Cohere Medicare Advantage Policy - Computed Tomography (CT), Face/Sinus

Clinical Policy for Medical Necessity Review

Version: 2
Cohere Health UMC Approval Date: October 16, 2025
Last Annual Review: October 16, 2025
Revision: Not Applicable
Next Annual Review: October 16, 2026

Important Notices

Notices & Disclaimers:

GUIDELINES ARE SOLELY FOR COHERE'S USE IN PERFORMING MEDICAL NECESSITY REVIEWS AND ARE NOT INTENDED TO INFORM OR ALTER CLINICAL DECISION-MAKING OF END USERS.

Cohere Health, Inc. ("**Cohere**") has published these clinical guidelines to determine the medical necessity of services (the "**Guidelines**") for informational purposes only, and solely for use by Cohere's authorized "**End Users**". These Guidelines (and any attachments or linked third-party content) are not intended to be a substitute for medical advice, diagnosis, or treatment directed by an appropriately licensed healthcare professional. These Guidelines are not in any way intended to support clinical decision-making of any kind; their sole purpose and intended use is to summarize certain criteria Cohere may use when reviewing the medical necessity of any service requests submitted to Cohere by End Users. Always seek the advice of a qualified healthcare professional regarding any medical questions, treatment decisions, or other clinical guidance. The Guidelines, including any attachments or linked content, are subject to change at any time without notice. This policy may be superseded by existing and applicable Centers for Medicare & Medicaid Services (CMS) statutes.

Other Notices:

Policy Information:

Specialty Area: Diagnostic Imaging
Policy Name: Computed Tomography (CT), Face/Sinus
Type: [**X**] Adult (18+ yo) | [**X**] Pediatric (0-17 yo)

Table of Contents

Medical Necessity Criteria

Service: Computed Tomography (CT), Face/Sinus

Related CMS Documents

Please refer to the CMS Medicare Coverage Database for the most current applicable CMS National Coverage.[1-5]

- National Coverage Determination (NCD). Computed tomography (220.1).
- Local Coverage Determination (LCD). MRI and CT scans of the head and neck (L37373).
  - Billing and Coding: MRI and CT scans of the head and neck (A57204).
- Local Coverage Determination (LCD). MRI and CT scans of the head and neck (L35175).
  - Billing and Coding: MRI and CT scans of the head and neck (A57215).

Description

Computed tomography (CT) is a common noninvasive imaging modality that allows for the creation of detailed cross-sectional images of the extracranial structures of the head and neck. It allows for the evaluation of the morphology and pathology of osseous and soft tissue structures. It can be performed both with and without contrast, depending on the structures being visualized.[6]

Medical Necessity Criteria

Indications

Computed tomography (CT), face/sinus (including soft tissues of the extracranial head and neck) is considered appropriate for **ANY** of the following:

- Conditions, known or suspected, including **ANY** of the following[6]:
  - Anatomic abnormalities (e.g., deviated septum), suspected as a cause of patient symptoms, and surgical management is being considered; **OR**
  - Bell's palsy or other facial nerve abnormalities requiring evaluation of the extracranial portion of the nerve (magnetic resonance imaging [MRI] is contraindicated or cannot be performed); **OR**
  - Congenital conditions and craniofacial abnormalities[7]; **OR**
  - Infective sinusitis, and **ANY** of the following[7-10]:
    - Four or more acute episodes per year and surgery/biologic therapy are considered; **OR**
    - Persists following completion of two courses of antibiotics; **OR**
    - Acute or subacute rhinosinusitis with a known or suspected complication (e.g., abscess formation, extension to orbits, cavernous sinus, or intracranial involvement)[A]; **OR**
    - The patient is immunocompromised, and invasive fungal sinusitis is suspected; **OR**
    - Allergic fungal sinusitis (AFS) suspected, with failed medical treatment or when surgery is considered; **OR**
    - Chronic rhinosinusitis, symptomatic (e.g. discharge, congestion, anosmia, pain), severity staging or restaging when management change is considered; **OR**
  - Suspected osteonecrosis when the patient is on bisphosphonates or post radiation treatments; **OR**
  - Osteomyelitis; **OR**
  - Odontogenic infections with suspected complications (e.g., abscess formation, facial swelling, nerve, sinus involvement); **OR**
  - Unexplained facial swelling (e.g., over the mandible); **OR**
  - Foreign body, suspected, clinically or seen on prior imaging; **OR**
  - Neoplastic conditions for initial staging, treatment planning, response assessment, and surveillance; **OR**

- Mass or lymphadenopathy when **ANY** of the following[7]:
  - Has been present for at least 2 weeks; **OR**
  - Not suspected to be due to infection; **OR**
  - Mass does not resolve after treatment with antibiotics for suspected infection; **OR**
  - Lymphadenopathy or mass is greater than 1.5 cm; **OR**
  - Ulceration of skin over the mass; **OR**
- Mass or lesion detected on laryngoscopy; **OR**
- Sinonasal polyposis detected on nasal endoscopy with **ALL** of the following[8,11]:
  - The patient is symptomatic; **AND**
  - No relief with appropriate medical therapy (e.g., corticosteroids, antihistamines, antibiotics); **AND**
  - Surgical intervention or biologic therapy is being considered; **OR**
- Known sinonasal polyposis with complications suspected, (e.g., involvement of the orbits); **OR**
- Noninfectious inflammatory involvement of the sinus is suspected based on clinical history and symptoms (e.g., history of granulomatosis with polyangiitis)[6]; **OR**
- Salivary stones, suspected, when ultrasound is non-diagnostic or further evaluation is needed[1]; **OR**
- Salivary gland inflammation (sialadenitis)[6]; **OR**
- Trigeminal neuralgia with **ANY** of the following[12]:
  - MRI is contraindicated or cannot be performed; **OR**
  - Atypical features present (e.g., symptoms outside of typical short-duration trigeminal nerve distribution pain); **OR**
  - Forty years of age or younger; **OR**
  - Failure of conservative management with failure of at least two concurrent agents (e.g., gabapentin, duloxetine) and surgery is being considered; **OR**
- Vascular malformations (e.g., arteriovenous malformations)[6,13]; **OR**

- For evaluation of **ANY** of the following:
  - Anosmia with **ANY** of the following[14]:
    - Persistent anosmia with nondiagnostic endoscopy; **OR**
    - Abnormal endoscopy with further evaluation needed; **OR**
    - Known or suspected neoplasm; **OR**
    - History of head or facial trauma; **OR**

    - Cerebrospinal fluid (CSF) leak, strong clinical history or confirmed on testing (e.g., prior trauma or CSF leak that increases after Valsalva maneuvers)[8]; **OR**
    - Epistaxis with failure of conservative management (e.g., nasal packing/tampon, cautery); **OR**
    - Epistaxis with detection of mass, polyp, or other pathology on examination that requires further evaluation[6]; **OR**
- Preoperative, postoperative, and pretreatment evaluation for surgery, radiation, or chemotherapy; **OR**
- Maxillofacial trauma based on history, swelling, prior imaging, and need for further evaluation; **OR**
- Repeat imaging (defined as a repeat request following recent imaging of the same anatomic region with the same or similar modality) will be considered reasonable and necessary if **ALL** of the following are **TRUE**:
    - There are no established guidelines; **AND**
    - **ANY** of the following:
        - There are new or worsening symptoms not addressed in the guidelines, such that repeat imaging would influence treatment; **OR**
        - There is need for a one-time clarifying follow-up of a prior indeterminate finding; **OR**
        - In the absence of change in symptoms, there is an established need for monitoring which would influence management.

Non-Indications

Computed tomography (CT), face/sinus (including soft tissues of the extracranial head and neck) with contrast is not considered appropriate if **ANY** of the following is **TRUE:**[15]

- The patient has undergone advanced imaging of the same body part within 3 months without undergoing treatment or developing new or worsening symptoms

*NOTE: The referring professional and radiologist should discuss the risks and benefits of contrast media administration, including possible prophylaxis, in patients with chronic or worsening kidney disease or severe renal failure.
*NOTE: CT in pregnant patients should be requested at the discretion of the ordering provider and obstetric care provider.
**NOTE: CT in patients with claustrophobia should be requested at the

discretion of the ordering provider.

Definitions

[A]Rhinosinusitis classification by symptom duration:[16]

- **Acute:** Symptoms lasting less than 4 weeks
- **Subacute:** Symptoms lasting more than 4 weeks but less than 12 weeks
- **Chronic:** Symptoms lasting more than 12 weeks

Disclaimer on Radiation Exposure in Pediatric Population

Due to the heightened sensitivity of pediatric patients to ionizing radiation, minimizing exposure is paramount. At Cohere, we are dedicated to ensuring that every patient, including the pediatric population, has access to appropriate imaging following accepted guidelines. Radiation risk is dependent mainly on the patient's age at exposure, the organs exposed, and the patient's sex, though there are other variables. The following technical guidelines are provided to ensure safe and effective imaging practices:

Radiation Dose Optimization: Adhere to the lowest effective dose principle for pediatric imaging. Ensure that imaging protocols are specifically tailored for pediatric patients to limit radiation exposure.[17,18]

Alternative Modalities: Prioritize non-ionizing imaging options such as ultrasound or MRI when clinically feasible, as they are less likely to expose the patient to ionizing radiation. For instance, MRI or ultrasound should be considered if they are more likely to provide an accurate diagnosis than CT, fluoroscopy, or radiography.[17,18]

Cumulative Dose Monitoring: Implement systems to track cumulative radiation exposure in pediatric patients, particularly for those requiring multiple imaging studies. Regularly reassess the necessity of repeat imaging based on clinical evaluation.[17,18]

CT Imaging Considerations: When CT is deemed the best method for achieving a correct diagnosis, use the lowest possible radiation dose that still yields reliable diagnostic images.[17,18]

Cohere Imaging Gently Guideline

The purpose of this guideline is to act as a potential override when clinically indicated to adhere to Imaging Gently and Imaging Wisely guidelines and As Low As Reasonably Possible (ALARA) principles.

Level of Care Criteria

Inpatient and Outpatient

Procedure Codes (CPT/HCPCS)

CPT/HCPCS Code	Code Description
70486	Computed tomography (CT), maxillofacial area; without contrast material
70487	Computed tomography (CT), maxillofacial area; with contrast material(s)
70488	Computed tomography (CT), maxillofacial area; without contrast material, followed by contrast material(s) and further sections
76380	Computed tomography, limited or localized follow-up study

Disclaimer: S Codes are non-covered per CMS guidelines due to their experimental or investigational nature.

Evaluation of Clinical Harms and Benefits

Clinical determinations for Medicare Advantage beneficiaries are made in accordance with 42 CFR 422.101 guidance outlining CMS's required approach to decision hierarchy in the setting of NCDs/LCDs identified as being "not fully established". When clinical coverage criteria are "not fully established" Medicare Advantage organizations are instructed to create publicly accessible clinical coverage criteria based on widely-accepted clinical guidelines and/or scientific studies backed by a robust clinical evidence base. Clinical coverage criteria provided by Cohere Health in this manner include coverage rationale and risk/benefit analysis.

The clinical benefits of using these criteria for computed tomography of the face and neck include:

- CT scanning is cost-effective as a primary diagnostic tool because it provides a robust, encompassing view of target structures, conceivably reducing downstream tests and reducing healthcare costs overall.[1]
- Widespread availability of CT scanners has increased clinical adoption of CT as a preferred diagnostic imaging method.[19]
- CT is a faster imaging tool with lower scan duration than similar imaging modalities (e.g., MRI) and decreased imaging processing time.[19]
- As an imaging modality, CT is noninvasive - particularly when compared to other modalities, such as endoscopic staging of sinus conditions.[20] It is widely accepted that noninvasive procedures are less costly, associated with fewer complications, and preferred by both patients and providers.
- Appropriate allocation of healthcare resources at the individual beneficiary and population levels.

The potential clinical harms of using these criteria for computed tomography of the face and neck may include:

- Inherent risk of procedure: There are inherent risks of imaging, including cumulative radiation exposure, contrast, allergy, nephrotoxicity, and contrast extravasation into surrounding tissues.[21-24]
- Potential danger to pregnancy: CT imaging completed during pregnancy confers a dose of ionizing radiation to the fetus and is generally only utilized when the potential benefits of this specific imaging modality outweigh the risks to the pregnancy.[25] Fetal risk includes fetal demise,

intrauterine growth restriction, microcephaly, delayed intellectual development, risk of childhood cancer, and fetal thyroid injury.[25]

- Increased healthcare costs and complications from the inappropriate use of additional interventions.[26]

Medical Evidence

Bedernik et al. (2022) conducted a randomized controlled trial (RCT) to assess image quality by comparing single-energy computed tomography (SECT) with automated tube voltage adaptation (TVA) to dual-energy CT (DECT) weighted average images. A total of 80 patients underwent SECT or radiation dose-matched DECT. The effective radiation dose showed no significant difference between the SECT and DECT study groups. Compared to the SECT group, the DECT group exhibited significantly higher contrast-to-noise ratio differences (CNRD) for jugular veins relative to fatty tissue and muscle tissue relative to fatty tissue. However, the CNRD for jugular veins relative to muscle tissue was comparable between groups. Image artifacts were also less pronounced, and overall diagnostic acceptability was higher in the DECT group. Overall, DECT-weighted average images demonstrate superior objective and subjective image quality compared to SECT performed with TVA in head and neck imaging.[27]

Smith-Bindman et al. (2020) performed an RCT to study the efficacy of interventions to lower radiation doses in patients undergoing a CT scan. The RCT included 864,080 adults at 100 facilities who underwent a CT scan, including CT of the head (n = 1,156,657 scans). The study included two primary measures: the percentage of high-dose CT scans and the average effective dose administered at the facility level. The study's secondary measure included the doses received by specific organs. The authors examined the change in outcomes following interventions, contrasting the data with preintervention data, utilizing hierarchical generalized linear models that accounted for temporal patterns and patient attributes. In conclusion, data regarding CT radiation dosage and practical recommendations may improve quality, including significant dose reductions, especially for organ-specific doses.[28]

Aulino et al. (2018) reported on a clinical trial that focused on an assessment tool for the late effect continuum of lymphedema and fibrosis (LEF) for patients with head and neck cancer (HNC) undergoing CT. The tool evaluates areas of soft tissue damage resulting from tumors, surgical interventions, or radiation therapy. The tool analyzed CT scans taken before and after

treatment in 10 patients with HNC. The finalized tool comprised 11 elements, including the assessment of fat stranding at six specific sites, epiglottic thickness measurement, and measurement of prevertebral soft tissue thickness at C3. A total of 176 CT scans from the 20 patients (with a range of 4-14 scans per patient) were evaluated. The final version of the LEF assessment tool (CT-LEFAT) offers a standardized approach to assess critical sites affected by soft tissue damage. Studies continue to evaluate reliability and validity.[29]

References

1. Centers for Medicare & Medicaid Services (CMS). National Coverage Determination (NCD). Computed tomography (220.1) Revision Effective Date March 12, 2008. https://www.cms.gov/medicare-coverage-database/view/ncd.aspx?ncdid=176&ncdver=2&bc=0
2. Centers for Medicare & Medicaid Services (CMS). Local Coverage Determination (LCD). MRI and CT scans of the head and neck (L37373). Revision Effective Date October 1, 2019. https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?lcdid=37373&ver=37&bc=0
3. Centers for Medicare & Medicaid Services (CMS). Billing and Coding: MRI and CT scans of the head and neck (A57204). Revision Effective Date October 1, 2025. https://www.cms.gov/medicare-coverage-database/view/article.aspx?articleid=57204&ver=37&=
4. Centers for Medicare & Medicaid Services (CMS). Local Coverage Determination (LCD). MRI and CT scans of the head and neck (L35175). Revision Effective Date January 29, 2020. https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?lcdid=35175&ver=63&bc=0
5. Centers for Medicare & Medicaid Services (CMS). Billing and Coding: MRI and CT scans of the head and neck (A57215). Revision Effective Date October 1, 2025. https://www.cms.gov/medicare-coverage-database/view/article.aspx?articleid=57215&ver=40&=
6. Sharma A, Kirsch CFE, et al. ACR appropriateness criteria hearing loss and/or vertigo. *J Am Coll Radiol*. 2018;15(11S):S321-S331. doi:10.1016/j.jacr.2018.09.020
7. American College of Radiology (ACR) ACR–ASNR–SPR practice parameter for the performance of computed tomography (CT) of the extracranial head and neck - resolution 5. Updated 2021.

https://www.acr.org/-/media/ACR/Files/Practice-Parameters/CT-Head-Neck.pdf

8. Hagiwara M, Policeni B, et al. ACR appropriateness criteria sinonasal disease: 2021 update. *J Am Coll Radiol*. 2022;19(5S):S175-S193. doi:10.1016/j.jacr.2022.02.011
9. Chow AW, Benninger MS, Brook I, et al. IDSA clinical practice guideline for acute bacterial rhinosinusitis in children and adults. *Clin Infect Dis*. 2012 Apr;54(8):e72-e112. doi:10.1093/cid/cir1043
10. Gregurić T, Prokopakis E, Vlastos I, et al. Imaging in chronic rhinosinusitis: A systematic review of MRI and CT diagnostic accuracy and reliability in severity staging. *J Neuroradiol*. 2021 Jun;48(4):277-281. doi:10.1016/j.neurad.2021.01.010
11. Kim SL, Rank MA, Peters AT. The chronic rhinosinusitis practice parameter. *Ann Allergy Asthma Immunol*. 2023 Sep;131(3):307-310. doi:10.1016/j.anai.2022.12.022
12. Krafft RM. Trigeminal neuralgia. *Am Fam Physician*. 2008 May;77(9):1291-6.
13. Ledbetter LN, Burns J, Shih RY, et al. Cerebrovascular diseases-aneurysm, vascular malformation, and subarachnoid hemorrhage. ACR appropriateness criteria [Internet] American College of Radiology (ACR). New 2021. http://www.acr.org
14. Rath TJ, Policeni B, et al. ACR appropriateness criteria cranial neuropathy: 2022 update. *J Am Coll Radiol*. 2022;19(11S):S266-S303. doi:10.1016/j.jacr.2022.09.021
15. Wasser EJ, Prevedello LM, Sodickson A, Mar W, Khorasani R. Impact of a real-time computerized duplicate alert system on the utilization of computed tomography. *JAMA Intern Med*. 2013;173(11):1024-1026. doi:10.1001/jamainternmed.2013.543
16. Cho SH, Ledford D, Lockey RF. Medical management strategies in acute and chronic rhinosinusitis. *J Allergy Clin Immunol Pract*. 2020;8(5):1559-1564. doi:10.1016/j.jaip.2020.02.020
17. The Image Gently Alliance. Procedures - cardiac imaging. Updated 2014. https://www.imagegently.org/Procedures/Cardiac-Imaging
18. National Cancer Institute. Radiation risks and pediatric computed

tomography (CT): A guide for health care. Updated September 4, 2018. https://www.cancer.gov/about-cancer/causes-prevention/risk/radiation/pediatric-ct-scans

19. Kim Y, Lee S, Abdelkhaleq R, Lopez-Rivera V, Navi B, Kamel H, Savitz SI, Czap AL, Grotta JC, McCullough LD, Krause TM. Utilization and availability of advanced imaging in patients with acute ischemic stroke. *Circ Cardiovasc Qual Outcomes*. 2021 Apr;14(4):e006989
20. Gregurić T, Prokopakis E, Vlastos I, et al. Imaging in chronic rhinosinusitis: A systematic review of MRI and CT diagnostic accuracy and reliability in severity staging. *J Neuroradiol*. 2021 Jun;48(4):277-281. doi: 10.1016/j.neurad.2021.01.010
21. Zhang F, Lu Z, Wang F. Advances in the pathogenesis and prevention of contrast-induced nephropathy. *Life Sci*. 2020;259:118379. doi:10.1016/j.lfs.2020.118379
22. Rudnick MR, Leonberg-Yoo AK, Litt HI, et al. The controversy of contrast-induced nephropathy with intravenous contrast: What is the risk?. *Am J Kidney Dis*. 2020;75(1):105-113. doi:10.1053/j.ajkd.2019.05.022
23. The Image Gently Alliance. Procedures - image gently and CT scans. Updated 2014. https://www.imagegently.org /Procedures/Computed-Tomography
24. Summers LN, Harry ML, Colling KP. Evaluating our progress with trauma transfer imaging: repeat CT scans, incomplete imaging, and delayed definitive care. *Emerg Radiol*. 2021;28(5):939-948. doi:10.1007/s10140-021-01938-x
25. Nguyen T, Bhosale PR, Cassia L, et al. Malignancy in pregnancy: Multimodality imaging and treatment. *Cancer*. 2023;129(10):1479-1491. doi:10.1002/cncr.34688
26. Kjelle E, Brandsæter IØ, Andersen ER, Hofmann BM. Cost of low-value imaging worldwide: A systematic review. *Appl Health Econ Health Policy*. 2024;22(4):485-501. doi:10.1007/s40258-024-00876-2
27. Bedernik A, Wuest W, May MS, et al. Image quality comparison of single-energy and dual-energy computed tomography for head and neck patients: A prospective randomized study. *Eur Radiol*. 2022 Nov;32(11):7700-7709. doi: 10.1007/s00330-022-08689-4

28. Smith-Bindman R, Chu P, Wang Y, et al. Comparison of the effectiveness of single-component and multicomponent interventions for reducing radiation doses in patients undergoing computed tomography: A randomized clinical trial. *JAMA Intern Med*. 2020 May 1;180(5):666-675. doi: 10.1001/jamainternmed.2020.0064
29. Aulino JM, Wulff-Burchfield EM, Dietrich MS, et al. Evaluation of CT changes in the head and neck after cancer treatment: Development of a measurement tool. *Lymphat Res Biol*. 2018 Feb;16(1):69-74. doi: 10.1089/lrb.2017.0024

Policy Revision History/Information

Original Date: October 17, 2024		
Review History		
Version 2	10/16/2025	Annual review. No changes to medical necessity criteria or procedure codes. Defined classifications of rhinosinusitis in definitions section. Rearranged bullets for improved usability and organization. Updated Harms and Benefits section. Added reference #14.