This guide is designed to assist with the coding and documentation requirements necessary to report Radiation Oncology services to insurance payers for reimbursement.
# TABLE OF CONTENTS

| DISCLAIMER | MEDICARE PHYSICIAN FEE SCHEDULE (MPFS) OVERVIEW | HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM (HOPPS) OVERVIEW | MEDICARE PROGRAM OVERVIEW | MEDICARE AS A SECONDARY PAYER | PAYMENT EDITS AND OVERSIGHT | PHYSICIAN BONUSES PER CMS.GOV | RECOVERY AUDIT CONTRACTOR (RAC) PROGRAM | CLINICAL SETTING | MEDICARE MEDICAL RECORD REQUIREMENTS | EVALUATION AND MANAGEMENT VISITS (PROFESSIONAL) | CLINICAL TREATMENT PLANNING (PROFESSIONAL ONLY) | SET-UP SIMULATION, IMMOBILIZATION AND IMAGE ACQUISITION | DOSIMETRY (PROFESSIONAL AND TECHNICAL) | IMAGE-GUIDED RADIATION THERAPY (IGRT) (PROFESSIONAL AND TECHNICAL) | EXTERNAL BEAM TREATMENT DELIVERY (TECHNICAL) | THERAPEUTIC PORT IMAGE(S) (TECHNICAL) | PHYSICS (TECHNICAL) | PHYSICIAN MANAGEMENT (PROFESSIONAL) | STEREOTACTIC RADIOSURGERY (SRS)/STEREOTACTIC BODY RADIATION THERAPY (SBRT) | BRACHYTHERAPY | PROTON THERAPY | HYPEROTHERMIA | REFERENCES/RESOURCES FOR CPT SECTIONS | CONTRIBUTING AUTHORS/EDITORS |
|-------------|-------------------------------------------------|-------------------------------------------------|-----------------------------|-----------------------------|-----------------------------|----------------------------------|----------------------------------|-----------------------------|----------------------------------|----------------------------------|----------------------------------|----------------------------------|-----------------------------|----------------------------------|----------------------------------|----------------------------------|----------------------------------|----------------------------------|-----------------------------|----------------------------------|----------------------------------|----------------------------------|----------------------------------|
| DISCLAIMER | MEDICARE PHYSICIAN FEE SCHEDULE (MPFS) OVERVIEW | HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM (HOPPS) OVERVIEW | MEDICARE PROGRAM OVERVIEW | MEDICARE AS A SECONDARY PAYER | PAYMENT EDITS AND OVERSIGHT | PHYSICIAN BONUSES PER CMS.GOV | RECOVERY AUDIT CONTRACTOR (RAC) PROGRAM | CLINICAL SETTING | MEDICARE MEDICAL RECORD REQUIREMENTS | EVALUATION AND MANAGEMENT VISITS (PROFESSIONAL) | CLINICAL TREATMENT PLANNING (PROFESSIONAL ONLY) | SET-UP SIMULATION, IMMOBILIZATION AND IMAGE ACQUISITION | DOSIMETRY (PROFESSIONAL AND TECHNICAL) | IMAGE-GUIDED RADIATION THERAPY (IGRT) (PROFESSIONAL AND TECHNICAL) | EXTERNAL BEAM TREATMENT DELIVERY (TECHNICAL) | THERAPEUTIC PORT IMAGE(S) (TECHNICAL) | PHYSICS (TECHNICAL) | PHYSICIAN MANAGEMENT (PROFESSIONAL) | STEREOTACTIC RADIOSURGERY (SRS)/STEREOTACTIC BODY RADIATION THERAPY (SBRT) | BRACHYTHERAPY | PROTON THERAPY | HYPEROTHERMIA | REFERENCES/RESOURCES FOR CPT SECTIONS | CONTRIBUTING AUTHORS/EDITORS | 1 | 2 | 177 | 39 | 433 | 466 | 522 | 544 | 577 | 59 | 611 | 677 | 755 | 78 | 82 | 97 | 1044 | 1077 | 1088 | 1111 | 1133 | 118 | 1333 | 1355 | 1388 | 1388 |
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Medicare Physician Fee Schedule (MPFS) Overview

MPFS Final Rule Summary

The CY 2017 may be located in its entirety by following the link below:

This document in PDF form is 1,401 pages in length. The format of the information on the following pages is intended to summarize information contained within the final rules pertaining to radiation oncology services. The information contains historic reference items, proposed information, comments received regarding proposed changes and finally, the final ruling as determined by CMS. The finalized changes are effective January 1, 2017. The format of the information on the following pages is intended to serve as highlights, and readers are encouraged to view the document in its entirety for further details.

CY 2017 MPFS Final Rule Highlights

Highlights of the Final Rule are provided below.

- Payment Rates
  - Conversion Factor (CF) is still applicable and changing for CY 2017 = $35.8887
    - CY 2016 CF = $35.8043 + 0.5% per MACRA; the following adjustments are then applied to this value to come up with the final CY 2017 CF:
      - CY 2017 RVU Budget Neutrality Adjustment = -0.013%.
      - CY 2017 Target Recapture Amount = 0.18%.
      - CY 2017 Imaging MPPR Adjustment = -0.07%.

- Estimated Impact on Total Allowed Charges by Specialty
  - Radiation Oncology = 0%.
  - Radiation Therapy Centers = 0%.

- Geographic Cost Practice Indices (GPCI)
  - Extension of 1.0 Work GPCI floor value per MACRA for services furnished through December 31, 2017.
  - The 1.5 work GPCI floor for Alaska and 1.0 PE (Practice Expense) GPCI floor for frontier states are permanent, applied in CY 2017 as well.
  - Fee schedule for areas in California are required to be Metropolitan Statistical Areas (MSAs) as defined by the Office of Management and Budget (OMB) effective in CY 2017.
    - Increased from 9 localities to 32.
Valuation of Radiation Oncology Codes

- Radiation Treatment Delivery Practice Expense RVUs (G6011)
  - A 10% decrease in Non-Facility PE RVUs code G6011, per PAMA (Patient Access and Medicare Protection Act) G-codes used for treatment and imaging associated “definitions, inputs, and values” must be maintained for CY 2017 and CY 2018.
  - Change due to significant change in specialty reporting the HCPCS code
  - Claims data used to set CY 2016 PE RVUs, dermatology furnished 51% of the services and radiation oncology only 43%.
  - Most recent claims reflect a dramatic change, dermatology 6% and radiation oncology 85%.
  - This swing in claims data impacts the PE RVUs, a specialty with a lower percentage of indirect PE results in fewer indirect PE RVUs being allocated so there is a lower overall PE RVU for the code even though the direct PE inputs have remained the same.
  - Very uncommon unless a code is found to have very low utilization.
  - Normally the code would be revalued under the misvalued codes initiative; per PAMA this cannot happen, but it will be considered in the future (after CY 2019).

- Radiation Treatment Devices (CPT® codes 77332, 77333 and 77334)
  - Identified through the high expenditures specialty screen.
  - Code 77332 was proposed to be changed significantly due to the time assigned under Work RVU.
  - Finalized the RVU proposed, Intra time assigned at 15 mins, 18 mins to total time for a Work RVU of 0.45.
  - Due to hierarchy of the codes 77332, 77333 and 77334 Work RVUs for all three were reduced.

- Special Radiation Treatment (CPT code 77470)
  - Identified through the high expenditures specialty screen.
  - Proposed the RUC recommended Work RVU of 2.03 and finalized as proposed.
  - CMS continues to have serious concerns regarding code 77470.

- Interstitial Radiation Source Codes (CPT codes 77778 and 77790)
  - Work RVU for code 77790 set at “0” and bundled into brachytherapy code 77778, complex interstitial treatment.
  - Work RVU in CY 2016 for 77778 was not increased to include work of 77790.
• Time values are drastically different from the RUC vs. specialty society; CMS cannot understand how the very different values were arrived at or why they are so different.

• Finalized for CY 2017 Work RVU of 8.78 for code 77778, an increase from CY 2016.

Moderate Sedation New CPT codes for CY 2017

- The AMA created several new moderate sedation codes effective for CY 2017.
- Comments received from specialty societies representing radiation oncology and brachytherapy.
- New codes are based upon the age of the patient and whether or not the physician performing the primary service also administered the sedation.
- Work RVUs for following moderate sedation codes:
  - Work RVU of 0.50 for CPT code 99151;
  - Work RVU of 0.25 for CPT code 99152;
  - Work RVU of 1.90 for CPT code 99155;
  - Work RVU of 1.65 for CPT code 99156 and
  - Work RVU of 1.25 for CPT code 99157.
- For procedures that currently include moderate sedation as an inherent part of the procedure, CMS finalized a 0.25 work RVU reduction from the current values, excluding code G0500.

- Valuations for Services Minus Moderate Sedation
  - 19298 Work RVU 5.75
  - 57155 Work RVU 5.15
  - 43253 work RVU 4.73
  - 49411 work RVU 3.57
  - 31626 work RVU 3.91
  - 32553 work RVU 3.55

Provider-Based Departments

- Finalized to pay for physician services provided in an off-campus provider based department under facility rates; had proposed to reimburse under the non-facility rates.

Recoupment or Offset of Payments to Providers Sharing the Same Taxpayer Identification Number

- CMS is authorized to recoup overpayments from the shared TIN when attempts to recoup from specific NPI are unsuccessful.
- Will allow for collection to take place more quickly and reduce additional interest assessment.
• Medicare Advantage Provider Enrollment
  o CY 2017 Final Rule requires providers and suppliers must be enrolled in Medicare in “approved status” in order to render services to beneficiaries in Medicare Advantage program.
  o Includes the following plans which must be enrolled: MA-PD plans, FDRs, PACE, Cost HMOs or CMPs, demonstration programs, pilot programs, locum tenens suppliers and incident-to-suppliers.
  o An “approved status” is a status whereby a provider or supplier is enrolled in, and is not revoked from, the Medicare program.

• Physician Self-Referral Law: Annual Update to the List of CPT/HCPCS Codes
  o A physician cannot refer a Medicare beneficiary for certain designated health services (DHS) to an entity with which the physician (or a member of the physician’s immediate family) has a financial relationship, unless an exception applies.
  o Radiation therapy services and supplies continue to be one of the DHS’s under the Physician Self-Referral Law.
  o No new radiation therapy services and supplies were added to the list for CY 2017, but two codes were deleted:
    ▪ 0019T, extracorporeal shockwave and A9545
    ▪ I-131 tositumomab

• Re-proposal of Limitation on the Types of Per-unit of Service Compensation Formulas for Determining Office Space and Equipment Rental Charges
  o CMS finalized “without modification a requirement that rental charges for the lease of office space or equipment are not determined using a formula based on per-unit of service rental charges, to the extent that such charges reflect services provided to patients referred by the lessor to the lessee.”
  o This does not mean an absolute prohibition per-unit service rental charges are permissible.
  o Per MPFS Final Rule for CY 2017, “per-unit of service rental charges for the rental of office space or equipment are permissible, but only in those instances where the referral for the service to be provided in the rented office space or using the rented equipment did not come from the lessor.”
  o CMS continues to believe that leasing space per unit or “click” is inappropriate due to program or patient abuse when the referred by the lessor to the lessee of the office space or equipment.

To expand on the highlighted list of items above, a more in-depth summary of these areas is provided on the subsequent pages.
Conversion Factor and Payment Rates for MPFS in CY 2017

For CY 2017 the value of the conversion factor (CF) will still have a direct impact on the reimbursement under MPFS. As outlined in the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) for years 2016, 2017, 2018 and 2019 the CF is set to raise 0.5% each year from the previous year’s set value. Using the value for CY 2016 of $35.8043, 0.5% was added to this; however, to maintain the budget neutrality of no more than $20 million in either direction, CMS had to apply several factors.

To maintain the necessary budget parameters a budget neutrality factor of 0.013 was subtracted from the conversion factor. When adjustments are made to fee schedules due to misvalued codes, then CMS must account for the additional reimbursement that is being paid and still maintain budget. The Protecting Access to Medicare Act of 2014 (PAMA) included a paragraph in the ACT which requires CMS “to establish an annual target for reductions in PFS expenditures resulting from adjustments to relative values of misvalued codes.” If the estimated net reduction in expenditures for the year is equal to or greater than the target for the year, then any reduced expenditures attributed to these adjustments will be redistributed in a budget-neutral manner within MPFS and in accordance with the current budget neutrality requirements. The Target Recapture Amount was created to accomplish this. Due to adjustments set for CY 2017, the Target Recapture Amount of 0.18 is also subtracted from the conversion factor.

Finally, the Imaging Multiple Procedure Payment Reduction (MPPR) Adjustment subtracts 0.07 from the conversion factor. In January 2012, the MPPR was implemented, which applied a 25% reduction on the professional component of advanced imaging services when multiple imaging procedures are performed by the same physician on the same patient in the same session and on the same day. In December of 2015, the Consolidation Appropriations Act added a section, which revised the payment reduction from 25% to 5%, effective January 1, 2017. This section exempts the reduced expenditures attributable to the revised 5% MPPR from the PFS budget neutrality provision. In order to implement the change from the 25% discount in 2016 to the 5% discount in 2017 within PFS budget neutrality, CMS measured the difference in total RVUs for the relevant services. This assumes an MPPR of 25% and the total RVUs for the same services without an MPPR and then applied that difference as an adjustment to the conversion factor to account for the increased expenditures attributable to the change, within PFS budget neutrality. CMS proposed this adjustment would be 0%, but other factors were proposed to be higher and in finalizing the adjustments a factor was needed.

To account for all of the changes an adjustment has been applied to again maintain budget neutrality. Applying these adjustments results in a final conversion factor of $35.8887 for CY 2017; this is reflected in the table below from CMS.
Estimated Impact on Total Allowed Charges by Specialty

With a finalized increase to the conversion factor in CY 2017 and RVU adjustments for radiation oncology services not too significant one way or the other, the overall impact to the specialty is set as 0%.

**TABLE 52: CY 2017 PFS Estimated Impact on Total Allowed Charges by Specialty**

<table>
<thead>
<tr>
<th>Specialty</th>
<th>(B) Allowed Charges (mil)</th>
<th>(C) Impact of Work RVU Changes</th>
<th>(D) Impact of PE RVU Changes</th>
<th>(E) Impact of MP RVU Changes</th>
<th>(F) Combined Impact**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Radiation Oncology</td>
<td>$1,726</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Radiation Therapy Centers</td>
<td>$44</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
</tbody>
</table>

** Column F may not equal the sum of columns C, D and E due to rounding.

Reimbursement

Using the finalized payment information, the following table reflects overall revenues for common courses to provide a snapshot of the reimbursement changes for CY 2017. The payment amounts are based upon the published National Average Medicare allowable for the Current Procedural Terminology (CPT®) codes. The primary reason for the negative adjustments is due to the RVUs for particular codes lowered from last year. The changes are explained in further detail later in this summary.

**TABLE 52: CY 2017 PFS Estimated Impact on Total Allowed Charges by Specialty**

<table>
<thead>
<tr>
<th>Type</th>
<th>2016 Course Collections</th>
<th>2017 Course Collections</th>
<th>2016 - 2017 Variance</th>
<th>Global</th>
<th>GLOBAL % Change</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2016 Global - CF = $35.8043</td>
<td>2016 Global - CF = $35.8887</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2D 10 fxs</td>
<td>$5,099.61</td>
<td>$5,068.92</td>
<td>-$30.69</td>
<td>-1%</td>
<td></td>
</tr>
<tr>
<td>3D w/IGRT 33 fxs</td>
<td>$17,266.62</td>
<td>$17,284.00</td>
<td>$17.37</td>
<td>0%</td>
<td></td>
</tr>
<tr>
<td>3D - w/out IGRT 33 fxs</td>
<td>$13,663.64</td>
<td>$13,640.94</td>
<td>-$22.70</td>
<td>0%</td>
<td></td>
</tr>
<tr>
<td>IMRT 44 fxs</td>
<td>$24,912.99</td>
<td>$25,095.53</td>
<td>$182.54</td>
<td>1%</td>
<td></td>
</tr>
<tr>
<td>IMRT 30 Fxs</td>
<td>$19,489.35</td>
<td>$19,614.25</td>
<td>$124.90</td>
<td>1%</td>
<td></td>
</tr>
<tr>
<td>SRS - Linac</td>
<td>$5,743.01</td>
<td>$5,506.76</td>
<td>-$236.25</td>
<td>-4%</td>
<td></td>
</tr>
<tr>
<td>SBRT Linac 5 Fractions</td>
<td>$12,079.65</td>
<td>$11,907.15</td>
<td>-$172.50</td>
<td>-1%</td>
<td></td>
</tr>
<tr>
<td>APBI Single Cath</td>
<td>$7,214.92</td>
<td>$7,260.64</td>
<td>$45.72</td>
<td>1%</td>
<td></td>
</tr>
<tr>
<td>APBI Multi-Cath</td>
<td>$10,065.30</td>
<td>$10,136.05</td>
<td>$70.74</td>
<td>1%</td>
<td></td>
</tr>
</tbody>
</table>
The Geographic Practice Cost Index Relative Value Units (GPCI RVUs) are applied to the reimbursement equation in order to adjust for the geographic location of the provider and variation in the costs of furnishing services in the particular location. There are three GPCIs (Work, PE [Practice Expense] and MP [Malpractice]) that are applied to the equation to determine how much each code is reimbursed. These RVUs are required to be reviewed and, if necessary, adjusted every three years. Each GPCI is calculated relative to a national average, but each one will have its own data source and methodology to calculate the value.

As part of MACRA the work GPCI floor of 1.0 was extended through December 31, 2017. In addition, for CY 2017 CMS is continuing to apply the 1.0 PE GPCI to the frontier states. The frontier states are Montana, Wyoming, North Dakota, South Dakota and Nevada and are defined as such due to the population in which at least 50% of the counties are considered as frontier and the population per square mile is less than six.

Another one of the components outlined in PAMA was the required modification of the fee schedule payment localities in California effective January 1, 2017. CMS does not propose changes to the physician fee schedule (PFS) locality structure without a statutory requirement, as was required with PAMA. CMS indicated it has been the practice to not adjust localities without the support of state medical association(s) and agreement on the changes due to the impacts the changes could have across varied medical specialties.

In California, the current localities are based on the revised locality structure implemented in 1997. Effective for CY 2017 the localities are required to be Metropolitan Statistical Areas (MSAs) as defined by the Office of Management and Budget (OMB) as of December 31 of the previous year. Based on this, the 9 current localities for California would expand to 27 and financially adjusted over six years due to the impact. This means for CY 2017 a county that is currently designated as “rest-of-state” and is now in an MSA, 1/6 of the GPCI will be weighted with the new locality values and the other 5/6 will use the current locality values. As each year passes the weight will adjust 1/6 until for CY 2022, when the weighted value is based entirely on the MSA locality. This incremental phase-in will apply only to the counties in transition areas that are now in MSAs.

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Work RVU 2017</th>
<th>PE RVU 2017</th>
<th>Malpractice RVU 2017</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prostate - HDR</td>
<td>$7,212.06</td>
<td>$7,239.11</td>
<td>$27.05</td>
<td>0%</td>
</tr>
<tr>
<td>Prostate - LDR</td>
<td>$3,157.94</td>
<td>$3,209.17</td>
<td>$51.23</td>
<td>2%</td>
</tr>
<tr>
<td>GYN T&amp;O - HDR</td>
<td>$5,309.42</td>
<td>$5,128.14</td>
<td>-$181.28</td>
<td>-3%</td>
</tr>
<tr>
<td>GYN Cylindr 1 Chan HDR</td>
<td>$3,535.32</td>
<td>$3,550.11</td>
<td>$14.79</td>
<td>0%</td>
</tr>
<tr>
<td>GYN Multi Chan HDR</td>
<td>$4,430.78</td>
<td>$4,453.43</td>
<td>$22.65</td>
<td>1%</td>
</tr>
</tbody>
</table>

**Geographic Cost Practice Indices (GPCI)**

The Geographic Practice Cost Index Relative Value Units (GPCI RVUs) are applied to the reimbursement equation in order to adjust for the geographic location of the provider and variation in the costs of furnishing services in the particular location. There are three GPCIs (Work, PE [Practice Expense] and MP [Malpractice]) that are applied to the equation to determine how much each code is reimbursed. These RVUs are required to be reviewed and, if necessary, adjusted every three years. Each GPCI is calculated relative to a national average, but each one will have its own data source and methodology to calculate the value.

As part of MACRA the work GPCI floor of 1.0 was extended through December 31, 2017. In addition, for CY 2017 CMS is continuing to apply the 1.0 PE GPCI to the frontier states. The frontier states are Montana, Wyoming, North Dakota, South Dakota and Nevada and are defined as such due to the population in which at least 50% of the counties are considered as frontier and the population per square mile is less than six.

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In California, the current localities are based on the revised locality structure implemented in 1997. Effective for CY 2017 the localities are required to be Metropolitan Statistical Areas (MSAs) as defined by the Office of Management and Budget (OMB) as of December 31 of the previous year. Based on this, the 9 current localities for California would expand to 27 and financially adjusted over six years due to the impact. This means for CY 2017 a county that is currently designated as “rest-of-state” and is now in an MSA, 1/6 of the GPCI will be weighted with the new locality values and the other 5/6 will use the current locality values. As each year passes the weight will adjust 1/6 until for CY 2022, when the weighted value is based entirely on the MSA locality. This incremental phase-in will apply only to the counties in transition areas that are now in MSAs.
Currently there are 58 counties in California and 50 of them are in transition. The eight counties not in transition will not be held harmless to any transition and may experience slight decreases in the assigned GPCI values from the current values. The eight counties that are not in transition areas are Alameda, Contra Costa, Los Angeles, Orange, San Francisco, San Mateo, Santa Clara and Ventura. So this means in CY 2017, these counties may see adjusted payment rates based on the new values without any phase-in to the changes.

CMS adjusted the final number of new localities from what was originally proposed. Due to the way MSAs include counties, one county in a locality could be in transition while another county listed in the same MSA is not, resulting in different GPCI values when calculated. To address this, CMS split the MSA into two different designations. The fee schedule area may be named the same, but there is a different locality number assigned and an increase in the total number of localities in CY 2017 from 27 to 32.

**Valuation of Radiation Oncology Codes**

On an annual basis the RUC (American Medical Association/Specialty Society Relative [Value] Update Committee) provides CMS with RVU (Relative Value Units) inputs for new, revised and potentially misvalued codes. CMS then reviews the recommendations presented by the RUC before the February 10 deadline for either acceptance or non-acceptance of the recommendations. Any recommendations received after the February 10 deadline are considered for the following year’s ruling. CMS also reviews claims data, medical literature, comparative databases, comparison to other codes, and discussion with physicians and other healthcare professionals before deciding whether to accept the RUC’s recommendations or establish different values. Based on recommendations by the RUC and other data received, the following codes relative to radiation oncology were adjusted for CY 2017.

** Radiation Treatment Delivery Practice Expense RVUs for Code G6011**

For CY 2017, comments were received regarding the 10% decrease in the non-facility practice expense (PE) RVUs for code G6011, complex treatment up to 5 MeV energy. Per PAMA, the G-codes implemented by CMS in CY 2015 and used for treatment and image guidance must maintain the assigned definitions, inputs and values for CY 2017 and CY 2018. Questions were raised as to why a decrease was applied when it is not allowed.

The new value is due to significant changes in the reporting of the code on claims data. Claims data reviewed to set the CY 2016 PE RVUs for code G6011 showed that 51% of the services were furnished by dermatology and 43% were furnished by radiation oncology. The most recent claims data, however, shows a dramatic shift in reporting with 85% furnished by radiation oncology and only about 6% by dermatology. The decrease in the PE RVU from CY 2016 to CY 2017 is due to the shift in specialty mix, and CMS indicated the changes were necessary and made with the limitations of PAMA in mind.
PE is calculated through two sets of values, direct and indirect. Direct PE is calculated by accounting for costs of clinical staff, medical supplies and equipment and indirect PE is calculated factoring in the other ancillary costs that may also have an impact on the resources for the service provided. Due to how the overall practice expense is calculated, a specialty with a lower percentage of indirect PE value results in fewer indirect PE RVUs being allocated. So a lower indirect PE value for a code will result in an overall lower PE RVU, even though the direct PE inputs have remained the same. To see a code change this much is typically due to very low utilization of the code and it would be revalued under the misvalued codes initiative. This is not allowed for code G6011 through CY 2018 per PAMA, but may need to be considered in the future.

**Radiation Treatment Devices (CPT codes 77332, 77333 and 77334)**

Utilizing the high expenditures specialty screen, codes 77332, 77333 and 77334 were identified as potentially misvalued. The RUC recommended no changes in the work RVUs for these three codes, but CMS believed the current RVUs overstated the work involved in furnishing the services. The RUC values did not reflect the degree by which the RUC concurrently recommended a decrease in the intra-service or total work time. Based on research by CMS, findings reflected code 77332 had a 34% decrease in total time assigned to the Work RVU.

CMS did not accept the RUC recommended value for code 77332 and instead finalized as proposed a Work RVU of 0.45, which is a decrease from the CY 2016 Work RVU of 0.54. In addition, CMS assigned an intra-time value of 15 minutes with an overall time of 18 minutes; current value in CY 2016 has 28 minutes of total time. Since code 77332 belongs to a hierarchy of codes which represent simple, intermediate and complex services, changes in values to one result in changes to all of them. Currently in CY 2016 the values for codes 77332 and 77334 are significantly higher than code 77333. The finalized values for codes 77332 and 77334 reflect a decrease in reimbursement of $15.23 and $21.17 respectively. Due to how low code 77333 was valued in CY 2016, it actually has a significant increase for CY 2017. The global rate for 77333 is increasing 83% ($44.63), the technical rate is increasing from $9.67 to $58.86 for a 508.8% increase, but the professional rate is decreasing from $44.04 to $39.48 for a 10.4% decrease.

**Special Treatment Procedure (CPT code 77470)**

Another code identified as potentially misvalued through the high expenditure screening tool was 77470, special treatment procedure. CMS had proposed to use the value recommended by the RUC, but believed the description of the code and vignette described different and unrelated treatments being performed by the physician and clinical staff for a typical patient. These differences create a disparity between the work RVUs and PE RVUs.
Ultimately CMS accepted the values as proposed by the RUC with a Work RVU of 2.03, which is a decrease from the current value of 2.09, resulting in a decrease in reimbursement of $11.11. Even though CMS accepted the RUCs values for this code there are serious concerns regarding how it is valued and how it is coded.

Complex Interstitial Brachytherapy (CPT codes 77778 and 77790)

In CY 2016, code 77778, complex interstitial treatment, was updated to reflect the addition of the supervision, handling and loading in the definition. In addition, CMS established an interim final value of no work RVU, consistent with the RUC’s recommendations, for code 77790. However, the work RVU for code 77778 was not adjusted to account for the work associated with code 77790 now part of the treatment code.

Through evaluation of the code and input, CMS found the time values indicated were drastically different between the RUC and specialty society. CMS did not refer code 77778 to the multispecialty refinement panel because no clinical information was received to evaluate after the CY 2017 proposed rule release. CMS could not understand the number of disparities in comments received from survey respondents. Many respondents felt the RUC had accurately estimated the Work RVU but had greatly overestimated the pre-service work time.

Several concerns were presented by CMS. First, how so many respondents who accepted the overestimated total time based on the RUC’s analysis could then accurately estimate the overall work of code 77778. Next, CMS was also concerned by statements attributed to the specialty society that the RUC does not consider the work of supervising the order of the isotope as part of the actual service, when the respondents to the survey clearly did. Per the data received, CMS stated that it appears there is no consensus between the RUC and the specialty society on which services are actually included in code 77778 vs. which services might be separate.

CMS did not finalize a change in the time associated with code 77778, but the recommended RVU values were accepted. The Work RVU will be 8.78 for CY 2017, an increase from 8.00 in CY 2016. The PE RVU is also slightly higher for an overall reimbursement increase of $47.44. The following table by CMS reflects the changes from proposed Work RVUs to finalized Work RVUs for the various codes discussed and pertinent to radiation oncology.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>77332</td>
<td>Treatment devices, design and</td>
<td>0.54</td>
<td>0.45</td>
<td>0.45</td>
<td>No</td>
</tr>
</tbody>
</table>
### Moderate Sedation New CPT codes for CY 2017

In CY 2015 CMS identified a trend in which it appeared endoscopic services were changing in that anesthesia was being provided separately from the endoscopic procedure itself. The resource costs for sedation were no longer incurred by the provider of the endoscopic procedure, but by another practitioner. Public comment was sought on how to address the approximately 400 diagnostic and therapeutic procedures in which moderate sedation is an inherent part of furnishing the service.

To assist with this, the CPT Editorial Committee created separate codes for reporting moderate sedation services. The new codes are based upon the age of the patient and whether or not the physician performing the primary service also administered the sedation.

The following are the new moderate sedation codes for CY 2017 with the assigned Work RVUs:

- Work RVU of 0.50 for CPT code 99151;
- Work RVU of 0.25 for CPT code 99152;

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>RVU 2015</th>
<th>RVU 2016</th>
<th>RVU 2017</th>
<th>Administered by</th>
</tr>
</thead>
<tbody>
<tr>
<td>77332</td>
<td>(Cont.) construction; simple (simple block, simple bolus)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>77333</td>
<td>Treatment devices, design and construction; intermediate (multiple blocks, stents, bite blocks, special bolus)</td>
<td>0.84</td>
<td>0.75</td>
<td>0.75</td>
<td>No</td>
</tr>
<tr>
<td>77334</td>
<td>Treatment devices, design and construction; complex (irregular blocks, special shields, compensators, wedges, molds or casts)</td>
<td>1.24</td>
<td>1.15</td>
<td>1.15</td>
<td>No</td>
</tr>
<tr>
<td>77470</td>
<td>Special treatment procedure (e.g., total body irradiation, hemibody radiation, per oral or endocavitary irradiation)</td>
<td>2.09</td>
<td>2.03</td>
<td>2.03</td>
<td>No</td>
</tr>
<tr>
<td>77778</td>
<td>Interstitial radiation source application, complex, includes supervision, handling, loading of radiation source, when performed</td>
<td>8.00</td>
<td>8.00</td>
<td>8.78</td>
<td>No</td>
</tr>
<tr>
<td>77790</td>
<td>Supervision, handling, loading of radiation source</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>No</td>
</tr>
</tbody>
</table>
• Work RVU of 1.90 for CPT code 99155;
• Work RVU of 1.65 for CPT code 99156 and
• Work RVU of 1.25 for CPT code 99157.

The following is a list of procedures applicable and part of radiation oncology which also include moderate sedation as an inherent part of the procedure. These codes are among many that will have a 0.25 Work RVU reduction in CY 2017 from the current values for CY 2016. The codes listed are primarily placement codes for applicators for brachytherapy treatment or fiducial marker placement. The values reflected show the 0.25 Work RVU reductions and reflect the CY 2017 value.

• CPT code 19298 Work RVU 5.75
• CPT code 31626 work RVU 3.91
• CPT code 32553 work RVU 3.55
• CPT code 43253 work RVU 4.73
• CPT code 49411 work RVU 3.57
• CPT code 57155 Work RVU 5.15

The following table outlines some of the financial impacts to codes per the adjustments in the RVUs as described above. The rates reflect Medicare National Average Rates for CY 2017 as compared to CY 2016.

<table>
<thead>
<tr>
<th>HCPCS</th>
<th>Mod</th>
<th>Description</th>
<th>2016 Final Payment Rate (CF$35.8043)</th>
<th>2017 Final Payment Rate (CF$35.8887)</th>
<th>Variance</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>77332</td>
<td></td>
<td>Radiation treatment aid(s)</td>
<td>$83.78</td>
<td>$68.55</td>
<td>$(15.23)</td>
<td>-18.2%</td>
</tr>
<tr>
<td>77332</td>
<td>TC</td>
<td>Radiation treatment aid(s)</td>
<td>$55.14</td>
<td>$44.50</td>
<td>$(10.64)</td>
<td>-19.3%</td>
</tr>
<tr>
<td>77332</td>
<td>26</td>
<td>Radiation treatment aid(s)</td>
<td>$28.64</td>
<td>$24.05</td>
<td>$(4.60)</td>
<td>-16.1%</td>
</tr>
<tr>
<td>77333</td>
<td></td>
<td>Radiation treatment aid(s)</td>
<td>$53.71</td>
<td>$98.34</td>
<td>$44.63</td>
<td>83.1%</td>
</tr>
<tr>
<td>77333</td>
<td>TC</td>
<td>Radiation treatment aid(s)</td>
<td>$9.67</td>
<td>$58.86</td>
<td>$49.19</td>
<td>508.8%</td>
</tr>
<tr>
<td>77333</td>
<td>26</td>
<td>Radiation treatment aid(s)</td>
<td>$44.04</td>
<td>$39.48</td>
<td>$(4.56)</td>
<td>-10.4%</td>
</tr>
<tr>
<td>77334</td>
<td></td>
<td>Radiation treatment aid(s)</td>
<td>$154.32</td>
<td>$133.15</td>
<td>$(21.17)</td>
<td>-13.7%</td>
</tr>
<tr>
<td>77334</td>
<td>TC</td>
<td>Radiation treatment aid(s)</td>
<td>$89.51</td>
<td>$72.50</td>
<td>$(17.02)</td>
<td>-19.0%</td>
</tr>
<tr>
<td>77334</td>
<td>26</td>
<td>Radiation treatment aid(s)</td>
<td>$64.81</td>
<td>$60.65</td>
<td>$(4.15)</td>
<td>-6.4%</td>
</tr>
<tr>
<td>77470</td>
<td></td>
<td>Special radiation treatment</td>
<td>$157.90</td>
<td>$146.78</td>
<td>$(11.11)</td>
<td>-7.0%</td>
</tr>
<tr>
<td>77470</td>
<td>TC</td>
<td>Special radiation treatment</td>
<td>$48.69</td>
<td>$39.48</td>
<td>$(9.22)</td>
<td>-18.9%</td>
</tr>
<tr>
<td>77470</td>
<td>26</td>
<td>Special radiation treatment</td>
<td>$109.20</td>
<td>$107.31</td>
<td>$(1.90)</td>
<td>-1.7%</td>
</tr>
<tr>
<td>Code</td>
<td>Service Description</td>
<td>Facility Rate</td>
<td>Provider Rate</td>
<td>Margin</td>
<td>Margin %</td>
<td></td>
</tr>
<tr>
<td>----------</td>
<td>---------------------------------------</td>
<td>----------------</td>
<td>----------------</td>
<td>---------</td>
<td>----------</td>
<td></td>
</tr>
<tr>
<td>77778</td>
<td>Apply interstit radiat compl</td>
<td>$789.13</td>
<td>$836.57</td>
<td>$47.44</td>
<td>6.0%</td>
<td></td>
</tr>
<tr>
<td>77778</td>
<td>TC Apply interstit radiat compl</td>
<td>$372.01</td>
<td>$375.04</td>
<td>$3.03</td>
<td>0.8%</td>
<td></td>
</tr>
<tr>
<td>77778</td>
<td>26 Apply interstit radiat compl</td>
<td>$417.12</td>
<td>$461.53</td>
<td>$44.41</td>
<td>10.6%</td>
<td></td>
</tr>
<tr>
<td>G6011</td>
<td>Radiation treatment delivery</td>
<td>$323.67</td>
<td>$292.85</td>
<td>($30.82)</td>
<td>-9.5%</td>
<td></td>
</tr>
<tr>
<td>19298</td>
<td>Place breast rad tube/caths</td>
<td>$1,069.83</td>
<td>$998.42</td>
<td>($71.41)</td>
<td>-6.7%</td>
<td></td>
</tr>
<tr>
<td>31626</td>
<td>Bronchoscopy w/markers</td>
<td>$926.97</td>
<td>$858.46</td>
<td>($68.52)</td>
<td>-7.4%</td>
<td></td>
</tr>
<tr>
<td>32553</td>
<td>Ins mark thor for rt perq</td>
<td>$603.30</td>
<td>$532.59</td>
<td>($70.71)</td>
<td>-11.7%</td>
<td></td>
</tr>
<tr>
<td>43253*</td>
<td>Egd US transmural injxn/mark</td>
<td>$281.78</td>
<td>$277.42</td>
<td>($4.36)</td>
<td>-1.5%</td>
<td></td>
</tr>
<tr>
<td>49411</td>
<td>Ins mark abd/pel for rt perq</td>
<td>$558.55</td>
<td>$491.68</td>
<td>($66.87)</td>
<td>-12.0%</td>
<td></td>
</tr>
<tr>
<td>57155</td>
<td>Insert uteri tandem/ovoids</td>
<td>$438.60</td>
<td>$372.52</td>
<td>($66.08)</td>
<td>-15.1%</td>
<td></td>
</tr>
</tbody>
</table>

*Code 43253 is listed as rarely, if ever, being performed in a freestanding facility or office setting, so CMS has no set values for it in this type of setting. The values listed reflect the facility-based reimbursement per CMS.

**Provider-Based Departments**

Within the CY 2017 Hospital Outpatient Prospective Payment System (HOPPS) Final Rule CMS spent a considerable amount of the ruling addressing changes for next year regarding provider-based departments (PBDs). From the hospital perspective a lot is changing as a result of the Bipartisan Budget Act of 2015, Section 603. Per the HOPPS ruling, PBDs will either be considered excepted or nonexcepted. From a billing and reimbursement perspective for the hospital, the changes are dramatic. For the physician working in either a PBD that is considered excepted or nonexcepted, the billing and reimbursement will still follow guidelines for facility-based.

CMS did not finalize the proposal that physicians would be reimbursed under non-facility rates for services in a nonexcepted off-campus PBD. Instead, for CY 2017 all PBDs, regardless of status, are still considered facilities and the physician billing for services will continue to bill on the CMS 1500 and report using the POS 19 for off-campus outpatient hospital. Reimbursement will follow the facility-based rate for the location of the center.

**Recoupment or Offset of Payments to Providers Sharing the Same Taxpayer Identification Number**

Historically, CMS used the National Provider Identifier (NPI) to recoup overpayments from Medicare providers and suppliers until these debts were paid in full or eligible for referral to the Department of Treasury for further collection action under the Debt Collection Improvement Act of 1996 and the Digital Accountability and Transparency Act of 2014. Once an overpayment is referred to the Treasury, the Treasury’s Debt Management Services uses various tools to collect the debt, including offset of federal payments against entities that share the same provider Taxpayer Identification Number (TIN).

Within the Affordable Care Act, an obligated provider of services that owes a past-due overpayment to the Medicare program can also affect other applicable providers sharing a TIN. Per statutes defined
within the ACT, applicable providers may also receive necessary adjustment to the payments to satisfy the amount due from the obligated provider. CMS provided the following example:

“For example, a health care system may own a number of hospital providers and these providers may share the same TIN while having different NPI or Medicare billing numbers. If one of the hospitals in this system receives a demand letter for a Medicare overpayment, then that hospital (Hospital A) will be considered the obligated provider while its sister hospitals (Hospitals B and C) will be considered the applicable providers. This authority allows us to recoup the overpayment of the obligated provider, Hospital A, against any or all of the applicable providers, Hospitals B and C, with which it, Hospital A, shares a TIN.”

CMS did propose and finalize changes to the Affordable Care Act statements, the first being that CMS can now collect overpayment debts directly or through MACs (Medicare Administrative Contractors) instead of referring to the Treasury Debt Management Services. This will save CMS money since they must pay a fee for each collection referred to Treasury Debt Management Services. Another change is that CMS was to submit a letter of recoupment to the provider that was overpaid as well as the TIN who will now be responsible for the payback. CMS is adjusting the language to include that a letter to both is not necessary. Information in the CY 2017 MPFS Final Rule as well as updates to the Medicare Financial Management Manual, plus language in the demand letters and releases through the Medicare Learning Network (MLN Matters), will all provide the necessary information regarding the recoupment of overpayments.

Prior to January 1, 2017 CMS will release information about the new process for recouping overpayments to Medicare providers about the implementation through Medicare Learning Network (MLN) or MLN Connects Provider eNews article(s).

**Medicare Advantage Provider Enrollment**

In a continued effort to prevent fraud, waste and abuse, CMS has finalized provisions regarding the providers of services and items through Medicare Advantage programs to Medicare enrollees. Any provider or supplier furnishing items or services to Medicare enrollees who receive benefits through a Medicare Advantage (MA) organization must be enrolled in Medicare and active with an “approved status”.

As outlined in the CY 2017 MPFS Final Rule, MA organization networks and other designated plans include MA-PD plans, FDRs, PACE, Cost HMOs or CMPs, demonstration programs, pilot programs, locum tenens suppliers and incident-to suppliers. Each of these plans will include the requirement that any provider or supplier to any enrollees in any of the previously mentioned plans must have an approved status under Medicare. This requirement aligns with other Medicare programs such as Part A, Part B and Part D. Medicare has not traditionally had direct oversight of providers and suppliers to MA
organizations. By ensuring that, as a minimum, anyone providing services to Medicare beneficiaries (traditional Medicare) or enrollees (MA organizations) CMS can ensure the providers are appropriate to provide services and supplies as well as receive reimbursement. In addition, if an organization or program does not ensure that providers and suppliers comply with the requirements, the organization or program may be subject to sanctions or termination by CMS.

The provisions outlined will be effective the first day of the next plan year that begins two years from the publication of the CY 2017 MPFS Final Rule. CMS indicated this should provide sufficient time to prepare for the requirements outlined in the final rule, as any change in requirements cannot be made mid-year to MA organizations.

**Physician Self-Referral Law Updates**

**Annual Update to the List of CPT/HCPCS Codes under the Physician Self-Referral Law**

The Physician Self-Referral Law is not new and the inclusion of radiation therapy services and supplies on the list of items which fall under it are also not new for CY 2017. Radiation therapy services and supplies have been a component of the physician self-referral law since it was enacted as part of the Omnibus Budget Reconciliation Act of 1989. Within the law are certain designated health services (DHS) that are prohibited from being referred for a Medicare beneficiary by a physician to another entity with which that physician has a financial relationship, unless an exception applies. In addition, the ACT prohibits the designated health services entity from, in turn, submitting claims to Medicare, billing the beneficiary or any other entity for Medicare-designated health services provided as a result of the prohibited referral.

The list of codes is updated annually as representative of recent CPT and HCPCS coding updates in publications. The list will also outline any services which may qualify for one of two exceptions to the physician self-referral prohibition. The codes that are prohibited are spread over the following four categories:

- Clinical Laboratory Services;
- Physical Therapy, Occupational Therapy and Outpatient Speech-Language Pathology Services;
- Radiology and certain other imaging services, and
- Radiation Therapy Services and supplies.

No new codes were added under the Radiation Therapy Services category for CY 2017; however, two were deleted. Codes 0019T, extracorporeal shockwave, and A9545, I-131 tositumomab, were both removed from the list effective January 1. 2017. The entire list, including those pertaining to radiation therapy can be found at

Office Space and Equipment Rental Charges

As outlined above, a physician cannot refer a Medicare beneficiary to another entity with which that physician has a financial relationship and that entity cannot bill Medicare (or another individual, entity or third party payer) or the beneficiary for the referred services. The Omnibus Budget Reconciliation Act of 1990 also clarifies definitions and reporting requirements relating to physician ownership and referrals. Finally, the Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2009 Rates released by CMS on August 19, 2008 included revisions to the physician self-referral regulations. This regulation included prohibition of certain per unit-of-service (“per-click”) and percentage-based compensation formulas for calculating rental charges for office space and equipment lease arrangements.

Due to concerns where per-click lease arrangements created incentive for referring physicians to over-utilize and over-refer services to a lessee through which they may or will receive revenue, CMS proposed changes for CY 2017. These changes included adjusting how rental charges for the leasing of office space or use of equipment are determined. CMS has finalized that the rental charges mentioned cannot be determined using a formula based on per-unit-of-service rental charges in which the services provided to patients are referred by the lessor to the lessee. This update to the final rule does not prohibit rental charges on units furnished; instead it limits setups where the “lessor generates the payment from the lessee through a referral to the lessee for a service to be provided in the rented office space or using the rented equipment.” The only way the arrangement is allowed is if the referral for the service provided in the rented office space or using the rented equipment was not by the lessor. Providers who may be involved in these types of lease agreements will need to review and determine how services currently being provided are actually referred to the lessee and who is billing the payers and/or receiving any of the reimbursements for the services provided.

Hospital Outpatient Prospective Payment System (HOPPS) Overview

HOPPS Final Rule Summary

The CY 2017 may be located in its entirety here:

This document in PDF form is 1,378 pages long. The format of the information on the following pages is intended to summarize information contained within the final rules pertaining to radiation oncology services. It is intended to serve as highlights, and readers are encouraged to view the document in its entirety for further details. The finalized changes are intended to be effective January 1, 2017.
The highlights of the Final Rule are provided below.

- **Payment Rates**
  - Increase to OPD fee schedule rates by 1.65%, based on the following:
    - 2.7% increase on projected hospital market basket.
    - -0.3% point adjustment for multi-factor productivity (MFP).
    - -0.75% adjustment required by law.
  - Conversion factor = $75.001 for nationally unadjusted.
    - $73.411 for hospitals failing to meet Hospital Outpatient Quality Reporting requirements.
- **Rural adjustment = 7.1% to the OPPS payments for certain rural sole community hospitals (SCHs).**
  - Excludes separately payable drugs and biologicals, devices paid under the pass-through payment policy and items paid at charges reduced to cost.
- **Cancer hospital payment adjustments = 0.91 target PCR (payment-to-cost ratio) used to determine the payment adjustment for the 11 designated cancer hospitals.**
- **Ambulatory Surgical Centers (ASCs) = 1.9% payment increase that meets quality reporting.**
- **Ambulatory Payment Classification (APC) Changes for 2017:**
  - SRS C-APC 5627 Level 7 Radiation Therapy will continue.
    - Will continue to pay for the 10 codes separately from codes 77371 and 77372.
    - 2018 to review whether to repackage all of the planning, preparation and imaging codes back into the C-APC.
    - Code 77371 has a final geometric mean cost of $10,105 and C-APC for 2017 set at $7,452.84.
    - C-APC payment has a slight increase for 2017 from 2016, up $152.60.
  - IORT (Intraoperative Radiation Treatment Delivery)
    - Commenters requested IORT treatment codes 77424 and 77425 from APC 5093 (Level 3 Breast/Lymphatic Surgery and Related Procedures) be moved to a radiation therapy APC since the IORT treatments are not clinically similar to the other breast services in the APC.
    - CMS agreed, for 2017 will be in C-APC 5627 Level 7 Radiation Therapy with 77371 and 77372.
    - If planning, preparation and imaging codes are packaged back into the SRS C-APC the adjusted mean geometric cost may be such that 77424 and 77425 will have to be moved again in 2018.
Comments received stated that brachytherapy insertion codes 57155, 20555, 31643, 41019, 43241, 55920 and 58346 include devices for some of them, but do not contain a brachytherapy treatment delivery code in them. Commenters requested insertion and treatment delivery code combination, since many felt codes were not reported together appropriately and affected how the codes were valued.

- Commenter also suggested CMS implement a composite APC for tandem and ovoid insertion code 57155, similar to PSI for insertion and treatment.
- Per CMS, “The calculation of OPPS relative payment weights that reflect the relative resources required for HOPD services is the foundation of the OPPS. We rely on hospitals to bill all HCPCS codes accurately in accordance with their code descriptors and CPT and CMS instructions, as applicable, and to report charges on claims and charges and costs on their Medicare hospital cost reports appropriately.”
- CMS indicated hospitals’ failure to bill for services correctly with the appropriate codes should not be a reason to remove claims or adjust how they are counted.
- Will examine in the future any need to adjust methodology or possible code edits.

- New C-APCs for 2017

  - CMS finalized 25 new C-APCs for 2017, most impact brachytherapy procedures.
  - Code 57155, T&O insertion status indicator of “J1”, all other ancillary services (simulation, planning, physics and brachytherapy treatments) all packaged into the placement code.
  - Other C-APCs for codes 19298, 20555, 31626, 43253, 55920, 0438T and 55875.

- Commenters requested new APC for code 77301, IMRT treatment plan.

  - Stated the costs reported will be undervalued since the initial simulation is now bundled into the planning code.
  - CMS indicated they prefer to wait for actual claims data to reassign any CPT code since cost of new bundled codes is difficult to predict.
  - Code 77301 moved from APC 5614 to APC 5613, slight increase in payment and still the same APC as 3D plan 77295.

- Commenters requested CMS not reassign codes 77370, 77280 and 77333 to APC 5611 (Level 1 Therapeutic Radiation Treatment Preparation) from APC 5612 (Level 2 Therapeutic Radiation Treatment Preparation) – reimbursement would decrease by $50.

  - CMS did not agree entirely; the cost differences between APC level 1 and 2 was minor, so combined the two APCs.
  - The four radiation therapy APCs from 2016 are reduced to three for 2017.
Codes 77370, 77280 and 77333 assigned to APC 5611 for CY 2017.
Decrease of $49.12 for all three codes from 2016 to 2017.

- Low Dose Rate (LDR) Prostate Brachytherapy Composite APC
  - No public comments received; will continue without modification setting the composite APC rate for codes 55875 and 77778 in composite APC 8001 based on CY 2015 claims available.

- Code 19298, placement of catheters into the breast, showed a decreased geometric mean cost.
  - Code 19298 moved from APC 5093 Level 3 to APC 5092 Level 2, decrease of 42% in reimbursement (2016 = $7,557.75 and 2017 = $4,417.60).

- Category III code 0438T, gel spacer placement
  - Status Indicator (SI) and APC finalized for 2017.
  - SI T = Paid under OPPS; separate APC payment.
  - APC 5374 = $2,541.49.

- Brachytherapy Sources
  - General methodology for rate setting of sources uses costs based on claims data to set the relative payment weights. Per CMS “This payment methodology results in more consistent, predictable, and equitable payment amounts per source across hospitals by averaging the extremely high and low values in contrast to payment based on hospitals’ charges adjusted to costs.”
  - The relative weights are used to set APC payment rates for brachytherapy sources, not the invoice costs or list price. This results in services not paid at 100% of the reported costs.
  - Comments were received specifically about the reimbursement of high dose vs. low dose sources; the rates assigned do not correlate to the cost, etc.
  - CMS explained that low-volume services (those which are not reported very often) tend to be more susceptible to changes in reimbursement when compared to services with a high volume of reporting.
  - Finalized setting payment rates for brachytherapy sources based on geometric mean costs.
  - New status indicator “E2” finalized for use with brachytherapy source codes which have no claims data to determine a payment rate. In CY 2017 it will be applied to code C2644, cesium-131 chloride solution.
  - CMS also states when services are denied based on MUE value, the provider may appeal the denial. MACs may pay in excess of the MUE or units indicated if the medical record supports medically reasonable and necessary units in excess of the value.

- Hospital Outpatient Quality Reporting (OQR) Program
• OP-33: External Beam Radiotherapy for Bone Metastases measure set for CY 2019 and 2020 reporting.
  o No other changes to it or additional radiation therapy specific measures for 2017.
  o Failure to meet reporting requirements will result in statutory 2% reduction in payments to the hospital, by applying a reporting factor of 0.98 to the OPPS payments and copayments for all applicable services. Includes brachytherapy services.

• Outlier Payments
  o Multiple thresholds set at 1.75 and fixed-dollar threshold set at $3,825.
  o Must exceed both of these when applying the hospital Cost-to-Charge Ratios (CCRs) to the cost.
  o Receive additional payment of 50% of the difference.

• Provider-Based Departments–Bipartisan Budget Act of 2015, Section 603
  o Services in a hospital are generally higher in payment than when provided in an office. The combined hospital claim under OPPS and physician facility rate claim under MPFS as compared to the global claims in an office setting are typically higher. This results in higher co-payments or financial burden for the Medicare beneficiaries as well.
  o Provisions outlined will not be delayed and will be effective January 1, 2017.
  o Excepted status:
    ▪ Will apply to any provider-based department that existed and billed for services to Medicare prior to November 2, 2015.
    ▪ Located within 35 miles of the campus of the main hospital, as was the designation prior to November 2, 2015 OR
    ▪ New provider based-department created after November 2, 2015 located within 250 yards of the main building of the campus.
    ▪ Continue to be paid under OPPS for services.
    ▪ No implementation of the 19 Clinical Families as proposed; at this time all services will be paid under OPPS—even new service lines added after January 1, 2017.
    ▪ There may be occasions where an excepted on-campus provider-based department loses exception, changes locations or changes ownership.
  o Nonexcepted off-campus status:
    ▪ Will apply to any provider-based department created or who did not bill for services to Medicare prior to the November 2, 2015 law.
    ▪ Located outside or more than 250 yards from main building of the campus.
    ▪ Modifier “PN” to be used to identify services nonexcepted on claims beginning January 1, 2017.
Reimbursement will be provided under MPFS as the “applicable payment system” for the majority of nonexcepted items and services furnished in an off-campus PBD.

- Public comments sought regarding proposed payment policies.
- The supervision rules that apply for hospitals will continue to apply for off-campus PBDs that furnish nonexcepted items and services.
- Radiation treatments will be reported using G-codes as adopted and in use by freestanding facilities with the “PN” modifier added.

- Interim Rule created.

- Establishment of Payment Rates under the Medicare Physician Fee Schedule for Nonexcepted Items and Services Furnished by Nonexcepted Off-Campus Provider-Based Departments of a Hospital.
- Has a comment period and is seeking public comments; adjustments will be made on payment mechanisms and rates through rulemaking that could be effective in CY 2017.
- CMS established a payment mechanism where the OPPS payment rates are scaled down by 50%; this apparently balances the rates when comparing services in the hospital to services in a freestanding cancer center. Radiation treatments and clinic visits were used as a mechanism when developing methodology.
- CMS also adopting packaging payment rates and multiple procedure payment reduction (MPPR) percentage that apply under the OPPS to establish the MPFS payment rates for nonexcepted items and services furnished by nonexcepted off-campus PBDs.
- For CY 2019 and beyond, CMS is looking to pay nonexcepted off-campus PBDs for their nonexcepted items and services at a MPFS-based rate that would reflect the relative resources involved in furnishing the services.

- The MPFS-based rate would equal the non-facility payment rate under MPFS minus the facility rate under MPFS.
- For services which CMS does not pay under MPFS, if it is paid under OPPS, the MPFS rate would equal the MPFS non-facility rate.
- For other services, the technical component rate under MPFS would serve as the MPFS-based rate.
- CMS believes this will decrease any incentive for hospitals to purchase physician offices and convert to provider-based departments.
- CMS also believes this will address the payment variances for the same procedure under HOPPS vs. MPFS.
Payment Rates under HOPPS in CY 2017

For CY 2017, CMS has finalized an increase to the Hospital Outpatient Department (OPD) fee schedule by a factor of 1.65%. This increase is due to the 2.7% increase on projected hospital market basket as outlined in the FY 2017 Inpatient Prospective Payment System (IPPS) which went into effect October 1, 2016. To this increase, 0.3% was subtracted as part of the multi-factor productivity adjustment and another 0.75% was subtracted as required by law of the Affordable Care Act. Overall hospitals are expected to see a 1.7% increase to payments. Ambulatory Surgical Centers (ASCs) were finalized with a 1.9% increase in payment, but only for those meeting the quality reporting requirements specific to ASCs.

The table below reflects the potential impacts to common courses of treatment in radiation oncology. The totals reflected are national averages and will vary depending upon the geographic location of a specific outpatient hospital under HOPPS. Even though overall payments were projected to increase, some radiation oncology codes were moved to different APCs resulting in a lower reimbursement. In addition, the payment for the APC with the proton treatment delivery codes was decreased.

### 2016-2017 Hospital Outpatient Prospective Payment System National Average Course Example

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>2D - 10 fxs</td>
<td>$3,885.92</td>
<td>$4,060.50</td>
<td>$174.58</td>
<td>4.49%</td>
</tr>
<tr>
<td>3D - w/ imaging (33 fxs)</td>
<td>$11,402.99</td>
<td>$11,850.26</td>
<td>$447.27</td>
<td>3.92%</td>
</tr>
<tr>
<td>3D - w/out imaging (33 fxs)</td>
<td>$11,712.48</td>
<td>$12,238.06</td>
<td>$525.58</td>
<td>4.49%</td>
</tr>
<tr>
<td>IMRT - Simple 44 fxs</td>
<td>$26,345.47</td>
<td>$26,042.12</td>
<td>($303.35)</td>
<td>-1.15%</td>
</tr>
<tr>
<td>IMRT - Complex 30 fxs</td>
<td>$18,623.93</td>
<td>$18,415.06</td>
<td>($208.87)</td>
<td>-1.12%</td>
</tr>
<tr>
<td>SRS- Linac</td>
<td>$9,180.54</td>
<td>$9,373.93</td>
<td>$193.39</td>
<td>2.11%</td>
</tr>
<tr>
<td>SRS- Cobalt Frame/Frameless (Same Day)</td>
<td>$8,888.77</td>
<td>$9,062.50</td>
<td>$173.73</td>
<td>1.95%</td>
</tr>
<tr>
<td>SRS- Cobalt Frameless</td>
<td>$9,180.54</td>
<td>$9,373.93</td>
<td>$193.39</td>
<td>2.11%</td>
</tr>
<tr>
<td>SBRT Linac 3 Fractions</td>
<td>$11,499.46</td>
<td>$11,766.06</td>
<td>$266.60</td>
<td>2.32%</td>
</tr>
<tr>
<td>SBRT Linac 5 Fractions (Brain)</td>
<td>$15,135.05</td>
<td>$15,378.67</td>
<td>$243.62</td>
<td>1.61%</td>
</tr>
<tr>
<td>SBRT - Cobalt 5 Fractions (Brain)</td>
<td>$15,135.05</td>
<td>$15,378.67</td>
<td>$243.62</td>
<td>1.61%</td>
</tr>
<tr>
<td>Proton - 25 Fractions</td>
<td>$31,611.91</td>
<td>$27,760.94</td>
<td>($3,850.97)</td>
<td>-12.18%</td>
</tr>
<tr>
<td>Prostate - HDR</td>
<td>$11,490.68</td>
<td>$12,247.25</td>
<td>$756.57</td>
<td>6.58%</td>
</tr>
<tr>
<td>Prostate - LDR</td>
<td>$9,442.13</td>
<td>$9,467.79</td>
<td>$25.66</td>
<td>0.27%</td>
</tr>
<tr>
<td>GYN - T&amp;O - HDR</td>
<td>$12,623.80</td>
<td>$6,371.30</td>
<td>($6,252.50)</td>
<td>-49.53%</td>
</tr>
<tr>
<td>GYN - Cylinder 1 Chan- HDR</td>
<td>$5,445.00</td>
<td>$5,503.85</td>
<td>$58.85</td>
<td>1.08%</td>
</tr>
<tr>
<td>GYN - Cylinder Multi Chan - HDR</td>
<td>$6,688.49</td>
<td>$6,939.33</td>
<td>$250.84</td>
<td>3.75%</td>
</tr>
<tr>
<td>APBI Single Channel - HDR</td>
<td>$12,790.60</td>
<td>$12,638.10</td>
<td>($152.50)</td>
<td>-1.19%</td>
</tr>
<tr>
<td>APBI Multi Channel - HDR</td>
<td>$12,974.97</td>
<td>$12,832.00</td>
<td>($142.97)</td>
<td>-1.10%</td>
</tr>
</tbody>
</table>
Unlike the conversion factor (CF) as set under the Medicare Physician Fee Schedule (MPFS), which is a separate ruling, the CF under HOPPS is not applied in the same manner or equation to set the reimbursement rates. For hospitals who have met the Outpatient Quality Reporting (OQR) requirements a CF of $75.001 will be applied; however, for those hospitals who fail to meet the OQR requirements, a 2% reduction will be applied and the adjusted CF will be $73.411.

Other payment rates finalized for CY 2017 under HOPPS include a rural adjustment of 7.1% for certain rural sole community hospitals (SCHs). This adjustment excludes separately payable drugs and biologicals, devices paid under the pass-through payment policy and items paid at charges reduced to cost. The 11 designated cancer hospitals will continue to receive the special payment adjustment in CY 2017. The payment-to-cost ratio (PCR) of 0.91 will be used to determine the additional payments made. The following table from the HOPPS Final Rule shows the estimated increase in payments for the designated cancer hospitals using the CY 2017 PCR.

<table>
<thead>
<tr>
<th>Provider Number</th>
<th>Hospital Name</th>
<th>Estimated Percentage Increase in OPPS Payments for CY 2017 due to Payment Adjustment</th>
</tr>
</thead>
<tbody>
<tr>
<td>050146</td>
<td>City of Hope Comprehensive Cancer Center</td>
<td>25.8%</td>
</tr>
<tr>
<td>050660</td>
<td>USC Norris Cancer Hospital</td>
<td>14.0%</td>
</tr>
<tr>
<td>100079</td>
<td>Sylvester Comprehensive Cancer Center</td>
<td>32.4%</td>
</tr>
<tr>
<td>100271</td>
<td>H. Lee Moffitt Cancer Center &amp; Research Institute</td>
<td>27.3%</td>
</tr>
<tr>
<td>220162</td>
<td>Dana-Farber Cancer Institute</td>
<td>49.8%</td>
</tr>
<tr>
<td>330154</td>
<td>Memorial Sloan-Kettering Cancer Center</td>
<td>50.4%</td>
</tr>
<tr>
<td>330354</td>
<td>Roswell Park Cancer Institute</td>
<td>30.0%</td>
</tr>
<tr>
<td>360242</td>
<td>James Cancer Hospital &amp; Solove Research Institute</td>
<td>37.9%</td>
</tr>
<tr>
<td>390196</td>
<td>Fox Chase Cancer Center</td>
<td>16.6%</td>
</tr>
<tr>
<td>450076</td>
<td>M.D. Anderson Cancer Center</td>
<td>52.3%</td>
</tr>
<tr>
<td>500138</td>
<td>Seattle Cancer Care Alliance</td>
<td>58.7%</td>
</tr>
</tbody>
</table>

Outlier payments are additional payments provided to hospitals as a means to assist in offsetting the risk in performing high-cost and complex procedures that may result in significant financial loss. For many of these procedures the APC (Ambulatory Payment Classification) rate assigned does not cover the procedure expenditures. To assist with these specific procedures an outlier payment calculation was established and has been in place for some time.
Specific thresholds must be met in order for a hospital to qualify to receive the additional outlier payment. When applying the hospital-assigned cost-to-charge ratio (CCR) to the cost of the procedure, if this exceeds the 1.75 time multiplier threshold of the APC payment and exceeds the APC payment amount plus $3,825, Medicare will pay the hospital 50% of the difference.

Ambulatory Payment Classification (APC) Changes for 2017

Services provided in a hospital are grouped into Ambulatory Payment Classifications (APCs). The services in each classification are considered comparable clinically to each other and with respect to the resources utilized. Packaged into each of the APCs are the costs associated with the items and services ancillary and supportive of the primary service each supports. This is why there are many services in the hospital setting that are considered packaged and reported on the claim form, but no additional payment is received. CMS has finalized continuing the process of recalibrating the relative payment weights of the APCs based on claims and cost report data for hospital outpatient department services. CMS will use the most recent data available to calculate the APC group weights.

In reviewing APC changes from CY 2016 to CY 2017, most of the radiation oncology-specific services will see an increase in the associated payment rate. There are a few APCs which will have decreases in CY 2017. Some of the biggest rate changes from CY 2016 – CY 2017 are listed below. Further explanations of some of the changes are also provided after the table.

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Short Descriptor</th>
<th>2016 APC</th>
<th>2016 Final HOPPS Rates</th>
<th>2017 APC</th>
<th>2017 Final HOPPS Rates</th>
<th>Variance</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>19298</td>
<td>Place breast rad tube/caths</td>
<td>5093</td>
<td>$7,557.75</td>
<td>5092</td>
<td>$4,417.60</td>
<td>($3,140.15)</td>
<td>-41.5%</td>
</tr>
<tr>
<td>20555</td>
<td>Place ndl musc/tis for rt</td>
<td>5121</td>
<td>$1,455.26</td>
<td>5113</td>
<td>$2,437.31</td>
<td>$982.05</td>
<td>67.5%</td>
</tr>
<tr>
<td>31626</td>
<td>Bronchoscopy w/markers</td>
<td>5155</td>
<td>$3,066.48</td>
<td>5155</td>
<td>$4,361.11</td>
<td>$1,294.63</td>
<td>42.2%</td>
</tr>
<tr>
<td>31643</td>
<td>Diag bronchoscope/catheter</td>
<td>5153</td>
<td>$1,037.50</td>
<td>5153</td>
<td>$1,269.25</td>
<td>$231.75</td>
<td>22.3%</td>
</tr>
<tr>
<td>41019</td>
<td>Place needles h&amp;n for rt</td>
<td>5164</td>
<td>$1,616.90</td>
<td>5165</td>
<td>$4,129.20</td>
<td>$2,512.30</td>
<td>155.4%</td>
</tr>
<tr>
<td>53444</td>
<td>Insert tandem cuff</td>
<td>5376</td>
<td>$7,428.27</td>
<td>5377</td>
<td>$14,357.55</td>
<td>$6,929.28</td>
<td>93.3%</td>
</tr>
<tr>
<td>77280</td>
<td>Set radiation therapy field</td>
<td>5612</td>
<td>$166.65</td>
<td>5611</td>
<td>$117.53</td>
<td>($49.12)</td>
<td>-29.5%</td>
</tr>
<tr>
<td>77306</td>
<td>Telethx isodose plan simple</td>
<td>5612</td>
<td>$166.65</td>
<td>5612</td>
<td>$311.43</td>
<td>$144.78</td>
<td>86.9%</td>
</tr>
<tr>
<td>77333</td>
<td>Radiation treatment aid(s)</td>
<td>5612</td>
<td>$166.65</td>
<td>5611</td>
<td>$117.53</td>
<td>($49.12)</td>
<td>-29.5%</td>
</tr>
<tr>
<td>77370</td>
<td>Radiation physics consult</td>
<td>5612</td>
<td>$166.65</td>
<td>5611</td>
<td>$117.53</td>
<td>($49.12)</td>
<td>-29.5%</td>
</tr>
<tr>
<td>77522</td>
<td>Proton trmt simple w/comp</td>
<td>5625</td>
<td>$1,150.69</td>
<td>5625</td>
<td>$993.70</td>
<td>($156.99)</td>
<td>-13.6%</td>
</tr>
</tbody>
</table>

CMS received comments asking for CPT code 77301 for IMRT treatment planning to be to be reassigned to a new APC, citing the recent changes in which the initial simulation (77280 – 77290) is now bundled into the code. Commenters felt code 77301 was now undervalued and the cost reporting for which the reimbursement would be based would not be reflective of the simulation as part of the service. CMS disagreed with commenters and indicated they do not reassign codes without data to support the impact.
of bundled services. Code 77301 was moved into a new APC for CY 2017, but it is still listed with 3D planning code 77295 and shows an increase in reimbursement of $38.98 for CY 2017 as compared to CY 2016.

Commenters also requested CMS not reassign CPT codes 77280, 77333 and 77370 to APC 5611 (Level 1 Therapeutic Radiation Treatment Preparation) from APC 5612 (Level 2 Therapeutic Radiation Treatment Preparation), citing significant reimbursement changes. CMS did not agree with commenters and felt the cost differences between Level 1 and Level 2 were minor and instead combined the two APCs and eliminated APC 5614. For CY 2017 there are now three APCs (5611, 5612 and 5613) instead of four as applies to CY 2016. The codes which were originally in APC 5614 (77301, 77295 and some marker insertion codes) were moved to APC 5613. Only code 77306, which was in APC 5612, was not moved but the reimbursement associated with the APC was increased. As a result, codes 77280, 77333 and 77370 have been moved to Level 1 and will be reimbursed $49.12 less in CY 2017 than in CY 2016.

In 2015 CMS initiated the comprehensive ambulatory payment classifications (C-APCs) program. CMS is expanding the program by finalizing the addition of 25 new C-APCs for CY 2017. C-APCs combine all of the ancillary services into one comprehensive payment classification tied to a primary service. Currently in radiation oncology a C-APC exists for SRS and IORT courses in the hospital. Most of the ancillary services provided as part of the SRS and IORT treatments are packaged and not separately reimbursed. Of the 25 new C-APCs that CMS added for CY 2017, several impact brachytherapy services involving surgical placement of an applicator or placement of fiducial markers.

In a majority of the C-APCs, the primary service is identified with status indicator (SI) code “J1”; however, some have SIs of “Q3” and “T”. Any other services performed as part of the same procedure or ancillary to the primary service that has SI of “J1” are not separately reimbursed. Services with an SI of “Q3” and “T” do not package services in the same manner as other C-APCs; therefore, the services may all be billed but reimbursement may be adjusted dependent on what was performed. When billing services the necessary edits and bundled codes must first be applied and any codes that edit out cannot be reported. The remaining codes are billed on the claim with the primary code; the payer will identify the primary code with the assigned J1 indicator, and reimbursement will be based on the C-APC rate and is intended to cover all packaged services. The C-APCs which have been established over the last couple of years are all “surgical” in some capacity. Any ancillary services billed on the same claim as the primary surgical procedure will not be separately reimbursed unless the SI for the ancillary service is one that is excluded from packaging, such as brachytherapy sources. Also, if multiple primary services with “J1” indicators are all on the same claim form, there is a hierarchy established by CMS that dictates the reimbursement of services.
Physicians (hospital- and office-based) and freestanding facilities that perform any of the procedures listed in this addendum will continue to bill for and be reimbursed for the services as supported and appropriate. C-APCs do not apply to physicians and freestanding facilities; services are reimbursed separately under MPFS.

The following table reflects the new C-APCs and some of the associated CPT codes as they pertain to oncology. If there are no codes associated with oncology in the C-APC the associated code cell is blank.

<table>
<thead>
<tr>
<th>C-APC</th>
<th>CY 2017 APC Title</th>
<th>Associated CPT Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>5072</td>
<td>Level 2 Excision/ Biopsy/ Incision and Drainage</td>
<td>19081, 19083, 19085, 38220 &amp; 38221</td>
</tr>
<tr>
<td>5073</td>
<td>Level 3 Excision/ Biopsy/ Incision and Drainage</td>
<td></td>
</tr>
<tr>
<td>5091</td>
<td>Level 1 Breast/Lymphatic Surgery and Related Procedures</td>
<td>19301 &amp; 19499</td>
</tr>
<tr>
<td>5092</td>
<td>Level 2 Breast/Lymphatic Surgery and Related Procedures</td>
<td>19298 &amp; 19302</td>
</tr>
<tr>
<td>5112</td>
<td>Level 2 Musculoskeletal Procedures</td>
<td></td>
</tr>
<tr>
<td>5113</td>
<td>Level 3 Musculoskeletal Procedures</td>
<td>20555</td>
</tr>
<tr>
<td>5153</td>
<td>Level 3 Airway Endoscopy</td>
<td></td>
</tr>
<tr>
<td>5154</td>
<td>Level 4 Airway Endoscopy</td>
<td></td>
</tr>
<tr>
<td>5155</td>
<td>Level 5 Airway Endoscopy</td>
<td>31626</td>
</tr>
<tr>
<td>5164</td>
<td>Level 4 ENT Procedures</td>
<td></td>
</tr>
<tr>
<td>5191</td>
<td>Level 1 Endovascular Procedures</td>
<td></td>
</tr>
<tr>
<td>5200</td>
<td>Implantation Wireless PA Pressure Monitor</td>
<td></td>
</tr>
<tr>
<td>5244</td>
<td>Level 4 Blood Product Exchange and Related Services</td>
<td></td>
</tr>
<tr>
<td>5302</td>
<td>Level 2 Upper GI Procedures</td>
<td>43253</td>
</tr>
<tr>
<td>5303</td>
<td>Level 3 Upper GI Procedures</td>
<td></td>
</tr>
<tr>
<td>5313</td>
<td>Level 3 Lower GI Procedures</td>
<td></td>
</tr>
<tr>
<td>5341</td>
<td>Abdominal/Peritoneal/Biliary and Related Procedures</td>
<td>55920</td>
</tr>
<tr>
<td>5373</td>
<td>Level 3 Urology &amp; Related Services</td>
<td></td>
</tr>
<tr>
<td>5374</td>
<td>Level 4 Urology &amp; Related Services</td>
<td>0438T and 55875</td>
</tr>
<tr>
<td>5414</td>
<td>Level 4 Gynecologic Procedures</td>
<td>57155</td>
</tr>
<tr>
<td>5431</td>
<td>Level 1 Nerve Procedures</td>
<td></td>
</tr>
<tr>
<td>5432</td>
<td>Level 2 Nerve Procedures</td>
<td></td>
</tr>
<tr>
<td>5491</td>
<td>Level 1 Intraocular Procedures</td>
<td></td>
</tr>
<tr>
<td>5503</td>
<td>Level 3 Extraocular, Repair, and Plastic Eye Procedures</td>
<td></td>
</tr>
<tr>
<td>5504</td>
<td>Level 4 Extraocular, Repair, and Plastic Eye Procedures</td>
<td></td>
</tr>
</tbody>
</table>

C-APC 5072 Level 2 Excision/ Biopsy/ Incision and Drainage

The codes in this C-APC apply to radiation and medical oncology and all are assigned status indicators of “J1”. The 2017 CMS national average reimbursement for C-APC 5072 is $1,236.10.
In the hospital setting for codes with marker placement at time of biopsy, the markers are already packaged into the placement codes and not separately reimbursed. Per the definition of the placement codes, the image guidance used to place the markers is bundled and not separately billable. When a service or code is bundled, it cannot be separately billed on the claim form, even for C-APCs. Only services which are packaged, not lost to edit or definition of the primary service are billed on the same claim.

C-APC 5072 includes the following CPT codes:

19081 Biopsy, breast, with placement of breast localization device(s) (e.g., clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; first lesion, including stereotactic guidance.

19083 Biopsy, breast, with placement of breast localization device(s) (e.g., clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; first lesion, including ultrasound guidance.

19085 Biopsy, breast, with placement of breast localization device(s) (e.g., clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; first lesion, including magnetic resonance guidance.

38220 Bone marrow; aspiration only.

38221 Bone marrow; biopsy, needle or trocar.

C-APC 5091 Level 1 Breast/Lymphatic Surgery and Related Procedures

Any of the ancillary services performed in conjunction with the partial mastectomy or unlisted breast procedure and billed on the same claim form are packaged into the primary code and not separately reimbursed. A review is needed to determine what, if any, other procedures are performed at the time of the partial mastectomy that may be packaged. In addition, if the breast unlisted procedure code is used, the other ancillary services performed with it are all packaged in as well. The 2017 CMS national average reimbursement for C-APC 5091 is $2,498.42.

C-APC 5091 includes the following CPT codes:

19301 Mastectomy, partial (e.g., lumpectomy, tylectomy, quadrantectomy, segmentectomy).

19499 Unlisted procedure, breast.

C-APC 5092 Level 2 Breast/Lymphatic Surgery and Related Procedures

The codes in this C-APC include the placement of catheters for HDR brachytherapy treatment using tube and buttons and partial mastectomy with axillary lymphadenectomy. The placement of the tube and buttons for HDR brachytherapy will need to be reviewed. Just as with CPT code 19296 (C-APC 5093 created in 2016) placement of balloon for HDR brachytherapy on separate date of partial mastectomy, a
review of the brachytherapy treatment course is needed to determine how all of the services are reported. If the whole course is part of the same surgical account—the placement, planning and treatments—then everything (except the brachytherapy source) is packaged into the placement code. The 2017 CMS national average reimbursement for C-APC 5092 is $4,417.60.

C-APC 5092 includes the following CPT codes:

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.

19302 Mastectomy, partial (e.g., lumpectomy, tylectomy, quadrantectomy, segmentectomy).

C-APC 5113 Level 3 Musculoskeletal Procedures
The code in C-APC 5113 pertaining to radiation oncology includes placement of needles or catheters into muscle or soft tissue for interstitial brachytherapy. Review of how this placement code is billed in relation to the brachytherapy treatment is needed. If the simulation, planning and treatments are part of the same claims as the placement code, they are not separately reimbursed; only the brachytherapy source is separately paid. The 2017 CMS national average reimbursement for C-APC 5113 is $2,437.31.

C-APC 5113 includes the following CPT code:

20555 Placement of needles or catheters into muscle and/or soft tissue for subsequent interstitial radioelement application (at the time of or subsequent to the procedure).

C-APC 5155 Level 5 Airway Endoscopy
C-APC 5155 includes the code for bronchoscopy, using fluoro for placement of fiducial markers. As a marker placement code, in a hospital setting the makers are already packaged and not separately reimbursed and the imaging, fluoroscopy is part of the placement and not reported on the claim form. This is not new to the procedure. Any other services billed on the same claim are packaged into the placement code. The 2017 CMS national average reimbursement for C-APC 5155 is $4,361.11.

C-APC 5155 includes the following CPT code:

31626 Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with placement of fiducial markers, single or multiple.

C-APC 5302 Level 2 Upper GI Procedures
C-APC 5302 includes fiducial marker placement by esophagogastroduodenoscopy. As a marker placement code, in the hospital the markers and image guidance are not separately reimbursed and have
been part of the placement. The 2017 CMS national average reimbursement for C-APC 5302 is $1,334.27.

C-APC 5302 includes the following CPT code:

43253  Esophagogastroduodenoscopy, flexible, transoral; with transendoscopic ultrasound-guided transmural injection of diagnostic or therapeutic substance(s) (e.g., 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).

C-APC 5341 Abdominal/Peritoneal/Biliary and Related Procedures
C-APC 5341 includes placement of needles or catheters into the pelvic organs or genitalia (non-prostate) for interstitial brachytherapy. Review of how this placement code is billed in relation to the brachytherapy treatment is needed. If the simulation, planning and treatments are part of the same claims as the placement code, they are not separately reimbursed; only the brachytherapy source is separately paid. The 2017 CMS national average reimbursement for C-APC 5113 is $2,861.53.

C-APC 5341 includes the following CPT code:

55920  Placement of needles or catheters into pelvic organs and/or genitalia (except prostate) for subsequent interstitial radionuclide application.

C-APC 5374 Level 4 Urology & Related Services
C-APC 5374 includes the spacer gel placement code and placement needles or catheters into the prostate for interstitial brachytherapy. The two codes pertaining to radiation oncology for this C-APC are slightly different than the other codes previously reviewed. The gel spacer code has a SI of “T”, subject to multiple procedure reductions. Depending on other services billed in conjunction with the space gel, the reimbursement may be impacted.

The placement of needles or catheters into the prostate for LDR, 55875, is part of a composite APC with code 77778. When codes 55875 and 77778 are reported on the same claim they are reimbursed under composite APC 8001, which pays for both services together. Another application of code 55875 is for prostate HDR and placement of the needles and catheters into the prostate for later HDR treatment in the radiation oncology department. Since the SI is “Q3” when the code is reported separately for the prostate HDR placement, it is paid as a single code and not combined with any other code for a composite APC payment. The 2017 CMS national average reimbursement for C-APC 5374 is $2,541.49.

C-APC 5374 includes the following CPT codes:
Transperineal placement of biodegradable material, peri-prostatic (via needle), single or multiple, includes image guidance.

Transperineal placement of needles or catheters into prostate for interstitial radioelement application, with or without cystoscopy.

C-APC 5414 Level 4 Gynecologic Procedures
C-APC 5414 includes the placement of the tandem and/or ovoids (T&O) for HDR brachytherapy and has a SI of “J1”. Due to the designation of the placement of the T&O, when billed with the applicator (77332), planning (77295, 77316, 77317 or 77318), physics services (77336 or 77370) and HDR brachytherapy treatments (77770, 77771 or 77772), only the placement and brachytherapy source (C1717) are separately reimbursed. Each placement is separately billable and reimbursed. If three fractions of T&O HDR brachytherapy are performed, then the three insertions and brachytherapy sources would be reimbursed. It is most likely all of the services in the hospital are billed on the same surgical account and the reimbursement for 57155 includes all of the ancillary services. The 2017 CMS national average reimbursement is $2,084.59.

C-APC 5414 includes the following CPT code:
57155 Insertion of uterine tandem and/or vaginal ovoids for clinical brachytherapy.

Comprehensive APC (C-APC) 5627 Level 7 Radiation Therapy, which includes SRS (stereotactic radiosurgery) treatment codes 77371 and 77372, will continue as it was set up in CY 2016. The 10 ancillary codes removed from the C-APC will continue to be reported and reimbursed separately. Pending the results of the two years of data and cost collecting by CMS, the planning, preparation and imaging codes may be repackaged back into the C-APC, or it may be possible some will continue to be reported and paid separately beginning in CY 2018. It was indicated the final geometric mean cost for code 77371 (Cobalt-60-based SRS Treatment) was reported as $10,105. The CY 2017 reimbursement for C-APC 5627 was finalized as $7,452.84, a slight increase from CY 2016.

Two other codes were added to C-APC 5627 along with the SRS codes: IORT (Intraoperative Radiation Treatment) delivery codes 77424 and 77425. Commenters requested the IORT treatment delivery codes be moved from the current C-APC 5093 (Level 3 Breast/Lymphatic Surgery and Related Procedures) since they were not clinically similar to the other breast service codes. Commenters suggested the codes be moved to a radiation therapy APC, and CMS agreed with this suggestion. For CY 2017, codes 77424 and 77425 will be paid at the same rate as codes 77371 and 77372. This change is temporary, pending the outcome of the changes for CY 2018 based upon the analysis of claims for the SRS services. If codes are repackaged into the C-APC, this would adjust the geometric mean cost enough that the IORT codes would need to be moved again.
Due to a change in the geometric mean cost for code 19298, placement of catheters into the breast, it was moved into APC 5092 with a 42% decrease in reimbursement for CY 2017. Category III code 0438T, placement of gel spacer, went into effect July 1, 2016, replacing HCPCS code C9743. CMS finalized the Status Indicator (SI) “T” for the new code, which means it is paid under OPPS; separate APC payment and was assigned to APC 5374 with a rate of $2,541.49.

Composite APC 8001, Low Dose Rate (LDR) Prostate Brachytherapy, will continue in CY 2017. Composite APC 8001 includes codes 55875, placement of needles into the prostate, and 77778, complex brachytherapy interstitial treatment delivery. When the codes are reported together on the same claim form, the composite APC amount is paid. When the codes are reported separately on different dates of surgical events, then separate payments are made. CMS used the partial CY 2015 claims to set the rate.

Comments were received by CMS regarding brachytherapy insertion codes 57155, 20555, 31643, 41019, 43241, 55920 and 58346. Commenters stated the some of the insertion codes include devices packaged into the code but do not contain a brachytherapy treatment delivery code as well. Requests were made to package or bundle the treatment delivery code into the insertion code. Many commenters indicated the lack of billing for the treatment delivery codes has directly impacted the values associated with the brachytherapy insertion codes. Another commenter specifically called out code 57155, insertion of tandem and ovoid applicator, asking it to be made into a composite APC similar to prostate seed implants.

CMS was rather succinct in addressing the missed billing by hospitals. Hospitals’ failure to bill correctly with appropriate codes is not considered a reason to remove claims or adjust how they are accounted for when setting rates for services. CMS went on further to state, “The calculation of OPPS relative payment weights that reflect the relative resources required for HOPD services is the foundation of the OPPS. We rely on hospitals to bill all HCPCS codes accurately in accordance with their code descriptors and CPT and CMS instructions, as applicable, and to report charges on claims and charges and costs on their Medicare hospital cost reports appropriately.” CMS did indicate they will review in the future to determine any adjustments needed to the methodology or possible code edits with the codes indicated.

**Brachytherapy Sources**

CMS follows a general methodology for rate setting of brachytherapy sources. Costs based on claims data are used to set the relative payment weights. CMS indicated “This payment methodology results in more consistent, predictable, and equitable payment amounts per source across hospitals by averaging the extremely high and low values in contrast to payment based on hospitals’ charges adjusted to costs.” Not adjusting the brachytherapy source reimbursement to payment based on hospitals’ charges adjusted
to cost provides incentive to hospitals to be more efficient in the treatment of Medicare beneficiaries with brachytherapy services. The relative weights are used to set APC payment rates for brachytherapy sources and not the invoice costs or list price. CMS confirmed services are not always paid at 100% of the reported costs.

Other commenters stated the rates assigned to low-dose vs. high-dose brachytherapy sources did not correlate with the cost of the respective sources. CMS explained that low-volume services (those which are not reported very often) tend to be more susceptible to changes in reimbursement when compared to services with a high volume of reporting. In addition, if hospitals are not reporting units or charges accurately for brachytherapy services, this can significantly influence the geometric mean costs that are used to base the payment rates on.

CMS also addressed comments received about quantities of billable brachytherapy sources, specifically Medically Unlikely Edit (MUE) values. CMS indicated a provider may appeal a denial when based on the MUE value. The Medicare Administrative Contractor (MAC) may pay for units of service above the MUE if the medical record documentation supports the services were medically necessary and supported in excess of the MUE value.

Brachytherapy sources have a Status Indicator (SI) of “U” assigned. Starting in CY 2017, code C2644 for cesium-131 chloride solution will be assigned SI “E2”, as there is no claims data to use to set the rate for this brachytherapy source. Status Indicator “E2” will be applied to other new sources in the future that also lack claims data needed to assign a rate.

**Hospital Outpatient Quality Reporting (OQR) Program**

CMS established the Hospital Outpatient Quality Reporting (OQR) Program as a means of promoting improved quality and efficiency of the care of Medicare beneficiaries. Measure PO-33: External Beam Radiotherapy for Bone Metastases was selected and finalized in earlier rulings, but was listed as it is still a measure for CY 2019 and subsequent years’ payment determination.

No other measures specific to radiation oncology have been introduced. As stated at the beginning of this summary, CMS will apply a statutory 2% reduction in payment to a hospital that fails to meet the reporting requirements for OQR measures. A factor of 0.98 will be applied to OPPS payments and copayments for all applicable services, including brachytherapy services.
Provider-Based Departments–Bipartisan Budget Act of 2015, Section 603

CMS spent a considerable amount of the CY 2017 HOPPS Final Rule addressing changes to provider-based departments. On November 2, 2015 the Bipartisan Budget Act of 2015 was signed into law. Section 603, Treatment of Off-Campus Outpatient Departments of a Provider, specifically outlined the changes CMS was called to address and make final in the CY 2017 Final Rule. Section 603 addressed concerns initially presented by MedPAC (Medicare Payment Advisory Committee) in a report regarding the reimbursement variances for the same procedure when performed in the hospital vs. office vs. ASC. It also addressed concerns regarding the increasing number of physician practices acquired by hospitals and now reimbursed under HOPPS.

Services provided in hospitals and by extension provider-based departments (PBD) tend to be reimbursed at a higher rate due to adding together the technical component (facility) payment and the professional component payment. In many circumstances the combined total of the reimbursement is higher than the global reimbursement for the same procedure in an office setting or the combined technical and professional components in an ASC for the exact same procedure.

The Physicians Advocacy Institute along with Avalere Health studied recent physician employment trends as recently as September 2016. An analysis of a database of physician and practice location information in conjunction with data from the CMS National Plan & Provider Enumeration System showed significant trends. Per the study, “Hospital ownership of physician practices has increased by 86 percent and the percent of hospital-employed physicians increased by almost 50 percent from July 2012 to July 2015.” Prior to the physician practices being converted to hospital-based, they were paid under MPFS per the place of service. The conversion from MPFS to hospital-based for the high number of practices along with the increased reimbursement has set up a scenario in which the financial burden is increasing for CMS.

Another difficulty is the assessment of the Direct and Indirect Practice Expense (PE) encountered by the physician practices when acquired by the hospital. MPFS rates are based on Relative Value Units (RVUs), and the practice expense is one of those factors. Due to the nature of how PBDs are set up, CMS could not ascertain how much of the practice expense was still part of the physician practice’s responsibility and how much—or what components—were now that of the hospital. This created issues with potential over value of RVUs assigned to codes.

To assist with this and lessen the burden of financial impact created by so many PBDs, Section 603 addressed necessary changes; some went into effect on November 2, 2015, when it was signed into law. One main change is the designation of what constitutes an on-campus PBD vs. an off-campus PBD.
Traditionally, up to November 1, 2015, the PBD had to be within 35 miles of the main hospital building. As of November 2, 2015 the distance was adjusted, and any new PBD had to be within 250 yards of the main building.

The change was made effective immediately so as not to allow hospitals to acquire more physician practices, establish them as PBDs, and receive reimbursement under HOPPS prior to the CY 2017 reimbursement changes. Even though on-campus and off-campus were defined and effective at the time of the law, Section 603 stated that any reimbursement changes would not be made until CY 2017. This means that any new PBDs providing the very first service or item to a patient on or after November 2, 2015 through December 31, 2016 were/are reimbursed under HOPPS, but this will change in CY 2017.

By setting a hard and fast date, preexisting PBDs (providing services prior to November 2, 2015) were still defined per the “old criteria” and any new acquisitions would now be bound per the “new criteria”. Initially information was difficult to obtain regarding the grandfathered status of pre-existing PBDs, but CMS addressed this in the HOPPS final rule publication.

Prior to release of Section 603, CMS released a new modifier, “PO”, which was mandatory in CY 2016 and applied to all services reported on the UB04 and performed in the PBD. The new modifier, along with a new Place of Service (POS) code for physicians (POS 19 for off-campus outpatient hospital), provided CMS with data to assist in developing the reimbursement methods for services as required for CY 2017.

The reason this was addressed and part of the CY 2017 HOPPS Final Rule is due to Section 603, which indicated reimbursement changes would take effect CY 2017. The law indicated payments would be provided under an “applicable payment system”. Due to time constraints, however, development of a new payment system was not possible. Since most of the physician practices acquired were originally paid under MPFS, CMS is using MPFS as the “applicable payment system” with some changes.

As a means of getting stakeholder input on the changes and to ensure the “applicable payment system” in place is not creating significant financial burden to providers or patients, CMS created an interim ruling within the CY 2017 HOPPS Final Rule. The interim rule, Establishment of Payment Rates under the Medicare Physician Fee Schedule for Nonexcepted Items and Services Furnished by Nonexcepted Off-Campus Provider-Based Departments of a Hospital, is seeking comments and feedback from stakeholders. Comments received will be reviewed and, as necessary, changes will be made that could be effective in CY 2017. However, CMS is moving forward with the rulings and guidelines established in the final rule release. Only if there are significant modifications made to the interim rule due to comments received will the same method apply for CY 2018. CY 2019 is the projected timing for payment system modifications to be made, however, still using a similar approach as outlined for CY 2017.
Per the ruling and effective for CY 2017, an excepted off-campus PBD is an entity that was in place and provided services to patients prior to November 2, 2015. This would also apply to a new PBD that may have provided services on a date prior to the November 2, 2015 deadline, but had not yet submitted the claim forms to CMS for reimbursement. The claim and documentation in the medical record would indicate that the date of service had been prior to this deadline. These excepted off-campus PBDs must still follow the original distance definition of being within 35 miles of the hospital’s main building, as the new distance definitions do not apply to them. An excepted off-campus PBD will continue to be paid under HOPPS for services provided and will not be limited to only the services provided in specific APCs as was proposed. New service lines can be added and as long as the status remains the same, reimbursement will be under HOPPS.

If an excepted off-campus PBD is sold or merges with another hospital, the PBDs provider-based status generally transfers and will be recognized as long as the new owners accept the prior hospital’s provider agreement. This is in keeping with and consistent with other hospital payment policies. If the provider agreement is terminated, the excepted off-campus PBD status is lost. In addition, if an excepted off-campus PBD needs to relocate due to conditions that are extraordinary and outside a hospital’s control, CMS will evaluate on a case-by-case basis. Examples of extraordinary circumstances provided include “natural disasters, significant seismic building code requirements, or significant public health and public safety issues that necessitate moving to a new building (either temporarily or permanently) without losing its excepted status”.

As of right now and in CY 2017, an excepted off-campus PBD will continue as usual and will receive reimbursement under the HOPPS Fee Schedule.

Effective January 1, 2017, a nonexcepted off-campus PBD is a department that did not provide any services or items to patients prior to November 2, 2015, regardless of whether it was new and open at this point or in mid-construction. Also, if the once-considered excepted off-campus PBD has been bought out and taken over but the previous agreement was not accepted by the new owner, the entity is considered a nonexcepted off-campus PBD.

A nonexcepted off-campus PBD is still considered a hospital entity per rules regarding supervision. Any supervision rules which apply for a hospital will continue to apply for nonexcepted off-campus PBDs. In addition, all “technical” services performed will continue to be reported on the UB04 claim form, but every line item will have a “PN” modifier applied. As of right now, many hospitals are not set up to send out CMS 1500 claim forms and the time frame to complete any work to do this would not be enough. Another factor is that CMS has several payment systems. The payment system used by hospitals is not set up to accept CMS 1500 claim forms for this type of setting nor do hospitals, including PBDs, meet the
requirements to bill under another payment system. The “PN” modifier will be used to identify the services in the nonexcepted off-campus PBD for application of payments under MPFS.

CMS has established a payment mechanism whereby nonexcepted off-campus PBDs will be paid 50% of the HOPPS payment rate per the codes billed. CMS felt this scale down would align the rates as seen for services in a non-facility-based setting (freestanding cancer center) when compared to the same services in a hospital setting. When evaluating data of the reporting of the “PO” modifier, CMS found the clinic visit, code G0463, was the most frequently billed service. Using this code along with radiation oncology treatment delivery codes to evaluate the variances in reimbursement for the same services between HOPPS and MPFS, CMS felt the 50% reduction to the HOPPS value would put services on an even level. CMS also indicated there may be circumstances where this reduction will still result in one setting being paid more than another. Physicians will continue to bill for their services when working in nonexcepted off-campus PBDs using POS 19 on the CMS 1500 claim form and will continue to be paid under the facility rate of MPFS.

All nonexcepted off-campus PBDs will deviate from current hospital billing for radiation oncology services to CMS. Instead of billing for treatment delivery codes using CPT codes 77402, 77407, 77412, 77385 or 77386, nonexcepted off-campus PBDs will use the G-codes (G6003 – G6016) in use under MPFS. The same will be applied for image guidance. Instead of billing 77387 for IGRT, nonexcepted off-campus PBDs will bill G6001, G6002, G6017 or 77014 for IGRT. Each code billed will be reported on the UB04 with a “PN” modifier.

CMS is also adopting packaging payment rates and a multiple procedure payment reduction (MPPR) percentage in alignment with HOPPS to establish the MPFS payment rates for nonexcepted items and services furnished by nonexcepted off-campus PBDs.

For CY 2019 and beyond, CMS is looking to pay nonexcepted off-campus PBDs for their nonexcepted items and services at an MPFS-based rate that would reflect the relative resources involved in furnishing the services. This MPFS-based rate would be equal to the non-facility payment rate minus the facility rate, both under MPFS. For services that CMS does not pay separately under MPFS, if paid under HOPPS, the MPFS rate would equal the MPFS non-facility rate. For other services, the technical component under MPFS would serve as the MPFS-based rate. There may also be additional services that are not billable under MPFS, but are under HOPPS; CMS would consider the resources related to providing the service and anticipate a rate similar to how an ASC is paid for similar services.

CMS feels by adopting this approach in CY 2019 the payment variances between the different entities would be nearly equal across the board. CMS also feels it would further deter hospitals from acquiring physician practices and converting to off-campus PBDs since the financial incentive would no longer be
there. In order to accomplish these projected changes, CMS will need to make substantial changes to the payment systems in order to pay nonexcepted PBDs under MPFS as outlined.
Medicare Program Overview
Medicare Administrative Contractors

Medicare Administrative Contractors (MACs) are entities which replaced the previously designated Medicare Fiscal Intermediaries (FI) and Carriers. An FI deals with Medicare Part A (hospitals) and Carriers handle Medicare Part B (freestanding radiation centers and physicians). The change was required by section 911 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) and first implemented in 2005 to provide a centralized point of contact between Medicare and providers. The established MACs are multi-state, regional for-profit contractors responsible for both Medicare Part A and Part B claims. This structure allows for centralized processing of claims from both hospitals and physicians. Due to the same processing of both hospitals and physicians, it is highly recommended that both entities communicate rationale for their process of care on a regular basis to support the level of complexity and number of units with the same reporting and utilization.

Contracts to MACs are awarded through an application process once every 10 years. As part of the Medicare Access and CHIP Reauthorization Act (MACRA) enacted on April 16, 2015, contract terms were extended from the previous 5-year agreements to 10 years. In addition, CMS must publish performance information on each MAC to the extent that any published information does not interfere with contract procurements. Contracts awarded prior to the MACRA can be extended another 5 years, to the maximum of 10.

CMS intends to consolidate several of the smaller Part A/B MAC workloads to form 10 larger Part A/B MAC jurisdictions. This transition has already consolidated three pairs of Part A/B MAC contract regions. Consolidation of the final two MACS has been delayed.

To better understand and appreciate the MAC Program, CMS has provided the following diagram to illustrate the Hub of the Medicare Fee-for-Service Program.
Find Your MAC

MACs are assigned in accordance with the Federal Acquisition Regulation and identify specific jurisdictions that cover assigned states. Click here to find an interactive map that indicates which MAC is assigned to each state:

Interactive Map >>> Find Your MAC

HHS OIG Work Plan for 2017

The Office of Inspector General's (OIG) Work Plan outlines several projects to be addressed during the fiscal year (FY 2017) by the Office of Audit Services, Office of Evaluation and Inspections, Office of Investigations, and Office of Counsel to the Inspector General. The work plan includes projects for each
of the major entities, including the Centers for Medicare & Medicaid Services. Projects outlined also account for those services or programs, such as state and local governments that use federal funds, and the functional areas of the Office of the Secretary of Health and Human Services (HHS).

The HHS OIG Work Plan for Fiscal Year 2017 summarizes new and ongoing reviews and activities that the OIG plans to pursue. The Work Plan outlines the primary objectives for each review and the anticipated year in which one or more reports on the review findings are expected to be released. As reports become available they are posted to the OIG website. Subscribers who have signed up via the OIG website to receive notifications will receive an email when a report is available.

One area of the work plan specific to radiation oncology was originally released in a FY 2015 Mid-Year Work Plan—and continues for 2016—and is related to intensity-modulated radiation therapy (IMRT):

“REVISED Intensity-Modulated Radiation Therapy

Intensity-modulated radiation therapy (IMRT) is an advanced mode of high-precision radiotherapy that uses computer-controlled linear accelerators to deliver precise radiation doses to malignant tumor or specific areas within the tumor. IMRT is provided in two treatment phases: planning and delivery. Certain services should not be billed when they are performed as part of developing an IMRT plan. Prior OIG reviews identified hospitals that incorrectly billed for IMRT services. We will review Medicare outpatient payments for IMRT to determine whether the payments were made in accordance with Federal requirements.”

OAS: W 00 16 35733; W-00-16-35740; various reviews, Expected Issue Date: FY 2017

Download the 2016 OIG Work Plan at:


Local Coverage Determinations

Each MAC is responsible for providing Local Coverage Determinations (LCDs), which are guidelines for what services are reasonable and appropriate for a given medical scenario and the documentation necessary to support reimbursement. The LCDs set by the respective MACs supersede any recommendations or policies established by other billing resources. The LCDs cover specifically what requirements are expected by the MAC with regard to documentation of each billable code, the required medical necessity that must be present throughout the course of therapy and the diagnoses covered by a particular course of radiation therapy. LCDs are updated regularly; however, not per a specific schedule. Each MAC allows for updates to providers of any changes made to existing LCDs, and providers are urged to access their MACs website and register for updates.
Several MACs have adopted similar LCDs nationwide; however, it is important to note that while there are many similarities there may also be subtle differences throughout. There are several MACs with retired or no published LCDs pertaining to radiation oncology practices. When a MAC has retired LCDs, these LCDs are still applicable for billing and coding guidelines, audits, medical necessity and Advanced Beneficiary Notice (ABNs). When a MAC has no LCDs available, published national practice standards and National Correct Coding Initiatives are utilized. In addition, any recommendations by national specialty organizations such as the American College of Radiation Oncology (ACRO) and the American Society for Radiation Oncology (ASTRO) are considered when establishing practice standards.

Due to the centralized processing of claims, any discrepancies between Part A (hospital/technical) and Part B (physician/professional) claims are more likely to raise concerns and result in denial of payment and/or audit by the governing MAC. Areas that tend to have the highest rate of difference between the Part A and Part B claims are dates of service, quantities, level of service billed and diagnosis codes. Prior to submission of all claim forms, it is recommended a review of each charge be made both professionally and technically to ensure there are no discrepancies that may result in nonpayment. If a discrepancy is found, it is recommended both the technical and professional representatives meet to review the documentation and support the associated charge. Once a consensus has been reached and supported through medical necessity and documentation, the corrected billing may be processed.

National Coverage Determinations (NCDs)

CMS has the authority to issue NCDs, which supersede LCDs and relate to coverage of all Medicare beneficiaries regardless of MAC region. These NCDs are often produced due to a direct Congressional mandate or secondary to results of Coverage with Evidence Development (CED) trials supported by CMS. Although the provider community has often requested publication of NCDs to avoid coverage differences across regional MACs, CMS has generally avoided this approach in favor of LCDs.

Advanced Beneficiary Notice (ABN)

Fee for Service Advance Beneficiary Notice of Noncoverage

The Advanced Beneficiary Notice of Noncoverage (ABN), Form CMS-R-131, is issued by providers (including independent laboratories), physicians, practitioners and suppliers to Original Medicare (fee for service) beneficiaries in situations where Medicare payment is expected to be denied. Guidelines for mandatory and voluntary use of the ABN are published in the Medicare Claims Processing Manual, Chapter 30, Section 50.

Any questions regarding the ABN can be emailed to RevisedABN_ODF@cms.hhs.gov.
As additional guidance, the ABN complete booklet can be located on CMS’ website:

Medicare as a Secondary Payer

Medicare Secondary Payer (MSP) has provisions, which protect the Medicare funds by ensuring that Medicare does not pay for services and items that other health insurance or coverage has the primary responsibility for paying. MSP provides national program savings; increased provider, physician, and other supplier revenue; and avoidance of Medicare recovery efforts.

To realize the benefits of MSP, it is imperative to have access to accurate, current information about all health insurance or coverage Medicare beneficiaries may have. It is required by law that entities confirm Medicare is the primary payer when billing for services or items rendered to Medicare. Time and money can be saved by collecting patient health insurance or coverage information at each patient visit. Some questions the providers should ask include, but are not limited to:

1. Is the patient covered by a Group Health Plan (GHP) through his or her current or former employment? If so, how many employees work for the employer providing coverage?
2. Is the patient covered by a GHP through his or her spouse or other family member’s current or former employment? If so, how many employees work for the employer providing the GHP?
3. Is the patient receiving Workers’ Compensation (WC) benefits?
4. Does the patient have a WC Medicare Set-aside Arrangement?
5. Is the patient covered under no-fault insurance or liability insurance?
6. Is the patient being treated for an injury or illness for which another party could be held liable?

There are instances when Medicare is considered the primary payer even when beneficiaries are covered by other types of health insurance or coverage. Primary payers have the responsibility for paying the claim for the services or items rendered. The table below, taken from CMS Medicare Learning Network, lists situations in which Medicare may be the primary or secondary payer.
<table>
<thead>
<tr>
<th>If the patient...</th>
<th>And this condition exists...</th>
<th>Then this program pays first...</th>
<th>And this program pays second...</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is age 65 or older, and is covered by a Group Health Plan (GHP) through current employment or spouse’s current employment</td>
<td>The individual is entitled to Medicare. The employer has less than 20 employees.</td>
<td>Medicare</td>
<td>Group Health Plan</td>
</tr>
<tr>
<td>Is age 65 or older, and is covered by a Group Health Plan through current employment or spouse’s current employment</td>
<td>The individual is entitled to Medicare. The employer has 20 or more employees, or at least one employer is a multi-employer group that employs 20 or more individuals</td>
<td>Group Health Plan</td>
<td>Medicare</td>
</tr>
<tr>
<td>Has an employer retirement plan and is age 65, older</td>
<td>The individual is entitled to Medicare</td>
<td>Medicare</td>
<td>Retiree coverage</td>
</tr>
<tr>
<td>Is under age 65, disabled and covered by a Group Health Plan through his or her own current employment or through a family member’s current employment</td>
<td>The individual is entitled to Medicare. The employer has less than 100 employees.</td>
<td>Medicare</td>
<td>Group Health Plan</td>
</tr>
<tr>
<td>Is under age 65, disabled and covered by a Group Health Plan through his or her own current employment or through a family member’s current employment</td>
<td>The individual is entitled to Medicare. The employer has 100 or more employees, or at least one employer is a multi-employer group that employs 100 or more individuals</td>
<td>Group Health Plan</td>
<td>Medicare</td>
</tr>
<tr>
<td>Has End Stage Renal Disease and Group Health Plan coverage was the primary plan prior to the individual becoming eligible and entitled to Medicare based on ESRD</td>
<td>Is in the first 30 months of eligibility or entitlement to Medicare</td>
<td>Group Health Plan</td>
<td>Medicare</td>
</tr>
<tr>
<td>Has End Stage Renal Disease and Group Health Plan Coverage</td>
<td>After 30 months of Medicare eligibility or entitlement</td>
<td>Medicare</td>
<td>Group Health Plan</td>
</tr>
<tr>
<td>Has End Stage Renal Disease and COBRA coverage prior to becoming eligible or entitled to Medicare</td>
<td>Is in the first 30 months of eligibility or entitlement to Medicare</td>
<td>COBRA</td>
<td>Medicare</td>
</tr>
<tr>
<td>Has End Stage Renal Disease and COBRA</td>
<td>After 30 months of Medicare eligibility or entitlement</td>
<td>Medicare</td>
<td>COBRA</td>
</tr>
<tr>
<td>Is covered under Workers’ Compensation because of a job-related illness or injury</td>
<td>The individual is entitled to Medicare. Workers’ Compensation (for health care items or services related to job-related illness or injury)</td>
<td>Medicare</td>
<td></td>
</tr>
<tr>
<td>Has been in an accident or other situation where no-fault or liability insurance is involved</td>
<td>The individual is entitled to Medicare. No-fault or liability insurance for accident or other situation related health care services</td>
<td>Medicare</td>
<td></td>
</tr>
<tr>
<td>Is age 65 or older OR is disabled and covered by Medicare and COBRA</td>
<td>The individual is entitled to Medicare.</td>
<td>Medicare</td>
<td>COBRA</td>
</tr>
</tbody>
</table>

*Source: Centers for Medicare & Medicaid Services, Medicare Learning Network*
If the primary payer other than Medicare denies the claim, Medicare may step in and make payment. The following situations may lead to a payment from Medicare:

- A no-fault or liability insurer does not pay during the “paid promptly” period or denies the medical bill.
- A WC program does not pay during the “paid promptly” period or denies payment (for example, where WC excludes a particular medical condition).
- Workers’ Compensation Medicare Set-Aside Arrangement (WCMSA) or the ORM benefits terminate or exhaust.
- A GHP denies payment for services because:
  - The beneficiary exhausted plan benefits for particular services.
  - The beneficiary is not entitled to benefits under the GHP.
  - The beneficiary needs services not covered by the GHP.

If providers fail to submit correct and accurate claims with Medicare, federal law permits Medicare to recover its conditional payments. If claims are knowingly, willfully and repeatedly submitted to Medicare with inaccurate information relating to the existence of other health insurance coverage, fines can be up to $2,000 per incident.
Payment Edits and Oversight

National Correct Coding Initiative (NCCI) Edits

Correct Coding Initiatives (CCI) for MPFS and Outpatient Coding Edits (OCE) for hospitals are released on a quarterly basis. Due to the number of CPT codes, the edits are listed in two evenly split files rather than separated by each division of codes. Each file contains six columns, shown below: a Column 1 code (primary code), a Column 2 code (secondary code to which the action is applied), Effective Date, Deletion Date, Indication, and the Edit Rationale for each set of codes and the indicator. In the event of an edit, the pairing of codes is governed by the rule listed in the Indication Column per the Rationale listed and applied to the Column 2 code. The rules are outlined below.

<table>
<thead>
<tr>
<th>Rule</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-rule</td>
<td>Does not allow for the billing of the two CPT codes in question on the same date of service. This designation does not allow for any kind of modifier to be attached to either code in the hopes of payment. The codes are mutually exclusive and the higher reimbursing code is the recommended CPT code to be billed.</td>
</tr>
<tr>
<td>1-rule</td>
<td>Does allow for payment when the two CPT codes in question are submitted; however, one of the codes will require a modifier attached for payment. The modifier is applied to the Column 2 code and does not guarantee payment.</td>
</tr>
<tr>
<td>9-rule</td>
<td>Edit no longer applies or was in error.</td>
</tr>
</tbody>
</table>

Below is an example of the CCI/OCE edits Excel document found on the CMS website:

<table>
<thead>
<tr>
<th>Column 1</th>
<th>Column 2</th>
<th>Effective Date</th>
<th>Deletion Date</th>
<th>Indication</th>
<th>Edit Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>77290</td>
<td>77336</td>
<td>20031001</td>
<td></td>
<td>1</td>
<td>Misuse of column two code with</td>
</tr>
<tr>
<td>77306</td>
<td>77300</td>
<td>20150101</td>
<td></td>
<td>0</td>
<td>CPT Manual or CMS manual coding instructions</td>
</tr>
<tr>
<td>77295</td>
<td>77290</td>
<td>19960101</td>
<td></td>
<td>0</td>
<td>More extensive procedure</td>
</tr>
<tr>
<td>77295</td>
<td>77307</td>
<td>20150101</td>
<td></td>
<td>0</td>
<td>Standards of medical / surgical</td>
</tr>
<tr>
<td>77295</td>
<td>77300</td>
<td>20160101</td>
<td>20160101</td>
<td>9</td>
<td>Misuse of column two code with column one code</td>
</tr>
<tr>
<td>77301</td>
<td>77290</td>
<td>20020101</td>
<td></td>
<td>0</td>
<td>Standards of medical / surgical</td>
</tr>
<tr>
<td>77321</td>
<td>77300</td>
<td>20150401</td>
<td></td>
<td>0</td>
<td>CPT Manual or CMS manual coding</td>
</tr>
<tr>
<td>77401</td>
<td>77334</td>
<td>20150401</td>
<td></td>
<td>0</td>
<td>CPT Manual or CMS manual coding</td>
</tr>
<tr>
<td>77778</td>
<td>77790</td>
<td>20160101</td>
<td></td>
<td>0</td>
<td>CPT Manual or CMS manual coding</td>
</tr>
</tbody>
</table>

In CY 2016 CMS, which owns NCCI, released an edit with codes 77295 (3-D plan) and 77300 (basic dosimetry calculations). The edit was effective January 1, 2016, but deleted and made retroactive to the original date. The National Correct Coding Initiative Policy Manual for Medicare (Medicaid) Services, Chapter IX (Radiation Oncology), subsection 17 of the 2016 version of the Manual, continued to state the
edit was in effect even after deletion. The manual has been updated for CY 2017 and all reference to the basic dosimetry calculations as a component of the 3-D plan has been removed.

Additional information and policy regarding the NCCI edits can be found within the NCCI Policy Manual for Medicare Services. This manual provides additional verbiage and rationale to the edits published each quarter. The policy manual is broken down by the CPT code sections. Chapter 9 contains the policy information for CPT codes 70000 – 79999, the radiation oncology series of codes.

Knowledge and use of the CCI/OCE edits ahead of submitting billing to payers can facilitate the payment process and decrease the number of denials. A quarterly review of any changes or additions to the CCI/OCE edits is recommended. The NCCI Policy Manual for Medicare Services Effective January 1, 2017 and National Correct Coding Initiatives Edits can be found at:

**Medically Unlikely Edits**

Medically Unlikely Edits (MUEs) are automated prepayment edits published on a quarterly basis by CMS and are located at https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/MUE.html. They are not intended to dictate a payment policy by Medicare, but instead improve and ensure accuracy of Medicare payments by reducing paid claim errors. This is accomplished by establishing the maximum number of allowable units a particular code can be billed on a single date of service. MUEs were first implemented in January 2007 and the limitations were based upon anatomical considerations, code descriptors, policies, nature of service/procedure, nature of equipment and clinical judgment. These limitations were not originally published; however, in October 2008 CMS did publish MUEs for CPT codes with a quantity of less than four, and continued until July 2014. The third quarter publication of the MUEs was adjusted per a recommendation by the OIG after review of Medicare claims relative to MUE levels.

Per the OIG findings, Medicare agreed changes were needed in light of the inappropriate billing using multiple lines to bypass MUEs and converted most MUEs to per day edits. These changes included quantities published that are above four and an indicator and rationale for the edit. The published MUEs now include designation of a Medicare Adjudication Indicator (MAI) which indicates the type of MUE (indicator) and its basis (rationale) within the spreadsheet.

An MAI of 3 is the most common per day edit and indicates an MUE that is based on clinical information such as:

- Billing patterns,
- Prescribing instructions or
• Other information.

Exceptions may occur, but would be rare, and the high volume of services or units billed would generally be considered an error. Providers are encouraged to carefully assess any denials based on an MAI of 3 to ensure it is not due to a clerical error or misinterpretation or application of coding instructions. In the rare instance in which, upon review of all information and interpretation of coding instructions, the provider still feels the quantity of the code was correctly reported and was appropriately documented as being medically necessary but still exceeds the MUE, a clearly supported appeal should be submitted.

An MAI of 2 indicates an edit in which the MUE is based on regulation, policy or something inherent to the code description itself. An example might be one in which the number of a particular body part only includes a certain anatomical number, such as seven cervical vertebrae. On a claim form there could not be a quantity of more than seven for a procedure which is “per cervical vertebrae”. Another example might include a code that has an amount of time included in the descriptor, such as “first 15 minutes”, when there are additional codes to report subsequent time with the patient. Only one code for the “first 15 minutes” could be supported. In both instances it is believed any reporting of quantities above the listed MAI of 2 are clerical errors or misinterpretations.

In the fourth quarter 2014 MUE publication, Medicare included CPT code 77300 with a published quantity per date of service. Prior to October 2014, MUEs for CPT code 77300 had not been published, as this code is typically reported in quantities in excess of four and Medicare does not publish these quantities to prevent fraudulent billing. Included within the fourth quarter 2014 publication, Medicare set an MUE limit of 10 per date of service with an MAI of 3 for CPT code 77300 and an MUE of three per date of service for CPT code 77331. Effective October 1, 2015, CMS established an MUE of 10 for CPT code 77334; this includes an MAI 3 and the quantity is per date of service. The following table outlines a sampling of the new MUE quantities, indicators and rationale as stated in the published spreadsheet for first quarter 2017.

<table>
<thead>
<tr>
<th>HCPCS/CPT Code</th>
<th>Practitioner &amp; Outpatient Hospital Services MUE Values</th>
<th>MUE Adjudication Indicator</th>
<th>MUE Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>77263</td>
<td>1</td>
<td>3 Date of Service Edit: Clinical</td>
<td>Nature of Service/Procedure</td>
</tr>
<tr>
<td>77290</td>
<td>1</td>
<td>3 Date of Service Edit: Clinical</td>
<td>Nature of Service/Procedure</td>
</tr>
<tr>
<td>77295</td>
<td>1</td>
<td>3 Date of Service Edit: Clinical</td>
<td>Nature of Service/Procedure</td>
</tr>
<tr>
<td>77300</td>
<td>10</td>
<td>3 Date of Service Edit: Clinical</td>
<td>Clinical: Data</td>
</tr>
<tr>
<td>77307</td>
<td>1</td>
<td>3 Date of Service Edit: Clinical</td>
<td>Nature of Service/Procedure</td>
</tr>
<tr>
<td>77321</td>
<td>1</td>
<td>2 Date of Service Edit: Policy</td>
<td>Code Descriptor / CPT</td>
</tr>
<tr>
<td>77331</td>
<td>3</td>
<td>3 Date of Service Edit: Clinical</td>
<td>Clinical: Data</td>
</tr>
<tr>
<td>77332</td>
<td>4</td>
<td>3 Date of Service Edit: Clinical</td>
<td>Clinical: Data</td>
</tr>
</tbody>
</table>
Medicare continues to state that the MUEs should not be interpreted as utilization guidelines. The published values do not represent quantities that can be billed to avoid medical review. Providers are encouraged to continue to report services that are appropriately documented as medically necessary and reasonable.

Requesting reopening a claim as opposed to an appeal can be done for all MUE edit denials, including MAI of 2 and 3, if a clerical error is identified by the provider and the correct value is equal to or less than the MUE. The request to reopen a claim due to the unintentional errors will result in delay of full payment.

### Modifiers

Modifiers are two-digit codes added to CPT or HCPCS codes that allow a provider to offer additional information about the service or procedure being reported. The use of a modifier informs the payer if a service or procedure has been altered for some specific circumstance but not changed in its definition. The application of modifiers should be carefully scrutinized to ensure they are appropriate to the circumstance and accepted by the payer. Modifiers may be used to indicate the following:

- A service or procedure had both a professional and technical component; however, seeking reimbursement of only one component.
- A service or procedure was increased or reduced.
- Only part of a service was performed.
- An adjunctive service was performed.
- A bilateral procedure was performed.
- A service or procedure was provided more than once.
- Unusual events occurred.

Of the modifiers used in radiation oncology, modifier -59, is the most widely used, sometimes inappropriately. Modifier -59 is defined for use with multiple circumstances and in many instances has become the catchall or modifier applied when nothing else seems to fit. While there may be instances in which a -59 modifier is appropriate, CMS believes more coding options, plus increased user education and selective editing, are needed to reduce errors. CMS introduced X-modifiers in 2014 to be used in
place of the -59 modifier and provide more information about the services billed. As of this writing, the guidance from CMS has not been clarified regarding how to utilize the new X-modifiers. Only if a payer has specifically instructed a provider to use the X-modifiers should they be used in place of the -59 modifier and applied as directed by the payer.

The following table reflects common modifiers used in radiation oncology.

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Descriptor</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>-25</td>
<td>Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service</td>
<td>It may be necessary to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed. A significant, separately identifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported (see Evaluation and Management Services Guidelines for instructions on determining level of E/M service). The E/M service may be prompted by the symptom or condition for which the procedure and/or service was provided. As such, different diagnoses are not required for reporting of the E/M services on the same date. This circumstance may be reported by adding modifier 25 to the appropriate level of E/M service. Note: This modifier is not used to report an E/M service that resulted in a decision to perform surgery. See modifier 57. For significant, separately identifiable non-E/M services, see modifier 59.</td>
</tr>
<tr>
<td>-26</td>
<td>Professional Component</td>
<td>Certain procedures are a combination of a physician or other qualified health care professional component and a technical component. When the physician or other qualified health care professional component is reported separately, the service may be identified by adding modifier 26 to the usual procedure number.</td>
</tr>
<tr>
<td>-TC</td>
<td>Technical Component</td>
<td>Under certain circumstances, a charge may be made for the technical component alone. Under those circumstances the technical component charge is identified by adding modifier “TC” to the usual procedure number. Technical component charges are institutional charges and not billed separately by physicians.</td>
</tr>
<tr>
<td>Modifier</td>
<td>Description</td>
<td>Information</td>
</tr>
<tr>
<td>----------</td>
<td>-------------</td>
<td>-------------</td>
</tr>
<tr>
<td>TC (Cont.)</td>
<td>Technical Component (Cont.)</td>
<td>However, portable x-ray suppliers only bill for technical component and should utilize modifier TC. The charge data from portable x-ray suppliers will then be used to build customary and prevailing profiles.</td>
</tr>
<tr>
<td>59</td>
<td>Distinct Procedural Service</td>
<td>Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used. Note: Modifier 59 should not be appended to an E/M service. To report a separate and distinct E/M service with a non-E/M service performed on the same date, see modifier 25.</td>
</tr>
<tr>
<td>76</td>
<td>Repeat Procedure or Service by Same Physician or Other Qualified Health Care Professional</td>
<td>It may be necessary to indicate that a procedure or service was repeated by the same physician or other qualified health care professional subsequent to the original procedure or service. This circumstance may be reported by adding modifier 76 to the repeated procedure or service. Note: This modifier should not be appended to an E/M service.</td>
</tr>
<tr>
<td>77</td>
<td>Repeat Procedure or Service by Another Physician or Other Qualified Health Care Professional</td>
<td>It may be necessary to indicate that a basic procedure or service was repeated by another physician or other qualified health care professional subsequent to the original procedure or service. This circumstance may be reported by adding modifier 77 to the repeated procedure or service. Note: This modifier should not be appended to an E/M service.</td>
</tr>
</tbody>
</table>
Medicare Redetermination Process

Once an initial claim determination has been made, beneficiaries, providers and suppliers have the right to appeal Medicare coverage and/or payment decisions. All appeal requests must be made in writing. It is recommended that facilities refer to their local payer’s websites for specific details and forms to be utilized in the redetermination process.

A summary of the appeals process is as follows:

<table>
<thead>
<tr>
<th>Level</th>
<th>What happens</th>
<th>Who performs the review?</th>
<th>When must appeal be requested?</th>
<th>When should decision be received?</th>
<th>Amount Remaining in Controversy</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st Level - Redetermination</td>
<td>Document review of initial claim determination</td>
<td>MAC</td>
<td>Within 120 days from the date of receipt of the Remittance Advice (RA) that lists the initial determination</td>
<td>60 days</td>
<td>No</td>
</tr>
<tr>
<td>2nd Level - Reconsideration</td>
<td>Document review of redetermination – submit any evidence not previously presented at this level</td>
<td>QIC</td>
<td>Within 180 days of receipt of the MRN or RA</td>
<td>60 days</td>
<td>No</td>
</tr>
<tr>
<td>3rd Level - ALJ Hearing</td>
<td>May be an on-the-record review or may be an interactive hearing between parties</td>
<td>ALJ</td>
<td>Within 60 days of receipt of the reconsideration decision letter or after the expiration of the reconsideration period</td>
<td>May be delayed due to volume</td>
<td>Yes*</td>
</tr>
<tr>
<td>4th Level - Medicare Appeals Council Review</td>
<td>Document review of ALJ’s decision or dismissal, but may request oral arguments</td>
<td>Appeals Council</td>
<td>Within 60 days of receipt of the ALJ’s decision or after the ALJ ruling time frame expires</td>
<td>90 days if appealing an ALJ decision or 180 days if an escalated appeal from date of receipt of request for escalation</td>
<td>No</td>
</tr>
<tr>
<td>5th Level - Judicial Review in U.S. District Court</td>
<td>Judicial review</td>
<td>U.S. District Court</td>
<td>Within 60 days of receipt of the Appeals Council’s decision or after the Appeals Council ruling time frame expires</td>
<td>No statutory time limit</td>
<td>Yes*</td>
</tr>
</tbody>
</table>

MAC = Medicare Administrative Contractor  
QIC = Qualified Independent Contractor  
ALJ = Administrative Law Judge  
AIC = Amount Remaining in Controversy

*The AIC is recalculated each year and may change. For 2017, the AIC threshold amounts are $160 for ALJ hearings and $1,560 for judicial review. The appellant must request a Federal District Court hearing within 60 days of receipt of the Medicare Appeals Council’s decision. Additional information may be located at [https://www.cms.gov/medicare/appeals-and-grievances/orgmedifsappeals/review-federal-district-court.html](https://www.cms.gov/medicare/appeals-and-grievances/orgmedifsappeals/review-federal-district-court.html) in “Related Links” section.


Providers should be aware third level appeals (ALJs) are performed on a de novo basis and therefore are not impacted by previous MAC or QIC denials. ALJs are not employed or responsible to the MACs or QICs; due to this, backlogs are such that determinations may not occur until three or more years after services are delivered and billed. Third level appeals should not be initiated unless the patient record contains all documentation appropriate to support payment for the denied service.
Physician Bonuses per [CMS.gov](https://www.cms.gov)

Health Professional Shortage Area (HPSA) Designations

Throughout the U.S. there are some geographic areas and facilities with too few primary care, dental and medical health providers and services. To address these deficiencies, Health Professional Shortage Areas (HPSAs) have been assigned and certain additional federal resources may be available. One specific resource is a 10% bonus payment to providers for primary care and dental and mental health services in designated HPSAs.

As outlined on the CMS website, MMA Section 413(b) required CMS to revise some of the policies that address HPSA bonus payments. Section 1833(m) of the Social Security Act provides bonus payments for physicians who furnish medical care services in geographic areas that are designated by the HRSA as primary medical care HPSAs under section 332 (a)(1)(A) of the Public Health Service (PHS) Act. In addition, for claims with dates of service on or after July 1, 2004, psychiatrists (provider specialty 26) furnishing services in mental health HPSAs are also eligible to receive bonus payments. If a ZIP code falls within both a primary care and mental health HPSA, only one bonus will be paid on the service. Additional information about the HPSA program can be found at [https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/HPSAfactsht.pdf](https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/HPSAfactsht.pdf).

Providers can review the latest HPSA designations on the HRSA website at [www.hrsa.gov/shortage/](https://www.hrsa.gov/shortage/).

MMA Changes

Per the CMS website, effective January 1, 2005, a modifier no longer has to be included on claims to receive the HPSA bonus payment, which will be paid automatically, if services are provided in ZIP code areas that either:

- Fall entirely in a county designated as a full-county HPSA; or
- Fall entirely within the county, through a USPS determination of dominance; or
- Fall entirely within a partial county HPSA.

However, if services are provided in ZIP code areas that do not fall entirely within a full county HPSA or partial county HPSA, the AQ modifier must be entered on the claim to receive the bonus.

The following are the specific instances in which a modifier must be entered:

- When services are provided in ZIP code areas that do not fall entirely within a designated full county HPSA bonus area;
• When services are provided in a ZIP code area that falls partially within a full county HPSA but is not considered to be in that county based on the USPS dominance decision;
• When services are provided in a ZIP code area that falls partially within a non-full county HPSA;
• When services are provided in a ZIP code area that was not included in the automated file of HPSA areas based on the date of the data run used to create the file.

To determine whether a service will automatically qualify to receive the bonus payment, review the information provided on the CMS website. The HRSA website should be reviewed for the most recent designations. Physicians may also use the HRSA website designations when deciding whether to include the HPSA modifier on their claims.

Some important points:

• Medicare contractors will base the bonus on the amount actually paid (not the Medicare-approved payment amount for each service), and the 10% bonus will be paid on a quarterly basis.
• The HPSA bonus pertains only to a physician's professional services. Should a service be billed that has both a professional and technical component, only the professional component will receive the bonus payment.
• The key to eligibility is not that the beneficiary lives in a HPSA or that the physician's office or primary location is in a HPSA, but rather that the services are actually rendered in a HPSA.
• To be considered for the bonus payment, the name, address and ZIP code of the location where the service was rendered must be included on all electronic and paper claim submissions.
• Physicians should verify the eligibility of their area for a bonus before submitting services with a HPSA modifier for areas they think may still require the submission of a modifier to receive the bonus payment.
• Services submitted with the AQ modifier will be subject to validation by Medicare.

Provider Center

For a one-stop resource web page focused on the informational needs and interests of Medicare Fee-for-Service (FFS) providers, including physicians, other practitioners and suppliers, visit this site. Additional information can be found under Related Links: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HPSAPSAPhysicianBonuses/index.html?redirect=/hpsapsaphysicianbonuses/.

Affordable Care Act of 2010 Changes (New as of January 2011 for the HSIP Bonus)

The Affordable Care Act of 2010, Section 5501 (b)(4) expands bonus payments for general surgeons in HPSAs. Effective January 1, 2011 through December 31, 2015, physicians serving in designated HPSAs
will receive an additional 10% bonus for major surgical procedures with a 10- or 90-day global period. This additional payment, referred to as the HPSA Surgical Incentive Payment (HSIP), will be combined with the original HPSA payment and will be paid on a quarterly basis. Modifier AQ should be appended for these major surgical procedures, similar to claims for the Medicare original HPSA bonus for which services are provided in ZIP code areas that do not fall entirely within a full or partial county HPSA.

Some points to remember:

- The current HPSA physician bonus program requirements will remain intact.
- Medicare contractors will identify and pay the additional bonus on eligible services rendered in eligible ZIP code areas based on the HPSA ZIP code file as of December 31 of the prior year.
- Medicare contractors will calculate the bonus amount based on the amount actually paid for the service, not the Medicare-approved amount.
- Services submitted with modifier AQ will be subject to validation by Medicare.
Recovery Audit Contractor (RAC) Program

Mission

The Recovery Audit Program’s mission is to identify and correct Medicare improper payments through the efficient detection and collection of overpayments made on claims of health care services provided to Medicare beneficiaries, and the identification of underpayments to providers so that the CMS can implement actions that will prevent future improper payments in all 50 states.

Background

The national Recovery Audit program is the product of a successful demonstration program that utilized Recovery Auditors to identify Medicare overpayments and underpayments to health care providers and suppliers in randomly selected states. The demonstration ran between 2005 and 2008 and resulted in more than $900 million in overpayments being returned to the Medicare Trust Fund and nearly $38 million in underpayments returned to health care providers. As a result, Congress required the Secretary of the Department of Health and Human Services to institute (under Section 302 of the Tax Relief and Health Care Act of 2006) a permanent and national Recovery Audit program to recoup overpayments associated with services for which payment is made under part A or B of title XVIII of the Social Security Act.

Each Recovery Auditor is responsible for identifying overpayments and underpayments in approximately a quarter of the country. The Recovery Audit Program jurisdictions match the DME MAC jurisdictions.

Throughout 2014 there were changes and delays to the RAC program as each of the RAC contracts was up for renewal. During the procurement process, and to allow for the then-current contracts to end without carryover, complex reviews were suspended, allowing for only automated reviews. To assist with some of the issues identified during, and as a part of, the procurement process a Provider Relations Coordinator was established. The Provider Relations Coordinator was created to increase transparency and offer more efficient resolutions to providers affected by the medical review process. Providers should continue to contact the Recovery Auditor or MAC with questions regarding specific claims, but any larger process issues are to be communicated to the Coordinator. In addition, suggestions or recommendations for improving the Recovery Auditor or MAC medical review process can also be provided to the CMS Provider Relations Coordinator.

On October 31, 2016 new Fee-for-Service (FFS) RAC contracts were awarded. The original Medicare FFS RACs are under contract with CMS until 2018 for administrative purposes. Providers may still receive correspondence from the original RACs related to claims adjusted.

Per the CMS website the new FFS RACs are as follows:
- Region 1: Performant Recovery Inc.
- Region 2: Cotiviti, LLC.
- Region 3: Cotiviti, LLC.
- Region 4: HMS Federal Solutions

Questions concerning the RAC program can be directly emailed to RAC@cms.hhs.gov.

The Scope of Work (SOW) for the RACs as updated November 30, 2016 can be located at https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/Downloads/New_RAC-SOW-Regions-1-4-clean.pdf.

The full Medicare website information on the RAC program is found at http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/.
Clinical Setting

Supervision

In the CY 2000 HOPPS Final Rule, CMS indicated direct supervision is the standard for all hospital outpatient therapeutic services covered and paid by Medicare. Therefore, a qualified physician should supervise all radiation therapy services provided. In addition, within the signature line on the CMS 1500 claim form and the CY 2016 updated “incident to” guidelines, services billed were medically necessary and personally supervised by the billing physician.

The CY 2013 HOPPS Final Rule continues to uphold this instruction from CMS as it pertains to radiation oncology services and the supervisory responsibility as being more than the capacity to respond to an emergency or to resume treatment that had been interrupted. The provider must be physically present, interruptible and immediately available to reassess the patient and resume treatment as appropriate. This could include modifying treatment as needed on a non-emergent basis, the ability to redirect or take over performance of the service and issue any additional orders. Supervising physicians should be clinically trained in the specialty they are overseeing and have within their state Scope of Practice the ability to provide the services they are supervising. These requirements alone indicate the supervision for radiation oncology services would only be appropriately provided by a radiation oncologist. Many nurse practitioners’ and physician assistants’ Scope of Practice does not account for the ability to manage radiation therapy side effects or make crucial decisions about simulation, planning, and daily treatment delivery and dosage. In addition, providers often contractually agree with payers to deliver services only for which they are board certified and have completed the required specialized education and training. As of the CY 2014 HOPPS Final Rule by CMS, the exclusion of critical access hospitals requiring direct supervision for outpatient therapeutic procedures has been discontinued.

In the CY 2016 MPFS Final Rules, CMS updated the guidelines related to incident to services. Incident to services require direct supervision of the auxiliary personnel providing the service by the physician or other practitioner. CMS is adjusting language to follow that the physician who supervises the service(s) is the billing physician. CMS stated, “To be certain that the incident to services furnished to a beneficiary are in fact an integral, although incidental, part of the physician’s or other practitioner’s personal professional service that is billed to Medicare, we believe that the physician or other practitioner who bills for the incident to service must also be the physician or other practitioner who directly supervises the service. It has been our position that billing practitioners should have a personal role in, and responsibility for, furnishing services for which they are billing and receiving payment as an incident to their own professional services.” This statement would follow the attestation statement on the back of every CMS1500 claim form submitted by the physician for payment of services. The attestation statement indicates the physician listed on the Medicare claim “personally furnished” the services which are billed on the front.
CMS is also revising the last sentence of the policy to state “that the physician (or other practitioner) supervising the auxiliary personnel need not be the same physician (or other practitioner) treating the patient more broadly.” CMS is also adding clarifying text, “that only the physician or other practitioner under whose supervision the incident to service(s) are being provided is permitted to bill the Medicare program for the incident to services.”
Medicare Medical Record Requirements

The medical record encompasses all documentation of a patient’s medical history and care. A complete medical record, as described by Medicare, includes accurate diagnosis coding, medical necessity and justification of treatment and all documents pertaining to the treatment course. The result or outcome of the patient’s course should be included as well as any documentation supporting the CPT codes billed for services rendered. A continuity of care among the patient’s health care providers should be demonstrated. Accurate and timely electronic or written approvals, including the date and time stamp of the applied approval, should be supported and located throughout the medical record.

Diagnosis Coding

Per Medicare guidelines, diagnosis coding should be based on the area of treatment for the patient’s current course and coded to the highest level of specificity. Diagnosis codes should be verified and updated each time the patient begins a new course of therapy or their malignancy changes, always prior to pre-authorizations and claim submissions. Payment is likely to be denied if the diagnosis code changes after pre-authorization and it is not altered prior to claim submission. In addition to the diagnosis being reported on the
claim form, Medicare further instructs that Z51.0 is to be used as the principal diagnosis for radiation therapy-specific procedures. This code is to be placed as the primary diagnosis followed by the diagnosis code associated to the malignancy for which therapy is being administered.

The transition to ICD-10 took place on October 1, 2015 for all entities covered by the Health Insurance Portability Accountability Act (HIPAA), not just those who submit Medicaid and Medicare claims. Diagnosis coding with ICD-10 includes three to seven digits instead of three to five, as with ICD-9. It is important to note that ICD-10 coding does not affect CPT codes reported for radiation therapy procedures. CMS provides resources for providers at https://www.cms.gov/Medicare/Coding/ICD10/ProviderResources.html.

Medical Necessity

Medicare requires the medical necessity for each service reported on a claim to be clearly documented within the patient’s medical record. Claims not supported by medical necessity are at risk for denial in the event of payer review. Payment for a service does not indicate all requirements have been met; rather, that the payer is making the assumption the medical necessity is supported within the medical record. If audited, services not supported by medical necessity may be denied, thus putting the provider at risk of recoupment of payment as well as fines, additional penalties and further review.

The medical necessity must be specific to each patient for the intended course of treatment. If this is not appropriately documented, overlooked or indicated with a simple marked check box that is the same from patient to patient, the entire course of treatment is open to question. These seemingly harmless but common mistakes that occur when documenting medical necessity remove the individuality of each patient’s treatment course and may be viewed as cloned documentation. As a result, reimbursement for the entire course of treatment could subsequently be delayed or denied.

Many payer LCDs contain medical necessity requirements for the services provided. For example, IMRT treatment routinely requires a physician statement to indicate the need for IMRT treatment planning over 3-D or other conventional forms of treatment. Medical necessity statements for IGRT should include the necessary type of imaging and frequency for it to be performed. Courses of stereotactic radiotherapy must support and meet the medical necessity and limitation guidelines outlined in the payer LCDs in addition to patient’s functional status and a description of current performance status.

Documentation

Medicare instructs all documentation for the patient be maintained and made available upon request. Documentation must include and clearly indicate the patient name, date of birth, date of service, and the
correct provider and should support the services being billed. The radiation treatment prescription does not include orders necessary for all services pertaining to treatment; separate orders from the physician will be needed. Supporting documentation and orders for services rendered and billed must be located within the patient's medical record, whether paper or electronic. If the service is not clearly documented, the Medicare auditor may determine the service was not performed, assuming, "If it was not documented, it did not occur." The documentation associated to the services provided should be completed at the time of service. It should be able to accurately support the service rendered and be legible to another reader. The medical record should provide clear, chronological, detailed and informative accounts of all procedures performed without needing further explanation. All records must be easily located due to the possibility of claims being reviewed several months or years after the service has been performed. Any documentation not easily accessible or understood poses a risk for potential liability, even if the service actually occurred. The necessity for any changes in initial treatment plans should be clearly documented.

The omission of specific orders and documentation for radiation oncology services is a common error observed throughout the country and can be a focus of payer reviews. It is important to reference the appropriate LCD when reviewing documentation requirements for all services, as the requirements can differ in regard to what is expected of supporting documentation, orders and medical necessity. Physicians 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. Below is a list, for illustrative purposes only, of common procedures in radiation oncology requiring written orders and documentation:

- Physician Clinical Treatment Plan
- Special Treatment Procedure
- Simulations
- Treatment Planning
- Basic Dosimetry Calculations
- Beam Shaping Devices
- IMRT QA
- Physics Services
- Weekly Treatment Management
- IGRT
- Port Films
- Special Dosimetry
- SRS/SBRT and Brachytherapy Treatment Procedure/Operative Notes
- Any other service performed
Simple check box forms for documenting orders, services and medical necessity are not recommended. The fact that they do not allow for individual patient-specific instructions and information and introduce the risk of clone documentation is problematic. Some templates provide limited options and/or space for the collection of information by using check boxes or predefined answers. CMS discourages the use of such templates. Claim reviews often reflect that limited space templates commonly fail to capture sufficient detailed clinical information to demonstrate that all coverage and coding requirements are met. With the increase of electronic documentation it is common for Medicare Contractors to address clone documentation within the LCD policies. The presence of clone documents within the patient’s chart could lead to denial of services and recoupment of any overpayments. Per Palmetto GBA, “The word ‘cloning’ refers to documentation that is worded exactly like previous entries. This may also be referred to as ‘cut and paste’ or ‘carried forward.’ Cloned documentation may be handwritten, but generally occurs when using a preprinted template or an Electronic Health Record (EHR). While these methods of documenting are acceptable, it would not be expected the same patient had the same exact problem, symptoms, and required the exact same treatment or the same patient had the same problem/situation on every encounter. Cloned documentation does not meet medical necessity requirements for coverage of services. Identification of this type of documentation will lead to denial of services for lack of medical necessity and recoupment of all overpayments made.” In the January 2014 OIG report, CMS and Its Contractors Have Adopted Few Program Integrity Practices to Address Vulnerabilities in EHRs (http://oig.hhs.gov/oei/reports/oei-01-11-00571.pdf), clone documentation is specifically addressed. The OIG recommends CMS, ZPIC and RAC auditors evaluate the EHR audit logs for copy and pasting, over documentation of evaluation and management reports and cloned documentation.

Medical record retention is another component of documentation that providers need to be familiar with as payer reviews can extend several years into the past. CMS addresses this within the MLN Matters Number: SE1022, Medical Record Retention and Media Formats for Medical Records. Even though this is typically set by each state, due to HIPAA guidelines there are rules which may overrule any state guidelines. The full transmittal can be found at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1022.pdf. An excerpt is provided below.

“State laws generally govern how long medical records are to be retained. However, the Health Insurance Portability and Accountability Act (HIPAA) of 1996 (HIPAA) administrative simplification rules require a covered entity, such as a physician billing Medicare, to retain required documentation for six years from the date of its creation or the date when it last was in effect, whichever is later. HIPAA requirements preempt State laws if they require shorter periods. Your State may require a longer retention period. The HIPAA requirements are available at 45 CFR 164.316(b)(2).”
Signatures

Specific signature requirements are detailed in chapter three of the Medicare Program Integrity Manual. Specifically, it states, “For medical review purposes, Medicare requires that services provided/ordered be authenticated by the author. The method used shall be a handwritten or an electronic signature. Stamp signatures are not acceptable.” Therefore, a physician’s signature with the date and time stamp is necessary with each entry into the medical record; by doing this, support for physician involvement is shown. Services provided that are technical only in nature are exceptions to these signature rules; physician involvement is not documented as part of the treatment delivery itself. The physician’s involvement in the treatment is represented within the physician management note provided every five fractions of treatment. Services with an associated professional component, even if medically necessary and appropriately performed, may be denied payment if not accompanied by the provider signature and date.

In regard to the timeliness of signatures, Medicare specifically instructs, “Providers should not add late signatures to the medical record (beyond the short delay that occurs during the transcription process) but instead may make use of the signature authentication process.” Therefore, it would be expected that physician signatures supporting the required direct supervision and the physician’s work and participation in that service would be applied to the documentation at the time of the service. Any physician signature applied after the service is completed, such as the next day or days later, makes it very difficult to support that the physician was present and the service is appropriate to bill.

Legibility

In addition to the requirement for signed documentation to be present within the medical record, the signatures must be legible to support the service. If the documentation cannot be understood due to illegibility, it cannot be included as supporting documentation. If it is included, there may be risk for potential recoupment of paid fees. This is especially evident with regard to physician signatures. This area has become a focus of review due to missed and illegible signatures or the lack of date and time stamping required by Medicare. The signature authentication process may also be used when illegible signatures are present within the patient’s record. This process includes the use of an additional handwritten signature on the document signifying the approval, submission of a signature log of individuals making note in a patient record or the use of an attestation statement.

With the government mandate requiring all facilities to transition into an electronic health record (EHR) the implementation of a complete EHR can significantly improve the patient’s medical record. EHRs provide the opportunity for specificity, procedure/service detail, efficiency and organization and legibility now creates the potential to eliminate confusion and duplication of information. As with a paper record, orders and supporting documentation still require an appropriate electronic signature of a physician, including the date and time stamp,
and should be clearly organized. When transitioning paper documentation to electronic medical recordkeeping, it is recommended to maintain knowledge of all supporting documentation and its corresponding location. Poor documentation within the medical record can affect patient safety, quality of care, departmental and staff efficiency, and reimbursement.


Correct Provider

Medicare requires all supporting documentation to include the name and credentials of the physician providing the service being billed. As previously mentioned, the signature line on the CMS 1500 claim form and the updated definition and guidelines for incident to state the services rendered were provided by the reporting physician. As published within the CMS MLN Matters, SE0441, “Incident to services are those services provided incident to professional services in a physician’s office.” Incident to services include those supervised by certain non-physician practitioners such as nurse practitioners, clinical nurse specialists and physician's assistants. It is important to note that incident services supervised by non-physician practitioners will be reimbursed at 85% of the physician fee schedule. The services provided still require direct supervision. This means the physician must be present in the office suite to provide assistance if needed. The patient record should document the essential requirements for incident to service. The possibility of the supervising physician varying from the consulting or prescribing physician is likely due to physician coverage from day to day. For example, if Dr. Covering is the supervising physician and approves the treatment plan in Dr. Attending’s absence, the claim form would indicate Dr. Covering submitting payment for those services. Failure to adhere to this policy may result in recoupment of charges, as well as potential penalties. The NPI of the physician performing/supervising the service must be listed on the CMS 1500 claim form when submitting to Medicare. This concept applies to all services performed.
The Process of Care

The information found in this section of the guide is organized based on a standard process of care in which the workflow is generally the same and can further assist in ensuring documentation and billing compliance. If a process is implemented to ensure each step in the patient care process is documented and billed appropriately, then errors can be reduced and ultimately a higher level of compliance can be obtained. The following diagram will assist in the understanding of the process of care.

![Diagram of the process of care]

Evaluation and Management Visits (Professional)

Evaluation and Management (E&M) codes are utilized to report the complexity and level of care provided to the patient during the visit with the radiation oncologist. Coding for these services varies depending on the designation of new versus established patient for the physician or professional group. Documentation by the physician performing the service is required to support level of complexity and designation of the type of visit.

Medicare no longer recognizes the previous outpatient 99241-99245 or inpatient 99251 – 99255 consultation codes. Instead, physicians must utilize the new patient 99201-99205 or established patient 99211 – 99215 outpatient visit CPT codes or initial hospital care 99221 – 99223 or 99231 – 99233 subsequent hospital care CPT codes for the Evaluation and Management visits. The appropriate outpatient code will depend upon whether the patient has been provided a service by the physician or a physician within the professional group of the same sub-specialty within the past three years. If the
patient has been provided a service, then the patient would be considered an established patient to all of the physicians in that same sub-specialty group. If the patient has not been seen within the last three years, the patient would be considered a new patient.

The initial visit by the physician while the patient is inpatient is to be coded as initial hospital care visit; each subsequent visit while the patient remains inpatient is billed as a subsequent inpatient visit. Subsequent hospital care visits are not reported once the patient has begun a radiation therapy course of treatment as they are inclusive to the weekly management CPT code 77427. In the event the documentation of the initial hospital visit by the physician does not support or meet the criteria of the initial hospital visit, the visit is coded as a subsequent hospital care visit. All levels of subsequent hospital care include reviewing the medical record, the results of diagnostic studies and changes in the patient's status (i.e., changes in history, physical condition and response to management) since the last assessment by the physician. These codes are inclusive to the weekly management CPT code 77427 if under current radiation therapy treatments.

The following chart, provided by the AMA, outlines the criteria for determining the correct new vs. established professional E&M service.
Decision Tree for New vs. Established Patients

Has the patient received any professional service from the physician or another physician in group of the same specialty within the past 3 years?

- Yes
  - Same specialty?
    - Yes
      - Exact same sub-specialty?
        - Yes
          - Established Patient
        - No
          - New Patient
    - No
      - New Patient
- No
  - New Patient
### Outpatient New Patient Visits (99201 – 99205)

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
</table>
| 99201 | Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components:  
A problem-focused history;  
A problem-focused examination; and  
Straightforward medical decision-making.  
Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.  
Usually, the presenting problem(s) are self-limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family. |
| 99202 | Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components:  
An expanded problem-focused history;  
An expanded problem-focused examination; and  
Straightforward medical decision-making.  
Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.  
Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 20 minutes face-to-face with the patient and/or family. |
| 99203 | Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components:  
A detailed history;  
A detailed examination; and  
Medical decision-making of low complexity.  
Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.  
Usually, the presenting problem(s) are of moderate severity. Physicians typically spend 30 minutes face-to-face with the patient and/or family. |
| 99204 | Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components:  
A comprehensive history;  
A comprehensive examination; and  
Medical decision-making of moderate complexity.  
Counseling and/or coordination of care with other providers or agencies are provided consistent with |
the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 45 minutes face-to-face with the patient and/or family.

<table>
<thead>
<tr>
<th>99205</th>
<th>Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: A comprehensive history; A comprehensive examination; and Medical decision-making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 60 minutes face-to-face with the patient and/or family.</th>
</tr>
</thead>
</table>

### Outpatient Established Patient Visits (99211 – 99215)

<table>
<thead>
<tr>
<th>99211</th>
<th>Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.</th>
</tr>
</thead>
<tbody>
<tr>
<td>99212</td>
<td>Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: A problem-focused history; A problem-focused examination; Straightforward medical decision-making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self-limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.</td>
</tr>
<tr>
<td>99213</td>
<td>Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: An expanded problem-focused history; An expanded problem-focused examination; Medical decision-making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.</td>
</tr>
</tbody>
</table>
Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 15 minutes face-to-face with the patient and/or family.

| 99214 | Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components:  
|       | A detailed history;  
|       | A detailed examination;  
|       | Medical decision-making of moderate complexity.  
|       | Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.  
|       | Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family. |

| 99215 | Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components:  
|       | A comprehensive history;  
|       | A comprehensive examination;  
|       | Medical decision-making of high complexity.  
|       | Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.  
|       | Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 40 minutes face-to-face with the patient and/or family. |

**Initial Hospital Care Visits (99221 – 99223)**

| 99221 | Initial hospital care, per day, for the evaluation and management of a patient which requires these three key components:  
|       | A detailed or comprehensive history;  
|       | A detailed or comprehensive examination; and  
|       | Medical decision-making that is straightforward or of low complexity.  
|       | Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.  
|       | Usually, the problem(s) requiring admission are of low severity. Physicians typically spend 30 minutes at the bedside and on the patient's hospital floor or unit. |

| 99222 | Initial hospital care, per day, for the evaluation and management of a patient, which requires these three key components:  
|       | A comprehensive history; |
A comprehensive examination; and
Medical decision-making of moderate complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the problem(s) requiring admission are of moderate severity. Physicians typically spend 50 minutes at the bedside and on the patient's hospital floor or unit.

<table>
<thead>
<tr>
<th>99223</th>
<th>Initial hospital care, per day, for the evaluation and management of a patient, which requires these three key components:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>A comprehensive history;</td>
</tr>
<tr>
<td></td>
<td>A comprehensive examination; and</td>
</tr>
<tr>
<td></td>
<td>Medical decision-making of high complexity.</td>
</tr>
<tr>
<td></td>
<td>Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.</td>
</tr>
<tr>
<td></td>
<td>Usually, the problem(s) requiring admission are of high severity. Physicians typically spend 70 minutes at the bedside and on the patient's hospital floor or unit.</td>
</tr>
</tbody>
</table>

Subsequent Hospital Care Visits (99231 – 99233)

<table>
<thead>
<tr>
<th>99231</th>
<th>Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least two of these three key components:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>A problem-focused interval history;</td>
</tr>
<tr>
<td></td>
<td>A problem-focused examination;</td>
</tr>
<tr>
<td></td>
<td>Medical decision-making that is straightforward or of low complexity.</td>
</tr>
<tr>
<td></td>
<td>Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.</td>
</tr>
<tr>
<td></td>
<td>Usually, the patient is stable, recovering or improving. Physicians typically spend 15 minutes at the bedside and on the patient's hospital floor or unit.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>99232</th>
<th>Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least two of these three key components:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>An expanded problem-focused interval history;</td>
</tr>
<tr>
<td></td>
<td>An expanded problem-focused examination;</td>
</tr>
<tr>
<td></td>
<td>Medical decision-making of moderate complexity.</td>
</tr>
<tr>
<td></td>
<td>Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.</td>
</tr>
<tr>
<td></td>
<td>Usually, the patient is responding inadequately to therapy or has developed a minor complication. Physicians typically spend 25 minutes at the bedside and on the patient's hospital floor or unit.</td>
</tr>
</tbody>
</table>
Clinic Visits HCPCS Code G0463 (Technical)

In a hospital outpatient setting there is opportunity to bill for the technical services, typically provided by the nurse, at the time of initial visit and follow-up. The HCPCS (Healthcare Common Procedure Coding System) code for this service is G0463. Per the CY 2014 HOPPS Final Rule, Medicare instructed facilities to discontinue reporting CPT codes 99201 – 99205 and 99211 – 99215 for the clinic visit service and begin reporting the HCPCS code G0463. The facility staff member performing the service will need to document within the EHR (Electronic Health Record) the scope of the visit and the work provided to support this service.

The professional and technical coding will differ due to the utilization of G0463 vs. 992XX, but can be reported on the same date of service. The hospital clinic visit and the professional evaluation and management service are independent of each other and require separate documentation.

Commercial payers may not recognize HCPCS code G0463. The previous coding methodology utilizing CPT codes 99201 – 99205 and 99211 – 99215 outpatient visit codes may be necessary to report, depending on payer rules and agreements.

Global Periods

The global period is a time frame following a surgical procedure in which services rendered are considered a component of the preceding procedure. For radiation oncology, the 90-day global period includes patient services provided within 90 days following the final treatment delivery. Medicare and a number of commercial payers consider these services to be included in the physician treatment management CPT code 77427. The 90-day global period includes all follow-up visits for the care of the patient for reasons specific to the treatment course just completed. However, if the patient presents with an issue unrelated to the diagnosis of the completed course of therapy within the 90-day global period, an established patient visit may be reported with the supporting documentation of the unrelated concern.
The 90-day global period is specific to the professional evaluation and management services. Hospitals can report the hospital clinic visit within the 90-day global time frame. When the global period applies, the following table serves as reference of the designated time frames.

<table>
<thead>
<tr>
<th>Global Periods</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Endoscopic or minor procedure with related preoperative and postoperative relative values on the day of the procedure only included in the fee schedule payment amount; evaluation and management services on the day of the procedure generally not payable. No global period for hospitals with regard to code G0463 for patient visits.</td>
</tr>
<tr>
<td>10</td>
<td>Minor procedure with preoperative relative values on the day of the procedure and postoperative relative values during a 10-day postoperative period included in the fee schedule amount; evaluation and management services on the day of the procedure and during the 10-day postoperative period generally not payable.</td>
</tr>
<tr>
<td>90</td>
<td>Major surgery with a 1-day preoperative period and 90-day postoperative period included in the fee schedule amount. Generally applies to radiation oncology codes after last reported 77XXX code for 90 days, UNLESS a new radiation oncology treatment area presents.</td>
</tr>
<tr>
<td>MMM</td>
<td>Maternity codes; usual global period does not apply.</td>
</tr>
<tr>
<td>XXX</td>
<td>The global concept does not apply to the code.</td>
</tr>
<tr>
<td>YYY</td>
<td>The carrier is to determine whether the global concept applies and establishes postoperative period, if appropriate, at the time of pricing.</td>
</tr>
<tr>
<td>ZZZ</td>
<td>The code is related to another service and is always included in the global period of the other service.</td>
</tr>
</tbody>
</table>

**Clinical Treatment Planning (Professional Only)**

The Physician’s Clinical Treatment Plan, CPT codes 77261, 77262 and 77263, represent the radiation oncologist’s cognitive thought process of the course of therapy utilized to treat the patient with radiation. The clinical treatment plan is a professional-only service. It is billable once per course of therapy; therefore, it is not appropriate to report an additional clinical treatment plan for the boost portion of a course of treatment. There may be exceptions to this rule, for example, if a patient is receiving an external beam portion supervised by one physician X which is then followed by a boost of a specialty such as brachytherapy supervised by another physician Y. Again, this exception would occur if the initial physician ordering and overseeing the initial external beam portion is not the same “specialized” physician who is ordering and overseeing the brachytherapy boost portion. In this scenario, the physician who is performing the brachytherapy portion of the course could document and bill a clinical treatment planning code for the documented work. If the initial physician is overseeing both, a new one is not billable, nor is when a physician may be filling in or simply covering for the initial physician.
Another exception is under rare circumstances when a second clinical treatment plan is needed, such as upon the diagnosis of a new primary or metastatic disease site prior to the completion of the original course. In this case, an additional clinical treatment plan would be considered medically necessary. The new clinical treatment plan has the same documentation requirements as the original plan in order to be billable, and may require the use of an updated diagnosis code in the event of a new primary or metastatic site.

Medicare requires a written treatment plan that has been approved by the physician with the associated date and time. It is also important to note that the documentation of the clinical treatment plan is considered a separately billable service from the evaluation and management service; therefore, it must be separately documented. Within the retired Novitas Solutions Inc. LCD Radiation Therapy Services, the information pertaining to what is expected to be included within clinical treatment planning note is as follows:

“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.”

There are opportunities within the clinical treatment plan for further documentation as well. Statements regarding the medical necessity of the chosen course of therapy can be included in the clinical treatment plan along with orders for services to be rendered throughout the course of treatment. Medical necessity is required by Medicare to be maintained at all times in the patient’s chart. Medicare Local Coverage Determination language such as the following is common and can be found in several LCDs nationwide and in the Federal Register: “Documentation supporting medical necessity should be legible, maintained in the patient’s medical record and made available to Medicare upon request.”

The clinical treatment plan also provides the radiation oncologist the opportunity to order and document the patient’s specific medical necessity for other services, such as special dosimetry (77331), special physics consultation (77370) and a special treatment procedure (77470). This could also include a supporting statement for IGRT and additional imaging procedures.

There are three levels of service associated with the clinical treatment plan: simple CPT 77261, intermediate CPT 77262 and complex CPT 77263. The billable level will correspond with the factors
considered by the physician and the supporting documentation. It is essential that documentation of the physician’s clinical treatment plan and the required orders and medical necessity information are provided prior to services being rendered.

The descriptors and examples of the three complexities of the clinical treatment planning services are provided below.

77261 Simple Clinical Treatment Plan is characterized by the following criteria:

- Simple planning requires a single volume of interest encompassed in a single port or simple parallel-opposed ports with simple or no blocking. *Examples would be PA spine, AP/PA hip with simple or no blocking, open brain or similar services.*

77262 Intermediate Clinical Treatment Plan is characterized by the following criteria:

- Intermediate planning requires three or more converging ports, two separate volumes of interest, or multiple pre-made or simple blocks or special time dose constraints. *Examples would be open four field box or shoulder and hip Metastatic treatment with simple or no blocking.*

77263 Complex Clinical Treatment Plan is characterized by the following criteria:

- Complex planning requires highly complex blocking, custom shielding blocks, tangential ports, special Wedges or compensators, three or more separate volumes of interest rotational or special beam considerations, Multi-leaf collimation, intensity modulated radiotherapy, three or more separate volumes of interest OR a combination of therapeutic modalities. *Examples would be breast tangents, IMRT (linac-based or compensator-based), 3-D and HDR.*

**Special Treatment Procedure (Professional and Technical)**

The special treatment procedure, CPT code 77470, represents additional work and effort required by the physician and/or staff for special radiation treatment procedures and the justification requires support via a written statement within the medical record. The service is not intended to be used routinely, but rather on a case-by-case basis to account for circumstances in which additional resources are required. Documentation of the use of a specific treatment technique or, for example, concurrent chemotherapy, would not alone support the necessity for the special treatment procedure. Additional information on the rationale for what specifically requires extra time and effort when utilizing a specific treatment technique or concurrent chemo would need to be included in the documentation.
Set-up Simulation, Immobilization and Image Acquisition

Set-up Simulation (Professional and Technical)

The field setting set-up simulation is the process of determining the most appropriate and reproducible treatment position for the patient in preparation for the physician’s requested course of therapy, as well as establishing both the superior and inferior regions of the treatment planning scan. The simulation may be carried out on a conventional simulator, CT or MR simulator. This process typically requires some form of immobilization device, which could be a customized device specific to the patient or potentially a more standardized device; however, such devices may not be considered billable by payers. Once the optimal position is accomplished, imaging is performed to supply patient data to the dosimetrist for the dosimetry planning process. This step within the overall process of care, illustrated earlier, may result in multiple billable services including the simulation, construction and use of treatment devices and a form of treatment planning imaging.

The complexity of the simulation will be determined based on the set-up and services provided during the simulation process. For example, the number of sites, complexity of the billable immobilization devices and the utilization of contrast will determine the appropriate level of the simulation in these cases. Documentation of the simulation must support the date of service, complexity reported and the physician’s signature. Each of the simulations should be medically necessary and individually documented to show set-up information including positioning, immobilization devices, verification of isocenter and other necessary information to ensure reproducibility.

Electron boosts, or initial field set-ups, may be set up in a simulator or as a clinical set-up in the treatment room. Documentation should be legible, dated, timed and include set-up instructions accompanied with photos of the “field set-up” with physician signature. Only one simulation is considered billable per particular date of service, with the exception of brachytherapy cases. During brachytherapy courses in which a patient has an a.m. and p.m. treatment resulting in either two simple 77280 verification simulations or a complex 77290 and simple 77280 simulation on the same date of service, both simulation codes are billable. Depending on payers’ instructions, a -59 or -76 modifier would be necessary on the second simulation (CPT code 77280) performed each day.

Multiple simulations may be required throughout the course of a patient’s treatment due to changes in tumor size, port size, blocking, boost volume or verification simulation, and each is reportable for billing. Simulations not supported by medical necessity are not billable. The examples provided below are based on common simulation processes and standards of practice.
The initial simulation and treatment planning CT are not billable for a course of IMRT when performed prior to or in the development of the IMRT plan. The medical record must still tell the story of all the work and resources provided to the patient, regardless of whether or not the services are considered billable. The documentation assists in supporting the course of care, and in the event the patient is treated again at some point in the future, the provider can review what was previously done and treat the patient as appropriate based on previous services documented. Due to the edits and payer transmittals, the only billable services at the time of the initial simulation would be any immobilization devices created that are considered billable.

In the event another simulation is performed or a new treatment planning CT is acquired for a boost or cone down resulting in a new IMRT treatment plan, these services are not billable as they are considered part of the development of a new IMRT plan.

**Simulations:**

- **77280 Simple Simulation** Therapeutic radiology simulation-aided field setting; simple simulation of a single treatment area.
  
  Examples:
  
  - Set-up simulations requiring no complex blocking or contrast; single site.
  - Block or brachytherapy verification simulation.
  - Subsequent simulations (after initial simulation) for brachytherapy source verification.
  - Open PA spine.

- **77285 Intermediate Simulation** Therapeutic radiology simulation-aided field setting; two separate treatment areas.
  
  Examples:
  
  - Hip and Shoulder; no complex blocking or contrast.
  - One or two sites with intermediate blocking.

- **77290 Complex Simulation** Therapeutic radiology simulation-aided field setting; three or more treatment areas if any of the following are involved: particle, rotation or arc therapy, complex blocking, custom shielding blocks, brachytherapy simulation, hyperthermia probe verification, any use of contrast materials.
  
  Examples:
  
  - Head and neck patient simulation with complex blocking.
  - Set-up simulation requiring customized blocking.
  - Set-up simulation requiring contrast.
  - Tangent fields on standard simulator or computer aided set-up.
77293 Respiratory motion management simulation. (List separately in addition to code for primary procedure.)

- Add-on code used in conjunction with 3-D Planning CPT code 77295 or IMRT Planning CPT code 77301.
- Must be ordered, documented and approved by the treating radiation oncologist.
- Only appropriate for treatment areas where respiratory motion needs to be accounted for.
- Creation of an internal target volume (ITV) to account for the breathing cycle utilizing 4D CT images.
  
  - Per the American Medical Association, "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 (e.g., 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."

- Additional information is located in the Dosimetry section.

Treatment Devices (Professional and Technical)

Immobilization Devices

Different types of treatment devices may be utilized depending on the specific step within the process of care and for each situation; coding, documentation and utilization guidelines may differ. The billable level of any treatment devices may vary depending on the geographic location and payer guidelines; it is recommended to reference the specific payer LCDs to determine the appropriate billable level of devices. Treatment devices are billed utilizing the established CPT codes 77332, 77333 and 77334. Documentation of immobilization treatment devices must indicate the date of service for design or construction as well as complexity. Since there is a technical and professional component to treatment devices, physician involvement is required and supported with a signature. During the set-up simulation, more than one device is considered billable if prescribed and medically necessary. Multiple devices or devices billed within the various complexity levels and as indicated by the NCCI edits may be reported in
some cases with a modifier. This may also be payer dependent, as some providers may not reimburse multiple devices during the simulation process; review of payer LCDs is recommended.

**Treatment Devices:**

- **77332** Treatment devices, design and construction; Simple (simple block, simple bolus).
  - Examples:
    - Pre-made electron block
    - Bolus

- **77333** Treatment devices, design and construction; Intermediate (multiple blocks, stents, bite blocks, special bolus).
  - Examples:
    - Bite block
    - Customized bolus

- **77334** Treatment devices, design and construction; Complex (irregular blocks, special shields, compensators, wedges, molds or casts).
  - Examples:
    - Aquaplast Mask
    - Alpha cradles
    - Vac-Lok™
    - Custom molds or multi-leaf collimators
    - Wedges, electronic or metal inserts

If there is a change in the treatment area such as a boost, reduction, change in set-up, movement from photon to electron or other scenarios, it may be appropriate for new treatment devices to be constructed and reported for billing purposes. Custom-made immobilization devices are appropriately billed at the complex level, CPT code 77334. Multi-use or passive restraints that are not customized to the patient such as straps, pillows, sandbags, belly boards, jump ropes, timos and the blue prone pillow are NOT billable treatment devices.

**Disposable Devices**

Within a published retired radiation oncology LCD by Novitas Solutions, Inc., a reference to the use of disposable devices is made stating, “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.”
Dosimetry (Professional and Technical)

The next step within the process of care includes dosimetry planning. These procedures are performed using a treatment planning system and are essential to determining the prescribed dose to the volume of interest and surrounding normal tissues. The dosimetry process is best described as a multi-step process including importing of images, contouring of critical structures and tumor volumes, computer-aided planning, calculations and design of treatment devices. In general, this process can be defined as isodose planning, 3-D planning or IMRT planning based on the complexity and methodology of the planning process, which in turn defines the applicable CPT codes.

Teletherapy Isodose Planning

An isodose plan is a graphic illustration of one or more treatment beams with corresponding radiation dose to the volume of interest and surrounding tissues, represented by CPT codes 77306 and 77307. CPT codes 77306 and 77307 have both a technical and professional component and may be billed in all radiation oncology settings.

77306 Teletherapy isodose plan; simple (one or two 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).

As referenced within the descriptor, the basic dosimetry calculation(s), CPT code 77300, is included within the isodose planning codes and not separately reportable. The AMA instructs, "(Do not report 77306, 77307 in conjunction with 77300)," which is consistent with the published NCCI edits. Per the NCCI edits, this is defined as a "0" edit, which indicates the code combination, will not be paid separately and no modifiers are appropriate.

The descriptor for the complex plan, CPT code 77307, also references multiple treatment areas as a factor in the level of complexity, which is a change from the previous isodose planning codes that were billable per separate volume of interest. With the new isodose planning codes, a case involving two separate volumes of interest, such as multiple bone metastases, would result in a single complex plan. This is also in agreement with the published MUE values for the CPT codes 77306 and 77307, which are set at one (1). The quantity per date of service is set at one (1); however, there may be instances in which additional isodose plans may be necessary as part of the treatment course due to changes in dosing, beam parameters, patient body habitus or tumor volume.
In addition to the isodose planning code, treatment devices representing beam modification devices designed and utilized as part of the planning process are considered separately billable utilizing CPT codes 77332, 77333 and 77334.

Documentation of the isodose planning process consists of the completed plan, prescription and monitor unit calculations, including signatures by the physicist and radiation oncologist. Payers indicate the documentation should specify the volume of interest, location of the tumor and the number of ports for each volume of interest. Furthermore, additional plans completed as part of a patient course should also be supported by medical necessity.

**Special Teletherapy Port Plan**

The special teletherapy port plan, CPT code 77321, has both a professional and technical component and may be billed in settings in which electrons, neutrons or protons are utilized. The coding frequency is one per patient course of treatment regardless of the number of plans provided.

**77321 Special teletherapy port plan, particles, hemibody, total body.**

This code is bundled with teletherapy isodose plans CPT codes 77306 and 77307; however, the NCCI edit with these codes is indicated as “1”, which allows for the use of a modifier to be added when two different volumes of interest are planned and treated. Similar to the teletherapy isodose plans previously described, the AMA also instructs basic dosimetry calculation(s), CPT code 77300, should not be reported in conjunction with CPT code 77321, which is consistent with the published NCCI edits. Per the NCCI edits, this is defined as a “0” edit, which indicates the code combination will not be paid separately and no modifiers are appropriate.

An example and most common use for CPT code 77321 would be an electron scar boost plan following treatment to the whole breast via breast tangents. Other examples provided within published Medicare LCDs include total skin irradiation and photons for hemibody irradiation, along with proton and neutron planning. Published Medicare LCDs specify an isodose plan is a vital piece of documentation to support this service; however, exceptions are noted for hemibody and total body photon and electron cases. Documentation of the planning process is required to be retained within the medical record, including the review and signature of the radiation oncologist.
3-D Planning

3-D planning is a more complex planning process than standard isodose planning due to the involvement of a contoured tumor volume and surrounding normal critical structure(s). It is reported utilizing CPT code 77295.

77295 Three-dimensional radiotherapy plan, including dose-volume histograms.
Within published LCDs, Medicare Administrative Contractors provide examples of instances in which 3-D planning may be justified. The following excerpt is provided as published within the retired Wisconsin Physicians Service Inc. Radiation Oncology Including Intensity Modulated Radiation Therapy (IMRT) LCD.

“Three dimensional simulation and treatment is clinically warranted when one or more of the following conditions exists:

a. The volume of interest is irregular and in close apposition to normal structures that must be protected.
b. The volume of interest is in such a location that its parameters can only be defined by MRI or CT.
c. The final boost volume of interest must be constructed to the exact tumor volume with its irregular configuration.
d. Multiple conformed portals are necessary to cover the volumes of interest with close margins and protect immediately adjacent normal structures.
e. “Beams eye view” of multiple portals must be established for conformal treatment delivery.
f. Volume of interest bordering a previously irradiated area.
g. 3-D reconstruction of tumor volume and critical structure volume in brachytherapy cases to develop a DVH.”

CPT code 77295 is considered billable once per course per treatment volume; however, exceptions do apply in uncommon situations due to significant changes in tumor volume or patient anatomy. The following statement is published within the retired Wisconsin Physicians Service Inc. Radiation Oncology Including Intensity Modulated Radiation Therapy (IMRT) LCD: “In those uncommon circumstances, where there is a substantial change in either patient anatomy or tumor conformation and 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 plan must be documented, along with the documentation of the new CT, MRI, PET or other diagnostic tool and the findings related to the change in tumor volume or patient anatomy. Such records must be made available upon request, whether in written form or electronic medical record.
The 3-D plan, CPT code 77295, is bundled with various CPT codes including 77014 CT Guidance for placement of radiation therapy fields; 77280, 77285 and 77290, Therapeutic radiology simulation; 77306 and 77307, Teletherapy isodose planning; and 77301 IMRT planning; therefore, these services are not reportable on the same date of service. Billing for device beam modification devices, CPT codes 77332-77334, is appropriate with 3-D planning.

Documentation of the 3-D planning process requires multiple components, including a copy of the computer-generated, three-dimensional tumor volume and critical structure and a three-dimensional representation of dose distribution in the form of dose clouds and/or dose volume histograms (DVH) of volume of interest and critical structures with evidence of review by the physician. It is also recommended that the radiation oncologist provide medical necessity and goal of the planning process.

**Intensity-Modulated Radiation Therapy (IMRT) Planning**

The appropriate CPT code for reporting the inverse planning process is 77301, IMRT treatment planning.

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

IMRT planning, designated by CPT code 77301, is a computer-based technique for treatment planning and delivery of modulated beams of radiation to a specific area of interest. The IMRT method is highly conformal and allows for irradiation of the planned target, which may be in close proximity, surrounding or encompassed by normal tissue as defined by CT, MRI, PET or fusion imaging. The use of these images and defined patient anatomy allows for a dose optimization process known as inverse planning, which allows for a more accurate and homogeneous treatment dose to the tumor volume while optimally sparing the surrounding normal tissue.

Inverse planning is the development of a patient-specific treatment plan of by the use of defined goals and dose constraints for both the tumor volume(s) and nearby critical structures (organs at risk/OARS). These goals and constraints are documented by the physician prior to the planning and are used in the computer-based optimization process to determine the customized treatment fields, which may be delivered utilizing high-resolution compensators or multi-leaf collimation (MLC), either dynamic or segmented.

The IMRT technique is considered standard-of-care for many diagnoses, including the central nervous system, head and neck, and prostate. Other areas such as the lung, pelvic and breast tumors may be appropriate for IMRT, but often require further review regarding coverage for the IMRT technique per
payer guidelines. For example, IMRT is often appropriate for left breast cases due to cardiac and pericardial structures, but is not routinely appropriate for the right breast.

A number of Medicare Administrative Contractors and other insurers have published LCDs specific to IMRT, which includes a detailed list of covered diagnoses and indications for coverage. Along with the list of diagnosis codes supporting the use of IMRT, further requirements for documentation and medical necessity for the course are outlined within these published policies. Below is a statement from Noridian Healthcare Solutions, Intensity Modulated Radiation Therapy (IMRT) LCD, addressing the documentation requirements, which are similar to documentation requirements published by other payers and the AMA within CPT publications.

“Documentation in the patient's medical records must support:

1. The reasonable and necessary requirements as outlined under the Indications and Limitations of Coverage and/or Medical Necessity section of this policy and must be available to Medicare for review upon request.

2. The prescription must define the goals and requirements of the treatment plan, including the specific dose constraints for the target(s) and nearby critical structures.

3. A statement by the treating physician documenting the special need for performing IMRT on the patient in question, rather than performing conventional or 3-dimensional treatment planning and delivery.

4. Signed and dated IMRT inverse plan that meets prescribed dose constraints for the planning target volume (PTV) and surrounding normal tissue using either dynamic multi-leaf collimator (DMLC) or segmented multi-leaf collimator (SMLC) (average number of "steps" required to meet IMRT delivery is 5), or inverse planned IMRT solid compensators to achieve intensity modulation radiation delivery.

5. The target verification methodology that includes the following:
   a. Documentation of the clinical treatment volume (CTV) and the planning target volume (PTV).
   b. Documentation of immobilization and patient positioning.
   c. Means of dose verification and secondary means of verification.
6. The monitor units (MUs) generated by the IMRT treatment plan must be independently checked before the patient's first treatment.

7. Documentation of fluence distributions re-computed in a phantom is required, or an equivalent methodology consistent with Patient Specific IMRT Treatment Verification described above.

8. Documentation that accounts for structures moving in and out of high and low dose regions created by respiration. Voluntary breath holding is not considered appropriate and the solution for movement can best be accomplished with gating technology.

9. Documentation for clinical treatment planning (77261-77263) should evidence the criteria are met which are outlined in *The ASTRO/ACR Guide to Radiation Oncology Coding 2005* (p.38).”

As addressed within published policies, IMRT is not a replacement for conventional and 3-D conformal techniques and considered appropriate when sparing of surrounding normal tissue is necessary and one of the following conditions met. The following list is provided as published with the Noridian Healthcare Solutions IMRT LCD.

1. Important dose limiting structures adjacent to, but outside the PTV, are sufficiently close and require IMRT to assure safety and morbidity reduction.

2. An immediately adjacent volume has been irradiated and abutting portals must be established with high precision.

3. Gross Tumor Volume (GTV) margins are concave or convex and in close proximity to critical structures that must be protected to avoid unacceptable morbidity.

4. Only IMRT techniques would decrease the probability of grade 2 or grade 3 radiation toxicity as compared to conventional radiation in greater than 15% of radiated similar cases.

This code is applicable for the inverse-based planning performed by either the dosimetrist or physicist, and it is billable one time per treatment course. The technique for IMRT-based planning differs depending on individual practice patterns, and in many facilities, the standard IMRT course may include multiple boost plans. These additional IMRT plans are not considered billable; however, in some scenarios the patient may require a new plan due to a substantial change in tumor volume or patient anatomy. In this case, the patient would require the acquisition of a new CT data set to be used for the new plan, as well as documentation by the physician indicating the medical necessity of the plan and a detail of the changes identified by the new CT scan. As mentioned, this would be appropriate in some scenarios but not performed routinely.
In May 2015, it was disclosed the CPT and RUC valued simulations as part of the IMRT treatment planning process for physicians and freestanding facilities in 2014, and this valuation continues today. The valuation of the simulation into the IMRT planning charge only applied to physicians (hospital- and office-based) and freestanding facilities since they are all paid under MPFS, with values set by the RUC and CMS. In addition, at the end of May 2015 the OIG released a mid-year work plan update, which included a review of hospitals and courses of IMRT. The reviews were focusing on whether or not the guidelines, as outlined by CMS in Chapter 4 of the Medicare Claims Processing Manual in place since 2008, were understood and being followed by hospitals.

During the same time many payer LCDs supported that the initial simulation was billable for an IMRT course, as long as it was not billed on the same date of service as the IMRT plan. After requests for clarification in the 2016 HOPPS Final Rule, CMS set definitive guidelines for the services considered bundled into IMRT planning code 77301. After several revisions, the following statement was finalized by CMS and can be found in Medicare Claims Processing Manual Chapter 4 - Part B Hospital, 200.3.1 - Billing Instructions for IMRT Planning and Delivery (Rev. 3557, Issued; 07-01-16; Effective: 07-01-16; Implementation: 07-05-16):

“Payment for the services identified by CPT codes 77014, 77280, 77285, 77290, 77295, 77306 through 77321, 77331, and 77370 are included in the APC payment for CPT code 77301 (IMRT planning). These codes should not be reported in addition to CPT code 77301 when provided prior to or as part of the development of the IMRT plan.”

Even though this statement is part listed under the chapter for Part B Hospital, all of the services outlined as not billable and included in the IMRT planning process would be extended to physicians (in hospitals and offices) and freestanding facilities. Chapter 9, Radiology Services, CPT code 70000 – 79999 for National Correct Coding Initiative Policy Manual for Medicare Services also states the following:

“14. Intensity modulated radiotherapy (IMRT) plan (CPT code 77301) includes therapeutic radiology simulation-aided field settings. Simulation-aided field settings for IMRT should not be reported separately using CPT codes 77280-77290. Although procedure to procedure edits based on this principle exist in NCCI for procedures performed on the same date of service, these edits should not be circumvented by performing the two procedures described by a code pair edit on different dates of service.”

In 2017, there is another adjustment to the IMRT planning process. The verification simulation, which up until this point was still a billable event when supported for a course of IMRT, is no longer considered billable effective January 1, 2017. Also found in Chapter 9 of the NCCI Policy Manual is the following update for 2017:
“15. CPT codes 77280-77290 (simulation-aided field settings) should not be reported for verification of the treatment field during a course of intensity modulated radiotherapy (IMRT) treatment.”

Another area of attention pertains to the use of IMRT planning and treatment delivery codes for forward-planned cases or field-in-field techniques. In this situation, the planning is performed utilizing “hot spots” to further adjust and modulate the beam rather than performing the expected inverse-based planning consisting of goals and dose constraints for nearby critical structures. This technique is commonly utilized for whole breast irradiation, but this planning technique does not support the IMRT CPT codes as described within Medicare LCDs and published information within the AMA CPT Manual. It is also noted that some payers have specific rules on items such as the number of ports, segments per beam, and the number of compensators used as part of the planning and delivery. It is recommended that site-specific IMRT practices be reviewed to ensure they meet published Medicare or payer requirements prior to reporting the IMRT planning or delivery codes.

All IMRT plans require QA and a secondary verification method to ensure the delivery of the planned beams is acceptable prior to the initiation of daily treatments. There are a variety of methods and equipment available for IMRT QA and the documentation of this process is required to be located within the patient’s medical record. Per Medicare and CPT Assistant guidelines, it is understood the monitor unit (MU) calculations provided by the treatment planning system are not to be billed, as they are considered a component of the IMRT plan. However, an independent secondary means of dose verification is required and is instructed to be reported as a basic dosimetry calculation, CPT code 77300. The following instruction is published within the AMA CPT Assistant:

“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 calculations are considered billable as one per gantry angle or treatment arc by most payers. Some Medicare payers no longer allow for billing of basic dosimetry calculations during a course of IMRT. As mentioned previously, the IMRT plan, CPT code 77301, is billable once per course regardless of the number of adjustments or boost plans performed; however, this does not apply to the 77300 code. The secondary calculations require a physician’s signature as there are professional and technical components to 77300, and several payer LCDs indicate the approval must occur before the first
In the case of boost planning, the additional calculations may be billable as documented as a component of the QA performed. A review of payer policies is needed to ensure ability to bill for the basis dosimetry calculation services.

An additional component of the IMRT QA is the verification of the intensity modulation of the treatment field as documented by fluence maps, which support the treatment devices developed as part of the planning process. Treatment devices are also considered billable for IMRT course and are reported utilizing CPT code 77338 for MLC-based IMRT devices.

**Respiratory Motion Management Simulation**
The appropriate CPT code to be used for reporting of the respiratory motion management simulation is add-on CPT code 77293.

**77293** Respiratory motion management simulation. (List separately in addition to code for primary procedure).

Respiratory motion management simulation involves the work and efforts completed as part of the simulation and planning process to account for the motion of the tumor volume and surrounding structures related to respiration. This code is pertinent to certain locations of the body, such as the thorax or upper abdomen, and involves the acquisition of multiple image data sets illustrating the respiratory motion. These data sets are fused, which allows for mapping of the movement of the target and surrounding structures allowing for the development of the field design and dosimetry plan while accounting for movement. This process typically involves the development of a maximum intensity projection (MIP) or an internal target volume (ITV).

This process is represented by CPT code 77293, respiratory motion management simulation, which is considered an add-on code. With this designation, CPT code 77293 must be listed separately in addition to a primary code, 3-D planning, CPT code 77295 or IMRT planning CPT code 77301. As a result, the respiratory motion management simulation is applicable when prescribed and documented; however, the code is required to be reported on the same claim and date of service as 77295 or 77301, or may be denied reimbursement.

At the writing of this guide, only a handful of published payer guidelines related to documentation requirements were available; however, based on standard payer expectations for supporting documentation, physician orders and medical necessity are recommended, along with a detailed account of the procedure performed. Wisconsin Physician Services Radiation Oncology Including IMRT retired LCD states the following regarding respiratory motion management, 77293:
“Respiratory Motion Management (CPT code 77293) describes the physician work involved in simulating a patient using motion (respiratory) tracking of a mobile target volume. This motion management provides information on field and portal design with precise knowledge about respiratory movement of target tissues and organs at risk. This simulation is indicated when there is a need to account for the breathing-related motion of thoracic or abdominal tumors that will be targeted with radiation therapy. This service is performed in addition to the simulation code. This motion management is identical for 3-D conformal and IMRT patients.”

Additional guidance is provided within the same LCD in the General Information, Associated Information, Documentation Requirements:

“Complete documentation is essential when reporting an add-on code. Documentation should include both the medical necessity of reporting CPT code +77293 as well as that the work the code describes was done. The documentation needs to be more extensive than just part of the simulation note since it is part of the isodose planning process. Physicians should work with their staff to ensure that proper documentation has been completed. Since the work that is included in +77293 occurs over several days, and it involves the therapists, the dosimetrist, the physicist, and the physician, the information that could support the code would appear in several documents. The simulation note would also document physician review of respiratory motion management set-up and use at the time of simulation. The treatment plan document would indicate that the physician created an ITV that covered the target volume in all phases of respiratory motion. Add-on codes are to be reflected as a separate claim line on electronic claim submission. Add-on codes should be listed separately in addition to the primary procedure code. This code is only charged once per 3-D or IMRT plan and should be reported on the same day as the primary planning code (77295 or 77301).

Note: This new code describes the work involved in simulating a patient using motion (respiratory) tracking of a mobile target volume. Similar to imaging services, CMS will not provide separate technical payment for the new respiratory management service (+77293) in the hospital outpatient environment.”

While this code will be billed at the time of dosimetry planning, documentation of the image acquisition, use of gating or compression techniques and patient instructions for breathing are recommended to be documented as part of the set-up simulation process. A separate procedure note dated on the billing date for 77295 or 77301 is also necessary to support this code, which may include an outline of the procedure performed, such as the import and fusion of the multiple data sets, development of the MIP or ITV to account for target movement, along with the subsequent contouring and field design.
Basic Dosimetry Calculations

The basic dosimetry calculation represents the dosimetry calculation performed to establish the dose at a particular point or volume of interest, the number of monitor units or time needed to deliver the dose prescribed by the physician, and is reported with CPT code 77300. The computation may be done by hand or computer and, regardless of the methodology, each calculation should be documented including a physician signature and located within the medical record.

77300 Basic radiation dosimetry calculation, central access 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.

Historically, basic dosimetry calculations were reported with each form of dosimetry planning regardless of the technique utilized; however, this is no longer true. Due to changes in the isodose planning codes for external beam and brachytherapy, basic dosimetry calculation(s), CPT code 77300 is bundled with CPT codes 77306, 77307, 77321, 77316, 77317 and 77318. CPT code 77300 continues to be separately reportable with 3-D and IMRT planning techniques. In these scenarios, basic dosimetry calculations may be reported multiple times as medically necessary during the patient’s course of treatment. As noted earlier, CPT code 77300 is not billable to all payers for IMRT planned courses. Cahaba Government Benefit Administrators LLC Radiology: Intensity Modulated Radiation Therapy (IMRT) (L36743) LCD states the following regarding basic dosimetry calculations:

“4. 77300 and 77301 may not be billed during the same IMRT episode of care. In such cases 77300 may be automatically considered part of bundled into the IMRT plan 77301.”

It is difficult to set a specific number of times a calculation will be necessary for a patient’s course of treatment, as it may range from one to greater than ten. The number of calculations is highly variable depending on, but not limited to, the complexity of the treatment to be delivered, tumor location and the proximity of critical structures, number of new plans (boosts) needed and treatment delivery techniques utilized. Multiple calculations may also be necessary throughout the course of therapy due to changes in the patient’s separation, adjustment in beam parameters, or other changes that may occur. Until recently, Medicare did not publish any MUE quantities related to CPT code 77300; however, as of October 1, 2015 this changed and the MUE for 77300 is ten (10) per date of service.

Any quantity of calculations above ten (10) must be supported by medical necessity and appropriate documentation. It is a Medicare expectation to also see ongoing documentation to support the need for any changes in dosimetry calculations and change in radiation treatment or frequency along with
documentation of medical necessity for any such modifications. Documentation of calculations should support the quantity reported and the date of service. In addition, code 77300 has both a technical and professional component and requires a physician’s signature.

The QA second checks for standard external beam therapy are not billable as additional calculations; however, they are good practice for quality assurance purposes. In contrast, payer instructions specify to bill for secondary, independent calculations for IMRT cases in place of the initial computer calculations. A review of local payer policies is recommended to determine the billing rules for your institution.

In general, CPT 77300 is reported once per treatment port or arc and requires documentation of each separate calculation. Although two opposed fields may result in the same monitor units, they may in fact be different calculations due to different depths, weighting or other factors considered for the calculation. In this scenario, these two calculations would be submitted separately due to the separate work involved. It is recommended that written documentation cover this specific scenario so an auditor will understand the rationale and medical necessity involved in reporting both calculations.

**Treatment Devices**

**Beam Modifying Devices**

Beam modification devices designed and utilized as part of the dosimetry planning process are described by CPT codes 77332, 77333, 77334 and 77338. These devices are used to spare normal tissue or “block” areas to avoid radiation by absorbing or shaping the beam in some fashion such as asymmetric jaws, MLC, compensators or wedges.

77332 Treatment devices, design and construction; simple (simple block, simple bolus).

77333 Treatment devices, design and construction; intermediate (multiple blocks, stents, bite blocks, special bolus).

77334 Treatment devices, design and construction; complex (irregular blocks, special shields, compensators, wedges, molds or casts).

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

Treatment devices have both a professional and technical component and supporting documentation is required, including support of the physician involvement in the creation of each device. Beam
modification devices are typically documented via Digitally Reconstructed Radiograph (DRR) or within the
detail of beam parameters for items such as wedges or bolus or fluence map distributions. Physician
signatures are required to support physician involvement for each device.

One beam altering treatment device is allowable per port or pair for mirrored devices; however, it is not
uncommon for a single port to include a variety of devices such as asymmetric jaws, MLC, wedges and
bolus. Payer instructions define the methodology in which these devices are reported. The following
statement is published within the retired Wisconsin Physicians Service Inc. Radiation Oncology Including
Intensity Modulated Radiation Therapy (IMRT) LCD: "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."

When determining the appropriate reporting of treatment devices, guidelines should be followed based on
information within published Local Coverage Determinations, as payer instruction can vary. The following
information is an example of the guidelines published within the retired Wisconsin Physicians Service Inc.
Radiation Oncology Including Intensity Modulated Radiation Therapy (IMRT) LCD with regard to the
simple, intermediate and complex devices. Remember to check your local MAC, as their ruling may be
different:

"Simple treatment devices (CPT code 77332) include any of the following:
- simple port blocks which include one or two hand positioned pre-made blocks
- simple prefabricated bolus that is capable of being shaped for an individual patient
- independent jaw motion or asymmetric collimation

Intermediate treatment devices (CPT code 77333) include any of the following:
- multiple port blocks which include three or more pre-made blocks such as corner pelvis blocks, beam -
splitter blocks, or midline spinal cord blocks
- stents
- bite blocks, or
- fabricated single patient use special bolus

Complex treatment devices (CPT code 77334) include any of the following:
- customized blocks (low temperature alloy)
- customized compensators
- wedges, molds or casts
-multi-leaf collimator
-intensity modulated therapy
-custom immobilization device (thermal plastic devices, solidifying polymers or vacuum devices)
-eye shields"

Common for many breast courses is a beam arrangement known as “field-in-field”. Field-in-field planning includes segments at each gantry angle; each segment is at the same gantry angle, but the MUs and beam modification may vary. Typically, there is one larger field and then different segments with doses and blocking to smaller areas, all at the same angle and collimator rotation. The naming of fields also follows a pattern tying the segments together.

Billing for the field-in-field beam modifying configurations will depend on how the fields are treated rather than how they were printed in the plan. If at the treatment console, each individual segment is treated with a separate mode up and “beam on” to activate the field and the dose is separately recorded, then the beam-modifying device for each segment is separately billable. If, however, when the segments are treated they are merged into one treatment field with one mode up and “beam on” for the medial and a separate one for the lateral, then only one beam-modifying device per the merged field is billable. The same holds true for the calculations. The billable number will correlate to the number of separate fields treated and match the beam-modifying devices.

Multi-leaf collimator (MLC) beam modifying devices developed for IMRT treatment courses are fluence maps and reported with CPT code 77338. Fluence maps may be developed within the treatment plan or as part of the required QA verification process within a phantom, film dosimetry or other fluence mapping devices. Since treatment devices have a technical and professional component, the fluence maps require a physician’s signature.

CPT code 77338 is billable once per IMRT plan, regardless of the number of ports. Unlike the IMRT planning code (77301), 77338 is billable for the IMRT MLC device(s) utilized for boosts as long as an associated IMRT plan is present in the medical record, even if the plan itself is not reportable. Oftentimes the boost planning occurs after the initiation of treatment and 77338 will be reported on the same day as IMRT treatment delivery. It is appropriate to bill the IMRT device on the same day as the IMRT treatment; however, due to a NCCI edit in place between these codes, a modifier would be required on code 77388 when billed on the same date as any IMRT treatment delivery code.

Compensator-based IMRT utilizes physical compensators in place of MLC-based devices. Courses utilizing compensators for IMRT treatment are billed using the complex treatment device CPT code 77334, and one compensator per port of entry may be billable. In situations where a static field and an
IMRT field are treated within the same course, such as an IMRT head and neck treatment with a static supraclavicular field, both the IMRT MLC device, CPT code 77338, and the complex treatment device, CPT code 77334, would be reportable per documentation.

**Special Dosimetry (Professional and Technical)**

Special dosimetry may occur when the physician documents his/her unique request for an independent measurement of radiation received at a specific point to confirm or modify the dosimetry plan and is reported utilizing CPT code 77331.

**77331** Special dosimetry (example TLD, microdosimetry, diode), only when prescribed by the treating physician.

Special dosimetry measurements can be accomplished with a variety of devices, such as diodes, thermoluminescent dosimeters (TLDs), ion chambers and film dosimetry. The most common form of special dosimetry involves an external measurement via diode or similar dosimeter and may involve an anticipated dose, actual dose and variance of dose; each should be documented. The results will be utilized to make any potential modifications to the patient's prescribed dose, treatment pattern, energy or a combination of factors.

The usual frequency or quantity varies from patient to patient and will vary upon medical necessity and complexity of the case. Per published Medicare guidelines, CPT code 77331 is considered medically necessary once per port when prescribed by the treating physician. It is not expected this service would be routinely performed each time the patient is treated; however, changes in dose or treatment parameters may support additional services. Documentation for this service includes physician orders, medical necessity and documentation of the measurement, including a review by the physician. Payers also specify the physician must define the type of special dosimetry to be performed.

As a component of the special dosimetry process, calculations may be performed to determine the expected readings or the variance once the reading is completed. Separate calculations CPT code 77300 for the expected special dosimetry readings are not allowed, as they are inherent in the CPT code 77331 code. Per the published NCCI edits, CPT codes 77331 and 77300 are mutually exclusive.

Additional forms of in vivo dosimetry are now available in the marketplace, and these include implantable dosimeters that measure the dose at the tumor site or systems which measure doses delivered daily as part of the treatment delivery. Cases involving implanted dosimeters should be discussed with your payer regarding the medical necessity and clinical benefits, as well as billable services instructions. For those cases in which ongoing daily verification of the delivered dose is measured, only when medically
necessary and ordered would the initial in vivo dosimetry measurement be billed. Repeat measurements are not considered billable as this service is not billed for repeat measurements and not to be routinely billed when performed.

**Verification Simulation**

The verification simulation process is a professional and technical charge. The process allows for verification of the planned field and blocking parameters designed through a “dry-run” process prior to treatment delivery. A verification simulation is only billable with teletherapy isodose and 3-D planned courses; as of January 1, 2017, it is no longer billable with any IMRT courses.

**77280** Therapeutic radiology simulation-aided field setting; simple.

A verification simulation includes the patient and involves a process in which the patient is first set up in the treatment position with all immobilization devices. The treatment fields are then activated and images of the designed blocking/beam modification are taken. The images are compared to the DRRs and any adjustments needed in order to deliver the prescribed and planned treatment are made.

Documentation of the verification simulation includes the images of each field with the corresponding blocking in place, and a note outlining all of the pre-treatment parameters verified. The radiation oncologist must review and approve all images, including the verification simulation note, prior to beam-on of the first treatment field. Since there is no required QA of the 2-D and 3-D courses, the verification simulation provides the pre-treatment course check of the fields as planned prior to delivery of any treatment dose. It is neither appropriate nor supportive of the verification simulation process to image the field blocking in air with no patient present.

If during the verification simulation process a field cannot be imaged due to machine limitations or placement of the gantry in relation to the couch, documentation in the verification simulation note is required. The verification simulation would still be billable, but other means may need to be employed to review the field on the patient. At the time of the boost treatment, if the blocking has changed from the original fields, another verification simulation may be billable if supported.

Effective January 1, 2017, verification simulations are no longer considered billable with IMRT courses of treatment. As outlined in Chapter 9 of the NCCI Policy Manual, “15. CPT codes 77280-77290 (simulation-aided field settings) should not be reported for verification of the treatment field during a course of intensity modulated radiotherapy (IMRT) treatment.”
Image-Guided Radiation Therapy (IGRT) (Professional and Technical)

Image-Guided Radiation Therapy (IGRT) is a method of utilizing imaging to determine patient changes and position adjustments prior to treatment delivery and can be performed by a variety of different methods. When specifically referencing IGRT, this refers to a group of codes utilized to visualize the intended target volume for treatment set-up of 3-D and IMRT treatment deliveries. Stereoscopic x-ray guidance for target localization, CT guidance for the placement of radiation therapy fields, US guidance for the placement of treatment and intra-fraction localization and tracking of target are all forms of IGRT, each having specific guidelines for use.

Due to coding changes by the AMA, many of the previous CPT codes were deleted in 2015 and replaced with a single CPT code to encompass all types of IGRT. CMS did not accept the AMA coding changes for all billing entities. Hospitals were approved to implement the single CPT code for reporting of IGRT when performed and billed to the payer under HOPPS; however, physicians (regardless of where employed or by whom) and freestanding facilities were instructed to use different codes. The G-codes were created as a direct crosswalk from the deleted image guidance code for all imaging except cone beam CT, 77014. CPT code 77014 was not deleted by the AMA and continues to be a valid code and reported by physicians, freestanding facilities and nonexcepted off-campus provider-based departments for cone beam CT at time of treatment delivery. In CY 2017 the appropriate code to select is dependent on whether the imaging service was performed. Hospitals will report the single AMA CPT code and physicians (regardless of where employed or by whom), freestanding facilities and nonexcepted off-campus provider-based departments will bill the G-codes or 77014. The G-codes, by law, will continue as is through December 31, 2018; after this it is uncertain what will happen.

Nonexcepted off-campus provider-based departments, as addressed previously, are considered facilities but report IGRT using the CMS G-codes and 77014. This is the same as freestanding facilities. The reimbursement for the IGRT is 50% of the HOPPS rate for the same code. Since the G-codes are not reimbursed in the hospital setting by CMS, the assumption would be that the methodology applied will crosswalk the G-code to the 77387 IGRT code. Code 77387 is not reimbursed in the hospital; therefore, it is not expected to be paid in the nonexcepted off-campus provider-based department either.

Commercial payers may not match CMS for the reportable codes for IGRT. Contacting commercial payers to determine the appropriate code to report for IGRT is strongly recommended. It is up to the payer’s discretion whether to accept the CMS-created G-codes or whether to accept the AMA CPT code for image guidance.

**Hospital Outpatient Cancer Centers:**

- One CPT code for all IGRT performed in the hospital and billed for the technical services is:
Guidance for localization of target volume for delivery of radiation treatment delivery; includes intrafraction tracking, when performed.

- For 3-D planning cases, when ordered, performed and medically necessary, CPT code 77387 is billed for the technical component, regardless of the form of IGRT performed.
- For IMRT planning cases, IGRT is now bundled with the new IMRT daily treatment codes; therefore, it is not separately reported for the technical component by the hospital.

**Physicians, Freestanding Facilities and Nonexcepted Off-Campus Provider-Based Departments:**

- CMS created G-codes are utilized.
- CMS G-codes dependent on the specific type of IGRT performed.
- Billable for both 3-D and IMRT, when medically necessary, ordered and documented by physicians (working in the hospital or freestanding facilities, freestanding facilities and nonexcepted off-campus provider-based departments).
- CMS-created G-codes for 2017 are as follows;
  - **G6001** Ultrasonic guidance for placement of radiation therapy fields.
  - **G6002** Stereoscopic x-ray guidance for localization of target volume for the delivery of radiation therapy.
  - **G6017** Intra-fraction localization and tracking of target or patient motion during delivery of radiation therapy (e.g., 3-D positional tracking, gating, 3-D surface tracking), each fraction of treatment.
- CPT code 77014 continues to be a valid code in 2017. This code is still available for use with IGRT by physicians, freestanding facilities and nonexcepted off-campus provider-based departments only.
  - **77014** Computed tomography guidance for placement of radiation fields, reported for IGRT.

Each of the IGRT codes can be reported professionally, when appropriate and supported, at a designated supervision level, which pertains to the technical component. As a result, the specific supervision level must be met in order to bill the technical component of the corresponding code. The supervision levels which pertain to these specific codes include General Supervision and Direct Supervision. As part of the Medicare Physician Fee Schedule Database, CMS has assigned one of the following numerical levels to each CPT code:

1. Procedure must be performed under the **general** supervision of a physician.
2. Procedure must be performed under the **direct** supervision of a physician.
The definitions for each level as published within the Medicare Benefit Policy Transmittal 51 and are provided below.

**General Supervision** indicates the procedure is furnished under the physician’s overall direction and control, but the physician’s presence is not required during the performance of the procedure. Under general supervision, the training of the non-physician personnel who actually performs the diagnostic (or therapeutic) procedure and the maintenance of the necessary equipment and supplies are the continuing responsibility of the physician.

**Direct Supervision** indicates the physician must be present in the office suite and immediately available to furnish assistance and direction throughout the performance of the procedure. It does not mean that the physician must be present in the room when the procedure is performed.

**Ultrasound Guidance** requires general supervision and is most commonly used for daily imaging of the prostate, but is not limited to this treatment area.

**CT Guidance** requires direct supervision and may be performed by a variety of different types of CT equipment; however, CPT code 77014 is reported regardless of the technology, or as part of the imaging performed prior to treatment delivery on the Linear Accelerator in a freestanding facility, and CPT code 77387 is reported in a hospital-based department when appropriate.

**Stereoscopic X-ray Guidance** requires direct supervision and may also be performed by a variety of methods; however, specific software must be utilized to identify the isocenter shift information as determined by the image overlay of either kV or MV images to the planned DRRs. Fiducial markers placed to delineate the volume of interest may also be required for the use of this code, as the code requires visualization of the target volume.

**Intra-fraction Localization and Tracking** may be performed by a variety of different types of equipment capable of localizing and tracking the breathing pattern of the patient during the radiation treatment. As a physician services code, no modifiers are used when reporting the technical vs. professional component of the work provided for intra-fraction localization and tracking.

It should be noted that IGRT is performed in conjunction with treatment delivery, and all treatment delivery codes have a requirement of Direct Supervision. Due to this, the level of supervision for the treatment code would override a lesser level of supervision for an imaging code such as the one for ultrasound guidance, creating an expectation of Direct Supervision for the service of IGRT and treatment delivery together. In a hospital outpatient setting the code (77387) is considered packaged with the
standard treatment delivery codes and bundled with IMRT treatment delivery codes. Packaged codes are still reported on the claim form, but are not separately reimbursed by Medicare; however, they may be reimbursed by commercial payers. Bundled codes cannot be reported on the claim form as they are part of a larger service and not considered billable. In a freestanding facility, code G6017 has no set RVUs and requires the negotiation of pricing with the individual payers. It is recommended to report the service as performed and documented in order to provide accurate data and utilization information for future pricing and to possibly set reimbursement.

At the time of treatment delivery, regardless of the number of different areas treated or the different types of IGRT performed, only one imaging code is billable per session of treatment. For example, if CBCT is performed to localize the target for treatment set-up and during treatment delivery, the intrafraction tracking system is used to monitor motion due to respiration; only one imaging service is billable. It is recommended to select the IGRT which, when questioned or in event of any issue, was the imaging used as the standard for the treatment delivery and bill the associated code. In a hospital setting, it is not an issue to select one code over another as there is only one code to select, but code 77387 can be reported only once per session.

Regardless of the type of IGRT performed, specific orders, frequency and medical necessity for the service must be provided by the physician and housed within the patient record. This order should indicate the type of imaging to be performed, the frequency of use, and the method in which the targeted volume will be visualized. The images and any calculated shift information provide documentation for the technical component of the IGRT code; however, the professional component requires the physician provide his or her professional opinion in the form of image review prior to that day’s treatment delivery, which would allow for intervention prior to radiation delivery. Documentation is required to be present within the patient’s record, whether paper or electronic, which clearly indicates the physician’s work was provided at the time the procedure was performed. This may be found in the form of time- and date-stamped images showing the review of the image by the physician prior to the treatment to which the image pertains, or as a note housed within the patient’s chart detailing the review of the images prior to treatment.

**Fiducial Markers/Implantable Dosimeters**

Fiducial markers are devices such as gold seeds or stainless steel tissue markers that are implanted into soft tissue or bone. These devices act as radiologic landmarks to aid in localizing the treatment target with millimeter precision. Placement codes are based on the anatomical location where the markers are placed. The markers placed are reported with HCPCS code A4648, and the type of setting where the placement was performed will determine how they are reported. Imaging performed as part of the marker placement may or may not be separately billable. Some placement codes include image guidance and
others do not. For those placement codes that do not include the image guidance, the appropriate code is billed per the type of imaging used.

As indicated, coding for the implantation of fiducial markers and/or the markers themselves is anatomically site-specific. The available fiducial marker placement procedure codes are listed in the table below.

<table>
<thead>
<tr>
<th>Code</th>
<th>Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>10035</td>
<td>Placement of soft tissue localization device(s) (e.g., clip, metallic pellet, wire/needle, radioactive seeds), percutaneous, including imaging guidance; first lesion</td>
</tr>
<tr>
<td>10036</td>
<td>Placement of soft tissue localization device(s) (e.g., clip, metallic pellet, wire/needle, radioactive seeds), percutaneous, including imaging guidance; each additional lesion. (List separately in addition to code for primary procedure.)</td>
</tr>
<tr>
<td>19281</td>
<td>Placement of breast localization device(s) (e.g., clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; first lesion, including mammographic guidance</td>
</tr>
<tr>
<td>19282</td>
<td>For each additional lesion. (Use in conjunction with 19281.)</td>
</tr>
<tr>
<td>19283</td>
<td>Placement of breast localization device(s) (e.g., clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; first lesion, including stereotactic guidance</td>
</tr>
<tr>
<td>19284</td>
<td>For each additional lesion. (Use in conjunction with 19283.)</td>
</tr>
<tr>
<td>19285</td>
<td>Placement of breast localization device(s) (e.g., clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; first lesion, including ultrasound guidance</td>
</tr>
<tr>
<td>19286</td>
<td>For each additional lesion. (Use in conjunction with 19285.)</td>
</tr>
<tr>
<td>19287</td>
<td>Placement of breast localization device(s) (e.g., clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; first lesion, including magnetic resonance guidance</td>
</tr>
<tr>
<td>19288</td>
<td>For each additional lesion. (Use in conjunction with 19287.)</td>
</tr>
<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>31626</td>
<td>Bronchoscopy , rigid or flexible, including fluoroscopic guidance, when performed; with placement of fiducial markers, single or multiple</td>
</tr>
</tbody>
</table>
Placement of interstitial device(s) for radiation therapy guidance (e.g., fiducial markers, dosimeter), percutaneous, intra-abdominal, intra-pelvic and/or retroperitoneum, single or multiple

Laparoscopy with placement of interstitial device(s) for radiation therapy guidance (e.g., fiducial markers, dosimeter), intra-abdominal, intra-pelvic, and/or retroperitoneum, including image guidance, if performed, single or multiple

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

The appropriate HCPCS code to report the fiducial markers is A4648, tissue marker, implantable, any type, each. The fiducial marker code is packaged into the placement code in the hospital and ASC setting; it is still reported, but there is no separate payment. Payment in the freestanding radiation oncology facilities and physician offices is payer-dependent, but is generally reimbursed based upon invoice pricing. When billing for markers on the CMS 1500 claim form, the HCPCS code is reported in quantity in line item fashion. In addition, in Box 19 of the claim form the invoice pricing of the markers is also listed. Payers may require or request submission of the invoice to support the amount of reimbursement.

Regardless of setting, HCPS code A4648 reported for the fiducial markers must be submitted on the same claim form as the applicable procedure code captured for the implantation of the device(s). In addition to the placement and marker code, the code representing the type of imaging used to place the markers is also reported. Medicare has indicated that when the placement code and HCPCS code for the markers are not reported together the claim will be denied.

Image guidance used for the placement of the markers into the body may include the following types and available codes. Review of the placement codes is necessary to determine whether the image guidance is separately billable or considered bundled into the placement and therefore not reported on the claim form. The following CPT codes are available for reporting and based on the type of imaging performed to place the markers.

76942 Ultrasonic guidance for needle placement (e.g., biopsy, aspiration, injection, localization device), imaging supervision and interpretation.

77002 Fluoroscopic guidance for needle placement (e.g., biopsy, aspiration, injection, localization device).

77012 Computed tomography guidance for needle placement (e.g., biopsy, aspiration, injection, localization device), radiological supervision and interpretation image guidance procedures.
Magnetic resonance guidance for needle placement (e.g., for biopsy, needle aspiration, injection, or placement of localization device) radiological supervision and interpretation.

**Spacer Gel for Prostate Patients**

Spacer gel is a device made of hydrogel that is placed to allow space between organs to reduce radiation doses. It is commonly used in prostate cancer patients to create space between the rectum and prostate and allow for wider margins in treating the prostate while sparing and decreasing toxicity to the rectum.

**0438T** Transperineal placement of biodegradable material, peri-prostatic (via needle), single or multiple, includes image guidance.

In July 2016, a Category III code was created for use in hospitals, ASCs and freestanding facilities/offices and by the physicians providing the service. For 2017 the code was changed by the AMA to remove the parenthetical which allowed for separate billing of the gel with the placement code. In addition, for hospitals in 2017 the placement code is in a C-APC with status indicator “T”. A review of other services is needed on the same claim to determine if the gel placement or other services are separately reimbursed.

CMS did establish a payment rate for hospitals and ASCs. As a physician service code, the placement is not billed with modifiers -26 to –TC to identify the professional and technical components. Code 0438T has no set reimbursement under MPFS; the code is Carrier priced. Review of the individual MAC jurisdictions and Carrier pricing files is necessary to determine if reimbursed under MPFS.

**External Beam Treatment Delivery (Technical)**

The external beam treatment delivery codes are technical in nature and each fraction of treatment must be clearly documented within the patient chart, whether paper or electronic, and specifically follow the radiation prescription as provided by the radiation oncologist. This prescription should support the fractionation, energy, daily dose and treatment area for the intended course. The external beam daily treatment documentation does not require a physician’s signature, but does require direct supervision and management.

One treatment delivery code is reported per date of service, regardless of the number of separate areas treated concurrently in the same session. Only in those circumstances in which a patient requires hyperfractionation of treatments can multiple treatment sessions be billed on a given date of service. When a course is hyperfractionated or treated BID, there must be a distinct break between the a.m. and p.m. treatment fractions, typically six hours. For BID treatment delivery, a modifier will be required on the
second or p.m. fraction to indicate it is not an error or duplication of service. Either the -76, -77 or -59 modifier is commonly used, but a particular payer may need to be contacted for specific billing instructions.

Orthovoltage and/or superficial external beam treatments continue to represent energies used for treatment that are below the megavoltage range and used for the treatment of skin lesions. Typical superficial radiation treatment energies up to 200 kV may be generated by various technologies. There are several services no longer reported with orthovoltage and superficial treatments; these include physician clinical treatment planning, treatment devices, isodose planning, physics consultation and physician management. Only simulation and basic dosimetry services can be reported with CPT code 77401. In addition, when medically necessary, a physician E&M can be reported alone with code 77401.

AMA CPT codes for daily treatment delivery are utilized only in the hospital setting and by those commercial payers who do not accept the CMS-created G-codes used for treatment in the freestanding facility. Contacting commercial payers is recommended to determine the appropriate treatment code to report in the freestanding cancer center setting.

**Hospital Outpatient Cancer Centers:**

- Superficial and/or orthovoltage continue to be reported as CPT code 77401.
  - **77401** Radiation treatment delivery, superficial and/or orthovoltage, per day.
  - According to the AMA CPT Manual the following codes are not separately billable with a course of superficial/orthovoltage:
    - “Energies below the megavoltage range may be used in the treatment of skin lesions. Superficial radiation energies (up to 200kV) may be generate 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.”
- Standard external beam AMA CPT codes are no longer energy dependent; codes follow the simple, intermediate and complex guidelines. The codes as billed in the hospital are as follows:
  - **77402** Radiation treatment delivery, ≥ 1MeV; simple:
    - Single treatment areas; one or two ports; and two or fewer simple blocks.
  - **77407** Radiation treatment delivery, ≥ 1MeV; intermediate;
- Two separate treatment areas; three or more ports on a single treatment area; or three or more simple blocks.
  - 77412 Radiation treatment delivery, ≥ 1MeV; complex:
    - 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.
- IMRT treatment delivery codes in the hospital are now diagnosis dependent for MLC-based.
  - 77385 IMRT radiation tx delivery includes guidance and tracking; when performed; simple.
    - Any of the following: prostate, breast and all sites using physical compensator-based IMRT.
  - 77386 IMRT radiation tx delivery includes guidance and tracking; when performed; complex.
    - IMRT all other sites if not using physical compensator-based IMRT.

**Freestanding Facilities and Nonexcepted Off-campus Provider-based Departments:**
- The G-Codes created by CMS will continue to be utilized in 2017 and through 2018.
- Nonexcepted off-campus provider-based departments will begin using the G-codes for treatment delivery in 2017.
- Superficial and/or orthovoltage continue to be reported as CPT code 77401.
  - 77401 Radiation treatment delivery, superficial and/or orthovoltage, per day.
  - According to the AMA CPT Manual the following codes are not separately billable with a course of superficial/orthovoltage:
    - “Energies below the megavoltage range may be used in the treatment of skin lesions. Superficial radiation energies (up to 200kV) may be generate 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.”
- Standard external beam and IMRT treatment codes in the freestanding center are as follows:
  - G6003 Radiation treatment delivery, single treatment area, single port or parallel opposed ports, simple blocks or no blocks: up to 5mev.
- \textbf{G6004} Radiation treatment delivery, single treatment area, single port or parallel opposed ports, simple blocks or no blocks: 6-10mev.
- \textbf{G6005} Radiation treatment delivery, single treatment area, single port or parallel opposed ports, simple blocks or no blocks: 11-19mev.
- \textbf{G6006} Radiation treatment delivery, single treatment area, single port or parallel opposed ports, simple blocks or no blocks: 20mev or greater.
- \textbf{G6007} Radiation treatment delivery, 2 separate treatment areas, 3 or more ports on a single treatment area, use of multiple blocks: up to 5mev.
- \textbf{G6008} Radiation treatment delivery, 2 separate treatment areas, 3 or more ports on a single treatment area, use of multiple blocks: 6-10mev.
- \textbf{G6009} Radiation treatment delivery, 2 separate treatment areas, 3 or more ports on a single treatment area, use of multiple blocks: 11-19mev.
- \textbf{G6010} Radiation treatment delivery, 2 separate treatment areas, 3 or more ports on a single treatment area, use of multiple blocks: 20 mev or greater.
- \textbf{G6011} Radiation treatment delivery, 3 or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, electron beam; up to 5mev.
- \textbf{G6012} Radiation treatment delivery, 3 or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, electron beam; 6-10mev.
- \textbf{G6013} Radiation treatment delivery, 3 or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, electron beam; 11-19mev.
- \textbf{G6014} Radiation treatment delivery, 3 or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, electron beam; 20mev or greater.
- \textbf{G6015} Intensity modulated treatment delivery, single or multiple fields/arcs, via narrow spatially and temporally modulated beams, binary, dynamic MLC, per treatment session.
- \textbf{G6016} 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.

\textbf{Therapeutic Port Image(s) (Technical)}

Due to the precision required for radiation oncology treatments and the importance of accurate reproduction of radiation fields, it may be necessary to monitor treated volumes with imaging services known as port images. Port images are utilized to verify static treatment parameters and patient
positioning, but are not suitable for motion management or daily image guidance and intrafraction verification.

**77417 Therapeutic radiology port image(s).**

Images may be acquired via hard copy films; however, more common are digital electronic images, which support the definition change from “films” to “images” in 2016. The film or electronic portal images are compared with the original treatment set-up images provided by the simulator or treatment planning system. The CPT code is technical only in nature; however, the imaging procedure requires specific orders by the radiation oncologist as well as documentation of review and approval or necessary adjustments to patient position, isocenter placement or field settings. The physician work in reviewing port images is not separately billable, and is included in the physician weekly treatment management service, CPT code 77427.

The frequency of port imaging may vary depending on a variety of patient and tumor factors; however, most payers have specific guidelines regarding the frequency of reporting of this code. Medicare typically accepts only one port image billed per five-fraction period regardless of the number of port images taken, but individual Medicare contractors may allow payment for one port image per treatment field per five-fraction period. In the case of BID treatment delivery, it would be possible to capture two units of 77417 within the two separate fraction periods, if requested, performed and documented. It is recommended facilities follow the specific Medicare LCD policies as published within each specific state or A/B MAC jurisdiction. For commercial payers, the guidelines for the use of code 77417 may differ, and may allow for the reporting of each port film performed and documented unless it is stated to follow Medicare guidelines.

**Physics (Technical)**

The billable elements of medical radiation physics are included in two distinct CPT codes. The performance of these services must be carried out and documented by a qualified medical physicist. Each code carries specific requirements for documentation and both are technical-only services.

**Continuing Medical Physics Consultation**

The continuing medical physics service described by CPT code 77336 is specific to the ongoing review of the patient chart, associated QA processes and includes a documented assessment of the patient’s treatment chart to verify the patient has received the prescribed radiation dosage, appropriate positioning and beam orientation, and that appropriate radiation safety procedures have been followed. The AMA defines a continuing medical physics consultation as the following:
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.

Per the NCCI Policy Manual for Medicare Services 2017 continuing medical physics consultation CPT code 77336 is reported “per week of therapy”. The code may be reported once within a five fraction period and at the end of a treatment course if at least three fractions have been completed within the final week of the course. In instances in which an entire course of therapy is prescribed for only one or two fractions, the code may be captured with appropriate supporting documentation.

Documentation of the continuing physics service should indicate the multiple aspects of each patient’s treatment reviewed by the physicist. Items which may be included, but are not limited to, are review of isodose plans, dosimetry calculations, monitor units, elapsed days, total dose, prescription comparison to the original plan, field size and orientation, machine calibration, diode calibration and other items pertinent to the course of therapy. It is recommended a checklist outlining the above-mentioned items and any other reviews or calculations performed be completed, dated and signed by the physicist once within each five fractions of treatment.

Because several individual LCDs are in place covering brachytherapy, it is recommended that the appropriate LCD specific to the region of the facility be reviewed for further instruction on reporting continuing medical physics in conjunction with any brachytherapy codes. Per the 2017 NCCI Policy Manual for Medicare Services, “Brachytherapy (CPT codes 77750-77790) includes radiation treatment management (CPT codes 77427 and 77431) and continuing medical physics consultation (CPT code 77336). CPT codes 77427, 77431, and 77336 should not in general be reported separately with brachytherapy services. However, if a patient receives external beam radiation treatment and brachytherapy treatment during the same time period, radiation treatment management and continuing medical physics consultation may be reported for the external beam radiation treatments. Additionally, if a patient has multi-step brachytherapy, it may be appropriate to separately report continuing medical physics consultation with the brachytherapy.”

When a course of multiple modalities is administered, such as external beam and concurrent brachytherapy, the brachytherapy fractions count toward the five fractions of treatment for any physics checks. For example, if external beam treatments are administered on fractions one through three and on fraction four an HDR treatment is given, this will count toward the number of fractions as to when a check can occur; the next treatment of either modality would count as fraction five. The HDR fractions are not to be counted separately from the external fractions when determining the timing of weekly physics checks.
Though weekly continuing medical physics consultation is medically necessary and physician-ordered, it remains a technical-only service performed by a physicist, and a physician’s signature is not required on the supporting documentation. The physician involvement in this service is included within the physician weekly treatment management service and is outlined in an additional section of this guide.

The services performed under CPT code 77336 may be carried out over a number of days, but the billing date should be the date of chart documentation unless a payer specifies a certain fraction in which the service should be reported. It is not required that each service is exactly five days or fractions apart; rather, only one service per five fractions is billed. If, for example, a service takes place on fraction four, another takes place on fraction seven and yet another on fraction 15, billing is acceptable as there is one service per five fractions of therapy.

Special Medical Radiation Physics Consultation

A special medical radiation physics consultation, CPT code 77370, can be reported when the treating physician requires the expertise of a qualified medical physicist for a specific medical physics concern while planning or during a course of radiation therapy for a particular patient. Possible indications could include, but are not limited to, assessing the interrelationships of mixed beam treatment courses such as photons and brachytherapy, computing dose from a previous course of treatment and its effects on the current course, assessing dose to a pacemaker in or near the area of treatment, complex dosimetric considerations using brachytherapy or stereotactic procedures, and calculation of total body doses or the computation of the dose to the fetus of a pregnant patient. The AMA defines a special physics consult as:

77370 Special medical radiation physics consultation.

A special physics consult would not be indicated for the quality assurance (QA) generated for IMRT plans, which is a required component of the IMRT plan. A special physics consult is reserved for cases in which the physician must request the expertise of the qualified medical physicist for planning and evaluation above and beyond the work routinely involved in the planning and QA processes.

The radiation oncologist must provide a documented request for the special physics consultation clearly stating a qualifying factor necessitating the work to be performed. In response to the physician’s request, the medical physicist is expected to spend considerable time and effort responding to the request from the physician and generating a customized, patient-specific report. Templated forms with pre-populated language do not allow for the specific, customized documentation required for use of this code and are not recommended, as these types of statements could lead to the inclusion of mistakes or misinformation in the report. Use of an electronic health record (EHR) template is permissible, but should serve only as a guide for formatting purposes. Although this service is technical-only, it requires documented review by
the physician with the date and time of that review. The billing date for special physics consult, 77370, is the documented date of the report generated by the qualified medical physicist.

**Physician Management (Professional)**

While a patient is undergoing radiation treatments, the radiation oncologist manages his or her progress, side effects and response to treatments. Four CPT codes provide reimbursement for this ongoing care, differing based on the number of fractions and type of treatment modality utilized. These codes are professional only, without any technical reimbursement.

**77427 Radiation Treatment Management, Five Treatments.**

The treatment management code is billed once per five fractions of treatment. Documentation of each visit is required by the physician. Treatment notes by a non-physician provider may be used routinely but do not serve as a satisfactory replacement for the once-weekly note by a radiation oncologist. Four components of the service recommended to be included by the physician include:

<table>
<thead>
<tr>
<th>1. Review of port films or images: Statement about any pertinent images (port films, stereoscopic x-ray images, cone beam CT images or U/S images) for the corresponding fraction period has been reviewed by the physician and is in good order or that necessary adjustments were made.</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Review of dosimetry and chart prescription: Statement that the plan and prescription have been reviewed and are to proceed as outlined, changes have been made and/or new orders were given.</td>
</tr>
<tr>
<td>3. Examination of patient set-up for treatment: Statement that the patient’s treatment set-up was reviewed by the physician.</td>
</tr>
<tr>
<td>4. Examination of the patient for medical evaluation and case management: This should include a statement by the physician as to how to proceed with further treatments, whether to continue treatment, place the patient on break, change the course of treatment or discontinue treatments. If the patient is experiencing any treatment-related side effects, this finding, as well as active intervention to deal with the side effect, should be described.</td>
</tr>
</tbody>
</table>

Documentation that the physician has examined the patient as part of the treatment management visit is required. Statements specific to changes within the prescribed treatment, how to proceed with further treatments and if the patient is experiencing any treatment related side effects should be included in the supporting documentation.

CPT code 77427 is billable once per five fractions of treatment. At the end of the course of therapy, if three or four fractions have been administered following the previous five fractions, a physician management visit would be appropriate with supporting documentation. Multiple fractions representing
two or more treatment sessions furnished on the same day may be counted separately as long as there has been a distinct break between the therapy sessions. Each five-fraction period requires at least one face-to-face visit in which the physician performs at least one exam of the patient and that takes place at some point during the five-fraction interval. The physician’s signature, date and time stamp are required for each visit note.

If a patient’s course of therapy is only three to seven fractions in length, one physician management visit is appropriate; alternatively, if the full course is eight to twelve fractions in length, two visits would be appropriate. If the course of therapy is 13 to 17 fractions in length, three visits would be appropriate. A physician may see the patient multiple times within a five-fraction interval but only one 77427 service is billable. It is not appropriate to “average out” the number of times a patient is seen over the course of therapy in order to bill every five fractions. If a patient was seen two times in the first four weeks of treatment and then three times in the last week of treatment due to increased side effects, the total number of face-to-face physician visits (five) are not eligible, and only three should be billed.

Three other physician management visit codes may be appropriate for use depending on the course of therapy or modality used for treatment:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>77431</td>
<td>Radiation therapy management with a complete course of therapy consisting of one or two fractions only. Examples include keloids and treatments for heterotopic bone formation and Total Body Irradiation. This code cannot be used for the last fraction period of a standard course of therapy when only one or two fractions were administered.</td>
</tr>
<tr>
<td>77432</td>
<td>Stereotactic radiation treatment management of cranial lesion(s) (complete course of treatment consisting of one session). Also includes image guidance.</td>
</tr>
<tr>
<td>77435</td>
<td>Stereotactic body radiation therapy, treatment management, per treatment course, to one or more lesions, including image guidance, entire course of treatment not to exceed five fractions. Do not report in conjunction with physician management codes 77427 and/or 77432.</td>
</tr>
</tbody>
</table>

Per the NCCI Policy Manual for Medicare Services 2017, “Brachytherapy (CPT codes 77750-77790) includes treatment management (CPT codes 77427 and 77431) . . . should not in general be reported separately with brachytherapy services. However, if a patient receives external beam radiation treatments during the same time period, radiation treatment management may be reported for the external beam radiation treatments.”

Consistent with AMA guidelines, ACRO does NOT recommend the sole use of a PA or NP for radiation treatment management visits to the patient. While the PA or NP may “assist” in the evaluation of a patient, there must be face-to-face time each week with each patient by a radiation oncologist in order to capture the radiation treatment management charge.
The billing date for each management visit is payer-dependent. It is recommended to follow payer guidelines. Some payers may require the billing date as the first fraction of the fraction period regardless of what date the visit took place, but the visit is not billed until the fifth fraction of treatment is delivered. Other payers may require the visit be billed on the date it actually took place, even though the management services occur over many fractions of therapy.

**Stereotactic Radiosurgery (SRS)/Stereotactic Body Radiation Therapy (SBRT)**

SRS and SBRT are radiation therapy treatment techniques using narrow, precisely aimed and highly conformal doses of ionizing radiation delivered in five or fewer treatment fractions. A variety of radiation delivery devices are available to deliver SRS/SBRT:

- **Cobalt-60 units** – These devices utilize multiple, small, radioactive sources spaced around a spherical chamber. The patient is positioned in the chamber so the isocenter is at the convergence of the cobalt source beams. When the unit is activated, all the sources converge on the targeted treatment area.
- **Linear accelerators** – Linear accelerator-based stereotactic treatment delivery may be via multiple non-coplanar or co-planar photon beams or arcs.
- **Heavy charged particles** – This class of devices includes proton, neutron, carbon and helium ion radiosurgery.

Due to the differing nature of this equipment, techniques and fractionation, different CPT codes may apply. Regardless of the stereotactic technique utilized, image guidance is a required component of stereotactic coding and should not be separately billed. This is referenced within the following NCCI Policy Manual Chapter 9:

> “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. (CPT code 76950 was deleted January 1, 2015.)”

Additional guidance is found in the AMA CPT Manual:

> “Stereotactic radiosurgery (SRS) and stereotactic body radiation treatment (SBRT) also include the professional component of guidance for localization of target volume for the delivery of radiation therapy (77387).”

Medicare Administrative Contractors (MAC) and private payers provide medical policies detailing the circumstances under which a particular service will be covered. Most medical coverage policies contain a
section that outlines the indication and limitations of stereotactic coverage, and it is essential physicians and staff adheres to the recommendations and documentation requirements to facilitate prompt and accurate reimbursement for services rendered. Indications and coverage guidelines for the stereotactic technique, whether SRS or SBRT, vary by payer and may include factors such as the patient diagnosis, extent of disease, or, if the indication is definitive or management of metastasis, Karnofsky Performance Status or Eastern Cooperative Oncology Group (ECOG) Performance Status or clinical benefit over other forms of treatment. Review of local payer guidelines is recommended, as well as required medical record documentation. An example of the required medical necessity documentation is provided as published within the Noridian Healthcare Solutions Stereotactic Radiation Therapy: Stereotactic Radiosurgery (SRS) and Stereotactic Body Radiation Therapy (SBRT) LCD:

“The patient’s record must support the necessity and frequency of treatment. The medical record must clearly indicate the critical nature of the anatomy or other circumstances necessitating the services. Medical records should include not only the standard history and physical but also the patient’s functional status and a description of current performance status (Karnofsky Performance Status). See Karnofsky Performance Status listed under Indications and Limitation of Coverage and/or Medical Necessity above.”

Documentation of stereotactic cases should include medical necessity documentation as outlined previously, as well as documentation of the treatment delivery and management details. The following statement is provided by Noridian Healthcare Solutions LCD, and is similar to other published Medicare LCDs: “Documentation should include the date and the current treatment dose. A radiation oncologist and a neurosurgeon must evaluate the clinical aspects of the treatment, and document and sign this evaluation as well as the resulting management decisions.”

In order to accomplish these documentation requirements, a procedure note for each fraction of treatment is necessary. Items to be included in this note are:

- Patient set-up and immobilization.
- Imaging for localization of isocenter or target volume and physician review.
- Treatment delivery, dose and fraction.
- Intra-fraction adjustments related to patient or target motion.

**Stereotactic Radiosurgery (SRS)**

Cranial or spinal SRS is usually performed in a single planning and treatment session. A team approach is composed of specialists from neurosurgery, radiation oncology, radiation physics and other appropriate surgeons, when indicated, in the delivery of this highly complex and time-consuming procedure. Specific CPT codes are available to be used for treatment delivery and treatment management of SRS courses as
defined by the treatment area and the number of fractions. The applicable treatment delivery codes are as follows:

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

CPT codes 77371 and 77372 are technical only codes and are utilized in a hospital outpatient or freestanding setting. Per payer instructions, these codes are utilized only in cases consisting of a single fraction; if more than one session is required, SBRT codes are to be utilized. In addition, as the descriptor implies, the codes are intended to include all lesions and only one treatment delivery code is to be billed per date of service, regardless of the number of lesions treated.

If the number or location of lesions is such that all of the lesions cannot be treated in the same SRS session and must be treated in separate sessions, each treatment cannot be billed as SRS (77371 or 77372). Instead, each session is part of a fractionated course (CPT code 77373), even if each treatment is a separate lesion, and the course cannot exceed five fractions or the course is not considered stereotactic radiotherapy. The intent of SRS is to treat all lesions in the same session. If this cannot be accomplished, then the course is not SRS.

Specific treatment management codes are also defined for the stereotactic technique:

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

CPT code 77432 is defined as a professional only code. Similar to the guidelines for the reporting of the treatment delivery code, payers instruct CPT code 77432 to be utilized for a complete course of treatment consisting of one session and are considered billable one time per course regardless of the number of lesions. Published Medicare guidelines also define this code is billable only when the radiation oncologist is fully participating in the management of the procedure.

**Stereotactic Body Radiation Therapy (SBRT)**

SBRT differs due to the prescribed dose delivery occurring in smaller doses over multiple sessions (not to exceed five sessions) to a generally larger site and/or multiple sites. The localization and planning methods are similar to SRS. SBRT coding is only appropriate if the entire course of treatment is
delivered in five or fewer fractions and meets the criteria outlined for stereotactic radiotherapy. If more than five fractions are delivered, then the treatment course is not considered stereotactic radiotherapy and the stereotactic procedure codes should not be utilized. Treatment may be delivered via the convergence of the active cobalt source on the target, static fields or multiple arcs on a Cobalt-60 device or linear accelerator and reported with the following treatment delivery code:

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

CPT 77373 is a technical-only code and is reported once per fraction of treatment up to a total of five fractions. When performing and billing stereotactic delivery, it is not appropriate to bill more than one treatment delivery code for the same date of service.

The corresponding treatment management code to be utilized for SBRT courses is:

77435 Stereotactic body radiation therapy, treatment management, per treatment course, to 1 or more lesions, including image guidance, entire course not to exceed 5 fractions.

Similar to the SRS treatment management code, CPT 77435 is a professional-only code and is billable once per course. Medicare LCDs also indicate that a radiation oncologist may not bill CPT codes 77432 and 77435 for the same course of treatment.

The treatment delivery codes for both SRS and SBRT have changed in previous years from the initial code design. Originally, a series of G-codes was developed for use in a hospital outpatient setting, while 77372 and 77373 were intended for use in the freestanding setting. The G-codes developed and defined differences between “robotic” and “non-robotic” treatment delivery, which was not a component of the 77XXX codes; therefore, Medicare allowed the use of G0339 and G0340 within a freestanding setting if the code was the best representation of the procedure performed and was defined as contractor-priced. In the 2014 HOPPS Final Rule, the G-codes were deleted and hospital outpatient departments were instructed to utilize the existing 77372 and 77373 codes; however, G0339 and G0340 were not removed from the MPFS Final Rule. CMS indicated a lack of sufficient data for pricing inputs for stereotactic services; therefore, the issue would be addressed in future rulemaking.

G0339 Image-guided robotic linear accelerator-based stereotactic radiosurgery, complete course of therapy in one session or first session of fractionated treatment.

G0340 Image-guided robotic linear accelerator-based stereotactic radiosurgery, delivery including collimator changes and custom plugging, fractionated treatment, all lesions, per session, second through fifth sessions, maximum five sessions per course of treatment.
Stereotactic Planning

While the stereotactic technique utilizes specific codes for treatment delivery and treatment management, the remainder of the process of care, including simulations, physics and dosimetry planning, utilize existing CPT codes. These codes are used as defined by payer guidelines; however, due to the timeline for SRS, NCCI edits may apply which may render codes as non-billable.

Specific to dosimetry planning for stereotactic courses, Medicare has defined codes related to stereotactic specifically include, but are not limited to, 3-D planning as represented by CPT code 77295, which would be reported along with associated basic dosimetry calculations, CPT code 77300, and treatment devices, CPT code 77334. Details from the CMS are outlined in Table 3 of the January 2014 Update of the Hospital Outpatient Prospective Payment System (HOPPS).

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Long Descriptor</th>
</tr>
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<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>

With regard to the basic dosimetry calculations and treatment devices, individual payers may have specific instructions pertinent to stereotactic techniques. Treatment devices for stereotactic cases may include helmets, cones, collimators, iris or MLC, which would be represented by CPT 77334. These would be billed in quantity based on each separate and distinct device utilized; however, no more than one device would be considered billable per port. Basic dosimetry calculations, CPT 77300, would also be billed in quantity and are defined as one per arc, port or shot. For both services, quantity limits may apply based on NCCI guidelines and published stereotactic coding guidelines, as shown in the example information published within the Noridian Healthcare Solutions Stereotactic Radiation Therapy: Stereotactic Radiosurgery (SRS) and Stereotactic Body Radiation Therapy (SBRT) LCD:

"6. Basic dosimetry calculations (77300) are limited to one (1) unit for each arc in a linear accelerator system and one (1) unit for each shot in Cobalt-60 system with a maximum of ten (10) units.
7. Treatment devices, complex (77334) is limited to one unit for each collimator in a linear accelerator system or one for each helmet in a cobalt-60 system. If the total number of units exceeds six (6) or the number of isocenters plus three (3) when multiple isocenters are necessary, a detailed explanation of medical necessity must be documented in the medical record. (See Documentation Guidelines.)"
In the event multiple lesions are treated, involving multiple isocenters, these expected quantities may be exceeded, but should be carefully documented. The medical record should clearly reflect the number of calculations or treatment devices medically necessary, which may be required in the event of an appeal or payer request. Review of local payer policies is recommended to ensure understanding of the expectations regarding quantities and supporting documentation.

In certain specific instances, it may be possible for a course of stereotactic radiotherapy to be billed as IMRT. If the criteria already discussed with the IMRT treatment planning section were met and the criteria for stereotactic radiotherapy courses were also met, the IMRT planning codes 77301, 77338 and 77300 could be billed.

If appropriate IMRT criteria are met, the stereotactic radiotherapy treatment machine must be able to modulate the beam and meet the requirements for the number of segments per field and ability to deliver the IMRT treatment. The initial simulation and treatment planning CT would not be billable with the course and only one treatment device is billable, regardless of the number of arcs or fields treated. In addition, it will be up to the payer to recognize and reimburse for the combination of highest-level services, IMRT and SRS/SBRT for a single course of treatment.

**Brachytherapy**

Radiation oncology consists of two primary treatment modalities: external beam radiation therapy (EBRT) and brachytherapy. Brachytherapy is a type of radiation therapy that utilizes radioactive isotopes or radionuclides temporarily or permanently implanted to treat malignancies or certain benign conditions and derive certain physical advantages. Brachytherapy is accomplished by placing small-encapsulated radioactive elements (also known as "seeds" or "sources"), directly in or near the tumor or treatment site. There are currently three basic clinical brachytherapy application formats: interstitial applications, intracavitary applications (also called intraluminal), and surface applications (placed directly on the skin or other external target surface). Brachytherapy applications may be high dose-rate (HDR) or low dose-rate (LDR) depending on source activity and radioactive emanation. LDR applications may be either temporary or permanent, but HDR applications are typically temporary. A treatment course of brachytherapy may be as monotherapy, or may be combined with external beam therapy. Regardless of the precise course of therapy ordered, the typical brachytherapy course will follow a generally standardized process of care:
Evaluation and Management (E&M)

A new or established patient visit may be appropriate prior to a course of brachytherapy; however, it may not be appropriate if planned as part of a multimodality course of therapy consisting of external beam and brachytherapy treatment. In some circumstances, if the brachytherapy and external beam treatment(s) are to be performed in different sites, by different physicians, separate evaluation and management codes may be appropriate. An established patient visit would be appropriate if the physician providing the brachytherapy portion is a brachytherapy specialist in the same practice, but not otherwise directing the external beam for the patient. Refer to the Evaluation and Management Section or specific payer guidelines to determine the appropriate code.

Clinical Treatment Planning

The clinical treatment planning CPT codes 77261, 77262 and 77263 account for the cognitive physician thought process and effort for the intended course of therapy. These codes are professional-only services and are billable only when appropriately documented prior to a course of brachytherapy monotherapy. If a course of brachytherapy is combined with external beam radiotherapy, treatment planning will usually be integrated as one service prior to initiation of the entire course of therapy. In this instance, a second charge for treatment planning for the brachytherapy phase of treatment would not be appropriate. If another physician with a separate tax ID, such as a brachytherapy specialist, is performing this service within the sphere of brachytherapy clinical treatment planning, it would be appropriate for this physician to report a separate clinical treatment plan. Refer to the Physician Clinical Treatment Plan Section for more information on selection of the appropriate code level.

Insertion of Device

To deliver radiation to the area of interest for brachytherapy, a specific source applicator or the radioactive source itself can be implanted or inserted into the patient. The appropriate CPT code used for the insertion by the physician will depend upon how and where the device is inserted. The table below
outlines available insertion codes for brachytherapy. The insertion code is billable at each fraction of HDR or LDR; however, if the applicator is to remain within the patient from the initial insertion until the completion of treatment, only one insertion is billable. Documentation of the insertion of the applicator or sources by the physician must be documented within the procedure note. The insertion code has both professional and technical components.

The applicator device inserted into the patient for the brachytherapy treatment is billable using the device CPT codes, 77332 or 77334 (which are also applicable to external beam devices). If the device used is manufactured for multiple-patient use and does not require custom modification a simple device CPT code 77332 is appropriate. If there is customization or construction of a device for a particular patient or procedure a custom-designed device CPT code 77334 for brachytherapy would apply. The physician typically documents the type of device within each procedure note.

Payment valuation for insertion codes 57155, insertion of uterine tandem and/or ovoids for clinical brachytherapy and 57156, insertion of a vaginal radiation afterloading apparatus for clinical brachytherapy, include both professional and technical components of the applicator, under MPFS. A physician working in a hospital or a freestanding center can no longer bill a device code for the applicator as the RUC has valued the insertion codes to include the applicator. The hospital setting can continue to bill the applicator device code for HDR procedures as appropriate.

Courses of prostate seed implant (PSI) utilize a template to assist in the placement of the brachytherapy needles. The template when supported and documented is billable as a simple device with code 77332. The Direct PE equipment values for code 77778 include the template used for needle placement under MPFS. Physicians and freestanding facilities cannot bill for the template used as part of the PSI procedure as it is included in the value of the code. Hospitals can continue to bill code 77332 for the template and are separately reimbursed.

The following table lists the insertion codes that are selected based upon the anatomical location of the device or the type of device placed. Billing for the codes is permissible for only the one physician actually performing the service, whether a radiation oncologist or participating surgical specialist.

<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>Placement of radiotherapy after loading balloon catheter into the breast for interstitial radioelement</td>
</tr>
<tr>
<td>CPT Code</td>
<td>Description</td>
</tr>
<tr>
<td>----------</td>
<td>-------------</td>
</tr>
<tr>
<td>19298</td>
<td>Placement of radiotherapy after loading 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 image guidance.</td>
</tr>
<tr>
<td>20555</td>
<td>Placement of needles or catheters into muscle and/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>
<tr>
<td>55875</td>
<td>Trans-perineal 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 and/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 after-loading 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>

**Brachytherapy Simulations**

The process of obtaining imaging of inserted treatment devices is referred to as brachytherapy simulation. The initial simulation with imaging performed for computerized treatment planning is a complex simulation CPT code 77290. For intracavitary and interstitial temporary brachytherapy, the documentation of the simulation is typically located either within the physician procedure note for the fraction of treatment or within a separate simulation note approved by the physician.

A simple brachytherapy verification simulation CPT code 77280 is billable with subsequent HDR fractions or when intermittent checks of other temporary implants are performed. There is no associated dose calculation with the verification simulation. If a new plan is generated based upon a new applicator device insertion for subsequent intracavitary insertions (such as tandem and ovoids or tandem and ring)
or if a significant adjustment is made to an interstitial implant which requires imaging and recalculation, then an additional complex simulation code 77290 may be supported, but should be carefully documented.

Brachytherapy courses for partial breast irradiation and other complex interstitial implants such as head and neck, sarcoma and gynecologic interstitial are often performed twice daily (BID). Such treatment courses may require twice daily (and rarely three times daily) simulations to check applicator integrity and position. The result is that multiple simulations on each day of treatment are commonly necessary. NCCI edits appropriately allow for multiple complex (77290) and simple (77280) simulations codes to be billed on the same date of service. This exception was created and intended specifically for brachytherapy twice-daily courses. When a complex simulation is performed and documented in the morning and then a verification simulation is performed and documented for the afternoon fraction, a modifier is needed on the lower level code CPT code 77280. In addition, if two brachytherapy simulations of the same level are documented as performed and medically necessary on the same date of service, a modifier should be applied to the later simulation (i.e. BID brachytherapy treatments accompanied by BID verification simulation). Code modifiers may be payer-specific, thus requiring the review of local payer policies to verify the appropriate modifier for use in these situations.

The imaging associated with brachytherapy simulation may include CT guidance for placement of radiation fields, CPT code 77014 (only reported in a hospital setting with any simulation process); ultrasound guidance for placement of radiation therapy fields, G6001, for physicians and freestanding facilities or 77387 for hospital-based departments (this may vary for specific commercial payers); or ultrasound guidance for interstitial radioelement application, CPT code 76965. These imaging services may be reported, if documented, in addition to the simulation charge. Documentation of the simulation and imaging may be within the physician procedure note or a separate document that describes brachytherapy simulation and brachytherapy imaging findings. For BID cases the multiple imaging codes can be reported again utilizing a modifier for the afternoon fraction as appropriate per the various imaging codes defined for 2016.

Over the past several years, electronically generated, low-energy radiation sources have been introduced, which may be applied with applicators similar to those utilized for isotopic brachytherapy. In the absence of specific codes available for these services, vendors and providers have utilized traditional isotopic brachytherapy billing codes. These services are now undergoing significant review and consideration of distinct codes, which may identify them as related to electronic radiation generation, with low radiation energy, similar to the previously reported superficial or orthovoltage sources. Currently, courses of electronic brachytherapy allow for billing of only a few codes per the course of treatment. Only the initial simulation would be billable for the course. The initial simulation would allow for the design and set-up of the course of treatment. A subsequent verification simulation would not be billable since the
applicator is placed externally on the patient and the need to verify the placement is not the same as a course in which the applicator is placed internally.

**Brachytherapy Isodose Plans**

Once the data and imaging from the simulation process have been collected, a treatment plan is created. A brachytherapy “internal radiation therapy” isodose plan is an illustration of the implant orientation, volume of treatment, number of sources, and rate of exposure and dose necessary to treat a tumor at close proximity with corresponding dosages to the target and normal surrounding tissues, which are usually described as organs at risk (OAR). With modern technology, treatment planning for intracavitary and interstitial implants is typically computer-based. Surface applications may also be performed on the basis of isodose nomograms.

Brachytherapy isodose plans and dose calculations (treatment plan calculations) based upon two-dimensional (2-D) images should be reported with the brachytherapy isodose plan, CPT codes 77316, 77317 and 77318. Brachytherapy isodose plan codes are available and consist of three levels based upon the number of sources or channels utilized. The number of sources or channels should be accurately recorded and documented within the isodose plan and physician procedure notes for each fraction.

Additional treatment plans for subsequent applicator insertions (e.g., serial intracavitary applications) or significant implant adjustments (e.g., HDR interstitial implants or a displaced implant or modified LDR implants) that require new dose calculations on the same patient are appropriate. Medical necessity and documentation should accompany the new isodose plans. Only one plan on a specific date of service is appropriate. The complexity levels for brachytherapy isodose planning for HDR now directly correspond with treatment delivery codes for HDR. The three levels of brachytherapy isodose plans are:

- **77316** Brachytherapy isodose plan; simple (calculation(s) made from a single plane, 1 to 4 sources, or remote afterloading brachytherapy, 1 channel), includes basic dosimetry calculation(s).

- **77317** Intermediate (calculation(s) made from a single plane, 5 to 10 sources, or remote afterloading brachytherapy, 2-12 channels), includes basic dosimetry calculation(s).

- **77318** Complex (calculation(s) made from a single plane, over 10 sources, or remote afterloading brachytherapy, over 12 channels), includes basic dosimetry calculation(s).

In the event a volume of interest and critical structures are utilized for 3-D conformal planning, the applicable code for 3-D planning, CPT code 77295, should be utilized in place of the specific 2-D brachytherapy isodose plan. Documentation for all brachytherapy isodose planning must support
physician participation, including physician signatures with date and time upon review and approval of the completed isodose plan.

In addition to the brachytherapy isodose plan, a decay factor calculation must be performed for the HDR source prior to each fraction of HDR to ensure accuracy of dose delivery. When performed, this calculation is documented by the actual calculation. The appropriate CPT code is 77300; however, due to coding guidelines this calculation is bundled and should not be separately reported when performed on the same date as brachytherapy isodose planning CPT codes 77316, 77317 or 77318 or HDR brachytherapy treatment delivery CPT codes 77767, 77768, 77770, 77771, 77772 or 0394T and 0395T. For LDR cases, a calculation may be necessary to assay the source to verify the current activity. The appropriate charge for the source assay may be a basic dosimetry, CPT code 77300, or special dosimetry CPT code 77331, depending on the methodology actually employed.

**Brachytherapy Treatments (LDR, HDR and Electronic Brachytherapy)**

The appropriate code for brachytherapy treatments corresponds to the type of treatment administered: low dose rate (LDR), high dose rate (HDR) or electronic brachytherapy.

**Low Dose-Rate (LDR) Applications**

**Intracavitary Radiation Source Application CPT codes 77761, 77762 and 77763**

Intracavitary brachytherapy is performed by placing applicators containing radioactive materials directly into or around a treatment target. The most common applications of intracavitary brachytherapy are in the treatment of carcinomas of the endometrium (uterus) or cervix. A number of radioactive sources are placed in an applicator in a specific geometric configuration encompassing the area of tumor, producing high-intensity localized radiation. The applicators are typically left in place for a period of 1-3 days. Cesium, iridium and cobalt are the most frequently utilized LDR sources. These sources are manufactured as small sealed sources of low intensity that are inserted into hollow carriers. The radiation dose is delivered over several days, so this source delivery method is termed “low dose-rate” (LDR). The sources and applicators are removed at the completion of planned brachytherapy dose delivery.

Similar to the brachytherapy isodose plans previously outlined, the intracavitary application codes are categorized by the number of sources or ribbons utilized. Supporting documentation of the treatment is a signed and dated procedure note by the attending physician outlining the brachytherapy process, including treatment parameters (including the radiation source type, number, and activity as well as insertion and removal dates and times). The three levels of intracavitary application are:

- **77761 Intracavitary radiation source application; simple; utilizes 1 – 4 sources/ribbons.**
77762 Intracavitary radiation source application; intermediate; utilizes 5 – 10 sources/ribbons.

77763 Intracavitary radiation source application; complex; utilizes over 10 sources/ribbons.

**Interstitial LDR Radiation Source Applications CPT codes 77778 and 77799**

LDR interstitial CPT codes 77776 and 77777 were deleted in CY 2016. In the event an interstitial course of treatment, such as eye plaque, is performed with less than 10 sources the appropriate LDR treatment delivery code is CPT code 77799, unlisted procedure, clinical brachytherapy. Changes in the definition to CPT code 77778 now include the handling and loading of radioactive sources; therefore, CPT code 77790 is no longer separately billable with any LDR brachytherapy courses.

Interstitial brachytherapy as indicated by CPT codes 77778 and 77799 is performed with needles, ribbons or wires containing radioactive materials that are inserted directly into and/or around the target tissue. The application may be similar to intracavitary except that the sources, as seeds in ribbons or wires, are temporarily or permanently inserted into small, hollow brachytherapy catheters or needles directly into the treatment target area. Temporary implants consist of applicator device(s) insertions which may be left in place over a period of several days. These applications may be used in conjunction with external beam radiation therapy or as monotherapy.

LDR interstitial applications are also performed using radioactive sources inserted permanently into the target tissue, where they decay to deliver the full therapeutic radiation dose. Permanent seed brachytherapy is most commonly done for prostate cancer, but the technique is applicable for cancers in other locations. Small sealed sources (usually referred to as seeds) of radioactive material (e.g., encapsulated Iodine-125, Palladium-103, Cesium-131 or Gold-198) are inserted directly into the target tissue either as individual, free seeds or as seeds in linear carriers (embedded in suture material). These radionuclides have a sufficiently low penetrating energy and/or half-life profile that safely allows for permanent placement even after the treatment dose has been delivered. In addition, the necessities of location, application and removal would make temporary placement of the sources impractical. These sources are often manufactured at higher activity levels and therefore may be used for either permanent or temporary brachytherapy. Supporting documentation of the treatment consists of a procedure note by the physician outlining the entire brachytherapy process, including treatment parameters as described above, and requires a physician's signature, date and time, as the treatment carries a professional and technical component. The two interstitial application codes are described below and differentiated by the number of sources or ribbons.
Interstitial radiation source application, complex, includes supervision, handling, loading of radiation source, when performed.

Unlisted procedure, clinical brachytherapy.

Documentation requirements for storage, handling, and performance of brachytherapy procedures are also regulated by the U.S. Nuclear Regulatory Commission (NRC) and or the appropriate Agreement State(s). Requirements for these regulatory authorities should be carefully reviewed and followed. These requirements have no relationship to payer billing criteria, but may often be utilized for multiple purposes.

LDR Brachytherapy Sources

When brachytherapy is performed in a hospital setting, the radioactive sources are also considered billable per the type of source utilized and supported quantity. Medicare has established a set price for each source type, and payment is made according to the number of sources purchased specifically for each patient’s planned treatment. The sources are classified by radionuclide, source intensity (high or low activity) and whether the sources are embedded in a suture-like stranded configuration.

When brachytherapy techniques require the manual loading of an isotope (interstitial and intracavitary), the supervision, loading and handling of the isotope CPT code 77790 should not be separately reported, as it is now bundled into all LDR brachytherapy techniques. Documentation of the handling and loading is still necessary to support the work was performed and is located in the procedure note by the physician. The table below outlines the available brachytherapy source codes:

<table>
<thead>
<tr>
<th>Code</th>
<th>Brachytherapy Sources and Radiopharmaceuticals</th>
</tr>
</thead>
<tbody>
<tr>
<td>A9600</td>
<td>Strontium Sr-89 chloride, therapeutic, per millicurie.</td>
</tr>
<tr>
<td>A9604</td>
<td>Samarium Sm-153 lexidronam, therapeutic, per treatment dose, up to 150 millicuries.</td>
</tr>
<tr>
<td>A9606</td>
<td>Radium Ra-223 dichloride, therapeutic, per microCurie (Xofigo).</td>
</tr>
<tr>
<td>A9699</td>
<td>Radiopharmaceutical, therapeutic, not otherwise classified.</td>
</tr>
<tr>
<td>A9527</td>
<td>Iodine I-125, sodium iodide solution, therapeutic, per millicurie.</td>
</tr>
<tr>
<td>A9530</td>
<td>Iodine I-131 sodium iodide solution, therapeutic, per millicurie.</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
</tr>
<tr>
<td>--------</td>
<td>----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>A9563</td>
<td>Sodium phosphate P-32, therapeutic, per millicurie.</td>
</tr>
<tr>
<td>A9564</td>
<td>Chromic phosphate P-32 suspension, therapeutic, per millicurie.</td>
</tr>
<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>
<tr>
<td>Q3001</td>
<td>Radioelement for brachytherapy; any type, each.</td>
</tr>
</tbody>
</table>
High Dose Rate (HDR) Afterloading CPT codes 77767, 77768, 77770, 77771 and 77772

HDR codes 77785, 77786 and 77787 were deleted in CY 2016 and replaced with two new skin treatment codes and three new interstitial/intracavitary CPT codes. The brachytherapy treatment codes now include basic dosimetry calculations, 77300, which means the calculations generated to verify the decay factor are no longer billable at the time of the brachytherapy isodose plan nor with any HDR radionuclide brachytherapy treatments.

Radionuclide Skin HDR
77767 Remote afterloading high dose rate radionuclide skin surface brachytherapy; includes basic dosimetry, when performed; lesion diameter up to 2.0 cm or 1 channel.

77768 Remote afterloading high dose rate radionuclide skin surface brachytherapy; includes basic dosimetry, when performed; lesion diameter over 2.0 cm and 2 or more channels, or multiple lesions.

Radionuclide Interstitial or Intracavitary HDR
77770 Remote afterloading high dose rate radionuclide interstitial or intracavitary brachytherapy, includes basic dosimetry, when performed; 1 channel.

77771 Remote afterloading high dose rate radionuclide interstitial or intracavitary brachytherapy, includes basic dosimetry, when performed; 2-12 channels.

77772 Remote afterloading high dose rate radionuclide interstitial or intracavitary brachytherapy, includes basic dosimetry, when performed; over 12 channels.

HDR is performed by using a remote afterloading device, a robotic source delivery device, to administer the radioactive source(s). HDR allows the dose to be delivered more quickly (hours instead of days) and is typically given in a series of multiple fractions. HDR may be done on an outpatient basis with several applicator placements or insertions followed by the HDR treatment, or it can be done as an inpatient procedure with a series of HDR treatment deliveries following one applicator insertion. The level of complexity of the treatment is determined by the number of channels through which the radioactive source travels to the planned dwell positions. The complexity levels for brachytherapy isodose planning for HDR now directly correspond with the treatment delivery codes for HDR; both are based on the number of channels used to deliver the treatment.

New for CY 2016, the appropriate radionuclide HDR treatment delivery code will depend on what type and where the treatment was delivered. For courses of treatment using radionuclides for skin surface
brachytherapy, the new treatment delivery codes are 77767 or 77768. The appropriate code is based upon the size of the lesion treated and/or the number or lesions total or channels used for treatment. The new skin surface treatment codes also include basic dosimetry calculations, 77300, which means decay factor calculations are no longer billable on the date of any HDR brachytherapy treatments. Work is still needed in order to verify the strength of the source and adjust the time necessary to deliver the dose; however, it is not separately billable.

Courses of radionuclide HDR brachytherapy delivered interstitially or by intracavitary means are billed using codes 77770, 77771 or 77772. The complexity of the code selected for treatment delivery will depend on the number of channels used. In addition, the level of treatment delivery will correspond to the level of brachytherapy isodose planning (if performed) since both series of codes are based on the number of channels. As with the new skin surface treatment codes, the interstitial and intracavitary treatment delivery codes also include basic dosimetry calculations, 77300, which means decay factor calculations are no longer billable on the date of any HDR brachytherapy treatments. Work is still needed in order to verify the strength of the source and adjust the time necessary to deliver the dose; however, it is not separately billable.

When multiple sites are treated in the same HDR brachytherapy session, each site is not billed with a separate code. The number of channels is totaled between the sites and this number will correspond to the appropriate single treatment delivery code. This is also applied to the planning process in determining the appropriate HDR brachytherapy isodose plan to bill for the sites planned.

Supporting documentation of the treatment, regardless if skin or interstitial/intracavitary, is a procedure note by the physician outlining the HDR brachytherapy process, including treatment parameters (including source strength, number of channels, number of dwells, treatment time), and requires a physician’s signature, date and time, as the treatment carries a professional and technical component.

**Electronic Brachytherapy Codes 0394T and 0395T**

Category III code 0182T was deleted and replaced with two Category III codes, 0394T and 0395T.

0394T High dose rate electronic brachytherapy, skin surface application, per fraction, includes basic dosimetry, when performed.

0395T High dose rate electronic brachytherapy, interstitial or intracavitary treatment, per fraction, includes basic dosimetry, when performed.
Electronic brachytherapy is a type of radiotherapy that utilizes a miniaturized high dose rate X-ray source instead of a radionuclide source used in radionuclide HDR brachytherapy discussed previously. Electronic brachytherapy is performed on an outpatient basis with several applicator placements or insertions and treatments.

When reporting the new electronic brachytherapy treatment codes 0394T and 0395T, the clinical treatment planning note, isodose and brachytherapy planning codes, devices, physician management code and special treatment procedure are no longer billable. Codes considered bundled into the electronic brachytherapy treatment delivery codes include 77261–77263, 77300, 77306–77307, 77316–77318, 77332–77334, 77336, 77427–77499, 77761–77772, 77778 and 77789. At this time, only the initial simulation is billable with a course of electronic brachytherapy. Verification simulations could be supported for interstitial or intracavitary treatments in order to verify the internal placement of the applicator. Courses of skin surface electronic brachytherapy would not support a verification simulation, as placement can be directly seen and there is essentially nothing to verify.

Supporting documentation of the treatment is a procedure note by the physician outlining the electronic brachytherapy process, including treatment parameters (number of channels and treatment time), and requires a physician’s signature, date and time, as the treatment carries a professional and technical component. CPT code 77300, basic dosimetry calculations, is no longer billable with electronic brachytherapy treatment codes starting in 2016.

In a freestanding facility, codes 0394T and 0395T have no set RVUs and require the negotiation of pricing with the individual payers. It is recommended to report the services appropriately as performed and documented in order to provide accurate data and utilization information for future pricing and to possibly set reimbursement.

**Infusion or Installation of Radioelement Solution**

Radiotherapy treatment can also be accomplished through an injection, infusion or oral administration of a radiopharmaceutical. Treatment may be delivered in the nuclear medicine department or elsewhere if properly licensed, but the expertise of the radiation oncologist and medical physicist are also needed. The following CPT codes are the available administration codes for radiopharmaceuticals, and the appropriate code will depend upon who performed the procedure and the method of administration. Documentation within the physician procedure note will support the appropriate code.

- **77750** Infusion or instillation of radioelement solution (includes 3-month follow-up care).
- **79005** Radiopharmaceutical therapy, by oral administration.
79101 Radiopharmaceutical therapy, by intravenous administration.

79403 Radiopharmaceutical therapy, radiolabeled monoclonal antibody by intravenous infusion.

In addition to the delivery method documented in the procedure note, it is necessary for the physician to document the clinical treatment plan, basic dosimetry calculation, handling and loading of the radioelement and the radioelement used as appropriate and supported per the work provided. CPT code 77790 supervision, handling, loading of radiation source, is not separately reportable with any of the above infusion or installation CPT codes (77750, 79005, 79101 or 79403).

The following is a coding example of a therapeutic radioelement treatment.

<table>
<thead>
<tr>
<th>Coding Example:</th>
</tr>
</thead>
<tbody>
<tr>
<td>A9604 Samarrium, Sm – 153 lexidronamm, therapeutic, per treatment dose, up to 150 millicuries (or J3490 - Unclassified Drug).</td>
</tr>
<tr>
<td>77261 Physician's clinical treatment plan.</td>
</tr>
<tr>
<td>77300 Basic dosimetry calculation.</td>
</tr>
<tr>
<td>77750 Infusion of radioelement solution, includes three-month follow-up.</td>
</tr>
</tbody>
</table>

In another example, A9600 Strontium SR-89 Chloride, Therapeutic, per millicurie may be used in place of the A9604 with a similar coding matrix.

Courses of Radium-223 (Xofigo) have additional considerations due to the fractionation of the course. A typical course includes one administration every four weeks for six months. Due to the complexity of the course the radiation oncologist could bill, if documented and per the specific payer guidelines, physician clinical treatment planning code 77263. If the radiation oncologist administers the Radium-223 the treatment code is 77750. If the nuclear medicine physician administers the drug, then the treatment code is 79101. When the radiation oncologist bills 77750 for the treatment delivery, there is a three-month follow-up period built into the code. At the next administration a modifier is needed on the treatments 2 – 6. It is recommended to use the -58 modifier on the administration code to identify that this is during the global period, but part of a surgical procedure and separately supported. Individual payers may not accept the -58 modifier, and a review may be necessary to identify the modifier accepted.

**General Coding Guidelines for Brachytherapy**

Below are general coding guidelines that may assist with documentation, submission of clean claims and appropriate coding.
The Correct Coding Initiative should be reviewed for all coding instructions in this guide and to ensure current rules are being satisfied.

A valid diagnosis coded to the highest level of specificity must be present on every claim submitted for payment.

A separate payment may be made for an expendable source under HCPCS procedure code Q3001 other than described for the hospital setting noted above. Radioelements for brachytherapy, any type, each, except for remote afterloading, HDR Brachytherapy procedures CPT codes 77767, 77768, 77770, 77770 and 77772. The HCPCS code Q3001 code is applicable in ASC, freestanding facilities and in hospitals that do NOT have an appropriate and existing “C” code for submission. If hospitals do have an existing source “C” then it should be submitted, except in the cases where a commercial payer does not recognize the source “C” code. In this instance or when no existing source “C” code is in place, submit the HCPCS code Q3001 with the quantity of sources. HCPCS code C1717 Brachytherapy source IR-192, per source, may be captured in a hospital setting per treatment for source recovery cost.

When external beam radiation treatment is given in combination with brachytherapy, only one Clinical Treatment Plan CPT code 77261, 77262 or 77263 will be submitted to the payer. In the instances when two different physicians are involved in the care through referral to a brachytherapy specialist, a different site or a different group, then each physician may bill for their respective plan code.

Use of simulation CPT codes 77280, 77285 and 77290 may be necessary prior to the procedure, day of the procedure or sometime after the brachytherapy implant procedure. Medical record documentation should support the particular level chosen for billing.

Dosimetry calculation, CPT 77300, during brachytherapy may be necessary to assay, or in rare instances, calculate dose to a point in the body of the patient. Documentation of any calculations is necessary; however, due to bundling CPT 77300 cannot be billed in conjunction with brachytherapy isodose planning CPT codes 77316, 77317 and 77318 performed on the same date. This will be the case for intracavitary and interstitial and with LDR, HDR and electronic brachytherapy. In addition, any decay factor or other calculations generated on the same date as any HDR brachytherapy treatments (radionuclide and electronic) are also considered bundled and not separately billable.

Isodose plans are reported using CPT codes 77316, 77317 and 77318. Typical courses of brachytherapy should require no more than three isodose plans.

Ultrasonic guidance for placement of radiation therapy fields is reported as G6001 for physician, freestanding facilities and nonexcepted off-campus provider-based departments or 77837 for hospital-based departments (this may vary for commercial payers). Ultrasonic guidance for interstitial radioelement application CPT code 76965 may be utilized when reporting associated ultrasonic procedures to aid in the placement of radiation therapy fields.

CPT procedure code 76873, ultrasound, transrectal; prostate volume study for brachytherapy treatment planning is utilized when a prostate volume study is performed.
Continuing medical physics, CPT code 77336, per the NCCI policy manual is only appropriate for courses of brachytherapy which are multi-step and not single fraction courses of treatment. Special physics consultation, CPT code 77370, may be appropriate and separately reported during a course of brachytherapy when ordered by the physician for the expertise of the qualified medical physicist and when the work documented to fulfill the request is performed solely by the qualified medical physicist.

CPT code 77790 is not reported for the radiation handling of the sources for LDR and radiopharmaceutical courses as it is considered bundled into the administration and treatment codes; this code is not reported for HDR courses.

Documented and informed consent for treatment must be located in the patient’s record.

A written, signed and dated prescription (written directive) and/or treatment plan designed by the radiation oncologist must be on file and located in the patient record. The prescription must contain:

- Treatment site or sites.
- Selected isotope.
- Selected number of source positions.
- Planned dose to a selected dose point, or points, or a relevant volume of interest.

Proton Therapy

Proton beam radiation therapy treatments, designated by CPT codes 77520, 77522, 77523 and 77525, allow for a curative dose to be delivered to areas of interest where conventional external beam radiation therapy has been limited due to the lack of protection of critical structures.

Radiation is delivered in the form of a particle beam which delivers the dose to the target with minimal dose deposition in surrounding tissue. Protons are not intended for use in systemic cancers, but rather localized disease. Due to the proton Bragg Peak, whereby the majority of radiation dose is delivered at a predictable depth, computer planning illustrates decreased dose to normal tissues and increased dose to the target area. The following outlines the treatment delivery CPT codes with the definitions of the different complexities.

Definitions

**Simple:** Proton treatment delivery to a single treatment area utilizing a single non-tangential/oblique port, custom block with compensation and without compensation.

**Intermediate:** Proton treatment delivery to one or more treatment areas utilizing two or more ports or one or more tangential/oblique ports, with custom blocks and compensators.
Complex: Proton treatment delivery to one or more treatment areas utilizing two or more ports per treatment area with matching or patching fields and/or multiple isocenters, with custom blocks and compensators.

**77520** Proton treatment delivery; simple, without compensation.

**77522** Proton treatment delivery; simple, with compensation.

**77523** Proton treatment delivery; intermediate.

**77525** Proton treatment delivery; complex.

Historically, the relative high cost of facility construction resulted in a minimal numbers of proton facilities and proton treatment being reserved for highly complex cases, especially pediatrics; however, advanced technology is now enabling facilities to be built on a smaller scale with lower costs. Indications for protons continue to grow and be explored by the larger numbers of practicing radiation oncologists in the proton arena.

The Proton Beam Therapy LCD by Wisconsin Physicians Service Insurance Corporation includes indications for the use of proton therapy per WPS’s designated jurisdictions. For a list of covered diagnoses, review of payer specific LCDs for proton beam therapy is recommended. As outlined by WPS, the following indications for the use of proton therapy are provided.

“**Indications:**

*Proton beam therapy will be considered medically reasonable and necessary for the following conditions:*

**Group 1**

1. Unresectable benign or malignant central nervous system tumors to include but not limited to primary and variant forms of astrocytoma, glioblastoma, medulloblastoma, acoustic neuroma, craniopharyngioma, benign and atypical meningiomas, pineal gland tumors, and arteriovenous malformations
2. Intraocular melanomas
3. Pituitary neoplasms
4. Chordomas and chondrosarcomas
5. Advanced staged and unresectable malignant lesions of the head and neck
6. Malignant lesions of the Para nasal sinus, and other accessory sinuses
7. Unresectable retroperitoneal sarcoma
8. Solid tumors in children”

In addition to the conditions considered medically necessary for the utilization of proton beam therapy, the following information is specific to the documentation requirements to support the use of protons and is
required to be housed within the patient medical record. This information is also contained within the Wisconsin Physicians Service Insurance Corporation, LCD Proton Beam Therapy.

“In addition to the criteria in Group I, Proton Beam Therapy indications must demonstrate that:

- **The Dose Volume Histogram (DVH) has one or more critical structures or organs protected by the use of Proton Beam Therapy;**

- **The dose to control or treat the tumor cannot be delivered without exceeding the tolerance of the normal tissue;**

- **There is documented clinical rationale that doses generally thought to be above the level otherwise attainable with other radiation methods might improve control rates; or**

- **There is documented clinical rationale that higher levels of precision associated with Proton Beam Therapy compared to other radiation treatments are clinically necessary.”**

Medicare Physician Fee Schedule payment rates for proton beam therapy codes may be established by some MACs under special Carrier pricing files on the individual websites. It is recommended to contact a governing MAC or review the specific Carrier priced files to determine if reimbursement exists for CPT codes 77520, 77522, 77523 and 77525 in freestanding facilities treating with proton therapy.

Payment rates for proton beam therapy codes are established for hospitals. Under HOPPS, proton CPT code 77520, proton treatment delivery; simple, without compensation, is now in APC 5623, separate from the other proton treatment delivery codes. Proton CPT codes 77522, proton treatment delivery; simple, with compensation), 77523 proton treatment delivery; intermediate and 77525, proton treatment delivery; complex are all within APC 5625 and reimbursed the same amount in a hospital setting.

**Hyperthermia**

Hyperthermia is a type of cancer treatment which consists of the use of heat to increase the temperature of a malignancy and result in cancer cell death. This heat may be generated by microwaves, ultrasound, low energy radiofrequency or some other heat-generating source. The heat causes increased blood flow to the tumor site and, in many instances, causes increased effectiveness of the radiation therapy. Hyperthermia typically involves heating the tissue to 40° - 44°C for approximately 30 minutes or longer and is provided within an hour prior to or after the radiation treatment.

Hyperthermia may be utilized as a sole modality; however, Medicare has stated it is not covered when performed alone. The Medicare Coverage Issues Manual Transmittal 131 Section 35-49 and Medicare
National Coverage Determination (NCD) Publication 100-3, *Hyperthermia for the Treatment of Cancer (110.1)* and the Medicare National Coverage Determinations Manual both indicate hyperthermia is not covered when performed alone, but is when performed in conjunction with radiation therapy. The following is quoted from the Medicare National Coverage Determinations Manual.

“110.1 - Hyperthermia for Treatment of Cancer

*(Rev. 1, 10-03-03)*

*CIM 35-49*

Local hyperthermia for treatment of cancer consists of the use of heat to make tumors more susceptible to cancer therapy measures.

Local hyperthermia is covered under Medicare when used in connection with radiation therapy for the treatment of primary or metastatic cutaneous or subcutaneous superficial malignancies. It is not covered when used alone or in connection with chemotherapy."

Similar to external beam and brachytherapy treatment techniques, hyperthermia has a consistent process of care for each case. This process of care may include applicator placement, simulation, treatment delivery, physics services and treatment management.

The AMA in the CPT descriptors for hyperthermia states that while the initial consultation is not included, the management during treatment and 90-day follow-up care are included in the hyperthermia CPT codes. CPT further states that “physics planning” and insertion of the temperature sensors are also included. The typical treatment for hyperthermia does not require the generation of isodose planning; however, a basic dosimetry calculation (77300) and simulation (77280 or 77290) may be medically necessary, documented and performed prior to each fraction of treatment. CPT code 77470, special treatment procedure, may be billable since the coordination and care of these patients when receiving external beam radiation in addition to hyperthermia treatment can be considered “special and time consuming”; however, if it is billed during the external beam portion it is not billable again during the hyperthermia portion. Documentation supporting the additional resources and time is required to support this code.

As with all procedure codes, documentation is vital and necessary; without the appropriate documentation, no code would be considered billable. Since hyperthermia is given in conjunction with radiation therapy codes, the codes specific to the radiation therapy and hyperthermia procedures should be reported as appropriate for each portion and per the work and therapy provided to the patient.

The appropriate procedure code for the type and depth of treatment will then be determined, billed accordingly and based on the five hyperthermia treatment codes below. Each treatment the patient
receives is billable, both professionally and technically; due to this the physician must clearly document a procedure note for each fraction of hyperthermia treatment.

The CPT codes for hyperthermia treatments are:

76000 Hyperthermia, externally generated; superficial (i.e., heating to a depth of 4 cm or less).

77605 Hyperthermia, externally generated; deep (i.e., heating to depths greater than 4 cm).

77610 Hyperthermia generated by interstitial probe(s); 5 or fewer interstitial applicators.

77615 Hyperthermia generated by interstitial probe(s); more than 5 interstitial applicators.

77620 Hyperthermia generated by intracavitary probe(s).
References/Resources for CPT Sections

Local Coverage Determinations (LCD) from numerous MACs, the CMS webpage for the Centers for Medicare and Medicaid Services cms.gov, and the CY 2011 – CY 2017 MPFS and HOPPS Federal Register.

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