

Brain - Stereotactic Radiation Therapy Treatment Plan Checklist

NIA has provided this checklist to assist you in gathering the clinical and treatment plan information needed to request a medical necessity review. The most efficient way to submit a review request is via www.RadMD.com or call the NIA Call Center toll free number. Please **do not fax** the checklist to NIA.

General Information	
Patient Name :	DOB: Health Plan ID :
Radiation Oncologist :	Radiation Therapy Facility :
Treatment Planning Start Date (i.e. Initial Simulation) :	Anticipated Treatment Start Date :
Patient Clinical Information	
What Condition is being treated?	
<input type="checkbox"/> Arteriovenous Malformation (AVM)	
<input type="checkbox"/> Brain Tumor - Primary	
✓ What is the type of brain tumor? <input type="checkbox"/> Acoustic Neuroma <input type="checkbox"/> Meningioma <input type="checkbox"/> Hemangioma <input type="checkbox"/> Pituitary Adenoma <input type="checkbox"/> Craniopharyngioma <input type="checkbox"/> Neoplasm of the Pineal Gland <input type="checkbox"/> Other	
✓ Initial or recurrent tumor? <input type="checkbox"/> Initial <input type="checkbox"/> Recurrent ✓ Active cancer in another organ system? <input type="checkbox"/> Yes <input type="checkbox"/> No	
✓ Previous SRS/SBRT? <input type="checkbox"/> Yes <input type="checkbox"/> No ✓ Treated initially with EBRT? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Brain Metastasis	
✓ Site of primary cancer? ✓ Receiving radiation to another site? <input type="checkbox"/> Yes <input type="checkbox"/> No	
✓ Initial or recurrent tumor? <input type="checkbox"/> Initial <input type="checkbox"/> Recurrent ✓ Active cancer in another organ system? <input type="checkbox"/> Yes <input type="checkbox"/> No	
✓ Previous SRS/SBRT? <input type="checkbox"/> Yes <input type="checkbox"/> No ✓ Treated initially with EBRT? <input type="checkbox"/> Yes <input type="checkbox"/> No	
✓ How many brain lesions are present? ✓ What is the patient's performance status? (ECOG Scale) <ul style="list-style-type: none"> <input type="checkbox"/> 0 – Fully active, able to carry on all pre-disease performance without restriction <input type="checkbox"/> 1 – Restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature, e.g., light house work, office work <input type="checkbox"/> 2 – Ambulatory and capable of all selfcare but unable to carry out any work activities. Up and about more than 50% of waking hours <input type="checkbox"/> 3 – Capable of only limited selfcare, confined to bed or chair more than 50% of waking hours <input type="checkbox"/> 4 – Completely disabled. Cannot carry on any selfcare. Totally confined to bed or chair 	
<input type="checkbox"/> Other What is the "Other" condition being treated?	
Treatment Planning Information	
✓ Which technique will be used? <input type="checkbox"/> Robotic – Linac Multi-Angle <input type="checkbox"/> Robotic – Tomotherapy <input type="checkbox"/> CyberKnife <input type="checkbox"/> Non-Robotic – Linac Multi-Angle <input type="checkbox"/> Non-Robotic - Tomotherapy <input type="checkbox"/> Gamma Knife <input type="checkbox"/> Other Explain:	
✓ How many lesions/volumes of interest? ✓ How many fractions per lesion?	
✓ How is each lesion treated? <input type="checkbox"/> All lesions treated on the same date of service <input type="checkbox"/> All lesions treated on separate dates <input type="checkbox"/> Other Explain	
✓ Please provide clinical rationale for treating lesions separately (if applicable)	

SRS/SBRT CPT Codes Requiring Pre-Authorization: 77371, 77372, 77373, 77432, 77435, G0173, G0251, G0339, G0340