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Clinical Appropriateness Guidelines

Advanced Imaging

Appropriate Use Criteria: Imaging of the Brain

Proprietary

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Description and Application of the Guidelines

The Carelon Clinical Appropriateness Guidelines (hereinafter “the Carelon Clinical Appropriateness Guidelines” or the “Guidelines”) are designed to assist providers in making the most appropriate treatment decision for a specific clinical condition for an individual. The Guidelines establish objective and evidence-based criteria for medical necessity determinations, where possible, that can be used in support of the following:

- To establish criteria for when services are medically necessary
- To assist the practitioner as an educational tool
- To encourage standardization of medical practice patterns
- To curtail the performance of inappropriate and/or duplicate services
- To address patient safety concerns
- To enhance the quality of health care
- To promote the most efficient and cost-effective use of services

The Carelon guideline development process complies with applicable accreditation and legal standards, including the requirement that the Guidelines be developed with involvement from appropriate providers with current clinical expertise relevant to the Guidelines under review and be based on the most up-to-date clinical principles and best practices. Resources reviewed include widely used treatment guidelines, randomized controlled trials or prospective cohort studies, and large systematic reviews or meta-analyses. Carelon reviews all of its Guidelines at least annually.

Carelon makes its Guidelines publicly available on its website. Copies of the Guidelines are also available upon oral or written request. Additional details, such as summaries of evidence, a list of the sources of evidence, and an explanation of the rationale that supports the adoption of the Guidelines, are included in each guideline document.

Although the Guidelines are publicly available, Carelon considers the Guidelines to be important, proprietary information of Carelon, which cannot be sold, assigned, leased, licensed, reproduced or distributed without the written consent of Carelon. Use of the Guidelines by any external AI entity without the express written permission of Carelon is prohibited.

Carelon applies objective and evidence-based criteria, and takes individual circumstances and the local delivery system into account when determining the medical appropriateness of health care services. The Carelon Guidelines are just guidelines for the provision of specialty health services. These criteria are designed to guide both providers and reviewers to the most appropriate services based on a patient’s unique circumstances. In all cases, clinical judgment consistent with the standards of good medical practice should be used when applying the Guidelines. Guideline determinations are made based on the information provided at the time of the request. It is expected that medical necessity decisions may change as new information is provided or based on unique aspects of the patient’s condition. The treating clinician has final authority and responsibility for treatment decisions regarding the care of the patient and for justifying and demonstrating the existence of medical necessity for the requested service. The Guidelines are not a substitute for the experience and judgment of a physician or other health care professionals. Any clinician seeking to apply or consult the Guidelines is expected to use independent medical judgment in the context of individual clinical circumstances to determine any patient’s care or treatment.

The Guidelines do not address coverage, benefit or other plan specific issues. Applicable federal and state coverage mandates take precedence over these clinical guidelines, and in the case of reviews for Medicare Advantage Plans, the Guidelines are only applied where there are not fully established CMS criteria. If requested by a health plan, Carelon will review requests based on health plan medical policy/guidelines in lieu of the Carelon Guidelines. Pharmaceuticals, radiotracers, or medical devices used in any of the diagnostic or therapeutic interventions listed in the Guidelines must be FDA approved or conditionally approved for the intended use. However, use of an FDA-approved or conditionally approved product does not constitute medical necessity or guarantee reimbursement by the respective health plan.

The Guidelines may also be used by the health plan or by Carelon for purposes of provider education, or to review the medical necessity of services by any provider who has been notified of the need for medical necessity review, due to billing practices or claims that are not consistent with other providers in terms of frequency or some other manner.

General Clinical Guideline

Clinical Appropriateness Framework

Critical to any finding of clinical appropriateness under the guidelines for a specific diagnostic or therapeutic intervention are the following elements:

- Prior to any intervention, it is essential that the clinician confirm the diagnosis or establish its pretest likelihood based on a complete evaluation of the patient. This includes a history and physical examination and, where applicable, a review of relevant laboratory studies, diagnostic testing, and response to prior therapeutic intervention.
- The anticipated benefit of the recommended intervention is likely to outweigh any potential harms, including from delay or decreased access to services that may result (net benefit).
- Widely used treatment guidelines and/or current clinical literature and/or standards of medical practice should support that the recommended intervention offers the greatest net benefit among competing alternatives.
- There exists a reasonable likelihood that the intervention will change management and/or lead to an improved outcome for the patient.

Providers may be required to submit clinical documentation in support of a request for services. Such documentation must a) accurately reflect the clinical situation at the time of the requested service, and b) sufficiently document the ordering provider's clinical intent.

If these elements are not established with respect to a given request, the determination of appropriateness will most likely require a peer-to-peer conversation to understand the individual and unique facts that would justify a finding of clinical appropriateness. During the peer-to-peer conversation, factors such as patient acuity and setting of service may also be taken into account to the extent permitted by law.

Simultaneous Ordering of Multiple Diagnostic or Therapeutic Interventions

Requests for multiple diagnostic or therapeutic interventions at the same time will often require a peer-to-peer conversation to understand the individual circumstances that support the medical necessity of performing all interventions simultaneously. This is based on the fact that appropriateness of additional intervention is often dependent on the outcome of the initial intervention.

Additionally, either of the following may apply:

- Current literature and/or standards of medical practice support that one of the requested diagnostic or therapeutic interventions is more appropriate in the clinical situation presented; or
- One of the diagnostic or therapeutic interventions requested is more likely to improve patient outcomes based on current literature and/or standards of medical practice.

Repeat Diagnostic Intervention

In general, repeated testing of the same anatomic location for the same indication should be limited to evaluation following an intervention, or when there is a change in clinical status such that additional testing is required to determine next steps in management. At times, it may be necessary to repeat a test using different techniques or protocols to clarify a finding or result of the original study.

Repeated testing for the same indication using the same or similar technology may be subject to additional review or require peer-to-peer conversation in the following scenarios:

- Repeated diagnostic testing at the same facility due to technical issues
- Repeated diagnostic testing requested at a different facility due to provider preference or quality concerns

- Repeated diagnostic testing of the same anatomic area based on persistent symptoms with no clinical change, treatment, or intervention since the previous study
- Repeated diagnostic testing of the same anatomic area by different providers for the same member over a short period of time

Repeat Therapeutic Intervention

In general, repeated therapeutic intervention in the same anatomic area is considered appropriate when the prior intervention proved effective or beneficial and the expected duration of relief has lapsed. A repeat intervention requested prior to the expected duration of relief is not appropriate unless it can be confirmed that the prior intervention was never administered. Requests for ongoing services may depend on completion of previously authorized services in situations where a patient's response to authorized services is relevant to a determination of clinical appropriateness.

Imaging of the Brain

General Information/Overview

Scope

These guidelines address advanced imaging of the brain in both adult and pediatric populations. For interpretation of the Guidelines, and where not otherwise noted, “adult” refers to persons age 19 and older, and “pediatric” refers to persons age 18 and younger. Where separate indications exist, they are specified as Adult or Pediatric. Where not specified, indications and prerequisite information apply to persons of all ages.

See the Coding section for a list of modalities included in these guidelines.

Technology Considerations

Advanced imaging is an umbrella term that refers to anatomy-based (structural), physiology-based (functional), and hybrid imaging methods that offer greater spatial and/or contrast resolution relative to conventional imaging methods in radiology such as radiography or ultrasound. Examples of advanced structural imaging include computed tomography (CT) and magnetic resonance imaging (MRI) and some technique variants. Advanced functional imaging includes positron emission tomography (PET) as well as those MRI/CT technique variants that create image contrast based on a physiological parameter (for example, functional magnetic resonance imaging (fMRI)). Hybrid advanced imaging techniques optimize diagnostic accuracy by coupling structural and functional approaches (such as PET-CT or PET-MRI).

Computed tomography (CT) is preferred in the following situations: initial evaluation of craniocerebral trauma; evaluation of acute intracranial hemorrhage (parenchymal, subarachnoid, subdural, epidural); evaluation of calcified intracranial lesions; osseous assessment of the calvarium, skull base, and maxillofacial bones, including detection of calvarial and facial bone structures; and imaging of midline structures and ventricular system. CT is utilized less frequently in neuroimaging due to inferior resolution when compared to MRI. CT also tends to result in beam-hardening artifact adjacent to the petrous bone, which may limit visualization in portions of the posterior fossa and brainstem. Standard anatomic coverage of head CT is from the base of the skull to its vertex, covering the entire calvarium and intracranial contents. Coverage may vary depending on the specific clinical indication. Disadvantages of CT include exposure to ionizing radiation and risks associated with infusion of iodinated contrast media, including allergic reactions or renal compromise.

Magnetic resonance imaging (MRI) is preferable to CT in most neuroimaging scenarios. It is the study of choice for visualization of brain parenchyma and white matter tracts. It is also preferred for imaging of the posterior fossa and brainstem structures. Standard anatomic coverage of head MRI is from the base of the skull to the vertex, covering the entire calvarium and intracranial contents, including the internal auditory canals. Coverage may vary depending on the specific clinical indication. The presence of implantable devices such as pacemakers or defibrillators, a potential need for sedation in pediatric patients, and claustrophobia are the main limitations of MRI. Infusion of gadolinium may also confer an unacceptable risk in persons with advanced renal disease.

Diffusion-weighted imaging (DWI) is a specific MRI sequence that gathers information on the movements of water molecules in the brain. DWI is most commonly used to diagnose pathologies in which water molecules demonstrate less ability to move through the histologic structure of the brain. Common examples include acute ischemic stroke, abscess, and certain tumors. DWI can also be used to image structure of white matter tracts by a process called **diffusion tensor imaging (DTI)**, which uses the data from the scan to make calculations. DTI may also be useful in neurosurgical planning.

Functional MRI (fMRI) is primarily utilized for mapping primary brain activities related to motor, sensory, and language functions. Studies have demonstrated that fMRI is comparable to the intracarotid sodium amobarbital procedure (Wada test) and direct electrical stimulation for language localization. fMRI is noninvasive, does not require ionizing radiation, and has a shorter time requirement for imaging and post-procedural recovery.

Positron emission tomography (PET or PET-CT) provides functional information about brain activity by mapping the relative concentrations of certain radiotracers within the parenchyma. PET brain imaging is primarily used to evaluate blood flow, metabolic changes, and neurotransmitter dynamics, and is frequently performed in conjunction with CT for anatomic localization. PET-CT can be used to evaluate many types of dementia and memory disorders, and it can also be used to localize epileptic seizures or stage brain tumors.

Magnetic resonance spectroscopy (MRS), usually performed with standard MRI, provides a biochemical profile of metabolic constituents in tissues. Alterations in specific metabolites such as choline and creatine are associated with certain disease states; this information can be used as an adjunct in cases where standard MRI fails to distinguish between diseased and healthy tissue. In neuroimaging, MRS is useful for differentiating between tumor, necrotic tissue, and certain types of infectious lesions.

Definitions

Phases of the care continuum are broadly defined as follows:

- **Screening** – testing in the absence of signs or symptoms of disease
- **Diagnosis** – testing based on a reasonable suspicion of a particular condition or disorder, usually due to the presence of signs or symptoms
- **Management** – testing to direct therapy of an established condition, which may include preoperative or postoperative imaging, or imaging performed to evaluate the response to nonsurgical intervention
- **Surveillance** – periodic assessment following completion of therapy, or for monitoring known disease that is stable or asymptomatic

Clinical Indications

The following section includes indications for which advanced imaging of the brain is considered medically necessary, along with prerequisite information and supporting evidence where available. Indications, diagnoses, or imaging modalities not specifically addressed are considered not medically necessary.

It is recognized that imaging often detects abnormalities unrelated to the condition being evaluated. Such findings must be considered within the context of the clinical situation when determining whether additional imaging is required.

Congenital and Developmental Conditions

Developmental delay (Pediatric only)

Advanced imaging is considered medically necessary in **EITHER** of the following conditions:

- Cerebral palsy
- Significant delay or loss of milestones in **ANY TWO (2)** of the following domains:
 - Activities of daily living
 - Cognition
 - Motor skills (gross/fine)
 - Social/personal
 - Speech/language

IMAGING STUDY

- CT brain

- MRI brain (preferred)

Congenital anomalies

Includes evaluation of Chiari malformation, craniosynostosis, macrocephaly, microcephaly, ataxia-telangiectasia, fragile X syndrome, and congenital anomalies of the posterior fossa

Advanced imaging is considered medically necessary for diagnosis and management.

IMAGING STUDY

- Ultrasound required as the initial study to evaluate macrocephaly in patients under 5 months of age
- CT brain (preferred with 3D reconstruction for craniosynostosis)
- MRI brain (preferred for congenital cerebral anomalies)

Rationale

Congenital anomalies of the central nervous system can be classified¹ into disorders of dorsal/ventral induction such as myelomeningocele, holoprosencephaly, Dandy-Walker variant, or craniosynostosis, disorders of neural proliferation such as microcephaly and megalencephaly, disorders of neuronal migration such as schizencephaly and cortical heterotopias, and disorders of myelination such as adrenoleukodystrophy and Canavan disease. There are characteristic imaging patterns for each of these congenital abnormalities, making imaging an important diagnostic test. Repeat imaging and surveillance imaging are indicated only if neurological complications of these conditions are suspected such as hydrocephalus.

Global developmental delay is defined as a delay in 2 or more developmental domains—gross/fine motor control, speech/language, cognition, social/personal, and activities of daily living—that affect children under the age of 5 years.² While history and physical exam are sufficient to establish the diagnosis in up to a third of cases,² structural abnormalities on neuroimaging are seen in 14% of unselected patients and in 41% of patients with suggestive physical exam findings such as macrocephaly or focal neurological deficits.²

Cerebral palsy is the most common physical disability in childhood and refers to a group of nonprogressive impairments of muscle tone, voluntary movement, and/or posture that manifests before age 2.³ MRI has a high sensitivity (86%-89%) for the condition⁴ with 70%-90% of patients having identifiable structural abnormalities. Neuroimaging in general and MRI in particular are recommended by the American Academy of Family Physicians to help establish the diagnosis, noting that MRI has higher specificity (approximately 89%) compared to CT for identifying intracranial abnormalities.⁵

MRI is the preferred imaging modality for evaluation of congenital and developmental abnormalities of the brain because it is more sensitive than CT for the detection of morphological abnormalities of the brain parenchyma and because it does not require ionizing radiation. Abnormalities on MRS have been associated with developmental delay but have not consistently been shown to improve diagnostic yield of change management as either an add-on or a replacement test to MRI.²

CT may be preferred to better characterize congenital abnormalities that primarily involve the calvarium, such as craniosynostosis.⁶ Ultrasound is also sensitive and should be considered in clinical practices with expertise in the technique.⁷

Ultrasound is an accurate and reliable initial modality for evaluating macrocephaly in neonates, and it can identify a small percentage (2%) of patients who require neurosurgical intervention.⁸ Macrocephaly without focal neurological deficits has a very low (3.5%) incidence of congenital abnormalities, and add-on MRI or CT detection has a very low (0%) impact on management.⁹

Sickle cell disease (Pediatric only)

Advanced imaging is considered medically necessary for periodic screening and surveillance for silent cerebral infarcts in patients with sickle cell disease.

IMAGING STUDY

- MRI brain

Infectious Conditions

Infectious conditions – not otherwise specified

Advanced imaging is considered medically necessary for diagnosis and management.

IMAGING STUDY

- CT brain
- MRI brain (preferred)

Inflammatory Conditions

Multiple sclerosis (MS) and other white matter diseases

Also see Head and Neck Imaging, Spine Imaging

Advanced imaging is considered medically necessary in **ANY** of the following scenarios:

- Diagnosis
 - Neurological signs or symptoms of demyelinating disease
- Management
 - Evaluation of new or recurrent neurological signs or symptoms
 - Recent or current use of natalizumab
 - New baseline prior to starting or changing therapy
 - Following a change in disease-modifying therapy: Initial imaging at 3–6 months and follow up at 6–12 months
 - Periodic evaluation of white matter diseases other than multiple sclerosis
- Surveillance
 - Clinically isolated syndrome (CIS) or radiologically isolated syndrome (RIS): Imaging 3–6 months after presentation, 6–12 months after presentation, and annually thereafter
 - Annual evaluation in stable patients with multiple sclerosis who have had no change in therapy within the past one year

IMAGING STUDY

- MRI brain

Rationale

Multiple sclerosis (MS) is a chronic, disabling autoimmune disease of the central nervous system¹⁰ and among the most common causes of neurological disability in young people, with an annual incidence ranging from 2 to 10 cases per 100,000 persons per year.¹¹ Its clinical manifestations typically occur between 20 and 40 years of age, with symptoms and signs involving different regions of the central nervous system: optic nerve, brainstem, cerebellum, cerebral hemispheres, and spinal cord. MS has a chronic course - relapses and disability progression evolving over 30 to 40 years are typical.¹¹

The revised 2017 McDonald criteria are commonly accepted criteria establishing the diagnosis of MS and are used in both clinical and research contexts. The McDonald criteria incorporate clinical presentation as well as laboratory and imaging biomarkers and brain MRI plays a central role in the diagnosis of MS by establishing evidence for dissemination in space and in time in patients with both typical (optic neuritis, brainstem syndrome) and atypical clinical presentations.¹² MRI may also inform the management of MS by confirming a disease flare when clinically suspected or by excluding other causes for the new neurological signs or symptoms. A 2022 guideline from the National Institute for Health and Care Excellence¹³ recommends diagnosing MS based on a combination of history, examination, MRI, and laboratory findings, and further

indicates that the diagnosis should not be made on the basis of MRI alone. The McDonald criteria apply in pediatrics, although MS is rare in this population and hence data is limited.¹²

While MS should not be diagnosed on the basis of MRI findings alone,^{12,14} patients rarely present with white matter disease typical of multiple sclerosis (not nonspecific) without clinical symptoms. These patients are classified as having a radiologically isolated syndrome (RIS). Follow up imaging in RIS is controversial, but RIS patients appear to be at increased risk for conversion to MS.¹⁵ Future research is likely to change recommendations for the diagnosis and management of RIS and additional studies have been identified as a high priority.¹²

There are over a dozen FDA-approved disease-modifying therapies (DMTs) for multiple sclerosis including interferon beta-1a, glatiramer acetate, fingolimod, and natalizumab and these therapies are recommended in patients with relapsing forms of MS with recent clinical relapses or MRI activity (strong recommendation based on moderate quality evidence).¹⁶ For patients without new clinical findings, MRI may therefore be used in the management (immediately prior to or after changing DMTs) or in surveillance for subclinical disease in patients without clinical or recent therapy changes). More frequent MRI evaluation is recommended in patients with a recent therapy change as recurrences are more likely within the first year. Patients on natalizumab (Tysabri) have a higher relative risk for progressive multifocal leukoencephalopathy (PML) and may require more frequent imaging.

Management and surveillance intervals for MS, CIS and RIS are primarily consensus based but addressed in several evidence and practice based guidelines.^{17 18 19 20}

CT is not recommended in the evaluation of demyelinating disease due to low sensitivity relative to MRI and other clinical and laboratory tests.²¹ Likewise, several nonconventional technique variants of MRI (magnetization transfer, diffusion tensor, functional MRI) have been proposed as add-on diagnostic tests for MS but they have not been validated at the individual level²⁰ or incorporated into the McDonald criteria or other standardized MS imaging protocols and require further research before incorporation into routine clinical practice.²²

Other demyelinating diseases of the central nervous system are rare and include autoimmune disseminated encephalomyelitis (ADEM) and neuromyelitis optica (NMO). Their clinical presentation can overlap with MS but clinical, laboratory, and MRI findings help to distinguish the etiologies. For instance, ADEM usually has an viral or vaccine prodrome and is more common in pediatric patients²³; NMO typically presents with longitudinally extensive transverse myelitis and a positive serum NMO-IgG/Aquaporin 4 (AQP4) antibody test.^{15, 24}

Inflammatory conditions – not otherwise specified

Advanced imaging is considered medically necessary for diagnosis and management.

IMAGING STUDY

- CT brain
- MRI brain (preferred)

Neurodegenerative Conditions

Movement disorders (Adult only)

Advanced imaging is considered medically necessary in **ANY** of the following scenarios:

- For pre-procedural evaluation of MR-guided focused ultrasound (MRgFUS) planned for essential tremor
- For perioperative evaluation related to placement of a deep brain stimulator
- For initial evaluation of the following movement disorders, to exclude an underlying structural lesion:
 - Hemifacial spasm
 - Huntington's disease
 - Multiple system atrophy
 - Parkinson's disease with atypical features
 - Progressive supranuclear palsy

- Secondary dystonia
- Other focal or lateralizing movement disorder, such as hemiballismus, athetosis, or chorea

Note: Imaging is generally not indicated for evaluation of typical Parkinson's disease or primary dystonia. Other than pre-procedural imaging for MRgFUS, imaging is generally not indicated for essential tremor.

IMAGING STUDY

- CT brain
- MRI brain (preferred)

Rationale

Structural imaging has a limited role in most movement disorder conditions. The most common of these are essential tremor, with a prevalence of 5% of individuals over the age of 65, and Parkinson's disease, with a prevalence of 1% in this population.

Structural MRI, as used in current clinical practice, does not reveal significant abnormalities in essential tremor. Diagnosis of essential tremor is based on clinical assessment of the phenomenological characteristics and its course.²⁵ However, when MR-guided focused ultrasound (MRgFUS) is being done for treatment of essential tremor, structural imaging is needed – CT head for assessment of calvarial thickness and density and, often, MRI for anatomic localization prior to the procedure.

Parkinson's disease is a clinical and pathological diagnosis, with MRI limited to atypical presentations of the disorder. Patients should initially be referred to a specialist for diagnosis. Rates of incorrect diagnosis for specialists average ~7%, while those for non-specialists run between 25%-47%.

Typical presentation: resting tremor, cogwheel rigidity, bradykinesia, with delayed onset of postural instability. When clinical signs and symptoms and response to medication are typical of Parkinson's disease, neuroimaging is not required.²⁶

Atypical features of Parkinson's disease²⁷ include the following: falls at presentation and early in the disease course; poor response to levodopa; symmetry at onset; rapid progression; lack of tremor; dysautonomia (urinary urgency/incontinence and fecal incontinence, urinary retention requiring catheterization, persistent erectile failure, or symptomatic orthostatic hypotension). Imaging may be indicated in cases of atypical Parkinson's disease to exclude treatable causes. Other movement disorders such as multiple system atrophy have characteristic imaging features that may be used to corroborate the diagnosis when clinically uncertain.^{26,27,28}

Dystonia is characterized by sustained muscle contractions, frequently causing repetitive twisting movements or abnormal postures. The diagnosis is clinical and specialist referral is recommended.

Features of primary dystonia include the following: absence of associated neurological signs or symptoms other than tremor; absence of additional motor abnormalities (weakness, spasticity, etc.); early onset (< 21 years) starts in the limbs and may generalize; late onset (≥ 21 years) begins in the neck/arm/face and does not generalize.

Structural brain imaging is not routinely required when there is a confident diagnosis of primary dystonia in adults but may be indicated to evaluate secondary forms of dystonia.²⁹

Neurocognitive disorders (Adult only)

Includes mild cognitive impairment, dementia, and variants (e.g., vascular, Alzheimer's disease, frontotemporal degeneration spectrum, diffuse Lewy body).

Advanced imaging is considered medically necessary to direct management in **ANY** of the following scenarios:

- Initial evaluation of documented cognitive abnormality when unexplained by clinical evaluation
- Evaluation of rapidly progressive symptoms
- In patients being treated with amyloid-targeting therapy (MRI brain only)

IMAGING STUDY

- CT brain
- MRI brain (preferred)

PET Brain is considered medically necessary for evaluation of memory loss or dementia when substantial diagnostic uncertainty remains after **ALL** of the following:

- Evaluation by a physician experienced in neurodegenerative disease
- Neuropsychological testing
- Structural imaging (CT or MRI brain)

IMAGING STUDY

- FDG PET or PET/CT
- Amyloid Brain PET or PET/CT when amyloid-targeting therapy is being considered

Rationale

Neurocognitive disorder (previously known as dementia) is an umbrella term for a group of symptoms associated with a decline in memory, executive, and/or other cognitive functions, including Alzheimer's disease and other conditions such as frontotemporal dementia. Two kinds of advanced imaging, structural and functional, are available for further characterization of dementia. Structural imaging includes MRI and CT, and evaluates for masses and for morphologic changes in the brain parenchyma. Functional imaging includes PET/CT with FDG or amyloid imaging agents.

Structural imaging

MRI is the preferred advanced imaging modality for initial evaluation. It is more sensitive than CT for the evaluation of treatable causes and offers the secondary benefit of improved contrast between grey and white matter; hence MRI provides better assessment of patterns of parenchymal atrophy that characterize specific forms of dementia (for instance, supranuclear palsy, frontotemporal dementia, and primary progressive aphasia).^{26,30,31}

Advanced structural imaging (MRI preferred) is indicated to exclude new treatable causes in a previously imaged patient with dementia, particularly when there is rapid (e.g., over 1 to 2 months) unexplained decline in cognition or function.^{32,33} Advanced imaging should be undertaken in the assessment of a person with cognitive impairment and unsuspected cerebrovascular disease, if it would change the clinical management.³²

Functional imaging

The American College of Radiology indicates that advanced imaging modalities such as FDG-PET are not routinely used in community or general practices for the diagnosis or differentiation of forms of dementia.²⁶ However, FDG-PET may be useful in select circumstances as a problem-solving technique to direct management. The European Federation of Neurological Societies recommends its use in those cases where the diagnosis remains in doubt after clinical and structural MRI workup and in particular clinical settings.³⁰ Gauthier et al.³⁴ indicate that FDG-PET may be useful in forming a differential diagnosis for a patient with dementia who has undergone the recommended baseline clinical and structural brain imaging evaluation and who has been evaluated by a dementia specialist, but whose underlying pathological process is still unclear, preventing adequate clinical management.

Evidentiary basis for the above recommendations includes several diagnostic accuracy studies of FDG-PET using clinical assessment as the reference standard. These studies found a diagnostic accuracy of 93% for differentiating Alzheimer's disease subjects from healthy subjects, with sensitivity of 96% and specificity of 90%. However, use of a clinical reference standard instead of histopathology limits internal validity. A multicenter analysis in 138 patients with histopathological diagnoses reported that FDG-PET correctly identified the presence or absence of Alzheimer's disease in 88% of the cases, with a sensitivity of 94% and a specificity of 73%.³⁰

MRI variants including fMRI and MRS are not recommended by high quality evidence-based guidelines for routine use in dementia imaging. These modalities do not have a role in the evaluation or monitoring of dementia,³⁰ and are intended only for specialized clinical and research settings.³² Future studies with large number of participants and longer period of follow up are needed to allow firm conclusions on the value of fMRI as an add-on test to MRI, for instance, in early detection of dementia.³⁴

Amyloid imaging involves radiopharmaceuticals that measure amyloid deposition in the brain. Amyloid is known to be associated with the pathogenesis of Alzheimer's and may predict conversion from mild cognitive impairment to Alzheimer's although a range of diagnostic accuracies has been reported in the literature^{35, 36} and the impact of testing on patient management and outcome is currently unknown. As targeted immunotherapies are being developed and shown to offer clinically significant reductions in cognitive and functional decline, the clinical utility of amyloid imaging is increasing as it can be useful in determining candidacy for therapy. There is a potential risk for amyloid-related imaging abnormalities (ARIA), which may present as ARIA-E (edema) or ARIA-H (hemorrhage), in patients being treated with such therapies. Patients are

often asymptomatic but this condition can be associated with complications, and therefore MRI is recommended during therapy.

Stroke and cerebrovascular disease

Stroke or transient ischemic attack (TIA)

Advanced imaging is considered medically necessary for diagnosis and management.

IMAGING STUDY

- CT brain (preferred for evaluation of acute hemorrhagic stroke)
- MRI brain (preferred for subacute or chronic hemorrhage and ischemia)

Rationale

Stroke is the fifth leading cause of mortality and one of the leading causes of morbidity in the U.S. The American Stroke Association predicts that nearly 800,000 people will suffer a stroke in 2018, of which more than 120,000 will die.³⁷ A stroke is a condition caused by insufficient blood flow to the brain. The 2 main types of stroke are ischemic and hemorrhagic. Ischemic strokes are caused by an occlusion of an arterial blood vessel and comprise almost 90% of all strokes.³⁸ These can develop locally (thrombotic stroke) or originate from other parts of the body (embolic stroke). Hemorrhagic strokes, on the other hand, are caused by bleeding, either intraparenchymal or subarachnoid. In both forms, patients may acutely present with partial or full paralysis of muscles, vision and speech disturbances, or change in level of consciousness.³⁷

Transient ischemic attack (TIA) has been traditionally defined as the sudden loss of neurologic function that recovers completely within 24 hours. TIA confers an increased risk of stroke—11.3% (95% CI, 7.5% to 16.6%) within the subsequent 90 days³⁹—and may be related to mimics such as migraine, epilepsy, functional disorders, and neoplasm in up to 50% of cases. Although the diagnostic yield of neuroimaging for an alternative etiology is low (< 5%),³⁹ imaging with CT or MRI is important to exclude a rare but treatable structural cause like a tumor or subdural hematoma. As clinical prediction rules—such as the ABCD2 score—miss up to 20% of post-TIA strokes⁴⁰ and as MRI (with diffusion-weighted imaging) may identify strokes in up to 34% of patients,³⁹ neuroimaging may be helpful in selecting patients for subsequent treatment, which may include more aggressive medical management such as dual antiplatelet therapy and high-dose statin therapy.⁴¹

Patients presenting with acute stroke who are candidates for tissue plasminogen activator (tPA) or mechanical thrombectomy benefit from immediate advanced brain and head and neck vascular imaging (CT/CTA or MR/MRA), as advanced imaging was a major selection criterion for the 5 recent randomized control trials—MR CLEAN, ESCAPE, REVASCAT, SWIFT PRIME, and EXTEND IA—that established the net benefit of thrombectomy in selected patients.⁴²

In patients presenting with stroke who are not candidates for tPA or mechanical thrombectomy, stroke evaluation may involve neuroimaging to establish the diagnosis and vascular imaging to identify critical extracranial stenosis or as otherwise needed to inform management.^{37, 43}

Cerebral perfusion imaging

Cerebral perfusion imaging is considered medically necessary to evaluate cerebral ischemia in ANY of the following scenarios:

- Acute or hemorrhagic stroke
- Cerebral hemorrhage
- Preoperative evaluation of cerebrovascular reserve in patients with arterial occlusive disease

IMAGING STUDY

- CT cerebral perfusion analysis

Rationale

CT perfusion analysis provides information about cerebral blood flow to the brain and/or tissues of the head, and is primarily indicated for evaluation of stroke by delineating presence and sites of vascular occlusion, extent of cerebral ischemia, and tissue viability, which may inform decisions for thrombolysis or thrombectomy. With the publication of the DAWN and

DEFUSE-3 trials, patients with acute stroke and wake-up stroke presenting with 6-24 hours may be candidates for thrombectomy when MR or CT perfusion shows a mismatch between at risk tissue and infarct core.^{44,45} CT perfusion may also assist in planning therapy for cervical or intracranial arterial occlusive disease (as an isolated test or in combination with a cerebrovascular reserve challenge).⁴⁶

Trauma

Trauma

ADULT

Advanced imaging is considered medically necessary in **EITHER** of the following scenarios:

- Acute head trauma when **ANY** of the following risk factors are present:
 - Age 65 years or older
 - Retrograde amnesia
 - At least 2 episodes of emesis
 - Evidence of open, depressed, or basilar skull fracture
 - Focal neurologic findings
 - Glasgow coma scale less than 15 or altered mental status
 - High-risk mechanism of injury
 - Seizure
 - Bleeding diathesis/coagulopathy
 - Intracranial shunt
- Subacute or chronic head trauma in **EITHER** of the following scenarios:
 - Cognitive or focal neurologic deficits
 - Nonfocal neurologic signs or symptoms (including post-concussive syndrome) refractory to therapy

PEDIATRIC

Advanced imaging is considered medically necessary in **EITHER** of the following scenarios:

- Acute head trauma when **ANY** of the following risk factors are present:
 - Altered mental status
 - Change in behavior
 - Vomiting
 - Loss of consciousness
 - History of high-risk motor vehicle accident or other mechanism of injury
 - Scalp hematoma when younger than age 2 years
 - Evidence of basilar skull fracture
 - Non-accidental injury
- Subacute or chronic head trauma in **ANY** of the following scenarios:
 - A follow-up study 3-6 weeks after head trauma in patients age 6 years or younger, when the neurologic exam is stable or inconclusive

- Cognitive or focal neurologic deficits
- Nonfocal neurologic signs or symptoms (including post-concussive syndrome) refractory to therapy

IMAGING STUDY

- CT brain
- MRI brain for non-acute trauma

Rationale

Carelon adult trauma guidelines follow well established clinical prediction rules for this indication. In particular, Carelon guidelines follow the Canadian Head CT rules (CCHR) developed and externally validated on thousands of North American level 1 trauma center patients, a population at highest risk for clinically significant head trauma.⁴⁷

While both the New Orleans Criteria and the Canadian Head CT rules have excellent sensitivity (100%; 95% CI, 96%-100%) for clinically important brain injury, the Canadian Head CT rules achieve this sensitivity with substantially greater specificity (range 37%-50.7% vs 3%-12.7%),⁴⁸⁻⁵⁰ resulting in improved overall diagnostic accuracy.

Of note, patients with new focal neurological deficits and seizures are usually candidates for neuroimaging regardless of whether they are post-traumatic and altered mental status (Glasgow coma scale < 15) is also addressed in separate Carelon guidelines and as such is included here as criteria even though it is not a part of the CCHR clinical prediction rule (which also applies to patients with a Glasgow coma scale of 13 to 15). Patients with bleeding diathesis or intracranial shunts were excluded from the development of the CCHR, so imaging can be performed whenever clinically significant trauma is suspected.

Guidelines for pediatric head trauma follow a similar approach, adopting the Pediatric Emergency Care Applied Research Network (PECARN) rules for the detection of clinically significant brain injury. The PECARN rules were developed (33,785) and validated (8627) in multiple North American emergency departments⁵¹ with—for example—subsequent separate multicenter geography validations.⁵² Sensitivity of PECARN in this population is 98.8% (95% CI, 89%-99.6%) and the rule did not miss neurosurgical head trauma in any pediatric patients.⁵¹ While PECARN is less specific (53% vs 91%) compared to clinical gestalt, the rule is substantially more sensitive (~100% vs 60%),⁵³ although the greater specificity of clinical gestalt is questioned by other studies.⁵⁴ Compared to other clinical prediction rules for pediatric head trauma (including CATCH and CHALICE), PECARN has a higher sensitivity (100% vs 91% and 84%, although confidence intervals overlap) and has undergone more extensive external validation.⁵⁴

High-risk mechanisms as defined in the Carelon adoption of PECARN include motor vehicle collision with patient ejection or rollover, death of another passenger, pedestrian or bicyclist without helmet struck by a motorized vehicle, high-impact head trauma, falls from more than 3 feet.

CT is the preferred imaging modality for acute head trauma because it is more sensitive for intracranial hemorrhage and fracture, more readily available than MRI, and takes less time to perform.⁵⁵ MRI is an add-on advanced imaging test in select cases of acute head trauma, especially in situations where abnormalities on the neurological exam are unexplained by head CT or are worsening or progressive.⁵⁶ MRI is more sensitive for the evaluation of diffuse axonal injury (DAI) and microhemorrhage, which may explain this discrepancy. The presence of DAI has been associated with a modest (odds ratio=3) risk of unfavorable outcome.⁵⁷

Advanced imaging for subacute or chronic trauma is indicated in patients with cognitive or neurologic deficit(s).^{58, 59} Post concussive syndrome (PCS) refers to a constellation of nonfocal neurological signs or symptoms (examples include headache, nausea, fatigue, blurred vision, memory, emotional and executive dysfunction) that persist following mild traumatic brain injury (mTBI). There is no consensus on the use of advanced imaging post-concussion in either adult or pediatric patients,⁶⁰ although the diagnostic yield of clinically significant findings is very low⁶¹ and imaging is not routinely recommended but is reserved for atypical cases when an intracranial lesion is suspected.⁶²⁻⁶⁴

Tumor or Neoplasm

Acoustic neuroma

Advanced imaging is considered medically necessary in **ANY** of the following scenarios:

- Management of known acoustic neuroma

- Signs, symptoms or imaging findings suggestive of recurrence or progression
- Surveillance
 - Neurofibromatosis type 2
 - Following nonoperative treatment or incomplete resection (including proton beam therapy or stereotactic radiosurgery): annually for 5 years, then every 5 years thereafter
 - Following gross total resection: Baseline study within the first year after surgery, and follow-up studies at 2 years, 5 years, and 10 years after surgery

IMAGING STUDY

- MRI brain

Meningioma

Advanced imaging is considered medically necessary in **EITHER** of the following scenarios:

Management

- For a patient with known meningioma and new or worsening symptoms

Surveillance in **EITHER** of the following scenarios:

- Every 6 months if **ANY** of the following are present:
 - Vasogenic edema on prior MRI
 - Interval growth on prior imaging
 - Lesion is located in the sphenoid wing, venous sinus, or skull base regions
 - Atypical or malignant/anaplastic meningioma (WHO grade II or grade III) on pathology
- Every 12 months if none of the above features are present

IMAGING STUDY

- MRI brain
- CT brain when MRI cannot be performed

Pituitary mass (including pituitary adenoma, incidentaloma)

Advanced imaging is considered medically necessary in **ANY** of the following scenarios:

- Incidental pituitary gland lesion detected on CT or MRI, when at least 10 mm in size and not a simple cyst
- Suspected pituitary adenoma when supported by signs or symptoms as well as laboratory findings
- Management (including perioperative evaluation) of known adenoma
- Surveillance of clinically stable adenoma in **EITHER** of the following:
 - Unresected adenoma
 - Macroadenoma (size greater than 10 mm)
 - Microadenoma (size 10 mm or less): Annual surveillance imaging
 - Resected adenoma
 - At least 3 months following resection

Note: Surveillance imaging applies to patients who are clinically stable and in whom there is no anticipated change in management. Management applies to patients with new or worsening signs or symptoms, or in whom resection or other change in treatment is planned.

IMAGING STUDY

- MRI brain
- CT brain for management or surveillance of microadenoma when MRI cannot be performed, or as an alternative to MRI brain for macroadenoma

Rationale

Pituitary adenomas can be broadly classified into clinically functioning (hormone-secreting, typically presenting with abnormal lab values and systematic signs/symptoms with or without neurologic ones) and clinically nonfunctioning (typically presenting with neurological signs/symptoms related to regional extension and mass effect).

For suspected functional adenomas, the Endocrine Society recommends MRI in patients with biochemically proven acromegaly to evaluate for a functioning pituitary adenoma as well as to visualize tumor size and regional extension; CT is suggested if MRI is contraindicated or unavailable.⁶⁵ In addition, the American College of Radiology identifies MRI with and without contrast as “usually appropriate” for patients with hyperthyroidism, hypopituitarism, Cushing’s syndrome, hyperprolactinemia, diabetes insipidus, and precocious puberty.⁶⁶ The Congress of Neurological Surgeons recommends MRI as the advanced imaging modality of choice in the preoperative diagnosis of nonfunctional pituitary adenomas with potential supplementation by CT, but notes insufficient evidence to support MR spectroscopy, perfusion, and PET/CT for this indication.⁶⁷

Pituitary apoplexy is a special case of pituitary adenoma that results from acute hemorrhage or infarct of the pituitary and that presents with severe headache (up to 97%), visual deficits, and/or ophthalmoplegia, and requires emergent MRI.^{66, 68} Apoplexy is commonly associated with pituitary adenomas (up to 90% of the time).⁶⁸

The Congress of Neurological Surgeons also recommends follow-up MRI for patients with known nonfunctional pituitary adenomas after surgery or radiation therapy, but notes that the evidence is insufficient to make recommendations about the frequency of imaging with the exception of surveillance. Additionally, subtotal resections should be followed more closely than gross total ones, and surveillance should begin at least 3 months after surgical intervention.⁶⁹

For patients with functional adenomas that are causing acromegaly, the Endocrine Society recommends MRI at least 12 weeks after surgery or serial MRI in patients receiving pegvisomant medical therapy,⁶⁵ while the American College of Radiology recommends MRI with and without contrast for further characterization of the postoperative sella.⁶⁶

A pituitary incidentaloma is a previously unsuspected pituitary lesion that is discovered on an imaging study performed for an unrelated reason.⁷⁰ The majority of pituitary incidentalomas are adenomas and the condition is prevalent occurring in 10% of autopsy specimens.⁷⁰ Pituitary cysts are most likely congenital Rathke’s cleft cysts and do not require treatment. An incidental pituitary lesion <5 mm does not require imaging follow-up to monitor growth, and mixed solid/cystic lesions less than 10 mm are most likely microadenomas and are rarely functional. The ACR consensus based white paper on incidental pituitary findings does not recommend follow up for simple cysts or mixed solid/cystic lesions less than 10 mm.⁷¹ There is no prospective evidence on the value of surveillance imaging in patients with small pituitary incidentalomas.

Tumor – not otherwise specified

See Oncologic Imaging guidelines for management of established malignancy and intracranial metastases.

Advanced imaging is considered medically necessary for diagnosis, management, and surveillance of tumor not otherwise specified* when suggested by prior imaging.

IMAGING STUDY

- CT brain
- MRI brain

**Exclusions: In the absence of suspicious features (hemorrhage, contrast enhancement, calcifications), routine surveillance of the following lesions is not indicated:*

- Arachnoid cyst
- Pineal cyst

- *Lipoma*
- *Epidermoid*

Rationale

MRI brain has the highest diagnostic accuracy in the evaluation of suspected intracranial neoplasm due to superior soft tissue contrast. Magnetic resonance spectroscopy (MRS) has moderate diagnostic accuracy in determining the grade of a glioma and distinguishing recurrent tumor from radiation necrosis^{72, 73} but adds little to brain MRI in the evaluation of suspected disease. Furthermore, lack of standardized protocols for MRS limit test reproducibility and reliability and the impact on patient management is unclear.

Pineal cysts generally show a benign course with very rare need for intervention. Features that are associated with a greater risk of hydrocephalus or malignancy include hemorrhage or contrast enhancement on MRI, as well as calcification.⁷⁴ In the absence of suspicious features, cyst growth is uncommon, and long-term neurosurgical follow-up is not routinely indicated.⁷⁵

Miscellaneous Conditions

Bell's palsy (peripheral facial nerve palsy)

Advanced imaging is considered medically necessary in **EITHER** of the following scenarios:

- Additional neurologic findings suggestive of intracranial pathology (atypical presentation)
- Symptoms persisting beyond 6 weeks in the absence of additional neurologic findings

IMAGING STUDY

- CT brain when MRI cannot be performed
- MRI brain

Rationale

Bell's palsy is an idiopathic disruption of facial nerve function that typically manifests as facial nerve paralysis and ipsilateral facial muscle weakness. It is most commonly self-limiting, resolving in 60%-90% of patients.^{76, 77} While Bell's palsy is a diagnosis of exclusion, it is rare for intracranial lesions to cause isolated facial nerve palsy.⁷⁶ Neuroimaging for Bell's palsy is generally reserved for patients with additional neurological signs and/or symptoms or in cases that fail to respond in a self-limited fashion. When imaging is appropriate, MRI is recommended over CT,⁷⁸ as MRI can visualize both the cisternal and intracranial course of the 7th cranial nerve.

Specialty society and practice-based guidelines recommend against routine imaging for Bell's palsy. The American Academy of Otolaryngology Guideline recommends that clinicians not routinely perform diagnostic imaging for patients with new-onset Bell's palsy.⁷⁹ The American College of Radiology states "In general, Bell's palsy patients need not be imaged unless the symptoms are atypical or persist for > 2 months."⁷⁸

Hematoma or hemorrhage – intracranial or extracranial

Also see Vascular Imaging

Advanced imaging is considered medically necessary for diagnosis and management.

IMAGING STUDY

- CT brain
- MRI brain

Horner's syndrome

Also see Chest Imaging and Head and Neck Imaging guidelines.

Advanced imaging is considered medically necessary for diagnosis and management.

IMAGING STUDY

- MRI brain
- CT brain when MRI cannot be performed or is nondiagnostic

Rationale

Horner's syndrome is condition that results from a disruption of the sympathetic nervous supply to the eye and is characterized by the triad of miosis, ptosis, and anhidrosis.⁸⁰

Evaluation of Horner's syndrome begins with a complete neurological and ophthalmological examination, which may reveal an etiology for the condition such as surgical trauma. Additional neurological features such as additional cranial nerve deficits may localize the pathology to the brain, in which case a sequential diagnostic testing strategy starting with brain MRI may be possible. In nonlocalized cases, the entire course of the oculosympathetic pathway may need to be visualized, including an MRI of the brain and an MRI, CT, or MRA/CTA of the neck if there is concern for carotid dissection as a cause. The yield of diagnostic imaging in isolated Horner's syndrome is approximately 15%-20%^{81, 82} and the most common etiologies identified by neuroimaging are carotid artery dissections and cavernous sinus masses.

Children can also develop Horner's syndrome and neuroimaging—typically MRI of the head, neck, and sometimes chest—identifies a cause in up to 33% of patients.⁸³ Unlike with adults, neoplasms such as neuroblastoma and Ewing sarcoma are the most common etiologies for Horner's syndrome identified by neuroimaging.

Hydrocephalus/ventricular assessment

Advanced imaging is considered medically necessary in **ANY** of the following scenarios:

- Evaluation of signs or symptoms suggestive of increased intracranial pressure or hydrocephalus
 - Ultrasound required for initial evaluation in patients under 5 months of age
- Diagnosis and management of congenital or secondary hydrocephalus
- Diagnosis of idiopathic normal pressure hydrocephalus (NPH) presenting with gait disturbance, cognitive impairment, and/or urinary incontinence
- Management of established hydrocephalus and ventricular shunts

IMAGING STUDY

- CT brain
- MRI brain

Rationale

Hydrocephalus is dilation of the ventricular system resulting from obstruction of cerebrospinal fluid flow or excess production.⁸⁴ Hydrocephalus can be further classified based on physiology and time of onset. Physiologically, hydrocephalus can be communicating (no macroscopic obstruction to cerebrospinal fluid (CSF) flow but inadequate resorption in the subarachnoid space) or obstructive (where a mass lesion blocks CSF flow within the ventricular system). Neuroimaging can be used to diagnose hydrocephalus based on clinical signs and symptoms of increased intracranial pressure and to follow changes in ventricular size after treatment or when recurrence is suspected.

Congenital hydrocephalus is most commonly caused by aqueductal stenosis, which can be visualized on MRI. Other etiologies such as neural tube defects, Chiari malformation, and Dandy-Walker Syndrome are disorders of brain parenchyma formation optimally visualized by MRI. While the evidence is insufficient to recommend a specific threshold for ventricular size change to evaluate treatment response,⁸⁵ changes in ventricular size measured by either CT or MRI can be helpful to assess for shunt malfunction.⁸⁶

Idiopathic normal pressure hydrocephalus (NPH) is a type of acquired hydrocephalus that typically occurs in older adults and is characterized by the triad of gait disturbance, urinary incontinence, and memory impairment. NPH is also characterized by the presence of normal CSF pressure on lumbar puncture (LP), neuroimaging findings of enlarged cerebral ventricles, and improvement after ventricular shunting. While neuroimaging—either by MRI or CT—can suggest the diagnosis of NPH, there is inconsistent and insufficient evidence for the prognostic value of imaging findings such as periventricular fluid and aqueductal flow voids.⁸⁷ However, moderate quality evidence suggests that the presence of one of the triad symptoms and suggestive MRI features are highly predictive of a positive tap test and shunt responsiveness. In neonates with open

fontanelles, cranial ultrasound allows reliable assessment of hydrocephalus and is the initial imaging modality of choice, since it does not require exposure of this high-risk population to ionizing radiation (unlike CT), or sedation and/or prolonged immobility (unlike MRI).⁸⁸

Acquired hydrocephalus can also be secondary due to obstructing lesions such as intraventricular tumors, intraventricular hemorrhage, or colloid cysts. Therefore, neuroimaging plays a central role in identifying an etiology for obstruction, with MRI being more sensitive than CT in the majority of cases.⁸⁴

Neurocutaneous disorders

Includes neurofibromatosis, Sturge-Weber syndrome, tuberous sclerosis, and von Hippel-Lindau disease

Advanced imaging is considered medically necessary for diagnosis and management (including perioperative evaluation) of central nervous system lesions associated with a known neurocutaneous disorder.

IMAGING STUDY

- CT brain
- MRI brain (preferred)

Seizure disorder and epilepsy

ADULT

Advanced imaging is considered medically necessary in **ANY** of the following scenarios:

- Initial evaluation of new or changing seizure, to rule out a structural brain lesion
- Seizures increasing in frequency or severity despite optimal medical management
- Prior to discontinuation of anticonvulsant therapy in patients who have not been previously imaged
- Epilepsy refractory to optimal medical management in surgical candidates

PEDIATRIC

Advanced imaging is considered medically necessary in **ANY** of the following scenarios:

- Neonatal/infantile seizure (age 2 years or younger) when **EITHER** of the following is present:
 - Initial evaluation of seizure not associated with fever
 - Periodic follow up at 6-month intervals up to 30 months, if initial imaging study is nondiagnostic
- Childhood/adolescent seizure (over age 2) when **ANY** of the following is present:
 - Focal neurologic findings at the time of the seizure
 - Persistent neurologic deficit in the postictal period
 - Idiopathic generalized epilepsy with atypical clinical course
 - Partial or absence seizures
 - Nondiagnostic EEG
 - Seizures increasing in frequency or severity despite optimal medical management
 - Prior to discontinuation of anticonvulsant therapy in patients who have not been previously imaged
 - Epilepsy refractory to optimal medical management in surgical candidates
- Complex febrile seizure (age 6 months to 5 years) when **EITHER** of the following is present:
 - More than one seizure during a febrile period
 - Seizure lasting longer than 15 minutes

Note: Imaging is not generally indicated for simple febrile seizures.

IMAGING STUDY

- CT brain
- MRI brain
- Functional MRI (fMRI) in epilepsy refractory to optimal medical management in surgical candidates when done as a replacement for a Wada test or direct electrical stimulation mapping
- PET brain imaging in epilepsy refractory to optimal medical management in surgical candidates

Rationale

Epilepsy is a heterogeneous group of disorders, with variations in seizure types, age of onset, and underlying pathology. The lifetime risk of developing a seizure can be as high 8%-10% in the general population with 0.5% to 1% occurring while in childhood.⁸⁹ Functional and/or structural imaging is often crucial in the evaluation of underlying systemic etiologies or abnormal pathology as well as to direct further therapy.

Adult seizures

The use of advanced imaging is indicated for the initial evaluation of adults with seizure in order to identify a treatable structural cause such as a bleed or a tumor.⁹⁰ The preferred modality is MRI due to its superior sensitivity over CT imaging.⁹⁰ Other indications for neuroimaging in adults include evaluation for structural abnormalities with change in seizure severity and frequency, as well as prior to discontinuation of anti-epileptic therapy if prior neuroimaging was not completed.

Pediatric seizures

For pediatric febrile seizure, the American Academy of Pediatrics does not recommend advanced imaging.⁹¹ The diagnostic yield of clinically significant abnormalities is very low; thus, imaging findings rarely impact management. Complex febrile seizures are defined as those that are focal onset, recurrent during the febrile illness, or prolonged (lasting more than 10 to 15 minutes).⁹² In pediatric patients with idiopathic generalized epilepsy diagnosed by EEG, the diagnostic yield is low (8%), and neuroimaging is not routinely warranted.⁹⁰ When other patterns are present, pediatric patients are more likely to have a structural cause for their seizures.⁹⁰ Imaging should be considered in individuals with any suggestion of a focal onset on history, examination, or EEG (unless there is clear evidence of benign focal epilepsy) as well as seizures refractory to first-line medication. When imaging is indicated, MRI is the preferred imaging modality⁹⁰ for its high diagnostic accuracy and lack of ionizing radiation. CT is an option if MRI is not available, contraindicated, or requires sedation.⁹⁰ In an acute setting, CT may be preferred for expedient determination of acute neurological lesion or illness.⁹⁰

Preoperative evaluation

In a meta-analysis evaluating the predictive value of MRI findings and benefit of epilepsy surgery, the odds of postoperative seizure-free rate were 2.03 times higher in MRI-positive patients (odds ratio=2.03 [95% CI, 1.67-2.47]; P<.00001).⁹³ The utility of MRI is further augmented with functional imaging in patients with refractory seizure and undergoing surgical treatment. Functional MRI can be used for presurgical evaluation of treatment-refractory seizure patients as a replacement for a Wada test or direct electrical stimulation mapping. In a 2015 single institution case series comparing electrocortical stimulation (ECS) and fMRI for localization of somatosensory and language cortex defects, ECS only identified somatosensory-related and language-related sites in 75% and 58% of the patients, respectively; fMRI revealed somatosensory-related sites in anatomically meaningful locations in 100% of the patients.⁹⁴ A second small single center case series study employing fMRI prior to surgery found that 7 out of the 9 surgery patients had imaging abnormalities concordant with surgical resection.⁹⁵

FDG-PET imaging also plays a role in presurgical evaluation of patients with medication-refractory epilepsy. A 2013 systematic review that included 39 studies reported that PET hypometabolism showed a 56%-90% agreement with seizure onset localized by intracranial electroencephalogram (EEG) in adults and 21%-86% in children.⁹⁶ In another recent systematic review of 13 primary studies, the proportion of adult and pediatric patients in whom PET correctly localized a seizure focus and had a good surgical outcome ranged from 36% to 89%. When PET results were combined with MRI or EEG, the sensitivity of detecting adult patients with good outcome increased by 8% to 23%. In terms of impact on patient management, PET findings influenced the clinical decision in 53% to 71% of adult patients and 51% to 95% of pediatric patients.⁹⁶

Spontaneous intracranial hypotension (SIH)

Also see Spine Imaging guidelines

Imaging is considered medically necessary for diagnosis in the setting of an orthostatic headache.

IMAGING STUDY

- MRI brain (preferred)
- CT brain

Rationale

Spontaneous intracranial hypotension (SIH) refers to a state of decreased cerebrospinal fluid (CSF) due to a spontaneous or idiopathic source of leakage, typically of spinal origin.⁹⁷ The condition is relatively rare with an estimated incidence of 2-5 per 100,000⁹⁸ and typically presents with an orthostatic headache in the setting of a low (< 6 cm H₂O) CSF pressure and only very rarely without headache.⁹⁷ MRI brain is nonspecific but findings such as pachymeningeal enhancement, subdural effusions, sagging of the brain parenchyma with sulcal and cisternal effacement support the diagnosis are a part of the International Classification of Headache Disorders (ICHD) criteria.⁹⁸ CT myelography may also be indicated to evaluate for an intracranial or spinal CSF leak and is covered in the Spine Imaging guidelines.

Trigeminal neuralgia and persistent idiopathic facial pain (Adult only)

Also see Vascular Imaging guidelines

Advanced imaging is considered medically necessary for diagnosis and management.

IMAGING STUDY

- MRI brain (to evaluate for a structural lesion or demyelinating disease as a cause of symptoms)

Procedural Imaging

Lumbar puncture risk assessment

Advanced imaging is considered medically necessary when at least **ONE** of the following is present:

- Papilledema
- Absent venous pulsations on funduscopic exam
- Altered mental status
- Abnormal neurological exam
- Evidence of meningeal irritation

IMAGING STUDY

- CT brain

Rationale

According to the American College of Emergency Physician Clinical Policy Statement on Acute Headache,⁹⁹ adult patients with headache and exhibiting signs of increased intracranial pressure (e.g., papilledema, absent venous pulsations on funduscopic examination, altered mental status, focal neurologic deficits, signs of meningeal irritation) should undergo a neuroimaging study before having a lumbar puncture. In the absence of clinical findings suggestive of increased intracranial pressure, a lumbar puncture can be performed without obtaining a neuroimaging study.

Magnetoencephalography and magnetic source imaging

Advanced imaging is considered medically necessary in **ANY** of the following scenarios:

- Preoperative seizure localization for intractable epilepsy, when MRI is nondiagnostic
- Preoperative mapping of eloquent cortex

IMAGING STUDY

- Magnetoencephalography (MEG) or magnetic source imaging (MSI)

Rationale

Magnetic source imaging (MSI) is a noninvasive functional imaging technique that superimposes magnetic brain activity from magnetoencephalography (MEG) onto MRI images of the brain. The main advantage of MSI is that magnetic fields are not affected by surrounding brain structures in the way EEG is, resulting in high-resolution functional/anatomical imaging. Professional society guidelines recommend against the use of magnetoencephalography in patients with seizure disorder, except in evaluation of patients who are surgical candidates, noting that available evidence suggests a complementary role in surgical planning for refractory seizure disorder.^{100, 101} The American Clinical Magnetoencephalography Society (ACMEGS) also supports “routine use of MEG/MSI for obtaining noninvasive localizing or lateralizing information regarding eloquent cortices (somatosensory, motor, visual, auditory, and language) in the pre-surgical evaluation of individuals with operable lesions preparing for surgery.”¹⁰²

Signs and Symptoms

Advanced imaging based on nonspecific signs or symptoms is subject to a high level of clinical review. Appropriateness of imaging depends upon the context in which it is requested. At a minimum, this includes a differential diagnosis and temporal component, along with documented findings on physical exam. Additional considerations that may be relevant include comorbidities, risk factors, and likelihood of disease based on age and gender. In general, the utility of structural brain imaging is limited to the following categories, each with a unique set of clinical presentations:

- Identification of a space occupying lesion or other focal abnormality (tumor, stroke)
- Detection of parenchymal abnormalities (atrophy, demyelinating disease, infection, ischemic change)
- Identification of ventricular abnormalities (hydrocephalus)

Abnormality on neurologic exam

Advanced imaging is considered medically necessary when **ALL** of the following apply:

- A focal abnormality is present on neurologic evaluation
- The abnormality has not been evaluated by advanced imaging, or has progressed since prior advanced imaging
- The abnormality is concerning for intracranial pathology

Note: This guideline does not apply to diffuse abnormalities such as generalized weakness.

IMAGING STUDY

- CT brain
- MRI brain (preferred)

Ataxia

Advanced imaging is considered medically necessary for diagnosis and management.

IMAGING STUDY

- CT brain
- MRI brain (preferred)

Dizziness or vertigo

Also see Head and Neck Imaging guidelines

Advanced imaging is considered medically necessary for dizziness associated with **ANY** of the following:

- Abnormal neurologic exam, audiogram or vestibular function testing suggestive of an intracranial or vestibulocochlear mass lesion
- Unilateral hearing loss or tinnitus
- Tullio's phenomenon (noise-induced dizziness)

Note: Vertigo or dizziness that is clearly related to positional change does not require advanced imaging.

IMAGING STUDY

- CT brain
- MRI brain

Rationale

Dizziness is a nonspecific term used to describe the sensation of disturbed or impaired spatial orientation without a false or distorted sense of motion. In the United States, approximately 5.6 million clinic visits per year list a primary complaint of dizziness.¹⁰³ Vertigo is a type of dizziness causing the sensation of self-motion (of head/body) when no self-motion is occurring or the sensation of distorted self-motion during an otherwise normal head movement. The differential diagnosis for vertigo may encompass benign to acutely life-threatening etiologies such as benign positional vertigo, migraines, stroke/TIA, acute vestibular syndrome, or Meniere's disease. The initial history and physical examination are key to confirming a suspected diagnosis and guiding additional diagnostic evaluation.

In patients with isolated vertigo without features of central vertigo, the diagnostic yield of identifying a structural cause is low. Between 17 and 42% of patients with vertigo are ultimately diagnosed with benign paroxysmal positional vertigo (BPPV).¹⁰³ The diagnostic yield for imaging of patients with benign positional vertigo on clinical exam is also low, such that advanced imaging is not warranted. The American Academy of Otolaryngology–Head and Neck Surgery recommends that “clinicians should not perform imaging for a patients who meets diagnostic criteria for benign paroxysmal positional vertigo in the absence of signs of symptoms inconsistent with BPPV” and to “reassess patients within 1 month after an initial period of observation or treatment to document resolution or persistence of symptoms.”¹⁰³

For patients with abnormal neurologic exam or HINTS (head impulse, nystagmus, test of skew) exam consistent with central vertigo, MRI is considered usually appropriate.¹⁰⁴ When central vertigo is suspected, prompt use of advanced imaging is generally appropriate to rule out acute potentially life-threatening causes. The odds ratios for identifying stroke in patients presenting with gait instability, neurologic findings, and focal neurologic deficits were 9.3, 8.7, and > 20, respectively.¹⁰⁵ In a 2 single-center retrospective studies, MRI changed management in 16%-21.6% of patients with central vertigo.^{106,107} CT imaging may also be performed, although MRI is more sensitive than CT for detection of posterior fossa strokes.^{105, 107}

Headache

Advanced imaging is considered medically necessary to evaluate headache not previously imaged by MRI in **ANY** of the following scenarios:

- Thunderclap or sentinel headache (sudden onset and severe, or worst headache of life, reaching maximal intensity within minutes)
- Headache triggered by or occurring in association with exertion or Valsalva (including cough, exercise, or sexual activity)
- Positional or orthostatic headache
- New headache onset after age 50
- Abnormal neurological exam
- Unexplained and unexpected increase in frequency and/or severity of headaches
- Change in headache pattern
- Trigeminal autonomic cephalgia (TAC), including cluster headaches
- Comorbid conditions increasing likelihood of an intracranial lesion (including malignancy, immunosuppression, sarcoidosis, neurocutaneous disorders (phakomatoses), or pregnancy)

Note: For headache related to trauma, infection, aneurysm, venous sinus thrombosis or other specific diagnoses, please refer to those indications in the Brain Imaging or Vascular Imaging guidelines.

For typical migraine or tension-type headache, without red flags and without a change in pattern, advanced imaging is not indicated.

IMAGING STUDY

- MRI brain (preferred)
- CT brain

Rationale

Headache is the most common neurological complaint seen by general practitioners and neurologists. It accounts for 1%-4% of primary care consultations, 1%-4% of emergency department visits,^{108, 109} and up to 30% of neurology appointments.^{110, 111} The ACR recommends against imaging for primary headache. For patients meeting criteria of these primary headache syndromes, having no red flags and a normal neurological examination, neuroimaging is not necessary based upon the current available data.¹¹² Additional advanced imaging evaluation should be avoided, as the likelihood of changing management or identification of relevant abnormality is low.¹¹³ In a systematic review and meta-analysis of incidental brain MRI findings based on 16 studies and 19,559 patients, the prevalence of incidental findings excluding markers of cerebrovascular disease was 2.7%, including 0.7% intracranial neoplasms, 0.35% intracranial aneurysms, and 0.5% arachnoid cysts.¹¹⁴ In addition to uncertainty around management for some of these incidental findings, particularly tiny aneurysms, there is the risk of over-testing and over-diagnosis. These incidental findings are particularly difficult in patients with headache who are at low risk for a structural cause and may lead the incidental finding to be misattributed as a cause of the headache.^{115 116 117 118 119}

Headache with a pattern change or increasing in frequency and/or severity without a pattern change

The majority of patients presenting with characteristic primary headaches will have spontaneous resolution of their symptoms. When headaches fail to respond to conservative therapy or change in pattern, frequency, or severity, additional imaging may be required. Consensus exists among a number of high-quality guidelines that further investigation, including neuroimaging, is appropriate in the following scenarios:

- Change in headache frequency, characteristics, or associated symptoms¹¹⁰
- Any recent change in the presentation of a primary headache that is suggestive of a secondary headache¹¹¹
- Patients with headaches that do not fit the typical pattern of migraine or tension-type headache, and patients with a major change in headache pattern should be considered for specialist consultation and/or neuroimaging, depending on the clinical judgment of the practitioner¹²⁰
- Chronic headache with new feature or neurologic deficit¹²¹
- Subacute and/or progressive, worsening headaches over weeks to months; rapidly increasing headache frequency¹²²

When neuroimaging is warranted, MRI is preferred over CT imaging due to its superior sensitivity.¹²³

Chronic headache (including typical migraine or tension headaches) without neurological signs or symptoms

Neuroimaging for patients with primary headache or chronic daily headache without additional neurological signs or symptoms has a low diagnostic yield. Based on high-quality evidence-based guidelines, further investigation including neuroimaging is usually not appropriate. Clinicians should use a detailed headache history—that includes duration of attacks and the exclusion of secondary causes—as the principal means to diagnose primary headache. Additional testing in patients without atypical symptoms or an abnormal neurologic examination is unlikely to be helpful.¹²² When neuroimaging is warranted, MRI is preferred over CT imaging for its superior sensitivity.¹²³

Headache with neurologic signs

Emergency care is recommended for headache associated with neurological signs.¹¹¹ The presence of subtle neurological signs suggests a secondary cause for headache. For example, meningismus, confusion, altered level of consciousness, memory impairment, papilledema, visual field defect, cranial nerve abnormalities, pronator drift, extremity weakness, significant sensory deficits, reflex asymmetry, extensor plantar response, or gait disturbance when accompanying a headache should elicit caution.¹²² In addition, patients with unexplained focal neurological signs and recurrent headache require specialist referral and/or neuroimaging to exclude a space-occupying central nervous system lesion. MRI is preferred in the non-urgent setting.¹²⁰ Patients presenting to the emergency department with headache and new abnormal findings on neurologic examination (focal deficit, altered mental status, altered cognitive function) should undergo emergent noncontrast

head CT.¹²⁴ In patients with atypical headache patterns, a history of seizures, or neurological signs or symptoms, or symptomatic illness such as tumors, AIDS, or neurofibromatosis, MRI may be indicated (to be carefully evaluated in each case).¹²⁵ Further investigation and/or referral for people who present with or without migraine headache and with atypical aura symptoms, motor weakness, double vision, visual symptoms affecting only one eye, poor balance, or decreased level of consciousness is also warranted.¹¹⁰

Sudden onset severe headache (including worst ever and thunderclap)

Neuroimaging in headache patients with sudden onset or thunderclap headache (peak intensity within one minute) is recommended by multiple high-quality evidence-based guidelines and moderate-quality evidence. Until there is evidence to the contrary, all patients complaining of headache who fulfill one criterion of the Ottawa clinical decision rule should be suspected of having subarachnoid hemorrhage.¹²⁶ A patient who presents with sudden-onset headache or headache associated with a neurological deficit should have an emergency CT scan.⁹⁹

Headache associated with cough, exertion or sexual activity (Valsalva headaches)

Valsalva or exertional headaches can signal an intracranial abnormality, usually of the posterior fossa.¹²²

Multiple evidence-based guidelines recommend neuroimaging for Valsalva headache, although the evidence quality supporting this risk factor is low-quality. Findings concerning for more insidious underlying pathology include exertional headaches that are new onset, occur after age 40, last beyond a few hours, or are accompanied by vomiting or focal neurologic symptoms.¹²¹ Patients with headache clearly precipitated by exertion, cough, or Valsalva should be considered for specialist referral and/or a brain MRI scan to exclude a Chiari 1 malformation or a posterior fossa lesion.¹²⁰

Hearing loss

Also see Head and Neck Imaging guidelines

ADULT

Advanced imaging is considered medically necessary for detecting a structural cause of hearing loss in **EITHER** of the following scenarios:

- Conductive hearing loss
- Sensorineural hearing loss characterized by **ANY** of the following features:
 - Idiopathic sudden onset hearing loss
 - Gradual onset of unilateral or asymmetric hearing loss demonstrated by audiometric testing (15 dB or greater at 2 consecutive frequencies between 0.5 and 8 kHz)
 - Hearing loss associated with at least one neurologic sign or symptom known to increase the pretest probability of a retrocochlear lesion

PEDIATRIC

Advanced imaging is considered medically necessary to evaluate for a structural cause of sensorineural, conductive, or mixed hearing loss.

IMAGING STUDY

- MRI brain for evaluation of sensorineural hearing loss
- CT orbit, sella, posterior fossa and outer, middle, or inner ear for evaluation of sensorineural hearing loss in pediatric patients; or in adult patients when MRI cannot be performed or is nondiagnostic
- CT orbit, sella, or posterior fossa and outer, middle, or inner ear for evaluation of conductive hearing loss
- MRI brain or CT orbit, sella, or posterior fossa and outer, middle, or inner ear for evaluation of mixed hearing loss, based on clinical scenario

Rationale

The primary purpose of imaging sensorineural hearing loss is to detect retrocochlear pathology, typically a tumor of the vestibular nerve (cranial nerve 8) or cerebellopontine angle (CPA). More than 85% of these tumors are acoustic neuromas

(also called vestibular schwannomas). However, vestibular schwannomas are rare, with an overall prevalence of 1 per 100,000, and they are found in only 2% to 8% of patients with autoimmune sensorineural hearing loss.

A 15 dB or greater difference at 2 consecutive frequencies has a sensitivity of 97% and a specificity of 49% for the diagnosis of vestibular schwannoma. For optimum specificity (~67%) with high sensitivity (~90%) the American Academy of Otolaryngology–Head and Neck Surgery protocol is recommended, which proposes ≥ 15 dB between ears, averaging 0.5 to 3 kHz.¹²⁷

MRI of the head and the internal auditory canal, commonly known as an IAC protocol, is most effective in screening for CPA tumors. Clinicians should not order CT of the head/brain in the initial evaluation of a patient with presumptive sudden sensorineural hearing loss.¹²⁸

Papilledema

Advanced imaging is considered medically necessary for diagnosis and management.

IMAGING STUDY

- CT brain
- MRI brain

Syncope

Also see Vascular Imaging guidelines.

Advanced imaging is considered medically for evaluation when **ANY** of the following features are present:

- Documented abnormality on neurological examination
- Presence of at least one persistent neurological symptom
- Seizure activity at the time of the episode

IMAGING STUDY

- CT brain
- MRI brain

Rationale

Syncope is a common medical complaint that is rarely due to intracranial disease. Multiple North American specialty societies recommend against routine neuroimaging in the evaluation of syncope:

- American College of Cardiology/American Heart Association/Heart Rhythm Society: “MRI and CT of the head are not recommended in the routine evaluation of patients with syncope in the absence of focal neurological findings or head injury that support further evaluation.”¹²⁹
- Canadian Society of Internal Medicine: “Don’t routinely obtain neuro-imaging studies (CT, MRI scans, or carotid Doppler ultrasonography) in the evaluation of simple syncope in patients with a normal neurological examination.”¹³⁰
- Canadian Association of Emergency Physicians: “Don’t order CT head scans in adult patients with simple syncope in the absence of high-risk predictors.”¹³¹

A recent systematic review of 15 studies evaluating syncope patients (N = 6944) found a high prevalence of neuroimaging (57% CT, 10% MRI), but very low diagnostic yield (1.18% CT, 3.74% MRI).¹³² In unselected patients, the diagnostic yield approaches 0%.¹³³ However, patients with a focal neurological deficit have a significantly higher risk of intracranial pathology, with an odds ratio of 5.2 (95% CI, 2.3-8.1) with nonhemorrhagic infarct, intracranial hemorrhage and neoplasm being the most common etiologies.¹³⁴

A joint ACC/AHA/HRS guideline recommends against the routine use of neuroimaging in syncope, stating that “syncope is due to global cerebral hypoperfusion, and brain structural abnormalities are rare. Nonetheless, MRI and CT are frequently used and infrequently helpful. In 5 studies investigating patients with syncope, MRI was used in 11% of 397 patients and established a diagnosis in only 0.24%. Similarly, in 10 studies of investigation of syncope, CT was used in 57% of 2728 patients and established a diagnosis in only 1%.”¹²⁹

Tinnitus

Also see *Vascular Imaging guidelines for evaluation of pulsatile tinnitus*

Advanced imaging is considered medically necessary in **EITHER** of the following scenarios:

- Evaluation for vascular pathology when tinnitus is pulsatile in quality
- Evaluation for retrocochlear pathology when at least **ONE** of the following features is present:
 - Associated neurologic findings
 - Unilateral or asymmetric symptoms

IMAGING STUDY

- MRI brain
- CT orbit, sella, or posterior fossa and outer, middle, or inner ear when MRI cannot be performed or is nondiagnostic

Visual disturbance

Also see *Head and Neck Imaging guidelines*.

Advanced imaging is considered medically necessary for visual symptoms when vision testing or fundoscopic exam* suggests central nervous system pathology.

*May include 3rd, 4th or 6th cranial nerve palsy, nystagmus, papilledema, or visual field deficits.

IMAGING STUDY

- CT brain
- MRI brain (preferred)

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Codes

The following code list is not meant to be all-inclusive. Authorization requirements will vary by health plan. Please consult the applicable health plan for guidance on specific procedure codes.

Specific CPT codes for services should be used when available. Nonspecific or not otherwise classified codes may be subject to additional documentation requirements and review.

CPT/HCPCS

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| | |
|-------|---|
| 70450 | CT head/brain, without contrast |
| 70460 | CT head/brain, with contrast |
| 70470 | CT head/brain, without contrast, followed by re-imaging with contrast |
| 70473 | Computed tomographic (CT) cerebral perfusion analysis with contrast material(s), including image postprocessing performed without concurrent CT or CT angiography of the same anatomy |
| 70480 | CT orbit, sella, or posterior fossa or outer, middle or inner ear, without contrast |
| 70481 | CT orbit, sella, or posterior fossa or outer, middle or inner ear, with contrast |
| 70482 | CT orbit, sella, or posterior fossa or outer, middle or inner ear, without contrast, followed by re-imaging with contrast |
| 70551 | MRI brain (including brain stem), without contrast |
| 70552 | MRI brain (including brain stem), with contrast |
| 70553 | MRI brain (including brain stem), without contrast, followed by re-imaging with contrast |
| 70554 | MRI brain functional, not requiring physician or psychologist administration |
| 70555 | MRI brain functional, requiring physician or psychologist administration of entire neurofunctional testing |
| 76390 | MRI spectroscopy |
| 78608 | Brain imaging PET, metabolic evaluation |
| 78609 | Brain imaging PET, perfusion evaluation |
| 78811 | PET imaging limited area chest head/neck |
| 78814 | PET imaging CT for attenuation limited area |

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| 95965 | Magnetoencephalography (MEG), recording and analysis; for spontaneous brain magnetic activity |
| 95966 | Magnetoencephalography (MEG), recording and analysis; for evoked magnetic fields, single modality |

ICD-10 Diagnosis

Refer to the ICD-10 CM manual

History

| Status | Review Date | Effective Date | Action |
|-----------------------------|-------------|--|---|
| Revised | 01/29/2026 | 09/19/2026 | Independent Multispecialty Physician Panel (IMPP) review. Added indication for Cerebral perfusion imaging. |
| Updated codes 01/01/2026 | n/a | Unchanged | CPT code update: added code 70473; removed termed code 0042T. |
| Revised | 01/30/2025 | 11/15/2025 except for Healthy Blue LA Medicaid, BCBS OH Medicaid; 01/01/2026 for Regence | IMPP review. Revised indications: Neurocognitive disorders, Trauma, Pituitary mass, Seizure disorder and epilepsy, Magnetoencephalography and magnetic source imaging, Dizziness or vertigo, and Headache. Added codes 95965 and 95966. Removed codes A9552, A9586, A9601, A9602, G0235, Q9982, Q9983, and S8085. |
| Revised | 01/23/2024 | 10/20/2024 except for Healthy Blue LA Medicaid | IMPP review. Revised indications: Movement disorders and Neurocognitive disorders. Added codes 78811 and 78814. |
| Revised | 07/18/2023 | 04/14/2024 except for Healthy Blue LA Medicaid | IMPP review. Revised indications: Movement disorders, Trauma, Acoustic neuroma, and Headache. |
| Updated | 01/23/2024 | Unchanged | Expanded guideline rationale. Added required language per new Medicare regulations. |
| Revised | 05/09/2022 | 04/09/2023 for commercial, Medicare, and Medicaid except LA; 06/18/2023 for LA Medicaid | IMPP review. Revised indications: Meningioma, Bell's palsy, and Seizure disorder and epilepsy. |
| Updated | - | 12/18/2022 | Added code A9602. |
| Updated | - | 09/01/2022 | Added codes A9552 and A9601. |
| Revised | 05/26/2021 | 03/13/2022 | IMPP review. Revised indications: Acoustic neuroma, Pituitary adenoma, Tumor, Headache. Added indications: Sickle cell disease, Meningioma, Pituitary incidentaloma. Added codes A9586, Q9982, and Q9983. |
| Revised | 02/03/2020 | 03/14/2021 | IMPP review. Revised indications: Ataxia, Acoustic neuroma, Pituitary adenoma, Tumor, Seizure disorder, Dizziness or vertigo, Headache, Hearing loss, Mental status change, Tinnitus. Added CPT code 0042T and HCPCS codes G0235 and S8085. |
| Revised | 01/28/2019 | 09/28/2019 | IMPP review. Revised indications: Infectious conditions – not otherwise specified (was Infection), Multiple sclerosis, |

| Status | Review Date | Effective Date | Action |
|--------------|-------------|----------------|---|
| | | | Movement disorders, Neurocognitive disorders, Trauma, Pituitary adenoma, Tumor – not otherwise specified, Hematoma or hemorrhage, Hydrocephalus, Pseudotumor cerebri, Seizure refractory, Spontaneous intracranial hypotension, Trigeminal neuralgia, Abnormality on neurologic exam, Ataxia, Dizziness or vertigo, Headache, Hearing loss, Tinnitus. |
| Restructured | 09/12/2018 | 01/01/2019 | IMPP review. Advanced Imaging guidelines redesigned and reorganized to a condition-based structure. Incorporated AIM guidelines for pediatric imaging. |
| Revised | 07/11/2018 | 03/09/2019 | IMPP review. Renamed the Administrative Guidelines to “General Clinical Guideline.” Retitled Pretest Requirements to “Clinical Appropriateness Framework” to summarize the components of a decision to pursue diagnostic testing. Revised to expand applicability beyond diagnostic imaging, retitled Ordering of Multiple Studies to “Ordering of Multiple Diagnostic or Therapeutic Interventions” and replaced imaging-specific terms with “diagnostic or therapeutic intervention.” Repeated Imaging split into two subsections, “repeat diagnostic testing” and “repeat therapeutic intervention.” |
| Reaffirmed | 08/15/2017 | 03/12/2018 | Annual review. |
| Revised | 11/01/2016 | 02/20/2017 | IMPP review. Revised indications: Movement disorders, Frontotemporal lobe dementia and Alzheimer’s disease. Added CPT code 78609 (PET brain). Restructured content and added clarification language. |
| Created | - | 03/30/2005 | Original effective date. |