In the last year or two, new procedures in radiation oncology have become more common and issues surrounding their reimbursement have surfaced at the same time. The procedures of Stereotactic RadioSurgery (SRS) and Stereotactic Body Radiation Therapy (SBRT) have now been recognized by most carriers as bonafide procedures to treat some cancers for their beneficiaries. With IMRT, these new procedures make liberal use of Image Guided Radiation Therapy (IGRT) to insure that the target tumors at the focus of these procedures are being treated precisely and accurately.

Because these new procedures involve planning and delivering large doses in a few fractions (hypofractionation), it is imperative that the radiation oncologist and medical physicist are “present” at each treatment fraction. The increase in complexity and treatment times for these procedures further insist on these presence requirements. Frequent imaging before and during treatment delivery require feedback from the radiation oncologist and medical physicist for accurate localization of the targets. Patients have the potential of injury if they are not supervised in the treatment delivery and there is greater onus on the treating Radiation Therapist to understand all of the mechanisms involved in these more complex delivery schemes. Unlike the presence requirements for HDR procedures which are rooted in a regulatory requirement (NRC and State agencies), the presence requirements for SRS/SBRT are rooted in the reimbursement values for these procedures with professional and technical times for the radiation oncologist and medical physicist.

Another area that has surfaced recently for activities of the medical physicist is in the fusion of image data sets to the base CT planning images used for treatment planning – not only for SRS/SBRT, but for IMRT and Conventional 3D where these image sets are utilized. Magnetic Resonance Imaging (MRI) is the most common image set one thinks of in fusing to the CT planning data set and has been used historically in cranial target RT. Other “foreign” image sets are coming to the fore also. These are PET and PET/CT data sets as well as Ultrasound and even, arteriograms. If these are DICOM compatible, most can be fused with the primary CT data set if the planning software is set up to accept these image sets. CPT 77370, Special Physics Consult is the primary CPT code used to cover this work, as the medical physicist (or dosimetrist under the supervision of the medical physicist) is primarily responsible for evaluating the goodness of anatomic fusion of these image sets to the primary CT data set. As with any work performed under CPT 77370, the request for fusion must come from the radiation oncologist in a signed/dated requisition and the medical physicist will generate a report back to the radiation oncologist referring to the congruence between the two image sets for a particular patient study. The report is signed/dated by the medical physicist, again, as with any