MEDICAL POLICY	Proton Beam Radiation Therapy (Medicare Only)
Effective Date: 9/1/2022	Medical Policy Number: 340
 9/1/2022	Medical Policy Committee Approved Date: 7/2022
Medical Officer Date	

See Policy CPT/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
Proton Beam Radiation Therapy or Proton Beam Therapy (PBT) – Any Indication	Company medical policy for Proton Beam Radiation Therapy (All Lines of Business Except Medicare) I. This procedure may be considered **medically necessary** when Company medical policy criteria are met. II. This procedure is considered **not medically necessary** for Medicare Plan members either when Company medical policy criteria are not met ***or*** when a service is always deemed to be "investigational" by the Company medical policy. *"Investigational" services are considered not medically necessary for Medicare Plan members. See Policy Guidelines below.*

POLICY GUIDELINES

Medicare and Medical Necessity

The Company policy for *PHA Medicare Medical Policy Development and Application* (MP50) provides details regarding Medicare's definition of medical necessity and the hierarchy of Medicare references and resources during the development of medical policies, as well as the Plan's use of evidence-based processes for policy development. In the absence of Medicare coverage policies (e.g., manual, national coverage determination [NCD], local coverage determination [LCD], article [LCA], etc.), Medicare regulatory guidelines do allow Medicare Advantage Organizations (MAOs) to make their own coverage determinations, as long as the MAO applies an objective, evidence-based process, based on authoritative evidence. *(Medicare Managed Care Manual, Ch. 4, §90.5)*

Following an evidence-based assessment of current peer-reviewed medical literature, the Company may consider certain medical services or technologies to be "investigational." The term "investigational" is not limited to devices or technologies which have not received the appropriate governmental regulatory approval (e.g., U.S. Food and Drug Administration [FDA]), but rather may also mean the procedure, device, or technology does not meet all of the Company's technology assessment criteria, as detailed within the Company policy for *Definition: Experimental/Investigational* (MP5).

For Medicare, only medically reasonable and necessary services or items which treat illness or injury are eligible for Medicare coverage, as outlined in *Title XVIII of the Social Security Act, §1862(a)(1)(A)*. Thus, services which lack scientific evidence regarding safety and efficacy because they are investigational are "not medically reasonable or necessary" for Medicare Plan members. *(Medicare Claims Processing Manual, Ch. 23, §30 A)*

Previous Medicare Guidance

The local Medicare contractor (MAC) for the health plan – Noridian, Jurisdiction F – used to have an available local coverage determination (LCD), which was the LCD for *Radiation Oncology: External Beam/Teletherapy* (L24354); however, this LCD was retired May 15, 2014. This now-retired LCD can be found on the Medicare Coverage Database Archive Site.

BILLING GUIDELINES

CPT codes 77520, 77522, 77523, and 77525 may be medically necessary when billed with diagnosis code C61 (malignant neoplasm of prostate).

If proton beam radiation therapy (PBT) is deemed to be not covered per medical necessity criteria above, then services and codes associated with PBT will also be denied. The following are examples of codes that may be billed in addition to the specific PBT codes:

77014	77295	77321	77336	77427
77280	77300	77333	77370	77470
77290	77307	77334	77387	G6002

Like all S-codes, the *National Physician Fee Schedule Relative Value File (NPFSRVF)*, which is published by Medicare[1], indicates HCPCS code S8030 has been assigned a Status Indicator of "I." This is defined as "Not valid for Medicare purposes." HCPCS code S8030 is not covered unless allowed under a Medicare Advantage provider contract exception, as indicated in the relevant Company coding policy, *(Coding Policy 22.0 HCPCS S-Codes and H-Codes)*.

CPT/HCPCS CODES

Medicare Only	
Prior Authorization Required *Note: Prior authorization is **not** required for the following diagnosis code, C61 (malignant neoplasm of prostate).*	
77520	Proton treatment delivery; simple, without compensation
77522	Proton treatment delivery; simple, with compensation
77523	Proton treatment delivery; intermediate
77525	Proton treatment delivery; complex
Not Covered	
S8030	Scleral application of tantalum ring(s) for localization of lesions for proton beam

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.

REFERENCES

1. Medicare Physician Fee Schedule (PFS) Relative Value Files; Available at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files