

*Evolut	
Clinical guideline: METASTATIC DISEASE	Original Date: November 2013
CPT Codes: All Treatment Modalities	Last Revised Date: May 2023
Guideline Number: Evolut_CG_228	Implementation Date: January 2024

GENERAL INFORMATION

- *It is an expectation that all patients receive care/services from a licensed clinician. All appropriate supporting documentation, including recent pertinent office visit notes, laboratory data, and results of any special testing must be provided. If applicable: All prior relevant imaging results and the reason that alternative imaging cannot be performed must be included in the documentation submitted.*
- *Where a specific clinical indication is not directly addressed in this guideline, medical necessity determination will be made based on widely accepted standard of care criteria. These criteria are supported by evidence-based or peer-reviewed sources such as medical literature, societal guidelines and state/national recommendations.*

INDICATIONS FOR THE TREATMENT OF METASTASIS

BRAIN: For metastasis to the brain, regardless of primary site, refer to the Evolut clinical guideline for Central Nervous System (CNS).

BONE: For metastasis to bone, refer to the Evolut clinical guideline for bone metastases.

LUNG¹:

- Conventional 2D and 3D-CRT treatment delivery is appropriate for all other secondary malignancies up to ten (10) to fifteen (15) fractions.
 - Treatment beyond ten fractions for 2D-3D-CRT requires a clinical rationale for additional fractions and will be reviewed on a case-by-case basis.

ALL OTHER SITES: For metastasis to any other site other than brain, lung, or bone:

- Conventional 2D and 3D-CRT treatment delivery is appropriate for all other secondary malignancies up to ten (10) fractions
 - Treatment beyond ten fractions for 2D-3D-CRT requires a clinical rationale for additional fractions and will be reviewed on a case-by-case basis.
- **IMRT** is not indicated for treatment of metastasis except for limited circumstances in which radiation therapy is indicated and 3D conformal radiation therapy (3D-CRT) techniques cannot adequately deliver the radiation prescription without exceeding normal tissue radiation

tolerance, the delivery is anticipated to contribute to potential late toxicity or tumor volume dose heterogeneity is such that unacceptable hot or cold spots are created. If IMRT is utilized, techniques to account for respiratory motion should be performed when appropriate.

- Clinical rationale and documentation for performing IMRT rather than 2D or 3D-CRT treatment planning and delivery will need to:
 - Demonstrate how 3D-CRT isodose planning cannot produce a satisfactory treatment plan (as stated above) via the use of patient-specific dose volume histograms and isodose plans. 3D-CRT techniques such as step-and-shoot or field-in-field should be considered for the comparison.
 - Confirm the IMRT requested will be inversely planned (forward plans or 'field-in-field' plans are not considered IMRT).
- **Selective Internal Radiation Therapy (SIRT)**, also known as radioembolization with microsphere brachytherapy device (RMBD) and transarterial radioembolization, uses microscopic radioactive spheres to deliver radiation to the tumor site. Treatment is delivered through catheter injection of radioactive Yttrium-90 (90Y) microspheres into the hepatic artery. [For Absolute Contraindication[†] and Relative Contraindications[‡], please see the notes below.] Indications for SIRT include^{2,3,4,5}
 - Unresectable metastatic liver tumors
 - Unresectable metastatic liver tumors from primary colorectal cancer
 - Unresectable primary hepatocellular carcinoma
 - Unresectable neuroendocrine tumors

†Note: Absolute Contraindication⁶

- Fulminant liver failure (absolute)

‡Note: Considerations/Relative Contraindications⁶

- The tumor burden should be liver dominant, not necessarily exclusive to the liver
- Patients should also have a performance status that will allow them to benefit from such therapy
- A life expectancy of at least 3 months
- Excessive tumor burden in the liver with greater than 50% to 70% of the parenchyma replaced by tumor
- Total bilirubin greater than 2 mg/dL (in the absence of obstructive cause), which indicates severe liver function impairment. Nonobstructive bilirubin elevations may indicate that liver metastases have caused liver impairment to the degree that risks outweigh benefits for this therapy. In contrast, patients with HCC and elevated bilirubin may be treated with radioembolization if a segmental or subsegmental infusion can be performed
- Prior radiation therapy to the liver or upper abdomen that included a significant volume of the liver
- **Oligometastatic Disease⁷**

- Stereotactic Body Radiation Therapy (SBRT) is medically necessary for extracranial oligometastatic disease for an individual with One (1) to Five (5) metastatic lesions when the following criteria are met:
 - Good performance status: ECOG less than 3 or Karnofsky Scale greater than or equal to 70% and stable systemic disease or reasonable systemic treatment options.
- All other treatment approaches require presentation of clinical rationale and documentation for the proposed treatment modality and plan and will be reviewed on a case-by-case basis.

REFERENCES

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2. Wang TH, Huang PI, Hu YW, et al. Combined Yttrium-90 microsphere selective internal radiation therapy and external beam radiotherapy in patients with hepatocellular carcinoma: From clinical aspects to dosimetry. *PLoS One*. 2018;13(1):e0190098. doi:10.1371/journal.pone.0190098
3. American College of Radiology. ACR Appropriateness Criteria®: Management of liver cancer. Updated 2022. Accessed December 6, 2022. <https://acsearch.acr.org/docs/69379/Narrative>
4. ACR–ABS–ACNM–ASTRO–SIR–SNMMI practice parameter for selective internal radiation therapy (SIRT) or radioembolization for treatment of liver malignancies (Resolution 21). American College of Radiology (ACR). Updated 2019. Accessed December 6, 2022. <https://www.acr.org/-/media/ACR/Files/Practice-Parameters/rmbd.pdf>
5. NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines): Hepatobiliary Cancers Version 3.2022. National Comprehensive Cancer Network (NCCN). Updated October 14, 2022. Accessed December 6, 2022. https://www.nccn.org/professionals/physician_gls/pdf/hepatobiliary.pdf
6. Lievens Y, Guckenberger M, Gomez D, et al. Defining oligometastatic disease from a radiation oncology perspective: An ESTRO-ASTRO consensus document. *Radiother Oncol*. Jul 2020;148:157-166. doi:10.1016/j.radonc.2020.04.003
7. American Society for Radiation Oncology. Model Policies: Stereotactic Body Radiation Therapy. American Society for Radiation Oncology (ASTRO). Updated June 2020. Accessed December 6, 2022,

POLICY HISTORY

Date	Summary
May 2023	<ul style="list-style-type: none">Deleted Additional ResourcesRemoved “physician review” language
January 2022	<ul style="list-style-type: none">Added indications for metastasis to lungUnder “All Other Sites”, added “lung” to state, “For metastasis to any other site other than brain, lung, or bone”Under SIRT, added notes for absolute contraindication and considerations/relative contraindicationsWithin Oligometastatic Disease, increased the range of metastatic lesions from “One (1) to Four (4)” to “One (1) to Five (5)”

Reviewed / Approved by Clinical Guideline Committee

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