THE ISSUES

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CMS Receives Five Compendia Requests

The Centers for Medicare & Medicaid Services (CMS) received five requests to recognize the addition and/or deletion of drug compendia. The period to submit applications for new compendia under the CMS process closed on Feb. 15, 2008.

The National Comprehensive Cancer Network (NCCN) submitted a request for its *Drugs & Biologics Compendium*™ to be recognized. Three additional applications also ask for compendia to be recognized: 1) Thomson Micromedex's *DrugPoints*®, submitted by the American Society of Clinical Oncology; 2) Thomson Micromedex's *DrugDex*®, submitted by Thomson Micromedex; and 3) the *Clinical Pharmacology* compendium, submitted by Gold Standard, Inc./Elsevier Health Sciences. The fifth application, made by CMS internally, requests that the now defunct *American Medical Association Drug Evaluations (AMA-DE)* compendium be removed from the approved list. The public comment period on these applications ended March 17, 2008. CMS will post a decision within 90 days following the close of the public comment period.

AHFS-DI is the only originally named compendium currently in publication, according to CMS.

Poll Reveals Adverse Patient Events as a Result of NCD on ESAs

In a national poll of medical oncologists and hematologists, 73 percent of respondents reported potentially avoidable transfusions in the 12-week period following the implementation of the new CMS coverage criteria for erythropoiesis stimulating agents (ESAs). These data seem to support ACCC's long-held concern that the NCD would have a negative impact on hospitals, which would bear the brunt of increased blood transfusions.

Last summer, ACCC conducted a survey to measure how much of an increase in the number of blood transfusions would strain hospital resources and services. Forty-one percent of survey respondents indicated that an increase in blood transfusions of 30 percent would cause a problem in carrying out normal operations. Another 16.5 percent responded that even a 10 percent or less increase would cause a problem, and about 22 percent of respondents indicated that any increase would result in a problem.

In the past, CMS has requested data showing the negative impact of its NCD, and now these data appear to be coming in. In addition to potentially unavoidable transfusions, survey participants reported other adverse outcomes including:

- Patients who remained symptomatic of anemia despite ESA use: 65 percent.
- Interruption of chemotherapy, dose reduced or changed due to anemia: 54 percent.
- ESA treatment terminated due to failure to meet the mandated hemoglobin response rates within 8 weeks: 39 percent.

Sponsored by US Oncology and conducted by the KJT Group, a national healthcare research company, the blinded, quantitative national survey included both closed and open-ended questions.

ACCC's Drug Bulletin: A Time of Transition

The March 2008 edition of the Association of Community Cancer Centers' (ACCC) *Compendia-based Drug Bulletin* features two significant changes:

- We have added a separate section that includes all oncology and supportive-care indications from Thomson Healthcare's *DrugPoints*®.
- We have added explanations and disclaimers about what ACCC's *Compendia-based Drug Bulletin* is and, importantly, is ***not***.

The compendia-based reimbursement process also reflects significant change. Starting in July 2007 one of the recognized drug compendia, the United States Pharmacopeia's *USP DI Drug Information for the Health Care Professional*, was succeeded by Thomson Healthcare's *DrugPoints*®. Still, CMS has ***not*** yet (as of February 15, 2008) issued guidance about whether it will accept *DrugPoints*® as a successor publication to *USP-DI*. To make matters more complicated, CMS has not issued guidance (as of February 15, 2008) about whether it will continue to accept indications listed in the *USP-DI* compendium.

All that said, oncology programs and oncology practices are urged to check with their Medicare carriers before submitting claims in this time of change. And please note, the March 2008 issue of ACCC's *Compendia-based Drug Bulletin* continues to include United States Pharmacopoeia *Drug Information (USP-DI)* indications.

Perhaps most importantly, oncology programs and practices must understand that ACCC's *Compendia-based Drug Bulletin* is ***not*** a Medicare-recognized compendium. This publication is a compilation of oncology- and supportive-care indications contained within the *USP-DI* and *AHFS-DI*—and, starting with the March 2008 issue, Thomson Healthcare's *DrugPoints*®. ACCC's *Compendia-based Drug Bulletin* is a resource and guide that allows you quick and easy access to the hundreds of oncology-related indications contained within the thousands of pages that make up the officially recognized compendia.

2008 Reimbursement Snapshot

by Linda B. Gledhill, MHA

Although the proposed 10.1 percent cut in the physician services payment rate was reversed by Congress in December, physicians were given only a temporary 0.5 percent increase in the conversion factor to $38.087 through June 30, 2008. As of July 1, 2008, the payment rate will revert back to the original -10.1 percent unless further action is taken.

Administration Codes

As noted in the January/February 2008 Coding Column, effective January 2008, three new codes were added for therapeutic and prophylaxis infusion:

- 90769 – Subcutaneous infusion for therapy or prophylaxis initial, up to 1 hour, including pump set-up and establishment of subcutaneous infusion site (16 minutes or more)
- 90770 – Each additional hour
- 90771 – Subcutaneous infusions additional pump set-up with establishment of new subcutaneous infusion site (once per encounter).

These codes are reimbursed in both the practice and hospital setting. Tables 4 and 5, on pages 9 and 10, compare 2008 and 2007 reimbursement in the practice and hospital outpatient department (HOPD) for these and other administration codes.

Hospitals should take particular note of code **90776,** each additional sequential IV push of the same substance/drug provided in a facility. 90776 is an add-on code to existing code 90774. While 90776 is not reimbursed by Medicare in 2008, it should be reported for data collection by CMS. To date, this code may only be reported by facilities.

Another change: code **90760,** IV infusion hydration, initial hour, now requires at least 31 minutes. Documentation of start and stop times becomes even more important in determining whether it is correct to use this code. If the infusion for hydration is less than 31 minutes, you are required to use the injection code.

Modifier Changes

In January, CMS released three transmittals related to coverage and payment for ESAs. Transmittal 1412 lists three new modifiers that are now required when reporting claims for ESAs (J0881, darbepoetin alfa 1mcg, and J0885, epoetin alfa, 1000 units).

- EA – ESA, anemia, chemo-induced
- EB – ESA, anemia, radiotherapy-induced
- EC – ESA, anemia, non-chemo and non-radiotherapy induced.

In addition to the modifier, all claims require reporting of either the most recent hematocrit or hemoglobin levels.

Two additional modifier changes relate to clinical trials:

- Q0 – Replaces QA and QR for investigational clinical services provided during a research study
- Q1 – Replaces the QV modifier for routine items or services provided in a Medicare Qualifying clinical trial on facility claims.

Drug Reimbursement

Under the 2008 HOPPS, hospital outpatient reimbursement for drugs was reduced to average sales price (ASP)+5 percent, and CMS has proposed to use 2008 as a transitional year for hospitals and to initiate ASP+3 percent in 2009. On the practice side, in 2008, pharmaceutical reimbursement remains at ASP+6 percent. Table 3 offers a snapshot of first quarter 2008 reimbursement in both the practice and hospital setting, and also includes projected reimbursement for 2009 at CMS's proposed rate of ASP+3 percent.

Radiation Therapy

Tables 1 and 2 show reimbursement for a sample IMRT treatment in the hospital and practice setting. On the practice side, the reimbursement outlook continues to be positive with a 2 percent increase in 2007 and an additional 4 percent increase in 2008.

In this sample IMRT regimen, hospitals saw a 6 percent decrease in reimbursement. Additionally, CMS has packaged or "bundled" three image guidance codes:

- 77014: CT guidance, packaged into APC 0282
- 76950: Daily ultrasound set-up, packaged into APC 0268
- 77417: Port films, packaged into APC 0260

Linda B. Gledhill, MHA, has more than 15 years oncology consulting experience.

Table 1. Hospital Sample IMRT Treatment Regimen

CPT/HCPCS Code	Description	2007 Payment	2008 Payment	Payment Difference	Percentage Difference
77014	CT guidance	$170.16	$40.75***	-$129.41	-76.05%
77263	Physician planning	$154.62	$152.35	-$2.27	-1.47%
77290	Pretreatment simulation	$319.59	$325.58	$5.99	1.87%
77301	IMRT planning (after CT imaging)	$1,234.56	$1,249.62	$15.06	1.22%
77334	Treatment devices (after planning)	$241.16	$242.97	$1.81	0.75%
77418	Daily treatment delivery	$336.42	$347.65	$11.23	3.34%
76950	Daily ultrasound set-up	$73.42	***	-$73.42	-100%
77417	Port films	$43.60	***	-$43.60	-100%
77336	Continuing physics	$96.72	$99.21	$2.49	2.57%
77427	Weekly physician management	$176.14	$177.10	$0.96	0.55%
77470-59	Special treatment procedures	$462.86	$470.59	$7.73	1.67%
Totals		$3,309.25	$3,105.82	-$203.43	-6.15%

Calculated using national, unadjusted 2008 physician fee schedule professional component and technical component from Addendum B, CMS Final Rule.
***Packaged technical codes.

Table 2. Practice Sample IMRT Treatment Regimen

CPT/HCPCS Code	Description	2007 Payment	2008 Payment	Payment Difference	Percentage Difference
77014	CT guidance	$170.33	$183.20	$12.87	7.56%
77263	Physician planning	$154.78	$152.35	-$2.43	-1.57%
77290	Pretreatment simulation	$396.52	$457.81	$61.29	15.46%
77301	IMRT planning (after CT imaging)	$1,755.27	$2,015.18	$259.91	14.81%
77334	Treatment devices (after planning)	$180.97	$171.39	-$9.58	-5.29%
77418	Daily treatment delivery	$641.60	$599.11	-$42.49	-6.62%
76950	Daily ultrasound set-up	$77.75	$74.65	-$3.10	-3.99%
77417	Port films	$21.60	$19.81	$-1.79	-8.29%
77336	Continuing physics	$101.57	$84.55	$-17.02	-16.76%
77427	Weekly physician management	$176.14	$177.10	$0.96	0.55%
77470-59	Special treatment procedures	$452.11	$358.78	$-93.33	-20.64%
Totals		$4,128.64	$4,293.93	$165.29	4%

Calculated using 2008 global, national unadjusted Medicare reimbursement

Table 3. A Snapshot of First Quarter 2008 ASP in the Practice and Hospital Settings

HCPCS Code	Description	Billing Units	1st Quarter 2008 Practice Drug Pricing ASP+6%	1st Quarter 2008 OPPS Drug Pricing ASP+5%	CMS 2009 Proposed OPPS Drug Pricing ASP+3%
J9000	Doxorubicin hcl 10 mg vl chemo	10 mg	$6.83	***	***
J9001	Doxorubicin hcl liposome inj	10 mg	$ 412.25	$396.15	$388.60
J9015	Aldesleukin/single use vial	1 each	$796.36	$ 788.84	$773.81
J9020	Asparaginase inj	10000 units	$54.78	$54.26	$53.23
J9031	Bcg live intravesical vac	1 each	$117.34	$113.75	$111.58
J9035	Bevacizumab inj	10 mg	$57.46	$56.93	$55.85
J9040	Bleomycin sulfate injection	15 units	$35.88	$42.93	$42.11
J9045	Carboplatin inj	50 mg	$7.05	$7.44	$7.30
J9060	Cisplatin 10 mg inj	10 mg	$2.55	***	***
J9065	Inj cladribine per 1 mg	1 mg	$33.66	$32.04	$31.43
J9070	Cyclophosphamide 100 mg inj	100 mg	$1.89	***	***
J9093	Cyclophosphamide lyophilized	100 mg	$1.93	***	***
J9120	Dactinomycin (actinomycin d)	0.5 mg	$493.43	$488.78	$479.47
J9130	Dacarbazine 100 mg inj	100 mg	$5.58	***	***
J9150	Daunorubicin	10 mg	$19.95	$19.33	$18.96
J9170	Docetaxel	20 mg	$319.42	$310.85	$304.93
J9181	Etoposide 10 mg inj	10 mg	$0.42	***	***
J9185	Fludarabine phosphate inj	50 mg	$237.51	$226.67	$222.35
J9190	Fluorouracil inj	500 mg	$1.81	***	***
J9201	Gemcitabine HCl	200 mg	$131.65	$127.31	$124.89
J9202	Goserelin acetate implant	3.6 mg	$191.86	$192.29	$188.63
J9206	Irinotecan inj	20 mg	$126.31	$124.61	$122.24
J9208	Ifosfamide inj	1 gm	$35.55	$38.13	$37.40
J9209	Mesna inj	200 mg	$7.90	$ 7.97	$7.82
J9211	Idarubicin hcl inj	5 mg	$290.42	$302.42	$296.66
J9212	Interferon alfacon-1	1 mcg	$4.66	$4.62	$4.53
J9216	Interferon gamma 1-b inj	3 million units	$309.58	$306.66	$300.82
J9217	Leuprolide acetate suspension	7.5 mg	$242.79	$236.06	$231.56
J9263	Oxaliplatin	0.5 mg	$9.47	$9.15	$8.98
J9265	Paclitaxel inj	30 mg	$13.58	$14.57	$14.29
J9266	Pegaspargase/single dose vial	1 each	$2,098.87	$2,080.19	$2,040.57
J9280	Mitomycin 5 mg inj	5 mg	$15.06	$14.39	$14.12
J9310	Rituximab cancer treatment	100 mg	$508.66	$504.40	$494.79
J9340	Thiotepa inj	15 mg	$41.21	$41.12	$40.34
J9350	Topotecan	4 mg	$875.46	$859.62	$843.52
J9355	Trastuzumab	10 mg	$59.02	$58.51	$ 57.40
J9360	Vinblastine sulfate inj	1 mg	$1.07	***	***
J9370	Vincristine sulfate 1 mg inj	1 mg	$7.73	***	***
J9390	Vinorelbine tartrate/10 mg	10 mg	$18.86	$21.41	$21.00

***Bundled; not separately paid in the hospital outpatient department (HOPD)

Pharmaceutical pricing based on CMS 1st quarter ASP table for physician practices (available at *http://cms.hhs.gov/McrPartBDrugAvgSalesPrice/01a_2008aspfiles.asp*) and Addendum B for the hospital outpatient department (available at *http://www.cms.hhs.gov/HospitalOutpatientPPS/HORD/*).

Table 4. Hospital Outpatient Administration Payments

CPT/HCPCS Code	Description	2007 Payment	2008 Payment	Payment Difference	Percent Difference
IV Infusion—Hydration					
90760	IV infusion, hydration, initial, at least 31 min. to 1 hour*	$111.20	$114.64	$3.44	3.09%
90761	Each additional hour, up to 8 hours (add-on code)	$24.25	$25.13	$0.88	3.63%
IV Infusion—Therapeutic					
90765	IV infusion, therapeutic, prophylaxis, initial, up to 1 hour*	$111.20	$114.64	$3.44	3.09%
90766	Each additional hour, up to 8 hours (add-on code)	$24.25	$25.13	$0.88	3.63%
90767	Additional sequential infusion, up to 1 hour (add-on code)	$24.25	$25.13	$0.88	3.63%
90768	Concurrent infusion (add-on code)	No Payment	No Payment	N/A	N/A
90769	Subcutaneous, initial, up to 1 hour including pump set-up and subcutaneous infusion site*	N/A	$114.64	NEW CODE	N/A
90770	Subcutaneous, each additional hour	N/A	$25.13	NEW CODE	N/A
90771	Subcutaneous, additional pump set-up with new infusion site	N/A	$51.22	NEW CODE	N/A
90776	Each additional sequential IV push of same substance/drug provided in a facility (add-on code)	N/A	No Payment	NEW CODE	N/A
Injections—Therapeutic, prophylactic, or diagnostic injections					
90772	Subcutaneous or intramuscular	$24.25	$25.13	$0.88	3.63%
90773	Intra-arterial	$48.82	$51.22	$2.40	4.92%
90774	IV push	$48.82	$51.22	$2.40	4.92%
90775	Additional injection (add-on code)	$48.42	$51.22	$2.80	5.78%
90779	Unlisted intra-arterial injection or infusion	$11.12	$16.21	$5.09	45.77%
Chemotherapy Injections					
96401	Anti-neoplastic, subcutaneous, or intramuscular	$48.42	$51.22	$2.80	5.78%
96402	Hormonal anti-neoplastic, subcutaneous, or intramuscular	$48.82	$51.22	$2.40	4.92%
96405	Intralesional, up to and including 7 lesions	$48.82	$51.22	$2.40	4.92%
96406	Intralesional, more than 7 lesions	$48.82	$51.22	$2.40	4.92%
96409	IV push technique, single or initial substance/drug*	$97.41	$105.38	$7.97	8.18%
96411	IV push, additional drug (add-on code)	$97.41	$105.38	$7.97	8.18%
Chemotherapy Infusion					
96413	Up to 1 hour, single or initial substance/drug*	$152.75	$149.34	-$3.41	-2.23%
96415	Each additional hour up to 8 hours (add-on code)	$48.82	$51.22	$2.40	4.92%
96416	Initiation of prolonged chemotherapy infusion (more than 8 hours) requiring use of portable or implantable pump	$152.75	$149.34	-$3.41	-2.23%
96417	Each additional sequential infusion (different substance/drug)	$48.82	$51.22	$2.40	4.92%
Chemotherapy, Intra-arterial					
96420	Push technique infusion up to 1 hour	$97.41	$105.38	$7.97	8.18%
96422	Infusion up to 1 hour	$152.75	$149.34	$-3.41	-2.23%
96423	Infusion each additional hour up to 8 hours (add-on code)	$48.82	$51.22	$2.40	4.92%
96425	Infusion technique, initiation of prolonged infusion (more than 8 hours) requiring use of a portable or implantable pump	$152.75	$149.34	-$3.41	-2.23%
Chemotherapy, Other					
96440	Administration into pleural cavity, requiring and including thoracentesis	$152.75	$149.34	-$3.41	-2.23%
96445	Administration into peritoneal cavity, requiring and including peritoneocentesis	$152.75	$149.34	-$3.41	-2.23%
96450	Administration into CNS (e.g., intrathecal), requiring and including spinal puncture	$152.75	$149.34	-$3.41	-2.23%
96521	Refilling and maintenance of portable pump	$111.20	$114.64	$3.44	3.09%
96522	Refilling and maintenance of implantable pump or reservoir for drug delivery, systemic (e.g., intravenous, intra-arterial)	$111.20	$114.64	$3.44	3.09%
96523	Irrigation of implanted venous access device for drug delivery systems	$31.36	$36.24	$4.88	15.56%
96542	Chemotherapy injection, subarachnoid or intraventricular via subcutaneous reservoir, single or multiple agents	$48.82	$51.22	$2.40	4.92%
96549	Unlisted chemotherapy procedure	$11.12	$16.21	$5.09	45.77%
C8957	Prolonged IV infusion, requiring pump	$152.75	$149.34	-$3.41	-2.23%

*Initial Code
Add-on code—List separately in addition to code for initial code
Pricing based on national, unadjusted Medicare reimbursement, Addendum B, CMS HOPPS 2008 Final Rule

Table 5. Practice Administration Payments

CPT/HCPCS Code	Description	2007 Payment	2008 Payment	Payment Difference	Percent Difference
IV Infusion—Hydration					
90760	IV infusion, hydration, initial, at least 31 min. to 1 hour*	$61.39	$60.56	-$0.83	-1.35%
90761	Each additional hour, up to 8 hours (add-on code)	$18.95	$18.28	-$0.67	-3.54%
IV Infusion-Therapeutic					
90765	IV infusion, therapeutic, prophylaxis, initial, up to 1 hour*	$75.04	$73.89	-$1.15	-1.53%
90766	Each additional hour, up to 8 hours (add-on code)	$24.25	$23.61	-$0.64	-2.64%
90767	Additional sequential infusion, up to 1 hour (add-on code)	$39.79	$38.09	-$1.70	-4.27%
90768	Concurrent infusion (add-on code)	$22.74	$22.09	-$0.65	-2.86%
90769	Subcutaneous, initial, up to 1 hour including pump set-up and subcutaneous infusion site*	N/A	$158.82	NEW CODE	N/A
90770	Subcutaneous, each additional hour	N/A	$16.00	NEW CODE	N/A
90771	Subcutaneous, additional pump set-up with new infusion site	N/A	$71.22	NEW CODE	N/A
Injections—Therapeutic, prophylactic, or diagnostic injections					
90772	Subcutaneous or intramuscular	$19.33	$20.57	$1.24	6.41%
90773	Intra-arterial	$18.18	$18.28	$0.10	0.55%
90774	IV push	$57.23	$57.89	$0.66	1.15%
90775	Additional injection (add-on code)	$26.15	$25.52	-$0.63	-2.41%
Chemotherapy Injections					
96401	Anti-neoplastic, subcutaneous, or intramuscular	$58.36	$64.75	$6.39	10.95%
96402	Hormonal anti-neoplastic, subcutaneous, or intramuscular	$42.45	$40.75	-$1.70	-4.00%
96405	Intralesional, up to and including 7 lesions	$121.65	$135.21	$13.56	11.15%
96406	Intralesional, more than 7 lesions	$145.15	$153.89	$8.74	6.02%
96409	IV push technique, single or initial substance/drug*	$119.76	$119.21	-$0.55	-0.46%
96411	IV push, additional drug (add-on code)	$68.97	$68.18	-$0.79	-1.15%
Chemotherapy Infusion					
96413	Up to 1 hour, single or initial substance/drug*	$165.99	$161.49	-$4.50	-2.71%
96415	Each additional hour up to 8 hours (add-on code)	$37.14	$36.18	-$0.96	-2.58%
96416	Initiation of prolonged chemotherapy infusion (more than 8 hours) requiring use of portable or implantable pump	$179.63	$175.20	-$4.43	-2.47%
96417	Each additional sequential infusion (different substance/drug	$81.48	$79.60	-$1.88	-2.31%
Chemotherapy, Intra-arterial					
96420	Push technique infusion up to 1 hour	$109.90	$112.36	$2.46	2.24%
96422	Infusion up to 1 hour	$181.91	$186.25	$4.34	2.39%
96423	Infusion each additional hour up to 8 hours (add-on code)	$78.07	$80.36	$2.29	2.93%
96425	Infusion technique, initiation of prolonged infusion (more than 8 hours) requiring use of a portable or implantable pump	$178.50	$182.82	$4.32	2.42%
Chemotherapy, Other					
96440	Administration into pleural cavity, requiring and including thoracentesis	$370.64	$346.59	-$0.01	-6.49%
96445	Administration into peritoneal cavity, requiring and including peritoneocentesis	$360.03	$335.55	-$24.48	-6.80%
96450	Administration into CNS (e.g., intrathecal), requiring and including spinal puncture	$300.15	$282.22	-$17.93	-5.97%
96521	Refilling and maintenance of portable pump	$145.91	$140.92	-$4.99	-3.42%
96522	Refilling and maintenance of implantable pump or reservoir for drug delivery, systemic (e.g., intravenous, intra-arterial)	$110.28	$112.36	$2.08	1.89%
96523	Irrigation of implanted venous access device for drug delivery systems,	$27.42	$27.42	$0.00	0.00%
96542	Chemotherapy injection, subarachnoid or intraventricular via subcutaneous reservoir, single or multiple agents	$182.29	$176.34	-$5.95	-3.26%

*Initial Code
Add-on code—List separately in addition to code for initial code
Pricing based on national, unadjusted Medicare reimbursement, 2008 Physician Fee Schedule

Stereotactic Radiosurgery and Radiotherapy Coding Essentials

by Cindy C. Parman, CPC, CPC-H, RCC

Stereotactic radiosurgery (SRS) is a form of computer-assisted radiation therapy for the destruction of lesions by high-dose radiation using 3D planning of convergent beam technologies. A high total radiation dose is delivered stereotactically to a small tumor volume through multiple discrete entry portals or arcs in a single fraction or a small number of fractions.

Physician offices and freestanding cancer centers report CPT procedure codes for all services related to SRS management and treatment delivery; however, hospitals are still required to use certain Level II Healthcare Common Procedure Coding System (HCPCS) codes developed by the Centers for Medicare & Medicaid Services (CMS) to define SRS treatment delivery services reported under the Outpatient Prospective Payment System (OPPS). Of note, the computer planning charges are reported with the same code set used for 3D conformal planning.

The stereotactic procedure codes can be categorized as:

1. Treatment delivery (facility) or treatment management (professional)
2. Treatment of cranial lesions or treatment of extracranial areas
3. Single fraction radiosurgery or fractionated stereotactic radiotherapy.

Cobalt-60 Treatment Delivery–Single Session

Procedure code 77371 is defined as: radiation treatment delivery, stereotactic radiosurgery (SRS), complete course of treatment of cranial lesion(s) consisting of one session; multi-source cobalt-60 based. The cobalt-60 technical treatment delivery code is reported regardless of the type of facility. In other words, both hospitals and freestanding cancer centers report the same code for this therapy modality.

Linear Accelerator Treatment Delivery–Single Session

Procedure code 77372 is defined as: radiation treatment delivery, stereotactic radiosurgery (SRS), complete course of treatment of cranial lesion(s) consisting of one session; linear accelerator-based. While freestanding cancer centers and physician offices can charge for this procedure, this code is *not* reimbursed by Medicare under OPPS. Instead, hospitals must report HCPCS Level II code G0173 (stereotactic radiosurgery, complete course of therapy in one session). As indicated in the code definition, the complete course of therapy must be delivered in a single treatment session. In addition, this code is not limited to the treatment of cranial lesions; any single-fraction radiosurgery treatment can be reported to Medicare with this HCPCS Level II code.

Linear Accelerator Treatment Delivery–Fractionated

Fractionated radiosurgery occurs when the total radiation dose is delivered to the patient in five fractions or less. Radiosurgery cannot be coded as a boost to external beam treatment, unless permitted by written payer policy. Procedure code 77373 is defined as stereotactic body radiation therapy, treatment delivery, per fraction to one or more lesions, including image guidance, entire course not to exceed five fractions. Freestanding cancer centers and physician offices can report procedure code 77373 daily for a course of treatment to any body area (including fractionated intracranial radiosurgery) that consists of five hypofractions or less. Hospitals may also charge this procedure code for non-Medicare patients *only*.

Under OPPS, hospitals must use HCPCS Level II G0251 (linear accelerator-based stereotactic radiosurgery, delivery including collimator changes and custom plugging, fractionated treatment, all lesions, per session, maximum five sessions per course of treatment). If the planned course of therapy will exceed five treatment sessions, conventional treatment delivery codes (procedure codes 77402-77416) must be assigned for each treatment day. As a result, it would *not* be appropriate to assign G0251 for the first five treatment days and then assign standard treatment delivery codes for the balance of therapy.

Image-guided Robotic SRS Treatment Delivery

CMS distinguishes linear accelerator-based SRS into two categories: gantry-based systems and image-guided robotic systems (see Transmittal 1139, dated Dec. 22, 2006). As such, the agency has assigned separate HCPCS Level II codes for robotic image-guided SRS delivery. Hospitals must bill HCPCS code G0339 (image-guided robotic linear accelerator-based stereotactic radiosurgery, complete course of therapy in one session or first session of fractionated treatment) for the first session. Hospitals should bill HCPCS code G0340 (image-guided robotic linear accelerator-based stereotactic radiosurgery, delivery including collimator changes and custom plugging, fractionated treatment, all lesions, per session, second through fifth sessions, maximum five sessions per course of therapy) for the second through fifth sessions. These codes are only reported when the equipment used to deliver the radiosurgery meets the CMS definition as outlined in Transmittal 1139. (This transmittal can be found online at: *www.cms.hhs.gov/transmittals/downloads/R1139CP.pdf*.) In addition, these codes are not limited to a particular diagnosis, so local carriers and private payer policies determine reimbursement amounts.

For non-robotic image-guided SRS delivery, hospitals must bill

Table 1. Stereotactic Radiosurgery and Radiotherapy Procedure Codes

Category	Code	Description
Single Fraction Delivery (Technical)	77371	Radiation treatment delivery, stereotactic radiosurgery, complete course of treatment of cranial lesion(s) consisting of 1 session; multi-source cobalt-60 based
	77372	Radiation treatment delivery, stereotactic radiosurgery, complete course of treatment of cranial lesion(s) consisting of 1 session; linear-accelerator-based
	G0173	Stereotactic radiosurgery, complete course of therapy in 1 session
	G0339	Image-guided robotic linear-accelerator-based stereotactic radiosurgery, complete course of therapy in 1 session or first session of fractionated treatment
Professional Management	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
Fractionated Delivery (Technical)	77373	Stereotactic body radiation therapy, treatment delivery, per fraction to 1 or more lesions, including image guidance, entire course not to exceed 5 fractions
	G0251	Linear-accelerator-based stereotactic radiosurgery, delivery including collimator changes and custom plugging, fractionated treatment, all lesions, per session, maximum 5 sessions per course of treatment
	G0339 + G0340	Image-guided robotic linear-accelerator-based stereotactic radiosurgery, complete course of therapy in 1 session or first session of fractionated treatment Image-guided robotic linear-accelerator-based stereotactic radiosurgery, delivery including collimator changes and custom plugging, fractionated treatment, all lesions, per session, second through fifth sessions, maximum 5 sessions per course of therapy
Professional Management	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

G0173 if the delivery occurs in one session and G0251 for delivery per session if delivery occurs during multiple sessions (not to exceed five sessions).

Professional Treatment Management

Two unique codes are available to report the professional component of stereotactic radiosurgery procedures: 77432 and 77435.

Professional code 77432 is limited to treatments where the total dose is delivered to a cranial lesion in a single fraction of treatment. It is *not* correct to report this code for management of the first treatment of a fractionated course of therapy. Instead, professional code 77435 (stereotactic body radiation therapy, treatment management, per treatment course, to one or more lesions, including image guidance, entire course not to exceed five fractions) is used to charge for fractionated treatment management.

Code 77435 is reported with one unit to report the management of the course of fractionated stereotactic treatment delivery to any body area, including fractionated intracranial radiosurgery. This professional treatment management service includes constant physician attendance during the daily treatments, contemporaneous review of all images taken throughout the course of the treatment to verify target localization, and assessment of tumor tracking and gating applications. If the planned course of therapy will exceed a total of five fractions, code 77435 is not reported. Non-stereotactic codes 77427 and 77431 are reported when the definition does not meet the criteria to report stereotactic radiosurgery.

When reporting claims information, several procedure codes for stereotactic radiosurgery treatment delivery and management are available. Keep in mind that these codes provide for increased specificity. At the same time, it is important to remember that reimbursement for these technologies is not driven solely by the existence of codes or documentation of medical necessity, but will instead be determined by individual insurance payor policies.

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