CUR-ONC-2026-001 Radiation Therapy Policy

Policy Number: CUR-ONC-2026-001

Effective Date: April 28, 2026

Field	Details
Effective Date	April 28, 2026
Last Reviewed	March 23, 2026
Next Review	April 1, 2027
Applies To	Level Funded, Fully Insured, ASO
States	TX, FL, GA, DC, MD, IN, OH
Age Group	Under 18 / 18 and Over
Version	3.0

SECTION 1: DISCLAIMER

> The inclusion of a service, procedure, or CPT/HCPCS code in this medical policy does not constitute a guarantee of coverage or a benefit of the member's health plan. Coverage is determined by the terms of the member's specific benefit plan and certificate of coverage. This policy provides clinical criteria for medical necessity determination only. All services are subject to the terms, conditions, limitations, and exclusions of the member's benefit plan.

SECTION 2: POLICY STATEMENT

Curative Health Plan covers radiation therapy services that are medically necessary for the diagnosis, staging, treatment, or palliation of malignant or specified benign conditions when provided by or under the direct supervision of a board-certified radiation oncologist, supported by an appropriate treatment plan, and consistent with evidence-based guidelines from the National Comprehensive Cancer Network (NCCN), the American Society for Radiation Oncology (ASTRO), the American Society of Clinical Oncology (ASCO), and applicable CMS Local Coverage Determinations (LCDs).

This policy establishes clinical criteria for the following radiation therapy categories:

1. Treatment Planning and Management — Simulation, dosimetry, physics consultation, and physician treatment management services
2. External Beam Radiation Therapy (EBRT) — Three-dimensional conformal radiation therapy (3D-CRT) and Intensity-Modulated Radiation Therapy (IMRT), coded under the 2026 complexity-based delivery code structure
3. Stereotactic Radiosurgery (SRS) and Stereotactic Body Radiation Therapy (SBRT)
4. Proton Beam Therapy (PBT)
5. Brachytherapy — Low-dose rate (LDR) and high-dose rate (HDR) techniques
6. Surface Radiation Therapy (SRT) — 2026 category (codes 77436–77439)
7. Other Radiation Oncology Services — Intraoperative radiation therapy (IORT), image-guided RT, and specialty codes

Core Medical Necessity Standard: Per 42 U.S.C. §1395y(a)(1)(A), services must be "reasonable and necessary for the diagnosis or treatment of illness or injury." All radiation therapy requests must demonstrate: (a) confirmed malignant or specified benign diagnosis, (b) documented performance status, (c) clinical staging with supporting imaging, (d) a complete radiation prescription meeting the requirements in Section 4 Universal Prerequisites, and (e) clinical appropriateness of the specific modality for the indicated condition.

Age-Specific Coverage: Criteria differ materially for patients under 18 years of age (pediatric) versus those 18 and over, particularly for proton beam therapy, IMRT indications, and anesthesia requirements. Age-specific criteria are designated throughout this policy.

2026 Coding Note: Effective January 1, 2026, radiation oncology delivery coding underwent its most significant overhaul in more than a decade. CPT codes 77385 (IMRT simple) and 77386 (IMRT complex) were deleted. CPT code 77401 (superficial/orthovoltage delivery) was deleted and replaced by new Surface Radiation Therapy codes 77437 and 77438. CPT codes 77417 (port images) and 77014 (CT guidance) were deleted. Codes 77402, 77407, and 77412 were revised into technique-agnostic complexity Levels 1, 2, and 3. IGRT technical component is bundled into delivery codes; 77387 is now professional-component-only (77387-26). HCPCS codes G6001, G6002, G6003–G6016, and G6017 were all deleted. New Surface Radiation Therapy codes 77436–77439 were added. See Section 3C and the Coding Crosswalk in Section 3H.

SECTION 3: APPLICABLE CPT/HCPCS CODES

Prior authorization (PA) is required for all codes listed below unless otherwise noted in the member's benefit plan. Codes are listed individually; ranges are not used in this policy.

3A. Treatment Planning

CPT Code	Official Descriptor
77261	Therapeutic radiology treatment planning; simple
77262	Therapeutic radiology treatment planning; complex
77263	Therapeutic radiology treatment planning; intermediate
77280	Simulation-aided field setting; simple
77285	Simulation-aided field setting; intermediate
77290	Simulation-aided field setting; complex
77293	Respiratory motion management simulation
77299	Unlisted procedure, therapeutic radiology treatment planning
77300	Basic radiation dosimetry calculation, each
77301	Intensity modulated radiotherapy (IMRT), planning, including computer-generated dose volumetric histogram
77306	Teletherapy isodose plan; simple
77307	Teletherapy isodose plan; complex
77316	Brachytherapy isodose plan; simple (calculation made from single plane, one to four sources/ribbon application; remote afterloading brachytherapy, 1–8 sources)
77317	Brachytherapy isodose plan; intermediate (calculation made from multiple planes, 5 to 10 sources/ribbon applications; remote afterloading brachytherapy, 9–12 sources)
77318	Brachytherapy isodose plan; complex

CPT Code	Official Descriptor
77321	Special teletherapy port plan, particles, hemibody, total body

3B. Treatment Management

CPT Code	Official Descriptor
77331	Special dosimetry, each field
77334	Treatment devices, design and construction; simple
77336	Continuing medical physics consultation, including assessment of treatment parameters, quality assurance of dose delivery, and review of patient treatment documentation in support of radiation oncology treatment (per 5 treatments)
77338	Multi-leaf collimator (MLC) device(s) for IMRT, design and construction per IMRT plan
77370	Special medical radiation physics consultation
77427	Radiation treatment management, per 5 fractions (or weekly if receiving daily radiation therapy)
77431	Radiation treatment management; 1 or 2 fractions only
77432	Stereotactic radiation treatment management of cranial lesion(s) (complete course of treatment)
77469	Intraoperative radiation treatment management
77470	Special treatment procedure (list in addition to code for primary procedure)

3C. External Beam Radiation Delivery (2026 Complexity-Based Codes)

> IMPORTANT 2026 CODING CHANGE: Effective January 1, 2026, CPT codes 77385 and 77386 (IMRT delivery simple/complex) are DELETED. CPT code 77401 (superficial/orthovoltage delivery) is DELETED and replaced by 77437/77438 (SRT-specific codes). CPT code 77417 (therapeutic radiology port images) is DELETED. CPT code 77014 (CT guidance for RT field placement) is DELETED — technical component bundled into delivery codes. HCPCS codes G6001, G6002, G6003–G6016, and G6017 are ALL DELETED. All external beam radiation therapy — including IMRT — is now reported using the revised complexity-based codes 77402, 77407, and 77412. See Section 3H for the coding crosswalk.

CPT Code	2026 Descriptor	Complexity Criteria
77373	Stereotactic body radiation therapy, treatment delivery, per fraction to 5 fractions total	Unchanged — per fraction, bundled (do NOT separately bill 77387 with SBRT)
77387-26	Guidance for localization of target volume for delivery of radiation treatment delivery — Professional Component Only (TC is bundled into 77402/77407/77412)	See Section 3G for billing frequency rules

CPT Code	2026 Descriptor	Complexity Criteria
77399	Unlisted procedure, medical radiation physics, dosimetry and treatment devices, and special services	
77402	Level 1 — Simple: Single electron field, multiple non-abutting electron fields, or 2D photon treatment	Approximately <5% of all EBRT
77407	Level 2 — Intermediate: Single isocenter 3D-CRT or IMRT, NO active motion management. "Workhorse" code. Includes standard prostate IMRT, breast 3D/IMRT	Approximately >50% of EBRT
77412	Level 3 — Complex: Requires ANY ONE of: (a) active motion management (gating, SGRT, breath-hold, 4D CBCT), (b) multiple isocenters, (c) mixed photon-electron modality, (d) total skin electron therapy	Approximately ~35% of EBRT
77424	Intraoperative radiation treatment delivery, electrons	
77425	Intraoperative radiation treatment delivery, photons	

3D. Proton Beam Therapy

CPT Code	Official Descriptor
77520	Proton treatment delivery; simple, without beam shaping
77522	Proton treatment delivery; simple, with beam shaping
77523	Proton treatment delivery; intermediate
77525	Proton treatment delivery; complex

3E. Brachytherapy

CPT Code	Official Descriptor
77750	Infusion or instillation of radioelement solution
77761	Intracavitary radiation source application; simple
77762	Intracavitary radiation source application; intermediate
77763	Intracavitary radiation source application; complex
77767	Remote afterloading high dose rate radionuclide skin surface brachytherapy, includes basic dosimetry when performed; lesion diameter up to 2.0 cm
77768	Remote afterloading high dose rate radionuclide skin surface brachytherapy; lesion diameter over 2.0 cm

CPT Code	Official Descriptor
77770	Remote afterloading high dose rate radionuclide intracavitary brachytherapy; 1 channel
77771	Remote afterloading high dose rate radionuclide intracavitary brachytherapy; 2–12 channels
77772	Remote afterloading high dose rate radionuclide intracavitary brachytherapy; more than 12 channels
77778	Interstitial radiation source application; complex
77790	Supervision, handling, loading of radiation source
77799	Unlisted procedure, clinical brachytherapy
Q3001	Radioelements for brachytherapy, any type, each

3F. Surface Radiation Therapy (SRT) — 2026 Codes

> 2026 SRT CODES: Surface radiation therapy (SRT) is a non-invasive, low-energy external beam technique used primarily for superficial skin cancers. The following codes are effective January 1, 2026. CPT 77401 (prior superficial/orthovoltage delivery code) is DELETED and replaced by 77437 and 77438. Note that 77290, 77280, 77300, 77334, 77427, and 77261 are NOT applicable to SRT — SRT uses its own dedicated planning and management code (77436) and 77336 for physics consultation. See Section 4G for full SRT medical necessity criteria and CMS LCD L40179.

CPT Code	Official Descriptor
77436	Surface radiation therapy; superficial treatment planning and simulation-aided field setting
77437	Surface radiation therapy; superficial, delivery, ≤150 kV, per fraction (e.g., electronic brachytherapy)
77438	Surface radiation therapy; orthovoltage, delivery, >150–500 kV, per fraction
77439	Surface radiation therapy; superficial or orthovoltage, image guidance, ultrasound for placement of radiation therapy fields for treatment of cutaneous tumors, per course of treatment (List separately in addition to code for primary procedure)
77336	Continuing medical physics consultation (applicable to SRT when licensed physicist provides oversight; billable weekly per 5 treatments)

> 77439 Billing Note: Code 77439 is an add-on code, billed ONCE per treatment course, only in conjunction with a primary SRT delivery code (77437 or 77438). It may not be billed independently. Per CMS LCD L40179 and Billing Article A60185, providers must append the KX modifier to 77437 when billing for SRT services covered by the LCD.

3G. Other Radiation Oncology Codes

CPT/HCPCS Code	Official Descriptor
0747T	Radiation treatment delivery, ultra-high dose rate (FLASH), per fraction
A9699	Radiopharmaceutical, diagnostic, not otherwise classified
G0339	Image-guided robotic linear accelerator-based stereotactic radiosurgery, complete course of therapy in one session, or first session of fractionated treatment
G0340	Image-guided robotic linear accelerator-based stereotactic radiosurgery, delivery including collimator changes and custom-fabricated stereotactic frames, fractionated treatment, per session, second through fifth sessions

DELETED 2026 CODES — DO NOT BILL:
The following codes are no longer valid as of January 1, 2026 and must not be submitted on claims for dates of service on or after January 1, 2026:

- 77385 — IMRT delivery, simple (DELETED 1/1/2026 — replaced by 77407 Level 2 or 77412 Level 3)
- 77386 — IMRT delivery, complex (DELETED 1/1/2026 — replaced by 77407 Level 2 or 77412 Level 3)
- 77401 — Radiation treatment delivery, superficial and/or orthovoltage (DELETED 1/1/2026 — replaced by 77437 or 77438 for SRT)
- 77417 — Therapeutic radiology port images (DELETED 1/1/2026 — bundled into delivery codes)
- 77014 — CT guidance for placement of radiation therapy fields (DELETED 1/1/2026 — TC bundled into delivery codes; professional component reported as 77387-26)
- G6001 — Ultrasonic guidance for placement of radiation therapy fields (DELETED 1/1/2026)
- G6002 — Stereoscopic x-ray guidance for localization of target volume (DELETED 1/1/2026)
- G6003 through G6016 — All G-codes for radiation therapy delivery (ALL DELETED 1/1/2026)
- G6017 — Intra-fraction localization and tracking of target or patient motion (DELETED 1/1/2026)

3H. 2026 Radiation Oncology Coding Crosswalk

The following crosswalk maps common 2025 clinical scenarios to the correct 2026 codes. This table is provided for reference to facilitate accurate billing transitions. (Source: ASTRO 2026 HOPPS Final Rule Summary; Cureus/PMC article on 2026 CMS changes.)

2025 Clinical Scenario	2025 Codes (OLD — Do Not Bill)	2026 Delivery Code	2026 IGRT (Professional)
Simple 2D/3D (e.g., Palliative Bone)	77402 / G6003	77402 (Level 1)	77387-26
Standard 3D (Single Isocenter)	77407 / G6007	77407 (Level 2)	77387-26
Prostate IMRT (Single Isocenter)	77385 / G6015	77407 (Level 2)	77387-26
H&N; IMRT (Multiple Isocenters)	77386 / G6016	77412 (Level 3)	77387-26
Lung SBRT/IMRT (w/ Gating/Tracking)	77386 + G6017	77412 (Level 3)	77387-26

2025 Clinical Scenario	2025 Codes (OLD — Do Not Bill)	2026 Delivery Code	2026 IGRT (Professional)
SBRT (Full Course)	77373	77373 (Unchanged)	Bundled — Do not bill 77387 separately
Superficial/Orthovoltage Skin Tx (≤150 kV)	77401	77437 (SRT Level ≤150 kV)	77439 (add-on, once per course, if ultrasound guidance used)
Orthovoltage Skin Tx (>150–500 kV)	77401	77438 (SRT orthovoltage)	77439 (add-on, once per course, if ultrasound guidance used)

77387 Billing Frequency Rules (2026):

- Weekly (standard EBRT): 77387-26 may be billed once per week for standard external beam radiation therapy courses
- Daily (exceptions): 77387-26 may be billed daily for: (a) boost treatments, (b) brachytherapy fractions, and (c) all SBRT fractions
- Documentation requirement: The radiation oncologist MUST document review of localization imaging in the daily/weekly clinical note. Without this documentation, 77387-26 will not be covered.
- 77387-TC bundling: The technical component of 77387 is bundled into delivery codes 77402, 77407, and 77412. Do NOT bill 77387-TC or 77387 without modifier -26 when paired with these delivery codes.

SECTION 4: MEDICAL NECESSITY CRITERIA — MEETS CRITERIA

> MEETS CRITERIA

Universal Prerequisites

All radiation therapy services, regardless of modality, require ALL of the following:

1. Confirmed diagnosis of a malignant neoplasm or a specified benign condition for which radiation therapy has established clinical benefit, supported by pathology report (histologic confirmation preferred) or by equivalent clinical evidence documented in the medical record where tissue biopsy is not clinically feasible.
2. Complete Radiation Prescription (replacing "signed radiation oncology treatment plan") — The radiation prescription must be a physician-signed document that includes ALL of the following elements:
    a. Diagnosis, stage, and treatment intent — Primary diagnosis with ICD-10-CM code(s); clinical stage (TNM or equivalent); explicit statement of intent (curative, adjuvant, palliative, or consolidative)
    b. Area(s) to be irradiated — Anatomic site(s) and target volume definition (GTV, CTV, PTV as applicable)

c. Modality to be used — Specific radiation modality (3D-CRT, IMRT at Level 1/2/3, SBRT, proton, brachytherapy, SRT, etc.)

d. Boost details — Whether a boost will be used; if yes, boost site, dose, fractionation, and technique

e. Dose prescription — Total dose, dose per fraction (Gy/fx), total number of fractions, AND type of dosimetry (forward planning, inverse planning, volumetric arc therapy, etc.)

f. Special treatment parameters — Any special blocking, respiratory motion management technique (gating, breath-hold, SGRT, 4D-CT), or beam modifications

g. Special treatment procedures with justification — If any special treatment procedures are planned (concurrent chemotherapy timing, intraoperative RT, brachytherapy boost, TBI/hemibody), these must be listed with clinical justification

h. Physics consultation — Whether special physics consultation is needed; if yes, the clinical justification

i. Concurrent systemic therapy — Whether concurrent chemotherapy, targeted therapy, or immunotherapy will be given during the radiation course

j. Normal tissue dose constraints — Organs at risk (OAR) dose constraints as applicable to the treatment site and technique

3. Supporting imaging within 90 days of treatment planning simulation prior to treatment planning:

– CT simulation scan; MRI, PET/CT, or diagnostic imaging as required by site and modality

4. Performance status documented using Karnofsky Performance Scale (KPS) or Eastern Cooperative Oncology Group (ECOG) scale. KPS and ECOG documentation is mandatory for SBRT and SRS; strongly recommended for all radiation therapy.

5. Tumor size, number of lesions, and anatomic relationship to critical structures documented.

6. The selected modality and fractionation schedule are consistent with evidence-based clinical practice guidelines (NCCN, ASTRO, ASCO) applicable to the patient's diagnosis, stage, and clinical circumstances.

4A. TREATMENT PLANNING AND MANAGEMENT

CPT: 77261, 77262, 77263, 77280, 77285, 77290, 77293, 77299, 77300, 77301, 77306, 77307, 77316, 77317, 77318, 77321, 77331, 77334, 77336, 77338, 77370, 77427, 77431, 77432, 77469, 77470

> Note: Codes 77261, 77262, 77263, 77280, 77285, 77290, 77293, 77299, 77300, 77301, 77306, 77307, 77316, 77317, 77318, 77321, 77331, 77334, 77427 are applicable to standard EBRT, SBRT, SRS, proton, and brachytherapy planning/management. These codes are NOT applicable to Surface Radiation Therapy (SRT), which uses its own dedicated codes (77436 for planning/simulation; 77336 for physics consultation). See Section 4G for SRT-specific criteria.

Criteria — Treatment Planning Codes (77261, 77262, 77263, 77280, 77285, 77290, 77293, 77300, 77301, 77306, 77307, 77316, 77317, 77318, 77321, 77331, 77334)

Coverage is met when ALL of the following apply:

1. A confirmed malignant or benign neoplasm requiring radiation therapy is documented, meeting the universal prerequisites in Section 4 above.
2. The complexity level of the planning code selected is consistent with the actual complexity of the treatment:
   – Simple (77261, 77280, 77306): Single treatment area, single treatment field, no special modality, no motion management requirements
   – Intermediate (77263, 77285, 77307): Two or more treatment areas or fields, or involvement of two or more regions requiring separate planning considerations
   – Complex (77262, 77290): Three or more treatment fields, use of special techniques (wedges, custom blocking, rotational techniques), or proximity to critical structures requiring detailed dosimetric optimization
3. Respiratory motion management simulation (77293): Covered when:
   – Target tumor exhibits clinically significant respiratory motion (e.g., lung, liver, upper abdominal tumors)
   – Treatment requires 4D-CT acquisition or equivalent motion management protocol
   – Respiratory motion management is required for IMRT, SBRT, or proton beam delivery to ensure target accuracy
4. IMRT planning (77301): Covered when:
   – IMRT delivery (77407 Level 2, or 77412 Level 3) is planned and medically indicated per Section 4B criteria
   – Inverse planning with computer-generated dosimetry is performed
   – Radiation oncologist reviews and signs dose-volume histograms (DVHs) for all targets and organs at risk
   – IMRT planning is not covered for treatments not meeting IMRT indications in Section 4B
5. Brachytherapy isodose plans (77316, 77317, 77318): Covered for every brachytherapy implant or application; complexity code matches number of channels, sources, and technique:
   – Simple (77316): Single-plane, 1–4 sources or remote afterloading 1–8 sources
   – Intermediate (77317): Multiple planes, 5–10 sources/ribbon applications; remote afterloading brachytherapy, 9–12 sources
   – Complex (77318): Multi-plane, complex volume reconstruction, or >12 channels
6. Unlisted planning code (77299): Requires individual clinical review and written justification from radiation oncologist documenting why no established code applies.

Criteria — Treatment Management (77336, 77370, 77427, 77431, 77432, 77469, 77470)

Coverage is met when:

1. Weekly radiation treatment management (77427): One unit per 5 fractions (or weekly if receiving daily radiation therapy) of external beam radiation therapy (EBRT). Requires documented radiation oncologist management visit per five treatment fractions covering: treatment tolerance assessment, review of imaging/port films, documentation of clinical

status, and plan modifications if indicated. Note: 77427 applies to standard EBRT, SBRT, SRS, proton, and brachytherapy courses. 77427 is NOT applicable to SRT (see Section 4G).

2. Short-course management (77431): Management of courses consisting of only 1 or 2 fractions total (e.g., single-fraction palliative, certain SRS courses). Not billable when 77432 or 77427 is more appropriate.

3. SRS management — complete course (77432): One unit for the complete course of SRS. Requires:

- Cranial SRS treatment
- Documented radiation oncologist evaluation of clinical and technical aspects
- Management decision recorded in treatment record

4. Continuing medical physics consultation (77336): Per 5 fractions of radiation treatment. Requires documented physicist review of treatment parameters, dosimetric accuracy, and quality assurance of dose delivery. Also applicable to SRT when a licensed medical physicist provides oversight; billable weekly (per 5 SRT treatments).

5. Special medical radiation physics consultation (77370): Covered for ONE of the following per consultation event:

- Brachytherapy combined with external beam radiation (combined planning/delivery oversight)
- Special brachytherapy equipment customization for non-standard applications
- Fusion of multiple image sets performed by physicist (PET-CT, MRI-CT, or multi-modality)
- Dosimetric analysis of overlapping or abutting radiation fields
- Dose analysis to fetus or implanted cardiac device (pacemaker, ICD)
- SRS/SBRT dosimetric parameters report requiring specific physics expertise

6. Intraoperative radiation treatment management (77469): Covered when:

- Radiation is delivered in an operating room or operating suite
- Requires same-day surgical procedure (open cavity or partial excision)
- Radiation oncologist is physically present in the operating room

7. Special treatment procedure (77470): Covered in addition to the primary RT delivery code when ONE or more of the following apply:

- Cytotoxic chemotherapy, targeted therapy, or immunotherapy administered DURING radiation requiring special timing of radiation and chemotherapy (not merely concurrent systemic therapy without required RT/systemic coordination)
- Brachytherapy combined with external beam radiation therapy in same course
- Proton beam therapy
- Total body irradiation (TBI) or hemibody irradiation
- [Under 18] Pediatric patient requiring general anesthesia or deep sedation for daily treatment with daily physician supervision
- Cases requiring reconstruction of a previous radiation treatment plan due to documented equipment change or treatment interruption
- Complex clinical circumstances requiring additional medical management not captured by standard management codes (must be documented in the record)

4B. EXTERNAL BEAM RADIATION THERAPY (3D-CRT AND IMRT)

CPT: 77402 (Level 1), 77407 (Level 2), 77412 (Level 3), 77387-26

> Note: Codes 77385, 77386, 77417, 77014, 77401, G6001, G6002, G6003–G6016, and G6017 are deleted effective January 1, 2026 and are no longer applicable. All EBRT — including all IMRT techniques — is reported under 77402, 77407, or 77412. Code selection is based on clinical complexity, not technique name. Code 77401 (superficial/orthovoltage) is deleted; SRT is reported using dedicated codes 77437 and 77438 (see Section 4G).

4B.1 — Delivery Code Level Selection

Level 1 — 77402 (Simple):

- Single electron field
- Multiple non-abutting electron fields
- 2D photon treatment
- Expected utilization: <5% of all EBRT cases

Level 2 — 77407 (Intermediate — "Workhorse"):

- Single isocenter, 3D-CRT or IMRT
- No active motion management (no gating, no SGRT, no breath-hold, no 4D CBCT during delivery)
- Examples: standard prostate IMRT (single isocenter), whole breast 3D or IMRT, pelvic nodal IMRT (single isocenter)
- Expected utilization: >50% of EBRT cases

Level 3 — 77412 (Complex):

- Requires documentation of ANY ONE of the following:
  - (a) Active motion management: Gating, surface-guided radiation therapy (SGRT), breath-hold technique, or 4D CBCT during delivery
  - (b) Multiple isocenters: Treatment requiring more than one isocenter
  - (c) Mixed photon-electron modality: Use of both photon and electron beams in the same treatment session
  - (d) Total skin electron therapy (TSET)
- Audit documentation requirement: Clinical documentation must explicitly state one of the following qualifying phrases:
  - "Multiple isocenters utilized" — required to support 77412(b)
  - "Active motion management (Gating/SGRT) employed" — required to support 77412(a)
  - Without one of these explicit statements in the clinical record, auditors may downcode 77412 to Level 2 (77407)
- Expected utilization: ~35% of EBRT cases

4B.2 — 3D Conformal Radiation Therapy (3D-CRT)

3D-CRT is medically necessary for any confirmed malignancy or specified benign condition where external beam radiation is clinically indicated per evidence-based guidelines. 3D-CRT does not require separate justification beyond the universal prerequisites. The following

site-specific criteria apply:

Breast Cancer:

- Whole breast irradiation (WBI) following breast-conserving surgery (lumpectomy/partial mastectomy) for invasive carcinoma or ductal carcinoma in situ (DCIS) — any stage
  - Preferred dose: 40–42.5 Gy in 15–16 fractions (moderate hypofractionation, NCCN Category 1)
  - Alternative: Conventional fractionation 45–50 Gy in 25–28 fractions
  - Tumor bed boost: 10–16 Gy in 4–8 fractions sequential, or simultaneous integrated boost
- Post-mastectomy radiation therapy (PMRT) for:
  - pN1–N3 axillary nodal involvement
  - T3–T4 primary tumors
  - Node-negative disease with high-risk features: positive or close surgical margins, extensive lymphovascular invasion (LVI), or clinical T3 disease
  - Preferred dose: 40–42.5 Gy in 15–16 fractions (ASTRO/ASCO/SSO 2025 Guideline)
- Regional nodal irradiation (RNI) when ≥4 positive axillary nodes, or medial tumor with ≥1 positive node, or clinical T3–T4 disease

Lung Cancer:

- Stage III non-small cell lung cancer (NSCLC): Concurrent chemoradiotherapy (CCRT) — 60 Gy in 30 fractions (2 Gy/fraction) with concurrent platinum-based doublet (NCCN Category 1). Dose escalation beyond 60 Gy is not supported by evidence and is not medically necessary.
- Small cell lung cancer, limited stage: Concurrent thoracic RT with chemotherapy; once-daily (1.8–2 Gy/fraction) or twice-daily (1.5 Gy BID) fractionation
- Prophylactic cranial irradiation (PCI): For SCLC patients with response to systemic therapy

Prostate Cancer (3D-CRT or IMRT):

- All risk groups when definitive radiation is chosen by the patient/physician team (low through very-high risk):
  - Moderate hypofractionation: 60–70 Gy in 20–28 fractions (preferred per ASTRO/ASCO/AUA joint guideline)
  - Conventional fractionation: 75.6–79.2 Gy in 42–44 fractions (acceptable; 78 Gy in 39 fractions commonly used)
  - IMRT is required for moderate hypofractionation with IGRT
  - Maximum fractions for prostate-only (no pelvic nodes): 44 fractions conventional; 28 fractions hypofractionated
  - Pelvic nodal irradiation: Up to 45 fractions total
- Post-prostatectomy RT (adjuvant or salvage):
  - Indications: pT3 disease, positive surgical margins, Gleason 8–10, extracapsular extension (ECE) or seminal vesicle invasion (SVI), or rising PSA post-prostatectomy
  - Dose: 64–72 Gy standard fractionation; or hypofractionated 52.5 Gy in 20 fractions; or 62.5 Gy in 25 fractions

Colorectal Cancer:

- Stage II–III rectal cancer: Neoadjuvant RT recommended
  - – Short-course: 25 Gy in 5 fractions (total neoadjuvant therapy [TNT] protocol)
  - – Long-course chemoradiation: 45–50.4 Gy in 25–28 fractions with concurrent fluoropyrimidine-based chemotherapy
  - – Both approaches acceptable as part of TNT when followed by consolidation chemotherapy
- RT precedes surgery when indicated; non-operative management is an option after complete clinical response to TNT

Lymphoma:

- Hodgkin lymphoma, Stage I–II: Combined modality therapy — involved-site RT (ISRT), 20–30 Gy following chemotherapy (NCCN Category 1)
- Stage I–II unfavorable: ISRT 30–36 Gy
- Non-Hodgkin lymphoma (NHL), limited stage: ISRT 24–30 Gy (2 Gy/fraction) as definitive or combined modality
- Indolent NHL, advanced stage (palliative): 4 Gy in 2 fractions or single fraction 4 Gy

Brain and CNS:

- Glioblastoma (GBM, WHO Grade 4): 60 Gy in 30 fractions with concurrent temozolomide (Stupp protocol, NCCN Category 1); hypofractionated 40 Gy in 15 fractions for elderly patients or those with poor performance status (KPS <70)
- Low-grade glioma (IDH-mutant, Grade 2–3): 50.4–54 Gy in 28–30 fractions
- Whole brain radiation therapy (WBRT): 30 Gy in 10 fractions or 37.5 Gy in 15 fractions. Hippocampal-avoidance WBRT (HA-WBRT) with memantine is preferred over standard WBRT when technically feasible

Head and Neck:

- All primary head and neck cancers: IMRT is the standard of care (see Section 4B.3)
- Palliative head and neck RT for metastatic or recurrent disease: 20–30 Gy in 5–10 fractions

Cervical Cancer:

- Definitive (locally advanced, Stage IB2–IVA): Pelvic EBRT 45 Gy in 25 fractions (1.8 Gy/fraction) with concurrent cisplatin + brachytherapy boost (see Section 4D)
- Adjuvant (postoperative): EBRT 45–50.4 Gy for high-risk features (positive nodes, positive margins, parametrial involvement — Peters criteria) ± concurrent cisplatin; EBRT alone for intermediate-risk features (Sedlis criteria)

Bone Metastases (Palliative):

- Symptomatic bone/spinal metastases, pain management, or imminent pathologic fracture risk. Four equivalent fractionation schedules:
  - – 8 Gy in 1 fraction (preferred for limited life expectancy)
  - – 20 Gy in 5 fractions
  - – 24 Gy in 6 fractions
  - – 30 Gy in 10 fractions
- Post-operative RT for non-spine bone metastases after surgical stabilization

- Malignant spinal cord compression (MSCC): Radiation in combination with surgery (for appropriate surgical candidates) and dexamethasone; conventional RT for non-surgical candidates

Other Covered Sites:

- Anal cancer: 54–59.4 Gy concurrent chemoradiotherapy (5-FU + mitomycin-C; NCCN Category 1)
- Bladder cancer (trimodality therapy): Concurrent chemoradiation following maximal TURBT for muscle-invasive bladder cancer in patients who decline or are unfit for cystectomy
- Endometrial cancer: Pelvic EBRT for intermediate- or high-risk features post-hysterectomy per NCCN guidelines (not indicated for low-risk Stage IA, Grade 1–2 disease)
- Esophageal cancer: Definitive or preoperative chemoradiation 41.4–50.4 Gy in 23–28 fractions
- Basal and squamous cell skin cancers: Definitive or postoperative RT per ASTRO guideline (updated 10/18/2025) when surgery is not feasible due to location, patient preference, or medical contraindication. For superficial/orthovoltage SRT technique, see Section 4G.
- Any histologically confirmed solid tumor at any site where EBRT provides clinically meaningful benefit per current NCCN guidelines

4B.3 — Intensity-Modulated Radiation Therapy (IMRT)

Note on 2026 Coding: IMRT is no longer billed with 77385 or 77386 (deleted). IMRT is reported as 77407 (Level 2, single isocenter, no active motion management) or 77412 (Level 3, multiple isocenters or active motion management). Planning code 77301 continues to apply.

IMRT is medically necessary when at least ONE of the following clinical indications is met:

Age-Specific — Pediatric (Under 18):

1. Any solid tumor in a patient under 18 years of age. IMRT is the standard of care for all pediatric solid tumors to minimize radiation dose to developing tissues, reduce secondary malignancy risk, and preserve growth and development.

CNS and Skull Base (All Ages):

2. Ocular tumors, including intraocular melanomas
3. Skull base tumors of any histology (chordoma, chondrosarcoma, meningioma, other)
4. Primary malignant or benign CNS tumors (including but not limited to glioma, GBM, ependymoma, medulloblastoma, craniopharyngioma, acoustic neuroma, pituitary neoplasm)
5. Primary or metastatic spinal or spinal cord tumors requiring dose escalation near the spinal cord
6. Craniospinal irradiation (primary or metastatic)

Head and Neck (All Ages):

7. All primary and secondary head and neck cancers requiring definitive, adjuvant, or palliative radiation, including: nasopharynx, nasal cavity, paranasal sinuses, oropharynx, oral cavity, hypopharynx, larynx, thyroid, salivary glands, mucosal melanoma, and

cutaneous malignancies with perineural or cranial nerve invasion at the skull base. Rationale: IMRT reduces grade ≥2 xerostomia by 41–47% versus 3D-CRT in randomized controlled trials and reduces loco-regional recurrence risk (HR 0.76) and mortality (HR 0.70).

Breast Cancer (Under 18 and 18 and Over):

8. Left-sided breast cancer where cardiac constraints (Heart V25 >10% or LAD mean dose >15 Gy) cannot be met with 3D conformal planning

9. Internal mammary node (IMN) irradiation when ≥4 positive axillary nodes, or medial tumor with nodal involvement

10. 3D-CRT isodose planning demonstrating hot spots >110% covering more than 2 cm^3 despite optimized forward planning

11. Accelerated partial breast irradiation (APBI) via IMRT

12. Previously irradiated breast field requiring reirradiation

13. Bilateral breast cancer requiring nodal irradiation on at least one side

14. Limited ipsilateral arm range of motion requiring arms-down treatment position

Thoracic (All Ages):

15. Primary or secondary mediastinal tumors

16. Early-stage NSCLC when SBRT is not feasible (central location, poor pulmonary function preventing SBRT tolerability)

17. Esophageal cancer (definitive or preoperative chemoradiation)

18. Stage III locally advanced NSCLC when mean lung dose (MLD) constraints cannot be met with 3D-CRT: documented V20 >30% with 3D planning, and IMRT reduces V20 by ≥10% and maintains V5 <65%

Abdominal/Pelvic (All Ages):

19. Primary hepatocellular carcinoma (HCC), intrahepatic cholangiocarcinoma, and biliary tract cancers

20. Pancreatic cancer (definitive, consolidative, or palliative intent)

21. Gastric cancer (adjuvant or definitive chemoradiation)

22. Cervical cancer (where EBRT pelvic fields plus involved para-aortic coverage required, and organ-at-risk constraints cannot be met with 3D planning)

23. Endometrial cancer with para-aortic nodal coverage

24. Bladder cancer requiring dose escalation or boost

25. Prostate cancer (required for moderate hypofractionation and ultra-hypofractionation per ASTRO/AUA/ASCO guideline)

Sarcoma:

26. Retroperitoneal sarcoma (unresectable or postoperative)

27. Desmoid tumors

28. Extremity soft tissue sarcomas near critical neurovascular structures

Lymphoma:

29. Mediastinal Hodgkin or non-Hodgkin lymphoma when IMRT reduces cardiac or pulmonary dose versus 3D-CRT

30. Head and neck lymphoma involvement

Reirradiation (All Sites):

31. Any site where prior radiation therapy was delivered and cumulative dose to critical structures would exceed established tolerance doses without IMRT dose-sculpting

IMRT-Specific Documentation Requirements:

- Explicit statement in the treatment record identifying the modality as IMRT (cannot be inferred from equipment)
- Explicit statement that inverse planning was used
- Treatment prescription specifying dose constraints for all target volumes and critical structures (see Universal Prerequisites Section 4, item 2)
- Radiation oncologist review and signature on isodose distributions and DVHs (with date)
- Description of beam/arc arrangements (number and location of fields, rotations, or portals)
- Dosimetric verification of treatment setup and delivery signed by both the radiation oncologist and medical physicist, with credentials and date
- For 77412 (Level 3) claims: Explicit statement in clinical documentation of the qualifying complexity factor: "Multiple isocenters utilized" OR "Active motion management (Gating/SGRT) employed" OR "Mixed photon-electron modality" OR "Total skin electron therapy." Absence of this language is grounds for downcoding to 77407.

4C. STEREOTACTIC RADIOSURGERY (SRS) AND STEREOTACTIC BODY RADIATION THERAPY (SBRT)

CPT: 77373, 77431, 77432, G0339, G0340, 77387-26

Definition: SBRT/SRS is a short course of radiation therapy delivered in 1 to 5 fractions, using stereotactic precision with image guidance and precise patient immobilization to deliver high dose per fraction. A course exceeding 5 fractions does not qualify as SBRT and must be coded as IMRT or conventional EBRT.

Important 2026 Note: Do NOT separately bill 77387 with SBRT (77373). Image guidance is bundled into the SBRT delivery codes. Separately billing 77387-26 with 77373 on the same date of service is a billing error.

4C.1 — SRS: Intracranial and Spinal Indications

Coverage is met when the patient has ONE of the following conditions AND meets the performance status criteria below:

Malignant Brain and Spine:

1. Brain metastases (1–4 intact lesions): SRS is preferred over WBRT for patients with KPS ≥70 (NCCN, ASCO/ASTRO/SNO 2021 Joint Guideline). Dose standards:
   - Lesion < 2 cm diameter: 20–24 Gy in 1 fraction
   - Lesion 2–3 cm: 18 Gy in 1 fraction
   - Lesion 3–4 cm: 15 Gy in 1 fraction
   - Resection cavity SRS: 12–20 Gy in 1 fraction or 27 Gy in 3 fractions
2. Brain metastases (>4 lesions): SRS to individual lesions is covered when total tumor volume is appropriate for single-session or fractionated SRS, PS is adequate (KPS ≥60),

and SRS can be delivered with acceptable risk; HA-WBRT remains an alternative

3. Post-surgical resection cavity (1–2 cavities): SRS preferred over WBRT

4. Primary CNS malignancies (GBM, other glioma, PCNSL): SRS as boost or salvage for lesions < 5 cm with adequate PS

5. Spinal/vertebral body metastases (SBRT): Covered for patients with:

– Good performance status (KPS ≥60 or ECOG ≤2)

– No epidural spinal cord compression requiring surgery first

– Controlled or oligoprogressive systemic disease

– Dose standards: 16–24 Gy in 1 fraction; 24 Gy in 2 fractions; 24–30 Gy in 3 fractions; 30–40 Gy in 5 fractions

6. Reirradiation of previously irradiated intracranial or spinal lesions where stereotactic precision is required to limit cumulative dose to the spinal cord or brainstem

Benign Brain and Skull Base Tumors:

7. Meningiomas (WHO Grade I–II), acoustic neuromas/vestibular schwannomas, pituitary adenomas, pineal gland tumors, craniopharyngiomas, glomus tumors, hemangioblastomas — when surgery is not feasible or patient declines surgery

8. Arteriovenous malformations (AVMs) and cavernous malformations of the brain

9. Trigeminal neuralgia refractory to medications and/or other interventional procedures (minimum 2 pharmacologic agents tried and failed must be documented)

Performance Status Requirement (Mandatory for all SRS/SBRT):

• KPS ≥ 40 OR ECOG ≤ 3 at time of treatment initiation

• For patients with stable systemic disease expected to recover: expected KPS ≥ 70 or ECOG ≤ 2 within a clinically reasonable timeframe

4C.2 — SBRT: Extracranial Indications (All Ages)

Coverage is met when the patient has ONE of the following:

Lung Cancer:

1. Early-stage NSCLC, T1–T3, N0, M0 (Stage I–II) — medically inoperable due to pulmonary function impairment (FEV1 < 50% predicted and/or DLCO < 50% predicted), cardiac comorbidity, or other medical contraindication to surgery. SBRT is Category 1 NCCN and the established standard of care.

– Peripheral tumor: 54 Gy in 3 fractions; 50 Gy in 4 fractions; 60 Gy in 5 fractions; or 48 Gy in 4 fractions

– Central tumor (within 2 cm of proximal bronchial tree): 50–60 Gy in 4–5 fractions (3-fraction regimen is NOT appropriate for central tumors)

– Ultra-central tumor (within 1 cm of critical structures): 5–8 fractions with individualized dosing

2. Early-stage NSCLC, medically operable but high operative risk (marginal lung function, advanced age with significant cardiac/pulmonary comorbidities): SBRT as alternative following multidisciplinary discussion (ASTRO conditional recommendation, moderate evidence). Tissue biopsy strongly recommended prior to SBRT.

3. Multiple primary lung cancers (synchronous or metachronous) following multidisciplinary tumor board discussion

Prostate Cancer:

4. Clinically localized prostate cancer, low- to intermediate-risk: Ultra-hypofractionated SBRT (36.25 Gy in 5 fractions; 7.25 Gy per fraction) (NCCN Category 2A; ASTRO conditional recommendation). Requires:
   – IMRT planning capability
   – Image guidance (IGRT) every fraction
   – Fiducial markers or equivalent target localization
   – Rectal spacer (e.g., SpaceOAR) if clinically appropriate
   – Documentation that patient was informed of all treatment options, risks, and benefits

Liver/Hepatic:

5. Hepatocellular carcinoma (HCC): Unresectable, not amenable to ablation, Child-Pugh A or B7, ≤3 lesions, total tumor volume compatible with safe dosing. Per CMS LCD L35076.

6. Liver metastases (oligometastatic): 1–5 lesions from controlled primary (colorectal, breast, NSCLC, melanoma, prostate, renal cell, sarcoma); controlled systemic disease; curative or consolidative intent documented by radiation oncologist

Kidney, Adrenal, Pancreas:

7. Primary renal cell carcinoma (unresectable or patient declines surgery)

8. Adrenal metastases (oligometastatic) with controlled primary

9. Pancreatic cancer (locally advanced, unresectable): SBRT as component of definitive therapy or consolidation (4–5 fractions)

Pelvic/Genitourinary:

10. Pelvic tumors (gynecologic, colorectal) that have recurred after prior pelvic irradiation — reirradiation with SBRT (stereotactic precision required to respect cumulative spinal cord/bowel dose)

11. Prostate cancer oligometastases: 1–3 metastatic bone or lymph node lesions with controlled primary tumor and PSMA-PET or equivalent staging confirming oligometastatic status

Head and Neck Reirradiation:

12. Recurrent head and neck cancer in a previously irradiated field: SBRT (≤5 fractions) is appropriate when reirradiation with conventional fractionation is not safe

Oligometastatic Disease (Any Primary Site, All Ages):

13. Oligometastatic disease defined as 1–5 measurable metastatic lesions; controlled primary tumor; good performance status (ECOG 0–2); curative or disease-control intent documented:
   – Eligible primary histologies: breast, colorectal, melanoma, NSCLC, prostate, renal cell carcinoma, sarcoma (NCCN Oncology Guidelines 2025; ASCO Oligometastatic Disease Guideline, June 2025)
   – Sites: lung, liver, adrenal, bone, lymph node
   – Each site treated per established dose/fractionation standards

Reirradiation (Any Site):

14. Any previously irradiated anatomic site where:

– High precision is required to minimize further injury to previously irradiated normal tissue
– Conventional radiation methods are not appropriate or safe due to proximity to critical structures
– Rationale is documented in the medical record

SBRT-Specific Documentation Requirements:

- KPS or ECOG score documented (mandatory)
- Radiation oncologist evaluation documenting clinical and technical aspects with resulting management decision
- For oligometastatic disease: Explicit written justification for aggressive local therapy, including expected clinical benefit (disease clearance, progression-free survival, or defined symptom control goal)
- For reirradiation: Prior radiation therapy records including dates, fields, and total doses received
- For lung SBRT: Histologic confirmation strongly recommended; if biopsy is not performed, multidisciplinary team (MDT) rationale documenting why biopsy was not obtained must be in the record
- Maximum 5 fractions per SBRT course

4D. PROTON BEAM THERAPY (PBT)

CPT: 77520, 77522, 77523, 77525

Medical Necessity Framework: Proton beam therapy is medically necessary when the clinical indication meets Group 1 criteria (Section 4D.1) OR when it meets Group 2 criteria with evidence development requirements (Section 4D.2). At least ONE of the following three core criteria (ASTRO PBT Model Policy, 2022) must be documented:

- Criterion A — Proximity to Critical Structure: The target volume is located near one or more critical structures requiring a steep dose gradient outside the target to avoid exceeding the tolerance dose of the adjacent organ at risk.
- Criterion B — Integral Dose Reduction: The proton technique would decrease the probability of clinically meaningful normal tissue toxicity by lowering the integral dose metric compared to the best achievable photon plan.
- Criterion C — Reirradiation: The patient has received prior radiation therapy to the same or adjacent anatomic area; dose must be sculpted to avoid exceeding cumulative tolerance dose of nearby normal tissue.

4D.1 — Group 1: Frequently Supports PBT (Medically Necessary)

Pediatric and Adolescent Patients (Under 18):

1. [Under 18] ALL malignant or benign tumors in patients under 18 years of age with curative intent — proton beam therapy is covered without requiring additional comparative dosimetry when one of Criteria A, B, or C is met. Rationale: Scattered low-dose radiation from photon therapy impairs bone growth, causes neurocognitive deficits, increases secondary malignancy incidence, and damages developing organs in children; proton Bragg peak physics substantially reduces these risks.

2. [Under 18] Pediatric patients requiring palliative radiation when other clinical criteria are met

3. [Under 18] Patients with hereditary cancer predisposition syndromes (neurofibromatosis type 1 [NF-1], Li-Fraumeni syndrome, ataxia-telangiectasia [ATM], retinoblastoma, BRCA 1/2, Lynch syndrome) — radiation volume minimization is paramount; proton beam is medically necessary regardless of age

CNS and Skull Base (All Ages):

4. Unresectable benign or malignant CNS tumors: astrocytoma, glioblastoma, medulloblastoma, acoustic neuroma/vestibular schwannoma, craniopharyngioma, benign or atypical meningioma, pineal gland tumors, AVMs

5. Ocular tumors, including uveal/choroidal melanomas and intraocular malignancies

6. Skull base tumors: chordoma, chondrosarcoma, other skull base histologies

7. Primary or metastatic spine/spinal cord tumors where spinal cord tolerance (45–50 Gy) may be exceeded with photon therapy, or where the spinal cord has been previously irradiated

8. Craniospinal irradiation (CSI) for primary or metastatic CNS disease

Head and Neck (18 and Over):

9. Nasopharynx, nasal cavity, paranasal sinuses, and other accessory sinus tumors

10. Advanced/unresectable head and neck cancers where critical structure proximity (optic apparatus, brainstem, spinal cord, mandible, salivary glands) requires proton precision

Thoracic (All Ages):

11. Primary esophageal cancer when proton beam achieves dosimetric superiority over photon IMRT for lung, cardiac, or spinal cord constraints

12. Mediastinal tumors: thymoma/thymic carcinoma, mediastinal lymphoma where proton reduces cardiac/lung dose, thoracic sarcomas

13. Malignant pleural mesothelioma

14. Mediastinal Hodgkin lymphoma or Non-Hodgkin lymphoma where PBT reduces pneumonitis, secondary malignancy, and cardiovascular late effects versus photon IMRT

Abdominal (All Ages):

15. Hepatocellular carcinoma (HCC) and intrahepatic cholangiocarcinoma: Unresectable, non-metastatic, curative intent — hypofractionated regimen

16. Unresectable retroperitoneal sarcomas

Pelvic (All Ages):

17. Advanced/unresectable pelvic tumors with significant pelvic or para-aortic nodal disease

18. Malignant lesions of the cervix with extensive pelvic/para-aortic nodal coverage where proton reduces bowel/bone marrow dose

19. Single kidney or transplanted pelvic kidney anatomically adjacent to the radiation field

Skeletal (All Ages):

20. Primary malignant or benign bone tumors of any site

Re-irradiation (All Ages):

21. Any prior irradiated site where prior radiation dose is the governing factor necessitating proton beam precision (Z92.3 diagnosis code required; prior RT records must be documented)

Pituitary Neoplasm:

22. Pituitary neoplasms requiring radiation (functional or non-functional) where proton beam achieves superior dose distribution

Prostate Cancer — Specific Documentation (18 and Over):

23. Non-metastatic prostate cancer (any NCCN risk group) when documented proton dosimetric advantage is demonstrated. Additional required documentation:

– Physician documentation of patient selection criteria per NCCN risk group

– Documentation that patient was informed of the full range of therapy choices with risks and benefits

– CT or MRI confirming T and N staging

– DVH demonstrating critical structure protection (rectum, bladder, femoral heads)

– Documented rationale for dose precision requirements specific to the individual patient

4D.2 — Group 2: Coverage with Evidence Development (CED) — Covered When Enrolled in Qualifying Registry or Trial

The following indications may be covered when the patient is enrolled in an IRB-approved clinical trial or multi-institutional patient registry with prospective data collection:

1. Other head and neck cancers not listed in Group 1 (periorbital, salivary gland, bilateral/unilateral H&N;)
2. Breast cancer (specific anatomic and dosimetric criteria per ASTRO model policy)
3. Early-stage lung cancer when photon-based plan cannot meet established dose constraints
4. Locally advanced lung cancer (Stage III NSCLC)
5. Pancreatic cancer with documented dosimetric superiority over IMRT
6. Renal cell carcinoma and adrenal metastases
7. Oligometastatic liver lesions with curative intent
8. Pelvic malignancies (rectal, bladder) in adults where dosimetric comparison demonstrates benefit
9. Anal canal cancer
10. Lymphoma (adult Hodgkin and Non-Hodgkin) outside of criteria listed in Group 1

Proton Beam Documentation Requirements (All Cases):

1. Statement identifying which ASTRO Core Criterion (A, B, or C) is met
2. Treatment prescription defining dose-volume parameters for target volumes and all organs at risk
3. Signed treatment plan meeting prescribed DVH parameters
4. Patient setup verification methodology (positioning protocol, immobilization system, IGRT frequency)
5. Independent dose calculation or physical measurement verification

6. For all cases outside Group 1 (all Group 2 cases): Direct patient-specific isodose comparison between the proton plan and the best achievable IMRT plan. A case-control or population comparison is not sufficient; the comparison must be performed for the individual patient.

7. For prostate cancer: Documentation that the patient was informed of all treatment options, including external beam RT, brachytherapy, surgery, and active surveillance, with risks and benefits of each

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4E. BRACHYTHERAPY

CPT: 77750, 77761, 77762, 77763, 77767, 77768, 77770, 77771, 77772, 77778, 77790, 77799, Q3001

4E.1 — Prostate Cancer (LDR and HDR Brachytherapy)

Under 18: Prostate cancer does not occur in the pediatric population. Codes below apply to patients 18 and over.

18 and Over:

1. LDR permanent seed implant (77778 primary; Q3001 for sources):
   – Low-risk prostate cancer: PSA ≤10 ng/mL, Gleason score ≤6 (ISUP Grade Group 1), cT1–T2a — LDR monotherapy is appropriate (I-125: 144–160 Gy; Pd-103: 115–125 Gy)
   – Favorable intermediate-risk prostate cancer: PSA 10–20 ng/mL or Gleason 7 (ISUP GG 2–3), cT2b–T2c — LDR monotherapy with or without short-term ADT
2. HDR monotherapy:
   – Intermediate-risk prostate cancer: Multiple HDR regimens are acceptable per ABS 2025 guidelines (e.g., 13.5 Gy × 2 fractions; 9.5 Gy × 4 fractions; 6.5 Gy × 6 fractions)
   – Requires institutional expertise and quality assurance documentation per ABS guidelines
3. HDR boost + EBRT (intermediate/high-risk):
   – Single implant: 15 Gy HDR boost + EBRT 45–50.4 Gy
   – Two implants: 9.5–11 Gy/fraction × 2 + EBRT 45–50.4 Gy
   – LDR boost + EBRT: Seeds + 45 Gy EBRT for high/very-high risk disease

4E.2 — Cervical Cancer

18 and Over:

1. Definitive treatment, locally advanced (Stage IB2–IVA):
   – Intracavitary HDR brachytherapy (tandem and ring/ovoids/cylinder) as required component after pelvic EBRT (45 Gy) + concurrent cisplatin
   – Image-guided brachytherapy (MRI-guided or CT-guided; EMBRACE protocol preferred for target delineation)
   – HDR dose: 7 Gy × 4 fractions (28 Gy brachy) to achieve combined EQD2 ≥ 85 Gy to HRCTV D90
   – Small tumors: total EQD2 ≥ 80 Gy to point A
   – LDR equivalent: 30 Gy to point A

2. Postoperative high-risk features (Peters criteria — positive nodes, positive margins, parametrial involvement):
   – Vaginal vault brachytherapy (HDR) in addition to pelvic EBRT

4E.3 — Endometrial/Uterine Cancer

18 and Over:

1. Postoperative vaginal vault brachytherapy (HDR):
   – Intermediate-risk endometrial cancer (Stage IA Grade 3, Stage IB Grade 1–2, Stage II) as alternative to pelvic EBRT
   – High-risk features without extrauterine disease: may be combined with pelvic EBRT
   – Dose options: 7 Gy × 3 fractions; 6 Gy × 5 fractions; 5.5 Gy × 4 fractions (to the vaginal surface)
2. Brachytherapy following hysterectomy for low-risk Stage IA Grade 1–2 disease without myometrial invasion is not indicated (per ASTRO Choosing Wisely)

4E.4 — Breast Cancer

18 and Over:

1. Accelerated partial breast irradiation (APBI) via multicatheter interstitial or intracavitary balloon brachytherapy:
   – Age ≥ 40 (invasive breast cancer) or ≥ 50 (DCIS)
   – Tumor ≤ 2 cm (T1)
   – Pathologically negative surgical margins
   – pN0 or pN0(i+) (node-negative)
   – Skin distance ≥ 6 mm from applicator surface to overlying skin
   – Dose: 34 Gy in 10 fractions (BID; ≥ 6-hour interfraction interval) or equivalent
2. Intraoperative RT (IORT) — 77424 (electrons) / 77425 (photons):
   – Age ≥ 50; tumor ≤ 3 cm; negative margins; N0; skin distance ≥ 6 mm
   – Delivered as single fraction in operating room at time of lumpectomy

4E.5 — Head and Neck Cancers

Under 18 and 18 and Over:

1. Lip cancer (T1–T2): Interstitial brachytherapy as definitive treatment for small, accessible lesions
2. Oral cavity, tongue, and floor of mouth: Interstitial brachytherapy (LDR or HDR) as boost or definitive treatment for select early-stage lesions
3. Tonsillar fossa tumors: Intracavitary or interstitial brachytherapy for select early-stage lesions
4. Nasopharynx (intracavitary): HDR intracavitary brachytherapy as boost to definitive EBRT

4E.6 — Skin Cancer

Under 18 and 18 and Over:

1. HDR skin surface brachytherapy (77767, 77768) for non-melanoma skin cancer (basal cell carcinoma, squamous cell carcinoma) when:
   – Surgery is not feasible due to location (nasal tip, eyelid, pinna, lip), patient refusal, or medical contraindication to surgery
   – Lesion diameter and depth are appropriate for surface applicator (electronic brachytherapy is excluded — see Section 5E and Section 4G.3 item 10)
2. Interstitial implants for complex-site skin cancers not amenable to surface applicator

4E.7 — Endobronchial Brachytherapy

18 and Over:

1. HDR endobronchial brachytherapy for symptomatic airway obstruction from primary or metastatic lung cancer:
   – Palliative intent (hemoptysis, dyspnea, post-obstructive atelectasis)
   – Bronchoscopically confirmed endobronchial lesion accessible to afterloading catheter placement

4E.8 — Ocular Brachytherapy

Under 18 and 18 and Over:

1. Episcleral plaque brachytherapy (radioactive plaque; associated with CPT 67218 for ophthalmic procedure):
   – Uveal melanoma/choroidal melanoma of appropriate size and location for plaque technique
   – Retinoblastoma (unilateral; tumor accessible to plaque technique after ophthalmologic evaluation)

4E.9 — Esophageal Brachytherapy

18 and Over:

1. Intraluminal HDR brachytherapy for residual, obstructing, or unresectable esophageal cancer (palliative intent — dysphagia relief)

4F. IMAGE-GUIDED RADIATION THERAPY (IGRT)

CPT: 77387-26

> 2026 Update: IGRT G-codes G6001, G6002, G6003–G6016, and G6017 are deleted effective January 1, 2026. CPT 77014 (CT guidance for placement of RT fields) is deleted. The technical component of IGRT is bundled into delivery codes 77402, 77407, and 77412. Only the professional component (77387-26) is separately reportable. See billing frequency rules in Section 3H.

IGRT professional services are covered as an integral component of SBRT, SRS, IMRT with hypofractionation, and proton beam therapy. Coverage criteria:

1. 77387-26 (IGRT — Professional Component): Covered for physician review and interpretation of localization imaging when:

– The radiation oncologist personally reviews localization images and documents this review in the daily or weekly clinical note
– Treatment requires daily or weekly image-based target localization to ensure treatment accuracy
– Billing frequency: Weekly for standard EBRT; daily for boost, brachytherapy, and SBRT

4G. SUPERFICIAL RADIATION THERAPY (SRT) FOR NON-MELANOMA SKIN CANCER

CPT: 77436, 77437, 77438, 77439, 77336

> 2026 SRT Policy: This section establishes comprehensive medical necessity criteria for Surface Radiation Therapy (SRT) using the new 2026 CPT codes (77436–77439). CPT 77401 (superficial/orthovoltage delivery) is DELETED effective January 1, 2026 and must NOT be billed. SRT coding does NOT use the standard EBRT planning codes (77280, 77290, 77300, 77334), treatment management code (77427), or planning codes (77261). SRT uses its own dedicated set: 77436 (planning/simulation), 77437/77438 (delivery per fraction), 77439 (add-on ultrasound guidance once per course), and 77336 (physics consultation per week of therapy).

4G.1 — Applicable 2026 SRT Codes

Code	Description
77436	Surface radiation therapy; superficial treatment planning and simulation-aided field setting
77437	Surface radiation therapy; superficial, delivery, ≤150 kV, per fraction (e.g., electronic brachytherapy)
77438	Surface radiation therapy; orthovoltage, delivery, >150–500 kV, per fraction
77439	Surface radiation therapy; superficial or orthovoltage, image guidance, ultrasound for placement of radiation therapy fields for treatment of cutaneous tumors, per course of treatment (add-on)
77336	Continuing medical physics consultation (applicable to SRT when licensed physicist provides oversight; billable weekly per 5 treatments)

> Note: 77439 is an add-on code, billed ONCE per treatment course, only in conjunction with a primary SRT delivery code (77437 or 77438). It may NOT be billed independently or on the same claim without the corresponding delivery code. Per CMS Billing Article A60185, providers must append the KX modifier to 77437 when billing for services covered under LCD L40179.

 MEETS CRITERIA

4G.2 — MEETS CRITERIA for SRT

Based on the ASTRO Clinical Practice Guideline (Likhacheva et al., Pract Radiat Oncol 2020, updated 10/18/2025) and CMS LCD L40179 (effective 1/3/2026):

SRT meets medical necessity when ALL of the following are documented:

1. Histologically confirmed basal cell carcinoma (BCC) or cutaneous squamous cell carcinoma (cSCC)
2. The tumor is a primary (not recurrent) non-melanoma skin cancer
3. The tumor is ≤4 cm in diameter
4. The tumor depth is ≤6 mm
5. The tumor does NOT have aggressive morphology (morpheaform, infiltrative, micronodular BCC; desmoplastic cSCC)
6. The tumor does NOT have perineural or perivascular invasion
7. The tumor is NOT a very high-risk SCC per NCCN criteria
8. AND at least ONE of the following:
   – (a) Patient is NOT a surgical candidate due to medical comorbidities, anticoagulation that cannot be safely held, or other documented contraindication to surgery (per CMS LCD L40179, documentation of nonsurgical candidacy is required)
   – (b) Patient declines surgery after informed consent discussion documenting surgical options
   – (c) Tumor is in an anatomically sensitive location (nose, ear, eyelid, lip, periorbital, perioral) where surgery would compromise function or cosmesis (ASTRO conditional recommendation, moderate evidence; per Likhacheva et al.)
   – (d) Patient has multiple simultaneous NMSCs in the same anatomically important area

Definitive RT dose-fractionation for BCC/cSCC (per ASTRO guideline, Likhacheva et al.):

- Conventional fractionation (180–200 cGy/fx): BED_{10} 70–93.5 (definitive), BED_{10} 59.5–79.2 (postoperative)
- Hypofractionation (210–500 cGy/fx): BED_{10} 56–88 (definitive), BED_{10} 56–70.2 (postoperative)
- Typical SRT regimen: 12–20 fractions
- Standard examples:
  – 5000 cGy in 20 fx (250 cGy/fx)
  – 5400 cGy in 18 fx (300 cGy/fx)
  – 4500 cGy in 15 fx (300 cGy/fx)

Postoperative RT indications (per ASTRO guideline):

Strong recommendations for cSCC:

- Gross perineural spread (clinically or radiologically apparent)
- Close or positive margins not correctable with further surgery
- Recurrence after prior margin-negative resection
- T3 or T4 tumors
- Desmoplastic or infiltrative tumors in immunocompromised patients

Conditional recommendations for BCC:

- Close or positive margins not correctable with further surgery
- Recurrence after prior margin-negative resection
- Locally advanced tumors involving bone or infiltrating muscle

Regional nodal RT (per ASTRO guideline):

- After therapeutic lymphadenectomy: 6000–6600 cGy conventional fractionation
- Elective nodal RT (cSCC with thickness >6 mm): 5000–5400 cGy conventional fractionation

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 DOES NOT MEET CRITERIA

4G.3 — DOES NOT MEET CRITERIA for SRT

SRT does NOT meet medical necessity when ANY of the following apply:

1. SRT used as first-line treatment in surgical candidates without documented contraindication to surgery or an anatomically sensitive location
2. Recurrent tumors in previously irradiated fields or where overlapping fields would be expected
3. Cutaneous SCC or BCC >4 cm
4. Tumor depth >6 mm
5. Aggressive histologic subtypes (morpheaform, infiltrative, micronodular BCC; desmoplastic cSCC) as sole treatment without additional evaluation
6. Very high-risk SCC per NCCN as primary SRT treatment without documented rationale
7. Perineural or perivascular invasion as sole treatment modality where postoperative approaches are more appropriate
8. Genetic conditions predisposing to heightened radiosensitivity (e.g., basal cell nevus syndrome, xeroderma pigmentosum) — per ASTRO guideline, definitive RT is conditionally not recommended in patients with genetic diseases predisposing to heightened radiosensitivity
9. Image-guided SRT (IG-SRT) using high-resolution dermal ultrasound (HRDUS) for daily dose adjustment during treatment delivery — per CMS LCD L40179, HRDUS guidance during SRT delivery is NOT considered reasonable and necessary and is not supported by the published literature
10. Electronic brachytherapy (EBT) for NMSCs — per CMS LCD L40179 and AAD/ASTRO/ABS consensus, electronic brachytherapy is not considered reasonable and necessary at this time; there is insufficient long-term efficacy and safety data to support the use of electronic surface brachytherapy
11. Advanced or metastatic BCC or SCC
12. Non-cutaneous SCC (mucosal, vulvar, penile, perianal)
13. Patient younger than 60 years old as primary treatment when surgery is available (per AUC consensus; Oganesyan V, et al., Skin Research and Technology 2023): SRT as primary treatment is generally not appropriate in patients under age 60 when surgical options exist and the patient is a surgical candidate

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4G.4 — Provider Qualifications

SRT should be administered by a board-certified radiation oncologist OR a board-certified dermatologist (Mohs surgeon) with documented adequate SRT training, working in conjunction with a licensed medical physicist trained and experienced in SRT. (Per Oganesyan V, et al., Skin Research and Technology 2023, and ASTRO/ACMS SRT Coding Statement.)

4G.5 — Documentation Requirements for SRT

All SRT claims require the following documentation in the medical record:

1. Pathology report confirming BCC or cSCC with histologic subtype and description of histologic characteristics (including notation of presence/absence of aggressive features)
2. Tumor measurements (diameter and depth), with clinical staging per NCCN
3. Clinical photographs at baseline (prior to treatment)
4. Documentation of why surgery is not the primary approach — must specify one of the following: (a) documented nonsurgical candidacy with reason(s), (b) anatomic location sensitivity with explanation of functional/cosmetic compromise expected from surgery, or (c) patient preference with documented informed consent discussion including surgical options and risks
5. Radiation prescription including: total dose, dose per fraction (cGy/fx), number of fractions, treatment energy (kV), field size, and applicator specifications
6. For 77439 (ultrasound guidance): documentation of ultrasound guidance performed at treatment planning; billed once per course only; do not bill 77439 for daily HRDUS guidance (not covered per LCD L40179)
7. For 77437 claims: KX modifier required when billing under CMS LCD L40179 coverage parameters

4H. OTHER CODES

A9699 — Radiopharmaceutical, Diagnostic, NOS:

Covered when a specific HCPCS code for the radiopharmaceutical agent does not exist. Requires documentation of the specific agent, clinical indication, and ordering physician credentials.

G0339 / G0340 — SBRT Delivery (Medicare Advantage/Medicaid billing):

Same medical necessity criteria as 77373 apply. G0339 is used for the first fraction; G0340 for fractions 2–5. Maximum 5 fractions per course.

SECTION 5: MEDICAL NECESSITY CRITERIA — DOES NOT MEET CRITERIA

> DOES NOT MEET CRITERIA

The following services do not meet medical necessity criteria and will be denied unless the requesting provider documents exceptional clinical circumstances that overcome these criteria:

5A. Universal — All Radiation Modalities

1. KPS < 40 or ECOG > 3 at time of treatment: Stereotactic radiation (SRS/SBRT) is not medically necessary when the patient's functional status falls below these thresholds at the time of treatment initiation (unless documentation demonstrates expected recovery to KPS ≥ 70 or ECOG ≤ 2 within a clinically defined timeframe).

2. Absence of confirmed or reasonably confirmed diagnosis: Radiation therapy without histologic confirmation of malignancy or documented clinical rationale for proceeding without biopsy (e.g., technically inaccessible lesion with MDT consensus documented).

3. Treatment unlikely to result in clinical benefit: When tumor burden is not completely targetable with acceptable risk to critical normal structures, or when reasonable survival expectation is absent for curative-intent treatment.

4. Duplicate/concurrent codes for same service: Billing of redundant planning, simulation, or management codes for the same treatment event (e.g., billing both 77285 and 77290 for a single simulation).

5. Unlisted codes without prior authorization: CPT 77299, 77399, and 77799 (unlisted procedures) are not covered without advance authorization and written clinical justification demonstrating that no existing code accurately describes the service.

6. Deleted codes submitted for dates of service on or after January 1, 2026: Claims submitted with CPT codes 77385, 77386, 77401, 77417, 77014 or HCPCS codes G6001, G6002, G6003–G6016, or G6017 for dates of service on or after January 1, 2026 will be denied. Providers must use the appropriate 2026 replacement codes:

- 77385 / 77386 → 77407 (Level 2) or 77412 (Level 3) as appropriate
- 77401 → 77437 (≤150 kV SRT) or 77438 (>150–500 kV orthovoltage SRT)
- 77417 → Bundled; no replacement (use delivery code)
- 77014 → TC bundled into delivery codes; professional component use 77387-26
- G6001 through G6017 → Deleted; no separate replacement; use primary delivery codes

5B. External Beam Radiation Therapy (EBRT) — Does Not Meet Criteria

1. Level 2 or Level 3 when Level 1 achieves equivalent dosimetric goals: When documented 3D-CRT or simple planning demonstrates target coverage with equivalent or superior critical structure sparing, a higher complexity level is not medically necessary.

2. IMRT for superficial/orthovoltage treatments: IMRT (77407/77412) is not indicated for non-melanoma skin cancers treated with superficial x-ray or electron beam where simple field arrangements are dosimetrically appropriate. SRT-specific codes 77437 and 77438 apply to low-energy superficial and orthovoltage skin treatments.

3. Fractionation schedules exceeding evidence-based norms without documentation:

- Whole breast irradiation exceeding 36 fractions without documented clinical rationale
- Prostate cancer EBRT exceeding 44 fractions (prostate-only) or 45 fractions (with pelvic nodes) without documented rationale

– Stage III NSCLC dose escalation beyond 60 Gy/30 fractions (RTOG 0617 demonstrated inferior OS with dose escalation to 74 Gy)

4. Routine post-operative RT for low-risk endometrial cancer: Stage IA, Grade 1–2 endometrial cancer without myometrial invasion — adjuvant RT is not indicated (ASTRO Choosing Wisely).

5. Adjuvant RT for resected NSCLC with negative margins and pN0–N1 disease: Postoperative radiotherapy for fully resected NSCLC with negative margins and pN0–N1 does not improve survival and is not medically necessary (ASTRO Choosing Wisely).

6. Routine WBRT in addition to SRS for limited brain metastases: Adding WBRT to SRS for 1–4 brain metastases does not improve OS and increases neurocognitive toxicity. WBRT in addition to SRS for limited brain metastases is not medically necessary as initial treatment (ASTRO Choosing Wisely, ASCO/ASTRO/SNO 2021 Joint Guideline).

7. Non-curative intent radiation without documentation of goals of care: Palliative radiation without documentation of treatment goals and palliative care consultation (or documented reason why palliative care consultation was not obtained).

8. Level 3 (77412) claims without qualifying documentation: Claims for 77412 without explicit documentation of an active motion management technique, multiple isocenters, mixed photon-electron modality, or total skin electron therapy will be downcoded to 77407 (Level 2).

5C. SBRT/SRS — Does Not Meet Criteria

1. SBRT as a boost following conventionally fractionated radiation therapy: SBRT is a complete, standalone course of treatment. SBRT codes (77373, G0339, G0340) used as a boost in addition to a full conventional RT course are not covered as SBRT.

2. Any SBRT course exceeding 5 fractions: By definition, SBRT requires ≤ 5 fractions per course. Any course of radiation exceeding 5 fractions must be coded as IMRT or conventional EBRT, not as SBRT.

3. Primary treatment of bone, breast, uterus, or ovary without specific documented justification: Per CMS LCD L35076, primary treatment (not reirradiation) of isolated bone metastases, breast tumors, uterine tumors, or ovarian tumors with SBRT does not meet standard SBRT covered indications and requires individual documented justification.

4. Widespread cerebral or systemic metastases with very limited life expectancy: SRS for patients with multiple (>10) brain metastases and/or rapidly progressing systemic disease with limited life expectancy unlikely to obtain clinical benefit within the expected survival timeframe.

5. Cobalt-60 pallidotomy: Specifically non-covered per CMS LCD L35076.

6. SBRT for recurrent or metastatic disease that is treatable by conventional methods without specific documentation: When conventional fractionated radiation therapy is clinically appropriate and safe, SBRT is not medically necessary unless the treatment record documents specific clinical or dosimetric reasons why conventional RT is not appropriate.

7. 77387 billed separately with SBRT (77373): Image guidance is bundled into SBRT delivery codes. Separately billing 77387-26 with 77373 on the same date of service is a billing error and will be denied.

5D. Proton Beam Therapy — Does Not Meet Criteria

18 and Over: The following conditions are not covered for proton beam therapy in adult patients (18 and over) without evidence of clinical trial enrollment meeting Group 2 CED criteria, or without individual documented dosimetric superiority:

1. Breast cancer (all types) — proton beam therapy for breast cancer is not medically necessary per current evidence (ASTRO PBT Model Policy 2022, Group 2 — Coverage with Evidence Development)
2. Esophageal cancer in adults (absent proton-specific dosimetric advantage not achievable with IMRT)
3. Gastric cancer
4. Gynecologic cancers in adults (cervical, endometrial, ovarian, vulvar) — absent exceptional anatomic or dosimetric circumstances
5. Lung cancer in adults (Stage I NSCLC, locally advanced Stage III, SCLC) — absent enrollment in qualifying clinical trial or registry
6. Lymphoma in adults (Hodgkin and Non-Hodgkin) — absent mediastinal proximity criteria or trial enrollment
7. Pancreatic cancer in adults — absent enrollment in qualifying clinical trial or registry
8. Prostate cancer when documented comparative dosimetry does not demonstrate superiority over IMRT, or when the required documentation elements in Section 4D.1 are absent

Under 18 and 18 and Over (all ages):

9. When no ASTRO Core Criterion (A, B, or C) is met: Proton beam therapy for any indication when the clinical rationale does not meet at least one of the three ASTRO core criteria is not medically necessary.
10. Group 2 indications without qualifying trial or registry enrollment: When enrollment documentation is absent.
11. When comparative dosimetry is required but not submitted: For any case outside Group 1, the absence of a patient-specific isodose comparison between proton and IMRT plans is grounds for denial.
12. When proton therapy constitutes the experimental arm of a clinical trial: Investigational-arm only coverage is not included in this policy; refer to the clinical trial coverage provisions in Section 7.

5E. Brachytherapy — Does Not Meet Criteria

1. Electronic brachytherapy (Xoft/Axxent and equivalent devices) for any indication: Electronic brachytherapy is not medically necessary for breast, gynecologic, prostate, or skin cancers. The published evidence does not demonstrate equivalence to HDR photon brachytherapy for efficacy or long-term outcomes. Codes 77767, 77768, 77770–77772, and 77778 do not apply to electronic brachytherapy devices. See also Section 4G.3 item 10.
2. Brachytherapy for systemic or diffuse disease: Intracavitary or interstitial brachytherapy is not appropriate for systemically disseminated malignancy where localized radiation does not provide meaningful clinical benefit.

3. Combined EBRT + brachytherapy boost for intermediate-risk prostate cancer (RTOG 0232 data): Combined modality treatment (EBRT + brachytherapy boost) for intermediate-risk prostate cancer does not improve freedom from progression compared to brachytherapy monotherapy but significantly increases grade ≥3 late GU/GI toxicity (8.2% vs. 3.8%). Combined modality for intermediate-risk prostate cancer requires documented clinical rationale for the individual patient.

4. Brachytherapy for low-risk Stage IA Grade 1–2 endometrial cancer without myometrial invasion: Postoperative brachytherapy is not indicated for this cohort.

5F. Surface Radiation Therapy (SRT) — Does Not Meet Criteria

The following SRT services do not meet medical necessity and will be denied:

1. SRT billed with deleted code 77401 (for DOS on or after 1/1/2026) — use 77437 or 77438
2. Standard EBRT planning codes (77280, 77290, 77300, 77334, 77427, 77261) billed for SRT services — these codes do not apply to SRT and will be denied when billed with SRT delivery codes
3. 77439 billed more than once per treatment course
4. 77439 billed without a corresponding primary SRT delivery code (77437 or 77438) on the same claim or course
5. HRDUS guidance during daily SRT delivery billed as image guidance — per LCD L40179, daily HRDUS guidance is not covered
6. Electronic brachytherapy (Xoft/Axxent) billed under SRT codes — not covered per LCD L40179 and AAD/ASTRO/ABS consensus
7. SRT for non-cutaneous malignancies (mucosal, visceral, or non-skin sites)
8. SRT for patients with documented radiosensitivity genetic syndromes (basal cell nevus syndrome, xeroderma pigmentosum)
9. SRT as primary treatment for patients under 60 years of age who are surgical candidates — requires documented individualized justification
10. Standard EBRT treatment management codes (e.g., 77427) billed for SRT services

5G. FLASH Radiation Therapy (0747T) — Investigational

1. 0747T (FLASH radiation therapy) is not covered as a standard clinical service. Ultra-high dose-rate (FLASH) radiation therapy is investigational. No current NCCN, ASTRO, or CMS coverage determination supports routine clinical use. Active clinical trials are ongoing (GBM, lung, esophageal, other sites). Coverage may be available only through clinical trial provisions in Section 7.

SECTION 6: CLINICAL BACKGROUND

6A. Evidence Summary — External Beam Radiation Therapy

Radiation therapy is a cornerstone of cancer treatment, used in approximately 50–60% of patients with cancer at some point in their treatment course. The therapeutic window — the

differential between dose required for tumor control and dose causing unacceptable normal tissue injury — determines modality selection.

3D-CRT uses CT-based volumetric planning to conform radiation dose distributions to tumor volumes in three dimensions. It is the standard modality for many cancers and remains appropriate when dose-volume histogram analysis demonstrates adequate target coverage with acceptable critical structure doses.

IMRT uses computer-optimized inverse planning to generate highly conformal dose distributions through multiple beam angles or arc rotations. Meta-analytic evidence demonstrates IMRT reduces grade ≥2 xerostomia by 41–47% versus 3D-CRT in head and neck cancers (7 RCTs, PMC7493335), reduces loco-regional recurrence (HR 0.76), and reduces mortality (HR 0.70) for head and neck cancers. IMRT with IGRT is the required technique for hypofractionated prostate cancer RT per ASTRO/ASCO/AUA guidelines.

Dose-fractionation science: Hypofractionation (larger doses per fraction, fewer fractions) exploits the favorable alpha/beta ratio of prostate and breast cancers. Moderate hypofractionation for whole breast irradiation (40–42.5 Gy/15–16 fx) and prostate (60–70 Gy/20–28 fx) is now preferred over conventional fractionation based on multiple Phase III RCT data.

6B. Evidence Summary — SBRT/SRS

Stereotactic radiation delivers ablative doses in 1–5 fractions with sub-millimeter precision, achieving biologically equivalent doses (BED) > 100 Gy in many regimens. Key evidence:

- NRG/RTOG 0236 (JAMA Oncology 2018): SBRT 60 Gy/3 fractions for inoperable early-stage NSCLC — 5-year primary tumor control 93%, 5-year OS 40%. Established SBRT as standard of care.
- ORIOLE (Phase II): SBRT for oligometastatic prostate cancer — reduced 6-month progression from 61% to 19% versus observation.
- COMET (Phase II RCT): SABR versus standard of care for 1–5 oligometastatic lesions — demonstrated PFS benefit across multiple primary histologies.
- RTOG 9508: SRS + WBRT improved survival versus WBRT alone for single unresectable brain metastasis. SRS is now preferred over WBRT for limited brain metastases.

6C. Evidence Summary — Proton Beam Therapy

Proton beam therapy exploits the Bragg peak — a physical property of charged particles that deposits the majority of radiation dose at a defined depth, with minimal exit dose. This physics advantage reduces integral radiation dose to surrounding normal tissues.

The clinical benefit of the Bragg peak advantage is most clearly established in pediatric cancers (where scattered low-dose radiation causes growth impairment, secondary malignancies, and neurocognitive injury), skull base tumors (chordoma, chondrosarcoma), ocular melanomas, and cases requiring reirradiation. The ASTRO PBT Model Policy (2022) provides the established framework for identifying indications where the dosimetric advantage is most likely to translate into clinical benefit.

6D. Evidence Summary — Brachytherapy

Brachytherapy delivers radiation from radioactive sources placed within or adjacent to tumors, achieving steep dose gradients. For prostate cancer, the ABS 2025 consensus demonstrates HDR brachytherapy boost achieves superior biochemical control and similar or reduced toxicity compared to dose-escalated EBRT alone. For cervical cancer, image-guided brachytherapy (MRI-based) per the EMBRACE protocol improves local control and reduces organ-at-risk doses compared to 2D techniques.

6E. Evidence Summary — Superficial Radiation Therapy (SRT)

SRT uses low-energy (50–500 kV) x-rays to treat superficial skin lesions, with >90% of dose deposited in the first 5–10 mm of tissue. SRT is most appropriate for basal cell carcinoma (BCC) and cutaneous squamous cell carcinoma (cSCC) in patients who are not surgical candidates or have anatomically sensitive tumors.

The ASTRO Clinical Practice Guideline (Likhacheva et al., 2020, updated 10/18/2025) provides strong evidence for SRT as definitive treatment when surgery is contraindicated or declined, and conditional evidence for anatomically sensitive locations. Local control rates for definitive SRT are approximately 85–95% at 5 years for BCC and cSCC ≤4 cm treated with adequate dose-fractionation. CMS LCD L40179, effective January 3, 2026, establishes specific coverage criteria that this policy incorporates.

Key evidence limitations: Electronic brachytherapy (EBT) and image-guided SRT with daily HRDUS dose adjustment lack sufficient long-term safety and efficacy data; both are excluded from coverage per LCD L40179 and multi-society consensus.

6F. NCCN Clinical Practice Guidelines — Evidence Categories and Integration

The National Comprehensive Cancer Network (NCCN) publishes Clinical Practice Guidelines in Oncology that stratify recommendations by evidence category. These categories are directly relevant to radiation therapy medical necessity determinations and are incorporated into this policy.

NCCN Evidence Categories Definitions

Category	Definition	Policy Implication
Category 1	Based upon high-level evidence; there is uniform NCCN consensus that the intervention is appropriate	Highest medical necessity support; denials require specific clinical rationale
Category 2A	Based upon lower-level evidence; there is uniform NCCN consensus that the intervention is appropriate	Medical necessity supported; discretionary alternative approaches may be considered
Category 2B	Based upon lower-level evidence; there is NCCN consensus that the intervention is appropriate	Supported with documentation; individualized review may apply
Category 3	Based upon any level of evidence but reflects major NCCN disagreement that the intervention is appropriate	Requires individualized clinical review

NCCN Category 1 Radiation Indications (Selected by Cancer Site)

The following radiation therapy indications carry NCCN Category 1 designation — the highest level of evidence and uniform expert consensus — and are considered medically necessary when the clinical criteria in Section 4 are met:

NCCN Breast Cancer Panel (Version 1.2025):

- Whole breast irradiation (WBI) following breast-conserving surgery — moderate hypofractionation 40–42.5 Gy/15–16 fx (Category 1)
- Post-mastectomy radiation therapy (PMRT) for pN1–N3 disease or T3–T4 tumors (Category 1)

NCCN NSCLC Panel (Version 1.2025):

- Stage III NSCLC: Concurrent chemoradiotherapy 60 Gy/30 fractions (Category 1)
- Early-stage NSCLC (T1–T2, N0, M0) medically inoperable: SBRT is Category 1 standard of care

NCCN Prostate Cancer Panel (Version 1.2025):

- Definitive EBRT or brachytherapy for all risk groups when chosen over surgery (Category 1 for multiple dose-fractionation schedules)
- Moderate hypofractionation for localized prostate cancer (Category 1 per ASTRO/ASCO/AUA joint guideline integration)

NCCN Head and Neck Cancers Panel (Version 2.2025):

- IMRT as the standard of care for all definitive and adjuvant head and neck radiation (Category 1 for H&N; sites)
- Concurrent cisplatin-based chemoradiation for locally advanced H&N; cancers (Category 1)

NCCN Rectal Cancer Panel:

- Neoadjuvant chemoradiation (long-course 45–50.4 Gy or short-course 25 Gy/5 fx) for Stage II–III rectal cancer (Category 1 within total neoadjuvant therapy framework)

NCCN CNS Cancers Panel (Version 1.2025):

- GBM: 60 Gy/30 fractions + concurrent temozolomide (Stupp protocol) (Category 1)

NCCN Hodgkin Lymphoma Panel:

- Involved-site RT (ISRT) 20–30 Gy following chemotherapy for Stage I–II Hodgkin lymphoma (Category 1)

NCCN Anal Canal Cancer Panel:

- Concurrent chemoradiation 54–59.4 Gy with 5-FU + mitomycin-C for anal cancer (Category 1)

NCCN Category 2A Radiation Indications (Selected)

The following carry NCCN Category 2A designation (uniform consensus, lower-level evidence):

NCCN Prostate Cancer Panel:

- Ultra-hypofractionated SBRT (36.25 Gy/5 fractions) for low- to intermediate-risk prostate cancer (Category 2A — see Section 4C.2, item 4)

NCCN Cervical Cancer Panel (Version 4.2025):

- Adjuvant pelvic EBRT for intermediate-risk features (Sedlis criteria) — Category 2A

NCCN Lymphoma (NHL) Panel:

- Involved-site RT for select early-stage indolent NHL — Category 2A

NCCN Guideline Panel Reference Index

Cancer Site	NCCN Guideline	NCCN Panel
Breast Cancer	NCCN Breast Cancer V1.2025	Breast Cancer Panel
Non-Small Cell Lung Cancer	NCCN NSCLC V1.2025	NSCLC Panel
Prostate Cancer	NCCN Prostate Cancer V1.2025	Prostate Cancer Panel
Head and Neck Cancers	NCCN H&N; V2.2025	Head and Neck Cancers Panel
Rectal Cancer	NCCN Rectal Cancer (current version)	Colon/Rectal Cancer Panel
CNS Cancers	NCCN CNS V1.2025	CNS Cancers Panel
Hodgkin Lymphoma	NCCN Hodgkin Lymphoma (current)	Hodgkin Lymphoma Panel
Non-Hodgkin Lymphoma	NCCN NHL (current)	NHL Panel
Cervical Cancer	NCCN Cervical Cancer V4.2025	Cervical Cancer Panel
Smoking Cessation	NCCN Smoking Cessation V3.2025	Smoking Cessation Panel

Maryland-Specific Note: Per Maryland Insurance Code § 15-142, step therapy override must be granted for stage IV cancer patients when the prescribed radiation therapy is indicated by NCCN guidelines. Curative Health Plan's Maryland utilization management staff must recognize all NCCN Category 1 and Category 2A radiation therapy indications as mandatory grounds for step therapy override in stage IV Maryland members. Denials of NCCN-indicated radiation sequences for stage IV Maryland members require specific clinical documentation beyond non-NCCN compliance.

6G. Impact of Tobacco Use on Radiation Therapy Outcomes

Background and NCCN Position

Smoking cessation is recognized by the NCCN Smoking Cessation Panel (NCCN Clinical Practice Guidelines in Oncology: Smoking Cessation, Version 3.2025) as an essential component of comprehensive cancer care. The NCCN and leading oncology societies now characterize smoking cessation as the "fourth pillar of cancer care" — alongside surgery, radiation therapy, and systemic therapy (chemotherapy/immunotherapy). Despite clear survival evidence, only approximately 1 in 5 cancer patients who smoke successfully quits within 6 months of diagnosis.

Clinical Evidence: Tobacco Use and Radiation Therapy Outcomes

All-Cause Mortality — Cross-Cancer Evidence (Tohmasi et al., JNCCN, 2025):

A large cohort study (Tohmasi S, et al., JNCCN — Journal of the National Comprehensive Cancer Network, 2025) followed more than 13,000 individuals with cancer to assess the impact of continued smoking after cancer diagnosis:

- Cancer patients who continued smoking had a 97% higher risk of death within 2 years compared to those who quit smoking (aHR = 1.97; 95% CI: 1.53–2.55)
- The survival benefit of cessation was observed across all cancer types and stages, including Stage III–IV advanced disease
- Among patients with advanced-stage (Stage III or IV) cancer, continued smoking was associated with a significantly elevated risk of all-cause mortality (aHR = 2.11; 95% CI: 1.60–2.79)
- Only 22.1% of current smokers at their index visit quit within the following 6 months
- Lead author conclusion: "It is never too late to quit." "Lifestyle change such as quitting smoking can prolong survival even more than some chemotherapies."
- Study conclusion: "Future cancer care must treat smoking cessation not as an optional extra, but as a core part of the treatment plan."

Head and Neck Cancer — Radiation-Specific Outcomes (Chen et al., Am J Clin Oncol / Int J Radiat Oncol Biol Phys, 2011):

Chen AM, et al. (International Journal of Radiation Oncology, Biology, Physics, 2011;79(2):414–419) conducted a matched cohort study of 101 head and neck cancer patients who continued smoking during radiation therapy, matched to 101 patients who quit before radiation:

Outcome	Active Smokers	Quitters	p-value
5-year Overall Survival	23%	55%	<0.05
5-year Locoregional Control	58%	69%	<0.05
5-year Disease-Free Survival	42%	65%	<0.05
Grade 3+ Late Complications	49%	31%	0.01

These differences remained statistically significant in both postoperative and definitive radiation subgroup analyses.

Biologic Mechanism: Tobacco smoking may reduce intratumoral oxygen availability. Because radiation therapy exerts its cytotoxic effect primarily through generation of reactive oxygen species (ROS) that damage DNA, reduced oxygen tension in tumors of active smokers may attenuate the therapeutic effect of radiation. Smoking-related hypoxia can blunt the radiation response and may contribute to the observed inferior locoregional control rates.

Neck Fibrosis and Late Toxicity: Frontiers in Oncology data (2021) demonstrate that smoking during radiotherapy is independently associated with increased incidence of neck fibrosis in head and neck cancer patients, compounding late-effect morbidity.

ASCO Position on Tobacco in Cancer Care

ASCO supports systematic tobacco treatment integration in oncology care. Per data published in JCO Oncology Practice (2024), smoking worsens both cancer symptom burden and severity. ASCO's position is that oncology providers should:

- Screen all cancer patients for tobacco use status at initial visit and at regular intervals
- Offer brief cessation counseling (as little as 3 minutes has demonstrated benefit over no counseling)
- Offer pharmacologic cessation support (nicotine replacement therapy, varenicline, or bupropion) combined with behavioral counseling
- Document smoking status and cessation efforts in the medical record

Curative Health Plan Policy Statement on Tobacco Use

> Curative Health Plan strongly recommends documentation of tobacco use status and smoking cessation counseling as part of every radiation therapy treatment plan. Tobacco cessation is associated with significantly improved radiation therapy outcomes across all cancer types — including reduced mortality, improved locoregional control, improved disease-free survival, and reduced rates of severe late complications. Radiation oncologists are strongly encouraged to refer all tobacco-using patients to a structured cessation program at the initiation of radiation therapy.

Tobacco use status and cessation counseling documentation, while not a prerequisite for radiation therapy authorization under this policy, are strongly recommended best practices and are consistent with NCCN Smoking Cessation Guidelines (Version 3.2025), ASCO tobacco treatment recommendations, and the emerging role of smoking cessation as the fourth pillar of cancer care.

SECTION 7: STATE AND FEDERAL REGULATORY CONSIDERATIONS

7A. Federal Requirements (Applicable to All Products)

ACA Essential Health Benefits (EHB): Fully insured individual and small group plans must cover radiation therapy services as ambulatory and hospitalization services under the ten EHB categories. No annual or lifetime dollar limits apply to EHB services. (Authority: 42 U.S.C. § 18022; 45 CFR § 156.110)

No Surprises Act — Emergency and Continuity of Care: Plans may not require prior authorization for emergency radiation therapy services (e.g., malignant spinal cord compression managed urgently). Members receiving ongoing cancer treatment have a 90-day continuity-of-care right at in-network cost-sharing when an in-network radiation oncology provider leaves the network. (Authority: Consolidated Appropriations Act 2021, Division BB)

ACA Clinical Trial Coverage: Non-grandfathered plans must cover routine patient care costs associated with FDA-approved, NIH-funded, VA-funded, DoD-funded, or IRB-approved clinical trials involving life-threatening conditions, including cancer. This includes radiation therapy services rendered as part of approved radiation oncology clinical trials. Experimental status alone does not permit exclusion of routine care costs. (Authority: ACA § 2709; 42 U.S.C. §

300gg-8)

CMS LCD Reference: CMS Local Coverage Determination L39553 (Radiation Therapies), LCD L35076 (SRS/SBRT), LCD L36658 (Proton Beam Therapy), LCD L40179 (Superficial Radiation Treatment, effective 1/3/2026), and Billing Article A59350 set clinical documentation standards used by this policy. Although these LCDs govern Medicare coverage, the documentation standards and clinical criteria are adopted by Curative Health Plan as consistent with evidence-based practice. CMS LCDs do not directly bind commercial coverage decisions.

ASO Plan Note: ASO (self-funded ERISA) plans are governed primarily by ERISA and federal law. State insurance mandates described in Sections 7B–7H generally do not apply to self-funded ERISA plans unless the plan sponsor voluntarily adopts them. Federal requirements (ACA clinical trial coverage for non-grandfathered plans, No Surprises Act continuity of care, MHPAEA NQTL requirements, ACA external review rights) apply to non-grandfathered ASO plans.

7B. Texas (TX) — State-Specific Requirements

Applies to: Fully Insured and Level Funded plans only (not ASO/self-funded ERISA plans)

PA Gold Card Program (TX Insurance Code §§ 4201.651–4201.660; HB 3459, amended HB 3812 eff. September 1, 2025):

Radiation oncology providers who achieve a ≥ 90% PA approval rate for a specific radiation therapy service over a 12-month evaluation period are exempt from prior authorization requirements for that service. Exemption rescissions may occur only in January, at least 12 months after the evaluation period's end date. Rescission determinations must be made by a Texas-licensed physician. Annual data reporting to TDI is required.

Stage IV Metastatic Cancer — Step Therapy Prohibition (TX Insurance Code Chapter 1369, Subchapter E-1; HB 1584, 2019):

Texas prohibits step therapy protocols for patients with stage IV advanced, metastatic cancer. A plan may not require a patient with stage IV cancer to try and fail an alternative treatment before covering a drug or service listed in a nationally recognized treatment protocol (e.g., NCCN guidelines) supported by peer-reviewed evidence. This prohibition applies to radiation oncology treatment decisions when step therapy-type sequencing requirements would delay access to medically indicated radiation.

PA Reviewer Requirements: All utilization review in Texas must be conducted under the direction of a Texas-licensed physician who is knowledgeable and currently active in practice. Administrative medicine licenses alone are insufficient. Specialty peer review is available within 15 working days upon provider request.

External Review: Texas operates under a state-supervised external review process (TDI), with the HHS-Administered Federal External Review Process also available. IRO decisions are binding on the plan. Oncology patients have access to expedited review for life-threatening conditions.

Source: TX Insurance Code Chapter 4201 (TDI HB 3459/HB 3812 FAQ: https://www.tdi.texas.gov/health/hb3459-faq.html); TX Insurance Code § 1369 Subchapter E-1 (https://statutes.capitol.texas.gov/Docs/IN/htm/IN.1369.htm)

7C. Florida (FL) — State-Specific Requirements

Applies to: Fully Insured and Level Funded plans only (not ASO/self-funded ERISA plans)

PA Timelines: Florida has no state-enacted commercial PA response time requirements as of the effective date of this policy. The federal ACA minimum standards apply: 15 calendar days for non-urgent pre-service requests; 72 hours for urgent pre-service requests (45 CFR § 147.136).

Step Therapy (FS § 627.42393): Florida requires insurers to publish a step therapy exemption process. A specific exemption applies when a patient has completed step therapy for the same drug required by a prior insurer that paid for that drug within 90 days. Florida does not have a categorical prohibition on step therapy for stage IV cancer.

External Review: Florida uses the HHS-Administered Federal External Review Process. Standard external review: 45 days; expedited: 72 hours.

Source: FS § 627.42391 (oral chemo parity); FS § 627.42393 (step therapy); CMS external review guidance

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7D. Georgia (GA) — State-Specific Requirements

Applies to: Fully Insured and Level Funded plans only; note that GA's stage IV prohibition extends to state employee plans and Medicaid MCO plans under O.C.G.A. § 33-24-59.20

PA Response Timelines (O.C.G.A. § 33-64-8; GA SB 80, 2021):

- Urgent services: Decision within 72 hours of receiving all necessary information
- Non-urgent services: Decision within 7 calendar days of receiving all necessary information
- PA for chronic conditions (including ongoing radiation therapy courses): Valid for 1 year or end of coverage, covers changes in dosage during authorization period
- PA cannot be retroactively revoked after services are provided within 45 business days of PA notice

Stage IV Metastatic Cancer — Step Therapy Prohibition (O.C.G.A. § 33-24-59.20; GA Insurance Commissioner Bulletin 25-EX-6, December 31, 2025):

Georgia prohibits any health benefit plan from requiring step therapy protocols for patients with stage IV advanced, metastatic cancer. This is one of the strongest prohibitions in Curative's operating footprint and explicitly covers state employee plans and Medicaid MCO plans in addition to commercial fully insured plans.

External Review: Georgia IRO process (GA Rules 120-2-111): Standard review 15 working days; expedited review 72 hours when treating provider certifies life/health/function risk. Reviewers must be currently active in the same/similar specialty.

Source: O.C.G.A. § 33-24-59.20; GA OCI Bulletin 25-EX-6 (https://oci.georgia.gov/document/bulletin/bulletin-25-ex-6-step-therapy-prohibited-stage-four-metastatic-cancer/download); GA Rules 120-2-111

7E. Washington, DC — State-Specific Requirements

Applies to: Fully Insured and Level Funded plans only (not ASO/self-funded ERISA plans); DC Law 25-100 is among the most comprehensive PA reform laws in Curative's operating footprint

PA Response Timelines (D.C. Law 25-100, effective January 17, 2024):

- Urgent requests: Decision within 24 hours
- Non-urgent (electronic portal): Decision within 3 business days
- Non-urgent (mail/phone/fax): Decision within 5 business days

PA Cost Prohibition: DC prohibits requiring PA based solely on the cost of a covered service. High-cost radiation oncology services (stereotactic radiosurgery, proton beam therapy) may not be subject to PA requirements justified solely by cost; PA must be based on medical necessity.

Pre-Denial Peer-to-Peer (Mandatory): Before issuing any adverse determination, Curative must notify the requesting provider and give the treating physician the opportunity to provide additional clinical information or clarification.

PA Validity — Chronic Conditions: PA for chronic conditions (including ongoing cancer treatment) is valid as long as the treatment is medically reasonable and necessary, effectively eliminating annual re-authorization burdens for stable patients on maintenance radiation or combined modality therapies.

Reviewer Qualifications: Adverse determinations must be made by a physician licensed in DC, MD, or VA with the same or similar specialty as the requesting provider. Pediatric decisions require a reviewer in a pediatric specialty.

Source: D.C. Law 25-100 (https://code.dccouncil.gov/us/dc/council/laws/25-100); DC Code § 31-2995.02 (oral chemo parity); DC Code § 31-2993.02 (clinical trials)

7F. Maryland (MD) — State-Specific Requirements

Applies to: Fully Insured and Level Funded plans only (not ASO/self-funded ERISA plans)

PA Response Timelines (MD Ins. Code § 15-851):

- Electronic PA (drugs): Real-time response if criteria met
- Non-urgent (electronic, services): 2 business days
- Non-urgent (electronic, drugs): 1 business day

Continuity of Care (MIA Bulletin 14-22): Maryland requires PA approvals to be honored by a new plan for 90 days or until the treatment course is completed, whichever is sooner. Cancer treatment is explicitly listed as a qualifying condition. This protects radiation therapy courses that span a plan transition.

Stage IV Cancer — NCCN Mandate (MD Insurance Code § 15-142): Maryland is the only state in Curative's operating footprint with a statutory reference to NCCN guidelines. Step therapy overrides must be granted when the prescribed treatment:

- Treats stage 4 metastatic cancer in a manner indicated by NCCN guidelines and supported by peer-reviewed medical literature
- Treats symptoms or side effects of stage 4 metastatic cancer consistent with best practices and peer-reviewed literature

Policy Implication: Curative's Maryland utilization management staff must recognize NCCN guideline support as a mandatory basis for step therapy override for stage IV cancer patients. Denials of NCCN-indicated radiation therapy treatment sequences for stage IV Maryland members require specific documented clinical rationale beyond non-NCCN-compliance.

External Review: Maryland provides "all care" external review rights. IRO must be accredited by a nationally recognized accrediting organization. Denial letters must include member appeal rights in prominent bold print.

Source: MD Ins. Code § 15-142 (https://mgaleg.maryland.gov/mgawebsite/Laws/StatuteText?article=gin&section;=15-142); MIA Bulletin 14-22 (https://insurance.maryland.gov/insurer/documents/bulletins/14-22-continuity-of-care-notice-amended.pdf); MD Ins. Code § 15-827 (clinical trials)

7G. Indiana (IN) — State-Specific Requirements

Applies to: Fully Insured and Level Funded plans only (not ASO/self-funded ERISA plans)

PA Response Timelines (IC §§ 27-13-7-23, 27-8-5-30; SB 400 2023):

- Urgent requests: Decision within 48 hours
- Non-urgent requests: Decision within 5 business days
- No retroactive denials except for fraud, incorrect information, or non-coverage on date of service

Stage IV/Advanced Metastatic Cancer — Step Therapy Prohibition (IN HB 1114, signed by Governor Braun March 2026):

Indiana prohibits state employee health plans, accident and sickness insurance policies, and HMOs from requiring step therapy or "fail first" protocols for patients with advanced, metastatic cancer. This enactment is effective as of March 2026. Curative's Indiana fully insured and level-funded oncology UM protocols must eliminate any step therapy requirements for metastatic cancer patients consistent with this law.

Clinical Trials Coverage (IC § 27-8-25): Indiana requires coverage of routine patient care costs for clinical trials related to cancer (all phases; no phase restriction).

Source: IN HB 1114, iga.in.gov (https://iga.in.gov/legislative/2026/bills/house/1114/details); Susan G. Komen IN HB 1114 statement (https://www.komen.org/news/statement-on-passage-of-legislation-increasing-access-to-treatments-for-metastatic-cancer-patients-in-indiana/); IC § 27-8-25

7H. Ohio (OH) — State-Specific Requirements

Applies to: Fully Insured and Level Funded plans only (not ASO/self-funded ERISA plans)

PA Response Timelines (ORC § 3902.50; SB 129, 2016):

- Urgent requests: Decision within 48 hours
- Non-urgent requests: Decision within 10 calendar days after receipt of all necessary information
- No retroactive denials when medical necessity and eligibility requirements were met at time of service

- Plans must post PA requirements (including the 30 most common CPT codes requiring PA and approval rates) on their provider portal

Step Therapy (ORC § 3901.832): Ohio has a step therapy exception process but does not have a categorical prohibition on step therapy for stage IV/metastatic cancer. Exceptions must be granted if the required drug is contraindicated, if the patient previously tried the drug and discontinued due to inefficacy or adverse event, or if the patient is stable on a current prescription. Decision timeline: 10 calendar days (non-urgent); 48 hours (urgent).

Oral Chemotherapy Parity (ORC § 3923.85): Ohio is unique in offering an alternative to equal cost-sharing: plans may alternatively cap oral chemotherapy out-of-pocket costs at $100 per prescription rather than matching IV cost-sharing. Curative must document which approach is used in Ohio plan documents.

WISeR Model Note: Ohio is one of six states where CMS is piloting the WISeR prior authorization model in traditional Medicare FFS (effective January 1, 2026). This model explicitly excludes oncology services. The WISeR model does not affect Curative's commercial or Level Funded plans.

Pending Legislation (Monitor): Ohio HB 220 (pending as of effective date) would prohibit retroactive PA denials, require peer-to-peer reviews with clinical peers who disclose specialty and qualifications, and prohibit PA appeal fees. Ohio HB 579/SB 164 would regulate AI use in PA determinations. Curative's compliance team should monitor for enactment.

Source: ORC § 3902.50; ORC § 3901.832; ORC § 3923.85; ORC § 3923.80 (clinical trials)

SECTION 8: APPLICABLE DIAGNOSIS CODES (ICD-10-CM)

The following ICD-10-CM categories represent the primary malignant and benign conditions for which radiation therapy services are covered under this policy. This list is illustrative and not exhaustive. Conditions not listed may be covered when clinical documentation supports medical necessity per the criteria in Section 4.

ICD-10-CM Code/Range	Condition
C00–C14	Malignant neoplasms of lip, oral cavity, and pharynx
C15	Malignant neoplasm of esophagus
C16	Malignant neoplasm of stomach
C17–C21	Malignant neoplasms of small intestine, colon, rectosigmoid junction, rectum, anal canal
C22	Malignant neoplasm of liver and intrahepatic bile ducts
C23–C26	Malignant neoplasms of biliary tract, pancreas, other digestive organs
C30–C32	Malignant neoplasms of nasal cavity, middle ear, accessory sinuses, larynx
C33–C34	Malignant neoplasm of trachea, bronchus, and lung
C37–C39	Malignant neoplasms of thymus, heart, mediastinum

ICD-10-CM Code/Range	Condition
C40–C41	Malignant neoplasms of bone and articular cartilage
C43–C44	Melanoma and other malignant neoplasms of skin
C44.0–C44.9	Non-melanoma skin cancers (BCC, cSCC) — primary SRT indication
C45–C49	Malignant neoplasms of mesothelial and soft tissue
C50	Malignant neoplasm of breast
C51–C57	Malignant neoplasms of female genital organs
C58	Malignant neoplasm of placenta
C60–C63	Malignant neoplasms of male genital organs
C64–C68	Malignant neoplasms of urinary tract
C69	Malignant neoplasm of eye and adnexa
C70–C72	Malignant neoplasms of meninges, brain, and other CNS
C73–C75	Malignant neoplasms of thyroid and other endocrine glands
C76	Malignant neoplasms of other and ill-defined sites
C77–C79	Secondary and unspecified malignant neoplasms (metastatic disease)
C80	Malignant neoplasm without specification of site
C81–C85	Malignant neoplasms of lymphoid, hematopoietic and related tissue (lymphoma)
C91–C96	Leukemias and other malignant neoplasms of lymphoid/hematopoietic tissue
D00–D09	In situ neoplasms (DCIS, CIS, etc.)
D10–D36	Benign neoplasms (where radiation therapy is clinically indicated)
D44	Neoplasm of uncertain behavior of endocrine glands (pituitary)
D49	Neoplasms of unspecified behavior
G50.0	Trigeminal neuralgia (SRS indication)
Q28.2	Arteriovenous malformation of cerebral vessels (SRS indication)
Z85.xxx	Personal history of malignant neoplasm (post-treatment surveillance context)
Z92.3	Personal history of irradiation (reirradiation documentation)
F17.xxx	Nicotine dependence (for tobacco cessation documentation and referral)

SECTION 9: REVISION HISTORY

Version	Effective Date	Reviewed Date	Description
1.0	April 1, 2026	March 21, 2026	Initial policy creation. Incorporates NCCN V1.2025 through V4.2025 guidelines; ASTRO 2024–2025 guideline updates (PMRT, bone metastases, rectal cancer); ASCO/ASTRO/SNO brain metastases joint guideline; ASTRO PBT Model Policy 2022; ABS 2025 HDR brachytherapy consensus; CMS LCDs L35076, L36658, L39553; Billing Article A59350; Indiana HB 1114 (March 2026); TX HB 3812 (September 2025); Georgia Bulletin 25-EX-6 (December 2025); DC Law 25-100 (January 2024); Maryland NCCN mandate (Ins. Code § 15-142).
2.0	April 1, 2026	March 23, 2026	Updated to 2026 CPT coding structure: deleted 77385, 77386, 77417, G6001, G6002, G6015, G6017, 77014; updated 77387 to professional component only (77387-26), with TC bundled into delivery codes; revised 77402/77407/77412 to complexity-based Levels 1/2/3 (technique-agnostic); added Surface Radiation Therapy codes 77436, 77437, 77438, 77439; added 2026 coding crosswalk table (Section 3H); added 77387-26 billing frequency rules. Updated radiation prescription documentation requirements (Section 4 Universal Prerequisites, item 2) to include all required prescription elements (a–j). Fixed 77427 language ("per 5 fractions or weekly"). Fixed 77470 chemotherapy criterion. Added 77412 audit documentation requirement. Added NCCN criteria integration section (Section 6E). Added tobacco/smoking cessation impact section (Section 6F). Added basal/squamous cell skin cancer RT to covered EBRT sites. Reviewed by Dr. Carol Palackdharry.
3.0	April 1, 2026	March 23, 2026	Full 2026 NCCI/HOPPS compliance audit — removed all deleted codes (77385, 77386, 77401, 77417, 77014, G6001–G6017) from active code tables and criteria. Updated all delivery code references to complexity-based Levels 1–3. Added 77401 explicitly to deleted codes list in Sections 3C and 3G (deleted, replaced by 77437/77438 for SRT); added complete list of G6003–G6016 as deleted codes in Section 3G deleted codes notice; corrected Section 4B CPT header to remove 77401; corrected SRT code descriptors in 3F to match 2026 AMA CPT language; added explicit notes in 4A and 5B clarifying that standard EBRT planning and management codes do not apply to SRT. Added comprehensive Superficial Radiation Therapy (SRT) section (4G) with ASTRO Clinical Practice Guideline (Likhacheva et al. 2020, updated 10/18/2025) clinical criteria, 2026 SRT CPT codes (77436–77439), CMS LCD L40179 (effective 1/3/2026) coverage standards, dose-fractionation guidelines, postoperative RT indications, regional nodal RT criteria, MEETS and DOES NOT MEET criteria, provider qualifications, and documentation requirements. Added Section 5F (SRT Does Not Meet Criteria) with specific non-covered SRT scenarios. Added Section 6E Evidence Summary for SRT. Added CMS LCD L40179 reference to Section 7A federal requirements. Added C44 skin cancer ICD-10 row to Section 8. Added references 65–70 (Likhacheva/ASTRO BCC/cSCC guideline, ASTRO/ACMS SRT Coding Statement, CMS LCD L40179, NCCI Chapter 9 2026, ASTRO 2026 HOPPS Final Rule Summary, Oganesyan et al. Cureus 2026 SRT coding). Physician Reviewer: Dr. Carol Palackdharry.

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For medical necessity determinations only. Coverage subject to member's benefit plan.