

Subject:	Intensity-Modulated Radiation Therapy (IMRT) Frequency Limitations		
Policy Number:	PO-RE-119v1		
Effective Date:	12/01/2024	Last Approval Date:	10/28/2024

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)
- Healthfirst Insurance Commercial (HFIC)
- 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.
- Claims will be reimbursed in accordance with the provider’s contract with Healthfirst or at the Healthfirst standard fee schedule.
- 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.

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

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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

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.