Local Coverage Determination (LCD):
Computed Tomography of the Abdomen and Pelvis (L33284)

Contractor Information

<table>
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<tr>
<th>Contractor Name</th>
<th>Contract Type</th>
<th>Contract Number</th>
<th>Jurisdiction</th>
<th>State(s)</th>
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<tr>
<td>First Coast Service Options, Inc.</td>
<td>A and B MAC</td>
<td>09101 - MAC A</td>
<td>J - N</td>
<td>Florida</td>
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<td>Puerto Rico, Virgin Islands</td>
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LCD Information

Document Information

LCD ID
L33284

Original ICD-9 LCD ID
L28806

LCD Title
Computed Tomography of the Abdomen and Pelvis

Proposed LCD in Comment Period
N/A

Source Proposed LCD
N/A

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CMS National Coverage Policy

Language quoted from CMS National Coverage Determinations (NCDs) and coverage provisions in interpretive manuals are italicized throughout the Local Coverage Determination (LCD). NCDs and coverage provisions in interpretive manuals are not subject to the LCD Review Process (42 CFR 405.860[b] and 42 CFR 426 [Subpart D]). In addition, an administrative law judge may not review an NCD. See § 1869 (f)(1)(A)(i) of the Social Security Act.

Unless otherwise specified, italicized text represents quotation from one or more of the following CMS sources:

- CMS Manual system, Pub. 100-02, Medicare Benefit Policy Manual, Chapter 15, Section 80.6 – 80.6.4
- CMS Manual System, Pub. 100-03, Medicare National Coverage Determinations Manual Chapter 1, Section 220.1
- Change Request 7121, Transmittal 2037, dated August 27, 2010

Coverage Guidance

Coverage Indications, Limitations, and/or Medical Necessity

CT of the abdomen includes the area between the dome of the diaphragm and the iliac crests, which also includes the base of the lungs. CT of the abdomen is generally indicated when only upper abdominal organs are of interest. A typical CT of the abdomen should include transaxial images from the dome of the diaphragm to the iliac crest with up to 10mm slice thickness. Pelvic CT includes the area between the iliac crests and the perineum. A typical CT of the pelvis would extend from the iliac crest to the ischial tuberosities with up to 10 mm slice thickness. If the patient has a suspected disease that may spread through the peritoneal cavity or by lymphatics, then the pelvic scan should also be performed. In some clinical situations, it may be medically necessary to perform complete CT scans of the abdomen and pelvis on the same date of service. These situations include but are not limited to the evaluation of inflammatory disease, staging of neoplasms and the evaluation of trauma.

Suggested indications for abdominal CT or pelvic CT examinations include, but are NOT LIMITED to the following:

- **Evaluation of pain**
  - **Abdomen**
    a. Upper abdominal pain if ultrasound is normal (*Note: Ultrasound does not work well in obese patients)
    b. Unexplained abdominal pain in patients older than 75 years or very frail
    c. Suspected diverticulitis or appendicitis
  - **Pelvis**
    a. Lower abdominal pain, if ultrasound is normal and clearly not a bowel problem
    b. Evaluation of pelvic fractures or bony tumors
    c. Bilateral hips for avascular necrosis as the femurs will be visualized on a pelvic study
    d. Inguinal hernia suspect incarceration

- **Evaluation of known or suspected abdominal or pelvic masses or fluid collections, primary or metastatic malignancies, abdominal or pelvic inflammatory processes, and abnormalities of abdominal or pelvic vascular structures (Note – CT Scans utilized initially for suspected malignancies)
Abdomen

a. Jaundice or abnormal liver function tests if ultrasound is normal or not indicated
b. Possible renal tumor (often will have ultrasound first)
c. Persistent unresolved symptoms not explained by initial imaging
d. Follow-up metastasis (i.e., breast, lung cancer, etc.)

Pelvis

a. Endometriosis follow-up of abnormal ultrasound
b. Inflammatory bowel disease, Crohn’s or colitis
c. Evaluation of bladder, cervical, ovarian, prostate or rectal cancer
d. Follow-up metastasis (i.e., breast, lung cancer, etc.)

· Evaluation of known or suspected primary breast cancer metastasis

· Evaluation of abdominal or pelvic trauma

Abdomen/Pelvis Combination

a. Blunt trauma – splenic laceration, trauma to the kidneys, suspicion of intra-abdominal fluid collections related to trauma

· Clarification of findings from other imaging studies or laboratory abnormalities

Abdomen

a. Delineation of known or suspected renal calculi
b. Pancreatitis, psuedocyst
c. Splenomegaly
d. Ascites
e. Hematuria or blood in urine (consider obtaining both abdomen and pelvis)
f. Hydronephrosis

Abdomen/Pelvis Combination

a. Fever and elevated white count, suspected abscess
b. Infection, unexpected weight loss

· Evaluation of known or suspected congenital abnormalities of abdominal or pelvic organs

· Guidance for interventional, diagnostic, or therapeutic procedures within the abdomen or pelvis

· Treatment planning for radiation therapy

Pelvis

a. Prostate tumor – staging for regional adenopathy, as part of radiation treatment planning
b. Follow-up of known mass, abscess or tumor
Abdomen/Pelvis Combination

a. Staging of known tumors or history of malignance
b. Assessment of response to chemotherapy and radiation therapy in individuals undergoing treatment
c. Lymphadenopathy, assessment of lymphomas
d. Presence or suspicion of abdominal mass/cancer

There are no absolute contraindications to abdominal CT or pelvic CT examinations. As with all procedures, the relative benefits and risks of the procedure should be evaluated prior to the performance of iodinated contrast-enhanced abdominal CT and pelvic CT. Appropriate precautions should be taken to minimize patient risk.

CT scans performed by mobile CT scan services are eligible for reimbursement only as specified in the Medicare National Coverage Determinations Manual Chapter 1-220.1.

CT scans performed on mobile units are subject to the same Medicare coverage requirements applicable to scans performed on stationary units, as well as certain health and safety requirements recommended by Health Resources and Services Administration (HRSA). As with scans performed on stationary units, the scans must be determined medically necessary for the individual patient. The scans must be performed on types of CT scanning equipment that have been approved for use as stationary units and must be in compliance with applicable State laws and regulations for control of radiation.

Coding Information

Bill Type Codes:
Contractors may specify Bill Types to help providers identify those Bill Types typically used to report this service. Absence of a Bill Type does not guarantee that the policy does not apply to that Bill Type. Complete absence of all Bill Types indicates that coverage is not influenced by Bill Type and the policy should be assumed to apply equally to all claims.

<table>
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<tr>
<th>Code</th>
<th>Description</th>
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<tr>
<td>012x</td>
<td>Hospital Inpatient (Medicare Part B only)</td>
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<td>013x</td>
<td>Hospital Outpatient</td>
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<tr>
<td>014x</td>
<td>Hospitals - Laboratory Services Provided to Non-patients</td>
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<tr>
<td>021x</td>
<td>Skilled Nursing - Inpatient (Including Medicare Part A)</td>
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<td>085x</td>
<td>Critical Access Hospital</td>
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Revenue Codes:

Contractors may specify Revenue Codes to help providers identify those Revenue Codes typically used to report this service. In most instances Revenue Codes are purely advisory. Unless specified in the policy, services reported under other Revenue Codes are equally subject to this coverage determination. Complete absence of all Revenue Codes indicates that coverage is not influenced by Revenue Code and the policy should be assumed to apply equally to all Revenue Codes.

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<td>032X</td>
<td>Radiology - Diagnostic - General Classification</td>
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<tr>
<td>035X</td>
<td>CT Scan - General Classification</td>
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CPT/HCPCS Codes

Group 1 Paragraph: N/A

Group 1 Codes:

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<td>72192</td>
<td>COMPUTED TOMOGRAPHY, PELVIS; WITHOUT CONTRAST MATERIAL</td>
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<td>72193</td>
<td>COMPUTED TOMOGRAPHY, PELVIS; WITH CONTRAST MATERIAL(S)</td>
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<tr>
<td>72194</td>
<td>COMPUTED TOMOGRAPHY, PELVIS; WITHOUT CONTRAST MATERIAL, FOLLOWED BY CONTRAST MATERIAL(S) AND FURTHER SECTIONS</td>
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ICD-10 Codes that Support Medical Necessity

Group 1 Paragraph: N/A

Group 1 Codes:

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<td>XX000</td>
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ICD-10 Codes that DO NOT Support Medical Necessity

Additional ICD-10 Information

N/A

General Information

Associated Information

Documentation Requirements

The documentation of the study requires a formal written report, with clear identifying demographics, the name of the interpreting provider, reason for the test, and interpretive report and copies of all images obtained. The computerized data with image reconstruction should also be maintained.

The medical record must contain documentation, including a written or electronic request for the procedure which fully supports the medical necessity of the procedure performed. This documentation includes, but is not limited to relevant medical history, physical examination, diagnosis (if known), pertinent signs and symptoms and results of pertinent diagnostic tests and/or procedures. This entire documentation—not just the test report or the findings/diagnosis on the order, must be made available upon request.

When a CT scan and MRI are performed on the same day for the same anatomical area, the medical record must clearly reflect the medical necessity for performing both tests.

If the provider of service is other than the ordering/referring physician, that provider must maintain hard copy documentation of test results and interpretation, along with copies of the ordering/referring physician’s order for the studies. The physician must state the clinical indication/medical necessity for the study in his order for the test.

Rules for Testing Facility to Furnish Additional Tests:

If the testing facility cannot reach the treating physician/practitioner to change the order or obtain a new order and documents this in the medical record, then the testing facility may furnish the additional diagnostic test if all of the following criteria apply:

- The testing center performs the diagnostic test ordered by the treating physician/practitioner;
- The interpreting physician at the testing facility determines and documents that, because of the abnormal result of the diagnostic test performed, an additional diagnostic test is medically necessary;
- Delaying the performance of the additional diagnostic test would have an adverse effect on the care of the beneficiary;
- The result of the test is communicated to and is used by the treating physician/practitioner in the treatment of the beneficiary; and
The interpreting physician at the testing facility documents in his/her report why additional testing was done.

Rules for Testing Facility Interpreting Physician to Furnish Different or Additional Tests:
The following applies to an interpreting physician of a testing facility who furnishes a diagnostic test to a beneficiary who is not a hospital inpatient or outpatient. The interpreting physician must document accordingly in his/her report to the treating physician/practitioner.

Test Design:
Unless specified in the order, the interpreting physician may determine, without notifying the treating physician/practitioner, the parameters of the diagnostic test (e.g., number of radiographic views obtained, thickness or tomographic sections acquired, use or non-use of contrast media).

Utilization Guidelines
It is expected that these services would be performed as indicated by current medical literature and/or standards of practice. When services are performed in excess of established parameters, they may be subject to review for medical necessity.

Sources of Information and Basis for Decision
FCSO reference LCD number(s) – L28813, L29119, L29137


Revision History Information

<table>
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<tr>
<th>Revision History Date</th>
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<th>Revision History Explanation</th>
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<td>10/01/2015</td>
<td>R1</td>
<td>The language and/or ICD-10-CM diagnoses were updated to be consistent with the current ICD-9-CM LCD’s language and coding.</td>
<td>Provider Education/Guidance</td>
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Associated Documents

Attachments
N/A

Related Local Coverage Documents
Article(s)
A54886 - Computed Tomography of the Abdomen and Pelvis - coding guidelines

Related National Coverage Documents N/A

Keywords
N/A Read the LCD Disclaimer