Medical Necessity Guidelines:
Stereotactic Radiosurgery and Stereotactic Body Radiotherapy

Effective: October 21, 2020

Prior Authorization Required If REQUIRED, submit supporting clinical documentation pertinent to service request.	**Yes ☒ No ☐**

Applies to:

COMMERCIAL Products

☒ Tufts Health Plan Commercial products; Fax: 617.972.9409

☒ Tufts Health Freedom Plan products; Fax: 617.972.9409

- CareLink℠ – Refer to CareLink Procedures, Services and Items Requiring Prior Authorization

TUFTS HEALTH PUBLIC PLANS Products

☒ Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product); Fax:888.415.9055

☒ Tufts Health Together – MassHealth MCO Plan and Accountable Care Partnership Plans; Fax: 888.415.9055

☒ Tufts Health RITogether – A Rhode Island Medicaid Plan; Fax: 857.304.6404

☒ Tufts Health Unify* – OneCare Plan (a dual-eligible product); Fax: 857.304.6304

*The MNG applies to Tufts Health Unify members unless a less restrictive LCD or NCD exists.

SENIOR Products

- Tufts Health Plan Senior Care Options (SCO), (a dual-eligible product) – Refer to the Tufts Health Plan SCO Prior Authorization List
- Tufts Medicare Preferred HMO, (a Medicare Advantage product) – Refer to the Tufts Medicare Preferred HMO Prior Authorization and Inpatient Notification List

Note: While you may not be the provider responsible for obtaining prior authorization, as a condition of payment you will need to make sure that prior authorization has been obtained.

OVERVIEW

Stereotactic Radiosurgery (SRS) is a procedure that involves the precise three-dimensional targeting of ionizing radiation to obliterate abnormal tissues such as vascular malformations, malignant or benign tumors, and malfunctioning neural tissue related to diseases such as trigeminal neuralgia, essential tremor or Parkinson's disease. The objective of SRS is to cause destruction of the target tissue while minimizing the amount of radiation delivered to the surrounding normal tissue (Hayes, Inc., 2006).

CLINICAL COVERAGE CRITERIA

Tufts Health Plan may authorize the coverage of stereotactic radiosurgery (SRS) or stereotactic body radiation therapy (SBRT) when the Member has **ONE** of the following diagnoses:

- Small intracranial or spinal arteriovenous malformations in members considered poor surgical candidates
- Primary intracranial tumors not suitable for complete surgical resection and/or in members who have failed conventional therapy
- Single or multiple metastatic brain lesions
- Vestibular Schwanoma or acoustic neurofibromatosis not amenable to surgical resection
- Pituitary Adenoma
- Acoustic neuroma
- Trigeminal neuralgia and glossopharyngeal neuralgia refractory to either carbamazepine or oxcarbazepine
- Low to intermediate risk prostate cancer (Up to six treatment sessions may be authorized for this diagnosis.)
- Stage I or II non-small cell lung cancer when the disease is inoperable or as an alternative to surgery for Members who are a high surgical risk or who refuse surgery after surgical consultation.

LIMITATIONS

The use of stereotactic radiotherapy for indications other than those listed above is considered investigational and, therefore, not medically necessary, including but not limited to:

- Noninvasive cardiac radioablation using stereotactic radiotherapy for the treatment of ventricular tachycardia

CODES

The following CPT code(s) require prior authorization:

Table 1: CPT Codes

Code	Description
32701	Thoracic target(s) delineation for stereotactic body radiation therapy (SRS/SBRT), (photon or particle beam), entire course of treatment
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
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
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

Below are the diagnosis codes associated with the above procedures:

Table 2: ICD-10 Codes

ICD-10 Code	Description
C34.00	Malignant neoplasm of unspecified main bronchus
C34.01	Malignant neoplasm of right main bronchus
C34.02	Malignant neoplasm of left main bronchus
C34.10	Malignant neoplasm of upper lobe, unspecified bronchus or lung
C34.11	Malignant neoplasm of upper lobe, right bronchus or lung

ICD-10 Code	Description
C34.12	Malignant neoplasm of upper lobe, left bronchus or lung
C34.2	Malignant neoplasm of middle lobe, bronchus or lung
C34.30	Malignant neoplasm of lower lobe, unspecified bronchus or lung
C34.31	Malignant neoplasm of lower lobe, right bronchus or lung
C34.32	Malignant neoplasm of lower lobe, left bronchus or lung
C34.80	Malignant neoplasm of overlapping sites of unspecified bronchus and lung
C34.81	Malignant neoplasm of overlapping sites of right bronchus and lung
C34.82	Malignant neoplasm of overlapping sites of left bronchus and lung
C34.90	Malignant neoplasm of unspecified part of unspecified bronchus or lung
C34.91	Malignant neoplasm of unspecified part of right bronchus or lung
C34.92	Malignant neoplasm of unspecified part of left bronchus or lung
C61	Malignant neoplasm of prostate
C71.0	Malignant neoplasm of cerebrum, except lobes and ventricles
C71.1	Malignant neoplasm of frontal lobe
C71.2	Malignant neoplasm of temporal lobe
C71.3	Malignant neoplasm of parietal lobe
C71.4	Malignant neoplasm of occipital lobe
C71.5	Malignant neoplasm of cerebral ventricle
C71.6	Malignant neoplasm of cerebellum
C71.7	Malignant neoplasm of brain stem
C71.8	Malignant neoplasm of overlapping sites of brain
C71.9	Malignant neoplasm of brain, unspecified
C79.31	Secondary malignant neoplasm of brain
D33.3	Benign neoplasm of cranial nerves
D35.2	Benign neoplasm of pituitary gland
D35.3	Benign neoplasm of craniopharyngeal duct
G50.0	Trigeminal neuralgia
G52.1	Disorders of glossopharyngeal nerve
Q28.2	Arteriovenous malformation of cerebral vessels
Q28.3	Other malformations of cerebral vessels
Q85.02	Neurofibromatosis, type 2

REFERENCES

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3. Hayes, Inc. Proton beam therapy. Hayes Directory. May 24, 2004.
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8. Hayes, Inc. Spinal applications for stereotactic surgery. Hayes Directory. Update Search. March 1, 2008.
9. Hayes, Inc. Stereotactic radiosurgery for arteriovenous malformations and intracranial tumors. Hayes Directory. January 8, 2009. Update Search. February 19, 2013.
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11. National Comprehensive Cancer Network. Clinical Practice Guidelines in Oncology (NCCN Guidelines®): Non-Small Cell Lung Cancer, Version 4.2016. Accessed September 6, 2016 at nccn.org.
12. Hayes, Inc.. Noninvasive Cardiac Radioablation for Ventricular Tachycardia. Hayes Clinical Research Response. August 16, 2018. Last accessed November 7, 2018 at Hayesinc.com.

APPROVAL HISTORY

October 16, 2006: Reviewed by the Medical Technology Assessment Committee

Subsequent endorsement date(s) and changes made:

- July 1, 2007: Criteria approved by Medical Affairs Medical Policy Committee on June 22, 2007.
- May 30, 2008: Reviewed and coding verified.
- October 1, 2008: Codes G0339 and G0340 were added to the Medical Necessity Guideline as requiring Prior Authorization.
- July 1, 2009: Codes 77371, 77372, 77373, 77432, 77435, G0173, G0251 were added to the Medical Necessity Guideline as requiring Prior Authorization.
- December 2009: Reviewed by Medical Affairs Medical Policy, requirement for surgery for those patients with trigeminal neuralgia removed and replaced with medical/pharmaceutical therapy.
- August 2010: Reviewed by Medical Affairs-Medical Policy. Cerebellar meningioma added to list of covered diagnoses, effective January 1, 2011.
- August 8, 2012: Reviewed at IMPAC (Integrated Medical Policy Advisory Committee). Limitation language removed; and ICD-9-CM codes added.
- December 20, 2012: Code 32701 added to the Medical Necessity Guideline as requiring Prior Authorization effective January 1, 2013.
- January 9, 2013: Reviewed at IMPAC, coverage for low to intermediate risk prostate cancer added. ICD-10 codes will be added prior to the next IMPAC review.
- November 25, 2013: Reviewed by IMPAC, guideline for coverage for low to intermediate risk prostate cancer clarified, up to six treatment sessions may be authorized with an effective date of April 1, 2014.
- December 10, 2014: Reviewed by IMPAC, renewed without changes
- December 31, 2014: Coding updated. Per AMA CPT®, effective December 31, 2014 the following code(s) deleted: G0173 and G0251.
- September 2015: Branding and template change to distinguish Tufts Health Plan products in "Applies to" section. Added Tufts Health Freedom Plan products, effective January 1, 2016.
- November 16, 2015: Reviewed by IMPAC, renewed without changes
- March 25, 2016: Coding updated; ICD-9-CM codes removed
- October 24, 2016: Reviewed by IMPAC, criteria added for non-small cell lung cancer.
- November 9, 2016: Reviewed by IMPAC, glossopharyngeal neuralgia added as a covered diagnosis.
- April 2017: Added RITogether Plan product to template. For MNGs applicable to RITogether, effective date is August 1, 2017
- December 13, 2017: Reviewed by IMPAC, renewed without changes
- October 10, 2018: Reviewed by IMPAC, renewed without changes
- October, 2018: Template and disclaimer updated
- November 14, 2018: Reviewed by IMPAC; addition of limitation language
- November 20, 2019: Reviewed by IMPAC, update to terminology (SBRT)
- October 21, 2020: Reviewed by IMPAC, renewed without changes
- November 9, 2020: Fax number for Unify updated

BACKGROUND, PRODUCT AND DISCLAIMER INFORMATION

Medical Necessity Guidelines are developed to determine coverage for benefits, and are published to provide a better understanding of the basis upon which coverage decisions are made. We make coverage decisions using these guidelines, along with the Member's benefit document, and in coordination with the Member's physician(s) on a case-by-case basis considering the individual Member's health care needs.

Medical Necessity Guidelines are developed for selected therapeutic or diagnostic services found to be safe and proven effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in our service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. We revise and update Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Medical Necessity Guideline and a self-insured Member's benefit document, the provisions of the benefit document will govern.

Treating providers are solely responsible for the medical advice and treatment of Members. The use of this guideline is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to eligibility and benefits on the date of service, coordination of benefits, referral/authorization, utilization management guidelines when applicable, and adherence to plan policies, plan procedures, and claims editing logic.

Provider Services