6.01.06	Miscellaneous (Noncardiac, Nononcologic) Applications of Fluorine 18 Fluorodeoxyglucose Positron Emission Tomography		
Original Policy Date:	December 15, 2014	**Effective Date:**	November 1, 2020
Section:	6.0 Radiology	**Page:**	Page 1 of 33

Policy Statement

Positron emission tomography (PET) using 2-[fluorine-18]-fluoro-2-deoxy-D-glucose (FDG) may be considered **medically necessary** for **one of more** of the following:

I. The assessment of select patients with epileptic seizures who are candidates for surgery and **all** of the following:
   A. History of complex partial seizures that have failed to respond to medical therapy
   B. The suspected epileptogenic focus is located in a region of the brain accessible to surgery
   C. Conventional noninvasive techniques for seizure localization suggest a seizure focus but are not sufficiently conclusive to permit surgery
   D. PET examination will reduce or avoid the morbidity of extended preoperative electroencephalographic recording with implanted electrodes

II. The diagnosis of chronic osteomyelitis

The use of FDG-PET for all other miscellaneous indications is considered **investigational**, including, but not limited to the following:

I. Central Nervous System Diseases (CNS)
   A. Autoimmune disorders with central nervous system manifestations, including:
      1. Behçet syndrome
      2. Lupus erythematosus
   B. Cerebrovascular diseases, including:
      1. Arterial occlusive disease (arteriosclerosis, atherosclerosis)
      2. Carotid artery disease
      3. Cerebral aneurysm
      4. Cerebrovascular malformations (arteriovenous malformation and Moya-Moya disease)
      5. Hemorrhage
      6. Infarct
      7. Ischemia
   C. Degenerative motor neuron diseases, including:
      1. Amyotrophic lateral sclerosis
      2. Friedreich ataxia
      3. Olivopontocerebellar atrophy
      4. Parkinson disease
      5. Progressive supranuclear palsy
      6. Shy-drager syndrome
      7. Spinocerebellar degeneration
      8. Steele-Richardson-Olszewski syndrome
      9. Tourette syndrome
   D. Dementias, including:
      1. Alzheimer disease
      2. Dementia with Lewy bodies
      3. Frontotemporal dementia
      4. Multi-infarct dementia
      5. Pick disease
      6. Presenile dementia
   E. Demyelinating diseases, such as multiple sclerosis
   F. Developmental, congenital, or inherited disorders, including:
      1. Adrenoleukodystrophy

2. Down syndrome
3. Huntington chorea
4. Kinky-hair disease (Menkes disease)
5. Sturge-weber syndrome (encephalofacial angiomatosis) and the phakomatoses

G. Miscellaneous
1. Chronic fatigue syndrome
2. Posttraumatic stress disorder
3. Sick building syndrome

H. Nutritional or metabolic diseases and disorders, including:
1. Acanthocytosis
2. Hepatic encephalopathy
3. Hepatolenticular degeneration
4. Metachromatic leukodystrophy
5. Mitochondrial disease
6. Subacute necrotizing encephalomyelopathy

I. Psychiatric diseases and disorders, including:
1. Affective disorders
2. Depression
3. Obsessive-compulsive disorder
4. Psychomotor disorders
5. Schizophrenia

J. Pyogenic infections, including:
1. Aspergillosis
2. Encephalitis

K. Substance abuse, including the central nervous system effects of alcohol, cocaine, and heroin

L. Trauma, including brain injury and carbon monoxide poisoning

M. Viral infections, including:
1. HIV/AIDS
2. AIDS dementia complex
3. Creutzfeldt-Jakob disease
4. Progressive multifocal leukoencephalopathy
5. Progressive rubella encephalopathy
6. Subacute sclerosing panencephalitis

N. Mycobacterium infection

O. Migraine

P. Anorexia nervosa

Q. Assessment of cerebral blood flow in newborns
1. Vegetative vs locked-in syndrome

II. Pulmonary Diseases

A. Adult respiratory distress syndrome

B. Diffuse panbronchiolitis

C. Emphysema

D. Obstructive lung disease

E. Pneumonia

III. Musculoskeletal Diseases

A. Spondylodiscitis

B. Joint replacement follow-up

IV. Other

A. Fever of unknown origin

B. Giant cell arteritis

C. Inflammation of unknown origin

D. Inflammatory bowel disease

E. Sarcoidosis

F. Vascular prosthetic graft infection

G. Vasculitis

Policy Guidelines

Coding

A PET scan involves 3 separate activities:

- Manufacture of the radiopharmaceutical, which may be manufactured on site or at a regional center with delivery to the institution performing PET
- Actual performance of the PET scan
- Interpretation of the results

The following CPT codes may be used:

- **78608**: Brain imaging, positron emission tomography (PET); metabolic evaluation
- **78609**: Brain imaging, positron emission tomography (PET); perfusion evaluation
- **78811**: Positron emission tomography (PET) imaging; limited area (e.g., chest, head/neck)
- **78812**: Positron emission tomography (PET) imaging; skull base to mid-thigh
- **78813**: Positron emission tomography (PET) imaging; whole body
- **78814**: Positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization imaging; limited area (e.g., chest, head/neck)
- **78815**: Positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization imaging; skull base to mid-thigh
- **78816**: Positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization imaging; whole body

There is a HCPCS code specific to the fluorodeoxyglucose (FDG) radiotracer:

- **A9552**: Fluorodeoxyglucose F-18 FDG, diagnostic, per study dose, up to 45 millicuries

Description

Positron emission tomography (PET) images biochemical and physiologic functions by measuring concentrations of radioactive chemicals that have been partially metabolized in a particular region of the body. Radiopharmaceuticals used for PET are generated in a cyclotron (nuclear generator) and then introduced into the body by intravenous injection or respiration.

Related Policies

- Cardiac Applications of Positron Emission Tomography Scanning
- Interim Positron Emission Tomography Scanning in Oncology to Detect Early Response During Treatment
- Oncologic Applications of Positron Emission Tomography Scanning

Benefit Application

Benefit determinations should be based in all cases on the applicable contract language. To the extent there are any conflicts between these guidelines and the contract language, the contract language will control. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage of these services as it applies to an individual member.

Some state or federal mandates (e.g., Federal Employee Program [FEP]) prohibits plans from denying Food and Drug Administration (FDA)-approved technologies as investigational. In these instances, plans may have to consider the coverage eligibility of FDA-approved technologies on the basis of medical necessity alone.

Regulatory Status

Following the U.S. Food and Drug Administration's (FDA) approval of the Penn-PET in 1989, a number of PET scan platforms have been cleared by FDA through the 510(k) process. These systems are intended to aid in detecting, localizing, diagnosing, staging and restaging of lesions, tumors, disease and organ function for the evaluation of diseases, and disorders such as, but not limited to, cardiovascular disease, neurologic disorders, and cancer. The images produced by the system can aid in radiotherapy treatment planning and interventional radiology procedures.

PET radiopharmaceuticals have been evaluated and approved as drugs by the FDA for use as diagnostic imaging agents. These radiopharmaceuticals are approved for specific conditions.

In December 2009, the FDA issued guidance for Current Good Manufacturing Practice for PET drug manufacturers[15] and, in August 2011, issued similar Current Good Manufacturing Practice guidance for small businesses compounding radiopharmaceuticals.[16] An additional final guidance document, issued in December 2012, required all PET drug manufacturers and compounders to operate under an approved new drug application (NDA) or abbreviated NDA, or investigational new drug application, by December 12, 2015.[17]

In 1994, the FDG radiotracer was originally approved by the FDA through the NDA (20-306) process. The original indication was for "the identification of regions of abnormal glucose metabolism associated with foci of epileptic seizures." Added indications in 2000 were for "Assessment of glucose metabolism to assist in the evaluation of malignancy..." and "Assessment of patients with coronary artery disease and left ventricular dysfunction...."

Multiple manufacturers have approved NDAs for FDG.[18]

See related Blue Shield of California Medical Policy: Oncologic Applications of Positron Emission Tomography Scanning and Interim Positron Emission Tomography Scanning in Oncology to Detect Early Response During Treatment for oncologic indications and Cardiac Applications of Positron Emission Tomography Scanning for cardiac indications for FDG.

Rationale

Background

Positron Emission Tomography

PET scans coupled position-emitting radionuclide tracers to other molecules, such as glucose, ammonia, or water. The radionuclide tracers simultaneously emit two high-energy photons in opposite directions that can be simultaneously detected (referred to as *coincidence detection*) by a PET scanner, which comprises multiple stationary detectors that encircle the region of interest.

A variety of tracers are used for PET scanning, including oxygen 15, nitrogen 13, carbon 11, and fluorine 18. The radiotracer most commonly used in oncology imaging has been fluorine 18, coupled with fluorodeoxyglucose (FDG), which has a metabolism related to glucose metabolism. While FDG has traditionally been used in cancer imaging, it potentially has many other applications.

Literature Review

Evidence reviews assess whether a medical test is clinically useful. A useful test provides information to make a clinical management decision that improves the net health outcome. That is, the balance of benefits and harms is better when the test is used to manage the condition than when another test or no test is used to manage the condition.

The first step in assessing a medical test is to formulate the clinical context and purpose of the test. The test must be technically reliable, clinically valid, and clinically useful for that purpose. Evidence reviews assess the evidence on whether a test is clinically valid and clinically useful. Technical reliability is outside the scope of these reviews, and credible information on technical reliability is available from other sources.

Fluorine 18 Fluorodeoxyglucose Positron Emission Tomography

Intractable Epilepsy

Clinical Context and Test Purpose

The purpose of FDG-PET in patients with epilepsy is to inform the decision on selecting treatment regimens.

The question addressed in this evidence review is: Does the use of FDG-PET improve the net health outcome in individuals with medically refractory or intractable epilepsy who are candidates for neurosurgery?

The following PICO was used to select literature to inform this review.

Patients

The population of interest is patients with intractable epilepsy. Approximately one-third of epilepsy do not achieve adequate seizure control with antiepileptic drugs.[8,8,] Individuals with drug-resistant epilepsy are candidates for other treatments such as surgery. Many effective surgical procedures are available and the treatment selected depends on characteristics of the seizures (e.g. , the epileptogenic zone) and the extent to which it can be resected safely.

Neuroimaging techniques, such as magnetic resonance imaging (MRI), electroencephalography, PET, single-photon emission computed tomography, electric and magnetic source imaging, and magnetic resonance spectroscopy, have been used to locate the epileptic focus, thereby helping to guide the operative strategy. Some patients with epilepsy will have no identifiable MRI abnormality to help identify the focal region. PET, particularly using FDG, is a neuroimaging technique frequently used in patients being considered for surgery. FDG-PET produces an image of the distribution of glucose uptake in the brain, presumably detecting focal areas of decreased metabolism.[9,] PET may be able to correctly identify the focus in patients with unclear or unremarkable MRI results or discordant MRI and that could reduce the need for invasive electroencephalography. PET scanning may also help to predict which patients will have a favorable outcome following surgery. The Engel classification system often used to describe the surgical outcome, is as follows: class I: seizure-free (or free of disabling seizures); class II: nearly seizure-free; class III: worthwhile improvement; and class IV: no worthwhile improvement.[10,]

Interventions

The intervention of interest is FDG-PET. For patients with epilepsy, FDG-PET would be conducted prior to surgery to identify the epileptogenic focus.

Comparators

Ictal scalp electroencephalography and MRI are currently being used to make preoperative decisions in patients with epilepsy for whom surgery is being considered.

Outcomes

For patients with epilepsy, the outcome of interest is to predict which patients will have a favorable outcome following surgery. Other outcomes of interest include symptoms, change in disease status, functional outcomes, health status measures, quality of life (QOL), hospitalizations, medication use, and resource utilization. For patients with epilepsy, FDG-PET would be conducted prior to surgery.

Study Selection Criteria

For the evaluation of the clinical validity of the tests, studies that meet the following eligibility criteria were considered:

- Reported on the accuracy of the marketed version of the technology (including any algorithms used to calculate scores)
- Included a suitable reference standard
- Patient/sample clinical characteristics were described
- Patient/sample selection criteria were described
- Included a validation cohort separate from development cohort.

Technically Reliable

Assessment of technical reliability focuses on specific tests and operators and requires a review of unpublished and often proprietary information. Review of specific tests, operators, and unpublished data are outside the scope of this evidence review and alternative sources exist. This evidence review focuses on the clinical validity and clinical utility.

Clinically Valid

A test must detect the presence or absence of a condition, the risk of developing a condition in the future, or treatment response (beneficial or adverse).

Systematic Reviews

A TEC Assessment (1996) reviewed the evidence on the use of PET in individuals with seizure disorders from 12 studies in which the results of PET scans were correlated with results of an appropriate reference standard test.[5] The highest quality blinded study (n=143) reported that PET correctly localized the seizure focus in 60% of patients, incorrectly localized it in 6%, and was inconclusive in 34%. Reviewers concluded that because localization can be improved with PET, selection of surgical candidates is improved and, therefore, PET for assessing patients who have medically refractory complex partial seizures and are potential candidates for surgery met TEC criteria. All other uses of PET for the management of seizure disorders did not meet the TEC criteria. Tables 1 and 2 summarize the characteristics and results of several meta-analyses of FDG-PET published since that TEC Assessment that have assessed either presurgical planning of patients who are candidates for epilepsy surgery or prediction of surgical outcomes. A brief discussion of each trial follows.

Table 1. Characteristics of Systematic Reviews Assessing Use of FGD-PET for Epilepsy

Study	Dates	Trials	N (Range)	Design	Duration
Jones et al (2016)[11]	1946-2014	27	3163 (25-434)	OBS	≥ 1 year
Wang et al (2016)[12]	2000-2015	18	391 (5-86)	NR	1-6.5 years
Burneo et al (2015)[13]	1946-2013	39	2650	OBS	1 year, median
Englot et al (2012)[14]	1990-2010	21[a]	1199 (13-253)[a]	OBS	> 4 years
Willmann et al (2007)[15]	1992-2006	46	1112 (2-117)	OBS	3 to 144 months

FDG-PET: fluorine 18 fluorodeoxyglucose positron emission tomography; OBS: observational; NR: not reported.
[a] Total number of studies and participants included; unclear if all studies included PET as a predictor.

Jones et al (2016) published a systematic review of neuroimaging for surgical treatment of temporal lobe epilepsy.[11] Inclusion criteria were systematic reviews, randomized controlled trials (RCTs), or observational studies (with >20 patients and at least 1-year follow-up) of neuroimaging in the surgical evaluation for temporal lobe epilepsy. Reviewers searched EMBASE, PubMed, and Cochrane databases. Twenty-seven studies with 3163 patients were included in the review, of which 11 observational studies with 1358 patients evaluated FDG-PET. Good surgical outcome was defined as Engel classes I and II. Meta-analysis was not performed. Results are summarized in Table 2.

Wang et al (2016) conducted a systematic review of prognostic factors for seizure outcomes in patients with MRI-negative temporal lobe epilepsy included a search of PubMed.[12] Eighteen studies (total n=391 patients) were included with a mean or median follow-up of more than 1 year. Seizure freedom was defined as freedom from any type of seizure or an Engel class I seizure outcome. Odds ratios and corresponding 95% confidence intervals (CIs) were calculated to compare the pooled proportions of seizure freedom between the groups who had localization of hypometabolism in the resected lobe vs those who did not. Table 2 shows the summary results. Burneo et al (2015) published a recommendation report for the Program in Evidence-based Care and the PET steering committee of Cancer Care Ontario, which was based on a systematic review of studies of diagnostic accuracy and clinical utility of FDG-PET in the presurgical evaluation of adult and pediatric patients with medically intractable epilepsy.[13] The literature review included searches of the PubMed, EMBASE, OVID, and Cochrane databases. Systematic reviews, RCTs, and observational studies that evaluated the use of FDG-PET in medically intractable epilepsy were eligible for inclusion. Reviewers included 39 observational studies (total n=2650 participants) in the qualitative review. Good surgical outcome was defined as Engel class I, II, or III, seizure-free, or significant improvement (<10 seizures per year and at least a 90% reduction in seizures from the preoperative year). Due to heterogeneity in patient populations, study designs, outcome measurements, and methods of PET interpretation, pooled estimates were not provided; ranges are provided in Table 2.

Englot et al (2012) performed a systematic review of predictors of long-term seizure freedom after surgery for frontal lobe epilepsy; they included articles found through a PubMed search that had at least 10 participants and 48 months of follow-up.[14] Long-term seizure freedom was defined as Engel class I outcome. Twenty-one studies (total n=1199 patients) were included; the number of studies that specifically addressed PET was not specified. Results are summarized in Table 2. Reviewers found that PET scans did not predict seizure freedom.

Willmann et al (2007) conducted a meta-analysis on the use of FDG-PET for preoperative evaluation of adults with temporal lobe epilepsy included 46 studies published identified through a PubMed search.[15] Follow-up ranged from 3 to 144 months. Engel class I and II were defined as a good surgical outcome. The prognostic positive predictive value (PPV) for ipsilateral PET hypometabolism was calculated but the reviewers noted a significant variation in study designs and lack of precise data. Reviewers found that ipsilateral PET hypometabolism had a predictive value for a good outcome of 86% (see Table 2). The incremental benefit of PET was unclear.

Table 2. Results of Systematic Reviews on Use of FDG-PET for Epilepsy

Study	Studies	N	Outcomes	Estimate or Range	95% CI	I^2	p
Jones et al (2016)[11]	11	1358	Surgical outcome	• No overall summary given • Reported conflicting findings on prognostic importance of PET-identified focal hypometabolism	No pooling	NR	NR
Wang et al (2016)[12]	5	NR	Surgical outcome (freedom from seizures)	OR for PET hypometabolism positive vs negative, 2.11	0.95 to 4.65	0	0.06
Burneo et al (2015)[13]	8	310	Percent agreement, localization with PET vs EEG	• 56%-90% overall (adults) • 63%-90% in temporal lobe epilepsy (adults)	No pooling	NR	NR
	13	1064	Prognostic accuracy (good surgical outcome)	36%-89% (adults)	No pooling	NR	NR
	6	690	Clinical decisions	• 53%-71% (adults) • 51%-95% (children)	No pooling	NR	NR

			(influence decision making)				
Englot et al (2012)[14]	21[a]	1199[a]	Prognostic accuracy (good surgical outcome)	% for PET focal vs PET nonfocal, 52% vs 48%	NR	NR	0.61
Willmann et al (2007)[15]	46	1112	Prognostic accuracy (good surgical outcome)	PPV=86%	NR	NR	NR

CI: confidence interval; EEG: electroencephalography; FDG: fluorine 18 fluorodeoxyglucose; NR: not reported; OR: odds ratio; PET: positron emission tomography; PPV: positive predictive value.
[a] Total number of studies and participants included; unclear if all studies included PET as a predictor.

Observational Studies
In a study published after the most recent systematic reviews, Traub-Weidinger et al (2016) reviewed a database of pediatric patients with epilepsy who underwent hemispherotomy and were evaluated with both FDG-PET and MRI before surgery (n=35).[16] Identifying the hemisphere harboring the epileptogenic zone before surgery has been shown to improve surgical outcomes. Seizure outcomes were measured using International League Against Epilepsy classifications. At 12 months postsurgery, 100% of patients with unilateral FDG-PET hypometabolism were seizure-free, while 95% of patients with unilateral lesions identified by MRI were seizure-free. For patients with bilateral FDG-PET hypometabolism, 75% were seizure-free at 12 months, while 71% of patients with bilateral lesions identified by MRI were seizure-free.

Clinically Useful
A test is clinically useful if the use of the results informs management decisions that improve the net health outcome of care. The net health outcome can be improved if patients receive correct therapy, or more effective therapy, or avoid unnecessary therapy, or avoid unnecessary testing.

Direct Evidence
Direct evidence of clinical utility is provided by studies that have compared health outcomes for patients managed with and without the test. Because these are intervention studies, the preferred evidence would be from RCTs.

- The recommendation report by Burneo et al (2015) discussed 3 retrospective studies demonstrating the impact of FDG-PET on clinical management of adults with epilepsy and 3 retrospective studies on change in clinical management based on FDG-PET results in children with epilepsy.[13] After receiving FDG-PET results on adults, some clinicians changed surgical decisions, used the results to guide intracranial electroencephalography, and ruled out additional evaluation of the patient. Among pediatric patients who underwent FDG-PET, clinicians reported using the results to alter surgical decisions, classify symptomatic infantile spasms, and avoid invasive monitoring due to localizing information. The study results were not pooled due to heterogeneity among the study designs and patient populations.

Section Summary: Epilepsy
The TEC Assessment and the Program in Evidence-based Care recommendations summarized evidence on the use of PET to localize seizure foci for presurgical evaluation. Although data were exclusively from observational studies and the results were heterogeneous, the findings generally supported the use of PET for presurgical evaluation of adult and pediatric patients with intractable epilepsy to localize foci. For predicting which patients would have a favorable surgery outcome, the data on PET were mixed but supported a possible moderate relation between PET findings and prognosis. There are several retrospective studies that surveyed clinicians on the utility of FDG-PET in managing patients with epilepsy. In general, the clinicians reported that the information from FDG-PET was helpful in surgical management decisions. Only

observational studies are available, most having small samples sizes with varying patient characteristics and definitions of good surgical outcomes.

Suspected Chronic Osteomyelitis
Clinical Context and Test Purpose
The purpose of FDG-PET in patients with chronic osteomyelitis is to confirm a diagnosis or to inform the decision on selecting treatment regimens.

The question addressed in this evidence review is: Does the use of FDG-PET improve the net health outcome in individuals with chronic osteomyelitis?
The following PICO was used to select literature to inform this review.

Patients
The population of interest is patients with chronic osteomyelitis.
Diabetic foot infections cause substantial morbidity and are a frequent cause of lower-extremity amputations. Foot infections can spread to contiguous deep tissues including the bone.

Diagnosis of osteomyelitis is challenging. The reference standard for diagnosis is an examination of bacteria from a bone biopsy along with histologic findings of inflammation and osteonecrosis. In an open wound, another potential test for osteomyelitis is a probe-to-bone test, which involves exploring the wound for palpable bone using a sterile blunt metal probe.[17,] Plain radiographs are often used as screening tests before biopsy but they tend to have low specificity especially in early infection. When radiographs are inconclusive, a more sophisticated imaging technique can be used. Neither MRI nor computed tomography (CT), both of which have high sensitivity in diagnosing osteomyelitis, can be used in patients with metal hardware.[18,] FDG-PET has high resolution that should be an advantage for accurate localization of leukocyte accumulation and can be used when MRI is not possible or inconclusive; in addition, PET semiquantitative analysis could facilitate the differentiation of osteomyelitis from noninfectious conditions such as neuropathic arthropathy

Interventions
The intervention of interest is FDG-PET. For patients with suspected chronic osteomyelitis, FDG-PET would be performed following inconclusive clinical examinations and standard radiographs.

Comparators
CT, radiography, and MRI are currently being used to make decisions about managing suspected chronic osteomyelitis.

Outcomes
For patients with suspected chronic osteomyelitis, the main outcomes interest are disease-related morbidity and mortality. Other outcomes of interest include test accuracy, test validity, symptoms, change in disease status, functional outcomes, health status measures, QOL, hospitalizations, medication use, and resource utilization.

Study Selection Criteria
For the evaluation of the clinical validity of the tests, studies that meet the following eligibility criteria were considered:

- Reported on the accuracy of the marketed version of the technology (including any algorithms used to calculate scores)
- Included a suitable reference standard
- Patient/sample clinical characteristics were described
- Patient/sample selection criteria were described
- Included a validation cohort separate from development cohort.

Technically Reliable
Assessment of technical reliability focuses on specific tests and operators and requires a review of unpublished and often proprietary information. Review of specific tests, operators, and unpublished data are outside the scope of this evidence review and alternative sources exist. This evidence review focuses on the clinical validity and clinical utility.

Clinically Valid
A test must detect the presence or absence of a condition, the risk of developing a condition in the future, or treatment response (beneficial or adverse).

Systematic Reviews
Lauri et al (2017) published a systematic review of 27 trials of diabetic patients with suspicion of osteomyelitis of the foot that compared the diagnostic performance of several imaging techniques.[19.] MRI, technetium 99m hexamethylpropyleneamineoxime white blood cell (WBC) scan, indium In 111 oxyquinoline WBC scan, or FDG-PET plus CT were assessed. In this population, the sensitivity and specificity of FDG-PET/CT (6 studies; 254 patients) were 89% (95% CI, 68% to 97%) and 92% (95% CI, 85% to 96%), respectively. The diagnostic odds ratio for FDG-PET was 95, and the positive and negative likelihood ratios were 11 and 0.11, respectively. Of the 4 modalities included, FDG-PET/CT and technetium 99m hexamethylpropyleneamineoxime WBC scans had greater specificity (both 92%) than MRI or In-oxine WBC scans (both 75%). Sensitivity did not differ significantly between modalities: 93% for MRI, 92% for indium In 111 oxyquinoline WBC, 91% for technetium 99m hexamethylpropyleneamineoxime WBC, and 89% for FDG-PET. The review was limited by the small size of studies included, which precluded subgroup or meta-regression analyses.

A systematic review by Treglis et al (2013) assessed 9 studies (total n=299 patients), FDG-PET and PET with CT were found to be useful for assessing suspected osteomyelitis in the foot of patients with diabetes.[20.] A meta-analysis of 4 studies found a sensitivity of 74% (95% CI, 60% to 85%), a specificity of 91% (95% CI, 85% to 96%), a positive likelihood ratio of 5.56 (95% CI, 2.02 to 15.27), a negative likelihood ratio of 0.37 (95% CI, 0.10 to 1.35), and a diagnostic odds ratio of 16.96 (95% CI, 2.06 to 139.66). The summary area under the receiver operating characteristic curve was 0.874.

Termaat et al (2005) conducted a systematic review of diagnostic imaging to assess chronic osteomyelitis.[21.] Reviewers assessed 6 imaging approaches to chronic osteomyelitis, including FDG-PET, and concluded that PET was the most accurate mode (pooled sensitivity, 96%; 95% CI, 88% to 99%; pooled specificity, 91%; 95% CI, 81% to 95%) for diagnosing chronic osteomyelitis, including leukocyte scintigraphy was adequate in the peripheral skeleton (sensitivity, 84%; 95% CI, 72% to 91%; specificity, 80%; 95% CI, 61% to 91%) but was inferior in the axial skeleton (sensitivity, 21%; 95% CI, 11% to 38%; specificity, 60%; 95% CI, 39% to 78%). The assessment of PET was based on 4 prospective, European studies published between 1998 and 2003 (total n=1660 patients). However, the study populations varied and included the following: (1) 57 patients with suspected spinal infection referred for FDG-PET and who had previous spinal surgery but not "recently"[22.]; (2) 22 trauma patients scheduled for surgery who had suspected metallic implant-associated infection[23.]; (3) 51 patients with recurrent osteomyelitis or osteomyelitis symptoms for more than 6 weeks, 36 in the peripheral skeleton and 15 in the central skeleton[24.]; and (4) 30 consecutive nondiabetic patients referred for possible chronic osteomyelitis.[25.] The results appeared to be robust across fairly diverse clinical populations, which strengthen the conclusions.

Prospective Studies
Rastogi et al (2016) published a study comparing the efficacy of FDG-PET plus CT with contrast-enhanced MRI in the detection of diabetic foot osteomyelitis in patients with Charcot neuroarthropathy.[26.] Patients with suspected diabetic foot osteomyelitis (n=23) underwent radiographs, FDG-PET/CT, and contrast-enhanced MRI. Bone culture, which is considered the criterion standard, identified 12 of the 23 patients with osteomyelitis. The sensitivity, specificity,

PPV, and negative predictive value (NPV) of FDG-PET/CT in diagnosing osteomyelitis were 83%, 100%, 100%, and 85%, respectively. The same measures for contrast-enhanced MRI were 83%, 64%, 71%, and 78%, respectively.

Clinically Useful
A test is clinically useful if the use of the results informs management decisions that improve the net health outcome of care. The net health outcome can be improved if patients receive correct therapy, or more effective therapy, or avoid unnecessary therapy, or avoid unnecessary testing.

Direct Evidence
Direct evidence of clinical utility is provided by studies that have compared health outcomes for patients managed with and without the test. Because these are intervention studies, the preferred evidence would be from RCTs.

- No RCTs identified assessed the evidence on the clinical utility of FDG-PET for diagnosing osteomyelitis.

Chain of Evidence
Indirect evidence on clinical utility rests on clinical validity. If the evidence is insufficient to demonstrate test performance, no inferences can be made about clinical utility.

- Diagnosing osteomyelitis is challenging and FDG-PET may provide additional information along the diagnostic pathway. Currently, a bone biopsy is considered the reference standard, and radiographs are often used as screening tests prior to bone biopsy. When radiographs are inconclusive, other imaging techniques have been used, such as MRI and CT. While MRI has been shown to have a high sensitivity in diagnosing osteomyelitis, FDG-PET has also been shown to have high sensitivity and can be used when MRI is inconclusive or not possible (e.g., patients with metal hardware).

Section Summary: Suspected Chronic Osteomyelitis
Evidence for the use of FDG-PET to diagnose chronic osteomyelitis includes 3 systematic reviews and a prospective study published after the systematic reviews. FDG-PET and FDG-PET/CT were found to have high specificity and PPVs in diagnosing osteomyelitis. Compared with other modalities, FDG-PET and FDG-PET/CT were found to have better diagnostic capabilities than contrast-enhanced MRI

Diagnosing Suspected Alzheimer Disease
Clinical Context and Test Purpose
The purpose of FDG-PET in patients with suspected AD is to confirm a diagnosis of AD.
The question addressed in this evidence review is: Does the use of FDG-PET improve the net health outcome in individuals with suspected AD?

The following PICO was used to select literature to inform this review.

Patients
The population of interest are patients with suspected AD.
A definitive diagnosis of AD requires histopathologic examination of brain tissue obtained by biopsy or autopsy. In practice, clinical criteria based on clinical examination, neurologic and neuropsychological examinations, and interviews with informants (e.g., family members or caregivers) are used to diagnose AD by excluding other diseases that can cause similar symptoms and distinguish AD from other forms of dementia.

Interventions
The intervention of interest is FDG-PET.
For patients with suspected AD, FDG-PET would be performed following inconclusive clinical examinations and standard radiographs.

Comparators
Clinical diagnosis without FDG-PET is currently being used for suspected AD.

Outcomes
For patients with suspected AD, the main outcomes interest are disease-related morbidity and mortality. Other outcomes of interest include test accuracy, test validity, symptoms, change in disease status, functional outcomes, health status measures, QOL, hospitalizations, medication use, and resource utilization.

Study Selection Criteria
For the evaluation of the clinical validity of the tests, studies that meet the following eligibility criteria were considered:

- Reported on the accuracy of the marketed version of the technology (including any algorithms used to calculate scores)
- Included a suitable reference standard
- Patient/sample clinical characteristics were described
- Patient/sample selection criteria were described
- Included a validation cohort separate from development cohort.

This evidence review does not discuss PET tracers that bind to amyloid beta plaques (see review 6.01.55).

Technically Reliable
Assessment of technical reliability focuses on specific tests and operators and requires a review of unpublished and often proprietary information. Review of specific tests, operators, and unpublished data are outside the scope of this evidence review and alternative sources exist. This evidence review focuses on the clinical validity and clinical utility.

Clinically Valid
A test must detect the presence or absence of a condition, the risk of developing a condition in the future, or treatment response (beneficial or adverse).

Systematic Reviews
Summaries of the characteristics and results of several meta-analyses of the early diagnosis of AD in people with cognitive impairment or for differentiating between potential causes of dementia are shown in Tables 3 and 4 and are briefly described below.

Table 3. Characteristics of Systematic Reviews on Use Assessing FDG-PET for AD and Dementia

Study	Dates	Studies	N (Range)	Design	Outcomes
Smailagic et al (2015)[27.]	1999-2013	16	697 (19-94)	OBS	Diagnostic accuracy for predicting conversion from MCI to AD
Davison et al (2014)[28.]	Up to 2013	9	NR	OBS	Diagnostic accuracy for diagnosis of AD, differential diagnosis in dementia, predicting conversion from MCI to AD
Bloudek et al (2011)[29.]	1990-2010	119	NR	OBS	Diagnostic accuracy for diagnosis of AD, differential diagnosis in dementia
Yuan et al (2009)[30.]	2001-2005	6	280 (17-128)	OBS	Diagnostic accuracy for predicting conversion from MCI to AD
Matchar et al (2001)[31.]	1995-2001	18	1018 (10-138)	OBS	Diagnostic accuracy for distinguishing AD from healthy controls and for differential diagnosis in dementia

AD: Alzheimer disease; FDG-PET: fluorine 18 fluorodeoxyglucose positron emission tomography; MCI: mild cognitive impairment; NR: not reported; OBS: observational.

Smailagic et al (2015) conducted a Cochrane review to assess the diagnostic accuracy of FDG-PET for detecting people who clinically convert to AD or other forms of dementia at follow-up.[27] Included studies evaluated the diagnostic accuracy of FDG-PET to determine the conversion from mild cognitive impairment (MCI) to AD or to other forms of dementia. Sixteen studies (total n=697 participants) were included in the qualitative review and 14 studies (n=421 participants) were included in the analysis. Because there are no accepted thresholds to define positive findings based on PET scans and studies used mixed thresholds for diagnosis, reviewers used a hierarchical summary receiver operating characteristic curve to derive pooled estimates of performance characteristics at fixed values. Results are shown in Table 4. Five studies evaluated the accuracy of FDG-PET for all types of dementia. The sensitivities ranged between 46% and 95% while the specificities between 29% and 100%; however, a meta-analysis could not be conducted because of the small number of studies sample sizes. Reviewers indicated that most studies were poorly reported and had an unclear risk of bias, mainly for the reference standard and participant selection domains.

In a systematic review (quality assessment of included studies was not reported), Davison et al (2014) reported on studies on the diagnostic performance of FDG-PET and single-photon emission CT identified through PubMed.[28] Three studies (197 patients) used histopathology as the reference standard. In patients with or without a clinical diagnosis of AD, sensitivity was 84% and specificity was 74%; in patients with memory loss or dementia, sensitivity was 94% and specificity was approximately 70%; in patients undergoing evaluation for dementia, sensitivity was 94% and specificity was 73%. Precision estimates were not given. In 3 different studies (271 participants), the sensitivities and specificities of FDG-PET for distinguishing AD from Lewy body dementia ranged from 83% to 99% and from 71% to 93%, respectively. I n 2 studies (183 participants), for predicting conversion from MCI to AD, sensitivity, and specificity of PET ranged from 57% to 82% and from 67% to 78%, respectively.

Bloudek et al (2011) assessed diagnostic strategies for AD in a meta-analysis.[29] Reviewers included 119 studies of diagnostic performance characteristics published from 1990 to 2010. Studies were identified through a search of PubMed and included imaging, biomarkers, and clinical diagnostic strategies. Twenty studies included performance characteristics of FDG-PET for diagnosing AD compared with normal, nondemented controls. Thirteen studies described characteristics of FDG-PET for diagnosing AD compared with demented controls. FDG-PET demonstrated the highest area under the receiver operating characteristic curve, sensitivity, and specificity among all of the diagnostic methods for distinguishing AD from normal controls but one of the lowest receiver operating characteristic comparing AD with non-AD demented controls (excluding MCI), due primarily to the low specificity in this group. Results are shown in Table 4.

In a meta-analysis, Yuan et al (2009) compared the prognostic capacity of FDG-PET, single-photon emission CT, and structural MRI to predict patients' conversion from MCI to AD.[30] Using 24 articles (total n=1112 patients) published between 1990 to 2008 (6 studies with 280 patients on FDG-PET, published 2001-2005), reviewers found no statistically significant difference among the 3 modalities in pooled sensitivity, pooled specificity, or negative likelihood ratio. Results are shown in Table 4. There was strong evidence of between-study heterogeneity and marked asymmetry in the funnel plot (with studies missing from the bottom left quadrant), indicating possible publication bias of studies with null results. Efforts to identify sources of heterogeneity (e.g., publication year, age, male-female ratio, follow-up interval, years of education, mean Mini-Mental State Examination score at baseline) yielded no significant results.

Using decision-analysis modeling, Matchar et al (2001) performed a technology assessment for the Agency for Healthcare Research and Quality to examine whether the use of FDG-PET would improve health outcomes for diagnosis of AD in 3 clinical populations: patients with dementia, patients with MCI, and subjects with no symptoms but with a first-degree relative with AD.[31] For the review, a search was performed using PubMed, CINAHL, and the HealthSTAR databases. Eighteen articles (total n=1018 participants) were included. The reference standard used in the

studies was either histopathology or clinical diagnosis. Studies reported on various cutoffs for PET positivity, and, therefore, an unweighted summary receiver operating characteristic method was used to calculate the pooled area under the curve. Results are summarized in Table 4. Reviewers concluded that outcomes for all 3 groups were better if all patients were treated with agents such as cholinesterase inhibitors rather than limiting treatment to patients based on FDG-PET results. The rationale was that the complications of treatment were relatively mild, and that treatment was considered to have some degree of efficacy in delaying the progression of AD.

Table 4. Results of Systematic Review on Use Assessing FDG-PET for AD and Dementia

Study	Studies	N	Outcomes	Estimate (95% CI)
Smailagic et al (2015)[27.]	14	421	Diagnostic accuracy	• Sensitivity range: 25%-100% • Specificity range: 15%-100% • PLR: 4.03 (2.97 to 5.47) • NLR: 0.34 (0.15 to 0.75)
Davison et al (2014)[28.]	3	197	Diagnostic accuracy	• Sensitivity: 84% • Specificity: 74%
•	2	183	Diagnostic accuracy, predicting conversion from MCI to AD	• Sensitivity range: 57%-82% • Specificity range: 67%-78%
•	5	292	Diagnostic accuracy, differentiating AD and LBD	• Sensitivity range: 83%-92% • Specificity range: 67%-93%
Bloudek et al (2011)[29.]	20	NR	Diagnostic accuracy	• Sensitivity: 90% (84% to 94%) • Specificity: 89% (81% to 94%)
•	13	NR	Diagnostic accuracy, AD vs other dementia	• Sensitivity: 92% (84% to 96%) • Specificity: 78% (69% to 85%)
Yuan et al (2009)[30.]	6	280	Diagnostic accuracy	• Sensitivity: 89% (92% to 94%) • Specificity: 85% (78% to 90%) • PLR: 4.6 (3.2 to 6.7) • NLR: 0.15 (0.05 to 0.48)
Matchar et al (2001)[31.]	15	729	Diagnostic accuracy	• Sensitivity: 88% (79% to 94%) • Specificity: 87% (77% to 93%)
•	3	289	Diagnostic accuracy, distinguishing AD from non-AD dementia	• Sensitivity range: 86% to 95% • Specificity range: 61% to 74%

AD: Alzheimer disease; CI: confidence interval; FDG-PET: fluorine 18 fluorodeoxyglucose positron emission tomography; LBD: Lewy body dementia; MCI: mild cognitive impairment; NLR: negative likelihood ratio; NR; not reported; PLR: positive likelihood ratio.

Retrospective Studies

In a study published after the systematic reviews, Pagani et al (2017) tested the accuracy of FDG-PET to discriminate between patients with MCI who progressed to AD and those who did not progress.[32.]The study population consisted of 42 normal elderly patients without MCI, 27 patients with MCI who had not converted to AD after a follow-up of at least 5 years since the first FDG-PET scan (mean follow-up, 7.5 years), and 95 patients with MCI who converted to AD within

5 years of the baseline FDG-PET (mean time to conversion, 1.8 years). The group that progressed to AD within 5 years showed significantly lower FDG-PET uptake values in the temporoparietal cortex than the other groups. Baseline FDG-PET identified patients who converted to AD with an accuracy of 89%.

Clinically Useful
A test is clinically useful if the use of the results informs management decisions that improve the net health outcome of care. The net health outcome can be improved if patients receive correct therapy, or more effective therapy, or avoid unnecessary therapy, or avoid unnecessary testing.

Direct Evidence
Direct evidence of clinical utility is provided by studies that have compared health outcomes for patients managed with and without the test. Because these are intervention studies, the preferred evidence would be from RCTs.

- Motara et al (2017) assessed the accuracy of dual-trained radiologists and nuclear medicine physicians to diagnose the type of cognitive impairment based on FDG-PET/CT images. Records of patients who had undergone FDG-PET/CT because of cognitive impairment (AD, frontotemporal dementia, mixed dementia, and dementia with Lewy bodies) following a negative CT or MRI scans were reviewed (n=136).[33.] Questionnaires were sent to the referring physicians to gather information on the final clinical diagnosis, usefulness of the PET/CT report, and whether the report impacted clinical management. The response rate was 72% (98/136) and mean patient follow-up was 471 days. For the diagnosis of AD, using the final clinical diagnosis as the reference standard, the sensitivity, specificity, PPV, and NPV were 87%, 97%, 93%, and 91%, respectively. Questionnaires received from the 98 physicians indicated that PET/CT: was useful (78%); had an impact on clinical management (81%); added confidence to the pretest clinical diagnosis (43%); reduced the need for further investigations (42%); changed the pretest clinical diagnosis (35%); and led to a change in therapy (32%).

Section Summary: Suspected Alzheimer Disease
Several systematic reviews offer evidence on FDG-PET for diagnosing AD in people with cognitive impairment and for differentiating between AD and other dementias. Studies included in these reviews were generally poor quality. There is no standard cutoff for positive amyloid findings on PET scanning for diagnosing AD, and many studies did not include postmortem confirmation of AD as the reference standard. These limitations lead to uncertainty about estimates of performance characteristics. Although it appears that FDG-PET has high sensitivity and specificity, the evidence does not compare the performance characteristics of clinical diagnosis with PET to clinical diagnosis without PET, so the incremental value of adding PET to the standard clinical diagnosis is unclear. No studies reported on clinical outcomes of patients diagnosed with vs without FDG-PET. A single study was identified that surveyed physicians on the clinical utility of FDG-PET/CT in managing patients with cognitive impairment. In general, the physicians found the FDG-PET/CT helpful but no clinical outcomes of patients were reported.

Suspected Large Vessel Vasculitis
Clinical Context and Test Purpose
The purpose of FDG-PET in patients with suspected LVV is to confirm a diagnosis or to inform the decision on selecting treatment regimens.

The question addressed in this evidence review is: Does the use of FDG-PET improve the net health outcome in individuals with suspected LVV?

The following PICO was used to select literature to inform this review.

Patients
The populations of interest include patients with suspected LVV.

LVV causes granulomatous inflammation primarily of the aorta and its major branches.[34.] There are 2 major types of LVV: giant cell arteritis (GCA) and Takayasu arteritis (TA). Classification criteria for GCA and TA were developed by American College of Rheumatology in 1990.[35,36.] The definitions have since been refined by the International Chapel Hill Consensus Conference on the Nomenclature of Vasculitides (2012).[37.] Biopsy and angiography are considered the criterion standard techniques for diagnosis but they are invasive and detect changes that occur late in the disease. In practice, the diagnosis is challenging because patients tend to have nonspecific symptoms such as fatigue, loss of appetite, weight loss, and low-grade fever as well as nonspecific lab findings such as increased C-reactive protein or erythrocyte sedimentation rate.[38.] Misdiagnosis is common particularly during the early stages of the disease. Unfortunately, late diagnosis can lead to serious aortic complications and death. Since activated inflammatory cells accumulate glucose, FDG-PET may be able to detect and visualize early inflammation in vessel walls and facilitate early diagnosis thereby allowing treatment with glucocorticoids before irreversible arterial damage has occurred.

Interventions
The intervention of interest is FDG-PET.
For patients with suspected LVV, FDG-PET would be performed following inconclusive clinical examinations and standard radiographs.

Comparators
Clinical diagnosis without FDG-PET is currently being used to make decisions about suspected LVV.

Outcomes
For patients with suspected LVV, the main outcomes interest are disease-related morbidity and mortality. Other outcomes of interest include test accuracy, test validity, symptoms, change in disease status, functional outcomes, health status measures, QOL, hospitalizations, medication use, and resource utilization.

Study Selection Criteria
For the evaluation of the clinical validity of the tests, studies that meet the following eligibility criteria were considered:

- Reported on the accuracy of the marketed version of the technology (including any algorithms used to calculate scores)
- Included a suitable reference standard
- Patient/sample clinical characteristics were described
- Patient/sample selection criteria were described
- Included a validation cohort separate from development cohort.

Technically Reliable
Assessment of technical reliability focuses on specific tests and operators and requires a review of unpublished and often proprietary information. Review of specific tests, operators, and unpublished data are outside the scope of this evidence review and alternative sources exist. This evidence review focuses on the clinical validity and clinical utility.

Clinically Valid
A test must detect the presence or absence of a condition, the risk of developing a condition in the future, or treatment response (beneficial or adverse).

Summaries of characteristics and results of several meta-analyses of FDG-PET that have been published on the diagnosis and management of LVV are shown in Tables 5 and 6 and are briefly described below.

Table 5. Characteristics of Systematic Reviews on Use of FDG-PET for Large Vessel Vasculitis

Study	Dates	Studies	N (Range)	Design	Outcomes
Lee et al (2016)[39.]	Up to 2015	8	400 (21-93)	OBS	Diagnostic accuracy for GCA and TA
Soussan et al (2015)[40.]	2000-2013	21	712 (18-93)	OBS	Diagnostic accuracy for GCA; assessment of disease activity in TA
Puppo et al (2014)[41.]	1999-2014	19	977 (8-304)	OBS	Diagnostic accuracy for GCA
Treglia et al (2011)[42.]	Up to 2011	32	604	OBS	Diagnostic accuracy for GCA and TA; assessment of disease activity; monitor treatment response
Besson et al (2011)[43.]	Up to 2011	14	Unclear	OBS	Diagnostic accuracy for GCA

FDG-PET: fluorine 18 fluorodeoxyglucose positron emission tomography; GCA: giant cell arteritis; OBS: observational; TA: Takayasu arteritis.

Lee et al (2016) performed a meta-analysis of the diagnostic accuracy of FDG-PET and PET/CT for LVV.[39.] The search included studies indexed in PubMed, EMBASE or Cochrane Library that used the American College of Rheumatology (ACR) classification system as the reference standard diagnosis. Eight studies (total n=400 participants) were identified for inclusion. Five studies included participants with both GCA and TA while 3 included only GCA. Five studies evaluated FDG-PET and 3 evaluated FDG-PET/CT. Pooled estimates of sensitivity, specificity, positive likelihood ratio and negative likelihood ratio were calculated using a random-effects model and are shown in Table 6. Interpretation of these results was limited by the use of ACR as the reference standard and the varying levels of disease activity in selected studies.

Soussan et al (2015) conducted a literature review assessing the role of FDG-PET in the management of LVV, focused on 3 issues: determining the FDG-PET criteria for diagnosing vascular inflammation; establishing the performance of FDG-PET for the diagnosis of large-vessel inflammation in GCA patients; and defining the performance of FDG-PET to evaluate the disease inflammatory activity in patients with TA.[40.] The PubMed, Cochrane Library, and EMBASE databases were searched for articles that evaluated the value of FDG-PET in LVV. Selection criteria included the use of the ACR classification for GCA or TA, the definition of a positive amyloid threshold for PET, and more than 4 cases included. The sensitivity and specificity of FDG-PET for the diagnosis of large-vessel inflammation were calculated from each selected study and then pooled for meta-analysis with a random-effects model. Disease activity was assessed with the National Institutes of Health Stroke Scale[44.] or another activity assessment scale. Twenty-one studies (413 patients, 299 controls) were included in the systematic review. FDG-PET showed FDG vascular uptake in 70% (288/413) of patients and 7% (22/299) of controls. Only vascular uptake equal to or greater than the liver uptake differed significantly between GCA plus TA patients and controls ($p<0.001$). A summary of the results is shown in Table 6. FDG-PET showed good performances in the diagnosis of large-vessel inflammation, with higher accuracy for diagnosing GCA patients than for detecting activity in TA patients. Although a vascular uptake equal to or greater than the liver uptake appears to be a good criterion for diagnosing vascular inflammation, further studies would be needed to define the threshold of significance as well as the clinical significance of the vascular uptake.

A systematic review by Puppo et al (2014) included studies of FDG-PET in GCA comparing the diagnostic performance of qualitative and semiquantitative methods of FDG-PET interpretation.[41.] Reviewers selected 19 studies (442 cases, 535 controls) found in PubMed or Cochrane Library. The selected studies had various reference standards. Ten used qualitative FDG uptake criteria to characterize inflammation, 6 used semiquantitative criteria, and 3 used both. Meta-analyses were not performed. Overall, qualitative methods were more specific but less sensitive, than semiquantitative methods. Diagnostic performance varied by vessel and by thresholds (cutoffs) for positivity. Results are shown in Table 6.

Treglia et al (2011) published a systematic review of PET and PET/CT in patients with LVV.[42] Reviewers searched PubMed and Scopus for publications on the role of FDG-PET in LVV. Reviewers identified 32 studies (total n=604 vasculitis patients). Selected publications related to diagnosis, assessment of disease activity, the extent of disease, response to therapy, and prediction of relapse or complications. Reviewers did not pool findings. They concluded that: (1) PET and PET/CT may be useful for initial diagnosis and assessment of severity of disease; (2) appeared to be superior to MRI in the diagnosis of LVV, but not in assessing disease activity under immunosuppressive treatment, in predicting relapse, or in evaluating vascular complications; (3) the role of these imaging methods in monitoring treatment response is unclear. Reviewers also concluded that "given the heterogeneity between studies with regard to PET analysis and diagnostic criteria, a standardization of the technique is needed." The studies cited in support of using PET for diagnosing LVV had small sample sizes.

Besson et al (2011) published a systematic review to assess use of FDG-PET for patients with suspected GCA; reviewers searched the PubMed, EMBASE, and the Cochrane databases.[43] Studies were included if they evaluated the performance of FDG-PET for the diagnosis of GCA, had at least 8 participants, used ACR criteria as the reference standard to confirm diagnosis of GCA, and included a control group. Fourteen studies were identified; the number of participants in those studies was unclear. Six studies with 283 participants (101 vasculitis, 182 controls) were included in a meta-analysis. The meta-analysis calculated pooled estimates of sensitivity, specificity, PPV, NPV, positive and negative likelihood ratio, and diagnostic accuracy using a random-effects model. Results are shown in Table 6. There was statistically significant between-study heterogeneity for sensitivity, PPV, and NPV. All studies in the meta-analysis were small case-control studies.

Table 6. Results of Systematic Reviews Assessing Use of FDG-PET for LVV

Study	Studies	N	Outcomes	Estimate (95% CI)
Lee et al (2016)[39]	8	400	Diagnostic accuracy of PET and PET/CT for GCA and TA	• Sensitivity: 76% (68% to 82%) • Specificity: 93% (89% to 96%) • PLR: 7.27 (3.71 to 14.24) • NLR: 0.30 (0.23 to 0.40)
•	3	133	Diagnostic accuracy of PET and PET/CT for GCA	• Sensitivity: 83% (72% to 91%) • Specificity: 90% (80% to 96%) • PLR: 7.11 (2.91 to 17.4) • NLR: 0.20 (0.11 to 0.34)
Soussan et al (2015)[40]	4	233	Diagnostic accuracy for GCA	• Sensitivity: 89.5% (78.5% to 96.0%) • Specificity: 97.7% (94% to 99%) • PLR: 28.7 (11.5 to 71.6) • NLR: 0.15 (0.07 to 0.29)
•	7	237	Diagnostic accuracy for disease activity in TA	• Sensitivity: 87% (78% to 93%) • Specificity: 73% (63% to 81%) • PLR: 4.2 (1.5 to 12) • NLR: 0.2 (0.1 to 0.5)
Puppo et al (2014)[41]	10	633	Diagnostic accuracy for GCA	• Sensitivity range: 56%-77% • Specificity range: 77%-100% • PPV range: 93%-100% • NPV range: 70%-82%
•	6	282	Diagnostic accuracy for GCA	• Sensitivity range: 58%-90% • Specificity range: 42%-95% • PPV range: 79%-89% • NPV range: 95%-98%
•	3	72	Diagnostic accuracy for GCA	• Sensitivity range: 65%-100% • Specificity range: 45%-100%
Treglia et al (2011)[42]	32	604	Diagnostic accuracy for GCA and TA; assessment of disease activity; monitor treatment response	• No pooling; concluded that FDG-PET is useful "in the initial diagnosis and in the assessment

				of activity and extent of disease in patients with LVV"
Besson et al (2011)[43]	6	283	Diagnostic accuracy for GCA	• Sensitivity: 80% (63% to 91%) • Specificity: 89% (78% to 94%) • PPV: 85% (62% to 95%) • NPV: 88% (72% to 95%) • PLR: 6.73 (3.55 to 12.77) • NLR: 0.25 (0.13 to 0.46)

CI: confidence interval; CT: computed tomography; FDG: fluorine 18 fluorodeoxyglucose; GCA: giant cell arteritis; LVV: large vessel vasculitis; NLR: negative likelihood ratio; NPV: negative predictive value; PET: positron emission tomography; PLR: positive likelihood ratio; PPV: positive predictive value; TA: Takayasu arteritis.

Observational Studies
In a study published after the systematic reviews, Sammel et al (2019) evaluated the accuracy of FDG-PET/CT as a first-line test for GCA in the 'Giant Cell Arteritis and PET Scan' (GAPS) study.[45] The GAPS study prospectively enrolled 64 patients with newly suspected GCA from 13 sites in Sydney, Australia between May 2016 and July 2018. Blinded physicians rated the FDG-PET scans as globally positive or negative for GCA and their ratings were compared to temporal artery biopsy and clinical diagnosis at 6 months. Sensitivity was 92% (95% CI, 62% to 100%) compared with temporal artery biopsy and 71% (95% CI, 48% to 89%) compared to clinical diagnosis. Specificity was 85% (95% CI, 71% to 94%) compared to temporal artery biopsy and 91% (95% CI, 78% to 97%). Interpretation of these findings is limited by the small sample size, as evidenced by the wide 95% confidence intervals.

Clinically Useful
A test is clinically useful if the use of the results informs management decisions that improve the net health outcome of care. The net health outcome can be improved if patients receive correct therapy, or more effective therapy, or avoid unnecessary therapy, or avoid unnecessary testing.

Direct Evidence
Direct evidence of clinical utility is provided by studies that have compared health outcomes for patients managed with and without the test. Because these are intervention studies, the preferred evidence would be from RCTs.
No RCTs identified assessed the evidence on the clinical utility of FDG-PET for diagnosing LVV.

Chain of Evidence
Indirect evidence on clinical utility rests on clinical validity. If the evidence is insufficient to demonstrate test performance, no inferences can be made about clinical utility.
Because the clinical validity of FDG-PET for diagnosing LVV has not been established, a chain of evidence supporting its clinical utility cannot be constructed.

Section Summary: Suspected Large Vessel Vasculitis
Several systematic reviews and a subsequent observational study have evaluated the diagnosis and management of GCA using FDG-PET. Most studies included were small, many lacked controls, and all results were heterogeneous. Studies comparing PET with the true reference standard (biopsy or angiography) are rare. There are no consensus criteria to define the presence of vascular inflammation by FDG-PET in LVV, and different parameters with visual and semiquantitative methods have been reported. Studies demonstrating changes in management based on PET results or improvements in clinical outcomes are lacking.

Diverse Noncardiac or Nononcologic Conditions
Clinical Context and Test Purpose
The purpose of FDG-PET in patients with diverse noncardiac or nononcologic conditions is to confirm a diagnosis or to inform the decision on selecting treatment regimens.

The question addressed in this evidence review is: Does the use of FDG-PET improve the net health outcome in individuals with diverse noncardiac or nononcologic conditions?
The following PICO was used to select literature to inform this review.

Patients
The populations of interest include patients with diverse noncardiac or nononcologic conditions (e.g., central nervous system, pulmonary, and musculoskeletal diseases).

Interventions
The intervention of interest is FDG-PET.
For patients with diverse noncardiac or nononcologic conditions, FDG-PET would be performed following inconclusive clinical examinations and standard radiographs.

Comparators
CT, radiograph, and MRI are currently being used to make decisions about managing diverse noncardiac or nononcologic conditions.

Outcomes
For patients with diverse noncardiac or nononcologic conditions, the main outcomes of interest are disease-related morbidity and mortality. Other outcomes of interest include test accuracy, test validity, symptoms, change in disease status, functional outcomes, health status measures, QOL, hospitalizations, medication use, and resource utilization.

For patients with other suspected noncardiac or nononcologic conditions, FDG-PET would be performed following inconclusive clinical examinations and standard radiographs.

Study Selection Criteria
For the evaluation of the clinical validity of the tests, studies that meet the following eligibility criteria were considered:

- Reported on the accuracy of the marketed version of the technology (including any algorithms used to calculate scores)
- Included a suitable reference standard
- Patient/sample clinical characteristics were described
- Patient/sample selection criteria were described
- Included a validation cohort separate from development cohort.

Technically Reliable
Assessment of technical reliability focuses on specific tests and operators and requires review of unpublished and often proprietary information. Review of specific tests, operators, and unpublished data are outside the scope of this evidence review and alternative sources exist. This evidence review focuses on the clinical validity and clinical utility.

Clinically Valid
Numerous systematic reviews have described the use of PET in patients with carotid stenosis[46.]; inflammatory diseases[47,48,49,50,51.]; fever of unknown origin[52,53,54.]; hyperinsulinemic hypoglycemia[55,56.]; spondylodiscitis [57.]; spinal infection[58.]; mycobacterium infection[59.]; Creutzfeldt-Jakob disease[60.]; vascular prosthetic graft infection[61,62.]; prosthetic infection after knee or hip arthroplasty[63,64.]; inflammatory bowel disease[65.]; atypical parkinsonism[66.]; and Huntington disease.[67.] Many studies cited in these reviews were small, retrospective, and lacked standard definitions of PET interpretation and positivity; many did not directly compare one modality with another in the same patient group or correlate the PET results in individual patients to improve clinical outcomes.

Clinically Useful
A test is clinically useful if the use of the results informs management decisions that improve the net health outcome of care. The net health outcome can be improved if patients receive

correct therapy, or more effective therapy, or avoid unnecessary therapy, or avoid unnecessary testing.

Direct Evidence
Direct evidence of clinical utility is provided by studies that have compared health outcomes for patients managed with and without the test. Because these are intervention studies, the preferred evidence would be from RCTs.

Numerous systematic reviews have been used to describe the use of FDG-PET in patients with diverse noncardiac or nononcologic conditions. However, most studies cited in these reviews were small, retrospective, and lacked standard definitions of PET interpretation and positivity; many did not directly compare one modality with another in the same patient group or correlate the PET results in individual patients to improve clinical outcomes.

No RCTs identified assessed the evidence on the clinical utility of FDG-PET for diagnosing diverse noncardiac or nononcologic conditions.

Chain of Evidence
Indirect evidence on clinical utility rests on clinical validity. If the evidence is insufficient to demonstrate test performance, no inferences can be made about clinical utility.
Because the clinical validity of FDG-PET for diagnosing diverse noncardiac or nononcologic condition has not been established, a chain of evidence supporting its clinical utility cannot be constructed.

Section Summary: Diverse Noncardiac and Nononcologic Conditions
Systematic reviews have assessed the use of FDG-PET or FDG-PET/CT for diagnosing or managing carotid stenosis, various inflammatory and immune-mediated diseases, fever of unknown origin, and various infections. However, studies included in these reviews are mostly small, retrospective, and lack standard definitions of PET interpretation and positive findings. Few studies have compared PET with other diagnostic modalities and no studies have reported on patient clinical outcomes.

Summary of Evidence
For individuals who have epileptic seizures who are candidates for surgery who have fluorine 18 fluorodeoxyglucose ([FDG]-PET), the evidence includes systematic reviews (following the publication of 3 TEC Assessments). Relevant outcomes are symptoms, change in disease status, functional outcomes, health status measures, quality of life (QOL), hospitalizations, medication use, and resource utilization. The TEC Assessments and Program in Evidence-based Care PET recommendation report all concluded that FDG-PET accurately localizes the seizure focus compared with appropriate reference standards. A recent systematic review suggested it was difficult to discern the incremental value of FDG-PET in patients who have foci well localized by ictal scalp electroencephalography and magnetic resonance imaging. The evidence on whether FDG-PET has a predictive value for a good surgical outcome is mixed. The evidence is sufficient to determine that the technology results in a meaningful improvement in the net health outcome.

For individuals who have suspected chronic osteomyelitis who receive FDG-PET, the evidence includes meta-analyses and a prospective study published after the meta-analyses. Relevant outcomes are test accuracy and validity, other test performance measures, change in disease status, functional outcomes, QOL, and hospitalizations. One systematic review and meta-analysis from 2013 of 9 studies revealed that FDG-PET and FDG-PET plus computed tomography were useful for diagnosing suspected osteomyelitis in the foot of patients with diabetes. The results of another meta-analysis (2005) showed that FDG-PET was the most accurate mode (pooled sensitivity, 96%; pooled specificity, 91%) for diagnosing chronic osteomyelitis. The results appear to be robust across fairly diverse clinical populations, which strengthen the conclusions.

The evidence is sufficient to determine that the technology results in a meaningful improvement in the net health outcome.

For individuals who have suspected Alzheimer disease (AD) who receive FDG-PET to diagnose the disease, the evidence includes systematic reviews of observational studies. Relevant outcomes are test accuracy and validity, other test performance measures, symptoms, QOL, and hospitalizations. The studies included in the reviews were generally of poor quality. There is no standard cutoff for PET positivity for diagnosing AD, and many studies have not included postmortem confirmation of AD as the reference standard, leading to uncertainty about estimates of performance characteristics. FDG-PET may have high sensitivity and specificity for diagnosing AD, but there is little evidence comparing the performance characteristics of clinical diagnosis using PET with the clinical diagnosis not using PET; therefore, the incremental value of adding PET to the standard clinical diagnosis is unclear. No studies have reported on clinical outcomes of patients diagnosed with and without FDG-PET. For individuals who have suspected AD who receive FDG-PET to determine the prognosis of their disease and to differentiate the disease from other dementias, the evidence includes systematic reviews of observational studies and a retrospective study assessing clinical utility. Relevant outcomes are test accuracy and validity, other test performance measures, symptoms, QOL, and hospitalizations. The studies included in the reviews were generally of poor quality. The evidence is insufficient to determine the effects of the technology on health outcomes for these indications.

For individuals who have suspected large vessel vasculitis who receive FDG-PET, the evidence includes 5 systematic reviews of observational studies and a subsequent observational study. Relevant outcomes are test accuracy and validity, other test performance measures, symptoms, morbid events, QOL, hospitalizations, and treatment-related morbidity. Most studies included in the reviews were small and lacked controls. The reported performance characteristics were heterogeneous but reviewers were unable to determine the source of heterogeneity. Studies comparing PET with the true reference standard of biopsy or angiography are rare. There are no consensus criteria to define the presence of vascular inflammation by FDG-PET in large vessel vasculitis, and different parameters with visual and semiquantitative methods have been reported. Studies demonstrating changes in management based on PET results or improvements in clinical outcomes are lacking. The evidence is insufficient to determine the effects of the technology on health outcomes.

For individuals who have diverse noncardiac or nononcologic conditions (e.g., central nervous system, pulmonary, and musculoskeletal diseases) who receive FDG-PET, the evidence includes several systematic reviews. Relevant outcomes are overall survival, symptoms, change in disease status, functional outcomes, health status measures, QOL, hospitalizations, medication use, and resource utilization. Many studies cited in the reviews were small, retrospective, and published in the 1990s to early 2000s; further, many studies did not directly compare a modality with another in the same patient group-nor did they correlate PET results in individual patients with improved clinical outcomes. Additional studies are needed to demonstrate FDG-PET results can change management, and therefore improve patient outcomes to support the utility of FDG-PET. The evidence is insufficient to determine the effect of the technology on health outcomes.

Supplemental Information
Practice Guidelines and Position Statements

American Academy of Neurology
Evidence-based practice parameters from the American Academy of Neurology are summarized in Table 7.

Table 7. Practice Parameters on Diagnosis of Dementia

Practice Parameter	Date	PET Recommendation
Diagnosis of dementia[68.]	2004: reaffirmed; update in progress	PET imaging not recommended for routine use in diagnostic evaluation of dementia (LOR: moderate clinical certainty)
Early detection of dementia[69.]	2003: reaffirmed; retired 2017[a]	Not addressed
Diagnosis of new-onset PD[70.]	2006: reaffirmed 2013; retired 2016	Evidence insufficient to support or refute FDG-PET as a means of distinguishing PD from other parkinsonian syndromes
Evaluation of depression, psychosis, and dementia in PD[71.]	2006; retired 2018	Not addressed
Mild cognitive impairment[72.]	2001; 2017; 2018	Not addressed

[a] Replaced by "Practice Guideline Update Summary: Mild Cognitive Impairment" (January 2018)
FDG: fluorine 18 fluorodeoxyglucose; LOR: level of recommendation; PD: Parkinson disease; PET: positron emission tomography.

American Academy of Orthopaedic Surgeons

The American Academy of Orthopaedic Surgeons (AAOS) (2019) published evidence-based, consensus guidelines on the diagnosis and prevention of periprosthetic joint infections.[73.] AAOS's recommendation regarding fluorine 18 fluorodeoxyglucose positron emission tomography (^{18}F-FDG PET) is that there is limited strength evidence supporting the use of 18F-FDG PET/CT to aid in the diagnosis of periprosthetic joint infections. The strength of the recommendation was rated as "limited," which was described as "Evidence from two or more 'Low' quality studies with consistent findings or evidence from a single 'Moderate' quality study recommending for or against the intervention or diagnostic test or the evidence is insufficient or conflicting and does not allow a recommendation for or against the intervention."

American College of Radiology

Evidence and consensus-based appropriateness criteria from the American College of Radiology are summarized in Table 8.

Table 8. Appropriateness Criteria for Miscellaneous Indications of FDG-PET/CT

Appropriateness Criteria	Last Reviewed	FDG-PET/CT Criteria
Suspected osteomyelitis, septic arthritis, or soft tissue infection (excluding spine and diabetic foot)[74.]	2017	Usually not appropriate for (1) suspected osteomyelitis with soft tissue or juxta-articular swelling with cellulitis and a skin lesion, injury, wound, ulcer, or blister; or (2) suspected osteomyelitis with pain and swelling or cellulitis associated with site of previous nonarthroplasty hardware. Usually not appropriate for suspected osteomyelitis with soft-tissue or juxta-articular swelling with a history of surgery, though "this is promising new technology but data are limited."
Diagnosis of dementia[75.]	2001, reaffirmed 2004; revised 2019	May be appropriate for: (1) initial imaging for cognitive decline, suspected Alzheimer disease; (2) initial imaging of suspected frontotemporal dementia; and (3) initial imaging of suspected dementia with Lewy bodies. Usually not appropriate as initial imaging for suspected vascular dementia.
Movement Disorders and Neurodegenerative Diseases[76.]	2019	May be appropriate as initial imaging for rapidly progressive dementia, suspected Creutzfeldt-Jakob disease; usually not appropriate for chorea, suspected Huntington disease; may be appropriate for initial imaging of parkinsonian syndromes; usually not appropriate for initial imaging of suspected

		neurodegeneration with brain iron accumulation; usually not appropriate for initial imaging of suspected motor neuron disease
Dementia and movement disorders[77.]	2016	May be appropriate in patients with possible or probable AD and to differentiate suspected FTD, LBD, CJD, or vascular dementia; usually not appropriate in patients with suspected HD, clinical features of PD or hemochromatosis, or motoneuron disease
Imaging after total knee arthroplasty[78.]	2017	Usually not appropriate for routine follow-up of asymptomatic patient, in work-up for suspected periprosthetic infection, or for evaluation of prosthetic loosening
Seizures and epilepsy[79.]	2014; revised 2019	Usually appropriate for surgical planning in known seizure disorder ; usually not appropriate for new-onset seizure, whether unrelated to trauma or with a history of trauma; may be appropriate (disagreement) for known seizure disorder with unchanged seizure semiology; may be appropriate for known seizure disorder with change in seizure semiology or new neurologic deficit or no return to previous neurologic baseline; may be appropriate (disagreement) for known seizure disorder with a history of trauma
Crohn disease[80.]	2014; revised 2019	Usually not appropriate
Fever without source - child[81.]	2015	May be appropriate. This procedure should not be used as the initial study. Consider if extensive clinical and imaging work-up is negative.
Suspected osteomyelitis of the foot in patients with DM[82.]	2012; revised 2019	Usually not appropriate for initial imaging. May be appropriate for soft-tissue swelling with or without ulcer, suspected osteomyelitis or early neuropathic arthropathy changes of the foot in patients with DM, suspected osteomyelitis of the foot in patients with DM with or without neuropathic arthropathy, and additional imaging following radiographs.

AD: Alzheimer disease; CJD: Creutzfeldt-Jakob disease; CT: computed tomography; DM: diabetes mellitus; FDG: fluorine 18 fluorodeoxyglucose; FTD: frontotemporal dementia; HD: Huntington disease; LBD: Lewy body disease; LOR: level of recommendation; PD: Parkinson disease; PET: positron emission tomography.

Infectious Diseases Society of America

The Infectious Diseases Society of America (IDSA; 2015) published evidence-based, consensus guidelines on the diagnosis and treatment of native vertebral osteomyelitis in adults.[83.] The guidelines stated that PET "is highly sensitive for detecting chronic osteomyelitis. A negative PET scan excludes the diagnosis of osteomyelitis, including native vertebral osteomyelitis, as the sensitivity of the test is expected to be very high in view of the high concentration of red marrow in the axial skeleton."

The IDSA (2013) published evidence-based, consensus guidelines on the diagnosis and management of prosthetic joint infections.[84.] The guidelines concluded that PET should not be routinely used to diagnose prosthetic joint infection (strength of recommendation: B [based on moderate evidence]; quality of evidence: III [expert opinion and descriptive studies]). These Guidelines have now been archived and replaced by an endorsement of the Clinical Practice Guidelines on the diagnosis and prevention of periprosthetic joint infections issued by AAOS (2019) described above.

The IDSA (2012) published evidence-based, consensus guidelines on the diagnosis and treatment of diabetic foot infections.[85.] The guidelines concluded that the role of FDG-PET in evaluating a diabetic foot infection has not been established. These Guidelines have now been archived.

The IDSA (2018) will be publishing guidelines on the diagnosis and management of bone and joint infections in children.

U.S. Preventive Services Task Force Recommendations

Not applicable.

Medicare National Coverage

The Centers for Medicare & Medicaid Services (CMS; 2004) released a national coverage decision for a subset of patients "with a recent diagnosis of dementia and documented cognitive decline of at least 6 months, who meet diagnostic criteria for both [Alzheimer disease] and frontotemporal dementia, who have been evaluated for specific alternative neurodegenerative diseases or causative factors, and for whom the cause of the clinical symptoms remains uncertain."[86.]

The national coverage determination for FDG-PET for dementia and neurodegenerative diseases (220.6.13) states that:

"Medicare covers FDG Positron Emission Tomography (PET) scans for either the differential diagnosis of frontotemporal dementia (FTD) and Alzheimer's disease (AD) under specific requirements; OR, its use in a Centers for Medicare & Medicaid Services (CMS)-approved practical clinical trial focused on the utility of FDG PET in the diagnosis or treatment of dementing neurodegenerative diseases."[87.]

Specific requirements for each indication are clarified in the document.
The national coverage determination for FDG-PET for infection and inflammation (220.6.16) states that:

"The CMS is continuing its national noncoverage of FDG PET for the requested indications. Based upon our review, CMS has determined that the evidence is inadequate to conclude that FDG PET for chronic osteomyelitis, infection of hip arthroplasty, and fever of unknown origin improves health outcomes in the Medicare populations, and therefore has determined that FDG PET for chronic osteomyelitis, infection of hip arthroplasty, and fever of unknown origin is not reasonable..."[88.]

Ongoing and Unpublished Clinical Trials

Currently ongoing and unpublished trials that might influence this review are listed in Table 9.

Table 9. Summary of Key Trials

NCT No.	Trial Name	Planned Enrollment	Completion Date
Ongoing			
NCT00811122	Biodistribution of 11C-PIB PET in Alzheimer's Disease, Frontotemporal Dementia, and Cognitively Normal Elderly	30	Apr 2022
NCT03022968	Tau Brain Imaging in Typical and Atypical Alzheimer's Disease	24	Nov 2019
NCT00194298	FDG-PET Imaging in Complicated Diabetic Foot	240	Jan 2021
NCT04154215	FDG Metabolism in Dementia With Lewy Body (DLB) Patients as Indicated by PET Dynamic Acquisition	100	Dec 2021
Unpublished			
NCT00329706	Early and Long-Term Value of Imaging Brain Metabolism	710	Jan 2017 (completed)
NCT02084147	PET-MRI: Evaluation, Optimization and Clinical Implementation	530	Oct 2018 (suspended [interim analysis])

NCT: national clinical trial.

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Documentation for Clinical Review

Please provide the following documentation:

- History and physical and/or consultation notes including:
  - Indication for PET scan
  - Previous treatment and response
- Previous Imaging reports (e.g., CT, MRI, SPECT)
- Pathology reports (if applicable)

Post Service (in addition to the above, please include the following):

- PET report

Coding

This Policy relates only to the services or supplies described herein. Benefits may vary according to product design; therefore, contract language should be reviewed before applying the terms of the Policy. Inclusion or exclusion of codes does not constitute or imply member coverage or provider reimbursement.

Type	Code	Description
CPT®	78608	Brain imaging, positron emission tomography (PET); metabolic evaluation
	78609	Brain imaging, positron emission tomography (PET); perfusion evaluation
	78811	Positron emission tomography (PET) imaging; limited area (e.g., chest, head/neck)
	78812	Positron emission tomography (PET) imaging; skull base to mid-thigh
	78813	Positron emission tomography (PET) imaging; whole body
	78814	Positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization imaging; limited area (e.g., chest, head/neck)
	78815	Positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization imaging; skull base to mid-thigh
	78816	Positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization imaging; whole body
HCPCS	A9552	Fluorodeoxyglucose F-18 FDG, diagnostic, per study dose, up to 45 millicuries
	G0235	PET imaging, any site, not otherwise specified

Policy History

This section provides a chronological history of the activities, updates and changes that have occurred with this Medical Policy.

Effective Date	Action
12/15/2014	Policy title change from Positron Emission Tomography (PET) Policy revision with position change
03/30/2015	Policy revision with position change
11/01/2016	Policy title change from Miscellaneous (Noncardiac, Nononcologic) Applications of Positron Emission Tomography Policy revision without position change
11/01/2017	Policy title change from Miscellaneous (Noncardiac, Nononcologic) Applications of Fluorodeoxyglucose F 18 Positron Emission Tomography Policy revision without position change
11/01/2018	Policy revision without position change
12/01/2019	Policy revision without position change
06/01/2020	Administrative update. Policy statement, guidelines and literature updated.
11/01/2020	Annual review. No change to policy statement. Literature review updated.

Definitions of Decision Determinations

Medically Necessary: Services that are Medically Necessary include only those which have been established as safe and effective, are furnished under generally accepted professional standards to treat illness, injury or medical condition, and which, as determined by Blue Shield, are: (a) consistent with Blue Shield medical policy; (b) consistent with the symptoms or diagnosis; (c) not furnished primarily for the convenience of the patient, the attending Physician or other provider; (d) furnished at the most appropriate level which can be provided safely and effectively to the patient; and (e) not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the Member's illness, injury, or disease.

Investigational/Experimental: A treatment, procedure, or drug is investigational when it has not been recognized as safe and effective for use in treating the particular condition in accordance with generally accepted professional medical standards. This includes services where approval by the federal or state governmental is required prior to use, but has not yet been granted.

Split Evaluation: Blue Shield of California/Blue Shield of California Life & Health Insurance Company (Blue Shield) policy review can result in a split evaluation, where a treatment, procedure, or drug will be considered to be investigational for certain indications or conditions, but will be deemed safe and effective for other indications or conditions, and therefore potentially medically necessary in those instances.

Prior Authorization Requirements (as applicable to your plan)

Within five days before the actual date of service, the provider must confirm with Blue Shield that the member's health plan coverage is still in effect. Blue Shield reserves the right to revoke an authorization prior to services being rendered based on cancellation of the member's eligibility. Final determination of benefits will be made after review of the claim for limitations or exclusions.

Questions regarding the applicability of this policy should be directed to the Prior Authorization Department at (800) 541-6652, or the Transplant Case Management Department at (800) 637-2066 ext. 3507708 or visit the provider portal at www.blueshieldca.com/provider.

Disclaimer: This medical policy is a guide in evaluating the medical necessity of a particular service or treatment. Blue Shield of California may consider published peer-reviewed scientific literature, national guidelines, and local standards of practice in developing its medical policy. Federal and state law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over medical policy and must be considered first in determining covered services. Member contracts may differ in their benefits. Blue Shield reserves the right to review and update policies as appropriate.