BlueCross BlueShield of North Carolina

Evidence Based Guideline

Intrahepatic Arterial Chemotherapy

File Name: intrahepatic_arterial_chemotherapy
Guideline Number: EBG.MED1260
Origination: 11/1999
Last Review: 4/2009
Next Review: 4/2011

Description of Procedure or Service

Intrahepatic arterial **chemotherapy** is a technique for delivering **chemotherapy** to the liver only, rather than the entire body. The procedure is designed for patients who have **metastases** to the liver but not to other organs in the body. There are two techniques for the procedure: 1) threading a catheter into the liver by special x-rays (fluoroscopy); and 2) implanting the catheter into the liver through a surgical incision. In both cases, the catheter is placed into the artery of the liver (**intra-arterial**, **intrahepatic**) and a pump delivers the **chemotherapy** drug (such as 5-FUdr) directly into the liver.

*****Please note that this guideline does not pertain to Chemoembolization of the Hepatic Artery, Transcatheter Approach or Selective Internal Radiation Therapy for Tumors of the Liver.**

Evidence Based Guideline for Intrahepatic Arterial Chemotherapy

Intrahepatic arterial chemotherapy may be appropriate when both of the following criteria are met:

A. **One** of the following conditions is present:
   1. Duke's Class D **colorectal** cancer with **metastases** only in the liver; **OR**
   2. Primary hepatocellular carcinoma

B. The patient meets **one** of the following criteria:
   1. The cancer in the liver is either **unresectable**, **OR**
   2. The patient refuses to undergo surgery to remove the liver cancer.

Medical Evidence regarding Intrahepatic Arterial Chemotherapy indicates it is not recommended in the following situations:

Intrahepatic arterial chemotherapy is not recommended when it is performed for any condition other than the listed indications shown above.

Benefits Application

Please refer to certificate for availability of benefit. This guideline relates only to the services or supplies described herein. Benefits may vary according to benefit design; therefore certificate language should be reviewed before applying the terms of the policy.

Billing/Coding/Physician Documentation Information

This policy may apply to the following codes. Inclusion of a code in this section does not guarantee that it will be reimbursed. For further information on reimbursement guidelines, please see Administrative Policies on the Blue Cross Blue Shield of North Carolina web site at www.bcbsnc.com. They are listed in the Category Search on the Medical Policy search page.

Applicable codes: 36260

Medical Term Definitions

Chemotherapy
refers to the treatment of disease by chemical agents; more commonly refers to the use of chemicals that have a specific toxic effect upon cancerous tissue.

Colorectal
pertaining to the colon and rectum.

Intra-arterial
within the artery.

Intrahepatic
within the liver.

Metastasis
spread of a disease, generally cancer, from the original site to another organ or body part.

Unresectable
cannot be removed by surgery.

Scientific Background and Reference Sources

Medicare Coverage issues Manual, Section 60-14

Medical Policy Advisory Group - 12/99

Specialty Matched Consultant Advisory Panel - 6/2001

Specialty Matched Consultant Advisory Panel - 6/2003

Specialty Matched Consultant Advisory Panel - 4/2005

Specialty Matched Consultant Advisory Panel - 4/2007

Specialty Matched Consultant Advisory Panel - 4/2009

Policy Implementation/Update Information

11/99 Original Policy issued.

12/99 Medical Policy Advisory Group

10/00 System coding changes.

6/01 Specialty Matched Consultant Advisory Panel review. No change to criteria.

6/03 Specialty Matched Consultant Advisory Panel review. No criteria changes.

4/04 Benefits Application and Billing/Coding sections updated for consistency.

11/11/04 Removed CPT codes 37204, 75894, and 75896 from policy as they do not apply to the subject of this policy. Added CPT code 36260 which is the appropriate code for this service.

5/5/05 Specialty Matched Consultant Advisory Panel meeting 4/14/2005. Added in the "Description of Procedure or Service" section; "***Please note that this policy does not pertain to Chemoembolization of the Hepatic Artery, Transcatheter Approach or Selective Internal Radiation Therapy for Tumors of the Liver."** No changes to criteria. References added.

9/18/06 Medical Policy changed to Evidence Based Guideline.

5/21/07 Specialty Matched Consultant Advisory Panel review 4/25/2007. No changes to evidence based guideline. References added.

5/18/09 Specialty Matched Consultant Advisory Panel review 4/21/2009. No changes to guideline. References added. (btw)

Medical policy is not an authorization, certification, explanation of benefits or a contract. Benefits and eligibility are determined before medical guidelines and payment guidelines are applied. Benefits are determined by the group contract and subscriber certificate that is in effect at the time services are rendered. This document is solely provided for informational purposes only and is based on research of current medical literature and review of common medical practices in the treatment and diagnosis of disease. Medical practices and knowledge are constantly changing and BCBSNC reserves the right to review and revise its medical policies periodically.