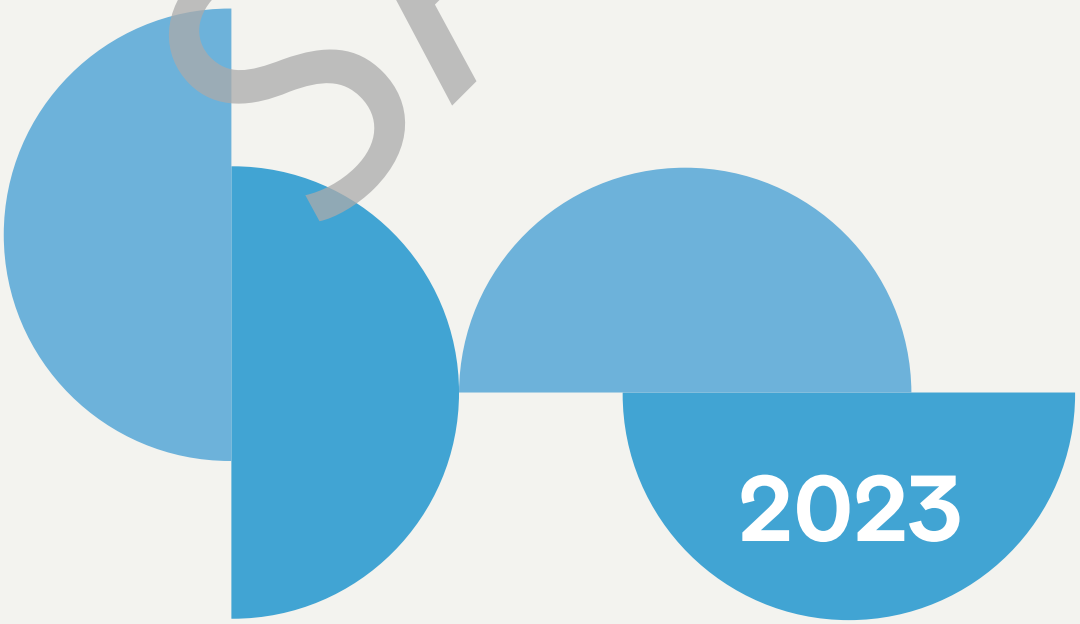
Optum

Coding &
Payment Guide

Medical Oncology/ Hematology Services

An essential coding, billing and reimbursement resource for oncology and hematology services



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Getting Started with Coding and Payment Guide

The *Coding and Payment Guide for Medical Oncology/Hematology Services* is designed to be a guide to the specialty procedures classified in the CPT® book. It is structured to help coders understand procedures and services and translate physician narrative into correct CPT codes by combining many clinical resources into one, easy-to-use source book.

The book also allows coders to validate the intended code selection by providing an easy-to-understand explanation of the procedure and associated conditions or indications for performing the various procedures. As a result, data quality and reimbursement will be improved by providing code-specific clinical information and helpful tips regarding the coding of procedures.

CPT Codes

For ease of use, evaluation and management codes related to oncology and hematology are listed first in the *Coding and Payment Guide*. All other CPT codes in *Coding and Payment Guide* are listed in ascending numeric order, including surgery, radiology, laboratory and medicine codes. Each CPT code is followed by its official CPT code description.

Resequencing of CPT Codes

The American Medical Association (AMA) employs a resequenced numbering methodology. According to the AMA, there are instances where a new code is needed within an existing grouping of codes, but an unused code number is not available to keep the range sequential. In the instance where the existing codes are not changed or had only minimal changes, the AMA assigned a code out of numeric sequence with the other related codes being grouped together. The resequenced codes and their descriptions have been placed with their related codes, out of numeric sequence.

Resequenced CPT codes within the *Optum360 Coding and Payment Guide* series display in brackets for easy identification.

ICD-10-CM

Overall, in the 10th revision of the ICD-10-CM codes, conditions are grouped with general epidemiological purposes and the evaluation of health care in mind. Features include icons to identify newborn, pediatric, adult, male only, female only, and laterality. Refer to the ICD-10-CM book for more ICD-10-CM coding information.

Detailed Code Information

One or more columns are dedicated to each procedure or service to a series of similar procedures/services. Following the specific HCPCS Level II and CPT code(s) and its narrative is a combination of features. A sample is shown on page 6. The black boxes with numbers in them correspond to the information on the page following the example.

Appendix Codes and Descriptions

Some CPT codes that are not commonly used in Oncology/Hematology, are presented in a less comprehensive format in the appendix. The CPT codes are also followed by the official CPT code description. The codes are presented in numeric order, and each code is followed by an easy-to-understand lay description of the procedure. Category III codes are included in the main body of the book.

CCI Edits and Other Coding Updates

The *Optum 360 Coding and Payment Guide* includes the list of codes from the official Centers for Medicare and Medicaid Services' *National Correct Coding Policy Manual for Part B Medicare Contractors* that are considered to be an integral part of the comprehensive code or mutually exclusive of it and should not be reported separately. The codes in the Correct Coding Initiative (CCI) section are from the version XX.X, the most current version available at press time. CCI edits are updated quarterly and will be posted on the product updates page listed below. The CCI edits are located in a section at the back of the book. As other CPT (including COVID-related vaccine and administration codes) and ICD-10-CM codes relevant to your specialty are released, updates will be posted to the Optum360 website. The website address is https://www.optum360coding.com/ProductUpdates/. The 2023 edition password is: **XXXXX**. Log in frequently to ensure you receive the most current updates.

Index

A comprehensive index is provided for easy access to the codes. The index entries have several axes. A code can be looked up by its procedural name or by the diagnoses commonly associated with it. Codes are also indexed anatomically. For example:

Bone
- Marrow
  - Aspiration, 38220, 38222
  - Biopsy, 38221-38222
  - Harvesting, 38230-38232
    - Allogeneic, 38230
    - Autologous, 38232

General Guidelines

Providers

The AMA advises coders that while a particular service or procedure may be assigned to a specific section, it is not limited to use only by that specialty group (see paragraphs two and three under "Instructions for Use of the CPT Codebook" on page xiii of the CPT book). Additionally, the procedures and services listed throughout the book are for use by any qualified physician or other qualified healthcare professional or entity (e.g., hospitals, laboratories, or home health agencies). Keep in mind that there may be other policies or guidance that can affect who may report a specific service.

Facilities

Many of the procedures and services in this *Coding and Payment Guide* are performed in an outpatient department of a hospital or in free standing outpatient facilities. In some instances the coding and or payment requirements are different than that reported by a healthcare provider. When the information provided is specific to the facility, the term **Facility Reporting**, will precede the facility-specific information provided.

Supplies

Some payers may allow physicians to separately report drugs and other supplies when reporting the place of service as office or other nonfacility setting. Drugs and supplies are to be reported by the facility only when performed in a facility setting. Because payment guidelines may vary by payer to payer or even geographical location, only the

96542

96542 Chemotherapy injection, subarachnoid or intraventricular via subcutaneous reservoir, single or multiple agents

Explanation

The physician or supervised assistant prepares and administers a chemotherapeutic medication to combat malignant neoplasms or microorganisms. This code applies to medication infused into the central nervous system through a catheter leading from a subcutaneous reservoir of medication in the brain's subarachnoid or intraventricular space.

Coding Tips

For radioactive isotope therapy, see 79005. For subcutaneous or intramuscular administration of chemotherapy, nonhormonal, antineoplastic, see 96401; hormonal, antineoplastic, see 96402. For intralesional chemotherapy administration, up to and including seven lesions, see 96405; more than seven lesions, see 96406. To report intravenous chemotherapy, push technique, single or initial substance/drug, see 96409; each additional substance or drug, see 96411. For chemotherapy administration, via IV infusion technique, up to one hour, single or initial substance/drug, see 96413; each additional hour, report 96415 in addition; initiation of prolonged chemotherapy involving more than eight hours, requiring the use of a portable or implantable pump, see 96416; each additional sequential infusion thereafter, up to one hour, report 96417. For provision of a chemotherapy agent, see the appropriate HCPCS Level II code. Medicare and some other payers may require HCPCS Level II codes Q0083, Q0084, and Q0085 be reported for this service.

Documentation Tips

Documentation should include the direct supervision as well as special considerations for preparation, dosage or disposal, frequent monitoring, and any complications that occur. The documentation must indicate the substance, dosage, and administration.

Reimbursement Tips

Preauthorization of these services may be required. Check with the specific payer to determine benefits specific to cancer treatment, as well as with the patient regarding any supplementary cancer policies.

ICD-10-CM Diagnostic Codes

C71.0	Malignant neoplasm of cerebrum, except lobes and ventricles
C71.1	Malignant neoplasm of frontal lobe
C71.2	Malignant neoplasm of temporal lobe
C71.3	Malignant neoplasm of parietal lobe
C71.4	Malignant neoplasm of occipital lobe
C71.5	Malignant neoplasm of cerebral ventricle
C71.6	Malignant neoplasm of cerebellum
C71.7	Malignant neoplasm of brain stem
C71.8	Malignant neoplasm of overlapping sites of brain
C79.31	Secondary malignant neoplasm of brain
C79.49	Secondary malignant neoplasm of other parts of nervous system
Z51.11	Encounter for antineoplastic chemotherapy

Associated HCPCS Codes

Q0083	Chemotherapy administration by other than infusion technique only (e.g., subcutaneous, intramuscular, push), per visit
Q0084	Chemotherapy administration by infusion technique only, per visit
Q0085	Chemotherapy administration by both infusion technique and other technique(s) (e.g. subcutaneous, intramuscular, push), per visit

AMA: **96542** 2018,Jan,8; 2018,Feb,11; 2017,Jan,8; 2016,Jan,13; 2015,Jan,16; 2014,Jan,11

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
96542	0.75	2.89	0.08	3.72
Facility RVU	**Work**	**PE**	**MP**	**Total**
96542	0.75	0.38	0.08	1.21

	FUD	Status	MUE	Modifiers				IOM Reference
96542	N/A	A	1(3)	N/A	N/A	N/A	80*	100-03,110.2; 100-04,4,230.2

* with documentation

Terms To Know

chemotherapy. Treatment of disease, especially cancerous conditions, using chemical agents.

intraventricular space. Fluid-filled areas near the center of the brain that are within the ventricles.

subarachnoid. Space located between the arachnoid membrane and the pia mater that contains cerebrospinal fluid.

1. CPT Codes and Descriptions

This edition of *Coding and Payment Guide for Medical Oncology/Hematology* is updated with CPT codes for year 2022. The following icons are used in the *Coding and Payment Guide*:

- ● This CPT code is new for 2023.
- ▲ This CPT code description is revised for 2023.
- ✚ This CPT code is an add-on code.
- [ ] CPT codes enclosed in brackets are resequenced and may not appear in numerical order.
- ★ This CPT code is identified by CPT as appropriate for telemedicine services

Telehealth Services

Telehealth/Telemedicine services are identified by CPT with the ★ icon at the code level. The Centers for Medicare and Medicaid Services (CMS) identify additional services that may be performed via telehealth. Due to the COVID-19 public health emergency (PHE) some services have been designated as temporarily appropriate for telehealth. These CMS approved services are identified in the coding tips where appropriate. Payers may require telehealth/telemedicine to be reported with place of service 02 Telehealth Provided Other than the Patient's Home or 10 Telehealth Provided in Patient's home and modifier 95 appended. If specialized equipment is used at the originating site code Q3014 may be reported. Individual payers should be contacted for additional or different guidelines regarding telehealth/telemedicine services. Documentation should include the type of technology used for the treatment in addition to the patient evaluation, treatment, and consents.

Add-on Codes

Add-on codes are not subject to bilateral or multiple procedure rules, reimbursement reduction, or appending modifier 50 or 51. Add-on codes describe additional intraservice work associated with the primary procedure performed by the same provider on the same date of service and are not reported as stand-alone procedures. Add-on codes for procedures performed on bilateral structures are reported by listing the add-on code twice.

2. Explanation

Every CPT code or series of similar codes is presented with its official CPT code description. However, sometimes these descriptions do not provide the coder with sufficient information to make a proper code selection. In *Coding and Payment Guide for Medical Oncology/Hematology*, a step-by-step clinical description of the procedure is provided, in simple terms. Technical language that might be used by the medical or radiation oncologist is included and defined. *Coding and Payment Guide for Medical Oncology/Hematology* describes the most common treatments.

3. Coding Tips

Coding tips provide information on how the code should be used, provide related procedure codes, and offer help concerning common billing errors and modifier usage. This information comes from consultants and subject matter experts at Optum360 and from the coding guidelines provided in the CPT book and by the Centers for Medicare and Medicaid Services (CMS).

4. Documentation Tips

Documentation tips provide code-specific tips to the coder regarding the information that should be noted in the documentation in order to support code assignment.

5. Reimbursement Tips

Reimbursement tips offer Medicare and other payer guidelines that could affect the reimbursement of this service or procedure.

6. ICD-10-CM Diagnostic Codes

ICD-10-CM diagnostic codes listed are common diagnoses or reasons the procedure may be necessary. This list in most cases is inclusive to the specialty. Some ICD-10-CM codes are further identified with the following icons:

- 🅽 Newborn: 0
- 🅿 Pediatric: 0-17
- Ⓜ Maternity: 9-64
- 🅰 Adult: 15-124
- ♂ Male only
- ♀ Female Only
- ☑ Laterality

Please note that in some instances, the ICD-10-CM codes for only one side of the body may have been listed with the CPT code. The associated ICD-10-CM codes for the other side and/or bilateral may also be appropriate. Codes that refer to a right or left are identified with the ☑ icon to alert the user to check for laterality. In some cases, not every possible code is listed and the ICD-10-CM book should be referenced for other valid codes.

7. HCPCS Associated Codes

Medicare and some other payers require the use of HCPCS Level II codes and not CPT codes when reporting certain services. The HCPCS codes and their description are displayed in this field. If there is not a HCPCS code for this service, this field will not be displayed.

8. AMA References

The AMA references for *CPT Assistant* are listed by CPT code, with the most recent reference listed first. Generally only the last six years of references are listed.

9. Relative Value Units/Medicare Edits

The 2022 Medicare edits were not available at the time this book went to press. Updated 2022 values will be posted at https://www.optum360coding.com/ProductUpdates/. The 2022 edition password is **CODING22**.

Relative Value Units

In a resource based relative value scale (RBRVS), services are ranked based on the relative costs of the resources required to provide those services as opposed to the average fee for the service, or average prevailing Medicare charge. The Medicare RBRVS defines three distinct components affecting the value of each service or procedure:

- Physician work component, reflecting the physician's time and skill
- Practice expense (PE) component, reflecting the physician's rent, staff, supplies, equipment, and other overhead
- Malpractice (MP) insurance component, reflecting the relative risk or liability associated with the service

There are two groups of RVUs listed for each CPT code. The first RVU group is for nonfacilities, which represents provider services performed in physician offices, patient's homes, or other nonhospital settings. The second RVU group is for facilities, which includes provider services performed in hospitals, ambulatory surgical centers, or skilled nursing facilities.

Medicare Follow-Up Days (FUD)

Information on the Medicare global period is provided here, even though it is not relevant to oncologist or hematologists' coding. These services, then, have a value of 0. The global period includes all the necessary services normally furnished before, during, and after a procedure. This includes preoperative visits after the decision is made to operate and follow-up visits during the postoperative period of the

Procedure Codes

The *Current Procedural Terminology* (CPT®) coding system was developed and is updated annually by the American Medical Association (AMA). The AMA owns and maintains the CPT coding system and publishes updates annually under copyright.

CPT codes predominantly describe medical services and procedures performed by physicians and nonphysician professionals. These codes are classified as Level I of the Healthcare Common Procedure Coding System (HCPCS). Typically, physicians use CPT codes to describe their services. Government studies of patient care evaluate utilization of services by reviewing CPT codes. Because payers may question or deny payment for a CPT code, direct communication is often useful in educating payers about qualified health care provider services and practice standards. Accurate coding also can help an insurer determine coverage eligibility for services provided.

Appropriate Codes for Services and Procedures

The CPT book is divided into six major sections by type of service provided (evaluation and management, anesthesia, surgery, radiology, pathology and laboratory, and medicine). These sections are subdivided primarily by body system.

CPT Symbols

There are several symbols used in the AMA's CPT book:

- A bullet (●) before the code means that the code is new to the CPT coding system in the current year.
- A triangle (▲) before the code means that the code narrative has been revised in the current year.
- The symbols ► ◄ enclose new or revised text other than that contained in the code descriptors.
- The ★ icon means that this CPT code is identified by CPT as appropriate for telemedicine services.
- Codes with a plus (+) symbol are "add-on" codes. Procedures described by "add-on" codes are always performed in addition to the primary procedure and should never be reported alone. This concept is applicable only to procedures or services performed by the same provider to describe any additional intraservice work associated with the primary procedure such as additional digits or lesions.
- The symbol ⃠ designates a code that is exempt from the use of modifier 51 when multiple procedures are performed even though they have not been designated as add-on codes.
- The number (#) symbol indicates that a code is out of numeric order or "resequenced." The AMA employs a numbering methodology of resequencing. According to the AMA there are instances where a new code is needed within an existing grouping of codes and an unused code number is not available. When the existing codes will not be changed or have minimal changes, the AMA will assign a code that is not in numeric sequence with the related codes. However, the code and description will appear in the CPT book with the other related codes.

  To facilitate the code sequence and maintain a sequential relationship according to the description of the codes, the CPT codes in this grouping will be resequenced. Resequencing is the practice of displaying the codes outside of numerical order according to the description relationship.

Modifiers

A system of two-digit modifiers has been developed to allow the provider to indicate that the service or procedure has been altered by certain circumstances or to provide additional information about a procedure that was performed, or a service or supply that was provided. Fee schedules have been developed based on these modifiers.

Addition of the modifier does not alter the basic description for the service, it merely qualifies the circumstances under which the service was provided. Circumstances that modify a service include the following:

- Procedures that have both a technical and professional component were performed
- More than one provider or setting was involved in the service
- Only part of a service was performed
- Unusual events occurred

Note that the CPT book uses the term "physician" when describing how a modifier is to be used. This does not limit the use of the modifiers to physicians; any qualified healthcare professional may use a modifier as long as the service or procedure to be modified can be performed within that practitioner's scope of work. The following is a list of modifiers used most often by the oncologist and hematologist:

22 **Increased Procedural Services.** When the work required to provide a service is substantially greater than typically required, it may be identified by adding modifier 22 to the usual procedure code. Documentation must support the substantial additional work and the reason for the additional work (ie, increased intensity, time, technical difficulty of procedure, severity of patient's condition, physical and mental effort required).

Note: This modifier should not be appended to an E/M service.

25 **Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service.** It may be necessary to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed. A significant or separately identifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M services to be reported (see Evaluation and Management Services Guidelines for instructions or determining level of E/M service). The E/M service may be prompted by the symptom or condition for which the procedure and/or service was provided. As such, different diagnoses are not required for reporting of the E/M service on the same date. This circumstance may be reported by adding modifier 25 to the appropriate level of E/M service.

Note: This modifier is not used to report an E/M service that resulted in a decision to perform surgery. See modifier 57. For significant, separately identifiable non-E/M services, see modifier 59.

26 **Professional Component.** Certain procedures are a combination of a physician or other qualified health care professional component and a technical component. When the physician component is reported separately, the service may be identified by adding modifier 26 to the usual procedure number.

Evaluation and Management Guidelines Common to All E/M Services

Information unique to this section is defined or identified below.

Classification of Evaluation and Management (E/M) Services

The E/M section is divided into broad categories such as office visits, hospital visits, and consultations. Most of the categories are further divided into two or more subcategories of E/M services. For example, there are two subcategories of office visits (new patient and established patient) and there are two subcategories of hospital visits (initial and subsequent). The subcategories of E/M services are further classified into levels of E/M services that are identified by specific codes.

The basic format of the levels of E/M services is the same for most categories. First, a unique code number is listed. Second, the place and/or type of service is specified, eg, office consultation. Third, the content of the service is defined. Fourth, time is specified. (A detailed discussion of time is provided following the Decision Tree for New vs Established Patients.)

Definitions of Commonly Used Terms

Certain key words and phrases are used throughout the E/M section. The following definitions are intended to reduce the potential for differing interpretations and to increase the consistency of reporting by physicians and other qualified health care professionals. The definitions in the E/M section are provided solely for the basis of code selection.

Some definitions are common to all categories of services, and others are specific to one or more categories only.

New and Established Patient

Solely for the purposes of distinguishing between new and established patients, **professional services** are those face-to-face services rendered by physicians and other qualified health care professionals who may report E/M services with a specific CPT® code or codes. A new patient is one who has not received any professional services from the physician/qualified health care professional or another physician/qualified health care professional of the **exact** same specialty **and subspecialty** who belongs to the same group practice, within the past three years.

An established patient is one who has received professional services from the physician/qualified health care professional or another physician/qualified health care professional of the **exact** same specialty **and subspecialty** who belongs to the same group practice, within the past three years. See the decision tree on the following page.

When a physician/qualified health care professional is on call or covering for another physician/qualified health care professional, the patient's encounter is classified as it would have been by the physician/qualified health care professional who is not available. When advanced practice nurses and physician assistants are working with physicians, they are considered as working in the exact same specialty and exact same subspecialties as the physician.

No distinction is made between new and established patients in the emergency department. E/M services in the emergency department category may be reported for any new or established patient who presents for treatment in the emergency department.

The decision tree on the following page is provided to aid in determining whether to report the E/M service provided as a new or an established patient encounter.

Time

The inclusion of time in the definitions of levels of E/M services has been implicit in prior editions of the CPT codebook. The inclusion of time as an explicit factor beginning in CPT 1992 was done to assist in selecting the most appropriate level of E/M services. Beginning with CPT 2021, except for 99211, time alone may be used to select the appropriate code level for the office or other outpatient E/M services codes (99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215). Different categories of services use time differently. It is important to review the instructions for each category.

Time is **not** a descriptive component for the emergency department levels of E/M services because emergency department services are typically provided on a variable intensity basis, often involving multiple encounters with several patients over an extended period of time. Therefore, it is often difficult to provide accurate estimates of the time spent face-to-face with the patient.

Time may be used to select a code level in office or other outpatient services whether or not counseling and/or coordination of care dominates the service. Time may only be used for selecting the level of the **other** E/M services when counseling and/or coordination of care dominates the service.

When time is used for reporting E/M services codes, the time defined in the service descriptors is used for selecting the appropriate level of services. The E/M services for which these guidelines apply require a face-to-face encounter with the physician or other qualified health care professional. For office or other outpatient services, if the physician's or other qualified health care professional's time is spent in the supervision of clinical staff who perform the face-to-face services of the encounter, use 99211.

A shared or split visit is defined as a visit in which a physician and other qualified health care professional(s) jointly provide the face-to-face and non-face-to-face work related to the visit. When time is being used to select the appropriate level of services for which time-based reporting of shared or split visits is allowed, the time personally spent by the physician and other qualified health care professional(s) assessing and managing the patient on the date of the encounter is summed to define total time. Only distinct time should be summed for shared or split visits (ie, when two or more individuals jointly meet with or discuss the patient, only the time of one individual should be counted).

When prolonged time occurs, the appropriate prolonged services code may be reported. The appropriate time should be documented in the medical record when it is used as the basis for code selection.

Face-to-face time (outpatient consultations [99241, 99242, 99243, 99244, 99245], domiciliary, rest home, or custodial services [99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337], home services [99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350], cognitive assessment and care plan services [99483]): For coding purposes, face-to-face time for these services is defined as only that time spent face-to-face with the patient and/or family. This includes the time spent performing such tasks as obtaining a history, examination, and counseling the patient.

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
99211	0.18	0.47	0.01	0.66
99212	0.7	0.88	0.05	1.63
99213	1.3	1.25	0.1	2.65
99214	1.92	1.7	0.14	3.76
99215	2.8	2.24	0.21	5.25
Facility RVU	**Work**	**PE**	**MP**	**Total**
99211	0.18	0.07	0.01	0.26
99212	0.7	0.29	0.05	1.04
99213	1.3	0.55	0.1	1.95
99214	1.92	0.82	0.14	2.88
99215	2.8	1.23	0.21	4.24

	FUD	Status	MUE	Modifiers				IOM Reference
99211	N/A	A	1(3)	N/A	N/A	N/A	80*	None
99212	N/A	A	2(3)	N/A	N/A	N/A	80*	
99213	N/A	A	2(3)	N/A	N/A	N/A	80*	
99214	N/A	A	2(3)	N/A	N/A	N/A	80*	
99215	N/A	A	1(3)	N/A	N/A	N/A	80*	

* with documentation

Terms To Know

established patient. Patient who has received professional services in a face-to-face setting within the last three years from the same physician/qualified health care professional or another physician/qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice. If the patient is seen by a physician/qualified health care professional who is covering for another physician/qualified health care professional, the patient will be considered the same as if seen by the physician/qualified health care professional who is unavailable.

evaluation. Dynamic process in which the dentist makes clinical judgments based on data gathered during the examination.

face to face. Interaction between two parties, usually provider and patient, that occurs in the physical presence of each other.

99217

99217 Observation care discharge day management (This code is to be utilized to report all services provided to a patient on discharge from outpatient hospital "observation status" if the discharge is on other than the initial date of "observation status." To report services to a patient designated as "observation status" or "inpatient status" and discharged on the same date, use the codes for Observation or Inpatient Care Services [including Admission and Discharge Services, 99234-99236 as appropriate.])

Explanation

This code describes the final processes associated with discharging a patient from outpatient hospital observation status and includes a patient exam, a discussion about the hospital stay, instructions for ongoing care, as well as preparing the medical discharge records. Report this code only when the patient has been discharged from observation services on a date other than the initial date of observation care. There are no key components or time estimates associated with this service.

Coding Tips

This code is used to report hospital outpatient observation discharge services. This code includes patient examination, discharge and follow-up care instructions, and preparation of all medical records. Time is not a factor when selecting this E/M service. For patients admitted and discharged from observation or inpatient status on the same date, see 99234-99236; for hospital inpatient discharge services, see 99238-99239. Medicare has provisionally identified this code as a telehealth/telemedicine service. Current Medicare coverage guidelines should be reviewed. Commercial payers should be contacted regarding their coverage guidelines. Telemedicine services may be reported by the performing provider by adding modifier 95 to this procedure code and using the appropriate place of service. Services at the origination site are reported with HCPCS Level II code Q3014.

Documentation Tips

Medicare allows only the medically necessary portion of the 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 of an E/M code. Medical necessity must be clearly stated and support the level of service reported. When a complication associated with a neoplasm, such as dehydration, is the reason for the treatment, the complication is reported as the principal/first listed condition and the neoplasm is reported as an additional code. However, official guidelines indicate that when the admission/encounter is for the management of anemia associated with malignancy and the only treatment is for the anemia, the malignancy is reported as the principal/first listed condition and the anemia is reported additionally.

Reimbursement Tips

The designation of "observation status" refers to the initiation of observation care and not to a specific area of the facility. The patient may be in "observation status" anywhere in the hospital; however, if such an area is available, these codes would be appropriate to report for that area. Report place-of-service code 22 for the outpatient setting. When a separately identifiable E/M service is reported at the same time as another procedure or service, modifier 25 should be appended to the E/M service to indicate the service is distinct from the other service performed.

ICD-10-CM Diagnostic Codes

The application of this code is too broad to adequately present ICD-10-CM diagnostic code links here. Refer to your ICD-10-CM book.

55876

55876 Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), prostate (via needle, any approach), single or multiple

Explanation

The physician places one or more interstitial devices for radiation therapy guidance into the prostate via needle, using various approaches. In one method, the patient is placed in the lithotomy position. Under guidance from a transrectal ultrasound wand, the physician injects a small capsule into the tissue of the prostate using a percutaneous needle injection device. The capsule allows for precision in targeting radiation and/or for measuring the radiation doses received. An injected capsule fiducial marker is visible by ultrasound and fluoroscopy, allowing for an accurate triangulation of the tissue to be treated. An injected capsule dosimeter relays radiation dose information so that the clinical team can monitor for any deviation between the radiation plan and the actual radiation received by the patient. The inserted capsule may act as a fiducial marker, dosimeter, or, in many cases, will serve in both roles. This code reports the needle insertion of one or more of these devices into the patient's prostate during a single surgical session.

Coding Tips

For transperineal placement of needles or catheters into the prostate for interstitial radioelement applications, with or without cystoscopy, see 55875. For imaging guidance used for placement of the device, see 76942, 77002, 77012, and 77021. The interstitial device is reported separately using the appropriate HCPCS Level II supply code. Placement of needles or catheters into pelvic organs and/or genitalia other than prostate for interstitial radioelement application is reported using code 55920.

Documentation Tips

When documenting neoplasm conditions, indicate the morphology (i.e., benign, malignant, uncertain), the specific type of the disease, the anatomical location including laterality, and if primary or secondary (metastatic).

Reimbursement Tips

When 55876 is performed with another separately identifiable procedure, the highest dollar value code is listed as the primary procedure and subsequent procedures are appended with modifier 51.

ICD-10-CM Diagnostic Codes

C61	Malignant neoplasm of prostate ♂
C79.82	Secondary malignant neoplasm of genital organs
D07.5	Carcinoma in situ of prostate ♂
D40.0	Neoplasm of uncertain behavior of prostate ♂

AMA: **55876** 2018,Jan,8; 2017,Jan,8; 2016,Jun,3; 2016,Jan,13; 2015,Jan,16

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
55876	1.73	2.48	0.17	4.38
Facility RVU	**Work**	**PE**	**MP**	**Total**
55876	1.73	1.02	0.17	2.92

	FUD	Status	MUE	Modifiers				IOM Reference
55876	0	A	1(2)	51	N/A	62*	N/A	None

* with documentation

55920

55920 Placement of needles or catheters into pelvic organs and/or genitalia (except prostate) for subsequent interstitial radioelement application

Explanation

The physician places needles or catheters into the pelvic organs and/or genitalia, excluding the prostate, for subsequent interstitial radioelement application. The radioactive isotopes that are introduced subsequently, such as iodine-125 or palladium-103, are contained within tiny seeds that are left in place to deliver radiation over a period of months. They do not cause any harm after becoming inert. This method provides radiation to the prescribed body area while minimizing exposure to normal tissue.

Coding Tips

For transperineal placement of needles or catheters into the prostate for interstitial radioelement application, with or without cystoscopy, see 55875. For placement of interstitial device(s) for radiation therapy guidance including dosimeter or fiducial markers, into the prostate, single or multiple, any approach, see 55876. For insertion of uterine tandems and/or vaginal ovoids for clinical brachytherapy, see 57155. For insertion of Heyman capsules for clinical brachytherapy, see 58346.

Documentation Tips

When documenting neoplasm conditions, indicate the morphology (i.e., benign, malignant, uncertain), the specific type of the disease, the anatomical location including laterality, and if primary or secondary (metastatic).

ICD-10-CM Diagnostic Codes

C20	Malignant neoplasm of rectum
C21.1	Malignant neoplasm of anal canal
C21.2	Malignant neoplasm of cloacogenic zone
C49.A3	Gastrointestinal stromal tumor of small intestine
C49.A5	Gastrointestinal stromal tumor of rectum
C51.0	Malignant neoplasm of labium majus ♀
C51.1	Malignant neoplasm of labium minus ♀
C51.2	Malignant neoplasm of clitoris ♀
C52	Malignant neoplasm of vagina ♀
C53.0	Malignant neoplasm of endocervix ♀
C53.1	Malignant neoplasm of exocervix ♀
C54.0	Malignant neoplasm of isthmus uteri ♀
C54.1	Malignant neoplasm of endometrium ♀
C54.2	Malignant neoplasm of myometrium ♀
C54.3	Malignant neoplasm of fundus uteri ♀
C56.1	Malignant neoplasm of right ovary ♀ ☑
C56.2	Malignant neoplasm of left ovary ♀ ☑
C56.3	Malignant neoplasm of bilateral ovaries ♀ ☑
C57.01	Malignant neoplasm of right fallopian tube ♀ ☑
C57.02	Malignant neoplasm of left fallopian tube ♀ ☑
C57.11	Malignant neoplasm of right broad ligament ♀ ☑
C57.12	Malignant neoplasm of left broad ligament ♀ ☑
C57.21	Malignant neoplasm of right round ligament ♀ ☑
C57.22	Malignant neoplasm of left round ligament ♀ ☑
C57.3	Malignant neoplasm of parametrium ♀
C58	Malignant neoplasm of placenta Ⓜ ♀
C60.0	Malignant neoplasm of prepuce ♂

77402-77412

77402 Radiation treatment delivery, => 1 MeV; simple

77407 intermediate

77412 complex

Explanation

Radiation treatment delivery involves the delivery of a beam of radioactive electromagnetic energy onto cancerous cells within the body from a treatment machine distanced from the treatment area. External radiation is often delivered by linear accelerator (also called LINAC), which can deliver x-rays (photon radiation) or electrons (particle radiation) to a targeted area. Cobalt teletherapy units and cesium teletherapy units are also used to direct gamma rays from a distance to the targeted area. Photons can target deeper lying tumor tissue, while electrons are used for the maximum dose of radiation near the skin surface, making the method suitable to treat skin, superficial lesions, and shallow tumor volumes where underlying tissues need to be protected. Report 77402 for simple treatment delivery of a single treatment area using one to two ports and two or less simple blocks; 77407 for intermediate treatment delivery for two distinct treatment areas using three or more ports for a single treatment area or three or more simple blocks; and 77412 for complex treatment delivery to three or more distinct treatment areas with custom-made blocks, tangential ports, wedges, rotating beams, and field-within-field or other compensation not meeting IMRT or electron beam treatment parameters.

Coding Tips

Radiation treatment delivery is only part of a series of services or procedures performed on a patient receiving radiation therapy. Clinical treatment planning, simulation-aided field setting, medical radiation physics, design and construction of treatment devices, and treatment management are billed separately in addition to this code. Do not report these codes with 77373. Medicare and some other payers may require HCPCS Level II codes as shown below:

CPT > HCPCS

77402 > G6003, G6004, G6005, or G6006

77407 > G6007, G6008, G6009, or G6010

77412 > G6011, G6012, G6013, or G6014

A hospital off-campus provider-based department (PBD) submitting claims for non-excepted radiation treatment delivery services must report HCPCS Level II codes G6003–G6014.

Facility reporting: Hospitals should not report weekly treatment management services (77427, 77431, and 77432); instead, radiation treatment delivery is reported using 77371–77373, 77401–77402, 77407, 77412, and 77423–77425.

Reimbursement Tips

These codes do not have a technical and professional component and should only be billed as a complete service. Preauthorization of these services may be required. Check with the specific payer to determine benefits specific to cancer treatment, as well as with the patient regarding any supplementary cancer policies.

ICD-10-CM Diagnostic Codes

This code is associated with general malignancies and associated codes are too numerous to list here. Refer to the ICD-10-CM Neoplasm section.

Associated HCPCS Codes

G6003 Radiation treatment delivery, single treatment area, single port or parallel opposed ports, simple blocks or no blocks: up to 5 mev

G6004 Radiation treatment delivery, single treatment area, single port or parallel opposed ports, simple blocks or no blocks: 6-10 mev

G6005 Radiation treatment delivery, single treatment area, single port or parallel opposed ports, simple blocks or no blocks: 11-19 mev

G6006 Radiation treatment delivery, single treatment area, single port or parallel opposed ports, simple blocks or no blocks: 20 mev or greater

G6007 Radiation treatment delivery, two separate treatment areas, three or more ports on a single treatment area, use of multiple blocks: up to 5 mev

G6008 Radiation treatment delivery, two separate treatment areas, three or more ports on a single treatment area, use of multiple blocks: 6-10 mev

G6009 Radiation treatment delivery, two separate treatment areas, three or more ports on a single treatment area, use of multiple blocks: 11-19 mev

G6010 Radiation treatment delivery, two separate treatment areas, three or more ports on a single treatment area, use of multiple blocks: 20 mev or greater

G6011 Radiation treatment delivery, three or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, electron beam; up to 5 mev

G6012 Radiation treatment delivery, three or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, electron beam; 6-10 mev

G6013 Radiation treatment delivery, three or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, electron beam; 11-19 mev

G6014 Radiation treatment delivery, three or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, electron beam; 20 mev or greater

AMA: **77402** 2018,Jan,8; 2017,Jan,8; 2016,Mar,7; 2016,Jun,9; 2016,Jan,13; 2016,Feb,3; 2015,Jan,16; 2015,Dec,14 **77407** 2018,Jan,8; 2017,Jan,8; 2016,Mar,7; 2016,Jun,9; 2016,Jan,13; 2016,Feb,3; 2015,Jan,16; 2015,Dec,14 **77412** 2018,Jan,8; 2017,Jan,8; 2016,Mar,7; 2016,Jun,9; 2016,Jan,13; 2016,Feb,3; 2015,Jan,16; 2015,Dec,14

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
77402	0.0	0.0	0.0	0.0
77407	0.0	0.0	0.0	0.0
77412	0.0	0.0	0.0	0.0
Facility RVU	**Work**	**PE**	**MP**	**Total**
77402	0.0	0.0	0.0	0.0
77407	0.0	0.0	0.0	0.0
77412	0.0	0.0	0.0	0.0

	FUD	Status	MUE	Modifiers				IOM Reference
77402	N/A	I	2(3)	N/A	N/A	N/A	80*	100-04,13,70.1
77407	N/A	I	2(3)	N/A	N/A	N/A	80*	
77412	N/A	I	2(3)	N/A	N/A	N/A	80*	

* with documentation

96413-96415

96413 Chemotherapy administration, intravenous infusion technique; up to 1 hour, single or initial substance/drug

\+ **96415** each additional hour (List separately in addition to code for primary procedure)

Explanation

The physician or supervised assistant prepares and administers a chemotherapeutic medication to combat malignant neoplasms or microorganisms. These codes describe infusions through catheter tubing placed in a vein. Report 96413 for a single or the initial substance given for up to one hour of service. Report 96415 for each additional hour of service beyond the initial hour.

Coding Tips

Only one initial infusion may be reported for the same date of service regardless of the number of substances administered unless protocol indicates that two separate IV sites must be used. Do not report two initial infusion codes in the case of restarting an IV or port access of indwelling multilumen catheters.

The following services are performed in the infusion or injection procedure and should not be reported separately:

- Administration of local anesthetic
- Initiation of the IV
- Access to indwelling IV, subcutaneous catheter or port
- Flush at beginning or conclusion of infusion
- Standard supplies

Only one hour of hydration is reported regardless of the number of hours administered when provided in conjunction with chemotherapy.

For the declotting of a catheter or port, see 36593. To identify therapeutic prophylactic or diagnostic drugs by infusion or injection, see codes 96367 and 96375 when administered as a secondary or subsequent service in conjunction with 96413 through the same IV access site.

When the encounter is solely for the administration of chemotherapy, immunotherapy, or radiation therapy, assign the appropriate code from category Z51 Encounter for other aftercare and medical care, as the principal or first-listed diagnosis. The specific malignancy code is assigned and reported as an additional condition.

When the medical record documentation clearly identifies that it is medically necessary to separates a substance into two doses (i.e., two injections or infusion in different sites), it is appropriate to code both doses with modifier 59 or the appropriate X [E, S, P, U] modifier. The preparation of chemotherapy agent(s) is included in the service for administration of the agent and is not reported as a separate service.

Drugs used when providing this procedure may be reported with the appropriate HCPCS Level II code. Verify the appropriate dosing requirements and units of service. Check with the specific payer to determine coverage.

Documentation Tips

Stop and start times should be clearly identified and notated in the medical record with as much specificity as possible including total amount of time calculated. Reporting only the total time is insufficient to determine correct reporting and sequencing.

These services are considered highly complex and require direct physician supervision for any or all purposes of patient assessment, provision of consent, safety oversight and intraservice supervision of staff. Documentation should include the direct supervision as well as special considerations for preparation, dosage or disposal, frequent monitoring, and any complications that occur. Chemotherapy and other highly complex drugs or biologic agent administration involves advanced practice training and competency for all staff members involved in providing these services due to the significant degree of patient risk and ongoing monitoring involved with administering these medications.

Review the documentation to verify the route of administration. Intramuscular injections will note an injection site deep into a muscle in the arm, thigh, or buttock. Subcutaneous injections will be performed just under the skin.

Reimbursement Tips

As an add-on code, 96415 is not subject to multiple procedure rules. No reimbursement reduction or modifier 51 is applied. Add-on codes describe additional intraservice work associated with the primary procedure. They are performed by the same physician on the same date of service as the primary service/procedure, and must never be reported as a stand-alone code. Code 96415 is to be reported with 96413.

Code 96415 is reported for infusion intervals exceeding 30 minutes beyond one hour increments.

Preauthorization of these services may be required. Check with the specific payer to determine benefits specific to cancer treatment, as well as with the patient regarding any supplementary cancer policies.

ICD-10-CM Diagnostic Codes

This code is associated with general malignancies and associated codes are too numerous to list here. Refer to the ICD-10-CM Neoplasm section.

AMA: **96413** 2018,Jan,8; 2018,Feb,11; 2017,Jan,8; 2016,Jan,13; 2015,Jan,16
96415 2018,Jan,8; 2018,Feb,11; 2017,Jan,8; 2016,Jan,13; 2015,Jan,16

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
96413	0.28	3.88	0.09	4.25
96415	0.19	0.69	0.02	0.9
Facility RVU	**Work**	**PE**	**MP**	**Total**
96413	0.28	3.88	0.09	4.25
96415	0.19	0.69	0.02	0.9

	FUD	Status	MUE	Modifiers				IOM Reference
96413	N/A	A	1(3)	N/A	N/A	N/A	80*	100-03,110.2; 100-03,110.6; 100-04,4,230.2
96415	N/A	A	8(3)	N/A	N/A	N/A	80*	

* with documentation

Terms To Know

infusion. Introduction of a therapeutic fluid, other than blood, into the bloodstream.

intravenous. Within a vein or veins.

Neoplasm Table

Note: The list below gives the code number for neoplasms by anatomical site. For each site there are six possible code numbers according to whether the neoplasm in question is malignant, benign, in situ, of uncertain behavior, or of unspecified nature. The description of the neoplasm will often indicate which of the six columns is appropriate; e.g., malignant melanoma of skin, benign fibroadenoma of breast, carcinoma in situ of cervix uteri. Where such descriptors are not present, the remainder of the Index should be consulted where guidance is given to the appropriate column for each morphological (histological) variety listed; e.g., Mesonephroma – see Neoplasm, malignant; Embryoma — see also Neoplasm, uncertain behavior; Disease, Bowen's – see Neoplasm, skin, in situ. However, the guidance in the Index can be overridden if one of the descriptors mentioned above is present; e.g., malignant adenoma of colon is coded to C18.9 and not to D12.6 as the adjective "malignant" overrides the Index entry "Adenoma — *see also* Neoplasm, benign, by site." Codes listed with a dash -, following the code have a required additional character for laterality. The tabular list must be reviewed for the complete code.

	Malignant Primary	Malignant Secondary	Ca in situ	Benign	Uncertain Behavior	Unspecified Behavior
Neoplasm, neoplastic	C80.1	C79.9	D09.9	D36.9	D48.9	D49.9
abdomen, abdominal	C76.2	C79.8-☑	D09.8	D36.7	D48.7	D49.89
cavity	C76.2	C79.8-☑	D09.8	D36.7	D48.7	D49.89
organ	C76.2	C79.8-☑	D09.8	D36.7	D48.7	D49.89
viscera	C76.2	C79.8-☑	D09.8	D36.7	D48.7	D49.89
wall — *see also* Neoplasm, abdomen, wall, skin	C44.509	C79.2	D04.5	D23.5	D48.5	D49.2
connective tissue	C49.4	C79.8-☑	—	D21.4	D48.1	D49.2
skin	C44.509	—	—	—	—	—
basal cell carcinoma	C44.519	—	—	—	—	—
specified type NEC	C44.599	—	—	—	—	—
squamous cell carcinoma	C44.529	—	—	—	—	—
abdominopelvic	C76.8	C79.8-☑	—	D36.7	D48.7	D49.89
accessory sinus — *see* Neoplasm, sinus						
acoustic nerve	C72.4-☑	C79.49	—	D33.3	D43.3	D49.7
adenoid (pharynx) (tissue)	C11.1	C79.89	D00.08	D10.6	D37.05	D49.0
adipose tissue — *see also* Neoplasm, connective tissue	C49.4	C79.89	—	D21.9	D48.1	D49.2
adnexa (uterine)	C57.4	C79.89	D07.39	D28.7	D39.8	D49.59
adrenal	C74.9-☑	C79.7-☑	D09.3	D35.0-☑	D44.1-☑	D49.7
capsule	C74.9-☑	C79.7-☑	D09.3	D35.0-☑	D44.1-☑	D49.7
cortex	C74.0-☑	C79.7-☑	D09.3	D35.0-☑	D44.1-☑	D49.7
gland	C74.9-☑	C79.7-☑	D09.3	D35.0-☑	D44.1-☑	D49.7
medulla	C74.1-☑	C79.7-☑	D09.3	D35.0-☑	D44.1-☑	D49.7
ala nasi (external) — *see also* Neoplasm, skin, nose	C44.301	C79.2	D04.39	D23.39	D48.5	D49.2
alimentary canal or tract NEC	C26.9	C78.80	D01.9	D13.9	D37.9	D49.0
alveolar	C03.9	C79.89	D00.03	D10.39	D37.09	D49.0
mucosa	C03.9	C79.89	D00.03	D10.39	D37.09	D49.0
lower	C03.1	C79.89	D00.03	D10.39	D37.09	D49.0
upper	C03.0	C79.89	D00.03	D10.39	D37.09	D49.0
ridge or process	C41.1	C79.51	—	D16.5	D48.0	D49.2
carcinoma	C03.9	C79.8-☑	—	—	—	—
lower	C03.1	C79.8-☑	—	—	—	—
upper	C03.0	C79.8-☑	—	—	—	—
lower	C41.1	C79.51	—	D16.5	D48.0	D49.2
mucosa	C03.9	C79.89	D00.03	D10.39	D37.09	D49.0
lower	C03.1	C79.89	D00.03	D10.39	D37.09	D49.0
upper	C03.0	C79.89	D00.03	D10.39	D37.09	D49.0
upper	C41.0	C79.51	—	D16.4	D48.0	D49.2
sulcus	C06.1	C79.89	D00.02	D10.39	D37.09	D49.0
alveolus	C03.9	C79.89	D00.03	D10.39	D37.09	D49.0
lower	C03.1	C79.89	D00.03	D10.39	D37.09	D49.0
upper	C03.0	C79.89	D00.03	D10.39	D37.09	D49.0
ampulla of Vater	C24.1	C78.89	D01.5	D13.5	D37.6	D49.0
ankle NEC	C76.5-☑	C79.89	D04.7-☑	D36.7	D48.7	D49.89
anorectum, anorectal (junction)	C21.8	C78.5	D01.3	D12.9	D37.8	D49.0
antecubital fossa or space	C76.4-☑	C79.89	D04.6-☑	D36.7	D48.7	D49.89
antrum (Highmore) (maxillary)	C31.0	C78.39	D02.3	D14.0	D38.5	D49.1
pyloric	C16.3	C78.89	D00.2	D13.1	D37.1	D49.0
tympanicum	C30.1	C78.39	D02.3	D14.0	D38.5	D49.1
anus, anal	C21.0	C78.5	D01.3	D12.9	D37.8	D49.0
canal	C21.1	C78.5	D01.3	D12.9	D37.8	D49.0
cloacogenic zone	C21.2	C78.5	D01.3	D12.9	D37.8	D49.0
margin — *see also* Neoplasm, anus, skin	C44.500	C79.2	D04.5	D23.5	D48.5	D49.2
overlapping lesion with rectosigmoid junction or rectum	C21.8	—	—	—	—	—
skin	C44.500	C79.2	D04.5	D23.5	D48.5	D49.2
basal cell carcinoma	C44.510	—	—	—	—	—
specified type NEC	C44.590	—	—	—	—	—
squamous cell carcinoma	C44.520	—	—	—	—	—
sphincter	C21.1	C78.5	D01.3	D12.9	D37.8	D49.0
aorta (thoracic)	C49.3	C79.89	—	D21.3	D48.1	D49.2
abdominal	C49.4	C79.89	—	D21.4	D48.1	D49.2
aortic body	C75.5	C79.89	—	D35.6	D44.7	D49.7
aponeurosis	C49.9	C79.89	—	D21.9	D48.1	D49.2
palmar	C49.1-☑	C79.89	—	D21.1-☑	D48.1	D49.2
plantar	C49.2-☑	C79.89	—	D21.2-☑	D48.1	D49.2
appendix	C18.1	C78.5	D01.0	D12.1	D37.3	D49.0
arachnoid	C70.9	C79.49	—	D32.9	D42.9	D49.7
cerebral	C70.0	C79.32	—	D32.0	D42.0	D49.7
spinal	C70.1	C79.49	—	D32.1	D42.1	D49.7
areola	C50.0-☑	C79.81	D05-☑	D24-☑	D48.6-☑	D49.3
arm NEC	C76.4-☑	C79.89	D04.6-☑	D36.7	D48.7	D49.89
artery — *see* Neoplasm, connective tissue						
aryepiglottic fold	C13.1	C79.89	D00.08	D10.7	D37.05	D49.0
hypopharyngeal aspect	C13.1	C79.89	D00.08	D10.7	D37.05	D49.0
laryngeal aspect	C32.1	C78.39	D02.0	D14.1	D38.0	D49.1
marginal zone	C13.1	C79.89	D00.08	D10.7	D37.05	D49.0
arytenoid (cartilage)	C32.3	C78.39	D02.0	D14.1	D38.0	D49.1
fold — *see* Neoplasm, aryepiglottic						
associated with transplanted organ	C80.2	—	—	—	—	—
atlas	C41.2	C79.51	—	D16.6	D48.0	D49.2
atrium, cardiac	C38.0	C79.89	—	D15.1	D48.7	D49.89
auditory canal (external) (skin)	C44.20-☑	C79.2	D04.2-☑	D23.2-☑	D48.5	D49.2
internal	C30.1	C78.39	D02.3	D14.0	D38.5	D49.1
nerve	C72.4-☑	C79.49	—	D33.3	D43.3	D49.7
tube	C30.1	C78.39	D02.3	D14.0	D38.5	D49.1
opening	C11.2	C79.89	D00.08	D10.6	D37.05	D49.0
auricle, ear — *see also* Neoplasm, skin, ear	C44.20-☑	C79.2	D04.2-☑	D23.2-☑	D48.5	D49.2
auricular canal (external) — *see also* Neoplasm, skin, ear	C44.20-☑	C79.2	D04.2-☑	D23.2-☑	D48.5	D49.2
internal	C30.1	C78.39	D02.3	D14.0	D38.5	D49.2
autonomic nerve or nervous system NEC (see Neoplasm, nerve, peripheral)						

HCPCS Level II Definitions and Guidelines

Structure and Use of HCPCS Level II

Codes

The main terms are in boldface type in the index. Main term entries include tests, services, supplies, orthotics, prostheses, medical equipment, drugs, therapies, and some medical and surgical procedures. Where possible, entries are listed under a common main term. In some instances, the common term is a noun; in others, the main term is a descriptor.

HCPCS Level II Codes: Sections A–V

Level II codes consist of one alphabetic character (letters A through V) and four numbers. Similar to CPT codes, they also can have modifiers, which can be alphanumeric or two letters. National modifiers can be used with all levels of HCPCS codes.

J Codes - Drugs

The table starting on this page identifies J codes common to medications/drugs used in oncology. They are usually injected/infused, but can be administered orally. They are generally not self-administered.

The Conventions: Symbols and Modifiers

Symbols used in the HCPCS Level II coding system may be presented in various ways, depending on the vendor. In this publication, the pattern established by the AMA in the CPT code book is followed. For example, bullets and triangles signify new and revised codes, respectively.

When a code is new to the HCPCS Level II system, a bullet (●) appears to the left of the code. This symbol is consistent with the CPT coding system's symbol for new codes. The bullet represents a code never before seen in the HCPCS coding system.

Example

● J9223 Injection, lurbinectedin, 0.1 mg

A triangle(s) is used (as in the CPT coding system) to indicate that a change in the narrative of a code has been made from the previous year's edition. The change made may be slight or significant, but it usually changes the application of the code.

Example

▲ J7189 Factor viia (antihemophilic factor, recombinant), (novoseven rt), 1 microgram

In certain circumstances, modifiers must be used to report the alteration of a procedure or service or to furnish additional information about the service, supply, or procedure that was provided. In the HCPCS Level I (CPT) coding system, modifiers are two-digit suffixes that usually directly follow the five-digit procedure or service code. In HCPCS Level II, modifiers are composed of two alpha or alphanumeric characters that range from AA to VP.

HCPCS Code	Generic Name	Brand Name	FDA Approved Usage
J0185	Aprepitant, injection, 1 mg	Emend	Nausea and vomiting associated with chemotherapy
J8501	Aprepitant, oral, 5 mg	Emend	Nausea and vomiting associated with chemotherapy
J8597	Antiemetic drug, oral, not otherwise specified		
J9030	BCG live intravesical instillation, 1 mg	Tice BCG, PACIS BCG, TheraCys	Used in a solution to stimulate the immune system in the treatment of bladder cancer
J8510	Busulfan; oral, 2 mg	Busulfex, Myleran	Chronic myelogenic leukemia
J8515	Cabergoline, oral, 0.25 mg	Dostinex	Hyperprolacteria
J8520	Capecitabine, oral, 150 mg	Xeloda	Breast, colorectal cancer
J8521	Capecitabine, oral, 500 mg	Xeloda	Breast, colorectal cancer
J9070	Cyclophosphamide, 100 mg	cytoxan, Endoxan-Asta	Acute lymphoblastic leukemia, acute myeloid leukemia, breast cancer, chronic lymphocytic leukemia, chronic myelogenous leukemia, hodgkin lymphoma, muyeliptle myeloma, mycosis fungoides, neuoblastoma, non-Hodgkin lymphoma, ovarian cancer
J8530	Cyclophosphamide, oral, 25 mg	cytoxan	Acute lymphoblastic leukemia, acute myeloid leukemia, breast cancer, chronic lymphocytic leukemia, chronic myelogenous leukemia, hodgkin lymphoma, muyeliptle myeloma, mycosis fungoides, neuoblastoma, non-Hodgkin lymphoma, ovarian cancer
J9130	Dacarbazine, 100 mg	DTIC-Dome	Hodgkin lymphoma, melanoma

G6016

G6016 Compensator-based beam modulation treatment delivery of inverse planned treatment using three or more high resolution (milled or cast) compensator, convergent beam modulated fields, per treatment session

Explanation

Compensator-based beam modulation treatment delivery of inversed planned treatment using three or more high-resolution (milled or cast) compensator convergent beam modulated fields is a method of delivering intensity modulated radiation therapy (IMRT). Prior to treatment delivery, a computerized planning system is used to calculate dose by inverse treatment planning method for IMRT optimization. The planner chooses beam angles and writes a prescription for targets identifying critical structures. The computerized planning system optimizes beam weights and modulation patterns and generates files for milling or casting of the required high-resolution compensators that are fabricated as prescribed and planned. During treatment delivery, solid filters modulate the beams. This code represents one treatment session.

Coding Tips

Intensity modulated treatment delivery is only part of a series of services/procedures performed on a patient receiving radiation therapy. Clinical treatment planning, simulation-aided field setting, medical radiation physics, treatment delivery, and treatment management are services/procedures that will be billed separately in addition to these codes.

Documentation Tips

Most third-party payers require that the medical record documentation for IMRT planning and delivery contain:

- The treatment plan defines the goals and requirements of the treatment, including the specific dose constraints for the target(s) and nearby critical structures.
- The treating physician's documentation includes the special need for performing IMRT on the patient, rather than performing conventional or three-dimensional treatment planning and delivery. The other organs at risk or adjacent critical structures must be identified.
- Review (signed and dated) by the radiation oncologist of the CT and/or MRI images of the target and all critical structures with representative isodose distributions that characterize the three-dimensional dose.
- Review by the radiation oncologist of dose-volume histograms for all targets and critical structures.
- A description of the number and location of each treatment step/rotation or portal to accomplish the treatment plan is recorded.
- Documentation of dosimetric verification of treatment setup and delivery, signed by both the radiation oncologist and the medical physicist.
- The unique compensator design should be documented for each step or portal for compensator-based IMRT.
- Documentation of fluence distributions recomputed in a phantom, or an equivalent methodology consistent with patient specific IMRT treatment verification must be recorded.
- The documentation must include the target verification methodology (including clinical treatment volume (CTV) and the planning target volume (PTV)) as well as documentation of immobilization and patient positioning, and means of dose verification and secondary means of verification.
- Documentation of any other procedures performed during the episode of care including the professional and technical components by identifying the place of service, the date of service, the supervising physician, and proof of work provided.

Reimbursement Tips

Preauthorization of these services may be required. Check with the specific payer to determine benefits specific to cancer treatment, as well as with the patient regarding any supplementary cancer policies.

ICD-10-CM Diagnostic Codes

This code is associated with general malignancies and associated codes are too numerous to list here. Refer to the ICD-10-CM Neoplasm section.

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
G6016	0.0	11.01	0.01	11.02
Facility RVU	**Work**	**PE**	**MP**	**Total**
G6016	0.0	11.01	0.01	11.02

	FUD	Status	MUE	Modifiers				IOM Reference
G6016	N/A	A	2(3)	N/A	N/A	N/A	80*	None

* with documentation

Terms To Know

IMRT. Intensity modulated radiation therapy. External beam radiation therapy delivery using computer planning to specify the target dose and to modulate the radiation intensity, usually as a treatment for a malignancy. The delivery system approaches the patient from multiple angles, minimizing damage to normal tissue.

radiotherapy. External source of high-energy rays (x-rays or gamma rays) or internally implanted radioactive substances used in destroying tissue and stopping the growth of malignant cells.