Radiation Treatment for Selected Nononcologic Indications

Policy

*Please see amendment for Pennsylvania Medicaid at the end of this CPB.*

Aetna considers low-dose or high-dose radiation (superficial or interstitial) medically necessary as an adjunctive therapy immediately following excisional surgery (within 7 days) in the treatment of keloids where medical necessity criteria for keloid removal are met. See CPB 0031 - Cosmetic Surgery (../1_99/0031.html) for medically necessary indications for keloid removal.

Aetna considers radiation therapy medically necessary for preventing heterotopic ossification in persons identified as being at high risk (previous heterotopic ossification, ankylosing spondylitis, diffuse idiopathic skeletal hyperostosis or spinal stenosis, unlimited hip motion preoperatively, and head injury).

Aetna considers use of beta irradiation medically necessary for prevention of primary or recurrent pterygium in cases that cannot be managed medically.

Aetna considers the TRASER (Total Reflection Amplification of Spontaneous Emission Radiation) device experimental and investigational for the treatment of nasal telangiectasias because its effectiveness has not been established.
Aetna considers ablative radiotherapy for the treatment of cardiac arrhythmia experimental and investigational because its effectiveness has not been established.

See also: CPB 0083 - Stereotactic Radiosurgery (../1_99/0083.html);
CPB 0231 - Grenz Ray Therapy for Skin Disorders (../200_299/0231.html);
CPB 0374 - Trigeminal Neuralgia: Treatments (../300_399/0374.html);
; CPB 0419 - Graves' Ophthalmopathy Treatments (../400_499/0419.html);
CPB 0491 - Coronary Artery Brachytherapy and Other Adjuncts to Coronary Interventions (../400_499/0491.html)
, CPB 0756 - Epiretinal Radiation Therapy (../700_799/0756.html); and
CPB 0800 - Dupuytren Contracture: Treatments (../800_899/0800.html).

Background

Keloids are benign fibrous growths that arise from proliferation of dermal tissue following skin injury. Conventional treatment options for keloids are occlusive dressings (including silicone-based materials), compression therapy, intra-lesional injections of corticosteroid, cryosurgery, and excision surgery. Newer modalities include the carbon dioxide laser, Nd:YAG laser, argon laser, pulsed dye laser, intra-lesional interferon-gamma and interferon-alfa 2b, and cultured epithelial autografts. In general, laser excision results in similar recurrence rates as conventional surgery. However, the incidence of recurrence is high following conventional forms of treatment. In particular, the recurrence rate of keloids after excision alone has been reported to be between 45 % and 100 %. It has also been reported that the recurrence rate following excision is higher with keloids forming at infected sites and in patients with a family history of keloids. The likelihood of recurrence does not appear to be affected by the person's age, sex, or ethnicity; keloid size or location; individual keloid history; or prior therapy.

Post-operative radiation therapy has been shown to be safe and effective in reducing recurrence of keloids after excision surgery. In addition, it has been reported that post-operative radiation therapy is a simpler treatment modality with better patient compliance than post-operative corticosteroid injections.
Kal and Veen (2005) stated that for successful prevention of recurrence of keloids after surgical excision, a relatively high-dose must be applied in a short overall treatment time. The optimal treatment probably is an irradiation scheme resulting in a biologically effective dose (BED) value of at least 30 Gy. A BED value of 30 Gy can be obtained with, for instance, 1 single acute dose of 13 Gy, 2 fractions of 8 Gy, or 3 fractions of 6 Gy, or 1 single dose of 27 Gy at low-dose rate. The radiation treatment should be administered within 2 days following surgery.

Ogawa and colleagues (2009) noted that keloids are best treated by a combination of surgery and post-operative radiation therapy, although randomized controlled trials testing this are still lacking. However, plastic surgeons tend to avoid radiation therapy for keloids for fear of inducing malignant tumors. Thus, the authors searched for previous reports of associations between carcinogenesis and keloid radiation therapy, and examined the evidence-based opinions of radiation oncologists regarding the acceptability of using radiation to treat keloids. A computerized literature search was carried out using PubMed that included citations from Medline and PubMed Central between 1901 and March of 2009. The following search terms were used: "keloid(s)," "hypertrophic scar(s)," "radiation," "radiation therapy," "radiotherapy," "carcinogenesis," "carcinoma," "cancer," "complications," and "side effects." Moreover, the references for each report were also retrieved. The authors located 5 cases of carcinogenesis (i.e., fibrosarcoma, basal cell carcinoma, thyroid carcinoma, and breast carcinoma) that were associated with radiation therapy for keloids. However, it was unclear if an appropriate dose of radiation was used and whether sufficient protection of surrounding tissues was provided. Moreover, a questionnaire study of radiation oncologists around the world revealed that approximately 80 % considered radiation to be acceptable for treating keloids. The authors concluded that the risk of carcinogenesis attributable to keloid radiation therapy is very low when surrounding tissues, including the thyroid and mammary glands, especially in children and infants, are adequately protected, and that radiation therapy is acceptable as a keloid treatment modality.

Heterotopic ossification (HO) is an overgrowth of bone that frequently occurs after a bone fracture (break). It commonly occurs in patients who have fractured bones of the spine, hip, or elbow. It causes pain and disability. Radiation therapy is a local treatment modality that works by damaging the DNA of cells.
Based on the clinical evidence, preoperative or postoperative radiation therapy has been proven to be effective in preventing heterotopic ossification for patients identified as being at risk (previous heterotopic ossification, ankylosing spondylitis, diffuse idiopathic skeletal hyperostosis or spinal stenosis, unlimited hip motion preoperatively, and head injury).

Grenfell and Borg (2014) stated that palmar and plantar fascial fibromatoses are benign hyper-proliferative disorders of the deep fascia of the palm and sole. These researchers examined the role of radiotherapy in the management of fascial fibromatosis. A total of 6 consecutive cases of early-stage fascial fibromatosis treated with radiotherapy between July 2008 and May 2011 were analyzed. The results of the case series were compared with a systematic review of the literature. All 6 cases regressed or showed a reduction of symptoms following radiotherapy. Treatment was well-tolerated with minor toxicities. Median follow-up for the case series was 38.5 months. The systematic review identified 7 studies describing the use of radiotherapy as primary treatment for fascial fibromatosis between 1946 and 2013. The literature indicated that radiotherapy can prevent disease progression and improve symptoms for early-stage disease, with low likelihood of significant toxicities. The authors concluded that early results from this case series were consistent with the literature, showing that radiotherapy can provide an effective management option for patients with early-stage fascial fibromatosis, and justified consideration of radiotherapy as a primary treatment for early-stage disease. These preliminary findings need to be validated by well-designed studies.

Nakamatsu et al (2011) noted that postoperative adjuvant treatment with strontium-90 radiation therapy (RT) is a proven technique for reducing the recurrence of pterygium. The authors conducted a single institutional randomized trial to evaluate whether a total dose of 40 Gy provides a better local control rate than a total dose of 30 Gy for surgically resected pterygia. Between 1999 and 2003, 74 pterygia in 71 patients were randomly allocated to 30 Gy/3 fractions/15 days (arm A) or to 40 Gy/4 fractions/22 days (arm B) and only primary pterygia cases for which RT could be started within 3 days of surgical resection were included. Postoperative RT was given by a strontium-90 eye applicator with a dose of 10 Gy per fraction delivered in weekly fractions (day 1, 8, 15, 22). The investigators found that of the 74 pterygia treated, 73 in 70 patients were analyzed and among these cases of pterygia, 41 were allocated to arm A, and the remaining 32 to arm B. The 2-year local control rates for arm A and arm B were 85% and 75%, respectively, without significant
difference. No serious acute and late complications were noted in either arm. The authors concluded that their new standard fractionation for postoperative RT for pterygia is 30 Gy/3 fractions.

Qin et al (2012) studied the long term effects of low dosage strontium-90 in 120 eyes from 104 patients with primary or recurrent pterygia who had been treated with surgery. Dosage was three times every other day at a total combined dosage of 2000 cGy to 3000 cGy and corneal topography was used to evaluate ocular surface regularity before and after treatment. Patient follow-up was performed for 10 years after surgery and no recurrence of pterygium was observed in any study participants. Obvious cataract progression was observed in 6 eyes, which the investigators hypothesized may be due to aging. During follow-up studies, only one eye was reported with dryness and foreign-body sensation. The authors concluded that Sr90 irradiation is effective in preventing the recurrence of primary and recurrent pterygia and that delivering a total combined dosage of 2000 cGy to 3000 cGy of Sr90 irradiation administered in three batches every other day starting from the sixth day after surgery is recommended.

Viani et al (2012a) conducted a prospective, randomized, single-center study to evaluate the effectiveness and safety of postoperative low single-dose of beta-irradiation (β-RT) in pterygium. The study compared conjunctival autograft (CAG) surgery with CAG plus adjuvant β-R with surgery performed in all cases according to the CAG technique. One hundred and eight pterygium cases were postoperatively to deliver 10 Gy to the sclera surface at a dose rate of between 200 and 250 cGy/min. One hundred and sixteen eyes with primary pterygium were operated on between February 2008 and September 2008 according to the trial protocol. In the 54 eyes randomized to receive CAG + β-RT, 5 relapses occurred compared with 12 recurrences in the 54 eyes in CAG. A crude control rate of 90.8 % vs. 78%; p = 0.032, respectively was seen at a mean follow-up of 18 months (range, 8-33). Treatment complications, including hyperemia, total dehiscence of the autograft and dellen, were significantly more frequent in the CAG group (p < 0.05). The β-RT group experienced better cosmetic results and improves of symptoms than CAG. The investigators concluded that a low single-dose of β-RT of 10 Gy after CAG surgery was a simple, effective, and safe treatment that reduced the risk of primary pterygium recurrence, improved symptoms after surgery and resulted in a better cosmetic effect than CAG alone.
Viani et al (2012b) conducted a randomized trial of 200 patients (216 pterygium). The purpose of this trial was to evaluate a technique for reducing the recurrence of pterygium by using a low fractionation dose of 2 Gy (within 10 fractions) that would provide local control similar to that after a high fractionation dose of 5 Gy (within 7 fractions) for surgically resected pterygium. Only patients with fresh pterygium resected using a bare sclera method and given RT within 3 days were included. Postoperative RT was delivered using a strontium-90 eye applicator. The pterygia were randomly treated using either 5 Gy within 7 fractions (Group 1) or 2 Gy within 10 fractions (Group 2) with the local control rate calculated from the date of surgery. Implementation of this study included randomization of the 216 pterygia, of which 112 were allocated to Group 1 and 104 to Group 2. The 3-year local control rates for Groups 1 and 2 was 93.8% and 92.3%, respectively (p = .616) and a statistically significant difference for cosmetic effect (p = .034), photophobia (p = .02), irritation (p = .001), and scleromalacia (p = .017) was noted in favor of Group 2. The authors concluded that no better local control rate for postoperative pterygium was obtained using high-dose fractionation vs. low-dose fractionation, but a low-dose fractionation schedule produced better cosmetic effects and resulted in fewer symptoms than high-dose fractionation. The authors further noted that pterygia can be safely treated in terms of local recurrence using RT schedules with a biologic effective dose of 24-52.5 Gy(10).

Guix et al (2001) analyzed the results obtained in a prospective group of patients with keloid scars treated by high-dose-rate (HDR) brachytherapy with or without surgery. A total of 169 patients (134 females and 35 males) with keloid scars were treated with HDR brachytherapy between December 1991 and December 1998. The distribution of keloid scars was as follows: face, 77; trunk, 73; and extremities, 19. The mean length was 4.2 cm (range of 2 to 22 cm), and the mean width 1.8 cm (range of 1.0 to 2.8 cm). In 147 patients, keloid tissues were removed before HDR brachytherapy, and in 22 HDR brachytherapy was used as definitive treatment. In patients who underwent prior surgery, a flexible plastic tube was put in place during the surgical procedure. Bottoms were used to fix the plastic tubes, and the surgical wound was repaired by absorbable suture. High-dose-rate brachytherapy was administered within 30 to 60 mins of surgery. A total dose of 12 Gy (at 1 cm from the center of the catheter) was given in 4 fractions of 300 cGy in 24 hrs (at 09.00 am, 15.00 pm, 21.00 pm, and 09.00 am next day). Treatment was optimized using standard geometric optimization. In patients who did not undergo surgery, standard brachytherapy was performed, and plastic tubes were placed through the skin to cover the whole scar. Local anesthesia was used in all procedures. In these
patients a total dose of 18 Gy was given in 6 fractions of 300 cGy in 1 and a half
days (at 9.00 am, 3.00 pm, and 9.00 pm; and at 9.00 am, 3.00 pm, and 9.00 pm
next day). No further treatment was given to any patient. Patients were seen in follow-
up visits every 3 months during the first year, every 6 months in the second year, and
yearly thereafter. No patient was lost to follow-up. Particular attention was paid to
keloid recurrence, late skin effects, and cosmetic results. All patients completed the
treatment. After a follow-up of 7 years, 8 patients (4.7 %) had keloid recurrences; 5 of
these had undergone prior surgery (local failure rate 3.4 %), and 3 had received only
HDR brachytherapy (local persistence rate 13.6 %). Cosmetic results were
considered to be good or excellent in 130/147 patients treated with prior surgery
and in 17/22 patients without surgery. Skin pigmentation changes were observed in
10 patients, and telangiectasias in 12 patients. No late effects such as skin atrophy
or skin fibrosis were observed during the 7 years of follow-up. The authors concluded
that HDR brachytherapy is an effective treatment for keloid scars. It was well-
tolerated and did not present significant side effects. The brachytherapy results were
more successful in patients who underwent previous surgical excision of keloid scar
than in patients without surgery. These investigators favored HDR brachytherapy
rather than superficial X-rays or low energy electron beams in keloid scars, because
HDR provided a better selective deposit of radiation in tissues and a lower degree of
normal tissue irradiation.

Other advantages of HDR brachytherapy over low-dose-rate (LDR) brachytherapy
included its low cost, the fact that it can be performed on an out-patient basis, its
excellent radiation protection, and the better dose distribution obtained. From the
clinical perspective, the technique provides a high local control rate without
significant sequelae or complications.

De Cicco et al (2014) reported their experience on the adjuvant LDR and HDR
interstitial brachytherapy. These investigators analyzed data on 70 consecutive
patients treated after complete keloid surgical excision. First 38 patients and 46
keloids were treated with adjuvant LDR brachytherapy and the following 39 patients
and 50 keloids underwent HDR treatment. Median delivered dose of LDR therapy
was 16 Gy; HDR median dose was 12 Gy. A total of 64 keloids (66.7 %) were
symptomatic at diagnosis with pain, itching, or stress. Fourteen relapses over 46
treated keloids (30.4 %) were observed in the LDR group and 19 of 50 keloids (38
%) in the HDR group (p = 0.521). Recurrence rate was significantly higher in males
(p = 0.009), in patients younger than 44 years (p < 0.0001), for arms, neck, and
chest wall anatomic sites (p = 0.0001) and for symptomatic keloids (p = 0.017).
Aesthetic outcome was better in case of larger keloids (greater than 8 cm) (p =

Symptomatic relief was achieved in 92% of HDR patients and only 68% of LDR patients (p = 0.032). The authors concluded that post-operative brachytherapy is an effective treatment for keloids. In this study, LDR and HDR treatments resulted in similar recurrence rate. Better symptomatic relief was reported in case of HDR treatment compared with the LDR regimen.

van Leeuwen et al (2014) noted that keloids cause aesthetic disfigurement and physical complaints, mainly pain and pruritus. Treatment of these scars is difficult, with high recurrence rates forming the main issue. Surgical excision with adjuvant radiotherapy is considered the most effective treatment. At their institution, the authors have been treating keloids with a HDR brachytherapy procedure for over 10 years, using a protocol with the lowest total radiation dosage known in the literature. This prospective study included 43 patients of all Fitzpatrick skin types, with 67 keloids in total. After extra-lesional excision, a radiation scheme of 2 × 6 Gy was administered in 2 fractions: the first within 4 hours after surgery and the second within 24 hours. Scars were measured and recurrence was judged. Scar appearance was evaluated using the Patient and Observer Scar Assessment Scale. The recurrence rate was 3.1% at a mean follow-up of 33.6 months. A significant average scar surface decrease of 56.7% was measured (p = 0.01); complaints of pain and pruritus decreased by 82.9 and 87.2%, respectively. Patients were satisfied with the treatment in 88.6% of the cases and with the cosmetic result in 77.1%. Pigmentation problems were seen in 21.4% of the patients, mostly in Fitzpatrick type V and VI/African American individuals. The authors concluded that the results of this prospective study showed a good cosmetic outcome with a low recurrence rate. The unique radiation schedule proved the safety and effectiveness of HDR brachytherapy and suggested the importance of immediate post-operative irradiation. In addition, only 1 out-patient treatment was needed following surgery, enhancing patient convenience.

Furthermore, an UpToDate review on “Management of keloid and hypertrophic scars following burn injuries” (Gauglitz, 2015) states that “Radiotherapy—Superficial x-rays, electron beam and low- or high-dose-rate brachytherapy have been employed with generally overall good results in terms of reduced recurrence”.

TRASER (Total Reflection Amplification of Spontaneous Emission Radiation) for the Treatment of Nasal Telangiectasias:

http://www.aetna.com/cpb/medical/data/500_599/0551.html
Friedman and colleagues (2017) stated that destruction of blood vessels by selective photo-thermolysis has been successfully achieved using a number of different laser and light systems, none of which provided significant independent variation in parameters such as wavelength. These researchers evaluated the safety and effectiveness of a novel configurable device in the treatment of nasal telangiectasias. A total of 15 subjects aged 42 to 73 years with Fitzpatrick skin types I and II were treated for nasal telangiectasias of various sizes; effectiveness was measured by blinded analysis of pre- and post-images and self-assessment by the subjects. The primary end-point was a 2-point improvement of telangiectasia based on a 5-point Telangiectasia Scale comparing the pre-treatment photograph to the post-treatment photograph at 30 days post final treatment by an independent reviewer. Treatment completion was defined as greater than 75% vessel clearance. The TRASER (Total Reflection Amplification of Spontaneous Emission Radiation) was configured to produce a narrow spectral output, peaking at 541±5 nm, with 20 to 40 millisecond pulses over an energy density range of 15 to 40 J/cm² utilizing a 12-mm spot size were delivered with contact sapphire cooling tip at approximately 10°C. All 13 subjects (100%) in the efficacy population achieved procedure success at the end of the final treatment, that is a 2-point improvement of telangiectasis on the telangiectasia scale (pre- versus post-treatment). A single treatment was effective in greater than 75% of patients with at least a 75% reduction in blood vessels. Larger vessels responded well to longer pulse durations (40 milliseconds) while smaller vessels responded best to shorter pulse durations (25 milliseconds). No serious adverse events (SAEs) were recorded. The authors concluded that the TRASER device is a safe and effective option for treatment of nasal telangiectasias with all subjects meeting primary end-point success at the end of treatment and the majority of subjects demonstrating clearance after only 1 treatment; these treatments were well-tolerated and provided high patient satisfaction. The main drawbacks of this study were its small sample size (n = 13) as well as short-term follow-up (1 month). These preliminary findings need to be validated by well-designed studies.

Geddes-Bruce and colleagues (2018) evaluated the long-term efficacy of treating nasal telangiectasias with the TRASER device. Subjects from the TRASER efficacy analysis clinical trial were invited for a 1-year follow-up. Standardized photographs were taken to compare to baseline. The same clinical trial evaluator graded the subjects’ current vessel clearance using the 5-point telangiectasia scale. The data were compiled and analyzed. Of the 9 subjects with available follow-up data, 44% maintained “complete vessel clearance,” 44% dropped down 1 grade to...
"almost complete vessel clearance," and 11% dropped down to "moderately clear vessel clearance". All showed clinically significant improvement in nasal telangiectasias from baseline. The authors concluded that the TRASER effectively treated nasal telangiectasias with minimal-to-mild recurrence at 1-year follow-up.

Ablative Radiotherapy for the Treatment of Cardiac Arrhythmia:

Cuculich and colleagues (2017) stated that recent advances have enabled non-invasive mapping of cardiac arrhythmias with electrocardiographic imaging and non-invasive delivery of precise ablative radiation with stereotactic body radiation therapy (SBRT). These researchers combined these techniques to perform catheter-free, electrophysiology-guided, non-invasive cardiac radio-ablation for ventricular tachycardia (VT). These investigators targeted arrhythmogenic scar regions by combining anatomical imaging with non-invasive electrocardiographic imaging during VT that was induced by means of an implantable cardioverter-defibrillator (ICD). SBRT simulation, planning, and treatments were performed with the use of standard techniques. Patients were treated with a single fraction of 25 Gy while awake. Efficacy was assessed by counting episodes of VT, as recorded by ICDs. Safety was assessed by means of serial cardiac and thoracic imaging.

From April through November 2015, a total of 5 patients with high-risk, refractory VT underwent treatment. The mean non-invasive ablation time was 14 minutes (range of 11 to 18). During the 3 months before treatment, the patients had a combined history of 6,577 episodes of VT. During a 6-week post-ablation "blanking period" (when arrhythmias may occur owing to post-ablation inflammation), there were 680 episodes of VT. After the 6-week blanking period, there were 4 episodes of VT over the next 46 patient-months, for a reduction from baseline of 99.9%. A reduction in episodes of VT occurred in all 5 patients. The mean left ventricular ejection fraction (LVEF) did not decrease with treatment. At 3 months, adjacent lung showed opacities consistent with mild inflammatory changes, which had resolved by 1 year. The authors concluded that in 5 patients with refractory VT, non-invasive treatment with electrophysiology-guided cardiac radio-ablation markedly reduced the burden of VT. These preliminary findings need to be validated by well-designed studies.

Zei and Soltys (2017) noted that stereotactic radio-ablation is a commonly utilized technology to non-invasively treat solid tumors with precision and efficacy. Using a robotic arm mounted delivery system, multiple low-dose ionizing radiation beams are delivered from multiple angles, concentrating ablative energy at the target.
Recently, this technology has been evaluated for treatment of cardiac arrhythmias. These investigators presented the basic underlying principles, proof-of-principle studies, and clinical experience with stereotactic arrhythmia radio-ablation. Most recently, stereotactic radio-ablation has been used to safely and effectively treat a limited number of patients with malignant arrhythmias, including atrial fibrillation (AF) and VT. The authors concluded that stereotactic radio-ablation is a well-established technology that has been shown to be a safe and effective therapy for patients with drug-refractory cardiac arrhythmias, including AF and VT. Moreover, they stated that properly-designed clinical trials are needed to define safety and efficacy of radio-ablation in larger populations of patients.

Kim and co-workers (2018) stated that non-invasive ablation of cardiac tissue to control VT is a novel therapeutic consideration in the management of ventricular arrhythmias associated with structural heart disease. The technique involves the use of stereotactic radiotherapy delivered to VT substrates. Although invasive mapping can be used to identify the target, the use of non-invasive ECG and imaging techniques combined with multi-electrode body-surface ECG recordings offers the potential of a completely non-invasive approach. The authors concluded that early case-series studies have demonstrated a consistent decrease in VT burden and sufficient early safety to allow more detailed multi-center studies to further evaluate this promising technology; such studies are currently in progress.

Radiotherapy for Drug-Resistant Non-Neoplastic Focal Epilepsy:

Eekers and associates (2018) stated that although the majority of adult epilepsy patients respond well to the current anti-epileptic drug treatment, 20 to 40% of them are drug-resistant. In these patients, resective epilepsy surgery is a curative therapeutic option, for which, however, only a limited number of patients is eligible. These researchers summarized the outcome of radiotherapy for drug-resistant, non-neoplastic, focal epilepsy and examined its efficacy for seizure outcome and long-term toxicity in adults. A systematic literature search was performed in PubMed, Ovid Medline, Cochrane library, Embase and Web of Science. The methodological quality was evaluated using an adapted QUADAS check-list. A total of 16 out of 170 initially identified studies were included in this systematic literature study (n = 170 patients); 12 of the 16 studies described a positive effect of radiotherapy on seizure frequency reduction, with 98 of the patients (on average 58%, range of 25% to 95%) reporting no or rare seizures (defined as radiotherapy-adapted Engel class [RAEC] I and II. In total, 20% (34 patients) of the patients
needed subsequent surgery due to radio-necrosis, cysts formation, edema, and intracranial hypertension or remaining seizures. A dose-effect model was fitted to the available response data in an attempt to derive a relationship between prescribed dose and RAEC frequency. The authors concluded that radiotherapy is a possible non-invasive therapeutic option for patients with drug-resistant, non-neoplastic, focal epilepsy. They stated that this systematic review showed that there is only level 4 evidence of primary radiotherapy reducing seizure frequency in adult patients; prospective randomized trials are needed to determine its exact value compared to other treatment approaches.

CPT Codes / HCPCS Codes / ICD-10 Codes

Information in the [brackets] below has been added for clarification purposes. Codes requiring a 7th character are represented by “+”:

<table>
<thead>
<tr>
<th>Code</th>
<th>Code Description</th>
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<tr>
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<td>CPT codes covered if selection criteria are met:</td>
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<tr>
<td>77401 - 77417</td>
<td>Radiation treatment delivery [includes beta irradiation]</td>
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<tr>
<td>77767 - 77772</td>
<td>Remote afterloading high dose rate radionuclide skin surface brachytherapy, includes basic dosimetry, when performed</td>
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<tr>
<td>77778</td>
<td>Interstitial radiation source application, complex, includes supervision, handling, loading of radiation source, when performed</td>
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<td></td>
<td>CPT codes not covered for indications listed in the CPB:</td>
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<td>TRASER(Total Reflection Amplification of Spontaneous Emission Radiation) - No specific code</td>
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<td></td>
<td>ICD-10 codes covered if selection criteria are met:</td>
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<tr>
<td>I78.1</td>
<td>Nevus, non-neoplastic [nasal telangiectasias]</td>
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Ablative radiotherapy:

CPT codes not covered for indications listed in the CPB:
The above policy is based on the following references:

Radiation Therapy for Keloids

Available at: http://www.clinicalanswers.nhs.uk/index.cfm?question=259.


27. Gauglitz GG. Management of keloid and hypertrophic scars following burn injuries. UpToDate Inc., Waltham, MA. Last reviewed April 2015.

Radiation Therapy for Heterotopic Ossification


**Beta Irradiation for Pterygium**


**Radiation Therapy for Miscellaneous Indications**


AETNA BETTER HEALTH® OF PENNSYLVANIA

Amendment to
Aetna Clinical Policy Bulletin Number: 0551 Radiation Treatment for Selected Nononcologic Indications

There are no amendments for Medicaid.