CIGNA MEDICAL COVERAGE POLICIES– RADIOLOGY

Pediatric 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.

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Table of Contents

Guideline Page

General Guidelines (PEDAB-1)....3
Generalized Abdominal Pain (PEDAB-2)....11
Right Lower Quadrant Pain (PEDAB-3)....16
Flank Pain, Renal Stone (PEDAB-4)....20
Urinary Tract Infection (UTI) (PEDAB-5)....23
Pediatric Acute Gastroenteritis (PEDAB-6)....29
Hematuria (PEDAB-7)....33
Right Upper Quadrant Pain (PEDAB-8)....37
Inflammatory Bowel Disease, Crohn Disease, or Ulcerative Colitis (PEDAB-9)....41
Abdominal Sepsis (Suspected Abdominal Abscess) (PEDAB-10)....46
Postoperative Pain within 60 Days Following Abdominal Surgery (PEDAB-11)....48
Constipation, Diarrhea, and Irritable Bowel Syndrome (PEDAB-12)....52
Abdominal Mass (PEDAB-13)....56
Renovascular Hypertension and Other Secondary Causes of Hypertension (PEDAB-14)....61
Liver Lesion Characterization (PEDAB-15)....66
Liver Disease (PEDAB-16)....73
Adrenal Lesions (PEDAB-17)....82
Hemochromatosis (PEDAB-18)....86
Indeterminate Renal Lesion (PEDAB-19)....90
Hydronephrosis (PEDAB-20)....94
Polycystic Kidney Disease (PEDAB-21)....98
Blunt Abdominal Trauma (PEDAB-22)....101
Hernias (PEDAB-23)....103
Abdominal Lymphadenopathy (PEDAB-24)....105
Left Upper Quadrant Pain (PEDAB-25)....107
Spleen (PEDAB-26)....110
Intussusception (PEDAB-27)....113
Bowel Obstruction (PEDAB-28)....116
Left Lower Quadrant Pain (PEDAB-29)....120
Celiac Disease (Sprue) (PEDAB-30)....123
Transplant (PEDAB-31)....126
Gaucher Disease (PEDAB-32)....128
Vomiting Infant, Malrotation, and Hypertrophic Pyloric Stenosis (PEDAB-33)....130
Pancreatitis (PEDAB-34)....134
Supplemental Material....138

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General Guidelines (PEDAB-1)

Guideline Page

General Guidelines (PEDAB-1.0).....4
Pediatric Abdominal Imaging Age Considerations (PEDAB-1.1)..... 6
Pediatric Abdomen Imaging Modality General Considerations (PEDAB-1.3)..... 7
References (PEDAB-1).....10

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General Guidelines (PEDAB-1.0)

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Criteria

- A pertinent clinical evaluation since the onset or change in symptoms including a detailed history, physical examination, appropriate laboratory studies, and basic imaging such as plain radiography or ultrasound should be performed prior to considering advanced imaging (CT, MR, Nuclear Medicine), unless the individual is undergoing guideline-supported scheduled imaging evaluation. A meaningful technological contact (telehealth visit, telephone call, electronic mail or messaging) since the onset or change in symptoms may serve as a pertinent clinical evaluation.
- These guidelines are based on the use of advanced imaging to answer specific clinical questions that will affect individual management. Imaging is considered not medically necessary when the results are not expected to affect individual management decisions. Standard medical practice dictates continuation of conservative therapy prior to advanced imaging in individuals who are improving on current treatment programs.
- Unless otherwise stated in a specific guideline section, the use of advanced imaging to screen asymptomatic individuals for disorders involving the abdomen is considered not medically necessary. Advanced imaging should only be considered medically necessary in individuals with documented active clinical signs or symptoms of disease.
- Unless otherwise stated in a specific guideline section, repeat advanced imaging of the same body area is considered not medically necessary unless there is documented evidence of progression of disease, new onset of disease, and/or documentation of how repeat imaging will alter individual management or treatment decisions.
- Ultrasound is considered medically necessary as the initial imaging study of choice in most pediatric individuals with abdominal conditions and should be performed prior to advanced imaging.
  - When advanced imaging is needed after ultrasound, the ultrasound findings can help guide selection of the appropriate modality, body area, imaging sequences, and contrast level to optimize diagnostic accuracy.
  - CPT® codes vary by body area and by presence or absence of Doppler imaging and are included in the table at the end of this guideline.

Red Flags

- The presence of any red flag signs or symptoms listed below in a pediatric individual with abdominal pain warrants further investigation. An initial ultrasound is not

required, and while additional laboratory testing may be helpful, it is not required. Requests for appropriate advanced imaging (e.g., CT or MRI) may be approved in accordance with the applicable condition-specific guideline.
  - Pain that awakens the pediatric individual from sleep
  - Unexplained fever greater than 100.4°F
  - History of malignancy with documented risk of abdominal or intra-abdominal metastasis
  - Dysphagia
  - Gastrointestinal (GI) bleeding
  - Significant or persistent vomiting
  - Elevated white blood cell count (WBC) above the testing laboratory's reference range
  - Low WBC (absolute neutrophil count less than 1,000 cells/mm³)
  - Guarding, rebound tenderness, or other peritoneal signs
  - Severe chronic diarrhea or nocturnal diarrhea in a toilet-trained child
  - Faltering weight (failure to thrive), unintentional weight loss, delayed linear growth, or delayed pubertal development
  - Family history of inflammatory bowel disease, familial polyposis syndrome, celiac disease, or peptic ulcer disease
  - Abdominal mass, hepatomegaly, and/or splenomegaly on physical examination
  - Jaundice
  - Perianal disease
  - Suspected or confirmed COVID-19 infection with concern for multisystem inflammatory syndrome in children (MIS-C)
  - Failure to respond to four weeks of provider-directed conservative care within the previous 60 days
- See the condition-specific sections for when the above list of exclusionary criteria applies and warrant direct progression to advanced imaging.
- The appropriate advanced imaging modality for each condition is listed in the corresponding condition-specific section.

Health Equity Considerations

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

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Pediatric Abdominal Imaging Age Considerations (PEDAB-1.1)

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- Many abdominal conditions affecting the pediatric population differ from those occurring in the adult population. For conditions that occur in both pediatric and adult populations, differences in management may exist due to age, comorbidities, and variations in the natural history of disease.
- Individuals under 19 years of age should be imaged according to the Pediatric Abdomen Imaging Guidelines when applicable.
  - Conditions not addressed in the Pediatric Abdomen Imaging Guidelines should be managed according to the General Abdomen Imaging Guidelines.
- Individuals 19 years of age or older should be imaged according to the General Abdomen Imaging Guidelines unless a condition-specific guideline directs otherwise.

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Pediatric Abdomen Imaging Modality General Considerations (PEDAB-1.3)

ABP.GG.0001.3.C
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Criteria

- MRI
  - MRI of the Abdomen is generally performed without and with contrast (CPT® 74183), unless the individual has a documented contraindication to gadolinium or otherwise stated in a condition-specific guideline section.
  - Due to duration of MRI acquisition and the need to minimize individual movement, anesthesia is typically required for most infants (excluding neonates), children younger than seven years of age, and older children with developmental or maturity-related limitations.
  - MRI protocols in this population should aim to minimize anesthesia exposure. When intravenous access has already been established for anesthesia and there are no contraindications to contrast, performing MRI both without and with contrast may be appropriate to avoid repeat imaging and additional anesthesia if the non-contrast study is inconclusive.
    - If multiple body areas are considered medically necessary by these guidelines for the clinical condition being evaluated, MRI of all necessary body areas may be obtained concurrently during the same imaging session.
  - The presence of surgical hardware or implanted devices may preclude MRI.
    - The selection of best examination may require coordination between the provider and the imaging facility. In these circumstances, CT may be the preferred imaging modality.
- CT
  - CT of the Abdomen typically extends from the dome of the diaphragm to the upper margin of the sacroiliac joints. CT of the Abdomen and Pelvis extends from the dome of the diaphragm through the ischial tuberosities.
    - CT Abdomen is generally used for evaluation of solid organs, whereas CT Abdomen and Pelvis is preferred for inflammatory, infectious, or hematuria-related conditions and when both regions are involved. Imaging may be limited to the region of interest, particularly during follow-up evaluation, to reduce radiation exposure.
  - Contrast use in the pediatric population should be based on the clinical indication. CT may be appropriate for further evaluation of findings identified on prior imaging

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or as specified in condition-based guideline sections; however, CT should not replace MRI solely to avoid sedation unless otherwise recommended.
    - Coordination between the provider and imaging facility may be necessary to determine the most appropriate imaging study.
- 3D Rendering
    - 3D Rendering indications in pediatric abdomen imaging are identical to those for in the General Imaging Guidelines. See: **3D Rendering (Preface-4.1)** in the Preface Imaging Guidelines.

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

Evidence Discussion

Magnetic resonance imaging (MRI) is a preferred cross-sectional imaging modality in pediatric abdominal evaluation due to its absence of ionizing radiation and superior soft-tissue contrast. These characteristics are particularly important in children who may require serial imaging or detailed tissue characterization over time. The American College of Radiology (ACR) and the Society for Pediatric Radiology (SPR) recommend MRI without and with contrast when contrast enhancement is expected to meaningfully increase diagnostic confidence or resolve indeterminate findings from prior imaging studies (American College of Radiology & Society for Pediatric Radiology, 2022).

Concerns regarding gadolinium-based contrast agents (GBCAs) stem primarily from evidence of gadolinium retention within the brain and other tissues. Early pediatric-focused literature documented signal intensity changes in deep brain nuclei following repeated GBCA exposure, establishing the biological plausibility of tissue deposition without demonstrating clinical sequelae (Blumfield et al., 2019). These findings prompted closer scrutiny of GBCA pharmacokinetics and reinforced the need for indication-driven use rather than routine administration.

Subsequent investigations have shifted the focus from tissue deposition alone to clinically relevant outcomes. A recent systematic review and meta-analysis incorporating pediatric-specific data found no association between GBCA exposure and adverse neurologic or systemic outcomes in children, including those with multiple prior contrast administrations (Yu et al., 2025). This analysis strengthens earlier observational data by providing pooled outcome-level evidence with extended follow-up, supporting the conclusion that gadolinium retention has not been shown to result in measurable clinical harm under current clinical practice.

Regulatory and professional guidance reflects this evolving evidence base. Contemporary literature indicates that, although gadolinium retention following GBCA exposure is well documented, current data have not demonstrated clinically significant adverse health effects attributable to this retention in patients with normal renal function

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(Starekova et al., 2024). Accordingly, expert consensus supports the continued use of GBCAs when clinically justified, emphasizing appropriate agent selection and risk–benefit assessment rather than avoidance based solely on retention concerns. Consistent with this position, the ACR Manual on Contrast Media emphasizes selective GBCA administration based on anticipated diagnostic benefit, particularly in pediatric populations, rather than avoidance driven solely by retention concerns (American College of Radiology & Society for Pediatric Radiology, 2022).

Complementing imaging guidance, broader pediatric care frameworks further emphasize evidence-based, targeted evaluation strategies. The joint North American Society For Pediatric Gastroenterology, Hepatology & Nutrition (NASPGHAN) and American Academy of Pediatrics (AAP) clinical practice guideline provides standardized recommendations for the diagnosis and management of faltering weight in pediatric individuals, replacing the outdated term "failure to thrive." The guideline emphasizes the use of z-score–based growth criteria, targeted diagnostic testing, and early nutritional intervention supported by multidisciplinary care. Collectively, these recommendations aim to reduce unnecessary testing, improve growth outcomes, and promote family-centered, non-stigmatizing care (Kersten et al., 2026). This emphasis on judicious, indication-driven evaluation aligns with imaging best practices, reinforcing the importance of avoiding unnecessary interventions while ensuring clinically meaningful diagnostic yield.

Pediatric Abdomen Imaging Guidelines

References (PEDAB-1)

v1.0.2027

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Generalized Abdominal Pain (PEDAB-2)

Guideline Page

Generalized Abdominal Pain (PEDAB-2).....12
References (PEDAB-2).....15

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Generalized Abdominal Pain (PEDAB-2)

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Criteria

- Ultrasound Abdomen (CPT® 76700 or CPT® 76705) is considered medically necessary as the initial imaging study for pediatric individuals without red flag signs or symptoms and with a normal physical examination and normal laboratory studies.
  - Relevant laboratory evaluation may include complete blood count (CBC), electrolytes, lipase, amylase, urinalysis, erythrocyte sedimentation rate (ESR), C-reactive protein (CRP), liver function tests (LFTs), and/or stool studies, including fecal occult blood testing and stool culture when diarrhea is present.
- CT Abdomen with contrast (CPT® 74160) or CT Abdomen and Pelvis with contrast (CPT® 74177) are considered medically necessary when any red flag signs or symptoms are present (as listed in **General Guidelines (PEDAB-1.0))**.
- Pediatric individuals with abdominal pain that can be localized to a particular area of the abdomen should be imaged according to the relevant guideline section:
  - **Right Lower Quadrant Pain (PEDAB-3)**
  - **Flank Pain, Renal Stone (PEDAB-4)**
  - **Right Upper Quadrant Pain (PEDAB-8)**
  - **Left Upper Quadrant Pain (PEDAB-25)**
  - **Left Lower Quadrant Pain (PEDAB-29)**

Background and Supporting Information

Pediatric abdominal pain encompasses a spectrum of conditions ranging from disorders of gut–brain interaction (DGBI) to acute inflammatory and surgical diseases. Under the Rome V framework, DGBI are defined by gastrointestinal symptoms arising from altered gut–brain signaling rather than structural or biochemical abnormalities (Drossman et al., 2026; Maqbool et al., 2024).

A substantial proportion of pediatric cases represent functional abdominal pain disorders, including functional dyspepsia, irritable bowel syndrome, and centrally mediated abdominal pain syndrome (Maqbool et al., 2024; Drossman et al., 2026). These conditions are characterized by symptoms such as epigastric pain or burning, postprandial fullness, and early satiety and may coexist with other gastrointestinal or systemic conditions (Drossman et al., 2026; Maqbool & Liacouras, 2024).

Clinical evaluation is guided by symptom characteristics, pain location, associated features, and age-specific considerations (Buel et al., 2024; Kim, 2013; Maqbool & Liacouras, 2024). Society recommendations, including Rome V criteria and the

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American College of Radiology (ACR) Appropriateness Criteria®, supports a structured clinically driven approach to evaluation and management (Drossman et al., 2026; Expert Panel on Pediatric Imaging et al., 2026).

Because many functional abdominal pain disorders and other DGBI are not associated with structural abnormalities, advanced imaging is often not routinely indicated. However, in pediatric individuals with persistent, atypical, or diagnostically complex presentations, gastroenterology (GI) specialist evaluation or consultation may be helpful in determining the need for advanced imaging and additional diagnostic testing, particularly when distinguishing DGBI from inflammatory, structural, or surgical conditions. This collaborative approach supports appropriate use of imaging while minimizing unnecessary diagnostic procedures (Expert Panel on Pediatric Imaging et al., 2026; Rosen et al., 2026).

Evidence Discussion

Evidence supports an initial clinical assessment of pediatric abdominal pain based on symptom patterns, pain localization, associated systemic findings, and age-specific factors to determine the need for imaging (Buel et al., 2024; Maqbool & Liacouras, 2024).

A large proportion of cases are attributable to disorders of gut–brain interaction, which are diagnosed clinically and lack identifiable structural pathology. In the absence of alarm features, routine imaging has not been shown to improve clinical outcomes and may lead to unnecessary downstream testing and increased healthcare utilization (Drossman et al., 2026; Maqbool & Liacouras, 2024).

When imaging is clinically indicated, evidence-based guidelines support ultrasound as the preferred initial imaging modality for many pediatric abdominal pain presentations due to its diagnostic accuracy and lack of ionizing radiation. Advanced imaging with CT or MRI is reserved for cases with equivocal ultrasound findings, suspected complications, or specific clinical scenarios as defined in condition-specific guidelines (Expert Panel on Pediatric Imaging, 2026).

Collectively, these data support reserving imaging for pediatric individuals with alarm features, abnormal physical examination findings, abnormal laboratory studies, persistent symptoms, or clinical concern for an underlying organic disorder. This approach balances diagnostic yield with avoidance of unnecessary imaging and radiation exposure (Buel et al., 2024; Expert Panel on Pediatric Imaging, 2026).

Health Equity Considerations

Abdominal pain is a common reason for Emergency Department (ED) assessment in the pediatric population. Children with abdominal pain are assessed for conditions that require urgent evaluation and treatment such as appendicitis, intussusception, volvulus,

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or adhesion (Kim, 2013). Appendicitis is an important diagnostic differential to consider for acute abdominal pain for potential urgent or emergent abdominal surgery. Health outcomes are dependent on appropriate diagnosis and treatment (Wang et al., 2015).

Health disparities influence children's healthcare as they may have long-term impacts on important outcomes such as health as an adult, educational attainment, and economic success (Montoya-Williams et al., 2020). Health disparities facing minority children with abdominal pain include lack of advanced imaging such as ultrasound or computed tomography (CT) scan, and having a higher appendiceal perforation rate (Goyal et al., 2021). Studies have shown that racial and ethnic minorities are less likely to receive opioid analgesia even when symptoms are severe (Guedj et al., 2021). Lastly, non-Hispanic Black and Hispanic individuals were more likely than non-Hispanic whites to have a prolonged length of stay (Johnson et al., 2013). Solutions to health disparity issues include continued data and research, policy interventions, and individual and family engagement.

Pediatric Abdomen Imaging Guidelines

References (PEDAB-2)

v1.0.2027

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Right Lower Quadrant Pain (PEDAB-3)

Guideline Page

Right Lower Quadrant Pain (PEDAB-3).....17
References (PEDAB-3).....19

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Right Lower Quadrant Pain (PEDAB-3)

ABP.RT.0003.A
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Criteria

- The presence of any red flag findings per **General Guidelines (PEDAB-1.0)** precludes adjudication based on any other criteria.
- Ultrasound Abdomen (CPT® 76700 or CPT® 76705) is considered medically necessary as the initial imaging study.
  - If ultrasound findings are positive or negative for uncomplicated appendicitis, no further imaging is considered medically necessary.
  - If the appendix is not visualized on ultrasound and the white blood cell count is not elevated, no further imaging is considered medically necessary.
- CT Abdomen and Pelvis with contrast (CPT® 74177), MRI Abdomen and Pelvis without contrast (CPT® 74181 and CPT® 72195), or MRI Abdomen and Pelvis without and with contrast (CPT® 74183 and CPT® 72197) is considered medically necessary for ANY of the following:
  - Individuals who are overweight (BMI at or above the 85th percentile for age)
  - Insufficient local ultrasound expertise
  - Ultrasound findings are inconclusive
  - Clinical suspicion or initial imaging findings suggestive of a complication (e.g., abscess, bowel obstruction)
- If the appendix is absent, follow guidelines in: **Generalized Abdominal Pain (PEDAB-2)**

Evidence Discussion

Ultrasound demonstrates high specificity and clinically useful sensitivity for appendicitis, particularly in pediatric settings, and can aid in distinguishing uncomplicated from complicated disease (Badlis et al., 2024). Although nonvisualization of the appendix remains a limitation, secondary sonographic findings can still provide important diagnostic information. Comparative evidence indicates that, while CT and MRI demonstrate higher sensitivity, ultrasound offers strong diagnostic performance without radiation exposure or the routine need for sedation, supporting a staged imaging approach rather than the use of cross-sectional imaging as a first-line modality (Castro-Luna et al., 2025).

The AJR Expert Panel and the ACR Appropriateness Criteria® recommend an ultrasound-first pathway, reserving CT or MRI for equivocal studies or ongoing clinical concern (Desoky et al., 2023). When ultrasound findings and laboratory results are not

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suggestive of appendicitis, the decision to pursue additional imaging may appropriately rely on the referring clinician's assessment of the overall clinical course.

Pediatric Abdomen Imaging Guidelines

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Flank Pain, Renal Stone (PEDAB-4)

Guideline Page

Flank Pain, Renal Stone (PEDAB-4)..... 21
References (PEDAB-4).....22

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Flank Pain, Renal Stone (PEDAB-4)

ABP.US.0004.C
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Criteria

- The presence of any red flag findings per **General Guidelines (PEDAB-1.0)** precludes adjudication based on any other criteria.
- Flank pain imaging indications in pediatric individuals are similar to those for adult individuals. See: **Flank Pain, Rule Out or Known Renal/Ureteral Stone (AB-4)** in the Abdomen Imaging Guidelines.
  - Ultrasound retroperitoneal (CPT® 76770 or CPT® 76775) is considered medically necessary as the initial imaging study for the evaluation of flank pain in pediatric individuals.
  - CT Abdomen and Pelvis without contrast (CPT® 74176) is considered medically necessary when ultrasound findings are inconclusive.
  - MRI Abdomen without and with contrast (CPT® 74183) and MRI Pelvis without and with contrast (CPT® 72197) is considered medically necessary when CT imaging is inconclusive or when there is significant concern regarding cumulative radiation exposure due to frequent CT imaging.
  - If hematuria is present, see: **Hematuria (PEDAB-7)** for imaging guidelines.

Evidence Discussion

In pediatric individuals presenting with flank pain or hematuria, imaging is used to confirm urolithiasis, assess for obstruction, and guide management while limiting radiation exposure.

Current American College of Radiology (ACR) Appropriateness Criteria® recommend ultrasound as the initial imaging modality due to its safety profile and ability to detect hydronephrosis, renal calculi, and secondary signs of obstruction without ionizing radiation (Expert Panel on Pediatric Imaging, 2018; Expert Panel on Urological Imaging, 2023).

Computed tomography (CT) is reserved for cases with nondiagnostic ultrasound findings and persistent clinical concern, with emphasis on selective use and radiation dose optimization when required (Expert Panel on Urological Imaging, 2023).

Although CT remains the preferred cross-sectional imaging modality for nephrolithiasis, MRI is appropriate when further evaluation of obstruction, associated complications, or indeterminate imaging findings is required and radiation exposure is a significant concern (Expert Panel on Urological Imaging, 2023).

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Urinary Tract Infection (UTI) (PEDAB-5)

Guideline Page

Upper Urinary Tract (PEDAB-5.1).....24
Lower Urinary Tract (PEDAB-5.2).....26
References (PEDAB-5).....28

Pediatric Abdomen Imaging Guidelines

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Upper Urinary Tract (PEDAB-5.1)

ABP.UT.0005.1.C
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Criteria

- Ultrasound retroperitoneal (CPT® 76770 or CPT® 76775) is considered medically necessary as the initial imaging study for first-time upper urinary tract infection in pediatric individuals to evaluate for hydronephrosis, pyelonephritis, or congenital renal anomalies.
  - If hydronephrosis is present, further evaluation with voiding cystourethrography (VCUG) is considered medically necessary to evaluate for vesicoureteral reflux.
    - In male individuals, fluoroscopic VCUG using iodinated contrast is considered medically necessary to evaluate for vesicoureteral reflux and to exclude urethral abnormalities.
    - In female individuals, either of the following are considered medically necessary for evaluation of vesicoureteral reflux:
      - Ureteral Reflux Study (Radiopharmaceutical Voiding Cystogram) (CPT® 78740) OR
      - Fluoroscopic VCUG
    - Contrast Enhanced Voiding Urosonography (CeVUS) is considered medically necessary for vesicoureteral reflux when performed at institutions with expertise in this modality.
- Diuretic renography using Tc-99m MAG 3 (CPT® 78707, CPT® 78708, or CPT® 78709) is considered medically necessary for:
  - Differentiation of dilated, non-obstructed urinary system from a true stenosis (e.g., ureteral-pelvic junction [UPJ] or ureterovesical junction obstruction)
  - Quantification of renal parenchymal function
  - Evaluation of ultrasound findings consistent with a multicystic dysplastic kidney to assess function of the affected kidney or to evaluate a ureteral-pelvic junction (UPJ) obstruction of the contralateral kidney
  - Diagnostic evaluation of upper urinary tract dilatation when VCUG findings are negative
  - Evaluation of renal function in individuals with hydronephrosis
- CT Abdomen and Pelvis with contrast (CPT® 74177) is considered medically necessary to evaluate the entire genitourinary tract for congenital abnormalities of distal urinary structures in individuals with complicated pyelonephritis.
- Magnetic resonance urography (MRU) (CPT® 74183 and CPT® 72197) is not considered a first-line imaging modality for routine evaluation of a urinary tract

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infection (UTI) but is considered medically necessary, when available, for evaluation of upper urinary tract dilation.

- Technetium-99m-dimercaptosuccinic acid (Tc-99m DMSA) scintigraphy (CPT® 78700, CPT® 78701, or CPT® 78803), is sensitive for evaluation of renal cortical damage.
  - DMSA scintigraphy is considered medically necessary for:
    - individuals with atypical or recurrent febrile acute urinary tract infections
      - Atypical findings may include lack of clinical improvement to antibiotics within 48 hours, elevated creatinine, poor urine stream, or infection caused by a non-Escherichia coli organism
    - individuals older than 5 years of age with febrile urinary tract infections and known vesicoureteral reflux
    - detection of post-pyelonephrotic renal scarring at least 6 months after the documented upper tract UTI in high-risk individuals with recurrent UTIs
- Ultrasound kidneys and bladder (CPT® 76770 or CPT® 76775) (preferred) and/or Voiding Cystourethrography (CPT® 78740) are considered medically necessary for pediatric individuals with:
  - Recurrent febrile urinary tract infections; OR
  - Atypical urinary tract infection including:
    - lack of clinical improvement to antibiotics within 48 hours
    - sepsis
    - poor urine stream
    - elevated creatinine
    - non-Escherichia coli infection

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Lower Urinary Tract (PEDAB-5.2)

ABP.UT.0005.2.A
v1.0.2027

Criteria

- Ultrasound retroperitoneal (CPT® 76770 or CPT® 76775) is considered medically necessary as the initial imaging study for pediatric individuals with a first-time urinary tract infection (UTI) to evaluate for hydronephrosis, pyelonephritis, or congenital renal anomalies.
  - Fluoroscopic Voiding cystourethrography (VCUG) is considered medically necessary for detection of possible vesico-ureteral reflux (VUR) in neonates or young children when hydronephrosis is seen on ultrasound.
- VCUG should be deferred until a second UTI occurs unless earlier evaluation is warranted due to ANY of the following:
  - atypical or complex clinical circumstances
  - renal or bladder ultrasound findings that reveal hydronephrosis, scarring, or obstructive uropathy
- Vesicoureteral Reflux (VUR)
  - Fluoroscopic VCUG is the standard initial imaging modality for the diagnosis and grading of VUR.
  - For follow-up imaging of known VUR, any of the following are considered medically necessary:
    - Ureteral Reflux Study (Radiopharmaceutical Voiding Cystogram) (CPT® 78740),
    - Fluoroscopic VCUG, or
    - Contrast-enhanced voiding urosonography (CeVUS)
- Male individuals with a first-time UTI should be evaluated with fluoroscopic VCUG rather than radionuclide cystography to allow for visualization of the male urethra and assessment for possible abnormalities, such as posterior urethral valves, strictures, or diverticula.
- In female individuals, radionuclide cystography (CPT® 78740) or fluoroscopic VCUG is considered medically necessary as the initial imaging study.
- Magnetic resonance urography (MRU) is considered medically necessary for evaluation of ectopic distal ureteral insertion or other complex lower urinary tract anatomy.
- Siblings of individuals with known vesicoureteral reflux can undergo Ureteral Reflux Study (Radiopharmaceutical Voiding Cystogram) (CPT® 78740) when either of the following is present:
  - renal scarring identified on ultrasound
  - history of UTI without prior evaluation for VUR

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Evidence Discussion

Imaging for pediatric urinary tract infection (UTI) is guided by the goal of identifying clinically significant abnormalities while avoiding unnecessary radiation exposure and invasive testing. Renal and bladder ultrasound (RBUS) is recommended as the initial imaging study after a febrile UTI because it is noninvasive and does not involve ionizing radiation. Evidence from a systematic review and meta-analysis of 29 studies including 9,170 children demonstrated that although ultrasound abnormalities are identified in approximately 22% of children after a first febrile UTI, only about 3% represented clinically important findings that altered management, supporting a selective imaging approach (Yang et al., 2023).

The ACR Appropriateness Criteria® for pediatric UTI reinforce ultrasound as the preferred initial modality for uncomplicated infection and do not recommend routine VCUG after a first UTI (Chandra et al., 2024). The ACR–Society for Pediatric Radiology (SPR) Practice Parameter further specifies that VCUG should be reserved for children with abnormal ultrasound findings, recurrent febrile UTIs, suspected anatomic obstruction, or vesicoureteral reflux (American College of Radiology [ACR], 2019).

CT imaging is not routinely used in the evaluation of pediatric UTI and is limited to complicated or atypical cases, such as severe pyelonephritis, poor response to therapy, or concern for abscess formation (Smith, 2022).

When assessment of renal cortical involvement or long-term renal injury is clinically warranted, technetium-99m DMSA scintigraphy may be used selectively. The updated Society of Nuclear Medicine and Molecular Imaging (SNMMI)/European Association of Nuclear Medicine (EANM) guideline recommends DMSA imaging for children with recurrent or atypical UTIs and emphasizes pediatric-specific dosing to minimize radiation exposure (Vali, 2022).

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Pediatric Acute Gastroenteritis (PEDAB-6)

Guideline Page

Pediatric Acute Gastroenteritis (PEDAB-6).....30
References (PEDAB-6).....32

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Pediatric Acute Gastroenteritis (PEDAB-6)

ABP.GE.0006.A
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Criteria

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

Evidence Discussion

Radiologic imaging has a minimal role in the evaluation of pediatric acute gastroenteritis because the diagnosis is primarily clinical. Most children present with dehydration, vomiting, and diarrhea, and recover with supportive care. When symptoms follow this typical pattern, imaging does not add diagnostic value (Hammershaimb, 2024).

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When red flag features are present, evidence supports contrast-enhanced CT of the abdomen and pelvis as the appropriate imaging modality. Examples include severe focal abdominal pain, concern for obstruction, or complications that cannot be evaluated adequately by examination or ultrasound. In these settings, CT clarifies alternative diagnoses and detects complications that mimic gastroenteritis, enabling timely intervention (Hammershaimb, 2024).

Pediatric Abdomen Imaging Guidelines

References (PEDAB-6)

v1.0.2027

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Hematuria (PEDAB-7)

Guideline Page

Hematuria (PEDAB-7)..... 34
References (PEDAB-7).....36

Pediatric Abdomen Imaging Guidelines

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Hematuria (PEDAB-7)

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v1.0.2027

Criteria

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

- Ultrasound Kidneys (CPT® 76770 or CPT® 76775) and bladder (CPT® 76856 or CPT® 76857) are considered medically necessary for asymptomatic gross hematuria or microscopic hematuria with proteinuria present.
- Imaging is considered not medically necessary for isolated asymptomatic microscopic hematuria without proteinuria on initial evaluation.
  - When isolated microscopic hematuria is identified, urinalysis should be repeated on at least two additional occasions over a 1-to 2-month period to distinguish transient from persistent hematuria.
  - If hematuria persists (present on at least 2 of 3 urinalyses), renal and bladder ultrasound is considered medically necessary for further evaluation.
- For painful hematuria and no recent trauma, ANY of the following studies is considered medically necessary:
  - CT Abdomen and Pelvis without contrast (CPT® 74176)
  - Ultrasound kidneys (CPT® 76770 or CPT® 76775)
  - Ultrasound bladder (CPT® 76856 or CPT® 76857)
- For hematuria in the setting of recent trauma, the following study is considered medically necessary:
  - CT Abdomen and Pelvis with contrast (CPT® 74177)
- CT Cystography (CT Pelvis with bladder contrast; CPT® 72193) is considered medically necessary when gross hematuria is present and pelvic fracture or traumatic bladder injury is suspected.
- 3-D reconstruction (CPT® 76377 or CPT® 76376) is considered medically necessary, if requested, for surgical planning.

Evidence Discussion

The ACR Appropriateness Criteria® designate renal and bladder ultrasound as the initial test for pediatric hematuria because it evaluates renal size, parenchymal echogenicity, hydronephrosis, and bladder pathology without ionizing radiation and can identify actionable abnormalities, including obstructive uropathy, congenital anomalies, and mass lesions (Dillman et al., 2018).

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Contemporary pediatric imaging reviews support ultrasound as the safest and most informative initial imaging study for pediatric individuals because of its ability to identify structural causes of hematuria without radiation exposure (Viteri et al., 2020). In contrast, isolated asymptomatic microscopic hematuria without proteinuria is frequently transient and is rarely associated with clinically significant structural abnormalities. As a result, repeat urinalysis is recommended to distinguish transient from persistent hematuria before imaging is pursued (Viteri et al., 2020). The presence of accompanying proteinuria, persistent microscopic hematuria, gross hematuria, or other concerning clinical findings increases the likelihood of underlying renal pathology and supports further imaging evaluation.

In suspected renal or urinary tract injury, contrast-enhanced CT of the abdomen and pelvis is the standard imaging modality for evaluation of solid organ injury, vascular involvement, and urinary extravasation. When gross hematuria occurs in the setting of pelvic fracture or suspected bladder rupture, CT cystography provides additional assessment of bladder integrity. These imaging pathways reflect the superior sensitivity and anatomic detail provided by contrast-enhanced CT in trauma while accounting for the clinical consequences of missed injury (Viteri et al., 2020).

Three-dimensional reconstructions support operative or interventional planning when detailed vascular or collecting system anatomy will alter the procedure. This is an adjunct to the primary cross-sectional exam and should be used when it changes management decisions (Viteri et al., 2020).

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Right Upper Quadrant Pain (PEDAB-8)

Guideline Page

Right Upper Quadrant Pain (PEDAB-8).....38
References (PEDAB-8).....40

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Right Upper Quadrant Pain (PEDAB-8)

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Criteria

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

Evidence Discussion

Hepatobiliary scintigraphy plays an established role in the evaluation of right upper quadrant pain (RUQ) in pediatric individuals when biliary pathology is suspected and ultrasound does not provide sufficient diagnostic clarity. The ACR-SPR Practice Parameter describes the high diagnostic accuracy of hepatobiliary scintigraphy for acute cholecystitis through identification of cystic duct obstruction. This is particularly relevant in pediatric individuals because acalculous cholecystitis occurs more frequently than in adults and may lack characteristic ultrasound findings (Gerard et al., 2021).

Scintigraphy also provides functional assessment of gallbladder filling and emptying, which may assist in the evaluation of biliary dyskinesia and other functional disorders in pediatric individuals with persistent RUQ pain and normal or nondiagnostic ultrasound findings. In addition, scintigraphy may demonstrate abnormal bile flow or bile leaks in postoperative or otherwise complex clinical situations. This evidence supports its use

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following nondiagnostic ultrasound findings and, in selected circumstances, as an initial imaging study when clinical suspicion for acute cholecystitis is high and ultrasound may not detect early or acalculous disease (Gerard et al., 2021).

Pediatric Abdomen Imaging Guidelines

References (PEDAB-8)

v1.0.2027

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

Guideline Page

Inflammatory Bowel Disease, Crohn Disease, or Ulcerative Colitis (PEDAB-9).....42
References (PEDAB-9).....45

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

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Criteria

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

Children with Suspected Crohn's Disease

- MR Enterography (CPT® 74183 or CPT® 74181 and CPT® 72197 or CPT® 72195), CT Enterography (CTE) (CPT® 74177), or MRI Abdomen and Pelvis without and with contrast (CPT® 74183 and CPT® 72197) is considered medically necessary for ANY of the following:
  - Evaluation of the severity and distribution of inflammatory changes
  - Identification of complications (e.g., fistulizing disease or abscess formation)
- MR Enterography (CPT® 74183 or CPT® 74181 and CPT® 72197 or CPT® 72195) or CT Enterography (CPT® 74177) is considered medically necessary for the evaluation of chronic abdominal pain associated with diarrhea and concern for inflammatory bowel disease if:
  - there is a positive family history of inflammatory bowel disease, **OR**
  - there are endoscopy or colonoscopy findings suggestive of inflammatory bowel disease, **OR**
  - elevated inflammatory markers (fecal lactoferrin greater than or equal to 4.0ug/g, CRP greater than 0.5mg/dL, or fecal calprotectin greater than or equal to 50ug/g), **OR**
  - diagnosis is still in doubt after colonoscopy and evaluation of inflammatory markers, and Crohn’s disease is suspected.
- MR Enterography (CPT® 74183 or CPT® 74181 and CPT® 72197 or CPT® 72195) or CT Enterography (CPT® 74177) is considered medically necessary prior to endoscopy if requested by or in consultation with the physician who will be performing the endoscopy.
- MRI Pelvis with contrast (CPT® 72196) or MRI Pelvis without and with contrast (CPT® 72197) is considered medically necessary for the following:
  - Concern for perianal fistula or abscess

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- See: **IBD (Crohn's Disease or Ulcerative Colitis) (AB-23.1)** in the Abdomen Imaging Guidelines for additional information regarding serologic markers

Children with Established IBD

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

Background and Supporting Information

Children with suspected Crohn's disease may present with clinical features including weight loss, loose stools, vomiting, and intermittent abdominal pain. Small bowel imaging can provide important anatomic and inflammatory information related to the presence, severity, extent, and complications of Crohn's disease, which may assist in treatment planning and disease monitoring. Initial diagnostic evaluation typically includes laboratory assessment and upper and lower endoscopy (Stein et al., 2024).

Evidence Discussion

Imaging is integral to the evaluation and management of pediatric Crohn's disease, both at initial diagnosis and during longitudinal disease monitoring. In children with suspected IBD, imaging complements endoscopy by defining disease extent, identifying small bowel involvement, and detecting complications such as strictures, fistulas, and abscesses (Stein et al., 2024). Selection of imaging modality is guided by diagnostic performance, safety considerations, and the need for repeated assessment over time.

Magnetic resonance enterography (MRE) is the preferred cross-sectional imaging modality for suspected and established Crohn's disease in pediatric individuals. The ACR Appropriateness Criteria® support MRE due to its high sensitivity for active inflammation, ability to assess transmural disease, and absence of ionizing radiation

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(Moore et al., 2022). Meta-analytic data demonstrate that MRE performs well in the detection of pediatric IBD and provides excellent evaluation of deep bowel segments and extraluminal complications (He et al., 2022). These findings support the use of enterography as the preferred advanced imaging approach for both initial evaluation and ongoing disease assessment.

In children with established Crohn's disease, imaging supports therapeutic monitoring, assessment of treatment response, evaluation of disease progression, and detection of complications such as penetrating disease, abscess formation, or bowel obstruction.

When enterography protocols are unavailable, contraindicated, or not tolerated, MRI of the abdomen and pelvis may provide an alternative cross-sectional imaging option for evaluation of disease activity and complications. CT enterography may also be appropriate when rapid evaluation is required or MRI is not feasible, although radiation exposure should be considered when selecting imaging modalities for pediatric individuals (Moore et al., 2022).

Pediatric Abdomen Imaging Guidelines

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

Guideline Page

Abdominal Sepsis (Suspected Abdominal Abscess) (PEDAB-10).....47

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

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

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

Guideline Page

Postoperative Pain within 60 Days Following Abdominal Surgery (PEDAB-11).....49
References (PEDAB-11).....51

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

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Criteria

- Any of the following studies are considered medically necessary in individuals with suspected postoperative complications (e.g., bowel obstruction, abscess, or anastomotic leak):
  - CT Abdomen and Pelvis with contrast (CPT® 74177)
  - Ultrasound Abdomen (CPT® 76700 or CPT® 76705)
  - MRI Abdomen and Pelvis without and with contrast (CPT® 74183 and CPT® 72197)
  - MRI Abdomen and Pelvis without contrast (CPT® 74181 and CPT® 72195)
    - Because MRI may not be practical for the timely evaluation of postoperative abscesses, MRI should only replace CT when the study can be completed in a similar time frame as CT.
- For evaluation of pain beyond 60 days postoperatively, see: **Generalized Abdominal Pain (PEDAB-2)**.

Evidence Discussion

Imaging is central to the evaluation of suspected postoperative abdominal complications in pediatric individuals, including obstruction, abscess formation, and anastomotic leak, particularly when clinical findings are nonspecific. The ACR supports selecting imaging modalities based on diagnostic needs, clinical urgency, and radiation considerations (American College of Radiology et al., 2021).

Contrast-enhanced CT provides rapid, comprehensive assessment of bowel obstruction, intra-abdominal fluid collections, and perforation, making it well suited for urgent postoperative evaluation. However, CT use should follow pediatric radiation dose optimization principles (Chang et al., 2020; American College of Radiology et al., 2021). MRI offers a radiation-free alternative with high soft tissue contrast for detecting abscesses and inflammatory changes, but its use depends on timely availability and individual stability (Greene et al., 2024). Ultrasound may identify fluid collections and facilitate image-guided intervention but has limitations in the evaluation of deep or complex intra-abdominal pathology.

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In individuals with postoperative fever or suspected peritonitis without a clearly identified source, radiopharmaceutical imaging may help detect occult infection or inflammation when conventional anatomic imaging findings are inconclusive. This evidence supports the selective use of nuclear medicine imaging in nonlocalizing clinical presentations (American College of Radiology et al., 2021).

Pediatric Abdomen Imaging Guidelines

References (PEDAB-11)

v1.0.2027

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

Guideline Page

Constipation, Diarrhea, and Irritable Bowel Syndrome (PEDAB-12).....53
References (PEDAB-12).....55

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

ABP.DC.0012.A
v1.0.2027

Criteria

- Constipation associated with additional signs or symptoms:
  - CT Abdomen with contrast (CPT® 74160) or CT Abdomen and Pelvis with contrast (CPT® 74177) is considered medically necessary when any red flag signs or symptoms are present (as listed in **General Guidelines (PEDAB-1.0)**)
  - Clinical suspicion of tethered cord, tumor, or traumatic injury (e.g., abnormal physical findings over the spine, abnormal neurological exam, or symptoms refractory to provider-directed treatment for at least 3 months), see: **Spinal Dysraphism and Tethered Cord (PEDSP-4)** in the Pediatric and Special Populations Spine Imaging Guidelines.
- Diarrhea associated with additional signs or symptoms:
  - CT Abdomen with contrast (CPT® 74160) or CT Abdomen and Pelvis with contrast (CPT® 74177) is considered medically necessary when any red flag signs or symptoms are present (as listed in **General Guidelines (PEDAB-1.0)**).
  - See: **Inflammatory Bowel Disease, Crohn Disease, or Ulcerative Colitis (PEDAB-9)** for concerns regarding suspected inflammatory bowel disease.
- Irritable bowel syndrome associated with additional signs or symptoms:
  - CT Abdomen with contrast (CPT® 74160) or CT Abdomen and Pelvis with contrast (CPT® 74177) is considered medically necessary when any red flag signs or symptoms are present (as listed in **General Guidelines (PEDAB-1.0)**).
- Hirschsprung disease:
  - MRI Pelvis without and with contrast (CPT® 72197) is considered medically necessary postoperatively in individuals who have signs of complications related to treatment to assess the position of the pulled-through bowel, the sphincter muscles, and the area of the posterior urethra.

Evidence Discussion

Most pediatric individuals with constipation, diarrhea, or IBS do not require imaging because these conditions are usually functional and can be evaluated through clinical history, growth assessment, and targeted laboratory testing. Functional constipation and IBS are diagnosed clinically using symptom-based criteria and do not benefit from routine imaging because imaging rarely alters management or improves clinical outcomes (Maqbool & Liacouras, 2024; Webster et al., 2024).

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Imaging is reserved for pediatric individuals with refractory constipation, red flag symptoms, or chronic diarrhea when structural disease or inflammatory processes are suspected. North American Society for Pediatric Gastroenterology, Hepatology and Nutrition (NASPGHAN) guidance identifies warning signs such as severe abdominal distention, persistent vomiting, delayed meconium passage, faltering weight (failure to thrive), and abnormal neurologic examination findings as indications for targeted imaging that evaluates for obstruction, motility disorders, or anatomic malformations (Kilgore et al., 2025; Quitadamo et al., 2024). In these scenarios, abdominal radiographs may assess stool burden or bowel obstruction; however, imaging does not establish a diagnosis of functional gastrointestinal disorders and should be used selectively.

In pediatric individuals with chronic diarrhea or clinical features concerning for inflammatory bowel disease, stool studies, inflammatory markers, and endoscopic evaluation guide diagnosis. Cross-sectional imaging is reserved for suspected IBD or disease-related complications and is not indicated for the routine evaluation of functional diarrhea. Evidence reviews of pediatric IBD demonstrate that MRI and ultrasound are preferred imaging modalities for the evaluation of inflammatory bowel pathology because of their diagnostic performance and lack of ionizing radiation exposure (Bouhuys et al., 2023; Thapar & Srivastava, 2024).

The available evidence does not support routine CT imaging for functional constipation, functional diarrhea, or irritable bowel syndrome in the absence of red flag findings. These data support limiting advanced imaging to individuals with concerning clinical features or suspected organic disease (Kilgore et al., 2025; Bouhuys et al., 2023).

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Abdominal Mass (PEDAB-13)

Guideline Page

Abdominal Wall Mass (PEDAB-13.1).....57
Intra-Abdominal Mass (PEDAB-13.2).....58
References (PEDAB-13).....60

Pediatric Abdomen Imaging Guidelines

Abdominal Wall Mass (PEDAB-13.1)

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v1.0.2027

Criteria

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

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Intra-Abdominal Mass (PEDAB-13.2)

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Criteria

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

Evidence Discussion

Imaging evaluation of pediatric abdominal masses follows a structured approach guided by clinical presentation and the suspected anatomic origin of the lesion. Ultrasound is a preferred initial modality because it can distinguish cystic from solid lesions, evaluate vascularity with Doppler imaging, and often identify the organ of origin while avoiding radiation and sedation (Birkemeier, 2020; Kim et al., 2022). These features support

its use as a first-line tool for both intra-abdominal and abdominal wall masses and for assessing vascular supply.

These characteristics support the use of ultrasound as the initial imaging study for both intra-abdominal and abdominal wall masses, including assessment of vascular supply. MRI is also appropriate during the initial or early stages of evaluation when additional lesion characterization is needed or when the extent of disease and relationships to adjacent structures require further assessment. This is particularly relevant for abdominal wall masses that extend beyond the superficial tissues or when preoperative planning is anticipated (Kim et al., 2022).

MRI provides superior soft tissue contrast without ionizing radiation and is therefore preferred for lesion characterization, local staging, and surgical planning. Additional imaging is reserved for situations in which ultrasound and/or MRI findings are inconclusive or insufficient to guide management decisions. CT is used selectively when evaluation of calcifications, vascular anatomy, metastatic disease, or other features would alter clinical management, or when MRI is unavailable, contraindicated, or not feasible (Allen-Rhoades & Steuber, 2021).

Pediatric Abdomen Imaging Guidelines

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v1.0.2027

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

Guideline Page

Renovascular Hypertension and Other Secondary Causes of Hypertension (PEDAB-14)..... 62
References (PEDAB-14).....65

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

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Criteria

- Clinical evaluation for suspected hypertension should include repeated blood pressure measurements (generally requires three or more measurements).
  - Trained health care professionals in the office setting should make a diagnosis of hypertension (HTN) if a child or adolescent has auscultatory-confirmed blood pressure (BP) readings at or above the 95th percentile at three different visits.

For Children Aged 1 year to younger than 13 years	For Children Aged 13 years or older
Normal BP: <90th Percentile	Normal BP: <120/<80 mm Hg
Elevated BP: ≥90th percentile to <95th percentile or 120/80 mm Hg to <95th percentile (whichever is lower)	Elevated BP: 120/<80 to 129/<80 mm Hg
Stage 1 HTN: ≥95th percentile to <95th percentile + 12 mmHg, or 130/80 to 139/89 mm Hg (whichever is lower)	Stage 1 HTN: 130/80 to 139/89 mm Hg
Stage 2 HTN: ≥95th percentile + 12 mm Hg, or ≥140/90 mm Hg (whichever is lower)	Stage 2 HTN: ≥140/90 mm Hg

- ANY of the following studies are considered medically necessary for the initial evaluation of a pediatric individual with suspected secondary hypertension:
  - Doppler or Duplex Ultrasound (CPT® 93975 or CPT® 93976)
  - Complete retroperitoneal Ultrasound (CPT® 76770)
  - Captopril renography (CPT® 78709) is not routinely used in current clinical practice and has largely been replaced by computed tomography angiography (CTA) and magnetic resonance angiography (MRA) of the abdomen. However,

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captopril renography may be considered medically necessary in unusual clinical circumstances when deemed appropriate for further evaluation.

Other considerations for imaging evaluation:

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

Evidence Discussion

Imaging evaluation for suspected renovascular hypertension in pediatric individuals should follow confirmation of elevated blood pressure using standardized measurement techniques and should be guided by the degree of clinical suspicion for renovascular disease (Flynn et al., 2017; Lee & Cho, 2025).

Ultrasound with Doppler is the preferred initial imaging modality, as it evaluates renal size asymmetry and hemodynamic indicators of renal artery stenosis without exposure

to ionizing radiation. However, its sensitivity is limited in younger children and in individuals with branch vessel or distal renal artery disease, warranting further imaging when clinical suspicion remains high despite negative or inconclusive ultrasound findings (de Oliveira Campos et al., 2021; Lee & Cho, 2025).

Computed tomography angiography (CTA) and magnetic resonance angiography (MRA) provide definitive vascular assessment. CTA offers high spatial resolution and excellent diagnostic performance compared with conventional angiography, whereas MRA avoids ionizing radiation and may be preferred when radiation minimization is a priority. However, evaluation of smaller branch vessels may be more limited with MRA (Fleury et al., 2021; Expert Panel on Urological Imaging et al., 2026).

Nuclear renal imaging provides functional assessment by evaluating differential renal function and the physiologic impact of suspected renovascular disease when anatomic imaging findings are inconclusive (ACR–ACNM–SPR, 2022; Santos & Ferreira, 2024). These findings support the selective use of nuclear medicine studies in pediatric individuals with severe hypertension, declining renal function, suspected renovascular disease, or inconclusive vascular imaging findings.

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Liver Lesion Characterization (PEDAB-15)

Guideline Page

Liver Lesion Characterization (PEDAB-15).....67
References (PEDAB-15).....72

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Liver Lesion Characterization (PEDAB-15)

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Criteria

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

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        - Contrast-Enhanced US (CEUS, CPT® 76978, CPT® 76979)
        - If the lesion remains indeterminate or not fully characterized after Contrast-Enhanced US or if Contrast-Enhanced US is not available:
            - MRI Abdomen without and with contrast (CPT® 74183) or CT Abdomen with contrast (CPT® 74160)
    - Indeterminate liver lesion greater than 3cm
        - MRI Abdomen without and with contrast (CPT® 74183) or CT Abdomen with contrast (CPT® 74160)
- For the imaging of specific focal liver lesions:
    - Suspected hepatic adenoma:
        - CT Abdomen 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 every 6 months for 2 years, and then annually, to establish any growth patterns and assess for malignant transformation.
    - Hepatic Hemangioma
        - Limited Ultrasound Abdomen in 6-12 months
            - If stable or decreasing in size: Continue surveillance imaging every 6-12 months until 2 years. After 2 years, no further follow-up is considered medically necessary unless it becomes symptomatic.
            - If increasing in size: Repeat imaging in 3-6 months or consider biopsy
            - See below for pre-operative considerations
    - Focal Nodular Hyperplasia (FNH):
        - MRI Abdomen without and with contrast (CPT® 74183) or CT Abdomen with contrast (CPT® 74160) or CT Abdomen without and with contrast(CPT® 74170) is considered medically necessary to confirm a diagnosis of FNH. The use of Eovist contrast is often diagnostic in differentiating FNH from other lesions seen on MRI or CT.
        - Additional follow-up is limited abdominal US in 6-12 months
            - If stable or decreasing in size: Continue surveillance imaging every 6-12 months until 2 years. After 2 years, no further follow-up is considered medically necessary unless it becomes symptomatic.
            - In adolescent females diagnosed with FNH who continue to use oral contraceptives: Additional follow-up with annual US for 2 to 3 years is recommended. Follow-up with CT or MRI is considered medically necessary if the lesion is not adequately visualized on US.
            - If increasing in size: Repeat imaging in 3-6 months or consider biopsy
    - Hepatic cysts:
        - Asymptomatic, simple cysts
            - Limited Ultrasound Abdomen in 6-12 months

    - If stable or decreasing in size: Continue surveillance imaging every 6-12 months until 2 years. After 2 years, no additional follow-up imaging is considered medically necessary unless it becomes symptomatic
    - If increasing in size: Repeat imaging in 3-6 months or consider biopsy
  - For complicated cysts (US shows internal septations, fenestrations, calcifications, irregular walls, as well as the presence of daughter cysts):
    - MRI Abdomen without and with contrast (CPT® 74183) or CT Abdomen with contrast (CPT® 74160) or CT Abdomen without and with contrast (CPT® 74170) is considered medically necessary
- Additional scenarios and follow-up imaging for an indeterminate lesion:
  - Indeterminate lesion less than 1cm in high-risk individuals detected on US, CT, or unenhanced MRI and not otherwise addressed in the guidelines above:
    - If **biopsy cannot be performed**, follow-up MRI is considered medically necessary at 3-6 months.
    - Additional imaging in this setting can be considered on an individual basis.
    - This timeframe would also apply if the lesion is indeterminate and an MRI with Eovist is requested for further evaluation.

Background and Supporting Information

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

Risk factors for malignant liver tumors in children

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

Evidence Discussion

Ultrasound is the preferred initial imaging modality for pediatric liver lesions, as studies demonstrate it reliably characterizes lesion morphology and vascularity while avoiding radiation and sedation (Hadian, 2024; Karmazyn, 2022).

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MRI is preferred for cross-sectional evaluation because it provides superior tissue characterization and hepatobiliary phase imaging, which improves differentiation of benign and malignant lesions compared with CT (Moreira-Silva et al., 2022; Rees et al., 2025). These findings support the use of MRI as the preferred advanced imaging modality in pediatric individuals whenever feasible to minimize radiation exposure.

For lesions less than 3cm, contrast-enhanced ultrasound (CEUS) provides real-time assessment of arterial and portal venous enhancement patterns, improving differentiation among hemangioma, focal nodular hyperplasia (FNH), and atypical cystic lesions without radiation exposure or sedation. CEUS may reduce the need for immediate cross-sectional imaging, although MRI or CT remains appropriate when CEUS is unavailable or when lesion characterization remains indeterminate (Ro et al., 2025; Moreira-Silva et al., 2022).This evidence supports the use of CEUS as an intermediate step for characterization of smaller indeterminate lesions identified on ultrasound, CT, or noncontrast MRI.

Lesions greater than 3cm are associated with an increased likelihood of neoplastic pathology, including hepatoblastoma and hepatic adenoma. MRI with hepatobiliary contrast improves differentiation of FNH, adenoma, and malignant tumors, while CT remains an acceptable alternative when MRI is unavailable, contraindicated, or not feasible (Rees et al., 2025; Karmazyn et al., 2022). These findings support direct progression to cross-sectional imaging for larger indeterminate lesions.

Hepatic adenomas warrant interval cross-sectional imaging because of the potential risks of growth, hemorrhage, and malignant transformation, particularly in adolescents and individuals with metabolic risk factors (Scheers, 2024). FNH often demonstrates characteristic hepatobiliary phase uptake on MRI, supporting diagnosis and allowing transition to ultrasound-based surveillance after lesion characterization is complete, with closer follow-up in higher-risk individuals (Ro et al., 2025). Ongoing estrogen exposure may influence lesion behavior and has been associated with interval growth in some individuals, supporting short-term surveillance in adolescents who continue oral contraceptive therapy (Scheers et al., 2024; Ro et al., 2025).

Infantile hemangiomas and simple hepatic cysts are frequently stable and may be followed with ultrasound surveillance unless interval growth or atypical imaging features are identified (Karmazyn et al., 2022; Moreira-Silva et al., 2022).

Pediatric individuals with tumor predisposition syndromes, such as Beckwith–Wiedemann spectrum, require earlier and more sensitive imaging evaluation for hepatoblastoma and other solid tumors. Surveillance guidelines support the use of cross-sectional imaging—preferably MRI, with CT as an alternative—when lesions are detected on screening ultrasound to enable accurate characterization and guide management (Kalish et al., 2024; Rees et al., 2025).

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For indeterminate lesions smaller than 1 cm in high-risk individuals, short-interval follow-up imaging may be appropriate because early characterization can be limited by lesion size. MRI surveillance allows assessment for interval growth or evolution of imaging characteristics that may warrant further evaluation or intervention (Kalish et al., 2024; Rees et al., 2025).

Pediatric Abdomen Imaging Guidelines

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v1.0.2027

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Liver Disease (PEDAB-16)

Guideline Page

Pediatric Liver Failure and Cirrhosis (PEDAB-16.1)..... 74
References (PEDAB-16.1).....76
Biliary Disease (PEDAB-16.2).....77
References (PEDAB-16.2).....79
Liver Elastography (PEDAB-16.3).....80
References (PEDAB-16.3).....81

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Pediatric Liver Failure and Cirrhosis (PEDAB-16.1)

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v1.0.2027

Criteria

- Elevated liver function testing imaging indications in pediatric individuals are very similar to those for adult individuals. See: **Abnormal Liver Chemistries (AB-30)** in the Abdomen Imaging Guidelines.
- Liver ultrasound (CPT® 76700) with duplex Doppler (CPT® 93975) is considered medically necessary as the initial imaging study prior to approving CT or MRI for pediatric individuals.
  - MRI Abdomen without and with contrast (CPT® 74183) is considered medically necessary when ultrasound findings are inconclusive or technically limited and is preferred over CT when feasible to minimize radiation exposure.
- Repeat liver ultrasound (CPT® 76705) with duplex Doppler (CPT® 93975 or CPT® 93976) is considered medically necessary in pediatric individuals in ANY of the following circumstances:
  - Annual surveillance of known chronic liver dysfunction or cirrhosis of any cause
  - New or worsening findings on history, physical exam, or laboratory results that suggest progression of liver disease
  - Clinical suspicion of portal venous congestion or portal hypertension

Background and Supporting Information

- Causes of liver failure or cirrhosis in pediatric individuals are different from adults, and are frequently idiopathic, but commonly due to ONE of the following
  - Biliary dysfunction (biliary atresia, cystic fibrosis, etc.)
  - Metabolic disease
  - Post-infectious
  - Idiopathic causes

Evidence Discussion

Pediatric individuals with chronic liver disease and cirrhosis are at risk for progressive portal hypertension, vascular complications, and focal hepatic lesions. Ultrasound with Doppler imaging is the preferred initial and surveillance imaging modality because it is noninvasive, readily repeatable, and provides both anatomic and hemodynamic information, including portal vein patency, flow direction, splenomegaly, and ascites,

which are important indicators of disease progression and decompensation (Squires & Balistreri, 2024; Hadian et al., 2024). These characteristics support its role in longitudinal surveillance in a population that often requires repeated imaging evaluation.

MRI, including magnetic resonance angiography (MRA) and magnetic resonance cholangiopancreatography (MRCP) when indicated, is appropriate for further characterization and staging when ultrasound findings are indeterminate or when complications such as focal hepatic lesions, biliary abnormalities, or vascular shunts are suspected. The absence of ionizing radiation is particularly important in pediatric individuals with chronic liver disease and cirrhosis, in whom repeated imaging may be necessary over time (Squires & Balistreri, 2024; Napolitano et al., 2021).

CT of the abdomen with intravenous contrast remains an appropriate alternative when MRI is unavailable, contraindicated, or not feasible, particularly for evaluation of complications, vascular anatomy, and liver transplant planning. Collectively, the evidence supports an ultrasound-first approach with selective use of MRI or CT based on clinical findings and the need for additional anatomic characterization.

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Biliary Disease (PEDAB-16.2)

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Criteria

- Ultrasound Abdomen (CPT® 76700 or CPT® 76705) is considered medically necessary as the initial imaging study.
  - Advanced imaging, such as CT or MRI, is rarely considered medically necessary unless otherwise indicated below.
- After initial ultrasound:
  - If biliary atresia is suspected:
    - Hepatobiliary system imaging (HIDA scan) is considered medically necessary if requested by the surgeon before liver biopsy.
  - If choledochal cyst is suspected:
    - CT Abdomen with contrast (CPT® 74160) or MRI/MRCP (CPT® 74183 or CPT® 74181) is considered medically necessary.
    - For preoperative assessment: MRI/MRCP (CPT® 74183 or CPT® 74181) is considered medically necessary.
  - If primary biliary disease such as primary sclerosing cholangitis or primary biliary cholangitis is suspected:
    - CT Abdomen with contrast (CPT® 74160) or MRI/MRCP (CPT® 74183 or CPT® 74181) is considered medically necessary.
- Follow-up of resected choledochal cysts (types I and IV, and type V not treated by transplantation):
  - Immediately after resection:
    - Ultrasound Abdomen (CPT® 76700 or CPT® 76705) AND MRI Abdomen with cholangiography (CPT® 74183) is considered medically necessary.
  - Years 1-20 post-resection:
    - Ultrasound Abdomen (CPT® 76700 or CPT® 76705), biannually
      - MRI Abdomen with cholangiography (CPT® 74183) is considered medically necessary on an every 3-year schedule (in lieu of ultrasound) for any of the following:
        - Ultrasound is not feasible due to body habitus
        - Ultrasound is unavailable
  - Years 21-40 post-resection:
    - Ultrasound Abdomen (CPT® 76700 or CPT® 76705), every 3 years

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- MRI Abdomen with cholangiography (CPT® 74183) is considered medically necessary on an every 4-year schedule (in lieu of ultrasound) for any of the following:
  - Ultrasound is not feasible due to body habitus
  - Ultrasound is unavailable

◦ Residual cystic tissue is present following resection:
  ▪ Ultrasound Abdomen (CPT® 76700 or CPT® 76705), annually

Background and Supporting Information

The definition of conjugated hyperbilirubinemia is a serum conjugated bilirubin level greater than 1mg/dL if total bilirubin is less than 5.0mg/dL, or a conjugated bilirubin level greater than 20% of the total bilirubin level when the total bilirubin level is greater than 5.0 mg/dL. Obstructive causes of liver disease should be evaluated. Additional laboratory testing may include total and fractionated bilirubin, AST, ALT, alkaline phosphatase, GGT, and/or urinalysis.

Evidence Discussion

In neonatal and infantile cholestasis, early differentiation of biliary atresia from other causes is critical because outcomes are time-dependent. Ultrasound is the first imaging step due to its availability, lack of radiation, and ability to assess gallbladder morphology, biliary dilation, and associated hepatic findings. Imaging must be interpreted in conjunction with laboratory results and the timing of jaundice onset to guide rapid triage (Fawaz et al., 2017; Napolitano et al., 2021).

When ultrasound is inconclusive, MRI with MRCP is appropriate to provide high-resolution delineation of the biliary tree and liver parenchyma without radiation exposure. Hepatobiliary scintigraphy (HIDA) is reserved for cases where functional biliary excretion must be demonstrated, particularly when biliary atresia remains a concern after initial evaluation. Evidence supports its use within a multidisciplinary diagnostic pathway rather than as a standalone or first-line study, especially given the need for timely surgical decision-making for Kasai portoenterostomy (Fawaz et al., 2017; Napolitano et al., 2021; ACR–ACNM–SNMMI–SPR, 2025).

Choledochal cysts require precise anatomic characterization before surgery and structured long-term surveillance, as ongoing malignancy risk has been reported even after resection (Koea et al., 2022). MRCP is the preferred imaging modality for both preoperative planning and post-resection follow-up because it provides detailed ductal mapping without radiation and supports repeated imaging over time. When MRCP is not feasible, contrast-enhanced CT is an acceptable alternative for defining biliary and vascular anatomy.

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Liver Elastography (PEDAB-16.3)

ABP.LD.0016.3.A
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Criteria

- The following are considered medically necessary for initial staging of liver fibrosis in individuals with suspected chronic liver disease:
  - Transient Elastography or Vibration-Controlled Transient Elastography (VCTE, e.g., Fibroscan) (CPT® 91200) is considered the preferred initial imaging modality.
  - Magnetic Resonance Elastography (MRE, CPT® 76391) is considered medically necessary for ANY of the following:
    - Transient Elastography failure despite use of an XL-probe, OR
    - BMI greater than or equal to 30kg/m² OR
    - Conflict between clinical picture and transient elastography results

Evidence Discussion

Assessment of hepatic fibrosis is important for risk stratification and monitoring in pediatric chronic liver disease. Transient elastography, including vibration-controlled transient elastography (VCTE), provides a noninvasive, radiation-free estimate of liver stiffness and is an appropriate initial imaging modality because it correlates with fibrosis severity while allowing serial assessment without the risks associated with liver biopsy (Squires & Balistreri, 2024; Hadian et al., 2024).

Magnetic resonance elastography (MRE) provides reliable assessment of liver stiffness when transient elastography is unsuccessful, limited by obesity or body habitus, or when elastography findings are inconsistent with the overall clinical presentation. These characteristics support the selective use of MRE when additional fibrosis characterization is needed (Squires & Balistreri, 2024; Hadian et al., 2024).

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Adrenal Lesions (PEDAB-17)

Guideline Page

Adrenal Lesions (PEDAB-17).....83
References (PEDAB-17).....85

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Adrenal Lesions (PEDAB-17)

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Criteria

- Indications for imaging evaluation of adrenal lesions in pediatric individuals are similar to those in adult individuals. For additional indications not specifically addressed below, refer to **Adrenal Cortical Lesions (AB-16)** in the General Abdomen Imaging Guidelines.
- Abdominal Ultrasound is considered medically necessary as the initial imaging study for adrenal masses in infants and pediatric individuals.
  - If an adrenal mass is detected, short interval follow-up retroperitoneal ultrasound (CPT® 76770) is considered medically necessary when performed seven or more days after the initial examination.
    - If repeat ultrasound is concerning for neuroblastoma or there is high clinical concern for neuroblastoma, MRI Abdomen without and with contrast (CPT® 74183) or CT Abdomen without and with contrast (CPT® 74170) are considered medically necessary to confirm the diagnosis.
    - If these studies confirm neuroblastoma ^{123}I-Metaiodobenzylguanidine (MIBG) scintigraphy is considered medically necessary for disease staging.
  - For ongoing management of neuroblastoma, See: **Neuroblastoma (PEDONC-6)** in the Pediatric and Special Populations Oncology Imaging Guidelines.

Evidence Discussion

In neonates and young children, adrenal masses most commonly represent adrenal hemorrhage or neuroblastoma, so imaging focuses on accurate differentiation while minimizing radiation exposure. Ultrasound is the preferred first-line imaging modality because it reliably characterizes suprarenal masses, detects adrenal hemorrhage, and avoids ionizing radiation. Short-interval follow-up ultrasound is appropriate when findings are consistent with adrenal hemorrhage to document the expected evolution of hemorrhage and identify persistent or atypical findings that warrant additional evaluation (Hryhorczuk & Paltiel, 2021; Zaki et al., 2025).

When ultrasound findings are indeterminate or suggest neoplasm, MRI is preferred for further characterization due to its ability to distinguish hemorrhage, necrosis, fat, and adjacent soft tissue involvement without radiation exposure. CT remains appropriate when MRI is unavailable, when rapid evaluation is required for surgical planning, or when detection of calcifications, a common feature of neuroblastoma, will affect diagnosis (Zaki et al., 2025; Ozcan et al., 2021).

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If imaging findings are concerning for neuroblastoma or other neuroendocrine tumors, iodine-123 metaiodobenzylguanidine (^{123}I-MIBG) scintigraphy is valuable for staging and treatment planning because it can identify functional and metastatic disease beyond that detected by anatomic imaging. Functional imaging also has an important role in the evaluation of suspected pheochromocytoma and paraganglioma, particularly when multifocal or metastatic disease is suspected (Sánchez-Vañó et al., 2025; Nölting et al., 2021). In endocrine-active adrenal disorders, biochemical confirmation is generally recommended before localization imaging to reduce false-positive findings and unnecessary procedures (Fleseriu et al., 2021; Adler et al., 2025).

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Hemochromatosis (PEDAB-18)

Guideline Page

Hereditary (Primary) Hemochromatosis (PEDAB-18.1)..... 87
Transfusion-Associated (Secondary) Hemochromatosis (PEDAB-18.2)..... 88
References (PEDAB-18)..... 89

Pediatric Abdomen Imaging Guidelines

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Hereditary (Primary) Hemochromatosis (PEDAB-18.1)

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

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

ABP.HC.0018.2.A
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Criteria

- The following studies are considered medically necessary for evaluation of transfusion-associated hemochromatosis:
  - MRI Abdomen without contrast (CPT® 74181) for liver iron evaluation AND/OR MRI Cardiac without contrast (CPT® 75557) for cardiac iron evaluation **OR**
  - MRI Chest without contrast (CPT® 71550) for combined cardiac and hepatic iron evaluation and may be approved as a single-study alternative to MRI Abdomen without contrast (CPT® 74181) and MRI Cardiac without contrast (CPT® 75557).
- Screening MRI is considered medically necessary every 12 months for chronically transfused individuals at risk of hemochromatosis.
- Imaging is considered medically necessary every 3 months for treatment response in individuals receiving active treatment (chelation and/or phlebotomy).

Evidence Discussion

Pediatric individuals with sickle cell disease, thalassemia, bone marrow failure syndromes, prior malignancy, or transplant exposure frequently accumulate excess iron after repeated transfusions. Annual MRI surveillance supports early detection of hepatic and cardiac iron deposition before symptoms develop and aligns with hematology and survivorship recommendations that emphasize noninvasive longitudinal monitoring in transfusion-dependent populations (Brandow et al., 2020; Devine et al., 2025).

Chelation therapy and phlebotomy alter iron balance over time. MRI approximately every 3 months during active treatment allows assessment of hepatic iron concentration and myocardial T2* recovery, supporting dose adjustment and reducing the risk of undertreatment or overtreatment (Reeder et al., 2023).

When validated protocols are used, a non-contrast chest MRI can acquire cardiac T2* alongside upper abdominal T2*/R2* measurements in a single session. This approach reduces sedation exposure, avoids duplicative imaging, and maintains accuracy when protocols are properly calibrated (Reeder et al., 2023).

Cumulative iron burden correlates with transfusion exposure. Iron overload becomes increasingly likely after repeated transfusions, particularly in individuals with hemoglobinopathies or bone marrow failure syndromes, supporting MRI-based surveillance in high-risk populations (Brandow et al., 2020; Devine et al., 2025).

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Indeterminate Renal Lesion (PEDAB-19)

Guideline Page

Indeterminate Renal Lesion (PEDAB-19).....91
References (PEDAB-19).....93

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Indeterminate Renal Lesion (PEDAB-19)

ABP.RL.0019.A
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Criteria

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

Evidence Discussion

Most indeterminate renal lesions in pediatric individuals are cysts or congenital anomalies rather than malignancies, consistent with the lower risk of malignant progression and supporting a conservative, ultrasound-first approach (Thomas et al., 2021; Gimpel et al., 2019). Evidence indicates that most simple renal cysts can be managed without additional imaging unless clinical or sonographic concerns arise (Dell & Hartung, 2024).

Simple cysts typically do not require cross-sectional imaging; however, in symptomatic individuals undergoing evaluation for potential surgical intervention, imaging is appropriate to define anatomy and exclude atypical features that would alter management. MRI is preferred to minimize radiation exposure, while CT is reserved for cases requiring rapid assessment or evaluation of calcification (Dell & Hartung, 2024; Thomas et al., 2021).

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Complex features on ultrasound, including septations, nodularity, or solid components, warrant contrast-enhanced MRI or CT to assess enhancement and stratify risk using a modified Bosniak framework validated in pediatric populations, guiding management and surgical consultation (Peard et al., 2022; Gimpel et al., 2019).

In pediatric individuals with suspected congenital urinary tract anomalies, functional assessment is an important component of evaluation. Consensus recommendations support diuretic renography for assessment of differential renal function and urinary drainage, while cystography remains necessary to evaluate for associated vesicoureteral reflux (ACR–ACNM–SPR, 2022; Bar-Sever et al., 2022; Majd et al., 2018).

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Hydronephrosis (PEDAB-20)

Guideline Page

Hydronephrosis (PEDAB-20).....95
References (PEDAB-20).....97

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Hydronephrosis (PEDAB-20)

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Criteria

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

- Retroperitoneal ultrasound (CPT® 76771) is considered medically necessary for evaluation of antenatal hydronephrosis (AHN)
  - Postnatal ultrasound is considered medically necessary in the neonatal period, preferably within the first 24 hours of life, for males with a distended bladder or infants with moderate/severe antenatal hydronephrosis diagnosed prenatally.
  - Postnatal ultrasound performed after seven days of life is considered medically necessary for infants with mild prenatal hydronephrosis.
  - A second postnatal ultrasound, even if initial is normal, at 4 to 6 weeks of age is considered medically necessary for all infants with antenatal hydronephrosis.
  - After this, infants with known hydronephrosis may be followed by ultrasound every 3 to 12 months until resolution of hydronephrosis.
    - This imaging represents a guideline-supported, scheduled follow-up imaging evaluation, as described in **Clinical Information (Preface-3.1)** in the Preface Imaging Guidelines.
- Voiding cystourethrogram (VCUG) (CPT® 74455) is considered medically necessary in newborn male individuals with a history of antenatal hydronephrosis to evaluate for vesicoureteral reflux (VUR) and posterior urethral valves (PUV).
- Hydronephrosis associated with urinary tract infection or vesicoureteral reflux, see: **Urinary Tract Infection (UTI) (PEDAB-5)** for imaging guidelines.
- In individuals with obstructive uropathy (including ureteropelvic junction obstruction (UPJO), ureterovesical junction obstruction (UVJO), and bladder outlet obstruction), retroperitoneal ultrasound (CPT® 76770) and diuretic renography (CPT® 78707, CPT® 78708, or CPT® 78709) are considered medically necessary for preoperative planning and postoperatively at 3 to 12 months.
  - If hydronephrosis has resolved on postoperative imaging, no further routine imaging is considered medically necessary.
- Magnetic resonance urography (MRU) (CPT® 74183 and CPT® 72197) is considered medically necessary when ultrasound and diuretic renography are inconclusive.
- CT Abdomen with contrast (CPT® 74160) is considered medically necessary when ultrasound is inconclusive and a vascular cause of ureteropelvic junction obstruction (UPJO) is suspected.

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Evidence Discussion

Imaging evaluation of infants with suspected urinary tract dilation or obstruction should prioritize diagnostic accuracy while minimizing ionizing radiation. Ultrasound is the first-line imaging modality for antenatal and postnatal hydronephrosis, as it reliably assesses renal dilation and urinary tract anatomy without radiation exposure (Brown et al., 2020; Darge & Siegel, 2019). The ACR Appropriateness Criteria® support ultrasound as the initial study, with follow-up and additional imaging guided by risk stratification and clinical progression (Brown et al., 2020; Nguyen et al., 2022). Serial ultrasound is appropriate for surveillance, as mild dilation may resolve with normal neonatal physiologic changes (Di Carlo & Crigger, 2024).

Voiding cystourethrogram (VCUG) is an important adjunctive imaging modality in the postnatal evaluation of infants with antenatal hydronephrosis when there is concern for vesicoureteral reflux (VUR) or lower urinary tract obstruction. The American Urological Association (AUA) guideline recommends evaluation for VUR in neonates and infants with prenatally diagnosed hydronephrosis, with VCUG serving as the gold standard diagnostic test for identifying reflux (Peters et al., 2010/2017). VCUG is typically performed following initial postnatal ultrasound when findings suggest increased risk, including moderate to severe hydronephrosis, ureteral dilation, abnormal bladder findings, or clinical history of urinary tract infection (Brown et al., 2020). In newborn male individuals, VCUG is particularly important for the identification of posterior urethral valves, a clinically significant obstructive cause of hydronephrosis that is not reliably detected by ultrasound alone and requires early diagnosis to prevent renal damage.

When ultrasound findings are indeterminate or suggest obstruction, further evaluation is warranted. Diuretic renography provides valuable information regarding urinary drainage and differential renal function, allowing distinction between obstructive and nonobstructive dilation. (Nguyen et al., 2022; Di Carlo & Crigger, 2024).

Magnetic resonance urography offers comprehensive anatomic and functional evaluation when ultrasound and renography findings remain inconclusive and may identify associated abnormalities not visible on ultrasound alone (Nguyen et al., 2022; Brown et al., 2020). Collectively, the available evidence supports a staged imaging approach using ultrasound as the initial study followed by VCUG, diuretic renography, or MR urography when clinically indicated (Brown et al., 2020; Chen et al., 2020).

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Polycystic Kidney Disease (PEDAB-21)

Guideline Page

Polycystic Kidney Disease (PEDAB-21).....99
References (PEDAB-21).....100

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Polycystic Kidney Disease (PEDAB-21)

ABP.PK.0021.A
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Criteria

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

Evidence Discussion

Imaging is central to the evaluation of suspected polycystic kidney disease in pediatric individuals. Ultrasound is the first-line imaging modality for diagnosis and screening, as it reliably assesses kidney size, echogenicity, and cyst distribution without ionizing radiation (Gimpel et al., 2019; Devarajan, 2024).

Consensus guidelines emphasize that imaging findings reflect disease type. In autosomal recessive polycystic kidney disease (ARPKD), diffuse renal enlargement and increased echogenicity predominate, whereas evaluation of autosomal dominant polycystic kidney disease (ADPKD) focuses on cyst number and distribution (Gimpel et al., 2019). Ultrasound is sufficient for most pediatric evaluations, and routine CT is not recommended because it provides limited additional diagnostic benefit while exposing individuals to ionizing radiation.

MRI is not routinely required in children younger than 15 years of age because validated MRI-based diagnostic criteria for ADPKD have not been established in this population. In older children and adolescents, MRI may be used similarly to adults for further lesion characterization and risk stratification, particularly when assessment of total kidney volume may influence management decisions (Torres et al., 2025).

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Blunt Abdominal Trauma (PEDAB-22)

Guideline Page

Blunt Abdominal Trauma (PEDAB-22)..... 102

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Blunt Abdominal Trauma (PEDAB-22)

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

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Hernias (PEDAB-23)

Guideline Page

Hernias (PEDAB-23).....104

Pediatric Abdomen Imaging Guidelines

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Hernias (PEDAB-23)

ABP.IH.0023.A

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

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Abdominal Lymphadenopathy (PEDAB-24)

Guideline Page

Abdominal Lymphadenopathy (PEDAB-24)..... 106

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Abdominal Lymphadenopathy (PEDAB-24)

ABP.AL.0024.A

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

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Left Upper Quadrant Pain (PEDAB-25)

Guideline Page

Left Upper Quadrant Pain (PEDAB-25)..... 108
References (PEDAB-25).....109

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Left Upper Quadrant Pain (PEDAB-25)

ABP.LT.0025.C

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- Left upper quadrant pain imaging indications in pediatric individuals are identical to those for adult individuals. See: **Abdominal Pain (AB-2)** in the Abdomen Imaging Guidelines.

Evidence Discussion

Ultrasound is the preferred initial modality for evaluating left upper quadrant pain in pediatric individuals, as it reliably assesses splenic size and focal lesions without radiation (Nadeem et al., 2021).

Cross-sectional imaging is reserved for cases in which ultrasound is inconclusive or complications are suspected. CT is most accurate for high-grade traumatic injury but should be used selectively due to radiation exposure, while MRI may assist in characterizing complex lesions (Nadeem et al., 2021).

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Pediatric Abdomen Imaging Guidelines

Spleen (PEDAB-26)

Guideline Page

Spleen (PEDAB-26).....111
References (PEDAB-26).....112

Pediatric Abdomen Imaging Guidelines

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Spleen (PEDAB-26)

ABP.SP.0026.C
v1.0.2027

Criteria

- Spleen imaging indications in pediatric individuals are very similar to those for adult individuals. See: **Spleen (AB-34)** in the Abdomen Imaging Guidelines.
- Pediatric-specific imaging considerations include the following:
  - MRI is preferred over CT when possible to reduce radiation exposure.

Evidence Discussion

Ultrasound is the primary imaging modality for pediatric splenic evaluation, as it reliably demonstrates splenic size, echotexture, and focal lesions without radiation. It is generally sufficient for detecting splenomegaly, cysts, abscesses, and infarcts (Di Serafino et al., 2019; Navarro & Siegel, 2019). Pediatric imaging approaches are similar to those used in adults but place greater emphasis on minimizing radiation exposure (Remiker & Brandow, 2024b).

When additional characterization is needed, MRI is preferred for evaluating splenic parenchyma and indeterminate lesions without radiation, while CT is reserved for acute trauma requiring rapid assessment (Navarro & Siegel, 2019; Remiker & Brandow, 2024a).

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Intussusception (PEDAB-27)

Guideline Page

Intussusception (PEDAB-27)..... 114
References (PEDAB-27)..... 115

Pediatric Abdomen Imaging Guidelines

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Intussusception (PEDAB-27)

ABP.IN.0027.A
v1.0.2027

Criteria

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

Evidence Discussion

Ultrasound is the preferred initial imaging modality for suspected pediatric intussusception because it provides rapid, radiation-free evaluation with consistently high diagnostic accuracy. Meta-analyses report sensitivities and specificities exceeding 95% when performed by experienced pediatric sonographers, reflecting the reliability of characteristic findings such as the transverse target sign and longitudinal pseudokidney sign, which directly depict telescoped bowel segments (Li et al., 2021; Rahmani et al., 2023).

Point-of-care ultrasound extends this capability to early triage, with trained providers demonstrating high diagnostic performance and reduced time to intervention (Lin Martore et al., 2022). Formal ultrasound remains the reference standard when further characterization is required, particularly to assess bowel wall viability or identify a pathologic lead point (Maqbool & Liacouras, 2024).

CT has a limited role in the routine evaluation of pediatric intussusception because ultrasound provides excellent diagnostic performance without radiation exposure. However, CT is appropriate when ultrasound findings suggest a pathologic lead point requiring further anatomic characterization, particularly in atypical presentations or older children (Maqbool & Liacouras, 2024).

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Bowel Obstruction (PEDAB-28)

Guideline Page

Bowel Obstruction (PEDAB-28.1).....117
References (PEDAB-28).....119

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Bowel Obstruction (PEDAB-28.1)

ABP.BO.0028.1.A
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Criteria

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

Evidence Discussion

When cross-sectional imaging is required for suspected pediatric small bowel obstruction, MRI of the abdomen and pelvis without and with contrast is preferred for both high-grade and intermittent or low-grade obstruction because it defines transition points, bowel wall edema, perfusion, and complications without ionizing radiation, consistent with pediatric risk reduction principles (Hull et al., 2022). This supports its use as the primary modality when available and feasible. In high-grade obstruction, MRI provides comprehensive assessment of obstruction severity, etiology, and signs of ischemia or closed-loop physiology. CT with contrast remains appropriate when MRI is not readily available or when rapid evaluation is required due to clinical instability (Expert Panel on Gastrointestinal Imaging, 2020). In intermittent or low-

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grade obstruction, MRI improves detection of subtle transition points, adhesions, and inflammatory causes. When the level or etiology remains indeterminate after CT, targeted techniques such as CT or MR enterography or enteroclysis are appropriate to further characterize partial obstruction, with modality selection guided by availability and the need to minimize radiation exposure (Hull et al., 2022; Expert Panel on Gastrointestinal Imaging, 2020).

Pediatric Abdomen Imaging Guidelines

References (PEDAB-28)

v1.0.2027

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Left Lower Quadrant Pain (PEDAB-29)

Guideline Page

Left Lower Quadrant Pain (PEDAB-29)..... 121
References (PEDAB-29).....122

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Left Lower Quadrant Pain (PEDAB-29)

ABP.LP.0029.A
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Criteria

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

- CT Abdomen and Pelvis with contrast (CPT® 74177) is considered medically necessary when any red flag signs or symptoms are present (as listed in **General Guidelines (PEDAB-1.0)**)
- In the absence of red flag signs or symptoms, advanced imaging is rarely helpful in the initial evaluation of these individuals.
  - Pelvic ultrasound (CPT® 76856) is considered medically necessary as the initial imaging study of choice for detecting gynecologic abnormalities that may cause left lower quadrant pain in pediatric individuals.
  - For male individuals or if pelvic ultrasound is inconclusive, advanced imaging may be considered medically necessary as directed by gastroenterological evaluation or consultation.

Evidence Discussion

Diverticulitis is rare in children, and most cases of left lower quadrant pain reflect functional, infectious, or gynecologic conditions rather than colonic inflammation. Pediatric literature consistently notes that diverticular disease is uncommon before adolescence and often associated with underlying anatomic or genetic predispositions rather than routine presentations of abdominal pain (Maqbool & Liacouras, 2024; Han et al., 2024). This low prevalence supports restricting CT imaging to cases with clinical red flag features, where contrast-enhanced CT provides accurate evaluation of diverticulitis, its severity, complications, and alternative diagnoses. In the absence of red flags, advanced imaging has limited diagnostic yield. Pelvic ultrasound is the preferred initial study when a gynecologic source is suspected, given its diagnostic utility and lack of radiation. For male individuals, or when ultrasound is inconclusive, further imaging may be appropriate only when symptoms persist or clinical evaluation, including gastroenterology consultation, indicates the need for additional characterization. This approach aligns imaging intensity with disease likelihood while minimizing unnecessary radiation exposure.

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Celiac Disease (Sprue) (PEDAB-30)

Guideline Page

Celiac Disease (Sprue) (PEDAB-30).....124
References (PEDAB-30).....125

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Celiac Disease (Sprue) (PEDAB-30)

ABP.CD.0030.A

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

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Transplant (PEDAB-31)

Guideline Page

Transplant (PEDAB-31)..... 127

Pediatric Abdomen Imaging Guidelines

Transplant (PEDAB-31)

ABP.TX.0031.A

v1.0.2027

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

Pediatric Abdomen Imaging Guidelines

Gaucher Disease (PEDAB-32)

Guideline Page

Gaucher Disease (PEDAB-32)..... 129

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Gaucher Disease (PEDAB-32)

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

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

Guideline Page

Vomiting Infant, Malrotation, and Hypertrophic Pyloric Stenosis (PEDAB-33)..... 131
References (PEDAB-33).....133

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

ABP.VI.0033.A
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Criteria

- Suspected malrotation is an indication for emergent imaging. If malrotation with mid-gut volvulus is suspected, Ultrasound Abdomen, limited (CPT® 76705) is considered medically necessary.
- Ultrasound Abdomen, limited (CPT® 76705) is considered medically necessary for infants with persistent projectile non-bilious vomiting.
  - If initial studies are not diagnostic, repeat studies are considered medically necessary (as frequently as daily) until the vomiting resolves or the diagnosis is made.

Background and Supporting Information

Vomiting in infants is generally classified as either bilious (implying obstruction distal to the Sphincter of Oddi) or non-bilious (Expert Panel on Pediatric Imaging et al., 2020; Bales & Liacouras, 2024).

Bilious vomiting may be a true emergency, as some of the conditions causing this could result in compromise of blood supply to the intestines, a potentially life-threatening situation (Bales & Liacouras, 2024; Yousef et al., 2025).

Hypertrophic Pyloric Stenosis is an idiopathic condition wherein the circular muscle controlling emptying of the stomach thickens causing a relative obstruction of the gastric outlet. The condition can occur at any age (including occasionally in adults), but the typical child is male, aged 2 to 6 weeks. Projectile non-bilious vomiting is the most common presenting complaint, but the description of projectile vomiting is subjective (Rich & Dolgin, 2021; Singh & Liacouras, 2024). The differential diagnosis for non-bilious vomiting includes common conditions such as viral gastroenteritis and gastro-esophageal reflux (Expert Panel on Pediatric Imaging et al., 2020; Singh & Liacouras, 2024).

Evidence Discussion

Imaging selection for infant vomiting is guided by clinical pattern of emesis and age-specific differential diagnoses (Expert Panel on Pediatric Imaging et al., 2020;

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Coley, 2019). In infants aged 2 to 8 weeks presenting with nonbilious projectile vomiting, ultrasound is the recommended initial imaging study of choice for suspected hypertrophic pyloric stenosis because it directly measures pyloric muscle thickness and channel length with high diagnostic accuracy (Expert Panel on Pediatric Imaging et al., 2020; Singh & Liacouras, 2024).

Systematic reviews and meta-analyses have demonstrated pooled sensitivities and specificities of 95% or greater when established diagnostic thresholds are applied, supporting ultrasound as a definitive first test, with physical examination findings adding limited incremental value when negative (van den Bunder et al., 2022; Rich & Dolgin, 2021). This performance reflects the clear anatomic changes in pyloric stenosis and supports reliance on ultrasound for confirmation.

Current pediatric and radiology practice references consistently prioritize ultrasound because it is readily available, does not expose infants to ionizing radiation, provides direct visualization of the pylorus, and demonstrates excellent reproducibility when performed by experienced operators (Expert Panel on Pediatric Imaging et al., 2020; Singh & Liacouras, 2024; Hwang, 2017).

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Pancreatitis (PEDAB-34)

Guideline Page

Acute Pancreatitis (PEDAB-34.1).....135
Chronic Pancreatitis (PEDAB-34.2).....136
References (PEDAB-34).....137

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Acute Pancreatitis (PEDAB-34.1)

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Criteria

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

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Chronic Pancreatitis (PEDAB-34.2)

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Criteria

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

Evidence Discussion

Imaging in pediatric pancreatitis is guided by clinical severity, the presence of concerning features, and the need to identify an underlying cause. Ultrasound remains the initial modality because it detects gallstones, biliary dilation, and pancreatic enlargement without radiation or contrast exposure, supporting identification of common etiologies such as biliary obstruction (Trout et al., 2021a). However, when red flag findings or clinical deterioration are present, cross-sectional imaging is required to assess complications and alternative diagnoses. MRI with MRCP is preferred in stable individuals because it provides high-resolution evaluation of pancreatic inflammation, ductal anatomy, and peripancreatic collections without ionizing radiation, and is particularly useful when the etiology is unclear or structural abnormalities are suspected (Trout et al., 2021a; Trout et al., 2021b). CT with contrast is appropriate when rapid assessment is needed or MRI is not available, given its reliability in detecting necrosis, hemorrhage, and infected collections. This approach supports the use of either MRI/MRCP or contrast-enhanced CT in higher-risk presentations, while reserving modality selection for clinical urgency, patient stability, and resource availability (Trout et al., 2021b).

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Supplemental Material

Guideline Page

Procedure Codes Associated with Abdomen Imaging..... 139

Pediatric Abdomen Imaging Guidelines

Procedure Codes Associated with Abdomen Imaging

ABP.GG.Procedure Codes.C
v1.0.2027

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.

MRI	**CPT®**
MRI Abdomen without contrast	74181
MRI Abdomen with contrast (rarely used)	74182
MRI Abdomen without and with contrast	74183
Unlisted MRI procedure (for radiation planning or surgical software)	76498
MRA	**CPT®**
MRA Abdomen	74185
CT	**CPT®**
CT Abdomen without contrast	74150
CT Abdomen with contrast	74160
CT Abdomen without and with contrast	74170
CT Abdomen and Pelvis without contrast	74176
CT Abdomen and Pelvis with contrast	74177
CT Abdomen and Pelvis without and with contrast	74178

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CT Guidance for Needle Placement (Biopsy, Aspiration, Injection, etc.)	77012
CT Guidance for and monitoring of Visceral Tissue Ablation	77013
CT Guidance for Placement of Radiation Therapy Fields	77014
Unlisted CT procedure (for radiation planning or surgical software)	76497
CTA	**CPT®**
CTA Abdomen	74175
CTA Abdomen and Pelvis	74174
Ultrasound	**CPT®**
Ultrasound, abdomen; complete	76700
Ultrasound, abdomen; limited	76705
Ultrasound, abdominal wall	76705
Ultrasound, retroperitoneal; complete	76770
Ultrasound, retroperitoneal; limited	76775
Ultrasound, transplanted kidney (with duplex Doppler)	76776
Duplex scan of arterial inflow and venous outflow of abdominal, pelvic, scrotal contents and/or retroperitoneal organs; complete study	93975
Duplex scan of arterial inflow and venous outflow of abdominal, pelvic, scrotal contents and/or retroperitoneal organs; limited study	93976
Duplex scan of aorta, inferior vena cava, iliac vasculature, or bypass grafts; complete	93978
Duplex scan of aorta, inferior vena cava, iliac vasculature, or bypass grafts; limited	93979

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