

# Molina Clinical Policy

## Abdomen Pelvis CT: Policy No. 638

Last Approval: 12/8/2021

Next Review Due By: December 2022



### DISCLAIMER

This Molina Clinical Policy (MCP) is intended to facilitate the Utilization Management process. Policies are not a supplementation or recommendation for treatment; Providers are solely responsible for the diagnosis, treatment and clinical recommendations for the Member. It expresses Molina's determination as to whether certain services or supplies are medically necessary, experimental, investigational, or cosmetic for purposes of determining appropriateness of payment. The conclusion that a particular service or supply is medically necessary does not constitute a representation or warranty that this service or supply is covered (e.g., will be paid for by Molina) for a particular Member. The Member's benefit plan determines coverage – each benefit plan defines which services are covered, which are excluded, and which are subject to dollar caps or other limits. Members and their Providers will need to consult the Member's benefit plan to determine if there are any exclusion(s) or other benefit limitations applicable to this service or supply. If there is a discrepancy between this policy and a Member's plan of benefits, the benefits plan will govern. In addition, coverage may be mandated by applicable legal requirements of a State, the Federal government or CMS for Medicare and Medicaid Members. CMS's Coverage Database can be found on the CMS website. The coverage directive(s) and criteria from an existing National Coverage Determination (NCD) or Local Coverage Determination (LCD) will supersede the contents of this MCP and provide the directive for all Medicare members. References included were accurate at the time of policy approval and publication.

### OVERVIEW

CT scans use X-ray technology and advanced computer analysis to create detailed pictures of your body. A CT scan of the abdomen and pelvis can help diagnose problems in the bladder, uterus, prostate, liver or bowels.

### COVERAGE POLICY

Abdomen Pelvis CT **may be considered medically necessary** when the following criteria are met:

#### 1. Chronic Abdominal/Pelvic Pain

The initial evaluation of abdominal pain consists of a detailed history and physical examination, appropriate laboratory studies, and frequently non-advanced imaging such as x-ray or ultrasound. The presence of certain "red flags" may preclude the initial performance of non-advanced imaging. In some cases, endoscopy may be the preferred study. In children under the age of 14, ultrasound should be the initial study performed for evaluation of abdominal pain.

For most clinical conditions, imaging of both the abdomen and pelvis is warranted. Imaging can be limited to part of the abdominal cavity for follow-up of specific organs or when the pathologist has localized imaging to a particular region of the abdominal cavity. A patient's exposure to ionizing radiation can be limited in these instances.

Location	Recommendations (Male)
Generalized	Initial ultrasound
Right Upper Quadrant	Initial ultrasound
Left Upper Quadrant	Consider ultrasound and/or evaluate for possible gastric causes
Left Lower Quadrant	CT if concern for conditions listed below
Right Lower Quadrant	Advanced imaging if other criteria are met.

Location	Recommendations (Female)
Generalized	Initial ultrasound
Right Upper Quadrant	Initial ultrasound
Left Upper Quadrant	Consider ultrasound and/or evaluate for possible gastric causes
Left Lower Quadrant	Initial pelvic ultrasound
Right Lower Quadrant	Initial pelvic ultrasound

OR

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**2. Kidney Stones (Suspected)**

- a. Flank pain and +/- hematuria.

**OR**

**3. Kidney Stones (Known or Follow Up)**

- a. If initial x-ray (KUB) or ultrasound is indeterminate.

**OR**

- 4. **Asymptomatic Microscopic Hematuria (AMH)** is only diagnosed by microscopy; a dipstick reading suggestive of hematuria should not lead to imaging or further investigation without confirmation of three or greater red blood cells per high power field.)

**OR**

**5. Known Tumor or Mass (limited to the upper abdominal cavity only [e.g., liver, kidney, adrenal])**

- a. Initial evaluation of a recently diagnosed cancer
- b. Follow up of a known tumor or mass after completion of treatment or with new signs/symptoms.
- c. Surveillance of a known tumor or mass according to accepted clinical standards.
- d. For initial staging of prostate cancer with a PSA of 20 or higher or a Gleason score of 7 or higher.

**OR**

**6. Suspected Tumor or Mass Not Confirmed as Cancer**

- a. Evaluation of an abnormality seen on x-ray or other imaging.
- b. Evaluation of an abnormality on physical examination and initial evaluation with x-ray or ultrasound has been completed.

**OR**

**7. Infection Suspected**

- a. Appendicitis, acute abdominal pain with at least one of the following:
  - Nausea/vomiting; **OR**
  - Fever of at least 100.3 or higher; **OR**
  - Abdominal rigidity, guarding/rebound tenderness, or other peritoneal signs; **OR**
  - Elevated white blood cell count (WBC).
- b. Diverticulitis including complication with severe abdominal tenderness or mass, not responding to antibiotics.
- c. Abscess (limited to the upper abdominal cavity only [e.g., liver, kidney, adrenal])
- d. Any known infection that is clinically suspected to have created an abscess.
- e. Re-evaluation of an abscess after treatment.

**OR**

**8. Fistula**

- a. Evaluation of a known or suspected fistula.

**OR**

**9. Inflammation**

- a. Suspected pancreatitis (new or recurrent) with abnormal amylase or lipase or severe focal pain.
- b. Known pancreatitis and concern for pseudocyst formation.
- c. Suspected inflammatory bowel disease (new or recurrent) with abdominal pain, persistent diarrhea or bloody diarrhea (abdomen / pelvic CT is recommended).

**OR**

**10. Trauma**

- a. Suspected abdominal or retroperitoneal hemorrhage.

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### 11. Vascular Disease (aneurysm, etc.)

- a. Vascular abnormality seen and indeterminate on other imaging studies.
- b. Aortic aneurysm and ultrasound is indeterminate or this is for preoperative planning.
- c. Follow up after endograph repair and CTA is not also ordered.

OR

### 12. Weight Loss

- a. Unintentional weight loss of 5% of body weight persisting for 6 months with initial evaluation of a chest x-ray, ultrasound, laboratory testing including TSH, and colon cancer screening (if over 50 years old) completed.
- b. Loss of 10% of body weight in less than 2 months with at least one MD visit documenting weight loss.

OR

### 13. Other

- a. Evaluation of an abnormality seen on other imaging and the diagnosis remains uncertain.
- b. For evaluation of a known or suspected ventral or incisional hernia.
- c. High Risk – any patient over 75 years of age or diabetic with persisting pain (not intermittent only).
- d. CT enterography for evaluation of known inflammatory bowel disease.

### Pre / Post-Procedural

- Pre-operative evaluation.
- Post-operative for routine recommended follow up or for potential post-operative complications.
- A repeat study may be needed to help evaluate a patient's progress after treatment procedure intervention or surgery. The reason for the repeat study and that it will affect care must be clear.

### Additional Critical Information

The above medical necessity recommendations are used to determine the best diagnostic study based on a Member's specific clinical circumstances. The recommendations were developed using evidence-based studies and current accepted clinical practices. Medical necessity will be determined using a combination of these recommendations as well as the Member's individual clinical or social circumstances.

- Tests that will not change treatment plans should not be recommended.
- Same or similar tests recently completed need a specific reason for repeat imaging.

**DOCUMENTATION REQUIREMENTS.** Molina Healthcare reserves the right to require that additional documentation be made available as part of its coverage determination; quality improvement; and fraud; waste and abuse prevention processes. Documentation required may include, but is not limited to, patient records, test results and credentials of the provider ordering or performing a drug or service. Molina Healthcare may deny reimbursement or take additional appropriate action if the documentation provided does not support the initial determination that the drugs or services were medically necessary, not investigational or experimental, and otherwise within the scope of benefits afforded to the member, and/or the documentation demonstrates a pattern of billing or other practice that is inappropriate or excessive.

## CODING & BILLING INFORMATION

### CPT Codes

CPT	Description
74176	CT abdomen / pelvis without contrast
74177	CT abdomen / pelvis with contrast
74178	CT abdomen / pelvis without and with contrast

**CODING DISCLAIMER.** Codes listed in this policy are for reference purposes only and may not be all-inclusive. Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement. Listing of a service or device code in this policy does not guarantee coverage. Coverage is determined by the benefit document. Molina adheres to Current Procedural Terminology (CPT®), a registered trademark of the American Medical Association (AMA). All CPT codes and descriptions are copyrighted by the AMA; this information is included for informational purposes only. Providers and facilities are expected to utilize industry standard coding practices for all submissions. When improper billing and coding is not followed, Molina has the right to reject/deny the claim and recover claim payment(s). Due to changing industry practices, Molina reserves the right to revise this policy as needed.

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### APPROVAL HISTORY

**12/8/2021** Policy reviewed; clarified clinical parameters for hematuria; updated references.  
**Review Dates** 12/19/2018, 12/10/2019, 12/9/2020  
**9/19/2017** New policy.

### REFERENCES

1. Penner RM, Fishman MB. Evaluation of the adult with abdominal pain. <http://www.uptodate.com>. Updated May 10, 2021. Accessed October 11, 2021. Registration and login required.
2. American College of Radiology (ACR). ACR appropriateness criteria. <https://www.acr.org/Clinical-Resources/ACR-Appropriateness-Criteria>. Accessed October 11, 2021.
3. American Urological Association Education and Research, Inc. Guideline for the management of clinically localized prostate cancer. <https://www.auanet.org/documents/education/clinical-guidance/Prostate-Cancer.pdf>. Updated 2007. Accessed October 11, 2021.
4. Jaffe TA, Gaca AM, Delaney S, Yoshizumi TT, Toncheva G, Nguyen G, Frush DP. Radiation doses from small-bowel follow through and abdominopelvic MDCT in Crohn's disease. *AJR Am J Roentgenol*. 2007 Nov;189(5):1015-22. doi: 10.2214/AJR.07.2427. Accessed October 11, 2021.
5. Hirsch AT, Haskal ZJ, Hertzner NR, Bakal CW, Creager MA, Halperin JL, et al. ACC/AHA 2005 guidelines for the management of patients with peripheral arterial disease (lower extremity, renal, mesenteric, and abdominal aortic): A collaborative report from the American Association for Vascular Surgery/Society for Vascular Surgery, Society for Cardiovascular Angiography and Interventions, Society for Vascular Medicine and Biology, Society of Interventional Radiology, and the ACC/AHA Task Force on Practice Guidelines (Writing Committee to Develop Guidelines for the Management of Patients With Peripheral Arterial Disease) endorsed by the American Association of Cardiovascular and Pulmonary Rehabilitation; National Heart, Lung, and Blood Institute; Society for Vascular Nursing; TransAtlantic Inter-Society Consensus; and Vascular Disease Foundation. *Circulation*. 2006 Mar 21;113(11):e463-654. doi: 10.1161/CIRCULATIONAHA.106.174526. Accessed October 11, 2021.
6. Israel GM, Francis IR, Roach M III, Abdel-Wahab M, Casalino, DD, et al. (2017). Expert Panel on Urologic Imaging and Radiation Oncology-Prostate. ACR Appropriateness Criteria® pretreatment staging prostate cancer. American College of Radiology (ACR). Available [here](https://www.acr.org/Clinical-Resources/ACR-Appropriateness-Criteria).
7. Fenlon HM, Nunes DP, Schroy PC III, et al. A comparison of virtual and conventional colonoscopy for the detection of colorectal polyps. *N Engl J Med*. 1999 Nov 11;341(20):1496-503. doi: 10.1056/NEJM199911113412003. Accessed October 11, 2021.
8. Bouras EP, Lange SM, Scolapio JS. Rational approach to patients with unintentional weight loss. *Mayo Clin Proc*. 2001 Sep;76(9):923-9. doi: 10.4065/76.9.923. Accessed October 11, 2021.
9. Talley NJ, Vakil N, Practice Parameters Committee of the American College of Gastroenterology. Guidelines for the management of dyspepsia. *Am J Gastroenterol*. 2005 Oct;100(10):2324-37. doi: 10.1111/j.1572-0241.2005.00225.x. Accessed October 11, 2021.
10. McNamara MM, Lalani T, Camacho MA, Carucci LR, Cash BD, Expert Panel on Gastrointestinal Imaging, et al. ACR appropriateness criteria: Left lower quadrant pain – suspected diverticulitis. *J Am Coll Radiol*. 2019 May;16(5S):S141-S149. doi: 10.1016/j.jacr.2019.02.015. Accessed October 11, 2021.
11. Fulgham PF, Assimos DG, Pearle MS, Preminger GM. Clinical effectiveness protocols for imaging in the management of ureteral calculus disease: AUA technology assessment. *J Urol*. 2013 Apr;189(4):1203-13. doi: 10.1016/j.juro.2012.10.031. Accessed October 11, 2021.
12. Lakkaraju A, Sinha R, Garikipati R, Edward S, Robinson P. Ultrasound for initial evaluation and triage of clinically suspicious soft-tissue masses. *Clin Radiol*. 2009; 64: 615-621. <https://doi.org/10.1016/j.crad.2009.01.012>. Accessed October 11, 2021.
13. Song JH, Chaudry FS, Mayo-Smith WW. The incidental indeterminate adrenal mass on CT (> 10 H) in individuals without cancer: Is further imaging necessary? Follow-up of 321 consecutive indeterminate adrenal masses. *AJR Am J Roentgenol*. 2007 Nov;189(5):1119-23. doi: 10.2214/AJR.07.2167. Accessed October 11, 2021.
14. Song JH, Chaudry FS, Mayo-Smith WW. The incidental adrenal mass on CT: Prevalence of adrenal disease in 1,049 consecutive adrenal masses in individuals with no known malignancy. *AJR Am J Roentgenol*. 2008 May;190(5):1163-8. doi: 10.2214/AJR.07.2799. Accessed October 11, 2021.
15. Zhang BH, Yang BH, Tang ZY. Randomized controlled trial of screening for hepatocellular carcinoma. *J Cancer Res Clin Oncol*. 2004 Jul;130(7):417-22. doi: 10.1007/s00432-004-0552-0. Accessed October 11, 2021.
16. Expert Panel on Gastrointestinal Imaging, Porter KK, Zaheer A., Kamel IR, Horowitz JM, et al. ACR appropriateness criteria acute pancreatitis. *J Am Coll Radiol*. 2019 Nov;16(11S):S316-S330. doi: 10.1016/j.jacr.2019.05.017. Accessed October 11, 2021.
17. Cohen RA, Brown RS. Clinical practice: Microscopic hematuria. *N Engl J Med*. 2003 Jun 5;348(23):2330-8. doi: 10.1056/NEJMcp012694. Accessed October 11, 2021.
18. Martin SG, Chen RC, Crispino T, Freedland S, Greene K, Klotz LH, et al. Clinically localized prostate cancer: AUA/ASTRO/SUO guideline. <https://www.guidelinecentral.com/summaries/clinically-localized-prostate-cancer-uaaastrosuo-guideline/#section-society>. Published 2017. Accessed October 11, 2021.

### APPENDIX

**Reserved for State specific information. Information includes, but is not limited to, State contract language, Medicaid criteria and other mandated criteria.**