CareSource

Qualified Health Plans offered in North Carolina by CareSource North Carolina Co., d/b/a CareSource

MEDICAL POLICY STATEMENT
North Carolina Marketplace

Policy Name & Number	Date Effective
Sinus & Maxillofacial CT-NC MP-MM-1388	01/01/2023-12/31/2023
Policy Type	
MEDICAL	

Medical Policy Statement prepared by CareSource and its affiliates are derived from literature based on and supported by clinical guidelines, nationally recognized utilization and technology assessment guidelines, other medical management industry standards, and published MCO clinical policy guidelines. Medically necessary services include, but are not limited to, those health care services or supplies that are proper and necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort. These services meet the standards of good medical practice in the local area, are the lowest cost alternative, and are not provided mainly for the convenience of the member or provider. Medically necessary services also include those services defined in any Evidence of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other policies and procedures.

Medical Policy Statements prepared by CareSource and its affiliates do not ensure an authorization or payment of services. Please refer to the plan contract (often referred to as the Evidence of Coverage) for the service(s) referenced in the Medical Policy Statement. If there is a conflict between the Medical Policy Statement and the plan contract (i.e., Evidence of Coverage), then the plan contract (i.e., Evidence of Coverage) will be the controlling document used to make the determination. According to the rules of Mental Health Parity Addiction Equity Act (MHPAEA), coverage for the diagnosis and treatment of a behavioral health disorder will not be subject to any limitations that are less favorable than the limitations that apply to medical conditions as covered under this policy.

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A. Subject
Sinus & Maxillofacial CT

B. Background
Computed tomography (CT) primarily provides information about bony structures but may also be useful in evaluating soft tissue masses. It can help document the extent of facial bone fractures, facial infections and abscesses, and can aid in diagnosing salivary stones. Additionally, CT may be useful in characterizing and identifying tumor extent in the face and may be used in the assessment of chronic osteomyelitis.

CT scans can provide more detailed information about the anatomy and abnormalities of the paranasal sinuses than plain films. A CT scan provides greater definition of the sinuses and is more sensitive than plain radiography for detecting sinus pathology, especially within the sphenoid and ethmoid sinuses. CT scan findings can be nonspecific, however, and should not be used routinely in the diagnosis of acute sinusitis. The primary role of CT scans of the sinuses and maxillofacial area is to aid in the diagnosis and management of recurrent and chronic sinusitis or to define the anatomy of the sinuses prior to surgery.

Magnetic Resonance Imaging (MRI) allows better differentiation of soft tissue structures within the sinuses. It is used occasionally in cases of suspected tumors or fungal sinusitis. Otherwise, MRI has no advantages over CT scanning in the evaluation of sinusitis. Disadvantages of MRI include high false-positive findings, poor bony imaging, and higher cost. MRI scans take considerably longer to accomplish than CT scans and may be difficult to obtain in patients who are claustrophobic.

C. Definitions
- **Computed Tomography (CT)** – A medical imaging technique that uses a combination of X-rays and computer technology to produce detailed images of internal organs, bones, soft tissue, and blood vessels.
- **Magnetic Resonance Imaging (MRI)** – A medical imaging technique that uses a magnetic field and computer-generated radio waves to create detailed images of organs and tissues.

D. Policy
I. CareSource considers Sinus and Maxillofacial CT medically necessary when **ANY** of following clinical criteria is met:
   A. Rhinosinusitis
      1. Symptoms that persist for more than 4 weeks and are not responding to medical management (e.g., 2 or more courses of antibiotics or any combination of antibiotics, steroids, or antihistamines for more than 4 weeks);
      2. Clinical suspicion of fungal infection;
      3. Clinical suspicion of complications, such as:
         a. Preseptal, orbital, or intracranial infection;
         b. Osteomyelitis;
         c. Cavernous sinus thrombosis;

4. Recurrent acute rhinosinusitis with 4 or more annual episodes without persistent symptoms in between;
5. Chronic recurrent sinusitis (symptoms for more than 12 weeks) not responding to at least 4 weeks of medical management and with at least two of the following:
   a. mucopurulent discharge;
   b. nasal obstruction and congestion;
   c. facial pain, pressure, and fullness;
   d. decreased or absent sense of small;
6. If suspected as a cause of poorly controlled asthma;
7. To evaluate in the setting of unilateral nasal polyps or obstruction (to evaluate for a potential neoplasm);

B. Pediatric Rhinosinusitis
   1. Persistent or recurrent sinusitis not responding to treatment (primarily antibiotics, treatment may require a change of antibiotics);
   2. Suspicion of orbital or central nervous system involvement (e.g., swollen eye, proptosis, altered consciousness, seizures, nerve deficit);
   3. Clinical suspicion of a fungal infection;

C. Deviated nasal septum, polyp, or other structural abnormality seen on imaging or direct visualization that may be causing significant airway obstruction (if needed to plan surgery or determine if surgery is appropriate);

D. Suspected sinonasal mass based on exam, nasal endoscopy, or prior imaging with contraindication to MRI or if bony involvement suspected;

E. Refractory asthma;

F. Anosmia or dysosmia noted on objective testing, is persistent, of unknown origin, and MRI cannot be performed;

G. Suspected Infection
   1. Osteomyelitis (after x-rays, MRI cannot be performed);
   2. Abscess;

H. Face mass
   1. Present on physical exam and remains non-diagnostic after x-ray or ultrasound is completed;
   2. Known or highly suspected head and neck cancer on examination;
   3. Failed 2 weeks of treatment for suspected infectious adenopathy;

I. Facial trauma
   1. Severe facial trauma;
   2. Suspected facial one fracture with indeterminate x-ray;
   3. For further evaluation of a known fracture for treatment or surgical planning;
   4. CSF (cerebrospinal fluid) rhinorrhea when looking to characterize a bony defect (for CSF otorrhea should be a Temporal Bone CT; for intermittent leaks and complex cases, consider CT/MRI/Nuclear Cisternography). CSF fluid should always be confirmed with laboratory testing (Beta-2 transferrin assay);

J. Salivary gland
   1. Suspicion of salivary gland stones or clinical concern for abscess;
   2. Sialadenitis with indeterminate ultrasound or bilateral symptoms;

K. Granulomatosis with polyangiitis (Wegener's granulomatosis) disease;
L. Suspected osteonecrosis of the jaw (possible etiologies: bisphosphonate treatment, dental procedures, Denosumab, radiation treatment);
M. Lesion seen on x-ray or other study requiring further characterization (e.g., primary or secondary bone tumor, metabolic disorder);
N. Trigeminal neuralgia/neuropathy if MRI is contraindicated or cannot be performed (for evaluation of the extracranial nerve course), and atypical features are present (i.e., bilateral, hearing loss, dizziness/vertigo, visual changes, sensory loss, numbness, pain > 2min, pain outside trigeminal nerve distribution, progression);
O. Pre-operative/procedural evaluation when medically necessary for a planned surgery or procedure;
P. Post-operative/procedural evaluation when imagining, physical, or laboratory findings indicate surgical or procedural complications;
Q. Combination sinus CT/chest CT for granulomatosis with polyangiitis (Wegener's granulomatosis) disease (GPA).

E. Conditions of Coverage

NA

F. Related Policies/Rules

NA

G. Review/Revision History

	DATE	ACTION
Date Issued	11/30/2022	
Date Revised		
Date Effective	01/01/2023	
Date Archived	12/31/2023	This Policy is no longer active and has been archived. Please note that there could be other Policies that may have some of the same rules incorporated and CareSource reserves the right to follow CMS/State/NCCI guidelines without a formal documented Policy.

H. References

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The MEDICAL Policy Statement detailed above has received due consideration as defined in the MEDICAL Policy Statement Policy and is approved.

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