Summary of Changes

Clarifications:

Deletions:

Additions:

Pg. 3, Section I, C, Requests for stereotactic radiosurgery and proton or neutron radiotherapy may be reviewed for coverage determination in either of the following:

- Recommendation by the National Comprehensive Cancer Network (NCCN) Guidelines for specific diagnosis, or
- Treatment in a clinical trial if the criteria of the Clinical Trials medical policy are met.

I. POLICY/CRITERIA

A. Stereotactic Radiosurgery

1. Stereotactic Radiosurgery by Gamma Knife, CyberKnife or linear accelerator is a covered benefit for any of the following if pre-authorized by Priority Health.

   a. Treatment of patients with symptomatic, small (less than 4 cm) arteriovenous malformations (AVM), aneurysms, and benign tumors (acoustic neuromas, vestibular schwannomas, meningiomas, hemangiomas, pituitary adenomas, craniopharyngiomas, and neoplasms of the pineal gland) if the lesion is unresectable due to its deep intracranial location or if the patient is unable to tolerate conventional operative intervention.

   b. Palliative treatment of initial or recurrent brain metastases, solitary or multiple, in patients with good performance status (Karnofsky > 70).

   c. Treatment of initial or recurrent primary brain malignancies that are less than 5 cm in diameter and Karnofsky status > 70.

   d. Treatment of nonoperable spinal tumors.

   e. Trigeminal neuralgia that has not responded to other more conservative treatments and contraindications to open procedure are present.

   f. Treatment of pulmonary tumors if one of the following:
      1. Medically inoperable Stage I non-small cell cancer, or
      2. Solitary pulmonary metastasis
g. Treatment of inoperable liver tumors if one of the following:
   1. Isolated liver metastasis, or
   2. Hepatocellular cancer

h. Treatment of pancreatic cancer if one of the following:
   1. Primary therapy for locally advanced disease, or
   2. Isolated local recurrence after prior therapy

2. Stereotactic radiosurgery is considered experimental and investigational for treatment of:
   a. Parkinson's disease and epilepsy (except when associated with treatment of AV malformations or brain tumors)
   b. Cancers in extracranial sites, except spine, lung, liver, and pancreas if criteria specified above are met, because definitive conclusions regarding its indications and efficacy have not been demonstrated in large, controlled clinical trials.
   c. cluster headaches
   d. all other indications not outlined in A1 above

B. Proton and neutron beam therapies

1. Proton beam radiotherapy (PBRT) may be medically necessary in any of the following radiosensitive tumors:
   a. Uveal melanomas confined to the globe (i.e. not distant metastases)*
      (the uvea is comprised of the iris, ciliary body, and choroid (the vascular middle coat of the eye)); or
   b. Chordomas or chondrosarcomas arising at the base of the skull or along the axial skeleton without distant metastases*; or
   c. Pituitary neoplasms*; or
   d. Other central nervous system tumors located near vital structures.*
* Proton beam radiotherapy may be used either with or without stereotactic guidance. Stereotactic administration of proton beam radiotherapy is considered medically necessary only for the above-listed lesions that are located intracranially. Stereotactic administration of proton beam radiotherapy for extracranial lesions (i.e., stereotactic body radiosurgery) is not considered medically necessary.

2. Proton beam radiotherapy for treatment of the following conditions is not covered because alternate equally effective forms of therapy which are more cost-effective exist.
   a. intracranial arteriovenous malformations
   b. prostate cancer

3. Proton beam radiotherapy is considered experimental and investigational for all other indications, including but not limited to:
a. Age-related macular degeneration  
b. Non-uveal melanoma.  
c. Hepatocellular carcinoma  

4. Neutron beam therapy is medically necessary for the treatment of any of the following salivary gland tumors:  
a. Locally advanced tumors especially in persons with gross residual disease;  
b. Unresectable tumors  
c. Inoperable tumors.  

5. Neutron beam radiotherapy is considered experimental and investigational for all other indications, including but not limited to:  
a. Pancreatic cancer;  
b. Prostate cancer;  
c. Rectal cancer;  
d. Soft tissue sarcomas;  
e. colon cancer  
f. kidney cancer  
g. lung cancer  

C. Requests for stereotactic radiosurgery and proton or neutron radiotherapy may be reviewed for coverage determination in either of the following:  
1. Recommendation by the National Comprehensive Cancer Network (NCCN) Guidelines for specific diagnosis, or  
2. Treatment in a clinical trial if the criteria of the Clinical Trials medical policy are met.  

Special Notes:  

- The Karnofsky performance status scale is widely used to evaluate the functional status of cancer patients to determine their eligibility for clinical trials and their prognosis.  

<table>
<thead>
<tr>
<th>Karnofsky Score</th>
<th>Description</th>
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<tbody>
<tr>
<td>70</td>
<td>Cares for self; unable to carry on normal activity or to do active work.</td>
</tr>
<tr>
<td>80</td>
<td>Normal activity with effort, some signs or symptoms of disease</td>
</tr>
<tr>
<td>90</td>
<td>Able to carry on normal activity; minor signs or symptoms of disease</td>
</tr>
<tr>
<td>100</td>
<td>Normal; no complaints; no evidence of disease</td>
</tr>
</tbody>
</table>
Proton and Neutron Beam Therapies were reviewed at Priority Health’s Technology Assessment Committee (TAC) on December 3, 2004. This policy follows the recommendations of the TAC.

Radiosurgery for extracranial indications was reviewed by Priority Health’s Technology Assessment Committee on September 7, 2007. This policy reflects recommendations of the TAC.

II. MEDICAL NECESSITY REVIEW

☒ Required ☐ Not Required ☐ Not Applicable

III. APPLICATION TO PRODUCTS

Coverage is subject to member’s specific benefits. Group specific policy will supersede this policy when applicable.

❖ HMO/EPO: This policy applies to insured HMO/EPO plans.
❖ POS: This policy applies to insured POS plans.
❖ PPO: This policy applies to insured PPO plans. Consult individual plan documents as state mandated benefits may apply. If there is a conflict between this policy and a plan document, the provisions of the plan document will govern.
❖ ASO: For self-funded plans, consult individual plan documents. If there is a conflict between this policy and a self-funded plan document, the provisions of the plan document will govern.
❖ INDIVIDUAL: For individual policies, consult the individual insurance policy. If there is a conflict between this medical policy and the individual insurance policy document, the provisions of the individual insurance policy will govern.
❖ MEDICARE: Coverage is determined by the Centers for Medicare and Medicaid Services (CMS); if a coverage determination has not been adopted by CMS, this policy applies.
❖ MEDICAID/HEALTHY MICHIGAN PLAN: For Medicaid/Healthy Michigan Plan members, this policy will apply. Coverage is based on medical necessity criteria being met and the appropriate code(s) from the coding section of this policy being included on the Michigan Medicaid Fee Schedule located at: http://www.michigan.gov/mdch/0,1607,7-132-2945,42542-42543-42546-42551-159815--,00.html. If there is a discrepancy between this policy and the Michigan Medicaid Fee Schedule located at: http://www.michigan.gov/mdch/0,1607,7-132-2945,5100-87572--,00.html, the Michigan Medicaid Provider Manual will govern. For Medical Supplies/DME/Prosthetics and Orthotics, please refer to the Michigan Medicaid Fee Schedule to verify coverage.
❖ MICHILD: For MICHILD members, this policy will apply unless MICHILD certificate of coverage limits or extends coverage.
IV. DESCRIPTION

Stereotactic Radiosurgery, by Gamma Knife, CyberKnife or linear accelerator (LINAC), delivers precisely defined ionizing beams of radiation.

Stereotactic guidance may also be used to deliver proton and/or neutron beam radiotherapy. Proton and Neutron Beam Therapies have been investigated for numerous conditions.

V. CODING INFORMATION

ICD9 codes:
Not specified – see criteria

CPT/HCPCS codes:
32701 Thoracic target(s) delineation for stereotactic body radiation therapy (SRS/SBRT), (photon or particle beam), entire course of treatment (No prior authorization needed)

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 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 Stereotactic body radiation therapy, treatment delivery, per fraction to 1 or more lesions, including image guidance, entire course not to exceed 5 fractions
77422  High energy neutron radiation treatment delivery; single treatment area using a single port or parallel-opposed ports with no blocks or simple blocking

77423  High energy neutron radiation treatment delivery; 1 or more isocenter(s) with coplanar or non-coplanar geometry with blocking and/or wedge, and/or compensator(s)

77432  Stereotactic radiation treatment management of cerebral lesion(s) (complete course of treatment consisting of one session)

77435  Stereotactic body radiation therapy, treatment management, per treatment course, to one or more lesions, including image guidance, entire course not to exceed 5 fractions

77520  Proton treatment delivery; simple, without compensation

77522  Proton treatment delivery; simple, with compensation

77523  Proton treatment delivery; intermediate

77525  Proton treatment delivery; complex

Facility billing only:

Revenue code:
0333  Radiation therapy (billed with 70,000 codes listed above)

HCPCS codes:
G0339  Image guided robotic linear accelerator base 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

These services are not covered:
S8030  Scleral application of tantalum ring(s) for localization of lesions for proton beam therapy

VI. REFERENCES:


Stereotactic Radiosurgery (SRS) and Stereotactic Body Radiotherapy (SBRT), Anthem Blue Cross Medical Policy @ https://www.anthem.com/ca/medicalpolicies/policies/mp_pw_a050201.htm (Retrieved July 27, 2015)