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

Clinical Policy for Medical Necessity Review

Version: 2
Cohere Health UMC Approval Date: October 16, 2025
Last Annual Review: October 16, 2025
Revision: Not Applicable
Next Annual Review: October 16, 2026

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.

Cohere Health, Inc. ("**Cohere**") has published these clinical guidelines to determine the medical necessity of services (the "**Guidelines**") for informational purposes only, and solely for use by Cohere's authorized "**End Users**". These Guidelines (and any attachments or linked third-party content) are not intended to be a substitute for medical advice, diagnosis, or treatment directed by an appropriately licensed healthcare professional. These Guidelines are not in any way intended to support clinical decision-making of any kind; their sole purpose and intended use is to summarize certain criteria Cohere may use when reviewing the medical necessity of any service requests submitted to Cohere by End Users. Always seek the advice of a qualified healthcare professional regarding any medical questions, treatment decisions, or other clinical guidance. The Guidelines, including any attachments or linked content, are subject to change at any time without notice. This policy may be superseded by existing and applicable Centers for Medicare & Medicaid Services (CMS) statutes.

Other Notices:

Policy Information:

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

Table of Contents

Important Notices **2**
Medical Necessity Criteria **4**
Service: Computed Tomography (CT), Abdomen/Pelvis **4**
Related CMS Documents 4
Description 4
Medical Necessity Criteria 4
Indications 4
Non-Indications 6
Definitions 7
Disclaimer on Radiation Exposure in Pediatric Populations 8
Level of Care Criteria 8
Procedure Codes (CPT/HCPCS) 9
Evaluation of Clinical Harms and Benefits 10
Medical Evidence **12**
References **13**
Policy Revision History/Information **18**

Medical Necessity Criteria

Service: Computed Tomography (CT), Abdomen/Pelvis

Related CMS Documents

Please refer to the CMS Medicare Coverage Database for the most current applicable CMS National Coverage.[1-5]

- National Coverage Determination (NCD). Computed tomography (CT) (220.1)
- Local Coverage Determination (LCD). CT of the abdomen and pelvis (L34415)
  - Billing and Coding: CT of the abdomen and pelvis (A56421)
- Local Coverage Determination (LCD). Multiple imaging in oncology (L35391)
  - Billing and Coding: Multiple imaging in oncology (A56848)

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.[6-9]

Medical Necessity Criteria

Indications

Computed tomography (CT), abdomen is considered appropriate if **ANY** of the following is **TRUE**[2]:

- Evaluation of **ANY** of the following:
  - Abdominal pain; **OR**
  - Abdominal masses (known or suspected); **OR**
  - Fluid collections (known or suspected); **OR**
  - Malignancies (primary or metastatic); **OR**
  - Abdominal inflammatory processes; **OR**
  - Abnormalities of abdominal vascular structures; **OR**
  - Abdominal trauma; **OR**
- Clarification of findings from other imaging studies of the abdomen; **OR**
- Laboratory abnormalities suggesting abdominal pathology; **OR**
- Guidance for interventional diagnostic or therapeutic procedures within the abdomen; **OR**
- Treatment planning for radiation therapy; **OR**
- Patient is being evaluated for potential transcatheter aortic valve implantation/replacement (TAVI or TAVR) and has not undergone a CT of the abdomen within the preceding 60 days.

Computed tomography (CT), pelvis is considered appropriate if **ANY** of the following is **TRUE**[2]:

- Evaluation of **ANY** of the following:
  - Cysts, tumors, or masses of the pelvic structure; **OR**
  - Metastases or primary cancers to the pelvic region; **OR**
  - Inflammatory processes in the pelvis; **OR**
  - Abnormalities of pelvic vascular structures; **OR**
  - Lymphadenopathy in this region; **OR**
  - Pain of **ANY** of the following;
    - Lower abdomen; **OR**
    - Generalized abdomen; **OR**
    - Pelvis; **OR**
  - Genitourinary (GU) disorders in which the physician cannot make a diagnosis on physical examination or by ultrasound; **OR**
  - Trauma to the pelvic structure/organs; **OR**

    - Effectiveness of a radiation treatment plan; **OR**
- Patient is being evaluated for potential transcatheter aortic valve implantation/replacement (TAVI or TAVR) and has not undergone a CT of the abdomen within the preceding 60 days.

Non-Indications

Computed tomography (CT), abdomen/pelvis with contrast is not considered appropriate if **ANY** of the following is **TRUE**[10]:

- The patient has undergone advanced imaging of the same body part within 3 months without undergoing treatment or developing new or worsening symptoms.

*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.

Definitions

Bosniak Classification[9-10]		
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.

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.[11,12]

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.[11,12]

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.[11,12]

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.[11,12]

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.

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

Disclaimer: S Codes are non-covered per CMS guidelines due to their experimental or investigational nature.

Evaluation of Clinical Harms and Benefits

Clinical determinations for Medicare Advantage beneficiaries are made in accordance with 42 CFR 422.101 guidance outlining CMS's required approach to decision hierarchy in the setting of NCDs/LCDs identified as being "not fully established". When clinical coverage criteria are "not fully established" Medicare Advantage organizations are instructed to create publicly accessible clinical coverage criteria based on widely-accepted clinical guidelines and/or scientific studies backed by a robust clinical evidence base. Clinical coverage criteria provided by Cohere Health in this manner include coverage rationale and risk/benefit analysis.

Clinical coverage criteria for computed tomography (CT), abdomen/pelvis were fully defined and established by NCDs and/or LCDs. Cohere Health did not supplement this policy with any additional criteria or interpretations.

Medical Evidence

Shah et al. (2022) performed a retrospective review of patients who had at least one CT scan of the abdomen (with or without pelvis) or MRI of the abdomen (with or without 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 concluded that the prevalence of CT scans in inflammatory bowel disease patients has escalated. Future research is needed regarding the determinants influencing the utilization of CT and MRI scans.[13]

Oldroyd et al. (2021) conducted a meta-analysis that focused on using CT to identify underlying asymptomatic cancers. CT scans of the thorax, abdomen, or pelvic organs proved to be 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.[14]

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.[15]

References

1. Centers for Medicare & Medicaid Services (CMS). National Coverage Determination (NCD). Computed tomography (220.1). Effective Date March 12, 2008. https://www.cms.gov/medicare-coverage-database/search.aspx
2. Centers for Medicare & Medicaid Services (CMS). Local Coverage Determination (LCD). CT of the abdomen and pelvis (L34415). Revision Effective Date August 28, 2022.

   https://www.cms.gov/medicare-coverage-database/search.aspx
3. Centers for Medicare & Medicaid Services (CMS). Billing and Coding: CT of the abdomen and pelvis (A56421). Revision Effective Date October 1, 2025. https://www.cms.gov/medicare-coverage-database/view/article.aspx?articleid=56421&ver=36&=
4. Centers for Medicare & Medicaid Services (CMS). Local Coverage Determination (LCD). Multiple imaging in oncology (L35391). Revision Effective Date January 24, 2025. https://www.cms.gov/medicare-coverage-database/search.aspx
5. Centers for Medicare & Medicaid Services (CMS). Billing and Coding: Multiple imaging in oncology (A56848). Revision Effective Date October 1, 2024. https://www.cms.gov/medicare-coverage-database/view/article.aspx?articleid=56848&ver=16&
6. American College of Radiology (ACR), Society for Advanced Body Imaging (SABI), Society of Abdominal Radiology (SAR), Society for Pediatric Radiology (SPR). ACR–SABI–SAR–SPR practice parameter for the performance of computed tomography (CT) of the abdomen and computed tomography (CT) of the pelvis - resolution 46. Updated 2021. https://www.acr.org/-/media/ACR/Files/Practice-Parameters/ct-abd-pel.pdf
7. Rudnick MR, Leonberg-Yoo AK, Litt HI, et al. The controversy of contrast-induced nephropathy with intravenous contrast: What is the risk? *Am J Kidney Dis*. 2020;75(1):105-113. doi: 10.1053/j.ajkd.2019.05.022

8. Ackman JB, Chung JH, et al. ACR appropriateness criteria - imaging of mediastinal masses. *J Am Coll Radiol*. 2021;18(5S):S37-S51. doi: 10.1016/j.jacr.2021.01.007
9. de Groot PM, Chung JH, et al. ACR appropriateness criteria - noninvasive clinical staging of primary lung cancer. *J Am Coll Radiol*. 2019;16(5S):S184-S195. doi: 10.1016/j.jacr.2019.02.008
10. Davenport MS, Perazella MA, Yee J, et al. Use of intravenous iodinated contrast media in patients with kidney disease: Consensus statements from the American College of Radiology and the National Kidney Foundation. *Radiology*. 2020;294(3):660-668. doi: 10.1148/radiol.2019192094
11. The Image Gently Alliance. Procedures - image gently and CT scans. Updated 2014. https://www.imagegently.org /Procedures/Computed-Tomography
12. National Cancer Institute. Radiation risks and pediatric computed tomography (CT): A guide for health care. Updated September 4, 2018. https://www.cancer.gov/about-cancer/causes-prevention/risk/radiation/pediatric-ct-scans
13. Shah R, Elangovan A, Jordan DW, et al. 10-year trend of abdominal magnetic resonance imaging compared with abdominal computed tomography scans in inflammatory bowel disease. *Inflamm Bowel Dis*. 2022 Sep 1;28(9):1357-1362. doi: 10.1093/ibd/izab284
14. Oldroyd AGS, Allard AB, Callen JP, et al. A systematic review and meta-analysis to inform cancer screening guidelines in idiopathic inflammatory myopathies. *Rheumatology (Oxford).* 2021 Jun 18;60(6):2615-2628. doi: 10.1093/rheumatology/keab166
15. Baron BJ, Benabbas R, Kohler C, et al. Accuracy of computed tomography in diagnosis of intra-abdominal injuries in stable patients with anterior abdominal stab wounds: A systematic review and meta-analysis. *Acad Emerg Med*. 2018 Jul;25(7):744-757. doi: 10.1111/acem.13380

Policy Revision History/Information

Original Date: October 29, 2024		
Review History		
Version 2	10/16/2025	Annual review Rewrote indications to conform to L34415. Reframed indications for concision and clarity. Updated conservative care language. Updated DI non-indication language (e.g. removed contrast allergy bullet). Updated references.