Insurance Advocacy
Insurance Approval for Proton Beam Therapy and its Impact on Delays in Treatment

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Billing/Insurance

https://jisbell22.wordpress.com/2014/05/02/frustration/
Patient interested in proton therapy, insurance policy coverage reviewed

Letter to insurance (consult note, etc.)

**DENIAL 1** – Appeal 1: request non-expert peer-to-peer (internal)

**DENIAL 2** – Appeal 2: first written appeal with comparison plan *(internal)*

**DENIAL 3** – Appeal 3: Request same specialty peer-to-peer *(external)*

**DENIAL 4** – initiate additional written appeals*

*Will start tx prior to insurance approval if pt willing to pay out of pocket*
Proton therapy and prostate cancer

The following are proven and medically necessary:

- PBT for **Definitive Therapy** of the following indications:
  - Intracranial arteriovenous malformations (AVMs)
  - Ocular tumors, including intraocular/uveal melanoma (includes the iris, ciliary body and choroid)
  - Skull-based tumors (e.g., chordomas, chondrosarcomas or paranasal sinus tumors)
  - Localized, unresectable hepatocellular carcinoma (HCC) in the curative setting when documentation is provided that sparing of the surrounding normal tissue cannot be achieved with standard radiation therapy techniques, including intensity-modulated radiation therapy (IMRT), and stereotactic body radiation therapy (SBRT), and selective internal radiation spheres, and transarterial therapy (for example, chemoembolization) is contraindicated or not technically feasible
- PBT may be covered for a diagnosis that is not listed above as proven, including recurrences or metastases in selected cases. Requests for exceptions will be evaluated on a case-by-case basis when both of the following criteria are met:
  - Documentation is provided that sparing of the surrounding normal tissue cannot be achieved with standard radiation therapy techniques; **and**
  - Evaluation includes a comparison of treatment plans for PBT, IMRT and SBRT

PBT and IMRT are proven and considered clinically equivalent for treating prostate cancer. Medical necessity will be determined based on the terms of the member’s benefit plan.

PBT is unproven and not medically necessary due to insufficient evidence of efficacy for treating ALL other indications not listed above as proven, including but not limited to:

- Age related macular degeneration (AMD)
- Bladder cancer
- Brain and spinal cord tumors
- Breast cancer
- Choroidal hemangioma
- Esophageal cancer
- Gynecologic cancers
- Lung cancer
- Lymphomas
- Pancreatic cancer
- Vestibular tumors (e.g., acoustic neuroma or vestibular schwannoma)
- PBT used in conjunction with IMRT
Exceptions for reconsideration

• Pediatric
  – Rhabdomyosarcomas

• Genetic syndrome (radiosensitivity)
  – NF1
  – Retinoblastoma

• Re-irradiation

• Young men, not eligible for brachytherapy
Comparison Planning

- Showing PT lowers the dose isn’t sufficient
- What QUANTEC endpoints are exceeded?
  - Bladder
    - V80<15%, V75<25%, V70<35%, V65<50%
  - Rectum
    - V50<50%, V60<35%, V65<25%, V70<20%, V75<15%
  - Penile Bulb
    - D95%<50 Gy, D70%<70 Gy
  - Small Bowel
    - V15<120cc, V45<195cc
Clinical Trials

• COMPPARE- NCT03561220