

ACROinsights

(Formerly known as “The Drip”)

©American College of Radiation Oncology. All rights reserved.

Ins-and-Outs of Intrafraction Tracking and Gating Documentation, Billing & Reimbursement

The goal of this series of articles is to ensure that radiation oncologists are aware of and provided with the knowledge to practice in a compliant manner. This installment will review the billing guidelines for intrafraction tracking and gating code G6017 and what this may mean for potential reimbursement.

Background on Intrafraction Tracking and Gating

Under the service line of image-guided radiation therapy (IGRT), there are several types of imaging performed in conjunction with treatment delivery for patients, i.e. Cone-Beam CT, Stereoscopic X-ray Guidance, Ultrasound, Port Film, Intra-Fraction Tracking, etc. A form of IGRT is performed simultaneously during radiation treatment to track motion of the target primarily to account for respiration or patient movement. Commonly referred to as intrafraction tracking and/or gating; it is a software alignment program along with a motion management apparatus which is utilized to track the motion of the patient. The software will alert a radiation therapist to patient motion due to respiration or movement outside the planned or expected range, which notifies the radiation therapist of a need for action. This action may result in the radiation beam being turned off until the respiration or movement is brought back under control or readjustment of patient positioning and alignment. A report of the treatment delivery and monitored respiration or motion is generated at each fraction of treatment in which the system is utilized. A copy of this report should be uploaded into the EMR so that all documentation is consolidated in one location and ideally should not be maintained separately in the proprietary software of the IGRT system.

Prior to 2015, billing for intrafraction tracking and gating was represented by a Category III code listed below:

- 0197T (Intra-fraction localization and tracking of target or patient motion during delivery of radiation therapy (eg, 3D positional tracking, gating, 3D surface tracking), each fraction of treatment).

Effective January 1, 2015 the AMA CPT® Editorial Panel deleted the previous codes for the forms of IGRT (76950, 77421 and 0917T) and replaced the three codes with a single IGRT code:

- 77387 (Guidance for localization of target volume for delivery of radiation treatment, includes intrafraction tracking, when performed).

CMS accepted the above AMA coding change for hospitals in 2015 but did not accept the change of codes for physicians and office settings reimbursed under the MPFS. Instead, CMS created temporary G-codes as a direct crosswalk from the previous billing codes, by using the exact same definitions and values each code was assigned prior to the change and applying to the newly created G-code. The temporary G-codes are currently set to expire December 31, 2019. A future ACROinsights article will be provided to review what occurred in 2015 regarding the origin of the G-codes used in radiation oncology by CMS, the codes created by the AMA and how the coding updates varied for HOPPS (hospital billing) and MPFS (physician billing) for the same services.

The impact of this 2015 change meant, billing code 0197T was changed to code G6017 with the same definition as code 0197T. It also meant the issues with billing and reimbursement for a Category III code such as 0197T,

applied to G6017. For many providers, this translated to the practical outcome of limited or no coverage or reimbursement for intrafraction tracking and gating.

Documentation, Billing and Reimbursement in 2019

Use of intrafraction tracking and gating requires the use of a system with software and some kind of motion management apparatus. A technique of deep inspiration breath hold (DIBH) alone with no system tracking motion of the respiration pattern per the planned target volume, is not considered intrafraction tracking and gating. In order to bill for IGRT with DIBH, there must be a specially designed software and hardware system used to track the patient and document this in the medical record.

Documentation is represented by a report from the tracking system outlining each application along with the treatment delivery and uploaded into the medical record. The report should include patient demographics, any notation of the motion due to respiration or patient movement which was tracked and any intervention or change to the treatment delivery. In order to comply, the physician must review the documentation of the IGRT. Whether this is in accordance with the department policy for review of all IGRT to be considered billable or at the very least as part of one component of the physician management visit.

When billing for intrafraction tracking and gating, key components of documentation include: the service provided, the setting where the service occurred. Payer billing guidelines will determine what code is appropriate to bill. Hospitals bill for intrafraction tracking and gating with billing code 77387 for 3-D planned courses only. Physicians and freestanding/office settings bill G6017, which is crosswalked from code 0197T. Use of G6017 means all of the past parameters associated with 0197T were also carried forward. Currently, code G6017 is considered a "Physician Service Code" and CMS defines this as follows:

"Physician Service Codes--Identifies codes that describe physician services. Examples include visits, consultations, and surgical procedures. The concept of PC/TC does not apply since physician services cannot be split into professional and technical components. Modifiers 26 [professional, physician component of code] and TC [technical component of code] cannot be used with these codes. The RVUS include values for physician work, practice expense and malpractice expense. There are some codes with no work RVUs."

Physicians working in a facility setting, such as a hospital, do not bill G6017 with modifier -26, because there is no currently existing split for professional or technical component as seen with the other forms of IGRT. Additionally, the status of the code by CMS is "C", which means that CMS does not set the reimbursement, instead, each Medicare Administrative Contractor (MAC) is tasked with setting a Carrier Priced rate; if the code is reimbursed.

Most of the MACs have Carrier Pricing for G6017 as a global charge under MPFS, but there is only one MAC that has a rate for a physician in a facility setting published. Most of the MACs do not recognize G6017 as reimbursed for the physician under place of service (POS) -19 (off-campus outpatient hospital) or -22 (on-campus outpatient hospital). This above results in many physicians in the facility setting having no billable charge for intrafraction tracking and gating with treatment delivery. Most payers who do recognize code G6017 have a global rate published on their websites.

Physicians working in an office setting or when billing of the office setting itself, POS 11, code G6017 is reported as a global charge, there is no split billing for this charge. The G-codes used to report treatment delivery in the office setting do not bundle IGRT into the treatment as do the codes in the hospital setting. The respective IGRT code can be billed if the course was planned as 3-D or IMRT in the office setting, as long as the treatment delivery code is a G-code.

For commercial/private payers, it is determined by their internal policy as to which code to accept for IGRT. This may result in payers who do not recognize G6017 for intrafraction tracking and gating and instead require code

77387 to be reported, even for physicians. Additionally, some payers may not recognize this type of IGRT as medically necessary or as a non-covered service for all beneficiaries. It is important to continue to monitor payer policy for intrafraction tracking and gating.

With the deletion of the temporary G-codes set to happen after December 31, 2019, it is unknown at this time what billing and reimbursement will look like in 2020. The wait and see period continues regarding information about any payment models which may address this.

What This Means

It is helpful for physicians and freestanding/office settings to be cognizant that certain services by physicians in a facility setting, such as billing code G6017, as well as incorrect application of modifiers -26 (professional, physician component of code) and TC (technical component of code) could affect reimbursement. Lack of awareness of these coding guidelines may result in overpayment or a global rate reimbursed for services which were not globally performed. Ultimately a recoupment of monies or denial of services by payers could be warranted and creates a compliance risk for services provided and billed.

In addition, incorrect utilization of these services may invite increased scrutiny and review by payers or other auditing entities due to the potential risk and liability to Medicare beneficiaries. All physicians and facilities should ensure that surveys from ACRO and other stakeholder organizations receive a prompt response to help preserve the current level of reimbursement from proper utilization.