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## **2008 Payment and Reimbursement Guidelines for Intraoperative Electron Radiation Therapy (IOERT)**

These guidelines have been developed to assist you in obtaining the appropriate physician payment and hospital reimbursement for the Mobetron therapy. Intraoperative Electron Radiation Therapy (IOERT) may be a covered service if they meet all of the requirements established by Medicare and the third-party payers. It is essential that each claim be coded properly and supported with adequate documentation in the medical record.

### **Principal Diagnosis Codes**

To comply with Medicare and third party payer requirements, all hospital and physician claim forms must indicate the ICD-9-CM codes (s) that describe the principal diagnosis responsible for the patient's condition. The following are examples of ICD-9 codes that may be appropriate to describe patients being treated for breast cancer:

<b>Diagnosis Codes</b>	<b>Description</b>
<b>BREAST</b>	
174	Malignant neoplasm of female breast
174	Malignant neoplasm of nipple and areola of female breast
174.1	Malignant neoplasm of central portion of female breast
174.2	Malignant neoplasm of upper-inner quadrant of female breast
174.3	Malignant neoplasm of lower-inner quadrant of female breast
174.4	Malignant neoplasm of upper-outer quadrant of female breast
174.5	Malignant neoplasm of lower-outer quadrant of female breast
174.6	Malignant neoplasm of axillary tail of female breast
174.8	Malignant neoplasm of other specified sites of female breast
174.9	Malignant neoplasm of breast (female), unspecified site
198	Secondary malignant neoplasm of other specified sites
198.8	Secondary malignant neoplasm of other specified sites
198.81	Secondary malignant neoplasm of breast
233	Carcinoma in situ of breast and genitourinary system
233	Carcinoma in situ of breast
239.3	Neoplasm of unspecified nature of breast



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### Physician Coding and Payment

*CPT Codes	Descriptors	**2008 MPFS Professional Payment Rate	
<b>Codes for breast surgical procedures</b>			
19316	Mastopexy	\$706.13	
19340	Immediate insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction	\$365.25	
19350	Nipple/areola reconstruction	\$617.39	
19357	Breast reconstruction, immediate or delayed, with tissue expander, including subsequent expansion	\$1,392.46	
19361	Breast reconstruction with latissimus dorsi flap, without prosthetic implant	\$1,445.40	
19364	Breast reconstruction with free flap	\$2,530.88	
19366	Breast reconstruction with other technique	\$1,261.06	
19367	Breast reconstruction with transverse rectus abdominis myocutaneous flap (TRAM), single pedicle, including closure of donor site;	\$1,653.36	
19369	Breast reconstruction with transverse rectus abdominis myocutaneous flap (TRAM), double pedicle, including closure of donor site	\$1,873.88	
<b>Codes representative to IOERT</b>			
77470	Special treatment procedures (e.g., total body irradiation, hemibody radiation, per oral, endocavitary or intraoperative cone irradiation).	100.67	
S8049	Intraoperative radiation therapy (single administration)	Not valid for Medicare	
<b>Codes for procedures associated with IOERT</b>			
77263	Therapeutic radiology treatment planning, complex	153.11	
77290	Therapeutic radiology simultaion-aided field setting, complex	74.64	



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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.	29.86	
76950	Ultrasonic guidance for placement of radiation therapy fields	27.94	
77321	Special teletherapy port plan, particles, hemi body, total body	45.93	
77333	Treatment devices, design and construction, intermediate (multiple blocks, stents, bite blocks, special bolus)	40.19	
77334	Treatment devices, design and construction, complex (irregular blocks, special shields, compensators, wedges, molds or casts)	59.33	
77431	Radiation therapy management with complete course of therapy consisting of one or two fractions	92.25	
<b>Professional Codes with Facility and Non-Facility Payments</b>		<b>Non-Facility</b>	<b>Facility</b>
99244	Office consultation for a new or established patient. Requires three components: a comprehensive history, a comprehensive examination and medical decision making of moderate complexity	179.9	146.22

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\*\* Note: the payment amounts indicated are based upon data elements made available by CMS on July 16, 2008. They also reflect legislation passed by congress on July 15, 2008. CMS may adjust any or all of the data inputs from time to time. All CPT codes are copyright AMA.



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### Documentation

When necessary, documentation will provide the Medicare Contractor or third party payer with information about the service performed and may play a significant role in their determination of the payment amount. This report should document why the procedure was performed, what was done and the expected outcome or benefit to be derived from this procedure. The purpose of this report is to support the medical necessity of the service to the payer and to provide information about the work involved. The report should be brief, (two or three paragraphs) and in simple, understandable language. Make sure the medical necessity for this service is substantiated in the first paragraph. If necessary, an operative report or other additional details can be attached to the claim for greater clarification.

### Hospital Inpatient Services

The following ICD-9-CM procedure code describes the IOERT procedure:

92.41            Intra-operative electron radiation therapy

### Medicare Inpatient Hospital Payment

Based on the procedures being performed, the following MS-DRGs may include the IOERT procedure. Bear in mind that the IOERT procedure will be considered a secondary procedure and will not drive the DRG assignment. The cost of capital is also part of the MS-DRG payment.

DRG	Descriptors	***2008 National Average Medicare Operating Payment
582	Mastectomy for malignancy W CC/MCC	\$5,077.97
583	Mastectomy for malignancy W/O CC/MCC	\$4,050.21
584	Breast biopsy, local excision & other breast proc W CC/MCC	\$6,721.10
585	Breast biopsy, local excision & other breast proc W/O CC/MCC	\$4,880.93

\*\*\* The payment amounts indicated are estimates only based upon data elements derived from various CMS sources. These sources include the 8/22/07 Federal Register, 10/10/07 Federal Register, The Payment impact file dated 9/30/07 and CMS manual system change request 5748 dated 10/18/07. Calculations assume that all hospitals are receiving the full 3.3% quality reporting update. Actual payment may vary based on various hospital-specific factors not reflected in the source data. Providers indicated by an asterisk (\*) may be paid based on a methodology which differs from the standard DRG payment calculation reflected in the amount shown (i.e., rural referral centers, hospitals in the state of Maryland). Actual payment may also vary based on adjustments that CMS may make from time to time.



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### Hospital Outpatient Services

CPT	APC	Descriptor	****2008 National Average APC Payment Rate
<b>Codes for breast surgical procedures</b>			
19316	29	Mastopexy	\$2,019.95
19340	30	Immediate insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction	\$2,536.24
19350	28	Nipple/areola reconstruction	\$1,314.75
19357	648	Breast reconstruction, immediate or delayed, with tissue expander, including subsequent expansion	\$3,603.64
19361	XXX	Breast reconstruction with latissimus dorsi flap, without prosthetic implant	\$0.00
19364	XXX	Breast reconstruction with free flap	\$0.00
19366	29	Breast reconstruction with other technique	\$2,019.95
19367	XXX	Breast reconstruction with transverse rectus abdominis myocutaneous flap (TRAM), single pedicle, including closure of donor site;	\$0.00
19369	XXX	Breast reconstruction with transverse rectus abdominis myocutaneous flap (TRAM), double pedicle, including closure of donor site	\$0.00
<b>Codes representative to IOERT</b>			
77470	0299	Special treatment procedures (e.g., total body irradiation, hemibody radiation, per oral, endocavitary or intraoperative cone irradiation).	\$369.40
*77412	0301	Radiation treatment delivery up to 5 MeV	\$141.19
*77413	0301	Radiation treatment delivery 6-10 MeV	\$141.19
XXXX	**XXXX	Single Dose IOERT	\$\$\$
<p>* Select only the treatment delivery code that is applicable to the energy utilized for the treatment  ** A new technology APC application has been submitted to CMS and is currently in review. The application requests reimbursement based on a single dose schedule, with rates comparable to stereotactic radiosurgery (\$3500-5000).</p>			
Note that S8049 is not recognized for payment by Medicare			



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Codes for procedures associated with IOERT			
CPT	APC	Descriptor	****2008 National Average APC Payment Rate
77290	305	Therapeutic radiology simulation-aided field setting, complex	\$250.16
76950	XXX	Ultrasonic guidance for placement of radiation therapy fields	\$0.00
77300	304	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.	\$99.21
77321	305	Special teletherapy port plan, particles, hemibody, total body	\$250.16
77333	303	Treatment devices, design and construction, intermediate (multiple blocks, stents, bite blocks, special bolus)	\$183.94
77334	303	Treatment devices, design and construction, complex (irregular blocks, special shields, compensators, wedges, molds or casts)	\$183.94
77336	304	Continuing medical physician consult	\$99.21
77370	304	Special physics consult	\$99.21
<p>**** The payment amounts indicated are estimates only based upon data elements derived from various CMS sources. These sources include CMS-1392-FC, and the OPPS Hospital specific file, both published on 11/1/07. Actual payment may vary based on various hospital specific factors not reflected in the source data. Actual payment may also vary based on adjustments that CMS may make from time to time.</p>			

*The information provided with this notice is general reimbursement information only as of May 2008; it is not legal advice, nor is it advice about how to code, complete or submit any particular claim for payment. Although we supply this information to the best of our current knowledge, it is always the provider's responsibility to determine and submit appropriate codes, charges, modifiers and bills for the services that were rendered. This information is provided as of the date listed above, and all coding and reimbursement information is subject to change without notice. Payers or their local branches may have their own coding and reimbursement requirements and policies. Before filing any claims, providers should verify current requirements and policies with the payer.*



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