

Coding Guidelines

LCD Title

Radiation Oncology Including Intensity Modulated Radiation Therapy (IMRT)

Contractor's Determination Number

RAD-014

CMS National Coverage Policy

Title XVIII of the Social Security Act section 1862 (a)(1)(A). This section allows coverage and payment of those services that are considered to be medically reasonable and necessary.

Title XVIII of the Social Security Act section 1862 (a)(7). This section excludes routine physical examinations and services

Reasons for Denial

Services performed for diagnoses not listed as covered in this policy or for excessive frequency will be denied as not medically necessary. Frequency is considered excessive when services are performed more frequently than generally accepted by peers and the reason for additional services is not justified by documentation.

Services not listed as covered under the " Indications and Limitations of Coverage and/or Medical Necessity" section above will be denied as not medically necessary.

When a hospital inpatient is transported to a freestanding facility for therapy, the technical component of the radiation oncology services cannot be paid to the freestanding facility [MCM 15022 B (1), (2)]. Unless the patient is discharged from the hospital and treated at the freestanding facility as an outpatient, this payment will be denied.

Appeals for denied claims must be accompanied by that portion of the patient's medical record that documents the reason for the service. It is not necessary to provide the complete medical record. Note: All documentation must be specific to the patient being treated or the claim will be denied.

Coding Guidelines

Radiation - General

- A. *Radiation physics services (CPT codes 77300-77334, 77399) include a professional component (PC) and a technical component (TC). These services are covered following the same logic as other radiologic services that include PC and TC components.*
 1. *The physician's professional component is covered in all settings when the billed service represents the physician's (e.g., radiologist, radiation oncologist) involvement in the care. Radiation dosimetry calculations are payable by Medicare Part B only when the physician personally performs the service described in the code, or when the physician participated in the provision of the service (e.g., reviewed or validated the physicist's calculation).*
 2. *The technical component is covered only in settings where the TC is payable (e.g., freestanding clinic). The services provided by a Radiation Physicist are considered a part of the TC.*

When the radiation physics service is provided in a hospital setting, it is considered a Part A service, therefore, is not billable to Part B. This is true whether the physicist is employed by a radiologist, or is employed by, or under contract with, the hospital. Therefore, Physicists may not:

- *direct bill for their services,*
- *submit "incident to" billing for services furnished to hospital inpatients or outpatients, or*
- *receive duplicate payment for the same services furnished by a radiation oncologist.*

3. *When the radiation physics service is provided in a freestanding clinic, the physicist's services are included in the global service billed by the physician.*

B. Radiation physics services (CPT codes 77336, 77370) are technical services only. These services are covered only in settings in which the technical component is payable (e.g., freestanding clinic).

C. ICD-9 codes must be used to the highest level of specificity.

D. The following services are bundled into the radiation therapy codes:
11920,11921,11922,16000,16010,16015,16020,16025,16030,36425,
53670,53675,99211,99212,99213,99214,99215,99238,99281,99282,
99283,99284,99285,90780,90781,90841,90843,90844,90847,99050,
99052,99054,99058,99071,99090,99150,99151,99180,99182,99185,
99371,99372, 99373

Anesthesia (whatever code billed)

Care of infected skin (whatever code billed)

Checking of treatment charts, verification of dosage, as needed (whatever code billed)

Continued patient evaluation, examination, written progress notes, as needed (whatever code billed)

Final physical examination (whatever code billed)

Medical prescription writing (whatever code billed)

Nutritional counseling (whatever code billed)

Pain management (whatever code billed)

Review & revision of treatment plan (whatever code billed)

Routine medical management of unrelated problem (whatever code billed)

Special care of ostomy (whatever code billed)

Written reports, progress notes (whatever code billed)

Follow-up examination and care for 90 days after last treatment (whatever code billed)

Please consult the latest version of Correct Coding Initiative (CCI) for rebundling combinations.

E. For Treatment Devices, Designs, and Construction (CPT codes 77332-77334). The number of different anatomic sites determines the number of sets or ports involved except opposing fields (such as AP/PA) which represent one set. Each set must be submitted on the claim, with the appropriate level of complexity at the onset of therapy or as appropriate when additional devices are implemented during a course of treatment.

F. Place of Service:

Payment is limited to services furnished in office (POS 11), inpatient hospital (POS 21), and outpatient hospital (POS 22). A freestanding radiation oncology center is considered, for billing purposes, an office.

- G. Refer to the individual sections of this policy for further clarification and coding guidelines.

IMRT

IMRT Treatment Planning

77301 *Intensity Modulated Radiation Therapy (IMRT) plan, including dose-volume histograms for target and critical structure partial tolerance specifications.*

(Dose plan is optimized using inverse or forward planning technique for modulated beam delivery (e.g., binary dynamic MLC) to create highly conformal dose distribution. Computer plan distribution must be verified for positional accuracy based on dosimetry verification of the intensity map with verification of treatment set-up and interpretation of verification methodology)

This code is typically reported only once per course of IMRT.

IMRT Treatment Delivery

Collimator-based IMRT Treatment Delivery

77418 *Intensity Modulated Radiation Therapy (IMRT) delivery, single or multiple fields/arcs, via narrow spatially and temporally modulated beams, binary, dynamic MLC, per treatment session*

Compensator-based IMRT Treatment Delivery

0073T *Compensator-based beam modulation treatment delivery of inverse planned treatment using three or more high resolution (milled or cast) compensator convergent beam modulated fields, per treatment session*

Medical Radiation Physics, Dosimetry and Treatment Devices for use with IMRT

Basic Radiation Dosimetry

Basic radiation dosimetry is a separate and distinct service from IMRT planning and should be reported accordingly. The radiation dose delivered by each IMRT beam must be individually calculated and verified before the course of radiation treatment begins. Thus, multiple basic dosimetry calculations (up to 10) are typically performed and reported on in a single day. Supporting documentation should accompany a claim for more than ten (10) calculations in a single day.

IMRT Dosimetry

77300 *radiation therapy dose plan*

Treatment Devices

There are several categories of treatment devices used in conjunction with the delivery of IMRT radiotherapy. Immobilization treatment devices are commonly employed to ensure that the beam is accurately on target. In addition, the radiation oncologist is responsible for the design of the series of treatment devices that define the beam geometry. The beam aperture, the dose constraints per beam, the couch and gantry angles for each portal, and the coverage requirements all must be evaluated in order to guide the generation of the multi-leaf collimator segments. It is appropriate to report a treatment device CPT code for each complex IMRT field (i.e., gantry/table angle for step and shoot and sliding windows). It should not be billed for each segment within the field. CPT code 77334 is typically billed multiple times (often on the same day of service), once for each of the separate IMRT fields as required by the plan during the course of IMRT treatment. The typical case will require up to ten (10) devices. A claim for the use of more than ten (10) should be submitted with supporting documentation.

Codes for IMRT Treatment Devices

- 77332** treatment devices, design and construction; simple
77333 treatment devices, design and construction; intermediate
77334 treatment devices, design and construction; complex

*Devices

***77338** Multi-Leaf Collimator (MLC) device(s) For Intensity Modulated Radiation Therapy (IMRT), design and construction per IMRT plan. Do not report 77338 more than once per IMRT plan. Do not report 77338 in conjunction with 0073T, compensator based IMRT.

***0073T** 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. For treatment planning, use 77301. Do not report 0073T in conjunction with 77401-77416, 77418

Image Guided Radiation Therapy

Image Guided Radiation Therapy (IGRT) utilizes imaging technology to modify treatment delivery to account for changes in the position of the intended target. IGRT is used in conjunction with IMRT in patients whose tumors are located near or within critical structures and/or in tissue with inherent setup variation. Thus, although IGRT is a distinct service, it may be used and documented along with IMRT treatment delivery (77418) when necessary.

CPT Codes for IGRT

- 76950** Ultrasonic guidance for placement of radiation therapy fields
77014 Computed tomography guidance for placement of radiation fields (*this code replaces 76370)
77421 Stereoscopic x-ray guidance for localization of target volume for the delivery of radiation therapy.
0197T Intra-fraction localization and tracking of target or patient motion during delivery of radiation therapy (eg, 3D positional tracking, gating, 3D surface tracking), each fraction of treatment

Bundling

CMS CCI edits will apply to radiation codes and may include the following:

The following CPT codes were used as *building blocks* during the development of the IMRT planning CPT code. They are components of CPT code 77301 and therefore should not be separately coded or billed on the same day of service.

CPT Code	CPT Code Descriptor
76370 / 77014 (deleted/current)	Computerized axial tomography guidance for placement of radiation therapy fields
76375/ 76376 (deleted/current)	Coronal, sagittal, multiplanar, oblique, three-dimensional and/or holographic reconstruction of computerized axial tomography, magnetic resonance imaging, or other tomography modality
77295	Therapeutic radiology simulation-aided field setting; Three-dimensional simulation
77331	Special radiation dosimetry

The following list of codes should also not be reported on the *same date of service* as IMRT planning (77301). They may, however, correctly be used, as needed, for medically necessary simulation and treatment planning during the course of IMRT treatment (i.e. with code 77418.).

CPT Code	CPT Code Descriptor
77280	Therapeutic radiology simulation-aided field setting, simple
77285	Therapeutic radiology simulation-aided field setting, intermediate
77290	Therapeutic radiology simulation-aided field setting, complex
77305	Teletherapy, isodose plan (whether had or computer calculated); simple (one or two parallel opposed unmodified ports directed to a single area of interest)
77310	Teletherapy, isodose plan (whether had or computer calculated); intermediate (three or more treatment ports directed to a single area of interest)
77315	Teletherapy, isodose plan (whether had or computer calculated); Complex (mantle or inverted Y, tangential ports, the use of wedges, compensators, complex blocking, rotational beam, or special beam considerations).

Submitting Documentation:

Part A

Do not attach information to the original claim.

If it is a service that we want to review documentation, then an edit would be set up and an ADR (development letter) would be generated when the claim is billed. From a Part A processing side, we would have to set up an edit, and if a claim hit the edit, an ADR would generate the day after it is submitted into our system and request records for review. That ADR request would also state what documentation we would like for them to submit for review, and where it should be sent. The provider then has 45 days to get us the documentation, or else it denies for No Records Received. The ADR is system generated, and they can view it via the FISS DDE system, or wait for their hard copy to arrive. The problem with waiting for the hard copy letter, is that the system automatically generates it to whatever address is on file with FISS DDE, so it could be going to a corporate headquarter and not straight to the facility. Providers should monitor their billing system for such edits.

On the Part A UB 04, Form Locator 80 is the remarks section. But this is only for providers that submit claims via paper. We only process about 1% of our providers via paper. This amounts to only about 0.1% of our business. Most providers bill on the FISS DDE, and they would add remarks to page 4 on the FISS DDE system. Below is the list off of the Part A website on what documentation we request when reviewing radiation therapy.

Radiation Therapy

A detailed itemization and supporting documentation for all services billed

Documentation of history of illness being treated

Documentation of physician involvement

Physician order(s) for treatment including current dosage

- Documentation to support all services billed were provided
 - o Dosimetry reports
 - o Physicist reports
 - o Simulation reports
 - o Oncology reports

Documentation of each treatment billed

Copy of radiological report or physician's interpretation

Documentation of any contrast material provided

Part B.

Do not attach information to the original claim.

Additional information can be placed in Item 19 on the 1500 form or it's electronic equivalent when needed.

If it is a service that we want to review documentation, then an edit would be set up and an ADR (development letter) would be generated when the claim is billed. If you have additional information that is too large for the claim form you may indicate this and the contractor will request this information if needed.

Original Determination Effective Date

08/16/2009

Revision Effective Date

04/01/2011

Start Date of Notice Period

(Published)

*07/01/2011; 01/01/2010; 07/01/2009

Revision History

*07/01/2011 added ICD-9 codes 209.31-209.36; 01/01/2010, Added CPT code 77338 effective 01/01/2010;