# Medicare Advantage Medical Policy

Blue Cross Blue Shield Blue Care Network of Michigan

Nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association

# Positron Emission Tomography (PET) for Oncologic Conditions – Medicare Advantage

**Medicare Advantage Plan**

☒ Medicare Plus Blue℠
☒ BCN Advantage℠

UM Committee Approval Date: 3/18/2026
Effective Date: 4/18/2026

## Description

Positron Emission Tomography (PET) is a minimally invasive, diagnostic imaging procedure that assesses the level of metabolic activity and perfusion in various organ systems of the body. A positron camera (tomograph) is used to produce cross-sectional tomographic images, which are obtained from positron-emitting radioactive tracer substances (radiopharmaceuticals) such as F-18 sodium fluoride (NaF-18).

## Related Medical Coverage Policies

- Positron Emission Tomography (PET) Scans for Cardiac Applications - Medicare Advantage
- Positron Emission Tomography (PET) Scans for Miscellaneous Applications (Non-Cardiac, Non-Oncologic) – Medicare Advantage

## Policy Guidelines

Blue Cross Blue Shield of Michigan (BCBSM) and Blue Care Network of Michigan (BCN) adhere to guidance from the Centers for Medicare and Medicaid Services (CMS), including when performing organization determinations for Medicare Advantage plan members. CMS Medicare statutes, regulations, manuals, National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), Local Coverage Articles (LCAs) and other sub-regulatory guidance provide the clinical guidelines for coverage determinations, payment integrity functions, and all other uses by CMS regulations. When CMS Medicare guidance is silent, incomplete, or insufficient, CMS permits BCBSM/BCN to utilize “internal coverage criteria”, such as independent criteria, health plan policy research, LCD/LCAs outside the services area or research from independent medical research repositories (i.e., Hayes) for coverage policies 42 CFR § 422.101. BCBSM/BCN internal medical coverage policies are developed and based on current evidence in widely accepted treatment guidelines or clinical literature; in addition, they address how clinical benefits may or may not outweigh member harm.

Clinical review follows guidance provided in the BCBSM Medicare Advantage Coverage Determination Hierarchy policy, which may be found at https://www.bcbsm.com/providers/mpradmin/ by entering the policy name.

## Coverage Guidance

To ensure consistency with coverage guidance, the Medicare statutes, regulations, coverage manuals, NCD, LCD, and LCA should be reviewed and applied first. BCBSM/BCN internal coverage criteria should only be applied when CMS guidance is silent, incomplete, or insufficient for a code.

Apart from durable medical equipment (DME), Medicare Administrative Contractor (MAC) jurisdiction for the purpose of clinical determination is based upon place of service. The place of service for laboratory testing is defined as the geographic location of the reference laboratory. Non-jurisdictional LCD/LCAs may not be utilized for a determination unless they have been specifically identified as internal coverage criteria by the policy. Alternatively, jurisdiction for DME MAC is determined by the member place of residence. Please see CMS Medicare Administrative Contractors (MAC) table for state MAC assignments below.

| CMS Guidance | Additional Guidance |
|---|---|
| **NCD with CED (Coverage with Evidence Development):** CAG- 00065R - NaF-18 PET for Bone Metastasis<br><br>NaF-18 PET for bone metastasis is non-covered when furnished outside of a CMS approved CED Study.<br><br>To access the list of studies that have been determined to meet the requirements for CED coverage, please visit CMS site for Coverage with Evidence Development at:<br><br>https://www.cms.gov/Medicare/Coverage/Coverage-with-Evidence-Development/<br><br>**National Coverage Determinations**<br>220.6.17 - PET (FDG) for Oncological Conditions<br><br>220.6.19 - PET (NaF-18) to Identify Bone Metastasis of Cancer<br><br>**Local Coverage Determinations and Articles**<br>**WPS**<br>None<br><br>**CGS**<br>None<br><br>**First Coast**<br>None<br><br>**NGS**<br>None<br><br>**Noridian JE**<br>None<br><br>**Noridian JF**<br>None<br><br>**Novitas**<br>L35391, A56848 – Multiple Imaging in Oncology | BCBSM/BCN will follow CMS guidance as the primary source for coverage determinations. However, in instances where CMS guidance is silent, incomplete, or insufficient for a particular code, BCBSM/BCN internal coverage criteria will be applied to ensure consistent and informed decision-making.<br><br>In such cases, please refer to the relevant BCBSM/BCN policy for guidance:<br><br>*Positron Emission Tomography (PET) Scan for Oncological Conditions*<br><br>To access this policy, please visit the BCBSM Medical Policy Router Search page at https://www.bcbsm.com/providers/mpradmin/ and enter the policy name in the search field. |

| CMS Guidance | Additional Guidance |
|---|---|
| **Palmetto**<br>None | |

| Code | Description |
|---|---|
| 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 |
| 78999 | Unlisted miscellaneous procedure, diagnostic nuclear medicine (use for separate charges for fusion service) |
| G0235 | PET imaging, any site not otherwise specified |
| A9593 | Gallium Ga-68 PSMA-11, diagnostic, (UCSF), 1 mCi |
| A9594 | Gallium Ga-68 PSMA-11, diagnostic, (UCLA), 1 mCi |
| A9595 | Piflufolastat f-18, diagnostic, 1 mCi |
| A9608 | Flotufolastat f 18, diagnostic, 1 millicurie |
| A9609 | Fludeoxyglucose f18 up to 15 millicuries |
| A9800 | Gallium Ga-68 gozetotide, diagnostic, (Locametz), 1 mCi |
| G0219 | PET imaging whole body; melanoma for noncovered indications (2002) |
| G0252 | PET imaging, full and partial-ring PET scanners only, for initial diagnosis of breast cancer and/or surgical planning for breast cancer (e.g., initial staging of axillary lymph nodes) (2002) |



The above information is current as of the review date for this policy. However, the coverage issues and policies maintained by CMS are updated and/or revised periodically. Therefore, the most current CMS information may not be contained in this document.

Please refer to the Medicare Coverage Database website at https://www.cms.gov/medicare-coverage-database/search.aspx for the most current applicable NCD, LCD, LCA, and CMS Online Manual System Transmittals.

## CMS Medicare Administrative Contractors (MAC) Jurisdictions Guidance

| Part A and Part B MAC Jurisdictions | |
|---|---|
| **Wisconsin Physicians Service Insurance Corporation (WPS)** | IA, IN, KS, MI, MO, NE |
| **CGS Administrators, LLC** | KY, OH |
| **First Coast Service Options, Inc** | FL, PR, US VI |

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|---|---|
| **National Government Services, Inc (NGS)** | CT, IL, MA, ME, MN, NH, NY, RI, VT, WI, |
| **Noridian Healthcare Solutions, LLC,** **Jurisdiction JE** | CA, HI, NV, American Samoa, Guam, Northern Mariana Islands |
| **Noridian Healthcare Solutions, LLC,** **Jurisdiction JF** | AK, AZ, ID, MT, ND, OR, SD, UT, WA, WY |
| **Novitas Solutions, Inc** | AR, CO, DC, DE, LA, MD, MS, NJ, NM, OK, PA, TX, |
| **Palmetto GBA** | AL, GA, TN NC, SC, VA, WV |
| **DME MAC Jurisdictions** | |
| **CGS Administrators, LLC,** **Jurisdictions JB and JC** | AL, AR, CO, FL, GA, IL, IN, KY, LA, MI, MN, MS, NM, NC, OH, OK, Puerto Rico, SC, TN, TX, VA, Virgin Island, WI, WV |
| **Noridian Healthcare Solutions, LLC,** **Jurisdictions JA and JD** | AK, American Soamoa, AZ, CA, CT, DE, DC, Guam, HI, ID, IA, KS, MA, MD, ME, MO, MT, ND, NE, NH, NJ, NV, NY, Northern Mariana Islands, OR, PA, RI, SD, UT, VT, WA, WY |

## Important Reminder

BCBSM and BCN follow CMS Medicare coverage guidance to limit coverage to items and services that are reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member. Medicare Advantage Medical Policies list the criteria BCBSM and BCN use to decide which medical services are considered “reasonable and necessary” when Medicare coverage rules are not fully developed, or as otherwise may permitted by CMS Medicare regulations. Individual member benefit plan documents, such as the Evidence of Coverage and Annual Notice of Change, as well as applicable laws govern benefit coverage, including any inclusion, exclusion, and/or other restrictions.

Medicare Advantage Medical policies are created when permitted by CMS Medicare regulations, reviewed regularly, and may be revised periodically. BCBSM/BCN Medical Policies are proprietary and should not be copied or disseminated without the express, prior written approval of BCBSM. All providers are required to review applicable BCBSM reimbursement policies prior to claim submission and bill for covered services in accordance with those policies. Additionally, providers contracted with BCBSM or BCN’s Medicare Advantage network(s) should review the provider manual for any additional claim submission requirements. Providers not contracted with BCBSM or BCN’s Medicare Advantage network may be required to submit documentation to BCBSM, BCN, or its delegated entity supporting billed claims, including but not limited to applicable medical records.

**Note**: U.S. Food and Drug Administration (FDA) approval for a specific indication or the issuance of a CPT code is not sufficient for a procedure to be considered medically reasonable and necessary. Similarly, the presence of a procedure/device code or payment amount for the service in the Medicare fee schedule does not necessarily indicate coverage. If a service is deemed not reasonable and necessary, to treat illness or injury for any reason (including lack of safety and efficacy because it is an experimental procedure, etc.), the procedure is considered not covered.

**Disclaimer:** This medical policy is not an authorization, certification, explanation of benefits, or a contract for the services, devices, or drugs that is referenced in the medical policy. Medical policies do not constitute medical advice and do not guarantee any results or outcomes or guarantee payment. The medical policy is not intended to replace independent medical judgment for the treatment of individuals. Treating physicians and health care providers are solely responsible for determining what care to provide to their patients. Identification of

selected brand names of devices, tests and procedures in a medical coverage policy is for reference only and is not an endorsement of any one device, test, or procedure over another.

Pursuant to Section 1557 and Section 504, Blue Cross does not discriminate on the basis of race, color, national origin, age, disability, or sex (including sex characteristics, intersex traits; pregnancy or related conditions; sexual orientation; gender identity, and sex stereotypes). This includes our rules, benefit designs and medical policies.

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## BCBSM/BCN Medicare Advantage Policy History

| Policy Effective Date | UM Committee Approval Date | Comments |
|---|---|---|
| 08/17/2024 | 07/17/2024 | Medicare Advantage policy established |
| 8/16/2025 | 7/16/2025 | Annual Review: MA policy foundational language updated. Adoption of JUMP policy updates. |
| 8/16/2025 | 7/16/2025 | 12/23/2025: NCD with CED language added to CMS Guidance |
| 4/18/2026 | 3/18/2026 | Annual Review: Reformatted coverage and code tables. Updated CMS Guidance: added LCD for L35391/A56848 Multiple Imaging in Oncology. Adoption of JUMP policy updates. |