Sentara Health Plans

Medicaid

Intra-arterial (IA) Chemotherapy, Medical 254

Table of Content

Effective Date	12/2008
Next Review Date	1/2026
Coverage Policy	Medical 254
Version	5

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 be 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:

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.

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:

- 2025: January – no changes references updated
- 2024: January
- 2023: February
- 2018: December
- 2017: December
- 2016: June
- 2011: October
- 2010: November

Effective Date:

- December 2008

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.

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:
  - Medicaid
    - 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.

- Service authorization requests must be accompanied by sufficient clinical records to support the request. Clinical records must be signed and dated by the requesting provider withing 60 days of the date of service requested.

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).

(LCD) Implantable Infusion Pump L33461. (2024, 3). Retrieved 1 2025, from CMS Local Coverage Determination (LCD): https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?lcdid=33461&ver=64&bc=0

(NCD) Infusion Pumps 280.14. (2005, 2). Retrieved 1 2025, from CMS: https://www.cms.gov/medicare-coverage-database/view/ncd.aspx?ncdid=223&ncdver=2&keyword=intra-arterial&keywordType=starts&areaId=all&docType=NCA,CAL,NCD,MEDCAC,TA,MCD,6,3,5,1,F,P&contractOption=all&sortBy=relevance&bc=1

(2024). Retrieved 1 2025, from National Comprehensive Cancer Network NCCN: https://www.nccn.org/guidelines/category_1

28th Edition. (2025). Retrieved 1 2025, from MCG: https://careweb.careguidelines.com/ed28/index.html

A meta-analysis of the efficacy of intra-arterial chemotherapy for the management of retinoblastoma patients. (2024, 3). Retrieved 1 2025, from Advances in Clinical and Experimental Medicine: https://advances.umw.edu.pl/en/article/2024/33/3/207/

Current Indications for Intraarterial Chemotherapy in Neurointerventional Surgery. (2022, 12). Retrieved 1 2025, from AHA/ASA Scientific Statements and Guidelines: https://www.ahajournals.org/doi/10.1161/SVIN.122.000425

Intraarterial Melphalan Infusion for Intraocular Retinoblastoma in Children. (2013). Retrieved 1 2025, from Hayes: https://evidence.hayesinc.com/search?q=%257B%2522text%2522:%2522Intraarterial%2522,%2522title%2522:null,%2522termsource%2522:%2522searchbar%2522,%2522page%2522:%257B%2522page%2522:0,%2522size%2522:50%257D,%2522type%2522:%2522all%2522,%2522sources%2522:%25

Provider Manual Title: Practitioner - Appendix D: Service Authorization Information. (Revision Date: 12/2/2022). Retrieved 1 2025, from DMAS: https://vamedicaid.dmas.virginia.gov/sites/default/files/2023-08/Physician-Practitioner%20Manual%20App%20D%20%28Updated%2012.2.22%29_Final.pdf

Keywords:

SHP Medical 139, 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)