Description

There is interest in screening and early identification of lung cancer because the disease, when identified clinically, tends to have a poor prognosis. Two proposed screening methods are chest radiographs and low-dose computed tomography (CT) scans. Due to biases inherent in screening studies, randomized trials that evaluate reduction in lung cancer morbidity and mortality are required to demonstrate the efficacy of screening.

Related Policies

- N/A

Policy

Policy

Low-dose computed tomography (CT) scanning, no more frequently than annually, may be considered medically necessary as a screening technique for lung cancer in individuals who meet ALL of the following criteria*:

- Between 55 and 80 years of age (see Policy Guidelines sections)
- History of cigarette smoking of at least 30 pack-years
- If former smoker, quit within the previous 15 years

* Patient selection criteria are based on the National Lung Screening Trial (NLST) and the U.S. Preventive Services Task Force (USPSTF) 2013 recommendation.

Low-dose CT scanning is considered investigational as a screening technique for lung cancer in all other situations.

Policy Guidelines

Policy Guidelines

This policy does not apply to individuals with signs and/or symptoms of lung disease. In symptomatic individuals, a diagnostic workup appropriate to the clinical presentation should be undertaken, rather than screening.

Computed Tomography (CT) Scanning

Although there is no specific CPT code for spiral or electron-beam CT scanning, CPT code 71250 (computerized axial tomography, thorax) may be used. Thus the distinction between medically necessary CT scans of the thorax and spiral or electron beam CT...
Medical Policy

Scans as a screening test cannot be based on CPT code alone. ICD-9 code V76.0 is defined as special screening for malignant neoplasms of the respiratory organs. Thus, when used in conjunction with CPT code 71250, these codes may identify spiral or electron beam CT scanning as a screening test for lung cancer.

The upper age limit for screening differs among the screening guidelines. National organizations’ recommendations regarding the upper age limit for screening are as follows:

USPSTF 2013 Recommendation (1,2):
80-years old (based on analysis evaluating 5 independent microsimulation models)

National Comprehensive Cancer Network (NCCN) 2014 guideline(3):
74-years old (based on NLST)

American College of Chest Physicians (ACCP) and American Society of Clinical Oncology (ASCO) 2012 joint statement(4):
74-years old (based on NSLT)

American Association for Thoracic Surgery (AATS) 2012 guideline(5):
79-years old (based on several factors including that the average life expectancy is 78.6 years and that age is a risk factor for lung cancer)

American Cancer Society (ACS) 2013 guideline(6):
74-years old (based on NSLT)

Screening Setting

The national organizations with recommendations on lung cancer screening all include a recommendation that the low-dose CT screening of eligible patients occurs in settings that use a multidisciplinary approach and involve participation of a subspecialty qualified medical team.

Chest Radiographs

Evidence from randomized controlled trials does not support the use of chest radiography as a screening technique for lung cancer. Chest radiography and sputum cytology are not considered to be valid methods for lung cancer screening at the present time.

Effective in January 2007, there are 2 category III codes to specifically denote when CAD is performed at the time of the reading of the chest radiograph or at some other time:

- 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) (Use 0174T in conjunction with 71010, 71020, 71021, 71022, 71030).
- 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 (Do not report 0175T in conjunction with 71010, 71020, 71021, 71022, 71030).
**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.

**Rationale**

**Background**

Given the poor prognosis of lung cancer, there has been longstanding research interest in developing screening techniques for those at high risk. Previous studies of serial sputum samples or chest radiographs failed to demonstrate that screening improved health outcomes. More recently, there has been interest in low-dose CT scanning as a screening technique, using either spiral (also referred to as helical) or electron beam (also referred to as ultrafast) CT scanning. Compared with conventional CT scans, these scans allow for the continuous acquisition of images, thus shortening the scan time and radiation exposure. A complete CT scan can be obtained within 10 to 20 seconds, or during 1 breath hold in most patients. The radiation exposure for this examination is greater than for that of a chest radiograph but less than for a conventional CT scan.

There are also growing applications of computer-aided detection or diagnosis (CAD) technologies that may have an impact on the use of CT scanning or chest radiographs for lung cancer screening. Computer-aided detection points out possible findings to the radiologist who then decides if the finding is abnormal. Computer-aided detection uses a computer algorithm to analyze features of a lesion to determine the level of suspicion and is intended to enhance the reader's diagnostic performance. Both of these technologies may be expected to offer more benefit when used by relatively inexperienced readers and may help to standardize diagnostic performance.

**Regulatory Status**

In March 2001, the U.S. Food and Drug Administration (FDA) approved the RapidScreen™ RS-2000 system as a CAD system intended to identify and mark regions of interest on digitized chest radiographs. In February 2004, FDA approved the R2 Technology ImageChecker® CT system 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 and Siemens' syngo® LungCARE CT.
Rationale

An initial literature search was performed in 2001. The policy was updated regularly with a literature review using MEDLINE; most recently, the literature was searched for the period November 2012 through January 22, 2014. Following is a summary of the literature on screening for lung cancer with chest radiographs or low-dose CT scanning.

High-quality, randomized trials that examine the effect of screening on lung cancer morbidity and mortality are necessary to determine the true impact of this technology on health outcomes. 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 nonlethal 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.

Chest Radiographs

Several randomized trials of chest radiograph as a screening technique were published in the 1980s. The studies found that, although patients undergoing screening with chest radiograph had a higher incidence of earlier stage lung cancers, more resectable lung cancer, and improved 5-year survival rate compared with the control group, there were no statistically significant differences in mortality attributable to lung cancer between the 2 groups. (7)

Findings from an additional randomized controlled trial (RCT) that evaluated the effectiveness of screening with chest radiographs, the Prostate, Lung, Colorectal and Ovarian (PLCO) cancer screening trial, have recently been published. Enrollment for the study was completed in 2001. (8) Approximately 155,000 individuals were randomly assigned to receive selected screening interventions, including chest radiographs, or usual care. Smokers received chest radiographs at baseline and annually for 3 years; never-smokers were screened at entry and annually for 2 years. Baseline results were reported in 2005. Of the 77,465 patients randomly assigned to the intervention arm, 5991 (8.9%) radiographs were suspicious for lung cancer. Of these, 206 patients underwent biopsy, and 126 cancers were diagnosed. Among these cancers, 44% were stage I. Rates of lung cancer for the initial screening ranged from 0.63% for current smokers to 0.04% in nonsmokers. Results of subsequent screenings were published in 2010. (9) Positivity rates were 7.1%, 6.6%, and 7.0%, respectively, for the first, second, and third yearly follow-up chest radiographs. Over the entire screening period, 18.5% of screened individuals had at least 1 positive screen. In 2011, the investigators published the main outcome data related to lung cancer screening. (10) The rate of lung cancer mortality did not differ significantly in the 2 groups. Over 13 years of follow-up, there were a total of 1213 lung cancer deaths in the intervention group and 1230 lung cancer deaths in the usual care group. Cumulative lung cancer mortality rates (per 10,000 person-years of observation)
were 14.0 in the intervention group and 14.2 in the control group (rate ratio [RR], 0.99; 95% confidence interval [CI], 0.87 to 1.22). There was also no benefit of screening with chest radiographs when the analysis was limited to individuals who met criteria for the NLST (discussed in a subsequent section of the policy). In this subset of study participants (n=30,321), there were 316 lung cancer deaths in the intervention group and 334 lung cancer deaths in the usual care group (RR=0.94; 95% CI, 0.81 to 1.10). The authors concluded that annual screening with chest radiographs did not reduce lung cancer mortality compared with usual care.

A 2013 Cochrane review of evidence on lung cancer screening identified only 1 trial comparing screening with chest radiographs to no screening; this was the PLCO trial, previously described. The Cochrane review identified 5 RCTs comparing more intensive screening with chest radiographs (with or without sputum cytology) to less intensive screening. A pooled analysis of data from 4 of these studies did not find a statistically significant difference in the risk of mortality with more intensive versus less intensive screening.

**CAD**

CAD may increase the sensitivity of chest radiographs. An RCT evaluating CAD-assisted chest radiography was published by Mazzone et al in 2013. The study included individuals between the ages of 40 and 75 years who (1) were a current or former smoker with at least a 10 pack-year history or; (2) had a first-degree relative with a history of lung cancer or; (3) had a diagnosis of chronic obstructive pulmonary disorder (COPD). A total of 1424 individuals were randomized, 710 to 3 annual CAD chest radiography screenings and 713 to placebo screening. The placebo intervention consisted of having patients stand as though they were receiving a chest radiograph, but no radiograph was taken. The primary study end point was development of symptomatic advanced stage lung cancer. After adjudication, 3 symptomatic advanced lung cancer events were identified, all in the control group. The number of events was too small for a meaningful statistical analysis of differences in primary outcome.

Several previous studies evaluated whether CAD improves diagnostic accuracy. For example, a 2010 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 mm in diameter identified at a CT screening that occurred within 6 weeks of the radiograph. Each radiograph was evaluated without and then with CAD findings; the OnGuard CAD system was used. CAD was not found to improve observer performance. The average sensitivity of the reviewers (2 radiologists and 4 residents) was similar without (49%) and with (51%) use of the CAD system. Observers correctly identified 27 lesions without CAD, and with CAD assistance, 3 additional malignancies were identified.

In addition, in 2009, a retrospective study identified radiographs with missed cancerous nodules and evaluated them with a CAD system (OnGuard 3.0, Riverain Medical). CAD correctly marked overlooked nodules in 46 of 89 (52%) patients, and there was a mean of 3.9 false positive results per image.

**Low-Dose Spiral CT**

RCTs

Findings from a large RCT in the United States that evaluated the impact of screening with low-dose CT on lung cancer morbidity and mortality, NLST, were published in 2011. In addition, several smaller European RCTs are ongoing. There is insufficient evidence to determine whether CAD technology may improve the accuracy of CT scanning.
interpretation. (15, 16) Following are descriptions of the major randomized trials evaluating CT screening:

**National Lung Screening Trial:**

The National Lung Screening trial sponsored by the National Institutes of Health was launched in 2002. (3) By April 2004, a total of 53,454 current or former smokers from 33 sites in the United States had been randomly assigned to screening in 3 consecutive years with either a chest radiograph or low-dose spiral CT. Study eligibility included age between 55 and 74 years, 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 that sufficient data were available to conclude that 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% 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 (NNS) for 3 years with a low-dose CT to prevent 1 death from lung cancer was 303. The authors reported an NNS of 320 based on per-protocol data from participants who underwent at least 1 screen. Overall mortality, a secondary outcome, was also significantly reduced in the low-dose CT screening group. There were a total of 1877 deaths (7.0%) in the low-dose CT group and 2000 deaths (7.5%) 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 NNS of 219 (95% CI, 111 to 5556).

Overall 3 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%) in the low-dose CT group and 4764 of 5043 (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 1 positive screening test.

During follow-up, 1060 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). 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. A total of 367 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 3 screenings.

Selected data from Table 3 of the August 2011 publication (3) on rates of follow-up diagnostic procedures after a positive screening result in the NSLT are shown next. Data represent all 3 screening rounds and include only cases for which diagnostic information is complete (over 97% of cases).
### Table 3

<table>
<thead>
<tr>
<th>Imaging exam</th>
<th>Low-Dose CT (N=17,702), n (% of total sample)</th>
<th>Chest Radiography (N=4953), n (% of total sample)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chest radiography</td>
<td>10,246 (57.9)</td>
<td>3884 (78.4)</td>
</tr>
<tr>
<td>Chest CT</td>
<td>2547 (14.4)</td>
<td>1613 (32.6)</td>
</tr>
<tr>
<td>FDG PET/PET-CT</td>
<td>8807 (49.8)</td>
<td>3003 (60.6)</td>
</tr>
<tr>
<td>Percutaneous cytologic exam or biopsy</td>
<td>1471 (8.3)</td>
<td>397 (8.0)</td>
</tr>
<tr>
<td>Bronchoscopy</td>
<td>322 (1.8)</td>
<td>172 (3.5)</td>
</tr>
<tr>
<td>Surgical procedure</td>
<td>671 (3.8)</td>
<td>225 (4.5)</td>
</tr>
<tr>
<td>Mediastinoscopy or mediastinotomy</td>
<td>713 (4.0)</td>
<td>239 (4.8)</td>
</tr>
<tr>
<td>Thoracoscopy</td>
<td>117 (0.7)</td>
<td>55 (1.1)</td>
</tr>
<tr>
<td>Thoracotomy</td>
<td>234 (1.3)</td>
<td>53 (1.1)</td>
</tr>
<tr>
<td></td>
<td>509 (2.9)</td>
<td>184 (3.7)</td>
</tr>
</tbody>
</table>

CT: computed tomography; FDG: fluorodeoxyglucose; PET: positron emission tomography.

Selected data from Table 4 of the August 2011 publication on complication rates after the most invasive screening-related diagnostic procedures are shown next. The data are from all 3 screening rounds and include only cases for which diagnostic information is complete (over 97% of cases). The frequencies of each major complication were not reported; rather the article included the total number of patients with any major complication. (Percent of total sample was calculated.)

### Table 4

<table>
<thead>
<tr>
<th>Lung cancer confirmed</th>
<th>Low-Dose CT, n (% of total sample)</th>
<th>Chest Radiography, n (% of total sample)</th>
</tr>
</thead>
<tbody>
<tr>
<td>At least 1 complication</td>
<td>649 (3.7)</td>
<td>279 (5.2)</td>
</tr>
<tr>
<td>At least 1 major complication</td>
<td>184 (1.0)</td>
<td>65 (1.3)</td>
</tr>
<tr>
<td>Death within 60 days after invasive diagnostic procedure</td>
<td>75 (0.4)</td>
<td>24 (0.5)</td>
</tr>
<tr>
<td>Lung cancer not confirmed</td>
<td>17,053 (96.3)</td>
<td>4674 (94.4)</td>
</tr>
<tr>
<td>At least 1 complication</td>
<td>17,053 (96.3)</td>
<td>4674 (94.4)</td>
</tr>
<tr>
<td>At least 1 major complication</td>
<td>17,053 (96.3)</td>
<td>4674 (94.4)</td>
</tr>
<tr>
<td>Death within 60 days after invasive diagnostic procedure</td>
<td>17,053 (96.3)</td>
<td>4674 (94.4)</td>
</tr>
</tbody>
</table>

CT: computed tomography.

* This does not include deaths among individuals who had follow-up diagnostic procedures but no invasive procedures: a total of n=5 in the low-dose CT group and n=4 in the radiography group.

Note: Major complications were defined as the following: acute respiratory failure, anaphylaxis, bronchopulmonary fistula, cardiac arrest, cerebral vascular accident/stroke, congestive heart failure, death, hemothorax requiring tube placement, myocardial infarction, respiratory arrest, wound dehiscence, bronchial stump leak requiring tube thoracostomy or other drainage for more than 4 days, empyema, injury to vital organ or vessel, prolonged mechanical ventilation over 48 hours postoperatively.
thromboembolic complications requiring intervention, chylous fistula, brachial plexopathy, lung collapse, and infarcted sigmoid colon.

Cancer stage was reported for cancers with a known stage; 1040 in the low-dose CT group and 929 in the radiography group. Of the 1040 confirmed lung cancers in the low-dose CT group, 416 (40%) were stage 1A, and 104 (10%) were stage 1B. Over half of the confirmed lung cancers identified by a positive screen (329 of 635, 52%) were stage 1A. In the radiography group, 90 of 275 confirmed cancers identified by a positive screen (32.7%) were stage 1A.

In summary, NLST was a large well-conducted trial. It found a statistically significantly lower rate of lung cancer mortality with 3 annual CT screens compared to chest radiographs; the NNS to prevent 1 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. There were few major complications 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 NLST evaluated the utility of a series of 3 annual CT screens; the efficacy of other screening regimens is not known.

In 2004, Brenner assessed the radiation risks associated with low-dose CT screening.(17) The estimated doses from low-dose CT screening were 5.2±0.9 mGy to the lung, based on the protocol used in NLST. (This would be equivalent to at least 250 standard chest radiographs.) Brenner concluded that the radiation-related lung cancer risks for a single examination at age 55 ranges from approximately 1 per 10,000 to approximately 5 per 10,000, depending on gender and whether the person is a current or former smoker. The study estimated that there would be a 1.8% increase (95% 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.

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 United States. Each study includes a somewhat different screening population and screening regimen.

**Danish Lung Cancer Screening Trial (DLCST)**

Between 2004 and 2006, a total of 4104 current or former smokers were randomized to screening with annual low-dose CT for 5 years or no screening; lung cancer mortality was the primary outcome measure.(18) After 5 annual rounds of screening, the mean annual participation rate was 95.5% in the screening group and 93.0% in the control group.(19) The mean lung cancer detection rate was 0.83% at baseline and 0.67% for each of the 4 follow-up rounds. After a median follow-up of 4.8 years, a total of 69 lung cancers were diagnosed in the screening group and 24 in the control group; the difference between groups was statistically significant, p<0.001). The number of early stage cancers diagnosed was significantly higher in the screening than the control group (48 vs 21, p=0.002). However the number of late stage cancers diagnosed was similar in the 2 groups (21 vs 16, p=0.509). As of the end of March 2010, 103 of 4013 study participants had died, 61 (3%) in the screening group and 42 (2%) in the control group (p=0.059 for overall mortality). Fifteen patients (0.73%) in the screening group and 11 patients (0.54%) in the control group died of lung cancer, p=0.428). This trial did not have adequate power to examine mortality outcomes on its own, the power calculation for mortality
assumed that data would be combined with that of the NELSON study (described next), another European screening trial.

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

This trial, conducted in Italy, randomly assigned 2811 male current or former smokers to receive 5 yearly spiral CT-screening exams or physical examination alone. 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. After a median of 33 months' follow-up, significantly more lung cancer was detected in the CT screening group compared with control (4.7% vs 2.8%, respectively, p=0.016). More stage-1 disease was detected by CT screening; the rate of advanced lung cancer detection was similar in the 2 groups.

**ITALUNG Trial**

Another Italian study randomly assigned 3206 current or former smokers to receive 4 yearly low-dose CT scans or no screening. Participants will be followed up by cancer registry for lung cancer incidence and mortality and contacted by telephone 4 years after randomization. At baseline, 1406 underwent CT screening, and 426 (30%) tested positive (nodule at or >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. The screening intervention consisted of a CT scan at baseline and 1 and 3 years after baseline. Recruitment occurred between 2004 and 2006. Of the 7557 participants who underwent the first round of screening, 196 (2.6%) had positive scans, and 177 (2.3%) were referred for workup. 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 1. The primary outcome of the trial is lung cancer mortality reduction after 10 years. Mortality results are expected in 2015 or 2016.

A total of 1466 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. They were given questionnaires before randomization, 2 months after the first screening round, and 2 years after baseline (6 months after the second screening round). The questionnaire response rate was 1288 (88%) at baseline and 931 (79%) 2 years later. No statistically significant differences between the screened and control groups were found in scores on any quality-of-life measures at 2 years. The authors interpreted this finding as suggesting that lung cancer screening did not negatively impact quality of life.

**German Lung Cancer Screening Intervention trial (LUSI)**

This study randomized 4052 heavy smokers age 50 to 69 years old to screening with 5 annual CT scans or a control group that is not being screened. Baseline screening findings were reported in 2012. A total of 2029 participants received a first-round CT scan. The baseline scan was negative for 1488 of participants (73%). The remaining 540 suspicious screens led to 31 biopsies (biopsy rate 1.5%) and 22 confirmed lung cancers (cancer detection rate 1.1%). Of these 22 cancers, 18 (82%) were stage I, one was stage II, and 3 were stage III. There was 1 interval cancer.
Systematic reviews and modeling studies

In 2012, Bach et al published a systematic review of literature on CT screening for lung cancer. The study identified 8 RCTs and 13 cohort studies; NLST was the largest RCT. Across studies, approximately 20% of participants in each round of screening had positive findings resulting in follow-up, and about 1% had lung cancer. There was heterogeneity across studies in the rate of positive findings and the type and frequency of follow-up investigations. The authors noted that the NLST trial was the only study to date that has found a significant lung cancer mortality benefit associated with low-dose CT screening. Other studies were described as too small, too poorly designed, or else the final results were not yet available.

In 2013, 2 studies funded by the Agency for Healthcare Research and Quality were published. Humphrey et al conducted a systematic review of evidence for the update of USPSTF recommendations on lung cancer screening. The review identified 4 trials focusing on low-dose CT screening in current and former smokers; the 4 trials consisted of the NLST and 3 European trials. The authors did not pool study findings. They noted that the 3 European trials were underpowered, and follow-up was not long enough to evaluate screening effectiveness.

Also in 2013, a study modeling benefits and harms of various approaches to screening was published. The modeling study evaluated models that varied screening programs by age of the participants, pack-years, years since quitting, and frequency of screening. The authors found that several possible approaches to screening and did not identify an approach that was clearly the “best” in terms of trade-offs between benefits and harms. One approach that was supported by the study was annual screening between the ages of 55 and 80 years for individuals with at least 30 pack-years of smoking and no more than 15 years since quitting for former smokers. This program is similar to NLST eligibility criteria, except the maximum screening age is 80 years rather than 74. Using this approach, the analysis estimated that 37 eligible individuals would need to be screened to prevent 1 death from lung cancer. The published modeling study did not report on models in which screening ended at age 74 years (or 75), but the lead author stated in personal communication that these models had been tested and were inferior in terms of numbers of deaths prevented.

Summary

The evidence on computed tomography (CT) screening for lung cancer includes several RCTs, some of which are still ongoing. The largest RCT, the National Lung Screening Trial (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 3 annual low-dose CT scans compared with chest radiographs. There is considerable uncertainty regarding the optimal length and interval of screening. Thus, screening for lung cancer with low-dose CT annually may be considered medically necessary for high-risk patients who meet criteria and investigational otherwise.

Practice Guidelines and Position Statements

On December 31, 2013, the USPSTF published updated recommendations on screening for lung cancer. The Task Force recommended annual screening for lung cancer with low-dose CT in adults between the ages of 55 and 80 years who have at least a 30 pack-year smoking history and who either currently smoke or quit smoking within the past 15 years. Moreover, the statement includes the recommendation that screening be discontinued when individuals have not smoked for at least 15 years, when they develop a health problem substantially limiting life expectancy, or when they are no longer willing
or able to have curative lung surgery. The recommendation was given a “B” recommendation, defined as “high certainty that the net benefit is substantial or the ability or willingness to have curative lung surgery.”

The 2014 (Version 1) lung cancer screening guideline from the National Comprehensive Cancer Network has the following recommendations regarding screening with low-dose CT:

- Screening is recommended for high-risk individuals, age 55 to 74 years old, at least a 30 pack-year history of smoking, and smoking cessation no more than 15 years ago. These criteria are based on the National Lung Screening Trial.
- Screening is also recommended for high-risk individuals aged 50 years and older with at least a 20 pack-year history of smoking and 1 additional risk factor for lung cancer (other than second-hand smoke). This recommendation is based on nonrandomized studies and observational data.
- For individuals who test negative on the initial screen, the NCCN recommends annual screens for an additional 2 years and then they recommend considering further annual screens until the patient is no longer eligible for definitive treatment. The guideline notes: “there is uncertainty about the appropriate duration of screening and the age at which screening is no longer appropriate.”

In January 2013, the American Cancer Society (ACS) website published guidelines on lung cancer screening with low-dose CT. They state that patients who meet all of the following criteria, which are based on NLST criteria, may be candidates for screening:

- 55 to 74 years old;
- Otherwise in good health;
- At least a 30 pack-year smoking history; AND
- Current smokers or quit smoking within the last 15 years.

For patients who meet the above criteria and choose screening, screening is recommend annually until age 74 for individuals who otherwise remain healthy. In addition, the ACS recommends that screening only take place in facilities with the correct type of CT scans, experience performing low-dose CT scans for lung cancer screening and a team of specialists that can provide appropriate care.

In May 2012, American College of Chest Physicians (ACCP) and American Society of Clinical Oncology issued a joint statement on CT screening for lung cancer. This statement was confirmed by the ACCP in May 2013. The statement included the following recommendations:

- “For smokers and former smokers aged 55 to 74 years who have smoked for 30 pack-years or more and either continue to smoke or have quit within the past 15 years, we suggest that annual screening with low-dose computed tomography (LDCT) should be offered over both annual screening with chest radiograph or no screening, but only in settings that can deliver the comprehensive care provided to NLST participants. (Grade of recommendation: 2B.)”
- “For individuals who have accumulated fewer than 30 pack years of smoking or are either younger than 55 years or older than 74 years, or individuals who quit smoking more than 15 years ago, and for individuals with severe comorbidities that would preclude potentially curative treatment, limit life expectancy, or both, we suggest that CT screening should not be performed. (Grade of recommendation: 2C.)”

(4,28)
The 2013 guideline noted that the most effective duration or frequency of screening remains unknown.

In 2012, American Association for Thoracic Surgery published guidelines for lung cancer screening. The guidelines recommend: “annual lung cancer screening with low-dose computed tomography screening for North Americans from age 55 to 79 years with a 30 pack-year history of smoking. Long-term lung cancer survivors should have annual low-dose computed tomography to detect second primary lung cancer until the age of 79 years. Annual low-dose computed tomography lung cancer screening should be offered starting at age 50 years with a 20 pack-year history if there is an additional cumulative risk of developing lung cancer of 5% or greater over the following 5 years. Lung cancer screening requires participation by a subspecialty-qualified team.”(5)

**Medicare National Coverage**

There is no national coverage determination (NCD). In the absence of an NCD, coverage decisions are left to the discretion of local Medicare carriers.

**References**


**Documentation Required for Clinical Review**

- History and physical and/or office notes including:
  - Reason for the request
  - Smoking history (pack-years)
  - Year(s) of smoking cessation (if applicable)
- Post Service
  - Computed tomography (CT) scan thorax/lung report

**Coding**

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.

**MN/IE**

The following service/procedure may be considered medically necessary in certain instances and investigational in others. Services may be medically necessary when policy criteria are met. Services are considered investigational when the policy criteria are not met or when the code describes application of a product in the position statement that is investigational.

<table>
<thead>
<tr>
<th>Type</th>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPT®</td>
<td>71250</td>
<td>Computed tomography, thorax; without contrast material</td>
</tr>
<tr>
<td>CPT®</td>
<td>For dates of service on or after 10/01/2015</td>
<td></td>
</tr>
<tr>
<td>HCPCS</td>
<td>S8032</td>
<td>Low-dose Computed Tomography For Lung Cancer Screening</td>
</tr>
<tr>
<td>ICD-9</td>
<td>87.41</td>
<td>Computerized axial tomography of thorax</td>
</tr>
<tr>
<td>ICD-9</td>
<td>87.44</td>
<td>Routine chest x-ray, so described</td>
</tr>
<tr>
<td>ICD-9</td>
<td>87.49</td>
<td>Other chest x-ray</td>
</tr>
<tr>
<td>ICD-10</td>
<td>BB09YZZ, BB0DZZZ</td>
<td>Imaging, respiratory system, plain radiography, tracheobronchial trees, bilateral or upper airways</td>
</tr>
<tr>
<td>ICD-10</td>
<td>BB24ZZZ</td>
<td>Imaging, respiratory system, computed tomography, lungs bilateral</td>
</tr>
<tr>
<td>ICD-9</td>
<td>All Diagnoses</td>
<td></td>
</tr>
</tbody>
</table>
**Medical Policy**

### Diagnosis

<table>
<thead>
<tr>
<th>ICD-10 Diagnosis</th>
<th>For dates of service on or after 10/01/2015</th>
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</thead>
<tbody>
<tr>
<td>F17.200 - F17.299</td>
<td>Nicotine dependence, code range</td>
</tr>
<tr>
<td>Z12.2</td>
<td>Encounter for screening for malignant neoplasm of respiratory organs</td>
</tr>
<tr>
<td>Z87.891</td>
<td>Personal history of nicotine dependence</td>
</tr>
</tbody>
</table>

IE

The following services are considered investigational and therefore not covered for any indication.

<table>
<thead>
<tr>
<th>Type</th>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPT®</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>0174T</td>
<td>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 (Use 0174T in conjunction with 71010, 71020, 71021, 71022, 71030)</td>
</tr>
<tr>
<td>HCPC</td>
<td>0175T</td>
<td>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 (Do not report 0175T in conjunction with 71010, 71020, 71021, 71022, 71030)</td>
</tr>
</tbody>
</table>

### Policy History

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

<table>
<thead>
<tr>
<th>Effective Date</th>
<th>Action</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>4/5/2007</td>
<td>New Policy Adoption</td>
<td>Medical Policy Committee</td>
</tr>
<tr>
<td>4/3/2009</td>
<td>Policy name change</td>
<td>Combined the following policies:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Electron Beam Computed Tomography (EBCT) for Detection and Evaluation of Coronary Artery Calcium Measurement</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Contrast-Enhanced Computed Tomography Angiography (CCTA) for Coronary Artery Evaluation</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Medical Policy Committee</td>
</tr>
</tbody>
</table>
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
10/31/2014  Policy title change from Screening for Lung Cancer Using CT Scanning or Chest Radiographs Policy revision with position change  Medical Policy Committee

Definitions of Decision Determinations

Medically Necessary: A treatment, procedure or drug is medically necessary only when it has been established as safe and effective for the particular symptoms or diagnosis, is not investigational or experimental, is not being provided primarily for the convenience of the patient or the provider, and is provided at the most appropriate level to treat the condition.

Investigational/Experimental: A treatment, procedure or drug is investigational when it has not been recognized as safe and effective for use in treating the particular condition in accordance with generally accepted professional medical standards. This includes services where approval by the federal or state governmental is required prior to use, but has not yet been granted.

Split Evaluation: Blue Shield of California / Blue Shield of California Life & Health Insurance Company (Blue Shield) policy review can result in a Split Evaluation, where a treatment, procedure or drug will be considered to be investigational for certain indications or conditions, but will be deemed safe and effective for other indications or conditions, and therefore potentially medically necessary in those instances.

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.

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.