



National Imaging Associates, Inc.	
Clinical guidelines BONE METASTASES	Original Date: June 2013
Radiation Oncology	Last Revised Date: April 2019
Guideline Number: NIA_CG_126	Implementation Date: January 2020

MEDICALLY NECESSARY INDICATIONS FOR RADIATION THERAPY:

- Conventional 2D planning techniques is appropriate for the treatment of bone metastases.
- 3D-CRT may be indicated in select cases such as situations of re-treatment, overlapping volumes or adjacent critical structures that are likely to cause complications. Requests for 3D-CRT must be accompanied by supporting clinical rationale.

Favorable Risk: (Good performance status = ECOG less than 3)

- EBRT –Up to 10 fractions for multiple bone metastases
- EBRT –Up to 14 fractions for spinal cord compression symptoms or single lesion or instances that require a longer fractionated course to minimize patient discomfort (e.g. nausea) (Lutz, 2017).

Unfavorable Risk: (Poor performance status = ECOG 3 or greater or progressive metastatic disease)

- EBRT – Up to 5 fractions

Requests and supporting rationale for additional fractions can be discussed with a physician reviewer.

TREATMENT OPTIONS REQUIRING PHYSICIAN REVIEW

Intensity modulated radiation therapy (IMRT)

IMRT is not indicated as a standard treatment option and should not be used routinely for the delivery of radiation therapy for bone metastasis. IMRT may be appropriate 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.

Requests for IMRT require physician review of the clinical rationale and documentation for performing IMRT rather than 2D or 3D-CRT treatment planning and delivery. Supporting documentation 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.
- Provide tissue constraints for both the target and affected critical structures.

Stereotactic Body Radiation Therapy (SBRT)

Stereotactic Body Radiation Therapy is not a standard treatment option for the treatment of bone metastasis (Lutz, 2017). A peer review is required with a radiation oncologist.

Proton Beam Radiation Therapy

Proton beam is not an approved treatment option for bone metastasis. Overall, studies of proton beam therapy have not shown clinical outcomes to be superior to conventional radiation therapy in bone metastases.

THE FOLLOWING APPLIES TO CMS (MEDICARE) MEMBERS ONLY:

For Proton Beam and Stereotactic Radiotherapy refer to Local Coverage Determination (LCD), if applicable.

BACKGROUND:

Bone metastases are a common manifestation of malignancy that can cause severe and debilitating effects including pain, spinal cord compression, hypercalcemia, and pathologic fracture. Radiation therapy has a proven track record in the palliation of bone metastases. Following a course of palliative treatment, approximately one-third of patients will have complete relief of pain and two-thirds of patients will have significant reduction in their pain. The optimal delivery of radiation therapy has been the focus of multiple trials looking at the best dose fractionation. Common dose fractionation schedules have shown good rates of palliation, including 8 Gy in 1 fraction, 20 Gy in 4 fractions, 24 Gy in 6 fractions, or 30 Gy in 10 fractions. All provide excellent pain control with minimal side effects. The benefit of the single fraction is that it is the most convenient for patients, whereas the advantage of a longer course of treatment has the advantage of a lower incidence of re-treatment to the same site. Dose fractionation is typically determined based on location of the metastasis, patient's clinical status, previous irradiation treatment, etc. Therefore, multiple factors must be reviewed prior to prescribing palliative radiotherapy.

POLICY HISTORY:

Review Date: February 2019

Review Summary: Added and updated references

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