Radiologic Therapeutic Procedures

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Instructions for Use

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Related Medicare Advantage Policy Guidelines

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

Coverage Guidelines

Therapeutic radiologic procedures are covered when Medicare criteria are met.

Therapeutic radiological services (inpatient or outpatient) used the treatment of disease, are covered when such services are determined to be reasonable and necessary. Examples include, but are not limited to:

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 table for Interventional Cardiology/Percutaneous Transluminal Coronary Interventions.

For coverage guidelines for states/territories with no LCDs/LCAs, refer to the WPS LCD for Percutaneous Coronary Interventions (L34761).
Note: After checking the Interventional Cardiology/Percutaneous Transluminal Coronary Interventions table and searching the Medicare Coverage Database, if no LCD/LCA is found, then use the policy referenced above for coverage guidelines.

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 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 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.

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 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.

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 currently.

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.

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 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 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.

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. Refer to the NCD for Hyperthermia for Treatment of Cancer (110.1). (Accessed November 11, 2020)

Computer-Assisted Surgical Navigation for Musculoskeletal Procedures (CPT code 20985)

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 titled Computer-Assisted Surgical Navigation for Musculoskeletal Procedures.
Note: After searching the Medicare Coverage Database, if no LCD/LCA is found, then use the policy referenced above for coverage guidelines.

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 September 22, 2021)

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 table for Magnetic Resonance Image Guided High Intensity Focused Ultrasound (MRgFUS).

For coverage guidelines for states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.
Note: After checking the Magnetic Resonance Image Guided High Intensity Focused Ultrasound (MRgFUS) table and searching the Medicare Coverage Database, if no LCD/LCA is found, then use the policy referenced above for coverage guidelines.

Supporting Information

Important Note: When searching the Medicare Coverage Database, if no LCD/LCA is found, then use the applicable referenced default policy below for coverage guidelines.

Interventional Cardiology/Percutaneous Transluminal Coronary Interventions Accessed October 6, 2021				
LCD/LCA ID	LCD/LCA Title	Contractor Type	Contractor Name	Applicable States/Territories
L33623 (A56823)	Percutaneous Coronary Intervention	Part A and B MAC	National Government Services, Inc.	CT, IL, MA, ME, MN, NH, NY, RI, VT, WI
L34761 (A57479)	Percutaneous Coronary Interventions	Part A MAC	Wisconsin Physicians Service Insurance Corporation	AK, AL, AR, AZ, CA, CO, CT*, DE, FL, GA, HI, IA, ID, IL*, IN, KS, KY, LA, MA*, MD, ME*, MI,

Interventional Cardiology/Percutaneous Transluminal Coronary Interventions Accessed October 6, 2021				
LCD/LCA ID	LCD/LCA Title	Contractor Type	Contractor Name	Applicable States/Territories
				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 Note: States notated with an asterisk should follow the other available state-specific LCD listed in this table. This WPS LCD only applies to states without asterisk.
L34761 (A57479)	Percutaneous Coronary Interventions	Part B MAC	Wisconsin Physicians Service Insurance Corporation	IA, IN, KS, MI, MO, NE
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Proton Beam Therapy/Proton Beam Radiotherapy Accessed October 6, 2021				
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 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 October 6, 2021				
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
A58245	Billing and Coding: Intensity Modulated Radiation Therapy (IMRT)	Part A and B MAC	Noridian Healthcare Solutions, LLC	AK, AZ, ID, OR, MT, ND, SD, UT, WA, WY
A58236	Billing and Coding: Intensity Modulated Radiation Therapy (IMRT)	Part A and B MAC	Noridian Healthcare Solutions, LLC	AS, CA, GU, HI, MP, NV
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
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Stereotactic Radiosurgery (SRS)/Stereotactic Body Radiation Therapy (SBRT) Accessed October 6, 2021				
LCD/LCA ID	LCD/LCA Title	Contractor Type	Contractor Name	Applicable States/Territories
L33410 (A57275)	Stereotactic Radiosurgery (SRS) and Stereotactic Body Radiation Therapy (SBRT)	Part A and B MAC	First Coast Service Options, Inc.	FL, PR, VI
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
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Magnetic Resonance Image Guided High Intensity Focused Ultrasound (MRgFUS) Accessed October 6, 2021				
LCD/LCA ID	LCD/LCA Title	Contractor Type	Contractor Name	Applicable States/Territories
L37790 (A56470)	Magnetic Resonance Guided Focused Ultrasound Surgery System (MRgFUS) for the Treatment of Neurologic Conditions	Part A and B MAC	CGS Administrators, LLC	KY, OH
L38506 (A57884)	Magnetic-Resonance-Guided Focused Ultrasound Surgery (MRgFUS) for Essential Tremor	Part A and B MAC	First Coast Service Options, Inc.	FL, PR, VI
L37421 (A57435)	Magnetic Resonance Image Guided High Intensity Focused Ultrasound (MRgFUS) for Essential Tremor	Part A and B MAC	National Government Services	CT, IL, MN, NY, MA, ME, NH, RI, WI, VT
L37738 (A57513)	Magnetic-Resonance-Guided Focused Ultrasound Surgery (MRgFUS) for Essential Tremor	Part A and B MAC	Noridian Healthcare Solutions, LLC	AK, AZ, ID, MT, ND, OR, SD, WA, UT, WY
L37729 (A57512)	Magnetic-Resonance-Guided Focused Ultrasound Surgery (MRgFUS) for Essential Tremor	Part A and B MAC	Noridian Healthcare Solutions, LLC	CA, HI, NV, AS, GU, MP
L37761 (A56690)	Magnetic Resonance Image Guided High Intensity Focused Ultrasound (MRgFUS) for Essential Tremor	Part A and B MAC	Palmetto GBA	AL, GA, NC, SC, TN, VA, WV

Magnetic Resonance Image Guided High Intensity Focused Ultrasound (MRgFUS) Accessed October 6, 2021				
LCD/LCA ID	LCD/LCA Title	Contractor Type	Contractor Name	Applicable States/Territories
L35490 (A56902)	Category III Codes	Part A MAC	Wisconsin Physicians Service Insurance Corporation	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* (Note: States notated with an asterisk should follow the other available state-specific LCD listed in this table. This WPS LCD only applies to states without asterisk.)
L35490 (A56902)	Category III Codes	Part B MAC	Wisconsin Physicians Service Insurance Corporation	IN, IA, KS, MI, MO, NE
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Policy History/Revision Information

Date	Summary of Changes
05/01/2021	**Template Update** • Reformatted policy; transferred content to new template

03/16/2021	**Stereotactic Radiosurgery (SRS)/Stereotactic Body Radiation Therapy (SBRT)**
	• Revised default guidelines for states/territories with no Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs):
	  ○ Added reference link to the UnitedHealthcare Commercial Medical Policy titled *Stereotactic Body Radiation Therapy and Stereotactic Radiosurgery*
	  ○ Removed reference link to MCG™ Care Guidelines, *24th* edition, *2020*, for *Stereotactic Radiosurgery ACG: A-0423 (AC) and Stereotactic Body Radiotherapy ACG: A-0694 (AC) and Stereotactic Radiosurgery*
	• Updated list of SBRT requiring individual consideration:
	  ○ Added:
	  ▪ Refractory epilepsy
	  ○ Removed:
	  ▪ Primary or metastatic pancreatic cancer
	  ▪ Primary or metastatic renal cancer
	  ▪ 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)
	Supporting Information
	• Updated LCD/LCA Availability Grids to reflect the most current reference links

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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).

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