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## OVERVIEW

Radiotherapy (RT) is an integral component in the treatment of many brain tumors, both benign and malignant. Intensity-modulated radiotherapy (IMRT) has been proposed as a method of RT that allows adequate RT to the tumor while minimizing the radiation dose to surrounding normal tissues and critical structures. IMRT also allows additional radiation to penetrate specific anatomic areas simultaneously, delivering radiation at a larger target volume.

## MEDICAL CRITERIA

### BlueCHiP for Medicare and Commercial Products

Intensity-modulated radiotherapy (IMRT) may be considered medically necessary when the criteria below is met:

- For the treatment of tumors of the central nervous system (CNS) when the tumor is in close proximity to organs at risk including:
  - Brain stem
  - Spinal Cord
  - Cochlea and eye structures including optic nerve and chiasm, lens and retina, and;
- Use of conventional radiation dosage will result in damage and complications for normal surrounding tissue.

## PRIOR AUTHORIZATION

Prior authorization is required for BlueCHiP for Medicare and recommended for Commercial Products via the online tool for participating providers. See the Related Policies section.

## POLICY STATEMENT

### BlueCHiP for Medicare and Commercial Products

Intensity-modulated radiotherapy (IMRT) may be considered medically necessary for the treatment of tumors of the central nervous system (CNS) when the criteria above is met.

IMRT is considered not covered for BlueCHiP for Medicare and not medically necessary for Commercial Products for the treatment of tumors of the CNS for all indications not listed above, as the evidence is insufficient to determine the effects of the technology on health outcomes.

## COVERAGE

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

## BACKGROUND

The standard approach to the treatment of brain tumors depends on the type and location of tumor. For glioblastoma multiforme, a malignant high-grade tumor, treatment is multimodal, with surgical resection followed by adjuvant RT and chemotherapy.

For benign and low-grade brain tumors, gross total resection remains the primary goal. However, RT may be used in selected cases. Some examples are when total resection is not possible, when a more conservative surgical approach may be necessary to achieve long-term treatment goals, and with atypical tumors that may

need RT even after gross total resection to reduce the risk of local recurrence. Therefore, RT, either definitive or in the postoperative adjuvant setting, remains an integral component in the management of residual, recurrent, and/or progressive benign and low-grade brain tumors for maximizing local control.

Brain metastases occur in up to 40% of adults with cancer and can shorten survival and detract from quality of life. Many patients who develop brain metastases will eventually die of progressive intracranial disease. Among patients with good performance status, controlled extracranial disease, favorable prognostic features, and a solitary brain metastasis, randomized studies have shown that surgical excision followed by whole-brain radiotherapy (WBRT) prolongs survival. Stereotactic radiosurgery (SRS) may be able to replace surgery in certain circumstances, delivering obliteratively high single doses to discrete metastases. For bulky cerebral metastases, level 1 evidence has also shown that delivering a higher radiation dose with an SRS boost is beneficial in addition to standard WBRT. The use of a concomitant boost with IMRT during WBRT has been attempted to improve overall local tumor control without the use of SRS to avoid additional planned radiation after WBRT (“phase II” or SRS) and its additional labor and expense. Another indication for use of IMRT in WBRT is to avoid radiation exposure to the hippocampus. It is thought that avoiding the hippocampus may minimize cognitive decline that has been associated with WBRT.

## **Radiotherapy Techniques**

### **Conventional External Beam Radiotherapy**

Methods to plan and deliver RT have evolved in ways that permit more precise targeting of tumors with complex geometries. Most early trials used 2-dimensional treatment planning, based on flat images and radiation beams with cross-sections of uniform intensity that were sequentially aimed at the tumor along 2 or 3 intersecting axes. Collectively, these methods are termed conventional external-beam radiotherapy.

### **Three-Dimensional Conformal Radiotherapy**

Treatment planning evolved by using 3-dimensional images, typically from computed tomography (CT) scans, to delineate the boundaries of the tumor and discriminate tumor tissue from adjacent normal tissue and nearby organs at risk for radiation damage. Computer algorithms were developed to estimate cumulative radiation dose delivered to each volume of interest by summing the contribution from each shaped beam. Methods also were developed to position the patient and the radiation portal reproducibly for each fraction and immobilize the patient, thus maintaining consistent beam axes across treatment sessions. Collectively, these methods are termed 3-dimensional conformal radiotherapy (3D-CRT). IMRT, which uses computer software and CT and magnetic resonance imaging (MRI) images, offers better conformality than 3D-CRT, as it is able to modulate the intensity of the overlapping radiation beams projected on the target and to use multiple shaped treatment fields.

### **Intensity-Modulated Radiotherapy**

IMRT, which uses computer software and CT and magnetic resonance images, offers better conformality than 3D-CRT because it modulates the intensity of the overlapping radiation beams projected on the target and uses multiple shaped treatment fields. Treatment planning and delivery are more complex, time-consuming, and labor-intensive for IMRT than for 3D-CRT. The technique uses a multileaf collimator (MLC), which, when coupled with a computer algorithm, allows for “inverse” treatment planning. The radiation oncologist delineates the target on each slice of a CT scan and specifies the target’s prescribed radiation dose, acceptable limits of dose heterogeneity within the target volume, adjacent normal tissue volumes to avoid, and acceptable dose limits within the normal tissues. Based on these parameters and a digitally reconstructed radiographic image of the tumor, surrounding tissues, and organs at risk, computer software optimizes the location, shape, and intensities of the beam ports to achieve the treatment plan’s goals.

Increased conformality may permit escalated tumor doses without increasing normal tissue toxicity and thus may improve local tumor control, with decreased exposure to surrounding, normal tissues, potentially reducing acute and late radiation toxicities. Better dose homogeneity within the target may also improve local tumor control by avoiding underdosing within the tumor and may decrease toxicity by avoiding overdosing.

Technologic developments have produced advanced techniques that may further improve RT treatment by improving dose distribution. These techniques are considered variations of IMRT. Volumetric modulated arc therapy delivers radiation from a continuous rotation of the radiation source. The principal advantage of volumetric modulated arc therapy is greater efficiency in treatment delivery time, reducing radiation exposure and improving target radiation delivery due to less patient motion. Image-guided RT involves the incorporation of imaging before and/or during treatment to deliver RT to the target volume more precisely.

IMRT methods to plan and deliver RT are not uniform. IMRT may use beams that remain on as MLCs move around the patient (dynamic MLC) or that are off during movement and turn on once the MLC reaches prespecified positions (“step and shoot” technique). A third alternative uses a very narrow single beam that moves spirally around the patient (tomotherapy). Each method uses different computer algorithms to plan treatment and yields somewhat different dose distributions in and outside the target. Patient position can alter target shape and thus affect treatment plans. Treatment plans are usually based on 1 imaging scan, a static 3D-CT image. Current methods seek to reduce positional uncertainty for tumors and adjacent normal tissues by various techniques. Patient immobilization cradles and skin or bony markers are used to minimize day-to-day variability in patient positioning. In addition, many tumors have irregular edges that preclude drawing tight margins on CT scan slices when radiation oncologists contour the tumor volume. It is unknown whether omitting some tumor cells or including some normal cells in the resulting target affects outcomes of IMRT.

## **CODING**

### **BlueCHiP for Medicare and Commercial Products**

**A4648:** Tissue marker, implantable, any type, each (Note: This code is not separately reimbursed for institutional providers.)

**Note:** To ensure correct pricing of HCPC code **A4648** for the Calypso 4D localization system, the procedure/clinical notes and the invoice must be submitted.

The following codes are covered for BlueCHiP for Medicare and commercial products when the criteria above is met:

#### **Intensity-modulated radiation therapy**

- 77301:** Intensity modulated radiotherapy plan, including dose-volume histograms for target and critical structure partial tolerance specifications
- 77338:** Multi-leaf collimator (MLC) device(s) for intensity modulated radiation therapy (IMRT), design and construction per IMRT plan
- 77385:** Intensity modulated radiation treatment delivery (IMRT), includes guidance and tracking, when performed; simple (Institutional providers)
- 77386:** Intensity modulated radiation treatment delivery (IMRT), includes guidance and tracking, when performed; complex (Institutional providers)
- G6015:** Intensity modulated treatment delivery, single or multiple fields/arcs, via narrow spatially and temporally modulated beams, binary, dynamic MLC, per treatment session: (Professional providers)
- G6016:** Compensator-based beam modulation treatment delivery of inverse planned treatment using 3 or more high resolution (milled or cast) compensator, convergent beam modulated fields, per treatment session: (Professional providers)

## **RELATED POLICIES**

Preauthorization via Web-Based Tool for Procedures

Intensity Modulated Radiotherapy: Abdomen and Pelvis

Intensity Modulated Radiotherapy: Head, Neck and Thyroid

Intensity Modulated Radiotherapy: Breast and Lung

## Intensity Modulated Radiotherapy: Prostate

### PUBLISHED

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### REFERENCES

1. Amelio D, Lorentini S, Schwarz M, et al. Intensity-modulated radiation therapy in newly diagnosed glioblastoma: a systematic review on clinical and technical issues. *Radiother Oncol.* 2010;97(3):361-369.
2. Gupta T, Wadasadawala T, Master Z, et al. Encouraging early clinical outcomes with helical tomotherapy-based image-guided intensity-modulated radiation therapy for residual, recurrent, and/or progressive benign/low-grade intracranial tumors: a comprehensive evaluation. *Int J Radiat Oncol Bioi Phys.* Feb 1 2012;82(2):756-764. PMID 21345610
3. Edwards AA, Keggin E, Plowman PN. The developing role for intensity-modulated radiation therapy (IMRT) in the non-surgical treatment of brain metastases. *Br J Radiol.* 2010;83(986):133-136.
4. Fuller CD, Choi M, Forthuber B, et al. Standard fractionation intensity modulated radiation therapy (IMRT) of primary and recurrent glioblastoma multiforme. *Radiat Oncol.* 2007;2:26. PMID 17629934
5. MacDonald SM, Ahmad S, Kachris S, et al. Intensity modulated radiation therapy versus three-dimensional conformal radiation therapy for the treatment of high grade glioma: a dosimetric comparison. *J Appl Clin Med Phys.* 2007;8(2):47-60.
6. Narayana A, Yamada J, Berry S, et al. Intensity-modulated radiotherapy in high-grade gliomas: clinical and dosimetric results. *Int J Radiat Oncol Bioi Phys.* 2006;64(3):892-897.
7. Huang E, The BS, Strother DR, et al. Intensity-modulated radiation therapy for pediatric medulloblastoma: early report on the reduction of ototoxicity. *Int J Radiat Oncol Bioi Phys.* 2002;52(3):599-605.
8. Milker-Zabel S, Zabel-du BA, Huber P, et al. Intensity-modulated radiotherapy for complex-shaped meningioma of the skull base: long-term experience of a single institution. *Int J Radiat Oncol Bioi Phys.* 2007;68(3):858-863.
9. Mackley HB, Reddy CA, Lee SY, et al. Intensity-modulated radiotherapy for pituitary adenomas: the preliminary report of the Cleveland Clinic experience. *Int J Radiat Oncol Bioi Phys.* 2007;67(1):232-239.
10. Sajja R, Barnett GH, Lee SY, et al. Intensity-modulated radiation therapy (IMRT) for newly diagnosed and recurrent intracranial meningiomas: preliminary results. *Technol Cancer Res Treat.* 2005;4(6):675-682.
11. Uy NW, Woo SY, Teh BS, et al. Intensity-modulated radiation therapy (IMRT) for meningioma. *Int J Radiat Oncol Bioi Phys.* 2002;53(5):1265-1270.

12. Zhou L, Liu J, Xue J, et al. Whole brain radiotherapy plus simultaneous in-field boost with image guided intensity- modulated radiotherapy for brain metastases of non-small cell lung cancer. *Radiat Oncol.* 2014;9:117. PMID 24884773
13. National Comprehensive Cancer Network (NCCN). NCCN Clinical Practice Guidelines in Oncology: Central Nervous System Cancers. Version 1.2016.  
[http://www.nccn.org/professionals/physician\\_gls/PDF/cns.pdf](http://www.nccn.org/professionals/physician_gls/PDF/cns.pdf). Accessed June 20 2017.

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