


<b>MEDICAL POLICY</b>	<b>Tumor Treatment Field Therapy for Glioblastoma (Medicare Only)</b>
<b>Effective Date: 8/1/2021</b>   <div style="text-align: right;">8/1/2021</div>	Medical Policy Number: 171
	Medical Policy Committee Approved Date: 8/19; 5/2020; 7/2021
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>	<ul style="list-style-type: none"> <li>• Local Coverage Determination (LCD): Tumor Treatment Field Therapy (TTFT) (<a href="#">L34823</a>)<sup>1</sup></li> <li>• Local Coverage Article: Tumor Treatment Field Therapy (TTFT) - Policy Article (<a href="#">A52711</a>)<sup>2</sup></li> </ul>

**BILLING GUIDELINES**

Centers for Medicare & Medicaid Services Local Coverage Determination (LCD): Tumor Treatment Field Therapy (TTFT) ([A52711](#))<sup>2</sup>

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**HCPCS CODES**

<b>Medicare Only</b>	
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.

**REFERENCES**

- Centers for Medicare & Medicaid Services. Local Coverage Determination (LCD): Tumor Treatment Field Therapy (TTFT) (L34823). Effective 1/1/2020. <https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=34823>. Accessed 5/18/2021.
- Centers for Medicare & Medicaid Services. Local Coverage Article: Tumor Treatment Field Therapy (A52711). Effective 1/1/2020. <https://www.cms.gov/medicare-coverage-database/details/article-details.aspx?articleId=52711>. Accessed 5/18/2021.