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2025 Computed Tomography (CT) Maxillofacial Sinus

Diagnostic Imaging

CT-Max-HH

Last Review Date: 04/02/2025
Previous Review Date:10/28/2025
Guideline Initiated: 06/30/2019

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Computed Tomography (CT) Maxillofacial Sinus

CT Maxillofacial Sinus National Coverage Determination (NCD)/Local Coverage Determination (LCD)

Please refer to https://www.cms.gov/medicare-coverage-database/search.aspx if applicable to the individual's health plan membership.

Type/ID Number	Title
NCD 220.1	Computed Tomography
LCD 35175	MRI and CT Scans of the Head and Neck
LCD 37373	MRI and CT Scans of the Head and Neck

Clinical Judgment

These medical policies are designed to provide clinical guidance and do not supplant a provider's independent professional judgment. Physicians retain full and independent authority to determine appropriate care based on each patient's individual clinical circumstances. Although services may be subject to documentation requirements, medical necessity review, or coverage limitations, nothing in this policy is intended to restrict or interfere with a physician's independent medical judgment.

CT General Contraindications

Computed tomography (CT) is contraindicated (relative) for **ANY** of the following:

- Allergy/idiosyncratic reaction to contrast material (if intravascular contrast material is used)
- Pregnancy
- Renal impairment (glomerular filtration rate [GFR] is less than 30 ml/min/1.73 m^2.)
  References: [1]

Preamble: Pediatric Diagnostic Imaging

HealthHelp's clinical guidelines for the Diagnostic Imaging program, are intended to apply to both adults and pediatrics (21 years of age or younger), unless otherwise specified within the criteria.

CT Maxillofacial Sinus Guideline

Computed tomography (CT) of the maxillofacial sinus area is considered medically appropriate when the documentation demonstrates **ANY** of the following:

1. Anosmia or dysosmia is known and **ALL** of the following:
    a. Endoscopy is abnormal, non-diagnostic or indeterminate.
    b. MRI is **contraindicated or unavailable**.
    c. Persistent (recurrs, does not resolve despite treatement)
    d. Unknown origin.

    References: [15]
2. Asthma is refractory and nasal pathology (eg, congestion, polyps) is present.
    References: [6]
3. Cancer is suspected or known and **ANY** of the following: (*__NOTE__: *CT is appropriate for suspected bony involvement or destruction. MRI is more appropriate for soft tissue abnormalities*.)
    a. Cancer of the face and sinuses is suspected or known, based on clinical findings.
    b. Recurrence or metastasis is suspected.
    c. Staging evaluation.
    d. Surveillance following the National Comprehensive Cancer Network (NCCN) Guidelines recommended schedule (see ***Surveillance*** section).
    e. Tumor, sinonasal mass, face mass or lesion, based on exam, nasal endoscopy or prior imaging.

    References: [4] [9] [15]
4. Cerebrospinal fluid (CSF) rhinorrhea is known, to further characterize a bony defect. (*__NOTE__: *CSF fluid should always be confirmed with laboratory testing [Beta-2 transferrin assay]*.)
    References: [9]
5. Granulomatosis with polyangiitis (Wegener's granulomatosis) disease is symptomatic, to determine extent of disease. (*__NOTE__: *MRI is appropriate for soft tissue extent*)
    References: [18]
6. Infectious or inflammatory condition evaluation for **ANY** of the following:
    a. Abscess is suspected or known.
    b. Infectious adenopathy is suspected, **AFTER** at least 10 days of antibiotic management **AND** symptoms persist (eg, elevated white blood cells, fever, swelling).
    c. Osteomyelitis is suspected **AFTER** prior X-ray is non-diagnostic or indeterminate **AND** MRI is **contraindicated or unavailable**.

d. Rhinosinusitis (sinusitis) evaluation for **ANY** of the following:

i. Acute (less than 4 weeks) or subacute (4 to 12 weeks), symptoms (eg, fever, pain, rhinorrhea) persist **AND EITHER** of the following:

A. Medication management (eg, antihistamines, nasal saline irrigation, steroids) **AND** antibiotics were attempted for at least 10 days each, in the past 3 months **AND** symptoms persist.

B. Recurrent (at least 4 occurrences in a year) infections **AND** symptoms persist.

ii. Chronic (more than 12 weeks) infection and **ALL** of the following:

A. **AT LEAST 2** of the following:

I. Discharge is mucopurulent.

II. Facial pain, pressure, fullness.

III. Nasal obstruction or congestion.

IV. Taste or smell are decreased or absent.

B. Medication management (eg, antibiotics, antihistamines, nasal saline irrigation, steroids) **FAILED**.

iii. Complications (eg, cavernous sinus thrombosis, infection [intracranial, preseptal or orbital], osteomyelitis, suspected cerebrospinal fluid [CSF] leak) are suspected.

iv. Fungal sinusitis is suspected.

v. Nasal polyp is known (especially unilaterally) **AND** extension outside the nasal cavity is suspected.

vi. Nasal polyp or obstruction (unilateral) is suspected. [10]

vii. Pediatric individual and **ANY** of the following: [17]

A. Fungal infection (more common in immunocompromised children) is suspected.

B. Orbital or central nervous system involvement (eg, altered level of consciousness, nerve deficit, proptosis, seizure, swollen eye) is suspected.

C. Sinusitis is persistent or recurrent and is **NOT** responding to treatment (primarily antibiotics, treatment may require a change of antibiotics).

viii. Symptoms (eg, elevated white blood cells, fever, rhinorrhea) persist despite medical management **AND** is a possible surgical candidate.

e. Sialadenitis is suspected, symptoms are bilateral (eg, fever, pain, swelling), abscess is suspected **OR** ultrasound is non-diagnostic or indeterminate.

References: [9] [5] [14] [7] [11] [10] [3]

7. Osteonecrosis of the jaw is suspected or known and X-rays are abnormal, non-diagnostic or indeterminate.
References: [2] [8]

8. Post-surgical assessments for evaluation of complications or disease recurrence

9. Salivary gland stones are suspected or known.
References: [12]

10. Structural abnormality (eg, deviated septum, polyp) or lesion is suspected or known and **ALL** of the following:

    a. Airway obstruction is caused by lesion and/or structural abnormality.

    b. Imaging is needed for treatment planning.

    c. Seen on prior imaging or direct visualization.

11. Trauma to the face is known and **ANY** of the following:

    a. Cerebrospinal fluid (CSF) leak is suspected. (*__NOTE__: *CSF fluid should always be confirmed with laboratory testing [Beta-2 transferrin assay]*.)

    b. Facial injury is severe (eg, bony step-off, depression, ecchymosis, malocclusion, nasal deformity) and fracture is suspected.

    c. Fracture is known, for treatment planning or surgical planning.

    References: [13] [16]

12. Trigeminal neuralgia or neuropathy is suspected or known, with atypical features (eg, bilateral hearing loss, dizziness/vertigo, numbness, pain more than 2 minutes, pain outside trigeminal nerve distribution, progression, sensory loss) and MRI is **contraindicated or unavailable**.
References: [15]

Head and Neck Cancer Surveillance section

Bone Cancer Surveillance

Bone cancer surveillance includes **ANY** of the following:

1. Chondrosarcoma surveillance for **ANY** of the following:
    a. Atypical cartilaginous tumor surveillance with cross-sectional imaging (CT + contrast, MRI ± contrast) every 6 to 12 months for 2 years, then annually as clinically indicated
    b. Low-grade, extracompartmental appendicular tumor, grade I axial tumors or high-grade (grade II or III, clear cell or extracompartmental) tumors surveillance with **ALL** of the following:
        i. Chest CT at least every 6 months for 5 years, then annually for at least 10 years, then if symptoms are new or progressing.
        ii. MRI (± contrast) or CT (+ contrast) if symptoms are new or progressing.
2. Chordoma surveillance with **ALL** of the following:
    a. Chest CT imaging every 6 months, annually for 5 years, then annually thereafter, then if symptoms are new or worsening.
    b. Imaging of primary site, timing and modality (eg, MRI ± CT [both + contrast]) if symptoms are new or progressing, up to 10 years
3. Ewing Sarcoma after primary treatment completed surveillance with **ALL** of the following:
    a. Chest CT: every 3 months
    b. Primary site imaging with MRI ± CT (both + contrast), increase intervals after 24 months and after 5 years, annually, then if symptoms are new or progressing (indefinitely) (*__NOTE__: *PET/CT [head-to-toe] is appropriate*)
4. Giant cell tumor of the bone surveillance with **ALL** of the following:
    a. Chest CT or MRI imaging every 6 to 12 months for 4 years, then annually thereafter, then if symptoms are new or progressing
    b. Surgical site imaging if symptoms are new or progressing (eg, CT and/or MRI, both with contrast)
5. Osteosarcoma surveillance with primary site and chest imaging (using same imaging that was done for initial work-up) for **ANY** of the following: (*__NOTE__: *PET/CT [head-to-toe] is appropriate*.)
    a. Image every 3 months for years 1 and 2
    b. Image every 4 months for year 3
    c. Image every 6 months for years 4 and 5
    d. Image annually for year 6 and thereafter, then if symptoms are new or progressing

References: [2025 Bone Cancer Version 1.2026]

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Central Nervous System (CNS) Cancer Surveillance

Central nervous system (CNS) cancer surveillance includes **ANY** of the following:

1. Brain metastasis, limited **OR** extensive, image with brain magnetic resonance imaging (MRI) every 2 to 3 months for 1 to 2 years, then every 4 to 6 months indefinitely
2. Glioblastoma, *IDH* wild-type, magnetic resonance imaging with (MRI) of the brain and **ANY** of the following:
    a. Pre-operative and post-operative; within 48 hours
    b. Pre-radiation planning; every 3 to 5 weeks, post-operatively
    c. Post-radiation; 3 to 6 weeks post-radiation, then every 2 to 3 months for 3 years, then every 2 to 4 months indefinitively
3. Glioma, imaging with MRI of the brain and **ANY** of the following:
    a. Astrocytoma, *IDH* mutated and **ANY** of the following:
        i. Grade 2 and **ANY** of the following:
            A. After radiation therapy (RT) **AND** chemotherapy: every 6 months until tumor progression
            B. After RT **OR** chemotherapy: every 3 to 4 months for the 1st 5 years, then every 3 to 4 months until tumor progression
            C. After surgery: every 3 to 4 months until tumor progression
        ii. Grade 3 and **ANY** of the following;
            A. After RT **AND** chemotherapy: every 6 months until tumor progression
            B. After RT **OR** chemotherapy: every 3 to 4 months for the 1st 5 years, then every 3 to 4 months until tumor progression
        iii. Grade 2 or 3, recurrent; image every 2 to 3 months
    b. Oligodendroglioma, *IDH* mutated, 1p/19q co-deleted and **ANY** of the following:
        i. Grade 2 and **ANY** of the following:
            A. After radiation therapy (RT) **AND** chemotherapy: every 6 to 9 months until tumor progression
            B. After RT **OR** chemotherapy: every 3 to 4 months for the 1st 5 years, then every 3 to 4 months until tumor progression

C. After surgery: every 3 to 4 months until tumor progression (*__NOTE__: *For individuals who underwent gross total resection, every 6 to 9 months for 5 years post-surgery until tumor progression*)

ii. Grade 3 and **ANY** of the following:

A. After radiation therapy (RT) **AND** chemotherapy: every 6 to 9 months until tumor progression

B. After RT **OR** chemotherapy: every 3 to 4 months for the 1st 5 years, then every 3 to 4 months until tumor progression

iii. Grade 2 or 3, recurrent, image every 3 to 4 months

4. Leptomeningeal metastases imaging with MRI of the brain and/or total spine every 2 to 3 months for the 1st 2 years, every 6 months until year 5, then annually indefinitively
5. Medulloblastoma, imaging with MRI of the brain every 2 to 3 months for 2 years
6. Primary CNS lymphoma, image every 2 to 3 months for 2 years

References: [2025 Central Nervous System Cancers Version 1.2025]

Esophageal and Esophagogastric Junction Cancer Surveillance

Esophageal and esophagogastric junction cancer surveillance includes **ANY** of the following[1]:

1. Adenocarcinoma, squamous cell carcinoma; imaging studies if symptoms are new or progressing
2. Tumor classification T1b[a] (N0 on ultrasound) after endoscopic resection or ablation, imaging surveillance includes computed tomography (CT) chest and abdomen (+ contrast, unless **contraindicated**) every 6 months for the first 2 years and annually for up to 5 years
3. Tumor classification T1b or greater, any N[a] or T1a N+, imaging surveillance includes esophagectomy performed with or **WITHOUT** adjuvant therapy then surveillance includes chest and abdomen CT (+ contrast, unless **contraindicated**) every 6 months for the first 2 years and annually for up to 5 years
4. Tumor classification any T and/or any N, with neoadjuvant chemotherapy **OR** chemoradiotherapy **AND** esophagectomy, with or **WITHOUT** adjuvant treatment, imaging surveillance includes chest and abdomen CT (+ contrast, unless **contraindicated**) every 6 months for up to 2 years, then annually for up to 5 years and EGD, then if symptoms are new or progressing

[1]Routine esophageal/esophagogastric junction cancers are **NOT** recommended for cancer-specific surveillance, for more than 5 years after the end of treatment.

5. Tumor classification (pretreatment) N0 to N+, T1b to T4, T4b, with definitive chemoradiation (**WITHOUT** esophagectomy), surveillance imaging includes chest and abdomen CT (+ contrast unless **contraindicated**) every 3 to 6 months for the first 2 years and annually for up to 5 years

References: [2025 Esophageal and Esophagogastric Junction Cancers Version 3.2025]

Head and Neck Cancers Surveillance

Head and neck cancers surveillance for locoregionally advanced disease after treatment, includes **ANY** of the following:

1. Short-term surveillance (less than 6 months after treatment), if there is high-risk of early recurrence, symptoms of early recurrence or before starting adjuvant post-operative therapy:
    a. Computed tomography (CT) or magnetic resonance imaging (MRI) within 3 to 4 months post-operatively to establish a new baseline for future comparisons
    b. FDG positron emissions tomography/computed tomography (FDG PET/CT) within 3 to 6 months of definitive radiation or systemic therapy/RT.
    c. Incomplete response is suspected: CT or MRI scan earlier (eg, 4 to 8 weeks) based on new or progressing symptoms. (*__NOTE__: *Use ultrasound [US] of the neck for targeted sampling.*)
2. Long-term surveillance (6 months or more from end-of-treatment, up to 5 years after treatment) with CT, MRI, FDG PET/CT to obtain surveillance for lesions that are recurrent, second primary or at distant sites.[2]

References: [2025 Head and Neck Cancer Version 2.2025]

Histiocytic Neoplasms Surveillance

NCCN Histiocytic Neoplasms Version 3.2024

Histiocytic neoplasms surveillance imaging includes **ANY** of the following:

1. Erdheim-Chester disease surveillance imaging includes **ANY** of the following:

[2]Per the National comprehensive cancer network (NCCN) Guidelines for Head and Neck Cancers, there are no consensus guidelines for the surveillance imaging type, frequency or duration for locoregionally advanced disease. If an FDG PET/CT at 3 months post-treatment is negative, there are no data to support substantial benefit for further routine imaging when asymptomatic with negative exam. In the absence of multi-institutional prospective data, a tailored approach to surveillance with attention to tumor type, stage, prognostic factors, symptomatology and physical exam changes or restrictions is recommended.

a. Fluorodoxyglucose (FDG)-positron emission tomography/computed tomography (PET/CT) every 3 to 6 months after starting therapy until stabilization of the disease, and as clinically indicated after 2 years.

b. Organ specific imaging with CT (+ contrast) or MRI (± contrast) every 3 to 6 months until disease stabilization and then every 6 to 12 months

2. Langerhans cell histiocytosis surveillance imaging includes FDG-PET/CT , FDG-PET or CT/ magnetic resonance imaging (MRI) every 3 to 6 months for the first 2 years after completion of therapy, then **NO** more than annually (*__NOTE__: *For individuals who are asymptomatic with a single-site bone lesion, imaging surveillance can end after 1 year, with continued tracking of symptoms*)

3. Rosai-Dorfman disease (RDD), surveillance imaging includes **ANY** of the following: (*__NOTE__: *for individuals who are asymptomatic with a single-site bone lesion, imaging surveillance can end after 1 year, with continued tracking of symptoms*)

a. FDG-PET/CT every 3 to 6 months after starting therapy until stabilization of disease

b. Organ specific imaging with CT (+ contrast) or MRI (± contrast) every 3 to 6 months until disease stabilization and then every 6 to 12 months

References: [2025 Histiocytic Neoplasms Version 3.2025]

Melanoma: Uveal Surveillance

Uveal melanoma surveillance imaging includes **ANY** of the following:

1. Low risk disease surveillance imaging every 12 months for 5 years or clinically as indicated, includes **ANY** of the following:

a. Chest/abdomen/pelvis computed tomography (CT) (+ contrast)

b. Magnetic resonance (MR) (+ contrast) or ultrasound of liver

2. Medium risk disease surveillance imaging every 6 to 12 months for 10 years, then as clinically indicated, includes **ANY** of the following:

a. Chest/abdomen/pelvis CT (+ contrast)

b. MR (+ contrast) or ultrasound of liver

3. High risk disease surveillance imaging every 3 to 6 months for 5 years, then every 6 to 12 months for 10 years, then clinically as indicated, includes **ANY** of the following:

a. Chest/abdomen/pelvis CT (+ contrast)

b. MR (+ contrast) or ultrasound of liver

References: [2025 Melanoma: Uveal Version 1.2025]

Pediatric Central Nervous System Cancers

Pediatric central nervous system cancer surveillance includes **ANY** of the following:

1. Medulloblastoma and **ANY** of the following:
    a. Risk is low or average (after completion of adjuvant/maintenance treatment) and **ALL** of the following:
        i. Brain magnetic resonance imaging (MRI) every 3 to 4 months for 2 years, then every 6 months for 3 years, then if symptoms are new or progressing.
        ii. Spine MRI (cervical, lumbar **AND** thoracic) every 6 months for 2 years, then if symptoms are new or progressing.
    b. Risk is high or very high (after completion of adjuvant/maintenance treatment) and **ANY** of the following:
        i. Brain MRI every 3 to 4 months for 2 years, then every 6 months for 3 years, then if symptoms are new or progressing.
        ii. Spine MRI (cervical, lumbar **AND** thoracic) every 3 to 4 month for 2 years, then annually for 3 years, then if symptoms are new or progressing.
2. Pediatric diffuse high-grade glioma, image with brain MRI 2 to 6 weeks after radiation therapy, then every 2 to 3 months for year 1, then every 3 to 6 months indefinitely

References: [2025 Pediatric Central Nervous System Cancers Version 3.2025]

Soft Tissue Sarcoma Surveillance

Soft tissue sarcoma surveillance includes **ANY** of the following: (*__NOTE__: *Use contrast imaging; for long term surveillance to minimize radiation exposure,MRI may be substituted.*)

1. Desmoid tumor (aggressive fibromatosis) imaging surveillance includes computed tomography (CT) or magnetic resonance imaging (MRI) every 3 to 6 months for 3 years, then every 6 to 12 months thereafter
2. Extremity, trunk or head and neck, for long-term follow-up with **ANY** of the following:
    a. Long-term follow-up with **ALL** of the following:
        i. Chest CT imaging (- contrast) to detect asymptomatic distant recurrence
        ii. MRI for imaging of primary site
    b. Stage I tumors and **ALL** of the following:
        i. Chest CT imaging (- contrast) every 6 to 12 months
        ii. Post-operative baseline and periodic imaging of primary site with MRI or CT if MRI is **contraindicated or unavailable**.

c. Stage II and III tumors and **ANY** of the following:

i. Baseline and periodic imaging of primary site

ii. Chest and other known sites of metastatic disease imaging (CT [- contrast] or X-ray) every 2 to 6 months for 2 to 3 years, then every 6 months to complete a total of 5 years, then annually.

iii. Post-operative reimaging to assess the primary tumor site and rule out metastatic disease (MRI or CT if MRI is **contraindicated or unavailable**.

3. Retroperitoneal/intra-abdominal, after management of primary disease imaging surveillance includes chest/abdomen/pelvis CT or MRI every 3 to 6 months for 3 years, then every 6 months for the next 2 years, then annually.

References: [2025 Soft Tissue Sarcoma Version 1.2025]

Thymomas and Thymic Carcinomas Surveillance

Thymomas and thymic carcinomas surveillance after primary treatment includes **ANY** of the following:

1. R0 resection surveillance imaging with chest computed tomography (CT) (+ contrast) or magnetic resonance imaging (MRI) for **ANY** of the following:
   a. Thymic carcinoma every 6 to 12 months for 2 years, then annually until year 5
   b. Thymoma every 6 months for 2 years, then annually until year 10
2. R1 and R2 resection surveillance imaging with chest CT (+ contrast) or MRI for **ANY** of the following:
   a. Thymic carcinoma every 3 to 6 months for 2 years, then annually for 5 years
   b. Thymoma every 6 months for 2 years, then annually for 10 years
3. Locally advanced disease surveillance imaging with chest CT (+ contrast) or MRI for **ANY** of the following:
   a. Thymic carcinoma every 3 to 6 months for 2 years, then annually for 5 years
   b. Thymoma every 6 months for 2 years, then annually for 10 years

References: [2025 Thymomas and Thymic Carcinomas Version 2.2025]

Thyroid Carcinoma Surveillance

Thyroid carcinoma surveillance imaging includes **ANY** of the following:

1. Anaplastic carcinoma (stage IVC surveillance imaging includes computed tomography (CT) or magnetic resonance imaging (MRI) (+ contrast) of brain, neck, chest, abdomen and

pelvis at frequent intervals as clinically indicated (*__NOTE__: *consider fluorodeoxyglucose-positron emission tomography (FDG-PET)/CT 3 to 6 months after initial therapy*)

2. Medullary carcinoma surveillance imaging includes **ANY** of the following:
    a. MRI of whole body, if calcitonin levels are very elevated 150 pg/ml or more.
    b. Calcitonin level is 150 pg/ml or more: surveillance with CT or MRI (+ contrast) of the neck, chest, and liver, as clinically indicated
    c. FDG-PET/CT or Ga-68 DOTATE or MRI (+ contrast) of the neck, chest, abdomen with liver protocol, based on calcitonin/carcinoembryonic antigen (CEA) doubling time

References: [2025 Thyroid Carcinoma Version 1.2025]

CT Maxillofacial Sinus Summary of Changes

CT Maxillofacial Sinus guideline had the following version changes from 2024 to 2025:

- Added the following to keep in line with current evidence:
    - "Asthma is refractory" per EBM
    - "Glomerular filtration rate" to "Renal impairment" under Contraindications
    - "X-rays are abnormal, non-diagnostic or indeterminate" to "Osteonecrosis of the jaw is suspected or known" as less advanced imaging should be done prior to CT.
- Removed combination studies as they are redundant

CT Maxillofacial Sinus Procedure Codes

Table 1. CT Maxillofacial/Sinus Associated Procedure Codes

CODE	DESCRIPTION
70486	Computed tomography, maxillofacial area; without contrast material
70487	Computed tomography, maxillofacial area; with contrast material(s)
70488	Computed tomography, maxillofacial area; without contrast material, followed by contrast material(s) and further sections

CT Maxillofacial Sinus Definitions

Abscess is a swollen area within body tissue, containing an accumulation of pus.
Adenopathy is any disease or enlargement involving glandular tissue, specifically lymph glands.
Anosmia is the loss or impairment of the sense of smell.
Asthma is a chronic lung disorder that is marked by recurring episodes of airway obstruction (as from bronchospasm) manifested by labored breathing accompanied especially by wheezing and

coughing and by a sense of constriction in the chest, and that is triggered by hyperreactivity to various stimuli (such as allergens or rapid change in air temperature).

Avascular necrosis is localized death of bone tissue due to impaired or disrupted blood supply (as from traumatic injury or disease).

Bilateral means affecting or involving both sides of the body or a paired organ.

Bony step-off is a type of malunion that occurs when bones heal but the joint surfaces are not aligned. A bony step-off can be seen and felt by an examiner when a fracture or dislocation is severe.

Cavernous sinus thrombosis is a rare blood clot that can form in response to an infection in your face or head and can be life threatening.

Cerebrospinal fluid (CSF) is a colorless liquid that is comparable to serum, is secreted from the blood into the lateral ventricles of the brain, and serves chiefly to maintain uniform pressure within the brain and spinal cord.

Cerebrospinal fluid (CSF) rhinorrhea is a condition where the fluid that surrounds the brain leaks into the nose and sinuses.

Computed tomography (CT) is an imaging test that uses X-rays to computer analysis to generate cross sectional images of the internal structures of the body that can be displayed in multiple planes.

Contrast material is a substance that enhances the visibility of internal organs, blood vessels or tissues during imaging tests. It's also known as contrast agents or dye.

Deviated septum is a condition where the nasal septum, the bone and cartilage that divide the nasal cavity, is displaced from the midline, potentially causing nasal obstruction and other symptoms.

Dysosmia is a qualitative olfactory dysfunction characterized by altered perception of odors, including parosmia (distorted perception of odors) and phantosmia (false perception of odors without an odor source).

Ecchymosis also known as a bruise or contusion, is a skin discoloration that occurs when blood vessels under the skin are damaged and leak blood. The dark purple spot appears on the skin when blood leaks out of blood vessels.

Endoscopy is a procedure that uses an endoscope to examine the inside of the body. An endoscope is a thin, tube-like instrument with a light and a lens for viewing. It may also have a tool to remove tissue to be checked under a microscope for signs of disease.

Fungal sinusitis, also known as fungal rhinosinusitis, is inflammation of the sinus lining caused by a fungal infection, often seen in individuals with weakened immune systems.

Glomerular filtration rate (GFR) is a blood test used to check how well the kidneys are working by estimating how much blood passes through the glomeruli (tiny filters in the kidneys that filter waste from the blood) each minute.

Granulomatosis is a chronic condition marked by the formation of numerous masses or nodules of chronically inflamed tissue with granulations that are usually associated with an infectious process.
Indeterminate findings are inconclusive or insufficient for treatment planning.
Magnetic resonance imaging (MRI) is a non-invasive diagnostic technique that produces computerized images of internal body tissues and is based on nuclear magnetic resonance of atoms within the body induced by the application of radio waves.
Malocclusion is the misalignment of teeth and/or incorrect relation between the teeth of the two dental arches when they approach each other as the jaws close.
Metastases is the spread of a disease-producing agency (such as cancer cells) from the initial or primary site of disease to another part of the body.
Neuropathy is damage, disease or dysfunction of one or more nerves, especially of the peripheral nervous system, that is typically marked by burning or shooting pain, numbness, tingling, muscle weakness or atrophy It is often degenerative and is usually caused by injury, infection, disease, drugs, toxins or vitamin deficiency.
Non-diagnostic is a result that does not lead to a confirmed diagnosis.
Olfactory training is a non-pharmacological intervention for patients with olfactory dysfunction, involving the repeated exposure to specific odors to stimulate and potentially improve the sense of smell.
Osteomyelitis is an infectious, inflammatory disease of bone. It is often painful, bacterial in origin and may result in the death of bone tissue.
Osteonecrosis is localized death of bone tissue due to impaired or disrupted blood supply.
Pediatric approximate ages are defined by the US Department of Health (USDH), the Food and Drug Administration (FDA), and the American Academy of Pediatrics (AAP) as the following:

1. Infancy, between birth and 2 years of age
2. Childhood, from 2 to 12 years of age
3. Adolescence, from 12 to 21 years of age, further defined by the AAP into:
    a. Early (ages 11–14 years)
    b. Middle (ages 15–17 years),
    c. Late (ages 18–21 years)
    d. Older ages may be appropriate for children with special healthcare needs.

Periprocedural is a medical term that means occurring before, during, or after a medical procedure. "Perioperative" is another term that refers to the time around surgery.
Polyangiitis is the inflammation of multiple types of vessels, such as small arteries and veins.
Polyps are mucosal or submucosal abnormal tissue growths.

Preseptal refers to the area anterior to the orbital septum, a fibrous tissue sheet that separates the front of the eyelid and surrounding tissues from the deeper orbital structures.
Proptosis (exophthalmos) is the abnormal protrusion or bulging. of the eyeball.
Recurrence is a new occurrence of something that happened or appeared before.
Refractory is resistance to treatment or cure.
Rhinorrhea is excessive mucous drainage from the nose.
Rhinosinusitis is inflammation of the mucous membranes of the nose and one or more paranasal sinuses that includes the following symptoms: mucopurulent discharge, nasal obstruction, congestion, facial pain, pressure, fullness and/or decreased sense of smell.
Seizure is a sudden, uncontrolled electrical disturbance in the brain. It can cause changes in behavior, movements or feelings and in levels of consciousness.
Sialadenitis is a salivary gland infection that causes inflammation and enlargement of one or more major salivary glands. It can be caused by bacteria or viruses.
Staging in cancer is the process of determining how much cancer is within the body (tumor size) and if it has metastasized (spread).
Surveillance in cancer is the ongoing, timely and systematic collection and analysis of information on new cancer cases, extent of disease, screening tests, treatment, survival and cancer deaths.
Thrombosis is the formation of a blood clot (partial or complete blockage) within blood vessels, whether venous or arterial, limiting the natural flow of blood and resulting in clinical sequela.
Trigeminal neuralgia is an intense paroxysmal neuralgia (pain radiating along the course of one or more nerves usually without demonstrable changes in the nerve structure) involving one or more branches of the trigeminal nerve.
Ultrasound is the diagnostic or therapeutic use of ultrasound and especially a noninvasive technique involving the formation of images used for the examination and measurement of internal body structures and the detection of bodily abnormalities.
Vertigo is a sensation of motion or spinning that is often described as dizziness. People with vertigo feel as though they are actually spinning or moving, or that the world is spinning around them.
Wegener's Granulomatosis is an uncommon disease of unknown cause characterized by inflammation of small blood vessels and granuloma formation, especially in the upper and lower respiratory tracts and kidneys, that typically has an onset during the ages of 40 to 65 years old.

CT Maxillofacial Sinus References

[1] American College of Radiology. (2023). ACR Manual on Contrast Media. *American College of Radiology*. Retrieved: February 2024. https://www.acr.org/-/media/ACR/Files/Clinical-Resources/Contrast_Media.pdf

[2] Assouline, S.L., Meyer, C., . . . Louvrier, A. (2021). How useful is intraoperative cone beam computed tomography in maxillofacial surgery? An overview of the current literature. *International Journal of Oral and Maxillofacial Surgery, 50*(2), 198-204.

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Disclaimer section

Purpose

The purpose of the HealthHelp's clinical guidelines is to assist healthcare professionals in selecting the medical service that may be appropriate and supported by evidence to safely improve outcomes. Medical information is constantly evolving, and HealthHelp reserves the right to review and update these clinical guidelines periodically. HealthHelp reserves the right to include in these guidelines the clinical indications as appropriate for the organization's program objectives. Therefore the guidelines are not a list of all the clinical indications for a stated procedure, and associated Procedure Code Tables may not represent all codes available for that state procedure or that are managed by a specific client-organization.

Clinician Review

These clinical guidelines neither preempt clinical judgment of trained professionals nor advise anyone on how to practice medicine. Healthcare professionals using these clinical guidelines are responsible for all clinical decisions based on their assessment. All Clinical Reviewers are instructed to apply clinical indications based on individual patient assessment and documentation, within the scope of their clinical license.

Payment

The use of these clinical guidelines does not provide authorization, certification, explanation of benefits, or guarantee of payment; nor do the guidelines substitute for, or constitute, medical advice. Federal and State law, as well as member benefit contract language (including definitions and specific contract provisions/exclusions) take precedence over clinical guidelines and must be considered first when determining eligibility for coverage. All final determinations on coverage and payment are the responsibility of the health plan. Nothing contained within this document can be interpreted to mean otherwise.

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National and Local Coverage Determination (NCD and LCD)

NOTICE
To ensure appropriate review occurs to the most current NCD and/or LCD, always defer to https://www.cms.gov/medicare-coverage-database/search.aspx.

Background

National Coverage Determinations (NCD) and Local Coverage Determinations (LCD) are payment policy documents outlined by the Centers for Medicare and Medicaid Services (CMS) and the government's delegated Medicare Audit Contractors (MACs) that operate regionally in jurisdictions.
CMS introduced variation between different jurisdictions/Medicare Audit Contractors (MACs) and their associated covered code lists with the transition to ICD 10. The variation resulted in jurisdictions independently defining how codes are applied for exclusions, limitations, groupings, ranges, etc. for the medical necessity indications outlined in the NCD and LCD. Due to this variation, there is an inconsistent use/application of codes and coverage determinations across the United States between the different MACs.
In addition, **WITHOUT** notice, CMS can change the codes that indicate medical necessity and the format of the coverage determinations/associated documents (eg, Articles). This is an additional challenge for organizations to keep up with ongoing, unplanned changes in covered codes and medical necessity indications.

Medical Necessity Codes

Due to the variation in code application between jurisdictions/MACs and that updates can happen without notification, HealthHelp is not able to guarantee full accuracy of the codes listed for any Coverage Determination, and advises that prior to use, the associated Coverage Determination Articles are reviewed to ensure applicability to HealthHelp's programs and any associated NCDs and LCDs.

For Internal Use Only:

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