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2025 Computed Tomography (CT) Neck

Diagnostic Imaging

CT-Neck-HH

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Last Review Date: 04/16/2025
Previous Review Date: 10/28/2024
Guideline Initiated: 06/30/2019

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Computed Tomography (CT) Soft Tissue Neck

CT Neck Soft Tissue 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: [1]

- 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.)

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 Neck Soft Tissue Guideline

Computed tomography (CT) of the soft tissue of the neck is considered medically appropriate when the documentation demonstrates **ANY** of the following:

1. Cancer is suspected or known and **ANY** of the following:

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a. Cancer in the head and neck is known and **ANY** of the following:

   i. Recurrence or metastasis is suspected by exam or symptoms.

   ii. Staging evaluation

   iii. Surveillance following the National Comprehensive Cancer Network (NCCN) Guidelines recommended schedule (see ***Surveillance*** section).

b. Exam findings include **ANY** of the following:

   i. Adenopathy, infectious, is suspected **AND FAILED** 2 weeks of antibiotic treatment.

   ii. Lesions in the mouth or throat are suspicious for malignancy. [19]

   iii. Mass/tumor is known **AND** prior imaging is abnormal, non-diagnostic or indeterminate, for further evaluation.

   iv. Neck mass or lymphadenopathy is **NOT** in the thyroid or parotid regions and **ANY** of the following: (*__NOTE__: *First imaging recommended is an ultrasound for discrete cystic lesions of the neck [excluding high suspicion of malignancy]*)

      A. Malignancy risk is increased due to **ANY** of the following:

         I. Cancer history

         II. Consistency is firm.

         III. Fixation to adjacent tissues

         IV. Mass is stable, present for 2 weeks or more (or uncertain duration) **AND** etiology is **NOT** infection.

         V. Size is more than 1.5 cm.

         VI. Ulceration of overlying skin is known.

      B. Pediatric individual and ultrasound is non-diagnostic or indeterminate **OR** cancer history

c. Neck mass in the parotid region and ultrasound is completed. (*__NOTE__: *First evaluation is an ultrasound to assess if the mass is located inside or outside the gland.*)

d. Neck mass in the thyroid region, ultrasound is abnormal, non-diagnostic or indeterminate and **ANY** of the following: (*__NOTE:__ *Thyroid-region masses should first have ultrasound evaluation. CT is preferred over MRI due to less respiratory motion artifact. CT chest may be included for some pre-procedural evaluations.*)

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i. Airway compression is suspected.

ii. Prior imaging suggests extension through the thoracic inlet into the mediastinum and imaging is to assess the extent of affected thyroid tissue.

iii. Thyroid cancer is known, for staging and recurrence monitoring.

References: [5] [10] [9] [8] [17] [3] [7] [2]

2. Cranial nerve palsy (CN IX to XII), objective, for evaluation of the extracranial nerve course
References: [13] [16]

3. Dysphagia is suspected or known **AND** endoscopy and/or fluoroscopy studies are non-diagnostic or indeterminate.
References: [11] [16]

4. Foreign body assessment **AND** prior imaging (endoscopy, fluoroscopy or X-ray) is non-diagnostic or indeterminate.
References: [14]

5. Hyperparathyroidism (primary, secondary or tertiary) is known and ultrasound is non-diagnostic or indeterminate **OR** for pre-surgical planning.
References: [20]

6. Infections, deep space or neck/pharynx abscess is suspected or known **AND** there are signs of infection (eg, fever, pain, swelling).
References: [15] [3]

7. Pre-procedural evaluation, to guide treatment planning or post-surgical assessments (within 90 days of procedure) for evaluation of complications or disease recurrence

8. Salivary gland stones are suspected or known and ultrasound is non-diagnostic or indeterminate.
References: [6]

9. Sialadenitis is suspected or known, abscess is suspected, **AND** symptoms are bilateral **OR** ultrasound is non-diagnostic or indeterminate.
References: [6]

10. Symptoms include **ANY** of the following:

    a. Pain in the ear that is unexplained, MRI is **contraindicated or unavailable**, when ordered by an otolaryngologist/ear, nose and throat specialist and **ALL** of the following:

        i. High risk for malignancy (eg, age over 50 years old, alcohol use, tobacco smoker, weight loss)

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ii. Otoscopic exam, nasolaryngoscopy and lab evaluation (eg, complete blood count [CBC], erythrocyte sedimentation rate [ESR]) are complete.

b. Pain in the throat is unexplained and present for **AT LEAST** 2 weeks, when ordered by an otolaryngologist/ear, nose and throat specialist and **ALL** of the following:

i. High risk for malignancy (eg, age over 50 years old, alcohol use, tobacco smoker, weight loss)

ii. Infection signs/symptoms are **NOT** present.

iii. Laryngopharyngeal reflux treatment **FAILED**.

iv. Laryngoscopy and otolaryngologic exam is completed.

References: [18]

11. Tracheal stenosis is suspected or known.
References: [4] [12]

12. Vocal cord lesions or vocal cord paralysis is suspected or known.
References: [16]

Combination CT and MRI for Metastases Evaluation Guideline

Combination CT/MRI studies (5 or less concurrent studies, with a CT or MRI appropriate for cancer location: abdomen, brain, cervical spine, chest, lumbar spine, neck, pelvis and/or thoracic spine) for **ANY** of the following situations:

1. Staging evaluation, for baseline pre-therapy
2. Surveillance following the National Comprehensive Cancer Network (NCCN) Guidelines recommended schedule (*See **Surveillance** section*)

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:

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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]

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:

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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

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

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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:
    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*)

[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.

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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.

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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.

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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]

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CT Neck Summary of Changes

CT Neck had the following version changes from 2024 to 2025:

- Removed the following as current evidence no longer supports the indication:
  - Combination studies as they are redundant
  - CT Neck Contraindications as they were all relative and many were redundant from the CT Contraindication section.
  - "Globus sensation and requested by gastrointestinal specialist **OR** barium esophagram is non-diagnostic or indeterminate." due to lack of EBM
  - "Glomerular filtration rate" to "Renal impairment" under Contraindications
  - "Visualization of area is difficult on follow-up exam." from under "Cancer in the head and neck is known" as it is too broad

CT Neck Soft Tissue Procedure Codes

Table 1. CT Neck Soft Tissue Associated Procedure Codes

CODE	DESCRIPTION
70490	Computed tomography, soft tissue neck; without contrast material
70491	Computed tomography, soft tissue neck; with contrast material(s)
70492	Computed tomography, soft tissue neck; without contrast material followed by contrast material(s) and further sections

CT Neck Soft Tissue 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.
Airway compression refers to the narrowing or collapse of the airways, typically occurring during forced expiration, when the pressure outside the airway (intrapleural pressure) exceeds the pressure inside the airway lumen.
Bell's palsy an acute, idiopathic, self-limited, typically monophasic paralysis of the face caused by dysfunction of the facial nerve (cranial nerve VII) with no detectable cause.
Compression is reducing in size, quantity or volume, as if by squeezing.
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.
Cranial nerve palsy is a dysfunction or paralysis of one or more of the twelve cranial nerves, which can result in various neurological deficits depending on the affected nerve.

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Deep neck space infections (neck) is a serious condition involving infection in the potential spaces and fascial planes of the neck, which can lead to life-threatening complications such as airway compromise and mediastinal spread of infection.

Dysphagia is difficulty with swallowing or the sensation of food getting stuck in the esophagus.

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.

Erythrocyte sedimentation rate (ESR) is a blood test that measures the rate at which red blood cells settle at the bottom of a test tube over one hour, indicating the presence of inflammation in the body.

Esophagram, also known as a barium swallow, is a fluoroscopic X-ray examination that visualizes the esophagus in action by having the patient swallow a barium solution, helping doctors identify disorders in the upper gastrointestinal tract.

Fluoroscopy is a type of x-ray imaging that provides real-time visualization of internal structures and their movements, often used with contrast agents to enhance visibility.

Globus sensation is defined as a persistent or intermittent nonpainful sensation of a lump, retained food bolus, or foreign body in the throat. It usually occurs between meals and improves with eating.

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.

Hyperparathyroidism is the presence of excess parathyroid hormone in the body resulting in disturbance of calcium metabolism with increase in serum calcium and decrease in inorganic phosphorus, loss of calcium from bone and renal damage with frequent kidney-stone formation.

Indeterminate findings are inconclusive or insufficient for treatment planning.

Laryngopharyngeal reflux (LPR), also known as silent reflux, is a condition where stomach contents, including acid and enzymes, backflow into the throat and voice box (larynx).

Laryngoscopy is a medical procedure that involves examining the larynx (voice box). It allows the healthcare provider to visualize the vocal cords and other structures in the larynx to diagnose and treat various conditions.

Lesion is a damaged or abnormal area of tissue in the body. Lesions can be caused by injury, infection, or disease. They can appear in many parts of the body, including the skin, brain, blood vessels, and other organs.

Lymphadenopathy refers to the swelling of lymph nodes which can be secondary to bacterial, viral or fungal infections, autoimmune disease and malignancy.

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.

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Malaise is an indefinite feeling of debility or lack of health often indicative of or accompanying the onset of an illness.
Malignant is the presence of cancerous cells that have the ability to spread to other sites in the body (metastasize) or to invade nearby (locally) and destroy tissues. Malignant cells tend to have fast, uncontrolled growth and do not die normally due to changes in their genetic makeup.
Mediastinum is the area in the middle of the chest that separates the lungs.
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.
Nasolaryngoscopy refers to a procedure where a flexible, lighted scope (nasolaryngoscope) is inserted through the nose to examine the throat and larynx (voice box).
Non-diagnostic is a result that does not lead to a confirmed diagnosis.
Parotid glands are two salivary glands that sit just in front of the ears.
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.
Recurrence is a new occurrence of something that happened or appeared before.
Salivary gland is a gland in the mouth that produces saliva.
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).
Stenosis is a narrowing or constriction of the diameter of a bodily passage or orifice.
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.
Thoracic inlet, also known as the superior thoracic aperture or thoracic outlet, is the opening at the top of the chest cavity, acting as a junction between the neck and chest, allowing passage of vital structures like the esophagus and trachea.

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Tracheal stenosis is a medical condition characterized by the narrowing of the trachea (windpipe), which can be caused by various factors, including injury, infection, inflammation or congenital abnormalities, potentially leading to breathing difficulties.
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.

CT Neck Soft Tissue References

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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

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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

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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.

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