

Medicare Advantage Medical Policy



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Intensity Modulated Radiation Therapy (IMRT) and Image Guided Radiation Therapy (IGRT): Cancer of the Head and Neck or Thyroid - Medicare Advantage

Medicare Advantage Plan

- ☒ Medicare Plus BlueSM
- ☒ BCN AdvantageSM

UM Committee Approval Date: 7/15/2026
Effective Date: 8/15/2026

Description

Radiation therapy is a common treatment for cancers of the head and neck and thyroid. Intensity-Modulated Radiation Therapy (IMRT) is an advanced type of external beam radiation therapy that allows radiation doses to be shaped more precisely to the tumor and involved treatment areas. This helps deliver the prescribed dose to the cancer while reducing radiation exposure to nearby healthy tissues and critical structures, such as the salivary glands, spinal cord, brainstem, esophagus, and oral cavity.

Image-Guided Radiation Therapy (IGRT) uses imaging taken before or during treatment to confirm the exact location of the treatment area and make adjustments if needed. In the treatment of head and neck and thyroid cancers, IGRT can help account for changes in patient positioning, weight loss, tumor shrinkage, and normal anatomical changes that may occur during the course of treatment. By improving treatment accuracy, IGRT helps ensure that radiation is delivered to the intended target while minimizing exposure to surrounding healthy tissue and critical organs.

Related Medical Coverage Policies

- Intensity Modulated Radiation Therapy (IMRT) and Image Guided Radiation Therapy (IGRT): Abdomen, Pelvis and Chest - Medicare Advantage
- Intensity Modulated Radiation Therapy (IMRT) and Image Guided Radiation Therapy (IGRT) of the Breast and Lung - Medicare Advantage
- Intensity Modulated Radiation Therapy (IMRT) and Image Guided Radiation Therapy (IGRT): Central Nervous System Tumors - Medicare Advantage
- Intensity Modulated Radiation Therapy (IMRT) and Image Guided Radiation Therapy (IGRT) of the Prostate - Medicare Advantage

Policy Guidelines

Blue Cross Blue Shield of Michigan (BCBSM) and Blue Care Network of Michigan (BCN) adhere to guidance from the Centers for Medicare and Medicaid Services (CMS), including when performing organization determinations for Medicare Advantage plan members. CMS Medicare statutes, regulations, manuals, National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), Local Coverage Articles (LCAs) and other sub-regulatory guidance provide the clinical guidelines for coverage determinations, payment integrity functions, and all other uses by CMS regulations. When CMS Medicare guidance is silent, incomplete, or insufficient, CMS permits BCBSM/BCN to utilize “internal coverage criteria”, such as independent criteria, health plan policy research, LCD/LCAs outside the services area or research from independent medical research repositories (i.e., Hayes) for coverage policies consistent with 42 CFR § 422.101. BCBSM/BCN internal medical coverage policies are developed and based on current evidence in widely accepted treatment guidelines or clinical literature; in addition, they address how clinical benefits may or may not outweigh member harm.

Clinical review follows guidance provided in the BCBSM Medicare Advantage Coverage Determination Hierarchy policy, which may be found at <https://www.bcbsm.com/providers/mpradmin/> by entering the policy name.

Coverage Guidance

To ensure consistency with coverage guidance, the Medicare statutes, regulations, coverage manuals, NCD, LCD, and LCA should be reviewed and applied first. BCBSM/BCN internal coverage criteria should only be applied when CMS guidance is silent, incomplete, or insufficient for a code.

Apart from durable medical equipment (DME), Medicare Administrative Contractor (MAC) jurisdiction for the purpose of clinical determination is based upon place of service. The place of service for laboratory testing is defined as the geographic location of the reference laboratory. Non-jurisdictional LCD/LCAs may not be utilized for a determination unless they have been specifically identified as internal coverage criteria by the policy. Alternatively, jurisdiction for DME MAC is determined by the member place of residence. Please see CMS Medicare Administrative Contractors (MAC) table for state MAC assignments below.

CMS Guidance	Additional Guidance
National Coverage Determinations 310.1 – Routine Costs in Clinical Trials For additional information regarding clinical trials evaluating intensity modulated radiation therapy (IMRT) and image guided radiation therapy (IGRT), please visit ClinicalTrials.gov at: https://clinicaltrials.gov	BCBSM/BCN will follow CMS guidance as the primary source for coverage determinations. However, in instances where CMS guidance is silent, incomplete, or insufficient for a particular code, BCBSM/BCN internal coverage criteria will be applied to ensure consistent and informed decision-making.
Local Coverage Determinations and Articles WPS None	In such cases, please refer to the relevant BCBSM/BCN policy for guidance: <i>Intensity Modulated Radiation Therapy (IMRT) and Image Guided Radiation Therapy (IGRT): Cancer of the head and neck or thyroid</i>
CGS None	
First Coast None	To access this policy, please visit the BCBSM Medical Policy Router Search page at https://www.bcbsm.com/providers/mpradmin/ and enter the policy name in the search field.
Noridian JE & JF None	

Novitas None Palmetto L39553, A59350 - Radiation Therapies Wellpoint Federal None	
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Code	Description
77301	Intensity modulated radiotherapy plan, including dose-volume histograms for target and critical structure partial tolerance specifications.
77338	Multi-leaf collimator (MLC) device(s) for intensity modulated radiation therapy (IMRT), design and construction per IMRT plan
77387	Guidance for localization of target volume for delivery of radiation treatment, includes intrafraction tracking, when performed.
77407	Radiation treatment delivery; Level 2, single-isocenter (e.g., 3D or IMRT), photons, including imaging guidance, when performed
77412	Radiation treatment delivery; Level 3, multiple isocenters with photon therapy (e.g., 2D, 3D, or IMRT) or a single-isocenter photon therapy (e.g., 3D or IMRT) with active motion management, or total skin electrons, or mixed-electron/photon field(s), including imaging guidance, when performed

CPT® codes, descriptions and materials are copyrighted by the American Medical Association (AMA).

HCPCS® codes, descriptions and materials are copyrighted by Centers for Medicare and Medicaid Services (CMS).

The above information is current as of the review date for this policy. However, the coverage issues and policies maintained by CMS are updated and/or revised periodically. Therefore, the most current CMS information may not be contained in this document.

Please refer to the Medicare Coverage Database website at <https://www.cms.gov/medicare-coverage-database/search.aspx> for the most current applicable NCD, LCD, LCA, and CMS Online Manual System Transmittals. For any code associated with a product or service determined to be noncovered by policy (either CMS or health plan policy if CMS is silent) medical record review, including prior authorization, will not be required.

CMS Medicare Administrative Contractors (MAC) Jurisdictions Guidance

Part A and Part B MAC Jurisdictions	
Wisconsin Physicians Service Insurance Corporation (WPS)	IA, IN, KS, MI, MO, NE
CGS Administrators, LLC	KY, OH
First Coast Service Options, Inc	FL, PR, US VI
Noridian Healthcare Solutions, LLC Jurisdiction JE	CA, HI, NV, American Samoa, Guam, Northern Mariana Islands
Noridian Healthcare Solutions, LLC Jurisdiction JF	AK, AZ, ID, MT, ND, OR, SD, UT, WA, WY
Novitas Solutions Inc.	AR, CO, DC, DE, LA, MD, MS, NJ, NM, OK, PA, TX
Palmetto GBA	AL, GA, TN, NC, SC, VA, WV
Wellpoint Federal - Previously known as National Government Services, Inc. (NGS)	CT, IL, MA, ME, MN, NH, NY, RI, VT, WI
DME MAC Jurisdictions	
CGS Administrators, LLC, Jurisdictions JB and JC	AL, AR, CO, FL, GA, IL, IN, KY, LA, MI, MN, MS, NM, NC, OH, OK, Puerto Rico, SC, TN, TX, VA, US Virgin Islands, WI, WV

Important Reminder

BCBSM and BCN follow CMS Medicare coverage guidance to limit coverage to items and services that are reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member. Medicare Advantage Medical Policies list the criteria BCBSM and BCN use to decide which medical services are considered “reasonable and necessary” when Medicare coverage rules are not fully developed, or as otherwise permitted by CMS Medicare regulations. Individual member benefit plan documents, such as the Evidence of Coverage and Annual Notice of Change, as well as applicable laws govern benefit coverage, including any inclusion, exclusion, and/or other restrictions.

Medicare Advantage Medical policies are created when permitted by CMS Medicare regulations, reviewed regularly, and may be revised periodically. BCBSM/BCN Medical Policies are proprietary and should not be copied or disseminated without the express, prior written approval of BCBSM. All providers are required to review applicable BCBSM reimbursement policies prior to claim submission and bill for covered services in accordance with those policies. Additionally, providers contracted with BCBSM or BCN’s Medicare Advantage network(s) should review the provider manual for any additional claim submission requirements. Providers not contracted with BCBSM or BCN’s Medicare Advantage network may be required to submit documentation to BCBSM, BCN, or its delegated entity supporting billed claims, including but not limited to applicable medical records.

Note: U.S. Food and Drug Administration (FDA) approval for a specific indication or the issuance of a CPT code is not sufficient for a procedure to be considered medically reasonable and necessary. Similarly, the presence of a procedure/device code or payment amount for the service in the Medicare fee schedule does not necessarily indicate coverage. If a service is deemed not reasonable and necessary, to treat illness or injury for any reason (including lack of safety and efficacy because it is an experimental procedure, etc.), the procedure is considered not covered.

Disclaimer: This medical policy is not an authorization, certification, explanation of benefits, or a contract for the services, devices, or drugs that is referenced in the medical policy. Medical policies do not constitute medical advice and do not guarantee any results or outcomes or guarantee payment. The medical policy is not intended to replace independent medical judgment for the treatment of individuals. Treating physicians and health care providers are solely responsible for determining what care to provide for their patients. Identification of selected brand names of devices, tests and procedures in a medical coverage policy is for reference only and is not an endorsement of any one device, test, or procedure over another.

Pursuant to Section 1557 and Section 504, Blue Cross does not discriminate on the basis of race, color, national origin, age, disability, or sex (including sex characteristics, intersex traits; pregnancy or related conditions; sexual orientation; gender identity, and sex stereotypes). This includes our rules, benefit designs and medical policies.

BCBSM/BCN Medicare Advantage Policy History

Policy Effective Date	UM Committee Approval Date	Comments
08/17/2024	07/17/2024	Medicare Advantage policy established.
08/16/2025	07/16/2025	Annual Review: MA Policy Foundational Language updated. Adopted JUMP policy Updates.
02/28/2026	01/28/2026	Annual Review: Adopted JUMP policy Updates.
08/15/2026	07/15/2026	Off Cycle Review: Reformatted guidance and code tables. Adopted JUMP policy updates including the addition of codes 77407 and 77412; deletion of codes 77385, 77386, G6015 & G6016; revision of description, and title change. Previous title: <i>Intensity Modulated Radiation Therapy (IMRT): Cancer of the Head and Neck or Thyroid - Medicare Advantage</i> .

Blue Cross Blue Shield of Michigan and Blue Care Network
Medicare Advantage
Policy Medical Director Annual Review

Name of Service: Intensity Modulated Radiation Therapy (IMRT) and Image Guided Radiation Therapy (IGRT): Cancer of the Head and Neck or Thyroid- Medicare Advantage

Recommendation: When available, BCBSM/BCN will apply CMS Medicare coverage criteria found in Medicare coverage manuals, NCD, LCD, LCA, or other regulatory guidance to determine medical necessity of service or item. In the absence of fully established Medicare coverage criteria the health plan's internal criteria will be applied for medical necessity decision-making.

☒ This service may be considered medically necessary if criteria is met.

☐ This service may not be considered medically necessary. This service is investigational and unproven and therefore NOT COVERED. There is insufficient reliable evidence in the form of high-quality peer-reviewed medical literature to establish the efficacy or effects on health care outcomes. If a procedure or device lacks scientific evidence regarding safety and efficacy because it is investigational or experimental, the service is noncovered as not reasonable and necessary to treat illness or injury. (Medicare IOM Pub. No. 100-04, Ch. 23, §30 A)

☐ This service is mixed for both established and investigational and therefore may meet medical necessity if criteria are met.

☐ Policy retired due to CMS regulations, clinical practice guidelines, clinical evidence, policy consolidation, vendor managed service, or technology obsolete.

 MD, MBA

Todd Johnson, MD, MBA
Sr. Medical Director
Blue Cross Blue Shield of Michigan

7/15/2026

Signature Date

7/15/2026

UM Committee Approval Date