



## **Stereotactic Radiosurgery (SRS) and Stereotactic Body Radiotherapy (SBRT)**

### **I. Policy**

University Health Alliance (UHA) will reimburse for stereotactic radiosurgery (SRS) and stereotactic body radiotherapy (SBRT) when it is determined to be medically necessary and when it meets the medical criteria guidelines (subject to limitations and exclusions) indicated below.

### **II. Criteria/Guidelines**

- A. SRS/SBRT for CNS/Head/Spine are covered (subject to Limitations/Exclusions and Administrative Guidelines) for the following circumstances:
1. Primary central nervous system malignancies, generally used as a boost or salvage therapy for lesions < 5 cm. Primary malignancies of the central nervous system (CNS), including but not limited to, high-grade gliomas (initial treatment or treatment of recurrence).
  2. Primary and secondary tumors involving the brain or spine parenchyma, meninges/dura, or immediately adjacent bony structures.
  3. Benign brain tumors and spinal tumors such as meningiomas, acoustic neuromas, other schwannomas, pituitary adenomas, pineocytomas, craniopharyngiomas, glomus tumors, hemangioblastomas.
  4. Cranial arteriovenous malformations, cavernous malformations, and hemangiomas.
  5. Other cranial non-neoplastic conditions such as trigeminal neuralgia. As a boost treatment for larger cranial or spinal lesions that have been treated initially with external beam radiation therapy or surgery (e.g., sarcomas, chondrosarcomas, chordomas, and nasopharyngeal or paranasal sinus malignancies).
  6. Metastatic brain or spine lesions, with stable systemic disease, Karnofsky performance status 40 or greater (or expected to return to 70 or greater with treatment), and otherwise reasonable survival expectations, or an eastern cooperative oncology group (ECOG) performance status of 3 or less (or expected to return to 2 or less with treatment) (See SBRT spine criteria).
  7. Relapse in a previously irradiated cranial or spinal field where the additional stereotactic precision is required to avoid unacceptable vital tissue radiation.
  8. Refractory movement disorders.
- B. Lesions which have received previous radiotherapy or are immediately adjacent to previously irradiated fields, where the additional precision of stereotactic radiotherapy is required to avoid unacceptable tissue radiation will be covered when other conditions of coverage are met (limitations) and this necessity is documented in the medical record.
- C. SBRT is covered (subject to Limitations/Exclusions and Administrative Guidelines) for the following indications:
1. Patients with stage T1 or T2a non-small cell lung cancer (not larger than 5 cm in diameter) showing no nodal or distant disease and who are not candidates for surgical resection
  2. Spinal or vertebral body tumors (metastatic or primary) in patients who have received prior radiation therapy

3. Spinal or vertebral metastases that are radio-resistant (e.g., renal cell carcinoma, melanoma and sarcoma)
- D. Fractionation may be medically necessary when stereotactic radiosurgery or stereotactic body radiotherapy are performed using fractionation for covered indications described above

**NOTE:**

*This UHA payment policy is a guide to coverage, the need for prior authorization and other administrative directives. It is not meant to provide instruction in the practice of medicine, and it should not deter a provider from expressing his/her judgment.*

*Even though this payment policy may indicate that a particular service or supply is considered covered, specific provider contract terms and/or member's individual benefit plans may apply, and this policy is not a guarantee of payment. UHA reserves the right to apply this payment policy to all UHA companies and subsidiaries.*

*UHA understands that opinions about and approaches to clinical problems may vary. Questions concerning medical necessity (see Hawaii Revised Statutes §432E-1.4) are welcome. A provider may request that UHA reconsider the application of the medical necessity criteria in light of any supporting documentation.*

### **III. Limitations/Exclusions**

- A. Applications of SRS that are not covered include, but are not limited to, the treatment of seizures and functional disorders (other than trigeminal neuralgia and refractory movement disorders), including chronic pain, and uveal melanoma as it is not known to be effective in improving health outcomes.
- B. SBRT is not covered as it has not been shown to improve health outcomes in the treatment of primary and metastatic tumors of the liver, pancreas, kidney, prostate and adrenal glands.
- C. SRS is not covered in the following circumstances as it is not known to be effective in improving health outcomes.
  1. Treatment for anything other than a severe symptom or serious threat to life or critical functions.
  2. Treatment unlikely to result in functional improvement or clinically meaningful disease stabilization, not otherwise achievable.
  3. Patients with wide-spread cerebral or extra-cranial metastases with limited life expectancy unlikely to gain clinical benefit within their remaining life.
  4. Patients with poor performance status (*Karnofsky Performance Status* less than 40 or an *ECOG performance* greater than 3)
  5. Lesions of bone, breast, uterus, ovary and other internal organs not listed are not covered for primary definitive SBRT as literature does not support improved health outcomes over other conventional radiation modalities but may be appropriate for SBRT in the setting of recurrence after conventional modalities.
- D. Due to the rapidly evolving nature and technology of SRS and SBRT; patients meeting all eligibility and inclusion criteria in the latest edition of the NCCN guidelines, recommendation strength 2a and above, may be eligible to have SRS/SBRT covered on a case by case basis.

### **IV. Administrative Guidelines**

- A. Prior authorization is required.



- B. To request prior authorization, please submit via UHA's online portal. If a login has not been established, you may contact UHA at 808-532-4000 to establish one.
- C. Requests must include the radiation oncologist's consultation notes.
- D. This policy may apply to the following codes. Inclusion of a code in the table below does not guarantee that it will be reimbursed.

CPT Code	Description
61796	Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); 1 simple cranial lesion
61797	Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); each additional cranial lesion, simple (List separately in addition to code for primary procedure)
61798	Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); 1 complex cranial lesion
61799	Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); each additional cranial lesion, complex (List separately in addition to code for primary procedure)
61800	Application of stereotactic headframe for stereotactic radiosurgery (List separately in addition to code for primary procedure)
63620	Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); 1 spinal lesion
63621	Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); each additional spinal lesion (List separately in addition to code for primary procedure)
77371	Radiation treatment delivery, stereotactic radiosurgery (SRS), complete course of treatment of cranial lesion(s) consisting of 1 session; multi-source Cobalt 60 based
77372	Radiation treatment delivery, stereotactic radiosurgery (SRS), complete course of treatment of cranial lesion(s) consisting of 1 session; linear accelerator based
77373	Stereotactic body radiation therapy, treatment delivery, per fraction to 1 or more lesions, including image guidance, entire course not to exceed 5 fractions
77432	Stereotactic radiation treatment management of cranial lesion(s) (complete course of treatment consisting of 1 session)
77435	Stereotactic body radiation therapy, treatment management, per treatment course, to 1 or more lesions, including image guidance, entire course not to exceed 5 fractions

HCPCS Code	Description
G0339	Image-guided robotic linear accelerator-based stereotactic radiosurgery, complete course of therapy in one session of fractionated treatment
G0340	Image-guided robotic linear accelerator-based stereotactic radiosurgery, delivery including collimator changes and custom plugging, fractionated treatment, all lesions, per session, second through fifth sessions, maximum 5 sessions per course of treatment

## V. Policy History

**Policy Number:** MPP-0030-120301

**Current Effective Date:** 08/01/2022

**Original Document Effective Date:** 03/01/2012

**Previous Revision Dates:** 06/12/2018, 07/03/2019

**PAC Approved Date:** 03/01/2012