Radiation and Oncologic Procedures

Policy Number: MMP077.12
Last Committee Approval Date: February 12, 2025
Effective Date: April 1, 2025

➲ Instructions for Use

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Coverage Rationale

High-Dose Rate Electronic Brachytherapy

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.

Implantable Beta-Emitting Microspheres for Treatment of Malignant Tumors

Medicare does not have an NCD for implantable beta-emitting microspheres for treatment of malignant tumors. LCDs/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.

Transarterial Chemoembolization (TACE)

Medicare does not have an NCD for transarterial chemoembolization (TACE). LCDs/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.

Image Guided Radiation Therapy (IGRT)

Medicare does not have an NCD for IGRT. LCDs/LCAs do not exist.

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

Special/Associated Services

Medicare does not have an NCD for the above special/associated services. LCDs/LCAs do not exist.

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

Standard Radiation Therapy (2D/3D)

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

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

Proton Beam Therapy (PBT)

Medicare does not have an NCD for PBT. LCDs/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.

Intensity Modulated Radiation Therapy (IMRT)

Medicare does not have an NCD for IMRT. LCDs/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.

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. LCDs/LCAs do not exist.

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

Stereotactic Radiosurgery (SRS)/Stereotactic Body Radiation Therapy (SBRT)

Medicare does not have an NCD for SRS/SBRT. LCDs/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.

Intraoperative Radiation Treatment (IORT)

Medicare does not have an NCD for intraoperative radiation treatment (IORT). LCDs/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.

Applicable Codes

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service; however, language may be included in the listing below to indicate if a code is non-covered. Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

CPT Code	Description
High-Dose Rate Electronic Brachytherapy	
0394T	High dose rate electronic brachytherapy, skin surface application, per fraction, includes basic dosimetry, when performed
0395T	High dose rate electronic brachytherapy, interstitial or intracavitary treatment, per fraction, includes basic dosimetry, when performed
Implantable Beta-Emitting Microspheres for Treatment of Malignant Tumors	
37243	Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for tumors, organ ischemia, or infarction
79445	Radiopharmaceutical therapy, by intra-arterial particulate administration
Transarterial Chemoembolization (TACE)	
37243	Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for tumors, organ ischemia, or infarction
Image Guided Radiation Therapy (IGRT)	
77014	Computed tomography guidance for placement of radiation therapy fields
77387	Guidance for localization of target volume for delivery of radiation treatment, includes intrafraction tracking, when performed
Special/Associated Services	
77331	Special dosimetry (e.g., TLD, microdosimetry) (specify), only when prescribed by the treating physician
77370	Special medical radiation physics consultation
77399	Unlisted procedure, medical radiation physics, dosimetry and treatment devices, and special services
77470	Special treatment procedure (e.g., total body irradiation, hemibody radiation, per oral or endocavitary irradiation)
Standard Radiation Therapy (2D/3D)	
77401	Radiation treatment delivery, superficial and/or ortho voltage, per day
77402	Radiation treatment delivery, => 1 MeV; simple
77407	Radiation treatment delivery, => 1 MeV; intermediate
77412	Radiation treatment delivery, => 1 MeV; complex
Proton Beam Therapy (PBT)	
77520	Proton treatment delivery; simple, without compensation
77522	Proton treatment delivery; simple, with compensation
77523	Proton treatment delivery; intermediate
77525	Proton treatment delivery; complex
Intensity Modulated Radiation Therapy (IMRT)	
77385	Intensity modulated radiation treatment delivery (IMRT), includes guidance and tracking, when performed; simple
77386	Intensity modulated radiation treatment delivery (IMRT), includes guidance and tracking, when performed; complex
Stereotactic Radiosurgery (SRS)/Stereotactic Body Radiation Therapy (SBRT)	
77371	Radiation treatment delivery, stereotactic radiosurgery (SRS), complete course of treatment of cranial lesion(s) consisting of 1 session; multi-source Cobalt 60 based
77372	Radiation treatment delivery, stereotactic radiosurgery (SRS), complete course of treatment of cranial lesion(s) consisting of 1 session; linear accelerator based
77373	Stereotactic body radiation therapy, treatment delivery, per fraction to 1 or more lesions, including image guidance, entire course not to exceed 5 fractions

CPT Code	Description
Intraoperative Radiation Treatment (IORT)	
77424	Intraoperative radiation treatment delivery, x-ray, single treatment session
77425	Intraoperative radiation treatment delivery, electrons, single treatment session
77469	Intraoperative radiation treatment management

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HCPCS Code	Description
Image Guided Radiation Therapy (IGRT)	
G6001	Ultrasonic guidance for placement of radiation therapy fields
G6002	Stereoscopic x-ray guidance for localization of target volume for the delivery of radiation therapy
G6017	Intra-fraction localization and tracking of target or patient motion during delivery of radiation therapy (e.g., 3D positional tracking, gating, 3D surface tracking), each fraction of treatment
Standard Radiation Therapy (2D/3D)	
G6003	Radiation treatment delivery, single treatment area, single port or parallel opposed ports, simple blocks or no blocks: up to 5 mev
G6004	Radiation treatment delivery, single treatment area, single port or parallel opposed ports, simple blocks or no blocks: 6-10 mev
G6005	Radiation treatment delivery, single treatment area, single port or parallel opposed ports, simple blocks or no blocks: 11-19 mev
G6006	Radiation treatment delivery, single treatment area, single port or parallel opposed ports, simple blocks or no blocks: 20 mev or greater
G6007	Radiation treatment delivery, two separate treatment areas, three or more ports on a single treatment area, use of multiple blocks: up to 5 mev
G6008	Radiation treatment delivery, two separate treatment areas, three or more ports on a single treatment area, use of multiple blocks: 6-10 mev
G6009	Radiation treatment delivery, two separate treatment areas, three or more ports on a single treatment area, use of multiple blocks: 11-19 mev
G6010	Radiation treatment delivery, two separate treatment areas, three or more ports on a single treatment area, use of multiple blocks: 20 mev or greater
G6011	Radiation treatment delivery, three or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, electron beam; up to 5 mev
G6012	Radiation treatment delivery, three or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, electron beam; 6-10 mev
G6013	Radiation treatment delivery, three or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, electron beam; 11-19 mev
G6014	Radiation treatment delivery, three or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, electron beam; 20 mev or greater
Intensity Modulated Radiation Therapy (IMRT)	
G6015	Intensity modulated treatment delivery, single or multiple fields/arcs, via narrow spatially and temporally modulated beams, binary, dynamic MLC, per treatment session
G6016	Compensator-based beam modulation treatment delivery of inverse planned treatment using three or more high resolution (milled or cast) compensator, convergent beam modulated fields, per treatment session
Stereotactic Radiosurgery (SRS)/Stereotactic Body Radiation Therapy (SBRT)	
G0339	Image guided robotic linear accelerator-based stereotactic radiosurgery, complete course of therapy in one session or first session of fractionated treatment
G0340	Image guided robotic linear accelerator-based stereotactic radiosurgery, delivery including collimator changes and custom plugging, fractionated treatment, all lesions, per session, second through fifth sessions, maximum five sessions per course of treatment

Centers for Medicare and Medicaid Services (CMS) Related Documents

After checking the table below and searching the Medicare Coverage Database, if no NCD, LCD, or LCA is found, refer to the criteria as noted in the Coverage Rationale section above.

NCD	LCD	LCA	Contractor Type	Contractor Name
High-Dose Rate Electronic Brachytherapy				
N/A	L35490 Category III Codes	A56902 Billing and Coding: Category III Codes	Part A and B MAC	WPS*
Proton Beam Therapy (PBT)				
N/A	L36658 Proton Beam Therapy	A55315 Billing and Coding: Proton Beam Therapy	Part A and B MAC	CGS
	L33937 Proton Beam Radiotherapy	A57669 Billing and Coding: Proton Beam Radiotherapy	Part A and B MAC	First Coast
	L35075 Proton Beam Therapy	A56827 Billing and Coding: Proton Beam Therapy	Part A and B MAC	NGS
Intensity Modulated Radiation Therapy (IMRT)				
N/A	L36773 Intensity Modulated Radiation Therapy (IMRT) **Retired 12/19/2024**	A56746 Billing and Coding: Intensity Modulated Radiation Therapy (IMRT) **Retired 12/19/2024**	Part A and B MAC	First Coast
	L36711 Intensity Modulated Radiation Therapy (IMRT) **Retired 12/19/2024**	A56725 Billing and Coding: Intensity Modulated Radiation Therapy (IMRT) **Retired 12/19/2024**	Part A and B MAC	Novitas**
	L39553 Radiation Therapies	A59350 Billing and Coding: Radiation Therapies	Part A and B MAC	Palmetto**
Stereotactic Radiosurgery (SRS)/Stereotactic Body Radiation Therapy (SBRT)				
N/A	L35076 Stereotactic Radiation Therapy: Stereotactic Radiosurgery (SRS) and Stereotactic Body Radiation Therapy (SBRT)	A56874 Billing and Coding: Stereotactic Radiation Therapy: Stereotactic Radiosurgery (SRS) and Stereotactic Body Radiation Therapy (SBRT)	Part A and B MAC	NGS
	L39553 Radiation Therapies	A59350 Billing and Coding: Radiation Therapies	Part A and B MAC	Palmetto**
Intraoperative Radiation Treatment (IORT)				
N/A	L37779 Intraoperative Radiation Therapy	A56684 Billing and Coding: Intraoperative Radiation Therapy	Part A and B MAC	Palmetto**

Medicare Administrative Contractor (MAC) With Corresponding States/Territories	
MAC Name (Abbreviation)	**States/Territories**
CGS Administrators, LLC (CGS)	KY, OH
First Coast Service Options, Inc. (First Coast)	FL, PR, VI

Medicare Administrative Contractor (MAC) With Corresponding States/Territories	
MAC Name (Abbreviation)	**States/Territories**
National Government Services, Inc. (NGS)	CT, IL, ME, MA, MN, NH, NY, RI, VT, WI
Noridian Healthcare Solutions, LLC (Noridian)	AS, AK, AZ, CA, GU, HI, ID, MT, NV, ND, Northern Mariana Islands, OR, SD, UT, WA, WY
Novitas Solutions, Inc. (Novitas)	AR, CO, DC, DE, LA, MD, MS, NJ, NM, OK, PA, TX, VA**
Palmetto GBA (Palmetto)	AL, GA, NC, SC, TN, VA**, WV
Wisconsin Physicians Service Insurance Corporation (WPS)*	IA, IN, KS, MI, MO, NE
Notes	
*Wisconsin Physicians Service Insurance Corporation: Contract Number 05901 applies only to WPS Legacy Mutual of Omaha MAC A Providers. **For the state of Virginia: Part B services for the city of Alexandria and the counties of Arlington and Fairfax are excluded for the Palmetto GBA jurisdiction and included within the Novitas Solutions, Inc. jurisdiction.	

Policy History/Revision Information

Date	Summary of Changes
04/01/2025	**Related Policies** • Removed reference link to the UnitedHealthcare Commercial Medical Policy titled *Transpupillary Thermotherapy* **Coverage Rationale** • Removed content/language addressing transpupillary thermotherapy (TTT) **Applicable Codes** • Removed list of applicable CPT codes: 67299 and 92499 **Supporting Information** • Archived previous policy version MMP077.11

Instructions for Use

The Medicare Advantage Policy documents are generally used to support UnitedHealthcare coverage decisions. It is expected providers retain or have access to appropriate documentation when requested to support coverage. This document may be used as a guide to help determine applicable:

- Medical necessity coverage guidelines; including documentation requirements, and/or
- Medicare coding or billing requirements.

Medicare Advantage Policies are applicable to UnitedHealthcare Medicare Advantage Plans offered by UnitedHealthcare and its affiliates. This Policy is provided for informational purposes and does not constitute medical advice. It is intended to serve only as a general reference 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. Treating physicians and healthcare providers are solely responsible for determining what care to provide to their patients. Members should always consult their physician before making any decisions about medical care.

Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The member specific benefit plan document identifies which services are covered, which are excluded, and which are subject to limitations. In the event of a conflict, the member specific benefit plan document supersedes this policy. For more information on a specific member's benefit coverage, please call the customer service number on the back of the member ID card or refer to the Administrative Guide.

Medicare Advantage Policies are developed as needed, are regularly reviewed, and updated, and are subject to change. They represent a portion of the resources used to support UnitedHealthcare coverage decision making. UnitedHealthcare may modify these Policies at any time by publishing a new version on this website. Medicare source materials used to develop these policies may include, but are not limited to, CMS statutes, regulations, National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), and manuals. This document is not a replacement for the Medicare

source materials that outline Medicare coverage requirements. The information presented in this Policy is believed to be accurate and current as of the date of publication. Where there is a conflict between this document and Medicare source materials, the Medicare source materials apply. Medicare Advantage Policies are the property of UnitedHealthcare. Unauthorized copying, use, and distribution of this information are strictly prohibited.

UnitedHealthcare follows Medicare coverage guidelines found in statutes, regulations, NCDs, and LCDs to determine coverage. The clinical coverage criteria governing certain items or services referenced in this Medical Policy 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, in these circumstances, UnitedHealthcare applies internal coverage criteria as referenced in this Medical Policy. The internal coverage criteria in this Medical Policy 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.

Providers are responsible for submission of accurate claims. Medicare Advantage Policies are intended to ensure that coverage decisions are made accurately. UnitedHealthcare Medicare Advantage Policies use Current Procedural Terminology (CPT®), Centers for Medicare and Medicaid Services (CMS), or other coding guidelines. References to CPT® or other sources are for definitional purposes only and do not imply any right to reimbursement or guarantee claims payment.

For members in UnitedHealthcare Medicare Advantage plans where a delegate manages utilization management and prior authorization requirements, the delegate's requirements need to be followed.