

March 12, 2002

Donald Liss, MD
Senior Medical Director
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Mail Stop U-29A
Blue Bell, Pennsylvania 19422

Dear Doctor Liss:

We are writing to express our concern regarding the CPT code update for myocardial perfusion imaging announced in the "*December 2001 Physician News for the Mid-Atlantic Region*".

Our primary concerns are focused specifically on the new reimbursement and coding policy discussed in the *Physician News*. The elements of the policy that raise concern include the following:

- Either Wall motion study (CPT code 78478) **or** the ejection fraction study (CPT code 78480) may be submitted for reimbursement in addition to the perfusion studies (CPT codes 78460-78465).
- Aetna/US Healthcare's assumption that computer programs now allow the perfusion studies to display ejection fraction values at the same time that the wall motion data is displayed.; and,
- Physicians do not have to exert significant additional effort or resources to obtain both the wall motion data and the ejection fraction values.

Both the wall motion studies and the ejection fraction studies provide distinct and valuable assessment of a specific cardiac function. Performing both studies is necessary for most patients.

The American College of Cardiology (ACC) and the American Society of Nuclear Cardiology (ASNC) adhere to accepted AMA/CPT guidelines that consider the CPT add-on codes to represent procedures commonly performed addition to the primary procedure. It is appropriate for these procedures to be billed in conjunction with the primary procedure and reimbursed separately.

The relative value units of the add-on codes reflect the fact they are performed in relation to the primary procedure. Therefore, a reduction or elimination of reimbursement would not be appropriate. The wall motion study and the ejection fraction are separate and distinct studies and to reduce or eliminate the reimbursement for either one would be erroneous.

Myocardial perfusion imaging is performed to assess regional perfusion and myocardial viability and to assess risk of subsequent cardiac events. Myocardial perfusion imaging is performed using the radiotracer thallium-201 or one of the newer technetium-based tracers. Imaging can be performed after tracer administration in the resting state, during exercise, or after

infusion of certain pharmacologic agents that induce an exercise like state. This is reflected on CPT code 78465. Since gated or first pass acquisitions can be obtained with the myocardial imaging technetium agents to study left ventricular regional and global function, additional codes are utilized 78478 and 78480.

CPT codes 78478 and 78480 are clearly two distinct services, wall motion and ejection fraction, respectively. Different software is required to evaluate each function. The software is costly, as it is proprietary and only available from the camera manufacturers. Thus, the technical component for each is substantial. In addition, the technologist is required to complete substantial processing for each of these evaluations. The physician separately reviews the wall motion and then the ejection fraction calculation. Unmistakably, these are two distinct services provided to the patient.

In order to obtain these evaluations gating has to be performed of the entire stress image. The ability to gate images was initiated in 1989. As gating became more prominent in clinical practice, physicians were able to evaluate wall motion and then ejection fraction.

At the present time, approximately 75 percent of SPECT images are gated. This ability to evaluate the function of the heart (the ability to view and describe the motion of the individual walls and obtain the ejection fraction) when combined with its ability to evaluate perfusion has made myocardial perfusion imaging a cornerstone of the practice of clinical cardiology.

Both ACC and ASNC recommend that when appropriate, the applicable “add-on” codes should be billed in conjunction with the primary procedure being performed. Because the “add-on” codes have been valued in such a manner to reflect an additional procedure relative to the primary procedure performed, no additional reduction in reimbursement of the “add-on” code should be considered.

We welcome the opportunity to discuss this issue with you in greater detail.

Sincerely,

Douglas P. Zipes, MD, F.A.C.C.
President, ACC

Gary V. Heller, M.D., Ph.D.
President, ASNC

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