04-70450-21

Original Effective Date: 09/15/09

Reviewed: 06/26/25

Revised: 07/15/25

Subject: Computed Tomography (CT) Thorax (Chest)

THIS MEDICAL COVERAGE GUIDELINE IS NOT AN AUTHORIZATION, CERTIFICATION, EXPLANATION OF BENEFITS, OR A GUARANTEE OF PAYMENT, NOR DOES IT SUBSTITUTE FOR OR CONSTITUTE MEDICAL ADVICE. ALL MEDICAL DECISIONS ARE SOLELY THE RESPONSIBILITY OF THE PATIENT AND PHYSICIAN. BENEFITS ARE DETERMINED BY THE GROUP CONTRACT, MEMBER BENEFIT BOOKLET, AND/OR INDIVIDUAL SUBSCRIBER CERTIFICATE IN EFFECT AT THE TIME SERVICES WERE RENDERED. THIS MEDICAL COVERAGE GUIDELINE APPLIES TO ALL LINES OF BUSINESS UNLESS OTHERWISE NOTED IN THE PROGRAM EXCEPTIONS SECTION.

DESCRIPTION:

Computed tomography (CT or CT scan) is an imaging modality used for the detection and evaluation of diseases and conditions in the chest (e.g., tumor, inflammatory disease, vascular disease, congenital abnormalities, trauma, and hemoptysis). CT involves the exposure of patients to ionizing radiation. CT should be performed under the supervision of a physician with training in radiation protection to optimize examination safety.

Summary and Analysis of Evidence: Computed tomography (CT) is a frequently used imaging modality for the diagnosis and evaluation of many thoracic diseases. CT is a radiologic modality for evaluating disorders of the thoracic including, but limited to disorders and conditions within the chest including, but not limited to cancer, lung cancer screening, and pulmonary emboli (ACR-ASNR-SPR, 2023).

POSITION STATEMENT:

Computed tomography (CT) of the thorax (chest) **meets the definition of medical necessity** for the following indications:

Known cancer

- Follow-up intervals for malignancies
- Cancer staging (includes unknown primary)
- Cancer restaging
- Suspicious signs or symptoms of recurrence
- Suspected cancer based on prior imaging (e.g., chest x-ray).

Chest mass (non-lung parenchymal)

- Mass or lesion, including lymphadenopathy, after non-diagnostic initial imaging
- Thymoma screening in myasthenia gravis members.

Interstitial lung disease

- Suspected or known based on restrictive pattern pulmonary function test or signs or symptoms after initial chest x-ray
- Signs or symptoms unresponsive to treatment
- Monitoring treatment response of known interstitial lung disease
- Known collagen vascular disease
- Guidance in selection of the most appropriate site for biopsy of diffuse lung disease.

Chronic cough (> 8 weeks) and chest x-ray completed

- After evaluation for other causes and failed treatment
- Clinical concern for bronchiectasis.

Tuberculosis (TB)

- Known or suspected tuberculosis and initial chest x-ray done.

Infection follow-up imaging

- Abscess, empyema, or pleural effusions on chest x-ray
- Evaluation of non-resolving pneumonia documented by at least two imaging studies for the following:
    - Unimproved with 4 weeks of antibiotic treatment; **OR**
    - Unresolved at 8 weeks.

Pneumothorax on chest x-ray

Vocal cord paralysis on endoscopic exam

Granulomatosis with polyangiitis (Wegener's granulomatosis)

Vascular disease

- CT chest is not preferred study for vascular disease, CTA should be considered
- Chest CT can be used to detect and follow-up thoracic aortic aneurysms.

Suspected pulmonary embolism (PE)

- Chest CT is considered not medically necessary for PE.

Congenital malformations

Hemoptysis (after x-ray completed)

Pre-operative/procedural evaluation

- Pre-operative evaluation for a planned surgery or procedure.

Post-operative/procedural evaluation

- Post-surgical follow-up when records document medical reason requiring additional imaging.

Chest wall pain (after initial evaluation with chest x-ray and/or rib films)

- History of known or suspected cancer
- Signs and symptoms of infection.

Chest CT and COVID-19 (Coronavirus)

Acute COVID

- Imaging is not indicated in members suspected of having coronavirus disease (COVID-19) and mild clinical features unless they are at risk for disease progression
- Imaging is indicated in a member with COVID-19 and worsening respiratory status
- In a resource-constrained environment, imaging is indicated for medical triage of members suspected of having COVID-19 who present with moderate-to-severe clinical features and a high pretest probability of disease.

Long (chronic) COVID

- Prior history of COVID with hypoxia or impaired lung function at follow-up
- Restricted diffusion on pulmonary function test (would need a high resolution CT (HRCT))
- Low oxygen saturation and a chest x-ray was done.

Lung cancer screening

Annual screening for lung cancer with low-dose (LDCT), non-contrast spiral (helical) multi-dector computed tomography (CT) **meets the definition of medical necessity** when **ALL** of the following criteria* are met:

- Member is between 50 and 80 years of age; **AND**

- There is at least a 20 pack-year smoking history; **AND**
- Member currently smokes or have quit within the past 15 years.

* Member selection criteria are based on the U.S. Preventive Services Task Force recommendation and the National Lung Screening Trial (NLST).

Nodule (lung) on initial LDC (linear discriminant classifier)

- Multiple nodules (the largest and type is used for decision)
- Follow-up with LDCT (see Lung RADS assessment category, Table 1).

Incidental lung nodules

- Incidental pulmonary nodules detected on a nonscreening chest CT
  - For member age ≥ 35 years old (see Fleischner Society Guidelines, Table 2)
  - Excludes:
    - Lung cancer screening (see lung cancer screening guidelines above)
    - History of primary cancer (imaging follow-up for surveillance is 3 months to detect interval nodule growth)
    - Immunosuppression (may require a shorter follow-up, such as 1 month, if suspicion of fulminant infection).

Incidental pulmonary nodules on non-chest CT

- Nodules >8mm or those with very suspicious features need further chest CT as early as possible
- Nodules ≤ 8mm (see Fleischner Society Gudelines, Table 2).

Table 1: Lung-RADS Assessment Category

Category Descriptor	Lung-RADS Score	Management
Incomplete	0	Additional lung cancer screening CT images and/or comparison to prior chest CT examinations is needed
Negative No nodules and definitely benign nodules	1	Continue annual screening with LDCT in 12 months
Benign Appearance or Behavior Nodules with a very low likelihood of becoming a clinically active cancer due to size or lack of growth	2	Continue annual screening with LDCT in 12 months
Probably Benign	3	6 month LDCT

Probably benign finding(s) - short term follow up suggested; includes nodules with a low likelihood of becoming a clinically active cancer		
Suspicious Findings for which additional diagnostic testing is recommended	4A	3 month LDCT; PET/CT may be used when there is a ≥ 8 mm (≥ 268 mm3) solid component
Very Suspicious Findings for which additional diagnostic testing and/or tissue sampling is recommended	4B 4X	Chest CT with or without contrast, PET/CT and/or tissue sampling depending on the *probability of malignancy and comorbidities. PET/CT may be used when there is a ≥ 8 mm (≥ 268 mm3) solid component. For new large nodules that develop on an annual repeat screening CT, a 1 month LDCT may be recommended to address potentially infectious or inflammatory conditions
Other Clinically Significant or Potentially Clinically Significant Findings (non lung cancer)	S	As appropriate to the specific finding

Adapted from: American College of Radiology (ACR) Lung-RADS® Version 1.1 Assessment Categories Release date: 2019

***Note:** See https://www.acr.org/-/media/ACR/Files/RADS/Lung-RADS/LungRADSAssessmentCategoriesv1-1.pdf for the full description of the LUNG-RADS® Assessment Categories. The link for this on-line LUNG-RADS® Assessment categories is to an outside source and is provided for your convenience only. Use of the link and related resources is subject to the terms and conditions of acr.org and is not warranted, maintained or affiliated with Florida Blue.

Table 2: Fleischner Society Guidelines for Management of Incidentally Detected Pulmonary Nodules

Solid Nodules*				
Nodule Type	Nodules < 6 mm (< 100 mm3)	Nodules 6-8 mm (100-200 mm3)	Nodules > 8 mm (> 250 mm3)	Comments
Single 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
Single High risk	Optional CT at 12 months	CT at 6–12 months, then at 18–24 months	Consider CT at 3 months, PET/CT,	Certain patients at high risk with suspicious nodule

			or tissue sampling	morphology, upper lobe location, or both may warrant 12-months follow-up (recommendation 1A)
Multiple 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)
Multiple High risk	Optional CT at 12 months	CT at 3–6 months, then 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)
Subsolid Nodules*				
Nodule Type	Nodules < 6 mm (< 100 mm3)	Nodules > 6 mm (> 100 mm3)	Comments	
Single Ground glass	No routine follow-up	CT at 6–12 months, to confirm persistence, then CT every 2 years until 5 year	For certain suspicious nodules < 6 mm, consider follow-up at 2 years and 4 years; if solid component(s) develops or growth occurs, consider resection (recommendations 3A and 4A)	
Partly solid	No routine follow-up	CT at 3–6 months to confirm persistence; if lesion is unchanged and solid component remains < 6 mm, annual CT should be performed for 5 years	In practice, partly solid nodules cannot be defined as such until they are > 6 mm, and nodules < 6 mm usually do not require follow-up, persistent partly solid nodules with a solid component ≥ 6 mm should be considered highly suspicious (recommendations 4A-AC)	
Multiple	CT at 3–6 months; if lesion	CT at 3–6 months; subsequent	Multiple > 6 mm pure ground glass nodules (GGNs) usually are benign, but	

	is stable, consider CT at 2 years and 4 years	management based on the most suspicious nodule(s)	consider follow-up at 2 years and 4 years in select patients at high risk (recommendation 5A)

Adapted from: Bueno J, Landeras L, Chung JH. Updated Fleischner Society Guidelines for Managing Incidental Pulmonary Nodules: Common Questions and Challenging Scenarios. Radiographics. 2018 Sep-Oct;38(5):1337-1350

Note: These recommendations do not apply to lung cancer screening, patients with immunosuppression, or patients with a known primary cancer. *Dimensions are the average of long and short axes, rounded to the nearest millimeter.

BILLING/CODING INFORMATION:

CPT Coding:

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
71271	Computed tomography, thorax, low dose for lung cancer screening, without contrast material(s)
76380	Computed tomography, limited or localized follow-up study

REIMBURSEMENT INFORMATION:

Reimbursement for computed tomography (71250 – 71270, 76380) performed on the same anatomical area is limited to two (2) computed tomography (71250 – 71270, 76380) within a 12-month period. Computed tomography (71250 – 71270, 76380) in excess of two (2) computed tomography (71250 – 71270, 76380) within a 12-month period are subject to medical review of documentation to support medical necessity. Documentation should include radiology reason for study, radiology comparison study-date and time, radiology comparison study observation, radiology impression, and radiology study recommendation.

Reimbursement for computed tomography (71250 – 71270, 76380) for an oncologic condition undergoing active treatment or active treatment completed within the previous 12 months on the same anatomical area is limited to four (4) computed tomography (71250 – 71270, 76380) within a 12-month period. Computed tomography (71250 – 71270, 76380) for an oncologic condition in excess of four (4) computed tomography (71250 – 71270, 76380) within a 12-month period are subject to medical review of documentation to support medical necessity. Documentation should include radiology reason for study, radiology comparison study-date and time, radiology comparison study observation, radiology impression, and radiology study recommendation.

Re-imaging or additional imaging due to poor contrast enhanced exam or technically limited exam is the responsibility of the imaging provider.

LOINC Codes:

The following information may be required documentation to support medical necessity: physician history and physical, physician progress notes, plan of treatment and reason for computed tomography (CT) of the thorax.

Documentation Table	LOINC Codes	LOINC Time Frame Modifier Code	LOINC Time Frame Modifier Codes Narrative
Physician history and physical	28626-0	18805-2	Include all data of the selected type that represents observations made six months or fewer before starting date of service for the claim
Attending physician progress note	18741-9	18805-2	Include all data of the selected type that represents observations made six months or fewer before starting date of service for the claim
Plan of treatment	18776-5	18805-2	Include all data of the selected type that represents observations made six months or fewer before starting date of service for the claim
Radiology reason for study	18785-6	18805-2	Include all data of the selected type that represents observations made six months or fewer before starting date of service for the claim
Radiology comparison study-date and time	18779-9	18805-2	Include all data of the selected type that represents observations made six months or fewer before starting date of service for the claim
Radiology comparison study observation	18834-2	18805-2	Include all data of the selected type that represents observations made six months or fewer before starting date of service for the claim
Radiology-study observation	18782-3	18805-2	Include all data of the selected type that represents observations made six months or fewer before starting date of service for the claim
Radiology-impression	19005-8	18805-2	Include all data of the selected type that represents observations made six months or fewer before starting date of service for the claim

Radiology study-recommendation (narrative)	18783-1	18805-2	Include all data of the selected type that represents observations made six months or fewer before starting date of service for the claim

PROGRAM EXCEPTIONS:

Federal Employee Plan (FEP): Follow FEP guidelines.

Medicare Advantage Products:

No Local Coverage Determination (LCD) were found at the time of the last guideline revised date.

The following National Coverage Determination (NCD) was reviewed on the last guideline review date: Computed Tomography, (220.1) located at cms.gov.

If this Medical Coverage Guideline contains a step therapy requirement, in compliance with Florida law 627.42393, members or providers may request a step therapy protocol exemption to this requirement if based on medical necessity. The process for requesting a protocol exemption can be found at Coverage Protocol Exemption Request

DEFINITIONS:

Effusion: the escape of fluid into a part or tissue, as an exudation or a transudation.

Hemoptysis: the expectoration of blood or of blood-stained sputum.

Myasthenia gravis: an autoimmune disease of neuromuscular function; characteristics include muscle fatigue and exhaustion that fluctuates in severity, without sensory disturbance or atrophy. It may be restricted to one muscle group or become generalized with severe weakness and sometimes respiratory insufficiency. It may affect any muscle of the body, especially those of the eyes, face, lips, tongue, throat, and neck. Called also Erb-Goldflam, Goldflam, or Goldflam-Erb disease.

Thymoma: a tumor derived from the epithelial or lymphoid elements of the thymus.

Tuberculosis: any of the infectious diseases of humans or other animals caused by species of Mycobacterium and characterized by the formation of tubercles and caseous necrosis in the tissues.

RELATED GUIDELINES:

Computed Tomography to Detect Coronary Artery Calcification, 04-70450-02
Computed Tomographic Angiography (CTA), 04-70450-03
Computed Tomography (CT), Head/Brain 04-70450-18
Computed Tomography (CT), Temporal Bone/Mastoid & Maxillofacial 04-70450-19
Computed Tomography (CT), of the Neck for Soft Tissue Evaluation 04-70450-20
Computed Tomography (CT) Abdomen and Pelvis 04-70450-22
Computed Tomography (CT), Spine (Cervical, Thoracic, Lumbar) 04-70450-23
Computed Tomography (CT), Extremity (Upper & Lower) 04-70450-24
Whole Body Computed Tomography (CT), 04-70450-25

OTHER:

Other name used to report computed tomography (CT) of the thorax (chest):

Note: The use of specific product names is illustrative only. It is not intended to be a recommendation of one product over another, and is not intended to represent a complete listing of all products available.

CAT scanning

Helical CT

Low-dose CT

Pediatric Examinations

The use of CT in pediatric examinations requires assessment of the risks, benefits and use of the studies. The lowest possible radiation dose consistent with acceptable diagnostic image quality should be used in pediatric examinations. Radiation doses should be determined periodically based on a reasonable sample of pediatric examinations. Technical factors should be appropriate for the size and the age of the child and should be determined with consideration of parameters (e.g., characteristics of the imaging system, organs in the radiation field, lead shielding).

REFERENCES:

1. American College of Radiology (ACR). ACR-STR Practice Parameter for the Performance of High-Resolution Computed Tomography (HRCT) of the Lungs in Adults, Revised 2020.
2. ACR-STR Practice Parameter for the Performance and Reporting of Lung Cancer Screening Thoracic Computed Tomography (CT), 2019.
3. ACR–SCBT-MR–SPR-STR Practice Parameter for the Performance of Thoracic Computed Tomography (CT), Revised 2023.
4. Bach PB, Mirkin JN, Oliver TK et al. Benefits and harms of CT screening for lung cancer: a systematic review. JAM 2012; 307(22): 2418-2429.
5. Bach PB, Silvestri GA, Hanger M et al. Screening for lung cancer* ACCP Evidence-Based Clinical Practice Guidelines (2nd Edition). Chest 2007; 132 (3): 69S-77S.
6. Barman M. Acute aortic dissection: An article from the e-journal of the ESC Council for Cardiology Practice. European Society of Cardiology 2014 Jul; 12(25).
7. Bruzzi JF, Komaki R, Walsh GL et al. Imaging of non-small cell lung cancer of the superior sulcus: part 1: anatomy, clinical manifestations, and management. Radiographics 2008; 28:551-560.
8. Bueno J, Landeras L, Chung JH. Updated Fleischner Society Guidelines for Managing Incidental Pulmonary Nodules: Common Questions and Challenging Scenarios. Radiographics. 2018 Sep-Oct;38(5):1337-1350.
9. Carter BW, Lichtenberger JP, Benveniste MK et al. Revisions to the TNM staging of lung cancer: rationale, significance, and clinical application. Radiographics 2018 Mar-Apr;38(2):374-391.
10. Detterbeck FC, Lewis SZ, Diekemper R et al. Diagnosis and Management of Lung Cancer, 3rd ed: American College of Chest Physicians Evidence-Based Clinical Practice Guidelines, Chest 2013 supplement; 143(5): 7S-37S.

11. Detterbeck FC, Lewis SZ, Diekemper R et al. Diagnosis and Management of Lung Cancer, 3rd ed: American College of Chest Physicians Evidence-Based Clinical Practice Guidelines, Chest 2013 supplement; 143(5): 7S-37S.
12. Dyer DS, Khan AR, Mohammed TL, et al. ACR Appropriateness Criteria on chronic dyspnea: suspected pulmonary origin. J Thorac Imaging. 2010 May;25(2): W21-3. [Abstract]
13. Expert Panel on Thoracic Imaging: de Groot PM, Chung JH, Ackman JB, et al. ACR Appropriateness Criteria® Noninvasive Clinical Staging of Primary Lung Cancer. J Am Coll Radiol. 2019 May;16(5S):S184-S195.
14. Expert Panel on Thoracic Imaging: Olsen KM, Manouchehr-Pour S, Donnelly EF, et al. ACR Appropriateness Criteria® Hemoptysis. J Am Coll Radiol. 2020 May;17(5S):S148-S159.
15. Fedullo PF, Tapson VF. The evaluation of suspected pulmonary embolism. The New England Journal of Medicine 2003; 349 (13): 1247-1256.
16. Ferreira Tda A, Chagas IS, Ramos RT, et al. Congenital thoracic malformations in pediatric patients: two decades of experience. J Bras Pneumol. 2015 Mar-Apr;41(2):196-9.
17. Hiratzka LF, Bakris GL, Beckman JA et al. 2010 ACCF/AHA/AATS/ACR/ASA/SCA/SCAI/SIR/STS/SVM Guidelines for the diagnosis and management of patients with thoracic aortic disease. A Report of the American College of Cardiology Foundation/American Heart Association Task Force on Practice Guidelines, American Association for Thoracic Surgery, American College of Radiology, American Stroke Association, Society of Cardiovascular Anesthesiologists, Society for Cardiovascular Angiography and Interventions, Society of Interventional Radiology, Society of Thoracic Surgeons, and Society for Vascular Medicine. J Am Coll Cardiol 2010 Apr 6;55(14): e27-e129.
18. Hocking WG, Hu P, Oken MM et al. Lung cancer screening in the randomized Prostate, Lung, Colorectal, and Ovarian (PLCO) Cancer Screening Trial. Journal of the National Cancer Institute 2010; 102(10): 722-731.
19. Humphrey LL, Deffebach M, Pappas M et al. Screening for lung cancer with low-dose computed tomography: a systematic review to update the U.S. Preventive Services Task Force Recommendation. Annals of Internal Medicine 2013; 159(6): 411-420.
20. Jaklitsch MT, JacobsonFL, Austin JH et al. The American Association for Thoracic Surgery guidelines for lung cancer screening using low-dose computed tomography scans for lung cancer survivors and other high-risk groups. Journal of Thoracic and Cardiovascular Surgery 2012; 144(1): 33-38.
21. Kumar R. Myasthenia graves and thymic neoplasms: A brief review. World J Clin Cases 2015 Dec 16; 3(12): 980-983.
22. Ko Y, Lee HY, Park YB et al. Correlation of microbiological yield with radiographic activity on chest computed tomography in cases of suspected pulmonary tuberculosis. PLoS One 2018 Aug 9; 13(8):e0201748.
23. Konstantinides SV, Torbicki A, Agnelli G et al. 2014 ESC guidelines on the diagnosis and management of acute pulmonary embolism. Eur Heart J. 2014 Nov 14;35(43):3033-69, 3069a-3069k.
24. Lij, Li C, Li J. Thoracic manifestation of Wegener's granulomatosis: Computed tomography findings and analysis of misdiagnosis. Exp Ther Med. 2018 Jul;16(1):413-419.
25. Little BP, Gilman MD, Humphrey KL et al. Outcome of recommendations for radiographic follow-up of pneumonia on outpatient chest radiography. AJR Am J Roentgenol. 2014 Jan;202(1):54-59.

26. Loverdos K, Fotiadis A, Kontogianni C, et al. A comprehensive review on current approach and management. Ann Thorac Med. 2019 Oct-Dec;14(4):226-238.
27. MacMahon H, Naidich DP, Goo JM et al. Guidelines for management of incidental pulmonary nodules detected on CT images: From the Fleischner Society 2017. Radiology 2017 Jul; 284(1):228-243.
28. Mazzone PJ, Silvestri GA, Patel S et al. Screening for Lung Cancer: CHEST Guideline and Expert Panel Report. Chest. 2018 Apr;153(4):954-985.
29. Munden RF, Swisher SS, Stevens CW et al. Imaging of the patient with non-small cell lung cancer. Radiology 2005; 327: 803-818.
30. National Comprehensive Cancer Network (NCCN) Clinical Practice Guidelines in Oncology. Lung Cancer Screening. Version 1.2022.
31. National Lung Screening Trial Research Team, Aberle DR, Adams AM et al. Reduced lung-cancer mortality with low-dose computed tomographic screening. New England Journal of Medicine 2011; 365: 395-409.
32. Pascall E, Tulloh RM. Pulmonary hypertension in congenital heart disease. Future Cardiol. 2018 Jul;14(4):343-353.
33. PDQ® Screening and Prevention Editorial Board. PDQ Lung Cancer Screening. Bethesda, MD: National Cancer Institute. Updated 07/30/2021.
34. Pynnonen MA, Gillespie MB, Roman B et al. Clinical Practice Guideline: Evaluation of the neck mass in adults. Otolaryngol Head Neck Surg. 2017 Sep;157(2_suppl): S1-S30.
35. Rubin GD, Ryerson CJ, Haramati LB, et al. The Role of Chest Imaging in Patient Management During the COVID-19 Pandemic: A Multinational Consensus Statement From the Fleischner Society. Chest. 2020 Jul;158(1):106-116.
36. US Preventive Services Task Force, Krist AH, Davidson KW, Mangione CM et al. Screening for Lung Cancer : US Preventive Services Task Force Recommendation Statement. JAMA. 2021 Mar 9; 325 (10): 962-970.
37. Wood DE, Kazerooni EA, Baum SL et al. Lung Cancer Screening, Version 3.2018, NCCN Clinical Practice Guidelines in Oncology. J Natl Compr Canc Netw. 2018 Apr;16(4):412-441.
38. Yang C, Liu R, Ming X et al. Thoracic organ doses and cancer risk from low pitch helical 4-dimensional computed tomography scans. Biomed Res Int. 2018 Sep 24; 2018:8927290.

COMMITTEE APPROVAL:

This Medical Coverage Guideline (MCG) was approved by the Florida Blue Medical Policy and Coverage Committee on 06/26/25.

GUIDELINE UPDATE INFORMATION:

09/15/09	New Medical Coverage Guideline.
01/01/10	Revised Florida Blue Radiology Management program exception section.
08/15/11	Scheduled review. Updated position statement. Added 76380. Revised limitation to two (2) within a 6-month period. Updated references.

10/01/11	Revision; formatting changes.
02/15/12	Updated position statement and references.
06/15/13	Scheduled review; MCG subject changed to “Computed Tomography Thorax (Chest)”. Revised and updated tumor, cancer or mass: added restaging and periodic follow-up of documented malignancy (primary neoplasm and metastatic disease). Added evaluation of suspicious mass/tumor (unconfirmed cancer diagnosis). Added interstitial lung disease. Updated infection or inflammatory disease: added evaluation of known inflammatory disease (initial, during treatment, new signs and symptoms) and evaluation of lung abscess, cavitary lesion, or empyema detected or suggested on prior imaging. Revised congenital anomalies: added vascular and nonvascular. Updated other section: changed 2 weeks duration for persistent unresolved cough to 4 weeks and deleted “has been performed”, changed to “is indeterminate. Added Wegener’s disease. Updated code descriptor (71260, 71270). Revision; Program Exceptions section updated. Updated related guidelines section and references.
01/01/14	Revision; added “with polyangitis” to Wegener’s granulomatosis.
04/15/14	Scheduled review; added position statement for low-dose computed tomography (CT) for lung cancer screening, added limitation statement for an oncologic condition; limited to four (4) computed tomography within a 12-month period, added “evaluation of” to congenital anomalies and hemoptysis, added “helical CT’ and “low-dose CT” to other section, and updated references.
04/15/15	Revised description. Deleted pulmonary embolism and pre-operative evaluation. Revised: tumor, cancer or mass, infection or inflammatory disease, vascular disease, congenital abnormalities, hemoptysis, post-operative evaluation and add “procedural” to header, and other. Added: indication for combination studies for initial pre-therapy staging of cancer, or ongoing tumor/cancer surveillance, or evaluation of suspected metastases, combination studies with chest CT, and combination of studies with chest CT/sinus CT.
05/28/15	Updated Billing/Coding section; added HCPCS code S8032 .
03/15/16	Updated Billing/Coding section; added HCPCS code G0297.
10/01/16	Quarterly HCPCS update; deleted S8032.
03/15/18	Revision; revised position statement. Added position statement for vascular disease. Updated references.
11/15/19	Revised position statements for (tumor, cancer or mass, lung cancer screening). Added position statement for pulmonary embolism (PE). Deleted indication for combination studies. Updated references.
04/15/20	Review/revision. Revised and expanded criteria for: (tumor (cancer or mass), interstitial lung disease, infection, inflammatory disease, congenital abnormality, pulmonary embolism, vascular disease, hemoptysis). Added indication and criteria for: (lung nodule, tuberculosis, pneumothorax, vocal cord paralysis, granulomatosis). Added indication: pre-operative evaluation. Deleted other indications for chest CT and combination studies with chest CT/sinus CT. Addd follow-up interval for low dose computed tomography. Updated references.
01/01/21	Annual HCPCS code update. Revised code descriptor (71250, 71260, 71270). Added 71271. Deleted G0297.

01/01/22	Revision; revised lung cancer screening. Changed age 55 to 50. Changed 30 pack to 20 pack. Updated references.
03/15/22	Review/revision. Revised and expanded criteria for: cancer and interstitial lung disease. Revised criteria for: chest mass and vascular disease. Revised and added criteria for pre-operative evaluation. Added indication and criteria for: chronic cough, chest wall pain, COVID-19, and incidental lung nodules. Added indication for pre-operative evaluation, neck and chest CT. Expanded criteria for lung nodule. Updated references.
07/01/22	Revision to Program Exceptions section.
07/08/23	Review: position statements and references updated.
08/21/23	Update to Program Exceptions section.
07/15/24	Review; no change in position statement. Updated references.
07/15/25	Review; no change in position statement.