

BLUE CROSS OF NORTHEASTERN PA "BCNEPA" MEDICAL POLICY BULLETIN	MANUAL: MEDICAL POLICY
	REFERENCE NO.: MPO-490-0069
EFFECTIVE DATE June 1, 2014	SUBJECT: Stereotactic Radiosurgery and Charged-Particle Radiation Therapy

Blue Cross of Northeastern Pennsylvania ("BCNEPA") Medical Policy

Medical policy is not an authorization, certification, explanation of benefits or a contract. Benefits and eligibility are determined before medical policy and claims payment policy are applied. Policies are provided for informational purposes only and are developed to assist in administering plan benefits and do not constitute medical advice. Treating providers are solely responsible for medical advice and treatment. Policies are based on research of current medical literature and review of common medical practices in the treatment and diagnosis of disease. Medical practices and information are constantly changing and BCNEPA may review and revise its medical policies periodically. Also, due to the rapid pace of changing technology and the advent of new medical procedures, BCNEPA may not have a policy to address every procedure. In those cases, BCNEPA may review other sources of information including, but not limited to, current medical literature and other medical resources, such as Technology Evaluation Center Assessments (TEC) published by the Blue Cross Blue Shield Association. BCNEPA may also consult with health care providers possessing particular expertise in the services at issue.

I. DESCRIPTION:

Stereotactic Radiosurgery (SRS) is a method of delivering high doses of ionizing radiation to small intracranial targets. SRS involves delivering highly focused convergent beams in a single session so that only the desired target is radiated, sparing adjacent structures.

Charged-particle beams consisting of protons or helium ions are a type of particulate radiation therapy. They contrast with conventional electromagnetic (i.e., photon) radiation therapy due to several unique properties including minimal scatter as particulate beams pass through tissue, and deposition of ionizing energy at precise depths (i.e., the Bragg peak). Thus, radiation exposure of surrounding normal tissues is minimized.

II. BENEFIT POLICY STATEMENT:

BCNEPA makes decisions on coverage based on Policy Bulletins, benefit plan documents, and the member's medical history and condition. Benefits may vary based on product line, group or contract, therefore, Member benefits must be verified. In the event of a conflict between the Member's benefit plan document and topics addressed in Medical Policy Bulletins (i.e., specific contract exclusions), the Member's benefit plan document always supersedes the information in the Medical Policy Bulletins. BCNEPA determines medical necessity only if the benefit exists and no contract exclusions are applicable.

Benefits are determined by the terms of the Member's specific benefit plan document [i.e., the Fully Insured policy, the Administrative Services Only (ASO) agreement applicable to the Self-Funded Plan Participant, or the Individual Policy] that is in effect at the time services are rendered.

III. MEDICAL POLICY STATEMENT:

Coverage is subject to the terms, conditions, and limitations of the member's contract.

Stereotactic Radiosurgery

- A. BCNEPA will provide coverage for stereotactic radiosurgery (SRS) using a gamma or LINAC unit when medically necessary.
 - 1. SRS using a gamma or LINAC unit may be considered medically necessary for the following indications:
 - a) Arteriovenous malformations;
 - b) Acoustic neuromas;
 - c) Pituitary adenomas;
 - d) Non-resectable, residual or recurrent meningiomas;
 - e) Craniopharyngiomas;
 - f) Glomus jugulare tumors;
 - g) 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);
 - h) Primary malignancies of the CNS (Central Nervous System) including but not limited to high grade gliomas (initial treatment or treatment of recurrence); and
 - i) Trigeminal neuralgia refractory to medical management.
 - 2. When SRS is performed using fractionation for the medically necessary indications described above, it is considered medically necessary.
- B. BCNEPA will not provide coverage for SRS for the following indications as they are considered investigational and, therefore, not covered because the safety and effectiveness of these services cannot be established by review of the available published peer-reviewed literature:
 - 1. The treatment of seizures and functional disorders other than trigeminal neuralgia, including chronic pain, and the treatment of uveal melanoma.
 - 2. All other indications not identified above as medically necessary.

Stereotactic Body Radiation Therapy

- C. BCNEPA will provide coverage for stereotactic body radiation therapy (SBRT) when medically necessary.

1. SBRT may be considered medically necessary for the following indications:
 - a) Patients with stage T1 or T2a non-small cell lung cancer (not larger than 5cm) showing no nodal or distant disease and who are not candidates for surgical resection;
 - b) Spinal or vertebral body tumors (metastatic or primary) in patients who have received prior radiation therapy;
 - c) Spinal or vertebral metastases that are radioresistant (e.g., renal cell carcinoma, melanoma and sarcoma).
 2. When SBRT is performed using fractionation for the medically necessary indications described above, it is considered medically necessary.
- D. BCNEPA will not provide coverage for SBRT for the following indications as they are considered investigational and, therefore, not covered because the safety and effectiveness of these services cannot be established by review of the available published peer-reviewed literature:
1. Primary and metastatic tumors of the liver, pancreas, kidney, adrenal glands and prostate.
 2. All other indications not identified above as medically necessary.

Charged-Particle (Proton or Helium Ion) Radiation Therapy

- E. BCNEPA will provide coverage for charged-particle irradiation with proton or helium ion beams when medically necessary.
1. Charged-particle irradiation with proton or helium ion beams may be considered medically necessary in the following clinical situations:
 - a) Primary therapy for melanoma of the uveal tract (iris, choroid, or ciliary body), with no evidence of metastasis or extrascleral extension, and with tumors up to 24 mm in largest diameter and 14 mm in height;
 - b) Postoperative therapy (with or without conventional high-energy x-rays) in patients who have undergone biopsy or partial resection of chordoma or low-grade (I or II) chondrosarcoma of the basisphenoid region (skull-base chordoma or chondrosarcoma) or cervical spine. Patients eligible for this treatment have residual localized tumor without evidence of metastasis.
 - c) In the treatment of pediatric (<21 yrs of age) central nervous system tumors.
 2. Charged-particle irradiation with proton beams using standard treatment doses is considered not medically necessary in patients with clinically localized prostate cancer.

- F. BCNEPA will not provide coverage for charged-particle irradiation for the following indications as they are considered investigational and, therefore, not covered because the safety and effectiveness of these services cannot be established by review of the available published peer-reviewed literature:
1. Use of proton beam therapy for non-small-cell lung cancer (NSCLC) at any stage or for recurrence.
 2. Pediatric non-central nervous system tumors.
 3. Tumors of the head and neck (other than skull-based chordoma or chondrosarcoma).
 4. All other indications not identified above as medically necessary.

IV. DEFINITIONS:

Five main methods of this technology exist: gamma-ray radiosurgery (gamma knife), proton-beam radiosurgery, helium-ion radiosurgery, linear-accelerator radiosurgery (LINAC), neutron-beam radiosurgery. The various radiation-delivery devices differ technically in several ways: source of radiation, size and shape of the radiation field, and range of radiation dosages.

The radiosurgical procedure is preceded by a process of localizing the target, which can be performed with one or more of the following techniques: cerebral angiography, computerized tomography, and magnetic resonance imaging. SRS is usually performed in one (1) session, usually requiring no more than an overnight hospital stay.

Stereotactic Body Radiation Therapy (SBRT): stereotactically guided radiation therapy applied over several days.

Stereotactic Radiosurgery (SRS): method of delivering high doses of ionizing radiation to small intracranial targets.

-PLEASE SEE CODING ON NEXT PAGE-

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BCNEPA CODING

Covered procedure codes are dependent upon meeting criteria of the policy and appropriate diagnosis code.

Benefits are determined by the Member's fully insured policy or the administrative services only agreement applicable to the Self-Funded plan Participant that is in effect at the time services are rendered.

PROCEDURE CODES

20660	61797	77371	77522	G0340
32701	61798	77372	77523	
61781	61799	77373	77525	
61782	61800	77432	G0173	
61783	63620	77435	G0251	
61796	63621	77520	G0339	

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ICD-9 DIAGNOSIS CODES

162.0	162.9	191.4	194.6	237.3
162.2	170.2	191.5	198.3	350.1
162.3	191.0	191.6	225.1	747.81
162.4	191.1	191.7	225.2	
162.5	191.2	191.8	227.3	
162.8	191.3	191.9	237.0	

ICD-10 DIAGNOSIS CODES INFORMATIONAL ONLY

C33	C34.31	C71.0	C71.9	D44.7
C34.00	C34.32	C71.1	C75.5	G50.0
C34.01	C34.80	C71.2	C79.31	Q28.0
C34.02	C34.81	C71.3	D32.0	Q28.1
C34.10	C34.82	C71.4	D32.9	Q28.2
C34.11	C34.90	C71.5	D33.3	Q28.3
C34.12	C34.91	C71.6	D35.2	
C34.2	C34.92	C71.7	D44.3	
C34.30	C41.2	C71.8	D44.4	

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