

Effective: August 1, 2023

<p>Prior Authorization Required If REQUIRED, submit supporting clinical documentation pertinent to service request.</p>	<p>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/></p>
<p>Applies to:</p> <p>Commercial Products</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> Harvard Pilgrim Health Care Commercial products; 800-232-0816 <input checked="" type="checkbox"/> Tufts Health Plan Commercial products; 617-972-9409 CareLinkSM – Refer to CareLink Procedures, Services and Items Requiring Prior Authorization <p>Public Plans Products</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product); 888-415-9055 <input checked="" type="checkbox"/> Tufts Health Together – MassHealth MCO Plan and Accountable Care Partnership Plans; 888-415-9055 <input checked="" type="checkbox"/> Tufts Health RITogether – A Rhode Island Medicaid Plan; 857-304-6404 <input checked="" type="checkbox"/> Tufts Health Unify* – OneCare Plan (a dual-eligible product); 857-304-6304 <p>*The MNG applies to Tufts Health Unify members unless a less restrictive LCD or NCD exists.</p> <p>Senior Products</p> <ul style="list-style-type: none"> <input type="checkbox"/> Harvard Pilgrim Health Care Stride Medicare Advantage; 866-874-0857 <input type="checkbox"/> Tufts Health Plan Senior Care Options (SCO), (a dual-eligible product); 617-673-0965 <input type="checkbox"/> Tufts Medicare Preferred HMO, (a Medicare Advantage product); 617-673-0965 <input type="checkbox"/> Tufts Medicare Preferred PPO, (a Medicare Advantage product); 617-673-0965 	

Note: This guideline does not apply to Medicare Members (includes dual eligible Members).

Overview

Intensity-modulated radiation therapy (IMRT) is an advanced form of three-dimensional conformal radiation therapy (3D-CRT). IMRT changes the intensity of radiation in different parts of a single radiation, allowing multiple treated areas to receive different doses. Conformal radiation therapy uses a three-dimensional image, typically CT, MRI or PET, to create a planning target volume and calculate dose distribution to the targeted area. The goal of IMRT is to deliver high radiation dose and conform the radiation dose to the target while avoiding and/or reducing radiation exposure to healthy tissue, limiting the side effects of treatment. IMRT is a treatment option when tumor targets are positioned near sensitive normal tissues and/or critical structures.

Clinical Guideline Coverage Criteria

1. The Plan considers intensity-modulated radiation therapy as medically necessary for definitive treatment of the following neoplasms when sparing of surrounding normal tissue and/or critical structure(s) (**e.g. heart, lung, esophagus, optic nerve**) is of proven clinical benefit and cannot be achieved by 3-D conformal radiation therapy:
 - a. Anal
 - b. Breast
 - c. Central nervous system (CNS) tumors (primary, metastatic or benign) including the brain, brainstem and spinal cord
 - d. Esophageal
 - e. Gynecological malignancies including uterine, cervical, vulvar
 - f. Head and neck cancers including nasopharyngeal, oropharyngeal, sinonasal
 - g. Hepatocellular carcinoma (HCC)

- h. Mediastinal including thymoma, lymphoma, thymic carcinoma, tracheal
 - i. Non-small cell lung cancer
 - j. Pancreatic
 - k. Prostate
 - l. Small bowel adenocarcinoma)
 - m. Thyroid
2. Re-irradiation using IMRT is considered medically necessary to limit dose and minimize toxicity of previously irradiated tissue and/or critical structures.

Limitations

The Plan considers simultaneous use of proton beam therapy and intensity-modulated radiation therapy (IMRT) to be noncovered, investigational for any diagnosis

Codes

The following code(s) is associated with this service:

Table 1: CPT/HCPCS Codes

Code	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
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 three or more high resolution (milled or cast) compensator, convergent beam modulated fields, per treatment session

References:

- American Society for Radiation Oncology (ASTRO). ASTRO model policies: Intensity modulated radiation therapy (IMRT). (Updated 06-06-2019). Accessed June 15, 2023. IMRTMP.pdf (astro.org).
- American College of Radiology (ACR) . Radiation Oncology Resources. Intensity-modulated radiation therapy (IMRT). Updated July 2021(b). <https://www.radiologyinfo.org/en/info.cfm?pg=imrt>. Accessed December 29, 2021.
- Gondi V, Bauman G, Bradfield L, et al. Radiation Therapy for Brain Metastases: An ASTRO Clinical Practice Guideline. *Pract Radiat Oncol.* 2022;12(4):265-282. doi:10.1016/j.ppro.2022.02.003
- Halasz LM, Attia A, Bradfield L, et al. Radiation Therapy for IDH-Mutant Grade 2 and Grade 3 Diffuse Glioma: An ASTRO Clinical Practice Guideline. *Pract Radiat Oncol.* 2022;12(5):370-386. doi:10.1016/j.ppro.2022.05.004
- Mitin T, MD, PhD. Radiation Therapy Techniques in Cancer Treatment. UpToDate. Accessed March 6, 2023. Radiation therapy techniques in cancer treatment - UpToDate
- Smith BD, Bellon JR, Blitza R, et al. Radiation therapy for the whole breast: Executive summary of an American Society for Radiation Oncology (ASTRO) evidence-based guideline. *Pract Radiat Oncol.* 2018;8(3):145-152. doi:10.1016/j.ppro.2018.01.012
- Eastham JA, Boorjian SA, Kirkby E. Clinically Localized Prostate Cancer: AUA/ASTRO Guideline. *J Urol.* 2022;208(3):505-507. doi:10.1097/JU.0000000000002854
- Chino J, Annunziata CM, Beriwal S, et al. Radiation Therapy for Cervical Cancer: Executive Summary of an ASTRO Clinical Practice Guideline. *Pract Radiat Oncol.* 2020;10(4):220-234. doi:10.1016/j.ppro.2020.04.002
- Wo JY, Anker CJ, Ashman JB, et al. Radiation Therapy for Rectal Cancer: Executive Summary of an ASTRO Clinical Practice Guideline. *Pract Radiat Oncol.* 2021;11(1):13-25. doi:10.1016/j.ppro.2020.08.004
- Wo JY, Anker CJ, Ashman JB, et al. Radiation Therapy for Rectal Cancer: Executive Summary of an ASTRO Clinical Practice Guideline. *Pract Radiat Oncol.* 2021;11(1):13-25. doi:10.1016/j.ppro.2020.08.004
- Chino J, Annunziata CM, Beriwal S, et al. Radiation Therapy for Cervical Cancer: Executive Summary of an ASTRO Clinical Practice Guideline. *Pract Radiat Oncol.* 2020;10(4):220-234. doi:10.1016/j.ppro.2020.04.002
- Salerno KE, Alektiar KM, Baldini EH, et al. Radiation Therapy for Treatment of Soft Tissue Sarcoma in Adults:

Executive Summary of an ASTRO Clinical Practice Guideline. *Pract Radiat Oncol*. 2021;11(5):339-351. doi:10.1016/j.prro.2021.04.005

13. Simone CB 2nd, Bogart JA, Cabrera AR, et al. Radiation Therapy for Small Cell Lung Cancer: An ASTRO Clinical Practice Guideline. *Pract Radiat Oncol*. 2020;10(3):158-173. doi:10.1016/j.prro.2020.02.009
14. National Comprehensive Cancer Network (NCCN). Clinical Practice Guidelines in Oncology. Anal carcinoma. V1.2023. [anal.pdf \(nccn.org\)](#)
15. National Comprehensive Cancer Network (NCCN). Clinical Practice Guidelines in Oncology. Biliary tract cancers. V1.2023. [btc.pdf \(nccn.org\)](#)
16. National Comprehensive Cancer Network (NCCN). Clinical Practice Guidelines in Oncology. Bone cancer. V2.2023. [bone.pdf \(nccn.org\)](#)
17. National Comprehensive Cancer Network (NCCN). Clinical Practice Guidelines in Oncology. Breast cancer. V3.2023. [breast.pdf \(nccn.org\)](#)
18. National Comprehensive Cancer Network (NCCN). Clinical Practice Guidelines in Oncology. Central nervous system cancers. V2.2022. [cns.pdf \(nccn.org\)](#)
19. National Comprehensive Cancer Network (NCCN). Clinical Practice Guidelines in Oncology. Cervical cancer. V1.2023. [cervical.pdf \(nccn.org\)](#)
20. National Comprehensive Cancer Network (NCCN). Clinical Practice Guidelines in Oncology. Esophageal and esophagogastric junction cancers. V2.2023. [esophageal.pdf \(nccn.org\)](#)
21. National Comprehensive Cancer Network (NCCN). Clinical Practice Guidelines in Oncology. Head and neck cancers. V1.2023. [head-and-neck.pdf \(nccn.org\)](#)
22. National Comprehensive Cancer Network (NCCN). Clinical Practice Guidelines in Oncology. Hepatocellular carcinoma. V1.2023. [hcc.pdf \(nccn.org\)](#)
23. National Comprehensive Cancer Network (NCCN). Clinical Practice Guidelines in Oncology. Hodgkin lymphoma. V2.2023. [hodgkins.pdf \(nccn.org\)](#)
24. National Comprehensive Cancer Network (NCCN). Clinical Practice Guidelines in Oncology. Non-small cell lung cancer. V2.2023. [nscl.pdf \(nccn.org\)](#)
25. National Comprehensive Cancer Network (NCCN). Clinical Practice Guidelines in Oncology. Pancreatic adenocarcinoma. V2.2022. [pancreatic.pdf \(nccn.org\)](#)
26. National Comprehensive Cancer Network (NCCN). Clinical Practice Guidelines in Oncology. Pediatric central nervous system cancers. V2.2023. [ped_cns.pdf \(nccn.org\)](#)
27. National Comprehensive Cancer Network (NCCN). Clinical Practice Guidelines in Oncology. Pediatric hodgkin lymphoma. V2.2023. [ped_hodgkin.pdf \(nccn.org\)](#)
28. National Comprehensive Cancer Network (NCCN). Clinical Practice Guidelines in Oncology. Prostate cancer. V1.2023. [prostate.pdf \(nccn.org\)](#)
29. National Comprehensive Cancer Network (NCCN). Clinical Practice Guidelines in Oncology. Small bowel adenocarcinoma. V1.2023. [small_bowel.pdf \(nccn.org\)](#)
30. National Comprehensive Cancer Network (NCCN). Clinical Practice Guidelines in Oncology. Thymomas and thymic carcinomas. V1.2023. [thymic.pdf \(nccn.org\)](#)
31. National Comprehensive Cancer Network (NCCN). Clinical Practice Guidelines in Oncology. Thyroid carcinoma. V3.2022. [thyroid.pdf \(nccn.org\)](#)
32. National Comprehensive Cancer Network (NCCN). Clinical Practice Guidelines in Oncology. Vulvar cancer. V1.2023. [vulvar.pdf \(nccn.org\)](#)

Approval And Revision History

March 15, 2023: Reviewed by the Medical Policy Approval Committee (MPAC). New coverage guideline created for Intensity Modulated Radiation Therapy, covered without prior authorization for effective date April 1, 2023

Subsequent endorsement date(s) and changes made:

- June 21, 2023: Reviewed by MPAC. Minor language clarifications, effective August 1, 2023

Background, Product and Disclaimer Information

Medical Necessity Guidelines are developed to determine coverage for benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. We make coverage decisions using these guidelines, along with the Member's benefit document, and in coordination with the Member's physician(s) on a case-by-case basis considering the individual Member's health care needs.

Medical Necessity Guidelines are developed for selected therapeutic or diagnostic services found to be safe and proven effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in our service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. We revise and update Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Medical Necessity Guideline and a self-insured Member's benefit document, the provisions of the benefit document will govern. For Tufts Health Together (Medicaid), coverage may be available beyond these guidelines for pediatric members under age 21 under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefits of the plan in accordance with 130 CMR 450.140 and 130 CMR 447.000, and with prior authorization.

Treating providers are solely responsible for the medical advice and treatment of Members. The use of this guideline is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to eligibility and benefits on the date of service, coordination of benefits, referral/authorization, utilization management guidelines when applicable, and adherence to plan policies, plan procedures, and claims editing logic.