Molina Clinical Policy
Brain CT: Policy No. 601
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

Brain CT can be used in the evaluation and diagnosis of brain conditions. In most clinical circumstances, Brain MRI is the preferred modality due to its lack of ionizing radiation and greater sensitivity for detecting brain abnormalities. Brain CT can be the preferred study when time is of importance, there are geoaccess problems, or there is concern for subarachnoid bleeding, acute trauma, or bone abnormalities. Brain CT is also appropriate when MRI imaging is contraindicated or cannot be performed.

COVERAGE POLICY

Brain CT **may be considered medically necessary** when **ANY** of the following criteria are met:

1. **Neurological Issues**
   - Weakness, numbness or tingling, sensory loss, lack of coordination, problems with speech, vision problems, cranial nerve deficits, or changes in mental status when these complaints are suspected to arise from the brain; **OR**
   - Suspected stroke or TIA (CT may be preferred in the acute setting).

OR

2. **Demyelinating Disease (Multiple Sclerosis, Neuromyelitis Optica, Clinically Isolate Syndrome)**
   - Suspected Demyelinating disease if MRI is not possible; **OR**
   - For evaluation of Members with symptoms consistent with a possible diagnosis of demyelinating disease.

OR

3. **Known Multiple Sclerosis (if MRI is not possible)**
   - Worsening or new symptoms without imaging in the past three months; **OR**
   - Follow up of or surveillance of known disease and no imaging within the last year; **OR**
   - Follow up of disease progression after a change in medications and no imaging in the last three months.

OR

4. **Movement Disorders**
   - New onset of movement disorders; **OR**
   - Suspected Parkinson's disease; **OR**
   - Known Parkinson's disease but with new symptoms.

OR

5. **Headache, with any of the following:**
   - Papilledema; **OR**
   - Awakens Member from sleep; **OR**
   - Member reports "worst headache of their life" (CT may be preferred in the acute setting); **OR**
   - Sudden change in headache pattern; **OR**
   - New onset of headache over the age of 50; **OR**
   - Recent head injury with headache (CT may be preferred in the acute setting); **OR**
   - Coital headaches; **OR**
   - Headaches which are clearly positional or worsen with coughing, sneezing; **OR**
   - History of cancer or HIV/AIDS; **OR**
   - Headache during pregnancy; **OR**
   - Uncontrolled vomiting; **OR**
   - New headache with a first-degree family history (e.g., sibling, parent or child) of aneurysm; **OR**
   - Abnormal neurological exam findings; **OR**
   - Member is under 6 years of age; **OR**
   - For a child, headache present on awakening; **OR**
   - Unresponsive to medical treatment.

OR

6. **Cognitive Dysfunction**
   - Mini-Mental State Examination (MMSE) testing with a score less than 25 or Montreal Cognitive Assessment (MoCA) testing with a score of less than 26 and Member has been screened for major depression. (Current recommendations do not specify modality thus CT can be utilized in certain clinical scenarios); **OR**
   - Acute onset of mental status changes (CT may be preferred in the acute setting).

OR

7. **Brain Tumor**
   - Follow up after completion of treatment or with new signs/symptoms; **OR**
   - Surveillance according to accepted clinical standards; **OR**
   - Suspected pituitary tumor with abnormal blood work or vision changes; **OR**
   - Screening for metastatic disease with known widespread disease or for certain malignancies with a high association of metastatic brain disease.

OR

8. **Seizure**
   - New onset; **OR**
   - Chronic, with a change in character or unresponsive to therapy.

OR

9. **Congenital Conditions**
   - Known or suspected neurocutaneous disease (e.g., neurofibromatosis, tuberous sclerosis); **OR**
   - Evaluation of known or suspected congenital brain abnormalities; **OR**
   - Macrocephaly in a child $\geq$6 months of age; should have ultrasound as initial study if $\leq$ 6 months of age; **OR**
   - Microcephaly; **OR**
   - Suspected craniosynostosis (CT is preferred).

OR

10. **Plagiocephaly (where bony detail is needed – CT is preferred)**
    - Follow up of a ventricular shunt (CT is acceptable for follow up evaluations); **OR**
    - Known or suspected Arnold Chiari malformation; **OR**
    - Developmental delay (NOTE: Determinations for Members on the autism spectrum is made clinically based on a careful history, clinical examination, and observation of behavior. Routine imaging is not recommended

unless this diagnosis remains in question or there is concern for underlying pathology based on other factors).

OR

11. **Head Trauma (CT is acceptable if there is concern for fractures or bleeding or in the acute setting)**
    - Headaches; **OR**
    - Vomiting; **OR**
    - Mental status changes; **OR**
    - Seizures; **OR**
    - Abnormal neurological exam findings.

OR

12. **Infection/Inflammatory Disease.**
    - Suspected meningitis or encephalitis; **OR**
    - Underlying medical condition associated with inflammatory conditions of the brain and symptoms suggestive of brain involvement.

OR

13. **Pre/Post Procedural.**
    - Pre-operative evaluation (CT may be preferred depending on the type of procedure); **OR**
    - Post-operative for routine recommended follow up or for potential post-operative complications. (CT may be preferred depending on the type of procedure); **OR**
    - A repeat study may be needed to help evaluate a Member's progress after treatment procedure intervention or surgery. The reason for the repeat study and that it will affect care must be clear.

OR

14. **Other**
    - Follow up of known hemorrhage or hematoma (CT is acceptable); **OR**
    - Persistent vertigo felt to be of central origin.

OR

15. **Brain/Cervical Spine CT Combination**
    - For evaluation of known multiple sclerosis follow up of Arnold Chiari malformation, syrinx, or syringomyelia; **OR**
    - Follow up of known hemorrhage or hematoma (CT is acceptable); **OR**
    - Persistent vertigo felt to be of central origin.

OR

16. **Brain/Cervical Spine CT Combination.**
    - For evaluation of known multiple sclerosis; **OR**
    - Follow up of Arnold Chiari malformation, syrinx, or syringomyelia.

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
70450	CT (Computed Tomography) head/brain without contrast
70460	CT (Computed Tomography) head/brain with contrast
70470	CT (Computed Tomography) head/brain 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.

APPROVAL HISTORY

12/8/2021	Policy reviewed, no updates to criteria, updated references.
Review Dates	9/19/2017, 12/13/2018, 12/10/2019, 12/9/2020
9/19/2017	New policy.

REFERENCES

Peer Reviewed Publications

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3. Crummer RW, Hassan GA. Diagnostic approach to tinnitus. Am Fam Physician. 2004 Jan 1;69(1):120-6. https://pubmed.ncbi.nlm.nih.gov/14727828/. Accessed October 1, 2021.
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5. Jagoda AS, Bazarian JJ, Bruns JJ Jr, et al. American College of Emergency Physicians and Centers for Disease Control and Prevention. Clinical policy: neuroimaging and decision making in adult mild traumatic brain injury in the acute setting. Ann Emerg Med. 2008 Dec;52(6):714-48. doi: 10.1016/j.annemergmed.2008.08.021. Accessed October 1, 2021.
6. Knopman DS, DeKosky ST, Cummings JL, Chui H, Corey-Bloom J. Practice parameter: Diagnosis of dementia (an evidence-based review). Neurology. 2001 May 8;56(9):1143-53. doi: 10.1212/wnl.56.9.1143. Accessed October 1, 2021.
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9. Wippold FJ, Cornelius RS, Broderick DF, et al. Expert panel on neurologic imaging, ACR appropriateness criteria, dementia and movement disorders. J Am Coll Radiol. 2015 Jan;12(1):19-28. doi: 10.1016/j.jacr.2014.09.025. Accessed October 1, 2021.

APPENDIX

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