



## DYNAMICS DRIVING THE ACCELERATED SHIFT TO CARDIAC PET AND PET-CT

### WEBINAR QUESTIONS & ANSWERS

**Question:** *Can the speakers comment on the recent announcement of some commercial payers stating they will not pay for cardiac PET/CT?*

**Answer:** Our understanding that the only Humana has made this announcement which is inclusive of all most dual modality equipment. While this is concerning, we feel that this position is not based in the data as PET/CT has been an overwhelmingly accepted technology for decades in oncology and cardiology and whose applications are growing into neurology. The anatomic information co-registered with PET scan has been invaluable in localization of tumors for diagnosis and treatment of cancer patients. As Dr. Heller discussed the benefits for using PET/CT in cardiology include faster scan times, ease of performing MBF and access to additional information such as calcium in the arteries. More recently, Medicare has established specific payment for cardiac PET/CT CPT 78431 at a higher payment rate than PET and this may be a reaction to this decision by Humana. MIS will work with industry partners and societies, as we have in the past, to address this this position by Humana. Both professional societies of ASNC and SNMMI have an active campaign to counter this announcement and are actively working with Humana.

**Question:** *Can one of the presenters tell us the benchmarks for accuracy of Pet/CT, sensitivity, specificity, Negative and positive predictive value?*

**Answer:** The data contained in this table, is representative of PET and PET/CT accuracy and is a good source to use when evaluating PET or PET/CT. Recent data continues to reflect similar outcomes and some more studies have shown that adding calcium score to assessments with PET/CT may further increase accuracy, as mentioned during the presentation.

Author	Total No. of Patients	Women Patients (%)	Patients with Prior CAD (%)	PET Radiotracer	Sensitivity (%)	Specificity (%)	PPV (%)	NPV (%)	Accuracy (%)
Sampson et al (28)	102	42	0	<sup>82</sup> Rb	93	83	80	94	87
Bateman et al (29)	112	46	25	<sup>82</sup> Rb	87	93	95	81	89
Marwick et al (30)	74	19	49	<sup>82</sup> Rb	90	100	100	36	91
Grover-McKay et al (31)	31	1	13	<sup>82</sup> Rb	100	73	80	100	87
Stewart et al (32)	81	36	42	<sup>82</sup> Rb	83	86	94	64	84
Go et al (33)	202	NR	47	<sup>82</sup> Rb	93	78	93	80	90
Demer et al (34)	193	26	34	<sup>82</sup> Rb/ <sup>13</sup> N-ammonia	83	95	98	60	85
Tamaki et al (35)	51	NR	75	<sup>13</sup> N-ammonia	98	1	100	75	98
Gould et al (36)	31	NR	NR	<sup>82</sup> Rb/ <sup>13</sup> N-ammonia	95	1	100	90	97
Weighted summary	877	29	35		90	89	94	73	90

Source: Cardiac PET/CT for the Evaluation of Known or Suspected Coronary Artery Disease. Marcelo F. Di Carli, MD and Venkatesh L. Murthy, MD, PhD, 2011



**Question: What is the PET/CT CPT code?**

**Answer:** CPT code 78431 (Myocardial imaging, positron emission tomography, perfusion study (including ventricular wall motion(s), and/or ejection fractions(s), when performed); multiple studies at rest and stress (exercise or pharmacologic), with concurrently acquired computed tomography transmission scan)

**Question: We have run into issues with getting private insurers to precert cardiac PET for patients that can walk. Any suggestions on getting that approved?**

**Answer:** We find that private insurers are more difficult to get approval for Cardiac PET and PET/CT because they typically they represent a younger subset of patients. MIS provides comprehensive education to our client's physicians and staff regarding Cardiac PET and PET/CT coverage criteria to assist staff obtaining approval for appropriate patients that will benefit for Cardiac PET imaging. Unfortunately, this varies by patient and insurer to so there is no one single answer to this question. An important strategy is to refer to the ASNC/SNMMI Position Statement of 2016 which clearly states that cardiac PET is a "preferred" imaging modality for all patients recommended for pharmacologic stress and "recommended" in high risk patients or in cases when attenuation artifacts are anticipated. Our experience is that private payers will refer to national recommendations, such as AUC and the 2016 ASNC/SNMMI PET Position Statement, and this has been successful in gaining insurance company approval. [Click here](#) to access Position Statement.

**Question: For denials received for the 78431, is there a payer directed appeal letter since this code is new to them? Like for BCBS, and other payers**

**Answer:** At MIS, we believe in a comprehensive approach to prevent claim denials, providing education to our client's physicians and staff regarding Cardiac PET and PET/CT coverage policies prior to ordering the study and supporting the billing staff after payment or denial to ensure all claims are processed appropriately. We occasionally find that some private insurers may have denials for new CPT codes or newly covered CPT codes. Unfortunately, all denials vary by both the individual patient claim and the insurer to so there is no one single answer to this question. One important strategy with new CPT codes is to review the Insurer's PET coverage policy, verify that the new CPT 78431 code is listed in the policy, and then refer to that policy in your appeal.

**Question: Can the presenters' comment on performing MBF imaging for ALL Pet patients that go through the lab?**

**Answer:** From a clinical perspective, there are benefits to gathering the data for each patient that has a cardiac PET scan but care must be taken to use the data within the context of each patient when using it in the diagnosis of each patient. Briefly, it is of great benefit for each patient undergoing pharmacologic stress PET to determine if vasodilation was successful, which MBF can provide. For all patients with no known CAD as was shown in the presentation there are multiple benefits including identifying low risk patients (normal perfusion, normal MBF) and those in which CAD has not been excluded (normal perfusion, abnormal MBF) in which the possibility of microvascular disease especially in diabetic and renal failure patients. For CAD patients, which it is not uncommon to continue to have abnormal MBF, this is not always the case and can assist on determining which vessel is critically diseased. Again for CAD patients knowing whether vasodilation has been achieved is very important especially in those with normal perfusion or fixed defects.