2011 Imaging Criteria

Magnetic Resonance Imaging (MRI), Neck[1*MDR, 2]

ICD-9-CM: 88.97
CPT: 70540, 70542, 70543
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

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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]**[3]
- 410 Baseline scan as part of staging
- 420 Baseline scan positive **[One]**[4]
  - 421 Periodic assessment during chemotherapy/radiation Rx[5]
  - 422 Restaging after chemotherapy/radiation Rx completed
- 430 New/worsening Sx/findings with known head/neck cancer[6, 7]

500 Neck mass/node **[One]**
- 510 > 1 cm by PE
- 520 High suspicion for malignancy by PE **[Both]**
  - 521 Nontender
  - 522 Fixed
- 530 Low suspicion for malignancy by PE **[One]**[8]

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531 Unchanged by PE after > 4 wks
532 Larger by PE after > 4 wks

600 Obstructive thyroid nodule/goiter **[One]**[9, 10]
610 Respiratory difficulty/dysphagia by Hx ♦[11]
620 Upper airway obstruction by PFTs[12]

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[13]
722 Epistaxis ≥ 2 episodes by Hx
730 Nasopharyngeal mass/ulceration by PE/nasal endoscopy[13]
740 Unilateral facial pain **[All]**[14]
741 Constant pain by Hx
742 Duration ≥ 2 wks
743 PE normal[13]
744 Nasal endoscopy normal

800 Suspected parathyroid tumor **[All]**[15]
810 Prior anterior neck surgery
820 Ca > normal
830 PTH > normal

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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 MRI when CT has already been performed require secondary medical review.

(2)

The following are examples of relative and absolute contraindications to the use of magnetic resonance imaging:

- Implanted devices that are electrically or magnetically activated (e.g., cardiac pacemakers, automatic cardioverter defibrillators, drug infusion pumps, cochlear implants)
- Ferromagnetic metal objects (e.g., cerebral aneurysm clips, intraocular metallic foreign body, prostheses, screws)
- Pregnancy, first trimester
- Renal insufficiency in cases when magnetic resonance imaging is performed with gadolinium-based contrast

(3)

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).

(4)

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

(5)

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

(6)

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).

(7)

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).

(8)

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).

(9)-DEF:

A goiter is an enlargement of the thyroid gland.

(10)

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

(11)

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).

(12)

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.

(13)

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

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(14)
The concern is occult malignancy of the sinuses or nasopharynx. Constant pain is unusual with neurologic problems such as tic douloureux or cluster headache.

(15)
US of the neck and sestamibi scanning are commonly used in patients with a suspected parathyroid tumor. If the diagnosis remains in question or is otherwise unclear, MRI may be obtained.

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