



Kaiser Foundation Health Plan of Washington

**Clinical Review Criteria
Low Dose Radiotherapy**

- Non-Melanoma Skin Cancer
- Non-Oncologic Conditions

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Criteria

For Medicare Members

Source	Policy
National Coverage Determinations (NCD)	None
Local Coverage Determinations (LCD)	<p>Noridian retired LCD Brachytherapy: Non-intracoronary (L34065).</p> <p>These services still need to meet medical necessity as outlined in the LCD and will require review. LCDs are retired due to lack of evidence of current problems, or in some cases because the material is addressed by a National Coverage Decision (NCD), a coverage provision in a CMS interpretative manual or an LCD. Most LCDs are not retired because they are incorrect. The criteria should be still referenced when making an initial decision. However, if the decision is appealed, the retired LCD cannot be specifically referenced. Maximus instead looks for "medical judgment" which could be based on our commercial criteria or literature search.</p> <p>Superficial Radiation Therapy (SRT) for the Treatment of Nonmelanoma Skin Cancer (L40176)</p> <p>Billing and Coding: Superficial Radiation Therapy (SRT) for the Treatment of nonmelanoma Skin Cancer (A60181)</p>

For Non-Medicare Members

Service	Criteria
Non-Melanoma Skin Cancer	There is insufficient evidence in the published medical literature to show that this service/therapy is as safe as standard services/therapies and/or provides better long-term outcomes than current standard services/therapies.
Non-Oncologic Conditions	
Palmar Fibromatosis (Dupuytren's Contracture)	There is insufficient evidence in the published medical literature to show that this service/therapy is as safe as standard services/therapies and/or provides better long-term outcomes than current standard services/therapies.
Cardiac Arrhythmia	There is insufficient evidence in the published medical literature to show that this service/therapy is as safe as

	standard services/therapies and/or provides better long-term outcomes than current standard services/therapies.
Heterotopic Ossification	Low dose radiation therapy may be considered medically necessary to prevent formation of heterotopic ossification in high-risk individuals when used immediately prior to or within 7 days after surgical removal of heterotopic ossification when conventional treatments (e.g., tamoxifen, verapamil and steroid injections) have failed. <i>Quantity limit: 1 treatment</i>
Image Guided Radiation Therapy (IGRT)	The use of IGRT with superficial radiation therapy is considered not medically necessary. The use of IGRT, including the use of ultrasound, in the treatment of non-melanomatous skin cancer is considered not medically necessary.
Keloids	Radiation therapy may be considered medically necessary to prevent the recurrence of keloid formation after surgical resection/revision when used in combination with intralesional corticosteroid injection. <i>Quantity limit: 3 treatments</i>
Osteoarthritis	There is insufficient evidence in the published medical literature to show that this service/therapy is as safe as standard services/therapies and/or provides better long-term outcomes than current standard services/therapies.
Plantar Fasciitis	Radiation therapy is not a preferred modality to treat plantar fasciitis; exceptions may be considered on a case -by-case basis when all other conventional therapy has failed including regular use of stretching, consistent use of arch support, and repeated corticosteroid injections.
Seborrheic Keratosis	There is insufficient evidence in the published medical literature to show that this service/therapy is as safe as standard services/therapies and/or provides better long-term outcomes than current standard services/therapies.
Hyperpigmentation of the skin	There is insufficient evidence in the published medical literature to show that this service/therapy is as safe as standard services/therapies and/or provides better long-term outcomes than current standard services/therapies.
Heel Spurs	There is insufficient evidence in the published medical literature to show that this service/therapy is as safe as standard services/therapies and/or provides better long-term outcomes than current standard services/therapies.
Pterygium	The preferred treatment for Pterygium is surgical excision with conjunctival autograft. Requests for low dose or superficial radiotherapy will be reviewed on a case-by-case basis.
TRASER For nasal telangiectasias	There is insufficient evidence in the published medical literature to show that this service/therapy is as safe as

	standard services/therapies and/or provides better long-term outcomes than current standard services/therapies.
All other non-oncologic indications	There is insufficient evidence in the published medical literature to show that this service/therapy is as safe as standard services/therapies and/or provides better long-term outcomes than current standard services/therapies.

If requesting this service (or these services), please send the following documentation to support medical necessity:

- Last 6 months of clinical notes from requesting provider &/or specialist

The following information was used in the development of this document and is provided as background only. It is provided for historical purposes and does not necessarily reflect the most current published literature. When significant new articles are published that impact treatment option, Kaiser Permanente will review as needed. This information is not to be used as coverage criteria. Please only refer to the criteria listed above for coverage determinations.

Background

Non-Melanoma Skin Cancer

Nonmelanoma skin cancer (NMSC) is the most common malignancy in the Caucasian population and its incidence continues to rise. It is estimated that more than two million Americans are affected by NMSC each year. Due to ultraviolet light exposure, over 95% of cancers are located in the head and neck region (nose, ears, eyelids, and lips). Basal cell carcinoma (BCC) represents approximately 75-80% of NMSCs and squamous cell carcinoma (SCC) 20-25%. It is reported that half of the patients with NMSC are over 65 years of age and that almost 50% of them may develop a second primary NMSC within 5 years. These cancers have a low mortality rate and are rarely life threatening, but they represent a significant burden on global health care services due to their increasing incidence (Alam 2011, Bhatnagar 2010 & 2013, Benkhaled, 2022).

Treatment options for NMSC include surgery, radiation therapy, chemotherapy, and photodynamic therapy. Surgery is considered the gold standard treatment; it provides the highest cure rates and has satisfactory cosmetic results. Surgical techniques include excision, curettage with electrodesiccation, and Mohs micrographic surgery (MMS). The choice of procedure depends on the histologic type, size, and location of the lesion. Some patients, however, are not suitable candidates for surgery because of their age, health condition, potential disfigurement, or functional defects when the cancer is located in high-risk areas. Radiation therapy has been used for selected skin cancers, typically reserved as a second-line therapy for patients with surgical contraindications or as adjuvant therapy for high-risk lesions. It is also an alternative to surgery for lesions located in areas where surgery may be more difficult, lead to disfigurement, or affect structural function e.g., eyelid, ear, or nose. Radiation therapy techniques used for NMSC include superficial x-rays, orthovoltage x-rays and megavoltage photons, electron beam irradiation, radionuclide-based brachytherapy (BT). (Bhatnagar 2010 & 2013, Frakulli 2015, Linos 2015, Safigholi 2015, Patel 2017, Ramachandran 2017).

Electronic brachytherapy (eBT, EBT, or EBX) is a relatively newer technology administering high-dose-rate brachytherapy (HDR-BT) with the use of a low energy miniaturized electronic X-ray source rather than a radionuclide-based source x-ray source. Potential advantages of EBT over traditional BT include isotope-free delivery, relatively reduced need for shielding, optimal sparing of normal tissues, shorter time of treatment, reduced dose to treating staff, and no radioactive waste. In addition, the EBT systems can be operated in a standard treatment room with minimal shielding due to low energy and no radiation leakage when off (Bhatnagar 2013, Safigholi 2015, Ouhib, 2015, Ramachandran 2017, Goyal 2021, Tang 2022).

Several types of EBT systems are currently available. The main component is a miniature X-ray tube that produces bremsstrahlung (electromagnetic) radiation using electron energies ranging from 20-70keV. Treatment of skin cancers is performed using conical applicators developed by the manufacturers and provided in different sizes (1cm, 2 cm, 3.5 cm, and 5 cm) to ensure adequate coverage of the clinical and planning target volume. Patients

are treated with different fractionation regimens depending on the location and depth of the lesion with the most frequent regimen being 40 Gy/8 fx. The therapy is typically delivered twice weekly over 4 weeks (Bhatnagar 2013, Safigholi 2015, Goyal 2021).

Radiotherapy for Dupuytren's Contracture

Dupuytren's contracture (DC) is a fibrotic tissue disorder affecting the hands. It is a benign condition characterized by thickening connective tissue in the palm eventually progressing to the formation of nodules and cords. Symptoms typically occur in both hands and progress gradually over time at variable rates. The lumps or dermal pits can be present for extended periods of time before a cord may develop causing the fingers to contract. The contracture, however, may not become troublesome for years or may never progress at all.

DC has a global prevalence of 3-6% primarily affecting males and Caucasian populations. Most patients will present with symptoms in middle age (Rizzo, Stern et al. 2013). Typically diagnosed upon physical examination, the etiology of DC is unknown, however, there is believed to be a strong genetic component as it most commonly occurs in people of Northern European or Scandinavian ancestry and often runs in families. The literature has also suggested associations with diabetes, seizures, smoking, alcohol, trauma and beta-blockers.

At present, there is no cure for DC. Available treatment options include both invasive and noninvasive modalities and typically focus on managing the disability and preventing progression (NICE 2010). Stretching, massage and splinting are frequently recommended while corticosteroid injections and fasciectomy have been used in more extreme and developed cases. In any case, most treatment options have limited effectiveness as 20% of patients experience recurrence of symptoms.

Radiation therapy or radiotherapy (RT) is a non-surgical treatment option that is reported to halt or slow the progression of DC in its early stages. Aimed to prevent or postpone the need for surgical intervention, the mechanism for action is unclear, but it is thought to affect the development and growth rate of fibroblasts within the palmar fascia. RT treatment of the affected nodules and cords can be performed with either superficial x-rays or electron beams. The technique is typically carried out over several consecutive visits until the intended radiation dose has been achieved

Medical Technology Assessment Committee (MTAC)

Electronic Brachytherapy for Non-Melanoma Skin Cancer

04/21/2014: MTAC REVIEW

Evidence Conclusion: There is insufficient published evidence to determine the safety and efficacy of EBT for the treatment of NMSC. There is an ongoing clinical trial "Electronic Brachytherapy for the Treatment of NMSC" (NLM Identifier NCT01016899) with the objective of recording the recurrence in patients treated for nonmelanoma (basal cell and squamous cell carcinomas) skin cancer using the Xofigo Axxent Electronic Brachytherapy System. The trial will also evaluate the cosmetic outcomes and skin toxicities related to the treatment.

Articles: The literature search for EBT for the treatment of NMSC identified only one study on the use of electronic brachytherapy for the treatment of NMSC. The initial results were reported in 2010 (Bhatnagar A, and Loper A, 2010) and 1-year results were published in 2013 (Bhatnagar A 2013). Bhatnagar A. Nonmelanoma skin cancer treated with electronic brachytherapy: results at 1 year. *Brachytherapy*. 2013; 12(2):134-140. See [Evidence Table](#). Bhatnagar A, Loper A. The initial experience of electronic brachytherapy for the treatment of non-melanoma skin cancer. *Radiat Oncol*. 2010; 5:87. doi: 10.1186/1748-717X-5-87 See [Evidence Table](#).

The use of electronic brachytherapy for non-melanoma skin cancer does not meet the *Kaiser Permanente Medical Technology Assessment Criteria*.

03/21/2016: MTAC REVIEW

Electronic Brachytherapy (EBT) for the treatment of non-melanoma skin cancer (NMSC)

Evidence Conclusion: There is insufficient published evidence to determine whether the safety and efficacy outcomes of electronic brachytherapy for NMSC are as good or superior to the outcomes of alternative treatment options. There are no published randomized or non-randomized controlled trials that compared EBT to an alternative therapy for the treatment of NMSC. The available published evidence consists of case series that used different systems for the delivery of HDR. The largest series (Bhatnagar 2010 & 2013) that used one of the three commercially available devices (the Axxent system, Xofigo Inc. Sunnyvale, CA) was reviewed by MTAC earlier in 2014, and did not provide sufficient evidence on the long-term efficacy or safety of the procedure.

The more recent case series identified by the search were small retrospective series with no comparison groups, and do not provide additional evidence to support the use of EBT for NMSC. In a recently published article, Linos and colleagues (2015), expressed their concern regarding the increase in the use of EBT for skin cancer. The authors analyzed Medicare claims data and found that EBT use for skin cancer is increasing rapidly in the Medicare population. They indicated this may be attributable to marketing by the manufacturers, and that there is insufficient long-term data on the efficacy and safety of the therapy to cover the period during which recurrence and radiation sequelae would be expected (Linos, 2015).

Articles: The updated literature search for the use of electronic brachytherapy in the treatment of NMSC did not identify any controlled trial that compared the therapy with an alternative mode of treatment. The search only identified a number of small retrospective case series and a systematic review of the observational studies reporting on the outcomes of low-dose or high-dose brachytherapy used for the treatment of NMSC of the eyelid (Frakulli 2015).

The use of electronic brachytherapy for non-melanoma skin cancer does not meet the *Kaiser Permanente Medical Technology Assessment Criteria*.

Per NCCN Guidelines Version 1.2017 Basal Cell Skin Cancer. P. 11

“There is insufficient long-term efficacy and safety data to support the routine use of electronic surface brachytherapy.”

07/08/2024: MTAC REVIEW

Evidence Conclusion

- There is insufficient published evidence to determine the comparative safety and efficacy of electronic brachytherapy and Mohs surgery in treating patients with NMSC.
- There is insufficient published evidence to determine the net health outcomes of electronic brachytherapy in patients with NMSC.
- Randomized controlled trials with sufficient follow-up duration are needed to determine the comparative long-term safety and efficacy of EBT and MMS in patients with NMSC.

Articles: The literature search for studies published after the 2016 MTAC review of the technology, did not identify any RCT that compared electronic brachytherapy to Mohs Surgery for the treatment of patients with nonmelanoma skin cancer. The search only revealed a matched pair cohort study that compared EBT vs. Mohs micrographic surgery for the treatment of early stage NMSC (Patel, et al 2017); a systematic review with meta-analysis of studies evaluating different treatment modalities used for indolent skin cancer (Lee, et al 2019); a small (N=34) prospective study reporting on short term cosmesis and QoL with electronic skin surface brachytherapy for keratinocyte carcinoma (Kuo et al, al 2023); two year outcomes of a small pilot single arm observational study with incomplete follow-up of 26 patients (Ballester-Sánchez, et al, 2017) , retrospective chart reviews; and case series of patients with NMSC treated with EBT. See [Evidence Table](#)

Patel, et al's 2017 matched pair cohort study was selected for critical appraisal. Lee, et al's meta-analysis was not selected for the current review as the authors excluded studies that used electronic brachytherapy due to the lack of long-term data.

The use of electronic brachytherapy for non-melanoma skin cancer does not meet the *Kaiser Permanente Medical Technology Assessment Criteria*.

Radiotherapy for Dupuytren's Contracture

10/20/2014: MTAC REVIEW

Evidence Conclusion: There is insufficient evidence to support the effectiveness of radiation therapy for patients with DC. There is insufficient evidence to support the safety of radiation therapy for the treatment of DC.

Articles: The literature was searched for publications assessing the safety and effectiveness of RT for DC. Several publications were revealed, many of which were published in languages other than English (primarily German). There were no randomized controlled trials (RCTs) comparing the effectiveness of RT with surgical intervention or any other medical intervention for that matter. One RCT was discovered that compared the effectiveness of two different radiation doses. In addition, two recent case series were included to address safety. The following articles were selected for critical appraisal: Zirbs M, Bruckbauer AH, Hoffman H, et al., Radiotherapy with soft X-rays in Dupuytren's disease – successful, well-tolerated and satisfying. European Academy of Dermatology and Venerology. 2014. See [Evidence Table 1](#). Seegenschmiedt MH, Olschewski T, Guntrum F. Radiotherapy optimization in early-stage dupuytren's contracture: first results of a randomized clinical study. Int J Radiation Oncology Biol Phys. 2001; 49(3):785-798. See [Evidence Table 2](#). Betz N, Ott OJ, Adamietz

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B, et al. Radiotherapy in early-stage Dupuytren’s contracture. *Strahlenther Onkol.* 2010;186(2): 82-90. See [Evidence Table 3](#).

The use of Radiotherapy for Dupuytren’s Contracture does not meet the *Kaiser Permanente Medical Technology Assessment Criteria*

Radiotherapy for Dupuytren’s Contracture

10/13/2025: MTAC REVIEW

Evidence Conclusion: There is insufficient evidence to evaluate the safety and efficacy of radiation therapy in patients with early-stage Dupuytren’s contracture (palmar fibromatosis) in comparison to either placebo, surgical (i.e., surgical fasciectomy), or non-surgical (i.e., collagenase injections) treatment.

Articles: KPWA review in 2014 indicated that there is insufficient evidence to support the effectiveness and safety of radiation therapy for patients with DC. Among the studies reviewed in this iteration, only Burgess et al. 2025 directly compared adjuvant radiotherapy with observation. The other studies did not include a control group. See [Evidence Table](#).

Hayes Technology Brief

Hayes, Inc. Hayes Technology Brief. Superficial Radiation Therapy for Treatment of Nonmelanoma Skin Cancer. Lansdale, PA: Hayes, Inc.; 3/2018

Hayes, Inc. Hayes Evolving Evidence Review. Low-Dose Radiation Therapy for Treatment of Knee Osteoarthritis. Retrieved December 15, 2025, from <https://evidence.hayesinc.com/report/eer.lowdose5964>

Applicable Codes

Considered Medically Necessary when criteria in the applicable policy statements listed above are met:

CPT® Codes	Description
0394T	High dose rate electronic brachytherapy, skin surface application, per fraction, includes basic dosimetry, when performed
77280	Therapeutic radiology simulation-aided field setting; simple
77285	Therapeutic radiology simulation-aided field setting; intermediate
77300	Basic radiation dosimetry calculation, central axis depth dose calculation, TDF, NSD, gap calculation, off axis factor, tissue inhomogeneity factors, calculation of non-ionizing radiation surface and depth dose, as required during course of treatment, only when prescribed by the treating physician
77336	Continuing medical physics consultation, including assessment of treatment parameters, quality assurance of dose delivery, and review of patient treatment documentation in support of the radiation oncologist, reported per week of therapy
77370	Special medical radiation physics consultation
77436	Surface radiation therapy; superficial or orthovoltage, treatment planning and simulation-aided field setting
77437	Surface radiation therapy; superficial, delivery, ≤150 kV, per fraction (eg, electronic brachytherapy)
77438	Surface radiation therapy; orthovoltage, delivery, >150-500 kV, per fraction
77412	Radiation treatment delivery, =>1 MeV; complex
G6001	Ultrasonic guidance for placement of radiation therapy fields
With diagnosis Code	
<i>Non-Melanoma Skin Cancer</i>	
C44.01	Basal cell carcinoma of skin of lip
C44.02	Squamous cell carcinoma of skin of lip
C44.1121	Basal cell carcinoma of skin of right upper eyelid, including canthus
C44.1122	Basal cell carcinoma of skin of right lower eyelid, including canthus
C44.1191	Basal cell carcinoma of skin of left upper eyelid, including canthus
C44.1192	Basal cell carcinoma of skin of left lower eyelid, including canthus
C44.1221	Squamous cell carcinoma of skin of right upper eyelid, including canthus
C44.1222	Squamous cell carcinoma of skin of right lower eyelid, including canthus
C44.1291	Squamous cell carcinoma of skin of left upper eyelid, including canthus

C44.1292	Squamous cell carcinoma of skin of left lower eyelid, including canthus
C44.212	Basal cell carcinoma of skin of right ear and external auricular canal
C44.219	Basal cell carcinoma of skin of left ear and external auricular canal
C44.222	Squamous cell carcinoma of skin of right ear and external auricular canal
C44.229	Squamous cell carcinoma of skin of left ear and external auricular canal
C44.311	Basal cell carcinoma of skin of nose
C44.319	Basal cell carcinoma of skin of other parts of face
C44.321	Squamous cell carcinoma of skin of nose
C44.329	Squamous cell carcinoma of skin of other parts of face
C44.41	Basal cell carcinoma of skin of scalp and neck
C44.42	Squamous cell carcinoma of skin of scalp and neck
C44.510	Basal cell carcinoma of anal skin
C44.511	Basal cell carcinoma of skin of breast
C44.519	Basal cell carcinoma of skin of other part of trunk
C44.520	Squamous cell carcinoma of anal skin
C44.521	Squamous cell carcinoma of skin of breast
C44.529	Squamous cell carcinoma of skin of other part of trunk
C44.612	Basal cell carcinoma of skin of right upper limb, including shoulder
C44.619	Basal cell carcinoma of skin of left upper limb, including shoulder
C44.622	Squamous cell carcinoma of skin of right upper limb, including shoulder
C44.629	Squamous cell carcinoma of skin of left upper limb, including shoulder
C44.712	Basal cell carcinoma of skin of right lower limb, including hip
C44.719	Basal cell carcinoma of skin of left lower limb, including hip
C44.722	Squamous cell carcinoma of skin of right lower limb, including hip
C44.729	Squamous cell carcinoma of skin of left lower limb, including hip
D04.0	Carcinoma in situ of skin of lip
D04.111	Carcinoma in situ of skin of right upper eyelid, including canthus
D04.112	Carcinoma in situ of skin of right lower eyelid, including canthus
D04.121	Carcinoma in situ of skin of left upper eyelid, including canthus
D04.122	Carcinoma in situ of skin of left lower eyelid, including canthus
D04.21	Carcinoma in situ of skin of right ear and external auricular canal
D04.22	Carcinoma in situ of skin of left ear and external auricular canal
D04.39	Carcinoma in situ of skin of other parts of face
D04.4	Carcinoma in situ of skin of scalp and neck
D04.5	Carcinoma in situ of skin of trunk
D04.61	Carcinoma in situ of skin of right upper limb, including shoulder
D04.62	Carcinoma in situ of skin of left upper limb, including shoulder
D04.71	Carcinoma in situ of skin of right lower limb, including hip
D04.72	Carcinoma in situ of skin of left lower limb, including hip
D04.8	Carcinoma in situ of skin of other sites
D07.1	Carcinoma in situ of vulva
D07.4	Carcinoma in situ of penis
<i>Radiotherapy for Dupuytren's Contracture</i>	
M72.0	Palmar fascial fibromatosis [Dupuytren]
<i>Cardiac Arrhythmias</i>	
I47.0	Re-entry ventricular arrhythmia
I47.1	Supraventricular tachycardia

I47.2	Ventricular tachycardia
I47.9	Paroxysmal tachycardia, unspecified
I48.0	Paroxysmal atrial fibrillation
I48.1	Persistent atrial fibrillation
I48.2	Chronic atrial fibrillation
I48.91	Unspecified atrial fibrillation
I49.0	Ventricular fibrillation
I49.1	Atrial premature depolarization
I49.2	Junctional premature depolarization
I49.3	Ventricular premature depolarization
I49.9	Cardiac arrhythmia, unspecified
<i>Heterotopic Ossification</i>	
M61.0	Myositis ossificans traumatica
M61.1	Myositis ossificans progressiva
M61.2	Other ossification of muscle
M61.9	Ossification of muscle, unspecified
<i>Keloids/Hypertrophic Scarring</i>	
L91.0	Hypertrophic scar
L91.1	Keloid scar
<i>Seborrheic Keratosis</i>	
L82.0	Inflamed seborrheic keratosis
L82.1	Other seborrheic keratosis
<i>Hyperpigmentation of the skin</i>	
L81.4	Other melanin hyperpigmentation
<i>Osteoarthritis</i>	
M15.0	Primary generalized osteoarthritis
M15.1	Heberden's nodes (with arthropathy)
M15.2	Bouchard's nodes (with arthropathy)
M15.3	Secondary multiple osteoarthritis
M15.4	Other multiple osteoarthritis
M15.9	Polyosteoarthritis, unspecified
M16.0	Primary coxarthrosis, bilateral
M16.1	Other primary coxarthrosis
M16.2	Bilateral coxarthrosis resulting from dysplasia
M16.3	Unilateral coxarthrosis resulting from dysplasia
M16.4	Bilateral post-traumatic coxarthrosis
M16.5	Unilateral post-traumatic coxarthrosis
M16.6	Other bilateral secondary coxarthrosis
M16.7	Other unilateral secondary coxarthrosis
M16.9	Coxarthrosis, unspecified

M17.0	Primary gonarthrosis, bilateral
M17.1	Other primary gonarthrosis
M17.2	Post-traumatic gonarthrosis, bilateral
M17.3	Other post-traumatic gonarthrosis
M17.4	Other secondary gonarthrosis, bilateral
M17.5	Other secondary gonarthrosis
M17.9	Gonarthrosis, unspecified
M18.0	Primary osteoarthritis of first carpometacarpal joint
M18.1	Other primary osteoarthritis of first carpometacarpal joint
M18.2	Post-traumatic osteoarthritis of first carpometacarpal joint
M18.3	Other post-traumatic osteoarthritis of first carpometacarpal joint
M18.4	Other secondary osteoarthritis of first carpometacarpal joint
M18.5	Other secondary osteoarthritis of first carpometacarpal joint
M18.9	Osteoarthritis of first carpometacarpal joint, unspecified
M19.0	Primary osteoarthritis of other joints
M19.1	Post-traumatic osteoarthritis of other joints
M19.011	Primary OA, right shoulder
M19.012	Primary OA, left shoulder
M19.021	Primary OA, right elbow
M19.031	Primary OA, right wrist
M19.041	Primary OA, right hand
M19.051	Primary OA, right ankle
M19.061	Primary OA, right foot
M19.90	Unspecified OA, unspecified site
<i>Pterygium</i>	
H11.0	Pterygium of eye
<i>Nasal Telangiectasias</i>	
I78.0	Hereditary hemorrhagic telangiectasia
I78.1	Nevus, non-neoplastic
I78.8	Other diseases of capillaries
I78.9	Disease of capillaries, unspecified
<i>Plantar Fascial fibromatosis & Plantar Fasciitis</i>	
M72.2	Plantar fascial fibromatosis
M79.671	Pain in right foot
M79.672	Pain in left foot
M79.673	Pain in unspecified foot
<i>Calcaneal Spur</i>	
M77.30	Calcaneal spur, unspecified foot
M77.31	Calcaneal spur, right foot
M77.32	Calcaneal spur, left foot

Image-Guided Radiation Therapy (IGRT)

Considered not medically necessary when criteria in the applicable policy statements listed above are met:

CPT® Codes	Description
77387	Guidance for localization of target volume for delivery of radiation treatment, includes intrafraction tracking, when performed
77439	Surface radiation therapy; superficial or orthovoltage, image guidance, ultrasound for placement of radiation therapy fields for treatment of cutaneous tumors, per course of treatment

***Note:** Codes may not be all-inclusive. Deleted codes and codes not in effect at the time of service may not be covered.

**To verify authorization requirements for a specific code by plan type, please use the [Pre-authorization Code Check](#).

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Date Created	Date Reviewed	Date Last Revised
12/02/2025	12/02/2025 ^{MPC}	02/03/2026

^{MPC} Medical Policy Committee

Revision History	Description
12/02/2025	MPC approved the updates to the low-dose radiation therapy criteria to clarify when the service is medically necessary and when it is not. Requires 60-day notice, effective May 1, 2026.
02/03/2026	Added the MTAC review for Palmar Fibromatosis (Dupuytren's Contracture)

References:

Canyilmaz E, Canyilmaz F, Aynaci O, Colak F, Serdar L, Uslu GH, Aynaci O, Yoney A. Prospective Randomized Comparison of the Effectiveness of Radiation Therapy and Local Steroid Injection for the Treatment of Plantar Fasciitis. *Int J Radiat Oncol Biol Phys*. 2015 Jul 1;92(3):659-66. doi: 10.1016/j.ijrobp.2015.02.009. Epub 2015 Apr 28. PMID: 25936814.

Ellis MM, Jones LR, Siddiqui F, Sunkara PR, Ozog DM. The Efficacy of Surgical Excision Plus Adjuvant Multimodal Therapies in the Treatment of Keloids: A Systematic Review and Meta-Analysis. *Dermatol Surg*. 2020 Aug;46(8):1054-1059. doi: 10.1097/DSS.0000000000002362. PMID: 32224709.

Hayes, Inc. Hayes Technology Brief. Superficial Radiation Therapy for Treatment of Nonmelanoma Skin Cancer. Retrieved December 15, 2025, from <https://evidence.hayesinc.com/report/htb.superficialskinca4162>

Hayes, Inc. Hayes Evolving Evidence Review. Low-Dose Radiation Therapy for Treatment of Knee Osteoarthritis. Retrieved December 15, 2025, from <https://evidence.hayesinc.com/report/eer.lowdose5964>

Hayes, Inc. Hayes Technology Brief. Radiation Therapy for Prevention of Keloid Scarring. Retrieved December 15, 2025, from <https://evidence.hayesinc.com/report/earb.keloid5803>

Shin JY, Lee JW, Roh SG, Lee NH, Yang KM. A Comparison of the Effectiveness of Triamcinolone and Radiation Therapy for Ear Keloids after Surgical Excision: A Systematic Review and Meta-Analysis. *Plast Reconstr Surg*. 2016 Jun;137(6):1718-1725. doi: 10.1097/PRS.0000000000002165. PMID: 27219228.