# CIGNA MEDICAL COVERAGE POLICIES– RADIOLOGY

## Neck Imaging Guidelines

Effective Date: February 02, 2027

**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.

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These guidelines may address procedures, services, or medications that EviCore does not review for Cigna. Please refer to the **Cigna Code Lists** for the current list of procedures, services, and medications reviewed by EviCore for Cigna.

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# Table of Contents

Guideline Page

**General (Neck-1)....3**
**Dysphagia and Upper Digestive Tract Disorders (Neck-3)....9**
**Neck Mass/Swelling/Adenopathy (Neck-5)....16**
**Recurrent Laryngeal Nerve Palsy (Neck-7)....21**
**Thyroid and Parathyroid (Neck-8)....25**
**Imaging of the Larynx, Trachea, and Bronchus (Neck-9)....37**
**Neck Pain/Neck Trauma (Neck-10)....41**
**Salivary Gland Disorders (Neck-11)....50**
**Sore Throat, Odynophagia, and Hoarseness (Neck-12)....54**
**Procedure Codes Associated with General Neck Imaging....59**

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# General (Neck-1)

Guideline Page

Abbreviations for Neck Imaging Guidelines....4
General Guidelines (Neck-1.0)....5
References (Neck-1)....8

Neck Imaging Guidelines

# Abbreviations for Neck Imaging Guidelines

**NK.GG.Abbreviations.A**
**v1.0.2027**

| Abbreviations for Neck Imaging Guidelines | |
|---|---|
| **ACSS** | anterior cervical spine surgery |
| **ALS** | amyotrophic lateral sclerosis |
| **CT** | computed tomography |
| **ENT** | Ear, Nose, Throat |
| **FNA** | fine needle aspiration |
| **FEES** | fiberoptic endoscopic evaluation of swallowing |
| **FFL** | flexible fiberoptic laryngoscopy |
| **FOE** | fiberoptic exam for laryngoscopy |
| **GERD** | gastroesophageal reflux disease |
| **GI** | gastrointestinal |
| **HIV** | human immunodeficiency virus |
| **HPV** | human papillomavirus |
| **MEN-2** | multiple endocrine neoplasia |
| **MRI** | magnetic resonance imaging |
| **TNE** | transnasal esophagoscopy |
| **VFSS** | videofluoroscopic swallow study |



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# General Guidelines (Neck-1.0)

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**Criteria**

- A pertinent clinical evaluation since the onset or change in symptoms including a detailed history, physical examination, appropriate laboratory studies, and basic imaging such as plain radiography or ultrasound should be performed prior to considering advanced imaging (CT, MR, Nuclear Medicine), unless the individual is undergoing guideline-supported scheduled imaging evaluation. A meaningful technological contact (telehealth visit, telephone call, electronic mail or messaging) since the onset or change in symptoms can serve as a pertinent clinical evaluation.
- Advanced imaging of the neck covers the following areas:
  - Skull base (thus, a separate CPT® code for head imaging in order to visualize the skull base is considered not medically necessary)
  - Nasopharynx
  - Upper oral cavity to the head of the clavicle
  - Parotid glands and the supraclavicular region
- Ultrasound of neck soft tissues including thyroid, parathyroid, parotid and other salivary glands, lymph nodes, cysts, etc. can be helpful in more ill-defined masses or fullness and differentiating adenopathy from mass or cyst, to define further advanced imaging.
- CT Neck
  - CT Neck is usually obtained with contrast only (CPT® 70491).
    - With the exception of 4D CT Neck without and with contrast (CPT® 70492) for parathyroid adenoma localization, little significant information is added by performing a CT Neck without and with contrast (CPT® 70492), and there is the risk of added radiation exposure, especially to the thyroid.
    - CT Neck without contrast (CPT® 70490) can be difficult to interpret due to difficulty identifying the blood vessels.
      - Exceptions include:
        - Contrast is generally considered not medically necessary when evaluating known or suspected tracheal anomalies with CT.
        - Additionally, non-contrast CT is considered medically necessary for the evaluation of salivary duct stones in the appropriate clinical circumstance where intravenous contrast may obscure high attenuation stones. Dual-phase CT imaging (without and with IV contrast) is considered not medically necessary in this situation.



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        - Contrast enhanced CT is helpful in the assessment of cervical adenopathy and preoperative planning, including in the setting of thyroid carcinomas.
            - Contrast may cause intense and prolonged enhancement of the thyroid gland which interferes with radioactive iodine nuclear medicine studies.
            - Use of IV contrast is an important adjunct, however, because it helps to delineate the anatomic relationship between the primary tumor and metastatic disease. Iodine is generally cleared within four to eight weeks in most individuals, so concern about iodine burden from IV contrast causing a clinically significant delay in subsequent whole-body scans (WBSs) or radioactive iodine (RAI) treatment after the imaging followed by surgery is generally unfounded. The benefit gained from improved anatomic imaging generally outweighs any potential risk of a several week delay in RAI imaging or therapy. Where there is concern, a urinary iodine to creatinine ratio can be measured.
- MRI Neck
    - MRI Neck is used less frequently than CT Neck.
    - MRI Neck without and with contrast (CPT® 70543) is considered medically necessary if CT suggests the need for further imaging or if ultrasound or CT suggests any of the following:
        - Neurogenic tumor (schwannoma, neurofibroma, glomus tumor, etc.)
        - Vascular malformations
        - Deep neck masses
        - Angiofibromas
        - Cystic neck mass
        - Concern for malignancy (see **Squamous Cell Carcinomas of the Head and Neck (ONC-3)**, **Salivary Gland Cancers (ONC-4)**, or **Thyroid Cancer (ONC-6)** as appropriate)
    - MRI Neck without and with contrast (CPT® 70543) is considered medically necessary if the head and neck surgeon or neurosurgeon, or the provider in consultation with the head and neck surgeon or neurosurgeon, has reasonable clinical concern:
        - for a skull base or nasopharyngeal neoplasm, or potential perineural invasion/ cranial nerve involvement.
        - that extensive dental amalgam may obscure the anatomy on CT in individuals with oral cavity neoplasm.

### Health Equity Considerations

Health equity is the highest level of health for all individuals; health inequity is the avoidable difference in health status or distribution of health resources due to the social conditions in which individuals are born, grow, live, work, and age. Social determinants

of health are the conditions in the environment that affect a wide range of health, functioning, and quality of life outcomes and risks. Examples include the following: safe housing, transportation, and neighborhoods; racism, discrimination, and violence; education, job opportunities, and income; access to nutritious foods and physical activity opportunities; access to clean air and water; and language and literacy skills.

Neck Imaging Guidelines

# References (Neck-1)

**v1.0.2027**


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# Dysphagia and Upper Digestive Tract Disorders (Neck-3)

Guideline Page

Dysphagia and Upper Digestive Tract Disorders (Neck-3.1)..... 10
References (Neck-3).....14



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# Dysphagia and Upper Digestive Tract Disorders (Neck-3.1)

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**Criteria**

- **General considerations**
  - A detailed history of the dysphagia symptoms is important to distinguish neurogenic, pharyngeal and esophageal disorders.
  - Dysphagia (difficulty swallowing) can be the result of a wide range of benign and malignant processes that affects the body's ability to move food or liquid from the mouth to the pharynx and into the esophagus.
  - A short duration (weeks to months) of rapidly progressive esophageal dysphagia with associated weight loss is highly suggestive of esophageal cancer.
- **Gastroesophageal reflux disease (GERD)**
  - Non-cardiac chest pain suspected of being GERD should be evaluated first to exclude cardiac and other etiologies. See **Non-Cardiac Chest Pain-Imaging (CH-4.1)** in the Chest Imaging Guidelines and Indications for EGD (EGD-1) in the **Gastrointestinal Endoscopic Procedure Guidelines**.
  - Gastric emptying study (CPT® 78264) for individuals with refractory GERD symptoms, and gastroparesis is being considered.
- **Suspected foreign body impaction and ingested foreign bodies**
  - Plain x-rays are considered medically necessary as initial imaging.
  - If imaging is inconclusive, and/or there is suspicion of a radiolucent foreign body (such as fish or chicken bones, wood, plastic, thin metal objects, aluminum can pop-ups, etc.):
    - CT Neck and/or Chest with or without contrast (CPT® 70491 or CPT® 70490 and/or CPT® 71260 or CPT® 71250).
    - If requested, 3-D reconstruction (CPT® 76377) is considered medically necessary in this setting.
- **Oropharyngeal dysphagia**
  - Oropharyngeal dysphagia (difficulty in transferring food from the mouth to the pharynx)
    - Suspected neurologic causes: See appropriate sections in the **Head Imaging Guidelines**.
    - Initial evaluation is with direct visualization (with laryngoscopy and/or upper endoscopy).



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- Flexible fiberoptic laryngoscopy (FFL), FiberOptic Exam for laryngoscopy (FOE), TransNasal Esophagoscopy (TNE), and/or FEES (Fiberoptic Endoscopic Evaluation of Swallowing). FEES is a dynamic evaluation of swallowing via direct visualization using transnasal laryngoscopy during speech pathologist-guided oral intake of various consistencies.

▪ CT Neck with contrast (CPT® 70491) is considered medically necessary for any documented anatomic abnormalities suggested by direct visualization—i.e., on exam with flexible laryngoscopy or rigid video stroboscopy or FEES.

- **Esophageal dysphagia**
  - Esophageal dysphagia (difficulty in transferring food down the esophagus in the retrosternal region, e.g., food sticking in the neck or chest)
    - Initial evaluation is with barium esophagram or upper gastrointestinal endoscopy.
    - Advanced imaging is considered medically necessary for the evaluation of structural abnormalities demonstrated on either esophagram or direct visualization (i.e., laryngoscopy/upper GI endoscopy), such as external compression, tumor, stricture, diverticulum, etc.
      - Contrasted CT Neck (CPT® 70491), CT Chest (CPT® 71260), **and/or** CT Abdomen (CPT® 74160) depending on the location of the abnormality identified.
- **Suspected perforation, abscess, or fistula**
  - CT Neck, Chest, **and/or** Abdomen, contrast as requested is considered medically necessary (preferably with contrast- CPT® 70491, CPT® 71260, CPT® 74160), depending on location.
- **Hiatal hernia**
  - See **Hiatal Hernia (AB-12.3)** in the **Abdomen Imaging Guidelines**.
- **Globus sensation**
  - For individuals with globus sensation (i.e., the sensation of a lump or foreign body in the throat), CT Neck with contrast (CPT® 70491) is considered medically necessary when laryngoscopy and/or upper endoscopy has been performed and the following criteria are met:
    - Negative or equivocal findings on laryngoscopy and/or upper endoscopy and at least one of the following **red flags**:
      - Weight loss
      - Odynophagia/throat pain
      - Referred otalgia
      - Hoarseness
      - Hemoptysis
      - Other unilateral presentation of concerning symptoms
      - Known history of upper aerodigestive or esophageal malignancy

  - Known history of lymphoma
  - History of previous neck, esophageal, or gastric surgery
  - Palpable abnormality on physical examination such as neck mass
- **Post-operative dysphagia**
  - Dysphagia following surgery on the oropharynx, soft tissues of the neck, cervical spine, esophagus, or stomach:
    - In the immediate post-operative period, within 3 months of the surgery, the concern is for fluid collections, anastomotic leaks, perforations, and abscess. Prior laryngoscopy/upper endoscopy and barium esophagram are considered not medically necessary initially.
      - CT Neck with contrast (CPT® 70491) **AND/OR** CT Chest with contrast (CPT® 71260)
    - In the delayed post-operative period—three months or greater from surgery, the primary modalities for evaluation are history, physical, endoscopy (laryngoscopy or EGD) and/or barium esophagram/videofluoroscopic swallow study (VFSS) to direct any additional advanced imaging.
      - If the results of endoscopy and/or barium esophagram or VFSS are abnormal or inconclusive, the following is considered medically necessary:
        - CT Neck with contrast (CPT®70491) **AND/OR** CT Chest with contrast (CPT® 71260)
- **Suspected vascular ring** (See **Dysphagia (PEDNECK-5)** )
  - CTA Chest (CPT® 71275) **OR** MRA Chest (CPT® 71555) are the preferred imaging studies in the evaluation of a suspected vascular ring.
  - CT Chest with contrast (CPT® 71260) **OR** MRI Chest without contrast (CPT® 71550), **OR** MRI Chest without and with contrast (CPT® 71552) can be performed as alternative exams in the evaluation of suspected vascular ring.

### Evidence Discussion

### Dysphagia

- Imaging studies are complementary to endoscopy (and in certain cases, also manometry) in the evaluation of esophageal dysphagia. The optimal imaging study depends on the nature and location of the dysphagia, as well as clinical setting (Mari et al., 2025).
- Modified barium swallow study (videofluoroscopic procedure performed in conjunction with a speech therapist) is generally first line for oropharyngeal dysphagia with an attributable cause. CT is generally considered not medically necessary because it does not assess motility, nor the oropharyngeal and esophageal mucosa as well. CT may be helpful for subsequent evaluation if initial studies are not revealing, or if

there are suspicious findings on direct visualization (Expert Panel on Gastrointestinal Imaging et al., 2019).

- Barium esophagram is considered medically necessary for initial imaging of retrosternal dysphagia. CT is generally considered not medically necessary because it does not assess motility, nor esophageal mucosa as well. CT may be helpful if subsequent evaluation if initial studies are not revealing, or if there are suspicious findings on direct visualization and/or barium esophagram (Expert Panel on Gastrointestinal Imaging et al., 2019).
- Fluoroscopy still remains the imaging of choice for initial evaluation of early (as well as late) post-operative dysphagia, within the oropharyngeal or retrosternal regions. Utilizing a water-soluble contrast first, followed by barium if necessary, suspected leaks or fistulas may be investigated. Esophagrams are highly specific for leaks, but not as sensitive as CT. If high clinical suspicion remains following negative esophagram, esophagography and CT combined have a sensitivity and negative predictive value of 100%, but a specificity of 27% and positive predictive value of 56% (Expert Panel on Gastrointestinal Imaging et al., 2019).
- For oropharyngeal and retrosternal dysphagia, contrasted CT of the neck and/or chest is considered medically necessary when there is concern of early post-operative complications, such as leak, fluid collection, abscess, or hematoma (Expert Panel on Gastrointestinal Imaging et al., 2019).

## Dysphagia and Upper Digestive Tract Disorders Health Equity Considerations

- Dysphagia is more commonly reported in individuals who are female, White/Caucasian, non-Hispanic, of older age, low income, of public insurance, and unemployed (Zheng et al.,2023; Zagloul et al., 2024).
- Individuals who are female and White/Caucasian are less likely to pursue diagnostic testing for upper digestive tract disorders (Zagloul et al., 2024).
- GERD is more common in females, but the rate of complications is higher in males (Bains et al., 2024).
- Hispanic and Latino Americans have the highest prevalence of GERD among all minority populations in the United States (Kamal et al., 2023).
- Reflux is more common in individuals who are female, White/Caucasian, non-Hispanic, and of public insurance (Osafo et al., 2025).



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# Neck Mass/Swelling/ Adenopathy (Neck-5)

Guideline Page

Neck Mass/Swelling/Adenopathy (Neck-5.1)..... 17
References (Neck-5).....19

Neck Imaging Guidelines

# Neck Mass/Swelling/Adenopathy (Neck-5.1)

**NK.NM.0005.1.A**
**v1.0.2027**

**Criteria**

- Cervical lymphadenitis is common and follows most viral or bacterial infections of the ears, nose and throat. Painful acute lymphadenopathy should be treated with a trial of conservative therapy for 2-weeks, including antibiotics if appropriate. If there is improvement with conservative treatment, advanced imaging is considered not medically necessary. If the adenopathy persists, it can be imaged as per below.
- CT Neck with contrast (CPT® 70491) is considered medically necessary if:
  - Neck mass with any ONE of the following:
    - Size greater than or equal to 1.5cm
    - Mass present greater than or equal to 2 weeks or of uncertain duration
    - Non-tender neck masses
    - Firm texture or fixation of the mass
    - Suspected peritonsillar, retropharyngeal or other cervical space abscess
    - Ulceration of skin overlying the neck mass
    - Ear pain ipsilateral to the neck mass
    - Associated onset of hoarseness persistent for greater than 3-weeks
    - Associated onset of throat pain, tonsil asymmetry, oral or oropharyngeal ulceration, weight loss, or hemoptysis
    - History of malignancy that would be primary or metastatic to the neck
    - Prior ultrasound results, if performed, are suspicious or indeterminate for malignancy
  - Isolated tonsil asymmetry with concerning features such as suspicious appearance, firmness, palatal immobility, rapid unilateral enlargement, history of malignancy, or immune compromise. This may or may not be accompanied by a neck mass.
  - Carcinoma found in a lymph node or other neck mass
  - Suspected or known sarcoidosis
  - Preoperative evaluation of any neck mass
  - Foreign body migration with neck swelling
- MRI Orbit/Face/Neck without and with contrast (CPT® 70543) is considered medically necessary if:
  - CT suggests the need for further imaging



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  - Ultrasound or CT suggests neurogenic tumor (schwannoma, neurofibroma, glomus tumor, etc.), vascular malformations, cystic neck mass, deep neck masses, or angiofibroma
- MRI Orbit/Face/Neck without and with contrast (CPT® 70543) is also considered medically necessary without prior CT Neck or ultrasound requirement, if the head and neck specialist, or the provider in consultation with the head and neck specialist, has reasonable clinical concern for:
  - skull base or nasopharyngeal neoplasm, **OR**
  - potential perineural invasion/cranial nerve involvement, **AND/OR**
  - extensive dental amalgam which may obscure the anatomy on CT in individuals with oral cavity neoplasm.
- Congenital cervical sinus, fistula, or cyst for preoperative planning:
  - MRI Orbit/Face/Neck without and with contrast (CPT® 70543) **OR**
  - CT Neck with contrast (CPT® 70491)

**Evidence Discussion**

- CT has several benefits that support its utilization as a primary imaging modality, including its availability and cost. CT imaging is generally easily tolerated by individuals because of short scanning time (less than 5 minutes) and large scanner bore. While CT utilizes ionizing radiation, the average dose of 3 mSv (equivalent to approximately 150 chest x-rays) is considered acceptable in the adult population (Walasangikar et al., 2021).
- MRI is preferred for tumors of the nasopharynx or when there is a cranial nerve concern on physical examination because of its sensitivity to abnormalities of the skull base and in the detection of perineural spread. MRI also offers improved tissue contrast and can help detect subclinical tumors not evident with nasal endoscopy (Walasangikar et al., 2021).
- Ultrasound is also used to characterize neck masses, to guide tissue sampling, and to search for additional masses. It is both noninvasive and inexpensive. Ultrasound is, however, best suited for evaluation of superficial tissue, in situations where there will be a delay in obtaining CT or MRI, if the use of contrast medium is contraindicated, or as an adjunct to expedite FNA biopsy (Feier et al., 2022).
- Tonsil asymmetry is a common exam finding in both adults and children and is often benign. In cases of associated suspicious characteristics, neck imaging is medically necessary, even if there is not an associated neck mass (Gao et al., 2026).



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# Recurrent Laryngeal Nerve Palsy (Neck-7)

Guideline Page

Recurrent Laryngeal Nerve Palsy (Neck-7.1)..... 22
References (Neck-7).....24



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# Recurrent Laryngeal Nerve Palsy (Neck-7.1)

**NK.PA.0007.1.A**
**v1.0.2027**

## Criteria

- The following are considered medically necessary with new diagnosis of idiopathic unilateral vocal fold paralysis/immobility or weakness, as identified on videostroboscopy or laryngoscopy by an Otolaryngologist—Head and Neck surgeon, or a clinician in consultation with such a specialist:
  - MRI Brain without and with contrast (CPT® 70553) **OR** MRI Brain without contrast (CPT® 70551)

    **AND**
  - MRI Orbit/Face/Neck with and without contrast (CPT® 70543) **OR** CT Neck with contrast (CPT® 70491)

    **AND**
  - CT Chest with contrast (CPT® 71260)

## Evidence Discussion

### Evaluation of Idiopathic Unilateral Vocal Fold Paralysis/Immobility

- Idiopathic unilateral vocal fold immobility is a diagnosis of exclusion. When it is noted that a vocal cord is immobile on laryngoscopy, the etiology must be sought. If it is not apparent on history and laryngoscopy, this work-up involves imaging the entire pathway of the motor nerve supply to the involved side of the larynx—from the skull base to the superior mediastinum (Politano et al., 2021).
- Repeat imaging for a pre-existing diagnosis of idiopathic unilateral vocal cord paralysis may be considered on a case by case basis. Recommendations include possibly repeating advanced imaging as above within 5 years after initial diagnosis and workup, or performing regular (annual) clinical evaluations with imaging reserved for the development of new symptoms or exam findings (Noel et al., 2016).
- Contrasted CT Chest can play a role in the evaluation of left vocal cord palsy due to its anatomical position. The nerve extends down to varying degrees depending on if it is on the right or left side. On the right side, it can extend into the upper mediastinum, going under the subclavian artery. On the left side, it can extend to just beneath the aortic arch (Paquette et al., 2012). According to Paquette et al. (2012), "On average, the right RLN is 5-6 cm in length from its origin at the level of the brachiocephalic artery to the cricothyroid joint, whereas the left RLN is nearly 12 cm in length from



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its origin at the aortic arch, with much of its course being mediastinal". For these reasons, depending upon the facility performing the CT, a CT Neck may not go far enough into the chest to view the complete nerve in which case a CT chest will also be needed (Stonebraker et al., 2025).

## Recurrent Laryngeal Nerve Palsy Health Equity Considerations

- Individuals with a higher socioeconomic status typically receive a greater number of interventions for recurrent laryngeal nerve palsy, as well as a longer duration of care (Nourmahnad et al., 2024).

Neck Imaging Guidelines

# References (Neck-7)

**v1.0.2027**


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# Thyroid and Parathyroid (Neck-8)

Guideline Page

Thyroid Nodule (Neck-8.1)..... 26
Parathyroid Imaging (Neck-8.3)..... 28
Parathyroid Incidentaloma (Neck-8.4)..... 32
References (Neck-8)..... 34



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# Thyroid Nodule (Neck-8.1)

**NK.PT.0008.1.C**
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**Criteria**

- **Serum thyrotropin (TSH)** should be measured in the initial evaluation of thyroid nodule/mass/asymmetry/goiter but is considered not medically necessary for follow-up imaging.
- See **Thyroid Cancer-Surveillance/Follow-Up (ONC-6.4)** for thyroid nodules that are biopsy proven thyroid cancer but are being monitored on active surveillance.
- A thyroid nodule detected for the first time during pregnancy should be managed in the same way as in non-pregnant individuals, except for avoiding the use of radioactive agents for diagnostic and therapeutic purposes.
- **Nuclear scan (CPT® 78013 or CPT® 78014)** is considered medically necessary if the serum TSH is subnormal and ANY of the following:
  - Single or multiple thyroid nodules
  - Suspicion of ectopic thyroid tissue
  - Presence of thyroid nodule in the setting of Grave's disease.
- Following thyroid ultrasound, **CT Neck with contrast (CPT® 70491), or CT Neck without contrast (CPT® 70490), or MRI Orbit/Face/Neck without contrast (CPT® 70540), or MRI Orbit/Face/Neck without and with contrast (CPT® 70543)** is considered medically necessary for ANY of the following:

  Imaging should be done only after initial thyroid ultrasound has been performed.

  - Evaluation of extent of known substernal goiter
  - Suspected airway compression, (i.e., subjective sense of dyspnea or choking sensation in the clinical history with known multinodular goiter)
  - Presence of pathologic lymph nodes in cervical regions not visualized on ultrasound
  - Clinically suspected advanced thyroid disease, including invasive primary tumor
  - Any preoperative planning for thyroid disease
- **CT Chest without contrast (CPT® 71250) or with contrast (CPT® 71260)** is also considered medically necessary for:
  - preoperative planning for individuals with substernal extension of the thyroid, pulmonary symptoms, or abnormalities on chest x-ray, and should be ordered by a surgeon or in consultation with a surgeon.
- **Thyroglossal duct cysts (TGDC)**
  - CT Neck with contrast (CPT® 70491) or MRI Neck without and with contrast (CPT® 70543) is considered medically necessary (when requested by a head and



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neck surgeon or by a provider in consultation with a head and neck surgeon) for EITHER of the following:

- Pre-operative planning
- Evaluation of a suspected recurrence

**Evidence Discussion**

- Ultrasound (US) plays a key role in determining which nodules display characteristics suspicious for malignancy and warrant biopsy. Of palpable thyroid nodules, the American College of Radiology (ACR) states, "US provides high-resolution imaging to show that the palpable abnormality is within the thyroid and is the best study to characterize the nodule for the risk of malignancy" (Expert Panel on Neurological Imaging et al., 2019). US is also the best study to demonstrate goiter size and evaluate thyroid morphology (Expert Panel on Neurological Imaging et al., 2019). US has a sensitivity of 88%, a specificity of 86%, and a diagnostic accuracy of 92% (Shi et al., 2022).
- Nuclear imaging with a radionuclide uptake and scan also plays an important role in thyroid imaging. In the setting of a suppressed thyroid stimulating hormone (TSH) level, nuclear imaging helps to determine whether the individual has thyrotoxicosis (Expert Panel on Neurological Imaging et al., 2019).
- A thyroid nuclear scan, in conjunction with thyroid ultrasound, is also useful in the setting of a multinodular goiter and a normal TSH to identify hypofunctioning or isofunctioning nodules which should be targeted for biopsy (Expert Panel on Neurological Imaging et al., 2019).
- Neck CT is useful in determining the extent of a substernal goiter, evaluating whether a goiter is causing tracheal compression or deviation, assessing the extent of invasive thyroid cancer, or for preoperative imaging. It does not have a role in distinguishing benign from malignant thyroid nodules (Expert Panel on Neurological Imaging et al., 2019).
- Neck CT is preferred to neck MRI, as there is less respiratory motion artifact (Expert Panel on Neurological Imaging et al., 2019).
- FDG-PET/CT does not have a role in the initial imaging of a thyroid nodule (Expert Panel on Neurological Imaging et al., 2019).

## Thyroid Health Equity Considerations

- Racial and ethnic minorities with thyroid disease have worse health outcomes for both benign and malignant disease (Chen et al., 2022).
- Socioeconomic status, insurance status, and differential access to healthcare all contribute to disparities in health outcomes (Chen et al., 2022).

# Parathyroid Imaging (Neck-8.3)

**NK.PT.0008.3.C**
**v1.0.2027**

**Criteria**

- Classic primary hyperparathyroidism
  - Parathyroid Planar Imaging (CPT® 78070), Parathyroid Planar Imaging with SPECT (CPT® 78071), or Parathyroid Planar Imaging with SPECT/CT (preferred study) (CPT® 78072) AND/OR 4D CT Neck without and with contrast (CPT® 70492) are considered medically necessary if BOTH of the following criteria have been met:
    - PTH and Calcium levels are elevated
    - Intention of the study is preoperative localization
      - All parathyroid nuclear scan codes (CPT® 78070, CPT® 78071, CPT® 78072) include thyroid subtraction when performed and no additional thyroid nuclear scan CPT® codes are required unless otherwise indicated in **Thyroid Nodule (Neck-8.1)**.
      - Reporting or billing CPT® 78800 for the purpose of intraoperative parathyroid localization using a gamma probe is considered not medically necessary if performed along with a parathyroid nuclear scan (CPT® 78070, CPT® 78071, CPT® 78072).
      - 3D Imaging (CPT® 76377) is considered medically necessary with a 4D CT Neck.
  - MRI Neck without and with contrast (CPT® 70543) is considered medically necessary for cases of re-operation, difficult localization or ionizing radiation contraindication as ordered by an Endocrinologist, Parathyroid surgeon, or Radiologist or any provider in consultation with one of these specialists.
  - CT Chest with contrast (CPT® 71260) is considered medically necessary for the evaluation of ectopic mediastinal parathyroid adenomas as ordered by an Endocrinologist, Parathyroid surgeon, or Radiologist or any provider in consultation with one of these specialists.
  - Choline PET/CT (CPT® 78815 or CPT® 78816) is considered experimental, investigational, or unproven for preoperative localization in cases of primary hyperparathyroidism.
  - Repeat imaging is considered medically necessary (when ordered by a surgeon with expertise in parathyroidectomy or by a provider in consultation with such a surgeon) for EITHER of the following:
    - Prior non-localizing imaging and no prior parathyroid exploration
    - Persistent or recurrent hyperparathyroidism after parathyroid surgery



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- Primary hyperparathyroidism variants
  - Primary hyperparathyroidism with non-elevated serum calcium (serum calcium level normal and PTH elevated)
    - Confirmatory study is elevated ionized calcium, elevated albumin corrected calcium or elevated historic calcium levels.
  - Hypercalcemia with inappropriately non-suppressed PTH (calcium level elevated and PTH normal)
    - PTH level greater than or equal to 25 pg/mL is consistent with primary hyperparathyroidism.
  - Intention of parathyroid imaging should be for pre-operative localization.
  - Use the same guidance on imaging modalities as described in classic primary hyperparathyroidism.

    Primary Hyperparathyroidism variants:

| Primary Hyperparathyroidism Variant | Calcium | PTH | Confirms/strongly suggests primary hyperparathyroidism |
|---|---|---|---|
| Classic primary hyperparathyroidism | High | High | Yes |
| Primary hyperparathyroidism with non-elevated serum calcium | Normal | High | Elevated ionized albumin corrected or historic calcium levels* |
| Hypercalcemia with inappropriately non-suppressed PTH | High | Normal | PTH greater than or equal to 25 pg/ml |

- Normocalcemic hyperparathyroidism
  - Serum calcium levels (including ionized calcium levels) are always normal and PTH levels are elevated.
  - Secondary causes of PTH elevation are excluded.
  - Calcium, PTH and clinical status should be monitored annually.
    - In the event of laboratory progression to hypercalcemia, refer to classic primary hyperparathyroidism for imaging guidance.
    - In the event of clinical progression (decline in bone mineral density or new fracture/renal stone/nephrocalcinosis), imaging as noted above for classic primary hyperparathyroidism for the intent of preoperative localization is

considered medically necessary after consultation with a specialist or any provider in consultation with a specialist.

- Secondary renal hyperparathyroidism
  - Serum calcium levels are low or normal (but may also be elevated in more advanced disease) and PTH levels are very elevated.
  - Imaging as noted above for classic primary hyperparathyroidism for the intent of preoperative localization is considered medically necessary after consultation with a specialist if all of the following are met:
    - Individual has stage 3a-stage 5 chronic kidney disease (GFR less than 60).
    - PTH level is greater than 9x upper limit of normal reference range for the lab testing facility (~585 pg/mL) despite standard medical or pharmacologic therapy (calcimimetics, calcitriol and/or vitamin D analogs).
- Tertiary hyperparathyroidism
  - Serum calcium and PTH levels are elevated as a result of long standing secondary hyperparathyroidism in individuals on renal replacement therapy or after renal transplant.
  - Imaging as noted above for classic primary hyperparathyroidism for the intent of preoperative localization is considered medically necessary after consultation with a specialist or any provider in consultation with a specialist.

Hyperparathyroidism subtypes:

| Hyperparathyroidism Subtype | Calcium | PTH | Clinical Hallmarks |
|---|---|---|---|
| Normocalcemic Hyperparathyroidism | Normal | High | Calcium never elevated |
| Secondary Renal Hyperparathyroidism | Low/Normal/High | Very High | Stage 3a-5 CKD, PTH greater than 9x ULN |
| Tertiary Hyperparathyroidism | High | High | ESRD/renal transplant |

**Evidence Discussion**

- The purpose of parathyroid imaging is to aid in localizing hyperfunctioning parathyroid gland(s) for the purpose of curative surgery. Imaging has no role in the diagnosis of hyperparathyroidism (Wilhelm et al, 2016).
- There may be a need for more than one modality in the localization of a parathyroid adenoma as studies have shown no one modality is superior over others (Wilhelm et al, 2016).

- The sensitivity and positive predictive value of imaging modalities will vary in different situations, such as whether the individual has a single parathyroid adenoma or if multiple parathyroid glands are involved, if the imaging is for an initial surgical intervention versus a re-operation, and whether the individual has primary, secondary, or tertiary hyperparathyroidism (Wilhelm et al, 2016).

Neck Imaging Guidelines

# Parathyroid Incidentaloma (Neck-8.4)

**NK.PT.0008.4.A**
**v1.0.2027**

**Criteria**

- A mass incidentally found on neck imaging that may represent an enlarged parathyroid gland should prompt laboratory testing including calcium and PTH levels.
  - If laboratory abnormalities suggest hyperparathyroidism, i.e., "functioning parathyroid incidentaloma", see **Hyperparathyroidism (NECK-8.3)** for imaging recommendations.
  - If there are no laboratory abnormalities and diagnoses other than parathyroid incidentaloma are suspected, see **Neck Mass/Swelling/Adenopathy (NECK-5.1)** for imaging recommendations.
  - Parathyroid nuclear scans are commonly requested for an evaluation of a parathyroid incidentaloma; however, the sensitivity of these scans are low in individuals with normal calcium/PTH and no clinical symptoms of primary hyperparathyroidism. Reliance on either a positive scan or negative scan to decide if surgery is considered medically necessary is not supported by current literature.
- If a parathyroid incidentaloma is suspected on imaging prior to planned thyroid surgery or other head/neck surgery, the following studies are considered medically necessary if ordered by the surgical team or any provider in consultation with the surgical team:
  - Parathyroid Planar Imaging (CPT® 78070), Parathyroid Planar Imaging with SPECT (CPT® 78071), or Parathyroid Planar Imaging with SPECT/CT (CPT® 78072) AND/OR 4D CT Neck without and with contrast (CPT® 70492)

**Evidence Discussion**

- With the advent of high resolution CT scans, ultrasounds, and other imaging modalities, along with their widespread use as diagnostic modalities, parathyroid lesions are increasingly being incidentally found on these imaging studies (Patel et al., 2020).
- The distinct features of parathyroid lesions are readily seen on ultrasound imaging (Patel et al., 2020).
- If lab work does not indicate hyperfunctioning of the parathyroid gland, then these lesions can be monitored annually with ultrasound, as parathyroid nuclear scans have low sensitivity for detection in individuals with normal parathyroid function (Patel et al, 2020).
- Parathyroid nuclear scans, 4D CT of the Neck, and Neck ultrasound studies can be used in evaluation of parathyroid incidentalomas found prior to a pending neck



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surgery to aid in preoperative evaluation, as determined by the surgical team (Patel et al., 2020).

Neck Imaging Guidelines

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**v1.0.2027**

## Thyroid


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# Imaging of the Larynx, Trachea, and Bronchus (Neck-9)

Guideline Page

Imaging of the Larynx, Trachea, and Bronchus (Neck-9.1)..... 38
References (Neck-9).....40



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# Imaging of the Larynx, Trachea, and Bronchus (Neck-9.1)

**NK.TR.0009.1.A**
**v1.0.2027**

**Criteria**

- Initial evaluation for suspected laryngotracheal pathology:
  - Direct visualization of the upper airway (via laryngoscopy, with or without bronchoscopy)
- To further evaluate abnormalities found on direct visualization, including laryngotracheal, tracheal, or bronchial anomalies, foreign bodies or persistent segmental or lobar lung collapse:
  - CT Neck with contrast (CPT® 70491) **OR** CT Neck without contrast (CPT® 70490) **AND/OR**
  - CT Chest with contrast (CPT® 71260) **OR** CT Chest without contrast (CPT® 71250), depending on the anatomic level of the lesion.
  - If requested, 3-D reconstruction (CPT® 76377 or CPT® 76376) is considered medically necessary in the evaluation of a known or suspected foreign body.
    - MRI Orbit/Face/Neck without contrast (CPT® 70540) OR MRI Neck without and with contrast (CPT® 70543) is considered medically necessary as a supplement to CT Neck or CT Chest if additional assessment is needed.
    - See **Squamous Cell Carcinomas of the Head and Neck—Suspected/ Diagnosis (ONC-3.1)** for suspected laryngotracheal tumor.
- For suspected subglottic stenosis (SGS) after evaluation by a specialist or in consultation with a specialist who has directly visualized the upper airway:
  - CT Neck with contrast (CPT® 70491) **OR** CT Neck without contrast (CPT® 70490) is considered medically necessary.
- For obstructive physiology in the setting of tracheomalacia:
  - Expiratory HRCT (CPT® 71250) is considered medically necessary.

**Evidence Discussion**

- Radiographs by means of neck and chest radiographs are sensitive for only those radioopaque foreign bodies but have value in providing information regarding other chest pathology such as presence of consolidation, atelectasis and bronchiectasis (Kara et al., 2024).
- CT is more sensitive than x ray in identifying airway foreign bodies due to its higher resolution (Liu et al., 2022).

- CT scan can rapidly and accurately identify laryngo-tracheo-bronchial abnormalities prior to bronchoscopy such as pneumonia, airway stenosis, atelectasis, effusion and consolidation (Liu et al., 2022; Abdel Razek, 2016; Wallis et al., 2019).
- CT provides a sensitivity of more than 96% and a specificity of more than 97% in comparison to bronchoscopy for detecting tracheomalacia. CT provides the advantage of simultaneously evaluating mediastinal, vascular and lung pathologies (McCullagh et al., 2022).
- According to a 2022 review by Pasick et al., "spiral computed tomography (CT) with multiplanar reformatting and virtual endoscopy has proven comparable to rigid bronchoscopy with a 100% sensitivity and 100% specificity of detecting SGS.The length and grade of stenosis as well as measurements of proximal and distal airway are accurate on CT".



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# Neck Pain/Neck Trauma (Neck-10)

Guideline Page

Neck Pain (Cervical) (Neck-10.1)....42
Torticollis and Dystonia (Neck-10.2)....43
Eagle Syndrome (Neck-10.3)....45
Neck Trauma (Neck-10.4)....47
References (Neck-10)....48



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# Neck Pain (Cervical) (Neck-10.1)

**NK.NP.0010.1.A**

**v1.0.2027**

- Neck pain is usually related to a specific process and therefore, found elsewhere in these guidelines.
  - For the evaluation of neck pain or other symptoms which may involve the cervical spine, including myelopathy and cervical radiculopathy, see the Spine Imaging Guidelines.
  - For evaluation of neck pain related to sore throat/pharygitis, see **Sore Throat/ Throat Pain/Odynophagia (Neck-12.1)**.
  - For evaluation of neck pain related to cervical adenopathy or neck mass, see **Neck Mass/Swelling/Adenopathy (Neck-5.1)**.
  - For evaluation of neck pain related to carotid dissection or vascular concerns, see **Cerebrovascular and Carotid Disease - Initial Imaging (PVD-3.1)**.
  - For evaluation of neck pain related to torticollis, see **Torticollis and Dystonia (Neck-10.2)**.



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# Torticollis and Dystonia (Neck-10.2)

**NK.NP.0010.2.A**
**v1.0.2027**

**Criteria**

**Older Child (beyond infancy) or Adult**

- Initial evaluation with history of trauma, and low suspicion of injury:
  - Plain radiographs of the cervical spine are considered medically necessary.
    - To identify fracture or malalignment if plain radiographs are inconclusive or in individuals with a high-risk mechanism of cervical spine injury within the last 3 months (see below**):
      - CT Neck with contrast (CPT® 70491) **AND/OR**
      - CT Cervical Spine without contrast (CPT® 72125) is considered medically necessary.
- In the clinical setting of cervical spine trauma with an associated neurologic deficit:
  - MRI Cervical Spine without contrast (CPT® 72141) is considered medically necessary.
- In the absence of trauma, to identify underlying abscess, bony, muscular, vascular, or neurological causes, ONE of the following is considered medically necessary:
  - CT Neck with contrast (CPT® 70491), **OR**
  - CT Cervical Spine without contrast (CPT® 72125), **OR**
  - MRI Cervical Spine without contrast (CPT® 72141), **OR**
  - MRI Orbit/Face/Neck without and with contrast (CPT® 70543), **OR**
  - MRA Neck without and with contrast (CPT® 70549)
    - Positive→ Further advanced imaging is considered not medically necessary if a local cause has been identified.
    - Negative→ MRI Brain without and with contrast (CPT® 70553) is considered medically necessary to exclude CNS cause.

**High-risk mechanisms of cervical spine injury may include:
- Head trauma and/or maxillofacial trauma
- Pedestrian in a motor vehicle accident
- Fall from above standing height
- Diving accident
- Head-on motor vehicle collision without/with airbag deployment
- Rollover motor vehicle collision
- Ejection from the vehicle in a motor vehicle collision



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- High speed of the vehicle at the time of collision
- Not wearing a seatbelt/shoulder harness in a motor vehicle collision
- Individuals with ankylosing spondylitis are at high-risk of cervical spine fractures even with minor direct/indirect trauma to the cervical spine which can result in quadriparesis/quadriplegia

**Evidence Discussion**

- Per the American College of Radiology et al. (2022), CT offers superior evaluation of the bony structures of the spine.
- Individuals with abnormal neurological findings benefit from MRI to help identify spinal cord abnormalities and soft tissue causes in the workup of dystonia and/or torticollis (Beckmann et al., 2019).
- Risks associated with imaging include, but are not limited to, radiation exposure and contrast complications (Beckmann et al., 2019).
- Torticollis is an abnormal twisting of the neck in which the head is rotated or twisted. Causes are variable and may be congenital or acquired (caused by trauma, juvenile idiopathic arthritis, neoplasm, etc.) (Haque et al., 2012).



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# Eagle Syndrome (Neck-10.3)

**NK.NP.0010.3.A**
**v1.0.2027**

Also known as "calcified stylohyoid ligament", "elongation of styloid process", or "stylocarotid artery syndrome".

**Criteria**

- **Eagle Syndrome**
  - If Eagle Syndrome is suspected on exam and/or lateral neck x-ray:
    - CT Maxillofacial with contrast (CPT® 70487) **OR** CT Maxillofacial without contrast (CPT® 70486) **AND/OR**
    - CT Neck with contrast (CPT® 70491) **OR** CT Neck without contrast (CPT® 70490)
    - CTA/CTV (CPT® 70498) is also considered medically necessary to assess for concerns of vascular compression. See also **General Guidelines - CT and MR Angiography (CTA and MRA) (HD-1.5)** and **General Guidelines – Other Imaging Situations (HD-1.7).**
- 3-D rendering (CPT® 76376 or CPT® 76377) is considered medically necessary as an add on to CT Neck (CPT® 70491 **or** CPT® 70490), if requested, for accurate evaluation of the styloid process in relation to its anatomic relationship with the other head and neck structures, in surgical planning. See **3D Rendering (Preface-4.1)**.

**Background and Supporting Information**

- Eagle syndrome is typically seen in individuals after pharyngeal trauma or tonsillectomy (Swanson et al., 2023).
- Eagle syndrome is characterized by recurrent pain in the oropharynx, face, and neck as a result of an elongated styloid process or calcified stylohyoid ligament (Jalisi et al., 2017).
- The pain is typically pharngeal and may be referred to the ear. There may also be a variety of other symptoms which include, but are not limited to a sensation of a foreign body in the throat, odynophagia, or cervicofacial pain (Swanson et al., 2023).
- Impingement upon structures near the styloid process, such as the internal carotid artery, internal jugular vein, or cranial nerve(s), may cause symptoms such as tinnitus and headache (Swanson, et al., 2023)
- CTA/CTV is used when there is a concern for vascular compression which can lead to a dissection of the carotid artery, or intracranial hypertension in cases of a compressed internal jugular vein (Liu et al., 2025). CTA in these instances is beneficial because it "...more accurately delineates the three-dimensional spatial



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relationship between the styloid process and the ICA [internal carotid artery]...and helps judge luminal deformation or dissection" (Liu et al., 2025).

**Evidence Discussion**

- CT is the preferred modality for evaluation of bony structures and detection of abnormalities associated with calcifications (Swanson et al., 2023).
- Indications for cervicocerebral computed tomography angiography (CTA) or magnetic resonance angiography (MRA) of the head and neck vessels include the diagnosis, characterization and/or surveillance of a variety of vascular conditions, including vascular compression of the internal or external carotid artery by an elongated styloid process (Eagle Syndrome) (American College of Radiology et al., 2025b).
- Risks of CTA include exposure to ionizing radiation; thus, magnetic resonance angiography (MRA) is available as an alternative to reduce radiation exposure. In addition, MRA is an alternative for individuals with iodinated contrast allergies or other contraindications to iodinated contrast (American College of Radiology et al., 2025a; Lind & Do-Nguyen, 2021).
- MRA, as an alternative modality, is noninvasive, and does not require iodinated contrast. Limitations include artifacts due to motion, slow or turbulent flow, susceptibility effects, and claustrophobia. Additionally, MRA may not be a feasible option for those with contraindications to MRI such as incompatible pacemakers, cochlear implants, neurostimulators or other devices. In these scenarios, CTA may be the appropriate alternative (American College of Radiology et al., 2025a; Lind & Do-Nguyen, 2021; Loss et al., 2025).

# Neck Trauma (Neck-10.4)

**NK.NP.0010.4.A**
**v1.0.2027**

## Criteria

- CT Neck with contrast (CPT® 70491) OR CT Neck without contrast (CPT® 70490) is considered medically necessary in individuals with neck trauma who have an altered state of consciousness, distracting injuries or intoxication, midline tenderness to palpation, laryngeal trauma, or neurological deficits.
- Penetrating neck trauma
  - CTA Neck (CPT® 70498) is considered medically necessary for evaluating vascular injury and/or aerodigestive injuries.
- Blunt neck trauma
  - For any evidence of blunt neck trauma, including but not limited to: neurologic deficit, infarction on CT Head, cervical seatbelt sign, and fractures of the skull, face, or spine, a CTA Neck (CPT® 70498) is considered medically necessary.
  - If CTA is negative but high clinical suspicion remains for esophageal injury, MRA Neck with contrast (CPT® 70548) OR MRA Neck without contrast (CPT® 70547) OR MRA Neck without and with contrast (CPT® 70549) is considered medically necessary.

## Evidence Discussion

- CTA has high sensitivity and specificity for stable individuals with penetrating neck trauma (Ibraheem et al., 2020.
- CTA is the primary imaging modality to assess aerodigestive injuries from penetrating neck trauma. However, a high number of esophageal injuries are missed on CTA, so a negative CTA with suspicion for esophageal injury warrants additional testing (Siletz & Inaba, 2024; Paladino et al., 2021).
- MRA Neck can be useful to detect dissections and intramural hematoma from blunt neck trauma (Abu et al., 2020).
- CT Neck without contrast is useful to assess laryngeal neck trauma, as it can assess the cartilaginous and bony components, as well as determine any fractures that may need stabilization (Malvi & Jain, 2022).



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# Salivary Gland Disorders (Neck-11)

Guideline Page

Salivary Gland Disorders (Neck-11.1)....51
References (Neck-11)....53

Neck Imaging Guidelines

# Salivary Gland Disorders (Neck-11.1)

**NK.SG.0011.1.C**
**v1.0.2027**

**Criteria**

- **Salivary Gland Stones, Sialadenitis or Stenosis:**
  - Sialography (contrast dye injection) under fluoroscopy is considered medically necessary to rule out a salivary duct stone or stricture, using
    - Post-sialography CT (CT Maxillofacial without contrast [CPT® 70486] for Stensen's duct of the parotid gland, which would be most common; **or** CT Neck without contrast [CPT® 70490] for the level of the Wharton's Duct); **or** post-sialography MRI (MRI Orbit/Face/Neck without contrast [CPT® 70540]) **OR**
  - CT Maxillofacial area with contrast (CPT® 70487) **OR**
  - CT Neck with contrast (CPT® 70491)
    - CT performed only without IV contrast (CPT® 70490) may be helpful in a small minority of cases, such as cases of follow-up for known salivary stones, or for post-sialography imaging, as described above **OR**
  - MRI Orbit/Face/Neck without and with contrast (CPT® 70543)
- **Parotid or Other Salivary Gland Mass**
  - Either of the following are considered medically necessary:
    - MRI Orbit/Face/Neck without and with contrast preferred (CPT® 70543), **or** MRI Orbit/Face/Neck without contrast (CPT® 70540) **OR**
    - CT Neck with contrast (CPT® 70491) preferred **or** CT Maxillofacial area with contrast (CPT® 70487)
- **Repeat Imaging (CT or MRI, as above)**
  - Repeat advanced imaging, as requested by the surgeon or those in consultation with the surgical team, is considered medically necessary if relevant history and exam demonstrate symptoms or signs concerning for:
    - complications of surgery, or
    - recurrence or progression of neoplasm/lesion.

**Evidence Discussion**

- Current history and comprehensive head & neck exam are required prior to any advanced imaging for suspected salivary gland pathology (Kim et al., 2024; Moore et al., 2023).
- A recent study in the American Journal of Neuroradiology comparing contrast enhanced and non-contrast enhanced CT in the evaluation of sialolithiasis demonstrated excellent sensitivity and specificity with no false-positive results using contrast-enhanced CT alone (without the addition of non-contrasted images



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for comparison) (PUrcell et al., 2017). The sensitivity of contrast-enhanced CT is 96-98%, and the specificity is 88-100% (Kim et al., 2024). Benefits of initial only contrast-enhanced CT include better evaluation of the ductal system, improved soft tissue contrast in assessing salivary masses and decreased radiation dose (compared to dual phase CT imaging (without and with IV contrast)) (Purcell et al., 2017).

- CT and MRI are both useful in the evaluation of salivary gland tumors. Both have unique advantages. CT is better than MRI at evaluating bone erosion from malignant tumors as well as looking for stones in the glands or ducts (Grace et al.,2025). MRI is better at evaluating the soft tissue and can be helpful in determining the extent of disease and deep space involvement (Kuang et al., 2025)

Neck Imaging Guidelines

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# Sore Throat, Odynophagia, and Hoarseness (Neck-12)

Guideline Page

Sore Throat/Throat Pain/Odynophagia (Neck-12.1).....55
Hoarseness (Neck-12.2).....57
References (Neck-12).....58



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# Sore Throat/Throat Pain/Odynophagia (Neck-12.1)

**NK.ST.0012.1.A**
**v1.0.2027**

## Criteria

- See **Dysphagia and Upper Digestive Tract Disorders (Neck-3.1)** for dysphagia as the primary symptom.
- Sore Throat/Throat Pain/Odynophagia
  - Uncomplicated viral or streptococcal pharyngitis with sore throat:
    - Imaging studies are considered not medically necessary. See **Neck Mass/ Swelling/Adenopathy (Neck-5.1)** for suspected complications of pharyngitis/ tonsillitis, such as a cervical space abscess.
  - Postoperative throat pain or odynophagia after head and neck procedure with suspected complication of procedure:
    - CT Neck with contrast (CPT® 70491)
  - Sore throat/throat pain/odynophagia that is persistent or progressive for two or more weeks in spite of any treatment measures or observation:
    - Initial evaluation is laryngoscopy
      - If the initial laryngoscopy is abnormal, or if it is negative, and if there is a continued concern for an occult lesion within the pharynx due to any red flag symptoms (weight loss, referred otalgia, hoarseness, hemoptysis, and/or unilateral presentation of symptoms):
        - CT Neck with contrast (CPT® 70491) **OR**
        - MRI Orbit/Face/Neck without and with contrast (CPT® 70543)
      - If subjective dysphagia AND odynophagia are both present and the initial laryngoscopy and neck exam are normal (i.e., no cervical space abscess or post-surgical complication is suspected), and no red flag symptoms are present, then barium esophagram (or GI upper endoscopy) is considered medically necessary prior to the advanced imaging studies of the neck listed above.

## Background and Supporting Information

- Odynophagia – Painful swallowing (Expert Panel on Gastrointestinal Imaging et al., 2019)

## Evidence Discussion

- Both CT and MRI can be used to delineate masses and provide cross sectional visualization of lesions that are deep to the mucosal surface. CT has the advantage to

being readily available, requiring less time and less expense when compared to MRI (Rahim et al., 2023; McCormack & Nicewicz, 2022).

Neck Imaging Guidelines

# Hoarseness (Neck-12.2)

**NK.ST.0012.2.A**
**v1.0.2027**

### Criteria

- Laryngoscopy is the primary diagnostic modality for evaluating individuals with hoarseness. Imaging studies, including CT and MRI, are considered not medically necessary in most individuals with hoarseness because most hoarseness is self-limited or caused by pathology that can be identified by laryngoscopy alone.
- The need for advanced imaging is based upon abnormal findings upon laryngoscopy, such as:
  - Immobile or partially mobile vocal cord [see **Recurrent Laryngeal Nerve Palsy (NECK-7.1)**]
  - Any growth, asymmetry, ulceration, or other suspected neoplasm of the glottis or supraglottis [see **Neck Mass/Swelling/Adenopathy (Neck 5.1)**; see also **ONC-3.0-3.4**].

### Background and Supporting Information

- Hoarseness – A change in voice quality reported by the individual (Stachler et al., 2018)

### Evidence Discussion

- An evaluation of an individual with hoarseness should include a complete exam of the head and neck (Stachler et al., 2018). According to Stachler et al. (2018), "...most dysphonia is self-limited and related to upper respiratory tract infection, which usually resolves in 7 to 10 days regardless of treatment". Laryngoscopy is an important diagnostic tool in the evaluation of hoarseness by identifying any possible underlying pathological cause (Stachler et al., 2018).



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# Procedure Codes Associated with General Neck Imaging

Guideline Page

Procedure Codes Associated with General Neck Imaging..... 60

Neck Imaging Guidelines

# Procedure Codes Associated with General Neck Imaging

**v1.0.2027**

The inclusion of any code in this table does not imply that the code is under management or requires prior authorization. Refer to the applicable health plan for management details. Prior authorization of a code listed in this table is not a guarantee of payment. The Certificate of Coverage or Evidence of Coverage policy outlines the terms and conditions of the member's health insurance policy.

| Code | Description |
|---|---|
| **70486** | Computed tomography, maxillofacial area; without contrast material |
| **70487** | Computed tomography, maxillofacial area; with contrast material(s) |
| **70490** | Computed tomography, soft tissue neck; without contrast material |
| **70491** | Computed tomography, soft tissue neck; with contrast material(s) |
| **70492** | Computed tomography, soft tissue neck; without contrast material followed by contrast material(s) and further sections |
| **70498** | Computed tomographic angiography, neck, with contrast material(s), including noncontrast images, if performed, and image postprocessing |
| **70540** | Magnetic resonance (eg, proton) imaging, orbit, face, and/or neck; without contrast material(s) |
| **70543** | Magnetic resonance (eg, proton) imaging, orbit, face, and/or neck; without contrast material(s), followed by contrast material(s) and further sequences |
| **70547** | Magnetic resonance angiography, neck; without contrast material(s) |
| **70548** | Magnetic resonance angiography, neck; with contrast material(s) |
| **70549** | Magnetic resonance angiography, neck; without contrast material(s), followed by contrast material(s) and further sequences |
| **70551** | Magnetic resonance (eg, proton) imaging, brain (including brain stem); without contrast material |
| **70553** | Magnetic resonance (eg, proton) imaging, brain (including brain stem); without contrast material, followed by contrast material(s) and further sequences |



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| Code | Description |
|---|---|
| **71250** | Computed tomography, thorax, diagnostic; without contrast material |
| **71260** | Computed tomography, thorax, diagnostic; with contrast material(s) |
| **71270** | Computed tomography, thorax, diagnostic; without contrast material, followed by contrast material(s) and further sections |
| **71275** | Computed tomographic angiography, chest (noncoronary), with contrast material(s), including noncontrast images, if performed, and image postprocessing |
| **71550** | Magnetic resonance (eg, proton) imaging, chest (eg, for evaluation of hilar and mediastinal lymphadenopathy); without contrast material(s) |
| **71552** | Magnetic resonance (eg, proton) imaging, chest (eg, for evaluation of hilar and mediastinal lymphadenopathy); without contrast material(s), followed by contrast material(s) and further sequences |
| **71555** | Magnetic resonance angiography, chest (excluding myocardium), with or without contrast material(s) |
| **72125** | Computed tomography, cervical spine; without contrast material |
| **72141** | Magnetic resonance (eg, proton) imaging, spinal canal and contents, cervical; without contrast material |
| **74160** | Computed tomography, abdomen; with contrast material(s) |
| **76376** | 3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality with image postprocessing under concurrent supervision; not requiring image postprocessing on an independent workstation |
| **76377** | 3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality with image postprocessing under concurrent supervision; requiring image postprocessing on an independent workstation |
| **78012** | Thyroid uptake, single or multiple quantitative measurement(s) (including stimulation, suppression, or discharge, when performed) |
| **78013** | Thyroid imaging (including vascular flow, when performed) |
| **78014** | Thyroid imaging (including vascular flow, when performed); with single or multiple uptake(s) quantitative measurement(s) (including stimulation, suppression, or discharge, when performed) |
| **78070** | Parathyroid planar imaging (including subtraction, when performed) |



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| Code | Description |
|---|---|
| **78071** | Parathyroid planar imaging (including subtraction, when performed); with tomographic (SPECT) |
| **78072** | Parathyroid planar imaging (including subtraction, when performed); with tomographic (SPECT), and concurrently acquired computed tomography (CT) for anatomical localization |
| **78230** | Salivary gland imaging |
| **78231** | Salivary gland imaging; with serial images |
| **78232** | Salivary gland function study |
| **78800** | Radiopharmaceutical localization of tumor, inflammatory process or distribution of radiopharmaceutical agent(s) (includes vascular flow and blood pool imaging, when performed); planar, single area (eg, head, neck, chest, pelvis), single day imaging |
| **78815** | Positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization imaging; skull base to mid-thigh |
| **78816** | Positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization imaging; whole body |
| **78264** | Gastric emptying study |



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