Medical Policy

Positron Emission Tomography (PET) Myocardial Imaging

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Policy Number: 837
BCBSA Reference Number: N/A

Related Policies

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- AIM High Technology Radiology Management Program CPT and HCPCS Codes, #900
- Oncologic Imaging, #960
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- Magnetic Resonance Imaging (MRI) Cardiac, #835
- Cardiac Computed Tomography (CT) for Quantitative Evaluation of Coronary Calcification), #832

Policy

Commercial Members: Managed Care (HMO and POS), PPO, and Indemnity

PET Perfusion Imaging

PET perfusion imaging is considered **MEDICALLY NECESSARY** as the initial noninvasive stress imaging test for suspected or established CAD for patients who have a relative contraindication(s) to conventional nuclear perfusion imaging (Table 1) and/or a contraindication to exercise stress testing (Table 2) who meet any of the indications for stress testing outlined below.

**Table 1. Relative contraindications to conventional nuclear perfusion imaging**
Morbid obesity (BMI ≥ 40 kg/m²)

Breast implant(s) in situ

Previous suboptimal conventional nuclear perfusion imaging which was suboptimal due to attenuation artifact

Previous conventional nuclear imaging discordant with coronary angiographic findings

Known pericardial or pleural effusion

Prior mastectomy

Chest wall deformity

Table 2. Contraindications to exercise stress testing

<table>
<thead>
<tr>
<th>1. Resting EKG abnormalities</th>
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<tbody>
<tr>
<td>a. Complete left bundle branch block LBBB</td>
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<tr>
<td>b. Electronically paced ventricular rhythm</td>
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<tr>
<td>c. Resting ST depression &gt; 1mm</td>
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<tr>
<td>d. Left ventricular hypertrophy (LVH) with secondary repolarization abnormalities</td>
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<tr>
<td>e. Digoxin effect</td>
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<tr>
<td>f. Pre-excitation (e.g. Wolfe Parkinson White syndrome)</td>
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<td>g. Previous false positive EKG stress test</td>
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<table>
<thead>
<tr>
<th>2. Conditions limiting exercise capacity such that target heart rate (HR) is unlikely to be achieved</th>
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<tbody>
<tr>
<td>a. Orthopedic or neurological impairment</td>
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<tr>
<td>b. Severe COPD</td>
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<tr>
<td>c. Severe heart failure</td>
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<tr>
<td>d. Severe claudication</td>
</tr>
<tr>
<td>e. Prior failure to achieve target HR</td>
</tr>
<tr>
<td>f. Use of negatively chronotropic medications which cannot be temporarily withheld for testing</td>
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</tbody>
</table>

| 3. Severe valvular stenosis |

| 4. Presence of an implanted cardioverter-defibrillator (ICD) |

**Suspected coronary artery disease in asymptomatic patients**

- Patients with high-risk of CAD (SCORE) who have not had evaluation of coronary artery disease (MPI, stress echo, cardiac PET, coronary CTA or cardiac catheterization) within the preceding three (3) years; OR
- Patients with moderate or high risk of CAD (SCORE) who have a high risk occupation that would endanger others in the event of a myocardial infarction, for example: airline pilot, law-enforcement officer, firefighter, mass transit operator, bus driver) who have not had evaluation of coronary artery disease (MPI, stress echo, cardiac PET, coronary CTA or cardiac catheterization) within the preceding three (3) years; OR
- Patients with diseases/conditions with which coronary artery disease commonly coexist and who have not had evaluation of coronary artery disease (MPI, stress echo, cardiac PET, coronary CTA or cardiac catheterization) within the preceding three (3) years:
  - Diabetes mellitus; OR
  - Abdominal aortic aneurysm; OR
  - Established and symptomatic peripheral vascular disease; OR
Prior history of cerebrovascular accident (CVA), transient ischemic attack (TIA) or carotid endarterectomy (CEA) or high grade carotid stenosis (>70%); OR
- Chronic renal insufficiency or renal failure; OR
- Patients who have undergone cardiac transplantation and have had no evaluation for coronary artery disease within the preceding one (1) year; OR
- Patients in whom a decision has been made to treat with interleukin 2; OR
- Patients awaiting solid organ transplantation who have not undergone evaluation for coronary artery disease within the preceding one (1) year

Suspected coronary artery disease in symptomatic patients who have not had evaluation of coronary artery disease (MPI, stress echo, cardiac PET, coronary CTA or cardiac catheterization) within the preceding sixty (60) days
- Chest pain
  - With intermediate or high pretest probability of CAD (Table 1); OR
  - With low or very low pretest probability of CAD (Table 1) and high risk of CAD (SCORE)
- Atypical symptoms: shortness of breath (dyspnea), neck, jaw, arm, epigastric or back pain, sweating (diaphoresis), or exercise-induced syncope
  - With moderate or high risk of CAD (SCORE)
- Other symptoms: palpitation, nausea, vomiting, anxiety, weakness, fatigue, or exercise-induced dizziness, lightheadedness, or near syncope, etc.
  - With high risk of CAD (SCORE)
- Patients with any cardiac symptom who have diseases/conditions with which coronary artery disease commonly coexists such as:
  - Diabetes mellitus; OR
  - Abdominal aortic aneurysm; OR
  - Established and symptomatic peripheral vascular disease; OR
  - Prior history of cerebrovascular accident (CVA), transient ischemic attack (TIA) or carotid endarterectomy (CEA) or high grade carotid stenosis (>70%); OR
  - Chronic renal insufficiency or renal failure; OR
- Patients who have undergone cardiac transplantation; OR
- Patients in whom a decision has been made to treat with Interleukin 2; OR
- Patients awaiting solid organ transplantation

Established coronary artery disease in asymptomatic patients
- Patients awaiting solid organ transplantation who have not undergone evaluation for coronary artery disease within the preceding one (1) year; OR
- Patients who have undergone cardiac transplantation and have had no evaluation for coronary artery disease within the preceding one (1) year

Established coronary artery disease* in patients who have new or worsening symptoms
*Diagnosed by MPI, cardiac PET, stress echo, or coronary angiography (CCTA or invasive) demonstrating coronary stenosis greater than 70% or FFR less than or equal to 0.8

Note: If symptoms are typical of myocardial ischemia, cardiac catheterization may be more appropriate than perfusion PET imaging

Established coronary artery disease* in patients who have not undergone revascularization and have no symptoms or stable symptoms
*Diagnosed by MPI, cardiac PET, stress echo, or coronary angiography (CCTA or invasive) demonstrating coronary stenosis greater than 70% or FFR less than or equal to 0.8
- No evaluation of CAD (MPI, stress echo, cardiac PET, coronary CTA or cardiac catheterization) within the preceding three (3) years
- No evaluation of CAD (MPI, cardiac PET, stress echo, coronary CTA or cardiac catheterization) within the preceding one (1) year in a patient who has undergone cardiac transplantation and has been found to have CAD since transplantation
Established coronary artery disease in patients who have undergone revascularization

- For evaluation of new or worsening cardiac symptoms
  - If symptoms are typical of myocardial ischemia cardiac catheterization may be more appropriate than MPI; OR

- For evaluation of stable patients who have undergone coronary artery bypass grafting more than five (5) years previously and who have not had an evaluation for coronary artery disease (MPI, stress echo, cardiac PET, coronary CTA or cardiac catheterization) within the past two (2) years
  - Stable patients whose revascularization has been incomplete may undergo MPI three (3) years following the procedure and every three (3) years thereafter; OR

- For evaluation of stable patients who have undergone percutaneous coronary intervention (PCI) more than three (3) years previously and who have not had an evaluation for coronary artery disease (MPI, stress echo, cardiac PET, coronary CTA or cardiac catheterization) within the past three (3) years when any of the following applies
  - The patient has undergone PCI of the left main (LM) coronary artery or the proximal left anterior descending (LAD) coronary artery
  - The patient has undergone PCI of more than one coronary artery
  - The patient has chronic total occlusion of a coronary artery and the vessel on which PCI was performed is supplying collateral flow to the occluded vessel
  - The patient is known to have only one patent coronary artery
  - Left ventricular ejection fraction LVEF is <35%

Established coronary artery disease in patients who have had myocardial infarction (ST elevation or non-ST elevation) or unstable angina within the preceding ninety (90) days provided that:

- The patient did not undergo coronary angiography at the time of the acute event; AND
- The patient is currently clinically stable

Established Kawasaki Disease with Coronary Artery Involvement

- Every two year evaluation for confirmed small to medium coronary artery aneurysm
- Annual evaluation for confirmed large (giant) coronary artery aneurysm, multiple or complex aneurysms or coronary artery obstruction confirmed by angiography

Patients with new onset arrhythmias (patient can be symptomatic or asymptomatic)
This policy applies to patients with suspected or established CAD

- Patients with sustained (lasting more than 30 seconds) or non-sustained (more than 3 beats but terminating within 30 seconds) ventricular tachycardia; OR
- Patients with atrial fibrillation or flutter and high or moderate risk of CAD (SCORE); OR
- Patients with atrial fibrillation or flutter and established CAD; OR
- Patients who have frequent premature ventricular contractions (PVC) defined as more than thirty (30) PVCs per hour on ambulatory EKG (Holter) monitoring
  - It is not clinically indicated to perform perfusion PET imaging for evaluation of infrequent premature atrial or ventricular depolarizations

Patients with new onset congestive heart failure or recently recognized left ventricular systolic dysfunction (patient can be symptomatic or asymptomatic)
This policy applies to patients with suspected or established CAD

For patients in this category whose CAD risk (SCORE) is high, cardiac catheterization may be more appropriate than non-invasive evaluation
- Provided that new or worsening CAD has not been excluded as the cause of LV dysfunction/CHF by any of the following tests: MPI, stress echo, cardiac PET, coronary CTA or cardiac catheterization

Patients with abnormal exercise treadmill test (performed without imaging)
This policy applies to patients with suspected or established CAD

- Abnormal findings on an exercise treadmill test include (chest pain, ST segment change, abnormal BP response or complex ventricular arrhythmias)

Patients with abnormal findings on cardiac CT / coronary CTA
**Symptomatic Patients:**
- With coronary artery calcium score > 400 Agatston units; OR
- Intermediate severity coronary stenosis on coronary CTA

**Note:** If symptoms are typical of myocardial ischemia cardiac catheterization may be more appropriate than MPI

**Asymptomatic patients who have not had MPI, stress echo, cardiac PET or cardiac catheterization within the preceding three (3) years:**
- With coronary artery calcium score > 400 Agatston units; OR
- Intermediate severity coronary stenosis coronary CTA

**Patients with abnormal findings on cardiac catheterization**
- To determine flow limiting significance of intermediate coronary stenosis

**Preoperative cardiac evaluation of patients undergoing non-cardiac surgery**
This policy applies to patients undergoing non-emergency surgery
It is assumed that those who require emergency surgery will undergo inpatient preoperative evaluation

- Patients with active cardiac conditions such as unstable coronary syndromes (unstable angina), decompensated heart failure (NYHA function of class IV, worsening or new onset heart failure), significant arrhythmias (third degree AV block Mobitz II AV block, uncontrolled supraventricular arrhythmia, symptomatic ventricular arrhythmias, ventricular tachycardia), symptomatic bradycardia or severe stenotic valvular lesions. It is recommended that these conditions be evaluated and managed per ACC/AHA guidelines prior to considering elective surgery. That evaluation may include MPI

**Low-risk surgery** (endoscopic procedures, superficial procedures, cataract surgery, breast surgery, ambulatory surgery)
- Provided that there are no active cardiac conditions (as outlined above), MPI prior to low-risk surgery is considered not medically necessary

**Intermediate risk surgery** (including but not limited to intraperitoneal and intrathoracic surgery, carotid endarterectomy, head and neck surgery, orthopedic surgery, prostate surgery, gastric bypass surgery) or **High-risk surgery** (including but not limited to aortic and other major vascular surgery, peripheral vascular surgery) when

- The patient has not had a normal coronary angiogram, SE, MPI, CCTA, Cardiac PET perfusion study or revascularization procedure within the previous one (1) year; AND
- At least one of the following applies:
  - Patient has established CAD (prior MI, prior PTCA, stent, or CABG) or presumed CAD (Q waves on EKG, abnormal MPI, SE or cardiac PET); OR
  - Patient has compensated heart failure or prior history of heart failure (CHF); OR
  - Patient has diabetes mellitus; OR
  - Patient has chronic renal insufficiency or renal failure; OR
  - Patient has a history of cerebrovascular disease (TIA, CVA or documented carotid stenosis requiring carotid endarterectomy)

**PET perfusion imaging is appropriate in follow up to other noninvasive stress imaging tests in the following situations:**

**Patients who have undergone recent (within the past 60 days) stress echocardiography or conventional nuclear perfusion imaging**
- When the initial test is technically suboptimal, technically limited, inconclusive, indeterminate, or equivocal, such that myocardial ischemia cannot be adequately excluded
  - It is not appropriate to perform PET perfusion imaging on patients who have had a recent normal or abnormal stress echocardiogram or conventional nuclear perfusion imaging test
  - An initial stress imaging test is deemed to be abnormal when there are echocardiographic or perfusion abnormalities. Studies with electrocardiographic abnormalities without
PET perfusion imaging – sarcoidosis:

PET perfusion imaging is appropriate in the evaluation of patients with suspected or established cardiac sarcoidosis when performed in conjunction with metabolic PET imaging.

Metabolic PET Imaging

Metabolic PET imaging for evaluation of myocardial viability – when all four of the following conditions are met:

- The patient has established coronary artery disease; AND
- Left ventricular systolic dysfunction; AND
- Viability status is not defined by other testing; AND
- Revascularization is being considered

Metabolic PET imaging for evaluation of non-coronary cardiac diseases

- Metabolic PET imaging (with or without perfusion imaging) may be used in the diagnosis or management of cardiac sarcoidosis

Prior Authorization Information

Inpatient

- For services described in this policy, precertification/preauthorization IS REQUIRED for all products if the procedure is performed inpatient.

Outpatient

- For services described in this policy, see below for products where prior authorization might be required if the procedure is performed outpatient.

<table>
<thead>
<tr>
<th>Commercial Managed Care (HMO and POS)</th>
<th>Outpatient</th>
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<tbody>
<tr>
<td>Commercial PPO and EPO</td>
<td>The requirements of BCBSMA Radiology Management Program may require a precertification/prior authorization via AIM Specialty Health. These requirements are member-specific:</td>
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<tr>
<td></td>
<td>Please verify member eligibility and requirements through Online Services by logging onto Provider Central. Refer to our Quick Tip for an overview of pre-certification and prior authorization requirements.</td>
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<td></td>
<td>Ordering clinicians should request pre-certification from AIM Specialty Health or call 1-866-745-1783 (when applicable).</td>
</tr>
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<td></td>
<td>Prior authorization information for Medicare HMO Blue and Medicare PPO Blue is addressed in medical policy #923, High Technology Radiology and Sleep Disorder Management for Medicare Advantage Products.</td>
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Indemnity

- Prior authorization is not required.

CPT Codes / HCPCS Codes / ICD Codes

Inclusion or exclusion of a code does not constitute or imply member coverage or provider reimbursement. Please refer to the member’s contract benefits in effect at the time of service to determine coverage or non-coverage as it applies to an individual member.

Providers should report all services using the most up-to-date industry-standard procedure, revenue, and diagnosis codes, including modifiers where applicable.

The following codes are included below for informational purposes only; this is not an all-inclusive list.
The above medical necessity criteria MUST be met for the following codes to be covered for Commercial Members: Managed Care (HMO and POS), PPO, and Indemnity:

CPT Codes

<table>
<thead>
<tr>
<th>CPT codes</th>
<th>Code Description</th>
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<tbody>
<tr>
<td>78459</td>
<td>PET myocardial, metabolic evaluation</td>
</tr>
<tr>
<td>78491</td>
<td>PET myocardial perfusion, single study</td>
</tr>
<tr>
<td>78492</td>
<td>PET myocardial perfusion, multiple studies</td>
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</tbody>
</table>

Policy History

<table>
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<tr>
<th>Date</th>
<th>Action</th>
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<tbody>
<tr>
<td>8/2018</td>
<td>Clarified coding information.</td>
</tr>
<tr>
<td>1/2018</td>
<td>Prior authorization information for Medicare HMO Blue and Medicare PPO Blue removed. Prior authorization information for Medicare HMO Blue and Medicare PPO Blue is addressed in medical policy #923, High Technology Radiology and Sleep Disorder Management for Medicare Advantage Products.</td>
</tr>
<tr>
<td>10/2017</td>
<td>Clarified coding information.</td>
</tr>
<tr>
<td>8/2017</td>
<td>National Coverage Determination (NCD) for PET for Perfusion of the Heart (220.6.1) added for Medicare Advantage members. National Coverage Determination (NCD) for FDG PET for Myocardial Viability (220.6.8) added for Medicare Advantage members.</td>
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<td>5/2017</td>
<td>Prior Authorization Information clarified.</td>
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Information Pertaining to All Blue Cross Blue Shield Medical Policies

Click on any of the following terms to access the relevant information:
- Medical Policy Terms of Use
- Managed Care Guidelines
- Indemnity/PPO Guidelines
- Clinical Exception Process
- Medical Technology Assessment Guidelines

References


Endnotes
1 Based on AIM Clinical Appropriateness Guidelines: Advanced Imaging: Cardiac Imaging.