Sentara Health Plans

Medicaid

Scintimammography and Breast Specific Gamma Imaging, Imaging 24

Table of Content

Effective Date	7/2009
Next Review Date	1/2026
Coverage Policy	Imaging 24
Version	6

All requests for authorization for the services described by this medical policy will be reviewed per Early and Periodic Screening, Diagnostic and Treatment (EPSDT) guidelines. These services may be authorized under individual consideration for Medicaid members under the age of 21-years if the services are judged to by medically necessary to correct or ameliorate the member's condition. Department of Medical Assistance Services (DMAS), Supplement B - EPSDT (Early and Periodic Screening, Diagnosis and Treatment) Manual *.

Description & Definitions:

Scintimammography utilizes radiopharmaceuticals that are given intravenously. These then accumulate in diseased breast tissue. Images are taken with a gamma camera to then try to capture the diseased tissue.

Breast Specific Gamma Imaging is a type of imaging machine with high-resolution gamma cameras used when performing Scintimammography.

Criteria:

Scintimammography and Breast Specific Gamma Imaging current role remains uncertain, based on review of existing evidence, there are currently no clinical indications for this technology. Therefore, not medically necessary for any clinical indications.

Document History:

Revised Dates:

- 2025: January – Procedure coding updated to align with changes to service authorization status. Annual review completed, no changes references updated.
- 2019: October
- 2016: April
- 2015: November

Reviewed Dates:

- 2024: May
- 2023: May
- 2022: May

- 2021: June
- 2020: July
- 2019: February
- 2018: February
- 2017: March
- 2015: January
- 2014: January
- 2013: June
- 2012: July
- 2011: July
- 2010: July
- 2009: July

Effective Date:

- July 2009

Coding:

Medically necessary with criteria:

Coding	Description
	None

Considered Not Medically Necessary:

Coding	Description
78800	Radiopharmaceutical localization of tumor, inflammatory process, or distribution of radiopharmaceutical agent(s) (includes vascular flow and blood pool imaging, when performed); planar, single area (eg, head, neck, chest, pelvis), single day imaging.
78801	Radiopharmaceutical localization of tumor, inflammatory process, or distribution of radiopharmaceutical agent(s) (includes vascular flow and blood pool imaging, when performed); planar, 2 or more areas (eg, abdomen and pelvis, head and chest), 1 or more days imaging or single area imaging over 2 or more days.
78803	Radiopharmaceutical localization of tumor, inflammatory process, or distribution of radiopharmaceutical agent(s) (includes vascular flow and blood pool imaging, when performed); tomographic (SPECT), single area (eg, head, neck, chest, pelvis), single day imaging.
S8080	Scintimammography (radioimmunoscintigraphy of the breast), unilateral, including supply of radiopharmaceutical.

U.S. Food and Drug Administration (FDA) - approved only products only.

The preceding codes are included above for informational purposes only and may not be all inclusive. Additionally, inclusion or exclusion of a treatment, procedure, or device code(s) does not constitute or imply member coverage or provider reimbursement.

Special Notes: *

- Coverage: See the appropriate benefit document for specific coverage determination. Member specific benefits take precedence over medical policy.
- Application to Products: Policy is applicable to Sentara Health Plan Virginia Medicaid products.

- Authorization Requirements: Pre-certification by the Plan is required.
- Special Notes:
    - This medical policy express Sentara Health Plan's determination of medically necessity of services, and they are based upon a review of currently available clinical information. These policies are used when no specific guidelines for coverage are provided by the Department of Medical Assistance Services of Virginia (DMAS). Medical Policies may be superseded by state Medicaid Plan guidelines. Medical policies are not a substitute for clinical judgment or for any prior authorization requirements of the health plan. These policies are not an explanation of benefits.
    - Medical policies can be highly technical and complex and are provided here for informational purposes. These medical policies are intended for use by health care professionals. The medical policies do not constitute medical advice or medical care. Treating health care professionals are solely responsible for diagnosis, treatment and medical advice. Sentara Health Plan members should discuss the information in the medical policies with their treating health care professionals. Medical technology is constantly evolving and these medical policies are subject to change without notice, although Sentara Health Plan will notify providers as required in advance of changes that could have a negative impact on benefits.
    - The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) covers services, products, or procedures for children, if those items are determined to be medically necessary to "correct or ameliorate" (make better) a defect, physical or mental illness, or condition (health problem) identified through routine medical screening or examination, regardless of whether coverage for the same service or support is an optional or limited service under the state plan. Children enrolled in the FAMIS Program are not eligible for all EPSDT treatment services. All requests for authorization for the services described by this medical policy will be reviewed per EPSDT guidelines. These services may be authorized under individual consideration for Medicaid members under the age of 21-years if the services are judged to by medically necessary to correct or ameliorate the member's condition. Department of Medical Assistance Services (DMAS), Supplement B - EPSDT (Early and Periodic Screening, Diagnosis and Treatment) Manual.

References:

Including but not limited to: Specialty Association Guidelines; Government Regulations; Winifred S. Hayes, Inc; UpToDate; Literature Review; Specialty Advisors; National Coverage Determination (NCD); Local Coverage Determination (LCD).

§ 38.2-3418.1:3. Cost sharing for breast examinations. (2024, 1). Retrieved 12 2024, from Code of Virginia (LIS): https://legacylis.virginia.gov/cgi-bin/legp604.exe?241+ful+HB230

28th Edition. (2024). Retrieved 12 2024, from MCG: https://careweb.careguidelines.com/ed28/index.html

(2024). Retrieved 12 2024, from CMS: https://www.cms.gov/medicare-coverage-database/search-results.aspx?keyword=breast&keywordType=all&areaId=all&docType=NCA,CAL,NCD,MEDCAC,TA,MCD,6,3,5,1,F,P&contractOption=all&sortBy=relevance

(2024). Retrieved 12 2024, from DMAS: https://vamedicaid.dmas.virginia.gov/manuals/provider-manuals-library

(2024). Retrieved 12 2024, from UpToDate: https://www.uptodate.com/contents/search?search=Scintimammography&sp=0&searchType=PLAIN_TEXT&source=USER_INPUT&searchControl=TOP_PULLDOWN&autoComplete=false

(2024, 1). Retrieved 11 2024, from Evolent (Formerly NIA): https://www1.radmd.com/sites/default/files/2024-06/2024%20Evolent%20Advanced%20Imaging%20Guidelines.pdf

ACR PRACTICE PARAMETER FOR THE PERFORMANCE OF MOLECULAR. (2022). Retrieved 12 2024, from American College of Radiology (ACR): https://www.acr.org/-/media/ACR/Files/Practice-Parameters/MBI.pdf

Breast Cancer. (2024). Retrieved 12 2024, from NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines): https://www.nccn.org/professionals/physician_gls/pdf/breast.pdf

Keywords:

SHP Scintimammography and Breast Specific Gamma Imaging, SHP Imaging 24, gamma cameras, radiopharmaceuticals, breast tissue, radioimmunoscintigraphy