

Radiology: Oncology

This section describes policies and guidelines for billing radiation oncology procedures. Radiation oncology services include initial consultation, clinical treatment planning, simulation, medical radiation physics, dosimetry, measurement devices, special services, and clinical treatment management procedures. They include normal follow-up care during the course of treatment and for three months following its completion.

Consultation: Clinical Management

Preliminary consultation, evaluation of the patient prior to the decision to treat, or full medical care (in addition to treatment management) when provided by the therapeutic radiologist should be identified by the appropriate Evaluation and Management (E&M) procedure codes.

Outpatient Visits and Radiation or Radiopharmaceutical Therapy

When recipients are being treated with radiation or radiopharmaceutical therapy and the provider is utilizing radiation oncology codes 77261 – 79999 for reimbursement, those same providers will not be reimbursed for E&M codes 99201 – 99210 and 99212 – 99499 when performed by the same provider, for the same recipient, on the same date of service.

Radiation Oncology and Radiopharmaceutical Therapy

Consult the CPT-4 code book for guidance in billing radiation oncology (codes 77261 – 77799) and radiopharmaceutical therapy (codes 79005 – 79999). These procedures do not cover the provision of radium or other radioactive materials.

CPT-4 Code 77338 Special Billing Instructions

CPT-4 code 77338 (multi-leaf collimator [MLC] device[s] for intensity modulated radiation therapy [IMRT], design and construction per IMRT plan) is split-billable. When billing for both the professional and technical service components of a split-billable procedure, a modifier is neither required nor allowed. When billing for only the professional component, use modifier 26. When billing for only the technical component, use modifier TC. Modifier U7 is allowed.

Note: Modifier 99 must not be billed in conjunction with modifier 26 and modifier TC. The claim will be denied.

**Radiation Treatment Codes
Not Split-Billable**

The following radiology oncology codes for professional and technical services are not split-billable and must not be billed with modifier 26 or TC.

| <u>CPT-4 Code</u> | <u>Description</u> |
|-------------------|--|
| 77371 | Radiation treatment delivery, stereotactic radiosurgery; Cobalt 60 based |
| 77372 | linear accelerator based |
| 77373 | Stereotactic body radiation therapy, treatment delivery, per fraction to one or more lesions |
| 77401 | Radiation treatment delivery, superficial and/or ortho voltage |
| 77402 | Radiation treatment delivery, single treatment area, single port or parallel opposed ports, simple blocks or no blocks; up to 5 MeV |
| 77403 | 6-10 MeV |
| 77404 | 11-19 MeV |
| 77406 | 20 MeV or greater |
| 77407 | Radiation treatment delivery, two separate treatment areas, three or more ports on a single treatment area, use of multiple blocks; up to 5 MeV |
| 77408 | 6-10 MeV |
| 77409 | 11-19 MeV |
| 77411 | 20 MeV or greater |
| 77412 | Radiation treatment delivery, three or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, electron beam; up to 5 MeV |
| 77413 | 6-10 MeV |
| 77414 | 11-19 MeV |
| 77416 | 20 MeV or greater |
| 77417 | Therapeutic radiology port film(s) |
| 77418 | Intensity modulated treatment delivery, single or multiple fields/arcs, via narrow spatially and temporally modulated beams, binary, dynamic MLC, per treatment session |
| 77427 | Radiation treatment management, five treatments |
| 77432 | Stereotactic radiation treatment management of cerebral lesion(s) (complete course of treatment consisting of one session) |

| <u>CPT-4 Code</u> | <u>Description</u> |
|-------------------|---|
| 77435 | Stereotactic body radiation therapy, treatment management |
| 77520 | Proton treatment delivery; simple, without compensation |
| 77522 | simple, with compensation |
| 77523 | intermediate |
| 77525 | complex |
| 77750 | Infusion or instillation of radioelement solution |
| 77761 | Intracavitary radiation source application; simple |
| 77762 | intermediate |
| 77763 | complex |
| 77776 | Interstitial radiation source application; simple |
| 77777 | intermediate |
| 77778 | complex |
| 77789 | Surface application of radiation source |
| 77790 | Supervision, handling, loading of radiation source |
| 77799 | Unlisted procedure, clinical brachytherapy |

CPT-4 codes 77520 – 77525
Billing Restriction

CPT-4 codes 77520 – 77525 are not reimbursable when claimed with ICD-9-CM code 185 (malignant neoplasm of prostate) or 233.4 (carcinoma in situ, prostate).

Clinical Brachytherapy Radioactive Materials

The radiologist is responsible for the supervision and dose interpretation of the radioactive materials. CPT-4 procedure codes 77750 – 77778 and 77789 – 77799 are not split-billable and must not be billed with modifier 26 or TC. If the radiologist also actively participates in the surgical procedure throughout the course of the surgery, it may be appropriate to bill the surgical procedure with modifier 80 (assistant surgeon).

In cases of clinical brachytherapy involving a radiologist and a surgeon, providers must bill using the appropriate modifier to avoid duplicating or overlapping reimbursement for services.

The following brachytherapy source codes are reimbursable: C2634, C2635, C2637 – C2641, C2644, C2698 and C2699. Claims for these codes must be billed “By Report” and must include an invoice with the actual cost of the substance. These codes are not split-billable and must not be billed with any modifier.

Brachytherapy
Codes C2698, C2699
Special Billing Instructions

HCPCS codes C2698 (brachytherapy source, stranded, not otherwise specified, per source) and code C2699 (brachytherapy source, non-stranded, not otherwise specified, per source) are non-specific radiology services. Providers are no longer required to document the procedure performed; however, an invoice for reimbursement must be attached to the claim.

Provision of Unlisted Radiopharmaceutical(s)

Provision of unlisted diagnostic radiopharmaceutical(s) (HCPCS code A4641) is not split-billed and must not be billed with modifier 26 or TC. The provider who supplies the materials used in the nuclear medicine procedure should bill for this service. An invoice with the actual cost of the materials must be attached to the claim.

Note: Bill for these materials, using the appropriate HCPCS codes, only if the provider supplies the materials.

Intraoperative Radiation Treatment Delivery

CPT-4 codes 77424 (intraoperative radiation treatment delivery, x-ray, single treatment session) and 77425 (intraoperative radiation treatment delivery, electrons, single treatment session) must be billed "By Report."

Radiation Treatment Management

Physicians and physician groups must bill CPT-4 code 77427 (radiation treatment management, five treatments) using the "from-through" method. This code is not split-billable, and must not be billed with modifier 26 or TC.

CPT-4 code 77469 (intraoperative radiation treatment management) represents only the intraoperative radiation treatment management and does not include medical evaluation and management outside of that session.

Stereotactic Radiation Therapy

The same physician should not report CPT-4 code 32701 (thoracic target[s] delineation for stereotactic body radiation therapy [SRS/SBRT]) in conjunction with codes 77261 – 77799.

**Local Hyperthermia
Cancer Treatment**

The following CPT-4 procedure codes should be used for billing local hyperthermia with radiation therapy as treatment for selected cancer cases.

| <u>CPT-4 Code</u> | <u>Description</u> |
|-------------------|--|
| 77600 | Hyperthermia, externally generated; superficial (ie, heating to a depth of 4 cm or less) |
| 77610 | Hyperthermia generated by interstitial probe(s); 5 or fewer interstitial applicators |
| 77615 | more than 5 interstitial applicators |

Coverage for the above procedures includes:

- Management during the course of therapy
- Follow-up care for three months after completion
- Physics planning and interstitial insertion of temperature sensors
- Use of external or interstitial heat-generating sources

Note: Local hyperthermia is a benefit only as an adjunct to radiation therapy and is not covered when billed separately or in connection with chemotherapy.

**Initial Consultation/
Radiation Therapy**

Initial consultation (CPT-4 codes 99241 – 99255) and radiation therapy may be billed separately from the hyperthermia treatment.

TAR and “By Report” Codes

CPT-4 codes 77600, 77610 and 77615 are subject to authorization through the *Treatment Authorization Request (TAR)* process. These codes are “By Report,” and claims should be accompanied by a description of the specific services provided on the date of service billed.

| | |
|---|--|
| Therapeutic Radiopharmaceutical Agents | Radiopharmaceuticals are radioactive agents that may be used as therapeutic agents in the treatment of a variety of diseases. |
| | Refer to “Diagnostic Radiopharmaceutical Agents” in the <i>Radiology: Nuclear Medicine</i> section of the appropriate Part 2 manual. |
| “Per treatment dose” agents | The following therapeutic radiopharmaceutical agents include the wording “per treatment dose” in their descriptor and reimbursement for the following HCPCS codes is limited to one unit (one treatment dose): A9543, A9545 and A9604. |
| Other agents | The following therapeutic radiopharmaceutical agents include “millicuries” in their descriptor and reimbursement for the following HCPCS codes is allowed as per their descriptor (exception A9699, see below): A9517, A9527, A9530, A9563, A9564, A9600 and A9699. |
| | Code A9699 (radiopharmaceutical, therapeutic, not otherwise classified) requires clinical information documenting the agent used, dose and strength administered and the condition being treated, which is either entered into the <i>Remarks</i> field (Box 80)/ <i>Additional Claim Information</i> field (Box 19) or attached to the claim form. An invoice is required for pricing. |
| Billing | The therapeutic radiopharmaceutical agent codes are non split-billable and must <u>not</u> be billed with any modifier. An invoice with the acquisition cost of the substance(s) must be attached to the claim. |
| No Price On File | For codes listed on the Medi-Cal website without a price, an invoice is required for pricing purposes. The invoices for these items must be dated prior to the date of service or the claim will be denied. |
| Ibritumomab Tiuxetan (Zevalin) | Yttrium-90 (Y-90) ibritumomab tiuxetan (Zevalin) injection (HCPCS code A9543) and Indium-111 (In-111) ibritumomab tiuxetan (HCPCS code A9542) are reimbursed when used to treat patients with relapsed or refractory low-grade follicular, or transformed B-cell non-Hodgkin’s lymphoma refractory to treatment with rituximab 100 mg injection (HCPCS code J9310). The use of ibritumomab tiuxetan is subject to authorization and is limited to a maximum Units/Visits/Studies (U/V/S) of one unit for each code when billed by the same provider, for the same recipient and date of service. |

Imaging and Therapy Protocol

Providers may be reimbursed for In-111 ibritumomab tiuxetan (HCPCS code A9542) and Y-90 ibritumomab tiuxetan (HCPCS code A9543) when treatment is administered under the following schedule:

Day 1: Imaging

- I.V. infusion of 250 mg/m² of rituximab (J9310)
- Within four hours – I.V. injection of In-111 (A9542) over a period of 10 minutes

Assessment of biodistribution:

- 1st image – 2 to 24 hours after injection of In-111 ibritumomab tiuxetan (A9542)
- 2nd image – 48 to 72 hours after injection of In-111 ibritumomab tiuxetan (A9542)
- 3rd image – 90 to 120 hours after injection of In-111 ibritumomab tiuxetan (A9542) (optional)

Days 7 – 9: Therapy

- I.V. infusion of 250 mg/m² of rituximab (J9310)
- Within four hours – I.V. injection of Y-90 ibritumomab tiuxetan (A9543) over a period of 10 minutes, not to exceed 32 mCi
 - 0.4 mCi/kg for patients with normal platelet counts
 - 0.3 mCi/kg for patients with platelet count of 100,000 – 149,000 cells/mm³

Billing Requirements

Imaging Sequence

1. Rituximab 250 mg/m² (J9310) may be billed with CPT-4 code 96413 (chemotherapy administration, intravenous infusion technique; up to one hour, single or initial substance/drug) and 96415 (... each additional hour, one to eight hours).
2. CPT-4 code 78802 (radiopharmaceutical localization of tumor or distribution of radiopharmaceutical agent[s]; whole body single day imaging) may be billed per scan to a maximum of three.

Therapy Protocol

1. Rituximab 250 mg/m² (J9310) may be billed with CPT-4 codes 96413 and 96415.
2. Y-90 ibritumomab tiuxetan (A9543) may be billed with CPT-4 codes 77750 (infusion or instillation of radioelement solution) and 77790 (supervision, handling, loading of radiation source).

HCPCS codes A9542 and A9543 are not split-billable and must not be billed with modifiers 26 or TC.

Authorization A *Treatment Authorization Request* (TAR) is required for treatment with Y-90 ibritumomab tiuxetan (HCPCS code A9543) and In-111 ibritumomab tiuxetan (A9542) and must include the following:

- A pathological report of low-grade follicular or transformed B-cell non-Hodgkin's lymphoma
- Documentation that the recipient has undergone a chemotherapy regimen that included rituximab (HCPCS code J9310) and that the lymphoma was refractory or became refractory to the chemotherapy regimen; and
- Documentation that the recipient's platelet count is not less than 100,000 cells/mm³.

Radium Ra 223 Dichloride Radium Ra 223 dichloride is an alpha particle-emitting radiotherapeutic drug. The active moiety is radium-223, which mimics calcium and forms complexes with the bone mineral hydroxyapatite at areas of increased bone turnover, such as bone metastases. The high linear energy transfer of alpha emitters leads to a high frequency of double-strand DNA breaks in adjacent cells, resulting in an anti-tumor effect on bone metastases.

Indications For the treatment of patients with castration-resistant prostate cancer, symptomatic bone metastases and no known visceral metastatic disease.

Authorization An approved TAR is required for reimbursement.

Dosage The recommended dose regimen is 50 kBq (1.35 microcurie) per kg body weight, given at four-week intervals for six injections. Safety and efficacy beyond six injections have not been studied. The radioactivity concentration of the product and the decay correction factor must be considered in determining the volume of drug to be administered.

Billing HCPCS code A9699 (radiopharmaceutical, therapeutic, not otherwise classified)

One billed unit equals the entire dose.

**Samarium Sm-153
Lexidronam (QUADRAMET)**

Samarium Sm-153 lexidronam is a therapeutic agent consisting of radioactive samarium and atetraphosphonatechelator, ethylenediamine -tetramethylenephosphonic acid. Samarium Sm-153 lexidronam has an affinity for bone and concentrates in areas of bone turnover in association with hydroxyapatite. In clinical studies employing planar imaging techniques, more samarium Sm-153 lexidronam accumulates in osteoblastic lesions than in normal bone with a lesion-to-normal bone ratio of approximately five. The mechanism of action of samarium Sm-153 EDTMP in relieving the pain of bone metastases is unknown.

Indications

Samarium Sm-153 lexidronam is indicated for relief of pain in patients with confirmed osteoblastic metastatic bone lesions that enhance on radionuclide bone scan.

Dosing

The recommended dose of samarium Sm-153 lexidronam is 1.0 mCi/kg, administered intravenously over a period of one minute. Dose adjustment in patients at the extremes of weight have not been studied. Caution should be exercised when determining the dose in very thin or very obese patients. Doses greater than 150 millicuries are allowed if documentation shows that the patient's weight exceeds 150 kg. Usage is limited to recipients 16 years of age or older and one treatment dose per day.

Billing

HCPCS code A9604 (samarium Sm-153 lexidronam, therapeutic, per treatment dose, up to 150 millicuries).

Implantable Tissue Marker

HCPCS codes A4648 (tissue marker, implantable, any type, each) and A4650 (implantable radiation dosimeter, each) are separately reimbursable only when billed with one of the following CPT-4 codes.

| CPT-4 Code | Description |
|------------|--|
| 32553 | Placement of interstitial device(s) for radiation therapy guidance (e.g., fiducial markers, dosimeter), percutaneous, and intra-thoracic, single or multiple |
| 49411 | Placement of interstitial device(s) for radiation therapy guidance (e.g., fiducial markers, dosimeter), percutaneous, intra-abdominal, intra-pelvic, (except prostate), and/or retroperitoneum, single or multiple |
| 55876 | Placement of interstitial device(s) for radiation therapy guidance (e.g., fiducial markers, dosimeter), percutaneous, and prostate, single or multiple |

Billing

HCPCS codes A4648 (tissue marker, implantable, any type, each) and A4650 (implantable radiation dosimeter, each) are not split-billable and must not be billed with any modifier. For reimbursement, an invoice with the actual cost of the item must be attached to the claim.