

Part B Insider (Multispecialty) Coding Alert

PART B CODING COACH :Oncology Coding in Focus: Dig Into 2 Dosimetry Examples and Unlock Payment

Note the one question you must put to your payer.

The descriptor for 77300 says its appropriate for a required calculation prescribed by the treating physician -- but after a few denials, you might start thinking that payers have their own definition of required.

Heres a rundown of the service -- and the trouble with multiple units.

Start With Basic Dosimetry Basics

What it is: Dosimetry requires the physician to select from the available inventory of photon or electron beams and that the proper energy and modality is used for each of the simulated treatment portals. There are four parts to dosimetry: 1) basic time dose relationships, 2) isodosimetry, 3) beam shaping and organ protection, and 4) special physics services, states AMAs CPT Assistant (October 1997). The calculation of the dose within the tumor or treatment site is often performed by computer (the billable service) and checked by manual calculation (quality assurance is not billable).

The appropriate code for basic dosimetry is 77300 (Basic radiation dosimetry calculation, central axis depth dose calculation, TDF, NSD, gap calculation, off axis factor, tissue inhomogeneity factors, calculation of ionizing radiation surface and depth dose, as required during course of treatment, only when prescribed by the treating physician).

Basic dosimetry calculation includes any of the following, according to **Lashelle Walker, CPC, CPC-I**, in her American Academy of Professional Coders Las Vegas 2009 conference presentation, You Dont Have to be Einstein to Understand Radiation Oncology Billing:

" Central axis depth dose

" Time dose factor (TDF)

" Nominal standard dose (NSD)

" Tissue inhomogeneity factors as required during a course of treatment only prescribed by the treating physician

" Gap calculation

" Off-axis factor.

Term tip: Calculating a gap in distance between ports at skinlevel to separate two overlapping beams is a gap calculation. If you see a calculation of a dose at a point other than the ports central axis, this is an off-axis calculation.

Be sure the documentation supports medical necessity for these calculations, and the radiation oncologist should give specific orders for these particular calculations for the patient.

Documentation tip: The team should document all calculations in the chart, Walker says. The physics employee should date and sign them on the date she performs the service. And the physician must also sign and date each charged calculation, she says.

Heres Where Payer Policy Comes In

Each port typically requires a calculation. Gap and off-axis calculations also merit their own 77300 charge. And if the patient requires a new calculation during treatment, because of weight change, for example, you may code 77300 again.

But two parallel opposed ports with the same parameters may require one calculation for both, says **Cindy Parman, CPC, CPC-H, RCC**, principal with Coding Strategies Inc. in Powder Springs, Ga.

Medicare may expect one to eight calculations during the initial course of therapy, Walker says. You may charge additional calculations for each boost (cone-down). Payers may deny charges that exceed this number, Walker warns.

Caution: Some coders report having to appeal any claim for more than four calculations.

Others have gotten word from their contractor to bill up to 10 units on a single line and put additional units on a separate line with modifier 76 (Repeat procedure or service by same physician). You may also find some payers who allow you to bill only one service per treatment area (such as the pelvis) regardless of the number of ports.

If you're receiving denials for multiple units, be sure to ask your payer for its policy -- in writing -- on reporting multiple 77300 services. If your payer has a frequency/medically unlikely edit in place, be sure you find out how to override the edit for medically necessary services. Some payers may ask for modifier 76, modifier 59 (Distinct procedural service), or modifier GD (Units of service exceeds medically unlikely edit value and represents reasonable and necessary services).

Learn by Doing With 2 Examples

Assuming your payer allows you to report each necessary calculation, decide how many times you would report 77300 for these examples. Note that MU stands for monitor units -- the time the treatment unit is in beam on mode.

Example 1: The patient requires treatment for his pelvis with four fields per day: anterior, posterior, right lateral, and left lateral.

The parameters for the AP and PA pelvis are the same. You are reporting the professional service only.

AP Pelvis: 90 MU

PA Pelvis: 90 MU

RT Lat Pelvis: 57 MU

LT Lat Pelvis: 59 MU

Solution: Report 77300-26 (Professional component) three times -- once for the right lateral, once for the left lateral, and once total for the AP and PA pelvis.

(When two parallel opposed ports have the same parameters -- mirror image calculations -- you should report only one 77300 service for both ports, says Parman.)

Example 2: A stereotactic radiosurgery patient requires six treatment fields and all six have different monitor units calculated.

You are reporting the professional service only.

Field 1: 77 MU

Field 2: 75 MU

Field 3: 90 MU

Field 4: 85 MU

Field 5: 72 MU

Field 6: 70 MU

Solution: Bill six 77300-26 charges (77300-26 x 6, for example), says Walker.