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Question: 1585

A radiation oncologist sees a patient for a consultation for a recurrent tumor. The MDM is high. The patient has Medicare. Which code is reported?

A. 99205
B. 99215
C. 99214
D. 99204

Answer: A

Explanation: For a Medicare patient (new patient for the consultation), high MDM corresponds to code 99205.

Question: 1586

A radiation oncology department utilizes high-dose-rate (HDR) brachytherapy for treating gynecological malignancies. For a single treatment application, the clinical team inserts multiple multichannel catheters, performs a computerized treatment planning session utilizing volumetric imaging, administers the radioactive source delivery, and subsequently removes the applicators. The coder reviews the documentation to select the appropriate CPT codes for the professional and technical services rendered during this single hospital outpatient encounter. Which combination reflects proper coding compliance?

A. Report the catheter insertion code and the planning code, while omitting the treatment delivery code because HDR is billed as a single bundled package.
B. Report the brachytherapy application code, the treatment planning code, and the source application treatment delivery code together on the claim form.
C. Report only the source application delivery code because all planning, catheter insertion, and management are bundled into the primary delivery fee.

D. Report the treatment planning code and the physician management code, omitting the applicator insertion code due to global surgical package rules.

Answer: B

Explanation: HDR brachytherapy billing requires reporting the specific component services provided during the procedure, which typically include the surgical placement of the radiation source applicators, the specialized three-dimensional treatment planning, and the radioactive source application delivery codes. Unlike traditional surgeries where minor components are bundled, HDR brachytherapy coding separates applicator placement, dosimetry planning, and treatment delivery into distinct codes that can be reported together when fully documented and supported by medical necessity guidelines.

Question: 1587

A patient is treated with IMRT for lung cancer. The physician bills 77301. Two weeks later, the patient's anatomy changes due to weight loss, and a new IMRT plan is required. How should the second IMRT plan be billed to ensure compliance?

A. Bill 77301 with no modifier at all
B. Bill 77301 with a modifier 59
C. Bill 77301 with a modifier 76
D. Bill 77399 (Unlisted procedure)

Answer: C

Explanation: If a repeat procedure is necessary during the same course of treatment, modifier 76 (Repeat Procedure or Service by Same Physician) should be used. In this scenario, the physician is performing a second IMRT planning session (77301)

because of a significant change in the patient's clinical status (weight loss affecting dosimetry). Appending modifier 76 informs the payer that this is not a duplicate bill but a medically necessary repetition of the planning process to ensure treatment accuracy.

Question: 1588

An established patient with prostate cancer schedules an office visit to discuss rising PSA levels following radiation therapy. During the same encounter, the radiation oncologist performs a distinct, medically necessary problem-focused evaluation for an unrelated acute skin laceration sustained earlier that day. Which modifier must be appended to the E/M code to report this separate service alongside a minor procedure or distinct evaluation?

A. Modifier 79
B. Modifier 59
C. Modifier 25
D. Modifier 57

Answer: C

Explanation: Modifier 25 is appended to outpatient evaluation and management codes to indicate that on the same day as a procedure or other service, the patient's condition required a significant, separately identifiable E/M service above and beyond the usual pre-procedure care associated with the procedure.

Question: 1589

A radiation oncologist oversees an IMRT plan for a breast cancer patient. The plan

involves inverse planning and multileaf collimator delivery. Which of the following HCPCS codes is commonly reported alongside CPT 77301 to report the delivery portion of IMRT?

A. HCPCS code G6015 for IMRT treatment delivery of multiple areas
B. HCPCS code G6001 for ultrasonic guidance for radiation therapy placement
C. HCPCS code 77331 for special dosimetry calculation and measurement
D. HCPCS code 77300 for basic radiation therapy dosimetry calculation

Answer: A

Explanation: While CPT 77301 covers the IMRT plan, treatment delivery is reported using HCPCS codes such as G6015 (or G6016 depending on technique) for IMRT delivery.

Question: 1590

A patient with a history of localized breast cancer treated with lumpectomy and radiation therapy ten years ago is diagnosed with a new primary lung cancer and is scheduled to begin a course of external beam radiation therapy to the chest. How should the diagnosis codes be sequenced for the radiation therapy sessions?

A. Z85.3 sequenced first, followed by C34.90 and Z51.0
B. Z51.0 sequenced first, followed by C34.90 and Z85.3
C. C34.90 sequenced first, followed by Z51.0 and Z85.3
D. Z08 sequenced first, followed by C34.90 and Z85.3

Answer: C

Explanation: When a patient undergoes active treatment for a new primary

malignancy, the code for the active cancer (C34.90 for malignant neoplasm of bronchus or lung) must be sequenced first. Code Z51.0 is required secondary for the radiation therapy services, and the unrelated historical breast cancer is captured using code Z85.3 (Personal history of malignant neoplasm of breast) as an additional secondary status code.

Question: 1591

The physician performs an E/M service and decides to proceed with an emergency radiation treatment for superior vena cava syndrome. Which modifier is used to indicate the decision for surgery/procedure?

A. Modifier 58
B. Modifier 51
C. Modifier 25
D. Modifier 57

Answer: D

Explanation: Modifier 57 (Decision for Surgery) is used on an E/M service that resulted in the initial decision to perform a major procedure (one with a 90-day global period) within 24 hours. While radiation is usually 0 or 10-day global, 57 is the standard for "decision for" in specific payer contexts.

Question: 1592

A patient undergoes simulation for radiation therapy where three separate anatomical regions are simulated independently with distinct setups and orthogonal

reference images. How should this multi-site simulation be coded?

A. CPT 77280 reported separately for each distinct simulation area
B. CPT 77290 reported as a single complex simulation procedure
C. CPT 77280 reported once for the entire multi-site simulation session
D. CPT 77285 reported for intermediate simulation of multiple areas

Answer: A

Explanation: When multiple distinct anatomical treatment areas are simulated independently during separate setups within a course, simulation codes can be reported for each distinct site treated, provided documentation supports separate planning needs. Single simulation codes do not inherently bundle separate non-contiguous distinct treatment areas.

Question: 1593

An ICD-10-CM diagnosis code is required for malignant neoplasm of the upper outer quadrant of the left female breast. Which code structure correctly reflects this diagnosis?

A. Code C50.512 representing lower outer quadrant left
B. Code C50.411 representing upper outer quadrant right
C. Code C50.412 representing upper outer quadrant left
D. Code C50.511 representing lower outer quadrant right

Answer: C

Explanation: In ICD-10-CM, code C50.412 designates a malignant neoplasm of the upper outer quadrant of the left female breast, where the fourth digit indicates the

specific anatomical subsite and the final digit designates the left side. Code C50.411 specifies the right breast, while codes C50.511 and C50.512 represent the lower outer quadrants.

Question: 1594

A physician documents clinical treatment planning for a patient with breast cancer. The plan involves treating the chest wall and the supraclavicular nodes. This is:

A. CPT code 77263
B. CPT code 77295
C. CPT code 77261
D. CPT code 77262

Answer: A

Explanation: Treatment of the breast/chest wall along with regional lymph nodes (like the supraclavicular or internal mammary nodes) involves multiple treatment volumes and is classified as complex clinical treatment planning (77263).

Question: 1595

A radiation oncology center is preparing for a ROCC certification audit. They are reviewing the use of ICD-10-CM codes. Which type of code should be used as the primary diagnosis when a patient is receiving radiation for a secondary malignancy of the bone?

A. The code for the symptom only
B. The code for the primary site

C. The code for the lung cancer
D. The code for the bone cancer

Answer: D

Explanation: In radiation oncology coding, the primary diagnosis code on the claim should be the specific site being treated. If the physician is treating a secondary (metastatic) site, the code for that secondary malignancy is listed first, followed by the code for the primary site.

Question: 1596

A 45-year-old female undergoes a total mastectomy for primary infiltrating ductal carcinoma of the right breast. Pathologic evaluation reveals positive margins, and the radiation oncologist recommends adjuvant external beam radiation therapy to the chest wall and regional lymph nodes. What is the correct ICD-10-CM code for the primary breast malignancy indicating the correct laterality?

A. C50.912 for malignant neoplasm of left female breast
B. Z48.11 for encounter for surgical follow-up care
C. C50.919 for malignant neoplasm of unspecified female breast
D. C50.911 for malignant neoplasm of right female breast

Answer: D

Explanation: ICD-10-CM codes for breast cancer require specific fifth and sixth characters to identify the gender and exact laterality. For a primary malignant neoplasm of the right female breast, the correct code is C50.911. Laterality is a critical data element in radiation oncology for documentation, treatment planning, and ensuring precise delivery to the correct anatomical field.

Question: 1597

A 15-year-old male is diagnosed with Ewing's sarcoma of the shaft of the right humerus. What is the correct ICD-10-CM code?

A. C40.00
B. C40.01
C. C41.9
D. C49.11

Answer: B

Explanation: Ewing's sarcoma is a primary malignancy of the bone. Category C40 is for malignant neoplasms of bone and articular cartilage of limbs. C40.0 identifies the scapula and long bones of the upper limb, and the 6th character 1 indicates the right side.

Question: 1598

A facility is billing for the technical component of an HDR brachytherapy session. The physicist performs a "source strength verification" and "treatment plan verification" on the day of treatment. Which CPT code is typically used to report these continuing medical physics services during a course of brachytherapy?

A. 77370 for the special medical physics consultation for the treatment
B. 77470 for the special radiation finishing and the management service
C. 77336 for the continuing medical physics consultation per each week

D. 77300 for the basic radiation dosimetry calculation for the treatment

Answer: C

Explanation: 77336 is the code for continuing medical physics consultation. It is reported once per week of treatment (or per every 5 fractions) to cover the ongoing quality assurance and verification performed by the physicist. While 77300 is for specific calculations, 77336 covers the weekly review of the patient's chart and the equipment safety checks relevant to that patient's care.

Question: 1599

A patient receives a course of 30 fractions of radiation therapy. The physicist performs a continuing medical physics consultation (77336) every 5 fractions. On the 30th fraction, the physicist also performs the final review. How many total units of 77336 should be billed for the entire course?

A. Five units of 77336 for the course
B. Seven units of 77336 for the course
C. Thirty units of 77336 for the course
D. Six units of 77336 for the course

Answer: D

Explanation: 77336 is billed once for every five fractions. For a 30-fraction course, $30/5 = 6$. Therefore, 6 units of 77336 are appropriate. Each unit must be supported by documentation of the physicist's review of the treatment record, dose delivery, and machine parameters for that block of five treatments.

Question: 1600

A radiation oncology coder notices that a complex clinical treatment plan (77263) was billed on the same date as an initial E/M consultation (99205) for the same patient by the same physician. Under standard coding guidelines, what applies?

A. Both are reportable if the E/M service is significant and separately identifiable, typically supported by modifier 25
B. The treatment plan must be cancelled and replaced by the E/M code
C. The E/M service must be refunded because planning supersedes evaluation
D. E/M services are strictly bundled into treatment planning on all occasions

Answer: A

Explanation: An initial evaluation and management service can be reported on the same date as treatment planning if it represents a significant, separately identifiable evaluation of the patient's condition, appropriately designated with modifier 25 when required by payer rules.

Question: 1601

A physician spends time reviewing a patient's previous radiation records from an outside facility, discussing the case with a surgeon, and developing a preliminary treatment strategy before the patient's consult. Can this time be billed as part of the 99204-99205 E/M service?

A. No, this is considered bundled work
B. Yes, if done on the encounter date
C. Yes, regardless of the date performed

D. No, only face-to-face time counts

Answer: B

Explanation: Under the current E/M guidelines (since 2021), total time on the date of the encounter includes both face-to-face and non-face-to-face time spent by the physician. This includes reviewing records, communicating with other professionals, and documenting in the EHR, provided it occurs on the same day as the visit.

Question: 1602

A radiation oncology department receives a formal written request from an orthopedic oncologist asking for an evaluation and treatment recommendation regarding a patient with a solitary lytic bone metastasis in the proximal femur. The radiation oncologist performs the evaluation, determines that palliative radiation is indicated, and sends a detailed written report back to the orthopedic oncologist. The billing specialist is preparing the claim for a commercial insurance payer that still mandates and accepts CPT consultation codes. Which code should be submitted?

A. CPT code 99254, representing an initial inpatient consultation for hospital-status cancer patients.
B. CPT code 99204, since Medicare rules override commercial insurance contracts for all specialty clinics.
C. CPT code 99243, provided the documentation supports an expanded problem-focused history and examination.
D. CPT code 99214, because all outpatient visits in hospital-owned facilities must default to established patient codes.

Answer: C

Explanation: When commercial insurance payers continue to recognize CPT consultation codes (99241-99245), meeting the core criteria—request from another physician, opinion rendered, and a written report sent back to the requesting provider—allows the billing team to select the appropriate consultation code based on the level of service documented. Because this is an outpatient setting, the office consultation range (99241-99245) applies, whereas inpatient codes (99251-99255) are restricted to hospitalized patients.

Question: 1603

A 68-year-old male with T3N1M0 prostate cancer presents for an initial consultation. The radiation oncologist spends 55 minutes in total time on the date of the encounter, which includes reviewing the biopsy pathology, multiparametric MRI, and discussing the risks and benefits of SBRT versus conventional fractionation. The documentation supports a high level of medical decision-making. Which CPT code is most appropriate for a Medicare beneficiary?

A. 99205
B. 99204
C. 99203
D. 99244

Answer: A

Explanation: For Medicare patients, consultation codes (99241-99245) are not recognized; therefore, a new patient office visit code must be used. According to the 2021/2023 E/M guidelines, code 99205 is appropriate when the physician spends 60-74 minutes of total time or performs high-level medical decision-making. Although the time (55 minutes) falls into the 99204 range (45-59 minutes), the high level of medical decision-making (MDM) documented allows for the selection of 99205.

Question: 1604

A patient with localized prostate cancer has an ICD-10-CM secondary malignant neoplasm code assigned for bone metastasis to the lumbar spine. Which code correctly represents secondary malignant neoplasm of the bone?

A. Code C78.7 reporting secondary malignant liver lesion
B. Code C78.00 reporting secondary malignant lung lesion
C. Code C79.51 reporting secondary malignant bone lesion
D. Code C79.31 reporting secondary malignant brain lesion

Answer: C

Explanation: Code C79.51 is the specific ICD-10-CM code for secondary malignant neoplasm of bone, commonly used when solid tumors metastasize to the skeletal system such as the lumbar spine. Code C78.00 represents secondary lung malignancy, code C78.7 represents secondary liver malignancy, and code C79.31 represents secondary brain malignancy.

Question: 1605

A patient with cervical cancer undergoes high-dose-rate brachytherapy combined with intracavitary hyperthermia. The hyperthermia is delivered using specialized applicators inserted into the uterine cavity alongside the brachytherapy tandem. Which CPT code correctly identifies this intracavitary hyperthermia procedure?

A. Code 77600 covers external local hyperthermia treatment delivered via superficial or shallow thermal heating modalities.
B. Code 77605 designates external local hyperthermia treatment applied to deep-

seated tumors requiring specialized gear.
C. Code 77615 represents interstitial hyperthermia treatment administered via implanted thermal catheters and heating elements.
D. Code 77620 describes intracavitary hyperthermia treatment delivered using specialized applicator probes inside cavities.

Answer: D

Explanation: Code 77620 is assigned for intracavitary hyperthermia treatments where specialized thermal applicators are placed within natural body cavities. Code 77600 covers superficial external heating, 77605 covers deep external heating, and 77615 applies to interstitial placements.

Question: 1606

A patient is treated with 3D conformal radiation. The physician bills for a 77300 (dosimetry calculation) for each of the four fields used in the plan. Which statement best describes Medicare's typical stance on billing multiple units of 77300?

A. Not allowed for any IMRT plans
B. Not allowed for any 3D plans
C. Allowed if fields are different
D. Allowed if fields are the same

Answer: C

Explanation: While IMRT planning (77301) bundles all dosimetry calculations, 3D planning allows for the billing of 77300. Medicare generally allows one unit per port or field, provided each calculation is unique and documented as necessary for the treatment plan's accuracy.

Question: 1607

A radiation oncologist performs clinical treatment planning for a patient with a solitary, biopsy-proven basal cell carcinoma on the left forearm. The physician determines the patient is a candidate for superficial X-ray therapy using a single treatment port and a simple block. No significant comorbidities are present. What is the correct CPT code?

A. CPT code 77261
B. CPT code 77300
C. CPT code 77263
D. CPT code 77262

Answer: A

Explanation: CPT 77261 is used for simple clinical treatment planning. This is appropriate when the planning involves a single treatment area, a single inflammatory or simple localized cancer, and uses simple or no blocking. A single site of basal cell carcinoma treated with superficial therapy typically falls under the simple classification.

Question: 1608

A radiation oncologist sees a patient for a consultation at the request of a primary care physician. The oncologist decides to proceed with treatment and performs the simulation (77280) on the same day. How should the oncologist code the E/M?

A. 99204-25

B. 99244-25

C. 99204

D. 99244

Answer: B

Explanation: For a non-Medicare payer, a consultation code (e.g., 99244) is appropriate. Because a procedure (simulation) was performed on the same day, modifier 25 must be added to the E/M code to ensure payment for both the evaluation and the procedural service.

Question: 1609

A radiation oncologist is asked to see a patient in the hospital for "emergency radiation for SVC syndrome." The oncologist sees the patient, reviews the imaging, and starts the first fraction of radiation therapy that same evening. The patient has Medicare. The MDM is high. Which code is used for the initial evaluation?

A. 99223

B. 77263

C. 99255

D. 77300

Answer: A

Explanation: For a Medicare inpatient, the initial evaluation is billed using the Initial Hospital Care codes. Given the high complexity of SVC syndrome, 99223 is appropriate. 77263 is for clinical treatment planning and is not an E/M code. 99255 is not recognized by Medicare.

Question: 1610

A radiation oncology practice reports a specialized brachytherapy procedure that involves the placement of radioactive sources in an intraoperative setting. The documentation specifies source handling, safety surveys, and supervision. Which HCPCS Level II code or CPT code correctly identifies the source isotope supply when reporting high-dose-rate iridium-192?

A. Code 77331 reporting special dosimetry calculation
B. Code A9590 reporting radioisotope source supply
C. Code 77778 reporting interstitial source application
D. Code C1715 reporting brachytherapy source wire

Answer: D

Explanation: HCPCS Level II code C1715 is utilized for brachytherapy source items such as iridium-192 sources and wires provided in outpatient hospital settings. Code A9590 represents an alternate radiopharmaceutical, while codes 77778 and 77331 represent professional or physics services rather than the specific material supply code for the isotope.

Question: 1611

A patient has a complex treatment plan that involves 3D conformal radiation to the prostate and a separate 2D plan for a bone metastasis in the shoulder. How should the clinical treatment planning be coded?

A. CPT 77263 only for the course
B. CPT 77262 only for two sites

C. CPT 77263 and CPT 77262-51

D. CPT 77261 and CPT 77263-59

Answer: A

Explanation: You only report one clinical treatment planning code per course of therapy. If there are multiple sites with different complexities, you report the single code that represents the highest level of complexity for the entire course. In this case, the complex prostate plan elevates the entire session to 77263.

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