

Radiology: Nuclear Medicine

Policies and guidelines for billing nuclear medicine procedures are listed below.

Single Photon Emission Computed Tomography (SPECT)

The following Single Photon Emission Computed Tomography (SPECT) procedures must be billed "By Report."

CPT-4

<u>Code</u>	<u>Description</u>
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78205	Liver imaging (SPECT)
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78320	Bone and/or joint imaging; tomographic (SPECT)
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Billing Requirements: Myocardial Perfusion

Reimbursement for CPT-4 radiology codes 78451 – 78454, 78466 and 78468 requires appropriate, medically justified ICD-9-CM diagnosis medically justified ICD-9-CM diagnosis codes for procedures documented on the claim. Myocardial perfusion imaging is not appropriate for general screening or routine testing to rule out disease.

CPT-4 codes 78451 – 78454 are reimbursable only for ICD-9-CM diagnosis codes 250.00 – 250.93, 410.00 – 414.03, 414.06, 414.07, 414.10 – 414.9, 425.0 – 425.9, 427.0 – 427.9, 428.0 – 428.1, 428.33, 428.40, 429.0 – 429.79, 434.00 – 434.91, 441.00 – 441.9, 443.21 – 443.24, 443.29, 443.9, 746.84 – 746.9, 786.00 and 786.50 – 786.59. These codes are split-billed, and must be billed with either modifier 26 or TC.

If a multiple study code is reimbursed, a single study code is not separately reimbursable when billed with a date of service within 48 hours of the multiple studies claim.

If the single study code was reimbursed, reimbursement for a multiple studies code for the same method will be reduced by the amount reimbursed for the single study code when billed with a date of service within 48 hours of the single study claim.

In addition, a planar myocardial perfusion code (78453, 78454, 78466 or 78468) is not separately reimbursable when billed with a SPECT myocardial perfusion code (78451 or 78452) in the same 48-hour period by the same provider for the same recipient.

Positron Emission Tomography (PET) Scan

Providers may be reimbursed for Positron Emission Tomography (PET) or PET-computed tomography (PET-CT) scans for malignant and non-malignant conditions.

Below is the PET scan coverage for biopsy proven or strongly suspected malignancies:

<u>Tumor Type</u>	<u>Initial Treatment Strategy</u>	<u>Subsequent Treatment Strategy</u>
Brain (differentiating recurrent tumor from treatment-related tissue necrosis)	No coverage	Covered
Breast (female and male)	Covered ²	Covered
Cervix	Covered ¹	Covered
Colorectal	Covered	Covered
Esophagus	Covered	Covered
Head and neck (not thyroid or CNS)	Covered	Covered
Lymphoma (Hodgkin's and non-Hodgkin's)	Covered	Covered
Malignant melanoma	Covered ³	Covered
Multiple myeloma	Covered	Covered
Non-small cell lung	Covered	Covered
Ovary	Covered	Covered
Pancreas	Covered	No coverage
Small cell lung	Covered	No coverage
Soft tissue sarcoma	Covered	No coverage
Testes	Covered	No coverage
Thyroid	Covered	Covered ⁴

Notes:

¹ Cervix: covered for the detection of pre-treatment metastases in newly diagnosed cervical cancer subsequent to conventional imaging that is negative for extra-pelvic metastasis.

² Breast: not covered for diagnosis and/or initial staging of axillary lymph nodes. Covered only for initial staging of metastatic disease.

³ Malignant melanoma: not covered for initial staging of regional lymph nodes. All other uses for initial staging are covered.

⁴ Thyroid: covered for subsequent treatment strategy of recurrent or residual thyroid cancer of follicular cell origin previously treated by thyroidectomy and radioiodine ablation and have a serum thyroglobulin >10ng/ml and have a negative I-131 whole body scan.

PET scans are covered for the following non-malignant conditions:

- Localization of seizure foci in patients with complex partial seizures that have failed medical therapy and are candidates for surgical therapy.
- Evaluation of a solitary pulmonary nodule.
- Differentiation of viable (hibernating) from nonviable myocardium in patients with left ventricular dysfunction due to ischemia

Note: A PET scan is not reimbursable for routine screening of patients with coronary artery disease.

Authorization

An approved *Treatment Authorized Request* (TAR) is required for reimbursement. PET scan codes are split-billed and require a modifier. See “Modifiers for TAR Submission on the following page.

When submitting a TAR for the evaluation of the myocardium, providers must document a patient’s prior myocardial infarction, history of bypass surgery, significantly reduced left ventricular ejection fraction or significant hypokinesia of the left ventricle.

Billing

<u>CPT-4 Code</u>	<u>Description</u>
78459	Myocardial imaging, positron emission tomography (PET), metabolic evaluation
78608	Brain imaging, positron emission tomography (PET); metabolic evaluation
78609	perfusion evaluation
78811	Tumor imaging, positron emission tomography (PET), limited area (eg, chest, head/neck)
78812	skull base to mid-thigh
78813	whole body
78814	PET with concurrent computed tomography (CT); limited area (eg, chest, head/neck)
78815	skull base to mid-thigh
78816	whole body

Only one of these codes may be reimbursed to any provider for the same recipient, same date of service.

Code A9552 (fluorodeoxyglucose F-18 FDG, diagnostic, per study dose) will be reimbursed only if a positron emission tomography (PET) scan code is billed on the same date of service.

Modifiers for TAR Submission

Modifiers to be used for PET CPT-4 codes are modifier TC (technical component) and 26 (professional component). Use one of the following scenarios when submitting a TAR.

- One TAR and one provider for both the professional (26) and technical (TC) components of service in which the TAR must be submitted with two lines of service. The first line must have the CPT-4 code and one of the two modifiers (26 or TC). The second line must have the same CPT-4 code and the corresponding modifier (26 and TC).
- One TAR and two different providers for the professional (26) and technical (TC) components of service with one of the providers submitting the TAR on behalf of both providers of the two components of service (26 and TC), and both providers should use the same TAR for claim submission. The TAR must be submitted with two lines of service. The first line must have the CPT-4 code and one of the two modifiers (26 or TC). The second line must have the same CPT-4 code and corresponding modifier (26 or TC). This is the preferred method for two different providers.
- Two TARs and two different providers for the professional (26) and technical (TC) components of service with each provider submitting their own TAR with one line of service and the appropriate modifier designating the service (26 or TC) they will provide or have provided.

Claim Completion

Providers use one of the following methods when submitting a claim for PET services:

- The facility and physician each bill for their service components, respectively, with modifiers 26 or TC. Each facility/provider submits their own claim with one line of service and the appropriate modifier. When billing only for the professional component, use modifier 26. When billing for only the technical component, use modifier TC.
- Physician Billing – The physician bills for both the professional and technical components and later reimburses the facility for the technical component, according to their mutual agreements. The physician submits a *CSM-1500* claim form, completing two separate claim lines. The first line contains the split-billable procedure code and one of the two modifiers (26 or TC). The second line contains the same procedure code and the other of the two modifiers (26 or TC).
- Facility Billing – The facility bills for both the technical and professional components and reimburses the physician for the professional component, according to their mutual agreements. The facility submits a *UB-04* claim form and completes two separate claim lines. The first line contains the split-billable procedure code and one of the two modifiers (26 or TC). The second line contains the same procedure code and the other of the two modifiers (26 or TC).

**Intravenous
Radiopharmaceutical
Therapy
(CPT-4 Code 79101)**

Radiopharmaceutical therapy, by intravenous administration (CPT-4 code 79101) is not reimbursable when billed with CPT-4 codes 36400, 36410, 79403, 90760, 90765 – 90768, 90780, 96360, 96374, 96375, 96408 and 96409.

**Diagnostic
Radiopharmaceutical Agents**

Radiopharmaceuticals are radioactive agents that have been used extensively in the field of nuclear medicine as noninvasive diagnostic imaging agents to provide both functional and structural information about organs and diseased tissues

Refer to “Therapeutic Radiopharmaceutical Agents” in the *Radiology: Oncology* section of the appropriate Part 2 manual.

“Per Study Dose” Agents

The following diagnostic radiopharmaceutical agents include the wording “per study dose” in their code descriptors and reimbursement is limited to one unit (one study dose):

A4642	A9536 – A9542	A9566 – A9572
A9500 – A9504	A9544	A9580
A9507	A9546	A9582
A9510	A9550 – A9555	A9599
A9521	A9557	
A9526	A9559 – A9562	

When billing for diagnostic radiopharmaceutical agents, services that include the acquisition of both the rest and stress data sets/images are considered one study and the billed amount includes the total dose administered to the recipient for their acquisition. For example, if a provider administers the radiopharmaceutical agent for the rest data set/image and then administers the same agent for the stress component, the total dose administered should be billed as one unit.

Code A9552 (fluorodeoxyglucose F-18 FDG, diagnostic, per study dose, up to 45 millicuries) will be reimbursed only if a positron emission tomography (PET) scan code is billed on the same date of service.

Other Agents

The following diagnostic radiopharmaceutical agents include “millicuries” in their descriptors and reimbursement is allowed as per their descriptors

A4641	A9520	A9547
A9505	A9524	A9548
A9508	A9528	A9556
A9509	A9529	A9558
A9512	A9531	
A9516	A9532	

Code A9520 (technetium Tc-99m, tilmanocept, diagnostic, up to 0.5 millicuries) requires an invoice for reimbursement.

Billing

Diagnostic radiopharmaceutical agent codes are not split-billable and must not be billed with any modifier. An invoice with the acquisition cost of the substance(s) must be attached to the claim.

No Price On File

For codes listed on the Medi-Cal rates website without a price, an invoice is required for pricing purposes. The invoices for these items must be dated prior to the date of service or the claim will be denied.