

MARYLAND MEDICARE PART A

Policy No: 98-1B

Topic: Radiation Oncology

Beginning Effective Date

February 12, 1998.

Ending Effective Date

09/28/2003.

Description

- The following policy addresses Current Procedure Terminology (CPT) codes associated with:
 - Simulation-aided field setting;
 - Radiation oncology dosimetry;
 - Special treatment devices;
 - Delivery of treatments; and,
 - Clinical treatment management.

Policy Type

Local medical review Policy

Indications and Limitations of Coverage and/or Medical Necessity

Simulation-aided Field Setting

77280© Therapeutic radiology simulation-aided field setting; simple

77285© intermediate

77290© complex

Radiation oncology simulation is defined as the process of determining and establishing the radiation therapy treatment portals to a specific treatment volume. Simulation is accomplished through the use of equipment such as

dedicated simulator, linear accelerator, cobalt unit, ortho voltage X-ray machine, diagnostic X-ray fluoroscopy unit, or other equipment used to establish areas to be treated without delivering radiation treatment. Ordering and interpreting special tests may be required to assist in the filed settings.

Report procedure code 77280 when only single or simple pair of parallel opposed fields are required for a single area of treatment. Only one or two films are necessary with or without fluoroscopy

Report procedure code 77285 when two or more portals coverage on a single treatment area or two separate areas of treatment, which require simulation. Two or more films, with or without fluoroscopy may be required.

Report procedure code 77290 when simulation of two or more treatment areas, rotation, arc, or tangential visualization, brachytherapy source verification, hyperthermia probe verification, with or without fluoroscopy, or contrast media is required

Multiple simulations may not be billed on the same day, even if repeat setups are required.

Documentation within the patient's medical record must support the medical necessity for repeated simulations during the same course of therapy

Radiation Oncology Dosimetry

77300© Basic radiation dosimetry calculation central axis depth dose, TDF, NSD, gap calculation, off axis factor, tissue inhomogeneity factors, as required during a course of treatment, only when prescribed by the treating physician

77305© Teletherapy isodose plan (whether hand or computer calculated); simple (one or two parallel opposed unmodified ports directed to a single area of interest)

77310© intermediate (three or more treatment ports directed to a single area of interest)

77315© complex (mantle or inverted y, tangential ports, the use of wedges, compensators, complex blocking, rotational beam or special beam considerations)

- 77321© Special teletherapy port plan, particles, hemibody total body
- 77326© Brachytherapy isodose calculation; simple (calculation made from single plane, one to four sources/ribbon application, remote afterloading brachytherapy 1 to 8 sources)
- 77327© intermediate (multiplane isodose plan, volume implant calculations, over ten sources/ribbons, remote afterloading brachytherapy 9 to 12 sources)
- 77328© complex (multiplane isodose plan, volume implant calculations, over ten sources/ribbons used, special spatial reconstruction, remote afterloading brachytherapy over 12 sources)
- 77331© Special dosimetry (e.g., TLD, microdosimetry) (specify), only when prescribed by the treating physician
- 77332© Treatment devices, design and construction; simple (simple block, simple bolus)
- 77333© intermediate (multiple blocks, stents, bite blocks, special bolus)
- 77334© complex (irregular blocks, special shields, compensators, wedges, molds, or casts)
- 77336© Continuing medical radiation physics consultation in support of therapeutic radiologist including continuing quality assurance reported per week of therapy
- 77370© Special medical radiation physics consultation

CPT codes in the 77300 series, with the exception of 77336 and 77370, were intended to recognize and report the physician's cognitive efforts in designing, selecting, blocks, or treatment devices, whether or not the physician was physically involved in these activities. The physician then uses this information to determine clinical implementation of appropriate radiation therapy.

Procedure code 77300 may involve multiple calculations dependent on the area to be treated. A single area of interest, such as the pelvis, may require use of multiple recognize quantity billing of this procedure on a given day, if more than one area of interest is being treated, and multiple beam calculations are required for each individual area of treatment interest. The physician must completely document

these requirements in legible and understandable terms (i.e., each area to be treated must be specified, including the number of beams used per area, radiation dosage, an frequency) within the patient's medical record. Medicare would expect to see ongoing documentation which would include an changes in dosimetry calculations and change in radiation treatment, and frequency.

Procedure code 77305 includes one or two ports on a single area of interest. The code may be reported only once per area of interest. An area of interest is the specific anatomical location of the tumor. The physician's documentation must be specific to the number of areas. The specific location of tumor(s) to be treated must be documented as well as the specific number of ports involved with each are treated. Procedure code 77310 includes tree or ore (generally up to four) treatment ports converging on a single area of interest. Procedure 77305 is considered by Medicare to be included in procedure 77310 and therefore, not billable separately on the same day. Procedure code 77310 may be reported for each area of interest that is being treated.

Procedure code 77315 includes complex ports converging on a single are of interest.

Procedure codes 77305 and 77310 are considered by Medicare to be included in procedure 77315 and therefore, not billable separately on the same day. Procedure code developed through the use of multi-planar or three-dimensional techniques should be reported using code 77315. Procedure 77321 is utilized when a plan for any special beam consideration is required, such as the use of heavy particles. Medicare understands that this code is a special circumstance code and not frequently used. Based on this information, Medicare would not expect procedure code 77321 to be frequently bulled. This code may not be quantity billed.

Procedure codes 77326-77328 are reported when dosimetry calculations are required t determine the appropriate delivery mechanism, dosage, and body area to be treated. Radiation therapy accomplished through brachytherapy utilizes an ionizing radiation source (man-made or natural radio elements) applied into or around the treatment area of interest, such as body surface, interstitial or intracavity placement o f radio elements.

Procedure codes 77326 and 77327 are considered by Medicare to be included in procedure 77328 and may not be billed in addition to 77328. Procedure 77326 is considered by Medicare to be included in procedure code 77327 and may not be billed in addition to procedure 77327.

Procedure codes 77326-77328 may not be quantity billed on the same day. “Sources” refer to intracavitary placement or permanent interstitial placement.

“Ribbons” refer to temporary interstitial placement.

Report procedure code 77331 when special dosimetry planning is prescribed by the treating physician. This code includes the use of special radiation measuring and monitoring devices such as thermoluminescent dosimeters, solid state diode probes, special dosimetry probes, film dosimetry, or other methods for measuring the specific dosage at a given point. This code may not be quantity billed. When reporting this code, the provider must specify the type of special dosimetry.

Manual and computer calculations e included in the above codes and not billable separately.

Special Treatment Devices

Report procedure codes 77332, 77333, and 77334 when special treatment devices are required or techniques must be utilized for beam shaping, patient immobilization, shielding of critical structures, beam modification, (this is not an all-inclusive list of devices and techniques used). Often devices must be custom designed and fabricated for the particular patient situation.

This is generally the time when necessary immobilization devices such as molds, cast, vacuum pillows, stents, and bite blocks must be designed and fabricated when necessary.

Report procedure code 77332 when a simple field block such as a corner block or a simple bolus is required. There is generally no special fabrication required for these blocks (pre-made blocks may be used). The physician must be involved in the selection and positioning of these blocks.

Report procedure code 77333 when multiple field blocks are required, utilizing cast or pre-made stents, bite blocks, standard shaped blocks, or special bolus.

The physician must be directly involved in the design, selection, and placement of these devices.

Report procedure code 77334 for the most complex treatment device, including all cast blocks for custom irregular field blocking, (i.e., special shields, compensators, the use of wedges, molds, immobilization devices, and casts). The physician must have direct input into the design, selection, and ultimate placement of the device. If additional sets of cast blocks are required due to a change in radiation therapy plans, the physician must document, within the patient's medical record, the reason for the change and the new type of device required. It is understood by Medicare that a set of blocks includes AP and PA blocks if they were made using the pattern from a single block panning film. If the patient is turned or moved, and a second block planning film must be done, then the blocks are considered to be different and two sets may be reported. The physician must be directly involved in the design, selection, and placement of these devices. The physician must document, within the patient's medical record, the medical necessity of two sets of blocks. Pre-made, multiple patient use, generic cast blocks are not considered to be customized and should not be reported as such. A combination of devices such as a wedge, compensator, bolus, or field block is considered to meet the definition of a single complex treatment device. When such combinations are used, they may not be quantity billed to Medicare.

Use procedure codes 77336 and 77370 (technical physics only) to report ongoing medical physics and consultation services. Procedure code 77336 is specific to the review of the weekly radiation treatment plan. This service is to ensure that the treatment administered conforms to the specification of the prescribing physician. This service includes review of the patient's treatment chart and record to verify that the patient received the prescribed radiation dosage, appropriate positioning and beam orientation and radiation safety. This procedure is reported on a weekly basis, which would relate back to the weekly radiation treatments administered to the patient. Procedure code arises during radiation therapy. This code requires a detailed written report describing the problem to be given to the requesting physician.

Delivery of Treatments

77401© Radiation treatment delivery superficial and/or ortho voltage

77402© Radiation treatment delivery single treatment area, single port or parallel opposed ports, simple blocks or no block; up to 5 MeV

77403© 6-10 MeV

77404© 11-19 MeV

77406© 20 MeV or greater

77407© Radiation treatment t delivery, two separate treatment areas, three or more ports on a single treatment t area, use of multiple blocks; up to 5 MeV

77408© 6-10 MeV

77409© 11-19 MeV

77411© 20 MeV or greater

77412© Radiation treatment delivery, three or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, special particle beam (e.g., electron or neutrons); up to 5 MeV

77413© 6-10 MeV

77414© 11-19 MeV

77416© 20 MeV or greater

77417© Therapeutic radiology port film(s)

Procedure codes 77401-77416 are technical codes only and should be used to report the energy level used in the radiation therapy treatment course.

Report procedure code 77401 for kilovoltage energy level, simple treatment.

Procedure code 77402-77406 represent the different energy levels used when a single treatment area is involved and single or parallel opposed ports and/or simple or no blocks are used.

Procedure codes 77412-77416 represent the different radiation energy levels used when three or more separate treatment areas are involved and custom blocking, tangential ports, wedges, rotational bean, and/or special particle beam (such as electrons or neutrons) are required. The physician's documentation within the patient's medical record must support the specific energy levels

reported to Medicare.

Use procedure 77417 to report port verification films. These films should agree with the original simulation films and dosimetry. This procedure may not be quantity billed to Medicare.

Clinical Treatment Management

77419©	Weekly radiation therapy management; conformal
77420©	Simple
77425©	intermediate
77430©	complex
77431©	Radiation therapy management with complete course of therapy consisting of one or two fractions only
77470©	Special treatment procedure 9 e.g., total body irradiation, hemibody irradiation, per oral, vaginal cone irradiation)

Clinical treatment management involves the continual evaluation of the way in which the radiation therapy is being delivered and the patient's ongoing response to the therapy. The frequency of direct examination of the patient by the physician may range from daily to weekly, dependent upon the patient's response to the treatment. Although the most common course of radiation treatment is five days per week, some specific situations may require a split course of therapy (i.e., every other day three days per week, one time per week, six days per week, or hyper-fractionation). These examples are not an all-inclusive list of radiation treatment regimes since each patient's needs are addressed on an individual basis.

Report procedure code 77420 when a patient has minimal or no risk of hematopoietic damage and damage and few if any critical structures may be affected by the treatment beam. A single area is being treated and blocking requirements are few to none.

Report procedure code 77425 when the patient's treatment requires close monitoring. The treatment involves the use of three or more ports directed up to two separate areas of interest. Multiple field blocks or bolus are checked frequently. Hyperfractionation or split course therapy may be planned, which

would require close observation of dosimetry and the patient's condition.

Report procedure code 77430 when the most complex clinical treatment management is required to achieve optimum benefit from the radiation therapy. The treatment involves three or more separate areas of interest and/or requires complex blocking, tangential ports, wedges, rotational compensators, or other special beam considerations.

Report procedure code 77431 when the full course of therapy is completed in one to two treatments.

Report all forms of kilovoltage clinical treatment management using procedure codes 77420, 77425, and 77430.

Report procedure code 77470 when a special treatment procedure management is required. This code represents the physician's effort and work necessary for the management of special procedures such as hyperfractionization, total body irradiation, vaginal cone irradiation, brachytherapy, hyperthermia, combination with chemotherapy, or other combined modality therapy, stereotactic radiosurgery intra-operative radiation therapy (this is not an all-inclusive list of special radiation procedures). Do not report this code more than one time per course of therapy, to Medicare.

HCPCS Section/Benefit Category

Radiology/Radiation Oncology

Type(s) of Bill

11X, 12X, 13X, 18X, 21X, 22X, 71X

Revenue Code(s)

32X, 33X, 34X, 35X, 40X, 60X

HCPCS Code(s)

77280© Therapeutic radiology simulation-aide field setting; simple

77285© intermediate

77290© complex

77300© Basic radiation dosimetry calculation central axis depth

dose, TDF, NSD, gap calculation, off axis factor, tissue inhomogeneity factors, as required during a course of treatment, only when prescribed by the treating physician

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77430© complex

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77470© Special treatment procedure 9 e.g., total body irradiation, hemibody irradiation, per oral, vaginal cone irradiation)

ICD-9_CM Codes that Support Medical Necessity

Specific ICD-9-CM codes should reflect the patient's condition.

Non-covered ICD-9-CM Code(s)

Not applicable at this time.

HCFA National Policy

- Establishment of national policy supercedes all previous contractor policy statements, including Local Medical Policy coverage guidelines.
- Title XVIII of the Social Security Act, Security Act, section 1862 (a) (1) (A). This section allows coverage and payment for only those services that are considered to be medically reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.
- Title XVIII of the Social Security Act, section 1862 (a) (7). This section excludes routine physical examinations.

Reasons for Denial

- All other indications not listed in the “Indications and Limitations of Coverage” section of this policy.
- The Medical record does not verify that the service described by the HCPCS code was provided.
- The service does not follow the guidelines of this policy.

Sources of information

- Carrier Advisory Committee Meeting, February 15, 1995.
- Special Medicare Part B Newsletter No. 136, dated June 15, 1995

Coding Guidelines

- To report this services, use the appropriate HCPCS code.
- All of the coverage criteria must be met before this service can be reimbursed by Medicare.
- Diagnosis (es) must be present on any claim submitted, and must be codes to the highest level of specificity
- The diagnosis code(s) must be representative of the patient’s condition.

Documentation Requirements

Be very specific when documenting radiation oncology services within the patient's medial records for Medicare purposes. Failure to document specifically and legibly the panned course of therapy, type and delivery of treatment and the level of clinical management involved may result in denial of claims. The patient's medical record should be legible, support, medical necessity for this service, and be available to Medicare upon request

Other Comments

This s policy does not reflect the sole opinion of the intermediary medical director or the carrier medical director. This policy was developed in cooperation with the Intermediary Advisor Committee and the Carrier Advisory Committee.

Start Date of Comment Period

November 07, 1997

Start Date of Notice Period

January 12,1998

Revision Date:

Revision Number

THIS BULLETIN SHOULD BE SHARED WITH ALL HEALTH CARE PRACTITIONERS AND MANAGERIAL MEMBERS OF THE PROVIDER/SUPPLIER STAFF. BULLETINS ISSUED AFTER OCTOBER 1,1999 ARE AVAILBABLE AT NO-COST FROM OUR WEBSITE AT www.marylandmedicare.com

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