Intensity Modulated Radiation Therapy (IMRT): Central Nervous System Tumors

Medical Policy

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Therapy

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Description

Radiation therapy is an integral component in the treatment of many brain tumors, both benign and malignant. Intensity modulated radiation therapy (IMRT) has been proposed as a method of radiation therapy that allows adequate radiation therapy to the tumor while minimizing the radiation dose to surrounding normal tissues and critical structures.

Radiation therapy and brain tumors

The standard approach to the treatment of brain tumors depends on the type and location of tumor. For glioblastoma multiforme (GBM), a malignant high-grade tumor, treatment is multimodal, with surgical resection followed by adjuvant radiation therapy and chemotherapy. (1)

For benign and low-grade brain tumors, gross total resection remains the primary goal. However, radiation therapy may be used in selected cases. Some examples are when total resection is not possible, when a more conservative surgical approach may be necessary to achieve long-term treatment goals, and with atypical tumors that may need radiotherapy even after gross total resection to reduce the risk of local recurrence. Therefore, radiation therapy, either definitive or in the postoperative adjuvant setting, remains an integral component in the management of residual, recurrent, and/or progressive benign and low-grade brain tumors for maximizing local control. (2)

Brain metastases occur in up to 40% of adults with cancer and can shorten survival and detract from quality of life. Many patients who develop brain metastases will eventually die of progressive intracranial disease. Among patients with good performance status, controlled extracranial disease, favorable prognostic features, and a solitary brain metastasis, randomized studies have shown that surgical excision followed by whole brain radiotherapy (WBRT) prolongs survival. (3) Stereotactic radiosurgery (SRS) may be able to replace surgery in certain circumstances, delivering obliteratively high single doses to discrete metastases. (3) For bulky cerebral metastases, level one evidence has also shown that delivering a higher radiation dose...
with an SRS boost is beneficial in addition to standard WBRT. The use of a concomitant boost with IMRT during WBRT has been attempted to improve overall local tumor control without the use of SRS to avoid additional planned radiation after WBRT (“Phase II” or SRS) and its additional labor and expense. (3)

Radiation techniques

Conventional external beam radiation therapy. Over the past several decades, methods to plan and deliver radiation therapy 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 radiation therapy.”

3-dimensional conformal radiation (3D-CRT). Treatment planning evolved by using 3-dimensional images, usually from computed tomography (CT) scans, to delineate the boundaries of the tumor and discriminate tumor tissue from adjacent normal tissue and nearby organs at risk for radiation damage. Computer algorithms were developed to estimate cumulative radiation dose 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 immobilize the patient, thus maintaining consistent beam axes across treatment sessions. Collectively, these methods are termed 3-dimensional conformal radiation therapy (3D-CRT).

Intensity-modulated radiation therapy (IMRT). IMRT, which uses computer software and CT and magnetic resonance imaging (MRI) images, offers better conformality than 3D-CRT as it is able to modulate the intensity of the overlapping radiation beams projected on the target and to use multiple shaped treatment fields. It uses a device (a multileaf collimator, MLC) which, coupled to 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 and surrounding tissues and organs at risk, computer software optimizes the location, shape and intensities of the beams ports, to achieve the treatment plan’s goals.

Increased conformality 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.

Since most tumors move as patients breathe, dosimetry with stationary targets may not accurately reflect doses delivered within target volumes and adjacent tissues in patients. Furthermore, treatment planning and delivery are more complex, time-consuming, and labor-intensive for IMRT than for 3D-CRT. Thus, clinical studies must test whether IMRT improves tumor control or reduces acute and late toxicities when compared with 3D-CRT.

Methodological issues with IMRT studies
Multiple-dose planning studies have generated 3D-CRT and IMRT treatment plans from the same scans, then compared predicted dose distributions within the target and in adjacent organs at risk. Results of such planning studies show that IMRT improves on 3D-CRT with respect to conformity to, and dose homogeneity within, the target. Dosimetry using stationary targets generally confirms these predictions. Thus, radiation oncologists hypothesized that IMRT may improve treatment outcomes compared with those of 3D-CRT. However, these types of studies offer indirect evidence on treatment benefit from IMRT, and it is difficult to relate results of dosing studies to actual effects on health outcomes.

Comparative studies of radiation-induced side effects from IMRT versus alternative radiation delivery are probably the most important type of evidence in establishing the benefit of IMRT. Such studies would answer the question of whether the theoretical benefit of IMRT in sparing normal tissue translates into real health outcomes. Single-arm series of IMRT can give some insights into the potential for benefit, particularly if an adverse effect 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 that IMRT is at least as good as other types of delivery, but in the absence of such comparative trials, it is likely that benefit from IMRT is at least as good as with other types of delivery.

**Regulatory status**

The U.S. Food and Drug Administration (FDA) has approved a number of devices for use in intensity-modulated radiation therapy (IMRT), including several linear accelerators and multileaf collimators. Examples of approved devices and systems are the NOMOS Slit Collimator (BEAK™) (NOMOS Corp.), the Peacock™ System (NOMOS Corp.), the Varian Multileaf Collimator with dynamic arc therapy feature (Varian Oncology Systems), the Saturne Multileaf Collimator (GE Medical Systems), the Mitsubishi 120 Leaf Multileaf Collimator (Mitsubishi Electronics America Inc.), the Stryker Leibinger Motorized Micro Multileaf Collimator (Stryker Leibinger), the Mini Multileaf Collimator, model KMI (MRC Systems GMBH), and the Preference® IMRT Treatment Planning Module (Northwest Medical Physics Equipment Inc.).

**Policy**

Intensity-modulated radiation therapy (IMRT) may be considered medically necessary for the treatment of tumors of the central nervous system when the tumor is in close proximity to organs at risk (brain stem, spinal cord, cochlea and eye structures including optic nerve and chiasm, lens and retina) and 3-D CRT planning is not able to meet dose volume constraints for normal tissue tolerance. (see Policy Guidelines)

**Policy Guidelines**

Organs at risk are defined as normal tissues whose radiation sensitivity may significantly influence treatment planning and/or prescribed radiation dose. These organs at risk may be particularly vulnerable to clinically important complications from radiation toxicity. The following table outlines radiation doses that are generally considered tolerance thresholds for these normal structures in the CNS.
### Radiation tolerance doses for normal tissues

<table>
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<tr>
<th>Site</th>
<th>Portion of organ involved</th>
<th>TD 5/5 (Gy) (^a)</th>
<th>TD 50/5 (Gy) (^b)</th>
<th>Complication End Point</th>
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<tr>
<td>Brain stem</td>
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<td>60</td>
<td>NP</td>
<td>65 Necrosis, infarct</td>
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<td>53</td>
<td>NP</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3/3</td>
<td>50</td>
<td>NP</td>
<td></td>
</tr>
<tr>
<td>Spinal cord</td>
<td>1/3</td>
<td>50 (5-10 cm)</td>
<td>NP</td>
<td>70 (5-10 cm) Myelitis, necrosis</td>
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<tr>
<td></td>
<td>2/3</td>
<td>47 (20 cm)</td>
<td>NP</td>
<td></td>
</tr>
<tr>
<td>Optic Nerve and chiasm</td>
<td>3/3</td>
<td>50</td>
<td>65</td>
<td>65 65 Blindness</td>
</tr>
<tr>
<td>Retina</td>
<td>1/3</td>
<td>45</td>
<td>65</td>
<td>65 65 Blindness</td>
</tr>
<tr>
<td>Eye lens</td>
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<td>65 Cataract requiring intervention</td>
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<tr>
<td></td>
<td>3/3</td>
<td>10</td>
<td>18</td>
<td>18 18 18 Cataract</td>
</tr>
</tbody>
</table>

Radiation tolerance doses for the cochlea have been reported to be 50 Gy

\(^a\)TD 5/5, the average dose that results in a 5% complication risk within 5 years

\(^b\)TD 50/5, the average dose that results in a 50% complication risk within 5 years

NP: not provided

cm=centimeters

The tolerance doses in the table are a compilation from the following two sources:


Kehwar TS, Sharma SC. Use of normal tissue tolerance doses into linear quadratic equation to estimate normal tissue complication probability. http://www.rooj.com/Radiation%20Tissue%20Tolerance.htm

The following CPT codes specifically describe intensity-modulated radiation therapy (IMRT):

77301: Intensity modulated radiotherapy plan, including dose-volume histograms for target and critical structure partial tolerance specification.
77418: Intensity modulated treatment delivery, single or multiple fields/arcs, via narrow spatially and temporally modulated beams, binary, dynamic MLC, per treatment session.

0073T: Compensator-based beam modulation treatment delivery of inverse planned treatment using three or more high resolution (milled or cast) compensator convergent beam modulated fields, per treatment session.

Effective in 2010, a new code was added:

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.

Rationale

Literature Review

This policy was created in 2011 with a MEDLINE literature search performed through August 2011. The literature on the use of intensity modulated radiation therapy (IMRT) in the central nervous system (CNS) consists of dosimetry planning studies and case series; no comparative studies using IMRT versus other conformal radiation modalities (e.g., 3-dimensional conformal radiation [3D-CRT]) were identified.

High-grade malignant tumors

Amelio and colleagues (2010) conducted a systematic review on the clinical and technical issues of using IMRT in newly diagnosed glioblastoma multiforme (GBM). (1) The articles included in the review were through December 2009 and included 17 studies (9 related to dosimetric data and technical considerations, 7 to clinical results, and 1 to both dosimetric and clinical results) for a total of 204 treated patients and 148 patient datasets used in planning studies. No randomized controlled studies (RCTs) were identified, and a meta-analysis was not performed.

For the 6 papers related to planning studies that compared either 3D-CRT versus IMRT, 1 study showed a noticeable difference between 3D-CRT and IMRT for the planning target volume (PTV) (13% benefit in V95 [volume that received 95% of the prescribed dose] from IMRT, p<0.001) (4); the remaining studies suggested that IMRT and 3D-CRT provide similar PTV coverage, with differences between 0 and 1%. Target dose conformity was found to be improved with IMRT.

The organs at risk (OAR) typically under consideration in the studies were the brainstem, optic chiasm, optic nerves, lens and retina. In general, IMRT allowed better sparing of the OAR than 3D-CRT but with considerable variation from study to study.

The 8 studies that included clinical results included 3 retrospective, 1 prospective Phase I and IV prospective Phase II single institution studies. Of these 8 studies, 2 used conventional total dose and dose per fraction, 2 used a hypofractionated regimen, and in the remaining, a hypofractionated scheme using a simultaneous integrated boost. Chemotherapy was administered in 6 of 8 series, concomitantly with radiation and in the adjuvant phase. Median
follow-up ranged from 8.8 and 24 months. Almost all patients (96%) were able to complete the treatment without interruption/discontinuation due to toxicity. Acute toxicity was reported as negligible with grade-3 side effects observed in only 2 studies at rates of 7% and 12%. Grade-4 toxicity was recorded in only 1 series with an absolute rate of 3%. Data for late toxicities were available in 6/8 studies, with 1 study recording grade-4 side effects with an incidence of 20%. One-year and 2-year overall survival (OS) varied between 30% and 81.9% and between 0% and 55.6%, respectively. When OS was reported as a median time, its value ranged from 7 to 24 months. Progression-free survival (PFS) ranged from 0% and 71.4% at 1 year and 0% and 53.6% at 2 years. Median PFS was reported as ranging from 2.5 to 12 months.

The authors also carried out a comprehensive qualitative comparison with data reported in the literature on similar non-IMRT clinical studies and offered the following conclusions. The results of the planning comparisons showed 3D-CRT and IMRT techniques provide similar results in terms of target coverage, IMRT is somewhat better than 3D-CRT in reducing the maximum dose to the OAR, although the extent varied from case to case, IMRT is clearly better than 3D-CRT in terms of dose conformity and sparing of the healthy brain at medium to low doses and that (in general) there were no aspects where IMRT seemed worse than 3D-CRT.

This evidence is limited by a number of factors. There is an absence of comparative studies with clinical outcomes, all of the studies were small in size, from a single institution, a majority of patients (53%) were retrospectively analyzed, and the administration of chemotherapy was variable across studies.

A representative sample of the comparative studies on dose planning and the single-arm studies with clinical outcomes are discussed below.

MacDonald and colleagues (2007) compared the dosimetry of IMRT and 3D-CRT in 20 patients treated for high-grade glioma. (5) Prescription dose and normal-tissue constraints were identical for the 3D-CRT and IMRT treatment plans. The IMRT plan yielded superior target coverage as compared with the 3D-CRT plan. The IMRT plan reduced the percent volume of brainstem receiving a dose greater than 45 Gy by 31% (p=0.004) and the percent volume of brain receiving a dose greater than 18 Gy, 24 Gy, and 45 Gy by 10% (p=0.059), 14% (p=0.015), and 40% (p< or=0.0001), respectively. With IMRT, the percent volume of optic chiasm receiving more than 45 Gy was reduced by 30.4% (p=0.047). As compared with 3D-CRT, IMRT significantly increased the tumor control probability (p< or=0.0005) and lowered the normal-tissue complication probability for brain and brain stem (p<0.033).

Narayana and colleagues (2006) reported the outcomes of 58 consecutive patients with high-grade gliomas treated with IMRT. (6) GBM accounted for 70% of cases and anaplastic gliomas for the remainder. Surgery consisted of biopsy alone in 26% of patients and of those that underwent resection, 63% had total or near total resection and 37% had partial resection. Eighty percent of patients received adjuvant chemotherapy. Median follow-up was 24 months. Acute neurotoxicities were grade 1/2 in 36% of patients, grade 3 in 7%, and grade 4 in 3%. Late toxicities were grade 1/2 in 10%, grade 3 in 7%, and no grade 4 or 5. Freedom from late neurotoxicity at 24 months was 85%. Median OS for the anaplastic astrocytomas was 36 months and 9 months for the GBM group. From these data, the authors concluded that the use of IMRT in high-grade gliomas does not appear to improve survival.

Narayana et al. (6) also performed a comparison of the IMRT treatment plans with 3D plans performed in 20 patients out of 58 total in that case series. Regardless of tumor location, IMRT
did not improve PTV target coverage compared to 3D planning. IMRT decreased the maximum
doze to the spinal cord, optic nerves, and eye by 16%, 7%, and 15%, respectively. These data
indicate that IMRT may result in decreased late toxicities.

Huang and colleagues (2002) compared ototoxicity with use of conventional (2D) radiotherapy
(n=11) versus IMRT (n=15) in 26 pediatric patients with medulloblastoma. (7) All of the patients
also received chemotherapy. When compared to conventional radiotherapy, IMRT delivered
68% of the radiation dose to the auditory apparatus, but full doses to the desired target volume.
Median follow-up for audiometric evaluation was 51 months (9-107 months) for the conventional
radiotherapy group and 18 months (8-37 months) for the group that received IMRT. Thirteen
percent of the IMRT group had grade-3 or -4 hearing loss, compared to 64% of the conventional
radiotherapy group (p<0.014).

Benign tumors

Milker-Zabel and colleagues (2007) reported the results of the treatment of complex-shaped
meningiomas of the skull base with IMRT in 94 patients. (8) Patients received radiotherapy as
primary treatment (n=26) postoperatively for residual disease (n=14) or after local recurrence
(n=54). Tumor histology was World Health Organization grade 1 in 54.3%, grade 2 in 9.6%, and
grade 3 in 4.2%. Median follow-up was 4.4%. Overall local tumor control was 93.6%. Sixty-nine
patients had stable disease (by computed tomography [CT]/magnetic resonance imaging [MRI]),
and 19 had a tumor volume reduction after IMRT. Six patients had local tumor progression on
MRI a median of 22.3 months after IMRT. In 39.8% of patients, preexisting neurologic deficits
improved. Treatment-induced loss of vision was seen in 1 of 53 re-irradiated patients with a
grade-3 meningioma 9 months after retreatment with IMRT.

Mackley and colleagues (2007) reported outcomes of treating pituitary adenomas with IMRT. (9)
A retrospective chart review was conducted on 34 patients treated between 1998 and 2003 at
the Cleveland Clinic. Median follow-up was 42.5 months. Radiographic local control was 89%,
and among patients with secretory tumors, 100% had a biochemical response. One patient
required salvage surgery for progressive disease, resulting in a clinical PFS of 97%. One patient
who received more than 46 Gy experienced optic neuropathy 8 months after radiation.

Sajja and colleagues (2005) reported the outcomes of 35 patients with 37 meningiomas treated
with IMRT. (10) Tumor histology was benign in 35 and atypical in 2 tumors. The median CT/MRI
follow-up was 19.1 months (range 6.4-62.4 months). Fifty-four percent of the meningiomas had
been previously treated with surgery/radiosurgery prior to IMRT, and 46% were treated with
IMRT, primarily after a diagnosis was established by CT/MRI. Three patients had local failure
after treatment. No long-term complications from IMRT were documented among the 35
patients.

Uy and colleagues (2002) assessed the safety and efficacy of IMRT in the treatment of
intracranial meningioma in 40 patients treated between 1994 and 1999. (11) Twenty-five
patients received IMRT after surgery either as adjuvant therapy for incomplete resection or for
recurrence, and 15 patients received definitive IMRT after a presumptive diagnosis of
meningioma on imaging. Thirty-two patients had skull base lesions and 8 had nonskull base
lesions. Follow-up ranged from 6 to 71 months (median 30 months). Defined normal structures
generally received a significantly lower dose than the target. The most common acute CNS
toxicity was mild headache, usually relieved with steroids. One patient experienced Radiation
Therapy Oncology Group (RTOG) Grade-3 acute CNS toxicity, and 2 experienced Grade 3 or
higher late CNS toxicity, with one possible treatment-related death. No toxicity was observed with mean doses to the optic nerve/chiasm up to 47 Gy and maximum doses up to 55 Gy. Cumulative 5-year local control, PFS, and OS were 93%, 88%, and 89%, respectively.

Brain metastases

Edwards and colleagues (2010) reported outcomes on the use of whole brain radiotherapy (WBRT) with an IMRT boost in 11 patients with metastatic disease to the brain ranging from 25-80 mm in maximum diameter. (3) Patients were excluded if they had more than 4 metastases. Histologies of the metastases included primary lung (n=5), breast (n=4), colon (n=1), and kidney (n=1). There were no acute or subacute complications. All tumors showed response on a 1-month post-radiotherapy scan. Median follow-up was 4 months. Four of the 11 patients died of systemic disease 6-9 months after radiotherapy. The remaining patients were alive with no evidence of progression of the treated brain disease or local recurrence at 2-9 months after radiotherapy. No brain complications occurred to date.

Physician Specialty Society and Academic Medical Center Input

In response to requests, input was received related to the use of IMRT to treat CNS tumors from 3 academic medical centers and 3 specialty medical societies (8 reviewers), for a total of 11 reviewers. While the various physician specialty societies and academic medical centers may collaborate with and make recommendations during this process, through the provision of appropriate reviewers, input received does not represent an endorsement or position statement by the physician specialty societies or academic medical centers, unless otherwise noted.

There was near uniform consensus that IMRT to treat tumors of the CNS should be considered medically necessary, particularly tumors in close proximity to critical structures. Reviewers generally felt that there is sufficient evidence for IMRT being at least as effective as 3D-conformal radiation therapy and that given the possible adverse events that could result if nearby critical structures receive toxic radiation doses (e.g., blindness) that IMRT dosimetric improvements should be accepted as meaningful evidence for its benefit.

Clinical Trials

A search of online site Clinicaltrials.gov returned no Phase III trials comparing IMRT to other radiation modalities for the treatment of CNS tumors.

Summary

The body of evidence available to evaluate IMRT in the treatment of CNS tumors consists of dose planning studies and case series. The case series are limited by small numbers, heterogeneous patient populations, and different types of tumors. No randomized trials have been reported that compare results using IMRT to other conformal radiation therapy modalities, nor do any of the reported case series using IMRT include concurrently treated control groups.

In general, the limited evidence suggests that IMRT provides tumor control and survival outcomes comparable to existing radiotherapy techniques. The evidence from treatment planning studies has shown that the use of IMRT decreases radiation doses delivered to critical CNS structures (e.g., optic chiasm, brainstem) and normal tissue adjacent to the tumor. This potentially lowers the risk of adverse events (acute and late effects of radiation toxicity), although the clinical benefit of reducing the radiation dose to critical structures and surrounding
normal tissue using IMRT is theoretical. Determination of whether adverse event rates are reduced with IMRT is further complicated by a lack of high-quality literature defining the adverse effects using 3D conformal radiation therapy for the CNS, the main comparator to IMRT. The single arm case series are of limited usefulness in determining the benefits of IMRT over other conformal radiation modalities.

Due to the limitations in this evidence, this policy underwent clinical vetting. There was near-uniform consensus that the use of IMRT in the CNS is at least as effective as 3D-conformal radiation therapy, and that given the possible adverse events that could result if nearby critical structures receive toxic radiation doses that IMRT dosimetric improvements should be accepted as meaningful evidence for its benefit. The results of the vetting, together with a strong indirect chain of evidence and the potential to reduce harms, led to the decision that IMRT may be considered medically necessary for the treatment of tumors of the central nervous system that are in close proximity to organs at risk.

Practice Guidelines and Position Statements

National Comprehensive Cancer Network Guidelines

The 2011 (v2.2011) National Comprehensive Cancer Network (NCCN) guidelines state that: when radiation is given to patients with low grade gliomas, it is administered with restricted margins. Every attempt should be made to decrease the radiation dose outside the target volume. This can be achieved with 3-dimensional planning or IMRT. (12)

NCCN guidelines do not address the use of IMRT in high-grade tumors or metastases of the CNS. (12)

Medicare National Coverage

There is no national coverage determination.

References:


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IMRT, brain