



POLICY AND PROCEDURE MANUAL

Policy Title: Stereotactic Body Radiation Therapy (SBRT), and Intensity Modulated Radiation Therapy (IMRT)	Policy Number: F.09
Primary Department: Medical Management	NCQA Standard: N/A
Affiliated Department(s): N/A	URAC Standard: N/A
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Applicable Lines of Business: <input type="checkbox"/> MeridianCare <input checked="" type="checkbox"/> MeridianHealth <input type="checkbox"/> MeridianComplete <input checked="" type="checkbox"/> MeridianChoice	
Applicable States: <input type="checkbox"/> All <input checked="" type="checkbox"/> MI <input checked="" type="checkbox"/> IL <input type="checkbox"/> OH <input type="checkbox"/> _____ <input type="checkbox"/> _____	
Applicable Programs: <input checked="" type="checkbox"/> All <input type="checkbox"/> Other _____	
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Policy: Stereotactic Body Radiation Therapy (SBRT) and Intensity Modulated Radiation Therapy (IMRT) are a method of beam radiation therapies that very precisely deliver a high dose of radiation to an intracranial or extracranial target. This results in a high dose of radiation directed at a precise target with a much lower dose to the surrounding structures. By focusing ionizing radiation onto the desired target adjacent structures are left relatively unaffected reducing unwanted side-effects. Guidance for this process can be provided by a variety of imaging techniques, including angiography, computerized tomography (CT), and magnetic resonance imaging (MRI). Key to SBRT and IMRT is precise patient positioning and immobilization so that targeting is exact.

SBRT and IMRT can be performed with a variety of tools, including a gamma knife, Cyberknife, or linear accelerator (LINAC). IMRT is a technology for delivering highly conformal external beam radiation to a well-defined treatment volume with radiation beams whose intensity varies across the beam. IMRT is particularly useful for delivering a highly conformal radiation dose to targets positioned near sensitive normal tissues. Technologies that are used to perform SRS, SBRT, and IMRT include linear accelerators, particle beam accelerators, and multisource Cobalt 60 units. In order to enhance precision, various devices may incorporate robotics and real time imaging.

Stereotactic radiation can also be utilized in extra-cranial sites. When this is done the procedure is known as Stereotactic Body Radiation Therapy (SBRT). A body frame has been designed to immobilize patients for such treatment. In addition, frameless methods of administering SBRT to the body have been developed. These frameless systems rely on skeletal landmarks or implanted markers to locate and guide the therapy beam to treatment targets within the body.

Radiation doses for cancer treatment are measured in a unit called a gray (Gy), which is a measure of the amount of radiation energy absorbed by 1 kg of human tissue.

Procedure:

Specific Diagnoses:

SBRT

1. Primary tumors and tumors metastatic to the lung, liver, kidney, adrenal gland or pancreas.
2. Pelvic and head and neck tumors that have recurred after primary irradiation
3. Prostate Cancer

IMRT: Considered medically necessary for the following indications when there is a concern about damage to surrounding critical structures with the use of external beam or 3D conformal radiation therapy:

1. Primary, metastatic or benign tumors of the central nervous system.
2. Primary, metastatic tumors of the spine where spinal cord tolerance may be exceeded by conventional treatment.
3. Anal cancer
4. Anaplastic thyroid cancer
5. Brain tumors in close proximity to critical structures
6. Esophageal cancer where dose exceeds 50 Gy
7. Gallbladder cancer where dose exceeds 50 Gy
8. Head and neck cancers which include, but are not limited to:
 - a. Oral cavity
 - b. Lip
 - c. Glottic larynx
 - d. Nasopharynx
 - e. Hypopharynx
 - f. Supraglottic Larynx
 - g. Ethmoid sinus tumors
 - h. Salivary gland
 - i. Mucosal melanoma
 - j. Excluding T1 and T2 glottic cancer
9. Left breast cancer if the lesion is in close proximity to the heart or other cardiovascular structures; *or*
10. Lung cancer if the lesion is in close proximity to the heart or other critical structures; *or*
11. Pancreatic cancer where dose exceeds 50 Gy
12. Postoperative radiation to pelvis for endometrial cancer
13. Prostate cancer.
14. Reirradiation that meets the requirements for medical necessity

IMRT may be necessary in some gynecologic tumors or in some genitourinary tumors where its high precision is especially necessary to avoid immediately adjacent structures such as bowel or where there is a special need to avoid marrow. It may also be necessary in some lymphomas, malignant lymph nodes, or sarcomas where anatomic location gives rise to a need for special care to avoid adjacent structures. Since these are likely to be only a relatively small fraction of gynecologic tumors, genitourinary tumors, lymphomas, malignant nodes or sarcomas, in each case particular care is required to document the necessity for IMRT.

All requests **MUST** be submitted to a Medical Director for review.

All clinical criteria used to make utilization decisions for procedures mentioned in this policy come from the IRSA and ASTRO clinical practice guidelines and statements.

The National Comprehensive Cancer Network (NCCN) provides specific guidelines based on location and type of neoplasm. These guidelines are peer reviewed and considered standard of care. NCCN guidelines can be utilized for SRS, SBRT, or IMRT cases. For some tumors, multiple radiation modalities may be recommended.

In keeping with the CMS mandate to always provide the most cost-effective and efficacious care available, Meridian will cover the radiation modality that is consistent with this mandate.

Absolute Contraindications:

- All other uses of SBRT and IMRT are considered **investigational and not medically necessary**.
- Meridian considers IMRT experimental, not medically necessary for right breast cancer.

Line of Business Applicability:

This policy applies to Michigan Medicaid, Illinois Medicaid, and Individual plans.

For **Medicaid/Medicaid Expansion Plan** members, this policy will apply. Coverage is based on medical necessity criteria being met and the codes being submitted and considered for review being included on either the Michigan Medicaid Fee Schedule (located at: http://www.michigan.gov/mdch/0,1607,7-132-2945_42542_42543_42546_42551-159815--,00.html), or the Illinois Medicaid Fee Schedule (located at: <http://www.illinois.gov/hfs/MedicalProviders/MedicaidReimbursement/Pages/default.aspx>) If there is a discrepancy between this policy and either the Michigan Medicaid Provider Manual (located at: http://www.michigan.gov/mdch/0,1607,7-132-2945_5100-87572--,00.html), or the Illinois Medicaid Provider Manual (located at: <http://www.illinois.gov/hfs/MedicalProviders/Handbooks/Pages/default.aspx>) the applicable Medicaid Provider Manual will govern.

For **Individual** members, consult the individual insurance policy. If there is a discrepancy between this policy and the individual insurance policy document, the guidelines in the individual insurance policy will govern.

State specific special instructions:

- None:
- MI:
- IL:
- OH:

References:

1. IRSA. "RadioSurgery Practice Guidelines." <http://www.irsa.org/guidelines.html>
2. ASTRO. "Clinical Practice Statements." <https://www.astro.org/Clinical-Practice-Statements.aspx>
3. ASTRO. "Model Policies." <https://www.astro.org/Daily-Practice/Reimbursement/Model-Policies/Model-Policies/>
4. NCCN Guidelines

State Letters/Bulletins					
CMS National/Local Coverage Determination (NCD/LCD)					
Medicare Managed Care Manual:					
Medicaid CFR:					
State Administrative Codes:					
Contract Requirements:					
Related Policies:					