

8.01.48	Intensity-Modulated Radiotherapy: Cancer of the Head and Neck or Thyroid		
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Section:	8.0 Therapy	Page:	Page 1 of 26

Policy Statement

- I. Intensity-modulated radiotherapy (IMRT) may be considered **medically necessary** for the treatment of head and neck cancers when the cancer to be treated is **one or more** of the following:
 - A. Oral cavity and lip
 - B. Larynx
 - C. Hypopharynx
 - D. Oropharynx
 - E. Nasopharynx
 - F. Paranasal sinuses and nasal cavity
 - G. Salivary glands
 - H. Occult primaries in the head and neck region
- II. Intensity-modulated radiotherapy may be considered **medically necessary** for the treatment of thyroid or other head and neck cancers when dosimetric planning with standard 3-dimensional conformal radiotherapy predicts that the radiation dose to an adjacent organ (e.g.: esophagus, salivary glands, spinal cord) would result in unacceptable normal tissue toxicity, as documented by **one or more** of the following:
 - A. The target volume is in close proximity to critical structures that must be protected and **both** of the following: * (see source below)
 1. Planned 3D-CRT exposure to critical adjacent structures is above normal tissue constraints
 2. Planned IMRT exposure to these critical adjacent structures does not exceed normal tissue constraints
 - B. The same or immediately adjacent area has been previously irradiated and abutting portals must be established with high precision
- III. Intensity-modulated radiotherapy is **investigational** for the treatment of thyroid or other head and neck cancers for all indications not meeting the criteria above.

Image Guided Radiation Therapy (IGRT)

- IV. IGRT may be considered **medically necessary** as an approach to delivering radiotherapy when combined with any of the following treatments (see [Policy Guidelines](#)):
 - A. Intensity-modulated radiotherapy (IMRT)
 - B. Stereotactic body radiation therapy (SBRT)
 - C. Proton delivery
- V. IGRT is considered **investigational** as an approach to delivering radiotherapy when combined with any of the following treatments:
 - A. Conventional three-dimensional conformal radiation therapy (3D CRT) (see Policy Guidelines for [considerations](#))
 - B. Stereotactic radiosurgery (SRS)
 - C. Electronic brachytherapy

NOTE: Refer to [Appendix A](#) to see the policy statement changes (if any) from the previous version.

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, thyroid and occult primaries in the head and neck region.

Cancers of the central nervous system (brain, brain stem, spinal cord and some cochlea and eye cancers) are not addressed in this policy; see Blue Shield of California Medical Policy: Intensity-Modulated Radiotherapy: Central Nervous System Tumors.

*The following Normal Tissue Constraint Guidelines are derived from the textbook: Radiation Oncology: A Question-Based Review published by Lippincott Williams & Wilkins, 2010 [author: Hristov et al., 2010]. According to the author, most dosages were derived from randomized studies or consensus guidelines; however, pediatric dose constraints will vary greatly from protocol to protocol. Sources used in the development of the guidelines included the American Brachytherapy Society (ABS); Clinical practice guidelines from Johns Hopkins Hospital (JHH); the International Journal of Radiation Oncology *Biology* Physics (IJROBP); the National Comprehensive Cancer Network (NCCN), Quantitative Analyses of Normal Tissue Effects in the Clinic (QUANTEC); and the Radiation Therapy Oncology Group (RTOG) protocols at the time of publication.

The following guidelines are only intended to serve as a guide and may not be applicable to all clinical scenarios.

Organ	Constraints
Central Nervous System (1.8-2.0 Gray/fraction [Gy/fx])	
• Spinal Cord	max 50 Gy (full cord cross-section); tolerance increases by 25% 6 mos after 1st course (for re-irradiation)
• Brain	max 72 Gy (partial brain); avoid >2 Gy/fx or hyperfractionation
• Chiasm/Optic Nerves	max 55 Gy
• Brainstem	Entire brainstem <54 Gy, V59 Gy <1–10 cc
• Eyes (globe)	mean <35 Gy, max 54 Gy
• Lens	max 7 Gy
• Retina	max 50 Gy
• Lacrimal Gland	max 40 Gy
• Inner ear/cochlea	mean <=45 Gy (consider constraining to <=35 Gy with concurrent cisplatin)
• Pituitary gland	max 45 Gy (for panhypopituitarism, lower for GH deficiency)
• Cauda equina	max 60 Gy
Central Nervous System (single fraction)	
• Spinal Cord	max 13 Gy (if 3 fxs, max 20 Gy)
• Brain	V12 Gy <5–10 cc
• Chiasm/Optic Nerves	max 10 Gy
• Brainstem	max 12.5 Gy
• Sacral plexus	V18 <0.035 cc, V14.4 <5 cc
• Cauda equina	V16 <0.035 cc, V14 <5 cc
Head and Neck (1.8–2.0 Gy/fx)	
• Parotid gland(s)	mean <25 Gy (both glands) or mean <20 Gy (1 gland)
• Submandibular gland(s)	mean <35 Gy
• Larynx	mean <=44 Gy, V50 <=27%, max 63–66 Gy (when risk of tumor involvement is limited)
• TMJ/mandible	max 70 Gy (if not possible, then V75 <1 cc)

Organ	Constraints
• Oral cavity	Non-oral cavity cancer: mean <30 Gy, avoid hot spots >60 Gy Oral cavity cancer: mean <50 Gy, V55 <1 cc, max 65 Gy
• Esophagus (cervical)	V45 <33%
• Pharyngeal constrictors	mean <50 Gy
• Thyroid	V26 <20%
Thoracic (1.8–2.0 Gy/fx)	
• Brachial plexus	max 66 Gy, V60 <5%
• Lung (combined lung for lung cancer treatment)	mean <20–23 Gy, V20 <30%–35%
• Lung (ipsilateral lung for breast cancer treatment)	V25 <10%
• Single lung (after pneumonectomy)	V5 <60%, V20 <4–10%, MLD <8 Gy
• Bronchial tree	max 80 Gy
• Heart (lung cancer treatment)	Heart V45 <67%; V60 <33%
• Heart (breast cancer treatment)	V25 <10%
• Esophagus	V50 <32% ;V60 <33%
Thoracic (hypofractionation)	
Note: the max dose limits refer to volumes >0.035 cc (~3 mm ³).	
• Spinal cord	1 fraction: 14 Gy 3 fractions: 18 Gy (6 Gy/fx) 4 fractions: 26 Gy (6.5 Gy/fx) 5 fractions: 30 Gy (6 Gy/fx)
• Esophagus	1 fraction: 15.4 Gy 3 fractions: 30 Gy (10 Gy/fx) 4 fractions: 30 Gy (7.5 Gy/fx) 5 fractions: 32.5 Gy (6.5 Gy/fx)
• Brachial plexus	1 fraction: 17.5 Gy 3 fractions: 21 Gy (7 Gy/fx) 4 fractions: 27.2 Gy (6.8 Gy/fx) 5 fractions: 30 Gy (6 Gy/fx)
• Heart/Pericardium	1 fraction: 22 Gy 3 fractions: 30 Gy (10 Gy/fx) 4 fractions: 34 Gy (8.5 Gy/fx) 5 fractions: 35 Gy (7 Gy/fx)
• Great vessels	1 fraction: 37 Gy 3 fractions: 39 Gy (13 Gy/fx) 4 fractions: 49 Gy (12.25 Gy/fx) 5 fractions: 55 Gy (11 Gy/fx)
• Trachea/Large Bronchus	1 fraction: 20.2 Gy 3 fractions: 30 Gy (10 Gy/fx) 4 fractions: 34.8 Gy (8.7 Gy/fx) 5 fractions: 40 Gy (8 Gy/fx)
• Rib	1 fraction: 30 Gy 3 fractions: 30 Gy (10 Gy/fx) 4 fractions: 32 Gy (7.8 Gy/fx) 5 fractions: 32.5 Gy (6.5 Gy/fx)
• Skin	1 fraction: 26 Gy 3 fractions: 30 Gy (10 Gy/fx) 4 fractions: 36 Gy (9 Gy/fx) 5 fractions: 40 Gy (8 Gy/fx)
• Stomach	1 fraction: 12.4 Gy 3 fractions: 27 Gy (9 Gy/fx) 4 fractions: 30 Gy (7.5 Gy/fx) 5 fractions: 35 Gy (7 Gy/fx)
Gastrointestinal (GI) (1.8–2.0 Gy/fx)	
• Stomach	TD 5/5 whole stomach: 45 Gy
• Small bowel	V45 <195 cc

Organ	Constraints
• Liver (metastatic disease)	mean liver <32 Gy (liver = normal liver minus gross disease)
• Liver (primary liver cancer)	mean liver <28 Gy (liver = normal liver minus gross disease)
• Colon	45 Gy, max dose 55 Gy
• Kidney (bilateral)	mean <18 Gy, V28 <20%, V23 Gy <30%, V20 <32%, V12 <55%. If mean kidney dose to 1 kidney >18 Gy, then constrain remaining kidney to V6 <30%.
Gastrointestinal (GI) (single fraction)	
• Duodenum	V16 <0.035 cc, V11.2 <5 cc
• Kidney (Cortex)	V8.4 <200 cc
• Kidney (Hilum)	V10.6 <66%
• Colon	V14.3 <20 cc, V18.4 <0.035 cc
• Jejunum/Ileum	V15.4 <0.035 cc, V11.9 <5 cc
• Stomach	V16 <0.035 cc, V11.2 <10 cc
• Rectum	V18.4 <0.035 cc, V14.3 <20 cc
Genitourinary (GU) (1.8-2.0 Gy/fx)	
• Femoral heads	V50 <5%
• Rectum	V75 <15%, V70 <20%, V65 <25%, V60 <35%, V50 <50%
• Bladder	V80 <15%, V75 <25%, V70 <35%, V65 <50%
• Testis	V3 <50%
• Penile bulb	Mean dose to 95% of the volume <50 Gy. D70 </=70 Gy, D50 </=50 Gy
Genitourinary (GU) (LDR prostate brachytherapy)	
• Urethra	Volume of urethra receiving 150% of prescribed dose (Ur150) <30%
• Rectum	Volume of rectum receiving 100% of prescribed dose (RV100) <0.5 cc
Gynecological (GYN)	
• Bladder point (cervical brachytherapy)	Max 80 Gy (LDR equivalent dose)
• Rectal point (cervical brachytherapy)	Max 75 Gy (LDR equivalent dose)
• Proximal vagina (mucosa) (cervical brachytherapy)	Max 120 Gy (LDR equivalent dose)
• Distal vagina (mucosa) (cervical brachytherapy)	Max 98 Gy (LDR equivalent dose)

Coding

Image Guided Radiation Therapy (IGRT) Considerations:

The following codes are for hospital outpatient IMRT/SBRT delivery use which includes image guidance in the delivery code for the facility (technical, or -TC modifier) component. However, the professional component (-26 modifier) is still allowed for payment.

- **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
- **77373:** Stereotactic body radiation therapy, treatment delivery, per fraction to 1 or more lesions, including image guidance, entire course not to exceed 5 fractions

Note: Proton delivery codes do not include image guidance, so IGRT codes for both TC and professional components can be billed separately when indicated. IGRT may be indicated for some conventional 3D CRT cases such as a morbidly obese individual with an abdominal target in which standard approaches for guidance are inadequate. Cases can be considered for approval on an individual basis

The Centers for Medicare & Medicaid Services (CMS) did not implement the above mentioned CPT codes (77385 & 77386) and instead created HCPCS G codes for freestanding outpatient centers. The following delivery codes may also be used for IMRT depending on the setting. They do not include image guidance, so both the technical and professional components are allowed when criteria are met.

- **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

The following codes are typical for IGRT. Up to one unit per session can be allowed (although balanced by additional radiation for the imaging, so IGRT may not take place with every treatment session).

- **77014:** Computed tomography guidance for placement of radiation therapy fields
- **G6001:** Ultrasonic guidance for placement of radiation therapy fields
- **G6002:** Stereoscopic x-ray guidance for localization of target volume for the delivery of radiation therapy

The following codes do not have a technical (facility) component but can be used for professional services only. Since there is no specific code for MRI guidance, 77387 can be considered for approval for professional services for MRI guidance when appropriate documentation is submitted, but can also be used for other types of guidance.

- **77387:** Guidance for localization of target volume for delivery of radiation treatment, includes intrafraction tracking, when performed
- **G6017:** Intra-fraction localization and tracking of target or patient motion during delivery of radiation therapy (e.g., 3D positional tracking, gating, 3D surface tracking), each fraction of treatment

Note: G6017 does not have a technical (facility) component (usually done by a technician covered by the facility delivery fee), and intra-fraction tracking is unusual to involve physician guidance, so documentation of that service should be provided if billed for professional services.

Code 77301 remains valid:

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

Code 77338 is to be reported only once per IMRT plan:

- **77338:** Multi-leaf collimator (MLC) device(s) for intensity modulated radiation therapy (IMRT), design and construction per IMRT plan

The following codes may also be used:

- **77261:** Therapeutic radiology treatment planning; simple
- **77262:** Therapeutic radiology treatment planning; intermediate
- **77263:** Therapeutic radiology treatment planning; complex
- **77293:** Respiratory motion management simulation (List separately in addition to code for primary procedure)
- **77300:** Basic radiation dosimetry calculation, central axis depth dose calculation, TDF, NSD, gap calculation, off axis factor, tissue inhomogeneity factors, calculation of non-ionizing radiation surface and depth dose, as required during course of treatment, only when prescribed by the treating physician

- **77306:** Teletherapy isodose plan; simple (1 or 2 unmodified ports directed to a single area of interest), includes basic dosimetry calculation(s)
- **77307:** Teletherapy isodose plan; complex (multiple treatment areas, tangential ports, the use of wedges, blocking, rotational beam, or special beam considerations), includes basic dosimetry calculation(s)
- **77331:** Special dosimetry (e.g., TLD, microdosimetry) (specify), only when prescribed by the treating physician
- **77332:** Treatment devices, design and construction; simple (simple block, simple bolus)
- **77334:** Treatment devices, design and construction; complex (irregular blocks, special shields, compensators, wedges, molds or casts)
- **77370:** Special medical radiation physics consultation
- **77470:** Special treatment procedure (e.g., total body irradiation, hemibody radiation, per oral or endocavitary irradiation)
- **77336:** Continuing medical physics consultation, including assessment of treatment parameters, quality assurance of dose delivery, and review of patient treatment documentation in support of the radiation oncologist, reported per week of therapy
- **77427:** Radiation treatment management, 5 treatments
- **77417:** Therapeutic radiology port image(s)

Allowable Codes and Frequencies for IMRT/Proton

Description	Code	Maximum per course of treatment	Notes
For IMRT: IGRT (Image Guided Radiation Therapy)	77014 (CT) 77387 (any) G6001 (stereotactic) G6002 (US) G6017	Professional portion allowed for up to 1 unit for each delivery session when provided	Facility fee (TC) included with delivery codes 77385/ 77386/ 77373 for IMRT/ SBRT. 77387 and G6017 are for pro fee only. Others need - 26 modifier for approval
For Proton: IGRT (Image Guided Radiation Therapy)	77014, 77387, G6001, G6002, G6017	Up to 1 unit per delivery session when provided	Facility fee (TC) not included with delivery codes for proton so they can be billed. 77387 and G6017 are for pro fee only. Others need - 26 or TC modifiers.
Clinical Treatment Planning	77261, 77262 or 77263	1	
Simulation	77280, 77285, 77290	0	May not be billed with 77301. 1 unit of 77290 + 1 boost is allowed for proton therapy when using 77295 instead
Verification Simulation	77280	0	One per simulation allowed
Respiratory Motion Management	77293	0	1 for breast, lung, and upper abdominal or thoracic cancer areas
3D CRT Plan	77295	0	May not be billed with 77301. 1 unit may be allowed for proton therapy.
IMRT Plan	77301	1	If comparison 3D plan is generated, it is included in 77301
Basic Dosimetry	77300	4+ 1 boost, up to a max of 10 with documentation	0 if billed with 77306, 77307, 77321, 0394T or 0395T
Teletherapy Isodose Plan, Simple	77306	1 for mid-Tx change in volume/contour	Not on the same day as 77300; may not bill 77306 and 77307 together; documentation of medical necessity is required for more than 1
Teletherapy Isodose Plan, Complex	77307	1 for mid-Tx change in volume/contour	Not on the same day as 77300; may not bill 77306 and 77307 together; documentation of medical necessity is required for more than 1
Special Dosimetry Calculation	77331	0	Needs documentation for review

Description	Code	Maximum per course of treatment	Notes
Treatment Devices, Designs, and Construction	77332, 77333, 77334	1, 5 or 10	-If billed w/ MLC (77338): 1 -If billed w/o MLC: 5 (any combination) -More may be allowed when documentation of medical necessity is provided (such as additional beams), maximum of 10
Multi-leaf Collimator (MLC)	77338	1	MLC may not be reported in conjunction with HCPCS G6016
Special Radiation Physics Consult	77370	0	May allow x 1; documentation of medical necessity required
Special MD Consultation (Special Tx Procedure)	77470	0	May allow x 1; documentation of medical necessity required
Medical Physics Management	77336	8	Allowed once per 5 courses of therapy
Radiation Treatment Management	77427	8	Allowed once per 5 courses of therapy
Radiation (IMRT or Proton) Delivery, prostate and breast cancer	IMRT 77385 or G6015; Proton 77520, 77522, 77523	Using IMRT or Proton: 28 for prostate cancer Using IMRT only: -16 for breast cancer without boost -24 for breast cancer with boost (IMRT only)	Prostate cancer: Documentation of medical necessity needed for more than 28 treatments Breast cancer: documentation of medical necessity needed for treatments beyond 16 IMRT delivery sessions without boost and/or 24 IMRT delivery sessions with boost.
Radiation (IMRT or Proton) Delivery, all other cancers	IMRT 77385, 77386; or G6015-G6016; Proton 77520, 77522, 77523, 77525	No limit	All cancers other than hypofractionated prostate or breast

Description

Radiotherapy (RT) is an integral component in the treatment of head and neck cancers. Intensity-modulated radiotherapy (IMRT) has been proposed as a method to allow adequate radiation to the tumor, minimizing the radiation dose to surrounding normal tissues and critical structures.

Related Policies

- Intensity-Modulated Radiotherapy: Abdomen, Pelvis and Chest
- Radiation Oncology
- Stereotactic Radiosurgery and Stereotactic Body Radiotherapy

Benefit Application

Benefit determinations should be based in all cases on the applicable contract language. To the extent there are any conflicts between these guidelines and the contract language, the contract language will control. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage of these services as it applies to an individual member.

Some state or federal mandates (e.g., Federal Employee Program [FEP]) prohibits plans from denying Food and Drug Administration (FDA)-approved technologies as investigational. In these

instances, plans may have to consider the coverage eligibility of FDA-approved technologies on the basis of medical necessity alone.

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 and 2004, respectively. 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 the 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 the FDA through the 510(k) process is the Varian IMRT system (Varian Medical Systems). FDA product code: IYE.

Rationale

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

Radiation therapy may be administered externally (i.e., a beam of radiation is directed into the body) or internally (i.e., a radioactive source is placed inside the body, near a tumor).¹ External radiotherapy (RT) techniques include "conventional" or 2-dimensional (2D) RT, 3-dimensional (3D) conformal RT, and intensity-modulated radiation therapy (IMRT).

Conventional External-Beam Radiotherapy

Methods to plan and deliver RT have evolved that permit more precise targeting of tumors with complex geometries. Conventional 2D treatment planning utilizes X-ray films to guide and position radiation beams.¹ Bony landmarks visualized on X-ray are used to locate a tumor and direct the radiation beams. The radiation is typically of uniform intensity.

Three-Dimensional Conformal Radiotherapy

Radiation treatment planning has evolved to use 3D images, usually from computed tomography (CT) scans, to more precisely delineate the boundaries of the tumor and to discriminate tumor tissue from adjacent normal tissue and nearby organs at risk for radiation damage. Three-dimensional conformal RT (3D-CRT) involves initially scanning the patient in the position that will be used for the radiation treatment.¹ The tumor target and surrounding normal organs are then outlined in 3D on the scan. Computer software assists in determining the orientation of radiation beams and the amount of radiation the tumor and normal tissues receive to ensure coverage of the entire tumor in order to minimize radiation exposure for at risk normal tissue and nearby organs. Other imaging

techniques and devices such as multileaf collimators (MLCs) may be used to "shape" the radiation beams. Methods have also been developed to position the patient and the radiation portal reproducibly for each fraction and to immobilize the patient, thus maintaining consistent beam axes across treatment sessions.

Intensity-Modulated Radiotherapy

Intensity-modulated radiotherapy is the more recent development in external radiation. Treatment planning and delivery are more complex, time-consuming, and labor-intensive for IMRT than for 3D-CRT. Similar to 3D-CRT, the tumor and surrounding normal organs are outlined in 3D by a scan and multiple radiation beams are positioned around the patient for radiation delivery.¹ In IMRT, radiation beams are divided into a grid-like pattern, separating a single beam into many smaller "beamlets". Specialized computer software 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 is proposed to 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.

Other advanced techniques 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 more precisely deliver RT to the target volume.

Literature Review

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, 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, 2 domains are examined: the relevance, and quality and credibility. To be relevant, studies must represent 1 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. Randomized controlled trials are rarely large 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.

Promotion of greater diversity and inclusion in clinical research of historically marginalized groups (e.g., People of Color [African-American, Asian, Black, Latino and Native American]; LGBTQIA (Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Asexual); Women; and People with Disabilities [Physical and Invisible]) allows policy populations to be more reflective of and findings more applicable to our diverse members. While we also strive to use inclusive language related to these groups in our policies, use of gender-specific nouns (e.g., women, men, sisters, etc.) will continue when reflective of language used in publications describing study populations.

Head and Neck Cancers

Clinical Context and Therapy Purpose

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

The following PICO was used to select literature to inform this review.

Populations

The relevant population of interest is individuals with head and neck cancers. Head and neck cancers account for about 4% of all cancer cases in the U.S.² 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.

Comparators

The following practices are currently being used to treat cancer of the head and neck: 3-dimensional conformal radiotherapy (3D-CRT) and 2-dimensional radiotherapy (2D-RT).

Outcomes

The general outcomes of interest are overall survival (OS), functional outcomes, and treatment-related morbidity (e.g. xerostomia). Evaluation of patient-reported outcomes and quality of life measures are also of interest.

Study Selection Criteria

Methodologically credible studies were selected using the following principles:

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

Review of Evidence

Systematic Reviews

Systematic reviews have evaluated IMRT compared to 2D-RT or 3D-CRT in patients with head and neck cancers. A comparison of the trials in more recent systematic reviews that included outcomes of interest is shown in Table 1. These systematic reviews included a total of 22 articles published between

2006 and 2018. Characteristics and results of these reviews are summarized in Tables 2 and 3. Overall, Du et al (2019)³ and Luo et al (2019)⁴ reported significantly improved OS, locoregional free survival/control, and progression- or disease-free survival (PFS or DFS) with IMRT versus 2D-RT or 3D-CRT among patients with nasopharyngeal carcinoma (NPC). Marta et al (2014)⁵ concluded that IMRT, when compared with 2D-RT or 3D-CRT, had no significant impact on OS or loco-regional control in previously untreated patients with non-metastatic head and neck cancers. The incidence of xerostomia was significantly reduced with IMRT as compared to patients undergoing 2D-RT or 3D-CRT.^{5,3}

There are inherent limitations to the data within some of these systematic reviews, including the prevalence of retrospective and nonrandomized study designs. Some studies had small sample sizes of 20 to 50 subjects. Studies also varied considerably with regard to tumor stage, length of follow-up, and radiological dose. All of these variations contributed to heterogeneity of the data. Additionally, 1 of the reviews specifically noted the existence of publication bias for the OS outcome.³

Table 1. Trials Included in Systematic Reviews of IMRT Versus 2D-RT or 3D-CRT

Trials	Systematic Reviews		
Kam et al (2007) ⁶	Marta et al (2014) ⁵	Luo et al (2019) ⁴	Du et al (2019) ³

Study	Dates	Trials	Participants	N (Range)	Design	Duration
Marta et al (2014) ⁵	To December 20, 2012	5 (6 publications corresponding to 5 trials)	Previously untreated patients with non-metastatic head and neck cancers treated with RT either primarily or combined with surgery or chemotherapy with or without brachytherapy boost	871 (45 to 616)	Prospective RCTs; 4 studies compared 2D-RT with IMRT	Follow-up data evaluated up to 5 years for certain outcomes

2D-RT: two-dimensional radiotherapy; 3D-CRT: three-dimensional conformal radiotherapy; CRT: conformal radiotherapy; IMRT: intensity-modulated radiotherapy; RCT: randomized controlled trial; RT: radiotherapy.

Table 3. Results of Systematic Reviews of IMRT versus 2D-RT or 3D-CRT

Study	Overall survival	Locoregional free survival/control rate	Progression- or disease-free survival	Metastasis-free survival	Xerostomia
Du et al (2019) ³		Local-regional free survival			
Total N	10,851	13,003	9380	10,432	1764
Pooled effect OR (95% CI)	1.70 (1.36 to 2.21) at 5 years	2.08 (1.82 to 2.37) at 5 years	1.40 (1.26 to 1.56) at 5 years	1.11 (0.99 to 1.24)	0.21 (0.09 to 0.51)
I²; p value	68.7%;.007	20.7%;.272	0%;.446	17.9%;.301	87.3%;.00
Luo et al (2019) ⁴		Locoregional control			
Total N	13,018	13,899	2464	4171	
Pooled effect OR (95% CI); p value	0.51 (0.41 to 0.65); <.00001	0.59 (0.52 to 0.67); <.00001	0.77 (0.65 to 0.91);.002	0.71 (0.54 to 0.94);.01	
I²; p value	63%;.002	44%;.06	38%;.15	54%;.03	
Marta et al (2014) ⁵		Locoregional control			
Total N	770	770			826
Pooled effect HR (95% CI); p value	1.12 (0.97 to 1.29);.11	1.07 (0.93 to 1.23);.35			0.76 (0.66 to 0.87); <.0001
I²; p value		0%; NR			0%; NR

2D-RT: two-dimensional radiotherapy; 3D-CRT: three-dimensional conformal radiotherapy; CI: confidence interval; HR: hazard ratio; NR: not reported; OR: odds ratio.

In addition, to the systematic reviews summarized in Tables 1 to 3, Ursino et al (2017) published a systematic review of 22 studies (N=1311 patients) that focused specifically on swallowing outcomes in patients treated with 3D-CRT or IMRT for head and neck cancer.²⁸ 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.

Ge et al (2020) recently evaluated the effects of IMRT as compared to conventional RT with regard to quality of life and xerostomia severity in 761 patients with head and neck cancer.²⁹ This meta-analysis included data from 7 studies: 3 RCTs, 2 prospective studies, 1 prospective case control study, and 1 retrospective study. Overall, patients who underwent IMRT had a better global health status (pooled standardized mean difference [SMD], 0.80; 95% confidence interval [CI], 0.26 to 1.35; p=.004) and improved cognitive function (pooled SMD, 0.30; 95% CI, 0.06 to 0.54; p=.013) as compared to patients who underwent conventional radiotherapy (RT). Intensity-modulated radiotherapy was also

associated with significantly lower scores for xerostomia than conventional RT (pooled SMD, -0.60; 95% CI, -0.97 to -0.24; $p=.001$). There were no differences between the groups with regard to emotional function ($p=.531$) and social function ($p=.348$). The analysis was limited by a small number of included studies, heterogeneity of data, and relatively small sample sizes.

Razavian et al (2023) performed a systematic review and meta-analysis that compared IMRT to 2D-RT or 3D-CRT in patients with early stage squamous cell carcinoma of the glottic larynx.³⁰ A total of 15 studies (14 retrospective, 1 prospective) consisting of 2083 patients were included. Among the studies ($n=5$) that reported outcomes of both treatment modalities (IMRT and 2D-RT/3D-CRT), no significant difference was found in the rate of local failure between the 2 modalities (log odds ratio, -0.48; 95% CI, -1.09 to 0.14; $p=.12$). Similarly, no significant difference was found in the rate of regional failure between the 2 modalities (log odds ratio, 0.25; 95% CI, -0.66 to 1.16; $p=.58$). Notably, all 5 studies used for the direct comparison between the 2 treatment techniques were retrospective, and employed different IMRT techniques and heterogeneous methods for treatment volume delineation. Despite these limitations, authors state that pooled outcomes data found that IMRT for early glottis larynx cancer is associated with low rates of local and regional failure, which are in line with historic outcomes of 2D-RT/3D-CRT.

Randomized Controlled Trials

Beyond the trials included in the systematic reviews, 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, PFS, and OS.³¹ Characteristics and results of this RCT are summarized in Tables 4 and 5. 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 clinical target volumes 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 ($p=.038$). At 2 years post-treatment, PFS and OS were improved for the SMART versus SIB-IMRT group (Table 5). 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 (HPV) status was not part of the pre-treatment workup; the treatment response and prognosis for HPV-positive tumors are considerably different compared to HPV-negative tumors, but this factor could not be included in the analysis. Relevance, study design, and conduct limitations of the RCT are detailed in Tables 6 and 7.

Table 4. Characteristics of an RCT Comparing SIB-IMRT versus SMART

Study	Countries	Sites	Dates	Participants	Interventions
Tandon et al (2018) ³¹	India	1	June 2014 to March 2016	Adults (18 to 65 years) with Stage III or non-metastatic Stage IV locally advanced head and neck cancer	RT using standard SIB-IMRT fractionation RT using SMART boost technique

RCT: randomized controlled trial; RT: radiotherapy; SIB-IMRT: simultaneous integrated boost-intensity-modulated radiotherapy; SMART: simultaneous modulated accelerated radiotherapy.

Table 5. Results of the SIB-IMRT versus SMART RCT

Study	Overall survival (2 years)	Progression-free survival (2 years)
Tandon et al (2018) ³¹		
N	NR	NR
SIB-IMRT	60%	53.3%
SMART	86.7%	80%
p value	.02	.28

NR: not reported; RCT: randomized controlled trial; SIB-IMRT: simultaneous integrated boost-intensity-modulated radiotherapy; SMART: simultaneous modulated accelerated radiotherapy.

Table 6. Study Relevance Limitations of the SIB-IMRT versus SMART RCT

Study	Population ^a	Intervention ^b	Comparator ^c	Outcomes ^d	Duration of follow-up ^e
Tandon et al (2018)³¹	4. Small sample sizes within each subgroup			1. Locoregional control not addressed	

RCT: randomized controlled trial; SIB-IMRT: simultaneous integrated boost-intensity-modulated radiotherapy; SMART: simultaneous modulated accelerated radiotherapy.

The study limitations stated in this table are those notable in the current review; this is not a comprehensive gaps assessment.

^aPopulation key: 1. Intended use population unclear; 2. Clinical context is unclear; 3. Study population is unclear; 4. Study population not representative of intended use.

^bIntervention key: 1. Not clearly defined; 2. Version used unclear; 3. Delivery not similar intensity as comparator; 4. Not the intervention of interest.

^cComparator key: 1. Not clearly defined; 2. Not standard or optimal; 3. Delivery not similar intensity as intervention; 4. Not delivered effectively.

^dOutcomes key: 1. Key health outcomes not addressed; 2. Physiologic measures, not validated surrogates; 3. No CONSORT reporting of harms; 4. Not establish and validated measurements; 5. Clinical significant difference not prespecified; 6. Clinical significant difference not supported.

^eFollow-Up key: 1. Not sufficient duration for benefit; 2. Not sufficient duration for harms.

Table 7. Study Design and Conduct Limitations of the SIB-IMRT versus SMART RCT

Study	Allocation ^a	Blinding ^b	Selective reporting ^c	Data Completeness ^d	Power ^e	Statistical ^f
Tandon et al (2018)³¹	3. Allocation using "chit method"	1, 2		1. During follow-up, there were 11 disease-related deaths (7 SIB-IMRT; 4 SMART) and 4 non-disease-related deaths each in both arms	3. Sample size calculated based on historical trials; power analysis done to detect a difference in incidence of toxicity not survival	1. Survival statistics required still follow-up for deriving clinically meaningful results

RCT: randomized controlled trial; SIB-IMRT: simultaneous integrated boost-intensity-modulated radiotherapy; SMART: simultaneous modulated accelerated radiotherapy.

The study limitations stated in this table are those notable in the current review; this is not a comprehensive gaps assessment.

^aAllocation key: 1. Participants not randomly allocated; 2. Allocation not concealed; 3. Allocation concealment unclear; 4. Inadequate control for selection bias.

^bBlinding key: 1. Not blinded to treatment assignment; 2. Not blinded outcome assessment; 3. Outcome assessed by treating physician.

^cSelective Reporting key: 1. Not registered; 2. Evidence of selective reporting; 3. Evidence of selective publication.

^dData Completeness key: 1. High loss to follow-up or missing data; 2. Inadequate handling of missing data; 3. High number of crossovers; 4. Inadequate handling of crossovers; 5. Inappropriate exclusions; 6. Not intent to treat analysis (per protocol for noninferiority trials).

^ePower key: 1. Power calculations not reported; 2. Power not calculated for primary outcome; 3. Power.

^fStatistical key: 1. Analysis is not appropriate for outcome type: (a) continuous; (b) binary; (c) time to event; 2. Analysis is not appropriate for multiple observations per patient; 3. Confidence intervals and/or p values not reported; 4. Comparative treatment effects not calculated.

Nonrandomized Comparative Studies

Nonrandomized comparative studies have evaluated late toxicities and quality-of-life 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.¹² 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 [HR], 0.30; 95% CI, 0.12 to 0.78; $p=.007$), as well as the 5-year DFS rate (85.7% vs. 71.2%, respectively; HR, 0.47; 95% CI, 0.23 to 0.94; $p=.029$). Grade 2, 3, and 4 xerostomia (52.7% vs. 34%, respectively; $p=.015$) and hearing loss (40.5% vs. 22.5%, respectively; $p=.01$) 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.³² 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 5 years posttreatment; then, at 6-month intervals thereafter. Late toxicities (e.g., 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 quality-of-life, 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 to 0.53). Late toxicities were less severe in the IMRT group, with adjusted odd ratios (ORs) 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.

Section Summary: Head and Neck Cancer

The literature on IMRT for head and neck cancer includes systematic reviews as well as RCTs and nonrandomized comparative studies. Some of the most recently published systematic reviews compared IMRT to 2D-RT and 3D-CRT in patients with NPC. Results revealed a significant improvement in clinical oncologic outcomes (e.g., OS, PFS, locoregional control/survival) and toxicities such as xerostomia with IMRT in this patient population. A 2014 systematic review concluded that IMRT, when compared with 2D-RT or 3D-CRT, had no significant impact on OS or locoregional control in previously untreated patients with non-metastatic head and neck cancers; however, a significant improvement in xerostomia was observed with IMRT. A 2023 systematic review concluded that retrospective data suggest that local and regional control are similar for patients with early stage glottic cancer treated with IMRT and 2D-RT or 3D-CRT. 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. Health-related quality of life was also improved with IMRT compared with 3D-CRT or with 2D-RT plus 3D-CRT boost. Comparators in these nonrandomized studies were generally older technologies (e.g., 2D-RT) with older treatment protocols, both of which limit interpretation of the results. For the outcomes of PFS and OS, another RCT compared 2 fractionation schedules of IMRT and found SMART superior to SIB-IMRT in the areas of 2-year PFS and OS.

Thyroid Cancer

Clinical Context and Therapy Purpose

The purpose of IMRT in individuals who have thyroid cancer is to provide a treatment option that is an alternative to or an improvement on existing therapies.

The following PICO was used to select literature to inform this review.

Populations

The relevant population of interest is individuals with thyroid cancer in close proximity to organs at risk. Anaplastic thyroid cancer occurs in less than 2% of patients with thyroid cancer.³³

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.

Comparators

The following practices are currently being used to treat cancer of the thyroid: 3D-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 OS, functional outcomes, and treatment-related morbidity. Evaluation of patient-reported outcomes and quality of life measures are also of interest. Locoregional control and OS should be assessed at 1 and 5 years.

Study Selection Criteria

Methodologically credible studies were selected using the following principles:

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

Review of Evidence

Case Series

The best available evidence for this indication consists of case series. For example, Bhatia et al (2010) published a series that reviewed institutional outcomes for anaplastic thyroid cancer treated with 3D-CRT or IMRT in 53 consecutive patients.³⁴ Thirty-one (58%) patients were irradiated with curative intent. Median radiation dose was 55 Gy (range, 4 to 70). Thirteen (25%) patients received IMRT to a median of 60 Gy (range, 39.9 to 69.0). 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 RT.³⁵ 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 to 72). Fifty-seven (44%) patients were treated with IMRT to a median dose of 60 Gy (range, 56 to 66). Median follow-up was 38 months (range, 0 to 134). 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. Intensity-modulated radiotherapy 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 case series data. High-quality studies that differentiate the superiority of any type of external-beam RT 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 (e.g., 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 (e.g., anaplastic thyroid carcinoma) or for thyroid tumors located near critical structures (e.g., 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.

Supplemental Information

The purpose of the following information is to provide reference material. Inclusion does not imply endorsement or alignment with the evidence review conclusions.

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.

2012 Input

In response to requests, input was received from 2 physician specialty societies (3 reviewers) and 4 academic medical centers while this policy 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 a near 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 (e.g., spinal cord, salivary glands), thus decreasing risks of adverse effects (e.g., xerostomia, esophageal stricture).

Practice Guidelines and Position Statements

Guidelines or position statements will be considered for inclusion in 'Supplemental Information' if they were issued by, or jointly by, a US professional society, an international society with US representation, or National Institute for Health and Care Excellence (NICE). Priority will be given to guidelines that are informed by a systematic review, include strength of evidence ratings, and include a description of management of conflict of interest.

National Comprehensive Cancer Network

The National Comprehensive Cancer Network (NCCN; v1.2023) guideline on head and neck cancers notes that: "Advanced RT [radiation therapy] technologies such as IMRT, tomotherapy, VMAT [volumetric modulated arc therapy], image-guided RT (IGRT), and PBT [proton beam therapy] may offer clinically relevant advantages in specific circumstances to spare important organs at risk (OARs)...and decrease the risk for late, normal tissue damage while still achieving the primary goal of local tumor control.³⁶ The demonstration of clinically significant dose-sparing of these OARS reflects best clinical practice." The NCCN guideline also notes that "randomized studies to test [advanced radiation therapy technologies] are unlikely to be done since specific clinical scenarios represent complex combinations of multiple variables. In light of that, the modalities and techniques that are

found best to reduce the doses to the clinically relevant OARs without compromising target coverage should be considered."

The NCCN (v1.2023) guideline for thyroid cancer states, "EBRT [external-beam radiotherapy] or IMRT can increase short-term survival in some patients with anaplastic thyroid carcinoma; EBRT or IMRT can also improve local control and can be used for palliation (e.g., to prevent asphyxiation)." Additionally, the guideline notes, "IMRT may be useful to reduce toxicity" in these patients.³⁷ The NCCN also states that the use of IMRT can be considered if an unresectable gross residual disease or locoregional recurrence threatens vital structures in the neck.

American Thyroid Association

The American Thyroid Association published guidelines for the management of patients with anaplastic thyroid cancer in 2021.³⁸ These guidelines contained the following recommendations regarding use of IMRT:

- "Following R0 or R1 resection, we recommend that good performance status patients with no evidence of metastatic disease who wish an aggressive approach should be offered standard fractionation IMRT with concurrent systemic therapy.
Strength of recommendation: strong; Quality of evidence: low.
- We recommend that patients who have undergone R2 resection or have unresectable but nonmetastatic disease with good performance status and who wish an aggressive approach be offered standard fractionation IMRT with systemic therapy.
Strength of recommendation: strong; Quality of evidence: low.
- Among patients who are to receive radiotherapy for unresectable thyroid cancer or in the postoperative setting, IMRT is recommended.
Strength of recommendation: strong; Quality of evidence: low."

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 8.

Table 8. Summary of Key Trials

NCT No.	Trial Name	Planned Enrollment	Completion Date
NCT01220583	A Randomized Phase II/Phase III Study of Adjuvant Concurrent Radiation and Chemotherapy Versus Radiation Alone in Resected High-Risk Malignant Salivary Gland Tumors	252	Oct 2028
NCT04448522	A Multicenter Randomized Controlled Trial Comparing Reduced Dose With Regular Dose Intensity-modulated Radiotherapy for Chemotherapy Sensitive Stage II-III Nasopharyngeal Carcinoma	508	Aug 2028
NCT05187091	The SWOAR Trial: A Phase III Trial Evaluating Sparing of Swallowing and Aspiration Related Organs at Risk & Submandibular Gland With Intensity Modulated Radiotherapy Versus Standard IMRT in Head and Neck Squamous Cell Carcinomas	136	Jun 2025
NCT03669432	Phase II Randomized Controlled Trial Of Postoperative Intensity Modulated Radiotherapy (IMRT) in Locally Advanced Thyroid Cancers	72	Jul 2026

NCT No.	Trial Name	Planned Enrollment	Completion Date
NCT03164460	Phase II Randomized Trial of Stereotactic Onco-Ablative Reirradiation Versus Conventionally Fractionated Conformal Radiotherapy for Patients With Small Inoperable Head and Neck Tumors (SOAR-HN)	100	May 2023

NCT: national clinical trial.

References

- Misher C. Radiation therapy: which type is right for me? University of Pennsylvania. OncoLink site. Reviewed March 16, 2022. https://www.oncolink.org/print/pdf/5965?print_5938_radiation_therapy_which_type_is_right_for_me.pdf. Accessed May 10, 2023.
- American Society of Clinical Oncology. Cancer.Net site. Head and neck cancer: statistics. March 2023. <https://www.cancer.net/cancer-types/head-and-neck-cancer/statistics>. Accessed May 10, 2023.
- Du T, Xiao J, Qiu Z, et al. The effectiveness of intensity-modulated radiation therapy versus 2D-RT for the treatment of nasopharyngeal carcinoma: A systematic review and meta-analysis. *PLoS One*. 2019; 14(7): e0219611. PMID 31291379
- Luo MS, Huang GJ, Liu HB. Oncologic outcomes of IMRT versus CRT for nasopharyngeal carcinoma: A meta-analysis. *Medicine (Baltimore)*. Jun 2019; 98(24): e15951. PMID 31192932
- Marta GN, Silva V, de Andrade Carvalho H, et al. Intensity-modulated radiation therapy for head and neck cancer: systematic review and meta-analysis. *Radiother Oncol*. Jan 2014; 110(1): 9-15. PMID 24332675
- Kam MK, Leung SF, Zee B, et al. Prospective randomized study of intensity-modulated radiotherapy on salivary gland function in early-stage nasopharyngeal carcinoma patients. *J Clin Oncol*. Nov 01 2007; 25(31): 4873-9. PMID 17971582
- Lai SZ, Li WF, Chen L, et al. How does intensity-modulated radiotherapy versus conventional two-dimensional radiotherapy influence the treatment results in nasopharyngeal carcinoma patients?. *Int J Radiat Oncol Biol Phys*. Jul 01 2011; 80(3): 661-8. PMID 20643517
- Peng G, Wang T, Yang KY, et al. A prospective, randomized study comparing outcomes and toxicities of intensity-modulated radiotherapy vs. conventional two-dimensional radiotherapy for the treatment of nasopharyngeal carcinoma. *Radiother Oncol*. Sep 2012; 104(3): 286-93. PMID 22995588
- Zhou GQ, Yu XL, Chen M, et al. Radiation-induced temporal lobe injury for nasopharyngeal carcinoma: a comparison of intensity-modulated radiotherapy and conventional two-dimensional radiotherapy. *PLoS One*. 2013; 8(7): e67488. PMID 23874422
- Moon SH, Cho KH, Lee CG, et al. IMRT vs. 2D-radiotherapy or 3D-conformal radiotherapy of nasopharyngeal carcinoma : Survival outcome in a Korean multi-institutional retrospective study (KROG 11-06). *Strahlenther Onkol*. Jun 2016; 192(6): 377-85. PMID 26972085
- Zhang MX, Li J, Shen GP, et al. Intensity-modulated radiotherapy prolongs the survival of patients with nasopharyngeal carcinoma compared with conventional two-dimensional radiotherapy: A 10-year experience with a large cohort and long follow-up. *Eur J Cancer*. Nov 2015; 51(17): 2587-95. PMID 26318726
- Qiu WZ, Peng XS, Xia HQ, et al. A retrospective study comparing the outcomes and toxicities of intensity-modulated radiotherapy versus two-dimensional conventional radiotherapy for the treatment of children and adolescent nasopharyngeal carcinoma. *J Cancer Res Clin Oncol*. Aug 2017; 143(8): 1563-1572. PMID 28342002
- Tang LL, Chen L, Mao YP, et al. Comparison of the treatment outcomes of intensity-modulated radiotherapy and two-dimensional conventional radiotherapy in nasopharyngeal carcinoma patients with parapharyngeal space extension. *Radiother Oncol*. Aug 2015; 116(2): 167-73. PMID 26316395

14. Lee AW, Ng WT, Chan LL, et al. Evolution of treatment for nasopharyngeal cancer--success and setback in the intensity-modulated radiotherapy era. *Radiother Oncol*. Mar 2014; 110(3): 377-84. PMID 24630534
15. Zhong H, Chen G, Lin D, et al. [Comparison of side effects of intensity modulated radiotherapy and conventional radiotherapy in 69 cases with nasopharyngeal carcinoma]. *Lin Chuang Er Bi Yan Hou Tou Jing Wai Ke Za Zhi*. May 2013; 27(9): 462-4. PMID 23898610
16. OuYang PY, Shi D, Sun R, et al. Effect of intensity-modulated radiotherapy versus two-dimensional conventional radiotherapy alone in nasopharyngeal carcinoma. *Oncotarget*. May 31 2016; 7(22): 33408-17. PMID 27058901
17. Jiang H, Wang G, Song H, et al. Analysis of the efficacy of intensity-modulated radiotherapy and two-dimensional conventional radiotherapy in nasopharyngeal carcinoma with involvement of the cervical spine. *Oncol Lett*. Nov 2015; 10(5): 2731-2738. PMID 26722233
18. Fang FM, Chien CY, Tsai WL, et al. Quality of life and survival outcome for patients with nasopharyngeal carcinoma receiving three-dimensional conformal radiotherapy vs. intensity-modulated radiotherapy-a longitudinal study. *Int J Radiat Oncol Biol Phys*. Oct 01 2008; 72(2): 356-64. PMID 18355980
19. Kuang WL, Zhou Q, Shen LF. Outcomes and prognostic factors of conformal radiotherapy versus intensity-modulated radiotherapy for nasopharyngeal carcinoma. *Clin Transl Oncol*. Oct 2012; 14(10): 783-90. PMID 22855156
20. Huang HI, Chan KT, Shu CH, et al. T4-locally advanced nasopharyngeal carcinoma: prognostic influence of cranial nerve involvement in different radiotherapy techniques. *ScientificWorldJournal*. 2013; 2013: 439073. PMID 24385882
21. Chen C, Yi W, Gao J, et al. Alternative endpoints to the 5-year overall survival and locoregional control for nasopharyngeal carcinoma: A retrospective analysis of 2,450 patients. *Mol Clin Oncol*. May 2014; 2(3): 385-392. PMID 24772305
22. Zou X, Han F, Ma WJ, et al. Salvage endoscopic nasopharyngectomy and intensity-modulated radiotherapy versus conventional radiotherapy in treating locally recurrent nasopharyngeal carcinoma. *Head Neck*. Aug 2015; 37(8): 1108-15. PMID 24764204
23. Bišof V, Rakušić Z, Bibić J, et al. Comparison of intensity modulated radiotherapy with simultaneous integrated boost (IMRT-SIB) and a 3-dimensional conformal parotid gland-sparing radiotherapy (ConPas 3D-CRT) in treatment of nasopharyngeal carcinoma: a mono-institutional experience. *Radiol Med*. Mar 2018; 123(3): 217-226. PMID 29094268
24. Pow EH, Kwong DL, McMillan AS, et al. Xerostomia and quality of life after intensity-modulated radiotherapy vs. conventional radiotherapy for early-stage nasopharyngeal carcinoma: initial report on a randomized controlled clinical trial. *Int J Radiat Oncol Biol Phys*. Nov 15 2006; 66(4): 981-91. PMID 17145528
25. Nutting CM, Morden JP, Harrington KJ, et al. Parotid-sparing intensity modulated versus conventional radiotherapy in head and neck cancer (PARSPORT): a phase 3 multicentre randomised controlled trial. *Lancet Oncol*. Feb 2011; 12(2): 127-36. PMID 21236730
26. Gupta T, Jain S, Agarwal JP, et al. Prospective assessment of patterns of failure after high-precision definitive (chemo)radiation in head-and-neck squamous cell carcinoma. *Int J Radiat Oncol Biol Phys*. Jun 01 2011; 80(2): 522-31. PMID 20646862
27. Gupta T, Agarwal J, Jain S, et al. Three-dimensional conformal radiotherapy (3D-CRT) versus intensity modulated radiation therapy (IMRT) in squamous cell carcinoma of the head and neck: a randomized controlled trial. *Radiother Oncol*. Sep 2012; 104(3): 343-8. PMID 22853852
28. Ursino S, D'Angelo E, Mazzola R, et al. A comparison of swallowing dysfunction after three-dimensional conformal and intensity-modulated radiotherapy : A systematic review by the Italian Head and Neck Radiotherapy Study Group. *Strahlenther Onkol*. Nov 2017; 193(11): 877-889. PMID 28616822
29. Ge X, Liao Z, Yuan J, et al. Radiotherapy-related quality of life in patients with head and neck cancers: a meta-analysis. *Support Care Cancer*. Jun 2020; 28(6): 2701-2712. PMID 31673782
30. Razavian NB, D'Agostino RB, Shenker RF, et al. Intensity Modulated Radiation Therapy for Early Stage Squamous Cell Carcinoma of the Glottic Larynx: A Systematic Review and Meta-Analysis. *Int J Radiat Oncol Biol Phys*. May 06 2023. PMID 37150263

31. Tandon S, Gairola M, Ahlawat P, et al. Randomized controlled study comparing simultaneous modulated accelerated radiotherapy versus simultaneous integrated boost intensity modulated radiotherapy in the treatment of locally advanced head and neck cancer. *J Egypt Natl Canc Inst.* Sep 2018; 30(3): 107-115. PMID 29960876
32. Huang TL, Chien CY, Tsai WL, et al. Long-term late toxicities and quality of life for survivors of nasopharyngeal carcinoma treated with intensity-modulated radiotherapy versus non-intensity-modulated radiotherapy. *Head Neck.* Apr 2016; 38 Suppl 1: E1026-32. PMID 26041548
33. American Thyroid Association. Anaplastic thyroid cancer. <https://www.thyroid.org/anaplastic-thyroid-cancer/>. Accessed May 10, 2023.
34. Bhatia A, Rao A, Ang KK, et al. Anaplastic thyroid cancer: Clinical outcomes with conformal radiotherapy. *Head Neck.* Jul 2010; 32(7): 829-36. PMID 19885924
35. Schwartz DL, Lobo MJ, Ang KK, et al. Postoperative external beam radiotherapy for differentiated thyroid cancer: outcomes and morbidity with conformal treatment. *Int J Radiat Oncol Biol Phys.* Jul 15 2009; 74(4): 1083-91. PMID 19095376
36. National Comprehensive Cancer Network (NCCN). NCCN Clinical practice guidelines in oncology: Head and neck cancers. Version 1.2023. Updated December 20, 2022. https://www.nccn.org/professionals/physician_gls/pdf/head-and-neck.pdf. Accessed May 10, 2023.
37. National Comprehensive Cancer Network (NCCN). NCCN Clinical practice guidelines in oncology: Thyroid Carcinoma. Version 1.2023. Updated March 24, 2023. https://www.nccn.org/professionals/physician_gls/pdf/thyroid.pdf. Accessed May 9, 2023.
38. Bible KC, Kebebew E, Brierley J, et al. 2021 American Thyroid Association Guidelines for Management of Patients with Anaplastic Thyroid Cancer. *Thyroid.* Mar 2021; 31(3): 337-386. PMID 33728999

Documentation for Clinical Review

Please provide the following documentation:

- (click here >>>) [Radiation Oncology – Prior Authorization fax form](#)
- (click here >>>) [Radiation Oncology – Post Service fax form](#)

Coding

This Policy relates only to the services or supplies described herein. Benefits may vary according to product design; therefore, contract language should be reviewed before applying the terms of the Policy.

The following codes are included below for informational purposes. Inclusion or exclusion of a code(s) does not constitute or imply member coverage or provider reimbursement policy. Policy Statements are intended to provide member coverage information and may include the use of some codes for clarity. The Policy Guidelines section may also provide additional information for how to interpret the Policy Statements and to provide coding guidance in some cases.

Type	Code	Description
CPT®	77014	Computed tomography guidance for placement of radiation therapy fields
	77261	Therapeutic radiology treatment planning; simple
	77262	Therapeutic radiology treatment planning; intermediate
	77263	Therapeutic radiology treatment planning; complex
	77293	Respiratory motion management simulation (List separately in addition to code for primary procedure)

Type	Code	Description
	77300	Basic radiation dosimetry calculation, central axis depth dose calculation, TDF, NSD, gap calculation, off axis factor, tissue inhomogeneity factors, calculation of non-ionizing radiation surface and depth dose, as required during course of treatment, only when prescribed by the treating physician
	77301	Intensity modulated radiotherapy plan, including dose-volume histograms for target and critical structure partial tolerance specifications
	77306	Teletherapy isodose plan; simple (1 or 2 unmodified ports directed to a single area of interest), includes basic dosimetry calculation(s)
	77307	Teletherapy isodose plan; complex (multiple treatment areas, tangential ports, the use of wedges, blocking, rotational beam, or special beam considerations), includes basic dosimetry calculation(s)
	77331	Special dosimetry (e.g., TLD, microdosimetry) (specify), only when prescribed by the treating physician
	77332	Treatment devices, design and construction; simple (simple block, simple bolus)
	77334	Treatment devices, design and construction; complex (irregular blocks, special shields, compensators, wedges, molds or casts)
	77336	Continuing medical physics consultation, including assessment of treatment parameters, quality assurance of dose delivery, and review of patient treatment documentation in support of the radiation oncologist, reported per week of therapy
	77338	Multi-leaf collimator (MLC) device(s) for intensity modulated radiation therapy (IMRT), design and construction per IMRT plan
	77370	Special medical radiation physics consultation
	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
	77387	Guidance for localization of target volume for delivery of radiation treatment, includes intrafraction tracking, when performed
	77417	Therapeutic radiology port image(s)
	77427	Radiation treatment management, 5 treatments
	77470	Special treatment procedure (e.g., total body irradiation, hemibody radiation, per oral or endocavitary irradiation)
HCPCS	G6001	Ultrasonic guidance for placement of radiation therapy fields
	G6002	Stereoscopic x-ray guidance for localization of target volume for the delivery of radiation therapy
	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
	G6017	Intra-fraction localization and tracking of target or patient motion during delivery of radiation therapy (e.g., 3D positional tracking, gating, 3D surface tracking), each fraction of treatment

Policy History

This section provides a chronological history of the activities, updates and changes that have occurred with this Medical Policy.

Effective Date	Action
03/30/2015	Policy title change from Intensity Modulated Radiation Therapy (IMRT) BCBSA Medical Policy adoption Policy revision without position change
10/01/2016	Policy revision without position change
09/01/2017	Policy revision without position change
09/01/2018	Policy revision without position change
09/01/2019	Policy revision without position change
06/01/2020	Administrative update. Policy statement and guidelines updated.
10/01/2020	Annual review. No change to policy statement. Literature review updated. Coding update.
11/20/2020	Policy statement and guidelines updated.
08/01/2021	Annual review. No change to policy statement. Policy guidelines updated.
12/01/2021	Administrative update. No change to policy statement. Policy guidelines and literature updated.
08/01/2022	Annual review. No change to policy statement.
09/01/2022	Administrative update. No change to policy statement. Literature review updated.
02/01/2023	Annual review. Policy statement and guidelines updated.
06/01/2023	Administrative update.
09/01/2023	Administrative update. No change to policy statement. Literature review updated.
03/01/2024	Annual review. No change to policy statement.

Definitions of Decision Determinations

Medically Necessary: Services that are Medically Necessary include only those which have been established as safe and effective, are furnished under generally accepted professional standards to treat illness, injury or medical condition, and which, as determined by Blue Shield, are: (a) consistent with Blue Shield medical policy; (b) consistent with the symptoms or diagnosis; (c) not furnished primarily for the convenience of the patient, the attending Physician or other provider; (d) furnished at the most appropriate level which can be provided safely and effectively to the patient; and (e) not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the Member's illness, injury, or disease.

Investigational/Experimental: A treatment, procedure, or drug is investigational when it has not been recognized as safe and effective for use in treating the particular condition in accordance with generally accepted professional medical standards. This includes services where approval by the federal or state governmental is required prior to use, but has not yet been granted.

Split Evaluation: Blue Shield of California/Blue Shield of California Life & Health Insurance Company (Blue Shield) policy review can result in a split evaluation, where a treatment, procedure, or drug will be considered to be investigational for certain indications or conditions, but will be deemed safe and effective for other indications or conditions, and therefore potentially medically necessary in those instances.

Prior Authorization Requirements and Feedback (as applicable to your plan)

Within five days before the actual date of service, the provider must confirm with Blue Shield that the member's health plan coverage is still in effect. Blue Shield reserves the right to revoke an authorization prior to services being rendered based on cancellation of the member's eligibility. Final determination of benefits will be made after review of the claim for limitations or exclusions.

Questions regarding the applicability of this policy should be directed to the Prior Authorization Department at (800) 541-6652, or the Transplant Case Management Department at (800) 637-2066 ext. 3507708 or visit the provider portal at www.blueshieldca.com/provider.

We are interested in receiving feedback relative to developing, adopting, and reviewing criteria for medical policy. Any licensed practitioner who is contracted with Blue Shield of California or Blue Shield of California Promise Health Plan is welcome to provide comments, suggestions, or concerns. Our internal policy committees will receive and take your comments into consideration.

For utilization and medical policy feedback, please send comments to: MedPolicy@blueshieldca.com

Disclaimer: This medical policy is a guide in evaluating the medical necessity of a particular service or treatment. Blue Shield of California may consider published peer-reviewed scientific literature, national guidelines, and local standards of practice in developing its medical policy. Federal and state law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over medical policy and must be considered first in determining covered services. Member contracts may differ in their benefits. Blue Shield reserves the right to review and update policies as appropriate.

Appendix A

POLICY STATEMENT (No changes)	
BEFORE	AFTER
<p>Intensity-Modulated Radiotherapy: Cancer of the Head and Neck or Thyroid 8.01.48</p> <p>Policy Statement:</p> <ol style="list-style-type: none"> I. Intensity-modulated radiotherapy (IMRT) may be considered medically necessary for the treatment of head and neck cancers when the cancer to be treated is one or more of the following: <ol style="list-style-type: none"> A. Oral cavity and lip B. Larynx C. Hypopharynx D. Oropharynx E. Nasopharynx F. Paranasal sinuses and nasal cavity G. Salivary glands H. Occult primaries in the head and neck region II. Intensity-modulated radiotherapy may be considered medically necessary for the treatment of thyroid or other head and neck cancers when dosimetric planning with standard 3-dimensional conformal radiotherapy predicts that the radiation dose to an adjacent organ (e.g.: esophagus, salivary glands, spinal cord) would result in unacceptable normal tissue toxicity, as documented by one or more of the following: <ol style="list-style-type: none"> A. The target volume is in close proximity to critical structures that must be protected and both of the following: * (see source below) <ol style="list-style-type: none"> 1. Planned 3D-CRT exposure to critical adjacent structures is above normal tissue constraints 2. Planned IMRT exposure to these critical adjacent structures does not exceed normal tissue constraints B. The same or immediately adjacent area has been previously irradiated and abutting portals must be established with high precision 	<p>Intensity-Modulated Radiotherapy: Cancer of the Head and Neck or Thyroid 8.01.48</p> <p>Policy Statement:</p> <ol style="list-style-type: none"> I. Intensity-modulated radiotherapy (IMRT) may be considered medically necessary for the treatment of head and neck cancers when the cancer to be treated is one or more of the following: <ol style="list-style-type: none"> A. Oral cavity and lip B. Larynx C. Hypopharynx D. Oropharynx E. Nasopharynx F. Paranasal sinuses and nasal cavity G. Salivary glands H. Occult primaries in the head and neck region II. Intensity-modulated radiotherapy may be considered medically necessary for the treatment of thyroid or other head and neck cancers when dosimetric planning with standard 3-dimensional conformal radiotherapy predicts that the radiation dose to an adjacent organ (e.g.: esophagus, salivary glands, spinal cord) would result in unacceptable normal tissue toxicity, as documented by one or more of the following: <ol style="list-style-type: none"> A. The target volume is in close proximity to critical structures that must be protected and both of the following: * (see source below) <ol style="list-style-type: none"> 1. Planned 3D-CRT exposure to critical adjacent structures is above normal tissue constraints 2. Planned IMRT exposure to these critical adjacent structures does not exceed normal tissue constraints B. The same or immediately adjacent area has been previously irradiated and abutting portals must be established with high precision

POLICY STATEMENT (No changes)	
BEFORE	AFTER
<p>III. Intensity-modulated radiotherapy is considered investigational for the treatment of thyroid or other head and neck cancers for all indications not meeting the criteria above.</p> <p>Image Guided Radiation Therapy (IGRT)</p> <p>IV. IGRT may be considered medically necessary as an approach to delivering radiotherapy when combined with any of the following treatments (see Policy Guidelines):</p> <ul style="list-style-type: none"> A. Intensity-modulated radiotherapy (IMRT) B. Stereotactic body radiation therapy (SBRT) C. Proton delivery <p>V. IGRT is considered investigational as an approach to delivering radiotherapy when combined with any of the following treatments:</p> <ul style="list-style-type: none"> A. Conventional three-dimensional conformal radiation therapy (3D CRT) (see Policy Guidelines for considerations) B. Stereotactic radiosurgery (SRS) C. Electronic brachytherapy 	<p>III. Intensity-modulated radiotherapy is considered investigational for the treatment of thyroid or other head and neck cancers for all indications not meeting the criteria above.</p> <p>Image Guided Radiation Therapy (IGRT)</p> <p>IV. IGRT may be considered medically necessary as an approach to delivering radiotherapy when combined with any of the following treatments (see Policy Guidelines):</p> <ul style="list-style-type: none"> A. Intensity-modulated radiotherapy (IMRT) B. Stereotactic body radiation therapy (SBRT) C. Proton delivery <p>V. IGRT is considered investigational as an approach to delivering radiotherapy when combined with any of the following treatments:</p> <ul style="list-style-type: none"> A. Conventional three-dimensional conformal radiation therapy (3D CRT) (see Policy Guidelines for considerations) B. Stereotactic radiosurgery (SRS) C. Electronic brachytherapy