## 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:** 03/19/2019

**Related Medicare Advantage Policy Guidelines:**
- Delivery of IMRT/SRS/SBRT
- Tumor Treatment Field Therapy

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**Coverage Statement:** Therapeutic radiologic procedures are covered when Medicare criteria are met.

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This information is being distributed to you for personal reference. The information belongs to UnitedHealthcare and unauthorized copying, use, and distribution are prohibited. This information is intended to serve only as a general reference resource and is not intended to address every aspect of a clinical situation. Physicians and patients should not rely on this information in making health care decisions. Each benefit plan contains its own specific provisions for coverage, limitations, and exclusions as stated in the Member’s Evidence of Coverage (EOC)/Summary of Benefits (SB). If there is a discrepancy between this policy and the member’s EOC/SB, the member’s EOC/SB provision will govern. The information contained in this document is believed to be current as of the date noted.

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).
Guidelines/Notes:
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:

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 state-specific LCDs/LCAs, refer to the [LCD Availability Grid](Attachment A).*
   - *For coverage guidelines for states with no LCDs, refer to the Wisconsin Physicians Services LCD for Percutaneous Coronary Interventions (L34761). (IMPORTANT NOTE: After checking the LCD Availability Grid and searching the Medicare Coverage Database, if no state LCD/LCA is found, then use the above referenced policy.)*
   - *Committee approval date: November 20, 2018*
   - *Accessed July 17, 2019*

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 state-specific LCDs/LCAs, refer to the [LCD Availability Grid](Attachment B).*
   - *For states with no LCDs, 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/peridiaphragmatic 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 Availability Grid and searching the Medicare Coverage Database, if no state LCD/LCA is found, then use the above referenced policy.)*
   - *Committee approval date: November 20, 2018*
   - *Accessed July 17, 2019*

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 state-specific LCDs/LCAs, refer to the LCD Availability Grid (Attachment C).

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

- **Committee approval date: November 20, 2018**
- **Accessed July 17, 2019**

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 state LCD/LCA is found, then use the above referenced policies.)
   - **Committee approval date: November 20, 2018**
   - **Accessed March 8, 2019**

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 state-specific LCDs/LCAs, refer to the LCD Availability Grid (Attachment D).
   - **For states with no LCDs, refer to the MCG™ Care Guidelines, 23rd edition, 2019, 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
   - (IMPORTANT NOTE: After checking the LCD Availability Grid and searching the Medicare Coverage Database, if no state LCD/LCA is found, then use the above referenced policies.)
   - **Committee approval date: March 19, 2019**
   - **Accessed July 17, 2019**

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 15, 2018)

7. **Stereotactic Computer Assisted Volumetric and/or Navigational Procedure (CPT code 20985)**
- Medicare does not have an NCD for stereotactic computer assisted volumetric and/or navigational procedure.
- There is only one Medicare Administrative Contractor (MAC) with LCDs, compliance with these policies is required where applicable. For state-specific LCDs, refer to the LCD Availability Grid (Attachment E).
- For states with no LCDs, refer to the UnitedHealthcare Commercial Medical Policy for Omnibus Codes for coverage guidelines. (IMPORTANT NOTE: After checking the LCD Availability Grid and searching the Medicare Coverage Database, if no state LCD/LCA is found, then use the above referenced policy.)
- Committee approval date: November 20, 2018
- Accessed July 17, 2019

8. Tumor Treatment Field Therapy (TTFT) (A4555 and E0766)
- Medicare does not have an NCD for TTFT.
- Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist for all 50 states and compliance with these policies is required where applicable. For state-specific LCDs/LCAs, refer to the LCD Availability Grid (Attachment F).
- Committee approval date: November 20, 2018
- Accessed July 17, 2019

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 state-specific LCDs/LCAs, refer to the LCD Availability Grid (Attachment G).
- For states with no LCDs, refer to the UnitedHealthcare Commercial Medical Policy for Omnibus Codes (IMPORTANT NOTE: After checking the LCD Availability Grid and searching the Medicare Coverage Database, if no state LCD/LCA is found, then use the above referenced policy.)
- Committee approval date: November 20, 2018
- Accessed July 17, 2019

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. LCDs for Proton Beam Therapy (L35075). (Accessed July 17, 2019)

**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 July 17, 2019)

**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
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 July 17, 2019)

III. REFERENCES

See above

IV. REVISION HISTORY

04/01/2019  • Updated policy introduction; added language to clarify:
  o There are instances where [the Coverage Summary] may direct readers to a UnitedHealthcare Commercial Medical Policy, Medical Benefit Drug Policy, and/or Coverage Determination Guideline (CDG)
  o 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)
  • Retitled reference links that direct users to UnitedHealthcare Commercial policies

03/19/2019  Re-review with the following update:
  Guideline 5 [Stereotactic Radiosurgery (SRS)/Stereotactic Body Radiation Therapy (SBRT)] - Updated the MCG™ Care Guidelines reference from 22nd 2018 edition 23rd 2019 edition; no change in MCG™ guideline; no change in the Coverage Summary guideline.

11/20/2018  Annual review with the following updates:
  • Guideline 7 [Stereotactic Computer Assisted Volumetric and/or Navigational Procedure (CPT codes 20985 and 0398T)] - Moved CPT 0398T to new guideline #9.
  • Guideline 9 [Magnetic Resonance Image Guided High Intensity Focused Ultrasound (MRgFUS) (CPT Code 0398T)] – New guideline to coverage summary.

Definition Section
  • Proton Beam Therapy (PBT) -
    o Removed the following language and CMS reference due to the Wisconsin LCD (L34634) being retired 09/01/2017:
      “Proton beam therapy is a radiation treatment modality that delivers high-dose radiation to a localized site. Protons, being particles instead of X-rays, slow down faster than photons. They deposit more energy as they slow down, culminating in a peak (called a Bragg peak). This allows the majority of radiation to be delivered to the target site with less scattering of radiation around and beyond to the adjacent normal tissues. LCD for Proton Beam Therapy (L34634).”
    o Replaced definition with the following National Government Services, Inc. LCD (L35075) language and CMS reference:
      “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 LCDs for Proton Beam Therapy (L35075).”

09/18/2018 Updated Local Coverage Determination (LCD) Availability Grids; removed instruction to “use the applicable LCD based on member’s residence/place and type of service” (this note only applies when selecting the appropriate DME LCD Policy)


01/16/2018 Re-review with the following updates:
Guideline 2 [Proton Beam Therapy (PBT)] – Updated the applicable LCDs to include the most recent website links and effective dates related to the Cahaba-Palmetto jurisdiction transition; no change in guideline.
Guideline 3 [Intensity Modulated Radiation Therapy (IMRT)] – Updated the applicable LCDs to include the most recent website links and effective dates related to the Cahaba-Palmetto jurisdiction transition; no change in guideline.
Guideline 5 [Stereotactic Radiosurgery (SRS)/Stereotactic Body Radiation Therapy (SBRT)] – Updated the applicable LCDs to include the most recent website links and effective dates related to the Cahaba-Palmetto jurisdiction transition; no change in guideline.

11/20/2017 Annual review with the following updates:
Guideline 2 [Proton Beam Therapy (PBT)] –
- Added the following diagnoses to individual consideration list:
  - Unresectable breast tumors in proximity to the heart,
  - Acoustic neuromas,
  - Pituitary neoplasms; and
  - Unresectable benign or malignant central nervous system tumors to include but not be limited to primary and variant forms of astrocytoma, glioblastoma, medulloblastoma, cranioopharyngioma, benign and atypical meningiomas, pineal gland tumors
- Removed “and extremity sarcoma” language from individual diagnosis of Unresectable retroperitoneal sarcoma.

Guideline 5 [Stereotactic Radiosurgery (SRS)/Stereotactic Body Radiation Therapy (SBRT)]
– Added following language to default for states without LCDs: “with individual consideration for following diagnoses for SBRT: 
  • primary or metastatic pancreatic cancer 
  • primary or metastatic renal cancer 
  • primary or metastatic adrenal gland cancer”

08/15/2017 Re-review with the following update:
Guideline 8 [Tumor Treatment Field Therapy (A4555 and E0766)] – added new to coverage summary based from DME MAC LCD Tumor Treatment Field Therapy (TTFT) (L34823).

03/21/2017 Re-review with the following update:

11/15/2016 Annual review with the following updates:
Guideline 2 [Proton Beam Therapy (PBT)]
- Removed the following from the individual consideration (IC) diagnosis list:
  o Malignant lesions of the para nasal sinus, and other accessory sinuses 
  o Left breast tumors
- Added the following to the IC diagnosis list:
  o Unresectable malignant lesions of the liver, biliary tract, anal canal and rectum 
  o Skin cancer with macroscopic perineural/cranial nerve invasion of skull base 
  o Advanced stage, unresectable pelvic tumors including those with peri-aortic nodes or malignant lesions of the cervix 
  o Prostate Cancer, non-metastatic

Definitions:
Stereotactic Radiosurgery (SRS) - Replaced CMS reference from the LCD for Stereotactic Radiation Therapy: Stereotactic Radiosurgery (SRS) and Stereotactic Body Radiation Therapy (SBRT) (L34136) (Retired) to the LCD for Stereotactic Radiation Therapy: Stereotactic Radiosurgery (SRS) and Stereotactic Body Radiation Therapy (SBRT) (L34151).

Stereotactic Body Radiation Therapy (SBRT) - Replaced CMS reference from the LCD for Stereotactic Radiation Therapy: Stereotactic Radiosurgery (SRS) and Stereotactic Body Radiation Therapy (SBRT) (L34136) (Retired) to the LCD for Stereotactic Radiation Therapy: Stereotactic Radiosurgery (SRS) and Stereotactic Body Radiation Therapy (SBRT) (L34151).

08/16/2016 Guideline 7 (Stereotactic Computer Assisted Volumetric and/or Navigational Procedure)
- Added the CPT codes 20985 and 0398T to the section title
- Changed default policy for states with no LCDs from the retired Noridian LCD for Stereotactic Computer Assisted Volumetric &/or Navigational Procedure (L35133) to the UnitedHealthcare Medical Policy for Omnibus Codes.


Guidelines, 20th edition updates will not be implemented until April 1, 2016)


Guideline 7 (Stereotactic Computer Assisted Volumetric and/or Navigational Procedure)
- Added guideline with default for states with no LCDs to the Noridian LCD for Stereotactic Computer Assisted Volumetric &/or Navigational Procedure (L35133) (new to the policy)
- Updated reference link(s) of the applicable LCDs to reflect the new condensed LCD link(s).

11/17/2015 Annual review, no updates.

10/01/2015 Updated reference link(s) to the applicable Medicare Administrative Contractor (MAC) LCDs to reflect the new/condensed LCD ID numbering effective October 1, 2015.

03/24/2015 Updated Guideline 5 [Stereotactic Radiosurgery (SRS)/Stereotactic Body Radiation Therapy (SBRT)] - Changed default guideline for states with no LCDs from Noridian LCD for Stereotactic Radiation Therapy: Stereotactic Radiosurgery (SRS) and Stereotactic Body Radiation Therapy (SBRT) (L32234) to MCG™ Care Guidelines, 19th edition, 2015, for Stereotactic Radiosurgery ACG: A-0423 (AC) and Stereotactic Body Radiotherapy ACG: A-0694 (AC) for coverage guidelines or information regarding medical necessity.

01/20/2015 Annual review with the following updates:

Guideline 1 [Percutaneous Transluminal Coronary Interventions (Interventional Cardiology)]
- Changed default guideline for states with no LCDs from National Government Services LCD for Percutaneous Coronary Intervention (L28395) to Wisconsin Physicians LCD for Percutaneous Coronary Interventions (L34139).
- Added language to indicate:
  - Coverage guidelines of the available LCDs align; there is uniformity.
  - There is no applicable UnitedHealthcare Medical Policy available at the time.

Guideline 2 [Proton Beam Therapy (PBT)]
- Changed default guideline for states with no LCDs from First Coast LCD for Proton Beam Therapy (L29263) to UnitedHealthcare Medical Policy titled Proton Beam Radiation Therapy with individual consideration for the following diagnoses:
  - Malignant lesions of the head and neck when the intent of treatment is to be curative
  - Malignant lesions of the para nasal sinus, and other accessory sinuses
  - Left breast tumors
  - Pancreatic and adrenal tumors
  - Unresectable retroperitoneal sarcoma and extremity sarcoma
  - Cancers of the lung and upper abdominal/peri-diaphragmatic cancers
- Added language to indicate:
  Coverage guidelines of the available LCD do not align; there is no uniformity. The UnitedHealthcare Medical Policy guidelines do not align with the available LCDs.

Guideline 3 [Intensity Modulated Radiation Therapy (IMRT)]
- Added language to indicate:
  Coverage guidelines of the available LCDs do not align; there is no uniformity. The UnitedHealthcare Medical Policy guidelines do not align with the available LCDs.
Guideline 5 (Conventional, Conformal and 3D Conformal External Beam Radiation Therapy)
- Removed guideline; only available LCD, i.e., LCD for Radiation Oncology: External Beam/Teletherapy (L24354) was retired; there is no applicable UnitedHealthcare Medical Policy available at this time.

Guideline 6 [Stereotactic Radiosurgery (SRS)/Stereotactic Body Radiation Therapy (SBRT)]
- Changed default guideline for states with no LCDs from Palmetto LCD for Stereotactic Radiosurgery (SRS) (L28303) and Novitas LCD for Stereotactic Body Radiation Therapy (SBRT) (L30277) to Noridian LCD for Stereotactic Radiation Therapy: Stereotactic Radiosurgery (SRS) and Stereotactic Body Radiation Therapy (SBRT) (L32234).
- Added language to indicate:
  Indications for coverage within available LCDs vary. There is no applicable UnitedHealthcare Medical Policy available at the time.

03/11/2014  Guideline #3 (Intensity Modulated Radiation Therapy)
- Revised guidelines for states with no LCDs
- Replaced Wisconsin LCD for Radiation Oncology Including Intensity Modulated Radiation Therapy (IMRT) (L30316) to the UnitedHealthcare Medical Policy for Intensity-Modulated Radiation Therapy

08/20/2013  Annual review, no updates

12/17/2012  Guidelines #4 (Combined Use of Proton Beam Radiation Therapy and Intensity-Modulated Radiation Therapy ) added
- Annual review
- Updated Guidelines #4 Conventional, Conformal and 3D Conformal External Beam Radiation Therapy to state that currently there is only one Contractor with LCDs for this procedure with no change in coverage guidelines for states with no LCDs

08/20/2012  LCD Grids (Attachments A – E) were updated

06/30/2011  LCD Availability Grids (Attachments A, B and C) updated
- Annual review
- Guidelines #1 Percutaneous Transluminal Coronary Interventions was updated
- Also updated to include Guidelines #4 Conventional, Conformal and 3D External Beam Radiation Therapy

04/11/2011  LCD Availability Grids (Attachments A, B and C) updated

V. ATTACHMENT(S)

<table>
<thead>
<tr>
<th>Attachment A - LCD Availability Grid</th>
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<tr>
<td>Interventional Cardiology/Percutaneous Transluminal Coronary Interventions</td>
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<td>CMS website accessed July 17, 2019</td>
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<td>L33623</td>
<td>Percutaneous Coronary Intervention</td>
<td>A and B MAC</td>
<td>National Government Services, Inc.</td>
<td>IL, MN, WI, CT, NY, ME, MA, NH, RI, VT</td>
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<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>
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UHC MA Coverage Summary: Radiologic Therapeutic Procedures
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### Attachment A - LCD Availability Grid

**Interventional Cardiology/Percutaneous Transluminal Coronary Interventions**

CMS website accessed July 17, 2019

<table>
<thead>
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<th>LCD ID</th>
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<th>Contractor Type</th>
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<td>Wisconsin Physicians Service Insurance Corporation</td>
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End of Attachment A

### Attachment B - LCD Availability Grid

**Proton Beam Therapy/Proton Beam Radiotherapy**

CMS website accessed July 17, 2019

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End of Attachment B

### Attachment C - LCD Availability Grid

**Intensity Modulated Radiation Therapy (IMRT)**

CMS website accessed July 17, 2019

<table>
<thead>
<tr>
<th>LCD ID</th>
<th>LCD Title</th>
<th>Contractor Type</th>
<th>Contractor</th>
<th>States</th>
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<tr>
<td>L34080</td>
<td>Intensity Modulated Radiation Therapy (IMRT)</td>
<td>MAC Part B</td>
<td>Noridian Healthcare Solutions, LLC</td>
<td>AK, AZ, ID, OR, MT, ND, SD, UT, WA, WY</td>
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<td>L36773</td>
<td>Intensity Modulated Radiation Therapy (IMRT)</td>
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<td>L36711</td>
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<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 Availability Grid

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

CMS website accessed July 17, 2019

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<tr>
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<th>LCD Title</th>
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<td>National Government Services, Inc.</td>
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<td>A and B MAC</td>
<td>Noridian Healthcare Solutions, LLC</td>
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### Attachment D - LCD Availability Grid

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

<table>
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<td>Noridian Healthcare Solutions, LLC</td>
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End of Attachment D

### Attachment E - LCD Availability Grid

**Stereotactic Computer Assisted Volumetric and/or Navigational Procedure**

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<tr>
<td>L33777</td>
<td>Noncovered Services</td>
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<td>L36954</td>
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<td>Palmetto GBA</td>
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End of Attachment E

### Attachment F - LCD Availability Grid

**Tumor Treatment Field Therapy (A4555 and E0766)**

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<tr>
<td>L34823</td>
<td>Tumor Treatment Field Therapy (TTFT)</td>
<td>DME MAC</td>
<td>CGS Administrators, LLC</td>
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<td>IL, IN, KY, MI, MN, OH, WI</td>
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<td>CT, DC, DE, MA, MD, ME, NH, NJ, NY, PA, RI, VT</td>
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<td></td>
<td>Noridian Healthcare Solutions, LLC</td>
<td>AK, AS, AZ, CA, GU, HI, IA, ID, KS, MO, MP MT, ND, NE, NV, OR, SD, UT, WA, WY</td>
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End of Attachment F

### Attachment G - LCD Availability Grid

**Magnetic Resonance Image Guided High Intensity Focused Ultrasound (MRgFUS) (CPT Code 0398T)**

<table>
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<tr>
<th>LCD ID</th>
<th>LCD Title</th>
<th>Contractor Type</th>
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<tr>
<td>L33777</td>
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<td>L35094</td>
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<td>Novitas Solutions, Inc.</td>
<td>AR, CO, DC, DE, LA, MD, MS, NJ, NM, OK, PA, TX</td>
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<tr>
<td>L37761</td>
<td>Magnetic Resonance Image Guided High Intensity Focused Ultrasound (MRgFUS) for Essential Tremor</td>
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<td>L37421</td>
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<td>National Government Services</td>
<td>CT, IL, MN, NY, MA, ME, NH, RI, WI, VT</td>
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## Magnetic Resonance Image Guided High Intensity Focused Ultrasound (MRgFUS) (CPT Code 0398T)

### LCD Availability Grid

**CMS website accessed July 17, 2019**

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<th>LCD ID</th>
<th>LCD Title</th>
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<td>A and B MAC</td>
<td>CGS Administrators, LLC</td>
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<td>L35490</td>
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<td>Wisconsin Physicians Service Insurance Corporation</td>
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<td>L37738</td>
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<td>Noridian Healthcare Solutions, LLC</td>
<td>CT, DC, DE, MA, MD, ME, NH, NJ, NY, PA, RI, VT</td>
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<td>L37729</td>
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<td>A and B MAC</td>
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**End of Attachment G**