Image Guidance and Motion Management Coding Update
This CY 2016 billing and coding reference is intended to be a general resource for physicians and reimbursement professionals and is current as of January 1, 2016. Contact payers directly for specific information on their coding, documentation and payment policies. Questions and comments on this guide can be referred to reimbursement@varian.com.

2016 IMAGE GUIDANCE AND MOTION MANAGEMENT BILLING AND CODING REFERENCE

Image guidance may also be used to confirm that the intended target remains within the radiation beam during the entire treatment delivery process. Accurate localization and tracking of the target helps to minimize radiation exposure to normal tissue surrounding the target. Accurate localization and tracking of the tumor target also helps to minimize radiation exposure to normal tissue surrounding the target.

A variety of technologies may be used to perform image guidance and prior to January 1, 2015 each of these technologies was reported using a CPT® code specific to that technology.

• 76950 – Ultrasound (US)
• 77421 – Stereoscopic guidance using kV imaging
• 77014 – Cone-beam computed tomography (CBCT)
• 0197T – Intrafraction tracking (e.g., 3D positional tracking, gating, 3D surface tracking)

CPT codes 76950, 77421 and 0197T were deleted by the AMA in 2014 and replaced with CPT code 77387. CPT code 77387 is to be reported regardless of the technology used to perform the image guidance. CPT code 77014 was not deleted but should no longer be used to account for CBCT images taken for guidance.

The Hospital Outpatient Prospective Payment System (HOPPS) will use CPT code 77387 for CY 2016 while the Medicare Physician Fee Schedule (MPFS) will continue to use the temporary G codes introduced by CMS in the CY 2015 final rule document. CPT code 77417 is still the correct code to report port films in either the hospital outpatient department or a freestanding cancer center.

IMAGE GUIDANCE CODING FOR HOSPITAL OUTPATIENT DEPARTMENTS

Reimbursement for image guidance is included in the treatment delivery codes for intensity-modulated radiation therapy (IMRT), stereotactic radiosurgery (SRS) or stereotactic body radiation therapy (SBRT) and should not be separately reported in addition to the treatment delivery codes for these modalities. If image guidance is performed for patients not receiving IMRT, SRS or SBRT, CPT code 77387 is separately reportable but is packaged by Medicare and will not be separately reimbursed by Medicare. However, some commercial payers may reimburse for image guidance when 77387 is included in payer contracts.

Physicians providing professional services in a hospital outpatient department should refer to the relative value units (RVUs) and payment rates associated with the -26 modifier in the Physicians and Freestanding Cancer Centers section.
For more information on how hospital outpatient payment rates are calculated, please visit the CMS website at www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/HospitalOutpaysysfctsht.pdf to view the Hospital Outpatient Prospective Payment System Fact Sheet. Providers must negotiate with commercial payer plans to establish contracted payment rates.

**IMAGE GUIDANCE CODING FOR PHYSICIANS AND FREESTANDING CANCER CENTERS**

Under the Medicare Physician Fee Schedule, CMS continues to delay the implementation of CPT code 77387 until CY 2016. Providers submitting services under the MPFS will continue to use the G codes created by CMS to report image guidance services. While the hospital outpatient department cannot separately report image guidance in conjunction with IMRT treatment delivery, physicians can report and be reimbursed for the professional component of the service. See the table below to determine which G code to report in place of the deleted imaging codes. CPT code 77014 was not deleted, so it will continue to be reported for CBCT.

**2016 NATIONAL AVERAGE MPFS REIMBURSEMENT INFORMATION**

<table>
<thead>
<tr>
<th>CPT</th>
<th>DESCRIPTOR</th>
<th>TOTAL RELATIVE VALUE UNITS (RVUs)</th>
<th>PAYMENT RATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>G6001</td>
<td>US guidance for placement of radiation therapy fields</td>
<td>1.46</td>
<td>$52</td>
</tr>
<tr>
<td>G6001-TC</td>
<td></td>
<td>.62</td>
<td>$22</td>
</tr>
<tr>
<td>G6001-26</td>
<td></td>
<td>.84</td>
<td>$30</td>
</tr>
<tr>
<td>77014</td>
<td>Computed tomography guidance for, and monitoring of, parenchymal tissue ablation</td>
<td>3.32</td>
<td>$118</td>
</tr>
<tr>
<td>77014-TC</td>
<td></td>
<td>2.08</td>
<td>$74</td>
</tr>
<tr>
<td>77014-26</td>
<td></td>
<td>1.24</td>
<td>$44</td>
</tr>
<tr>
<td>G6002</td>
<td>Stereoscopic X-ray guidance for localization of target volume for the delivery of radiation therapy</td>
<td>2.12</td>
<td>$76</td>
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<tr>
<td>G6002-TC</td>
<td></td>
<td>1.55</td>
<td>$56</td>
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<tr>
<td>G6002-26</td>
<td></td>
<td>.57</td>
<td>$20</td>
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</tbody>
</table>

For more information on how physician payment rates are calculated, please visit the CMS website at www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MedcrePhysFeeSchedfctsht.pdf to view the Medicare Physician Fee Schedule Payment System Fact Sheet. Providers must negotiate with commercial payer plans to establish contracted payment rates.
MOTION MANAGEMENT FOR PHYSICIANS AND FREESTANDING CANCER CENTERS

In certain clinical cases, it may be necessary to monitor respiratory motion during treatment delivery. Beginning January 1, 2014, new CPT code 77293 was implemented to account for the additional physician work necessary when simulating a patient using respiratory motion tracking. While the additional work is performed during the simulation process, 77293 was created as an add-on code and must be billed on the same date as either a 3D radiotherapy plan (77295) or IMRT plan (77301).

2016 NATIONAL AVERAGE MPFS REIMBURSEMENT INFORMATION

<table>
<thead>
<tr>
<th>CPT</th>
<th>DESCRIPTOR</th>
<th>TOTAL RELATIVE VALUE UNITS (RVUs)</th>
<th>PAYMENT RATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>+77293</td>
<td>Respiratory motion management simulation (List separately in addition to code for primary procedure)</td>
<td>13.16</td>
<td>$471</td>
</tr>
<tr>
<td>+77293-TC</td>
<td></td>
<td>10.23</td>
<td>$366</td>
</tr>
<tr>
<td>+77293-26</td>
<td></td>
<td>2.93</td>
<td>$105</td>
</tr>
</tbody>
</table>

2 Obtained from the 2016 Medicare Physician Fee Schedule (MPFS) Relative Value file posted to CMS.gov on 1/21/16.
3 Payment is calculated using the 2016 conversion factor (CF) of $35.8043.
4 Codes with the add-on indicator (+) must be submitted in conjunction with the correct primary procedure code.

Under HOPPS, code 77293 has a status indicator of N, which means that the payment for this service is packaged into payment for other services and there is no separate APC payment available. Physicians providing services in a hospital outpatient department would submit 77293 with a 26 modifier to signify that the provider is seeking professional reimbursement only.

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The information provided herein has been gathered from third-party sources which include, but are not limited to government and commercially available coding guides, professional societies and research conducted by coding and reimbursement consultants, and is subject to change without notice as a result of complex and frequently changing laws, regulations, rules and policies. This information should not be construed as authoritative and is presented for illustrative and informational purposes only. It does not constitute either reimbursement or legal advice. The entity billing Medicare, other government programs and/or third-party payers is solely responsible for determining medical necessity, the proper site for delivery of any services and to submit accurate and appropriate codes, charges, and modifiers for services that are rendered and reflected in a patient’s medical record. Varian does not have access to medical records, and therefore cannot recommend codes for specific cases. Varian recommends that you consult with your payers, reimbursement specialists and/or legal counsel regarding coding, coverage and reimbursement matters. Varian’s products have been cleared for use by the FDA as set forth in our Instructions for Use and nothing in this document should be construed as promoting any use outside of those instructions.

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Intended Use Summary
Varian Medical Systems’ linear accelerators are intended to provide stereotactic radiosurgery and precision radiotherapy for lesions, tumors, and conditions anywhere in the body where radiation treatment is indicated.

Safety
Radiation treatments may cause side effects that can vary depending on the part of the body being treated. The most frequent ones are typically temporary and may include, but are not limited to, irritation to the respiratory, digestive, urinary or reproductive systems, fatigue, nausea, skin irritation, and hair loss. In some patients, they can be severe. Treatment sessions may vary in complexity and time. Radiation treatment is not appropriate for all cancers.

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