# Electric Tumor Treatment Field Therapy (for Indiana Only)

**Policy Number**: CS146IN.06
**Effective Date**: March 1, 2024

Ü Instructions for Use

**Table of Contents** **Page**



| Related Policies |
| --- |
| None |

## Application

This Medical Policy only applies to the state of Indiana.

## Coverage Rationale

**Electric Tumor Treatment Field Therapy is considered proven and medical necessary in certain circumstances.** For medical necessity clinical coverage criteria for newly diagnosed glioblastoma multiforme (GBM), refer to the Indiana Health Coverage Programs Provider Reference Module: Durable and Home Medical Equipment and Supplies.

**Electric Tumor Treatment Field Therapy for all other indications is medically necessary in certain circumstances**. For medical necessity clinical coverage criteria, refer to the InterQual® CP: Durable Medical Equipment, Tumor Treatment Field Therapy (TTFT) Devices. If medical necessity cannot be determined using these criteria, refer to the InterQual® Medicare: Durable Medical Equipment, Tumor Treatment Field Therapy (TTFT).

Click here to view the InterQual® criteria.

**Computer software used for therapeutic radiology clinical treatment planning in conjunction with electric TTF therapy is unproven and not medically necessary due to insufficient evidence of efficacy**.

## Applicable Codes

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by federal, state, or contractual requirements and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

| CPT Code | Description |
|---|---|
| *77299 | Unlisted procedure, therapeutic radiology clinical treatment planning |

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| HCPCS Code | Description |
|---|---|
| *A4555 | Electrode/transducer for use with electrical stimulation device used for cancer treatment, replacement only |
| E0766 | Electrical stimulation device used for cancer treatment, includes all accessories, any type |

**Note**: Codes labeled with an asterisk (*) are not managed for medical necessity review for the state of Indiana at the time this policy became effective. Refer to the most up to date prior authorization list for Indiana at Prior Authorization and Notification: UnitedHealthcare Community Plan of Indiana.

# Description of Services

The NovoTAL™ (transducer array layout) system is optional simulation software for use in clinical treatment planning with Optune therapy that may be leased from the manufacturer. Its purpose is to determine the optimal location of the transducer arrays based on the individual's most recent magnetic resonance imaging (MRI) scan, head size, and tumor location.

# Clinical Evidence

## NovoTAL™ Simulation System

There is limited published clinical evidence related to the NovoTAL™ simulation system and insufficient data to support improved long-term health outcomes with its use. This includes a small case series (Connelly et al., 2016), human head model (Wenger et al., 2016), and a user group survey (Chaudry et al., 2015). A framework for the use of NovoTAL in treatment planning has been proposed by Trusheim et al. (2016).

# U.S. Food and Drug Administration (FDA)

This section is to be used for informational purposes only. FDA approval alone is not a basis for coverage.

The Optune Treatment Kit, formerly the NovoTTF-100A System, (Novocure) was approved by the FDA in April 2011, as a novel device to treat adults age 22 years or older with glioblastoma (GBM) that recurs or progresses after receiving chemotherapy and radiation therapy. The Optune is categorized by the FDA as a stimulator, low electric field, tumor treatment; refer to the following website for the initial Premarket Approval information: https://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfpma/pma.cfm?id=P100034. (Accessed June 5, 2023)

A supplemental FDA premarket approval was received in October 2015 for Optune with Temozolomide in adults with newly diagnosed, Supratentorial glioblastoma following maximal debulking surgery and completion of radiation therapy together with concomitant standard of care chemotherapy. Refer to the following website for more information: https://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfpma/pma.cfm?id=P100034S013. (Accessed June 5, 2023)

The FDA has approved a humanitarian device exemption (HDE) application for the NovoTTF™100L System for mesothelioma. Refer to the following website for more information: https://www.accessdata.fda.gov/cdrh_docs/pdf18/H180002B.pdf. (Accessed June 5, 2023)

Refer to the following website for additional information on supplemental FDA approvals for the Optune using product code NZK: http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfPMA/pma.cfm. (Accessed June 5, 2023)

NovoTAL simulation software is not regulated by the FDA.

# References

Chaudhry A, Benson L, Varshaver M, et al. NovoTTF™100A System (Tumor Treating Fields) transducer array layout planning for glioblastoma: a NovoTAL™ System user study. World J Surg Oncol. 2015; 13:316.

Connelly J, Hormigo A, Mohilie N, et al. Planning TTFields treatment using the NovoTAL system-clinical case series beyond the use of MRI contrast enhancement. BMC Cancer. 2016 Nov 4;16(1):842.

Indiana Health Coverage Programs, Provider Reference Module. Durable and Home Medical Equipment and Supplies. Version 4.0. Available at: https://www.in.gov/medicaid/providers/files/durable-and-home-medical-equipment-and-supplies.pdf. Accessed July 20, 2023.

# Policy History/Revision Information

| Date | Summary of Changes |
|---|---|
| 03/01/2024 | **Applicable Codes**<br>• Added notation to indicate CPT code 77299 is not managed for medical necessity review for the state of Indiana at this time; refer to the most current *Prior Authorization and Notification List* for UnitedHealthcare Community Plan of Indiana<br>• Removed notation indicating HCPCS codes E0766 is not managed for medical necessity review for the state of Indiana at this time; refer to the most current *Prior Authorization and Notification List* for UnitedHealthcare Community Plan of Indiana<br>**Supporting Information**<br>• Archived previous policy version CS146IN.05 |

# Instructions for Use

This Medical Policy provides assistance in interpreting UnitedHealthcare standard benefit plans. When deciding coverage, the federal, state, or contractual requirements for benefit plan coverage must be referenced as the terms of the federal, state, or contractual requirements for benefit plan coverage may differ from the standard benefit plan. In the event of a conflict, the federal, state, or contractual requirements for benefit plan coverage govern. Before using this policy, please check the federal, state, or contractual requirements for benefit plan coverage. UnitedHealthcare reserves the right to modify its Policies and Guidelines as necessary. This Medical Policy is provided for informational purposes. It does not constitute medical advice.

UnitedHealthcare may also use tools developed by third parties, such as the InterQual® criteria, to assist us in administering health benefits. The UnitedHealthcare Medical Policies are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.