Sentara Health Plans

Medicaid

Cytoreductive Surgery (Tumor Debulking), Surgical 02

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Effective Date	12/2009
Next Review Date	1/2026
Coverage Policy	Surgical 02
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All requests for authorization for the services described by this medical policy will be reviewed per Early and Periodic Screening, Diagnostic and Treatment (EPSDT) guidelines. These services may be authorized under individual consideration for Medicaid members under the age of 21-years if the services are judged to by medically necessary to correct or ameliorate the member's condition. Department of Medical Assistance Services (DMAS), Supplement B - EPSDT (Early and Periodic Screening, Diagnosis and Treatment) Manual.*.

Description & Definitions:

Cytoreductive surgery also known as debulking, is a surgical procedure to remove and debulk as much of a tumor/cancer as possible.

Hyperthermic intraperitoneal chemotherapy (HIPEC) applies heated medication within the peritoneal cavity during surgery.

Multidisciplinary Tumor Board recommendations aid in the decision making process for treatment.

Criteria:

Cytoreductive surgery with or without Hyperthermic intraperitoneal chemotherapy (HIPEC) is considered medically necessary for **1 or more of the following:**

- Cytoreductive surgery for **1 or more** of the following:
  - An individual with pseudomyxoma peritonei when used in conjunction with hyperthermic intraperitoneal chemotherapy
  - An individual with ovarian cancer, fallopian tube cancer and primary peritoneal cancer
  - An individual with gastrointestinal stromal tumors
  - An individual with peritoneal mesothelioma when used in conjunction with hyperthermic intraperitoneal chemotherapy
- Hyperthermic intraperitoneal chemotherapy (HIPEC) for **1 or more** of the following:
  - An individual with pseudomyxoma peritonei
  - An individual with peritoneal carcinomatosis from colorectal or gastric cancer without distant metastases
  - An individual with malignant peritoneal mesothelioma without extra-abdominal metastases (limited only to abdominal cavity)

- An individual with Stage III epithelial ovarian cancer

Cytoreductive surgery with or without Hyperthermic intraperitoneal chemotherapy (HIPEC) is considered **not medically necessary** for any use other than those indicated in clinical criteria.

Document History:

Revised Dates:

- 2025: January – Annual policy reviewed - no changes. Policy format and references updated. CPT 49203-49205 deleted 1/1/25, added 96547 and 96548.
- 2023: January
- 2021: January
- 2019: November
- 2014: March
- 2013: December
- 2012: September
- 2011: October

Reviewed Dates:

- 2024: January
- 2022: January
- 2020: January
- 2018: April, November
- 2015: August
- 2014: August
- 2013: August
- 2010: December

Effective Date:

- December 2009

Coding:

Medically necessary with criteria:

Coding	Description
49203	Excision or destruction, open, intra-abdominal tumors, cysts or endometriomas, 1 or more peritoneal, mesenteric, or retroperitoneal primary or secondary tumors; largest tumor 5 cm diameter or less
49204	Excision or destruction, open, intra-abdominal tumors, cysts or endometriomas, 1 or more peritoneal, mesenteric, or retroperitoneal primary or secondary tumors; largest tumor 5.1-10.0 cm diameter
49205	Excision or destruction, open, intra-abdominal tumors, cysts or endometriomas, 1 or more peritoneal, mesenteric, or retroperitoneal primary or secondary tumors; largest tumor greater than 10.0 cm diameter
96547	Intraoperative hyperthermic intraperitoneal chemotherapy (HIPEC) procedure, including separate incision(s) and closure, when performed; first 60 minutes (List separately in addition to code for primary procedure)
96548	Intraoperative hyperthermic intraperitoneal chemotherapy (HIPEC) procedure, including separate incision(s) and closure, when performed; each additional 30 minutes (List separately in addition to code for primary procedure)

Considered Not Medically Necessary:

Coding	Description
	None

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

The preceding codes are included above for informational purposes only and may not be all inclusive. Additionally, inclusion or exclusion of a treatment, procedure, or device code(s) does not constitute or imply member coverage or provider reimbursement.

Special Notes: *

- Coverage: See the appropriate benefit document for specific coverage determination. Member specific benefits take precedence over medical policy.
- Application to Products: Policy is applicable to Sentara Health Plan Virginia Medicaid products.
- Authorization Requirements: Pre-certification by the Plan is required.
- Special Notes:
    - This medical policy express Sentara Health Plan's determination of medically necessity of services, and they are based upon a review of currently available clinical information. These policies are used when no specific guidelines for coverage are provided by the Department of Medical Assistance Services of Virginia (DMAS). Medical Policies may be superseded by state Medicaid Plan guidelines. Medical policies are not a substitute for clinical judgment or for any prior authorization requirements of the health plan. These policies are not an explanation of benefits.
    - 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.

- The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) covers services, products, or procedures for children, if those items are determined to be medically necessary to "correct or ameliorate" (make better) a defect, physical or mental illness, or condition (health problem) identified through routine medical screening or examination, regardless of whether coverage for the same service or support is an optional or limited service under the state plan. Children enrolled in the FAMIS Program are not eligible for all EPSDT treatment services. All requests for authorization for the services described by this medical policy will be reviewed per EPSDT guidelines. These services may be authorized under individual consideration for Medicaid members under the age of 21-years if the services are judged to by medically necessary to correct or ameliorate the member's condition. Department of Medical Assistance Services (DMAS), Supplement B - EPSDT (Early and Periodic Screening, Diagnosis and Treatment) Manual.

References:

Including but not limited to: Specialty Association Guidelines; Government Regulations; Winifred S. Hayes, Inc; UpToDate; Literature Review; Specialty Advisors; National Coverage Determination (NCD); Local Coverage Determination (LCD).

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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Keywords:

Cryoreduction, debulking, surgical 02, 2, pseudomyxoma peritonei, hyperthermic intraperitoneal chemotherapy, ovarian cancer, fallopian tube cancer, primary peritoneal cancer, gastrointestinal stromal tumors, peritoneal mesothelioma, tumor debulking, SHP Cytoreduction Surgery (Tumor Debulking), Tumor Debulking, Cytoreduction Surgery (CRS), Tumor Cytoreductive Surgery, Surgical Cytoreduction