

**Policy: MP084**

**Section: Medical Benefit Policy**

**Subject: Stereotactic Radiosurgery and Stereotactic Body Radiation Therapy**

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**I. Policy:** Stereotactic Radiosurgery (SRS) and Stereotactic Body Radiation Therapy (SBRT)

**II. Purpose/Objective:**

To provide a policy of coverage regarding Stereotactic Radiosurgery (SRS) and Stereotactic Body Radiation Therapy (SBRT)

**III. Responsibility:**

- A. Medical Directors
- B. Medical Management

**IV. Required Definitions**

1. Attachment – a supporting document that is developed and maintained by the policy writer or department requiring/authoring the policy.
2. Exhibit – a supporting document developed and maintained in a department other than the department requiring/authoring the policy.
3. Devised – the date the policy was implemented.
4. Revised – the date of every revision to the policy, including typographical and grammatical changes.
5. Reviewed – the date documenting the annual review if the policy has no revisions necessary.

**V. Additional Definitions**

Medical Necessity or Medically Necessary means Covered Services rendered by a Health Care Provider that the Plan determines are:

- a. appropriate for the symptoms and diagnosis or treatment of the Member's condition, illness, disease or injury;
- b. provided for the diagnosis, and the direct care and treatment of the Member's condition, illness disease or injury;
- c. in accordance with current standards of good medical treatment practiced by the general medical community.
- d. not primarily for the convenience of the Member, or the Member's Health Care Provider; and
- e. the most appropriate source or level of service that can safely be provided to the Member. When applied to hospitalization, this further means that the Member requires acute care as an inpatient due to the nature of the services rendered or the Member's condition, and the Member cannot receive safe or adequate care as an outpatient.

**Medicaid Business Segment**

Medical Necessity shall mean a service or benefit that is compensable under the Medical Assistance Program and if it meets any one of the following standards:

- (i) The service or benefit will, or is reasonably expected to, prevent the onset of an illness, condition or disability.
- (ii) The service or benefit will, or is reasonably expected to, reduce or ameliorate the physical, mental or development effects of an illness, condition, injury or disability.
- (iii) The service or benefit will assist the Member to achieve or maintain maximum functional

capacity in performing daily activities, taking into account both the functional capacity of the Member and those functional capacities that are appropriate for members of the same age.

**DESCRIPTION:**

Stereotactic radiosurgery and Stereotactic Body Radiation Therapy are a non-invasive method of delivering high doses of ionizing radiation utilizing three-dimensional planning of stereotactic and convergent beam technologies to small intracranial, some extracranial lesions, and tissues or lesions that may be inaccessible or unsuitable for open surgery. Stereotactic radiosurgery entails delivering highly focused convergent beams in a single session or multiple sessions (fractionated stereotactic radiotherapy) so that only the desired target is radiated, sparing adjacent structures. Four main methods of this technology exist: gamma-ray radiosurgery (e.g. Cyberknife or Gamma Knife®), linear accelerator radiosurgery (Linac), helium-ion radiosurgery, and neutron-beam radiosurgery. The four radiation delivery devices differ technically in several ways: source of radiation, size and shape of the radiation field, and range of radiation dosages. Other frameless systems involve the use of image-guided robotics, including Cyberknife, Neuromate and Mehrkoordinaten Manipulator (MKM), which recognizes the treatment sites by integrating images from preoperative CT and MRI techniques with intraoperative target localization tactics.

**INDICATIONS:**

Stereotactic radiosurgery or stereotactic body radiation therapy for treatment of the following lesions may be considered medically necessary:

- Angiographically visible arteriovenous malformations that because of their location, cannot be excised without a significant risk of serious neurological sequelae
- Acoustic neuromas (Schwannoma)
- Pituitary adenomas (e.g. Cushing's disease or acromegaly)
- Pineal tumors
- Non-resectable, residual, or recurrent meningiomas less than 4 cm in diameter
- Solitary or multiple brain metastases associated with good performance status and no active systemic disease
- Intracranial tumors that are not amenable to surgical excision or other conventional forms of treatment, for local tumor control, or for non-operative skull base sarcomas
- High-grade gliomas (primary or recurrent less than 4 cm in diameter) or Oligodendrogliomas
- Craniopharyngiomas
- Nasopharyngeal or paranasal tumors
- Spinal and paraspinal tumors
- Trigeminal neuralgia refractory to aggressive pharmacological medical management
- Ocular melanoma
- Chordomas
- Mediastinal tumors
- Pulmonary tumors
- Retroperitoneal metastases
- Hepatic tumors
- Pancreatic tumors
- Paragangliomas
- Essential tremor coverage is limited to patients who cannot be controlled with medication, has major systemic disease or coagulopathy, and who is unwilling or unsuited for open surgery or Deep Brain Stimulation. Coverage is limited to unilateral thalamotomy
- Renal cell carcinoma
- Non-small cell lung cancer (NSCLC) or pulmonary metastasis
- Refractory mesial temporal lobe epilepsy if standard surgery is contraindicated or not an option

\*For information regarding Proton Beam Radiation, please see MP226 – Proton Beam Radiation.

**EXCLUSIONS:**

Stereotactic radiosurgery by any method for treatment of the following lesions is considered experimental, investigational or unproven:

- Intractable pain (except for tic douloureux/trigeminal neuralgia)
- Psychoses and psychiatric illness
- Seizures other than noted under Indications

**Note: A complete description of the process by which a given technology or service is evaluated and determined to be experimental, investigational or unproven is outlined in MP 15 - Experimental Investigational or Unproven Services or Treatment.**

**CODING ASSOCIATED WITH:** Stereotactic Radiosurgery (SRS) and Stereotactic Body Radiation Therapy (SBRT)

***The following codes are included below for informational purposes and may not be all inclusive. Inclusion of a procedure or device code(s) does not constitute or imply coverage nor does it imply or guarantee provider reimbursement. Coverage is determined by the member specific benefit plan document and any applicable laws regarding coverage of specific services. Please note that per Medicare coverage rules, only specific CPT/HCPCS Codes may be covered for the Medicare Business Segment. Please consult the CMS website at [www.cms.gov](http://www.cms.gov) or the local Medicare Administrative Carrier (MAC) for more information on Medicare coverage and coding requirements.***

- 20660 Application of cranial tongs, caliper, or stereotactic frame including removal
- 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
- 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
- 61800 Application of stereotactic headframe for stereotactic radiosurgery
- 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
- 77331 Special dosimetry only when prescribed by the treating physician
- 77370 Special medical radiation physics consultation
- 77371 Radiation treatment delivery, stereotactic radiosurgery (SRS), complete course of treatment of cerebral lesion(s) consisting of 1 session, multi-source Cobalt 60 based
- 77372 Radiation treatment delivery, stereotactic radiosurgery (SRS), complete course of treatment of cerebral lesion(s) consisting of 1 session, linear accelerator based
- 77373 Radiation treatment delivery, stereotactic radiosurgery (SRS), treatment delivery, per fraction to 1 or more lesions, including image guidance, entire course not to exceed 5 fractions
- 77435 Radiation treatment delivery, stereotactic radiosurgery (SRS), treatment management, per treatment course, to one or more lesions, including image guidance, entire course not to exceed 5 fractions
- 77432 Stereotactic radiation treatment management of cerebral lesion(s) (complete course of treatment consisting of one treatment)
- C9728 Placement of interstitial device(s) for radiation therapy/surgery guidance (eg, fiducial markers, dosimeter), other than prostate (any approach), single or multiple
- G0173 Stereotactic radiosurgery, complete course of therapy in one session.
- G0242 Multi-source photon stereotactic radiosurgery plan
- G0243 Multi-source photon stereotactic radiosurgery delivery
- G0251 Linear accelerator based stereotactic radiosurgery, delivery including collimator changes and custom plugging, fractionated treatment, all lesions, per session, maximum five sessions per course of treatment.
- G0338 Linear accelerator based stereotactic radiosurgery plan including dose volume histograms for target and critical structure tolerances, plan optimization performed for highly conformal distributions, plan positional accuracy and dose verification, all lesions
- G0339 Image guided robotic linear accelerator based stereotactic radiosurgery, complete course of therapy in one session, or first 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 five sessions per course of treatment

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**LINE OF BUSINESS:**

**Eligibility and contract specific benefits, limitations and/or exclusions will apply. Coverage statements found in the line of business specific benefit document will supersede this policy. For Medicare, applicable LCD's and NCD's will supersede this policy. For PA Medicaid Business segment, this policy applies as written.**

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**Devised:** 12/96

**Revised:** 7/97, 2/03, 2/04, 2/05, 2/06, 2/07 (coding);2/08 (Add'l indications added) ; 3/09 (wording,coding); 4/11 (indication revision), 4/12 (essential tremor indication added); 6/12 (add stereotactic body radiation therapy), 6/13 (added indications); 5/15 (removed auth); 5/20(add indication, exclusion)

**Reviewed:** 4/10, 6/14, 6/15, 6/16, 5/17, 5/18, 5/19

Geisinger Health Plan may refer collectively to health care coverage sponsors Geisinger Health Plan, Geisinger Quality Options, Inc., and Geisinger Indemnity Insurance Company, unless otherwise noted. Geisinger Health Plan is part of Geisinger, an integrated health care delivery and coverage organization.