Harvard Pilgrim Health Care | TUFTS Health Plan

Medical Necessity Guidelines:

Stereotactic Radiosurgery and Stereotactic Body Radiotherapy

Effective: December 1, 2025

Prior Authorization Required If REQUIRED, submit supporting clinical documentation pertinent to service request.	Yes ☒ No ☐
Notification Required If REQUIRED, concurrent review may apply	Yes ☐ No ☒

Applies to:

Commercial Products

☒ Harvard Pilgrim Health Care Commercial products; 800-232-0816
☒ Tufts Health Plan Commercial products; 617-972-9409

Public Plans Products

☒ Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product); 888-415-9055
☒ Tufts Health Together – MassHealth MCO Plan and Accountable Care Partnership Plans; 888-415-9055
☒ Tufts Health RITogether – A Rhode Island Medicaid Plan; 857-304-6404
☒ Tufts Health One Care-- A dual-eligible product; 857-304-6304

Senior Products

☐ Tufts Health Plan Senior Care Options (SCO), (a dual-eligible product); 617-972-9409
☐ Tufts Medicare Preferred HMO, (a Medicare Advantage product); 617-972-9409
☐ Tufts Medicare Preferred PPO, (a Medicare Advantage product); 617-972-9409

Note: While you may not be the provider responsible for obtaining prior authorization or notifying Point32Health, as a condition of payment you will need to ensure that any necessary prior authorization has been obtained and/or Point32Health has received proper notification. If notification is required, providers may additionally be required to provide updated clinical information to qualify for continued service.

Overview

Stereotactic radiosurgery (SRS) is similar in concept to SBRT and refers to stereotactically guided radiation therapy delivered to intracranial targets and selected tumors near the base of the skull. Stereotactic radiosurgery (SRS) delivers a single or very limited number of fractions of high dose of radiation to a well-defined tumor volume, rather than repeated small fractions to both cancer and normal cells.

Stereotactic body radiation therapy (SBRT) is a radiation treatment modality that couples a high degree of anatomic targeting accuracy and reproducibility with very high doses of extremely precise, externally generated, ionizing radiation. The therapeutic intent of SBRT is to maximize cell-killing effect on the target(s) while minimizing radiation-related injury in adjacent normal tissues. Stereotactic body radiation therapy refers to multifractional (typically two to five fractions) treatment of intracranial, spinal, or extracranial sites, such as the lung, head and neck, liver, pancreas, and prostate. SBRT can also be used for the treatment of oligometastatic disease.

Clinical Guideline Coverage Criteria

The Plan uses guidance from the Centers for Medicare and Medicaid Services (CMS) and MassHealth for coverage determinations for its Dual Product Eligible plan members. CMS National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), Local Coverage Articles (LCAs) and documentation included in the Medicare manuals and MassHealth Medical Necessity Determinations are the basis for coverage determinations where available. For **Tufts**

Health One Care plan members the following criteria is used: Stereotactic Radiation Therapy: Stereotactic radiosurgery (SRS) and Stereotactic Body Radiation Therapy (SBRT) LCD L35076

1. The Plan may authorize the coverage of stereotactic radiosurgery (SRS) when the Member meets **ONE** of the following:
    a. Small intracranial or spinal arteriovenous malformations and the Member is considered a poor surgical candidate.
    b. Primary intracranial tumors not suitable for complete surgical resection or the Member has failed conventional therapy.
    c. Metastatic brain lesion(s) and the Member is with good performance status (Karnofsky Performance Status of ≥70% or Eastern Cooperative Oncology Group (ECOG) Status ≤2)
    d. Vestibular schwannoma or acoustic neurofibromatosis not amenable to surgical resection
    e. Pituitary adenoma
    f. Craniopharyngioma
    g. Glomus jugulare tumors
    h. Hemangiomas of the brain
    i. Meningioma
    j. Pineal gland tumors
    k. Uveal or ocular melanoma
    l. Trigeminal neuralgia and glossopharyngeal neuralgia refractory to treatment.
2. The Plan may authorize the coverage of definitive stereotactic body radiation therapy (SBRT) for treatment of primary non-metastatic lesions listed below when **ALL** of the following criteria are met:
    a. A high level of precision and accuracy or a high dose per fraction is necessary to minimize the risk of injury to surrounding normal tissues and treatment with conventional methods is not appropriate or safe for the Member; **AND**
    b. Member is with good performance status (Karnofsky Performance Status of ≥70% or Eastern Cooperative Oncology Group (ECOG) Status ≤2); **AND**
    c. The Member is with **ONE** of the following:
        i. Prostate cancer without evidence of distant metastasis (Up to six treatment sessions may be authorized for this diagnosis); or
        ii. Stage I or II non-small cell lung cancer and **ONE** of the following is met;
            - the disease is inoperable; or
            - when SBRT is requested as an alternative to surgery for Member who is a high surgical risk or who refuses surgery after surgical consultation; or
        iii. Pancreatic adenocarcinoma without evidence of distant metastasis; or
        iv. Hepatocellular carcinoma without evidence of regional or distant metastasis; or
        v. Primary renal cell carcinoma when it cannot be treated surgically.
3. The Plan may authorize the coverage of stereotactic body radiation therapy (SBRT) for the treatment of bone metastases (including vertebral) when the Member has persistent or recurrent bone pain after a standard course of EBRT.
4. The Plan may authorize the coverage of stereotactic body radiation therapy (SBRT) for the treatment of oligometastatic disease of extracranial sites when **ALL** of the following criteria are met:
    a. Primary tumor is breast, colorectal, melanoma, non-small cell lung, prostate, renal cell, or sarcoma; **and**
    b. ≤ 5 metastatic lesions[22]; **and**
    c. A controlled primary tumor: defined as at least 3 months since original tumor was treated definitively, with no progression at primary site[12,13]; **and**
    d. All metastatic sites are safely treatable; **and**
    e. Member is with good performance status (Karnofsky Performance Status of ≥70% or Eastern Cooperative Oncology Group (ECOG) Status ≤2)[13]; **and**
    f. No documentation of evidence of malignant pleural effusion, leptomeningeal or peritoneal carcinomatosis

Karnofsky performance status measures

Score Definition

- 100 - Normal; no complaints; no evidence of disease.
- 90 - Able to carry on normal activity; minor signs or symptoms of disease.
- 80 - Normal activity with effort; some signs or symptoms of disease

- 70 - Cares for self; unable to carry on normal activity or to do active work
- 60 - Requires occasional assistance but is able to care for most of their personal needs.
- 50 - Requires considerable assistance and frequent medical care.
- 40 - Disabled; requires special care and assistance.
- 30 - Severely disabled; hospital admission is indicated although death not imminent.
- 20 - Very sick; hospital admission necessary; active supportive treatment necessary
- 10 - Moribund; fatal processes progressing rapidly.
- 0 - Dead

Eastern Cooperative Oncology Group (ECOG)

Score Definition

- 0 – Asymptomatic. Fully active, able to carry on all pre-disease activities without restriction.
- 1 – Symptomatic but completely ambulatory. Restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature (e.g., light housework, office work).
- 2 – Symptomatic, <50% in bed during the day. Ambulatory and capable of all self-care but unable to carry out any work activities. Up and about more than 50% of waking hours.
- 3 – Symptomatic, >50% in bed, but not bedbound. Capable of only limited self-care, confined to bed or chair 50% or more of waking hours.
- 4 – Bedbound. Completely disabled. Cannot carry on any self-care. Totally confined to bed or chair.
- 5 – Death

Codes

The following code(s) require prior authorization:

Table 1: CPT/HCPCS Codes

Code	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 (List separately in addition to code for primary procedure)
61798	Stereotactic radiosurgery (particle beam, gamma ray or linear accelerator); 1 complex cranial lesion
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)
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
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

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Approval And Revision History

October 20, 2020: Reviewed by the Medical Technology Assessment Committee renewed with no changes.

Subsequent endorsement date(s) and changes made:

- December 21, 2022: Reviewed by MPAC, renewed without changes.
- January 18, 2023: Reviewed by the Medical Policy Approval Committee (MPAC). Effective April 1, 2023 ocular melanoma added to allowed conditions, SRS. Criteria requirement for SBRT, oligometastatic disease, changed from 3 to 5 metastatic lesions; CPT codes 32701, 61799 and 61800 no longer required prior authorization, Medical Necessity Guidelines are applicable to Harvard Pilgrim Health Care.
- June 21, 2023: Reviewed by MPAC. Removed limitation noninvasive cardiac radio-ablation using stereotactic radiotherapy for the treatment of ventricular tachycardia, effective August 1, 2023
- November 2023: Rebranded Unify to One Care and updated One Care criteria effective January 1, 2024
- August 30, 2024: Reviewed by MPAC, renewed without changes, effective October 1, 2024.
- August 20, 2025: Reviewed by MPAC. Added new indication; Primary renal cell carcinoma. Effective December 1, 2025. References updated.
- September 5, 2025: Harvard Pilgrim Health Care Stride Medicare Advantage removed as an applicable product from the template. Fax numbers for Senior Care Options, Tufts Medicare Preferred HMO and Tufts Medicare Preferred PPO updated; language for Carelink removed

Background, Product and Disclaimer Information

Medical Necessity Guidelines are developed to determine coverage for benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. We make coverage decisions using these guidelines, along with the Member's benefit document, and in coordination with the Member's physician(s) on a case-by-case basis considering the individual Member's health care needs.

Medical Necessity Guidelines are developed for selected therapeutic or diagnostic services found to be safe and proven effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in our service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. We revise and update Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Medical Necessity Guideline and a self-insured Member's benefit document, the provisions of the benefit document will govern. For Tufts Health Together (Medicaid), coverage may be available beyond these guidelines for pediatric members under age 21 under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefits of the plan in accordance with 130 CMR 450.140 and 130 CMR 447.000, and with prior authorization.

Treating providers are solely responsible for the medical advice and treatment of Members. The use of this guideline is not a guarantee of payment, or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to eligibility and benefits on the date of service, coordination of benefits, referral/authorization, utilization management guidelines when applicable, and adherence to plan policies, plan procedures, and claims editing logic.