Stereotactic Radiosurgery (SRS) and Fractionated Stereotactic Body Radiotherapy (SRBT)

I. Policy

University Health Alliance (UHA) will reimburse for stereotactic radiosurgery and fractionated stereotactic radiotherapy 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 utilizing a gamma-ray or linear-accelerator unit is covered (subject to Limitations/Exclusions and Administrative Guidelines) for the following indications:
   1. Arteriovenous malformations (AVMs)
   2. Acoustic neuromas
   3. Pituitary adenomas
   4. Primary malignancies of the central nervous system, including but not limited to high grade gliomas
   5. Solitary or multiple brain metastases in patients having good performance status and no active systemic disease (defined as extracranial disease that is stable or in remission)
   6. Primary and secondary tumors of the skull base
   7. Nasopharyngeal, oropharyngeal and high hypopharyngeal malignancies, spinal cord and meninges
   8. Primary central nervous system malignancies or metastatic brain lesions
   9. Patients with disabling symptoms from Parkinson's disease refractory to conventional therapies
   10. Patients with trigeminal neuralgia not responsive to other modalities

B. 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 because of co-morbid conditions
   2. Spinal or vertebral body tumors (metastatic or primary) in patients who have received prior radiation therapy

C. 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, including chronic pain.

B. SBRT has not been shown to improve health outcomes in the treatment of extracranial sites, except for cases of spinal tumors after prior radiation therapy and stage 1 non-small cell lung cancer as noted above.

IV. Administrative Guidelines

A. Prior authorization is required.

B. To request prior authorization, please go to UHA’s website: http://www.uhahealth.com/forms/form_request_auth.pdf and submit it:

   Via Fax: 1-866-572-4384

   Via Mail:
   UHA Health Care Services
   700 Bishop Street, Suite 300
   Honolulu, HI 96813

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.

<table>
<thead>
<tr>
<th>CPT Codes</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>61796</td>
<td>Stereotactic radiosurgery (particle beam, gamma ray or linear accelerator), 1 simple cranial lesion</td>
</tr>
<tr>
<td>61797</td>
<td>each additional cranial lesion, simple (list separately in addition to code for primary procedure)</td>
</tr>
<tr>
<td>61798</td>
<td>Stereotactic radiosurgery (particle beam, gamma ray or linear accelerator), 1 complex cranial lesion</td>
</tr>
<tr>
<td>61799</td>
<td>each additional cranial lesion, complex (list separately in addition to code for primary procedure)</td>
</tr>
<tr>
<td>61800</td>
<td>Application of stereotactic headframe for stereotactic radiosurgery (list separately in addition to code for primary procedure)</td>
</tr>
<tr>
<td>63620</td>
<td>Stereotactic radiosurgery (particle beam, gamma ray or linear accelerator); 1 spinal lesion</td>
</tr>
<tr>
<td>63621</td>
<td>each additional spinal lesion (list separately in addition to code for primary procedure)</td>
</tr>
<tr>
<td>77371</td>
<td>Radiation treatment delivery, stereotactic radiosurgery (SRS), complete course of treatment of cerebral lesion(s) consisting of 1 session; multi-source Cobalt 60 based</td>
</tr>
<tr>
<td>77372</td>
<td>linear accelerator based</td>
</tr>
</tbody>
</table>
### HCPCS Code Description

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>G0173</td>
<td>Linear accelerator based stereotactic radiosurgery, complete course of therapy in one session</td>
</tr>
</tbody>
</table>

### V. Policy History

- **Policy Number:** M.RAD.05.120301
- **Current Effective Date:** 03/01/2012
- **Original Document Effective Date:** 03/01/2012
- **Previous Revision Dates:** N/A