Reimbursement and Coding Guide

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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 Hospital Outpatient Setting

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 hospital outpatient setting, the cost of diagnostic radiopharmaceuticals is "packaged" into the reimbursement for the nuclear study. Packaged payment is unique to Medicare outpatient payment and means that CMS has factored the cost of a supply or accompanying procedure into the primary procedure with which is performed. In this case, the cost of the radiopharmaceutical has been factored into the reimbursement provided for the imaging procedure. As such, there is no separate payment for ***diagnostic*** radiopharmaceuticals with Medicare in the outpatient setting.

Medicare pays separately for all ***therapeutic*** radiopharmaceuticals at ASP + 6% with the exception of those drugs that do not exceed the packaging threshold. For CY 2023, the Medicare packaging threshold for drug, biologicals and radiopharmaceuticals that are paid separately is $135. If ASP data are not available, therapeutic radiopharmaceuticals are paid at Wholesale Acquisition Cost (WAC) + 3%. If ASP and WAC data are not available, then they are paid at 95 percent of the most recent AWP. Therapeutic radiopharmaceuticals that are paid based upon the ASP file are updated quarterly and can be accessed through the following CMS website: CMS ASP Drug Pricing Files.

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 Hospital Outpatient Reimbursement

Status Indicators

In the hospital outpatient prospective payment system, CMS assigns all CPT and HCPCS codes a status indicator (SI) which indicates when and how a service is reimbursed. Below is a list of status indicators used in this guide and their definitions:

A	Services furnished to a hospital outpatient that are paid under a fee schedule or payment system other than OPPS. Clinical diagnostic laboratory services are an example.
E1	Not covered by Medicare
G	Pass-through drug or biological
K	Non-pass-through drugs and non-implantable biologicals, including therapeutic radiopharmaceuticals; paid separately
N	Payment is packaged into payment for other services.
Q1	Packaged APC payment if billed on the same claim as a HCPCS code assigned status indicator “S”, “T”, or “V"; otherwise paid separately
S	Paid separately, not subject to multiple procedure discount

Non-HEU Derived Tc-99m Doses*

CPT	Descriptor	SI	OPPS
Tc-99m			
Q9969	Tc-99m from non-highly enriched uranium source, full cost recovery add-on, per study dose	K	$10 per study dose

**Jubilant Radiopharma provides customers with non-HEU Tc99m. CMS has implemented a $10 per dose reimbursement that applies to all non-HEU Tc-99m doses. Report Q9969 in addition to the study dose and study related procedures and drugs.*

Diagnostic Radiopharmaceuticals

CPT	Descriptor	SI	OPPS
I-123 Labeled			
A9509	Iodine I-123 sodium iodide, diagnostic, per mCi	N	Packaged
A9516	Iodine I-123 sodium iodide, diagnostic, per 100 µCi, up to 999 µCi	N	Packaged
A9582	Iodine I-123 iobenguane, diagnostic, per study dose, up to 15 mCi	N	Packaged
A9584	Iodine 1-123 ioflupane, diagnostic, per study dose, up to 5 mCi	N	Packaged
I-131 Labeled			
A9508	Iodine I-131 iobenguane sulfate, diagnostic, per 0.5 mCi	N	Packaged
A9524	Iodine I-131 iodinated serum albumin, diagnostic, per 5 µCi	N	Packaged
A9528	Iodine I-131 sodium iodide capsule(s), diagnostic, per mCi	N	Packaged
A9529	Iodine I-131 sodium iodide solution, diagnostic, per mCi	N	Packaged
A9531	Iodine I-131 sodium iodide, diagnostic, (up to 100 microcuries)	N	Packaged
Indium-111 Labeled			
A4642	Indium In-111 satumomab pendetide, diagnostic, per study dose, up to 6 mCi	N	Packaged
A9507	Indium In-111 capromab pendetide, diagnostic, per study dose, up to 10 mCi	N	Packaged

CPT	Descriptor	SI	OPPS
A9542	Indium In-111 ibritumomab tiuxetan, diagnostic, per study dose, up to 5 mCi	N	Packaged
A9547	Indium In-111 oxyquinoline, diagnostic, per 0.5 mCi	N	Packaged
A9548	Indium In-111 pentetate, diagnostic, per 0.5 mCi	N	Packaged
A9570	Indium In-111 labeled autologous white blood cells, diagnostic, per study dose	N	Packaged
A9571	Indium In-111 labeled autologous platelets, diagnostic, per study dose	N	Packaged
A9572	Indium In-111 pentetreotide, diagnostic, per study dose, up to 6 mCi	N	Packaged
Technetium Tc-99m			
A9500	Technetium Tc-99m sestamibi, diagnostic, per study dose	N	Packaged
A9502	Technetium Tc-99m tetrofosmin, diagnostic, per study dose	N	Packaged
A9503	Technetium Tc-99m medronate, diagnostic, per study dose, up to 30 mCi	N	Packaged
A9510	Technetium Tc-99m disofenin, diagnostic, per study dose, up to 15 mCi	N	Packaged
A9512	Technetium Tc-99m pertechnetate, diagnostic, per mCi	N	Packaged
A9521	Technetium Tc-99m exametazime, diagnostic, per study dose, up to 25 mCi	N	Packaged
A9537	Technetium Tc-99m mebrofenin, diagnostic, per study dose, up to 15 mCi	N	Packaged
A9538	Technetium Tc-99m pyrophosphate, diagnostic, per study dose, up to 25 mCi	N	Packaged
A9539	Technetium Tc-99m pentetate, diagnostic, per study dose, up to 25 mCi	N	Packaged
A9540	Technetium Tc-99m macroaggregated albumin, diagnostic, per study dose, up to 10 mCi	N	Packaged
A9541	Technetium Tc-99m sulfur colloid, diagnostic, per study dose, up to 20 mCi	N	Packaged
A9551	Technetium Tc-99m succimer, diagnostic, per study dose, up to 10 mCi	N	Packaged
A9557	Technetium Tc-99m bicisate, diagnostic, per study dose, up to 25 mCi	N	Packaged
A9560	Technetium Tc-99m labeled red blood cells, diagnostic, per study dose, up to 30 mCi	N	Packaged
A9561	Technetium Tc-99m oxidronate, diagnostic, per study dose, up to 30 mCi	N	Packaged
A9562	Technetium Tc-99m mertiatide, diagnostic, per study dose, up to 15 mCi	N	Packaged
A9567	Technetium Tc-99m pentetate, diagnostic, aerosol, per study dose, up to 75 mCi	N	Packaged
A9568	Technetium Tc-99m arcitumomab, diagnostic, per study dose, up to 45 mCi	N	Packaged
Miscellaneous/Not Otherwise Classified			
A4641	Radiopharmaceutical, diagnostic, not otherwise classified Iodine-123 Hippurate Orthoiodohippurate (usual dosage 150-250 µCi) Indium-111 diethylenetriamine pentaacetic acid (DTPA/usual dosage 500 µCi Indium-111 hydrochloride (HCL/usual dosage 0.1 – 1.0 µCi) Technetium Tc-99m human serum albumin (usual dosage 2-20 mCi) Technetium Tc-99m iminodiacetic acid (IDA/usual dosage 5-12mCi)	N	Packaged
A9505	Thallium Tl-201 thallous chloride, diagnostic, per mCi	N	Packaged
A9553	Chromium Cr-51 sodium chromate, diagnostic, per study dose, up to 250 microcuries	N	Packaged
A9556	Gallium Ga-67 citrate, diagnostic, per mCi	N	Packaged
A9558	Xenon Xe-133 gas, diagnostic, per 10 mCi	N	Packaged
A9569	Technetium Tc-99m exametazime labeled autologous white blood cells, diagnostic, per study dose	N	Packaged
A9591	Fluoroestradiol F 18 (Cerianna™), diagnostic, 1 mCi	N	Packaged
A9592	Copper cu-64, dotatate, diagnostic, 1 mCi	N	Packaged
A9608	Flotufolastat f18, diagnostic, 1 millicurie	G	$632.688

CPT	Descriptor	SI	OPPS
A9609	Fludeoxyglucose f18 up to 15 millicuries	N	Packaged
C9067	Gallium ga-68, dotatoc, diagnostic, 0.01 mCi	N	Packaged

Cardiovascular Imaging Procedures

CPT	Descriptor	SI	OPPS	Physician Professional
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 determinations	S	$515	$20
78428	Cardiac shunt detection	S	$393	$35
78445	Non-cardiac vascular flow imaging (ie, angiography, venography)	S	$393	$24
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)	S	$1,353	$62
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	S	$1,353	$73
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)	N	Packaged	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)	S	$1,353	$44
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	S	$1,353	$61
78456	Acute venous thrombosis imaging, peptide	S	$1,353	$45
78457	Venous thrombosis imaging, venogram; unilateral	S	$515	$35
78458	Venous thrombosis imaging, venogram; bilateral	S	$393	$42
78466	Myocardial imaging, infarct avid, planar; qualitative or quantitative	S	$393	$31
78468	Myocardial imaging, infarct avid, planar; with ejection fraction by first pass technique	S	$515	$36
78469	Myocardial imaging, infarct avid, planar; tomographic SPECT with or without quantification	S	$515	$41
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	S	$393	$44
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	S	$393	$66

CPT	Descriptor	SI	OPPS	Physician Professional
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	S	$515	$44
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	S	$515	$66
78494	Cardiac blood pool imaging, gated equilibrium, SPECT, at rest, wall motion study plus ejection fraction, w/ or w/o quantitative processing	S	$393	$53
78496	Cardiac blood pool imaging, gated equilibrium, single study, at rest, with right ventricular ejection fraction by first pass technique (List separately in addition to code for primary procedure)	N	Packaged	$23
78499	Unlisted cardiovascular procedure, diagnostic nuclear medicine	S	$393	By report‡

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

Endocrine (Thyroid, Parathyroid, Adrenal) Imaging Procedures

CPT	Descriptor	SI	OPPS	Physician Professional
78012	Thyroid uptake, single or multiple quantitative measurement(s) (including stimulation, suppression, or discharge, when performed)	S	$393	$9
78013	Thyroid imaging (including vascular flow, when performed)	S	$393	$17
78014	Thyroid imaging (including vascular flow, when performed); with single or multiple uptake(s) quantitative measurement(s) (including stimulation, suppression, or discharge, when performed)	S	$393	$22
78015	Thyroid carcinoma metastases imaging; limited area (e.g., neck and chest only)	S	$393	$31
78016	Thyroid carcinoma metastases imaging; with additional studies (e.g., urinary recovery)	S	$393	$31
78018	Thyroid carcinoma metastases imaging; whole body	S	$515	$37
78020	Thyroid carcinoma metastases uptake (List separately in addition to code for primary procedure)	N	Packaged	$25
78070	Parathyroid planar imaging (including subtraction, when performed)	S	$393	$36
78071	Parathyroid planar imaging (including subtraction, when performed); with tomographic (SPECT)	S	$393	$54
78072	Parathyroid planar imaging (including subtraction, when performed); with tomographic (SPECT), and concurrently acquired computed tomography (CT) for anatomical localization	S	$515	$71
78075	Adrenal imaging, cortex and/or medulla	S	$1,353	$34

Gastrointestinal System Imaging Procedures

CPT	Descriptor	SI	OPPS	Physician Professional
78201	Liver imaging; static only	S	$515	$19
78202	Liver imaging; with vascular flow	S	$515	$23
78215	Liver and spleen imaging; static only	S	$393	$22
78216	Liver and spleen imaging; vascular flow	S	$393	$25
78226	Hepatobiliary system imaging, including gallbladder when present;	S	$393	$34

CPT	Descriptor	SI	OPPS	Physician Professional
78227	Hepatobiliary system imaging, including gallbladder when present; w/pharmacologic intervention, including quantitative measurement(s) when performed	S	$515	$41
78230	Salivary gland imaging;	S	$393	$21
78231	Salivary gland imaging; with serial images	S	$393	$20
78232	Salivary gland function study	S	$393	$18
78258	Esophageal motility	S	$393	$32
78261	Gastric mucosa imaging	S	$393	$27
78262	Gastroesophageal reflux study	S	$393	$31
78264	Gastric emptying imaging study (e.g., solid, liquid, or both);	S	$393	$36
78265	Gastric emptying imaging study (e.g., solid, liquid, or both); w/small bowel transit	S	$393	$44
78266	Gastric emptying imaging study (e.g., solid, liquid, or both); with small bowel and colon transit, multiple days	S	$515	$47
78267	Urea breath test, C-14 (isotopic); acquisition for analysis	A*	$11†	N/A
78268	Urea breath test, C-14 (isotopic); analysis	A*	$94†	N/A
78278	Acute gastrointestinal blood loss imaging	S	$393	$45
78282	Gastrointestinal protein loss	S	$393	$15
78290	Intestine imaging (e.g., ectopic gastric mucosa, Meckel's localization, volvulus)	S	$393	$30
78291	Peritoneal-venous shunt patency test (e.g., for LeVeen, Denver shunt)	S	$393	$41
78299	Unlisted gastrointestinal procedure, diagnostic nuclear medicine	S	$393	By Report‡

†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	SI	OPPS	Physician Professional
78700	Kidney imaging morphology	S	$393	$20
78701	Kidney imaging morphology; with vascular flow	S	$393	$22
78707	Kidney imaging morphology; with vascular flow and function, single study without pharmacological intervention	S	$515	$43
78708	Kidney imaging morphology; with vascular flow and function, single study, with pharmacological intervention (e.g., angiotensin converting enzyme inhibitor and/or diuretic)	S	$515	$54
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)	S	$515	$63
78725	Kidney function study, non-imaging radioisotopic study	S	$393	$16
78730	Urinary bladder residual study (List separately in addition to code for primary procedure; use in conjunction with 78740)	N	Packaged	$7
78740	Ureteral reflux study (radiopharmaceutical voiding cystogram)	S	$393	$26
78761	Testicular imaging with vascular flow	S	$393	$33
78799	Unlisted genitourinary procedure, diagnostic nuclear medicine	S	$393	By Report‡

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

Hematopoietic, Reticuloendothelial & Lymphatic System Imaging Procedures

CPT	Descriptor	SI	OPPS	Physician Professional
78102	Bone marrow imaging; limited area	S	$393	$24
78103	Bone marrow imaging; multiple areas	S	$393	$29
78104	Bone marrow imaging; whole body	S	$393	$35
78110	Plasma volume, radiopharmaceutical volume-dilution technique (separate procedure); single sampling	S	$1,353	$8
78111	Plasma volume, radiopharmaceutical volume-dilution technique (separate procedure); multiple samplings	S	$1,353	$9
78120	Red cell volume determination (separate procedure); single sampling	S	$393	$9
78121	Red cell volume determination (separate procedure); multiple samplings	S	$515	$12
78122	Whole blood volume determination, including separate measurement of plasma volume and red cell volume (radiopharmaceutical volume-dilution technique)	S	$515	$20
78130	Red cell survival study	S	$393	$24
78140	Labeled red cell sequestration, differential organ/tissue (e.g., splenic and/or hepatic)	S	$393	$24
78185	Spleen imaging only, with or without vascular flow Platelet survival study	S	$393	$15
78191	Platelet survival study	S	$393	$24
78195	Lymphatics and lymph nodes imaging	S	$515	$54
78199	Unlisted hematopoietic, reticuloendothelial and lymphatic procedure, diagnostic nuclear medicine	S	$393	By Report‡

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

Musculoskeletal System Imaging Procedures

CPT	Descriptor	SI	OPPS	Physician Professional
78300	Bone and/or joint imaging; limited area	S	$393	$28
78305	Bone and/or joint imaging; multiple areas	S	$393	$37
78306	Bone and/or joint imaging; whole body	S	$393	$39
78315	Bone and/or joint imaging; 3 phase study	S	$393	$46
78350	Bone density (bone mineral content) study, 1 or more sites; single photon absorptiometry	E1	Not paid	$10
78351	Bone density (bone mineral content) study, 1 or more sites; dual photon absorptiometry, 1 or more sites	E1	Not paid	$14.91†
78399	Unlisted musculoskeletal procedure, diagnostic nuclear medicine	S	$393	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	SI	OPPS	Physician Professional
78600	Brain imaging, less than 4 static views;	S	$393	$20
78601	Brain imaging, less than 4 static views; with vascular flow	S	$393	$23
78605	Brain imaging, minimum 4 static views;	S	$515	$25
78606	Brain imaging, minimum 4 static views; with vascular flow	S	$515	$29
78608	Brain imaging, positron emission tomography (PET); metabolic evaluation	S	$1,491	$66
78609	Brain imaging, positron emission tomography (PET); perfusion evaluation	E1	Not Paid	$69
78610	Brain imaging, vascular flow only	S	$515	$13
78630	Cerebrospinal fluid flow, imaging (not including introduction of material); cisternography	S	$515	$30
78635	Cerebrospinal fluid flow, imaging (not including introduction of material); ventriculography	S	$515	$28
78645	Cerebrospinal fluid flow, imaging (not including introduction of material); shunt evaluation	S	$515	$26
78650	Cerebrospinal fluid leakage detection and localization	S	$1,353	$24
78660	Radiopharmaceutical dacryocystography	S	$393	$20
78699	Unlisted nervous system procedure, diagnostic nuclear medicine	S	$393	By Report‡

†Not covered by Medicare
‡By Report: MAC determines payment based on the description of the procedure/service provided.

Pulmonary Imaging Procedures

CPT	Descriptor	SI	OPPS	Physician Professional
78579	Pulmonary ventilation imaging (e.g., aerosol or gas)	S	$393	$22
78580	Pulmonary perfusion imaging (e.g., particulate)	S	$393	$33
78582	Pulmonary ventilation (e.g., aerosol or gas) and perfusion imaging	S	$515	$48
78597	Quantitative differential pulmonary perfusion, including imaging when performed	S	$393	$32
78598	Quantitative differential pulmonary perfusion and ventilation (e.g., aerosol or gas), including imaging when performed	S	$515	$37

78599	Unlisted respiratory procedure, diagnostic nuclear medicine	S	$393	By report‡

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

Other Diagnostic Imaging Procedures

CPT	Descriptor	SI	OPPS	Physician Professional
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*	S	$393	$30
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	S	$393	$33
78802	; planar, whole body, single day imaging	S	$1,353	$36
78804	; planar, whole body, requiring 2 or more days imaging	S	$1,353	$45
78803	; tomographic (SPECT), single area (e.g., head, neck, chest, pelvis), or acquisition, single day imaging	S	$1,353	$48
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	S	$1,353	$65
78831	; tomographic (SPECT), minimum 2 areas (e.g., pelvis and knees, abdomen and pelvis), single day imaging, or single area imaging over 2 or more days	S	$1,353	$82
78832	; 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	S	$1,491	$93
78835	Radiopharmaceutical quantification measurement(s) single area (List separately in addition to code for primary procedure)	N	Packaged	$20
78808	Injection procedure for radiopharmaceutical localization by non-imaging probe study, intravenous (e.g., parathyroid adenoma)	Q1	$393	N/A
78811	Positron emission tomography (PET) imaging; limited area (e.g., chest, head/neck)	S	$1,353	$68
78812	Positron emission tomography (PET) imaging; skull base to mid-thigh	S	$1,491	$86
78813	Positron emission tomography (PET) imaging; whole body	S	$1,491	$88
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)	S	$1,491	$98
78815	Positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization imaging; skull base to mid-thigh	S	$1,491	$109
78816	Positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization imaging; whole body	A	$1,491	$110
78999	Unlisted miscellaneous procedure, diagnostic nuclear medicine	S	$393	By report‡

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

Therapeutic Radiopharmaceuticals

CPT	Descriptor	SI	OPPS
A9513	Lutetium Lu 177, dotatate, (Lutathera®), therapeutic, 1 mCi	K	$290.440
A9517	Iodine I-131 sodium iodide capsule(s), therapeutic, per mCi	K	$24.340
A9530	Iodine I-131 sodium iodide solution, therapeutic, per mCi	K	$20.400
A9543	Yttrium Y-90 ibritumomab tiuxetan, therapeutic, per treatment dose, up to 40 mCi	K	$65,476.582
A9564	Chromic Phosphate P-32 suspension, therapeutic, per mCi	E1	Not Paid
A9590	Iodine I-131, iobenguane, (Azedra®), 1 mCi	K	$339.613
A9563	Sodium Phosphate P-32, therapeutic, per mCi	N	Packaged
A9600	Strontium Sr-89 chloride, therapeutic, per mCi	K	$4,156.573
A9604	Samarium Sm-153 lexidronam, therapeutic, per treatment dose, up to 150 mCi	K	$17259.853
A9606	Radium Ra-223 dichloride, (Xofigo™), therapeutic, per mCi	K	$161.162

Radiopharmaceutical Therapy

CPT	Descriptor	SI	OPPS	Physician Professional
C9898	Radiolabeled product provided during a hospital inpatient stay	N	Packaged	N/A
79005	Radiopharmaceutical therapy, by oral administration	S	$237	$81
79101	Radiopharmaceutical therapy, by intravenous administration	S	$237	$90
79200	Radiopharmaceutical therapy, by intracavitary administration	S	$237	$76
79300	Radiopharmaceutical therapy, by interstitial radioactive colloid administration	S	$237	$61
79403	Radiopharmaceutical therapy, radiolabeled monoclonal antibody by intravenous infusion	S	$237	$106
79440	Radiopharmaceutical therapy, by intra-articular administration	S	$237	$76
79445	Radiopharmaceutical therapy, by intra-arterial particulate administration	S	$237	$105
79999	Radiopharmaceutical therapy, unlisted procedure	S	$237	By report‡

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

References

- CY 2024 Hospital Outpatient Prospective Payment and Ambulatory Payment Systems – Final Rule (CMS-1786-FC); Addendum B
- 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).

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