

## **ACROInsights – Taking the Confusion Out of Stereotactic Radiotherapy Billing**

The goal of this series of articles is to ensure that radiation oncologists are aware of and provided with the knowledge to ensure day-to-day processes are being addressed in a compliant manner. This installment will discuss coding and billing for stereotactic radiotherapy (e.g., stereotactic radiosurgery (SRS) and stereotactic body radiotherapy (SBRT), courses of treatment. Readers will note that we will not use the terminology stereotactic ablative radiotherapy (SABR) which has come into favor in certain circles, but which is not recognized by the American Medical Association Current Procedural Terminology (CPT®) Editorial Panel, Medicare, or commercial payers. The information contained within this ACROinsights article is meant as general guidance and is not intended to replace appropriate legal or authoritative guidance.

### **Defining a Course of Treatment**

Radiation therapy may often be prescribed for more than one area or diagnosis simultaneously; or for a new area (metastatic or primary) found subsequently to the original diagnosis, during an ongoing course of treatment. When the treatment modality being employed is external beam (EBRT) of any level or technique, what can and cannot be billed requires some basic understanding of payer guidelines and procedure-to-procedure edits. Adding use of stereotactic radiotherapy treatments, into a course with other treatment areas or modalities, requires clear understanding of the guidelines due to specific definitions and limitations of the applicable codes.

The key to understanding the limitations related to SRS and SBRT treatment delivery and physician management AMA CPT® codes, begins with their definitions and what constitutes a course of treatment. The information in this article will focus on the CPT® codes for SRS and SBRT, but the definitions for the Centers for Medicare and Medicaid Services (CMS) robotic G-codes (G0339 and G0340) include similar language.

SRS treatment delivery codes are for treatment of cranial lesions delivered in a single session, either Co-60 or linear accelerator based. The physician management code for SRS mimics the treatment delivery codes.

**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** – Radiation treatment delivery, stereotactic radiosurgery (SRS), **complete course of treatment of cranial lesion(s) consisting of 1 session**; linear accelerator based

**77432** - Stereotactic radiation treatment management of cranial lesion(s) (**complete course of treatment consisting of 1 session**)

SBRT treatment delivery includes lesions treated anywhere else in the body, with up to 5 total fractions for the full course, this includes cranial lesions which will be treated in 2 – 5 sessions. The physician management code for SBRT mimics the treatment delivery code.

**77373** – Stereotactic body radiation therapy, treatment delivery, per fraction to 1 or more lesions, including image guidance, **entire course not to exceed 5 fractions**

**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**

The physician management codes listed above are billable by radiation oncologist. In the event a neurosurgeon or physician of another specialty provides services for the stereotactic radiotherapy patient, they would bill their designated codes (i.e., CPT® 61796-61799 for neurosurgeons, 32701 for thoracic surgeons) per the definitions and published guidelines. The codes billed by the specialty surgeons are not per treatment session, but for all of the lesions treated. Their participation in the stereotactic radiotherapy process is typically defined by payers and may require their presence at each fraction of treatment when treatments are fractionated.

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These definitions of a course of treatment have been defined by the AMA since 1997. Since that time Medicare Administrative Contractors (MACs) and other payers have utilized the definitions. The course of treatment starts at the time of the initial evaluation and management (E/M) visit with the patient and extends through simulation, planning, treatment delivery and management.

AMA CPT® Assistant, October 1997<sup>i</sup>, outlines the course of treatment begins at the consultation, covering the plan of care by the physician for the area(s) and diagnoses addressed in the initial E/M visit. The course is not per area or diagnosis, instead it is the coordination and plan to address the problems addressed in the consultation together. Once the patient agrees to treatment, the physician will outline orders for the necessary services to treat the patient within the clinical treatment plan. Following this, begins the process of developing the treatment parameters, the patient is simulated, necessary immobilization is created, and data is acquired for the dosimetry staff to develop a treatment plan. The patient is treated, the physician will manage the patient throughout and physics will continue to monitor the clinical aspects of treatment. **For 90 days following the completion of treatment, the patient is continued to be managed for the area(s) treated.**

### AMA CPT® Assistant, October 1997:

A course of radiation therapy consists of several stages. Each stage contains several parts that lead progressively into the next until the patient has completed his or her therapy. A course of radiation therapy consists of the five stages listed below:

- consultation;
- clinical treatment planning;
- developing treatment parameters;
- radiation delivery and management; and
- follow-up evaluation and management services.

In order to correctly code for this treatment, one must first have a clear understanding of radiation oncology and its course of treatment.

Within the CPT® code definitions provided above; the portions related to course length have been **bolded** to emphasize the importance of this specific language. To appropriately bill for an SRS treatment course, all lesions must be treated in the same single day session. CMS clarified this in the 2014 Hospital Outpatient Prospective Payment System (OPPS) final rule<sup>ii</sup> when the robotic codes were no longer recognized for use by hospitals,

“The term “single session” means that the entire intracranial lesion(s) that comprise the patient’s diagnosis are treated in their entirety during a single treatment session on a single day.

Fractionated SRS treatment is any SRS delivery service requiring more than a single session of SRS treatment for a cranial lesion, up to a total of no more than five fractions, and one to five sessions (but no more than five) for non-cranial lesions. CPT code 77373 is to be used for any fraction (including the first fraction) in any series of fractionated treatments, regardless of the anatomical location of the lesion or lesions being radiated. Fractionated cranial SRS is any cranial SRS that exceeds one treatment session. Fractionated non-cranial SRS is any non-cranial SRS, regardless of the number of fractions but never more than five. Therefore, CPT code 77373 is the exclusive code (and the use of no other SRS treatment delivery code is permitted) for any and all fractionated SRS treatment services delivered anywhere in the body, including, but not limited to, the cranium or head. 77372 is not to be used for the first fraction of a fractionated cranial SRS treatment series and must only be used in cranial SRS when there is a single treatment session to treat the patient’s entire condition.”

### Possible Scenarios

Putting this into action when SRS or SBRT is the only treatment modality for a single area is something most physicians understand; however, when there are multiple areas known at the time of consult or when a new

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area is diagnosed mid-course, coding utilization may get challenging. These are not all of the possible scenarios, just a representation of some that may be common or to assist in reviewing billing guidelines.

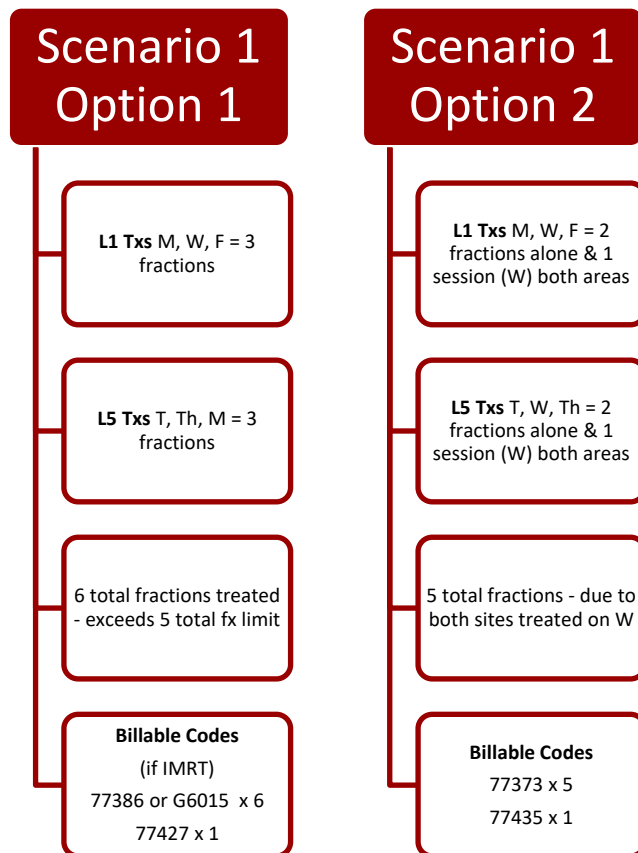
It is important to note, there is no magic number of days or a break between one course and another to support billing SRS or SBRT for each multiple area. When a known diagnosis or problem is purposely delayed treatment to maximize the ability or potential to bill for more codes, this could be considered circumventing payment guidelines. Documentation of workup findings which indicate multiple neoplasm(s), malignancies or condition(s) necessitating radiation treatment, but each area split into a separate evaluation and management (E/M) “consultation” visit, to create an opportunity to bill for each area as SRS or SBRT, would not be appropriate.

The documentation for the E/M visit lists the problems discussed. This is also one of the measurable criteria for determining the level of the visit when using the medical decision making (MDM) method. If the documentation supports multiple “problems” or areas were discussed, if an area is not to be treated or managed the medical necessity by the physician must support this. Some payers do have payment guidelines limiting services within so many days of IMRT planning code 77301, others may have limitations in coverage or authorization for sequential stereotactic radiotherapy services. Bringing unwanted scrutiny to the specialty of radiation oncology for inappropriate billing or attempting to “game the system” can and does have long term effects which could negatively affect payments and coverage of services.

### **Scenario #1 – Consult of patient with bone metastases to L1 and L5 of spine, previously treated for prostate cancer.**

The patient is seen in consultation due to low back pain and imaging which showed two separate lesions in the lumbar spine affecting L1 and L5. The physician plans to treat the patient with 3 fractions of SBRT to each vertebral body. The physician outlines the clinical treatment plan for the course, the patient is simulated, 3-D treatment plans generated, and is being scheduled for treatment. Because both lesions were known at the time of consultation, they are considered part of the same single course. Due to the fractionated delivery and non-cranial location, the only stereotactic radiotherapy codes available are 77373 and 77435.

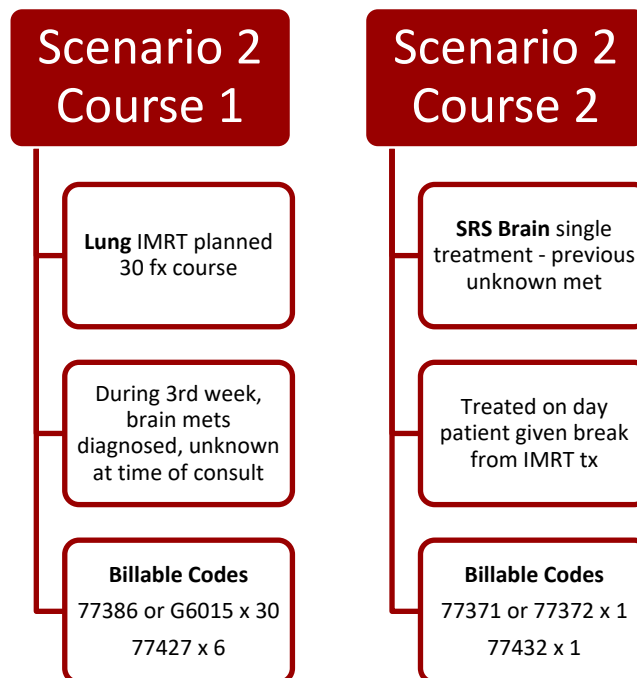
If treatments are alternated L1 on Monday, Wednesday, and Friday and L5 on Tuesday, Thursday, and the following Monday, this is 6 total fractions and exceeds the entire course limit of 5 fractions and would be billed based upon the planning, if 3-D plan (77295) then 77412 x 6, if IMRT plan then 77386 x 6 (due to many codes bundle or edit with IMRT code 77301, not all codes may be billable as they would with 77295) and physician management is billed as 77427 x 1. If treatments are delivered with L1 treated alone on Monday and Friday and L5 treated alone on Tuesday and Thursday, and both L1 and L5 are treated together on Wednesday. The total number of fractions is 5, treatments are billed as 77373 x 5 and 77435 x 1.



**Scenario #2 – Consult of patient with lung cancer primary, imaging workup no known brain metastases. During the third week of treatment the patient presents with a new and progressive headache. Imaging confirms solitary brain metastasis, not previously known.**

The patient is seen in consultation due to progressive cough, shortness of breath, and weight loss. Imaging confirms 4 cm right upper lobe lung lesion, no metastatic disease, no brain metastasis on pre-treatment imaging. The physician plans to treat the lung lesion with 30 fractions of IMRT with IGRT. During the third week of treatment the patient presents with a new and progressive headache. MRI confirms solitary brain metastasis, not previously known. ***The physician plans to treat with SRS and give the patient a day off from IMRT treatment to the lung to treat the SRS.*** As a new area and previously unknown diagnosis, this represents a new course of treatment. The brain metastasis was not known at the time of consultation.

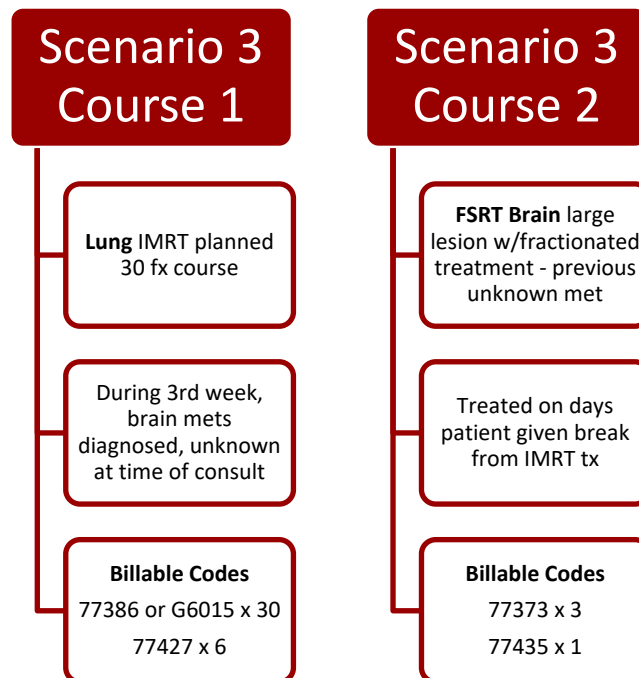
SRS for the brain can be billed with 77371 or 77372, depending on whether utilizing Co-60 or linac-based treatment respectively and physician management of 77432. Because the lung course was planned with IMRT, review of the codes specific to the SRS course that overlap the IMRT codes is necessary. Although they are two distinct areas with 2 different modalities, there are many codes (i.e., simulation) which edit, are not billable, with IMRT specific codes. Ensure documentation is clear, the work is specific to the SRS course and done on different dates and prepare any appeals as necessary if codes are denied. If the lung is treated with IMRT and SRS is delivered on the same date, only the SRS treatment is billable, no other treatments can be billed on that day. Due to this, the physician may elect to give a one-day break to IMRT lung treatment to treat the brain metastasis with SRS.



**Scenario #3 – Consult of patient with lung cancer primary, imaging workup no known brain metastases. During the third week of treatment the patient presents with a new and progressive headache. Imaging confirms large brain metastasis, not previously known.**

The patient is seen in consultation due to progressive cough, shortness of breath, and weight loss. Imaging confirms 4 cm right upper lobe lung lesion, no metastatic disease, no brain metastasis on pre-treatment imaging. The physician plans to treat the lung lesion with 30 fractions of IMRT with IGRT. During the third week of treatment the patient presents with a new and progressive headache. MRI confirms a large brain metastasis, not previously known. The physician plans to treat with fractionated SRT, over 3 sessions, due to inability of patient to tolerate lengthier treatment time. The patient will be treated on alternating days and not treated with IMRT treatment for the lung on those same dates. As a new area and previously unknown diagnosis, this represents a new course of treatment. The brain metastasis was not known at the time of consultation.

Fractionated stereotactic radiation therapy (FSRT) for the brain lesion split over 3 sessions to treat all of it and can be billed as 77373 per session of treatment and physician management of 77435 once. As the lung course was planned with IMRT, review of the codes specific to the FSRT (Same billing as SBRT) course that overlap the IMRT codes is necessary. Although they are two distinct areas with 2 different modalities, there are many codes (i.e., simulation) which edit, are not billable, with IMRT specific codes. Ensure documentation is clear, the work is specific to the FSRT course and done on different dates and prepare any appeals as necessary if codes are denied. If the lung is treated with IMRT and FSRT is delivered on the same date, only the FSRT treatment is billable for that day, no other treatments can be billed. Due to this, the physician may elect to give a break from IMRT lung treatment to treat the brain metastasis with FSRT.



#### Scenario #4 – Consult of patient with lung cancer primary and single bone metastasis to L1.

The patient is seen in consultation due to progressive cough, shortness of breath, extreme low back pain, and weight loss. Imaging confirms 4 cm right upper lobe lung lesion, no brain metastasis, but there is a single bone metastasis of the spine at L1. The physician plans to treat the lung lesion with 30 fractions of IMRT and IGRT and the L1 bone met with 5 fractions of SBRT.

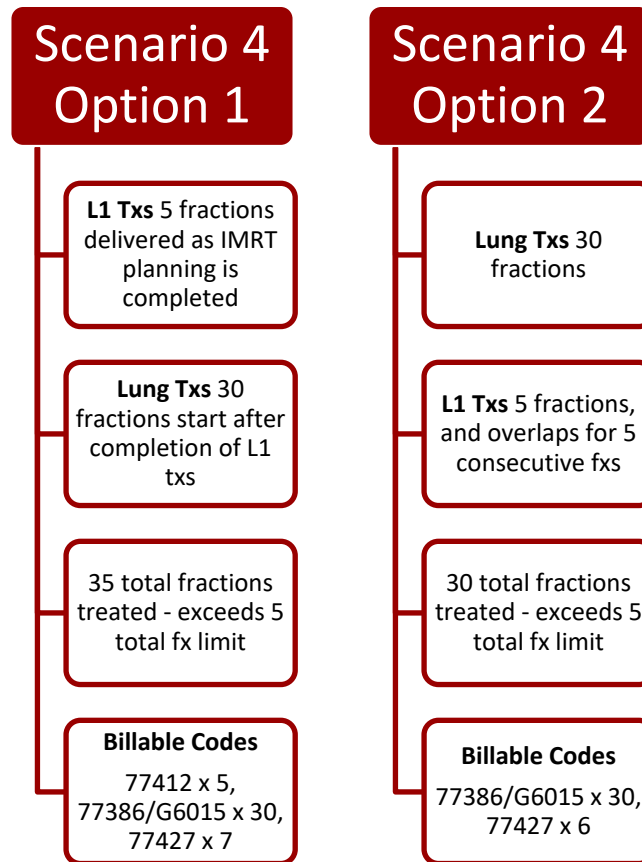
The physician outlines the course of treatment in the clinical treatment plan for the lung lesion and bone metastasis, the patient is simulated, immobilization created, an IMRT plan for the lung lesion and 3-D plan for the bone met are generated and is being scheduled for treatment. Because both lesions were known at the time of consultation, they are considered part of the same single course.

One option has the patient starting treatment to the bone mets, while the IMRT planning is completed. A 3-D plan is generated, and the patient is treated with 5 fractions of radiation. Treatments, 30 fractions, to the lung are started the day after the spine completes treatment. The total number of treatments for this course is 35, 5 for bone metastasis and 30 for lung lesion. The treatments and physician management for the bone mets *are not* billable as SBRT, the total number of treatments for the single course exceeds the limit of 5 fractions as defined by the treatment and management codes. The bone mets, started before the lung lesion in this option, are billed as 77412 x 5 (assuming complex field blocking). The lung treatments are billable as 77386 (or G6015) x 30. The opportunity for physician management visits is 7, one per 5 fractions of treatment, 77427 x 7.

The second option has the patient start treatment for the IMRT planned lung lesion and 3-D planned spine treatments on same initial day. Although they are two distinct areas with 2 different modalities, there are many codes (i.e., simulation) which edit, are not billable, with IMRT specific codes. Ensure documentation is clear, the work is specific to the SBRT course and done on different dates and prepare any appeals as necessary if codes are denied. The lung and spine will be treated on the same date, for 5 consecutive fractions, only one treatment delivery code is billable per session of treatment. Because SBRT codes are not supported for the treatment of the spine metastasis; the total number of treatments for this course is 30, the lung lesion and the bone metastasis overlap, the treatments and physician management for the bone mets *are not* billable as SBRT. The treatments

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are billable as 77386 (or G6015) x 30. The opportunity for physician management visits is 6, one per 5 fractions of treatment, 77427 x 6.



### Scenario #5 – Consult of patient with lung cancer primary and two brain metastases.

The patient is seen in consultation due to progressive cough, shortness of breath, extreme low back pain, and weight loss. Imaging confirms 4 cm right upper lobe lung lesion, with 2 brain metastases. The physician plans to treat the lung lesion with 30 fractions of IMRT and IGRT and the brain metastases each with a single fraction for a total of 2 fractions of SBRT.

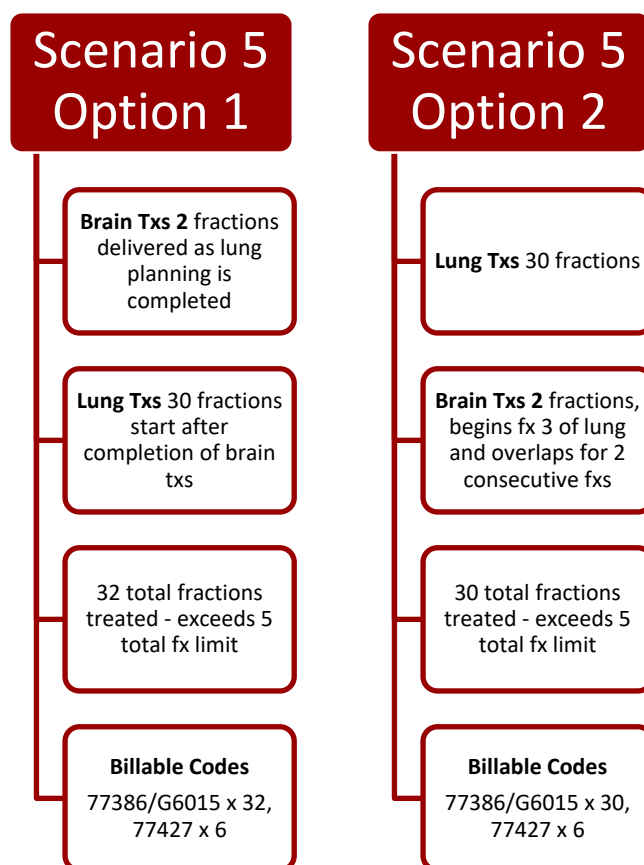
The physician outlines the course of treatment in the clinical treatment plan for the lung lesion and brain metastases, the patient is simulated, immobilization created, an IMRT plan for the lung lesion and IMRT plans for the brain mets are generated and is being scheduled for treatment. Because the lung and brain lesions were known at the time of consultation, they are considered part of the same single course. Due to the ordered IMRT planning for each lesion, a close review of the supporting documentation, including medical necessity, and timing of the plans is needed to verify billing when services overlap, bundle, or edit with each other.

One option has the patient start treatment for the brain lesions, while the planning for the lung is completed. An IMRT plan is generated for each lesion, and the patient is treated with 2 fractions of radiation, one per lesion. Treatments, 30 fractions, to the lung are started the day after the brain completes treatment. The total number of treatments for this course is 32, 2 for brain metastases and 30 for lung lesion. The treatments and physician management for the brain mets *are not* billable as SBRT (or as SRS one for each lesion), the total number of

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treatments for the single course exceeds the limit of 5 fractions as defined by the treatment and management codes. The brain mets, started before the lung lesion in this option, are billed as 77386 (or G6015) x 2. The lung treatments are billable as 77386 (or G6015) x 30. The opportunity for physician management visits is 6, one per 5 fractions of treatment, 77427 x 6.

The second option might be where the patient starts treatment for the IMRT planned lung lesion, as they are very nervous, then beginning fraction 3 the brain treatments are added on the same dates the lung is treated, until the 2 fractions are delivered. IMRT plans generated for the brain, a review of edits is needed to determine what can and cannot be billed each day due to potential edits with lung IMRT codes. The lung and brain will be treated on the same date, for 2 consecutive fractions, due to this only one IMRT treatment code is billable. Because SBRT codes are not supported for the treatment of the brain metastases; the total number of treatments for this course is 30, the lung lesion and the brain metastases overlap, the treatments and physician management for the brain mets *are not* billable as SRS. The treatments are billable as 77386 (or G6015) x 30. The opportunity for physician management visits is 6, one per 5 fractions of treatment, 77427 x 6.



### The Take Home Message

The definitions and guidelines for SRS and SBRT treatment and management determine whether the associated codes are billable. A technique for treatment may meet stereotactic criteria from a delivery standpoint but does not meet the criteria to be billed as such. There may be scenarios like the ones reviewed, or others, in which the guidelines for billing the services are not met; it is the responsibility of the radiation oncologist and their coding and billing staff to recognize the differences. As care continues to evolve, increasing use of resources over shorter fractions and treatment times, understanding how to bill, and be paid appropriately for the work provided becomes increasingly important. Inappropriate use of CPT® codes for services does not become just a problem for that provider, it can and does become a problem for the specialty of radiation oncology. To avoid



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this, taking part in ongoing education, asking for clarification or guidance, and participating in moving radiation oncology forward is something everyone can be a part of.

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<sup>i</sup> American Medical Association, CPT® Assistant, <https://www.ama-assn.org/member-benefits/practice-benefits-discounts/cpt-assistant-member-benefits>

<sup>ii</sup> Centers for Medicare and Medicaid Services, January 2014 Update of the Hospital Outpatient Prospective Payment System (OPPS), <https://www.cms.gov/regulations-and-guidance/guidance/transmittals/downloads/r2845cp.pdf>