Clinical Policy: Stereotatic Body Radiation Therapy

Reference Number: WA.CP.MP.22
Last Review Date: 11/24
Effective Date: 01/01/25

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

This policy describes the medical necessity guidelines for stereotactic body radiation therapy (SBRT) and stereotactic radiation surgery (SRS).

Policy/Criteria

I. It is the policy of Coordinated Care of Washington, Inc., in accordance with the Health Care Authority Health Technology Assessment and Health Care Authority Billing Buidelines, that stereotactic body radiation therapy (SBRT) is considered **medically necessary** in the following situations:

A. Spine and Paraspinal Cancer when *all* of the following are met:
   1. Primary and secondary tumors involving spine parenchyma, meninges/dura, *or* immediately adjacent bony structures, and
   2. Evaluation includes multidisciplinary team analysis (e.g., tumor board) including a surgical specialist and radiation oncologist.

B. Localized Prostate Cancer when *all* of the following are met:
   1. Very low, low, or intermediate risk prostate cancer, as defined by NCCN based on stage, Gleason score, and PSA level, and
   2. Evaluation includes multidisciplinary team analysis (e.g., tumor board) including a surgical specialist and radiation oncologist.

C. Non-Small Cell Lung Cancer (NSCLC) when *all* of the following are met:
   1. Stage I and Stage II (node negative),
   2. Tumor is deemed to be unresectable, or patient is deemed too high risk, or declines operative intervention, and
   3. Evaluation includes multidisciplinary team analysis (e.g., tumor board) including a surgical specialist and radiation oncologist.

D. Small Cell Lung Cancer (SCLC) when *all* of the following are met:
   1. Stage I and Stage II (node negative) and *at least one* of the following:
      a. Tumor is deemed to be unresectable, or
      b. Patient is deemed too high risk, and
   2. Operative intervention declined, and
   3. Evaluation includes multidisciplinary team analysis (e.g., tumor board) including a surgical specialist and radiation oncologist.

E. Pancreatic Adenocarcinoma when *all* of the following are met:
   1. Non-metastatic disease and member/enrollee is either deemed not a candidate for induction chemotherapy or has already undergone induction chemotherapy and *at least one* of the following:
      a. Tumor is deemed to be unresectable, or
      b. Patient is deemed too high risk for surgery

2. Operative intervention declined, and
3. Evaluation includes multidisciplinary team analysis (e.g., tumor board) including a surgical specialist and radiation oncologist

F. Oligometastatic disease when *all* of the following are met:
1. Five or fewer total metastatic lesions (maximum 3 per organ),
2. Controlled primary tumor,
3. Life expectancy greater than 6 months, and
4. Evaluation includes multidisciplinary team analysis (e.g., tumor board) including a surgical specialist and radiation oncologist.

G. Hepatocellular Carcinoma when *all* of the following are met:
1. Liver confined disease,
2. Five or fewer lesions,
3. Life expectancy greater than 6 months, and
4. Evaluation includes multidisciplinary team analysis (e.g., tumor board) including a surgical specialist and radiation oncologist.

H. Cholangiocarcinoma when *all* of the following are met:
1. Non-metastatic disease and *at least one* of the following:
   a. Tumor is deemed to be unresectable,
   b. Patient is deemed too high risk for surgery, or
   c. Operative intervention declined, and
2. Evaluation includes multidisciplinary team analysis (e.g., tumor board) including a surgical specialist and radiation oncologist.

I. Renal Cancer when *all* of the following are met:
1. Non-metastatic disease and *at least one* of the following:
   a. Tumor is deemed to be unresectable,
   b. Patient is deemed too high risk for surgery, or
   c. Operative intervention declined, and
2. Evaluation includes multidisciplinary team analysis (e.g., tumor board) including a surgical specialist and radiation oncologist.

II. It is the policy of Coordinated Care of Washington, Inc., in accordance with the Health Care Authority Health Technology Assessment and Health Care Authority Billing Buidelines that stereotactic body radiation therapy (SBRT) is not medically necessary for treatment of primary tumor of bone, head and neck, adrenal, melanoma, Merkel cell, breast, ovarian, and cervical cancers.

III. It is the policy of Coordinated Care of Washington, Inc., in accordance with the Health Care Authority Health Technology Assessment and Health Care Authority Billing Buidelines that stereotatic radiation surgery (SRS) is considered medically necessary when all of the following are met:

A. Request is for treatment of central nervous system (CNS) and metastatic tumors,
B. Member/enrollee functional status score meets *one* of the following:
1. Karnofsky score greater than or equal to 50, or
2. ECOG greater than or equal to 2, and

C. Evaluation includes multidisciplinary team analysis (e.g., tumor board), including surgical input.

Background

This policy is based entirely on Washington State Health Care Authority (HCA) Health Technology Assessment (HTA) and Health Care Authority Billing Guidelines.

Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2023, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CPT® Codes	Description
32701	Target delineation for stereotactic radiation therapy
61796	Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); one cranial lesion, simple
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)
77370	Special medical radiation physics consultation
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

HCPCS Codes	Description
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

Reviews, Revisions, and Approvals	Revision Date	Approval Date
Policy developed.	06/24	06/24
Annual review. Added CPT codes 32701 and 77370. Struck "and not covered" from section II. Updated references.	11/24	11/24

References

1. Shaw, B., Robalino, S., King, V. Use of Stereotactic Body Radiation Therapy. Washington Health Technology Assessment Final Evidence Report. April 10, 2023.
2. Washington Health Care Authority Health Technology Clinical Committee. Draft Final Findings and Decision. Stereotatic Body Radiation Therapy. November 17, 2023, pending final adoption.
3. Washington Health Care Authority Issue #37919. Update via email dated 5/31/24.
4. Washington State Health Care Authority. Physician-related Services/Health Care Billing Guide. https://www.hca.wa.gov/assets/billers-and-providers/Physician-related-services-bg-20241001.pdf. Revision effective October 1, 2024.

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and

limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members/enrollees. This clinical policy is not intended to recommend treatment for members/enrollees. Members/enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

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Note: For Medicaid members/enrollees, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.