HIGHMARK RADIATION THERAPY AUTHORIZATION PROGRAM
FREQUENTLY ASKED QUESTIONS

Revised: April 1, 2015

GENERAL POLICIES AND PROCEDURES

Q1. Can you provide me with an overview of this program?

A1. Highmark developed the Radiation Therapy Authorization Program in an effort to help ensure that the radiation therapy services provided to members are consistent with nationally recognized clinical guidelines. The program promotes quality and patient safety for members who require radiation therapy services.

Effective for dates of service beginning January 1, 2012, authorizations will be required for select outpatient radiation therapy services performed in either a professional or facility setting before claims can be paid. The radiation oncologist who formulates the treatment plan and provides and/or coordinates the radiation therapy treatment will be responsible for requesting authorizations for Highmark members whose coverage requires authorization.

Highmark has partnered with eviCore healthcare (formerly CareCore National) to support the Radiation Therapy Authorization Program by completing pre-authorization reviews and granting authorizations where applicable for select outpatient radiation therapy services.

Q2. What medical policies are used for pre-authorization reviews?

A2. Highmark medical policies are used. If there is no specific Highmark medical policy, requests for authorization are reviewed according to eviCore's evidence-based radiation therapy criteria. The clinical criteria used by eviCore healthcare in making medical necessity determinations are consistent with Highmark Medical Policy. eviCore's Radiation Therapy Criteria are available on Highmark's Provider Resource Center as well as the eviCore website.

Q3. What are the components of the radiation therapy authorization process?

A3. The Radiation Therapy Program is comprised of two parts: the authorization review process and the claims process.

First, a decision is rendered when eviCore collects pertinent information regarding the patient's diagnosis and the physician's intended treatment plan. The information required for authorization is based on the physician worksheets, which are located on the Highmark Provider Resource Center and also on the eviCore website under *Radiation Therapy Tools and Criteria*. An authorization encompasses all services from the initial simulation through the delivery of the last fraction of radiation.

Second, claims are submitted to Highmark, forwarded to eviCore, and matched against the authorization to ensure that the included CPT codes are being appropriately billed for the approved treatment plan.

Q4. Does the program include inpatient services?
A4. No. This is an outpatient-only program.

Q5. Which Places of Service require an authorization?
A5. Authorizations will be required for select outpatient radiation therapy services performed in either a professional or facility setting for Highmark members whose coverage requires authorization.

Q6. Will urgent requests be accepted?
A6. Yes. Urgent requests will be accepted and a determination expedited if clinically indicated.

Q7. What are ASTRO and ACR? How is this information accessed?
A7. ASTRO and ACR stand for the American Society for Radiation Oncology and the American College of Radiology. These organizations recognize quality radiation oncology practices and establish standards of performance derived from evidence-based guidelines. Highmark and eviCore rely on ASTRO and ACR Coding Guidelines to ensure that billing for each episode of care is consistent with all applicable billing standards.

Q8. A provider's fax number, phone number, or address needs to be updated. Should they contact eviCore?
A8. No. eviCore receives contact information from Highmark's database. The provider should contact Highmark to have his or her information updated. Once Highmark has updated this information, it will be electronically sent to eviCore. The best way to ensure that a provider or facility receives written communication from eviCore is to provide updated phone, fax, and address information to Highmark.

PRE-AUTHORIZATION REVIEWS

Q9. What is the best way to obtain a pre-authorization review?
A9. The fastest way for physicians to obtain a pre-authorization review is by submission using NaviNet.® Approvals may be provided immediately online. If you do not have access to the Internet, then you can request a pre-authorization review by calling eviCore healthcare at 1-888-564-5492 or 1-800-547-3627, Option 5.

A completed physician worksheet will assist both the provider and eviCore by allowing a decision to be rendered without delay. Information required for pre-authorization review may include: cancer type being treated, staging of the patient, treatment intent and technique, and number of fractions. The worksheets are available on the Highmark Provider Resource Center and at www.evicore.com. All clinical questions that are asked of the provider during the authorization request are listed on the worksheet.

Q10. Can physician worksheets be submitted by fax?
A10. No. All requests for pre-authorization reviews must be submitted via NaviNet® or by phone.

Q11. How long does it take to receive an answer after a request is submitted?

A11. If the request is processed without hitting an exception that requires the case to go to a physician for review, the approval is instantaneous. The approval process can take up to two days but is usually much shorter. The pre-authorization review time frame is further governed by applicable state regulations.

Q12. How long do the authorizations last?

A12. The authorization expiration date varies by the case. eviCore communicates the expiration date once the approval is generated, both verbally and in written correspondence that is either faxed or mailed to the office using the address and fax information provided to eviCore by Highmark. If a patient needs to stop treatment for some reason or needs a break from treatment, the provider may call eviCore and report the issue to receive an extension to the authorized treatment period.

The time frame for authorizations depends on the cancer type and the number of fractions needed for treatment. Authorization date ranges can vary from six weeks to six months, depending on the individual case, but always allow ample time to render treatment.

Q13. Can an eviCore authorization number expire?

A13. Yes. The approval and expiration dates are included in the letters. Providers can also confirm these dates by calling eviCore Customer Service at 1-888-564-5492 or 1-800-547-3627, Option 5.

Q14. Is a new authorization required if a member requires additional treatment (such as a recurrence of disease or change in patient clinical condition)?

A14. Yes. The authorization is valid for the treatment plan that has been requested by the physician (an episode of care). If the physician is going to provide the member with another episode of care, a new authorization will be required.

If during a course of treatment the physician intends to modify an approved treatment plan, then the physician should call eviCore to discuss the new treatment plan to allow the existing authorization to be adjusted appropriately. The modifications to the treatment plan that are determined to be medically necessary will be communicated to the physician.

Q15. Can an authorization be obtained for multiple sites of therapy for the same patient at the same time?

A15. Yes, after the therapy is deemed medically necessary and authorized accordingly.

Q16. Who is responsible for obtaining an authorization?

A16. The radiation oncologist who has determined the radiation therapy treatment plan is responsible.

Q17. What if my initial request for treatment is not automatically approved?

A17. The majority of requests for treatment are approved following clinical review via either phone or NaviNet.® Those that are not automatically approved are sent for clinical review with a board-certified radiation oncologist.

If a case is partially approved or denied, the provider can initiate the reconsideration process. During this process, the provider can submit additional clinical information **or** participate in a peer-to-peer conversation

that allows the referring physician or their representative to speak with an eviCore radiation oncologist regarding the treatment plan.

Q18. What is the process for a peer-to-peer conversation?

A18. A designee from the radiation oncologist's office may call eviCore to schedule a peer-to-peer conversation pertaining to a partially denied or denied case. If the requesting radiation oncologist is not available, the eviCore physician will speak with a physician assistant, nurse practitioner, dosimetrist, or physicist. Peer-to-peer conversations are performed within one to two business days of a request. A peer-to-peer conversation may be scheduled by calling 1-888-564-5492, or by faxing clinical information to 1-866-669-8128. eviCore medical directors will return calls within one business day of the request.

Q19. Where should the provider send an appeal for a request for authorization that has been denied or partially denied?

A19. eviCore recommends that the provider should utilize the reconsideration process before filing an appeal. Reconsiderations are completed by submitting additional clinical information or through peer-to-peer conversations and allow the eviCore physicians to take the patient's particular circumstances into account. If the initial decision is upheld, then the next step is an appeal. Provider appeals for commercial members should be submitted directly to eviCore. Provider appeals for Medicare Advantage members should be submitted to Highmark. All member appeals, commercial or Medicare Advantage, should be submitted to Highmark.

Q20. What if a physician does not agree with eviCore's decision following reconsideration and wants to file an appeal?

A20. Where appeals are sent is dependent on whether the member is commercial or Medicare Advantage:

- Within 180 days, the provider can appeal a clinical decision for a **commercial** member's authorization to eviCore:
  eviCore APPEALS DEPARTMENT
  400 Buckwalter Place Blvd.
  Bluffton, SC 29910
  Fax: 1-866-699-8128
- Within 60 days, the provider can appeal a clinical decision for a **Medicare Advantage** member's authorization to Highmark:
  Medicare Health Plan Appeals Department
  P.O. Box 535047
  Pittsburgh, PA 15253-5047
  Fax: 412-544-1513 (Attn: Appeals Department)

APPEAL INFORMATION IS SENT IN THE DECISION LETTERS TO THE PHYSICIAN, MEMBER, AND SITE.
Providers may submit additional documentation to support their appeal.

POST-SERVICE CLAIMS

Q21. Why is my post-service claim denying?

A21. The most common reasons for post-service claim denials are:

- An authorization for radiation therapy has not been obtained. A physician worksheet must be completed, and eviCore must be contacted to obtain authorization. Once this has been completed, claims can be resubmitted against the approved treatment plan.
- Dates of service are outside of the approved authorization date range. Please make sure that the authorization includes all of the dates of service.
- The CPT code is not authorized for the approved treatment plan or that particular code cannot be billed on the same date of service as another billed code. Please refer to the coding guidelines located in the *Coding s*ection of this document and on the Highmark Provider Resource Center for information about coding resources.

Q22: What clinical information should a provider submit with a claim appeal?

A22: Please refer to the *Payment Appeal Documentation Requirements* worksheet located on the Highmark Provider Resource Center or at www.evicore.com. This worksheet describes what clinical documentation is required depending on the CPT code that is being appealed.

Q23: I have a rejected claim and want to submit a claim appeal.

A23: **All claim appeals for both commercial and Medicare Advantage should be directed to Highmark.** Providers will need to submit supporting documentation for any services/treatments that were not covered in the initial treatment course. There is no reconsideration option for claim denials. **To submit a claim appeal, call Highmark Provider Services:**

- **For Commercial members: 1-800-547-3627, Option 7;**
- **For Medicare Advantage members: 1-866-588-6967.**

Q24: I have a denial for services I have provided and was not authorized (post-service denial).

A24: All post-service appeals for previously denied cases should be submitted directly to Highmark. Providers may submit additional documentation to support their appeal.

For quick reference:

Where do I send my appeal?	Commercial Member	Medicare Advantage Member
Pre-service	eviCore	Highmark
Post-service	Highmark	Highmark

OPTIONS AFTER A PRE-AUTHORIZATION REVIEW DENIAL

Q25: I have not started treating the patient but my request for an authorization has been denied or partially denied. What are my options?

A25: Following a pre-authorization review denial decision by an eviCore physician, the provider has the following options:

- Reconsideration by submitting additional clinical information or through a peer-to-peer conversation with an eviCore physician.
- Expedited Appeal: An expedited appeal can be requested for pre-service or concurrent cases only. The provider can request an expedited appeal and submit additional supporting documentation for review. A decision will be returned to the provider within a 72-hour time frame. This option is available for 180 days following the date of the initial denial for commercial cases, and 60 days for Medicare Advantage. A physician discussion can be performed during the appeal process. Appeals will be reviewed by a different eviCore physician than during the initial review process. If a provider requests an expedited appeal, the peer-to-peer option for the initial review is waived.
- Standard Appeal: A standard appeal can be requested on any eviCore medical necessity denial. The provider can request a standard appeal and submit additional supporting documentation for review. A decision will be returned to the provider within a 30-day time frame. This option is available for 180 days following the date of the initial denial for commercial cases, and 60 days for Medicare Advantage. A physician discussion can be performed during the appeal process. This will be done with a different eviCore physician than during the initial review and expedited appeal review (if exercised). If a provider exercises a standard appeal, the reconsideration option for the initial review and expedited appeal options are waived.

Q26: I completed treatment on the patient without requesting a pre-authorization review from eviCore. My claims are being denied with the following: "The patient's coverage required authorization for the reported service. The authorization requirements were not met. Therefore, no payment can be made." What are my options?

A26: First, complete a physician treatment plan worksheet and call eviCore to request a pre-authorization review. Then, if the case is partially approved or denied, the provider has the following options:

1. Reconsideration via peer-to-peer (PTP) conversation with the eviCore physician.
2. Standard Appeal (an expedited appeal can be exercised for pre-service or concurrent cases only): The provider can request a standard appeal and submit additional supporting documentation for review. A decision will be returned to the provider within a 30-day time frame. This option is available for 180 days following the date of the initial denial for commercial cases, and 60 days for Medicare Advantage. A physician discussion can be performed during the appeal process. This will be done with a different eviCore physician than during the initial review process.

POLICIES AND PROCEDURES SPECIFIC TO RADIATION ONCOLOGY

Q27: When should the provider contact eviCore for an authorization?

A27: The provider should contact eviCore after the patient's initial consultation when radiation therapy is prescribed. If there is a change in the treatment plan, the provider should notify eviCore of the changes.

Q28: What will a radiation therapy pre-authorization review authorize?

A28: Pre-authorization review will authorize a complete treatment plan to include the consultation, treatment planning, and treatment delivery.

Q29: What information is required from the physician for a pre-authorization review?

A29: The specific information varies by diagnosis. In general, eviCore requires information about the patient's clinical presentation and the physician's intended treatment plan to determine medical necessity. Provider worksheets specific to each cancer type are available on NaviNet,® the Highmark Provider Resource Center, and at www.evicore.com under *Solutions – Radiation Therapy - Radiation Therapy Tools and Criteria*. These worksheets list all clinical questions that are asked of the provider during the initial pre-authorization review either online or by phone. The provider should ensure that the worksheets are completed prior to the initiation of a pre-authorization review.

Q30: What are the main components of the authorization/denial letter?

A30: The letter will include the authorization number, time frame for which the treatment is valid, type of technique, number of phases, and number of fractions, or, if applicable, reason for denial. The letter will also include specific information about the member and provider appeal rights, including where to send information via mail. If the provider has any questions about what is authorized, they should contact eviCore at 1-888-564-5492.

Q31: When should the provider use the *Other Cancer Type* worksheet?

A31: The physician treatment plan worksheets are specific to the most common sites being treated with radiation therapy. If the condition being treated does not fall into the listed categories below, then the *Other Cancer Type* worksheet should be used (e.g., esophageal cancer).

- Bone Metastases
- Brain Metastases
- Breast Cancer
- Cervical Cancer
- CNS Lymphoma
- CNS Neoplasm
- Endometrial Cancer
- Gastric (stomach) Cancer
- Head or Neck Cancer
- Non-Small Cell Lung Cancer
- Small Cell Lung Cancer
- Non-Cancerous Diagnosis
- Pancreatic Cancer
- Prostate Cancer
- Rectal Cancer
- Skin Cancer

NAVINET QUESTIONS

Q32: When is an authorization viewable on NaviNet®?

A32: Approval information is only available on NaviNet® when a case is submitted via NaviNet® and is automatically approved. The approved services are located under the comments section in NaviNet.® If this information is not visible on NaviNet,® the provider can contact eviCore to obtain the approval information.

Q33: How can eviCore find the NaviNet® authorization number in their system?

A33: When authorization requests are submitted via NaviNet,® an eviCore reference number is generated. This number is located at the top of the page and begins with a "C." eviCore representatives can also search for authorizations by using a member's name, ID number, and date of birth.

CODING

Q34: Does eviCore list every approved CPT code when a case is approved?

A34: No. eviCore uses information obtained during clinical review to create a list of CPT codes based on American Society for Radiation Oncology (ASTRO)/American College of Radiology (ACR) coding guidelines. This list accounts for all of the possible ways that a patient can be treated with radiation. When a treatment plan is approved, provides the specific techniques, number of treatment sessions, and, in some cases, the gantry angles. eviCore does not list out each payable radiation therapy code because they do not want to limit the physician's clinical decision making.

Q35: How do I know which CPT codes will be authorized for a particular treatment plan?

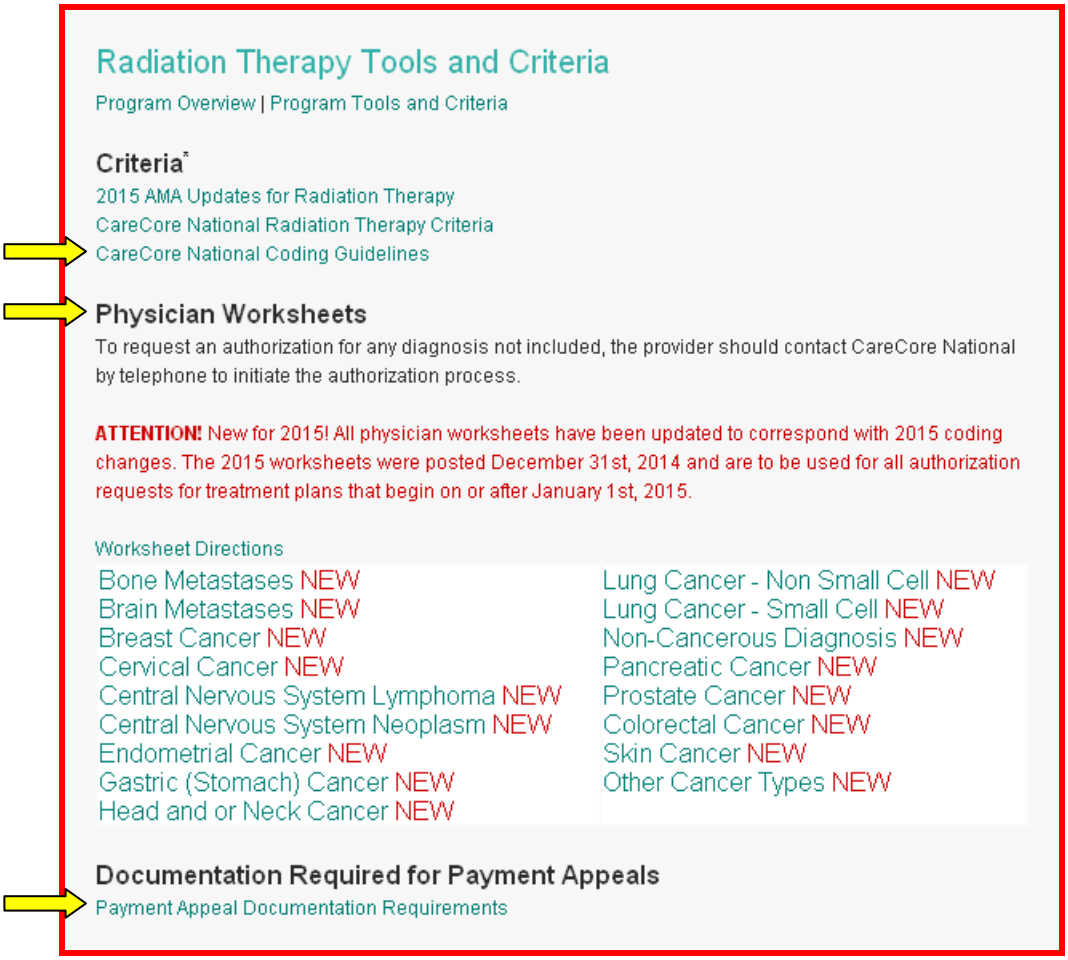
A35: When a treatment plan is authorized, the approved treatment techniques, number of sessions, and, in certain cases, number of gantry angles are provided. This information is enough to determine what to bill according to the ASTRO/ACR coding guidelines without restricting the clinical options available to the radiation oncologist. Physicians will be reimbursed based on the approved treatment plan that they have submitted. CPT code-specific reimbursement is based on correct coding and in accordance with ASTRO/ACR and American Medical Association (AMA) guidelines.

Q36: What can I reference in order to learn which CPT codes are appropriate for my treatment plan and how to bill for them correctly?

A36: In addition to the ASTRO/ACR guidelines, providers can use the available physician worksheets, *eviCore Coding Guidelines*, and *Payment Appeal Documentation Requirements* to assist in knowing what CPT codes are appropriate to bill for each treatment plan. The *Payment Appeal Documentation Requirements* worksheet illustrates the clinical documentation needed in order to appeal a denied CPT code and, therefore, explains what must be performed in order to warrant the billing of certain codes.

ADDITIONAL SUPPORT

Providers can go to www.evicore.com to access additional information about eviCore's radiation therapy management program. Under the *Solutions* tab, select *Radiation Therapy,* and then *Radiation Therapy Tools and Criteria*. The physician treatment plan worksheets, *eviCore Coding Guidelines*, and *Payment Appeal Documentation Requirements* are available. They are also available on the Highmark Provider Resource Center.



Radiation Therapy Tools and Criteria

Program Overview | Program Tools and Criteria

Criteria*

2015 AMA Updates for Radiation Therapy

CareCore National Radiation Therapy Criteria

CareCore National Coding Guidelines

Physician Worksheets

To request an authorization for any diagnosis not included, the provider should contact CareCore National by telephone to initiate the authorization process.

ATTENTION! New for 2015! All physician worksheets have been updated to correspond with 2015 coding changes. The 2015 worksheets were posted December 31st, 2014 and are to be used for all authorization requests for treatment plans that begin on or after January 1st, 2015.

Worksheet Directions

Bone Metastases NEW
Brain Metastases NEW
Breast Cancer NEW
Cervical Cancer NEW
Central Nervous System Lymphoma NEW
Central Nervous System Neoplasm NEW
Endometrial Cancer NEW
Gastric (Stomach) Cancer NEW
Head and or Neck Cancer NEW
Lung Cancer - Non Small Cell NEW
Lung Cancer - Small Cell NEW
Non-Cancerous Diagnosis NEW
Pancreatic Cancer NEW
Prostate Cancer NEW
Colorectal Cancer NEW
Skin Cancer NEW
Other Cancer Types NEW

Documentation Required for Payment Appeals

Payment Appeal Documentation Requirements

CareCore NATIONAL | MEDSOLUTIONS

Radiation Therapy Payment Appeal Documentation Requirements
(As of 01 Jan 2015)

CPT Code	Definition	Clinical Documentation
77014 (TC)	CT for Treatment Planning	Simulation sheet for date of service in question showing CT slices acquired for initial setup. For boost setup, need physician's note detailing medical necessity of additional planning CT. As of 2014, code 77014 is included in the simulation code 77290 for CT simulations and should not be separately reported when performed at the same time in the same department.
77014, 77387, G6001, G6002, G6017	IGRT Procedure	Physician's note detailing the type and frequency of IGRT along with why IGRT was medically necessary.
77261 - 77263	Physician Clinical Treatment Plan (Prescription)	Physician's signed/dated clinical treatment plan identifying patient's prescribed course of treatment.
77280 - 77290	Simulation Procedure	Simulation sheet along with physician's procedure note for date of service in question and physician's treatment summary. If allowed units exceeded then clinical needs to support why additional units were needed.
77295	3D Planning	3D physics plan, including DVH, and physician's note detailing medical necessity of the 3D plan.
77300	Basic Radiation Dose Calculation	Basic dose calculation, isodose plan or dose verification such as RadCalc, IMSure, etc for date of service in question and physician's treatment summary. If allowed units exceeded then clinical needs to support why additional units were needed. As of Jan 1, 2015, code 77300 is included in codes 77306, 77307, 77316, 77317 and 77318.
77301	IMRT Plan	IMRT physics plan and physician's note detailing medical necessity of the IMRT plan.
77306 - 77307	2D Isodose Plan	Physics photon plan for date of service in question.
77321	Special Port Plan	Electron physics plan for date of service in question.
77316-77318	Brachytherapy Isodose Plan	Brachytherapy physics plan for date of service in question.
77331	Special Dosimetry (Diode)	Physician's order for diodes, diode reading for date of service in question and physician's note detailing why diodes were medically necessary.
77332 - 77334	Treatment Device	Documentation of immobilization device and /or each treatment device reported for date of service in question and physician's treatment summary.
77336	Continuing Physics	Documentation of physic's weekly chart check for date of service in question.
77370 77399	Special Physics Consult Unlisted Procedure, Special Physics Service	Physician's request and physicist's report for date of service in question. Documentation/report for date of service in question.
77402, 77407, 77412, 77385, 77386, G6002-G6016	Radiation Treatment Delivery	Treatment record identifying treatment on date of service in question and physician's treatment summary.
77417	Port Film	Treatment record identifying treatment field for port film image on date of service in question.
77427	Radiation Treatment Management	Physician's weekly progress note or On Treatment Visit note for date of service in question and physician's treatment summary.
77470	Special Treatment Procedure	Physician's note explaining the additional work effort beyond standard of care (i.e. concurrent chemo, BID) required for patient treatment.

QUICK REFERENCE GUIDE

1. Fill out a physician worksheet prior to initial simulation, found on the Highmark Provider Resource Center or at www.evicore.com.
2. Obtain authorization for treatment via NaviNet® or by calling eviCore at 1-888-564-5492 or 1-800-547-3627 Option 5, using the physician treatment plan worksheet to answer questions.
3. To address partially approved or denied cases:
   - First use the reconsideration option by calling eviCore.
   - File a provider appeal, expedited or standard, **to Highmark for Medicare Advantage** members and **to eviCore for commercial** members.

     Submit medical necessity denial appeal requests to:

HIGHMARK for **MEDICARE ADVANTAGE** members:	**EVICORE** for **COMMERCIAL** members:
Medicare Health Plan Appeals Department P.O. Box 535047 Pittsburgh, PA 15253-5047 **Fax:** 412-544-1513	eviCore Appeals Department 400 Buckwalter Place Blvd. Bluffton, SC 29910 **Fax:** 1-866-699-8128

4. To appeal claims, first make sure there is a valid authorization on file with eviCore, and then submit appropriate clinical documentation to Highmark for all commercial and Medicare Advantage members. **To submit a claim appeal, call Highmark Provider Service at:**
   - **For Commercial members: 1-800-547-3627, Option 7.**
   - **For Medicare Advantage members: 1-866-588-6967**