healthfirst
Health Insurance for New Yorkers

Reimbursement Policy

Subject:	Intensity-Modulated Radiation Therapy (IMRT) Frequency Limitations		
Policy Number:	PO-RE-119v2		
Effective Date:	12/01/2024	**Last Approval Date:**	12/5/2025

I. Policy Description

This policy outlines the reimbursement guidelines for Intensity-Modulated Radiation Therapy (IMRT) services provided by healthcare providers. IMRT, specifically represented by CPT code 77301 (Intensity-modulated radiotherapy [IMRT] plan), is subject to frequency limitations to ensure appropriate billing practices and compliance with regulatory requirements.

This policy applies to the following lines of business:

- Child Health Plus (CHP)
- Medicaid Managed Care (MMC)
- Medicare Advantage
- Personal Wellness Plan (PWP)/Health & Recovery (HARP)
- Essential Plan (EP)
- Medicaid Advantage Plus/MAP (CompleteCare)
- Medicare PPO
- Qualified Health Plan (QHP)

Policy Scope

This policy applies to all healthcare providers and facilities who perform IMRT services and seek reimbursement for such services. The policy addresses the frequency limitations, billing guidelines, and documentation requirements for IMRT procedures to align with industry standards and regulatory directives.

- IMRT Frequency Limitation Guidelines:
  - CPT code 77301 (intensity-modulated radiation therapy [IMRT] plan) should only be billed once per treatment course. A typical radiation oncology course of treatment is defined as eight (8) weeks) 56 days) according to the American Society for Radiation Oncology guidelines.

- Exceptions:
  - Additional billing of CPT 77301 may be justified when there is documentation of significant changes in patient anatomy during treatment, requiring repeat planning and CT scanning.

- Billing Restrictions:

- According to CMS policy, separate payment is not permitted for IMRT treatment codes (77014, 77280, 77285, 77290, 77295, 77306-77307, 77316-77318, 77321, 77331, 77370) when billed two weeks prior to or as a part of an IMRT plan (77301) for the same medical condition. This restriction is in place to prevent duplicate billing for IMRT services within a short timeframe.

- Healthfirst expects healthcare providers to adhere to these IMRT frequency limitation guidelines when submitting claims for reimbursement. Non-compliance with these guidelines may result in claim denials or audit findings. It is essential for providers to maintain accurate documentation supporting the medical necessity and appropriateness of additional IMRT services beyond the standard billing frequency.

Adjudication and Appeal Process

1. Reimbursement for IMRT services will be determined based on the provider's scope of services and the reimbursement rates outlined in the provider's contract with Healthfirst.

2. Claims submitted by providers that do not adhere to this policy will be denied or rejected. It is the responsibility of the provider to ensure claims are coded accurately.

3. If the line of business (LOB) is not mentioned in this policy, the services are not covered and not eligible for reimbursement.

4. This policy is a provider resource for understanding Healthfirst's reimbursement guidelines. It does not guarantee coverage or payment. Final reimbursement decisions depend on benefit coverage, state/federal mandates, medical necessity, and provider contract.

5. Claims submissions will be subject to timely filing requirements, as set forth in the provider contract with Healthfirst and in the Healthfirst Provider Manual. *Refer to: Healthfirst Provider Manual Subsection 17.6, "Claims Inquiries, Corrected Claims, Claim Reconsideration, and Appeal Process" in this section.*

Please be advised that all services provided are subject to the member's individual benefit coverage.

II. Applicable Codes

Code	Description	Comment
77014	Computed tomography guidance for placement of radiation therapy fields	
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	3-dimensional radiotherapy plan, including dose-volume histograms	
77301	Intensity modulated radiotherapy plan, including dose-volume histograms for target and critical structure partial tolerance specifications	
77306	Teletherapy isodose plan; simple (1 or 2 unmodified ports directed to a single area of interest), includes basic dosimetry calculation(s)	
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)	
77316	Brachytherapy isodose plan; simple (calculation[s] made from 1 to 4 sources, or remote afterloading brachytherapy, 1 channel), includes basic dosimetry calculation(s)	
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)	
77318	Brachytherapy isodose plan; complex (calculation[s] made from over 10 sources, or remote afterloading brachytherapy, over 12 channels), includes basic dosimetry calculation(s)	
77321	Special teletherapy port plan, particles, hemibody, total body	
77331	Special dosimetry (eg, TLD, microdosimetry) (specify), only when prescribed by the treating physician	
77370	Special medical radiation physics consultation	

III. Definitions

Term	Meaning

IV. Related Policies

Policy Number	Policy Description
PO-RE-123	Intensity-Modulated Radiation Therapy

Procedure codes appearing in Reimbursement Policy documents are included only as a general reference tool for each policy. They may not be all-inclusive.

V. Reference Materials

CMS Intensity Modulated Radiation Therapy (IMRT) LCD
Radiation Oncology Coding Resource - American Society for Radiation Oncology (ASTRO) - American Society for Radiation Oncology (ASTRO)

VI. Revision History

Revision Date	Summary of Changes
12/5/2025	Added Adjudication and Appeals section.

Disclaimer

Healthfirst's claim edits follow national industry standards aligned with CMS standards that include, but are not limited to, the National Correct Coding Initiative (NCCI), the National and Local Coverage Determination (NCD/LCD) policies, appropriate modifier usage, global surgery and multiple procedure reduction rules, medically unlikely edits, duplicates, etc. In addition, Healthfirst's coding edits incorporate industry-accepted AMA and CMS CPT, HCPCS and ICD-10 coding principles, National Uniform Billing Editor's revenue coding guidelines, CPT Assistant guidelines, New York

State-specific coding, billing, and payment policies, as well as national physician specialty academy guidelines (coding and clinical). Failure to follow proper coding, billing, and/or reimbursement policy guidelines could result in the denial and/or recoupment of the claim payment.

This policy is intended to serve as a resource for providers to use in understanding reimbursement guidelines for professional and institutional claims. This information is accurate and current as of the date of publication. It provides information from industry sources about proper coding practice. However, this document does not represent or guarantee that Healthfirst will cover and/or pay for services outlined. Reimbursement decisions are based on the terms of the applicable evidence of coverage, state and federal requirements or mandates, and the provider's participation agreement. This includes the determination of any amounts that Healthfirst or the member owes the provider.