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ORION™ HDR MRI LINE MARKER

2026 Orion HDR MR Line Marker Coding and Reimbursement Guide

INTRODUCTION

The information contained in this document is provided to assist health care providers understand reimbursement guidelines and procedures. It is intended to help obtain accurate coding, coverage and payment for medically necessary health care services provided to patients under physician orders. It is not intended to increase or maximize reimbursement.

The information referenced is based upon coding experience and research of current coding practices and published payer policies. They are based upon commonly used codes and procedures. The final decision for coding of any procedure must be made by the provider of care considering the medical necessity of the services, supplies provided and the regulations of insurance carriers including local, state or federal laws that apply.

Although a particular service or supply may be considered medically necessary by the provider, the final coverage decision is based upon a review of the available clinical information and does not mean the service or supply will be covered by any payer. Each payer and benefit plan contains its own specific provisions for coverage and detailed exclusions. Please consult individual payers to determine policy specific guidelines and whether there are any exclusions or other benefit limitations applicable to a particular service or supply.

CODING METHODOLOGY

The Physicians' Current Procedural Terminology® (CPT) developed by the American Medical Association (AMA) and HCPCS Level II codes developed by the Centers for Medicare and Medicaid Services (CMS) are listings of descriptive and identifying codes for medical services and procedures performed by health care providers and reported to third party carriers. The codes in the CPT Manual are copyrighted by the AMA and updated annually by the CPT Editorial Panel.

Third party payers have adopted the CPT and HCPCS coding systems for providers to communicate services provided to patients. Therefore, it is important to identify the services and supplies to accurately adjudicate claims. For this system to be effective, it is essential that the coding description accurately describes what transpired at the patient encounter.

CORRECT CODING INITIATIVE

The CMS developed the National Correct Coding Initiative (NCCI) to ensure that payment policies and procedures were standardized for all Medicare Administrative Contractors (MACs) to promote correct coding methodologies. The coding edits developed are based on coding conventions defined in the AMA's CPT manual, national and local policies, coding guidelines developed by national societies, analysis of standard medical and surgical practice, and reviews of current coding practice.

Procedures should be reported with the CPT/HCPCS codes that most comprehensively describe the services performed. Unbundling occurs when multiple procedure codes are billed for a group of procedures that are covered by a single comprehensive code or when a single payment episode is split into two or more episodes so multiple payments can be collected.

The NCCI edits have been developed for application to services billed by a single provider for a single patient on the same date of service. The NCCI represents a more comprehensive approach to unifying coding practices. Quarterly updates are available for hospitals and physicians at Medicare National Correct Coding Initiative (NCCI) Edits.

The Orion HDR line marker is placed within the high dose rate (HDR) brachytherapy treatment applicator at the time of treatment to assist in identification of the applicator for treatment delivery. The brachytherapy applicator for intracavitary treatment or needles for interstitial treatment is inserted into the patient to administer the prescribed radiation treatment.

The procedure codes provided on the following page reflect the potential codes available for the placement of HDR applicator, Orion Line Marker, and treatment delivery. Providers should report the appropriate treatment planning and management codes separately.

Always code appropriately based upon medical necessity of procedures performed and supporting documentation

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PLACEMENT OF ORION HDR MR LINE MARKER

In the hospital outpatient prospective payment system (OPPS) CMS assigns all CPT and HCPCS codes a status indicator (SI) to indicate if and how a service is reimbursed. In the Ambulatory Surgical Center (ASC), CMS assigns CPT and HCPCS codes a Payment Indicator (PI) to indicate how payment is determined.

*Status Indicators (SI) and Payment Indicators (PI)

- A2 Surgical procedure on ASC list in CY 2007; payment based on OPPS relative payment weight
- G2 Non office-based surgical procedure added in CY 2008 or later; payment based on OPPS relative payment weight
- J1 Paid under OPPS; all covered Part B services on the claim are packaged with the primary "J1" service for the claim, except services with SI=F, G, H, L and U. ASC Note: Comprehensive APCs do not apply; procedures are paid separately
- N/N1 Payment packaged with the primary procedure
- P3 Office-based surgical procedure added to ASC list in CY 2008 or later with MPFS nonfacility PE RVUs; payment based on MPFS nonfacility PE RVUs
- S Separate payment under OPPS; not subject to multiple procedure discount
- T Separate payment under OPPS; subject to multiple procedure discount

CPT/HCPCS	Descriptor	OPPS		ASC		Physician (MPFS)	
		SI*	Payment	PI*	Payment	Non-Facility	Facility
Placement of HDR Applicator and Orion Line Marker							
49411 µ	Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), percutaneous, intra-abdominal, intra-pelvic (except prostate), and/or retroperitoneum, single or multiple	S	$1,414	P3	$346	$473	$159
55875	Transperineal placement of needles or catheters into prostate for interstitial radioelement application, with or without cystoscopy	J1	$5,478	A2	$2,730	N/A	$689
55920	Placement of needles or catheters into pelvic organs and/or genitalia (except prostate) for subsequent interstitial radioelement application	J1	$5,111	G2	$2,296	N/A	$385
57155	Insertion of uterine tandem and/or vaginal ovoids for clinical brachytherapy	J1	$5,111	A2	$2,296	$400	$239
57156	Insertion of a vaginal radiation afterloading apparatus for clinical brachytherapy	T	$311	G2	$167	$225	$127
Orion HDR Line Marker							
A4648 µ	Tissue marker, implantable, any type, each	N	Packaged	N1	Packaged	Invoice	N/A
A4649	Surgical supply; miscellaneous	N	Packaged	N1	Packaged	N/A	N/A

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Image Guidance							
76498	Unlisted magnetic resonance procedure (eg, diagnostic, interventional)	S	$89	Not ASC Approved		Contractor Priced	Contractor Priced
76965	Ultrasonic guidance for interstitial radioelement application	N	Packaged	N1	Packaged	$97	$68
77387	Guidance for localization of target volume for delivery of radiation treatment, includes intrafraction tracking, when performed	N	Packaged	N1	Packaged	$37	$37
HDR Treatment Delivery							
77770	Remote afterloading high dose rate radionuclide interstitial or intracavitary brachytherapy, includes basic dosimetry, when performed; 1 channel	S	$712	Z3	$249	$352	$102
77771	Remote afterloading high dose rate radionuclide interstitial or intracavitary brachytherapy, includes basic dosimetry, when performed; 2-12 channels	S	$712	Z2	$387	$617	$201
77772	Remote afterloading high dose rate radionuclide interstitial or intracavitary brachytherapy, includes basic dosimetry, when performed; over 12 channels	S	$712	Z2	$387	$923	$28
C1717	Brachytherapy source, non-stranded, high dose rate Iridium-192, per source	U	$357	H2	$357	N/A	N/A
HDR Source							
Q3001	Radioelements for brachytherapy, any type, each	N/A	NA	N/A	NA	Invoice	Invoice

μ Per CMS Transmittal 745, A4648 is separately paid in the office-setting when reported with CPT 49411

REFERENCES

- CY 2026 Medicare OPPS & ASC Payment System Final Rule (CMS-1834-FC); Addendum B and ASC Addenda.
- CY 2026 Physician Fee Schedule Final Rule (CMS-1832-F); Addendum B. All MPFS Fee Schedules calculated using the Non-Qualifying QP CF of $33.4009.
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