Instructions for use

The following coverage policy applies to health benefit plans administered by Cigna. Coverage policies are intended to provide guidance in interpreting certain standard Cigna benefit plans and are used by medical directors and other health care professionals in making medical necessity and other coverage determinations. Please note the terms of a customer’s particular benefit plan document may differ significantly from the standard benefit plans upon which these coverage policies are based. For example, a customer’s benefit plan document may contain a specific exclusion related to a topic addressed in a coverage policy.

In the event of a conflict, a customer’s benefit plan document always supersedes the information in the coverage policy. In the absence of federal or state coverage mandates, benefits are ultimately determined by the terms of the applicable benefit plan document. Coverage determinations in each specific instance require consideration of:

1. The terms of the applicable benefit plan document in effect on the date of service
2. Any applicable laws and regulations
3. Any relevant collateral source materials including coverage policies
4. The specific facts of the particular situation

Coverage policies relate exclusively to the administration of health benefit plans. Coverage policies are not recommendations for treatment and should never be used as treatment guidelines.

This evidence-based medical coverage policy has been developed by eviCore, Inc. Some information in this coverage policy may not apply to all benefit plans administered by Cigna.

These guidelines include procedures eviCore does not review for Cigna. Please refer to the Cigna CPT code list for the current list of high-tech imaging procedures that eviCore reviews for Cigna.

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<td>71552</td>
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<td>76882</td>
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PEDCH-1.1 Pediatric Chest Imaging Age Considerations

✓ Many conditions affecting the chest in the pediatric population are different diagnoses than those occurring in the adult population. For those diseases that occur in both pediatric and adult populations, minor differences may exist in management due to individual age, comorbidities, and differences in disease natural history between children and adults. Individuals age < 18 years old should be imaged according to the Pediatric Chest Imaging Guidelines, and individuals age ≥ 18 years should be imaged according to the Chest Imaging Guidelines, except where directed otherwise by a specific guideline section.

PEDCH-1.2 Pediatric Chest Imaging Appropriate Clinical Evaluation

✓ A recent (within 60 days) face-to-face evaluation including a detailed history, physical examination, and appropriate laboratory studies should be performed prior to considering advanced imaging, unless the individual is undergoing guideline-supported scheduled follow-up imaging evaluation.

✓ Unless otherwise stated in a specific guideline section, the use of advanced imaging to screen asymptomatic individuals for disorders involving the chest is not supported. Advanced imaging of the chest should only be approved in individuals who have documented active clinical signs or symptoms of disease involving the chest.

✓ Unless otherwise stated in a specific guideline section, repeat imaging studies of the chest are not necessary unless there is evidence for progression of disease, new onset of disease, and/or documentation of how repeat imaging will affect individual management or treatment decisions.

PEDCH-1.3 Pediatric Chest Imaging Modality General Considerations

✓ MRI
  o MRI Chest is generally performed without and with contrast (CPT® 71552) unless the individual has a documented contraindication to gadolinium or otherwise stated in a specific guideline section
  o Due to the length of time for image acquisition and the need for stillness, anesthesia is required for almost all infants and young children (age < 7 years), as well as older children with delays in development or maturity. In this individual population, MRI imaging sessions should be planned with a goal of avoiding a short-interval repeat anesthesia exposure due to insufficient information using the following considerations:
MRI should always be performed without and with contrast unless there is a specific contraindication to gadolinium use. Since the individual already has intravenous access for anesthesia.

If multiple body areas are supported by eviCore guidelines for the clinical condition being evaluated, MRI of all necessary body areas should be obtained concurrently in the same anesthesia session.

- The presence of surgical hardware or implanted devices may preclude MRI.
- The selection of best examination may require coordination between the provider and the imaging service.

**CT**

- CT Chest is generally performed either with contrast (CPT® 71260) or without contrast (CPT® 71250).
  - There are no generally accepted pediatric indications for CT Chest without and with contrast (CPT® 71270).
- CT should not be used to replace MRI in an attempt to avoid sedation unless listed as a recommended study in a specific guideline section.
- The selection of best examination may require coordination between the provider and the imaging service.

**Ultrasound**

- Ultrasound of the chest (CPT® 76604) or axilla (CPT® 76882) is indicated as an initial study for evaluating adenopathy, palpable chest wall lesions, pleural effusion or thickening, and patency of thoracic vasculature.
- For those individuals who do require advanced imaging, ultrasound can be very beneficial in selecting the proper modality, body area, image sequences, and contrast level that will provide the most definitive information for the individual.

The guidelines listed in this section for certain specific indications are not intended to be all-inclusive; clinical judgment remains paramount and variance from these guidelines may be appropriate and warranted for specific clinical situations.

**References**


Axillary lymphadenopathy imaging indications in pediatric individuals are identical to those for adult individuals.
  o See CH-2.2~Axillary Lymphadenopathy for imaging guidelines.

Supraclavicular adenopathy in pediatric individuals is almost always pathologic, and advanced imaging is indicated prior to excisional biopsy. Fine needle aspiration, while common in adults prior to advanced imaging, is inappropriate for evaluating lymphadenopathy in pediatric individuals. Any of the following studies may be approved for evaluation of supraclavicular adenopathy in children:
  o CT Chest with contrast (CPT® 71260)
  o MRI Chest without and with contrast (CPT® 71552)
  o Ultrasound of the chest (CPT® 76604)

If malignancy is suspected, see the appropriate imaging guidelines as below:
  o Lymphoma: PEDONC-5~Pediatric Lymphomas
  o Soft tissue sarcoma: PEDONC-8~Pediatric Soft Tissue Sarcomas
  o Neuroblastoma: PEDONC-6~Neuroblastoma

Reference
The causes of mediastinal masses in children are generally different than those in adults, and the imaging considerations are different.

✓ Chest x-ray is indicated as an initial study for all individuals with suspected mediastinal mass

✓ CT Chest with contrast (CPT® 71260) is indicated for any pediatric individual with a mediastinal mass
  o Masses can be very large and anterior masses frequently cause compression of the trachea and/or mediastinal blood vessels

✓ MRI Chest without and with contrast (CPT® 71552) is indicated for any pediatric individual with:
  o A posterior (paravertebral) mediastinal mass
  o CT findings are inconclusive regarding specific anatomy
  o MRI should not be used for individuals with large anterior mediastinal masses if anesthesia is necessary to complete the study

✓ If lymphoma is strongly suspected or there is evidence of tracheal compression on CT imaging, PET/CT (CPT® 78815) is indicated prior to biopsy in pediatric individuals.
  o See PEDONC-5 Pediatric Lymphoma for imaging guidelines.

✓ If neuroblastoma is strongly suspected, MIBG (CPT® 78804) is indicated and can be approved prior to biopsy in pediatric individuals.
  o See PEDONC-6~Neuroblastoma for imaging guidelines.

✓ Ultrasound can be approved in children younger than 5 years old to distinguish prominent but otherwise normal thymus from true mediastinal mass

✓ A single repeat CT Chest with contrast (CPT® 71260) can be approved to confirm stability and avoid biopsy for individuals with NONE of the following features:
  o Anterior mediastinal mass
  o Enlarged lymph nodes anywhere in the imaging field
  o Lymphopenia
  o Pleural effusion
References


PEDCH-4.1 Imaging

✓ True hemoptysis is rare in pediatric individuals, and a face-to-face evaluation including a detailed history, physical examination, and appropriate laboratory studies should be performed prior to considering advanced imaging
  o Aspirated blood from epistaxis or emesis frequently presents as hemoptysis, and history and physical examination will aid in this assessment

✓ Chest X-ray is indicated as an initial study for stable individuals
  o Advanced imaging is not indicated for individuals with epistaxis and a normal chest radiograph and no personal or family history of underlying lung disease or bleeding disorder

✓ Chest CT with contrast (CPT® 71260) is indicated for all other pediatric individuals with hemoptysis
  o Chest CT without contrast (CPT® 71250) can be approved for individuals with a documented allergy to CT contrast or significant renal dysfunction

✓ MRI is not indicated in the evaluation of pediatric hemoptysis

References
PEDCH-5.1 Cystic Fibrosis

✓ Chest x-ray is the primary study for initial evaluation of acute clinical symptoms in individuals with cystic fibrosis

✓ CT Chest without contrast (CPT® 71250) or with contrast (CPT® 71260) is indicated for the following (without initial chest x-ray):
  o Hemoptysis
  o Pneumonia worsening despite antibiotic therapy
  o Pleural effusion or empyema
  o Suspected fungal pneumonia
  o Monitoring treatment changes on bronchiectasis
  o Expiratory CT for evaluating small airways disease

✓ Low dose CT Chest without contrast (CPT® 71250) is indicated every 2 years for monitoring of bronchiectasis and small airways disease

PEDCH-5.2 Bronchiectasis Not Associated with Cystic Fibrosis

✓ Bronchiectasis not associated with cystic fibrosis is rare in pediatric individuals, and imaging indications are identical to those for adult individuals.
  o See CH-7~BRONCHIECTASIS for imaging guidelines.

References

Bronchiolitis is a self-limiting viral infection causing lower respiratory tract illness, most common in infants under 12 months of age.

✓ Advanced imaging is not indicated for routine evaluation or monitoring of bronchiolitis, but can be approved for the following:
  o Pleural effusion or empyema on recent chest x-ray
  o Immunocompromised individuals with acute pulmonary symptoms
  o Abnormality on recent chest x-ray suggesting condition other than bronchiolitis

Reference

Pneumonia imaging indications in pediatric individuals are very similar to those for adult individuals. See CH-13~PNEUMONIA for imaging guidelines.

Pediatric-specific imaging considerations include the following:
  - Immunocompromised individuals with acute pulmonary symptoms should be imaged using CT Chest with contrast (CPT® 71260)
  - Individuals with recurrent lower respiratory tract infections should undergo CT Chest without contrast (CPT® 71250) or with contrast (CPT® 71260)
  - Ultrasound of the chest (CPT® 76604) can be approved for evaluation of childhood pneumonia

References
The Fleischner Society guidelines for solitary pulmonary nodule management do not apply to pediatric individuals. An incidental solitary pulmonary nodule in a child representing a primary lung carcinoma has never been reported in the literature. Similarly, an extrathoracic malignancy presenting with an incidental solitary pulmonary nodule in an otherwise healthy child is very rare.

- All children with a pulmonary nodule incidentally discovered on other imaging should have CT Chest with contrast (CPT® 71260) as a one-time evaluation.

- Follow up imaging of incidental solitary pulmonary nodules in asymptomatic healthy children is not necessary.
  - Follow up imaging is indicated for the following:
    - Immunocompromised individuals
    - Malignancy (see below)
    - Invasive infection
    - New or worsening pulmonary symptoms

- Children with a malignant solid tumor who have pulmonary nodules of any size should have imaging according to the guideline section for the specific cancer type. See Pediatric Oncology Imaging Guidelines for specific imaging indications.

- This guideline section does not apply to multiple pulmonary nodules, which are imaged according to the underlying disorder in pediatric individuals.

References

Positive PPD and tuberculosis imaging indications in pediatric individuals are identical to those for adult individuals. See CH-14~Positive PPD or Tuberculosis (TB) for imaging guidelines.

Radiopharmaceutical nuclear medicine imaging (CPT® 78805, 78806, or 78807) is rarely performed, but is indicated for evaluation of tuberculosis.

References

Advanced imaging is not indicated for routine evaluation or monitoring of asthma, but CT Chest without (CPT® 71250) or with (CPT® 71260) contrast can be approved for the following:

- Pleural effusion or empyema on recent chest x-ray
- Immunocompromised individual with acute pulmonary symptoms
- Abnormality on recent chest x-ray suggesting condition other than asthma

Reference
CT Chest without contrast (CPT®71250) is indicated in individuals with a pectus deformity for:
  o Preoperative planning
  o Significant cardiac displacement after chest x-ray and echocardiography (CPT®93306)
  o Evidence of pulmonary impingement after chest x-ray and pulmonary function tests (PFTs) if increasing shortness of breath. Note: It may not be possible to obtain PFTs in children younger than 9 years old.
  o CT Chest with contrast (CPT®71260) is indicated when suspected congenital heart disease or Marfan’s syndrome in those with Pectus Carinatum

References
✓ See PEDONC-17~Pediatric Breast Masses for imaging guidelines.
PEDCH-13~VASCULAR MALFORMATIONS

PEDCH-13.1 Vascular Ring

Vascular rings generally present with either respiratory symptoms (stridor, wheezing, tachypnea, cough) or feeding difficulties (dysphagia, slow feeding, hyperextension of the head while feeding, weight loss, failure to thrive) but can also be discovered incidentally on imaging obtained for other purposes.

✓ Chest x-ray is the recommended initial study in individuals with respiratory symptoms
✓ Barium esophagram is the recommended initial study in individuals with feeding difficulties
✓ Either Chest CTA (CPT®71275) or Chest MRA (CPT®71555) can be approved in individuals with known or suspected vascular ring after chest x-ray or barium esophagram
✓ Echocardiogram can be approved to rule out associated congenital heart disease
  o CPT® codes 93303, 93306, 93320, and 93325 can be approved for initial evaluation of individuals with vascular ring and no prior echocardiograms

PEDCH-13.2 Other Vascular Malformations

See PEDPVD-2~Vascular and Lymphatic Malformations for imaging guidelines.

Reference