

Clinical Policy: Stereotactic Body Radiation Therapy

Reference Number: CP.MP.22

Date of Last Revision: 08/23

[Coding Implications](#)

[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

Description

Stereotactic body radiation therapy (SBRT) and stereotactic radiosurgery (SRS) are radiation therapies delivered via stereotactic guidance to a small, precise target. Both largely spare the surrounding tissue by converging multiple non-parallel radiation beams into one sharply defined target, thereby greatly reducing the amount of radiation to which the surrounding tissue is exposed. SBRT is used to treat extra-cranial sites and can be performed in one to five sessions (fractions). SRS is used to treat intra-cranial and spinal targets. SRS is typically performed in a single session but can be performed in a limited number of sessions, up to a maximum of five. Gamma-ray photons, X-ray photons, protons, helium ions, and neutrons have all been used for SBRT and SRS.

Note: For criteria applicable to Medicare plans, please see MC.CP.MP.22 Stereotactic Body Radiation Therapy.

Policy/Criteria

- I. It is the policy of non-Medicare health plans affiliated with Centene Corporation® that up to five sessions of stereotactic body radiation therapy (SBRT) are **medically necessary** for any of the following indications:
 - A. Early stage non-small cell lung cancer (i.e., stage I through II, NO) as an alternative to surgery;
 - B. Acoustic neuroma;
 - C. Localized malignant conditions in the body where highly precise application of high-dose radiotherapy is required, including tumors of any type arising in or near previously irradiated regions;
 - D. Recurrences of metastatic spine cancer after previous radiation;²¹
 - E. Hepatocellular carcinoma, as an alternative to ablation/embolization techniques or when these therapies have failed or are contraindicated;
 - F. Recurrent malignant disease requiring palliation and/or as palliative treatment for liver-related symptoms;
 - G. Low to intermediate risk localized prostate cancer;
 - H. High risk prostate cancer when combined with androgen deprivation therapy, when delivering longer courses of external beam radiation therapy would present a documented hardship;
 - I. Inoperable spinal tumors causing compression or intractable pain;
 - J. Pancreatic adenocarcinoma:
 1. Locally advanced disease, without distant metastases;
 2. Combination therapy not feasible;
 3. Isolated local recurrence, respecting normal organ tolerance.
 - K. Extracranial oligometastatic disease, all of the following:
 1. One to three metastatic lesions involving the lungs, liver or bone;

CLINICAL POLICY**Stereotactic Body Radiation Therapy**

2. Primary tumor is breast, colorectal, melanoma, non-small cell lung, prostate, renal cell, or sarcoma;
3. Primary tumor is controlled;
4. No prior history of metastatic disease.

II. It is the policy of non-Medicare health plans affiliated with Centene Corporation that up to five sessions of stereotactic radiosurgery (SRS) are **medically necessary** for any one of the following indications:

- A. Cranial indications when unresectable due to deep intracranial location or member/enrollee is unable to tolerate conventional operative intervention, one of the following:
 1. Inoperable, small (≤ 3 cm) arteriovenous (AV) malformations,
 2. Benign tumors including meningiomas, pituitary adenomas, craniopharyngiomas, hemangiomas, and neoplasms of the pineal gland;
- B. Small acoustic neuromas (≤ 3 cm) or enlarging neuromas in patients who are not candidates for surgery;
- C. Brain malignancies, primary and/or metastatic lesions;
- D. Intracranial lesions where the patient refuses surgery;
- E. Severe, sustained trigeminal neuralgia not responsive to other treatments,
- F. Booster treatment for larger cranial or spinal lesions that have been treated initially with external beam radiation therapy or surgery. Avoid when in close proximity to cranial nerves II and VIII if the maximal dose delivered exceeds 10 Gy;
- G. Relapse in previously irradiated cranial or spinal field where additional stereotactic precision is required to avoid unacceptable vital tissue radiation;
- H. Inoperable spinal tumors causing compression or intractable pain;
- I. Refractory epileptic seizures in children when the lesion is located where a conventional surgical approach is technically difficult or excessively risky.³⁵

III. It is the policy of non-Medicare health plans affiliated with Centene Corporation[®] that there is insufficient evidence to support more than five sessions of SBRT or SRS for indications other than those listed above.

Background

Stereotactic body radiation therapy or stereotactic ablative therapy (SBRT) and stereotactic radiosurgery (SRS) both pair a high degree of anatomic targeting accuracy and reproducibility with very high doses of extremely precise, externally generated, ionizing radiation to inactivate or eradicate a defined target(s). The target is defined by high resolution stereotactic imaging. The procedure involves a multidisciplinary team often consisting of a surgeon, radiation oncologist, radiologist, medical radiation physicist, dosimetrist, radiation therapist, radiation therapy nurse and a specialist of the disease site such as a neurologist.²

Stereotactic describes a procedure during which a target lesion is localized relative to a fixed 3-D reference system, such as a rigid head frame affixed to a patient, fixed bony landmarks, a system of implanted fiducial markers, or other similar system. This localization procedure allows physicians to perform image-guided procedures with a high degree of accuracy and precision.²

CLINICAL POLICY

Stereotactic Body Radiation Therapy

The risk of developing permanent damage following SRS varies by the location of the lesion in the brain. Lesions located deep in the gray matter (thalamus, basal ganglia) or brainstem (pons, midbrain) carry the maximum risk of neurologic complications. Complications are less likely with lesions in the frontal and temporal lobes. Fractionated radiation therapy is often preferred to SRS for the treatment of lesions in the deep gray matter or the brainstem.

Technologies that are used to perform SBRT and SRS include Gamma Knife[®], LINAC (linear accelerator), CyberKnife[®] and proton beam or heavy-charged-particle radiosurgery. In order to enhance precision, various devices may incorporate robotics and real time imaging.³

Gamma Knife

Standard gamma knife uses 192 or 201 beams of highly focused gamma rays all aiming at the target region. The Gamma Knife is ideal for treating small to medium size lesions.¹⁵

Linear accelerator- (LINAC)

LINAC machines deliver high-energy x-rays, also known as photons. It can provide treatment on larger tumors in a single session or during multiple sessions (fractionated SRT). The principles of LINAC are identical to GammaKnife.^{3,10,15}

CyberKnife

This device combines a mobile LINAC machine with an image guided robotic system that delivers either a single large dose or fractionated radiation therapy. The overall length of time of treatment on a CyberKnife is typically longer than with other radiation therapy modalities.^{3,9}

Proton Beam

There is limited use of proton beam in North America; however, the number of centers has dramatically increased in the last several years.¹⁵ Protons are atoms that carry a positive charge. Compared to the use of photons (x-rays), the energy from protons conforms to the tumor better and causes less damage to the surrounding tissue. This allows a greater dose of radiation to be used due to minimizing the effects to normal tissue.³⁰

The National Comprehensive Cancer Network (NCCN) states that SBRT/extremely hypofractionated image-guided intensity-modulated radiation therapy (IMRT) regimens (6.5 Gy per fraction or greater) can be considered as an alternative to conventionally fractionated regimens in the treatment of prostate cancer at clinics with appropriate technology, physics, and clinical expertise. Longer follow-up and prospective multi-institutional data are required to evaluate longer-term results, especially because late toxicity theoretically could be worse in hypofractionated regimens compared to conventional fractionation (1.8 Gy to 2.0 Gy).¹¹ Results from a study comparing the efficacy of SBRT plus androgen deprivation therapy (ADT) to fractionated radiotherapy plus ADT in higher risk prostate cancer support recent NCCN guideline updates, which include SBRT as a non-preferred option for higher risk biological males. Findings demonstrated no difference in survival between SBRT + ADT and standard of care external beam radiation therapy + ADT for high risk prostate cancer.⁴⁰

CLINICAL POLICY

Stereotactic Body Radiation Therapy

The World Health Organization notes the following information regarding Grade I meningiomas: stereotactic or image guided therapy is recommended when using tight margins or when close to critical structures.²¹

A revision to the metastatic spine guideline notes that in selected cases or recurrences after previous radiation, SBRT is appropriate.²¹

Definitive radiation therapy, particularly SBRT, is recommended for individuals with early stage non-small cell lung cancer (i.e., stage I through II, NO) who are medically inoperable or those who refuse surgery.²²

SBRT for the treatment of pancreatic adenocarcinoma should be delivered at an experienced high-volume center with technology that allows for image-guided radiation therapy or in a clinical trial.²³ Most recent guidelines from NCCN on the principles of radiation therapy note that data are limited to support radiation therapy recommendations for locally advanced disease. The guidelines include SBRT as an “option” in select patients with pancreatic adenocarcinoma with good performance status and locally advanced disease without systemic metastasis. Chemo radiation or SBRT may also be an option in select patients who are not candidates for combination therapy, an option in disease progression when SBRT had not been previously given, and as an option for isolated local recurrence. SBRT should be avoided if direct invasion of the bowel or stomach is observed on imaging and/or endoscopy.²³

SBRT can be considered in patients with hepatocellular carcinoma, as an alternative to ablation/embolization techniques or when these therapies have failed or are contraindicated. SBRT (1 to 5 fractions) is often used for patients with 1 to 3 tumors. SBRT could be considered for larger lesions or more extensive disease, if there is sufficient uninvolved liver and liver radiation tolerance can be respected. There should be no extrahepatic disease, or it should be minimal and addressed in a comprehensive management plan. (Category 2B recommendation)²⁴

There is currently insufficient evidence to recommend SBRT for treatment of head and neck cancers, however, it might be beneficial for palliation or for older adults. When using SBRT techniques in reirradiation, selection of patients who do not have circumferential carotid involvement is advised. The best outcomes are seen in patients with smaller tumors and no skin involvement.³²

A systematic review and meta-analysis of 32 retrospective studies published between 1999 and 2019 demonstrated that the effectiveness and safety of stereotactic radiosurgery (SRS) for brainstem metastases (BSM) was comparable to SRS for nonbrainstem brain metastases. Death related to BSM progression following treatment with SRS was rare and patients often experienced symptomatic improvement. Based upon the apparent effectiveness and safety of SRS for BSM in the context of acute morbidity or death from BSM growth, consideration of SRS on emerging trials of targeted therapy for nonbrainstem brain metastases should be considered.³⁸

The American Academy of Neurology states there is insufficient evidence to make recommendations regarding the use of gamma knife thalamotomy in the treatment of essential

CLINICAL POLICY

Stereotactic Body Radiation Therapy

tremor.²⁵ Per UpToDate, “Gamma knife thalamotomy has not generally been adopted for essential tremor due to concerns about delayed radiation side effects, including risk of radiation necrosis and a theoretical risk of secondary tumor formation.”²⁹

Gamma knife stereotactic radiosurgery can offer a less invasive approach for resection of medial temporal structures in mesial temporal sclerosis (MTS) by allowing increased preservation of tissue. SRS may be an excellent option for patients unwilling to undergo invasive open surgical treatment of MTS. Further randomized trials are ongoing to assess the continued efficacy and outcomes of SRS as a treatment option in patients with MTS.³⁹ Per UpToDate on seizures and epilepsy in children, “Stereotactic radiosurgery may be helpful for selected cases when the lesion is located where a conventional surgical approach is technically difficult or excessively risky. More information is needed on long-term outcome before wider application of this procedure.”³⁵

American Society for Radiation Oncology (ASTRO), the American Society of Clinical Oncology (ASCO), and the American Urological Association (AUA)

Per a recent new guideline on hypofractionated radiation therapy for localized prostate cancer from ASTRO, ASCO, and the AUA, “Based on high-quality evidence, strong consensus was reached for offering moderate hypofractionation across risk groups to patients choosing external beam radiation therapy. The task force reached a weaker consensus for ultrahypofractionated radiation therapy. Extremely hypofractionated radiation therapy, also known as ultrahypofractionation, SBRT or stereotactic ablative radiation therapy (SABR) may be offered for low and intermediate risk prostate cancer, but strongly encourages treatment of intermediate-risk patients on a clinical trial or multi-institutional registry. For high-risk disease, the panel does not suggest offering ultrahypofractionation outside of a trial or registry.”³¹ Recommendations for ultrahypofractionation were graded by the panel as conditional, reflecting the limited base of current evidence on this approach. The guideline recommends large-scale randomized clinical trials and stresses the importance of shared decision making between clinicians and patients.³¹

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 2020, 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
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
61798	Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); 1 complex cranial lesion

CLINICAL POLICY
Stereotactic Body Radiation Therapy

CPT® Codes	Description
61799	Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator;) each additional cranial lesion, complex
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
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

HCPS	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
Updated codes and disclaimers for HIX products	05/13	
Added low to intermediate risk localized prostate cancer to section I as medically necessary. Updated background. Revised coding section, combining ICD 10 codes into applicable categories. References reviewed and updated.	01/19	01/19
Revised wording in I.A from “in patients who are not surgical candidates” to “as an alternative to surgery”; Added to section I. Indications for SBRT: Pancreatic cancer and high risk prostate cancer, when specific criteria are met; Added to section II- indication for SRS: Refractory epileptic seizures in children, when criterion is met. Updated background information regarding NCCN recommendations on pancreatic cancer. Added note that ICD 10 code list may not be all inclusive. Added the following ICD-10 code/code ranges: C25.0	12/19	01/20

Reviews, Revisions, and Approvals	Revision Date	Approval Date
through C25.9, C78.89, G40.011 through G40.019, G40.111 through G40.119, G40.211 through G40.219, G40.311 through G40.319, G40.A11 through G40.A19, G40.B11 through G40.B19, G40.411 through G40.419, G40.803 through G40.804, G40.813 through G40.814, G40.823 through G40.824, and G40.911 through G40.919. Internal and external specialist review.		
Annual review of policy. References reviewed and updated. Added CPT- 61800. Replaced “member” with” member/enrollee” in all instances.	12/20	01/21
Annual Review. In II.A., clarified that “one of the following” must be met. Removed “SBRT” from the note about proximity to cranial nerves in II.F. “Experimental/investigational” verbiage replaced in criteria III. with descriptive language. Changed "Last Review Date" in the header to "Date of Last Revision" and "Date" in revision log to "Revision Date". Reviewed by specialist.	01/22	01/22
Annual review completed. Added I.F. “Recurrent malignant disease requiring palliation and/or as palliative treatment for liver-related symptoms”. “Inoperable spinal tumors” added as criteria I.I. Added I.K. “Extracranial oligometastatic disease: 1. One to three metastatic lesions involving the lungs, liver or bone; 2. Primary tumor is breast, colorectal, melanoma, non-small cell lung, prostate, renal cell, or sarcoma; 3. Primary tumor is controlled; 4. No prior history of metastatic disease”. Background updated and minor rewording with no clinical significance. ICD-10 Code table removed. References reviewed and updated. Reviewed by external specialist.	01/23	01/23
Added note to policy to refer to MC.CP.MP.22 for Medicare criteria. Added “non-Medicare” to health plans in Policy/Criteria I., II. and III.	08/23	

References

1. American College of Radiology. ACR-ARS Practice Parameter for the Performance of Brain Stereotactic Radiosurgery. Accessed at: <https://www.acr.org/-/media/ACR/Files/Practice-Parameters/stereobrain.pdf> Published 1997 (revised 2021). Accessed December 6, 2022.
2. American Society for Radiation Oncology (ASTRO). Model Policy: Stereotactic body radiation therapy (SBRT). www.astro.org. Updated June 2020. Accessed December 7, 2022.
3. Chen CC, Chapman PH, Loeffler JS. Stereotactic cranial radiosurgery. UpToDate. www.uptodate.com. Updated April 5, 2022. Accessed December 7, 2022.
4. Koyfman SA. General principles of radiation therapy for head and neck cancer. UpToDate. www.uptodate.com. Updated October 10, 2022. Accessed December 7, 2022.
5. Health Technology Assessment: Stereotactic radiosurgery for movement disorders. Hayes. www.hayesinc.com. Updated October 7, 2022. Accessed December 7, 2022.
6. Heinzerling JH, Timmerman RD. Stereotactic body radiation therapy for lung tumors. UpToDate. www.uptodate.com. Updated August 26, 2022. Accessed December 7, 2022.
7. Tuleasca C, Régis J, Sahgal A, et al. Stereotactic radiosurgery for trigeminal neuralgia: a systematic review. *J Neurosurg*. 2018;130(3):733 to 757. doi:10.3171/2017.9.JNS17545

CLINICAL POLICY**Stereotactic Body Radiation Therapy**

8. Karajannis MA, Marcus KJ. Focal brainstem glioma. UpToDate. www.uptodate.com. Updated July 28, 2022. Accessed December 7, 2022.
9. Loeffler JS, Shih HA. Radiation therapy of pituitary adenomas. UpToDate. www.uptodate.com. Updated April 20, 2021. Accessed December 7, 2022.
10. Mitin T. Radiation therapy techniques in cancer treatment. UpToDate. www.uptodate.com. Updated August 31, 2022. Accessed December 7, 2022.
11. National Comprehensive Cancer Network. Prostate cancer version 1.2023. National Comprehensive Cancer Network website www.nccn.org. Published September 16, 2022. Accessed December 7, 2022.
12. Local Coverage Determination (LCD): Stereotactic radiation therapy: stereotactic radiosurgery (SRS) and stereotactic body radiation therapy (SBRT) (L35076). Centers for Medicare and Medicaid Services website. <https://www.cms.gov/medicare-coverage-database/new-search/search.aspx>. Published October 1, 2015 (revised April 1, 2020). Accessed December 7, 2022.
13. Park JK, Vernick DM, Ramakrishna N. Vestibular schwannoma (acoustic neuroma). UpToDate. www.uptodate.com. Updated September 28, 2022. Accessed December 7, 2022.
14. Pollock BE, Lunsford LD. A call to define stereotactic radiosurgery. *Neurosurgery*. 2004 Dec;55(6): 1371 to 1373.
15. Stereotactic radiosurgery (SRS) and stereotactic body radiotherapy (SBRT). Radiological Society of North America website. <https://www.radiologyinfo.org/en/info.cfm?pg=stereotactic>. Published May 28, 2019 (Reviewed July 30, 2021). Accessed December 7, 2022.
16. Singer RJ, Ogilvy CS, Rordorf G. Brain arteriovenous malformations. UpToDate. www.uptodate.com. Updated August 23, 2022. Accessed December 7, 2022.
17. Synderman C. Chordoma and chondrosarcoma of the skull base. UpToDate. www.uptodate.com. Updated April 13, 2022. Accessed December 7, 2022.
18. Cancers treated with proton therapy. The National Association for Proton Therapy website. <https://www.proton-therapy.org/science/tumors-diseases/>. Accessed December 7, 2022.
19. Owen D, Iqbal F, Pollock BE, et al. Long-term follow-up of stereotactic radiosurgery for head and neck malignancies. *Head Neck*. 2015;37(11):1557 to 1562. doi:10.1002/hed.23798.
20. National Comprehensive Cancer Network. Non-Small Cell Lung Cancer (Version 6.2022). https://www.nccn.org/professionals/physician_gls/pdf/nscl.pdf Published December 2, 2022. Accessed December 7, 2022.
21. National Comprehensive Cancer Network. Central Nervous System Cancers (Version 2.2022). <https://www.nccn.org/guidelines/guidelines-detail?category=1&id=1425> Published September 29, 2022. Accessed December 7, 2022.
22. Videtic GMM, Donington J, Giuliani M, et al. Stereotactic body radiation therapy for early-stage non-small cell lung cancer: executive Summary of an ASTRO evidence-based guideline. *Pract Radiat Oncol*. 2017;7(5):295 to 301. doi:10.1016/j.prro.2017.04.014
23. National Comprehensive Cancer Network. Pancreatic Adenocarcinoma (Version 2.2022). https://www.nccn.org/professionals/physician_gls/pdf/pancreatic.pdf Published December 6, 2022. Accessed December 7, 2022.
24. National Comprehensive Cancer Network. Hepatocellular Carcinoma (Version 3.2022). <https://www.nccn.org/guidelines/guidelines-detail?category=1&id=1438> Published October 14, 2022. Accessed December 7, 2022.

25. Zesiewicz TA, Elble RJ, Louis ED, et al. Evidence-based guideline update: treatment of essential tremor: report of the Quality Standards subcommittee of the American Academy of Neurology. *Neurology*. 2011 (Reaffirmed July 2022);77(19):1752 to 1755. doi:10.1212/WNL.0b013e318236f0fd
26. Curley SA, Stuart KE, Schwartz JM, et al. Localized hepatocellular carcinoma: liver-directed therapies for nonsurgical candidates not eligible for local thermal ablation. UpToDate. www.uptodate.com. Updated December 6, 2022. Accessed December 7, 2022.
27. Caivano D, Valeriani M, Russo I, et al. Stereotactic body radiation therapy in primary and metastatic liver disease. *Anticancer Res*. 2017 Dec;37(12):7005 to 7010.
28. Su TS, Liang P, Liang J, et al. Long-term survival analysis of stereotactic ablative radiotherapy versus liver resection for small hepatocellular carcinoma. *Int J Radiat Oncol Biol Phys*. 2017 Jul 1;98(3):639 to 646.
29. Chou KL, Tarsy D. Surgical treatment of essential tremor. UpToDate. www.uptodate.com. Updated October 26, 2022. Accessed December 7, 2022.
30. DiBiase SJ, Roach M. External beam radiation therapy for localized prostate cancer. UpToDate. www.uptodate.com. Updated October 19, 2022. Accessed December 7, 2022.
31. Morgan SC, Hoffman K, Loblaw DA, et al. Hypofractionated radiation therapy for localized prostate cancer: executive summary of an ASTRO, ASCO, and AUA evidence-based guideline. *Pract Radiat Oncol*. 2018;8(6):354 to 360. doi:10.1016/j.prro.2018.08.002
32. National Comprehensive Cancer Network. Head and neck Cancers (Version 2.2022). https://www.nccn.org/professionals/physician_gls/pdf/head-and-neck.pdf Published April 26, 2022. Accessed December 7, 2022.
33. Ryan DP, Mamon H. Initial chemotherapy and radiation for nonmetastatic, locally advanced, unresectable and borderline resectable, exocrine pancreatic cancer. UpToDate. www.uptodate.com. Updated August 10, 2022. Accessed December 7, 2022.
34. Zelefsky MJ, Kollmeier M, McBride S, et al. Five-year outcomes of a phase 1 dose-escalation study using stereotactic body radiosurgery for patients with low-risk and intermediate-risk prostate cancer. *Int J Radiat Oncol Biol Phys*. 2019;104(1):42 to 49. doi:10.1016/j.ijrobp.2018.12.045
35. Wilfong A. Seizures and epilepsy in children: refractory seizures. UpToDate. www.uptodate.com. Updated September 20, 2022. Accessed December 7, 2022.
36. Health Technology Assessment. Stereotactic Radiosurgery for Trigeminal Neuralgia. Hayes. www.hayesinc.com. Updated October 20, 2022. Accessed December 7, 2022.
37. Loeffler JS. Overview of the treatment of brain metastases. UpToDate. www.uptodate.com. Updated November 11, 2022. Accessed December 7, 2022.
38. Chen WC, Baal UH, Baal JD, et al. Efficacy and Safety of Stereotactic Radiosurgery for Brainstem Metastases: A Systematic Review and Meta-analysis. *JAMA Oncol*. 2021;7(7):1033 to 1040. doi:10.1001/jamaoncol.2021.1262
39. Chang EF, Englot DJ, Vadera S. Minimally invasive surgical approaches for temporal lobe epilepsy. *Epilepsy Behav*. 2015;47:24 to 33. doi:10.1016/j.yebeh.2015.04.033
40. Patel SA, Switchenko JM, Fischer-Valuck B, et al. Stereotactic body radiotherapy versus conventional/moderate fractionated radiation therapy with androgen deprivation therapy for unfavorable risk prostate cancer. *Radiat Oncol*. 2020;15(1):217. Published 2020 Sep 15. doi:10.1186/s13014-020-01658-5

CLINICAL POLICY**Stereotactic Body Radiation Therapy**

41. Luo G, Cameron BD, Wang L, et al. Targeting for stereotactic radiosurgical thalamotomy based on tremor treatment response [published online ahead of print, 2021 Oct 29]. *J Neurosurg.* 2021;1 to 8. doi:10.3171/2021.7.JNS21160
42. Reshko LB, Baliga S, Crandley EF, et al. Stereotactic body radiation therapy (SBRT) in recurrent, persistent or oligometastatic gynecological cancers. *Gynecol Oncol.* 2020;159(3):611 to 617. doi:10.1016/j.ygyno.2020.10.001
43. Milano MT, Chowdhry AK, Salama JK, Chmura SJ. Signals from SABR-COMET time to move on to phase III studies. *Ann Transl Med.* 2019;7(Suppl 8):S316. doi:10.21037/atm.2019.09.152

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 member/enrollees. This clinical policy is not intended to recommend treatment for member/enrollees. Member/enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

CLINICAL POLICY

Stereotactic Body Radiation Therapy

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.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, member/enrollees and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, member/enrollees and their representatives agree to be bound by such terms and conditions by providing services to member/enrollees and/or submitting claims for payment for such services.

Note: For Medicaid member/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.

Note: For Medicare member/enrollees, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at <http://www.cms.gov> for additional information.

©2016 Centene Corporation. All rights reserved. All materials are exclusively owned by Centene Corporation and are protected by United States copyright law and international copyright law. No part of this publication may be reproduced, copied, modified, distributed, displayed, stored in a retrieval system, transmitted in any form or by any means, or otherwise published without the prior written permission of Centene Corporation. You may not alter or remove any trademark, copyright or other notice contained herein. Centene® and Centene Corporation® are registered trademarks exclusively owned by Centene Corporation.