



Medica Central Coverage Policy

Policy Name: Scintimammography MP9692

Effective Date: 01/01/2026

Important Information – Please Read Before Using This Policy

These services may or may not be covered by all Medica Central plans. Coverage is subject to requirements in applicable federal or state laws. Please refer to the member's plan document for other specific coverage information. If there is a difference between this general information and the member's plan document, the member's plan document will be used to determine coverage. With respect to Medicare, Medicaid, and other government programs, this policy will apply unless these programs require different coverage.

Members may contact Medica Customer Service at the phone number listed on their member identification card to discuss their benefits more specifically. Providers with questions may call the Provider Service Center. Please use the Quick Reference Guide on the Provider Communications page for the appropriate phone number. <https://mo-central.medica.com/Providers/SSM-employee-health-plan-for-IL-MO-OK-providers>

Medica Central coverage policies are not medical advice. Members should consult with appropriate health care providers to obtain needed medical advice, care, and treatment.

Coverage Policy

Scintimammography is considered investigative and therefore **NOT COVERED** for all applications, including but not limited to its use as a screening procedure for breast cancer, as an adjunct to mammography. There is insufficient reliable evidence in the form of high quality peer-reviewed medical literature to establish the efficacy or effects on health care outcomes.

Description

Scintimammography is a non-invasive diagnostic technique that detects abnormal breast tissue based on the uptake of technetium-99m sestamibi, which emits gamma rays and tends to accumulate in cancerous breast tissue. Scintimammography is typically used as a confirmatory test following mammography and a clinical breast exam. This technique utilizes gamma cameras specifically devoted to breast imaging.

FDA Approval

Scintimammography is a procedure and not subject to FDA regulation. However, the equipment used to conduct scintimammography is subject to regulation. Cameras approved for use as class I radiologic devices include but are not limited to:

- LumaGem Scintillation Camera (CMR Naviscan).
- ERGO Imaging System (Digirad).

Prior Authorization

Prior authorization is not applicable. Claims for this service are subject to retrospective review and denial of coverage, as investigative services are not eligible for reimbursement.



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Coding Considerations

Use the current applicable CPT/HCPCS code(s). The following codes are included below for informational purposes only, and are subject to change without notice. Inclusion or exclusion of a code does not constitute or imply member coverage or provider reimbursement.

CPT Codes:

- **S8080** - Scintimammography (radioimmunosintigraphy of the breast), unilateral, including supply of radiopharmaceutical

	Committee/Source	Date(s)
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