Applicable To:
- ☑ Medicare (excluding AZ, KY and UAM-NY)
- ☑ Medicaid – FL,GA,HI,MO,NE,NJ, NY,SC

Claims and Payment Policy: Intensity Modulated Radiation Therapy (IMRT)

Policy Number: CPP-108
Original Effective Date: 07/01/2019
Revised Date(s): N/A

BACKGROUND

Intensity Modulated Radiation Therapy (IMRT), also known as conformal radiation, delivers radiation with adjusted intensity to preserve adjoining normal tissue. IMRT can deliver a higher dose of radiation within the tumor while delivering a lower dose of radiation to surrounding healthy tissue. IMRT is provided in two treatment phases, planning and delivery.

When IMRT is furnished to beneficiaries in a hospital outpatient department that is paid under the hospital OPPS, hospitals must remember that CPT codes 77014, 77280, 77285, 77290, 77295, 77306, 77307, 77316, 77317, 77318, 77321, 77331, and 77370 are included in the Ambulatory Payment Classification (APC) payment for CPT code 77301 (IMRT planning). You should not report these codes in addition to CPT code 77301, when provided prior to, or as part of, the development of the IMRT plan. The charges for these services should be included in the charge associated with CPT code 77301, even if the individual services associated with IMRT planning are performed on dates of service other than the date on which CPT code 77301 is reported.

POSITION STATEMENT

In accordance with the American Medical Association (AMA) and the Centers for Medicare and Medicaid Services (CMS) National Correct Coding Initiative (NCCI) Policy Manual, Wellcare Health Plans considers the IMRT plan, CPT 77301, to include the work of all services performed in the development of the IMRT plan on the same or different dates of service for the same tumor. To report services for a different tumor on a different date of service, use the appropriate modifier to identify that it is separate, distinct and unrelated to the IMRT plan.

Pre Pay Review

For Wellcare Health Plan's purposes, services incidental to IMRT (CPT codes 77014, 77280, 77285, 77290, 77295, 77306, 77307, 77316, 77317, 77318, 77321, 77331, and 77370) reported with a date of service 30 days after or 90 days prior to the date of service reported for the IMRT plan (CPT code 77301) are considered included in the IMRT plan when reported by the Same Group Physician and/or Other Health Care Professional. If these services are billed separately, the incidental service claim submission will be

denied. If the provider does not agree with Wellcare's determination, they may dispute the denial or resubmit the claim with the appropriate modifier.

In addition to the CPT codes incidental to IMRT planning, the IMRT plan code itself (77301) is not permitted to be billed twice within 90 days for the same member when reported by the Same Group Physician and/or Other Health Care Professional.

Post Pay Review

Wellcare may retrospectively audit providers regarding the bundling of services incidental to IMRT. Services incidental to IMRT (CPT codes 77014, 77280, 77285, 77290, 77295, 77306, 77307, 77316, 77317, 77318, 77321, 77331, and 77370) reported with a date of service 30 days after or 90 days prior to the date of service reported for the IMRT plan (CPT code 77301) will be considered included in the IMRT plan when reported by the Same Group Physician and/or Other Health Care Professional. Wellcare will issue a finding and recovery letter to the provider if they are paid seperately.

Please note: The Pre and Post Pay Reviews described above apply to the same or different dates of service for CPT codes 77014, 77280, 77285, 77290, 77295, 77306, 77307, 77316, 77317, 77318, 77321, 77331, and 77370 bundled with CPT code 77301. Standard National Correct Coding Initiative (NCCI) Policy Manual edits still apply for all other CPT codes billed on the same date of service.

CODING & BILLING

CPT code **77014**	Computed tomography guidance for placement of radiation therapy fields
CPT code **77280**	Simple; simulation of a single treatment area
CPT code **77285**	Intermediate; simulation of two separate treatment areas
CPT code **77290**	Complex; simulation of three or more treatment areas; or any number of treatment areas if any of the following are involved: particle, rotation or arc therapy, complex blocking, custom shielding blocks, brachytherapy simulation, hyperthermia probe verification, any use of contrast materials.
*CPT code **77301**	Intensity modulated radiotherapy plan, including dose-volume histograms for target and critical structure partial tolerance specifications
CPT code **77306**	Teletherapy isodose plan; simple (1 or 2 unmodified ports directed to a single area of interest), includes basic dosimetry calculation(s)
CPT code **77307**	Teletherapy isodose plan; complex (multiple treatment areas, tangential ports, the use of wedges, blocking, rotational beam, or special beam considerations), includes basic dosimetry calculation(s)
CPT code **77316**	Brachytherapy isodose plan; simple (calculation[s] made from 1 to 4 sources, or remote afterloading brachytherapy, 1 channel), includes basic dosimetry calculation(s)
CPT code **77317**	Brachytherapy isodose plan; intermediate (calculation[s] made from 5 to 10 sources, or remote afterloading brachytherapy, 2-12 channels), includes basic dosimetry calculation(s)
CPT code **77318**	Brachytherapy isodose plan; complex (calculation[s] made from over 10 sources, or remote afterloading brachytherapy, over 12 channels), includes basic dosimetry calculation(s)

CPT code **77321**	Special teletherapy port plan, particles such as electrons, neutrons and protons, hemibody and total body
CPT code **77331**	Special dosimetry (e.g., TLD/thermoluminescent dosimetry, microdosimetry), only when prescribed by the treating physician
CPT code **77370**	Special medical radiation physics consultation

Coding information is provided for informational purposes only. The inclusion or omission of a CPT, HCPCS, or ICD-10 code does not imply member coverage or provider reimbursement. Consult the member's benefits that are in place at time of service to determine coverage (or non-coverage) as well as applicable federal / state laws.

MODIFIERS

Modifier	Modifier Description
59	**Distinct Procedural Service** Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different size or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used. Note: Modifier 59 should not be appended to an E/M service. To report a separate and distinct E/M service with a non-E/M service performed on the same date, see modifier 25.
xu	**Unusual Non-Overlapping Service** Unusual non-overlapping service, the use of a service that is distinct because it does not overlap usual components of the main service.

DEFINITIONS

Intensity Modulated Radiation Therapy (IMRT)	Intensity modulated radiotherapy plan, including dose-volume histograms for target and critical structure partial tolerance specifications.
Same Group Physician and/or Other Health Care Professional	All physicians and/or other health care professionals of the same group reporting the same Federal Tax Identification number.

REFERENCES

1. American Medical Association, Current Procedural Terminology (CPT®) and associated publications and services
2. Centers for Medicare and Medicaid Services (CMS), National Correct Coding Initiative (NCCI) publications
3. Individual state Medicaid regulations, manuals & fee schedule

4. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network MLN/MLNMattersArticles/downloads/SE18013.pdf
5. https://downloads.cms.gov/medicare-coverage-database/lcd_attachments/30316_20/l30316_rad014_cbg_080111.pdf
6. https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3471CP.pdf

IMPORTANT INFORMATION ABOUT THIS DOCUMENT

Claims and Payment Policies (CPPs) are policies regarding claims or claim line processing and/or reimbursement related to the administration of health plan benefits. They are not recommendations for treatment, nor should they be used as treatment guidelines. Providers are responsible for diagnosing, treating, and making clinical recommendations to the member. CPPs are subject to, but not limited to, the following:

- State and federal laws and regulations;
- Policies and procedures promulgated by the Centers for Medicare and Medicaid Services, including National Coverage Determinations and Local Coverage Determinations;
- The health plan's contract with Medicare and/or a state's Medicaid agency, as applicable;
- Other CPPs and clinical policies as applicable including, but not limited to, *Pre-Payment and Post-Payment Review*.
- The provisions of the contract between the provider and the health plan; and
- The terms of a member's particular benefit plan, including those terms outlined in the member's Evidence of Coverage, Certificate of Coverage, and other policy documents.

In the event of a conflict between a CPP and a member's policy documents, the terms of a member's benefit plan will always supersede the CPP.
The use of this policy is neither a guarantee of payment, nor a prediction of how a specific claim will be adjudicated. Any coding information is for informational purposes only. No inference should be made regarding coverage or provider reimbursement as a result of the inclusion, or omission, in a CPP of a CPT, HCPCS, or ICD-10 code. Always consult the member's benefits that are in place at time of service to determine coverage or non-coverage. Claims processing is subject to a number of factors, including the member's eligibility and benefit coverage on the date of service, coordination of benefits, referral/authorization requirements, utilization management protocols, and the health plan's policies. Services must be medically necessary in order to be covered.
References to other sources and links provided are for general informational purposes only, and were accurate at the time of publication. CPPs are reviewed annually but may change at any time and without notice, including the lines of business for which they apply. CPPs are available at www.Wellcare.com. Select the "Provider" tab, then "Tools" and then "Payment Guidelines".

Care1st Health Plan Arizona, Inc. ~ Easy Choice Health Plan ~ Harmony Health Plan of Illinois ~ Missouri Care ~ 'Ohana Health Plan, a plan offered by Wellcare Health Insurance of Arizona ~ OneCare (Care1st Health Plan Arizona, Inc.) ~ Staywell of Florida ~ ~ Wellcare Prescription Insurance
Wellcare (Arkansas, Connecticut, Florida, Georgia, Illinois, Kentucky, Louisiana, Mississippi, Nebraska, New Jersey, New York, South Carolina, Tennessee, Texas)

RULES, PRICING & PAYMENT COMMITTEE HISTORY AND REVISIONS

Date	Action
07/30/2019	• Approved by RGC