Tobacco Cessation Counseling

Effective March 22, 2005, Medicare initiated coverage for two levels of smoking cessation counseling. Medicare removed prior coverage limits effective January 1, 2011 and currently provides reimbursement for a patient:

- Who uses tobacco, regardless of whether the patient has signs or symptoms of tobacco-related disease;
- Who is competent and alert at the time that counseling is provided; and
- Whose counseling is furnished by a qualified physician or other Medicare-recognized practitioner.

Medicare covers two (2) attempts each year, and each attempt may include a maximum of four (4) intermediate or intensive sessions (the patient and physician determine the intensity of the session). This means that Medicare covers a maximum of eight (8) sessions in one year, but healthcare professionals should charge only one (1) unit of a smoking cessation service per date of service. The following codes report these services:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>99406</td>
<td>Smoking and tobacco-use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes</td>
</tr>
<tr>
<td>99407</td>
<td>intensive, greater than 10 minutes</td>
</tr>
</tbody>
</table>

A minimal counseling service, defined as 3 minutes or less in duration, bundles into the E/M service the physician performs, and physicians should not separately charge for it.

The behavior change intervention provided is more than a review of the patient’s smoking status and may include risks and benefits of management options, importance of compliance with selected management option, risk factor reduction and education.

CMS recommends that health care providers use standard printed materials as part of the counseling effort, such as those located at: [http://smokefree.gov/](http://smokefree.gov/)

Smoking and tobacco use cessation counseling claims are reported with the diagnosis code that reflects the condition the patient has that is adversely affected by the use of tobacco, the condition the patient is being treated for with a therapeutic agent whose metabolism or dosing is affected by the tobacco use, code Z71.6 (tobacco abuse counseling) and a nicotine dependence code from subcategory F17.2- that represents the patient’s current nicotine use status.

Based on AMA guidance, a physician or qualified nonphysician health care provider may perform these services. In the outpatient hospital department, the hospital may report these codes when documentation supports a physician order and the qualified personnel who performed the counseling service.

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Dosimetry

Dosimetry is the mathematical calculation of the radiation dose distribution within a tumor site or a given treatment volume. This calculation may be performed by hand or computer, and by a medical physicist or dosimetrist. There is both a professional and technical component for separately billable basic dosimetry services. Charges for code 77300 are included in teletherapy and brachytherapy isodose plans and subject to bundling edits and payor guidelines.

<table>
<thead>
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<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>77300</td>
<td>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 the course of treatment, only when prescribed by the treating physician</td>
</tr>
</tbody>
</table>

Because the definition of code 77300 includes “only when prescribed by the treating physician,” it is important for the physician to include dosimetry orders in the clinical treatment plan along with medical necessity and instructions regarding computer planning. Prior to beginning the course of treatment, all treatment fields must be set and approved. The final preparation is calculating dosimetry for each of the fields as they have been tentatively set, subject to revision after the dosimetry plan has been completed and reviewed by the radiation oncologist.

Most of the brachytherapy administration codes have been redefined to include basic dosimetry calculations. As a result, source decay calculations for subsequent implants will no longer be separately charged. Due to the inclusion of calculations in other brachytherapy planning and administration codes, there are few, if any, situations where basic dosimetry will be charged in connection with brachytherapy services.

This means that codes 77316-77318 (brachytherapy isodose plans) include region of interest and point dose calculation charges, and all HDR brachytherapy administration codes (radionuclide and electronic) include the charge for source strength (source decay) calculations.

The professional service for dosimetry (77300-26) is intended to recognize and report the physician’s cognitive efforts in selecting and interpreting the results of the calculations, regardless of whether the physician was physically involved in these activities; this is billed by the physician who signed the plan/calculations.

The date of service is typically the authentication date (physician signature date), and the physician’s signature or initials on the dosimetry calculations document the professional component of the dosimetry service. The radiation oncologist should sign-off and date all dosimetry calculations in addition to the physicist’s signature.
A brachytherapy isodose plan identifies the radiation distribution surrounding one or more brachytherapy radioactive sources represented by a plotting of isodose distribution (lines of the same radiation dosage) through the treatment volume of interest. This service has both a professional and technical component.

Each brachytherapy procedure, whether preloaded, afterloaded, or remote afterloading high intensity brachytherapy (with the possible exception of intravascular brachytherapy), requires the radiation oncologist and physics staff to generate a brachytherapy isodose plan. The isodose plan is necessary for the physician to determine the exact distribution of radiation around the brachytherapy radiation sources and the radiation dose that will be applied to adjacent normal structures. In conventional brachytherapy, adjustments can be made by changing the sources’ geometry to generate the desired plan.

Both the physician and the facility may report brachytherapy isodose plans more than once during the course of treatment, when medically necessary. For example, billing for both the pre-treatment isodose plan and for the post-implant isodose plan for certain therapies is appropriate. The post-procedure simulation and/or brachytherapy isodose plan are performed to ensure that the dose calculated and the dose received are the same.

Many physicians and physicists believe that to maintain full coverage while reducing dose to the organs at risk, they should base the dose distribution treatment planning algorithm on 3D anatomical data. Most payors reimburse for a 3D plan for brachytherapy treatment; the following is included in the WPS Medicare brachytherapy policy.98

CPT® code 77295 may be billed as part of the brachytherapy process when the needed parameters are included (i.e. 3D volume reconstruction with DVH for target and normal tissues, etc. This information can be obtained from CT, U/S or MRI.).

A plan may be required for each modification of the source strength and/or position during temporary afterloading brachytherapy and both before and after permanent seed implantation for some temporary implants where volume pre-planning is required to determine quality and strength of sources required for this procedure. The physician should document the medical necessity for multiple brachytherapy isodose plans in the clinical treatment plan.

The physician should document the medical necessity for multiple brachytherapy isodose plans in the clinical treatment plan. In addition, the radiation oncologist must order the specific type of plan (3D or brachytherapy isodose plan) for the individual.
Intracavitary Brachytherapy

Intracavitary brachytherapy consists of placing the radioactive sources within an existing body cavity such as the vagina, uterus, lung, esophagus, biliary system or other cavity that the physician can enter without a major invasive surgical procedure.

<table>
<thead>
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<tbody>
<tr>
<td>77761</td>
<td>Intracavitary radiation source application; simple (1-4 sources/ribbons)</td>
</tr>
<tr>
<td>77762</td>
<td>Intracavitary radiation source application; intermediate (5-10 sources/ribbons)</td>
</tr>
<tr>
<td>77763</td>
<td>Intracavitary radiation source application; complex (over 10 sources/ribbons)</td>
</tr>
</tbody>
</table>

Providers should report these codes for LDR (low dose rate, 10 to 100 cGy per hour) brachytherapy, which physicians usually deliver over several days in the hospital setting, although it is becoming more common as an ambulatory procedure. When admitted, patients are generally kept under radiation safety conditions in isolation to protect medical personnel from low level exposure to radiation. For high dose rate (HDR) treatment delivery, refer to codes 77767-77772 and 0394T-0395T.

According to WPS Medicare:121

Common temporarily inserted seeds are Iridium 192 and Cesium 137. Iridium is physically smaller and can be used for interstitial implants (breast, head and neck, complex gynecological, sarcomas and others). The Cesium is contained in a larger tube and is used mostly for intracavitary gynecological implants.

The intracavitary treatment usually lasts 24 to 72 hours, and then the radiation oncologist removes the sources and applicators. This kind of brachytherapy is considered a low dose rate because the physician uses low intensity radiation sources and treatment time is measured in hours to days.122 The patient generally remains in the hospital with the applicators in place until treatment is completed.

An example of intracavitary brachytherapy is lung or bronchus treatment. During lung brachytherapy, the physician usually places a bronchoscope down through the nose into the diseased bronchus. S/he then removes the bronchoscope, but a small plastic tube that houses the radiation source remains in place for approximately 30 minutes. The surgical procedure is reported with code:

<table>
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<tbody>
<tr>
<td>31643</td>
<td>Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with placement of catheter(s) for intracavitary radioelement application</td>
</tr>
</tbody>
</table>

The parenthetical note following the code in the CPT® Manual indicates that it does not describe the brachytherapy itself, but rather the intracavitary placement of the catheters for the radioelement application. Procedure code 31643 represents a Comprehensive-APC (C-APC) for purposes of Medicare reimbursement.


122 CPT® Assistant, September 2005