Radiation and Oncologic Procedures

Policy Number: MCS077.07
Committee Approval Date: February 14, 2024
Effective Date: April 1, 2024

Instructions for Use

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Related Policies
None

Coverage Guidelines

Therapeutic radiologic procedures are covered when Medicare criteria are met.

Note: The guidelines in this Coverage Summary are for specific procedures only. For procedures not addressed in this Coverage Summary, refer to the Medicare Coverage Database to search for applicable coverage policies (National Coverage Determination, Local Coverage Determinations and Local Coverage Articles).
(Accessed January 18, 2024)

High-Dose Rate Electronic Brachytherapy (CPT Codes 0394T and 0395T)

Medicare does not have a National Coverage Determination (NCD) for high dose electronic brachytherapy. Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist and compliance with these policies is required where applicable. For specific LCDs/LCAs and applicable coverage guidelines, refer to the table for High Dose Electronic Brachytherapy.

For coverage guidelines for states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.

Note: After checking the High Dose Electronic Brachytherapy table and searching the Medicare Coverage Database, if no LCD/LCA is found, then use the policy referenced above for coverage guidelines.
(Accessed January 18, 2024)

Implantable Beta-Emitting Microspheres for Treatment of Malignant Tumors (CPT Codes 37243 and 79445)

Medicare does not have a National Coverage Determination (NCD) for implantable beta-emitting microspheres for treatment of malignant tumors. Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist.

For coverage guidelines, refer to the UnitedHealthcare Commercial Medical Policy titled Implantable Beta-Emitting Microspheres for Treatment of Malignant Tumors.

Note: After searching the Medicare Coverage Database, if no LCD/LCA is found, then use the policy referenced above for coverage guidelines.
(Accessed January 18, 2024)

Image Guided Radiation Therapy (IGRT) (CPT Codes 77014, 77280, and 77387 and HCPCS Codes G6001, G6002, and G6017)

Medicare does not have National Coverage Determination (NCD) for IGRT. Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist.

For coverage guidelines, refer to the UnitedHealthcare Commercial Medical Policy titled Radiation Therapy: Fractionation, Image-Guidance, and Special Services.

Note: After searching the Medicare Coverage Database, if no LCD/LCA is found, then use the policy referenced above for coverage guidelines.
(Accessed January 18, 2024)

Special/Associated Services (CPT Codes 77331, 77370, 77399, and 77470)

Medicare does not have National Coverage Determination (NCD) for the above special/associated services. Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist.

For coverage guidelines, refer to the UnitedHealthcare Commercial Medical Policy titled Radiation Therapy: Fractionation, Image-Guidance, and Special Services.

Note: After searching the Medicare Coverage Database, if no LCD/LCA is found, then use the policy referenced above for coverage guidelines.
(Accessed January 18, 2024)

Standard Radiation Therapy (2D/3D) (CPT Codes 77401, 77402, 77407, and 77412 and HCPCS Codes G6003, G6004, G6005, G6006, G6007, G6008, G6009, G6010, G6011, G6012, G6013, and G6014)

Medicare does not have National Coverage Determination (NCD) for the above standard radiation therapy (2D/3D). Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist.

For coverage guidelines, refer to the UnitedHealthcare Commercial Medical Policy titled Radiation Therapy: Fractionation, Image-Guidance, and Special Services.

Note: After searching the Medicare Coverage Database, if no LCD/LCA is found, then use the policy referenced above for coverage guidelines.
(Accessed January 18, 2024)

Proton Beam Therapy (PBT) (CPT Codes 77520, 77522, 77523, and 77525)

Medicare does not have a National Coverage Determination (NCD) for PBT. Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist and compliance with these policies is required where applicable. For specific LCDs/LCAs, refer to the table for Proton Beam Therapy/Proton Beam Radiotherapy.

For coverage guidelines for states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Policy titled Proton Beam Radiation Therapy with individual consideration by a Medical Director for following diagnoses:

- Malignant lesions of the head and neck when the intent of treatment is to be curative
- Pancreatic and adrenal tumors
- Unresectable retroperitoneal sarcoma
- Cancers of the lung and upper abdominal/peri-diaphragmatic cancers
- Unresectable malignant lesions of the liver, biliary tract, anal canal and rectum
- Skin cancer with macroscopic perineural/cranial nerve invasion of skull base
- Advanced stage, unresectable pelvic tumors including those with peri-aortic nodes or malignant lesions of the cervix
- Acoustic neuromas
- Pituitary neoplasms
- Unresectable benign or malignant central nervous system tumors to include but not be limited to primary and variant forms of astrocytoma, glioblastoma, medulloblastoma, craniopharyngioma, benign and atypical meningiomas, pineal gland tumors

Note: After checking the Proton Beam Therapy/Proton Beam Radiotherapy table and searching the Medicare Coverage Database, if no LCD/LCA is found, then use the policy referenced above for coverage guidelines.
(Accessed January 18, 2024)

Intensity Modulated Radiation Therapy (IMRT) (CPT Codes 77385 and 77386 and HCPCS Codes G6015 and G6016)

Medicare does not have a National Coverage Determination (NCD) for IMRT. Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist and compliance with these policies is required where applicable. For specific LCDs/LCAs, refer to the table for Intensity Modulated Radiation Therapy (IMRT).

For coverage guidelines for states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Policy titled Intensity-Modulated Radiation Therapy.

Note: After checking the Intensity Modulated Radiation Therapy (IMRT) table and searching the Medicare Coverage Database, if no LCD/LCA is found, then use the policy referenced above for coverage guidelines.
(Accessed January 18, 2024)

Combined use of Proton Beam Therapy (PBT) and Intensity-Modulated Radiation Therapy (IMRT)

Medicare does not have a National Coverage Determination (NCD) for combined use of PBT and IMRT. Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist.

For coverage guidelines, refer to the UnitedHealthcare Commercial Medical Policy titled Proton Beam Radiation Therapy and Intensity-Modulated Radiation Therapy.

Note: After searching the Medicare Coverage Database, if no LCD/LCA is found, then use the policy referenced above for coverage guidelines.
(Accessed January 18, 2024)

Stereotactic Radiosurgery (SRS)/Stereotactic Body Radiation Therapy (SBRT) (CPT Codes 77371, 77372, and 77373 and HCPCS Codes G0339 and G0340)

Medicare does not have a National Coverage Determination (NCD) for SRS/SBRT. Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist and compliance with these policies is required where applicable. For specific LCDs/LCAs, refer to the table for Stereotactic Radiosurgery (SRS)/Stereotactic Body Radiation Therapy (SBRT).

For states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Policy titled Stereotactic Body Radiation Therapy and Stereotactic Radiosurgery for coverage guidelines or information regarding medical necessity with individual consideration by a Medical Director for following diagnoses for SBRT:

- Pelvic, and head and neck tumors that have recurred after primary irradiation

- Primary or metastatic adrenal gland cancer
- Primary central nervous system malignancies, generally under 5 cm
- Primary and secondary tumors involving the brain parenchyma, meninges/dura, or immediately adjacent bony structures
- Tumors arising in or near previously irradiated regions when a high level of precision and accuracy is required to minimize the risk of injury to surrounding normal tissues
- Refractory epilepsy

Note: After checking the Stereotactic Radiosurgery (SRS)/Stereotactic Body Radiation Therapy (SBRT) table and searching the Medicare Coverage Database, if no LCD/LCA is found, then use the policy referenced above for coverage guidelines. (Accessed January 18, 2024)

Tumor Treatment Field Therapy (TTFT) (HCPCS Codes A4555 and E0766)

Medicare does not have an NCD for TTFT. Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist for all states/territories and compliance with these policies is required where applicable.

For coverage guidelines, refer to the DME MAC LCD for Tumor Treatment Field Therapy (TTFT) (L34823). (Accessed January 18, 2024)

Intraoperative Hyperthermic Intraperitoneal Chemotherapy (HIPEC) (CPT Code 96549)

Medicare does not have an NCD for intraoperative hyperthermic intraperitoneal chemotherapy (HIPEC). Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist.

For coverage guidelines, refer to the UnitedHealthcare Commercial Medical Policy titled Intraoperative Hyperthermic Intraperitoneal Chemotherapy (HIPEC).

Note: After searching the Medicare Coverage Database, if no LCD/LCA is found, then use the policy referenced above for coverage guidelines. (Accessed January 18, 2024)

Supporting Information

Proton Beam Therapy/Proton Beam Radiotherapy
Accessed January 18, 2024

LCD/LCA ID	LCD/LCA Title	Contractor Type	Contractor Name	Applicable States/Territories
L36658 (A55315)	Proton Beam Therapy	Part A and B MAC	CGS Administrators, LLC	KY, OH
L33937 (A57669)	Proton Beam Radiotherapy	Part A and B MAC	First Coast Service Options, Inc.	FL, PR, VI
L35075 (A56827)	Proton Beam Therapy	Part A and B MAC	National Government Services, Inc.	CT, IL, MA, ME, MN, NH, NY, RI, VT, WI

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Intensity Modulated Radiation Therapy (IMRT)
Accessed January 18, 2024

LCD/LCA ID	LCD/LCA Title	Contractor Type	Contractor Name	Applicable States/Territories
L36773 (A56746)	Intensity Modulated Radiation Therapy (IMRT)	Part A and B MAC	First Coast Service Options, Inc.	FL, PR, VI
L36711 (A56725)	Intensity Modulated Radiation Therapy (IMRT)	Part A and B MAC	Novitas Solutions, Inc.	AR, CO, DC, DE, LA, MD, MS, NJ, NM, OK, PA, TX

Intensity Modulated Radiation Therapy (IMRT) Accessed January 18, 2024				
LCD/LCA ID	**LCD/LCA Title**	**Contractor Type**	**Contractor Name**	**Applicable States/Territories**
L39553 (A59350)	Radiation Therapies	Part A and B MAC	Palmetto GBA	AL, GA, NC, SC, TN, VA, WV
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Stereotactic Radiosurgery (SRS)/Stereotactic Body Radiation Therapy (SBRT) Accessed January 18, 2024				
LCD/LCA ID	**LCD/LCA Title**	**Contractor Type**	**Contractor Name**	**Applicable States/Territories**
L35076 (A56874)	Stereotactic Radiation Therapy: Stereotactic Radiosurgery (SRS) and Stereotactic Body Radiation Therapy (SBRT)	Part A and B MAC	National Government Services, Inc.	CT, IL, MA, ME, MN, NH, NY, RI, VT, WI
L39553 (A59350)	Radiation Therapies	Part A and B MAC	Palmetto GBA	AL, GA, NC, SC, TN, VA, WV
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High Dose Electronic Brachytherapy Accessed January 18, 2024				
LCD/LCA ID	**LCD/LCA Title**	**Contractor Type**	**Contractor Name**	**Applicable States/Territories**
L35490 (A56902)	Category III Codes	Part A and B MAC	Wisconsin Physicians Service Insurance Corporation	IA, IN, KS, MI, MO, NE
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Policy History/Revision Information

Effective Date	Summary of Changes

04/01/2024	**Coverage Guidelines**
	• Removed content/language addressing:
	  ○ Computer-assisted surgical navigation for musculoskeletal procedures (CPT code 20985); refer to the UnitedHealthcare Medicare Advantage Coverage Summary titled *Orthopedic Procedures, Devices and Products* for applicable coverage guidelines
	  ○ Magnetic resonance image guided high intensity focused ultrasound (MRgFUS) (CPT code 0398T); refer to the UnitedHealthcare Medicare Advantage Coverage Summary titled *Neurologic Services and Procedures*
	Intraoperative Hyperthermic Intraperitoneal Chemotherapy (HIPEC) (CPT Code 96549) (new to policy)
	• Added language to indicate:
	  ○ Medicare does not have a National Coverage Determination (NCD) for intraoperative hyperthermic intraperitoneal chemotherapy (HIPEC)
	  ○ Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist
	  ○ For coverage guidelines, refer to the UnitedHealthcare Commercial Medical Policy titled *Intraoperative Hyperthermic Intraperitoneal Chemotherapy (HIPEC)*
	  ○ After searching the Medicare Coverage Database, if no LCD/LCA is found, then use the policy referenced above for coverage guidelines

Effective Date	Summary of Changes
	Supporting Information • Updated list of available LCDs/LCAs to reflect the most current information • Archived previous policy version MCS077.06

Instructions for Use

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The benefit information in this Coverage Summary is based on existing national coverage policy; however, Local Coverage Determinations (LCDs) may exist and compliance with these policies are required where applicable.

UnitedHealthcare follows Medicare coverage guidelines found in statutes, regulations, NCDs, and LCDs to determine coverage. The clinical coverage criteria governing the items or services in this coverage summary have not been fully established in applicable Medicare guidelines because there is an absence of any applicable Medicare statutes, regulations, NCDs, or LCDs setting forth coverage criteria and/or the applicable NCDs or LCDs include flexibility that explicitly allows for coverage in circumstances beyond the specific indications that are listed in an NCD or LCD. As a result, UnitedHealthcare applies internal coverage criteria in the UnitedHealthcare commercial policies referenced in this coverage summary. The coverage criteria in these commercial policies was developed through an evaluation of the current relevant clinical evidence in acceptable clinical literature and/or widely used treatment guidelines. UnitedHealthcare evaluated the evidence to determine whether it was of sufficient quality to support a finding that the items or services discussed in the policy might, under certain circumstances, be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.