GE HealthCare

MYOVIEW™

(Kit for the Preparation of Technetium Tc99m Tetrofosmin for Injection)

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Coding and Reimbursement Guide

We are pleased to provide Myoview customers with a range of reimbursement services and solutions. Our dedicated team can assist you with:

- Answering coding/billing questions
- Navigating payer-level challenges
- Understanding coverage policies
- Preparing a payer landscape analysis specific to Myoview and your facility

GE HealthCare Reimbursement Hotline

For coding, billing, and coverage questions, contact our toll-free reimbursement hotline: 800 767 6664

About this Guide

All information included in this guide is for informational purposes only. It is intended to assist in the coding and reimbursement process. It represents no statement of guarantee by GE HealthCare. The existence of codes does not guarantee coverage of or payment for any procedure or imaging agent by any payer. The final decision for coding of any procedure must be made by the provider of care after considering the medical necessity of the services and supplies provided, as well as considering any regulations and local, state, or federal laws that may apply. All coding and reimbursement information is subject to change without notice, and specific payers may have their own coding and reimbursement requirements and policies. Please contact your local payer for interpretation of the appropriate codes to use for specific procedures.

Coding and Reimbursement Guide for Myoview™

Basics of Reimbursement

Securing reimbursement for a medical procedure or service is dependent on having not only the appropriate coding to bill the procedure or service, but also the appropriate coverage and payment by the specific health plan.

Basics of Coding

Healthcare providers identify a patient's diagnosis, procedures, drugs and devices provided using various coding systems. The purposes of these systems are to provide a uniform language that describes medical, surgical, and diagnostic services.

International Classification of Diseases, 10th Revision (ICD-10) is a medical coding system, created by the Centers for Medicare & Medicaid Services (CMS) and the National Center for Health Statistics (NCHS) with oversight by the World Health Organization (WHO), that represents patient information on claims records, data collection for use in performance measurement and reimbursement for medical claims.

Healthcare Common Procedure Coding System (HCPCS) is a standardized coding system developed by the Centers for Medicare and Medicaid Services (CMS) for reporting medical procedures, supplies, products and services to Medicare, Medicaid and third-party payers.

National Drug Code (NDC) codes are unique, 10-digit numeric codes used to identify drugs. The first segment of the code identifies the manufacturer, the second segment identifies the product, and the third identifies the packaging.

To receive appropriate reimbursement, physicians should report the appropriate HCPCS code for the product along with the appropriate CPT® code for the procedure. Some payers may also require the NDC and ICD-10.

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CMS, Centers for Medicare and Medicaid Services; **HCPCS**, Healthcare Common Procedure Coding System;
ICD-10, International Classification of Diseases, 10th Revision; **NDC**, National Drug Code

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Coverage

The existence of codes that describe a product or procedure does not guarantee payment or coverage. Each payer has unique coverage policies and guidelines.

Medicare

For procedures and products covered by Medicare Part B, coverage decisions are typically made through local coverage determinations (LCDs). LCDs are specific to the jurisdiction of a Medicare Administrative Contractor (MAC). An LCD only applies to the specific issuing MAC.

Commercial/Private Payers

Commercial or private payers each determine their own coverage policy. Coverage may also vary based on a patient's benefits or on the negotiated contract between the providers and the payer.

Medicaid

Each Medicaid program is administered by its specific state. The state determines its own coverage policies or guidelines.

Payment

Payment is the amount that a payer renders to a healthcare entity or provider for covered services and products. The payment methodology and amount vary based on site of service.

CMS sets a reimbursement amount for procedures, drugs, and/or supplies to allow for a uniform method of payment. Their rates are set nationally, with adjustments made to reflect geographic differences in costs.

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LCDs, Local Coverage Determinations; **MAC**, Medicare Administrative Contractor

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Please click here for Important Safety Information About Myoview. Prior to administration, please read the full Prescribing Information for the following doses: For 10mL, click here. For 30mL, click here.

Myocardial Perfusion Imaging CPT Codes

Code	Description
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, rest or stress (exercise or pharmacologic)
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 re-injection
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)
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 re-injection

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APC, Ambulatory Payment Classification; **CPT**, Current Procedural Terminology; **HCPCS,** Healthcare Common Procedure Coding System; **IDTF**, Independent Diagnostic Testing Facility; **SPECT**, Single Photon Emission Computed Tomography

Coding and Reimbursement Guide for Myoview™

MYOVIEW

In the hospital outpatient setting, Medicare claims for use of Myoview are paid per the Ambulatory Payment Classification (APC). Under APCs hospitals are paid one amount per encounter. Both the procedure and the radiopharmaceutical should be indicated on the claim, but the radiopharmaceutical is not paid separately.

In the physician office or independent diagnostic testing facility (IDTF) setting, payment is based on each CPT and HCPCS code billed.

Medicare Part B

Code	Description	Payment	
		Hospital Outpatient	**Physcian Office or IDTF**
HCPCS: A9502	Technetium Tc-99m Tetrofosmin, diagnostic, per study dose	Packaged payment included in APC 5593	Payment based on Average Wholesale Price (AWP), Average Sale Price (ASP) or invoice

- Providers should ensure the number of units reported is consistent with the quantity of radiopharmaceutical administered to complete the study.

	National Drug Code (NDC)
Myoview, 10 mL	**17156-024-05**
Myoview, 30 mL	**17156-026-30**

APC, Ambulatory Payment Classification; **ASP**, Average Sale Price; **AWP**, Average Wholesale Price; **HCPCS**, Healthcare Common Procedure Coding System; **NDC**, National Drug Code

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GE HealthCare Customer Service for Ordering Support

800 292 8514

GE HealthCare Medical Affairs for Clinical or Scientific Support

800 654 0118 (option 2, then option 3) or
medical.affairs@ge.com

GE HealthCare Reimbursement Hotline for Coding, Coverage, or Payment Support

800 767 6664

GE HealthCare Website for Additional Product Information

gehealthcare.com/myoview

Prior to administration, please read the full Prescribing Information for the dosages below:

- **For 10mL, click here.**
- **For 30mL, click here.**

To report SUSPECTED ADVERSE REACTIONS, contact GE HealthCare at 800 654 0118 (option 2, then option 1), or the FDA at 800 FDA 1088 or www.fda.gov/medwatch.

REFERENCES

1. CPT 2023 Professional Edition, American Medical Association
2. HCPCS Level II Professional 2023, American Medical Association

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