Cohere Medical Policy - Computed Tomography (CT), Abdomen/Pelvis

Clinical Policy for Medical Necessity Review

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Important Notices

Notices & Disclaimers:

GUIDELINES ARE SOLELY FOR COHERE'S USE IN PERFORMING MEDICAL NECESSITY REVIEWS AND ARE NOT INTENDED TO INFORM OR ALTER CLINICAL DECISION-MAKING OF END USERS.

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Other Notices:

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Policy Information:

Specialty Area: Diagnostic Imaging
Policy Name: Computed Tomography (CT), Abdomen/Pelvis
Type: [**X**] Adult (18+ yo) | [**X**] Pediatric (0-17 yo)

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Medical Necessity Criteria

Service: Title Computed Tomography (CT), Abdomen/Pelvis

Cohere Health takes an evidence-based approach to reviewing imaging and procedure requests, meaning that sufficient clinical information must be provided at the time of submission to determine medical necessity. Documentation must include a recent and detailed history, physical examination related to the onset or change in symptoms, relevant lab results, prior imaging, and details of previous treatments. Advanced imaging or procedures should be requested after a clinical evaluation by the treating provider, which may include a referral to a specialist.

- When a specific clinical indication is not explicitly addressed in the Cohere Health medical policy, medical necessity will be determined based on established clinical best practices, as supported by evidence-based literature, peer-reviewed sources, professional society guidelines, and state or national recommendations, unless otherwise directed by the health plan.
- Requests submitted without clinical documentation, or those that do not align with the provided clinical information—such as mismatched laterality, body part, or CPT code—may be denied for lack of medical necessity due to insufficient or inconsistent clinical information.
- Repeat diagnostic testing due to technical issues—such as patient motion, incomplete exams, or incorrect imaging sequences—may not be considered medically necessary, as it is the responsibility of the imaging center to deliver appropriate, high-quality studies as originally authorized. Similarly, repeat imaging requested at a different facility based solely on provider preference may not be approved for medical necessity.
- When there are multiple diagnostic or therapeutic procedures requested simultaneously or within the past three months, each will be reviewed independently. Clinical documentation must clearly justify all of the following:
    - The medical necessity of each individual request

    - Why prior imaging or procedures were inconclusive or why additional/follow-up studies are needed
    - How the results will impact patient management or treatment decisions
- Requests involving adjacent or contiguous body parts may be considered not medically necessary if the documentation demonstrates that the patient's primary symptoms can be adequately assessed with a single study or procedure.
- Cohere Health evaluates imaging exams based on medical necessity, regardless of contrast use. If an initial non-contrast study is completed and the radiologist later determines that contrast is needed to clarify a finding, the original authorization number may be used—provided the contrast-enhanced exam is performed at the same imaging center and within the original request's validity period, unless otherwise directed by the health plan.

Description

Computed tomography (CT) of the abdomen/pelvis is a cross-sectional imaging modality that visualizes the abdomen and pelvis. CT generates detailed images, especially of the soft tissue, bones, and blood vessels. Intravenous and oral contrast can be used to better characterize certain pathologies in greater detail.

Medical Necessity Criteria

Indications

Computed tomography (CT), abdomen/pelvis is considered appropriate if **ANY** of the following is **TRUE**[1]:

- Suspicion of peritonitis with peritoneal signs or symptoms (e.g., severe abdominal pain with rebound tenderness, rigidity, or guarding)[2]; **OR**
- Conditions related to the hepatobiliary system (liver, bile ducts, gallbladder, and associated structures) and **ALL** of the following:
  - Ultrasound is indeterminate or abnormal; **AND**
  - Further imaging is needed; **AND**
  - **ANY** of the following:
    - Indeterminate liver lesion and **ANY** of the following[3]:
      - The lesion is greater than 1 cm; **OR**
      - The lesion is less than 1 cm with history of extrahepatic malignancy or chronic liver disease; **OR**
    - Abnormal liver function tests (LFTs) and **ANY** of the following[4]:
      - Moderate or severe aminotransferase increase; **OR**
      - Hyperbilirubinemia as indicated by jaundice, dark urine, or pale stools; **OR**
      - Elevated alkaline phosphatase with or without elevated gamma-glutamyl transpeptidase (GGT); **OR**
    - Right upper quadrant pain, and **ANY** of the following[5]:
      - Suspected biliary disease with indeterminate or negative ultrasound; **OR**
      - Suspected acalculous cholecystitis when nuclear medicine gallbladder scan is indeterminate or cannot be performed; **OR**
- Conditions related to the pancreas, including **ANY** of the following:
  - **ALL** of the following:
    - Duct obstruction (e.g., calculi, stricture, or mass) is suspected based on prior imaging; **AND**
    - MRI is inconclusive or cannot be performed; **OR**
  - Follow-up of pancreas-related fluid collections (e.g., pseudocysts or walled-off necrosis) detected on prior imaging for **ANY** of the following reasons:
    - Evaluation of treatment response; **OR**
    - Worsening clinical condition; **OR**
    - Continual symptoms for greater than 4 weeks; **OR**

- Pancreatitis (acute or chronic) and **ANY** of the following[6]:
  - Diagnosis of acute pancreatitis is suspected with atypical signs and symptoms (equivocal amylase and lipase); **OR**
  - Concern for complications if greater than 48 to 72 hours have elapsed since the onset of symptoms; **OR**
  - Known pancreatic or peripancreatic fluid collection with continued symptoms (e.g., abdominal pain, early satiety, nausea, vomiting, or signs of infection) greater than 4 weeks since symptom onset; **OR**
  - Clinical symptoms of chronic pancreatitis (prior episodes of acute pancreatitis, characteristic abdominal pain, exocrine insufficiency) or genetic polymorphisms suggestive of chronic pancreatitis[7]; **OR**
- Indeterminate pancreatic cyst and **ALL** of the following:
  - The patient is asymptomatic; **AND**
  - The patient is a potential surgical candidate; **AND**
  - **ANY** of the following[8]:
    - The patient is under 65 years of age and requires **ANY** of the following:
      - The cyst is less than 1.5 cm and **ANY** of the following:
        - If the cyst is stable, **ANY** of the following:
          - Annual imaging for 5 years following diagnosis; **OR**
          - Imaging 7 years following diagnosis; **OR**
          - Imaging 9 years following diagnosis; **OR**
        - Annual imaging if the cyst demonstrates interval growth; **OR**
      - The cyst is greater than 1.5 cm but less than 1.9 cm, and **ALL** of the following:
        - Demonstrates interval growth; **AND**
        - **ANY** of the following:
          - Annual imaging for 5 years following diagnosis; **OR**
          - After completion of annual imaging (5 years following diagnosis), every other year for 4 years; **OR**
      - The cyst is greater than 2.0 cm but less than 2.5 cm, and **ALL** of the following:
        - Demonstrates interval growth; **AND**
        - **ANY** of the following:
          - Imaging every 6 months for 2 years following diagnosis; **OR**

            - After completion of biannual imaging for 2 years, annual imaging for 2 years; **OR**
            - After completion of annual imaging (4 years following diagnosis), every other year for 6 years; **OR**
- The patient is between 65 and 79 years of age, and **ANY** of the following:
    - Stable cyst with imaging every other year for 10 years; **OR**
    - The cyst remains less than 1.5 cm, and **ALL** of the following:
        - Demonstrates interval growth; **AND**
        - Annual imaging for 10 years; **OR**
    - The cyst is larger than 1.5 cm but less than 1.9 cm, and **ALL** of the following:
        - Demonstrates interval growth; **AND**
        - **ANY** of the following:
            - Annual imaging for 5 years following diagnosis; **OR**
            - After completion of annual imaging, every other year for 4 years; **OR**
    - The cyst is greater than 2.0 cm but less than 2.5 cm, and **ALL** of the following:
        - Demonstrates interval growth; **AND**
        - **ANY** of the following:
            - Imaging every 6 months for 2 years; **OR**
            - After completion of biannual imaging, annual imaging for 2 years; **OR**
            - After completion of annual imaging (4 years following diagnosis), every other year for 6 years; **OR**
- The patient is greater than or equal to 80 years of age, and **ANY** of the following:
    - The cyst is 2.5 cm or smaller at **ANY** of the following intervals:
        - Every other year for 2 years; **OR**
        - After completion of biannual imaging, **ANY** of the following:
            - If the cyst is stable, biannual imaging for 2 more years; **OR**
            - The cyst demonstrates interval growth but is still 2.5 cm or smaller, then **ANY** of the following:
                - Annual imaging until size stabilizes; **OR**
                - Annual imaging until the patient is no longer a surgical candidate; **OR**

        - The cyst is greater than 2.5 cm, and **ALL** of the following:
            - The cyst demonstrates low-risk features (e.g., no mural nodule, no peripheral calcifications, no wall thickening, normal caliber pancreatic duct); **AND**
            - Imaging every other year for 4 years until size stabilizes; **OR**
    - The patient is under 80 years of age, and **ALL** of the following:
        - The cyst is greater than 2.5 cm; **AND**
        - The cyst demonstrates low-risk features (e.g., no mural nodule, no peripheral calcifications, no wall thickening, normal caliber pancreatic duct); **AND**
        - **ANY** of the following:
            - Imaging every 6 months for 2 years; **OR**
            - If stable at completion of biannual imaging, then every year for 2 years; **AND**
            - After completion of annual imaging, then every other year for 3 years; **OR**
- Conditions related to the spleen, including **ANY** of the following[9,10]:
    - Splenic or perisplenic abnormalities detected on prior imaging that requires further workup or follow-up; **OR**
    - Splenomegaly detected clinically, and **ALL** of the following:
        - Ultrasound is inconclusive; **AND**
        - **ANY** of the following:
            - Additional anatomic detail is required; **OR**
            - Suspicion for malignancy; **OR**
- Conditions related to the kidneys, including **ALL** of the following:
    - An ultrasound of the kidneys has been performed for the present condition; **AND**
    - Further workup is required; **AND**
    - **ANY** of the following:
        - Renal cysts, and **ALL** of the following:
            - Classification of Bosniak IIF or above; **AND**
            - **ANY** of the following intervals[11]:
                - Imaging 6 months after discovery, **OR**
                - Imaging 1 year after discovery; **OR**
                - Imaging annually for 5 years after discovery; **OR**
        - Renal mass, and **ALL** of the following[11]:
            - Solid, indeterminate mass; **AND**
            - Mass is less than 1 cm; **AND**

    - **ANY** of the following:
        - Imaging 3-6 months after discovery; **OR**
        - Imaging 1 year after discovery; **OR**
        - Imaging annually after discovery until greater than 1 cm; **OR**
- Annual follow-up of a solid indeterminate renal mass greater than 1 cm; **OR**
- Renal angiomyolipoma evaluation at **ANY** of the following intervals[11]:
    - Every 5 years when 2 to 3 cm; **OR**
    - Every 2 years when 3 to 4 cm; **OR**
    - Up to annually when greater than 4 cm; **OR**
- Characterization of other indeterminate lesions detected with other imaging modalities; **OR**
- Known polycystic kidney disease (PKD) with concerning signs/symptoms (e.g., pain, concern for rupture, infection, hemorrhage)[12]; **OR**
- Anatomic abnormalities, congenital or acquired (e.g., horseshoe kidney, ectopic insertion of the ureter, retroperitoneal fibrosis); **OR**
- The patient is pregnant with concern for pyelonephritis and **ANY** of the following:
    - Ultrasound or MRI is equivocal; **OR**
    - Ultrasound or MRI cannot be performed; **OR**
- Infectious/inflammatory disease (e.g., pyelonephritis), and **ANY** of the following[13,14]:
    - High risk for complicated pyelonephritis, (e.g., history of renal stones or renal obstruction, diabetes, immunocompromised, advanced age, vesicoureteral reflux,); **OR**
    - Concern for complications (e.g., abscess, obstruction, or lack of response to treatment); **OR**
    - Recurrent pyelonephritis; **OR**
- Before a planned procedure or intervention; **OR**
- Further evaluation of unexplained hydronephrosis when detected on ultrasound; **OR**
- Renal transplant complication[15]; **OR**
- Gross hematuria[16]; **OR**
- Microscopic hematuria (3 or more RBC/high power field)[11] with risk factors (e.g., male, smoker, age greater than 35, occupational chemical exposure, history of pelvic irradiation, chronic urinary tract infection) and **ALL** of the following:

        - No recent vigorous exercise; **AND**
        - No acute cystitis; **AND**
        - No current or recent menstruation **AND**
        - No known renal parenchymal disease; **AND**
        - The patient is not pregnant; **OR**
- Prostatitis, and **ALL** of the following[17]:
    - Transrectal ultrasound is non-diagnostic/equivocal; **AND**
    - **ANY** of the following:
        - The patient remains febrile for more than 36 hours; **OR**
        - The patient's symptoms do not improve on antibiotics; **OR**
- Prostate cancer, for **ANY** of the following:
    - Initial staging, and **ALL** of the following:
        - Cancer is at least unfavorable intermediate-risk; **AND**
        - MRI or PSMA-PET has not been performed; **AND**
        - **ANY** of the following is **TRUE**[18]:
            - **AT LEAST TWO** of the following:
                - cT2b–cT2c; **OR**
                - Grade Group 2 or above; **OR**
                - Prostate-specific antigen (PSA) 10–20 ng/m; **OR**
            - **ANY** of the following:
                - Grade Group 3 or above (e.g., 4+3 = 7. Note that 3+4=7 is considered Grade Group 2); **OR**
                - At least 50% of biopsy cores positive for cancer; **OR**
                - PSA greater than 20 ng/mL; **OR**
    - Restaging, and **ALL** of the following[18]:
        - PSMA-PET or MRI cannot be performed; **AND**
        - Positive DRE or PSA recurrence; **AND**
        - **ANY** of the following is **TRUE**:
            - Imaging for symptoms or increasing PSA; **OR**
            - Failure for PSA to become undetectable after complete prostatectomy; **OR**
            - Radiographic evidence of metastases; **OR**
            - Rise of PSA by **ANY** of the following:
                - Greater than or equal to 2 ng/mL above the lowest post-treatment PSA; **OR**
                - Less than 2 ng/mL above the lowest post-treatment PSA in patients who are young and healthy; **OR**
            - Persistently rising PSA levels on two tests; **OR**

        - Poorly differentiated carcinoma (may not produce PSA); **OR**
- Conditions related to the genitourinary system, including **ANY** of the following:
    - Bladder conditions, including **ANY** of the following[19]:
        - Further evaluation of known bladder pathology seen on cystoscopy; **OR**
        - Concern for bladder or urothelial (kidney or ureter) neoplasm based on prior imaging or clinical abnormalities (e.g., persistent gross hematuria)[16]; **OR**
        - Concern for stricture based on prior imaging or clinical abnormalities (e.g., persistent gross hematuria)[16]; **OR**
    - Acute onset of flank pain with suspicion of renal stones and **ANY** of the following[20]:
        - The patient is not pregnant; **OR**
        - Pregnant patient with indeterminate ultrasound; **OR**
    - Follow-up of known renal stones with **ANY** of the following[21,22]:
        - **ALL** of the following:
            - The patient is currently undergoing medical therapy **AND**
            - Stones are radiolucent (i.e., not visible on x-ray); **AND**
            - **ANY** of the following:
                - The patient is symptomatic; **OR**
                - The patient is asymptomatic, but stone has not passed; **OR**
        - **ALL** of the following:
            - Stones are radiolucent; **AND**
            - The patient has been treated with lithotripsy; **AND**
            - **ANY** of the following:
                - Ultrasound shows hydronephrosis; **OR**
                - The patient has symptoms (flank pain, hematuria); **OR**
        - **ALL** of the following:
            - The patient has been treated with ureteroscopic extraction; **AND**
            - **ANY** of the following:
                - The patient has symptoms (flank pain, hematuria); **OR**
                - Ultrasound shows hydronephrosis; **OR**
                - Predisposing conditions (e.g., medullary nephrocalcinosis, hypercalcemia, or hypercalciuria with non-diagnostic ultrasound); **OR**
    - For preoperative or pre-procedural planning if the patient has staghorn calculi; **OR**

- Persistent postpartum hemorrhage, following caesarian or vaginal delivery, and **ALL** of the following[23]:
  - Ultrasound is inconclusive or contraindicated; **AND**
  - Documentation of failed conservative management (e.g., uterine tamponade with packing or balloon catheter and massage, uterotonic medications, or correction of coagulopathy); **OR**
- Evaluation of other reproductive organs, including the uterus/ovaries/testicles/fallopian tube/cervix, when ultrasound is indeterminate; **OR**
- Ovarian cysts or indeterminate masses, when ultrasound and MRI are inconclusive, highly suspicious, or cannot be performed[24]; **OR**

- Conditions related to the vascular system, known or suspected, including **ANY** of the following:
  - Unrepaired abdominal aortic aneurysm (AAA) when ultrasound is inconclusive, cannot be performed, or requires further workup and follow-up evaluation is based on aneurysm size when **ANY** of the following is **TRUE**[25]:
    - 3-3.9 cm, every 3 years; **OR**
    - 4-4.9 cm for male patients or 4-4.4 cm in female patients, annually; **OR**
    - Greater than 5 cm in male patients or greater than 4.5 cm in female patients, every 6 months; **OR**
  - Abdominal aortic aneurysm (AAA) screening, one-time, and **ALL** of the following:
    - Ultrasound is non-diagnostic; **AND**
    - **ANY** of the following:
      - Between 65 to 75 years of age, and **ANY** of the following:
        - A history of tobacco use; **OR**
        - Family history of AAA ; **OR**
      - Over 75 years of age but in good health, and **ANY** of the following:
        - A history of tobacco use; **OR**
        - Family history of AAA ; **OR**
  - Known or suspected syndromes with increased risk of vascular anomalies, including **ALL** of the following[26]:
    - There is concern for patient contrast allergy or renal toxicity; **AND**
    - **ANY** of the following:

        - As a one-time screening for syndromes with a vascular component (e.g., fibromuscular dysplasia, neurofibromatosis, Williams syndrome, tuberous sclerosis); **OR**
        - Vascular Ehlers-Danlos syndrome (vEDS) (biannually; surveillance as indicated depending on abnormalities found); **OR**
        - Marfan syndrome (initial MRA at time of diagnosis, then every 3 years depending on abnormalities found); **OR**
        - Loeys-Dietz syndrome (every 2 years for screening; surveillance as indicated depending on abnormalities found); **OR**
        - Other syndromes not otherwise specified, follow-up as clinical documentation supports; **OR**
    - Surveillance imaging following endovascular aortic repair (EVAR), and **ALL** of the following[26]:
        - CTA, MRA, and ultrasound are inconclusive or cannot be performed; **AND**
        - **ANY** of the following:
            - At one month post-procedure; **OR**
            - If a Type II endoleak is detected on first post-procedure screening, then repeat imaging at 6 months; **OR**
            - If a Type II endoleak is associated with a stable or shrinking aneurysm sac, then repeat imaging every 6 months for 2 years; **OR**
            - Annual imaging is recommended if no endoleak or aneurysm sac enlargement; **OR**
    - Following open aortic aneurysm surgical repair (OSR), cross-sectional CT (or MR) imaging surveillance should be performed once every 5 years[26]; **OR**
    - Concern for aneurysm as evidenced by **ANY** of the following[26]:
        - Pulsatile abdominal mass; **OR**
        - Other high-risk clinical sign or symptom concerning for aneurysm (e.g., severe abdominal pain, hypotension, suspicion on prior imaging); **OR**
    - Aortoenteric fistula[26]; **OR**
    - Retroperitoneal bleed, suspected[27]; **OR**
    - Systemic (e.g., IVC) or portal venous thrombosis; **OR**
    - Arteriovenous anomalies (e.g., shunt, fistula, malformation); **OR**
- Gastrointestinal conditions, including **ANY** of the following:
    - Small bowel conditions, including **ANY** of the following:

- Refractory celiac disease (persistent symptoms despite maintaining a gluten-free diet for 12 months or more)[28]; **OR**
- Suspected or known Crohn's disease when **ANY** of the following is **TRUE**[29]:
  - For initial diagnosis (CT enterography preferred) with persistent symptoms (e.g., moderate to severe abdominal pain, diarrhea, fatigue, or weight loss) and **ANY** of the following:
    - Positive family history of inflammatory bowel disease; **OR**
    - Endoscopic/colonoscopic findings suggestive of inflammatory bowel disease; **OR**
    - Elevated inflammatory markers (ESR, CRP, fecal lactoferrin, fecal calprotectin); **OR**
    - Strong clinical suspicion despite normal endoscopy/colonoscopy and absence of other above criteria; **OR**
  - Follow-up for **ANY** of the following:
    - Acute exacerbation; **OR**
    - Concern for potential complications including abscess, perforation, fistula, or obstruction; **OR**
    - Concern for progression (e.g., increased calprotectin); **OR**
    - Monitoring response to therapy; **OR**
  - Concern for small bowel obstruction with supporting clinical symptoms (e.g., abdominal pain or distension with absent or high-pitched bowel sounds, nausea/vomiting)[30]; **OR**

- Large bowel conditions, including **ANY** of the following:
  - Right or left lower quadrant pain in an adult patient (e.g., diverticulitis, appendicitis, epiploic appendagitis) with no suspected hernia[31,32]; **OR**
  - Acute appendicitis in a pediatric (less than or equal to 17 years of age) patient, and **ANY** of the following[33x]:
    - Ultrasound is inconclusive, or appendix is not seen; **OR**
    - MRI is inconclusive or cannot be performed; **OR**
    - The patient is high clinical risk (e.g., fever, nausea or vomiting, anorexia, leukocytosis, neutrophilia); **OR**
    - Peritoneal signs/symptoms present (e.g., rebound tenderness or severe pain); **OR**
    - Clinical suspicion of complications (e.g., abscess, bowel obstruction); **OR**

- Acute appendicitis in a pregnant patient, and **ALL** of the following[32]:
  - Symptoms of acute appendicitis (e.g., fever, leukocytosis, right lower quadrant pain); **AND**
  - **ANY** of the following:
    - Ultrasound is inconclusive, or appendix is not seen; **OR**
    - MRI is inconclusive or cannot be performed; **OR**
- Initial or follow-up evaluation of ulcerative colitis or other inflammatory pathology limited to the colon, and **ANY** of the following[34]:
  - Colonoscopy is inconclusive or cannot be performed; **OR**
  - Newly diagnosed patient where the distinction between Crohn's disease and ulcerative colitis is in question (e.g., abdominal symptoms not explained by endoscopically active disease, symptoms suspicious for CD [predominantly watery diarrhea, weight loss, or abdominal pain], or where proximal extent of involvement cannot be evaluated because of severity of inflammation); **OR**
  - There is a concern for a complication, such as perforation, abscess, or extraluminal complication, based on clinical exam findings (e.g., abdominal pain, peritoneal signs, elevated white blood cell count); **OR**
- Concern for colon obstruction with supporting clinical symptoms (e.g., severe constipation, lack of flatus, or concerning history such as prior abdominal surgery); **OR**

○ Acute presentation of mesenteric ischemia or ischemic enteritis/colitis, and **ANY** of the following[35]:
- Suspicion for ischemic enteritis/colitis or mesenteric/bowel infarct by another imaging study; **OR**
- High clinical suspicion for mesenteric ischemia and severe abdominal pain or abdominal pain that is out of proportion to the physical exam; **OR**
- **ALL** of the following:
  - **ANY** of the following:
    - Known risk factors (e.g., hypercoagulable states, portal hypertension, recent surgery); **OR**
    - Known vascular disease (e.g., known coronary artery disease [CAD] or peripheral artery disease [PAD]); **AND**

        - Severe abdominal pain/pain that is out of proportion to the physical exam; **OR**
    - Suspicion for chronic mesenteric ischemia, and **ALL** of the following:
        - Known risk factors (e.g., age 60 and above, risk factors for atherosclerosis [i.e., hypertension, hyperlipidemia, and smoking history])[36]; **AND**
        - **ANY** of the following:
            - Post-prandial abdominal pain causing weight loss or fear of food; **OR**
            - Nausea and vomiting; **OR**
            - Diarrhea; **OR**
            - Hematachezia; **OR**
    - Symptoms or signs indicating non-localized recurrent lower GI bleeding, and **ALL** of the following[37]:
        - The patient is hemodynamically stable; **AND**
        - The patient has undergone negative upper and lower endoscopy procedures; **OR**
    - Initial workup of bowel volvulus when suspected on **ANY** of the following:
        - Clinical symptoms; **OR**
        - Prior imaging; **OR**
        - Planned perioperative imaging; **OR**
- Gastric conditions, and **ANY** of the following[38]:
    - Endoscopy is inconclusive or cannot be performed; **OR**
    - Complication is suspected (e.g., perforated gastric ulcer, gastric outlet obstruction, volvulus); **OR**
- For evaluation and management of known hiatal hernia, and **ALL** of the following:
    - When upper GI study or endoscopy is equivocal, non-diagnostic, or cannot be performed; **AND**
    - Complex anatomy or complications are suspected; **OR**
- Suspicion for catecholamine-producing adrenal tumor, such as pheochromocytoma or paraganglioma, and **ANY** of the following:
    - Elevation of 24-hour urine fractionated metanephrines; **OR**
    - Elevation of plasma-free metanephrines following a 30-minute supine test; **OR**
- Indeterminate adrenal mass, and **ALL** of the following[24,39]:
    - Asymptomatic; **AND**
    - At least 1.0 cm; **AND**

- Discovered incidentally on prior imaging; **AND**
- Mass does not contain fat (e.g., is not a myelolipoma) or mass measures more than 10 HU on CT, if performed; **AND**
- Mass is not primarily calcification; **AND**
- **ANY** of the following:
  - **ALL** of the following:
    - Patient has a history of cancer; **AND**
    - The lesion is between 1 and 4 cm; **OR**
  - If 1 to 4 cm with no prior imaging (other than imaging with incidental discovery, if non-diagnostic), or with a history of cancer, and **ANY** of the following:
    - **ALL** of the following:
      - The mass is 1 to 2 cm; **AND**
      - The request is for a 12-month follow-up since discovery; **OR**
    - The mass is 2 to 4 cm; **OR**
  - If 1 to 4 cm with prior imaging available, and **ANY** of the following:
    - Mass is new or enlarging with no history of cancer; **OR**
    - Follow-up of a stable mass for up to 1 year; **OR**

- Screening, follow-up, and surveillance of malignancies, and **ANY** of the following:
  - Increased risk of hepatocellular cancer due to **ANY** of the following:
    - Primary sclerosing cholangitis after age 20; **OR**
    - **ALL** of the following:
      - **ANY** of the following:
        - Cirrhosis; **OR**
        - Chronic viral hepatitis; **AND**
      - Ultrasound is inconclusive/limited/requires further work-up; **AND**
      - Triple phase CT liver protocol is requested; **OR**
  - Rising alpha-fetoprotein (AFP) in a patient who is high-risk for hepatocellular carcinoma (HCC), as suggested by **ANY** of the following[40]:
    - Cirrhosis; **OR**
    - Chronic hepatitis B (CHB) viral infection; **OR**
    - Hepatitis C; **OR**
  - Elevated CA 19-9 or CEA levels and cancer is suspected[21]; **OR**
  - Painless jaundice; **OR**
  - Other biomarker or paraneoplastic syndrome suggestive of underlying malignancy; **OR**

- Screening of a patient with an increased risk of cancer due to **ANY** of the following:
  - Tuberous sclerosis surveillance every 1-3 years, and **ALL** of the following:
    - The patient has known angiomyolipoma or renal cystic disease[41]; **AND**
    - MRI is inconclusive or cannot be performed; **OR**
  - Von Hippel Lindau every other year when MRI is inconclusive or cannot be performed[42]; **OR**
  - Peutz-Jeghers syndrome starting at 18 years of age when MRI is inconclusive or cannot be performed; **OR**
  - Known mutation that increases susceptibility to pancreatic cancer, and **ALL** of the following[43]:
    - Endoscopic ultrasound (EUS) and MRI of the pancreas are inconclusive or cannot be performed[44]; **AND**
    - **ANY** of the following:
      - Autosomal dominant hereditary pancreatitis, starting at 40 years of age, or 20 years after developing pancreatitis, whichever is earlier[45]; **OR**
      - The patient has two or more first-degree or second-degree relatives with pancreatic cancer from the same side of the family, starting at age 50 or 10 years earlier than the youngest family member with pancreatic cancer[44]; **OR**
      - **ALL** of the following:
        - **ANY** of the following:
          - Pathogenic mutation (including but not limited to BRCA1, BRCA2, ATM, CDKN2A, MLH1, MSH2, MSH6, PALB2, PMS2, STK11, and TP53)[46]; **OR**
          - Familial pancreatic cancer (FPC); **OR**
          - Lynch syndrome; **AND**
        - **ANY** of the following intervals[47]:
          - CT starting at 50 years of age; **OR**
          - Starting at 10 years earlier than the youngest family member with pancreatic cancer; **OR**
      - Familial atypical multiple mole melanoma syndrome (FAMMM), and **ANY** of the following[47]:
        - CT starting at 40 years of age; **OR**

        - Starting at 10 years earlier than the youngest family member with pancreatic cancer; **OR**
- Neoplastic conditions (including masses or mass-like conditions) and **ANY** of the following:
    - Initial staging for known neoplasms (see specific non-indications below); **OR**
    - Surveillance as per nationally accepted guidelines such as National Comprehensive Cancer Network (NCCN); **OR**
- Unintentional weight loss exceeding 5% of the patient's body weight within a 6-12-month interval and **ANY** of the following is **TRUE**[48,49]:
    - Persistent weight loss after a period of observation (3 months) with a negative comprehensive clinical evaluation and **ALL** of the following:
        - Documentation of complete history and physical examination; **AND**
        - The patient is up-to-date on age-appropriate cancer screening; **AND**
        - Chest radiograph has been performed; **AND**
        - Initial laboratory evaluation has been performed; **OR**
    - Positive findings of malignancy on history, physical exam, imaging, or laboratory evaluation; **OR**
- Non-localized, acute abdominal pain, and **ANY** of the following[2,50]:
    - Fever, with or without recent surgery; **OR**
    - Neutropenic or immunocompromised; **OR**
    - The patient is greater than or equal to 75 years of age; **OR**
    - Abnormal laboratory evaluation (e.g., UA, WBC, LFTs, amylase, lipase, urine pregnancy, etc.); **OR**
- Acute pelvic pain, and **ALL** of the following[51,52]:
    - Ultrasound is non-diagnostic; **AND**
    - **ANY** of the following:
        - The patient is pregnant (positive β-HCG), and **ANY** of the following:
            - MRI is indeterminate or inconclusive; **OR**
            - MRI cannot be performed; **OR**
        - The patient is not pregnant (negative β-HCG) and a gynecologic cause of symptoms is suspected; **OR**
        - The patient is not pregnant (male, post-menopausal, or negative β-HCG) and a non-gynecologic cause of symptoms is suspected; **OR**
- Preoperative or postoperative evaluation for **ANY** of the following:
    - Surgical planning when surgery is already planned; **OR**

    - Postoperative evaluation if complications are suspected (abscess, bleeding, anastomotic leak); **OR**
    - Post-treatment complications when surgery was recently performed; **OR**
    - Prior to percutaneous gastrostomy (PEG), when there are any of the following:
        - Abdominal wall defects; **OR**
        - Prior major abdominal surgery; **OR**
        - Known situs inversus; **OR**
        - Known paraesophageal hernia; **OR**
        - There is a need to determine a safe window for percutaneous access when this cannot be determined by fluoroscopy; **OR**
- Penetrating trauma or major blunt trauma[51]; **OR**
- For evaluation of **ANY** of the following uncategorized/miscellaneous symptoms when applicable:
    - Palpable mass in the abdomen or pelvis with an ultrasound that is non-diagnostic or requires further workup; **OR**
    - Follow-up for retroperitoneal fibrosis, suspected or known; **OR**
    - Presence of an isolated right-sided varicocele with additional signs or symptoms of malignancy[53]; **OR**
    - Diffuse edema in the lower extremity with ultrasound Doppler for deep vein thrombosis (DVT) that is non-diagnostic for cause; **OR**
    - Suspected inguinal or femoral hernia, and **ALL** of the following:
        - **ANY** of the following:
            - Groin swelling/bulge of uncertain origin; **OR**
            - Symptoms of bowel obstruction; **OR**
            - Groin pain and suspicion for hernia: **AND**
        - Musculoskeletal etiology is not suspected (i.e., "sports hernia" or athletic pubalgia [chronic groin pain in an athlete], representing unilateral groin pain in the absence of demonstrable hernia); **AND**
        - **ANY** of the following:
            - Ultrasound is inconclusive; **OR**
            - There is a suspected complication (e.g., strangulation, bowel obstruction); **OR**
            - Required for surgical planning and surgery is planned; **OR**
    - For evaluation and management of suspected abdominal wall hernia (including ventral, umbilical, incisional, or spigelian hernia) and **ANY** of the following:

        - Ultrasound is equivocal or non-diagnostic; **OR**
        - There is a suspected complication (e.g., strangulation, bowel obstruction); **OR**
        - Required for surgical planning and surgery is planned; **OR**;
    - For evaluation and management of suspected parastomal, diaphragmatic (including Bochdalek or Morgani hernia), deep pelvic (including obturator, sciatic or perineal hernia), or internal hernia (e.g., herniation of organs, most commonly bowel, into defects in the mesentery); **OR**
    - Enteric fistulas[54]; **OR**
    - Lymphadenopathy when **ANY** of the following is **TRUE**[55,56]:
        - When lymphoproliferative disorder is suspected based on prior imaging; **OR**
        - When enlarged lymph nodes are palpable, and **ANY** of the following:
            - The patient has suspicious symptoms (e.g., night sweats, fever, weight loss); **OR**
            - Nodes are in an unusual location (e.g., supraclavicular, popliteal, iliac); **OR**
        - Follow-up of known abdominal lymphadenopathy at least 3 months after diagnosis, and **ANY** of the following suspicious findings:
            - 1 cm or larger in short axis; **OR**
            - Round indistinct hilum; **OR**
            - 3 or more lymph nodes in a single region or cluster; **OR**
            - 2 or more lymph nodes in 2 or more regions; **OR**
        - Fever of unknown origin greater than 101°F for at least 3 weeks where laboratory and clinical workup has been performed and does not reveal a diagnosis[57,58]; **OR**
- Repeat imaging (defined as a repeat request following recent imaging of the same anatomic region with the same or similar modality) will be considered reasonable and necessary if **ALL** of the following are **TRUE**:
    - There are no established guidelines; **AND**
    - **ANY** of the following:
        - There are new or worsening symptoms not addressed in the guidelines, such that repeat imaging would influence treatment; **OR**
        - There is need for a one-time clarifying follow-up of a prior indeterminate finding; **OR**
        - In the absence of change in symptoms, there is an established need for monitoring which would influence management.

Non-Indications

Computed tomography (CT), abdomen/pelvis is **NOT** considered appropriate if **ANY** of the following is **TRUE**:

- The patient has undergone advanced imaging of the same body part within 3 months without undergoing treatment or developing new or worsening symptoms[59]; **OR**
- Initial staging of **ANY** of the following known neoplasms:
  - Low or favorable intermediate risk prostate cancer[18]; **OR**
  - Vulvar cancer with tumor less than 4 cm when there is no clinical suspicion for pelvic or distal metastatic disease[60]; **OR**
  - Stage I or IIa breast cancer[61]; **OR**
- Abdominal lymphadenopathy if there is prior imaging demonstrating that the node(s) have been stable for more than one year.[55,56]

*NOTE: The referring professional and radiologist should discuss the risks and benefits of contrast media administration, including possible prophylaxis, in patients with chronic or worsening kidney disease or severe renal failure.
**NOTE: CT in pregnant patients should be requested at the discretion of the ordering provider and obstetric care provider.
***NOTE: CT in patients with claustrophobia should be requested at the discretion of the ordering provider.

Disclaimer on Radiation Exposure in Pediatric Populations

Due to the heightened sensitivity of pediatric patients to ionizing radiation, minimizing exposure is paramount. At Cohere, we are dedicated to ensuring that every patient, including the pediatric population, has access to appropriate imaging following accepted guidelines. Radiation risk is dependent mainly on the patient's age at exposure, the organs exposed, and the patient's sex, though there are other variables. The following technical guidelines are provided to ensure safe and effective imaging practices:

Radiation Dose Optimization: Adhere to the lowest effective dose principle for pediatric imaging. Ensure that imaging protocols are specifically tailored for pediatric patients to limit radiation exposure.[62,63]

Alternative Modalities: Prioritize non-ionizing imaging options such as ultrasound or MRI when clinically feasible, as they are less likely to expose the patient to ionizing radiation. For instance, MRI or ultrasound should be considered if they are more likely to provide an accurate diagnosis than CT, fluoroscopy, or radiography.[62,63]

Cumulative Dose Monitoring: Implement systems to track cumulative radiation exposure in pediatric patients, particularly for those requiring multiple imaging studies. Regularly reassess the necessity of repeat imaging based on clinical evaluation.[62,63]

CT Imaging Considerations: When CT is deemed the best method for achieving a correct diagnosis, use the lowest possible radiation dose that still yields reliable diagnostic images.[62,63]

Cohere Imaging Gently Guideline
The purpose of this guideline is to act as a potential override when clinically indicated to adhere to Imaging Gently and Imaging Wisely guidelines and As Low As Reasonably Possible (ALARA) principles.

Tables

Bosniak Classification[64,65]		
Stage	**Malignancy Risk (%)**	**Features**
I	0	Hairline-thin wall; water attenuation; no septa, calcifications, or solid components; non-enhancing.
II	0	1. Few thin septa with or without perceived (not measurable) enhancement; fine calcification or a short segment of slightly thickened calcification in the wall or septa. 2. Homogeneously high-attenuating masses less than or equal to 3 cm that are sharply marginated and do not enhance.
IIF	5	1. Minimally thickened or more than a few thin septa with or without perceived (not measurable) enhancement that may have thick or nodular calcification. 2. Intrarenal non-enhancing hyperattenuating renal masses greater than 3 cm.
III	50	Thickened (less than 3 mm) wall or septa with enhancement.
IV	90	Soft tissue components (e.g., nodules) with measurable enhancement.

Level of Care Criteria

Inpatient or Outpatient

Procedure Codes (CPT/HCPCS)

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

Medical Evidence

Shah et al. (2022) performed a retrospective review of patients who had at least one CT scan of the abdomen (± pelvis) or MRI of the abdomen (± pelvis) at least 30 days post-diagnosis of Crohn's disease (CD) or ulcerative colitis (UC). The review identified factors associated with patients undergoing more than 5 CT scans of the abdomen between 2010 and 2019 and included 176,110 patients with CD and 143,460 patients with UC. From 2010 to 2019, the prevalence of individuals undergoing at least one annual CT scan of the abdomen increased with a mean annual percentage change of +3.6% for CD and +4.9% for UC. A 3.8% increase was found in the proportion of CD patients receiving greater than or equal to 5 CT scans of the abdomen annually compared to a 2.4% increase among UC patients over the ten years. The authors conclude that the prevalence of CT scans in IBD patients has escalated. Future research is needed regarding the determinants influencing the utilization of CT and MRI scans.[66]

Oldroyd et al. (2021) conducted a meta-analysis that focused on using CT to identify underlying asymptomatic cancers. CT scans of thorax, abdomen, or pelvis organs proved to be the most effective in diagnosing cancer cases, accounting for most detections (5 out of 18, 28%). Due to widespread availability and relatively low cost, CT scanning is a potentially valuable approach for cancer screening.[67]

Baron et al. (2018) performed a systematic review and meta-analysis on the accuracy of CT in the diagnosis of intra-abdominal injuries in patients presenting to the emergency department (ED) with anterior abdominal stab wounds. The study aimed to assess the precision of abdominal and pelvic computed tomography (CTAP) in diagnosing intra-abdominal injuries that necessitate therapeutic laparotomy (THER-LAP) in ED patients with acute abdominal or abdominal and pelvic blunt trauma. A total of 575 patients were included. For stable patients with suspected abdominal aortic syndromes, relying solely on a negative CT scan without a period of observation is insufficient to rule out significant intra-abdominal injuries.[68]

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Policy Revision History/Information

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Version 2	08/20/2024	Annual review and policy restructure.
Version 3	10/30/2024	Edited repeat imaging criteria language.
Version 4	08/28/2025	Annual review. Aligned indications and references with the most recent guidelines from ACR and NCCN (wording changes and restructuring). Expanded indications for pancreatic cysts, pancreatitis, abnormal liver function tests, internal hernias, renal masses and diseases, Crohn's disease, and mesenteric ischemia. Further specified the existing indications of prostatitis and prostate cancer. Removed indication for undescended testicle. Added new indications for renal stones, acute flank pain, appendicitis in pediatric patients and pregnant patients, postpartum hemorrhage, hiatal hernia, adrenal tumor, and prolonged unexplained weight loss. Included risk factors in one-time AAA screening section (i.e., advanced age, tobacco use, family history). Further specification for post-EVAR/post-OSR aortic surveillance indications. Added non-indication for initial screening of certain malignancies. Removed relative contraindication (contrast allergy).