This content has been created to supplement the MCG care guidelines. MCG Health has neither reviewed nor approved the modified material.

SHP Chemotherapy Administration

AUTH: SHP Medical 316 v3 (AC)

MCG Health
Ambulatory Care
25th Edition

Link to Codes

Coverage

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See the appropriate benefit document for specific coverage determination. Member specific benefits take precedence over medical policy.

Standard reference compendia not applicable to Medicare and Self-Funded Lines of Business

Benefits will not be denied for any drug prescribed, on an inpatient or outpatient basis, to treat a covered indication so as long as the drug has been approved by the United States Food and Drug Administration for at least one indication and the drug is recognized for treatment of the covered indication in one of the standard reference compendia or in substantially accepted peer-reviewed medical literature.

Benefits will not be denied for any drug, prescribed on an inpatient or outpatient basis, approved by the United States Food and Drug Administration for use in the treatment of cancer on the basis that the drug has not been approved by the United States Food and Drug Administration for the treatment of specific type of cancer for which the drug has been prescribed, provided the drug has been recognized as safe and effective for treatment of that specific type of cancer in any of the standard reference compendia.

Benefits will not be denied for any drug, prescribed on an inpatient or outpatient basis, approved by the United States Food and Drug Administration for use in the treatment of cancer pain for the reason that the dosage is in excess of the recommended dosage of the pain relieving agent, if the prescription has been prescribed for a person with intractable cancer pain.

Application to Products

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- Policy is applicable to all products.

Authorization Requirements

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Pre-certification by the Plan is required.

Description of Item or Service

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- Chemotherapy is the use of certain drugs to treat disease, most commonly cancer, as distinct from other forms of treatment, such as surgery.
- Medically Necessary services and/or supplies means the use of services or supplies as provided by a Hospital, Skilled Nursing Facility, Physician or other provider which are:
  - Required to identify, evaluate or treat the Member's condition, disease, ailment or injury, including pregnancy related conditions; and
  - In accordance with recognized standards of care for the Member's condition, disease, ailment or injury; and
  - Appropriate with regard to standards of good medical practice; and
  - Not solely for the convenience of the Member, or a participating Physician, Hospital, or other health care provider; and
  - The most appropriate supply or level of service which can be safely provided to the Member as substantiated by the records and documentation maintained by the provider of the services or supplies.

Exceptions and Limitations

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- Drugs not meeting the minimum levels of evidence based on one or more of the following Standard reference compendia are not Covered Services:
  - American Hospital Formulary Service Drug Information;
  - National Comprehensive Cancer Network's Drugs & Biologics Compendium;
  - Elsevier Gold Standard's Clinical Pharmacology.
- Drugs or other services that are considered experimental under the SHPs definition are not covered services:
  - Experimental/Investigational: a drug, device, medical treatment or procedure may be considered Experimental/Investigational if:
    - The majority of the medical community does not support the use of the drug, device, medical treatment or procedure; or
    - The use of this drug, device, medical treatment or procedure may have been shown to be unsafe and/or of no or questionable use as reported by current scientific literature and/or regulatory agencies; or
    - The research regarding this drug, device, medical treatment or procedure may be so limited that an evaluation of safety and efficacy cannot be made; or
    - The drug or device is not approved for marketing by the Food and Drug Administration (FDA); or
    - The drug, device, or medical treatment is approved as Category B Non-Experimental/Investigational by the FDA
- There is insufficient scientific evidence to support the medical necessity of Chemotherapy Administration for uses other than those listed in the clinical indications for procedure section.

Clinical Indications for Procedure

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- Chemotherapy, Immunotherapy, and hormonal agent administration are considered medically necessary for **ALL** of the following
  - The service, drug, or supplies needed for the service, must be prescribed by a physician and be performed by a provider properly licensed or certified to provide the therapy service; and administered as part of a doctor's office, or home healthcare visit, or at an inpatient or outpatient facility
  - The service, drug, or supplies needed for the service, must meet SHP's definition of Medically Necessary
  - The service, drug, or supplies needed for the service, are not experimental.

Document History

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- Revised Dates:
- Reviewed Dates:
  - 2022: May
  - 2021: May
  - 2020: July
- Effective Date: October 2019

Coding Information

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- CPT/HCPCS codes covered if policy criteria is met:
  - CPT 96401 - Chemotherapy administration, subcutaneous or intramuscular; non-hormonal anti-neoplastic
  - CPT 96402 - Chemotherapy administration, subcutaneous or intramuscular; hormonal anti-neoplastic
  - CPT 96405 - Chemotherapy administration; intralesional, up to and including 7 lesions
  - CPT 96406 - Chemotherapy administration; intralesional, more than 7 lesions
  - CPT 96409 - Chemotherapy administration; intravenous, push technique, single or initial substance/drug
  - CPT 96411 - Chemotherapy administration; intravenous, push technique, each additional substance/drug (List separately in addition to code for primary procedure)
  - CPT 96420 - Chemotherapy administration, intra-arterial; push technique
  - CPT 96422 - Chemotherapy administration, intra-arterial; infusion technique, up to 1 hour
  - CPT 96423 - Chemotherapy administration, intra-arterial; infusion technique, each additional hour (List separately in addition to code for primary procedure)
  - CPT 96425 - Chemotherapy administration, intra-arterial; infusion technique, initiation of prolonged infusion (more than 8 hours), requiring the use of a portable or implantable pump
  - CPT 96440 - Chemotherapy administration into pleural cavity, requiring and including thoracentesis
  - CPT 96446 - Chemotherapy administration into the peritoneal cavity via indwelling port or catheter
  - CPT 96450 - Chemotherapy administration, into CNS (eg, intrathecal), requiring and including spinal puncture
  - CPT 96542 - Chemotherapy injection, subarachnoid or intraventricular via subcutaneous reservoir, single or multiple agents
  - CPT 96549 - Unlisted chemotherapy procedure
- CPT/HCPCS codes considered not medically necessary per this Policy:
  - None

References

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References used include but are not limited to the following:

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Codes

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CPT® : 96401, 96402, 96405, 96406, 96409, 96411, 96420, 96422, 96423, 96425, 96440, 96446, 96450, 96542, 96549

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