Radiation Treatment — Hospital Outpatient

Physician Professional Payment

Ultrasonic Guidance, Physics, Dosimetry Planning and Management

CPT® Code/ HCPCS Code[1]	Description	Site of Service Component	RVU[2]	2018 National Average Medicare Rate[3]
G6001	Ultrasonic guidance for placement of radiation therapy fields	Facility (Professional)	0.86	$30.96
76965	Ultrasonic guidance for interstitial radioelement application	Facility (Professional)	1.92	$69.12
77014	Computed tomography guidance for placement of radiation therapy fields	Facility (Professional)	1.26	$45.36
77263	Therapeutic radiology treatment planning; complex	Facility (Professional)	4.74	$170.64
77290	Therapeutic radiology simulation-aided field setting; complex	Facility (Professional)	2.32	$83.52
77295*	3-dimensional radiotherapy plan, including dose-volume histograms	Facility (Professional)	6.35	$228.60
77316	Brachytherapy isodose plan; simple (calculation[s] made from 1 to 4 sources, or remote afterloading brachytherapy, 1 channel), includes basic dosimetry calculation(s)	Facility (Professional)	2.08	$74.88
77470	Special treatment procedure (eg, total body irradiation, hemibody radiation, per oral or endocavitary irradiation)	Facility (Professional)	3.00	$108.00

* 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	Site of Service Component	RVU[2]	2018 National Average Medicare Rate[3]
77280	Therapeutic radiology simulation-aided field setting; simple	Facility (Professional)	1.04	$37.44
77770†	Remote afterloading high dose rate radionuclide interstitial or intracavitary, includes basic dosimetry; 1 channel	Facility (Professional)	2.88	$103.68
77771◊	Remote afterloading high dose rate radionuclide interstitial or intracavitary, includes basic dosimetry; 2-12 channels	Facility (Professional)	5.63	$202.68
77799	Unlisted procedure, clinical brachytherapy	Facility (Professional)	NA	Determined by contractors

† Replaces 77785 which has been deleted. 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. Please follow Medicare and commercial guidelines on the use of modifiers.

◊ Replaces 77786 which has been deleted. 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. Please follow Medicare and commercial guidelines on the use of modifiers.

Modifier information[4]

Modifier	Description	Explanation
26	Professional component	Certain procedures are a combination of a physician or other qualified health care professional component and a technical component When the physician or other qualified health care professional component is reported separately, the service may be identified by adding modifier 26 to the usual procedure number
59	Distinct Procedural Service	Under certain circumstances, it may be necessary to indicate that procedure or service was distinct or independent from other non-E/M services performed on the same day
76	Repeat procedure or service by same physician or other qualified health care professional	It may be necessary to indicate that a procedure or service was repeated by the same physician or other qualified health care professional subsequent to the original procedure or service. The circumstance may be reported by adding modifier 76 to the repeated procedure or service. Note: this modifier should not be appended to an E/M service
77	Repeat Procedure by Another Physician or Other Qualified Health Care Professional	It may be necessary to indicate that a basic procedure or other qualified health care professional subsequent to the original procedure or service
XE*	Separate Encounter	A service that is distinct because it occurred during a separate encounter
XP*	Separate Practitioner	A service that is distinct because it was performed by a different practitioner

* Specific Modifiers for Distinct Procedural Services, CMS Transmittal 1422, available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1422OTN.pdf

1. American Medical Association (AMA), 2018 Current Procedural Terminology (CPT), Professional Edition. CPT codes and descriptions only are copyright 2017 AMA. All rights reserved. The AMA assumes no liability for data contained herein. No fee schedules, basic units, relative or related listings are included in CPT. Applicable FARS/DFARS Restrictions Apply for Government Use. Centers for Medicare & Medicaid Services (CMS), 2018 Healthcare Common Procedure Coding System (HCPCS) codes, available at http://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/Alpha-Numeric-HCPCS.html
2. The 2018 physician relative value units (RVUs) are from the latest 2018 RVU file available on the CMS website at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files.html?DLSort=0&DLEntries=10&DLPage=1&DLSortDir=descending.
3. The national average 2018 Medicare rates to physicians shown are based on the 2018 conversion factor of $35.9996 and do not reflect payment cuts due to sequestration. Medicare payment for a given procedure in a given locality in 2018 should be available in the Medicare Physician Fee Schedule Look-up file accessible through the CMS website at http://www.cms.gov/apps/physician-fee-schedule/overview.aspx. Any payment rates listed may be subject to change without notice. Actual payment to a physician will vary based on geographic location and may also differ based on policies and fee schedules outlined as terms in your health plan and/or payer contracts.
4. AMA, 2018 CPT, Professional Edition.

Radiation Treatment — Hospital Outpatient

Facility Payment

Ultrasonic Guidance, Physics, Dosimetry Planning and Management

CPT® Code[1]	Description	Site of Service Component	APC[2]	Status Indicator[2]	2018 National Average Medicare Rate[2]
76965	Ultrasonic guidance for interstitial radioelement application	Hospital	NA	N	Packaged
77014	Computed tomography guidance for placement of radiation therapy fields	Hospital	NA	N	Packaged
77290	Therapeutic radiology simulation-aided field setting; complex	Hospital	5612	S	$323.07
77295*	3-dimensional radiotherapy plan, including dose-volume histograms	Hospital	5613	S	$1,186.60
77316	Brachytherapy isodose plan; simple (calculation[s] made from 1 to 4 sources, or remote afterloading brachytherapy, 1 channel), includes basic dosimetry calculation(s)	Hospital	5612	S	$323.07
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	Hospital	5611	S	$125.35
77387	Guidance for localization of target volume for delivery of radiation treatment delivery, includes intrafraction tracking, when performed	Hospital	NA	N	Packaged
77470	Special treatment procedure (eg, total body irradiation, hemibody radiation, per oral or endocavitary irradiation)	Hospital	5623	S	$522.28

* 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/ HCPCS Code[1]	Description	Site of Service Component	APC[2]	Status Indicator[2]	2018 National Average Medicare Rate[2]
77280	Therapeutic radiology simulation-aided field setting; simple	Hospital	5611	S	$125.35
77770†	Remote afterloading high dose rate radionuclide interstitial or intracavitary, includes basic dosimetry; 1 channel	Hospital	5624	S	$714.06
77771†	Remote afterloading high dose rate radionuclide interstitial or intracavitary, includes basic dosimetry; 2-12 channels	Hospital	5624	S	$714.06
77799	Unlisted procedure, clinical brachytherapy	Hospital	5621	S	$124.72
C1717†	Brachytherapy source, non-stranded high dose rate iridium-192, per source	Hospital	2646	U	$294.57

† 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 non-stranded 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.

Status Indicator Information[2]

Status Indicator	Explanation
N	Payment is packaged into payment for other services. Therefore, there is no separate APC payment
S	Significant procedure paid as separate APC payment under OPPS. Multiple procedure reduction does not apply
U	Brachytherapy sources paid as separate APC payment under OPPS

1. American Medical Association (AMA), 2018 Current Procedural Terminology (CPT), Professional Edition. CPT codes and descriptions only are copyright 2017 AMA. All rights reserved. The AMA assumes no liability for data contained herein. No fee schedules, basic units, relative or related listings are included in CPT. Applicable FARS/DFARS Restrictions Apply for Government Use. Centers for Medicare & Medicaid Services (CMS), 2018 Healthcare Common Procedure Coding System (HCPCS) codes, available at http://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/Alpha-Numeric-HCPCS.html
2. The national average 2018 Medicare rates for the hospital outpatient setting are from Hospital Outpatient Prospective Payment System (OPPS) Addendum B, January 2018, accessible at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html. The national average 2018 Medicare rates for the ambulatory surgical center setting are from the Ambulatory Surgical Center Approved HCPCS Codes and Payment Rates Addenda AA and BB, January 2018, accessible at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/11_Addenda_Updates.html. Any payment rates listed are Medicare national averages that may be subject to change without notice and do not reflect payment cuts due to sequestration. Actual payment to a hospital or ambulatory surgical center will vary based on geographic location and may also differ based on policies and fee schedules outlined as terms in your health plan and/or payer contracts.

Hologic Inc., provides this coding guide for informational purposes only. This guide is not an affirmative instruction as to which 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 payer for specific coding and coverage guidelines. Hologic cannot guarantee medical benefit coverage or reimbursement with the codes listed in this guide.

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