Coverage Summary

Radiologic Therapeutic Procedures

Policy Number: R-003  Products: UnitedHealthcare Medicare Advantage Plans  Original Approval Date: 04/02/2008

Approved by: UnitedHealthcare Medicare Benefit Interpretation Committee  Last Review Date: 01/19/2021

Related Medicare Advantage Policy Guidelines:

- Delivery of IMRT/SRS/SBRT
- Tumor Treatment Field Therapy

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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.

There are instances where this document may direct readers to a UnitedHealthcare Commercial Medical Policy, Medical Benefit Drug Policy, and/or Coverage Determination Guideline (CDG). In the absence of a Medicare National Coverage Determination (NCD), Local Coverage Determination (LCD), or other Medicare coverage guidance, CMS allows a Medicare Advantage Organization (MAO) to create its own coverage determinations, using objective evidence-based rationale relying on authoritative evidence (Medicare IOM Pub. No. 100-16, Ch. 4, §90.5).

INDEX TO COVERAGE SUMMARY

I. COVERAGE
1. Percutaneous Transluminal Coronary Interventions (Interventional Cardiology)
2. Proton Beam Therapy (PBT)
3. Intensity Modulated Radiation Therapy (IMRT)
4. Combined use of Proton Beam Therapy (PBT) and Intensity-Modulated Radiation Therapy (IMRT)
5. Stereotactic Radiosurgery (SRS)/Stereotactic Body Radiation Therapy (SBRT)
6. Local Hyperthermia
8. Tumor Treatment Field Therapy (TTFT)
9. Magnetic Resonance Image Guided High Intensity Focused Ultrasound (MRgFUS)

II. DEFINITIONS

III. REFERENCES

IV. REVISION HISTORY

V. ATTACHMENTS

I. COVERAGE

Coverage Statement: Therapeutic radiologic procedures are covered when Medicare criteria are met.
Guidelines/Notes:
Therapeutic radiological services (inpatient or outpatient) used for the treatment of disease are covered when such services are determined to be reasonable and necessary. Examples include, but are not limited to:

1. Percutaneous Transluminal Coronary Interventions (Interventional Cardiology)
   - *Medicare does not have a National Coverage Determination (NCD) for transluminal coronary interventions (interventional cardiology).*
   - *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 LCD/LCA Availability Grid (Attachment A).*
   - *For coverage guidelines for states/territories with no LCDs/LCAs, see the Wisconsin Physicians LCD for Percutaneous Coronary Interventions (L34761). (IMPORTANT NOTE: After checking the LCD/LCA Availability Grid and searching the Medicare Coverage Database, if no LCD/LCA is found, then use the above referenced policy.)*
   - *Committee approval date: November 17, 2020*
   - *Accessed January 14, 2021*

2. Proton Beam Therapy (PBT)
   - *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 LCD/LCA Availability Grid (Attachment B).*
   - *For coverage guidelines for states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Policy for Proton Beam Radiation Therapy with individual consideration 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.*
   - *(IMPORTANT NOTE: After checking the LCD/LCA Availability Grid and searching the Medicare Coverage Database, if no LCD/LCA is found, then use the above referenced policy.)*
   - *Committee approval date: November 17, 2020*
   - *Accessed January 14, 2021*

3. Intensity Modulated Radiation Therapy (IMRT)
   - *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 LCD/LCA Availability Grid (Attachment C).*
For coverage guidelines for states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Policy for Intensity-Modulated Radiation Therapy. (IMPORTANT NOTE: After checking the LCD/LCA Availability Grid and searching the Medicare Coverage Database, if no LCD/LCA is found, then use the above referenced policy.)

- **Committee approval date:** November 17, 2020
- **Accessed January 14, 2021**

4. **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 at this time.
   - **For coverage guidelines, refer to the UnitedHealthcare Commercial Medical Policy for Proton Beam Radiation Therapy** and UnitedHealthcare Commercial Medical Policy for Intensity-Modulated Radiation Therapy. (IMPORTANT NOTE: After searching the Medicare Coverage Database, if no LCD/LCA is found, then use the above referenced policies.)
   - **Committee approval date:** November 17, 2020
   - **Accessed November 11, 2020**

5. **Stereotactic Radiosurgery (SRS)/Stereotactic Body Radiation Therapy (SBRT)**
   - 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 LCD/LCA Availability Grid (Attachment D).
   - **For states/territories with no LCDs/LCAs, refer to the MCG™ Care Guidelines, 24th edition, 2020, for Stereotactic Radiosurgery ACG: A – 0423 (AC) and Stereotactic Body Radiotherapy ACG: A-0694 (AC) and Stereotactic Radiosurgery for coverage guidelines or information regarding medical necessity with individual consideration for following diagnoses for SBRT:**
     - Pelvic, and head and neck tumors that have recurred after primary irradiation
     - Primary or metastatic pancreatic cancer
     - Primary or metastatic renal cancer
     - Primary or metastatic adrenal gland cancer
     - Primary central nervous system malignancies, generally under 5 cm
     - Relapse in a previously irradiated cranial or spinal field where the additional stereotactic precision is required
     - As a boost treatment for larger cranial or spinal lesions that have been treated initially with external beam radiation therapy or surgery (e.g., sarcomas, chondrosarcomas, chordomas, and nasopharyngeal or paranasal sinus malignancies)
     - 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
   - Click [here](#) to view the MCG™ Care Guidelines. (IMPORTANT NOTE: After checking the LCD/LCA Availability Grid and searching the Medicare Coverage Database, if no
LCD/LCA is found, then use the above referenced policies.)

- **Committee approval date: January 19, 2021**
- **Accessed January 14, 2021**

6. **Local Hyperthermia**

Local hyperthermia is covered when used in connection with radiation therapy for the treatment of primary or metastatic cutaneous or subcutaneous superficial malignancies. It is not covered when used alone or in connection with chemotherapy. See the *NCD for Hyperthermia for Treatment of Cancer (110.1)*. (Accessed November 11, 2020)


- Medicare does not have an NCD for computer-assisted surgical navigation for musculoskeletal procedures.
- Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist.
- **For coverage guidelines**, refer to the *UnitedHealthcare Commercial Medical Policy for Computer-Assisted Surgical Navigation for Musculoskeletal Procedures*. (IMPORTANT NOTE: After searching the Medicare Coverage Database, if no LCD/LCA is found, then use the above referenced policy.)

- **Committee approval date: November 17, 2020**
- **Accessed November 11, 2020**

8. **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).
- **Committee approval date: November 17, 2020**
- **Accessed January 14, 2021**

9. **Magnetic Resonance Image Guided High Intensity Focused Ultrasound (MRgFUS) (CPT code 0398T)**

- Medicare does not have a National Coverage Determination (NCD) for MRgFUS.
- 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 LCD/LCA Availability Grid (Attachment E).
- **For coverage guidelines for states/territories with no LCDs/LCAs**, refer to the *UnitedHealthcare Commercial Medical Policy for Omnibus Codes*. (IMPORTANT NOTE: After checking the LCD/LCA Availability Grid and searching the Medicare Coverage Database, if no LCD/LCA is found, then use the above referenced policy.)
- **Committee approval date: November 17, 2020**
- **Accessed January 14, 2021**

**II. DEFINITIONS**

**III. REFERENCES**
IV. REVISION HISTORY

01/19/2021  Guideline 5 [Stereotactic Radiosurgery (SRS)/Stereotactic Body Radiation Therapy (SBRT)]
- Revised language pertaining to states with no LCDs/LCAs; updated list of SBRT requiring individual consideration:
  - Replaced “head and neck tumors that have recurred after primary irradiation” with “pelvic and head and neck tumors that have recurred after primary irradiation”

V. ATTACHMENTS

Attachment A – LCD/LCA Availability Grid

<table>
<thead>
<tr>
<th>ID #</th>
<th>Title</th>
<th>Contractor Type</th>
<th>Contractor</th>
<th>States/Territories</th>
</tr>
</thead>
<tbody>
<tr>
<td>L33623</td>
<td>Percutaneous Coronary Intervention</td>
<td>A and B MAC</td>
<td>National Government Services, Inc.</td>
<td>CT, IL, MA, ME, MN, NH, NY, RI, VT, WI</td>
</tr>
<tr>
<td>L34761</td>
<td>Percutaneous Coronary Interventions</td>
<td>MAC Part A</td>
<td>Wisconsin Physicians Service Insurance Corporation</td>
<td>AK, AL, AR, AZ, CA, CO, CT*, DE, FL, GA, HI, IA, ID, IL*, IN, KS, KY, LA, MA*, MD, ME*, MI, MO, MS, MT, NC, ND, NE, NH*, NJ, NM, NV, OH, OK, OR, PA, RI*, SC, SD, TN, TX, UT, VA, VT*, WA, WI*, WV, WY</td>
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</tbody>
</table>

(Note: States notated with an asterisk should follow the other available state-specific LCD listed on this grid. This WPS LCD only applies to states without asterisk.)

End of Attachment A

Attachment B – LCD/LCA Availability Grid

<table>
<thead>
<tr>
<th>ID #</th>
<th>Title</th>
<th>Contractor Type</th>
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<th>States/Territories</th>
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<tbody>
<tr>
<td>L36658</td>
<td>Proton Beam Therapy</td>
<td>A and B MAC</td>
<td>CGS Administrators, LLC</td>
<td>KY, OH</td>
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<tr>
<td>L33937</td>
<td>Proton Beam Radiotherapy</td>
<td>MAC Part B</td>
<td>First Coast Service Options, Inc.</td>
<td>FL, PR, VI</td>
</tr>
<tr>
<td>L35075</td>
<td>Proton Beam Therapy</td>
<td>A and B MAC</td>
<td>National Government Services, Inc.</td>
<td>CT, IL, MA, ME, MN, NH, NY, RI, VT, WI</td>
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End of Attachment B
### Attachment C – LCD/LCA Availability Grid

**Intensity Modulated Radiation Therapy (IMRT)**

CMS website accessed January 14, 2021

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<tr>
<th>ID #</th>
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<th>States/Territories</th>
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</thead>
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<tr>
<td>L36773 (A56746)</td>
<td>Intensity Modulated Radiation Therapy (IMRT)</td>
<td>A and B MAC</td>
<td>First Coast Service Options, Inc.</td>
<td>FL, PR, VI</td>
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<tr>
<td>A58245</td>
<td>Billing and Coding: Intensity Modulated Radiation Therapy (IMRT)</td>
<td>A and B MAC</td>
<td>Noridian Healthcare Solutions, LLC</td>
<td>AK, AZ, ID, OR, MT, ND, SD, UT, WA, WY</td>
</tr>
<tr>
<td>A58236</td>
<td>Billing and Coding: Intensity Modulated Radiation Therapy (IMRT)</td>
<td>A and B MAC</td>
<td>Noridian Healthcare Solutions, LLC</td>
<td>AS, CA, GU, HI, MP, NV</td>
</tr>
<tr>
<td>L36711 (A56725)</td>
<td>Intensity Modulated Radiation Therapy (IMRT)</td>
<td>A and B MAC</td>
<td>Novitas Solutions, Inc.</td>
<td>AR, CO, DC, DE, LA, MD, MS, NJ, NM, OK, PA, TX</td>
</tr>
</tbody>
</table>

End of Attachment C

### Attachment D – LCD/LCA Availability Grid

**Stereotactic Radiosurgery (SRS)/Stereotactic Body Radiation Therapy (SBRT)**

CMS website accessed January 14, 2021

<table>
<thead>
<tr>
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<th>Title</th>
<th>Contractor Type</th>
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<tbody>
<tr>
<td>L33410 (A57275)</td>
<td>Stereotactic Radiosurgery (SRS) and Stereotactic Body Radiation Therapy (SBRT)</td>
<td>A and B MAC</td>
<td>First Coast Service Options, Inc.</td>
<td>FL, PR, VI</td>
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<tr>
<td>L35076 (A56874)</td>
<td>Stereotactic Radiation Therapy: Stereotactic Radiosurgery (SRS) and Stereotactic Body Radiation Therapy (SBRT)</td>
<td>A and B MAC</td>
<td>National Government Services, Inc.</td>
<td>CT, IL, MA, ME, MN, NH, NY, RI, VT, WI</td>
</tr>
</tbody>
</table>

End of Attachment D

### Attachment E – LCD/LCA Availability Grid

**Magnetic Resonance Image Guided High Intensity Focused Ultrasound (MRgFUS)**

CMS website accessed January 14, 2021

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<tr>
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<th>Contractor</th>
<th>States/Territories</th>
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<tr>
<td>L37790 (A56470)</td>
<td>Magnetic Resonance Image Guided High Intensity Focused Ultrasound (MRgFUS) for Essential Tremor</td>
<td>A and B MAC</td>
<td>CGS Administrators, LLC</td>
<td>KY, OH</td>
</tr>
<tr>
<td>L38506 (A57884)</td>
<td>Magnetic-Resonance-Guided Focused Ultrasound Surgery (MRgFUS) for Essential Tremor</td>
<td>A and B MAC</td>
<td>First Coast Service Options, Inc.</td>
<td>FL, PR, VI</td>
</tr>
<tr>
<td>L37421 (A57435)</td>
<td>Magnetic Resonance Image Guided High Intensity Focused Ultrasound (MRgFUS) for Essential Tremor</td>
<td>A and B MAC</td>
<td>National Government Services</td>
<td>CT, IL, MN, NY, MA, ME, NH, RI, WI, VT</td>
</tr>
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<td>L37738 (A57513)</td>
<td>Magnetic-Resonance-Guided Focused Ultrasound Surgery (MRgFUS) for Essential Tremor</td>
<td>A and B MAC</td>
<td>Noridian Healthcare Solutions, LLC</td>
<td>AK, AZ, ID, MT, ND, OR, SD, WA, UT, WY</td>
</tr>
</tbody>
</table>

Page 6 of 7

UHC MA Coverage Summary: Radiologic Therapeutic Procedures

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### Attachment E – LCD/LCA Availability Grid

**Magnetic Resonance Image Guided High Intensity Focused Ultrasound (MRgFUS)**

CMS website accessed January 14, 2021

<table>
<thead>
<tr>
<th>ID #</th>
<th>Title</th>
<th>Contractor Type</th>
<th>Contractor</th>
<th>States/Territories</th>
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<tbody>
<tr>
<td>L37729 (A57512)</td>
<td>Magnetic-Resonance-Guided Focused Ultrasound Surgery (MRgFUS) for Essential Tremor</td>
<td>A and B MAC</td>
<td>Noridian Healthcare Solutions, LLC</td>
<td>CA, HI, NV, AS, GU, MP</td>
</tr>
<tr>
<td>L37761 (A56690)</td>
<td>Magnetic Resonance Image Guided High Intensity Focused Ultrasound (MRgFUS) for Essential Tremor</td>
<td>A and B MAC</td>
<td>Palmetto GBA</td>
<td>AL, GA, NC, SC, TN, VA, WV</td>
</tr>
</tbody>
</table>

(Note: States notated with an asterisk should follow the other available state-specific LCD listed on this grid. This WPS LCD only applies to states without asterisk.)

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<th>Contractor Type</th>
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<th>States/Territories</th>
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</thead>
<tbody>
<tr>
<td>L35490 (A56902)</td>
<td>Category III Codes</td>
<td>MAC Part B</td>
<td>Wisconsin Physicians Service Insurance Corporation</td>
<td>IN, IA, KS, MI, MO, NE</td>
</tr>
</tbody>
</table>

End of Attachment E