FACT SHEET

Radiation Therapy

Medicare allows only the medically necessary portion of a visit. Even if a complete note is generated, only the necessary services for the condition of the patient at the time of the visit can be considered in determining the level/medical necessity of any service.

Clinical Indications for IMRT Planning

Target volume in close proximity to critical structures that must be protected:

- Volume of interest must be covered with narrow margins to protect adjacent structures
- Immediately adjacent area has previously been irradiated and abutting portals require high precision.
- Target volume is concave or convex and critical normal tissues are within/around the arc.
- Dose escalation is planned to deliver doses in excess of those commonly utilized for similar tumors with conventional treatment.

Specific need for the use of IMRT must be present rather than 3 dimensional planning.

Place of Service

Typically these services are performed in a facility setting:

- When performed in POS 24 (Ambulatory Surgical Center,) 22 (outpatient hospital), or 21 (inpatient hospital)
  - For Dates of Service prior to 12/31/2014 CPT code 77418 (IMRT delivery-single or multiple fields/arcs, via narrow spatially and temporally modulated beams, binary, dynamic multi-leaf collimators PER TREATMENT SESSION) is a technical component code and may be submitted on the facility claim only
  - For Dates of Service on or after 01/01/2015
    - HCPCS CodeG6015 (Intensity modulated treatment delivery, single or multiple fields/ arcs,via narrow spatially and temporally modulated beams, binary, dynamic mlc, per treatment session)
    - HCPCS Code G6016 (Compensator-based beam modulation treatment delivery of inverse planned treatment using 3 or more high resolution (milled or cast) compensator, convergent beam modulated fields, per treatment session)
- POS 11 (office)
  - Documentation MUST show:
    - Practice location
    - Employment of appropriate staff and supervision requirements
- Medicare does NOT make a payment to a physician under the Medicare Physician Fee Schedule (MPFS) when the physician provides ONLY direct supervision of hospital outpatient therapeutic service but NO direct professional services

This Fact Sheet is for informational purposes only and is not intended to guarantee payment for services, all services billed to Medicare must meet Medical Necessity. The definition of "medically necessary" for Medicare purposes is located in Section 1862(a)(1)(A) of the Social Security Act – Medical necessity (http://www.ssa.gov/OP_Home/ssact/title18/1862.htm).

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Radiation Therapy

Documentation for CPT Code 77418/HCPCS G6015 or G6016

(IMRT delivery single or multiple fields/arcs, via narrow spatially and temporally modulated beams, binary, dynamic multi-leaf collimators PER TREATMENT SESSION)

Claim submission requirements:

- **This code represents the technical component only and may only be submitted in non-facility settings (e.g., physician office).**
  - The practice must employ the medical physicist and or radiation therapist who are under direct supervision of the physician (in this situation – billing is GLOBAL since both components are submitted together)

Documentation requirements:

- Dated and signed record of administration
- Record of machine settings corresponding to the IMRT treatment plan
- Verification of accurate delivery
- Documentation of fractioned/multiple sessions in one day
- All documentation from clinical treatment planning (CPT 77263- Therapeutic radiology treatment planning, complex)
  - Goals of treatment
  - Volume of treatment
  - Time/dose considerations
  - Dose constraints for target volumes
  - Organs at risk
- Initial Complex Simulation (CPT code 77290) should include:
  - Fudicial marking
  - Creation of immobilization device (patient-specific block)
  - Review of scout images
  - Review of physician work
  - Additional minor procedures required prior to treatment such as barium/rectal catheter placement, urethrograms, cross-sectional imaging

Documentation for CPT Code 77301

(Intensity modulated radiotherapy plan, including dose-volume histograms for target and critical structure partial tolerance specifications)

- Diagnosis
- Verification of the treatment plan
- Means of reproducible patient position (blocks/aids/bumps etc)
- Consideration of target organ and motion

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Radiation Therapy

References:

- CMS Publication 100-04, Chapter 12, sec 70: Payment Conditions for Radiology Services http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf
- CMS Publication 100-04, Chapter 13: Radiology Services and Other Diagnostic Procedures http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c13.pdf
- CGS Specialty Manual –Oncology http://www.cgsmedicare.com/partb/pubs/specman/pdf/SPECMAN_oncology.pdf

- Ultrasounds, CT guidance and/or implantation of marker seeds
  - All elements associated with implementation
  - Images of treatment portals
  - Physical dose measures (calculations of the IMRT does distribution)
  - Daily, ongoing correlation between image-based IMRT plan and dose delivery
- Qualified medical physicist has appropriately commissioned the IMRT planning and delivery system according to state, federal, and practice guidelines for quality assurance and delivery monitoring system.

Claim submission:

- Report CPT code 77301 ONCE per course of therapy, even if there is a planned “cone-down” treatment feature or change in field size. If this occurs, coding for conventional treatment should be used.
- A second unit may be submitted only if there are changes in patient ANATOMY during treatment that requires a repeat CT scan.

Additional Information

- Special radiation dosimetry is incorporated into CPT code 77301 and cannot be submitted separately
- Multiple treatment sessions on the same day are payable as long as there has been a distinct break in therapy services, and the individual sessions are of the character usually furnished on different days. CPT modifier 59 must be submitted with the appropriate codes to indicate a distinct and separate session.
- Please note that ALL services ordered or rendered to Medicare beneficiaries MUST be signed. Signatures may be handwritten or electronically signed; exceptions for stamped signatures are described in MLN Matters article MM8219 (http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8219.pdf).
- You should NOT add late signatures to a medical record but instead make use of the signature authentication process outlined in MLN Matters article MM6698 (http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM6698.pdf). A sample attestation statement is available on the CGS website (http://www.cgsmedicare.com/partb/cert/attestation_form.pdf).
- Guidelines regarding signature requirements are located in the CMS Program Integrity Manual (Pub. 100-08), chapter 3, section 3.3.2.4 (http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c03.pdf).

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