

## Tumor Treating Fields Therapy, Medical 166

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**Member-specific benefits take precedence over medical policy and benefits may vary across plans. Refer to the individual's benefit plan for details [\\*](#).**

### Purpose:

This policy addresses the medical necessity of Tumor Treating Fields Therapy.

### Description & Definitions:

**Tumor Treatment Field Therapy (TTFT)** is a device that generates electromagnetic fields transmitted through electrodes or transducers placed on the surface of the body.

### Criteria:

Tumor treating fields therapy is considered medically necessary for **All** of the following:

- Individual has histologically confirmed glioblastoma (grade IV astrocytoma) and **1 or more** of the following:
  - Individual has a confirmed recurrence in the supratentorial region of the brain after receiving chemotherapy
  - Individual has newly diagnosed disease in the supratentorial region of the brain following standard treatments that include surgery, chemotherapy, and radiation therapy.

Tumor Treatment Field Therapy (TTFT) is considered not medically necessary for any use other than those indicated in clinical criteria, to include but not limited to:

- malignant pleural mesothelioma (MPM)
- breast cancer
- lung cancer

Tumor treatment field therapy are considered **not medically necessary** for **any** of the following:

- the for the treatment of other malignant tumors (e.g., malignant pleural mesothelioma (MPM), breast, and lung, (not an all-inclusive list)
- treatment planning software (i.e., NovoTAL)
- other than those listed in the clinical indications for procedure section.

## Coding:

### Medically necessary with criteria:

Coding	Description
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

### Considered Not Medically Necessary:

Coding	Description
77299	Unlisted procedure, therapeutic radiology clinical treatment planning

*The preceding/following codes for treatments and procedures applicable to this policy are included above for informational purposes only. Inclusion or exclusion of a procedure, diagnosis or device code(s) does not constitute or imply member coverage or provider reimbursement policy. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage of these services as it applies to an individual member.*

## Document History:

### Revised Dates:

- 2025: January – Procedure coding updated to align with changes in service authorization status.
- 2024: February
- 2021: February
- 2020: January, March

### Reviewed Dates:

- 2023: February
- 2022: February
- 2018: March, November
- 2017: March
- 2016: July
- 2015: August
- 2014: August
- 2013: December

### Effective Date:

- August 2013

## References:

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### Special Notes: \*

Medical policies can be highly technical and complex and are provided here for informational purposes. These medical policies are intended for use by health care professionals. The medical policies do not constitute medical advice or medical care. Treating health care professionals are solely responsible for diagnosis, treatment, and medical advice. Sentara Health Plan members should discuss the information in the medical policies with their treating health care professionals. Medical technology is constantly evolving, and these medical policies are subject to change without notice, although Sentara Health Plan will notify providers as required in advance of changes that could have a negative impact on benefits.

Services mean both medical and behavioral health (mental health) services and supplies unless We specifically tell You otherwise. We do not cover any services that are not listed in the Covered Services section unless required to be covered under state or federal laws and regulations. We do not cover any services that are not Medically Necessary. We sometimes give examples of specific services that are not covered but that does not mean that other similar services are covered. Some services are covered only if We authorize them. When We say You or Your We mean You and any of Your family members covered under the Plan. Call Member Services if You have questions.

### Keywords:

SHP Tumor Treating Fields Therapy, Novocure, Optune, SHP Medical 166, glioblastoma, grade IV astrocytoma, supratentorial region, brain, glioblastoma multiforme, GBM