Coverage Guidelines: Hyperthermic Intraperitoneal Chemotherapy (HIPEC)

Effective: November 9, 2016

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Applies to: ☒ Tufts Health Plan Commercial Plans products; Fax: 617.972.9409
☒ Tufts Health Public Plans products
  ☒ Tufts Health Direct — Health Connector; Fax: 888.415.9055
  ☒ Tufts Health Together — A MassHealth Plan; Fax: 888.415.9055
  ☐ Tufts Health Unify — OneCare Plan; Fax: 781.393.2607
  ☒ Tufts Health RITogether — A Rhode Island Medicaid Plan; Fax: 857.304.6404
☒ Tufts Health Freedom Plan products; Fax: 617.972.9409

OVERVIEW
Hyperthermic Intraperitoneal Chemotherapy (HIPEC) is used as an adjunct to surgery for the treatment of some cancers that have metastasized within the peritoneal cavity. HIPEC is delivered into the peritoneal space once the cytoreductive surgical procedure is completed. The goal of HIPEC is to enhance the cytotoxic effect of chemotherapeutic drugs, thereby eliminating micrometastases and disseminated tumor cells remaining in the peritoneal space. The chemotherapeutic agents employed in HIPEC need to have a cell cycle nonspecific mechanism of action and should ideally show a heat-synergistic cytotoxic effect. Specific technical training and a solid knowledge of regional chemotherapy management are required. Treatment-related toxicity is a risk and should be considered during patient selection process.

COVERAGE GUIDELINES
PRIOR AUTHORIZATION IS NOT REQUIRED: Providers will not routinely be required to submit documentation to Tufts Health Plan prior to providing services. However, documentation may be requested at any time to confirm that the services provided meet current standards referenced below:

Tufts Health Plan covers Hyperthermic Intraperitoneal Chemotherapy (HIPEC) when used as an adjunct to cytoreductive surgery for the following medical conditions:
- Pseudomyxoma peritonei
- Diffuse malignant peritoneal mesothelioma
- Prophylactic use of hyperthermic intraperitoneal chemotherapy (HIPEC) in patients with peritoneal carcinomatosis resulting from gastric cancer, without macroscopic peritoneal metastases or distant metastases, who do not have a medical condition that precludes major surgery.

LIMITATIONS
- Tufts Health Plan considers cytoreductive surgery and perioperative intraperitoneal chemotherapy for all other indications unproven and investigational.

CODES
Table 1: CPT Code(s)

<table>
<thead>
<tr>
<th>CPT/HCPCS Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>77605</td>
<td>Hyperthermia, externally generated; deep (i.e., heating to depths greater than 4 cm)</td>
</tr>
<tr>
<td>77620</td>
<td>Hyperthermia generated by intracavitary probe(s)</td>
</tr>
<tr>
<td>96446</td>
<td>Chemotherapy administration into the peritoneal cavity via indwelling port or catheter</td>
</tr>
</tbody>
</table>
### CPT/HCPCS Code

<table>
<thead>
<tr>
<th>CPT/HCPCS Code</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>96549</td>
<td>Unlisted chemotherapy procedure</td>
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</tbody>
</table>

### Table 2: ICD-10-CM Diagnosis code(s)

<table>
<thead>
<tr>
<th>ICD-10 Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>C18.1</td>
<td>Malignant neoplasm of appendix</td>
</tr>
<tr>
<td>C45.1</td>
<td>Mesothelioma of peritoneum (malignant)</td>
</tr>
<tr>
<td>C48.0</td>
<td>Malignant neoplasm of retroperitoneum</td>
</tr>
<tr>
<td>C48.1</td>
<td>Malignant neoplasm of specified parts of peritoneum</td>
</tr>
<tr>
<td>C48.8</td>
<td>Malignant neoplasm of overlapping sites of retroperitoneum and peritoneum</td>
</tr>
<tr>
<td>C78.6</td>
<td>Secondary malignant neoplasm of retroperitoneum and peritoneum</td>
</tr>
</tbody>
</table>

### Table 3: ICD-10-PCS Procedure Code(s)

<table>
<thead>
<tr>
<th>ICD-10 Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>DWY38ZZ</td>
<td>Hyperthermia of Abdomen</td>
</tr>
<tr>
<td>DWY68ZZ</td>
<td>Hyperthermia of pelvic region</td>
</tr>
</tbody>
</table>

### REFERENCES


### APPROVAL HISTORY


Subsequent endorsement date(s) and changes made:
- March 25, 2016: Coding updated; ICD-9-CM codes and ICD-9 Inpatient Procedure codes removed.
- November 9, 2016: Reviewed by IMPAC, renewed without changes
- April 2017: Added RITogether Plan product to template. For MNGs applicable to RITogether, effective date is August 1, 2017

### 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 the 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.

Medical Necessity Guidelines apply to the fully insured Commercial and Medicaid products when Tufts Health Plan conducts utilization review unless otherwise noted in this guideline or in the Member’s benefit document, and may apply to Tufts Health Unify to the same extent as Tufts Health Together. This guideline does not apply to Tufts Medicare Preferred HMO, Tufts Health Plan Senior Care Options or to certain delegated service arrangements. 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. Applicable state or federal mandates or other requirements will take precedence. For CareLinkSM Members, Cigna conducts utilization review so Cigna’s medical necessity guidelines, rather than these guidelines, will apply.

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.