Reimbursement and Coding Guide

Prepared by:

THE PINNACLE HEALTH GROUP

Reimbursement Support is available at:
Jubilant@thepinnaclehealthgroup.com
866-369-9290

For Our Customers:

JUBILANT RADIOPHARMA

When reporting services provided for nuclear medicine, procedures must be coded correctly when submitting claims to Medicare and commercial payers. The most common CPT (Current Procedural Terminology) and HCPCS (Healthcare Common Procedure Coding System) codes are listed in this guide for your reference.

Disclaimer: Coding and reimbursement information is provided for educational purposes and does not assure coverage of the specific item or service in any given case. Information provided in this document is for educational purposes only and is not intended to provide legal, patient specific coding or claims submission information. Information is provided based upon the current landscape utilizing the information that is currently available.

Procedure coding should always be based upon medically necessary procedures and supplies provided to the patient. Jubilant Radiopharma and The Pinnacle Health Group make no guarantee of coverage or reimbursement. Contact the local Medicare Administrative Contractor (MAC) or CMS for specific information as payment rates listed are subject to change. To the extent that you submit cost information to Medicare, Medicaid or any other reimbursement program to support claims for services or items, you are obligated to accurately report the actual price paid for such items, including any subsequent adjustments. Current Procedural Terminology numeric codes, descriptions, and modifiers are trademarks and copyrights of the AMA.

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Guidelines for Nuclear Medicine Studies and Radiopharmaceuticals

Coding

General Billing and Coding guidelines require the provider to report radiopharmaceuticals, regardless of whether the items are paid separately or packaged, using the appropriate HCPCS code. The appropriate units of service, as per the HCPCS code description, must also be provided. The HCPCS code for the radiopharmaceutical must appear on the same claim as the study. The claim must indicate the actual date the service was provided. Therefore, if the study is performed on a different date of service from the radiopharmaceutical the claim may contain more than one date of service.

CMS Payment for Radiopharmaceuticals in the Physician Office

CMS categorizes radiopharmaceuticals into two groups for payment purposes: diagnostic and therapeutic. Diagnostic radiopharmaceuticals function as products that enable the provision of an independent service, specifically, a diagnostic nuclear medicine scan. Conversely, therapeutic radiopharmaceuticals are themselves the primary therapeutic modality. CMS requires claims with payable nuclear medicine procedures to include the radiopharmaceutical. Payment for radiopharmaceuticals is inclusive of the acquisition cost and pharmacy overhead. The pharmacy costs should not be reported separately on the claim.

In the physician office all radiopharmaceuticals are contractor priced. This means that each Medicare Administrative Contractor (MAC) will determine pricing for each Radiopharmaceutical HCPCS code. Some MACs may establish fee schedule pricing for some or all radiopharmaceuticals, while others may require cost information to be submitted on all claims containing a radiopharmaceutical. In this case, the MAC will utilize this information to establish appropriate reimbursement. Providers should check with their local MAC to determine if a payment rate has been assigned and/or if there any invoice/cost reporting requirements.

Use of the JW and JZ Modifier

Effective January 1, 2017, providers and suppliers are required to report the JW modifier on all claims that bill for drugs and biologicals paid *separately* under Medicare Part B, with unused and discarded amounts from single-dose containers or single-use packages. Also, providers and suppliers must document the amount of discarded drugs in Medicare beneficiaries' medical records. Effective July 1, 2023, providers and suppliers are required to report the JZ modifier on all claims that bill for drugs from single-dose containers that are separately payable under Medicare Part B when there are no discarded amounts. The JW and JZ modifier requirement applies to all separately payable drugs from single-dose containers assigned status indicators "G" (Pass-Through Drugs and Biologicals) or "K" (NonpassThrough Drugs and Nonimplantable Biologicals, *Including Therapeutic Radiopharmaceuticals*) under the OPPS for which there is a discarded amount. For additional information please refer to the following resources:

- Discarded Drugs and Biologicals – JW Modifier and JZ Modifier Policy Frequently Asked Questions
- A55932: Billing and Coding: JW and JZ Modifier Billing Guidelines

2024 Physician Office Coding and Medicare Values

Diagnostic Radiopharmaceuticals

CPT	Descriptor	Physician Global Fee
Indium-111 Labeled		
A4642	Indium In-111 satumomab pendetide, diagnostic, per study dose, up to 6 mCi	Contractor Priced*
A9507	Indium In-111 capromab pendetide, diagnostic, per study dose, up to 10 mCi	Contractor Priced*
A9542	Indium In-111 ibritumomab tiuxetan, diagnostic, per study dose, up to 5 mCi	Contractor Priced*
A9547	Indium In-111 oxyquinoline, diagnostic, per 0.5 mCi	Contractor Priced*
A9548	Indium In-111 pentetate, diagnostic, per 0.5 mCi	Contractor Priced*
A9571	Indium In-111 labeled autologous platelets, diagnostic, per study dose	Contractor Priced*
A9570	Indium In-111 labeled autologous white blood cells, diagnostic, per study dose	Contractor Priced*
A9572	Indium In-111 pentetreotide, diagnostic, per study dose, up to 6 mCi	Contractor Priced*
Technetium Tc-99m Labeled		
A9512	Technetium Tc-99m pertechnetate, diagnostic, per mCi	Contractor Priced*
A9500	Technetium Tc-99m sestamibi, diagnostic, per study dose	Contractor Priced*
A9502	Technetium Tc-99m tetrofosmin, diagnostic, per study dose	Contractor Priced*
A9503	Technetium Tc-99m medronate, diagnostic, per study dose, up to 30 mCi	Contractor Priced*
A9510	Technetium Tc-99m disofenin, diagnostic, per study dose, up to 15 mCi	Contractor Priced*
A9521	Technetium Tc-99m exametazime, diagnostic, per study dose, up to 25 mCi	Contractor Priced*
A9537	Technetium Tc-99m mebrofenin, diagnostic, per study dose, up to 15 mCi	Contractor Priced*
A9538	Technetium Tc-99m pyrophosphate, diagnostic, per study dose, up to 25 mCi	Contractor Priced*
A9539	Technetium Tc-99m pentetate, diagnostic, per study dose, up to 25 mCi	Contractor Priced*
A9540	Technetium Tc-99m macroaggregated albumin, diagnostic, per study dose, up to 10 mCi	Contractor Priced*
A9541	Technetium Tc-99m sulfur colloid, diagnostic, per study dose, up to 20 mCi	Contractor Priced*
A9551	Technetium Tc-99m succimer, diagnostic, per study dose, up to 10 mCi	Contractor Priced*
A9557	Technetium Tc-99m bicisate, diagnostic, per study dose, up to 25 mCi	Contractor Priced*
A9560	Technetium Tc-99m labeled red blood cells, diagnostic, per study dose, up to 30 mCi	Contractor Priced*
A9561	Technetium Tc-99m oxidronate, diagnostic, per study dose, up to 30 mCi	Contractor Priced*
A9562	Technetium Tc-99m mertiatide, diagnostic, per study dose, up to 15 mCi	Contractor Priced*
A9567	Technetium Tc-99m pentetate, diagnostic, aerosol, per study dose, up to 75 mCi	Contractor Priced*
A9568	Technetium Tc-99m arcitumomab, diagnostic, per study dose, up to 45 mCi	Contractor Priced*
A9569	Technetium Tc-99m exametazime labeled autologous white blood cells, diagnostic, per study dose	Contractor Priced*
Miscellaneous/Not Otherwise Classified		
A9505	Thallium Tl-201 thallous chloride, diagnostic, per mCi	Contractor Priced*
A9553	Chromium Cr-51 sodium chromate, diagnostic, per study dose, up to 250 µCi	Contractor Priced*
A9556	Gallium Ga-67 citrate, diagnostic, per mCi	Contractor Priced*
A9558	Xenon Xe-133 gas, diagnostic, per 10 mCi	Contractor Priced*

*Contractor Priced: No formal fee schedule payment has been established; coverage and payment are subject to the Medicare Administrative Contractor (MAC) review process. Contact local MAC to determine appropriate claim requirements for payment determination.

Cardiovascular Imaging Procedures

CPT	Descriptor	Physician Global Fee
78414	Determination of central c-v hemodynamics (non-imaging) (e.g., ejection fraction with probe technique) with or without pharmacologic intervention or exercise, single or multiple	Contractor Priced*
78428	Cardiac shunt detection	$171
78445	Non-cardiac vascular flow imaging (ie, angiography, venography)	$185
78451	Myocardial perfusion imaging, tomographic (SPECT) (including attenuation correction, qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); single study, at rest or stress (exercise or pharmacologic)	$307
78452	Myocardial perfusion imaging, tomographic (SPECT) (including attenuation correction, qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); multiple studies, at rest and/or stress (exercise or pharmacologic) and/or redistribution and/or rest reinjection	$425
0742T	Absolute quantitation of myocardial blood flow (AQMBF), single-photon emission computed tomography (SPECT), with exercise or pharmacologic stress, and at rest, when performed (List separately in addition to code for primary procedure)	Contractor Priced*
78453	Myocardial perfusion imaging, planar (including qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); single study, at rest or stress (exercise or pharmacologic)	$262
78454	Myocardial perfusion imaging, planar (including qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); multiple studies, at rest and/or stress (exercise or pharmacologic) and/or redistribution and/or rest reinjection	$391
78456	Acute venous thrombosis imaging, peptide	$283
78457	Venous thrombosis imaging, venogram; unilateral	$152
78458	Venous thrombosis imaging, venogram; bilateral	$189
78466	Myocardial imaging, infarct avid, planar; qualitative or quantitative	$164
78468	Myocardial imaging, infarct avid, planar; with ejection fraction by first pass technique	$180
78469	Myocardial imaging, infarct avid, planar; tomographic SPECT with or without quantification	$202
78472	Cardiac blood pool imaging, gated equilibrium; planar, single study at rest or stress (exercise and/or pharmacologic), wall motion study plus ejection fraction, with or without additional quantitative processing	$207
78473	Cardiac blood pool imaging, gated equilibrium; multiple studies, wall motion study plus ejection fraction, at rest and stress (exercise and/or pharmacologic), with or without additional quantification	$263
78481	Cardiac blood pool imaging (planar), first pass technique; single study, at rest or with stress (exercise and/or pharmacologic), wall motion study plus ejection fraction, with or without quantification	$162
78483	Cardiac blood pool imaging (planar), first pass technique; multiple studies, at rest and with stress (exercise and/or pharmacologic), wall motion study plus ejection fraction, with or without quantification	$218
78494	Cardiac blood pool imaging, gated equilibrium, SPECT, at rest, wall motion study plus ejection fraction, with or without quantitative processing	$208
78496	Cardiac blood pool imaging, gated equilibrium, single study, at rest, with right ventricular ejection fraction by first pass technique (List in addition to code for primary procedure)	$41
78499	Unlisted cardiovascular procedure, diagnostic nuclear	By Report†

*Contractor Priced: No formal fee schedule payment has been established; coverage and payment are subject to the Medicare Administrative Contractor (MAC) review process. Contact local MAC to determine appropriate claim requirements for payment determination.

†By Report: MAC determines payment based on the description of the procedure/service provided.

Endocrine (Thyroid, Parathyroid, Adrenal) Imaging Procedures

CPT	Descriptor	Physician Global Fee
78012	Thyroid uptake, single or multiple quantitative measurement(s) (including stimulation, suppression, or discharge, when performed)	$80
78013	Thyroid imaging (including vascular flow, when performed)	$168
78014	Thyroid imaging (including vascular flow, when performed); with single or multiple uptake(s) quantitative measurement(s) (including stimulation, suppression, or discharge, when performed)	$214
78015	Thyroid carcinoma metastases imaging; limited area (e.g., neck and chest only)	$208
78016	Thyroid carcinoma metastases imaging; with additional studies (e.g., urinary recovery)	$248
78018	Thyroid carcinoma metastases imaging; whole body	$279
78020	Thyroid carcinoma metastases uptake (List separately in addition to code for primary procedure)	$77
78070	Parathyroid planar imaging (including subtraction, when performed)	$265
78071	Parathyroid planar imaging (including subtraction, when performed); with tomographic (SPECT)	$315
78072	Parathyroid planar imaging (including subtraction, when performed); with tomographic (SPECT), and concurrently acquired computed tomography (CT) for anatomical localization	$390
78075	Adrenal imaging, cortex and /or medulla	$399

Gastrointestinal System Imaging Procedures

CPT	Descriptor	Physician Global Fee
78201	Liver imaging; static only	$174
78202	Liver imaging; with vascular flow	$191
78215	Liver and spleen imaging; static only	$179
78216	Liver and spleen imaging; vascular flow	$125
78226	Hepatobiliary system imaging, including gallbladder when present;	$291
78227	Hepatobiliary system imaging, including gallbladder when present; with pharmacologic intervention, including quantitative measurement(s) when performed	$391
78230	Salivary gland imaging;	$161
78231	Salivary gland imaging; with serial images	$102
78232	Salivary gland function study	$100
78258	Esophageal motility	$194
78261	Gastric mucosa imaging	$181
78262	Gastroesophageal reflux study	$222
78264	Gastric emptying imaging study (e.g., solid, liquid, or both);	$297
78265	Gastric emptying imaging study (e.g,. solid, liquid, or both); with small bowel transit	$353
78266	Gastric emptying imaging study (e.g., solid, liquid, or both); with small bowel and colon transit, multiple days	$401
78267	Urea breath test, C-14 (isotopic); acquisition for analysis	$11†
78268	Urea breath test, C-14 (isotopic); analysis	$94†
78278	Acute gastrointestinal blood loss imaging	$313
78282	Gastrointestinal protein loss	Contractor Priced*
78290	Intestine imaging (e.g., ectopic gastric mucosa, Meckel's localization, volvulus)	$295
78291	Peritoneal-venous shunt patency test (e.g., for LeVeen, Denver shunt)	$238

CPT	Descriptor	Physician Global Fee
78299	Unlisted gastrointestinal procedure, diagnostic nuclear medicine	By Report‡

*Contractor Priced: No formal fee schedule payment has been established; coverage and payment are subject to the Medicare Administrative Contractor (MAC) review process. Contact your local MAC to determine appropriate claim requirements for payment determination.
†Paid under the Clinical Diagnostic Laboratory Fee Schedule.
‡By Report: MAC determines payment based on the description of the procedure/service provided.

Genitourinary System Imaging Procedures

CPT	Descriptor	Physician Global Fee
78700	Kidney imaging morphology	$156
78701	Kidney imaging morphology; with vascular flow	$204
78707	Kidney imaging morphology; with vascular flow and function, single study without pharmacological intervention	$211
78708	Kidney imaging morphology; with vascular flow and function, single study, with pharmacological intervention (e.g., angiotensin converting enzyme inhibitor and/or diuretic)	$172
78709	Kidney imaging morphology; with vascular flow and function, multiple studies, with and without pharmacological intervention (e.g., angiotensin converting enzyme inhibitor and/or diuretic) (For introduction of radioactive substance in association with renal endoscopy, use 77778)	$332
78725	Kidney function study, non-imaging radioisotopic study	$95
78730	Urinary bladder residual study (List separately in addition to code for primary procedure); use in conjunction with 78740)	$67
78740	Ureteral reflux study (radiopharmaceutical voiding cystogram)	$207
78761	Testicular imaging with vascular flow	$194
78799	Unlisted genitourinary procedure, diagnostic nuclear medicine	By Report‡

‡By Report: MAC determines payment based on the description of the procedure/service provided.

Hematopoietic, Reticuloendothelial & Lymphatic System Imaging Procedures

CPT	Descriptor	Physician Global Fee
78102	Bone marrow imaging; limited area	$158
78103	Bone marrow imaging; multiple areas	$168
78104	Bone marrow imaging; whole body	$226
78110	Plasma volume, radiopharmaceutical volume-dilution technique (separate procedure); single sampling	$68
78111	Plasma volume, radiopharmaceutical volume-dilution technique (separate procedure); multiple samplings	$72
78120	Red cell volume determination (separate procedure); single sampling	$69
78121	Red cell volume determination (separate procedure); multiple samplings	$76
78122	Whole blood volume determination, including separate measurement of plasma volume and red cell volume (radiopharmaceutical volume-dilution technique)	$96
78130	Red cell survival study	$122
78140	Labeled red cell sequestration, differential organ/tissue (e.g., splenic and/or hepatic)	$107
78185	Spleen imaging only, with or without vascular flow Platelet survival study	$152
78191	Platelet survival study	$122
78195	Lymphatics and lymph nodes imaging	$318
78199	Unlisted hematopoietic, reticuloendothelial and lymphatic procedure, diagnostic nuclear medicine	By Report‡

‡By Report: MAC determines payment based on the description of the procedure/service provided.

Musculoskeletal Imaging Procedures

CPT	Descriptor	Physician Global Fee
78300	Bone and/or joint imaging; limited area	$203
78305	Bone and/or joint imaging; multiple areas	$245
78306	Bone and/or joint imaging; whole body	$265
78315	Bone and/or joint imaging; 3 phase study	$311
78350	Bone density (bone mineral content) study, 1 or more sites; single photon absorptiometry	$31
78351	Bone density (bone mineral content) study, 1 or more sites; dual photon absorptiometry, 1 or more sites	N/A
78399	Unlisted musculoskeletal procedure, diagnostic nuclear medicine	By Report‡

§Not covered by Medicare

‡By Report: MAC determines payment based on the description of the procedure/service provided.

Nervous System Imaging Procedures

CPT	Descriptor	Physician Global Fee
78600	Brain imaging, less than 4 static views;	$165
78601	Brain imaging, less than 4 static views; with vascular flow	$197
78605	Brain imaging, minimum 4 static views;	$183
78606	Brain imaging, minimum 4 static views; with vascular flow	$296
78608	Brain imaging, positron emission tomography (PET); metabolic evaluation	Contractor Priced*
78609	Brain imaging, positron emission tomography (PET); perfusion evaluation	$69
78610	Brain imaging, vascular flow only	$159
78630	Cerebrospinal fluid flow, imaging (not including introduction of material); cisternography	$302
78635	Cerebrospinal fluid flow, imaging (not including introduction of material); ventriculography	$303
78645	Cerebrospinal fluid flow, imaging (not including introduction of material); shunt evaluation	$290
78650	Cerebrospinal fluid leakage detection and localization	$243
78660	Radiopharmaceutical dacryocystography	$130
78699	Unlisted nervous system procedure, diagnostic nuclear medicine	By Report‡

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§Not covered by Medicare

‡By Report: MAC determines payment based on the description of the procedure/service provided.

Pulmonary Imaging Procedures

CPT	Descriptor	Physician Global Fee
78579	Pulmonary ventilation imaging (e.g., aerosol or gas)	$169
78580	Pulmonary perfusion imaging (e.g., particulate)	$213
78582	Pulmonary ventilation (e.g., aerosol or gas) and perfusion imaging	$298
78597	Quantitative differential pulmonary perfusion, including imaging when performed	$180
78598	Quantitative differential pulmonary perfusion and ventilation (e.g., aerosol or gas), including imaging when performed	$270
78599	Unlisted respiratory procedure, diagnostic nuclear medicine	By Report‡

‡By Report: MAC determines payment based on the description of the procedure/service provided.

Other Diagnostic Imaging Procedures

CPT	Descriptor	Physician Global Fee
78800	Radiopharmaceutical localization of tumor, inflammatory process or distribution of radiopharmaceutical agent(s) (includes vascular flow and blood pool imaging, when performed); planar, single area (e.g., head, neck, chest, pelvis), single day imaging	$228
78801	; planar, 2 or more areas (e.g., abdomen and pelvis, head and chest), 1 or more days imaging or single area imaging over 2 or more days	$245
78802	; planar, whole body, single day imaging	$276
78804	; planar, whole body, requiring 2 or more days imaging	$576
78803	; tomographic (SPECT), single area (e.g., head, neck, chest, pelvis) or acquisition, single day imaging	$341
78830	; tomographic (SPECT) with concurrently acquired computed tomography (CT) transmission scan for anatomical review, localization and determination/detection of pathology, single area (e.g., head, neck, chest, pelvis) or acquisition, single day imaging	$427
78831	; tomographic (SPECT), minimum 2 areas (eg, pelvis and knees, chest and abdomen) or separate acquisitions (eg, lung ventilation and perfusion), single day imaging, or single area or acquisition over 2 or more days	$639
78832	; tomographic (SPECT) with concurrently acquired computed tomography (CT) transmission scan for anatomical review, localization and determination/detection of pathology, minimum 2 areas (e.g., pelvis and knees, abdomen and pelvis), single day imaging, or single area imaging over 2 or more days	$807
78835	Radiopharmaceutical quantification measurement(s) single area (List separately in addition to code for primary procedure)	$87
78808	Injection procedure for radiopharmaceutical localization by non-imaging probe study, intravenous (e.g., parathyroid adenoma)	$39
78811	Positron emission tomography (PET) imaging; limited area (e.g., chest, head/neck)	Contractor Priced*
78812	Positron emission tomography (PET) imaging; skull base to mid-thigh	Contractor Priced*
78813	Positron emission tomography (PET) imaging; whole body	Contractor Priced*
78814	Positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization imaging; limited area (e.g., chest, head/neck)	Contractor Priced*
78815	Positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization imaging; skull base to mid-thigh	Contractor Priced*
78816	Positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization imaging; whole body	Contractor Priced*
78999	Unlisted miscellaneous procedure, diagnostic nuclear medicine	By Report‡

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‡By Report: MAC determines payment based on the description of the procedure/service provided.

References

- CY 2024 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies; (CMS-1784-F); Addendum B. All MPFS Fee Schedules calculated using CF of $32.7442 effective January 1, 2024. Please note, payments rates may be subject to change pending legislation (H.R.6683 - Preserving Seniors' Access to Physicians Act of 2023

Jubilant DraxImage Inc. dba Jubilant Radiopharma™
750 Township Line Road, Yardley, PA 19067
Phone: 1.888.633.5343 Fax:514. 694.3865
www.jubilantradiopharma.com