

Table of Contents

1.0	Description of the Procedure	1
2.0	Eligible Recipients	1
2.1	General Provisions	1
2.2	EPSDT Special Provision: Exception to Policy Limitations for Recipients under 21 Years of Age	2
3.0	When the Procedure, Product, or Service Is Covered	2
3.1	General Criteria	3
3.2	Specific Criteria	3
4.0	When the Procedure, Product, or Service Is Not Covered	4
4.1	General Criteria	4
4.2	Specific Criteria	4
4.3	Treatment Management	5
5.0	Requirements for and Limitations on Coverage	7
5.1	Prior Approval	7
5.2	Radiation Treatment Management	7
5.2.1	CPT Code 77427	7
5.2.2	CPT Code 77431	8
5.2.3	CPT Code 77432	8
5.2.4	CPT Code 77435	8
5.2.5	CPT Code 77470	9
5.3	Radiation Treatment Delivery	9
5.4	Therapeutic Radiology Port Film	9
6.0	Providers Eligible to Bill for the Procedure, Product, or Service	9
7.0	Additional Requirements	9
7.1	Compliance	9
7.2	Medical Record Documentation	10
8.0	Policy Implementation/Revision Information	10
Attachment A:	Claims-Related Information	11
A.	Claim Type	11
B.	Diagnosis Codes	11
B.1	Stereotactic Radiation Therapy Procedures—Exclusions	11
C.	Procedure Codes Covered	12
C.1	Clinical Treatment Planning	12
C.2	Medical Radiation Physics, Dosimetry, Treatment Devices, and Special Services	13
C.3	Stereotactic Radiation Treatment Delivery	13
C.4	Radiation Treatment Delivery	14
C.5	Radiation Treatment Management	14

C.6	Hyperthermia	15
C.7	Clinical Brachytherapy	15
C.8	Computed Tomography Guidance	16
D.	Modifiers.....	16
E.	Billing Units.....	16
F.	Place of Service	16
G.	Co-payments	16
H.	Reimbursement	16

1.0 Description of the Procedure

Radiation oncology is the specialty of medicine that utilizes high-energy ionizing radiation in the treatment of malignant neoplasms and certain non-malignant conditions. Radiation therapy is a modality. It is a complex process involving trained personnel who carry out a variety of interrelated activities, including clinical evaluation, establishing treatment goals, treatment planning, simulation of treatment, treatment aids, physics, patient evaluation during treatment, and follow-up evaluation. Radiation *treatment delivery* codes recognize both the technical component and the various energy levels administered. Radiation *therapy management* codes represent the professional services of the physician managing a course of radiation therapy. Radiation oncology may include any of the following:

- a. External beam radiotherapy, the most frequently used form of radiotherapy, uses a machine to aim high-energy rays at the cancer from outside of the body.
- b. Brachytherapy is a procedure in which small encapsulated radioactive elements (“seeds” or “sources”) are placed in or near the tumor or target tissue. They emit a relatively high dose of radiation to the tumor and a considerably lower dose to normal surrounding tissue.
- c. Hyperthermia treatments, in which body tissue is exposed to high temperatures to damage and kill cancer cells or to make cancer cells more sensitive to the effects of radiation and certain anticancer drugs, include external (superficial and deep), interstitial, and intracavitary types. Hyperthermia is used only as an adjunct to radiation therapy or chemotherapy.
- d. Stereotactic radiosurgery (SRS) is a technique for delivering a dose of radiation to a specific target while delivering a minimal dose to surrounding tissues. SRS refers to treatment of intracranial lesions. Stereotactic body radiation therapy (SBRT) refers to treatment of the spine and other anatomical sites.
- e. Intensity Modulated Radiation Therapy (IMRT) is an advanced mode of high-precision radiotherapy that utilizes computer-controlled x-ray accelerators to deliver precise radiation doses to a defined, specific area. IMRT allows the radiation dose to conform to the 3-dimensional shape of the tumor by controlling or modulating the intensity of the beam. This is crucial in terms of normal tissue sparing.
- f. Image-Guided Radiation Therapy (IGRT) is a process of using various imaging techniques to locate a tumor target prior to the actual radiation treatment on a daily basis. This process improves treatment accuracy on a day-to-day basis so the need for larger target margins is diminished and therefore spares more normal tissue.
- g. 3D Conformal Radiation Therapy (CRT) is radiation therapy that uses computers to create a 3-dimensional picture of the tumor so that more than 2 radiation beams can be shaped or conformed to the contour of the targeted area. This takes less intensive planning than IMRT, but similar, except for the intensity of individual beams

2.0 Eligible Recipients

2.1 General Provisions

Medicaid recipients may have service restrictions due to their eligibility category that would make them ineligible for this service.

2.2 EPSDT Special Provision: Exception to Policy Limitations for Recipients under 21 Years of Age

42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act]

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid recipients under 21 years of age **if** the service is **medically necessary health care** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination** (includes any evaluation by a physician or other licensed clinician). This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his/her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems. Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the recipient's physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the recipient's right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product, or procedure

- a. that is unsafe, ineffective, or experimental/investigational.
- b. that is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

Service limitations on scope, amount, duration, frequency, location of service, and/or other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider's documentation shows that the requested service is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

**EPSDT and Prior Approval Requirements

- a. If the service, product, or procedure requires prior approval, the fact that the recipient is under 21 years of age does **NOT** eliminate the requirement for prior approval.
- b. **IMPORTANT ADDITIONAL INFORMATION** about EPSDT and prior approval is found in the *Basic Medicaid Billing Guide*, sections 2 and 6, and on the EPSDT provider page. The Web addresses are specified below.

Basic Medicaid Billing Guide: <http://www.ncdhhs.gov/dma/medbillcaguide.htm>

EPSDT provider page: <http://www.ncdhhs.gov/dma/EPSDTprovider.htm>

3.0 When the Procedure, Product, or Service Is Covered

IMPORTANT NOTE: EPSDT allows a recipient less than 21 years of age to receive services in excess of the limitations or restrictions below and without meeting the specific criteria in this section when such services are **medically necessary health care services** to correct or ameliorate

a defect, physical or mental illness, or a condition [health problem]; that is, documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

EPSDT DOES NOT ELIMINATE THE REQUIREMENT FOR PRIOR APPROVAL IF PRIOR APPROVAL IS REQUIRED. For additional information about EPSDT and prior approval requirements, see **Section 2.0** of this policy.

3.1 General Criteria

Medicaid covers procedures, products, and services related to this policy when they are medically necessary and

- a. the procedure, product, or service is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the recipient's needs;
- a. the procedure, product, or service can be safely furnished, and no equally effective and more conservative or less costly treatment is available statewide; and
- b. the procedure, product, or service is furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

3.2 Specific Criteria

Medicaid covers the following:

- a. Local hyperthermia services for a diagnosis of cancer
- b. Brachytherapy services for the following conditions:
 1. Head and neck cancers
 2. Respiratory and digestive tract cancers
 3. Genitourinary cancers
 4. Eye tumors
 5. Brain tumors
 6. Soft tissue sarcomas
 7. Multi-catheter interstitial or balloon brachytherapy (such as MammoSite) for breast cancer is covered
 - (a) for the treatment of early-stage breast cancer, in conjunction with external whole-breast radiation therapy following breast-conserving surgery; or
 - (b) as the sole method of breast radiation therapy for the treatment of breast cancer following breast-conserving surgery, when all of the following medical necessity criteria are met:
 - i. Recipient is at least 45 years old or is postmenopausal
 - ii. Recipient has invasive ductal carcinoma or ductal carcinoma in situ (DCIS)
 - iii. Total tumor size (invasive and DCIS) is less than or equal to 3 cm
 - iv. Microscopic surgical margins of excision are negative
 - v. Axillary/sentinel lymph nodes are negative

4.0 When the Procedure, Product, or Service Is Not Covered

IMPORTANT NOTE: EPSDT allows a recipient less than 21 years of age to receive services in excess of the limitations or restrictions below and without meeting the specific criteria in this section when such services are **medically necessary health care services** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem]; that is, documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

EPSDT DOES NOT ELIMINATE THE REQUIREMENT FOR PRIOR APPROVAL IF PRIOR APPROVAL IS REQUIRED. For additional information about EPSDT and prior approval requirements, see **Section 2.0** of this policy.

4.1 General Criteria

Procedures, products, and services related to this policy are not covered when

- a. the recipient does not meet the eligibility requirements listed in **Section 2.0**;
- b. the recipient does not meet the medical necessity criteria listed in **Section 3.0**;
- c. the procedure, product, or service unnecessarily duplicates another provider's procedure, product, or service; or
- d. the procedure, product, or service is experimental, investigational, or part of a clinical trial.

Note: Routine costs of care in a clinical trial may be covered if the treatment is considered acceptable standard of medical practice and if there are no other safe and effective alternatives for treatment.

4.2 Specific Criteria

Medicaid does not cover the following:

- a. Stereotactic radiation oncology procedures for obsessive-compulsive disorder; epilepsy, recurrent seizures, or convulsions; Parkinson's disease; or migraine headaches
- b. Neutron beam procedures
- c. Proton beam procedures
- d. Category III CPT codes
- e. Brachytherapy for breast cancer in any of the following situations, as in these cases it is considered experimental, investigational, or unproven:
 1. When it follows induction chemotherapy as treatment for inoperable locally advanced breast cancer
 2. When the tumor is located in an area of insufficient tissue (very small breasts, inframammary fold, the Tail of Spence)
 3. When the tumor is multifocal, has extensive nodal involvement, or is a lobular carcinoma
- f. Electronic/kilovoltage brachytherapy, as it is considered experimental, investigational or unproven

- g. Stereotactic body radiation therapy in conjunction with other radiation treatment delivery procedures
- h. Stereoscopic x-ray guidance in conjunction with stereotactic radiation treatment management procedures

4.3 Treatment Management

Treatment management can include any of the following activities. Payments for the Radiation Oncologist services are bundled with these codes. This is true regardless of which code is billed:

- a. Anesthesia
- b. Care of infected skin
- c. Checking of treatment charts
- d. Verification of dosage, as needed
- e. Continued patient evaluation, examination, written progress notes, as needed
- f. Final physical examination
- g. Medical prescription writing
- h. Nutritional counseling
- i. Pain management
- j. Review and revision of treatment plan
- k. Routine medical management of unrelated problem
- l. Special care of ostomy
- m. Written reports, progress notes
- n. Follow-up examination and care for 90 days after last treatment

The following CPT codes are included in radiation treatment management during the course of the treatment and for 90 days following completion of the treatment.

CPT Code	Description
11921	Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; 6.1 to 20.0 sq cm
16000	Initial treatment, first degree burn, when no more than local treatment is required
16020	Dressings and/or debridement of partial-thickness burns, initial or subsequent; small
16025	Dressings and/or debridement of partial-thickness burns, initial or subsequent; medium
16030	Dressings and/or debridement of partial-thickness burns, initial or subsequent; large
36425	Venipuncture, cutdown; age 1 or over
51701	Insertion of non-indwelling bladder catheter
51702	Insertion of temporary indwelling bladder catheter; simple
51703	Insertion of temporary indwelling bladder catheter; complicated
97802	Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes

CPT Code	Description
97803	Medical nutrition therapy; re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes
99183	Physician attendance and supervision of hyperbaric oxygen therapy, per session
99185	Hypothermia; regional
99211	Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician. Usually the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.
99212	Office or other outpatient visit for the evaluation and management of an established patient. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.
99213	Office or other outpatient visit for the evaluation and management of an established patient. Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 15 minutes face-to-face with the patient and/or family.
99214	Office or other outpatient visit for the evaluation and management of an established patient. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family.
99215	Office or other outpatient visit for the evaluation and management of an established patient. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 40 minutes face-to-face with the patient and/or family.
99238	Hospital discharge day management; 30 minutes or less
99281	Emergency department visit for the evaluation and management of a patient. Usually, the presenting problem(s) are self limited or minor.
99282	Emergency department visit for the evaluation and management of a patient. Usually, the presenting problem(s) are of low to moderate severity.
99283	Emergency department visit for the evaluation and management of a patient. Usually, the presenting problem(s) are of moderate severity.
99284	Emergency department visit for the evaluation and management of a patient. Usually, the presenting problem(s) are of high severity and require urgent evaluation by the physician but do not pose an immediate significant threat to life or physiologic function.
99285	Emergency department visit for the evaluation and management of a patient. Usually, the presenting problem(s) are of high severity and pose an immediate significant threat to life or physiologic function.
99354	Prolonged physician service in the office or other outpatient setting requiring direct patient contact beyond the usual service; first hour
99355	Prolonged physician service in the office or other outpatient setting requiring direct patient contact beyond the usual service; each additional 30 minutes
99356	Prolonged physician service in the inpatient setting, requiring direct patient contact beyond the usual service; first hour

CPT Code	Description
99357	Prolonged physician service in the inpatient setting, requiring direct patient contact beyond the usual service; each additional 30 minutes
99360	Physician standby service, requiring prolonged physician attendance, each 30 minutes

5.0 Requirements for and Limitations on Coverage

IMPORTANT NOTE: EPSDT allows a recipient less than 21 years of age to receive services in excess of the limitations or restrictions below and without meeting the specific criteria in this section when such services are **medically necessary health care services** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem]; that is, documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

EPSDT DOES NOT ELIMINATE THE REQUIREMENT FOR PRIOR APPROVAL IF PRIOR APPROVAL IS REQUIRED. For additional information about EPSDT and prior approval requirements, see **Section 2.0** of this policy.

5.1 Prior Approval

Prior approval is not required for radiation oncology.

5.2 Radiation Treatment Management

Radiation treatment management represents the physician's professional services and typically consists of

- a. the review of portal films;
- b. the review of dosimetry, dose delivery, and treatment parameters;
- c. the review of recipient treatment setup; and
- d. the examination of the recipient for medical evaluation and management to assess the recipient's response to treatment.

5.2.1 CPT Code 77427

Requirements and limitations include the following:

- a. Report as one unit for every five treatment sessions, regardless of the actual time period in which the services are furnished.
- b. "Weekly" is interpreted as five treatments, not a calendar week.
- c. The services need not be furnished on consecutive days.
- d. Use when there are three or four sessions beyond a multiple of five at the end of a course of treatment.
- e. Multiple treatment sessions furnished on the same day may be counted separately, as long as there has been a distinct break in therapy sessions.
- f. Twice-daily treatment will require documentation of physician management for every five treatments.
- g. Use for external beam treatments only.

5.2.2 CPT Code 77431

Requirements and limitations include the following:

- a. Use when one or two treatments comprise the full course of therapy.
- b. Do not use to report the last one or two days of a longer treatment course.
- c. Use for external beam treatments only.

5.2.3 CPT Code 77432

Requirements and limitations include the following:

- a. Complete course of treatment consists of one session.
- b. This code cannot be reported for the same episode of care as CPT code 77435.
- c. The same physician should not report both 77432 and the following stereotactic radiosurgery services:

CPT CODE	DESCRIPTION
61796	Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); 1 simple cranial lesion
+61797	Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); each additional cranial lesion, simple (List separately in addition to code for primary procedure)
61798	Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); 1 complex cranial lesion
+61799	Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); each additional cranial lesion, complex (List separately in addition to code for primary procedure)
+61800	Application of stereotactic headframe for stereotactic radiosurgery (List separately in addition to code for primary procedure)

5.2.4 CPT Code 77435

Requirements and limitations include the following:

- a. Complete course of treatment is one to five fractions.
- b. If more than five treatments are given, code 77427 (radiation treatment management, five treatments) should be billed instead of 77435.
- c. Code 77435 cannot be reported for the same episode of care as CPT code 77432.
- d. The same physician should not report both 77435 and the following stereotactic radiosurgery services:

CPT CODE	DESCRIPTION
61796	Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); 1 simple cranial lesion
+61797	Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); each additional cranial lesion, simple (List separately in addition to code for primary procedure)

61798	Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); 1 complex cranial lesion
+61799	Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); each additional cranial lesion, complex (List separately in addition to code for primary procedure)
+61800	Application of stereotactic headframe for stereotactic radiosurgery (List separately in addition to code for primary procedure)
63620	Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); 1 spinal lesion
+63621	Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); each additional spinal lesion (List separately in addition to code for primary procedure)

5.2.5 CPT Code 77470

The use of this code assumes that the procedure is performed once during the course of therapy, in addition to daily or weekly patient management.

5.3 Radiation Treatment Delivery

CPT codes include the following:

CPT Code	Reference
77371 through 77373	See Attachment A, Section C.3 , for description.
77401 through 77416 and 77418	See Attachment A, Section C.4 , for description.

Requirements and limitations for radiation treatment delivery codes (77401 through 77416 and 77418) include the following:

- e. Limit to three treatments per day.
- f. When more than one treatment is performed on the same day (for example, hyperfractionation), report each treatment on a separate detail line, with the appropriate number of units indicated.

5.4 Therapeutic Radiology Port Film

Therapeutic radiology port film is limited to one per day, regardless of the number of films required.

6.0 Providers Eligible to Bill for the Procedure, Product, or Service

Providers who meet Medicaid's qualifications for participation and are currently enrolled with the N.C. Medicaid program are eligible to bill for procedures, products, and services related to this policy when they are within the scope of their practice.

7.0 Additional Requirements

7.1 Compliance

Providers must comply with all applicable federal, state, and local laws and regulations, including but not limited to the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements.

7.2 Medical Record Documentation

Medical record documentation must include the planned course of therapy, type and delivery of treatment, level of clinical management involved, and ongoing documentation of any changes in course of treatment. Documentation should be in accordance with the current *American College of Radiology Practice Guideline for Communication: Radiation Oncology* (online at http://www.acr.org/SecondaryMainMenuCategories/quality_safety/guidelines/ro/comm_radiation_oncology.aspx).

8.0 Policy Implementation/Revision Information

Original Effective Date: July 1, 1977

Revision Information:

Date	Section Revised	Change
	Throughout	Initial promulgation of current coverage.

Attachment A: Claims-Related Information

Reimbursement requires compliance with all Medicaid guidelines, including obtaining appropriate referrals for recipients enrolled in the Medicaid managed care programs.

A. Claim Type

Professional (CMS-1500/837P transaction)

Institutional (UB-04/837I transaction)

B. Diagnosis Codes

Providers must bill the ICD-9-CM diagnosis codes(s) to the highest level of specificity that supports medical necessity.

B.1 Stereotactic Radiation Therapy Procedures—Exclusions

Stereotactic radiation therapy procedures (CPT 77371, 77372, 77373, and 77435) are *not* covered for the following diagnoses.

ICD-9-CM Code	Description
301.4	Obsessive-compulsive personality disorder
332.0	Parkinson's disease, paralysis agitans
332.1	Parkinson's disease, secondary parkinsonism
345.00	Epilepsy and recurrent seizures, generalized nonconvulsive epilepsy, without mention of intractable epilepsy
345.01	Epilepsy and recurrent seizures, generalized nonconvulsive epilepsy, with intractable epilepsy
345.10	Epilepsy and recurrent seizures, generalized convulsive epilepsy, without mention of intractable epilepsy
345.11	Epilepsy and recurrent seizures, generalized convulsive epilepsy, with intractable epilepsy
345.20	Epilepsy and recurrent seizures, petit mal status, without mention of intractable epilepsy
345.21	Epilepsy and recurrent seizures, petit mal status, with intractable epilepsy
345.30	Epilepsy and recurrent seizures, grand mal status, without mention of intractable epilepsy
345.31	Epilepsy and recurrent seizures, grand mal status, with intractable epilepsy
345.40	Epilepsy and recurrent seizures, localization-related (focal) (partial) epilepsy and epileptic syndromes with complex partial seizures, without mention of intractable epilepsy
345.41	Epilepsy and recurrent seizures, localization-related (focal) (partial) epilepsy and epileptic syndromes with complex partial seizures, with intractable epilepsy
345.50	Epilepsy and recurrent seizures, localization-related (focal) (partial) epilepsy and epileptic syndromes with simple partial seizures, without mention of intractable epilepsy

ICD-9-CM Code	Description
345.51	Epilepsy and recurrent seizures, localization-related (focal) (partial) epilepsy and epileptic syndromes with simple partial seizures, with intractable epilepsy
345.60	Epilepsy and recurrent seizures, infantile spasms, without mention of intractable epilepsy
345.61	Epilepsy and recurrent seizures, infantile spasms, with intractable epilepsy
345.70	Epilepsy and recurrent seizures, epilepsia partialis continua, without mention of intractable epilepsy
345.71	Epilepsy and recurrent seizures, epilepsia partialis continua, with intractable epilepsy
345.80	Epilepsy and recurrent seizures, other forms of epilepsy and recurrent seizures, without mention of intractable epilepsy
345.81	Epilepsy and recurrent seizures, other forms of epilepsy and recurrent seizures, with intractable epilepsy
345.90	Epilepsy and recurrent seizures, epilepsy, unspecified, without mention of intractable epilepsy
345.91	Epilepsy and recurrent seizures, epilepsy, unspecified, with intractable epilepsy
346.00	Migraine, classical migraine, without mention of intractable migraine
346.01	Migraine, classical migraine, with intractable migraine, so stated
346.10	Migraine, common migraine, without mention of intractable migraine
346.11	Migraine, common migraine, with intractable migraine, so stated
346.20	Migraine, variants of migraine, without mention of intractable migraine
346.21	Migraine, variants of migraine, with intractable migraine, so stated
346.80	Migraine, other forms of migraine, without mention of intractable migraine
346.81	Migraine, other forms of migraine, with intractable migraine, so stated
346.90	Migraine, migraine unspecified, without mention of intractable migraine
346.91	Migraine, migraine unspecified, with intractable migraine, so stated
780.39	Convulsions, other

C. Procedure Codes Covered

C.1 Clinical Treatment Planning

CPT Code	Description
77261	Therapeutic radiology treatment planning; simple
77262	Therapeutic radiology treatment planning; intermediate
77263	Therapeutic radiology treatment planning; complex
77280	Therapeutic radiology simulation-aided field setting; simple

CPT Code	Description
77285	Therapeutic radiology simulation-aided field setting; intermediate
77290	Therapeutic radiology simulation-aided field setting; complex
77295	Therapeutic radiology simulation-aided field setting; 3-dimensional

C.2 Medical Radiation Physics, Dosimetry, Treatment Devices, and Special Services

CPT Code	Description
77300	Basic radiation dosimetry calculation, central axis depth dose calculation, TDF, NSD, gap calculation, off axis factor, tissue inhomogeneity factors, calculation of non-ionizing radiation surface and depth dose, as required during course of treatment, only when prescribed by the treating physician
77301	Intensity modulated radiotherapy plan, including dose-volume histograms for target and critical structure partial tolerance specifications
77305	Teletherapy, isodose plan; simple
77310	Teletherapy, isodose plan; intermediate
77315	Teletherapy, isodose plan; complex
77321	Special teletherapy port plan, particles, hemibody, total body
77326	Brachytherapy isodose plan; simple
77327	Brachytherapy isodose plan; intermediate
77328	Brachytherapy isodose plan; complex
77331	Special dosimetry, only when prescribed by the treating physician
77332	Treatment devices, design and construction; simple
77333	Treatment devices, design and construction; intermediate
77334	Treatment devices, design and construction; complex
77336	Continuing medical physics consultation, including assessment of treatment parameters, quality assurance of dose delivery, and review of patient treatment documentation in support of the radiation oncologist, reported per week of therapy
77370	Special medical radiation physics consultation

C.3 Stereotactic Radiation Treatment Delivery

CPT Code	Description
77371	Radiation treatment delivery, stereotactic radiosurgery (SRS), complete course of treatment of cranial lesion(s) consisting of 1 session; multi-source Cobalt 60 based
77372	Radiation treatment delivery, stereotactic radiosurgery (SRS), complete course of treatment of cranial lesion(s) consisting of 1 session; linear accelerator based
77373	Stereotactic body radiation therapy, treatment delivery, per fraction to 1 or more lesions, including image guidance, entire course not to exceed 5 fractions

C.4 Radiation Treatment Delivery

CPT Code	Description
77401	Radiation treatment delivery, superficial and/or ortho voltage
77402	Radiation treatment delivery, single treatment area, single port or parallel opposed ports, simple blocks or no blocks; up to 5 MeV
77403	Radiation treatment delivery, single treatment area, single port or parallel opposed ports, simple blocks or no blocks; 6-10 MeV
77404	Radiation treatment delivery, single treatment area, single port or parallel opposed ports, simple blocks or no blocks; 11-19 MeV
77406	Radiation treatment delivery, single treatment area, single port or parallel opposed ports, simple blocks or no blocks; 20 MeV or greater
77407	Radiation treatment delivery, two separate treatment areas, three or more ports on a single treatment area, use of multiple blocks; up to 5 MeV
77408	Radiation treatment delivery, two separate treatment areas, three or more ports on a single treatment area, use of multiple blocks; 6-10 MeV
77409	Radiation treatment delivery, two separate treatment areas, three or more ports on a single treatment area, use of multiple blocks; 11-19 MeV
77411	Radiation treatment delivery, two separate treatment areas, three or more ports on a single treatment area, use of multiple blocks; 20 MeV or greater
77412	Radiation treatment delivery, three or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, electron beam; up to 5 MeV
77413	Radiation treatment delivery, three or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, electron beam; 6-10 MeV
77414	Radiation treatment delivery, three or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, electron beam; 11-19 MeV
77416	Radiation treatment delivery, three or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, electron beam; 20 MeV or greater
77417	Therapeutic radiology port film(s)
77418	Intensity modulated treatment delivery, single or multiple fields/arcs, via narrow spatially and temporally modulated beams, binary, dynamic MLC, per treatment session
77421	Stereoscopic X-ray guidance for localization of target volume for the delivery of radiation therapy

C.5 Radiation Treatment Management

CPT Code	Description
77427	Radiation treatment management, five treatments
77431	Radiation therapy management with complete course of therapy consisting of one or two fractions only

CPT Code	Description
77432	Stereotactic radiation treatment management of cranial lesion(s) (complete course of treatment consisting of one session)
77435	Stereotactic body radiation therapy, treatment management, per treatment course, to one or more lesions, including image guidance, entire course not to exceed 5 fractions
77470	Special treatment procedure (eg, total body irradiation, hemibody radiation, per oral, endocavitary or intraoperative cone irradiation)

C.6 Hyperthermia

CPT Code	Description
77600	Hyperthermia, externally generated; superficial
77605	Hyperthermia externally generated; deep
77610	Hyperthermia generated by interstitial probe(s); 5 or fewer interstitial applicators
77615	Hyperthermia generated by interstitial probe(s); more than 5 interstitial applicators
77620	Hyperthermia generated by intracavitary probe(s)

C.7 Clinical Brachytherapy

CPT Code	Description
77750	Infusion or instillation of radioelement solution
77761	Intracavitary radiation source application; simple
77762	Intracavitary radiation source application; intermediate
77763	Intracavitary radiation source application; complex
77776	Interstitial radiation source application; simple
77777	Interstitial radiation source application; intermediate
77778	Interstitial radiation source application; complex
77781	Remote afterloading high intensity brachytherapy; 1-4 source positions or catheters Note: End-dated 12/31/2008, see 77785
77782	Remote afterloading high intensity brachytherapy; 5-8 source positions or catheters Note: End-dated 12/31/2008, see 77786)
77783	Remote afterloading high intensity brachytherapy; 9-12 source positions or catheters Note: End-dated 12/31/2008, see 77787)
77784	Remote afterloading high intensity brachytherapy; over 12 source positions or catheters Note: End-dated 12/31/2008, see 77787)
77785	Remote afterloading high dose rate radionuclide brachytherapy; 1 channel Note: New code effective 01/01/2009
77786	Remote afterloading high dose rate radionuclide brachytherapy; 2-12 channels Note: New code effective 01/01/2009
77787	Remote afterloading high dose rate radionuclide brachytherapy; over 12 channels Note: New code effective 01/01/2009

CPT Code	Description
77789	Surface application of radiation source
77790	Supervision, handling, loading of radiation source

C.8 Computed Tomography Guidance

CPT Code	Description
77014	Computed tomography guidance for placement of radiation therapy fields

D. Modifiers

Providers are required to follow applicable modifier guidelines.

E. Billing Units

Not applicable

F. Place of Service

Inpatient, outpatient, physician's office

G. Co-payments

Co-payment is not required for radiation therapy.

H. Reimbursement

Providers must bill their usual and customary charges.