



# Packaging OR Bundled

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# Thank you SROA

- I would like to thank SROA for their continued commitment in providing resources to their members.
- If you hadn't heard, Churchill Consulting, Inc. has been sold and will now be known as Crux Quality Solutions, LLC DBA Churchill Consulting ("CruxQS") effective August 24, 2015.
- It is my pleasure to present this topic, which will be my last talk for SROA.



# Presentation Order

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# Ok, I'll Talk About that TOO!

- And due to popular demand, I'll touch on reporting the pre-planning simulation (or not)!



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# Where Are The Edits?

OCE vs NCCI

# OCE vs NCCI

## Two Edit Systems

- **OCE:** The Outpatient Code Editor (OCE)
  - ◆ *Hospital outpatient*
  - ◆ *Used for OPPS Claim processing*
- **NCCI:** The National Correct Coding Initiative (NCCI)
  - ◆ *For MPFS*
  - ◆ *Used for fiscal intermediary and carrier-related claims.*





# Packaged OR Bundled

Let's Begin By Defining These Terms

# Packaged OR Bundled

Packaged and bundled are often used interchangeably; they are entirely different.



# Packaged OR Bundled

## **Packaging** is a **payment** concept

- ◆ *A single payment is made for packaged services*
- ◆ *All services are still reported*
- ◆ *Hospital based status indicators N, Q1, Q2, Q3 reflect packaged codes*



# Packaged OR Bundled

**Bundling** is a **coding** concept.

- ◆ *NCCI Edits Define Bundled Services*
- ◆ *Under most circumstances, bundled codes are not reported*
- ◆ *Under some circumstances, modifiers are used to bypass an edit if the services are unrelated.*





# Report, or Not....

# Report or Not

- Packaged Codes ARE Reported



# Report or Not

- Bundled Codes ARE **NOT** Reported



# Report or Not

## Packaged Services-

- **Are Reported**
  - ◆ *They just do receive reimbursement, i.e., imaging codes*
- Packaging is a hospital payment concept
- All services should be reflected on the claim form
  - ◆ *CMS uses information for data collection*
- Professional component of packaged hospital services are still paid under MPFS
- Some private carriers may also pay for services that are packaged under OPFS



# Report or Not

## Bundled Services-

- Are Not Reported
- Restricted code groups are indicated in NCCI Edit publications
  - ◆ *The component code that is bundled requires a modifier if both services are reported on the same DOS.*
  - ◆ *Modifier use must be supported by documentation in the medical record.*
  - ◆ *Modifiers should not arbitrarily be used to bypass an Edit for reimbursement.*





# Packaged

What Constitutes a Packaged Code

# Packaged

## Packaging

- Under OPPS, CMS lists many services as packaged
- Payment for the 'packaged' service is included in the 'primary' service.
- Example: All imaging is packaged in RO.
  - ◆ *IGRT 77387 and port films 77417*
- The use of modifiers will not change the packaging policy, you simply do not get paid.
  - *We will discuss CAPC later*





# Bundling

What Constitutes a Bundled Code

# Bundling

## Bundling

- **Bundling** refers to the application of coding rules to ensure that the procedure codes submitted on the claim accurately reflect the services performed.
- Services that are inherently a part of the primary service are not reported separately.



# Unbundling

- Unbundling is defined as the billing of multiple procedure codes for a group of procedures covered by a single, comprehensive code.
- Medicare lists two types of unbundling:
  - ◆ *unintentional, resulting from a misunderstanding of coding*
  - ◆ *intentional, when an entity manipulates coding in order to maximize payment*
  - ◆ *This can include down-coding a service in order to report additional codes that would otherwise not be paid*



# Bundling Guidelines

## Bundling Guidelines

- The **NCCI** guidelines define what procedures may not be reported with a primary procedure.
- An edit may sometimes be bypassed with a modifier (*if the procedure was distinct or independent from other services performed on the same day*)
  - ◆ Do not arbitrarily add modifiers just to get paid.



# Bundling Guidelines

## Mutually Exclusive Edits

- ME, or mutually exclusive edits, were formerly contained in a separate table.
- Now the guidelines (NCCI) contain column 1 and column 2 code edits in the same table
- The tables consist of two codes (procedures) which cannot reasonably be performed together based on the code definitions or anatomic considerations.
- Each edit consists of a column 1 and column 2 code.



# Bundling Guidelines

## Mutually Exclusive Edits

- If the two codes of an edit are billed by the same provider for the same beneficiary for the same date of service without an appropriate modifier, the column 1 code is paid.
- If clinical circumstances justify appending a National Correct Coding Initiative-associated modifier to the column 2 code of a code pair edit, payment of both codes may be allowed if the modifier indicator is "1".
  - (FAQ11232), (FAQ11238)



# Sample Edits with IMRT Device Code

Code	Column 1 Conflicts	Modifier	Column 2 Conflicts	Modifier
77338	61796, 61798	0	77332-77334	1
	63620		99201-99205	1
			99211-99215	1
			99221-99223	1
			99231-99233	1
			99238-99239	0
			97802-97804	0





# Bypassing Edits

Modifier Use

# Bypassing Edits

## Bypassing Edits

- The NCCI tables list column 1 and column 2 conflicts.
  - ◆ *Column 1 = comprehensive code*
  - ◆ *Column 2 = component code*
- If the conflict code has a '0', there is **no** modifier that will bypass the edit.



# Bypassing Edits

## Bypassing Edits

If the conflict code has a '1', a modifier can bypass the edit.

- The physician's documentation must support a procedure or service that was distinct or separate from other services performed on the same day.
- The modifier used must be appropriate and supported in the medical record.
  - ◆ *Modifiers should not be added by coders to automatically bypass an edit.*



# Bypassing Edits

## Bypassing Edits

- The following modifiers are allowed with the National Correct Coding Initiative (NCCI) edits:
  - ◆ *Global surgery modifiers: 25, 58, 78, 79*
  - ◆ *Other modifiers: 27, 59, 91*
  - ◆ *Anatomic modifiers: E1-E4, FA, F1-F9, TA, T1-T9, LT, RT, LC, LD, RC*



# Bypassing Edits

## Modifier -25

- Modifier "-25" should be appended to an evaluation and management (E&M) code when reported with another procedure on the same day of service to indicate a "significant and separately identifiable" E&M service.
  - *(FAQ11260)*



# Bypassing Edits

## Modifier -58

Staged or Related Procedure or Service by the Same Physician During the Postoperative Period

- The physician may need to indicate that the performance of a procedure or service during the postoperative period was:
  - ◆ *a) planned prospectively at the time of the original procedure (staged);*
  - ◆ *b) more extensive than the original procedure; or*
  - ◆ *c) for therapy following a diagnostic surgical procedure. This circumstance may be reported by adding the modifier -58 to the staged or related procedure, or the separate five digit modifier 09958 may be used.*
    - *Note: This modifier is not used to report the treatment of a problem that requires a return to the operating room.*





# -59 Modifier

**-X[ESPU]**

# -59 Modifier

- Modifier -59 is used to indicate a "distinct procedural service".
  - ◆ *Modifier 59 may not be appended to the evaluation and management (E&M) services or radiation treatment management Current Procedural Terminology (CPT code 77427).  
(FAQ11258)*



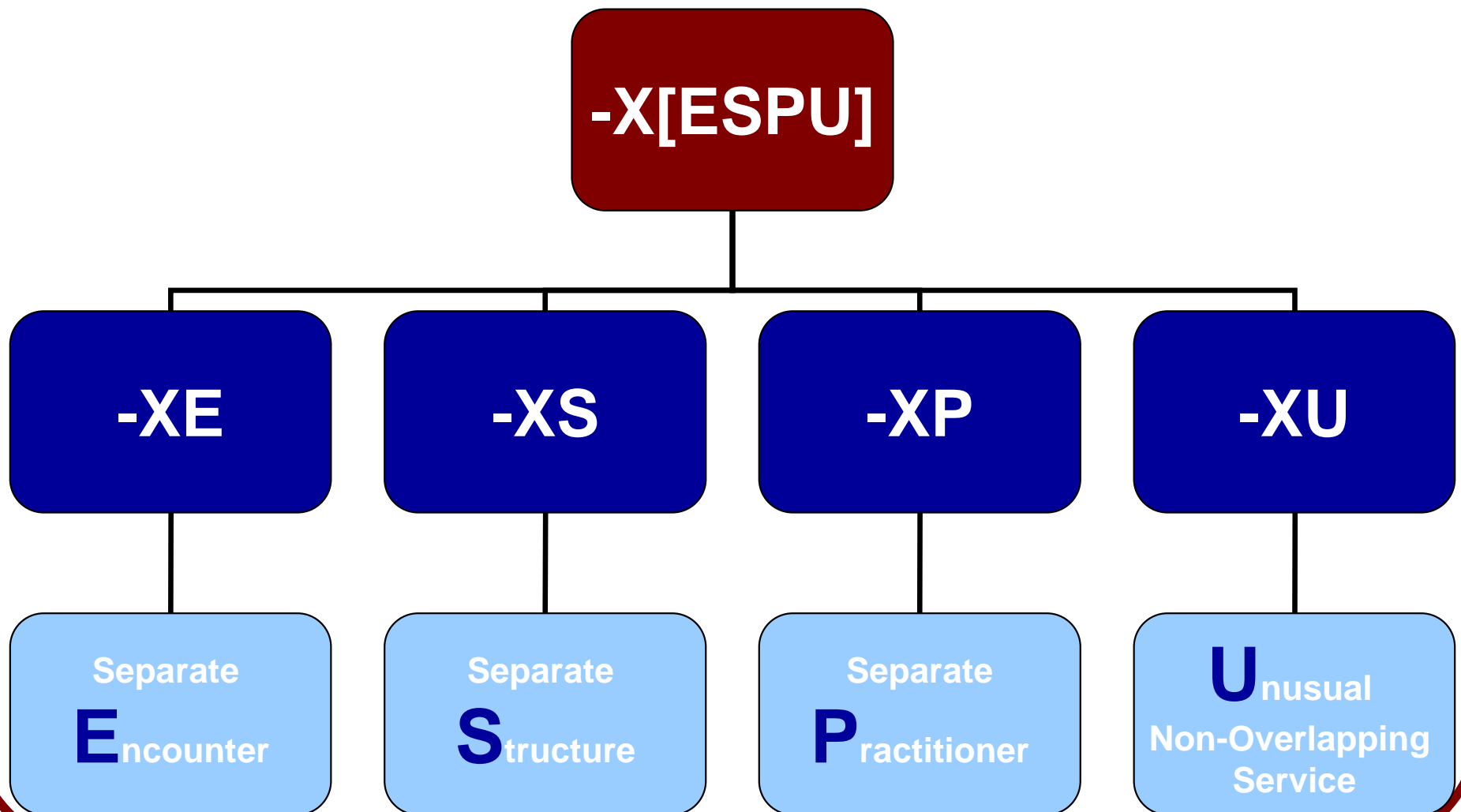
# -59 Modifier + XE, XS, XP, XU

## Reducing the errors associated with modifier 59 overpayment

- CMS has defined four new HCPCS modifiers to selectively identify subsets of Distinct Procedural Services (-59 modifier).
- *Modifiers **XE, XS, XP, XU** are effective January 1, 2015.*
  - <http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/downloads/modifier59.pdf>



# -X[ESPU]



# -59 Modifier + XE, XS, XP, XU

- *These modifiers were developed to provide greater reporting specificity in situations where modifier 59 was previously reported and may be utilized in lieu of modifier 59 whenever possible.*
- *(Modifier 59 should only be utilized if no other more specific modifier is appropriate.)*
- *Although NCCI will eventually require use of these modifiers rather than modifier 59 with certain edits, providers may begin using them for claims with dates of service on or after January 1, 2015.*



# -59 Modifier + XE

- XE
  - ◆ ***XE*** – “Separate encounter, A service that is distinct because it occurred during a separate encounter” This modifier should only be used to describe separate encounters on the same date of service.
    - *Example: Patient is treated at 8:00 am and returns 6 hours later for another treatment.*



# -59 Modifier + XS

- XS
  - ◆ **XS** – *“Separate Structure, A service that is distinct because it was performed on a separate organ/structure”*
    - *Example: Photon plan to one area and electron plan to a non-contiguous area.*
    - *Reporting 77306 or 77307 for the photon area and 77321 for the electron area will require a modifier.*



# -59 Modifier + XP

- XP
  - ◆ **XP** – “*Separate Practitioner, A service that is distinct because it was performed by a different practitioner*”
    - *BID Treatment performed by a different physician.*



# -59 Modifier + XU

- XU
  - ◆ **XU** – *“Unusual Non-Overlapping Service, The use of a service that is distinct because it does not overlap usual components of the main service”*
    - When a provider designs and constructs a treatment or immobilization device separate and distinct from the “device” derived from the computerized IMRT plan, the provider may then report 77332-77334, as appropriate, with modifier - XU-unusual, non-overlapping service.
    - The medical record must support this use of modifier XU. A treatment device could also be appropriate where it applies to another modality (e.g. an accompanying “boost” with external beam).



# -59 Modifier

- These modifiers, collectively referred to as -X{ESPU} modifiers, define specific subsets of the -59 modifier.
- CMS will not stop recognizing the -59 modifier but notes that CPT instructions state that the -59 modifier should not be used when a more descriptive modifier is available.



# -59 Modifier

- CMS will continue to recognize the -59 modifier in many instances but may selectively require a more specific – X{ESPU} modifier for billing certain codes at high risk for incorrect billing.
  - ◆ *For example, a particular NCCI PTP code pair may be identified as payable only with the -XE separate encounter modifier but not the -59 or other -X{ESPU} modifiers.*
  - ◆ *The -X{ESPU} modifiers are more selective versions of the -59 modifier so it would be incorrect to include both modifiers on the same line.*



# Example -59

- NCCI Policy Manual 1/2015
  - ◆ *Continuing medical physics consultation (CPT code 77336) is reported “per week of therapy”. It may be reported after every five radiation treatments. (It may also be reported if the total number of radiation treatments in a course of radiation therapy is less than five.) Since radiation planning procedures (CPT codes 77261-77334) are generally performed before radiation treatment commences, the NCCI contains edits preventing payment of CPT code 77336 with CPT codes 77261-77295, 77301-77328, and 77332-77334.*



# Example -59

- NCCI Policy Manual 1/2015
  - ◆ *Because radiation planning procedures may occasionally be repeated during a course of radiation treatment, the edits allow modifier 59 to be appended to CPT code 77336 when the radiation planning procedure and continuing medical physics consultation are reported on the same date of service.*





# Two Physicians

Not BID but two MDs

# Two Docs?

- Can two physicians doing different work on the same day be billed.
  - ◆ *Yes, the limiting edit is for the services being provided for the same beneficiary/patient, on the same date of service by the same performing provider.*
  - ◆ *Two providers, both will be paid.*





# Other Modifiers – Other Edits

MUE (Medically Unlikely Edits)

# MUE

## Medically Unlikely Edit (MUE)

- In addition to the NCCI Edits, most codes are assigned an MUE [medically unlikely edit].
- An MUE (Medically Unlikely Edit) is a unit of service (UOS) edit for a Healthcare Common Procedure Coding System (HCPCS)/Current Procedural Terminology (CPT) code for services rendered by a single provider/supplier to a single beneficiary on the same date of service.



# MUE

## Medically Unlikely Edit (MUE)

- The ideal MUE is the maximum UOS that would be reported for a HCPCS/CPT code on the vast majority of appropriately reported claims.
- MUEs are adjudicated either as claim line edits or date of service edits.





# DOS MUE

Date of Service  
Medically Unlikely Edits

# MUE

## DOS (MUE)

- Medically Unlikely Edits (MUEs) may be maximized at either one per day or one per line.
- An MUE denial is a coding denial, **not a medical necessity denial**.
- Providers should **not** interpret MUE values as utilization guidelines.
- Providers should report only services that are medically reasonable and necessary.



# DOS MUE

- Effective April 1, 2013, CMS is converting some claim line Medically Unlikely Edits (MUEs) to date of service (DOS) MUEs.
- The total units of service (UOS) from all claim lines for a Healthcare Common Procedure Coding System (HCPCS)/Current Procedural Terminology (CPT) code with the same date of service will be summed and compared to the MUE value.
  - ◆ *Claims denied based on DOS MUEs may be appealed using similar processes to claim line MUE denials.*



# DOS MUE

- DOS MUEs are based on criteria including, but not limited to, anatomic considerations, CPT code descriptors or instructions, and nature of equipment or service.
  - ◆ *CMS does not publish which codes have DOS MUEs.*
- Since all UOS for a HCPCS/CPT code on all claim lines with the same date of service are summed, reporting additional UOS on separate claim lines with a HCPCS/CPT modifier will not result in payment of UOS in excess of the MUE value.
  - (FAQ11342)



# MUE Updates

- CMS publishes updates to the MUE Edits quarterly.
- The MUE for codes 77385 [IMRT simple], 77386 [IMRT complex] and 77387 [IGRT] increased from MUE 1 to MUE 2 in July 2015.
- This allows IMRT treatments and IGRT services to be reported for BID treatments, previously restricted when the MUE was 1.





# Bypassing MUE

# Bypassing MUE Edits

## Bypassing MUE Edits

- When it is medically reasonable and necessary to exceed the MUE limitation on a single DOS, the same code would be entered on a separate line, appending the -76 or -77 modifier.
- You should **NOT**, as a matter of practice, post services on multiple claim lines to bypass the MUE.
  - ◆ *For example: Do not enter 77334 x 1 on one claim line and additional 77334 x # on another claim line with the -76 modifier to bypass the MUE limitation.*



# Bypassing MUE Edits

## **-76 Repeat Procedure by Same Physician**

- The physician may need to indicate that a procedure or service was repeated subsequent to the original procedure or service. This circumstance may be reported by adding the modifier -76 to the repeated procedure/service or the separate five digit modifier code 09976 may be used.



# Bypassing MUE Edits

## **-77 Repeat Procedure by Another Physician**

- The physician may need to indicate that a basic procedure or service performed by another physician had to be repeated. This situation may be reported by adding modifier -77 to the repeated procedure/service or the separate five digit modifier code 09977 may be used.



# Bypassing MUE Edits

## Bypassing MUE Edits

- Modifiers used on separate claim lines include the -76 modifier and the -77 modifier
- In most cases, the new X[ESPU] codes will replace these modifiers for BID treatments.
- Check with your carrier.





# Status Indicators

Built In Restrictions

# Status Indicators

- All CPT codes have a status indicator [SI] associated with it.
- There are different SI for OPPS [hospital] and MPFS [Medicare physician fee schedule]
- The SI category defines how the code is treated on a claim.



# Sample Status Indicators

CPT/ HCPCS	Description	OPPS SI	APC	MPFS SI
77263	Radiation therapy planning	B		A
77280	Set radiation therapy field	S	0304	A
77290	Set radiation therapy field	S	0305	A
77293	Respirator motion mgmt simul	N		A
77295	3-d radiotherapy plan	S	0310	A
77299	Radiation therapy planning	S	0304	C
77300	Radiation therapy dose plan	S	0304	A
77301	Radiotherapy dose plan imrt	S	0310	A
77306	Telethx isodose plan simple	S	0304	A
77318	Brachytx isodose complex	S	0305	A
77321	Special teletx port plan	S	0305	A
77331	Special radiation dosimetry	S	0304	A
77334	Radiation treatment aid(s)	S	0303	A
77336	Radiation physics consult	S	0304	A
77338	Design mlc device for imrt	S	0305	A
77370	Radiation physics consult	S	0304	A
77371	Srs multisource	J1	0067	C
77372	Srs linear based	J1	0067	A
77373	Sbrt delivery	S	0066	A
77401	Radiation treatment delivery	S	0300	A
77402	Radiation treatment delivery	S	0300	I



# MPFS SI

The following are the status indicators associated with codes listed on the 'Addendum B' MPFS release

# MPFS SI

## **A = Active code**

- These codes are separately paid under the physician fee schedule if covered. There will be RVUs and payment amounts for codes with this status. The presence of an "A" indicator does not mean that Medicare has made a national coverage determination regarding the service; carriers remain responsible for coverage decisions in the absence of a national Medicare policy.



# MPFS SI

## **B = Bundled code**

- Payment for covered services is always bundled into payment for other services not specified.
- Payment for covered services is always bundled into payment for other services not specified. There will be no RVUs or payment amounts for these codes and no separate payment is ever made. When these services are covered, payment for them is subsumed by the payment for the services to which they are incident (an example is a telephone call from a hospital nurse regarding care of a patient).



# MPFS SI

## **C = Contractor-priced code**

- Contractors will establish RVUs and payment amounts for these services, generally on an individual case basis following review of documentation such as an operative report.

## **D = Deleted codes.**

- These codes are deleted effective the beginning of the year.



# MPFS SI

## **E = Excluded from the PFS by regulation**

- These codes are for items and services that CMS chose to exclude from the PFS by regulation. No RVUs are shown, and no payment may be made under the PFS for these codes. Payment for them, when covered, continues under reasonable charge procedures.



# MPFS SI

## **I = Not valid for Medicare purposes**

- Medicare uses another code for reporting of, and payment for, these services.
- (Code NOT subject to a 90 day grace period.)



# MPFS SI

## **M = Measurement codes, used for reporting purposes only**

- There are no RVUs and no payment amounts for these codes. CMS uses them to aid with performance measurement. No separate payment is made.

## **N = Non-covered service**

- These codes are noncovered services. Medicare payment may not be made for these codes. If RVUs are shown, they are not used for Medicare payment. .



# MPFS SI

## **P = Bundled/excluded codes**

- There are no RVUs and no payment amounts for these services. No separate payment is made for them under the fee schedule. If the item or service is covered as incident to a physician service and is provided on the same day as a physician service, payment for it is bundled into the payment for the physician service to which it is incident (an example is an elastic bandage furnished by a physician incident to a physician service). If the item or service is covered as other than incident to a physician service, it is excluded from the fee schedule (for example, colostomy supplies) and is paid under the other payment provision of the Act.



# MPFS SI

## **Q = Therapy functional limitation code**

- Used for required reporting purposes only. No separate payment is made.

## **R = Restricted coverage**

- Special coverage instructions apply. If the service is covered and no RVUs are shown, it is contractor-priced.



# MPFS SI

## **T = Paid as only service**

- These codes are paid only if there are no other services payable under the PFS billed on the same date by the same practitioner. If any other services payable under the PFS are billed on the same date by the same practitioner, these services are bundled into the service(s) for which payment is made.



# MPFS SI

## **X = Statutory Exclusion**

- These codes represent an item or service that is not within the statutory definition of “physicians’ services” for PFS payment purposes (for example, ambulance services). No payment may be made under the PFS and generally, no RVUs are shown for these codes.





# OPPS SI

## Hospital Status Indicators

# OPPS SI

- There are too many to include in these slides.
- The following five are the SI that appear with the 77xxx codes, noting that there may be other SI categories that are not discussed.
  - ◆ *B, C, D, S, N, J1, Q3*



# OPPS SI

## B

- Codes that are not recognized by OPPS when submitted on an outpatient hospital Part B bill type (12x and 13x).
  - ◆ *Not paid under OPPS.*
  - ◆ *May be paid by MACs when submitted on a different bill type*
  - ◆ *77261-77262, 77263, 77427, 77431, 77432, 77469, 77499, G0339, G0340*



# OPPS SI

## C

- Inpatient Procedures

- ◆ *Not paid under OPPOS. Admit patient. Bill as inpatient*



# OPPS SI

## D

- Discontinued Codes

- ◆ *Not paid under OPPOS or any other Medicare payment system.*



# OPPS SI

## J1 (CAPC)

- Hospital Part B services paid through a **comprehensive APC**
  - ◆ *Paid under OPPS; all covered Part B services on the claim are packaged with the primary "J1" service for the claim, except services with OPPS SI=F,G, H, L and U; ambulance services; diagnostic and screening mammography; all preventive services; and certain Part B inpatient services.*
  - ◆ *77371, 77372, 77424, 77425*



# OPPS SI

## N

- Items and Services Packaged into APC Rates
  - ◆ *Paid under OPPS; payment is packaged into payment for other services. Therefore, there is no separate APC payment.*
  - ◆ *Services are still reported as performed.*
    - *The professional component of these services ARE paid under MPFS.*
  - ◆ *77293, 77387, 77417, 77790*
  - ◆ *19297, 31627, 49327, 76942, 76965, 0190T*



# OPPS SI

## Q3

- Codes That May Be Paid Through a Composite APC
  - ◆ *Paid under OPPS; Addendum B displays APC assignments when services are separately payable.*
  - ◆ *Addendum M displays composite APC assignments when codes are paid through a composite APC.*
    - *(1) Composite APC payment based on OPPS composite-specific payment criteria. Payment is packaged into a single payment for specific combinations of services.*
    - *(2) In other circumstances, payment is made through a separate APC payment or packaged into payment for other services.*
  - ◆ *G0463 (Room code – only one level)*
  - ◆ *77778 (Composite)*





# C-APC

## Comprehensive APC Categories

# C-APC

- Single session stereotactic radiosurgery and intraop radiation have been classified into comprehensive APC categories.
- A single payment will be made for all services on the claim, regardless of the span of the date(s) of service.
  - ◆ *The stereotactic radiosurgery codes (single session) are still assigned to the APC category 0067, but the status indicator was changed to J1, making it a comprehensive APC.*
  - ◆ *CPT codes 77424 and 77425 (intraoperative radiation therapy treatment (IORT) was assigned the J1 status in the C-APC 0648 (Level IV Breast and Skin Surgery) category.*



# Reporting C-APC

- CMS provides a single payment for all services on the claim regardless of the span of the date(s) of service.
- Conceptually, the C-APC is designed so there is a single primary service on the claim, identified by a status indicator (SI) of J1.
- All adjunctive services provided to support the delivery of the primary service are also included on the claim.



# Reporting C-APC

- You do report all services.
- A single claim will be sent to the patient.
- The professional component of all services will still be paid.



# C-APC

APC	HCPCS	Single Session Cranial Stereotactic Radiosurgery	SI	CY 2015	CY 2014
0067	77371	SRS multisource	J1	\$9,765.40	\$3,591.62
0067	77372	SRS linear based	J1	\$9,765.40	\$3,591.62
APC		Level IV Breast and Skin Surgery	SI	CY 2015	CY 2014
0067	77424	IORT rad tx delivery by x-ray	J1	\$7,461.40	\$1,248.28
0067	77425	IORT rad tx deliver by electrons	J1	\$7,461.40	\$1,248.28





# PO Modifier

Place of Service

# PO Modifier

- CMS is creating a **new** POS code (POS 19) and **revising** the current POS code description for outpatient hospital (POS 22), effective January 2016.
- These Place of Service (POS) codes are designed to differentiate between *on-campus* and *off-campus* provider-based hospital departments.



# New POS Modifiers

New and Revised POS Codes Effective January 1, 2016	
Code	Descriptor
POS 19 Off Campus Outpatient Hospital	Descriptor: A portion of <b>an off-campus hospital provider based department</b> which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.
POS 22 On Campus Outpatient Hospital	Descriptor: A portion of <b>a hospital's main campus</b> which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.



# PO Modifier

- The modifier will gather data on provider-based status.
  - ◆ *It should be noted that it costs Medicare more money for provider-based services than services provided in freestanding facilities because hospitals are paid under OPPS and then physicians receive a separate professional fee.*





# NCCI Manual

In addition to Edits, NCCI offers a detailed manual that includes explicit directives.

# NCCI Manual

- Know the authoritative source guidelines.
- NCCI supersedes your LCD.
- This manual is available online.



# NCCI Manual: H&L

- *Supervision and handling of radionuclide(s) is integral to nuclear medicine procedures (e.g., CPT codes 78012-79999.)*
  - ◆ *Physicians should not separately report CPT code 77790 (supervision, handling, and loading of radiation source) for this service.*



# NCCI Manual: E&M

- Except for an initial visit evaluation and management (E&M) service at which the decision to perform radiation therapy is made, E&M services are not separately reportable with radiation oncology services with one exception as noted in the following slide for HDR.
  - ◆ *Effective January 1, 2010, CMS eliminated payment for consultation E&M CPT codes 99241-99255.*



# NCCI Manual: E&M

- The initial E&M visit for radiation oncology services may be reported as follows:
  - ◆ *Office/outpatient E&M CPT codes 99201-99215*
  - ◆ *Initial hospital care E&M CPT codes 99221-99223*
  - ◆ *Subsequent hospital care E&M CPT codes 99231-99233*
  - ◆ *Observation/inpatient hospital care with same day admission and discharge E&M CPT codes 99234-99236.*



# NCCI Manual: E&M +

- The only radiation oncology services that may be reported with E&M services in addition to an initial visit E&M service are CPT codes 77785-77787 (remote afterloading high dose rate radionuclide brachytherapy...).
- ◆ *E&M services reported with these brachytherapy codes must be significant, separate and distinct from radiation treatment management services.*



# NCCI Manual: 77336

- Continuing medical physics consultation (CPT code 77336) is reported “per week of therapy”.
  - ◆ *It may be reported after every five radiation treatments. (It may also be reported if the total number of radiation treatments in a course of radiation therapy is less than five.)*



# NCCI Manual: 77336

- Since radiation planning procedures (CPT codes 77261-77334) are generally performed before radiation treatment commences, the NCCI contains edits preventing payment of CPT code 77336 with CPT codes 77261-77295, 77301-77328, and 77332-77334.
  - ◆ *Because radiation planning procedures may occasionally be repeated during a course of radiation treatment, the edits allow modifier 59 to be appended to CPT code 77336 when the radiation planning procedure and continuing medical physics consultation are reported on the same date of service.*
    - *Or, XU if directed by your carrier.*



# NCCI Manual: Bundled Services RO

- *Medicare Claims Processing Manual, Publication 100-04, Chapter 13, Section 70.2 (Services Bundled Into Treatment Management Codes)* defines services that may not be reported separately with radiation oncology procedures.
  - ◆ *Based on these requirements, the NCCI contains edits bundling the following CPT codes into all radiation therapy services:*



# NCCI Manual: Bundled Services RO

- 11920-11921 (Tattooing)
- 16000-16030 (Treatment of burns)
- 36000, 36410, 36425 (Venipuncture or Introduction of catheter)
- 51701-51703 (Urinary bladder catheterization)
- 96360-96368 (Intravenous infusion)
- 90832-90838 (Psychotherapy)
- 90846 (Psychotherapy)



# NCCI Manual: Bundled Services RO

- 90847 (Psychotherapy)
- 90863, M0064(Pharmacologic management)
- 97802-97804 (Medical nutrition therapy)
- 99143-99144 (Anesthesia – Moderate conscious sedation)
- 99185 (Regional hypothermia)(CPT code 99185 was deleted January 1, 2010.)
- **99201-99215 (Evaluation & Management)**
- 99217-99239 (Evaluation & Management)
- 99281-99480 (Evaluation & Management)



# NCCI Manual: Brachytherapy

- Brachytherapy (CPT codes 77750-77790) includes radiation treatment management (CPT codes 77427 and 77431) and continuing medical physics consultation (CPT code 77336).
  - ◆ *CPT codes 77427, 77431, and 77336 should not in general be reported separately with brachytherapy services.*



# NCCI Manual: Brachytherapy

- However, if a patient receives external beam radiation treatment and brachytherapy treatment during the same time period, radiation treatment management and continuing medical physics consultation may be reported for the external beam radiation treatments.
- Additionally, if a patient has multi-step brachytherapy, it may be appropriate to separately report continuing medical physics consultation with the brachytherapy.



# NCCI Manual: Interstitial

- The procedures described by CPT codes 77776-77778 (interstitial radiation source application...) require that a radiation source be applied interstitially.
  - ◆ *Reporting a CPT code requires that all essential components of the procedure are performed. These codes should not be reported by a radiation oncologist for intraoperative work with another physician who surgically places catheters interstitially unless the radiation oncologist also applies the radiation source at the same patient encounter.*



# NCCI Manual: Interstitial

- The intraoperative work of the radiation oncologist may be reportable with a non-brachytherapy code.
  - ◆ *If the radiation source application occurs postoperatively in a different room, the radiation oncologist may report CPT codes 77785-77787 (remote afterloading high dose rate radionuclide brachytherapy...) for the radiation source application.*



# NCCI Manual: SRS

- Stereotactic radiosurgery (SRS) treatment delivery (CPT codes 77371-77373) includes stereotactic guidance for placement of the radiation therapy fields for treatment delivery.
  - ◆ *CPT codes 77014 (computed tomography guidance for placement of radiation therapy fields) and 76950 (ultrasonic guidance for placement of radiation therapy fields) should not be reported additionally for guidance for placement of the radiation therapy field for SRS treatment delivery.*



# NCCI Manual: 77387

- *CPT code 77387 (guidance for localization of target volume for delivery of radiation treatment delivery, includes intrafraction tracking when performed) includes localization of the radiation field.*
  - ◆ *It should not be reported with other CPT codes describing localization of the radiation field such as CPT codes 76950 (ultrasonic guidance for placement of radiation therapy fields) or 77014 (computed tomography guidance for placement of radiation therapy fields).*



# NCCI Manual: APBI

- Partial breast high dose rate brachytherapy may be performed two times a day. The first therapeutic radiology simulation for the course of therapy may be complex and reported as CPT code 77290.
  - ◆ *Comment: A 3D brachytherapy isodose plan is generally done for APBI. Therefore, code 77295 would be reported – 77290 would bundle with 77295.*
- However, subsequent simulations during the course of therapy should be reported as CPT code 77280.
  - ◆ *Comment: Report the procedure, not the equipment that the image is derived from. Confirming placement with CT or US is still a simple simulation.*



# NCCI Manual: IMRT

- Intensity modulated treatment (IMRT) delivery (e.g., CPT codes **77418**, 77385, 77386) is not normally reported with treatment device design and construction CPT codes 77332-77334.
- The latter codes are generally reported for treatment device(s) design and construction for external beam radiation therapy.
- IMRT planning (CPT code 77301) includes many treatment device(s) required for IMRT.



# NCCI Manual: IMRT

- Multi-leaf collimator (MLC) device(s) (*CPT code 77338*) may be reported separately once per IMRT plan.
- However, patients receiving IMRT occasionally require an additional treatment device at a later date due to decreased tumor volume or patient weight.
  - ◆ *This device may be reported with CPT codes 77332-77334. (CPT code 77418 was deleted January 1, 2015.)*



# NCCI Manual: IMRT

- Intensity modulated radiotherapy (IMRT) plan (CPT code 77301) includes therapeutic radiology simulation-aided field settings. *(We will discuss this wording.....)*
- 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.



# And then there is now.....

- In regards to reporting the pre-planning simulation with IMRT, ASTRO had released a 'recommendation' that this simulation not be reported as the work is 'bundled' in the IMRT planning code 77301.
- This recommendation reflects MPFS, i.e., physician or global billing.
- In the hospital setting, the reimbursement is the same for 77295 and 77301.



# Rates: IMRT

Code	APC	APC Rate	Pro Rate	Global Rate
77290	0305	\$314.55	\$80.85	\$513.49
7295	0310	\$1,038.53	\$223.51	\$491.57
77301	0310	\$1,038.53	\$415.75	\$1,950.83



# And then there is now.....

- The majority of centers are following ASTRO's advice and have stopped billing the pre-planning simulation.
- Many centers have LCD Policies that state that the pre-planning simulation is a reportable event.
- It is always wise to obtain a written ruling from your carrier when in doubt over the appropriateness of billing a service.



# And then there is now.....

- It seems inequitable to apply this rule to the hospital when the same payment is made for 3D and IMRT plans.
- However, there has been a precedent set in the hospital setting – the ruling citing the Medicare Claims Processing Manual.
- Hopefully, the Federal Register due out shortly will include clear directions, or the SI will change, or increase under APC.



# Q&A

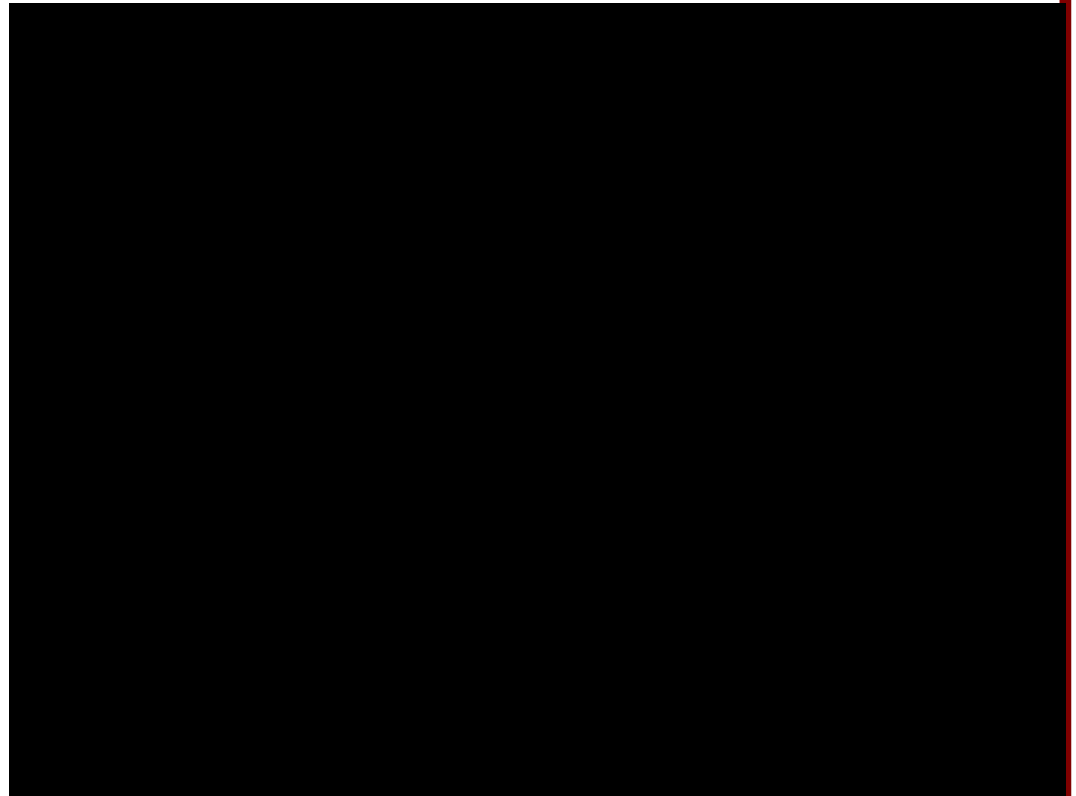
- Thanks for joining me.
- All final questions will be entertained now.
- After today.....



# Next.....



**This is where you can find me now.  
Hopefully, there won't be too many  
people in my race track to slow me  
down!!!**



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