

Laser Linear Accelerator Based Stereotactic Radiosurgery Criteria

Iowa Medicaid Program:	Prior Authorization	Effective Date:	5/14/2008
Revision Number:	4	Last Review Date:	7/21/2017
Reviewed By:	Medicaid Clinical Advisory Committee	Next Review Date:	7/2018
Approved By:	Medicaid Medical Director	Approved Date:	8/16/2017

Criteria:

At least ONE of the following criteria must be met:

1. For treatment of non-operable primary central nervous system tumors invading the spine.
2. For treatment of initial or recurrent primary brain malignancies for members otherwise in relatively good health.
3. Stereotactic radiosurgery 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.
4. Arteriovenous malformations of the brain or spine that are not amenable to surgical resection.
5. Trigeminal neuralgia not responsive to medical management.
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.

Stereotactic Radiosurgery is not considered medically necessary under the following circumstances:

1. Treatment for anything other than a severe symptom or serious threat to life or critical functions.
2. Treatment unlikely to result in functional improvement of clinically meaningful disease stabilization, not otherwise achievable.
3. In patients, with more than three (3) primary or metastases lesions SRS is inappropriate and consideration should be given to whole brain irradiation.
4. Patients with wide spread cerebral or extra cranial metastases with limited life expectancy unlikely to gain clinical benefit within their remaining life.
5. Patients with poor performance status (Karnofsky Performance Status less than 40 or an ECOG Performance greater than 3).

CPT Codes:

Radiosurgery 77371 through 77373

References Used:

CMS LCD L30318, last accessed at CMS.gov on 7/14/15

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.

Change History:

Change Date:	Changed By:	Description of Change:	New Version Number:
7/19/13	CAC	Criterion #3-c changed cobalt-60-bases to cobalt-60-based.	1
7/14/15	Medical Director	Added "at least one" of preface. Made other indications notation a separate paragraph. Added trigeminal neuralgia and thalamotomy for tremor and contraindications (as per CMS LCD L30318).	2
7/17/15	CAC	Added last paragraph in References Used.	3
7/15/16	Medical Director	Added "Laser" to the criteria title.	4



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