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RE: BSC8.06 Radiation Oncology Medical Policy, 8.01.62 Electronic Brachytherapy for Nonmelanoma Skin Cancer

Dear Dr. Plass:

The American Society for Radiation Oncology (ASTRO)¹ appreciates Blue Shield of California's (BSCA) continued dialogue with the Society regarding the BSC8.06 Radiation Oncology medical policy. During a conference call held in December of 2020, ASTRO and BSCA discussed edits to sections of the policy, which BSCA summarized in a document entitled, "Policy modifications after 12.2020 ASTRO meeting" (enclosed). Outlined below please find feedback regarding these policy modifications, BSCA's BSC8.06 Radiation Oncology medical policy, and BSCA's Electronic brachytherapy for nonmelanoma skin cancer policy.

Policy Modifications after 12.2020 ASTRO meeting

ASTRO recognizes BSCA's inclusion of several additional considerations throughout this document resulting from our previous discussions. While ASTRO generally agrees with the changes regarding simulations during external beam radiation therapy (EBRT), currently BSCA's policy limits simulations to one per course of treatment. However, routinely, **four simulation charges (77280-77290) are utilized when EBRT with a subsequent boost is planned.** The initial simulation (77290) is routinely verified with verification simulation (77280), and this process is repeated for the boost simulation and subsequent verification. **We urge BSCA to increase the simulation limitation to four.**

In the Teletherapy Isodose Plan section of the document, a "Note" was edited to preclude billing CPT codes 77306 and 77307 during the same episode of care as a Three-Dimensional Conventional Radiotherapy (3D CRT) plan (CPT 77295) or Intensity Modulated Radiation Therapy (IMRT) plan (CPT 77301). This is incorrect. The relevant National Correct Coding Initiative edit takes effect if a provider reports two codes of an edit pair for the same beneficiary on the *same date of service*, not the same episode of care. There are many reasons why these services are billed on a different date of service prior to a 3D CRT plan. For instance, an additional CT simulation may be performed for subsequent photon breast "boost" plans after the initial phase of "tangent fields" planning. **Therefore, we urge BSCA use the wording from the previous version of the policy, "Only one teletherapy isodose plan is allowed**

¹ *ASTRO members are medical professionals, who practice at hospitals and cancer treatment centers in the United States and around the globe and make up the radiation therapy treatment teams that are critical in the fight against cancer. These teams often include radiation oncologists, medical physicists, medical dosimetrists, radiation therapists, oncology nurses, nutritionists and social workers, and treat more than one million cancer patients each year. We believe this multi-disciplinary membership makes us uniquely qualified to provide input on the inherently complex issues related to Medicare payment policy and coding for radiation oncology services.*

per volume of interest and is not covered if billed on the same date of service as a 3D-CRT plan (CPT 77295) or an IMRT plan (CPT 77301)."

In the final update to the "Policy Modifications after 12.2020 ASTRO meeting," BSCA increased the number of Treatment Devices, Designs and Construction codes (CPT 77332, 77333, 77334) from two to five, and will allow more than five when medically necessary. Treatment devices includes custom cast blocks, immobilization devices, wedges, compensators, and eye shields. More than one type of device may be used for each patient to optimize the quality of treatment delivery. ASTRO underscores the importance of this update, as most patients will require one or more devices during their course of treatment.

BSC8.06 Radiation Oncology

BSCA concludes in its Radiation Oncology medical policy that,

"Moderately hypofractionated radiotherapy has been shown to be as efficient and safe as conventionally fractionated radiotherapy for most breast cancer patients who need adjuvant radiotherapy after breast-conserving surgery and is the preferred radiation schedule recommended by both the National Comprehensive Cancer Network (NCCN) and American Society for Radiation Oncology (ASTRO)."

Though ASTRO guidelines generally support hypofractionation for the treatment of breast and prostate cancer, these guidelines stress that shared decision making between the physician and patient should come first. **We urge BSCA to edit the policy to recognize that some patients have certain clinical characteristics and situations where longer course treatments are appropriate, and that the treatment regimen should be determined through shared decision making between doctors and patients.** Some of these situations include:

- Breast patients with:
 - Triple negative disease.
 - Anatomic conditions, such as pectus excavatum, that require to treat across the heart.
 - Patients with significant cardiopulmonary comorbidities.
 - Patients who have variants or pathogenic mutations in genes where there is little data on outcomes.
 - Prior history of radiation.
 - Patients with connective tissue disease.
 - Clinical trial participation.
- Additional consideration ***may also be warranted*** for patients with:
 - Very young patients (<45 yo)
 - History of breast augmentation/reconstruction.
 - Previous taxanes.
 - Post-operative infection.
 - Multiple surgeries required.
 - Oncoplastic rearrangement or reduction is done at the time of surgery.

BSCA also states in the policy that radiation treatment courses are set at six months, as in "It is unlikely a patient would receive two separate courses of radiation therapy within six months." However, patients with metastatic cancers often receive more than one course of radiation therapy in a six-month period. **We urge BSCA to remove this limitation from the policy to prevent disruption of care for patients with metastatic disease.**

Additionally, the Radiation Oncology medical policy considers CPT codes 77336, Continuing medical radiation physics consultation, and 77427, Radiation treatment management, five treatments, medically necessary when billed once per every five fractions of radiation treatment delivery. ASTRO's *Radiation Oncology Coding Resource*, which we have shared with BSCA, explains that these services are typically reported once in five fractions or treatment sessions; however, the *Resource* notes that three to four fractions at the end of a course of therapy may qualify for another Radiation treatment management or Continuing medical physics charge (pages 31, 75). **We urge BSCA to add this clarification regarding three to four fractions at the end of a course of therapy to the policy.**

ASTRO appreciates BSCA's coverage of Respiratory motion management simulation, CPT +77293; however, we are concerned that the parameters outlined in the various "Allowable Codes and Frequencies" tables are limiting. Respiratory motion management simulation is performed when there is a need to account for the breathing-related motion of thoracic or abdominal tumors that will be targeted with radiation therapy. This can include lung cancers or upper abdominal tumors, such as hepatic or pancreatic cancers, esophageal cancers, as well as breast cancers, in which the motion from respiration may cause significant movement of the intended target volume during different phases of the respiratory cycle. **Therefore, we recommend BSCA change "Breast and lung cancers only" to "Thorax and upper abdominal cancers only."**

Finally, we have several concerns regarding "Table 4: Allowable Codes and Frequencies for Brachytherapy" found on pages six and seven of the policy. This table states that, "When used as stand alone or with external beam, only one [brachytherapy treatment] plan is allowed." This accounts only for intracavitary cylinder planning and does not account for patients receiving tandem and ovoid/ring or interstitial brachytherapy, who will require one treatment plan per brachytherapy insertion, in addition to an EBRT plan. Additionally, the policy allows Special treatment procedure, CPT 77470, to be billed per course of Brachytherapy, when documented as medically necessary. [ASTRO's Brachytherapy Model Policy](#) explains,

"The delivery of brachytherapy often requires special arrangements with the operating room, radiation safety team and/or inpatient ward, coordination with other specialists, preparation and provision of the applicators and related equipment, scheduling and integration of required physics support, and acquisition and preparation of the radiation sources. Brachytherapy is often delivered in conjunction with external radiation, chemotherapy or surgery. Integration of these processes makes brachytherapy a special treatment procedure."

Therefore, we urge BSCA to edit this portion of the policy to acknowledge that it can be clinically appropriate to bill more than one unit of treatment planning, brachytherapy planning, and to allow billing of Special Treatment Procedure during a course of brachytherapy. If this work is not performed, and appropriate modifications to the treatment regime are not instituted, the patient may be seriously harmed because of the irreversible nature of the radiation treatment delivery.

8.01.62 Electronic Brachytherapy for Nonmelanoma Skin Cancer

Blue Shield of California's Electronic Brachytherapy for Nonmelanoma Skin Cancer (8.01.62) considers the procedure investigational for squamous cell carcinomas and basal cell carcinomas. ASTRO's Clinical Practice Guideline, *Definitive and Postoperative Radiation Therapy for Basal and Squamous Cell Cancers of the Skin*², states that high dose rate (HDR) brachytherapy is used to successfully treat squamous cell carcinomas and basal cell carcinomas. The *Guideline* further explains that electronically generated low-energy sources "lend themselves particularly well to moderate and

² [https://www.practicalradonc.org/article/S1879-8500\(19\)30323-6/fulltext#secsectitle0100](https://www.practicalradonc.org/article/S1879-8500(19)30323-6/fulltext#secsectitle0100).

extreme hypofractionation” as, “Dose falloff for these modalities is rapid, resulting in relative sparing of deeper structures.” **ASTRO recommends BSCA edit this policy to allow coverage of electronic brachytherapy for nonmelanoma skin cancers.**

Thank you for your consideration of our comments. Should you have any questions or wish to continue our conversations regarding radiation therapy as patient-centered care, please contact Jessica Adams, Health Policy Analyst (703) 839-7396 or via email at Jessica.adams@astro.org.

Sincerely,



Laura I. Thevenot
Chief Executive Officer

Enclosed: Policy modifications after 12.20202 ASTRO meeting
*Fractionation for Whole Breast Irradiation: An American Society for Radiation Oncology (ASTRO)
Evidence-based Guideline*