

Rectal Cancer Radiation Therapy Treatment Plan Checklist

NIA has provided this checklist to assist you in gathering the clinical and treatment plan information needed to request a medical necessity review. The most efficient way to submit a review request is via www.RadMD.com or call the NIA Call Center toll free number. Please **do not fax** the checklist to NIA.

General Information		
Patient Name :	DOB:	Health Plan ID :
Radiation Oncologist :	Radiation Therapy Facility :	
Treatment Planning Start Date (i.e. Initial Simulation) :		Anticipated Treatment Start Date :
Patient Clinical Information		
<input checked="" type="checkbox"/> Treatment Intent : <input type="checkbox"/> Pre Operative <input type="checkbox"/> Post Operative- Adjuvant <input type="checkbox"/> Primary Therapy- No Surgery <input type="checkbox"/> Palliative		
T Stage: <input type="checkbox"/> TX <input type="checkbox"/> T0 <input type="checkbox"/> Tis <input type="checkbox"/> T1 <input type="checkbox"/> T2 <input type="checkbox"/> T3 <input type="checkbox"/> T4	N Stage: <input type="checkbox"/> NX <input type="checkbox"/> N0 <input type="checkbox"/> N1 <input type="checkbox"/> N2 Does patient have distant metastasis (M1)? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> If palliative, what is the reason for radiation therapy? (e.g. bleeding, pain, etc.) <input checked="" type="checkbox"/> Margin Status: (Post Operative Only) <input type="checkbox"/> Negative <input type="checkbox"/> Close <input type="checkbox"/> Positive <input type="checkbox"/> Not Applicable <input checked="" type="checkbox"/> Are you treating a recurrent tumor: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input checked="" type="checkbox"/> Is chemotherapy planned : <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Treatment Planning Information		
<input checked="" type="checkbox"/> What is the prescription radiation dose for the <u>ENTIRE</u> course of external beam treatment?		Gy
Initial Treatment Phase – Select Therapy		
<input type="checkbox"/> 2-Dimension	<input checked="" type="checkbox"/> Number of ports/arcs/fields: _____	
<input type="checkbox"/> 3D Conformal	<input checked="" type="checkbox"/> Fractions: _____	
<input type="checkbox"/> IMRT	<input checked="" type="checkbox"/> Will any of the following take place during the simulation: custom device created, contrast utilized or custom blocking determined? <input type="checkbox"/> Yes <input type="checkbox"/> No	
IMRT Only	<input checked="" type="checkbox"/> Which technique will be used? <input type="checkbox"/> Linac Multi-Angle <input type="checkbox"/> Compensator-Based <input type="checkbox"/> Helical <input type="checkbox"/> Arc Therapy <input type="checkbox"/> Other	
<i>Note: IMRT treatment requests will be reviewed for medical necessity by a radiation oncologist. Clinical rationale for performing IMRT is required and should include a comparison 3D-CRT plan and tissue constraints and target goals of the plan. Field in field or forward planning is not considered IMRT.</i>		
<input type="checkbox"/> High Dose Rate (HDR) Brachytherapy: (HDR)	<input checked="" type="checkbox"/> Fractions: _____	
<input type="checkbox"/> IGRT Technique:	<input type="checkbox"/> None (select none for port films)	<input type="checkbox"/> CT Guidance (Conebeam CT) <input type="checkbox"/> Stereoscopic Guidance (kV or mV with fiducial markers)
<input checked="" type="checkbox"/> At what frequency will the IGRT be performed? <input type="checkbox"/> Daily <input type="checkbox"/> 1 time per week <input type="checkbox"/> Other _____		

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Boost Phase 1 – Select Therapy

- 2-Dimension** ✓ Number of ports/arcs/fields: _____
- 3D Conformal** ✓ Fractions: _____
- IMRT** ✓ Will any of the following take place during the simulation: custom device created, contrast utilized or custom blocking determined? Yes No

IMRT Only ✓ Which technique will be used? Linac Multi-Angle Compensator-Based Helical Arc Therapy Other

***Note:** IMRT treatment requests will be reviewed for medical necessity by a radiation oncologist. Clinical rationale for performing IMRT is required and should include a comparison 3D-CRT plan and tissue constraints and target goals of the plan. Field in field or forward planning is not considered IMRT.*

- High Dose Rate (HDR) Brachytherapy: (HDR)** ✓ Fractions: _____

IGRT Technique: None (select none for port films) CT Guidance (Conebeam CT) Stereoscopic Guidance (kV or mV with fiducial markers)

✓ At what frequency will the IGRT be performed? Daily 1 time per week Other _____

Boost Phase 2 – Select Therapy

- 2-Dimension** ✓ Number of ports/arcs/fields: _____
- 3D Conformal** ✓ Fractions: _____
- IMRT** ✓ Will any of the following take place during the simulation: custom device created, contrast utilized or custom blocking determined? Yes No

IMRT Only ✓ Which technique will be used? Linac Multi-Angle Compensator-Based Helical Arc Therapy Other

***Note:** IMRT treatment requests will be reviewed for medical necessity by a radiation oncologist. Clinical rationale for performing IMRT is required and should include a comparison 3D-CRT plan and tissue constraints and target goals of the plan. Field in field or forward planning is not considered IMRT.*

- High Dose Rate (HDR) Brachytherapy: (HDR)** ✓ Fractions: _____

IGRT Technique: None (select none for port films) CT Guidance (Conebeam CT) Stereoscopic Guidance (kV or mV with fiducial markers)

✓ At what frequency will the IGRT be performed? Daily 1 time per week Other _____

Special Services – Please note if you are faxing additional information

Special Dosimetry (CPT® 77331) Provide requested quantity and the rationale for performing the service.

Special Physics Consultation (CPT® 77370) Provide the rationale for performing the service.

Special Treatment Procedure (CPT® 77470) Provide the rationale for performing the service.