Part B Insider (Multispecialty) Coding Alert

Stereotactic Radiosurgery: Are Gamma Knife Mistakes Cutting Into Your Profits?

Surgeons, radiation oncologists must stick to their separate areas

Whenever doctors collaborate on a procedure, the potential for a coding mishap exists. Stereotactic radiosurgery, also known as gamma knife surgery, requires complex planning and the efforts of a surgeon and a radiation oncologist.

Fortunately, coordinating the billing between the two physicians is simple if you remember these important rules:

-The surgeon only bills one code, 61793 (Stereotactic radiosurgery [particle beam, gamma ray or linear accelerator], one or more sessions). You should use this code for brain, lung, prostate or other stereotactic surgery, says **Jim Hugh,** vice president of **American Medical Accounting & Consulting** in Atlanta.

The radiation oncologist bills several codes from the 77000 series, but surgeons shouldn't use any of these, Hugh adds. Some surgeons wrongly believe they can **bill for 77295** (Therapeutic radiology simulation-aided field setting; three-dimensional) or 77315 (Tele-therapy, isodose plan [whether hand or computer calculated]; complex).

-You can only bill one planning per session. Surgeons can never bill for planning, and radiation oncologists may only report one type of planning for a given session. Sometimes radiation oncologists try to bill for two different types of planning at once, such as two-dimensional and three-dimensional, Hugh notes. You can't bill both, he warns. For example, with stereotactic surgery, no matter how many lesions you treat, the patient only has one brain.

The surgeon bills only one code, but the radiation oncologist bills a number of codes. For neurosurgery, these would include 77432 (Stereotactic radiation treatment management of cerebral lesion[s]), plus planning and dosimetry.

-The surgeon can bill multiple units of 61793 for multiple lesions. According to **Wisconsin Physicians Services'** July 2004 newsletter, the **American Medical Association** (AMA) reversed on this issue. In the May 2003 CPT Assistant, the AMA said surgeons should report 61793 only once per session, no matter how many lesions the patient might have.

But after discussions with the **American College of Neurosurgery**, the AMA reversed course in the April 2004 CPT Assistant. The question: Could the surgeon report the code twice if the patient had two lesions, one on the right side and one on the left. The AMA responded the surgeon could code 61793 twice and use modifier -59 (Distinct procedural service) or -51 (Multiple procedures), depending on payer requirements. "Code 61793 is valued for a single metastatic lesion," and multiple lesions require "significantly more physician work" on radiosurgical planning and treatment, the AMA admitted.

-Don't bill separately for some additional services. The National Correct Coding Initiative (NCCI) bundles 61795 (Stereotactic computer-assisted volumetric [navigational] procedure, intracranial, extracranial or spinal) and 20660 (Application of cranial tongs, caliper or stereotactic frame, including removal) into 61793, notes **Eric Sandhusen,** director of compliance with **Columbia University Department of Surgery.** You may be able to bill these codes separately for non-Medicare payers.

-Pay attention to consultation issues. As with other collaborations, you should know which physician is requesting an opinion from the other physician, notes Sandhusen. Make sure you have the correct paperwork to be able to bill for a consult.