Webinar: Medicare Coverage of Beta Amyloid PET in Dementia and Neurodegenerative Disease

March 7, 2024
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Medicare Coverage and Amyloid PET

Monique Nolan
Beta Amyloid PET NCD (220.6.20) – History

• Beta Amyloid PET in Dementia and Neurodegenerative Disease (NCD 220.6.20)
  • Established September 27, 2013
    – Non-coverage prior to 2013
  • Imposed Coverage with Evidence Development (CED)
    – Coverage only available in the context of clinical studies (Section 1862(a)(1)(E) of the Social Security Act)
• Research Parameters (Two Scenarios):
  – To exclude Alzheimer’s disease (AD) in narrowly defined and clinically difficult differential diagnoses
  – To enrich clinical trials seeking better treatments or preventive strategies, by allowing selection of patients based on biological, clinical, and epidemiological factors
• Limit: Only one PET scan per patient lifetime
CMS Reconsiders NCD for PET Beta Amyloid Imaging

- CMS conducts a National Coverage Analysis (NCA) of 220.6.20 (CAG-00431R)

- CMS’ Rationale for Retiring the National Policy
  - Recognized advances in medical care and treatment of AD, including new treatments directed against Amyloid
    - Has altered application of amyloid PET scans
    - Appropriate patient selection is necessary to outweigh harms of therapies
  - Agreed that single lifetime limit is outdated and no longer clinically appropriate; NCD removal reduces provider/patient burden
  - Allowing MAC discretion to make a coverage decision “better serves the needs of the Medicare program and its beneficiaries at this time”
  - Allows MACs to take into account local clinical environment and institutional factors
  - Recognized health disparities related to AD prevalence and under-representation of such groups in AD research as additional factors
  - CMS signaled expectation of consistent coverage across MAC regions

<table>
<thead>
<tr>
<th>NCD 220.6.20 NCA Timeline</th>
<th>Action Taken &amp; Key Events</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monoclonal Antibodies AD Drug NCD</td>
<td>CMS Opens NCA</td>
<td>June 16, 2022</td>
</tr>
<tr>
<td>FDA grants traditional approval of AD Monoclonal Antibody Drug</td>
<td>Initial public comment period closes (36 comments)</td>
<td>July 15, 2022</td>
</tr>
<tr>
<td></td>
<td>CMS defers issuing a proposed decision memo; considers newly published evidence</td>
<td>December 15, 2022</td>
</tr>
<tr>
<td></td>
<td>Proposed decision memo posted</td>
<td>July 6, 2023</td>
</tr>
<tr>
<td></td>
<td>Second public comment period ends (90 comments)</td>
<td>August 16, 2023</td>
</tr>
<tr>
<td></td>
<td>CMS issues final decision memo – Retires NCD 220.6.20</td>
<td>October 13, 2023</td>
</tr>
</tbody>
</table>
Beta Amyloid PET NCD Retirement - Significance

Effective for dates of service beginning October 13, 2023, NCD 220.6.20 is removed.


01 Coverage with Evidence Development (CED) no longer applies.
  - Beta Amyloid PET scan coverage may be within or outside of a CMS-approved study.

02 Coverage of Amyloid PET left to contractor discretion under section 1862(a)(1)(A):
  - Could result in coverage or non-coverage
  - Currently, coverage is at the claim level
  - MACs could develop LCDs

03 MACs may cover more than one scan per patient’s lifetime.
  - Other Medicare-covered treatments for AD remain relevant (amyloid beta-directed antibody drugs for treatment of AD)
Medicare Coverage Determinations

National Coverage Determinations (NCDs)
- Made by CMS
- Defined in Section 1869(f)(1)(B)
- Apply Nationally -- Can Confer Coverage or Non-Coverage
- Can Include Requirements for provider and setting
- Two Different R&N Standards Can be Applied

Local Coverage Determinations (LCDs)
- Made by Medicare claims processing contractors (MACs)
- Defined in Section 1869(f)(2)(B)
- Only apply in certain geographic jurisdictions
- Rely on clinical evidence and involve public consultation
- Apply Section 1862(a)(1)(A) Standard

Claim Adjudication
- Coverage is determined by the MAC at the claim processing level
- Vast majority of coverage determinations
Requirements for Medicare Advantage Plans

• For basic benefits, CMS regulations require Medicare Advantage plans to comply with:

  (1) CMS’ national coverage determinations;

  (2) General coverage and benefit conditions included in Traditional Medicare laws, unless superseded by laws applicable to MA plans. This includes criteria for determining whether an item or service is a benefit available under Traditional Medicare. For example, this includes payment criteria for inpatient admissions at 42 CFR 412.3, services and procedures that the Secretary designates as requiring inpatient care under 42 CFR 419.22(n), and requirements for payment of Skilled Nursing Facility (SNF) Care, Home Health Services under 42 CFR part 409, and Inpatient Rehabilitation Facilities (IRF) at 42 CFR 412.622(a)(3).

  (3) Written coverage decisions of local Medicare contractors with jurisdiction for claims in the geographic area in which services are covered under the MA plan.

Source: 42 CFR 422.101(b)
Medicare Administrative Contractors (MACs)

- **Are private health insurers** who are awarded a geographic jurisdiction to process Medicare Part B and B (A/B) medical claims, or DME claims for FFS beneficiaries. Four A/B MACs also process Home Health/Hospice claims.

- **Multi-state, regional contractors**

- **Serve as the primary operational contacts** between the Medicare program and health care providers

- Currently there are 12 A/B MAC Jurisdictions and 4 DME MAC Jurisdictions for nearly 35 million FFS beneficiaries.

- For FY2022, the MACs Processed **more than 1.1 billion FFS claims**

Key Medicare Administrative Contractor Roles & Responsibilities

Sources: Noridian, Contractor Medical Director (CMD) - JE Part A - Noridian (noridianmedicare.com); Provider Outreach and Education Advisory Group (POE AG) - JE Part B - Noridian (noridianmedicare.com);

**Contractor Medical Director**
- A physician with expertise in medicine and Medicare
- Determines clinical coverage
- Trains staff on clinical matters
- Collaborates with medical societies and peer groups

**Medical Policy Review**
- Works closely with CMDs
- Conducts clinical and/or technical research for proposed or existing LCDs and local coverage articles
- Coordinates and provides ongoing management of medical policies

**Provider Education**
- Member-only group that focuses on compliance with regulatory requirements
- Creates content and provides training to providers
Coverage at the Local Level – *Current Outlook*

- In response to comments that CMS should ensure consistent MAC coverage across regions, CMS stated –
  
  “While there will not be an NCD, the MACs also use an evidence-based process for making coverage determinations. Based on the evidence, we believe there will be consistent coverage across regions for appropriate Medicare patients.” (emphasis added)

- Currently, no MACs have opened or solicited comments on opening LCDs

- Contractors will determine coverage under the reasonable and necessary standard – “…reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member…” [Section 1862(a)(1)(A) of the Social Security Act]
Implementation Considerations

Transition Requires Education & Patience
Reimbursement Resources

- Medicare Advantage Coverage Letter Template – February 9, 2021; Updated April 26, 2022
- Nuts & Bolts of Medicare Reimbursement for New IDEAS – April 22, 2021
  - Recorded Webinar - Nuts and Bolts of Medicare Reimbursement – May 12, 2021
- Updated Sample Claim Forms – January 4, 2024 (Note: Claim forms applicable to scans conducted *after* October 13, 2023)
- Sample Claim Forms – January 21, 2021 (Note: Claim forms applicable to scans conducted *before* October 13, 2023)
- Claim Denial Check List – January 13, 2021
- Amyloid PET Scan Denial Appeal Letter Template (Download Instructions) – May 25, 2023
- New IDEAS Medicare Advantage Plan Guidance and Frequently Asked Questions

CMS Transmittals and MLN Matters Articles

- Transmittal R12364CP and R12364NCD and MM13429 (Released November 16, 2023) - NCD 220.6.20 - Beta Amyloid Positron Emission Tomography in Dementia and Neurodegenerative Disease
- Transmittal R1753OTN and MM9751 (Released November 17, 2016) - Coding Revisions to National Coverage Determination (NCDs)
- Transmittal R2955CP and MM8401 (Released May 14, 2014) - Mandatory Reporting of an 8-Digit Clinical Trial Number on Claims
- Transmittal 2915CP, Transmittal 164NCD, and MM8526 (Released March 27, 2014) - Medicare National Coverage Determination (NCD) for Beta Amyloid Positron Emission Tomography (PET) in Dementia and Neurodegenerative Disease

Reimbursement FAQ
Example Claim Form
NEW IDEAS

Form Locator 67 & 67 A-C:
Enter ICD-10-CM code for principal diagnosis in FL 67.

Form Locator 42:
Enter revenue codes.

Form Locators 39-41:
Enter code D4 & Clinical Trials No. 04426539
If paper claim include CT, CT 04426539
If electronic submission do not include the CT

Form Locator 18-28:
Enter the condition “30” Qualifying Clinical Trials Non-research services provided to all patients, including managed care enrollees in a Qualified Clinical Trial.

Form Locator 44:
Enter CPT or HCPCS code for procedure, radiopharmaceutical and modifier

Choose the radiopharmaceutical administered:

**Q9983** Florbetaben F-18, diagnostic, per study dose, up to 8.1 millicuries

**Q9982** Flutemetamol F-18, diagnostic, per study dose, up to 5 millicuries

**A9586** Florbetapir F-18, diagnostic, per study dose, up to 10 millicuries

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CPT codes, descriptors and 2-digit modifiers only are copyright, 2020 AMA. All rights reserved.
New IDEAS Study to End Accrual on Friday, March 1, 2024 (11:59PM EST)

This decision was difficult; however, Study leadership is confident that this is the best course of action based on the following factors:

• CMS retiring of National Coverage Determination (NCD) on amyloid PET, ending Coverage with Evidence Development (CED) as a criterion for coverage of these scans. ²

• Recent increases in prior authorization denials of Study participants’ amyloid PET scans, namely for patients with Medicare Advantage (MA) plans.

• Disconnect between the protocol and the real-world may jeopardize the relationship between the patient, practice, and imaging facilities, and poses billing risks outside of the control of Study Team oversight.
SNMMI web site; Advocacy, Government Relations News, CMS removes NCD

Click on story takes you here.

Government Relations News

Sample Claims
Example Claim Form
Removal of CED requirement

Sample Hospital Technical Billing
Medicare / Managed Medicare

Hospital Outpatient Prospective Payment System
(HOPPS) Setting

Form Locator 67 & 67 A-

Enter ICD-10-CM code for principal diagnosis in FL 67.

F03.90 Unspecified dementia w/o behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety.

(Example code listed is an example and not meant to suggest coverage.)

The MACs will be covering based on medical necessity.

As with any claim maintain good documentation to support the service and be prepared to provide if requested.

At the time of publication, no MAC has provided any lists of covered or non-covered ICD-10-CM codes. The 220.6.20 Amyloid NCD list of ICD-10-CM codes has been removed.

Form Locator 42:
Enter revenue codes.

0404 PET Procedures
0343 Diagnostic Radiopharmaceutical

Form Locator 46:
Enter the number of units based on the CPT or HCPCS code description

Form Locator 44:
Enter CPT or HCPCS code for procedure, radiopharmaceutical and modifier

Choose the radiopharmaceutical administered:

Q9983 Florbetaben F-18, diagnostic, per study dose, up to 8.1 millicuries
Q9982 Florbetapir F-18, diagnostic, per study dose, up to 5 millicuries
A9586 Flutemetamol F-18, diagnostic, per study dose, up to 10 millicuries

Form Locator 43:

For Managed Medicare (e.g., Medicare MA Plan)
Submit claim to MA Plan, NOT MAC. MA plans vary, however typically require prior authorization and may dictate imaging site be part of their network, out of network can be possible.

0404 IDEAS PET, limited
0343 F-18 Florbetaben, Per Study Dose
Q9983 Q9982 A9586

Example Claim Form
Removal of CED requirement

Smith, Stephen S.

Smith, Stephen S.
Change in Policy – Good News-Bad News

• Education, Education, Education, & Patience during Implementation Dates for Claim Processing
  • Providers, Payers, Claims Processing- Programmers

• Did the CPT codes change, **NO**

• Did the ICD-10 diagnosis codes change, **Maybe**

• Did the submission of claims change, **YES**, since no longer CED do not put the Q0 (zero) modifiers, or Clinical Trial Number (NCT) on the claim, or Z006 in second diagnosis position, or hospital only claims do not report condition code 30, these were only for CED claims processing.
CMS reconsidered NCD 220.6.20 and made a final determination on October 13, 2023, to remove the NCD in its entirety.

B. Policy: Effective for claims with dates of service on and after October 13, 2023, CMS removed NCD 220.6.20 from Publication 100-03, the NCD Manual, ending CED and the once-in-a-lifetime requirement for PET beta amyloid imaging and permitting Medicare coverage determinations for PET beta amyloid imaging to be made by the Medicare Administrative Contractors under section 1862(a)(1)(A) of the Social Security Act. See NCD Manual chapter 1, section 220.6.20, Claims Processing Manual, chapter 13, section 60.12, and the attached spreadsheet.
**Transmittal 12364 – November 16, 2023**


**EFFECTIVE DATE:** October 13, 2023  
*Unless otherwise specified, the effective date is the date of service.*

**IMPLEMENTATION DATE:** December 19-2023 - A/B MACs; April 1, 2024 - CWF, MCS, FISS

<table>
<thead>
<tr>
<th>NCD:</th>
<th>220.6.20</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>NCD Title:</strong></td>
<td>Beta Amyloid PET for Dementia and Neurodegenerative Disease</td>
</tr>
</tbody>
</table>

CMS reserves the right to add or remove codes associated with its NCDs in order to implement those NCDs in the most efficient manner within the confines of the policy.

<table>
<thead>
<tr>
<th>ICD-10 CM</th>
<th>ICD-10 DX Description</th>
</tr>
</thead>
</table>
ICD-10-CM
CMS approved in Amyloid CED Study

Prior CMS List May be Reasonable to use, in the absence of, Payer listed ICD 10 codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>F03.90</td>
<td>Unspecified dementia without behavioral disturbance</td>
</tr>
<tr>
<td>F03.91</td>
<td>Unspecified dementia with behavioral disturbance</td>
</tr>
<tr>
<td>F01.50</td>
<td>Vascular dementia without behavioral disturbance</td>
</tr>
<tr>
<td>F01.51</td>
<td>Vascular dementia with behavioral</td>
</tr>
<tr>
<td>F02.80</td>
<td>Dementia in other diseases classified elsewhere without behavioral disturbance</td>
</tr>
<tr>
<td>F02.81</td>
<td>Dementia in other diseases classified elsewhere with behavioral disturbance</td>
</tr>
<tr>
<td>G30.9</td>
<td>Alzheimer's disease, unspecified</td>
</tr>
<tr>
<td>G31.01</td>
<td>Pick's disease</td>
</tr>
<tr>
<td>G31.83</td>
<td>Dementia with Lewy bodies</td>
</tr>
<tr>
<td>G31.84</td>
<td>Mild cognitive impairment, so stated</td>
</tr>
<tr>
<td>G31.85</td>
<td>Corticobasal degeneration</td>
</tr>
<tr>
<td>G31.09</td>
<td>Other frontotemporal dementia</td>
</tr>
<tr>
<td>R41.1</td>
<td>Anterograde amnesia</td>
</tr>
<tr>
<td>R41.2</td>
<td>Retrograde amnesia</td>
</tr>
<tr>
<td>R41.3</td>
<td>Other amnesia (Amnesia NOS, Memory loss NOS)</td>
</tr>
</tbody>
</table>
According to the AIT, appropriate candidates for amyloid PET imaging include:

- Those who complain of persistent or progressive unexplained memory problems or confusion and who demonstrate impairments using standard tests of cognition and memory.
- Individuals meeting tests for possible Alzheimer’s disease, but who are unusual in their clinical presentation.
- Individuals with progressive dementia and atypically early age of onset (before age 65).

For information about amyloid imaging for Alzheimer’s disease, go to, [Amyloid Brain Imaging Infographic](#)
Amyloid Appropriate Use Criteria (AUC)
January 28, 2013

_Inappropriate candidates for amyloid PET imaging include:_

- Those who are age 65 or older and meet standard definitions and tests for Alzheimer’s dementia, since a positive PET scan would provide little added value.

- Asymptomatic people or those with a cognitive complaint but no clinical confirmation of impairment.

_Amyloid PET imaging is also inappropiate:_

- As a means of determining the severity of dementia.

- When requested solely based on a family history of dementia or presence of other risk factors for Alzheimer’s disease (AD), such as the ApoE-e4 gene.

- As a substitute for genetic testing for mutations that cause AD.

- For non-medical reasons, such as insurance, legal or employment decisions.
Updates coming!

Request for Comments

Appropriate Use Criteria on Amyloid and Tau PET Imaging

Dramatic recent advances in diagnostic and therapeutic approaches to Alzheimer’s disease (AD) prompted The Alzheimer's Association and the Society of Nuclear Medicine and Molecular Imaging (SNMMI) to convene a workgroup to review the current data and update the 2013 appropriate use criteria (AUC) for amyloid PET. This update is inclusive of both amyloid and tau brain imaging.

This multidisciplinary workgroup, co-chaired by Dr. Gil D. Rabinovici and Dr. Keith A. Johnson, was composed of clinicians and other healthcare professionals with relevant expertise including neurologists, radiology/nuclear medicine physicians, PET imaging methodologist, neuro-ethnicist, and pathology and laboratory medicine biomarker researcher.

A draft of the Updated Appropriate Use Criteria for Amyloid and Tau PET manuscript is available for public comment until Monday, February 26 at close of business.

Source
Examples of DRAFT Amyloid AUC

Please note, these are preliminary from the open comment period. They are subject to change, please see the final AUC which are coming soon.

Appropriate Use Criteria---Score:

- 1 – 3 = Rarely appropriate
- 4 – 6 = May be appropriate
- 7 – 9 = Appropriate

<table>
<thead>
<tr>
<th>Clinical Scenarios</th>
<th>Amyloid PET Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Clinical Scenario # 5</strong>: Patients presenting with mild cognitive impairment or dementia syndrome who are below 65 years and in whom AD pathology is suspected</td>
<td>9</td>
</tr>
<tr>
<td><strong>Clinical Scenario # 6</strong>: Patients presenting with mild cognitive impairment or dementia syndrome which is often consistent with AD pathology (amnestic presentation) with onset at 65 years of age or older</td>
<td>8</td>
</tr>
<tr>
<td><strong>Clinical Scenario # 7</strong>: Patients presenting with mild cognitive impairment or dementia syndrome that could be consistent with AD pathology but has atypical features (e.g., non-amnestic clinical presentation, rapid or slow progression, etiologically mixed presentation)</td>
<td>8</td>
</tr>
<tr>
<td><strong>Clinical Scenario # 8</strong>: To determine disease severity or track disease progression in patients with an established biomarker-supported diagnosis of mild cognitive impairment or dementia due to AD pathology</td>
<td>1</td>
</tr>
<tr>
<td><strong>Clinical Scenario # 9</strong>: Patients presenting with prodromal Lewy Body disease or dementia with Lewy Bodies.</td>
<td>2</td>
</tr>
</tbody>
</table>
Examples of **DRAFT** Amyloid AUC

*Please note, these are preliminary from the open comment period. They are subject to change, please see the final AUC which are coming soon.*

Appropriate Use Criteria---Score:

- 1 – 3 = Rarely appropriate
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<th>Amyloid PET Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Scenario # 11: Patients with MCI or dementia with equivocal or inconclusive results on recent CSF biomarkers</td>
<td>8</td>
</tr>
<tr>
<td>Clinical Scenario # 12: To inform the prognosis of patients presenting with mild cognitive impairment due to clinically suspected AD pathology</td>
<td>8</td>
</tr>
<tr>
<td>Clinical Scenario # 13: To inform the prognosis of patients presenting with dementia due to clinically suspected AD pathology</td>
<td>4</td>
</tr>
<tr>
<td>Clinical Scenario # 14: To determine eligibility for treatment with an approved amyloid targeting therapy</td>
<td>9</td>
</tr>
<tr>
<td>Clinical Scenario # 15: To monitor response among patients that have received an approved amyloid targeting therapy</td>
<td>8</td>
</tr>
</tbody>
</table>
# Amyloid Imaging

## CPT® & HCPCS Level II Codes

<table>
<thead>
<tr>
<th>CPT® or HCPCS Code</th>
<th>Long Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>78811</strong></td>
<td>Positron emission tomography (PET) imaging; <em>limited area</em> (eg, chest, head/neck)</td>
</tr>
<tr>
<td><strong>78814</strong></td>
<td>Positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization imaging; <em>limited area</em> (eg, chest, head/neck)</td>
</tr>
<tr>
<td><strong>A9586</strong></td>
<td>Florbetapir F-18, diagnostic, per study dose, up to 10 millicuries</td>
</tr>
<tr>
<td><strong>Q9982</strong></td>
<td>Flutemetamol f18, diagnostic, per study dose, up to 5 millicuries</td>
</tr>
<tr>
<td><strong>Q9983</strong></td>
<td>Florbetaben f18, diagnostic, per study dose, up to 8.1 millicuries</td>
</tr>
</tbody>
</table>

Joint ACR & SNMMI consensus and Q&As coming soon.
SNMMI Coding Recommendations

To report beta amyloid plaque imaging, for covered procedures, SNMMI recommends one of two CPT\textsuperscript{(R)} codes based on the protocol and equipment utilized.

- CPT 78811 Positron emission tomography (PET) imaging; *limited area* (eg, chest, head/neck)
- CPT 78814 Positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization imaging; *limited area* (eg, chest, head/neck).
Some Payers – this is INCORRECT

To report beta amyloid plaque imaging, for covered procedures.

• CPT 78608  *Brain imaging, positron emission tomography (PET)*; **metabolic** evaluation  or
• CPT 78609  *Brain imaging, positron emission tomography (PET)*; **perfusion** evaluation
Some Payers – this is INCORRECT

To report beta amyloid plaque imaging, for covered procedures.

• CPT 78608  Brain imaging, positron emission tomography (PET); metabolic evaluation
• CPT 78609  Brain imaging, positron emission tomography (PET); perfusion evaluation
# Amyloid PET scan:

CPT codes covered for indications listed in the CPB:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>78608</td>
<td>Brain imaging, positron emission tomography (PET); metabolic evaluation</td>
</tr>
<tr>
<td>78609</td>
<td>Brain imaging, positron emission tomography (PET); perfusion evaluation</td>
</tr>
</tbody>
</table>

HCPCS codes covered if selection criteria are met:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A9586</td>
<td>Florbetapir f18, diagnostic, per study dose, up to 10 millicuries</td>
</tr>
<tr>
<td>A9601</td>
<td>Florotaucepir f18 injection, diagnostic, 1 millicurie</td>
</tr>
<tr>
<td>Q9982</td>
<td>Flutemetamol F18, diagnostic, per study dose, up to 5 millicuries</td>
</tr>
<tr>
<td>Q9983</td>
<td>Florbetaben f18, diagnostic, per study dose, up to 8.1 millicuries</td>
</tr>
</tbody>
</table>

Other HCPCS codes related to the CPB:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>J0172</td>
<td>Injection, aducanumab-avwa, 2 mg</td>
</tr>
<tr>
<td>J0174</td>
<td>Injection, lecanemab-irmb, 1 mg</td>
</tr>
</tbody>
</table>

ICD-10 codes covered if selection criteria are met:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>G30.0 - G30.9</td>
<td>Alzheimer's disease</td>
</tr>
<tr>
<td>G31.84</td>
<td>Mild cognitive impairment, so stated</td>
</tr>
</tbody>
</table>

AETNA – CPT is INCORRECT

https://www.aetna.com/cpb/medical/data/1_99/0071.html
Some Payers – CPT is INCORRECT


<table>
<thead>
<tr>
<th><em>National Imaging Associates, Inc.</em></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Clinical guidelines</strong></td>
<td><strong>Original Date:</strong> July 1999</td>
</tr>
<tr>
<td>BRAIN PET SCAN</td>
<td></td>
</tr>
<tr>
<td><strong>CPT Codes:</strong> 78608, 78609</td>
<td><strong>Last Revised Date:</strong> May 2023</td>
</tr>
<tr>
<td><strong>Guideline Number:</strong> NIA.CG.071</td>
<td><strong>Implementation Date:</strong> January 2024</td>
</tr>
</tbody>
</table>
PI and PS Modifiers –Use for Medicare Oncologic Indications only

https://www.snmmi.org/IssuesAdvocacy/QandADetail.aspx?ItemNumber=41080&navItemNumber=24950

Question: Is it only Medicare that requires the modifiers PI, PS, and KX when ordering PET/CT scans? Is KX still used and if so, what are the parameters for its use?

Answer:

• We are not aware of any other payers that require the PI, PS or KX modifiers for oncologic PET procedures. The PI, PS or KX are necessary for Medicare patients to determine coverage because CMS put in place a national coverage determination that requires the use of the PI or PS modifiers to determine coverage for varying indications.

The PI (eye) is to identify if the procedure is for an initial study (such as to diagnose a patient when a biopsy is not attainable). The initial study modifier does not mean it is the first PET study; rather it identifies what stage the patient is in regarding their disease. The PS for a subsequent study, is when a patient has a diagnosis and the PET is being used to determine the next course of treatment, or if the disease is progressing such as with metastasis. The KX is necessary for claims processing and is used for the reading of the study when billed independently. Since the PET procedure codes have broad definitions, the modifiers are necessary for payment during claims processing for oncologic indications for Medicare patients.
SNMMI & ACR
CPT, ICD-10 Guidance for Amyloid Imaging

Stay Tuned... will appear on both society web pages
Q&As for Amyloid Imaging
Medical Necessity Letter,
Sample List of ICD-10-CM codes
SNMMI will continue our relationship with our CMS Contacts for MA Plans

• Through the SNMMI work on NOPR and IDEAS we have developed relationships with CMS high level administrators that govern the MA plans.

• We will work with these officials to continue to provide access for Medicare Advantage (MA) patients, as it is important that all Medicare patients have similar access to important services regardless of their choice of traditional or MA plan.
THANK YOU!

- Email Contact--- Merlinohccc@gmail.com

- Tell us if you are getting paid YES, or No, we need to know so we can assist; SNMMI members may contact Health Policy staff at HPRA@snmmi.org

- ACR has a similar Economics Committee
Questions?

HPRA@SNMMI.org