Endobronchial brachytherapy may be considered medically necessary for either of the following clinical situations:

- In patients with primary endobronchial tumors who are not otherwise candidates for surgical resection or external-beam radiotherapy due to comorbidities or location of the tumor
- As a palliative therapy for airway obstruction or severe hemoptysis in patients with primary, metastatic, or recurrent endobronchial tumors

Other applications of endobronchial brachytherapy are considered investigational including, but not limited to:

- Its use as a radiation “boost” to curative external-beam radiotherapy
- As a treatment for asymptomatic recurrences of non-small-cell lung cancer
- In the treatment of hyperplastic granulation tissue

Endobronchial brachytherapy is a multistep procedure requiring a series of radiation oncology CPT codes for radiation treatment planning, radiation physics, treatment delivery, and clinical treatment management. CPT codes 77761-77787 describe various types of radiation source application; these codes are used to describe the brachytherapy delivery. Unlike other types of radiotherapy, endobronchial brachytherapy requires the services of a radiation oncologist, and a pulmonologist or other physician to perform the bronchoscopy and insert the catheter.

There is a CPT code that specifically identifies the catheter placement:

- 31643: Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with placement of catheter(s) for intracavitary radioelement application

Endobronchial brachytherapy is the delivery of radiotherapy directly to endobronchial lesions, either intraluminally or interstitially, using permanently implanted radioactive seeds or a temporary after loading implant. The technique permits targeted radiation while minimizing exposure to surrounding radiosensitive structures, such as normal lung, heart, and spinal cord.

Benefit determinations should be based in all cases on the applicable contract language. To the extent there are any conflicts between these guidelines and the contract language, the contract language will control. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage of these services as it applies to an individual member.
instances, plans may have to consider the coverage eligibility of FDA-approved technologies on the basis of medical necessity alone.

**Regulatory Status**

Several bronchoscopes (Food and Drug Administration product code: EOQ) and remote-controlled afterload/radionuclide applicator systems (Food and Drug Administration product code: JAQ) have been cleared for marketing by the Food and Drug Administration through the 510(k) process. Examples of both include the Video Sciences BRS-5000 Video Bronchoscopy with EndoSheath System (Vision-Sciences) and microSelectron (Nucletron), respectively.

**Rationale**

**Background**

**Endobronchial Lesions**

**Brachytherapy**

Endobronchial brachytherapy has been primarily investigated as a palliative treatment of obstructing primary or metastatic tumors, particularly in non-small-cell lung cancer. Endobronchial brachytherapy has also been used as a tool in curative treatment for some primary bronchial and tracheal tumors. Two to 4 fractions delivered weekly is a typical schedule. Median overall survival of patients with obstructing endobronchial tumors is typically less than 9 months.

In the outpatient setting, the patient receives local anesthesia and monitored sedation. A flexible bronchoscope is passed transnasally; a separate port on the bronchoscope allows passage of the after-loading catheter to the target lesion. Once the catheter is placed, the radioisotope can be administered by the high-dose-rate radiotherapy after loading machine. Patients with potential airway compromise due to bleeding may require treatment with a rigid bronchoscope, which requires general anesthesia and frequently an overnight stay.

**Other Treatments**

Endobronchial brachytherapy is an approach to the local treatment of endobronchial lesions. Other technologies include electrocoagulation, cryosurgery, laser resection, endosurgery, and endobronchial stent placement. In some instances, the therapies may be used together, such as laser therapy for initial debulking followed by brachytherapy.

**Literature Review**

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

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

Clinical Context and Test Purpose

The purpose of endobronchial brachytherapy for palliation of patients who have obstructive lesions is to provide a treatment option that is an alternative to or an improvement on existing therapies.

The question addressed in this evidence review is: Does the use of endobronchial brachytherapy in the treatment of non-small-cell lung cancer (NSCLC) improve the net health outcome?

The following PICOTS were used to select literature to inform this review.

Patients

The relevant population of interest are patients with recurrent or metastatic tumors of the bronchus who are experiencing obstructive symptoms such as dyspnea, cough, hemoptysis, and post obstructive pneumonia.

Many patients with NSCLC are initially treated with external-beam radiotherapy (EBRT) but ultimately experience local recurrence. Many are not candidates for additional EBRT due to limited tolerance of normal tissue.

Interventions

The test being considered is endobronchial brachytherapy.

Comparators

The following practices and treatments are currently being used to treat obstructive lesions of the bronchus: EBRT, laser resection, and surgical resection.

Outcomes

The general outcomes of interest are overall survival (OS), symptoms, morbid events, and treatment-related morbidity. Specific benefits include palliation of obstructive symptoms, avoidance of blood loss due to hemoptysis, and avoidance of adverse events associated with more invasive therapies. Specific harms may be early due to immediate procedure-related complications. Late-occurring and the most serious complications described for endobronchial brachytherapy are massive hemoptyses, the formation of tracheoesophageal fistulas, bronchospasm, bronchial stenosis, radiation bronchitis, and palliative care.

Timing

The duration of follow-up for advanced malignant lesions treated with endobronchial brachytherapy is weeks to months.

Setting

Endobronchial brachytherapy would be administered in an inpatient or outpatient hospital setting equipped for monitored anesthesia and handling of radionuclide products.

Systematic Reviews

The best available evidence consists of systematic reviews, several small prospective trials, and case series.

A comparative effectiveness review by Ratko et al (2013), prepared for the Agency for Healthcare Research and Quality, assessed local nonsurgical therapies for symptomatic obstructive NSCLC. For patients with an obstruction due to inoperable NSCLC, 4 RCTs (n=268 patients) examined endobronchial brachytherapy alone or in combination with EBRT or Nd-YAG laser therapy for palliative or curative intent. All RCTs were determined to be of poor quality.
Seven, single-arm studies (n=740 patients) examined endobronchial brachytherapy alone or in combination with EBRT, stent placement, or chemotherapy plus photodynamic therapy for palliative or curative intent. The evidence was considered "insufficient to permit conclusions on the comparative effectiveness of local nonsurgical therapies for ... inoperable NSCLC patients with endoluminal tumor causing pulmonary symptoms."

A 2008 Cochrane review (updated in 2012) assessing palliative endobronchial brachytherapy for NSCLC analyzed 13 RCTs but did not conduct meta-analyses because of heterogeneity in the doses of radiotherapy delivered, patient characteristics, and outcomes measured. Reviewers concluded that EBRT alone was more effective for palliation of symptoms than endobronchial brachytherapy alone. Findings did not provide conclusive evidence that endobronchial brachytherapy plus EBRT improved symptom relief, reduced complication rates, or extended survival compared with EBRT alone. Additionally, reviewers did not find sufficient evidence to recommend endobronchial brachytherapy as an add-on to first-line EBRT, chemotherapy, or Nd-YAG laser palliative treatment. For patients previously treated with EBRT who remain symptomatic, endobronchial brachytherapy was considered an option.

Ung et al (2006) conducted a systematic review of endobronchial brachytherapy for palliative treatment of NSCLC. Based on 29 studies, including 6 randomized trials, reviewers also concluded that EBRT alone was more effective than endobronchial brachytherapy alone for symptom palliation in previously untreated patients. Unlike the Cochrane reviews, however, the Ung et al (2006) review concluded that endobronchial brachytherapy plus EBRT seems to provide better symptom relief than EBRT alone, yet the final recommendation was to use endobronchial brachytherapy only for symptomatic recurrent endobronchial obstruction after EBRT.

Randomized Controlled Trials
Mallick et al (2006), in a prospective randomized trial from India (n=45), suggested that endobronchial brachytherapy alone and endobronchial brachytherapy plus EBRT have similar efficacy and safety profiles in the palliative management of NSCLC.

Nonrandomized Studies
Goldberg et al (2015) reported on a prospective, observational cohort study evaluating the quality of life and symptom-related outcomes for 98 patients with locally advanced inoperable lung cancer receiving high-dose rate (HDR) endobronchial brachytherapy. Patients were followed every three months for one year. Most (78%) were treated for a newly diagnosed disease that was inoperable at diagnosis. The OS rate was 13.4% at 12 months. Endobronchial brachytherapy was not associated with longer OS or improved quality of life, compared with chemotherapy or EBRT, in multivariable analyses.

Ozkok et al (2008) published a case series from Turkey on the use of HDR endobronchial brachytherapy for palliation of symptoms in 158 patients with 3 lung cancer profiles. Group A comprised 43 patients with stage IIIA or IIIB NSCLC, who received endobronchial brachytherapy plus EBRT; group B comprised 74 previously untreated patients with incurable, locally advanced lung cancer; and group C comprised 41 patients with symptomatic endobronchial recurrences who had previously received full-dose radiotherapy. Participants in group A were from a previously reported prospective trial by Gejerman et al (2002); data from these participants were reanalyzed for symptom palliation in the Ozkok et al (2008) report. Not all patients received the intended number of fractions due to patient refusal or deterioration in performance status. A few patients required more than the prescribed doses due to repetitive obstructive symptoms. Response rates for a cough, dyspnea, and hemoptysis were measured using the Speiser Symptom Index scoring system. Response rates in group A were 58% for cough (30% complete response [CR]), 77% for dyspnea (76% CR), and 100% for hemoptysis (92% CR). Groups B and C had CR rates of 57% and 55% for a cough and 90% and 78% for dyspnea, respectively. Eighteen (11%) patients died of hemoptysis, with a median time to an event of 7 months. Significant prognostic factors for fatal hemoptysis were the use of brachytherapy intended as a treatment
(as opposed to palliation, p<0.001), total radiobiologic equivalent dose (p<0.001), and the number of HDR endobronchial brachytherapy fractions (p<0.001). The authors concluded that HDR endobronchial brachytherapy was effective for palliation of symptoms related to inoperable lung cancer, either alone or in combination with EBRT. They cautioned that optimal dose, fractionation, and combination schedule with EBRT were unknown.

Although endobronchial brachytherapy is often used to palliate hemoptysis, historically, there has been concern about an observed association between treatment with endobronchial brachytherapy and fatal hemoptysis. The largest study retrospectively reviewed 938 patients treated with external irradiation and/or endobronchial brachytherapy for inoperable NSCLC. In this study, Langendijk et al (1998) reported that 101 (10.8%) patients died from massive hemoptysis; 78 (77%) of those who died had clinical or radiologic evidence of tumor progression while 23 (23%) did not. On multivariate analysis, intrabronchial tumor extension in the main bronchus, hemoptysis before radiotherapy, and tumor location in the upper bronchus were independently associated with massive hemoptysis. A dose-response relation between fraction dose and massive hemoptysis also was found; in all subgroups, a higher incidence of massive hemoptysis was seen after fraction dose of 15 gray (Gy). These data were largely consistent with data from Hennequin et al (1998) who reported that hemoptysis was most likely due to disease progression, with brachytherapy facilitating bleeding, rather than directly causing bleeding. However, for tumors located in the upper lobes, brachytherapy may be causal. Tumor location was cited as the most important factor in predicting pulmonary hemoptysis in a case series reported by Bedwinek et al (1992), in which 32% of patients died of massive hemoptysis after brachytherapy.

Dagnault et al (2010) retrospectively reviewed 81 patients treated with brachytherapy for symptom palliation due to endobronchial primary lung tumors or metastases. Between 2002 and 2007, 81 patients who were not candidates for surgery or EBRT because of poor respiratory function, medical comorbidities, or previous treatment with thoracic radiation or surgery, were treated at a single institution. Mean patient age was 66 years (range, 39-87 years). Previous treatment included surgical resection of the primary tumor in 58% of patients, lung radiotherapy in 44%, and chemotherapy in 41%. After endobronchial brachytherapy, patients were followed until death or loss to follow-up. Patient characteristics included 59 (73%) with a lung primary and the remainder with metastatic disease, including primary colorectal cancer (13%), kidney, gynecologic, or head and neck cancers (4% each), and other cancers (2%). Presenting symptoms included dyspnea (66%), cough (47%), hemoptysis (28%), and no symptoms (6%). After brachytherapy, major symptomatic improvement was seen in most patients: dyspnea improved during or shortly after the end of treatment in 85% of patients; hemoptysis stopped in all 23 patients; a cough improved in 77% of patients, and 18% remained stable. At 6-week follow-up, 72% of tumors were evaluable for bronchoscopic response. A visible bronchoscopic response was evident in 77 patients; for 42 (52%) of 81 patients, the tumor shrank significantly during treatment. Median survival was 14.7 months; local progression-free survival (PFS) was 77% at 12 months and 64% at 24 months. For comparison, the authors stated that OS estimates for most patients with inoperable endobronchial tumors or metastases were less than six months. The incidence of complications was low, and all complications resolved.

Guarnaschelli et al (2010) reviewed treatment outcomes of 52 patients with recurrent endobronchial tumors who underwent palliative HDR endobronchial brachytherapy between 1995 and 2005 at a single institution. Objective response was assessed by bronchoscopy and chest computed tomography, and subjective clinical response by patient reports. All patients had histologically confirmed bronchogenic carcinoma, recurrent or persistent symptoms (hemoptysis, cough, dyspnea, or post obstructive pneumonia), previous definitive EBRT, and bronchoscopic evidence of endobronchial obstruction. The mean patient age was 63 years (range, 41-83 years); 37% of patients were women. Tumor histology was non-small-cell in 77% of patients, small cell in 13% adenoid cystic in 2%, and metastatic in 2%. Patient symptoms before brachytherapy included dyspnea on exertion (79%), cough (89%), hemoptysis (62%), wheezing (52%), dysphagia (8%), chest pain (15%), and shortness of breath (83%). Symptomatic
improvement was defined as significant if there was an improvement in two or more symptoms and mild if only one symptom improved. Forty-eight (92%) patients showed symptom reductions. One patient had worsening hemoptysis, and 2 (4%) of 52 patients did not return for assessment. Median time to symptom relapse after the first fraction of brachytherapy was six months (range, 1 to >6 months). Complete or partial tumor regression was confirmed in 44 (85%) patients on repeat bronchoscopy. For the entire cohort, the median follow-up was 31 months, and median actutimes OS from the first brachytherapy session was 7 months (range, 0-55 months). Fifty (96%) patients tolerated treatment without acute, treatment-related complications. Significant patients: treatment-related complications (grade 3 or 4) were reported as possibly occurring in 2 (4%) 1 developed a pneumothorax 6 weeks after brachytherapy, and another died from hemoptysis 48 hours after treatment (it was unknown whether hemoptysis was due to brachytherapy or to the erosion of tumor into a blood vessel).

Section Summary: Endobronchial Brachytherapy as Palliative Treatment
Single-arm series and RCTs summarized in systematic reviews comprise the evidence base for use of endobronchial brachytherapy with palliative intent for NSCLC. Overall, the RCTs were assessed as low-quality, and there is no evidence that endobronchial brachytherapy improved survival. However, the single-arm studies suggested that endobronchial brachytherapy reduced symptoms (pulmonary obstruction, hemoptysis), particularly in patients not candidates for EBRT.

Endobronchial Brachytherapy as Primary Treatment
Clinical Context and Test Purpose
The purpose of endobronchial brachytherapy as primary treatment for patients who have NSCLC is to provide a treatment option that is an alternative to or an improvement on existing therapies.

The question addressed in this evidence review is: Does the use of endobronchial brachytherapy as primary treatment of NSCLC improve the net health outcome?

The following PICOTS were used to select literature to inform this review.

Patients
The relevant population of interest are patients with early-stage endobronchial tumors who are not candidates for surgical resection or EBRT due to comorbidities or tumor location. Most studies have been case series, which have reported CR rates of 50% to 80%.

Interventions
The test being considered is endobronchial brachytherapy as first-line treatment.

There also have been investigations using brachytherapy to deliver a focused radiation boost to patients undergoing curative EBRT. Because patients usually present with surgically unresectable disease and because NSCLC is unresponsive to chemotherapy, the primary treatment for most patients with NSCLC is typically EBRT.

Comparators
The following practices and treatments are currently being used to treat NSCLC: EBRT and surgical resection.

Outcomes
The general outcomes of interest are OS, symptoms, morbid events, and treatment-related morbidity. Specific benefits include avoidance of blood loss due to hemoptysis and avoidance of adverse events associated with more invasive therapies. Specific harms may be early due to immediate procedure-related complications. Late-occurring and the most serious complications described for endobronchial brachytherapy are massive hemoptyses, the formation of tracheoesophageal fistulas, bronchospasm, bronchial stenosis, radiation bronchitis, and palliative care.
Timing
The duration of follow-up for early-stage lesions treated with endobronchial brachytherapy is one to five years.

Setting
Endobronchial brachytherapy would be administered in an inpatient or outpatient hospital setting equipped for monitored anesthesia and handling of radionuclide products.

Case Series
Aumont-le Guilcher et al (2011) reported on 226 patients with primary NSCLC (endobronchial only) who underwent HDR brachytherapy because of contraindications to surgery and EBRT. The patient sample comprised 223 men and 3 women from 9 institutions; the mean age was 62 years (range, 40-84 years). Tumor histology was squamous cell carcinoma in 96%, adenocarcinoma in 2%, and other in 2%. Response to HDR brachytherapy at 2 to 3 months was classified as a complete histologic response (disappearance of the lesion by bronchoscopy and negative biopsy), complete macroscopic response (disappearance of the lesion but no biopsy), partial response (>50% decrease in endobronchial tumor volume), or progression (increase in endobronchial tumor volume or tumor visible on computed tomography scan). At 3 months, complete local response was observed in 213 (94%) patients, and in 137 patients with biopsies, 126 (91%) had a CR. Also, seven patients had tumor progression, five had a partial response, and one had stable disease. The OS rate was 57% at 2 years and 29% at 5 years. Median survival was 28.6 months. The cancer-specific survival rate was 81% at 2 years and 56% at 5 years.

Complications led to treatment interruption in 4.5% of patients. Fatal complications (most commonly fatal hemoptysis) occurred in 6% of patients.

Skowronek et al (2013) reported on a small cohort of 34 patients in Poland who had stage IB, II, or III lung cancer (74% squamous cell carcinoma histology; all distant metastasis-free) and had undergone lobar resection. Thirteen (38%) patients developed postoperative recurrence in the bronchial stump, and 21 (72%) patients had histopathologically positive margins after nonradical resection. All patients had dyspnea and cough, and 8 (24%) patients had hemoptysis. Median patient age was 57 years (range, 47-73 years). Median time to recurrence after surgery was 11 months. It was not specified whether patients were candidates for reoperation. Nine patients received HDR endobronchial brachytherapy (total dose, 12 Gy) in combination with EBRT (total dose, 50 Gy), and 25 patients received brachytherapy alone (total dose, 30 Gy). At 1 month, complete local and radiologic response was observed in 25 (74%) patients, with 100% CR in the nonradical surgery group. All partial responses occurred in the recurrent tumor group (9 [69%] of 13 patients). Median OS for the entire cohort was 19 months. With a median follow-up of 2 years, the 2-year OS rate was 15% in the group with recurrent tumor and 48% in the nonradical resection group (p=0.05). Adverse events were not reported.

Rochet et al (2013) reported on a cohort of 35 patients in Germany who had stage I, II, or III inoperable NSCLC (31% squamous cell carcinoma histology; all distant metastasis-free) and received primary treatment with HDR endobronchial brachytherapy (median total dose, 15 Gy) in combination with EBRT (median total dose, 50 Gy). Mean age was 64 years (range, 45-75 years). With a median follow-up of 26 months, the median OS was 39 months. One-, 2-, and 5-year OS rates were 76%, 61%, and 28% respectively. Median PFS and local PFS were 17 months and 42 months, respectively. In patients without mediastinal node involvement, the 5-year local PFS rate was 56% and 11% with positive mediastinal nodes (p=0.008). Grade 3 adverse events were hemoptysis in two patients and necrosis in one patient. Fatal hemoptysis in one patient resulted from tumor recurrence.

Hosni et al (2016) reported on a series of 10 patients with endobronchial tumors treated at a single center with endobronchial brachytherapy with curative intent, with (n=8) or without (n=2) EBRT. Among the 10 patients treated with curative intent, the median follow-up was 17 months. For these patients, the 2-year local control rate was 89% (95% confidence interval, 79% to 99%)
and the 2-year OS rate was 67% (95% confidence interval, 51% to 83%). Given the high rate of combination therapy, it is difficult to draw conclusions about brachytherapy alone.

**Section Summary: Endobronchial Brachytherapy as Primary Treatment**
For primary treatment (i.e., with intent to improve survival outcomes), the effects of endobronchial brachytherapy on survival outcomes compared with alternative therapies are not well-defined. Additional comparative data are needed.

**Endobronchial Brachytherapy to Treat Hyperplastic Granulation Tissue**

**Clinical Context and Test Purpose**
The purpose of endobronchial brachytherapy in patients who have hyperplastic granulation tissue is to provide a treatment option that is an alternative to or an improvement on existing therapies.

The question addressed in this evidence review is: Does the use of endobronchial brachytherapy in the treatment of hyperplastic granulation tissue improve the net health outcome?

The following PICOTS were used to select literature to inform this review.

**Patients**
The relevant population of interest are patients with hyperplastic granulation tissue causing recurrent airway stenosis after lung transplantation or stent placement.

**Interventions**
The test being considered is endobronchial brachytherapy.

**Comparators**
The following practices and treatments are currently being used to treat obstructive lesions of the bronchus: surgical resection and other endobronchial therapies.

**Outcomes**
The general outcomes of interest are symptoms, morbid events (e.g., recurrence of central airway obstructions), and treatment-related morbidity. Specific benefits include avoidance of blood loss due to hemoptysis and avoidance of adverse events associated with more invasive therapies. Specific harms may be early due to immediate procedure-related complications.

**Timing**
The duration of follow-up for hyperplastic granulation tissue treated with endobronchial brachytherapy is weeks to months.

**Setting**
Endobronchial brachytherapy would be administered in an inpatient or outpatient hospital setting equipped for monitored anesthesia and handling of radionuclide products.

**Case Series**
Tendulkar et al (2008) reported on a case series assessing endobronchial brachytherapy in 8 patients after excision of obstructive granulation tissue; 6 (75%) patients showed a good or excellent subjective early response for the first 6 months.21 In another case series, Madu et al (2006) used endobronchial brachytherapy to treat five patients with benign, post-lung transplantation granulation tissue refractory to multiple other bronchoscopic interventions.22 After a median follow-up of 12 months, 3 (60%) of 5 patients had marked symptom improvement.

Rahman et al (2010) reported on long-term follow-up for 115 patients who underwent various flexible bronchoscopic therapeutic modalities for the management of benign tracheal stenosis between 2001 and 2009.23 HDR endobronchial brachytherapy was used in cases defined as
requiring three or more interventions within six months due to refractory stent-related granulation tissue formation. All patients presented with signs and symptoms of upper airway obstruction, including shortness of breath, stridor, cough, dyspnea, and wheezing. Stents were placed in 33 patients to restore airway patency, and 28 of them underwent brachytherapy to prevent granulation tissue reformation. All 28 experienced a reduction in therapeutic bronchoscopic procedures after brachytherapy compared with the pretreatment period; no further details about response duration or other outcomes were reported. There were no treatment-related complications. Small sample size and concerns about outcomes reporting limit conclusions that can be drawn from this series.

Section Summary: Endobronchial Brachytherapy to Treat Hyperplastic Granulation Tissue
The evidence for endobronchial brachytherapy for hyperplastic granulation tissue is limited by sample sizes. The available case series also typically included endobronchial brachytherapy as part of multimodal management, making it difficult to assess the specific contribution of brachytherapy.

Summary of Evidence
For individuals with NSCLC with airway obstruction or severe hemoptysis who receive endobronchial brachytherapy as palliative treatment, the evidence includes single-arm series and RCTs summarized in systematic reviews. The relevant outcomes are OS, symptoms, morbid events, and treatment-related morbidity. Overall, the RCTs were assessed as low-quality and provided no evidence that endobronchial brachytherapy improves survival. However, the single-arm studies have suggested that endobronchial brachytherapy reduces symptoms (pulmonary obstruction, hemoptysis), particularly in patients who are not candidates for EBRT. If symptoms persist after EBRT, endobronchial brachytherapy is well-accepted as short-term palliation for symptoms such as hemoptysis, cough and dyspnea, and resolution of obstructive atelectasis or pneumonitis. The evidence is sufficient to determine that the technology results in a meaningful improvement in the net health outcome.

For individuals with NSCLC who receive endobronchial brachytherapy as primary treatment, the evidence includes single-arm series. The relevant outcomes are OS, symptoms, morbid events, and treatment-related morbidity. For primary treatment (i.e., with intent to improve survival outcomes), the effects of endobronchial brachytherapy on survival outcomes compared with alternative therapies are not well-defined. Additional comparative data are needed. The evidence is insufficient to determine the effects of the technology on health outcomes.

For individuals with endobronchial hyperplastic granulation tissue who receive endobronchial brachytherapy, the evidence includes case series. The relevant outcomes are symptoms, morbid events, and treatment-related morbidity. The evidence for endobronchial brachytherapy for hyperplastic granulation tissue is limited. The available case series typically include endobronchial brachytherapy as part of multimodal management, making it difficult to assess the specific contribution of brachytherapy. The evidence is insufficient to determine the effects of the technology on health outcomes.

Supplemental Information
Practice Guidelines and Position Statements
The National Comprehensive Cancer Network Guidelines (v.4.2019) for non-small-cell lung cancer include external-beam radiotherapy (EBRT) and brachytherapy as treatment options for severe hemoptysis in locoregional recurrent disease (category 2A).24, American College of Radiology et al Practice guidelines published jointly by American College of Radiology and the American Brachytherapy Society (2017) addressed the use of high-dose-rate brachytherapy (≥12 gray per hour) in the treatment of multiple medical conditions, including malignancies in the endobronchial region.25. The guidelines cited studies on the use of high-dose-rate brachytherapy
as palliative care and as primary care and noted that brachytherapy might be combined with EBRT.

Both groups also published guidelines (2017) on the use of low-dose-rate radionuclide brachytherapy, defined as a treatment between 4 and 200 centigray per hour. The guidelines considered low-dose-rate brachytherapy an appropriate treatment for a number of malignancy types, including those found in the bronchus or trachea. Such treatment may be especially appropriate when used to augment EBRT, or when the target volume may be defined.

Both sets of joint guidelines provided a standard for procedural protocol, as well as a summary of the potential treatment sites of the respective types of brachytherapy.

American College of Chest Physicians
Guidelines on the treatment of a cough as a symptom of lung cancer from the American College of Chest Physicians (2017) were updated. The systematic review used to inform the guidelines included a number of low-quality studies and the strength of the recommendations were diminished, accordingly. Acknowledging a lack of studies about the effect of brachytherapy on specific lung cancer symptoms (e.g., cough), the College recommended that endobronchial brachytherapy be used in patients who cannot receive surgery, chemotherapy, or EBRT (grade 2C evidence). Citing the accompanying risk of side effects such as hemoptysis, the College suggested that a pharmacologic therapy trial be considered initially, or, if endobronchial brachytherapy is used, that caregivers administer the lowest dose.

American Brachytherapy Society
The American Brachytherapy Society (2016) issued consensus guidelines on thoracic brachytherapy for lung cancer. The guidelines included the following recommendations:

- As palliative care for patients with central, obstructive lesions, particularly those who have previously received EBRT.
- Alone or in combination with "endobronchial resection, laser therapy, stenting, and photodynamic therapy."
- As either "high dose rate or pulsed dose rate with the ability to optimize dose" (low dose rate not recommended).

U.S. Preventive Services Task Force Recommendations
Not applicable.

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

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

Table 1. Summary of Key Trials

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NCT: national clinical trial.
References


**Documentation for Clinical Review**

**Please provide the following documentation (if when requested):**

- History and physical and/or consultation notes including:
  - Tumor classification
  - Past medical and/or surgical treatment and response
- Operative report(s) or procedure report(s)
- Pathology report(s)
- Radiation treatment plan including: type of brachytherapy, therapy schedule, and number of treatments
### Coding

This Policy relates only to the services or supplies described herein. Benefits may vary according to product design; therefore, contract language should be reviewed before applying the terms of the Policy. Inclusion or exclusion of codes does not constitute or imply member coverage or provider reimbursement.

### MN/IE

The following services may be considered medically necessary in certain instances and investigational in others. Services may be considered medically necessary when policy criteria are met. Services may be considered investigational when the policy criteria are not met or when the code describes application of a product in the position statement that is investigational.

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<thead>
<tr>
<th>Type</th>
<th>Code</th>
<th>Description</th>
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</thead>
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<tr>
<td>CPT</td>
<td>31643</td>
<td>Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with placement of catheter(s) for intracavitary radionuclide application</td>
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<tr>
<td></td>
<td>77316</td>
<td>Brachytherapy isodose plan; simple (calculation[s] made from 1 to 4 sources, or remote afterloading brachytherapy, 1 channel), includes basic dosimetry calculation(s)</td>
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<tr>
<td></td>
<td>77317</td>
<td>Brachytherapy isodose plan; intermediate (calculation[s] made from 5 to 10 sources, or remote afterloading brachytherapy, 2-12 channels), includes basic dosimetry calculation(s)</td>
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<tr>
<td></td>
<td>77318</td>
<td>Brachytherapy isodose plan; complex (calculation[s] made from over 10 sources, or remote afterloading brachytherapy, over 12 channels), includes basic dosimetry calculation(s)</td>
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<tr>
<td></td>
<td>77761</td>
<td>Intracavitary radiation source application; simple</td>
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<tr>
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<td>77762</td>
<td>Intracavitary radiation source application; intermediate</td>
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<tr>
<td></td>
<td>77763</td>
<td>Intracavitary radiation source application; complex</td>
</tr>
<tr>
<td></td>
<td>77770</td>
<td>Remote afterloading high dose rate radionuclide interstitial or intracavitary brachytherapy, includes basic dosimetry, when performed; 1 channel</td>
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<tr>
<td></td>
<td>77771</td>
<td>Remote afterloading high dose rate radionuclide interstitial or intracavitary brachytherapy, includes basic dosimetry, when performed; 2-12 channels</td>
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<td>77772</td>
<td>Remote afterloading high dose rate radionuclide interstitial or intracavitary brachytherapy, includes basic dosimetry, when performed; over 12 channels</td>
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<td>77790</td>
<td>Supervision, handling, loading of radiation source</td>
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<tr>
<td>HCPCS</td>
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<td>ICD-10 Procedure</td>
<td>0BH001Z</td>
<td>Insertion of Radioactive Element into Tracheobronchial Tree, Open Approach</td>
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<td>0BH031Z</td>
<td>Insertion of Radioactive Element into Tracheobronchial Tree, Percutaneous Approach</td>
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<td></td>
<td>0BH041Z</td>
<td>Insertion of Radioactive Element into Tracheobronchial Tree, Percutaneous Endoscopic Approach</td>
</tr>
<tr>
<td></td>
<td>0BH071Z</td>
<td>Insertion of Radioactive Element into Tracheobronchial Tree, Via Natural or Artificial Opening</td>
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<tr>
<td></td>
<td>0BH081Z</td>
<td>Insertion of Radioactive Element into Tracheobronchial Tree, Via Natural or Artificial Opening Endoscopic</td>
</tr>
<tr>
<td>Type</td>
<td>Code</td>
<td>Description</td>
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<tr>
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<td>0BHK01Z</td>
<td>Insertion of Radioactive Element into Right Lung, Open Approach</td>
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<td>0BHL81Z</td>
<td>Insertion of Radioactive Element into Left Lung, Via Natural or Artificial Opening Endoscopic</td>
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</table>

**Policy History**

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

<table>
<thead>
<tr>
<th>Effective Date</th>
<th>Action</th>
<th>Reason</th>
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<tbody>
<tr>
<td>06/30/2015</td>
<td>Policy title change from Brachytherapy for Oncologic Indications</td>
<td>Medical Policy Committee</td>
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<tr>
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<td>Policy revision with position change</td>
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<tr>
<td></td>
<td>BCBSA Medical Policy adoption</td>
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<tr>
<td>02/01/2016</td>
<td>Coding update</td>
<td>Administrative Review</td>
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<td>02/01/2017</td>
<td>Policy revision without position change</td>
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<td>02/01/2018</td>
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<td>09/01/2018</td>
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</tr>
<tr>
<td>09/01/2019</td>
<td>Policy revision without position change</td>
<td>Medical Policy Committee</td>
</tr>
</tbody>
</table>

**Definitions of Decision Determinations**

**Medically Necessary:** A treatment, procedure, or drug is medically necessary only when it has been established as safe and effective for the particular symptoms or diagnosis, is not investigational or experimental, is not being provided primarily for the convenience of the patient or the provider, and is provided at the most appropriate level to treat the condition.

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

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

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

Questions regarding the applicability of this policy should be directed to the Prior Authorization Department. Please call (800) 541-6652 or visit the provider portal at www.blueshieldca.com/provider.

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