

Radiation Treatment – Hospital Outpatient

2011 CODING & REIMBURSEMENT GUIDE

Facility Payment

Ultrasonic Guidance, Physics, Dosimetry Planning and Management

CPT® CODE ¹	DESCRIPTION	APC ²	STATUS INDICATOR ²	2011 NATIONAL AVERAGE MEDICARE RATE ^{2,3}
76950	Ultrasonic guidance for placement of radiation therapy fields	268	N	Packaged
76965	Ultrasonic guidance for interstitial radioelement application	309	N	Packaged
77014	Computed tomography guidance for placement of radiation therapy fields	282	N	Packaged
77290	Therapeutic radiology simulation-aided field setting; complex	305	X	\$271.61
77295*	Therapeutic radiology simulation-aided field setting; 3-dimensional	310	X	\$926.74
77326	Brachytherapy isodose plan; simple (calculation made from single plane, one to four sources/ribbon application, remote afterloading brachytherapy 1 to 8 sources)	304	X	\$104.48
77336 (per 5 fractions)	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, report per week of therapy	304	X	\$104.48
77370	Special medical radiation physics consultation	304	X	\$104.48
77470	Special treatment procedure (eg, total body irradiation, hemibody radiation, per oral, endocavitary or intraoperative cone irradiation)	299	S	\$388.58

*Medicare's National Correct Coding Initiative includes edits that will not permit payment for 77014 or 77290 if either of these codes are reported by the same physician for the same patient on the same date of service when 77295 is reported

Treatment Delivery

CPT® CODE ¹	DESCRIPTION	APC ²	STATUS INDICATOR ²	2011 NATIONAL AVERAGE MEDICARE RATE ^{2,3}
77280 (per day of treatment)	Therapeutic radiology simulation-aided field setting; simple	304	X	\$104.48
77300 (per fraction)	Basic radiation dosimetry calculation, central axis depth dose calculation, TDF, NSD, gap calculation, off axis factor, tissue inhomogeneity factors, calculation of non-ionizing radiation surface and depth dose, as required during course of treatment, only when prescribed by the treating physician	304	X	\$104.48
77785 **(per fraction)	Remote afterloading high intensity brachytherapy; 1 channel	313	S	\$700.10
77786 **(per fraction)	2-12 channels	313	S	\$700.10
77799	Unlisted procedure, clinical brachytherapy *may consider reporting for catheter removal	312	S	\$354.95
C1717 **(per fraction)	Brachytherapy source, high dose rate iridium 192, per source	1717	U	\$218.87

** Multiple treatment sessions on the same day are generally payable as long as there has been a distinct break between therapy services and the individual sessions are of the character usually furnished on different days. When billing more than one (1) treatment session on the same date of service, the first treatment may be coded with the appropriate treatment delivery code and the second may be coded again on a separate line with a -59 modifier. Policies for use of modifiers vary by carrier/health plan/payer so please check your local organizations for specific guidelines.

- American Medical Association, CPT® 2010, Professional Edition and HCPCS 2010, Professional Edition.
- Medicare 2011 Outpatient Final Rule published in the Federal Register, November 2, 2010.
- Physician relative value units (RVUs) are based on a correction notice to the Medicare 2011 Physician Fee Schedule Final Rule published in the Federal Register on December 30, 2010. The National Average Medicare rates are based on the 2011 conversion factor of \$33.9764. Actual payment to a physician will vary based on geographic location. Payment for a given procedure in a given locality is available in the Medicare Physician Fee Schedule Look-up file posted in the Physician Center of the CMS website. The payment rates could be further revised if Congress were to enact legislation that would change the conversion factor, which has typically occurred in recent years.
- Coding with Modifiers: A Guide to Correct CPT® and HCPCS Level II Modifier Usage 3rd Edition; 2007 American Medical Association.

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Physician Payment

Ultrasonic Guidance, Physics, Dosimetry Planning and Management

CPT® CODE¹	DESCRIPTION	RVU³	2011 NATIONAL AVERAGE MEDICARE RATE²,⁴
76950	Ultrasonic guidance for placement of radiation therapy fields	.86	\$29.22
76965	Ultrasonic guidance for interstitial radioelement application	2.01	\$68.29
77014	Computed tomography guidance for placement of radiation therapy fields	1.25	\$42.47
77263	Therapeutic radiology, treatment planning; complex	4.76	\$161.73
77290	Therapeutic radiology simulation-aided field setting; complex	2.30	\$78.15
77295*	Therapeutic radiology simulation-aided field setting; 3-dimensional	6.75	\$229.34
77326	Brachytherapy isodose plan; simple (calculation made from single plane, one to four sources/ribbon application, remote afterloading brachytherapy 1 to 8 sources)	1.36	\$46.21
77470	Special treatment procedure (eg, total body irradiation, hemibody radiation, per oral, endocavitary or intraoperative cone irradiation)	3.09	\$104.99

* Medicare's National Correct Coding Initiative includes edits that will not permit payment for 77014 or 77290 if either of these codes are reported by the same physician for the same patient on the same date of service when 77295 is reported

Treatment Delivery

CPT® CODE¹	DESCRIPTION	RVU⁴	2011 NATIONAL AVERAGE MEDICARE RATE²,⁴
77280 (per day of treatment)	Therapeutic radiology simulation-aided field setting; simple	1.03	\$35.00
77300 (per fraction)	Basic radiation dosimetry calculation, central axis depth dose calculation, TDF, NSD, gap calculation, off axis factor, tissue inhomogeneity factors, calculation of non-ionizing radiation surface and depth dose, as required during course of treatment, only when prescribed by the treating physician	.92	\$31.26
77785 **(per fraction)	Remote afterloading high intensity brachytherapy; 1 channel	2.10	\$71.35
77786 **(per fraction)	2-12 channels	4.76	\$161.73
77799	Unlisted procedure, clinical brachytherapy *may consider reporting for catheter removal	Status Code C	Carrier/payer prices code. RVU's and payment amounts may be established for these services following review of documentation

** Multiple treatment sessions on the same day are generally payable as long as there has been a distinct break between therapy services and the individual sessions are of the character usually furnished on different days. When billing more than one (1) treatment session on the same date of service, the first treatment may be coded with the appropriate treatment delivery code and the second maybe coded again on a separate line with a 76 modifier. Policies for use of modifiers vary by carrier/health plan/payer so please check with these organizations for specific guidelines.

Modifier Information⁴

MODIFIER	DESCRIPTION	EXPLANATION
26	Professional component	Certain procedures are a combination of a physician component and a technical; component. When the physician component is reported separately, the service may be identified by adding a modifier 26 to the usual procedure number
76	Distinct Procedural Service	Repeat procedure by same physician

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Hologic Inc., provides this coding guide for informational purposes only. This guide is not an affirmative instruction as to which CPT®/HCPCS codes and modifiers to use for a particular service, supply, procedure or treatment. It is the provider's responsibility to determine and submit the appropriate codes and modifiers for any service, supply, procedure or treatment rendered. Actual codes and/or modifiers used are at the sole discretion of the treating physician and/or facility. Contact your local carrier and payer organizations for specific coding guidelines. Hologic cannot guarantee medical benefit coverage or reimbursement with the codes listed in this guide. Any payment rates listed are Medicare averages that may be subject to change without notice. Reimbursement may differ based on geographic regional variance and/or policies and fee schedules outlined as terms in your health plan, payer and/or carrier contracts.