Coding Guidelines

LCD Title
Brachytherapy

Contractor's Determination Number
RAD-036

CMS National Coverage Policy
Title XVIII of the Social Security Act, section 1862 (a)(7) - This section excludes routine physical checkups.
Title XVIII of the Social Security Act, section 1862 (a)(1)(A) - This section states that no Medicare payment shall be made for items or services that are not reasonable and necessary for the diagnosis or treatment of illness or injury.
Title XVIII of the Social Security Act, section 1833 (e) - This section prohibits Medicare payment for any claim that lacks the necessary information for processing.

Medicare Claims Processing Manual - Chapter 13 - Radiology Services and Other Diagnostic Procedures

70.4 - Clinical Brachytherapy (CPT Codes 77750 - 77799) (Rev. 1, 10-01-03)
Carriers must apply the bundled services policy to procedures in this family of codes other than CPT code 77776. For procedures furnished in settings in which TC payments are made, carriers must pay separately for the expendable source associated with these procedures under CPT code Q3001 except in the case of remote after-loading high intensity brachytherapy procedures (CPT codes 77781-77784). In the four codes cited, the expendable source is included in the RVUs for the TC of the procedures. There are specific C codes for certain radioelements payable under OPPS. These C codes are not payable by the Carrier.

70.5 - Radiation Physics Services (CPT Codes 77300 - 77399)
(Rev. 1, 10-01-03)
Carriers pay for the PC and TC of CPT codes 77300-77334 and 77399 on the same basis as they pay for radiologic services generally. For professional component billings in all settings, carriers presume that the radiologist participated in the provision of the service, e.g., reviewed/validated the physicist's calculation. CPT codes 77336 and 77370 are technical services only codes that are payable by carriers in settings in which only technical component is/are payable.

Medicare Claims Processing, Pub 100-04, Transmittal 1611, Date: OCTOBER 3, 2008, Change Request 6205
SUBJECT: October 2008 Update to the Ambulatory Surgical Center (ASC) Payment System; Summary of Payment Policy Changes
I. SUMMARY OF CHANGES: This Recurring Update Notification applies to Pub. 100-04, chapter 14, section 10.2.
Effective Date: October 1, 2008
Implementation Date: October 6, 2008

Formerly:
Medicare Carrier's Manual, section 15022 (D)(2 and 4)

General Coding Guidelines:

1. A valid ICD-9-CM diagnosis code must be present on every claim.
   All ICD-9-CM diagnosis codes must be coded to the highest level of specificity

2. Correct Coding Initiatives apply
   The following services are bundled into the radiation therapy codes 77750-77799 except for procedure code 77776:
   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.

3. <u>Advance Beneficiary Notice of Noncoverage (ABN) Modifier Guidelines (for outpatient services):</u>

   Services not meeting medical necessity guidelines should be billed with modifier -GA or -GZ.
   An ABN may be used for services which are likely to be non-covered , whether for medical necessity or for other reasons.
   Services not meeting medical necessity guidelines should be billed with modifier -GA or -GZ.
   The –GA modifier should be used when physicians, practitioners, or suppliers want to indicate that they expect that Medicare will deny a specific service as not reasonable and necessary and they do have an ABN signed by the beneficiary on file. An ABN, Form CMS-R-131, should be signed by the beneficiary to indicate that he/she accepts responsibility for payment. The -GA modifier may also be used on assigned claims when a patient refuses to sign the ABN and the latter is properly witnessed. For claims submitted to the Fiscal Intermediary, occurrence code 32 and the date of the ABN is required.

   The –GZ modifier should be used when physicians, practitioners, or suppliers want to

indicate that they expect that Medicare will deny an item or service as not reasonable and necessary and they have not had an ABN signed by the beneficiary.

If the service is statutorily non-covered, or without a benefit category, submit the appropriate CPT/HCPCS code with the -GY modifier.

For claims submitted to the carrier:

1. The physician's professional component for the brachytherapy procedure includes any necessary hospital admission and hospital care during the time that the patient is undergoing the brachytherapy procedure. Admission, subsequent hospital care and discharge day summary is included in the global fee for brachytherapy procedure.

2. **Special treatment procedure (77470)** (eg., total body irradiation, hemibody irradiation, per oral irradiation, endocavitary or intraoperative cone irradiation, ***brachytherapy***). The delivery of brachytherapy often requires special arrangements with the operating room and radiation safe ward, coordination of the applicator insertion process with other specialists, preparation and provision of the applicators and related equipment, scheduling and integration of required physics support, and acquisition and preparation of the radiation sources. Brachytherapy is often delivered in conjunction with external radiation, chemotherapy, or surgery. Integration of these processes makes brachytherapy a special treatment procedure.

3. The physician may report the appropriate CPT procedure code from the range of 77761-77789 (instillation/application of the radioelement) in addition to treatment planning, isodose calculation, and the code for the expendable source.
In addition, when performing all services alone, the radiation oncologist/radiologist may report the surgical codes for catheter, needle or applicator placement, where appropriate. However, when the radiation oncologist/radiologist collaborates with another physician, he/she may only submit the appropriate code from the range of 77750-77789 and not any of the surgical placement codes.

4. Brachytherapy simulation (77290) The complex process of obtaining images of the implanted region for purposes of making position adjustments and for performing dose calculations. Non-radioactive "dummy" sources are used to geographically define the "eventual position" of the radioactive sources in temporary implant devices, whereas permanently implanted sources are imaged directly. Contrast may be utilized to delineate adjacent normal tissues and organs. Subsequent "check" verification simulations during the course of temporary implants to confirm or correct applicator position are reported as simple CPT code 77280

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

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

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

8. The radiation oncologist should bill for the treatment plan with CPT procedure codes 77261-77263. Only one treatment planning code is allowed per course of treatment. When brachytherapy is used as an adjunct to external beam radiation therapy (EBRT), a single complex plan (77263) is reported to indicate that both modalities were utilized. If there is concurrent EBRT with brachytherapy refer to policy RAD014 for further information.

9. CPT code 77790 (Supervision, handling, loading of radioelement) is designated for manual-loading LDR brachytherapy only.

10. Dosimetry calculation during brachytherapy (the determination of dwell times, other than those times estimated in the isodose plan) should be reported with CPT procedure code 77300.

11. Isodose plans are reported using CPT procedure codes 77326-77328. A plan may be required for each modification of the source strength and/or position during temporary afterloading brachytherapy and both before and after permanent seed implantation. A typical course of brachytherapy usually requires no more than 3 isodose plans but may require multiple the calculation generating multiple isodose plans, typically equal to the number of applicator placements or major adjustments. (Example 6 HDR intracavitary applications would potentially involve 6 separate isodose plans).

    The complexity of the isodose plan is defined as follows:

	LDR (Permanent and Temporary)	HDR afterloading
77326 Simple	1-4 Sources/Ribbons	1-8 Dwell Positions
77327 intermediate	5-10 Sources/Ribbons	9-12 Dwell Positions
77328 Complex	>10 Sources/Ribbons	>12 Dwell Positions

12. CPT procedure code 77295 is to be used for 3 dimensional volume reconstruction and dose distribution calculations in LDR or HDR brachytherapy.

13. CPT procedure codes 76872, 76950, or 76965 are to be used when reporting associated ultrasonic procedures to aid in the placement of radiation therapy fields.

14. CPT procedure code 76873 (echography, transrectal; prostate volume study for brachytherapy treatment planning [separate procedure]) is used to report the plan for treatment protocol for prostate cancer.

15. The services of the qualified medical physicist and/or the dosimetrist under the direction of the qualified medical physicist are reported with CPT procedure code 77336.
(HDR brachytherapy is generally fractionated. Unlike external beam radiation, this fractionation may be weekly or daily. Since each fraction may be fundamentally different within each course of therapy, a separate charge (77336) may be required if the HDR fraction falls mid-week during a course of external beam treatment, since the prescription and review are fundamentally different for the two courses of therapy.)

16. Special medical radiation physics (CPT code 77370) is used for brachytherapy when requested by the physician for a consultation on an individual patient. It requires a written report for the patient's chart that must be analyzed by the physician to design or modify a brachytherapy treatment plan. This code may be reported once per course of treatment.

17. Do not report radiographs used in brachytherapy simulation with CPT procedure code 77417.

18. The HDR code (7778x) is employed for each HDR application (or fraction of treatment, whether multiple fractions daily, weekly or monthly). The following levels of complexity are recognized according to the number of source positions within HDR applicators or the number of dwell positions used in treatment.

CPT Code	Number source or dwell positions
77781	1-4
77782	5-8
77783	9-12
77784	>12

The remote afterloading CPT codes are used each time a treatment is given (i.e. each time the equipment is used to load radioactive material into the patient and provide a therapeutic dose of radiation.

19. The procedure code 77790 may be reported only for brachytherapy techniques requiring manual loading (CCI). The remote afterloading CPT codes are used each time a treatment is given (i.e. each time the equipment is used to load radioactive material into the patient and provide a therapeutic dose of radiation).

20. Brachytherapy is routinely designated complex (CPT code 77263) because it requires complex treatment volume design, dose levels near normal tissue tolerance, analysis of special tests, complex fractionation, or delivery concurrent with other therapeutic modalities or treatment of previously irradiated tissues. A separate treatment planning charge is not generated when external beam radiation therapy and brachytherapy are performed by physicians using the same provider numbers. However, if the two separate services are provided by physicians with different provider numbers, then each may charge 77263.

21. Brachytherapy simulation CPT code 77290 is the complex process of obtaining images of the implanted region for purposes of making position adjustments and for performing dose calculations. Non-radioactive "dummy" sources are used to geographically define the "eventual position" of the radioactive sources in temporary implant devices, whereas permanently implanted sources are imaged directly. Contrast may be utilized to delineate adjacent normal tissues and organs. Subsequent "check" verification simulations during the course of temporary implants to confirm or correct applicator position are reported as simple CPT code 77280.

22. Computer-generated, three-dimensional reconstruction may be used for brachytherapy. Documentation is required with three-dimensional reconstruction and distribution. The scan images used for computer data entry should be based on three-dimensional depictions of the implanted site. The source positions may be digitized directly from these images or the three-dimensional reconstruction and the tumor volume and normal tissue image may be merged electronically. Simple three-dimensional representations by treatment planning computer programs derived from planar radiographic images are not sufficient justification for the use of

this code. Code 77295 precludes the use of codes 77326-77328 Brachytherapy Isodose for the same treatment volume.

23. Services 77750-77799 include admission to the hospital and daily visits.

Coding guidance in relation to where the service is rendered.

Global
Global brachytherapy procedures can be reimbursed by Medicare Part B only in the office or free-standing facility setting (11) or independent clinic (49).

Technical
Technical component or technical only codes can be reimbursed by Medicare Part B only in the office or free-standing facility setting (11) or independent clinic (49). In the ASC (24), the ASC usually bills the technical component of the surgical code to the carrier.

Professional
Professional component or professional only codes may be reimbursed by Part B in an inpatient hospital (21), outpatient hospital setting (22) as well as an office or free-standing radiology facility (11), independent clinic (49) or an ASC (24).

Prostate Brachytherapy Performed in an Ambulatory Surgical Center (ASC)
Please refer to CMS payment rules for ASCs which can be found at:
http://www.cms.hhs.gov/ASCPayment/

Brachytherapy performed for the treatment of prostate cancer includes low dose rate (permanent seed) and high dose rate (HDR) brachytherapy. This addresses the treatment of prostate cancer utilizing low dose rate (permanent seed) brachytherapy performed at an ASC- an entity approved by Medicare as a supplier of certain ambulatory surgery services that bills the Part B carrier and is licensed by the state.

CPT 55875 [formerly 55859] (Transperineal placement of needles or catheters into prostate for interstitial radio element application, with or without cystoscopy) was added to the list of Medicare-approved ASC procedures effective July 1, 2003. Other ASC approved codes are 19296, 19297 and 19298 for breast, 57155 and 58346 for gynecological, 31643 pulmonary, and 43241 for esophageal applicator insertions. As of 01/01/2008 there are new CMS ASC billing instructions.

***Radioelements**
In all cases, the radioisotope must be billed by the provider licensed and trained in nuclear materials use. **The date of service for the radioelement claim must match the date of service for the procedure performed.**

1. The expendable source Q3001 is only reimbursed when billed in an office or free-standing radiological facility (11), independent clinic (49).
   For electronic billing in item 19 narrative, list iodine (I-125); palladium (Pd-103); and cesium (Cs-131), the number of seeds ordered, invoice price and the number of seeds used in the procedure. It is recognized that a small number of additional seeds is ordered and billed to cover plan changes or intra-operative loss.

2. In the OPPS setting use the source specific C code that best describes the radioelement should be used and it is priced off the OPPS fee schedule. Note that when billing for stranded sources, providers should bill the number of units of the appropriate source HCPCS C-

code according to the number of brachytherapy sources in the strand, and should not bill as one unit per strand.

3. In the ASC (24) setting, effective 01/01/2008, use the source specific C code that best describes the radioelement should be used. Prior to 01/01/2008 Code Q3001 was used in the ASC.
Payment for Brachytherapy Sources in an ASC.
The Medicare Improvement for Patients and Providers Act of 2008 requires CMS to pay for brachytherapy sources for the period of July 1, 2008 through December 31, 2009, at hospitals' charges adjusted to costs. As a result of the legislative amendment, there is no prospective rate under the OPPS for that period. Therefore, contrary to the payment policy, payment indicators and payment rates included in previous guidance, including Addendum BB to the November 27, 2007 OPPS/ASC final rule, for dates of service July 1, 2008 through December 31, 2009, payment for brachytherapy sources will be made at contractor-priced amounts, consistent with payment policy for the revised ASC payment system when no OPPS prospective rate is available. CR-6205

Note that when billing for stranded sources, providers should bill the number of units of the appropriate source HCPCS C-code according to the number of brachytherapy sources in the strand, and should not bill as one unit per strand.

For electronic billing in item 19 narrative, list iodine (I-125); palladium (Pd-103); and cesium (Cs-131), the number of seeds ordered, invoice price and the number of seeds used in the procedure. It is recognized that a small number of additional seeds is ordered and billed to cover plan changes or intra-operative loss.

Until standard pricing can be established, the contractor will request by mail additional documentation (operative note and seed invoice) to confirm billed amount and number of seeds used.

For claims submitted to the fiscal intermediary:

Hospital Inpatient Claims:

1. The hospital should report the patient's principal diagnosis in Form Locator (FL) 67 of the UB-04. *The principal diagnosis is the condition established after study to be chiefly responsible for this admission.*

2. *The hospital enters ICD-9-CM codes for up to eight additional conditions in FLs 67A-67Q if they co-existed at the time of admission or developed subsequently, and which had an effect upon the treatment or the length of stay. It may not duplicate the principal diagnosis listed in FL 67.*

3. For inpatient hospital claims, the admitting diagnosis is required and should be recorded in FL 69. (See CMS Publication 100-04, *Medicare Claims Processing Manual*, Chapter 25, Section 75 for additional instructions.)

Hospital Outpatient Claims:

1. *The hospital should report the full ICD-9-CM code for the diagnosis shown to be chiefly responsible for the outpatient services in FL 67.* If no definitive diagnosis is made during the outpatient evaluation, the patient's symptom is reported. If the patient arrives without a referring diagnosis, symptom or complaint, the provider *should report an ICD-9-CM code for Persons Without Reported Diagnosis Encountered During Examination and Investigation of Individuals and Populations (V70-V82).*

2. *The hospital enters the full ICD-9-CM codes in FLs 67A-67Q for up to eight other diagnoses that co-existed in addition to the diagnosis reported in FL 67.*

Radioelements inserted in the in-patient or outpatient setting should not be billed to Medicare Part B but to Part A under OPPS or Inpatient billing rules.
In the hospital setting (21 or 22) the radioelement is covered by source specific C-codes. The code C1717 code should be billed for each fraction of HDR given (77781-4).

Bill Type Guidelines:

CMS Publication 100-04, *Medicare Claims Processing Manual,* Chapter 9, Section 100(B) states that *no type of technical services, such as…a technical component of a diagnostic or screening service, is ever billed on TOBs 71x or 73x...Technical services/components associated with professional services/components performed by independent RHCs or FQHCs are billed to Medicare carriers…Technical services/components associated with professional services/components performed by provider-based RHCs or FQHCs are billed by the base-provider on the TOB for the base-provider and submitted to the FI.*

Per CMS Publication 100-04, Medicare Claims Processing Manual, Chapter 9, Section 100(B), only four types of services are billed on TOBs 71X and 73X: Professional or primary services not subject to the Medicare outpatient mental health treatment limitation are bundled into line item(s) using revenue code 052X; services subject to the Medicare outpatient mental health treatment limitation are billed under revenue code 0900 (previously 0910); …telehealth originating site facility fees under revenue code 0780 [and] FQHC supplemental payments are billed under revenue code 0519, effective for dates of service on or after 01/01/2006.

For dates of service on or after July 1, 2006, the following revenue codes should be used when billing for RHC or FQHC services, other than those services subject to the Medicare outpatient mental health treatment limitation or for the FQHC supplement payment…: 0521, 0522, 0524, 0525, 0527 and 0528 (See CMS Publication 100-04, *Medicare Claims Processing Manual,* Chapter 9, Section 100[B].)

Hospitals have been instructed to provide Hospital-Issued Notices of Noncoverage (HINNs) to beneficiaries prior to admission, at admission, or at any point during an inpatient stay if the hospital determines that the care the beneficiary is receiving, or is about to receive, is not covered because it is:

- Not medically necessary;
- Not delivered in the most appropriate setting; or
- Is custodial in nature.

Revision Effective Date
07/16/2012

Revision History
06/01/2012 -This guideline is effective for J-8 providers in Michigan MAC B 07/16/12, Michigan MAC A 07/23/12,
Indiana MAC A 07/23/12 and Indiana MAC B 08/20/12.