## IMPORTANT NOTE ABOUT THIS REIMBURSEMENT POLICY

This policy is applicable to UnitedHealthcare Medicare Advantage Plans offered by UnitedHealthcare and its affiliates.

You are responsible for submission of accurate claims. This reimbursement policy is intended to ensure that you are reimbursed based on the code or codes that correctly describe the health care services provided. UnitedHealthcare reimbursement policies use Current Procedural Terminology (CPT®*), Centers for Medicare and Medicaid Services (CMS), or other coding guidelines. References to CPT or other sources are for definitional purposes only and do not imply any right to reimbursement.

This reimbursement policy applies to all health care services billed on CMS 1500 forms and, when specified, to those billed on UB04 forms (CMS 1450). Coding methodology, industry-standard reimbursement logic, regulatory requirements, benefits design and other factors are considered in developing reimbursement policy. This information is intended to serve only as a general resource regarding UnitedHealthcare’s reimbursement policy for the services described and is not intended to address every aspect of a reimbursement situation. Accordingly, UnitedHealthcare may use reasonable discretion in interpreting and applying this policy to health care services provided in a particular case. Further, the policy does not address all issues related to reimbursement for health care services provided to UnitedHealthcare enrollees. Other factors affecting reimbursement may supplement, modify or, in some cases, supersede this policy. These factors may include, but are not limited to: legislative mandates, the physician or other provider contracts, and/or the enrollee’s benefit coverage documents. Finally, this policy may not be implemented exactly the same way on the different electronic claims processing systems used by UnitedHealthcare due to programming or other constraints; however, UnitedHealthcare strives to minimize these variations.

UnitedHealthcare may modify this reimbursement policy at any time by publishing a new version of the policy on this Website. However, the information presented in this policy is accurate and current as of the date of publication.

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This reimbursement policy applies to services reported using the Health Insurance Claim Form CMS-1500 or its electronic equivalent or its successor form, and services reported using facility claim form CMS-1450 or its electronic equivalent or its successor form. This policy applies to all products, all network and non-network physicians, and other health care professionals.

The HCPCS/CPT code(s) may be subject to Correct Coding Initiative (CCI) edits. This policy does not take precedence over CCI edits. Please refer to the CCI for correct coding guidelines and specific applicable code combinations prior to billing UnitedHealthcare. It is not enough to link the procedure code to a correct, payable ICD-9-CM diagnosis code. The diagnosis must be present for the procedure to be paid. Compliance with the
Brachytherapy is a type of radiation therapy that utilizes natural or manufactured radioactive isotopes or radionuclides that are temporarily or permanently implanted to treat malignancies or certain benign conditions and derives a physical advantage based upon the inverse square law of physics. Brachytherapy is accomplished by placing small encapsulated radioactive elements (also known as "seeds" or "sources"), directly in or near the tumor or treatment site. There are currently three basic clinical brachytherapy formats: interstitial applications, intra-cavitary applications (also called intraluminal), and surface applications (placed directly on the skin or other external target surface). Brachytherapy may use a solid radioactive source such as a "seed" or liquid colloid isotopes, and may be either temporary or permanent. Further, brachytherapy may be high dose rate or low dose rate.

Brachytherapy may be used independently as the sole treatment or as an adjunctive treatment in combination with external beam therapy and/or other modalities such as surgery or chemotherapy.

Brachytherapy may be performed concomitantly with surgical resection or in conjunction with procedures such as endoscopy or angioplasty, which are required to achieve access to the site of the disease. There are two distinct phases required to complete the process known as brachytherapy: the insertion of non-radioactive applicators or conduits that receive or transmit the radioactive material into the body, and the loading of the radioactive material (the active or therapeutic agent) into the conduits or directly into tissue.

**Accelerated Partial Breast Irradiation**

Survival after breast-conservation therapy (BCT) is equivalent to survival after mastectomy for patients diagnosed with tumors categorized as stage I or II. The standard of care for local management is breast-conserving surgery to excise the tumor with adequate margins (lumpectomy), followed by whole-breast external-beam radiation therapy (WB-EBRT).

APBI differs from WB-EBRT in two ways. First, the radiation targets only a segment surrounding the tumor rather than the entire breast. Second, since the duration of treatment is 4 to 5 days rather than 5 to 6 weeks, radiation is delivered in fewer fractions at larger doses per fraction. APBI comprises several techniques, including interstitial brachytherapy via catheters, a partial breast brachytherapy system, accelerated external beam radiotherapy, and intra-operative radiotherapy delivery.

The rationale for APBI is supported by contemporary pathologic data (microscopic disease extension from the primary lesion should be less than 1 cm in the majority of patients) and the in-breast failure patterns reported following breast conservation treatment (in-breast failure remote from the site of lumpectomy is infrequent (<5%)).

When compared with whole breast irradiation, APBI offers the potential advantages of convenience and decreased radiation dose to healthy breast tissue. Although existing studies show comparable recurrence rates to standard therapy when strict selection criteria are used, the studies are small with follow-up of five years or less. There have been no head to head randomized studies comparing APBI with WB-EBRT.

**Reimbursement Guidelines**

**Indications:**

Brachytherapy may be indicated as a primary or adjunctive therapy in a variety of tumors. A dose rate is selected based on the individual needs of the patient. LDR (low dose rate) and HDR (high dose rate) brachytherapy are two delivery systems for brachytherapy, which use radioactive material to deliver a dose of intensive radiation therapy to a specific well-defined local site (treatment volume). In both LDR and HDR, the...
treatment site should be defined and accessible to the applicators that are the delivery medium for the radioactive sources. This is done to treat a primary or metastatic neoplasm, while sparing sensitive, adjacent normal tissues. LDR and HDR procedures may be given with the intent to cure, to palliate, or to obtain local control (either cure or palliation). Both may be given in conjunction with a course of external beam radiation therapy, or as a single modality.

HDR is performed by using a remote after loading device to deliver the radioactive source(s). HDR allows the dose to be delivered customarily in minutes and usually on an outpatient basis and is often given in a series of multiple fractions.

**Limitations:**
- Although radiographs may be used in brachytherapy simulation, these images are not to be reported as port-films.
- Follow-up visits for 90 days after treatment are not separately payable. (This does not apply to a patient visit for complaints unrelated to the current treatment).
- Products used for the patient’s comfort may not be charged as treatment devices (e.g., pillows, pad, or cushions).
- Only a physician authorized as a user by the Nuclear Regulatory Commission or an Agreement State for brachytherapy should work with radioactive materials.

CPT Evaluation and Management (E/M) codes are available for use by the physician when seeing new patients in the office, the freestanding clinic or the hospital setting.

The physician’s professional component for the brachytherapy procedure includes any necessary hospital admission and hospital care during the time that the patient is undergoing the brachytherapy procedure. Admission, subsequent hospital care and discharge day summary are included in the global fee for brachytherapy procedures.

**Accelerated Partial Breast Irradiation**

APBI after breast-conserving surgery for early stage breast cancer is only considered a medically appropriate treatment option with strict selection criteria:

**Selection Criteria (ALL must be present)**
- Age: Greater than or equal to 50 years of age
- Diagnosis: Invasive ductal carcinoma
- Size: Greater than or equal to 2cm
- Margin status: Negative - at least 2 mm in all directions
- Nodal status: For patients with invasive disease, negative axillary lymph node dissection or sentinel lymph node evaluation or clinically negative lymph nodes in patients over 70 years of age.

**Documentations Requirements**
- Documentation supporting the medical necessity of these services, such as ICD-9-CM codes, must be submitted with each claim. Claims submitted without such evidence will be denied as not medically necessary.
- The treatment goal must be documented (curative, palliative or tumor control) in the medical record.
- The record must contain documentation of the patient’s informed consent to treatment.
- A written, signed and dated prescription or treatment plan designed by the radiation oncologist must be on file. The prescription must include all of the following information: designation of the treatment site, designation of the isotope, designation of the number of source positions, the planned dose to each point.
- Given the multiplicity of services that are inherent in brachytherapy, it is essential that the medical records reflect each service in a clear, linear and temporally logical form. Flow charts, where helpful, are recommended. All procedures must be documented with a procedural note.
- Medical records must be made available to UnitedHealthcare upon request.

When the documentation does not meet the criteria for the service rendered or the documentation does not establish the medical necessity for the services, such services will be denied as "not reasonable and necessary" under Section 1862(a)(1) of the Social Security Act.
# High Dose Rate Electronic Brachytherapy

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<th>Description</th>
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<td>0182T</td>
<td>High Dose Rate Electronic Brachytherapy, Per Fraction</td>
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## References Included (but not limited to):

- **CMS LCD(s)**
  Numerous LCDs

- **CMS Claims Processing Manual**
  Chapter 4; § 61.4 Billing and Payment for Brachytherapy Sources

- **MLN Matters**
  Article MM8338, July 2013 Update of the Hospital Outpatient Prospective Payment System (OPPS)

## History

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<tr>
<th>Date</th>
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<tr>
<td>10/09/2013</td>
<td>Re-review presented to MRPC for approval</td>
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<tr>
<td>08/22/2012</td>
<td>Policy updates presented to MRP Committee</td>
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<tr>
<td>08/09/2012</td>
<td>Policy re-reviewed and updates made to Reimbursement Guidelines</td>
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<tr>
<td>06/08/2011</td>
<td>Policy developed and approved</td>
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