

## Medical Coverage Policy | Stereotactic Radiosurgery and Stereotactic Body Radiation



**EFFECTIVE DATE:** 09/01/2009  
**POLICY LAST UPDATED:** 09/17/2013

### OVERVIEW

This policy documents the coverage guidelines for multiple fraction stereotactic body radiation therapy (SBRT) for cranial and spinal lesions.

### PRIOR AUTHORIZATION

Prior authorization is required for SBRT for BlueCHiP for Medicare and recommended for Commercial products.

Prior authorization is not required for the covered stereotactic radiosurgery (SRS) for BlueCHiP for Medicare and for Commercial products.

### POLICY STATEMENT

BlueCHiP for Medicare and Commercial Products:

Stereotactic radiosurgery (SRS) is covered.

BlueCHiP for Medicare and Commercial Products:

Stereotactic body radiation therapy (SBRT) is covered for any of the conditions listed in the medical criteria.

BlueCHiP for Medicare and Commercial Products:

SBRT is considered not medically necessary for all other indications not listed in the medical criteria as there is insufficient clinical evidence to support its efficacy.

### MEDICAL CRITERIA

BlueCHiP for Medicare:

Stereotactic body radiation therapy (SBRT) is considered medically necessary for the following indications:

- Retroperitoneal metastases;
- Hepatic and Pancreatic tumors;
- Pulmonary tumors;
- Mediastinal tumors;
- Prostate neoplasm;
- Spinal tumors;
- Intracranial lesions

Medicare policy is developed separately from BCBSRI policy. Medicare policy incorporates consideration of governmental regulations from CMS (Centers for Medicare and Medicaid Services), such as national coverage determinations or local coverage determinations. In addition to benefit differences, CMS may reach different conclusions regarding the scientific evidence than does BCBSRI. Medicare and BCBSRI policies may differ. However, BlueCHiP for Medicare members must be offered, at least, the same services as Medicare offers.

#### Commercial Products:

Stereotactic body radiation therapy (SBRT) is considered medically necessary for any the following indications:

- Patients with stage T1 or T2a non-small cell lung cancer (not larger than 5 cm) showing no nodal or distant disease and who are not candidates for surgical resection;
- Spinal or vertebral body tumors (metastatic or primary) in patients who have received prior radiation therapy.
- Intracranial lesions

#### BACKGROUND

Stereotactic radiosurgery (SRS) and stereotactic body radiation therapy (SBRT) are non invasive treatments using high doses of focused radiation beams precisely delivered to intracranial and extracranial targets, therefore sparing adjacent tissue structures from irradiation. The difference between stereotactic radiosurgery (SRS) and stereotactic body radiation therapy (SBRT) is that in SRS, high dose radiation is delivered in one fraction, to a small area, while in SBRT, radiation is delivered in multiple fractions (2-5) at a somewhat lower dose than SRS to a larger area.

#### Stereotactic radiosurgery (SRS):

Most commonly used to treat disorders of the head or neck (intracranial), malignancies (including primary and metastatic tumors), arteriovenous malformations (AVMs), acoustic neuromas, and other benign intracranial tumors (e.g., meningiomas or pituitary adenomas) with a single, high dose, precise delivery of radiation in a one day session. This technique differs from conventional radiotherapy, which exposing larger areas of intracranial tissue to relatively broad fields of radiation over a number of sessions.

The radiosurgical procedure, however, can also be used with hypofractionation (two to five fractions), also called SBRT, and conventional fractionation. It is important to note that stereotactic treatment to intracranial lesions using two to five fractions is considered SBRT. Any treatment using greater than five fractions is not considered SBRT.

Five main methods of this technology exist: gamma-knife radiosurgery (Gamma Knife®), robotic radiosurgery system (CyberKnife®) with image-guided radiotherapy, linear-accelerator radiosurgery (LINAC), proton-beam radiosurgery, helium-ion radiosurgery, and neutron-beam radiosurgery. The latter three energy sources are collectively referred to as charged particles.

Stereotactic radiosurgery (SRS) using a gamma or LINAC unit is typically covered for the following indications:

- Arteriovenous malformations;
- Acoustic neuromas;
- Pituitary adenomas;
- Non-resectable, residual, or recurrent meningiomas;
- 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);
- Primary malignancies of the CNS, including but not limited to high-grade gliomas (initial treatment or treatment of recurrence);
- Trigeminal neuralgia refractory to medical management;
- \*Primary and recurrent gliomas less than 4 cm in diameter;
- \*Small meningiomas (less than 4 cm in diameter in all dimensions) which are non-resectable, residual or recurrent;
- \*Multiple or recurrent brain metastases with four (4) or fewer lesions;
- \*Pituitary adenomas;

- \*Certain epileptic disorders;
- \*Inoperable arteriovenous malformations (AVMs) of the brain which are 5 cm or less in greatest dimension;
- \*Schwannomas;
- \*Ocular melanomas;
- \*Pineal tumors and adenomas;
- \*Parangliomas;
- \*Chordomas;
- \*Tic douloureux;
- \*Trigeminal neuralgia.
- \*Indicates covered conditions for Medicare members.

Investigational applications of stereotactic radiosurgery include, but are not limited to, the treatment of seizures and functional disorders other than trigeminal neuralgia, including chronic pain.

Stereotactic body radiation therapy or radiotherapy (SBRT):

Similar in technique to intracranial stereotactic radiosurgery except that the target areas are typically in the body and do not include the head or neck. SBRT delivers a single high-dose radiation delivery or, a few fractionated radiation deliveries. This fractionated form of radiotherapy is made possible by the recent availability of non-invasive repositioning devices that can be used in lieu of a head frame.

NOTE: In some cases, SBRT may be used to treat intracranial lesions when two to five fractions of radiation are used instead of one single dose.

Based on clinical evidence it was found that SBRT was proven to be effective in patients with stage 1 (non-small cell lung cancer (not larger than 5 cm in diameter) showing no nodal or distant disease) who are not candidates for surgical resection because of co-morbid conditions. SBRT has also been shown to improve outcomes (reduce pain) in patients with spinal (vertebral) tumors that recur after prior radiation therapy. Data for other extra-cranial uses of SBRT are limited, and these clinical situations are still considered investigational.

## COVERAGE

Benefits may vary between groups and contracts. Please refer to the appropriate Evidence of Coverage or Subscriber Agreement for the applicable radiation therapy benefits/coverage.

## CODING

Single Fraction:

Cranial SRS-Stereotactic Radiosurgery authorization not required.

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61800

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Two to Five (2-5) Fractions:

**Cranial** SBRT-Stereotactic body radiation therapy

Preauthorization is required for BlueCHiP for Medicare and recommended for Commercial products.

77435

One to Five (1-5) Fractions:

**Spinal** SBRT Stereotactic body therapy

Preauthorization is required for BlueCHiP for Medicare and recommended for Commercial products.

32701

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The following related codes are covered when performed in conjunction with a covered indication.

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The following HCPCS codes are covered but **not separately reimbursed** as providers should file with the appropriate CPT code:

**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

## RELATED POLICIES

None

## PUBLISHED

Provider Update Nov 2013

Provider Update Jan 2012

Provider Update Feb 2011

Policy Update Jul 2008

Policy Update Nov 2007

Policy Update Aug 2007

Policy Update Aug 2006

## REFERENCES

Blue Cross and Blue Shield Association. Medical Policy Reference Manual 6.01.10 Stereotactic Radiosurgery and Stereotactic Body Radiation Therapy.

Centers for Medicare and Medicaid Services. Local Coverage Determination (LCD) for STEREOTACTIC BODY RADIATION Therapy (L28366)

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