

PET / CT Imaging Indications and Guidelines

All of these indications can be “monitor response to treatment”

SPN (Solitary Pulmonary Nodule) – if multiple nodules or bigger than 5 cm, must have documentation why it cannot be biopsied

- Focal solitary lesion detected by CT, CXR, or other detection method – Diagnosis only
- Lesion must be characterized as “indeterminate” or “possibly malignant”
- Lesion must be 5 cm or less
- No PET scan should have been performed within the last 90 days to characterized lesion

NSCLC

- Initial Treatment Strategy:** Lesion must be larger than 4 cm or more than one lesion & the physician may be requested to write a letter of medical necessity if required by insurance company. Statement or evidence of NSCLC by pathology & patient must not have received treatment or surgery.
- Subsequent Treatment Strategy:** The PET scan should be scheduled after completion of a course of treatment. Must be documented by physician that recurrence is suspected or known.
- Monitor Response to Treatment:** There must be documentation that a patient is currently undergoing treatment

Colorectal Cancer

- Initial Treatment Strategy:** Statement of colorectal cancer by pathology & patient must not have received treatment or surgery.
- Subsequent Treatment Strategy:** The PET scan should be scheduled after completion of a course of treatment or no PET within 12 months. Or Documentation that recurrence is known or suspected by change in patient’s symptoms or rising CEA level.
- Monitor Response to Treatment:** There must be documentation that a patient is currently undergoing treatment

Lymphoma

- Initial Treatment Strategy:** PET is not used for the diagnosis of lymphoma unless physician writes a letter of medical necessity stating why a tissue biopsy cannot be done before PET. Statement or evidence of diagnosis of lymphoma by pathology report & treatment not initiated.
- Subsequent Treatment Strategy:** The PET scan should be scheduled after completion of a course of treatment or no PET has been done within 50 days, unless clinical change is documented. Must be documented by physician that recurrence is suspected or known.
- Monitor Response to Treatment:** There must be documentation that a patient is currently undergoing treatment

Melanoma

- Initial Treatment Strategy:** Statement or evidence of diagnosis of melanoma by pathology & treatment has not been initiated.
- Subsequent Treatment Strategy:** The PET scan should be scheduled after completion of a course of treatment. Must be documented by physician that recurrence is suspected or known. The patient should not have had a Gallium scan less than 50 days ago at this facility.
- Monitor Response to Treatment:** There must be documentation that a patient is currently undergoing treatment

Esophageal

- Initial Treatment Strategy:** Statement or evidence of esophageal cancer by pathology & patient has not received treatment or surgery.
- Subsequent Treatment Strategy:** The PET scan should be scheduled after completion of a course of treatment. Or must be documented by physician that recurrence is suspected or known.
- Monitor Response to Treatment:** There must be documentation that a patient is currently undergoing treatment

Head & Neck

- Initial Treatment Strategy:** Statement or evidence for head & neck cancer by pathology and patient has not received treatment or surgery.
- Subsequent Treatment Strategy:** The PET scan should be scheduled after completion of a course of treatment. Or must be documented by physician that recurrence is suspected or known.
- Monitor Response to Treatment:** There must be documentation that a patient is currently undergoing treatment

Breast Cancer

- Initial Treatment Strategy:** Statement or evidence of breast cancer by pathology & patient must not have received treatment or surgery.
- Subsequent Treatment Strategy:** To evaluate treatment effectiveness during the course of treatment. PET scan should be scheduled after completion of a course of treatment. Must be documented by physician that recurrence is suspected or known. Not to be used in place or sentinel node biopsy.
- Monitor Response to Treatment:** There must be documentation that a patient is currently undergoing treatment

Thyroid Cancer

- Follicular cell pathology
- Previously treated by total thyroidectomy or radioiodine ablation
- Serum thyroglobulin or greater than 10mg/ml
- Negative I-131 whole body scan

Cervical Cancer

- Initial Treatment Strategy:** Before treatment. After conventional imaging (MRI or CT) is negative (-) for extra pelvic metastases
- Subsequent Treatment Strategy:** Must be documentation that a recurrence is suspected or known.
- Monitor Response to Treatment:** There must be documentation that a patient is currently undergoing treatment

Cancers and Indications Eligible for Entry in the NOPR

***Registry patients must have Medicare or be Medicare eligible

Cancers and indications that are reimbursable by Medicare are NOT eligible for entry in the NOPR. Cancers and indications that are specifically excluded for Medicare reimbursement are also not eligible for entry in the NOPR.

C = Covered – Not eligible for entry in the NOPR

NC = Non-covered nationally – Not eligible for entry in the NOPR

NOPR = Covered only with entry in the NOPR

Indications	Initial Treatment Strategy (formerly diagnosis and initial staging)	Subsequent Treatment Strategy (includes treatment monitoring, restaging & detection of suspected recurrence)
Lip, Oral Cavity, and Pharynx (140-149)	C	C
Esophagus (150)	C	C
Stomach (151)	C	NOPR
Small Intestine (152)	C	NOPR
Colon (153) and Rectum (154)	C	C
Anus (154)	C	NOPR ¹
Liver and Intrahepatic Bile Ducts (155)	C	NOPR
Gallbladder & Extrahepatic Bile Ducts (156)	C	NOPR
Pancreas (157)	C	NOPR
Retroperitoneum & Peritoneum (158)	C	NOPR
Nasal Cavity, Ear, and Sinuses (160)	C	C
Larynx (161)	C	C
Lung, Non-Small Cell (162)	C	C
Lung, Small Cell (162)	C	NOPR
Pleura (163)	C	NOPR
Thymus, Heart, Mediastinum (164)	C	NOPR
Bone / Cartilage (170)	C	NOPR
Connective / Other Soft Tissue (171)	C	NOPR
Melanoma (172)	C / NC ²	C
Non-Melanoma Skin (173)	C	NOPR
Female Breast (174)	C / NC ^{2,3}	C
Male Breast (175)	C / NC ^{2,3}	C
Kaposi's Sarcoma (176)	C	NOPR
Uterus, Unspecified (179)	C	NOPR
Cervix (180)	C / NOPR ⁴	C
Uterus, Body (182)	C	NOPR
Placenta (181)	C	NOPR
Ovary (183.0)	C	C
Uterine Adnexa (183.2 – 183.9)	C	NOPR
Other and Unspecified Female Genitalia (184)	C	NOPR
Prostate (185)	NC	NOPR
Testis (186)	C	NOPR
Penis and Other Male Genitalia (187)	C	NOPR
Bladder (188)	C	NOPR
Kidney and Other Urinary Tract (189)	C	NOPR
Eye (190)	C	NOPR
Primary Brain (191)	C	NOPR
Other and Unspecified Nervous System (192)	C	NOPR
Thyroid (193)	C	C / NOPR ⁵
Other Endocrine Glands and Related Structures (194)	C	NOPR
Metastatic Cancer / Unknown Primary Origin (196-199)	C	NOPR
Lymphoma (200-202)	C	C
Myeloma (203)	C	C
Leukemia (204-208)	NOPR	NOPR
Neuroendocrine Tumor (209)	C	NOPR
Other or Not Listed	C	NOPR

¹Some Medicare contractors include anal cancer in their local coverage of "colorectal cancer"; for PET facilities served by those carriers, PET for subsequent treatment evaluation of anal cancer would be a covered indication.

²PET is non-covered for initial staging of axillary lymph nodes in patients with breast cancer and of regional lymph nodes in patients with melanoma, but is covered for detection of distant metastatic disease in high-risk patients with breast cancer or melanoma.

³PET is non-covered for "diagnosis" of breast cancer to evaluate a suspicious breast mass. However, PET is covered for initial treatment strategy evaluation of a patient with axillary nodal metastasis of unknown primary origin or in a patient with a paraneoplastic syndrome potentially caused by an occult breast cancer.

⁴Patient must have prior CT or MRI negative for extrapelvic metastatic disease for PET to qualify as a covered indication for initial treatment strategy evaluation. Patients who do not qualify for this covered indication (e.g. because Ct or MRI was not done or because either CT or MRI showed extrapelvic metastatic disease) can be entered on NOPR.

⁵To qualify as a covered indication for subsequent treatment strategy evaluation, thyroid cancer must be of follicular cell origin and been previously treated by thyroidectomy and radioiodine ablation and the patient must have a serum thyroglobulin > 10 ng/mL and a negative whole-body I-131 scan. Patients who do not qualify for this covered indication (e.g. because the tumor is of other than follicular cell origin, the thyroglobulin is not elevated, or I-131 whole-body imaging was not performed or is positive) can be entered on NOPR.

PET / CT Guidelines

PET is not eligible for payment when performed to monitor tumor response during a planned course of treatment when no change in treatment is being contemplated. The use of PET in this instance is not medically necessary. PET imaging used to evaluate asymptomatic patients is considered screening. Screening a patient without specific signs and/or symptoms of disease is not medically necessary.

Diagnosis:

PET is covered for diagnosis only in clinical situations in which PET results may assist in avoiding an invasive diagnostic procedure, or in which the PET results may assist in determining the optimal anatomical location to perform an invasive diagnostic procedure. The use of PET in the diagnosis of esophageal, colorectal, lymphoma and melanoma should be rare.

Initial treatment strategy:

PET is used for staging and is considered medically necessary in the following clinical situations:

1. When the stage of the cancer remains in doubt following a standard diagnostic workup, including conventional imaging (e.g. CT, MRI, ultrasound) or
2. PET could potentially replace one or more conventional imaging studies when it is expected that the information obtained from these conventional studies is insufficient for the clinical management of the patient; or
3. When clinical management of the patient would differ depending on the stage of the cancer identified.

PET scans following a tissue diagnosis are typically performed for the purpose of staging, not diagnosis.

Subsequent treatment strategy:

Restaging only occurs after a course of treatment is completed. PET for restaging is covered after the completion of treatment to detect residual disease, suspected recurrence, or determine the extent of a known recurrence.

Notes

- ✓ Highmark BC/BS
 - Needs authorization
 - Confirm on Navinet
 - There are very few plans that do not require authorization
- ✓ Health America - Advantra
 - Needs authorization, except GE employees
- ✓ Commercial Carriers
 - Typically needs authorization
- ✓ Medicare Patients
 - Do not need an official authorization
 - Must meet medical necessity according to medical policy
- ✓ If plan does not require an authorization per the referring office, they must note the phone # that they called to verify this and the name of the person that they spoke to prior to appointment being scheduled.
- ✓ All outside offices MUST send all required documentation
 - Diagnosis testing performed to date
 - Pathology report, if applicable
 - Office notes to prove medical necessity
 - Insurance information must be provided in detail
- ✓ MUST complete a PET / CT Scheduling Request form PRIOR to scheduling an appointment