

Evolut Clinical Guideline ~~006-12054~~ for Temporal Bone, Mastoid, Orbits, Sella, Internal Auditory Canal Computed Tomography (CT)

Guideline or Policy Number: Evolut_CG_006-12054	Applicable Codes	
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STATEMENT

General Information

- *It is an expectation that all patients receive care/services from a licensed clinician. All appropriate supporting documentation, including recent pertinent office visit notes, laboratory data, and results of any special testing must be provided. -If applicable: All prior relevant imaging results and the reason that alternative imaging cannot be performed must be included in the documentation submitted.*
- *Where a specific clinical indication is not directly addressed in this guideline, medical necessity determination will be made based on widely accepted standard of care criteria. These criteria are supported by evidence-based or peer-reviewed sources such as medical literature, societal guidelines and state/national recommendations.*
- [The guideline criteria in the following sections were developed utilizing evidence-based and peer-reviewed resources from medical publications and societal organization guidelines as well as from widely accepted standard of care, best practice recommendations.](#)

Purpose

Temporal bone, mastoid, orbits, sella and internal auditory canal computed tomography (CT) is performed for problems, such as conductive hearing loss, chronic otitis media, mastoiditis, cholesteatoma, congenital hearing loss and cochlear implants. It is a modality of choice because it provides 3D positional information and offers a high degree of anatomic detail. It is rarely used for evaluation of VIIth or VIIIth nerve tumors.

INDICATIONS FOR ORBIT CT

Orbit CT ⁽¹⁾

- [Orbital trauma](#) ^(2,3)
 - [Physical findings of direct eye injury](#)
 - [Suspected orbital trauma with indeterminate or abnormal prior imaging](#)
 - [For further evaluation of an injury seen on prior imaging to assist in management decision-making](#)
- [Suspected or known orbital or ocular mass/neoplasm](#) ⁽⁴⁾
- [Evaluate for possible compressive lesion in the setting of suspected optic neuritis](#)
- [Clinical suspicion of orbital infection](#) ⁽²⁾
- ~~[Abnormal external or direct eye exam](#)~~ ⁽¹⁾;
- [Congenital orbital anomalies \(such as coloboma, microphthalmia, anophthalmia, dermoid cysts, hypertelorism\)](#) ⁽⁵⁾

- CT Imaging of the orbits is indicated **only** when MRI is contraindicated or cannot be performed for any **ONE** of the following:
 - Exophthalmos (proptosis) or enophthalmos (sunken eye)
 - Ophthalmoplegia with concern for orbital pathology ⁽²⁾
 - Clinical suspicion of osteomyelitis with any **ONE** of the following ⁽⁶⁾:
 - Direct visualization of bony deformity
 - Indeterminate or abnormal prior imaging
 - Unilateral optic disk swelling ~~if MRI is contraindicated or cannot be performed~~ ^(3,4,5)
 - Documented visual defect ~~if MRI is contraindicated or cannot be performed~~ ^(6,7) (s) with any **ONE** of the following ⁽⁷⁾:
 - Unilateral ~~or with abnormal visual defects~~
 - Optic disc(s) (~~i.e., abnormalities on exam~~ (such as optic disc blurring, edema, or pallor); **AND** not explained by an underlying known diagnosis, (such as glaucoma, ~~or~~ macular degeneration)

Suspected Optic Neuritis ~~if MRI is contraindicated or cannot be performed~~

- ~~If~~ with atypical presentation (such as bilateral, absence of pain, optic nerve hemorrhages, severe visual impairment, lack of response to steroids, poor recovery or recurrence) ⁽⁸⁾ ^(9,1)

~~If needed to confirm optic neuritis and rule out compressive lesions~~

~~Orbital trauma~~

~~Physical findings of direct eye injury~~

Suspected Orbital ~~trauma with indeterminate x-ray~~

~~For further evaluation of a fracture seen on x-ray for treatment or surgical planning~~

~~Orbital or ocular mass/tumor, suspected, or known~~ ^(1,12)

~~Clinical suspicion of orbital infection~~ ^(13,14)

~~Clinical suspicion of osteomyelitis~~ ^(15,16)

~~Direct visualization of bony deformity~~ **OR**

~~Abnormal x-rays~~

- ~~Clinical suspicion of Orbital Inflammatory Disease (e.g., eye pain and restricted eye movement with suspected orbital pseudotumor) if MRI is contraindicated or cannot be performed~~ ⁽¹⁷⁾ also known as Orbital Inflammatory Pseudotumor

~~Congenital orbital anomalies~~ ⁽¹⁸⁾

- Complex strabismus ~~(with ophthalmoplegia or (ophthalmoparesis) to aid in diagnosis,~~ treatment and/or surgical planning ^(19,20,21) management

CT is preferred for visualizing bony detail and calcifications. MRI is superior for the evaluation of the visual pathways, globe, and soft tissue.^(1,22) Brain CT is often ordered along with CT of the orbit for head injury with orbital trauma. MRI Orbits is preferred over CT Orbits except in the case of orbital trauma, infection, or bone abnormalities.

~~Indications for Combination Studies~~

~~Orbit CT~~

- ~~• Brain CT/Orbit CT if MRI is contraindicated or cannot be performed;~~
- ~~○ Optic neuropathy or unilateral optic disk swelling of unclear etiology to distinguish between a compressive lesion of the optic nerve, optic neuritis, ischemic optic neuropathy (arteritic or non-arteritic), central retinal vein occlusion, or optic nerve infiltrative disorders.⁽²³⁾~~
- ~~○ Bilateral optic disk swelling (papilledema) with vision loss.⁽⁴⁾~~
- ~~○ Approved indications as noted above and being performed in high-risk populations and will need anesthesia for the procedure and there is a suspicion of concurrent intracranial pathology.⁽⁴⁾~~

INDICATIONS FOR SELLA CT ⁽²⁴⁾

Sella CT ⁽⁹⁾

When MRI is contraindicated or cannot be performed^(25,26):

- For further evaluation of known sellar and/or parasellar masses
- Suspected pituitary gland disorder ⁽²⁷⁾ based on any **ONE** of the following:
 - Documented visual field defect suggesting compression of the optic chiasm; **OR**
 - Laboratory findings suggesting pituitary dysfunction ⁽²⁸⁾; **OR** such as abnormal levels of prolactin, growth hormone, cortisol, testosterone, oxytocin, TSH, ACTH, LH, FSH, ADH
 - Pituitary apoplexy ~~with~~ (sudden loss of pituitary function often due ischemia or hemorrhage) with acute onset of neurological and hormonal symptoms; **OR**
 - ~~Other~~ Prior imaging suggesting sella (pituitary) mass

INDICATIONS FOR TEMPORAL BONE, MASTOID, INTERNAL AUDITORY CANAL (IAC) CT

Hearing Loss (Documented on Audiogram) ^(29,30)

Asymmetric Suspected Neoplasm or Malignancy

- Suspicious lesion that is indeterminate or abnormal on prior imaging and requires further evaluation ⁽¹⁰⁾

Suspected acoustic neuroma (Schwannoma) or cerebellar pontine angle tumor based on clinical signs and symptoms (sSuch as unilateral or a sensorineural loss, vertigo, disturbed balance or gait, unilateral/asymmetric tinnitus, facial weakness, or altered sense of taste) when MRI is contraindicated ^(31,32)

Conductive or mixed ⁽³³⁾

Congenital ⁽³³⁾

Cochlear implant evaluation ^(34,35,36,37)

Note: For congenital/childhood sensorineural hearing loss suspected to be due to a structural abnormality, CT is the preferred imaging modality for the osseous structures and malformations of the inner ear. MRI is used for evaluating CNVIII, the brain parenchyma, or the membranous labyrinth.

Tinnitus ^(38,39,40)

Pulsatile tinnitus with concern for osseous pathology of the temporal bone or a retrotympenic lesion seen on otoscopy

- Unilateral non-pulsatile tinnitus and MRI is contraindicated or or cannot be performed. ⁽¹¹⁾
- Ear Suspected glomus tumor based on exam and/or prior imaging ⁽¹¹⁾

Infection and Inflammation

- Chronic otitis externa that has failed prior treatment (such as antibiotics, debridement, ear canal wicks) particularly in high-risk populations (such as immunocompromised, poorly controlled diabetes, prior radiation therapy) ⁽¹²⁾
- Suspected necrotizing otitis externa (formally known as malignant otitis externa) particularly in high-risk populations (such as immunocompromised, poorly controlled diabetes, prior radiation therapy) ⁽¹²⁾
- Chronic otitis media (with or without cholesteatoma on exam) that has failed prior treatment (such as antibiotics, ear tube placement) ⁽¹³⁾
- Clinical suspicion of acute mastoiditis as a complication of acute otitis media ^(41,42,43); including any ONE of the following ^(13,14):
 - Systemic illness or toxic appearance
 - Suspected mastoiditis (infection of the mastoid bone/mastoid air cells)
 - Signs/symptoms of extracranial possible complications (e.g., such as postauricular swelling/erythema, auricular protrusion, (Prominauria), retro-orbital pain, hearing loss, facial nerve paresis)
 - Signs/symptoms of possible intracranial complications (sSuch as headache, tinnitus, vertigo, nystagmus)

- Known **OR** suspected cholesteatoma (abnormal growth of epithelial tissue within the middle ear) ⁽¹⁵⁾

Cranial Nerve Abnormalities

Facial Nerve Paresis/Bell's Palsy/Hemifacial Spasm (CN VII) ^(16,17)

- If MRI is contraindicated or cannot be performed ~~Not responding to treatment~~

Note: MRI is also indicated if there are signs of intracranial complications (e.g., meningeal signs,

- Facial nerve paresis/ Bell's palsy / hemifacial spasm with poor prognostic clinical factors (sSuch as complete paresis, incomplete improvement at 3 months, bilateral facial nerve involvement, other cranial nerve deficits, focal neurological findings, altered mental status). This history of malignancy)

Hearing Loss (Documented on Audiogram) (CN VIII) ⁽¹⁸⁾

- Congenital hearing loss (unilateral or bilateral, conductive or sensorineural)
NOTE: "Congenital" refers to a condition, trait, or exposure that is most common present at birth that is due to genetic factors, non-genetic factors, or a combination of both. However, hearing loss can be mild initially and progress over time after birth, so the diagnosis of congenital hearing loss is not necessarily limited to young children only
- Conductive hearing loss (CHL) **OR** mixed hearing loss (both sensorineural hearing loss (SNHL) and CHL present on audiogram)
- Cochlear implant evaluation (preoperative or postoperative)
- Bone-anchored hearing aid (BAHA) evaluation (preoperative or postoperative)
- CT Imaging of the temporal bone is indicated **only** when MRI is contraindicated or cannot be performed for any **ONE** of the following:
 - Asymmetric or unilateral sensorineural hearing loss (SNHL)
 - Suspected auditory neuropathy

Tinnitus (CN VIII) ^(11,19)

- Pulsatile tinnitus (unilateral or bilateral) ⁽²⁰⁾
NOTE: Vascular imaging (CTA or MRA) of the brain and/or neck may also be indicated in the pediatric population evaluation of pulsatile tinnitus.
- Non-pulsatile, unilateral or asymmetric tinnitus **AND** MRI is contraindicated or cannot be performed
NOTE: For non-pulsatile, bilateral tinnitus advanced imaging is indicated only based on the type and level of the associated hearing loss (see hearing loss criteria)

Peripheral Vertigo (CN VIII) ^(18,21)

- Advanced imaging is indicated for peripheral vertigo (source within the temporal bone) with ALL of the following:
 - Clinical evidence of a peripheral source of vertigo (such as head-impulse with saccade, spontaneous unidirectional horizontal nystagmus, positive Dix-Hallpike maneuver, Electronystagmography (ENG) testing and/or rotary chair testing indicating peripheral vertigo)
 - Persistent symptoms after a trial of pharmacotherapy (such as meclizine, diazepam) AND four weeks or more of vestibular therapy (such as Epley’s maneuvers, vestibular rehabilitation)

NOTE: For patients with suspected central vertigo (source within the central nervous system (CNS)) imaging with MRI Brain (or CT Head if MRI is contraindicated or not available) is indicated

Trauma (22)

Temporal Bone Fracture (23) ~~Chronic Otitis Media~~

- Indeterminate or abnormal prior imaging (such as X-ray, non-temporal bone CT)

Suspected temporal bone fracture with or without cholesteatoma on exam (42,45)

- Failed treatment for any ONE of the following acute otitis media signs/symptoms:
 - ~~Cholesteatoma~~ (46,47)
 - CSF-Suspicious mechanism of injury (such as penetrating or blunt trauma to the lateral skull)
 - Facial nerve dysfunction
 - Hearing loss
 - Tinnitus
 - Vertigo
 - Nystagmus
 - Otorrhea (ear canal drainage)
- For procedure/surgical planning to manage a known temporal bone fracture

Congenital Abnormalities

- Aural atresia and/or microtia on physical exam

Cerebral Spinal Fluid (CSF) Otorrhea (24,25)

- When looking to characterize a bony defect (for intermittent leaks and complex cases consider CT/MR/Nuclear Cisternography). There should be a high CT temporal bone imaging for possible CSF otorrhea (or secondary CSF rhinorrhea via the eustachian tube) is indicated with any ONE of the following (8):

- High index of suspicion or confirmatory CSF fluid laboratory testing (of CSF leak based on clinical evidence (such as consistent nasal leaking, worse leaking with provocative maneuvers (Valsalva), positive Beta-2 transferrin assay of the leakage)
- Prior imaging (such as MRI, nuclear medicine imaging) suggesting bony defect/lesion contributing to suspected/~~known~~ CSF leak

~~Temporal Bone Fracture~~ ^(50,51,52)

~~Suspected based on mechanism of injury OR~~

~~Indeterminate findings on initial~~ Vascular Abnormalities

- Advanced imaging OR
- For further evaluation of a known fracture or suspected vascular abnormality of the temporal bone is indicated for treatment or surgical planning any ONE of the following ⁽²⁶⁾:
 - ~~Vascular Indications~~ ^(53,54)
 - ~~Suspected or known with need for further evaluation~~
 - Dehiscence and/or abnormal position of the jugular bulb ~~or~~
 - Dehiscence of the carotid canal ~~OR~~
 - Other vascular anomalies of the temporal bone (i.e., Aberrant internal carotid artery
 - , high jugular bulb, Persistent stapedial artery
 - Aberrant petrosal sinus)
 - ~~Peripheral Vertigo~~ ^(55,56,57)
 - Suspected glomus tumor based on clinical exam (Head Impulse with saccade, Spontaneous unidirectional horizontal nystagmus, Dix-Hallpike maneuver); AND
 - Persistent symptoms after a trial of medication and four weeks of vestibular therapy (e.g., Epley's maneuvers)
 - Bell's Palsy/Hemifacial Spasm
 - ~~If MRI is contraindicated or cannot be performed (for evaluation of the extracranial nerve course);~~
 - If atypical signs, slow resolution beyond three weeks, no improvement at four months, or facial twitching/spasms/or prior to onset ⁽⁵⁸⁾; imaging
 - Other vascular abnormality where the need for advanced imaging is clearly documented

PREOPERATIVE OR POSTOPERATIVE ASSESSMENT

PROCEDURAL EVALUATION

When not otherwise specified in the guideline:

Preoperative evaluation:

- ~~f~~For a planned surgery or procedure
- Pre-operative imaging with CT of the temporal bone/Internal auditory canal is indicated for ANY of the following procedures:
 - Cochlear implantation
 - Bone-anchored hearing aid (BAHA)
 - Eustachian tube procedures (such as balloon dilation)
 - Aural atresia and/or microtia repair
- Imaging of the area requested is needed to develop a surgical plan

Postoperative Evaluation:

- ~~When imaging, physical, or laboratory findings indicate surgical~~Known or ~~procedural~~suspected complications
- ~~A clinical reason follow-up study may be needed to help evaluate a patient's progress after treatment, procedure, intervention, or surgery. Documentation requires a medical reason that clearly indicates why additional imaging is needed for the type and area(s) requested.~~is provided how imaging may change management

NOTE: This section applies only within the first few months following surgery

FURTHER EVALUATION OF INDETERMINATE FINDINGS ~~ON PRIOR IMAGING~~

Unless Follow-up is Otherwise Specified Within the Guideline:

- For initial evaluation of an inconclusive finding on a prior imaging report that requires further clarification.
- One follow-up exam of a prior indeterminate MR/CT finding to ensure no suspicious interval change has occurred. (No further surveillance unless specified as highly suspicious or change was found on last follow-up exam)

OTHER INDICATIONS FOR COMBINATION STUDIES WITH TEMPORAL BONE, MASTOID, ORBITS, SELLA,

IAC CT

NOTE: When medical necessity is met for an individual study **AND** conscious sedation is required (such as for young pediatric patients or patients with significant developmental delay), the entire combination is indicated)

Brain/Orbit CT

- Brain CT/Orbit CT if MRI is contraindicated or cannot be performed; with any **ONE** of the following:
 - Optic neuropathy or unilateral optic disk swelling of unclear etiology to distinguish between a compressive lesion of the optic nerve, optic neuritis, ischemic optic neuropathy (arteritic or non-arteritic), central retinal vein occlusion, or optic nerve infiltrative disorders ^(1,7)
 - Bilateral optic disk swelling (papilledema) with vision loss ⁽¹⁾
 - Meets indications as noted above for orbital CT with also any **ONE** of the following:
 - High-risk population (sSuch as known malignancy, immunocompromised, uncontrolled diabetes)
 - Need anesthesia for the imaging study (sSuch as pediatric patients) and there is a suspicion of concurrent intracranial pathology ⁽²⁷⁾

Neck/Face/Sinus/Orbit CT and PET

- Suspected or known malignancy of the head and neck with any **ONE** of the following ⁽²⁸⁾
 - For initial staging, restaging, or suspected recurrence of head and neck cancer
 - For surgical or radiation planning
 - 3-4 months after end of treatment in patients with locoregionally advanced disease or with altered anatomy
 - Annually when it is documented that the area of original disease is difficult to follow with direct visualization and/or endoscopy (such as orbit, nasopharynx, base of tongue, hypopharynx, pyriform sinus)

CT Internal Auditory Canal (IAC)/MRI IAC

- CT IAC / MRI IAC are both indicated prior to cochlear implantation with any **ONE** of the following:
 - Genetic syndrome diagnosis (sSuch as Usher syndrome, Pendred syndrome, Waardenburg syndrome, Branchio-Oto-Renal (BOR) syndrome, Trisomy 21)
 - Known temporal bone anatomic abnormality (sSuch as enlarged vestibular aqueduct, aural atresia, aberrant facial nerve)
 - History of prior temporal bone surgery

- [History of meningitis](#)
- [Mixed hearing loss \(conductive hearing loss and sensorineural hearing loss\)](#)
- [Extensive history of otitis media](#)
- [Pediatric patient where sedation will be needed to complete either study](#)


CODING AND STANDARDS

Coding

CPT Codes

70480, 70481, 70482, +0722T

Applicable Lines of Business

<input checked="" type="checkbox"/>	CHIP (Children's Health Insurance Program)
<input checked="" type="checkbox"/>	Commercial
<input checked="" type="checkbox"/>	Exchange/Marketplace
<input checked="" type="checkbox"/>	Medicaid
<input checked="" type="checkbox"/> 	Medicare Advantage

BACKGROUND

~~Pulsatile tinnitus has many etiologies, and the choice of study should be based on accompanying signs and symptoms. For general screening, MRI brain with IAC/MRA brain and neck is approvable. If IIIH is suspected (typically with headache and vision changes in a younger woman with a high BMI) MRI/MRV brain is indicated. If there is concern for vascular etiology, CTA or MRA brain/neck is indicated. If there is associated hearing loss and neurological signs/symptoms, MRI brain with IAC is indicated. If the temporal bone is suspected to be involved and/or retrotympenic lesion is seen on otoscopy, CT temporal bone/IAC is indicated. If there is concurrent concern for boney and a vascular issue, CTA of the head and neck can be used to evaluate both.~~

Contraindication and Preferred Studies

- Contraindications and reasons why a CT/CTA cannot be performed may include: impaired renal function, significant allergy to IV contrast, pregnancy (depending on trimester)

- Contraindications and reasons why an MRI/MRA cannot be performed may include: impaired renal function, claustrophobia, non-MRI compatible devices (such as non-compatible defibrillator or pacemaker), metallic fragments in a high-risk location, patient exceeds weight limit/dimensions of MRI machine

SUMMARY OF EVIDENCE

ACR Appropriateness Criteria® Orbits Vision and Visual Loss ⁽¹⁾

Study Design: This document provides evidence-based guidelines developed by a multidisciplinary expert panel. The guidelines are reviewed annually and include an extensive analysis of current medical literature from peer-reviewed journals.

Target Population: Patients with visual loss due to abnormalities along the visual pathway, including the globe, optic nerve, optic chiasm, optic tract, thalamus, optic radiations, or primary visual cortex.

Key Factors: The guidelines emphasize a compartmental approach to imaging analysis, using CT and MRI as primary modalities. The document discusses various clinical scenarios, including traumatic visual defects, nontraumatic orbital asymmetry, suspected orbital cellulitis, optic neuritis, and visual loss with identified etiology.

ACR Appropriateness Criteria® Neuroendocrine Imaging ⁽⁹⁾

Study Design: This document outlines evidence-based guidelines for neuroendocrine imaging, developed by a multidisciplinary expert panel. The guidelines are reviewed annually and include an extensive analysis of current medical literature from peer-reviewed journals.

Target Population: Patients with suspected hyper- and hypofunction of the pituitary gland, including conditions such as pituitary adenomas, diabetes insipidus, and pituitary apoplexy.

Key Factors: The guidelines recommend MRI with high-resolution protocols as the best first-line test for evaluating the sella turcica and parasellar region. CT provides complementary information regarding bony anatomy. The document discusses various clinical scenarios, including hypofunctioning and hyperfunctioning pituitary gland, diabetes insipidus, pituitary apoplexy, and surveillance post-pituitary or sellar mass resection.

Temporal Bone Trauma: Typical CT and MRI Appearances and Important Points for Evaluation ⁽²²⁾

Study Design: This document reviews the typical CT and MRI appearances of temporal bone trauma and provides important points for evaluation. It includes a detailed analysis of the anatomy, pathophysiology of injuries, and associated complications.

Target Population: Patients with temporal bone trauma, including those with altered consciousness and severe bodily injury.

Key Factors: The document discusses the classification of temporal bone fractures, the importance of distinguishing true fractures from mimics, and the evaluation of complications

such as hearing loss, dizziness, facial nerve paralysis, and vascular injury. It emphasizes the use of multidetector CT with multiplanar reconstruction and the role of MRI in providing additional information.

ANALYSIS OF EVIDENCE

Analysis ^(1,9,22):

CT is consistently recognized as a valuable imaging modality across all three articles. Its high resolution and ability to provide detailed images of bone structures make it particularly useful in evaluating fractures, structural abnormalities, and lesions. However, the articles also highlight the complementary role of MRI, especially for soft tissue evaluation and detailed lesion characterization.

The use of contrast in CT imaging is another common theme, with all articles acknowledging its importance in enhancing lesion visibility and providing additional diagnostic information. The consideration of radiation exposure is also emphasized, particularly in the context of selecting the most appropriate imaging modality for specific clinical scenarios.

In summary, while the specific recommendations and clinical scenarios differ, the shared conclusions underscore the importance of CT in initial imaging and its complementary role alongside MRI. The differing conclusions highlight the tailored use of CT based on the condition being evaluated, with each article providing specific guidelines and recommendations for its use.

Shared Conclusions

- **Role of CT in Initial Imaging:** All three articles agree that CT is a valuable initial imaging modality for various conditions. CT is often used to evaluate structural abnormalities, fractures, and lesions due to its high resolution and ability to provide detailed images of bone structures.
- **Complementary Role of MRI:** Each article emphasizes that while CT is useful, MRI often provides complementary information, especially for soft tissue evaluation. MRI is preferred in cases where detailed soft tissue characterization is needed.
- **Use of Contrast:** The use of contrast in CT imaging is discussed across all articles. Contrast-enhanced CT can provide additional information, particularly in identifying vascular structures and enhancing lesion characterization.

POLICY HISTORY

Date	Summary
<u>July 2025</u>	<ul style="list-style-type: none"> ● <u>Added a Summary of Evidence and Analysis of Evidence</u>

Date	Summary
June 2025	<ul style="list-style-type: none"> ● This guideline replaces Evolent Clinical Guideline 006-1 for Temporal Bone, Mastoid, Orbits, Sella, Internal Auditory Canal CT ● Added in general information statement regarding guideline criteria development by reputable sources, standard of care, and best practices ● Clarified indications for complications of acute otitis media, hearing loss, vertigo, tinnitus, CSF otorrhea, and temporal bone trauma ● Added indications for refractory otitis externa and combo studies for cochlear implantation ● Updated language in the preoperative/postoperative section ● Segment added to combinations studies about if the required use of conscious sedation is needed the entire combination is indicated ● Applicable Line of Business adjusted – Medicare checked ● Updated and expanded references ● Reduced background
May 2024	<ul style="list-style-type: none"> ● Updated references and background ● Added CPT code +0722T to align with UM Matrix Codes ● Contraindications and preferred studies section added to the background ● Added pulsatile tinnitus with concern for osseous pathology of the temporal bone <i>or a retrotymppanic lesion seen on otoscopy</i>
April 2023	<ul style="list-style-type: none"> ● Updated references ● Added: <ul style="list-style-type: none"> ○ Note on congenital hearing loss ○ Section on further evaluation of indeterminate or questionable findings on prior imaging ○ General Information moved to beginning of guideline with added statement on clinical indications not addressed in this guideline ● Clarified: ● There should be a high suspicion of CSF leak or confirmatory

Date	Summary
	CSF fluid laboratory testing (Beta-2 transferrin assay)

LEGAL AND COMPLIANCE

Guideline Approval

Committee

Reviewed / Approved by Evolent Specialty Services Clinical Guideline Review Committee

Disclaimer

Evolent Clinical Guidelines do not constitute medical advice. Treating health care professionals are solely responsible for diagnosis, treatment, and medical advice. Evolent uses Clinical Guidelines in accordance with its contractual obligations to provide utilization management. Coverage for services varies for individual members according to the terms of their health care coverage or government program. Individual members' health care coverage may not utilize some Evolent Clinical Guidelines. Evolent clinical guidelines contain guidance that requires prior authorization and service limitations. A list of procedure codes, services or drugs may not be all inclusive and does not imply that a service or drug is a covered or non-covered service or drug. Evolent reserves the right to review and update this Clinical Guideline in its sole discretion. Notice of any changes shall be provided as required by applicable provider agreements and laws or regulations. Members should contact their Plan customer service representative for specific coverage information.

Evolent Clinical Guidelines are comprehensive and inclusive of various procedural applications for each service type. Our guidelines may be used to supplement Medicare criteria when such criteria is not fully established. When Medicare criteria is determined to not be fully established, we only reference the relevant portion of the corresponding Evolent Clinical Guideline that is applicable to the specific service or item requested in order to determine medical necessity.

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