



Medicare Greatly Increases Coverage for PET/CT in Oncology

The Centers for Medicare & Medicaid Services (CMS) announced a new coverage policy for oncologic PET and PET/CT scans effective April 6, 2009. The new coverage utilizes the PET/CT imaging information gleaned from the results of 2006-2009 National Oncological PET Registry (NOPR).

Under the new guidelines, PET/CT coverage is now classified as a diagnostic tool for one of two strategies: Initial Treatment Strategy and Subsequent Treatment Strategy. Both strategies provide greatly expanded PET/CT coverage ([see Indication Matrix below](#)) over the previous 4-phase coverage that was limited to diagnosis, staging, restaging and monitoring response to therapy.

Initial Treatment Strategy

PET/CT performed as part of an evaluation for determination of an initial treatment strategy is now covered by CMS in the 13 major cancer types, including myeloma. Additionally, all other types of solid tumors not included in the major 13 listed are now covered. The coverage includes PET/CT in clinical situations when (1) the PET/CT results may assist in avoiding an invasive diagnostic procedure, or when (2) the PET/CT results may assist in determining the optimal anatomical location to perform an invasive diagnostic procedure. In general, for most solid tumors, a tissue diagnosis is made prior to doing a PET/CT scan and therefore the scan is performed for staging rather than diagnosis.

Subsequent Treatment Strategy

PET/CT is also a CMS-covered service when used in subsequent treatment strategy evaluation (formerly restaging, detection of suspected recurrence, and treatment monitoring) of patients with the following cancers: breast, cervix, colorectal, esophageal, head and neck, lymphoma, melanoma, myeloma, non-small cell lung, ovary, and thyroid. For all other cancers, PET/CT coverage for subsequent treatment strategy evaluation requires participation in the new NOPR 2009 registry. (Washington Imaging Services is a participant in this cancer registry.)

PET/CT is covered for *restaging* and *detection of suspected recurrences*:

- *after* completion of treatment for the purpose of detecting residual disease; or
- for detecting suspected recurrence or metastasis; or
- to determine the extent of a known recurrence—if it could potentially replace one or more conventional imaging studies when it is expected that conventional study information is insufficient for the clinical management of the patient.

Restaging applies to testing *after* a course of treatment is completed, and is covered subject to the conditions above.

Important Considerations

As noted above, PET/CT is not covered as a screening test (i.e., testing patients without specific signs and symptoms of disease) and thus is not covered for surveillance of patients treated for cancer in whom there is no clinical reason to suspect recurrent disease.

Treatment monitoring refers to use of PET/CT to monitor tumor response to treatment *during* the planned course of therapy (i.e., when a change in therapy is anticipated).

As an example, PET/CT performed under NOPR 2009 may be covered for *monitoring* after 2 or 3 of a planned 6 cycles of chemotherapy in a patient considered not to be responding as expected.

What Does This Mean for Cancer Patients?

Routine coverage for initial treatment for lymphoma, melanoma, breast cancer, colorectal cancer, esophageal cancer, head & neck cancer, and non-small cell lung cancer has been expanded to include brain cancer, ovarian cancer, pancreatic cancer, small cell lung cancer, soft tissue sarcoma, thyroid cancer, testicular cancer, and all other solid cancerous tumors. Clinicians will now have the assistance of PET/CT as a diagnostic tool for all of Medicare patients with all solid tumors. This expanded coverage should trickle down over the next few months to include private insurance companies as well.

Additionally, restaging and monitoring for response to therapy now routinely covers the 7 most common types of cancer and NOPR 2009 covers the remainder. Clinicians will be able to utilize the salient features of PET/CT to restage patients and to monitor response to treatment regimens.

What Else Should I Know?

PET/CT is explicitly not covered by CMS for initial treatment strategy evaluation for several specific cancer types/indications:

- diagnosis and auxiliary nodal staging of breast cancer.
- assessment of regional lymph nodes in melanoma—all other uses for initial staging are covered.
- diagnosis of prostate cancer and initial staging of newly diagnosed prostate cancer.
- thyroid cancer is covered for restaging of follicular cell types only.
- cervical cancer for initial treatment strategy evaluation is covered for the detection of pre-treatment metastases (i.e., staging) in newly diagnosed cervical cancer subsequent to conventional imaging that is negative for extra-pelvic metastasis. All other uses are CED.

The day-to-day procedure for ordering a PET/CT has not changed. Minor changes will appear on the Rx form to reflect the increased coverage. Please call Gary Beneze at Washington Imaging Services (425-462-4742) if you have any questions..

CMS Coverage Indication Matrix

	Final Framework	
Solid Tumor Type	Initial Treatment Strategy*	Subsequent Treatment Strategy**
Colorectal	Covered	Covered
Esophagus	Covered	Covered
Head & Neck (not thyroid or CNS)	Covered	Covered
Lymphoma	Covered	Covered
Non-small cell lung	Covered	Covered
Ovary	Covered	Covered
Brain	Covered	NOPR 2009

Cervix	1 or NOPR 2009	Covered
Small cell lung	Covered	NOPR 2009
Soft Tissue Sarcoma	Covered	NOPR 2009
Pancreas	Covered	NOPR 2009
Testes	Covered	NOPR 2009
Breast (female and male)	2	Covered
Melanoma	3	Covered
Prostate	N/C	NOPR 2009
Thyroid	Covered	4 or NOPR 2009
All other solid tumors	Covered	NOPR 2009
Myeloma	Covered	Covered
All other cancers not listed herein	NOPR 2009	NOPR 2009

* Formerly “diagnosis” and “staging”

** Formerly “restaging” and “monitoring response to treatment when a change in treatment is anticipated”

n/c Not covered

(1) Cervix: Covered for the detection of pre-treatment metastases (i.e., staging) in newly diagnosed cervical cancer subsequent to conventional imaging that is negative for extra-pelvic metastasis. All other uses are CED.

(2) Breast: Not covered for diagnosis and/or initial staging of auxiliary lymph nodes. Covered for initial staging of metastatic disease.

(3) Melanoma: Not covered for initial staging of regional lymph nodes. All other uses for initial staging are covered.

(4) Thyroid: 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 uses for subsequent treatment strategy are CED (NOPR 2009—Coverage with Evidence Development).