healthfirst
Health Insurance for New Yorkers

Reimbursement Policy

Subject:	Tumor Treatment Field Therapy (TTFT)		
Policy Number:	PO-RE-161v1		
Effective Date:	12/1/2025	**Last Approval Date:**	1/15/2026

I. Policy Description

Tumor Treatment Field Therapy (TTFT) is a non-invasive cancer treatment using alternating electric fields to inhibit cancer cell division. The device (HCPCS code E0766) is primarily used in the treatment of newly diagnosed Glioblastoma Multiforme (GBM). This policy provides billing, reimbursement, and documentation guidelines for TTFT services rendered under Healthfirst plans, in accordance with NYS Medicaid and CMS regulatory standards.

The information below applies to the following lines of business:

- Medicaid Managed Care (MMC)
- Personal Wellness Plan (HARP)
- Medicaid Advantage Plus/MAP (CompleteCare)

Policy Scope

- This policy applies to Healthfirst members 22 years of age or older, diagnosed with Glioblastoma Multiforme (GBM), WHO grade IV astrocytoma**.**
- Tumor Treatment Field Therapy (TTFT) is billable under HCPCS code E0766, the reimbursement includes the device and all supplies for the duration of the therapy.
    - Replacement transducers are billed separately using HCPCS code A4555.

Reimbursement Guidelines

A. Authorization Requirements:

1. Initial authorization is required prior to initiation of Tumor Treatment Field Therapy (TTFT). Approval is for 3 months, contingent on the member meeting all clinical and eligibility criteria outlined in MP-173, including:
    - Age ≥ 22
    - Confirmed newly diagnosed GBM (WHO Grade IV)
    - Completed debulking surgery, chemotherapy, and radiotherapy

- Therapy initiated within 7 weeks of final chemo/radiation dose
- Karnofsky Performance Score ≥ 70
- No evidence of disease progression (per RANO)
- No implanted intracranial device
- TTFT prescribed for ≥18 hours/day average use
- Confirmation of non-pregnancy (if applicable)
- Providers must submit supporting documentation verifying each criterion at time of request. Authorization decisions will follow standard Utilization Management workflows and medical policy MP-173.

2. Reauthorization (Continued Coverage):

To request continued reimbursement beyond the initial 3 months:

- Providers must submit a reauthorization request between Day 60 and Day 91 of therapy start.
- Required documentation includes:
  - Clinical re-evaluation by treating provider
  - Evidence of continued clinical benefit
  - Documentation of therapy adherence (average of 18 hours/day use, excluding medically justified interruptions)

Failure to meet reauthorization requirements or to submit documentation in a timely manner may result in denial of further coverage.

Billing Requirements

1. Covered HCPCS and CPT Codes

Code	Description
E0766	Electrical stimulation device used for cancer treatment, includes all accessories
A4555	Electrode/transducer for use with electrical stimulation device, replacement only
77299	Unlisted procedure, therapeutic radiology clinical treatment planning

- These codes must be submitted with appropriate documentation and according to plan-specific authorization protocols.

Adjudication and Appeal Process

1. Reimbursement for TTFT services will be determined based on the provider's scope of services and the reimbursement rates outlined in the provider's contract with Healthfirst.

2. Claims submitted by providers that do not adhere to this policy will be denied or rejected. It is the responsibility of the provider to ensure claims are coded accurately.

3. This policy applies only to the line(s) of business (LOB) identified at the beginning of the policy and does not apply to other LOBs. For policies applicable to other lines of business, please visit www.hfproviders.org.

4. This policy is a provider resource for understanding Healthfirst's reimbursement guidelines. It does not guarantee coverage or payment. Final reimbursement decisions depend on benefit coverage, state/federal mandates, medical necessity, and provider contract.

5. Claims submissions will be subject to timely filing requirements, as set forth in the provider contract with Healthfirst and in the Healthfirst Provider Manual. *Refer to: Healthfirst Provider Manual Subsection 17.6, "Claims Inquiries, Corrected Claims, Claim Reconsideration, and Appeal Process" in this section.*

Note on Medicaid Advantage Plus/MAP (CompleteCare)

For members enrolled in Medicaid Advantage Plus/MAP (CompleteCare), a Healthfirst plan that integrates Medicare and Medicaid benefits with long-term care services, coverage for Tumor Treatment Field Therapy (TTFT) is contingent on meeting CMS clinical criteria as outlined in MP-173.

If a MAP-CompleteCare member does not meet CMS coverage criteria, Medicaid coverage will apply under the same clinical and documentation standards defined in this policy. Providers must ensure that documentation submitted clearly supports the applicable criteria (Medicare or Medicaid) based on the member's eligibility pathway.

For any questions or further clarification regarding this policy, providers are encouraged to reach out to their designated contact within our organization

II. Applicable Codes

Code	Description	Comment
E0766	Electrical stimulation device used for cancer treatment, includes all accessories	
A4555	Electrode/transducer for use with electrical stimulation device, replacement only	
77299	Unlisted procedure, therapeutic radiology clinical treatment planning	

III. Definitions

Term	Meaning

GBM	Glioblastoma Multiforme
TTFT	Tumor Treatment Field Therapy

IV. Related Policies

Policy Number	Policy Description
MP-173	Tumor Treatment Field Therapy

Procedure codes appearing in Reimbursement Policy documents are included only as a general reference tool for each policy. They may not be all-inclusive.

V. Reference Materials

New York State Medicaid Provider Manuals - DME
eMedNY Provider Manuals
New York State Medicaid Update - September 2025 Volume 41 - Number 9

VI. Revision History

Revision Date	Summary of Changes

Disclaimer

Healthfirst's claim edits follow national industry standards aligned with CMS standards that include, but are not limited to, the National Correct Coding Initiative (NCCI), the National and Local Coverage Determination (NCD/LCD) policies, appropriate modifier usage, global surgery and multiple procedure reduction rules, medically unlikely edits, duplicates, etc. In addition, Healthfirst's coding edits incorporate industry-accepted AMA and CMS CPT, HCPCS and ICD-10 coding principles, National Uniform Billing Editor's revenue coding guidelines, CPT Assistant guidelines, New York State-specific coding, billing, and payment policies, as well as national physician specialty academy

guidelines (coding and clinical). Failure to follow proper coding, billing, and/or reimbursement policy guidelines could result in the denial and/or recoupment of the claim payment.

This policy is intended to serve as a resource for providers to use in understanding reimbursement guidelines for professional and institutional claims. This information is accurate and current as of the date of publication. It provides information from industry sources about proper coding practice. However, this document does not represent or guarantee that Healthfirst will cover and/or pay for the services outlined. Reimbursement decisions are based on the terms of the applicable evidence of coverage, state and federal requirements or mandates, and the provider's participation agreement. This includes the determination of any amounts that Healthfirst or the member owes the provider.