MEDICAL POLICY

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Medical Policy Title	**Stereotactic Radiosurgery and Stereotactic Body Radiation Therapy**
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Our medical policies are based on the assessment of evidence based, peer-reviewed literature, and professional guidelines. Eligibility for reimbursement is based upon the benefits set forth in the member's subscriber contract. (Link to Product Disclaimer)

POLICY STATEMENT(S)

I. Stereotactic Radiosurgery (SRS) is considered **medically appropriate** for the following indications:

A. Benign Conditions:

1. Arteriovenous malformations;
2. Acoustic neuromas;
3. Pituitary adenomas;
4. Nonresectable, residual, or recurrent meningiomas;
5. Craniopharyngiomas;
6. Glomus tumors;
7. Hemangioblastoma;
8. Pineocytoma;
9. Schwannoma;
10. Cavernous malformations.

B. Brain:

1. Primary tumors of the brain that have been previously irradiated.
2. Reirradiation of recurrent inoperable malignant gliomas in individuals with an Eastern Cooperative Oncology Group (ECOG) performance status of 0-2.
3. Intact brain metastases with no history of surgical intervention when **ALL** the following conditions are met:
   a. All lesions can be encompassed in a single treatment plan;
   b. The patient has a ECOG performance status of 0-2;
   c. Systemic disease is limited and under control or good options for systemic treatment are available;

d. There is no leptomeningeal disease; or the primary histology is not germ cell, small cell, or lymphoma;

e. The total volume of treated lesions should be considered safe to deliver SRS in alignment with current guidelines from the American Society for Therapeutic Radiation Oncology (ASTRO); **and**

f. **EITHER** of the following conditions (Policy Criteria i. or ii. below) are met:

i. The total number of treated brain metastases is less than or equal to four (4); **and**

a) Diameter for each lesion is less than 4 cm; **or**

b) Diameter for each lesion is between 4 cm and less than or equal to 6 cm when **ALL** the following criteria are met:

(i) Individual is not a candidate for surgery;

(ii) There is no presence of a mass effect; **and**

(iii) Documentation is provided demonstrating neurosurgery input;

OR

ii. The total number of treated brain metastases is greater than or equal to five (5) and less than or equal to ten (10) when **ALL** the following criteria are met:

a) Individual is not a candidate for surgery;

b) There is no presence of a mass effect; **and**

c) Documentation is provided demonstrating neurosurgery input.

4. Prior treatment with whole brain irradiation (WBRT) when **ALL** the following criteria are met:

a. The total number of brain metastases is less than or equal to four (4);

b. The patient has a ECOG performance status of 0-2; **and**

c. Systemic disease is under control.

5. Prior treatment with SRS when **ALL** of the following criteria are met:

a. Total number of brain metastases is less than or equal to four (4);

b. The patient has a ECOG performance status of 0-2;

c. The patient's systemic disease is under control;

d. New lesions are present (no lesion is greater than 4 cm); **and**

e. The patient has not been treated with more than two (2) episodes of radiosurgery in the past nine (9) months.

6. Recurrent brain lesions and no prior treatment with WBRT when **ALL** the following criteria are met:
    a. Recurrence involves one (1) to four (4) lesions;
    b. More than six (6) months have elapsed since radiation therapy;
    c. The patient has a ECOG performance status of 0-2; **and**
    d. Systemic disease is under control.
7. Post-operative SRS after surgical debulking when the patient has a combination of up to four (4) resected and unresected lesions, each of which, individually, is less than 4 cm in size.

C. For the following neurologic indications that are refractory to medical management or invasive neurosurgical treatment:
1. Trigeminal neuralgia;
2. Movement disorders (e.g., epilepsy, Parkinson's disease, essential tremor, or familial tremor classifications with major systemic disease).

II. Stereotactic Body Radiation Therapy (SBRT) is considered **medically appropriate** for **ALL** the following indications, when the specific criteria are met:

A. Cervical Cancer:
1. When there is a history of previous radiation to the same or abutting region; **and**
2. An inability to deliver therapeutic doses of radiation with other techniques;

B. Head and Neck Cancer:
1. For retreatment of individuals who have no evidence of metastatic disease;

C. Intrahepatic Bile Duct Cancer (Cholangiocarcinoma):
1. Unresectable;
2. Localized; and
3. For definitive treatment; **or**
4. For extrahepatic bile duct cancer, refer to Policy Statement IV.D;

D. Liver Cancer, Primary (Hepatocellular Carcinoma [HCC]):
1. In the definitive setting;
2. Concurrent treatment of one (1) or more tumors; **and**
3. There is evidence of the ability to protect an adequate volume of uninvolved liver;

E. Nasopharyngeal Carcinoma:
1. Recurrent or residual carcinoma at primary site; **and**

2. When radiation therapy treatments such as three-dimensional conformal or Intensity-modulated radiation therapy (IMRT) cannot be utilized;

F. Non-Small Cell Lung Cancer (NSCLC):

1. Tumor is stage I or stage II; **and**
2. Inoperable;

G. Pancreatic Cancer:

1. Locally advanced disease in individuals who have an ECOG status of 0-1; **and**
   a. Are not candidates for induction chemotherapy or combination systemic treatment and are without systemic metastases; **or**
   b. With disease progression where chemoradiation was not previously given and primary site is the sole site of progression; **or**
   c. Presents with poorly controlled pain or local invasion with bleeding; **or**
2. Preoperative (neoadjuvant) treatment of borderline resectable cases; **and**
   a. Following chemotherapy and restaging; **and**
   b. No evidence of tumor progression; **or**
   c. For neoadjuvant treatment, refer to Policy Statement IV.H;

   *SBRT should not be used if direct invasion of the bowel or stomach is observed on imaging.

H. Prostate Cancer:

*The use of a biodegradable perirectal spacer (e.g., SpaceOar system) is considered **medically appropriate** for the treatment of prostate cancer when disease is clinically localized.

I. Soft Tissue Sarcoma:

1. Recurrent; **and**
2. Is within a previously irradiated area;

J. Small Cell Lung Cancer:

1. Limited Stage I; **or**
2. Node-negative stage IIA;

K. Spinal or Vertebral Body Tumors:

1. Site has been previously irradiated; **or**
2. Presence of compression or intractable pain; **or**

3. Tumor is radioresistant (e.g., sarcoma, melanoma, hepatocellular carcinoma, or renal cell carcinoma); **and**
    a. Tumor ablation is a goal of treatment.

III. SBRT is considered **medically appropriate** for extracranial oligometastatic disease for:

A. Synchronous Disease when:

1. Less than six (6) months interval between oligometastatic disease and primary cancer diagnosis; **and**
2. **ANY** of the following neoplasms presenting with one (1) to five (5) metastases when local control of the primary tumor is expected, and treatment of the metastases may result in an increased disease-free interval and possible survival:
    a. For an individual with non-small cell lung cancer who has had or will undergo curative treatment of the primary tumor (based on T and N stage);
    b. For an individual with prostate cancer when the goal of treatment is ablation of the primary tumor; **or**
    c. For an individual with colorectal cancer who:
        i. has had or will undergo curative treatment of the primary tumor; **and**
        ii. whose metastases are in the lung or liver; **and**
        iii. for whom surgical resection is not possible.

B. Metachronous/Metachronous Oligorecurrent Disease when:

1. Greater than or equal to six (6) months have elapsed between oligometastastic disease and the primary cancer diagnosis); **and**
2. Clinical presentation of one to five (5) metastases to the adrenal gland, lung, liver, or bone when **ALL** the following criteria are met:
    a. the histology is non-small cell lung, colorectal, prostate, breast, sarcoma, renal cell or melanoma;
    b. there is no prior evidence of metastatic disease (cranial or extracranial);
    c. the primary tumor received curative local and/or systemic therapy and is controlled;
    d. there has been a systemic therapy-free interval of time prior to the diagnosis of metachronous disease;
    e. all metastatic lesions present on imaging will be treated concurrently in a single episode.

IV. SBRT is considered a **medically appropriate** treatment option for Metachronous Oligoprogressive Prostate Cancer (greater than six [6] months have elapsed since the primary

diagnosis and the individual is under treatment with active systemic therapy when new oligometastatic disease is detected).

V. SBRT is considered **not medically necessary** for **ANY** of the following indications:

A. Metachronous Oligoprogressive Disease for any indication other than prostate cancer (refer to Policy Statement IV. above) (greater than six [6] months have elapsed since the primary diagnosis and the individual is under treatment with active systemic therapy when new oligometastatic disease is detected);

B. Extracranial Repeat Oligometastatic Disease (history of oligometastic disease, local and systemic treatment has failed, disease has not progressed to polymetastatic), including repeat oligoprogression and repeat oligopersistent disease;

C. Extracranial Induced Oligometastatic Disease (history of polymetastatic disease, has been treated with partially effective systemic treatment) including induced oligorecurrence, induced oligoprogression and induced oligopersistent disease;

D. Extrahepatic bile duct cancer (cholangiocarcinoma);

E. Gallbladder cancer;

F. Chronic pain;

G. The adjuvant (post-operative) curative treatment of primary adrenocortical carcinoma;

H. Planned neoadjuvant treatment of pancreatic cancer when:

1. The primary tumor is otherwise fully resectable;
2. The postoperative setting; **or**
3. The palliative setting.

VI. SBRT is considered **investigational** for **ALL** other indications including, but not limited to,:

A. As an alternative to brachytherapy for the treatment of cervical cancer;

B. To induce abscopal effects.

RELATED POLICIES

Corporate Medical Policy

6.01.11 Proton Beam Radiation Therapy

7.01.23 Deep Brain Stimulation

11.01.03 Experimental or Investigational Services

POLICY GUIDELINE(S)

SBRT, as a complete course of therapy, must be completed in five (5) fractions or less within a single episode of care.

DESCRIPTION

Stereotactic Radiosurgery (SRS)

SRS or fractionated radiosurgery is a method of delivering high doses of ionizing radiation to small intracranial targets. This technique differs from conventional radiotherapy, which involves exposing large areas of tissue to relatively broad fields of radiation over a number of sessions. SRS entails delivering highly focused convergent beams in a single session so that only the desired target is radiated, sparing adjacent structures.

Stereotactic Body Radiation therapy (SBRT)

SBRT is often referred to as stereotactic ablative radiotherapy (or SABR) in the literature. As stated in the guideline developed by the American College of Radiology (ACR) and the American Society for Therapeutic Radiation Oncology (ASTRO) (2019), stereotactic body radiation therapy (SBRT) is an external beam radiation therapy method used to deliver, very precisely, a high dose of radiation to an extracranial target within the body, in five (5) fractions or less. Specialized treatment planning results in high target dose and steep dose gradients beyond the target. The ability to deliver a single or a few fractions of high-dose ionizing radiation with high targeting accuracy and rapid dose falloff gradients encompassing tumors within a patient provides the basis for the development of SBRT. SBRT can be applied using noninvasive or minimally invasive stereotactic localization and radiation delivery techniques. It requires significantly improved delivery precision over that required for conventional radiotherapy. Specialized imaging techniques may be required, either to limit or to compensate for target movement during treatment planning and delivery.

Perirectal Hydrogel Spacer Use

SpaceOAR (Spacing Organs At Risk (OAR)) (Augmenix, Inc, Waltham, MA), is one example of a polyethylene glycol-based hydrogel spacer. It received U.S. Food and Drug Administration approval in 2015. Prior to radiation, the spacer is injected into the perirectal space, temporarily positioning the rectum further away from the radiation field reducing the dose of radiation outside of the designated treatment area. Perirectal spacers are proposed to improve patient's quality of life by reducing potential toxicities. The hydrogel remains in place for 3 months after which it is then absorbed and excreted through the patient's urine.

ECOG Performance Status

Performance Status	Description
0	Fully active; no performance restrictions
1	Strenuous physical activity restricted; fully ambulatory and able to carry out light work

2	Capable of all self-care but unable to carry out any work activities Up and about > 50% of waking hours.
3	Capable of only limited self-care; confined to bed or chair >50% of waking hours
4	Completely disabled; cannot carry out any self-care; totally confined to bed or chair

SUPPORTIVE LITERATURE

Radiosurgery has been known to improve health outcomes by providing local tumor control and increasing survival rates but can be associated with complications such as radionecrosis or central nervous system toxicity.

SRS for Benign Conditions

Literature regarding SRS as first-line treatment of meningioma consists of prospective and retrospective case series, which conclude that SRS provides high rates of tumor growth control or regression in patients with benign meningiomas with low-risk, and in patients with cavernous sinus meningioma.

SRS performed on inoperable arteriovenous malformations (AVM's) with diameters less than 4 cm have been found to have obliteration rates up to 94%.

SRS for the treatment of acoustic neuroma increases the preservation of facial nerve function and decreases hearing loss associated with alternative treatments. A single-institution study reported outcomes of single fractions versus fractionated LINAC-based SRS in 129 patients with acoustic neuromas. With an average follow-up of 33 months, there was no difference in outcome in terms of local tumor control, facial nerve preservation, and hearing preservation.

SRS of the Brain and Spine

In a systematic review (Giraldo et al 2024) explored the role of SRS in the management of metastatic spine disease. The authors conducted a comprehensive literature review of studies published between 2012 and 2022 to assess the efficacy, safety, and clinical outcomes of SRS in this context. Traditionally, spinal metastases have been managed with surgery, chemotherapy, and conventional radiotherapy, but these approaches often come with significant limitations. SRS has emerged as a non-invasive alternative that delivers high-dose, targeted radiation while sparing surrounding healthy tissue. The review found that SRS offers excellent local tumor control and pain relief, even in cases involving radioresistant tumors such as melanoma and renal cell carcinoma. Pain relief was reported in over 85% of patients, with many experiencing improvements within two weeks. The authors emphasized the importance of individualized treatment planning and called for further research to refine dosing protocols and long-term safety assessments. Overall, the study supports SRS as a safe, effective, and increasingly integral component of multidisciplinary care for spinal metastases.

SRS for Neurologic Conditions Refractory to Treatment

A 2023 meta-analysis by Chen et al, evaluated the safety and efficacy of SRS for treating brainstem metastases (BSM), a particularly challenging subset of neurologic conditions due to the critical anatomy involved. The study pooled data from 32 studies encompassing 1,446 patients, revealing a local control rate of 86%, indicating strong effectiveness in halting tumor progression at the treatment site. Additionally, symptom improvement was reported in 63% of patients, and the objective response rate—defined as measurable tumor shrinkage—was 65%. Despite the sensitive location, grade ≥3 toxic effects occurred in only 2.6% of cases, and death due to brainstem progression was rare (2.7%), underscoring the safety of SRS in this population. The one-year overall survival rate was 32%, and two-year survival was 13%, reflecting the serious nature of the underlying disease but also the potential for meaningful life extension with SRS.

Trigeminal Neuralgia

SRS for trigeminal neuralgia refractory to medical management has similar outcomes compared to alternative treatments (e.g., microvascular decompression), is the least invasive non-pharmacologic treatment, and is associated with less complications (facial paresis, pain recurrence) than alternative treatments.

Refractory Movement Disorders

Gamma knife radiosurgery is a form of SRS. Small case series examined the role of gamma knife radiosurgery in the treatment of refractory movement disorders, although radiofrequency ablation or deep brain stimulation would be considered the gold standard therapies for this indication. The ordering provider must certify that the usual and customary treatments outlined above would not be successful in managing the member's condition.

SBRT

Literature has increased regarding stereotactic radiosurgery/radiotherapy of other extracranial sites. Numerous studies address SBRT of the lung and liver (for both primary and metastatic lesions), renal cell carcinoma (for both primary and metastatic lesions), pancreas, and adrenal glands. These studies are generally of small sample size but show that the control rate is similar to the control rate for brain metastases (over 90%).

Tchelebi et al (2016) conducted a systematic review and meta-analysis comparing rates of overall survival and toxicity in SBRT and conventionally fractionated radiation therapy with concurrent chemotherapy. The analysis represented 1147 patients with N0-1 M0 locally advanced pancreatic cancer. The authors compared one- and two-year overall survival and acute and late grade 3/4 toxicity using three different methods of assessment, including rates, random effects estimates and a sensitivity analysis which excluded three SBRT studies that had utilized unusually high doses of radiation that would not be considered in current practice. Overall, the analysis demonstrated improved overall survival and reduced acute and late grade 3/4 toxicities with SBRT versus chemoradiation utilizing all three methods of analysis. Authors concluded that SBRT may offer modest improvements in overall survival compared with conventional fractionation and concurrent chemotherapy.

SBRT of Pancreatic Adenocarcinoma

Surgical resection is currently the only known treatment with a potential for curing pancreatic adenocarcinoma, with a majority of patients presenting with surgically unresectable disease. The median overall survival for patients with locally advanced disease is only 12 months. The resectability of a pancreatic tumor typically depends on its position within the pancreas, and its location relative to the surrounding blood vessels. The role of radiation therapy in this patient population is evolving. SBRT may allow for a shorter time frame from the start of radiation therapy to the time of resection.

SBRT for Polymetastatic Disease/Oligometastic Disease

Polymetastatic disease typically refers to wide-spread dissemination of metastatic cancer, while oligometastic disease has been described as an intermediate state between limited and systemically metastasized disease and is often synonymous with few (less than five) metastases. Historically, there is not a standard definition in the literature for either, nor is there a clear boundary of where each occurs on the spectrum of disease, which is often not linear and is dependent on an individual's response to therapy. Oligometastatic disease is currently diagnosed via imaging and clinical judgement. An anticipation exists among the literature for the identification of biomarkers that would be able to identify precisely when each oligometastatic stage begins and ends, to guide in treatment planning.

In 2020, The European Society for Radiotherapy and Oncology (ESRO) and the European Organisation for Research and Treatment of Cancer (EORTC) developed a consensus recommendation to characterize and classify oligometastatic disease (Guckenberger et al). The document makes several references to initial descriptions of oligometastic disease as defined in 1995 by Hellman and Weischselbaum. Within the consensus recommendation, ESRO/EORTC classify oligometastatic disease as an umbrella term for nine distinct states which are summarized as follows:

I. Oligometastatic Disease- an intermediate state between localized and systemically metastasized disease.
    A. De-novo oligometastatic disease- individual does not have a history of oligometastatic disease
        1. Synchronous oligometastatic disease- there is no history of oligometastatic disease and less than six (6) months have elapsed between the primary cancer diagnosis and oligometastatic disease.
        2. Metachronous oligometastatic disease- individual does not have a history of oligometastatic disease and more than six (6) months have elapsed between the time of primary diagnosis and oligometastatic disease
            a. Metachronous oligorecurrence- the primary cancer was diagnosed and treated, there has been a systemic therapy-free interval of time, and now there is a small number of new oligometastases (occurring greater than six (6) months after the primary diagnosis) detected.
            b. Metachronous oligoprogression- the primary cancer was diagnosed and treated, the individual is currently under treatment with active systemic

therapy, and now there is a small number of new oligometastases (occurring greater than six (6) months after the primary diagnosis).

B. Repeat oligometastatic disease- individual has a previous diagnosis of oligometastatic disease that has not progressed to polymetastatic, after failure of local and/or systemic treatment, and has new oligometastases.
    1. Repeat oligorecurrence- individual has a previous diagnosis of oligometastases, has received local and/or systemic treatment, there has been a systemic therapy-free interval of time, and now there are a few new and growing or regrowing oligometastes.
    2. Repeat oligoprogression- individual has a previous diagnosis of oligometastases, the individual is currently under treatment with active systemic therapy, and now there is a small number of new oligometastases.
    3. Repeat oligopersistence- individual has a previous diagnosis of oligometastases after receiving local and/or systemic treatment, the individual is currently under treatment with active systemic therapy and is diagnosed with persistent non-progressive oligometastases.
C. Induced oligometastatic disease- individual has a history of polymetastatic disease, systemic therapy has failed to destroy remaining metastases and has new oligometastases.
    1. Induced oligorecurrence- individual has a diagnosis of polymetastatic disease, had systemic and/or local treatment, there has been a systemic therapy-free interval of time, now there are new and growing or regrowing oligometastases.
    2. Induced oligoprogression- individual has a diagnosis of polymetastatic disease, has had systemic and/or local treatment, is currently receiving active systemic therapy and is now diagnosed with new and growing or regrowing oligometastases.
    3. Induced oligopersistence- individual has a diagnosis of polymetastatic disease, has had systemic and/or local treatment, is currently receiving active systemic therapy and is diagnosed with persistent non-progressive oligometastases.

Lievens et al (2020) summarized a European Society for Radiotherapy and Oncology (ESTRO)-ASTRO consensus document aimed to define oligometastatic disease from a radiation oncology perspective. The authors acknowledged that several definitions exist in literature for the different states of oligometastatic disease, including the use of the term "induced." The treatment goal for these individuals is improved quality of life or local control, rather than overall survival. Oligoprogression that is identified during active systemic therapy is believed to have worse prognosis compared to disease that is considered de novo. Additionally, the authors address the number of oligometastases that can be safely treated with radiotherapy, when the intent is curative in nature. The most commonly used quantifications in the literature available are up to three (3), or five (5) oligometastatic lesions. Little data includes the treatment of more than five (5) lesions, and therefore, the authors agreed that this should be the upper limit for consideration until further research is available and emphasize the need to consider balancing efficacy with toxicity, which is to be considered dependent on disease location.

ESRO/EORTC (Guckenberger et al 2020) address the goals of treatment for individuals with oligometastatic disease. Historically, individuals with induced oligometastatic disease, were not treated radically with curative intent. Recent trials and interest in the oligometastatic state have changed the focus to prolong the time to systemic therapy, enhance sensitivity to the current systemic therapy or potentiate a deeper response. Given the lack of scientific evidence, the value for the use of SBRT in the state of induced oligometastases, is unknown. Additionally, to date, there is no data available regarding the frequency or the outcomes of individuals with repeat oligometastatic disease. Future studies are warranted to determine if the use of SBRT improves the net health outcome in these stages of oligometastatic disease.

ESTRO/ASTRO endorse the classification system presented by ESRO/EORTC and are jointly participating in an observational prospective cohort study (NCT03818503) estimated to be completed in 2026 known as E^2-RADIatE: EORTC-ESTRO RADiotherapy InfrAstrucTure for Europe. The primary outcome measure is the number of patients treated with radiotherapy enrolled in the program. Secondary outcome measures include disease-free survival, local-regional control, distant metastasis free survival, overall survival, and the incidence of adverse events related to treatment. The study has a target follow-up duration of five years.

SBRT to Induce Abscopal Effects

Abscopal effects are reported to be rare immune-response phenomenon in which treatment of one tumor with radiation therapy typically combined with immunotherapy, may cause the regression of other, untreated tumors. Abscopal responses have been documented in case series of patients with melanoma, breast, lung, and liver cancers however, the mechanism of which to induce this reported effect is not clearly understood, nor is the type of patient who is more likely to respond. The evidence is not sufficient to determine that utilizing SBRT to induce an abscopal effect, results in a meaningful improvement in the net health outcome.

SBRT for Prostate Cancer

Literature is active with respect to the use of SBRT for treatment of prostate cancer and the NCCN guidelines V.1.2026 consider it an acceptable treatment regimen for patients with prostate cancer across all risk groups and for locoregional and/distant metastases in practices with appropriate technology and expertise. For primary sites and/or regional nodal treatment with SBRT, simultaneous integrated boost for dosing of prostate, intraprostatic, seminal vesicle, and/or regional nodal targets to differing doses may be used. In select patients, SBRT to the prostate may also be used as a boost in combination with fractionated EBRT." Further, that SBRT is recommended for metastasis-directed therapy in the following circumstances: In a patient with limited metastatic disease (e.g., oligometastatic) when ablation is the goal, in a patient with limited progression (e.g., oligoprogression) or limited residual disease on otherwise effective systemic therapy where progression free survival is the goal, in a symptomatic patient where the lesion occurs in or immediately adjacent to a previously irradiated treatment field, at physician discretion for more durable control of pain."

For individuals who have prostate cancer and are undergoing radiation therapy who receive a hydrogel spacer, the evidence includes a pivotal RCT with a 3-year follow up, observational studies,

and systematic reviews. Mariados and colleagues (2015) conducted a manufacturer sponsored, prospective, multi-center, single-blind study, evaluating the percent of the rectal volume receiving 70 Gy in dose planning studies of 222 men randomized 2:1 to either a spacer or control group. All men received IMRT (79.2 Gy in 1.8-Gy fractions) to the prostate. Those with spacer use experienced a lower percentage of rectal volume receiving 70 Gy (3.3% versus 11.7%). They evaluated the effectiveness of the SpaceOAR system in reducing adverse gastrointestinal events with IMRT. and demonstrated a significant reduction in mean rectal V70 with the device in place. There were no reports of device-related adverse events, rectal perforations, serious bleeding, or infections, and acute rectal adverse events were similar between the two groups, however there was significantly less pain experience reported by the treatment group. A reduction in late rectal toxicity (three to 15 months after RT) has been observed, and no patients treated with the spacer experienced greater than grade 1 toxicity. The 3-year follow up study (Hamstra et al. 2017) involved 63% of the original participants (94 SpaceOAR subjects and 46 control group) and demonstrated a reduction of Grade ≥ 1 adverse event in the treatment group (2% versus 9%, p<.03).

Phase 2 trials have investigated the benefits of SBRT in the treatment oligometastatic disease. The STOMP trial (Ost et al 2018) evaluated the time to start of androgen deprivation therapy (ADT) after metastasis directed therapy (MDT) using SBRT or surgery versus surveillance in 62 patients. Eligibility criteria included oligorecurrent prostate cancer (PCa); biochemical recurrence after primary PCa treatment with curative intent, three or fewer metastases visible on choline PET-CT; serum testosterone levels >50ng/nL; a treated and controlled primary tumor; and WHO performance status 0-1. A total of 31 patients were randomly assigned to each group. The primary outcome was ADT-free survival, defined as time between random assignment and the start of palliative ADT or death (as a result of any cause). Secondary outcomes included quality of life measurement and PSA progression, defined as an increase of ≥25% and ≥ 2 ng/mL if PSA was ≥2 ng/mL from baseline, or a PSA increase of≥25% if PSA was < 2 ng/mL at random assignment. The median follow-up time was three years. SBRT (n=25) was the more common MDT, surgery occurred in six patients. In the MDT group, 11 patients were treated with a repeated course of MDT because of oligometastatic progression. The median ADT-free survival for the surveillance group was 13 months (80%CI 12-17 months) compared to 21 months for the intervention group. PSA decline occurred in 74% of patients treated with MDT, while 42% had PSA decline in the surveillance group. The median time for PSA progression for the intention to treat analysis was six months for the surveillance group and 4 months for the MDT group. The quality-of-life measurement between the groups were similar and there were no toxicities of grade 2 to 5 observed. A group of patients received a temporary course of adjuvant ADT at the time of SBRT (n=50%) and the type of ADT provided was left to the discretion of the provider. With no comparator arm, the authors concluded that although ADT-free survival seemed longer with MDT than surveillance alone for oligorecurrent PCa, it should be explored further in phase III trials.

Palma and colleagues (2019) investigated the effect of SBRT on the survival, outcomes, toxicity, and quality of life experienced in patients with a controlled primary tumor and one to five oligometastatic lesions. The SABR-COMET trial was a phase II randomized open-label trial. A total of 99 patients with differing primary tumor histologies were allocated to two treatment arms, palliative standard of care alone (control) or palliative standard of care with SABR. The primary endpoint for the study was

overall survival. The median follow-up was 25 months for the control arm and 26 months for the SABR arm. The median overall survival for the control arm was 28 months (95%CI 19-33) versus 41 months for the SABR arm (26-not reached) (HR 0.57, 95% CI 0.30-1.10); stratified log rank p=0.090). Palma published five-year results to the SABR-COMET study in 2020, identifying the most common primary tumor types being breast (n=18), colorectal (n=18), lung (n=18), and prostate (n=16). Median follow up was 51 months. The overall survival rate was 17.7% in the control arm (95% CI, 6% to 34%) versus 42.3% in the SABR arm (95% CI, 28% to 56%; stratified log-rank P= .006). The five-year progression free survival rate was 17.3% in the SABR arm but not reached in the control group. The death as a result of any-cause rate was 73% for the control arm and 53% in the SABR arm. The Median overall survival was 28 months in the control arm (95% CI, 18-39 months) versus 50 months in the SABR arm (95%CI, 29 to 83 months; stratified log-rank test P=.006; HR, 0.47; 95% CI, 0.27 to 0.81). There were no new adverse events or changes in quality of life noted with the extended follow-up. Although the results of the trial are promising, they cannot be extrapolated onto any particular histology. Further research is warranted.

SBRT for Treatment of Chronic Pain

Due to a lack of clinical trials, there is insufficient evidence to permit conclusions about health outcomes with SBRT for the treatment of chronic pain.

SBRT for Lung Cancer

A study published in 2018 (Shioyama et al) that retrospectively analyzed 43 patients diagnosed with small-cell lung cancer, treated with SBRT at 11 Japanese institutions. The two-year overall survival was 72.3%, progression-free survival was 44.6%, and distant metastasis free survival rates were 47.2%. Of the patients selected for inclusion, 80% were inoperable. The number of distant metastases was high at 47%, authors noting that only a small number of patients received chemotherapy using standard regimens, but their progression free survival was higher than those treated with SBRT alone (70.0% versus 44.6%). 2-year local control was 80.2% signaling effectiveness in the stage I population.

SBRT for Adrenocortical Carcinoma

The role of radiotherapy in the adjuvant treatment of adrenocortical carcinoma has been controversial. The literature consists of small cohort studies and case series. The evidence is insufficient to determine that treatment with SBRT in this population results in meaningful improvement in the net health outcome.

SBRT for Hepatobiliary Cancers

Surgical resection is the only potentially curative treatment for extrahepatic bile duct (cholangiocarcinoma) and gallbladder cancer. SBRT has not been proven in the peer-reviewed scientific literature to improve the net health outcome in unresectable cases and therefore, it is considered not medically necessary.

PROFESSIONAL GUIDELINE(S)

SRS of the Brain and Spine

Guidelines from ASTRO released in 2022 provided strong recommendations for safe treatment of brain metastases using SRS, including the number and size of lesions. The consensus is that up to four (4) intact brain metastases can be safely treated in patients with reasonable performance status. The guidelines state that optimal treatment for patients with five (5) or more metastases remain controversial due to the lack of published prospectively randomized data, and therefore, conditionally recommends SRS to patients with five (5) to ten (10) intact brain metastases who have a ECOG performance status of 2 or better. Treatment of lesions that measure less than 2 cm in diameter comes with a strong recommendation for SRS. Lesions that are >2 cm and ≤ 3 cm have a conditional recommendation for single-fraction SRS, patients with lesions ≥ 3 cm to ≤4 cm are conditionally recommended for multi-fraction SRS. The task force identifies that for tumors exerting mass effect and/or are ≥4 cm in size, that multidisciplinary discussion with neurosurgery to consider surgical resection is suggested, and that due to limited evidence, SRS for tumor size greater than 6 cm is discouraged.

NCCN guidelines (V.2.2025) for principles of central nervous system cancers includes guidelines addressing the treatment of both extensive and limited brain metastases and that multiple phase III randomized trials comparing SRS alone to SRS plus whole brain radiation therapy have demonstrated similar overall survival and even superior cognitive preservation and quality of life with SRS alone versus SRS with WBRT.

In reference to treatment of the spine, the NCCN guidelines also state that "SRS or SBRT for spinal cases may be preferred for patients with life expectancy ≥3 months where tumor ablation is a goal of treatment, in tumors considered radioresistant (e.g., renal cell, melanoma, sarcoma, hepatocellular, some colorectal and non-small cell lung cancer, and in select patients for optimal pain relief", and that "stereotactic radiation approaches may also be preferred in the setting of tumor recurrence after prior radiation as a strategy to limit radiation dose to the spinal cord or other critical structures. Careful adherence to consensus guidelines for radiosurgery planning and delivery is recommended."

SBRT of Pancreatic Adenocarcinoma

NCCN guidelines (V.2.2025) for principles of radiation therapy for pancreatic adenocarcinoma state that "If disease progression occurs in patients with locally advanced disease, chemoradiation or SBRT are treatment options if all of the following are true: good performance status is maintained, chemoradiation or SBRT were not previously given, and the primary site is the sole site of progression."

SBRT is the delivery of ultra-hypofractionated radiation therapy. The use of hypofractionation has been shown to increase the risk of acute moderate gastrointestinal (GI) toxicity when compared to conventional fractionation. The ASTRO Guideline on Radiation Therapy for Pancreatic Cancer (2019) states that the radiation oncologist, in collaboration with the qualified medical physicist, will determine the need to utilize devices to stabilize or pull away organs at risk from inadvertently moving into the field of treatment, and includes spacers as an example.

SBRT for Prostate Cancer

NCCN guidelines V.1.2026 for principles of radiation therapy for prostate cancer state that biocompatible and biodegradable perirectal spacer materials may be implanted between the prostate

and rectum in patients undergoing external radiotherapy with organ-confined prostate cancer in order to displace the rectum from high radiation dose regions. A randomized phase III trial demonstrated reduced rectal bleeding in patients undergoing the procedure, compared to controls. The guidelines state, "Overall, the panel believes that biocompatible and biodegradable perirectal spacer materials may be implanted between the prostate and rectum in patients undergoing external radiotherapy with organ-confined prostate cancer in order to displace the rectum from high radiation dose regions." Patients with obvious rectal invasion or visible T3 or posterior extension should not undergo perirectal spacer implantation.

SBRT for Lung Cancer

The NCCN SCLC Panel (V.1.2026) recommends SBRT followed by systemic therapy as an option for select patients with clinical stage I to IIA (T1-2 N0) small cell lung cancer who are medically inoperable or decline surgery (category 2A), and that treatment should follow the Non-Small Cell Lung Cancer Guidelines (V.8.2025).

SBRT for Adrenocortical Carcinoma

The NCCN guidelines for neuroendocrine and adrenal tumors (V.2.2025) do not reference SBRT as a treatment recommendation for this indication.

REGULATORY STATUS

Devices used for stereotactic radiation therapy are highly specialized systems designed to deliver precise, high-dose radiation to targeted areas while minimizing exposure to surrounding healthy tissue.

The U.S Nuclear Regulatory Commission (NRC) is responsible for the regulation of radioactive materials. Whereas the Food & Drug Administration (FDA) is responsible for device regulation.

Refer to U.S. NRC website. Available from: https://www.nrc.gov/about-nrc [accessed 2025 Sept 25].

Refer to the FDA Radiation-Emitting Products website. Available from: https://www.fda.gov/radiation-emitting-products [accessed 2025 Sept 25].

CODE(S)

- Codes may not be covered under all circumstances.
- Code list may not be all inclusive (AMA and CMS code updates may occur more frequently than policy updates).
- (E/I)=Experimental/Investigational
- (NMN)=Not medically necessary/appropriate

CPT Codes

Code	Description
31626	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with placement of fiducial markers, single or multiple

Code	Description
31627	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with computer-assisted, image-guided navigation (List separately in addition to code for primary procedure(s))
32553	Placement of interstitial device(s) for radiation therapy guidance (e.g., fiducial markers, dosimeter), percutaneous, intra-thoracic, single or multiple
49411	Placement of interstitial device(s) for radiation therapy guidance (e.g., fiducial markers, dosimeter), percutaneous, intra-abdominal, intra-pelvic (except prostate), and/or retroperitoneum, single or multiple
49412	Placement of interstitial device(s) for radiation therapy guidance (e.g., fiducial markers, dosimeter), open, intra-abdominal, intrapelvic, and/or retroperitoneum, including image guidance, if performed, single or multiple (List separately in addition to code for primary procedure)
55874	Transperineal placement of biodegradable material, peri-prostatic, single or multiple injection(s), including image guidance, when performed
55876	Placement of interstitial device(s) for radiation therapy guidance (e.g., fiducial markers, dosimeter), prostate (via needle, any approach), single or multiple
61796	Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); one 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); one complex cranial lesion
61799	Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); each additional cranial lesion, complex (List separately in addition to code for primary procedure)
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); one 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 one session; multi-source Cobalt 60 based

Code	Description
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 one or more lesions, including image guidance, entire course not to exceed five fractions
77432	Stereotactic radiation treatment management of cranial lesion(s) (complete course of treatment consisting of one session)
77435	Stereotactic body radiation therapy, treatment management, pretreatment course, to one or more lesions, including image guidance, entire course not to exceed five fractions

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HCPCS Codes

Code	Description
G0339	Image guided robotic linear accelerator-based stereotactic radiosurgery, complete course of therapy in one session, or first session of fractionated treatment. (Considered medically appropriate for the diagnosis codes listed below)
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. (Considered medically appropriate for the diagnosis codes listed below)

ICD10 Codes

Code	Description
C11.0-C11.9	Malignant neoplasm of nasopharynx
C22.0-C22.9	Malignant neoplasm of liver and intrahepatic bile ducts (code range)
C25	Malignant neoplasm of pancreas
C34.00-C34.92	Malignant neoplasm of bronchus and lung (code range)
C41.0	Malignant neoplasm of bones of skull and face
C41.2	Malignant neoplasm of vertebral column
C49	Malignant neoplasm of other connective and soft tissue

Code	Description
C53.0-C53.9	Malignant neoplasm of cervix uteri
C61	Malignant neoplasm of prostate
C64.1-C64.9	Malignant neoplasm of kidney, except renal pelvis (code range)
C65.1-C65.9	Malignant neoplasm of renal pelvis (code range)
C70.0-C70.9	Malignant neoplasm of meninges (code range)
C71.0-C71.9	Malignant neoplasm of brain (code range)
C72.0-C72.1	Malignant neoplasm of spinal cord and cauda equina (code range)
C75.1-C75.3	Malignant neoplasm of other endocrine glands and related structures (code range)
C78.7	Secondary malignant neoplasm of liver and intrahepatic bile duct
C79.00-C79.02	Secondary malignant neoplasm of kidney and renal pelvis (code range)
C79.31	Secondary malignant neoplasm of brain
D01.5	Carcinoma in situ of liver, gallbladder and bile ducts
D18.02	Hemangioma of intracranial structures
D32.0-D32.9	Benign neoplasm of meninges (code range)
D33.0-D33.4	Benign neoplasm of brain and other parts of central nervous system (code range)
D35.0-D35.4	Benign neoplasm of other and unspecified endocrine glands (code range)
D37.6	Neoplasm of uncertain behavior of liver, gallbladder and bile ducts
D42.0-D42.9	Neoplasm of uncertain behavior of meninges (code range)
D43.0-D43.4	Neoplasm of uncertain behavior of brain and central nervous system (code range)
D44.3-D44.5	Neoplasm of uncertain behavior of pituitary gland and craniopharyngeal duct and pineal gland (code range)
G20.0	Parkinson’s disease
G25.0	Essential Tremor
G50.0	Trigeminal neuralgia
Q04.9	Congenital malformation of brain, unspecified

Code	Description
Q06.9	Congenital malformation of spinal cord, unspecified
Q07.9	Congenital malformation of nervous system, unspecified
Q27.9	Congenital malformation of peripheral vascular system, unspecified
Q28.2	Arteriovenous malformation of cerebral vessels
Q28.3	Other malformations of cerebral vessels

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SEARCH TERMS

CyberKnife, Fractionated stereotactic radiosurgery, Gamma knife, Linac, Linear accelerator, Stereotactic radiotherapy, Space Oar and Perirectal hydrogel spacer.

CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS)

LCD - Stereotactic Radiation Therapy: Stereotactic Radiosurgery (SRS) and Stereotactic Body Radiation Therapy (SBRT) (L35076) [accessed 2025 Sept 2]

PRODUCT DISCLAIMER

- Services are contract dependent; if a product does not cover a service, medical policy criteria do not apply.
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- If a Medicare HMO-Dual Special Needs Program (DSNP) product DOES NOT cover a specific service, please refer to the Medicaid Product coverage line.

POLICY HISTORY/REVISION

Committee Approval Dates

01/20/00, 09/19/01, 07/18/02, 07/17/03, 08/19/04, 09/15/05, 08/17/06, 09/20/07, 10/23/08, 07/16/09, 08/19/10, 11/17/11, 09/20/12, 05/23/13, 02/20/14, 08/21/14, 11/19/15, 10/20/16, 02/15/18, 06/20/19, 06/18/20, 06/17/21, 07/21/22, 11/17/22, 01/19/23, 12/21/23, 10/17/24, 10/16/25

Date	Summary of Changes
10/16/25	• Annual review; life expectancy criteria removed from policy criteria. EviCore effective date will be 11/16/25.
01/01/25	• Summary of changes tracking implemented.
01/20/00	• Original effective date