

Subject: CT Orbit/Sella/Temporal Bone (IAC) including Mastoid/Posterior Fossa (70480, 70481, 70482)		Original Effective Date: 12/13/2017
Policy Number: MCR: 602	Revision Date(s): 11/26/18	
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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.

ORBITS CT or SINUS CT

- **Trauma** with physical exam evidence of damage, including temporal bone (does not require X-ray first).
- **Decreased range of motion** of the eyes.
- **Proptosis** (exophthalmos).(such as Grave's Disease)
- **Progressive vision loss.**
- **Optic neuritis** if MRI is contraindicated or is unable to be performed.

- **Abnormal X-ray**
- **Unilateral visual deficit.**
- **Papilledema** (including Pseudotumor)
- Orbital or facial **Infection** (including Osteomyelitis)
- **Tumor or mass** found on X-ray, Physical Exam, or Ultrasound (including Parotid or submandibular)
- **Sinus infection** (and reason for not doing CT is provided), unresolved **sinusitis** after four (4) consecutive weeks of medication, e.g., antibiotics, steroids or decongestants.
- **Sinus inflammation** (and reason for not doing CT is provided), 3 weeks of nasal steroids have failed

ORBIT CT combined with BRAIN CT:

- Brain CT/Orbit CT –
- Patient who will need anesthesia for the procedure and there is a suspicion of concurrent intracranial tumor (e.g. “young child with trilateral retinoblastoma”)*
- Unilateral papilledema: (e.g. optic nerve lesion, optic neuritis, central retinal vein occlusion or optic nerve infiltration)

TEMPORAL BONE CT (Including (IAC) Internal Auditory Canal) OR MASTOID CT:

- Conductive hearing loss.
- Chronic otitis media, ear infections or drainage.
- Mastoiditis.
- Cholesteatoma.
- Congenital hearing loss or deformity.
- Dehiscence of the jugular bulb or carotid canal.
- Aberrant blood vessels or malformations.
- Cochlear implants.

Pre/Post Procedural

- Pre-operative/ Pre-procedural evaluation when detail is needed
- Post-operative/Post-procedural 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 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 prior surgery, malignancy or known or suspected infection

REFERENCES USED FOR DETERMINATIONS

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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
	70480: CT (Computed Tomography) Orbits without contrast
	70481: CT (Computed Tomography) Orbits with contrast
	70482: CT (Computed Tomography) Orbits with and without contrast
	70480: CT (Computed Tomography) Temporal Bones without contrast
	70481: CT (Computed Tomography) Temporal Bones with contrast
	70482: CT (Computed Tomography) Temporal Bones without and with contrast