Clinical Policy: Intensity-Modulated Radiotherapy

Reference Number: LA.CP.MP.69 Coding Implications
Date of Last Revision: ~~2~~1/2~~3~~2 Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description
Medical necessity criteria for intensity-modulated radiotherapy (IMRT). IMRT is an advanced form of 3-dimensional (3-D) conformal radiation therapy that delivers a more precise radiation dose to the tumor while sparing healthy surrounding tissue. While IMRT empirically offers advances over other radiation therapies, accepted practices and the risks and benefits of IMRT over conventional or 3-D conformal radiation must be considered.

Policy/Criteria

I. It is the policy of Louisiana Healthcare Connections that IMRT is medically necessary for any of the following indications:

A. Age ≤ 18 years;
B. Target volume is in close proximity to critical structures that must be protected;
C. The volume of interest must be covered with narrow margins to adequately protect immediately adjacent structures;
D. An immediately adjacent area has been previously irradiated and abutting portals must be established with high precision;
E. The target volume is concave or convex, and critical normal tissues are within or around that convexity or concavity;
F. Dose escalation is planned to deliver radiation doses in excess of those commonly utilized for similar tumors with conventional treatment;
G. Indications by cancer site include any of the following:
    1. Primary or benign tumor(s) of the central nervous system, including brain, brain stem, and spinal cord;
    2. Primary tumor(s) of the spine where spinal cord tolerance may be exceeded by conventional treatment;
    3. Primary or benign lesion(s) of the head and neck area including orbits, sinuses, skull base, aerodigestive tract (lips, mouth, tongue, tonsils, nose, throat, vocal cords and part of the trachea and esophagus), salivary glands, and thyroid;
    4. Anal or perianal cancer, excluding locally recurrent perianal cancer;
    5. Prostate cancer, definitive (curative) treatment;
    6. Vulvar cancer, definitive (curative) treatment;
    7. Cervical cancer, curative treatment, any of the following:
        a. Post-hysterectomy;
        b. For treatment that includes para-aortic nodes;
        c. For high doses of radiation in the presence of gross disease in regional lymph nodes;
    8. Select breast cancer cases, any of the following:
        a. Homogeneity of dose cannot be achieved with conventional three dimensional planning techniques, demonstrated by any of the following:
            i. A maximum dose of greater than 110% is given to a volume of at least 0.3 cc;

ii. The volume of breast tissue receiving 105% of the prescribed dose exceeds 10% (or 20% for a large volume breast defined as greater than 800 cc);
iii. Hot spots in the inframammary fold are 105% or greater;

b. The volume of lung tissue receiving 20 Gy exceeds 20%;
c. The volume of heart tissue receiving 25 Gy exceeds 2%.

Background

A major goal of radiation therapy is the delivery of an appropriate dose of radiation to the targeted tissue while minimizing radiation exposure to the surrounding healthy tissue. The introduction of IMRT allowed for significant improvement of dose distributions by irradiating sub-regions of the target to different levels. It uses a computer-based planning method called inverse planning that allows the delivery of generally narrow, patient specific spatially and often temporally modulated beams of radiation to solid tumors within a patient.

IMRT changes the intensity of radiation in different parts of a single radiation beam while treatment is delivered. The dose of radiation given by each beam can also vary, enabling IMRT to simultaneously treat multiple areas within the target to different dose levels. Theoretical concerns about IMRT include dose inhomogeneity, additional time required for planning computation and quality assurance (QA) verification, and exposure of larger volumes of normal tissues to a lower dose of radiation.

There were numerous ~~a number of~~ studies done, including a multicenter, randomized, double-blind trial that indicated ~~have noted~~ IMRT improved the homogeneity of the radiation dose distribution and decreased acute toxicity, when used for breast cancer. [23,24,25,26,27~~23-27~~]

NCCN

NCCN recommends IMRT in a number of cancer types, including cancers whose radiation treatment may affect organs or other critical structures at risk.

Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2020, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only and may not support medical necessity. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CPT® Codes	Description
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

CPT® Codes	Description
77385	Intensity modulated radiation treatment delivery (IMRT), includes guidance and tracking, when performed; simple
77386	Intensity modulated radiation treatment delivery (IMRT) includes guidance and tracking, when performed; complex

HCPCS Codes	Description
G6015	Intensity modulated treatment delivery, single or multiple fields/arcs, via narrow spatially and temporally modulated beams, binary, dynamic MLC, per treatment session
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

~~ICD-10-CM Diagnosis Codes that Support Coverage Criteria~~

~~ICD-10-CM Code~~	~~Description~~
~~C00.0-C14.9~~	~~Malignant neoplasm of lip, oral cavity, and pharynx~~
~~C15.3-C15.9~~	~~Malignant neoplasm of esophagus~~
~~C21.0-C21.8~~	~~Malignant neoplasm of anus and anal canal~~
~~C25.0-C25.9~~	~~Malignant neoplasm of pancreas~~
~~C26.9~~	~~Malignant neoplasm of ill-defined sites within the digestive system~~
~~C30.0~~	~~Malignant neoplasm of nasal cavity~~
~~C31.0-C31.9~~	~~Malignant neoplasm of accessory sinus~~
~~C32.0-C32.9~~	~~Malignant neoplasm of larynx~~
~~C33~~	~~Malignant neoplasm of trachea~~
~~C41.0~~	~~Malignant neoplasm of bones of skull and face~~
~~C41.2~~	~~Malignant neoplasm of vertebral column~~
~~C44.500~~	~~Unspecified malignant neoplasm of anal skin~~
~~C48.0~~	~~Malignant neoplasm of retroperitoneum~~
~~C48.1~~	~~Malignant neoplasm of specified parts of peritoneum~~
~~C48.8~~	~~Malignant neoplasm of overlapping sites of retroperitoneum and peritoneum~~
~~C50.011-C50.929~~	~~Malignant neoplasm of breast~~
~~C51.0-C51.9~~	~~Malignant neoplasm of vulva~~
~~C53.0-C53.9~~	~~Malignant neoplasm of cervix uteri~~
~~C61~~	~~Malignant neoplasm of prostate~~
~~C69.60-C69.62~~	~~Malignant neoplasm of orbit~~
~~C70.0-C70.9~~	~~Malignant neoplasm of meninges~~
~~C71.0-C71.9~~	~~Malignant neoplasm of brain~~

~~ICD-10-CM Code~~	~~Description~~
~~C72.0–C72.9~~	~~Malignant neoplasm of spinal cord, cranial nerves and other parts of central nervous system~~
~~C76.1~~	~~Malignant neoplasm of thorax~~
~~C76.2~~	~~Malignant neoplasm of abdomen~~
~~C73~~	~~Malignant neoplasm of thyroid gland~~
~~C76.3~~	~~Malignant neoplasm of pelvis~~
~~D10.0–D11.9~~	~~Benign neoplasm of mouth and pharynx~~
~~D13.0~~	~~Benign neoplasm of esophagus~~
~~D14.1~~	~~Benign neoplasm of larynx~~
~~D14.2~~	~~Benign neoplasm of trachea~~
~~D16.4~~	~~Benign neoplasm of bones of skull and face~~
~~D31.60–D31.62~~	~~Benign neoplasm of unspecified site of orbit~~
~~D33.0–D33.9~~	~~Benign neoplasm of brain, and other parts of central nervous system~~
~~D34~~	~~Benign neoplasm of thyroid gland~~
~~Z85.01~~	~~Personal history of malignant neoplasm of esophagus~~
~~Z85.020–Z85.028~~	~~Personal history of malignant neoplasm of stomach~~
~~Z85.040–Z85.048~~	~~Personal history of malignant neoplasm of rectum, rectosigmoid junction, and anus~~
~~Z85.07~~	~~Personal history of malignant neoplasm of pancreas~~
~~Z85.12~~	~~Personal history of malignant neoplasm of trachea~~
~~Z85.21~~	~~Personal history of malignant neoplasm of larynx~~
~~Z85.22~~	~~Personal history of malignant neoplasm of nasal cavities, middle ear, and accessory sinuses~~
~~Z85.3~~	~~Personal history of malignant neoplasm of breast~~
~~Z85.41~~	~~Personal history of malignant neoplasm of cervix uteri~~
~~Z85.44~~	~~Personal history of malignant neoplasm of other female genital organs~~
~~Z85.46~~	~~Personal history of malignant neoplasm of prostate~~
~~Z85.810–Z85.819~~	~~Personal history of malignant neoplasm of lip, oral cavity, and pharynx~~
~~Z85.840~~	~~Personal history of malignant neoplasm of eye~~
~~Z85.841~~	~~Personal history of malignant neoplasm of brain~~
~~Z85.850~~	~~Personal history of malignant neoplasm of thyroid~~
~~Z86.011~~	~~Personal history of benign neoplasm of brain~~
~~Z86.018~~	~~Personal history of other benign neoplasm~~

Reviews, Revisions, and Approvals	Revision Date	Approval Date
Converted corporate to local policy.	12/1/2020	

Reviews, Revisions, and Approvals	Revision Date	Approval Date
Annual review. References reviewed and updated. Reviewed by specialist. Changed "Last Review Date" in the header to "Date of Last Revision" and "Date" in revision log to "Revision Date". Added "and may not support medical necessity" to coding implications	2/22	
Background updated. ICD-10 code table removed.	1/23	

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Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. LHCC makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and

limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable LHCC administrative policies and procedures.

This clinical policy is effective as of the date determined by LHCC. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. LHCC retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members/enrollees. This clinical policy is not intended to recommend treatment for members/enrollees. Members/enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom LHCC has no control or right of control. Providers are not agents or employees of LHCC.

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