Status
Active

Medical and Behavioral Health Policy
Section: Radiology
Policy Number: V-24
Effective Date: 04/23/2014

POSITRON EMISSION MAMMOGRAPHY

Description: Positron emission mammography (PEM) uses a high-resolution, mini-camera detection technology for imaging the breast. As with positron emission tomography (PET), PEM provides functional rather than anatomical information on the breast. PEM has been proposed for use in presurgical planning and staging, monitoring response to therapy, and monitoring for recurrence of breast cancer.

PEM involves administration of a radiotracer, usually 18F-fluorodeoxyglucose (FDG). Mild compression is used, with the detector(s) mounted directly on the compression paddle(s). Proposed advantages for PEM include: the detection of lesions smaller than 2 cm; creation of images that are more easily compared to mammography; and three-dimensional reconstruction of images.

In August 2003, the PEM 2400 PET Scanner (PEM Technologies, Inc.) was cleared for marketing by the U.S. Food and Drug Administration (FDA) through the 510(k) process. The FDA determined that this device was substantially equivalent to existing devices for use in "medical purposes to image and measure the distribution of injected positron emitting radiopharmaceuticals in human beings for the purpose of determining various metabolic and physiologic functions within the human body." In March 2009, the Naviscan PEM Flex Solo II High Resolution PET Scanner (Naviscan, Inc.) was cleared for marketing by the FDA through the 510(k) process for the same indication.

Policy: The use of positron emission mammography (PEM) is considered **INVESTIGATIVE** due to a lack of clinical evidence demonstrating its impact on improved health outcomes**.**

Coverage: Blue Cross and Blue Shield of Minnesota medical policies apply generally to all Blue Cross and Blue Plus plans and products. Benefit

plans vary in coverage and some plans may not provide coverage for certain services addressed in the medical policies.

Medicaid products and some self-insured plans may have additional policies and prior authorization requirements. Receipt of benefits is subject to all terms and conditions of the member's summary plan description (SPD). As applicable, review the provisions relating to a specific coverage determination, including exclusions and limitations. Blue Cross reserves the right to revise, update and/or add to its medical policies at any time without notice.

For Medicare NCD and/or Medicare LCD, please consult CMS or National Government Services websites.

Refer to the Pre-Certification/Pre-Authorization section of the Medical Behavioral Health Policy Manual for the full list of services, procedures, prescription drugs, and medical devices that require Pre-certification/Pre-Authorization. Note that services with specific coverage criteria may be reviewed retrospectively to determine if criteria are being met. Retrospective denial of claims may result if criteria are not met.

Coding: *The following codes are included below for informational purposes only, and are subject to change without notice. Inclusion or exclusion of a code does not constitute or imply member coverage or provider reimbursement.*

This service would be reported with an unlisted CPT code.

Policy History: **Developed April 13, 2011**

Most recent history:
Reviewed April 11, 2012
Reviewed April 10, 2013
Reviewed April 9, 2014

Cross Reference: Scintimammography / Breast-Specific Gamma Imaging / Molecular Breast Imaging, V-06
Digital Breast Tomosynthesis, V-25