Common symptoms and symptom complexes are addressed by this tool. Imaging requests for patients with atypical symptoms or clinical presentations that are not specifically addressed will require physician review. Consultation with the referring physician may provide additional insight.

This version incorporates MSI accepted revisions prior to 12/31/14

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©2015 MedSolutions, Inc. Chest Imaging Guidelines
# CHEST IMAGING GUIDELINES

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## ABBREVIATIONS for CHEST GUIDELINES

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<tr>
<td>AAA</td>
<td>abdominal aortic aneurysm</td>
</tr>
<tr>
<td>ACE</td>
<td>angiotensin-converting enzyme</td>
</tr>
<tr>
<td>AVM</td>
<td>arteriovenous malformation</td>
</tr>
<tr>
<td>BI-RADS</td>
<td>Breast Imaging Reporting and Database System</td>
</tr>
<tr>
<td>BP</td>
<td>blood pressure</td>
</tr>
<tr>
<td>BRCA</td>
<td>tumor suppressor gene</td>
</tr>
<tr>
<td>CAD</td>
<td>computer-aided detection</td>
</tr>
<tr>
<td>CBC</td>
<td>Complete blood count</td>
</tr>
<tr>
<td>COPD</td>
<td>chronic obstructive pulmonary disease</td>
</tr>
<tr>
<td>CT</td>
<td>computed tomography</td>
</tr>
<tr>
<td>CTA</td>
<td>computed tomography angiography</td>
</tr>
<tr>
<td>CTV</td>
<td>computed tomography venography</td>
</tr>
<tr>
<td>DCIS</td>
<td>ductal carcinoma in situ</td>
</tr>
<tr>
<td>DVT</td>
<td>deep venous thrombosis</td>
</tr>
<tr>
<td>ECG</td>
<td>electrocardiogram</td>
</tr>
<tr>
<td>EM</td>
<td>electromagnetic</td>
</tr>
<tr>
<td>EMG</td>
<td>electromyogram</td>
</tr>
<tr>
<td>FDA</td>
<td>Food and Drug Administration</td>
</tr>
<tr>
<td>FDG</td>
<td>fluorodeoxyglucose</td>
</tr>
<tr>
<td>FNA</td>
<td>fine needle aspiration</td>
</tr>
<tr>
<td>GERD</td>
<td>gastroesophageal reflux disease</td>
</tr>
<tr>
<td>GI</td>
<td>gastrointestinal</td>
</tr>
<tr>
<td>HRCT</td>
<td>high resolution computed tomography</td>
</tr>
<tr>
<td>IPF</td>
<td>idiopathic pulmonary fibrosis</td>
</tr>
<tr>
<td>LCIS</td>
<td>lobular carcinoma in situ</td>
</tr>
<tr>
<td>LFTP</td>
<td>localized fibrous tumor of the pleura</td>
</tr>
<tr>
<td>MRA</td>
<td>magnetic resonance angiography</td>
</tr>
<tr>
<td>MRI</td>
<td>magnetic resonance imaging</td>
</tr>
<tr>
<td>MRV</td>
<td>magnetic resonance venography</td>
</tr>
<tr>
<td>NCV</td>
<td>nerve conduction velocity</td>
</tr>
<tr>
<td>PE</td>
<td>pulmonary embolus</td>
</tr>
<tr>
<td>PEM</td>
<td>positron-emission mammography</td>
</tr>
<tr>
<td>PET</td>
<td>positron emission tomography</td>
</tr>
<tr>
<td>PFT</td>
<td>pulmonary function tests</td>
</tr>
<tr>
<td>PPD</td>
<td>purified protein derivative of tuberculin</td>
</tr>
<tr>
<td>RODEO</td>
<td>Rotating Delivery of Excitation Off-resonance MRI</td>
</tr>
<tr>
<td>SPN</td>
<td>solitary pulmonary nodule</td>
</tr>
<tr>
<td>SVC</td>
<td>superior vena cava</td>
</tr>
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</table>
### BI-RADS™ Categories Chart

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Category 0: Incomplete</strong></td>
<td>Need additional imaging evaluation or prior mammograms for comparison.</td>
</tr>
<tr>
<td><strong>Category 1: Negative</strong></td>
<td>There is nothing to comment on. The breasts are symmetrical and no masses, architectural disturbances or suspicious calcifications are present.</td>
</tr>
<tr>
<td><strong>Category 2: Benign Finding</strong></td>
<td>This is also a negative mammogram, but the interpreter may wish to describe a finding. Involuting, calcified fibroadenomas, multiple secretory calcifications, fat containing lesions such as oil cysts, lipomas, galactoceles, and mixed density hamartomas all have characteristic appearances, and may be labeled with confidence. The interpreter might wish to describe intramammary lymph nodes, implants, etc. while still concluding that there is no mammographic evidence of malignancy.</td>
</tr>
<tr>
<td><strong>Category 3: Probably Benign Finding – Short Interval Follow-up Suggested</strong></td>
<td>A finding placed in this category should have a very high probability of being benign. It is not expected to change over the follow-up interval, but the radiologist would prefer to establish its stability. Data is becoming available that sheds light on the efficacy of short interval follow-up. At the present time, most approaches are intuitive. These will likely undergo future modification as more data accrue as to the validity of an approach, the interval required, and the type of findings that should be followed.</td>
</tr>
<tr>
<td><strong>Category 4: Suspicious Abnormality – Biopsy Should Be Considered</strong></td>
<td>There are lesions that do not have the characteristic morphologies of breast cancer but have a definite probability of being malignant. The radiologist has sufficient concern to urge a biopsy. If possible, the relevant possibilities should be cited so that the patient and her physician can make the decision on the ultimate course of action.</td>
</tr>
<tr>
<td><strong>Category 5: Highly Suggestive of Malignancy-Appropriate Action Should Be Taken</strong></td>
<td>These lesions have a high probability of being cancer and should be biopsied or treated surgically.</td>
</tr>
<tr>
<td><strong>Category 6: Known Biopsy-Proven Malignancy – Appropriate Action Should Be Taken</strong></td>
<td>These lesions have been biopsied and are known to be malignant.</td>
</tr>
</tbody>
</table>
A current clinical evaluation (within 60 days), which includes a relevant history and physical examination and appropriate laboratory studies and non-advanced imaging modalities, such as plain x-ray or ultrasound, are required prior to considering advanced imaging. Other meaningful contact (telephone call, electronic mail or messaging) by an established patient can substitute for a face-to-face clinical evaluation.

A Pulmonary or Thoracic Surgical Specialist can be helpful in evaluating thoracic disorders.

**CH-1.1 General Guidelines - Chest X-ray**

- A recent chest x-ray (generally within the last 60 days) that has been overread by a radiologist would be performed in many of these cases prior to considering advanced imaging.
  - Identify and compare with previous chest films to determine presence and stability
  - Exceptions may include:
    - Supraclavicular lymphadenopathy
    - Bronchiectasis
    - Interstitial lung disease
    - Positive PPD or tuberculosis
    - Pulmonary AVM

**CH-1.2 General Guidelines - Chest Ultrasound**

- Chest ultrasound (CPT®76604) includes transverse, longitudinal, and oblique images of the chest wall with measurements of chest wall thickness, and also includes imaging of the mediastinum.
- Chest x-ray should be performed prior to chest ultrasound

**Chest Ultrasound Coding Notes**

- Chest ultrasound: CPT®76604
- Breast ultrasound
  - CPT®76641: unilateral, complete
  - CPT®76642: unilateral, limited
  - CPT®76641 and CPT®76642 should be reported only once per breast, per imaging session
- Axillary ultrasound: CPT®76882 (unilateral); if bilateral can be reported as CPT®76882 x 2
CH-1.3 General Guidelines - Chest CT

✓ Intrathoracic abnormalities found on chest x-ray, fluoroscopy, abdominal CT scan, or other imaging modalities may be further evaluated with chest CT with contrast (CPT®71260).
  o “Abnormalities” through these guidelines may include suspected lung or pleural nodules or masses, pleural effusion, adenopathy or other findings that are not considered benign.
  o Lung nodule(s) identified incidentally on Chest CTA without and with contrast (CPT®71275), Chest MRI without contrast (CPT®71550), Chest MRI without and with contrast (CPT®71552) or Chest MRA without and with contrast (CPT®71555) can replace Chest CT with contrast (CPT®71260) or Chest CT without contrast (CPT®71250) as the initial dedicated study.
  o See also: CH-16-Solitary Pulmonary Nodule (SPN)
  o See also: ONC-8.2 Non-Small Cell Lung Cancer, Suspected/Diagnosis

✓ Chest CT without contrast (CPT®71250) can be used for the following:
  o Patient has contraindication to contrast
  o Follow-up of pulmonary nodule(s)
  o High Resolution CT (HRCT)
  o Low-dose chest CT (CPT®71250 or S8032) may be approved for non-Medicare lung cancer screening if all of the following criteria are met:
    • Patient has not received a low-dose CT lung screening in less than 12 months; and
    • Patient has NO signs or symptoms suggestive of underlying lung cancer, and is able and willing to undergo curative lung surgery; and
    • Patient is between 55 and 80 years of age; and
    • Patient has at least a 30 pack-year history of cigarette smoking; and
    • Currently smokes or quit less than 15 years ago
  o Other circumstances as specified in the guidelines
  o Low-dose chest CT (CPT®71250 or S8032) may be approved for Medicare lung cancer screening if all of the following criteria are met:

<table>
<thead>
<tr>
<th>Screening Indications - Medicare</th>
<th>Imaging Study</th>
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<tr>
<td>All criteria below must be met for approval:</td>
<td>Low-Dose Chest CT without contrast (CPT®71250 or S8032)** (not both)</td>
</tr>
<tr>
<td>• Patient has not received a low-dose CT lung screening in less than 12 months; and</td>
<td>**Code selection is based on individual payor claim payment policy.</td>
</tr>
<tr>
<td>• Patient has NO signs or symptoms* suggestive of underlying lung cancer, and is able and willing to undergo curative lung surgery; and</td>
<td>☑NOTE: Certain payors’ policies may NOT include</td>
</tr>
</tbody>
</table>

*NOTE: Certain payors’ policies may NOT include
• Patient is between 55 and 77 years of age; and
• Patient has at least a 30 pack-year history of cigarette smoking; and
• Currently smokes or quit less than 15 years ago
• A written order for LDCT lung cancer screening that includes counseling and shared decision making*

*A written order for LDCT lung cancer screening that meets the following criteria:
• For the initial LDCT lung cancer screening service: the beneficiary must receive a written order for LDCT lung cancer screening during a lung cancer screening counseling and shared decision making visit, furnished by a physician [as defined in Section 1861(r)(1) of the Social Security Act (the Act)] or qualified non-physician practitioner (physician assistant, nurse practitioner, or clinical nurse specialist as defined in §1861(aa)(5) of the Act).
• For subsequent LDCT lung cancer screenings: the beneficiary must receive a written order, which may be furnished during any appropriate visit (for example: during the Medicare annual wellness visit, tobacco cessation counseling services, or evaluation and management visit) with a physician (as defined in Section 1861(r)(1) of the Act) or qualified non-physician practitioner (physician assistant, nurse practitioner, or clinical nurse specialist as defined in Section 1861(aa)(5) of the Act).
• A lung cancer screening counseling and shared decision making visit includes the following elements (and is appropriately documented in the beneficiary’s medical records):
  ➢ Determination of beneficiary eligibility including age, absence of signs or symptoms of lung disease, a specific calculation of cigarette smoking pack-years; and if a former smoker, the number of years since quitting;
  ➢ Shared decision making, including the use of one or more decision aids, to include benefits, harms, follow-up diagnostic testing, over-diagnosis, false positive rate, and total radiation exposure;
  ➢ Counseling on the importance of adherence to annual LDCT lung cancer screening, impact of comorbidities and ability or willingness to undergo diagnosis and treatment;
  ➢ Counseling on the importance of maintaining cigarette smoking abstinence if former smoker, or smoking cessation if current smoker and, if appropriate, offering additional Medicare-covered tobacco cessation counseling services; and
  ➢ If appropriate, the furnishing of a written order for lung cancer screening with LDCT. Written orders for both initial and subsequent LDCT lung cancer screenings must contain the following information, which must also be documented in the beneficiaries’ medical records:
    ▪ Beneficiary date of birth,
    ▪ Actual pack-year smoking history (number);
    ▪ Current smoking status, and for former smokers, the number of years since quitting smoking;
    ▪ Statement that the beneficiary is asymptomatic; and NPI of the ordering practitioner

lunge cancer screening. Their coverage policies may take precedence over MedSolutions’ guidelines.
✓ Chest CT without and with contrast (CPT®71270) does not add significant diagnostic information above and beyond that provided by chest CT with contrast, unless a question regarding calcification, most often within a lung nodule, needs to be resolved.

**Chest CT Coding Notes:**

High resolution chest CT should be reported only with an appropriate code from the set CPT®71250-CPT®71270. No additional CPT® codes should be reported for the “high resolution” portion of the scan. The “high resolution” involves additional slices which are not separately billable.

**CH-1.4 General Guidelines - Chest CTA (CPT®71275)**

✓ Chest CTA can be considered for suspected Pulmonary Embolism and Thoracic Aortic disease

✓ CTA prior to minimally invasive or robotic surgery.
  (See: CD-1.10 in the Cardiac Imaging Guidelines.)

**CH-1.5 General Guidelines-Chest MRI without and with contrast (CPT®71552)**

✓ Indications for chest MRI are infrequent and include:

  Concerns about CT contrast such as renal insufficiency or contrast allergy
  o Clarification of some equivocal findings on previous imaging studies, which are often in the thymic mediastinal region or determining margin (vascular/soft tissue) involvement with tumor and determined on a case by case basis
  o Certain conditions, including
    • Chest wall mass (CH-23-Chest Wall Mass)
    • Chest muscle tendon injuries (MS-11-Muscle/Tendon Injuries)
    • Brachial plexopathy (PN-4-Brachial Plexus) and
    • Thymoma (ONC-10.2 Thymoma)

**CH-2~LYMPHADENOPATHY**

**CH-2.1 Supraclavicular Region**

✓ Allows simultaneous ultrasound-guided fine needle aspiration (FNA) (CPT®76942)

✓ If ultrasound is indeterminate, Neck CT with contrast (CPT®70491) or chest CT with contrast (CPT®71260) can be performed.
CH-2.2 Axillary Lymphadenopathy

There is no evidence-based support for advanced imaging of clinically evidenced axillary lymph adenopathy without biopsy. Most axillary adenopathy is infectious in primary care settings. Metastatic axillary involvement from a lung or chest primary is highly unusual (CT Chest not often warranted).

Localized axillary lymphadenopathy should prompt:
- Search for adjacent hand or arm injury or infection, and
- 3-4 week observation if benign clinical picture, and
- Excisional biopsy of most abnormal lymph node if condition persists or malignancy suspected
- No advanced imaging indicated

Generalized axillary lymphadenopathy should prompt:
- Diagnostic work-up, including serological tests, for systemic diseases and
- Excisional biopsy of most abnormal lymph node if uncertainty persists
- See: ONC-27~Lymphomas in the Oncology Imaging Guidelines

✓ Occult Primary Cancer in axillary lymph node(s)
- Breast MRI (CPT®77059) can be performed if breast cancer is suspected and if physical exam and mammography are negative. Otherwise, imaging of other possible primary sites are led by symptomatology, and risk factors

See “Equivocal or Occult Findings” in: CH-25.5 Breast MRI Indications.

See also: ONC-30~Metastatic Cancer and Carcinomas of Unknown Primary Site

Axillary Lymphadenopathy - Practice Notes
Adenocarcinoma is the most common histology, with breast cancer seen most often; non-palpable breast cancer and axillary metastases accounts for less than 0.5% of all breast cancers. Carcinomas of the lung, thyroid, stomach, colon, rectum, and pancreas have the potential to spread to axillary lymph nodes, but these metastases are rarely the first manifestations of disease.

CH-2.3 Mediastinal Lymphadenopathy
✓ Chest CT with contrast (CPT®71260) can be performed if mediastinal abnormalities are detected on a chest x-ray (overread by a radiologist) or other non-dedicated advanced chest imaging.

✓ Follow-up chest CT (CPT®71260) can be performed at 4 weeks if
  - Enlarged lymph nodes are in the mediastinum with no other thoracic abnormalities;
  - Low risk or no clinical suspicion for malignancy
  - Thereafter, stability does not require further advanced imaging
Further evaluations
- Lymph node biopsy (see methods below) should be considered for:
  - 1.) persistent lymphadenopathy on follow-up chest CT; or
  - 2.) suspected malignancy

Practice Notes
Lymphadenopathy from neoplasms as well as from benign sources of inflammation can result in a positive PET scan. Therefore, the use of PET may not be helpful prior to histologic diagnosis.

Less invasive methods of mediastinal biopsies are percutaneous biopsy, transbronchial biopsy, transbronchial biopsy using endobronchial ultrasound, and endoscopic ultrasound-guided FNA.

More invasive and traditional methods are mediastinoscopy or thoracoscopy/thoracotomy.

References
4. Stigt, Jos A. MD; Boers, James E. MD, PhD; Oostdijk, Ad H. MD; van den Berg, Jan-Willem K. MD, PhD; Groen, Harry J. MD, PhD. Mediastinal Incidentalomas, *Journal of Thoracic Oncology*: August 2011 – Volume 6 – Issue 8 – pp 1345-1349.

CH-3~COUGH

CH-3.1 Cough
- Initial evaluation should include a recent chest x-ray<sup>1</sup>
  - Discontinue all medications known to cause coughing (e.g. ACE inhibitors) <sup>1</sup>
- If the initial chest x-ray is without abnormalities, a chest CT (either with contrast [CPT® 71260] or without contrast [CPT® 71250]) can be performed for the following:
  - Cough in non-smoker after the following sequence for a total 3 week trial and investigation:
    - Antihistamine and decongestant treatment <sup>1</sup>
    - Bronchoprovocation challenge (e.g. methacholine challenge, exhaled nitric oxide test) and spirometry should be performed to rule out asthma <sup>1</sup>
    - Empiric trial of corticosteroids <sup>1</sup>
    - Treatment of gastroesophageal reflux disease (GERD) <sup>1</sup>
  - Current or past cigarette smokers with:
• New cough lasting greater than 2 weeks (URI based cough can be prolonged)
  Changed chronic cough in worsening frequency or character
• See: CH-6~Hemoptysis

✓ For any abnormalities present on the initial chest x-ray, advanced chest imaging can be performed according to the relevant Chest Imaging Guidelines section.¹

**Practice Notes**
The resolution of cough usually will occur at a median time of 26 days of stopping use of the angiotensin-converting enzyme (ACE) inhibitor drug.¹ Smoking cessation is “almost always effective” in resolving cough in smoker.¹

It should be realized that cough after URI (Upper Respiratory Infection) can typically last beyond 2-3 weeks.²

**References**
doi:10.1378/chest.129.1_suppl.222S
CHEST IMAGING GUIDELINES

CH-4~NON-CARDIAC CHEST PAIN

See also the following guidelines:
- CH-27~Pulmonary Embolism
- CH-30.1 Aortic Dissection
- CD-1~General Guidelines
- CD-8~CT Heart and Coronary Computed Tomography Angiography (CCTA)

CH-4.1 Non-Cardiac Chest Pain - Imaging

✓ Initial evaluation should include a chest x-ray.¹,²

✓ If x-ray is abnormal, chest CT with contrast (CPT® 71260) can be performed ¹,²,³,⁴.

✓ If x-ray is normal, patient should undergo evaluation of other possible causes of pain prior to advanced imaging (CT chest with contrast) including: ¹,²,³,⁴
  - Cardiac (ECG, echocardiogram, stress test) ¹,², and
  - GI (trial of anti-reflux medication, possible upper endoscopy, pH probe, esophageal manometry),¹ and
  - Pulmonary (PFT’s) ¹,²

CH-4.2 Costochondritis/Other Musculoskeletal Chest Wall Syndrome

✓ Costochondritis or other suggested musculoskeletal chest wall syndrome does not require advanced imaging (CT or MRI) unless it meets other criteria in these guidelines. Costochondritis can be readily diagnosed with palpation tenderness and/or hooking maneuver and imaging is non-specific. ³,⁴

✓ Chest CT with contrast (CPT® 71260) can be performed if:
  - The initial chest x-ray reveals no abnormalities; and
  - Failed minimum 6 weeks trial of treatment (may include rest, analgesics, and anti-inflammatory medication) and investigations without improvement
    - MRI is not supported, in the evaluation of chest pain ¹,²,⁴
    - Repeat advanced imaging of the chest in patients with unchanged or improving symptoms is not appropriate.

Practice Notes

Chest x-ray could identify pneumothorax, pneumomediastinum, fractured ribs, acute and chronic infections, and malignancies.¹

References

Appropriateness Criteria® acute nonspecific chest pain - low probability of coronary artery disease. American College of Radiology (ACR); 2011.


4. UpToDate, Clinical Evaluation of Musculoskeletal Pain, acquired April 15, 2014
CH-5~DYSPNEA/SHORTNESS OF BREATH

CH-5.1 Dyspnea/Shortness of Breath

Dyspnea is the subjective experience of breathing discomfort.

✓ Initial evaluation should include a recent chest x-ray.\textsuperscript{1,2} If x-ray is abnormal, chest CT without contrast (CPT\textsuperscript{®} 71250) can be performed\textsuperscript{1,2}.

✓ If the initial chest x-ray is indeterminate, Chest CT without contrast (CPT\textsuperscript{®} 71250, including HRCT), or Chest CT with contrast (CPT\textsuperscript{®} 71260) can be performed if the following evaluations have been conducted and are indeterminate\textsuperscript{2}:
  o ECG, echocardiogram or stress testing\textsuperscript{2}, and
  o Pulse oximetry and pulmonary function studies (PFT's)\textsuperscript{2}, and/or
  o Blood work including CBC and thyroid function tests\textsuperscript{2} if appropriate

If pulmonary embolus (PE) is suspected, see CH-27~Pulmonary Embolism

References


CH-6~HEMOPTYSIS

CH-6.1 Hemoptysis

✓ Chest CT with contrast (CPT\textsuperscript{®} 71260) OR without contrast (CPT\textsuperscript{®} 71250) OR CTA chest (CPT\textsuperscript{®} 71275) may be performed after:
  o Abnormal chest x-ray, or
  o No chest x-ray needed if any of the following:
    • High risk for malignancy with >40 years of age and >40 pack-year smoking history, or
    • Massive hemoptysis (>30cc per episode or unable protect airway)\textsuperscript{1}

References

BRONCHIAL TREE

CH-7~BRONCHIECTASIS

CH-7.1 Bronchiectasis - Imaging
✓ High resolution chest CT scan (HRCT) without contrast (CPT®71250):
  o To confirm suspected diagnosis of bronchiectasis after an initial x-ray 1,2; or
  o For known bronchiectasis with worsening symptoms or worsening PFT’s 2.
  o For hemoptysis with known or suspected bronchiectasis 3.

References

CH-8~BRONCHITIS

CH-8.1 Bronchitis
✓ Advanced imaging is not needed for bronchitis 1,2.
✓ Chest x-ray to determine if any abnormality is present

References
CH-9~ASBESTOS EXPOSURE

CH-9.1 Asbestos Exposure

✓ Chest x-ray as radiographic screening for asbestos exposure\(^1,2\).
  o Stable calcified pleural plaques on chest x-ray do not require advanced imaging of the chest\(^2\)

✓ CT of the chest should not be used to screen populations at risk for asbestos-related diseases.\(^2\)

✓ High resolution chest CT (HRCT) (CPT\(^71250\)) is considered for \(^2\):
  o Any change seen on chest x-ray;
  o Thereafter, chest CT without contrast (CPT\(^71250\)) every 3 to 6 months can be considered

Practice Notes

Asbestosis and asbestos-related diseases include: pleural effusion, pleural plaques, lung cancer, and malignant mesothelioma. The risk of developing mesothelioma increases with increasing intensity and duration of exposure.

Reference

1. OSHA, Occupational Safety and Health Standards, Medical surveillance guidelines for asbestos, 1910.1001 App H.
CH-10.1 COPD - Imaging

✓ Chest CT without or with contrast (CPT®71250 or CPT®71260)\(^1,\,2,\,3,\,4\) can be performed if emphysema is suspected and:
  o Pre-operative study for Lung Volume Reduction Surgery (LVRS) \(^1,\,2,\,3,\,4\)
  o Symptoms disproportionate to spirometric impairment \(^2,\,3\)

✓ Lung cancer screening is discussed in the following guideline:
  o See “Screening Indications” in ONC-8~Non-Small Cell Lung Cancer

Practice Notes
COPD includes asthmatic bronchitis, chronic bronchitis, and emphysema. COPD is airflow reduction (FEV1/FVC ratio < 0.7 or FEV1 ≥ 80% predicted) in the presence of respiratory symptoms, such as dyspnea. Advanced chest imaging is not typically indicated in COPD exacerbation, which is an acute change in baseline dyspnea, cough, and/or sputum beyond normal day-to-day variations.\(^2,\,3\)

References
CH-11~INTERSTITIAL DISEASE

CH-11.1 Interstitial Disease

✓ High resolution chest CT (HRCT) without contrast (CPT®71250) is the diagnostic modality of choice to evaluate for 1:
  o Interstitial changes identified on other imaging (including chest x-ray) in patients with pulmonary symptoms and abnormal pulmonary function studies (PFT’S)  
(See: CH-5~Dyspnea)
  o Initial request to identify interstitial disease with a connective tissue disease diagnosis, including rheumatoid arthritis, scleroderma and the myopathies 2,3
  o New or worsening pulmonary symptoms or worsening PFT’s in any type of interstitial disease, including connective tissue diseases, 1,2,3 or
  o Once a year in patients with known idiopathic pulmonary fibrosis (IPF) if showing progression or regression of disease will change patient management 4

References
CH-12~MULTIPLE PULMONARY NODULES

CH-12.1 Multiple Pulmonary Nodules
✓ The largest of multiple pulmonary nodules should be imaged based on guideline: **CH-16~Solitary Pulmonary Nodule (SPN)**

✓ Suspected infection with multiple pulmonary nodules can have first follow-up chest CT (CPT®71250 [without contrast] or CPT®71260 [with contrast]) sooner than 3 months.

**Practice Notes**
More than 6 nodules and clustering of multiple nodules in a single location usually indicate inflammatory lung disease although a dominant nodule with adjacent small satellite nodules can be seen in primary lung cancer.

**References**

CH-13~PNEUMONIA

CH-13.1 Pneumonia
✓ Chest x-ray would be performed initially in all patients with suspected pneumonia, prior to considering advanced imaging. ¹ ²

✓ Chest CT with contrast (CPT®71260) if initial or repeat chest x-ray findings reveal:
  o Complication of pneumonia (e.g. abscess, effusion, hypoxemia, respiratory distress, necrotizing pneumonia, pneumothorax), ¹ ²
  o Possible lung mass associated with the infiltrate, ²

**References**
CH-14.1 PPD or TB

✓ Chest CT with contrast (CPT®71260) is appropriate for individuals with:
  o Positive PPD skin test or other positive tuberculin skin tests and normal chest x-ray who have not had a previous normal chest CT, or
  o Suspected complications or progression of tuberculosis (e.g. pleural tuberculosis, empyema, mediastinitis).

✓ If chest CT is unremarkable, there is insufficient data to support performing subsequent chest CT unless symptoms develop or chest x-ray shows a new abnormality.

✓ Follow-up chest CT with contrast (CPT®71260) with frequency at the discretion of the pulmonary specialist.
  o Re-evaluate individuals undergoing active treatment for tuberculosis who had abnormalities seen only on chest CT.

Practice Notes

Chest CT can show evidence of tuberculosis (e.g. primary complexes, mediastinal or hilar lymphadenopathy) in up to 20% of patients with unremarkable chest x-rays.

References

CH-15.1 Sarcoid

✓ Chest CT either with contrast (CPT®71260) or without contrast (CPT®71250) is appropriate for the following:
  o Establish or rule out the diagnosis when suspected,
  o Development of worsening symptoms,
  o New symptoms appear after a period of being asymptomatic, or
  o Treatment change is being considered in known sarcoid

✓ PET may be useful in making the diagnosis of sarcoid if other evaluations are equivocal, but, definitive diagnosis can only be made by biopsy.
  o There is currently no evidence-based data to support performing serial PET scans to monitor disease activity while tapering steroid therapy.
  o Cardiac PET (CPT®78459). See: CD-7~CARDIAC PET

See also: ONC-29.4 Sarcoidosis in the Oncology Imaging Guidelines and
HD-22~Cerebral Vasculitis in the Head Imaging Guidelines

References
CH-16.1 SPN - Imaging

✓ Chest CT with contrast (CPT® 71260) or chest CT without contrast (CPT® 71250) (with contrast is preferred for initial evaluation) can be performed for discrete nodule(s) in the following scenarios:
  o Lung nodule(s) seen on an imaging study other than a “dedicated” chest CT or MR (chest x-ray, abdominal CT, spine MRI, coronary artery CTA, etc.). Examples of other studies: chest x-ray, abdominal CT, spine MRI, coronary CTA
    (See: CH-1.3 General Guidelines - Chest CT)
  o Lung nodule(s) identified incidentally on any of the following dedicated chest studies can replace Chest CT with contrast (CPT® 71260) or Chest CT without contrast (CPT® 71250) as the initial dedicated study: (See: CH-1.3)
    • Chest CT without and with contrast (CPT® 72170)
    • Chest CTA without and with contrast (CPT® 71275)
    • Chest MRI without contrast (CPT® 71550)
    • Chest MRI without and with contrast (CPT® 71552)
    • Chest MRA without and with contrast (CPT® 71555)
  o After preliminary comparison with any available previous chest films to determine if nodule was present and stable
  o Using largest measurement of multiple lung nodule
    (See: CH-12-Multiple Pulmonary Nodules)
  o Similar-sized pleural nodule is treated as a pulmonary nodule, except does not require PET scan (See: CH-12-Multiple Pulmonary Nodules)
  o Following the Fleischner Society Guidelines for high risk* below:

<table>
<thead>
<tr>
<th>NODULE SIZE (mm)</th>
<th>CHEST CT INTERVAL (months)</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;= 4</td>
<td>Follow-up at 12; if unchanged, no further follow-up</td>
</tr>
<tr>
<td>&gt; 4, but &lt; 6</td>
<td>Follow-up at 6-12; then at 18-24 (complete to 24)</td>
</tr>
<tr>
<td>&gt;= 6, but &lt; 8</td>
<td>Follow-up at 3-6; then 9-12 mo; then 24 mo</td>
</tr>
<tr>
<td>&gt;= 8</td>
<td>Follow-up at 3, 9 and 24, consider PET or biopsy</td>
</tr>
</tbody>
</table>

*High risk is applied to all individuals since the Fleischner Society has not defined these factors (which may be considered smoking history, age, family history, cancer history or previous radiation therapy).

  o No further advanced imaging is necessary if a nodule has been stable for 2 years, and may be shorter or not needed if:
    • Nodule stable on chest x-ray for at least 2 years
    • Decreasing or disappearing nodule(s)
    • Stable nodule(s) >4mm
• \( \leq 4 \) mm nodule(s) only requires 12 months
• At any time, if.
  ➢ classically benign characteristics by chest x-ray or previous CT (e.g. benign calcification pattern typical for a granuloma or hamartoma)
  ➢ Decreasing or disappearing nodule(s)
• Except ground glass or sub-solid densities, which can be imaged beyond 2 years

**SPECIAL SITUATIONS Chest CT imaging interval:**

<table>
<thead>
<tr>
<th>CLINICAL FINDINGS</th>
<th>CHEST CT INTERVAL (months)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Negative PET</td>
<td>3 (after PET), 9, and 24</td>
</tr>
<tr>
<td>Previous or current malignancy and pulmonary nodule(s) that would reasonably metastasize to the lungs</td>
<td>3, 6, 12, and 24</td>
</tr>
<tr>
<td>Ground Glass or Subsolid Nodules</td>
<td>3, then every 6 months and beyond 2 years</td>
</tr>
</tbody>
</table>

✔ PET (CPT®78812 or CPT®78815) is appropriate for a distinct lung nodule \( \geq 8 \) mm on chest CT(A) or MR(A).
  o PET is not appropriate for infiltrate, ground glass opacity, or hilar enlargement
  o Serial PET studies are not considered appropriate

**Practice Notes**

A **nodule** is any pulmonary or pleural lesion that is a discrete, spherical opacity 2-30 mm in diameter surrounded by normal lung tissue. A larger nodule is called a mass. Entities that are not nodules, and are considered benign, include non-spherical linear, sheet-like, two-dimensional or scarring opacities.

**Malignant** nodule features can include spiculation, abnormal calcification, size greater than 7-10 mm, ground glass opacity, interval growth, history of a cancer that tends to metastasize to the lung or mediastinum, and/or smoking history.
  o A nodule that grows at a rate consistent with cancer (doubling time 30 to 360 days) may be sampled for biopsy or resected.
  o Less than 1\% of \( <7 \) mm nodules are malignant.
  o A nodule that does not grow in 6 months has a risk of malignancy at \(<10\%\).

**Benign** features can include benign calcification (80\% granuloma, 10\% hamartoma), multiple areas of calcification, small size, multiple nodules, negative PET, and stability of size over 2 years.

**Ground glass** or subsolid opacities, which can harbor indolent adenocarcinoma, may require longer follow-up time than 2 years and may be resected if greater than 2 cm or if are more dominantly nodular (part-solid or solid). According to the Fleischner Society (2013), focal nodular areas of increased lung attenuation mostly identified on CT scan, which have typically been separated as either “pure” or “part-solid” ground glass”, should better be unified as “subsolid nodules.”

**Repeat PET** is discouraged, since if the original PET is positive, biopsy may be
performed. If the original PET is negative but subsequent chest CT shows increase in size of the nodule, biopsy may be performed.

**False positive PET** can occur with infection or inflammation; false negatives can occur with small size nodule, ground glass lesions and indolent cancers such as bronchoalveolar or carcinoid.

**References**

CH-17.1 Pleural-Based Nodules and Other Abnormalities

✓ Chest CT with contrast (CPT®71260) or chest CT without contrast (CPT®71250) (with contrast is preferred for initial evaluation) can be performed for pleural nodule(s) 1,2:
  o Pleural nodule(s) seen on an imaging study other than a “dedicated” chest CT or MR (See: CH-1.3) 1,2
  o Pleural nodule(s) identified incidentally on any of the following dedicated chest studies can replace Chest CT as the initial dedicated study 1,2 (See: CH-1.3)
  o After preliminary comparison with any available previous chest films to determine presence and stability
  o Using largest measurement of multiple nodule(s) 1 (See: CH-12~Multiple Pulmonary Nodules)
  o Following the Fleischner Society Guidelines for high risk see CH-16.1 1

✓ PET can be considered if dedicated CT or MRI Chest identifies a pleural nodule/mass or defined area of pleural thickening when there is a likelihood of malignancy including current or previous malignancy, pleural effusion, bone erosion, chest pain. 2

Practice Notes
Pleural nodule/mass or thickening without suggestion of malignancy would undergo surveillance or biopsy. 2

Reference
CH-18~Pleural Effusion

CH-18.1 Pleural Effusion

☑ Chest CT with contrast (CPT®71260) can be performed after both:
  o Chest x-ray including lateral decubitus films; and
  o Thoracentesis to determine if fluid is exudative and remove as much as possible
    (fluid obscures underlying lung parenchyma and mass).

☑ Chest ultrasound (CPT®76604) can be used as an alternative to evaluate for the
  presence of fluid within the pleural spaces.

Practice Notes

Bilateral effusions are more often systemic related transudates (CHF, RF, liver
insufficiency, etc) and advanced imaging is rarely needed. Large unilateral effusions can
be malignant. Analysis of fluid may include cytology, culture, cell count, biochemical
studies.

References

1. Light RW, MacGregor MI, Luchsinger PC, et al. Pleural effusions: the diagnostic separation of
2. N A Maskell1, R J A Butland, BTS guidelines for the investigation of a unilateral pleural effusion in
CH-19~PNEUMOTHORAX/HEMOTHORAX

CH-19.1 Pneumothorax/Hemothorax

✓ Chest CT with contrast (CPT®71260) or without contrast (CPT®71250) if:
  o Diagnosis of a small pneumothorax is in doubt, and the presence of a pneumothorax will affect patient treatment decisions
  o Preoperative study for treatment of pneumothorax
  o Associated with hemothorax or suspected complications from hemothorax (e.g. empyema).

Practice Notes
Expiration chest x-ray can enhance evaluation of equivocal plain x-ray. There is no data supporting the use of serial chest CT to follow patients with known pneumothorax or hemothorax who are asymptomatic or have stable symptoms. With the exception of the indications above, advanced imaging of the chest is rarely indicated in the diagnosis or management of pneumothorax. Inspiratory/expiratory chest x-rays are helpful in defining whether a pneumothorax is present.

References
CH-20~Mediastinal Lymphadenopathy

See: CH-2.3 Mediastinal Lymphadenopathy

CH-21~MEDIASTINAL MASS

CH-21.1 Mediastinal Mass

✓ Chest CT with contrast (CPT®71260) is the imaging study of choice to evaluate mediastinal abnormalities on chest x-ray
✓ Chest CT without contrast (CPT®71250) is an alternative if thyroid disease or myasthenia gravis is considered as the mass
✓ Suspected substernal goiter: neck ultrasound (CPT®76536) or radionuclide study are the initial studies to confirm extension of the thyroid to the sternum. (see NECK-9~Thyroid and Parathyroid)

References
CH-22.1 Chest Trauma

✓ Chest CT without contrast (CPT®71250) or with contrast (CPT®71260) is appropriate for the following situations:

✓ Rib or Sternal Fracture:
  - With associated complications identified clinical or by other imaging, including pneumothorax, hemothorax, pulmonary contusion, atelectasis, flail chest, cardiovascular injury and/or injuries to solid of hollow abdominal organs
  - Single fractures, multiple fractures, non-acute fractures, or occult rib fractures are NOT an indication for chest CT unless malignancy is suspected in the etiology.

✓ Routine follow-up advanced imaging of rib or sternal fractures is not indicated

✓ No advanced imaging of the abdomen or pelvis is indicated when there is chest trauma and no physical examination or laboratory evidence of injury

References


CH-23.1 Chest Wall Mass

✓ Chest x-ray should be performed initially in all cases of chest wall mass.

✓ Chest CT with contrast (CPT®71260) or Chest CT without contrast (CPT®71250) or MRI chest without and with contrast (CPT®71552) can be considered when the following are met:
  o Chest x-ray completed
  o Not an obvious lipoma
✓ Chest ultrasound (CPT®76604) can be used to evaluate a chest wall mass if requested.

Practice Notes

Chest x-rays of chest wall masses can detect calcification, ossification, or bone destruction as well as location and size. ³

References

CH-24.1 Pectus Excavatum and Carinatum

Chest CT without contrast (CPT®71250) or MRI chest with or without 3-D Reconstruction
✓ can be considered if 1, 2:
  o Candidates for surgical correction 1, 2
  o Cardiac or pulmonary dysfunction has been identified 1, 2
✓ ECG and echocardiography if cardiac symptoms or evidence of abnormalities of cardiac function. (1)
✓ Chest x-ray and PFT’s if increasing shortness of breath. 1

See also PACCH-12-Pectus Excavatum and Pectus Carinatum in the Pediatric Chest Imaging Guidelines

Reference
1. UpToDate, Pectus Excavatum: Etiology and evaluation, acquired April 15, 2014.
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CHEST IMAGING GUIDELINES

CH-25~BREAST ABNORMALITIES

See BI-RADS™ Categories Chart for full description of BI-RADS™ categories.

CH-25.1 Breast Ultrasound

✓ Routine performance of breast ultrasound with diagnostic mammography is inappropriate.
  o Do NOT use breast ultrasound to screen general population as either a stand-alone study or a combined study with screening mammography.

✓ Breast ultrasound (CPT® 76641: unilateral, complete or CPT® 76642: unilateral, limited) can be used to further evaluate abnormalities found on mammography, especially in differentiating cysts from solid lesions.

✓ Palpable breast masses should be evaluated with mammography and breast ultrasound, in any order, regardless of age. Ultrasound can enhance biopsy.

✓ Axilla ultrasound (CPT® 76882)
  o For women with clinically suspicious lymph nodes, preoperative axillary ultrasound with a FNA or biopsy can help identify patients who have positive nodes.
  o Bilateral should be coded CPT® 76882 x 2

CH-25.2 Breast MRI

✓ Breast MRI is usually bilateral (CPT® 77059) or can be unilateral (CPT® 77058) in some after mastectomy, per physician request.

✓ If diagnostic breast MRI has previously been performed, and the currently requested breast MRI is being performed solely to guide a breast biopsy, then the breast MRI portion of the procedure is included in the CPT® code for the MRI-guided procedure (CPT® 77021) and requests for CPT® 77058 or CPT® 77059 are inappropriate.
  o Exception: If the previous diagnostic breast MRI was of poor quality or an unanswered clinical question remains, a repeat diagnostic breast MRI (CPT® 77058 or CPT® 77059) can be performed prior to MRI guided breast biopsy, especially if the biopsy is being performed at a different facility than the original breast MRI.

✓ MRI Breast can be repeated at least 6 months after an MRI directed breast biopsy to document successful lesion sampling if histology is benign and nonspecific, equivocal or uncertain.
Breast MRI - Practice Notes
The American Cancer Society, the Society of Breast Imaging, and the National Comprehensive Cancer Network (NCCN) Clinical Guidelines in Oncology recommend breast MRI be performed in facilities that have the capability to perform MRI-guided breast biopsies.

Although breast MRI has superior sensitivity in identifying new unknown malignancies, it carries a significant false positive risk when compared to mammogram and ultrasound. Incidental lesions are seen on 15% of breast MRI’s and increase with younger age. The percentage of incidental lesions that turn out to be malignant varies from 3% to 20% depending on the patient population. Cancer is identified by breast MRI in only 0.7% of those with “inconclusive mammographic lesions.”

CH-25.3 Breast Reconstruction
✓ CTA or MRA of the body part from which the free tissue transfer flap is being taken, can be performed for breast reconstruction preoperative planning.  
  o For example, CTA (CPT®74175 and CPT®72191) or MRA (CPT®74185 and CPT®72198) of the abdomen and pelvis for Deep Inferior Epigastric Perforators (DIEP) flap

✓ There is currently insufficient evidence-based data to support the need for routine advanced imaging for TRAM flaps or other flaps performed on a vascular pedicle.

CH-25.4 CAD for Breast MRI
✓ The use of CAD with breast MRI is currently considered investigational, experimental, and/or unproven.
  o 3D rendering codes (CPT®76376 or CPT®76377) should not be used in conjunction with code 0159T.

    See: Preface-4.1 3D Rendering

CH-25.5 Breast MRI Indications
✓ Breast MRI is indicated for Breast Augmentation, Breast Implants (saline or silicone), Breast Reconstruction, Free Injection, and Capsular Contracture to:
  o Evaluate or confirm breast implant rupture when mammography or ultrasound is uninterpretable.
    • If leakage is detected on MRI or any other modality, the implant(s) should be removed and no further surveillance MRI of the affected breast(s) is indicated.
    • Surveillance for silent/asymptomatic rupture of silicone implants is considered investigational; however, certain payers may cover this surveillance.
    • Certain payers do not include breast implants in their coverage policies if the breast implants were placed as part of purely cosmetic surgery. Thus, surveillance MRI in these patients would also not be included in the coverage policy. Their coverage policies will take precedence over MedSolutions’ guidelines.
✓ Annual breast MRI is indicated for high risk histologies:
  o Atypical ductal hyperplasia (ADH); Atypical lobular hyperplasia (ALH); Lobular carcinoma in situ (LCIS)

✓ Annual breast MRI should begin at age 25 for patients considered high risk:

<table>
<thead>
<tr>
<th>Any one of the following qualify an individual as High Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. BRCA 1 or BRCA 2 mutation</td>
</tr>
<tr>
<td>2. First degree relative (parent, sibling, child) with BRCA 1 or BRCA 2, even if patient has not been tested for BRCA mutation</td>
</tr>
<tr>
<td>3. Two or more first degree relatives with breast or ovarian cancer</td>
</tr>
<tr>
<td>4. One first degree relative with breast cancer or ovarian cancer that was diagnosed &lt; age 50</td>
</tr>
<tr>
<td>5. One first degree relative with bilateral breast cancer, or both breast and ovarian cancer</td>
</tr>
<tr>
<td>6. Presence of Cowdan, Bannayan-Riley-Ruvalcaba or Li-Fraumeni Syndromes (TPEN of TP53 Gene)</td>
</tr>
<tr>
<td>7. A first or second degree male relative (father, brother, uncle) diagnosed with breast cancer</td>
</tr>
<tr>
<td>8. Begin screening 10 years before the age of relative when he/she was first diagnosed with breast cancer</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Additional Risks:</th>
</tr>
</thead>
<tbody>
<tr>
<td>9. Clinical lifetime risk estimated at greater than or equal to 20% using clinical risk estimator such as the Gail, Claus, Tyrer-Cuzick or BRCAPRO models</td>
</tr>
<tr>
<td>10. Ashkenazi Jewish women from families with onset of breast cancer before age 40</td>
</tr>
<tr>
<td>11. Women with history of radiation to the chest between ages 10 and 30. (If history of Hodgkin’s Disease, breast screening should start 8 to 10 years post-therapy, or at age 40, whichever comes first)</td>
</tr>
</tbody>
</table>

✓ Equivocal or Occult Findings
  o Radiologist Report Recommendation for Breast MRI and one of the following:
    • Inconclusive or conflicting findings on mammography or ultrasound of a lesion that is not a palpable mass
    • Dense breasts
  o A probably benign lesion on MRI (MRI BI-RADS™ 3) should undergo repeat MRI in 6 months.

✓ Newly Diagnosed Breast Cancer

✓ Newly Diagnosed Paget’s Disease (thereafter treat as DCIS according to these guidelines)

✓ Residual or Recurrent Malignancy
  o Assessment of residual tumor in patients who have undergone lumpectomy and have close or positive margins, when the findings may indicate a significant change in surgical management.
  o Evaluate clinical suspicion of recurrence, following evaluations with mammography and/or ultrasound, if those evaluations are inconclusive or conflict with physical examination or other clinical indicators. This applies to intact breasts, reconstructed breasts, and possible chest wall recurrences following mastectomy.
Breast MRI Indications - Practice Notes
MRI should not be used in lieu of mammographically, clinically, and/or sonographically suspicious findings (ACR Practice Guidelines).

CH-25.6 Breast MRI is NOT Indicated
✓ Breast MRI should not be used to determine biopsy recommendations for suspicious or indeterminate lesion(s) that can be readily biopsied, either using imaging guidance or physical exam, such as palpable masses and microcalcifications.

✓ MRI should not be used for routine surveillance in patients with history of breast cancer, unless there are physical exam, imaging findings, recurrent, or residual disease at the mastectomy site
  o Annual screening breast MRI study is indicated for high risk patients as outlined in CH-25.5 Breast MRI Indications

✓ Patients with dense breasts as determined by mammogram
  o To date, evidence does not suggest improved outcomes for women whose only risk factor is breast density⁹ (see heading “Equivocal or Occult Findings” (Radiologist Report) in CH-25.5 Breast MRI Indications)

✓ Low risk, probably benign (BI-RADS™ 3) lesions
  o Repeat the original type study (mammogram, US or MRI) in 6 months, thereafter screening or surveillance does not require MRI

✓ Suspicious (BI-RADS™ 4 or 5) lesion on mammogram and/or ultrasound
  o Bilateral total breast ultrasound (CPT®-76641: unilateral, complete), and bilateral axillary ultrasound (CPT®-76882) are recommended for patients who have BI-RADS™ 4 or 5 abnormalities. If additional suspicious breast lesions or more extensive malignant breast disease is detected by ultrasound, the extent of disease can be mapped with ultrasound-guided biopsies (CPT®-76942).
  o A lesion categorized as have BI-RADS™ 4 or 5 should be biopsied.
  o A palpable lesion should be considered for biopsy.
CH-25.7 Nipple Discharge/Galactorrhea

✓ Mammogram should be obtained. Ultrasound (CPT®76641: unilateral, complete or CPT®76642: unilateral, limited), may be helpful to locate a duct papilloma, an intraductal nodule, or dilated duct.

✓ Current evidence does not support the use of MRI in the evaluation of nipple discharge/galactorrhea.8

✓ If examination and laboratory findings reveal:
  o Bloody or palpable abnormality – consider open biopsy
  o Milky or clear discharge - Prolactin and TSH levels to diagnose prolactinoma; pituitary imaging is not needed if normal serum Prolactin
  o Ductogram and duct excision can be considered for papilloma which can undergo excisional biopsy.

Nipple Discharge/Galactorrhea – Practice Notes

If mammography and endocrine studies are normal, observation and clinical re-evaluation should be performed. If clinical evaluation at the time of follow-up does not reveal any palpable or visible abnormalities, the patient should return to routine screening interval studies with mammogram or clinical exam.

CH-25.8 Breast Pain

✓ Mammogram and ultrasound are the initial imaging for breast pain

✓ Advanced imaging is NOT routinely indicated in patients with breast pain and negative evaluation (evaluation includes patient history and physical exam, pregnancy test, mammogram and ultrasound (CPT®76641: unilateral, complete or CPT®76642: unilateral, limited).
  o If evaluation is not negative, see CH-25.5 Breast MRI Indications

Breast Pain – Practice Notes

The risk of malignancy following a negative examination has been estimated to be only 0.5%.9

CH-25.9 Newer Breast Imaging Techniques

✓ RODEO MRI: Rotating Delivery of Excitation Off-Resonance MRI is a trademarked version of MRI.
  o There is no unique CPT® code or different reimbursement for breast MRI scans performed using the RODEO system, and the indications for breast MRI are no different (see CH-25.5 Breast MRI Indications).

✓ Positron-Emission Mammography (PEM) or Naviscan® (See: CH-33.3)
Breast Tomosynthesis:
- This is 3-D mammography
- There is insufficient data currently to generate appropriateness criteria for the use of breast tomosynthesis; this procedure should be considered investigational at this time.

Coding Notes:
- CPT® 77061: Digital breast tomosynthesis; unilateral
- CPT® 77062: Digital breast tomosynthesis; bilateral
- CPT® +77063: Screening digital breast tomosynthesis (used in conjunction only with screening bilateral mammography code CPT® 77057)
- 3D rendering (CPT® 76376 or CPT® 76377) should not be assigned with any 3-D mammography code.

Scintimammography
- Nuclear medicine study that uses a radioisotope such as Tc-99 tetrofosmin to image the breast. Breast cancer typically shows increased uptake of the radioisotope compared to benign lesions.
- There is insufficient data currently to generate appropriateness criteria for the use of scintimammography
- Scintimammography is not currently an MSI contracted service

References
2. ACR Practice Guidelines.
CH-26~Pulmonary Arteriovenous Fistula (AVM)

CH-26.1 Pulmonary AVM
✓ Chest CT with contrast, chest CTA (preferred modality) (CPT®71275), or chest MRA (CPT®71555) or can be obtained for evaluation of:
  o Suspected pulmonary AVM
  o First degree relatives of a patient with a primary pulmonary AVM

Practice Notes
Pulmonary AVMs are abnormal connections between pulmonary arteries and veins, usually found in the lower lobes, that can be either primary or acquired (such as trauma, bronchiectasis). They can be identified in up to 98% of chest x-rays by a peripheral, circumscribed, non-calcified lesion connected by blood vessels to the hilum of the lung. Treatment is often by surgery or embolization of the feeding artery using platinum coils or detachable balloons.

References
**CH-27.1 Pulmonary Embolism**

✓ Chest CT with contrast with PE protocol (CPT®71260) or chest CTA (CPT®71275) would be considered with any one of the 3 from each of both sets.

✓ With any one of the 3
  1. Dyspnea, new onset and otherwise unexplained;
  2. Chest Pain, pleuritic;
  3. Tachypnea

AND, with any one of the 3:
  1. Abnormal D-dimer test;
  2. Wells Criteria score* higher than 4 points;
  3. One Risk Factor** or Symptom** of new onset demonstrating high clinical probability of PE

<table>
<thead>
<tr>
<th>RISK FACTORS**</th>
<th>SYMPTOMS ATTRIBUTED TO PE**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immobilization at least 3 days or surgery in last 4 weeks or recent trauma</td>
<td>Signs or symptoms of DVT</td>
</tr>
<tr>
<td>Previous history of DVT or PE</td>
<td>Hemoptysis</td>
</tr>
<tr>
<td>Cancer actively treated in last 6 months or receiving palliative treatment</td>
<td>Right heart strain or failure</td>
</tr>
<tr>
<td>Recent history of a long airplane flight</td>
<td>Systolic BP&lt;90</td>
</tr>
<tr>
<td>Use of estrogen-based contraceptives (birth control pills, the patch, and vaginal ring)/Oral estrogen</td>
<td>Syncope</td>
</tr>
<tr>
<td>Advanced age (&gt;=/70)</td>
<td>Cough</td>
</tr>
<tr>
<td>Congestive heart failure</td>
<td>Heart Rate &gt;100</td>
</tr>
<tr>
<td>Obesity (BMI &gt;/= 35)</td>
<td>Palpitations</td>
</tr>
</tbody>
</table>

**Well’s Criteria for Clinical Probability of PE***

| Clinical signs/symptoms of DVT (at minimum: leg swelling and pain with palpation of the deep veins) | 3 |
| PE is likely or equally likely diagnosis                                                               | 3 |
| Heart rate >100                                                                                        | 1.5 |
| Immobilization at least 3 days or surgery in last 4 weeks                                             | 1.5 |
| Previous history of DVT or PE                                                                         | 1.5 |
| Hemoptysis                                                                                             | 1 |
| Cancer actively treated in last 6 months or receiving palliative treatment                             | 1 |

Calculate Probability: Low <2 Moderate 2 to 6 High >6

*Using the above criteria, only 3% of patients with a low pretest probability had PE versus 63% of those with a high pretest probability.
✓ Non-urgent cases which do not meet above 2-step criteria, should undergo prior to advanced imaging:
  o Chest x-ray (to rule out other causes of acute chest pain)
  o Primary cardiac and pulmonary etiologies should be eliminated.

✓ Pregnant women with suspected PE are suggested to proceed with
  o D-dimer and/or;
  o Doppler studies of the lower extremities;
  o V/Q preferred if Doppler negative; Chest CTA (CPT®71275) or chest MRA (CPT®71555) can be performed if V/Q scanning is not available.

✓ Follow-up Imaging in Stable or Asymptomatic Patients with Known PE is not warranted
  o Chest CT with contrast with PE protocol (CPT®71260) or chest CTA (CPT®71275) can be performed for any of the following indications:
    • Recurrent signs or symptoms such as dyspnea, or
    • Elevated d-dimer which is persistent or recurrently elevated, or
    • Right heart strain or failure identified by EKG, ECHO or Heart catheterization

**Practice Notes**

Pulmonary embolism is found in approximately 10% of all those that present with suspicion of PE. Dyspnea, pleuritic chest pain and tachypnea occur with about 50% incidence with leg swelling or pain just over 50%.

D-dimer level has a high sensitivity and low specificity for diagnosing PE.
  o A negative D-dimer in combination with low or moderate PE risk classification has a negative predictive value approaching 100%.
  o D-dimer can be falsely elevated with recent surgery, injury, malignancy, sepsis, diabetes, pregnancy, or other conditions where fibrin products are likely to be present.

CT imaging has supplanted V/Q scanning since the latter is difficult to obtain quickly, does not provide a substantial cost savings, and does not diagnose other pulmonary pathology.

The decision to terminate anticoagulation treatment after previous pulmonary embolism (PE) with absent or stable symptoms is based on clinical evaluation and risk factors.
  o Repeat studies do not allow one the ability to distinguish new from residual clot, with luminal diameter and clot character poorly correlated to symptoms and ECHO findings.
  o Two thirds after primary thromboembolism have residual pulmonary artery clot at 6 months and 50% remains at one year.
  o Subsequent persistence or elevation of D-dimer is associated with increased risk of recurrent PE. ECHO and Right Heart Catheterization (RHC) can identify those with pulmonary hypertension. Yet, 1/2 of all have persistent or new pulmonary hypertension after primary thromboembolism and only half of this latter group has dyspnea at rest or exercise intolerance.
References


THORACIC VASCULAR DISORDERS

PULMONARY HYPERTENSION

See PVD-5~Pulmonary Artery Hypertension in the Peripheral Vascular Disease Imaging Guidelines

CH-28~SUBCLAVIAN STEAL SYNDROME

Occurs from blood flowing up the contralateral vertebral artery to the basilar artery and retrograde down the ipsilateral vertebral artery (reversal of flow) to supply collateral circulation to the arm on the side and past the stenotic or occluded proximal subclavian or innominate artery to perfuse that arm.

CH-28.1 Subclavian Steal Syndrome

✓ Initial evaluation should include clinical findings satisfying the symptom complex and initial imaging with carotid duplex study (CPT®93882)
  o Satisfying the symptom complex
    • Difference in the brachial systolic blood pressure of at least 30 mmHg between the two arms associated with a bruit in the supraclavicular area on the affected side.
    • Symptoms include vertebral basilar artery insufficiency, vertigo, limb paresis, and paresthesias. Bilateral cortical visual disturbances, ataxia, syncope, and dysarthria occur less frequently.
    • Symptoms of cerebral ischemia may be produced by exercise of the affected arm.
  o Carotid duplex study (CPT®93882) is the initial and definitive imaging study
    • Reversal of flow in the ipsilateral vertebral artery.
    • If diagnostic and there are no symptoms of vertebrobasilar ischemia, then no further imaging is generally needed.

✓ Neck and chest MRA (CPT®70548 and CPT®71555) or CTA (CPT®70498 and CPT®71275) can be performed for diagnosis in patients with symptoms of vertebrobasilar ischemia if the clinical exam and duplex study are positive, indeterminate, or as preoperative studies if they will substitute for invasive angiography.

✓ Upper extremity MRA (CPT®73225) or CTA (CPT®73206) can be performed in symptomatic patients if needed to exclude pathology distal to the subclavian artery and if they will substitute for invasive angiography.

See also HD-21.1 Vertebrobasilar Ischemia in the Head Imaging Guidelines.

Treatment options include ligation of the ipsilateral vertebral artery, aorta-subclavian artery bypass graft, or subclavian endarterectomy.
References
CH-29~Superior Vena Cava (SVC) Syndrome

**CH-29.1 SVC Syndrome**

- Chest CT with contrast (CPT®71260) is the initial imaging studies of choice for the evaluation of suspected SVC syndrome based on the facial cyanosis and UE swelling without anasarca

- MRV (CPT®71555) or CTV (CPT®71275) of the chest may be indicated when stenting of the SVC is being considered.

**Practice Notes**

SVC syndrome is caused by acute or subacute, intrinsic or extrinsic obstruction of the SVC, most commonly from lung cancer (80-85%) and less often benign (fibrosis, mediastinitis, indwelling devices). Other symptoms include dyspnea, headache and dizziness.

**Reference**

Thoracic aortic diseases are variable and critical; selected imaging procedures are dependent upon the physicians’ preference and expertise. As a result, all thoracic imaging in this section (CH-32) can be one of the following studies listed in the table below:

### Table of Thoracic Aorta Imaging Options

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>CT</td>
<td>Chest, and/or abdomen, and/or pelvis (contrast as requested);</td>
</tr>
<tr>
<td>MRI</td>
<td>Chest, and/or abdomen, and/or pelvis (contrast as requested);</td>
</tr>
<tr>
<td>CTA</td>
<td>Chest, and/or abdomen, and/or pelvis (CPT®71275, CPT®74175, CPT®72191);</td>
</tr>
<tr>
<td>MRA</td>
<td>Chest, and/or abdomen, and/or pelvis (CPT®71555, CPT®74185, CPT®72198);</td>
</tr>
</tbody>
</table>

### CH-30.1 Aortic Dissection

Classic symptoms of sharp, severe acute onset of retrosternal or interscapular chest pain is seen in 96% and is best adapted to the emergent setting. CXR is imprecise; any suspicion should be considered since up to 10% present without classic symptoms.

- For suspected aortic dissection, conduct CTA or MRA of the entire aorta (including arch branches) and extending through the femoral arteries
- For follow-up, any requested imaging from the “Table of Thoracic Aorta Imaging Options” can be performed
  - “Medically” treated (usually type B)
    - Every 6 months if total aortic diameter is ≥4.5 cm
    - Annually if total aortic diameter is <4.5 cm
  - Surgery or Stent for any type dissection (A or B)
    - First Year: 1 month, 3 months, 6 months, 12 months, then annually

### CH-30.2 Thoracic Aortic Aneurysm (TAA)

- For suspected TAA, any requested imaging from the “Table of Thoracic Aorta Imaging Options” above:
  - Abnormalities identified on Chest x-ray (abnormality including widened mediastinal) or other imaging studies (fluoroscopy, spine MRI, etc) abnormality
- For known TAA and chest pain or back pain, any requested imaging from the “Table of Thoracic Aorta Imaging Options” above
- For follow-up, any requested imaging from the “Table of Thoracic Aorta Imaging Options” above for the following:
  - “Medically” treated/observation
    - 3.0 to 4.4 cm TAA can be followed annually
● >/= 4.5 cm TAA can be followed every 6 months
● >/= 3.0 cm TAA when there is concern for growth can have a one-time 3 month interval advanced imaging
  ○ Surgery or Stent
    ● Preoperative open or endovascular (stent) repair imaging is appropriate
    ● Open Repair imaging every 3 to 5 years
  ○ Endovascular graft/stent
    ● First year: 1 month, 3 months, 6 months, 12 months, then annually

✓ Screening with Abdominal Aortic Aneurysm (AAA)
  ○ Known TAA can be screened for AAA using Abdominal Imaging Guidelines (usually US) (see: AB-17.1 Abdominal Aortic Aneurysm)
  ○ Known AAA screening for TAA is not supported by sufficient evidence

For educational information on the normal size of the aortic arch and descending thoracic, see Practice Notes.

CH-30.3 Screening Guidelines for Familial Syndromes
✓ Screening for Familial Syndromes and Genetic Syndromes
  ○ Suspected Familial Thoracic Aortic Aneurysm
    ● ECHO (CPT®93306, CPT®93307, or CPT®93308) and CXR for all First-degree relatives (parents, siblings, children) of patients with TAA and/or dissection
    ○ Any imaging listed can be performed if these studies identify a TAA or are equivocal or do not visualize the ascending aorta adequately
  ○ Follow-Up per TAA Follow-Up guidelines

✓ Screening for Marfan Syndrome or Ehlers-Danlos Syndrome, Vascular form or Type IV
  ○ Suspected, ECHO (CPT®93306, CPT®93307, or CPT®93308) at the time of diagnosis.
  ○ Follow-up:
    ● Annual ECHO (CPT®93306, CPT®93307, or CPT®93308) or per TAA Follow-Up guidelines

For educational information on familial TAA, see Practice Notes.

CH-30.4 Thoracic Aorta in Individuals with Bicuspid Aortic Valve
✓ Screening for Bicuspid Aortic Valve
  ○ Suspected, any requested imaging from the “Table of Thoracic Aorta Imaging Options” and/or ECHO (CPT®93306, CPT®93307, or CPT®93308)
    ● Additional imaging such as cardiac MRI, cardiac CT, or CCTA is NOT generally indicated.
    ● There is no evidence-based data to support screening relatives of patients with bicuspid aortic valve.
  ○ Follow-up per TAA Follow-Up guidelines
• If no dilatation of the aortic root or ascending thoracic aorta is found, there is no evidence-based data to support continued surveillance imaging.

*For more educational information on the Bicuspid Aortic Valve, see Practice Notes*

**Practice Notes**

**Aortic Dissection**

There are two general types of aortic dissection:

1. **Type A**: Those that begin in the ascending aorta
2. **Type B**: Those that begin from just distal to the left subclavian artery branch of the aorta

**Type A** often requires urgent surgical intervention with placement of an aortic graft or endovascular stent graft.

**Type B** can usually be treated medically with careful blood pressure control. Surgery is reserved for distal dissections that are leaking, ruptured, or compromising blood flow to a vital organ, or if there is inability to control the blood pressure. Transesophageal echo may be equally diagnostic compared to CT or MRI.

Routine follow-up imaging is important because 30%-40% of chronic dissections will become aneurysmal in 5 years and will require intervention, with less patent false lumina at higher risk.

Penetrating ulcer (through the intima) and intramural hematoma (no intimal tear) are variant forms of aortic dissection and should follow that of aortic dissection, since they are considered precursors of aortic dissection.

**TAA**

The normal size of the aortic arch and descending thoracic aorta is 3 cm. The aortic root is normally 3.5 cm:

- TAA occurs most often in the descending (50%) and then equally likely in the ascending or arch aorta.
- Risk factors include atherosclerosis, prolonged hypertension and trauma with mean age 65.
- Risk of rupture is 0% if < 4 cm and 31% if > 6 cm, which is when surgery is often recommended.

**Familial TAA**

Familial TAA presents at an earlier age, has a faster aortic growth rate, is seen in about 20% or non-Marfan TAA and has autosomal dominant inheritance, when compared to non-familial TAA.

**Bicuspid Aortic Valve**

Since 20% of individuals who underwent bicuspid aortic valve surgery had concurrent ascending aortic aneurysms that needed repair. All patients with bicuspid aortic valve should have both the aortic root and ascending thoracic aorta evaluated for evidence of aortic dilatation.
References

CH-31~Elevated Hemidiaphragm

CH-31.1 Elevated Hemidiaphragm

✓ Chest CT with contrast (CPT®71260) and neck CT with contrast (CPT®70491) (if requested) with new diaphragmatic paralysis after:
  o Previous available chest x-rays reviewed to determine if the diaphragm was previously elevated, and/or
  o Fluoroscopic examination ("sniff test") to differentiate true paralysis from weakness

✓ CT abdomen with contrast (CPT®74160) to rule out liver or abdominal process if Chest CT is negative

✓ Repeat advanced imaging studies in the absence of new signs or symptoms are not indicated.

Practice Notes:

o The right hemidiaphragm sits about 2 cm higher than the left.

o “Eventration” is thin membranous replacement of muscle, usually on the left, as the most common cause of elevation.

o Any injury to the phrenic nerve from neck to diaphragm can lead to paralysis.

o Common phrenic causes are traumatic or surgical injury or malignancy involving the mediastinum.

o Any loss of lung volume or increased abdominal pressure can lead to diaphragm elevation.

References


THORACIC VASCULAR DISORDERS

CH-32~Thoracic Outlet Syndrome (TOS)

CH-32.1 Thoracic Outlet Syndrome

✓ Suspect Arterial or Venous TOS
  o Neck and chest MRA (CPT®70548 and CPT®71555) or CTA (CPT®70498 and CPT®71275)

✓ Suspected Neurogenic TOS
  o EMG/NCV initially to exclude carpal tunnel syndrome
    Also see PN-4~Brachial Plexus in the Peripheral Nerve Disorders Guidelines
  o After EMG, Chest MRI (CPT®71550) or upper extremity other than joint MRI (CPT®73218) may be conducted

Practice Notes
TOS refers to compression of the subclavian vessels and/or brachial plexus at the thoracic outlet of the chest (the area bounded by the two scalene muscles and the first rib).

There are 3 types, with neurogenic seen in 80%, venous (also called effort thrombosis) 15% and the remaining 5% arterial.

Since this is such a rare entity and diagnosis is difficult, specialist evaluation by a vascular surgeon or thoracic surgeon is helpful in determining the appropriate imaging pathway.

Reference
CH-33.1 Virtual Bronchoscopy

- There is insufficient data currently to generate appropriateness criteria for the use of virtual bronchoscopy, and this procedure should be considered investigational at this time.

- Virtual bronchoscopy uses multidetector CT with 3D rendering (CPT® 71260 and CPT® 76377) to generate an image of the tracheobronchial tree down to the level of the sixth- to seventh-generation bronchi, and can visualize areas inaccessible to the flexible bronchoscope.

CH-33.2 EM-Guided Peripheral Bronchoscopy

- EM Guided Peripheral Bronchoscopy is currently an experimental/investigational procedure. Current evidence does support its use in performing biopsies of peripheral lesions of the lungs.

- Peripheral bronchoscopy using electromagnetic (EM) navigational guidance on a CT road map is a technology for performing biopsies of peripheral lesions of the lungs.

- Clinical trials are currently underway to evaluate this technique for mediastinal lymph node biopsies.

**Coding Notes**

- Planning is included in the navigational bronchoscopy code (CPT® +31627).

- Neither separate unlisted codes, (CPT® 76499 or CPT® 76497), nor other diagnostic CT codes are not reported for the planning phase and pre-procedure imaging acquisition.

- 3D Rendering, (CPT® 76376 and CPT® 76377), is not reported in conjunction with CPT® +31627.

CH-33.3 Positron Emission Mammography

- There is currently insufficient data to generate appropriateness criteria for this modality, and this procedure should be considered investigational at this time.

- High-resolution positron-emission mammography (PEM) by Naviscan™ PET Systems, also referred to as Naviscan™ or PET mammography, performs high-resolution metabolic imaging of breast cancer using FDG tracer. The PEM detectors are integrated into a conventional mammography system, allowing acquisition of the emission images immediately after the mammogram.

- Requesting providers often ask for PEM as CPT® 78811 or “PET scan of the breast.”
The spatial resolution of this technique is at the individual duct level (1.5 mm) and allows visualization of intraductal as well as invasive breast cancers. This technique is especially adept at detecting ductal carcinoma in situ.

Early clinical trials have shown high clinical accuracy in characterizing lesions identified as suspicious on conventional imaging or physical examination, as well as detecting incidental breast cancers not seen on other imaging modalities.

A prospective multi-center clinical trial for women with newly diagnosed breast cancer anticipating breast-conservation surgery was performed. These women underwent both high-resolution PEM imaging and breast MRI. Results showed that PEM and MRI had comparable breast-level sensitivity, although MRI had greater lesion-level sensitivity and more accurately depicted the need for mastectomy. PEM had greater specificity at the breast and lesion levels. 3.6% of the women had tumors seen only at PEM.

The radiation exposure from a PEM study is 23 times higher than for digital mammography.

References
CH-34.1 Pre-Transplant Imaging Studies

✓ Individuals on the waiting list or being considered for the lung transplant can undergo advanced imaging per that institution’s protocol as long as the studies do not exceed the following:
  o Chest CT with and without contrast (CPT®71270), Chest CT with (CPT®71260), or Chest CT without contrast (CPT®71250),
  o ECHO,
  o Imaging Stress Test (MPI, SE, MR) or Heart Catheterization (Right and Left); Heart catheterization can also be done after a positive stress test

✓ Other studies that will be considered include V/Q scan, Six Minute Walk

✓ Initial post-transplant follow-up: CT chest with and without contrast (CPT®71270), CT chest with (CPT®71260), or CT chest without contrast (CPT®71250)
  o Requests for subsequent follow-up imaging will go to medical director review.

✓ See: CD-1.6 Transplant Patients

References

1. Imaging of Lung Transplantation Review, American Journal of Roentgenology Vol_ 192, No_3_supplement (AJR).htm