Sentara Health Plans

Medicaid

Tumor Treating Fields Therapy

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Effective Date	9/2013
Next Review Date	2/2025
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All requests for authorization for the services described by this medical policy will be reviewed per Early and Periodic Screening, Diagnostic and Treatment (EPSDT) guidelines. These services may be authorized under individual consideration for Medicaid members under the age of 21-years if the services are judged to be medically necessary to correct or ameliorate the member's condition. Department of Medical Assistance Services (DMAS), Supplement B - EPSDT (Early and Periodic Screening, Diagnosis and Treatment) Manual.*.

Purpose:

This policy addresses the medical necessity for Tumor Treatment Field Therapy (TTFT).

Description & Definitions:

Tumor Treatment Field Therapy (TTFT) is a device that generates an 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
A45555	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
	None

U.S. Food and Drug Administration (FDA) - approved only products only.

Document History:

Revised Dates:

- 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:

Including but not limited to: Specialty Association Guidelines; Government Regulations; Winifred S. Hayes, Inc; UpToDate; Literature Review; Specialty Advisors; National Coverage Determination (NCD); Local Coverage Determination (LCD).

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Special Notes: *

This medical policy express Sentara Health Plan's determination of medically necessity of services, and they are based upon a review of currently available clinical information. These policies are used when no specific guidelines for coverage are provided by the Department of Medical Assistance Services of Virginia (DMAS). Medical Policies may be superseded by state Medicaid Plan guidelines. Medical policies are not a substitute for clinical judgment or for any prior authorization requirements of the health plan. These policies are not an explanation of benefits.

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.

The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) covers services, products, or procedures for children, if those items are determined to be medically necessary to "correct or ameliorate" (make better) a defect, physical or mental illness, or condition (health problem) identified through routine medical screening or examination, regardless of whether coverage for the same service or support is an optional or limited service under the state plan. Children enrolled in the FAMIS Program are not eligible for all EPSDT treatment services. All requests for authorization for the services described by this medical policy will be reviewed per EPSDT guidelines. These services may be authorized under individual consideration for Medicaid members under the age of 21-years if the services are judged to by medically necessary to correct or ameliorate the member's condition. *Department of Medical Assistance Services (DMAS), Supplement B - EPSDT (Early and Periodic Screening, Diagnosis and Treatment) Manual.*

Keywords:

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