TUMOR TREATMENT FIELD THERAPY

Guideline Number: MPG330.05

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Overview
For any item to be covered by Medicare, it must 1) be eligible for a defined Medicare benefit category, 2) be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, and 3) meet all other applicable Medicare statutory and regulatory requirements. For the items addressed in this policy guideline, the criteria for "reasonable and necessary", based on Social Security Act § 1862(a)(1)(A) provisions, are defined by the following coverage indications, limitations and/or medical necessity.

Glioblastoma, also known as glioblastoma multiforme (GBM) is an aggressive type of brain cancer. It is rare, with an incidence of 3.21 cases per 100,000 population per year in the US.

Tumor Treatment Field Therapy (TTFT) uses alternating electric fields to target cancer cells. Alternating electric fields are produced by a pulse generator and transmitted by ceramic transducers placed on a patient’s head. The electric fields reportedly attract and repel charged proteins during cancer cell division. Cellular proteins, because they are highly polarized, are presumed to be prevented from moving to their correct locations thus disrupting cancer cell division.

Guidelines

Initial Coverage for Newly Diagnosed Glioblastoma Multiforme
Effective for DOS on or after 09/01/2019, Tumor treatment field therapy (E0766) is covered for the treatment of newly diagnosed Glioblastoma Multiforme (GBM) only when ALL of the following criteria are met:

- The member has histologically confirmed (World Health Organization (WHO) grade IV astrocytoma), newly diagnosed, supratentorial GBM; and,
- The member has received initial treatment with maximal debulking surgery (when feasible), followed by chemotherapy and radiotherapy; and,
- Tumor treatment field therapy is initiated within 7 weeks from the last dose of concomitant chemotherapy or radiotherapy, whichever is later; and,
- The member has no evidence of progression by Response Assessment in Neuro-Oncology (RANO) criteria; and,
- The member has a Karnofsky Performance Score (KPS) of at least 70; and,
- The member will use TTFT for an average of 18 hours per day.

If all of the coverage criteria above are not met, claims for code E0766 will be denied as not reasonable and necessary.

Continued Coverage for Newly Diagnosed GBM Beyond the First Three Months of Therapy
Continued coverage of TTFT (E0766) beyond the first three months of therapy requires that no sooner than the 60th day but no later than the 91st day after initiating therapy, the treating practitioner must conduct a clinical re-evaluation and document that the member is continuing to use and is benefiting from TTFT.
Documentation of clinical benefit is demonstrated by:
1. Face-to-face clinical re-evaluation by the treating practitioner; and,
2. Objective evidence of adherence to therapy, reviewed by the treating practitioner.

Adherence to therapy is defined as the use of TTFT for an average of 18 hours per day (excluding days the treating practitioner has documented a medical need to limit or interrupt treatment).

If the above criteria are not met, continued coverage of TTFT will be denied as not reasonable and necessary.

If the practitioner re-evaluation does not occur until after the 91st day but the evaluation demonstrates that the member is benefiting from TTFT as defined in criteria 1 and 2 above, continued coverage of TTFT will commence with the date of that re-evaluation.

**Recurrent GBM**
Tumor treatment field therapy (E0766) will be denied as not reasonable and necessary for the treatment of recurrent GBM.

**Other Uses**
The use of TTFT for any indications other than newly diagnosed GBM will be denied as not reasonable and necessary.

**Coding Guidelines**
Code E0766 describes devices that generate electromagnetic fields utilized in the treatment of cancer. The electromagnetic energy generated is transmitted to the body by means of surface electrodes or transducers. This code is inclusive of all associated supplies necessary for the effective use of code E0766 including, but not limited to, transducers/surface electrodes, lead wires, adhesive patches, connectors, conductive gel and skin preps.

Code A4555 is not valid for billing to Medicare. If code A4555 is billed, it will be denied as an invalid code.

**Documentation Requirements**
In order to justify payment for DMEPOS items, suppliers must meet the following requirements:
- Prescription (orders)
- Medical Record Information (including continued need/use if applicable)
- Correct Coding
- Proof of Delivery

Items billed before a signed and dated order has been received by the supplier must be submitted with an EY modifier added to each affected HCPCS code.

Devices coded E0766 are classified by the Food & Drug Administration as Class III devices; therefore, all claims for code E0766 must include the KF modifier.

**Initial Coverage (First Three Months)**
On claims for the first through third months, suppliers must add a KX modifier to code E0766 only if all of the criteria has been met.

**Continued Coverage Beyond the First Three Months of Therapy**
On the fourth month's claim (and any month thereafter), the supplier must add a KX modifier to code E0766 only if both the "Initial Coverage" criteria and the "Continued Coverage" criteria have been met.

If the supplier does not obtain information from the practitioner that the member has demonstrated benefit from the use of, and is adhering to, TTFT treatment in time for submission of the fourth or succeeding months’ claims, the supplier may still submit the claims, but a KX modifier must not be added.

If the supplier chooses to hold claims for the fourth and succeeding months pending receipt of information from the treating practitioner that the member received a clinical re-evaluation between the 60th and 91st day, had documented benefit from the use of, and is adhering to, TTFT treatment, those claims may then be submitted with the KX modifier.

If the supplier chooses to hold claims for the fourth and succeeding month pending receipt of information from the treating practitioner but learns that the member did not receive a clinical re-evaluation between the 60th and 91st day but rather was re-evaluated at a later date and had documented benefit from the use of, and is adhering to, TTFT treatment, those claims may then be submitted with the KX modifier but only for dates of service following the date of the clinical re-evaluation.
Documentation of adherence to TTFT shall be accomplished through direct download or visual inspection of usage data with documentation provided in a written report format to be reviewed by the treating practitioner and included in the member’s medical record. This information does not have to be submitted with the claim but must be available upon request.

If TTFT is interrupted for any reason, it is expected that the treating practitioner will document the reason for the interruption in therapy. This information does not have to be submitted with the claim but must be available upon request.

**APPLICABLE CODES**

The following list(s) of codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this guideline does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Description</th>
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<tr>
<td>A4555</td>
<td>Electrode/transducer for use with electrical stimulation device used for cancer treatment, replacement only <em>(Status Indicator 'I' (Invalid Code))</em></td>
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<tr>
<td>E0766</td>
<td>Electrical stimulation device used for cancer treatment, includes all accessories, any type</td>
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<table>
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<tr>
<th>Modifier</th>
<th>Description</th>
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<tr>
<td>EY</td>
<td>No physician or other licensed health care provider order for this item or service</td>
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<tr>
<td>GZ</td>
<td>Item or service expected to be denied as not reasonable and necessary</td>
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<tr>
<td>KF</td>
<td>Item designated by FDA as Class III device</td>
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<tr>
<td>KX</td>
<td>Requirements specified in the medical policy have been met</td>
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**DEFINITIONS**

**Karnofsky Performance Scale:**

100 - Normal; no complaints, no evidence of disease
90 - Able to carry on normal activity; minor signs or symptoms of disease
80 - Normal activity with effort; some signs or symptoms of disease
70 - Cares for self; unable to carry on normal activity or to do active work
60 - Requires occasional assistance but is able to care for most needs
50 - Requires considerable assistance and frequent medical care
40 - Disabled; requires special care and assistance
30 - Severely disabled; hospitalization is indicated although death not imminent
20 - Very sick; hospitalization necessary; active supportive treatment is necessary
10 - Moribund, fatal processes progressing rapidly
   0 - Dead

**PURPOSE**

The Medicare Advantage Policy Guideline documents are generally used to support UnitedHealthcare Medicare Advantage claims processing activities and facilitate providers’ submission of accurate claims for the specified services. The document can be used as a guide to help determine applicable:

- Medicare coding or billing requirements, and/or
- Medical necessity coverage guidelines; including documentation requirements.

UnitedHealthcare follows Medicare guidelines such as LCDs, NCDs, and other Medicare manuals for the purposes of determining coverage. It is expected providers retain or have access to appropriate documentation when requested to support coverage. Please utilize the links in the References section below to view the Medicare source materials used to develop this resource document. This document is not a replacement for the Medicare source materials that outline Medicare coverage requirements. Where there is a conflict between this document and Medicare source materials, the Medicare source materials will apply.
REFERENCES

CMS Local Coverage Determinations (LCDs)

<table>
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<tr>
<th>LCD</th>
<th>DME</th>
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<tr>
<td>L34823 (Tumor Treatment Field Therapy (TTFT)) Noridian</td>
<td>CGS: AL, AR, CO, FL, GA, IL, IN, KY, LA, MI, MN, MS, NC, NM, OH, OK, PR, SC, TN, TX, VA, VI, WI, WV Noridian: AK, AS, AZ, CA, CT, DC, DE, GU, HI, IA, ID, KS, MA, MD, ME, MO, MP, MT, ND, NE, NH, NJ, NV, NY, OR, PA, RI, SD, UT, VT, WA, WY</td>
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CMS Articles

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<th>Article</th>
<th>DME</th>
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<tr>
<td>A52711 (Tumor Treatment Field Therapy (TTFT)) Noridian</td>
<td>CGS: AL, AR, CO, FL, GA, IL, IN, KY, LA, MI, MN, MS, NC, NM, OH, OK, PR, SC, TN, TX, VA, VI, WI, WV Noridian: AK, AS, AZ, CA, CT, DC, DE, GU, HI, IA, ID, KS, MA, MD, ME, MO, MP, MT, ND, NE, NH, NJ, NV, NY, OR, PA, RI, SD, UT, VT, WA, WY</td>
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A55426 (Standard Documentation Requirements for All Claims Submitted to DME MACs) Noridian | CGS: AL, AR, CO, FL, GA, IL, IN, KY, LA, MI, MN, MS, NC, NM, OH, OK, PR, SC, TN, TX, VA, VI, WI, WV Noridian: AK, AS, AZ, CA, CT, DC, DE, GU, HI, IA, ID, KS, MA, MD, ME, MO, MP, MT, ND, NE, NH, NJ, NV, NY, OR, PA, RI, SD, UT, VT, WA, WY |

UnitedHealthcare Commercial Policies

Electric Tumor Treatment Field Therapy

GUIDELINE HISTORY/REVISION INFORMATION

Revisions to this summary document do not in any way modify the requirement that services be provided and documented in accordance with the Medicare guidelines in effect on the date of service in question.

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<th>Action/Description</th>
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| 08/14/2019 | • Annual review  
|            | • Revisions within the body of the policy based on updated CMS coverage |

TERMS AND CONDITIONS

The Medicare Advantage Policy Guidelines are applicable to UnitedHealthcare Medicare Advantage Plans offered by UnitedHealthcare and its affiliates.

These Policy Guidelines are provided for informational purposes, and do not constitute medical advice. Treating physicians and healthcare providers are solely responsible for determining what care to provide to their patients. Members should always consult their physician before making any decisions about medical care.

Benefit coverage for health services is determined by the member specific benefit plan document* and applicable laws that may require coverage for a specific service. The member specific benefit plan document identifies which services are covered, which are excluded, and which are subject to limitations. In the event of a conflict, the member specific benefit plan document supersedes the Medicare Advantage Policy Guidelines.

Medicare Advantage Policy Guidelines are developed as needed, are regularly reviewed and updated, and are subject to change. They represent a portion of the resources used to support UnitedHealthcare coverage decision making. UnitedHealthcare may modify these Policy Guidelines at any time by publishing a new version of the policy on this website. Medicare source materials used to develop these guidelines include, but are not limited to, CMS National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), Medicare Benefit Policy Manual, Medicare Claims Processing Manual, Medicare Program Integrity Manual, Medicare Managed Care Manual, etc. The information presented in the Medicare Advantage Policy Guidelines is believed to be accurate and current as of the date of publication, and is provided on an "AS IS" basis. Where there is a conflict between this document and Medicare source materials, the Medicare source materials will apply.

You are responsible for submission of accurate claims. Medicare Advantage Policy Guidelines are intended to ensure that coverage decisions are made accurately based on the code or codes that correctly describe the health care services provided. UnitedHealthcare Medicare Advantage Policy Guidelines use Current Procedural Terminology (CPT®),
Centers for Medicare and Medicaid Services (CMS), or other coding guidelines. References to CPT® or other sources are for definitional purposes only and do not imply any right to reimbursement or guarantee claims payment.

Medicare Advantage Policy Guidelines are the property of UnitedHealthcare. Unauthorized copying, use and distribution of this information are strictly prohibited.

*For more information on a specific member’s benefit coverage, please call the customer service number on the back of the member ID card or refer to the Administrative Guide.