MRI:
  - Imaging is diagnostic of a benign lesion (e.g., simple cyst or hemangioma) or characteristics are benign-appearing (homogeneous, low attenuation, no enhancement, smooth margins):
    - No follow-up imaging is required
  - Imaging characteristics are not diagnostic:
    - Prior imaging available:
      - One year of stability: no follow up imaging
      - Lack of stability: consider MRI Abdomen without and with contrast (CPT® 74183) if not already performed, biopsy, or PET/CT (CPT® 78815).
    - No prior imaging available:
      - No known malignancy:
        - Suspicious imaging features: (suggestive of possible malignancy)
          - MRI Abdomen without and with contrast (CPT® 74183) if not already performed or biopsy
          - If MRI remains inconclusive and biopsy is not feasible, then PET/CT (CPT® 78815) is considered medically necessary.
        - Indeterminate imaging features: (equivocal but not suspicious for malignancy)
          - Follow up MRI Abdomen without and with contrast (CPT® 74183) in 6 and 12 months.
      - Known malignancy:
        - Lesion less than 1 cm: follow-up MRI Abdomen without and with contrast (CPT® 74183) in 6 and 12 months.
        - Lesion 1 cm or greater: consider MRI Abdomen without and with contrast (CPT® 74183) if not already performed, or biopsy
          - If MRI remains inconclusive and biopsy is not feasible then PET/CT (CPT® 78815) is considered medically necessary.
        - Refer to diagnosis-specific criteria in the Oncology Imaging Guidelines, when applicable

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- Clinically detected splenomegaly
  - Abdominal US (CPT® 76700 or CPT® 76705) should be the first imaging study to evaluate splenic size.
  - If splenomegaly is confirmed, the following evaluation is considered medically necessary prior to advanced imaging:
    - CBC, evaluation of the peripheral blood smear, LFTs, UA, chest x-ray, HIV testing.
      - CT Abdomen without and with contrast or with (CPT® 74170 or CPT® 74160) is considered medically necessary if the etiology of the splenomegaly remains unexplained.
      - MRI Abdomen without and with contrast (CPT® 74183) is considered medically necessary for pregnant individuals, or individuals with iodinated contrast allergy.

Background and Supporting Information

Splenomegaly is defined as abnormal enlargement of the spleen and is typically a manifestation of an underlying systemic disorder rather than a primary splenic condition. Common causes include infectious diseases, hematologic disorders, portal hypertension related to chronic liver disease, inflammatory and autoimmune conditions, infiltrative diseases, and malignancies. Because splenomegaly has a broad differential diagnosis, evaluation is directed toward identifying the underlying etiology and associated systemic manifestations (Aldulaimi & Mendez, 2021).

Initial evaluation commonly includes a comprehensive history and physical examination, laboratory studies such as a complete blood count with differential and liver chemistries, and peripheral blood smear examination when clinically indicated. Additional diagnostic testing and imaging are guided by the suspected underlying cause and associated clinical findings (Aldulaimi & Mendez, 2021).

Evidence Discussion

Evidence supporting routine follow-up imaging of incidental splenic lesions is limited. In a retrospective observational study of 379 individuals with splenic masses identified incidentally on CT, Siewert et al. (2018) found that malignancy was uncommon among individuals without a history of malignancy, constitutional symptoms, or left upper quadrant pain. Among 205 asymptomatic individuals without a known malignancy, only two malignant lesions were identified, and both cases demonstrated additional imaging findings suggestive of systemic disease rather than isolated splenic abnormalities.

Notably, isolated splenic malignancy was exceedingly rare in the study population. Based on these findings, the authors concluded that incidental splenic masses identified in asymptomatic individuals without a history of malignancy are highly likely to be benign, regardless of imaging appearance. The study further suggested that additional

imaging follow-up may not be necessary when no clinical or imaging features raise concern for malignancy (Siewert et al., 2018).

These findings have called into question earlier recommendations for routine surveillance of indeterminate incidental splenic lesions and support a more individualized approach to management. Decisions regarding further evaluation should incorporate clinical presentation, history of malignancy, lesion characteristics, and the presence of additional suspicious imaging findings rather than relying solely on the detection of an incidental splenic lesion (Siewert et al., 2018).

More recent radiology reviews recognize that CT and MRI are valuable tools for characterizing indeterminate splenic lesions, particularly when lesions demonstrate atypical imaging features or occur in individuals with known malignancy or other risk factors. At the same time, these reviews acknowledge the limited evidence supporting serial surveillance of lesions with benign imaging characteristics or long-term stability. Current literature therefore supports additional imaging when clinical or imaging findings raise concern for malignancy, while the benefit of routine surveillance imaging for asymptomatic individuals with benign-appearing incidental lesions remains unproven (Bird et al., 2026; Corvino et al., 2023).

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Splenic Trauma (AB-34.2)

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Criteria

- Ultrasound Abdomen (CPT® 76700 or CPT® 76705) and Ultrasound Pelvis (CPT® 76856 or CPT® 76857) or CT Abdomen and Pelvis without and with contrast (CPT® 74178) or CT Abdomen and Pelvis with contrast (CPT® 74177) is considered medically necessary for ANY of the following:
  - Blunt abdominal trauma with suspected splenic rupture, OR
  - Suspected post-procedural splenic injury, OR
  - Individuals with penetrating trauma to the left upper quadrant. See: **Blunt Abdominal Trauma (AB-10)**

Background and Supporting Information

The spleen is a highly vascular organ and is among the most frequently injured abdominal organs following blunt abdominal trauma. Splenic injuries range from minor capsular injuries to life-threatening hemorrhage. Prompt diagnosis is important because imaging findings may influence decisions regarding nonoperative management, angioembolization, or surgical intervention (Kozar et al., 2018; Shi et al., 2019).

Evidence Discussion

The spleen is one of the most commonly injured abdominal organs following blunt abdominal trauma and is at risk for significant hemorrhage because of its highly vascular nature (Kozar et al., 2018; Shi et al., 2019). The primary goal of imaging is the rapid detection of splenic injury and associated intra-abdominal bleeding.

Ultrasound, particularly focused assessment with sonography for trauma (FAST), can rapidly identify free intraperitoneal fluid and is useful in the initial evaluation of trauma individuals. However, ultrasound has limited sensitivity for characterizing splenic parenchymal and vascular injuries (Shi et al., 2019; Patlas, 2021).

In hemodynamically stable individuals, contrast-enhanced CT is the preferred imaging modality because it accurately identifies splenic injury, active hemorrhage, vascular injury, and associated abdominal trauma. CT findings assist in determining injury severity and guiding subsequent management, including observation, embolization, or surgery (Patlas, 2021; Expert Panel on Polytrauma Imaging et al., 2026).

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Indeterminate Renal Lesion (AB-35)

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Indeterminate Renal Lesion – General Information (AB-35.0)

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For acute flank pain, rule out renal stone, see: **Flank Pain, Rule Out or Known Renal/ Ureteral Stone (AB-4)**

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Indeterminate Renal Lesion (AB-35.1)

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Criteria

- Incidental Renal Mass on Ultrasound
  - If categorized as simple cyst or Bosniak I or II, no further imaging is considered medically necessary.
  - Otherwise ONE of the following is considered medically necessary:
    - CT Abdomen without and with contrast (CPT® 74170)
    - MRI Abdomen without and with contrast (CPT® 74183)
    - Contrast-Enhanced Ultrasound (CPT® 76978) for one lesion
    - Targeted Dynamic Ultrasound (CPT ® 76979) if more than one lesion
- CT Abdomen without and with contrast (CPT® 74170) or MRI Abdomen without and with contrast (CPT® 74183) is considered medically necessary for further characterization if the original study reveals incomplete visualization of a renal lesion (for example, if only partially visualized on a CT Chest).

- Incidental Renal Mass on CT
  - If characterized as heterogeneous (thick or irregular wall, mural nodule, septa, or calcification):
    - Considered indeterminate: MRI Abdomen without and with contrast (CPT® 74183) OR CT Abdomen without and with contrast (CPT® 74170) is considered medically necessary
  - If characterized as homogeneous (thin or imperceptible wall, NO mural nodule, septa, or calcification):
    - 10 to 20 HU (Hounsfield units)
      - Likely benign, not fully characterized: no further work-up
    - 21 to 69 HU
      - Considered indeterminate: MRI Abdomen without and with contrast (CPT® 74183) OR CT Abdomen without and with contrast (CPT® 74170) is considered medically necessary
    - 70 HU or greater
      - Hemorrhagic or proteinaceous cyst, unlikely to be neoplastic: no further work-up
  - If characterized as TSTC (too small to characterize) and homogeneous:
    - If labeled likely benign cyst, not fully characterized:
      - No further work-up
    - If labeled inconclusive based on subjective evaluation:

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        - Considered indeterminate: MRI Abdomen without and with contrast (CPT® 74183) (preferred) OR CT Abdomen without and with contrast (CPT® 74170) is considered medically necessary ideally within 6-12 months but no sooner than 6 months.
- Incidental cystic renal mass on CT or MRI without and with contrast (completely characterized, and does NOT contain fat)
  - Bosniak I (benign simple) or II (minimally complicated)
    - No further work-up
  - Bosniak IIF
    - CT Abdomen without and with contrast (CPT® 74170) or MRI Abdomen without and with contrast (CPT® 74183) is considered medically necessary at 6 and 12 months, then yearly for 5 years
    - If no changes for 5 years, cyst is considered benign and of no clinical significance
  - Bosniak III or IV should be referred for additional management or if chosen, active surveillance see: **Surveillance (ONC-17.4)** in the Oncology Imaging Guidelines
- Incidental solid renal mass or incidental mass too small to characterize evaluated on CT or MRI without and with contrast and does NOT contain fat
  - TSTC (too small to characterize)
    - If labeled likely benign cyst:
      - No further work-up
    - If labeled inconclusive based on subjective evaluation:
      - MRI Abdomen without and with contrast (CPT® 74183) (preferred), OR CT Abdomen without and with contrast (CPT® 74170) is considered medically necessary ideally within 6-12 months but no sooner than 6 months.
  - If solid mass less than 1.0 cm
    - MRI Abdomen without and with contrast (CPT® 74183) (preferred), OR CT Abdomen without and with contrast (CPT® 74170) is considered medically necessary beginning at 6 months, then yearly for 5 years
    - If stable at 5 years (average growth of 3 mm or less per year): No further work-up
    - If mass shows growth (4 mm or greater per year) or morphologic change: refer for management, consider renal biopsy. If biopsy is technically challenging or relatively contraindicated, a T2 weighted image MRI Abdomen without and with contrast (CPT® 74183) is considered medically necessary
  - Solid mass 1.0-4.0 cm:
    - Considered a small renal neoplasm: refer for management, consider biopsy. If biopsy is technically challenging or relatively contraindicated, a T2 weighted imaging MRI Abdomen without and with contrast (CPT® 74183) is considered medically necessary. If active surveillance chosen due to limited life expectancy

or co-morbidities, see: **Surveillance (ONC-17.4)** in the Oncology Imaging Guidelines
    - Solid renal mass greater than 4.0 cm
        - Considered a renal neoplasm: refer for management, or biopsy. If biopsy is technically challenging or relatively contraindicated, a T2 weighted image MRI Abdomen without and with contrast (CPT® 74183) is medically necessary. If active surveillance chosen due to limited life expectancy or co-morbidities, see: **Surveillance (ONC-17.4)** in the Oncology Imaging Guidelines
- Incidental renal mass containing fat (contains a region of interest that measures 10 HU or less on CT)
    - No calcification angiomyolipoma (AML)
        - Solitary and without documentation of growth:
            - Less than 4 cm: no further work-up
                - If no prior imaging study for comparison, one follow-up MRI Abdomen without and with contrast (CPT® 74183) OR CT Abdomen without and with contrast (CPT® 74170) can be repeated in 6-12 months to assess for any growth.
            - 4 cm or greater and considered an AML with potential for clinical symptoms: refer for management.
        - Multiple lesions or growth documented based on old studies:
            - Refer for management. If active surveillance chosen due to limited life expectancy or co-morbidities, see: **Surveillance (ONC-17.4)** in the Oncology Imaging Guidelines.
    - With calcification (suspected renal cell carcinoma):
        - CT Abdomen without and with contrast (CPT® 74170) OR MRI Abdomen without and with contrast (CPT® 74183) is considered medically necessary if only a non-contrast CT has been performed. If active surveillance is chosen due to limited life expectancy or co-morbidities, see: **Surveillance (ONC-17.4)** in the Oncology Imaging Guidelines.
- Active Surveillance: For all Active Surveillance indications, see: **Surveillance (ONC-17.4)** in the Oncology Imaging Guidelines

Note: PET/CT or PET/MRI are not considered medically necessary because their role evaluating the incidental renal mass is limited.

Background and Supporting Information:

Bosniak Classification:

Bosniak I (Benign Simple Cyst): Well-defined cyst with a thin (2 mm or less), smooth wall; homogeneous simple fluid attenuation (-9 to 20 HU on CT); no septa, calcifications,

or solid components. Enhancement of the wall may be present but no enhancing septa or nodules are identified (Silverman et al., 2019).

Bosniak II (Benign Cystic Lesion): Cystic mass with a thin (2 mm or less), smooth wall and up to three thin (2 mm or less) septa. Septa and wall may enhance. Calcifications of any type may be present. Also includes homogeneous hyperattenuating cysts (70 HU or greater on noncontrast CT), homogeneous nonenhancing masses greater than 20 HU on renal mass protocol CT, and homogeneous low-attenuation lesions too small to characterize (Silverman et al., 2019).

Bosniak IIF (Probably Benign): Cystic mass with either a smooth minimally thickened (3 mm) enhancing wall or septa, or many (4mm or greater) thin enhancing septa. These lesions are generally benign but warrant imaging surveillance because of a small risk of malignancy (Silverman et al., 2019).

Bosniak III (Indeterminate Cystic Mass): One or more enhancing thick (4 mm or greater) walls or septa, or enhancing irregular walls or septa with convex protrusions measuring 3 mm or less. These lesions have a substantial risk of malignancy and are considered indeterminate (Silverman et al., 2019)

Bosniak IV (Malignant Cystic Mass): Cystic mass containing one or more enhancing nodules (defined as a convex protrusion measuring 4 mm or greater with obtuse margins, or a convex protrusion of any size with acute margins). These lesions are highly likely to represent malignant cystic renal neoplasms, including cystic renal cell carcinoma (Silverman et al., 2019).

The risk of malignancy generally increases with advancing Bosniak category. Bosniak I and II lesions are considered benign and do not require surveillance. Bosniak IIF lesions warrant imaging follow-up because of a low but measurable risk of malignancy, whereas Bosniak III and IV lesions typically require urologic consultation and consideration of biopsy, surveillance, ablative therapy, or surgical management based on lesion characteristics and individual factors (Campbell et al., 2021; Silverman et al., 2019).

Evidence Discussion

Ultrasound is often sufficient to characterize simple renal cysts, which generally do not require additional imaging evaluation (Expert Panel on Urologic Imaging et al., 2020; Silverman et al., 2019). However, solid renal masses, complex cystic lesions, or lesions that remain incompletely characterized on ultrasound generally warrant further evaluation with multiphasic contrast-enhanced CT or MRI (Silverman et al., 2019; Wang et al., 2020).

The American Urological Association (AUA) recommends obtaining high-quality, multiphase cross-sectional imaging for individuals with a solid or complex cystic renal mass to allow optimal lesion characterization and risk assessment (Campbell et al., 2021a, 2021b; Wang et al., 2020). Similarly, the ACR Appropriateness Criteria support

contrast-enhanced CT or MRI for the evaluation of indeterminate renal masses because these modalities provide detailed assessment of lesion enhancement, complexity, and malignant potential (Wang et al., 2020).

The Bosniak Classification Version 2019 further emphasizes the importance of contrast-enhanced CT or MRI in the characterization and management of cystic renal masses, facilitating risk stratification and clinical decision-making (Silverman et al., 2019).

Evidence also suggests that contrast-enhanced ultrasound (CEUS) may improve characterization of selected indeterminate renal lesions, particularly in individuals for whom iodinated CT contrast or gadolinium-based MRI contrast is undesirable. CEUS can help distinguish cystic from solid components and assess lesion vascularity. Despite these advantages, CT and MRI remain the primary modalities for comprehensive evaluation and management planning because of their broader anatomic assessment and well-established role in renal mass characterization (Wang et al., 2020; Zarzour et al., 2017).

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Pre-operative Assessment for Robotic Kidney Surgery (AB-35.2)

RL.AB.0035.2.A
v1.0.2027

Criteria

- Pre-operative imaging for robotic kidney surgery is considered medically necessary as follows:
  - If not previously performed:
    - CT Abdomen without and with contrast (CPT® 74170) OR
    - MRI Abdomen without and with contrast (CPT® 74183)
  - CTA Abdomen (CPT® 74175) or CTA Abdomen and Pelvis (CPT® 74174) OR
  - MRA Abdomen (CPT® 74185), or MRA Abdomen and Pelvis (CPT® 74185 and CPT® 72198)

Background and Supporting Information

Robotic kidney surgery, including partial and radical nephrectomy, is commonly performed for the treatment of renal masses. Preoperative imaging is used to define tumor characteristics, assess anatomic relationships, evaluate renal vasculature, and guide surgical planning to optimize operative outcomes (Campbell et al., 2021a; Campbell et al., 2021b).

Evidence Discussion

Robotic kidney surgery is most commonly performed for localized renal masses. Preoperative cross-sectional imaging is essential for lesion characterization, determination of tumor size and location, assessment of local extension, evaluation of regional anatomy, and visualization of the renal vasculature to facilitate surgical planning (Campbell et al., 2021a; Campbell et al., 2021b).

The American Urological Association recommends high-quality, multiphase cross-sectional abdominal imaging for the evaluation of solid and complex cystic renal masses because imaging findings are central to risk assessment and treatment planning (Campbell et al., 2021a). Contrast-enhanced CT provides detailed anatomic and vascular information and is commonly used for preoperative assessment of renal tumors, including evaluation of tumor complexity, involvement of adjacent structures, and renal arterial and venous anatomy (Herts et al., 2018; Wang et al., 2020).

MRI without and with contrast provides comparable diagnostic information and may be used when CT is contraindicated or when additional soft tissue characterization

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is needed. MRI is particularly useful in individuals with contraindications to iodinated contrast administration and for further evaluation of indeterminate renal masses (Campbell et al., 2021a; Wang et al., 2020).

Abdomen Imaging Guidelines

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Renal Failure (AB-36)

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Renal Failure (AB-36.1)

AB.PCRF.0036.1.C
v1.0.2027

Criteria

- Initial imaging evaluation of acute or chronic renal failure with EITHER of the following:
  - Ultrasound kidney and bladder (CPT® 76770 or CPT® 76775)
  - Doppler Ultrasound (CPT® 93975 or CPT® 93976)
- MRA Abdomen (CPT® 74185) is considered medically necessary when there is suspected:
  - renal vein/caval thrombosis OR
  - renal artery stenosis as cause of renal failure
- CT Abdomen without contrast (CPT® 74150) is considered not medically necessary except to rule out ureteral obstruction or retroperitoneal mass.

Evidence Discussion

Renal ultrasound is the preferred initial imaging examination for the evaluation of acute and chronic renal failure because it provides assessment of renal morphology and is highly sensitive for the detection of hydronephrosis and bladder distention without exposing individuals to ionizing radiation or nephrotoxic contrast agents. Current guidelines support kidney imaging as part of the evaluation of structural kidney abnormalities and potentially reversible causes of kidney dysfunction (KDIGO CKD Work Group, 2024; Nikolaidis et al., 2021).

In individuals with suspected renovascular disease, magnetic resonance angiography (MRA) plays an established role in the evaluation of renal vascular abnormalities. MRA provides detailed assessment of renal artery stenosis, renal vein thrombosis, and other vascular disorders that may contribute to impaired renal function. Vascular imaging is most useful when the clinical presentation or laboratory findings suggest a renovascular etiology of kidney dysfunction (Nikolaidis et al., 2021).

CT without contrast may be useful when urinary tract obstruction or retroperitoneal pathology is suspected, particularly when ultrasound findings are inconclusive or incomplete. CT can identify the presence, location, and cause of urinary tract obstruction and detect retroperitoneal masses affecting renal function (Nikolaidis et al., 2021).

In renal transplant recipients, imaging plays a central role in the evaluation of allograft dysfunction. Ultrasound with Doppler assessment is typically the initial imaging modality because it can evaluate graft perfusion, vascular complications, collecting system abnormalities, and obstructive processes. Additional imaging studies may provide

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complementary information when structural or functional graft impairment is suspected. Current ACR Appropriateness Criteria support the use of multimodality imaging tailored to the suspected cause of transplant dysfunction (Taffel et al., 2025).

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Renovascular Hypertension (AB-37)

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Renovascular Hypertension (AB-37.1)

AB.37.1.A
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- For consideration of Renovascular Hypertension/Renal Artery Stenosis, see: **Renovascular Hypertension/Renal Artery Stenosis (PVD-6.6)** in the Peripheral Vascular Disease Imaging Guidelines

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Polycystic Kidney Disease (AB-38)

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Polycystic Kidney Disease (AB-38.1)

AB.PK.0038.1.A
v1.0.2027

Criteria

- Retroperitoneal ultrasound (CPT® 76770 or CPT® 76775) is considered medically necessary for:
  - suspected polycystic kidney disease OR
  - screening individuals at risk for autosomal dominant polycystic disease (ADPKD)
    - In the absence of any clinical change, follow-up screening is considered not medically necessary if a screening ultrasound was performed at age 40 or later and was negative for any cysts.
    - If an initial ultrasound is negative for any cysts, a follow-up ultrasound is considered medically necessary at the discretion of the ordering provider for individuals less than 40 years of age.
- MRI Abdomen without contrast (CPT® 74181) or CT abdomen without contrast (CPT® 74150) is considered medically necessary for evaluation or management of suspected or confirmed autosomal dominant polycystic kidney disease (ADPKD):
  - if a cystic renal lesion is detected in an individual at-risk of PKD, for diagnostic clarification and prognostic assessment
  - for measurement of volume averaging (Total Kidney Volume – TKV) for risk stratification prior to disease-modifying therapy and for post-treatment follow-up for PKD.
  - Annual follow up imaging at the discretion of the ordering provider

Background and Supporting Information

Ultrasound is the primary imaging modality for screening and diagnosis of autosomal dominant polycystic kidney disease (ADPKD) because it is widely available, noninvasive, and highly effective for detecting renal cysts. Current guidelines support ultrasound as the preferred initial imaging examination for most individuals undergoing evaluation for ADPKD. However, ultrasound may have reduced sensitivity for detecting small renal cysts in younger individuals and in those with early-stage disease, particularly when cyst burden is limited (Gordon et al., 2025; Torres et al., 2025).

Ultrasound also has a high negative predictive value for excluding ADPKD in at-risk individuals, particularly with increasing age. Reported negative predictive values for a negative ultrasound examination are approximately 100% for both PKD1 and PKD2 in individuals aged 40 years and older, 100% for PKD1 and 96.8% for PKD2 in individuals aged 30 to 39 years, and 99.1% for PKD1 and 83.5% for PKD2 in individuals aged 25 to 29 years. These findings support the utility of ultrasound as a screening tool while

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highlighting its lower sensitivity for excluding disease in younger individuals, especially those with PKD2-associated disease (Torres et al., 2025).

Evidence Discussion

Imaging plays a central role in the diagnosis, risk stratification, and management of autosomal dominant polycystic kidney disease (ADPKD). Screening of at-risk individuals with ultrasound is supported by its ability to reliably detect and characterize renal cysts and by its high negative predictive value for excluding disease in appropriate age groups. Ultrasound remains the preferred initial imaging modality because it is widely available, noninvasive, and effective for establishing the diagnosis in most individuals with suspected ADPKD (Gordon et al., 2025; Torres et al., 2025).

Following diagnosis, imaging may be used to assess disease severity and progression. Total kidney volume (TKV) has been shown to correlate with disease progression and future decline in kidney function and is used to inform prognosis and treatment decisions. MRI provides the most accurate and reproducible assessment of TKV and is commonly used for risk stratification, selection of candidates for disease-modifying therapy, and treatment follow-up. CT may also be used when MRI is unavailable or contraindicated (Caserta et al., 2026; Torres et al., 2025).

Advanced imaging may also be necessary to further characterize renal lesions identified in individuals with ADPKD and to support diagnostic clarification when ultrasound findings are inconclusive. MRI is particularly useful for detecting small cysts and providing more detailed assessment of renal anatomy. Although imaging is frequently incorporated into longitudinal disease management, optimal follow-up intervals have not been uniformly established and should be individualized based on disease severity, treatment status, clinical changes, and the intended purpose of imaging evaluation (Caserta et al., 2026; Gordon et al., 2025).

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Hematuria and Hydronephrosis (AB-39)

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Hematuria with Urinary Tract Infection (UTI) (AB-39.1)

AB.HH.0039.1.A
v1.0.2027

Criteria

- Individuals suspected to have a UTI as the etiology of microscopic hematuria should be treated for the UTI and should then undergo repeat urinalysis to confirm resolution of the hematuria.
- If the hematuria persists following treatment of UTI, proceed with the risk-based evaluation as per **Asymptomatic Hematuria (AB-39.2)**.

Background and Supporting Information

Signs and symptoms of urinary tract infection (UTI) may include urinary frequency, urinary urgency, dysuria, and burning with urination. Associated laboratory and clinical findings may include positive urine leukocyte esterase, pyuria, fever, and leukocytosis based on laboratory-specific reference ranges. The presence and severity of symptoms vary according to the location and extent of infection and should be interpreted in the context of clinical and laboratory findings (Ward et al., 2026).

Evidence Discussion

The American Urological Association (AUA)/Society of Urodynamics, Female Pelvic Medicine & Urogenital Reconstruction (SUFU) Microhematuria Guideline defines microhematuria as the presence of three or more red blood cells per high-power field on microscopic urinalysis (Barocas et al., 2025). When hematuria is identified in the setting of a urinary tract infection, the infection should be treated and urinalysis repeated following resolution of the infection to determine whether hematuria persists. This approach helps distinguish transient infection-related hematuria from hematuria requiring further diagnostic evaluation (Barocas et al., 2025).

Persistent microhematuria following treatment of a urinary tract infection warrants additional evaluation based on the individual's risk for genitourinary malignancy. The AUA/SUFU guideline recommends a risk-stratified approach that incorporates factors such as age, sex, smoking history, degree of hematuria, and other clinical risk factors to guide the need for cystoscopy and upper tract imaging. Similarly, the ACR Appropriateness Criteria for Hematuria support the use of advanced imaging only after persistent hematuria has been confirmed and the individual's risk profile has been assessed (Barocas et al., 2025; Wolfman et al., 2020).

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This risk-based approach reduces unnecessary imaging and associated costs while maintaining diagnostic effectiveness for clinically significant urinary tract pathology. Evidence suggests that targeting imaging to individuals at elevated risk improves the balance between diagnostic yield and potential harms, including radiation exposure and downstream testing. Individuals with persistent hematuria may ultimately require evaluation for urinary tract malignancy, urolithiasis, or other structural abnormalities based on their overall risk profile and clinical presentation (Barocas et al., 2025; Georgieva et al., 2019; Wolfman et al., 2020).

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Asymptomatic Hematuria (AB-39.2)

AB.HH.0039.2.A
v1.0.2027

Criteria

- Prior to imaging for the evaluation of microscopic hematuria, individuals should be stratified into low, intermediate, or high risk, based on the following criteria:
  - Low risk (individual meets ALL criteria listed)
    - Women younger than 50 years of age or men younger than 40 years of age
    - Never smoker or fewer than 10 pack years of smoking exposure
    - 3-10 red blood cell (RBC)/high power field (HPF) on a single urinalysis
    - No additional risk factors for urothelial cancer, including:
      - Irritative lower urinary tract symptoms
      - Prior pelvic radiation therapy
      - Prior cyclophosphamide/ifosfamide chemotherapy
      - Family history of urothelial cancer or Lynch Syndrome
      - Occupational exposures to benzene chemicals or aromatic amines (e.g., rubber, petrochemicals, dyes)
      - Chronic indwelling foreign body in the urinary tract
  - Intermediate risk (individual meets ANY ONE of these criteria)
    - Women age 50-59 years, men age 40-59 years
      - 10-30 pack years of smoking
      - 11-25 RBC/HPF on a single urinalysis
      - Low-risk individual with no prior evaluation and 3-10 RBC/HPF on repeat urinalysis
      - Any additional risk factor for urothelial cancer listed above
  - High-risk (individual meets ANY ONE of these criteria)
    - Women or men 60 years of age or older
    - More than 30 pack-years of smoking
    - More than 25 RBC/HPF on a single urinalysis
    - Gross hematuria
- Low- or intermediate-risk individuals:
  - Renal ultrasound (combined with cystoscopy)
    - Low-risk individuals may elect for observation with repeat urinalysis within 6 months. If imaging was not performed initially, and follow-up urinalysis reveals persistent hematuria with 3-10 RBC/HPF the individual may be imaged according to Intermediate-Risk criteria. If more than 10 RBC/HPF, they should be imaged according to High-risk guidelines.

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- High-risk individuals
  - CT Urogram (CPT® 74178) is considered medically necessary (3D imaging is appropriate if requested)
    - If CT is contraindicated, MR Urography is considered medically necessary (CPT® 74183 and 72197)
      - If both CT and MR are contraindicated due to contrast, non-contrast CT Urography or renal ultrasound should be performed. See also: **General Guidelines (AB-1.0): Pregnancy Considerations for Imaging**.
- Persistent microscopic hematuria if previously evaluated by renal ultrasound
  - Imaging as per High-risk individuals above
- For the evaluation of microscopic hematuria in individuals with inherited risk factors for renal cortical tumors, ONE of the following imaging studies is considered medically necessary:
  - Renal ultrasound OR
  - CT Abdomen without and with contrast (CPT® 74170) OR
  - MRI Abdomen without and with contrast (CPT® 74183)

Note:

Inherited risk factors for renal cortical tumors include:

- Von Hippel Lindau
- Birt-Hogg-Dube
- Hereditary Papillary Renal Cell Cancer
- Hereditary Leiomyomatosis Renal Cell Cancer
- Tuberous Sclerosis

- Follow-up
  - Individuals with a negative hematuria evaluation who undergo repeat urinalysis
    - If repeat urinalysis is negative:
      - No further imaging evaluation is considered medically necessary.
    - If repeat urinalysis demonstrates persistent hematuria
      - Repeat imaging with renal ultrasound or CT urography may be considered medically necessary based on clinical circumstances.
- **Note:** 3-D Reconstruction enhances a CT Urogram. Requests for 3-D reconstruction (CPT® 76377 or 76376) for a CT Urogram can be considered medically necessary.

Background and Supporting

Hematuria may be categorized as gross hematuria or microhematuria. The American Urological Association (AUA)/Society of Urodynamics, Female Pelvic Medicine & Urogenital Reconstruction (SUFU) guideline defines microhematuria as 3 or more red

blood cells per high-power field on microscopic urinalysis. A positive urine dipstick alone is insufficient to establish the diagnosis and should be confirmed with microscopic examination of the urine (Barocas et al., 2025).

Evidence Discussion

The AUA/SUFU guideline recommends a risk-stratified approach to the evaluation of microhematuria (3 red blood cells per high-power field on microscopy) based on an individual's risk of genitourinary malignancy. When microhematuria is confirmed on microscopic urinalysis, individuals should be categorized as low, intermediate, or high risk to guide subsequent evaluation and imaging (Barocas et al., 2025).

Low-risk individuals may elect repeat urinalysis before proceeding with further evaluation. Intermediate- and high-risk individuals should undergo evaluation of both the upper and lower urinary tracts because the likelihood of identifying clinically significant pathology, including genitourinary malignancy, increases with risk category (Barocas et al., 2025; Wolfman et al., 2020).

For low- and intermediate-risk individuals, renal ultrasound is an appropriate initial upper tract imaging modality because the overall incidence of urinary tract malignancy is low. Ultrasound is noninvasive, readily available, does not expose individuals to ionizing radiation, and demonstrates good sensitivity for detecting renal masses and hydronephrosis (Barocas et al., 2025; Wolfman et al., 2020).

For high-risk individuals, multiphasic CT urography is the preferred initial upper tract imaging study because it provides comprehensive evaluation of the kidneys, collecting systems, and urothelium. MR urography is an appropriate alternative when CT urography is contraindicated (Barocas et al., 2025; Wolfman et al., 2020).

Individuals with contraindications to both CT and MRI, including severe renal dysfunction or contrast allergy, may be evaluated with renal ultrasound or noncontrast CT in conjunction with retrograde pyelography (Barocas et al., 2025).

Individuals with microhematuria and a family history of renal cell carcinoma or a known hereditary renal tumor syndrome should undergo upper tract imaging regardless of risk category because of their increased risk for renal malignancy (Barocas et al., 2025).

In individuals with persistent or recurrent microhematuria following a previously negative evaluation, repeat upper tract imaging may be considered on the basis of ongoing risk assessment, interval clinical change, and shared decision-making. Evidence suggests that a risk-based approach to repeat evaluation balances diagnostic yield with the potential harms and costs associated with unnecessary imaging (Barocas et al., 2025; Georgieva et al., 2019; Wolfman et al., 2020).

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Hematuria and Flank Pain (Suspicion for Renal/Ureteral Stones) (AB-39.3)

AB.HH.0039.3.A
v1.0.2027

Criteria

- CT Abdomen and Pelvis without contrast (CPT® 74176) OR CT Urogram (CPT® 74178)
  - Request for 3-D reconstruction (CPT® 76377 or CPT® 76375) to be performed with a CT Urogram is considered medically necessary.
  - US abdomen or retroperitoneum is considered medically necessary in lieu of CT for any of the above indications.

Background and Supporting Information

Flank pain accompanied by microscopic or gross hematuria is a common presentation of urinary tract stone disease. Urolithiasis may involve the kidneys or ureters and can result in urinary obstruction, hydronephrosis, infection, or renal impairment. Clinical presentation may include flank pain, hematuria, nausea, vomiting, and urinary symptoms (Gupta et al., 2023; Wolfman et al., 2020).

Evidence Discussion

CT of the abdomen and pelvis is the most sensitive imaging modality for the detection and characterization of urinary calculi. It provides accurate assessment of stone size, location, burden, and degree of urinary tract obstruction while also identifying alternative causes of flank pain and hematuria. Noncontrast CT is generally the preferred examination for suspected urolithiasis because of its high diagnostic accuracy for urinary stones. CT urography may be appropriate when evaluation of additional urinary tract pathology, including urothelial malignancy or other structural abnormalities, is clinically indicated (Gupta et al., 2023; Wolfman et al., 2020).

Ultrasound of the abdomen or retroperitoneum is an acceptable alternative initial imaging modality and may be selected when radiation exposure is a concern or when clinically appropriate. Ultrasound can identify hydronephrosis and many renal calculi but is generally less sensitive than CT for detection of ureteral stones (Gupta et al., 2023).

When CT urography is performed, three-dimensional image reconstruction may provide improved visualization of the renal collecting systems, ureters, and urinary bladder. These reconstructed images can facilitate evaluation of urinary tract anatomy, improve assessment of complex abnormalities, and assist in the detection and characterization

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of urothelial lesions when clinically indicated (Wolfman et al., 2020). While MR urography may be considered in select circumstances, such as when ionizing radiation or iodinated contrast administration should be avoided, CT urography remains the preferred modality for comprehensive evaluation of the upper urinary tract because of its superior spatial resolution, broader availability, and higher sensitivity for detecting urothelial lesions and urinary tract calculi (Wolfman et al., 2020).

Abdomen Imaging Guidelines

Hydronephrosis of Unexplained or Indeterminate Cause (AB-39.4)

AB.HH.0039.4.A
v1.0.2027

Criteria

- CT Urogram (CPT® 74178)
  - Requests for 3-D reconstruction (CPT® 76377 or CPT® 76375) to be performed with a CT Urogram is considered medically necessary.
  - US abdomen or retroperitoneum is considered medically necessary in lieu of a CT for any of the above indications.
- Retroperitoneal Ultrasound (CPT® 76770) is considered medically necessary every 6 to 12 months for the following:
  - uncomplicated hydronephrosis OR
  - neurogenic bladder OR
  - myelomeningocele (open spinal dysraphism) OR
  - spina bifida

Background and Supporting Information

Hydronephrosis is dilatation of the renal collecting system resulting from impaired urine drainage. Causes may include urinary tract obstruction, vesicoureteral reflux, neurogenic bladder, or other anatomic abnormalities. Identification of the underlying cause is important because persistent obstruction can lead to progressive renal dysfunction (Whitworth et al., 2024).

Evidence Discussion

Newly identified hydronephrosis without a known cause warrants further evaluation to determine the presence and etiology of urinary tract obstruction. CT urography provides comprehensive evaluation of the kidneys, ureters, and bladder and may identify obstructing calculi, strictures, masses, or other causes of hydronephrosis. Three-dimensional reconstruction may provide additional assessment of urinary tract anatomy when CT urography is performed (Whitworth et al., 2024).

Ultrasound of the abdomen or retroperitoneum is an appropriate alternative initial imaging modality and can identify hydronephrosis without exposure to ionizing radiation or intravenous contrast (Whitworth et al., 2024).

Individuals with uncomplicated chronic hydronephrosis, neurogenic bladder, myelomeningocele, or spina bifida may undergo periodic surveillance with

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retroperitoneal ultrasound to monitor for progression and potential renal deterioration (Whitworth et al., 2024).

Abdomen Imaging Guidelines

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Urinary Tract Infection (UTI) (AB-40)

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Urinary Tract Infection (AB-40.0)

AB.UT.0040.0.A
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These guidelines refer to UTI without Hematuria.

For UTI with Hematuria, see: **Hematuria and Hydronephrosis (AB-39)**

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Pyelonephritis (AB-40.1)

AB.UT.0040.1.A
v1.0.2027

Criteria

- CT Abdomen and Pelvis without and with contrast (CPT® 74178) or CT Abdomen and Pelvis with contrast (CPT® 74177) is considered medically necessary if:
  - complicated clinical context, including diabetes mellitus, immunocompromised state, history of nephrolithiasis, prior renal or urologic surgery, OR
  - fever (101 degrees Fahrenheit [38.5 degrees Celsius] or higher) OR
  - not responding to therapy after 3 days OR
  - recurrent pyelonephritis (at least 1 prior pyelonephritis) OR
  - males with first time UTI or recurrent UTI without etiology

  Note:

  3-D Reconstruction enhances a CT Urogram (CPT® 74178).

  Requests for 3-D reconstruction (CPT® 76377 or 76376) for a CT Urogram can be considered medically necessary.
- MRI Abdomen without or without and with contrast (CPT® 74181 or CPT® 74183) is considered medically necessary if:
  - Elevated creatinine
- Pregnant individuals should be evaluated initially by renal ultrasound (CPT® 76770 or CPT® 76775) and if further imaging is considered medically necessary, MRI Abdomen and Pelvis without contrast (CPT® 74181 and CPT® 72195).

Background and Supporting Information

Acute pyelonephritis is an infection of the renal parenchyma and collecting system that is typically diagnosed based on clinical presentation and laboratory findings. Common manifestations include fever, flank pain, costovertebral angle tenderness, dysuria, urinary frequency, urgency, pyuria, and bacteriuria (Smith et al., 2022).

Evidence Discussion

Acute pyelonephritis is primarily a clinical diagnosis, and most individuals respond to appropriate antimicrobial therapy without the need for advanced imaging. Therefore, routine imaging is generally not recommended for uncomplicated cases (Smith et al., 2022).

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Advanced imaging may be warranted when complicated infection is suspected, including in individuals with diabetes mellitus, immunocompromising conditions, nephrolithiasis, prior renal or urologic surgery, recurrent pyelonephritis, or persistent symptoms despite appropriate therapy. Contrast-enhanced CT is the preferred imaging modality for evaluating potential complications such as obstruction, abscess, or other structural abnormalities because it demonstrates high diagnostic performance for acute pyelonephritis (reported sensitivity 86.8%, specificity 87.5%) while providing comprehensive assessment of renal and perinephric complications (Smith et al., 2022; Nikolaidis et al., 2022).

MRI may be used when CT is contraindicated or when renal dysfunction limits the use of iodinated contrast. In pregnant individuals, renal ultrasound is the preferred initial imaging modality, with MRI without contrast preferred when additional evaluation is needed. However, according to the American College of Obstetricians and Gynecologists (ACOG), although ultrasonography and MRI are the imaging modalities of choice during pregnancy, CT should not be withheld when these modalities are insufficient, unavailable, or when timely diagnosis is clinically necessary. When the potential maternal benefit outweighs the theoretical fetal risk, CT may be performed to facilitate prompt diagnosis and management, particularly in conditions such as acute pyelonephritis, where delayed diagnosis may increase the risk of maternal complications and preterm labor (ACOG, 2017; Smith et al., 2022).

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Lower Urinary Tract Infection (AB-40.2)

AB.UT.0040.2.A
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Criteria

- CT Abdomen and Pelvis without and with contrast (CPT® 74178) is considered medically necessary if:
  - complicated clinical context including, diabetes mellitus, immunocompromised state, history of nephrolithiasis, prior renal or urological surgery, OR
  - fever (101 degrees Fahrenheit (38.5 degrees Celsius) or higher) OR
  - not responding to therapy after 3 days OR
  - males with first time UTI or recurrent UTI without etiology OR
  - recurrent UTI, defined as 3 or more episodes per year OR
  - recommendation by or in consultation with a urologist or specialist

  Note: 3-D Reconstruction enhances a CT Urogram (CPT® 74178). Requests for 3-D reconstruction (CPT® 76377 or 76376) for a CT Urogram can be considered medically necessary.
- MRI Abdomen and MRI Pelvis without or without and with contrast (CPT® 74181 and CPT® 72195 or CPT® 74183 and CPT® 72197) is considered medically necessary if requested when ALL of the following apply:
  - Criteria (as above) for CT Abdomen and Pelvis without and with contrast (CPT® 74178) are met, AND
  - Elevated creatinine
- See: **Periurethral Cysts and Urethral Diverticula (PV-13)** in the Pelvis Imaging Guidelines

Background and Supporting Information

Lower urinary tract infection (cystitis) is an infection involving the bladder and lower urinary tract. Common symptoms include dysuria, urinary frequency, urinary urgency, suprapubic pain, and pyuria. Most uncomplicated lower urinary tract infections are diagnosed clinically and respond to appropriate antimicrobial therapy (Anger et al., 2022; Venkatesan et al., 2020).

Evidence Discussion

Advanced imaging is generally not indicated for uncomplicated lower urinary tract infections because most individuals respond to appropriate antimicrobial therapy without progression to upper urinary tract disease (Anger et al., 2022; Venkatesan et al., 2020).

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Imaging may be warranted in individuals with a complicated urinary tract infection, recurrent urinary tract infections, or when underlying structural abnormalities are suspected. Risk factors for complicated infection include diabetes mellitus, immunocompromising conditions, nephrolithiasis, prior renal or urologic surgery, and fever. Males with urinary tract infection may also require further evaluation for an underlying anatomic or functional abnormality (Venkatesan et al., 2020).

CT of the abdomen and pelvis is the preferred advanced imaging modality when evaluation for complications or structural abnormalities is required. CT demonstrates high diagnostic performance for acute pyelonephritis and provides superior evaluation of urinary tract obstruction, nephrolithiasis, gas-forming infections, renal abscesses, and other perinephric complications. MRI may be used as an alternative when CT is contraindicated or when renal dysfunction limits the use of iodinated contrast; however, MRI is generally less sensitive for detecting urinary calculi and may be less readily available in acute clinical settings (Venkatesan et al., 2020).

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Patent Urachus (AB-41)

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Abdomen Imaging Guidelines

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Patent Urachus (AB-41.1)

AB.41.1.A
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For evaluation of suspected patent urachus, see: **Patent Urachus (PV-23.1)** in the Pelvis Imaging Guidelines.

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Transplant (AB-42)

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Liver Transplant, Pre-Transplant (AB-42.1)

AB.TX.0042.1.A
v1.0.2027

Criteria

- Individuals **WITHOUT hepatocellular carcinoma (HCC)** referred to a transplant center for liver transplant evaluation can undergo advanced imaging as follows:
  - Per the transplant institution's protocol, OR
  - Per the studies and intervals listed below:

Imaging Study	Interval	Comments
Both of the following US studies: ◦ Abdominal US (CPT® 76700 or CPT® 76705) and ◦ Doppler (CPT® 93975)	◦ Every 6 months	
ONE of the following abdomen/pelvis advanced imaging studies: ◦ CT Abdomen with contrast or without and with contrast (CPT® 74160 or CPT® 74170) ◦ MRI Abdomen without and with contrast (CPT® 74183)	◦ Annually ▪ Individuals with known cholangiocarcinoma may have more frequent repeat of studies at left per institution's protocol	

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Imaging Study	Interval	Comments
Additional abdomen/ pelvis advanced imaging, for individuals on the transplant list with known Primary Sclerosing Cholangitis (PSC): ◦ MRCP (See: **MRCP (AB-27.1)** for acceptable CPT® codes)	◦ Per the transplant institution's protocol	
◦ CT Chest with or without contrast (CPT® 71260 or CPT® 71250)	◦ One-time ▪ Individuals with known cholangiocarcinoma may have more frequent repeat of studies at left per institution's protocol	◦ Repeat studies based on clinical indications per **Chest Imaging Guidelines**
ONE of the following: ◦ MRI Bone Marrow Blood Supply (CPT® 77084) or ◦ Bone scan (CPT® 78306)	◦ One-time	
Echocardiography with ONE of the following: ◦ CPT® 93306 (preferred) ◦ CPT® 93307 ◦ CPT® 93308	◦ Annually	See: **Cardiac Imaging in Transplant CD-16** for descriptions of CPT codes or further indications
CT Coronary angiography (CCTA) (CPT® 75574)	◦ Annually	See: **Cardiac Imaging in Transplant CD-16** for descriptions of CPT codes or further indications

Imaging Study	Interval	Comments
Stress imaging in place of but not in addition to CT Coronary angiography (CCTA) - ONE of the following: ◦ CPT® 93350 ◦ CPT® 93351 ◦ CPT® 78452 ◦ CPT® 75563 ◦ CPT® 78492 ◦ CPT® 78431	◦ Annually	See: **Cardiac Imaging in Transplant CD-16** for descriptions of CPT codes or further indications
For individuals with systemic amyloidosis: ◦ Cardiac MRI – ONE of the following: ▪ CPT® 75557 ▪ CPT® 75561 ◦ If Cardiac MRI is contraindicated or indeterminate, ONE of the following SPECT studies may be performed: ▪ CPT® 78803 ▪ CPT® 78830	◦ One-time	See: **Cardiac Imaging in Transplant CD-16** for descriptions of CPT codes or further indications

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Imaging Study	Interval	Comments
If required to further assess CAD seen on a recent CCTA that is of uncertain physiologic significance, CT-FFR (Noninvasive estimated coronary fractional flow reserve derived from coronary computed tomography angiography) with ONE of the following: ◦ CPT® 0501T ◦ CPT® 75580	◦ One-time	See: **Cardiac Imaging in Transplants CD-16** for descriptions of CPT codes or further indications

Imaging Study	Interval	Comments
In place of CT Coronary angiography or stress imaging for initial pre-transplant evaluation, OR If CT Coronary angiography and/or CT-FFR or stress imaging is abnormal WITH addition of right heart catheterization if requested for evaluation of pulmonary hypertension: ◦ Left heart catheterization or left and right heart catheterization with ONE of the following: ▪ CPT® 93458 ▪ CPT® 93454 ▪ CPT® 93460 ▪ CPT® 93456 ◦ Or if prior CABG, with ONE of the following: ▪ CPT® 93459 ▪ CPT® 93455 ▪ CPT® 93461 ▪ CPT® 93457	◦ One-time	Repeat studies as per **Cardiac Imaging in Transplant CD-16**
ONE of the following, for vascular evaluation in anticipation of transplant: ◦ CTA (CPT® 74175) ◦ MRA Abdomen (CPT® 74185)	◦ One-time	

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Imaging Study	Interval	Comments
ANY of the following may be performed immediately prior to transplant: ◦ Abdominal US (CPT® 76700 or CPT® 76705) AND Doppler (CPT® 93975) ◦ CT Abdomen with contrast or without and with contrast (CPT® 74160 or CPT® 74170) OR MRI Abdomen without and with contrast (CPT® 74183) ◦ CT Abdomen and Pelvis with contrast (CPT® 74177) or CT Pelvis with contrast (CPT® 72193) ◦ CTA (CPT® 74175) OR MRA Abdomen (CPT® 74185)	◦ Once, immediately prior to transplant	

- Individuals **WITH hepatocellular carcinoma (HCC)** referred to a transplant center for liver transplant evaluation can undergo advanced imaging as follows:
  - Per the transplant institution's protocol, OR
  - Per the studies and intervals listed below:

Imaging Study	Interval	Comments
Both of the following US studies: ◦ Abdominal US (CPT® 76700 or CPT® 76705) and ◦ Doppler (CPT® 93975)	◦ Every 6 months	

Imaging Study	Interval	Comments
ONE of the following abdomen/pelvis advanced imaging studies: ◦ CT Abdomen with contrast or without and with contrast (CPT® 74160 or CPT® 74170) ◦ MRI Abdomen without and with contrast (CPT® 74183)	◦ Every 3 months ▪ Can be approved at interval as requested according to the transplant center's protocol for waitlisted individuals under active locoregional therapy to control tumor growth (i.e., tumor ablation)	
◦ CT Chest with contrast (CPT® 71260)	◦ Every 6 months ▪ Can be approved at interval as requested according to the transplant center's protocol for waitlisted individuals under active locoregional therapy to control tumor growth (i.e., tumor ablation)	
◦ Bone Scan (CPT® 78306)	◦ Every 6 months	
Echocardiography with ONE of the following: ◦ CPT® 93306 (preferred) ◦ CPT® 93307 ◦ CPT® 93308	◦ Annually	See: **Cardiac Imaging in Transplant CD-16** for descriptions of CPT codes or further indications
CT Coronary angiography (CCTA) (CPT® 75574)	◦ Once in 3 years	See: **Cardiac Imaging in Transplant CD-16** for descriptions of CPT codes or further indications

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Imaging Study	Interval	Comments
Stress imaging in place of but not in addition to CT Coronary angiography (CCTA) - ONE of the following: ◦ CPT® 93350 ◦ CPT® 93351 ◦ CPT® 78452 ◦ CPT® 75563 ◦ CPT® 78492 ◦ CPT® 78431	◦ Annually	See: **Cardiac Imaging in Transplant CD-16** for descriptions of CPT codes or further indications
For individuals with systemic amyloidosis: ◦ Cardiac MRI – ONE of the following: ▪ CPT® 75557 ▪ CPT® 75561 ◦ If Cardiac MRI is contraindicated or indeterminate, ONE of the following SPECT studies may be performed: ▪ CPT® 78803 ▪ CPT® 78830	◦ One-time	See: **Cardiac Imaging in Transplant CD-16** for descriptions of CPT codes or further indications

Imaging Study	Interval	Comments
If required to further assess CAD seen on a recent CCTA that is of uncertain physiologic significance, CT-FFR (Noninvasive estimated coronary fractional flow reserve derived from coronary computed tomography angiography) with ONE of the following: ◦ CPT® 0501T ◦ CPT® 75580	◦ One-time	See: **Cardiac Imaging in Transplant CD-16** for descriptions of CPT codes or further indications

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Imaging Study	Interval	Comments
In place of CT Coronary angiography or stress imaging for initial pre-transplant evaluation, OR If CT Coronary angiography and/or CT-FFR or stress imaging is abnormal WITH addition of right heart catheterization if requested for evaluation of pulmonary hypertension: ◦ Left heart catheterization or left and right heart catheterization with ONE of the following: ▪ CPT® 93458 ▪ CPT® 93454 ▪ CPT® 93460 ▪ CPT® 93456 ◦ Or if prior CABG, with ONE of the following: ▪ CPT® 93459 ▪ CPT® 93455 ▪ CPT® 93461 ▪ CPT® 93457	◦ One-time	Repeat studies as per **Cardiac Imaging in Transplant CD-16**

Imaging Study	Interval	Comments
ANY of the following may be performed immediately prior to transplant: ◦ Abdominal US (CPT® 76700 or CPT® 76705) AND Doppler (CPT® 93975) ◦ CT Abdomen with contrast or without and with contrast (CPT® 74160 or CPT® 74170) OR MRI Abdomen without and with contrast (CPT® 74183) ◦ CT Abdomen and Pelvis with contrast (CPT® 74177) or CT Pelvis with contrast (CPT® 72193) ◦ CTA (CPT® 74175) OR MRA Abdomen (CPT® 74185) ◦ MRI Bone Marrow Blood Supply (CPT® 77084)	◦ Once, immediately prior to transplant	

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Liver Transplant, Living Donor Pre-Transplant Imaging (Donor Imaging) (AB-42.2)

AB.TX.0042.2.A
v1.0.2027

Criteria

- CT Abdomen with contrast (CPT® 74160) OR CT Abdomen without and with contrast (CPT® 74170) OR MRI Abdomen without and with contrast (CPT® 74183) is considered medically necessary to assess liver anatomy and volumetrics.
- MRCP is considered medically necessary to assess biliary anatomy (See: **MRCP (AB-27.1)** for proper coding)
- CTA Abdomen without and with contrast (CPT® 74175) OR MRA Abdomen without and with contrast (CPT® 74185) is considered medically necessary to assess vascular anatomy.
- For donor imaging post-transplant, imaging is considered medically necessary per transplant center protocol. If no transplant center protocol exists, see condition-specific guideline appropriate to the individual's signs and symptoms.

Evidence Discussion

Imaging plays a critical role in the evaluation of potential living liver donors. Comprehensive preoperative assessment of hepatic parenchyma, liver volume, vascular anatomy, and biliary anatomy is necessary to determine donor suitability and support operative planning (Bailey et al., 2023; Cai et al., 2016).

CT, MRI, and MRCP are complementary imaging modalities commonly used during donor evaluation. CT provides detailed assessment of hepatic arterial and venous anatomy and allows accurate liver volumetric analysis, while MRI and MRCP provide detailed evaluation of the hepatic parenchyma and biliary anatomy (Bailey et al., 2023; Borhani et al., 2021; Vernuccio et al., 2021).

Identification of vascular and biliary anatomic variants is critical because these findings may influence donor eligibility, operative technique, and transplant outcomes for both donors and recipients. Consequently, living donor liver transplant evaluation commonly incorporates CT, MRI/MRCP, and dedicated vascular imaging to provide comprehensive preoperative assessment (Bailey et al., 2023; Cai et al., 2016; Dove et al., 2025).

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Liver Transplant, Post-Transplant Imaging (AB-42.3)

AB.TX.0042.3.A
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Criteria

- Cardiac Imaging:
  - See: **Cardiac Imaging in Transplants CD-16** in the Cardiac Imaging Guidelines
- Suspected post-operative complications:
  - Vascular thrombosis (suspected hepatic artery thrombosis) imaging is considered medically necessary as follows:
    - Doppler ultrasound (CPT® 93975)
    - CTA Abdomen without and with contrast (CPT® 74175) OR MRA Abdomen without and with contrast (CPT® 74185)
  - Suspicion of biliary anastomotic strictures:
    - MRCP (See: **MRCP (AB-27.1)** for appropriate CPT codes)
    - Vascular imaging as above for vascular thrombosis may also be requested and considered medically necessary for this indication
  - Other suspected post-operative complications (e.g., infection)
    - Imaging as requested by the transplant institution or team
- Transplant individuals without prior HCC or cholangiocarcinoma:
  - Routine post-transplant imaging is considered not medically necessary.
  - If cirrhosis develops post-transplant:
    - See: **Cirrhosis and Liver Screening for Hepatocellular Carcinoma (HCC) (AB-26.1)**, **Ascites (AB-26.2)**, and **Portal Hypertension (AB-26.3)** for HCC screening guidelines.
  - Fibrosis assessment post-liver transplant:
    - Transient elastography (CPT® 91200) is considered medically necessary, which is the most studied modality in this setting.
- Surveillance after transplant for HCC is medically necessary as follows:
  - Based on RETREAT score
    - 0 points: No additional screening needed
    - 1-3 points: CT or MRI Abdomen (CPT® 74160, or CPT® 74170, or CPT® 74183) and CT Chest (CPT® 71260 or CPT® 71250) every 6 months for 2 years.
    - 4 points: CT or MRI Abdomen (CPT® 74160, or CPT® 74170, or CPT® 74183) and CT Chest (CPT® 71260 or CPT® 71250) every 6 months for 5 years

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        - 5 points or greater: CT or MRI Abdomen (CPT® 74160, or CPT® 74170, or CPT® 74183) and CT Chest (CPT® 71260 or CPT® 71250) every 3 months for 2 years, then every 6 months between the 2nd and 5th years.
- If there is a suspicion of recurrent tumor based on clinical findings and/or sequentially increasing AFP:
    - CT Abdomen with contrast (CPT® 74160), CT Abdomen without and with contrast (CPT® 74170) or MRI Abdomen without and with contrast (CPT® 74183) is considered medically necessary
- Imaging after transplant for primary sclerosing cholangitis (PSC):
    - Suspected recurrence of PSC;
        - MRCP (See: **MRCP (AB-27.1)** for proper coding)
- Imaging after transplant for cholangiocarcinoma is considered medically necessary as follows:
    - Liver ultrasound (CPT® 76705 or CPT® 76700) or MRI Abdomen and MRCP (CPT® 74183) every 6 months for 5 years post-transplantation.
    - CT Chest without contrast (CPT® 71250) or CT Chest with contrast (CPT® 71260) every 6 months for 5 years post-transplantation

Background and Supporting Information

Consensus recommendations regarding post-transplant surveillance imaging after liver transplantation for hepatocellular carcinoma (HCC) have not been universally established. To address this limitation, Mehta et al. (2017) developed and validated the Risk Estimation of Tumor Recurrence After Transplant (RETREAT) score using cohorts from the University of California, San Francisco (UCSF), Mayo Clinic-Rochester, and Mayo Clinic-Jacksonville, with subsequent external validation in an independent cohort. The RETREAT score is an evidence-based prognostic model designed to estimate the risk of HCC recurrence following liver transplantation and has been incorporated into post-transplant surveillance strategies at several transplant centers, including UCSF (Mehta et al., 2017).

The RETREAT score incorporates three variables: (1) serum alpha-fetoprotein (AFP) level at the time of liver transplantation, (2) the presence or absence of microvascular invasion on explant pathology, and (3) the sum of the diameter of the largest viable tumor and the number of viable tumors identified in the explanted liver. Points are assigned for each variable and combined to generate a total score ranging from 0 to 8, with higher scores indicating a greater risk of post-transplant HCC recurrence (Mehta et al., 2017).

For example, a RETREAT score of 0 is assigned when the AFP level at transplantation is 20 ng/mL or lower, there is no evidence of microvascular invasion, and no viable tumor is identified in the explanted liver. Individuals with a RETREAT score of 0 have an estimated 5-year post-transplant recurrence risk of less than 3% (Mehta et al., 2017).

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The RETREAT score is calculated as follows:

Risk Factor	Score
Alpha-fetoprotein level before LT	
0-20	0
21-99	1
100-999	2
≥1000	3
Microvascular invasion present	2
Sum of the diameter of the largest viable tumor and the number of viable nodules	
0	0
1.1-4.9	1
5.0-9.9	2
≥10	3

Evidence Discussion

Imaging plays a central role in the evaluation of liver transplant recipients because clinical manifestations of graft dysfunction are often subtle and nonspecific. Ultrasound with Doppler evaluation is commonly used for routine assessment of the liver allograft and its vascular structures, while CT, MRI, MR angiography, and MR cholangiography may be utilized when further evaluation of vascular, biliary, parenchymal, or extrahepatic abnormalities is required (Te et al., 2026; Wahab et al., 2026).

There is no universally accepted imaging surveillance schedule following liver transplantation, and imaging is typically guided by transplant center protocols, clinical symptoms, or abnormal laboratory findings. Consequently, multiple imaging modalities

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may be required throughout the lifetime of the liver transplant recipient depending on the suspected complication (Sharma et al., 2025; Wahab et al., 2026).

Individuals with a history of hepatocellular carcinoma (HCC) prior to liver transplantation remain at risk for post-transplant tumor recurrence. Current guidelines support surveillance with multiphasic contrast-enhanced CT or MRI of the abdomen, with chest imaging as appropriate, and risk stratification tools such as the RETREAT score may help guide surveillance decisions (Dove et al., 2026; Filgueira, 2019; Mehta et al., 2017).

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Post-Transplant Lymphoproliferative Disorder (PTLD) (AB-42.4)

AB.TX.0042.4.A
v1.0.2027

Criteria

- CT Chest with contrast (CPT® 71260) and CT Abdomen and Pelvis with contrast (CPT® 74177) is considered medically necessary for known or suspected PTLD.
- Additional evaluation of suspected PTLD is the same as the evaluation of lymphoma. See: **Post-Transplant Lymphoproliferative Disorders (ONC-27.9)** in the Oncology Imaging Guidelines for further recommendations
- Routine use of imaging to screen for PTLD is considered not medically necessary as there is insufficient supporting evidence.

Background and Supporting Information

Post-transplant lymphoproliferative disorder (PTLD) is a serious complication of solid organ transplantation characterized by abnormal lymphoid proliferation that ranges from benign lymphoid hyperplasia to aggressive lymphoma. PTLD is associated with chronic immunosuppression and is frequently related to Epstein-Barr virus (EBV) infection. The risk and presentation vary according to the type of transplant, degree of immunosuppression, and EBV status of the donor and recipient (Lee et al., 2023; Ligeti et al., 2017).

Evidence Discussion

Imaging plays an important role in the evaluation of suspected PTLD because disease involvement may occur in lymph nodes, solid organs, or extranodal sites and may not be readily identified on ultrasound examination. Contrast-enhanced CT of the chest, abdomen, and pelvis is commonly used to evaluate the extent of disease because PTLD frequently involves multiple nodal and extranodal sites. Advanced cross-sectional imaging assists with detection, staging, treatment planning, and assessment of treatment response (Lee et al., 2023; Ligeti et al., 2017).

Early diagnosis is important because PTLD may respond to reduction of immunosuppressive therapy and other targeted treatments. Advanced cross-sectional imaging can facilitate detection, staging, and treatment planning in individuals with suspected or confirmed PTLD (Lee et al., 2023; Ligeti et al., 2017).

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Kidney Transplant, Pre-Transplant Imaging Studies (AB-42.5)

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v1.0.2027

Criteria

Pre-Transplant Evaluation (Per Institution Protocol)

- Individuals referred to a transplant center for kidney or kidney-pancreas transplant evaluation can undergo advanced imaging as follows:
  - Per the transplant institution's protocol, OR
  - Per the studies and intervals listed below:

Imaging Study	Interval	Comments
ONE of the following abdomen/pelvis imaging studies is considered medically necessary: • CT Abdomen and Pelvis without contrast (CPT® 74176) • CT Abdomen and Pelvis with contrast (CPT® 74177) • CTA Abdomen without and with (CPT® 74175) • CTA Abdomen and Pelvis (CPT® 74174) • CTA Pelvis without and with (CPT® 72191)	One-time	
ONE of the following echocardiography studies is considered medically necessary: • CPT® 93306 (preferred) • CPT® 93307 • CPT® 93308	Annual	See also: **Cardiac Imaging in Transplant CD-16** for descriptions of CPT codes or further indications

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Imaging Study	Interval	Comments
ONE of the following stress imaging studies is considered medically necessary: • CPT® 93350 • CPT® 93351 • CPT® 78452 • CPT® 75563 • CPT® 78492 • CPT® 78431	Annual	See also: **Cardiac Imaging in Transplant CD-16** for descriptions of CPT codes or further indications

Additional Pre-Transplant Evaluation (Per Indication)

Individuals referred to a transplant center for kidney or kidney-pancreas transplant evaluation can undergo the following additional advanced imaging when the listed indications are met:

Indication	Imaging Study	Interval	Comments
• 20 pack-year history of smoking	ONE of the following is considered medically necessary: • CT Chest without contrast (CPT® 71250) • CT Chest with contrast (CPT® 71260)	One-time	For lung cancer screening with Low Dose Computed Tomography (LDCT), see: **U.S. Preventative Services Task Force: Lung Cancer Screening (Commercial and Medicaid) (CH-33.1)**
• Autosomal dominant polycystic kidney disease	ONE of the following is considered medically necessary: • MRA Head (CPT® 70544, 70545, or 70546) • CTA Head (CPT® 70496)	One-time	Repeat imaging as per **Intracranial Aneurysms (HD-12.1)**

Indication	Imaging Study	Interval	Comments
• History of stroke, or • History of TIA, or • Carotid bruit on exam	ONE of the following is considered medically necessary: • Carotid duplex bilateral study (CPT® 93880 or CPT® 93882)	One-time	Repeat imaging as per **Initial Imaging (PVD-3.1)**
• Presence of systemic amyloidosis	ONE of the following cardiac MRI studies is considered medically necessary: • CPT® 75557 • CPT® 75561	One-time	See also: **Cardiac Imaging in Transplant CD-16** for descriptions of CPT codes or further indications
BOTH of the following: • Presence of systemic amyloidosis AND • Cardiac MRI is either contraindicated or indeterminate	ONE of the following nuclear medicine studies is considered medically necessary: • CPT® 78803 • CPT® 78830	One-time	See also: **Cardiac Imaging in Transplant CD-16** for descriptions of CPT codes or further indications
• In place of stress imaging for initial pre-transplant evaluation, or • Stress imaging is positive for ischemia	ONE of the following heart catheterization is considered medically necessary: • CPT® 93458 • CPT® 93454 • If prior CABG: ◦ CPT® 93459 ◦ CPT® 93455	One-time	Repeat imaging as per **Cardiac Imaging in Transplant CD-16**

Kidney Donor Nephrectomy or Pre-Transplant Nephrectomy

Indication	Imaging Study	Comments
• Individuals being evaluated for living kidney donation, or • Individual is planning removal of one or both kidneys	ONE of the following is considered medically necessary: • CTA Abdomen (CPT® 74175) • MRA Abdomen (CPT® 74185) • MRI Abdomen without and with contrast (CPT® 74183)	For CTA and MRA, 3D rendering is included with the original study

Background and Supporting Information

Kidney transplantation requires careful preoperative evaluation of both transplant candidates and potential living donors. Imaging is used to assess renal anatomy, vascular anatomy, and potential abdominal or pelvic abnormalities that may affect transplant eligibility, operative planning, or post-transplant outcomes (Cheng et al., 2022; Lentine et al., 2017).

Evidence Discussion

Individuals undergoing evaluation for kidney or kidney-pancreas transplantation may require cross-sectional imaging of the abdomen and pelvis to identify anatomic abnormalities, assess vascular anatomy, and detect conditions that could affect transplant candidacy or surgical planning (Cheng et al., 2022; Lentine et al., 2017).

CTA or MRA may be utilized to evaluate vascular anatomy and, in selected individuals, to assess the native kidneys when pre-transplant nephrectomy is being considered. Imaging protocols may vary among transplant centers and are often incorporated into standardized transplant evaluation pathways (Lentine et al., 2017).

Because cardiovascular disease is a major cause of morbidity and mortality in individuals with chronic kidney disease, pre-transplant evaluation commonly includes cardiac risk assessment. Additional cardiac imaging may be appropriate in selected high-risk individuals based on transplant center protocols and clinical findings (Cheng et al., 2022; VanWagner et al., 2018).

Individuals with autosomal dominant polycystic kidney disease (ADPKD) may undergo CT or MR angiography of the head to evaluate for intracranial aneurysms when clinically indicated (Lentine et al., 2017). Potential living kidney donors typically undergo CT or

MR angiography to assess renal size, anatomy, and vascular variants that may affect donor suitability and surgical planning (Aghayev et al., 2019; Lentine et al., 2017).

Abdomen Imaging Guidelines

Kidney Transplant, Post-Transplant (AB-42.6)

AB.TX.0042.6.A
v1.0.2027

Criteria

- Ultrasound of transplanted kidney:
  - Current ultrasound imaging protocols of the transplanted kidney commonly include a Doppler study and are coded as CPT® 76776.
    - Do not report non-invasive vascular codes CPT® 93975 and CPT® 93976 in conjunction with CPT® 76776.
  - Ultrasound of the transplanted kidney performed without duplex Doppler should be reported as a limited retroperitoneal ultrasound (CPT® 76775).

Background and Supporting

Kidney transplant recipients require ongoing monitoring for graft function and potential post-transplant complications. Complications may include vascular abnormalities, urinary obstruction, fluid collections, rejection, infection, and other causes of allograft dysfunction (Expert Panel on Urological Imaging, Taffel et al., 2025).

Evidence Discussion

Imaging plays an important role in the evaluation of the renal allograft for routine surveillance and assessment of suspected graft dysfunction. Ultrasound with Doppler is the preferred initial imaging modality because it is noninvasive, widely available, and allows assessment of transplant kidney morphology, perfusion, vascular patency, and urinary tract obstruction without exposure to ionizing radiation or intravenous contrast (Expert Panel on Urological Imaging, Taffel et al., 2025).

Current transplant kidney ultrasound protocols routinely incorporate Doppler evaluation because vascular complications are an important cause of graft dysfunction. Doppler assessment provides evaluation of transplant perfusion and vascular integrity as part of the standard sonographic examination (Expert Panel on Urological Imaging, Taffel et al., 2025).

Additional imaging may be required when ultrasound findings are inconclusive or when further evaluation of transplant-related complications is needed. The choice of imaging modality is typically guided by clinical findings, laboratory abnormalities, and transplant center protocols (Expert Panel on Urological Imaging, Taffel et al., 2025).

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Heart Transplant (AB-42.7)

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- For cardiac transplant imaging indications, see: **Cardiac Imaging in Transplants (CD-16)**

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Hepatic and Abdominal Arteries (AB-43)

Guideline Page

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Hepatic Arteries and Veins (AB-43.1)

AB.HA.0043.1.A
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Criteria

- **Portal Vein Thrombosis (PVT):**
  - Doppler US (CPT® 93975) is the initial noninvasive modality for the diagnosis of Portal Vein Thrombosis
  - CT Abdomen with contrast (CPT® 74160 or 74170 – 4 phase CT), MRI Abdomen without and with contrast (CPT® 74183) or CTA Abdomen (CPT® 74175) is considered medically necessary for ANY of the following:
    - to assess the extension of thrombus into the mesenteric veins when Doppler US (or other imaging, such as abdominal US) is positive for PVT
    - to exclude tumor thrombus among individuals with cirrhosis who develop new portal and/or mesenteric vein thrombosis
    - for continued concern for PVT (for example in an individual with a hypercoagulable state or abdominal malignancy) if Doppler US is negative or inconclusive
  - To assess for development of intestinal ischemia among individuals with known portal and/or mesenteric vein thrombosis (MVT) (e.g., development of fever, rebound, leukocytosis, elevated serum lactate levels):
    - See: **Mesenteric Ischemia (AB-6.1)** for additional imaging indications
  - For suspicion of portal hypertensive or portal cavernoma cholangiopathy in individuals with known PVT or MVT (cholestatic liver chemistry profile (See **Abnormal Liver Chemistries (AB-30.1)**), known portal cavernoma, extrahepatic biliary abnormalities on imaging):
    - MRCP (CPT® 74183 or CPT® 74181) is considered medically necessary
- **For routine follow-up of PVT:**
  - US/Doppler every 6 months. If these are reported as not providing adequate visualization, CT Abdomen (CPT® 74160), MRI Abdomen (CPT® 74183), or CTA Abdomen (CPT® 74175), is considered medically necessary.
- **For follow-up of PVT being treated with anticoagulation:**
  - US/Doppler, CT Abdomen with contrast (CPT® 74160), MRI Abdomen without and with contrast (CPT® 74183), or CTA Abdomen (CPT® 74175) is considered medically necessary in 3-6 months.
  - Further follow-up every 6 months with US/Doppler unless these are reported as not providing adequate visualization, in which case any of the above studies can be approved.
- **TIPS (transjugular intrahepatic portosystemic shunt):**

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- Pre-procedure evaluation:
  - Abdominal US, including Doppler (CPT® 76700 and/or CPT® 93975), Multiphase CT Abdomen with contrast or without and with contrast (CPT® 74160 or CPT® 74170), Multiphase CTA Abdomen (CPT® 74175), Multiphase MRA Abdomen (CPT® 74185), or MRI Abdomen liver protocol (CPT® 74183) is considered medically necessary
  - Echocardiogram (CPT® 93306) (see: **Transthoracic Echocardiography (TTE) – Indications/Initial Evaluation (CD-2.2)**)
- For routine follow-up to monitor stent patency:
  - US with Doppler (CPT® 93975) is considered medically necessary 7-14 days after shunt creation, and then at 3 months, 6 months, and then every 6 months thereafter.
    - If requested earlier than the above intervals because of a clinical deterioration or suspicion of stent occlusion, the Doppler is considered medically necessary.
- If Doppler imaging is indeterminate or if there is a negative Doppler with clinical signs of worsening portal hypertension the following is considered medically necessary:
  - Multiphase CT Abdomen with contrast or without and with contrast (CPT® 74160 or CPT® 74170), Multiphase CTA Abdomen (CPT® 74175), Multiphase MRA Abdomen (CPT® 74185), or MRI Abdomen liver protocol (CPT® 74183)
- Echocardiogram (CPT® 93306) is considered medically necessary for the following:
  - One time post-procedure for routine follow up
  - Any time post-procedure:
    - for new signs or symptoms
    - for concern for new or worsening pulmonary hypertension
    - See also: **Frequency of Echocardiography Testing (CD-2.3)** in the Cardiac Imaging Guidelines

- **For the evaluation of Budd-Chiari Syndrome (BCS)**
  - Doppler US (CPT® 93975) is the initial diagnostic test for the evaluation of BCS.
  - CT Abdomen with contrast (CPT® 74160), or MRI Abdomen without and with contrast (CPT® 74183) or CTA Abdomen (CPT® 74175) is considered medically necessary for ANY of the following:
    - to assess thrombus extension
    - to rule out tumor thrombus
    - to assess response to anticoagulation therapy
    - if there is high suspicion of BCS despite a negative or inconclusive Doppler US

        - to additionally assess indeterminate hepatic nodules detected on the prior US (any of the above studies or CT Abdomen without and with contrast CPT® 74170)
    - For pre-operative evaluation of anticipated interventional vascular therapies or TIPS the following is considered medically necessary:
        - Abdominal US, including Doppler (CPT® 76700 and/or CPT® 93975), Multiphase CT Abdomen (CPT® 74160 or CPT® 74170), Multiphase CTA Abdomen (CPT® 74175), Multiphase MRA Abdomen (CPT® 74185), or MRI Abdomen liver protocol (CPT® 74183)
    - For HCC Surveillance in individuals with chronic BCS the following is considered medically necessary:
        - Abdominal US (CPT® 76700 or CPT® 76705) and serum alpha-fetoprotein every 6 months
        - Triphasic CT Abdomen (CPT® 74160 or CPT® 74170), or MRI Abdomen (CPT® 74183) for the evaluation of hepatic nodules seen on US or AFP greater than or equal to 15 ng/ml.
        - The LiRADS reporting system does not apply to HCC surveillance in this population, due to the vascular origin of many of the hepatic imaging abnormalities.
- **Hereditary Hemorrhagic Telangiectasia (HHT)**
    - The liver may be involved in individuals with HHT, and artery-to-vein or vein-to-vein shunting may occur resulting in liver vascular malformations (LVMs).
    - Screening the liver for LVMs is considered not medically necessary.
    - For symptoms suggestive of liver vascular malformations (LVMs) (including an audible bruit or palpable thrill over the hepatic region on physical examination, abnormal liver tests) or for the development of signs or symptoms of heart failure, biliary ischemia, hepatic encephalopathy, mesenteric ischemia, or portal hypertension the following is medically necessary:
        - CT Abdomen with contrast (CPT® 74160), CTA Abdomen (CPT® 74175), MRI Abdomen without and with (CPT® 74183), MRCP (CPT® 74183), or MRA Abdomen (CPT® 74185)
- CTA Abdomen and Pelvis (CPT® 74174), or CTA Abdomen (CPT® 74175) or MRA Abdomen (CPT® 74185) is considered medically necessary additionally for:
    - Evaluation of portal and hepatic veins prior to or following surgical intervention for the treatment of portal hypertension (See: **Portal Hypertension (AB-26.3)**)
    - Evaluation of hepatic vasculature prior to and following embolization procedure (See: **Hepatocellular Carcinoma (HCC) – Restaging/Recurrence (ONC-14.4)** and **Hepatocellular Carcinoma (HCC) – Surveillance/Follow-up (ONC-14.5)** and **Liver Metastases (ONC-31.2)** in the Oncology Imaging Guideline)
    - Evaluation of hepatic vasculature prior to planned hepatectomy (See: **Liver Transplant, Pre-Transplant (AB-42.1)**)

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- Evaluation of liver donor (See: Liver Transplant, **Living Donor Pre-Transplant Imaging (Donor Imaging) (AB-42.2)** for specific guidance)

- **Hepatic arterial aneurysms:**
  - See: **Visceral Artery Aneurysm (PVD-6.5)** in the Peripheral Vascular Disease Imaging Guidelines

Background and Supporting Information

Primary Budd-Chiari syndrome is a rare vascular liver disorder caused by thrombotic obstruction of the hepatic venous outflow tract, involving the hepatic veins and, less commonly, the inferior vena cava. Most affected individuals have an underlying prothrombotic condition, including myeloproliferative neoplasms, inherited thrombophilias, systemic inflammatory disorders, or hormonal risk factors. Secondary Budd-Chiari syndrome occurs when hepatic venous outflow is impaired by external compression or direct invasion of the hepatic veins by a malignant or nonmalignant mass (Simonetto et al., 2020).

The clinical manifestations of Budd-Chiari syndrome vary according to the extent and duration of venous obstruction and may include abdominal pain, hepatomegaly, ascites, portal hypertension, and progressive liver dysfunction. Long-standing disease may result in hepatic fibrosis and cirrhosis (Simonetto et al., 2020).

The Liver Imaging Reporting and Data System (LI-RADS) should not be applied to individuals younger than 18 years of age or to individuals with cirrhosis related to congenital hepatic fibrosis or vascular disorders, including Budd-Chiari syndrome, chronic portal vein occlusion, cardiac congestion, and hereditary hemorrhagic telangiectasia. These populations were not included in the validation cohorts used to develop LI-RADS, and imaging findings may differ from those observed in more typical causes of cirrhosis (Simonetto et al., 2020).

Evidence Discussion

Imaging plays a central role in the diagnosis and management of hepatic venous and portal venous disorders. Doppler ultrasound is commonly used as the initial imaging modality for suspected Budd-Chiari syndrome and portal venous disorders because it can evaluate vessel patency, direction of flow, and hemodynamic abnormalities associated with hepatic venous outflow obstruction (Northup et al., 2021; Simonetto et al., 2020).

Cross-sectional imaging with contrast-enhanced CT, MRI, CTA, or MRA may be necessary when ultrasound findings are inconclusive or when more comprehensive assessment of thrombus extent, collateral vessels, adjacent structures, and treatment planning is required. These modalities provide detailed evaluation of the hepatic and portal vasculature and may identify associated complications or underlying causes of

vascular obstruction (Margini & Berzigotti, 2017; Northup et al., 2021; Simonetto et al., 2020).

Cross-sectional vascular imaging is particularly important when interventional treatment is being considered. Detailed evaluation of the hepatic and portal venous systems facilitates procedural planning for transjugular intrahepatic portosystemic shunt (TIPS) placement, variceal embolization, and retrograde transvenous obliteration by defining vascular anatomy, identifying collateral pathways, and determining technical feasibility. Imaging findings may directly influence procedural approach and treatment selection (Boike et al., 2022; Dariushnia et al., 2016; Lee et al., 2024).

Current American College of Gastroenterology guidance does not support routine screening for liver vascular malformations in asymptomatic individuals because evidence is insufficient to demonstrate improved clinical outcomes from screening in the absence of symptoms or other clinical indications. Imaging is therefore generally directed by clinical presentation, suspected complications, and the need for diagnostic or therapeutic planning (Simonetto et al., 2020).

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Abdominal Veins Other than Hepatic and Portal Veins (AB-43.2)

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Criteria

- CTA Abdomen and Pelvis (CPT® 74174), or CTA Abdomen (CPT® 74175) or MRA Abdomen (CPT® 74185) is considered medically necessary if ONE of the following:
  - Nephrotic syndrome
  - Renal vein thrombosis
  - Mesenteric vein thrombosis
- Suspicion of iliac vein thrombus when a lower extremity duplex or abdominal duplex is inconclusive or equivocal, see: **Acute Deep Venous Thrombosis (DVT) (PVD 12.2)**
- Suspicion of inferior vena cava thrombus when a lower extremity duplex or abdominal duplex is inconclusive or equivocal, see: **Acute Deep Venous Thrombosis (DVT) (PVD 12.2)**

Background and Supporting Information

Abdominal venous disorders may involve the renal veins, mesenteric veins, inferior vena cava, or other non-hepatic abdominal venous structures. Venous thrombosis can impair venous drainage and may lead to abdominal pain, bowel ischemia, renal dysfunction, portal hypertension, or other significant complications. Accurate assessment of venous patency and thrombus extent is important for diagnosis and management (Simonetto et al., 2020; Björck et al., 2017).

Evidence Discussion

Cross-sectional vascular imaging plays an important role in the diagnosis and management of abdominal venous thrombosis. CT angiography (CTA) provides detailed evaluation of the abdominal venous system, adjacent abdominal organs, and surrounding soft tissues and has high diagnostic accuracy for identifying mesenteric venous thrombosis. In addition to detecting venous thrombus, CTA can assess bowel wall changes, mesenteric edema, bowel ischemia, and other intra-abdominal complications that may influence treatment decisions and prognosis (Björck et al., 2017; Expert Panels on Vascular Imaging and Gastrointestinal Imaging et al., 2018).

MR angiography (MRA) provides comprehensive evaluation of the abdominal venous circulation and may serve as an alternative to CTA when avoidance of ionizing radiation

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or iodinated contrast is desirable. Both CTA and MRA allow assessment of thrombus location, extent, collateral venous pathways, and involvement of adjacent vascular structures. These modalities are useful for diagnosis, treatment planning, and follow-up of mesenteric venous thrombosis, renal vein thrombosis, and other abdominal venous disorders (American College of Radiology (ACR), North American Society for Cardiovascular Imaging (NASCI), & Society for Pediatric Radiology (SPR)., 2020; Simonetto et al., 2020).

Individuals with nephrotic syndrome are at increased risk for venous thromboembolic complications, including renal vein thrombosis. Advanced vascular imaging may therefore be necessary when venous thrombosis is suspected in this population (Chopard et al., 2020; Simonetto et al., 2020).

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Renal Vein Thrombosis (AB-43.3)

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Criteria

- MRA Abdomen (CPT® 74185) is considered medically necessary if ONE of the following:
  - Nephrotic syndrome
  - Proteinuria – 3 grams or more in 24 hours
  - Lupus nephritis
  - Hypercoagulable state, ONE of the following:
    - Antiphospholipid antibodies
    - Behçet's syndrome
    - Protein C deficiency
    - Protein S deficiency

Background and Supporting Information

Renal vein thrombosis (RVT) is a thrombotic occlusion of the renal venous system that may occur in association with nephrotic syndrome, severe proteinuria, lupus nephritis, and inherited or acquired hypercoagulable disorders. Clinical manifestations may include flank pain, hematuria, declining renal function, or may be asymptomatic in some individuals. Nephrotic syndrome is among the most common predisposing conditions because of the increased risk of venous thromboembolism associated with urinary loss of anticoagulant proteins (Chopard et al., 2020; Northup et al., 2021).

Evidence Discussion

Individuals with nephrotic syndrome, significant proteinuria, lupus nephritis, and hypercoagulable disorders are at increased risk for renal vein thrombosis. Early diagnosis is important because untreated renal vein thrombosis may contribute to renal dysfunction and other thromboembolic complications (Chopard et al., 2020; Northup et al., 2021).

Magnetic resonance angiography (MRA) provides noninvasive evaluation of the renal venous system and can identify renal vein thrombosis, assess thrombus extent, and evaluate associated vascular abnormalities. MRA provides comprehensive vascular assessment without exposure to ionizing radiation and may serve as an alternative to catheter-based angiography when detailed evaluation of abdominal venous pathology is required (ACR, NASCI, & SPR, 2020).

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Advanced vascular imaging is particularly valuable when renal vein thrombosis is suspected in individuals with nephrotic syndrome, lupus nephritis, or known hypercoagulable states because these conditions substantially increase the risk of venous thromboembolic disease. Cross-sectional vascular imaging can confirm the diagnosis, define the extent of venous involvement, identify collateral venous pathways, and support treatment planning and longitudinal management (Chopard et al., 2020; Northup et al., 2021).

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Abdomen Imaging Guidelines

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Liver Elastography (AB-45)

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Abdomen Imaging Guidelines

Liver Elastography (AB-45)

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Criteria

- Initial staging of liver fibrosis in suspected fatty liver disease (hepatic steatosis):
  - Transient Elastography or Vibration-Controlled Transient Elastography (VCTE, e.g. Fibroscan) (CPT® 91200) is considered medically necessary as the initial imaging modality.
    - Typically repeated within a 3-year period
    - If repeat transient elastography is technically unsuccessful or unreliable, refer to MRE criteria below.
  - Magnetic Resonance Elastography (MRE, CPT® 76391) is considered medically necessary for ANY of the following:
    - Transient Elastography failure despite use of an XL-probe
    - BMI 35 kg/m² or greater
    - Conflict between clinical picture and transient elastography results (e.g., individual with portal hypertension but VCTE suggests no fibrosis)
    - VCTE liver stiffness measurement of 8 kPa or greater
    - FIB 4 score greater than 2.67
    - Liver biopsy demonstrates fibrosis stage F2-F4
- Special considerations for MRE:
  - For MRE requests in the setting of hemochromatosis, see: **Hereditary (Primary) Hemochromatosis (HH) and Other Iron Storage Diseases (AB-11.2)**)
  - For individuals for whom drug treatment is a consideration and EITHER of the following:
    - Evaluation for liver stiffness as part of required assessment for drug candidacy
    - Evaluation for liver stiffness to assess treatment efficacy as required by the drug manufacturer and/or FDA
  - Note: The correct CPT code for MR Elastography is CPT® 76391. It is a stand-alone code and it does not require an additional CPT code such as MRI Abdomen (CPT® 74183).
  - An additional MRI Abdomen code should only be approved if there is another appropriate indication for it, other than the Elastography study (for example, MRE for fibrosis scoring in MASLD (formerly known as NAFLD) due to a BMI of 35 kg/m² or greater, AND further evaluation of an indeterminate hepatic lesion).
- The use of other ultrasound elastographic codes (CPT® 76981, CPT® 76982, and CPT® 76983) is considered not medically necessary.

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Background and Supporting Information

Liver fibrosis is a key determinant of prognosis in chronic liver disease because the severity of fibrosis is closely associated with risks of hepatic decompensation, hepatocellular carcinoma, liver-related mortality, and overall mortality. Histologic fibrosis is commonly staged using the METAVIR scoring system, which ranges from F0 (no fibrosis) to F4 (cirrhosis). Other validated histologic staging systems include the Ishak and Batts-Ludwig classifications (Lim et al., 2017; Sterling et al., 2025).

Assessment of liver fibrosis has increasingly shifted toward noninvasive methods because liver biopsy carries procedural risks and is subject to sampling variability. Current gastroenterology and hepatology guidelines support vibration-controlled transient elastography (VCTE) as a first-line noninvasive modality for fibrosis assessment in many chronic liver diseases because it is widely available, well validated, and capable of identifying advanced fibrosis and cirrhosis. Magnetic resonance elastography (MRE) may be particularly useful when VCTE results are unreliable, technically limited, or when assessment of fibrosis is needed in selected higher-risk populations, including individuals with metabolic dysfunction-associated steatotic liver disease (MASLD) (Lim et al., 2017; Sterling et al., 2025).

Vibration-controlled transient elastography (VCTE; e.g., FibroScan®, CPT® 91200) is the most extensively studied elastography technique and is incorporated into multiple evidence-based practice guidelines for fibrosis assessment. Current national guidelines do not recommend acoustic radiation force impulse imaging (ARFI) or real-time tissue elastography (RTTE) in preference to VCTE for routine clinical evaluation of liver fibrosis (Lim et al., 2017; Sterling et al., 2025).

The Fibrosis-4 (FIB-4) Index is a commonly used noninvasive fibrosis assessment tool that incorporates age, aspartate aminotransferase (AST), alanine aminotransferase (ALT), and platelet count. The index is calculated as: FIB-4 = (Age × AST) ÷ [Platelet Count × √ALT]. FIB-4 is frequently used as an initial risk-stratification test because it can help identify individuals who are unlikely to have advanced fibrosis and those who may benefit from additional evaluation with elastography or specialist referral (Kanwal et al., 2021; Rinella et al., 2023; Younossi et al., 2021).

Evidence Discussion

Targeted screening of individuals at increased risk for advanced chronic liver disease is recommended to facilitate identification of clinically significant fibrosis and cirrhosis before the development of hepatic decompensation and other liver-related complications. Early detection allows implementation of risk-reduction strategies, monitoring, and disease-specific treatment when appropriate (Cusi et al., 2022; Kanwal et al., 2021; Rinella et al., 2023).

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Although liver biopsy remains the reference standard for fibrosis staging, its use is limited by sampling variability, procedural risk, and cost. Consequently, noninvasive fibrosis assessment tools have become increasingly important in clinical practice (Lim et al., 2017; Sterling et al., 2025).

Among laboratory-based fibrosis assessments, the Fibrosis-4 (FIB-4) Index is one of the most extensively validated noninvasive tools and is frequently used as an initial risk-stratification test. FIB-4 can help identify individuals at low risk for advanced fibrosis and those who may benefit from additional evaluation with elastography or specialist referral. A FIB-4 score greater than 2.67 is associated with an increased likelihood of advanced fibrosis and warrants further assessment (Kanwal et al., 2021; Rinella et al., 2023).

Liver stiffness measurement obtained through VCTE is an established noninvasive method for fibrosis assessment. VCTE-derived liver stiffness measurements less than 8 kPa may help exclude advanced fibrosis, particularly when used in conjunction with FIB-4. Values between 8 and 12 kPa may be associated with significant fibrosis, while values greater than 12 kPa are associated with a high likelihood of advanced fibrosis or cirrhosis (Sterling et al., 2025; Vuppalanchi et al., 2018; Rinella et al., 2023).

Magnetic resonance elastography (MRE) is generally not considered a first-line fibrosis risk-stratification test but may be valuable when VCTE results are inconclusive, when clinical findings and elastography results are discordant, when cross-sectional imaging is otherwise indicated, or when technical factors limit VCTE reliability. In individuals with metabolic dysfunction-associated steatotic liver disease (MASLD), MRE may demonstrate greater diagnostic accuracy and lower false-positive rates compared with VCTE for the detection of advanced fibrosis (Imajo et al., 2022; Lim et al., 2017; Selvaraj et al., 2021).

Noninvasive fibrosis assessment also has an important role in longitudinal disease monitoring and treatment decision-making. Serial liver stiffness measurements may help assess fibrosis progression or regression over time and may provide objective evidence of response to therapy. In individuals receiving treatment with resmetirom, follow-up elastography may assist in monitoring treatment response and disease progression as part of ongoing clinical management (Chen et al., 2025; Gidener et al., 2023; Sterling et al., 2025).

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Hiccups (AB-46)

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Abdomen Imaging Guidelines

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Hiccups (AB-46.0)

AB.HI.0046.0.A
v1.0.2027

Criteria

- Hiccups may be associated with cerebrovascular disease, brain tumors, and intracranial injury, though it would be very rare for hiccups to be the only presenting symptom of serious neurologic disease. If concern is expressed for neurologic involvement, please see the appropriate guideline in HD imaging (e.g., **Neuromyelitis Optica and NMO Spectrum Disorders (HD-16.2)** and **Anti-MOG syndromes (HD-16.3)**)
- Hiccups lasting less than 48 hours without any localizing or specific symptoms:
  - No advanced imaging is considered medically necessary
- Hiccups lasting 48 hours or longer:
  - History and physical examination, laboratory and CMP and baseline chest x-ray
  - Abnormal or negative chest x-ray with symptoms referable to the chest:
    - CT Chest with contrast (CPT® 71260) is considered medically necessary
  - Lab or history/physical findings suggest a gastrointestinal etiology:
    - CT Abdomen with contrast (CPT® 74160) is considered medically necessary

Evidence Discussion

Hiccups are involuntary, repetitive contractions of the diaphragm and intercostal muscles followed by abrupt closure of the glottis. Most episodes are benign, self-limited, and resolve without diagnostic testing or treatment. As a result, advanced imaging is generally not indicated for acute hiccups in the absence of concerning symptoms or abnormal clinical findings (Bredenoord, 2013; Moretto et al., 2013).

Persistent hiccups, defined as symptoms lasting 48 hours or longer, warrant further clinical evaluation because they may be associated with gastrointestinal, neurologic, cardiopulmonary, metabolic, infectious, or neoplastic disorders. Initial evaluation typically includes a thorough history, physical examination, laboratory testing, and chest radiography. Additional diagnostic testing should be guided by clinical findings and suspected underlying etiologies (Arwani et al., 2023; Brañuelas Quiroga et al., 2016; Steger et al., 2015).

Thoracic symptoms such as wheezing, dyspnea, cough, abnormal chest radiography, or other findings suggestive of intrathoracic pathology may warrant CT imaging of the chest. When gastrointestinal symptoms, laboratory abnormalities, or other clinical findings suggest an abdominal, hepatic, pancreatic, or esophageal source, abdominal imaging and/or gastrointestinal evaluation may be appropriate. Neurologic

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evaluation should also be considered in individuals with persistent or intractable hiccups particularly if accompanied by focal neurologic deficits or other findings suggestive of central nervous system pathology, if workup of other causes is unrevealing, or if other symptoms are persistent despite treatment/intervention. In such cases, brain MRI is generally preferred because brainstem and medullary lesions, including stroke, demyelinating disease, tumors, and other structural abnormalities, have been reported as causes of persistent or intractable hiccups (Brañuelas Quiroga et al., 2016; Leung et al., 2020; Steger et al., 2015). Because persistent hiccups may occasionally be the presenting manifestation of serious underlying disease, diagnostic evaluation should be individualized according to the clinical presentation (Bredenoord, 2013; Pooran et al., 2006; Yamazaki et al., 2008).

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Retroperitoneal Fibrosis (AB-47)

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Retroperitoneal Fibrosis (AB-47.0)

AB.RP.0047.0.A
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Criteria

- Individuals diagnosed with retroperitoneal fibrosis:
  - ONE of the following every 3 months is considered medically necessary until stability demonstrated:
    - CT Abdomen and Pelvis with contrast (CPT® 74177)
    - MRI Abdomen and Pelvis without contrast (CPT® 74181 and CPT® 72195)
    - MRI Abdomen and Pelvis without and with contrast (CPT® 74183 and CPT® 72197)
    - Retroperitoneal or Abdominal ultrasound (CPT® 76770 or CPT® 76700) can be considered medically necessary if requested.
  - After stability established repeat imaging is considered medically necessary every 6 months.
  - Requests for non-contrasted studies in individuals with renal insufficiency is considered medically necessary. Gadolinium may induce nephrogenic systemic fibrosis in individuals with moderate or severe renal insufficiency, especially if the GFR is less than 30 ml/min.
  - Additional imaging:
    - CT Chest with contrast (CPT® 71260) is also considered medically necessary upon initial diagnosis if requested, to further evaluate for the possibility of malignancy as an underlying etiology.
- PET/CT (CPT® 78815)
  - Can be considered medically necessary initially, after diagnosis, to establish avidity patterns to assess for the likelihood of malignancy and for stratification for the likelihood of response to steroids.
  - Follow-up is considered medically necessary if there is documentation of an anticipated therapeutic change based on the results (such as a change in immunosuppression therapy or stent removal).
- Methysergide-induced retroperitoneal fibrosis:
  - Individual screening is considered medically necessary at baseline and then every 6 months with ONE of the following:
    - CT Abdomen and Pelvis with contrast (CPT® 74177)
    - CT Abdomen and Pelvis without contrast (CPT® 74176)
    - MRI Abdomen and Pelvis without and with contrast (CPT® 74183 and CPT® 72197)
    - MRI Abdomen and Pelvis without contrast (CPT® 74181 and CPT® 72195)

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- Retroperitoneal ultrasound (CPT® 76770 or CPT® 76775)

Background and Supporting Information

Retroperitoneal fibrosis is a rare fibroinflammatory disorder that may be idiopathic, including IgG4-related and non-IgG4-related forms, or secondary to other conditions. Secondary causes include malignancy, infection, prior radiation therapy, prior abdominal surgery, and certain medications. Although methysergide is no longer widely available, it has historically been associated with the development of retroperitoneal fibrosis (Kermani et al., 2011; Vaglio et al., 2026).

The disease commonly involves the retroperitoneal soft tissues surrounding the abdominal aorta and iliac vessels and may result in ureteral obstruction, hydronephrosis, vascular involvement, and renal dysfunction (Łoń et al., 2022; Vaglio et al., 2026).

Evidence Discussion

Cross-sectional imaging plays a central role in the diagnosis, characterization, and follow-up of retroperitoneal fibrosis. Although ultrasound may be useful as an initial screening examination, it has limited sensitivity and is often insufficient to distinguish retroperitoneal fibrosis from other retroperitoneal masses (Mehedra et al., 2025; Peisen et al., 2020).

CT and MRI are the primary imaging modalities used for evaluation of retroperitoneal fibrosis. These modalities allow assessment of the extent and morphology of disease, involvement of adjacent vascular and urinary tract structures, and the presence of associated abdominal abnormalities. They are also useful for monitoring disease progression and response to treatment (Peisen et al., 2020; Vaglio et al., 2026).

FDG-PET may provide additional information regarding disease activity and may be useful for differentiating active inflammation from inactive fibrosis, assessing treatment response, or evaluating for underlying malignancy. However, PET findings are nonspecific and should not be used as the sole basis for diagnosis (Peisen et al., 2020; Vaglio et al., 2026).

Periodic follow-up imaging may be appropriate to assess disease stability, progression, or therapeutic response. Because the clinical course of RPF is variable and relapse may occur despite treatment, imaging surveillance should be individualized according to disease activity, treatment status, symptom burden, and the presence of complications such as ureteral obstruction or renal dysfunction (Kermani et al., 2011; Vaglio et al., 2026).

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Fistulae (AB-48)

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Abdomen Imaging Guidelines

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Fistulae (AB-48)

AB.FD.0048.A
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Criteria

- Suspected enteric fistulae
  - ONE of the following is considered medically necessary:
    - MR Enterography (CPT® 74183 or CPT® 74181 and CPT® 72197 or CPT® 72195), OR
    - CT Enterography or CT Abdomen and Pelvis with contrast (CPT® 74177), OR
    - MRI Abdomen and Pelvis without and with contrast (CPT® 74183 and CPT® 72197)
- Suspected colovesical fistulae
  - ONE of the following is considered medically necessary:
    - CT Abdomen and Pelvis without contrast (CPT® 74176), OR
    - MR Enterography (CPT® 74183 or CPT® 74181 and CPT® 72197 or CPT® 72195), OR
    - MRI Abdomen and Pelvis without and with contrast (CPT® 74183 and CPT® 72197)
- Enterocutaneous fistulae
  - Suspected enterocutaneous fistulae or surgical planning of known complex fistulae:
    - ONE of the following is considered medically necessary:
      - CT Abdomen and Pelvis with contrast (CPT® 74177), OR
      - MR Enterography (CPT® 74183 or CPT® 74181 and CPT® 72197 or CPT® 72195), OR
      - MRI Abdomen and Pelvis without and with contrast (CPT® 74183 and CPT®72197)
- Complicated diverticulitis with fistula, see: **Lower Abdominal Pain (AB-2.2)**
- Perianal/perirectal fistulae and abscess related to Crohn's disease, see: **Perirectal/ Perianal Crohn's Disease (AB-23.3)**
- Other fistulae related to Crohn's disease, see: **Known IBD (AB-23.2)**
- Perianal/perirectal fistulae NOT related to Crohn's disease, see: **Fistula in Ano (PV-21.1)** in the Pelvis Imaging Guidelines
- For colovaginal, rectovesicular, rectovaginal, or urinary-vaginal communicating fistulae, see: **Pelvic Fistula (PV-21.3)** in the Pelvis Imaging Guidelines
- For pilonidal cyst, see: **Pilonidal Cyst (PV-21.4)** in the Pelvis Imaging Guidelines

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Background and Supporting Information

Gastrointestinal fistulae are abnormal communications between the gastrointestinal tract and adjacent organs, tissues, vascular structures, or the skin. Examples include tracheoesophageal, bronchoesophageal, enterocutaneous, enteroenteric, enterocolic, enterovesical, colovesical, rectovaginal, perianal, and aortoenteric fistulae.

Fistulae may arise from a variety of underlying conditions, including inflammatory bowel disease (particularly Crohn's disease), diverticulitis, malignancy, prior surgery, radiation therapy, obstetric injury, trauma, infection, or foreign bodies. Postoperative fistulae represent the most common cause of intestinal fistula formation, although inflammatory and neoplastic conditions remain important etiologies depending on the fistula location and individual population (Dolejs et al., 2019; Lichtenstein et al., 2018).

Evidence Discussion

MR enterography is particularly valuable in the evaluation of Crohn's disease-related fistulae and small bowel disease because it provides detailed assessment of both luminal and extraintestinal manifestations. MR enterography can identify active bowel inflammation, sinus tracts, fistulae, abscesses, and other penetrating complications while simultaneously evaluating disease extent and activity. As a result, it has become an important imaging modality for diagnosis, treatment planning, and disease monitoring in individuals with Crohn's disease (Greer & Taylor, 2022; Guimarães et al., 2020; Kucharzik et al., 2025).

CT and CT enterography provide excellent anatomic detail and remain important imaging modalities for evaluation of enteric, enterocutaneous, and colovesical fistulae, particularly when acute complications, abscesses, bowel perforation, post-operative abnormalities, or associated intra-abdominal pathology are suspected. CT may also facilitate preoperative planning in individuals with complex fistulous disease (Dolejs et al., 2019; Expert Panel on Gastrointestinal Imaging et al., 2020).

Both MRI and CT play important roles in the detection and characterization of fistulous disease. In a meta-analysis evaluating small bowel Crohn's disease, MR enterography and CT enterography demonstrated similar diagnostic performance for assessing active disease, with pooled sensitivities of 87.9% and 85.8% and pooled specificities of 81.2% and 83.6%, respectively (Qiu et al., 2014). MRI may be preferred in individuals with Crohn's disease who require repeated imaging because it avoids cumulative radiation exposure and provides superior soft-tissue characterization, particularly for pelvic and perianal fistulous disease. CT remains particularly valuable in acute clinical settings because of its rapid acquisition, widespread availability, and ability to evaluate associated abdominal complications. Imaging selection should therefore be individualized according to the suspected fistula type, underlying disease process, clinical presentation, and local expertise (Greer & Taylor, 2022; Qiu et al., 2014; Yanai et al., 2025).

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Procedure Codes Associated with General Abdomen Imaging Guidelines

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Procedure Codes Associated with General Abdomen Imaging

AB.ProcedureCodes.A
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The inclusion of any code in this table does not imply that the code is under management or requires prior authorization. Refer to the applicable health plan for management details. Prior authorization of a code listed in this table is not a guarantee of payment. The Certificate of Coverage or Evidence of Coverage policy outlines the terms and conditions of the member's health insurance policy.

Code	Description
71250	Computed tomography, thorax, diagnostic; without contrast material
71260	Computed tomography, thorax, diagnostic; with contrast material(s)
72191	Computed tomographic angiography, pelvis, with contrast material(s), including noncontrast images, if performed, and image postprocessing
72192	Computed tomography, pelvis; without contrast material
72193	Computed tomography, pelvis; with contrast material(s)
72195	Magnetic resonance (eg, proton) imaging, pelvis; without contrast material(s)
72197	Magnetic resonance (eg, proton) imaging, pelvis; without contrast material(s), followed by contrast material(s) and further sequences
72198	Magnetic resonance angiography, pelvis, with or without contrast material(s)
74150	Computed tomography, abdomen; without contrast material
74160	Computed tomography, abdomen; with contrast material(s)
74170	Computed tomography, abdomen; without contrast material, followed by contrast material(s) and further sections
74174	Computed tomographic angiography, abdomen and pelvis, with contrast material(s), including noncontrast images, if performed, and image postprocessing
74175	Computed tomographic angiography, abdomen, with contrast material(s), including noncontrast images, if performed, and image postprocessing
74176	Computed tomography, abdomen and pelvis; without contrast material
74177	Computed tomography, abdomen and pelvis; with contrast material(s)

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Code	Description
74178	Computed tomography, abdomen and pelvis; without contrast material in one or both body regions, followed by contrast material(s) and further sections in one or both body regions
74181	Magnetic resonance (eg, proton) imaging, abdomen; without contrast material(s)
74182	Magnetic resonance (eg, proton) imaging, abdomen; with contrast material(s)
74183	Magnetic resonance (eg, proton) imaging, abdomen; without contrast material(s), followed by with contrast material(s) and further sequences
74185	Magnetic resonance angiography, abdomen, with or without contrast material(s)
74261	Computed tomographic (CT) colonography, diagnostic, including image postprocessing; without contrast material
74262	Computed tomographic (CT) colonography, diagnostic, including image postprocessing; with contrast material(s) including non-contrast images, if performed
74263	Computed tomographic (CT) colonography, screening, including image postprocessing
76497	Unlisted computed tomography procedure (eg, diagnostic, interventional)
76498	Unlisted magnetic resonance procedure (eg, diagnostic, interventional)
76391	Magnetic resonance (eg, vibration) elastography
78811	Positron emission tomography (PET) imaging; limited area (eg, chest, head/neck)
78812	Positron emission tomography (PET) imaging; skull base to mid-thigh
78813	Positron emission tomography (PET) imaging; whole body
78814	Positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization imaging; limited area (eg, chest, head/neck)
78815	Positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization imaging; skull base to mid-thigh
78816	Positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization imaging; whole body

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Code	Description
76376	3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality with image postprocessing under concurrent supervision; not requiring image postprocessing on an independent workstation
76377	3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality with image postprocessing under concurrent supervision; requiring image postprocessing on an independent workstation
76700	Ultrasound, abdominal, real time with image documentation; complete
76705	Ultrasound, abdominal, real time with image documentation; limited (eg, single organ, quadrant, follow-up)
76770	Ultrasound, retroperitoneal (eg, renal, aorta, nodes), real time with image documentation; complete
76775	Ultrasound, retroperitoneal (eg, renal, aorta, nodes), real time with image documentation; limited
76776	Ultrasound, transplanted kidney (with duplex Doppler)
76830	Ultrasound, transvaginal
76856	Ultrasound, pelvic (nonobstetric), real time with image documentation; complete
76857	Ultrasound, pelvic (nonobstetric), real time with image documentation; limited or follow-up (eg, for follicles)
76978	Ultrasound, targeted dynamic microbubble sonographic contrast characterization (non-cardiac); initial lesion
76979	Ultrasound, targeted dynamic microbubble sonographic contrast characterization (non-cardiac); each additional lesion with separate injection (List separately in addition to code for primary procedure
76981	Ultrasound, elastography; parenchyma (eg, organ)
76982	Ultrasound, elastography; first target lesion
76983	Ultrasound, elastography; each additional target lesion

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Code	Description
0648T	Quantitative magnetic resonance for analysis of tissue composition (eg, fat, iron, water content), including multiparametric data acquisition, data preparation and transmission, interpretation and report, obtained without diagnostic MRI examination of the same anatomy (eg, organ, gland, tissue, target structure) during the same session; single organ
0649T	Quantitative magnetic resonance for analysis of tissue composition (eg, fat, iron, water content), including multiparametric data acquisition, data preparation and transmission, interpretation and report, obtained with diagnostic MRI examination of the same anatomy (eg, organ, gland, tissue, target structure); single organ (List separately in addition to code for primary procedure
0697T	Quantitative magnetic resonance for analysis of tissue composition (eg, fat, iron, water content), including multiparametric data acquisition, data preparation and transmission, interpretation and report, obtained without diagnostic MRI examination of the same anatomy (eg, organ, gland, tissue, target structure) during the same session; multiple organs
0698T	Quantitative magnetic resonance for analysis of tissue composition (eg, fat, iron, water content), including multiparametric data acquisition, data preparation and transmission, interpretation and report, obtained with diagnostic MRI examination of the same anatomy (eg, organ, gland, tissue, target structure); multiple organs (List separately in addition to code for primary procedure
75580	Noninvasive estimate of coronary fractional flow reserve (FFR) derived from augmentative software analysis of the data set from a coronary computed tomography angiography, with interpretation and report by a physician or other qualified health care professional
78226	Hepatobiliary System Imaging, Including Gallbladder When Present
78227	Hepatobiliary System Imaging, Including Gallbladder When Present; with Pharmacologic Intervention, Including Quantitative Measurement(s) When Performed
78707	Kidney Flow and Function, Single Study without Pharmacologic Intervention
78708	Kidney Imaging with Vascular Flow and Function with Pharmacological Intervention, Single
78709	Kidney Imaging with Vascular Flow and Function with and without Pharmacological Intervention, Multiple

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Code	Description
78801	Radiopharmaceutical localization of tumor, inflammatory process or distribution of radiopharmaceutical agent(s) (includes vascular flow and blood pool imaging, when performed); planar, 2 or more areas (eg, abdomen and pelvis, head and chest), 1 or more days imaging or single area imaging over 2 or more days
78802	Radiopharmaceutical localization of tumor, inflammatory process or distribution of radiopharmaceutical agent(s) (includes vascular flow and blood pool imaging, when performed); planar, whole body, single day imaging
78803	Radiopharmaceutical localization of tumor, inflammatory process or distribution of radiopharmaceutical agent(s) (includes vascular flow and blood pool imaging, when performed); tomographic (SPECT), single area (eg, head, neck, chest, pelvis) or acquisition, single day imaging
78804	Radiopharmaceutical localization of tumor, inflammatory process or distribution of radiopharmaceutical agent(s) (includes vascular flow and blood pool imaging, when performed); planar, whole body, requiring 2 or more days imaging
78830	Radiopharmaceutical localization of tumor, inflammatory process or distribution of radiopharmaceutical agent(s) (includes vascular flow and blood pool imaging, when performed); tomographic (SPECT) with concurrently acquired computed tomography (CT) transmission scan for anatomical review, localization and determination/detection of pathology, single area (eg, head, neck, chest, pelvis) or acquisition, single day imaging
78831	Radiopharmaceutical localization of tumor, inflammatory process or distribution of radiopharmaceutical agent(s) (includes vascular flow and blood pool imaging, when performed); tomographic (SPECT), minimum 2 areas (eg, pelvis and knees, chest and abdomen) or separate acquisitions (eg, lung ventilation and perfusion), single day imaging, or single area or acquisition over 2 or more days
78832	Radiopharmaceutical localization of tumor, inflammatory process or distribution of radiopharmaceutical agent(s) (includes vascular flow and blood pool imaging, when performed); tomographic (SPECT) with concurrently acquired computed tomography (CT) transmission scan for anatomical review, localization and determination/detection of pathology, minimum 2 areas (eg, pelvis and knees, chest and abdomen) or separate acquisitions (eg, lung ventilation and perfusion), single day imaging, or single area or acquisition over 2 or more days
78075	Adrenal Nuclear Imaging of the cortex and/or medulla

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Code	Description
78264	Gastric Emptying Study
78265	Gastric emptying study with small bowel transit
78266	Gastric emptying study with small bowel and colon transit
78278	Gastrointestinal Bleeding Scintigraphy
78290	Meckel's diverticulum imaging
78291	Peritoneal-Venous Shunt Patency
78201	Liver Imaging Static
78202	Liver Imaging with Vascular Flow
78215	Liver and Spleen Imaging Static
78216	Liver and Spleen Imaging with Vascular Flow
78700	Kidney Imaging (Nuclear) Static
78701	Kidney Imaging (Nuclear) with Vascular Flow
78707	Kidney Flow and Function, Single Study without Pharmacologic Intervention
78708	Kidney Imaging with Vascular Flow and Function with Pharmacological Intervention, Single
78709	Kidney Imaging with Vascular Flow and Function with and without Pharmacological Intervention, Multiple
91200	Liver elastography, mechanically induced shear wave (eg, vibration), without imaging, with interpretation and report
75557	Cardiac magnetic resonance imaging for morphology and function without contrast material;
75561	Cardiac magnetic resonance imaging for morphology and function without contrast material(s), followed by contrast material(s) and further sequences;
75563	Cardiac magnetic resonance imaging for morphology and function without contrast material(s), followed by contrast material(s) and further sequences; with stress imaging
75574	Computed tomographic angiography, heart, coronary arteries and bypass grafts (when present), with contrast material, including 3d image postprocessing (including evaluation of cardiac structure and morphology, assessment of cardiac function, and evaluation of venous structures, if performed)

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Code	Description
78431	Myocardial imaging, positron emission tomography (PET), perfusion study (including ventricular wall motion[s] and/or ejection fraction[s], when performed); multiple studies at rest and stress (exercise or pharmacologic), with concurrently acquired computed tomography transmission scan
78452	Myocardial perfusion imaging, tomographic (spect) (including attenuation correction, qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); multiple studies, at rest and/or stress (exercise or pharmacologic) and/or redistribution and/or rest reinjection
78492	Myocardial imaging, positron emission tomography (PET), perfusion study (including ventricular wall motion[s] and/or ejection fraction[s], when performed); multiple studies at rest and stress (exercise or pharmacologic)
93306	Echocardiography, transthoracic, real-time with image documentation (2d), includes m-mode recording, when performed, complete, with Spectral doppler echocardiography, and with color flow doppler echocardiography
93307	Echocardiography, transthoracic, real-time with image documentation (2d) with or without m-mode recording; complete
93308	Echocardiography, transthoracic, real-time with image documentation (2d) with or without m-mode recording; follow-up or limited study
93350	Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report;
93351	Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report; including performance of continuous electrocardiographic monitoring, with supervision by a physician or other qualified health care professional
93454	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation

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Code	Description
93455	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with catheter placement(s) in bypass graft(s) (internal mammary, free arterial venous grafts) including intraprocedural injection(s) for bypass graft angiography
93456	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with right heart catheterization
93457	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) including intraprocedural injection(s) for bypass graft angiography and right heart catheterization
93458	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed
93459	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed, catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) with bypass graft angiography
93460	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with right and left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed
93461	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with right and left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed, catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) with bypass graft angiography
93975	Duplex scan of arterial inflow and venous outflow of abdominal, pelvic, scrotal contents and/or retroperitoneal organs; complete study

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Code	Description
93976	Duplex scan of arterial inflow and venous outflow of abdominal, pelvic, scrotal contents and/or retroperitoneal organs; limited study

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