APPENDIX to Screening for Lung Cancer Using CT Scanning or Chest Radiographs Policy

Prior Authorization Requirements

This service (or procedure) is considered **medically necessary** in certain instances and **investigational** in others (refer to policy for details).

For instances when the indication is **medically necessary**, clinical evidence is required to determine **medical necessity**.

For instances when the indication is **investigational**, you may submit additional information to the Prior Authorization Department.

Within five days before the actual date of service, the Provider MUST confirm with Blue Shield that the member's health plan coverage is still in effect. Blue Shield reserves the right to revoke an authorization prior to services being rendered based on cancellation of the member's eligibility. Final determination of benefits will be made after review of the claim for limitations or exclusions.

Questions regarding the applicability of this policy should also be directed to the Prior Authorization Department. Please call 1-800-541-6652 or visit the Provider Portal www.blueshieldca.com/provider.

Evidence Basis for the Policy

Rationale

According to the National Cancer Institute (NCI), in 2011 alone, it is estimated "221,130 men and women (115,060 men and 106,070 women) will be diagnosed with and 156,940 men and women will die of cancer of the lung and bronchus." Thus, there is interest in screening and early identification of lung cancer because the disease, when identified clinically, tends to have a poor prognosis. Chest x-ray and sputum cytology are commonly used for lung cancer screening. However, there is insufficient evidence these methods reduce mortality from lung cancer (Patz et al., 2000; Alberts et al., 2007; Bach et al., 2007; NCI, 2011). Other proposed screening methods are computer-aided detection or diagnosis (CAD) technology with chest radiographs and low-dose computed tomography (CT) scans.

Due to biases inherent in screening studies, high-quality, randomized trials that evaluate reduction in lung cancer morbidity and mortality are required to demonstrate the efficacy of screening. While survival from time of screening is commonly reported in screening

trials, the apparent increase in survival may be confounded by one or more biases associated with screening:

- Lead-time bias: Lead time refers to the length of time between when a cancer is detected by screening and when the first signs or symptoms would have appeared. If screening identifies lung cancer earlier, survival could be longer due to the lead time rather than because of effective early treatment.
- Length-time bias: This bias refers to the greater likelihood that screening will detect slow-growing indolent cancers (which take longer to become symptomatic) than faster-growing, more aggressive cancer. Patients with screen-detected cancer may appear to live longer because the cancers are more indolent.
- Overdiagnosis: This bias occurs when screening identifies non-lethal cancer (sometimes called pseudodisease). When this type of cancer is identified and removed, the patient appears to have benefited from screening, although the cancer would not have been fatal if left undetected.

The following is a summary of the literature on screening for lung cancer using CAD technology with chest radiography or low-dose CT scanning.

Computer-Aided Detection or Diagnosis of Chest Radiographs

Computer-aided detection or diagnosis has become a principal research area in diagnostic radiology. Cancer nodules can be small or subtle and difficult to identify through chest x-rays alone. Computer-aided detection software in tandem with standard chest x-ray may increase the sensitivity of chest x-rays. The CAD software analyzes digital chest x-ray images for regions that resemble lung lesions and nodules. In March 2001, the United States Food and Drug Administration (FDA) approved the RapidScreen® RS-2000 system (Deus Technologies, LLC, Rockville, MD) as a CAD system intended to identify and mark regions of interest on digitized chest radiographs. Presently, there are two diseases for which the FDA has given premarket approval for CAD systems: 1) detection of breast cancer (adjunct to mammography) and 2) detection of signs consistent with lung cancer on chest radiographs. It should be noted the FDA labeling regarding the RapidScreen CAD system advised "The device is of little value when used for patients who are not at high-risk for lung cancer." Currently, the OnGuard™ CAD System, (Riverain Medical®, Dayton, OH) is the only FDA-approved CAD system with a Product Device Description of "Analyzer, Medical Image" for chest x-rays (Product Code MYN). The Philips xLNA (x-ray lung nodule assessment) or Philips CAD Chest System (Philips Medical Systems, Hamburg, Germany) uses the IQQA® Chest Software Package (EDDA Technology, Princeton Junction, NJ) under the Product Device Description of Picture Archiving and Communications System. This system uses real-time interactive pulmonary nodule analysis for chest digital radiographic image softcopy reading and is intended to be employed during the review of digital chest radiographic images. According to the manufacturer, the IQQA software "is designed to support the physician in the identification of lung lesions, as well as the confirmation, evaluation and documentation of such physician-identified lesions." Various detection software systems and algorithms have been discussed in the literature (Schilham et al., 2005; Shraishi et al., 2007; Hardie et al., 2008). However, it is uncertain whether other CAD systems are seeking FDA approval for lung cancer detection on chest x-ray.

Early published literature regarding CAD for chest x-rays consisted primarily of technical capabilities of CAD systems (Freedman et al., 2002; Freedman, 2004; Kakeda et al., 2004). More recently, a retrospective study identified chest x-rays with missed cancerous nodules and evaluated them with the OnGuard 3.0™ CAD system (White et al., 2009). Computer-aided detection correctly marked overlooked nodules in 46 of 89 (52%) patients, and there was a mean of 3.9 false-positive results per image. The study only included radiographs of lung cancer patients; CAD was not evaluated for screening. De Boo and colleagues (2009) advised detection of focal pulmonary lesions was limited by quantum and anatomical noise and highly influenced by variable perception capacity of the reader. Multiple studies have shown that the detection performance can be improved using CAD especially for less experienced readers at a variable amount of decreased specificity. There was a substantial learning process, for both the experienced and inexperienced readers to be able to optimally differentiate between false-positive and true-positive lesions and adequately trust in the systems' capabilities in order to use them at their full advantage. The authors concluded further research was needed to evaluate the performance of these systems "in clinical routine and to determine the trade-off between performance increase in terms of increased sensitivity and decreased inter-reader variability and loss of specificity and secondary indicated follow-up examinations for further diagnostic workup."

A retropective study by Szucs-Farkas and colleagues (2010) evaluated the performance of a CAD program for the detection of pulmonary nodules in original and energy-subtracted (ES) chest x-rays with special regard to the number of false-positives. The results were compared with the findings by human observers and CT was used as the reference standard. Eighty-three patients were included in the study; 58 with pulmonary nodules and 25 control subjects without nodules. Computer-aided detection results were compared to the five reader's findings. Computer-aided detection performed with ES images produced significantly fewer false-positives than with non-subtracted images (1.75 and 2.14 false-positives per image; $p = 0.029$). The authors concluded depending on the reader's experience, CAD detected between 11 and 21 nodules missed by readers. The human observers found three to 16 lesions missed by the CAD software. Another retrospective study, conducted in Europe, evaluated chest radiographs from 46 individuals who had histologically proven lung cancer and 65 control patients who had no nodules larger than 5 millimeters (mm) in diameter identified at a CT screening that occurred within six weeks of the x-ray (de Hoop et al., 2010). Each radiograph was evaluated without and then with CAD findings using the OnGuard CAD system. Computer-aided detection was not found to improve observer performance. The average sensitivity of the reviewers (two radiologists and four residents) was similar without (49%) and with (51%) use of the CAD system. Observers correctly identified 27 lesions without CAD and with CAD assistance three additional malignancies were identified.

The United States Preventative Services Task Force (USPSTF, 2004) and the NCI (2010) advised screening for lung cancer with chest x-ray and/or sputum cytology did not reduce mortality from lung cancer and that screening could lead to false-positive tests and unnecessary invasive diagnostic procedures and treatments. Computer-aided detection technology was not discussed in these statements. The National Comprehensive Cancer Network (NCCN, 2011) Guidelines for Detection, Prevention, and Risk Reduction for

lung cancer screening (Version 1.2012) did not mention screening with chest radiographs or the use of CAD technology.

In summary, there is insufficient evidence to determine whether CAD technology may improve the accuracy of chest x-ray interpretation. The published literature regarding CAD for chest x-rays consists primarily of technical capabilities or CAD systems and no studies were identified where a CAD system for chest x-rays was specifically used as a screening tool (Freedman et al., 2002; Freedman, 2004; Kakeda et al., 2004). Comparison of chest x-ray CAD results to a second radiologist opinion or CT results are needed to establish CADs clinical value. High-quality, randomized controlled trials (RCTs) that examine the effect of screening on lung cancer morbidity and mortality are necessary to determine the true impact of this technology on meaningful health outcomes. Therefore, the use of CAD technology with chest x-ray for lung cancer screening is considered investigational.

Low-Dose Spiral Computed Tomography

In February 2004, the FDA approved the ImageChecker® CT Lung CAD system (R2 Technology, Inc., Sunnyvale, CA) as a technique to assist in the detection of lung nodules on multidetector CT scans of the chest. The R2 Technology ImageChecker also received FDA clearance for the Temporal Comparison software module in June 2004 and for the CT-LN 1000 in July 2004. The Temporal Comparison software module provides the ability to automatically track lung nodule progression or regression over time. The ImageChecker CT-LN 1000 is used for the detection of solid nodules in the lungs. Other systems that have been developed include iCAD's Second Look CT lung (iCAD, Inc., Nashua, NH) and the syngo® LungCARE CT (Siemens Medical Solutions, Erlangen, Germany).

Findings from a large United States (U.S.) RCT, the National Lung Screening Trial (NSLT), evaluating the impact of screening with low-dose CT on lung cancer morbidity and mortality, were published in 2011 (NLST Research Team; Aberle et al., 2011). In addition, several smaller European RCTs are ongoing. Following are descriptions of the major randomized trials:

National Lung Screening Trial

The NLST trial, sponsored by the National Institutes of Health, was launched in 2002. By April 2004, there were 53,454 current or former smokers from 33 sites in the U.S.that had been randomly assigned to screening in three consecutive years with either a chest x-ray or low-dose spiral CT. Study eligibility included being between the ages of 55 and 74 years of age, having a history of cigarette smoking of at least 30 pack-years and for former smokers, quitting within the past 15 years. Individuals with a previous diagnosis of lung cancer or who had signs and/or symptoms suggestive of lung cancer were excluded. There was no study-wide diagnostic follow-up algorithm; individuals who had positive test findings were managed according to protocols at their local center. A total of 95% of participants in the low-dose CT group and 93% in the radiography group adhered to the screening protocol. In October 2010, the independent safety and monitoring board determined sufficient data were available to conclude there was a statistically significant reduction in the primary outcome, lung cancer mortality. Consequently, the trial was

terminated and study results that occurred through December 31, 2009 were analyzed and reported.

During a median 6.5-year follow-up, a total of 356 of 26,722 (1.33%) participants in the low-dose CT group and 443 of 26,732 (1.66%) participants in the radiography group died of lung cancer, representing a relative risk reduction of 20% (95% confidence interval [CI]: 6.8% to 26.7%, p = 0.004). Using intention-to-treat analysis, the absolute risk reduction was 0.33% and the number needed to screen for three years with a low-dose CT to prevent one death from lung cancer was 303. The authors reported a number needed to screen of 320 based on per-protocol data from participants who underwent at least one screen (p. 403).

Overall mortality, a secondary outcome, was also significantly reduced in the low-dose CT screening group. There were a total of 1,877 deaths (7.0%) in the low-dose CT group and 2,000 (7.5%) deaths in the radiography group-relative risk reduction 6.7% (95% CI: 1.2% to 13.6%, p = 0.02); absolute risk reduction of 0.46% and the number needed to screen of 219 (95% CI: 111 to 5556).

Over all three screenings, the frequency of positive tests was 24.2% in the low-dose CT group and 6.9% in the radiography group. Of these, 17,497 of 18,146 (96.4%) participants in the low-dose CT group and 4,764 of 5,043 (94.5%) in the radiography group were false-positives. The remaining 649 tests (3.6% of total positive tests) in the low-dose CT scan group and 279 (5.5% of total positive tests) in the radiography group were confirmed lung cancers. During the screening phase, a total of 39.1% of participants in the low-dose CT group and 16.0% of those in the radiography group had at least one positive screening test.

During follow-up, 1,060 lung cancers were identified in the low-dose CT group and 941 lung cancers were identified in the radiography group. The difference in the cancer rates between groups was statistically significant, with a rate ratio of 1.13 (95% CI: 6.8 to 26.7, p = 0.004) (p. 400). In addition to the screen-detected cancers, 44 cancers in the low-dose CT group and 137 in the radiography group were diagnosed after a negative screen. Three-hundred sixty-seven cancers in the low-dose CT group and 525 cancers in the radiography group were diagnosed among participants who either missed screening or who had completed their three screenings.

Cancer stage was reported for cancers with a known stage; 1,040 in the low-dose CT group and 929 in the radiography group. Of the 1,040 confirmed lung cancers in the low-dose CT group, 416 (40%) were stage IA and 104 (10%) were stage IB. Over half of the confirmed lung cancers identified by a positive screen (329 of 635; 52%) were stage IA. In the radiography group, 90 of 275 confirmed cancers identified by a positive screen (32.7%) were stage IA.

Additional research assessed the radiation risks associated with low-dose CT screening based on the protocol used in the NLST (Brenner, 2004). The estimated doses from low-dose CT screening were 5.2 milligray (mGy) + 0.9 to the lung; this would be equivalent to at least 250 standard chest x-rays. Brenner concluded the radiation-related lung cancer risks for a single examination at age 55 ranges from approximately one per 10,000 to approximately five per 10,000, depending on gender and whether the person was a current or former smoker. The study estimated there would be a 1.8% increase (CI: 0.5%

to 5.5%) in the number of lung cancers associated with radiation from screening if 50% of all current and former smokers in the U.S. aged 50 to 75 years received annual CT screening. The risks of screening could be reduced by scanning less frequently or beginning screening at a later age.

In summary, the NLST was a large well-conducted trial. It found a statistically significantly lower rate of lung cancer mortality with three annual CT screens compared to chest radiographs; the number needed to screen to prevent one lung cancer death was 320 (95% CI: 193 to 934). The study also found a statistically significant but modestly lower overall mortality in low-dose CT group. There was a high rate of follow-up imaging tests but relatively low rates of invasive tests. Few major complications were reported after invasive testing, although major complications that did occur were not well characterized. The rates of other potential complications, in particular radiation-induced cancers, are not yet known. Findings of the trial cannot be generalized to other populations (e.g., younger individuals or lighter smokers). The NSLT evaluated the utility of a series of three annual CT screens; the efficacy of other screening regimens is not known.

Several smaller European trials that evaluate spiral CT screening are ongoing. Findings may ultimately be pooled with those from other RCTs in Europe and the U.S. Each study includes a somewhat different screening population and screening regimen.

Danish Lung Cancer Screening Trial

Between 2004 and 2006, a total of 4,104 current or former smokers were randomized to screening with annual low-dose CT for five years or no screening; lung cancer mortality was the primary outcome measure (Pedersen et al., 2009). Among the 2,052 individuals who received baseline CT scans, 179 (8.7%) had positive findings; a large proportion of these findings (162 of 179, 91%) were false-positive. Seventeen individuals (0.8%) were found to have lung cancer; 10 cases were stage I disease.

Detection and Screening of Early Lung Cancer by Novel Imaging Technology and Molecular Essays (DANTE) Trial

This trial, conducted in Italy, randomly assigned 2,811 male current or former smokers to receive five yearly spiral CT screening exams or physical examination alone (Infante et al., 2008). All participants had baseline chest radiographs. The study was initiated in 2001 and recruitment was completed in 2006. Three-year findings were published in 2009 (Infante et al., 2009). After a median of 33 months' follow-up, significantly more lung cancer was detected in the CT screening group compared to control (4.7% versus 2.8%, respectively, $p = 0.016$). More stage I disease was detected by CT screening; the rate of advanced lung cancer detection was similar in the two groups. The authors advised lung cancer screening by spiral CT should not be proposed outside research programs.

ITALUNG Trial

Another Italian study randomly assigned 3,206 current or former smokers to receive four yearly low-dose CT scans or no screening (Lopes et al., 2009). Participants will be followed up by cancer registry for lung cancer incidence and mortality and contacted by telephone four years after randomization. At baseline, 1,406 underwent CT screening and

426 (30%) tested positive (nodule at or greater than 5 mm). Twenty individuals were found to have lung cancer; 406 of 426 (95%) of positive screens were false-positive.

Netherlands-Leuvens Longkanger Screenings Onderzoek (NELSON) Trial

This study, conducted in the Netherlands and Belgium, randomly assigned current or former smokers to CT screening or no screening (van Iersel et al., 2007; van Klaveren et al., 2009). The screening intervention consisted of a CT scan at baseline then one and three years after baseline. Recruitment occurred between 2004 and 2006. Of the 7,557 participants who underwent the first round of screening, 196 (2.6%) had positive scans and 177 (2.3%) were referred for work-up. Seventy of the 177 were diagnosed with lung cancer; this represents 39.5% of participants worked up after a positive scan and 0.9% of screened individuals. The 70 individuals had 72 lung cancers; 46 (64%) of these were classified as stage I. The primary outcome of the trial is lung cancer mortality reduction after 10 years. This trial differs from the NLST trial in that the control arm will not receive x-rays or screenings and the two annual incidence screens will occur at one year versus three years after the first prevalence screen (Black, 2007).

A total of 1,466 participants in the NELSON trial participated in a related quality-life-study; 733 were randomized to the screening arm and 733 to the control arm (van den Bergh et al., 2011). They were given questionnaires before randomization, two months after the first screening round, and two years after baseline (six months after the second screening round). The questionnaire response rate was 1,288 (88%) at baseline and 931 (79%) two years later. No statistically significant differences between the screened and control groups were found in scores on any quality of life measures at two years. The authors interpreted this finding as suggesting that lung cancer screening did not negatively impact quality of life.

In addition to the RCTs described above, a large observational study, by the International Early Lung Cancer Action Program (I-ELCAP), received attention in 2006. The publication reported results from 31,657 patients who underwent a baseline and then annual CT scan for detection of lung cancer. The study included smokers and former smokers; approximately 10% of the population included individuals with occupational or secondhand exposure to smoke. Of the 31,567 participants who had a baseline examination, 4,186 (13%) had a positive result that required further workup. A diagnosis of lung cancer was found in 484 patients (1.53%); 412 of 2,834 (85%) were stage I cancer. The majority of lung cancers (405 of 484) were found during the baseline evaluation. A total of 535 patients underwent biopsies during the study. Of the biopsies from patients with clinical stage I cancer, 14% were squamous cell and 71% were adenocarcinoma. The 10-year survival rates were estimated, although approximately 20% of participants had follow-up completed beyond five years. The estimated 10-year survival rate of individuals diagnosed with lung cancer was 88% (CI: 84% to 91%). While these results were encouraging for the number of cases identified with stage I disease, they did not indicate CT screening improved health outcomes due to lack of a comparison group and potential biases such as lead time, length time, and overdiagnosis. Moreover, there was a high rate of false-positives, approximately 11.5% of the screened population (Croswell et al., 2010).

The USPSTF Guide to Clinical Preventive Services 2010-2011 advised there was insufficient evidence to recommend for or against screening asymptomatic persons for lung cancer with low-dose CT, chest x-ray, sputum cytology, or a combination of these tests due to poor evidence that screening would reduce lung cancer mortality rates (USPSTF, 2004).

A statement by the American Cancer Society (ACS), updated in July 2011, stated no major professional organization, including the ACS, recommended routine lung cancer screening. However, the statement also acknowledged that as results of the NSLT are further analyzed, some organizations may update their recommendations. As of September 2011, the ACS created interim guidance for people and their doctors regarding the use of low-dose CT scans for the early detection of lung cancer, until a complete evaluation of the evidence was completed. The interim guidance document stated:

- Adults between the ages of 55 to 74 who meet the eligibility criteria of the NLST and are concerned about their risk of lung cancer may consider screening for early lung cancer detection with their physician or other primary provider. Individuals interested in screening should weigh the currently known benefits of low-dose CT screening with the currently known limitations and risks and make a shared decision as to whether they should be screened for lung cancer. Physicians who are concerned about the risk of lung cancer in their patients who meet NLST entry criteria may choose to initiate a discussion about lung cancer screening.
- At this time, adults who do not meet the NLST entry criteria should be informed that there is uncertainty regarding the balance of benefits and harms for individuals at younger ages and/or with less lifetime exposure to tobacco smoke and therefore screening is not recommended. This is especially the case among individuals with no smoking history. Although some individuals diagnosed with lung cancer were never smokers, and there has been interest in offering never smokers an early detection option, at this time the net balance of potential harms to benefits from screening in this group is estimated to be extremely unfavorable. The issue of broadening appropriateness criteria will be addressed during the guidelines process as more data become available.
- Adults who choose to be screened should follow the NLST protocol of annual screening.
- Adults who choose to undergo lung screening should enter an organized screening program at an institution with expertise in low-dose CT screening, with access to a multidisciplinary team skilled in the evaluation, diagnosis, and treatment of abnormal lung lesions. Referring physicians should help their patients identify settings with this expertise.
- There is always benefit to smoking cessation. Active smokers entering a screening program should be vigorously urged to enter a smoking cessation program. Screening should not be viewed as an alternative to smoking cessation.

The NCCN Guidelines for non-small cell lung cancer (Version 2.2012) advised lung cancer screening by low-dose CT decreases lung cancer mortality in certain high-risk individuals (age > 55 years and smoking >/= 30 pack/years). The NCCN guidelines for Lung Cancer Screening (Version 1.2012) recommended annual low-dose CT screening for three years and until age 74 for those patients with no lung nodule(s) found on

baseline low-dose CT. Additionally, the guidelines stated, "There is uncertainty about the appropriate duration of screening and the age at which screening is no longer appropriate."

In summary, the evidence on CT screening for lung cancer includes numerous RCTs that report on yield and stage of screening and one RCT that reports on clinical outcomes. The largest RCT, the NLST, was a multicenter trial published in 2011. This was a high-quality trial that reported a decrease in both lung cancer mortality and overall mortality in a high-risk population screened with three annual low-dose CT scans compared to chest radiographs. Thus, screening for lung cancer with low-dose CT may be considered medically necessary for high-risk patients who meet the major eligibility criteria of the NLST and investigational otherwise.

Benefit Application

Specific contractual exclusions for screening tests may also affect coverage eligibility for CT scanning as a screening test for lung cancer.

Benefit determinations should be based in all cases on the applicable contract language. To the extent there are any conflicts between these guidelines and the contract language, the contract language will control. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage of these services as it applies to an individual member.

Some state or federal mandates (e.g., Federal Employee Program (FEP)) prohibit Plans from denying Food and Drug Administration (FDA) - approved technologies as investigational. In these instances, plans may have to consider the coverage eligibility of FDA-approved technologies on the basis of medical necessity alone.

This Policy relates only to the services or supplies described herein. Benefits may vary according to benefit design; therefore, contract language should be reviewed before applying the terms of the Policy. Inclusion or exclusion of a procedure, diagnosis or device code(s) does not constitute or imply member coverage or provider reimbursement Policy

Type	Number	Description
CPT	0174T	Computer-aided detection (CAD) (computer algorithm analysis of digital image data for lesion detection) with further physician review for interpretation and report, with or without digitization of film radiographic images, chest radiograph(s), performed concurrent with primary interpretation (List separately in addition to code for primary procedure)

Type	Number	Description
	0175T	Computer-aided detection (CAD) (computer algorithm analysis of digital image data for lesion detection) with further physician review for interpretation and report, with or without digitization of film radiographic images, chest radiograph(s), performed remote from primary interpretation
	71250	Computed tomography, thorax; without contrast material
	71260	Computed tomography, thorax; with contrast material(s)
	71270	Computed tomography, thorax; without contrast material, followed by contrast material(s) and further sections
HCPC	S8092	Electron beam computed tomography (also known as ultrafast CT, cine CT)
ICD9 Procedure		
	87.41	Computerized axial tomography of thorax
ICD9 Diagnosis	All Diagnoses	
Place of Service	All Places of Service	

Tables

N/A

Definitions

Screening - The periodic testing of asymptomatic individuals in the general population to detect previously unrecognized conditions. Screening is distinct from surveillance, which is aimed at subpopulations of high-risk groups (e.g., smokers, occupational groups) and monitoring, which is follow-up of individuals with a known medical condition.

Index / Cross Reference of Related BSC Medical Policies

The following Medical Policies share diagnoses and/or are equivalent BSC Medical Policies:

N/A

Key / Related Searchable Words

- Computed tomography lung
- Computed tomography thorax
- CT lung
- CT thorax
- Helical CT
- Lung cancer
- Spiral CT

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Policy History

This section provides a chronological history of the activities, updates and changes that have occurred with this Medical Policy.

Effective Date	Action	Reason
4/5/2007	New Policy Adoption	Medical Policy Committee
4/3/2009	Policy name change Combined the following policies: • Electron Beam Computed Tomography (EBCT) for Detection and Evaluation of Coronary Artery Calcium Measurement Contrast-Enhanced Computed Tomography Angiography (CCTA) for Coronary Artery Evaluation	Medical Policy Committee
8/28/2009	Policy Revision	Administrative Review
4/21/2011	Coding update	Administrative Review
1/6/2012	Policy title change from Computer Aided Detection (CAD) of Chest Radiographs and CT Scanning for Lung Cancer Screening with position change	Medical Policy Committee
5/3/2013	Coding update	Administrative Review

The materials provided to you are guidelines used by this plan to authorize, modify, or deny care for persons with similar illness or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under your contract. These Policies are subject to change as new information becomes available.

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