



Cohere Medicare Advantage Policy – Computed Tomography (CT), Chest

Clinical Policy for Medical Necessity Review

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Important Notices

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Policy Information:

Specialty Area: Diagnostic Imaging

Policy Name: Cohere Medicare Advantage Policy - Computed Tomography (CT), Chest

Type: Adult (18+ yo) | Pediatric (0-17 yo)

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Medical Necessity Criteria

Service: Computed Tomography (CT), Chest

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 \(LCD\). Computerized axial tomography \(CT\), thorax \(L33459\)](#)
 - [Billing and Coding: Computerized axial tomography \(CT\), thorax \(A56580\)](#)
- [Local Coverage Determination \(LCD\). Multiple imaging in oncology \(L35391\)](#)
 - [Billing and Coding: Multiple imaging in oncology \(A56848\)](#)

Description

Diagnostic examinations of the head (head scans) and of other parts of the body (body scans) performed by computerized tomography (CT) scanners are covered if medical and scientific literature and opinion support the effective use of a scan for the condition, and the scan is reasonable and necessary for the individual patient. CT scans have become the primary diagnostic tool for many conditions and symptoms. CT scanning used as the primary diagnostic tool can be cost-effective because it can eliminate the need for a series of other tests, is non-invasive and thus virtually eliminates complications, and does not require hospitalization.¹ CT of the chest can be performed as a screening examination in high-risk patients and to diagnose and evaluate a myriad of thoracic processes involving the lungs, mediastinum/hilum, pleura, and chest wall. Contrast usage is guided by the clinical scenario being investigated.⁶

Medical Necessity Criteria

Indications

Computed tomography (CT), chest is considered appropriate if **ANY** of the following is **TRUE**¹:

- Chest radiograph and/or physical examination have been performed and are indeterminate, or findings require further evaluation for **ANY** of the following:
 - Evaluation of pulmonary, mediastinal, pleural, or chest wall infections and their complications²; **OR**
 - Diagnosis and management of mediastinal neoplasms and other processes, including but not limited to thymoma and mediastinal lymphadenopathy^{2,4,7}; **OR**
 - For the evaluation of cardiopulmonary failure or insufficiency (e.g., unexplained shortness of breath, heart failure)²; **OR**
 - Neoplastic or hematologic conditions with involvement or potential involvement of the thorax for **ANY** of the following^{2,8,9}:
 - Initial staging⁴; **OR**
 - Treatment planning⁴; **OR**
 - Response assessment⁴; **OR**
 - Surveillance with **ANY** of the following⁴:
 - The patient is assumed to have either no known disease or disease that is stable or clinically insignificant (every 6-12 months for an overall duration [e.g., 5 years]); **OR**
 - Suspected recurrence/progression; **OR**
 - Evaluating response to treatment, when a change in therapy is contemplated (no more often than after 2 cycles of chemotherapy and/or 6-8 weeks since the prior imaging evaluation); **OR**
 - Detection and determination of nature and extent of cardiovascular abnormalities, such as, but not limited to, aneurysm, dissection, embolism, thrombosis, congenital anomalies, postoperative complications, and sequelae of atherosclerotic disease^{2,6}; **OR**
 - For assessing and/or guiding drainage of pulmonary or pleural fluid collections such as abscess, empyema, effusion, or pneumothorax²; **OR**

- For characterizing and follow-up evaluation of interstitial and alveolar lung disease due to idiopathic, allergic, collagen-vascular, environmental, or other causes^{2,6}; **OR**
- For evaluating thoracic sequelae of remote processes, including, but not limited to, pancreatitis, gastrointestinal perforation, and other processes²; **OR**
- For assessing injury, potential injury, or thoracic sequelae after trauma, burn, surgery, transplantation, radiation therapy, chemotherapy, or invasive procedure such as pacemaker placement, chest tube placement, or mechanical ventilation²; **OR**
- Evaluation of the patient with symptoms that may be arising from the chest, or be referred to the chest, including, but not limited to, cough, hemoptysis, chest pain, abdominal pain, and others²; **OR**
- To further characterize a suspected abnormality detected by another imaging test²; **OR**
- For the evaluation of a patient with myasthenia gravis to rule out thymic tumors²; **OR**
- Performance of CT-guided biopsies and drainage procedures when fluoroscopy is inadequate²; **OR**
- Repeat imaging (defined as 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 a change in symptoms, there is an established need for monitoring, which would influence management.

Non-Indications

Computed tomography (CT), chest with contrast is not considered appropriate if **ANY** of the following is **TRUE**:

- The patient has undergone advanced imaging of the same body part and for the same indication within 3 months without undergoing treatment or developing new or worsening symptoms.¹⁰

*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.

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.¹¹⁻¹²

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.¹¹⁻¹²

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.¹¹⁻¹²

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.¹¹⁻¹²

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.

Definitions

Fleischner Society 2017 Guidelines for Management of Incidentally Detected Pulmonary Nodules in Adults ¹⁴				
Solid Nodules*				
	Size			
Nodule Type	<6mm (<100 mm ³)	6–8 mm (100–250 mm ³)	>8 mm (>250 mm ³)	Comments
<i>Single</i>				
Low Risk**	No routine follow-up	CT at 6–12 months, then consider CT at 18–24 months	Consider CT at 3 months, PET/CT, or tissue sampling	Nodules <6 mm do not require routine follow-up in low-risk patients (recommendation 1A).
High Risk**	Optional CT at 12 months	CT at 6–12 months, then CT at 18–24 months	Consider CT at 3 months, PET/CT, or tissue sampling	Certain patients at high-risk with suspicious nodule morphology, upper lobe location, or both may warrant a 12-month follow-up (recommendation 1A).
<i>Multiple</i>				
Low Risk**	No routine follow-up	CT at 3–6 months, then consider CT at 18–24 months	CT at 3–6 months, then consider CT at 18–24 months	Use most suspicious nodule as guide to management. Follow-up intervals may vary according to size and risk (recommendation 2A).
High Risk**	Optional CT at 12 months	CT at 3–6 months, then at 18–24 months	CT at 3–6 months, then at 18–24 months	Use most suspicious nodule as guide to management. Follow-up intervals may vary according to size and risk (recommendation 2A).

Subsolid Nodules*			
	Size		
Nodule Type	<6mm (<100 mm³)	≥ 6 mm (>100 mm³)	Comments
<i>Single</i>			
Ground Glass	No routine follow-up	CT at 6–12 months to confirm persistence, then CT every 2 years until 5 years	In certain suspicious nodules <6 mm, consider follow-up at 2 and 4 years. If solid component(s) or growth develops, consider resection. (Recommendations 3A and 4A).
Part Solid	No routine follow-up	CT at 3–6 months to confirm persistence. If unchanged and solid component remain <6 mm, annual CT should be performed for 5 years.	In practice, part-solid nodules cannot be defined as such until ≥6 mm, and nodules <6 mm do not usually require follow-up. Persistent part-solid nodules with solid components 6mm should be considered highly suspicious (recommendations 4A–4C).
<i>Multiple</i>	CT at 3–6 months. If stable, consider CT at 2 and 4 years	CT at 3–6 months. Subsequent management based on the most suspicious nodule(s)	Multiple <6 mm pure ground-glass nodules are usually benign, but consider follow-up in selected patients at high risk at 2 and 4 years (recommendation 5A).

Lung-RADS® (2022) ⁴

Lung-RADS	Category Descriptor	Findings	Management
0	Incomplete Estimated Population Prevalence: ~1%	Prior chest CT examination being located for comparison (see note 9)	Comparison to prior chest CT
		Part of all of the lungs cannot be evaluated	Additional lung cancer screening CT imaging needed
		Findings suggestive of an inflammatory or infectious process (see note 10)	1-3 month LDCT
1	Negative Estimated Population Prevalence: 39%	No lung nodules; OR Nodule with benign features: <ul style="list-style-type: none"> Complete, central, popcorn, or concentric ring calcifications; OR Fat-containing 	
		Juxtapleural Nodule <ul style="list-style-type: none"> < 10 mm (524 mm³) mean diameter at baseline or new; AND Solid; smooth margins; and oval, lentiform, or triangular shape 	
2	Benign Based on imaging features or indolent behavior Estimated Population Prevalence: 45%	Solid Nodule <ul style="list-style-type: none"> < 6 mm (< 113 mm³) at baseline; OR New < 4 mm (< 34 mm³) 	12-month screening LDCT
		Part Solid Nodule <ul style="list-style-type: none"> < 6 mm (< 113 mm³) total mean diameter at baseline 	
		Non-Solid Nodule (GGN) <ul style="list-style-type: none"> < 30 mm (< 14,137 mm³) at baseline, new or growing; OR ≥ 30 mm (≥ 14,137 mm³) stable or slowly growing (see note 7) 	
		Airway nodule , subsegmental - at baseline, new, or stable (see note 11)	

		<ul style="list-style-type: none"> Category 3 lesion that is stable or decreased in size at 6-month follow-up CT; OR Category 4B lesion proven to be benign in etiology following appropriate diagnostic workup 	
3	<p>Probably Benign</p> <p>Based on imaging features or behavior</p> <p>Estimated Population Prevalence: 9%</p>	<p>Solid Nodule</p> <ul style="list-style-type: none"> ≥ 6 mm to < 8 mm (≥ 113 to < 268 mm³) at baseline; OR New 4 mm to < 6 mm (34 to < 113 mm³) 	6-month LDCT
		<p>Part Solid Nodule</p> <ul style="list-style-type: none"> ≥ 6 mm (≥ 113 mm³) total mean diameter with solid component < 6 mm (< 113 mm³) at baseline New < 6 mm (< 113 mm³) total mean diameter 	
		<p>Non-Solid Nodule (GGN)</p> <ul style="list-style-type: none"> ≥ 30 mm ($\geq 14,137$ mm³) at baseline or new 	
		<p>Atypical Pulmonary Cyst (see note 12)</p> <ul style="list-style-type: none"> Growing cystic component (mean diameter) of a thick-walled cyst 	
		<p>Category 4A lesion that is stable or decreased in size at 3-month follow-up CT (excluding airway nodules)</p>	
4A	<p>Suspicious</p> <p>Estimated Population Prevalence: 4%</p>	<p>Solid Nodule</p> <ul style="list-style-type: none"> ≥ 8 mm to < 15 mm (≥ 268 to < 1767 mm³) at baseline; OR Growing < 8 mm (< 268 mm³) New 6 to < 8 mm (113 to < 268 mm³) 	<p>3-month LDCT;</p> <p>PET/CT may be considered if there is a ≥ 8 mm (≥ 268 mm³) solid nodule or solid component</p>
		<p>Part Solid Nodule</p> <ul style="list-style-type: none"> ≥ 6 mm (≥ 113 mm³) total mean diameter with solid component ≥ 6 mm to < 8 mm (≥ 113 to < 268 mm³) at baseline; OR New or growing < 4 mm (< 34 mm³) solid component 	
		<p>Airway Nodule, segmental or more proximal - at baseline (see note 11)</p>	
		<p>Atypical Pulmonary Cyst (see note 12)</p> <ul style="list-style-type: none"> Thick-walled cyst; OR Multilocular cyst at baseline; OR Thin- or thick-walled cyst that becomes multilocular 	

4B	Very Suspicious Estimated Population Prevalence: 2%	Airway Nodule , segmental or more proximal - stable or growing (see note 11)	Referral for further clinical evaluation
		Solid Nodule <ul style="list-style-type: none"> ≥ 15 mm (≥ 1767 mm³) at baseline; OR New or growing ≥ 8 mm (≥ 268 mm³) 	Diagnostic chest CT with or without contrast; PET/CT may be considered if there is a ≥ 8 mm (≥ 268 mm ³) solid nodules or solid component;
		Part Solid Nodule <ul style="list-style-type: none"> Solid component ≥ 8 mm (≥ 268 mm³) at baseline; OR New or growing ≥ 4 mm (≥ 34 mm³) solid component 	
		Atypical Pulmonary Cyst (see note 12) <ul style="list-style-type: none"> Thick-walled cyst with growing wall thickness/nodularity; OR Growing multilocular cyst (mean diameter); OR Multilocular cyst with increased loculation or new/increased opacity (nodular, ground glass, or consolidation) 	Tissue sampling; and/or referral for further clinical evaluation;
Slow-growing solid or part-solid nodule that demonstrates growth over multiple screening exams (see note 8)	Management depends on clinical evaluation, patient preference, and the probability of malignancy (see note 13)		
4X	Estimated Population Prevalence: <1%	Category 3 or 4 nodules with additional features or imaging findings that increase suspicion for lung cancer (see note 14)	
S	Significant or Potentially Significant Estimated Population Prevalence: 10%	Modifier: May add to category 0-4 for clinically significant or potentially clinically significant findings unrelated to lung cancer (see note 15)	As appropriate to the specific finding

Level of Care Criteria

Inpatient or Outpatient

Procedure Codes (CPT/HCPCS)

CPT/HCPCS Code	Code Description
71250	Computed tomography (CT), thorax; without contrast material
71260	Computed tomography (CT), thorax; with contrast material(s)
71270	Computed tomography (CT), thorax; 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.

Clinical coverage criteria for computed tomography (CT) of the chest were fully defined and established by NCDs and/or LCDs. Cohere Health did not supplement this policy with any additional criteria or interpretations.

Medical Evidence

Hassankhani et al. (2023) conducted a systematic review and meta-analysis of the diagnostic utility of multidetector computed tomography (MDCT) scans in penetrating diaphragmatic injuries. The study investigates the diagnostic efficacy of MDCT in detecting diaphragmatic injuries caused by penetrating trauma, with a focus on the potential risks of missed injuries and complications in cases managed nonoperatively despite the recognized value of CT scans for stable patients. The progression of CT technology, notably with the emergence of MDCT, has significantly improved the capacity to identify and assess diaphragmatic injuries caused by penetrating trauma. Although CT has solidified its role in evaluating blunt abdominal trauma patients who are hemodynamically stable, becoming the preferred imaging method in this regard, utilization in cases of penetrating thoracoabdominal trauma remains an ongoing subject of investigation. The study underscores the efficacy of MDCT in identifying diaphragmatic injury resulting from penetrating trauma with moderate to high diagnostic accuracy.¹⁵

Cramer et al. (2021) provide a secondary analysis of a randomized control trial (RCT) on the incidence of second primary lung cancer after low-dose CT versus chest X-ray screening in head and neck cancer survivors. A total of 53,452 participants were enrolled in the study; 171 survivors of head and neck cancer were identified (82 had screening via low-dose CT of the chest and 89 via chest X-ray). The average age of participants was 61 years, with 132 being male (77%). The incidence of lung cancer was notably higher among head and neck cancer survivors compared to those without. In head and neck cancer survivors, the incidence of second primary lung cancer was 2610 cases per 100,000 person-years in the low-dose CT group versus 1594 cases per 100,000 person-years in the chest X-ray group. Overall survival in head and neck cancer survivors was 7.07 years with low-dose CT compared to 6.66 years with chest X-ray. The secondary analysis of the RCT indicates that head and neck cancer survivors face a heightened risk of developing second primary lung cancer. Low-dose CT screening is essential for such survivors, particularly individuals with a significant history of cigarette smoking who are deemed suitable for curative treatment.¹⁶

Oldroyd et al. (2021) performed a systematic review and meta-analysis to determine the clinical factors linked with cancer susceptibility in idiopathic inflammatory myopathies (IIMs) and conducted a comprehensive review of the available evidence concerning cancer screening within this context. The meta-analysis assessed the cancer risk linked with numerous clinical risk factors and myositis-specific autoantibodies (MSAs), providing insights for cancer screening strategies among IIM patients. The authors note that findings can collectively contribute to refining cancer screening guidelines, potentially facilitating earlier cancer detection and enhancing patient outcomes.¹⁷

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Policy Revision History/Information

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Review History

Version 2	10/16/2025	<p>Annual review.</p> <p>Rearranged bullets for improved usability and organization.</p> <p>Added sub-indication for neoplastic conditions for evaluating response to treatment/change in therapy.</p> <p>Revised the indication for assessment of injury or complications to include “invasive procedure such as pacemaker placement, chest tube placement, or mechanical ventilation.”</p> <p>Added indication for “CT-guided biopsies and drainage procedures when fluoroscopy is inadequate.”</p> <p>Clarified indications for repeat imaging to improve usability and organization.</p> <p>Removed duplicative language for aortic dissection.</p> <p>Added non-indication for “advanced imaging of the same body part and for the same indication within 3 months without undergoing treatment or developing new or worsening symptoms.”</p> <p>Removed note for contrast anaphylaxis allergy.</p>
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