HEALTHHELP®

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2025 Computed Tomography (CT) Abdomen and Pelvis

Diagnostic Imaging

CT-ABDPelvis-HH

Last Review Date: 03/07/2025
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Guideline Initiated: 06/30/2019

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CT Abdomen and Pelvis guideline

NCD 220.1
See also, **NCD 220.1**: Computed Tomography at https://www.cms.gov/medicare-coverage-database/search.aspx *if applicable to individual's healthplan membership*.

Preamble: Pediatric Diagnostic Imaging

HealthHelp's clinical guidelines for the Diagnostic Imaging program, are intended to apply to both adults and pediatrics (21 years of age or younger), unless otherwise specified within the criteria.

CT General Contraindications

Computed tomography (CT) is contraindicated (relative) for **ANY** of the following:

1. Allergy/idiosyncratic reaction to contrast material (if intravascular contrast material is used)
2. Pregnancy
3. Renal impairment (glomerular filtration rate [GFR] is less than 30 ml/min/1.73 m^2.)
   References: [7]

CT Abdomen and Pelvis Guideline

Computed tomography (CT) abdomen and pelvis is considered medically appropriate when the documentation demonstrates **ANY** of the following:
(*__NOTE__: *Aneurysm for diagnosis and monitoring is completed with CT angiography [CTA] or magnetic resonance angiography [MRA] if CTA is* ***contraindicated or unavailable*** *when ultrasound is non-diagnostic or indeterminate. See CTA or MRA Abdomen and Pelvis guidelines*)
References: [19] [23]

1. Cancer is known and **EITHER** of the following:
   a. Initial diagnosis for staging and metastasis evaluation
   b. Surveillance (*Follow the NCCN surveillance. See* ***Surveillance*** *section below*)

   References: [35] [5] [65] [38] [56] [42] [27]
2. Infection or inflammation and **EITHER** of the following:
   a. Crohn's disease, ulcerative colitis or diverticulitis complication evaluation and symptoms are persistent. (**NOTE**: *Use CT enterography [CTE]*)

b. Diverticulitis, inflammatory bowel disease or peritonitis is suspected, for diagnosis.

References: [55] [40] [45] [63] [26] [47]

3. Pain, localized to the abdomen/pelvis and **ANY** of the following:
   a. Age is over 65 years old **AND** abdominal pain is acute.
   b. Initial workup is non-diagnostic or indeterminate. (***NOTE:** *initial workup must include: ultrasound, laboratory testing [eg, complete blood count [CBC], chemistry, urinalysis, amylase/lipase if pancreatitis is suspected, liver function tests if hepatic disease is suspected.])*

   References: [35] [55] [46] [8] [68]
4. Post-surgical assessments for evaluation of complications or disease recurrence.
5. Prior abdomen/pelvis ultrasound is non-diagnostic or indeterminate.
   References: [28] [36] [41]
6. Renal pathologies (hematuria, renal colic, complicated UTI) are suspected and ultrasound is non-diagnostic or indeterminate. (***NOTE**: *use CT urography for hematuria evaluation and kidney stone complications.*)
   References: [73] [21] [34] [59] [66]
7. Small bowel bleeding when endoscopy is non-diagnostic or indeterminate. (**NOTE**: *Use CTE*)
   References: [39]
8. Trauma, blunt, to the abdomen is known and complications are suspected.
   References: [58]
9. Weight loss occurred and is unintentional and unexplained (more than 10% of body weight in 2 months or more than 5% of body weight in 6 months).

LCD 34415
See also, **LCD 34415**: CT of the Abdomen and Pelvis at https://www.cms.gov/medicare-coverage-database/search.aspx *if applicable to individual's healthplan membership*.

LCD 35391
See also, **LCD 35391**: Multiple Imaging in Oncology at https://www.cms.gov/medicare-coverage-database/search.aspx *if applicable to individual's healthplan membership*.

Abdomen and Pelvis Surveillance section

Insert text

Anal Cancer Surveillance

Anal cancer surveillance includes **ANY** of the following:

1. Complete remission, when local or inguinal node recurrence is suspected and **EITHER** of the following: (**NOTE**: *FDG-PET/CT scan is **NOT** indicated*)
    a. Chest, abdomen and pelvis CT (+ contrast) and abdomen and pelvis MRI (+ contrast), annually for 3 years
    b. Chest CT (- contrast) and abdomen and pelvis MRI (+ contrast), annually for 3 years
2. Peri-anal cancer, with biopsy proven squamous cell carcinoma surveillance with **BOTH** of the following: (**NOTE**: *FDG-PET/CT scan is **NOT** indicated*)
    a. Chest, abdomen and pelvis CT (+ contrast) and abdomen and pelvis MRI (+ contrast), annually for 3 years
    b. Chest CT (- contrast) and abdomen and pelvis MRI (+ contrast), annually for 3 years
3. Persistent disease surveillance as follows:
    a. Chest, abdomen and pelvis CT (+ contrast) and abdomen and chest MRI (+ contrast), annually for 3 years
    b. Chest CT (- contrast), abdomen and pelvis MRI (+ contrast), annually for 3 years
4. Progressive disease is biopsy proven, locally recurrent for restaging and **EITHER** of the following:
    a. Chest, abdomen and pelvis CT (+ contrast) and abdomen and chest MRI (+ contrast), annually for 3 years
    b. Chest CT (- contrast) and abdomen and chest MRI (+ contrast), annually for 3 years

References: [2025 Anal Carcinoma Version 3.2025]

Biliary Tract Cancer Surveillance reuse

Biliary tract cancer surveillance includes **ANY** of the following:

1. Computed tomography (CT) (± contrast) of the chest **AND** multiphasic (+ contrast) CT or magnetic resonance imaging (MRI) of the abdomen and pelvis are recommended for follow-up imaging.

2. PET/CT has limited sensitivity but high specificity and prior imaging is non-diagnostic of indeterminate **OR** on a case-by-case basis.
3. Intrahepatic or extrahepatic cholangiocarcinoma follow-up with CT of the chest (+) contrast and CT or MRI of the abdomen and pelvis (+ contrast)

References: [2025 Biliary Tract Cancers Version 2.2025]

Bladder Cancer Surveillance

Bladder cancer imaging surveillance includes **ANY** of the following:

1. Metastatic disease surveillance includes **ANY** of the following:
    a. Computed tomography urography (CTU) or magnetic resonance urography (MRU); follow-up every 3 to 6 months **AND** when symptoms are new or changing.
    b. CT chest, abdomen and pelvis; follow-up every 3 to 6 months **AND** when symptoms are new or changing. (*__NOTE__: *FDG positron emission tomography/ computed tomography (PET/CT) for category 2B*)
2. Muscle invasive bladder cancer (MIBC) and upper tract (greater then or equal to T2 disease) surveillance includes **ANY** of the following:
    a. Abdominal and pelvic imaging and **ANY** of the following:
        i. Abdomen and pelvis CT/MRI/FDG-PET imaging every 3 to 6 months for 2 years, then annually for up to 5 years and then clinically as indicated
        ii. FDG PET/CT for category 2B, if **NOT** previously completed
        iii. FDG PET/CT when high risk and metastatic disease is suspected. (*__NOTE__: *Use for biopsy guidance and should **NOT** be used to delineate the anatomy of the upper urinary tract.*)
    b. Chest imaging for follow-up, with or **WITHOUT** cystectomy **OR** cT4b disease and **ANY** of the following:
        i. Chest CT (± contrast); Use as a single exam when abdomen and pelvis imaging is needed.
        ii. FDG PET/CT for category 2B, if **NOT** previously completed
        iii. FDG PET/CT when high risk and metastatic disease is suspected. (*__NOTE__: *Use help guide biopsy*)
    c. Post-bladder sparing (eg, chemoradiation or partial cystectomy) or post-cystectomy follow-up and **ANY** of the following:
        i. Years 1 and 2 and **ALL** of the following:

A. Chest CT; every 3 to 6 months

B. CTU or MRU; every 3 to 6 months

C. FDG PET/CT for category 2B **ONLY** when metastatic disease is suspected; every 3 to 6 months.

ii. Years 3 to 5 and **ALL** of the following:

A. Abdominal and pelvis CT or MRI, annually

B. Chest CT; annually

C. FDG PET/CT for category 2B **ONLY** when metastatic disease is suspected; annually.

3. Non-muscle invasive bladder cancer (NMIBC) and upper tract (less than or equal to T1 disease) surveillance includes **ANY** of the following:

   a. Low-risk and intermediate risk NMIBC: CT/MRI imaging at baseline of abdomen/ pelvis and then as clinically indicated

   b. High-risk NMIBC: Imaging of upper tract baseline, then every 1 to 2 years through year 10 then as clinically indicated thereafter

   c. Post-cystectomy NIMBC; follow-up with CTU or MRU at 3 months and 12 months, then annually through year 5

4. Urothelial carcinoma of the prostate **OR** primary carcinoma of the urethra and **ANY** of the following:

   a. Low risk T1 or less than T1 disease: MRI or CT of pelvis (± contrast)

   b. High risk T1 or T2 or higher disease chest CT **AND** MRI or CT of the abdomen and pelvis: every 3 to 6 months for 2 years and then annually

References: [2025 Bladder Cancer Version 1.2025]

Bone Cancer Surveillance

Bone cancer surveillance includes **ANY** of the following:

1. Chondrosarcoma surveillance for **ANY** of the following:

   a. Atypical cartilaginous tumor surveillance with cross-sectional imaging (CT + contrast, MRI ± contrast) every 6 to 12 months for 2 years, then annually as clinically indicated

   b. Low-grade, extracompartmental appendicular tumor, grade I axial tumors or high-grade (grade II or III, clear cell or extracompartmental) tumors surveillance with **ALL** of the following:

i. Chest CT at least every 6 months for 5 years, then annually for at least 10 years, then if symptoms are new or progressing.

ii. MRI (± contrast) or CT (+ contrast) if symptoms are new or progressing.

2. Chordoma surveillance with **ALL** of the following:
   a. Chest CT imaging every 6 months, annually for 5 years, then annually thereafter, then if symptoms are new or worsening.
   b. Imaging of primary site, timing and modality (eg, MRI ± CT [both + contrast]) if symptoms are new or progressing, up to 10 years
3. Ewing Sarcoma after primary treatment completed surveillance with **ALL** of the following:
   a. Chest CT: every 3 months
   b. Primary site imaging with MRI ± CT (both + contrast), increase intervals after 24 months and after 5 years, annually, then if symptoms are new or progressing (indefinitely) (*__NOTE__: *PET/CT [head-to-toe] is appropriate*)
4. Giant cell tumor of the bone surveillance with **ALL** of the following:
   a. Chest CT or MRI imaging every 6 to 12 months for 4 years, then annually thereafter, then if symptoms are new or progressing
   b. Surgical site imaging if symptoms are new or progressing (eg, CT and/or MRI, both with contrast)
5. Osteosarcoma surveillance with primary site and chest imaging (using same imaging that was done for initial work-up) for **ANY** of the following: (*__NOTE__: *PET/CT [head-to-toe] is appropriate*.)
   a. Image every 3 months for years 1 and 2
   b. Image every 4 months for year 3
   c. Image every 6 months for years 4 and 5
   d. Image annually for year 6 and thereafter, then if symptoms are new or progressing

References: [2025 Bone Cancer Version 2.2025]

Cervical Cancer Surveillance

Cervical cancer surveillance includes **ANY** of the following: (*__NOTE__: *if first post-treatment imaging is non-diagnostic or indeterminate, consider repeating in 3 months*)

1. Stage I cervical cancer and **ANY** of the following:
   a. Fertility sparing, pelvic magnetic resonance imaging (MRI) (+ contrast); follow-up 6 months after surgery and then annually for 2 to 3 years

b. Non-fertility sparing, stage IB3 or high risk factors requiring post-operative adjuvant radiation or chemotherapy follow-up with positron emission tomography/ computed tomography (PET/CT) (abdomen, chest, groin, neck, pelvis) 3 to 6 months after completion of treatment. Imaging is based on symptomatology and clinical concern for recurrent/metastatic disease.

2. Stage II to IV cervical cancer and **ANY** of the following:

   a. PET/CT of the abdomen, chest, groin, neck and pelvis **OR** CT of the abdomen, chest and pelvis; follow-up 3 to 6 months after completion of therapy.

   b. MRI (+ contrast) of the pelvis; follow-up 3 to 6 months after completion of therapy

   c. Other imaging should be based on symptomatology and clinical concern for recurrent/metastatic disease.

3. Stage IVB or recurrence; follow-up imaging as appropriate (CT, MRI, or FDG-PET/CT) to assess response or to determine further therapy. (**NOTE**: *If first post-treatment FDG-PET/CT is indeterminate, then consider repeating in 3 months.)*

4. Suspected recurrence or metastasis and **ANY** of the following:

   a. Neck, chest, abdomen, pelvis, groin FDG-PET/CT

   b. MRI (+ contrast) of the pelvis

References: [2025 Cervical Cancer Version 4.2025]

Colon Cancer Surveillance

Colon cancer surveillance includes **ANY** of the following: (*__Note__: *Routine computed tomography [CT] scanning are **NOT** recommended beyond 5 years.*)

1. Stage II or III disease surveillance includes CT chest, abdomen and pelvis every 6 to 12 months from date of surgery, for a total of 5 years. (**NOTE**: *PET/CT is **NOT** indicated*.)

2. Stage IV disease surveillance includes CT chest, abdomen and pelvis every 3 to 6 months for 2 years, then every 6 to 12 months for a total of 5 years. (**NOTE**: *PET/CT is **NOT** indicated*.)

References: [2025 Colon Cancer Version 3.2025]

Esophageal and Esophagogastric Junction Cancer Surveillance

Esophageal and esophagogastric junction cancer surveillance includes **ANY** of the following[1]:

[1]Routine esophageal/esophagogastric junction cancers are **NOT** recommended for cancer-specific surveillance, for more than 5 years after the end of treatment.

1. Adenocarcinoma, squamous cell carcinoma; imaging studies if symptoms are new or progressing
2. Tumor classification T1b[a] (N0 on ultrasound) after endoscopic resection or ablation, imaging surveillance includes computed tomography (CT) chest and abdomen (+ contrast, unless **contraindicated**) every 6 months for the first 2 years and annually for up to 5 years
3. Tumor classification T1b or greater, any N[a] or T1a N+, imaging surveillance includes esophagectomy performed with or **WITHOUT** adjuvant therapy then surveillance includes chest and abdomen CT (+ contrast, unless **contraindicated**) every 6 months for the first 2 years and annually for up to 5 years
4. Tumor classification any T and/or any N, with neoadjuvant chemotherapy **OR** chemoradiotherapy **AND** esophagectomy, with or **WITHOUT** adjuvant treatment, imaging surveillance includes chest and abdomen CT (+ contrast, unless **contraindicated**) every 6 months for up to 2 years, then annually for up to 5 years and EGD, then if symptoms are new or progressing
5. Tumor classification (pretreatment) N0 to N+, T1b to T4, T4b, with definitive chemoradiation (**WITHOUT** esophagectomy), surveillance imaging includes chest and abdomen CT (+ contrast unless **contraindicated**) every 3 to 6 months for the first 2 years and annually for up to 5 years

References: [2025 Esophageal and Esophagogastric Junction Cancers Version 3.2025]

Gastric Cancer Surveillance

Gastric cancer surveillance includes **ANY** of the following (**NOTE**: *Routine gastric cancer surveillance is **NOT** recommended beyond 5 years*):

1. Tumor type Tis (successfully treated by endoscopic resection [ER]); recurrent disease is suspected, based on symptoms (eg, abdominal pain, bloating, diarrhea); image with chest, abdomen and pelvis computed tomography (CT) (+ contrast), then if symptoms are new or progressing
2. Tumor types: p stage I (T1a [treated by ER] or T1a, T1b, N0 [treated by surgical resection]) imaging surveillance includes CT chest, abdomen and pelvis (+ contrast), then if symptoms are new or progressing
3. Tumor types: p stage II/III or yp stage I to III (treated with neoadjuvant ± adjuvant therapy) surveillance imaging with chest, abdomen and pelvis CT (+ contrast), every 6 months for the first 2 years then annually up to 5 years

References: [2025 Gastric Cancer Vesion 2.2025]

Gastrointestinal Stromal Tumors (GISTs) Surveillance

Gastrointestinal stromal tumors (GISTs) surveillance includes **ANY** of the following:

1. After treatment for progressive disease, abdominal/pelvic CT or MRI to evaluate therapeutic response (Use PET/CT if CT results are non-diagnostic or indeterminate).
2. Completely resected primary disease, image with abdomen and pelvis CT (+ contrast) MRI (± contrast) every 3 to 6 months for 5 years, then annually (*__NOTE__: *Less frequent imaging surveillance is acceptable for low-risk or very small tumors [smaller than 2 cm]. More frequent imaging surveillance is required for individuals with high-risk disease that discontinue [tyrosine kinase inhibitor] TKI therapy.*)
3. **INCOMPLETELY** resected disease or discovery of metastatic disease during surgery, image with abdomen and pelvis CT and/or MRI every 3 to 6 months.

References: [2025 Gastrointestinal Stromal Tumors Version 1.2025]

Gestational Trophoblastic Neoplasia Surveillance reuse

Gestational trophoblastic neoplasia surveillance for intermediate trophoblastic tumor (placental site trophoblastic tumor [PSTT] or epithelioid trophoblastic tumor [ETT]), after treatement includes FDG-PET/CT (whole body) at the completion of chemotherapy and then FDG-PET/CT or CT chest, abdomen and pelvis every 6 to 12 months for 2 to 3 years.
References: [2025 Gestational Trophoblastic Neoplasia Version 3.2025]

Hepatocellular Carcinoma Surveillance

Hepatocellular carcinoma surveillance includes imaging with multiphasic (+ contrast) computed tomography (CT) or magnetic resonance imaging (MRI) of the abdomen and pelvis, if initial ultrasound is non-diagnostic or indeterminate; every 6 months.
References: [2025 Hepatocellular Carcinoma Version 1.2025]

Kidney Cancer Surveillance

Kidney cancer surveillance includes **ANY** of the following:

1. Long-term surveillance after 5 years: abdominal CT/MRI imaging follow-up with increasing intervals (due to risk of metachoronous tumors/late recurrences). (*__NOTE__: *For stages 3 or 4 of disease, use chest imaging at increasing intervals.*)
2. Relapsed, stage IV and surgically unresectable disease surveillance includes **ALL** of the following:
    a. CT or MRI chest, abdomen and pelvis at baseline pre-treatment and at start of surveillance period with follow-up every 6 to 16 weeks

b. MRI or CT of head at baseline and if symptoms are new or progressing

c. MRI of the spine if symptoms are new or progressing.

3. Stage I kidney cancer surveillance and **ANY** of the following:

a. Follow-up during active surveillance includes **ALL** of the following;

i. Abdominal computed tomography (CT) or magnetic resonance imaging (MRI) (± contrast, if **NO contraindication**) within 6 months of starting active surveillance; then CT or MRI at least annually thereafter

ii. Chest CT at baseline, then annually to assess for pulmonary metastasis as clinically indicated (if intervention is planned, use repeat chest imaging)

b. Follow-up after ablative techniques includes **ALL** of the following:

i. Abdominal CT or MRI (± contrast, unless **contraindicated**) at 1 to 3 months, 6 months and 12 months, then annually thereafter

ii. Chest CT annually for 5 years for individuals with biopsy-proven, low-risk pathologic features (**NO** sarcomatoid, low-grade [grade 1 or 2] renal cell carcinoma [RCC], non-diagnostic biopsies or **NO** prior biopsy)

c. Follow-up after partial or radical nephrectomy includes **ALL** of the following:

i. Abdominal CT or MRI within 3 to 12 months of surgery, then annually for up to 5 years or longer if clinically indicated (*__NOTE__: *More frequent imaging schedule is considered if positive margins or adverse pathologic features [such as sarcomatoid, high-grade [grade 3/4]*)

ii. Chest CT annually for at least 5 years, then if symptoms are new or progressing. (*__NOTE__: *More frequent imaging schedule is considered if positive margins or adverse pathologic features*)

4. Stage II kidney cancer surveillance, after a partial or radical nephrectomy, and **ANY** of the following:

a. Abdominal CT or MRI for baseline, every 6 months for 2 years, then annually for up to 5 years, then if symptoms are new or progressing. (*__NOTE__: *More frequent imaging schedule is considered if positive margins or adverse pathologic features (such as sarcomatoid, high-grade [grade 3/4]*)

b. Chest CT annually for 5 years, then if symptoms are new or progressing. (*__NOTE__: *More frequent imaging schedule is considered if positive margins or adverse pathologic features*)

5. Stage III kidney cancer **OR** follow-up after adjuvant therapy surveillance includes **ALL** of the following:

a. Abdominal CT or MRI for baseline and within 3 to 6 months after surgery, then CT or MRI (for category 2B for stage III) every 3 to 6 months for 3 years, then annually up to 5 years and, then if symptoms are new or progressing.

b. Chest CT for baseline and within 3 to 6 months, followed by continued imaging every 3 to 6 months for at least 3 years, annually up to 5 years, then if symptoms are new or progressing.

c. MRI of the spine if symptoms are new or progressing.

References: [2025 Kidney Cancer Version 3.2025]

Mesothelioma: Peritoneal Surveillance

Mesothelioma: peritoneal surveillance includes CT chest **AND** CT or MRI abdomen and pelvis every 3 to 6 months for 5 years then annually.
References: [2025 Mesothelioma: Peritoneal Version 2.2025]

Neuroendocrine and Adrenal Tumors Surveillance

Neuroendocrine and adrenal cancer surveillance includes **ANY** of the following:[2]

1. Adrenal gland tumors surveillance imaging includes **ANY** of the following:
   a. Localized disease: chest computed tomography (CT) (± contrast) and abdominal CT or magnetic resonance imaging (MRI) (+ contrast) every 3 to 12 months up to 5 years, then if symptoms are new or progressing.
   b. Locoregional unresectable or metastatic disease; chest CT (± contrast) and CT or MRI abdomen and pelvis (+ contrast) or FDG positron emission tomography (PET)/CT every 3 to 12 months up to 5 years, then if symptoms are new or progressing.
2. Carcinoid syndrome surveillance imaging includes **BOTH** of the following:
   a. Abdominal/pelvic multiphasic CT or MRI every 3 to 12 months and chest CT (± contrast) if symptoms are new or progressing.
   b. Echocardiogram (ECHO) every 1 to 3 years or as clinically indicated **WITHOUT** known carcinoid heart disease (CHD) and at least annually for individuals with established CHD.
3. Gastrointestinal tract (well-differentiated grade 1/2), lung and thymus imaging and **ANY** of the following:

[2]**NO** surveillance is indicated for appendiceal tumors 2 cm or smaller **WITHOUT** aggressive features (eg, high-grade cytologic atypia, infiltrative invasion lymphatic and hematogenous metastases).

a. Lung nodules, multiple or tumorlets, image with chest CT (- contrast) every 12 to 24 months if symptoms are new or progressing.

b. Rectal tumor is 1 cm to 2 cm or less: image with rectal MRI at 6 and 12 months if symptoms are new or progressing.

4. Gastrointestinal (GI) tract (jejunum/ileum/colon, duodenum, rectum), lung and/or thymus neuroendocrine tumor (NET) surveillance includes imaging post-resection with **ANY** of the following:

   a. Jejunum/ilium/colon, duodenum, rectum and thymus, surveillance imaging with abdominal ± pelvic multiphasic CT or MRI according to **ONE** of the following levels of frequency[3]:

      i. Within 3 months to 12 months post-operatively

      ii. After 12 months, image every 12 to 24 months for 10 years

      iii. After 10 years if symptoms are new or progressing.

   b. Lung/thymus tumors surveillance chest CT (± contrast) for primary tumors, (as clinically indicated for primary GI tumors) according to **ONE** of the following levels of frequency:

      i. Within 12 weeks to 12 months post-operatively

      ii. After 12 months, image every 12 to 24 months for 10 years

      iii. After 10 years if symptoms are new or progressing.

5. Grade 3, well-differentiated neuroendocrine surveillance includes chest CT (± contrast) as clinically indicated for **ANY** of the following:

   a. Locally advanced/metastatic disease with favorable biology (low Ki-67 [eg, less than 55%], positive somastatin receptor [SSTR] based PET imaging) includes abdominal/pelvic MRI (+ contrast) or abdominal/pelvic multiphasic CT for surveillance with **ANY** of the following:

      i. Resectable disease surveillance every 3 to 6 months for 2 years, then every 6 to 12 months for up to 10 years **AND** chest CT if symptoms are new or progressing.

      ii. Unresectable disease surveillance every 12 weeks to 24 weeks (depending on tumor biology) **AND** chest CT (± contrast), SSTR-PET/CT, SSTR-PET/MRI or FDG-PET/CT; if symptoms are new or progressing.

   b. Locally advanced/metastatic disease with unfavorable biology (high Ki-67 [eg 55% or higher], rapid growth rate, FDG avid tumors, negative SSTR-based PET

[3]High-grade tumors are appropriate for more frequent monitoring.

imaging), includes surveillance imaging, every 8 weeks to 12 weeks (depending on tumor biology) with **ALL** of the following:

i. Abdominal/pelvic MRI (+ contrast) or abdominal/pelvic multiphasic CT and FDG PET/CT as clinically indicated

ii. Chest CT (± contrast) if symptoms are new or progressing.

iii. FDG-PET/CT, if symptoms are new or progressing.

c. Locoregional disease (resectable) abdominal/pelvic MRI (+ contrast) or abdominal/pelvic multiphasic CT with frequency of **ONE** of the following:

i. Every 3 to 6 months for 2 years (depending on tumor biology, Ki-67) and chest CT as clinically indicated

ii. Every 6 months to 12 months for up to 10 years (depending on tumor biology, Ki-67) and chest CT as clinically indicated

d. Multiple endocrine neoplasia, type 1 (MEN1) screening surveillance for **ANY** of the following tumor types: (*__NOTE__: *For prolonged surveillance, use imaging studies without radiation.*)

i. Lung/thymic NETs: chest CT or MRI (+ contrast) every 1 to 3 years

ii. PanNET: abdominalpelvic CT or MRI (+ contrast) every 1 to 3 years

iii. Parathyroid: if calcium rises, re-image with single-photon emission computed tomography (SPECT) scan (SPECT-CT preferred) or 4D-CT

iv. Pituitary: pituitary or sella MRI (+ contrast) of the pituitary every 3 to 5 years

e. Poorly differentiated large or small cell carcinoma and/or mixed neuroendocrine/non-neuroendocrine neoplasm or unknown primary, imaging surveillance includes **ALL** of the following:

i. Locoregional unresectable or metastatic disease surveillance imaging includes **EITHER** chest CT (± contrast) with abdominal/pelvic MRI (+ contrast) **OR** chest/abdominal/pelvic multiphasic CT; every 6 weeks to 16 weeks

ii. Resectable surveillance imaging includes **EITHER** chest CT (± contrast) with abdominal/pelvic MRI (+ contrast) **OR** chest, abdomenl and pelvis multiphasic CT; every 12 weeks for the 1st year, and every 6 months thereafter

f. Post-operative from potentially curative surgery surveillance for at least 10 years (longer if high-risk)

6. Pancreatic neuroendocrine tumor surveillance imaging, post-resection, includes chest CT (± contrast) as clinically indicated and abdominal multiphasic CT or MRI with imaging frequency of **ONE** of the following[4]:
    a. Within 3 to 12 months post-operatively
    b. After 12 months, image every 6 to 12 months for 10 years
    c. After 10 years if symptoms are new or progressing.
7. Pheochromocytoma/paranganglioma surveillance imaging and **ANY** of the following:
    a. Locally unresectable disease or distant metastases, imaging every 12 weeks for 12 months, includes **ANY** of the following:
        i. Chest, abdomen and pelvis CT with contrast
        ii. Chest CT (± contrast) and abdominal/pelvic MRI (- contrast) (if risk for hypertensive episode)
        iii. FDG-PET/CT for bone dominant disease
        iv. SSTR-PET/CT or SSTR-PET/MRI (if previous SSTR-positive or concern for disease progression) prior to radionuclide therapy
    b. Resectable disease, post-resection includes chest CT (± contrast) and abdominal/ pelvic CT or MRI (+ contrast), if clinically indicated with imaging frequency of **ONE** of the following:
        i. 12 weeks to 12 months after resection
        ii. Every 6 to 12 months for the 1st 3 years
        iii. Annually from year 4 to 10.
        iv. More than 10 years, then as clinically indicated

[4]High-grade tumors are appropriate for more frequent monitoring.

TIP

NCCN recommends following the surveillance protocols from designated guidelines for the following hereditary endocrine neoplasia syndromes :

- Thyroid cancer guideline, use for: Multiple endocrine neoplasia, type 2 (MEN2) with genetic evaluation of inherited syndromes
- Kidney cancer, use for:
  - Hereditary paraganglioma/pheochromocytoma syndrome
  - Tuberous sclerosis complex (TSC1 and TSC2)
  - von Hippel Lindau syndrome (VHL)
- Genetic/Familial High-Risk Assessment: Breast, Ovarian, and Pancreatic, use for:
  - Neurofibromatosis type 1 (NF1)
  - Li-Fraumeni syndrome (TP53)
  - Lynch syndrome (MLH1, EPCAM/MSH2, MSH6, PMS2)
- Genetic/Familial High-Risk Assessment: Colorectal, use for:
  - Lynch syndrome (MLH1, EPCAM/MSH2, MSH6, PMS2)
  - Familial adenomatous polyposis (APC)

References: [2025 Neuroendocrine and Adrenal Tumors Version 2.2025]

Occult Primary Cancer Surveillance

Occult primary cancer surveillance imaging for long-term surveillance includes diagnostic tests based on symptomatology.

References: [2025 Occult Primary Version 2.2025]

Ovarian, Fallopian Tube or Primary Peritoneal Cancers Surveillance

Ovarian, fallopian tube or primary peritoneal cancer surveillance includes **ALL** of the following:

1. Malignant germ cell/sex cord-stromal tumor surveillance for **ANY** of the following:
   a. Malignant germ cell tumors surveillance with chest/abdomen/pelvis CT every 3 months for years 1 and 2, every 6 to 12 months for year 3, then clinically as indicated.

b. Malignant sex cord-stromal tumors surveillance when symptomatic (eg, abdominal distention, pain, uterine bleeding), biomarkers are elevated or physical exam demonstrates suspicious findings.

2. Stage I through IV, primary treatment was received; follow-up imaging if symptoms are new or progressing.

References: [2025 Ovarian, Fallopian Tube or Primary Peritoneal Cancers Version 2.2025]

Pancreatic Adenocarcinoma Surveillance

Pancreatic adenocarcinoma surveillance includes post-operative surveillance imaging with chest CT and abdomen and pelvis CT or MRI (+ contrast) unless **contraindicated**.
References: [2025 Pancreatic Adenocarcinoma Version 2.2025]

Penile Cancer Surveillance

Penile cancer surveillance when there is lymph node involvement, includes **ANY** of the following:

1. Classification pN0, N1 imaging with CT abdomen and pelvis **and** chest X-ray every 6 months for the first 2 years, then every 12 months in years 3 and 4.
2. Classification pN2, N3 imaging with CT abdomen and pelvis **and** chest CT every 3 months in year 1, then every 6 months in years 2 to 4.
3. Inguinal region surveillance with CT (+ contrast) or MRI (+ contrast)

References: [2025 Penile Cancer Version 2.2025]

Prostate Cancer Surveillance

Prostate cancer active surveillance candidates repeat multiparametric MRI (mpMRI) pelvis every 12 months (or longer) when life expectancy is longer than 10 years
Active surveillance includes **ALL** of the following:

1. Prostate specific antigen (PSA) every 6 months or more
2. Digital rectal exam every 12 months or more
3. Repeat prostate biopsy every 2 to 5 years, but **NO** more often than 12 months or more
4. Repeat mpMRI pelvis every 12 months or more

Active surveillance candidates must have the following:

1. Life expectancy is 10 years or more.
2. Prostate cancer classification is very-low-risk, low risk or favorable intermediate-risk

References: [2025 Prostate Cancer Version 2.2025]

Rectal Cancer Surveillance

Rectal cancer surveillance includes **ANY** of the following: (*__NOTE__: *Routine CT scanning is **NOT** recommended beyond 5 years*.)

1. Non-operative management surveillance imaging includes **ALL** of the following:
    a. Computed tomography (CT) chest and abdomen every 6 to 12 months for a total of 5 years (*__NOTE__: *CT pelvis is included once MRI rectum has been exhausted*.)
    b. Magnetic resonance imaging (MRI) rectum every 6 months for up to 3 years
2. Operative management surveillance imaging includes **ANY** of the following:
    a. Endoscopic submucosal dissection (ESD) surveillance pelvis MRI (+ contrast) every 3 to 6 months for 2 years, then every 6 month up to year 5.
    b. Stage II and III surveillance imaging includes **ALL** of the following:
        i. Chest, abdomen and pelvis CT every 6 to 12 months for a total of 5 years.
        ii. Fluorodeoxyglucose-positron emission tomography (FDG-PET)/computed tomography (CT) is **NOT** recommended.
    c. Stage IV surveillance imaging includes **ALL** of the following:
        i. Chest, abdomen and pelvis CT every 3 to 6 months for 2 years, then every 6 to 12 months for a total of 5 years.
        ii. FDG-PET/CT scan is **NOT** recommended.
    d. Transanal local excision only, surveillance imaging includes pelvis MRI (+ contrast), every 3 to 6 months for the first 2 years, then every 6 months for a total of 5 years.

References: [2025 Rectal Cancer Version 2.2025]

Small Bowel Adenocarcinoma Surveillance

Small bowel adenocarcinoma surveillance (duodenum and jejunum/ilium) includes chest, abdominal and pelvic CT every 6 to 12 months for 2 years, then every 12 months for years 3 to 5. (*__NOTE__: *Fluorodeoxyglucose-positron emission tomography (FDG-PET)/computed tomography (CT) is **NOT** indicated.*)

References: [2025 Small Bowel Adenocarcinoma Version 3.2025]

Soft Tissue Sarcoma Surveillance

Soft tissue sarcoma surveillance includes **ANY** of the following: (*__NOTE__: *Use contrast imaging; for long term surveillance to minimize radiation exposure,MRI may be substituted.*)

1. Desmoid tumor (aggressive fibromatosis) imaging surveillance includes computed tomography (CT) or magnetic resonance imaging (MRI) every 3 to 6 months for 3 years, then every 6 to 12 months thereafter
2. Extremity, trunk or head and neck, for long-term follow-up with **ANY** of the following:
    a. Long-term follow-up with **ALL** of the following:
        i. Chest CT imaging (- contrast) to detect asymptomatic distant recurrence
        ii. MRI for imaging of primary site
    b. Stage I tumors and **ALL** of the following:
        i. Chest CT imaging (- contrast) every 6 to 12 months
        ii. Post-operative baseline and periodic imaging of primary site with MRI or CT if MRI is **contraindicated or unavailable**.
    c. Stage II and III tumors and **ANY** of the following:
        i. Baseline and periodic imaging of primary site
        ii. Chest and other known sites of metastatic disease imaging (CT [- contrast] or X-ray) every 2 to 6 months for 2 to 3 years, then every 6 months to complete a total of 5 years, then annually.
        iii. Post-operative reimaging to assess the primary tumor site and rule out metastatic disease (MRI or CT if MRI is **contraindicated or unavailable**.
3. Retroperitoneal/intra-abdominal, after management of primary disease imaging surveillance includes chest/abdomen/pelvis CT or MRI every 3 to 6 months for 3 years, then every 6 months for the next 2 years, then annually.

References: [2025 Soft Tissue Sarcoma Version 1.2025]

Testicular Cancer Surveillance

Testicular cancer surveillance includes **ANY** of the following: (*__NOTE__: *If a magnetic resonance imaging (MRI) is being considered instead of the abdomen/pelvis computed tomography [CT] [eg, CT **contraindicated**], MRI protocol should include **ALL** nodes needing assessment. The same imaging modality (CT or MRI) should be used throughout surveillance*.)

1. Nonseminoma stage I **WITHOUT** recurrence risk factors (eg, lymphovascular invasion, or an invasion spermatic cord or scrotum) for active surveillance with **ALL** of the following intervals:
    a. Abdomen ± pelvis CT (+ contrast) or MRI and the following intervals:
        i. 1st year every 4 to 6 months

ii. 2nd year every 6 months

iii. 3rd year annually

iv. 4th and 5th year as clinically indicated

b. Chest CT (+ contrast) (when thoracic symptoms are present) and the following intervals:

i. 1st year at 4 months and 12 months

ii. 2nd year, annually

iii. 3rd to 5th year, clinically as indicated

2. Nonseminoma stage I with recurrence risk factors (eg, lymphovascular invasion, or an invasion spermatic cord or scrotum) for active surveillance for **ALL** of the following:

a. Abdomen ± pelvis CT (+ contrast) or MRI and the following intervals:

i. 1st year every 4 months

ii. 2nd year every 4 to 6 months

iii. 3rd year every 6 months

iv. 4th year annually

v. 5th year clinically as indicated

b. Chest CT (+ contrast) (when thoracic symptoms are present) and the following intervals:

i. 1st year every 4 months

ii. 2nd year every 4 to 6 months

iii. 3rd year every 6 months

iv. 4th year annually

v. 5th year clinically as indicated

3. Nonseminoma stage IA/B after 1 cycle of adjuvant bleomycin, etopside, cisplatin (BEP) chemotherapy or primary retroperitoneal lymph node dissection (RPLND) surveillance and **ALL** of the following:

a. Abdomen ± pelvis CT (+ contrast) or MRI annually for the first 2 years, then clinically as indicated

b. Chest CT (+ contrast) (when thoracic symptoms are present) and the following intervals:

i. 1st year every 6 to 12 months

ii. 2nd year annually, then clinically as indicated

4. Nonseminoma stage II to III after complete response to chemotherapy ± post-chemotherapy RPLND surveillance for **ALL** of the following intervals:
   a. Abdomen ± pelvis CT (+ contrast) or MRI and the following intervals:
      i. 1st year every 4 to 6 months
      ii. 2nd year every 6 to 12 months
      iii. 3rd year annually
      iv. 4th and 5th year, clinically as indicated
   b. Chest CT (+ contrast) (when thoracic symptoms are present) and the following intervals:
      i. 1st year every 4 to 6 months
      ii. 2nd year every 6 to 12 months
      iii. 3rd to 5th years, clinically as indicated.
5. Nonseminoma pathologic stage IIA/B post primary RPLND and treated with adjuvant chemotherapy, surveillance with abdominal ± pelvic CT (+ contrast) or MRI 4 months after RPLND, then as clinically indicated, **AND** chest CT (+ contrast) (when thoracic symptoms are present) every 6 months for the 1st year then annually through year 5
6. Nonseminoma pathologic stage II A/B post-primary RPLND and **NOT** treated with adjuvant chemotherapy surveillance **ALL** of the following intervals:
   a. Abdomen ± pelvis CT (+ contrast) or MRI and the following intervals:
      i. 1st year, at 4 months
      ii. 2nd year annually with chest X-ray or chest CT (+ contrast) (when thoracic symptoms are present) every 3 to 6 months.
      iii. 3rd through 5th year clinically as indicated
   b. Chest CT (+ contrast) (when thoracic symptoms are present) and the following intervals:
      i. 1st year every 2 to 4 months
      ii. 2nd year every 3 to 6 months
      iii. 3rd through 5th year annually
7. Seminoma stage I surveillance after orchiectomy with chest CT (+ contrast) (for symptomatic patients), as clinically indicated **AND** abdomen ± pelvis CT (± contrast) or MRI (± contrast) for **ANY** of the following intervals:

a. 1st year, at 4 to 6 months and 12 months
b. 2nd year every 6 months
c. 3rd year, every 6 to 12 months
d. 4th and 5th year, every 12 to 24 months

8. Seminoma stage I seminoma surveillance after adjuvant treatment (chemotherapy or radiation) with chest CT (+ contrast) (in symptomatic patients) as clinically indicated **AND** abdomen ± pelvis CT (± contrast), annually for the first 3 years, then clinically as indicated for years 4 and 5

9. Seminoma stage IIA and non-bulky IIB seminoma surveillance after radiotherapy and/or post-chemotherapy with chest CT (+ contrast) (when thoracic symptoms are present) every 6 months for first 2 years, then clinically as indicated **AND** abdomen ± pelvis CT (+ contrast) or MRI and **ANY** of the following intervals:

a. 1st year, at 3 months and then 9 **OR** 12 months
b. 2nd and 3rdyear, annually
c. 4th and 5th year, clinically as indicated

10. Seminoma II, **NOT** treated with adjuvant chemotherapy and post-primary retroperitoneal lymph node dissection surveillance imaging with CT or MRI abdomen and pelvis and or chest CT (+ contrast) (when thoracic symptoms are present) and **ANY** of the following:

a. 1st year, every 4 months
b. 2nd year, every 6 months
c. 3rd year, annually
d. 4th and 5th year, clinically as indicated

11. Seminoma II, after adjuvant chemotherapy and post-primary retroperitoneal lymph node dissection surveillance imaging includes abdomen and pelvis CT or MRI and chest CT (+ contrast) (when thoracic symptoms are present) follow-up every 6 months for the 1st year, annually year 2, then clinically as indicated for years 3 to 5

12. Seminoma bulky stage IIB, IIC and III surveillance after chemotherapy, with for **ANY** of the following intervals: (***NOTE**: *Fluorodeoxyglucose (FDG) PET skull base to mid thigh as clinically indicated*)

a. CT or MRI of the abdomen and pelvis
    i. 1st year, every 4 months
    ii. 2nd year, every 6 months

iii. 3rd and 4th year, annually

iv. 5th year, clinically as indicated

b. Chest CT (+ contrast) (when thoracic symptoms are present) and the following intervals:

i. 1st year every 4 months

ii. 2nd year every 6 months

iii. 3rd to 5th year annually

13. Seminoma with residual mass larger than 3 cm, surveillance with a PET/CT scan from skull base to mid-thigh to delineate viable residual tumor (CT is **NOT** specific enough); if PET-negative following chemotherapy, surveillance with abdominal and pelvis CT (+ contrast) every 6 months for the 1st year, then annually thereafter.

References: [2025 Testicular Cancer Version 2.2025]

Uterine Neoplasm Surveillance

Uterine neoplasm surveillance includes **ANY** of the following:

1. Endometrial carcinoma surveillance includes **ANY** of the following:

a. Fertility-sparing treatment for **ANY** of the following:

i. Pelvic ultrasound for individuals with ovarian preservation

ii. Other imaging should be based on symptomatology and clinical concern for metastatic disease.

iii. Repeat pelvic magnetic resonance imaging (MRI) for individuals with persistent endometrial carcinoma after 6 to 9 months of **FAILED** medical therapy (eg, chemotherapy, radiation), especially if considering further fertility-sparing approaches.

b. Non–fertility-sparing treatment- Imaging should be guided by individual symptoms, risk assessment and clinical concern for recurrent or metastatic disease.

2. Uterine sarcoma surveillance imaging includes **ALL** of the following:

a. Abdominal/pelvic MRI and chest CT (- contrast), every 3 to 6 months for the first 3 years, then every 6 to 12 months for the next 2 years. (*__NOTE__: *Depending on histology grade and initial stage, use annual to biannual imaging thereafter, for up to an additional 5 years*.)

b. Chest/abdomen/pelvis computed tomography (CT) every 3 to 6 months for the first 3 years, then every 6 to 12 months for the next 2 years. (*__NOTE__: *Depending on*

histology grade and initial stage, use annual to biannual imaging thereafter, for up to an additional 5 years.)

c. Neck/chest/abdomen/pelvis/groin fluorodeoxyglucose (FDG)-positron emission tomography/CT (PET) if metastasis is suspected.

d. Additional imaging should be based on symptomatology and clinical concern for metastatic disease.

References: [2025 Uterine Neoplasms Version 3.2025]

Vaginal Cancer Surveillance section

Vaginal cancer surveillance includes fluorodeoxyglucose-positron emission tomography/computed tomography (FDG-PET/CT) of the pelvis 3 to 4 months after completion of radiation therapy, repeat clinically as indicated (MRI is used if FDG-PET/CT is **contraindicated or unavailable** or non-diagnostic or indeterminate).
References: [2025 Vaginal Cancer Version 5.2025]

Vulvar Cancer Surveillance

Vulvar cancer surveillance includes **ANY** of the following:

1. Vulvar cancer surveillance includes **ANY** of the following:
    a. Computed tomography (CT) chest, abdomen and pelvis or fluorodeoxyglucose-positron emission tomography (FDG-PET)/CT neck, chest, abdomen, pelvis and groin if recurrence or metastasis is suspected.
    b. FDG-PET/CT or pelvis magnetic resonance imaging (MRI) at 3 to 6 months to assess treatment response after definitive primary treatment
2. Vulvovaginal melanoma surveillance includes **ANY** of the following:
    a. CT pelvis every 3 to 12 months
    b. FDG-PET/CT in cases of high-risk disease, every 3 to 12 months

References: [2025 Vulvar Cancer Version 1.2025]

Wilms Tumor (Nephroblastoma) Surveillance

Wilms tumor (nephroblastoma) surveillance imaging includes chest and abdominal imaging every 3 months for 2 years, then every 6 months for 2 years (*__NOTE__: *Chest X-ray and abdominal ultrasound are used in place of cross sectional imaging with chest computed tomography [CT] and abdominal CT or magnetic resonance imaging [MRI]*)
References: [2025 Wilms Tumor (Nephroblastoma) Version 1.2025]

Blood/Bone Marrow Cancers Surveillance section

Acute Lymphoblastic Leukemia Surveillance

Acute lymphoblastic leukemia: No imaging surveillance suggested.
References: [2024 Acute Lymphoblastic Leukemia Version 3.2024]

Acute Myeloid Leukemia Surveillance reuse

Blastic plasmacytoid dendritic cell neoplasm surveillance includes a repeat PET/CT for individuals with prior evidence of extramedullary disease.
References: [2025 Acute Myeloid Leukemia (Age ≥18) Version 2.2025]

Chronic Lymphocytic Leukemia/Small Cell Lymphocytic Lymphoma Surveillance

Chronic lymphocytic leukemia/small cell lymphocytic lymphoma: No imaging surveillance suggested.
References: [2025 Chronic Lymphocytic Leukemia/Small Lymphocytic Leukemia Version 1.2025]

Chronic Myeloid Leukemia Surveillance

Chronic Myeloid Leukemia: No imaging surveillance suggested.
References: [2025 Chronic Myeloid Leukemia Version 3.2024]

Hairy Cell Leukemia Surveillance

Hairy cell leukemia: No imaging surveillance suggested.
References: [2025 Hairy Cell Leukemia Version 1.2025]

Multiple Myeloma Surveillance

Multiple myeloma surveillance includes **ANY** of the following:

1. Multiple myeloma, surveillance imaging when recurrence is suspected with **ANY** of the following:
    a. CT scan, low dose
    b. FDG PET/CT
    c. MRI (- contrast material), whole-body
2. Smoldering myeloma, surveillance imaging annually (or more often when recurrence is suspected) with **ANY** of the following:

a. CT scan, low dose

b. FDG PET/CT

c. MRI (- contrast material), whole-body

References: [2025 Multple Myeloma Version 2.2025]

CT Abdomen and Pelvis Summary of Changes

CT abdomen and pelvis guideline had the following version changes from 2024 to 2025:

- Added "Glomerular filtration rate" to "Renal impairment" under Contraindications
- Cancer indications condensed into more concise indications.
- Hematuria included in broader "Renal pathologies (hematuria, renal colic, complicated UTI) are suspected and ultrasound is non-diagnostic or indeterminate."
- Included in broader "Ultrasound is non-diagnostic or indeterminate" indication:
  - Hernia
  - Pancreatitis
- Infection/Inflammatory indications included in broader "Infection or inflammation for diagnosis of diverticulitis, inflammatory bowel disease and peritonitis." and "Inflammatory diseases, for evaluation of complications of Crohn's disease, ulcerative colitis and diverticulitis and symptoms are persistent **DESPITE** treatment."
- Removed "Retroperitoneal bleed or hematoma is suspected from recent trauma, based on physical findings and laboratory findings (hematocrit, hemoglobin)." as it is regarding trauma and guideline is for outpatient setting.
- Removed the following as current evidence no longer supports the indication:
  - Combination studies as they are redundant
  - "Fistula is known **OR** fistula recurrence is suspected, in the abdomen and pelvis." as this falls under the "Prior abdominal/pelvis ultrasound" indication
  - "Iliac vein compression" as this falls under the "Prior abdominal/pelvis ultrasound" indication
  - "Pelvic congestion syndrome" as this falls under the "Prior abdominal/pelvis ultrasound" indication
  - "Pheochromocytoma, for localization, with clear biochemical evidence (eg, abdominal and pelvic imaging)" as this falls under the "Prior abdominal/pelvis ultrasound" indication

- "Retroperitoneal fibrosis and **EITHER** of the following:" as this falls under the "Prior abdominal/pelvis ultrasound" indication
- "Varicocele, isolated on the right, for further evaluation with signs and symptoms suggestive of malignancy **OR** prior imaging is suspicious." as this falls under the "Prior abdominal/pelvis ultrasound" indication

CT Abdomen and Pelvis Procedure Codes

Table 1. CT Abdomen and Pelvis Associated Procedure Codes

CODE	DESCRIPTION
74176	Computed tomography, abdomen and pelvis; without contrast material
74177	Computed tomography, abdomen and pelvis; with contrast material(s)
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

CT Abdomen and Pelvis Definitions

Abscess is a swollen area within body tissue, containing an accumulation of pus.
Aneurysm refers to weakness in an artery wall, allowing it to abnormally balloon out or widen.
Anorexia is defined as a loss of appetite or an inability to eat, which can be secondary to various conditions such as depression, infection, cancer, or medication side effects.[1] Anorexia nervosa, on the other hand, is a complex psychological disorder characterized by restrictive eating leading to significantly low body weight, intense fear of gaining weight, and distorted body image.
Appendicitis is defined as acute inflammation of the vermiform appendix, which is a wormlike diverticulum originating at the base of the cecum.
B symptoms refer to systemic symptoms of fever, night sweats and weight loss which can be associated with both Hodgkin lymphoma and some non-Hodgkin lymphomas. The presence of B symptoms is a prognostic factor for some lymphomas.
Carcinoembryonic antigen (CEA) is a glycoprotein involved in intercellular adhesion, produced by columnar and goblet cells, and found in normal colonic mucosa, but overexpressed in various malignancies, particularly colorectal cancer.
Colonoscopy is a nonsurgical procedure used to examine the entire large intestine using a flexible fiberoptic endoscope, typically performed with sedation after adequate bowel preparation.
Complicated urinary tract infection (UTI)

I. **Women**: UTI is considered complicated in **ANY** of the following situations:
   A. Immunocompromised
   B. Multi-drug resistant bacteria

C. Persistence of bacteria or symptoms after culture specific treatment

D. Rapid recurrence with same bacteria after treatment

E. Suspicion of renal caliculi or obstruction

II. **Men**: Any UTI is considered complicated due to high likelihood of anatomic abnormalities

Computed tomography (CT) is an imaging test that uses X-rays to computer analysis to generate cross sectional images of the internal structures of the body that can be displayed in multiple planes.

Computed tomography angiography (CTA) is a medical test that combines a computed tomography (CT) scan with an injection of a special dye to produce pictures of blood vessels and tissues in a part of the body.

Computed tomography urography (CTU) is a imaging exam that evaluates the urinary tract system using contrast medium.

Computed tomography venography (CTV) is a technique targeted to assess venous anatomy, determine venous patency and delineate collateral circulation, often using contrast material.

C-reactive protein (CRP) is a pentameric protein synthesized by the liver, whose level rises in response to inflammation.

Creatinine is a waste product that comes from the digestion of protein in food and the normal breakdown of muscle tissue. It is removed from the blood through the kidneys.

Crohn's disease is chronic inflammation that typically involves the lower portion of the ileum, often spreads to the colon, and is characterized by diarrhea, cramping, loss of appetite and weight and the development of abscesses and scarring.

Cystoscopy is a rigid endoscope for inspecting and passing instruments into the urethra and bladder.

Dermatomyositis is a rare disease that causes muscle inflammation and skin rash. Symptoms include a red or purple rash on sun exposed skin and eyelids, calcium deposits under the skin, muscle weakness and trouble talking or swallowing.

Diverticulitis is inflammation of an abnormal pouch or sac opening from a hollow organ (such as the intestine or bladder).

Edema an abnormal infiltration and excess accumulation of serous fluid in connective tissue or in a serous cavity.

Endograft is a minimally invasive procedure helps protect the aneurysm by placing a stent directly inside the aneurysm, using a guide wire that is inserted into the groin. Once placed at the site of the aneurysm, the graft expands to seal the aneurysm and exclude it from circulation.

Endoscopy is a procedure that uses an endoscope to examine the inside of the body. An endoscope is a thin, tube-like instrument with a light and a lens for viewing. It may also have a tool to remove tissue to be checked under a microscope for signs of disease.

Endovascular aneurysm repair (EVAR) is a minimally invasive procedure that treats abdominal aortic aneurysms (AAAs). The procedure involves placing a stent-graft within the aorta to reduce the risk of rupture.

Erythrocyte sedimentation rate (ESR) is a blood test that measures the rate at which red blood cells settle at the bottom of a test tube over one hour, indicating the presence of inflammation in the body.

Fever of unknown origin is defined as a fever of 38.3°C (100.9°F) or higher on several occasions, persisting for at least 3 weeks despite thorough investigation, including at least three outpatient visits or three days in the hospital, without a definitive diagnosis.

Fibrosis is the pathological replacement of normal tissue architecture with rigid, collagen-rich connective tissue, leading to organ dysfunction.

Fistula is an abnormal connection between two epithelialized surfaces, often involving organs such as the gut, bladder, vagina, or skin, and can result from various causes including surgery, trauma, Crohn's disease, diverticular disease, or malignancy.

Gastroscopy , also known as an esophagogastroduodenoscopy (EGD), is a procedure that involves direct visualization of the upper gastrointestinal tract using a video gastroscope, and it can include tissue biopsy from suspicious areas.

Hematoma is a mass of usually clotted blood that forms in a tissue, organ or body space as a result of a broken blood vessel.

Hematuria is the presence of blood or blood cells in the urine. (*__NOTE__: *this is best determined by urinalysis as dipstick tests can be unreliable*.)

Hernia is a gap in the muscular wall that allows the contents inside the abdomen to protrude outward.

High-power field (HPF), in microscopy, is the area visible under the maximum magnification power of the objective.

Hydronephrosis is the dilation of the renal pelvis and calyces due to urine accumulation, which can result from various causes including obstruction, vesicoureteral reflux, or excessive urine production.

Iliac artery compression is a clinical syndrome of unilateral lower extremity swelling and pain due to venous hypertension caused by an iliac artery compressing an overlying iliac vein.

Incisional hernia is a hernia that develops along a prior surgical incision in the abdomen.

Indeterminate findings are inconclusive or insufficient for treatment planning.

Inflammatory bowel disease is a group of chronic inflammatory conditions that affect the gastrointestinal tract, primarily the intestines. The two main types of IBD are Crohn's disease and ulcerative colitis.

Ischemia is a deficient supply of blood to a body part (such as the heart or brain) due to obstruction of the inflow of arterial blood.

Kattan Nomogram is a commonly used pre-operative prediction tool used for estimating individualized risk of biochemical recurrence after radical prostatectomy. The nomogram can be found at: https://www.mskcc.org/nomograms/prostate

Kidney stones are hard, pebble-like pieces of material that form in one or both of the kidneys when high levels of certain minerals, like calcium, are in the urine.

Lithotripsy is a procedure that uses shock waves to break up stones in the kidney and parts of the ureter (tube that carries urine from the kidneys to the bladder). After the procedure, the tiny pieces of stones pass out of the body in the urine.

Lymphadenitis refers to the infection and inflammation of lymph nodes, often caused by bacterial or viral agents, and is characterized by painful, enlarged nodes with redness and warmth.

Magnetic resonance angiogram (MRA) is a test that uses a magnetic field and pulses of radio wave energy to provide images of blood vessels inside the body, allowing for evaluation of blood flow and blood vessel wall condition. MRA is used to look for aneurysms, clots, tears in the aorta, arteriovenous malformations and stenosis caused by plaque in the carotid arteries (neck) or blood vessels leading to the lungs, kidneys or legs.

Magnetic resonance venogram (MRV) is a diagnostic procedure that uses a combination of a large magnet, radiofrequencies, and a computer to produce detailed images of organs and structures within the body. An MRV uses magnetic resonance technology and intravenous (IV) contrast dye to visualize the veins. Contrast dye causes the blood vessels to appear opaque on the X-ray image, allowing the visualization the blood vessels being evaluated. MRV is useful in some cases because it can help detect causes of leg pain other than vein problems.

Mammogram is an X-ray of the breasts that can be used to screen for breast cancer or for diagnostic purposes. During a mammogram, the breasts are compressed between two firm surfaces to spread them out.

May-Thurner syndrome (iliac vein compression syndrome) is a condition where the left common iliac vein is compressed by the overlying right common iliac artery and the underlying vertebral body, leading to venous congestion and stasis, which predisposes to venous thromboembolism (VTE).

Memorial Sloan Kettering Cancer Center (MSKCC) nomograms are prediction tools designed to help patients and their physicians understand the nature of their prostate cancer, assess risk based on specific characteristics of a patient and his disease, and predict the likely outcomes of treatment. The nomograms can be located at: https://www.mskcc.org/nomograms/prostate

Mesenteric is a fold of membrane that attaches the intestine to the abdominal wall and holds it in place.

Mesenteric panniculitis (MP) is predominately a disease of the small bowel of unknown etiology. Characterized by fibrosis and chronic inflammation of fatty tissue of the mesentery in the small bowel.

Metastases is the spread of a disease-producing agency (such as cancer cells) from the initial or primary site of disease to another part of the body.
Necrosis is localized death of living tissue.
Non-diagnostic is a result that does not lead to a confirmed diagnosis.
Occult hernia or hidden hernia, also commonly referred to as an occult inguinal hernia, is an undetectable mass of herniated tissue.
Pancreatitis is an inflammatory condition of the pancreas that can be acute or chronic, leading to symptoms such as abdominal pain, nausea, and vomiting, and may result in complications like necrosis, fibrosis and organ failure.
Paraneoplastic syndrome is a group of rare disorders that are triggered by an abnormal immune system response to a cancerous tumors.
Pediatric approximate ages are defined by the US Department of Health (USDH), the Food and Drug Administration (FDA), and the American Academy of Pediatrics (AAP) as the following:

- Infancy, between birth and 2 years of age
- Childhood, from 2 to 12 years of age
- Adolescence, from 12 to 21 years of age, further defined by the AAP into:
    1. Early (ages 11–14 years)
    2. Middle (ages 15–17 years),
    3. Late (ages 18–21 years)
    4. Older ages may be appropriate for children with special healthcare needs.

Pelvic congestion syndrome occurs when varicose veins develop around the ovaries, similar to varicose veins that occur in the legs. The valves in the veins no longer function normally, which causes blood to back up. The veins become engorged or "congested", which can be very painful.
Peritonitis is inflammation of the smooth transparent serous membrane that lines the cavity of the abdomen of a mammal and is folded inward over the abdominal and pelvic viscera.
Pheochromocytoma is a small vascular tumor of the adrenal medulla, causing irregular secretions of epinephrine and norepinephrine, leading to attacks of raised blood pressure, palpitations and headaches.
Prostate specific antigen (PSA) is a protease (an enzyme that hydrolyzes proteins) secreted by epithelial cells of the prostate gland. PSA's concentration in blood serum tends to be proportional to the clinical stage of the disease, making it useful in detecting prostate cancer.
Pseudocyst is a fluid-filled cavity resembling a cyst but lacking a wall or lining.
Pyelonephritis is inflammation of both the lining of the renal pelvis and the parenchyma of the kidney, especially due to bacterial infection.
Recurrence is a new occurrence of something that happened or appeared before.

Renal colic is a sudden, acute pain in the kidney area caused by the obstruction of urine flow from the kidney to the bladder. Kidney stones are the most frequent cause of obstruction.
Retroperitoneal describes the area behind the smooth transparent serous membrane that lines the cavity of the abdomen.
Retroperitoneal bleed occurs when blood enters into space immediately behind the posterior reflection of the abdominal peritoneum. The organs of this space include the esophagus, aorta, inferior vena cava, kidneys, ureters, adrenals, rectum, parts of the duodenum, parts of the pancreas and parts of the colon.
Retroperitoneal fibrosis (RPF) occurs when extra fibrous tissue forms in the area behind the stomach and intestines. The tissue forms a mass (or masses) or tough fibrotic tissue. It can block the tubes that carry urine from the kidney to the bladder. The cause of this problem is mostly unknown.
Spigelian hernia is a rare ventral hernia that is defined as herniation of abdominal contents or peritoneum through a defect, namely the Spigelian fascia which is comprised of the transversus abdominis and the internal oblique aponeuroses.
Staging in cancer is the process of determining how much cancer is within the body (tumor size) and if it has metastasized (spread).
Stent is a small, narrow tube made of metal or plastic that is inserted into a hollow structure in the body to keep a passageway open.
Surveillance in cancer is the ongoing, timely and systematic collection and analysis of information on new cancer cases, extent of disease, screening tests, treatment, survival and cancer deaths.
Ulcerative colitis (UC) is a nonspecific inflammatory disease of the colon of unknown cause characterized by diarrhea with discharge of mucus and blood, cramping abdominal pain, inflammation and edema of the mucous membrane with patches of ulceration.
Ultrasound is the diagnostic or therapeutic use of ultrasound and especially a noninvasive technique involving the formation of images used for the examination and measurement of internal body structures and the detection of bodily abnormalities.
Umbilical hernia occurs when part of the intestine bulges through the opening in the abdominal muscles near the navel.
Ureteroscopy is a procedure to address kidney stones, and involves the passage of a small telescope, called a ureteroscope, through the urethra and bladder and up the ureter to the point where the stone is located.
Varicocele is abnormal dilation and enlargement of the scrotal venous pampiniform plexus which drains blood from each testicle.

CT Abdomen and Pelvis References

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Disclaimer section

Purpose

The purpose of the HealthHelp's clinical guidelines is to assist healthcare professionals in selecting the medical service that may be appropriate and supported by evidence to safely improve outcomes. Medical information is constantly evolving, and HealthHelp reserves the right to review

and update these clinical guidelines periodically. HealthHelp reserves the right to include in these guidelines the clinical indications as appropriate for the organization's program objectives. Therefore the guidelines are not a list of all the clinical indications for a stated procedure, and associated Procedure Code Tables may not represent all codes available for that state procedure or that are managed by a specific client-organization.

Clinician Review

These clinical guidelines neither preempt clinical judgment of trained professionals nor advise anyone on how to practice medicine. Healthcare professionals using these clinical guidelines are responsible for all clinical decisions based on their assessment. All Clinical Reviewers are instructed to apply clinical indications based on individual patient assessment and documentation, within the scope of their clinical license.

Payment

The use of these clinical guidelines does not provide authorization, certification, explanation of benefits, or guarantee of payment; nor do the guidelines substitute for, or constitute, medical advice. Federal and State law, as well as member benefit contract language (including definitions and specific contract provisions/exclusions) take precedence over clinical guidelines and must be considered first when determining eligibility for coverage. All final determinations on coverage and payment are the responsibility of the health plan. Nothing contained within this document can be interpreted to mean otherwise.

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National and Local Coverage Determination (NCD and LCD)

NOTICE
To ensure appropriate review occurs to the most current NCD and/or LCD, always defer to https://www.cms.gov/medicare-coverage-database/search.aspx.

Background

National Coverage Determinations (NCD) and Local Coverage Determinations (LCD) are payment policy documents outlined by the Centers for Medicare and Medicaid Services (CMS) and the government's delegated Medicare Audit Contractors (MACs) that operate regionally in jurisdictions.

CMS introduced variation between different jurisdictions/Medicare Audit Contractors (MACs) and their associated covered code lists with the transition to ICD 10. The variation resulted in jurisdictions independently defining how codes are applied for exclusions, limitations, groupings, ranges, etc. for the medical necessity indications outlined in the NCD and LCD. Due to this variation, there is an inconsistent use/application of codes and coverage determinations across the United States between the different MACs.

In addition, **WITHOUT** notice, CMS can change the codes that indicate medical necessity and the format of the coverage determinations/associated documents (eg, Articles). This is an additional challenge for organizations to keep up with ongoing, unplanned changes in covered codes and medical necessity indications.

Medical Necessity Codes

Due to the variation in code application between jurisdictions/MACs and that updates can happen without notification, HealthHelp is not able to guarantee full accuracy of the codes listed for any Coverage Determination, and advises that prior to use, the associated Coverage Determination Articles are reviewed to ensure applicability to HealthHelp's programs and any associated NCDs and LCDs.

For Internal Use Only:

11248 11249 11253 11282 11325 11328 11333 11349 11350 11351 11352 11354 11355 11356 11358 11359 11360 11361 11362 11365 11366 11367 11368 11369 11370 11374 11375 11394 11395 11396 11565