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eviCore healthcare

eviCore Radiation Therapy Program

The eviCore Radiation Therapy Prior Authorization program is designed to review and approve a specific radiation therapy treatment plan. These authorizations include approvals for the radiation technique, the number of fractions (treatments), the number of phases (or cone-downs), and image guided radiation therapy (IGRT). Providers should bill according to the treatment plan that was rendered, and billing should align with CMS billing policies for radiation therapy. If the claims received fall outside of these billing guidelines or do not align with the approved treatment plan, the claim is not guaranteed for payment.

When claims associated with eviCore radiation therapy are rejected, providers should review the following issues and, once addressed, resubmit the claim:

1. Authorization is on the eviCore portal
2. The dates of service on the authorization match the dates of service on the claims
3. Units billed do not exceed the units approved on the authorization
4. If IGRT was billed, the approval is included in the authorization letter

Common reasons that a provider may encounter a claim denial for CPT codes managed under the eviCore Radiation Therapy Prior Authorization Program:

- Claim is not payable due to lack of approved or partially approved authorization.

  When claims are submitted prior to the authorization being obtained and prior to approval or partial approval of that authorization, then the claim may not be paid. The authorization should be submitted to eviCore prior to radiation therapy treatment delivery and prior to the submission of any claims.

- Claim is not payable because the date of service of the CPT code is outside the authorized treatment time span.

  The treatment time span associated with the approved or partially approved authorization is indicated on the authorization fax notification letters. If the date of service of the reported CPT code falls outside of this time span then the CPT code may not be payable. For example, if the treatment expands past the original expiration date associated with the authorization and CPT codes are submitted with dates of service that are after the expiration date, then the CPT code may not be payable.

    - If the provider knows the date of service associated with a CPT code falls outside of the authorized treatment time span then it is recommended that the provider notify eviCore prior to submitting the claim

- CPT codes associated with Image Guided Radiation Therapy [IGRT] are billed but not paid.

  If IGRT is requested when the authorization is submitted then the approval (or lack of approval) of IGRT will be included in the authorization provided by eviCore.
    - The authorization letter/fax notifications will indicate one of the following:
        - If IGRT was requested but is not approved, and the reason why it was not approved
        - If IGRT is approved.
    - To the extent that IGRT is not requested when the initial authorization is submitted but is subsequently determined to be required for the treatment plan, the provider must notify eviCore of the updated treatment plan to obtain IGRT approval.

- It is recommended that providers follow CMS MUE and CCI edits for appropriate billing of IGRT. ASTRO's website has a FAQ dedicated to IGRT billing practices that does not require a membership or subscription: https://www.astro.org/Daily-Practice/Coding/Coding-Guidance/FAQ-IGRT/.

- Claims are received that do not align with National Billing Guidelines for Radiation Therapy.

  Coding edits are in line with CMS guidelines and edits. It is important that offices remain up to date with CMS National Correct Coding Initiative [NCCI] and Medically Unlikely Edits [MUEs] which can be found on https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/MUE.html

  - **Example:** 77412 should be used for complex delivery treatment >= MeV which requires any of the following criteria are met: 3 or more separate treatment areas, custom blocking, tangential ports, sedges, rotational beam, field-in-field or other tissue compensation that does not meet IMRT guidelines, or electron beam. This code is only used by OPPS.
    77412 is most often not payable because it is billed more than once on one date of service. If the code must be reported more than once per date of service, then provider should reference the corresponding MUEs in order to follow proper billing procedures for codes.
    CMS published the following guidelines as it relates to IMRT billing which addresses 77412 specifically:

https://downloads.cms.gov/medicare-coverage-database/lcd_attachments/34652_13/L34652_RAD014_BCG.pdf

- Reported CPT code is not payable because the CPT Code Is Not Authorized.

  A low volume of claims is rejected due to CPT codes being billed that do not match CPT codes authorized. The claim may not be payable if the reported CPT code is not consistent with the requested and approved treatment plan associated with the authorization. Billing should be in accordance with the treatment plan requested and authorized. For example, if 3D Conformal treatment plan is requested and authorized then it is expected that services and procedures pertinent to a 3D conformal treatment plan will be billed as opposed to services and procedures pertinent to an Intensity Modulated Radiation Therapy [IMRT].

  - If it is determined that a radiation therapy technique different than what was originally requested and authorized is required, then please call eviCore to update the treatment plan prior to the first treatment session and if possible, prior to billing.

  - If the CPT code has already been billed and was not payable because the code was not authorized, then please review the treatment plan submitted and authorized at eviCore. It is also recommended that the provider appeal the claim and provide documentation to support the use of the reported service.

    - Example: 77386 (IMRT); for these denials, providers requested and was approved for 3D but billed this IMRT code. The letter states "Phase 1: 30 fractions (treatment sessions) of 3D conformal" under approved services. If the provider decides that they need IMRT instead of 3D, then the provider should call eviCore to modify the request.

The following resource related to the radiation therapy eviCore program and billing are recommended:

- https://downloads.cms.gov/medicare-coverage-database/lcd_attachments/34652_13/L34652_RAD014_BCG.pdf
- https://downloads.cms.gov/medicare-coverage-database/lcd_attachments/30316_20/l30316_rad014_cbg_080111.pdf
- https://www.astro.org/Daily-Practice/Coding/Coding-Guidance/Coding-FAQ-s-and-Tips/
- https://www.evicore.com/ReferenceGuidelines/eviCore%20Radiation%20Therapy%20Coding%20Guidelines.pdf

If a claim is denied, please follow Blue Cross Blue Shield of Michigan's Post Service Claim Appeal Process.

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