Priority Health	BILLING POLICY No. 174
Tumor Treatment Field Therapy (TTFT) Billing Policy	
Date of origin: December 2025	**Review dates: 2/2026**

DEFINITION

This policy outlines billing and payment requirements associated with Tumor Treatment Field Therapy (TTFT).

Tumor Treatment Field Therapy (TTFT)- Tumor Treatment Field Therapy is a type of non-invasive cancer treatment that uses low-intensity electric fields to disrupt cancer cell division and growth.

Glioblastoma (GBM)- Also known as glioblastoma multiforme (GBM) is an aggressive form of brain cancer. It is rare, with an incidence of 3.21 cases per 100,000 population per year in the US.

Tumor Treatment Field Therapy (TTFT)- Tumor Treatment Field Therapy is a type of non-invasive cancer treatment that uses alternating electric fields to target cancer cell division and growth. Alternating electric fields are produced by a pulse generator and transmitted by ceramic transducers placed on a patient's head.

MEDICAL POLICY

- Stimulation Therapy And Devices Medical Policy No. 91468-R29

FOR MEDICARE

For indications that don't meet criteria of NCD, local LCD or specific medical policy a Pre-Service Organization Determination (PSOD) will need to be completed. Get more information on PSOD in our Provider Manual.

POLICY SPECIFIC INFORMATION

Documentation requirements

Complete and thorough documentation to substantiate the procedure performed is the responsibility of the Provider. In addition, the Provider should consult any specific documentation requirements that are necessary for any applicable defined guidelines.

Tumor treatment field therapy (E0766) is covered for the treatment of newly diagnosed Glioblastoma Multiforme (GBM) only when all the following criteria are met:

1. The member has histologically confirmed (World Health Organization (WHO) grade IV astrocytoma), newly diagnosed, supratentorial GBM; and,
2. The member has received initial treatment with maximal debulking surgery (when feasible), followed by chemotherapy and radiotherapy; and,
3. Tumor treatment field therapy is initiated within 7 weeks from the last dose of concomitant chemotherapy or radiotherapy, whichever is later; and,

4. The member has no evidence of progression by Response Assessment in Neuro-Oncology (RANO) criteria; and,
5. The member has a Karnofsky Performance Score (KPS) of at least 70; and,
6. The member will use TTFT for an average of 18 hours per day.

If all requirements above are not met, code E0766 will be denied.

CONTINUED PAYMENT FOR NEWLY DIAGNOSED GBM BEYOND THE FIRST THREE MONTHS OF THERAPY:

Continued payment of TTFT (E0766) beyond the first three months of therapy requires that no sooner than the 60th day but no later than the 91st day after initiating therapy, the treating practitioner must conduct a clinical re-evaluation and document that the member is continuing to use and is benefiting from TTFT.

Supporting documentation of clinical benefit is shown by:

1. In-person clinical re-evaluation by the treating practitioner; and,
2. Objective evidence of adherence to therapy, reviewed by the treating practitioner.

Adherence to therapy is defined as the use of TTFT for an average of 18 hours per day (excluding days the treating practitioner has documented a medical need to limit or interrupt treatment).

If the above requirements are not met, continued coverage of TTFT will be denied.

If the provider re-evaluation does not happen until after the 91st day, but the evaluation shows that the member is benefiting from TTFT as defined in criteria 1 and 2 above, continued coverage of TTFT will begin with the date of that re-evaluation. See Policy Specific Documentation Requirements in the LCD-related Policy Article, located in the Related Local Coverage Documents section of this LCD, for information about KX modifier use.

RECURRENT GBM

Tumor treatment field therapy (E0766) will be denied as not payable for the treatment of recurrent GBM.

OTHER USES

The use of Tumor Treatment Field Therapy for any indications other than newly diagnosed GBM will be denied.

Coding specifics

Code	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

Modifiers

Priority Health follows standard billing and coding guidelines which include CMS NCCI. Modifiers should be applied when applicable based on this guidance and only when supported by documentation.

- **EY** - No physician or other licensed health care provider order for this item or service
- **GA** - Waiver of liability statement issued as required by payer policy, individual case
- **GZ** - Item or service expected to be denied as not reasonable and necessary
- **KF** - Item designated by FDA as Class III device
- **KX** - Requirements specified in the medical policy have been met

Resources

- Tumor Treatment Field Therapy (TTFT) Policy Article A52711
- Tmor Treatment Field Therapy (TTFT) LCD L34823

DISCLAIMER

CMS and/or MDHHS guidelines apply unless otherwise specified in this policy or provider manual. Where such guidance is absent, this policy applies. Priority Health's billing policies outline our guidelines to assist providers in accurate claim submissions and define reimbursement or coding requirements if the service is covered by a Priority Health member's benefit plan. The determination of visits, procedures, DME, supplies and other services or items for coverage under a member's benefit plan or authorization isn't being determined for reimbursement. Authorization requirements and medical necessity requirements appropriate to procedure, diagnosis and frequency are still required. We use Current Procedural Terminology (CPT), Centers for Medicare and Medicaid Services (CMS), Michigan Department of Health and Human Services (MDHHS) and other defined medical coding guidelines for coding accuracy.

An authorization isn't a guarantee of payment when proper billing and coding requirements or adherence to our policies aren't followed. Proper billing and submission guidelines must be followed. We require industry standard, compliant codes defined by CPT, HCPCS and revenue codes for all claim submissions. CPT, HCPCPS, revenue codes, etc., can be reported only when the service has been performed and fully documented in the medical record to the highest level of specificity. Failure to document for services rendered or items supplied will result in a denial. To validate billing and coding accuracy, payment integrity pre- or post-claim reviews may be performed to prevent fraud, waste and abuse. Unless otherwise detailed in the policy, our billing policies apply to both participating and non-participating providers and facilities.

If guidelines detailed in government program regulations, defined in policies and contractual requirements aren't followed, Priority Health may:

- Reject or deny the claim
- Recover or recoup claim payment

An authorization on file for an item or services doesn't supersede coding, billing or reimbursement requirements.

These policies may be superseded by mandates defined in provider contracts or state, federal or CMS contracts or requirements. We make every effort to update our policies in a timely manner to align to these requirements or contracts. If there's a delay in implementation of a policy or requirement defined by state or federal law, as well as contract language, we reserve the right to recoup and/or recover claim payments to the effective dates per our policy. We reserve the right to update policies when necessary. Our most current policy will be made available in our Provider Manual.

CHANGE / REVIEW HISTORY

Date	Revisions made
12/18/2025	Policy created
2/17/2026	Reviewed No Updates