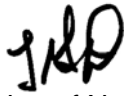




Commonwealth of Massachusetts
Executive Office of Health and Human Services
Office of Medicaid
www.mass.gov/masshealth



MassHealth
Transmittal Letter ROC-1
May 2011

TO: Radiation Oncology Centers (ROC) Participating in MassHealth
FROM: Terence G. Dougherty, Medicaid Director 
RE: *Radiation Oncology Center Manual* (Adoption of New Provider Regulations and Service Codes)

The regulations and instructions governing provider participation in MassHealth are published in the Provider Manual Series. MassHealth publishes a separate manual for each provider type.

Each provider manual contains information relevant to all providers, as well as provider-specific information. The all-provider sections include administrative and billing regulations (Subchapters 1 through 3), administrative and billing instructions (Subchapter 5), and several appendices.

This letter establishes the *Radiation Oncology Center Manual* by transmitting new program regulations (Subchapter 4) and service codes (Subchapter 6). These regulations codify eligibility criteria and participation requirements established as part of Radiation Oncology Center Bulletin 1 (June 2009), and have an effective date of June 1, 2011.

Effective June 1, 2011, consultation codes (99241-99245) are no longer recognized by MassHealth for payment. Radiation oncology centers should use the appropriate evaluation and management (E/M) office or other outpatient visit code (99201-99205; 99211-99215) when billing for services previously reported under a consultation code. Two additional service codes, 77014 (Computed tomography guidance for placement of radiation therapy fields) and 77338 (Multi-leaf collimator (MLC) device(s) for intensity modulated radiation therapy (IMRT), design and construction per IMRT plan), were added to the list of payable service codes.

If you wish to obtain a fee schedule, you may download the Division of Health Care Finance and Policy regulations at no cost at www.mass.gov/dhcfp. You may also purchase a paper copy of Division of Health Care Finance and Policy regulations from either the Massachusetts State Bookstore or from the Division of Health Care Finance and Policy (see addresses and telephone numbers below). You must contact them first to find out the price of the paper copy of the publication. The regulation title for medicine services is 114.3 CMR 17.00 and radiology services is 114.3 CMR 18.00.

Massachusetts State Bookstore
State House, Room 116
Boston, MA 02133
Telephone: 617-727-2834
www.mass.gov/sec/spr

Division of Health Care Finance and Policy
Two Boylston Street
Boston, MA 02116
Telephone: 617-988-3100
www.mass.gov/dhcf

MassHealth Web Site

This transmittal letter, attached pages, and other resources are available on the MassHealth Web site at www.mass.gov/masshealthpubs. Click on Provider Library to access provider communications and resources. Then click on MassHealth Provider Manuals to download a copy of the new *Radiation Oncology Center Manual*.

Questions

If you have any questions about the information in this transmittal letter, please contact MassHealth Customer Service at 1-800-841-2900, e-mail your inquiry to providersupport@mahealth.net, or fax your inquiry to 617-988-8974.

NEW MATERIAL

(The pages listed here contain new or revised language.)

Radiation Oncology Center Manual

Pages iv, vi, vii, 4-1 through 4-6, and 6-1 through 6-6

OBSOLETE MATERIAL

(The pages listed here are no longer in effect.)

Radiation Oncology Center Manual

There are no obsolete pages.

Commonwealth of Massachusetts MassHealth Provider Manual Series Radiation Oncology Center Manual	Subchapter Number and Title Table of Contents	Page iv
	Transmittal Letter ROC-1	Date 06/01/11

4. Program Regulations

436.401: Introduction	4-1
436.402: Definitions	4-1
436.403: Eligible Members	4-2
436.404: Provider Eligibility	4-2
436.405: Maximum Allowable Fees	4-3
436.406: Individual Consideration	4-3
436.407: Prior Authorization.....	4-4
436.408: Report Requirements.....	4-4
(130 CMR 436.409 through 436.412 Reserved)	
436.413: Payment	4-5
436.414: Levels of Physician Supervision	4-5
436.415: Covered Services.....	4-5
436.416: Noncovered Services.....	4-5
436.417: Recordkeeping Requirements.....	4-6
436.418: Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services.....	4-6

Commonwealth of Massachusetts MassHealth Provider Manual Series Radiation Oncology Center Manual	Subchapter Number and Title Table of Contents	Page vi
	Transmittal Letter ROC-1	Date 06/01/11

6. Service Codes and Descriptions

Introduction	6-1
Service Codes and Descriptions.....	6-1
Appendix A. Directory	A-1
Appendix B. Enrollment Centers	B-1
Appendix C. Third-Party-Liability Codes	C-1
Appendix W. EPSDT Services: Medical and Dental Protocols and Periodicity Schedules.....	W-1
Appendix X. Family Assistance Copayments and Deductibles	X-1
Appendix Y. EVS Codes/Messages	Y-1
Appendix Z. EPSDT/PPHSD Screening Services Codes.....	Z-1

Commonwealth of Massachusetts MassHealth Provider Manual Series Radiation Oncology Center Manual	Subchapter Number and Title Preface	Page vii
	Transmittal Letter ROC-1	Date 06/01/11

The regulations and instructions governing provider participation in MassHealth are published in the Provider Manual Series. MassHealth publishes a separate manual for each provider type.

Manuals in the series contain administrative regulations, billing regulations, program regulations, service codes, administrative and billing instructions, and general information. MassHealth regulations are incorporated into the Code of Massachusetts Regulations (CMR), a collection of regulations promulgated by state agencies within the Commonwealth and by the Secretary of State. MassHealth regulations are assigned Title 130 of the Code. Pages that contain regulatory material have a CMR chapter number in the banner beneath the subchapter number and title.

Administrative regulations and billing regulations apply to all providers and are contained in 130 CMR Chapter 450.000. These regulations are reproduced as Subchapters 1, 2, and 3 in this and all other manuals.

Program regulations cover matters that apply specifically to the type of provider for which the manual was prepared. For radiation oncology centers, those matters are covered in 130 CMR Chapter 436.000, reproduced as Subchapter 4 in the *Radiation Oncology Center Manual*.

Revisions and additions to the manual are made as needed by means of transmittal letters, which furnish instructions for substituting, adding, or removing pages. Some transmittal letters will be directed to all providers; others will be addressed to providers in specific provider types. In this way, a provider will receive all those transmittal letters that affect its manual, but no others.

The Provider Manual Series is intended for the convenience of providers. Neither this nor any other manual can or should contain every federal and state law and regulation that might affect a provider's participation in MassHealth. The provider manuals represent instead MassHealth's effort to give each provider a single convenient source for the essential information providers need in their routine interaction with MassHealth and its members.

Commonwealth of Massachusetts MassHealth Provider Manual Series Radiation Oncology Center Manual	Subchapter Number and Title 4. Program Regulations (130 CMR 436.000)	Page 4-1
	Transmittal Letter ROC-1	Date 06/01/11

436.401: Introduction

130 CMR 436.000 establishes the requirements for the provision and reimbursement of radiation oncology services under MassHealth. The MassHealth agency pays for radiation oncology services that are medically necessary and appropriately provided in accordance with 130 CMR 450.204. All radiation oncology centers participating in MassHealth must comply with all MassHealth regulations including, but not limited to, 130 CMR 436.000 and 450.000.

436.402: Definitions

The following terms used in 130 CMR 436.000 have the meanings given in 130 CMR 436.402, unless the context clearly requires a different meaning. The reimbursability of services defined in 130 CMR 436.000 is not determined by these definitions, but by application of regulations elsewhere in 130 CMR 436.000 and in 450.000.

Direct Supervision — the physician is present in the office suite and immediately available to furnish assistance and direction throughout the performance of the procedure. It does not require that the physician be present in the room when the procedure is performed.

General Supervision — the procedure is furnished under the physician’s overall direction and control, but the physician is not necessarily required during the performance of the procedure.

Non-Physician Personnel — technicians, employed or contracted by the radiation oncology center, whose function is to perform the technical component of a given procedure.

Personal Supervision — a physician is physically in the room during the performance of the procedure.

Referring Physician — a physician who requests or orders the service but does not necessarily perform the service.

Supervising Physician — the physician responsible for the personal, direct or general supervision of the testing performed, the quality of the testing performed, the proper operation and calibration of the equipment used to perform tests, and the actions of non-physician personnel who use the equipment.

Commonwealth of Massachusetts MassHealth Provider Manual Series Radiation Oncology Center Manual	Subchapter Number and Title 4. Program Regulations (130 CMR 436.000)	Page 4-2
	Transmittal Letter ROC-1	Date 06/01/11

436.403: Eligible Members

(A) (1) MassHealth Members. The MassHealth agency pays for services provided by radiation oncology centers to MassHealth members, subject to the restrictions and limitations described in MassHealth regulations. 130 CMR 450.105 specifically states for each MassHealth coverage type, which services are covered and which members are eligible to receive those services.

(2) Recipients of Emergency Aid to the Elderly, Disabled and Children Program. For information on covered services for recipients of the Emergency Aid to the Elderly, Disabled and Children Program, see 130 CMR 450.106.

(B) Member Eligibility and Coverage Type. For information on verifying member eligibility and coverage type, see 130 CMR 450.107.

436.404: Provider Eligibility

The MassHealth agency makes payment for services, described in 130 CMR 436.000, only to eligible providers of radiation oncology services who are participating in MassHealth on the date of service. The participating provider is responsible for the quality of all services for which payment is claimed, the accuracy of such claims, and compliance with all regulations applicable to radiation oncology services under MassHealth. In order to claim payment, the participating provider must be the radiation oncology center that actually performed the service. A radiation oncology center must have one or more supervising physicians who are responsible for the personal, direct, or general supervision of the facility and its personnel in accordance with Medicare requirements at 42 CFR 410.323(b)(3), the operation and calibration of the equipment, and the quality of the testing performed.

(A) In State. To be eligible to participate as a MassHealth provider, a radiation oncology center must

- (1) be located and doing business in the Commonwealth of Massachusetts;
- (2) operate under a clinic license issued by the Massachusetts Department of Public Health (DPH), in accordance with regulations at 105 CMR 140.000. (Providers operating as a satellite location under a Massachusetts DPH hospital license, or otherwise have Medicare provider-based status under 42 CFR 413.65, do not meet this requirement.);
- (3) obtain a current determination of need or acceptable substitute such as a physician's exemption letter issued by the Massachusetts Department of Public Health, to provide radiation therapy services;
- (4) employ to perform, oversee, and direct all care provided at the center one or more physicians licensed by Commonwealth of Massachusetts as a radiation oncologist, nuclear medicine provider, or radiologist;
- (5) ensure that non-physician medical technicians providing services are licensed by the Commonwealth of Massachusetts to provide such services in accordance with regulations at 105 CMR 120.000; and
- (6) participate in the Medicare program as a radiation therapy provider.

(B) Out of State. A radiation oncology center located outside of Massachusetts that does not otherwise meet the requirements of 130 CMR 436.404(A) may participate in MassHealth if it meets the requirements of 130 CMR 436.404(A)(6), 450.109, and the following:

- (1) employs to perform, oversee, and direct all care provided at the center one or more physicians licensed as a radiation oncologist, nuclear medicine provider, or radiologist in the same state the radiation oncology center is located and operating;
- (2) ensures that non-physician medical technicians providing services are licensed in the same state in which the radiation oncology center is located and operating; and
- (3) participates in the Medicare program as a radiation therapy provider.

Commonwealth of Massachusetts MassHealth Provider Manual Series Radiation Oncology Center Manual	Subchapter Number and Title 4. Program Regulations (130 CMR 436.000)	Page 4-3
	Transmittal Letter ROC-1	Date 06/01/11

436.405: Maximum Allowable Fees

(A) The MassHealth agency pays for radiation oncology center services with rates set by the Massachusetts Division of Health Care Finance and Policy (DHCFP), subject to the conditions, exclusions, and limitations set forth in 130 CMR 436.000.

(B) The maximum allowable fee is full compensation for the radiation oncology service and any related administrative or supervisory duties in connection with the services, regardless of where the service was provided.

436.406: Individual Consideration

(A) Some services listed in Subchapter 6 of the *Radiation Oncology Center Manual* are designated "I.C.," an abbreviation for individual consideration. Individual consideration means that a fee has not been established for these services. Payment for an individual-consideration service is determined by the MassHealth agency's professional advisers, based on the radiation oncology centers descriptive report of the services furnished, which must be included with the claim.

(B) If a service is not listed in Subchapter 6 of the *Radiation Oncology Center Manual*, a radiation oncology center may submit a claim by using the appropriate "unlisted service" service code. Payment for an unlisted service is determined by individual consideration, based on the center's descriptive report of the service, which must be included with the claim.

(C) The MassHealth agency considers the following factors when determining the appropriate payment for an individual-consideration service:

- (1) the amount of time required to perform the service;
- (2) the degree of skill required to perform the service;
- (3) the policies, procedures, and practices of other third-party insurers, both governmental and private;
- (4) prevailing professional ethics and accepted customs of the diagnostic testing and radiation oncology community; and
- (5) other standards and criteria as may be adopted by DHCFP or the MassHealth agency.

Commonwealth of Massachusetts MassHealth Provider Manual Series Radiation Oncology Center Manual	Subchapter Number and Title 4. Program Regulations (130 CMR 436.000)	Page 4-4
	Transmittal Letter ROC-1	Date 06/01/11

436.407: Prior Authorization

(A) The MassHealth agency requires the radiation oncology center to obtain prior authorization for services that are designated "P.A." in the service descriptions listed in Subchapter 6 of the *Radiation Oncology Center Manual*.

(B) Prior authorization determines only the medical necessity of the authorized service and does not establish or waive any other prerequisites for payment such as member eligibility or resort to health insurance payment.

(C) All requests for prior authorization must be submitted in accordance with the instructions found in Subchapter 5 of the *Radiation Oncology Center Manual*. No payment will be made for such services unless prior authorization has been obtained from the MassHealth agency before the delivery of service. The MassHealth agency will not grant retroactive prior-authorization requests.

436.408: Report Requirements

A general written report or a discharge summary must accompany the claim for payment for any service that is listed in Subchapter 6 of the *Radiation Oncology Center Manual* as requiring a report or individual consideration (I.C.), or if the code is for an unlisted service. This report must be sufficiently detailed to enable the MassHealth agency to assess the extent and nature of the service.

(436.409 through 436.412 Reserved)

Commonwealth of Massachusetts MassHealth Provider Manual Series Radiation Oncology Center Manual	Subchapter Number and Title 4. Program Regulations (130 CMR 436.000)	Page 4-5
	Transmittal Letter ROC-1	Date 06/01/11

436.413: Payment

(A) Global Fee. Payment for a diagnostic procedure performed at a radiation oncology center will include facility costs, technical costs, and professional costs.

(B) Terminated Procedures. Upon review, the MassHealth agency may pay for procedures that were unable to be completed after the procedure was initiated.

436.414: Levels of Physician Supervision

Radiation oncology centers must provide the appropriate level of physician supervision for each procedure in accordance with Medicare requirements at 42 CFR 410.323(b)(3). The definition of each level of physician supervision is set forth in 130 CMR 436.402.

436.415: Covered Services

The MassHealth agency pays for radiation oncology services necessary for the diagnosis, detection, and treatment of disease, and for the maintenance of the health of MassHealth members, subject to all restrictions and limitations described in MassHealth regulations at 130 CMR 436.000 and 450.000.

436.416: Noncovered Services

The MassHealth agency does not pay for the following services:

(A) services performed for experimental or investigational purposes, or that are themselves experimental or investigational; and

(B) services provided by a physician who individually or through a group practice has contractual arrangements with an acute, chronic, or rehabilitation hospital, medical school, or other medical institution that involve a salary, compensation in kind, teaching, research, or payment from any other source, if such payment would result in dual compensation for professional, supervisory, or administrative services related to member care.

Commonwealth of Massachusetts MassHealth Provider Manual Series Radiation Oncology Center Manual	Subchapter Number and Title 4. Program Regulations (130 CMR 436.000)	Page 4-6
	Transmittal Letter ROC-1	Date 06/01/11

436.417: Recordkeeping Requirements

(A) The radiation oncology center is responsible for ensuring the medical necessity of the services and maintaining test results in the patient's health record.

(B) Radiation oncology centers must maintain a medical-record system promoting quality and confidential patient care in accordance with Massachusetts Department of Public Health regulations at 105 CMR 140.000. This system must collect and retain data in a comprehensive and efficient manner and permit the prompt retrieval of information. Accurate and complete medical records must be maintained for each member receiving testing services from the radiation oncology center. The data maintained in the member's medical record must also be sufficient to justify any further diagnostic procedures. The medical record must be clear and legible, and readily accessible to health care practitioners and the MassHealth agency. The medical record must be maintained by the radiation oncology center for at least six years.

(C) The medical record must contain, at a minimum, the following information:

- (1) the member's name, address, telephone number, date of birth, and MassHealth identification number;
- (2) the date of service;
- (3) the name, title and signature of the referring physician;
- (4) a written order for the tests or treatment to be performed;
- (5) the name, title, and signature of the person performing the service;
- (6) the name of the supervising physician;
- (7) pertinent findings on examination; and
- (8) the tests and treatment performed and the respective results.

436.418: Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services

The MassHealth agency pays for all medically necessary radiation oncology center services for EPSDT-eligible members in accordance with 130 CMR 450.140 et seq., without regard to service limitations described in 130 CMR 436.000, and with prior authorization.

REGULATORY AUTHORITY

130 CMR 436.000: M.G.L. c. 118E, §§ 7 and 12.

Commonwealth of Massachusetts MassHealth Provider Manual Series	Subchapter Number and Title 6. Service Codes and Descriptions	Page 6-1
	Transmittal Letter ROC-1	Date 06/01/11
Radiation Oncology Center Manual		

601 Introduction

MassHealth pays for the services represented by the codes listed in Subchapter 6, in effect at the time of service subject to all conditions and limitations in MassHealth regulations at 130 CMR 436.000 and 450.000. A provider may request prior authorization for any medically necessary service reimbursable under the federal Medicaid Act in accordance with 130 CMR 450.144, 42 U.S.C. 1396d(a), and 42 U.S.C. 1396d(r)(5) for a MassHealth Standard or CommonHealth member younger than 21 years of age, even if it is not designated as covered or payable in Subchapter 6 of the *Radiation Oncology Center Manual*.

602 Service Codes and Descriptions

Service
Code

Service Description

Computed Tomography Guidance

77014 Computed tomography guidance for placement of radiation therapy fields

Radiation Oncology

Clinical Treatment Planning

77261 Therapeutic radiology treatment planning; simple
77262 intermediate
77263 complex
77280 Therapeutic radiology simulation-aided field setting; simple
77285 intermediate
77290 complex
77295 3-dimensional
77299 Unlisted procedure, therapeutic radiology clinical treatment planning

Medical Radiation Physics, Dosimetry, Treatment Devices, and Special Services

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 (whether hand or computer calculated); simple (1 or 2 parallel opposed unmodified ports directed to a single area of interest)
77310 intermediate (3 or more treatment ports directed to a single area of interest)
77315 complex (mantle or inverted Y, tangential ports, the use of wedges, compensators, complex blocking, rotational beam, or special beam considerations)
77321 Special teletherapy port plan, particles, hemibody, total body
77326 Brachytherapy isodose plan; simple (calculation made from single plane, 1 to 4 sources/ribbon application, remote afterloading brachytherapy, 1 to 8 sources)
77327 intermediate (multiplane dosage calculations, application involving 5 to 10 sources/ribbons, remote afterloading brachytherapy, 9 to 12 sources)
77328 complex (multiplane isodose plan, volume implant calculations, over 10 sources/ribbons used, special spatial reconstruction, remote afterloading brachytherapy, over 12 sources)

Commonwealth of Massachusetts MassHealth Provider Manual Series	Subchapter Number and Title 6. Service Codes and Descriptions	Page 6-2
	Transmittal Letter ROC-1	Date 06/01/11
Radiation Oncology Center Manual		

602 Service Codes and Descriptions (cont.)

Service
Code

Service Description

- 77331 Special dosimetry (e.g., TLD, microdosimetry) (specify), only when prescribed by the treating physician
- 77332 Treatment devices, design and construction; simple (simple block, simple bolus)
- 77333 intermediate (multiple blocks, stents, bite blocks, special bolus)
- 77334 complex (irregular blocks, special shields, compensators, wedges, molds or casts)
- 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
- 77338 Multi-leaf collimator (MLC) device(s) for intensity modulated radiation therapy (IMRT), design and construction per IMRT plan
- 77370 Special medical radiation physics consultation

Sterotactic Radiation Treatment Delivery

- 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 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

Other Procedures

- 77399 Unlisted procedure, medical radiation physics, dosimetry and treatment devices, and special services (I.C.)

Radiation Treatment Delivery

- 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 6-10 MeV
- 77404 11-19 MeV
- 77406 20 MeV or greater
- 77407 Radiation treatment delivery, 2 separate treatment areas, 3 or more ports on a single treatment area, use of multiple blocks; up to 5 MeV
- 77408 6-10 MeV
- 77409 11-19 MeV
- 77411 20 MeV or greater
- 77412 Radiation treatment delivery, 3 or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, electron beam; up to 5 MeV
- 77413 6-10 MeV
- 77414 11-19 MeV
- 77416 20 MeV or greater

Commonwealth of Massachusetts MassHealth Provider Manual Series	Subchapter Number and Title 6. Service Codes and Descriptions	Page 6-3
	Transmittal Letter ROC-1	Date 06/01/11
Radiation Oncology Center Manual		

602 Service Codes and Descriptions (cont.)

Service
Code

Service Description

- 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

Neutron Beam Treatment Delivery

- 77422 High energy neutron radiation treatment delivery; single treatment area using a single port or parallel-opposed ports with no blocks or simple blocking
77423 1 or more isocenter(s) with coplanar or non-coplanar geometry with blocking and/or wedge, and/or compensator(s)

Radiation Treatment Management

- 77427 Radiation treatment management, 5 treatments
77431 Radiation therapy management with complete course of therapy consisting of 1 or 2 fractions only
77432 Stereotactic radiation treatment management of cranial lesion(s) (complete course of treatment consisting of 1 session)
77435 Stereotactic body radiation therapy, treatment management, per treatment course, to 1 or more lesions, including image guidance, entire course not to exceed 5 fractions
77470 Special treatment procedure (e.g., total body irradiation, hemibody radiation, per oral, endocavitary or intraoperative cone irradiation)
77499 Unlisted procedure, therapeutic radiology treatment management (I.C.)

Hyperthermia

- 77600 Hyperthermia, externally generated; superficial (i.e., heating to a depth of 4 cm or less)
77605 deep (i.e., heating to depths greater than 4 cm)
77610 Hyperthermia generated by interstitial probe(s); 5 or fewer interstitial applicators
77615 more than 5 interstitial applicators

Clinical Intracavity Hyperthermia

- 77620 Hyperthermia generated by intracavitary probe(s)

Commonwealth of Massachusetts MassHealth Provider Manual Series	Subchapter Number and Title 6. Service Codes and Descriptions	Page 6-4
	Transmittal Letter ROC-1	Date 06/01/11
Radiation Oncology Center Manual		

602 Service Codes and Descriptions (cont.)

Service

Code Service Description

Clinical Brachytherapy

77750	Infusion or instillation of radioelement solution (includes 3-month follow-up care)
77761	Intracavitary radiation source application; simple
77762	intermediate
77763	complex
77776	Interstitial radiation source application; simple
77777	intermediate
77778	complex
77785	Remote afterloading high dose rate radionuclide brachytherapy; 1 channel
77786	2-12 channels
77787	over 12 channels
77789	Surface application of radiation source
77799	Unlisted procedure, clinical brachytherapy

Evaluation and Management

Office or Other Outpatient Services

99201	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: <ul style="list-style-type: none"> • A problem focused history; • A problem focused examination; • Straightforward medical decision making.
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Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.

99202	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: <ul style="list-style-type: none"> • An expanded problem focused history; • An expanded problem focused examination; • Straightforward medical decision making.
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Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 20 minutes face-to-face with the patient and/or family.

Commonwealth of Massachusetts MassHealth Provider Manual Series Radiation Oncology Center Manual	Subchapter Number and Title 6. Service Codes and Descriptions	Page 6-5
	Transmittal Letter ROC-1	Date 06/01/11

602 Service Codes and Descriptions (cont.)

Service
Code

Service Description

99203 Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components:

- A detailed focused history;
- A detailed examination;
- Medical decision making of low complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the presenting problem(s) are of moderate severity. Physicians typically spend 30 minutes face-to-face with the patient and/or family.

99204 Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components:

- A comprehensive history;
- A comprehensive examination;
- Medical decision making of moderate complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 45 minutes face-to-face with the patient and/or family.

99205 Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components:

- A comprehensive history;
- A comprehensive examination;
- Medical decision making of high complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 60 minutes face-to-face with the patient and/or family.

Established Patient

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.

Commonwealth of Massachusetts MassHealth Provider Manual Series	Subchapter Number and Title 6. Service Codes and Descriptions	Page 6-6
	Transmittal Letter ROC-1	Date 06/01/11
Radiation Oncology Center Manual		

602 Service Codes and Descriptions (cont.)

Service
Code

Service Description

99212

Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components:

- A problem focused history;
- A problem focused examination;
- Straightforward medical decision making.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

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, which requires at least 2 of these 3 key components:

- An expanded problem focused history;
- An expanded problem focused examination;
- Medical decision making of low complexity.

Counseling and coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

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, which requires at least 2 of these 3 key components:

- A detailed focused history;
- A detailed examination;
- Medical decision making of moderate complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

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, which requires at least 2 of these 3 key components:

- A comprehensive focused history;
- A comprehensive examination;
- Medical decision making of high complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

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.