STATE OF IOWA DEPARTMENT OF
Health AND Human
SERVICES

Laser Linear Accelerator Based Stereotactic Radiosurgery
SRG-009

Iowa Medicaid Program:	Prior Authorization	**Effective Date:**	5/14/2008
Revision Number:	7	**Last Rev Date:**	7/21/2023
Reviewed By:	Medicaid Medical Director	**Next Rev Date:**	7/19/2024
Approved By:	Medicaid Clinical Advisory Committee	**Approved Date:**	8/16/2017

Criteria

At least **ONE** of the following must be met:

1. For treatment of non-operable primary central nervous system tumors invading the spine; **OR**
2. For treatment of initial or recurrent primary brain malignancies for members otherwise in relatively good health; **OR**
3. Stereotactic radiosurgery (SRS) is considered medically necessary for treatment of:
   a. Intracranial tumors in hard-to-reach locations; **AND**
   b. Tumors with very unusual shapes; **AND**
   c. Tumors located in such close proximity to a vital structure (e.g., optic nerve or hypothalamus) that even a very accurate high-dose single fraction of multi-source cobalt-60-based stereotactic radiosurgery could not be tolerated; **OR**
4. Arteriovenous malformations of the brain or spine that are not amenable to surgical resection; **OR**
5. Trigeminal neuralgia not responsive to medical management; **OR**
6. Essential tremor: coverage is limited to the patient who cannot be controlled with medication, has major systemic disease or coagulopathy, and who is unwilling or unsuited for open surgery. Coverage is further limited to unilateral thalamotomy. Gamma knife pallidotomy remains non-covered and will be denied.

All other indications would not be covered as they are considered experimental, investigational, or unproven.

SRS is not medically necessary under the following circumstances:

1. Treatment for anything other than a severe symptom, serious threat to life, or critical functions; **AND**
2. Treatment unlikely to result in functional improvement of clinically meaningful disease stabilization, not otherwise achievable; **AND**
3. In patients, with more than three primary or metastases lesions SRS is inappropriate, and consideration should be given to whole brain irradiation; **AND**
4. Patients with wide spread cerebral or extra cranial metastases with limited life expectancy unlikely to gain clinical benefit within their remaining life; **AND**

5. Patients with poor performance status (Karnofsky performance status less than 40 or an ECOG performance greater than 3).

Coding

The following list of codes is provided for reference purposes only and may not be all inclusive. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment, nor does the exclusion of a code imply that its association to the HCPCS/CPT code is inappropriate.

CPT	Description
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.

Compliance

1. Should conflict exist between this policy and applicable statute, the applicable statute shall supersede.
2. Federal and State law, as well as contract language, including definitions and specific contract provisions or exclusions, take precedence over medical policy and must be considered first in determining eligibility for coverage.
3. Medical technology is constantly evolving and Iowa Medicaid reserves the right to review and update medical policy on an annual or as-needed basis.

Medical necessity guidelines have been developed for determining coverage for member benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. Medical necessity guidelines are developed for selected physician administered medications found to be safe and proven to be effective in a limited, defined population or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in the service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. Criteria are revised and updated annually, or more frequently if new evidence becomes available that suggests needed revisions.

References

CMS LCD L30318, last accessed at CMS.gov on July 14, 2015.

Development of utilization management criteria may also involve research into other state Medicaid programs, other payer policies, consultation with experts and review by the Medicaid Clinical Advisory Committee (CAC). These sources may not be referenced individually unless they are specifically published and are otherwise applicable to the criteria at issue.

Criteria Change History

Change Date	Changed By	Description of Change	Version
Signature			

Change Date	Changed By	Description of Change	Version
Signature			

Change Date	Changed By	Description of Change	Version
7/21/2023	CAC	Annual review.	7
Signature William (Bill) Jagiello, DO			

Change Date	Changed By	Description of Change	Version
7/15/2022	CAC	Annual review.	6
Signature William (Bill) Jagiello, DO			

Change Date	Changed By	Description of Change	Version
7/16/2021	CAC	Annual review. Added Compliance section. Formatting changes.	5
Signature William (Bill) Jagiello, DO			

Change Date	Changed By	Description of Change	Version
7/15/2016	Medical Director	Added "Laser" to the criteria title.	4
Signature C. David Smith, MD			

Change Date	Changed By	Description of Change	Version
7/17/2015	CAC	Added last paragraph in References.	3
Signature			

Criteria Change History (continued)

Change Date	Changed By	Description of Change	Version
7/14/2015	Medical Director	Added "at least **one**" in preface. Made other indications notation a separate paragraph. Added trigeminal neuralgia and thalamotomy for tremor and contraindications (as per CMS LCD L30318).	2
Signature			

Change Date	Changed By	Description of Change	Version
7/19/2013	CAC	Criterion #3-c changed cobalt-60-bases to cobalt-60-based.	1
Signature			