

## MEDICAL POLICY – 8.01.62

# Electronic Brachytherapy for Nonmelanoma Skin Cancer

BCBSA Ref. Policy: 8.01.62

Effective Date: Oct. 1, 2025

Last Revised: Jan. 1, 2026


Replaces: N/A

RELATED MEDICAL POLICIES:

N/A

Select a hyperlink below to be directed to that section.

[POLICY CRITERIA](#) | [CODING](#) | [RELATED INFORMATION](#)  
[EVIDENCE REVIEW](#) | [REFERENCES](#) | [HISTORY](#)

 Clicking this icon returns you to the hyperlinks menu above.

## Introduction

Brachytherapy is a type of radiation therapy. “Brachy-” means “short,” so brachytherapy is a way of giving radiation that doesn’t travel far through other tissues to reach the cancerous tissue. Electronic brachytherapy is being studied as a treatment for skin cancer other than melanoma. Surgery is usually used to treat nonmelanoma skin cancer. With electronic brachytherapy, a high-dose x-ray is used to deliver radiation directly to the cancerous area. Typically, a mold is made and then placed over the treatment area. A probe — the source of radiation — is inserted into the mold so that the source touches the skin. The radiation is then activated. Once the radiation is delivered, the source is turned off, and the probe and mold are removed. Several sessions are required to complete the treatment. Electronic brachytherapy for nonmelanoma skin cancer is unproven. More studies are needed to see if this treatment is as good as or better than surgery and other types of radiation treatment.

**Note:** The Introduction section is for your general knowledge and is not to be taken as policy coverage criteria. The rest of the policy uses specific words and concepts familiar to medical professionals. It is intended for providers. A provider can be a person, such as a doctor, nurse, psychologist, or dentist. A provider also can be a place where medical care is given, like a hospital, clinic, or lab. This policy informs them about when a service may be covered.

## Policy Coverage Criteria

Treatment	Investigational
<b>Electronic brachytherapy (nonmelanoma skin cancer)</b>	<b>Electronic brachytherapy for the treatment of nonmelanoma skin cancer (e.g., squamous cell and basal cell carcinoma) is considered investigational.</b>

## Coding

Code	Description
<b>CPT</b>	
0394T	High dose rate electronic brachytherapy, skin surface application, per fraction, includes basic dosimetry, when performed (code termed 01/01/26)
77436	Surface radiation therapy; superficial or orthovoltage, treatment planning and simulation-aided field setting (new code effective 01/01/26)
77437	Surface radiation therapy; superficial, delivery, =150 KV, per fraction (e.g., electronic brachytherapy) (new code effective 01/01/26)
77438	Surface radiation therapy; orthovoltage, delivery, >150-500 KV, per fraction (new code effective 01/01/26)
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 (list separately in addition to code for primary procedure) (new code effective 01/01/26)

**Note:** CPT codes, descriptions and materials are copyrighted by the American Medical Association (AMA). HCPCS codes, descriptions and materials are copyrighted by Centers for Medicare Services (CMS).

## Related Information

### Benefit Application

Electronic brachytherapy for the treatment of breast cancer is a covered diagnosis.



### Description

Electronic brachytherapy is a form of radiotherapy designed to deliver high-dose rate radiation to treat nonmelanoma skin cancer (NMSC). This technique focuses a uniform dose of x-ray source radiation to the lesion with the aid of a shielded surface application.

### Background

#### Nonmelanoma Skin Cancer

Squamous cell carcinoma and basal cell carcinoma are the most common types of NMSC in the United States, affecting between 1 million and 3 million people per year<sup>1,2</sup> respectively, and increasing at a rate of 3% to 8% per year.<sup>2</sup> Other types (e.g., T-cell lymphoma, Merkel cell tumor, basosquamous carcinoma, Kaposi sarcoma) are much less common. Skin cancer can affect anyone, regardless of skin color; however, the incidence of skin cancer among non-Hispanic White individuals is approximately 30 times higher than that among non-Hispanic Black or Asian/Pacific Islander individuals.<sup>3</sup> In individuals with darker skin tones, skin cancer is often diagnosed at a later stage when it is more difficult to treat. Additionally, these individuals are prone to skin cancer in areas not commonly exposed to the sun such as the palms of the hands, soles of the feet, the groin, and inside of the mouth.

The primary risk factor for NMSC is sun exposure, with additional risk factors such as toxic exposures, other ionizing radiation exposure, and immunosuppression playing smaller roles.<sup>2</sup> Although these cancers are rarely fatal, they can impact quality of life, functional status, and physical appearance.

### Treatment

In general, the most effective treatment for NMSC is surgical. If surgery is not feasible or preferred, cryosurgery, topical therapy, or radiotherapy can be considered, though the cure rate may be lower.<sup>4</sup> When considering the most appropriate treatment strategy, recurrence rate, preservation of function, individual expectations, and potential adverse events should be considered.

## ***Surgical***

The choice of surgical procedure depends on the histologic type, size and location of the lesion. Individual preferences can also play a factor in surgical decisions due to cosmetic reasons, as well as the consideration of comorbidities and individual risk factors such as anticoagulation. Local excisional procedures, such as electrodesiccation and curettage or cryotherapy, can be used for low-risk lesions, while surgical excision is indicated for lesions that are not low risk. Mohs surgery is an excisional procedure that uses microscopic guidance to achieve greater precision and sparing of normal tissue. In individuals who meet criteria for Mohs surgery, 5-year cure rates for basal cell cancer range from 98% to 99%,<sup>5</sup> making Mohs surgery the preferred procedure for those who qualify.

## ***Radiotherapy***

Radiotherapy is indicated for certain NMSCs not amenable to surgery. In some cases, this is due to the location of the lesion on the eyelid, nose, or other structures that make surgery more difficult, and which may be expected to have a less desirable cosmetic outcome. In other cases, surgery may be relatively contraindicated due to clinical factors such as bleeding risk or advanced age. In elderly individuals with a relatively large tumor that would require extensive excision, the benefit/risk ratio for radiotherapy may be considered favorable. The 5-year control rates for radiotherapy range from 80% to 92%, which is lower than that of surgical excision.<sup>5</sup> A randomized controlled trial by Avril et al (1997) reported that radiotherapy for basal cell carcinoma resulted in greater numbers of persistent and recurrent lesions compared with surgical excision.<sup>6</sup>

When radiotherapy is used for NMSC, the primary modality is external beam radiotherapy. A number of different brachytherapy techniques have also been developed, including low-dose rate systems, iridium-based systems, and high-dose rate systems.<sup>5</sup>

## ***Electronic Brachytherapy***

Electronic brachytherapy is a form of radiotherapy delivered locally, using a miniaturized electronic x-ray source rather than a radionuclide-based source. A pliable mold, constructed of silicone or polymethyl-methacrylate, is fitted to the tumor surface. This mold allows treatment to be delivered to nonflat surfaces such as the nose or ear. A radioactive source is then inserted

into the mold to deliver a uniform radiation dosage directly to the lesion.<sup>5</sup> Multiple treatment sessions within a short time period (typically within a month) are required.

This technique is feasible for well-circumscribed, superficial tumors because it focuses a uniform dose of x-ray source radiation on the lesion with the aid of a shielded surface application. Advantages of this treatment modality compared with standard radiotherapy include a shorter treatment schedule, avoidance of a surgical procedure and hospital stay, less severe side effects because the focused radiation spares healthy tissue and organs, and the avoidance of radioisotopes.<sup>5</sup>

## Summary of Evidence

For individuals who have NMSC who receive electronic brachytherapy, the evidence includes two systematic reviews, a comparative prospective cohort study, and non-comparative observational studies. Relevant outcomes are overall survival, disease-specific survival, change in disease status, and treatment-related morbidity. No controlled trials were identified that have compared electronic brachytherapy with alternative treatment options. A 2016 systematic review of case series found local control rates ranging from 83% to 100% and recurrence rates ranging from 0% to 17%. In most studies, the recurrence rate was less than 5%. A 2019 meta-analysis reported brachytherapy cosmesis grades and 5-year local control rates that were comparable to both MMS and conventional excision. Preliminary results from a prospective matched pair cohort study reported no statistically significant difference in outcomes for the use of electronic brachytherapy compared to MMS in NMSC. In the absence of randomized controlled studies, conclusions cannot be drawn about the efficacy and safety of electronic brachytherapy compared with other treatments for NMSC. Controlled trials are needed in defined populations that compare electronic brachytherapy with alternatives, specifically other forms of radiotherapy or surgical approaches. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

## Ongoing and Unpublished Clinical Trials

Some currently ongoing and unpublished trials that might influence this policy are listed in [Table 1](#).

**Table 1. Summary of Key Ongoing Trials**

NCT No.	Trial Name	Planned Enrollment	Completion Date
<b>Ongoing</b>			
<b>NCT02131805</b>	A Multicenter Pilot Study of Electronic Skin Surface Brachytherapy for Cutaneous Basal Cell and Squamous Cell Carcinoma	36	May 2025
<b>Unpublished</b>			
<b>NCT01016899<sup>a</sup></b>	Xoft Electronic Brachytherapy Clinical Protocol for the Primary Treatment of Non-Melanoma Skin Cancer	187 (actual)	Aug 2013 completed

NCT: national clinical trial.

<sup>a</sup> Denotes industry-sponsored or cosponsored trial

## Practice Guidelines and Position Statements

The purpose of the following information is to provide reference material. Inclusion does not imply endorsement or alignment with the evidence review conclusions.

Guidelines or position statements will be considered for inclusion if they were issued by, or jointly by, a US professional society, an international society with US representation, or National Institute for Health and Care Excellence (NICE). Priority will be given to guidelines that are informed by a systematic review, include strength of evidence ratings, and include a description of management of conflict of interest.

## American Academy of Dermatology

In 2018, the American Academy of Dermatology published guidelines on the management of basal cell carcinoma<sup>4</sup> and the management of squamous cell carcinoma.<sup>21</sup> Electronic brachytherapy was rated as a C recommendation, with a level of evidence of II and III. By comparison, surgery, cryosurgery, topical therapies, and photodynamic therapies are rated as A and B recommendations.

## American Brachytherapy Society

The American Brachytherapy Society issued a consensus statement on electronic brachytherapy following a literature review focused on trials, prospective studies, multi-institutional series, and single institution reports addressing clinical outcomes and toxicities.<sup>22</sup> Due to a lack of comparative data to traditional treatments and limited long-term follow-up, prospective studies with a larger number of individuals undergoing electronic brachytherapy for nonmelanoma skin cancer are recommended. At this time, the statement recommends that treatment with electronic brachytherapy in this individual population should be performed in the context of a clinical registry or trial. This recommendation was reaffirmed in a 2020 American Brachytherapy Society consensus statement on skin brachytherapy.<sup>23</sup>

## American Society for Radiation Oncology

The American Society for Radiation Oncology (ASTRO) issued clinical practice guidelines regarding definitive and postoperative radiation therapy for basal and squamous cell cancers of the skin.<sup>24</sup> Key questions were addressed by a systematic literature review and recommendations were developed via consensus with a modified Delphi approach. Consensus recommendations for specific dose-fractionation schemes are detailed for the definitive and post-operative settings. The guideline also states that appropriate use of any of the four major radiation modalities, including electronically generated low energy sources such as electronic brachytherapy, result in similar local control and cosmetic outcomes. Therefore, "the decision of which modality and fractionation scheme to use should be based on both tumor characteristics (e.g., shape, contour, depth, and location) and normal tissue considerations."

## National Comprehensive Cancer Network

The National Comprehensive Cancer Network guidelines on basal cell carcinoma (v.2.2025)<sup>25</sup> and squamous cell skin cancer (v.2.2025)<sup>26</sup> both contain the following statement on brachytherapy: "There is insufficient long-term efficacy and safety data to support the routine use of electronic surface brachytherapy."

## Medicare National Coverage

There is no national coverage determination.



## Regulatory Status

Electronic brachytherapy systems for the treatment of NMSCs are designed to deliver high-dose rate brachytherapy to treat skin surface lesions. This technique focuses a uniform dose of x-ray source radiation to the lesion with the aid of a shielded surface application. The Superficial X-Ray Radiation Therapy SRT-100 Vision System (Sensus Healthcare), Esteya Electronic Brachytherapy System (Nucletron BV [now Elekta]) and the Xofig Axxent Electronic Brachytherapy System (iCAD; now Elekta Xofig Axxent Electronic Brachytherapy (eBx) System [Elekta]) are systems that have been cleared for marketing by the US Food and Drug Administration (FDA) through the 510(k) process.

FDA product code: JAD.

## References

1. Bhatnagar A. Nonmelanoma skin cancer treated with electronic brachytherapy: results at 1 year. *Brachytherapy*. 2013; 12(2): 134-40. PMID 23312675
2. Madan V, Lear JT, Szeimies RM. Non-melanoma skin cancer. *Lancet*. Feb 20 2010; 375(9715): 673-85. PMID 20171403
3. American Academy of Dermatology Association. Skin cancer. Updated March 25, 2025. <https://www.aad.org/media/stats-skin-cancer>. Accessed August 8, 2025.
4. Kim JYS, Kozlow JH, Mittal B, et al. Guidelines of care for the management of basal cell carcinoma. *J Am Acad Dermatol*. Mar 2018; 78(3): 540-559. PMID 29331385
5. Alam M, Nanda S, Mittal BB, et al. The use of brachytherapy in the treatment of nonmelanoma skin cancer: a review. *J Am Acad Dermatol*. Aug 2011; 65(2): 377-388. PMID 21496952
6. Avril MF, Auperin A, Margulis A, et al. Basal cell carcinoma of the face: surgery or radiotherapy? Results of a randomized study. *Br J Cancer*. 1997; 76(1): 100-6. PMID 9218740
7. Lee CT, Lehrer EJ, Aphale A, et al. Surgical excision, Mohs micrographic surgery, external-beam radiotherapy, or brachytherapy for indolent skin cancer: An international meta-analysis of 58 studies with 21,000 patients. *Cancer*. Oct 15 2019; 125(20): 3582-3594. PMID 31355928
8. Delishaj D, Rembielak A, Manfredi B, et al. Non-melanoma skin cancer treated with high-dose-rate brachytherapy: a review of literature. *J Contemp Brachytherapy*. Dec 2016; 8(6): 533-540. PMID 28115960
9. Patel R, Strimling R, Doggett S, et al. Comparison of electronic brachytherapy and Mohs micrographic surgery for the treatment of early-stage non-melanoma skin cancer: a matched pair cohort study. *J Contemp Brachytherapy*. Aug 2017; 9(4): 338-344. PMID 28951753
10. Cox JD, Stetz J, Pajak TF. Toxicity criteria of the Radiation Therapy Oncology Group (RTOG) and the European Organization for Research and Treatment of Cancer (EORTC). *Int J Radiat Oncol Biol Phys*. Mar 30 1995; 31(5): 1341-6. PMID 7713792





11. Cheng J, Henry GV, Lyden MR, et al. The Elekta Esteya ® electronic brachytherapy system in non-melanoma skin cancers: A post-market observational study. *J Contemp Brachytherapy*. Dec 2024; 16(6): 478-488. PMID 39943976
12. Doggett SW, Willoughby M, Miller KA, et al. Long-term clinical outcomes of non-melanoma skin cancer patients treated with electronic brachytherapy. *J Contemp Brachytherapy*. Feb 2023; 15(1): 9-14. PMID 36970438
13. Kuo AM, Lee EH, Rossi AM, et al. A Multicenter Prospective Trial of Electronic Skin Surface Brachytherapy for Keratinocyte Carcinoma: Early Cosmesis, Quality of Life, and Adverse Events. *Int J Radiat Oncol Biol Phys*. Jul 01 2023; 116(3): 544-550. PMID 36586493
14. Pellizzon ACA, Fogaroli R, Chen MJ, et al. High-dose-rate brachytherapy using Leipzig applicators for non-melanoma localized skin cancer. *J Contemp Brachytherapy*. Oct 2020; 12(5): 435-440. PMID 33299432
15. Paravati AJ, Hawkins PG, Martin AN, et al. Clinical and cosmetic outcomes in patients treated with high-dose-rate electronic brachytherapy for nonmelanoma skin cancer. *Pract Radiat Oncol*. 2015; 5(6): e659-64. PMID 26432680
16. Delishaj D, Laliscia C, Manfredi B, et al. Non-melanoma skin cancer treated with high-dose-rate brachytherapy and Valencia applicator in elderly patients: a retrospective case series. *J Contemp Brachytherapy*. Dec 2015; 7(6): 437-44. PMID 26816500
17. Tormo A, Celada F, Rodriguez S, et al. Non-melanoma skin cancer treated with HDR Valencia applicator: clinical outcomes. *J Contemp Brachytherapy*. Jun 2014; 6(2): 167-72. PMID 25097557
18. Bhatnagar A, Loper A. The initial experience of electronic brachytherapy for the treatment of non-melanoma skin cancer. *Radiat Oncol*. Sep 28 2010; 5: 87. PMID 20875139
19. Gauden R, Pracy M, Avery AM, et al. HDR brachytherapy for superficial non-melanoma skin cancers. *J Med Imaging Radiat Oncol*. Apr 2013; 57(2): 212-7. PMID 23551783
20. Guix B, Finestres F, Tello J, et al. Treatment of skin carcinomas of the face by high-dose-rate brachytherapy and custom-made surface molds. *Int J Radiat Oncol Biol Phys*. Apr 01 2000; 47(1): 95-102. PMID 10758310
21. Kim JYS, Kozlow JH, Mittal B, et al. Guidelines of care for the management of cutaneous squamous cell carcinoma. *J Am Acad Dermatol*. Mar 2018; 78(3): 560-578. PMID 29331386
22. Tom MC, Hepel JT, Patel R, et al. The American Brachytherapy Society consensus statement for electronic brachytherapy. *Brachytherapy*. 2019; 18(3): 292-298. PMID 30497939
23. Shah C, Ouhib Z, Kamrava M, et al. The American Brachytherapy society consensus statement for skin brachytherapy. *Brachytherapy*. 2020; 19(4): 415-426. PMID 32409128
24. Likhacheva A, Awan M, Barker CA, et al. Definitive and Postoperative Radiation Therapy for Basal and Squamous Cell Cancers of the Skin: Executive Summary of an American Society for Radiation Oncology Clinical Practice Guideline. *Pract Radiat Oncol*. 2020; 10(1): 8-20. PMID 31831330
25. National Comprehensive Cancer Network (NCCN). NCCN Clinical Practice Guidelines in Oncology: Basal Cell Skin Cancer. Version 2.2025. [https://www.nccn.org/professionals/physician\\_gls/pdf/nmsc.pdf](https://www.nccn.org/professionals/physician_gls/pdf/nmsc.pdf). Accessed August 8, 2025.
26. National Comprehensive Cancer Network (NCCN). NCCN Clinical Practice Guidelines in Oncology: Squamous Cell Skin Cancer. Version 2.2025. [https://www.nccn.org/professionals/physician\\_gls/pdf/squamous.pdf](https://www.nccn.org/professionals/physician_gls/pdf/squamous.pdf). Accessed August 8, 2025.

## History



Date	Comments
07/14/15	New Policy. Policy created with literature review through April 30, 2015. Electronic brachytherapy is considered investigational for the treatment of nonmelanoma skin cancer.
01/20/16	Coding update. New CPT codes 0394T-0395T, effective 1/1/16, added to policy.
10/01/16	Annual Review, approved September 13, 2016. Policy created with literature review through June 13, 2016; references 9-10 added. Added delete date in coding section. Policy statement unchanged.
09/01/17	Annual Review, approved August 22, 2017. Policy created with literature review through June 6, 2017; reference 6 added. Policy statement unchanged.
10/01/18	Annual Review, approved September 20, 2018. Policy created with literature review through May 2018; references 3 and 15 added. Policy statement unchanged.
03/01/19	Coding update, removed CPT code 0395T.
10/01/19	Annual Review, approved September 5, 2019. Policy updated with literature review through May 2019; references added and updated. Policy statement unchanged.
10/01/20	Annual Review, approved September 17, 2020. Policy updated with literature review through April 2020; no references added. Policy statement unchanged.
10/01/21	Annual Review, approved September 2, 2021. Policy updated with literature review through June 6, 2021; references added. Policy statement unchanged.
09/01/22	Annual Review, approved August 22, 2022. Policy updated with literature review through May 24, 2022; reference added. Policy statement unchanged.
10/01/23	Annual Review, approved September 11, 2023. Changed the wording from "patient" to "individual" throughout the policy for standardization. Policy updated with literature review through May 18, 2023; references added. Policy statement unchanged.
10/01/24	Annual Review, approved September 9, 2024. Policy updated with literature review through May 30, 2024; Policy statement unchanged.
10/01/25	Annual Review, approved September 8, 2025. Policy updated with literature review through May 27, 2025; reference added. Policy statement unchanged.
01/01/26	Coding update. Added new CPT codes 77436, 77437, 77438, and 77439 which replace CPT code 0394T effective January 1, 2026.

**Disclaimer:** This medical policy is a guide in evaluating the medical necessity of a particular service or treatment. The Company adopts policies after careful review of published peer-reviewed scientific literature, national guidelines and local standards of practice. Since medical technology is constantly changing, the Company reserves the right to review and update policies as appropriate. Member contracts differ in their benefits. Always consult the member benefit booklet or contact a member service representative to determine coverage for a specific medical service or supply. CPT codes, descriptions and materials are copyrighted by the American Medical Association (AMA). ©2026 Premera All Rights Reserved.



**Scope:** Medical policies are systematically developed guidelines that serve as a resource for Company staff when determining coverage for specific medical procedures, drugs or devices. Coverage for medical services is subject to the limits and conditions of the member benefit plan. Members and their providers should consult the member benefit booklet or contact a customer service representative to determine whether there are any benefit limitations applicable to this service or supply. This medical policy does not apply to Medicare Advantage.

