Intensity-modulated radiotherapy may be considered **medically necessary** for the treatment of head and neck cancers.

Intensity-modulated radiotherapy may be considered **medically necessary** for the treatment of thyroid cancers in close proximity to organs at risk (esophagus, salivary glands, spinal cord) and 3-dimensional conformal radiotherapy planning is not able to meet dose volume constraints for normal tissue tolerance (see Policy Guidelines section).

Intensity-modulated radiotherapy is **not medically necessary** for the treatment of thyroid cancers for all indications not meeting the criteria above.

**POLICY GUIDELINES**

For this policy, head and neck cancers are those arising from the oral cavity and lip, larynx, hypopharynx, oropharynx, nasopharynx, paranasal sinuses and nasal cavity, salivary glands, and occult primaries in the head and neck region.

Organs at risk are defined as normal tissues whose radiation sensitivity may significantly influence treatment planning and/or prescribed radiation dose. These organs at risk may be particularly vulnerable to clinically important complications from radiation toxicity. Table PG1 outlines radiation doses that are generally considered tolerance thresholds for these normal structures in the area of the thyroid. Clinical documentation based on dosimetry plans may be used to demonstrate that radiation by 3-dimensional conformal radiotherapy without intensity-modulated radiotherapy would exceed tolerance doses to structures at risk.
Table PG1. Radiation Tolerance Doses for Normal Tissues

<table>
<thead>
<tr>
<th>Site</th>
<th>Portion of Organ Involved</th>
<th>TD 5/5, Gray&lt;sup&gt;a&lt;/sup&gt;</th>
<th>Portion of Organ Involved</th>
<th>TD 50/5, Gray&lt;sup&gt;b&lt;/sup&gt;</th>
<th>Complication End Point</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1/3</td>
<td>2/3</td>
<td>3/3</td>
<td>1/3</td>
<td>2/3</td>
</tr>
<tr>
<td>Esophagus</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>60 (5-10 cm)</td>
<td>58</td>
<td>55</td>
<td>72</td>
<td>70</td>
</tr>
<tr>
<td>Salivary glands</td>
<td></td>
<td>32</td>
<td>32</td>
<td>32</td>
<td>46</td>
</tr>
<tr>
<td>Spinal cord</td>
<td></td>
<td>NP</td>
<td>47 (20 cm)</td>
<td>70 (5-10 cm)</td>
<td>NP</td>
</tr>
</tbody>
</table>


NP: not provided; TD: tolerance dose.

<sup>a</sup>TD 5/5 is the average dose that results in a 5% complication risk within 5 years.

<sup>b</sup>TD 50/5 is the average dose that results in a 50% complication risk within 5 years.

CODING

The following CPT codes are used for simple and complex intensity-modulated radiotherapy delivery:

- 77385 Intensity-modulated radiation treatment delivery (IMRT), includes guidance and tracking, when performed; simple
- 77386 complex.

The Centers for Medicare & Medicaid Services decided not to implement these CPT codes and instead created HCPCS G codes with the language of the previous CPT codes. So the following codes may be used for IMRT:

- G6015 Intensity-modulated treatment delivery, single or multiple fields/arcs, via narrow spatially and temporally modulated beams, binary, dynamic multi-leaf collimator (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.

Code 77301 remains valid:

- 77301 Intensity-modulated radiotherapy plan, including dose volume histograms for target and critical structure partial tolerance specifications.

BENEFIT APPLICATION

BLUECARD/NATIONAL ACCOUNT ISSUES

State or federal mandates (eg, Federal Employee Program) may dictate that certain U.S. Food and Drug Administration–approved devices, drugs, or biologics may not be considered investigational, and thus these devices may be assessed only by their medical necessity.
BACKGROUND

HEAD AND NECK CANCERS
This evidence review focuses on cancers affecting the oral cavity and lip, larynx, hypopharynx, oropharynx, nasopharynx, paranasal sinuses and nasal cavity, salivary glands, and occult primaries in the head and neck region.

RADIOThERAPY TECHNIQUES

Conventional External-Beam Radiotherapy
Methods to plan and deliver radiotherapy (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, usually 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 were also 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).

Intensity-Modulated Radiotherapy
Intensity-modulated radiotherapy (IMRT), which uses computer software and CT and magnetic resonance imaging images, offers better conformity 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 conformity 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 continuously rotating 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 a single 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.

REGULATORY STATUS
In general, IMRT systems include intensity modulators, which control, block, or filter the intensity of radiation; and RT planning systems, which plan the radiation dose to be delivered.

A number of intensity modulators have been cleared for marketing by the U.S. Food and Drug Administration (FDA) through the 510(k) process. Intensity modulators include the Innocure Intensity Modulating Radiation Therapy Compensators (Innocure) and decimal tissue compensator (Southeastern Radiation Products), cleared in 2006. FDA product code: IXI. Intensity modulators may be added to standard linear accelerators to deliver IMRT when used with proper treatment planning systems.

Radiotherapy treatment planning systems have also been cleared for marketing by FDA through the 510(k) process. They include the Prowess Panther (Prowess) in 2003, TiGRT (LinaTech) in 2009, and the Ray Dose (RaySearch Laboratories). FDA product code: MUJ.

Fully integrated IMRT systems also are available. These devices are customizable and support all stages of IMRT delivery, including planning, treatment delivery, and health record management. One such device cleared for marketing by FDA through the 510(k) process is the Varian IMRT system (Varian Medical Systems). FDA product code: IYE.

RATIONALE
This evidence review was created in April 2009 and has been regularly updated with searches of the MEDLINE database. The most recent literature update was performed through May 28, 2019.

Evidence reviews assess the clinical evidence to determine whether the use of technology improves the net health outcome. Broadly defined, health outcomes are the length of life, quality of life (QOL), and ability to function—including benefits and harms. Every clinical condition has specific outcomes that are important to patients and managing the course of that condition. Validated outcome measures are necessary to ascertain whether a condition improves or worsens; and whether the magnitude of that change is clinically significant. The net health outcome is a balance of benefits and harms.

To assess whether the evidence is sufficient to draw conclusions about the net health outcome of technology, two domains are examined: the relevance, and quality and credibility. To be relevant, studies must represent one or more intended clinical use of the technology in the intended population and compare an effective and appropriate alternative at a comparable intensity. For some conditions,
the alternative will be supportive care or surveillance. The quality and credibility of the evidence depend on study design and conduct, minimizing bias and confounding that can generate incorrect findings. The randomized controlled trial (RCT) is preferred to assess efficacy; however, in some circumstances, nonrandomized studies may be adequate. RCTs are rarely large enough or long enough to capture less common adverse events and long-term effects. Other types of studies can be used for these purposes and to assess generalizability to broader clinical populations and settings of clinical practice.

**Head and Neck Cancers**

**Clinical Context and Test Purpose**

The purpose of intensity-modulated radiotherapy (IMRT) in patients who have head and neck cancers is to provide a treatment option that is an alternative to or an improvement on existing therapies.

The question addressed in this evidence review is: Does the use of IMRT improve the net health outcome in patients with head and neck cancers?

The following PICO(s) were used to select literature to inform this review.

**Patients**

The relevant population of interest are individuals with head and neck cancers. Head and neck cancers account for 3% to 5% of cancer cases in the U.S. The generally accepted definition of head and neck cancers includes those arising from the oral cavity and lip, larynx, hypopharynx, oropharynx, nasopharynx, paranasal sinuses, and nasal cavity, salivary glands, and occult primaries in the head and neck region. Cancers generally not considered as head and neck cancers include uveal and choroidal melanoma, cutaneous tumors of the head and neck, esophageal cancer, and tracheal cancer.

**Interventions**

The test being considered is IMRT. A proposed benefit of IMRT is to reduce toxicity to adjacent structures, allowing dose escalation to the target area and fewer breaks during treatment to reduce side effects.

IMRT is performed by radiation oncologists in an outpatient clinical setting.

**Comparators**

The following practices are currently being used to make decisions about the treatment of head and neck cancers: 3-dimensional conformal radiotherapy (3D-CRT) and 2-dimensional radiotherapy (2D-RT).

3D-CRT and 2D-RT are performed by radiation oncologists in an outpatient clinical setting.

**Outcomes**

The general outcomes of interest are locoregional control, overall survival (OS), and treatment-related morbidity. Evaluation of patient-reported outcomes and QOL measures are also of interest.

**Study Selection Criteria**

Methodologically credible studies were selected using the following principles:

- a. To assess efficacy outcomes, comparative controlled prospective trials were sought, with a preference for RCTs;
- b. In the absence of such trials, comparative observational studies were sought, with a preference for prospective studies.
c. To assess long-term outcomes and adverse events, single-arm studies that capture longer periods of follow-up and/or larger populations were sought.

d. Studies with duplicative or overlapping populations were excluded.

Systematic Reviews

Ursino et al (2017) published a systematic review of 22 studies (total n=1311 patients) evaluating swallowing outcomes in patients treated with 3D-CRT or IMRT for head and neck cancer. The heterogeneity of the population limited analysis, but reviewers concluded that IMRT produced markedly better results than 3D-CRT in terms of swallowing impairments, aspiration, pharyngeal residue, and functional parameters, especially when swallowing-related organs at risk were specifically taken into account during IMRT treatment planning. The analysis was limited by a lack of standardized evaluation questionnaires, objective instrumental parameter scores, amount and consistency of bolus administration, and timing of evaluations.

Marta et al (2014) reported on a systematic review and meta-analysis of 5 prospective phase 3 randomized trials comparing IMRT with 2D-RT or 3D-CRT for head and neck cancer. A total of 871 patients were randomized to IMRT (n=434) or to 2D-RT or 3D-CRT (n=437). Xerostomia grades 2, 3, or 4 were found to be significantly lower in patients treated with IMRT than with 2D-RT and 3D-CRT for all studies (hazard ratio, 0.76; 95% confidence interval, 0.66 to 0.87; p<0.001). Locoregional control and OS were similar across all three technologies.

A comparative effectiveness review on radiotherapy for head and neck cancers was published by Samson et al (2010) for the Agency for Healthcare Research and Quality. This report noted that, based on moderate strength evidence, IMRT reduced late xerostomia and improved QOL domains related to xerostomia compared with 3D-CRT. Reviewers also found that no conclusions on tumor control or survival could be drawn from the evidence. An update, published by Ratko et al (2014), was consistent with and strengthened the findings of the original review on late xerostomia.

Randomized Controlled Trials

I, Tandon et al (2018) published a non-blinded RCT which compared 2 fractionation schedules of IMRT for locally advanced head and neck cancer — simultaneous integrated boost (SIB-IMRT) and simultaneous modulated accelerated radiotherapy (SMART)—with the endpoint measures of toxicity, progression-free survival (PFS), and overall survival. Sixty patients with locally advanced head and neck cancer were randomized to either SIB-IMRT (control arm) or SMART (study arm). The SIB-IMRT group received 70, 63, and 56 gray (Gy) in 35 fractions to clinical target volumes 1, 2, and 3, respectively. The SMART group received 60 and 50 Gy to clinical target volumes 1 and 3, respectively. No statistically significant differences in acute or late toxicities were found between the groups except in fatigue, which was experienced by 66.7% of the control group and 40.0% of the study group (P = 0.038). At 2 years post-treatment, PFS was 53.3% and 80.0% (P = 0.028) for the SIB-IMRT and SMART groups, respectively. Two-year OS was also higher for the SMART group, with rates of 60.0% vs 86.7% (P = 0.020) for SIB-IMRT and SMART, respectively. The small sample sizes within subgroups, which result in greater standard errors and less power, may have prevented any meaningful interpretation of subgroup analysis. Also, due to cost, human papillomavirus status was not part of the pretreatment workup; the treatment response and prognosis for human papillomavirus-positive tumors are considerably different compared to human papillomavirus-negative tumors, but this factor could not be included in the analysis.

Of the 5 phase 3 RCTs included in the Marta et al (2014) meta-analysis, only 1 trial (Gupta et al [2012]) compared IMRT with 3D-CRT. Long-term results from this trial were published by Ghosh-Laskar et al.
This trial included 60 patients with squamous cell carcinoma of the head and neck and was powered to detect a 35% difference in toxicity between treatments (85% vs 50%). The proportion of patients with salivary gland toxicity was lower in the IMRT group (59%) than in the 3D-CRT group (89%; p=0.009). The percentage of patients with substantial weight loss was significantly lower in the IMRT group at one and two years. There were no significant differences between the two groups for acute dysphagia, mucositis, dermatitis, or requirements for tube feeding. Xerostomia decreased over follow-up in both groups, but significant differences in late salivary toxicity persisted through five years. At 2 years posttreatment, grade 2 or worse xerostomia was 0% in the IMRT group compared with 28% following 3D-CRT (p=0.017). At 5 years, salivary toxicity was 0% in the IMRT group compared with 17% following 3D-CRT (p=0.041). Locoregional control and OS did not differ significantly between groups.

The other 4 RCTs reviewed by Marta et al (2014) compared IMRT with 2D-RT. An RCT by Pow et al (2006) on IMRT for nasopharyngeal carcinoma (NPC) included only 45 patients. Nutting et al (2011) reported on the Parotid-sparing intensity modulated versus conventional radiotherapy in head and neck cancer, a randomized phase 3 trial, which also compared conventional RT with parotid-sparing IMRT in 94 patients with T1, T2, T3, or T4 tumor stage, and N0, N1, N2, or N3, and M0 nodal stage pharyngeal squamous cell carcinoma. One year after treatment, grade 2 or worse xerostomia was reported in 38% of patients in the IMRT group, which was significantly lower than the reported 74% in the conventional RT group. Xerostomia rates continued to be significantly lowered 2 years posttreatment in the IMRT group (29% vs 83%, respectively). At 24 months, rates of locoregional control, nonxerostomia late toxicities, and OS did not differ significantly between treatment groups.

Peng et al (2012) compared IMRT with 2D-RT in 616 patients with NPC. At a median follow-up of 42 months (range, 1-83 months), patients in the IMRT group had significantly lower radiation-induced toxicities. The 5-year OS rate was 80% in the IMRT group and 67% in the 2D-CRT group.

**Nonrandomized Comparative Studies**

Several nonrandomized comparative studies have evaluated late toxicities and QOL after treatment with IMRT, 2D-RT, and 3D-CRT.

Qiu et al (2017) published a retrospective, single-center study comparing 2D-CRT and IMRT as treatments for NPC in children and adolescents. All 176 patients (74 treated with 2D-CRT, 102 with IMRT) identified for the study were between 7 and 20 years old and treated at a single institution. The OS rate at 5 years was significantly higher for IMRT than 2D-CRT (90.4% vs 76.1%, respectively; hazard ratio, 0.30; 95% confidence interval, 0.12 to 0.78; p=0.007), as well as the 5-year disease-free survival rate (85.7% vs 71.2%, respectively; hazard ratio, 0.47; 95% confidence interval, 0.23 to 0.94; p=0.029). Grade 2, 3, and 4 xerostomia (52.7% vs 34%, respectively; p=0.015) and hearing loss (40.5% vs 22.5%, respectively; p=0.01) were also significantly lower with IMRT than with 2D-CRT. The duration of follow-up for late-onset radiation-induced toxicity and small sample size are limitations of the report.

A cross-sectional study by Huang et al (2016) assessed patients who had survived more than 5 years after treatment for NPC. Of 585 NPC survivors, data were collected on 242 patients who met study selection criteria (no history of tumor relapse or second primary cancers, cancer-free survival >5 years, completion of the self-reported questionnaire). Treatments were given from 1997 to 2007, with the transition to the IMRT system in 2002. One hundred patients were treated with IMRT. Prior to use of IMRT, treatments included 2D-RT (n=39), 3D-CRT (n=24), and 2D-RT plus 3D-CRT boost (n=79). Patients had scheduled follow-ups at 3- to 4-month intervals until five years posttreatment; then, at 6-month intervals thereafter. Late toxicities (eg, neuropathy, hearing loss, dysphagia, xerostomia, neck fibrosis) were routinely assessed at clinical visits. At the time of the study, the mean follow-up was 8.5 years.
after 2D-RT or 3D-CRT, and 6.4 years after IMRT. The IMRT group had statistically and clinically superior results for both clinician-assessed and patient-assessed (global QOL, cognitive functioning, social functioning, fatigue, and 11 scales of a head and neck module) outcomes with moderate effect sizes after adjusting for covariates (Cohen d range, 0.47-0.53). Late toxicities were less severe in the IMRT group, with adjusted odds ratios of 3.2, 4.8, 3.8, 4.1, and 5.3 for neuropathy, hearing loss, dysphagia, xerostomia, and neck fibrosis, respectively. No significant differences in late toxicities were observed between the 2D-RT and the 3D-CRT groups.


The study included 241 patients with head and neck squamous cell carcinoma (cancers arising from the oral cavity, oropharynx, hypopharynx, nasopharynx, or larynx and those with neck node metastases from squamous cell cancer of unknown primary) treated with bilateral irradiation with or without chemotherapy. All patients were included in a program that prospectively assessed acute and late morbidity and HRQOL at regular intervals. Before October 2004, all patients were treated with 3D-CRT (n=150); starting that October, 91 patients received IMRT. The use of IMRT significantly reduced the mean dose to the parotid glands (27Gy vs 43 Gy; p<0.001). During radiation, grade 3 or higher xerostomia at 6 weeks was significantly less common with IMRT (20%) than after 3D-CRT (45%). At 6 months, the prevalence of grade 2 or higher xerostomia was significantly lower after IMRT (32%) than with 3D-CRT (56%). Treatment with IMRT also had a positive effect on several general and head and neck cancer-specific HRQOL measures.


In this study, which treated 32 patients with IMRT and 23 with 3D-CRT, late xerostomia occurred in 15% of the IMRT patients and in 94% of the 3D-CRT patients.

**Section Summary: Head and Neck Cancer**

The literature on IMRT for head and neck cancer includes 4 systematic reviews, including 2 meta-analyses of RCTs, as well as RCTs and nonrandomized comparative studies. Most RCTs have compared IMRT with 2D-RT, which has been replaced by 3D-CRT. One RCT that compared IMRT with 3D-CRT found a significant benefit of IMRT for reduced xerostomia that persisted through five years. Oncologic outcomes did not differ significantly between treatments. Nonrandomized comparative studies have compared IMRT with 3D-CRT or with 2D-RT plus 3D-CRT boost. These studies support the findings that both short- and long-term xerostomia is reduced with IMRT. HRQOL was also improved with IMRT compared with 3D-CRT with 2D-RT plus 3D-CRT boost. Comparators in these nonrandomized studies were generally older technologies (eg, 2D-RT) with older treatment protocols, both of which limit interpretation of the results. However, more recent evidence has also supported the conclusions of the comparative effectiveness review that treatment of head and neck cancers with IMRT reduces xerostomia compared with other external-beam radiotherapy techniques. For the outcomes of PFS and OS, another RCT compared two fractionation schedules of IMRT and found SMART superior to SIB-IMRT in the areas of two-year PFS and OS. And an additional nonrandomized study concluded that IMRT followed by chemotherapy as opposed to IMRT alone led to better OS rates for high-risk patients. However, the evidence permits no conclusions on tumor control or survival.

**Thyroid Cancer**

**Clinical Context and Test Purpose**

The purpose of IMRT in patients who have thyroid cancer is to provide a treatment option that is an alternative to or an improvement on existing therapies.
The question addressed in this evidence review is: Does the use of IMRT improve the net health outcome in patients with thyroid cancer?

The following PICO(s) were used to select literature to inform this review.

**Patients**

The relevant population of interest are patients with thyroid cancer in close proximity to organs at risk. Anaplastic thyroid cancer occurs in less than 5% of thyroid cancers.

**Interventions**

The test being considered is IMRT. A proposed benefit of IMRT is to reduce toxicity to adjacent structures, allowing dose escalation to the target area and fewer breaks during treatment to reduce side effects. IMRT is delivered in tertiary oncology care settings where complex imaging, radiation physics, and treatment planning resources are available.

**Comparators**

The following practices are currently being used to make decisions about the treatment of thyroid cancer: 3-D CRT and 2D-RT. Conventional external-beam radiotherapy is uncommonly used in the treatment of thyroid cancers but may be considered in patients with anaplastic thyroid cancer and for locoregional control in patients with incompletely resected high-risk or recurrent differentiated (papillary, follicular, or mixed papillary-follicular) thyroid cancer. In particular, for patients with anaplastic thyroid cancer variants, which are uncommon but have often demonstrated local invasion at the time of diagnosis, RT is a critical part of locoregional therapy.

**Outcomes**

The general outcomes of interest are locoregional control, OS, and treatment-related morbidity. Evaluation of patient-reported outcomes and QOL measures are also of interest. Locoregional control and OS should be assessed at one and five years.

**Study Selection Criteria**

Methodologically credible studies were selected using the following principles:

a. To assess efficacy outcomes, comparative controlled prospective trials were sought, with a preference for RCTs;

b. In the absence of such trials, comparative observational studies were sought, with a preference for prospective studies.

c. To assess long-term outcomes and adverse events, single-arm studies that capture longer periods of follow-up and/or larger populations were sought.

d. Studies with duplicative or overlapping populations were excluded.

**Case Series**

The best available evidence for this indication consists of case series. For example, the largest series comparing IMRT with 3D-CRT was published by Bhatia et al (2010). This series reviewed institutional outcomes for anaplastic thyroid cancer treated with 3D-CRT or IMRT in 53 consecutive patients. Thirty-one (58%) patients were irradiated with curative intent. Median radiation dose was 55 Gy (range, 4-70 Gy). Thirteen (25%) patients received IMRT to a median of 60 Gy (range, 39.9-69.0 Gy). The Kaplan-Meier estimate of OS at 1 year for definitively irradiated patients was 29%. Patients without distant metastases receiving 50 Gy or more had superior survival outcomes; in this series, use of IMRT or 3D-CRT did not influence toxicity.
Schwartz et al (2009) retrospectively reviewed single-institution outcomes for patients treated for differentiated thyroid cancer with postoperative conformal external-beam radiotherapy. One hundred thirty-one consecutive patients with differentiated thyroid cancer who underwent RT between 1996 and 2005 were included. Histologic diagnoses included 104 papillary, 21 follicular, and 6 mixed papillary-follicular types. Thirty-four (26%) patients had high-risk histologic types, and 76 (58%) had recurrent disease. Extraglandular disease progression was seen in 126 (96%) patients, microscopically positive surgical margins were seen in 62 (47%) patients, and gross residual disease was seen in 15 (11%) patients. Median RT dose was 60 Gy (range, 38-72 Gy). Fifty-seven (44%) patients were treated with IMRT to a median dose of 60 Gy (range, 56-66 Gy). Median follow-up was 38 months (range, 0-134 months). Kaplan-Meier estimates of locoregional relapse-free survival, disease-specific survival, and OS at 4 years were 79%, 76%, and 73%, respectively. On multivariate analysis, high-risk histologic features, M1 (metastatic) disease, and gross residual disease were predictors for inferior disease-specific survival and OS. IMRT did not impact survival outcomes but was associated with less frequent severe late morbidity (12% vs 2%, respectively), primarily esophageal stricture.

Section Summary: Thyroid Cancer

The evidence on IMRT in individuals who have thyroid cancer includes nonrandomized, retrospective studies. High-quality studies that differentiate the superiority of any type of external-beam radiotherapy technique to treat thyroid cancer are not available. Limitations of published evidence include patient heterogeneity, variability in treatment protocols, short follow-up periods, inconsistency in reporting important health outcomes (eg, OS vs PFS or tumor control rates), and inconsistency in reporting or collecting outcomes. However, the published evidence plus additional dosimetry considerations together suggest IMRT for thyroid tumors may be appropriate in some circumstances (eg, anaplastic thyroid carcinoma) or for thyroid tumors located near critical structures (eg, salivary glands, spinal cord), similar to the situation for head and neck cancers. Given the rarity of both anaplastic thyroid cancer and papillary thyroid cancers that are not treatable by other methods, high-quality trials are unlikely. Thus, when adverse events could result if nearby critical structures receive toxic radiation doses, the ability to improve dosimetry with IMRT may be accepted as meaningful evidence for its benefit.

Summary of Evidence

For individuals who have head and neck cancer who receive IMRT, the evidence includes systematic reviews, RCTs, and nonrandomized comparative studies. The relevant outcomes are OS, functional outcomes, QOL, and treatment-related morbidity. One RCT that compared IMRT with 3D-CRT found a significant benefit of IMRT on xerostomia that persisted through five years. Oncologic outcomes did not differ significantly between treatments. Another RCT compared two fractionation schedules of IMRT for locally advanced head and neck cancer and found a benefit in using SMART boost over SIB-IMRT. Nonrandomized cohort studies have supported the findings that both short- and long-term xerostomia are reduced with IMRT. Overall, the evidence has shown that IMRT significantly and consistently reduces both early and late xerostomia and improves QOL domains related to xerostomia compared with 3D-CRT. For the outcomes of PFS and OS, another RCT compared two fractionation schedules of IMRT and found SMART superior to SIB-IMRT in the areas of two-year PFS and OS. And an additional nonrandomized study concluded that IMRT followed by chemotherapy as opposed to IMRT alone led to better OS rates for high-risk patients. The evidence is sufficient to determine that the technology results in a meaningful improvement in the net health outcome.
For individuals who have thyroid cancer in close proximity to organs at risk who receive IMRT, the evidence includes nonrandomized, retrospective studies. The relevant outcomes include OS, functional outcomes, QOL, and treatment-related morbidity. High-quality studies that differentiate the superiority of any type of external-beam radiotherapy to treat thyroid cancer are not available. However, the published evidence plus additional dosimetry considerations together suggest IMRT may be appropriate for thyroid tumors in some circumstances, such as for anaplastic thyroid carcinoma or thyroid tumors located near critical structures (eg, salivary glands, spinal cord), similar to the situation for head and neck cancers. Thus, when adverse events could result if nearby critical structures receive toxic radiation doses, the ability to improve dosimetry with IMRT might be accepted as meaningful evidence for its benefit. The evidence is sufficient to determine that the technology results in a meaningful improvement in the net health outcome.

SUPPLEMENTAL INFORMATION

Clinical Input From Physician Specialty Societies and Academic Medical Centers

While the various physician specialty societies and academic medical centers may collaborate with and make recommendations during this process, through the provision of appropriate reviewers, input received does not represent an endorsement or position statement by the physician specialty societies or academic medical centers, unless otherwise noted.

In response to requests, input was received from 2 physician specialty societies (3 reviewers) and 4 academic medical centers while this review was under review in 2012. There was a uniform consensus that intensity-modulated radiotherapy (IMRT) is appropriate for the treatment of head and neck cancers. There was an almost-uniform consensus that IMRT is appropriate in select patients with thyroid cancer. Respondents noted IMRT for head, neck, and thyroid tumors may reduce the risk of exposure to radiation in critical nearby structures (eg, spinal cord, salivary glands), thus decreasing risks of adverse effects (eg, xerostomia, esophageal stricture).

Practice Guidelines and Position Statements

National Comprehensive Cancer Network

The NCCN (v.1.2019) guidelines on head and neck cancer note that: "Advanced radiation therapy technologies such as IMRT, tomotherapy, VMAT [volumetric modulated arc therapy], image-guided radiation therapy (IGRT), and PBT [proton beam therapy] may offer clinically relevant advantages in specific circumstances to spare important organs at risk (OARS). The demonstration of significant dose-sparing of these OARS reflects best clinical practice."

The NCCN (v.1.2019) guidelines for thyroid cancer state, “IMRT is useful for thyroid cancers because of its ability to spare the larynx, brachial plexus, and esophagus.” The NCCN supports the use of intensity-modulated radiotherapy if an unresectable, gross residual disease or locoregional recurrence threatens vital structures in the neck.

U.S. Preventive Services Task Force Recommendations

Not applicable.

Medicare National Coverage

There is no national coverage determination. In the absence of a national coverage determination, coverage decisions are left to the discretion of local Medicare carriers.

Ongoing and Unpublished Clinical Trials
Some currently unpublished trials that might influence this review are listed in Table 1.

Table 1. Summary of Key Trials

<table>
<thead>
<tr>
<th>NCT No.</th>
<th>Trial Name</th>
<th>Planned Enrollment</th>
<th>Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>NCT02048254</td>
<td>A Randomized Control Trial (RCT) of Using Iodine-125 Brachytherapy Versus Intensity-modulated Radiation Therapy (IMRT) to Treat Inoperable Salivary Gland Cancer</td>
<td>90</td>
<td>Jun 2018 No related publications</td>
</tr>
</tbody>
</table>

NCT: national clinical trial.

**ESSENTIAL HEALTH BENEFITS**

The Affordable Care Act (ACA) requires fully insured non-grandfathered individual and small group benefit plans to provide coverage for ten categories of Essential Health Benefits (“EHBs”), whether the benefit plans are offered through an Exchange or not. States can define EHBs for their respective state. States vary on how they define the term small group. In Idaho, a small group employer is defined as an employer with at least two but no more than fifty eligible employees on the first day of the plan or contract year, the majority of whom are employed in Idaho. Large group employers, whether they are self-funded or fully insured, are not required to offer EHBs, but may voluntary offer them.

The Affordable Care Act requires any benefit plan offering EHBs to remove all dollar limits for EHBs.

**REFERENCES**

5. Tandon S, Gairola M, Ahlawat P, et al. Randomized controlled study comparing simultaneous modulated accelerated radiotherapy versus simultaneous integrated boost intensity modulated...


# CODES

<table>
<thead>
<tr>
<th>Codes</th>
<th>Number</th>
<th>Description</th>
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<tbody>
<tr>
<td><strong>CPT</strong></td>
<td>77301</td>
<td>Intensity-modulated radiotherapy plan, including dose volume histograms for target and critical structure partial tolerance specification</td>
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<tr>
<td>77338</td>
<td>Multi-leaf collimator (MLC) device(s) for intensity-modulated radiation therapy (IMRT), design and construction per IMRT plan</td>
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</tr>
<tr>
<td>77385</td>
<td>Intensity-modulated radiation treatment delivery (IMRT), includes guidance and tracking, when performed; simple</td>
<td></td>
</tr>
<tr>
<td>77386</td>
<td>complex</td>
<td></td>
</tr>
<tr>
<td><strong>HCPCS</strong></td>
<td>G6015</td>
<td>Intensity-modulated treatment delivery, single or multiple fields/arcs, via narrow spatially and temporally modulated beams, binary, dynamic MLC, per treatment session</td>
</tr>
<tr>
<td>G6016</td>
<td>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</td>
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<tr>
<td><strong>ICD-10-CM</strong></td>
<td>C00.0-C14.8</td>
<td>Malignant neoplasm of lip, oral cavity and pharynx code range</td>
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<tr>
<td>C30.0</td>
<td>Malignant neoplasm of nasal cavity</td>
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<tr>
<td>C31.0-C31.9</td>
<td>Malignant neoplasm of accessory sinuses code range</td>
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<td>C32.0-C32.9</td>
<td>Malignant neoplasm of larynx code range</td>
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<td><strong>ICD-10-PCS</strong></td>
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<td>Radiation oncology, ear, nose, mouth, and throat, beam radiation, codes by anatomical location and modality (photons &lt; 1 MeV, photons 1-10 MeV and photons &gt; 10 MeV)</td>
</tr>
</tbody>
</table>

*ICD-10-PCS codes are only used for inpatient services. There is no specific ICD-10-PCS code for this therapy.*
### Type of service
- Radiation oncology, anatomical regions, beam radiation, head and neck, codes by modality (photons < 1 MeV, photons 1-10 MeV and photons > 10 MeV)

### Place of service

<table>
<thead>
<tr>
<th>Date</th>
<th>Action</th>
<th>Description</th>
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<tbody>
<tr>
<td>06/12/14</td>
<td>Replace policy</td>
<td>Policy updated with literature review through May 21, 2014, references 4-5 added, added a not medically necessary policy statement for thyroid indications not included in the medically necessary statement</td>
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<tr>
<td>11/13/14</td>
<td>Replace policy – coding update only</td>
<td>New CPT and HCPCS codes added.</td>
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<tr>
<td>06/11/15</td>
<td>Replace policy</td>
<td>Policy updated with literature review through April 28, 2015; reference 4 added. Policy statements unchanged.</td>
</tr>
<tr>
<td>08/13/15</td>
<td>Replace policy</td>
<td>Policy updated with literature review through July 2, 2015; no references added. Policy statements unchanged.</td>
</tr>
<tr>
<td>08/11/16</td>
<td>Replace policy</td>
<td>Policy updated with literature review through June 6, 2016; references 4-5 and 8-9 added; references 17-18 and 20-23 updated. Rationale revised; policy statements unchanged.</td>
</tr>
<tr>
<td>07/25/17</td>
<td>Replace policy</td>
<td>Policy updated with literature review through June 2, 2017; references 17-18 and 20-23 updated. Policy statements unchanged.</td>
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<tr>
<td>07/25/18</td>
<td>Replace policy</td>
<td>Blue Cross of Idaho adopted changes as noted. Policy updated with literature review through May 24, 2018; references 1 and 10 added. Policy statements unchanged.</td>
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<tr>
<td>07/22/19</td>
<td>Replace policy</td>
<td>Blue Cross of Idaho adopted changes as noted, effective 07/22/2019. Policy updated with literature review through May 28, 2019; references added. Policy statements unchanged.</td>
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