Reimbursement & Coding for Radiation Oncology

HSCO

November 14th, 2014
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• Commercial Interest - Revenue Cycle Inc, RCBilling Inc, The Oncology Group, Infinity Oncology
• Relationship with Commercial Interest - Consultant, Employee
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Full Revenue Cycle Work Takes A Team That Communicates

- Denial Management & Accounts Receivable
- Education & Support
- Credentialing & Contracting
- Registration & Financial Counseling
- Coding & Compliance
- Interfacing & Claim Submission
- Payment Posting & Reconciliation

- Payor Trends
- Bundling
- Appeals
- Patient Collections

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Objectives

- Stress Importance of Compliance
- Discuss the Process of Care
- Educate Attendees on Applying Proper Coding
- Provide Guidance on Appropriate Documentation
- Emphasize Utilization of Current Reference Materials
- Allow Interactive Discussion for Questions & Advice
Our Policy

Consistent with Medicare Guidelines
- Local Coverage Determinations
- Medicare Manuals
- CCI/OCE Edits

CPT® Definitions & Advice for AMA

Published OIG Compliance Standards

Professional Society Publications

In Absence of Published Guidelines
- Revenue Cycle Inc. experience and observations nationally
Rules & Regulations

Authoritative Guidance:

• Federal Register
• Centers for Medicare & Medicaid Services (CMS)
  – National Coverage Determinations (NCD)
  – Local Coverage Determinations (LCD)
  – Medicare Manuals
  – Coding Edits: NCCI, OCE, MUE
• American Medical Association (AMA)
• Commercial Payor Policies
Annual Updates to Rules

- Stay up to date
- Stay informed
- Get involved

Hospital Outpatient: Hospital Billing Technical Charges

Physician/Facility: Physician Practicing in a Hospital Setting & Freestanding Facilities

http://www.gpoaccess.gov/index.html
2015 Final Rule

MEDICARE PHYSICIAN FEE SCHEDULE (MPFS)
MPFS Equation

Work RVU * Work GPCI + PE RVU * PE GPCI + MP RVU * MP GPCI * Conversion Factor

Physician work provided per service

Practice expense, overhead etc. for service

Malpractice is professional liability insurance

Used to convert RVUs into $$$ by multiplying sum of RVU by CF

GPCI = Geographic Practice Cost Index (adjusts each different type of RVU) for a particular locality in the country
ICD-10 Delayed

As part of the SGR patch, Congress approved a one-year delay in mandatory implementation date for use of ICD-10. Originally scheduled to go live on October 1, 2014, the law now prohibits the Secretary of HHS from mandating use of ICD-10 until October 1, 2015.

UPDATE! On July 31, 2014 Department of HHS issued a rule finalizing October 1, 2015 as the new compliance date to begin ICD-10.
Protecting Access to Medicare Act of 2014

- Extends the .5% update to the Conversion Factor in place since January, 2014, through the remainder of calendar year of 2014.
- Freeze the update to the single conversion factor at 0.00% for January 1, 2014 through March 31, 2015.
- Sequestration extended to 2024, in the first 6 months of 2024 the 2% sequestration will be raised to 4% and for the final 6 months it will be changed to 0%.
### Historical Conversion Factors

<table>
<thead>
<tr>
<th>Year</th>
<th>CF Pre-Legislation</th>
<th>CF Post Legislation</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>CY 2006</td>
<td>$37.8975</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>CY 2007</td>
<td>$35.9848</td>
<td>$37.8975</td>
<td>5.32%</td>
</tr>
<tr>
<td>CY 2008</td>
<td>$34.0682</td>
<td>$38.0870</td>
<td>11.80%</td>
</tr>
<tr>
<td>CY 2009</td>
<td>$30.1510</td>
<td>$36.0666</td>
<td>19.62%</td>
</tr>
<tr>
<td>CY 2010</td>
<td>$28.3868</td>
<td>$36.0846 (Jan-May)</td>
<td>27.12%</td>
</tr>
<tr>
<td>CY 2010</td>
<td>$28.3868</td>
<td>$36.8729 (June-Nov)</td>
<td>29.89%</td>
</tr>
<tr>
<td>CY 2011</td>
<td>$28.3868</td>
<td>$36.8729 (Dec-Dec 31st)</td>
<td>29.89%</td>
</tr>
<tr>
<td>CY 2011</td>
<td>$25.4999</td>
<td>$33.9764</td>
<td>33.24%</td>
</tr>
<tr>
<td>CY 2012</td>
<td>$24.6712</td>
<td>$34.0376</td>
<td>37.96%</td>
</tr>
<tr>
<td>CY 2013</td>
<td>$24.7124</td>
<td>$34.0230</td>
<td>37.68%</td>
</tr>
<tr>
<td>CY 2014</td>
<td>$27.2006</td>
<td>$35.8228 (Jan-Mar 31st, 2015)</td>
<td>31.70%</td>
</tr>
<tr>
<td>CY 2015</td>
<td>$35.8013</td>
<td>$35.8013</td>
<td>1%</td>
</tr>
</tbody>
</table>
Conversion Factor Update

• The Protecting Access to Medicare Act of 2014 (PAMA) replaced the reduction in the PFS for April 1, 2014 – March 31, 2015
  – resulting in a zero percent update for the first three months of 2015
• CF for January 1, 2015 – March 31, 2015 = $35.8013
  – Slight reduction due to budget neutrality
• Beginning April 1, 2015 the published CF is $28.2239
  – 21.2% reduction
  – Unless Congressional action is taken
This is significantly different from the proposed rule projected impact due to treatment vault proposed changes not being finalized!
Practice Expense Updates

- CPT® 77373 – equipment time of 104 minutes finalized instead of the proposed 86 minutes
- CPT® 77600 – CY2014 interim equipment times for hyperthermia finalized
- CPT® codes 77785, 77786 and 77787 – the “emergency service container – safety kit” will remain an indirect PE and the CY2014 interim value was finalized
- CPT® codes 77300, 77306 and 77307 PE time value of 5 minutes was refined to 0 minutes resulting in a cost change of -$3.10 for each code
Deletion of G codes (SRS/SBRT)

• The current CPT® codes 77372 and 77373 were felt to accurately describe the services provided and accurately account for PE inputs
• After reviewing comments CMS feels there is lacking information to make the decision at this time
• G0339 and G0340 for robotic stereotactic radiotherapy will not be deleted
• Will continue to be carrier priced
• Possibility of deleting these codes will be revisited in future rulemaking Oncology Measures Group

Remember the G codes were deleted for the hospital for 2014!
CPT® Code 77293

- Clinical Labor Input Error
  - Listed as L052A (Audiologist) instead of L152A (Medical Physicist), which has a higher cost per minute.
- CMS has finalized the correction to reflect Medical Physicist
  - Medical Physicist designation has a higher cost per minute
Potentially Misvalued Codes

- New statutory category was established, “codes that account for the majority of spending under the physician fee schedule”, the list of 65 codes, two of which are specific to Radiation Oncology, may be potentially misvalued.

<table>
<thead>
<tr>
<th>Code</th>
<th>Short Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>77263</td>
<td>Radiation therapy planning</td>
</tr>
<tr>
<td>77334</td>
<td>Radiation treatment aid(s)</td>
</tr>
</tbody>
</table>

- Based on resources required over the next several years to revalue services with global periods, Medicare is not finalizing the codes identified as potentially misvalued at this time.
- Medicare instructed they will re-run the high expenditure screen at a future date and further proposals for review will be provided.
# TABLE 71: Oncology Measures Group for 2015 and Beyond

<table>
<thead>
<tr>
<th>NQF/PQRS</th>
<th>Measure Title and Description</th>
<th>Measure Developer</th>
</tr>
</thead>
<tbody>
<tr>
<td>0387/071</td>
<td>Breast Cancer: Hormonal Therapy for Stage I-III Estrogen Receptor/Progesterone Receptor (ER/PR) Positive Breast Cancer: Percentage of female patients aged 18 years and older with Stage I-III, ER or PR positive breast cancer who were prescribed tamoxifen or aromatase inhibitor (AI) during the 12-month reporting period</td>
<td>AMA-PCPI/ASCO/NCCN</td>
</tr>
<tr>
<td>0385/072</td>
<td>Colon Cancer: Chemotherapy for AJCC Stage III Colon Cancer Patients: Percentage of patients aged 18 through 80 years with AJCC Stage III colon cancer who are referred for adjuvant chemotherapy, prescribed adjuvant chemotherapy, or have previously received adjuvant chemotherapy within the 12-month reporting period</td>
<td>AMA-PCPI/ASCO/NCCN</td>
</tr>
<tr>
<td>0041/110</td>
<td>Preventive Care and Screening: Influenza Immunization: Percentage of patients aged 6 months and older seen for a visit between October 1 and March 31 who received an influenza immunization OR who reported previous receipt of an influenza immunization</td>
<td>AMA-PCPI</td>
</tr>
<tr>
<td>0419/130</td>
<td>Documentation of Current Medications in the Medical Record: Percentage of visits for patients aged 18 years and older for which the eligible professional attests to documenting a list of current medications using all immediate resources available on the date of the encounter. This list must include ALL known prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND must contain the medications’ name, dosage, frequency and route of administration</td>
<td>CMS/QIP</td>
</tr>
<tr>
<td>0384/143</td>
<td>Oncology: Medical and Radiation – Pain Intensity Quantified: Percentage of patients, regardless of patient age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy in which pain intensity is quantified</td>
<td>AMA-PCPI</td>
</tr>
<tr>
<td>0383/144</td>
<td>Oncology: Medical and Radiation – Plan of Care for Pain: Percentage of visits for patients, regardless of age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy who report having pain with a documented plan of care to address pain</td>
<td>AMA-PCPI</td>
</tr>
<tr>
<td>0028/226</td>
<td>Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention: Percentage of patients 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user</td>
<td>AMA-PCPI</td>
</tr>
</tbody>
</table>
Provider Based Status

• The increased trend of hospitals acquiring physicians and physician practices has posed concern with regard to effectively and accurately establishing payment rates for the facility based pricing.

• Typically the payment for services in a hospital setting are higher than those received in an office-based or free-standing center.

• Medicare indicated serious concerns in the ability to set prices and accurately establish PE and RUVs for PFS services resulting in the need for new POS modifiers.
Provider Based Status

- Place of Service code 22 for Hospital Outpatient will be deleted and replaced with two new POS codes
  - 1. On-campus, remote or satellite location of a hospital
  - 2. Off-campus provider-based department
  - New codes not expected to be available prior to July 1, 2015
  - When codes are established immediate use will be required
- Will assist in accurately assessing PE data
  - Understand which PE costs are actually incurred by the physician and which are incurred by the hospital
- Collection of data to provide understanding of trend toward hospital acquisition of physicians and physician practices
Locum Tenens Payment Policy

- Medicare solicited comments due to
  - Concerns with operational and program integrity issues that may occur when utilizing a substitute physician to fill staffing needs or replace a physician.
  - Services being billed under departed physician’s NPI at previous location and new location

- Comments were received in response to the Proposed Rule request; however no adjustments will be made at this time
- Comments will be considered in future rulemaking
Physician Self Referrals

Additions to the Physician Self-Referral List

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A9606</td>
<td>Radium Ra223 dichloride therapy</td>
</tr>
<tr>
<td>C2644</td>
<td>Brachytherapy cesium-131 chloride</td>
</tr>
<tr>
<td>77306</td>
<td>Teletherapy isodose plan simple</td>
</tr>
<tr>
<td>77307</td>
<td>Teletherapy isodose plan complex</td>
</tr>
<tr>
<td>77316</td>
<td>Brachytherapy isodose plan simple</td>
</tr>
<tr>
<td>77317</td>
<td>Brachytherapy isodose intermediate</td>
</tr>
<tr>
<td>77318</td>
<td>Brachytherapy isodose complex</td>
</tr>
<tr>
<td>77385</td>
<td>Nsyst modul rad tx dlvr smpl</td>
</tr>
<tr>
<td>77386</td>
<td>Nsyst modul rad tx dlvr cplx</td>
</tr>
<tr>
<td>G6001</td>
<td>Echo guidance radiotherapy</td>
</tr>
<tr>
<td>G6002</td>
<td>Stereoscopic x-ray guidance</td>
</tr>
<tr>
<td>G6003</td>
<td>Radiation treatment delivery</td>
</tr>
<tr>
<td>G6004</td>
<td>Radiation treatment delivery</td>
</tr>
<tr>
<td>G6005</td>
<td>Radiation treatment delivery</td>
</tr>
<tr>
<td>G6006</td>
<td>Radiation treatment delivery</td>
</tr>
<tr>
<td>G6007</td>
<td>Radiation treatment delivery</td>
</tr>
<tr>
<td>G6008</td>
<td>Radiation treatment delivery</td>
</tr>
<tr>
<td>G6009</td>
<td>Radiation treatment delivery</td>
</tr>
<tr>
<td>G6010</td>
<td>Radiation treatment delivery</td>
</tr>
<tr>
<td>G6011</td>
<td>Radiation treatment delivery</td>
</tr>
<tr>
<td>G6012</td>
<td>Radiation treatment delivery</td>
</tr>
<tr>
<td>G6013</td>
<td>Radiation treatment delivery</td>
</tr>
<tr>
<td>G6014</td>
<td>Radiation treatment delivery</td>
</tr>
<tr>
<td>G6015</td>
<td>Radiation tx delivery imrt</td>
</tr>
<tr>
<td>G6016</td>
<td>Delivery comp imrt</td>
</tr>
<tr>
<td>G6017</td>
<td>Infrafraction track motion</td>
</tr>
</tbody>
</table>

Radiation Therapy Services and Supplies is a designated health services (DHS) category for which physicians are prohibited from referring a Medicare beneficiary to an entity where the physician has a financial relationship, unless an exception applies.
Radiation Therapy Code Revisions

Not all of the newly introduced radiation therapy CPT® codes for 2015 will be adopted for MPFS use in 2015

- The timing of the release of new codes by the AMA and RUC is creating an issue for CMS
- Postponement until 2016 will allow for proper valuation and review of impact on stakeholders
- Deleted 2014 codes for treatment delivery, planning and IGRT will still be deleted; however, new Gcodes will be used for some of the new replacement and/or revised codes for 2015
Radiation Therapy Code Revisions

• For CY2015 the new isodose planning codes were accepted and made final to be implemented effective January 1, 2015
• The following table details the crosswalk from the deleted code to the new CY2015 code

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>77305</td>
<td>Teletx isodose plan simple</td>
<td>77306</td>
<td>Teletx isodose plan simple</td>
</tr>
<tr>
<td>77310</td>
<td>Teletx isodose plan intermed</td>
<td>77307</td>
<td>Teletx isodose plan cplx</td>
</tr>
<tr>
<td>77315</td>
<td>Teletx isodose plan complex</td>
<td>77316</td>
<td>Brachy isodose plan simple</td>
</tr>
<tr>
<td>77326</td>
<td>Brachy isodose calc simp</td>
<td>77317</td>
<td>Brachy isodose plan intermed</td>
</tr>
<tr>
<td>77327</td>
<td>Brachy isodose calc interm</td>
<td>77318</td>
<td>Brachy isodose plan complex</td>
</tr>
<tr>
<td>77328</td>
<td>Brachy isodose calc compl</td>
<td>77014*</td>
<td>CT for therapy guide</td>
</tr>
</tbody>
</table>

*CPT code 77014 was not deleted by the AMA, but they did indicate it cannot be reported for IGRT. For CY2015 in freestanding centers, it will still be used as currently used for CY2014.
## Radiation Therapy Code Revisions

### Table 27: Radiation Therapy G-Codes Replacing CY2015 CPT Codes

<table>
<thead>
<tr>
<th>CY 2014 CPT Code¹</th>
<th>CY 2015 HCPCS Code</th>
<th>Long Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>76950</td>
<td>G6001</td>
<td>Ultrasoundic guidance for placement of radiation therapy fields</td>
</tr>
<tr>
<td>77421</td>
<td>G6002</td>
<td>Stereotactic X-ray guidance for localization of target volume for the delivery of radiation therapy.</td>
</tr>
<tr>
<td>77402</td>
<td>G6003</td>
<td>Radiation treatment delivery, single treatment area, single port or parallel opposed ports, simple blocks or no blocks; up to 5MeV</td>
</tr>
<tr>
<td>77403</td>
<td>G6004</td>
<td>Radiation treatment delivery, single treatment area, single port or parallel opposed ports, simple blocks or no blocks; 6-10MeV</td>
</tr>
<tr>
<td>77404</td>
<td>G6005</td>
<td>Radiation treatment delivery, single treatment area, single port or parallel opposed ports, simple blocks or no blocks; 11-19MeV</td>
</tr>
<tr>
<td>77405</td>
<td>G6006</td>
<td>Radiation treatment delivery, single treatment area, single port or parallel opposed ports, simple blocks or no blocks; 20 MeV or greater</td>
</tr>
<tr>
<td>77407</td>
<td>G6007</td>
<td>Radiation treatment delivery, 2 separate treatment areas, 3 or more ports on a single treatment area, use of multiple blocks; up to 5MeV</td>
</tr>
<tr>
<td>77408</td>
<td>G6008</td>
<td>Radiation treatment delivery, 2 separate treatment areas, 3 or more ports on a single treatment area, use of multiple blocks; 6-10MeV</td>
</tr>
<tr>
<td>77409</td>
<td>G6009</td>
<td>Radiation treatment delivery, 2 separate treatment areas, 3 or more ports on a single treatment area, use of multiple blocks; 11-19MeV</td>
</tr>
<tr>
<td>77411</td>
<td>G6010</td>
<td>Radiation treatment delivery, 2 separate treatment areas, 3 or more ports on a single treatment area, use of multiple blocks; 20 MeV or greater</td>
</tr>
<tr>
<td>77412</td>
<td>G6011</td>
<td>Radiation treatment delivery, 3 or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, electron beam; up to 5MeV</td>
</tr>
<tr>
<td>77413</td>
<td>G6012</td>
<td>Radiation treatment delivery, 3 or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, electron beam; 6-10MeV</td>
</tr>
<tr>
<td>77414</td>
<td>G6013</td>
<td>Radiation treatment delivery, 3 or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, electron beam; 11-19MeV</td>
</tr>
<tr>
<td>77416</td>
<td>G6014</td>
<td>Radiation treatment delivery, 3 or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, electron beam; 20MeV or greater</td>
</tr>
<tr>
<td>77418</td>
<td>G6015</td>
<td>Intensity modulated treatment delivery, single or multiple fields/ars, via narrow spatially and temporally modulated beams, binary, dynamic MLC, per treatment session</td>
</tr>
<tr>
<td>0073T</td>
<td>G6016</td>
<td>Compensator-based beam modulation treatment delivery of inverse planned treatment using 3 or more high resolution (milled or cast) compensator, convergent beam modulated fields, per treatment session</td>
</tr>
<tr>
<td>0197T</td>
<td>G6017</td>
<td>Intra-fraction localization and tracking of target or patient motion during delivery of radiation therapy (e.g., 3D positional tracking, gating, 3D surface tracking), each fraction of treatment</td>
</tr>
</tbody>
</table>

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# Treatment Codes

<table>
<thead>
<tr>
<th>CY2014 Codes</th>
<th>AMA New Codes CY2015</th>
<th>CMS Final Codes CY2015</th>
<th>CY2016 Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>77401</td>
<td>77401</td>
<td>77401</td>
<td>77401</td>
</tr>
<tr>
<td>77402</td>
<td>77402</td>
<td>G6003</td>
<td>77402</td>
</tr>
<tr>
<td>77403</td>
<td>Deleted</td>
<td>G6004</td>
<td>-</td>
</tr>
<tr>
<td>77404</td>
<td>Deleted</td>
<td>G6005</td>
<td>-</td>
</tr>
<tr>
<td>77406</td>
<td>Deleted</td>
<td>G6006</td>
<td>-</td>
</tr>
<tr>
<td>77407</td>
<td>77407</td>
<td>G6007</td>
<td>77407</td>
</tr>
<tr>
<td>77408</td>
<td>Deleted</td>
<td>G6008</td>
<td>-</td>
</tr>
<tr>
<td>77409</td>
<td>Deleted</td>
<td>G6009</td>
<td>-</td>
</tr>
<tr>
<td>77411</td>
<td>Deleted</td>
<td>G6010</td>
<td>-</td>
</tr>
<tr>
<td>77412</td>
<td>77412</td>
<td>G6011</td>
<td>77412</td>
</tr>
<tr>
<td>77413</td>
<td>Deleted</td>
<td>G6012</td>
<td>-</td>
</tr>
<tr>
<td>77414</td>
<td>Deleted</td>
<td>G6013</td>
<td>-</td>
</tr>
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<td>77416</td>
<td>Deleted</td>
<td>G6014</td>
<td>-</td>
</tr>
<tr>
<td>77418</td>
<td>77385 or 77386</td>
<td>G6015</td>
<td>77385 or 77386</td>
</tr>
<tr>
<td>0073T</td>
<td>77385</td>
<td>G6016</td>
<td>77385</td>
</tr>
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</table>
Image Guidance

<table>
<thead>
<tr>
<th>CY2014 Codes</th>
<th>AMA New Codes</th>
<th>CMS Final Codes CY2015</th>
<th>CY2016 Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>76950</td>
<td>77387</td>
<td>G6001</td>
<td>77387</td>
</tr>
<tr>
<td>77421</td>
<td>77387</td>
<td>G6002</td>
<td>77387</td>
</tr>
<tr>
<td>0197T</td>
<td>77387</td>
<td>G6017</td>
<td>77387</td>
</tr>
<tr>
<td>77014*</td>
<td>77387</td>
<td>-</td>
<td>77387 or 77014</td>
</tr>
</tbody>
</table>

*77014 was not deleted, per AMA it is no longer billable for IGRT. Still may be reported for treatment planning CTs. For IGRT report 77387, for treatment planning report 77014-TC.
Additional Code Revision Updates

- CPT® 77401 – Per CPT manual only E&M is billable with 77401, all simulation, planning, physics and physician management are bundled into 77401
  - CMS is interested in information on whether or not the new code set with the bundled codes typically reported with superficial treatment are accurate
- New codes 77387, G6001 and G6002 (imaging) are subject to the cap on imaging codes defined by the DRA and is open to public comment
- CMS disagrees with the RUC established RVU for 77316 and has established an interim work RVU 77316 by cross walking it to 77306, a similar simple planning code
**Reimbursement by Treatment Modality**

Examples provided based upon the Medicare allowable and using the CF as set for January 1, 2015 – March 31, 2015

<table>
<thead>
<tr>
<th>Type</th>
<th>2014 Course Collections - CF = $35,8228</th>
<th>2015 Course Collections - CF = $35,8013</th>
<th>2014 - 2015 Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>2D</td>
<td>$1,068.59</td>
<td>$1,223.71</td>
<td>$4,534.81</td>
</tr>
<tr>
<td>3D - 35 Fractions</td>
<td>$3,921.52</td>
<td>$12,762.95</td>
<td>$16,731.04</td>
</tr>
<tr>
<td>3D w/Hyperthermia</td>
<td>$4,691.71</td>
<td>$16,859.64</td>
<td>$21,551.35</td>
</tr>
<tr>
<td>IMRT - 35 Fractions</td>
<td>$3,347.64</td>
<td>$18,828.82</td>
<td>$22,176.46</td>
</tr>
<tr>
<td>SRS - Linac</td>
<td>$1,518.17</td>
<td>$2,404.43</td>
<td>$3,822.60</td>
</tr>
<tr>
<td>SBRT Linac 5 Fractions</td>
<td>$1,635.67</td>
<td>$7,512.04</td>
<td>$9,147.71</td>
</tr>
<tr>
<td>APBI MultiCath</td>
<td>$2,901.65</td>
<td>$6,385.06</td>
<td>$9,286.70</td>
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<tr>
<td>Prostate - HDR</td>
<td>$2,243.22</td>
<td>$3,239.81</td>
<td>$5,483.04</td>
</tr>
<tr>
<td>Prostate - LDR</td>
<td>$1,874.61</td>
<td>$968.85</td>
<td>$2,025.06</td>
</tr>
<tr>
<td>GYN T&amp;O - HDR</td>
<td>$3,032.76</td>
<td>$2,128.23</td>
<td>$5,160.99</td>
</tr>
<tr>
<td>GYN Cyl 1 Chan HDR</td>
<td>$2,294.09</td>
<td>$2,779.13</td>
<td>$5,073.22</td>
</tr>
<tr>
<td>GYN Multi Chan HDR</td>
<td>$2,768.74</td>
<td>$3,540.37</td>
<td>$6,309.11</td>
</tr>
<tr>
<td>MWA Liver</td>
<td>$5,164.57</td>
<td>$0.00</td>
<td>$5,058.18</td>
</tr>
</tbody>
</table>
2015 Final Rule

HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM (HOPPS)
CY 2015 HOPPS Final Rule Highlights

- Payment rates – overall 2.2% increase in OPPS payments to providers, estimated total OPPS payments to be approximately $56.1 billion, increase of approximately $5.1 billion compared to CY 2014
  - Increase of 2.3% for urban hospitals and rural 1.9% increase
  - 2.0% point reduction for hospitals failing to meet the hospital outpatient quality reporting requirements
  - ASC proposed increase of 1.4%
- Conversion Factor – proposed for CY 2015 $74.144
- Wage Index – Frontier States to continue with 1.000
  - IPPS finalized wage indexes are used for HOPPS
  - CBSA has been updated and changes are reflected in the new localities for 2015
- Cancer hospital payment adjustments – will continue and payment to-cost ratio (PCR) of 0.89 to determine the final CY 2015 cancer hospital payment adjustment
- Payment of Drugs, Biologicals, and Radiopharmaceuticals – those which do not have pass-through status will be set at statutory default of average sales price (ASP) plus 6 percent.
HOPPS Final Rule Highlights cont.

- Outlier Payments – Increase in Fixed Dollar Threshold to $2,775, multiple threshold still at 1.75 times and payment made at 50% of the amount by which furnishing service is more than 1.75 times the APC reimbursement.
- Packaging Policies – when services are integral, ancillary, supportive, dependent, or adjunctive to a primary service, those services which have a proposed APC geometric mean cost (prior to application of status indicator Q1) of less than or equal to $100 will be packaged.
- Comprehensive APC (C-APC 0067) - single-session cranial stereotactic radiosurgery (SRS) finalized.
- IORT codes 77424 and 77425 finalized to be reassigned to 0648 (Level IV Breast and Skin Surgery).
- Composite APC 8001 for brachytherapy LDR will continue with final geometric mean cost of $3,745.00.
- Off Campus Provider-Based – “PO” – short descriptor “Serv/proc off-campus pbd,” or long descriptor “Services, procedures and/or surgeries furnished at off-campus provider-based outpatient departments.”
HOPPS Final Rule Highlights cont.

- APC re-assignments and changes
  - APC 0066 (includes code 77373) Level V Radiation Therapy exception to the 2 times rule for CY2015
  - To correct 2 times rule violation in APC 0664, Proton CPT code 77520 is moved to APC 0412 and Proton CPT code 77522 reassigned to APPC 0667
  - Delete APC 0065 (IORT, MRgFUS, and MEG) since the services are final to be reassigned to other APCs
  - CPT code 77373 will continue to be assigned to APC 0066 along with MRgFUS HCPCS codes 0017T, 0072T, 0301T and C9734
  - Code 57155 moved from APC 0193 to APC 0192, resulting in 63% reduction
  - MEG CPT code 95965 and 95966 moved from APC 0065 to APC 0446
  - IORT CPT codes 77424 and 77425 moved to comprehensive APC 0648

- Brachytherapy sources – rates will continue to be set and will be based upon the geometric mean costs

- ASC change in payment indicator for CPT 19296, placement of breast catheter to account for designation as office-based
SRS/SBRT APCs

- CPT® code 77373 will continue in APC 0066 along with MRgFUS HCPCS codes 0071T, 0072T, 0301T and C9734 even though this presents a 2 times rule violation.
  - CMS does expect to re-evaluate all SRS APC assignments in future CY2016 rulemaking.
- Comprehensive APC created to include CPT® codes 77371 (SRS Cobalt 60 based) and 77372 (SRS linac based) with a national average payment $9,765.40
  - Any ancillary and integral services performed on the same date and reported on the same claim as the SRS treatment will not be reimbursed:
    - Clinic visit
    - Imaging
    - Treatment planning
    - physics
Provider Based Status

- As outlined within the proposed rules and the MPFS CY2015 Final Rule, the need for additional information regarding provider based status was addressed
- Medicare created a two-digit HCPCS modifier
  - PO -“Services procedures and/or surgeries furnished at off-campus provider-based outpatient departments”
  - Used with each code for hospital services furnished in an off-campus provider-based department of a hospital
  - Voluntary use beginning 1/1/15 and mandatory use starting 1/1/16
Proton APCs

- Proton CPT code 77520 (Proton treatment delivery; simple, without compensation) was moved from APC 0064 and reassigned to APC 0412 (Level III Radiation Therapy) thus fixing a 2 times rule violation
- Proton CPT code 77522 (Proton treatment delivery; simple, with compensation) was also moved from APC 0064 and reassigned to APC 0667 with the other proton treatment codes
  - APC 0667 name change from Level II Proton Beam Radiation Therapy to Level IV Radiation Therapy to match pattern of other similar APCs
Hyperthermia APCs

- CPT code 77600 (Hyperthermia, externally generated; superficial (ie, heating to a depth of 4 cm or less) finalized move from APC 0299 to APC 0301
  - APC 0301 also includes codes 77408 – 77416 & 77750
  - Move results in 53% reimbursement cut for hyperthermia
- Remaining hyperthermia codes (77605, 77610, 77615 & 77620) moved to APC 0412
  - APC 0412 also includes codes 77418 & 77470
- Code 77470 moved to APC 0412 = 23% increase!
Surgical APCs

- Code 57155 (Insertion of uterine tandem and/or vaginal ovoids for clinical brachytherapy)
  - moved once again from APC 0193 to 0192
    - CY2014 payment APC 0193= $1,375.20
    - CY2015 APC payment 0192= $487.06 a 63% reduction!
- IORT codes 77424 & 77425 finalized move from APC 0065 to C-APC 0648 (Level IV Breast and Skin Surgery)
- APC 0065 deleted, leaving MRgFUS codes and MEG codes 95965 and 95966 being moved to APC 0446
Packaging Policies

- Medicare is finalizing packaging policies to be applied to services which are integral, ancillary, supportive, dependent, or adjunctive to a primary service
  - Must have a final APC geometric mean cost (prior to the application of the status indicator Q1) of less than $100
  - Current method and $100 cost limit of the APC is an initial set of conditionally packaged ancillary service APCs and does not represent a threshold
  - Current method is a basis for selecting the initial set of APCs and will likely be updated and expanded in the future
  - Excludes brachytherapy and pass-through drugs, biologicals and devices that are separately payable by statute
Comprehensive APCs (C-APC)

- For CY2015 Medicare has established 25 C-APCs and continue to package all add-on codes furnished as part of a comprehensive service.
- Medicare has stated the entire hospital stay, defined as all services reported on the hospital claim reporting the primary service, is considered to be one comprehensive service for the provision of a primary service into which all other services appearing on the claim would be packaged.
- Results in a single Medicare payment and a single beneficiary copayment under the OPPS for the comprehensive service.
- Exclusions to the C-APC Methodology include:
  - Any services which are recurring therapy services, unrelated to the comprehensive service and reported on a separate facility claim.
  - Brachytherapy services and pass-through drugs, biologicals and devices which are separately payable.
C-APCs cont.

- Status indicator X will be deleted and replaced with status indicator J1 as part of C-APC policy, or Q1 status indicator for ancillary services.
- All codes reported on same date of service and claim which are integral, ancillary, supportive, dependent, or adjunctive to the primary service are packaged.
- All services are reported on the claim for cost reporting, but not separately reimbursed.
  - SRS packaged services include treatment planning scan, simulations, treatment plan, MU calculations. Devices and physics services.
  - Anything reported on the account claim for the SRS procedure.
Reporting on Claim Form

- Primary service with SI “J1” is reported on as single unit
- All packaged services are reported as appropriate and per work provided
  - Applying appropriate coding principals, codes descriptors and CMS instructions for all services furnished
  - To calculate cost of procedure, all codes are listed but reimbursed with one payment per the C-APC
C-APCs for Radiation Oncology

- Finalized APC 0067 move to C-APC 0067 - Single Session Cranial Stereotactic Radiosurgery
  - Includes CPT codes 77371 & 77372 as the primary services
  - CY2105 C-APC payment = $9,767.98
- Finalized move of IORT codes (77424 & 77425) from APC 0064 into C-APC 0648 Level IV Breast and Skin Surgery
  - Clinical data supports use of IORT codes for breast treatments
  - CY2015 C-APC 0648 payment = $7,461.40
LDR Brachytherapy C-APC 8001

- In place since 2008 and will continue use of C-APC 8001 for LDR prostate brachytherapy services
- Includes codes 55875 and 77778
  - If reported together then under C-APC payment, if performed separately then reimbursed under individual APCs – very different than other C-APCs
  - For payment in ASC if performed together use G0458
- Final geometric mean cost = $3,475.00
- Final CY2015 C-APC 8001 payment = $3,844.64
ASC Breast Catheter Plcmt. Codes

- CPT®19296 - Placement of radiotherapy afterloading expandable catheter (single or multichannel) into the breast for interstitial radioelement application following partial mastectomy, includes imaging guidance; on date separate from partial mastectomy

- Change in payment indicator to account for office-based

**TABLE 46—ASC COVERED SURGICAL PROCEDURES NEWLY DESIGNATED AS PERMANENTLY OFFICE-BASED FOR CY 2015**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>10022</td>
<td>Fine needle aspiration; with imaging guidance</td>
<td>G2</td>
<td>P3</td>
<td>P3</td>
</tr>
<tr>
<td>19296</td>
<td>Placement of radiotherapy afterloading expandable catheter (single or multichannel) into the breast for interstitial radioelement application following partial mastectomy, includes imaging guidance; on date separate from partial mastectomy</td>
<td>G2</td>
<td>P2</td>
<td>P2</td>
</tr>
</tbody>
</table>

* Final payment indicators are based on a comparison of the final rates according to the ASC standard rate-setting methodology and the MPFS final rates effective January 1, 2015. We note that these payment indicators do not include the effect of the negative update to the MPFS payment rates effective April 1, 2015 under current law. Updates to the ASC rates and payment indicators effective April 1, 2015 will be included in the April 2015 quarterly ASC addenda posted on the CMS Web site. For a discussion of the MPFS rates, we refer readers to the CY 2015 MPFS final rule with comment period.
ASC Breast Catheter Plcmt. Codes cont.

- 19298 - Placement of radiotherapy afterloading brachytherapy catheters (multiple tube and button type) into the breast for interstitial radioelement application following (at the time of or subsequent to) partial mastectomy, includes imaging guidance
- 53444 - Insertion of tandem cuff (dual cuff)
- Proposing modifier to identify No Cost/Full Credit and Partial Credit Devices, applied to placement code
- “FB” modifier for devices furnished at no cost or full credit from the manufacturer
- “FC” modifier for devices furnished at partial credit
### Example Reimbursement by Modality

Utilizing the information within the HOPPS CY2015 Final Rule the following examples are provided.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>2D</td>
<td>$3,851.79</td>
<td>$3,441.45</td>
<td>-$410.34</td>
<td>-10.65%</td>
</tr>
<tr>
<td>3D - w/imaging</td>
<td>$13,567.69</td>
<td>$13,032.65</td>
<td>-$535.04</td>
<td>-3.94%</td>
</tr>
<tr>
<td>3D - w/out imaging</td>
<td>$11,911.18</td>
<td>$11,604.89</td>
<td>-$306.29</td>
<td>-2.57%</td>
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<tr>
<td>3D w/out Imaging Hyperthermia</td>
<td>$10,037.35</td>
<td>$9,632.03</td>
<td>-$405.32</td>
<td>-4.04%</td>
</tr>
<tr>
<td>IMRT - Simple</td>
<td>$21,436.35</td>
<td>$21,326.67</td>
<td>-$109.68</td>
<td>-0.51%</td>
</tr>
<tr>
<td>IMRT - Complex</td>
<td>$21,092.40</td>
<td>$20,987.31</td>
<td>-$105.09</td>
<td>-0.50%</td>
</tr>
<tr>
<td>SRS- Linac</td>
<td>$6,888.18</td>
<td>$9,765.40</td>
<td>$2,877.22</td>
<td>41.77%</td>
</tr>
<tr>
<td>SRS- Cobalt</td>
<td>$6,888.18</td>
<td>$9,765.40</td>
<td>$2,877.22</td>
<td>41.77%</td>
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<tr>
<td>SBRT Linac 3 Fractions</td>
<td>$9,060.43</td>
<td>$9,102.22</td>
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<tr>
<td>SBRT Linac 5 Fractions</td>
<td>$12,903.03</td>
<td>$12,907.18</td>
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<td>0.03%</td>
</tr>
<tr>
<td>SBRT - Cobalt 5 Fractions</td>
<td>$14,658.38</td>
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<td>0.04%</td>
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<td>Proton - 25 Fractions</td>
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<td>-$3,323.45</td>
<td>-9.81%</td>
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<tr>
<td>Prostate - HDR</td>
<td>$16,152.84</td>
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<td>-$2,396.50</td>
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<td>-5.91%</td>
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<tr>
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<td>$11,563.41</td>
<td>$8,965.43</td>
<td>-$2,597.98</td>
<td>-22.47%</td>
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<tr>
<td>GYN - Cylinder 1 Chan - HDR</td>
<td>$8,184.51</td>
<td>$8,403.59</td>
<td>$219.08</td>
<td>2.68%</td>
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<tr>
<td>Microwave Ablation Liver</td>
<td>$8,593.40</td>
<td>$8,066.76</td>
<td>-$526.64</td>
<td>-6.13%</td>
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</tbody>
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# The MACs

<table>
<thead>
<tr>
<th>MAC</th>
<th>States Covered By</th>
</tr>
</thead>
<tbody>
<tr>
<td>Novitas-Solutions</td>
<td>Arkansas, Colorado, Delaware, DC, Louisiana, Maryland, Mississippi, New Jersey, New</td>
</tr>
<tr>
<td>Cahaba GBA</td>
<td>Alabama, Georgia, Tennessee</td>
</tr>
<tr>
<td><a href="http://www.cahabagba.com">www.cahabagba.com</a></td>
<td></td>
</tr>
<tr>
<td><a href="http://www.noridianmedicare.com">www.noridianmedicare.com</a></td>
<td></td>
</tr>
<tr>
<td>Palmetto GBA</td>
<td>North Carolina, South Carolina, Virginia (except areas noted as Novitas), West Virginia</td>
</tr>
<tr>
<td><a href="http://www.palmettogba.com">www.palmettogba.com</a></td>
<td></td>
</tr>
<tr>
<td>NGS</td>
<td>Connecticut, Illinois, Maine, Massachusetts, Minnesota, New Hampshire, New York, Rhode</td>
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<tr>
<td><a href="http://www.ngsmedicare.com">www.ngsmedicare.com</a></td>
<td>Island, Vermont, Wisconsin</td>
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<tr>
<td>First Coast Service Options</td>
<td>Florida, Puerto Rico, Virgin Islands</td>
</tr>
<tr>
<td><a href="http://www.medicare.fcso.com">www.medicare.fcso.com</a></td>
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<tr>
<td>Wisconsin Physicians Service</td>
<td>Indiana, Iowa, Kansas, Michigan, Missouri, Nebraska</td>
</tr>
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<tr>
<td>CGS</td>
<td>Kentucky, Ohio</td>
</tr>
<tr>
<td><a href="http://www.cgsmedicare.com">www.cgsmedicare.com</a></td>
<td></td>
</tr>
</tbody>
</table>
### NCCI Edits

- Provided in Excel spreadsheet
- Available CPT® codes in either Column 1 or Column 2
- **Indication:**
  - 0 – Rule “zero chance of getting paid” = Modifier not allowed
  - 1 – Rule “one chance of getting paid” = Modifier allowed
  - 9 – Rule no longer applicable “typically in place originally in error”

<table>
<thead>
<tr>
<th>Column 1</th>
<th>Column 2</th>
<th>Effective Date</th>
<th>Deletion Date</th>
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<td>77336</td>
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<td>77418</td>
<td>77414</td>
<td>20020101</td>
<td></td>
<td>0</td>
</tr>
</tbody>
</table>
Modifiers

- Two digit designation added to the end of a CPT® code provide additional information about the billed procedure
- Classified as either:
  - *Payment modifiers*
  - *Information modifiers*

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>-25</td>
<td>E&amp;M / procedure on same day</td>
</tr>
<tr>
<td>-26</td>
<td>Professional Component Only</td>
</tr>
<tr>
<td>-TC</td>
<td>Technical Component Only</td>
</tr>
<tr>
<td>-58</td>
<td>Staged or related procedure</td>
</tr>
<tr>
<td>-59</td>
<td>Distinct Procedural Service</td>
</tr>
<tr>
<td>-76</td>
<td>Repeat procedure or service</td>
</tr>
</tbody>
</table>
2015 Update

- New HCPCS modifiers to define subsets of the -59 modifier
- Defined for codes at high risk for incorrect billing
- Result of abuse and high numbers of reviews
- Prevents unbundling and overpayments

CMS Manual System Pub 100-20 states:

“According to the 2013 CERT Report data, a projected $2.4 Billion in MPFS payments were made on lines with modifier -59, with a $320 Million projected error rate. In facility payments, primarily OPPS, a projected $11 Billion was billed on lines with a -59 modifier with a projected error of $450 Million. This is a projected 1 year error of $770 Million.”
New HCPCS Modifiers

XE Separate Encounter, A Service That Is Distinct Because It Occurred During A Separate Encounter

XS Separate Structure, A Service That Is Distinct Because It Was Performed On A Separate Organ/Structure

XP Separate Practitioner, A Service That Is Distinct Because It Was Performed By A Different Practitioner

XU Unusual Non-Overlapping Service, The Use Of A Service That Is Distinct Because It Does Not Overlap Usual Components Of The Main Service

CMS will accept either the 59 or X modifier, but migration to X modifier is encouraged.
Medically Unlikely Edits (MUEs)

Pre-determined quantity allowed for a particular CPT® code on a date of service

Most are published on Medicare Website

Updated quarterly

Separate files for Practitioner Services and Facility Outpatient Services
Recent MUE Changes

At the recommendation of the Office of the Inspector General (OIG), the Centers for Medicare & Medicaid Services (CMS) has examined its claims data relative to MUE levels and has confirmed a pattern of inappropriate billing using multiple lines to bypass the MUEs. Agreeing with the OIG that this practice overcharges both beneficiaries and the Medicare program, CMS is converting most MUEs into per day edits. The MUE Adjudication Indicator (MAI) indicates the type of MUE and its basis. Effective with the July 1, 2014 update, published per day edits are identified on the CMS NCCI website (http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/MUE.html) by their MAI value of 2 or 3.

MAI of 3

MLN Matters® Number: SE1422:

“An MAI of 3, the most common per day edit, indicates an edit for which the MUE is based on clinical information such as

• billing patterns;
• prescribing instructions; or
• other information…

…In the rare instance where the provider has verified all information, including the correct interpretation of coding instructions, and still believes that the correctly coded medically necessary service exceeds the MUE, the provider should submit a clearly supported appeal.”
MAI of 2

MLN Matters® Number: SE1422:

“An MAI of 2 indicates an edit for which the MUE is based on regulation or subregulatory instruction (“policy”), including the instruction that is inherent in the code descriptor or its applicable anatomy…

…CMS expects all claims reporting services in excess of the MUE for edits with an MAI of 2 will represent either clerical errors or errors in the interpretation of instructions. CMS has not identified any instances in which a higher value would be correct and payable. MACs have therefore been instructed that this subregulatory instruction is binding on the MAC for both initial determinations and redeterminations, as is all subregulatory instruction.”
## Practitioner Services Eff. 10/1/2014

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<thead>
<tr>
<th>Code</th>
<th>Qty</th>
<th>Description</th>
<th>Nature of Service/Procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td>77261</td>
<td>1</td>
<td>3 Date of Service Edit: Clinical</td>
<td>Nature of Service/Procedure</td>
</tr>
<tr>
<td>77262</td>
<td>1</td>
<td>3 Date of Service Edit: Clinical</td>
<td>Nature of Service/Procedure</td>
</tr>
<tr>
<td>77263</td>
<td>1</td>
<td>3 Date of Service Edit: Clinical</td>
<td>Nature of Service/Procedure</td>
</tr>
<tr>
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<td>2</td>
<td>1 Line Edit</td>
<td>Nature of Service/Procedure</td>
</tr>
<tr>
<td>77285</td>
<td>1</td>
<td>1 Line Edit</td>
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</tr>
<tr>
<td>77290</td>
<td>1</td>
<td>1 Line Edit</td>
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<tr>
<td>77293</td>
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<td>77336</td>
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<td>77371</td>
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<td>Code Descriptor / CPT Instruction</td>
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<td>77373</td>
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## Payment Systems

### MPFS

<table>
<thead>
<tr>
<th>CPT®</th>
<th>Modifier</th>
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<tbody>
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<td>77280</td>
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### HOPPS

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<tbody>
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<td>$113.12</td>
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<td>77295</td>
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<td>$1,038.12</td>
</tr>
<tr>
<td>77301</td>
<td>0310</td>
<td>$1,038.12</td>
</tr>
</tbody>
</table>

In a hospital setting the physician is still paid based on MPFS for the professional component.
Billing Rules

**HOPPS on UB04**
- Date of service same as Pro
- Series Accounts
- Physician = Attending MD
  - Commonly, which MD saw the patient first
  - Series accounts will minimize confusion

**MPFS on CMS1500**
- Date of service same Pro & Tech
- Could Submit Claims Daily
- Physician =
  - MD providing service/supervision
  - MD signing documentation
  - For large groups, potentially a daily change
- Address on Claim Form should match the physical location services rendered
- Q6 Modifier for Locums
Documentation Templates

Reference: Medicare Program Integrity Manual, Ch 3-Verifying Potential Errors and Taking Corrective Actions

3.3.2.1.1 – Progress notes and Templates
3.3.2.4 – Signature Requirements
3.3.2.5 – Amendments, Corrections and Delayed Entries in Medical Documentation

3.3.2.1.1 – Progress Notes and Templates

(Rev. 455, Issued: 03-15-13, Effective: 12-10-12, Implementation: 03-21-13)

A. Definitions

For the purposes of Section 3.3.2.1.1, the following definitions apply:

1. "Progress Notes" -- visit notes, encounter notes, Evaluation and Management documentation, office notes, face-to-face evaluation notes or any other type of record of the services provided by a physician or other licensed/certified medical professional (LCMP) in the medical record. Progress notes may be in any form or format, hardcopy or electronic.

2. "Template" -- a tool/instrument/interface that assists in documenting a progress note. Templates may be paper or electronic.
B. Guidelines Regarding Which Documents Review Contractors Will Consider

CMS does not prohibit the use of templates to facilitate record-keeping. CMS also does not endorse or approve any particular templates. A physician/LCMP may choose any template to assist in documenting medical information.

Some templates provide limited options and/or space for the collection of information such as by using “check boxes,” predefined answers, limited space to enter information, etc. CMS discourages the use of such templates. Claim review experience shows that limited space templates often fail to capture sufficient detailed clinical information to demonstrate that all coverage and coding requirements are met.

Physician/LCMPs should be aware that templates designed to gather selected information focused primarily for reimbursement purposes are often insufficient to demonstrate that all coverage and coding requirements are met. This is often because these documents generally do not provide sufficient information to adequately show that the medical necessity criteria for the item/service are met.

If a physician/LCMP chooses to use a template during the patient visit, CMS encourages them to select one that allows for a full and complete collection of information to demonstrate that the applicable coverage and coding criteria are met.
OIG Recommendation

- January 2014 Report
- OIG recommending contractors look in EHR Audit Logs
- Looking for:
  - Copy & Paste
  - Clone Documentation
  - Over-documenting (E&M)

Signature Guidelines

Written Signatures
- Full name or first initial and last name
- Legible or accompanied by signature log
- Date and time

Electronic Signatures
- Provided via secure login and password
- Printed statement
- Name, credentials, date and time
- Medicare example:

“Electronically Signed By: John Doe, M.D. 06/19/2013 @ 03:25pm”
Supervision

History

• In the CY 2000 OPPS final rule, CMS indicated that direct supervision is the standard for all hospital outpatient therapeutic services covered and paid by Medicare in hospitals and in provider-based departments (PBDs) of hospitals

• CMS stated since outpatient services are furnished “incident to” a physician’s professional service, they believe conditions for payment, including the direct supervision standard should apply to services
Supervision – Who Is Qualified?

“...must be prepared to step in and perform the service, not just respond to an emergency. This includes the ability to take over the performance of a procedure and, as appropriate to both the supervisory physician or non-physician practitioner and the patient, to change a procedure or the course of treatment being provided to a particular patient.”

Typical Radiation Oncology Issues

- Dose changes
- Block/MLC adjustments
- Review of dosimetry planning and imaging
- Treatment breaks
OIG – Annual Work Plan 2015

- Reconciliations of outlier payments
- Medicare oversight of provider-based status
- Comparison of provider-based and free-standing clinics
- Outpatient evaluation and management services billed at the new-patient rate
- Bone marrow or stem cell transplants
- Oversight of pharmaceutical compounding
- Oversight of hospital privileging
- Evaluation and management services-Inappropriate payments
- Physicians-Place-of-service coding errors
- Manufacturer reporting of average sales prices for Part B drugs
- Comparison of average sales prices to average manufacturer prices
- Part B payments for drugs purchased under the 340B Program
- Payments for outpatient drugs and administration of the drugs
OIG Recommends

Development of a compliance program including:

- Conduct internal monitoring and auditing
- Implement compliance and practice standards
- Designate a compliance officer or contact
- Conduct appropriate training and education
- Respond appropriately to detected offenses and develop corrective action
- Develop open lines of communication with employees
- Enforce disciplinary standards through well-publicized guidelines

http://oig.hhs.gov/fraud/complianceguidance.asp
Also Include

Your processes to ensure compliance

- Documentation processes
- Charge capture
- Charge review
- Chart audits & findings
- Correction of errors
- Staff education
- Resources

If you do have an outside review, consider formulating a “response document” to include with your report to show your review of information and your corrective actions.
## Disclaimer:

Content is **not** intended to dictate treatment patterns; only to aid in coding

Billing and coding should match actual procedures performed and documented

Never manipulate dates for reimbursement

Follow the rules; do not attempt to get around them.

Understand the process of care

Documentation MUST clearly illustrate and support services provided and billed and should not need further explanation from a staff member.
Make a Roadmap and Make sure all know how to read it

- E&M
- Clinical Planning
- Set-Up Simulation
- Dosimetry
- Verification or IGRT
- Treatment Delivery
- Physics & Treatment Management
Evaluation & Management

**Physicians**

- Billed based on type of patient
  - New Patient (99201-99205)
  - Established (99211-99215)
  - Inpatient Initial (99221-99223)
  - Inpatient Subsequent (99231-99233)
- Coding based on documentation
  - History
  - Examination
  - Medical Decision Making
  - Time (Face-to-Face)

**Hospital Clinic Visits**

- G0463
- Implemented in 2014
- Does not differentiate between new and established
- Documentation required
Clinical Treatment Planning

Professional Only

• **77261** Simple planning requires a single treatment area of interest encompassed in a single port or simple parallel opposed ports with simple or no blocking.

• **77262** Intermediate planning requires three or more converging ports, two separate treatment areas, multiple blocks, or special time dose constraints.

• **77263** Complex planning requires highly complex blocking, custom shielding blocks, tangential ports, special wedges or compensators, three or more separate treatment areas, rotational or special beam considerations, combination of therapeutic modalities.
Utilization Guidelines

• Billed for the Radiation Oncologist’s cognitive thought process
• Billable once per course – where is the note located? When??
• Documentation must support date of service and complexity

Clinical treatment planning includes interpretation of special testing, tumor localization, treatment volume determinations, treatment time/dosage determinations, choice of treatment modality(ies), selection of appropriate treatment devices and other procedures such as concurrent or sequential chemotherapy or surgery. The documentation must support the separately itemized, specific services provided. Review of records, pathology reports and/or imaging studies are typically part of the basis for claiming either a higher-level E/M service preceding treatment planning, or as a component of this code, but this same work should not be counted as a basis for both services.
Sample Documentation

Code the Procedure:

- Date of Service
- CPT® Code
- Provider

<table>
<thead>
<tr>
<th>The Cancer Center</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Name:</td>
</tr>
<tr>
<td>SSN:</td>
</tr>
<tr>
<td>Procedure Date:</td>
</tr>
<tr>
<td>Attending Physician:</td>
</tr>
</tbody>
</table>

**Physician Clinical Treatment Planning Note**

Betty Ross has agreed to proceed with Radiation Therapy. Tests and supporting medical records were interpreted to outline the tumor location and extent of disease. Further imaging will be necessary to contour and delineate the volume to which the radiation will be applied.

**Clinical Evaluation**

- Treatment Site: Right Breast
- Intent: Curative
- Modality: External beam

The initial prescription reflecting the treatment parameters i.e. fractions, energy, beam arrangement and total dose will be provided on the prescription card in the patient's chart upon completion and my evaluation of the requested deliverable.

This proposed plan is medically necessary in order to treat any residual disease while sparing healthy lung and heart tissue.

**Additional Planning Directives**

- Boost tumor bed delineated by surgical clips

**Physician Orders/Requests**

In order to accomplish this plan, I am ordering/prescribing the following:

- CT Guidance for placement of VRT fields
  - Scan Area: Thorax
  - Scan Direction: In
  - Contrast: No
  - Slice Thickness: 0.5 cm

- Treatment fractions will be performed to accomplish a reproducible treatment position, to determine optimal treatment ports/beam arrangements, to design beam modifying devices, verify treatment orthos on patient and to verify/achieve therapy source placement prior to the commencement of Radiation Therapy.

- Devices, for immobilization and beam shaping
  - Weekly port films
  - Daily imaging for set up assistance

- Image Guided Radiation Therapy
  - Frequency:
  - Special dosimetry requested for: electron output
  - Weekly physics checks

- Special Physics Consult requested for the following reason:
  - Other requests

**Special Treatment Procedure**

Special treatment procedure is not applicable.
Standard of Care

- As techniques or modalities become standard of care, they are no longer considered “special” by our payors. Once during a course of treatment

The following statement is found within LCDs by Novitas, Noridian and First Coast

Use of "Special Treatment Procedure" in IMRT (CPT 77470)

A claim for "Special treatment procedure (eg, total body Irradiation, hemibody radiation, per oral, endocavitary or intraoperative cone irradiation)" would not be appropriate for services that are a necessary part of IMRT planning, but might rarely be appropriate during a course of IMRT where the respective treatment is being delivered as a separate therapy. Providers are cautioned that the use of this code implies a special treatment procedure with moderate physician work and very considerable practice expense (such as in TBI). This service is not to be claimed for much less significant "special procedures" that would more appropriately use 77499 or are a regular variant of IMRT or regular combination with IMRT.
Set-Up Simulation

Professional & Technical

77280  **Simple** simulation of a single treatment area

77285  **Intermediate** simulation two separate treatment areas

77290  **Complex** simulation of three or more treatment areas, particle beam, rotation or arc therapy, complex or custom blocking, brachytherapy simulation, hyperthermia probe verification, or any use of contrast material

- AMA indicates contiguous sites should be considered a single treatment area
CT Guidance and Sim

- Since 2014, the Practice Expense (PE) takes into account the cost of the CT unit for MPFS
  - For freestanding facilities, CT guidance (CPT® 77014-TC) is included within the simulation
  - No longer billable at the time of initial simulation
- For HOPPS, packaging continues
  - Continue to report for utilization; however, not separately reimbursed
Utilization Guidelines

- Documentation must support the date of service and complexity
- Simulation process may include use of treatment devices, which are separately coded
- Documentation should also include verbiage as to the form of treatment and type of shielding if any
- Physician signature required for all documentation

Noridian Healthcare Solutions LCD states:

The typical course of radiation therapy may require between one and three simulations. Frequency in excess of three simulations may require additional documentation. However, no more than one simulation should be reported on any given day.

Therapeutic Radiation Simulation-Aided Field Setting (CPT codes 77280-77295)

Documentation of simulation requires a written record of the procedure and hard copy of electronic images and evidence of image review by physicians including signature or initials and date of review.
Simulations & IMRT

• Common coding error due to incorrect interpretation of payor transmittal in previous years

Noridian Healthcare Solutions IMRT LCD states:

Use of Simulation-Aided Field Setting in IMRT (CPT 77280-77295)

Simulation-aided field setting complex (77290) during a course of IMRT is appropriate for the initial set up of the patient where an immobilization device may be constructed, isocenter(s) and volume of interest are determined, and CT or other imaging is obtained for subsequent reconstruction of target(s) and critical structure(s). CT and other imaging are separately coded (e.g. 77014), when necessary and performed. Also, a simple simulation (77280) may be appropriately provided and claimed once during a course of IMRT, either as a separate or at the time of the first fraction, where the record documents the simulation is for the purpose of field verification, and occurs on a separate day from and after 77290.
Coding For Treatment Devices

**Device Codes**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>77332</td>
<td>Simple (simple block, simple bolus)</td>
<td><em>pre-made electron block, bolus</em></td>
</tr>
<tr>
<td>77333</td>
<td>Intermediate (multiple blocks, stents, bite blocks, special bolus)</td>
<td><em>Bite block, customized bolus</em></td>
</tr>
<tr>
<td>77334</td>
<td>Complex (irregular blocks, special shields, compensators, wedges, molds or casts)</td>
<td><em>Aquaplast masks, alpha cradles, Vac-Lok™, custom molds</em></td>
</tr>
</tbody>
</table>

**Note:** The Breast Board is considered a simple treatment device in most parts of the country, however, in one LCD it is considered an intermediate device.
Disposable Devices

Novitas Solutions, Inc. states:

Disposable treatment devices do not constitute a medically necessary replacement device. It is not reasonable to report a treatment device for every therapy treatment for the use of a disposable device. The use of disposable treatment devices is appropriately reported as one complex device for the entire course of therapy.
Documentation Example

Code the Procedure:
- Date of Service
- CPT® Code(s)
- Provider
- Signatures
Teamwork Approach Dr. Approve? When? How?

- Simulation
- Technical Portion

77290-TC

77290-26

Simulation Note Illustrates Technical & Professional Work

- Devices
- Technical Portion

77334-TC

77334-26

- Devices
- Professional Portion
Dosimetry Processes

Isodose Planning
- Isodose Plan
- Beam Modifiers
- Calculations

3D Radiotherapy Plan
- 3D Planning
- Beam Modifiers
- Calculations

IMRT Planning
- IMRT Plan
- IMRT Device
- Fluence Maps
- Secondary Calculations

Stereotactic Planning
- 3D Planning
- Beam Modifiers
- Calculations

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## Coding for Isodose Plans in 2014

<table>
<thead>
<tr>
<th>Isodose Planning Codes</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>77305</td>
<td>77305 Teletherapy, isodose plan (whether hand or computer calculated); simple (1 or 2 parallel opposed unmodified ports directed to a single area of interest)</td>
</tr>
<tr>
<td>77310</td>
<td>77310 Intermediate (3 or more treatment ports directed to a single area of interest)</td>
</tr>
<tr>
<td>77315</td>
<td>77315 Complex (mantle or inverted Y, tangential ports, the use of wedges, compensators, complex blocking, rotational beam, or special beam considerations)</td>
</tr>
<tr>
<td>77321</td>
<td>77321 Special teletherapy port plan, particles, hemibody, total body i.e., protons, neutrons and electrons</td>
</tr>
</tbody>
</table>
Basic Dosimetry Calculation

77300 Basic radiation dosimetry calculation, central axis depth dose calculation, TDF, NSD, gap calculation, off axis factor, tissue inhomogeneity factors, calculation of non-ionizing radiation surface and depth dose, as required during course of treatment, only when prescribed by the treating physician.

Utilization Guidelines

Applicable for all types of dosimetry planning until 2015
Supporting documentation must support quantity and date of service
Requires physician signature
## Coding For Treatment Devices

### Device Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>77332</td>
<td>Simple (simple block, simple bolus)</td>
<td><em>pre-made block, asymmetric jaw, bolus</em></td>
</tr>
<tr>
<td>77333</td>
<td>Intermediate (multiple blocks, stents, bite blocks, special bolus)</td>
<td><em>multiple pre-made blocks, beam splitter</em></td>
</tr>
<tr>
<td>77334</td>
<td>Complex (irregular blocks, special shields, compensators, wedges, molds or casts)</td>
<td><em>custom block or MLC, compensator, wedge</em></td>
</tr>
</tbody>
</table>
Utilization Guidelines

- One device is billable per port
- Mirrored devices may be considered one device
- Supporting documentation must be signed by the physician and housed within the patient record

Wisconsin Physicians Service LCD states:

When the patient has a combination of a wedge, a compensator, a bolus, or a port block covering the same treatment portal, this would be billed as a single complex treatment device charge rather than a separate charge rendered for each of the individual items. If devices of two separate levels of complexity are utilized for the same treatment portal only the one of highest complexity will be billable.
Electron Processes

Clinical Set-Up

- Set-Up Simulation
  - 77290
  - Beam Modifier(s)
  - 77332 or 77334
  - Calculation(s)
  - 77300

Computer Assisted Set-Up

- Computer Aided Field Setting Sim
  - 77290
  - Beam Modifier(s)
  - 77332 or 77334
  - Special Teletherapy Port Plan
  - 77321
  - Calculation(s)
  - 77300
  - Verification Simulation
  - 77280
2015 Changes

- 77305, 77310 and 77315 will be deleted January 1, 2015
- New codes to be used:
  - 77306 Teletherapy isodose plan; simple (1 or 2 unmodified ports directed to a single area of interest), includes basic dosimetry calculation(s)
  - 77307 Teletherapy isodose plan; complex (multiple treatment areas, tangential ports, the use of wedges, blocking, rotational beam, or special beam considerations), includes basic dosimetry calculation(s)
2015 Changes Cont.

- 77300 no longer billable with the 77321
- CPT® Manual states:
  
  “(Do not report 77300 in conjunction with 77306, 77307, 77316, 77317, 77318, 77321)”
2015 Isodose Planning Changes

Summary

- 2014 isodose planning codes deleted
- 2 new codes created to replace simple and complex
  - Includes calculations
- Codes to be used for HOPPS and MPFS
  - No G-codes for MPFS created

<table>
<thead>
<tr>
<th>2014 CPT®</th>
<th>2015 HOPPS</th>
<th>2015 MPFS</th>
</tr>
</thead>
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<tr>
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<td>No code</td>
</tr>
<tr>
<td>77315</td>
<td>77307</td>
<td>77307</td>
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</table>
3D Radiotherapy Plan

3 Dimensional Radiotherapy Plan, Including DVH

3D Plan
- 77295
Beam Modifiers
- 77332-77334
Calculations
- 77300
Respiratory Management
- 77293 (if applicable)

Computer Aided Process that includes:
- Delineation of volumes
- Placement of isocenter & beams
- Development of isodose plan & DVH

For 2014, this code was renamed and moved into a different section of the CPT® Manual, therefore, included with planning codes.
Coding for 3D Radiotherapy Planning

3D Radiotherapy Planning

77295 - describes the work of the physician, physics, and dosimetry planning, not simulation, and is critical to prepare for treatment following the simulation. To further clarify, code 77295 represents the work that provides the necessary calculations and creates the isodose plans to enable the desired treatment to be delivered. This process generally does not require the presence of the patient.
3D Planning Utilization Guidelines

- Must include volume of interest and critical structure
- Includes simulation process to design treatment fields and isodose planning (not separately billable)
- Billable once per course

Wisconsin Physicians Service LCD states:

Additional simulations may be required when they are done to verify plan parameters before starting new portals or boosts. In those uncommon circumstances where there is a substantial change in either patient anatomy or tumor conformation where a second CT dataset is required to produce an accurate, efficacious and safe "cone-down" plan, a second 77295 charge may be appropriate. When the physician deems this to be the case, the medical necessity for the second 77295 simulation must be documented.
Respiratory motion management simulation (list separately in addition to code for primary procedure)

- “Primary procedure” is either 77295 or 77301 and will be billed on same date as one of these codes

As stated by AMA in CPT® Changes, November 2013 Issue, Page 11

“Increasingly, simulation is performed with respiratory motion management because respiratory movement is an important consideration when devising treatment plans for patients with diseases in certain locations (eg, thoracic tumors, upper abdominal tumors). In these patients, the treatment area is not a static target, but rather the treatment area moves with continuous respiration, and therefore requires the acquisition of multiple data sets showing the respiratory motion. Because multiple scans are produced and fused with motion respiratory tracking, respiratory motion management provides precise mapping of the field and portal design defining the respiratory movement of the target tissue and the possible organs at risk. This process is performed more frequently as motion management techniques are applied to conformal or intensity modulated radiation therapy (IMRT) plans. In response, code 77293 has been established for CPT 2014 to report respiratory motion management in addition to the primary procedure.”
What is an add-on code?

Per the MLN Matters® Article # SE1320, Revised August 16, 2013

“An add-on code is a Health Care Common Procedure System (HCPCS) code or Current Procedural Terminology (CPT) code that describes a service that, with one exception (see Background Section below), is always performed in conjunction with another primary service. An add-on code is eligible for payment only if it is reported with an appropriate primary procedure performed by the same practitioner on the same date of service.”

Documentation for CPT® 77293

• Revenue Cycle Inc. recommends a procedure note for this Respiratory Motion Management Simulation
• Content would describe process performed by physician and staff
• Understand it is a process, therefore, note must detail the work involved
• Look for payor guidelines for use of new code
3D Conformal Treatment Planning Summary Note

Patient: Betty Boop
MR#: 123456789
Diagnosis: 162.3 Lung upper lobe
DOS: 4/3/14

Betty Boop underwent a 4DCT simulation on April 1, 2014 for her right upper lobe lung cancer diagnosis. The patient was placed in the appropriate treatment position and the simulation therapist instructed her on the proper breathing technique for the procedure. At that time, the 4DCT was acquired and the data was processed in development of the MIP, which was then transferred to the Eclipse Treatment Planning System. The MIP was then fused with the planning CT and utilized to contour the ITV to define the primary tumor volume and confirm tumor coverage. Critical structures were also contoured including the heart, spinal cord and normal lung tissue.

Utilizing the contoured regions of interest, a 3D conformal plan was completed consisting of a total of five treatment ports including custom blocking. The dose distribution to the contoured anatomy was evaluated in the coronal, sagittal and transverse planes for uniformity and doses to critical structures. The 95% isodose line accomplished the desired plan. Dose volume histograms were analyzed for each requested critical structure. Digitally Reconstructed Radiographs (DRRs) will be generated for each individual field, as well as computation of the monitor unit calculations. QA of each port and associated parameters will be completed prior to initiation of treatment.

Electronically Approved By: Dr. Bobby Jones 4/3/14 09:45
IMRT Planning

IMRT Plan
- 77301
IMRT Device
- 77338
Secondary Calculations
- 77300
Respiratory Management
- 77293 (if applicable)

Key Documentation Requirements for IMRT Planning:
- Medical necessity = why IMRT?
- Dose objectives & constraints
- Approved IMRT Plan and QA
Coding for IMRT Planning

IMRT Plan

77301 Intensity modulated radiotherapy plan, including dose-volume histograms for target and critical structure partial tolerance specifications
**IMRT Calculations**

- Must be performed & documented for all IMRT cases prior to the start of treatment
- Must be reviewed and approved by physician
- One per gantry angle or arc

*First Coast Services Options LCD states:*

> Basic radiation dosimetry is a separate service from CPT code 77301 (Radiation dose plan, IMRT). CPT code 77300 (Radiation therapy dose plan) is used to report dosimetry calculations that arrive at the relationship between monitor units (or time) and dose, and the physician’s verification, review and approval of this. The documentation should contain the independent check for each field, separate from the computer-generated IMRT plan.

*CPT® Assistant, November 2009; page 3:*

> After the plan is complete, in a separate process, the physicist must perform basic dose calculations on each of the modulated beams. This evaluation is reported with code 77300, *Basic radiation dosimetry calculation, central axis depth dose calculation, TDF, NSD, gap calculation, off axis factor, tissue inhomogeneity factors, calculation of non-ionizing radiation surface and depth dose, as required during course of treatment, only when prescribed by the treating physician.* These patient-specific monitor unit computations verify through a second (independent of treatment planning computer) dose-calculation method that the computer has correctly performed the treatment planning calculations.
IMRT Device

- 77338 Multi-leaf collimator (MLC) device(s) for intensity modulated radiation therapy (IMRT), design and construction per IMRT plan

Utilization Guidelines:
- Re-computation of fluence distribution in a phantom is required
- One per plan
- Billable for boost planning

*Noridian Healthcare Solutions LCD states:*

The CPT code 77338 is used for the MLC treatment device used in IMRT. Normally, CPT 77338 is used **once per IMRT plan**. In certain instances, e.g., when a radiotherapy boost is performed, it may be used more than once during a course of therapy. **This CPT code 77338 is not to be used with compensator based IMRT.**
Coding Tip

- Code **77334** may still be used in the IMRT process of care to report the immobilization device constructed at time of the complex simulation (code **77290**).
- Code **77338** should only be used with MLC-derived radiation beam modulation. For compensator-based IMRT, use code **77334** to capture the use of the compensator.
- Code **77338** is reported once per IMRT plan, but it may be used more than once during an IMRT treatment course when a cone-down technique is used in the treatment plan because a new set of MLC devices are required. If a new set of MLC devices are used, a second code (**77338**) may be reported, but it should not be reported if a per-gantry-angle code, such as code **77334**, was previously reported.
Stereotactic Planning Process

Stereotactic Planning

3D Plan
• 77295

Beam Modifiers
• 77334

Calculations
• 77300

Respiratory Management
• 77293 (if applicable)

Key documentation requirements for SRS & SBRT:
• Medical necessity = why?
• Intent
• Potential for cure
• Performance status
In addition, for the planning services, hospitals must report the specific CPT code that accurately describes the service provided. The planning services may include but are not limited to CPT code 77290, 77295, 77300, 77334, or 77370, listed in Table 3 below.

**Table 3 – CPT Codes that are Reportable for SRS Planning Services**
*Effective January 1, 2014*

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Long Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>77290</td>
<td>Therapeutic radiology simulation-aided field setting; complex</td>
</tr>
<tr>
<td>77295</td>
<td>Therapeutic radiology simulation-aided field setting; 3-dimensional</td>
</tr>
<tr>
<td>77300</td>
<td>Basic radiation dosimetry calculation, central axis depth dose calculation, tdf, nsd, gap calculation, off axis factor, tissue inhomogeneity factors, calculation of non-ionizing radiation surface and depth dose, as required during course of treatment, only when prescribed by the treating physician</td>
</tr>
<tr>
<td>77334</td>
<td>Treatment devices, design and construction; complex (irregular blocks, special shields, compensators, wedges, molds or casts)</td>
</tr>
<tr>
<td>77370</td>
<td>Special medical radiation physics consultation</td>
</tr>
</tbody>
</table>
Devices for SRS/SBRT

- Devices will vary depending on SRS/SBRT delivery method
- Potential Scenarios:
  - One per arc
  - One per unique MLC
  - One per cone
  - One per helmet or helmet change
  - One per unique plug pattern
- Payor limits may apply to allowed quantities
Verification Process

Process depends on treatment modality and medical necessity. Only one form of verification is appropriate.
Verification Simulation

Description:
Simulation provided to verify the accuracy of custom blocks and treatment parameters, prior to beginning a treatment.

- Requires verification of all treatment ports prior to start of treatment
- Documentation required:
  - Written record of procedure
  - Images
  - Evidence of image review by physician
The Cancer Center

Verification Simulation Note

Supervising Physician: Dr. Joe Jones

As requested by Dr. Webb, a verification simulation was performed in preparation for treatments for the patient's breast cancer. Janet Robertson was placed in the treatment position on the linear accelerator and the required source centers were applied. The simulator was then verified via AP and right lateral ports. Necessary adjustments were made and then the medial and lateral tangents were imaged. Following the ports, the SSIs were verified and additional marks were placed for set up assistance.

Approved films are fed within the Offline Review section of RIA.

Physician Comments: Review of the tangent fields showed good alignment and appropriate blocking of the lung. All images have been reviewed and the patient is approved to start treatment.

Therapist performing simulation: Suite Block, RT (T) and Jason Wright, BSRT (T)

[Image of a medical scan]
Image Guided Radiation Therapy (IGRT) utilizes various imaging technologies to account for changes in the position of the intended target before or during treatment delivery.

- **76950** Ultrasonic guidance for placement of radiation therapy fields
- **77014** Computed tomography guidance for placement of radiation fields
- **77421** Stereoscopic x-ray guidance for localization of target volume for the delivery of radiation therapy.
- **0197T** Intra-fraction localization and tracking of target or patient motion during delivery of radiation therapy (e.g. 3D positional tracking, gating, 3D surface tracking), each fraction of treatment.
Utilization Guidelines

• May be performed with 3D conformal and IMRT
• Able to visualize the intended target (may require fiducial markers)
• Only one IGRT process is billable per fraction

Supporting Documentation:
✓ Medical Necessity
✓ Orders (specify type and frequency)
✓ Image and any shift information (technical component)
✓ Evidence of physician work regarding involvement & timing of participation/approvals
Verification for SRS/SBRT

• Imaging to confirm positioning, beam placement, etc. is required
• Imaging is inclusive in the SRS and/or SBRT procedure and not separately billable
• Documentation of verification process should be included within the required procedure note performed by MD
7. Stereotactic radiosurgery (SRS) treatment delivery (CPT codes 77371-77373) includes stereotactic guidance for placement of the radiation therapy fields for treatment delivery. CPT codes 77014 (computed tomography guidance for placement of radiation therapy fields) and 76950 (ultrasonic guidance for placement of radiation therapy fields) should not be reported additionally for guidance for placement of the radiation therapy field for SRS treatment delivery.
Medical Necessity for IGRT

As stated by Novitas Solutions, Inc. LCD

CT Guidance in IMRT (77014)

It is anticipated that CT guidance for placement of radiation therapy fields may be needed in the field setting process and therefore may be performed along with simple simulation. Routine pretreatment CT scans are not considered medically necessary; however, pretreatment CT scans may be medically necessary in the treatment of certain tumors based upon factors, including, but not limited to, size, location, and adjacent structures where failure to verify treatment location could result in damage to structures resulting in harm to the patient. The medical record must clearly document the medical necessity for such pretreatment CT scans. The Contractor will conduct data analysis and focused medical review to ensure that the documentation for daily CT guidance reported with IMRT services supports the medical necessity for the pretreatment scans.
Additional Payor Reference

As stated within the IGRT Policy by Blue Cross Blue Shield of NJ

Historical methodology of using port films to confirm patient set-up and block placement has not been replaced by IGRT. Outside of treatment procedures requiring only isocenter placement, port films and/or verification simulations are still the appropriate modalities. If the isocenter placement is the primary concern, i.e. for IMRT, then IGRT is typically the method utilized. This does, however, imply the target can be localized with the specific IGRT modality requested, i.e., stereoscopic imaging for target localization, computed tomography (CT) guidance for field placement or ultrasound (US) guidance for field placement. In the event no target is localized, blocking and patient set-up is accomplished through typical alignment of bony structures using portal imaging; appropriate coding for port films would apply.
2015 IGRT Changes

- 77421, 76950 and 0197T will be deleted as of January 1, 2015
- 77014 no longer associated with IGRT
- New code for IGRT not dependent upon type
  - 77387 Guidance for localization of target volume for delivery of radiation treatment delivery, includes intrafraction tracking, when performed
  - 77387 TC bundled with IMRT delivery codes
  - 77387 26 separately billable when supported
  - 77387 TC and 77387 26 separately billable for 3D delivery when supported
- G-codes created for 2016 MPFS use
2015 IGRT Summary

- IGRT codes deleted
  - 77014 not deleted, however not to be used for IGRT
- One new code created
  - Not dependent upon type of IGRT
  - G-codes for MPFS use

<table>
<thead>
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<th>2014 CPT®</th>
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<tr>
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<tr>
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<td>77387</td>
<td>G6002</td>
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<tr>
<td>0197T</td>
<td>77387</td>
<td>G6017</td>
</tr>
<tr>
<td>77014</td>
<td>77387</td>
<td>77387</td>
</tr>
</tbody>
</table>
To Visualize the “Target”

- May require the implantation of Fiducial Markers
- Example process outlined below:

  **Image Guidance**
  CPT® 76942
  - Ultrasonic guidance for needle placement (e.g., biopsy, aspiration, injection, localization device), imaging supervision and interpretation

  **Placement of Markers**
  CPT® 55876
  - Placement of interstitial device(s) for radiation therapy guidance (e.g., fiducial markers, dosimeter), prostate (via needle, any approach), single or multiple

  **Documentation**
  - Procedure Note Necessary

** Markers will also be billed using the appropriate code
# Fiducials Marker Placement Codes

<table>
<thead>
<tr>
<th>CPT ®</th>
<th>Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>32553</td>
<td>Placement of interstitial device(s) for radiation therapy guidance (e.g., fiducial markers, dosimeter), percutaneous, intra-thoracic, single or multiple</td>
</tr>
<tr>
<td>43253</td>
<td>Esophagogastroduodenoscopy, flexible, transoral; with transendoscopic ultrasound-guided transmural injection of diagnostic or therapeutic substance(s) (eg, anesthetic, neurolytic agent) or fiducial marker(s) (includes endoscopic ultrasound examination of the esophagus, stomach, and either the duodenum or a surgically altered stomach where the jejunum is examined distal to the anastomosis)</td>
</tr>
<tr>
<td>49327</td>
<td>Laparoscopy with placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), intra-abdominal intra-pelvic, and/or retroperitoneum, including image guidance, if performed, single or multiple (List separately in addition to code for primary procedure)</td>
</tr>
<tr>
<td>49411</td>
<td>Placement of interstitial device(s) for radiation therapy guidance (e.g., fiducial markers, dosimeter), percutaneous, intra-abdominal, intra-pelvic (except prostate), and/or retroperitoneum, single or multiple</td>
</tr>
<tr>
<td>49412</td>
<td>Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), open intra-abdominal intra-pelvic, and/or retroperitoneum, including image guidance, if performed, single or multiple (List separately in addition to code for primary procedure)</td>
</tr>
<tr>
<td>55876</td>
<td>Placement of interstitial device(s) for radiation therapy guidance (e.g., fiducial markers, dosimeter), prostate (via needle, any approach), single or multiple</td>
</tr>
<tr>
<td>C9728</td>
<td>Placement of interstitial device(s) for radiation therapy/surgery guidance (e.g., fiducial markers, dosimeter), other than prostate (any approach), single or multiple</td>
</tr>
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</table>
# Placement Codes – Breast at Biopsy

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Long Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>19081</td>
<td>Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; first lesion, <strong>including stereotactic guidance</strong></td>
</tr>
<tr>
<td>19082</td>
<td>Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; each additional lesion, including stereotactic guidance (List separately in addition to code for primary procedure)</td>
</tr>
<tr>
<td>19083</td>
<td>Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; first lesion, <strong>including ultrasound guidance</strong></td>
</tr>
<tr>
<td>19084</td>
<td>Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; each additional lesion, including ultrasound guidance (List separately in addition to code for primary procedure)</td>
</tr>
<tr>
<td>19085</td>
<td>Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; first lesion, <strong>including magnetic resonance guidance</strong></td>
</tr>
<tr>
<td>19086</td>
<td>Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; each additional lesion, including magnetic resonance guidance (List separately in addition to code for primary procedure)</td>
</tr>
<tr>
<td>HCPCS Code</td>
<td>Long Descriptor</td>
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<td>----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>19281</td>
<td>Placement of breast localization device(s) (eg, clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; first lesion, including mammographic guidance</td>
</tr>
<tr>
<td>19282</td>
<td>Placement of breast localization device(s) (eg, clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; each additional lesion, including mammographic guidance (list separately in addition to code for primary procedure)</td>
</tr>
<tr>
<td>19283</td>
<td>Placement of breast localization device(s) (eg, clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; first lesion, including stereotactic guidance</td>
</tr>
<tr>
<td>19284</td>
<td>Placement of breast localization device(s) (eg, clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; each additional lesion, including stereotactic guidance (list separately in addition to code for primary procedure)</td>
</tr>
<tr>
<td>19285</td>
<td>Placement of breast localization device(s) (eg, clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; first lesion, including ultrasound guidance</td>
</tr>
<tr>
<td>19286</td>
<td>Placement of breast localization device(s) (eg, clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; each additional lesion, including ultrasound guidance (list separately in addition to code for primary procedure)</td>
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<tr>
<td>19287</td>
<td>Placement of breast localization device(s) (eg clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; first lesion, including magnetic resonance guidance</td>
</tr>
<tr>
<td>19288</td>
<td>Placement of breast localization device(s) (eg clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; each additional lesion, including magnetic resonance guidance (list separately in addition to code for primary procedure)</td>
</tr>
</tbody>
</table>
Fiducial Markers

- A4648 – Tissue marker, implantable, any type, each
- A4650 – Implantable radiation dosimeter, each

Billing for Markers
- Hospital or ASC – markers are packaged into the placement code, not separately paid
- FSC or Office – markers are paid at invoice cost

- Report the invoice price per marker in Box 19 of CMS1500 claim form
Simple

77401 (Superficial or Orthovoltage)

Intermediate

77407

Complex

77412

IMRT

77418 (Dynamic MLC)

77418 (Compensator Based)
2015 Conventional Treatment Delivery

• 77403, 77404, 77406, 77408, 77409, 77411, 77413, 77414, 77416, 77418 and 0073T deleted as of January 1, 2015

Conventional treatment delivery:

– 77402 Radiation treatment delivery, ≥ 1 MeV; simple
– 77407 Radiation treatment delivery, ≥ 1 MeV; intermediate
– 77412 Radiation treatment delivery, ≥ 1 MeV; complex

• G-codes created for MPFS use in 2015
2015 Conventional Treatment Delivery

- **Simple:** All of the following criteria are met (and none of the complex or intermediate criteria are met): single treatment area; one or two ports; and two or fewer simple blocks

- **Intermediate:** Any of the following criteria are met (and none of the complex criteria are met): two separate treatment areas; three or more ports on a single treatment area; or three or more simple blocks

- **Complex:** Any of the following criteria are met: three or more separate treatment areas; custom blocking; tangential ports; wedges; rotational beam; field-in-field or other tissue compensation that does not meet IMRT guidelines; or electron beam
Energies below the megavoltage range may be used in the treatment of skin lesions. Superficial radiation energies (up to 200kV) may be generated by a variety of technologies and should not be reported with megavoltage (77402, 77407, 77412) for surface application. Do not report clinical treatment planning (77261, 77262, 77263), treatment devices (77332, 77333, 77334), isodose planning (77306, 77307, 77316, 77317, 77318), physics consultation (77336), or radiation treatment management (77427, 77431, 77432, 77435, 77469, 77470, 77499) with 77401. When reporting 77401 alone, physician evaluation and management, when performed, may be reported with the appropriate E/M codes.”
### 2015 Conventional Treatment Delivery

- All but 3 deleted
- Remaining 3 adjusted to remove energy dependence
- G-codes created for MPFS
- 77401 not deleted

<table>
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<tr>
<td>77416</td>
<td>77412</td>
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</tbody>
</table>
2015 IMRT Treatment Delivery

- 77418 deleted for CY2015
- Two new codes created
  - 77385 - Intensity modulated radiation treatment delivery (IMRT), includes guidance and tracking, when performed; simple
  - 77386 - Intensity modulated radiation treatment delivery (IMRT), includes guidance and tracking, when performed; complex
- G-codes created for MPFS use in 2015

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2015 IMRT Treatment Delivery

- **Simple** Any of the following: prostate, breast, and all sites using physical compensator-based IMRT

- **Complex** Includes all other sites if not using physical compensator-based IMRT
2015 IMRT Treatment Delivery

- 2014 codes deleted
- Two new codes created
  - Simple
  - Complex
- G-codes created for MPFS
- IGRT included for HOPPS
- IGRT possible for MPFS

<table>
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<tr>
<th>2014 CPT®</th>
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</table>
Stereotactic Treatment Delivery

MPFS & HOPPS

**77371** Radiation treatment delivery, stereotactic radiosurgery (SRS), complete course of treatment of cranial lesion(s) consisting of 1 session; multi-source Cobalt 60 based

**77372** Radiation treatment delivery, stereotactic radiosurgery (SRS), complete course of treatment of cranial lesion(s) consisting of 1 session; linear accelerator based

**77373** Stereotactic body radiation therapy, treatment delivery, per fraction to 1 or more lesions, including image guidance, entire course not to exceed 5 fractions
Documentation Guidelines

Procedure note is necessary for each fraction of SRS and/or SBRT

5 fraction course = 5 Procedure notes
Radiation Oncologist Participation

As stated within Novitas Solutions, Inc. LCD:

Each SBRT case, regardless of the number of sessions, involves a specialist from the field of Radiation Oncology who manages and oversees:

- Imaging for localization
- Computer-assisted tumor localization with respiratory correlation, if required
- Treatment planning and approval of the ongoing images used for localization or tumor tracking
- Setup and accuracy verification testing
- Simulation of prescribed arcs or fixed portals
- Radiation treatment delivery
- Real-time adjustments in response to patient motion or target movement
- Evaluation of the response to treatment
Treatment Management

77427  Radiation treatment management, 5 treatments

77431  Radiation therapy management with complete course of therapy consisting of 1 or 2 fractions only

77432  Stereotactic radiation treatment management of cranial lesion(s) (complete course of treatment consisting of 1 session)

77435  SBRT, treatment management, per treatment course, to 1 or more lesions, including image guidance, entire course not to exceed 5 fx

Utilization Guidelines

- As published within the 2011CPT®: “Radiation treatment management requires and includes a minimum of one examination of the patient by the physician for medical evaluation and management for each reporting of the radiation treatment management service.”

Utilization Guidelines:

- Billable once per course regardless of number of lesions or sessions
- 77432 & 77435 cannot be billed for same course
- Supporting documentation required
Special Dosimetry

- 77331 Special dosimetry (e.g., TLD, microdosimetry) (specify), only when prescribed by the treating physician

Utilization Guidelines:

- Services may vary which include, electron measurements, TLD, diodes, film dosimetry, etc.
- Billable once per portal
- Required to be ordered by physician
- Supporting documentation is required to be signed by physician
- Measured date is the billable date
Continuing Medical Physics

- 77336 Continuing medical physics consultation, including assessment of treatment parameters, quality assurance of dose delivery, and review of patient treatment documentation in support of the radiation oncologist, reported per week of therapy

Utilization Guidelines:
- Billable once per five fractions
- Applicable for single fraction or two fraction courses
- Billable during the final week of treatment if three or more fractions are delivered
- Documentation required to support physics review and parameters checked
Special Physics Consult

- 77370 Special medical radiation physics consultation

Utilization Guidelines:
- Must be ordered by a physician for a specific reason
- Report by the physicist addressing the specific request
- Physician signature on the report is necessary acknowledging their review
- Billed on the date of the report
77370 Special Medical Physics Consultation
The special medical radiation physics consultation code is used when the radiation oncologist makes a direct request to the qualified medical physicist for a special consultative report or for specific physics services on an individual patient. Such a request may be made when the complexity of the treatment plan is of such magnitude that a thorough written analysis is necessary to address a specific problem or when the service to be performed requires the expertise of a qualified medical physicist. The clinical indication that justified the request for the special physics consultation should also be documented.

Examples of problems that might justify the use of this code include:
- Complex interrelationships of electron and photon ports and complex dosimetric considerations in brachytherapy, including high dose rate remote afterloader applications, intravascular brachytherapy treatments, and interstitial radioactive seed implantation.
- Analysis of customized beam modification devices and special blocking procedures (and their dosimetric evaluation) to protect critical organs during treatment;
- Analysis of the effects of previous radiation therapy with assessment of cumulative radiation dose to critical organs;
- Computation of dose to the fetus in a pregnant patient undergoing radiation therapy, or
- Special brachytherapy equipment developed by the qualified medical physicist to treat a particular patient.

The qualified medical physicist will spend a considerable amount of time and effort on behalf of a specific patient and will render a customized written report (which will form part of the patient's chart) to the radiation oncologist in reference to the problem or service being addressed.

CPT code 77370 must be used for consultative purposes when a problem or special situation arises during radiation therapy. This code requires a detailed written report describing the problem to be given to the requesting physician.
Brachytherapy

For All Brachytherapy Procedures:

• Practice patterns differ from physician to physician
• Process of care differs for each treatment site
• Billing Templates are NOT recommended
• Bill Only Work Performed & Documented
• Codes Vary from HDR & LDR
• A “Procedure Note” or an “Operative Note” is necessary for all brachytherapy procedures

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Key Components

Clinical Planning

Applicator Placement

Simulation & Imaging

Dosimetry

Treatment Delivery
Applicator Placement

Wisconsin Physician Services Brachytherapy LCD states:

Brachytherapy may be performed concomitantly with surgical resection or in conjunction with procedures such as endoscopy or angioplasty, which are required to achieve access to the site of the disease. There are two distinct phases required to complete the process known as brachytherapy:

1. The insertion or placement of non-radioactive applicators or conduits that receive or transmit the radioactive material into the body, and
2. The loading of the radioactive material (the active or therapeutic agent) into the conduits or directly into tissue.

*May be performed by the radiation oncologist or in collaboration with another physician.*
Collaboration

As stated within the WPS Brachytherapy LCD,

5. The urologist who collaborates with the radiation oncologist to place needle/applicators for brachytherapy may bill his/her portion of the procedure with the appropriate surgical codes (55860, 55862 or 55865: 55875) The urologist should not report their services with the brachytherapy codes.

6. The gynecologist who collaborates with the radiation oncologist to place needle/applicators for brachytherapy may bill his/her portion of the procedure with the appropriate surgical codes (*55920). The gynecologist should not report their services with the brachytherapy codes.

7. The pulmonologist who collaborates with the radiation oncologist to place needle/applicators for brachytherapy may bill his/her portion of the procedure with the endoscopy code 31643. The pulmonologist should not report their services with the brachytherapy codes.
## Placement Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>19296</td>
<td>Placement of radiotherapy after loading balloon catheter into the breast for interstitial radioelement application following partial mastectomy, includes image guidance; on date separate from partial mastectomy</td>
</tr>
<tr>
<td>19297</td>
<td>concurrent with partial mastectomy</td>
</tr>
<tr>
<td>19298</td>
<td>Placement of radiotherapy after loading brachytherapy catheters (multiple tube &amp; button type) into the breast for interstitial radioelement application following (at the time of or subsequent to) partial mastectomy, includes image guidance</td>
</tr>
<tr>
<td>20555</td>
<td>Placement of needles or catheters into muscle &amp;/or soft tissue for subsequent interstitial radioelement application (at the time of or subsequent to the procedure)</td>
</tr>
<tr>
<td>31643</td>
<td>Bronchoscopy with placement of catheter(s) for intracavitary radioelement application</td>
</tr>
<tr>
<td>41019</td>
<td>Placement of needles, catheters, or other device(s) into the head and/or neck region (percutaneous, transoral, or transnasal) for subsequent interstitial radioelement application</td>
</tr>
<tr>
<td>43241</td>
<td>Endoscopy with transendoscopic intraluminal tube or catheter placement</td>
</tr>
</tbody>
</table>
### Placement Codes Cont.

<table>
<thead>
<tr>
<th>Code</th>
<th>Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>55875</td>
<td>Transperineal placement of needles or catheters into prostate for interstitial radioelement application, with or without cystoscopy</td>
</tr>
<tr>
<td>55920</td>
<td>Placement of needles or catheters into pelvic organs &amp;/or genitalia (except prostate) for subsequent interstitial radioelement application</td>
</tr>
<tr>
<td>57155</td>
<td>Insertion of uterine tandem and/or ovoids for clinical brachytherapy</td>
</tr>
<tr>
<td>57156</td>
<td>Insertion of a vaginal radiation afterloading apparatus for clinical brachytherapy</td>
</tr>
<tr>
<td>58346</td>
<td>Insertion of Heyman capsules for clinical brachytherapy</td>
</tr>
<tr>
<td>C9725</td>
<td>Placement of endorectal Intracavitary application for high intensity brachytherapy</td>
</tr>
<tr>
<td>0190T</td>
<td>Placement of intraocular source</td>
</tr>
</tbody>
</table>
“The process of measuring the anatomy and placing marks on the skin or immobilization device to help the team direct the radiation safely and exactly to the intended location is called "simulation." For example, in code 77290, brachytherapy simulation is the complex process of making position adjustments and for performing dose calculations (code 77290). Nonradioactive "dummy" sources are used to geographically define the "eventual position" of the radioactive sources in temporary implant devices. Code 77280 is used to report the simple simulation for subsequent "check" verification simulations during the course of radiotherapy with temporary implants to confirm or correct applicator position.”
9. Partial breast high dose rate brachytherapy may be performed two times a day. The first therapeutic radiology simulation for the course of therapy may be complex and reported as CPT code 77290. However, subsequent simulations during the course of therapy should be reported as CPT code 77280.
2015 Changes

- 77326, 77327 and 77328 will be deleted January 1, 2015
- New codes include:
  - 77316 Brachytherapy isodose plan; simple (calculation[s] made from 1 to 4 sources, or remote afterloading brachytherapy, 1 channel), includes basic dosimetry calculation(s)
  - 77317 intermediate (calculation[s] made from 5 to 10 sources, or remote afterloading brachytherapy, 2-12 channels), includes basic dosimetry calculation(s)
  - 77318 complex (calculation[s] made from over 10 sources, or remote afterloading brachytherapy, over 12 channels), includes basic dosimetry calculation(s)
2015 Brachytherapy Isodose Planning Changes Summary

• 2014 isodose planning codes deleted
• 3 new codes created
  – Include calculations
• Codes to be used for HOPPS and MPFS
  – No G-codes for MPFS created

<table>
<thead>
<tr>
<th>2014 CPT®</th>
<th>2015 HOPPS</th>
<th>2015 MPFS</th>
</tr>
</thead>
<tbody>
<tr>
<td>77326</td>
<td>77316</td>
<td>77316</td>
</tr>
<tr>
<td>77327</td>
<td>77317</td>
<td>77317</td>
</tr>
<tr>
<td>77328</td>
<td>77318</td>
<td>77318</td>
</tr>
</tbody>
</table>
## Treatment Delivery (LDR)

### Intracavitary
- **77761** Intracavitary simple; 1-4 sources
- **77762** Intracavitary intermediate; 5-10 sources
- **77763** Intracavitary complex; >10 sources

### Interstitial
- **77776** Interstitial simple; 1-4 sources
- **77777** Interstitial intermediate; 5-10 sources
- **77778** Interstitial complex; >10 sources
Handling & Loading

- **77790** Supervision, handling, loading of radiation source

Utilization Guidelines:
- LDR only
- No APC for this CPT® code but previously utilized for tracking purposes.
- Documentation of this services is typically found in the “Procedure Note” or “Operative Note”

NCCI edit implemented on Oct 1, 2014 with all LDR treatment delivery codes
Treatment Delivery (HDR)

- **77785** Remote afterloading high dose rate radionuclide brachytherapy; **1 channel**
- **77786** Remote afterloading high dose rate radionuclide brachytherapy; **2-12 channels**
- **77787** Remote afterloading high dose rate radionuclide brachytherapy; **over 12 channels**

Electronic HDR

- **0182T** High dose rate electronic brachytherapy, per fraction
  - No professional fees established
  - Do not report with other brachytherapy treatment delivery codes
<table>
<thead>
<tr>
<th>Code</th>
<th>Brachytherapy Source (or Radiopharmaceutical)</th>
</tr>
</thead>
<tbody>
<tr>
<td>C1716</td>
<td>Gold 198, per source</td>
</tr>
<tr>
<td>C1717</td>
<td>High dose rate iridium 192, per source</td>
</tr>
<tr>
<td>C1719</td>
<td>Non-high dose rate iridium 192, per source</td>
</tr>
<tr>
<td>C2616</td>
<td>Non-stranded, Yttrium-90, per source</td>
</tr>
<tr>
<td>C2634</td>
<td>Non-stranded, high activity, Iodine 125, &gt;1.01 mCi, per source</td>
</tr>
<tr>
<td>C2635</td>
<td>Non-stranded, high activity, Palladium-103, &gt;2.2 mCi, per source</td>
</tr>
<tr>
<td>C2636</td>
<td>Linear source, non-stranded, Palladium-103, per 1mm</td>
</tr>
<tr>
<td>C2637</td>
<td>Non-stranded, Ytterbium-169, per source</td>
</tr>
<tr>
<td>C2638</td>
<td>Stranded, Iodine-125, per source</td>
</tr>
<tr>
<td>C2639</td>
<td>Non-stranded, Iodine-125, per source</td>
</tr>
<tr>
<td>C2640</td>
<td>Stranded, Palladium-103, per source</td>
</tr>
<tr>
<td>C2641</td>
<td>Non-stranded, Palladium-103, per source</td>
</tr>
<tr>
<td>C2642</td>
<td>Stranded, Cesium-131, per source</td>
</tr>
<tr>
<td>C2643</td>
<td>Non-stranded, Cesium-131, per source</td>
</tr>
<tr>
<td>C2644</td>
<td>Brachytherapy source, Cesium-131 chloride solution, per millicurie</td>
</tr>
<tr>
<td>C2698</td>
<td>Brachytherapy source, stranded, not otherwise specified, per source</td>
</tr>
<tr>
<td>C2699</td>
<td>Brachytherapy src, non-stranded, not otherwise specified, per src</td>
</tr>
</tbody>
</table>
More Brachytherapy & Misc.

<table>
<thead>
<tr>
<th>Code</th>
<th>Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>C1715</td>
<td>Brachytherapy needle</td>
</tr>
<tr>
<td>C1728</td>
<td>Catheter, brachytherapy seed administration</td>
</tr>
<tr>
<td>Q3001</td>
<td>Radioelement for brachytherapy; any type, each</td>
</tr>
<tr>
<td>19499</td>
<td>Unlisted procedure, breast</td>
</tr>
<tr>
<td>53899</td>
<td>Unlisted procedure, urinary system</td>
</tr>
<tr>
<td>55899</td>
<td>Unlisted procedure, male genital system</td>
</tr>
<tr>
<td>58999</td>
<td>Unlisted procedure, female genital system (non-obstetrical)</td>
</tr>
<tr>
<td>77799</td>
<td>Unlisted procedure, clinical brachytherapy</td>
</tr>
</tbody>
</table>
Prostate Seed Implant (PSI) Sample Process

Orders, Medical Necessity & Preplanning

- Physician Clinical Plan
- Special Treatment Procedure
- Volume Study
- Pubic Arch
- Dosimetry Plan
- Seed Assay

Implant

- US imaging
- Device
- Needle Insertion
- Treatment Delivery
- Verification Simulation
- Sources & Needles

Post Planning

- CT Guidance
- Dosimetry Plan

Other possible charges include:
- Special Physics Consult
Breast HDR Sample Process

Orders & Medical Necessity
- Physician Clinical Plan
- Special Treatment Procedure

Simulation & Planning
- Insertion of guide wire
- Imaging
- Dosimetry

AM Fraction(s)
- Simulation & Imaging
- Source Activity
- Treatment Delivery
- Source

PM Fraction(s)
- Simulation & Imaging
- Source Activity
- Treatment Delivery
- Source

Other possible charges include:
- Special Physics Consult

Note: the source activity i.e. calculation of time prior to each fraction is only billable if the work is performed and documented.
Sample Coding

Typical Coding:

- **77261** Physician’s Clinical Treatment Plan
- **77300** Basic Dosimetry Calculation
- **77750** Infusion of radioelement solution
  (or **79101** – Radiopharmaceutical Therapy)
- **Source** Billed per type of radiopharmaceutical and dose
Microsphere Therapy Process
Yttrium-90 Example

Orders & Medical Necessity
- Physician Clinical Plan
- Includes meeting w/Interventional Radiologist on patient selection and scheduling
- Provide written directive
- CPT® 77263

Treatment Volumes & Dosimetry
- Determine volumes
- Contouring using TPS
- Calculation
- CPT® 77399 & 77300 x 1

Administration of Microsphere Therapy
- Radiopharmaceutical therapy, by intra-arterial particulate administration
- Handling & Loading
- Radioactive Source
- CPT® 79445 & C2616 x 1

Other possible codes:
Special Physics Consult CPT® 77370

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Question #1

• Documentation may occur whenever the staff gets around to it as long as it is done before the patient completes treatment?

A. False, it needs to occur when performed same day
B. True, the patient can be interviewed for accuracy
Question #2

- G codes are not real codes and not utilized for payers, they are just a place holder.

A. False, Radiation Oncology has numerous new codes going into effect Jan 1st 2015. They should be cross walked appropriately from existing codes.

B. True, new codes will be assigned Jan 1st, 2015 in place of the G codes

C. There are new 77XXX codes that are in effect for 2015
Question #3

- Hospitals and Physicians have the same payment rates?
  A. Yes, the codes are the same for hospitals and physicians so the rates are the same also
  B. The codes are generally the same as well as the rules but there are some differences and payment differs as well
  C. The technical for both are identical for payment in Hawaii
Question #4

Simulations are medically necessary to set up and verify a patient, therefore it does not matter as to the complexity or number done on a day as long as supporting documentation is present to support they were medically necessary, were actually performed and approved in the medical record and will be paid?

A. Correct as stated
B. Depends on payor policy
Question #5

• Supervision can be performed by anyone the physician says is qualified in their absence?
• A. False specific criteria must be satisfied in order to submit claims in the supervisor’s name
• B. True as the physician absorbs all liability for their patient
Question #6

- Approvals only require initials and date from the physician?

A. Correct, this has been the case for years

B. No longer correct and the physician must provide first initial and last name along with date whether electronic or paper.

C. No longer correct and the physician must provide first initial and last name along with date whether electronic or paper as well as time.