


MEDICAL POLICY	Tumor Treatment Field Therapy for Glioblastoma (Medicare Only)
Effective Date: 8/1/2022  8/1/2022	Medical Policy Number: 171
	Medical Policy Committee Approved Date: 8/19; 5/2020; 7/2021; 7/2022
Medical Officer	Date

See Policy HCPCS CODE section below for any prior authorization requirements

SCOPE:

Providence Health Plan, Providence Health Assurance, Providence Plan Partners, and Ayin Health Solutions as applicable (referred to individually as “Company” and collectively as “Companies”).

APPLIES TO:

Medicare Only

MEDICARE POLICY CRITERIA

The following Centers for Medicare & Medicaid Service (CMS) guidelines should be utilized for medical necessity coverage determinations. Click the link provided in the table below to access applicable medical necessity criteria. All listed guidelines apply.

Service	Medicare Guidelines
<i>Tumor Treatment Field Therapy for Glioblastoma</i>	Local Coverage Determination (LCD): Tumor Treatment Field Therapy (TTFT) (L34823)

BILLING GUIDELINES

General

See associated local coverage articles (LCAs) for related billing and coding guidance:

- LCA: Tumor Treatment Field Therapy (TTFT) - Policy Article ([A52711](#))

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HCPCS CODES

Medicare Only	
Prior Authorization Required	
A4555	Electrode/transducer for use with electrical stimulation device used for cancer treatment, replacement only
E0766	Electrical stimulation device used for cancer treatment, includes all accessories, any type

INSTRUCTIONS FOR USE

Company Medical Policies serve as guidance for the administration of plan benefits. Medical policies do not constitute medical advice nor a guarantee of coverage. Company Medical Policies are reviewed annually and are based upon published, peer-reviewed scientific evidence and evidence-based clinical practice guidelines that are available as of the last policy update. The Companies reserve the right to determine the application of Medical Policies and make revisions to Medical Policies at any time. Providers will be given at least 60-days’ notice of policy changes that are restrictive in nature.

The scope and availability of all plan benefits are determined in accordance with the applicable coverage agreement. Any conflict or variance between the terms of the coverage agreement and Company Medical Policy will be resolved in favor of the coverage agreement.

REGULATORY STATUS

Mental Health Parity Statement

Coverage decisions are made on the basis of individualized determinations of medical necessity and the experimental or investigational character of the treatment in the individual case. In cases where medical necessity is not established by policy for specific treatment modalities, evidence not previously considered regarding the efficacy of the modality that is presented shall be given consideration to determine if the policy represents current standards of care.