Radiation and Oncologic Procedures

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Last Committee Approval Date: September 11, 2024
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➲ Instructions for Use

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Related Policies
None

Coverage Guidelines

Therapeutic radiologic procedures are covered when Medicare criteria are met.

Note: The guidelines in this Coverage Summary are for specific procedures only. For procedures not addressed in this Coverage Summary, refer to the Medicare Coverage Database to search for applicable coverage policies (National Coverage Determination, Local Coverage Determinations and Local Coverage Articles).
(Accessed August 22, 2024)

High-Dose Rate Electronic Brachytherapy (CPT Codes 0394T and 0395T)

Medicare does not have a National Coverage Determination (NCD) for high dose electronic brachytherapy. Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist and compliance with these policies is required where applicable. For specific LCDs/LCAs and applicable coverage guidelines, refer to the table for High Dose Electronic Brachytherapy.

For coverage guidelines for states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.

Note: After checking the High Dose Electronic Brachytherapy table and searching the Medicare Coverage Database, if no LCD/LCA is found, then use the policy referenced above for coverage guidelines.
(Accessed August 22, 2024)

Implantable Beta-Emitting Microspheres for Treatment of Malignant Tumors (CPT Codes 37243 and 79445)

Medicare does not have an NCD for implantable beta-emitting microspheres for treatment of malignant tumors. Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist.

For coverage guidelines, refer to the UnitedHealthcare Commercial Medical Policy titled Transarterial Radioembolization (TARE)/Selective Internal Radiation Therapy (SIRT) for the Treatment of Malignant Cancers of the Liver.

Note: After searching the Medicare Coverage Database, if no LCD/LCA is found, then use the policy referenced above for coverage guidelines.
(Accessed August 22, 2024)

Transarterial Chemoembolization (TACE) (CPT Code 37243)

Medicare does not have an NCD for transarterial chemoembolization (TACE). Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist.

For coverage guidelines, refer to the InterQual® CP: Procedures, Ablative or Transarterial Therapy, Liver.

Click here to view the InterQual® criteria.

Note: After searching the Medicare Coverage Database, if no LCD/LCA is found, then use the InterQual® criteria referenced above for coverage guidelines.
(Accessed August 22, 2024)

Image Guided Radiation Therapy (IGRT) (CPT Codes 77014, 77280, and 77387, and HCPCS Codes G6001, G6002, and G6017)

Medicare does not have an NCD for IGRT. Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist.

For coverage guidelines, refer to the UnitedHealthcare Commercial Medical Policy titled Radiation Therapy: Fractionation, Image-Guidance, and Special Services.

Note: After searching the Medicare Coverage Database, if no LCD/LCA is found, then use the policy referenced above for coverage guidelines.
(Accessed August 22, 2024)

Special/Associated Services (CPT Codes 77331, 77370, 77399, and 77470)

Medicare does not have an NCD for the above special/associated services. Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist.

For coverage guidelines, refer to the UnitedHealthcare Commercial Medical Policy titled Radiation Therapy: Fractionation, Image-Guidance, and Special Services.

Note: After searching the Medicare Coverage Database, if no LCD/LCA is found, then use the policy referenced above for coverage guidelines.
(Accessed August 22, 2024)

Standard Radiation Therapy (2D/3D) (CPT Codes 77401, 77402, 77407, and 77412, and HCPCS Codes G6003, G6004, G6005, G6006, G6007, G6008, G6009, G6010, G6011, G6012, G6013, and G6014)

Medicare does not have an NCD for the above standard radiation therapy (2D/3D). Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist.

For coverage guidelines, refer to the UnitedHealthcare Commercial Medical Policy titled Radiation Therapy: Fractionation, Image-Guidance, and Special Services.

Note: After searching the Medicare Coverage Database, if no LCD/LCA is found, then use the policy referenced above for coverage guidelines.
(Accessed August 22, 2024)

Proton Beam Therapy (PBT) (CPT Codes 77520, 77522, 77523, and 77525)

Medicare does not have an NCD for PBT. Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist and compliance with these policies is required where applicable. For specific LCDs/LCAs, refer to the table for Proton Beam Therapy/Proton Beam Radiotherapy.

For coverage guidelines for states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Policy titled Proton Beam Radiation Therapy.

Note: After checking the Proton Beam Therapy/Proton Beam Radiotherapy table and searching the Medicare Coverage Database, if no LCD/LCA is found, then use the policy referenced above for coverage guidelines.
(Accessed August 22, 2024)

Intensity Modulated Radiation Therapy (IMRT) (CPT Codes 77385 and 77386, and HCPCS Codes G6015 and G6016)

Medicare does not have an NCD for IMRT. Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist and compliance with these policies is required where applicable. For specific LCDs/LCAs, refer to the table for Intensity Modulated Radiation Therapy (IMRT).

For coverage guidelines for states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Policy titled Intensity-Modulated Radiation Therapy.

Note: After checking the Intensity Modulated Radiation Therapy (IMRT) table and searching the Medicare Coverage Database, if no LCD/LCA is found, then use the policy referenced above for coverage guidelines.
(Accessed August 22, 2024)

Combined Use of Proton Beam Therapy (PBT) and Intensity-Modulated Radiation Therapy (IMRT)

Medicare does not have an NCD for combined use of PBT and IMRT. Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist.

For coverage guidelines, refer to the UnitedHealthcare Commercial Medical Policy titled Proton Beam Radiation Therapy and Intensity-Modulated Radiation Therapy.

Note: After searching the Medicare Coverage Database, if no LCD/LCA is found, then use the policy referenced above for coverage guidelines.
(Accessed August 22, 2024)

Stereotactic Radiosurgery (SRS)/Stereotactic Body Radiation Therapy (SBRT) (CPT Codes 77371, 77372, and 77373, and HCPCS Codes G0339 and G0340)

Medicare does not have an NCD for SRS/SBRT. Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist and compliance with these policies is required where applicable. For specific LCDs/LCAs, refer to the table for Stereotactic Radiosurgery (SRS)/Stereotactic Body Radiation Therapy (SBRT).

For states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Policy titled Stereotactic Body Radiation Therapy and Stereotactic Radiosurgery.

Note: After checking the Stereotactic Radiosurgery (SRS)/Stereotactic Body Radiation Therapy (SBRT) table and searching the Medicare Coverage Database, if no LCD/LCA is found, then use the policy referenced above for coverage guidelines.
(Accessed August 22, 2024)

Tumor Treatment Field Therapy (TTFT) (HCPCS Codes A4555 and E0766)

Medicare does not have an NCD for TTFT. Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist for all states/territories and compliance with these policies is required where applicable.

For coverage guidelines, refer to the DME MAC LCD for Tumor Treatment Field Therapy (TTFT) (L34823). (Accessed August 22, 2024)

Intraoperative Radiation Treatment (IORT) (CPT Codes 77424, 77425, and 77469)

Medicare does not have an NCD for intraoperative radiation treatment (IORT). Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist and compliance with these policies is required where applicable. For specific LCDs/LCAs, refer to the table for Intraoperative Radiation Treatment (IORT).

For coverage guidelines for states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.

Note: After checking the Intraoperative Radiation Treatment (IORT) table and searching the Medicare Coverage Database, if no LCD/LCA is found, then use the policy referenced above for coverage guidelines. (Accessed August 22, 2024)

Transpupillary Thermotherapy (TTT) (CPT Codes 67299 and 92499)

Medicare does not have an NCD for transpupillary thermotherapy (TTT). Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist.

For coverage guidelines, refer to the UnitedHealthcare Commercial Medical Policy titled Transpupillary Thermotherapy.

Supporting Information

Proton Beam Therapy/Proton Beam Radiotherapy
Accessed August 22, 2024

LCD/LCA ID	LCD/LCA Title	Contractor Type	Contractor Name	Applicable States/Territories
L36658 (A55315)	Proton Beam Therapy	Part A and B MAC	CGS Administrators, LLC	KY, OH
L33937 (A57669)	Proton Beam Radiotherapy	Part A and B MAC	First Coast Service Options, Inc.	FL, PR, VI
L35075 (A56827)	Proton Beam Therapy	Part A and B MAC	National Government Services, Inc.	CT, IL, MA, ME, MN, NH, NY, RI, VT, WI

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Intensity Modulated Radiation Therapy (IMRT)
Accessed August 22, 2024

LCD/LCA ID	LCD/LCA Title	Contractor Type	Contractor Name	Applicable States/Territories
L36773 (A56746)	Intensity Modulated Radiation Therapy (IMRT)	Part A and B MAC	First Coast Service Options, Inc.	FL, PR, VI
L36711 (A56725)	Intensity Modulated Radiation Therapy (IMRT)	Part A and B MAC	Novitas Solutions, Inc.	AR, CO, DC, DE, LA, MD, MS, NJ, NM, OK, PA, TX
L39553 (A59350)	Radiation Therapies	Part A and B MAC	Palmetto GBA	AL, GA, NC, SC, TN, VA, WV

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Stereotactic Radiosurgery (SRS)/Stereotactic Body Radiation Therapy (SBRT) Accessed August 22, 2024				
LCD/LCA ID	**LCD/LCA Title**	**Contractor Type**	**Contractor Name**	**Applicable States/Territories**
L35076 (A56874)	Stereotactic Radiation Therapy: Stereotactic Radiosurgery (SRS) and Stereotactic Body Radiation Therapy (SBRT)	Part A and B MAC	National Government Services, Inc.	CT, IL, MA, ME, MN, NH, NY, RI, VT, WI
L39553 (A59350)	Radiation Therapies	Part A and B MAC	Palmetto GBA	AL, GA, NC, SC, TN, VA, WV
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High Dose Electronic Brachytherapy Accessed August 22, 2024				
LCD/LCA ID	**LCD/LCA Title**	**Contractor Type**	**Contractor Name**	**Applicable States/Territories**
L35490 (A56902)	Category III Codes	Part A and B MAC	Wisconsin Physicians Service Insurance Corporation*	IA, IN, KS, MI, MO, NE
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Intraoperative Radiation Treatment (IORT) Accessed August 22, 2024				
LCD/LCA ID	**LCD/LCA Title**	**Contractor Type**	**Contractor Name**	**Applicable States/Territories**
L37779 (A56684)	Intraoperative Radiation Therapy	Part A and B MAC	Palmetto GBA	AL, GA, NC, SC, TN, VA, WV
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MACs With Corresponding States/Territories	
MACs	**States/Territories**
CGS	KY, OH
First Coast	FL, PR, VI
NGS	CT, IL, ME, MA, MN, NH, NY, RI, VT, WI
Noridian	AK, AS, AZ, CA, GU, HI, ID, MT, NV, ND, Northern Mariana Islands, OR, SD, UT, WA, WY
Novitas	AR, CO, DC, DE, LA, MD, MS, NJ, NM, OK, PA, TX
Palmetto	AL, GA, NC, SC, TN, VA, WV
WPS*	IA, IN, KS, MI, MO, NE
*__Note__: Wisconsin Physicians Service Insurance Corporation Contract Number 05901 – applies only to WPS Legacy Mutual of Omaha MAC A Providers	

Policy History/Revision Information

Date	Summary of Changes

11/01/2024	**Coverage Guidelines**
	Transpupillary Thermotherapy (TTT) (CPT Codes 67299 and 92499)
	• Added language to indicate:
	  ○ Medicare does not have a National Coverage Determination (NCD) for transpupillary thermotherapy (TTT)
	  ○ Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist

Date	Summary of Changes
	○ For coverage guidelines, refer to the UnitedHealthcare Commercial Medical Policy titled *Transpupillary Thermotherapy* **Administrative** • Archived previous policy version MCS077.09

Instructions for Use

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. Physicians and patients must exercise their independent clinical discretion and judgment in determining care. 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.

UnitedHealthcare follows Medicare coverage guidelines found in statutes, regulations, NCDs, and LCDs to determine coverage. The clinical coverage criteria governing the items or services in this coverage summary have not been fully established in applicable Medicare guidelines because there is an absence of any applicable Medicare statutes, regulations, NCDs, or LCDs setting forth coverage criteria and/or the applicable NCDs or LCDs include flexibility that explicitly allows for coverage in circumstances beyond the specific indications that are listed in an NCD or LCD. As a result, UnitedHealthcare applies internal coverage criteria in the UnitedHealthcare commercial policies referenced in this coverage summary. The coverage criteria in these commercial policies was developed through an evaluation of the current relevant clinical evidence in acceptable clinical literature and/or widely used treatment guidelines. UnitedHealthcare evaluated the evidence to determine whether it was of sufficient quality to support a finding that the items or services discussed in the policy might, under certain circumstances, be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.