

# Health Plus Medical & Claims Payment Bulletin

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**Subject: Positron Emission Tomography (PET) Scans**

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## **Definition:**

Positron Emission Tomography (PET) Scan – is a noninvasive diagnostic imaging procedure that assesses the level of metabolic activity and perfusion in various organ systems of the body.

## *Claim Submission:*

- All PET Scans must be pre-authorized by Health Plus. In pre-authorizing requests for PET scan, Health Plus will use the standards published in the Medicare Coverage Issues Manual.
- Claims for non-institutional providers for PET scan services must be billed on Form-CMS 1500 or the electronic equivalent with the appropriate HCPCS or CPT code and diagnosis codes (coded to highest specificity).
- For institutional providers, PET scans must be billed on the UB-92 or the electronic equivalent with the appropriate HCPCS or CPT code (under revenue code 0404) and diagnosis codes (coded to highest specificity).
- Claims may be billed globally as contracted for by Health Plus (see below for reimbursement limits). If separate claims are submitted for either the technical or professional component, the claim will be rejected as part of another service.

The following CPT codes are used to report covered PET scan indications:

- 78459 - Myocardial imaging, positron emission tomography (PET), metabolic evaluation
- 78491 – Myocardial imaging, positron emission tomography (PET), perfusion, single study at rest or stress
- 78492 – Myocardial imaging, positron emission tomography (PET), perfusion, multiple studies at rest and/or stress

- 78608 – Brain imaging, positron emission tomography (PET); metabolic evaluation
- 78609 – Brain imaging, positron emission tomography (PET); perfusion evaluation
- 78811 – Tumor imaging, positron emission tomography (PET); limited area (e.g. chest, head/neck)
- 78812 – Tumor imaging, positron emission tomography (PET); skull base to mid thigh
- 78813 – Tumor imaging, positron emission tomography (PET); whole body
- 78814 – Tumor imaging, positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization; limited area (e.g. chest, head/neck)
- 78815 – Tumor imaging, positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization; skull base to mid thigh
- 78816 – Tumor imaging, positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization; whole body

The following are the applicable HCPCS Level II codes for PET billing:

- A4641 – Supply of radiopharmaceutical diagnostic imaging agent, not otherwise classified (Report A4641 for the tracer rubidium 82)
- A9526 – Supply of radiopharmaceutical diagnostic imaging agent, ammonia N-13, per dose

Effective for dates of service on or after January 28, 2005, the majority of temporary ‘G’ codes for PET scans were rendered invalid and therefore not payable. But, the following ‘G’ codes are valid for PET services:

- G0219 - Melanoma for noncovered indications
- G0235 – Noncovered service PET imaging, any site not otherwise specified
- G0252 – Initial diagnosis of breast cancer and/or surgical planning for breast cancer (e.g. initial staging of axillary lymph nodes), not covered (full-and partial-ring PET scanners only)

The following list contains codes for the radiopharmaceutical diagnostic imaging agent (tracer) necessary to perform a PET scan, applicable to CPT codes 78491 - 78492:

- A4641 – Supply of radiopharmaceutical diagnostic imaging agent, not otherwise classified
- A9526 – Supply of radiopharmaceutical diagnostic imaging agent, ammonia N-13

Tracer codes applicable to CPT codes 78459, 78608, 78609, 78811 – 78816:

- A4641 - Supply of radiopharmaceutical diagnostic imaging agent, not otherwise classified

*Payment:*

- Codes 78811 – 78816 are to be billed once per imaging session and no more than a single PET scan is payable on the same date of service.
- Reimbursement for PET scans using FDG as a tracer is limited to \$2,400 for the global procedure or to such other limits set by the Medicaid Bureau of Medical Review and Payment and published in the New York State Medicaid Update or other official publication.

This maximum amount is for the global (complete) procedure (professional, technical, and administrative components), including the tracer.

But, if the place of service is inpatient (21), the radiologist reimbursement will be at the contracted RBRVS rate.

- Reimbursement for scans using Rubidium 82 as the tracer is limited to \$1,850 for the global procedure.

This maximum amount is for the global (complete) procedure (professional, technical, and administrative components) including the tracer.

- If billed separately, claims for the FDG or the Rubidium 82 tracer will be denied as part of another service.

But, if the place of service is inpatient (21), the radiologist reimbursement will be at the contracted RBRVS rate.

**Policies in this manual are intended to reflect standard Health Plus procedures. In instances where a provider's contract contains other policies which may be more or less restrictive than those in this manual, these contractual provisions will apply.**

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