Intensity-modulated radiotherapy (IMRT) may be considered **medically necessary** in the treatment of localized prostate cancer (see Policy Guidelines).

Intensity-modulated radiotherapy (IMRT) may be considered **medically necessary** after radical prostatectomy as:

- **Adjuvant therapy** when there are adverse pathologic findings at prostatectomy or with a persistently detectable prostate-specific antigen level after prostatectomy (see Policy Guidelines)
- **Salvage therapy** when there is evidence of biochemical or local recurrence when there is no evidence of distant metastatic disease (see Policy Guidelines)

Intensity-modulated radiotherapy (IMRT) is considered **investigational** for the treatment of prostate cancer when the above criteria are not met.

**Brachytherapy with Intensity-Modulated Radiotherapy Boost**

Intensity-modulated radiotherapy (IMRT) may be considered **medically necessary** in conjunction with permanent transperineal implantation of radioactive seeds or high-dose rate temporary brachytherapy.

**Policy Guidelines**

**Localized Prostate Cancer: Radiotherapy (RT) as Definitive Treatment**

Localized prostate cancer can be defined as cancer confined to the prostate gland T1-T2N0-NXM0 or as locally advanced cancer. Locally advanced cancer is defined as cancer confined to adjacent structures and includes T3a-T3bN0-NXM0. The presence of tumor invasion beyond extra capsular extension or other than seminal vesicles, or with evidence of regional lymph node involvement, in the absence of distant metastases T4N0-N1M0, does not necessarily preclude definitive therapy.

The National Comprehensive Cancer Network (NCCN) has recommended a dose of 75.6 to 79.2 gray (Gy) in conventional fractions (with or without seminal vesicles) for patients with low-risk cancers (based on findings from Kuban et al, 2008). Low-risk features in localized prostate cancer are defined as stage T1 to T2a, a Gleason score of 6 or less, and a prostate-specific antigen (PSA) level less than 10 ng/mL.

The National Comprehensive Cancer Network (NCCN) has recommended doses up to 81.0 Gy for patients with intermediate- and high-risk cancers, defined as: intermediate risk: stage T2b to T2c or Gleason score of 7 or PSA levels between 10 ng/mL and 20 ng/mL; and high risk: stage T3a or Gleason score of 8 to 10 or PSA level greater than 20 ng/mL (based on Eade et al, 2007; and Xu et al, 2011).

**Post Prostatectomy: Radiotherapy as Adjuvant or Salvage Therapy**

Radiotherapy (RT) after prostatectomy is used as adjuvant therapy in patients at a higher risk of recurrence (before recurrence). In the adjuvant setting, adverse pathologic findings at prostatectomy include positive surgical margins, seminal vesicle invasion, extra prostatic extension, and Gleason scores of 8 to 10.

Use of radiotherapy (RT) as salvage therapy included treating the prostate bed and possibly surrounding tissues, including lymph nodes, in a patient with locoregional recurrence after
surgery. In the salvage setting, biochemical recurrence is defined as a detectable or rising PSA level of 0.2 ng/mL or more after surgery, with a confirmatory test level of 0.2 ng/mL or higher.

American Urological Association and American Society for Radiation Oncology (Thompson et al, 2013) guidelines recommend a minimum dose of 64 to 65 Gy in the post prostatectomy setting.

**Fractionation**

In the treatment of prostate cancer, conventional radiotherapy (RT) applies total doses in excess of 74 Gy over up to 9 weeks, whereas hypofractionated radiotherapy involves daily doses greater than 2 Gy and has an overall shorter treatment time. Published randomized controlled trials have failed to demonstrate the superiority of hypofractionation in definitive RT for prostate cancer, either for efficacy or late toxicity. Ongoing phase 3 noninferiority trials might provide insight.

The National Comprehensive Cancer Network (NCCN) guidelines state that because, in the treatment of prostate cancer, moderately hypofractionated intensity-modulated radiotherapy (IMRT) regimens (2.4-4 Gy per fraction over 4-6 weeks) have been tested in randomized controlled trials, and efficacy and toxicity have been found similar to conventionally fractionated IMRT, hypofractionation may be considered as an alternative to conventionally fractionated regimens when clinically indicated.

When radiation therapy is provided to the same target volume by two different modalities, e.g., brachytherapy with IMRT boost, the combined dose is used to determine compliance with this policy.

**Radiation Tolerance of Normal Tissue**

Organs at risk are defined as normal tissues whose radiation sensitivity may significantly influence treatment planning and/or prescribed radiation dose. Organs at risk may be particularly vulnerable to clinically important complications from radiation toxicity.

IMRT should be considered when a tumor is near organs at risk, and 3-dimensional conformal radiotherapy planning does not meet dose-volume constraints for normal tissue tolerance.

Requests for the above exceptions and all other indications not discussed in this policy will be reviewed on a case-by-case basis.

Tables PG1 and 2 outline radiation doses generally considered tolerance thresholds for these normal structures in the pelvis.

### Table PG1. Radiation Tolerance Doses for Normal Tissues of the Pelvis

<table>
<thead>
<tr>
<th>Site</th>
<th>TD 5/5, Gray&lt;sup&gt;a&lt;/sup&gt;</th>
<th>TD 50/5, Gray&lt;sup&gt;b&lt;/sup&gt;</th>
<th>Complication End Point</th>
</tr>
</thead>
<tbody>
<tr>
<td>Portion of Organ Involved</td>
<td></td>
<td>Portion of Organ Involved</td>
<td></td>
</tr>
<tr>
<td>1/3</td>
<td>2/3</td>
<td>3/3</td>
<td></td>
</tr>
<tr>
<td>Spinal cord</td>
<td>50</td>
<td>50</td>
<td>Myelitis, necrosis</td>
</tr>
<tr>
<td>Small intestine</td>
<td>50</td>
<td>NP</td>
<td>Obstruction, perforation</td>
</tr>
<tr>
<td>Colon</td>
<td>55</td>
<td>NP</td>
<td>Obstruction, perforation, ulceration, fistula</td>
</tr>
<tr>
<td>Rectum</td>
<td>NP</td>
<td>NP</td>
<td>Severe proctitis, necrosis, Stenosis, fistula</td>
</tr>
<tr>
<td>Bladder</td>
<td>NP</td>
<td>80</td>
<td>Symptomatic bladder contracture and volume loss</td>
</tr>
<tr>
<td>Femoral head</td>
<td>NP</td>
<td>NP</td>
<td>Necrosis</td>
</tr>
</tbody>
</table>

<sup>a</sup> Tolerance doses in the table were compiled from 2 sources: (1) Morgan MA (2011). Radiation oncology. In DeVita, Lawrence, and Rosenberg, Cancer (p.308). Philadelphia: Lippincott Williams and Wilkins; and (2)
8.01.47  Intensity-Modulated Radiotherapy of the Prostate
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a TD 5/5 is the average dose that results in a 5% complication risk within 5 years.
b TD 50/5 is the average dose that results in a 50% complication risk within 5 years.

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

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

Table PG2. Radiation Dose Volume (1.8-2.0 Gy/fx) for Normal Tissues of the Pelvis

<table>
<thead>
<tr>
<th>Organ</th>
<th>Constraints</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Central Nervous System (1.8-2.0 Gray/fraction [Gy/fx])</strong></td>
<td></td>
</tr>
<tr>
<td>Spinal Cord</td>
<td>max 50 Gy (full cord cross-section); tolerance increases by 25% 6 mos after 1st course (for re-irradiation)</td>
</tr>
<tr>
<td>Brain</td>
<td>max 72 Gy (partial brain); avoid &gt;2 Gy/fx or hyperfractionation</td>
</tr>
<tr>
<td>Chiasm/Optic Nerves</td>
<td>max 55 Gy</td>
</tr>
<tr>
<td>Brainstem</td>
<td>Entire brainstem &lt;54 Gy, V59 Gy &lt;1-10 cc</td>
</tr>
<tr>
<td>Eyes (globe)</td>
<td>mean &lt;35 Gy, max 54 Gy</td>
</tr>
<tr>
<td>Lens</td>
<td>max 7 Gy</td>
</tr>
<tr>
<td>Retina</td>
<td>max 50 Gy</td>
</tr>
<tr>
<td>Lacrimal Gland</td>
<td>max 40 Gy</td>
</tr>
<tr>
<td>Inner ear/cochlea</td>
<td>mean &lt;45 Gy (consider constraining to &lt;5 Gy with concurrent cisplatin)</td>
</tr>
<tr>
<td>Pituitary gland</td>
<td>max 45 Gy (for panhypopituitarism, lower for GH deficiency)</td>
</tr>
<tr>
<td>Cauda equina</td>
<td>max 60 Gy</td>
</tr>
<tr>
<td><strong>Central Nervous System (single fraction)</strong></td>
<td></td>
</tr>
<tr>
<td>Spinal Cord</td>
<td>max 13 Gy (if 3 fx, max 20 Gy)</td>
</tr>
<tr>
<td>Brain</td>
<td>V12 Gy &lt;5-10 cc</td>
</tr>
<tr>
<td>Chiasm/Optic Nerves</td>
<td>max 10 Gy</td>
</tr>
<tr>
<td>Brainstem</td>
<td>max 12.5 Gy</td>
</tr>
<tr>
<td>Sacral plexus</td>
<td>V18 &lt;0.035 cc, V14.4 &lt;5 cc</td>
</tr>
<tr>
<td>Cauda equina</td>
<td>V16 &lt;0.035 cc, V14 &lt;5 cc</td>
</tr>
<tr>
<td><strong>Head and Neck (1.8-2.0 Gy/fx)</strong></td>
<td></td>
</tr>
<tr>
<td>Parotid gland (s)</td>
<td>mean &lt;25 Gy (both glands) or mean &lt;20 Gy (1 gland)</td>
</tr>
<tr>
<td>Submandibular gland (s)</td>
<td>mean &lt;35 Gy</td>
</tr>
<tr>
<td>Larynx</td>
<td>mean &lt;44 Gy, V50 &lt;27%, max 63-66 Gy (when risk of tumor involvement is limited)</td>
</tr>
<tr>
<td>TMJ/mandible</td>
<td>max 70 Gy (if not possible, then V75 &lt;1 cc)</td>
</tr>
<tr>
<td>Oral cavity</td>
<td>Non-oral cavity cancer: mean &lt;30 Gy, avoid hot spots &gt;60 Gy Oral cavity cancer: mean &lt;50 Gy, V55 &lt;1 cc, max 65 Gy</td>
</tr>
<tr>
<td>Esophagus (cervical)</td>
<td>V45 &lt;33%</td>
</tr>
<tr>
<td>Pharyngeal constrictors</td>
<td>mean &lt;50 Gy</td>
</tr>
<tr>
<td>Thyroid</td>
<td>V26 &lt;20%</td>
</tr>
</tbody>
</table>
### Organ Constraints

**Thoracic (1.8-2.0 Gy/fx)**

- **Brachial plexus**
  - max 66 Gy, V60 <5%

- **Lung (combined lung for lung cancer treatment)**
  - mean <20-23 Gy, V20 <30%-35%

- **Lung (ipsilateral lung for breast cancer treatment)**
  - V25 <10%

- **Single lung (after pneumonectomy)**
  - V5 <60%, V20 <4-10%, MLD <8 Gy

- **Bronchial tree**
  - max 80 Gy

- **Heart (lung cancer treatment)**
  - Heart V45 <67%; V60 <33%

- **Heart (breast cancer treatment)**
  - V25 <10%

- **Esophagus**
  - V50 <32%, V60 <33%

**Thoracic (hypofractionation)**

Note: the max dose limits refer to volumes >0.035 cc (~3 mm³).

- **Spinal cord**
  - 1 fraction: 14 Gy
  - 3 fractions: 18 Gy (6 Gy/fix)
  - 4 fractions: 26 Gy (6.5 Gy/fix)
  - 5 fractions: 30 Gy (6 Gy/fix)

- **Esophagus**
  - 1 fraction: 15.4 Gy
  - 3 fractions: 30 Gy (10 Gy/fix)
  - 4 fractions: 30 Gy (7.5 Gy/fix)
  - 5 fractions: 32.5 Gy (6.5 Gy/fix)

- **Brachial plexus**
  - 1 fraction: 17.5 Gy
  - 3 fractions: 21 Gy (7 Gy/fix)
  - 4 fractions: 27.2 Gy (6.8 Gy/fix)
  - 5 fractions: 30 Gy (6 Gy/fix)

- **Heart/Pericardium**
  - 1 fraction: 22 Gy
  - 3 fractions: 30 Gy (10 Gy/fix)
  - 4 fractions: 34 Gy (8.5 Gy/fix)
  - 5 fractions: 35 Gy (7 Gy/fix)

- **Great vessels**
  - 1 fraction: 37 Gy
  - 3 fractions: 39 Gy (13 Gy/fix)
  - 4 fractions: 49 Gy (12.25 Gy/fix)
  - 5 fractions: 55 Gy (11 Gy/fix)

- **Trachea/Large Bronchus**
  - 1 fraction: 20.2 Gy
  - 3 fractions: 30 Gy (10 Gy/fix)
  - 4 fractions: 34.8 Gy (8.7 Gy/fix)
  - 5 fractions: 40 Gy (8 Gy/fix)

- **Rib**
  - 1 fraction: 30 Gy
  - 3 fractions: 30 Gy (10 Gy/fix)
  - 4 fractions: 32 Gy (7.8 Gy/fix)
  - 5 fractions: 32.5 Gy (6.5 Gy/fix)

- **Skin**
  - 1 fraction: 26 Gy
  - 3 fractions: 30 Gy (10 Gy/fix)
  - 4 fractions: 36 Gy (9 Gy/fix)
  - 5 fractions: 40 Gy (8 Gy/fix)

- **Stomach**
  - 1 fraction: 12.4 Gy
  - 3 fractions: 27 Gy (9 Gy/fix)
  - 4 fractions: 30 Gy (7.5 Gy/fix)
  - 5 fractions: 35 Gy (7 Gy/fix)

**Gastrointestinal (GI) (1.8-2.0 Gy/fix)**

- **Stomach**
  - TD 5/5 whole stomach: 45 Gy

- **Small bowel**
  - V45 <195 cc

- **Liver (metastatic disease)**
  - mean liver <32 Gy (liver = normal liver minus gross disease)

- **Liver (primary liver cancer)**
  - mean liver <28 Gy (liver = normal liver minus gross disease)

- **Colon**
  - 45 Gy, max dose 55 Gy
<table>
<thead>
<tr>
<th>Organ</th>
<th>Constraints</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kidney (bilateral)</td>
<td>mean &lt;18 Gy, V28 &lt;20%, V23 Gy &lt;30%, V20 &lt;32%, V12 &lt;55% If mean kidney dose to 1 kidney &gt;18 Gy, then constrain remaining kidney to V6 &lt;30%</td>
</tr>
</tbody>
</table>

### Gastrointestinal (GI) (single fraction)

<table>
<thead>
<tr>
<th>Organ</th>
<th>Constraints</th>
</tr>
</thead>
<tbody>
<tr>
<td>Duodenum</td>
<td>V16 &lt;0.035 cc, V11.2 &lt;5 cc</td>
</tr>
<tr>
<td>Kidney (Cortex)</td>
<td>V8.4 &lt;200 cc</td>
</tr>
<tr>
<td>Kidney (Hilum)</td>
<td>V10.6 &lt;66%</td>
</tr>
<tr>
<td>Colon</td>
<td>V14.3 &lt;20 cc, V18.4 &lt;0.035 cc</td>
</tr>
<tr>
<td>Jejunum/Ileum</td>
<td>V15.4 &lt;0.035 cc, V11.9 &lt;5 cc</td>
</tr>
<tr>
<td>Stomach</td>
<td>V16 &lt;0.035 cc, V11.2 &lt;10 cc</td>
</tr>
<tr>
<td>Rectum</td>
<td>V18.4 &lt;0.035 cc, V14.3 &lt;20 cc</td>
</tr>
</tbody>
</table>

### Genitourinary (GU) (1.8-2.0 Gy/fx)

<table>
<thead>
<tr>
<th>Organ</th>
<th>Constraints</th>
</tr>
</thead>
<tbody>
<tr>
<td>Femoral heads</td>
<td>V50 &lt;5%</td>
</tr>
<tr>
<td>Rectum</td>
<td>V75 &lt;15%, V70 &lt;20%, V65 &lt;25%, V60 &lt;35%, V50 &lt;50%</td>
</tr>
<tr>
<td>Bladder</td>
<td>V80 &lt;15%, V75 &lt;25%, V70 &lt;35%, V65 &lt;50%</td>
</tr>
<tr>
<td>Testis</td>
<td>V3 &lt;50%</td>
</tr>
<tr>
<td>Penile bulb</td>
<td>Mean dose to 95% of the volume &lt;50 Gy, D70 &lt;70 Gy, D50 &lt;50 Gy</td>
</tr>
</tbody>
</table>

### Genitourinary (GU) (LDR prostate brachytherapy)

<table>
<thead>
<tr>
<th>Organ</th>
<th>Constraints</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urethra</td>
<td>Volume of urethra receiving 150% of prescribed dose (Ur150) &lt;30%</td>
</tr>
<tr>
<td>Rectum</td>
<td>Volume of rectum receiving 100% of prescribed dose (RV100) &lt;0.5 cc</td>
</tr>
</tbody>
</table>

### Gynecological (GYN)

<table>
<thead>
<tr>
<th>Organ</th>
<th>Constraints</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bladder point (cervical brachytherapy)</td>
<td>Max 80 Gy (LDR equivalent dose)</td>
</tr>
<tr>
<td>Rectal point (cervical brachytherapy)</td>
<td>Max 75 Gy (LDR equivalent dose)</td>
</tr>
<tr>
<td>Proximal vagina (mucosa) (cervical brachytherapy)</td>
<td>Max 120 Gy (LDR equivalent dose)</td>
</tr>
<tr>
<td>Distal vagina (mucosa) (cervical brachytherapy)</td>
<td>Max 98 Gy (LDR equivalent dose)</td>
</tr>
</tbody>
</table>

### Coding

The following CPT codes for simple and complex IMRT delivery are available:

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

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

- **G6015**: Intensity modulated treatment delivery, single or multiple fields/arcs, via narrow spatially and temporally modulated beams, binary, dynamic MLC, per treatment session
- **G6016**: Compensator-based beam modulation treatment delivery of inverse planned treatment using 3 or higher resolution (milled or cast) compensator, convergent beam modulated fields, per treatment session

Code 77301 remains valid:

- **77301**: Intensity-modulated radiotherapy plan, including dose-volume histograms for target and critical structure partial tolerance specifications
The following CPT code may also be used:

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

Code 77338 is to be reported only once per IMRT plan and should not be reported with 0073T.

**Description**

Radiotherapy (RT) is an integral component of treatment for prostate cancer. Intensity-modulated radiotherapy (IMRT) has been proposed as a method of external-beam radiotherapy that delivers adequate radiation to the tumor volume, while minimizing the radiation dose to surrounding normal tissues and structures.

**Related Policies**

- Brachytherapy for Clinically Localized Prostate Cancer Using Permanently Implanted Seeds
- Charged-Particle (Proton or Helium Ion) Radiotherapy
- High-Dose Rate Temporary Prostate Brachytherapy
- Stereotactic Radiosurgery and Stereotactic Body Radiotherapy

**Benefit Application**

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

Some state or federal mandates [e.g., Federal Employee Program (FEP)] prohibits plans from denying Food and Drug Administration (FDA)-approved technologies as investigational. In these instances, plans may have to consider the coverage eligibility of the FDA-approved technologies on the basis of medical necessity alone.

**Regulatory Status**

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

A number of intensity modulators have been cleared for marketing by the U.S. Food and Drug Administration (FDA) through the 510(k) process. Intensity modulators include the Innocure Intensity Modulating Radiation Therapy Compensators (Innocure, Tempe, AZ), cleared in 2006, and the decimal tissue compensator (Southeastern Radiation Products, Sanford, FL), cleared in 2004. FDA product code: IXI. Intensity modulators may be added to standard linear accelerators to deliver IMRT when used with proper treatment planning systems.

RT treatment planning systems have also been cleared for marketing by the FDA through the 510(k) process. These include the Prowess Panther™ (Prowess, Concord, CA) in 2003, TiGRT (LinaTech, Sunnyvale, CA) in 2009, the RayDose (RaySearch Laboratories, Stockholm, Sweden) in 2008, and the eIMRT Calculator (Standard Imaging, Middleton, WI). FDA product code: MUJ.

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

Background
For localized prostate cancer, radiotherapy (RT) is an accepted option for primary (definitive) treatment. Other options include surgery (radical prostatectomy), hormonal treatment, or active surveillance.

In the postoperative setting, RT to the prostate bed is an accepted procedure for patients with an increased risk of local recurrence, based on 3 randomized controlled trials that showed a significant increase in biochemical recurrence-free survival. Professional society guidelines have recommended adjuvant RT to patients with adverse pathologic findings at the time of prostatectomy and salvage RT for patients with prostate-specific antigen (PSA) recurrence or local recurrence after prostatectomy in the absence of metastatic disease.

RT Techniques
Conventional External-Beam Radiotherapy
Over the past several decades, methods to plan and deliver radiotherapy (RT) have evolved in ways that permit more precise targeting of tumors with complex geometries. Most early trials used 2-dimensional treatment planning, based on flat images and radiation beams with cross-sections of uniform intensity that were sequentially aimed at the tumor along 2 or 3 intersecting axes. Collectively, these methods are termed conventional external-beam radiotherapy.

Three-Dimensional Conformal Radiotherapy
Treatment planning evolved by using 3-dimensional images, usually from computed tomography scans, to delineate the boundaries of the tumor and to discriminate tumor tissue from adjacent normal tissue and nearby organs at risk for radiation damage. Computer algorithms were developed to estimate cumulative radiation doses delivered to each volume of interest by summing the contribution from each shaped beam. Methods also were developed to position the patient and the radiation portal reproducibly for each fraction and to immobilize the patient, thus maintaining consistent beam axes across treatment sessions. Collectively, these methods are termed 3-dimensional conformal radiotherapy (3D-CRT).

Intensity-Modulated Radiotherapy
Imaging images, offers better conformation than 3D-CRT, because it is able to modulate the intensity of the overlapping radiation beams projected on the target and to use multiple shaped treatment fields. Treatment planning and delivery are more complex, time consuming, and labor intensive for IMRT than for 3D-CRT. The technique uses a multileaf collimator (MLC), which, when coupled with a computer algorithm, allows for “inverse” treatment planning. The radiation oncologist delineates the target on each slice of a CT scan and specifies the target’s prescribed radiation dose, acceptable limits of dose heterogeneity within the target volume, adjacent normal tissue volumes to avoid, and acceptable dose limits within the normal tissues. Based on these parameters and a digitally reconstructed radiographic image of the tumor, surrounding tissues, and organs at risk, computer software optimizes the location, shape, and intensities of the beam ports to achieve the treatment plan’s goals.

Increased conformation may permit escalated tumor doses without increasing normal tissue toxicity and thus may improve local tumor control, with decreased exposure to surrounding normal tissues, potentially reducing acute and late radiation toxicities. Better dose homogeneity within the target may also improve local tumor control by avoiding underdosing within the tumor and may decrease toxicity by avoiding overdosing.

Technologic development has produced advanced techniques that may further improve RT treatment by improving dose distribution. These techniques are considered variations of IMRT. Volumetric modulated arc therapy delivers radiation from a continuous rotation of the radiation source. The principal advantage of volumetric modulated arc therapy is greater efficiency in treatment delivery time, reducing radiation exposure and improving target radiation delivery.
due to less patient motion. Image-guided RT involves the incorporation of imaging before and/or during treatment to more precisely deliver RT to the target volume.

IMRT methods to plan and deliver RT are not uniform. IMRT may use beams that remain on as MLCs move around the patient (dynamic MLC) or that are off during movement and turn on once the MLC reaches prespecified positions ("step and shoot" technique). A third alternative uses a very narrow single beam that moves spirally around the patient (tomotherapy). Each method uses different computer algorithms to plan treatment and yields somewhat different dose distributions in and outside the target. Patient position can alter target shape and thus affect treatment plans. Treatment plans are usually based on 1 imaging scan, a static 3D-CT image. Current methods seek to reduce positional uncertainty for tumors and adjacent normal tissues by various techniques. Patient immobilization cradles and skin or bony markers are used to minimize day-to-day variability in patient positioning. In addition, many tumors have irregular edges that preclude drawing tight margins on CT scan slices when radiation oncologists contour the tumor volume. It is unknown whether omitting some tumor cells or including some normal cells in the resulting target affects outcomes of IMRT.

**Literature Review**

Multiple-dose planning studies have generated 3-dimensional conformal radiotherapy (3D-CRT) and intensity-modulated radiotherapy (IMRT) treatment plans from the same scans, and then compared predicted dose distributions within the target and adjacent organs at risk. Results of such studies have shown that IMRT improves on 3D-CRT on conformity to, and dose homogeneity within, the target. Dosimetry using stationary targets generally confirms these predictions. Thus, radiation oncologists have hypothesized that IMRT may provide better treatment outcomes than 3D-CRT. However, these types of studies offer indirect evidence for IMRT treatment benefit, and it is difficult to relate dosing study results to actual effects on health outcomes.

Comparative studies of radiation-induced adverse events from IMRT vs alternative radiation delivery would constitute definitive evidence of establishing the benefit of IMRT. Single-arm series of IMRT can give insights into the potential for benefit, particularly if an adverse event that is expected to occur at high rates is shown to decrease by a large amount. Studies of treatment benefit are also important to establish whether IMRT is at least as good as other types of delivery, but, absent such comparative trials, it is likely that benefit from IMRT is at least as good as with other types of delivery.

In general, when the indication for IMRT is to avoid radiation to sensitive areas, dosimetry studies have been considered sufficient evidence to demonstrate that harm would be avoided using IMRT. For other indications, such as using IMRT to provide better tumor control, comparative studies of health outcomes are needed to demonstrate such a benefit.

A proposed benefit of IMRT is to reduce toxicity to adjacent structures, allowing dose escalation to the target area and fewer breaks in treatment courses due to a reduction in side effects. However, this may come with a loss of locoregional control and overall survival (OS) due to factors discussed above. Thus, outcomes of interest are toxicity, quality of life, locoregional recurrence, and OS. The following is a summary of the literature to date.

This evidence review includes systematic reviews that have evaluated outcomes of IMRT treatment in patients with prostate cancer, summarizes the data on adverse effects from these systematic reviews, and includes additional primary studies. Because a reduction in adverse events is likely to be the greatest potential benefit of IMRT, the most relevant trials compare IMRT with 3D-CRT and report on adverse event rates following treatment. The following is a summary of key findings to date.
Primary (Definitive) Therapy for Localized Prostate Cancer

Systematic Reviews

A 2016 meta-analysis by Yu et al. included 23 studies (total N=9556 patients) that compared IMRT with 3D-CRT for gastrointestinal (GI), genitourinary (GU), and rectal toxicity, biochemical control, and overall survival (OS). The meta-analysis included 16 retrospective comparisons and 5 prospective cohort studies published before July 2015. The relative risk for the pooled analysis was considered significant if the 95% confidence intervals did not overlap at 1 at the p<0.05 level. IMRT resulted in less acute and late GI toxicity, less rectal bleeding, and improved biochemical control (see Table 1). There was a modest increase in acute GU toxicity, and no significant differences between the treatments in acute rectal toxicity, late GU toxicity, and OS.

Table 1. Outcomes for IMRT Compared With 3D-CRT

<table>
<thead>
<tr>
<th>Comparison</th>
<th>No. of Studies</th>
<th>No. of Patients</th>
<th>RR IMRT vs 3D-CRT</th>
<th>95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute GI toxicity</td>
<td>12</td>
<td>4142</td>
<td>0.59</td>
<td>0.44 to 0.78</td>
</tr>
<tr>
<td>Late GI toxicity</td>
<td>13</td>
<td>6519</td>
<td>0.54</td>
<td>0.38 to 0.78</td>
</tr>
<tr>
<td>Acute rectal toxicity</td>
<td>4</td>
<td>2188</td>
<td>1.03</td>
<td>0.45 to 2.36</td>
</tr>
<tr>
<td>Late rectal bleeding</td>
<td>5</td>
<td>1972</td>
<td>0.48</td>
<td>0.27 to 0.85</td>
</tr>
<tr>
<td>Acute GU toxicity</td>
<td>14</td>
<td>4603</td>
<td>1.08</td>
<td>1.00 to 1.17</td>
</tr>
<tr>
<td>Late GU toxicity</td>
<td>12</td>
<td>5608</td>
<td>1.03</td>
<td>0.82 to 1.30</td>
</tr>
<tr>
<td>Biochemical control</td>
<td>6</td>
<td>2416</td>
<td>1.17</td>
<td>1.08 to 1.27</td>
</tr>
<tr>
<td>Overall survival</td>
<td>3</td>
<td>924</td>
<td>1.07</td>
<td>0.96 to 1.19</td>
</tr>
</tbody>
</table>

CI: Confidence Interval; GI: Gastrointestinal, Grade 2-4 Toxicity; GU: Genitourinary, grade 2-4 toxicity; IMRT: Intensity-Modulated Radiotherapy; RR: Relative Risk; 3D-CRT: 3-Dimensional Conformal Radiotherapy.

In 2012, Bauman et al. published a systematic review that examined the evidence for IMRT in the treatment of prostate cancer to quantify its potential benefits and to make recommendations for radiation treatment programs considering adopting this technique within the province of Ontario, Canada. Based on a review of 11 published reports through March 2009 (9 retrospective cohort studies, 2 randomized controlled trials [RCTs]) including 4559 patients, reviewers recommended IMRT over 3D-CRT for aggressive treatment of localized prostate cancer where an escalated radiation (>70 gray [Gy]) dose would be required. Four studies (3 retrospective cohort studies, 1 RCT) reported differences in adverse events between IMRT and 3D-CRT. The RCT (N=78 patients) reported significantly less frequent acute GI toxicity in the IMRT group than in the 3D-CRT group. This was true for grade 2, 3, or 4 toxicity (20% vs 61%, p=0.001), grade 3 or 4 toxicity (0% vs 13%, p=0.001), and for acute proctitis (15% vs 38%, p=0.03). A second RCT included in this systematic review reported no differences in toxicity between IMRT and 3D-CRT.

For late GI toxicity, 4 of 9 studies, all retrospective cohort studies (total N=3333 patients), reported differences between IMRT and 3D-CRT. One RCT, reporting on late GI toxicity, did not find any differences between IMRT and 3D-CRT. Five of 9 studies reported on late GU effects: only one reported a difference in late GU effects in favor of 3D-CRT. Two retrospective cohort studies reported mixed findings on quality of life outcomes. A 2012 economic analysis (based on this systematic review data) suggested IMRT was more cost-effective than an equivalent dose of 3D-CRT based on 2009 data from the Canadian health care system.

A 2010 systematic review by Hummel et al. on the clinical effectiveness of IMRT for the radical treatment of prostate cancer was undertaken for the U.K. Health Technology Assessment Programme. The literature search through May 2009 identified 8 nonrandomized studies comparing IMRT with 3D-CRT. Clinical outcomes were OS, biochemical (prostate-specific antigen [PSA]) relapse-free survival, toxicity, and health-related quality of life. The biochemical relapse-free survival was not affected by treatment received, except when doses differed between groups; in those cases, a higher dose with IMRT was favored over lower doses with 3D-CRT. There was some indication that GU toxicity was worse for patients treated with dose-escalated IMRT. However, any group difference resolved by 6 months after treatment. Data
comparing IMRT with 3D-CRT supported the theory that higher doses (up to 81 Gy) can improve biochemical survival for patients with localized prostate cancer. Most studies reported an advantage for IMRT in GI toxicity, particularly for the volume of the rectum treated, because toxicity can be reduced by increasing conformality of treatment, which can be more easily achieved with IMRT than with 3D-CRT.

### Primary Studies Reporting on Outcomes and Adverse Events

Additional studies not included in the 2016 Yu meta-analysis are described next.

In 2016, Viani et al reported on a pseudorandomized trial (sequential allocation) that compared toxicity levels between IMRT and 3D-CRT in 215 men who had localized prostate cancer. Treatment consisted of hypofractionated radiotherapy (RT) at a total dose of 70 Gy at 2.8 Gy per fraction using either IMRT or 3D-CRT. The primary end point was toxicity, defined as any symptoms up to 6 months after treatment (acute) or that started 6 months after treatment (late). Quality of life was assessed with a prostate-specific module. The trial was adequately powered, and the groups were comparable at baseline. However, blinding of patients and outcome assessors was not reported. As shown in Table 2, the 3D-CRT group reported significantly more acute and late GI and GU toxicity, with similar rates of biochemical control (PSA nadir +2 ng/mL). The combined incidence of acute GI and GU toxicity was 28% for the 3D-CRT group compared with 11% for the IMRT group. Prostate-specific quality of life was reported to be worse in the 3D-CRT group at 6, 12, and 24 months, but not at 36 months post treatment.

**Table 2. Acute and Late Toxicity Rates with 3D-CRT and IMRT**

<table>
<thead>
<tr>
<th>Comparison</th>
<th>3D-CRT (n=109), %</th>
<th>IMRT (n=106), %</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute gastrointestinal toxicity, grade ≥2</td>
<td>24</td>
<td>7</td>
<td>0.001</td>
</tr>
<tr>
<td>Acute genitourinary toxicity, grade ≥2</td>
<td>27</td>
<td>9</td>
<td>0.001</td>
</tr>
<tr>
<td>Late gastrointestinal toxicity, grade ≥2</td>
<td>21.7</td>
<td>6.4</td>
<td>0.001</td>
</tr>
<tr>
<td>Late genitourinary toxicity, grade ≥2</td>
<td>12.3</td>
<td>3.7</td>
<td>0.02</td>
</tr>
<tr>
<td>Biochemical control</td>
<td>94.3</td>
<td>95.4</td>
<td>0.678</td>
</tr>
</tbody>
</table>

IMRT: Intensity-Modulated Radiotherapy; 3D-CRT: 3-Dimensional Conformal Radiotherapy.

A 2013 study by Michalski et al reported comparative data for IMRT and 3D-CRT from the high-dose arm of the Radiation Therapy Oncology Group 0126 prostate cancer trial. In this trial, the initial protocol only included 3D-CRT, but during the trial, the protocol was amended to include IMRT. As a result, 491 patients were treated with 3D-CRT and 257 were treated with IMRT. Patients treated with 3D-CRT received 55.8 Gy to the prostate and seminal vesicles and then 23.4 Gy to the prostate only. All IMRT patients received 79.2 Gy to the prostate and seminal vesicles. Radiation exposure for the bladder and rectum were significantly reduced with IMRT. There was a significant decrease in grade 2, 3, and 4 late GI toxicity for IMRT on univariate analysis (p=0.039). On multivariate analysis, there was a 26% reduction in grade 2, 3, and 4 GI toxicity for the IMRT group, but this difference was not statistically significant (p=0.099). There were no differences in early or late GU toxicity between groups.

In 2013, Vora et al reported on 9-year tumor control and chronic toxicities observed in 302 patients treated with IMRT for clinically localized prostate cancer at a single institution. Median dose delivered was 76 Gy (range, 70-77 Gy), and 35% of patients received androgen deprivation therapy. Local and distant recurrence rates were 5% and 8.6% respectively. At 9 years, biochemical control rates were 77% for low-risk, 70% for intermediate-risk, and 53% for high-risk patients (p=0.05). At last follow-up, none had persistent GI and only 0.7% had persistent GU toxicities of grade 3 or 4. The high-risk group was associated with a higher distant metastasis rate (p=0.02) and death from prostate cancer (p=0.001).

In 2009, Wong et al reported on a retrospective study of radiation dose escalation in 853 patients with localized (T1c-T3N0M0) prostate cancer. RTs used included conventional dose (71 Gy) 3D-CRT (n=270), high-dose (75.6 Gy) IMRT (n=314), permanent transperineal brachytherapy (n=225), and external-beam radiotherapy plus brachytherapy boost (n=44). All patients were followed for a median of 58 months (range, 3-121 months). The 5-year OS rate for the entire group was 97%.
The 5-year biochemical no evidence of disease rates, local control rates, and distant control rates were 74%, 93%, and 96%, respectively, for 3D-CRT; 87%, 99%, and 97%, respectively, for IMRT; 94%, 100%, and 99%, respectively, for brachytherapy alone; and 94%, 100%, and 97%, respectively, for external-beam radiotherapy plus brachytherapy. The biochemical no evidence of disease rates for 3D-CRT were significantly lower than those of the other higher dose modalities (p<0.001).

In 2008, Cahlon et al reported on preliminary biochemical outcomes and toxicity with high-dose IMRT (86.4 Gy) for localized prostate cancer. For this study, 478 patients were treated between 1997 and 2004 with 86.4 Gy using a 5- to 7-field IMRT technique. Median follow-up was 53 months. Thirty-seven (8%) patients experienced acute grade 2 GI toxicity, with no acute grade 3 or 4 GI toxicity; 105 (22%) patients experienced acute grade 2 GU toxicity, with 3 (0.6%) patients having grade 3 GU toxicity. Sixteen (3%) patients developed late grade 2 GI toxicity while 2 patients (<1%) developed late grade 3 GI toxicity; 60 (13%) patients had late grade 2 GU toxicity while 12 (<3%) experienced late grade 3 GU toxicity. The 5-year actuarial relapse-free survival rates (using PSA nadir + 2 ng/mL) were 98%, 85%, and 70% for the low-, intermediate-, and high-risk National Comprehensive Cancer Network (NCCN) prognostic groups, respectively.

Evidence Supporting NCCN Recommendations for RT Dose for Low-Risk vs Intermediate- to High-Risk Prostate Cancer

NCCN has made recommendations for the use of RT for patients with prostate cancer based on risk stratification by clinical and pathologic findings. These recommendations are based on some studies that did and did not include IMRT as the mode of RT.

In 1993, a U.S. cancer research center initiated an RCT comparing toxicity levels with outcomes after 3D-CRT (at 78 Gy) and 2-dimensional RT (at 70 Gy) in patients with localized prostate cancer. The long-term results were reported by Kuban et al (2008). The trial included 301 patients with stage T1b to T3 disease who received 70 Gy (n=150) or 78 Gy (n=151). Median follow-up was 8.7 years. Patient risk levels in the 70- and 78-Gy groups were low (n=31 and n=30), intermediate (n=71 and n=68), and high (n=48 and n=53), respectively. When analyzed by risk group, patients with low-risk disease treated to 78 Gy vs 70 Gy, had a freedom from biochemical or clinical failure (FFF) of 88% and 63%, respectively (p=0.042). The intermediate-risk patients showed no statistically significant difference in FFF based on dose level (p=0.36). Patients with high-risk disease showed a significant difference in FFF based on dose (63% vs 26%, p=0.004), although when these high-risk patients were stratified by PSA level, only those patients with a PSA level greater than 10 ng/mL showed a difference in FFF.

NCCN guidelines also cite the 2008 Kuban study as evidence for a dose of 75.6 to 79.2 Gy (with or without the inclusion of the seminal vesicles) as appropriate for patients with low-risk cancers and that the conventional dose of 70 Gy is no longer considered adequate.

For patients with intermediate- and high-risk prostate cancer, NCCN has cited the following studies. For example, in 2011, Xu et al reported on a toxicity analysis of dose escalation from 75.6 to 81.0 Gy in 189 patients receiving definitive RT for prostate cancer. Patients were at high, intermediate, and low risk according to NCCN definitions, and received a dose at physician discretion. A total of 119 patients received 75.6 Gy and 70 received 81.0 Gy. Patients were followed at intervals of 3 to 6 months for 5 years and yearly after that (median follow-up, 3 years). The method of RT was at the discretion of the treating physician. The 81.0-Gy group had higher rates of grade 2 acute GU toxicity (p<0.001), late GU toxicity (p=0.001), and late GI toxicity (p=0.082), but a lower rate of acute GI toxicity (p=0.002). There were no notable differences in final GU (p=0.551) or final GI (p=0.194) toxicity levels compared with the 75.6-Gy group.

In 2007, Eade et al reported on the results of 1530 consecutive patients treated for localized prostate cancer with 3D-CRT between 1989 and 2002. Patients were grouped by dose level: less than 70 Gy (n=43), 70 to 74.9 Gy (n=552), 75 to 79.9 Gy (n=568), and 80 Gy or more (n=367).
Median follow-up ranged from 46 to 86 months. The group receiving 80 Gy or more had a median follow-up of 45.6 months. That group was mixed, with 64 (17%) patients having a low risk of cancer, 247 (67%) having an intermediate risk, and 56 (16%) having a high risk. Intermediate-plus high-risk patients made up 44% 46%, and 48% of the less than 70 Gy, 70 to 74.9 Gy, and 75 to 79.9 Gy groups, respectively. Adjusted 5-year estimates of freedom from biochemical failure for the 4 groups were 60%, 68%, 76%, and 84% using the American Society for Radiation Oncology criteria and 70%, 81%, 83%, and 89% using Phoenix criteria, respectively. Adjusted 5- and 10-year estimates of freedom from distant metastases for the 4 groups were 96% and 93%, 97% and 93%, 99%, and 95%, and 98% and 96% The authors concluded that a pronounced RT dose-response by freedom from biochemical failure was seen after adjusting for pretreatment PSA, Gleason score, and tumor stage and that the vast majority of patients should receive 80 Gy or more, although a subgroup of patients may be adequately treated with less radiation.

Section Summary: Primary (Definitive) RT for Localized Prostate Cancer

The evidence on IMRT for definitive treatment of localized prostate cancer includes several prospective comparative studies, retrospective comparative studies, and systematic reviews of these studies. Results generally show that IMRT provides tumor control and survival outcomes similar to 3D-CRT, with reductions in GI and GU toxicity. A reduction in clinically significant complications of RT is likely to improve quality of life for treated patients.

RT for Prostate Cancer after Prostatectomy

Systematic Reviews

The 2012 Bauman systematic review (discussed earlier) found insufficient data to recommend IMRT over 3D-CRT after prostatectomy. The 2013 joint American Urological Association and the American Society for Radiation Oncology guidelines on the use of adjuvant and salvage RT after prostatectomy was based on a systematic review of the literature from 1990 to 2012, which yielded 294 articles. The panel’s comments on RT techniques stated that it attempted to determine which technique and doses produced optimal outcomes, but that it was not possible to answer these questions from available data because most data came from observational studies and approximately one-third treated patients with conventional (2D) external-beam modalities. Of the literature included in the review, less than 5% of studies reported using IMRT. The panel stated that 64 to 65 Gy is the minimum dose that should be delivered after prostatectomy, but that dosage should be individualized to the patient.

Nonrandomized Comparative Studies

In 2009, Alongi et al reported results of acute toxicity of whole pelvis irradiation in 172 consecutive patients with clinically localized prostate cancer treated with IMRT or 3D-CRT as adjuvant (n=100) or salvage (n=72) RT after radical prostatectomy and pelvic lymph node dissection. Whole pelvis radiation was considered in patients with a limited lymphadenectomy and/or in the presence of a high risk of nodal involvement, in patients with positive lymph nodes and/or in the presence of adverse prognostic factors (Gleason score >7 and/or preoperative PSA level >10 ng/mL). Eighty-one patients underwent 3D-CRT, and 91 underwent IMRT. No grade 3 or 4 acute GU or lower GI side effects were observed. Acute grade 2 GU and acute lower GI grade 2 events did not differ significantly between treatment groups (see Table 3). There was a higher incidence of acute upper GI grade 2, 3, and toxicity in the 3D-CRT group. The authors concluded that acute toxicity following postoperative whole pelvis irradiation was reduced with IMRT compared with 3D-CRT; this effect was most significant for upper GI symptoms, owing mainly to better bowel sparing with IMRT.

Table 3. Acute and Late Toxicity Rates with 3D-CRT and IMRT

<table>
<thead>
<tr>
<th>Comparison</th>
<th>3D-CRT, n (%)</th>
<th>IMRT, n (%)</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute lower gastrointestinal toxicity, grade ≥2</td>
<td>7 (8.6)</td>
<td>3 (3.3)</td>
<td>0.14</td>
</tr>
<tr>
<td>Acute upper gastrointestinal toxicity, grade ≥2</td>
<td>18 (22.2)</td>
<td>6 (6.6)</td>
<td>0.004</td>
</tr>
<tr>
<td>Acute genitourinary toxicity</td>
<td>10 (12.3)</td>
<td>6 (6.6)</td>
<td>0.19</td>
</tr>
</tbody>
</table>

IMRT: Intensity-Modulated Radiotherapy; 3D-CRT: 3-Dimensional Conformal Radiotherapy.
In 2013, Massaccesi et al reported preliminary acute toxicity results from a phase 2 trial of hypofractionated IMRT with simultaneous integrated boost to the pelvic nodes and prostate bed after prostatectomy. Between 2008 and 2012, 49 patients considered to be at high risk of relapse after radical prostatectomy or who had biochemical relapse received 45 Gy in 1.8-Gy fractions to the whole pelvis and 62.5 Gy in 2.5-Gy fractions (equivalent dose, 68.75 Gy) to the prostate bed. The toxicity findings were compared with those of 52 consecutive patients selected from an electronic database who underwent adjuvant or salvage 3D-CRT with standard 2-Gy fractionation to the prostatic bed and regional pelvic nodes. Grade 1, 2, 3, and 4 acute GU toxicity occurred in 71.2% of all patients without a significant difference between the groups (hypofractionated IMRT vs conventionally fractionated 3D-CRT; p=0.51). Grade 2 acute GU toxicity, reported in 19.8% of all patients, was less frequent in patients in the IMRT group (9.6% vs 28.8%, p=0.02). There were no cases of grade 3 acute GU toxicity. Thirty (29.7%) patients developed grade 2 acute GI toxicity; the difference between groups was not statistically significant. No cases of grade 3 acute GI toxicity were reported. The study concluded that the acute toxicity profile for hypofractionated high-dose simultaneous integrated boost IMRT after prostatectomy compared favorably with that of conventionally fractionated high-dose 3D-CRT.

**Single-Arm Studies**

Several prospective single-arm phase 2 studies have evaluated the safety and efficacy of different methods of delivering IMRT (e.g., integrated boost, hypofractionation).

**PLATIN 3 Trial**

In 2014, initial results of the phase 2 Prostate and Lymph Node Irradiation With Integrated Boost-IMRT After Neoadjuvant Antihormonal Treatment (PLATIN 3) trial were published. This trial evaluated the safety and feasibility of irradiating the pelvic lymph nodes simultaneously with a boost to the prostate bed in 40 patients with high-risk features or inadequate lymphadenectomy after radical prostatectomy. Treatment consisted of 2 months of antihormonal treatment before IMRT of the pelvic lymph nodes (51.0 Gy) with a simultaneous integrated boost to the prostate bed (68.0 Gy). No acute grade 3 or 4 toxicity occurred. Nearly 23% of patients experienced acute grade 2 GI and GU toxicity and 10% late grade 2 GI and 5% late grade 2 GU toxicity. One patient developed late grade 3 proctitis and enteritis. At a median of 24 months, 89% of patients were free of a PSA recurrence.

**PRIAMOS1 Trial**

In 2014, acute toxicity results from the Hypofractionated RT of the Prostate Bed With or Without the Pelvic Lymph Nodes (PRIAMOS1) trial were reported. This prospective phase 2 trial assessed the safety and toxicity of hypofractionated RT of the prostate bed with IMRT as a basis for further prospective trials. Forty patients with indications for adjuvant or salvage therapy (pathologic stage T3 and/or R1/2 or with a PSA recurrence after prostatectomy) were enrolled from February to September 2012; 39 were evaluated. All patients received a total dose of 54.0 Gy to the prostate bed, 28 for salvage and 11 in the adjuvant setting. Based on preoperative staging, patients were risk-stratified as low (n=2), intermediate (n=27), or high (n=10). Ten weeks after completion of therapy, there were no adverse events exceeded grade 3. Acute GI toxicity rates were 56.4% and 17.9% for grade 1 and 2, respectively, and acute GU toxicity was recorded in 35.9% of patients at a maximum grade of 1.

In 2013, Corbin et al reported on the adverse events in high-risk men 2 years after IMRT and prostatectomy. Between 2007 and 2010, 78 consecutive men received either adjuvant RT (n=17 [22%]) or salvage RT (n=61 [78%]). The median IMRT dose was 66.6 Gy (range, 60-72 Gy). Quality of life data were collected prospectively at 2, 6, 12, 18, and 24 months, and included urinary incontinence, irritation or obstruction, bowel or rectal function, and sexual function. No significant changes were observed from baseline through 2-year follow-up, with global urinary irritation or obstruction scores unchanged or improved over time from baseline, global urinary incontinence improved from baseline to 24 months in the subset of patients receiving adjuvant therapy, and global bowel and sexual domain scores improved or unaffected over follow-up (though initially lower at 2 months).
Section Summary: RT for Prostate Cancer after Prostatectomy
The evidence on IMRT for prostate cancer after prostatectomy includes nonrandomized comparative studies, single-arm phase 2 trials, retrospective series, and systematic reviews of these studies. Although the comparative studies are primarily retrospective, the evidence has generally shown that IMRT provides tumor control and survival outcomes similar to 3D-CRT. Notably, a retrospective comparative study found a significant improvement in acute GI toxicity with IMRT compared with 3D-CRT, mainly due to better bowel sparing with IMRT. Another retrospective comparative study found a reduction in GU toxicity. A reduction in clinically significant complications of RT is likely to improve the quality of life for treated patients.

Summary of Evidence
For individuals who have localized prostate cancer and are undergoing definitive radiotherapy (RT) who receive intensity-modulated radiotherapy (IMRT), the evidence includes several prospective comparative studies, retrospective studies, and systematic reviews of these studies. Relevant outcomes are overall survival, disease-free survival, quality of life, and treatment-related morbidity. Although there are few prospective comparative trials, the evidence has generally shown that IMRT provides tumor control and survival outcomes similar to 3-dimensional conformal radiotherapy (3D-CRT) while reducing gastrointestinal and genitourinary toxicity. These findings are supported by treatment planning studies, which have predicted that IMRT improves target volume coverage and sparing of adjacent organs compared with 3D-CRT. A reduction in clinically significant complications of RT is likely to improve the quality of life for treated patients. The evidence is sufficient to determine that the technology results in a meaningful improvement in the net health outcome.

For individuals who have prostate cancer and are undergoing RT after prostatectomy who receive IMRT, the evidence includes retrospective comparative studies, single-arm phase 2 trials, and systematic reviews of these studies. Relevant outcomes are overall survival, disease-free survival, quality of life, and treatment-related morbidity. Although the comparative studies are primarily retrospective, the evidence has generally shown that IMRT provides tumor control and survival outcomes similar to 3D-CRT. Notably, a retrospective comparative study found a significant improvement in acute upper gastrointestinal toxicity with IMRT compared with 3D-CRT, mainly due to better bowel sparing with IMRT. Another retrospective comparative study found a reduction in genitourinary toxicity. A reduction in clinically significant complications of RT is likely to improve the quality of life for treated patients. The evidence is sufficient to determine that the technology results in a meaningful improvement in the net health outcome.

Supplemental Information
Practice Guidelines and Position Statements

National Comprehensive Cancer Network
Recent National Comprehensive Cancer Network guidelines (v.2.2017) for prostate cancer indicate that highly conformal radiotherapy should be used in conventional fraction doses of 75.6 to 79.2 gray (Gy) for low-risk prostate cancer and up to 81 Gy for intermediate- and high-risk prostate cancer.22 For adjuvant and salvage external-beam radiotherapy, the recommended doses are 64 to 72 Gy in standard fractionation. National Comprehensive Cancer Network guidelines also indicate that intensity-modulated radiotherapy is used increasingly in clinical practice because of reduced risk of gastrointestinal toxicities and rates of salvage therapy in some studies.

American Urological Association and American Society for Radiation Oncology
The 2013 American Urological Association and American Society for Radiation Oncology guidelines addressed the use of adjuvant and salvage RT after radical prostatectomy.4 The guidelines stated that adjuvant RT should be given to patients with adverse pathologic findings at prostatectomy and salvage RT to patients with prostate-specific antigen recurrence or local recurrence after prostatectomy if there is no evidence of distant metastases. However, the
available data did not identify which RT technique and dose produce optimal outcomes in this setting.

**American Society of Clinical Oncology**
American Society of Clinical Oncology endorsed the American Urological Association and the American Society for Radiation Oncology clinical practice guidelines for adjuvant and salvage RT after prostatectomy. An update of this guideline is scheduled for publication mid-2017.

**American College of Radiology**
The American College of Radiology Appropriateness Criteria (2014) have indicated intensity-modulated radiotherapy is the standard for definitive external-beam radiotherapy of the prostate.

**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 affect this review are listed in Table 4.

<table>
<thead>
<tr>
<th>NCTNo.</th>
<th>Trial Name</th>
<th>Planned Enrollment</th>
<th>Completion Date</th>
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<tbody>
<tr>
<td>NCT00331773</td>
<td>A Phase III Randomized Study of Hypofractionated 3D-CRT/MRT vs Conventionally Fractionated 3D-CRT/MRT With Favorable-Risk Prostate Cancer</td>
<td>1115</td>
<td>Nov 2020</td>
</tr>
<tr>
<td>NCT00033631</td>
<td>A Phase III Randomized Study Of High Dose 3D-CRT/IMRT Versus Standard Dose 3D-CRT/IMRTIn Patients Treated For Localized Prostate Cancer</td>
<td>1532</td>
<td>Apr 2022</td>
</tr>
</tbody>
</table>

NCT: National Clinical Trial.

**References**


### Documentation for Clinical Review

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

- History and physical and radiation oncology consultation report including:
  - Medical necessity for performing IMRT rather than conventional or 3D treatment planning
  - Past history of radiation (site) (if applicable)
  - Past surgical procedures (pertaining to request)
  - Primary cancer type and location
- Goals/requirements of the IMRT treatment plan and proposed IMRT treatment dose (dose volume histogram [DVH] - in color preferred; organs at risk)
- Comparison 3D-CRT dose volume histogram (DVH) (in color preferred; organs at risk) (as applicable)
- Radiology report(s) for the past 2 months

### Post Service

- Results/reports of tests performed
- Procedure report(s)

### 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 a procedure, diagnosis or device code(s) 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.

<table>
<thead>
<tr>
<th>Type</th>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td><strong>CPT®</strong></td>
<td>77301</td>
<td>Intensity modulated radiotherapy plan, including dose-volume histograms for target and critical structure partial tolerance specifications</td>
</tr>
<tr>
<td></td>
<td>77338</td>
<td>Multi-leaf collimator (MLC) device(s) for intensity modulated radiation therapy (IMRT), design and construction per IMRT plan</td>
</tr>
<tr>
<td></td>
<td>77385</td>
<td>Intensity modulated radiation treatment delivery (IMRT), includes guidance and tracking, when performed; simple</td>
</tr>
<tr>
<td></td>
<td>77386</td>
<td>Intensity modulated radiation treatment delivery (IMRT), includes guidance and tracking, when performed; complex</td>
</tr>
<tr>
<td><strong>HCPCS</strong></td>
<td>G6015</td>
<td>Intensity modulated treatment delivery, single or multiple fields/arcs, via narrow spatially and temporally modulated beams, binary, dynamic MLC, per treatment session</td>
</tr>
<tr>
<td></td>
<td>G6016</td>
<td>Compensator-based beam modulation treatment delivery of inverse planned treatment using 3 or more high resolution (milled or cast) compensator, convergent beam modulated fields, per treatment session</td>
</tr>
<tr>
<td><strong>ICD-10 Procedure</strong></td>
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</tbody>
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### 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>
</tr>
</thead>
<tbody>
<tr>
<td>03/30/2015</td>
<td>Policy title change from Intensity Modulated Radiation Therapy (IMRT)</td>
<td>Medical Policy Committee</td>
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<td>BCBSA Medical Policy adoption</td>
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<td>Policy revision without position change</td>
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<td>05/01/2016</td>
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<tr>
<td>09/01/2017</td>
<td>Policy revision without position change</td>
<td>Medical Policy Committee</td>
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### 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.