Radiation Oncology Payment Policy

Applies to the following Tufts Health Plan products:

- ☒ Tufts Health Plan Commercial (including Tufts Health Freedom Plan)[1]
- ☒ Tufts Medicare Preferred HMO (a Medicare Advantage product)[2]
- ☒ Tufts Health Plan Senior Care Options (SCO) (a dual-eligible product)[2]

Applies to the following Tufts Health Public Plans products:

- ☒ Tufts Health Direct (a Massachusetts Qualified Health Plan [QHP]; a commercial product)
- ☒ Tufts Health Together (a MassHealth MCO Plan and Accountable Care Partnership Plans)
- ☒ Tufts Health RITogether (a Rhode Island Medicaid Plan)
- ☒ Tufts Health Unify (OneCare Plan; a dual-eligible product)

The following payment policy applies to Tufts Health Plan contracting providers. For information on oncology services, refer to the Oncology Payment Policy.

In addition to the specific information contained here, providers must adhere to the policy information outlined in the Professional Services and Facilities Payment Policy.

Note: Audit and disclaimer information is located at the end of this document.

POLICY

Tufts Health Plan covers medically necessary radiation oncology[3] services, in accordance with the member's benefit.

GENERAL BENEFIT INFORMATION

Services and subsequent payment are pursuant to the member's benefit plan document. Member eligibility and benefit specifics should be verified prior to initiating services by logging on to the secure Provider portal or by contacting Provider Services.

Note: There is no member responsibility for covered services for Tufts Health Plan SCO, Tufts Health Unify, Tufts Health Together or Tufts Health RITogether members.

REFERRAL/PRIOR AUTHORIZATION/NOTIFICATION REQUIREMENTS

Certain procedures, items and/or services may require referral and/or prior authorization. While you may not be the provider responsible for obtaining prior authorization, as a condition of payment you must confirm that prior authorization has been obtained. For a comprehensive list of services that require prior authorization, refer to the Medical Necessity Guidelines section of the Resource Center.

For plans with referral requirements, a PCP referral is required for radiation oncology services.

BILLING INSTRUCTIONS

Unless otherwise stated, Tufts Health Plan follows industry standard coding guidelines. Refer to current industry standard coding guidelines for a complete list of ICD, CPT/HCPCS, revenue codes, modifiers and their usage. Providers may only bill the procedure code(s) in accordance with the applicable financial exhibits of their provider agreements and applicable fee schedules. For more information, refer to the Professional Services and Facilities Payment Policy.

Use of noncontracting labs may have the unintended consequence of subjecting the member to unnecessary services not ordered by the treating provider or other unreasonable financial exposure. In

---

[1] Commercial products include HMO, POS, PPO, Tufts Health Freedom Plan, and CareLink℠ when Tufts Health Plan is the primary administrator.

[2] Tufts Medicare Preferred and Tufts Health Plan SCO are collectively referred to in this payment policy as Senior Products.

[3] Tufts Health Plan aligns its business practices with the AMA definition of radiation oncology.

such circumstances, Tufts Health Plan may hold the ordering provider accountable for any inappropriate behavior on the part of the nonparticipating lab that has been selected.

Professional, Technical and Global

Only services that have a professional and technical component may be billed with modifiers 26 and TC, respectively. Refer to the AMA Principles of CPT Coding for additional information.

Procedures that are defined as technical component only in nature do not require a modifier and therefore should not be billed with modifier TC or 26. Refer to the CMS National Physician Relative Value File for additional information.

Radiation Oncology Procedure Codes

The following radiation oncology procedure codes are accepted by Tufts Health Plan (this list may not be all-inclusive):

Note: Senior Products, Tufts Health Together, Tufts Health Unify and Tufts Health RITogether members may be covered for additional Medicare and/or Medicaid-only procedures, items or services not listed below. Refer to the MassHealth Radiation Oncology Center Provider Manual or National Coverage Determinations (NCD) and Local Coverage Determinations (LCD) for additional information.

Stereotactic Radiosurgery[4]

Procedure Code	Description
32701	Thoracic target(s) delineation for stereotactic body radiation therapy (SRS/SBRT), (photon or particle beam), entire course of treatment
61796	Stereotactic radiosurgery (SRS) (particle beam, gamma ray, or linear accelerator); one simple cranial lesion
61797	SRS; each additional cranial lesion, simple
61798	SRS; one complex cranial lesion
61799	SRS; each additional cranial lesion, complex
61800	Application of stereotactic headframe for stereotactic radiosurgery
63620	SRS; 1 spinal lesion
63621	SRS; each additional spinal lesion
77371	Radiation treatment delivery, stereotactic radiosurgery (SRS), complete course of treatment of cranial lesion(s) consisting of one session; multi-source Cobalt 60 based
77372	linear accelerator based
77373	Stereotactic body radiation therapy, treatment delivery, per fraction to one or more lesions, including image guidance, entire course not to exceed 5 fractions
77432	Stereotactic radiation treatment management of cranial lesion(s) (complete course of treatment consisting of one session)
77435	Stereotactic body radiation therapy, treatment management, per treatment course, to 1+ lesions, including image guidance, entire course not to exceed 5 fractions
G0339	Image-guided robotic linear accelerator-based SRS, complete course of therapy in one session or first session of fractionated treatment
G0340	Image-guided robotic linear accelerator-based SRS, delivery including collimator changes and custom plugging, fractionated treatment, all lesions, per session, second through fifth sessions, maximum 5 sessions per course of treatment

Other Procedure Codes

Procedure Code	Description
77261	Therapeutic radiology treatment planning; simple

[4] Prior authorization is required for Commercial and Tufts Health Public Plans members only.

Procedure Code	Description
77262	Therapeutic radiology treatment planning; intermediate
77263	Therapeutic radiology treatment planning; complex
77280	Therapeutic radiology simulation-aided field setting; simple
77285	Therapeutic radiology simulation-aided field setting; intermediate
77290	Therapeutic radiology simulation-aided field setting; complex
77295	Therapeutic radiology simulation-aided field setting; 3-dimensional
77299	Unlisted procedure, therapeutic radiology clinical treatment planning
77300	Basic radiation dosimetry calculation
77301	Intensity modulated radiotherapy plan (IMRT), including dose-volume histograms for target and critical structure partial tolerance specifications
77321	Special teletherapy port plan, particles, hemibody, total body
77331	Special dosimetry (e.g., TLD, microdosimetry) (specify), only when prescribed by the treating physician
77332	Treatment devices, design and construction; simple (simple block, simple bolus)
77333	Treatment devices, design and construction; intermediate (multiple blocks, stents, bite blocks, special bolus)
77334	Treatment devices, design and construction; complex (irregular blocks, special shields, compensators, wedges, molds or casts)
77336	Continuing medical physics consultation, including assessment of treatment parameters, quality assurance of dose delivery, and review of patient treatment documentation in support of the radiation oncologist, reported per week of therapy
77370	Special medical radiation physics consultation
77399	Unlisted procedure, medical radiation physics, dosimetry and treatment devices, and special services
77401	Radiation treatment delivery, superficial and/or ortho voltage
77402	Radiation treatment delivery, 1 treatment area, single port or parallel opposed ports, simple blocks or no blocks; up to 5 MeV
77407	Radiation treatment delivery, 2 separate treatment areas, 3+ ports on a single treatment area, use of multiple blocks; up to five MeV
77412	Radiation treatment delivery, 3+ separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, electron beam; up to 5 MeV
77417	Therapeutic radiology port film(s)
77423	One or more isocenter(s) with coplanar or non-coplanar geometry with blocking and/or wedge, and/or compensator(s)
77427	Radiation treatment management, five treatments
77431	Radiation therapy management with complete course of therapy; 1-2 fractions
77470	Special treatment procedure (e.g., total body irradiation, hemibody radiation, per oral, endocavitary or intraoperative cone irradiation)
77499	Unlisted procedure, therapeutic radiology treatment management
77520	Proton treatment delivery; simple, without compensation
77522	Proton treatment delivery; simple, with compensation
77523	Proton treatment delivery; intermediate
77525	Proton treatment delivery; complex

COMPENSATION/REIMBURSEMENT INFORMATION

Providers are compensated according to the applicable network contracted rates and applicable fee schedules, regardless of the address where the service is rendered. For additional information, refer to the Professional Services and Facilities Payment Policy.

Frequency Policies and Descriptions

Tufts Health Plan sets the following frequency limits on certain procedures:

Policy	Code(s)	Units	Time Frame
Clinical treatment for planning	77261, 77262, 77263	1	56 days (per diagnosis)
Therapeutic radiology simulation, aided field setting	77280, 77285, 77290, 77295	5	56 days
Basic radiation dosimetry	77300	10	
Intensity modulated radiotherapy (IMRT)	77301	1 date of service	
Special dosimetry	77331	6	
Treatment devices (simple, intermediate, complex)	77332, 77333, 77334	12	53 days
Continuing medical radiation physics consultation	77336	1	5 days
Therapeutic port film(s)	77417	1	7 days
Radiation treatment management services	77427, 77431	1	5 days

Tufts Health Plan does not routinely compensate for the following:

Policy	Description
Basic radiation and special dosimetry	Basic radiation dosimetry calculation if billed for more than six units per day by any provider unless the diagnosis is head & neck cancer, prostate cancer or Hodgkin's disease and a complex therapy service has not been billed for the same date of service or within two weeks, before or after.
	Basic radiation dosimetry calculation if billed for more than six units in eight weeks by any provider unless the diagnosis is head & neck cancer, prostate cancer or Hodgkin's disease, and a complex therapy service has not been billed for the same date of service or within two weeks, before or after.
Brachytherapy Services	Brachytherapy sources when billed without an associated brachytherapy procedure.
Intensity modulated radiotherapy (IMRT)	IMRT unless a qualifying diagnosis, recognized by CMS Local Coverage Determinations (LCDs) is also present on the claim.
	Radiation oncology services when billed with IMRT unless a qualifying diagnosis, recognized by CMS LCDs is present on the claim.
Radiation therapy treatment devices	Treatment devices (simple, intermediate, or complex) when billed for more than 7 units per day or more than 7 units in 53 days by any provider unless the diagnosis is head and neck or prostate cancer and a complex therapy service has been billed for the same date of service or within two weeks, before or after.

Policy	Description
Special treatment procedure	77470 (special treatment procedure ([e.g., total body irradiation, hemibody radiation, per oral or endocavitary irradiation]) unless billed with malignant neoplasms of any the following and a complex therapy service has not been billed for the same date of service or within 14 days, before or after: • Tongue • Gum • Floor of mouth • Other and unspecified parts of mouth • Oropharynx or testis • Lymphosarcoma • Reticulosarcoma • Multiple myeloma • Leukemia • Immunoproliferative neoplasms • Lymphoid leukemia • Neoplasm of uncertain behavior of unspecified sites and tissues • Unspecified disorders of metabolism • Disorders involving the immune mechanism or aplastic anemia • Other bone marrow failure syndromes

Procedure Code Guidelines

Tufts Health Plan compensates for the following when billed for one date of service within 56 days, per clinical guidelines and the AMA CPT and HCPCS Level II Manuals:

- 77470 (special treatment procedure [e.g., total body irradiation, hemibody radiation, per oral or endocavitary irradiation]).
- Multi-leaf collimator (MLC) device(s) for intensity modulated radiation therapy (IMRT), design and construction per IMRT plan

Professional Component of Radiology Services in Facility Places of Service

Tufts Health Plan does not routinely compensate professional radiology services billed by radiation oncologists in an inpatient or outpatient hospital setting.

DOCUMENT HISTORY

- September 2020: Reviewed by Committee; added Tufts Health Public Plans applicability; template updates
- November 2018: Added edit for professional component of radiology services in facility places of service effective for dates of service on or after January 1, 2019
- September 2018: Policy reviewed by committee; added link to Oncology Payment Policy; separated SRS codes requiring prior authorization from larger table; condensed claim edits and frequency limitations for clarity
- June 2018: Template updates
- July 2017: Added edit for brachytherapy services effective for dates of service on or after October 1, 2017
- January 2017: Template updates
- October 2016: Policy reviewed by committee; template updates
- July 2016: Added special dosimetry edit effective for dates of service on or after October 1, 2016

AUDIT AND DISCLAIMER INFORMATION

Tufts Health Plan reserves the right to conduct audits on any provider and/or facility to ensure compliance with the guidelines stated in this payment policy. If such an audit determines that a provider/facility did not comply with this payment policy, Tufts Health Plan will expect the provider/facility to refund all payments related to noncompliance. For more information about Tufts Health Plan's audit policies, refer to the Provider website.

This policy provides information on Tufts Health Plan claims adjudication processes. As every claim is unique, this policy is neither a guarantee of payment, nor a final indication of how specific claim(s) will be adjudicated. Claims payment is subject to member eligibility and benefits on the date of service,

coordination of benefits, referral/authorization and utilization management requirements (when applicable), adherence to plan policies and procedures, and claims editing logic. An authorization is not a guarantee of payment. Claims for services subject to authorization may be reviewed for accuracy and compliance with payment policies.

This policy applies to the Tufts Health Plan products, as identified in the checkboxes on the first page, and to CareLink℠ for providers in Massachusetts and Rhode Island service areas. Providers in the New Hampshire service area are subject to Cigna's provider agreements with respect to CareLink members. This policy does not apply to the Private Health Care Systems (PHCS) network (also known as Multiplan). Tufts Health Plan reserves the right to amend a payment policy at its discretion.