

2011 Imaging Criteria

Computed Tomography (CT), Neck^(1*MDR)

ICD-9-CM: 88.38

CPT: 70490, 70491, 70492, 76380

I/O Setting: Outpatient

INDICATION(S)

- 100 Submandibular gland mass by PE
- 200 Parotid mass by PE
- 300 Suspected head/neck abscess ♦
- 400 Head/neck cancer
- 500 Neck mass/node
- 600 Obstructive thyroid nodule/goiter
- 700 Suspected nasopharyngeal tumor
- 800 Suspected parathyroid tumor
- 900 Suspected recurrent medullary thyroid carcinoma
- 1000 Suspected submandibular duct stone
- 1100 Suspected laryngeal fracture ♦

100 Submandibular gland mass by PE

200 Parotid mass by PE

300 Suspected head/neck abscess **[All]** ♦

310 Temperature > 100.4 F(38.0 C)

320 Pain at site by Hx

330 Oral cavity/neck swelling by PE

400 Head/neck cancer **[One]**⁽²⁾

410 Baseline scan as part of staging

420 Baseline scan positive **[One]**⁽³⁾421 Periodic assessment during chemotherapy/radiation Rx⁽⁴⁾

422 Restaging after chemotherapy/radiation Rx completed

430 New/worsening Sx/findings with known head/neck cancer^(5, 6)500 Neck mass/node **[One]**

510 > 1 cm by PE

520 High suspicion for malignancy by PE **[Both]**

InterQual® criteria are intended solely for use as screening guidelines with respect to the medical appropriateness of healthcare services and not for final clinical or payment determination concerning the type or level of medical care provided, or proposed to be provided, to the patient.

The Clinical Content is confidential and proprietary information and is being provided to you solely as it pertains to the information requested. Under copyright law, the Clinical Content may not be copied, distributed or otherwise reproduced. Use permitted by and subject to license with McKesson Corporation and/or one of its subsidiaries.

InterQual® copyright © 2011 and CareEnhance® Review Manager copyright © 2011 McKesson Corporation and/or one of its subsidiaries. All Rights Reserved.

May contain CPT® codes. CPT only © 2010 American Medical Association. All Rights Reserved.

Licensed for use exclusively by Royal Health Care.

- 521 Nontender
- 522 Fixed
- 530 Low suspicion for malignancy by PE **[One]**⁽⁷⁾
 - 531 Unchanged by PE after > 4 wks
 - 532 Larger by PE after > 4 wks
- 600 Obstructive thyroid nodule/goiter **[One]**^(8, 9)
 - 610 Respiratory difficulty/dysphagia by Hx **♦**⁽¹⁰⁾
 - 620 Upper airway obstruction by PFTs⁽¹¹⁾
- 700 Suspected nasopharyngeal tumor **[One]**
 - 710 Chronic unilateral serous otitis media **[Both]**
 - 711 Fluid behind TM by PE
 - 712 Duration ≥ 2 wks
 - 720 Recurrent epistaxis **[Both]**
 - 721 No visible mucosal bleeding site by PE/nasal endoscopy⁽¹²⁾
 - 722 Epistaxis ≥ 2 episodes by Hx
 - 730 Nasopharyngeal mass/ulceration by PE/nasal endoscopy⁽¹²⁾
 - 740 Unilateral facial pain **[All]**⁽¹³⁾
 - 741 Constant pain by Hx
 - 742 Duration ≥ 2 wks
 - 743 PE normal⁽¹²⁾
 - 744 Nasal endoscopy normal
- 800 Suspected parathyroid tumor **[Both]**
 - 810 Ca > normal
 - 820 PTH > normal
- 900 Suspected recurrent medullary thyroid carcinoma **[One]**
 - 910 Calcitonin increasing⁽¹⁴⁾
 - 920 New neck mass by PE
- 1000 Suspected submandibular duct stone **[One]**⁽¹⁵⁾
 - 1010 Recurrent submandibular gland infection **[Both]**
 - 1011 ≥ 2 episodes by Hx
 - 1012 Sx/findings during acute episode **[All]**
 - 1 Pain in gland by Hx
 - 2 Tenderness of gland
 - 3 Temperature > 100.4 F(38.0 C)
 - 1020 Continued infection after Abx Rx ≥ 2 wks

- 1100 Suspected laryngeal fracture **[Both]** ♦
 - 1110 Direct trauma to neck by Hx
 - 1120 Findings by PE **[One]**
 - 1121 Stridor
 - 1122 Hoarseness
 - 1123 Subcutaneous emphysema anterior neck

Notes

(1)-MDR:

Whether to perform CT, MRI, or US for imaging of the neck is a matter of clinical judgment. It is unusual to require all studies for the evaluation of a specific problem. Requests for CT when MRI has already been performed require secondary medical review.

(2)

Most head and neck cancers present as squamous cell carcinoma of the larynx, pharynx, and the oral cavity. Patients most often present with an enlarged cervical node since these tumors tend to metastasize to regional lymph nodes (Fletcher et al., J Nucl Med 2008; 49(3): 480-508).

(3)

A repeat scan is usually not necessary unless the initial scan was positive.

(4)

The assessment is generally not necessary more frequently than every two cycles of chemotherapy.

(5)

Symptoms and exam findings of head and neck conditions include pain, difficulty speaking, eating, or swallowing, aspiration, trouble moving the tongue or mouth, a new mass, enlarged lymph nodes, or a change in the PE findings at the primary site (e.g., edema).

(6)

CT or MRI is preferred as the first step in evaluating most new or worsening symptoms in patients with known head or neck disease. PET/CT is performed in addition to CT or MRI because head or neck cancer is highly likely to metastasize and PET/CT provides better information on nodal disease and contralateral involvement than either CT or MRI alone (Blodgett et al., Radiology 2007; 242(2): 360-385).

(7)

The most common cause of a neck mass is an enlarged lymph node. Treatable causes (e.g., local infection) should be treated appropriately. Patients with no obvious oral or pharyngeal lesions and no symptoms or findings suggestive of malignancy are generally followed and re-evaluated. Persistent nodes may require further evaluation. If the PE and nasal endoscopy are normal, imaging for further evaluation depends on the presence of risk factors for head or neck malignancy (e.g., smoking, alcohol use).

(8)-DEF:

A goiter is an enlargement of the thyroid gland.

(9)

Imaging is performed to assess the extent of tracheal compression by the thyroid nodule or goiter.

(10)

Dysphagia is difficulty swallowing and represents impairment of the oral, pharyngeal, or esophageal stages of swallowing. Oropharyngeal dysphagia results from dysfunction of the oropharyngeal swallowing mechanism and may be associated with the sensation of impaired swallowing. Esophageal dysphagia may be secondary to motility disorders or due to obstructing lesions (Lind, Gastroenterol Clin North Am 2003; 32(2): 553-575).

(11)

PFTs must be performed from reclining and upright positions with inspiratory and expiratory flow-volume loops. With tracheal compression, the PFTs are worse in the reclining position.

(12)

A speculum-assisted examination of the anterior nasal vault (also known as anterior rhinoscopy) is generally performed in addition to a fiberoptic examination.

(13)

The concern is occult malignancy of the sinuses or nasopharynx. Constant pain is unusual with neurologic problems such as tic douloureux or cluster headache.

(14)

After surgical resection, patients are monitored by periodic serum calcitonin levels. An increasing level raises the concern of tumor recurrence.

(15)

Obtaining a nonenhanced CT is useful when there is a suspicion of multiple stones and assists in distinguishing a cluster of stones from a single large stone. Contrast-enhanced CT is often indicated when there is an associated abscess that cannot be clearly defined on US (Madani and Beale, Semin Ultrasound CT MR 2006; 27(6): 440-451).