

AAPM CODING FREQUENTLY ASKED QUESTIONS*

GENERAL CODING Q & A's

May I bill treatment devices (CPT codes 77332-77334) more than once per day?

Yes. Multiple units of a treatment device code may be billed on the same day but requires a modifier.

If beam modification devices of two different levels of complexity are utilized for the same treatment port, only the device of highest complexity is reported.

A physician has requested the medical physicist to assist in Iodine-131 therapy. What code should be billed for the medical physicist's work?

The physician should request a special medical radiation physics consultation (CPT 77370). The medical physicist should perform the work and send a patient specific consultation report to the physician. The physician must sign the report and place it in the patient's medical record.

Can we get reimbursed for CPT 77399 *Unlisted procedure, medical radiation physics, dosimetry and treatment devices, and special services*?

In the freestanding center, Medicare does not provide reimbursement of "unlisted" codes (i.e. CPT xxx99). These codes are carrier-priced and you must contact your local Medicare carrier to determine their specific coverage and payment policies. Medicare does provide reimbursement for some unlisted codes in the hospital outpatient setting, including CPT 77399.

Some private payers do provide reimbursement for unlisted codes (i.e. 77399) but documentation must be submitted with the claim.

Where does one access the full descriptor for HCPCS codes?

You may purchase a HCPCS coding manual from the AMA Press (800-621-8335) or locate the complete HCPCS descriptors on the Medicare website at:

<http://www.cms.hhs.gov/HCPCSReleaseCodeSets/>

IMRT Q & A's

My Medicare carrier is denying continuing medical physics consultation (CPT 77336) for IMRT patients that had previously been billed for CPT 77301 for IMRT planning.

The current Medicare policy is that CPT 77336 *Continuing medical physics consultation, including assessment of treatment parameters, quality assurance of dose delivery, and review of patient treatment documentation in support of the radiation oncologist, reported per week of therapy* may not be reported when the service is part of the IMRT planning process (CPT 77301). CPT 77336 is appropriate for the “weekly” continuing medical physics process and reports the work and oversight of the medical physicist in the care of the patient.

I understand that a special medical radiation physics consultation (CPT 77370) should not be billed for IMRT quality assurance, because the work is covered in the IMRT planning code (CPT 77301). What additional tasks would allow for billing CPT 77370 when performing IMRT?

You are correct that according to the current coding rules the work to verify IMRT delivery does not allow billing a special medical radiation physics consultation (CPT 77370). If some other task is performed (e.g. pregnant patient and dose measurements and shielding are required; patient develops an unusual reaction and dose measurement and complex analysis are performed; major change in the patient body habitus and a repeat plan is done with extensive physics work to map the earlier dose distribution onto the new patient volumes) then CPT 77370 may be billed.

Some patients start with an initial IMRT plan (CPT 77301) and then need another IMRT boost plan five weeks later. Is it okay for the hospital to charge a second 77301 at the time of the boost plan?

While individual payer guidelines always take precedence, *CPT Changes 2002: An Insider's View* states the following, “Only one intensity modulated radiotherapy plan may be reported for a given course of therapy to a specific treatment area. However, if there is a clinical indication to change the treatment plan, because of either changes in clinical condition or the need to change the parameters of treatment, such as would be encountered in “boost” situation, then the additional plan would be reported.”

In general, a new CT (or other imaging modality) dataset is required to obtain payment for a second three-dimensional plan and we believe that this will also be the case for an IMRT boost plan. If the IMRT plan is generated from the same CT dataset as the original IMRT plan, then only one plan will typically be reimbursed by insurance carriers. However, if medical necessity is documented that indicates the need to obtain a new CT dataset (a second set of CT slices for treatment planning) after the initial course of therapy in order to complete the second IMRT plan, then it is possible payers will allow for both the original and boost IMRT plans.

If a separate plan is done, where medically necessary, using the same data set, then CPT 77315 *Teletherapy, isodose plan; complex* may be billed.

Why does Aetna deny payment for lung IMRT treatments?

Many insurance carriers consider IMRT for lung cancer experimental, investigational or unproven. Some do provide coverage of lung IMRT (most Medicare Part B plans), some do not, some cover with conditions (e.g. protecting vital organs like the heart). Always check with each individual payer regarding IMRT coverage policies.

MEDICARE Q & A's

What is the National Correct Coding Initiative and where do I find the code edits?

The Centers for Medicare and Medicaid Services (CMS) developed the National Correct Coding Initiative (NCCI) to promote national correct coding methodologies and to control improper coding leading to inappropriate payment in Medicare claims. The purpose of the NCCI edits is to prevent improper payment when incorrect code combinations are reported. The NCCI contains two tables of edits. The Column One/Column Two Correct Coding Edits table and the Mutually Exclusive Edits table include code pairs that should not be reported together for a number of reasons explained in the Coding Policy Manual.

The NCCI is updated quarterly and is available to the public at:

<http://www.cms.hhs.gov/NationalCorrectCodInitEd/>

We are treating a Medicare patient for prostate cancer in the hospital outpatient department. Can we get reimbursed for the cost of the gold fiducials?

The 2008 CPT manual advises to "report the device separately" from procedure code 55876 *Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), prostate (via needle, any approach) single or multiple*.

In the hospital outpatient setting, Medicare states that the payment for this procedure includes the implantable devices, unless those devices are paid separately based on their transitional pass-through status. CMS states that there are two new HCPCS supply codes effective January 1, 2008 (A4648 & A4650) but these codes and existing HCPCS code C1789 are packaged and will not be paid separately. These supply codes and their associated charges should be reported with procedure code 55876.

Many private payers do provide separate payment for fiducial markers. Effective January 1, 2008 you should use HCPCS code A4648 *Implantable tissue marker* to report the supply cost.

Does the High Dose Rate (HDR) Iridium-192 source receive separate payment under Medicare?

In the hospital outpatient setting, Medicare pays separately for the HDR Iridium-192 source. Use HCPCS code C1717 *Brachytherapy source, High Dose Rate Iridium-192, per source*.

In freestanding centers, the HDR Iridium-192 source is not paid separately. The cost of the source is bundled into the brachytherapy procedure payment (CPT 77781-77784).

We acquire prostate ultrasound images for preplanning several weeks prior to the implant. Normally this is done in our ultrasound suite under local anesthesia, but occasionally we encounter a patient who cannot tolerate the procedure. In these few cases, we move the patient to the operating room and acquire the images under general anesthesia. How should we bill these procedures?

The procedure started but terminated may be reported with its usual procedure code with the addition of modifier 74 *Discontinued outpatient hospital/ambulatory surgical center procedure after administration of anesthesia*.

DOCUMENTATION Q & A's

When do we charge for computer generated treatment plans? On the day of the computer printout? On the day that the physician signs the plan?

The facility should establish a policy for billing that includes the dating of charges so that the dating of charges is done in a consistent manner. In the case of computer generated treatment plans, it would seem reasonable to charge on the date that the physician reviews and approves the plan. This would result in the plan being billed at the completion of both the development and approval phases and would result in the same date being used for the technical and professional billing.

When printing dosimetry plans, what pages should the physicist sign?

Generally, the medical physicist will review the entire plan for accuracy and completeness. The medical physicist should sign or initial the plan in the same manner as the reviewing physician, either on the front sheet of the plan indicating that the entire plan has been reviewed and approved by the medical physicist or on individual printed sheets per facility policy. The physicist should also review and sign the independent dose to monitor unit calculation. If IMRT, the medical physicist should review and sign or initial the documentation that describes the results of the plan specific measured dose and measured dose distributions

Is there a rule that states that the date of the charge (i.e., isodose plan, monitor unit calculation) must be the same as the date printed on the charged item? Example: Date of the isodose plan = the printed date on the plan.

Our view is that the charge submitted must reflect the day the work was done and documented. There are situations, however, where the date on a printed plan may not match the date the charge was submitted. For example, in some institutions an IMRT plan may be approved on the computer by the physician and printed out on the next day, so the date on a printed IMRT plan may not match the day the physician work was done. In such instances practices have to work out their own ways of documenting that work by a note or electronic date stamp on the computer plan.

*The opinions referenced are those of members of the AAPM Professional Economics Committee based on their coding experience and they are provided, without charge, as a service to the profession. They are based on the commonly used codes in radiation oncology, which are not all inclusive. Always check with your local insurance carriers, as policies vary by region. The final decision for coding of any procedure must be made by the physician and/or facility, considering regulations of insurance carriers and any local, state or federal laws that apply to the facility and physicians' practice. Neither AAPM nor any of its officers, directors, agents, employees, committee members or other representatives shall have any liability for any claim, whether founded or unfounded, of any kind whatsoever, including but not limited to any claim for costs and legal fees, arising from the use of these opinions.