

AmeriHealth Caritas Louisiana

National Imaging Associates, Inc.*	
Clinical guidelines PELVIS CTAngiography	Original Date: July 2008
CPT Codes: 72191	Last Revised Date: May 2020
Guideline Number: NIA_CG_038	Implementation Date: January 2021 TBD

GENERAL INFORMATION:


It is an expectation that all patients receive care/services from a licensed clinician. All appropriate supporting documentation, including recent pertinent office visit notes, laboratory data, and results of any special testing must be provided. All prior relevant imaging results, and the reason that alternative imaging (gold standard, protocol, contrast, etc.) cannot be performed must be included in the documentation submitted.

IMPORTANT NOTE:

Abd/Pelvis CTA & Lower Extremity CTA Runoff Requests: Only one authorization request is required, using CPT Code 75635 Abdominal Arteries CTA. This study provides for imaging of the abdomen, pelvis and both legs. The CPT code description is CTA aorto-iliofemoral runoff; abdominal aorta and bilateral ilio-femoral lower extremity runoff.

INDICATIONS FOR PELVIS CT Angiography / CT Venography -- Abdominal CTA can be added when indicated:

For evaluation of known or suspected vascular disease (Eren, 2010)

- For pelvic extent of known large vessel diseases (abdominal aorta, inferior vena cava, superior/inferior mesenteric, celiac, splenic, renal or iliac arteries/veins), e.g., aneurysm, dissection, arteriovenous malformations (AVMs), and fistulas, intramural hematoma, and vasculitis.
- Evidence of vascular abnormality seen on prior imaging studies.
- For suspected pelvic extent of aortic dissection.
- Evaluation of known or suspected aneurysms limited to the pelvis or in evaluating pelvic extent of aortic aneurysm (Khosa, 2011; Uberoi, 2011; Wanhainen, 2019)*
 - Known or suspected iliac artery aneurysm **AND** equivocal or indeterminate Doppler ultrasound results
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 - If repeat Doppler ultrasound is indeterminate

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- ~~OR~~
- Suspected complications of known aneurysm as evidenced by clinical findings such as new onset of pelvic pain.
- Follow up of iliac artery aneurysm:
 - Every three years for diameter 2.0 – 2.9 cm ~~and~~
 - ~~a~~ **Annually for 3.0-3.4 cm, if Doppler ultrasound is inconclusive.** ~~Six month if between 3.0-3.5 cm and if stable follow yearly.~~
 - If > 3.5 cm, < six month follow up (and consider intervention): **(Wainhainen, 2019)**
- **Suspected retroperitoneal hematoma or hemorrhage (to determine a vascular source of hemorrhage in the setting of trauma, tumor invasion, fistula or vasculitis; otherwise CT (rather than CTA) is sufficient and the modality of choice for diagnosing hemorrhage when an underlying neoplasm is suspected and prior imaging is inconclusive (Abe, 2010).**
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- For evaluation of suspected pelvic vascular disease or pelvic congestive syndrome when findings on ultrasound are indeterminate (MR or CT venography may be used as the initial study for pelvic thrombosis or thrombophlebitis) **(Knuttninen, 2015, Bookwalter, 2019; Knuttninen, 2015, ACR, 2013; Eren, 2010).**
- For evaluation of venous thrombosis in the inferior vena cava (Aw-Zoretic, 2016).
- Venous thrombosis if previous studies have not resulted in a clear diagnosis (ACR, 2013).
- **Vascular invasion or displacement by tumor (Conventional CT or MRI also appropriate) (Certik, 2015; Smillie, 2015).**
- **For known and/or suspected mesenteric ischemia/-ischemic colitis (can include abdomen CTA) (ACR, 2018).**

Other vascular indications

- For suspected May-Thurner Syndrome (iliac vein compression syndrome) **(can include abdomen CTA)** (Al-Nouri, 2011; Kalu, 2013)
- ~~For known and/or suspected mesenteric ischemia/ ischemic colitis (can include abdomen CTA) (ACR, 2018).~~
- Lower gastrointestinal hemorrhage: Active bleeding in a hemodynamically stable patient or non-localized intermittent bleeding as an alternative to Tc-99m RBC scan when colonoscopy did not localize the bleeding, is contraindicated or unavailable (ACR, 2014; Clerc, 2017).
- For evaluation of erectile dysfunction when a vascular cause is suspected and Doppler ultrasound is inconclusive (Shindel, 2018)
- **For patients with fibromuscular dysplasia (FMD), a one-time vascular study of the abdomen and pelvis (Kadian-Dodov, 2016)**
- **For patients with vascular Ehlers-Danlos syndrome or Marfan syndrome recommend a one-time vascular study of the abdomen and pelvis.**
- **For Loeystz-Dietz vascular imaging every two years (include abdomen CTA) (Chu, 2014)**
- **For spontaneous coronary artery dissection (SCAT) at time of coronary arteriography (includes CTA abdomen) (Crousillat, 2020)**

Pre- operative evaluation

(ACR, 2017)

- Evaluation of interventional vascular procedures prior to endovascular aneurysm repair (EVAR), or for luminal patency versus restenosis due to conditions such as atherosclerosis, thromboembolism, and intimal hyperplasia.
- [Imaging of the deep inferior epigastric arteries for surgical planning \(breast reconstruction surgery\) include abdomen CTA/MRA \(ACR, 2017\)](#)
- [Prior to uterine artery embolization for fibroids \(MRA preferred\) \(Maciel, 2017\)](#)

Post- operative or post-procedural evaluation

- Evaluation of post-operative complications of renal transplant allograft (Bultman, 2014).
- Evaluation of endovascular/interventional vascular procedures for luminal patency versus restenosis due to conditions such as atherosclerosis, thromboembolism, and intimal hyperplasia.
- Evaluation of post-operative complications e.g., pseudoaneurysms, related to surgical bypass grafts, vascular stents and stent-grafts in the pelvis.
- Follow-up for post-endovascular repair (EVAR) or open repair of abdominal aortic aneurysm (AAA) and iliac artery aneurysms ([ACR, 2017](#); Chaikof, 2018; [ACR, 2017](#); Uberoi, 2011).
 - Routine, baseline study (post-op/intervention) is warranted within 1-3 months.
 - Asymptomatic at six (6) month intervals, for one (1) year, then annually.
 - Symptomatic/complications related to stent graft – more frequent imaging may be needed.
 - Follow-up study may be needed to help evaluate a patient’s progress after treatment, procedure, intervention or surgery. Documentation requires a medical reason that clearly indicates why additional imaging is needed for the type and area(s) requested.

Chest CTA and Abdomen CTA or Abdomen/Pelvis CTA combo

- For preoperative or preprocedural evaluation such as TAVR (transcatheter aortic valve replacement) or transcatheter venous ablation (ACR, 2017; Ohana, 2015).
- Acute aortic dissection (Barman, 2014).
- [Takayasu’s arteritis \(Keser, 2014\).](#)
- [Marfans syndrome](#)
- [Loeytz-Dietz syndrome](#)
- [Spontaneous Spontaneous coronary artery dissection \(SCAD\)](#)
- [Vascular Ehlers-Danlos syndrome](#)
- Post-operative complications (Bennet, 2017; Choudhury, 2017)

BACKGROUND:

Computed tomographic angiography (CTA) is used in the evaluation of many conditions affecting the veins and arteries of the pelvis or lower extremities. It is not appropriate as a screening tool for asymptomatic patients without a previous diagnosis.

OVERVIEW:

CT/MRI and acute hemorrhage: MRI is not indicated and MRA/MRV (MR Angiography/Venography) is rarely indicated for evaluation of intraperitoneal or retroperitoneal hemorrhage, particularly in the acute setting. CT is the study of choice due to its availability, speed of the study and less susceptibility to artifact from patient motion. Advances in technology have allowed conventional CT to not just detect hematomas but also the source of acute vascular extravasation. In special cases finer vascular detail to assess the specific source vessel responsible for hemorrhage may require the use of CTA. CTA in diagnosis of lower gastrointestinal bleeding is such an example (Clerc, 2017).

*Follow-up of asymptomatic, incidentally-detected iliac artery aneurysms- (Uberoi, 2011)

The definition of an iliac artery aneurysm (IAA) is dilatation to more than 1.5 times its normal diameter; in general a common iliac artery ≥ 18 mm in men and ≥ 15 mm in women; an internal iliac artery (IIA) > 8 mm is considered aneurysmal. There are four types of isolated iliac aneurysms classified by Reber. Suggested surveillance is extrapolated from AAA surveillance and can be done by Doppler ultrasound or CTA if hard to visualize by ultrasound (Wainhanen, 2019)

- ~~< 3.0 cm: rarely rupture, grow slowly, follow-up not generally needed~~
- ~~$3.0-3.5$ cm: followed-up initially at 6 months
 - if stable, then annual imaging~~
- ~~> 3.5 cm: greater likelihood of rupture
 - < 6 month follow up
 - consider intervention~~

POLICY HISTORY:

Review Date: June 2019

Review Summary:

- Added important note for runoff requests and authorizations
- Added note that abdominal CTA can be added when indicated
- Removed iliac artery aneurysm size restriction of > 2.5 cm in diameter and changed to 'if repeat Doppler US is indeterminate
- For retroperitoneal hematoma or hemorrhage, specified 'when an underlying neoplasm is suspected and prior imaging is inconclusive'
- Added pelvic congestive syndrome; suspected May-Thurner Syndrome; erectile dysfunction when vascular cause is suspected and Doppler US inconclusive; post-operative complications of renal transplant allograft
- Modified combo study from 'Chest CTA/Pelvis CTA' to 'Chest CTA and Abdomen CTA or Abdomen/Pelvis CTA combo'
- Updated background information and references

Review Date: May 2020

Review Summary:

- Added evaluation of FMD, Vascular Ehlers-Danlos syndrome, Loetz-Dietz and SCAD
- Added uterine artery embolization
- Added combo studies

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