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2025 Computed Tomography (CT) Abdomen

Diagnostic Imaging

CT-Abdomen-HH

Last Review Date: 05/16/2025
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CT Abdomen Overview

The documents provide comprehensive guidelines for the use of computed tomography (CT) in diagnosing and managing abdominal conditions. Emphasis is placed on appropriate usage, contraindications and the integration of ultrasound and magnetic resonance imaging (MRI) as complementary modalities.

Role of Ultrasound

Ultrasound is prioritized as the initial imaging modality for many abdominal conditions due to its safety and cost-effectiveness. It avoids ionizing radiation, making it especially suitable for:

- Children and young adults: Reduces radiation exposure.
- Pregnant women: Safeguards against fetal radiation risks.

Key conditions where ultrasound is used:

- Renal pathologies: First-line imaging for renal colic and kidney stones.
- Hernias and abscesses: Evaluates hernia complications and localized abscesses.
- Cancer surveillance: Applied in hepatocellular carcinoma and lymph node assessments.

When ultrasound findings are non-diagnostic or indeterminate, CT or MRI is recommended.

Pediatric Considerations for Computed Tomography

While computed tomography (CT) is used in children, magnetic resonance imaging (MRI) or ultrasound is preferred for initial evaluation to minimize radiation exposure. CT is reserved for complex cases where detailed imaging is required. By integrating ultrasound and adhering to these guidelines, healthcare providers can optimize diagnostic accuracy while minimizing risks associated with radiation.

Recommendations for CT imaging include **ALL** of the following:

1. Ultrasound first: Utilize ultrasound as the initial modality where appropriate.
2. CT for complex cases: Reserve CT for when ultrasound or MRI is inadequate.
3. Adhere to guidelines: Follow established protocols to ensure safety and efficacy.
4. Minimize radiation exposure: Especially important for children, young adults and pregnant women.

Computed Tomography (CT) Abdomen

CT Abdomen Related National Coverage Determination (NCD)/ Local Coverage Determination (LCD)

Please refer to https://www.cms.gov/medicare-coverage-database/search.aspx if applicable to the individual's health plan membership.

Type/ID Number	Title
NCD 220.1	Computed Tomography
LCD 34415	CT of the Abdomen and Pelvis
LCD 35391	Multiple Imaging in Oncology

Clinical Judgment

These medical policies are designed to provide clinical guidance and do not supplant a provider's independent professional judgment. Physicians retain full and independent authority to determine appropriate care based on each patient's individual clinical circumstances. Although services may be subject to documentation requirements, medical necessity review, or coverage limitations, nothing in this policy is intended to restrict or interfere with a physician's independent medical judgment.

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)
   References: [2025 ACR Manual on Contrast Media]
2. Pregnancy
   References: [2025 ACR Manual on Contrast Media]
3. Renal impairment (glomerular filtration rate [GFR] is less than 30 ml/min/1.73 m^2.)
   References: [2025 ACR Manual on Contrast Media]

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.

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CT Abdomen Guideline

(*__NOTE__: *For syndromes for which imaging starts in the pediatric individual, use magnetic resonance imaging [MRI].*)
(*__NOTE__: *Aneurysm for diagnosis and monitoring is completed with CT angiography [CTA] or magnetic resonance angiography [MRA] See CTA or MRA Abdomen and Pelvis guidelines*)
References: [2] [3]
Computed tomography (CT) of the abdomen is considered medically appropriate when the documentation demonstrates **ANY** of the following:

1. Cancer is suspected or known for **ANY** of the following:
    a. Cancer screening. (See the **National Comprehensive Cancer Network [NCCN] Guidelines** for more information.)
    b. Recurrence or metastasis is suspected based on new symptoms or abnormal physical exam.
    c. Staging, restaging and surveillance following the NCCN Guidelines recommended schedule. (See the **National Comprehensive Cancer Network [NCCN] Guidelines** for more information.)

    References: [6] [4]
2. Infection or inflammatory disease, limited to the abdomen, is suspected or known, for **ANY** of the following:
    a. Biliary disease, Crohn's disease, pancreatitis or ulcerative colitis complication evaluation and symptoms are persistent (10 days or more) (eg, cramping, diarrhea, pain).
    b. Inflammatory disease or peritonitis is suspected (eg, abdominal distention, pain, rigidity) for diagnosis.

    References: [5]
3. Pain in the abdomen is known, with unknown diagnosis/etiology, and **ANY** of the following:
    a. Age over 65 years old **AND** abdominal pain is acute (initial diagnosis, up to 4 weeks).
    b. Initial workup is non-diagnostic or indeterminate. (***NOTE:** *initial workup must include: imaging [eg, 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: [10] [8]

4. Peri-procedural care to guide invasive procedure planning **OR** post-operative follow-up.
5. Prior abdominal ultrasound is non-diagnostic or indeterminate.
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.*)
7. Trauma, blunt, to the abdomen is known (based on mechanism of injury) and complications are suspected (eg, hemorrhage, organ laceration, peritonitis)
   References: [9]
8. 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).
   References: [7]

Combination CT and MRI for Metastases Evaluation Guideline

Combination CT/MRI studies (5 or less concurrent studies, with a CT or MRI appropriate for cancer location: abdomen, brain, cervical spine, chest, lumbar spine, neck, pelvis and/or thoracic spine) for **ANY** of the following situations:

1. Staging evaluation, for baseline pre-therapy
2. Surveillance following the National Comprehensive Cancer Network (NCCN) Guidelines recommended schedule (*See **Surveillance** section*)

Abdomen Surveillance section

Ampullary Adenocarcinoma Surveillance

Ampullary Adenocarcinoma: No imaging surveillance suggested.
References: [2025 Ampullary Adenocarcinoma Version 2.2025]

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 1.2026]

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. 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

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

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]

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.

[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).

3. Gastrointestinal tract (well-differentiated grade 1/2), lung and thymus imaging and **ANY** of the following:
    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.

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

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 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 3.2025]

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]

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]

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 1.2026]

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 1.2026]

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 Summary of Changes

CT Abdomen guideline had the following version changes from 2024 to 2025:

Table 1. 2025 CT Abdomen Summary of Changes

Date	Type of Change	Summary
05/16/2025	Annual	• Added the following to keep in line with current evidence: ▪ "Glomerular filtration rate" to "Renal impairment" under Contraindications ▪ "Note: Aneurysm" per ACR ▪ "Prior abdominal ultrasound is non-diagnostic or indeterminate" as less advanced imaging is more appropriate ▪ "Renal pathologies" per ACR ▪ "Trauma, blunt" per ACR ▪ "Weight loss occurred" per EBM • Changed "Cancer" criteria for more clarity • Changed wording of criteria under "Infection or inflammation" and removed "Endoscopy" criteria as ultrasound is more appropriate • 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" as this falls under the "Prior abdominal ultrasound" indication ▪ From under "Infection or inflammatory disease" as this falls under the "Prior abdominal ultrasound" indication ◦ "Fluid collection is abnormal, limited to abdomen" as this falls under the "Prior abdominal ultrasound" indication ◦ "Infection is known and abscess" as this falls under the "Prior abdominal ultrasound" indication ▪ "Hernia is suspected or known" as this falls under the "Prior abdominal ultrasound" indication ▪ "Mass, pelvic, is suspected" from under "Cancer" as this fall under the "Prior pelvis ultrasound" indication ▪ "Organ evaluation **OR** previous organ imaging is non-diagnostic or indeterminate and **ANY** of the following" as this falls under the "Prior abdominal ultrasound" indication

CT Abdomen Procedure Codes

Table 1. CT Abdomen Associated Procedure Codes

CODE	DESCRIPTION
74150	Computed tomography, abdomen; without contrast material
74160	Computed tomography, abdomen; with contrast material(s)

CODE	DESCRIPTION
74170	Computed tomography, abdomen; without contrast material, followed by contrast material(s) and further sections

CT Abdomen Definitions

Abscess is a swollen area within body tissue, containing an accumulation of pus.
Adenoma describes a benign tumor or a glandular structure or of glandular origin.
Adrenal glands, also known as suprarenal glands, are small, triangular-shaped glands located on top of both kidneys. Adrenal glands produce hormones that help regulate your metabolism, immune system, blood pressure, response to stress and other essential functions.
Alanine Transaminase (ALT) is an enzyme which promotes transfer of an amino group from glutamic acid to pyruvic acid and when present in abnormally high levels in the blood is a diagnostic indication of liver disease or damage.
Alkaline phosphatase (ALP) refers to any of the phosphatases that are optimally active in alkaline medium and occur in especially high concentrations in bone, the liver, the kidneys and the placenta. It is commonly used to diagnose liver damage or bone disorders.
Alpha-fetoprotein (AFP) is a fetal blood protein present abnormally in adults with some cancers (as of the liver) and normally in the amniotic fluid of pregnant women with high or low levels tending to be associated with certain birth defects (such as spina bifida or Down syndrome).
Amylase is an enzyme, or special protein, that helps digest carbohydrates. Most of the amylase in the body is made by the pancreas and salivary glands. A small amount of amylase in the blood and urine is normal.
Aneurysm refers to weakness in an artery wall, allowing it to abnormally balloon out or widen.
Angiomyolipoma is a benign (noncancer) tumor of fat and muscle tissue that usually is found in the kidney. Angiomyolipomas rarely cause symptoms, but may bleed or grow large enough to be painful or cause kidney failure.
Beckwith-Wiedemann syndrome (BWS) is an inherited disease that is present at birth and is characterized especially by abdominal wall defects, increased birth weight, enlarged tongue, hypoglycemia, tumors usually of embryonic origin and enlargement of internal organs.
Biliary disease refers to conditions affecting the gallbladder, bile ducts and other structures involved in the production and flow of bile.
Bilirubin is a yellowish pigment that is produced when red blood cells break down. It is an important metabolite of heme, which coordinates iron in proteins.
Biochemical profile is a series of blood tests used to evaluate the functional capacity of several critical organs and systems, such as the liver and kidneys.
Bosniak Classification System is a system for classifying renal cystic masses based on imaging characteristics on contrast-enhanced computed tomography (CT). The classification system helps predict a risk of malignancy and suggests either follow up or treatment.

The Bosniak classification system divides renal cystic masses into five categories:

- Bosniak I:
  - Simple, benign cyst with imperceptible, rounded wall
  - ~0% malignant
  - **NO** follow-up required
- Bosniak 2:
  - Minimally complex
    - Few thin septa or calcifications
    - Non-enhancing attenuation
    - Renal lesions less than 3 cm
    - Well marginated
  - ~0% malignant
  - **NO** follow-up required
- Bosniak 2F:
  - Minimally complex
    - Hyperdense cyst greater than 3 cm diameter, mostly intrarenal (less than 25% of wall visible); no enhancement
    - Increased number of septa, minimally thickened with nodular or thick calcifications
    - Perceived (but not measurable) enhancement of a hairline-thins, mooth septa
  - ~5% malignant
  - Ultrasound/CT follow-up at 6 months
- Bosniak 3: Considered to have a malignancy risk greater than 80% and surgical excision is recommended in able-bodied patients.
  - Indeterminate with thick, nodular multiple septa or wall with measurable enhancement, hyperdenseon CT
  - ~55% malignant
  - Partial nephrectomy or radiofrequency ablation in elderly or poor surgical candidates
- Bosniak 4: Defined by their degree of complexity

- Clearly malignant; solid mass with large cystic or necrotic component
- ~100% malignant
- Partial or total nephrectomy

Cancer Antigen (CA) 19-9 is a tumor marker that can indicate advanced pancreatic cancer. It's also associated with cancers in the colon, stomach and bile duct.
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.
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.
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.
Cyst is a closed sac having a distinct membrane and developing abnormally in a cavity or structure of the body.
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.
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.
Focal nodular hyperplasia (FNH) is a benign tumor or lesion that forms in the liver.
Glomerular filtration rate (GFR) is a blood test used to check how well the kidneys are working by estimating how much blood passes through the glomeruli (tiny filters in the kidneys that filter waste from the blood) each minute.
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*.)
Hepatitis inflammation of the liver tissue, which can be caused by various factors including viral infections, alcohol consumption, certain drugs, autoimmune diseases, and fatty liver disease.
Hepatoma also known as hepatocellular carcinoma (HCC), is a malignant epithelial neoplasm originating in the liver, characterized by hepatic differentiation and often associated with cirrhosis or chronic viral hepatitis.
Hernia is a gap in the muscular wall that allows the contents inside the abdomen to protrude outward.

Idiosyncratic refers to an unusual or unexpected individual response to a substance, particularly a drug, that is not shared by most people and is not related to the drug's intended pharmacological effect.
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.
Insulinoma is a usually benign insulin-secreting tumor of the islets of Langerhans (one of the clusters of small slightly granular endocrine cells that form anastomosing trabeculae among the tubules and alveoli of the pancreas and secrete insulin and glucagon).
Intraductal papillary mucinous neoplasm (IPMN) is a type of pancreatic cystic lesion that produces mucin and has the potential to transform into pancreatic cancer.
Jaundice is the yellow-orange discoloration of the skin, conjunctivae, and mucous membranes due to elevated plasma bilirubin levels, typically becoming evident at plasma bilirubin levels greater than 3 to 4 mg/dL.
Lipase is a digestive enzyme that breaks down fats during digestion. It is produced in the pancreas, mouth and stomach.
Liver function tests (LFT) are blood tests that measure different enzymes, proteins and other substances (eg, alanine transaminase [ALT], aspartate transaminase [AST], serum bilirubin) made by the liver.
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 cholangiopancreatography (MRCP) is a type of MRI scan that uses computer software to create images of the pancreatic and bile ducts. It can also be used to see pancreatic cysts and blockages in the ducts.
Magnetic resonance enterography (MRE) is a type of magnetic resonance imaging (MRI) that uses a contrast material to produce detailed images of the small intestine and bowel.
Magnetic resonance imaging (MRI) is a non-invasive diagnostic technique that produces computerized images of internal body tissues and is based on nuclear magnetic resonance of atoms within the body induced by the application of radio waves.
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.
Mucinous cystic neoplasm (MCN) is a usually large uni- or multilocular thick-walled cyst, most often filled with mucinous fluid, but may also have a hemorrhagic or serous content.
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.
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:

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

Peutz-Jeghers syndrome (PJS) is a familial polyposis inherited as an autosomal dominant trait that is characterized by numerous polyps in the stomach, small intestine and colon along with melanin-containing spots on the skin and mucous membranes especially the lips and gums.
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.
Polycystic kidney disease (PKD) is a genetic disorder that causes fluid-filled cysts to grow in the kidneys. The cysts can grow very large and cause the kidneys to enlarge and lose function. PKD cysts can reduce kidney function and lead to kidney failure.
Pseudocyst is a fluid-filled cavity resembling a cyst but lacking a wall or lining.
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.
Renal impairment is a condition in which the kidneys stop working and are not able to remove waste and extra water from the blood or keep body chemicals in balance.
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).

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.
Total Kidney Volume (TKV) is the sum of the volume of the left and right kidneys. It is the primary measure of kidney growth and can provide information on disease status and progression.
Tuberous sclerosis is a genetic disorder of the skin and nervous system that is characterized by the formation of small benign tumors in various organs (such as the brain, kidney, eye and heart), is accompanied by variable symptoms including seizures, developmental delay or intellectual disability, skin lesions (as hypopigmented macules of the trunk and limbs or telangiectatic facial papules) and is inherited as an autosomal dominant trait or results from spontaneous mutation.
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.
Von Hippel-Lindau disease is a rare genetic disease that is characterized by hemangiomas of the retina and cerebellum, cysts or tumors of the central nervous system, pancreas, kidneys, adrenals and reproductive organs that is typically inherited as an autosomal dominant trait.

CT Abdomen 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

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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:

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