Clinical Review Criteria
DaT-SPECT
(Dopamine Transporter-Single Photon Emission Computed Tomography)
• Imaging with (123)Iioflupane, DaTscan, or (123)IFP-CIT

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Criteria
For Medicare Members
Review not required for Medicare members

For Non-Medicare Members
There is insufficient evidence in the published medical literature to show that this service/therapy is as safe as standard services/therapies and/or provides better long-term outcomes than current standard services/therapies.

The following information was used in the development of this document and is provided as background only. It is not to be used as coverage criteria. Please only refer to the criteria listed above for coverage determinations.

Background
Movement disorders are neurological conditions that affect the speed, fluency, quality, and ease of movement. They include a wide range of disorders including, but not limited to, Parkinsonian syndromes (PS) and essential tremor (ET). ET, the most common movement disorder, typically involves involuntary shaking movement with no cause. PS, on the other hand, is a group of neurodegenerative disorders that have similar features and symptoms, of which, the most frequent form is idiopathic Parkinson’s disease (PD) accounting for 80% of all PS. Although ET and PS have different underlying etiologies, they present with similar clinical features, especially in the early stages of disease progression, thus complicating diagnostic differentiation. Accurate diagnosis of patients with suspected PS is critical for patient management because the disease course, therapy and prognosis greatly differ from non-degenerative diseases (Dauer and Przedborski 2003; de Lau and Breteler 2006).

Currently, the gold standard for the diagnosis of PS is post-mortem neuropathological examination. In practice, however, diagnosis is based on the presence of two or more classical motor features including bradykinesia, rigidity, tremor, and postural instability which can be atypical or mild in the early stages of the disease. Long-term clinical follow-up and good response to dopaminergic drugs have also been used to support clinical diagnosis (de la Fuente-Fernández 2012). Pathologic studies have shown that the lack of an objective diagnostic tool has resulted in an error rate of 10-30% (Rajput, Rozdilsky et al. 1991). Misdiagnosis can lead to unnecessary disability if effective treatment options are not initiated, and inappropriate therapies may unnecessarily expose patients to the potential side effects thus warranting an early and accurate diagnostic tool to ensure appropriate management.

DaTscan™ is a recent advance in imaging technology that supports the clinician in the differential diagnosis of PS and ET. While there is limited knowledge on the etiology of ET, the main pathological hallmark of PS is the loss of dopaminergic neurons in the substantia nigra, leading to striatal dopamine depletion (Dauer and Przedborski 2003). The DaTscan™ technology is able to determine the location and measure the amount of dopamine transporter (DaT) in the brain. More specifically, through small amounts of a contrast agent called (123)Iioflupane and using a single photon emission computerized tomography (SPECT) scanner, DaTscan™ is able to demonstrate reduced striatal uptake of DaT where PS is present and, in contrast, normal striatal uptake in patients with ET. The results of DaTscan™ are not intended to differentiate between different PS disorders, but instead, should be used when diagnosis is inconclusive to rule out other movement disorders with similar presenting symptoms.

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In January 2011, the U.S. Food and Drug Administration (FDA) approved the DaTscan™ for striatal dopamine transporter (DaT) visualization using SPECT brain imaging to assist in the evaluation of adult patients presenting with symptoms or signs suggestive of dopaminergic neurodegeneration. In these patients, DaTscan may be used to help differentiate ET from tremor due to PS and is intended for use as an adjunct to other diagnostic evaluations.

**Medical Technology Assessment Committee (MTAC)**

**DaT-SPECT**

**02/10/2014: MTAC REVIEW**

**Evidence Conclusion:** Marshall and colleagues conducted a prospective, longitudinal study. Among 102 patients with an early Parkinsonian syndrome with or without tremor (possible and probable) vs. a combination of patients with non-PD tremor (essential or dystonic tremor) and healthy volunteers. Clinical and DaTscan assessments were made at baseline, 18 month, and 36 month follow-up. The primary endpoint was the baseline DaTscan image assessment by three independent blinded readers as normal or abnormal. The standard of truth was the clinical diagnosis established by two independent movement disorder specialists in consensus, based on the assessment of patients clinical examination videos at 36 months of follow-up. The standard of truth was used to judge whether or not a subject had a striatal dopaminergic deficit (Marshall, Reininger et al. 2009). Ultimately, the study concluded that in the 99 patients who completed all three assessments, on-site clinical diagnosis over-diagnosed degenerative parkinsonism at baseline (sensitivity was 93% and specificity was 46%) compared with the standard of truth clinical diagnosis (sensitivity 78% and specificity 97%). See Evidence Table. Vlaar and colleagues meta-analysis included eight studies that specifically assessed the diagnostic differentiation between PD and ET and concluded that SPECT with presynaptic tracers may accurately differentiate between patients with PD and ET with a reported sensitivity ranging from 88-100% and specificity of 80%-100%. Two of the included studies compared the diagnostic accuracy of the treating physician with the SPECT in its capacity to delineate PD from ET. Initial clinical diagnosis in these trials reached a sensitivity of respectively 76% and 87% and a specificity of 50% and 80%. More often than not, the included studies compared DaTscan diagnoses with clinical diagnoses, and it is not known how often the clinical diagnosis was wrong. Ideally, a study would follow patients until death to confirm diagnosis with autopsy (Vlaar, van Kroonenburgh et al. 2007). See Evidence Table.

**Risks of Diagnostic Test:** The Marshall et al. study, recorded adverse events (AE) at each follow-up visit. During the 36-month period, a total of 4 subjects died and 32 subjects (18%) experienced 71 nonfatal serious AEs, none of which were deemed to be related to the DaTscan. Only 24 (6.0%) AEs, reported by 13 subjects were considered to be related to the DaTscan. The most common AEs were headache (3%), nausea (2%), injection site hematoma (1%), dizziness (1%) and dysgeusia (1%) (Marshall, Reininger et al. 2009). Kupsch and colleagues also collected information on AE in their study which only resulted in two patients with AE that were considered related to the DaTscan. Both of the events, sleep disorder and headache, occurred following administration and prior to imaging and required no treatment (Kupsch, Bajaj et al. 2012). Impact on Diagnosis and Patient Management: In practice, clinical diagnosis is sufficient and accurate for many patients with advanced and typical manifestations of PD. There is a subset of patients, however, with suspected PS, particularly those with early-stage disease or atypical signs and symptoms, who theoretically may benefit from further diagnostic evaluation. The recently published, and rigorous evaluation of the impact of diagnostic test on clinical outcomes is a randomized, prospective, multicenter, global (US and Europe), controlled clinical trial conducted by Kupsch and colleagues in 2012. The study sought to demonstrate the impact of ($^{123}$I)ioflupane on clinical management, diagnosis and confidence of diagnosis during a one-year follow-up in 273 patients with clinically uncertain PS of whom 138 were randomized to ($^{123}$I)ioflupane and 135 randomized to no imaging. Significantly more patients in the ($^{123}$I)ioflupane imaging group had at least one change in their actual clinical management after 12 weeks (p=0.002) and after 1 year (p=0.001) compared with patients in the control group. In addition, significantly more ($^{123}$I)ioflupane patients had changes in diagnosis and an increased confidence diagnosis at 4 weeks, 12 weeks and 1 year (all p<0.001) compared with control patients (Kupsch, Bajaj et al. 2012). See Evidence Table. Although the literature reports good accuracy with minimal safety concerns, the studies should be interpreted with caution. It is important to remember that throughout the literature, there was no autopsy confirmation of diagnosis, and thus no confirmed “gold standard”. The interpretation of the imaging data is controversial due to inter-reader reliability and the target populations are poorly defined with many studies using clearly defined later-stage patients that are obviously not representative of the FDA indication. Even with the use of the DaTScan, the diagnosis of PS remains a clinical judgment based on imaging technology. Finally, it should be noted that the majority of the literature has received some sort of industry sponsoring. Conclusion: The evidence supports high sensitivity and specificity but the lack of a gold standard limits the value of these numbers. There is evidence to indicate that the use of DaTscan™ can sometimes result in changes in diagnosis and treatment, however, there is no evidence to support that these changes result in improved health outcomes.

**Articles:** The literature search for studies on the accuracy of DaTscan in patients with suspected PS revealed almost 200 articles that assessed the DaTscan in a variety of differential diagnostic situations. This search was...
further narrowed down to include studies that specifically addressed diagnostic differentiation between PS and ET. For the most part, the literature was comprised of studies that were small with limited methodology due to a lack of gold standard for diagnosis.

The following articles were selected for critical appraisal:

The use of DaT-SPECT does not meet the *Kaiser Permanente Medical Technology Assessment Criteria*.  

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MPC Medical Policy Committee

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Codes  
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