Radiation Oncology Coding Update 2016

Here We Go Again!

January 2016

Coding Strategies® provides exceptional consulting and educational services designed to improve compliance and ensure appropriate reimbursement for the financial health of your business.
Coding Guidance

Authoritative guidance

- American Medical Association
- American Hospital Association
- Insurance Payors

Opinions

- Specialty Societies
- Other Medical Groups
- Healthcare Consultants
- Billing Companies

2016 CODE UPDATES

Prolonged Clinical Staff Time

New codes effective January 1, 2016; not reported by facilities (e.g., hospitals).

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>+99415</td>
<td>Prolonged clinical staff service (the service beyond the typical service time) during an evaluation and management service in the office or outpatient setting, direct patient contact with physician supervision; first hour (List separately in addition to code for outpatient Evaluation and Management service)</td>
</tr>
<tr>
<td>+99416</td>
<td>Prolonged clinical staff service (the service beyond the typical service time) during an evaluation and management service in the office or outpatient setting, direct patient contact with physician supervision; each additional 30 minutes (List separately in addition to code for prolonged service)</td>
</tr>
</tbody>
</table>

The physician or qualified health care professional must be present to provide direct supervision of the clinical staff. Prolonged services of less than 45 minutes are not reported. The typical face-to-face time of the E/M code is used as the beginning time for the prolonged clinical staff service. For example, 99214 has a typical time of 25 minutes, so 99415 cannot be reported in conjunction with 99214 unless there is at least 70 minutes of face-to-face clinical staff time (25 minutes for 99214 and 45 minutes for 99415). These codes cannot be used together with the physician codes for prolonged services. Also, they cannot be reported for more than 2 simultaneous patients.

Not reported by facilities & bundles into treatment delivery under MPFS.
Lung Cancer Screening

CMS issued an NCD on February 5, 2015 stating that Medicare would reimburse for Low-Dose CT for lung cancer screening. For CY 2016, CMS developed HCPCS codes and reimbursement allowances for the shared decision-making visit and the LDCT lung cancer screening.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>G0296</td>
<td>Counseling visit to discuss the need for lung cancer screening (LDCT) using low dose CT scan (service is for eligibility determination and shared decision making)</td>
</tr>
<tr>
<td>G0297</td>
<td>Low dose CT scan (LDCT) for lung cancer screening</td>
</tr>
</tbody>
</table>


Advance Care Planning

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>99497</td>
<td>Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms; when performed), by the physician or other qualified health care professional; first 30 minutes, face-to-face with the patient, family member(s) and/or surrogate</td>
</tr>
<tr>
<td>+99498</td>
<td>each additional 30 minutes (List separately in addition to code for primary procedure)</td>
</tr>
</tbody>
</table>

Codes are used to report the face-to-face service between a physician or other qualified healthcare professional and a patient, family member or surrogate in counseling and discussing advance directives, with or without completing relevant legal forms.

A “physician or other qualified health care professional” is an individual who is qualified by education, training licensure/regulation (when applicable), and facility privileging (when applicable) who performs a professional service within his/her scope of practice and independently reports that professional service.

Can be reported in addition to the E/M Visit code; codes 99497 and 99498 are packaged when performed in the outpatient department of the hospital.

Documentation:

- Cognitive evaluation to determine patient’s capacity to understand risks, benefits and alternatives to the advance care planning choices
- Discuss diagnosis, prognosis and patient’s condition
- Review blank advance care directive and physician orders for life-sustaining treatment forms
- Explain and discuss advance directives with patient, family, surrogate
- As appropriate, talk about palliative care options
- Discuss ways to avoid hospital admission/readmission
- Discuss designated agent(s) as substitute decision maker if patient loses decision making capacity (including family dynamics)
- Answer all questions from patient, family member, surrogate

Conditionally packaged for hospitals and bundles into most professional radiation oncology services, including weekly management.
MPFS 2016 Final Rule:

We agree with commenters that advance care planning as described by the proposed CPT® codes is primarily the provenance of patients and physicians. Accordingly we expect the billing physician or NPP to manage, participate and meaningfully contribute to the provision of the services, in addition to providing a minimum of direct supervision.

This means that the physician/nonphysician practitioner documents the services s/he performed and other practitioners document the extent of services each performed.

Image-Guided Soft Tissue Localization

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>10035</td>
<td>Placement of soft tissue localization device(s) (e.g., clip, metallic pellet, wire/needle, radioactive seeds), percutaneous, including image guidance; first lesion</td>
</tr>
<tr>
<td>+10036</td>
<td>each additional lesion (List separately in addition to code for primary procedure)</td>
</tr>
</tbody>
</table>

These codes (effective January 1, 2016) can be used for image-guided soft tissue marker placement in any area of the body unless there is a more specific code available, such as breast marker placement. The codes are reported once per “target” regardless of the number of markers placed.

Do not report a separate imaging guidance code.

Radiology – Written Reports

A new “Imaging Guidance” section has been added to various chapter guidelines:

When imaging guidance or imaging supervision and interpretation is included in a procedure, guidelines for image documentation and report, included in the guidelines for Radiology (Including Nuclear Medicine and Diagnostic Ultrasound) will apply.

NO CHANGE TO TREATMENT DELIVERY & IGRT CODES

CMS will continue to reimburse for the HCPCS Level II G codes in freestanding centers and CPT® codes in hospitals.

In the Medicare Physician Fee Schedule 2016 Final Rule, CMS states:

We believe that significant changes to the codes need to be made before we can develop accurate payment rates under the PFS for these services.

We will continue the use of the current G-codes and values for CY 2016 while we seek more information, including public comments and recommendations regarding new codes to be developed either through the CPT® process or through future PFS rulemaking.

Changes would include:

- developing a code set that recognizes the difference in costs between kinds of imaging guidance modalities;
- making sure that this code set facilitates valuation that incorporates the cost of imaging based on how frequently it is actually provided;
- and developing treatment delivery codes that are structured to differentiate payment based on the equipment resources used.
Despite these comments, we were unable to reconcile the inconsistencies and potential rank order anomalies associated with including the image guidance costs in the IMRT treatment delivery codes but not including the image guidance costs in the conventional radiation treatment delivery codes even though both use the same capital equipment.

Based on the RUC recommendations and the information from the commenters, we understand that the same linear accelerator is typically used for all of these services, and that the image guidance is integrated into the only linear accelerator that is currently being manufactured and that, therefore, the image guidance costs should always be included in the RVUs for the IMRT treatment delivery codes.

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1631-FC.html?DLPage=1&DLEntries=10&DLSort=2&DLSortDir=descending

PATIENT ACCESS AND MEDICARE PROTECTION ACT

On December 18, 2015 the House and Senate unanimously passed the Patient Access and Medicare Protection Act. In brief, this legislation includes:

1. The RVUs for codes G6001 through G6015 (CMS radiation therapy codes) will be frozen at the 2016 level.
2. CMS is prohibited from classifying these temporary codes as “misvalued” for calendar years 2017 and 2018.
3. CMS is directed to submit a report to Congress on the development of an Alternative Payment Model or episode-of-care payment methodology for radiation therapy services delivered in nonfacility (e.g., non-hospital) settings.

The text of the Act is located here:

https://www.congress.gov/bill/114th-congress/senate-bill/2425/text?q=%7B%22search%22%3A%5B%22%22%5C%22%22%5D%22%22%5C%22%22%5D%7D&resultIndex=1

Simulation Prior to IMRT

The Medicare Claims Processing Manual, Chapter 4 (Part B Hospital) states:

200.3.1 - Billing for IMRT Planning and Delivery

(Rev. 1445, Issued: 02-08-08; Effective: 01-01-08; Implementation: 03-10-08)

Additionally, in the context of billing 77301, regardless of the same or different dates of service, CPT® codes 77014, 77280-77295, 77305-77321, 77331, 77336, and 77370 may only be billed in addition to 77301 if they are not provided as part of developing the IMRT treatment plan.


As listed by CMS, this policy was effective for hospitals on January 1, 2008 and both the simulation and image fusion by the physicist (code 77370) are included in IMRT planning. The National Correct Coding Policy Manual, Chapter 9 includes:

12. Intensity modulated radiotherapy (IMRT) plan (CPT® code 77301) includes therapeutic radiology simulation-aided field settings. Simulation field settings for IMRT should not be reported separately with CPT® codes 77280-77295. Although procedure to procedure edits based on this principle exist in NCCI for procedures performed on the same date of service, these edits should not be circumvented by performing the two procedures described by a code pair edit on different dates of service.
The reference in the NCCI Policy Manual is effective January 1, 2014 and applies to hospitals as well as physician professional services and freestanding centers.

In MLN Matters MM9486 CMS updated this verbiage to state (under OPPS):

Payment for services identified by CPT® codes 77014, 77280 through 77295, 77305 through 77321, 77331 and 77370 is included in the APC payment for CPT® code 77301 (IMRT planning). These codes should not be reported in addition to CPT code 77301 (on either the same or a different date of service) unless these services are being performed in support of a separate and distinct on-IMRT radiation therapy for a different tumor.


IMRT Audits

The 2016 OIG Work Plan includes:

OIG will review Medicare outpatient payments for intensity-modulated radiation therapy (IMRT) to determine whether the payments were made in accordance with Federal rules and regulations. IMRT is an advanced mode of high-precision radiotherapy that uses computer-controlled linear accelerators to deliver precise radiation doses to a malignant tumor or specific areas within the tumor. Prior OIG reviews have identified hospitals that have incorrectly billed for IMRT services. To be processed correctly and promptly, a bill must be completed accurately. In addition, certain services should not be billed when they are performed as part of developing an IMRT plan.


The April 2015 issue of the Medicare Quarterly Compliance Newsletter included information on billing errors for IMRT planning (code 77301) and IMRT calculations (code 77300).


CMS has also assigned the review of IMRT services as a special project to StrategicHealthSolutions, a Supplemental Medicare Review Contractor.


As part of their effort to accomplish this review, StrategicHealthSolutions has published a sample documentation request letter:


Bundled Calculations

Effective January 1, 2016 CMS will bundle basic dosimetry calculations into the 3D computer plan. According to the National Correct Coding Initiative Policy Manual:

Calculations described by CPT® code 77300 are integral to the procedure described by CPT® code 77295. CPT® code 77300 should not be reported with CPT code 77295.

Verbiage Update

Code 77417 has been slightly redefined:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>77417</td>
<td>Therapeutic radiology port image(s)</td>
</tr>
</tbody>
</table>

Brachytherapy Code Changes

New guidelines were added to the Clinical Brachytherapy section for HDR brachytherapy:

*High dose-rate brachytherapy involves treatment with radiation sources that cannot safely be handled manually. These systems are remotely controlled and place a radionuclide source (radioelement or radioisotope) within an applicator placed in or near the target. These applicators may be placed in the body or on the skin surface.*

*Small electronic X-ray sources placed into an applicator within or close to the target may also be used to generate radiation at high-dose rates. This is referred to as high dose-rate electronic brachytherapy.*

*To report high dose-rate electronic brachytherapy, see 0394T, 0395T.*

The same treatment delivery and image-guidance codes will be used in all sites of service effective January 1, 2016. The following codes have been deleted:

- 77776 – Interstitial radiation source application; simple
- 77777 – Interstitial radiation source application; intermediate

Official coding instructions state to report unlisted code 77999 (Unlisted procedure, clinical brachytherapy) when simple or intermediate interstitial brachytherapy is performed. The code for complex interstitial source application has been revised:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>77778</td>
<td>Interstitial radiation source application, complex, includes supervision, handling, loading of radiation source, when performed</td>
</tr>
</tbody>
</table>

Code 77778 now includes source handling, so it should not be reported with code 77790 (supervision, handling loading of source). Effective January 1, 2016 code 77778 bundles code 77300 as well.

Code 77789 has been revised to specify LDR source:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>77789</td>
<td>Surface application of low dose rate radionuclide source</td>
</tr>
</tbody>
</table>

There is also a new brachytherapy radioelement code:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>C2645</td>
<td>Brachytherapy planar source, palladium-103, per square millimeter</td>
</tr>
</tbody>
</table>
The following codes have also been deleted effective January 1, 2016:
- 77785 – Remote afterloading HDR radionuclide brachytherapy; 1 channel
- 77786 – Remote afterloading HDR radionuclide brachytherapy; 2-12 channels
- 77787 – Remote afterloading HDR radionuclide brachytherapy; over 12 channels
- 0182T – HDR electronic brachytherapy, per fraction

New HDR brachytherapy codes include separate codes for skin and intracavitary/interstitial treatment:

**HDR Skin Surface Brachytherapy**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>77767</td>
<td>Remote afterloading high dose rate radionuclide skin surface brachytherapy, includes basic dosimetry, when performed; lesion diameter up to 2.0 cm or 1 channel</td>
</tr>
<tr>
<td>77768</td>
<td>Remote afterloading high dose rate radionuclide skin surface brachytherapy, includes basic dosimetry, when performed; lesion diameter over 2.0 cm and 2 or more channels, or multiple lesions</td>
</tr>
</tbody>
</table>

**HDR Interstitial or Intracavitary Brachytherapy**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>77770</td>
<td>Remote afterloading high dose rate radionuclide interstitial or intracavitary brachytherapy, includes basic dosimetry, when performed; 1 channel</td>
</tr>
<tr>
<td>77771</td>
<td>Remote afterloading high dose rate radionuclide interstitial or intracavitary brachytherapy, includes basic dosimetry, when performed; 2-12 channels</td>
</tr>
<tr>
<td>77772</td>
<td>Remote afterloading high dose rate radionuclide interstitial or intracavitary brachytherapy, includes basic dosimetry, when performed; over 12 channels</td>
</tr>
</tbody>
</table>

**Electronic Brachytherapy**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0394T</td>
<td>High dose rate electronic brachytherapy, skin surface application, per fraction, includes basic dosimetry, when performed</td>
</tr>
<tr>
<td>0395T</td>
<td>High dose rate electronic brachytherapy, interstitial or intracavitary treatment, per fraction, includes basic dosimetry, when performed</td>
</tr>
</tbody>
</table>

The following services are not reported with electronic HDR brachytherapy:
- Basic dosimetry (77300)
- Teletherapy isodose plan (77306, 77307)
- Brachytherapy isodose plan (77316, 77317, 77318)
- Treatment devices (77332, 77333, 77334)
- Continuing medical physics consultation (77336)
- Radiation treatment management (77427, 77431)
- Stereotactic treatment management (77432, 77435)
• Intraoperative treatment management (77469)
• Unlisted treatment management (77499)
• Special treatment procedure (77470)
• Intracavitary or interstitial source application (77761-77763, 77778)
• Remote afterloading brachytherapy (77767-77768, 77770-77772)
• Surface application of LDR source (77789)

Because Category III procedure codes are “contractor priced” they include all related services.

2016 MPFS Proposed Rule

2016 Estimated Impact Table

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Allowed Charges (mil)</th>
<th>Impact of Work RVU Changes</th>
<th>Impact of PE RVU Changes</th>
<th>Impact of MP RVU Changes</th>
<th>Combined Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hematology/Oncology</td>
<td>$1,788</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Radiation Oncology</td>
<td>$1,766</td>
<td>0%</td>
<td>-2%</td>
<td>0%</td>
<td>-2%</td>
</tr>
<tr>
<td>Radiation Therapy Centers</td>
<td>$52</td>
<td>0%</td>
<td>-2%</td>
<td>0%</td>
<td>-2%</td>
</tr>
</tbody>
</table>

Linear Accelerator Utilization

CMS will use a 60 percent utilization rate assumption for CY 2016 and a 70 percent utilization rate assumption for CY 2017. CMS continues to seek evidence to verify the usage assumptions. CMS also seeks comments on several aspects related to superficial radiation therapy.

Misvalued Codes

The Protecting Access to Medicare Act (PAMA) was amended by the Achieving a Better Life Experience Act of 2014 (ABLE):

• Establishes for CYs 2016 through 2018 an annual target for net reduction in PFS expenditures through adjustments to the RVUs of codes identified as misvalued.
• If CMS meets or exceeds the annual savings target, then savings from revaluing these codes are redistributed within the PFS.
• If CMS fails to meet the annual target, then all expenditures under the PFS are reduced proportionately to make up the shortfall between the actual savings and the annual target.

CMS has identified the following potentially misvalued codes for review during CY 2016:

• 77263 – Complex clinical treatment plan
• 77334 – Complex treatment device
• 77470 – Special treatment procedure

New Physician POS Codes:

On August 6, 2015 the Centers for Medicare & Medicaid Services (CMS) issued MLN Matters MM9231 listing new and revised place of service (POS) codes for physicians billing on the CMS1500 claim form.
POS Code | Descriptor
--- | ---
19 | A portion of an off-campus hospital provider-based department which provides diagnostic, therapeutic (both surgical and non-surgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization

22 | A portion of a hospital’s main campus which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization


**Incident-To Clarification**

The 2016 Final Rule includes another clarification that the physician or NPP who bills for the incident-to service (e.g., name on the claim form) must be the individual who provided the direct supervision.

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**2016 OPPS Proposed Rule**

Overall -0.3% decrease in outpatient reimbursements across all hospital departments. CMS will continue separate payments for the 11 designated cancer hospitals.

**Packaged Services**

CMS will continue to conditionally or unconditionally package drugs and biologicals that function as supplies.

CMS will continue to package image guidance, including IGRT.

Clinical laboratory tests remain packaged, and the hospital will continue to use modifier L1 for tests that are an exception to the packaging rules.

For CY 2016, CMS will not limit conditional packaging to services costing less than or equal to $100. CMS will now package ancillary services assigned to APCs 5734 (Level 4 minor procedures), 5673 (Level 3 pathology) and 5674 (Level 4 pathology).

**Off-Campus Provider-Based Departments**

For hospital claims, CMS created a HCPCS modifier that is to be reported with every code for outpatient hospital services furnished in an off-campus provider-based department.

**PO** | Services, procedures and/or surgeries provided at off-campus provider-based outpatient departments

Mandatory effective January 1, 2016.

2015 OPPS Final Rule

CMS defines the campus as “the physical area immediately adjacent to the provider’s main buildings, other areas and structures that are not strictly contiguous to the main buildings but are located within 250 yards of the main buildings, and any other areas determined on an individual case basis, by the CMS regional office, to be part of the provider’s campus.”
Restructured Radiation APCs

- 4 levels of Radiation Treatment Preparation
- 7 levels of Radiation Therapy

Comprehensive APCs (C-APCs)

According to CMS in the 2015 OPPS Final Rule:

This would result in a single Medicare payment and a single beneficiary copayment under the OPPS for the comprehensive service based on all included charges on the claim.

Commenters expressed concern regarding the misalignment between hospitals’ billing practices and systems and the proposal to package all services on a claim into the payment for the comprehensive service. The commenters observed that a significant number of comprehensive service claims spanned more than 5 days, with some claims spanning close to 30 days. The commenters recommended that CMS limit the payment bundle to services provided within 1 or 2 days of the primary service, or defining the bundle based on episodes of care.

Response: Our intent is to capture all of the services associated with the primary service assigned to a C-APC, except those services that would still be separately paid under the OPPS, even when provided in conjunction with the comprehensive service. We believe that it would not be an undue hardship for some hospitals to alter their processes such that they file separate claims for services that are unrelated both clinically and in regard to time to the comprehensive service. We also do not expect that these claims for comprehensive services in the outpatient setting would extend beyond a few days because the 219 procedures assigned to the 25 C-APCs are almost entirely surgical procedures.

In the 2016 Final Rule, CMS states that they are aware that certain “planning and preparation” services that are integrally associated with the direct provision of SRS have been incorrectly billed on separate claim forms. CMS stated that payment for these pre-procedure services performed prior to treatment administration was included in the C-APC allowance, and should not have been separately billed and separately paid.

Hospitals have 2 choices in 2016:

1. All services related to the SRS procedure are billed on one claim submission, regardless of date of service. This includes all preparatory and planning services that occur in the 30-day period leading up to treatment – from the initial patient visit through the delivery of radiosurgery.

2. The hospital can report preparatory and planning services on separate claims as they occur, appending modifier CP to each procedure that constitutes a service related to the SRS procedure. Every service that occurs up to 30 days prior to treatment related to the single-fraction SRS procedure billed on a separate claim must have this modifier.

<table>
<thead>
<tr>
<th>CP</th>
<th>Adjunctive service related to a procedure assigned to a comprehensive ambulatory payment classification (C-APC) procedure, but reported on a different claim</th>
</tr>
</thead>
</table>

The services represented by codes 77014, 77011, 70551, 70552, 70553, 77280, 77285, 77290 and 77295 are the only codes CMS plans to remove from the C-APC bundle and pay separately. However, there are problems with these codes:

- Code 77014 is not billed with simulation (2016 bundling edits)
- Code 77011 is not billed with radiosurgery
• Codes 70551, 70552, 70553 are diagnostic
  o Treatment planning MRI is 76498
• Codes 77280, 77285, 77290 bundle into 77295 same day

There is also a C-APC for IORT (codes 77424 & 77425)

**Appropriate Use Criteria**

Protecting Access to Medicare Act of 2014 (PAMA) requires CMS to establish a program to promote Appropriate Use Criteria (AUC) for CT, MR, PET, nuclear medicine. Help ordering professionals make the most appropriate treatment decision. CMS can only approve AUC that are developed or endorsed by provider-led entities. AUC will be evidence-based & CMS can approve more than one set of AUC for a specific imaging service. The ordering practitioner will access AUC through a Clinical Decision Support (CDS) tool.


**Bipartisan Budget Act of 2015**

Extended 2% sequestration reduction of Medicare provider reimbursement until 2025. Hospitals that purchase physician offices or ASCs cannot convert them to outpatient departments that receive OPPS payments.


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**Speaker Contact Information**

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