Coverage of any medical intervention discussed in a Dean Health Plan medical policy is subject to the limitations and exclusions outlined in the member’s benefit certificate.

Stereotactic Radiosurgery

Covered Service: Yes–when meets criteria below

Prior Authorization Required: Yes

Additional Information: None

Medicare Policy: Dean Health Plan covers when Medicare also covers the benefit.

BadgerCare Plus Policy: Dean Health Plan covers when BadgerCare Plus also covers the benefit. Please refer to Forward Health: https://www.forwardhealth.wi.gov/WIPortal/Default.aspx

Dean Health Plan Medical Policy:

1.0 Stereotactic Radiosurgery requires prior authorization through the Quality and Care Management Division and is considered medically necessary for one or more of the following:

2.0 Vestibular schwannoma, (acoustic neuroma, acoustic schwannoma) smaller than 3 cm and with one or more of the following:

2.1 Unilateral sensorineural hearing loss or tinnitus; or

2.2 Signs of brainstem compression (e.g. facial weakness, numbness or hypesthesias, diplopia, fixation nystagmus etc); or

2.3 Signs of cerebellar compression (e.g. loss of balance, ataxia); or

2.4 Vertigo or dizziness; or

2.5 Tumor growth seen with MRI monitoring; or

2.6 Postoperative residual or recurrent tumor

3.0 Brain metastasis, as indicated by ALL of the following:

3.1 Four or fewer brain metastasis; and

3.2 Stable extracranial disease (i.e. cancer absent or controlled in other organ systems); and

3.3 Absence of large tumor (e.g. 4 cm) on diagnostic imaging; and

3.4 Absence of mass effect (e.g. midline shift) on diagnostic imaging; and
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4.0 Chordoma as indicated by **1 or more** of the following:

4.1 Contraindications to microsurgical resection (e.g. unacceptable operative risk or tumor adjacent to critical structures); or

4.2 Residual tumor following surgery.

5.0 Spinal cord metastasis, as indicated by **ALL** of the following:

5.1 No evidence of spinal cord compression; and

5.2 No significant spinal instability; and

5.3 Well-circumscribed lesion (i.e. easily outlined for treatment planning.); and

5.4 Additional conventional irradiation or surgery is not appropriate; and

6.0 Pituitary adenoma when **ALL** of the following criteria are met:

6.1 Failed medical treatment for prolactinoma or failed pituitary microsurgery; and

6.2 Conventional surgery is not indicated due to **one or more** of the following:

6.2.1 Tumor extension or size prohibits more traditional surgical approach; or

6.2.2 Unacceptable risk of reresection; or

6.2.3 Unacceptable operative (e.g. advanced age, comorbidity).

7.0 Arteriovenous malformation (intracranial), as indicated by **one or more** of the following:

7.1 Arteriovenous malformation location makes microsurgery high-risk approach (e.g. deep area of brain or speech center); or

7.2 Unacceptable operative risk (e.g. advanced age, comorbidity); or

7.3 Patient not at significant risk of hemorrhage during period between stereotactic radiosurgery and obliteration of arteriovenous malformation.

8.0 Trigeminal neuralgia when **ALL** of the following criteria are met:

8.1 Symptoms persist despite maximal medical treatment; and

8.2 Patient declines microvascular decompression or has unacceptable operative risk (e.g. advanced age, comorbidity).

9.0 Epilepsy, as indicated by **ALL** of the following:

9.1 EEG shows localized epileptogenic source (e.g. mesial temporal lobe); and

9.2 Brain MRI findings consistent with EEG findings; and

9.3 Seizures refractory to at least 2 different anticonvulsant medications; and Brain MRI findings consistent with EEG findings.

10.0 Intracranial meningioma when **one or more** of the following criteria are met:
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10.1 Skull base meningioma; or
10.2 Contraindications to microsurgical resection (e.g., unacceptable operative risk or tumor is adjacent to critical structures); or
10.3 Residual or recurrent intracranial meningioma following microsurgical resection.

11.0 Essential tremor as indicated by ALL of the following:

11.1 Deep brain stimulation is not option due to 1 or more of the following:
   11.1.1 Patient declines deep brain stimulation; or
   11.1.2 Patient has coagulopathy or uses anticoagulants; or
   11.1.3 Patient has contraindication to permanent hardware implantation (e.g., chronic infection, immunocompromised); or
   11.1.4 Patient is elderly; or
   11.1.5 Patient is unable to keep mandatory, regular, frequent follow-up appointments

11.2 Disability of one or more limbs from resting, positional, or kinetic tremor that affects safety, functional status, or quality of life; and
11.3 Tremor refractory to 1 year or more of standard medication; and
11.4 Contraindications to microsurgical resection (e.g., unacceptable operative risk or tumor adjacent to critical structures); and
11.5 Residual or recurrent glomus jugulare tumor following microsurgical resection.

12.0 Intra cavernous malformation, as indicated by ALL of the following:

12.1 Associated symptoms including 1 or more of the following:
   12.1.1 Intractable epilepsy
   12.1.2 Progressive neurological deterioration
   12.1.3 Recurrent hemorrhage

12.2 Contraindications to microsurgical resection (e.g., unacceptable operative risk or tumor adjacent to critical structures).

13.0 Stereotactic radiosurgery is investigational/experimental and therefore is not a covered service for the treatment of but no limited to:

13.1 Cluster headaches; or
13.2 Chronic pain.

14.0 Stereotactic radiotherapy for treatment of Parkinson’s does not demonstrated improved clinical outcomes and is considered not medically necessary and therefore not a covered service.
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Effective: 05/01/2017