Medical Policy
Dopamine Transporter Imaging with Single Photon Emission Computed Tomography

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Policy Number: 918
BCBSA Reference Number: 6.01.54 (For Plan internal use only)
NCD/LCD: N/A

Related Policies
Deep Brain Stimulation, #473

Policy
Commercial Members: Managed Care (HMO and POS), PPO, and Indemnity
Medicare HMO Blue℠ and Medicare PPO Blue℠ Members

Dopamine transporter imaging with single-photon emission computed tomography may be considered MEDICALLY NECESSARY when used for individuals with:
• clinically uncertain Parkinson disease; or
• clinically uncertain dementia with Lewy bodies.

Use of dopamine transporter imaging with single-photon emission computed tomography is considered INVESTIGATIONAL for all other indications not included above.

Prior Authorization Information
Inpatient
• For services described in this policy, precertification/preauthorization IS REQUIRED for all products if the procedure is performed inpatient.

Outpatient
• For services described in this policy, see below for products where prior authorization might be required if the procedure is performed outpatient.

<table>
<thead>
<tr>
<th>Commercial Managed Care (HMO and POS)</th>
<th>Outpatient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prior authorization is not required.</td>
<td></td>
</tr>
</tbody>
</table>

| Commercial PPO and Indemnity | Prior authorization is not required. |

| Medicare HMO Blue℠ | Prior authorization is not required. |

| Medicare PPO Blue℠ | Prior authorization is not required. |
CPT Codes / HCPCS Codes / ICD Codes

Inclusion or exclusion of a code does not constitute or imply member coverage or provider reimbursement. Please refer to the member’s contract benefits in effect at the time of service to determine coverage or non-coverage as it applies to an individual member.

Providers should report all services using the most up-to-date industry-standard procedure, revenue, and diagnosis codes, including modifiers where applicable.

The following codes are included below for informational purposes only; this is not an all-inclusive list.

The above medical necessity criteria MUST be met for the following codes to be covered for Commercial Members: Managed Care (HMO and POS), PPO, Indemnity, Medicare HMO Blue and Medicare PPO Blue:

HCPCS Codes

<table>
<thead>
<tr>
<th>HCPCS codes:</th>
<th>Code Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A9584</td>
<td>Iodine I-123 ioflupane, diagnostic, per study dose, up to 5 millicuries</td>
</tr>
</tbody>
</table>

The following ICD Diagnosis Codes are considered medically necessary when submitted with the HCPCS code above if medical necessity criteria are met:

ICD-10 Diagnosis Coding

<table>
<thead>
<tr>
<th>ICD-10-CM-diagnosis codes:</th>
<th>Code Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>F02.80</td>
<td>Dementia in other diseases classified elsewhere without behavioral disturbance</td>
</tr>
<tr>
<td>F02.811</td>
<td>Dementia in other diseases classified elsewhere, unspecified severity, with agitation</td>
</tr>
<tr>
<td>F02.818</td>
<td>Dementia in other diseases classified elsewhere, unspecified severity, with other behavioral disturbance</td>
</tr>
<tr>
<td>G20</td>
<td>Parkinson's disease</td>
</tr>
<tr>
<td>G21.9</td>
<td>Secondary parkinsonism, unspecified</td>
</tr>
<tr>
<td>G31.83</td>
<td>Dementia with Lewy bodies</td>
</tr>
<tr>
<td>R25.0</td>
<td>Abnormal head movements</td>
</tr>
<tr>
<td>R25.1</td>
<td>Tremor, unspecified</td>
</tr>
<tr>
<td>R25.8</td>
<td>Other abnormal involuntary movements</td>
</tr>
<tr>
<td>R25.9</td>
<td>Unspecified abnormal involuntary movements</td>
</tr>
<tr>
<td>R26.0</td>
<td>Ataxic gait</td>
</tr>
<tr>
<td>R26.2</td>
<td>Difficulty in walking, not elsewhere classified</td>
</tr>
<tr>
<td>R26.89</td>
<td>Other abnormalities of gait and mobility</td>
</tr>
<tr>
<td>R26.9</td>
<td>Unspecified abnormalities of gait and mobility</td>
</tr>
<tr>
<td>R41.89</td>
<td>Other symptoms and signs involving cognitive functions and awareness</td>
</tr>
<tr>
<td>R41.9</td>
<td>Unspecified symptoms and signs involving cognitive functions and awareness</td>
</tr>
</tbody>
</table>

Description

Parkinsonian Syndromes

Parkinsonian syndromes are a group of diseases that share similar cardinal signs, characterized by bradykinesia, rigidity, resting tremor, and gait disturbance. Parkinson Disease (PD) is the most common cause of parkinsonism.

Despite the well-known symptoms of PD, diagnosis is challenging even for experienced clinicians, particularly in the early stages of the disease. In addition, other etiologies such as essential tremor, corticobasal degeneration, multiple system atrophy, progressive supranuclear palsy, vascular parkinsonism, and drug-induced parkinsonism can lead to a similar set of symptoms. One recent
approach to improve the accuracy of clinical diagnosis of PD and other parkinsonian syndromes is to evaluate the integrity of dopaminergic pathways in the brain using dopamine transporter imaging with single-photon emission computed tomography (DaT-SPECT) imaging.

**Dementia with Lewy Bodies**
Dementia with Lewy bodies is a type of dementia characterized by parkinsonism, visual hallucinations, cognitive fluctuation, sleep disorders, and severe neuroleptic sensitivity. Dementia with Lewy bodies is the second most common form of degenerative dementia; Alzheimer disease, which can have similar symptoms at onset, is the most common.

Diagnosis can be challenging, particularly when patients have multiple comorbidities including cerebrovascular disease and/or Alzheimer disease. As with PD, dementia with Lewy bodies is characterized by the degeneration of nigrostriatal neurons; as such, DaT-SPECT is also proposed to differentiate dementia with Lewy bodies from Alzheimer disease.

**DaT-SPECT**
DaT-SPECT is based on the selective affinity of dopamine transporter (DaT) ligands for dopamine-synthesizing neurons, which allows visualization of deficits in the nigrostriatal dopaminergic pathway.

DaT ligands include iodine 123I-2β-carbomethoxy-3β-(4-iodophenyl) tropane (123I-β-CIT), which is a cocaine analogue with an affinity for both dopamine and serotonin transporters. Intravenous 123I-β-CIT requires a delay between injection and scan of about 24 hours. Iodine-123 N-(3-fluoropropyl)-2β-carbomethoxy-3β-(4-iodophenyl) nortropane (123I-FP-CIT) is a fluoropropyl derivative of β-CIT that is selective for brain striatal DaT but can also bind to the serotonin transporter. Intravenous 123I-FP-CIT can be injected 3 to 6 hours before the scan (DaTscan). Other SPECT ligands with affinity for dopamine transporter include technetium 99m (2β((N,N¢-bis(2-mercaptoethyl) ethylene diaminomethyl) and 3β-(4-chlorophenyl) tropane (99mTc-TRODAT-1).

Binding of ligands with an affinity for DaT ligands in the striatum is, in general, reduced in PD, genetic parkinsonism, dementia with Lewy bodies, corticobasal degeneration, progressive supranuclear palsy, and multiple system atrophy. In contrast, striatal DaT ligand binding is expected to be within the normal range of Alzheimer disease, essential tremor, dystonic tremor, orthostatic tremor, drug-induced parkinsonism, and psychogenic parkinsonism.

Visualization of striatal dopamine transporter binding, through DaT-SPECT, permits assessment of presynaptic dopaminergic deficit. It is proposed that an abnormal DaT-SPECT scan supports the diagnosis of PD, dementia with Lewy bodies, or other neurodegenerative parkinsonian syndromes, while a normal DaT-SPECT scan in a symptomatic patient supports the diagnosis of a disease not affecting the nigrostriatal dopaminergic pathway.

Analysis of DaT-SPECT images can be visual, semiquantitative, or quantitative. In patients with PD, physical symptoms start after 30% to 50% of dopaminergic neurons have degenerated. Symptomatic patients with PD would be thus expected to have sufficient abnormality on DaT-SPECT for visual analysis to be adequate for interpretation. A variety of methods are being tested to improve the validity and reliability of ratings, including commercially available software to define the region of interest for analysis and the development of an atlas for visual interpretation. Several research centers are developing quantitative and semiquantitative classification methods for the evaluation of DaT-SPECT images.

Anatomic variation in the brain, including vascular lesions, may interfere with the distribution of the iodine-123 tracer and could result in an abnormal scan. Dopamine agonists and levodopa may also affect DaT expression, which could influence the ability of DaT-SPECT to monitor the progression of disease unless these agents are discontinued prior to imaging. Patients with clinically diagnosed PD or dementia with Lewy bodies, who present with a normal DaT-SPECT scan, are referred to in the literature as having "scans without evidence of dopaminergic deficit." While many of these patients are ultimately diagnosed with non-PD syndromes, a portion of patients with normal DaT-SPECT imaging are confirmed to have PD or dementia with Lewy bodies by the reference standard. In studies where clinical diagnosis is used as an
endpoint, scans without evidence of dopaminergic deficit are present in 3% to 20% of PD patients. In a study of patients clinically diagnosed with dementia with Lewy bodies, van der Zande et al (2016) found that 10% of these patients had normal scans. Further research may shed light on these cases.

**Summary**

Dopamine transporter imaging with single-photon emission computed tomography (DaT-SPECT), using radiopharmaceutical ioflupane injection, is a neuroimaging modality being evaluated to improve the differential diagnosis of parkinsonian syndromes from nonparkinsonian tremor, as well as dementia with Lewy bodies from Alzheimer disease.

**Summary of Evidence**

For individuals who have clinically uncertain Parkinson disease (PD) who receive DaT-SPECT, the published evidence includes randomized controlled trials (RCTs), cohort studies, and case series studies. Relevant outcomes are symptoms, functional outcomes, and treatment-related mortality and morbidity. In populations with clinically apparent PD, studies of diagnostic accuracy have reported high sensitivity and specificity for PD. Studies of clinical validity in the target population of clinically uncertain PD are limited by gaps in study design, conduct, and relevance. Evidence on clinical utility in the target population includes an RCT showing no significant difference in outcomes over time between patients who received a DaT-SPECT scan and those who did not. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

For individuals who have clinically uncertain dementia with Lewy bodies who receive DaT-SPECT, the published evidence includes RCTs, cohort studies, and case series studies. Relevant outcomes are symptoms, functional outcomes, and treatment-related mortality and morbidity. No studies with the optimal reference standard to assess clinical validity have been performed in the target population of clinically uncertain dementia with Lewy bodies. No studies have directly evaluated the effect of DaT-SPECT on health outcomes in the target population. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

**Policy History**

<table>
<thead>
<tr>
<th>Date</th>
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<td>12/2022</td>
<td>Annual policy review. No references added. Policy statements unchanged.</td>
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<td>10/2022</td>
<td>Clarified coding information.</td>
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<td>12/2021</td>
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<td>1/2020</td>
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<tr>
<td>10/2019</td>
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<td>Annual policy review. New references added.</td>
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<tr>
<td>10/2013</td>
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<tr>
<td>2/2013</td>
<td>New policy describing non-coverage.</td>
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**Information Pertaining to All Blue Cross Blue Shield Medical Policies**

Click on any of the following terms to access the relevant information:

- [Medical Policy Terms of Use](#)
- [Managed Care Guidelines](#)
References


