PROVIDER NOTIFICATION OF POLICY CRITERIA CHANGE					
POLICY TITLE	**POLICY NUMBER**	**CRITERIA CHANGE**	**MATERIAL AMENDEMENT**	**EFFECTIVE DATE**	**LINK TO FULL POLICY**
Proton and Neutron Beam Radiation Therapy	2008012	Coverage criteria updated: **Head and Neck** For cancers of the nasopharynx, nasal cavity, paranasal sinuses and other accessory sinuses, advanced stage and unresectable head and neck cancers and Oropharyngeal cancers when the following conditions are met: ○ Clinical documentation supporting treatment with conventional or advanced photon-based radiotherapy cannot meet dose-volume constraints for normal tissue radiation tolerance AND ○ The tumors are near critical anatomical structures, such as the orbit, optic nerve, optic chiasm, brainstem, skull base, or cavernous sinus or with intracranial extension.	YES	01/01/2027	https://secure.arkansasbluecross.com/members/report.aspx?policyNumber=2008012
Radiation Therapy for Non-Malignant Disease	2026015	New coverage policy with criteria for radiation therapy for non-malignant disease	YES	01/01/2027	https://secure.arkansasbluecross.com/members/report.aspx?policyNumber=2026015
Low-Dose Radiotherapy (LDRT)	2023016	Effective January 01, 2027, this policy will be re-titled “Radiation Therapy for Skin Cancer.” Coverage criteria updated: Superficial, Orthovoltage, and 2D or 3D Conformal Radiotherapy meets member benefit certificate Primary Coverage Criteria that there be scientific evidence of effectiveness in improving health outcomes or for members with contracts without Primary Coverage Criteria is considered Medically Necessary and is covered for skin cancer when the following criteria are met: To treat the following Nonmelanoma skin cancer (NMSC):	YES	01/01/2027	https://secure.arkansasbluecross.com/members/report.aspx?policyNumber=2023016

		○ Cutaneous basal cell carcinoma (BCC); **or** ○ Cutaneous squamous cell carcinoma (SCC); **or** ○ Cutaneous squamous cell carcinoma (SCC) in situ When EITHER of the following conditions are met: ○ As an alternative to surgery; or ○ As postoperative treatment after surgery when there are positive margins or other high-risk features (eg. positive nodal status, high mitotic rate, Breslow thickness, lymphovascular invasion, perineural invasion and degree of tumor regression) Intensity Modulated Radiation Therapy (IMRT) Radiotherapy meets member benefit certificate Primary Coverage Criteria that there be scientific evidence of effectiveness in improving health outcomes or for members with contracts without Primary Coverage Criteria is considered Medically Necessary and is covered for skin cancer when ANY of the following conditions are met: ○ To treat a skin cancer of the head and neck region when the regional lymphatics will be treated; or ○ To treat cutaneous melanoma when not a candidate for surgery; or ○ To treat a previously irradiated field Brachytherapy Radiotherapy meets member benefit certificate Primary Coverage Criteria that there be scientific evidence of effectiveness in improving health outcomes or for members with contracts without Primary Coverage Criteria is considered Medically Necessary and is covered for skin cancer when EITHER of the following conditions is met:			

		○ To treat a skin cancer which is not amenable to surgery or external beam radiation; or ○ To treat a previously irradiated field			