Molina Clinical Policy
Chest CT: Policy No. 612

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

CT imaging of the chest provides detailed information related to the lung and lung parenchyma. In most clinical scenarios, a chest x-ray should still be performed as the initial study.

COVERAGE POLICY

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

1. **For Annual Lung Cancer Screening.**
   a. Member is a candidate for potential treatment; **OR**
   b. Is between the age of 50 - 80; **AND**
   c. Has at least a 20 pack per year history of cigarette smoking; **AND**
   d. Is still actively smoking or has quit within the last 15 years.

OR

2. **Known Tumor or Mass**
   a. Initial evaluation of a recently diagnosed cancer; **OR**
   b. Follow up of a known tumor or mass after completion of treatment or with new signs/symptoms; **OR**
   c. Surveillance of a known tumor or mass according to accepted clinical standards; **OR**
   d. Lung nodule follow up per Fleischner criteria.

OR

3. **Interstitial Lung Disease**
   a. Known or suspected interstitial lung disease and initial x-ray has been performed; **OR**
   b. Restrictive lung defect on pulmonary function testing.

OR

4. **Infectious / Inflammatory Lung Disease**
   a. Tests for known or suspected infection or inflammatory disease and initial x-ray have been performed; **OR**
   b. For evaluation of non-resolving pneumonia documented on at least two imaging studies despite a course of treatment; **OR**
   c. Evaluation of hilar or mediastinal adenopathy after initial Chest x-ray.

OR

5. **Vascular Disease**
   a. For evaluation of known or suspected vascular disease. CTA or MRA may be a more appropriate study; **OR**
   b. Suspected pulmonary embolism (CTA is preferred). For low risk patients, a D-dimer should be performed and if negative, imaging should not be performed.*

* Low risk of pulmonary embolism is defined as answering NO to **ALL** of the following criteria:
  - Clinical signs and symptoms of a DVT; **AND**
  - Pulmonary embolism is the most likely diagnosis; **AND**
  - Heart rate is greater than 100 bpm; **AND**
  - Member has undergone surgery in the last four (4) weeks or has been recently immobilized; **AND**
  - Member had a prior DVT or pulmonary embolism; **AND**
  - Member reports episodes of hemoptysis; **AND**
  - Member has an underlying malignancy.

6. **Other**
   a. Persistent hemoptysis and initial x-ray have been completed; **OR**
   b. Vocal cord paralysis; **OR**
   c. For evaluation of suspected thymoma in the setting of Myasthenia Gravis; **OR**
   d. Chronic cough for at least 4 weeks and initial x-ray has been completed; **OR**
   e. Evaluation of an abnormality seen on x-ray requiring further imaging.

Pre / Post Procedural

- Pre-operative evaluation when surgery is planned on the chest; **OR**
- Post-operative for routine recommended follow up or for potential post-operative complications; **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.

Additional Critical 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 present at the time of the request.

- 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
71250	CT (Computed Tomography) chest/thorax without contrast
71260	CT (Computed Tomography) chest/thorax with contrast
71270	CT (Computed Tomography) chest/thorax 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, updated criteria from USPSTF; updated references.
Review Dates	9/19/2017, 12/13/2018 ,12/10/2019, 12/9/2020

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12. United States Preventive Services Task Force (USPSTF). Final recommendation statement: Lung cancer – screening. Available from USPSTF. Updated March 9, 2021. 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.*