Medical Necessity Guidelines: Proton Beam Therapy (PBT)

Effective: December 13, 2017


Applies to:
☒ Tufts Health Plan Commercial Plans products; Fax: 617.972.9409
☒ Tufts Health Public Plans products
☐ Tufts Health Direct — Health Connector; Fax: 888.415.9055
☒ Tufts Health Together — A MassHealth Plan; Fax: 888.415.9055
☒ Tufts Health Unify — OneCare Plan; Fax: 781.393.2607
☒ Tufts Health RITogether — A Rhode Island Medicaid Plan; Fax: 857.304.6404
☐ Tufts Health Freedom Plan products; Fax: 617.972.9409

Note: While you may not be the provider responsible for obtaining prior authorization, as a condition of payment you will need to make sure that prior authorization has been obtained.

OVERVIEW
Proton beam therapy (PBT) uses a beam of protons that are targeted in a precise manner to irradiate specific diseased tissue while minimizing exposure to surrounding areas.

COVERAGE GUIDELINES
Tufts Health Plan considers proton beam therapy covered as medically necessary for the following indications:
- Melanoma of the uveal tract (iris, choroid, or ciliary body) with no evidence of metastasis or extra-scleral extension
- Skull based tumors (e.g., chordomas and chondrosarcomas)
- Medulloblastoma
- Brain and spinal cord tumors

LIMITATIONS
Tufts Health Plan considers proton beam therapy coverage excluded as not the least intensive, most cost-effective service that can safely and effectively be applied for the following indications:
- Prostate cancer
- Intracranial arteriovenous malformations (AVM)
- Acoustic neuroma
- Hepatocellular carcinoma
- Lung cancer

Tufts Health Plan considers proton beam therapy non-covered, investigational for the following indications:
- Age-related macular degeneration
- Bladder cancer
- Breast cancer
- Choroidal hemangioma
- Gastrointestinal cancers, including esophageal and pancreatic
- Gynecological cancers
- Head and neck cancers
- Lymphomas

Note: Tufts Health Plan considers proton beam therapy in combination with intensity-modulated radiation therapy (IMRT) to be noncovered, investigational for any diagnosis.

CODES
The following CPT codes require prior authorization:

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<th>Code</th>
<th>Description</th>
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<tr>
<td>Code</td>
<td>Description</td>
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<td>--------</td>
<td>----------------------------------------------------</td>
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<td>77520</td>
<td>Proton treatment delivery; simple, without compensation</td>
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<tr>
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<tr>
<td>77525</td>
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**REFERENCES**


**APPROVAL HISTORY**

October 8, 2014: Reviewed by the Integrated Medical Policy Advisory Committee (IMPAC). For providers notified November 1, 2014, the effective date will be January 1, 2015.

Subsequent endorsement date(s) and changes:
- November 19, 2014: Reviewed by IMPAC. For Tufts Health Plan Network providers notified February 1, 2015, the effective date will be April 1, 2015.
- July 23, 2015: Reviewed by IMPAC, renewed without changes.
- September 2015: Branding and template change to distinguish Tufts Health Plan products in "Applies to" section. Added Tufts Health Freedom Plan products, effective January 1, 2016.
- July 20, 2016: Reviewed by IMPAC, renewed without changes.
- September 9, 2016: Reviewed by IMPAC, renewed without changes.
- April 2017: Added RITogether Plan product to template. For MNGs applicable to RITogether, effective date is August 1, 2017.
- July 20, 2017: Reviewed by IMPAC, renewed without changes.
- December 13, 2017: Reviewed by IMPAC, renewed without changes.

**Background, Product and Disclaimer Information**

Medical Necessity Guidelines are developed to determine coverage for benefits, and are published to provide a better understanding of the basis upon which coverage decisions are made. We make coverage decisions using these guidelines, along with the Member's benefit document, and in coordination with the Member's physician(s) on a case-by-case basis considering the individual Member's health care needs.

Medical Necessity Guidelines are developed for selected therapeutic or diagnostic services found to be safe and proven effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in our service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. We revise and update Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

Medical Necessity Guidelines apply to the fully insured Commercial and Medicaid products when Tufts Health Plan conducts utilization review unless otherwise noted in this guideline or in the Member's benefit document, and may apply to Tufts Health Unify to the same extent as Tufts Health Together. This guideline does not apply to Tufts Medicare Preferred HMO, Tufts Health Plan Senior Care Options or to certain delegated service arrangements. For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Medical Necessity Guideline and a self-insured Member's benefit document, the provisions of the benefit document will govern. Applicable state or federal mandates or other requirements will take precedence. For CareLink℠ Members, Cigna conducts utilization review so Cigna’s medical necessity guidelines, rather than these guidelines, will apply.
Treating providers are solely responsible for the medical advice and treatment of Members. The use of these guidelines is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to eligibility and benefits on the date of service, coordination of benefits, referral/authorization, utilization management guidelines when applicable, and adherence to plan policies, plan procedures, and claims editing logic.