Radiation Therapy

Program Overview and Billing Instructions

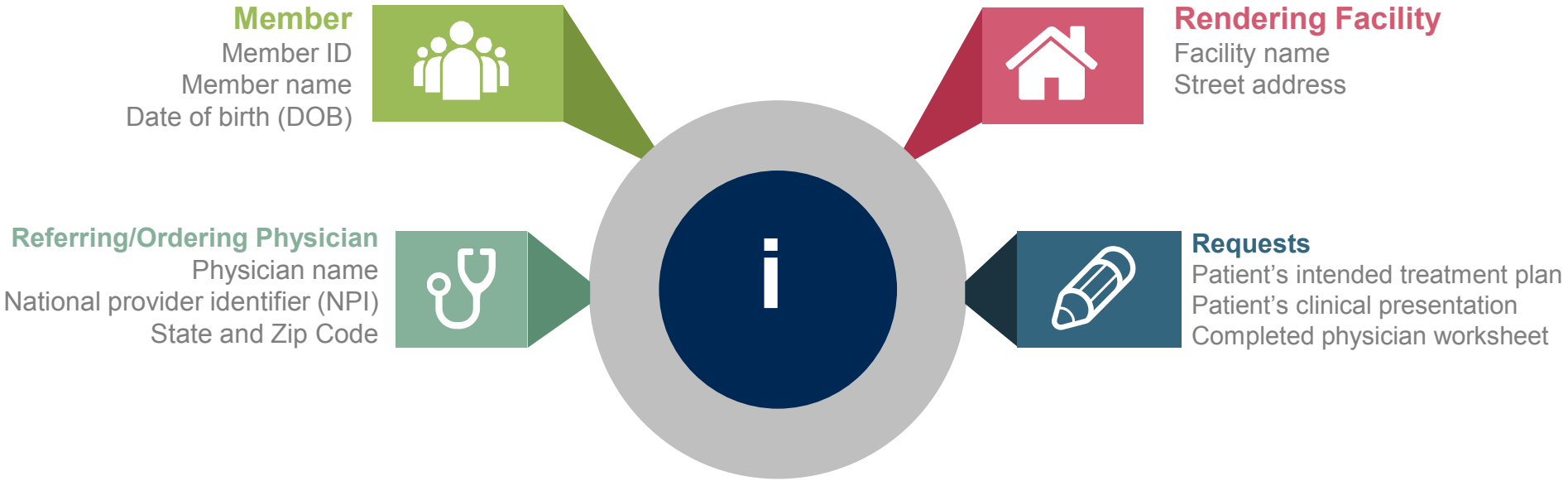
Agenda

- Information Needed to Start a Case
- Program Overview
- Common Reasons Claims May Not Receive Payment on the First Attempt

Information Needed to Start a Case

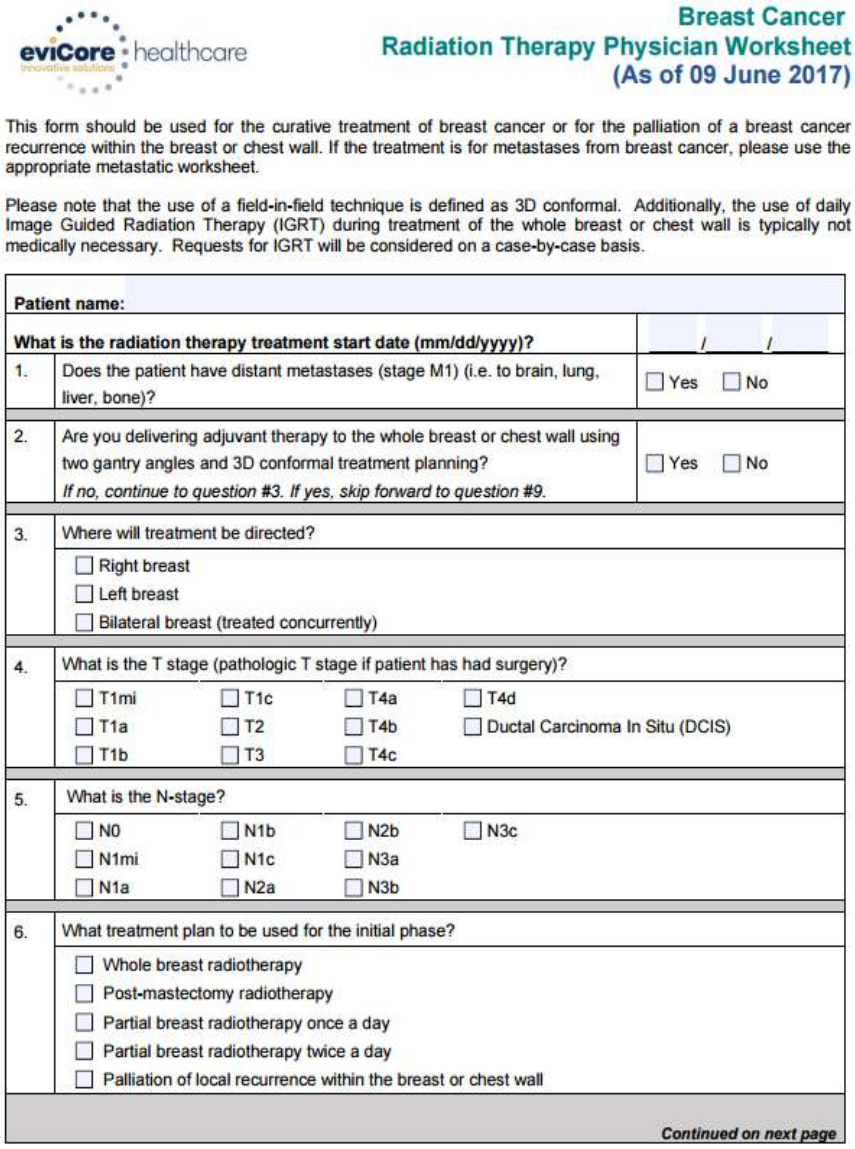
Needed Information

Please Note: Clinical Worksheets are required and should be filled out by the physician



Physician Worksheet

- **The physician worksheet is best completed by the physician during the initial consultation with the patient.**
- Inaccurate information causes authorized services to differ from those that are actually delivered and can lead to adverse determinations.
- You can access the physician worksheets online: https://www.evicore.com/resources/pages/providers.aspx?solution=Radiation%20Therapy#ReferenceGuidelines



evicore healthcare

Breast Cancer
Radiation Therapy Physician Worksheet
(As of 09 June 2017)

This form should be used for the curative treatment of breast cancer or for the palliation of a breast cancer recurrence within the breast or chest wall. If the treatment is for metastases from breast cancer, please use the appropriate metastatic worksheet.

Please note that the use of a field-in-field technique is defined as 3D conformal. Additionally, the use of daily Image Guided Radiation Therapy (IGRT) during treatment of the whole breast or chest wall is typically not medically necessary. Requests for IGRT will be considered on a case-by-case basis.

Patient name:

What is the radiation therapy treatment start date (mm/dd/yyyy)? ____/____/____

1. Does the patient have distant metastases (stage M1) (i.e. to brain, lung, liver, bone)? ☐ Yes ☐ No

2. Are you delivering adjuvant therapy to the whole breast or chest wall using two gantry angles and 3D conformal treatment planning? ☐ Yes ☐ No
   If no, continue to question #3. If yes, skip forward to question #9.

3. Where will treatment be directed?
   - ☐ Right breast
   - ☐ Left breast
   - ☐ Bilateral breast (treated concurrently)

4. What is the T stage (pathologic T stage if patient has had surgery)?
   - ☐ T1mi ☐ T1a ☐ T1b
   - ☐ T1c ☐ T2 ☐ T3
   - ☐ T4a ☐ T4b ☐ T4c
   - ☐ T4d ☐ Ductal Carcinoma In Situ (DCIS)

5. What is the N-stage?
   - ☐ N0 ☐ N1mi ☐ N1a
   - ☐ N1b ☐ N1c ☐ N2a
   - ☐ N2b ☐ N3a ☐ N3b
   - ☐ N3c

6. What treatment plan to be used for the initial phase?
   - ☐ Whole breast radiotherapy
   - ☐ Post-mastectomy radiotherapy
   - ☐ Partial breast radiotherapy once a day
   - ☐ Partial breast radiotherapy twice a day
   - ☐ Palliation of local recurrence within the breast or chest wall

Continued on next page

Program Overview

Holistic Treatment Plan Review

eviCore healthcare relies on information about the patient's unique presentation and physician's intended treatment plan to authorize all services from the initial simulation through the delivery of the last fraction of radiation.

- Providers specify a diagnosis rather than request individual CPT codes
- Diagnosis and treatment plan compared to the evidence-based guidelines developed by our Medical Advisory Board
- If the request is authorized/covered or partially authorized/covered, then the treatment technique and number of fractions will be provided
- For questions about specific CPT codes that are included with each episode of care, please reference the **eviCore Radiation Therapy Coding Guidelines** located online: https://www.evicore.com/resources/pages/providers.aspx?solution=Radiation%20Therapy#ReferenceGuidelines
- The eviCore Radiation Therapy Prior Authorization program is designed to review and approve a specific radiation therapy treatment plan. Such authorizations include approvals for the radiation technique, the number of fractions (treatments), the number of phases (or cone-downs), image guided radiation therapy (IGRT). Providers should bill according to the treatment plan that was rendered, and billing should align with the national billing guidelines for radiation therapy. If the claims received fall outside of these billing guidelines or do not align with the approved treatment plan, the claim submission may not be guaranteed for payment.

Common Reasons a Claim May not Receive Payment on the First Attempt

Top Reasons for Radiation Therapy Denials

The eviCore Radiation Therapy Prior Authorization program is designed to review and approve a specific radiation therapy treatment plan. Such authorizations include approvals for the radiation technique, the number of fractions (treatments), the number of phases (or cone-downs), image guided radiation therapy (IGRT). Providers should bill according to the treatment plan that was rendered, and billing should align with CMS billing policies for radiation therapy. If the claims received fall outside of these billing guidelines or do not align with the approved treatment plan, the claim submission may not be guaranteed for payment.

When claims associated with eviCore radiation therapy are rejected, providers should review the following and once addressed, resubmit the claim:

1. Authorization is on the eviCore portal
2. The dates of service on the authorization match the dates of services the claims were billed
3. Units billed do not exceed the units approved on the authorization
4. If IGRT was billed, the approval is included in the authorization letter

Top Reasons for Radiation Therapy Code Denials (cont'd)

Common reasons that a provider may encounter a claim denial for CPT Codes managed under the eviCore Radiation Therapy Prior Authorization Program:

Claim is not payable due to lack of approved or partially approved authorization.

When claims are submitted prior to the authorization being obtained and prior to approval or partial approval of that authorization then the claim may not be paid. The authorization should be submitted to eviCore prior to the start of radiation therapy treatment delivery and prior to submission of any claims.

Claim is not payable because the date of service of the CPT Code is outside of the authorized treatment timespan.

The treatment timespan associated with the approved or partially approved authorization is indicated on the authorization fax notification letters. If the date of service of the reported CPT code falls out of this timespan then the CPT code may not be payable. For example, if the treatment expands past the original expiration date associated with the authorization and CPT Codes are submitted with dates of service that are after the expiration date then the CPT Code may not be payable.

If it is known the date of service associated with a CPT code falls outside of the treatment time span then it is recommended the provider notify eviCore.

Top Reasons for Radiation Therapy Code Denials (cont'd)

CPT Codes associated with Image Guided Radiation Therapy [IGRT] are billed but not paid.

If IGRT is requested during submittal of the authorization then the approval (or lack of approval) of IGRT will be included in the authorization provided by eviCore.

The authorization letter/fax notifications will indicate one of the following:

- If IGRT was requested, if IGRT was requested/is not approved and the reason as to why it is not approved
- If IGRT is approved.

To the extent that IGRT is not requested during initial submission of the authorization but subsequently found to be required for the treatment plan, eviCore must be notified of the updated treatment plan to obtain approval.

It is recommended to follow CMS MUE and CCI edits for appropriate billing of IGRT. ASTRO's website has an FAQ dedicated to IGRT billing practices that does not require a membership or subscription: https://www.astro.org/Daily-Practice/Coding/Coding-Guidance/FAQ-IGRT/.

Top Reasons for Radiation Therapy Code Denials (cont'd)

Claims are received that do not align with National Billing Guidelines for Radiation Therapy.

Coding edits are in line with CMS guidelines and edits. It is important that offices remain up to date with CMS National Correct Coding Initiative [NCCI] and Medically Unlikely Edits [MUEs] which can be found at:

https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/MUE.html

- **Example:** 77412 should be used for complex delivery treatment >= MeV which requires any of the following criteria are met: 3 or more separate treatment areas, custom blocking, tangential ports, sedges, rotational beam, field-in-field or other tissue compensation that does not meet IMRT guidelines, or electron beam. This code is only used by OPPS. Code 77412 is most often not payable because it is billed more than once on one date of service. If the code must be reported more than once per date of service, then provider should reference the corresponding MUEs in order to follow proper billing procedures for codes.

CMS published the following guidelines as it relates to IMRT billing which addresses 77412 specifically:

https://downloads.cms.gov/medicare-coverage-database/lcd_attachments/34652_13/L34652_RAD014_BCG.pdf

Top Reasons for Radiation Therapy Code Denials (cont'd)

Reported CPT Code is not payable due to reason that the CPT Code Is Not Authorized.

A low volume of claims are rejected due to CPT codes being billed that do not match CPT codes authorized. The claim may not be payable if the reported CPT Code is not consistent with the requested and approved treatment plan associated with the authorization. Billing should be in accordance to what treatment plan was requested and authorized. For example, if 3D Conformal treatment plan is requested and approved then it is expected services and procedures pertinent to a 3D conformal treatment plan are reported as opposed to services and procedures pertinent to an Intensity Modulated Radiation Therapy [IMRT].

- If it becomes known a radiation therapy technique that is different than what was originally requested and authorized at eviCore is required, then please call eviCore to update the treatment plan prior to the first treatment session and if possible, prior to billing.

- If the CPT Code has already been billed and was not payable for the reason that the code was not authorized, then please review what treatment plan was submitted and authorized at eviCore. It is also recommended the claim is appealed and documentation is provided to support the use of the reported service.

- Example: 77386 (IMRT); for these denials, providers requested and were approved for 3D but billed this IMRT code. The letter states "Phase 1: 30 fractions (treatment sessions) of 3D conformal" under approved services. If the provider decides that they need IMRT instead of 3D, then the provider should call in to modify the request.

Resources

The following resources related to the radiation therapy eviCore program and billing are recommended:

- https://downloads.cms.gov/medicare-coverage-database/lcd_attachments/34652_13/L34652_RAD014_BCG.pdf
- https://downloads.cms.gov/medicare-coverage-database/lcd_attachments/30316_20/l30316_rad014_cbg_080111.pdf
- https://www.astro.org/Daily-Practice/Coding/Coding-Guidance/Coding-FAQ-s-and-Tips/
- https://www.evicore.com/ReferenceGuidelines/eviCore%20Radiation%20Therapy%20Coding%20Guidelines.pdf

Additional Resource:

- https://www.evicore.com/healthplan/BCBSM
  - This is the link to the eviCore & BCBSMI implementation site. Here you can find FAQs and the newly published “Radiation Therapy Billing and Claims Support Document” found under “Resources” of the Radiation Therapy implementation page.

If a claim is denied, please follow BCSBMI Post Service Claim Appeal Process.

Thank You!