Radiation Oncology

Reimbursement Policy ID: RPC.0070.0900

Recent review date: 12/2025

Next review date: 12/2026

AmeriHealth Caritas New Hampshire reimbursement policies and their resulting edits are based on guidelines from established industry sources, such as the Centers for Medicare and Medicaid Services (CMS), the American Medical Association (AMA), state and federal regulatory agencies, and medical specialty professional societies. Reimbursement policies are intended as a general reference and do not constitute a contract or other guarantee of payment. AmeriHealth Caritas New Hampshire may use reasonable discretion in interpreting and applying its policies to services provided in a particular case and may modify its policies at any time.

In making claim payment determinations, the health plan also uses coding terminology and methodologies based on accepted industry standards, including Current Procedural Terminology (CPT); the Healthcare Common Procedure Coding System (HCPCS); and the International Classification of Diseases,10th Revision, Clinical Modification (ICD-10-CM), and other relevant sources. Other factors that may affect payment include medical record documentation, legislative or regulatory mandates, a provider's contract, a member's eligibility in receiving covered services, submission of clean claims, and other health plan policies, and other relevant factors. These factors may supplement, modify, or in some cases supersede reimbursement policies.

This reimbursement policy applies to all health care services billed on a CMS-1500 form or its electronic equivalent, or when billed on a UB-04 form or its electronic equivalent.

To the extent that any procedure and/or diagnosis codes are specified in this policy, such inclusion is provided for reference purposes only, may not be all inclusive, and is not intended to serve as billing instructions. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by federal, state, or contractual requirements and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

Policy Overview

This policy addresses reimbursement of external beam radiation therapy that includes the following: intensity modulated radiation therapy (IMRT), brachytherapy, proton beam radiation therapy (PBRT), and stereotactic body radiation therapy (SBRT).

Exceptions

N/A

Reimbursement Guidelines

Reimbursement of the various radiation oncology services are as follows:

Treatment Devices

- Treatment devices (simple, intermediate, or complex – codes 77332-77334) are limited to twelve units in eight weeks by any provider.
- Any combination of 77332-77334 is limited to seven units per day with a qualifying diagnosis, or 7 units in 8 weeks when a complex therapy service has not been billed for the same date of service or within two weeks (before or after)

Special treatment procedure

Special treatment procedures, code 77470, include total body irradiation, hemibody radiation, per oral or endocavitary irradiation. The code is used to cover the additional physician effort and work required for:

- 3D CRT
- Any other special time-consuming treatment plan
- Brachytherapy
- Heavy particles (e.g., protons/neutrons)
- Hyperfractionation
- Hyperthermia
- IMRT
- Intracavitary cone use
- Intra-operative radiation therapy and hemibody irradiation
- Planned combination with chemotherapy or another combined modality therapy
- Radiation response modifiers
- Stereotactic radiosurgery
- Total body irradiation

Intensity modulated radiation therapy (IMRT)

- IMRT services are reimbursable for cancers of bone, brain and central nervous system, colorectal, gastrointestinal, gynecological, head and neck (including thyroid), lung, Hodgkin's and non-Hodgkin's lymphoma, prostate, sarcoma, thymoma, thymic carcinoma and pediatric tumors. For appropriate reimbursement a qualifying diagnosis is required .
- If the IMRT is billed two weeks prior to the IMRT plan, the claim will be denied.
- The IMRT plan (77301) will be denied when billed for more than one (1) date of service in eight weeks.

Proton beam radiation therapy (PBRT)

PBRT is used to treat brain and spine tumors, breast cancer, prostate cancer, liver cancer, lung cancer, head and neck cancers, esophageal cancer, anal, colon, and rectal cancer, pancreatic cancer, eye melanoma, lymphoma, sarcoma, tumors of the base of the skull. A qualifying diagnosis is required for reimbursement .

Definitions

N/A

Edit Sources

I. Current Procedural Terminology (CPT) and associated publications and services.
II. Healthcare Common Procedure Coding System (HCPCS)
III. cms.gov/medicare-coverage-database/lcd_attachments/34652_13/L34652_RAD014_BCG.pdf
IV. International Classification of Diseases,10th Revision, Clinical Modification (ICD-10-CM)
V. https://www.astro.org/Daily-Practice/Coding/Coding-Guidance/Coding-Guidance-Articles/77301
VI. https://www.astro.org/News-and-Publications/ASTROnews/2023/2023-Winter-ASTROnews.
VII. New Hampshire Medicaid Fee Schedule(s).

Attachments

N/A

Associated Policies

RPC.0063.0900 Place of Service

Policy History

12/2025	Reimbursement Policy Committee Approval
12/2025	Annual review • No revisions
04/2025	Revised preamble
02/2025	Reimbursement Policy Committee Approval
04/2024	Revised preamble
08/2023	Removal of policy implemented by [Insert plan name] from Policy History section
01/2023	Template Revised • Revised preamble • Removal of Applicable Claim Types table • Coding section renamed to Reimbursement Guidelines • Added Associated Policies section