Medical Coverage Policy | Radioembolization for Primary and Metastatic Tumors of the Liver

EFFECTIVE DATE: 10|06|2009
POLICY LAST UPDATED: 08|21|2018

OVERVIEW

Radioembolization (RE), referred to as selective internal radiation therapy or "SIRT" in older literature has been developed for the treatment of unresectable primary and secondary liver cancer.

MEDICAL CRITERIA

Radioembolization may be considered medically necessary as a treatment for any of the following:

- Primary hepatocellular carcinoma that is unresectable and limited to the liver.
- In primary hepatocellular carcinoma as a bridge to liver transplantation.
- Hepatic metastases from neuroendocrine tumors (carcinoid and noncarcinoid) with diffuse and symptomatic disease when systemic therapy has failed to control symptoms.
- Unresectable hepatic metastases from colorectal carcinoma melanoma (ocular or cutaneous), or breast cancer that are both progressive and diffuse, in patients with liver-dominant disease who are refractory to chemotherapy or are not candidates for chemotherapy.
- Primary intrahepatic cholangiocarcinoma in patients with unresectable tumors.

PRIOR AUTHORIZATION

Prior authorization is required for BlueCHiP for Medicare members and recommended for Commercial products.

POLICY STATEMENT

BlueCHiP for Medicare and Commercial Products

Radioembolization is considered medically necessary when the medical criteria have been met.
Radioembolization is considered not covered for BlueCHiP for Medicare and not medically necessary for Commercial products for all other indications.

COVERAGE

Benefits may vary between groups and contracts. Please refer to the appropriate Benefit Booklet, Evidence of Coverage, or Subscriber Agreement for the applicable radiology benefits.

BACKGROUND

TREATMENTS FOR HEPATIC AND NEUROENDOCRINE TUMORS

The use of external beam radiotherapy and the application of more advanced radiotherapy approaches (e.g., intensity-modulated radiotherapy) may be of limited use in patients with diffuse, multiple lesions due to the low tolerance of normal liver to radiation compared with the higher doses of radiation needed to kill the tumor.

Various nonsurgical ablative techniques have been investigated that seek to cure or palliate unresectable hepatic tumors by improving locoregional control. These techniques rely on extreme temperature changes (cryosurgery or radiofrequency ablation, particle and wave physics (microwave or laser ablation), or arterial embolization therapy including chemoembolization, bland embolization, or Radioembolization.

Radioembolization
Radioembolization (referred to as selective internal radiotherapy in older literature) delivers small beads (microspheres) impregnated with yttrium 90 intra-arterially via the hepatic artery. The microspheres, which become permanently embedded, are delivered to tumors preferentially because the hepatic circulation is uniquely organized, whereby tumors greater than 0.5 cm rely on the hepatic artery for blood supply while the normal liver is primarily perfused via the portal vein.

Yttrium-90 is a pure beta-emitter with a relatively limited effective range and short half-life that helps focus the radiation and minimize its spread. Candidates for Radioembolization are initially examined by hepatic angiogram to identify and map the hepatic arterial system. At that time, a mixture of technetium 99-labeled albumin particles is delivered via the hepatic artery to simulate microspheres. Single photon emission computed tomography imaging is used to detect possible shunting of the albumin particles into the gastrointestinal or pulmonary vasculature.

REGULATORY STATUS
Currently, 2 forms of yttrium-90 microspheres have been approved by FDA.

In 1999, TheraSphere® (manufactured by Nordion, under license by BTG International), a glass sphere system, was approved by FDA through the humanitarian drug exemption process for radiotherapy or as a neoadjuvant treatment to surgery or transplantation in patients with unresectable hepatocellular carcinoma HCC who can have placement of appropriately positioned hepatic arterial catheters.

In 2002, SIR-Spheres® (Sirtex Medical), a resin sphere system, was approved by FDA through the premarket approval process for the treatment of inoperable colorectal cancer metastatic to the liver.

For individuals who have unresectable hepatocellular carcinoma who receive RE or RE with a liver transplant, the evidence includes primarily retrospective and prospective observational studies, with limited evidence from randomized controlled trials (RCTs). Relevant outcomes are overall survival, functional outcomes, quality of life, and treatment-related morbidity. Observational studies have suggested that RE has high response rates compared with historical controls. Two small pilot RCTs have compared RE with alternative therapies for hepatocellular carcinoma, including transarterial chemoembolization and transarterial chemoembolization with drug-eluting beads. Both trials reported similar outcomes for RE compared with alternatives. Evidence from observational studies has demonstrated that RE can permit successful liver transplantation in certain patients. The evidence is sufficient to determine that the technology results in a meaningful improvement in the net health outcome.

For individuals who have unresectable intrahepatic cholangiocarcinoma who receive RE, the evidence includes case series. Relevant outcomes are overall survival, functional outcomes, quality of life, and treatment-related morbidity. Comparisons of these case series to case series of alternative treatments have suggested that RE for primary intrahepatic cholangiocarcinoma has response rates similar to those seen with standard chemotherapy. RE may play a role for patients with unresectable tumors that are chemorefractory or who are unable to tolerate systemic chemotherapy. However, the evidence is not yet sufficiently robust to draw definitive conclusions about treatment efficacy. The evidence is insufficient to determine the effects of the technology on health outcomes.

For individuals who have unresectable neuroendocrine tumors who receive RE, the evidence includes an open-label phase 2 study, retrospective reviews, and case series, some of which have compared RE with other transarterial liver-directed therapies. Relevant outcomes are overall survival, functional outcomes, quality of life, and treatment-related morbidity. This evidence has suggested that RE provides outcomes similar to standard therapies and historical controls for patients with neuroendocrine tumor-related symptoms or progression of liver tumor. The evidence is sufficient to determine that the technology

results in a meaningful improvement in the net health outcome.

For individuals who have unresectable intrahepatic metastases from colorectal cancer and prior treatment failure who receive RE, the evidence includes several small- to moderate-sized RCTs, prospective trials, and retrospective studies using a variety of comparators, as well as systematic reviews of these studies. Relevant outcomes are overall survival, functional outcomes, quality of life, and treatment-related morbidity. RCTs of patients with prior treatment failure have methodologic problems, do not show definitive superiority of RE compared with alternatives, but tend to show greater tumor response with RE. The evidence is sufficient to determine that the technology results in a meaningful improvement in the net health outcome.

For individuals who have unresectable intrahepatic metastases from other cancers (eg, breast, melanoma, pancreatic) who receive RE, the evidence includes observational studies. Relevant outcomes are overall survival, functional outcomes, quality of life, and treatment-related morbidity. These studies have shown significant tumor response; however, improvement in survival has not been demonstrated in controlled comparative studies. The evidence is insufficient to determine the effects of the technology on health outcomes.

Clinical input obtained in 2010, 2011, and 2015 has supported the use of RE for primary hepatocellular carcinoma, intrahepatic cholangiocarcinoma, hepatic metastases from neuroendocrine tumors, chemorefractory colorectal carcinoma, chemorefractory breast cancer, and chemorefractory melanoma, despite the lack of rigorous comparative clinical trials for many of the indications.

CODING

BlueCHiP for Medicare and Commercial Products

There are no specific CPT codes describing radioembolization therapy. Providers should file using the unlisted CPT code:

77399

RELATED POLICIES

None

PUBLISHED

Provider Update, November 2018
Provider Update, November 2017
Provider Update, October 2016
Provider Update, January 2016
Provider Update, February 2015
Provider Update, January 2014
Provider Update, December 2012
Provider Update, March 2011

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