



Proton Beam Therapy Clinical Coverage Criteria

Overview

Proton beam therapy (PBT) is a form of external radiation therapy in which positively charged subatomic particles (protons) are precisely targeted to a specific tissue mass using a sophisticated stereotactic treatment planning and delivery system. The goal of PBT is to deliver a higher target dose with lower normal tissue exposure than is possible with conventional photon irradiation, thereby improving local control of tumors and reducing acute and late complications.

Conventional external beam radiation therapy (EBRT), three-dimensional conformal radiation therapy (3D-CRT), and intensity modulated radiation therapy (IMRT) are delivered via photon beams. Proton beams differ from photon beams mainly in the way they deposit energy in living tissue. Whereas photons deposit energy in small packets all along their path through tissue, protons deposit much of their energy at the end of their path (called the Bragg peak) and deposit less energy along the way. In theory, use of protons should reduce the exposure of normal tissue to radiation, possibly allowing the delivery of higher doses of radiation to a tumor.

PBT is considered reasonable in instances where sparing the surrounding normal tissue is of added clinical benefit to the patient and cannot be adequately achieved with photon-based radiation therapy.

Policy

This Policy applies to the following Fallon Health products:

- Fallon Medicare Plus, Fallon Medicare Plus Central (Medicare Advantage)
- MassHealth ACO
- NaviCare HMO SNP (Dual Eligible Medicare Advantage and MassHealth)
- NaviCare SCO (MassHealth-only)
- PACE (Summit Eldercare PACE, Fallon Health Weinberg PACE)
- Community Care (Commercial/Exchange)

Prior authorization is required for proton beam therapy.

Fallon Health Clinical Coverage Criteria

Fallon Health Clinical Coverage Criteria apply to MassHealth ACO and Community Care members.

Effective for dates of service on or after September 1, 2024, Fallon Health will use InterQual® Criteria when making medical necessity determinations for spinal cord stimulation.

For coverage criteria, refer to the InterQual® Criteria in effect on the date of service:

- InterQual® CP:Procedures, Proton Beam Radiotherapy (PBRT)
- InterQual® CP:Procedures, Proton Beam Radiotherapy (PBRT) (Pediatric)

Fallon Health makes InterQual® criteria available through the Transparency Tool on our website, effective January 1, 2024.

Documentation Requirements

Documentation in the patient's medical record must:

1. Support one or more indications as described in InterQual® Criteria.
2. Include a treatment prescription that defines the goals of the treatment plan – including specific dose-volume parameters for the target and nearby critical structures – as well as pertinent details of beam delivery, such as the method of beam modulation, field arrangement, and expected positional and range uncertainties.
3. Include a treatment plan, signed by a physician, which meets the prescribed dose-volume parameters for the clinical target volume and surrounding organs at risk in the presence of expected uncertainties.
4. Describe the target setup verification methodology, including patient positioning, immobilization, image guidance and frequencies.
5. Include verification of planned dose distribution via independent dose calculation or physical measurement.

Medicare Variation

Medicare statutes and regulations do not have coverage criteria for proton beam therapy. Medicare does not have an NCD for proton beam therapy. National Government Services, Inc., the Part A and B Medicare Administrative Contractor with jurisdiction in the Plan's service area has an LCD for Proton Beam Therapy (L35075) (Medicare Coverage Database search 08/25/2025). Coverage criteria for proton beam therapy are fully established by Medicare; therefore, the Plan's coverage criteria are not applicable.

[Link: National Government Services, Inc. LCD Proton Beam Therapy \(L35075\)](#)

MassHealth Variation

MassHealth does not have Guidelines for Medical Necessity Determination for proton beam therapy (MassHealth website search 08/25/2025), therefore, the Plan's coverage criteria are applicable.

Exclusions

- While proton beam therapy is not a new technology, there is a need for continued clinical evidence development and comparative effectiveness analyses for the appropriate use of proton beam therapy for the following conditions:
 - Breast cancer
 - Esophageal cancer
 - Gastric cancer
 - Gynecologic cancer
 - Lung cancer
 - Lymphoma (Hodgkin and non-Hodgkin)
 - Pancreatic cancer
 - Prostate cancer

Coding

The following codes are included below for informational purposes only; inclusion of a code does not constitute or imply coverage or reimbursement.

Selection of the correct proton beam delivery code is based on the complexity and compensation of the treatment:

- Simple proton beam therapy delivery to a single treatment area is billed with either CPT 77522 (with compensation) or CPT 77520 (without compensation).
- Intermediate proton beam therapy delivery to one or more treatment areas utilizing two or more ports or one or more tangential/oblique ports with custom blocks and compensators is billed with CPT 77523.
- Complex proton beam therapy delivery to one or more treatment areas utilizing two or more ports per treatment area with matching or patching fields and/or multiple isocenters, with custom blocks and compensators is billed with CPT 77525.

| 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

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2. ASTRO. Proton Beam Therapy for Prostate Cancer Position Statement. Available at: <https://www.astro.org/daily-practice/reimbursement/model-policies/proton-beam-therapy-for-prostate-cancer-position-statement>. Accessed 08/22/2024.
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Policy history

Origination date: 11/15/2012
Approval(s): Technology Assessment Committee: 11/15/2012, 12/03/2014 (updated template, references, criteria expanded) 12/15/2015 (updated references), 03/22/2017 (updated references), 03/28/2018 (updated Medicare plan coverage, updated references), 03/27/2019 (updated references), 07/10/2021 (added clarifying language related to Medicare Advantage, NaviCare and PACE under policy section), 08/27/2024 (annual review, adopted InterQual® Criteria effective 09/01/2024, updated References), 08/26/2025 (annual update, no changes to coverage criteria, added new sections for Medicare and MassHealth Variation).
Utilization Management Committee: 09/16/2025 (annual review, approved with no changes to coverage criteria).

Instructions for Use

Fallon Health complies with CMS's national coverage determinations (NCDs), local coverage determinations (LCDs) of Medicare Contractors with jurisdiction for claims in the Plan's service area, and applicable Medicare statutes and regulations when making medical necessity determinations for Medicare Advantage members. When coverage criteria are not fully established in applicable Medicare statutes, regulations, NCDs or LCDs, Fallon Health may create internal coverage criteria under specific circumstances described at § 422.101(b)(6)(i) and (ii).

Fallon Health generally follows Medical Necessity Guidelines published by MassHealth when making medical necessity determinations for MassHealth members. In the absence of Medical Necessity Guidelines published by MassHealth, Fallon Health may create clinical coverage criteria in accordance with the definition of Medical Necessity in 130 CMR 450.204.

For plan members enrolled in NaviCare, Fallon Health first follows CMS's national coverage determinations (NCDs), local coverage determinations (LCDs) of Medicare Contractors with jurisdiction for claims in the Plan's service area, and applicable Medicare statutes and regulations when making medical necessity determinations. When coverage criteria are not fully established in applicable Medicare statutes, regulations, NCDs or LCDs, or if the NaviCare member does not meet coverage criteria in applicable Medicare statutes, regulations, NCDs or LCDs, Fallon Health then follows Medical Necessity Guidelines published by MassHealth when making necessity determinations for NaviCare members.

Each PACE plan member is assigned to an Interdisciplinary Team. PACE provides participants with all the care and services covered by Medicare and Medicaid, as authorized by the interdisciplinary team, as well as additional medically necessary care and services not covered by Medicare and Medicaid. With the exception of emergency care and out-of-area urgently needed care, all care and services provided to PACE plan members must be authorized by the interdisciplinary team.

Not all services mentioned in this policy are covered for all products or employer groups. Coverage is based upon the terms of a member's particular benefit plan which may contain its own specific provisions for coverage and exclusions regardless of medical necessity. Please consult the product's Evidence of Coverage for exclusions or other benefit limitations applicable to this service or supply. If there is any discrepancy between this policy and a member's benefit plan, the provisions of the benefit plan will govern. However, applicable state mandates take

precedence with respect to fully insured plans and self-funded non-ERISA (e.g., government, school boards, church) plans. Unless otherwise specifically excluded, federal mandates will apply to all plans.