Sentara® Health Plans

Commercial

Intra-arterial (IA) Chemotherapy

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Effective Date	12/2008
Next Review Date	1/23/2024
Coverage Policy	Medical 254
Version	4

Member-specific benefits take precedence over medical policy and benefits may vary across plans. Refer to the individual's benefit plan for details *.

Purpose:

This policy addresses the medical necessity of Intra-arterial chemotherapy.

Description & Definitions:

Intra-arterial chemotherapy is a localized treatment for cancer. A cannula is inserted directly into the artery that specifically supplies a chemotherapeutic agent directly to the tumor.

Criteria:

Intra-arterial (IA) Chemotherapy is considered medically necessary for **1 or more of the following**:

- Individual with retinoblastoma
- Individual with liver cancer and **1 or more of the following:**
  - Primary liver cancer (Hepatocellular and cholangiocarcinoma)
  - Metastatic colorectal cancer where metastasis are limited to the liver and are unresectable

Intra-arterial (IA) Chemotherapy is considered **not medically necessary** for uses other than those listed in the clinical criteria.

Coding:

Medically necessary with criteria:

Coding	Description
36260	Insertion of implantable intra-arterial infusion pump (eg, for chemotherapy of liver)
36261	Revision of implanted intra-arterial infusion pump
36262	Removal of implanted intra-arterial infusion pump
61650	Endovascular intracranial prolonged administration of pharmacologic agent(s) other than for thrombolysis, arterial, including catheter placement, diagnostic angiography, and imaging guidance; initial vascular territory
96422	Chemotherapy administration, intra-arterial; infusion technique, up to 1 hour

96423	Chemotherapy administration, intra-arterial; infusion technique, each additional hour (List separately in addition to code for primary procedure)
96425	Chemotherapy administration, intra-arterial; infusion technique, initiation of prolonged infusion (more than 8 hours), requiring the use of a portable or implantable pump

Considered Not Medically Necessary:

Coding	Description
	None

U.S. Food and Drug Administration (FDA) - approved only products only.

Document History:

Revised Dates:

- 2022: February
- 2021: February
- 2020: January, February
- 2015: April, November
- 2014: June
- 2013: January, August
- 2012: August
- 2010: December
- 2009: December

Reviewed Dates:

- 2024: January
- 2023: February
- 2018: December
- 2017: December
- 2016: June
- 2011: October
- 2010: November

Effective Date:

- December 2008

References:

Specialty Association Guidelines; Government Regulations; Winifred S. Hayes, Inc; UpToDate; Literature Review; Specialty Advisors; National Coverage Determination (NCD); Local Coverage Determination (LCD).

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Special Notes: *

Medical policies can be highly technical and complex and are provided here for informational purposes. These medical policies are intended for use by health care professionals. The medical policies do not constitute medical advice or medical care. Treating health care professionals are solely responsible for diagnosis, treatment, and medical advice. Sentara Health Plan members should discuss the information in the medical policies with their treating health care professionals. Medical technology is constantly evolving, and these medical policies are subject to change without notice, although Sentara Health Plan will notify providers as required in advance of changes that could have a negative impact on benefits.

Services mean both medical and behavioral health (mental health) services and supplies unless We specifically tell You otherwise. We do not cover any services that are not listed in the Covered Services section unless required to be covered under state or federal laws and regulations. We do not cover any services that are not Medically Necessary. We sometimes give examples of specific services that are not covered but that does not mean that other similar services are covered. Some services are covered only if We authorize them. When We say You or Your We mean You and any of Your family members covered under the Plan. Call Member Services if You have questions.

Keywords:

Intra-arterial Chemotherapy, SHP Medical 254, retinoblastoma, IA, IAC, intra-arterial chemoinfusion, ophthalmic artery chemosurgery (OAC), superselective chemotherapy, arterial-directed therapies, intra-hepatic chemotherapy (infusion), Hepatic artery infusion (HAI)