

GE Healthcare

# Reimbursement Information for Positron Emission Tomography (PET)<sup>1</sup>



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This overview addresses coding, coverage, and payment for Positron Emission Tomography (PET) procedures when performed in the hospital outpatient settings, Independent Diagnostic Testing Facility (IDTF) and in the physician office setting<sup>2</sup>. While this advisory focuses on Medicare program policies, these policies may also be applicable to selected private payers throughout the country. For appropriate code selection, contact your local payer prior to claims submittal.

## Current Procedural Terminology (CPT)<sup>3</sup> Coding, Definitions and Medicare Payment Rates

The following provides 2010 national Medicare physician fee schedule (MPFS) and facility payment rates for example CPT codes that may be used. **Payment will vary by geographic regions.**

### 2010 Medicare reimbursement for procedures related to positron emission tomography (PET) procedures

CPT/HCPCS Code	Physician		Facility	
	Reimbursement Component	Medicare Physician Fee Schedule Amount <sup>4</sup>	APC	Hospital Outpatient Payment <sup>5</sup>
<b>CPT 78811</b> Positron emission tomography (PET) imaging; limited area (eg, chest, head/neck)	Professional (-26)*	\$80.11	0308	\$1037.34
	Technical (-TC)**	Carrier Priced		
	Global	Carrier Priced		
<b>CPT 78812</b> Positron emission tomography (PET) imaging; skull base to mid-thigh	Professional (-26)	\$98.87	0308	\$1037.34
	Technical (-TC)	Carrier Priced		
	Global	Carrier Priced		
<b>CPT 78813</b> Positron emission tomography (PET) imaging; whole body	Professional (-26)	\$102.84	0308	\$1037.34
	Technical (-TC)	Carrier Priced		
	Global	Carrier Priced		
<b>CPT 78608</b> Brain imaging, positron emission tomography (PET); metabolic evaluation	Professional (-26)	\$76.50	0308	\$1037.34
	Technical (-TC)	Carrier Priced		
	Global	Carrier Priced		
<b>CPT 78609***</b> Brain imaging, positron emission tomography (PET); perfusion evaluation	Professional (-26)	\$75.42 (NOPR)****	N/A	N/A
	Technical (-TC)	Not covered by Medicare-(NOPR)		
	Global	Not covered by Medicare-(NOPR)		

Continued on next page

CPT/HCPCS Code	Physician		Facility	
	Reimbursement Component	Medicare Physician Fee Schedule Amount <sup>4</sup>	APC	Hospital Outpatient Payment <sup>5</sup>
<b>CPT 78814</b> Positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization imaging; (leg, chest, head/neck)	Professional (-26)	\$112.94	0308	\$1037.34
	Technical (-TC)	Carrier Priced/ DRA-CAP		
	Global	Carrier Priced/ DRA-CAP		
<b>CPT 78815</b> Positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization imaging; skull base to mid-thigh	Professional (-26)	\$124.85	0308	\$1037.34
	Technical (-TC)	Carrier Priced		
	Global	Carrier Priced		
<b>CPT 78816</b> Positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization imaging; whole body	Professional (-26)	\$127.74	0308	\$1037.34
	Technical (-TC)	Carrier Priced		
	Global	Carrier Priced		
<b>CPT 78459</b> Myocardial imaging, positron emission tomography (PET), metabolic evaluation	Professional (-26)	\$78.30	0307	\$1,432.87
	Technical (-TC)	Carrier Priced		
	Global	Carrier Priced		
<b>CPT 78491</b> Myocardial imaging, positron emission tomography (PET), perfusion; single study at rest or stress	Professional (-26)	\$79.39	0307	\$1,432.87
	Technical (-TC)	Carrier Priced		
	Global	Carrier Priced		
<b>CPT 78492</b> Myocardial imaging, positron emission tomography (PET), perfusion; multiple studies at rest and/or stress	Professional (-26)	\$99.59	0307	\$1,432.87
	Technical (-TC)	Carrier Priced		
	Global	Carrier Priced		
<b>HCPCS G0219*</b> PET imaging whole body; melanoma for noncovered indications	N/A	N/A	N/A	N/A
<b>HCPCS G0235***</b> PET imaging, any site, not otherwise specified	N/A	N/A	N/A	N/A
<b>HCPCS G0252***</b> 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)	Professional (-26)	\$78.66 (NOPR)	N/A	N/A
	Technical (-TC)	N/A		
	Global	N/A		

## TC-Technical Component

This modifier would be used to bill for services by the owner of the equipment only to report the technical component of the service. This modifier is most commonly used if the service is performed in an Independent Diagnostic Testing Facility (IDTF).

## 59-Distinct procedural service

Under certain circumstances, the physician may need to indicate that a procedure or service was distinct or independent from other services performed on the same day. Modifier 59 is used to identify procedures/services that are not normally reported together, but are appropriate under the circumstances. This may represent a different session or patient encounter, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same physician. However, when another already established modifier is appropriate, it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used.

## Q0

Investigational clinical service provided in a clinical research study that is in an approved clinical research study

Two modifiers have been created in response to the new National Coverage Determination (NCD) for PET procedures. The new modifiers are used when submitting claims for CPT codes 78608, 78811 – 78816.

On September 18, 2009, CMS reissued the Guidance to MACs and Billing Instructions for the April 2009 changes to the NCD on Positron Emission Tomography (FDG). Providers will have two new modifiers to consider when submitting claims with a date of service (DOS) April 3, 2009 for CPT codes 78608, 78811-78816. Available on or after the implementation dates of October 30, or based on the site of service, providers submitting claims with a DOS on or after April 3, 2009 for CPT codes 78608, 78811-78816 will be required to identify the procedure as either for initial treatment strategy or subsequent treatment strategy by appending the following modifiers:

## PI

*Positron Emission Tomography (PET) or PET/Computed Tomography (CT) to inform the initial treatment strategy of tumors that are biopsy proven or strongly suspected of being cancerous based on other diagnostic testing.* Short descriptor: PET tumor init tx strat

## PS

*Positron Emission Tomography (PET) or PET/Computed Tomography (CT) to inform the subsequent treatment strategy of cancerous tumors when the beneficiary's treating physician determines that the PET study is needed to inform subsequent anti-tumor strategy.* Short descriptor: PET tumor subsq tx strategy

The transmittals regarding these new modifiers can be found by going to

<http://www.cms.hhs.gov/transmittals/downloads/R1833CP.pdf>  
<http://www.cms.hhs.gov/transmittals/downloads/R108NCD.pdf>

## Hospital Inpatient-ICD-9-CM Procedure Coding

ICD-9-CM procedure codes are used to report procedures performed in a hospital inpatient setting. The following are the ICD-9-CM procedure codes that are typically used to report PET procedures:

- 92.01 Thyroid scan and radioisotope function studies
- 92.02 Liver scan and radioisotope function study
- 92.03 Renal scan and radioisotope function study
- 92.04 Gastrointestinal scan and radioisotope function study
- 92.05 Cardiovascular and hematopoietic scan and radioisotope function study
- 92.09 Other radioisotope function studies
- 92.11 Cerebral scan
- 92.12 Scan of other sites of head
- 92.13 Parathyroid scan
- 92.14 Bone scan
- 92.15 Pulmonary scan
- 92.16 Scan of lymphatic system
- 92.17 Placental scan
- 92.18 Total body scan
- 92.19 Scan of other site

## ICD-9-CM Diagnosis Coding

It is the physician's ultimate responsibility to select the codes that appropriately represent the service performed, and to report the ICD-9-CM code based on his or her findings or the pre-service signs, symptoms or conditions that reflect the reason for doing the PET procedure.

## Documentation Requirements

The American College of Radiology (ACR) has developed standards that outline the minimum information that should be included in a final written report. The ACR also notes that it is important to confirm state or federal requirements for final written reporting. Here is a brief outline of the ACR's reporting standards:

- Demographics
- Name of patient and other identifying information

- Name of the referring physician
- Date of scan
- Relevant clinical information
- Procedure and materials
- Findings, including any factors that may limit the sensitivity and specificity of the scan
- Conclusion or diagnosis

For more detailed information, refer to the ACR standards at [http://www.acr.org/SecondaryMainMenuCategories/quality\\_safety/guidelines/dx/comm\\_diag\\_rad.aspx](http://www.acr.org/SecondaryMainMenuCategories/quality_safety/guidelines/dx/comm_diag_rad.aspx)

## Payment Methodologies for PET Imaging Procedures

### Independent diagnostic testing facility (IDTF) or a Physician office setting

If the technical portion of PET imaging procedure is performed in a physician's office or IDTF setting, then the payment would be based on the technical component of the Medicare Physician Fee Schedule (MPFS), which is "carrier priced." Carrier-priced means the local Medicare contractors will establish, for their region, payment amounts for these services. The physician's professional services would be reimbursed based on the professional component of the MPFS.

### Hospital Outpatient Setting

When the PET imaging procedures are performed in the hospital outpatient setting, physicians may not submit a global charge to Medicare because the global charge includes both the professional and technical components of the service.

If the procedure is performed in the hospital outpatient setting, the hospital may bill for the technical component of the PET service as an outpatient service.

The CPT code filed by the hospital will be assigned to a hospital outpatient system Ambulatory Payment Classification (APC) payment system, and payment will be based on the APC grouping. However, for Medicare, the hospital outpatient facility and the physician must report the same CPT code. If the physician is a hospital employee, the hospital may submit a charge for the global service.

### Hospital Inpatient Setting

Charges for services occurring in the hospital inpatient setting would be considered part of the charges submitted for the inpatient stay and payment would be made under the Medicare MS-DRG payment system. However, the physician may still submit a bill for his/her professional services.

## Payment for Diagnostic Radiopharmaceuticals

### Independent diagnostic testing facility (IDTF) or a Physician office setting

For IDTFs and physician offices, diagnostic radiopharmaceuticals are paid at 95% of the average wholesale price (AWP) or carrier priced, which is typically invoice price.<sup>6</sup>

### Hospital Outpatient Setting

For PET imaging procedures performed in the hospital outpatient department, Medicare packages the payment for the diagnostic radiopharmaceutical into the APC payment for the base imaging procedure.

Regardless of whether the radiopharmaceutical is separately paid, CMS recommends coding and billing separately for the radiopharmaceutical to ensure an accurate record of the costs associated with the product.<sup>7</sup>

### Hospital Inpatient Setting

Charges for services occurring in the hospital inpatient setting would be considered part of the charges submitted for the inpatient stay and payment would be made under the Medicare MS-DRG payment system.

## Medicare Coverage

On April 3, 2009, The Centers for Medicare & Medicaid Services (CMS) issued a National coverage decision (NCD) for PET titled "Decision Memorandum for Positron Emission Tomography (PET) for Solid Tumors and Myeloma". The following chart is the cancers and the indications that are covered by Medicare or are eligible for entry in the National Oncologic PET Registry 2009 (NOPR2009):

<b>Indications</b>	<b>Initial Treatment Strategy (formerly Diagnosis and Initial Staging)</b>	<b>Subsequent Treatment Strategy (Includes Treatment Monitoring, Restaging and Detection of Suspected Recurrence)</b>
Lip, Oral Cavity, and Pharynx	Covered	Covered
Esophagus	Covered	Covered
Stomach	Covered	NOPR
Small Intestine	Covered	NOPR
Colon and Rectum	Covered	Covered
Anus	Covered	NOPR <sup>a</sup>
Liver and intrahepatic bile ducts	Covered	NOPR
Gallbladder & extrahepatic bile ducts	Covered	NOPR
Pancreas	Covered	NOPR
Retroperitoneum and peritoneum	Covered	NOPR
Nasal cavity, ear, and sinuses	Covered	Covered
Larynx	Covered	Covered
Lung, non-small cell	Covered	Covered
Lung, small cell	Covered	NOPR
Pleura	Covered	NOPR
Thymus, heart, mediastinum	Covered	NOPR
Bone/cartilage	Covered	NOPR
Connective/other soft tissue	Covered	NOPR
Melanoma	Covered/Non Covered <sup>b</sup>	Covered
Non-melanoma skin	Covered	NOPR
Female breast	Covered/Non Covered <sup>b,c</sup>	Covered
Male breast	Covered/Non Covered <sup>b,c</sup>	Covered
Kaposi's sarcoma	Covered	NOPR
Uterus, unspecified	Covered	NOPR
Cervix	Covered/Non Covered <sup>d</sup>	Covered
Uterus, body	Covered	NOPR
Placenta	Covered	NOPR
Ovary	Covered	Covered
Uterine adnexa	Covered	NOPR
Other and unspecified female genitalia	Covered	NOPR
Prostate	Non Covered	NOPR
Testis	Covered	NOPR
Penis and other male genitalia	Covered	NOPR

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Indications	Initial Treatment Strategy (formerly Diagnosis and Initial Staging)	Subsequent Treatment Strategy (Includes Treatment Monitoring, Restaging and Detection of Suspected Recurrence)
Bladder	Covered	NOPR
Kidney and other urinary tract	Covered	NOPR
Eye	Covered	NOPR
Primary Brain	Covered	NOPR
Other and unspecified nervous system	Covered	NOPR
Thyroid	Covered	Covered/NOPR <sup>e</sup>
Other endocrine glands and related structures	Covered	NOPR
Metastatic cancer/unknown primary origin	Covered	NOPR
Lymphoma	Covered	Covered
Myeloma	Covered	Covered
Leukemia	NOPR	NOPR
Neuroendocrine tumor	Covered	NOPR
Other or not listed	Covered	NOPR

**Chart notes:**

<sup>a</sup>Some Medicare contractors include anal cancer in their local coverage of “colorectal cancer”; for PET facilities served by those carriers, PET for subsequent treatment evaluation of anal cancer would be a covered indication.

<sup>b</sup>PET is non-covered for initial staging of axillary lymph nodes in patients with breast cancer and of regional lymph nodes in patients with melanoma, but is covered for detection of distant metastatic disease in high-risk patients with breast cancer or melanoma.

<sup>c</sup>PET is non-covered for “diagnosis” of breast cancer to evaluate a suspicious breast mass. However, PET is covered for initial treatment strategy evaluation of a patient with axillary nodal metastasis of unknown primary origin or in a patient with a paraneoplastic syndrome potentially caused by an occult breast cancer.

<sup>d</sup>PET is non-covered for “diagnosis” of cervical cancer. However, PET is covered for initial staging of cervical cancer.

<sup>e</sup>To qualify as a covered indication for subsequent treatment strategy evaluation, thyroid cancer must be of follicular cell origin and been previously treated by thyroidectomy and radioiodine ablation and the patient must have a serum thyroglobulin > 10 ng/mL and a negative whole-body I-131 scan. Patients who do not qualify for this covered indication (e.g., because the tumor is of other than follicular cell origin, the thyroglobulin is not elevated, or I-131 whole-body imaging was not performed or is positive) can be entered on NOPR.

**Note:**

The scientific evidence concerning the clinical utility of FDG-PET is generally less robust for cancers and indications that are currently covered by Medicare only in the NOPR than for cancers and indications that are currently covered without the requirement for clinical data submission to the NOPR. For this reason, Medicare has conditioned coverage of FDG-PET under the NOPR on the collection of clinical data. These data will be used to help determine the clinical utility of FDG-PET for conditionally covered cancers and indications. The billing physician remains responsible for documenting medical necessity, which is required for the coding and billing of both covered and NOPR-eligible PET studies. Eligibility for the NOPR does not constitute a clinical management recommendation for the use of PET for the conditionally covered cancers and indications, by either the Medicare program or NOPR investigators. Referring and interpreting physicians are thus advised to refer to the published literature to better understand the potential limitations of FDG-PET for NOPR-eligible uses.

The NCD can be found by going to <http://www.cms.hhs.gov/mcd/viewdecisionmemo.asp?from2=viewdecisionmemo.asp&id=218&>

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### Footnotes:

<sup>1</sup> Information presented in this document is current as of January 1, 2010.

Any subsequent changes which may occur in coding, coverage and payment are not reflected herein.

<sup>2</sup> The federal statute known as the Stark Law (42 U.S.C. §1395nn) imposes certain requirements, which must be met in order for physicians to bill Medicare patients for in-office radiology services. In some states, similar laws cover billing for all patients. In addition, licensure, certificate of need, and other restrictions may be applicable.

<sup>3</sup> Current Procedural Terminology © 2009 American Medical Association. All Rights Reserved. No fee schedules, basic units, relative values, or related listings are included in CPT. The AMA assumes no liability for the data contained herein.

<sup>4</sup> Third party reimbursement amounts and coverage policies for specific procedures will vary by payer and by locality. The technical and professional components are paid under the Medicare physician fee schedule (MPFS). The MPFS payment is based on relative value units published in Federal Register, Vol. 74, No. 226, November

25, 2009 and the Federal Register, Vol. 74, No. 236, December 10, 2009, and updated as per Transmittal R1887CP, dated January 6, 2010. Amounts do not necessarily reflect any subsequent changes in payment since publication. To confirm reimbursement rates for specific codes, consult with your local Medicare contractor.

<sup>5</sup> Third party reimbursement amounts and coverage policies for specific procedures will vary by payer and by locality. Only national rates unadjusted for local wage and cost differences are provided. The technical component is a payment amount assigned to an Ambulatory Payment Classification under the hospital outpatient prospective payment system, as published in the Federal Register, Vol. 74, No. 223, November 20, 2009. The professional component is paid under the Medicare physician fee schedule (MPFS). To confirm reimbursement rates for specific codes, consult with your local Medicare contractor.

<sup>6</sup> Federal Register, Vol. 69, No. 179, September 16, 2004 and the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, sec. 303(h).

<sup>7</sup> CMS Transmittal 1760, Change Request 6492, June 23, 2009.

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