ADMINISTRATIVE POLICY AND PROCEDURE		
Policy #:	**1406**	
Subject:	**PET Scan (Positron Emission Tomography)**	
Section:	**Care Management**	
Effective Date:	**01/01/2001**	
Revision Date(s):	**11/02, 09/03, 07/04, 09/05, 10/06, 11/07, 09/08, 09/09, 09/10, 11/11, 12/12, 10/13, 10/14, 10/15**	
Review Date(s):	**10/16**	
Responsible Parties:	**Patryce Toye, MD**	
Responsible Department(s):	**Utilization Management**	
Regulatory References:	**See end of policy**	
Approved:		
	Carol Attia, RN **AVP, Care Management**	**Patryce A. Toye, MD** **Senior Medical Director**

Purpose: **To define the conditions under which MedStar Family Choice utilization management staff may authorize PET scans.**

Scope: **MedStar Family Choice, MD; MedStar Family Choice, District of Columbia Healthy Families and Alliance.**

Policy: **It is the policy of MFC to authorize PET scans by nurse utilization management staff as outlined in the criteria below. Requests that do not specifically meet the criteria may be submitted with supporting medical records, articles from the literature, etc. and will be reviewed by a Physician Advisor for a Medical Exception.**

Background: **PET is a rapidly advancing technology that utilizes the positron emitting radionuclides of carbon, nitrogen, oxygen, and fluorine to serve as tracers for biological processes in vivo. It takes advantage of the high rate of glycolysis seen in many tumors and has multiple applications in oncology, indications in cardiology and uses are being investigated in many other areas.**

MFC will, at a minimum, authorize PET scans for the indications approved by the Centers for Medicare and Medicaid Services (CMS). The detailed criteria for each of these indications may be found on the CMS website under National Coverage Decisions.

Procedure:

A. Nurse utilization management staff may authorize PET scans when the following criteria are met:
    1. Documentation indicates clinical situations where staging or diagnosis is in doubt and situations where the result has the potential to impact the clinical management of the patient. Restaging includes restaging in the event of a recurrence as well as after therapy to evaluate the response to therapy.
    2. Clinical is provided and documents the presence of one of the following tumor types.
    3. Tumors listed as covered may be approved by the nurse. Others must be forwarded for Physician Advisor review.

FDG PET Coverage for Solid Tumors and Myeloma

Tumor Type	Initial Treatment Strategy (formerly "diagnosis" & "staging")	Subsequent Treatment Strategy (formerly "restaging" & "monitoring response to treatment")
Colorectal	Cover	Cover
Esophagus	Cover	Cover
Head & Neck (not thyroid or CNS)	Cover	Cover
Lymphoma	Cover	Cover
Non-small cell lung	Cover	Cover
Ovary	Cover	Cover
Brain	Cover	Cover
Cervix	Cover w/exception*	Cover
Small cell lung	Cover	Cover
Soft Tissue Sarcoma	Cover	Cover
Pancreas	Cover	Cover
Testes	Cover	Cover
Breast (female and male)	Cover w/exception*	Cover
Melanoma	Cover w/exception*	Cover
Prostate	Non-Cover	Cover
Thyroid	Cover	Cover
All other solid tumors	Cover	Cover
Myeloma	Cover	Cover
All other cancers not listed	Cover	Cover

*Cervix: Nationally non-covered for the initial diagnosis of cervical cancer related to initial anti-tumor treatment strategy. All other indications for initial treatment strategy for cervical cancer are nationally covered.
*Breast: Nationally non-covered for initial diagnosis and/or staging of axillary lymph nodes. Nationally covered for initial staging of metastatic disease. All other indications for initial treatment strategy for breast cancer are nationally covered.
*Melanoma: Nationally non-covered for initial staging of regional lymph nodes. All other indications for initial anti-tumor treatment strategy for melanoma are nationally covered.
*Thyroid: Nationally covered for subsequent treatment strategy of recurrent or residual thyroid cancer of follicular cell origin previously treated by thyroidectomy and radioiodine ablation and have a serum thyroglobulin >10ng/ml and have a negative I-131 whole body scan. All other indications for subsequent anti-tumor treatment strategy for thyroid cancer are nationally covered under CED.

References:

National Coverage Determination (NCD) for Positron Emission Tomography (FDG) for Oncologic Conditions (220.6.17) CMS website: http://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=331&ncdver=3&bc=AAAAgAAAAAAA& Accessed 10/15/15.

http://www4a.cms.gov/medicare-coverage-database/details/nca-details.aspx?NCDId=331&ncdver=3&NCAId=71&NcaName=Positron+Emission+Tomography+(FDG)+for+Breast+Cancer&IsPopup=y&bc=AAAAAAAABAAA&
http://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=211&ncdver=5&bc=AAAAgAAAAAAAAA%3d%3d&

MLN Matters Article: MM8739 Revised Release Date January 8, 2015
https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/MM8739.pdf Accessed 10/15/15

Summary of Changes:	**10/16:** • No changes **10/15:** • Updated references