Medical Necessity Guidelines: Proton Beam Therapy (PBT)

Effective: October 21, 2020

Prior Authorization Required If REQUIRED, submit supporting clinical documentation pertinent to service request.	**Yes ☒ No ☐**

Applies to:

COMMERCIAL Products

☒ Tufts Health Plan Commercial products; Fax: 617.972.9409

☒ Tufts Health Freedom Plan products; Fax: 617.972.9409

- CareLink℠ – Refer to CareLink Procedures, Services and Items Requiring Prior Authorization

TUFTS HEALTH PUBLIC PLANS Products

☒ Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product); Fax:888.415.9055

☒ Tufts Health Together – MassHealth MCO Plan and Accountable Care Partnership Plans; Fax: 888.415.9055

☒ Tufts Health RITogether – A Rhode Island Medicaid Plan; Fax: 857.304.6404

☒ Tufts Health Unify* – OneCare Plan (a dual-eligible product); Fax: 857.304.6304

*The MNG applies to Tufts Health Unify members unless a less restrictive LCD or NCD exists.

SENIOR Products

- Tufts Health Plan Senior Care Options (SCO), (a dual-eligible product) – Refer to the Tufts Health Plan SCO Prior Authorization List
- Tufts Medicare Preferred HMO, (a Medicare Advantage product) – Refer to the Tufts Medicare Preferred HMO Prior Authorization and Inpatient Notification List

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.

CLINICAL COVERAGE CRITERIA

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:

Code	Description
77520	Proton treatment delivery; simple, without compensation
77522	Proton treatment delivery; simple, with compensation
77523	Proton treatment delivery; intermediate
77525	Proton treatment delivery; complex

REFERENCES

1. Hayes, Inc. Directory. Proton beam therapy for prostate cancer. October 28, 2006. ©Winifred S. Hayes, Inc. Last Annual Review September 10, 2010.
2. Hayes, Inc. Directory. Proton beam therapy for ocular tumors, hemangiomas, and macular degeneration. July 16, 2004. Last Annual Review June 12, 2009.
3. Hayes, Inc. Search & Summary. Proton beam therapy for oligodendroglioma. August 10, 2011.
4. Hayes, Inc. Directory. Proton beam therapy for thoracic and abdominal organs. October 24, 2006. Last Annual Review September 10, 2010.
5. Hayes, Inc. Search & Summary. Proton beam therapy for treatment of tonsillar cancer. July 7, 2016.
6. Institute for Clinical and Economic Review. Technology Assessment. Proton beam therapy. March 2014. icer-review.org/wp-content/uploads/2014/07/pbt_final_report_040114.pdf. Accessed October 3, 2014. Last accessed July 20, 2016.
7. Hayes, Inc. Directory. Proton Beam Therapy for Prostate Cancer. June 9, 2016.

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.
- November 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
- October 10, 2018: Reviewed by IMPAC, renewed without changes
- October, 2018: Template and disclaimer updated
- October 16, 2019: Reviewed by IMPAC, renewed without changes
- October 21, 2020: Reviewed by IMPAC, renewed without changes
- November 9, 2020: Fax number for Unify updated

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.

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.

Treating providers are solely responsible for the medical advice and treatment of Members. The use of this guideline 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.