Subject: CT FACE, CT SINUS (70486, 70487, 70488)		Original Effective Date: 12/13/2017
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DISCLAIMER

This Molina Clinical Review (MCR) is intended to facilitate the Utilization Management process. 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 (i.e., 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 Molina Clinical Review (MCR) document and provide the directive for all Medicare members.

DESCRIPTION OF PROCEDURE/SERVICE/PHARMACEUTICAL

CT (Computed Tomography) or CAT (Computed Axial Tomography) is an imaging scan that electronically processes many X-ray images obtained at different angles to produce detailed cross sectional views of soft tissues, bones and vascular structures. These cross sectional views can be reconstructed, rotated and displayed in many different planes. A CT scan can be performed either without (non-enhanced) or with (contrast enhanced) injection of iodine containing contrast material into a vein.

APPROVAL SUPPORT

For many clinical situations **either MRI or CT** are appropriate. MRI's often show soft tissue details better, and CT's often show boney detail better. The choice should be made by the radiologist and the ordering provider as to which is best for a given clinical situation.

FACE (Maxillofacial) CT or SINUS CT:

- For the evaluation of sinonasal or facial **tumor**.
- **Osteomyelitis** of facial bone where imaging study, (such as plain films, or brain MRI, etc.) demonstrates an abnormality or is indeterminate.
- For the diagnosis of **parotid or submandibular gland stones** with abnormal physical exam or ultrasound.

- For the assessment of trauma, (e.g. suspected facial bone fractures).

- For the diagnosis of facial abscesses.

- For evaluation of known or suspected **infectious or inflammatory** disease:
  - Unresolved **sinusitis** after four (4) consecutive weeks of medication, e.g., antibiotics, steroids or decongestants.
  - Sinus symptoms in **Immunocompromised** patient (including but not limited to AIDS, transplant patient or patient with genetic or acquired deficiencies) or conditions predisposed to sinusitis (e.g., cystic fibrosis and immotile cilia syndrome).
- For evaluation of known or suspected tumor with **Abnormal or indeterminate** prior imaging, physical exam, or endoscopy.

- **For evaluation of trauma:**
  - Suspected fracture AND prior imaging was nondiagnostic or equivocal.

- **Pre-operative evaluation:**
  - Planned maxillo-facial surgery.
  - For use as adjunct to image guided sinus exploration or surgery.

- **Post-operative evaluation**:
  - Complications, e.g., suspected CSF leak, post-operative bleeding as evidenced by persistent opaqueness on imaging.
  - **Non-improvement** two (2) or more weeks after surgery.

<u>Other indications for Sinus CT:</u>
- For **poorly controlled asthma** associated with upper respiratory tract infection. May be performed without failing 4 consecutive weeks of treatment with medication.
- For **Polyposis** – may be associated with aspirin intolerance, nickel exposure or allergic rhinitis

ADDITIONAL INFORMATION

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

- Tests that will not change treatment recommendations should not be approved.
- Tests completed recently need a specific reason for repeat
- Tests done very recently that have an abnormality that requires the test be done again with contrast can be approved.

- Contrast should be used if there is a history of -malignancy or known or suspected infection

CODING INFORMATION: THE CODES LISTED IN THIS POLICY ARE FOR REFERENCE PURPOSES ONLY. LISTING OF A SERVICE OR DEVICE CODE IN THIS POLICY DOES NOT IMPLY THAT THE SERVICE DESCRIBED BY THIS CODE IS COVERED OR NON-COVERED. COVERAGE IS DETERMINED BY THE BENEFIT DOCUMENT. THIS LIST OF CODES MAY NOT BE ALL INCLUSIVE.

CPT	Description
	70486: CT (Computed Tomography) Face/Sinuses without contrast
	70487: CT (Computed Tomography) Face/Sinuses with contrast
	70488: CT (Computed Tomography) Face/Sinuses without and with contrast

REFERENCES USED FOR DETERMINATIONS

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