Coverage Statement: Therapeutic radiologic procedures are covered when Medicare criteria are met.
Guidelines/Notes:

Therapeutic radiological services (inpatient or outpatient) used to treat 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 Physician 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: July 21, 2020
   - Accessed October 7, 2020

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
     - Prostate Cancer, non-metastatic
     - Unresectable breast tumors in proximity to the heart
     - 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 19, 2019
   - Accessed October 7, 2020

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 19, 2019
- **Accessed October 7, 2020**

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 19, 2019
   - **Accessed February 18, 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:
     - 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
   - 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:** March 17, 2020
   - **Accessed October 7, 2020**

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**
   - 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**: July 21, 2020
   - Accessed August 12, 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**: July 21, 2020
   - Accessed September 21, 2020

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**: July 21, 2020
   - Accessed October 7, 2020

II. DEFINITIONS

**Proton Beam Therapy (PBT):** PBT is a technology for delivering conformal external beam radiation with positively charged atomic particles to a well-defined treatment volume. PBT is approved by the U.S. Food and Drug Administration.

Due to its unique dose deposition characteristics, PBT can, in certain situations, deliver the prescribed target dose while giving a lower dose to normal tissues as compared to photon-based forms of external beam radiotherapy.

Photon beams deposit their greatest amount of energy beneath the patient's surface with a gradual reduction in energy deposition along the beam path as photons pass through the target and then through an exit point out of the body. In contrast, the physical profile of a beam of proton particles allows for the majority of its energy to be deposited over a very narrow range of tissue at a depth largely determined by the energy of the proton beam. A proton beam deposits relatively less radiation energy upon entering the body compared to a photon beam. The energy deposition of the proton
beam then rapidly increases over a narrow range of tissue at a desired depth to produce an intense dose distribution pattern called the Bragg peak. Beyond the Bragg peak, energy and dose deposition rapidly decrease, resulting in the absence of any significant exit dose deposited in normal tissue beyond the target. National Government Services, Inc. LCD for Proton Beam Therapy (L35075). (Accessed August 12, 2020)

**Stereotactic Radiosurgery (SRS):** The adjective “Stereotactic” describes a procedure during which a target lesion is localized relative to a fixed three dimensional reference system, such as a rigid head frame (61800) affixed to a patient, fixed bony landmarks, a system of implanted fiducial markers, or other similar system. This type of localization procedure allows physicians to perform image-guided procedures with a high degree of anatomic accuracy and precision.

Stereotactic radiation therapy (SRT) couples this anatomic accuracy and reproducibility with very high doses of highly precise, externally generated, ionizing radiation, thereby maximizing the ablative effect on the target(s) while minimizing collateral damage to adjacent tissues. SRT requires computer-assisted, three-dimensional planning and delivery with stereotactic and convergent-beam technologies, including, but not limited to, multiple convergent cobalt sources (e.g., Gamma Knife®), protons, multiple, coplanar or non-coplanar photon arcs or angles (e.g., XKnife®), fixed photon arcs or image-directed robotic devices (e.g., CyberKnife®) that meet the criteria.

SRS is a distinct discipline that utilizes externally generated ionizing radiation in certain cases to inactivate or eradicate a defined target(s) in the head or spine without the need to make an incision. The target is defined by high-resolution stereotactic imaging. To assure quality of patient care the procedure involves a multidisciplinary team consisting of a neurosurgeon, radiation oncologist, and medical physicist. SRS typically is performed in a single session, using a rigidly attached stereotactic guiding device, other immobilization technology and/or a stereotactic-guidance system, but can be performed in a limited number of sessions, up to a maximum of five. Technologies that are used to perform SRS include linear accelerators, particle beam accelerators, and multisource Cobalt 60 units. In order to enhance precision, various devices may incorporate robotics and real-time imaging. LCD for Stereotactic Radiation Therapy: Stereotactic Radiosurgery (SRS) and Stereotactic Body Radiation Therapy (SBRT) (L34151). (Accessed August 12, 2020)

**Stereotactic Body Radiation Therapy (SBRT):** A treatment that couples a high degree of anatomic targeting accuracy and reproducibility with very high doses of extremely precise, externally generated, ionizing radiation, thereby maximizing the cell-killing effect on the target(s) while minimizing radiation-related injury in adjacent normal tissues.

The adjective “stereotactic” describes a procedure during which a target lesion is localized relative to a known three dimensional reference system that allows for a high degree of anatomic accuracy and precision. Examples of devices used in SBRT for stereotactic guidance may include a body frame with external reference markers in which a patient is positioned securely, a system of implanted fiducial markers that can be visualized with low-energy (kV) x-rays, and CT imaging-based systems used to confirm the location of a tumor immediately prior to treatment.

All SBRT is performed with at least one form of image guidance to confirm proper patient positioning and tumor localization. To minimize intra-treatment tumor motion associated with respiration or other motion, some form of motion control or “gating” may be used.

SBRT may be fractionated (up to 5 fractions). Each fraction requires an identical degree of precision, localization and image guidance.

Since the goal of SBRT is to intensify the potency of the radiotherapy by completing an entire course of treatment within an extremely accelerated time frame, any course of radiation treatment extending beyond five fractions is not considered SBRT and is not to be billed using these codes. LCD for Stereotactic Radiation Therapy: Stereotactic Radiosurgery (SRS) and Stereotactic Body
Transluminal Interventions: Encompass balloon dilatation, a variety of atherectomy devices as well as approved stents for coronary placement. Complementing medical therapy and aortocoronary bypass, transluminal interventions have emerged as a third therapeutic option for the management of patients with chronic angina, acute coronary insufficiency and evolving myocardial infarction. LCD for Percutaneous Coronary Intervention (L33623), (Accessed August 12, 2020)

III. REFERENCES

See above.

IV. REVISION HISTORY

07/21/2020  Guideline 1 [Percutaneous Transluminal Coronary Interventions (Interventional Cardiology)]

- Revised language pertaining to Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) to indicate:
  - LCDs/LCAs exist and compliance with these policies is required where applicable
  - For coverage guidelines for states/territories with no LCDs/LCAs, refer to the Wisconsin Physician Service Insurance Corporation (WPS) LCD for Percutaneous Coronary Interventions (L34761)

Guideline 7 [Computer-Assisted Surgical Navigation for Musculoskeletal Procedures (CPT code 20985)]

- Revised language pertaining to LCDs/LCAs to indicate:
  - LCDs/LCAs do not exist at this time
  - For coverage guidelines, refer to the UnitedHealthcare Commercial Medical Policy titled Computer-Assisted Surgical Navigation for Musculoskeletal Procedures

Guideline 8 [Tumor Treatment Field Therapy (TTFT) (CPT codes A4555 and E0766)]

- Added language to clarify LCDs/LCAs exist for all states/territories and compliance with these policies is required where applicable

Guideline 9 [Magnetic Resonance Image Guided High Intensity Focused Ultrasound (MRgFUS) (CPT code 0398T)]

- Revised language pertaining to LCDs/LCAs to indicate:
  - LCDs/LCAs exist [for some states/territories] and compliance with these policies is required where applicable
  - For coverage guidelines for states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Medical Policy titled Omnibus Codes

Attachments

- Updated LCD/LCA Availability Grids to reflect the most current reference links
- Removed LCD/LCA Availability Grid for Magnetic Resonance Image Guided High Intensity Focused Ultrasound (MRgFUS) (CPT Code 0398T)
## Attachment A – LCD/LCA Availability Grid

### Interventional Cardiology/Percutaneous Transluminal Coronary Interventions

<table>
<thead>
<tr>
<th>ID #</th>
<th>Title</th>
<th>Contractor Type</th>
<th>Contractor</th>
<th>States/Territories</th>
</tr>
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<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>
</tr>
<tr>
<td>L34761</td>
<td>Percutaneous Coronary Interventions</td>
<td>MAC – Part B</td>
<td>Wisconsin Physicians Service Insurance Corporation</td>
<td>IA, IN, KS, MI, MO, NE</td>
</tr>
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End of Attachment A

## Attachment B – LCD/LCA Availability Grid

### Proton Beam Therapy/Proton Beam Radiotherapy

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<tr>
<th>ID #</th>
<th>Title</th>
<th>Contractor Type</th>
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<td>A and B MAC</td>
<td>CGS Administrators, LLC</td>
<td>KY, OH</td>
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<tr>
<td>L33937</td>
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<td>MAC Part B</td>
<td>First Coast Service Options, Inc.</td>
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<tr>
<td>L35075</td>
<td>Proton Beam Therapy</td>
<td>A and B MAC</td>
<td>National Government Services, Inc.</td>
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End of Attachment B

## Attachment C – LCD/LCA Availability Grid

### Intensity Modulated Radiation Therapy (IMRT)

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<th>ID #</th>
<th>Title</th>
<th>Contractor Type</th>
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<td>A and B MAC</td>
<td>First Coast Service Options, Inc.</td>
<td>FL, PR, VI</td>
</tr>
<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>
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<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>
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<td>L36711</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>
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End of Attachment C
### Attachment D – LCD/LCA Availability Grid

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

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<td>First Coast Service Options, Inc.</td>
<td>FL, PR, VI</td>
</tr>
<tr>
<td>L35076</td>
<td>Stereotactic Radiation Therapy; Stereotactic Radiosurgery (SRS) and Stereotactic Body Radiation Therapy (SBRT)</td>
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<td>National Government Services, Inc.</td>
<td>CT, IL, MA, ME, MN, NH, NY, RI, VT, WI</td>
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<td>L34224</td>
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<td>Noridian Healthcare Solutions, LLC</td>
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<td>Noridian Healthcare Solutions, LLC</td>
<td>AK, AZ, ID, OR, MT, ND, SD, UT, WA, WY</td>
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End of Attachment D

### Attachment E – LCD/LCA Availability Grid

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

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<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>
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<tr>
<td>L37421</td>
<td>Magnetic Resonance Image Guided High Intensity Focused Ultrasound (MRgFUS) for Essential Tremor</td>
<td>A and B MAC</td>
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<td>L37738</td>
<td>Magnetic-Resonance-Guided Focused Ultrasound Surgery (MRgFUS) for Essential Tremor</td>
<td>A and B MAC</td>
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<td>L37729</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>
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<tr>
<td>L37761</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>
## Attachment E – LCD/LCA Availability Grid

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

CMS website accessed October 7, 2020

<table>
<thead>
<tr>
<th>ID #</th>
<th>Title</th>
<th>Contractor Type</th>
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<tr>
<td>L35490 (A56902)</td>
<td>Category III Codes</td>
<td>MAC Part B</td>
<td>Wisconsin Physicians Service Insurance Corporation</td>
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(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 E