



Amplitude-Modulated Radiofrequency Electromagnetic Fields (RF-EMF) for Cancer Treatment

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IMPORTANT REMINDER

The Medicare Advantage Medical Policy manual is not intended to override the member Evidence of Coverage (EOC), which defines the insured’s benefits, nor is it intended to dictate how providers are to practice medicine. Physicians and other health care providers are expected to exercise their medical judgment in providing the most appropriate care for the individual member, including care that may be both medically reasonable and necessary.

The Medicare Advantage medical policies are designed to provide guidance regarding the decision-making process for the coverage or non-coverage of services or procedures in accordance with the member EOC and Centers of Medicare and Medicaid Services (CMS) policies and manuals, along with general CMS rules and regulations. In the event of a conflict, applicable CMS policy or EOC language will take precedence over the Medicare Advantage Medical Policy. In the absence of a specific CMS coverage determination for a requested service, item or procedure, the health plan may apply CMS regulations, as well as their Medical Policy Manual or other applicable utilization management vendor criteria developed with an objective, evidence-based process using scientific evidence, current generally accepted standards of medical practice, and authoritative clinical practice guidelines.

Some services or items may appear to be medically indicated for an individual, but may be a direct exclusion of Medicare or the member’s benefit plan. Medicare and member EOCs exclude from coverage, among other things, services or procedures considered to be investigational (experimental) or cosmetic, as well as services or items considered not medically reasonable and necessary under Title XVIII of the Social Security Act, §1862(a)(1)(A). In some cases, providers may bill members for these non-covered services or procedures. Providers are encouraged to inform members in advance when they may be financially responsible for the cost of non-covered or excluded services. Members, their appointed representative, or a treating provider can request coverage of a service or item by submitting a pre-service organization determination prior to services being rendered.

DESCRIPTION

Amplitude-modulated radiofrequency electromagnetic fields at tumor-specific frequencies is intended to treat advanced cancer.

MEDICARE ADVANTAGE POLICY CRITERIA

CMS Coverage Manuals* None

National Coverage Determinations (NCDs)* None

Noridian Healthcare Solutions (Noridian) Local Coverage Determinations (LCDs) and Articles (LCAs)*

None

Medical Policy Manual

Medicare coverage guidance is not available for amplitude-modulated radiofrequency electromagnetic fields for cancer treatment. Therefore, the health plan's medical policy is applicable.

Amplitude-Modulated Radiofrequency Electromagnetic Fields for Cancer Treatment, [Policy No. DME96](#) (see "NOTE" below)

NOTE: If a procedure or device lacks scientific evidence regarding safety and efficacy because it is investigational or experimental, the service is noncovered as not reasonable and necessary to treat illness or injury. ([Medicare IOM Pub. No. 100-04, Ch. 23, §30 A](#)). According to Title XVIII of the Social Security Act, §1862(a)(1)(A), only medically reasonable and necessary services are covered by Medicare. In the absence of a NCD, LCD, or other coverage guideline, CMS guidelines allow a Medicare Advantage Organization (MAO) to make coverage determinations, applying an **objective, evidence-based process, based on authoritative evidence**. ([Medicare IOM Pub. No. 100-16, Ch. 4, §90.5](#)). The Medicare Advantage Medical Policy - Medicine Policy No. M-149 - provides further details regarding the plan's evidence-assessment process (see Cross References).

POLICY GUIDELINES

Note, the fact a new service or procedure has been issued a CPT/HCPCS code or is FDA approved for a specific indication does not, in itself, make the procedure medically reasonable and necessary. The FDA determines safety and effectiveness of a device or drug, but does not establish medical necessity. While Medicare may adopt FDA determinations regarding safety and effectiveness, Medicare or Medicare contractors evaluate whether or not the drug or device is reasonable and necessary for the Medicare population under §1862(a)(1)(A).

REGULATORY STATUS

The Food and Drug Administration (FDA) approved the Therabionic P1 device in September 2023 through the Humanitarian Device Exemption (HDE) process for the treatment of adults aged 18 years and older with advanced hepatocellular carcinoma (HCC) after first and second lines of therapy have failed.

CROSS REFERENCES

[Tumor Treating Field Therapy \(TTFT\)](#), Durable Medical Equipment, Policy No. M-DME85

REFERENCES

None

CODING

| Codes | Number | Description |
|-------|--------|--|
| CPT | None | |
| HCPCS | E0767 | Intrabuccal, systemic delivery of amplitude-modulated, radiofrequency electromagnetic field device, for cancer treatment, includes all accessories |

***IMPORTANT NOTE:** Medicare Advantage medical policies use the most current Medicare references available at the time the policy was developed. Links to Medicare references will take viewers to external websites outside of the health plan's web control as these sites are not maintained by the health plan.