RADIATION THERAPY SERVICES

CSHCN SERVICES PROGRAM PROVIDER MANUAL

MAY 2025

TEXAS
Health and Human
Services

RADIATION THERAPY SERVICES

Table of Contents

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34.1 Enrollment

To enroll and be reimbursed for services in the CSHCN Services Program, radiation therapy services providers must be actively enrolled in Texas Medicaid, have a valid Provider Agreement with the CSHCN Services Program, have completed the CSHCN Services Program enrollment process, and comply with all applicable state and federal laws and requirements. Out-of-state radiation therapy services providers must meet all the above conditions and be located in the United States within 50 miles of the Texas state border.

Physicians, hospitals, and free-standing radiation treatment centers are eligible to enroll in Texas Medicaid and to receive reimbursement for CSHCN Services Program radiation therapy services.

Important: *CSHCN Services Program providers are responsible for knowing, understanding, and complying with the laws, administrative rules, and policies of the CSHCN Services Program and Texas Medicaid.*

By enrolling in the CSHCN Services Program, providers are charged not only with knowledge of the adopted CSHCN Services Program agency rules published in Title 26 Texas Administrative Code (TAC), but also with knowledge of the adopted Medicaid agency rules published in 1 TAC, Part 15, and specifically including the fraud and abuse provisions contained in Chapter 371.

CSHCN Services Program providers also are required to comply with all applicable laws, administrative rules, and policies that apply to their professions or to their facilities. Specifically, it is a violation of program rules when a provider fails to provide health-care services or items to recipients in accordance with accepted medical community standards and standards that govern occupations, as explained in 1 TAC §371.1659 for Medicaid providers, which also applies to CSHCN Services Program providers as set forth in 26 TAC §351.6(b)(1). Accordingly, CSHCN Services Program providers can be subject to sanctions for failure to deliver, at all times, health-care items and services to recipients in full accordance with all applicable licensure and certification requirements. These include, without limitation, requirements related to documentation and record maintenance, such that a CSHCN Services Program provider can be subject to sanctions for failure to create and maintain all records required by his/her profession, as well as those required by the CSHCN Services Program and Texas Medicaid.

Refer to: Section 2.1, "Provider Enrollment" in Chapter 2, "Provider Enrollment and Responsibilities" for more detailed information about CSHCN Services Program provider enrollment procedures.

34.2 Benefits, Limitations, and Authorization Requirements

The CSHCN Services Program may reimburse radiation therapy services performed by physicians, radiation treatment centers, and inpatient and outpatient hospitals.

Radiation therapy services include, but are not limited to, the following:

- Clinical brachytherapy
- Clinical treatment planning
- Intensity modulated radiation therapy (IMRT) (prior authorization required)
- Medical radiation physics, dosimetry, and treatment devices
- Proton- or neutron-beam therapy (prior authorization required)
- Radiation treatment management and delivery
- Stereotactic radiation therapies

All drugs given during the course of radiation therapy should be billed separately for appropriate reimbursement.

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All inpatient radiation therapy services must be billed with the appropriate procedure code(s) in addition to the revenue code (333).

Note: *Outpatient hospital services include those services performed in the emergency room or clinic setting of a hospital. In instances of sudden illness or injury, the client may receive treatment in the emergency room and be discharged, admitted for observation, or admitted for further care as an inpatient. If the client is admitted as an inpatient within 24 hours of treatment in the emergency room or clinic, the emergency room or clinic charges must be submitted as ancillary charges.*

Refer to: Chapter 24, "Hospital" for more information about inpatient, outpatient, ER, and observation services.

Normal follow-up care by the same physician on the same day as any therapeutic radiology service will be denied. Any other E/M office visit will not be reimbursed when billed with the same date of service by the same provider as the radiation treatment or a radiation treatment complication. If complications occur on the same day as a therapeutic radiology service, or if medical visits are necessary for services unrelated to the radiation treatment, additional care may be reimbursed on appeal with documentation of medical necessity.

Providers may use modifier 25 to indicate the additional visit was for a separate, distinct service unrelated to the radiation treatment or radiation treatment complication. Documentation that supports the provision of a significant, separately-identifiable E/M service must be maintained in the client's medical record and made available to the CSHCN Services Program upon request.

Note: *Each provider is responsible for verifying client eligibility. Any services that are provided outside of the client's eligibility period or beyond the limitations of the CSHCN Services Program are not considered for reimbursement.*

34.2.1 Prior Authorization Requirements

Prior authorization is required for stereotactic radiation therapies, proton- or neutron-beam treatment delivery, and IMRT. Prior authorization is not required for all other radiation therapy services. Prior authorization must be obtained before submitting claims for the services rendered. Prior authorization is a condition for reimbursement; it is not a guarantee of payment. Prior authorization is given only if the client is eligible for CSHCN Services Program benefits when TMHP receives the request.

Refer to: Chapter 4, "Prior Authorizations and Authorizations" for more information about authorizations and prior authorizations.

34.2.2 Clinical Brachytherapy

The following surgical procedure codes for brachytherapy may be reimbursed:

Surgery Procedure Codes									
10035	10036	19296	19297	19298	31626	31643	32553*	49327*	49411
49412	55860	55862*	55865*	55874	55875	55876	57156	58346	61770
92974									
***Assistant surgeons also may be reimbursed for procedure codes 32553, 49327, 55862, and 55865.**									

Add-on procedure codes 10036, 19297, 49327, 49412 and 92974 must be billed with the appropriate primary procedure code, on the same day, by the same provider.

The following radiation therapy procedure codes may be reimbursed:

Radiation Therapy Procedure Codes									
77321	77470	77750*	77761*	77762*	77763*	77767	77768	77770	77771
***Total component only.**									

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Radiation Therapy Procedure Codes			
77772	77778*	77789	77799
*Total component only.			

Clinical brachytherapy services include admission to the hospital, daily care, and same-day office visits. Initial and subsequent hospital care and same-day office visits will be denied when billed with the same date of service as clinical brachytherapy services.

34.2.3 Clinical Treatment Planning

The following radiation therapy procedure codes must be used to bill clinical treatment planning services:

Procedure Codes								
77261	77262	77263	77280	77285	77290	77293	77295	77299

Therapeutic radiology field setting procedure code 77295 is limited to once per day.

Procedure code 77293 will be denied if not billed on the same date of service by the same provider as either procedure code 77295 or 77301.

An office visit performed on the same day by the same provider as clinical treatment planning is included in the therapeutic radiology procedure.

Clinical treatment planning includes interpretation of special testing, tumor localization, treatment volume determination, treatment time/dosage determination, choice of treatment modality, determination of number and size of treatment ports, selection of appropriate treatment devices, and other procedures.

The following procedure codes will not be reimbursed by the CSHCN Services Program:

Procedure Codes								
77331	77336	77370	77600	77605	77610	77615	77620	77790

34.2.4 Intensity Modulated Radiation Therapy (IMRT)

IMRT (procedure codes 77385 and 77386) must be prior-authorized and may be considered after review of documentation of medical necessity along with a review of current literature supporting the requested use.

34.2.5 Medical Radiation Physics, Dosimetry, Treatment Devices, and Special Services

The following procedure codes may be reimbursed for medical radiation physics, dosimetry, treatment devices, and special services:

Procedure Codes									
77300	77301	77306	77307	77316	77317	77318	77332	77333	77334
77338	77399								

34.2.6 Proton-Beam and Neutron-Beam Delivery

The following procedure codes may be used to bill proton-beam and neutron-beam treatment delivery services:

Procedure Codes
Proton-Beam

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Procedure Codes				
77520	77522	77523	77525	S8030
Neutron-Beam				
77423				

34.2.6.1 Prior Authorization Requirements

Prior authorization requirements for proton-beam and neutron-beam treatment delivery may include, but are not limited to, diagnoses indicating one of the following medical conditions:

34.2.6.1.1 Proton-Beam Treatment Delivery

- Melanoma of the uveal tract (iris, choroid, ciliary body)
- Postoperative treatment for chordomas or low grade chondrosarcomas of the skull or cervical spine
- Prostate cancer
- Pituitary neoplasms
- Other central nervous system tumors located near vital structures

34.2.6.1.2 Neutron-Beam Treatment Delivery

- Malignant neoplasms of the salivary glands

Other diagnoses may be considered for proton-beam and neutron-beam treatment delivery after a review of medical necessity documentation along with a review of current literature supporting the use of the requested therapy.

Providers must use the CSHCN Services Program Authorization and Prior Authorization Request form to submit requests for prior authorization.

Refer to: Chapter 4, "Prior Authorizations and Authorizations" for more information about authorizations and prior authorizations.

34.2.7 Radiation Treatment Management and Delivery

The total radiation therapy component for the following procedure codes may be reimbursed for radiation treatment management services:

Radiation Treatment Management Procedure Codes				
77427	77431	77432	77435	77499

The following procedure codes may be reimbursed for radiation treatment delivery services:

Radiation Treatment Delivery/Port Films									
77385*	77386*	77387	77401**	77417**	77423*	G6002*	G6003*	G6004*	G6005*
G6006*	G6007*	G6008*	G6009*	G6010*	G6011*	G6012*	G6013*	G6014*	G6015*
G6016*	G6017*								
***Total component only. **Technical component only.**									

Radiation treatment delivery/port films procedure codes may be billed in addition to procedure codes 77427 and 77431 when provided in the office setting.

34.2.7.1 Radioisotope Therapy

The CSHCN Services Program may reimburse therapeutic radioisotopes separately.

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Diagnostic radioisotopes are considered part of the diagnostic service and will not be reimbursed separately.

34.2.8 Stereotactic Radiosurgery

The surgical component of the following procedure codes may be reimbursed for stereotactic radiosurgery services (SRS) and stereotactic body radiation therapy (SBRT):

Surgery Procedure Codes									
32701	61781	61782	61783	61796	61797	61798	61799	61800	63620
63621									

Add-on procedure codes 61781, 61782, 61783, 61797, 61799, 61800, and 63621 must be billed with the appropriate primary procedure code, on the same day, by the same provider.

The total radiation therapy component of the following procedure codes may be reimbursed for SRS and SBRT:

Radiation Therapy Procedure Codes					
77371	77372	77373	G0339	G0340	G6002

The benefit and limitation information listed in the following table applies to the procedure codes indicated:

Procedure Code	Benefits and Limitations
61796	Services will not be reimbursed more than once per course of treatment. Procedure codes 61796 and 61798
61797	Procedure code 61797 will not be reimbursed more than once per lesion. Procedure code 61797 may be reimbursed up to four times for the entire course of treatment regardless of the number of lesions treated.
61798	Procedure code 69718 will be denied if it is billed with procedure code 61796.
61799	Procedure code 61799 will not be reimbursed more than once per lesion. Procedure code 61799 may be reimbursed up to four times for the entire course of treatment regardless of the number of lesions treated.
63620	Procedure code 63620 may be reimbursed once per course of treatment. Procedure code 63620 will not be reimbursed for services rendered on the same date of service by the same provider as radiation treatment management procedure code 77435.
63621	Procedure code 63621 may be reimbursed two times for the entire course of treatment, regardless of the number of lesions treated. Procedure code 63621 will not be reimbursed for services rendered on the same date of service by the same provider as radiation treatment management procedure code 77435.

34.2.8.1 Prior Authorization Requirements

Prior authorization will be considered for SRS and SBRT procedure codes with a diagnosis indicating one of the following medical conditions:

- Benign and malignant tumors of the central nervous system
- Vascular malformations
- Soft tissue tumors in the chest, abdomen, and pelvis

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- Trigeminal neuralgia refractory to medical management

  Note: *SRS and SBRT are considered investigational and not a benefit of the CSHCN Services Program for all other indications including, but not limited to, epilepsy, chronic pain, and pancreatic adenocarcinoma.*

Providers must use the CSHCN Services Program Authorization and Prior Authorization Request form to submit requests for prior authorization.

Documentation that supports the provision of special procedures must be maintained in the client's medical record and made available to the CSHCN Services Program upon request.

Refer to: Chapter 4, "Prior Authorizations and Authorizations" for more information about authorizations and prior authorizations.

34.2.9 Strontium-89

Strontium-89 is a benefit of the CSHCN Services Program. Procedure code A9600 may be reimbursed once every 90 days by any provider.

Procedure code A9600 must be submitted with one of the following diagnosis codes to be considered for reimbursement:

Diagnosis Codes							
C50011	C50012	C50019	C50021	C50022	C50029	C50111	C50112
C50119	C50121	C50122	C50129	C50211	C50212	C50219	C50221
C50222	C50229	C50311	C50312	C50319	C50321	C50322	C50329
C50411	C50412	C50419	C50421	C50422	C50429	C50511	C50512
C50519	C50521	C50522	C50529	C50611	C50612	C50619	C50621
C50622	C50629	C50811	C50812	C50819	C50821	C50822	C50829
C50911	C50912	C50919	C50921	C50922	C50929	C61	C7951
C7952							

34.2.10 Technetium TC 99M Tetrofosmin

Procedure codes A9500 and A9502 are limited to a quantity of three each per day when billed by the same provider.

34.3 Claims Information

Claims for radiation therapy services must include the following:

- *The referring provider.* Radiologists are required to identify the referring provider by full name and address or CSHCN Services Program provider identifier in Block 17 of the CMS-1500 paper claim form. Baseline screening or comparison studies are not benefits.
- *Authorization and prior authorization number (as appropriate).* All claims must meet all authorization and prior authorization requirements and claim filing and authorization deadlines. Details are given in the description of the services and in more detail in association with services described in this chapter and in Chapter 4, "Prior Authorizations and Authorizations."

Radiation therapy services must be submitted to TMHP in an approved electronic format or on the CMS-1500 paper claim form or the UB-04 CMS-1450 paper claim form. Providers may purchase CMS-1500 paper claim forms or UB-04 CMS-1450 paper claim forms from the vendor of their choice. TMHP does not supply the forms.

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When completing a CMS-1500 paper claim form or a UB-04 CMS-1450 paper claim form, all required information must be included on the claim, as information is not keyed from attachments. Superbills, or itemized statements, are not accepted as claim supplements.

The Healthcare Common Procedure Coding System (HCPCS)/Current Procedural Terminology (CPT) codes included in policy are subject to National Correct Coding Initiative (NCCI) relationships. Exceptions to NCCI code relationships that may be noted in CSHCN Services Program medical policy are no longer valid. Providers should refer to the Centers for Medicare & Medicaid Services (CMS) NCCI web page for correct coding guidelines and specific applicable code combinations. In instances when CSHCN Services Program medical policy quantity limitations are more restrictive than NCCI Medically Unlikely Edits (MUE) guidance, medical policy prevails.

Refer to: Chapter 41, "TMHP Electronic Data Interchange (EDI)" for information about electronic claims submissions.

Chapter 5, "Claims Filing, Third-Party Resources, and Reimbursement" for general information about claims filing.

Chapter 5, "CMS-1500 Paper Claim Form Instructions" and Section 5.7.2.7, "Instructions for Completing the UB-04 CMS-1450 Paper Claim Form" in Chapter 5, "Claims Filing, Third-Party Resources, and Reimbursement" for instructions on completing paper claims. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

Inpatient and outpatient hospitals must use the UB-04 CMS-1450 paper claim form to submit charges for covered services. If the client is admitted as an inpatient within 24 hours of treatment in the emergency room or clinic, the emergency room or clinic charges must be submitted on the UB-04 CMS-1450 paper claim form as an ancillary charge.

34.4 Reimbursement

Physicians and radiation treatment centers may be reimbursed the lower of the billed amount or the amount allowed by Texas Medicaid.

Inpatient hospitals may be reimbursed at 80 percent of the All Patient Refund Diagnosis Groups (APR-DRG) payment for CSHCN Services. Outpatient hospital may be reimbursed at 72 percent of the billed amount multiplied by the hospital's Medicaid interim rate.

For fee information, providers can refer to the Online Fee Lookup (OFL) on the TMHP website at www.tmhp.com.

The CSHCN Services Program implemented rate reductions for certain services. The OFL includes a column titled "Adjusted Fee" to display the individual fees with all percentage reductions applied. Additional information about rate changes is available on the TMHP website at www.tmhp.com/resources/rate-and-code-updates/rate-changes.

Note: *Certain rate reductions including, but not limited to, reductions by place of service, client type program, or provider specialty may not be reflected in the Adjusted Fee column.*

34.5 TMHP-CSHCN Services Program Contact Center

The TMHP-CSHCN Services Program Contact Center at 1-800-568-2413 is available Monday through Friday from 7 a.m. to 7 p.m., Central Time, and is the main point of contact for the CSHCN Services Program provider community.

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